2025 COMMUNITY HEALTH NEEDS ASSESSMENT

GUIDING YOU TO BETTER
Hannibal Regional

UNITED WAY
Mark Twain Area

HANNIBAL REGIONAL
EDC
ECONOMIC DEVELOPMENT COUNCIL

Public Health
MARION COUNTY
Health Department

Ralls County
Health Department
WE CARE!

Monroe County
HEALTH DEPARTMENT

SHELBY COUNTY
HEALTH DEPARTMENT

Prepared by:
STRONG
CONSULTING

Table of Contents

Executive Summary

The 2025 Community Health Needs Assessment (CHNA) for Hannibal Regional Healthcare System provides a comprehensive analysis of the health status, challenges, and opportunities across Lewis, Marion, Monroe, Pike, Ralls, and Shelby counties in Northeast Missouri. Led through a collaboration between Hannibal Regional, the United Way of the Mark Twain Area, the Hannibal Regional Economic Development Council, and county health departments, this CHNA was conducted in compliance with Section 501(r)(3) of the Patient Protection and Affordable Care Act (ACA). More importantly, it was driven by the shared missions of these organizations to strengthen community well-being, promote health equity, and ensure that every resident has the opportunity to thrive. By combining broad community engagement with a rigorous analysis of primary and secondary data, this assessment not only fulfills regulatory requirements but also catalyzes action to build a healthier, more resilient Northeast Missouri.

Scope and Purpose

The CHNA fulfills federal requirements by:

- Defining the community served by Hannibal Regional Healthcare System and its partners,
- Identifying and prioritizing significant health needs,
- Engaging individuals representing the broad interests of the community, including medically underserved, low-income, and minority populations,
- Documenting this report's findings and making it widely available to the public.

Our goal is not only to comply with IRS regulations, but also to build a foundation for strategic investments that improve the health and quality of life across Northeast Missouri.

Community Engagement and Methodology

Primary data collection was central to this CHNA, ensuring that the authentic voices of community members were captured. Community input was gathered through:

- **Public Survey** (691 responses)
- **Partners Survey** (44 responses)
- **Stakeholder Interviews** (31 participants)

These efforts sought out individuals and organizations representing medically underserved, low-income, minority, and rural populations.

Secondary data from credible sources, including County Health Rankings, the U.S. Census Bureau, and national public health datasets, were used to supplement and validate the primary findings. Together, these data sources offer a robust, multidimensional view of the region’s health landscape.

Community Profile

The combined CHNA region is predominantly rural, with a projected 2024 median age of 41.9 years and a population comprising 90.5% White individuals, along with small but significant minority and Hispanic communities. Economic challenges persist, with a median household income of $61,205, notably below the national average. Housing trends indicate a higher rate of owner-occupied homes compared to national figures, but also highlight concerns regarding housing vacancies and affordability. These socioeconomic factors strongly influence the overall health and well-being of the region.

Major Health Findings

Primary Data Highlights

The voices of residents across all six counties consistently emphasized the following critical health challenges:

- **Mental Health and Substance Use Disorders**: Community members reported high rates of depression, frequent mental distress, loneliness, and concerns about suicide, compounded by limited access to behavioral health services.
- **Chronic Disease Burden**: Diabetes, obesity, coronary heart disease, and cancer were frequently cited as major health concerns.
- **Access to Care**: Barriers to healthcare access, including cost, transportation, insurance gaps, and provider shortages, were noted across all six counties.
- **Social Determinants of Health**: Economic hardship, food insecurity, and lack of transportation were major contributors to poor health outcomes.

Secondary Data Highlights

Secondary data analysis supports these community observations:

- **Premature death rates** in the region are higher than national averages, indicating significant disparities in life expectancy and early mortality.
- **Rates of chronic disease**, particularly diabetes and obesity, are elevated across the CHNA counties.
- **Mental health distress indicators**, such as frequent mental distress days and depression diagnoses, are alarmingly high compared to state and national figures.
- **Social and community conditions** impact health outcomes, including income inequality, educational disparities, and limited access to healthy foods.

Community Conditions

Beyond clinical care, broader community conditions—including economic opportunity, housing stability, transportation access, education quality, and social cohesion—play a pivotal role in health outcomes. Data show:

- Challenges in income equality and educational attainment are associated with poorer health outcomes.
- Access gaps in broadband, childcare, and transportation infrastructure exacerbate health inequities.
- Positive developments in community resiliency initiatives led by local organizations, but a clear need for expanded investment in health promotion and harm reduction services.

These social determinants of health are critical levers for improving health equity across the CHNA region.

Next Steps

Hannibal Regional's 2025 Community Health Needs Assessment (CHNA) represents a thorough, inclusive, and data-driven community health assessment. By emphasizing broad community input, aligning with IRS guidelines, and integrating both qualitative and quantitative evidence, the CHNA lays a strong foundation for an effective Community Health Improvement Plan that drives real, measurable improvements across Northeast Missouri.

The findings will guide Hannibal Regional, in partnership with community stakeholders, to invest strategically in programs and services that are community-centered, equity-focused, and designed to foster healthier, more resilient communities.

SCOPE & PURPOSE

Section 501(r)(3)(A) of the federal Patient Protection and Affordable Care Act (ACA) requires a hospital organization to conduct a community health needs assessment (CHNA) every three years and to adopt an implementation strategy to meet the community health needs identified through the CHNA.
The CHNA must:

- Take into account input from persons who represent the broad interests of the community served by the hospital facility, including those with special knowledge of or expertise in public health, and
- Be made widely available to the public.

The Steps

To conduct a CHNA, a hospital facility must complete the following steps:

1. Define the community it serves.
2. Assess the health needs of that community.
3. In assessing the community's health needs, solicit and take into account input received from persons who represent the broad interests of that community, including those with special knowledge of or expertise in public health.
4. Document the CHNA in a written report (CHNA report) that is adopted for the hospital facility by an authorized body of the hospital facility.
5. Make the CHNA report widely available to the public.

A hospital facility is considered to have conducted a CHNA on the date it has completed all of these steps, including making the CHNA report widely available to the public.

COMMUNITY SERVED

A hospital facility may consider all the relevant facts and circumstances in defining the community it serves. This includes:

- The geographic area served by the hospital facility,
- Target populations served, such as children, women, or the aged, and
- Principal functions, such as a focus on a particular specialty area or targeted disease.

However, a hospital facility may not define its community in a way that excludes medically underserved, low-income, or minority populations who live in the geographic areas from which it draws its patients (unless such populations are not part of the hospital facility's target population or affected by its principal functions) or otherwise should be included based on the method the hospital facility uses to define its community.

Medically underserved populations include populations experiencing health disparities or that are at risk of not receiving adequate medical care because of being uninsured or underinsured, or due to geographic, language, financial, or other barriers. Populations with language barriers include those with limited English proficiency. Medically underserved populations also include those living within a hospital facility's service area but not receiving adequate medical care from the facility because of cost, transportation difficulties, stigma, or other barriers.

Additionally, in determining its patient populations for purposes of defining its community, a hospital facility must take into account all patients without regard to whether (or how much) they or their insurers pay for the care received or whether they are eligible for assistance under the hospital facility's financial assistance policy.

If a hospital facility consists of multiple buildings that operate under a single state license and serve different geographic areas or populations, the community served by the hospital facility is the aggregate of these areas or populations.

THE PROCESS

To assess the health needs of its community, a hospital facility must identify the significant health needs of the community. It must also prioritize those health needs, as well as identify resources potentially available to address them. Resources can include organizations, facilities, and programs in the community, including those of the hospital facility, potentially available to address those health needs.

The health needs of a community include requisites for the improvement or maintenance of health status both in the community at large and in particular parts of the community, such as particular neighborhoods or populations experiencing health disparities. Needs may include, for example, the need to:

- Address financial and other barriers to accessing care,
- Prevent illness,
- Ensure adequate nutrition, or
- Address social, behavioral, and environmental factors that influence health in the community.

A hospital facility may determine whether a health need is significant based on all the facts and circumstances present in the community it serves. Additionally, a hospital facility may use any criteria to prioritize the significant health needs it identifies, including, but not limited to the:

- Burden, scope, severity, or urgency of the health need,
- Estimated feasibility and effectiveness of possible interventions,
- Health disparities associated with the need, or
- Importance the community places on addressing the need.

SOURCES OF INPUT

A hospital must both solicit and take into account input received from all of the following sources in identifying and prioritizing significant health needs and in identifying resources potentially available to address those health needs.

1. At least one state, local, tribal, or regional governmental public health department (or equivalent department or agency), or a State Office of Rural Health described in Section 338J of the Public Health Services Act, with knowledge, information, or expertise relevant to the health needs of the community.
2. Members of medically underserved, low-income, and minority populations in the community served by the hospital facility, or individuals or organizations serving or representing the interests of these populations.
3. Written comments received on the hospital facility's most recently conducted CHNA and most recently adopted implementation strategy

In addition to soliciting input from the three required sources, a hospital facility may solicit and take into account input received from a broad range of persons located in or serving its community. This includes, but is not limited to:

- Health care consumers and consumer advocates
- Nonprofit and community-based organizations
- Academic experts
- Local government officials
- Local school districts
- Health care providers and community health centers
- Health insurance and managed care organizations,
- Private businesses, and
- Labor and workforce representatives.

Although a hospital facility is not required to solicit input from additional persons, it must take into account input received from any person in the form of written comments on the most recently conducted CHNA or most recently adopted implementation strategy.

Documentation of a CHNA

A hospital facility must document its CHNA in a report that is adopted by an authorized body of the hospital facility. The CHNA report must include the following items.

- A definition of the community served by the hospital facility and a description of how the community was determined.
- A description of the process and methods used to conduct the CHNA.
- A description of how the hospital facility solicited and took into account input received from persons who represent the broad interests of the community it serves.
- A prioritized description of the significant health needs of the community identified through the CHNA. This includes a description of the process and criteria used in identifying certain health needs as significant and prioritizing those significant health needs.
- A description of resources potentially available to address the significant health needs identified through the CHNA.
- An evaluation of the impact of any actions that were taken to address the significant health needs identified in the immediately preceding CHNA,

A CHNA report will:

- Describes the data and other information used in the assessment,
- Describes the methods of collecting and analyzing this data and information,
- Identifies any parties with whom the hospital facility collaborated or contracted for assistance in conducting the CHNA.

A hospital facility may rely on (and the CHNA report may describe) external source material in conducting its CHNA. In such cases, the hospital facility may simply cite the source material rather than describe the methods of collecting the data.

Documentation of a CHNA

A hospital facility's CHNA report must describe how the hospital facility took into account input received from persons who represent the broad interests of the community it serves. The CHNA report should:

- Summarize, in general terms, the input provided by such persons,
- Describe how and over what time period such input was provided (whether through meetings, focus groups, interviews, surveys, or written comments and between what approximate dates),
- Provide the names of any organizations providing input and summarizes the nature and extent of the organization's input, and
- Describe the medically underserved, low-income, or minority populations being represented by organizations or individuals that provided input.

However, a CHNA report does not need to name or otherwise individually identify any individuals providing input on the CHNA, including individuals participating in community forums, focus groups, survey samples, or similar groups. If a hospital facility solicits, but cannot obtain, input from a required source representing the broad interests of the community, the hospital facility's CHNA report must describe the hospital facility's efforts to solicit the input from such source.

A hospital facility must make its CHNA report widely available to the public. This must be done by making the CHNA report widely available on a website and by making a paper copy of the CHNA report available for public inspection upon request and without charge at the hospital facility. Prior CHNA reports must remain widely available to the public, both on a website and in paper, until the hospital facility has made two subsequent CHNA reports widely available to the public.

Implementation Strategy

A hospital facility's implementation strategy must be a written plan that, for each significant health need identified, either:

- Describes how the hospital facility plans to address the health need, or
- Identifies the health need as one that the hospital facility does not intend to address and explains why it does not intend to address the health need.

Although an implementation strategy must consider all of the significant health needs identified through a hospital facility's CHNA, it is not limited to considering only those health needs and may describe activities to address health needs that the hospital facility identifies in other ways.

Addressing a significant health need
In describing how a hospital facility plans to address a significant health need identified through the CHNA, the implementation strategy must:

- Describe the actions the hospital facility intends to take to address the health need and the anticipated impact of these actions.
- Identify the resources the hospital facility plans to commit to address the health need, and
- Describe any planned collaboration between the hospital facility and other organizations to address the health need.

Not addressing a significant health need
If the hospital facility does not intend to address a significant health need, I would appreciate it if you could briefly explain its reason for not addressing the health need. Reasons for not addressing a significant health need may include, but are not limited to:

- Resource constraints,
- Other facilities or organizations in the community are addressing the need,
- Relative lack of expertise or competencies to effectively address the need,
- A relatively low priority assigned to the need, and/or
- A lack of identified effective interventions to address the need.

Implementation Strategy

Joint implementation strategies
As with the CHNA report, a hospital may develop an implementation strategy in collaboration with other hospitals or organizations. This includes, but is not limited to, related and unrelated hospital organizations and facilities, for-profit and government hospitals, governmental departments, and nonprofit organizations.

In general, a hospital that collaborates with other facilities or organizations in developing its implementation strategy must still document it in a separate written plan tailored to the particular hospital facility, taking into account its specific resources.

However, a hospital facility that adopts a joint CHNA report may also adopt a joint implementation strategy. With respect to each significant health need identified through the joint CHNA, the joint implementation strategy must either describes how one or more of the collaborating facilities or organizations plan to address the health need, or identify the health need as one the collaborating facilities or organizations do not intend to address. It must also explain why they do not intend to address the health need.

A joint implementation strategy adopted for the hospital facility must also:

- Be clearly identified as applying to the hospital facility,
- Clearly identify the hospital facility's role and responsibilities in taking the actions described in the implementation strategy as well as the resources the hospital facility plans to commit to such actions, and
- Include a summary or other tool that helps the reader easily locate those portions of the joint implementation strategy that relate to the hospital facility.

Adoption of implementation strategy
An authorized body of the hospital facility must adopt the implementation strategy. See the discussion of the Financial Assistance Policy below for the definition of an authorized body.

- This must be done on or before the 15th day of the fifth month after the end of the taxable year in which the hospital facility finishes conducting the CHNA.
- This is the same due date (without extensions) of the Form 990

Methodology

Phase 1

Community Engagement and Data Collection

- Defining the Community
- Community Engagement
- Primary Data Collection
- Secondary Data Collection
- Stakeholder Consultation

Phase 2

Community Priorities and Strategies

- McNellis Compression Planning® Session
- Criteria-Based Health & Need Prioritization
- SWOT+ Analysis and Resource Identification
- Community Health Needs Assessment and Plan Report

Phase 1

Community Engagement and Data Collection

Defining the Community

Define the community served by Hannibal Regional Healthcare System and its partners to include all geographic areas across the six counties, focusing on children, women, older adults, and populations facing health disparities, such as medically underserved, low-income, and minority groups. This definition should also reflect broader economic development and social well-being needs, recognizing the region's diverse challenges and opportunities.

Community Engagement

Engage various stakeholders to meet CHNA requirements and inform the broader community of needs. Include public health departments, community members, representatives of underserved populations, economic development partners, and nonprofits. Gather input from diverse sectors such as healthcare consumers, local businesses, educators, community health centers, nonprofit leaders, and local officials. This inclusive approach ensures CHNA compliance while supporting economic development and community well-being.

Primary Data Collection

Collect firsthand information through both public and partners surveys, interviews, a public meeting, and direct community engagement efforts. Ensure a representative and inclusive process that captures the voices of all community members, particularly those from marginalized groups, to meet both CHNA and broader community development needs.

Secondary Data Collection

Use pre-existing data from publicly available datasets, including government and public sector, nonprofit, economic, education, healthcare, community well-being and social indicators, housing, and others. This data will help build a comprehensive understanding of community health, social trends, and economic conditions.

Stakeholder Consultation

Conduct consultations with key stakeholders, including Hannibal Regional Healthcare System, Marion County Health Department, Hannibal Regional Economic Development Council, and United Way of the Mark Twain Area. These consultations will aim to identify data gaps, align expectations, and ensure that all findings inform both health priorities and community/economic development initiatives.

Phase 2

Community Priorities and Strategies

McNellis Compression Planning® Session

Facilitate a 5-hour Compression Planning® Session with community members to collaboratively identify and prioritize both significant health needs and broader community challenges. This session will help establish a shared vision, determine strategic priorities for health and community well-being, and align efforts across health, social services, and economic development.

Criteria-Based Health & Need Prioritization

Prioritize significant health and community needs using established criteria such as burden, scope, severity, and urgency. Consider health disparities, feasibility of interventions, economic impact, and community input when making these determinations to ensure alignment with the CHNA requirements as well as broader community goals.

SWOT+ Analysis and Resource Identification

Conduct a SWOT+ Analysis to assess the strengths, weaknesses, opportunities, and threats across the health, social, and economic sectors. Identify local resources and partnerships, including community programs, economic initiatives, healthcare facilities, and organizations with aligned missions, that can be leveraged to address these needs.

Community Health Needs Assessment and Plan Report

Develop Comprehensive Community Health Needs Assessment and Plan Reports that document the process, methods, significant health and community needs identified, and the prioritized strategies for addressing these needs. This report will be adopted by the authorized body of the hospital, made publicly available, and also serve as a resource for guiding the strategic work of the United Way and economic development initiatives.

Deliverables

Community Health Needs Assessment

A comprehensive document that identifies and analyzes the key needs, challenges, and resources within a community. It includes data collection, community input, and stakeholder engagement and serves as the foundational tool for Compression Planning.

Compression Planning® Session

A professional facilitation of an in-person 5-hour Compression Planning® Session. Compression Planning is a visual brainstorming process designed to bring out a group's best thinking and energy on a specific issue in an environment of fair play and equal participation, led by a skilled facilitator. Compression Planning helps key leaders leverage their collaborative time to make better decisions faster...which leaves more time for strategic thinking and better results.

Compression Planning® Report

This report captures the unedited version of all ideas, discussions, and brainstorming generated during a Compression Planning session. It is a transparent record of participants' contributions, providing a clear and comprehensive summary of the raw thoughts, potential solutions, and collaborative insights that emerged during the facilitated session. This report ensures that nothing is lost from the group's efforts and provides a foundation for further refinement, prioritization, and strategic planning.

Community Plan

Strategic document that builds on the findings of a Community Health Needs Assessment and Compression Planning Session to establish clear priorities and actionable strategies for addressing identified community needs. The Community Health Improvement Plan serves as a roadmap for coordinated community action, helping guide decision-making and resource allocation to achieve meaningful, positive change.

COLLABORATING PARTNERS

Hannibal Regional

HANNIBAL REGIONAL EDC
ECONOMIC DEVELOPMENT COUNCIL

UNITED WAY
Mark Twain Area

Monroe County
HEALTH DEPARTMENT

MCHD
Public Health
Marion County Health Department

Ralls County
Health Department
WE CARE!

SHELBY COUNTY
HEALTH DEPARTMENT

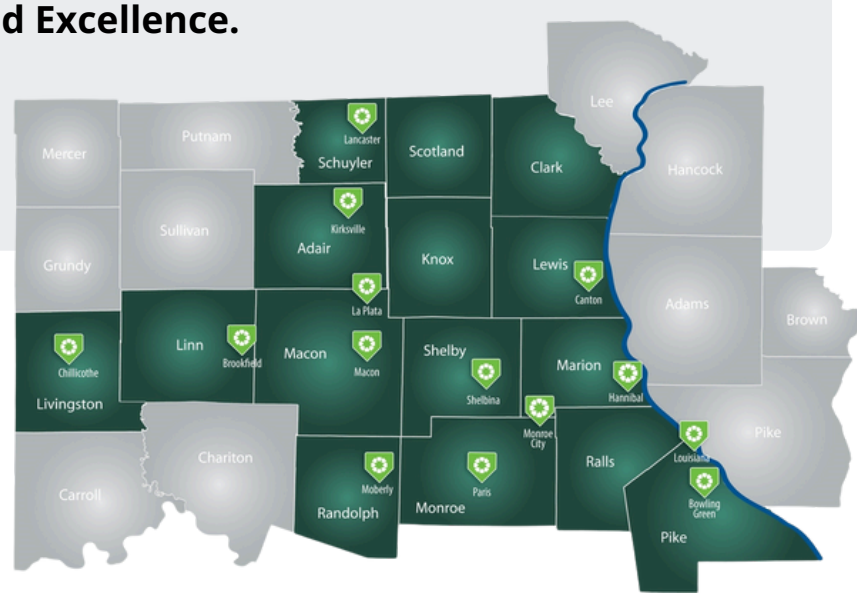
Hannibal Regional

Hannibal Regional Healthcare System (HRHS) serves residents throughout northeast Missouri and west-central Illinois, offering state-of-the-art technology close to home. The system's origins trace back to the early 20th century with the establishment of Levering Hospital in 1903 and St. Elizabeth's Hospital in 1914. These institutions merged in the late 1980s, leading to the opening of the new Hannibal Regional Hospital in 1993 on a 105-acre campus. Today, the campus encompasses Hannibal Regional Hospital, Hannibal Regional Medical Group, Hannibal Regional Foundation, James E. Cary Cancer Center, and the Hannibal Regional Cancer Institute. The HRHS team comprises nearly 1,000 mission-driven professionals committed to providing community-based, contemporary healthcare services.

Mission | **Your Health is Our Mission.**

Values | **Respect, Integrity, Service, and Excellence.**

6000 Hospital Drive, Hannibal, MO 63401
President and CEO: C. Todd Ahrens
www.hannibalregional.org



Hannibal Regional Hospital Services:

- Adult Psychiatry
- Bariatrics
- Cancer Care
- Emergency Department
- Gastroenterology
- Heart Center
- Imaging/Radiology
- Inpatient Rehabilitation
- Laboratory
- Orthopedics
- Sleep Medicine
- Surgery
- Weight Management Solutions
- Wound Care Center
- Home Health Services
- Hospitalist Services
- Lymphedema Therapy
- Nutrition Services
- Pediatric Therapy
- Physical Therapy
- Speech Therapy
- Spine Center
- Travel Medicine
- Telehealth
- Vascular Surgery

Hannibal Regional Medical Group (HRMG) Services:

- Audiology
- Cardiology
- Diabetes Education
- Endocrinology
- Family Practice
- Internal Medicine
- Neurology
- OB/GYN
- Occupational Medicine
- Otolaryngology (ENT)
- Pain Management
- Pediatrics
- Plastic Surgery
- Podiatry
- Pulmonology
- Rheumatology
- Urology

Additional Services:

- Auxiliary
- Chris Coons Women's Care Center
- Diabetes Center
- Hannibal Children's Center
- Hannibal Regional Foundation
- James E. Cary Cancer Center
- Pharmacy

Express Care Clinics:

- Express Care at Hannibal Regional
- Express Care at Walmart
- Urgent Care in Bowling Green

UNITED WAY
Mark Twain Area

United Way of the Mark Twain Area is a local, independent nonprofit serving the communities of Lewis, Marion, Monroe, Ralls, and Shelby counties in Northeast Missouri. For over 80 years, United Way has been dedicated to improving lives by mobilizing the caring power of the community to address its most pressing needs. Through collaboration, strategic investments, and innovative programs, United Way supports a strong network of local nonprofits and community partners focused on health, education, financial stability, and crisis response. Every dollar raised stays local—building a stronger, more resilient region for all.

Mission l To increase the capacity of people to care for one another.

Vision l To empower all individuals to achieve their potential by providing them the support they need..

3062 Highway 61 North, Hannibal, MO 63401
573-221-2761
Executive Director: Denise Damron
www.unitedwaymta.org

Core Focus Areas:

- Healthy Community: Improving health and well-being for all.
- Youth Opportunity: Helping young people realize their full potential.
- Financial Security: Building financial stability and strength.
- Community Resiliency: Addressing urgent needs today for a better tomorrow.

Strategic Priorities

- Supporting Critical Services: Ensuring access to food, shelter, safety, and health resources.
- Providing Opportunities for Upward Mobility: Promoting self-sufficiency through education, mentoring, and skill development.

Community Impact Program

United Way partners with local nonprofits each year through its Community Impact Program. Participating agencies receive monthly funding, volunteer support, marketing assistance, and training opportunities.
Community Impact Agencies:

- AVENUES
- Birthday Blessings
- CHADS Coalition for Mental Health
- CHART Teen Task Force
- Coyote Hill
- Douglass Community Services
- Hannibal Free Clinic
- Hannibal Parents as Teachers
- Harvest Outreach Ministries: Loaves & Fishes
- Hannibal Alliance for Youth Success (HAYS)
- Heartland Resources
- Learning Opportunities/Quality Works
- Monroe City Food Pantry
- Northeast Community Action Corporation (NECAC)
- The Salvation Army
- Shelby County Cares
- The Child Advocacy Center of Northeast Missouri
- YMCA of Hannibal

Special Initiatives:

- Community Help Line and Community Resource Directory: Connect community members to the help they need.
- Reaching Independence through Support and Education (RISE): A 17-week program with weekly classes and one-on-one mentoring to empower individuals who are struggling to become self-reliant.
- Hogs for Hunger: Facilitate donations of livestock to local food pantries and senior centers, covering processing costs.
- MyFreeTaxes: Offers free online tax filing for households with an annual income under $73,000.
- Tri-County Alliance for Unmet Needs: Provides assistance when other resources are unavailable.
- Northeast Missouri Unmet Needs Committee: Assists with long-term disaster recovery efforts after disasters.
- 2-1-1: A free, confidential helpline connecting individuals to health and human services.

Established in 1984, the Hannibal Regional Economic Development Council (HREDC) is a nonprofit, public-private partnership dedicated to promoting growth and investment in Hannibal, Marion County, and Ralls County. HREDC serves as a central resource for business expansion, recruitment, and entrepreneurial development, aiming to enhance the quality of life for residents by fostering economic opportunities. Through collaboration with local governments, businesses, and organizations, HREDC provides assistance to new and existing businesses to help them sustain, grow, and excel.

Mission l To provide assistance to new and existing businesses in the Hannibal region that will help them sustain, grow, and excel.

Vision l Position Hannibal Regional Economic Development Council as the premier choice for economic development in the Midwest.

3817 McMasters Avenue, Suite D,
Hannibal, MO 63401
573-221-1033
Executive Director: Maria Kuhns
www.hredc.com

Service Area

- Hannibal
- Palmyra
- New London
- Marion and Ralls Counties in Northeast Missouri

Strategic Focus Areas

- Business Expansion and Attraction: Facilitating growth of existing businesses and attracting new enterprises to the region.
- Entrepreneurial Development: Supporting startups and small businesses through resources and counseling.
- Workforce Development: Collaborating with partners to enhance workforce readiness and address labor needs.
- Infrastructure Enhancement: Promoting improvements in transportation and industrial site readiness.
- Marketing and Outreach: Amplifying the region's opportunities to internal and external stakeholders.
- hredc.com

Key Programs and Resources

- Missouri Small Business Development Center (SBDC) at HREDC: Offers confidential, one-on-one counseling and training events on various business topics to assist businesses at all stages.
- Ignite Program: An entrepreneurial ecosystem initiative providing networking events, mentorship, and support for local entrepreneurs.
- Site Selector Toolkit: Provides comprehensive data on available buildings and sites, workforce statistics, transportation, incentives, and more to assist businesses considering the Hannibal region.
- Marion-Ralls Regional Port Authority: Collaborates with HREDC to promote transportation, logistics, and revitalization efforts to stimulate economic growth.

The Marion County Health Department is dedicated to safeguarding and enhancing the health of Marion County residents. Through comprehensive assessments, policy development, and prioritization of health initiatives, the department ensures that public health needs are effectively addressed. Many services are available to all residents, regardless of financial status, with some offered free of charge and others based on service costs.

Mission l To protect and promote the health of Marion County residents by assessing health status and needs, developing policies and priorities, and ensuring that public health needs are met.

Vision l To become a county of healthy people living in a healthy environment.

3105 Palmyra Road,
Hannibal, MO 63401
573-221-1166
Administrator: Craig Parsons
www.marioncountyhd.org

Strategic Focus Areas

- **Women, Infants, and Children (WIC):** nutrition education, supplemental foods, health screenings, breastfeeding support, and referrals for pregnant women, new mothers, and children 0-5 years.
- **Immunizations:** vaccinations for all ages, adhering to CDC and ACIP guidelines. Vaccines are available through private insurance, Medicare, Medicaid, and programs like VFC and 317 for eligible individuals.
- **Vital Records:** certified copies of birth and death certificates for events occurring in Missouri. Proper identification is required, and fees apply.
- **Maternal & Child Health:** Focuses on reducing youth suicide rates, obesity, and smoking among adolescents and women by promoting supportive environments and mental wellness resources.
- **Environmental Health**: inspects food service establishments, lodging, and daycare facilities; oversees wastewater systems; and provides education on lead hazards, mold, radon, and rabies.
- **Communicable Disease Control:** Monitors and investigates reportable diseases per state guidelines to prevent and control outbreaks.
- **Emergency Preparedness:** Develops and disseminates information on preparedness for natural disasters such as floods, tornadoes, and winter storms.
- **School Health Services**: Collaborates with schools to provide consultations and health screenings (vision, hearing, scoliosis) and supports school nurses in managing student health concerns.
- **Health Education:** tailored health education programs for businesses, community groups, schools, and other organizations.
- **Tuberculosis Program:** TB skin testing and treatment for diagnosed cases in collaboration with the Missouri Department of Health.
- **Sexually Transmitted Infections (STIs):** Offers confidential consultations, testing for STIs including HIV and syphilis, and collaborates with healthcare providers to ensure appropriate treatment.
- **Pregnancy Testing:** Available at a nominal fee, with services provided to all individuals.
- **Childhood Lead Screening:** Conducts blood lead level testing for children aged 6 months to 6 years to identify and manage lead exposure risks.
- **Office Visits:** blood pressure monitoring and other health services under physician guidance or order.
- **First Aid/CPR Classes**
- **Community Engagement:** The department actively participates in the Wellness Coalition and collaborates with community organizations to promote health Marion County.

Monroe County
HEALTH DEPARTMENT

The Monroe County Health Department is dedicated to ensuring the health and well-being of residents in Paris, Monroe City, Holliday, Madison, Stoutsville, Granville, Duncan's Bridge, Santa Fe, Florida, and Goss, Missouri. By providing comprehensive healthcare and environmental services, the department aims to foster a healthier community through accessible and high-quality programs.

Mission l To assure that the citizens of Monroe County have the opportunity to receive the highest quality of healthcare through the development of programs that focus on citizens' needs.

Vision l Monroe County will become a healthier environment for family living.

Core Values l The Monroe County Health Department is a responsible and responsive organization of inspired employees committed to continuous improvements in the health status of our population through partnerships with the Missouri Department of Health and Senior Services, local physicians, and Monroe County residents. Our first responsibility is to our county residents.

310 North Market Street, Paris, MO 65275
660-327-4653 or 660-327-4259
Administrator: Paula Delaney
www.monroecountyhealth.com

Public Health Services

- **Testing & Immunizations:** Provides various immunization services; contact the department for more information.
- **Flu Shots:** Seasonal influenza vaccinations are available.
- **WIC Program:** Nutrition education and food supplements for pregnant or breastfeeding women, infants, and children up to five years old.
- **School Health:** Health services and screenings in collaboration with local schools.
- **Child Care Health Consultation Program:** Health guidance for child care providers.
- **Car Seat Program:** Promotes proper installation and use of car seats by trained technicians.
- **Communicable Diseases:** Monitoring and management of reportable diseases.
- **Blood Pressure & Blood Sugar Checks:** Routine health screenings.
- **Venipuncture:** Blood draw services.
- **STD/HIV Testing:** Confidential testing services.
- **Day Care Nurse Consultant:** Health consultations for daycare providers.
- **Lead Screenings:** Testing for lead exposure in children.
- **Pregnancy Testing:** Available services for pregnancy confirmation.
- **Equipment Loan Program:** Provides medical equipment such as wheelchairs and walkers.

Environmental Health Services

- **Food Establishment Inspections:** Regular inspections of food service establishments, including schools and senior centers.
- **Lodging Establishment Inspections:** Ensures sanitary conditions in lodging facilities.
- **Wastewater & Septic System Inspections:** A permit fee of $150.00 applies for permitting and inspecting septic systems.

The Ralls County Health Department is committed to providing exceptional public health services to the residents of Ralls County, Missouri. Through community partnerships, needs assessment, targeted interventions, and health education, the department strives to enhance the well-being of the community. Services are funded through county, state, and federal sources, as well as Medicare, Medicaid, private insurance, and private pay. All services are provided on a non-discriminatory basis.

Mission l To provide exceptional public health services to the Ralls County community by improving community partnerships, identifying needs, implementing interventions, and providing education.

405 West First Street, PO Box 434,
New London, MO 63459
573-985-7121
Administrator: Maekayla Wiler, BSN, RN
www.rallscountyhealth.org

Public Health Services

- **Immunizations:** Childhood immunizations for uninsured, underinsured, and Medicaid-eligible children; some adult vaccines available.
- **Walk-In Services:** Including glucose (blood sugar), cholesterol, hemoglobin (iron), blood pressure, pregnancy testing, lead testing, STD testing, and Hepatitis C testing.
- **Health Screenings:** TB testing (available Mondays and Tuesdays), PT/INRs, nail care (some services require a physician's order).
- **Health Education & Counseling:** Information on diabetes, communicable diseases, nutrition, and more.
- **CPR & First Aid Training:** Heart Save CPR, AED training, BLS for healthcare providers.
- **Car Seat Safety & Safe Sleep Programs:** Education and resources for child safety.
- **Durable Medical Equipment Lending:** Availability of walkers, crutches, bedside commodes, shower chairs, and other equipment.
- **Vital Records:** Certified copies of Missouri birth (post-1920) and death (post-1980) certificates.
- **Bioterrorism Threat & Event Response:** Preparedness and response planning for potential bioterrorism events.

Environmental Services

- **Food Safety Inspections:** Regular inspections of food establishments to ensure compliance with health regulations.
- **Temporary Food Stand Permits:** New fee schedule effective January 1, 2024.
- **Environmental Health Assessments:** Monitoring and management of environmental health concerns.

Women, Infants, and Children (WIC) Program

Provides nutrition education, supplemental foods, and support for pregnant women, new mothers, and young children.

SHELBY COUNTY
HEALTH DEPARTMENT

The Shelby County Health Department is dedicated to promoting and maintaining a healthy lifestyle and environment for all residents. By providing core public health services and striving to ensure accessibility to personal health services within available resources, the department plays a vital role in the community's well-being.

Mission l To promote and help maintain a healthy lifestyle and environment, provide core public health services, and strive to assure accessibility of personal health services for all within available resources.

Vision l Shelby County will be a community of safe, healthy, knowledgeable individuals free to live their lives and pursue their dreams.

700 E. Main Street, Shelbyville, MO 63469
573-633-2353
Administrator: Audrey Gough, RN
www.shelbycountyhealth.com

Public Health Services

- **Disease/Epidemiology:** Monitoring and prevention of communicable diseases, health education, and policy development to improve population health.
- **Emergency Preparedness:** Planning and response coordination for public health emergencies.
- **Immunizations:** Vaccinations for children and adults to prevent various diseases.
- **Walk-In Services:** Accessible health services without the need for an appointment.
- **Vital Records:** Issuance of certified birth and death certificates for events occurring in Missouri.

Family Health Services

- **WIC (Women, Infants, and Children):** A supplemental food and educational program assisting low-income families, including pregnant, breastfeeding, and postpartum women, as well as infants and children up to age five.
- **Breast Pump Rentals:** Providing breast pumps to support breastfeeding mothers.
- **Car Seat Program:** Education and resources to ensure the safe transportation of children.
- **Home Health Services:** In partnership with Lewis County Home Health Agency, offering skilled nursing, physical therapy, and personal care services to homebound individuals in Shelby County.

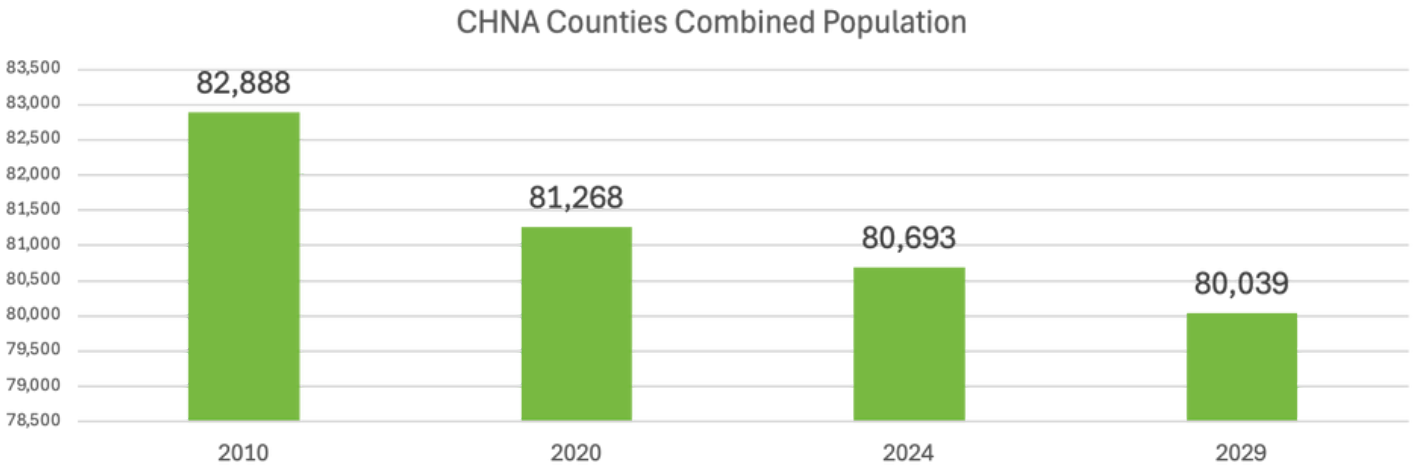
Environmental Services

- **Inspection Reports:** Conducting inspections of local businesses to ensure compliance with health and safety standards.

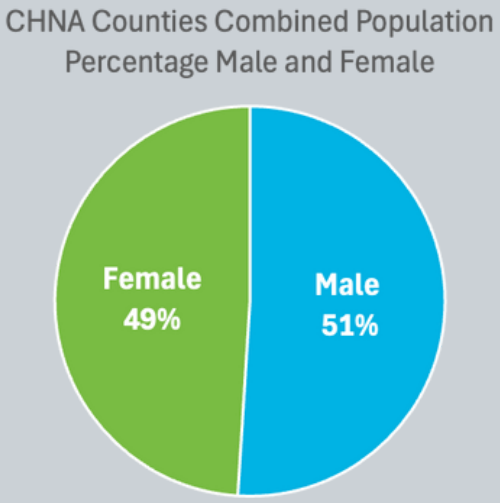
COMBINED COUNTIES SNAPSHOT

Combined Counties Snapshot

This Community Health Needs Assessment encompasses the Northeast Missouri counties of Lewis, Marion, Monroe, Pike, Ralls, and Shelby, all of which are served by Hannibal Regional Hospital. The following pages reflect combined data from these counties.



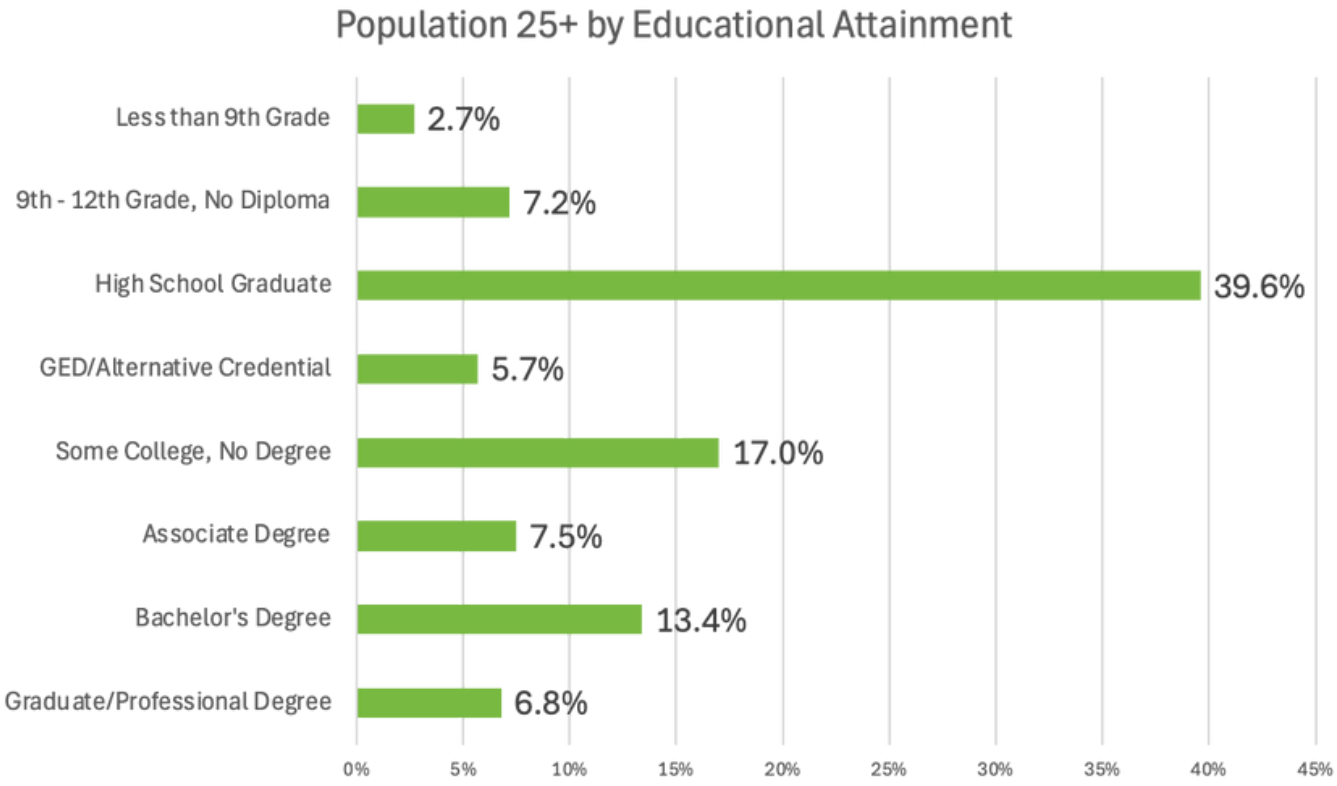
2024 Population by Race/Ethnicity	Percentage
White	90.5%
Black	3.5%
American Indian	0.3%
Asian	0.3%
Pacific Islander	0.0%
Some Other Race	0.7%
Two or More Races	4.6%
Hispanic Origin	1.8%

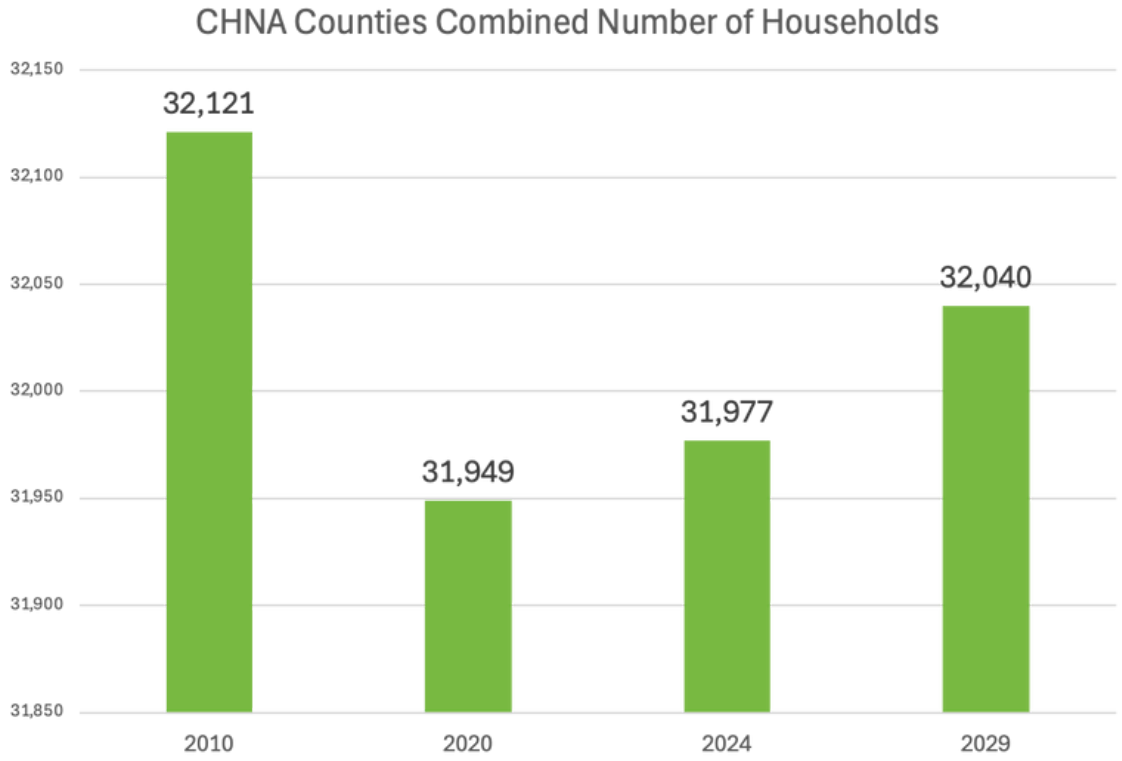


Year	Median Age
2020	41.6 years
2024	41.9 years

Source: Esri forecasts for 2024. U.S. Census Bureau decennial Census data.

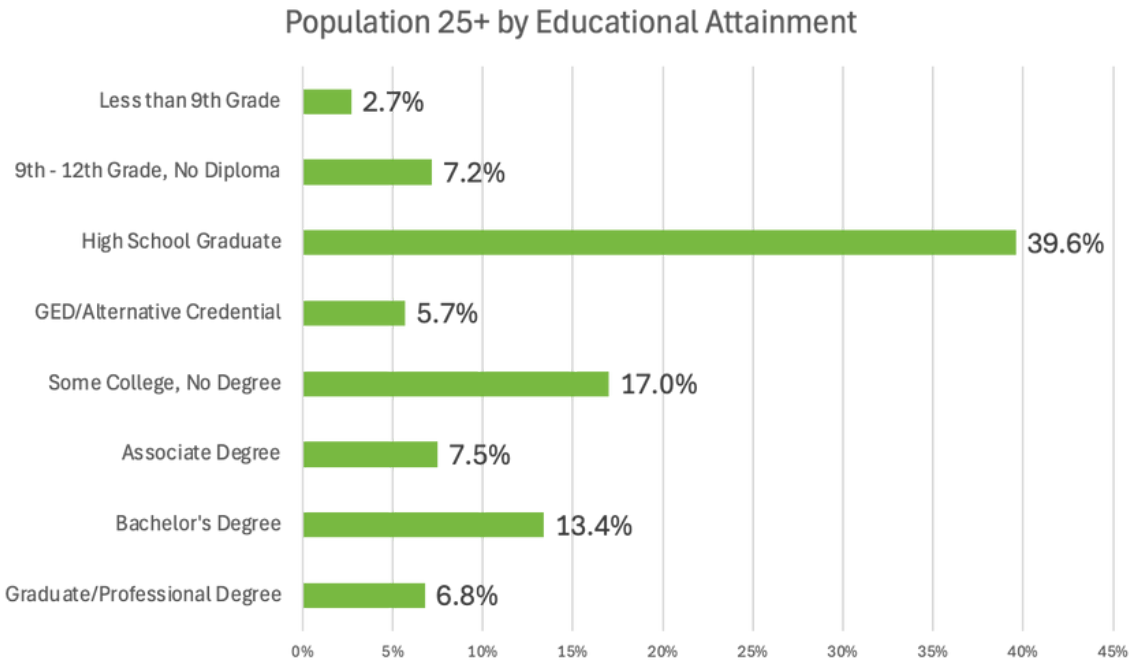
Combined Counties Snapshot

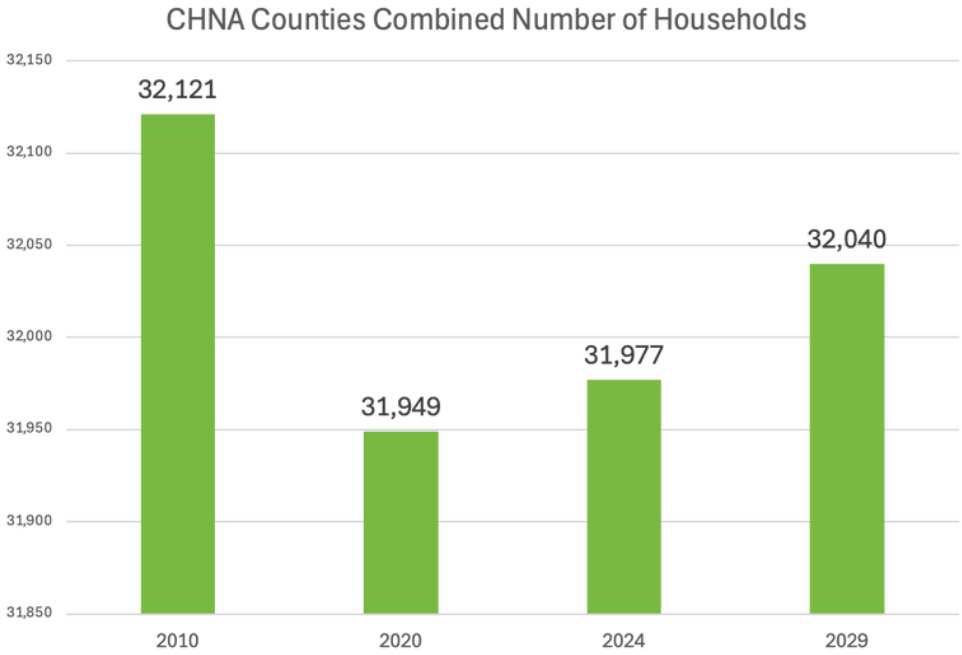


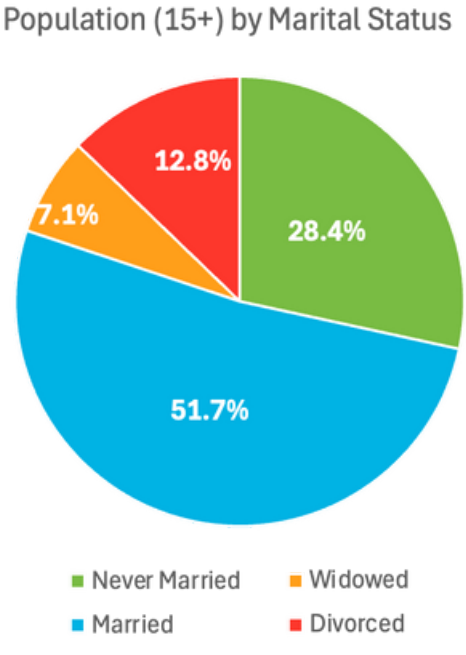


Source: Esri forecasts for 2024. U.S. Census Bureau decennial Census data.

Combined Counties Snapshot







Source: Esri forecasts for 2024. U.S. Census Bureau decennial Census data.

Households by Income

The current median household income in the area is $61,205, compared to $79,068 for all U.S. households. Median household income is projected to be $69,965 in five years, compared to $91,442 for all U.S. households.

The current average household income in this area is $78,153, compared to $113,185 for all U.S. households. The average household income is projected to be $88,548 in five years, compared to $130,581 for all U.S. households.

The area's current per capita income is $31,017, compared to the U.S. per capita income of $43,829. The per capita income is projected to be $35,493 in five years, compared to $51,203 for all U.S. households.

Median Household Income	
2024 Median Household Income	$61,205
2029 Median Household Income	$69,965
2024-2029 Annual Rate	2.71%
Average Household Income	
2024 Average Household Income	$78,153
2029 Average Household Income	$88,548
2024-2029 Annual Rate	2.53%
Per Capita Income	
2024 Per Capita Income	$31,017
2029 Per Capita Income	$35,493
2024-2029 Annual Rate	2.73%

Source: Esri forecasts for 2024. U.S. Census Bureau decennial Census data.

Housing

Currently, 62.1% of the 37,370 housing units in the CHNA area are owner-occupied, 23.5% are renter-occupied, and 14.4% are vacant. In the U.S., 57.9% of the housing units in the area are owner-occupied, 32.1% are renter-occupied, and 10.0% are vacant.

In 2020, there were 37,206 housing units in the CHNA area, and 14.1% were vacant. The annual rate of change in housing units since 2020 is 0.10%.

The median home value in the CHNA area is $168,418, compared to $355,577 in the U.S. In five years, the median value is projected to change by 1.54% annually to $181,826.

	CHNA Region 2024	United States
Owner-occupied	62.1%	57.9%
Renter-occupied	23.5%	32.1%
Vacant	14.4%	10%
Total	37,370	

	CHNA Region	United States
Median Home Value	$168,418	$355,577
Projected 5 Yr Change	1.54% = $181,26	

Source: Esri forecasts for 2024. U.S. Census Bureau decennial Census data.

Population Health and Well-Being and Community Conditions

Population Health and Well-Being

Population health and well-being are something we create as a society, not something an individual can attain in a clinic or be responsible for alone. Health is more than being free from disease and pain; health is the ability to thrive. Well-being encompasses both the quality of life and the ability of individuals and communities to contribute to the world. Population health involves optimal physical, mental, spiritual, and social well-being.

Community Conditions

Community conditions include the social and economic factors, physical environment, and health infrastructure in which people are born, live, learn, work, play, worship, and age. These conditions are also referred to as the social determinants of health.

County	*Population Health and Well-Being	*Community Conditions
Lewis	Same	Slightly worse
Marion	Same	Slightly better
Monroe	Same	Same
Pike	Same	Slightly worse
Ralls	Same	Same
Shelby	Slightly better	Slightly better

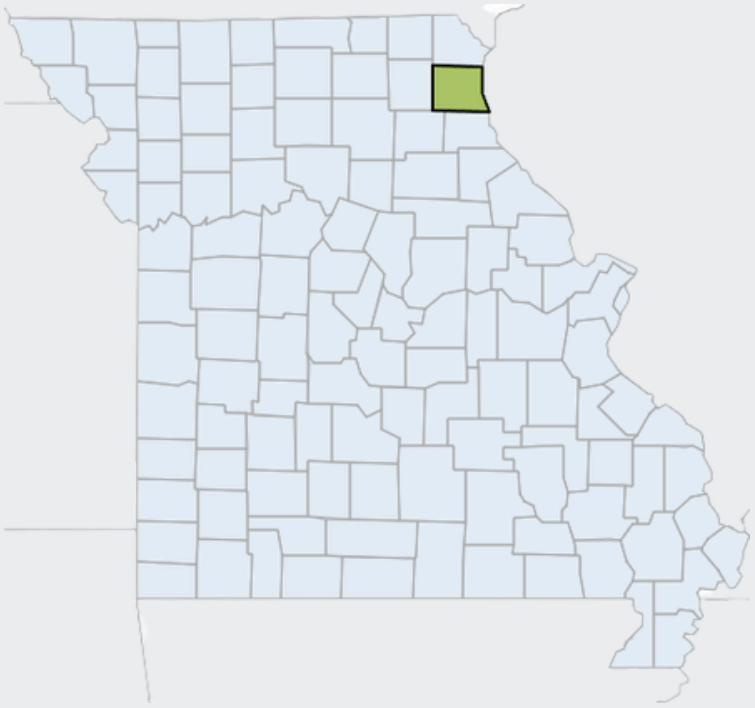
*As compared to the average county in Missouri.

Source: County Health Rankings & Roadmaps 2025 Annual Data Release

COUNTY SNAPSHOTS

Lewis County

Total Population	9,870
Households	3,723
Families	2,379
Average Household Size	2.39
Owner-Occupied Housing Units	2,756
Renter-Occupied Housing Units	967
Median Age	39.5



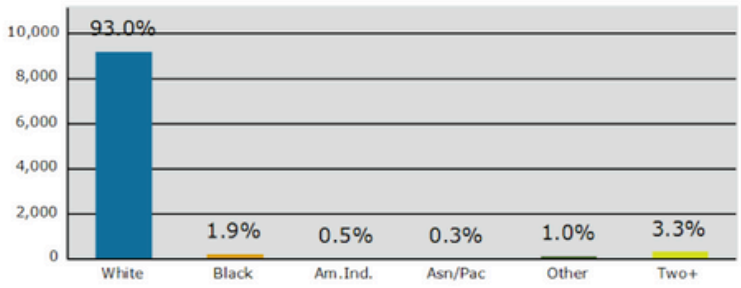
Source: Esri forecasts for 2024 and 2029. U.S. Census Bureau 2000 and 2010 decennial Census data converted by Esri into 2020 geography.

Community	2025 Population	2020 Population	Change	Type	Density
Canton	2712	2772	-0.4%	City	1187
La Grange	787	826	-1.0%	City	506
La Belle	635	664	-0.9%	City	934
Lewistown	497	519	-0.8%	Town	992
Ewing	383	400	-0.8%	City	614
Monticello	102	106	-1.0%	Village	391
Williamstown	50	84	6.4%	CDP	185

Sources: US Census: 2024 Missouri Place Gazetteer Files; City and Town Population Totals: 2020-2023

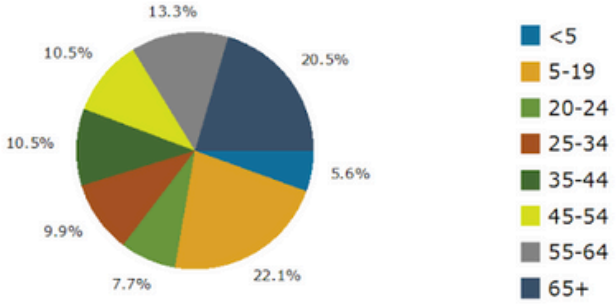
Lewis County

2024 Population by Race

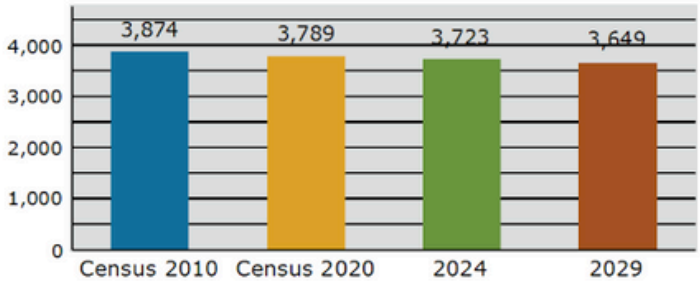


2024 Percent Hispanic Origin:1.8%

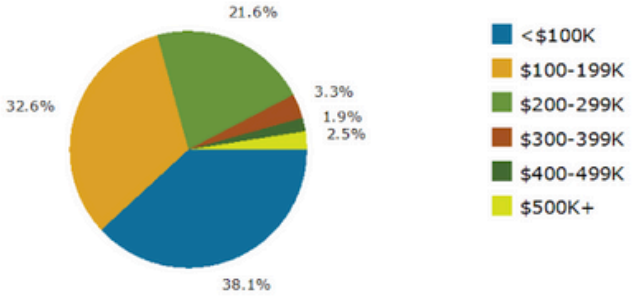
2024 Population by Age



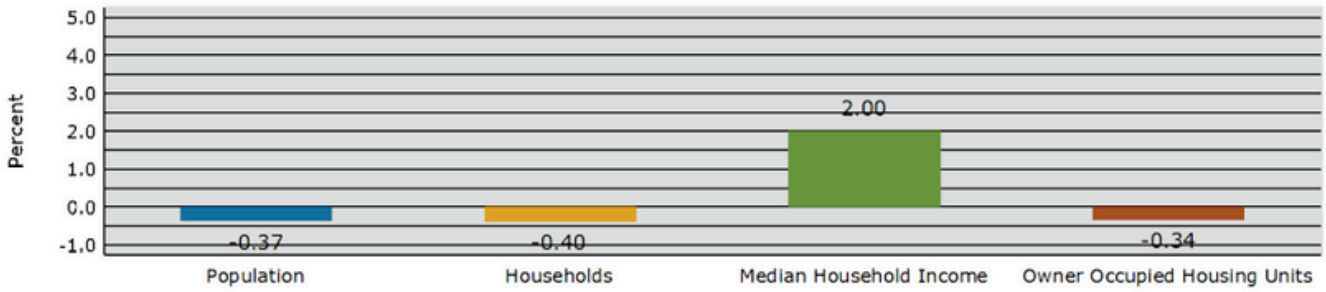
Households



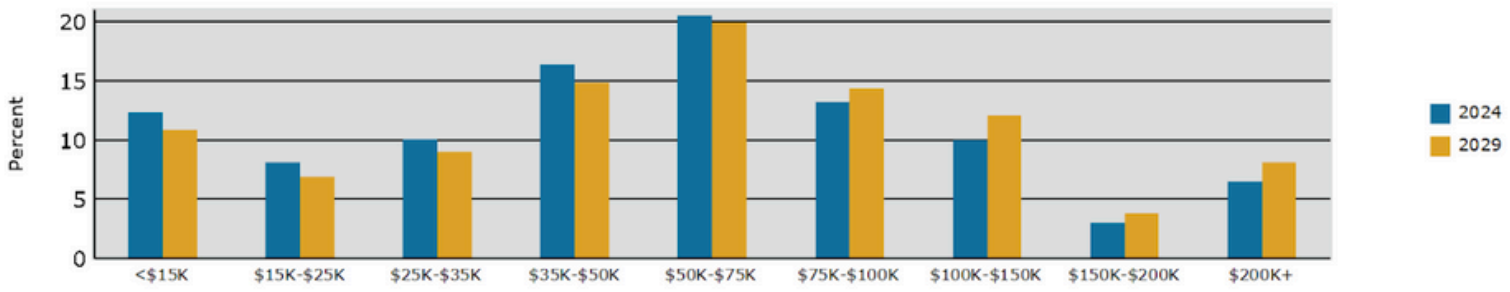
2024 Home Value



2024-2029 Annual Growth Rate



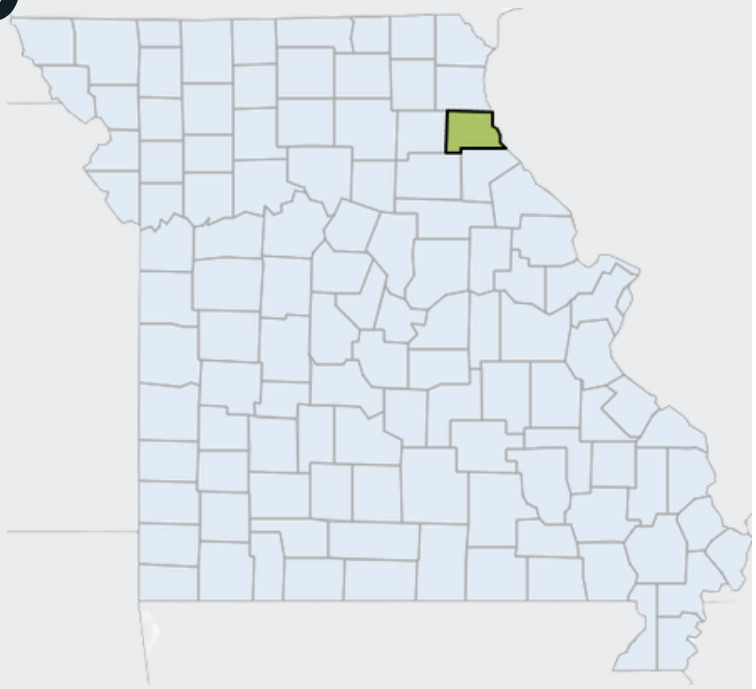
Household Income



Source: Esri forecasts for 2024 and 2029. U.S. Census Bureau 2000 and 2010 decennial Census data converted by Esri into 2020 geography.

Marion County

Total Population	28,394
Households	11,540
Families	7,278
Average Household Size	2.36
Owner-Occupied Housing Units	7,566
Renter-Occupied Housing Units	3,974
Median Age	40.6



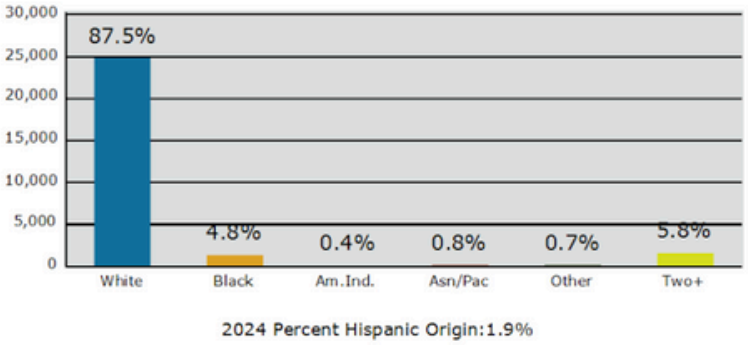
Source: Esri forecasts for 2024 and 2029. U.S. Census Bureau 2000 and 2010 decennial Census data converted by Esri into 2020 geography.

Community	2025 Population	2020 Population	Change	Type	Density
Hannibal	16,684	17,069	-0.46%	City	1,043
Palmyra	3,588	3,618	-0.17%	City	1,156
Philadelphia	378	186	7.39%	CDP	499
Rensselaer	253	250	0.40%	Village	129
Sundown	199	106	6.99%	CDP	136
Taylor Township	141	140	0%	Township	8

Sources: US Census: 2024 Missouri Place Gazetteer Files; City and Town Population Totals: 2020-2023

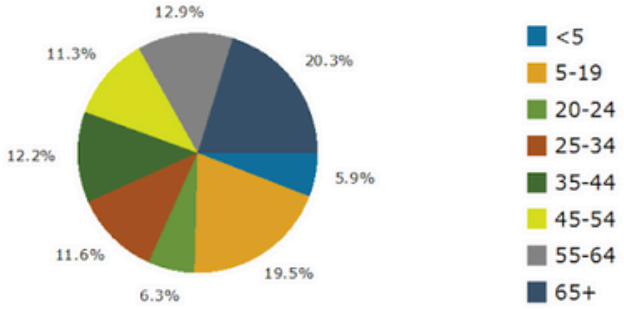
Marion County

2024 Population by Race

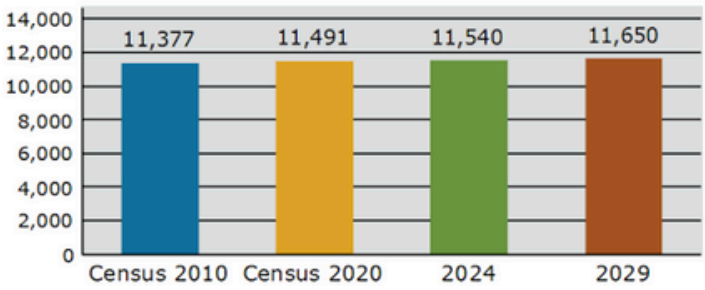


2024 Percent Hispanic Origin:1.9%

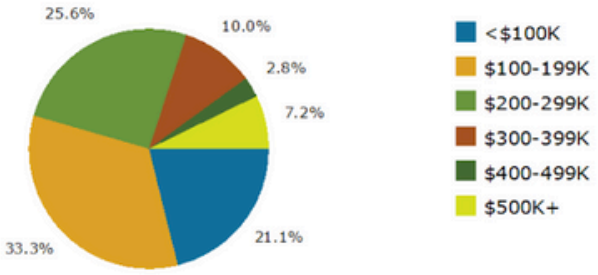
2024 Population by Age



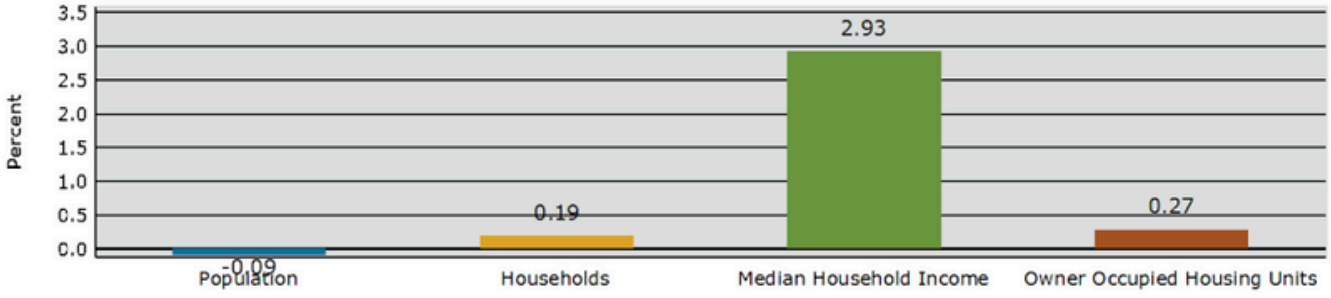
Households



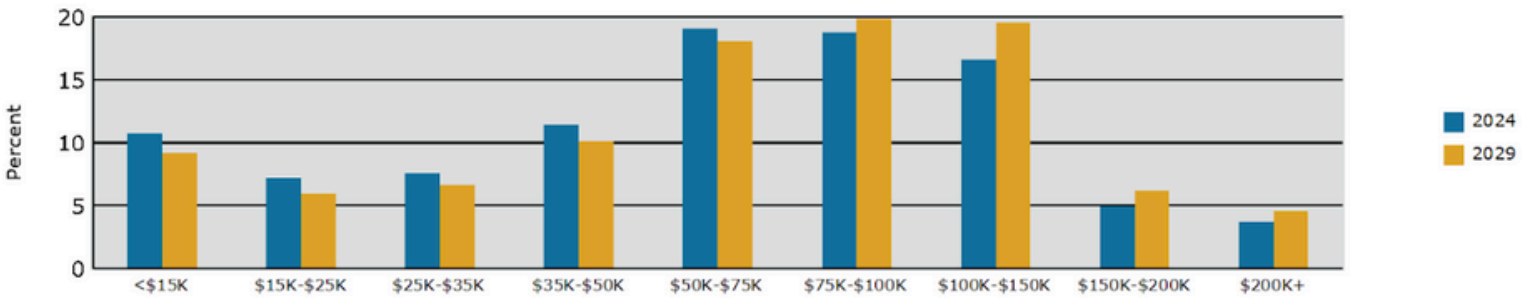
2024 Home Value



2024-2029 Annual Growth Rate



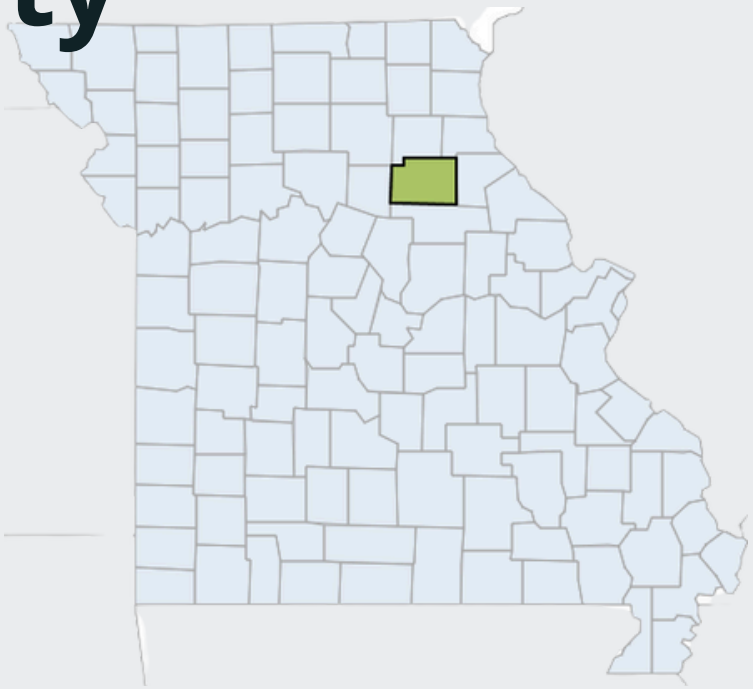
Household Income



Source: Esri forecasts for 2024 and 2029. U.S. Census Bureau 2000 and 2010 decennial Census data converted by Esri into 2020 geography.

Monroe County

Total Population	8,592
Households	3,568
Families	2,345
Average Household Size	2.37
Owner-Occupied Housing Units	2,784
Renter-Occupied Housing Units	784
Median Age	45.7



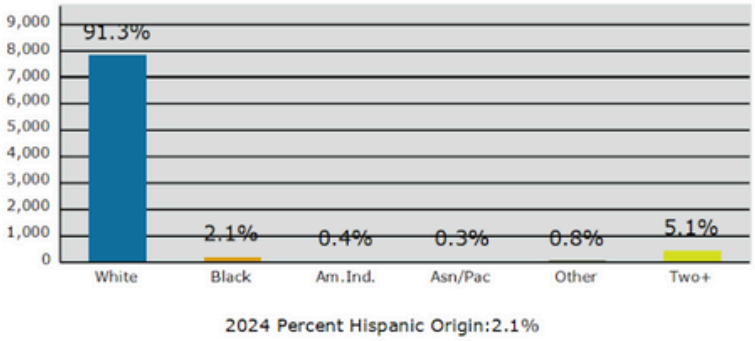
Source: Esri forecasts for 2024 and 2029. U.S. Census Bureau 2000 and 2010 decennial Census data converted by Esri into 2020 geography.

Community	2025 Population	2020 Population	Change	Type	Density
Monroe City	2,653	2,657	-0.04%	City	879
Paris	1,152	1,154	0%	City	912
Madison Township	598	603	-0.50%	Township	17
Madison	520	520	0%	City	1,161
Madison Township	419	421	-0.48%	Township	11
Madison Township	247	247	0.41%	Township	6
Holliday	114	114	0%	Village	437
Middle Grove	60	37	7.14%	CDP	108
Stoutsville	37	37	0%	Village	45

Sources: US Census: 2024 Missouri Place Gazetteer Files; City and Town Population Totals: 2020-2023

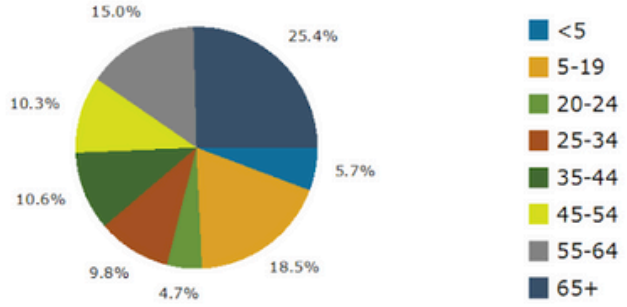
Monroe County

2024 Population by Race

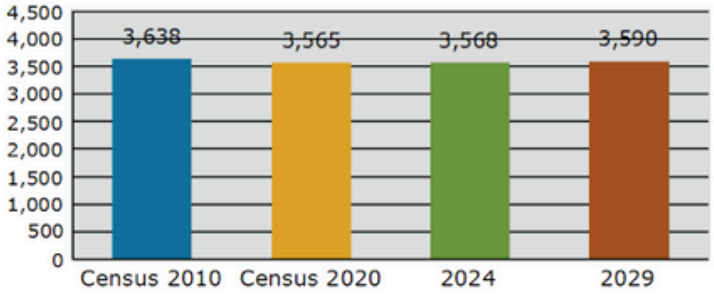


2024 Percent Hispanic Origin:2.1%

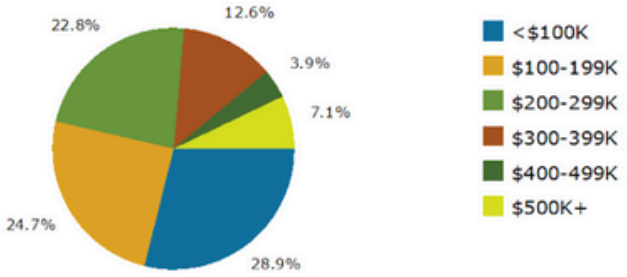
2024 Population by Age



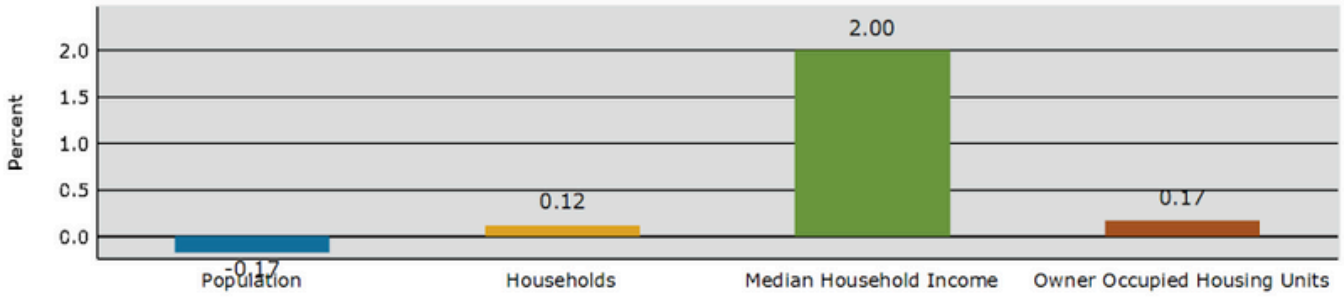
Households



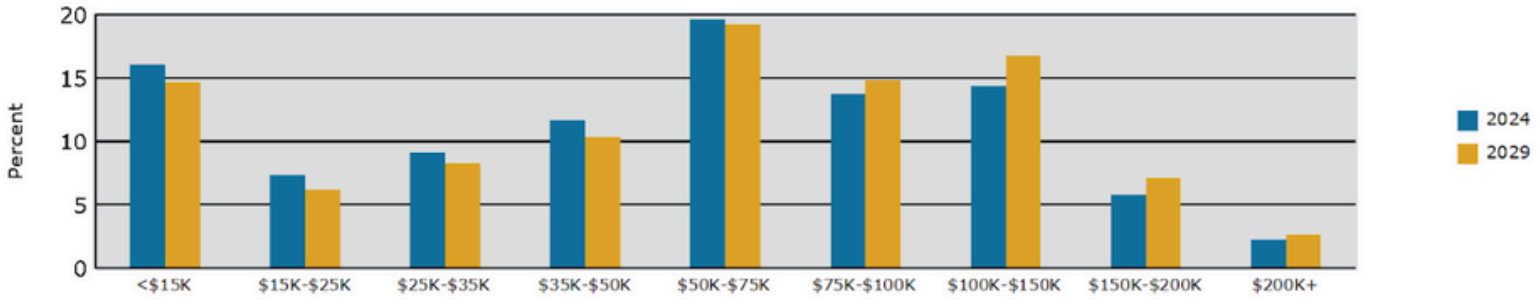
2024 Home Value



2024-2029 Annual Growth Rate



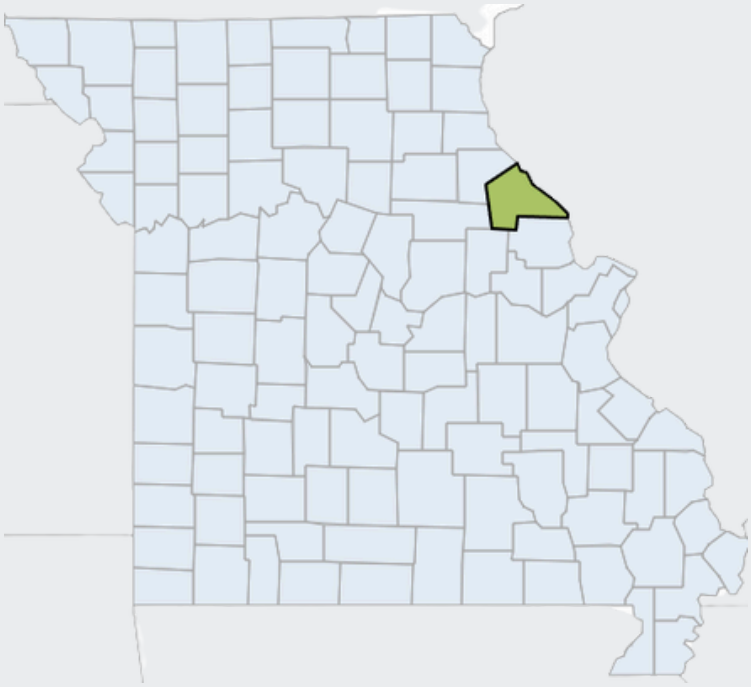
Household Income



Source: Esri forecasts for 2024 and 2029. U.S. Census Bureau 2000 and 2010 decennial Census data converted by Esri into 2020 geography.

Pike County

Total Population	17,521
Households	6,544
Families	4,287
Average Household Size	2.46
Owner-Occupied Housing Units	4,737
Renter-Occupied Housing Units	1,807
Median Age	41.1



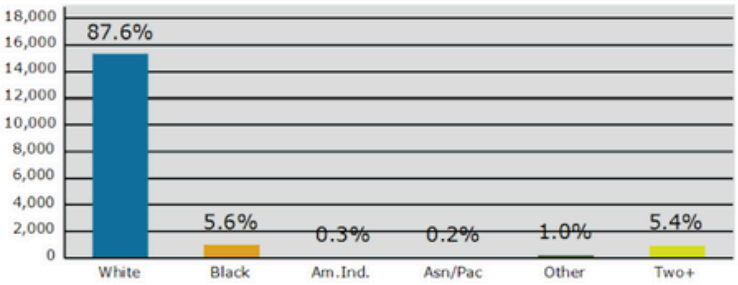
Source: Esri forecasts for 2024 and 2029. U.S. Census Bureau 2000 and 2010 decennial Census data converted by Esri into 2020 geography.

Community	2025 Population	2020 Population	Change	Type	Density
Bowling Green	4,565	4,004	2.52%	City	1,698
Louisiana	3,276	3,206	0.43%	City	1,045
Eolia	490	475	0.62%	Village	402
Clarksville	378	372	0.27%	City	651
Frankford	353	343	0.57%	City	806
Curryville	206	198	0.98%	City	752
Bowling Green Township	92	92	0%	Township	2
Paynesville	61	60	0%	Village	232
Annada	12	12	0%	Village	197

Sources: US Census: 2024 Missouri Place Gazetteer Files; City and Town Population Totals: 2020-2023

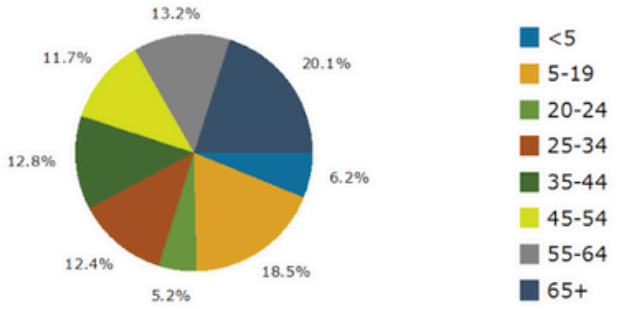
Pike County

2024 Population by Race

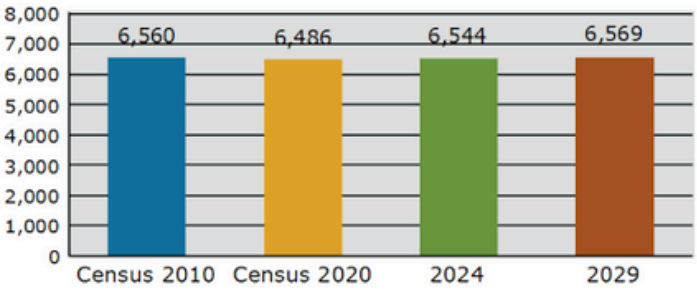


2024 Percent Hispanic Origin:2.6%

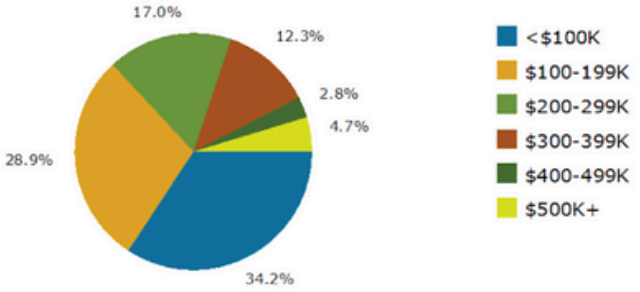
2024 Population by Age



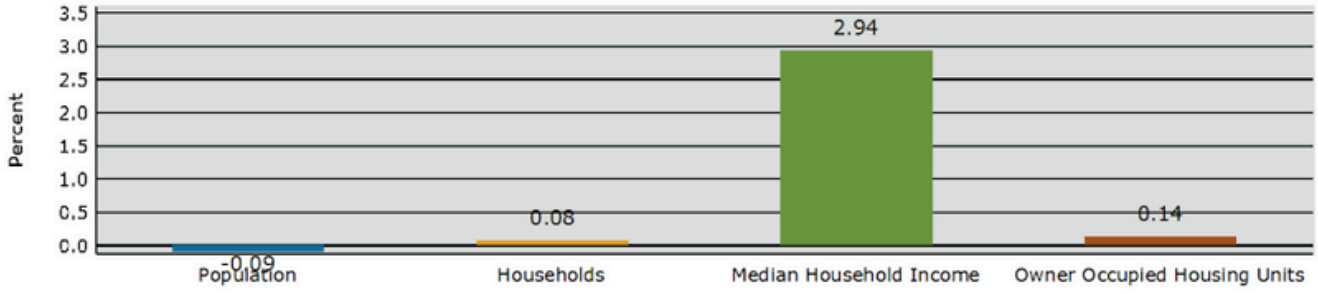
Households



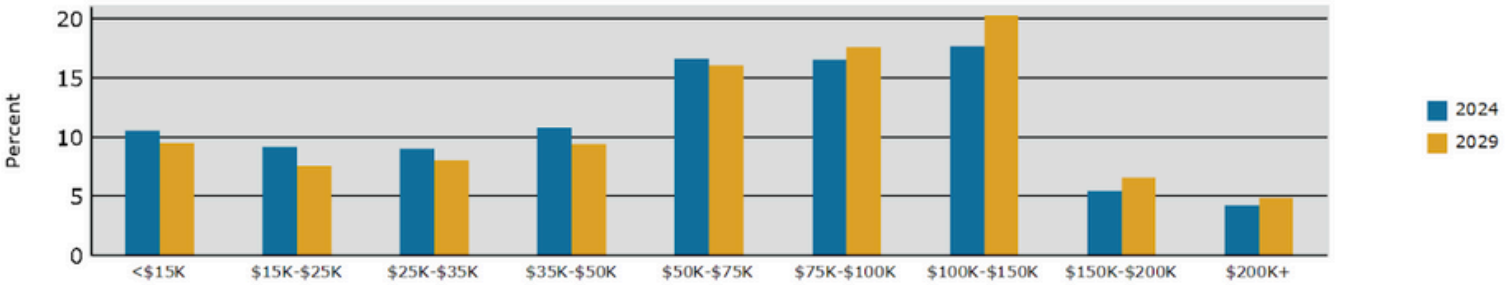
2024 Home Value



2024-2029 Annual Growth Rate



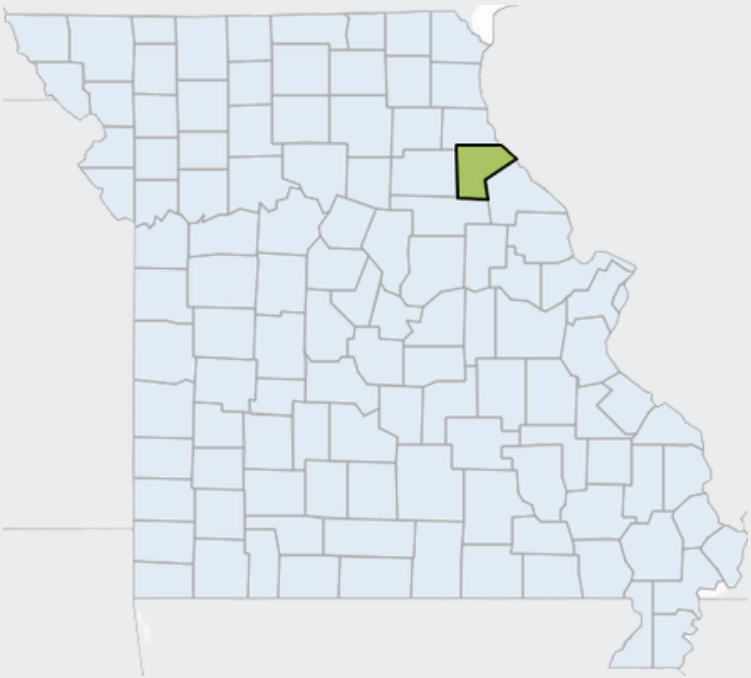
Household Income



Source: Esri forecasts for 2024 and 2029. U.S. Census Bureau 2000 and 2010 decennial Census data converted by Esri into 2020 geography.

Ralls County

Total Population	10,380
Households	4,163
Families	2,990
Average Household Size	2.47
Owner-Occupied Housing Units	3,523
Renter-Occupied Housing Units	640
Median Age	46.1



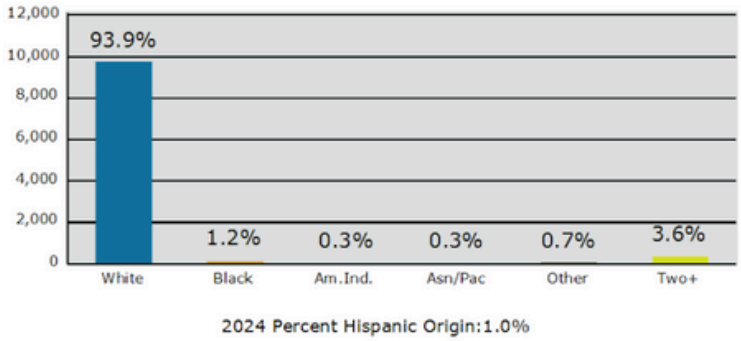
Source: Esri forecasts for 2024 and 2029. U.S. Census Bureau 2000 and 2010 decennial Census data converted by Esri into 2020 geography.

Community	2025 Population	2020 Population	Change	Type	Density
Center Township	9,517	9,366	0.65%	Township	264
New London	988	938	1.02%	City	1,424
Perry	694	668	0.73%	City	502
Center	539	536	0.19%	City	1,321
Saverton	110	118	6.80%	CDP	114

Sources: US Census: 2024 Missouri Place Gazetteer Files; City and Town Population Totals: 2020-2023

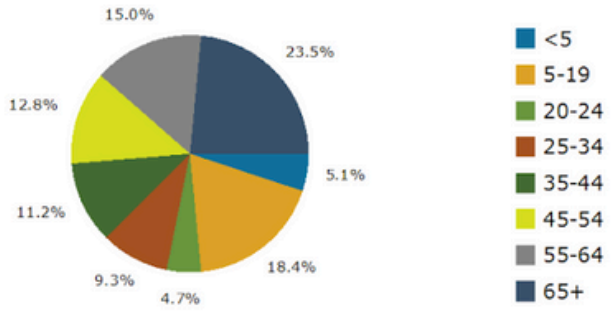
Ralls County

2024 Population by Race

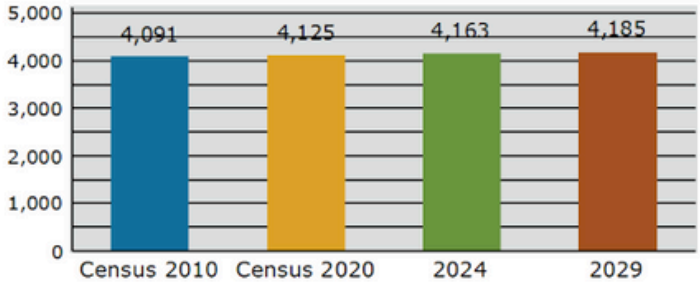


2024 Percent Hispanic Origin:1.0%

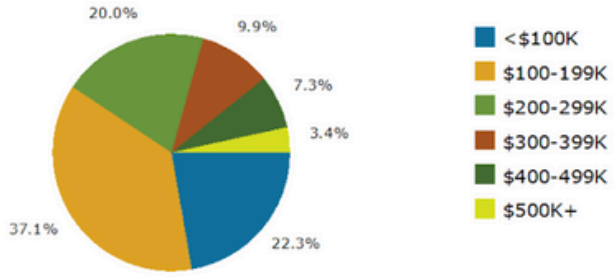
2024 Population by Age



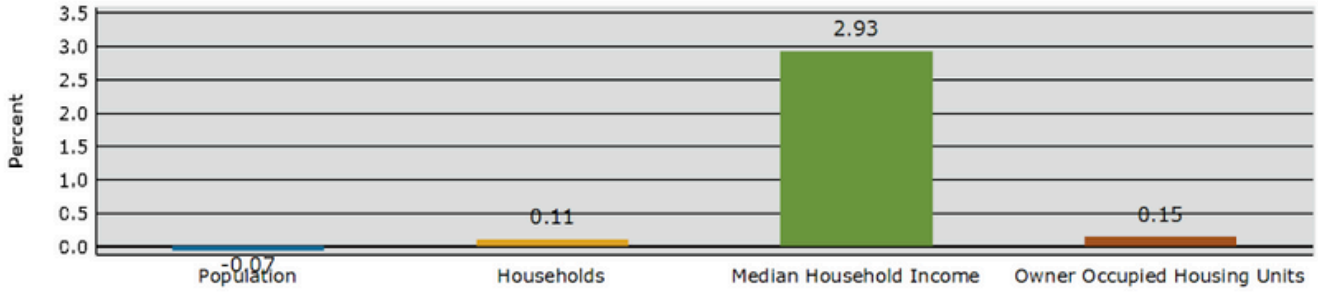
Households



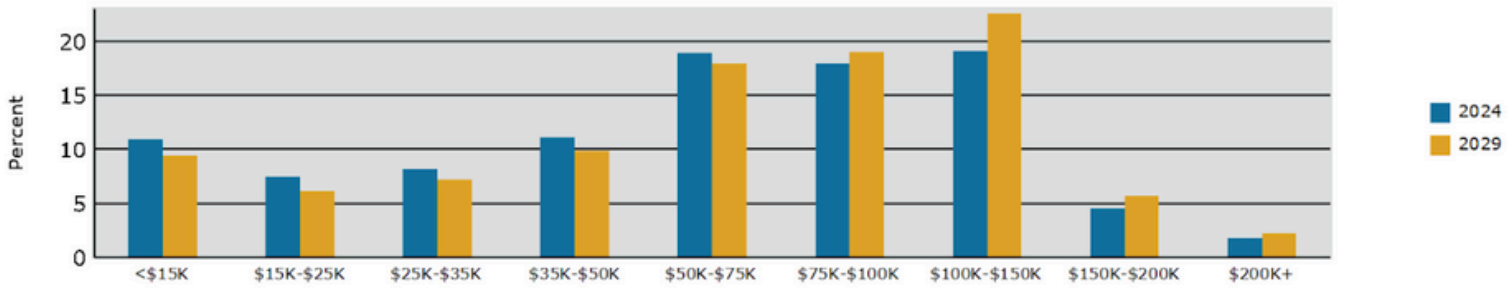
2024 Home Value



2024-2029 Annual Growth Rate



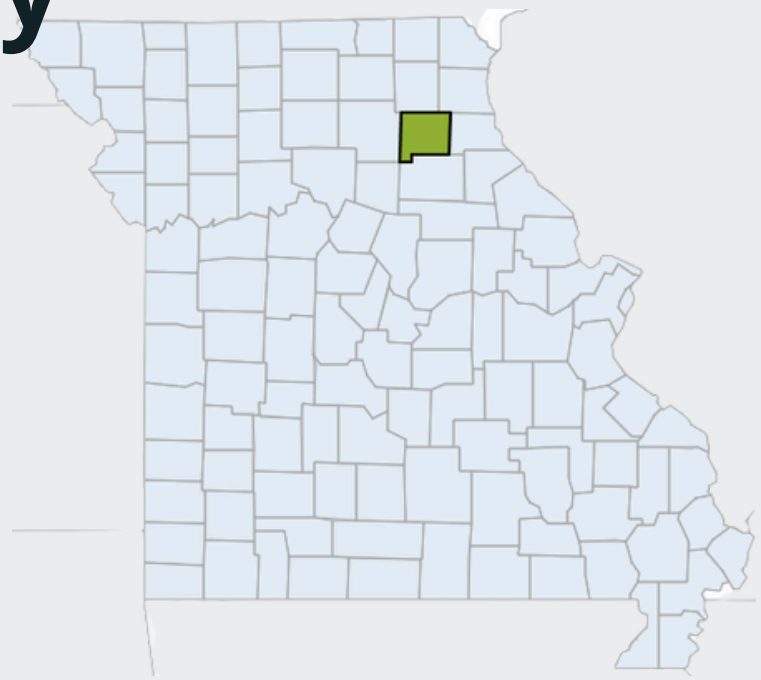
Household Income



Source: Esri forecasts for 2024 and 2029. U.S. Census Bureau 2000 and 2010 decennial Census data converted by Esri into 2020 geography.

Shelby County

Total Population	5,936
Households	2,439
Families	1,608
Average Household Size	2.35
Owner-Occupied Housing Units	1,833
Renter-Occupied Housing Units	606
Median Age	42.8



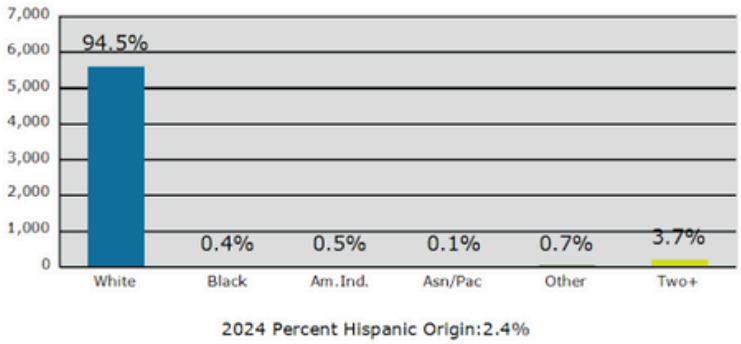
Source: Esri forecasts for 2024 and 2029. U.S. Census Bureau 2000 and 2010 decennial Census data converted by Esri into 2020 geography.

Community	2025 Population	2020 Population	Change	Type	Density
Shelbina	1,540	1,607	-0.84%	City	659
Clarence	710	735	-0.70%	City	614
Shelbyville	495	519	-1%	City	638
Hunnewell	132	136	-0.75%	City	214
Bethel	125	132	-0.79%	Village	906
Leonard	53	57	-1.85%	Village	165

Sources: US Census: 2024 Missouri Place Gazetteer Files; City and Town Population Totals: 2020-2023

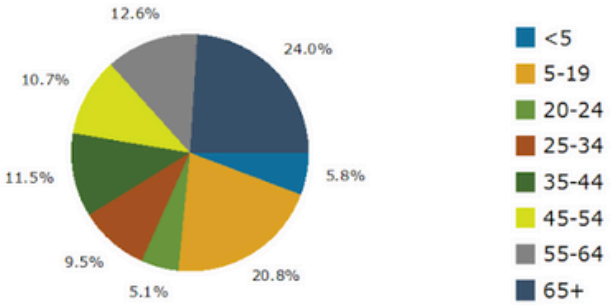
Shelby County

2024 Population by Race

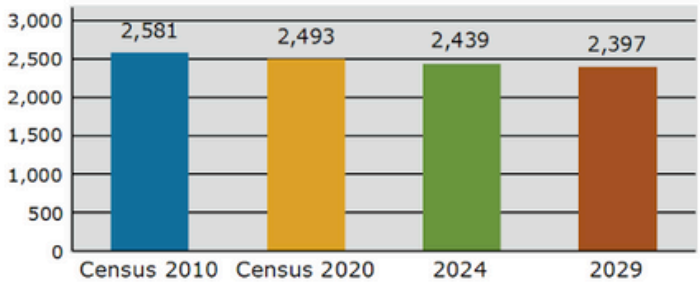


2024 Percent Hispanic Origin:2.4%

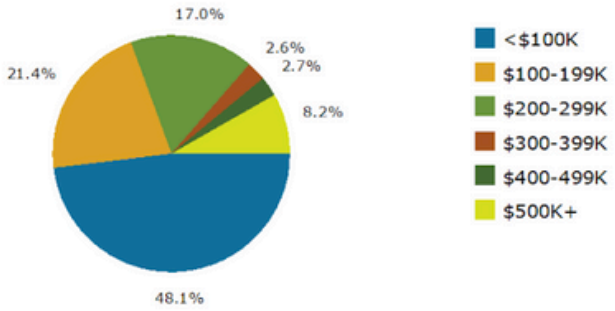
2024 Population by Age



Households

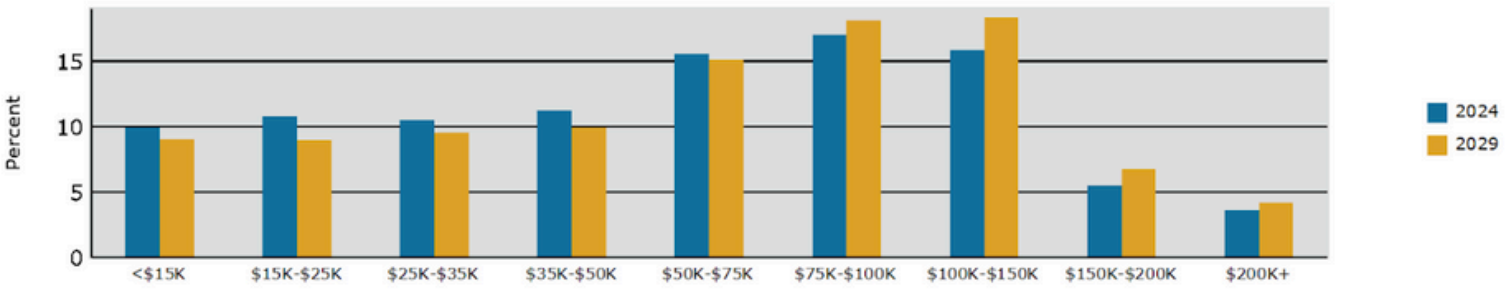


2024 Home Value



2024-2029 Annual Growth Rate

Household Income



Source: Esri forecasts for 2024 and 2029. U.S. Census Bureau 2000 and 2010 decennial Census data converted by Esri into 2020 geography.

PRIMARY DATA

Primary Data

Public Survey

As part of the 2025 Hannibal Regional Community Health Needs Assessment (CHNA), a public survey was conducted to gather community input on health issues, access to care, and social factors influencing well-being. A total of 691 individuals from across six counties responded to the survey, offering critical insights into the region's health landscape.

Demographics and Insurance Coverage
Most respondents were from Marion County, and 682 provided valid zip codes. The majority of survey participants identified as female and were between the ages of 25 and 64. Income levels varied, with nearly 20% reporting annual household incomes under $25,000. Despite economic variation, 94% reported having health insurance.

Healthcare Access and Utilization
Primary care physicians were the most common source of healthcare (86%), followed by urgent care clinics (23%). However, several barriers to routine care emerged, with cost, lack of insurance, and transportation frequently cited. Over 40% of respondents reported difficulties accessing dental and vision care, and more than a quarter experienced challenges obtaining primary care.

When asked about emergency services, most respondents indicated they could reach care within 30 minutes. Yet, when asked if there were enough healthcare providers in their area, 53% said no.

Community Health Priorities
Mental health was consistently identified as the most pressing health concern, followed closely by substance use and chronic diseases. More than 75% of respondents reported either personal or second-hand experience with mental health struggles, and over two-thirds said they would seek help if services were available.

Cost of care, transportation, and provider shortages were highlighted as the top barriers to improving community health. Respondents recommended expanding access to primary and mental health care, improving transportation options, and increasing availability of health education and local fitness programs.

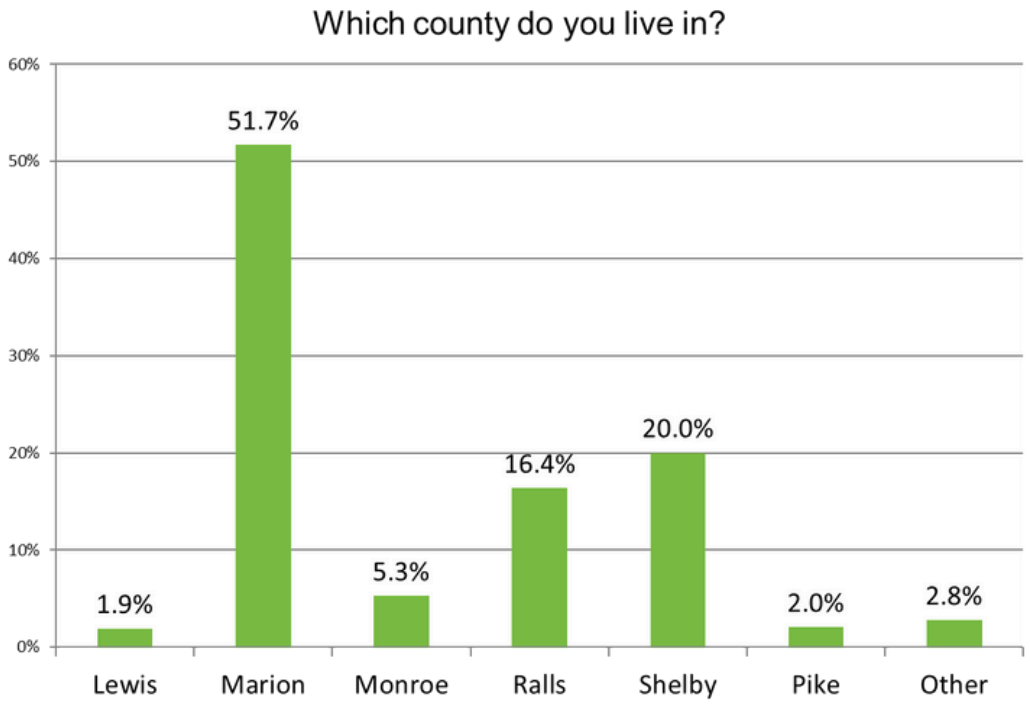
Communication Preferences
Social media was identified as the most effective channel for sharing health information, followed by email newsletters and flyers at community locations.

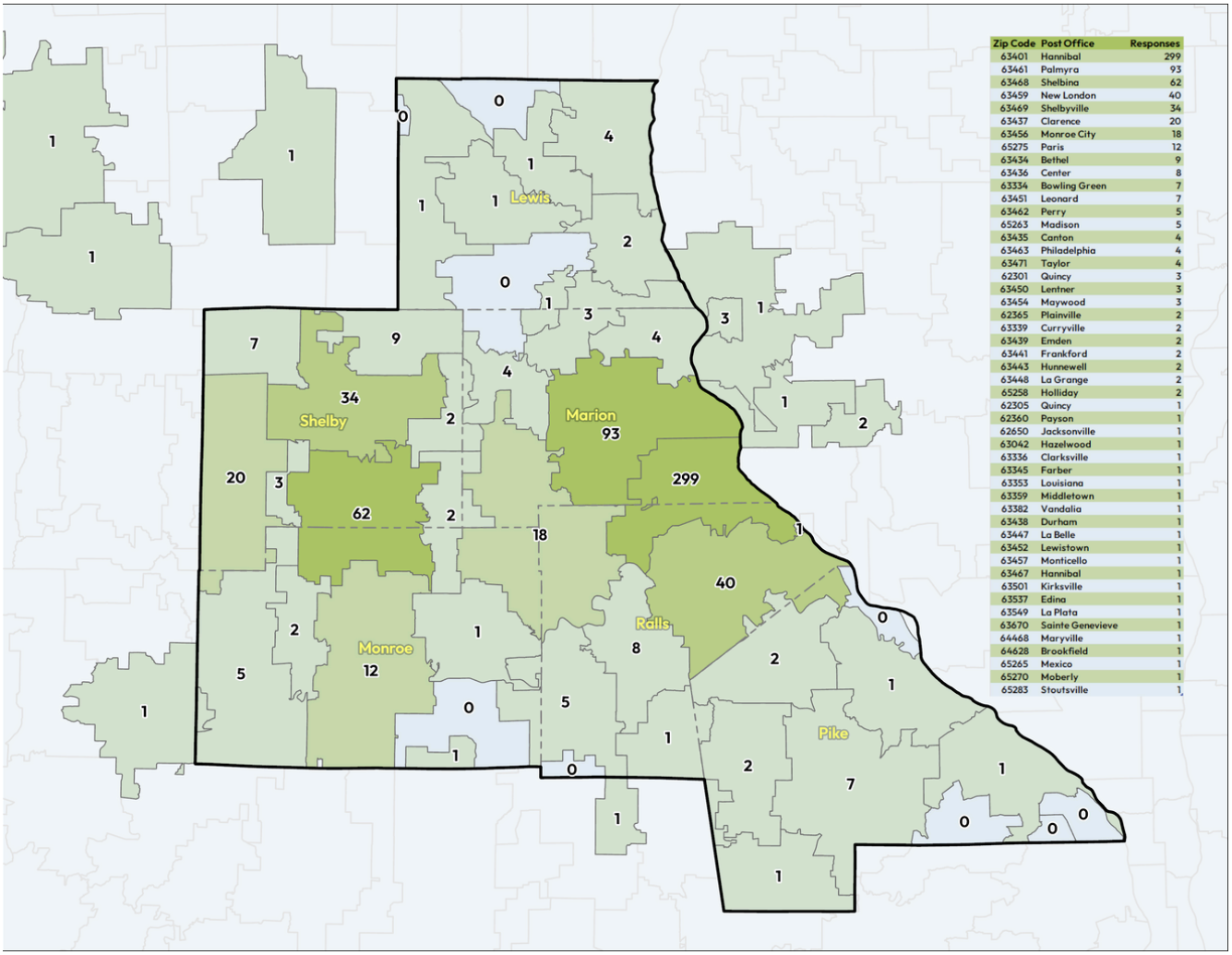
This feedback will guide regional strategies to improve health outcomes by addressing service gaps, economic and geographic barriers, and community-specific priorities. The insights from this survey emphasize the importance of accessible, affordable, and community-connected care throughout the region.

Public Survey

Primary Data

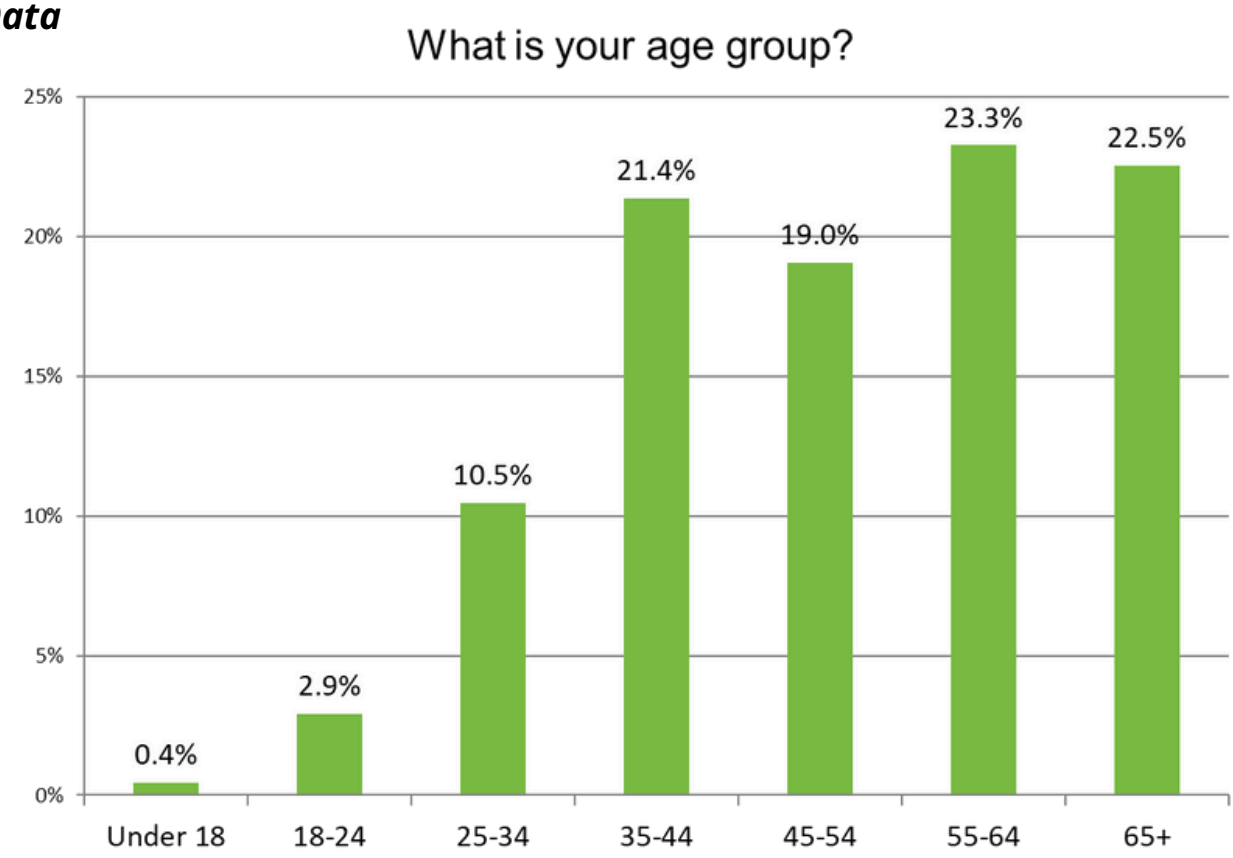
691
Respondents

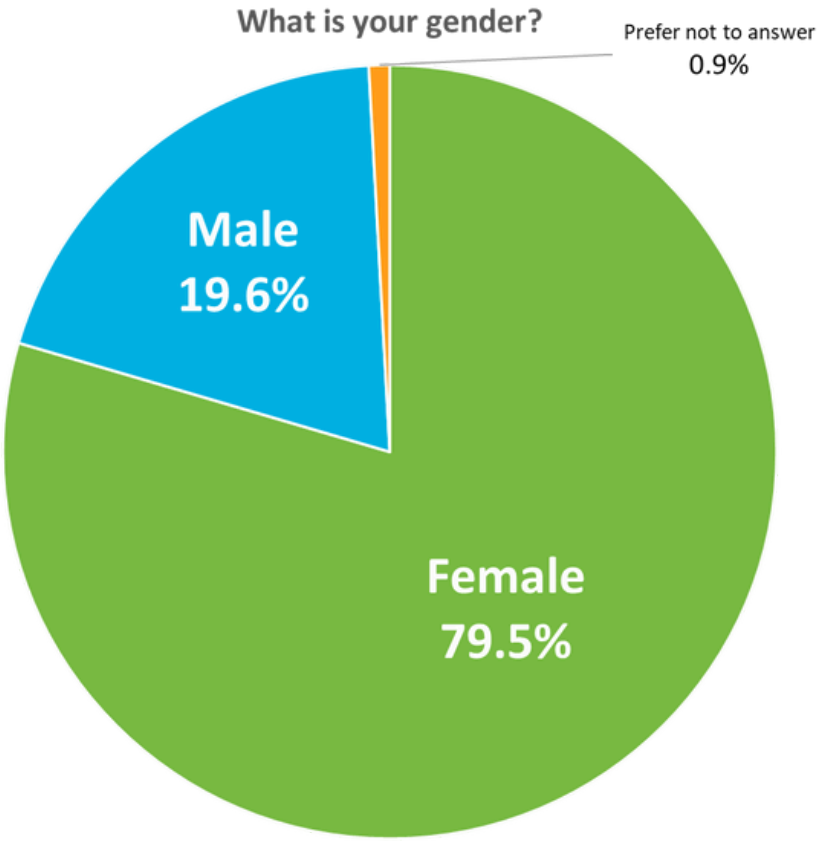




Public Survey

Primary Data





Public Survey

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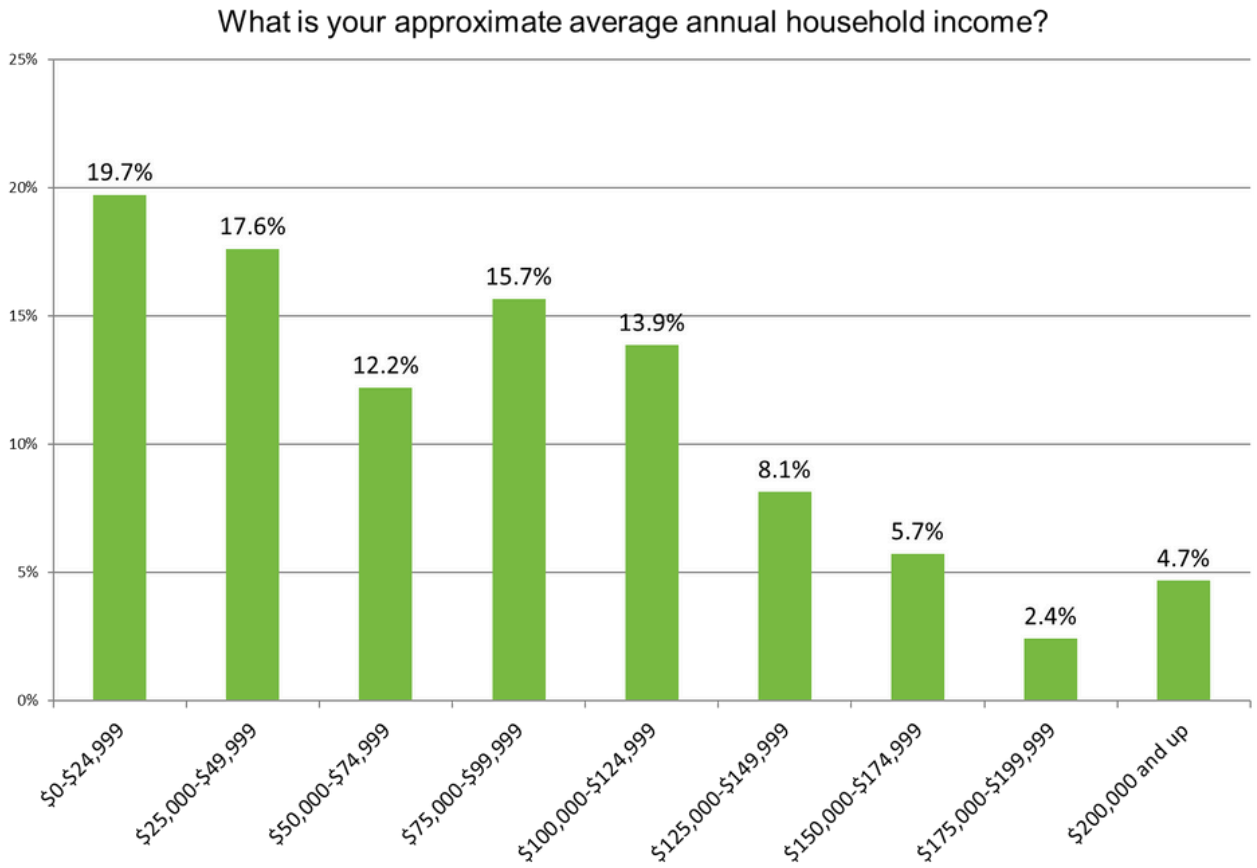

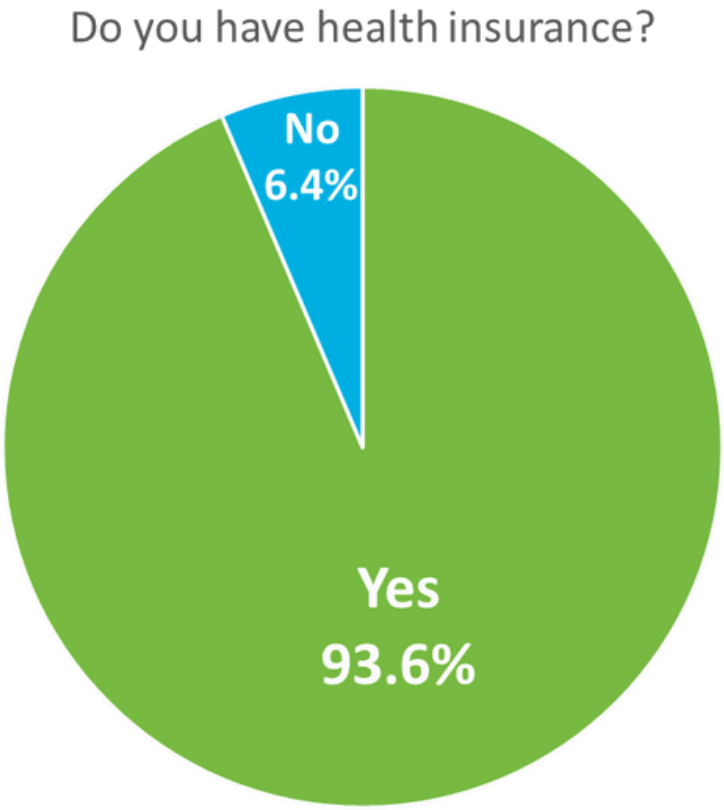

Public Survey

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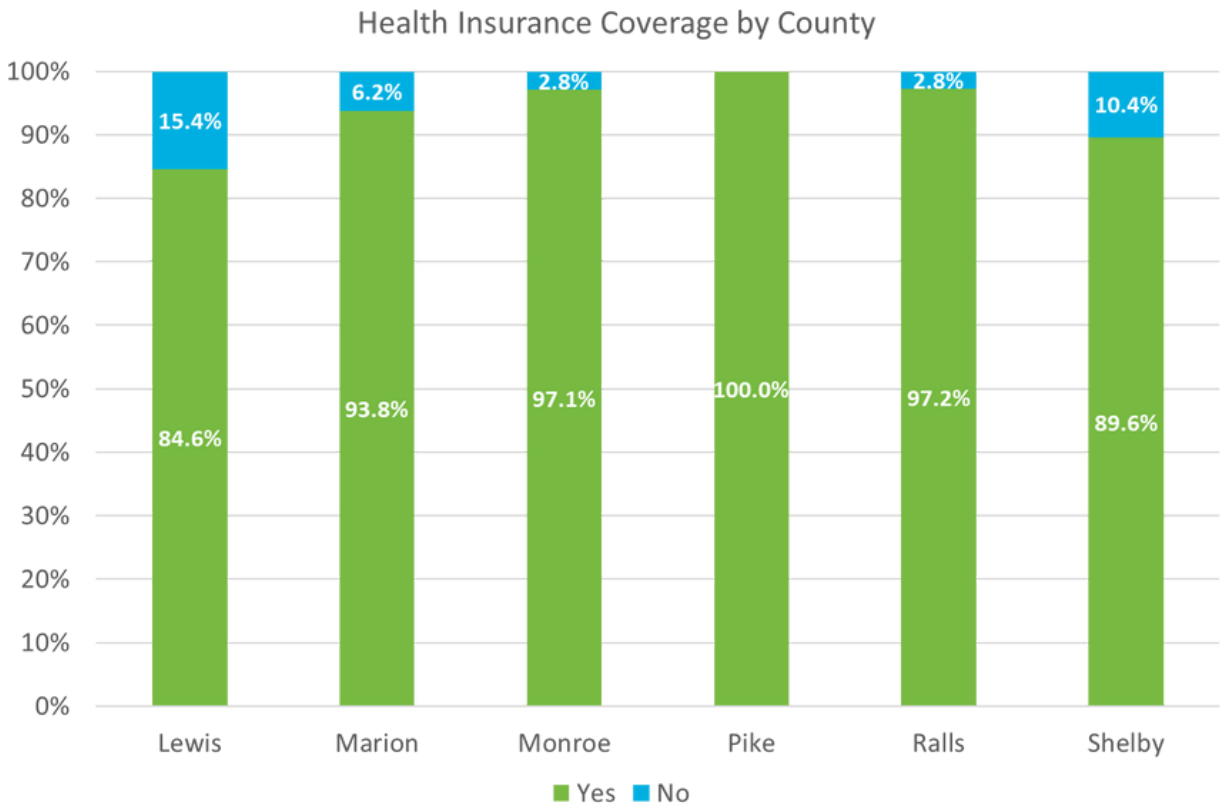

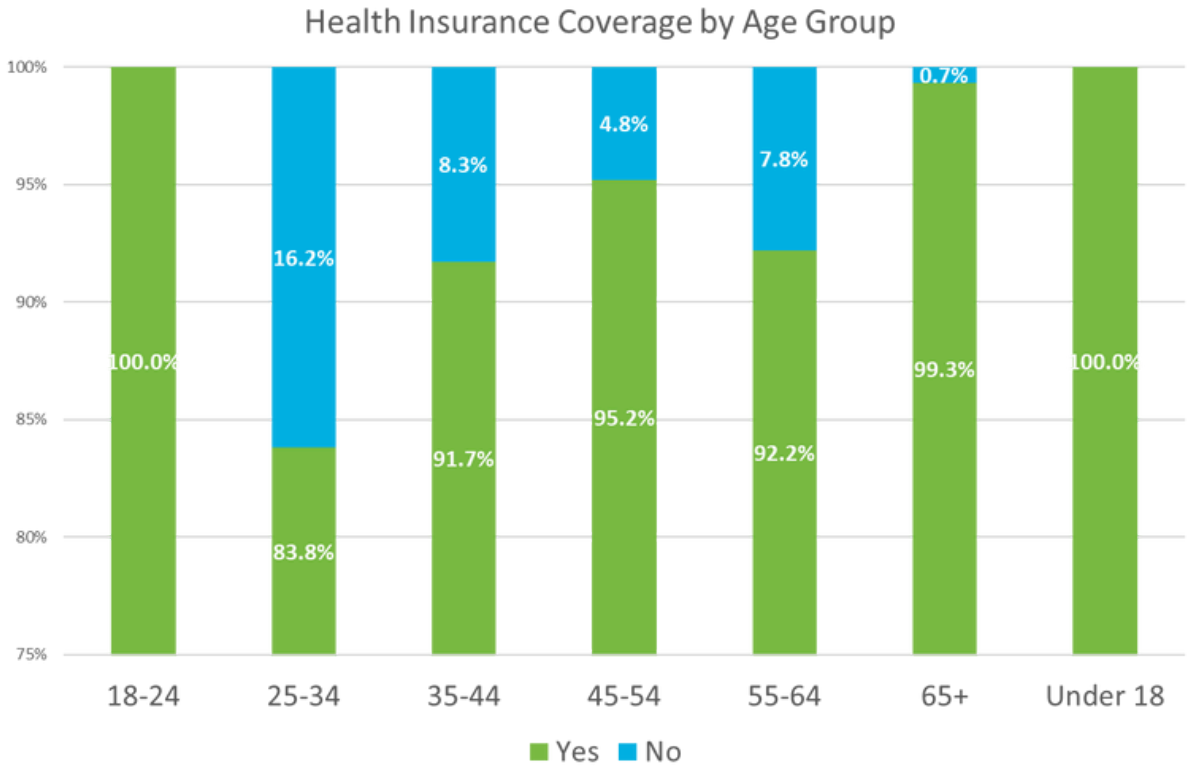

Public Survey

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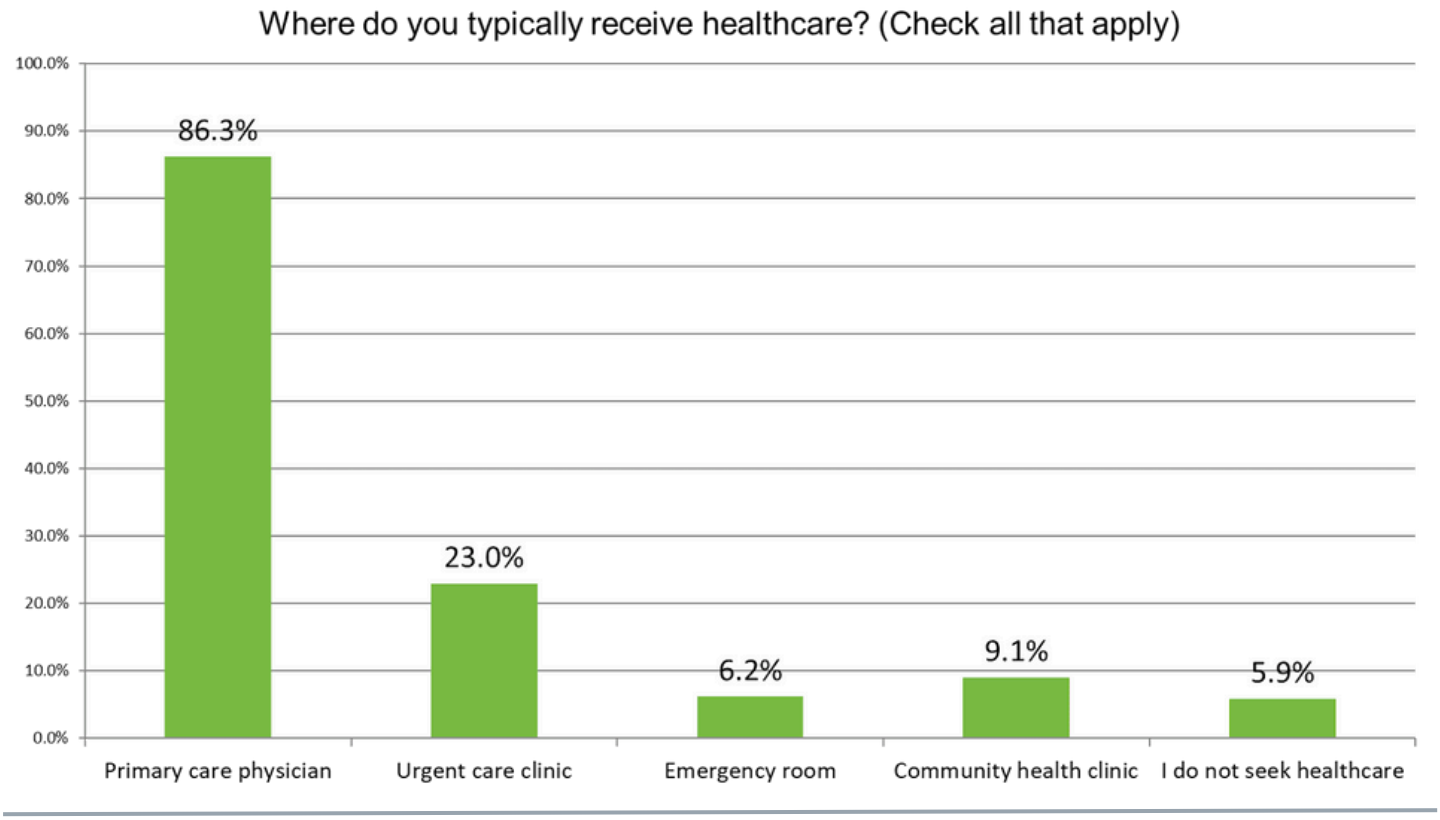
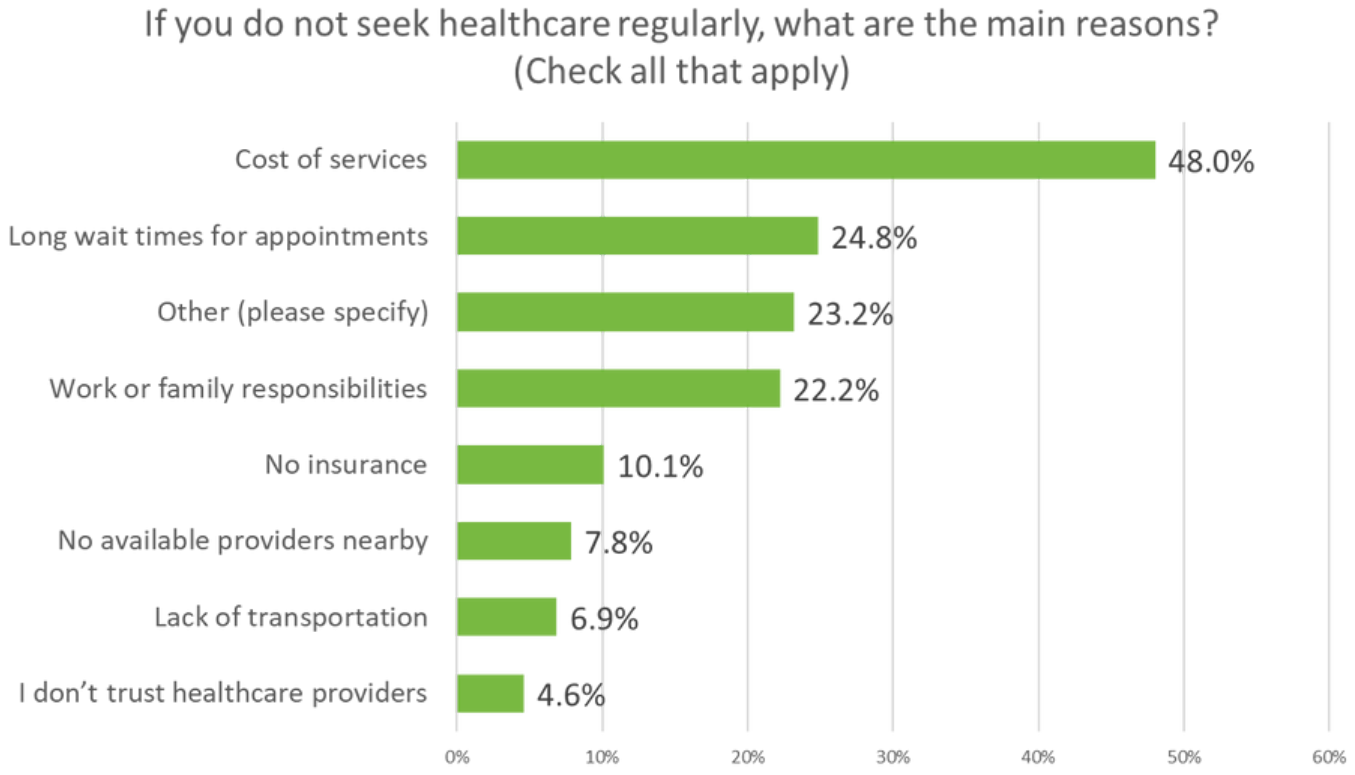




Public Survey

Primary Data

Summary of "Other" Responses -
Reasons for Not Seeking Healthcare Regularly

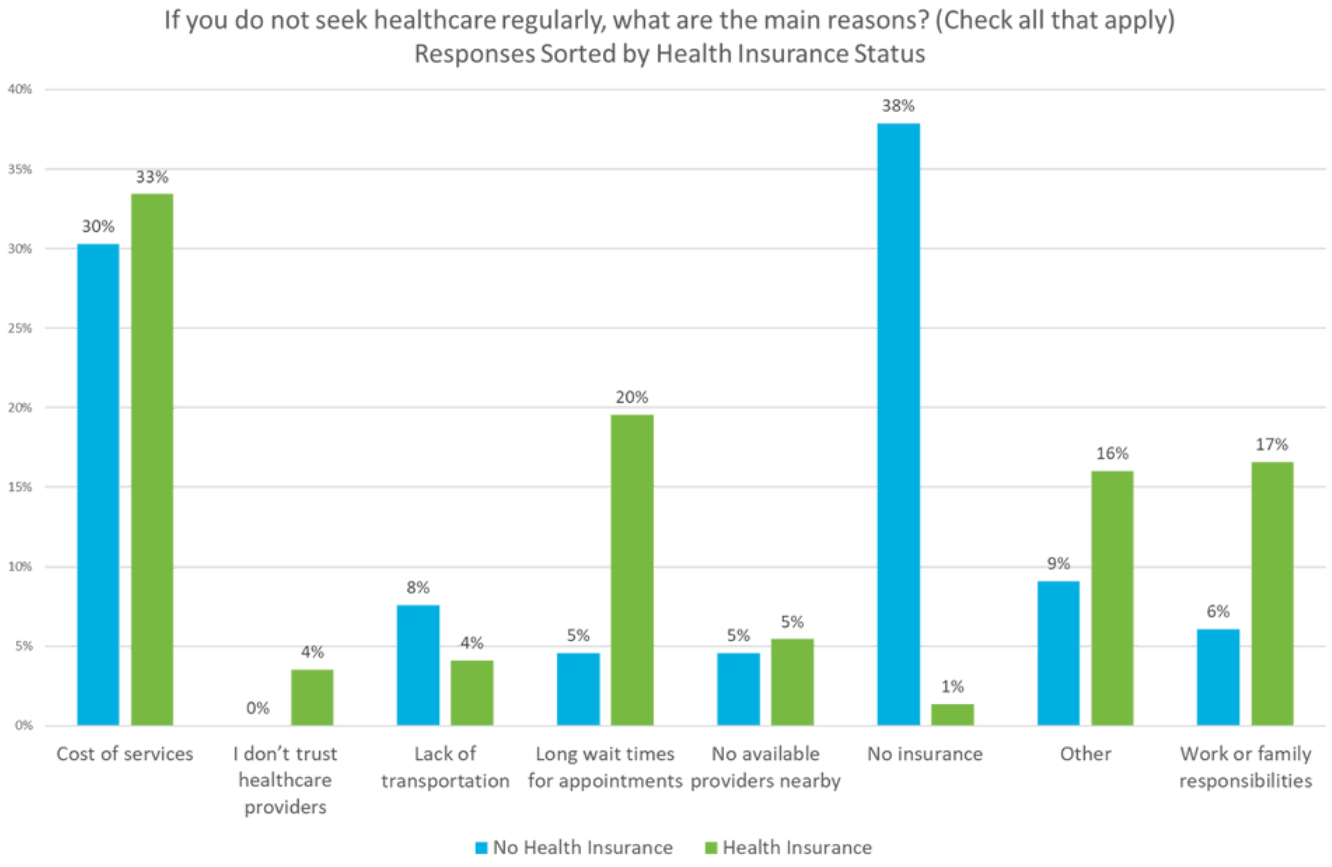
Among those who selected "Other," the following themes emerged:

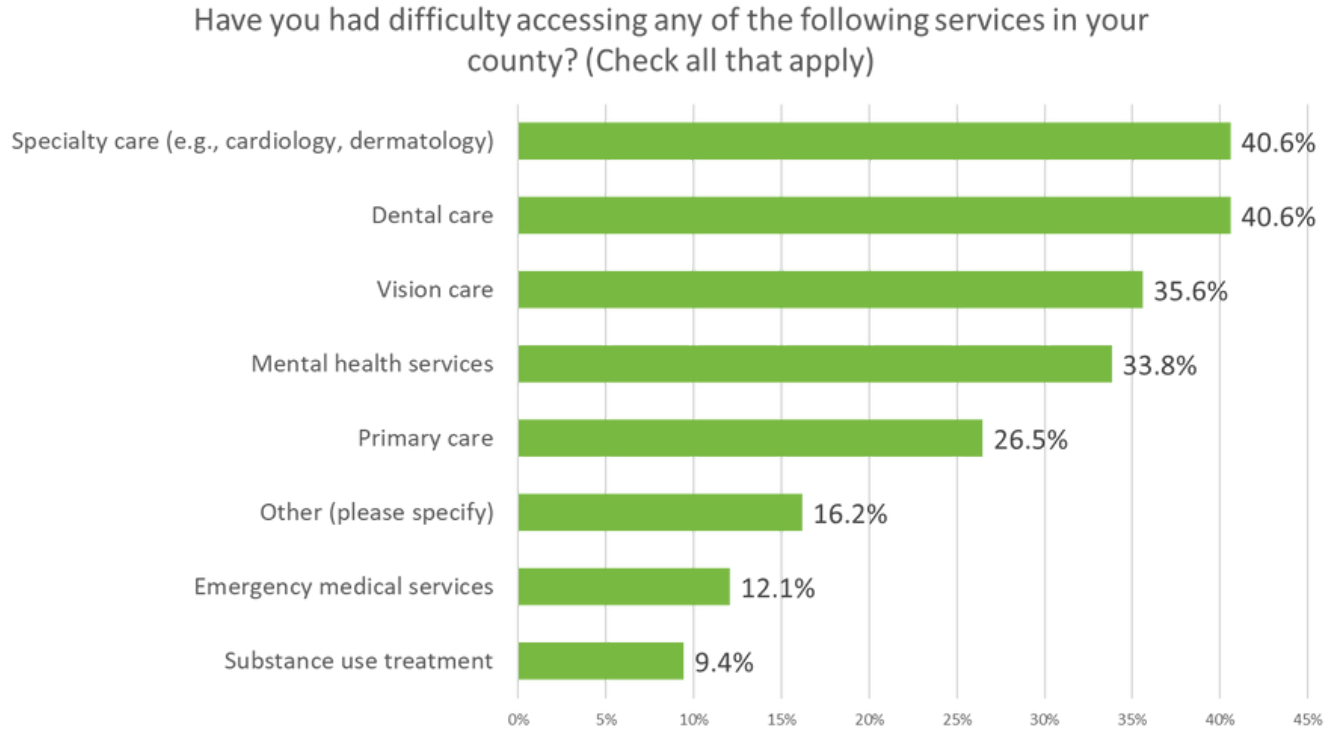
- Affordability Despite Insurance: Many respondents cited high healthcare costs even with insurance, including high deductibles and provider charges that far exceed alternatives.
- Perceived Good Health: Several participants noted they are healthy, don't get sick often, or only seek care when absolutely necessary.
- Access Issues: Respondents mentioned challenges such as difficulty getting appointments, lack of after-hours care, and providers not accepting their insurance.
- Distrust or Dissatisfaction with Care: Concerns included providers not listening, only treating symptoms, or being perceived as incompetent.
- Lifestyle and Time Barriers: Work obligations, lack of time, or no available childcare were also mentioned.
- Other Specific Barriers: Some noted a lack of safe spaces for LGBTQ+ individuals, reliance on natural medicine, or being new to the area and unfamiliar with available care.

These responses highlight the complexity of barriers beyond traditional categories like cost or transportation.

Public Survey

Primary Data





Public Survey

Primary Data

Respondents who selected "Other" described the following challenges in accessing healthcare services in their county:

Limited Availability or Access:

- Specialty care access is limited, including endocrinology, rheumatology, neurology, orthopedics, pain management, and primary pediatric care.
- Specific services mentioned include home health care, hearing aids, chiropractic, dietitians (especially with specific knowledge), alternative/eastern medicine, vision care, and gender-affirming care.
- A few noted only one dentist available, with some not accepting new patients or retiring soon.

Geographic and Travel Barriers:

- Some respondents reported needing to travel long distances (e.g., to Columbia, St. Louis, or Hannibal) for specialized care or to receive services at all.

Wait Times and Scheduling Issues:

- Concerns were raised about long wait times for appointments and limited availability for urgent care on weekends.
- Difficulty rescheduling appointments was noted as a challenge, with delays extending up to a year in some cases.

Perceptions and Preferences:

- Some indicated they choose to go out of county for better care.
- One noted that a local center (Hannibal Nutrition Center) lacks education on nutrition.

Service Gaps for Specific Needs:

- Difficulties were highlighted in getting substance use treatment promptly and accessing gender-affirming care.

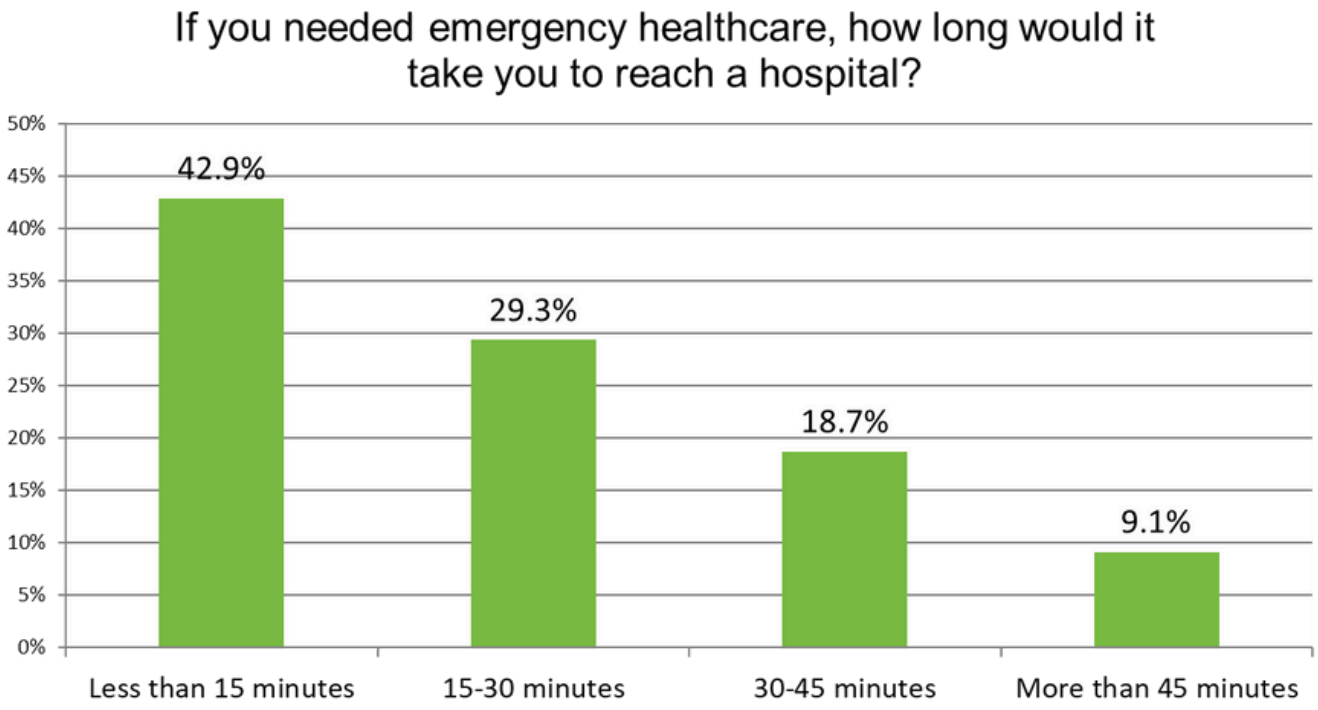
No Issues Reported:

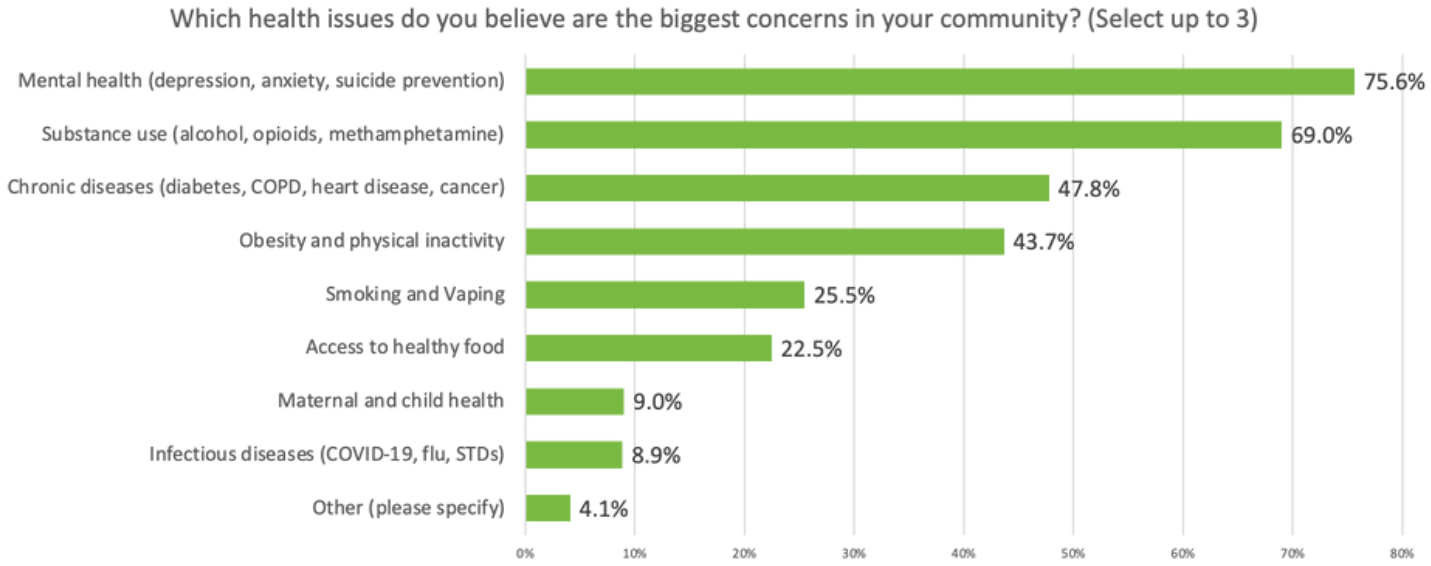
- A large number of responses explicitly stated no difficulties, no problems, or that the question did not apply to them.

These responses reflect a mix of systemic gaps in specialty care, access limitations due to provider availability or policy, and individual choices to seek care outside the county.

Public Survey

Primary Data





Public Survey

Primary Data

Summary of "Other" Responses – Biggest Health Concerns in the Community

Respondents who selected "Other" identified a range of health-related concerns not captured in the main survey options.

These included:

Access and Availability of Services:
- Lack of doctors and specialists
- Limited access to dental care, comprehensive women's care (especially post-childbearing), elder care, and long-term care facilities
- Medical emergencies and need for transportation to reach services
- Challenges due to rural isolation, with some traveling 30+ miles for anything beyond primary care

Health Education and Information:
- Need for better health education and parent support
- Desire for accurate information on alternative and traditional treatments
- Concerns about distracted driving and lack of community awareness

Nutrition and Wellness:
- Specific concerns about nutrition for elderly and disabled populations, including super tasters/bitter genes
- Comments on the quality of food at facilities like the Hannibal Nutrition Center
- Removal of fluoride from water supplies raised as a concern

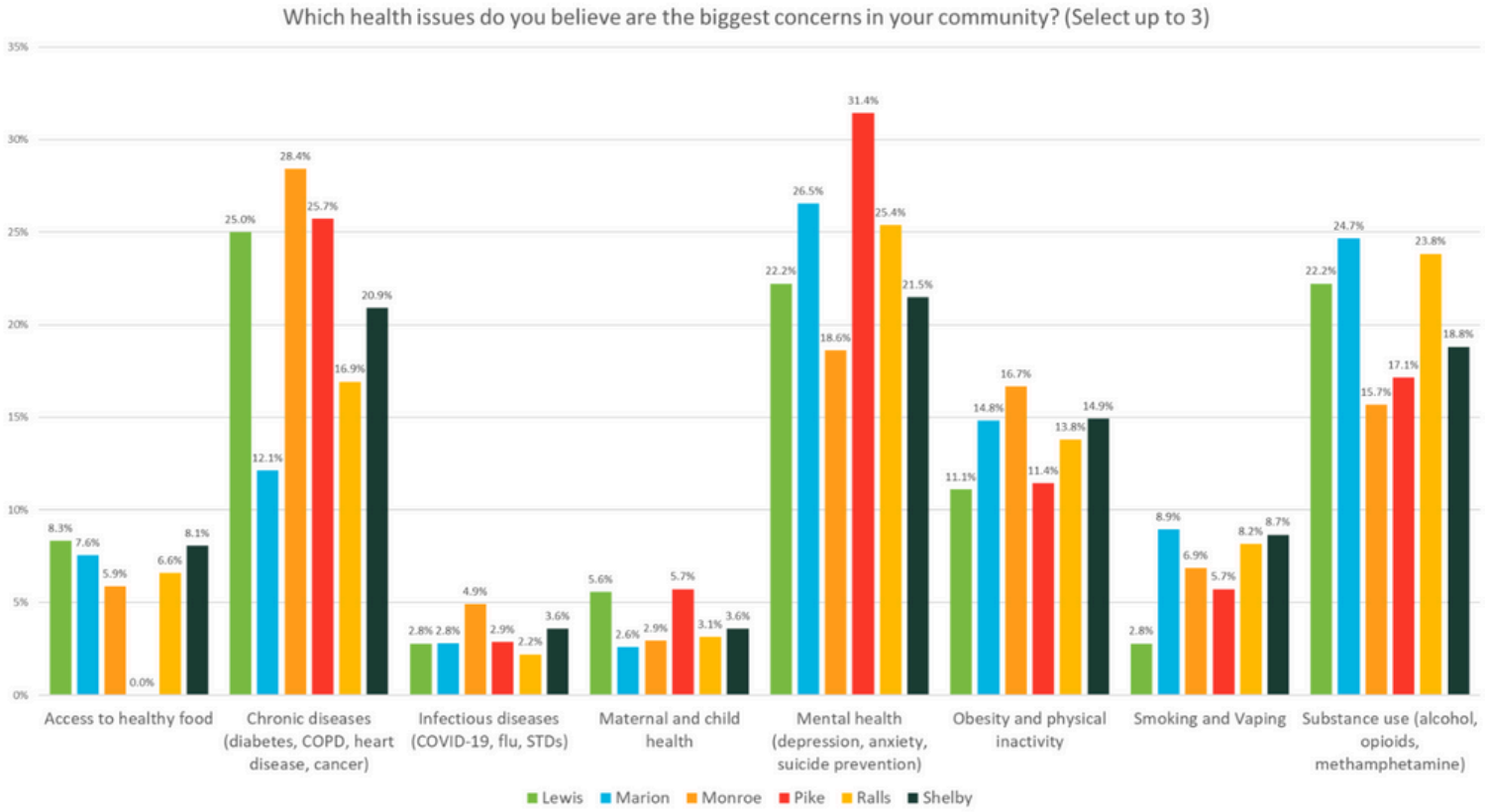
Substance and Health Behavior Issues:
- Cannabis use and opposition to vaping, particularly its local availability

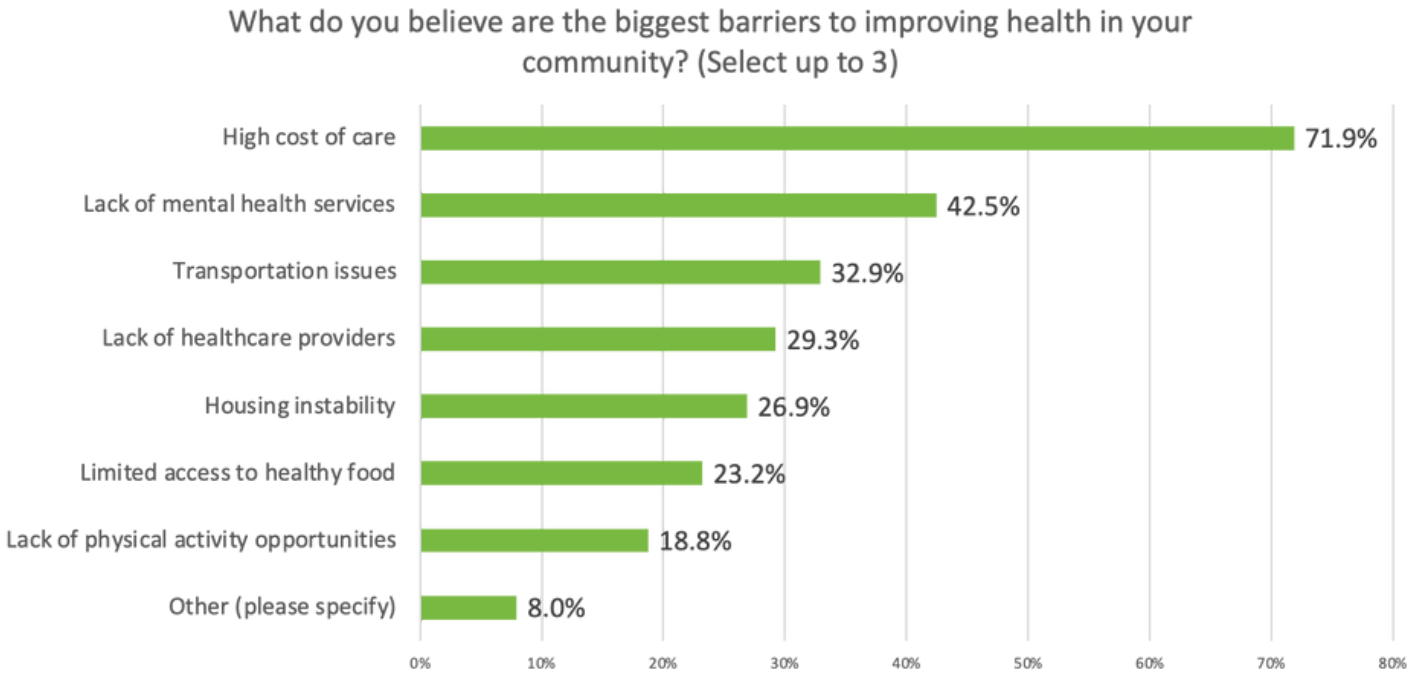
Social and Emotional Support:
- Lack of support groups for infant loss and parenting resources

This variety of responses highlights the importance of both service access and broader community health education and support systems, especially in rural or underserved areas.

Public Survey

Primary Data





Public Survey

Primary Data

Summary of "Other" Responses – Barriers to Improving Health in the Community

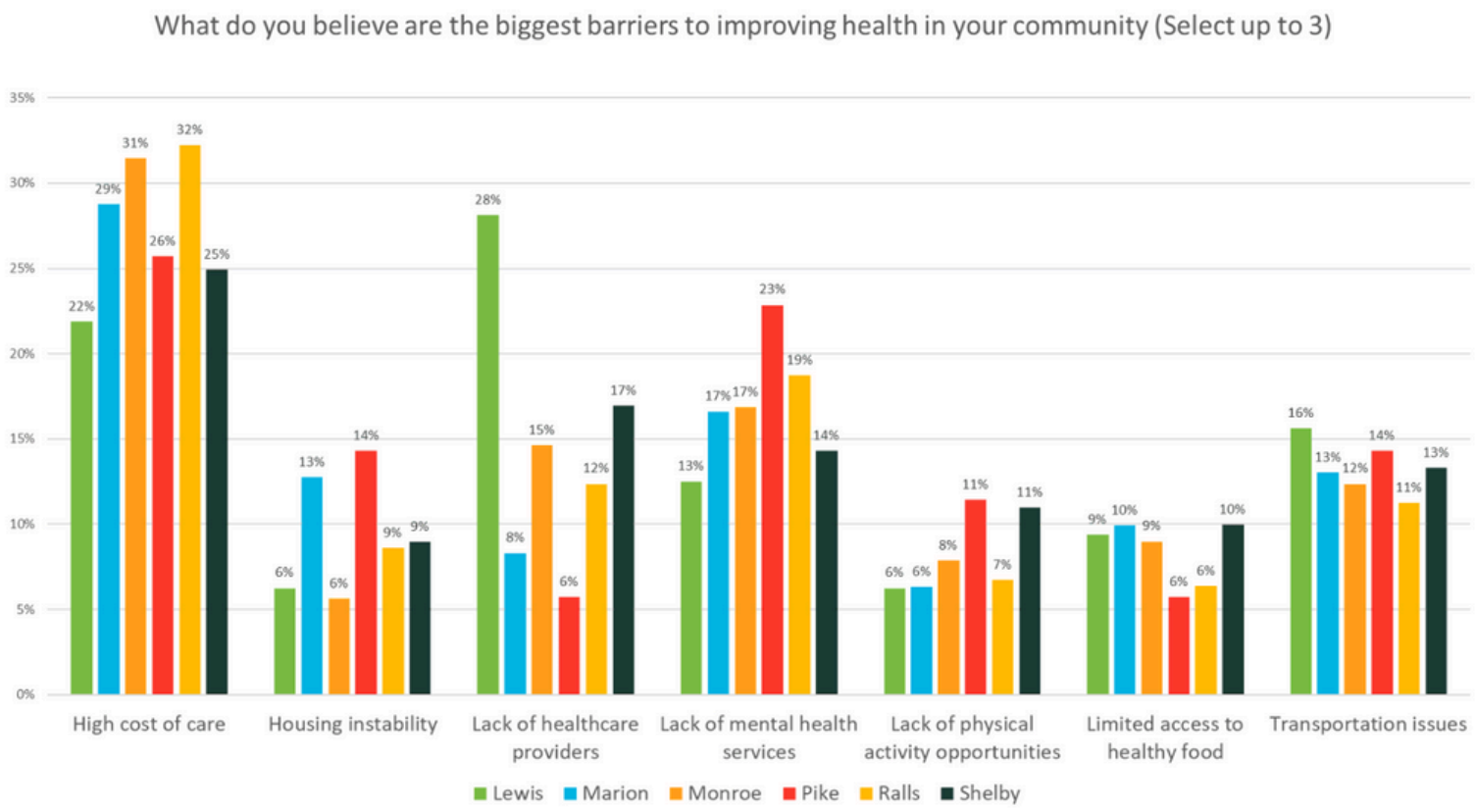
Respondents who selected "Other" shared a broad range of perceived barriers. The following key themes emerged:

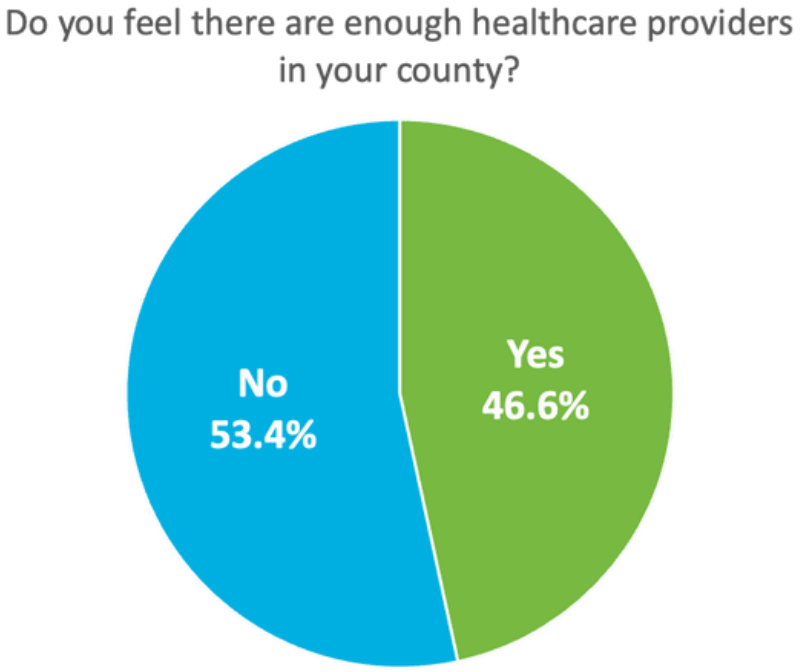
1. **Healthcare Access and System Limitations**
   - Monopoly and high charges from the local hospital
   - Limited clinic hours and long wait times
   - Lack of home health services and free clinics
   - Insurance coverage issues, including no insurance
   - Prescription costs and lack of knowledgeable medical personnel (e.g., in nutrition or rare conditions)
2. **Mental and Behavioral Health**
   - Lack of mental health services for adults and children
   - Illegal drug use
   - Lack of support groups and motivation to seek help
3. **Food and Nutrition Challenges**
   - High cost of healthy food, especially organic and non-GMO
   - Inflation in food prices
   - Low-quality Meals on Wheels options
   - Lack of knowledge about food preparation and nutrition
   - Dependence on processed/convenience foods
   - Misinformation (e.g., outdated food pyramid guidance)
4. **Transportation and Location**
   - Lack of public transportation, especially to providers outside city limits
   - No nearby gyms or YMCA
5. **Education and Awareness**
   - Lack of health education and awareness about available resources
   - Need for better understanding of side effects from medications and diets
6. **Economic and Social Factors**
   - Lack of income and job opportunities
   - Limited affordable housing
   - No outside support and lack of positive role models
   - Cultural norms that don't prioritize health
   - Politics and policy gaps that hinder access or support unhealthy choices
7. **Personal and Community Responsibility**
   - Laziness, lack of motivation, or unhealthy habits
   - Lack of willingness to change or seek help
   - Personal accountability emphasized by several respondents

These responses reflect a complex interplay between systemic, educational, behavioral, and cultural factors affecting health outcomes in the community.

Public Survey

Primary Data





Public Survey

Primary Data

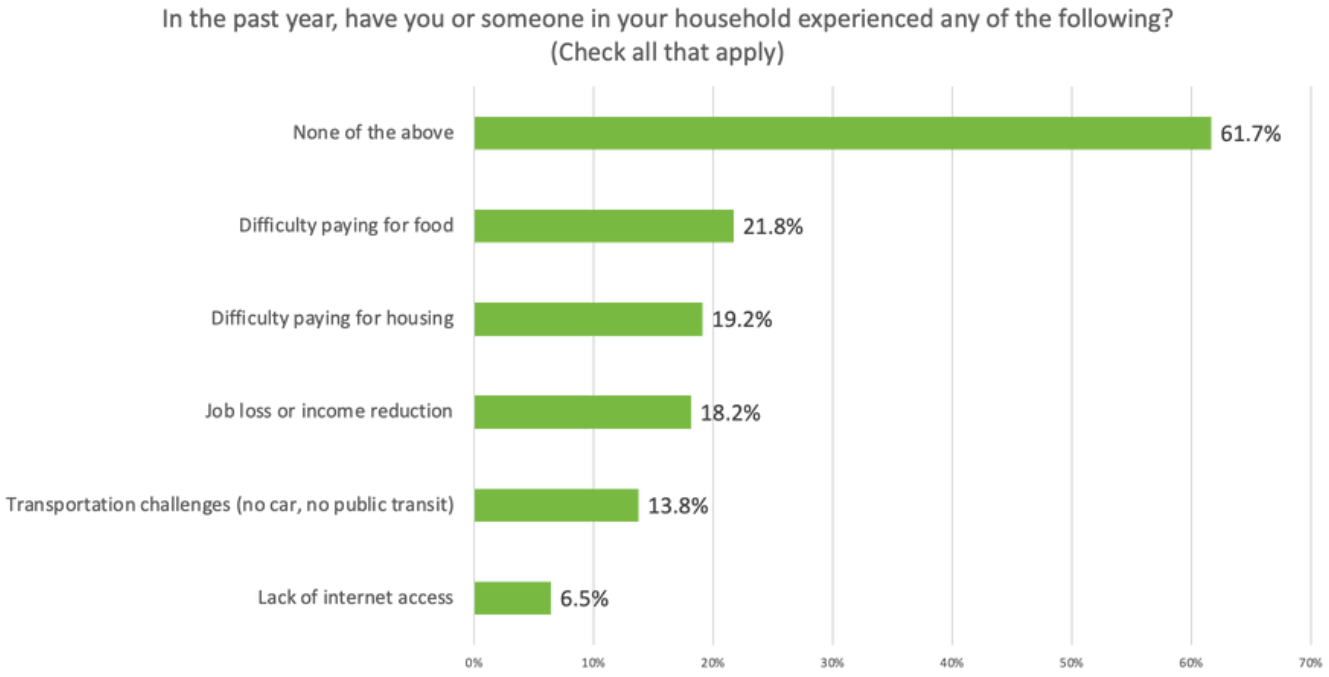
Summary of Responses: If You Could Improve One Thing About Healthcare in Your Community

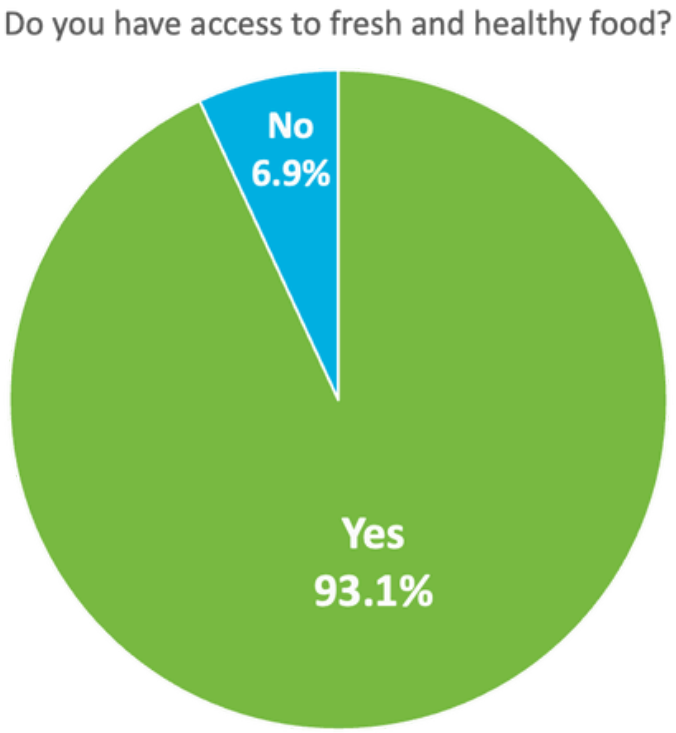
Based on community input, the most frequently mentioned improvements fall into the following key themes:

1. **Affordability & Cost Transparency**
   - Most common concern: Overwhelming demand for reduced healthcare costs, including services, prescriptions, insurance, testing, and billing transparency.
   - Many cited delaying or avoiding care due to fear of high bills, especially for those with fixed or low incomes.
   - Suggested solutions included free clinics, sliding scale fees, affordable insurance, and income-based programs.
2. **Access to Mental Health & Substance Use Services**
   - Second most cited theme: Calls for more accessible, affordable, and immediate mental health care.
   - Gaps identified in crisis response, therapy access, school-based and youth services, postpartum care, and substance use recovery programs.
   - Several respondents emphasized long wait times and lack of providers.
3. **Primary Care Availability**
   - Many shared frustration with difficulty accessing primary care due to long wait times, provider shortages, and clinic hour limitations.
   - Comments emphasized the need for more family physicians and general practitioners, especially those who live in and serve rural areas.
4. **Workforce Shortages & Provider Retention**
   - Turnover and staffing shortages among physicians, specialists, and nurses were frequently mentioned.
   - Respondents want more providers who are committed, caring, and locally available, with better staff compensation and reduced reliance on nurse practitioners.
5. **Expanded Specialty & Preventive Care**
   - Participants called for increased access to specialists, especially in rural counties, via satellite clinics, mobile units, or scheduled visits.
   - Preventive and holistic care—including nutrition education, screenings, and integrated care models—was also highlighted.
6. **System Navigation & Customer Service**
   - Respondents noted barriers like delays in referrals, appointment scheduling, and billing disputes.
   - Calls for more integrated care, follow-up support, easier appointment booking, and better communication with providers.
7. **Transportation & Geographic Access**
   - Limited transportation options, especially for rural and low-income residents, hinder access to care.
   - Suggestions included medical shuttle services, extended hours, and services in closer proximity to where people live.
8. **Facilities & Infrastructure**
   - Requests for new or expanded local clinics, community health centers, exercise facilities, and centralized care hubs.
   - Several highlighted the need to reopen or repurpose existing spaces (e.g., former hospital buildings) and improve ER capacity.
9. **Health Education & Community Outreach**
   - Community members asked for better public education on nutrition, prevention, smoking, vaccines, and how to access services.
   - Emphasis on meeting people where they are and engaging underserved populations.
10. **Equity, Inclusion & Specific Population Needs**
    - Access concerns for low-income individuals, older adults, people without insurance, veterans, women, and marginalized communities.
    - Requests included women's health centers, sliding scale services, and culturally competent care.

Public Survey

Primary Data





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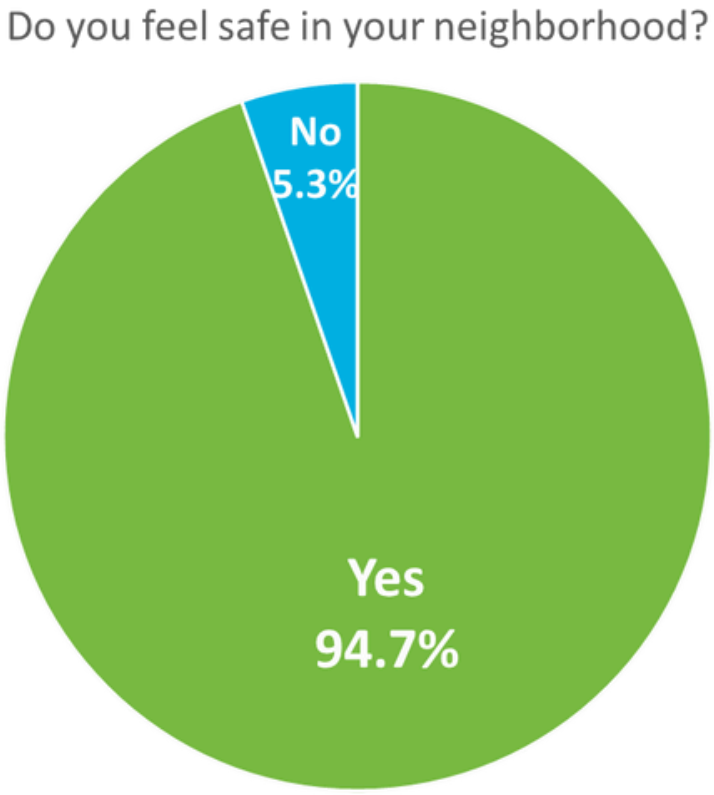

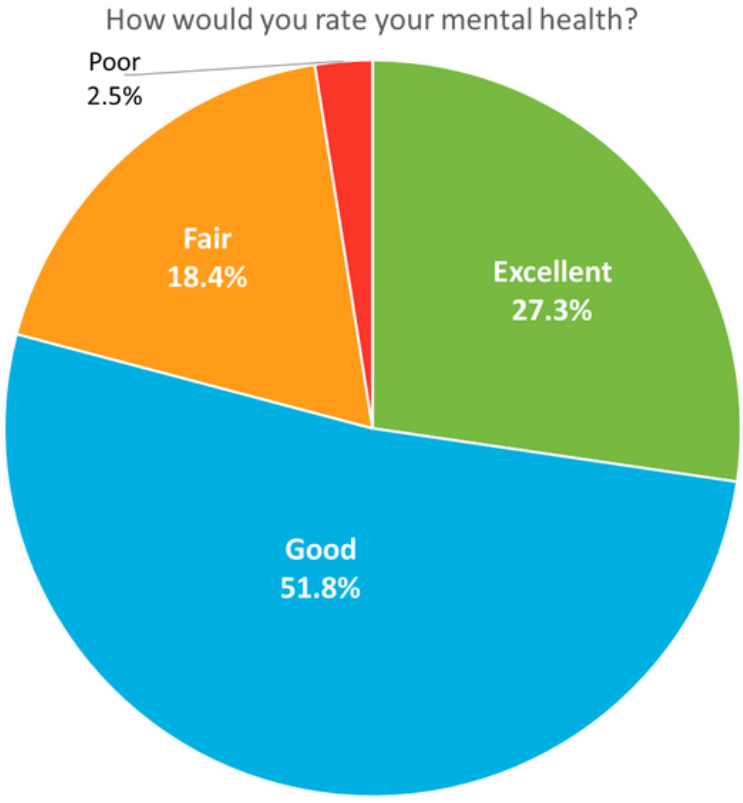

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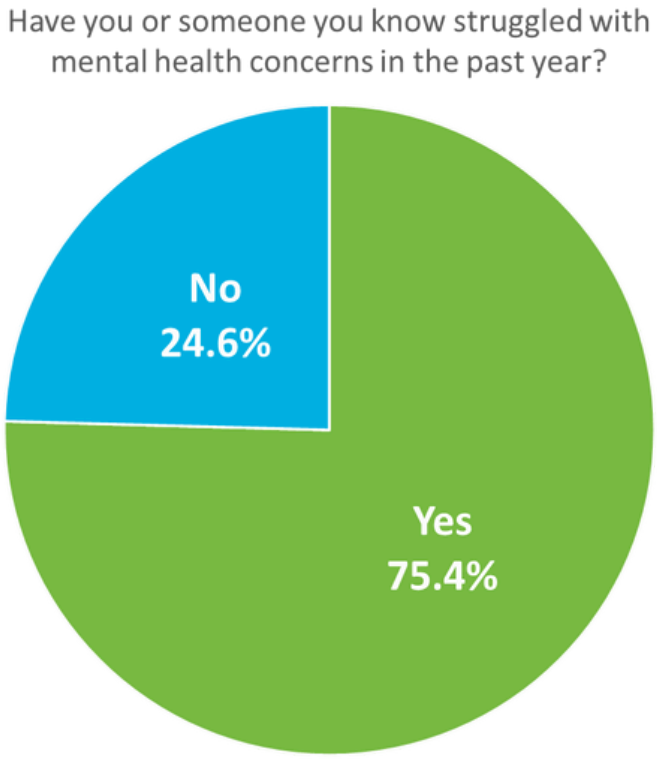

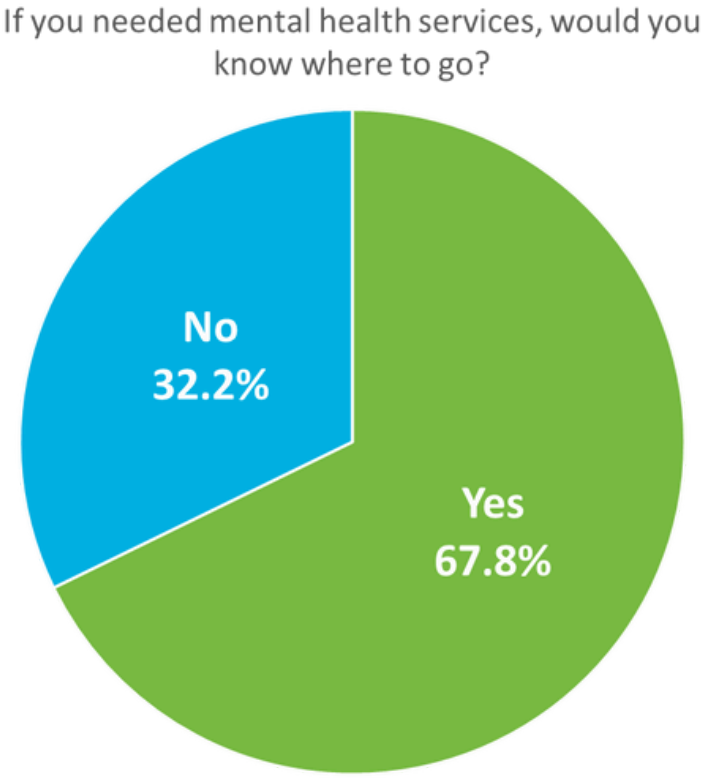

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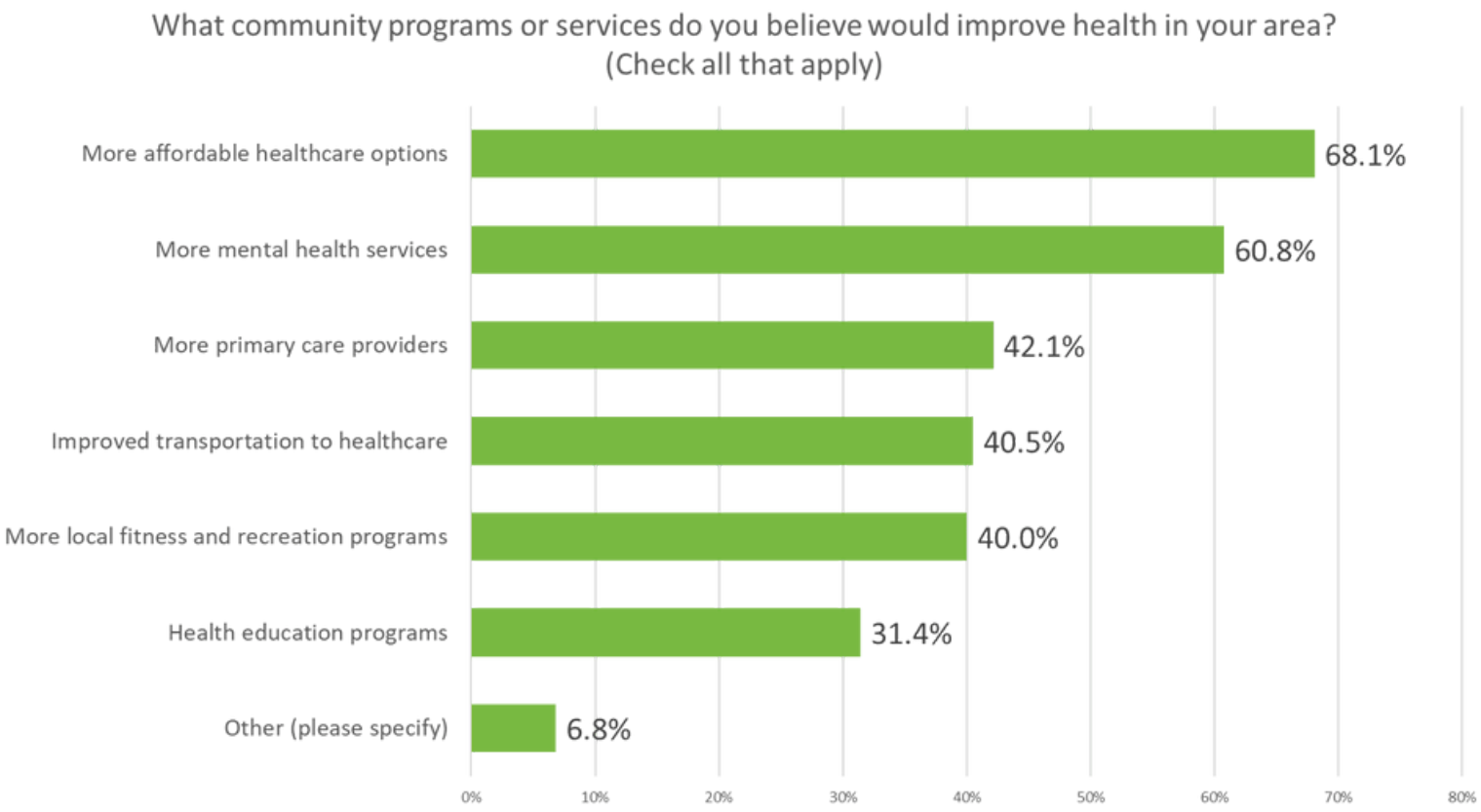


Public Survey

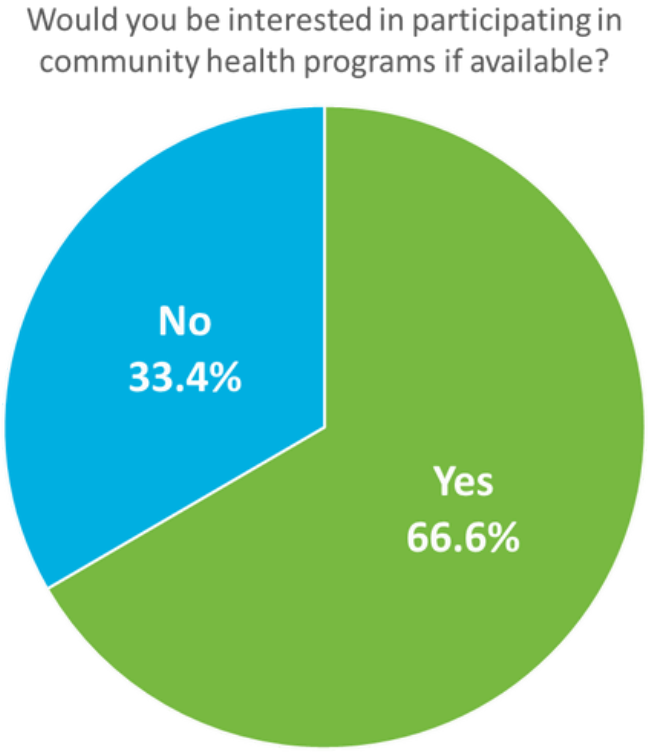
Primary Data

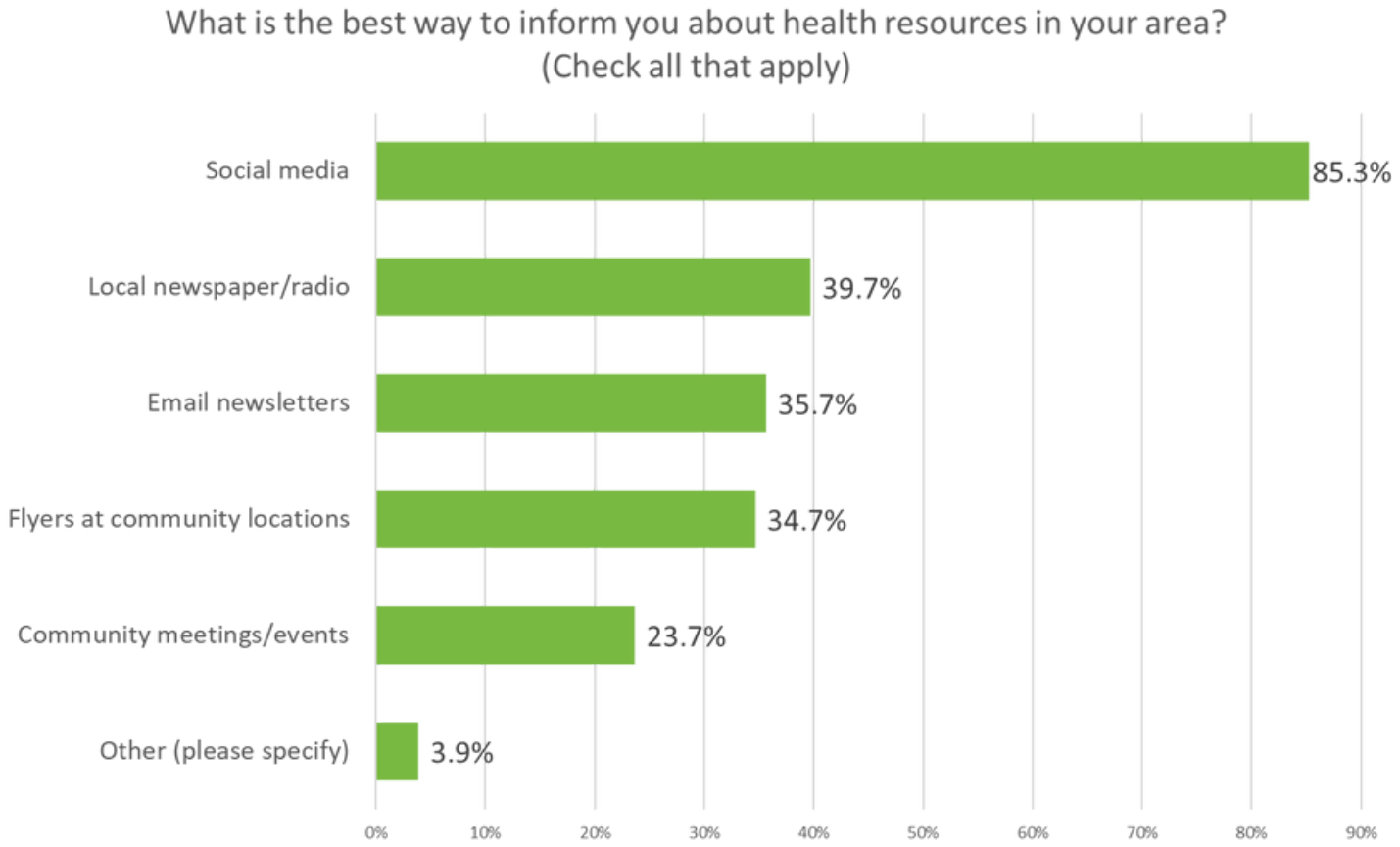
Summary of "Other" Responses – Community Programs or Services That Would Improve Health
Respondents who selected "Other" for this question identified a wide range of program and service needs. These can be grouped into the following themes:

1. **Affordable and Accessible Healthcare Services**
   - Medical and Dental Care: More doctors, dentists, primary care physicians, and GI specialists, particularly in underserved ZIP codes (e.g., 63434 and 63468).
   - Local pharmacy access and affordable prescription drug costs were also mentioned.
   - Inpatient mental health and drug rehabilitation services were identified as urgent needs.
   - Desire for coverage of naturopathic services and natural supplements by insurance.
2. **Nutrition and Healthy Food Access**
   - Strong calls for:
   - Affordable, whole, unprocessed foods
   - Programs teaching cooking, parenting, and nutrition
   - Revitalization of food programs like the FACT kitchen
   - Specific concerns about poor food quality at Hannibal Nutrition Center and Meals on Wheels
   - Need for access to healthy food and affordable grocery options, especially for low-income families
3. **Housing and Shelter**
   - Requests for low-income housing
   - Need for emergency overnight shelters and temporary homeless shelters
4. **Mental Health and Youth Services**
   - agement opportunities for older adults
   - Concerns about the closure of clinics in rural areas, particularly Center, MO, and its impact on aging populations
5. **Health Education and Prevention**
   - Workshops on managing chronic illness, nutrition, preventive care, and healthy living
   - Education for medical staff on issues like Super Tasters/Bitter Genes
   - Community programs to reduce smoking, drinking, and partying
6. **Systemic and Structural Solutions**
   - Support for public shuttles to healthcare
   - Expanded services from MDs/DOs
   - Desire for more compassionate providers who care about the community
   - These responses reflect a desire for comprehensive, community-rooted solutions that integrate affordable care, education, housing, nutrition, and transportation, especially for low-income, elderly, and rural residents.Services for struggling teens with mental illness
   - Greater visibility, support, and crisis care for people with mental health needs
   - Calls for wellness programs and better outreach/advertising so residents know where to find help
7. **Fitness, Recreation, and Transportation**
   - Suggested improvements included:
   - Walking and biking trails
   - Dog parks
   - Free fitness programs, such as walking groups or outdoor gym equipment
   - Need for transportation services, especially in rural areas and for families without access to vehicles
8. **Elder Care and Senior Services**
   - Home care, transportation, and eng

Public Survey

Primary Data





Public Survey

Primary Data

In your opinion, what are the top three most pressing issues facing your community today?

Top Themes from Responses:

1. **Mental Health**
    - Most frequently mentioned issue
    - Includes lack of providers, long wait times, unaffordability, crisis care gaps, and no inpatient options
    - Often linked with youth, the elderly, trauma, and school concerns
2. **Substance Use & Addiction**
    - High concern over meth, opioids, alcohol, and vaping
    - Frequently tied to homelessness, mental health, and crime
    - Repeated calls for rehab services, transitional programs, and prevention
3. **Housing & Homelessness**
    - Affordable housing shortages are consistently cited
    - Many mentioned rising rent, homelessness, lack of emergency shelters, and poor housing conditions
    - Especially critical for low-income families, the elderly, and those with disabilities
4. **Healthcare Access & Affordability**
    - Includes high cost of care, lack of insurance or underinsurance, and few local providers or specialists
    - Difficulty getting timely appointments and reliance on ER for basic care
    - Barriers to dental, vision, and chronic disease management were also frequently noted
5. **Food Insecurity & Cost of Living**
    - High grocery and utility prices are straining household budgets
    - Lack of access to healthy food, especially for rural and low-income residents
    - Repeated concerns about food banks lacking nutritious options
6. **Transportation**
    - Lack of public and affordability
    - able transportation, especially in rural areas
    - Barriers to accessing healthcare, food, work, and other services
    - Demand for community shuttle services and regional transit options
7. **Economic Struggles & Jobs**
    - Poverty, low wages, inflation, and lack of good-paying or stable jobs
    - Concerns about retaining young people and workforce participation
    - Struggles are especially noted by veterans, disabled individuals, and families
8. **Childcare & Youth Services**
    - Shortage of affordable childcare and after-school programming
    - Needs for parent education, youth activities, and support for young parents
    - Youth mental health and family support were also highlighted
9. **Education & Awareness**
    - Lack of health education, awareness of local resources, and digital literacy
    - Miscommunication or distrust in healthcare and public systems
    - The community called for better advertising, outreach, and school nutrition
10. **Community Infrastructure & Safety**
    - Issues included poor roads, sewer systems, stray animals, and blight
    - Concerns about lack of safe public spaces and exercise opportunities
    - Some mentioned crime, discrimination, and lack of accountability

Partner Survey

Primary Data

As part of the 2025 Hannibal Regional Community Health Needs Assessment (CHNA), regional partners—including representatives from healthcare, education, faith-based organizations, and the business community—were invited to share their insights on healthcare challenges and opportunities. A total of 44 individuals completed the survey, providing valuable perspectives from across Northeast Missouri.

Key Community Needs and Priorities
Respondents were asked to identify their top health priorities and offer potential solutions. Mental health access, substance use prevention, and primary care availability were frequently cited. Many emphasized the importance of addressing service gaps in rural areas, enhancing access to transportation, and supporting preventive care.

Strategies and Solutions
Twenty-three individuals shared specific strategies to improve healthcare access. Recommendations included:

- Increasing availability of telehealth services,
- Recruiting and retaining qualified physicians and providers,
- Hosting community health fairs and outreach events,
- Establishing a centralized rural health hub,
- Expanding support for individuals with disabilities and chronic conditions.

Community Roles and Partnerships
Nearly 30 responses emphasized the role of cross-sector collaboration. Partners suggested that:

- Businesses should offer wellness benefits and foster a culture of health,
- Nonprofits and faith-based organizations can extend outreach and education,
- Government entities must lead infrastructure improvements and funding efforts.

Vision for Transformational Impact
When asked what they would implement with unlimited resources, respondents proposed:

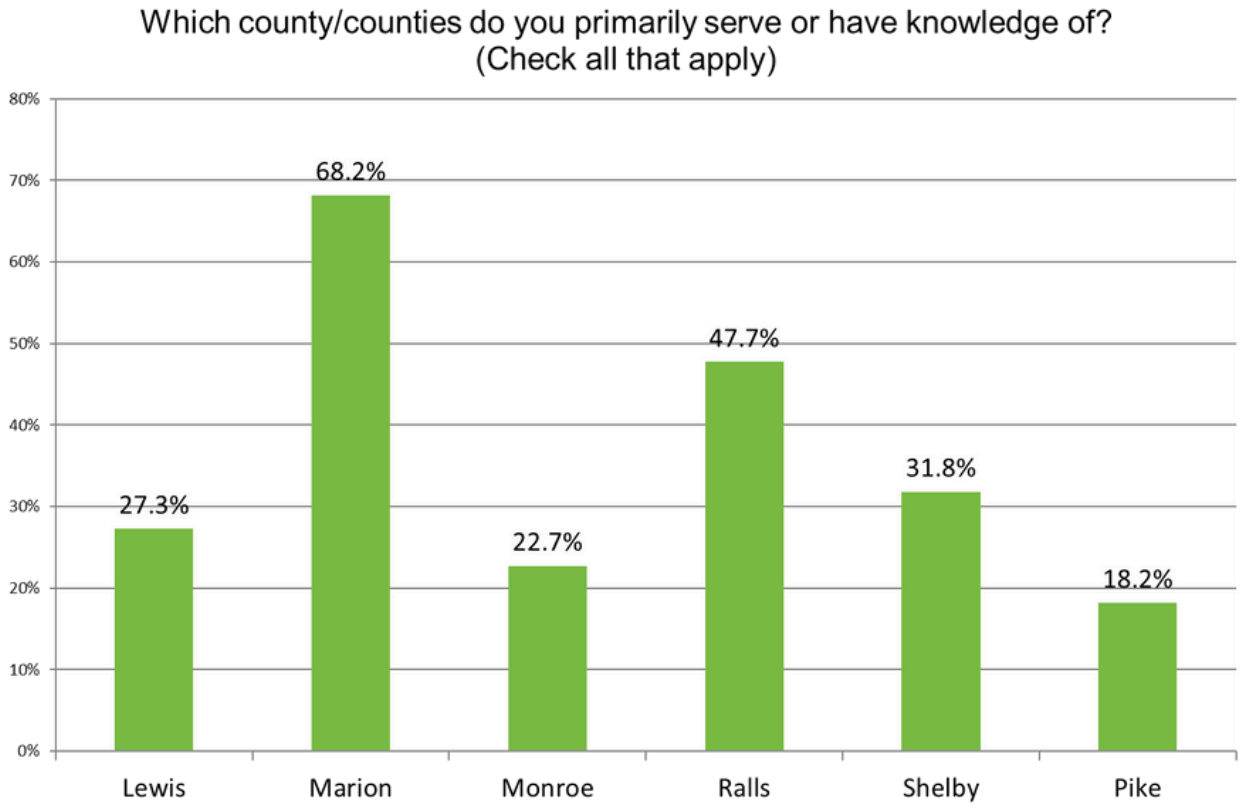
- A fully staffed rural health center,
- Free or subsidized primary care services,
- Expanded behavioral health infrastructure,
- Programs targeting obesity, prenatal care, and chronic disease prevention.

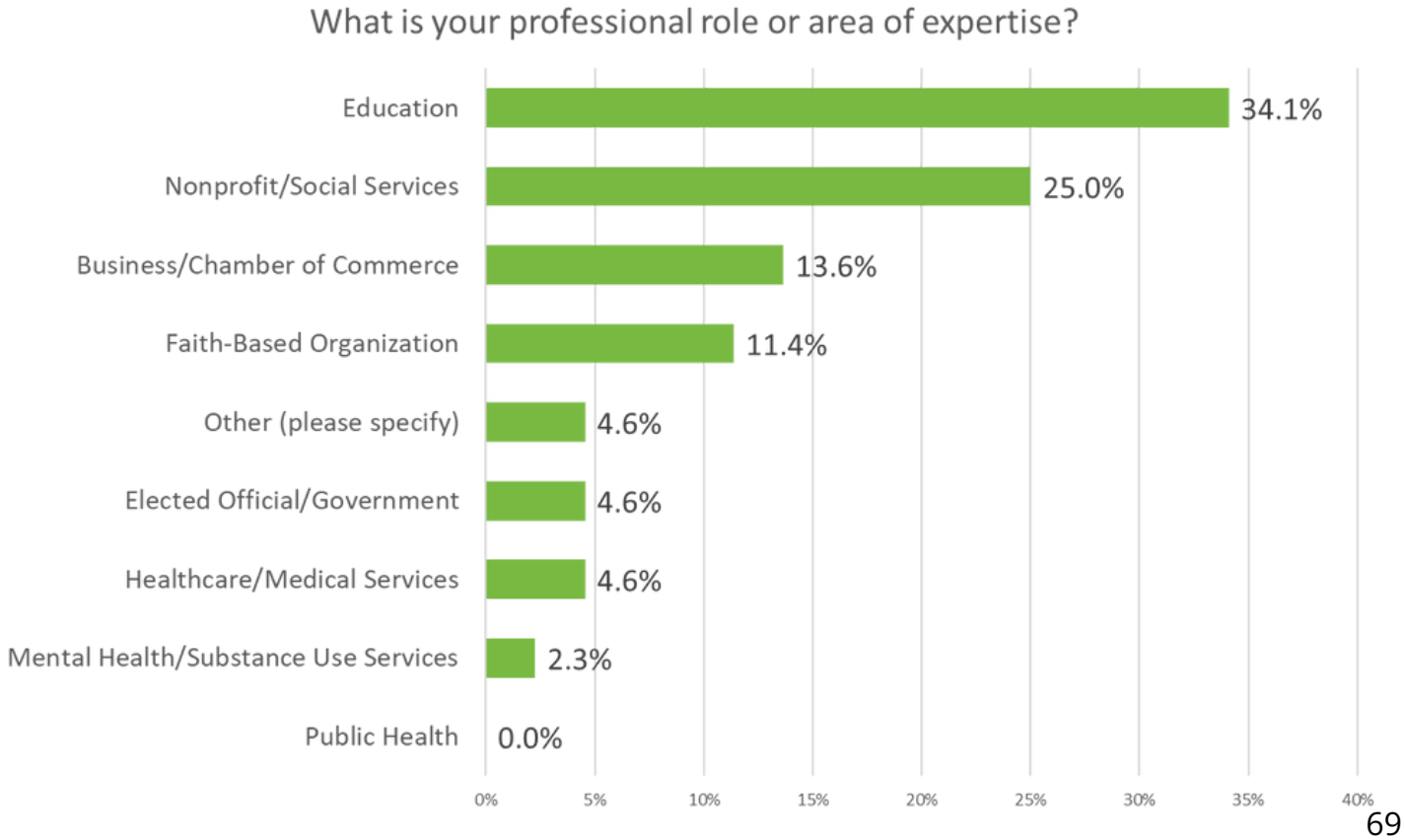
Additional Insights
Thirteen participants shared final reflections, calling for more localized leadership, improved quality of life supports, and greater investment in early intervention services—particularly for children.

Engagement
Several respondents expressed interest in ongoing CHNA efforts, including participation in the May 2025 Compression Planning Session at Hannibal Regional Hospital.

Partner Survey

Primary Data





Partner Survey

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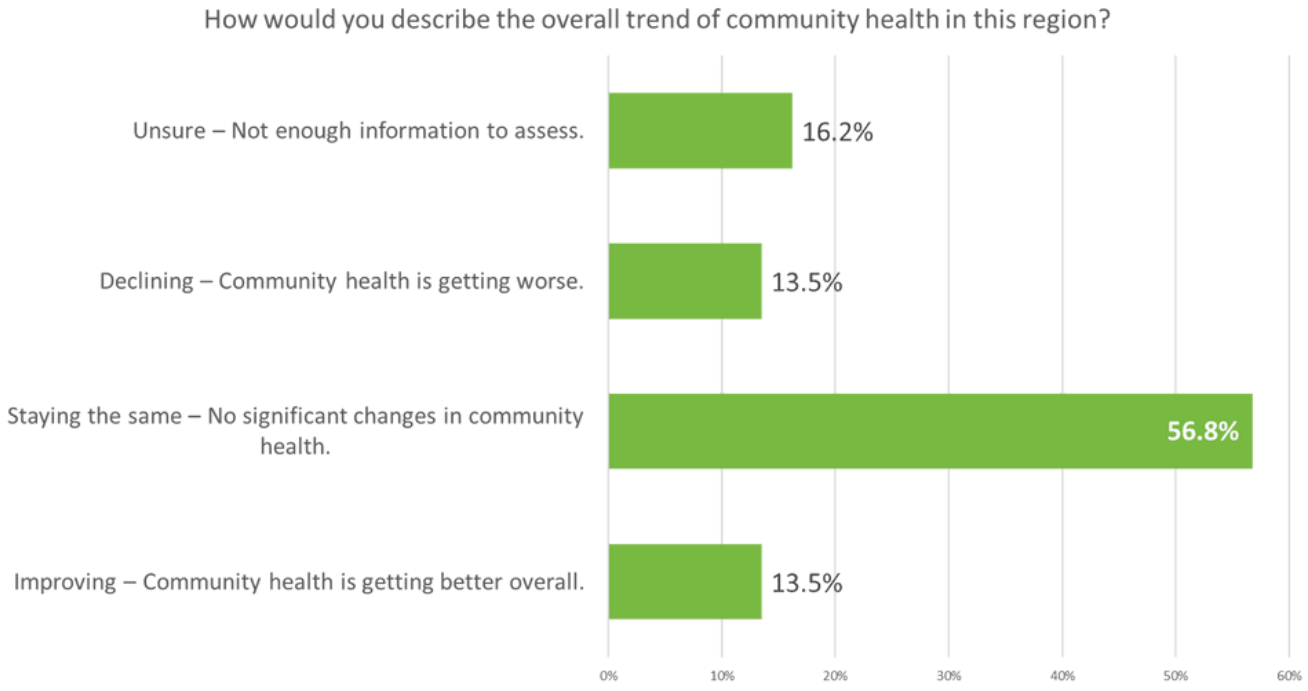
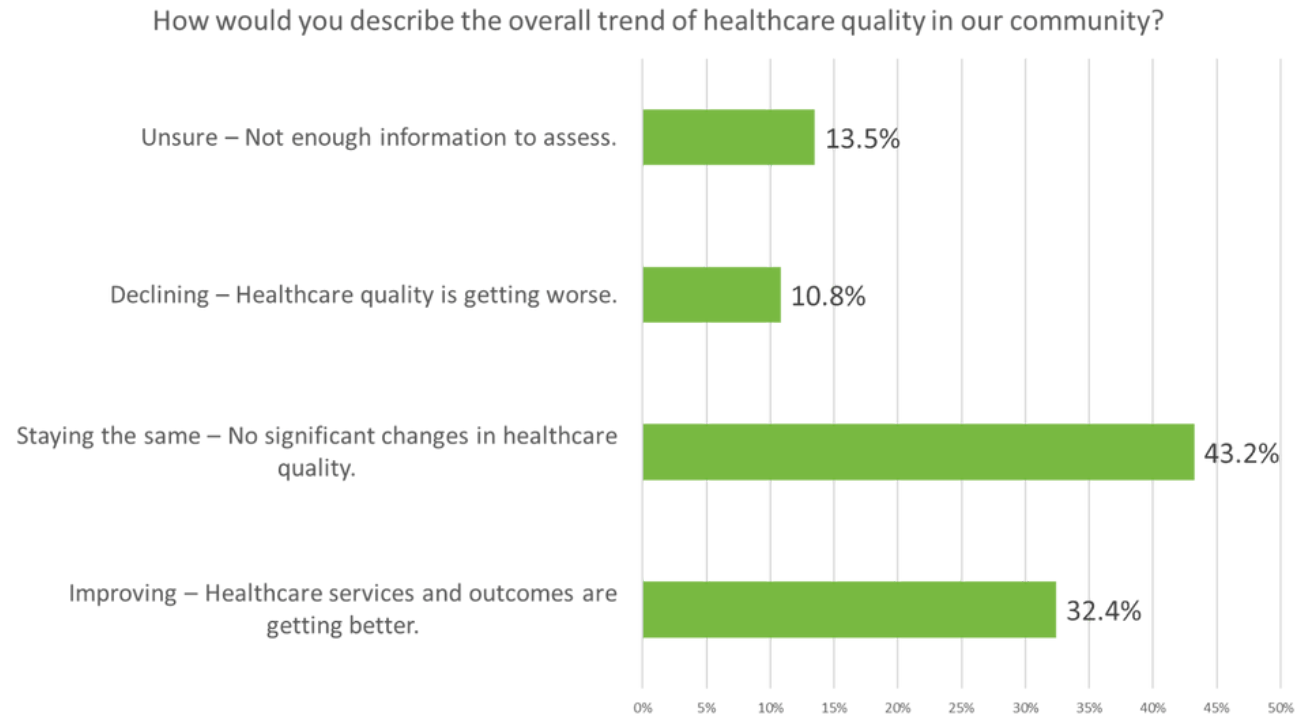




Partner Survey

Primary Data

What are the most critical health issues currently affecting the community? (List up to 3 top concerns.)

Survey responses highlighted Mental Health, Substance Use and Addiction, and Access to Care as the most critical health issues facing the community today. Cost and affordability emerged as significant barriers to both primary and specialty care. Respondents also frequently expressed concern over chronic diseases—particularly obesity, cancer, and heart disease—and the challenges associated with prevention and management. The feedback underscores the need for improved access, expanded mental health and substance abuse services, and more affordable, preventative, and community-based care solutions.

Top 5 Critical Health Issues (most frequently mentioned):

1. **Mental Health**
   - Frequently cited using various terms: mental health, mental health disorders, mental health care, social-emotional health
   - Includes concern for both adults and youth, as well as access to services and provider shortages.
2. **Substance Use and Addiction**
   - Includes mentions of drug use, substance abuse, opioid epidemic, addiction, illegal substances
   - Often noted alongside mental health, suggesting a co-occurring crisis.
3. **Access to Healthcare**
   - Includes barriers such as: lack of primary care providers, appointment availability, follow-through, provider shortages, especially in rural areas
   - Also includes specialty care access, lack of resources, and affordability as access barriers.
4. **Cost and Affordability of Care**
   - Includes mentions of: insurance constraints, high out-of-pocket costs, affordability issues, cost with or without insurance
   - This was often paired with access and trust concerns.
5. **Chronic Diseases and Conditions**
   - Includes obesity, diabetes, heart disease, cancer, COPD, smoking-related illness
   - Obesity and cancer were especially frequent among the chronic issues noted.

Additional Concerns Noted:

- Senior Health & In-Home Care Needs
- Dental Health
- Child Maltreatment
- Poverty-Related Health Issues
- Lack of Health Education / Preventative Care Awareness
- Distrust in the Healthcare System

See Appendix A for Survey Responses

Partner Survey

Primary Data

What are the top quality of life challenges impacting residents? (Examples: housing, transportation, employment, education, access to healthcare, food insecurity, etc.) (List up to 3 top challenges.)

Survey respondents identified housing, transportation, access to healthcare, childcare, and economic instability as the most pressing quality of life challenges facing their communities. Housing concerns—including affordability, homelessness, and lack of rental stock—were the most frequently mentioned. Many respondents also cited limited transportation options, particularly in rural areas, as a major barrier to work, healthcare, and services. Access to affordable and consistent healthcare, including dental and mental health services, remains a significant issue. The cost and availability of childcare are also impeding family stability and employment. These responses reflect ongoing concerns about economic resilience and basic needs not being consistently met.

Ranked List of Top Quality of Life Challenges

1. **Housing and Homelessness**
    - Commonly referenced terms include housing, affordable housing, decent housing, homelessness, and lack of rentals. Many noted the high cost of buying or renting, limited quality options, and a general shortage of safe, stable housing.
2. **Transportation**
    - Respondents frequently cited a lack of public or community-based transportation, primarily affecting rural areas. Transportation due to rural areas and safe infrastructure were specific concerns.
3. **Access to Healthcare**
    - This includes affording healthcare, access to healthcare providers, a lack of dental care, and inadequate health insurance. Multiple responses also tied in mental health service access and the cost burden of care.
4. **Childcare**
    - Challenges include availability, cost, affordability, and lack of options. Several respondents emphasized that the lack of reliable childcare has a direct impact on family stability and the ability to work.
5. **Employment and Economic Stability**
    - Issues mentioned include job availability, poverty, cost of living, lack of full-time work, inflation, and lack of a skilled workforce. These responses reflect ongoing economic insecurity and workforce gaps.

See Appendix B for Survey Responses

Partner Survey

Primary Data

Ranked List of Top Quality of Life Challenges (continued)

6. **Food Insecurity**
    - Multiple mentions of food insecurity and food access highlight that basic needs are not consistently being met for some residents.

Summary of Key Themes

- **Housing** was overwhelmingly the most cited issue, with concerns about affordability, availability, and quality.
- **Transportation** barriers—especially in rural settings—limit access to healthcare, work, and essential services.
- **Healthcare** access remains a major concern, particularly around affordability and availability of services, including dental and mental health.
- **Childcare** access and affordability were consistently noted as a barrier to work and family stability.
- **Economic challenges**, including underemployment, lack of living wages, and rising costs, continue to strain residents' quality of life.
- **Food insecurity** remains a persistent concern among many, reflecting broader systemic issues around poverty and resource access.

See Appendix B for Survey Responses

Partner Survey

Primary Data

Which populations are most at risk or vulnerable in terms of health and well-being? (Examples: low-income families, seniors, rural residents, children, people with disabilities, etc.)

Respondents overwhelmingly identified low-income families, seniors, and people with disabilities as the most at-risk populations in terms of health and well-being. Many highlighted the compounding challenges faced by individuals living in poverty, including a lack of access to healthcare, transportation, and basic resources. Children in low-income or unstable households, rural residents facing service gaps, and those with mental health needs were also commonly mentioned. A recurring concern was the unmet needs of middle-income families, who often earn too much to qualify for aid but cannot afford care out-of-pocket, placing them at a growing risk of health-related hardship.

Ranked List of At-Risk Populations

1. **Low-Income Families**
   - The most frequently cited group. Responses referenced poverty, families without support systems, those living paycheck-to-paycheck, generational poverty, and those who are un- or underinsured. Many noted this group often lacks consistent access to healthcare, transportation, and healthy food.
2. **Seniors / Older Adults**
   - Frequently mentioned as being on fixed incomes, isolated, or managing multiple chronic conditions. Some responses noted increased vulnerability among widowed or single seniors.
3. **People with Disabilities**
   - Repeated references to individuals with physical and mental disabilities, including concerns about access to specialized services and long-term support needs.
4. **Children**
   - Responses highlighted children in low-income households as especially vulnerable, especially when support structures like childcare, food, or healthcare are lacking.
5. **Rural Residents**
   - Identified as vulnerable due to geographic isolation, transportation barriers, and limited service availability. Some also noted stigma in rural areas as a barrier to seeking help.
6. **People with Mental Health Needs**
   - Included individuals needing services for mental illness or emotional support, often grouped with broader access issues or stigma concerns.

See Appendix C for Survey Responses

Partner Survey

Primary Data

Ranked List of At-Risk Populations (continued)

7. **Homeless and Housing-Insecure Individuals**
    - Responses noted those who are unhoused, couch-surfing, or living in doubled-up situations as especially at risk due to lack of stability and barriers to care.
8. **Middle-Class Families with High Medical Costs**
    - A few respondents noted that working-class or middle-income families fall into a "gap"—earning too much to qualify for assistance, but unable to afford care due to insurance deductibles and out-of-pocket costs.

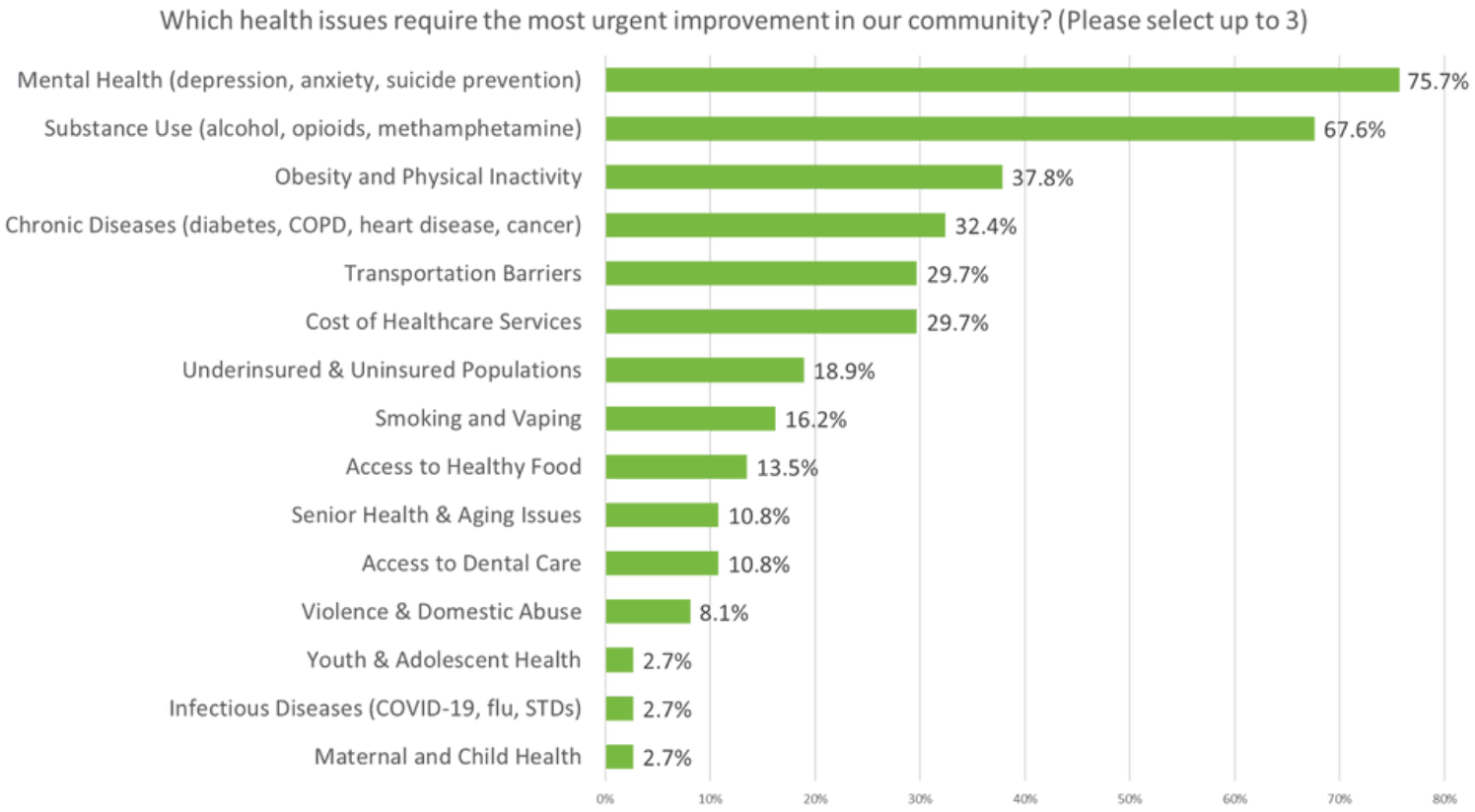
Summary of Key Themes

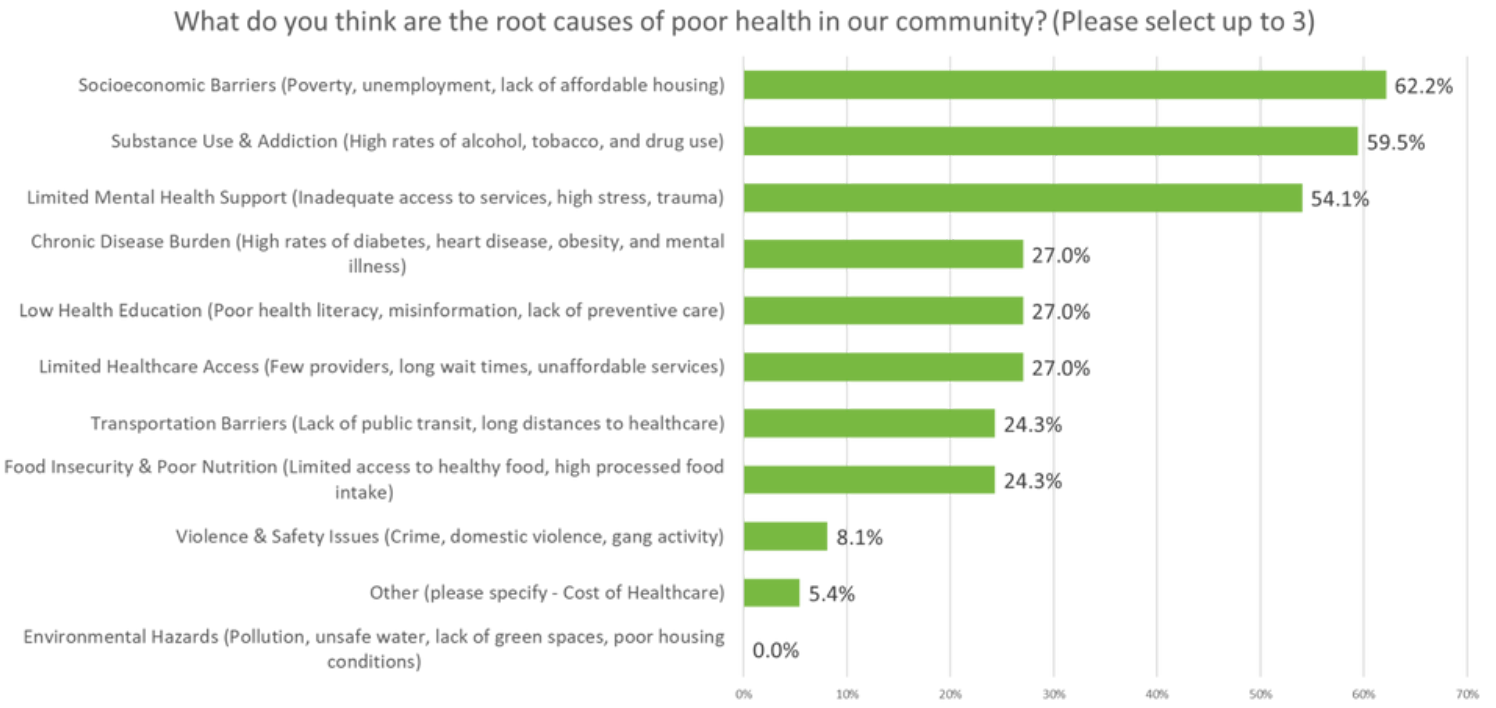
- Low-income families were overwhelmingly identified as the most vulnerable group due to barriers in accessing healthcare, transportation, and other basic needs.
- Seniors face challenges related to isolation, chronic illness, and limited financial flexibility.
- People with disabilities continue to struggle with access to care, support services, and community integration.
- Children, especially those in disadvantaged or unstable households, are seen as highly vulnerable to health and social risks.
- Rural residents face geographic, systemic, and cultural challenges in getting the help they need.
- A growing concern was also expressed about those who fall through the cracks, especially middle-income families facing affordability gaps.

See Appendix C for Survey Responses

Partner Survey

Primary Data





Partner Survey

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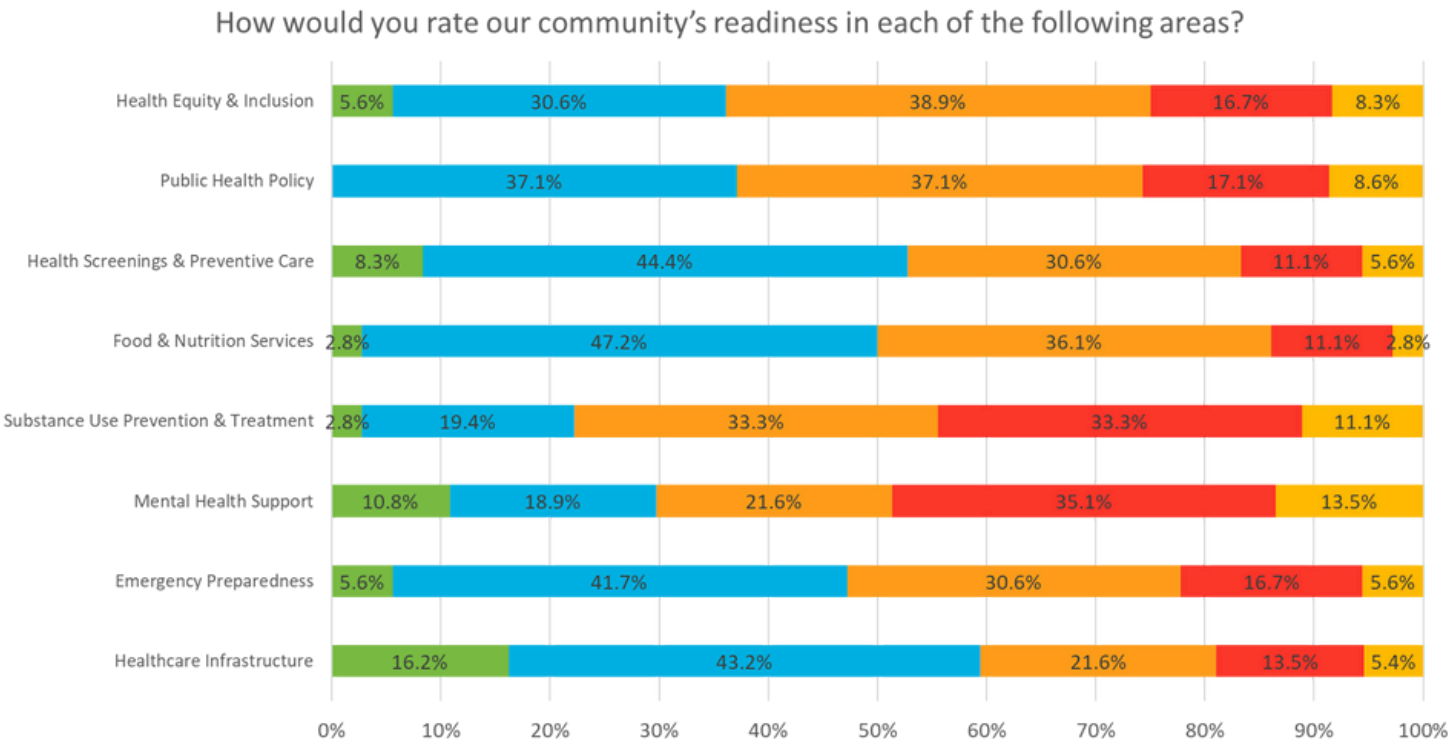


Partner Survey

Primary Data

What are the top 3 things that should be prioritized to improve community health over the next 3-5 years?

Survey respondents identified mental health services, healthcare access and affordability, and substance use treatment as the top three priorities for improving community health over the next three to five years. Many emphasized the need for in-person mental health treatment, expanded provider access, and reduced stigma. High healthcare costs and limited local service options were noted as significant barriers, particularly for rural and underinsured populations. Respondents also emphasized the importance of transportation, preventive health education, and stable housing as fundamental needs. These responses highlight the need for comprehensive, community-wide investments in both direct care services and the social determinants of health.

Ranked List of Top Priorities

1. **Access to Mental Health Services**
    - Nearly every response group mentioned mental health, including therapy access, residential treatment, crisis response, awareness, suicide prevention, and the need for in-person and expanded options. Mental health is a clear and urgent priority.
2. **Affordable and Accessible Healthcare**
    - Respondents emphasized the need for lower healthcare and medication costs, more local providers, improved insurance coverage, and accessible services, particularly in rural areas or for underinsured or uninsured individuals.
3. **Substance Use Treatment and Prevention**
    - Includes strong concern around opioid and drug use, calls for more rehabilitation programs, in-person treatment, prevention education, and collaboration with law enforcement and healthcare providers.
4. **Transportation**
    - Cited as a barrier to accessing care, especially for rural residents. Respondents want better public transportation options and improved infrastructure to access services.
5. **Health and Wellness Education / Prevention**
    - Focus on chronic disease prevention, healthy eating, physical fitness, school-based health education, and patient wrap-around support for managing health conditions.
6. **Affordable Housing and Social Supports**
    - Responses reflect concern about homelessness, housing stability, and the need for social services that address the root causes of poor health, such as poverty and unstable living conditions.

See Appendix D for Survey Responses

Partner Survey

Primary Data

Ranked List of Top Priorities (continued)

7. **Dental Health Services**
    - Several respondents highlighted the lack of affordable dental care, which is often overlooked in discussions about general health access.

Summary of Key Themes

- Mental health services emerged as the top priority, with respondents highlighting the need for greater availability, affordability, and in-person options, especially in underserved and rural areas.
- Healthcare access and affordability remain significant concerns, particularly regarding provider shortages, the cost of care, and inadequate insurance coverage.
- Substance use prevention and recovery programs were mentioned consistently, often alongside mental health needs, reflecting the urgency of addressing addiction in the community.
- Transportation is both a standalone priority and a barrier that intersects with all other concerns.
- Respondents also called for more health education and preventive care—from school-based programs to adult lifestyle coaching—as well as affordable housing and dental care, which rounded out the top priorities for long-term improvement.

See Appendix D for Survey Responses

Partner Survey

Primary Data

What strategies or solutions would you recommend to improve access to healthcare and social services?
Survey participants recommended a range of strategies to improve access to healthcare and social services, with transportation access, provider recruitment, and mobile or community-based services emerging as top priorities. Respondents emphasized the need to bring services closer to residents, primarily through mobile clinics, telehealth, and increased mental health capacity. Transportation challenges were seen as a persistent barrier, with support for expanded public or volunteer-driven transit options. Additional suggestions included strengthening community partnerships, implementing centralized referral systems, and increasing public awareness about available services. These strategies reflect a desire for both structural investments and grassroots engagement to close access gaps.

Ranked List of Top Themes

1. **Expand Transportation Options**
    - Most frequently mentioned strategy. Suggestions included public transportation systems, volunteer driver programs, rideshare partnerships, and funding for transportation to appointments, especially for rural residents.
2. **Increase Provider Access and Recruitment**
    - Many emphasized the need to bring more qualified providers, including physicians, dentists, and mental health professionals, especially to rural areas. Recommended strategies included loan forgiveness, incentives, and local training pipelines.
3. **Mobile and Community-Based Services**
    - A popular approach involved mobile clinics, on-site services, and community health events or fairs. These strategies were seen as effective for meeting people where they are, especially in underserved or hard-to-reach areas.
4. **Telehealth Expansion**
    - Multiple responses recommended increasing telehealth and virtual care options, particularly for individuals with transportation barriers or residing in rural areas with limited local healthcare providers.
5. **Stronger Cross-Sector Partnerships and Referrals**
    - Suggested improvements included collaboration among nonprofits, healthcare providers, schools, and local businesses, as well as the development of centralized databases for service referrals and coordination.

See Appendix E for Survey Responses

Partner Survey

Primary Data

Ranked List of Top Themes (continued)

6. **Public Awareness and Health Education**
    - Respondents noted the need for improved promotion of available services and community education on how to access care, including assistance with navigating systems such as Medicaid and completing forms.
7. **Reduce Costs and Barriers to Care**
    - Strategies included offering low-cost or no-cost healthcare services, subsidizing insurance premiums, and expanding preventive care programs to reduce long-term healthcare costs.
8. **Mental Health Capacity**
    - Many called for expanded mental health services, shorter wait times, and diversification of care options beyond nonprofits, pointing to a shortage of private providers in the area.

Summary of Key Themes

- **Transportation** is the most consistently mentioned barrier and solution. Respondents identified reliable and affordable transportation as crucial for enhancing access, particularly in rural and underserved communities.
- The need to **increase the healthcare workforce**, particularly in **mental health and dental services**, was emphasized, with recommendations for incentive programs and local partnerships to attract providers.
- **Community-based care models**, such as *mobile clinics and health fairs*, are widely supported as effective ways to connect services directly with populations in need.
- Respondents also support **expanding telehealth** and strengthening **collaborations** across sectors to streamline referrals and outreach.
- Several respondents emphasized the importance of **education and awareness,** ensuring that people are aware of the services available and how to access them, while also reducing stigma and confusion about the options.

Partner Survey

Primary Data

What role do you believe businesses, nonprofits, faith-based organizations, and government should play in improving community health?
Respondents believe that businesses, nonprofits, faith-based organizations, and government all play critical and complementary roles in improving community health. A recurring theme was the need for greater collaboration and shared responsibility across sectors to support health and well-being. Key recommendations included funding community services, offering workplace wellness programs, hosting outreach and educational events, and expanding access to mental health and crisis support services. Respondents emphasized that organizations should also take active roles in raising awareness of available resources, coordinating services, and advocating for infrastructure and policy improvements. The overarching message was clear: community health requires collective action.

Ranked List of Top Themes

1. **Collaboration and Shared Responsibility**
   - The most common theme. Respondents emphasized that all sectors—business, nonprofit, faith-based, and government—must collaborate, sharing responsibility and aligning their efforts to achieve meaningful community health improvements.
2. **Funding and Resource Support**
   - Many respondents stressed the need for financial investment, donation of supplies, fundraising, and grant support. These sectors are seen as critical enablers for sustaining local health initiatives, services, and staff.
3. **Education and Awareness**
   - Respondents suggested that organizations educate community members about health, available resources, and healthy living practices. Suggestions included offering incentives for healthy behavior, providing access to printed materials, and conducting public information campaigns.
4. **Direct Services and Program Delivery**
   - Several responses called for these sectors to host health events, provide outreach, offer wellness programs, and assist in service delivery, especially in underserved areas. Sponsoring services for those who cannot afford them was also mentioned.
5. **Workplace and Congregation-Based Health Initiatives**
   - Businesses were encouraged to offer insurance, wellness programs, and mental health support to employees. Faith-based organizations were encouraged to provide support groups, emergency aid, and safe community spaces.

See Appendix F for Survey Responses

Partner Survey

Primary Data

Ranked List of Top Themes (continued)

6. **Policy and Systems Advocacy (Government-Specific)**
    - Government was repeatedly identified as needing to lead infrastructure improvements (e.g., transportation, broadband) and pass policies that attract healthcare providers and fund public health efforts.
7. **Information Sharing and Coordination**
    - A recurring concern was that people are unaware of the services available. Several responses emphasized the importance of a centralized, accessible resource directory and better communication among organizations.

Brief Explanation of Each Theme

- **Collaboration** is viewed as foundational; siloed efforts won't move the needle on health outcomes.
- **Funding and resourcing** are critical: even the most active nonprofits or programs cannot meet demand without additional support.
- **Education** is both a strategy and an expectation for all sectors to help empower residents with health knowledge.
- **Direct service delivery** from these organizations—whether it involves sponsoring care or hosting outreach events—was viewed as a tangible, necessary role.
- **Workplace wellness** and **faith-based outreach** were highlighted as trusted, underutilized points of health engagement.
- **Government** has the power to build the infrastructure and policy environment that enables health equity.

Communication and referral systems are crucial in bridging the awareness gap and connecting residents to the help they need.

Partner Survey

Primary Data

If funding were not a constraint, what would be the one initiative or program you would implement to improve health in the region?
When asked to imagine solutions without funding limits, respondents overwhelmingly prioritized mental health and substance use services, along with the creation of comprehensive health hubs offering integrated, walk-in, and mobile care. A clear desire emerged for accessible, no-cost healthcare, especially for primary and preventive services. Respondents also stressed the importance of transportation infrastructure, school-based mental health programs, and support for food and housing insecurity. Several responses emphasized the importance of community wellness activities in promoting both physical and mental health. These ideas reflect a vision for a more equitable, integrated, and proactive health system that meets people where they are—geographically, financially, and emotionally.

Ranked List of Top Themes

1. **Mental Health and Substance Use Services**
    - Respondents consistently prioritized expanding mental health support, including inpatient psychiatric care, crisis intervention, school-based counseling, and substance use recovery programs. Suggestions included integrated services and crisis stabilization units.
2. **Comprehensive Community Health Centers**
    - Many proposed creating centralized, full-service health hubs offering primary care, preventive services, walk-in clinics, health education, and mobile units to reach rural populations. Some also envisioned these hubs as places for housing assistance, life skills training, and wraparound services.
3. **Free or Low-Cost Healthcare Access**
    - Several responses emphasized the importance of universal access to care, proposing initiatives such as free clinics, annual physicals, vaccinations, and coverage for those unable to afford it. The importance of affordable or no-cost services was a recurring concern.
4. **Transportation to Care**
    - Respondents emphasized the need for free, reliable public or community transportation, especially for rural residents or those without access to vehicles. This included on-demand options, not just fixed appointment shuttles.
5. **School- and Youth-Based Support Services**
    - Suggestions included placing case managers or counselors in schools, increasing access to mental health services for children, and addressing barriers faced by rural families in reaching care for their children.

See Appendix G for Survey Responses

Partner Survey

Primary Data

Ranked List of Top Themes (continued)

6. **Addressing Food Insecurity and Homelessness**
    - Several responses highlighted the importance of nutrition programs, food access, and housing support as critical health-related interventions.
7. **Health Promotion and Physical Activity**
    - Some emphasized the importance of *prevention through fitness and education*, including *community events, sports, walking programs,* and education on *chronic disease prevention*.

Brief Explanation of Each Theme

- **Mental health and substance use services** topped the list due to current shortages and urgent community needs across all age groups.
- **Comprehensive health hubs** were envisioned as efficient one-stop solutions, especially for underserved areas.
- **Cost-free healthcare** reflects the continued concern that *financial barriers prevent people from accessing care, even when programs exist*.
- **Transportation solutions** were frequently mentioned as a foundational requirement for accessing other services.
- **Youth and school supports** recognize schools as key access points, particularly in rural areas.
- **Social determinants, such as food and housing,** were seen as inseparable from health outcomes.
- **Fitness and education programs** emphasize community-wide health improvement through lifestyle change and preventive care.

Partner Survey

Primary Data

Is there anything else you would like to share about community health, quality of life, or access to care?

In closing comments, survey respondents reiterated that mental health and substance use services are among the most urgent unmet needs in the community, with profound implications for both individuals and families. Concerns about access to quality, affordable healthcare, particularly for children and rural residents, remain a prominent issue. Respondents also emphasized the need for increased coordination across healthcare, education, nonprofit, and business sectors to address systemic challenges. Housing affordability, transportation barriers, and lack of developmental services for children were also cited as key obstacles to health and well-being. While community pride and resilience were noted, there is a clear call for more substantial and unified efforts to improve the quality of life and health outcomes for all.

Ranked List of Top Themes

1. **Mental Health and Substance Use Services**
   - The most common concern. Respondents emphasized the urgent need for expanded access to mental health care, crisis response, and substance use treatment, particularly for children, rural residents, and those facing stigma.
2. **Healthcare Access and Quality**
   - Many called for readily accessible, high-quality healthcare services for all, especially preventive care and pediatric diagnostics. Long wait times and a lack of providers were mentioned as critical issues.
3. **Rural and Agricultural Community Challenges**
   - Responses specifically noted the stress, isolation, and stigma faced by farmers and rural residents, highlighting the need for tailored outreach and farmer-specific support programs.
4. **Collaboration Across Sectors**
   - Several responses stressed the importance of coordinated action among healthcare providers, schools, nonprofits, and businesses, and suggested mobile services and telehealth as viable strategies.
5. **Children's Health and Development**
   - Respondents highlighted the lack of timely access to professionals who diagnose developmental or learning disabilities, such as dyslexia, as well as child-focused mental health care.
6. **Housing and Social Determinants of Health**
   - A few comments highlighted the impact of housing insecurity and rental costs on health and stability, particularly for vulnerable populations utilizing services such as warming centers.

See Appendix H for Survey Responses

Partner Survey

Primary Data

Ranked List of Top Themes (continued)

7. **Community Strength and Engagement**
    - Some expressed optimism about the community's willingness to respond to need, but noted that systemic support and leadership from health departments is still lacking.

Brief Explanation of Each Theme

- **Mental health and substance use** continue to be viewed as the most pressing and interrelated health issues, with ripple effects across employment, education, and family stability.
- **Access to healthcare**, especially *preventive and pediatric services*, remains limited, and *geographic and financial barriers* were frequently noted.
- **Rural residents**, especially in the farming community, face unique barriers due to stigma, stress, and limited service availability.
- **Cross-sector collaboration** was seen as essential for maximizing resources and delivering care more efficiently and locally.
- **Developmental health for children** is under-resourced, with families facing long waits and few providers.
- **Housing costs and instability** were linked to worsening health outcomes, especially for low-income and unhoused populations.

Community spirit was noted as a strength, but several respondents emphasized that more *institutional leadership and coordinated action* are still needed.

See Appendix H for Survey Responses

Stakeholder Interviews

Stakeholder Interviews Executive Summary

This CHNA draws upon in-depth interviews with 31 individuals representing a diverse cross-section of professional and community leadership across Northeast Missouri. Participants span sectors including healthcare, public health, education, business, agriculture, law enforcement, local government, philanthropy, and nonprofit services. Many hold executive roles in hospitals, school systems, and civic institutions, while others work directly with community members through grassroots efforts, faith-based services, and social work. Their collective insights reflect firsthand experience across Lewis, Marion, Monroe, Ralls, Shelby, and Pike counties, providing a regionally interconnected and locally grounded perspective on persistent and emerging health needs.

Stakeholders described the overall health of the community as either stagnant or declining, with mental health, substance abuse, and chronic illness emerging as persistent challenges. Barriers to healthcare access include affordability, availability of providers, transportation, and health literacy. Social determinants, such as poverty, housing, and education, were consistently cited as the root causes of poor health. Stakeholders emphasized that local strengths—including community partnerships, available land, and existing programs—could be leveraged to improve outcomes. Participants recommended mobile health units, expanded mental health services, workforce development, and community-based education as top solutions. Across interviews, there was a clear call for collaboration between health systems, nonprofits, businesses, and local government to drive sustainable change.

Stakeholder Perceptions of Community Health

▼ Declining – 13 Participants

- These interviewees explicitly described overall health in the community as getting worse, citing mental health crises, chronic disease, substance use, and systemic access issues.

● Stagnant / Staying the Same – 11 Participants

- These individuals described health as mostly unchanged, often with pockets of worsening outcomes for specific groups.

● Improving – 4 Participants

- A small number reported mild or localized improvements, often attributed to wellness programs or increased awareness following the pandemic.

Top Themes

Stakeholder Interviews

1. Mental Health & Substance Use as Dominant Health Challenges

Every interview included concerns about the mental health crisis, citing both a lack of services and growing demand. Substance use, especially meth and opioids, is also a persistent issue. Mental health challenges were universally cited as one of the region's most urgent and under-resourced issues. Stakeholders noted long wait times for services (often exceeding three months), shortages of healthcare providers, and rising demand across all age groups, particularly among young people and the elderly who live alone. Substance use, particularly methamphetamine addiction, remains widespread, with some interviewees citing its intergenerational impact and connection to trauma, poverty, and inadequate treatment options.

Quotes:

- "Mental health is the biggest concern—people are struggling in silence, and services are either far away or waitlisted for months."
- "Mental health is the biggest challenge in the community."
- "Meth is accessible, cheap, and it's ruining people. We don't have anywhere to send them."
- "Addiction spans generations now. We're seeing it in both youth and older adults."
- "Mental health and substance use are top issues. We're seeing it across generations."
- "We have to wait three months for a mental health appointment—that's not helpful."
- "There's a huge shortage of mental health providers. We really need an inpatient facility."

2. Access Barriers: Affordability, Availability, and Transportation

Stakeholders described systemic barriers, including the cost of care, a shortage of specialists, long wait times, and a lack of reliable transportation, especially in rural areas. Geographic and financial barriers to care persist, exacerbated by a rural healthcare workforce crisis. Interviewees cited shortages in primary and specialty care—especially in mental health, dental, and pediatric specialties—and expressed concerns over transportation, cost, and navigating care. Several noted that the lack of coordinated, continuous care leads many residents to forgo preventive services or rely on emergency rooms.

Quotes:

- "Even with insurance, people can't afford to go. The deductible is too high, so they just wait until things get worse."
- "Transportation is a huge issue. Even with Medicaid transport, the logistics are a nightmare."
- "People don't go to the doctor unless it's an emergency—because they can't afford it."
- "If you don't have transportation, you don't have healthcare."

Top Themes

Stakeholder Interviews

3. Social Determinants: Poverty, Housing, and Education

Interviewees consistently pointed to poverty, lack of affordable housing, and education gaps as root causes affecting health and well-being. Poverty, unstable housing, transportation, and food insecurity were consistently named as drivers of poor health outcomes. Generational poverty and systemic underinvestment in infrastructure (e.g., sidewalks, internet access, childcare) limit residents' ability to make healthy choices. Vulnerable populations include low-income families, isolated seniors, people with disabilities, and rural residents disconnected from services.

Quotes:

- "Generational poverty feeds into everything—education, food, stress, and ultimately health."
- "We have kids coming to school hungry, tired, and traumatized. That's where health starts."
- "Affordable housing isn't just a housing issue—it's a health issue."
- "The cycle of poverty is real. You can't just tell people to eat better or exercise when they can't meet basic needs."
- "We're dealing with generational unhealthy behaviors. This doesn't change overnight."
- "People are living in houses without running water. That affects health, too."
- "People aren't lazy—they just don't see wellness as realistic. When you're working two jobs, a salad isn't priority one."

4. Community Strengths & Willingness to Collaborate

- Despite challenges, stakeholders identified community assets—such as local programs, nonprofits, and civic-minded businesses—as critical to driving solutions. While the region faces deep-rooted challenges, stakeholders identified promising community assets. These include grassroots nonprofits, strong partnerships between schools and public health, local foundations, and cross-sector collaboration efforts. Many emphasized the need to build on these strengths through mobile health delivery, prevention-focused strategies, upstream investments in early childhood and family well-being, and better provider coordination.

Quotes:

- "There's a lot of pride and connection here. The community will step up—if we ask."
- "Businesses like ours are willing to host gardens, sponsor wellness programs, we just need direction."

Top Themes

Stakeholder Interviews

Quotes:

- “United Way and our health department work well together—it’s a good foundation to build on.”
- “I think collaboration is our greatest strength. We just have to keep building on it.”
- “There's a role for everyone—businesses, nonprofits, government—we need to be rowing in the same direction.”
- “We’ve got the right partners—it’s just about connecting them better and having someone lead the charge.”

5. Recommended Solutions: Mobile Clinics, Education, and Workforce

Stakeholders advocated for practical, scalable solutions, including mobile health units, expanding mental health infrastructure, increasing healthcare education, and improving rural provider recruitment.

Quotes:

- “If we had unlimited resources, I’d build an inpatient psych facility yesterday.”
- “Bring the services to people—mobile clinics are a no-brainer in rural areas.”
- “Mobile care is the future. We need to meet people where they are—in schools, at churches, in parking lots.”
- “We need to train and attract the next generation of healthcare workers—and keep them here.”
- “We know what works—prevention, education, and community trust. Now, we need the infrastructure to do it.”
- “We’ve got heart. But we need a brain. Someone has to own this work and keep the momentum going.”

Stakeholder Interview Participants:

Allie Bennett
Michael Blase
Rhonda Byers
Paula Delaney
Andy Dorian
Jolie Foreman
Abe Gray
Jason Harper
Stephanie Himmel
Larry Hinds
Wendy Johnson
Meghan Karr
Alisha Krietemeyer
Brad Kurz
Amy Lehenbauer
Crystal McWilliams
Lacey Miller
Marshall Miller
Eric Murfin
Chief Jacob Nacke
Bryan Nichols
Craig Parsons
Ryan Pickett
Deanna Pinkham
Darin Redd
Mary Lynne Richards
Debbie Sommers
Talley Smith
Cindy Whiston
Beth Wiemelt
Maekayla Wiler

SECONDARY DATA

Population Health and Well-Being

The Population Health and Well-Being section provides an overview of key indicators that reflect both how long and how well people live across the CHNA region. It includes measures of length of life, such as premature death and life expectancy, as well as quality of life indicators like poor physical and mental health days, frequent distress, and self-reported overall health.

The section also highlights the prevalence of chronic conditions, including obesity, diabetes, coronary heart disease, cancer, and HIV. Additional indicators such as low birth weight, suicide rates, and feelings of loneliness offer insight into maternal and mental health challenges. Together, these data points paint a comprehensive picture of community health, illuminating disparities, risk factors, and potential areas for public health improvement.

Length of Life

- **Life Span**
  - Premature Death
  - Life Expectancy
  - Premature Age-Adjusted Mortality
  - Cancer
  - Coronary Heart Disease

Quality of Life

- **Physical Health**
  - Poor Physical Health Days
  - Low Birth Weight
  - Frequent Physical Distress
  - Diabetes Prevalence
  - HIV Prevalence
  - Adult Obesity
- **Mental Health**
  - Poor Mental Health Days
  - Frequent Mental Distress
  - Suicides
  - Depression Rates
- **Life Satisfaction**
  - Poor or Fair Health
  - Feelings of Loneliness

Population Health and Well-Being Snapshot

Population Health and Well-Being								
Length of Life	**LEWIS**	**MARION**	**MONROE**	**RALLS**	**SHELBY**	**PIKE**	**MISSOURI**	**U.S.**
Premature Death	9,100	11,100	9,800	10,300	8,500	9,000	10,000	8,400
Quality of LIfe								
Poor Physical Health Days	5.1	4.8	5	4.6	5.2	4.8	4.2	3.9
Low Birth Weight	9%	9%	10%	10%	7%	9%	9%	8%
Poor Mental Health Days	5.9	5.9	5.9	5.7	6	5.9	5.5	5.1
Poor or Fair Health	23%	19%	21%	18%	22%	21%	17%	17%

Community Conditions								
Health Infrastructure	**LEWIS**	**MARION**	**MONROE**	**RALLS**	**SHELBY**	**PIKE**	**MISSOURI**	**U.S.**
Flu Vaccinations	26%	21%	37%	25%	34%	31%	47%	48%
Access to Exercise Opportunities	30%	83%	48%	21%	36%	31%	77%	84%
Food Environment Index	6.7	7.4	7.4	8.2	6.5	7	6.6	7.4
Primary Care Physicians	5,000:1	980:1	2,900:1	10,360:1	5,980:1	5,920:1	1,420:1	1,330:1
Mental Health Providers	2,450:1	310:1	4,350:1	1,750:1	5,930:1	1,380:1	380:1	300:1
Dentists	9,890:1	1,180:1	8,650:1	10,420:1	2,990:1	2,940:1	1,600:1	1,360:1
Preventable Hospital Stays	3,441	3,705	3,582	2,757	2,306	3,044	2,938	2,666
Mammography Screening	41%	52%	46%	49%	44%	40%	46%	44%
Uninsured	13%	10%	13%	10%	13%	13%	10%	10%
Physical Environment	**LEWIS**	**MARION**	**MONROE**	**RALLS**	**SHELBY**	**PIKE**	**MISSOURI**	**U.S.**
Severe Housing Problems	12%	11%	11%	12%	8%	11%	13%	17%
Driving Alone to Work	78%	78%	82%	82%	83%	82%	76%	70%
Long Commute- Driving Alone	39%	20%	39%	25%	26%	28%	31%	37%
Air Polution: Particulate matter	7.9	7.9	7.6	7.8	7.5	7.9	7.5	7.3
Drinking Water Violations	No	Yes	Yes	Yes	No	Yes	N/A	N/A
Broadband Access	72%	89%	80%	89%	82%	84%	88%	90%
Library Access	<1	2	6	<1	2	3	2	2
Social and Economic Factors	**LEWIS**	**MARION**	**MONROE**	**RALLS**	**SHELBY**	**PIKE**	**MISSOURI**	**U.S.**
Some College	53%	56%	49%	54%	56%	36%	67%	68%
High School Completion	87%	90%	90%	91%	90%	87%%	92%	89%
Unemployment	2.9%	3.1%	3.2%	2.8%	2.7%	3.2%	3.1%	3.6%
Income Inequality	4.5	4.2	5.7	4.3	4.6	4.7	4.5	4.9
Children in Poverty	19%	15%	15%	15%	19%	19%	15%	16%
Injury Deaths	83	100	65	109	90	84	104	84
Social Associations	12.1	17.2	9.2	8.6	28.4	13	11.4	9.1
Child Care Cost Burden	25%	31%	28%	26%	24%	29%	31%	28%

Length of Life

Length of life measures the time between birth and death and how often people die early. Everyone should have the resources and opportunities to live long and well, regardless of where they live.

Life Span

Premature Death

This indicator reports the Years of Potential Life Lost (YPLL) before age 75 per 100,000 population for all causes of death. Figures are reported as crude rates and as rates age-adjusted to the year 2000 standard. YPLL measures premature death and is calculated by subtracting the age of death from the 75-year benchmark. Data were from the National Center for Health Statistics - Mortality Files (2020-2022) and are used for the 2025 County Health Rankings. This indicator is relevant because a measure of premature death can provide a unique and comprehensive look at overall health status.

Within the report area, there are a total of 1,528 premature deaths from 2020 to 2022. This represents an age-adjusted rate of 9,962 years potential life lost before age 75 per every 100,000 total population.

Report Area	Premature Deaths	Years of Potential Life Lost	Years of Potential Life Lost
	2020-2022	2020-2022	Rate per 100,000 Population
CHNA Counties	1,528	22,112	9,962
Lewis	167	2,456	9,061
Marion	558	8,760	11,135
Monroe	160	2,278	9,787
Pike	336	4,351	8,951
Ralls	200	2,900	10,269
Shelby	107	1,367	8,507
Rural Missouri	17,430	245,049	11,340
Missouri	105,598	1,708,954	9,970
United States	4,763,989	77,421,586	8,367

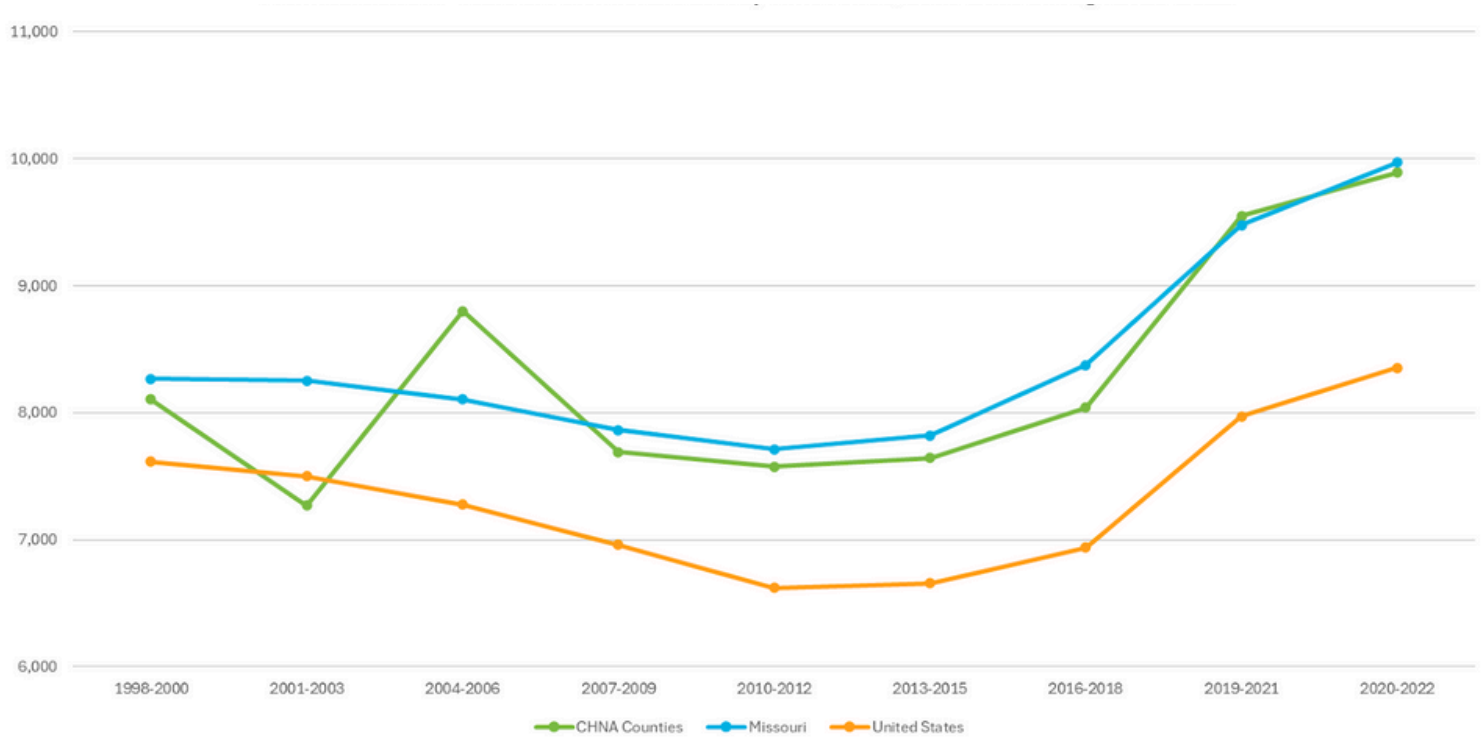
Source: Recovery Friendly Workplace Missouri

Premature Death

Length of Life | *Life Span*

Premature Death

Years of Potential Life Lost by Time Period, 1998-2000 through 2020-2022

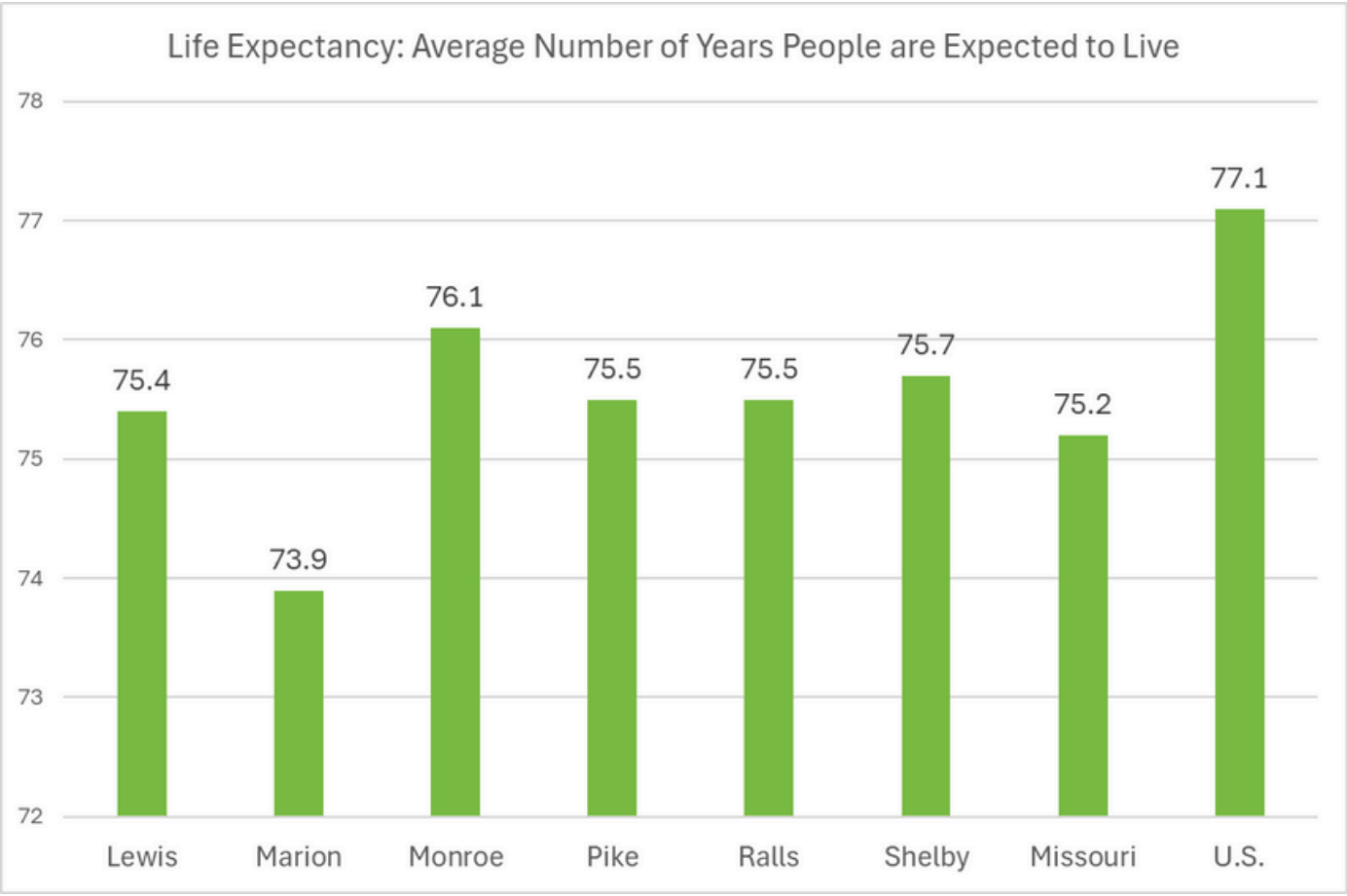


Source: Recovery Friendly Workplace Missouri

Life Expectancy

Length of Life | ***Life Span***

This measure reflects the average number of years a person is expected to live, using data from 2020–2022. Life expectancy is a widely recognized indicator of overall population health and is often easier to understand than more complex mortality metrics. It captures the cumulative impact of social, economic, environmental, and health system factors on community well-being and serves as a benchmark for comparing health outcomes across populations and regions.

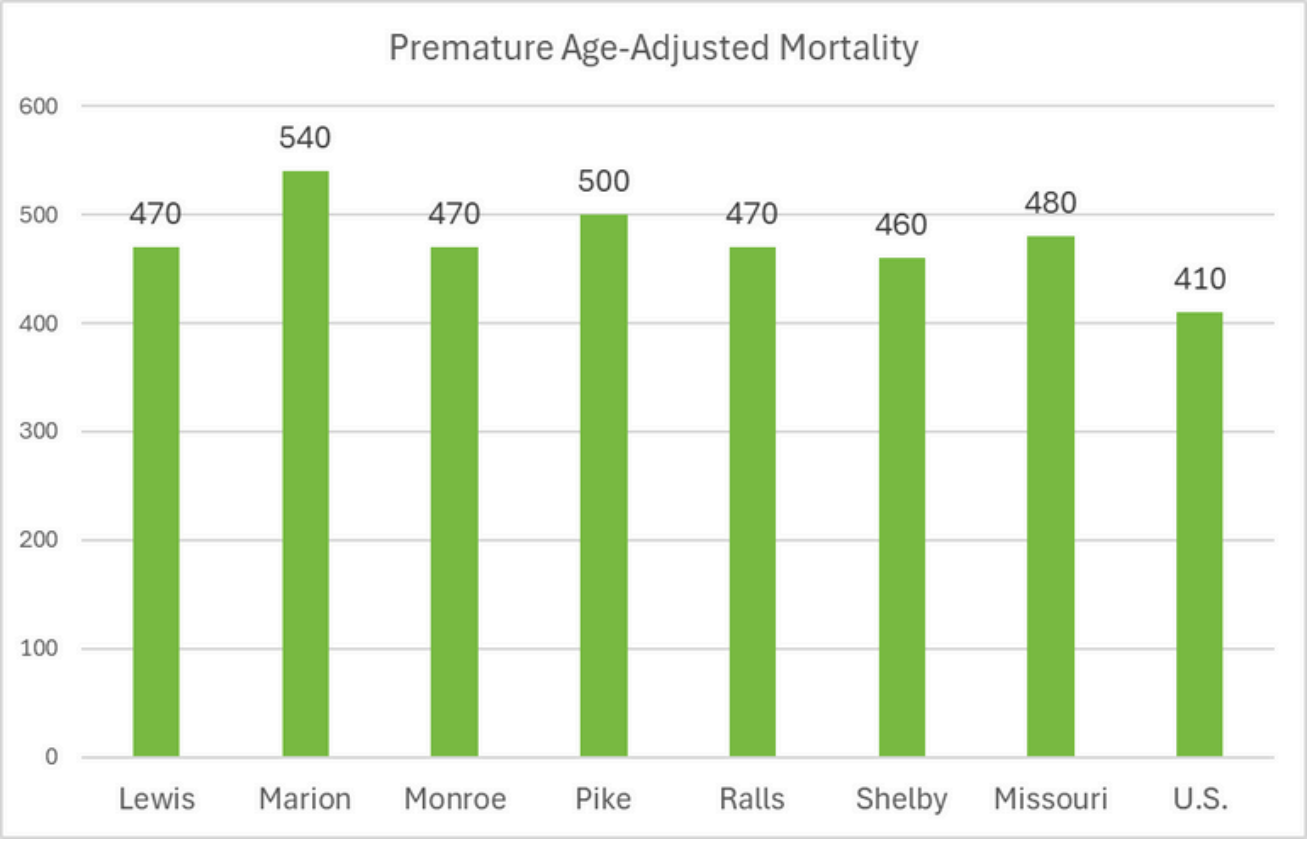


Source: County Health Rankings & Roadmaps 2025 Annual Data Release

Premature Age-Adjusted Mortality

Length of Life | ***Life Span***

This measure reflects the number of deaths among residents under age 75 per 100,000 population, adjusted for age, using data from 2020–2022. It highlights preventable early deaths and is a key indicator of community health. Tracking premature mortality helps identify geographic disparities and populations at higher risk of early death, often linked to chronic disease, substance use, violence, and other social determinants of health.

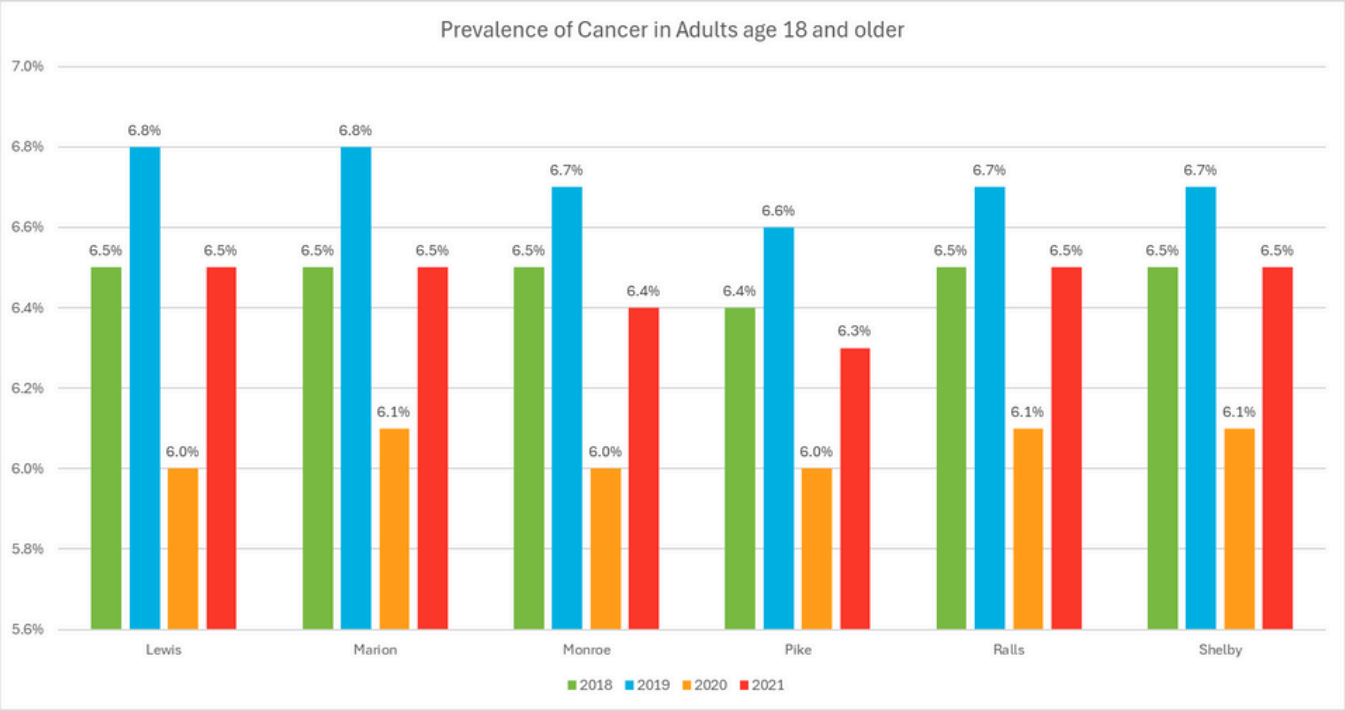


Source: County Health Rankings & Roadmaps 2025 Annual Data Release

Cancer

Length of Life | *Life Span*

This measure reflects the percentage of adults aged 18 and older who have been diagnosed with cancer. Cancer remains one of the leading causes of death and disease burden in the United States. Prevalence data help identify the overall impact of cancer in communities and inform prevention, early detection, and treatment strategies. Understanding cancer prevalence is critical for allocating resources, guiding public health programs, and addressing health disparities.

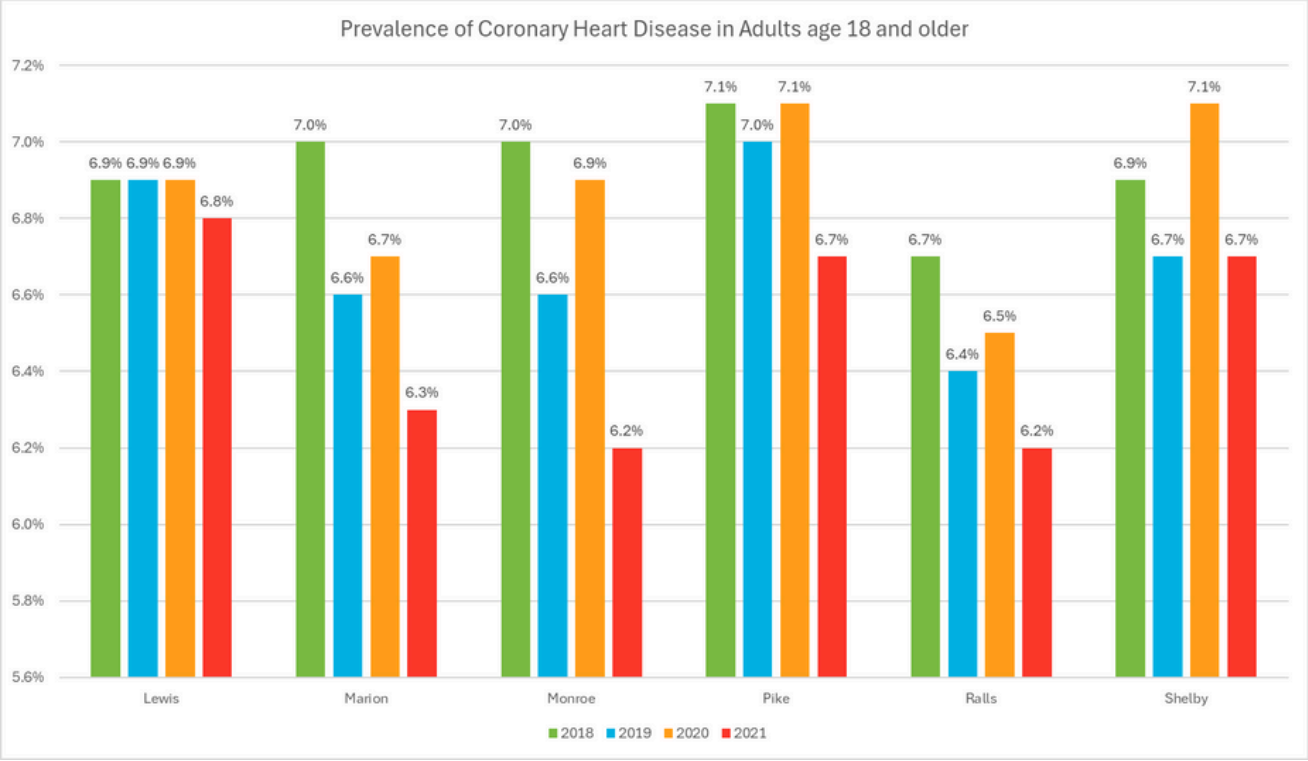


Source: Source: National Environmental Public Health Tracking Network
Accessed From: https://ephtracking.cdc.gov/DataExplorer. Accessed on 04/18/2025

Coronary Heart Disease

Length of Life | *Life Span*

This measure indicates the percentage of adults aged 18 and older diagnosed with coronary heart disease (CHD). CHD is a leading cause of death in the United States and contributes significantly to morbidity, especially among older adults. Tracking CHD prevalence helps communities assess the burden of cardiovascular disease, identify at-risk populations, and guide interventions focused on prevention, lifestyle modification, and management of heart health.



Source: National Environmental Public Health Tracking Network
Accessed From: https://ephtracking.cdc.gov/DataExplorer. Accessed on 04/18/2025

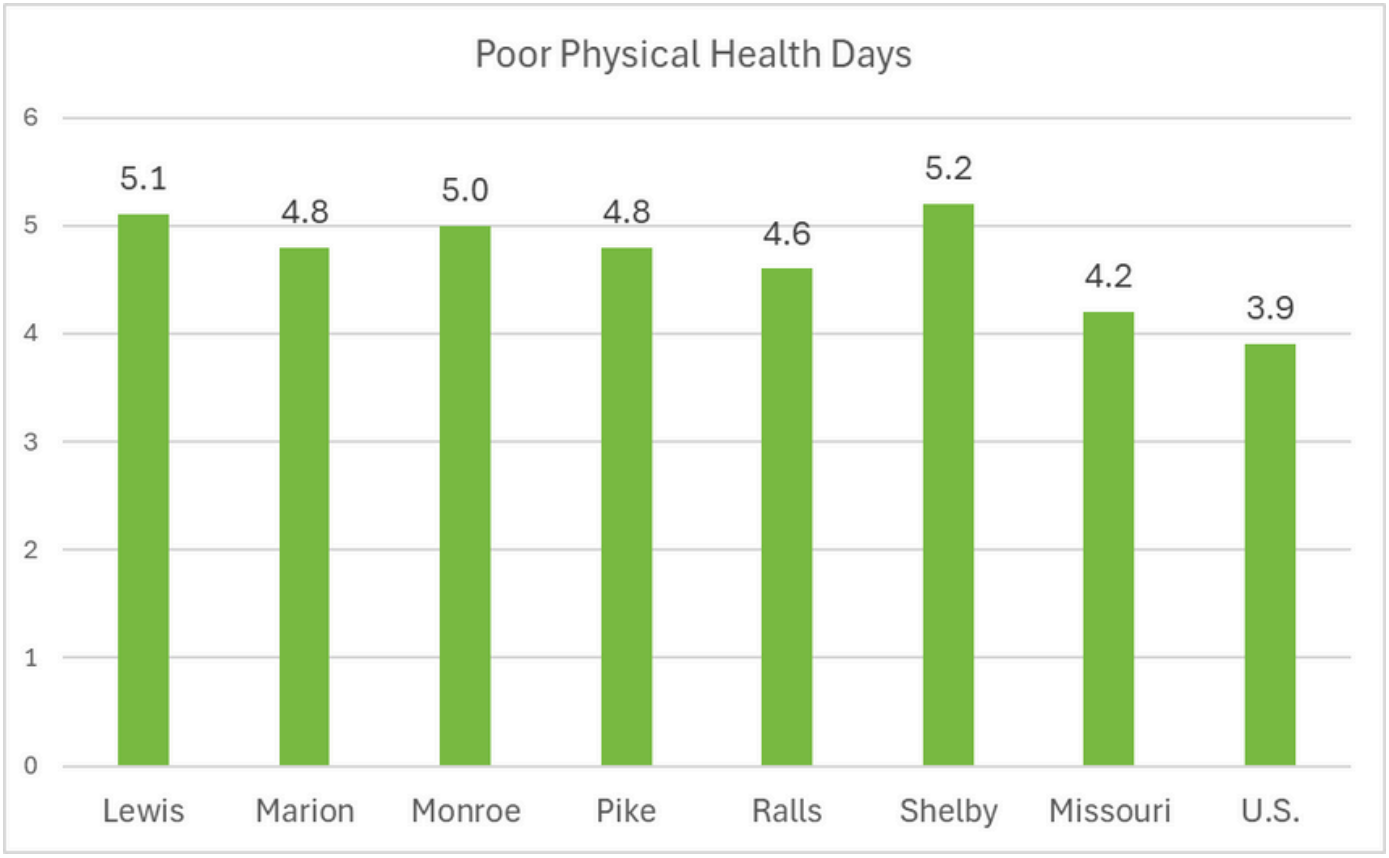
Quality of Life

Quality of life underscores the importance of physical, mental, social and emotional health throughout the life course. Quality of life reflects internal conditions, such as perceived health, life satisfaction and self-esteem. Quality of life also includes external aspects that enable people to live well, such as environmental and housing quality and community safety. Quality of life data tell us how people assess their overall well-being. Self-assessed health correlates with actual health outcomes. Health-related quality of life focuses on how a person's health impacts their ability to live a full life.

Physical Health

Poor Physical Health Days

This measure reflects the average number of physically unhealthy days reported by adults in the past 30 days (age-adjusted), based on 2022 data. It serves as an important indicator of health-related quality of life (HRQoL), especially for individuals with chronic conditions or disabilities. Research shows that communities with more unhealthy days also tend to have higher rates of poverty, unemployment, disability, and lower educational attainment. While self-reported health data are reliable, differences in reporting by race, ethnicity, and cultural perceptions of health should be considered when making comparisons across populations.

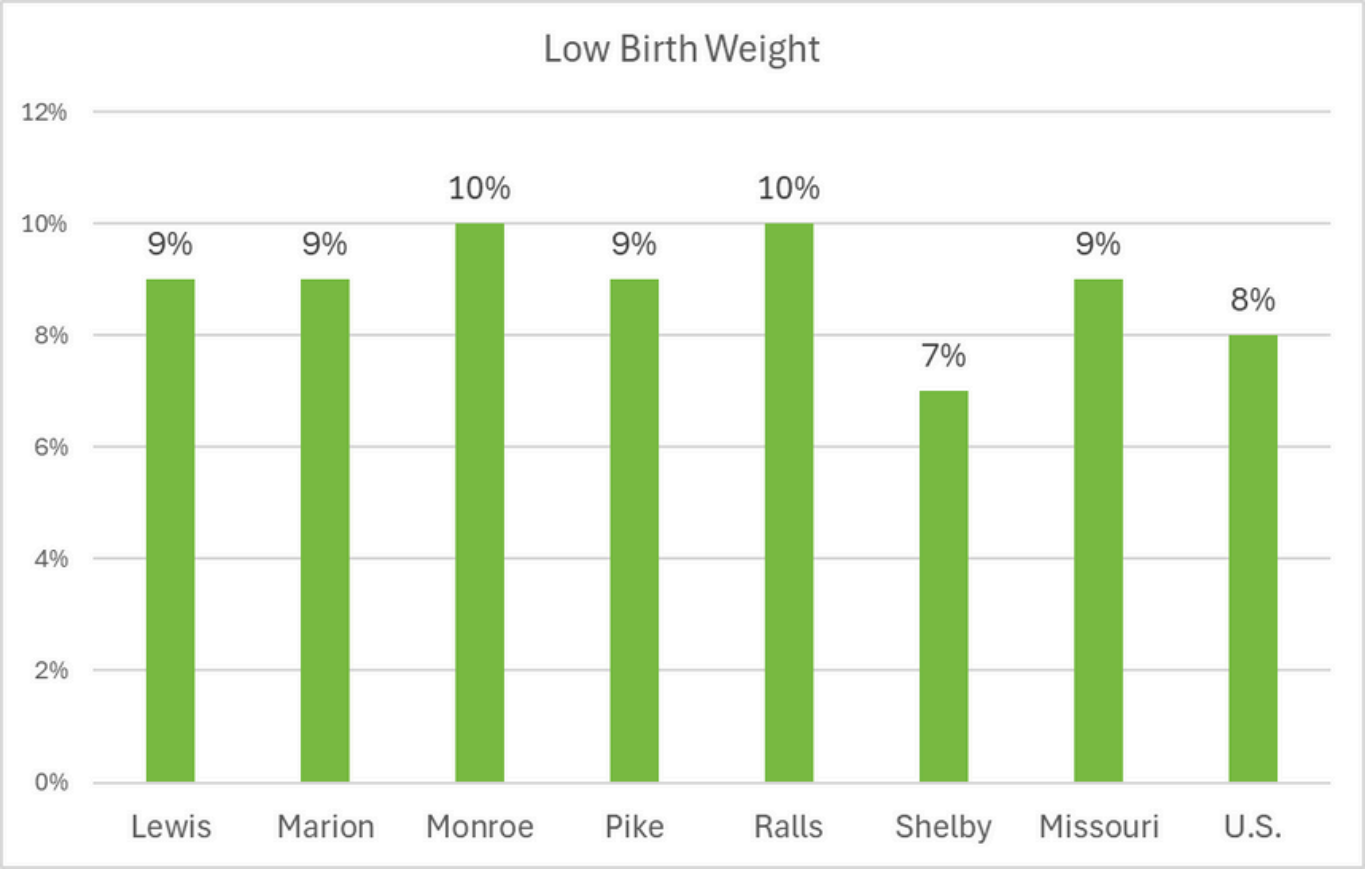


Source: County Health Rankings & Roadmaps 2025 Annual Data Release

Low Birth Weight

Quality of Life | ***Physical Health***

Low birth weight refers to infants born weighing less than 2,500 grams (5 pounds, 8 ounces). Based on 2017–2023 data, this measure highlights risks associated with preterm births and restricted fetal growth—both linked to higher infant mortality and long-term health challenges. Contributing factors include inadequate prenatal care, poor maternal nutrition, high stress, environmental pollution, and certain infections or pregnancy complications. Low birth weight is a key indicator of maternal and infant health, as well as broader social conditions such as healthcare access and poverty. Affected infants face higher risks of developmental delays and chronic health issues later in life.

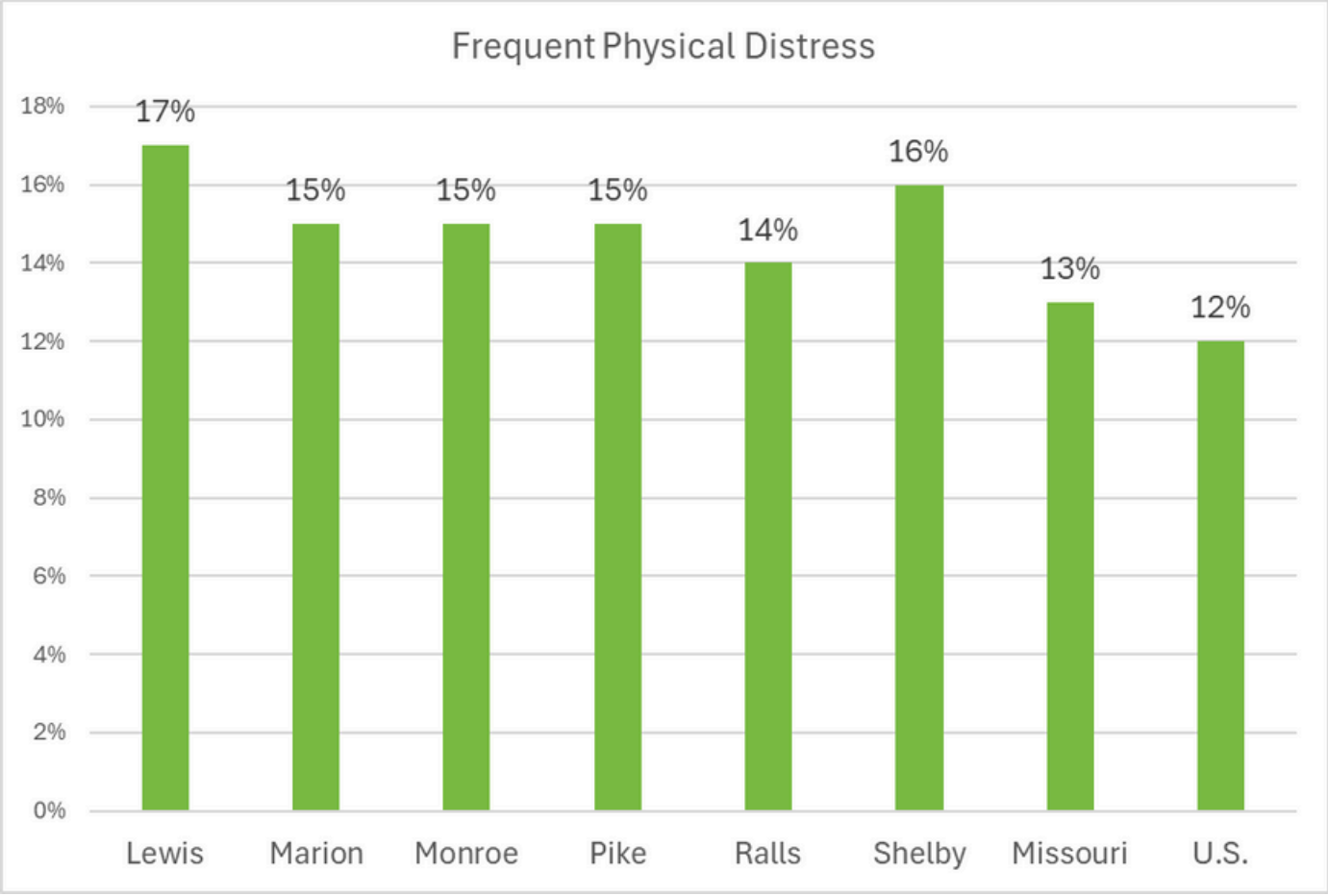


Source: County Health Rankings & Roadmaps 2025 Annual Data Release

Frequent Physical Distress

Quality of Life | ***Physical Health***

This measure reflects the percentage of adults who report experiencing 14 or more days of poor physical health in the past month, age-adjusted, using 2022 data. It complements the "Poor Physical Health Days" measure by focusing on individuals with more persistent or severe physical health issues. Frequent physical distress is associated with chronic conditions, disability, and reduced quality of life, making it a valuable indicator for identifying populations with high health needs.

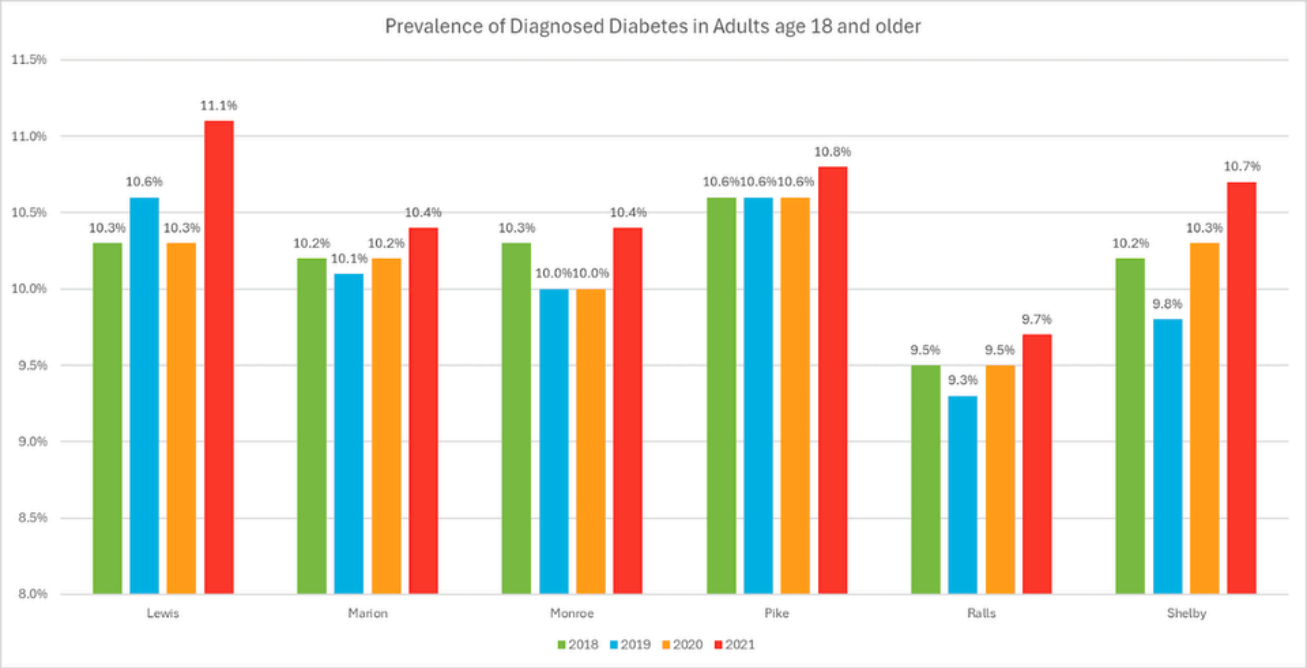


Source: County Health Rankings & Roadmaps 2025 Annual Data Release

Diabetes Prevalence

Quality of Life | *Physical Health*

This measure reflects the age-adjusted percentage of adults aged 18 and older who have been diagnosed with diabetes. Diabetes is a chronic disease with significant impacts on physical, mental, and social well-being. It is a major contributor to other serious health conditions, including cardiovascular disease, kidney failure, and vision loss. As the eighth leading cause of death in the U.S., diabetes prevalence is a key indicator for public health planning and chronic disease prevention efforts.



Sources: National Environmental Public Health Tracking Network
Accessed From: https://ephtracking.cdc.gov/DataExplorer. Accessed on 04/18/2025
County Health Rankings & Roadmaps 2025 Annual Data Release

HIV Prevalence

Quality of Life l *Physical Health*

This measure reflects the number of individuals aged 13 and older living with an HIV diagnosis per 100,000 population, based on 2022 data. HIV is primarily transmitted through sexual contact, injection drug use, and perinatal exposure. In 2022, over 38,000 new diagnoses were reported nationwide. Managing HIV requires a robust system of care and prevention, as treatment is complex and often more costly than other chronic conditions. Community-level interventions are critical to reducing prevalence and improving long-term health outcomes.

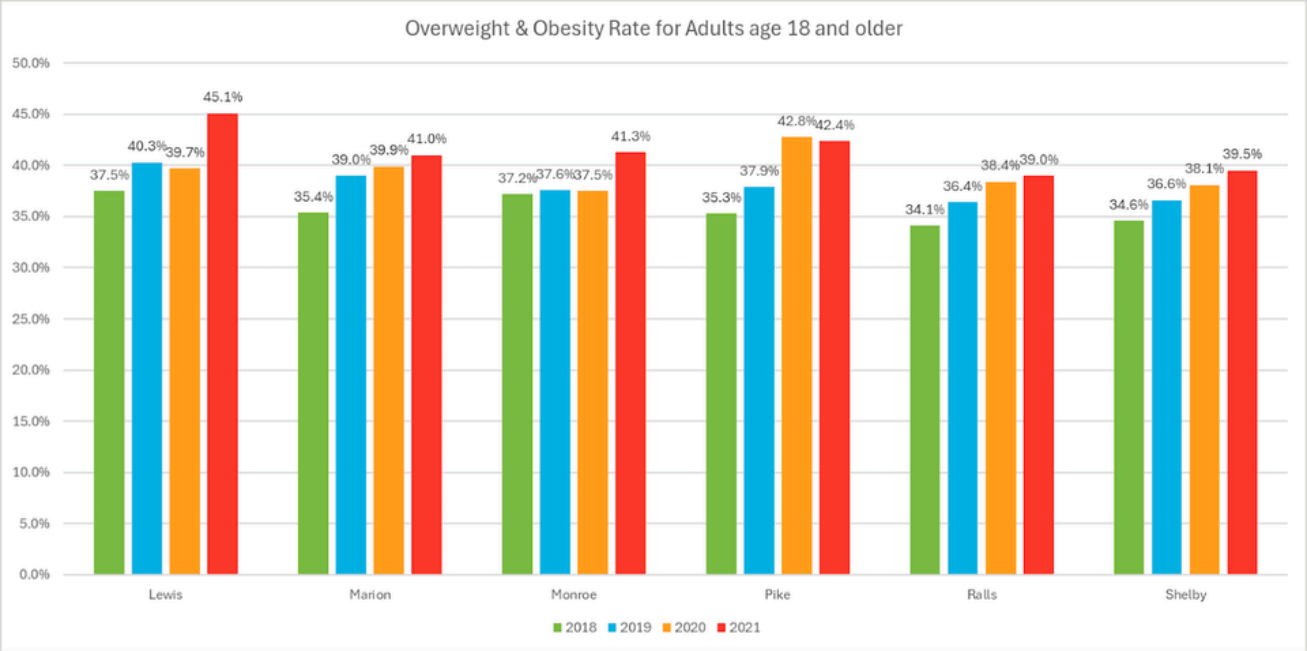
Lewis	Marion	Monroe	Pike	Ralls	Shelby	Missouri	U.S.
NA	88	109	148	NA	0	254	387

NA = Data for this measure are not available.
Source: County Health Rankings & Roadmaps 2025 Annual Data Release

Adult Obesity

Quality of Life | ***Physical Health***

This measure reflects the percentage of adults (age 18 and older) with a body mass index (BMI) of 30 or higher, using age-adjusted data from 2022. Obesity is a chronic condition linked to increased risk of heart disease, diabetes, mental illness, and certain cancers. Its prevalence is shaped by individual, environmental, and systemic factors—including access to healthy food, safe places for physical activity, and experiences of stigma or discrimination. Communities affected by disinvestment and structural inequities often face higher obesity rates. Stigma related to weight can also lead to poorer health outcomes and disparities in care.

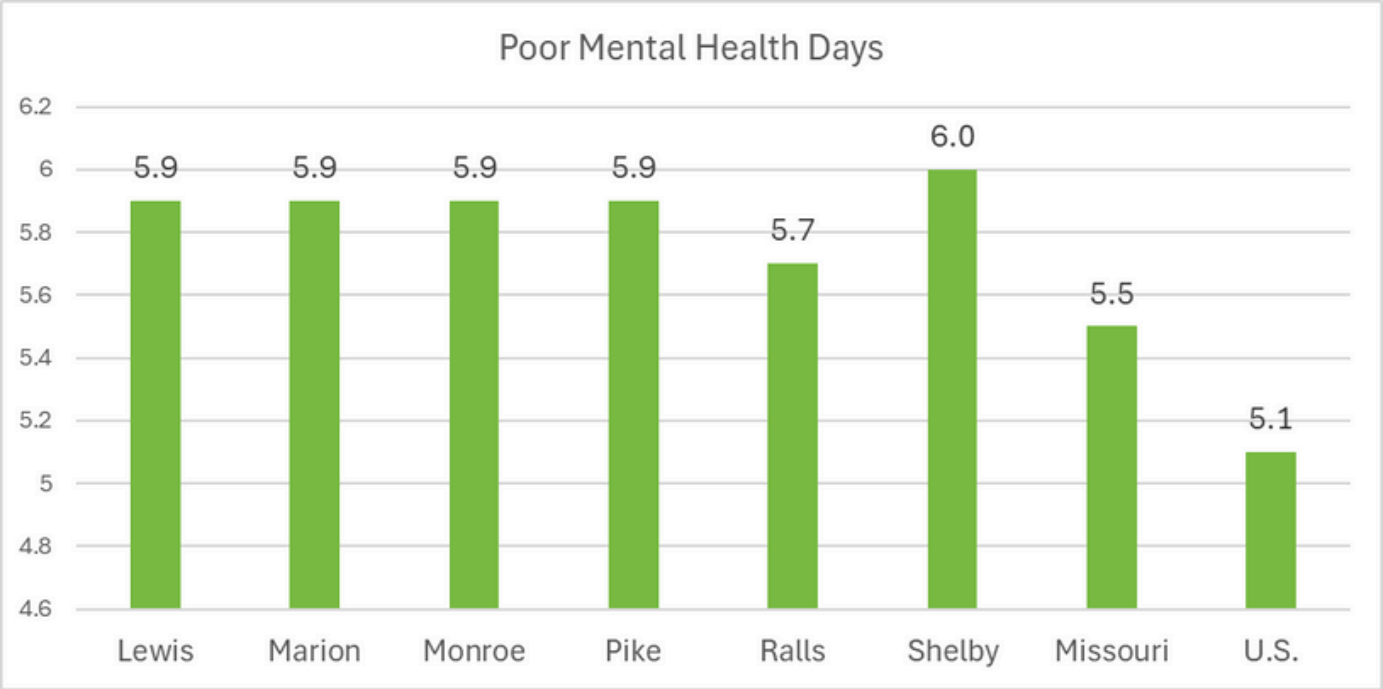


Source: County Health Rankings & Roadmaps 2025 Annual Data Release

Mental Health

Poor Mental Days

This measure captures the average number of mentally unhealthy days adults report over the past 30 days (age-adjusted), using 2022 data. It serves as a key indicator of health-related quality of life (HRQoL), especially among individuals with chronic conditions or disabilities. Higher rates of poor mental health days often correlate with social challenges such as poverty, unemployment, and limited education. While self-reported data are reliable, cultural differences in how people define and report mental health may influence comparisons across population groups.

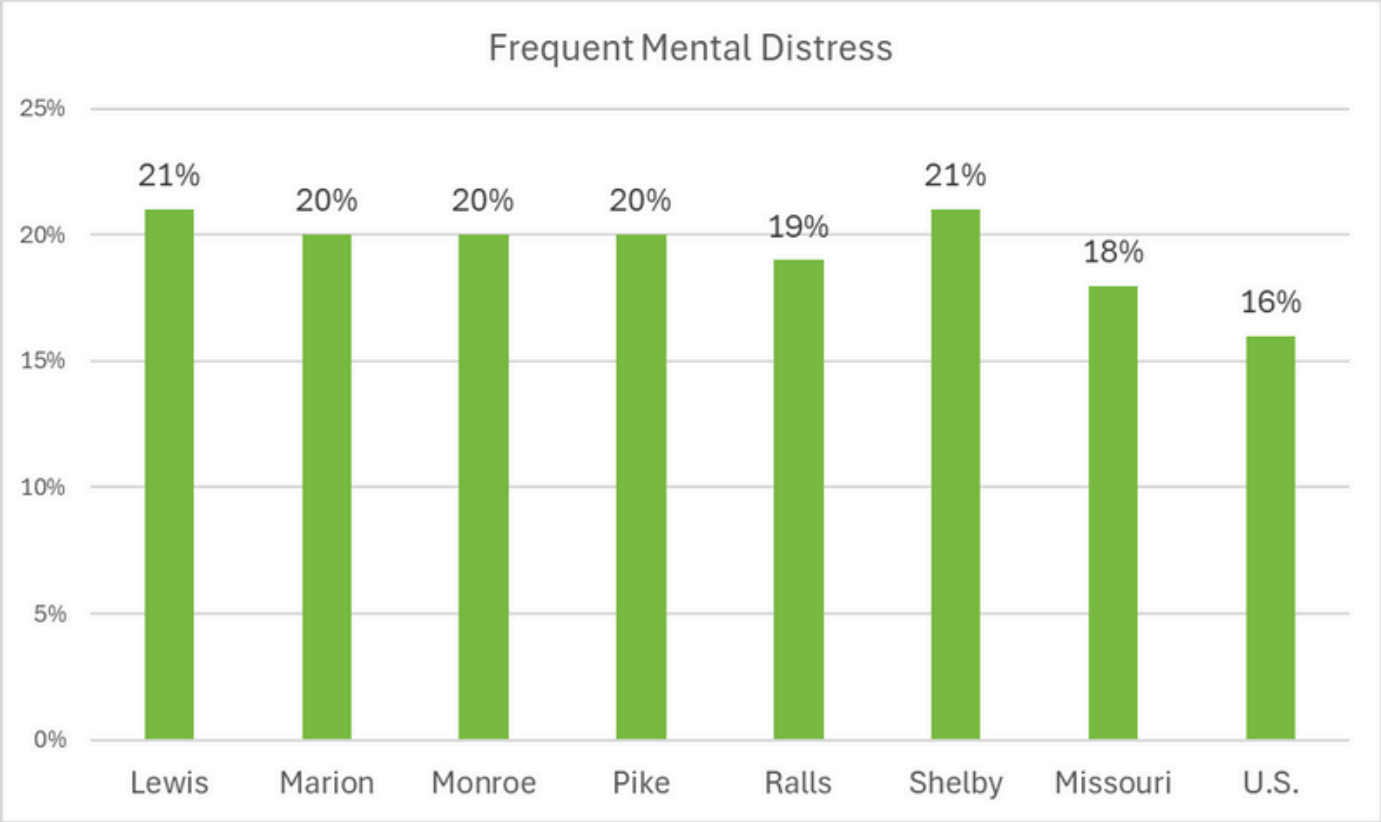


Source: County Health Rankings & Roadmaps 2025 Annual Data Release

Frequent Mental Distress

Mental Health

This measure reflects the percentage of adults who report experiencing 14 or more mentally unhealthy days in the past month (age-adjusted), based on 2022 data. While similar to Poor Mental Health Days, it highlights individuals likely facing more chronic or severe mental health challenges. Tracking frequent distress helps identify populations with ongoing mental health needs and informs targeted intervention efforts.

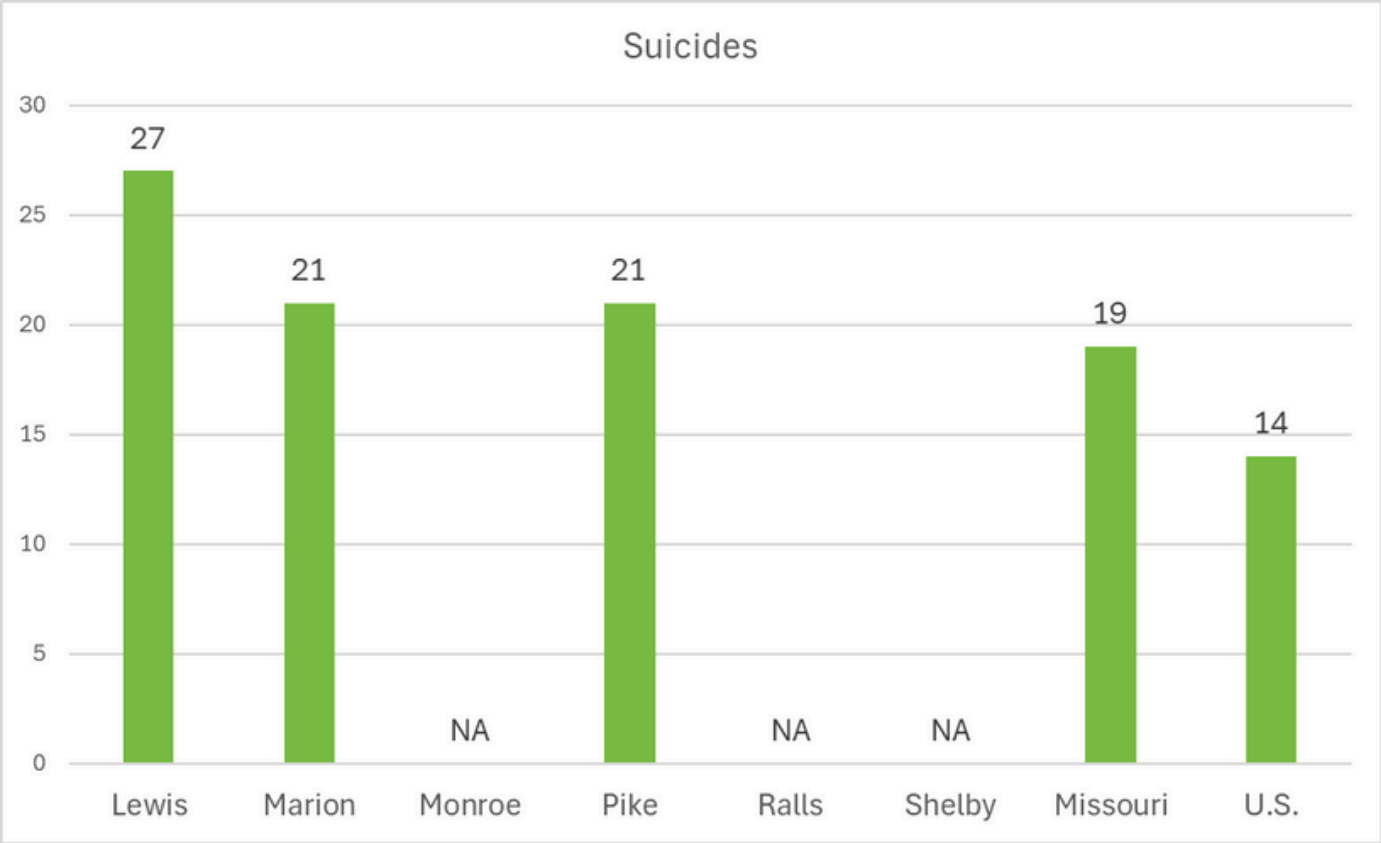


Source: County Health Rankings & Roadmaps 2025 Annual Data Release

Suicides

Mental Health

This measure captures the number of suicide deaths per 100,000 population (age-adjusted), using data from 2018–2022. Suicide is a critical indicator of community mental health and has wide-ranging effects on families and social networks. Nationally, suicide rates have risen by approximately 36% since 2000, with nearly 50,000 deaths reported in 2022—equating to one death every 11 minutes. Monitoring suicide trends helps identify areas in need of increased mental health resources and prevention efforts.

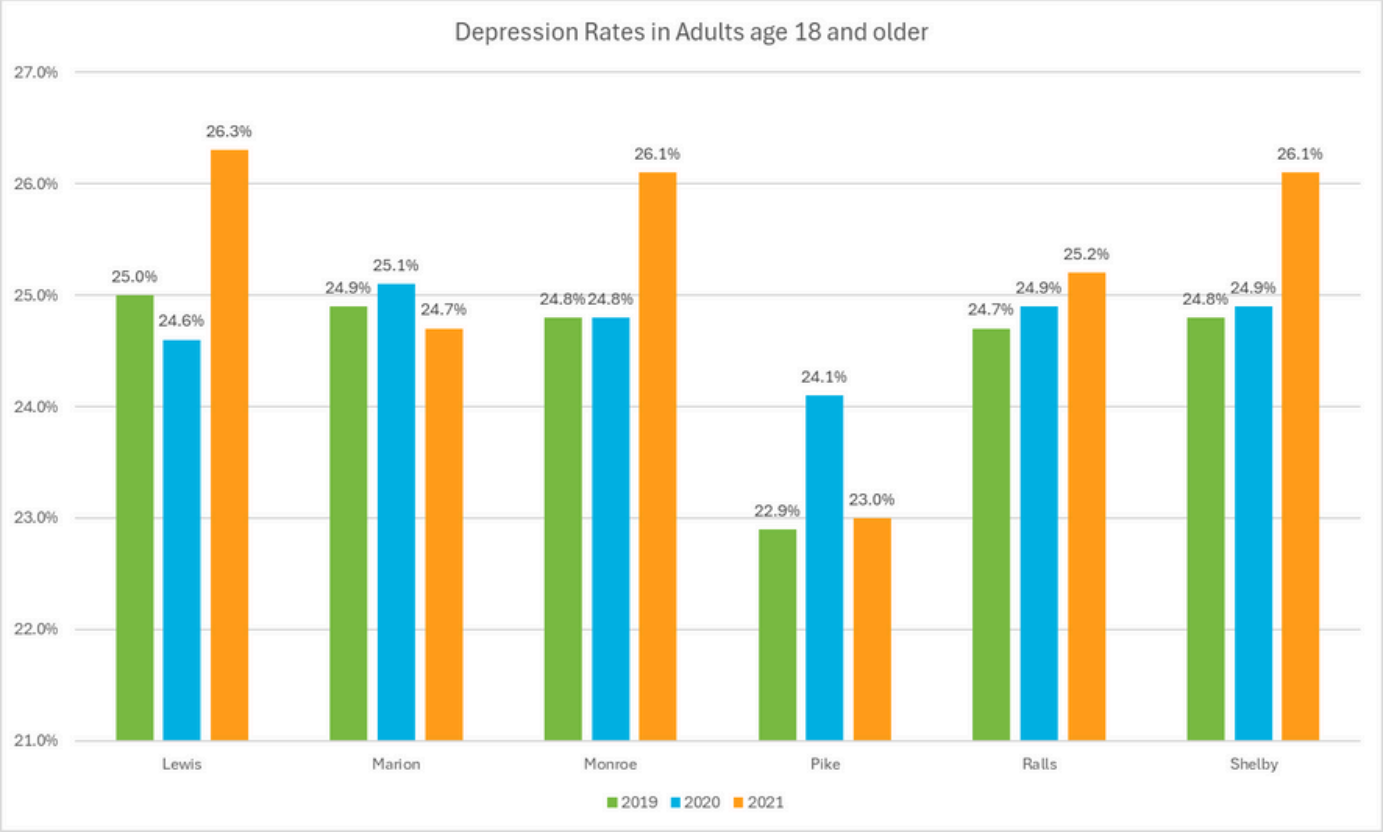


NA = Data for this measure are not available.
Source: County Health Rankings & Roadmaps 2025 Annual Data Release

Depression Rates

Mental Health

This measure reflects the percentage of adults aged 18 and older who have been diagnosed with depression, based on data from 2019–2021. Depression is a common and serious mental health condition that can significantly impact quality of life, daily functioning, and physical health. High rates of diagnosed depression may indicate growing awareness and access to mental health care, but can also reflect broader stressors such as social isolation, economic hardship, and limited behavioral health resources. Tracking this measure helps identify populations at increased risk and supports planning for mental health services and community-based interventions.

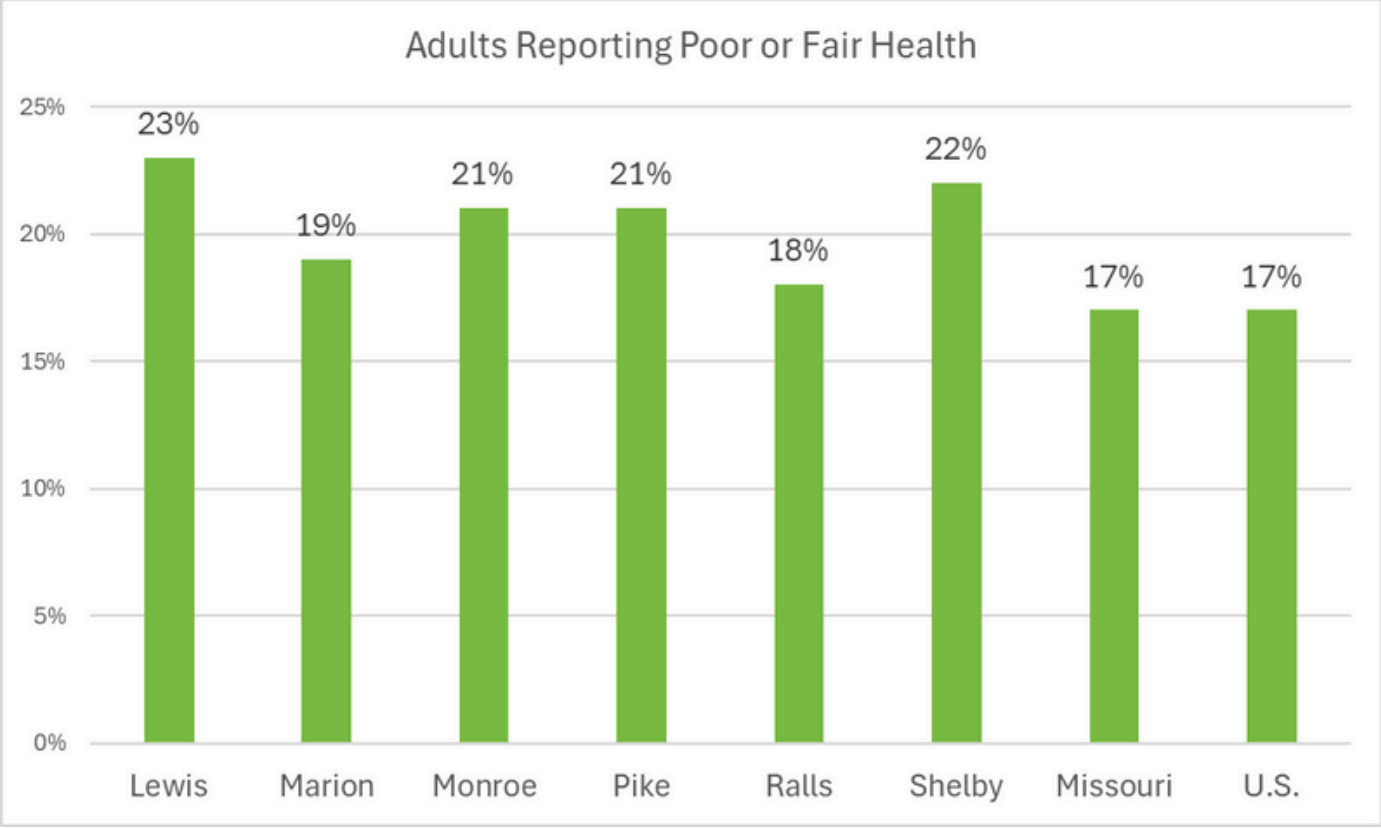


Source: National Environmental Public Health Tracking Network

Life Satisfaction

Poor or Fair Health

This measure reflects the percentage of adults who report their health as fair or poor (age-adjusted), based on 2022 data. It is a widely used and reliable indicator of health-related quality of life (HRQoL), capturing how individuals perceive their overall well-being. Self-reported health status is strongly associated with actual health outcomes, including mortality risk. While simple to collect, this subjective measure can vary based on cultural, racial, and age-related differences in how health is defined and reported, which should be considered when comparing across groups.

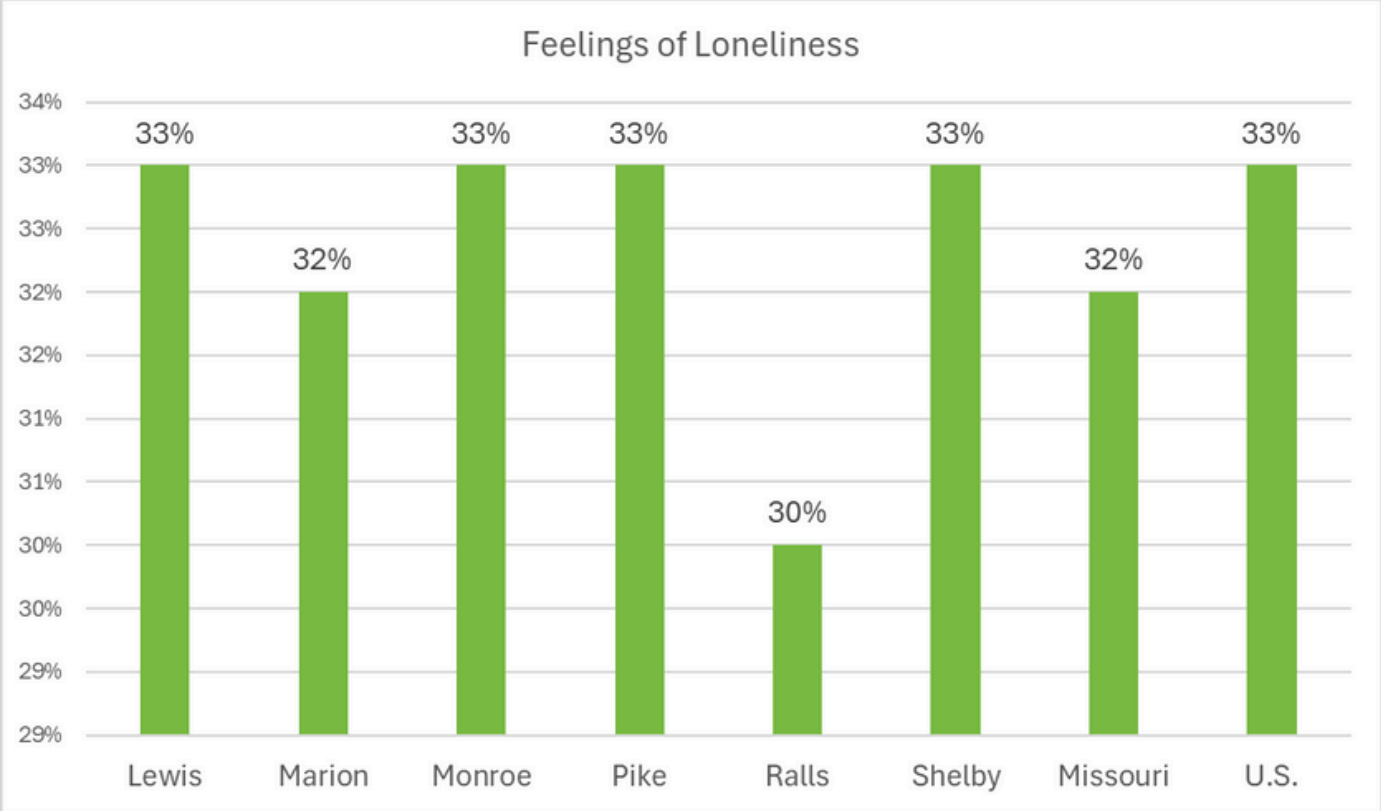


Source: County Health Rankings & Roadmaps 2025 Annual Data Release

Feelings of Loneliness

Life Satisfaction

This measure reflects the percentage of adults who report always, usually, or sometimes feeling lonely, based on 2022 data. Loneliness results from a gap between desired and actual social connection and can be shaped by both the quantity and quality of relationships. It is linked to poorer physical and mental health outcomes, especially among marginalized groups. High rates of loneliness have been reported among bisexual and transgender individuals, driven in part by stigma, discrimination, and lack of support. Addressing loneliness requires understanding both individual experiences and broader social and structural barriers to connection.



Source: County Health Rankings & Roadmaps 2025 Annual Data Release

Community Conditions

Community conditions include the social and economic factors, physical environment and health infrastructure in which people are born, live, learn, work, play, worship and age. Community conditions are also referred to as the social determinants of health.

Health Infrastructure

- **Health Promotion and Harm Reduction**
  - Flu Vaccinations
  - Access to Exercise Opportunities
  - Food Environment Index
  - Limited Access to Healthy Foods
  - Food Insecurity
  - Insufficient Sleep
  - Breastfeeding Initiation
  - Teen Births
  - Sexually Transmitted Infections
  - Excessive Drinking
  - Alcohol-Impaired Driving Deaths
  - Drug Overdose Deaths
  - Adult Smoking
  - Physical Inactivity

Clinical Care

- Primary Care Physicians
- Mental Health Providers
- Dentists
- Preventable Hospital Stays
- Mammography Screening
- Uninsured Adults
- Uninsured Children
- Insured Population
- Health Insurance Topics

Physical Environment

- **Housing and Transportation**
  - Severe Housing Problems
  - Driving Alone to Work
  - Long Commute - Driving Alone
  - Traffic Volume
  - Homeownership
  - Severe Housing Cost Burden
- **Air, Water and Land**
  - Air Pollution: Particulate Matter
  - Drinking Water Violations
  - Access to Parks

Physical Environment (continued)

- **Climate**
  - Adverse Climate Events

Social and Economic Factors

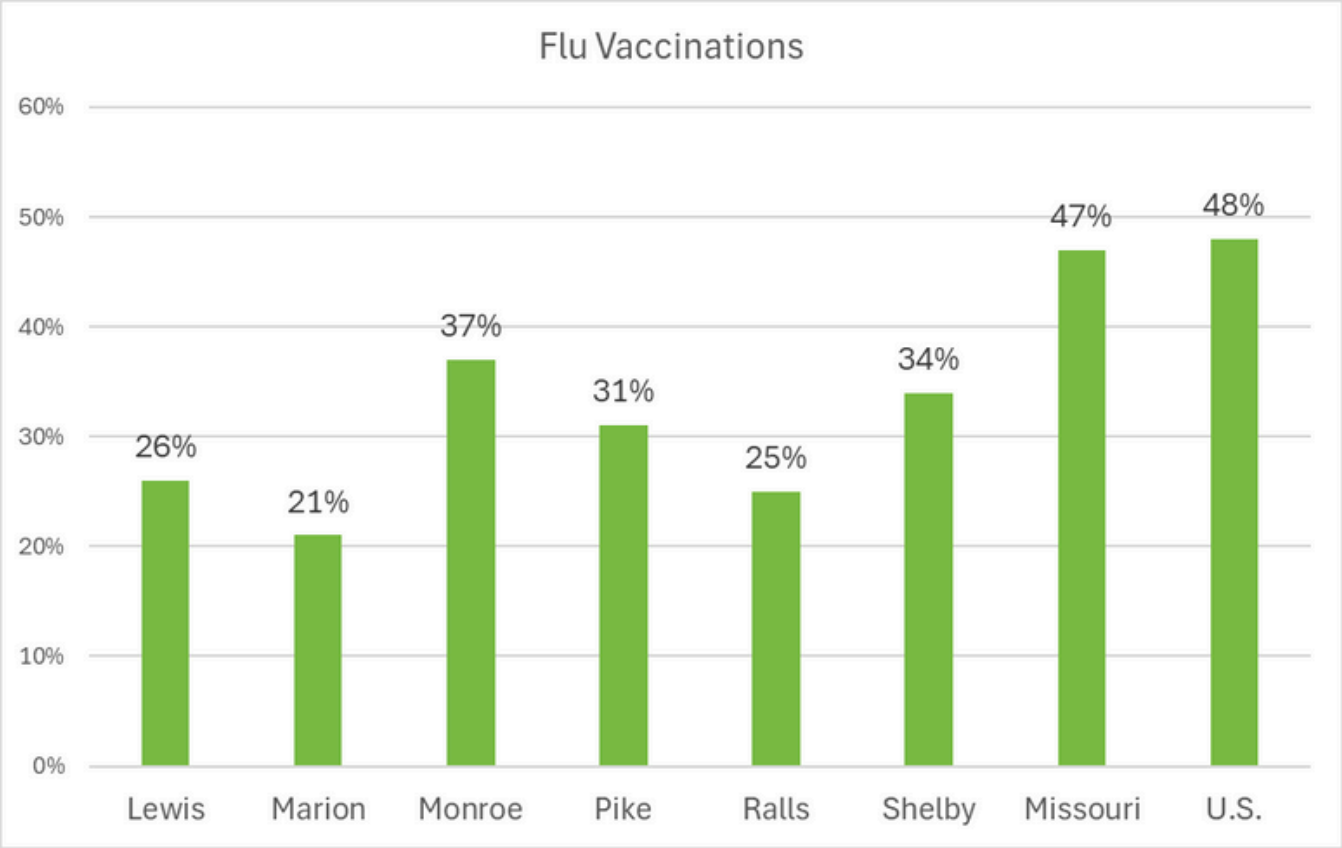
- **Civic and Community Resources**
  - Broadband Access
  - Library Access
  - Census Participation
  - Voter Turnout
- **Education**
  - Some College
  - High School Completion
  - High School Graduation
  - Reading Scores
  - Math Scores
  - School Funding Adequacy
- **Income, Employment and Wealth**
  - Unemployment
  - Income Inequality
  - Children in Poverty
  - Children Eligible for Free or Reduced Price Lunch
  - Gender Pay Gap
  - Median Household Income
  - Living Wage
- **Safety and Social Support**
  - Injury Deaths
  - Social Associations
  - Child Care Cost Burden
  - Child Care Centers
  - Residential Segregation - Black/White
  - Motor Vehicle Crash Deaths
  - Firearm Fatalities
  - Lack of Social and Emotional Support

Health Infrastructure

Health Promotion and Harm Reduction

Flu Vaccinations

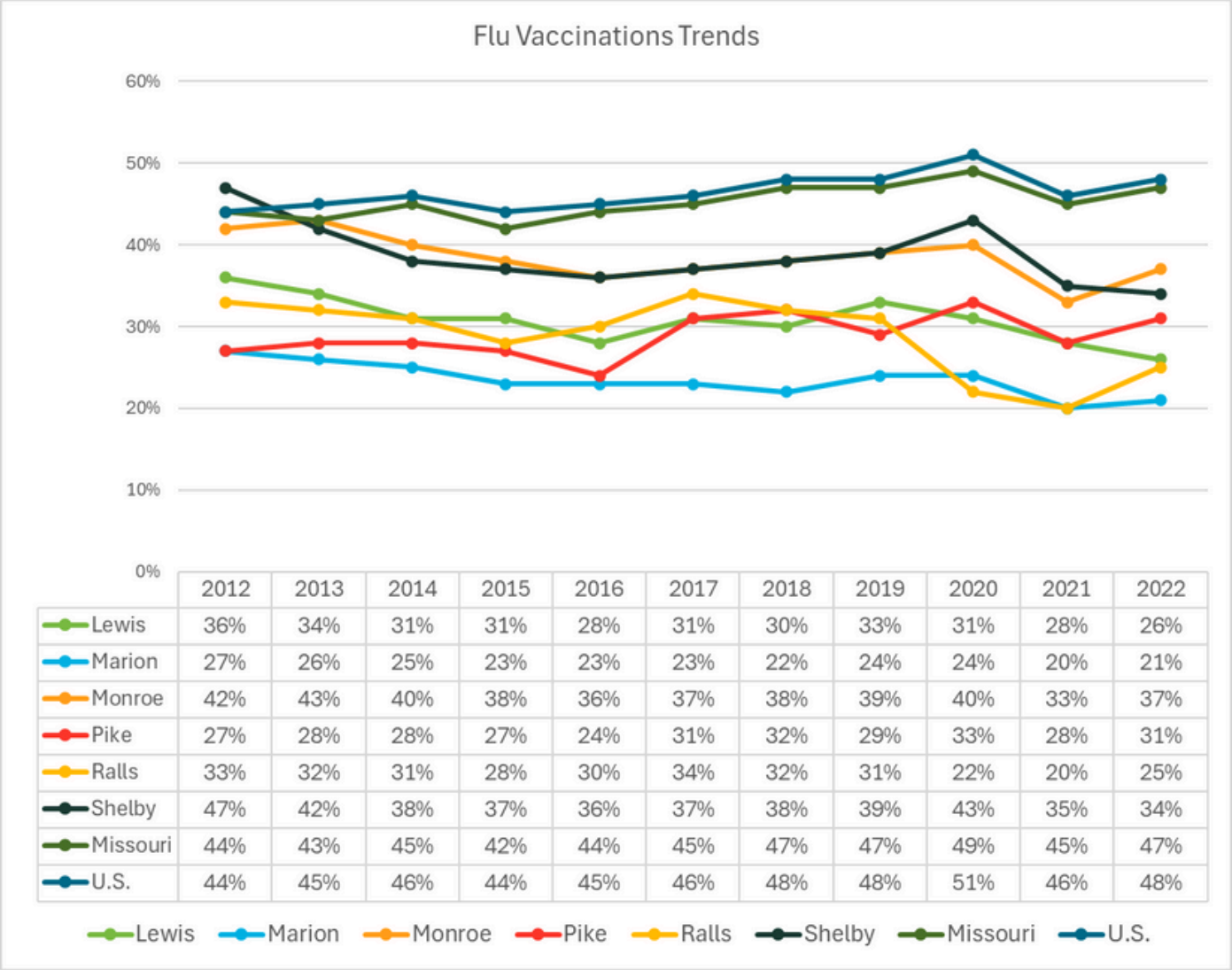
This measure represents the percentage of fee-for-service (FFS) Medicare enrollees who received an annual flu vaccination, based on 2022 data. Influenza is a serious illness that causes significant health impacts each year, including hospitalizations and deaths. Annual flu vaccines are the most effective way to reduce illness, complications, and mortality, particularly for high-risk groups such as older adults and pregnant individuals. Widespread vaccination is a critical public health strategy to protect vulnerable populations and reduce strain on healthcare systems.



Source: County Health Rankings & Roadmaps 2025 Annual Data Release

Flu Vaccinations

Health Promotion and Harm Reductions | ***Health Infrastructure***



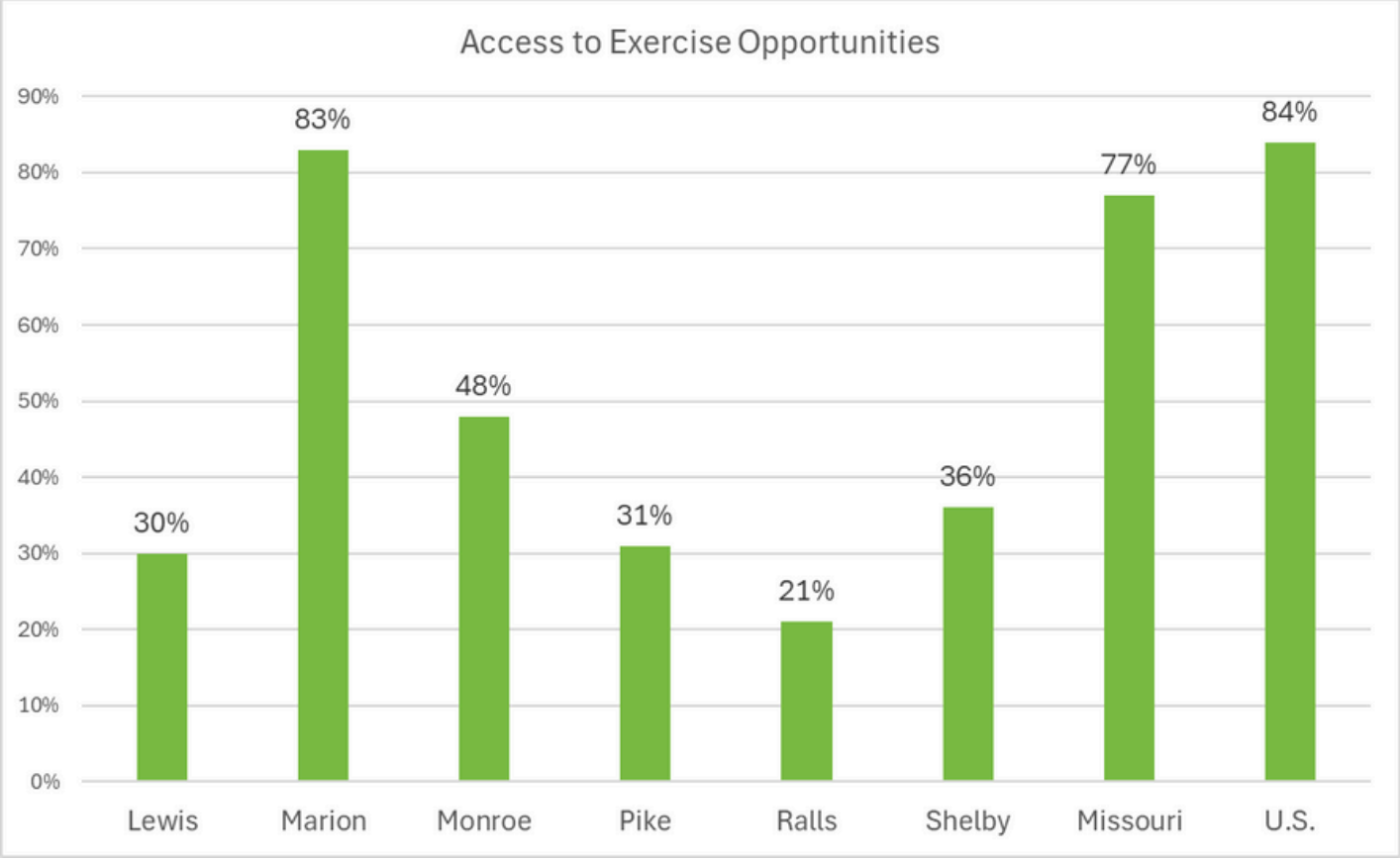
	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021	2022
Lewis	36%	34%	31%	31%	28%	31%	30%	33%	31%	28%	26%
Marion	27%	26%	25%	23%	23%	23%	22%	24%	24%	20%	21%
Monroe	42%	43%	40%	38%	36%	37%	38%	39%	40%	33%	37%
Pike	27%	28%	28%	27%	24%	31%	32%	29%	33%	28%	31%
Ralls	33%	32%	31%	28%	30%	34%	32%	31%	22%	20%	25%
Shelby	47%	42%	38%	37%	36%	37%	38%	39%	43%	35%	34%
Missouri	44%	43%	45%	42%	44%	45%	47%	47%	49%	45%	47%
U.S.	44%	45%	46%	44%	45%	46%	48%	48%	51%	46%	48%

Source: County Health Rankings & Roadmaps 2025 Annual Data Release

Access to Exercise Opportunities

Health Promotion and Harm Reductions | ***Health Infrastructure***

This measure reflects the percentage of the population with adequate access to locations for physical activity, using data from 2020, 2022, and 2024. Access to recreational spaces—such as parks, sidewalks, and gyms—plays a critical role in supporting regular physical activity, which helps prevent chronic diseases like obesity, diabetes, heart disease, and cancer. Communities with well-designed built environments are more likely to engage in physical activity and experience better overall health outcomes.

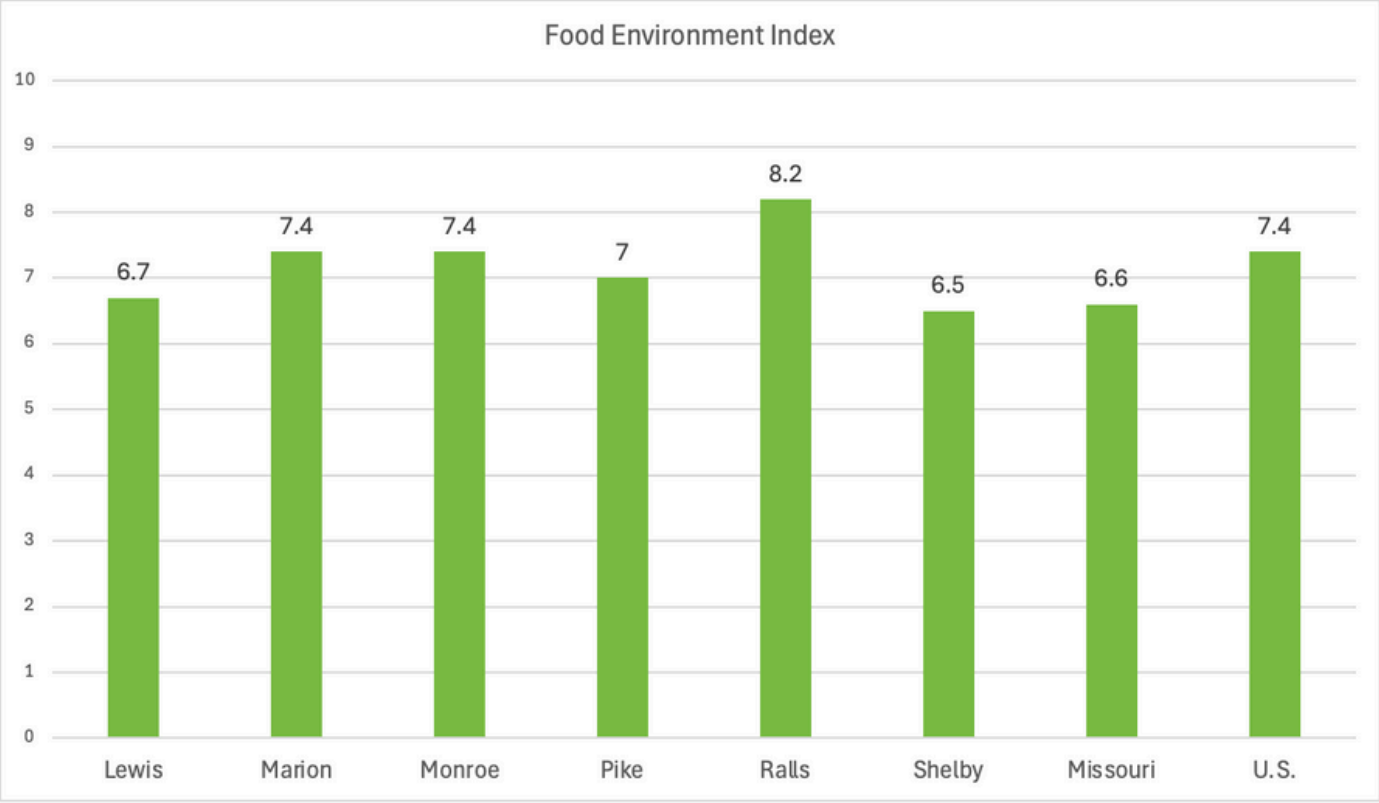


Source: County Health Rankings & Roadmaps 2025 Annual Data Release

Food Environment Index

Health Promotion and Harm Reductions | ***Health Infrastructure***

This index ranges from 0 (worst) to 10 (best) and reflects both access to and affordability of healthy food, using data from 2019 and 2022. It accounts for proximity to grocery stores and supermarkets, as well as barriers such as income and transportation. Poor food environments—often called food deserts—are associated with higher rates of obesity, chronic disease, and premature death. Limited access to nutritious food contributes to a range of negative health outcomes and increased healthcare costs, particularly among low-income populations.

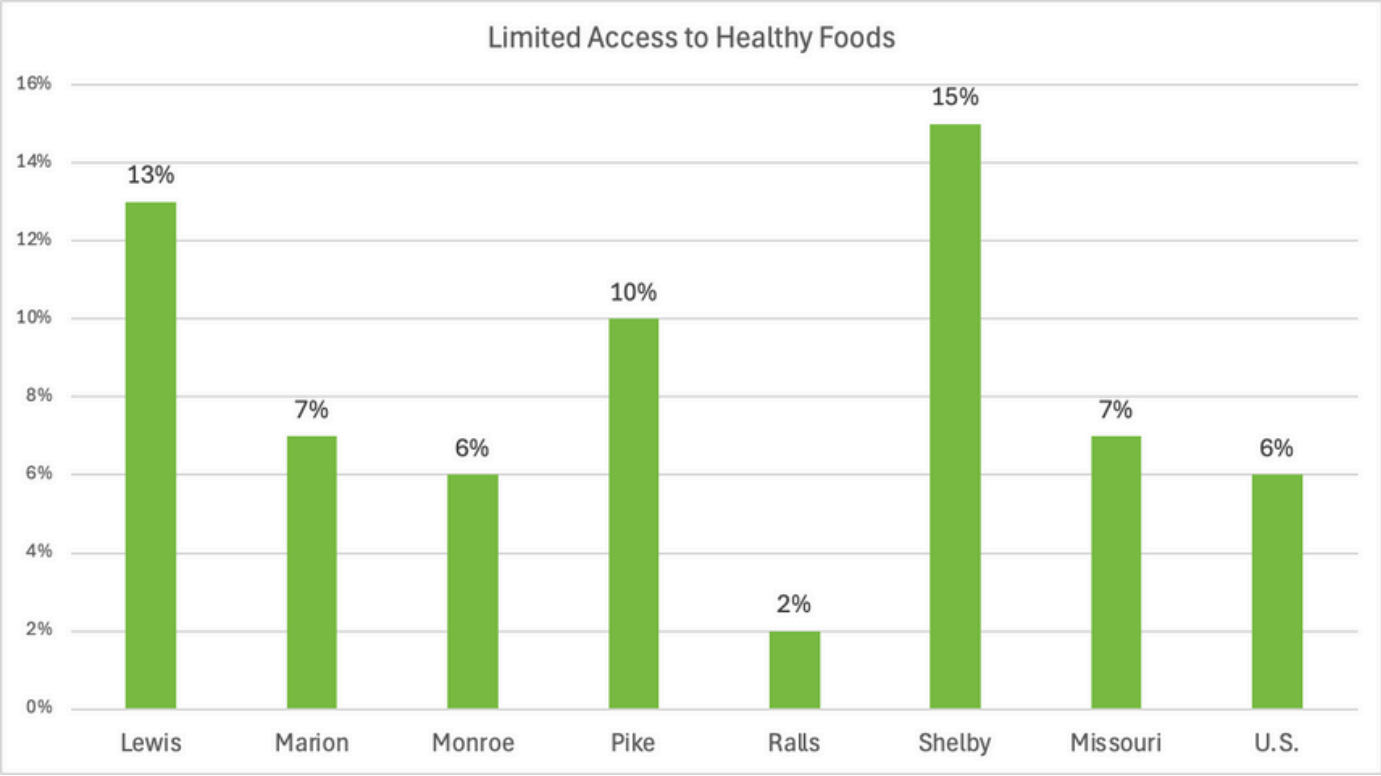


Source: County Health Rankings & Roadmaps 2025 Annual Data Release

Limited Access to Healthy Foods

Health Promotion and Harm Reductions | ***Health Infrastructure***

This measure represents the percentage of the population that is both low-income and lives far from a grocery store, based on 2019 data. Limited access to healthy food—common in food deserts—is strongly associated with higher rates of obesity, poor nutrition, and premature death. Residents in low-income neighborhoods often face greater barriers to obtaining fresh fruits and vegetables, including higher costs and fewer nearby options. These challenges contribute to the consumption of cheaper, calorie-dense, low-nutrient foods, negatively impacting long-term health outcomes.

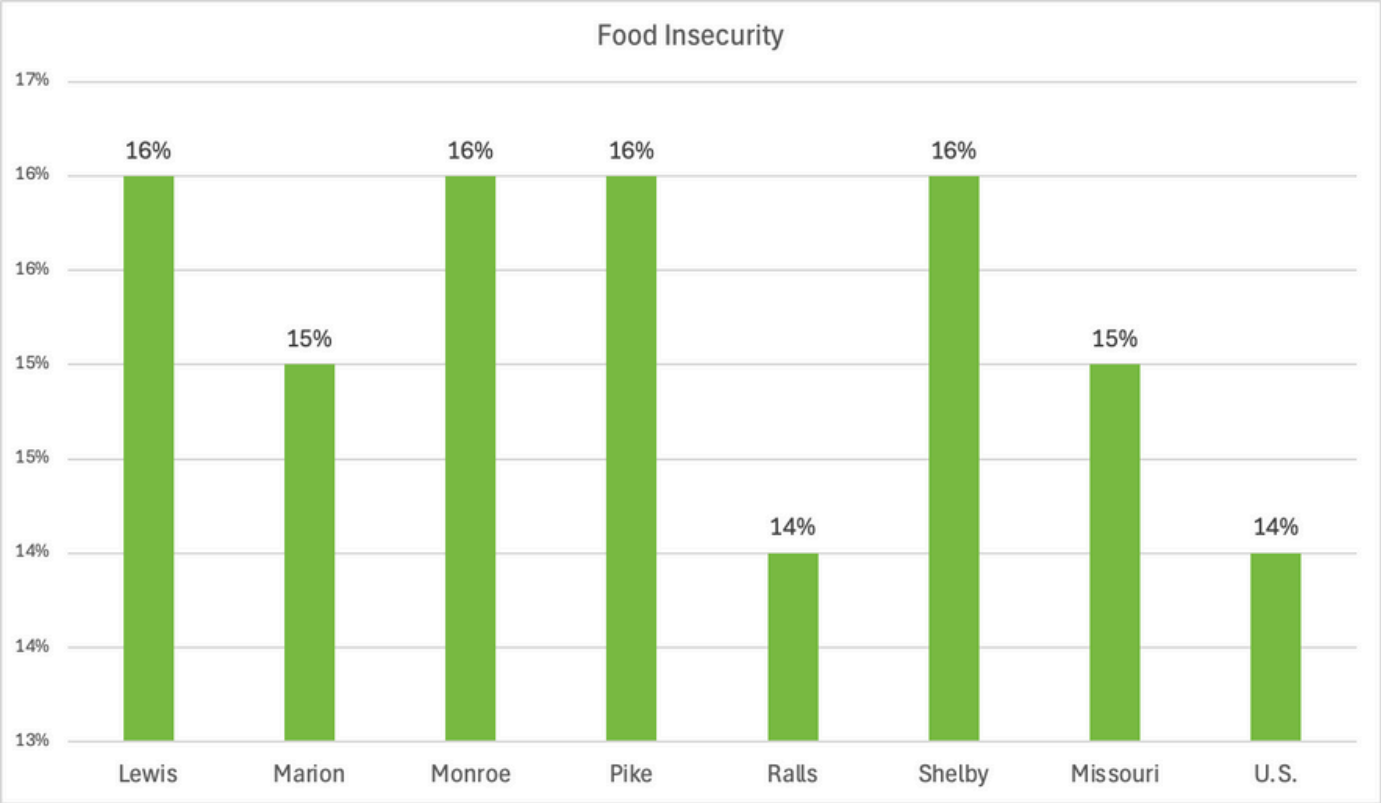


Source: County Health Rankings & Roadmaps 2025 Annual Data Release

Food Insecurity

Health Promotion and Harm Reductions | ***Health Infrastructure***

This measure indicates the percentage of the population lacking consistent access to enough food for an active, healthy life, based on 2022 data. Food insecurity is linked to negative health outcomes, including weight gain, chronic illness, and premature death. It also reflects challenges in obtaining balanced meals with adequate fruits and vegetables, highlighting broader barriers to healthy eating and overall well-being.

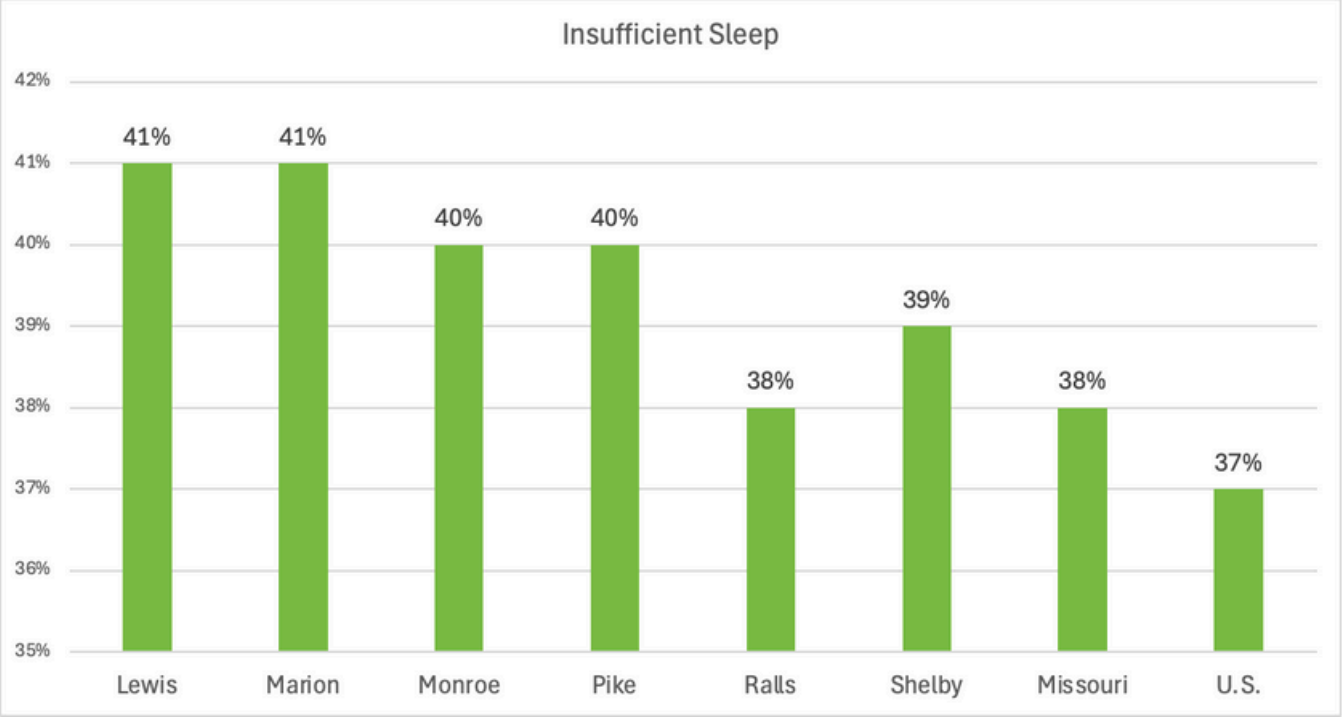


Source: County Health Rankings & Roadmaps 2025 Annual Data Release

Insufficient Sleep

Health Promotion and Harm Reductions | ***Health Infrastructure***

This measure reflects the percentage of adults who report getting fewer than 7 hours of sleep per night, based on age-adjusted 2022 data. Inadequate sleep is linked to a range of health issues, including heart disease, stroke, diabetes, depression, and anxiety. It also increases the risk of accidents, such as motor vehicle crashes, and contributes to overall reduced well-being and cognitive function. Prioritizing sleep is essential for both individual and public health.

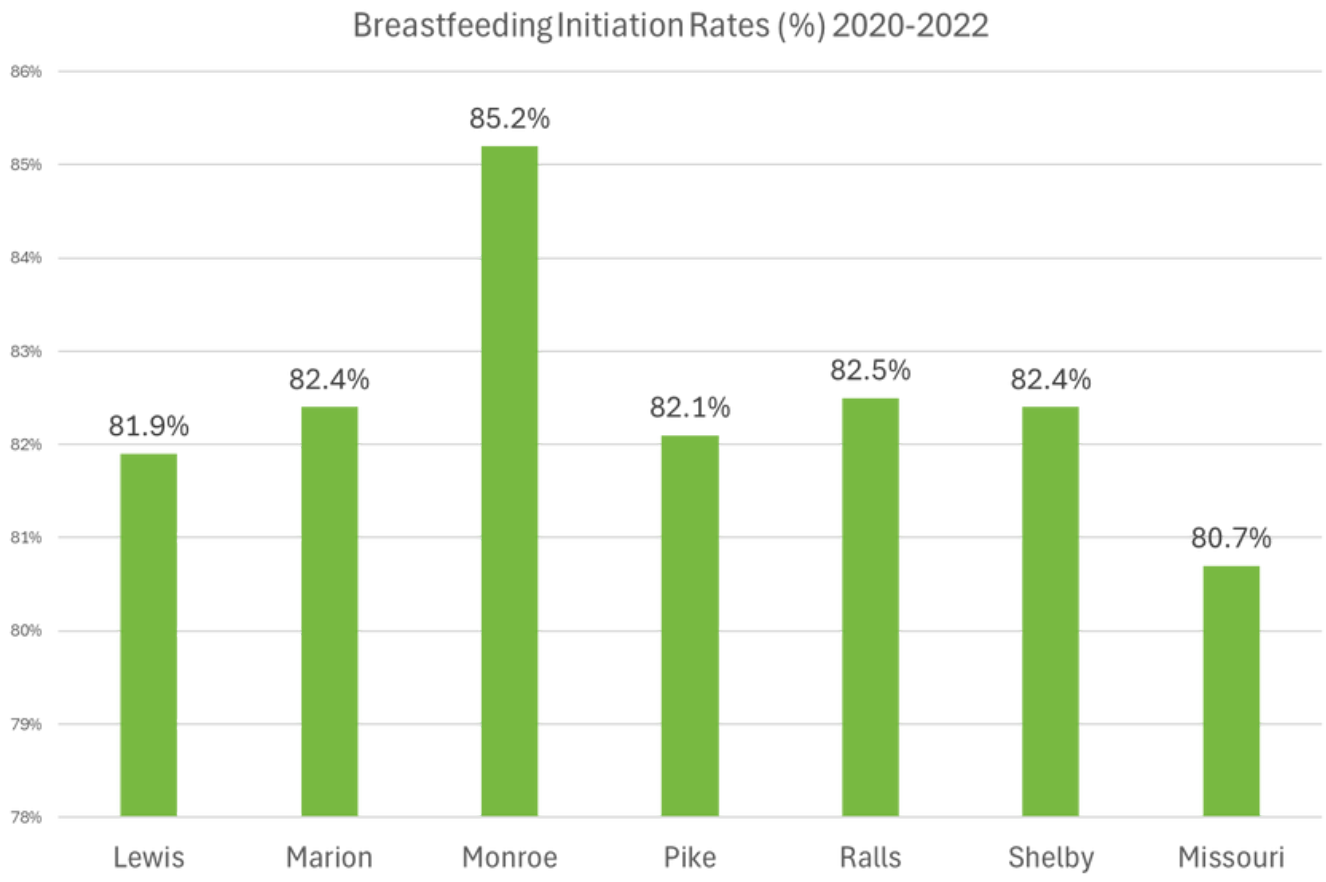


Source: County Health Rankings & Roadmaps 2025 Annual Data Release

Breastfeeding Initiation

Health Promotion and Harm Reductions | ***Health Infrastructure***

This measure reflects the percentage of infants who are breastfed shortly after birth, based on data from 2020–2022. Breastfeeding supports optimal infant nutrition, strengthens the immune system, and reduces risks of infections, obesity, and chronic disease later in life. For mothers, it lowers the risk of certain cancers and type 2 diabetes. Initiation rates also highlight access to supportive healthcare systems, maternal education, and community resources. Disparities in breastfeeding initiation often mirror broader inequities in health access, income, and social support, making this an important indicator of both individual and community health.

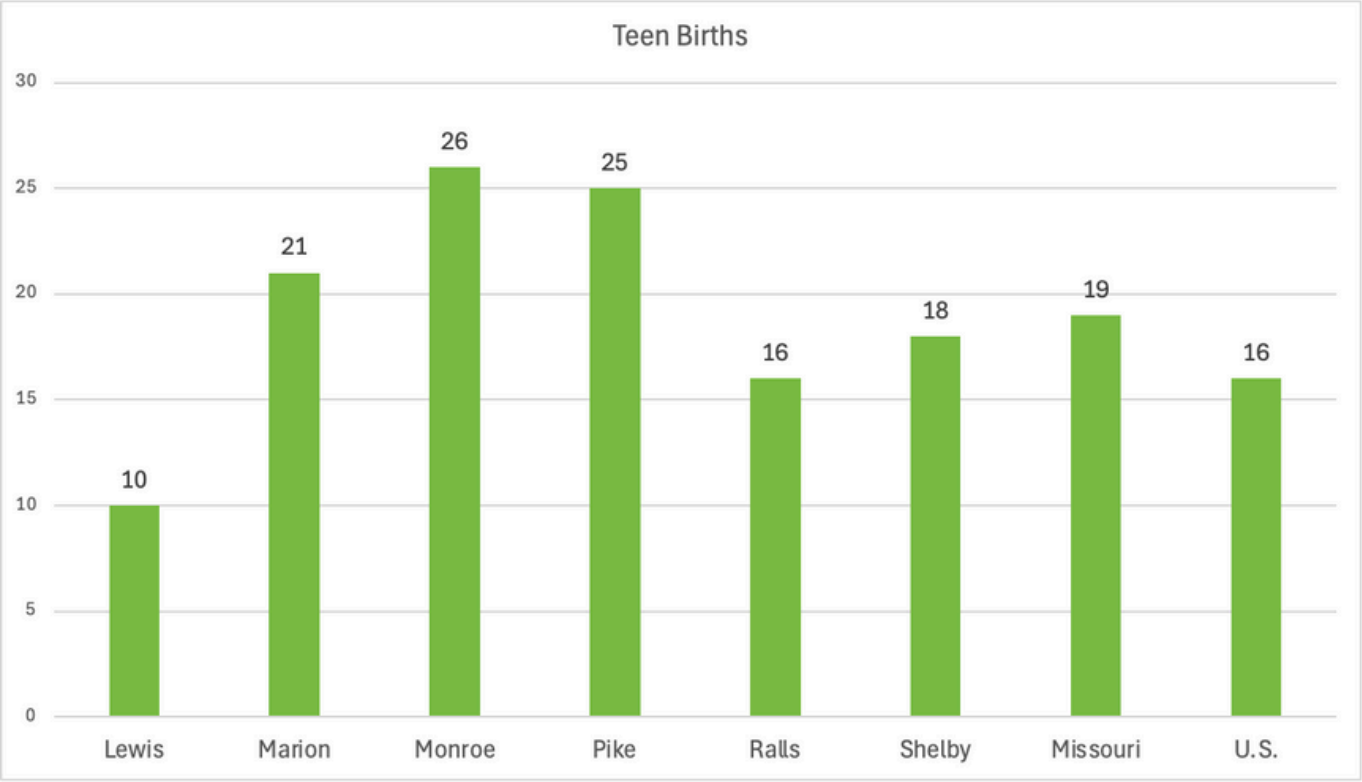


Source: Maternal and Infant Health Mapping Tool, Health Resources and Services Administration, Accessed on [04/15/2025]

Teen Births

Health Promotion and Harm Reductions | ***Health Infrastructure***

This measure tracks the number of births per 1,000 females ages 15–19, using data from 2017–2023. Teen childbearing is linked to increased risks of poor health outcomes for both mother and child, including preterm birth, low birth weight, and higher rates of infant and maternal mortality. These outcomes are often tied to broader social disadvantages such as poverty, instability, and limited access to healthcare or education. Teen parents frequently encounter barriers to completing school, finding employment, and securing childcare and transportation. Youth without legal documentation may face additional challenges in accessing essential services, further compounding risk and vulnerability.

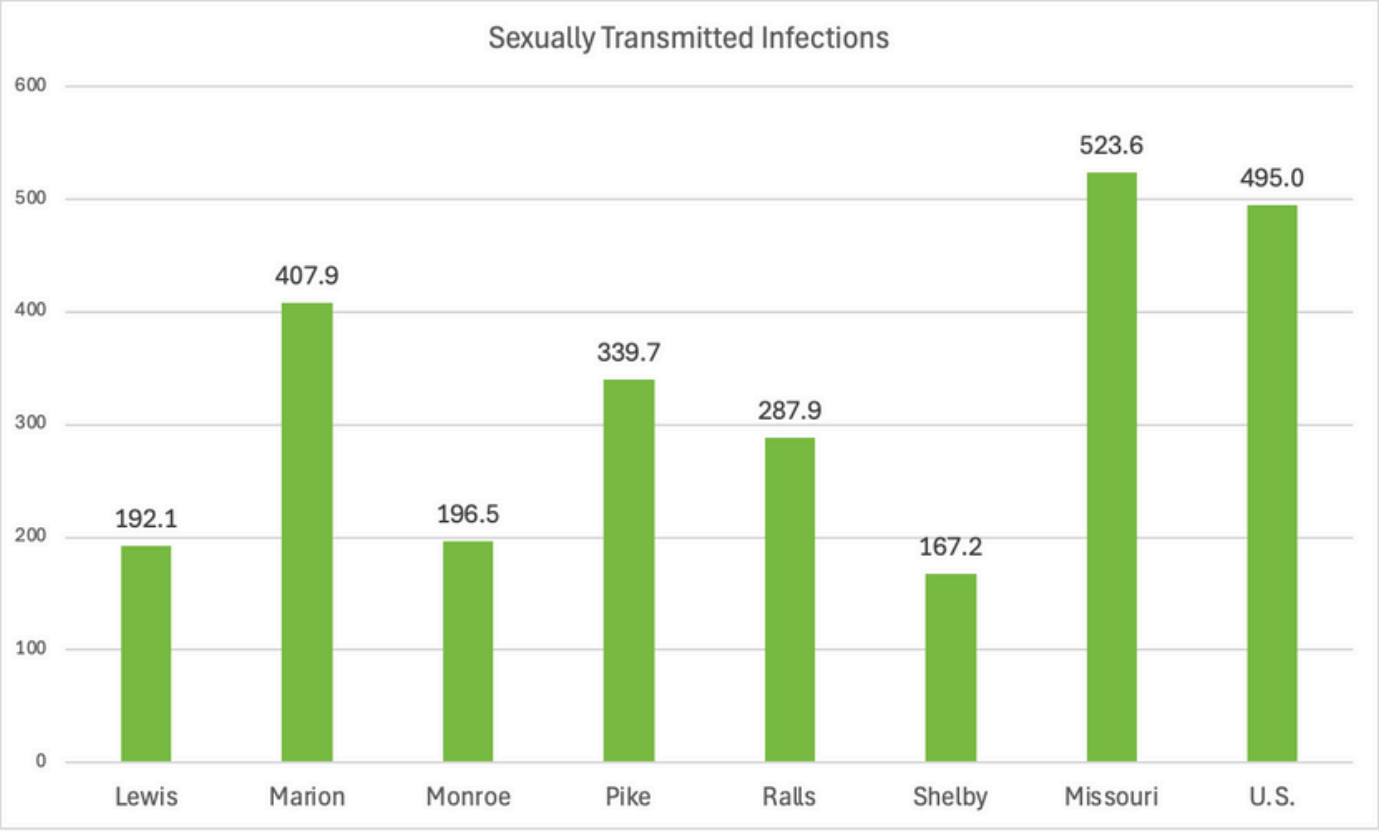


Source: County Health Rankings & Roadmaps 2025 Annual Data Release

Sexually Transmitted Infections

Health Promotion and Harm Reductions | ***Health Infrastructure***

This measure reflects the number of newly diagnosed chlamydia cases per 100,000 population, based on 2022 data. Chlamydia is the most common bacterial STI in North America and can lead to serious health complications such as infertility, pelvic inflammatory disease, and ectopic pregnancy if left untreated. Adolescents, especially females aged 15–19, face the highest risk. STIs also contribute to broader health inequities, disproportionately affecting underserved and minoritized communities. In addition to health impacts, STIs carry a significant social and economic burden.

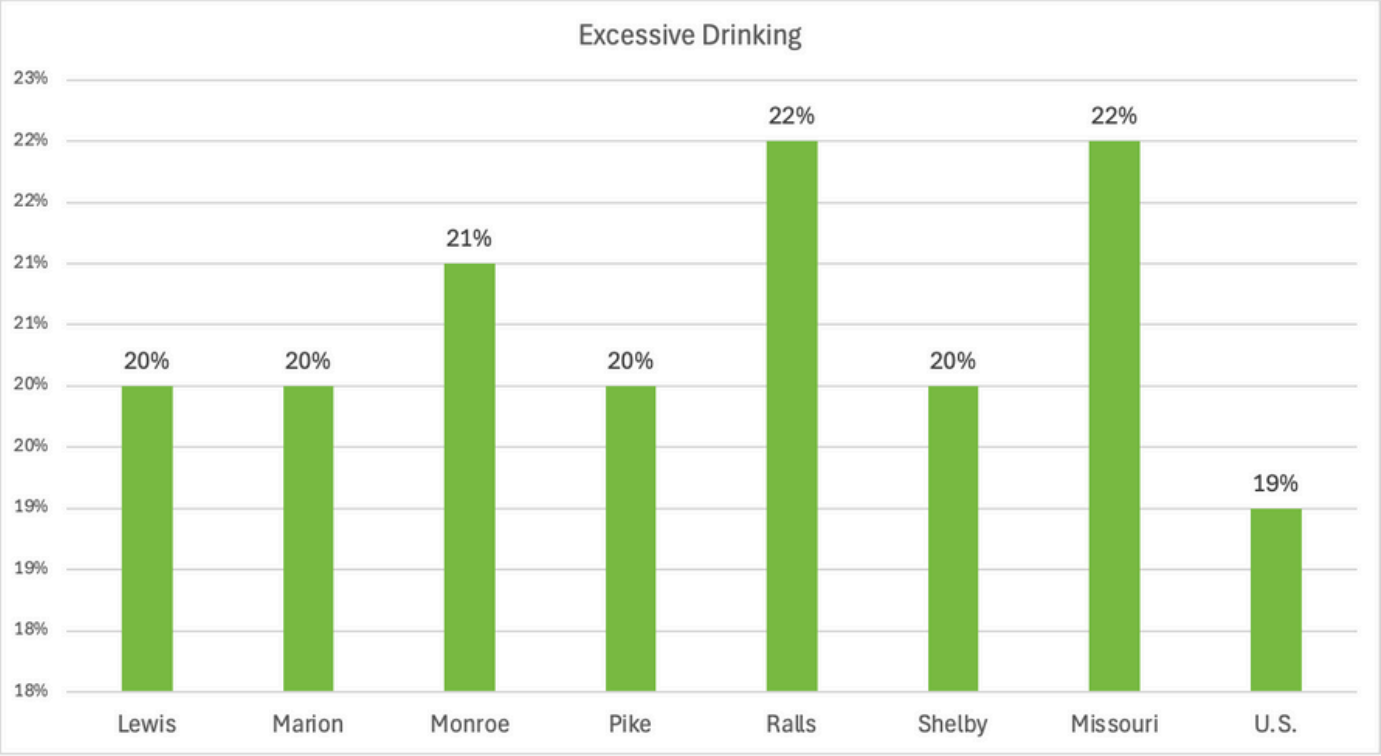


Source: County Health Rankings & Roadmaps 2025 Annual Data Release

Excessive Drinking

Health Promotion and Harm Reductions | ***Health Infrastructure***

This measure captures the percentage of adults who report binge or heavy drinking (age-adjusted), using 2022 data. Excessive alcohol use is linked to a wide range of health risks, including liver disease, high blood pressure, injuries, sexually transmitted infections, unintended pregnancies, and mental health issues such as depression and suicide. It also contributes to motor vehicle crashes and violence. Nearly 1 in 6 U.S. adults engage in binge drinking, and the broader social and economic impacts—estimated at $249 billion in 2010—include lost productivity, property damage, and increased healthcare costs.

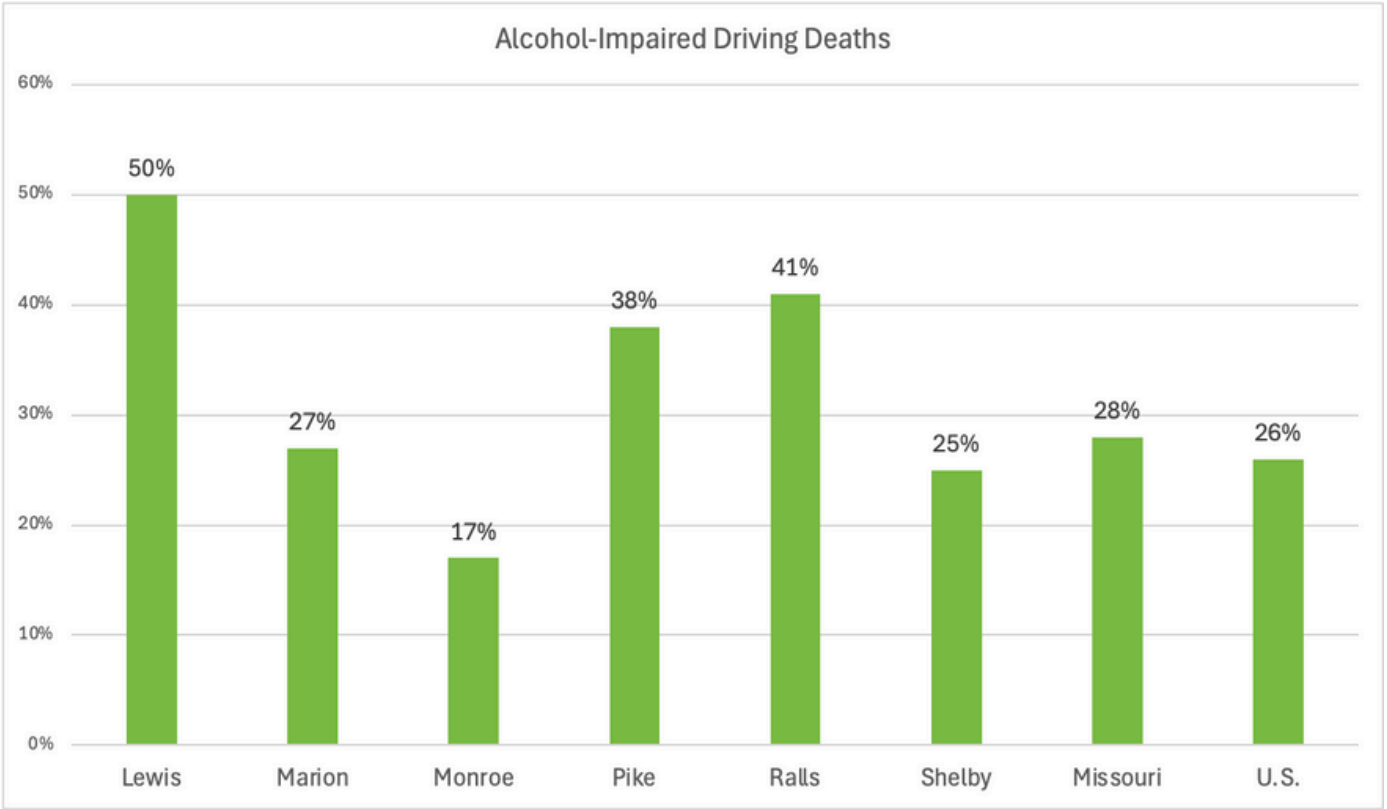


Source: County Health Rankings & Roadmaps 2025 Annual Data Release

Alcohol-Impaired Driving Deaths

Health Promotion and Harm Reductions | ***Health Infrastructure***

This measure reflects the percentage of motor vehicle deaths involving alcohol, based on data from 2018–2022. Alcohol impairs coordination, judgment, and reaction time—factors critical to safe driving. In 2022, alcohol-related crashes claimed 13,524 lives in the U.S., with the highest death rates among drivers aged 21–34. The financial cost of these crashes exceeds $58 billion annually. These deaths are preventable and highlight the ongoing need for public health strategies that reduce impaired driving.



Source: County Health Rankings & Roadmaps 2025 Annual Data Release

Drug Overdose Deaths

Health Promotion and Harm Reductions | ***Health Infrastructure***

This measure represents the number of drug overdose deaths per 100,000 population, using data from 2020–2022. Drug overdoses are a major and growing cause of premature death in the U.S., with overdose fatalities in 2022 reaching ten times the number recorded in 1999. Opioids—both prescribed (e.g., oxycodone, methadone) and illicit (e.g., fentanyl, heroin)—were involved in 76% of these deaths. From 1999 to 2022, more than 727,000 lives were lost to opioid overdoses. These deaths are largely preventable and underscore the urgent need for comprehensive prevention, treatment, and harm reduction strategies.

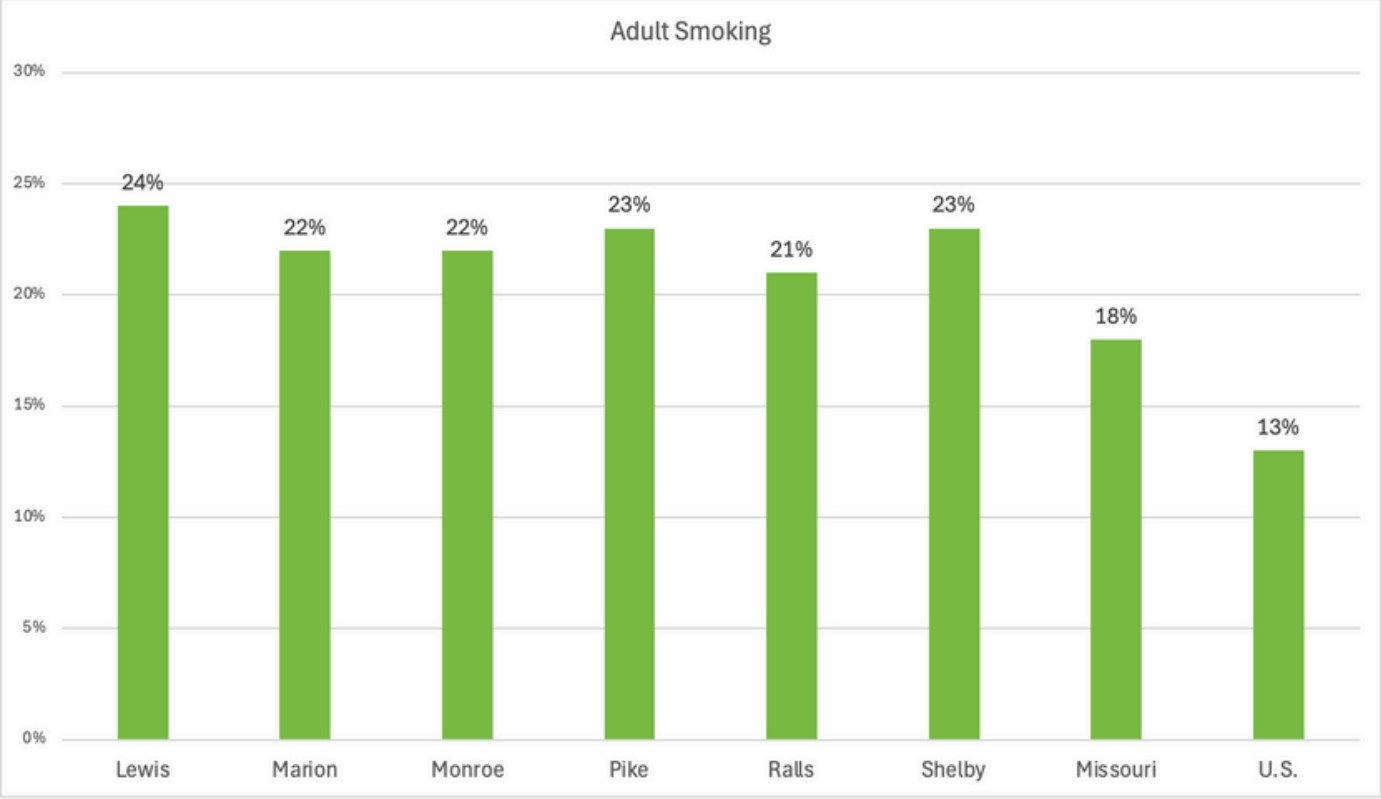
Lewis	Marion	Monroe	Pike	Ralls	Shelby	Missouri	U.S.
NA	26	NA	30	NA	NA	34	31

NA = Data for this measure are not available.
Source: County Health Rankings & Roadmaps 2025 Annual Data Release

Adult Smoking

Health Promotion and Harm Reductions | ***Health Infrastructure***

This measure shows the percentage of adults who currently smoke cigarettes (age-adjusted), based on 2022 data. Smoking is a leading cause of preventable death, responsible for approximately 480,000 premature deaths annually in the U.S. It contributes to cancer, heart disease, respiratory illness, and low birth weight. Smoking rates are often higher among individuals with low socioeconomic status, where stress and environmental factors increase the likelihood of tobacco use. Monitoring smoking prevalence helps guide public health strategies, including prevention and cessation programs.

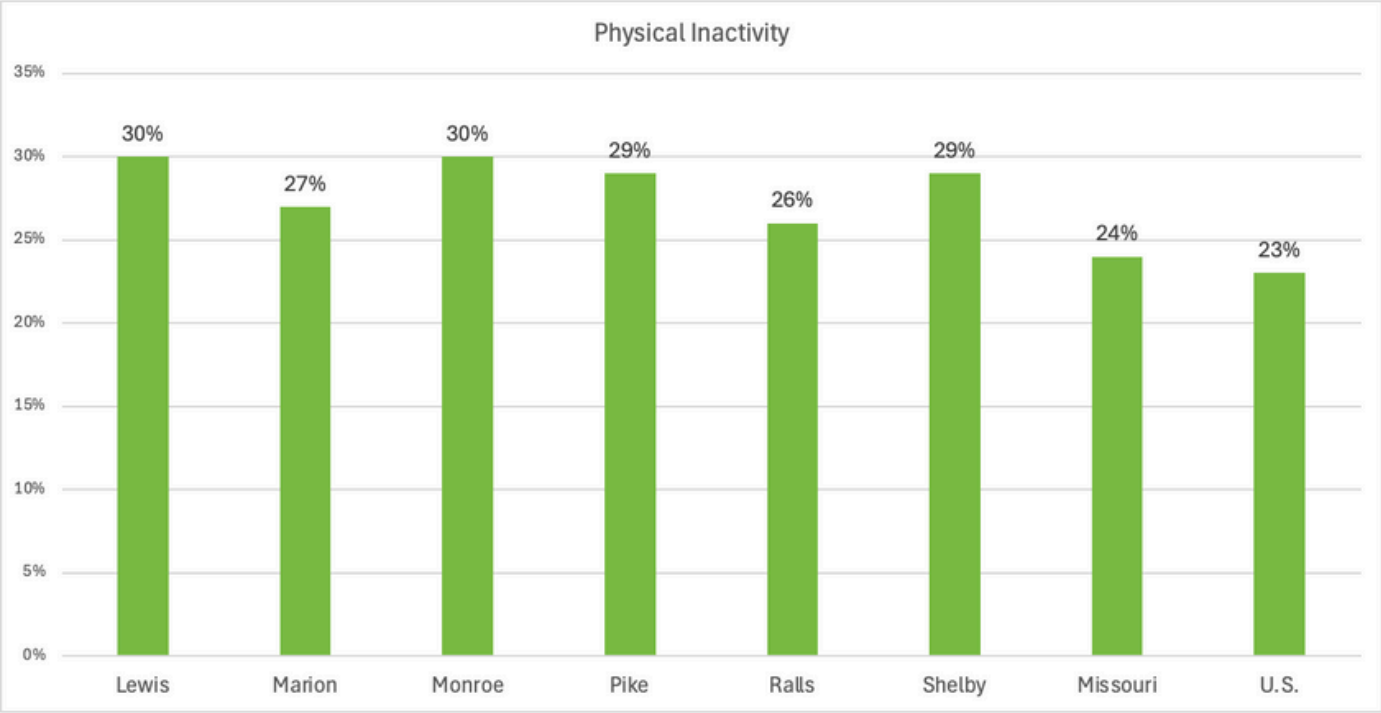


Source: County Health Rankings & Roadmaps 2025 Annual Data Release

Physical Inactivity

Health Promotion and Harm Reductions | ***Health Infrastructure***

This measure reflects the percentage of adults aged 18 and over who report no leisure-time physical activity (age-adjusted), based on 2022 data. Physical inactivity is a major risk factor for chronic diseases such as heart disease, diabetes, stroke, and certain cancers. It also contributes to shorter life expectancy and increased risk of obesity. Regular activity improves sleep, cognitive health, and musculoskeletal function. Access to safe and affordable places for recreation—such as parks, trails, and sidewalks—is critical, yet often limited in communities affected by poverty, segregation, and disinvestment.



Source: County Health Rankings & Roadmaps 2025 Annual Data Release

Primary Care Physicians

Clinical Care | *Health Infrastructure*

This measure represents the ratio of the population to primary care physicians, based on 2021 data. Adequate access to primary care is essential for preventive services, early diagnosis, and effective management of chronic conditions. While specialist care is important, a strong foundation of primary care improves overall health outcomes and helps ensure appropriate referrals when more advanced care is needed. Insufficient access to primary care can delay treatment and contribute to poorer health at the population level.

Population to Primary Care Physician Ratio

Year	Lewis	Marion	Monroe	Pike	Ralls	Shelby	Missouri	U.S.
2010	3400:1	1030:1	2930:1	3700:1	5100:1	null	1500:1	1370:1
2011	3410:1	1150:1	2890:1	3110:1	5150:1	null	1460:1	1360:1
2012	3390:1	1150:1	2890:1	3710:1	5130:1	null	1440:1	1340:1
2013	3380:1	1150:1	2910:1	3720:1	5090:1	null	1420:1	1320:1
2014	5060:1	1070:1	2890:1	3700:1	5140:1	null	1420:1	1320:1
2015	5090:1	1030:1	2850:1	3060:1	5090:1	null	1420:1	1320:1
2016	5070:1	1030:1	2850:1	3690:1	5110:1	null	1420:1	1330:1
2017	4980:1	1100:1	2870:1	3090:1	5110:1	null	1430:1	1330:1
2018	4930:1	1100:1	2890:1	3080:1	5110:1	null	1420:1	1320:1
2019	4890:1	1020:1	2880:1	3660:1	10310:1	5930:1	1400:1	1310:1
2020	4910:1	1050:1	2890:1	4390:1	10300:1	5920:1	1410:1	1310:1
2021	5000:1	980:1	2900:1	5920:1	10360:1	5980:1	1420:1	1330:1

The data in this table reflect the average population served by a single primary care physician.
Source: County Health Rankings & Roadmaps 2025 Annual Data Release

Mental Health Providers

Clinical Care | *Health Infrastructure*

This measure reflects the number of mental health providers—such as licensed clinical social workers, psychologists, counselors, and psychiatrists—per 100,000 population, based on CMS National Provider Identifier (NPI) data. In the CHNA region, there are 123 providers, equating to a rate of 151.35 per 100,000 residents. Access to qualified mental health professionals is essential for addressing behavioral health needs, supporting early intervention, and improving mental health outcomes across all age groups.

Location	Total Population (2020)	Number of Facilities	Number of Providers	Providers, Rate per 100,000 Population
Lewis	10,032	1	4	39.87
Marion	28,525	12	93	326.03
Monroe	8,666	0	2	23.08
Pike	17,587	6	12	68.23
Ralls	10,355	2	11	106.23
Shelby	6,103	0	1	16.39
Missouri	6,154,913	2,150	17,964	291.86
U.S.	334,735,155	143,553	1,057,118	315.81

Sources: Recovery Friendly Workplace Missouri Community Data Report Tool
County Health Rankings & Roadmaps 2025 Annual Data Release

Dentists

Clinical Care | *Health Infrastructure*

This measure indicates the ratio of population to dentists, using 2022 data. Access to dental care is essential for overall health, as untreated oral health issues can lead to pain, infection, tooth loss, and other serious complications. Despite the importance of dental care, provider shortages remain a major barrier—over 10,000 Dental Health Professional Shortage Areas were identified in 2024, affecting more than 59 million people nationwide. Ensuring access to dental services is critical for prevention and early intervention.

Year	Lewis	Marion	Monroe	Pike	Ralls	Shelby	Missouri	U.S.
2010	10200:1	2060:1	4400:1	3700:1	10190:1	3190:1	2110:1	1700:1
2011	10240:1	2060:1	4340:1	3730:1	10300:1	3120:1	2050:1	1660:1
2012	10160:1	2060:1	4340:1	3710:1	10270:1	3120:1	1990:1	1620:1
2013	10140:1	1920:1	4370:1	3720:1	10180:1	3080:1	1920:1	1580:1
2014	10120:1	2060:1	4340:1	3700:1	10280:1	3060:1	1860:1	1540:1
2015	10190:1	1700:1	4280:1	3670:1	10180:1	3070:1	1840:1	1520:1
2016	10130:1	1610:1	4280:1	3690:1	10220:1	3040:1	1810:1	1480:1
2017	9970:1	1510:1	4310:1	3710:1	10220:1	3010:1	1760:1	1460:1
2018	9860:1	1430:1	4330:1	3080:1	10210:1	3030:1	1720:1	1450:1
2019	9780:1	1240:1	8640:1	3050:1	10310:1	2970:1	1670:1	1400:1
2020	9810:1	1240:1	8670:1	2930:1	10300:1	2960:1	1650:1	1400:1
2021	10000:1	1190:1	8710:1	2960:1	10360:1	2990:1	1620:1	1380:1
2022	9890:1	1180:1	8650:1	2940:1	10420:1	2990:1	1600:1	1360:1

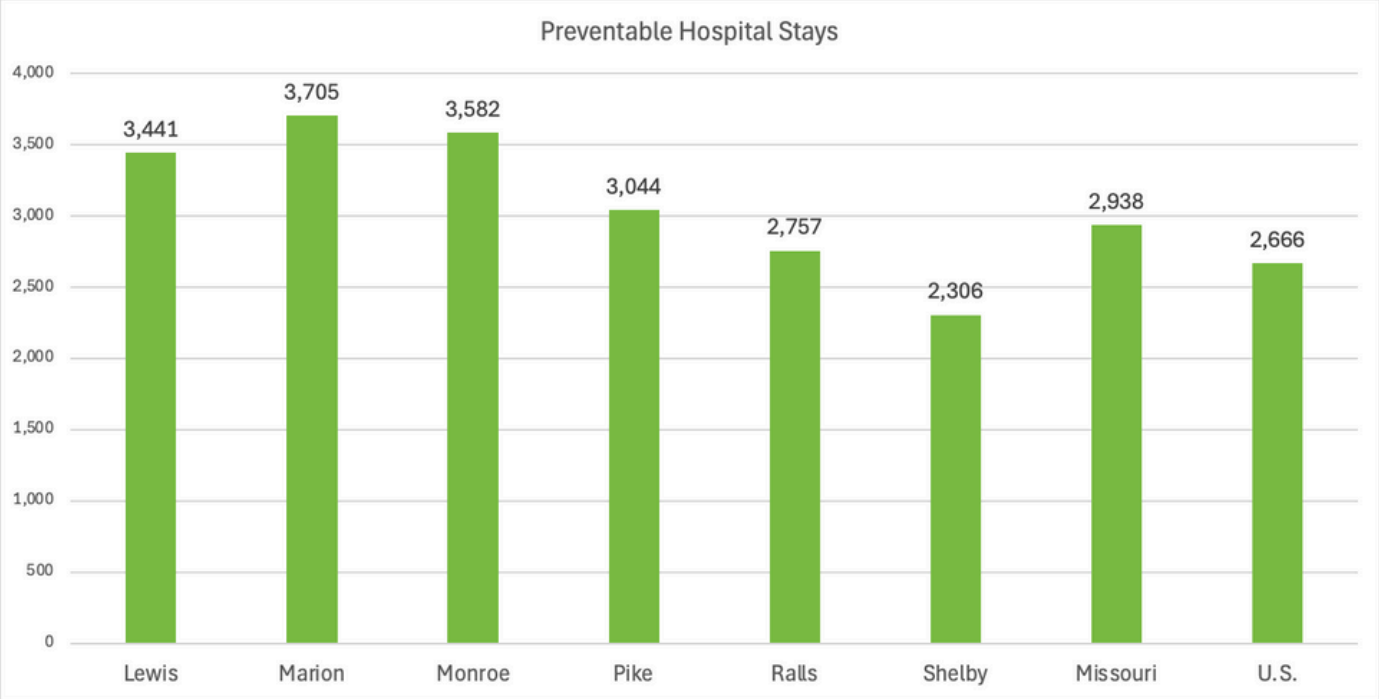
The data in this table reflect the average population served by a single dentist.
Source: County Health Rankings & Roadmaps 2025 Annual Data Release

Preventable Hospital Stays

Clinical Care | *Health Infrastructure*

This measure represents the rate of hospitalizations for conditions that could typically be managed with quality outpatient care—such as congestive heart failure, pneumonia, and urinary tract infections—per 100,000 Medicare enrollees, using 2022 data. High rates may indicate limited access to or poor quality of primary care and a reliance on emergency services for routine health needs. These avoidable hospitalizations are costly, often impact underserved populations more heavily, and can lead to long-term health and financial consequences.

Source: County Health Rankings & Roadmaps 2025 Annual Data Release



Year	Lewis	Marion	Monroe	Pike	Ralls	Shelby	Missouri	U.S.
2012	4,487	5,361	3,976	7,182	5,893	3,074	5,184	4,863
2013	4,022	5,062	4,567	6,154	5,756	3,927	4,869	4,583
2014	5,568	6,174	4,473	5,835	3,461	4,072	4,620	4,358
2015	4,485	6,532	4,417	6,876	4,676	4,169	4,319	4,040
2016	5,437	6,073	3,911	5,497	6,341	3,828	4,743	4,447
2017	5,368	7,374	4,656	6,550	6,435	4,745	4,800	4,475
2018	5,793	8,075	4,907	5,185	5,528	5,145	4,638	4,236
2019	5,035	6,902	3,844	4,883	4,409	4,907	4,155	3,767
2020	2,592	4,567	3,619	3,067	3,539	2,992	3,052	2,809
2021	3,293	4,550	3,689	2,801	4,052	2,950	3,016	2,681
2022	3,441	3,705	3,582	3,044	2,757	2,306	2,938	2,666

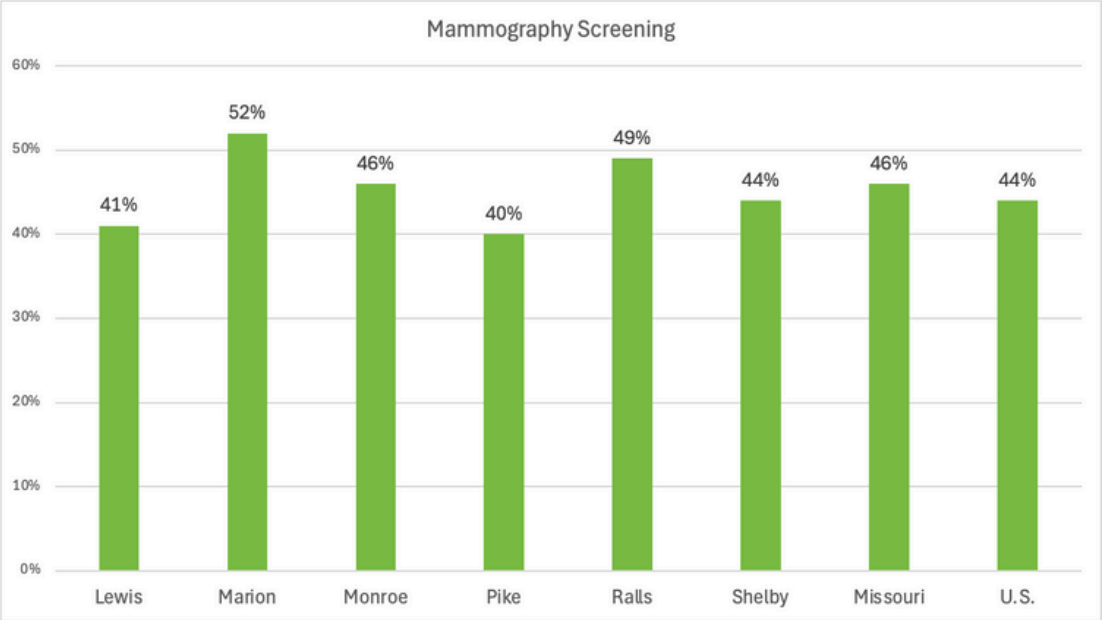
Preventable hospital stays per 100,000 Medicare enrollees Trends

Mammography Screening

Clinical Care | *Health Infrastructure*

This measure shows the percentage of female Medicare enrollees ages 65–74 who received an annual mammogram, based on 2022 data. Mammography screening is proven to reduce breast cancer mortality, especially when initiated at age 40 and followed by timely treatment. Access to screening can be limited by factors such as transportation, cost, food and housing insecurity, and social isolation. Black women experience a 40% higher breast cancer mortality rate than White women and are more likely to develop aggressive cancers at younger ages—underscoring the need for early, equitable screening and follow-up care.

Source: County Health Rankings & Roadmaps 2025 Annual Data Release



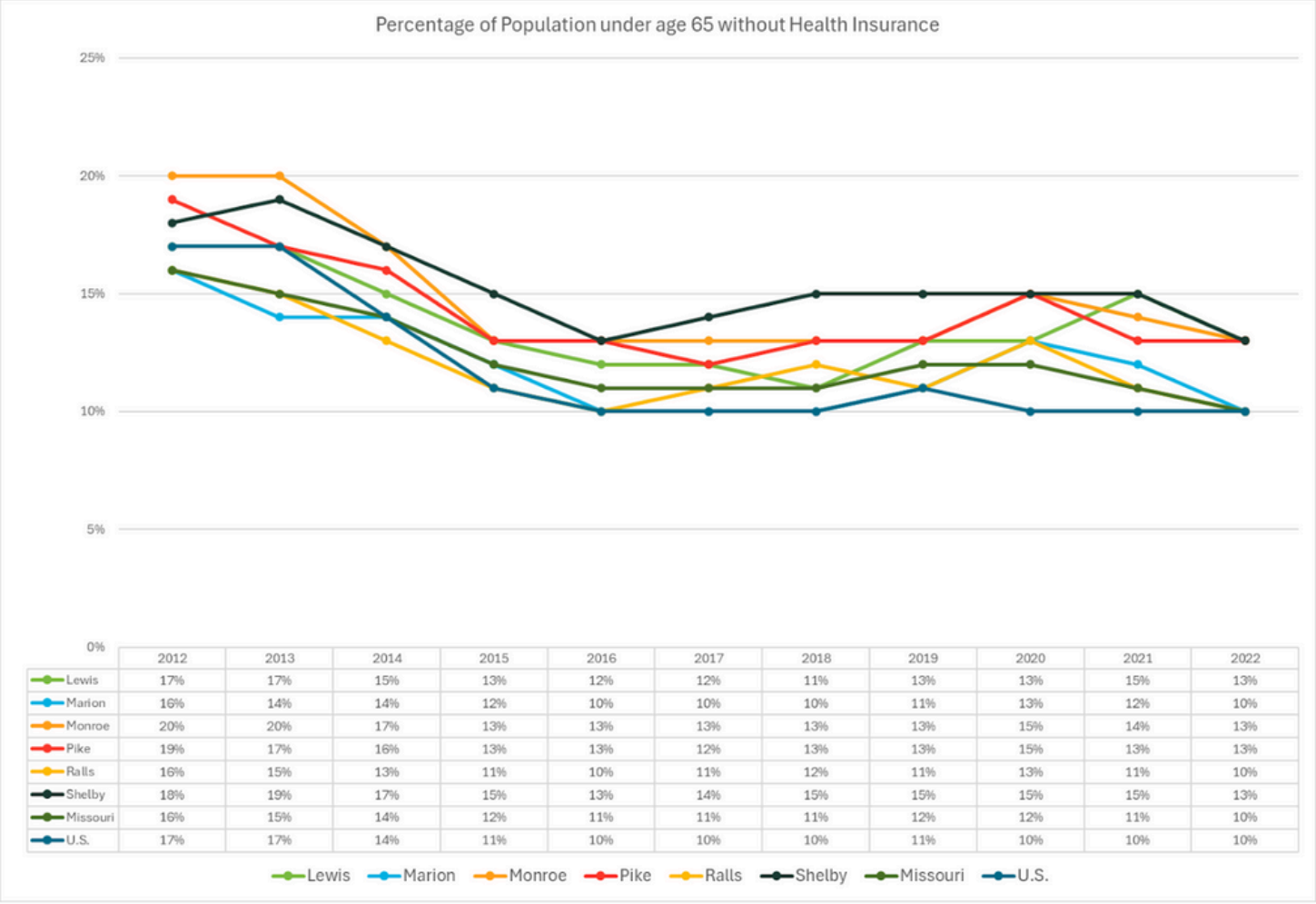
Year	Lewis	Marion	Monroe	Pike	Ralls	Shelby	Missouri	U.S.
2012	41%	43%	43%	36%	40%	47%	41%	40%
2013	41%	45%	40%	33%	46%	47%	41%	40%
2014	38%	45%	42%	33%	47%	43%	41%	40%
2015	40%	45%	42%	35%	50%	45%	41%	40%
2016	41%	47%	47%	36%	48%	46%	43%	41%
2017	40%	52%	50%	37%	49%	45%	43%	42%
2018	40%	50%	48%	38%	53%	45%	44%	42%
2019	42%	51%	48%	37%	50%	44%	45%	43%
2020	35%	44%	41%	33%	46%	42%	40%	37%
2021	39%	52%	45%	41%	53%	42%	45%	43%
2022	41%	52%	46%	40%	49%	44%	46%	44%

Percentage Trends of female Medicare enrollees ages 65-74 who received an annual mammography screening

Uninsured Adults

Clinical Care | ***Health Infrastructure***

This measure reflects the percentage of adults under age 65 without health insurance, based on 2022 data. Being uninsured is a major barrier to accessing preventive care, managing chronic conditions, and protecting against financial hardship due to medical costs. Many uninsured adults cite affordability as the primary obstacle, and those in non-Medicaid expansion states often fall into coverage gaps. Compared to insured individuals, the uninsured are less likely to receive timely care and more likely to face high out-of-pocket expenses when they do seek treatment.



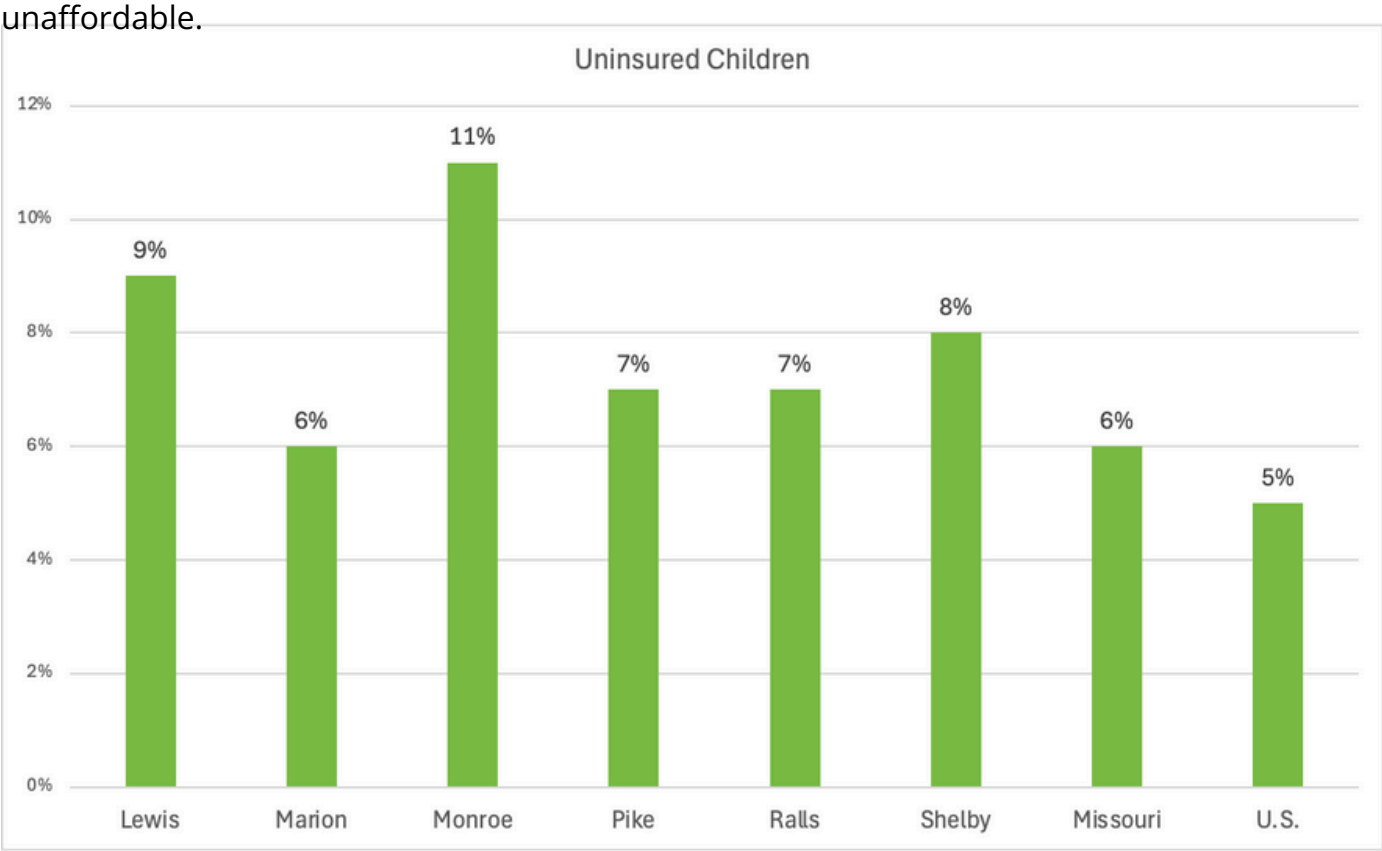
	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021	2022
Lewis	17%	17%	15%	13%	12%	12%	11%	13%	13%	15%	13%
Marion	16%	14%	14%	12%	10%	10%	10%	11%	13%	12%	10%
Monroe	20%	20%	17%	13%	13%	13%	13%	13%	15%	14%	13%
Pike	19%	17%	16%	13%	13%	12%	13%	13%	15%	13%	13%
Ralls	16%	15%	13%	11%	10%	11%	12%	11%	13%	11%	10%
Shelby	18%	19%	17%	15%	13%	14%	15%	15%	15%	15%	13%
Missouri	16%	15%	14%	12%	11%	11%	11%	12%	12%	11%	10%
U.S.	17%	17%	14%	11%	10%	10%	10%	11%	10%	10%	10%

Source: County Health Rankings & Roadmaps 2025 Annual Data Release

Uninsured Children

Clinical Care | ***Health Infrastructure***

This measure represents the percentage of children under age 19 without health insurance, based on 2022 data. Lack of coverage significantly limits access to preventive services such as vaccinations and well-child visits, and often leads to delayed or missed care. Uninsured children are more likely to experience poor health outcomes and financial hardship due to medical costs. Families without insurance may face higher charges for services, and many are already burdened by low income and limited savings—making even routine care unaffordable.



Source: County Health Rankings & Roadmaps 2025 Annual Data Release

Insured Population

Total Population with Health Insurance Coverage by CHNA County (2023)

Lewis	Marion	Monroe	Pike	Ralls	Shelby
9,766	27,983	8,513	15,879	10,330	5,847

Source: U.S. Census American Community Survey

Health Insurance Topics

Clinical Care | ***Health Infrastructure***

Health Insurance Topics	Units	Time Period	U.S.	Lewis	Marion	Monroe	Ralls	Shelby	Pike
Employment-based health insurance	% of residents	2023	54.7%	53.7%	56.0%	50.5%	53.5%	48.0%	51.6%
ACA marketplace enrollments	plan selections	2024		392	1440	627	410	229	790
Medicare beneficiaries	beneficiaries	2012		1657	4270	1479	1553	1204	2647
Medicaid coverage	% of residents	2023	21.3%	16.4%	19.5%	14.1%	16.1%	22.8%	19.5%
Medicare coverage	% of residents	2023	18.8%	20.9%	20.4%	26.2%	25.9%	22.5%	22.7%
Medicare beneficiaries eligible for Medicaid	% of beneficiaries	2022	17.0%	13.0%	18.9%	11.8%	10.9%	12.7%	13.5%
No health insurance	% of adults	2022	11.6%	12.7%	11.5%	12.2%	11.3%	12.2%	13.8%
Public health insurance	% of residents	2023	37.4%	35.3%	37.2%	36.7%	40.8%	43.4%	39.4%
Private health insurance	% of residents	2023	67.0%	64.2%	66.4%	63.7%	68.5%	58.7%	62.5%
Marketplace consumers	% of residents	2023	3.7%	3.1%	3.5%	5.5%	3.2%	3.6%	3.2%
TriCare/military health coverage	% of residents	2023	2.8%	1.1%	1.2%	2.2%	2.3%	1.6%	0.7%
Uninsured residents	residents	2023		1033	2218	976	590	587	1429
Uninsured rate	% of residents	2023	7.9%	10.6%	7.9%	11.5%	5.7%	10.0%	9.0%
VA Health Care coverage	% of residents	2023	2.2%	3.6%	3.8%	4.4%	4.5%	4.5%	1.9%
Child psychologists per capita	Physicians per 100,000 residents	2022	2.82	0	7.01	0	0	0	0

Source: County Health Rankings & Roadmaps 2025 Annual Data Release

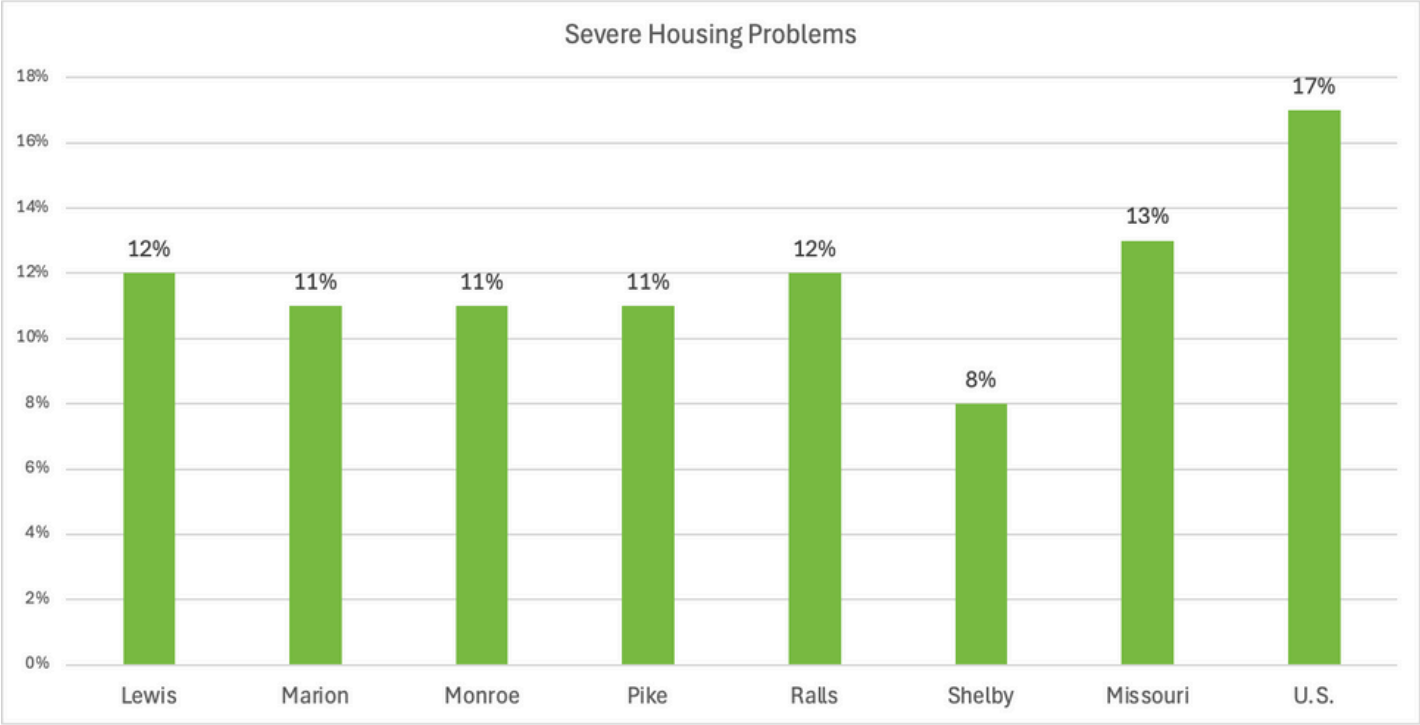
Physical Environment

Housing and Transportation

Housing is a basic human need. Housing includes houses, apartments, and congregate housing like nursing homes or halfway houses. Transportation connects us to the places where we live, work, learn and play. Transportation systems can include buses, subways, trains as well as sidewalks, streets, bike paths, highways and air travel.

Severe Housing Problems

This measure reflects the percentage of households experiencing at least one of four issues: overcrowding, high housing costs, lack of kitchen facilities, or lack of plumbing, based on data from 2017–2021. Safe, stable housing is essential for good health, while poor housing conditions are linked to chronic disease, injuries, stress, and developmental challenges. High housing costs often force families to sacrifice other essentials—like healthcare, food, and transportation—leading to increased financial and emotional strain. Housing quality also serves as a broader indicator of socioeconomic well-being.

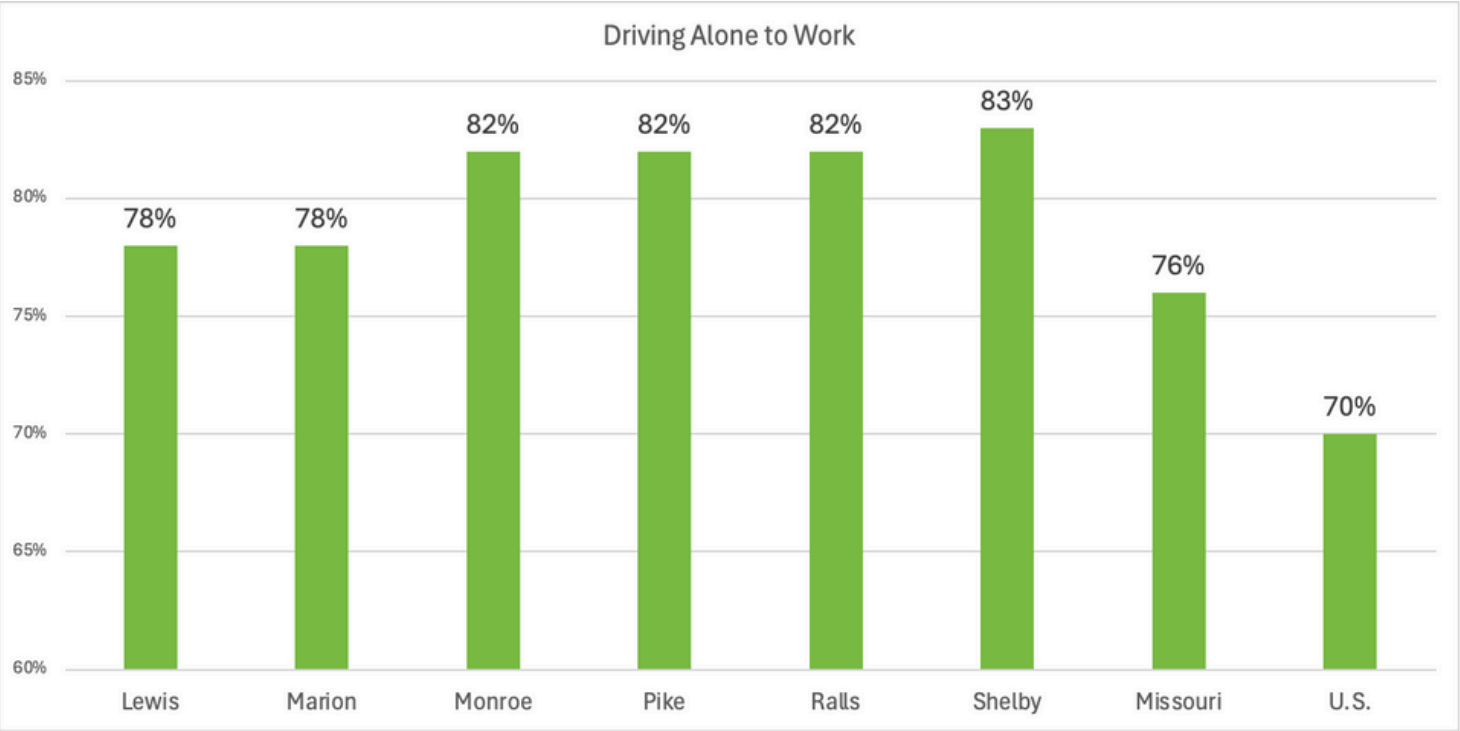


Source: County Health Rankings & Roadmaps 2025 Annual Data Release

Driving Alone to Work

Housing and Transportation | ***Physical Environment***

This measure indicates the percentage of the workforce that commutes to work by driving alone, using data from 2019–2023. While common, solo car commuting is associated with negative health impacts, including reduced physical activity, higher body fat percentage, and poorer air quality. In contrast, active or mixed-method commuting—such as walking, biking, or using public transit—can improve fitness, reduce BMI, and support healthier communities. Transportation choices are shaped by factors like infrastructure, affordability, and safety, highlighting the importance of equitable, accessible commuting options.

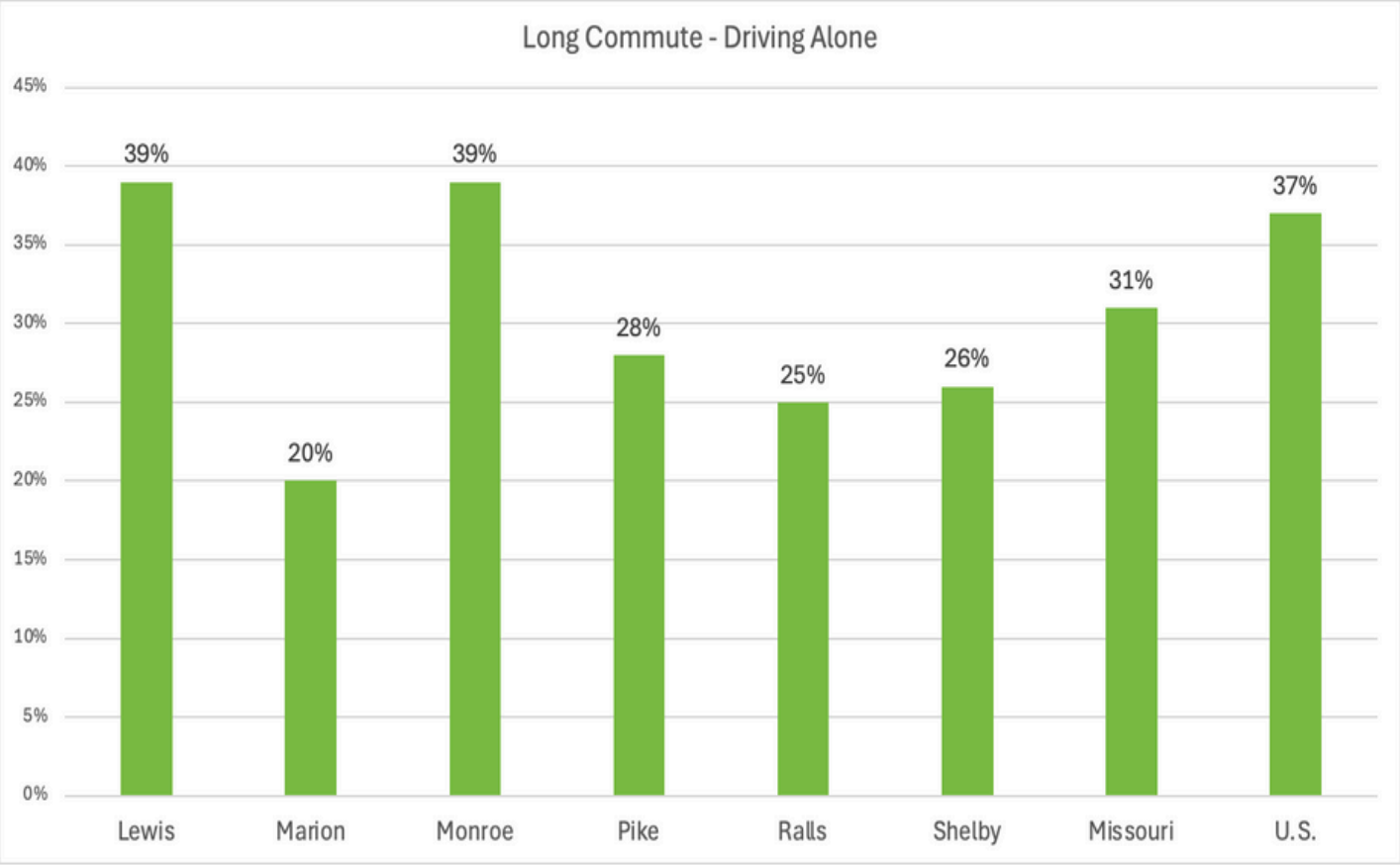


Source: County Health Rankings & Roadmaps 2025 Annual Data Release

Long Commute- Driving Alone

Housing and Transportation | ***Physical Environment***

This measure reflects the percentage of solo drivers whose commute exceeds 30 minutes, based on data from 2019–2023. Long commutes are linked to negative health outcomes, including increased blood pressure, higher BMI, reduced physical activity, and poorer mental health. Each additional hour spent commuting by car daily raises the risk of obesity by 6%. These extended drives not only affect physical well-being but also contribute to emotional strain and reduced time for health-promoting activities.

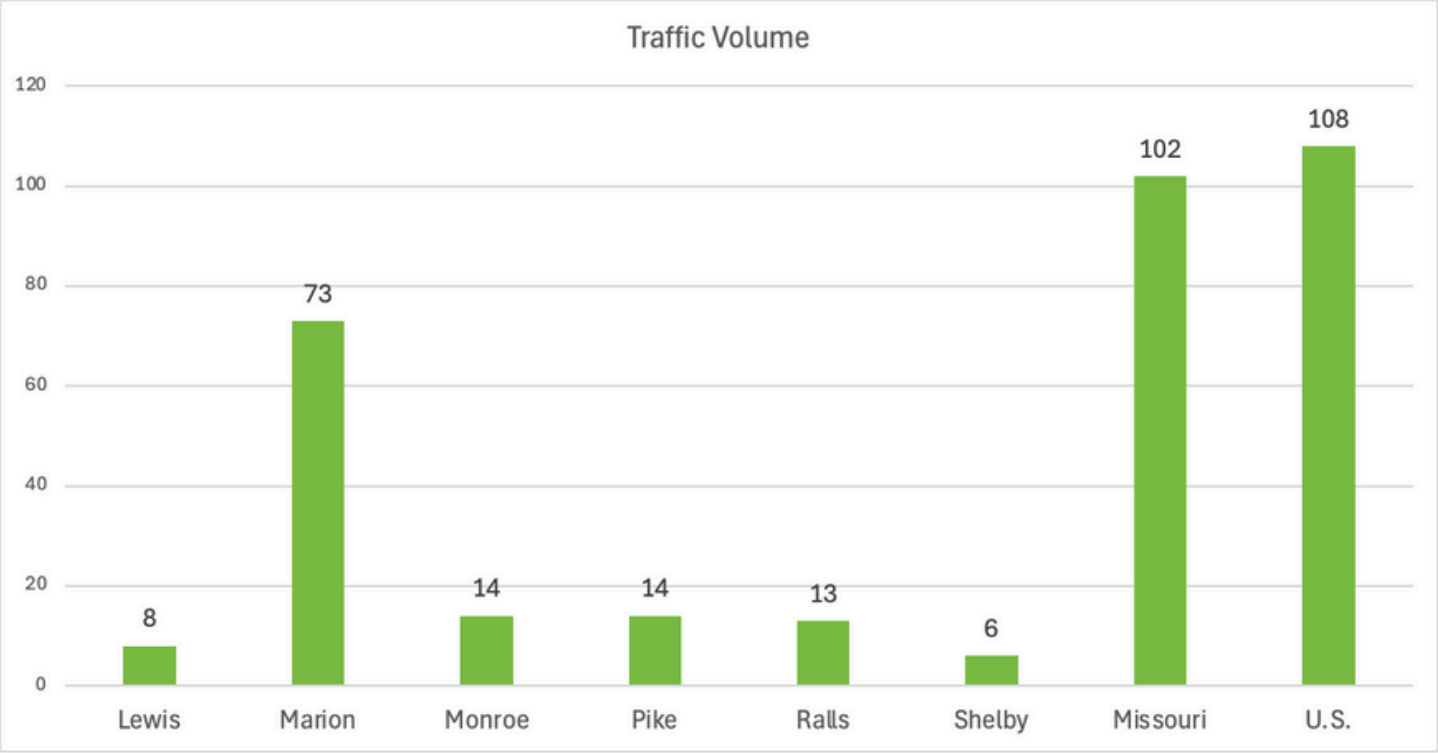


Source: County Health Rankings & Roadmaps 2025 Annual Data Release

Traffic Volume

Housing and Transportation | *Physical Environment*

This measure reflects the average traffic volume per meter of major roadways in a county, based on 2020 data. Living near high-traffic areas increases exposure to air and noise pollution, which is linked to a range of health issues including asthma, cardiovascular disease, and higher mortality rates. Traffic-related air pollution has also been associated with the onset of asthma, heart attacks, and subclinical atherosclerosis. Additionally, chronic noise exposure from traffic can elevate stress levels and contribute to poor mental and physical health outcomes.

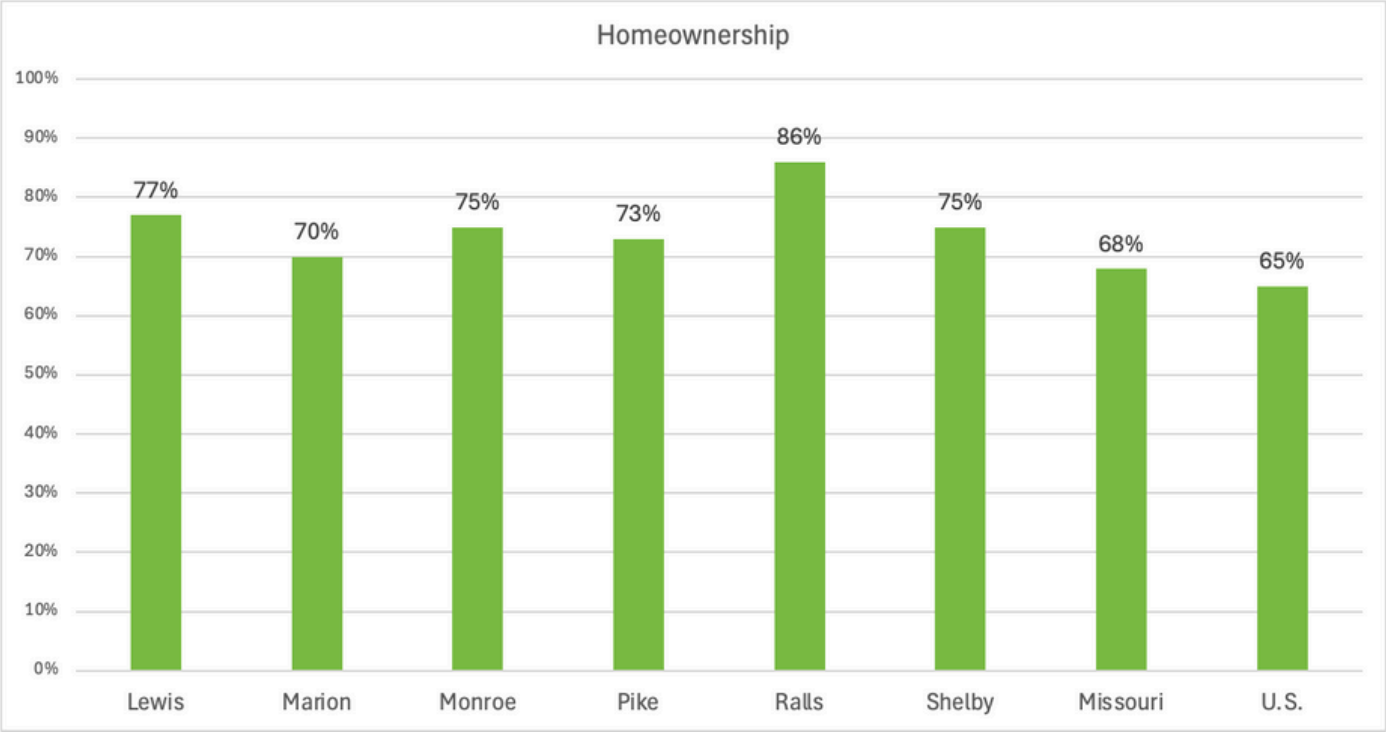


Source: County Health Rankings & Roadmaps 2025 Annual Data Release

Homeownership

Housing and Transportation | ***Physical Environment***

This measure represents the percentage of housing units that are owner-occupied, based on data from 2019–2023. Homeownership is linked to better overall health, fewer illnesses, and lower rates of depression and anxiety. It contributes to housing stability, community cohesion, and long-term financial security, which are all important to individual and community well-being. Over time, owning a home can help build wealth and provide a foundation for future health and economic opportunities.

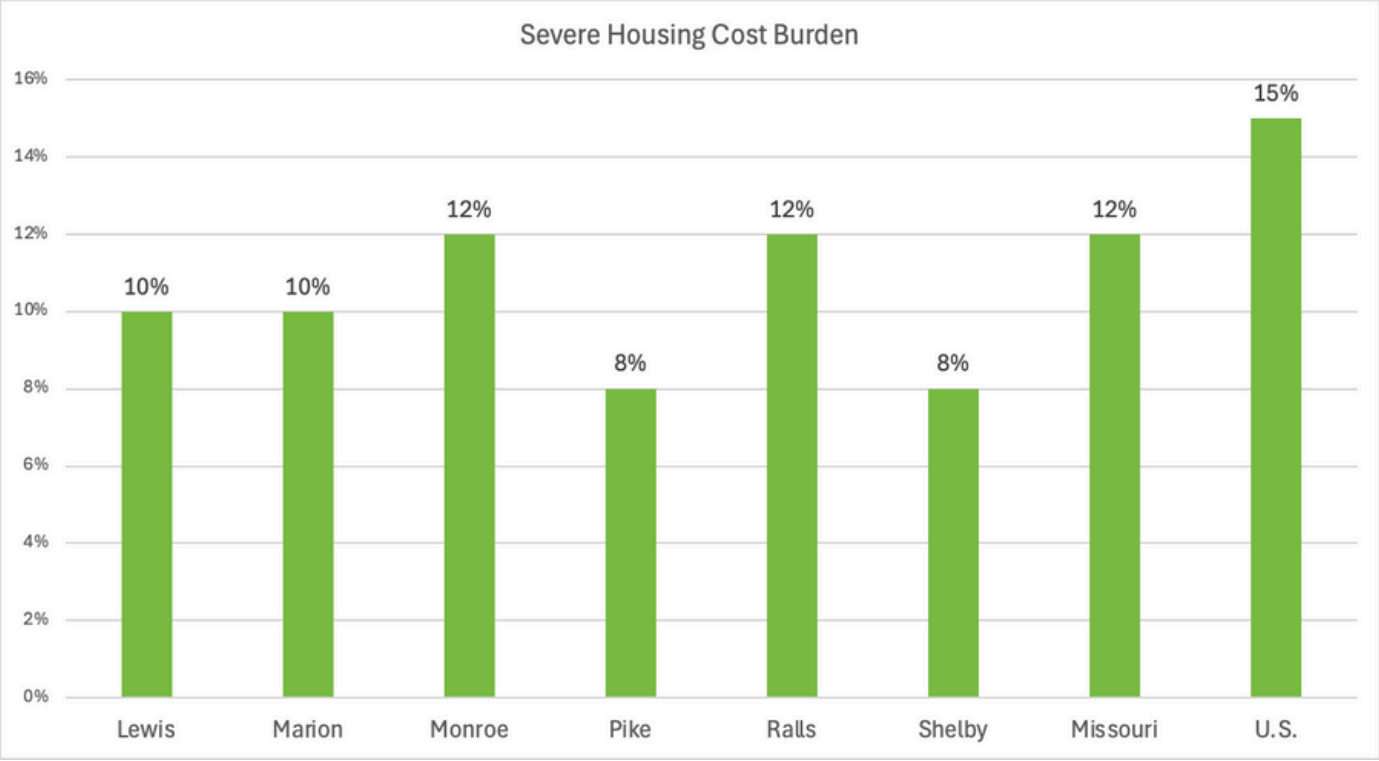


Source: County Health Rankings & Roadmaps 2025 Annual Data Release

Severe Housing Cost Burden

Housing and Transportation | ***Physical Environment***

This measure reflects the percentage of households spending 50% or more of their income on housing, using data from 2019–2023. When housing costs consume the majority of a household's income, families often face trade-offs that compromise their ability to meet other basic needs—such as healthcare, food, utilities, and transportation. These financial strains can increase stress and negatively impact overall health. Stable and affordable housing is essential for physical, mental, and economic well-being.



Source: County Health Rankings & Roadmaps 2025 Annual Data Release

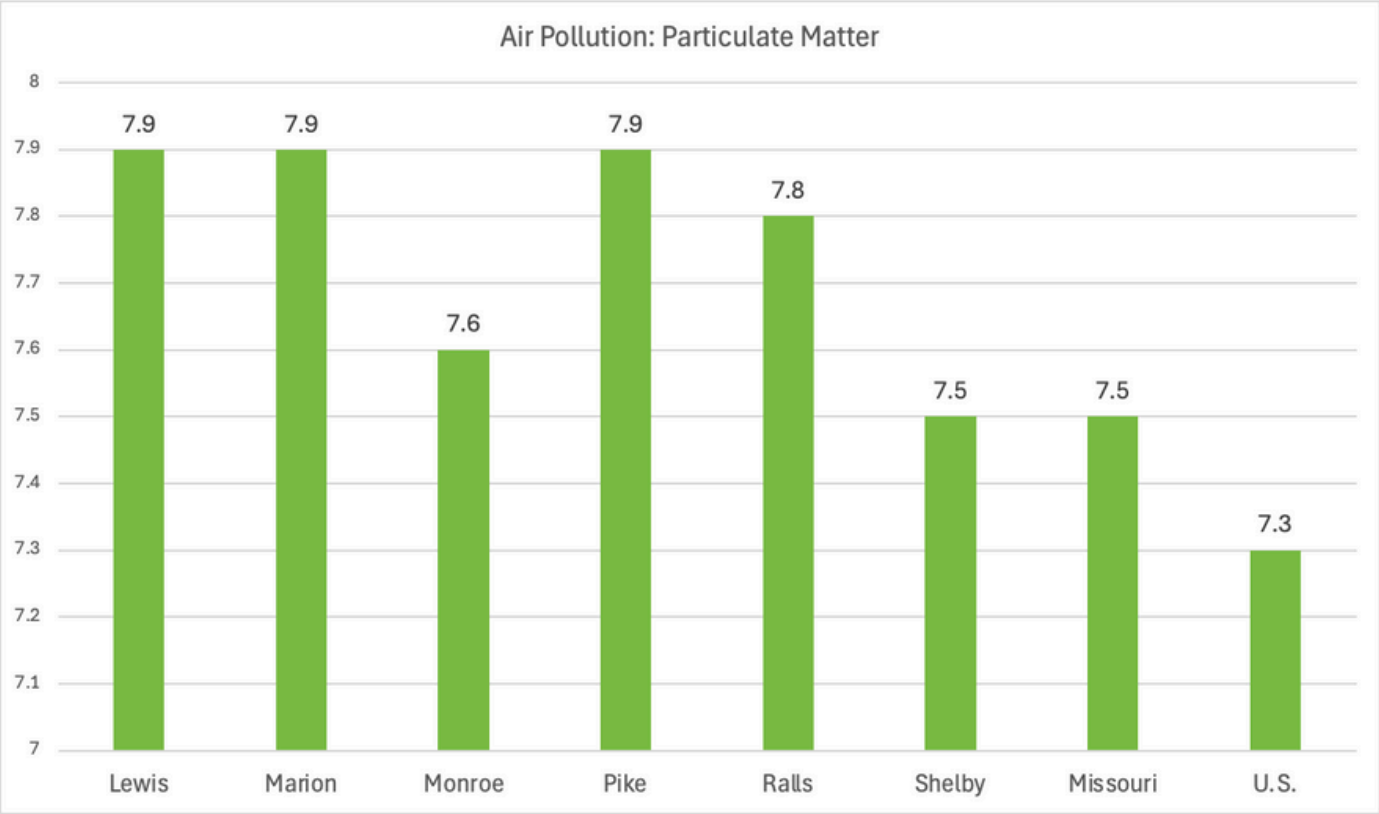
Physical Environment

Air, Water, and Land

Air, water and land are the fundamental natural resources that provide what we need to survive and thrive. Many Indigenous peoples understand that air, water and land are sacred, living entities in a reciprocal relationship with us.

Air Pollution: Particulate Matter

This measure reflects the average daily density of fine particulate matter (PM2.5) in micrograms per cubic meter, based on 2020 data. PM2.5 is linked to serious health conditions including asthma, chronic bronchitis, reduced lung function, and increased risk of premature death—particularly among older adults. Long-term exposure poses health risks even below national air quality standards. Communities of color and those in poverty are more likely to be exposed due to historic discriminatory housing policies and proximity to environmental hazards, such as power plants.



Source: County Health Rankings & Roadmaps 2025 Annual Data Release

Drinking Water Violations

Air, Water, and Land | ***Physical Environment***

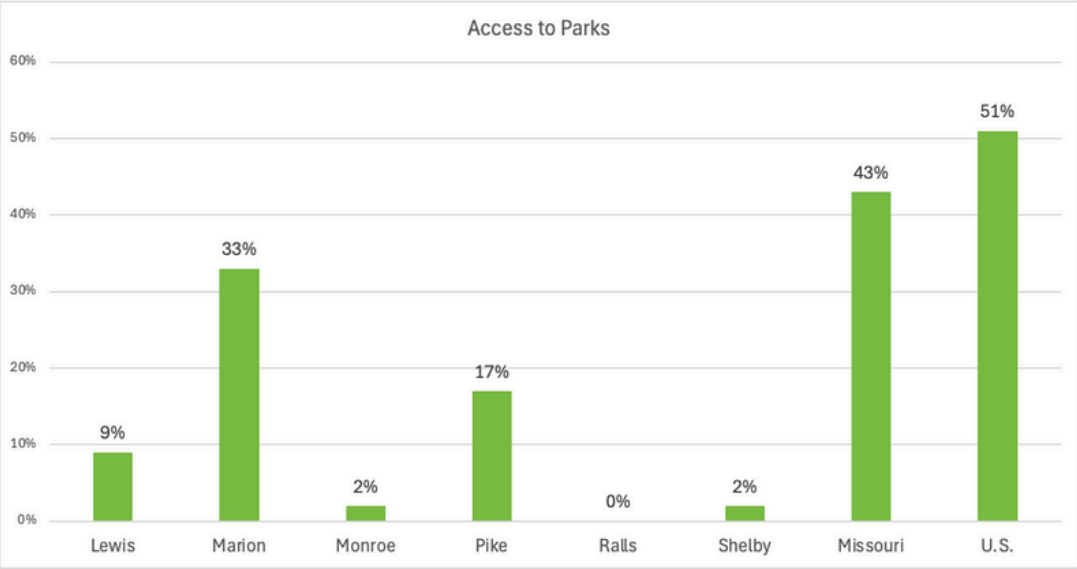
This indicator reflects whether a county had health-related drinking water violations in 2023. 'Yes' indicates the presence of a violation, 'No' indicates no violation. Safe drinking water is essential for preventing a wide range of health issues, including infections, cancer, and birth defects. Violations in water systems are linked to increased healthcare costs and public health risks. Historically marginalized and racially segregated communities are more likely to face water contamination due to systemic disinvestment, aging infrastructure, and proximity to environmental hazards. Monitoring and addressing these violations is critical to health equity and community well-being.

Source: County Health Rankings & Roadmaps 2025 Annual Data Release

Lewis	Marion	Monroe	Pike	Ralls	Shelby
No	Yes	Yes	Yes	Yes	No

Access to Parks

This measure reflects the percentage of the population living within a half mile of a park, using data from 2020 and 2024. Parks support physical and mental health by providing spaces for exercise, relaxation, and social connection. Access to green space is associated with reduced risks of chronic disease, improved mental well-being, and increased physical activity. In urban areas, parks help mitigate heat, manage stormwater, and improve air and water quality. They also enhance community cohesion and offer refuge from noise and environmental stressors.



Source: County Health Rankings & Roadmaps 2025 Annual Data Release

Climate

Physical Environment

Climate is the long-term pattern of temperature and precipitation for local, regional or global areas. Climate can be described by averages and extremes of temperature and precipitation.

Adverse Climate Events

This measure identifies counties that experienced one or more of the following between 2019 and 2023: 300+ days of extreme heat (above 90°F), 65+ weeks of moderate or greater drought, or 2+ presidential disaster declarations. These climate and weather-related events —such as extreme heat, droughts, and natural disasters—are increasing in frequency and severity. They pose immediate risks to physical health, disrupt health systems, damage infrastructure, and contribute to mental health challenges. Vulnerable populations, including older adults, children, and those with preexisting conditions, are especially at risk. Climate impacts also strain resources, displace communities, and require extensive recovery efforts.

Lewis	Marion	Monroe	Pike	Ralls	Shelby
0	0	0	1	1	1

Source: County Health Rankings & Roadmaps 2025 Annual Data Release

Social and Economic Factors

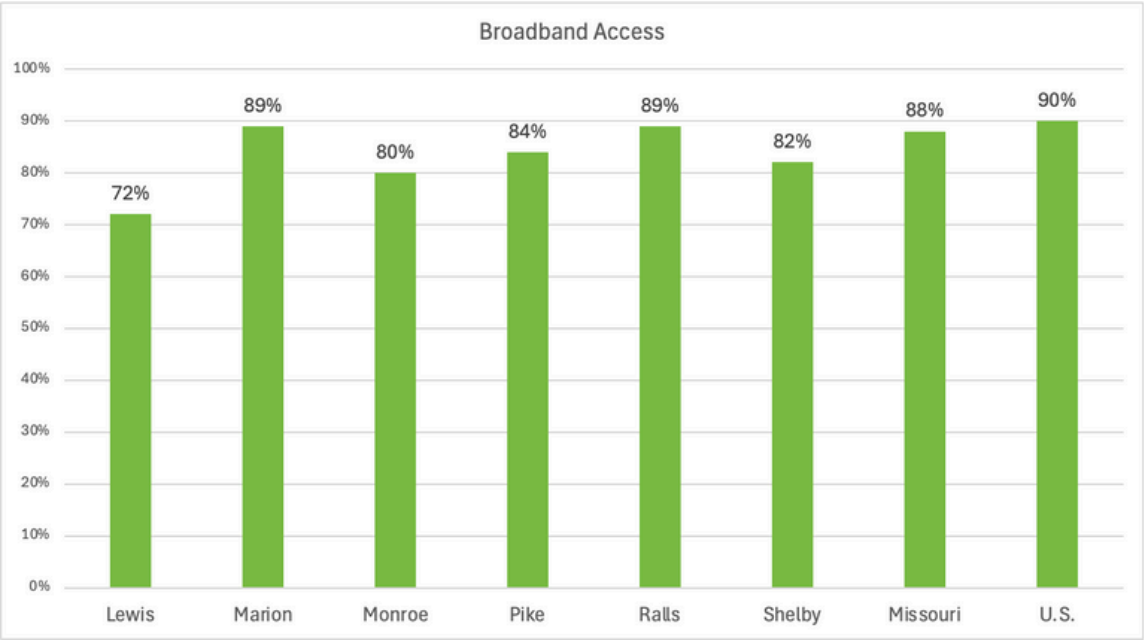
Social and economic factors influence the choices and opportunities available in a community. Economic factors include which jobs and benefits are available and to whom, and whether education, health insurance and child care are accessible and affordable. Social factors enable connection and inclusion within and between communities and include social safety net and other support.

Civic and Community Resources *Climate Events*

Civic and community resources include the physical and social infrastructure that help us stay connected and make community participation possible. Civic and community resources include spaces such as libraries or community centers, programs that promote volunteering and social connection and policies that make it easier to vote.

Broadband Access

This measure represents the percentage of households with broadband internet access, based on data from 2019–2023. Reliable high-speed internet is critical for education, employment, telehealth, and civic engagement. Despite federal investment to expand broadband, an estimated 14.5 million Americans still lack access. Many low-income and historically marginalized communities face digital redlining—systematic exclusion from broadband infrastructure. Inadequate access limits opportunities and increases isolation, particularly for older adults, while reliable connectivity supports social inclusion, access to services, and economic development.

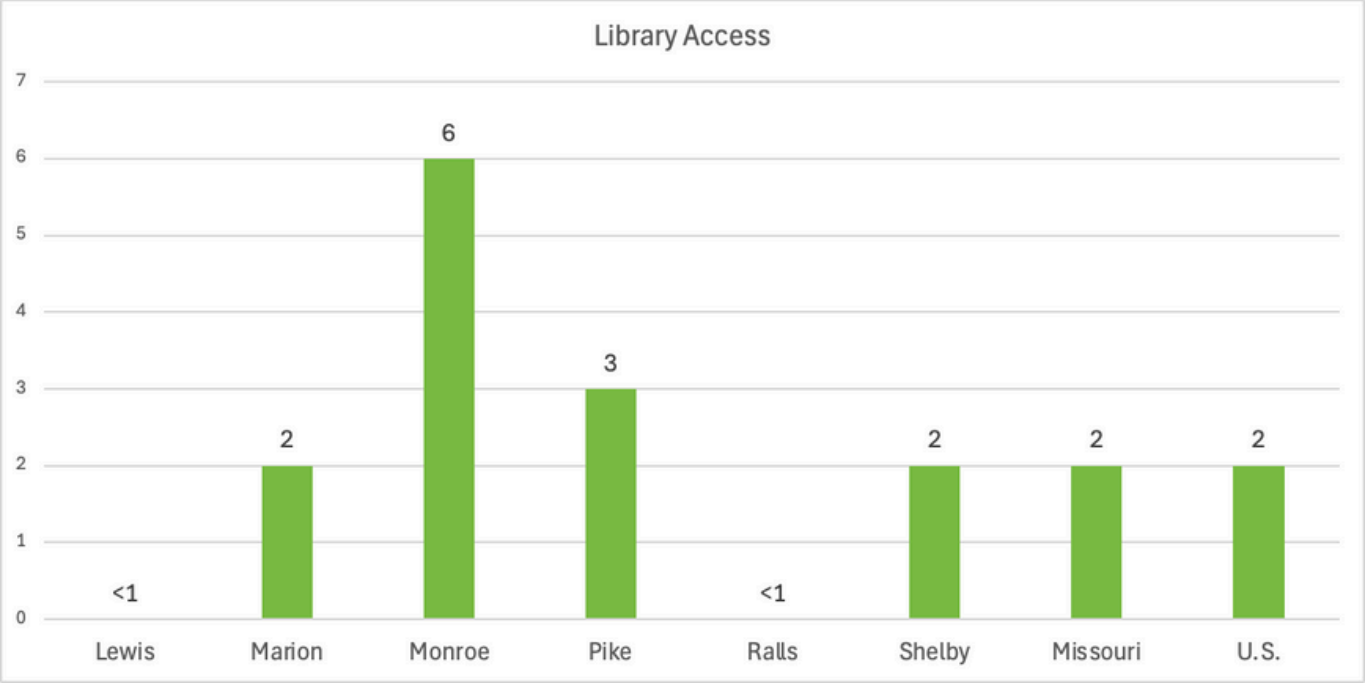


Source: County Health Rankings & Roadmaps 2025 Annual Data Release

Library Access

Civic and Community Resources | ***Social and Economic Factors***

This measure reflects the number of annual library visits per person within a library's service area, based on 2022 data. Public libraries are vital civic institutions that promote health equity, digital inclusion, and community well-being. They provide free access to educational resources, technology, and essential services such as flu vaccinations, financial literacy classes, and food assistance. Libraries also serve as trusted spaces for connection, learning, and civic engagement, especially for low-income residents, immigrants, and older adults. Library usage is a valuable indicator of community participation and access to shared resources.

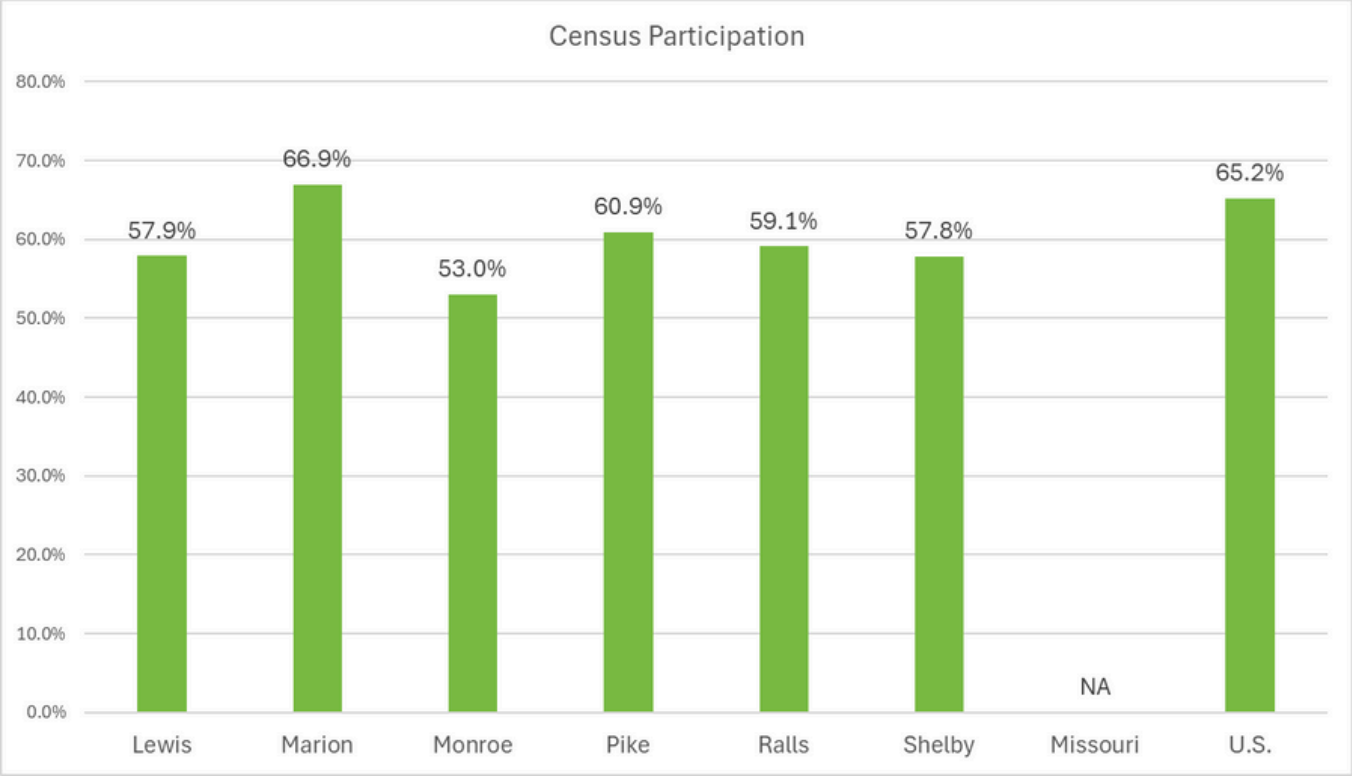


Source: County Health Rankings & Roadmaps 2025 Annual Data Release

Census Participation

Civic and Community Resources | ***Social and Economic Factors***

This measure represents the percentage of households that self-responded to the 2020 Census by internet, mail, or phone. Census participation is vital for equitable political representation, resource allocation, and public health planning. Census data guides the drawing of congressional districts and the distribution of billions in federal funding for infrastructure, education, healthcare, and safety net programs. It also informs emergency response planning and efforts to address racial, economic, and health disparities. High participation ensures communities are accurately counted and better equipped to meet local needs.

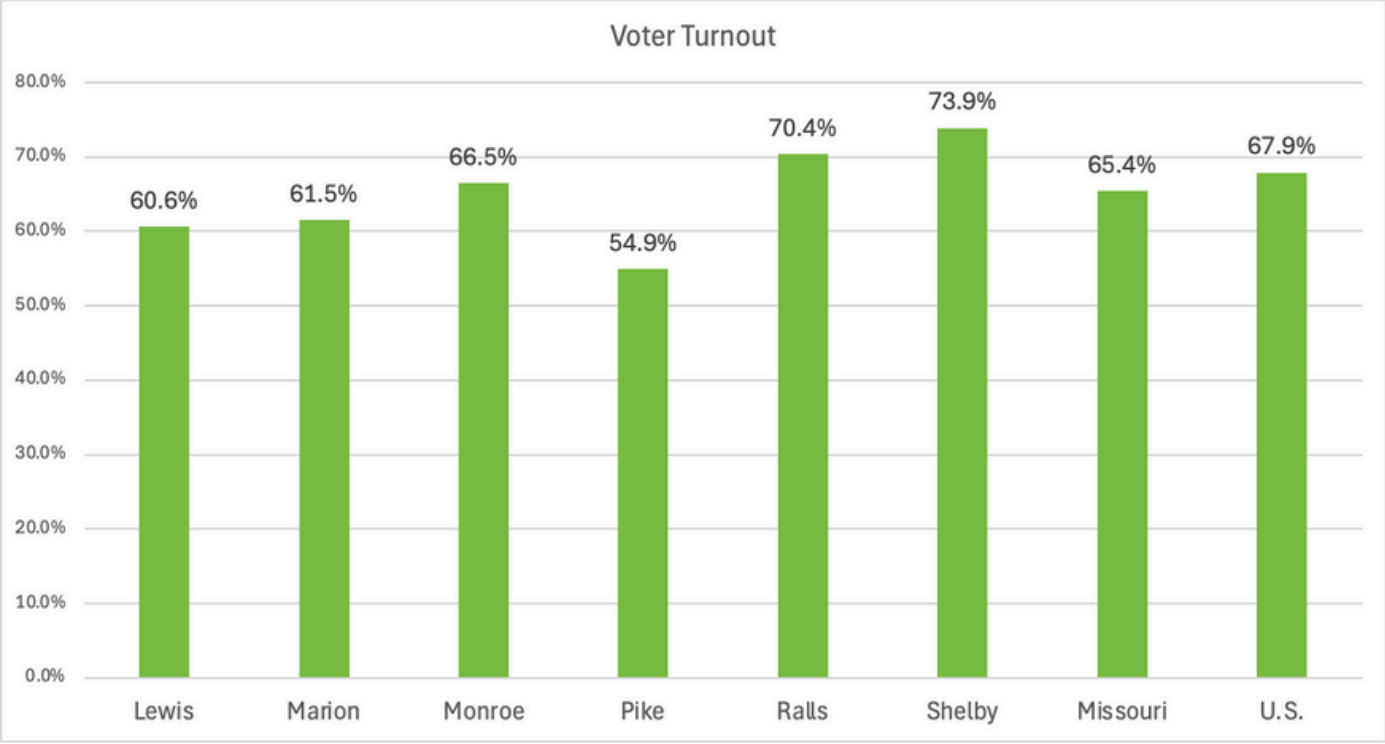


Source: County Health Rankings & Roadmaps 2025 Annual Data Release

Voter Turnout

Civic and Community Resources | ***Social and Economic Factors***

This measure reflects the percentage of the citizen population aged 18 and older who voted in the 2020 U.S. Presidential election, using data from 2016–2020. Voting is a key indicator of civic engagement and community health. Higher voter turnout is associated with better health outcomes, including fewer chronic conditions and lower rates of depression. However, structural barriers—such as voter registration restrictions, disenfranchisement laws, and limited access to polling—disproportionately affect marginalized groups and can suppress participation. Low turnout may reflect broader inequities in access to civic life and decision-making.



Source: County Health Rankings & Roadmaps 2025 Annual Data Release

Education

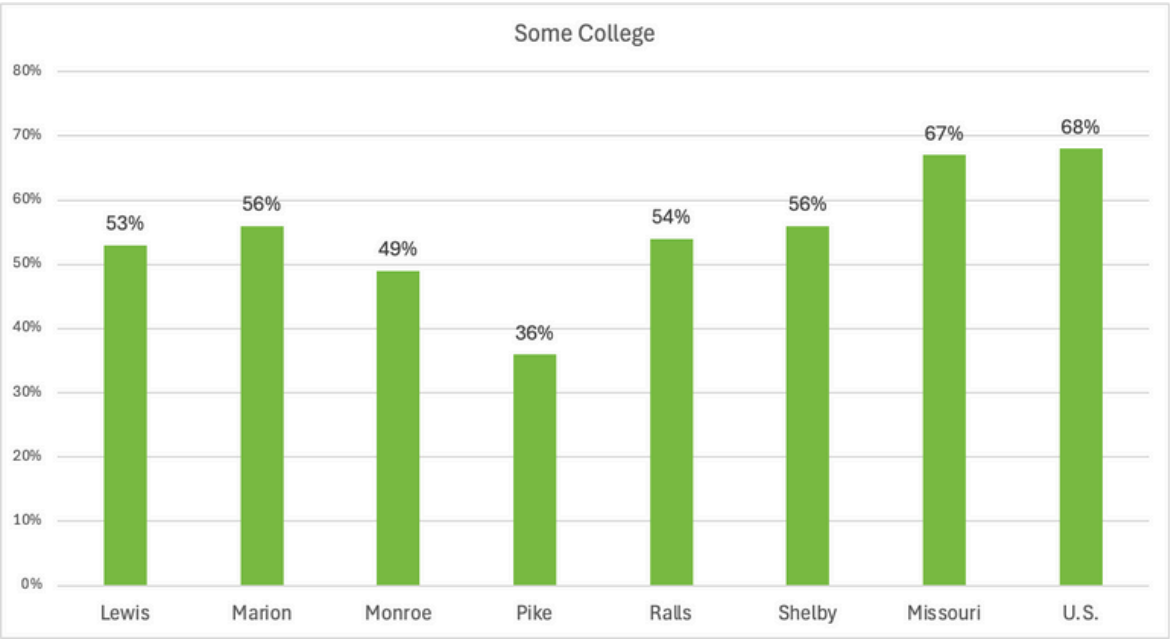
Social and Economic Factors

Education is a lifelong process that begins in early childhood and continues through K–12, higher education, and vocational training. Access to quality education is strongly linked to better health outcomes, as it opens doors to higher income, stable employment, healthier behaviors, and social support. At the same time, health can impact educational success—children in poor health may struggle with attendance, concentration, and academic achievement.

However, educational opportunity is not equitably distributed. Historic and ongoing policies have disproportionately disadvantaged students of color, those from low-income families, students with disabilities, and LGBTQ+ youth. For instance, school segregation, funding inequities, and biased disciplinary practices continue to create barriers to academic success. Thriving, inclusive education systems are essential for building healthy, equitable communities where all students are supported and can succeed.

Some College

This measure reflects the percentage of adults ages 25–44 who have attended some post-secondary education, based on data from 2019–2023. Higher education is strongly associated with improved health outcomes through pathways like increased income, better job opportunities, reduced stress, and healthier behaviors. However, access to higher education is not equitably distributed. Systemic barriers—rooted in historical and current policies—disproportionately impact students of color, low-income families, individuals with disabilities, and LGBTQ+ students, limiting opportunities and contributing to health disparities.

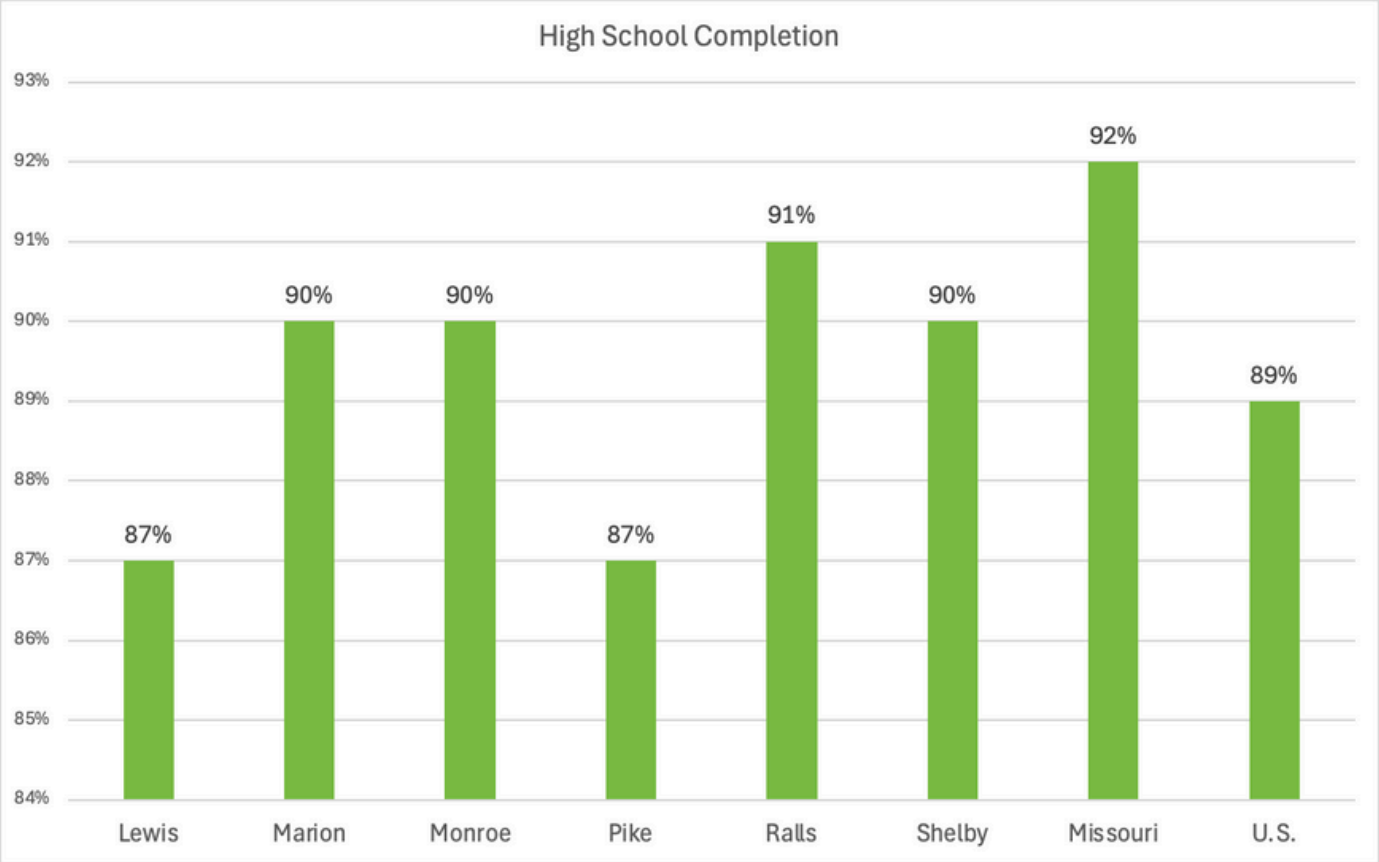


Source: County Health Rankings & Roadmaps 2025 Annual Data Release

High School Completion

Education | ***Social and Economic Factors***

This measure represents the percentage of adults ages 25 and over who have earned a high school diploma or equivalent, using data from 2019–2023. Completing high school is strongly linked to better health outcomes, including longer life expectancy, lower rates of chronic illness, and improved self-reported health. It is also associated with healthier behaviors and greater economic stability, as high school graduates are more likely to be employed and earn higher incomes than those without a diploma.

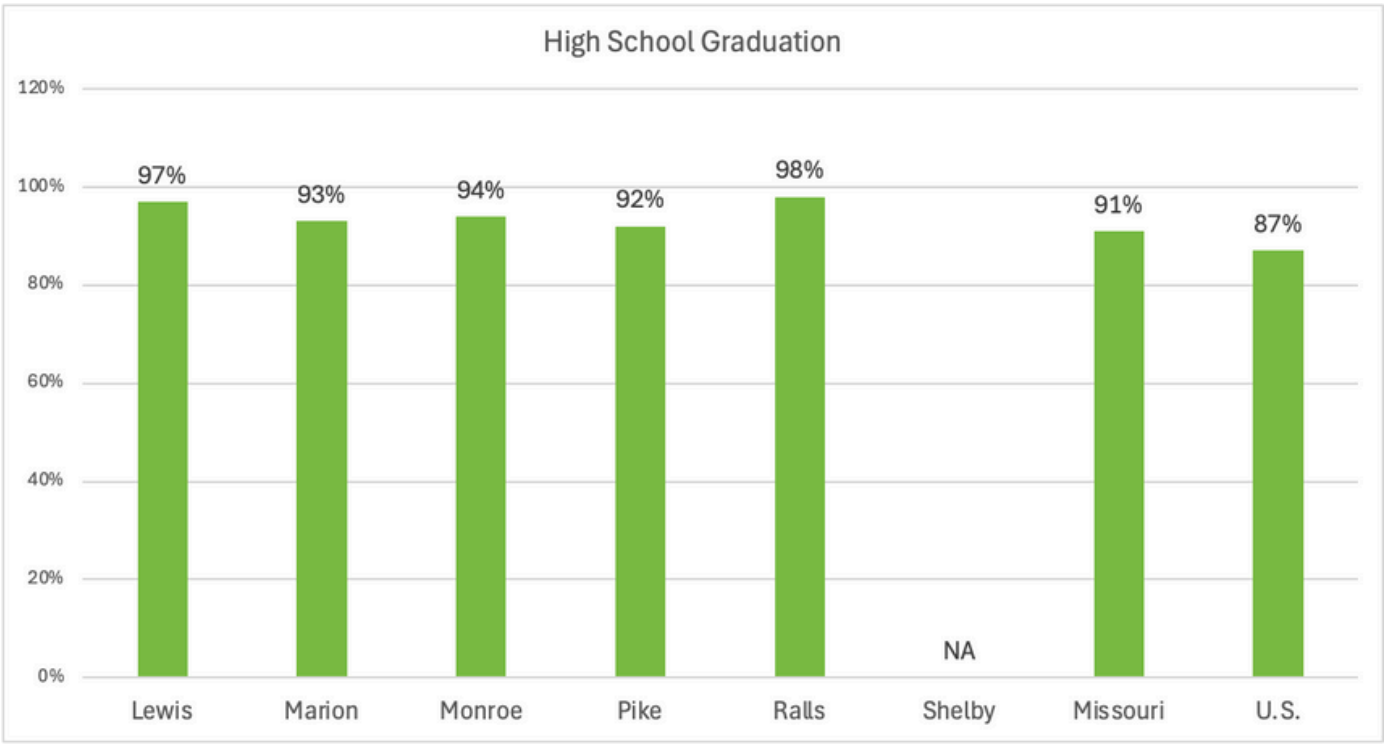


Source: County Health Rankings & Roadmaps 2025 Annual Data Release

High School Graduation

Education | ***Social and Economic Factors***

This measure reflects the percentage of a ninth-grade cohort that graduates within four years, using data from 2021–2022. High school graduation is a strong predictor of health, linked to better physical and mental well-being, healthier behaviors, and greater economic opportunities. Graduates are more likely to earn higher incomes and experience lower stress over the long term. However, access to quality education is not equitable—historical and current systemic barriers disproportionately affect students of color, low-income families, and students with disabilities. Graduating with a high school diploma is associated with significantly better health outcomes compared to earning a GED.



NA = Data for this measure is not available.
Source: County Health Rankings & Roadmaps 2025 Annual Data Release

Reading Scores

Education | ***Social and Economic Factors***

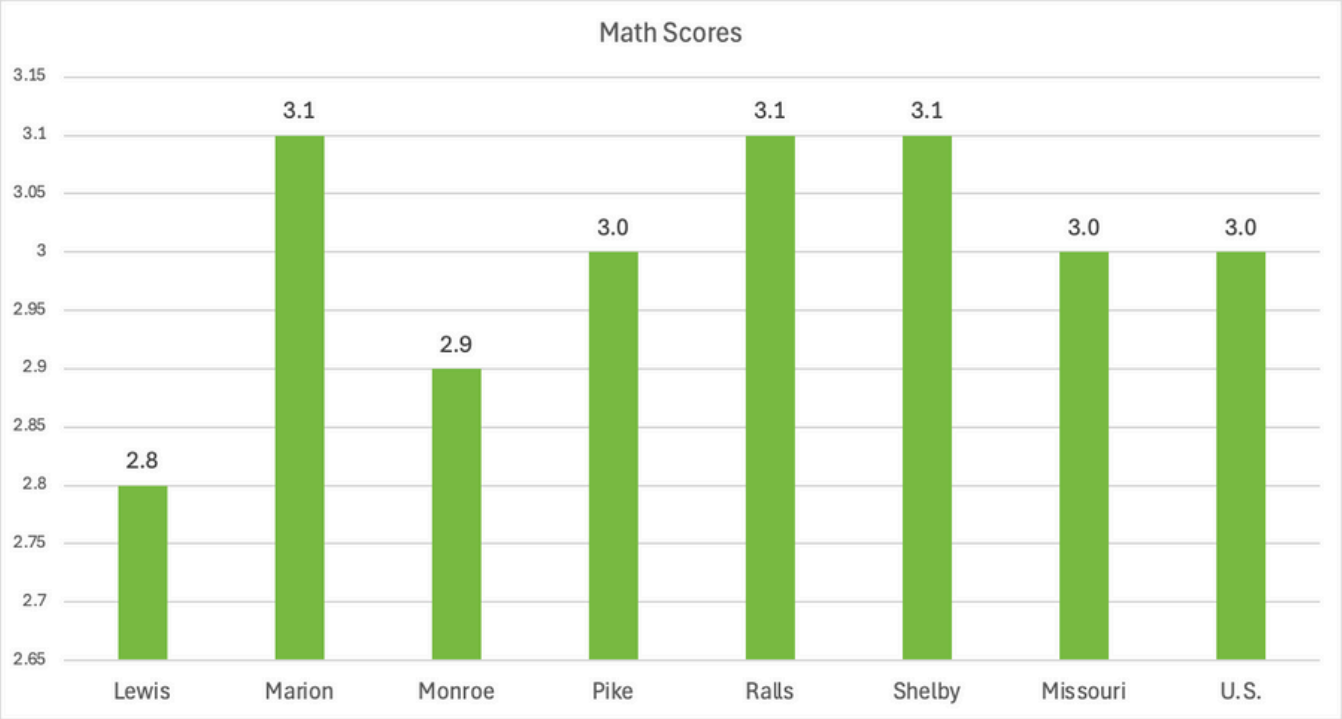
This measure reflects the average English Language Arts performance level of 3rd grade students compared to national grade-level standards, with a score of 3.0 indicating grade-level proficiency, based on 2019 data. Early reading proficiency is a key predictor of future academic success, high school graduation, and long-term health outcomes. Students who fall behind in 3rd grade reading often struggle to catch up, widening achievement gaps over time. These scores also reflect broader educational and community resource access, making them an important indicator of both academic opportunity and future health and economic well-being.

Source: County Health Rankings & Roadmaps 2025 Annual Data Release

Math Scores

Education | ***Social and Economic Factors***

This measure reflects the average math performance of 3rd grade students compared to national grade-level standards, with a score of 3.0 indicating proficiency, based on 2019 data. Early math achievement is a key indicator of future academic success and educational opportunity. Standardized test scores reflect both in- and out-of-school factors, including access to learning resources and community support. Strong academic performance is associated with improved long-term health outcomes through higher educational attainment, better employment opportunities, and increased life satisfaction.

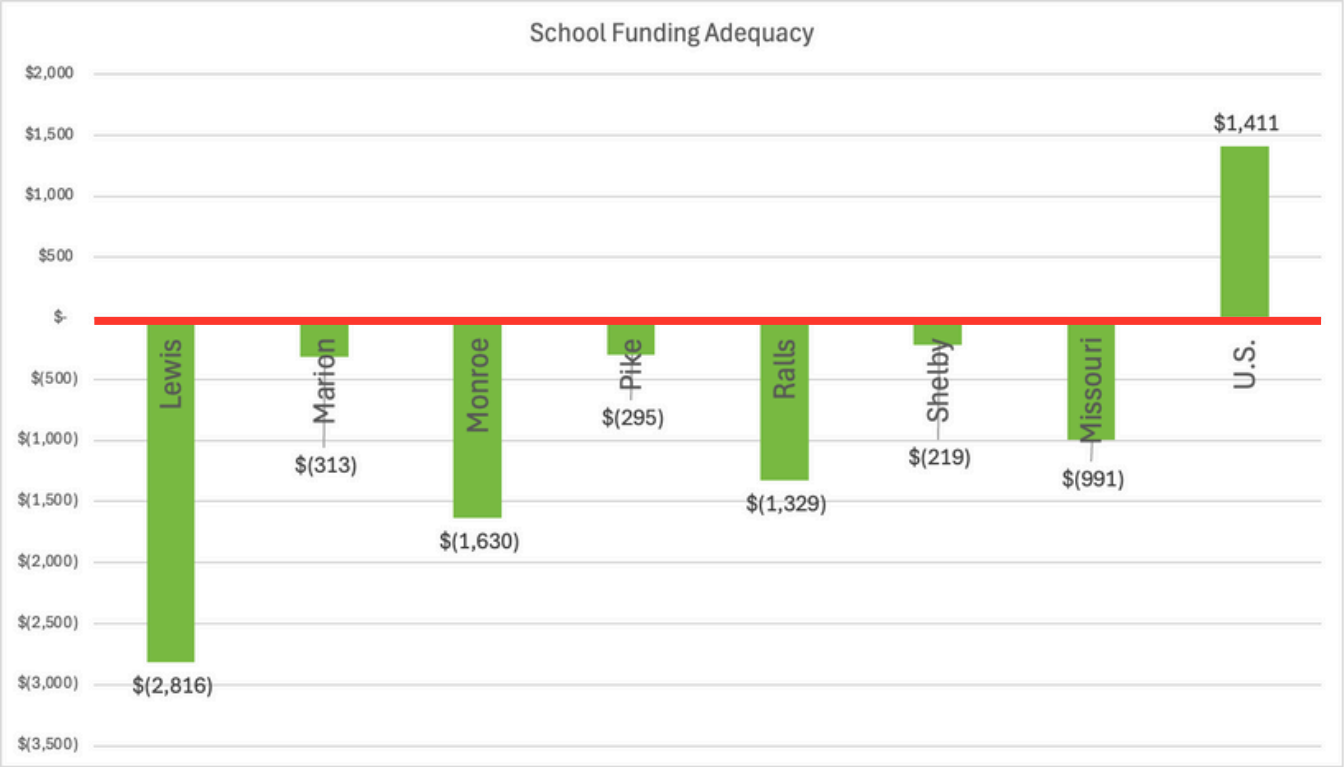


Source: County Health Rankings & Roadmaps 2025 Annual Data Release

School Funding Adequacy

Education | *Social and Economic Factors*

This measure reflects the average dollar gap between actual and estimated per-pupil spending needed to achieve U.S. average test scores, based on 2022 data. Adequate school funding is essential for equitable educational outcomes, especially for students from low-income or historically marginalized backgrounds. Well-funded schools can offer smaller class sizes, more instructional time, better resources, and higher teacher salaries—factors that directly improve student achievement. Increased funding has been linked to higher graduation rates, college attainment, test scores, earnings, and lower poverty rates in adulthood.



Source: County Health Rankings & Roadmaps 2025 Annual Data Release

Income, Employment, and Wealth

Social and Economic Factors

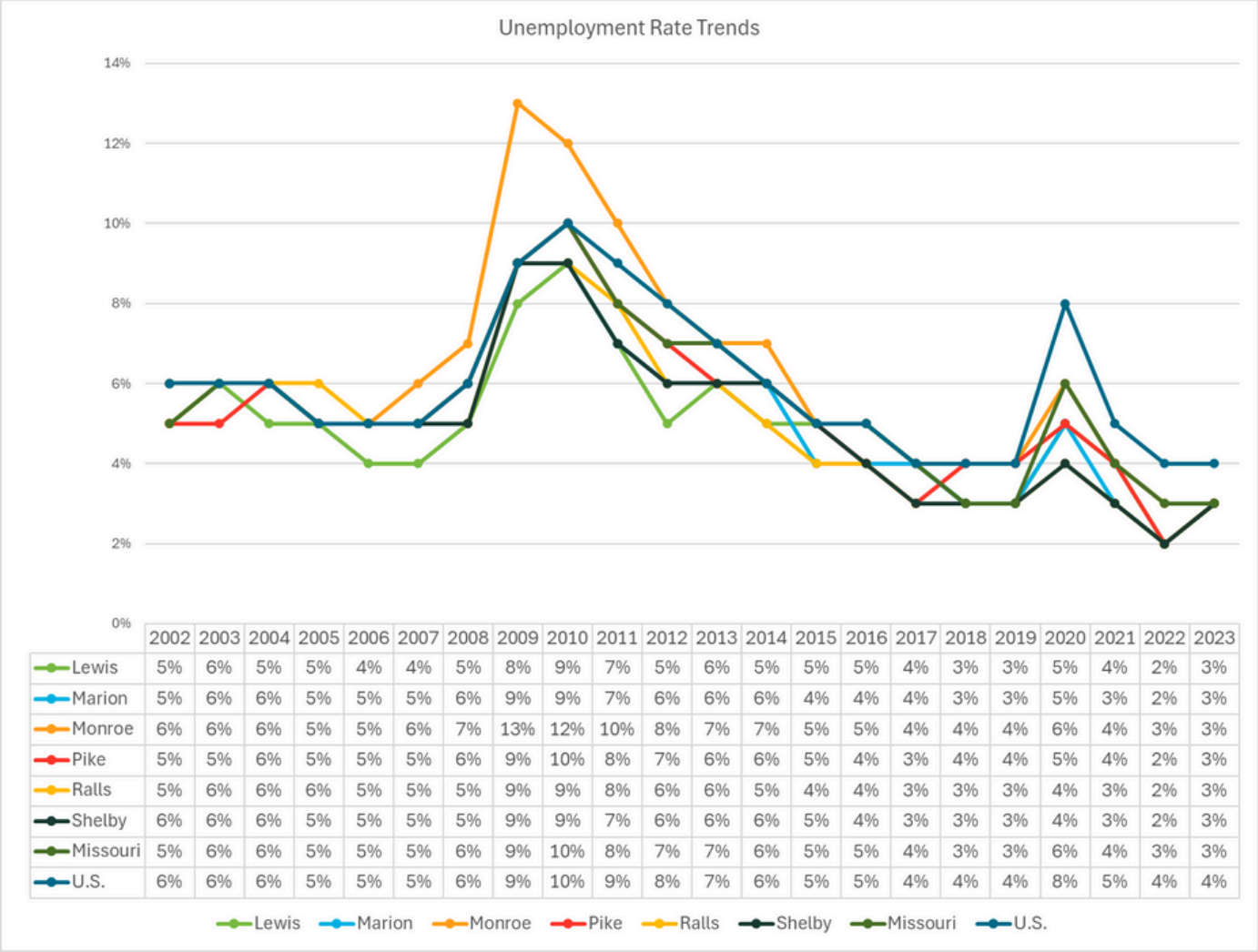
Employment provides income and benefits that shape access to essential resources like housing, healthcare, and education. Wealth—accumulated assets—offers long-term security and the ability to manage life events, such as job loss or medical emergencies. Higher levels of income and wealth are consistently linked to better health outcomes, while economic instability contributes to chronic illness, poor birth outcomes, and reduced life expectancy. Many low-wage workers, particularly people of color and those in essential jobs, face hazardous conditions and lack benefits like paid leave or health insurance. Systemic inequities disproportionately impact communities of color, people with disabilities, and other marginalized groups, reinforcing health and economic disparities. Individuals in the top income brackets live significantly longer—up to 15 years more—than those with the lowest incomes, highlighting the deep connection between economic opportunity and health.

Source: County Health Rankings & Roadmaps 2025 Annual Data Release

Unemployment

Income, Employment, and Wealth | ***Social and Economic Factors***

This measure reflects the percentage of individuals ages 16 and older who are unemployed but actively seeking work, based on 2023 data. Unemployment is closely linked to poorer physical and mental health, increased mortality, and reduced access to healthcare—especially in systems where health insurance is tied to employment. While employment generally supports economic stability and well-being, job quality—including wages, hours, and working conditions—also plays a critical role in health outcomes. Structural barriers and inequities can further influence how unemployment impacts different communities.



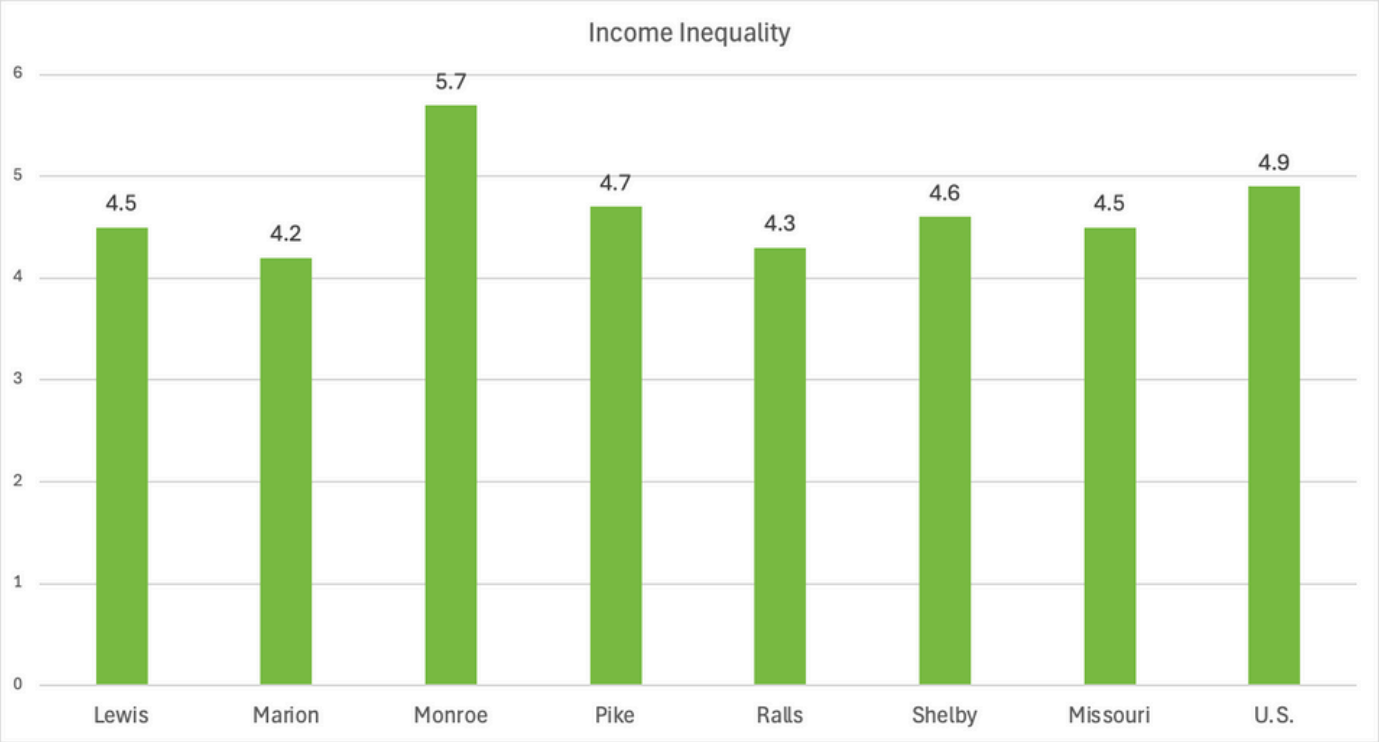
	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021	2022	2023
Lewis	5%	6%	5%	5%	4%	4%	5%	8%	9%	7%	5%	6%	5%	5%	5%	4%	3%	3%	5%	4%	2%	3%
Marion	5%	6%	6%	5%	5%	5%	6%	9%	9%	7%	6%	6%	6%	4%	4%	4%	3%	3%	5%	3%	2%	3%
Monroe	6%	6%	6%	5%	5%	6%	7%	13%	12%	10%	8%	7%	7%	5%	5%	4%	4%	4%	6%	4%	3%	3%
Pike	5%	5%	6%	5%	5%	5%	6%	9%	10%	8%	7%	6%	6%	5%	4%	3%	4%	4%	5%	4%	2%	3%
Ralls	5%	6%	6%	6%	5%	5%	5%	9%	9%	8%	6%	6%	5%	4%	4%	3%	3%	3%	4%	3%	2%	3%
Shelby	6%	6%	6%	5%	5%	5%	5%	9%	9%	7%	6%	6%	6%	5%	4%	3%	3%	3%	4%	3%	2%	3%
Missouri	5%	6%	6%	5%	5%	5%	6%	9%	10%	8%	7%	7%	6%	5%	5%	4%	3%	3%	6%	4%	3%	3%
U.S.	6%	6%	6%	5%	5%	5%	6%	9%	10%	9%	8%	7%	6%	5%	5%	4%	4%	4%	8%	5%	4%	4%

Source: County Health Rankings & Roadmaps 2025 Annual Data Release

Income Inequality

Income, Employment, and Wealth | ***Social and Economic Factors***

This measure reflects the ratio of household income at the 80th percentile to that at the 20th percentile, based on data from 2019–2023. Income inequality is linked to poorer health outcomes regardless of individual income. High inequality can increase stress, reduce social cohesion, and erode trust and support within communities. These effects are associated with higher rates of chronic disease, mental health challenges, and premature death. More equitable income distribution supports stronger, healthier, and more resilient communities.

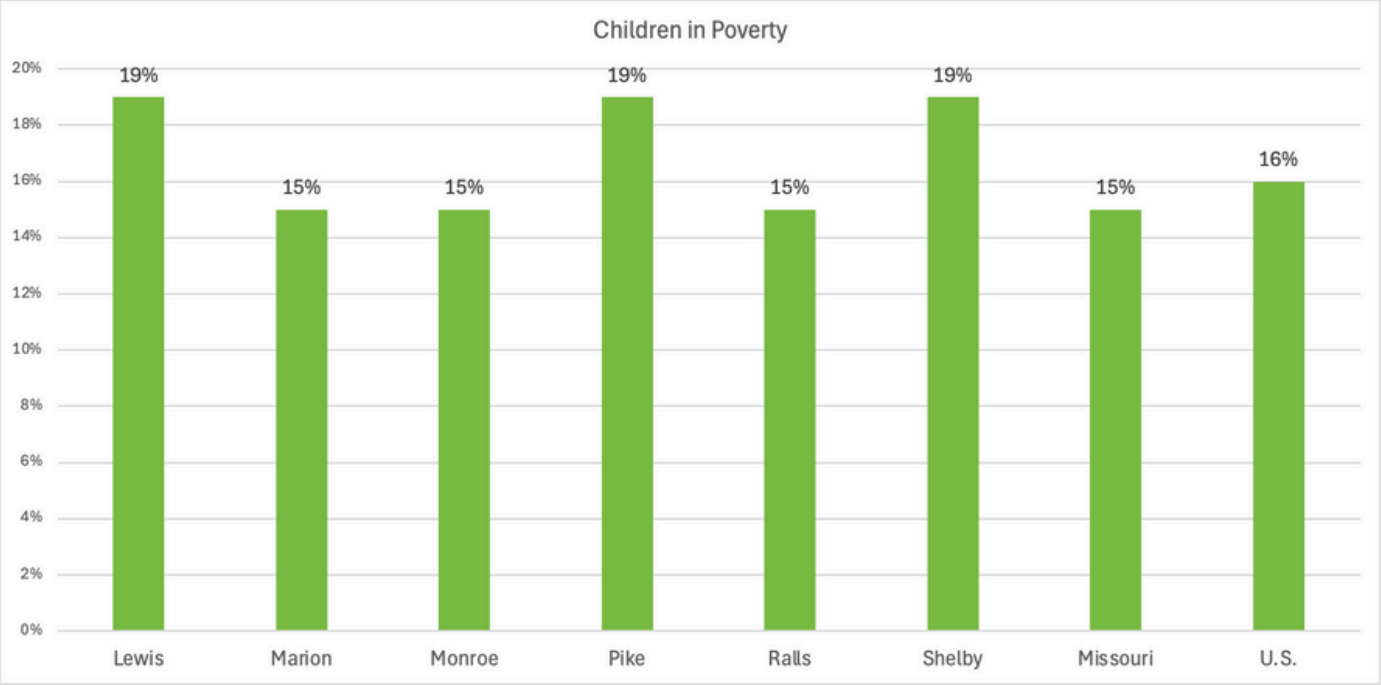


Source: County Health Rankings & Roadmaps 2025 Annual Data Release

Children in Poverty

Income, Employment, and Wealth | ***Social and Economic Factors***

This measure represents the percentage of individuals under age 18 living in poverty, based on data from 2023 and 2019–2023. Childhood poverty is linked to long-term negative outcomes in health, education, and income. Children in low-income households face higher risks of injury, chronic illness (e.g., asthma, obesity, diabetes), and mental health conditions such as anxiety and behavioral disorders. Poverty-related stress and limited access to resources can affect development and contribute to lifelong disparities in health and opportunity.

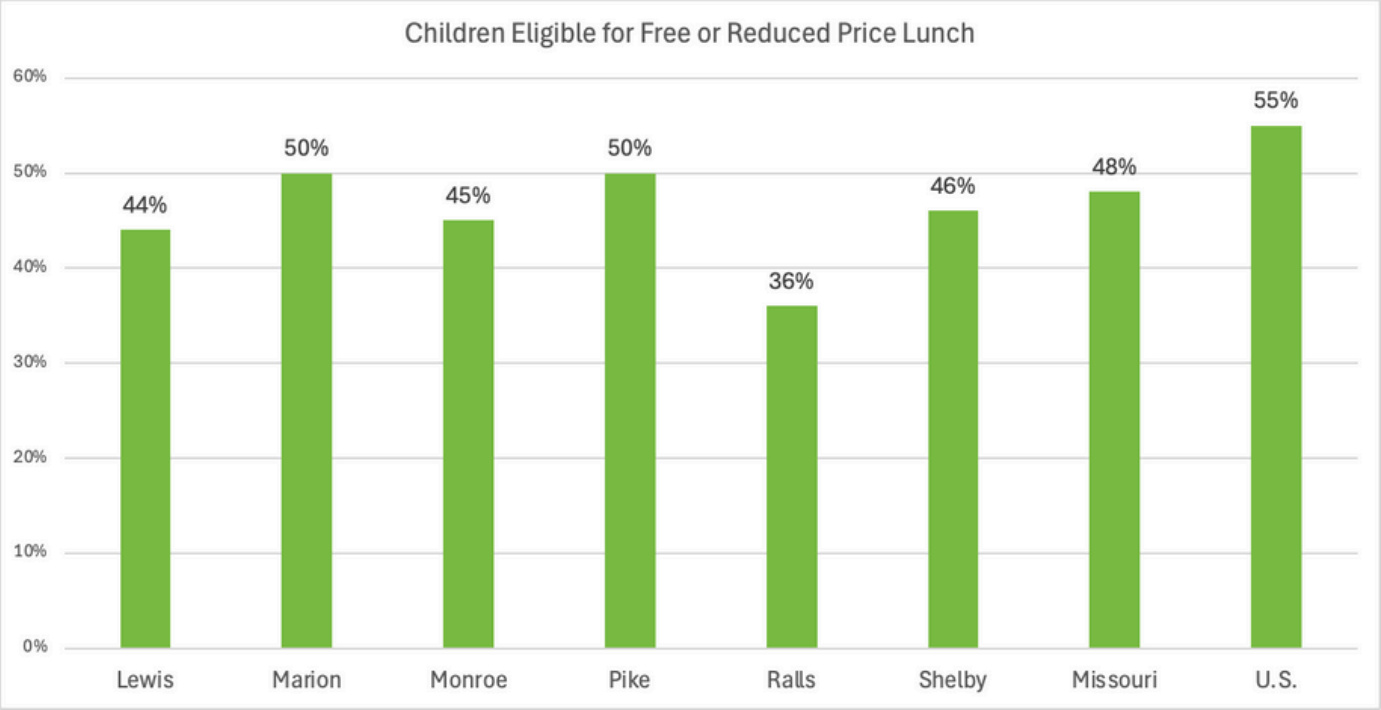


Source: County Health Rankings & Roadmaps 2025 Annual Data Release

Children Eligible for Free or Reduced Price Lunch

Income, Employment, and Wealth | ***Social and Economic Factors***

This measure reflects the percentage of public school students eligible for free or reduced-price lunch, based on 2022–2023 data. Eligibility is determined by household income and family size, making this a key indicator of child poverty. Access to school meals through the National School Lunch Program helps reduce food insecurity, support healthy development, and prevent obesity. Because hunger and inadequate nutrition impair learning and increase health risks, this measure also highlights broader socioeconomic disparities affecting children's well-being and academic success.

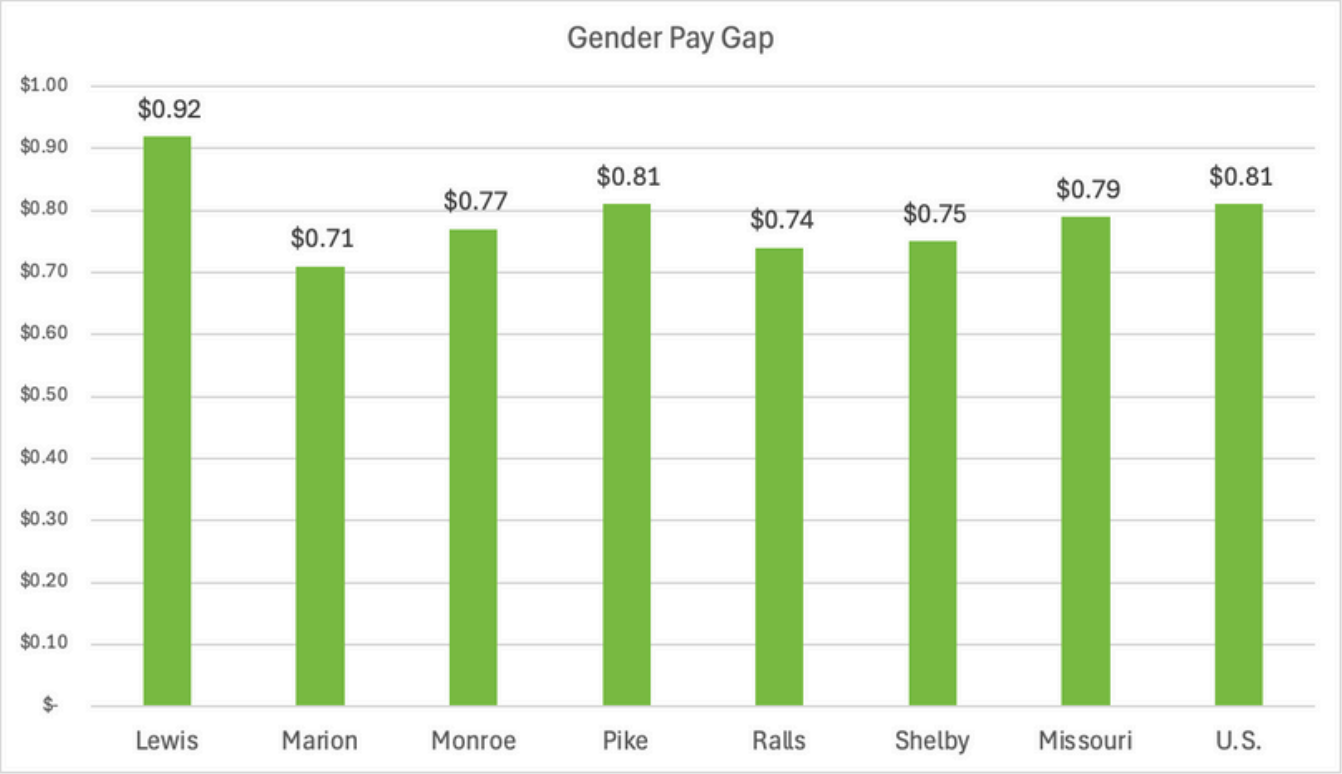


Source: County Health Rankings & Roadmaps 2025 Annual Data Release

Gender Pay Gap

Income, Employment, and Wealth | ***Social and Economic Factors***

This measure represents the ratio of women's to men's median earnings for full-time, year-round workers, expressed as cents earned by women for every dollar earned by men, based on data from 2019–2023. Women in the U.S. earn approximately 80 cents for every dollar earned by men, with lifetime losses exceeding $500,000—and nearly $800,000 for college-educated women. The gender wage gap contributes to higher rates of poverty among women and is linked to poorer mental and physical health outcomes, including increased risk of depression, anxiety, disability, and premature death. Closing the gap would significantly improve economic stability and health, particularly for single-mother households.

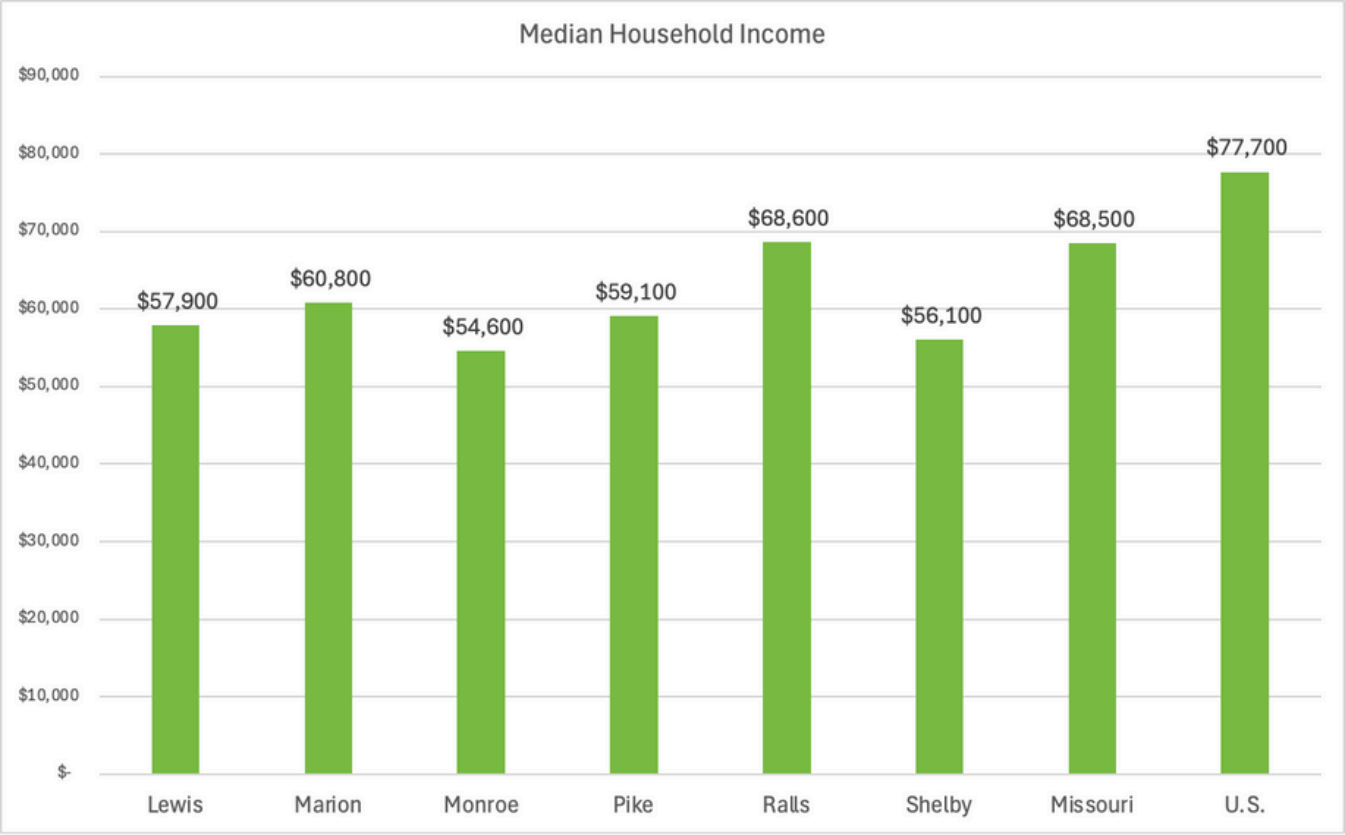


Source: County Health Rankings & Roadmaps 2025 Annual Data Release

Median Household Income

Income, Employment, and Wealth | ***Social and Economic Factors***

This measure reflects the midpoint of household income in a county, where half of households earn more and half earn less, based on data from 2023 and 2019–2023. Median household income is a key indicator of economic well-being and is closely linked to health outcomes. Higher income levels are associated with better access to healthcare, nutritious food, stable housing, and reduced stress. This measure also strongly correlates with child poverty rates and can help identify communities at greater risk of poor health due to financial insecurity.



Source: County Health Rankings & Roadmaps 2025 Annual Data Release

Living Wage

Income, Employment, and Wealth | ***Social and Economic Factors***

This measure reflects the hourly wage required to meet the basic needs of a household with one adult and two children, based on 2024 data. Calculated by The Living Wage Institute, it accounts for essential expenses such as housing, food, childcare, healthcare, transportation, internet, and taxes. Unlike the federal poverty threshold, this geographically specific estimate provides a more accurate picture of the income needed to maintain an adequate standard of living without public assistance. Living wages are critical for promoting financial stability, health equity, and overall well-being.

Source: County Health Rankings & Roadmaps 2025 Annual Data Release

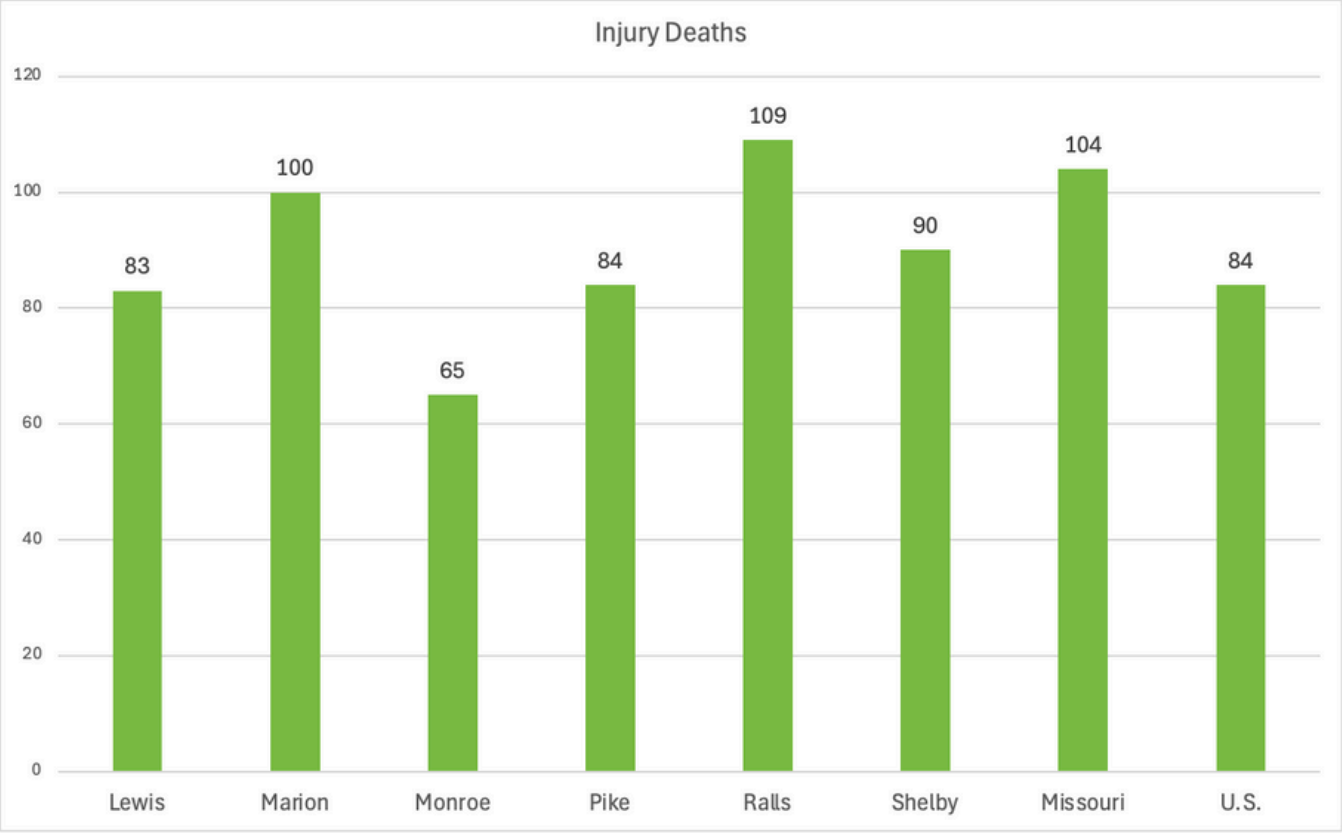
Safety and Social Support

Social and Economic Factors

Safety and social support reflect how communities care for one another by fostering belonging, connection, and protection from harm. This includes access to mental health services, housing assistance, community centers, and financial support programs. Strong social support networks and safe environments promote well-being, reduce stress, and help prevent violence and injury. When communities meet individual and family needs while ensuring accountability, they create the conditions for everyone to thrive—physically, emotionally, and socially.

Injury Deaths

This measure reflects the number of deaths due to injury—including homicides, suicides, motor vehicle crashes, poisonings, and other causes—per 100,000 population, using data from 2018–2022. Injuries, whether intentional or unintentional, are among the leading causes of death in the U.S. In 2022, unintentional injuries ranked as the third leading cause of mortality, especially affecting individuals ages 1–44. Leading causes include poisoning, vehicle collisions, drowning, and falls. Injury deaths highlight the importance of safe environments, effective prevention strategies, and strong social supports to protect community well-being.

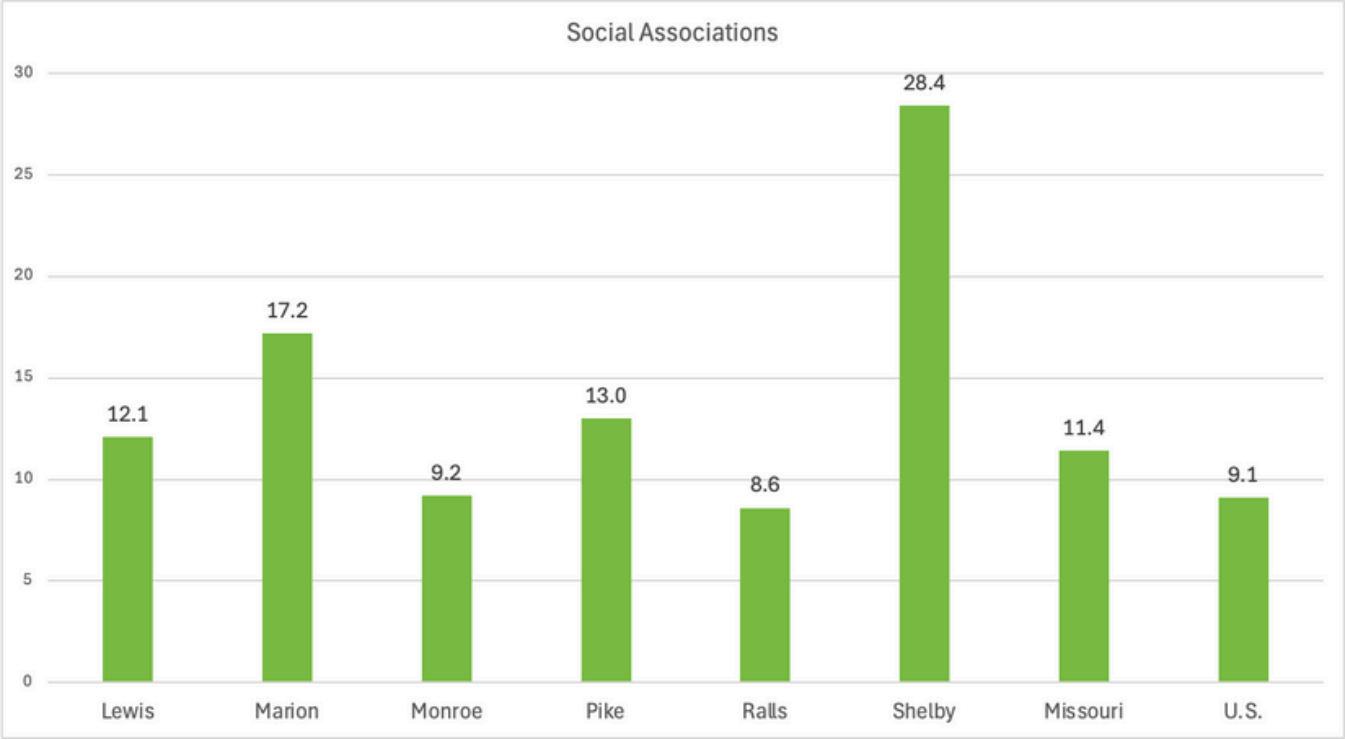


Source: County Health Rankings & Roadmaps 2025 Annual Data Release

Social Associations

Safety and Social Support | ***Social and Economic Factors***

This measure reflects the number of membership-based associations—such as civic, religious, sports, political, and professional organizations—per 10,000 population, using 2022 data. Strong social networks and community engagement are vital for health and well-being. Belonging to social groups can reduce loneliness and isolation, which are associated with increased risk of chronic disease, mental health issues, and premature death. Communities with more social associations tend to have higher levels of trust, stronger support systems, and better health outcomes, as social connections encourage healthy behaviors and provide emotional and practical support.

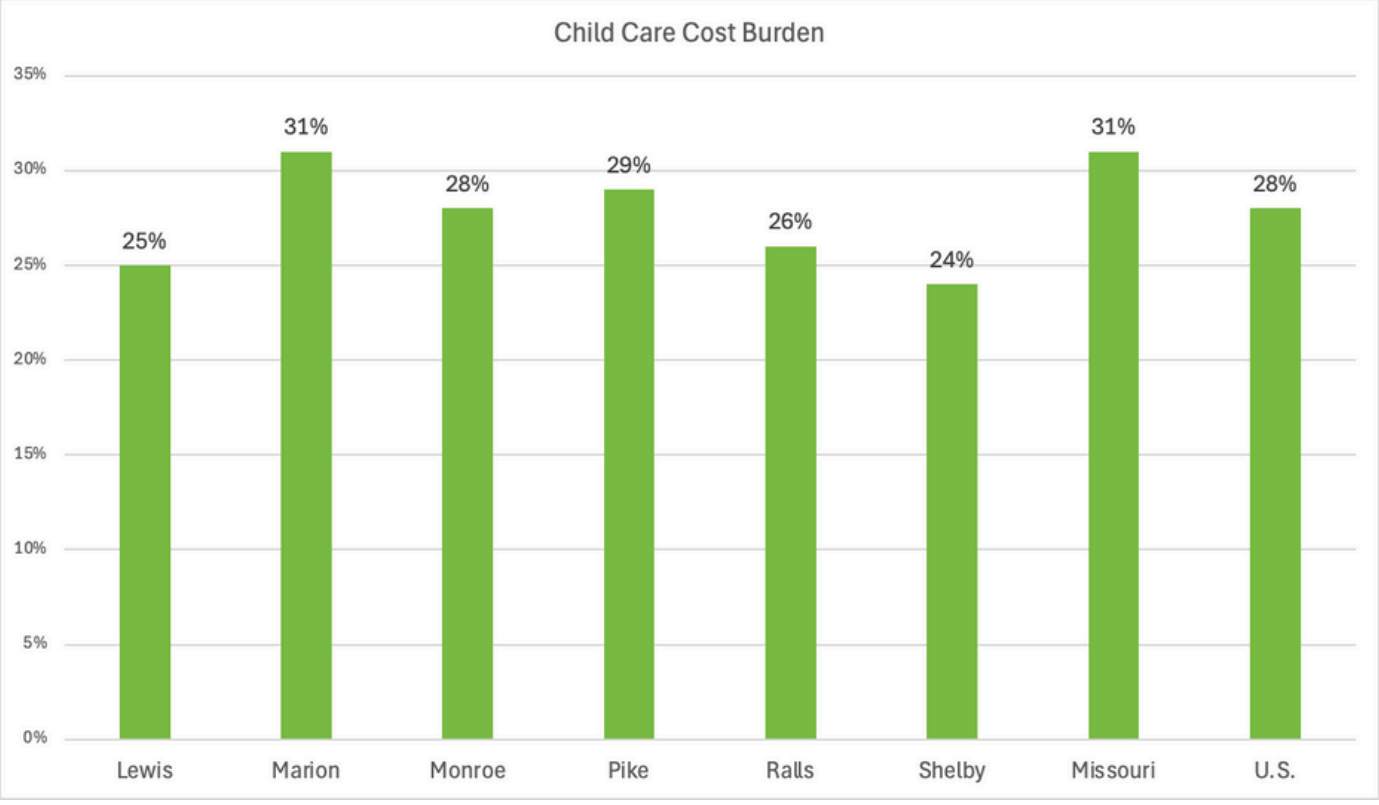


Source: County Health Rankings & Roadmaps 2025 Annual Data Release

Child Care Cost Burden Associations

Income, Employment, and Wealth | ***Social and Economic Factors***

=This measure reflects child care costs for a household with two children as a percentage of median household income, based on 2023 and 2024 data. High child care costs can strain family budgets, forcing trade-offs in essential expenses like housing, healthcare, and transportation. When care is affordable and accessible, it supports parents' ability to work or pursue education while also promoting children's health, development, and long-term success—especially for those from low-income or marginalized backgrounds. However, quality care remains largely inaccessible for low-income families, who often spend a disproportionate share of their income on child care or are excluded from tax-based benefits.

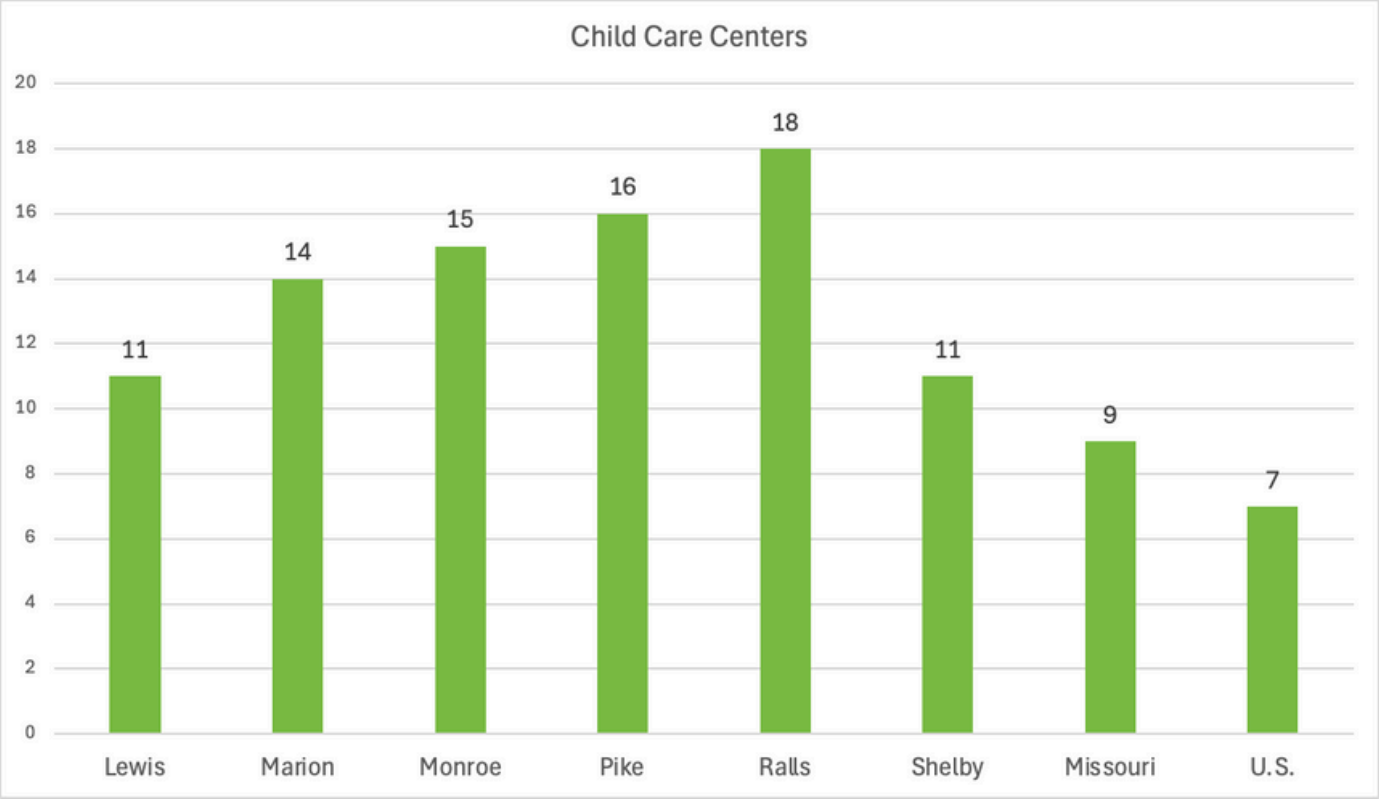


Source: County Health Rankings & Roadmaps 2025 Annual Data Release

Child Care Center

Income, Employment, and Wealth | ***Social and Economic Factors***

This measure reflects the number of licensed child care centers per 1,000 children under age 5, using data from 2010–2022. The availability of child care centers is a key indicator of community infrastructure supporting families. Access to affordable, high-quality care enables parents to work or pursue education while supporting early childhood development—especially for children in low-income or marginalized households. This measure complements other indicators like child care cost burden and single-parent household prevalence, and is influenced by household structure, including reliance on extended family for in-home care.

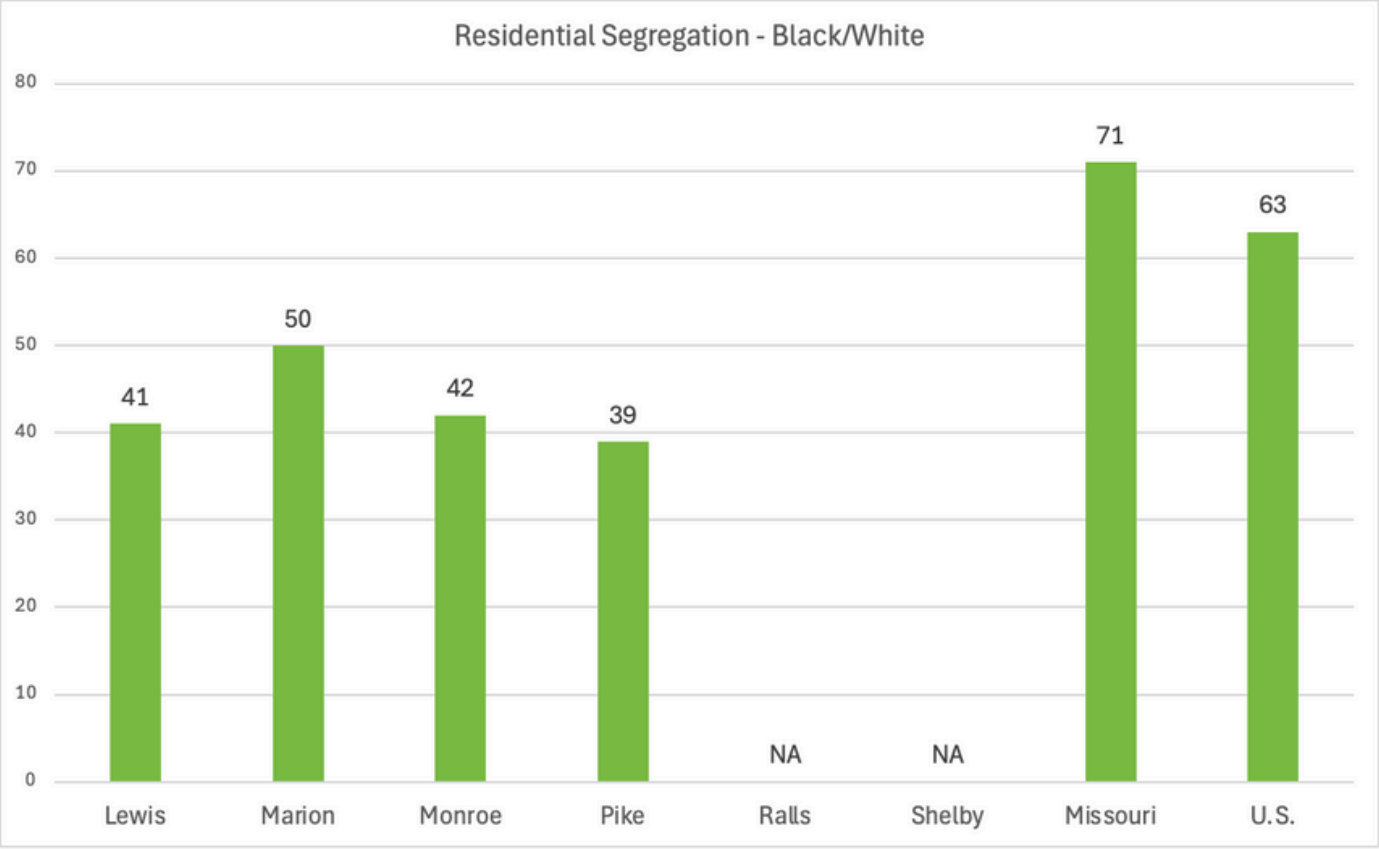


Source: County Health Rankings & Roadmaps 2025 Annual Data Release

Residential Segregation-Black/White

Income, Employment, and Wealth | ***Social and Economic Factors***

This measure captures the index of dissimilarity, which reflects how evenly Black and White residents are distributed across a county. Higher values indicate greater segregation, based on data from 2019–2023. While overtly discriminatory laws have been eliminated, residential segregation persists due to structural and institutional racism. This segregation limits access to quality housing, education, healthcare, and employment, and contributes to environmental exposures, violence, and poor health outcomes. It remains a key driver of racial health disparities and social inequities in the United States.

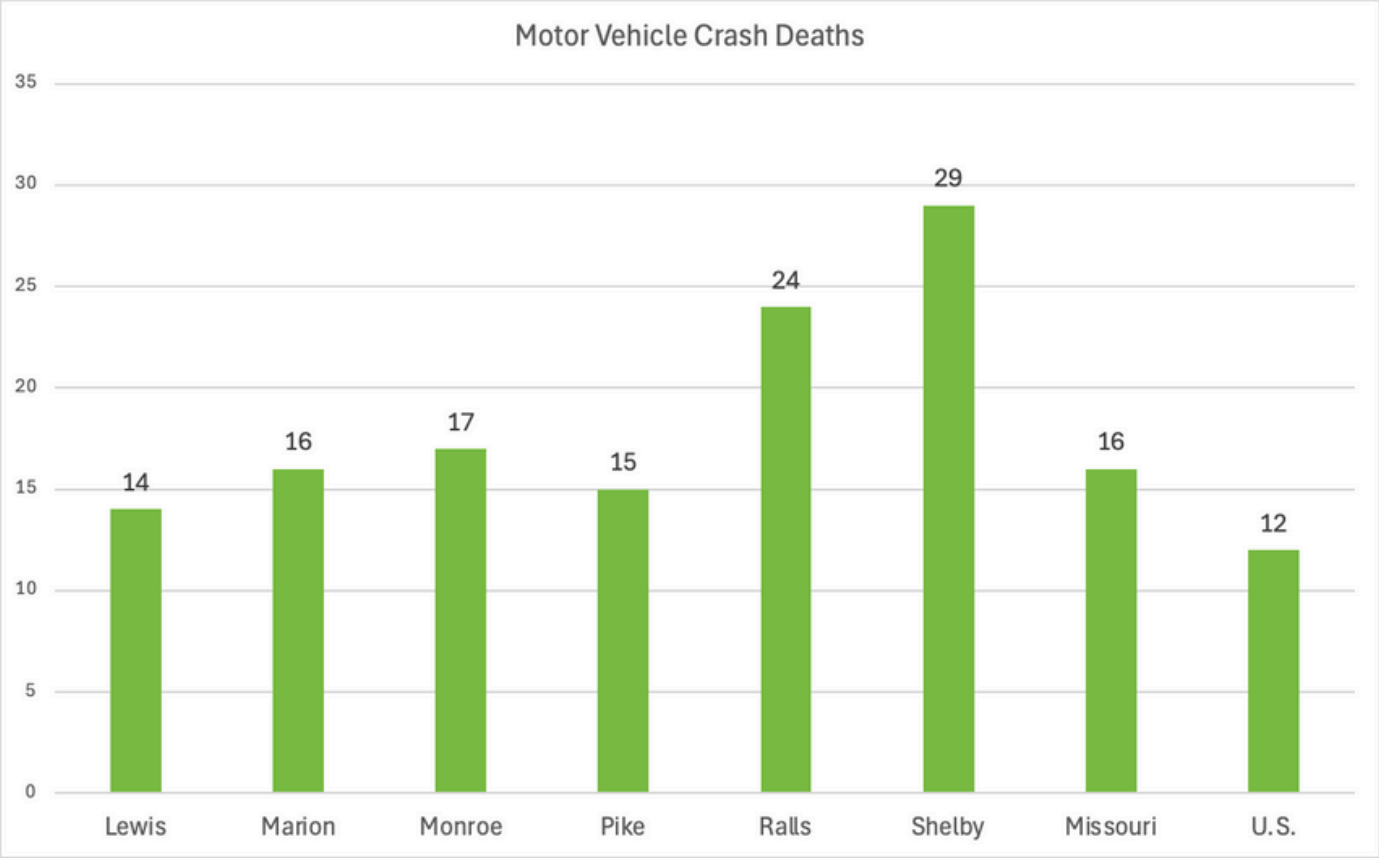


Source: County Health Rankings & Roadmaps 2025 Annual Data Release

Motor Vehicle Crash Death

Income, Employment, and Wealth | ***Social and Economic Factors***

This measure reflects the number of motor vehicle crash deaths per 100,000 population, using data from 2016–2022. Motor vehicle crashes remain a leading cause of death in the U.S., with over 100 fatalities occurring daily. Contributing factors include impaired driving, distracted driving, lack of seat belt use, and other unsafe driving behaviors. In addition to the tragic loss of life, crash-related injuries and fatalities result in significant economic costs—exceeding $75 billion annually in medical expenses and lost productivity.

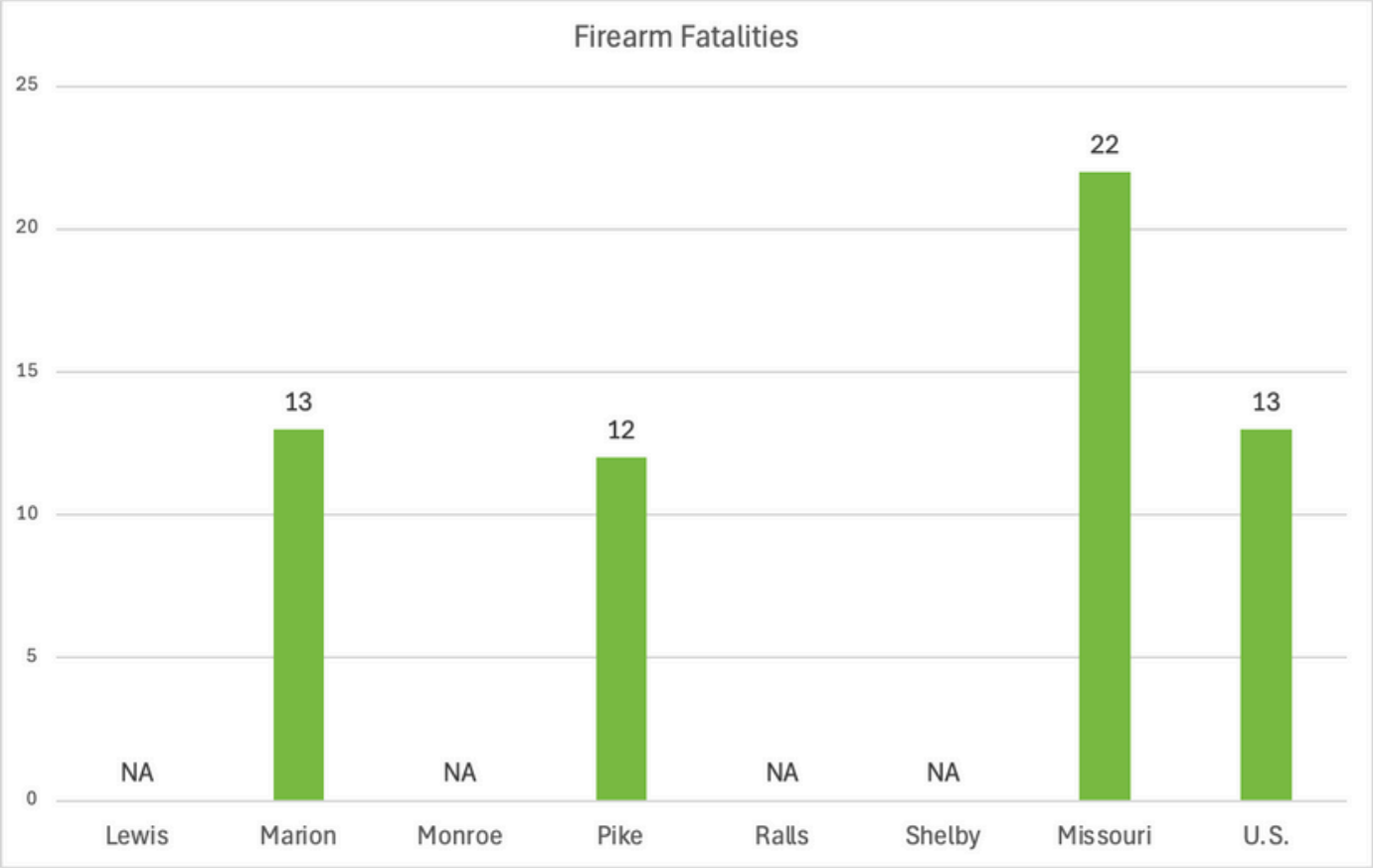


Source: County Health Rankings & Roadmaps 2025 Annual Data Release

Firearm Fatalities

Income, Employment, and Wealth | ***Social and Economic Factors***

This measure reflects the number of firearm-related deaths per 100,000 population, based on data from 2018–2022. Firearm fatalities—primarily suicides (54%) and homicides (43%)—are a major public health concern in the U.S. and are largely preventable. The U.S. experiences firearm suicide and homicide rates far exceeding those of other high-income countries. Gun availability is strongly linked to fatal suicide attempts and overall homicide rates. Neighborhood-level factors such as poverty, segregation, and historical redlining practices also contribute to elevated firearm violence, especially in underserved communities.

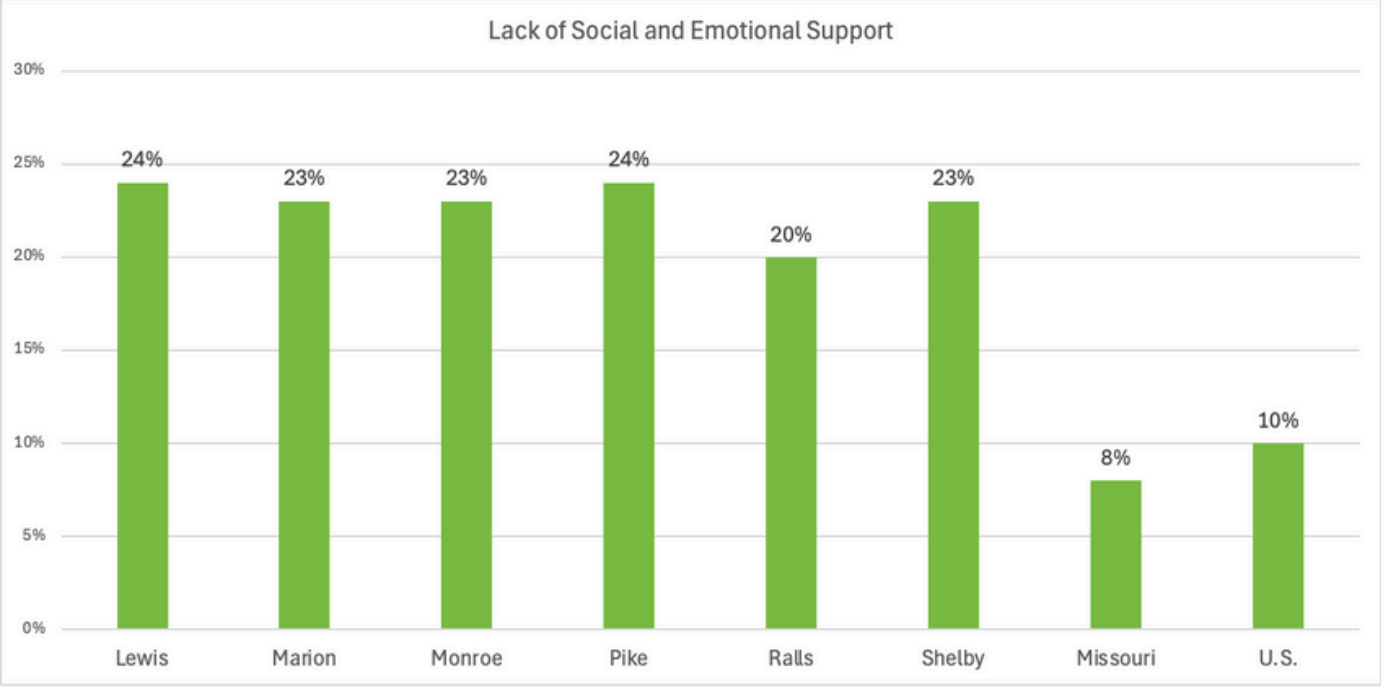


NA = Data for this measure are not available.
Source: County Health Rankings & Roadmaps 2025 Annual Data Release

Lack of Social and Emotional Support

Income, Employment, and Wealth l *Social and Economic Factors*

This measure reflects the percentage of adults who report that they sometimes, rarely, or never receive the social and emotional support they need, based on 2022 data. Supportive relationships are essential for mental and physical well-being. Adults lacking social and emotional support are more likely to experience chronic stress, depression, frequent mental distress, and serious health conditions like heart disease, stroke, and dementia. This lack of support is also linked to poorer self-rated health, especially among older adults. Nationwide, about one in four adults report insufficient social support.



Source: County Health Rankings & Roadmaps 2025 Annual Data Release

APPENDIX

Survey Responses

What are the most critical health issues currently affecting the community? (List up to 3 top concerns.)

Partner Survey | *Primary Data*

Health Issue 1	Health Issue 2	Health Issue 3
having a family doctor	being able to get an appointment for a health care need	lack of readily available resources
Mental Health	Access to Primary & Specialty Care	Substance Use & Opioid Epidemic
Mental Health	Senior Health	Preventative Medicine
Cancer	Mental health	Drug use
Substance Abuse	Mental Health	Chronic Health Diseases
Drug use	Mental health	Obesity
Affordable options	Constraints of insurance	
Access	Affordability	Mental Health Resources
Heart Disease	COPD	Obesity
Cancer	Obesity	Communicable Diseases
DRUGS	Cancer	Mental health
Obesity	Social - Emotional - Mental Health	Drug Use and Abuse
access to care	mental health	chronic disease management
Addiction	Mental Heath	
the overall health of individuals	mental health needs	affording healthcare
Substance Abuse	Mental Health disorders	Diabetes
Mental Health	Obesity	
obesity	heart disease	cancer
Preventable health issues being rappant due to lack of education	Mental Healthcare not being available at rate needed	People not accessing primary care
child abuse and maltreatment	lack of resources for families	
Mental Health	Substance Abuse - Mental Health	
Mental Health	Cleanliness	Poverty
Mental Health Care	Substance abuse programs	Care for elderly who need help to stay in their homes, but can't afford home health care

What are the most critical health issues currently affecting the community? (List up to 3 top concerns.)

Partner Survey | ***Primary Data***

Health Issue 1	Health Issue 2	Health Issue 3
Insurance cost	Cost of healthcare with or without insurance	Lack of trust in healthcare, families get the run around so much of the time and spend a lot of money to go and not receive help they are looking for
Lack of access	Not enough primary care doctors	Mental health provider access
Mental health	Cancer	
Mental Health	Dental Care	Cost of Health Care
Substance abuse	Mental Health	Obesity
Mental health	Insurance/costs	Addiction
Cancer- various types	Heart conditions	Diabetes
Availability	Cost	Follow through
Access to medical and mental health assistance	Increase in drug use of lower socio-economic adults	Cost of medical care
Mental Health	Illegal Substances	Poverty related illnesses
smoking	drugs	mental health

What are the top quality of life challenges impacting residents? (Examples: housing, transportation, employment, education, access to healthcare, food insecurity, etc.) (List up to 3 top challenges.)

Partner Survey | ***Primary Data***

Challenge 1	Challenge 2	Challenge 3
access to health care	cost of health care	no support for dental work
Economic Struggles	Healthcare Access - limited providers	Lack of public or community-based transportation
Housing	Access to Healthcare	Transportation
access to healthcare	childcare	housing
Homelessness	Lack of Housing	Food Insecurity
Shortage of childcare availability and cost	Housing	
Access to healthcare	Childcare	Employment
Cost of Living	Housing	Poverty
Decent Affordable Housing	Transportation	Affordable Childcare
Transportation	Housing	Resources for Utilities
healthcare	employment	
Transportation	Child care access	Employment
Housing	Family Structure	Wellness education
housing	transportation	food insecurity
Jobs	Food	Childcare
inflation	affording healthcare	disfunction and breakdown of healthy family units
Transportation	Housing	employment
Homelessness	Housing	Education
employment	education	transportation
Housing	Childcare	Workforce (employees not being skilled)
employment	transportation	
Housing	Childcare	Infrastructure for safe transportation

What are the top quality of life challenges impacting residents? (Examples: housing, transportation, employment, education, access to healthcare, food insecurity, etc.) (List up to 3 top challenges.)

Partner Survey | ***Primary Data***

Health Issue 1	Health Issue 2	Health Issue 3
Lack of employment	Lack of transportation	Lack of incentive to progress
Affordable housing	Public transportation	Affordable childcare
Is the cost of insurance and healthcare wrapped up	Housing- to purchase a home has increased dramatically over the last few years. Our county also does not have nice or even semi nice homes to rent.	child care- it's also a rising cost and makes it hard for families. There is also not enough options available in our community as well
Access to healthcare	Transportation	Affordable housing
Daycare	Health insurance	
Childcare	Housing	Food security
transportation	poverty	job preparedness
childcare	attendance/education	access to mental health services
employment	housing	food insecurity
Housing	Employment	Transportation
Access to Healthcare		
Lack of public transportation	Lack of full-time employment opprotunities	Lack of affordable housing
Food insecurity	Housing	Transportation due to rural areas
housing	food insecurity	access to healthcare

Which populations are most at risk or vulnerable in terms of health and well-being? (Examples: low-income families, seniors, rural residents, children, people with disabilities, etc.)

Partner Survey | *Primary Data*

Populations most at risk or vulnerable in terms of health and well-being
seniors and those with physical and mental disabilities
Farmers and rural residents, low-income families, and seniors and people with disabilities.
SeniorsPeople with disabilitiesPeople needing mental health services
Low-income families, older adults who rely on medicare, people with disabilities or health concerns who may not receive the assistance they need
Low Income families, children, people with disabilities
Low-income, seniors
Low income and seniors
low-income families, seniors, rural residents, children, people with disabilities
Those living in poverty
Low-income families, seniors
Middle class is the ones struggling because low income qualifies for all the assistance
Low income, seniors, people with disabilities
Low Income FamiliesPeople with disabilities
Low incomeSeniors
low-income, seniors, people with disabilities
Low-income families and seniors
low income families
Families living within generational poverty, unhoused/double bunked community members
children
Low income families with a lack of support system and rural communities where stigma interferes with willingness to seek help.
Low income families
Low income, especially the un-housed.

Which populations are most at risk or vulnerable in terms of health and well-being? (Examples: low-income families, seniors, rural residents, children, people with disabilities, etc.)

Partner Survey | ***Primary Data***

Populations most at risk or vulnerable in terms of health and well-being
I believe middle class to lower class. I have found that many middle class families that do not qualify for any assistance are the ones hurting. They pay high fees for insurance but cannot afford to go because they have high deductibles to meet as well.
Homeless
Senior men who have lost spousesDisabled
children; low-income families
low-income families and children
Low-income and children
low income families, children and people with disabilities
all populations
Seniors and low income
Low-income and Seniors on a fixed income.
Low income families
low income families

What are the top 3 things that should be prioritized to improve community health over the next 3-5 years?

Partner Survey | *Primary Data*

Priority 1	Priority 2	Priority 3
access to immediate health care	having a family physician	dental health care provision
Expanding Mental Health & Crisis Intervention Services – Increase access to therapy, suicide prevention programs, and crisis response teams, particularly for rural residents and the agricultural community.	Improving Healthcare Accessibility – Address provider shortages, long wait times, and transportation barriers so residents can receive timely care.	Substance Use Prevention & Recovery Support – Strengthen opioid addiction treatment, harm reduction programs, and prevention education, including partnerships with law enforcement and healthcare providers.
Access to mental health care	Access to services for people with disabilities	Access to knowledge to prevent chronic illness
Improved access to low-cost primary care	Increased options for mental health services (online, extended hours, etc.)	
Overall physical, social, and mental health status	Quality of life	Disease prevention - including substance abuse
Improved access and availability of mental health services	Reduction of drug use in our community	Reduction in obesity in our community
Access to healthcare		
Affordability	Accessibility	Education
Mental Health Residential Treatment Center	Reduce Homeless Population	Public Transportation
Transportation	Housing	Affordable Nutritional Food
lower cost healthcare	Lower cost medication	Drugs
Education, not just from major health care institutions		
Access and Normalization of Mental Health Care	Access to healthy foods	
affordable care options	transportation	
less expensive healthcare	education/programs that promote healthy mindsets and what that looks like putting those things into action	
Housing	Substance Abuse treatment	Inpatient Psych facility

What are the top 3 things that should be prioritized to improve community health over the next 3-5 years?

Partner Survey | *Primary Data*

Priority 1	Priority 2	Priority 3
Mental Health	Homeless	Healthy Eating Education
Preventative Care and Training	Increasing & Expanding Services & Care	Health Education Quality & Quantity in School(s)
Providing Health Services in Downtown Hannibal where unserved community members are located	Providing wrap around education for patients to help them with chronic health conditions to educate on lifestyle changes	
Prevention and Education	Transportation Access	
Access to Mental Health treatment IN PERSON	Access to Substance abuse treatment IN PERSON	Nutrition and lifestyle
Health programs	Physical fitness prioritization	Dietician training/healthy options
Mental health	Rehab for substance abusers	Help for underinsured
More primary care physicians	Transportation	Get rid of substance abuse
Affordable healthcare	Accessible healthcare	Communication within the community
healthcare cost	mental health awareness and resources	any way to offfer families resources to help with financial burden
Mental health		
Mental Health Services	Dental Health Services	Health Education - need for medical home
access to mental health		
Improved employment opportunities with Full-Time employment and benefits.	Affordable quality of life needs (housing, medicine, mental health services, etc.))	Public Transportation
Transportation	Cost	Service providers
Cost for healthcare is too high	Cost for tests needed for healthcare too high	
Increased mental health services	Increased social services	Increased support in rural areas

What strategies or solutions would you recommend to improve access to healthcare and social services?

Partner Survey | ***Primary Data***

Responses
to bring in more qualified physicians and provide dental DDS
Increase telehealth options to serve rural residents with limited transportation.Develop mobile healthcare clinics that travel to underserved areas.Expand transportation assistance through volunteer driver programs, rideshare partnerships, or local government funding.Strengthen partnerships between nonprofits, schools, businesses, and local providers to offer on-site services and community health events.Advocate for funding & policy changes to attract healthcare professionals to rural areas through incentives and loan forgiveness programs.
Community health fairs for all ages to help educate about services available in the county.Greater support for non profit entities that provide services in the county.
I would suggest meeting people where they are in the communities because they are often unwilling or unable to seek help themselves. I would find educators or other professionals who can help explain needed services to people who may be unable to understand what they need to do, how to complete forms, etc.
Low cost options, transportation assistance
Decrease stigmas
Hannibal Regional establishing a public transportation system to get people to and from healthcare appointments
Transportation
If the cost of healthcare were lower more people would go to the dr, we need to educate our children on the usage of drugs
Continue to fund counseling opportunities in schools, and providing medical care and health education opportunities for students.
health access in the communities with highest needs and greatest barriers- clinics in town. Remove barriers to access via no cost transportation.
People taking some responsibility to improve their lives with the availability of supportive programs to help them achieve that.

What strategies or solutions would you recommend to improve access to healthcare and social services?

Partner Survey | ***Primary Data***

Responses
I think we do a good job in our community of getting the information out to the public. We have an active public health department and active non-profit organizations.
Homeless shelter
not sure
Ensure community members are connected to services in the area.Increase the capacity of mental health care available in the area in order to ensure community members are not having to wait for 6 months when needing to see a practitioner/therapist.Create streamline processes to enroll community members in Medicare/Medicaid to alleviate concerns of accessing care.
Central Database for all partnering agencies to have access to and make referrals as well as monitor overlapping services
We rely too heavily on non-for profit organizations and government to provide care for mental health issues. There is a lack of private sector providers in the area.
Transportation, incentivized seasonal check ups, proactive prevention
Lobby state and federal legislature on the needs of communities. Organize community members to put pressure on legislature to make healthcare a priority. Government can support research project to improve healthcare then share with communities
Transportation
A better awareness of what is available could be helpful in improving access. Not only for those that would utilize services but also individuals that might be willing to help support them either with their time or finances.
Implement studies to understand costs involved with promoting the area to recruit businesses to come to the area and also to review public transportation options and costs involved.

What role do you believe businesses, nonprofits, faith-based organizations, and government should play in improving community health?

Partner Survey | ***Primary Data***

Responses
This is a large-scale question. Help to assist folks in need where to go for immediate assistance.
Businesses: Provide insurance benefits, wellness programs, and workplace mental health initiatives for employees; financially support local health programs.Nonprofits: Deliver mental health services, substance use prevention, and crisis support, and advocate for underserved populations.Faith-Based Organizations: Serve as safe spaces for support groups, provide community outreach, and offer emergency assistance (food, shelter, financial aid).Government: Secure funding for rural healthcare, support policy changes to attract providers, and improve public health infrastructure (transportation, broadband for telehealth, crisis services).
These entities can play a role by allowing the different health care entities to train their staff. They could also allow these entities to make written materials available in their businesses.Faith based and businesses could make donations to health care entities to support their work.
These places can sponsor patients, exams, procedures, etc. for people who have proven they have a physical or mental need but are unable to pay. They can also purchase needed equipment or materials. They could host events to raise awareness or funding.
Our local city governments should be taking a more active role in working as a region to help improve community health. Political commitment and policies working with healthcare providers would make a significant positive impact.
Advisory. Also encouraging employees to live a healthy lifestyle.
Unsure
Funds and resources
Easily accessible, comprehensive resource directory
Having funds available to help support people who may be referred to them. In the past year, a lot of programs do not have funding available to refer families to them.
We all need to lower the cost of health insurance and healthcare in general

What role do you believe businesses, nonprofits, faith-based organizations, and government should play in improving community health?

Partner Survey | ***Primary Data***

Responses
Without additional financial support, it is difficult for already stretched resources to provide or implement new programming, staffing, service delivery systems.
Promote employee health and well-being. I know it is something that I can improve upon.
They all bear equal responsibility to work together intentionally to improve the quality of life for the community.
Educating, teaching and offering incentives to people regarding how to become healthier and not just depending on others or the government to support them
It should be their focus, they exist to improve the health of our community.
Work together and be united for a common goal
the churches in Hannibal should be a part of an alliance of sorts to "team up" to help our community in many regards
They should collaborate to find and implement solutions together with the goal in mind of not making their organizations look good, but doing what needs done to make the community better.
A huge role. They part of the community and should be invested in it's health to make it a better place to live.
Support staff not the main resource. Currently this is not the case.
Huge role. They should be leading by example
Government should see that tax dollars head here, with all paying a fair share according to ability to pay. Nonprofits and faith-based organizations could fund raise, educate their members and the community, and provide volunteers as needed.
These groups can be helpful in sharing information in what is available and that in turn helps to boost the communication within the community.
Gatherings of folks to deal with their substance abuse and mental health problems
partners
Support all populations in the area. Have a mindset to give back to the community to improve the well-being of the less fortunate.
Community health is lacking, presents in the community and follow through

If funding were not a constraint, what would be the one initiative or program you would implement to improve health in the region?

Partner Survey | ***Primary Data***

Responses
have readily available health care
A Rural Community Health Hub – A fully staffed, centrally located facility offering:Walk-in mental health and crisis intervention services.Primary and preventive healthcare with visiting providers.A substance use recovery program with on-site counseling & referrals.A mobile unit to serve outlying rural areas.Community education programs on mental health, suicide prevention, and chronic disease management.
A hospital with birthing and emergency services would be a huge start to improving health in our region.
Free primary or emergency care, with guidelines on when to seek out each type of service
Eliminating drug usage.
Low cost clinics, free vaccinations,
Healthcare access and quality
Reduce the homeless population
Restaurants-more nutritional and more affordable, lowering cost of utilities, food, and everyday living
Free physicals for everyone in the community and if testing is needed it would be free as well once a year
Mental health services for individuals and families
Universal access to preventative healthcare services, mental health support programs, and health education/promotion.
No cost public transport to improve access to care.
A rehabilitation center where people could learn how to improve all aspects of their lives whether that would be physical and mental, becoming independent financially or other life skills they would need.
Inpatient psych unit and inpatient substance abuse treatment program. More active crisis stabilization unit.
Mental Health service that connects current entities and services (maybe homeless shelter)
"Good Dads" is a program which will help resolve a root issue addressing, equipping, and supporting dad's to take next steps which will directly improve the lives/health of the families.
Provide Community Health Workers to provide intake and connection to services in the community to help marginalized community members connect into networks needed to help them get on their feet and stay on their feet.
Case managers in every school....they see the kids everyday and can help determine what level of care/assistance families may need from education to healthcare.
Counseling services.

If funding were not a constraint, what would be the one initiative or program you would implement to improve health in the region?

Partner Survey | ***Primary Data***

Responses
Physical fitness activities, games, fair, hikes, and sports venues. People need to be encouraged to work on their PHYSICAL health in order to maintain the mental. You cannot think your way into a better place in life. A walk would do way more for a person in the treatment for depression than any thought that they could conjure up. Get outside! Let’s live again!!!
Mental health services for children and adolescent that work with schools to help school counselors. So many students have needs beyond what schools can meet. Parents either can't afford, or can't find time to find private counselors. This is especially true for rural schools, where parents must drive 60 miles to a counselor.
More physicians to see all patients regardless of payment
More assistance for food insecurity and homelessness.
access to health for all - no cost if needed
Some type of free or extremely inexpensive transportation system that is dependable to get people without vehicles to get around the community.
Transportation to facilities, not just a set day to go to appointments. Some facilities do not have appointments on those days
You can have all the funded programs you want but when it still costs more to go to the doctor than people can afford it doesn't matter

Is there anything else you would like to share about community health, quality of life, or access to care?

Partner Survey | ***Primary Data***

Responses
just do what needs to be done to provide for quality health care, that is readily accessible, available and excellent quality,
Shelby County has made great strides in increasing awareness of mental health and suicide prevention, but significant gaps remain. Access to mental health services, crisis intervention, and substance use treatment is still severely limited, and transportation remains a barrier to care.The rural agricultural community faces unique challenges, including high stress, financial strain, and stigma around seeking help. Targeted outreach, farmer-specific mental health support, and reducing barriers to care are critical.Collaboration between healthcare providers, nonprofits, schools, and businesses is essential. Expanding mobile health services, telehealth, and community-based interventions will be key to improving overall well-being in the region.
Our young children need increased access to professionals who can diagnose learning disabilities like dyslexia. There are not enough medical professionals available and the wait is too long to see children for issues like this and other concerns, like mental health, that have a big impact on their education.
Substance use prevents people from obtaining and keeping employment
We live in an area that steps up and accomplishes great things when there is a need. I see huge issues with mental health in both kids and adults on a daily basis. Addressing those needs will filter into every other area of health concerns we have. That along with universal access to preventative healthcare services would be huge for our communities.
There are so many aspects and situations in our communities, it's really hard to say what things would solve all the problems in a community.
Housing and unaffordable rental prices are creating a hardship for many community members.
Get outside! Become active. Incentivize games. Plan park activities
Working at a warming center the last 2 winters has opened my eyes to needs in our community.
Health departments not dealing with these problem

DATA SOURCES

- Centers for Disease Control and Prevention, National Center for Health Statistics
- Esri forecasts for 2024 and 2029. U.S. Census Bureau 2000 and 2010 decennial Census data
- Maternal and Infant Health Mapping Tool, Health Resources and Services Administration
- National Environmental Public Health Tracking Network
- Recovery-Friendly Workplace Missouri
- University of Wisconsin Population Health Institute. County Health Rankings & Roadmaps. www.countyhealthrankings.org.
- U.S. Census: 2024 Missouri Place Gazetteer Files; City and Town Population Totals: 2020-2023
- U.S. Census Bureau American Community Survey (ACS)

Strong Consulting is a Quincy, Illinois-based strategy and communications firm specializing in community and economic development, planning, and public engagement. We position communities and organizations for growth through effective planning, strategic communication, and stakeholder engagement.

Our approach is rooted in the belief that thriving communities empower all people, and that healthy organizations are essential to community vitality. We help clients solve problems by leveraging local talent, forging strong public-private partnerships, and designing solutions that are data-informed and widely supported.

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