Community Health Needs Assessment

Mercy Southwest Missouri and Southeast Kansas Communities

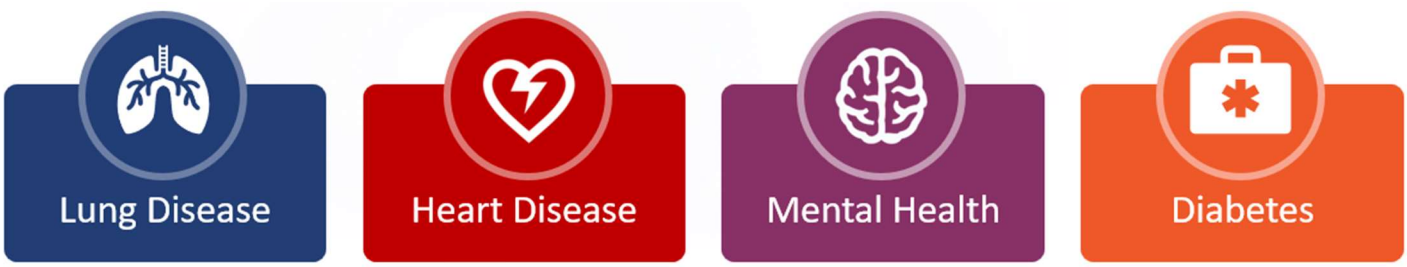
Fiscal Year 2025

Mercy | *Your life is our life's work.*

Contents

FY22-24 Impact

The 2022 community health needs assessment identified four priority health areas:



In response to the priority health needs identified in the 2022 Community Health Needs Assessment (CHNA), Mercy Hospitals in the Southwest Missouri and Southeast Kansas Communities developed and implemented community health improvement plans focused on the needs identified in the 2022 CHNA through the areas of access to care and diabetes prevention:

Programs and initiatives by facility:

Mercy Hospital Joplin

Community Health Worker Program
Concert Health Collaborative Care
Diabetes Prevention Program
Dispensary of Hope

Mercy Hospital Carthage

Community Health Worker Program
COVID-19 Outpatient Clinic

Mercy Hospital Columbus

Health Screening & Education

Mercy Specialty Hospital Southeast Kansas

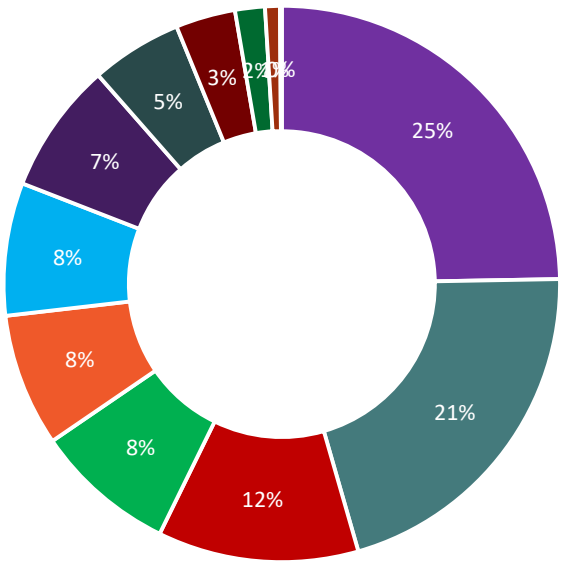
Health Screening & Education

Access to Care

Community Health Worker Program: Community Health Workers (CHWs) have been serving at Mercy since 2018, screening for health-related social needs that impact social drivers of health (SDOH) and providing care navigation to services within Mercy and in the community. Expansion of the CHW program to all Mercy Communities began in 2019, with CHW integration into Emergency Departments, inpatient care, and clinics, connecting patients to community resources to address social needs and assisting with applications for Medicaid and/or charity care programs, reducing barriers to accessing health care services.

In 2024, Mercy Hospital Joplin grew the program further into inpatient care and health equity. Gaining one additional CHW focused specifically on health equity initiatives, CHW's now guide patients with post-hospitalization planning, connection to resources supporting social needs, assistance with transportation to follow-up appointments, aiding in medication assistance programs, and supporting other health-related social needs in the transition to community care and patient self-management.

Mercy Hopital Joplin Community Resources



- Financial Assistance
- Insurance Coverage
- Transportation Issues
- Food Insecurity
- Healthcare Access
- Housing Assistance
- Medication Assistance
- Homelessness
- Utilities Assistance
- Insurance Issues
- Employment Concerns
- Social Isolation

Mercy Hospital Joplin currently employs four CHWs and Mercy Hospital Carthage is working to integrate the CHW program as an ongoing goal. In FY23, CHWs assisted 1,068 patients through 1,913 patient and in FY24 assisted 1,189 patients through 2,138 encounters with care navigation and community resource connections, which is an increase of approximately 11% year to year.

In FY24, the most common requested resources were for financial assistance (including charity care), insurance coverage (including Medicaid), transportation support, food insecurity, finding health care, housing, and medication assistance. In addition, CHW's helped patients get connected with utilities assistance, insurance help, employment assistance, and other resources, demonstrating their diverse and critical roles in supporting community health needs.

Concert Health Collaborative Care: Collaborative care is an evidence-based model to identify and treat patients with mental health challenges. Mercy has partnered with Concert Health, a behavioral health medical group to expand patient access to behavioral health services. In collaboration with a patient's Primary Care Provider (PCP), the program provides a behavioral health manager who interacts directly with the patient, performs an assessment, and initiates treatment. In FY23, the first full year after the program launched, Concert Health Collaborative Care referrals experienced rapid growth with a sharp increase in referrals (166%), followed by a steadier increase (40%) of patient referrals in FY24, where 209 total patients were referred to Collaborative Care.

COVID-19 Outpatient Clinic: Mercy Hospital Carthage provided outpatient treatment services and education to community members experiencing health effects from the COVID-19 virus. Although the State of Missouri transitioned to endemic response on April 1, 2022, and the federal public health emergency declaration expired on May 11, 2023, preventing the spread of COVID-19, and treating the long-term health effects remains a priority. This program is continuing through health equity initiatives directly focused on patients with specific chronic disease conditions that may have been caused or complicated by COVID-19, such as heart disease.

Dispensary of Hope: The Dispensary of Hope is a charitable medication program that provides patients without insurance who are below the Federal Poverty Line (FPL) with life-saving medications at no cost for up to one year. This initiative is still in development at Mercy Hospital Joplin and work is ongoing to establish the program.

Health Screening and Education: Mercy Hospital Columbus and Mercy Specialty Hospital Southeast Kansas provided health screening and education in their communities at events throughout the year with health services, such as immunizations, sports medicine, and physical therapy services, and connection to other community resources.

Diabetes Prevention

Diabetes Prevention Program: The Diabetes Prevention Program (DPP) is an evidence-based lifestyle intervention program developed by the Centers for Disease Control and Prevention (CDC). Led by a trained lifestyle coach, people who are at risk for diabetes, or with prediabetes, receive education and support in a group setting to reduce the risk of developing type 2 diabetes. In FY24, Mercy Hospital Joplin had three patients participate in DPP, with two successfully completing the program.

Preface:

Mercy Southwest Missouri & Southeast Kansas Communities

Mercy's mission is centered on delivering "compassionate care and exceptional service" to every individual, especially those who experience the greatest barriers to health and well-being. The Community Health Needs Assessment (CHNA) is a vital tool in this mission and continues Mercy's long-standing legacy of community engagement, rooted in the tradition of the Walking Sisters, who actively went out into communities to address urgent health needs.

This cycle, Mercy Hospitals in the Southwest Missouri and Southeast Kansas Communities partnered with a regional collaboration known as the Ozarks Health Commission (OHC). Since 2016, hospital systems, local public health agencies (LPHAs), and other healthcare partners in the greater Ozarks region have worked together to release comprehensive CHNAs every three years. This collaboration continues with the 2025 CHNA, building on the regional approach introduced in 2022.

The CHNA process itself involves reviewing both quantitative and qualitative data to capture the full scope of the community's health needs. As part of the Tri-State Community subregion, Mercy Hospital Carthage, Mercy Hospital Columbus, Mercy Hospital Joplin, Mercy Hospital Pittsburg, and Mercy Specialty Hospital Southeast Kansas are represented in this report.

Mercy Southwest Missouri and Southeast Kansas Communities FY24 at a glance:

Mercy Hospital Carthage

Originally founded in 1929 and named McCune-Brooks, the hospital joined Mercy in 2012 and became Mercy Hospital Carthage, a Critical Access Hospital in Carthage, Missouri. After a tornado destroyed Mercy's hospital in Joplin, Mercy partnered with McCune-Brooks Regional Hospital to provide care in both communities and surrounding counties.

25 Beds	23 Providers	$1.05M Charity Care
22,674 ER Visits	1,057 Inpatient Discharges	69,688 Outpatient Visits

Mercy Hospital Columbus

Established in 1917, Maude Norton Memorial City Hospital originated from a home donated to the City of Columbus, Kansas. Then in 1999, it became part of St. John's Joplin, and renamed St. John's Maude Norton. As that relationship grew, in 2009 the hospital joined the Sisters of Mercy Health System becoming Mercy Hospital Columbus and designated a Critical Access Hospital.

25 Beds	3 Providers	$63,758 Charity Care
2,081 ER Visits	79 Inpatient Discharges	6,120 Outpatient Visits

Mercy Southwest Missouri and Southeast Kansas Communities FY24 at a glance:

Mercy Hospital Joplin

The Sisters of Mercy established a hospital in Joplin, Missouri in 1896. It became St. John's Regional Medical Center in 1968, then rejoined the Sisters of Mercy in 2009. In 2011, the hospital was destroyed by an EF5 tornado. Mercy continued to serve the community in temporary facilities until 2015 when the new "storm hardened" building opened, and renamed Mercy Hospital Joplin.

240 Beds	**184** Providers	**$6.36M** Charity Care
37,195 ER Visits	**13,647** Inpatient Discharges	**164,054** Outpatient Visits

Mercy Hospital Pittsburg

Founded as Mt. Carmel Hospital in 1903, it is continuing over a century of care in Pittsburg, Kansas as part of Mercy. Formerly known as Via Christi Hospital, it transferred ownership in 2024, becoming Mercy Hospital Pittsburg.

Mercy Hospital Pittsburg is located within the defined Tri-State Community service area. Although Mercy Hospital Pittsburg is newly affiliated with Mercy, it is situated in a region already encompassed by the geographic scope. At the time of this report, facility-specific data beyond what is already included in the regional report is not avialable.

76 Beds	**20** Providers	**2,529** Inpatient Discharges

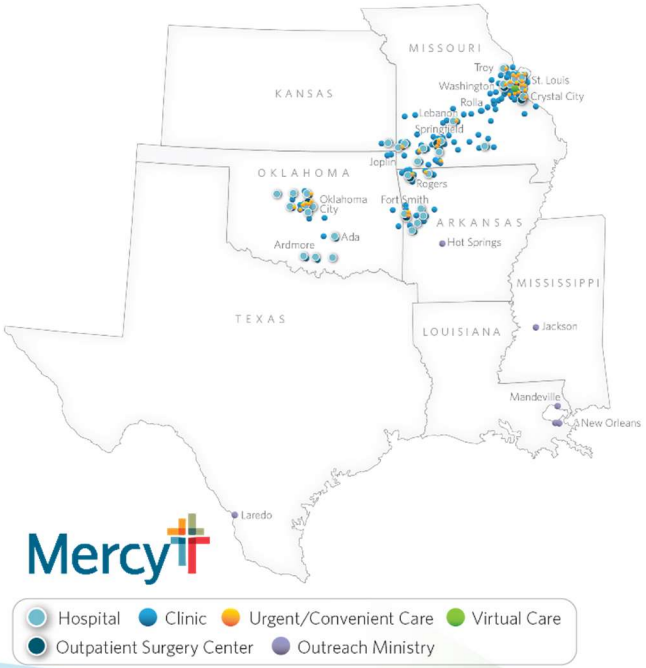
Mercy Specialty Hospital Southeast Kansas

Mercy Specialty Hospital Southeast Kansas is an acute care hospital located in Galena, Kansas. Originating from a group of medical centers that joined Mercy in 2020, Mercy Specialty Hospital Southeast Kansas provides surgical care, orthopedics and sports medicine, physical therapy services, and other specialty care.

304 Inpatient Discharges

36 Beds

$255,143 Charity Care



This CHNA fulfills a legal requirement for nonprofit health systems, mandated by the Patient Protection and Affordable Care Act (PPACA). Under this law, nonprofit hospitals must conduct a community health needs assessment every three years, soliciting input from individuals who represent the broad interests of the community, particularly those with specialized knowledge of public health and populations with unmet health needs.

In addition to IRS requirements for nonprofit healthcare organizations, this collaborative assessment meets the Public Health Accreditation Board (PHAB) standards for local public health agencies. Through this process, Mercy not only fulfills federal compliance but also reinforces its ongoing commitment to improving the health and well-being of the community and supporting community partnerships.

The 2025 CHNA findings reflect the collaborative work of the OHC and its partners, with a continued focus on health equity and using a social drivers of health framework. The CHNA identified seven key health priorities, with three selected as focus areas for the Tri-State Community over the next three years:

- **Chronic disease**
- **Behavioral health**
- **Nutrition and physical exercise**

Alongside the focus areas identified for the Tri-State Community, cancer, infectious diseases, dental care, and unintentional injuries are also recognized as significant health priorities. While these issues were not selected as primary focus areas for this assessment, they are included to provide a broader snapshot of conditions impacting the community.

Mercy Hospitals in the Southwest Missouri and Southeast Kansas Communities remain deeply committed to improve health outcomes in these areas and addressing critical community needs. We recognize that many of the root causes, such as social drivers of health, often intersect across these priorities. Even when not designated as focal points, these issues are impacted by our broader efforts. Through the indirect effects of our work towards focused heath needs and in collaboration with local schools, businesses, and health organizations, we are working to build a culture of health, equity, and resilience across the Southwest Missouri and Southeast Kansas Communities.

These findings will guide Mercy Hospital Carthage, Mercy Hospital Columbus, Mercy Hospital Joplin, Mercy Hospital Pittsburg, and Mercy Specialty Hospital Southeast Kansas's community benefit planning and Community Health Improvement Plans (CHIPs) that address health disparities and create actionable plans for improving the health of local communities.

For more information about Mercy and to access the full reports, please visit: https://www.mercy.net/about/community-benefits/

We welcome ongoing collaboration and feedback as we work together to build a healthier community.

Jeremy Drinkwitz
President
Mercy Southwest Missouri and Southeast Kansas Communities

Your life is our life's work.

OZARKS HEALTHCOMMISSION

2025 Community Health Needs Assessment

Tri-State Community Report

2025

TRI-STATE COMMUNITY

Table of Contents

PART 1

Executive summary

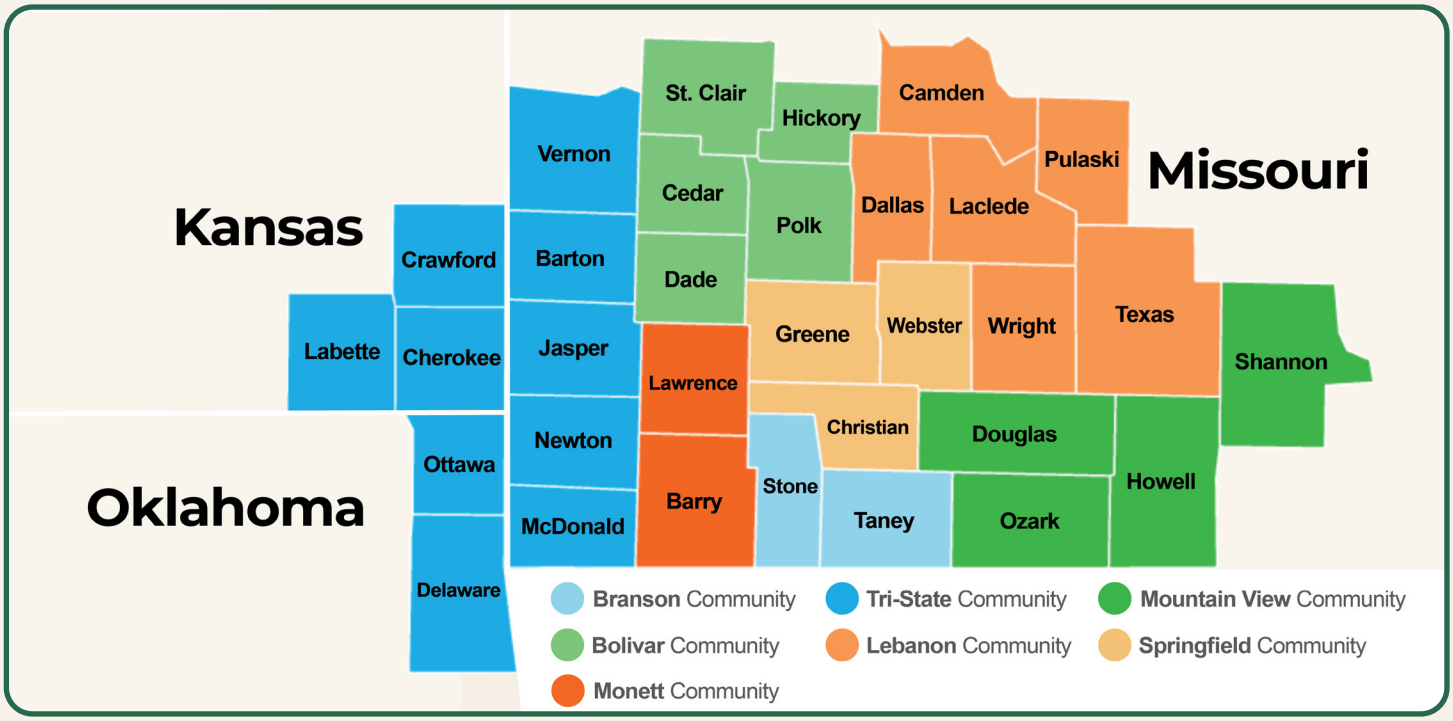
The Tri-State Community is a 10-county area that includes three hospital systems: CoxHealth, Freeman Health System and Mercy. This report will present key findings and identify, assess and prioritize top health issues of concern for the Tri-State Community. This is done through a health equity lens. Health equity is defined as making sure every person, no matter their background or circumstances, has the same opportunity to be healthy.

The goals of this report are to provide collaborating partners, community-based organizations and community members with a greater understanding of health needs and of people most affected by poor health outcomes. The Tri-State Community uses a social determinants of health (SDOH) framework to determine broad categories for priority health outcomes and behaviors. This enables individuals and organizations to identify root causes when developing improvement plans, based on feasibility and resources available. By working together, community members and organizations can mobilize resources to have a collective impact on improving health and well-being for all residents in the community.

> **"Social determinants of health are the conditions in the environments where people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning and quality-of-life outcomes and risks."**
>
> *– Healthy People 2030*

TRI-STATE COMMUNITY

Service area



The Tri-State Community is made up of 10 counties across three states. Missouri counties include Vernon, Barton, Jasper, Newton and McDonald. In Kansas: Crawford, Cherokee and Labette. In Oklahoma: Ottawa and Delaware. In the Ozarks Health Commission (OHC), CoxHealth, Freeman Health System, Mercy, Jasper County Health Department and Joplin Health Department represent the Tri-State Community.

Three health systems' hospitals, in addition to local public health departments, define the Tri-State Community as their service area. This includes the following:

CoxHealth

- Cox Barton County Hospital
- CoxHealth Clinics

Freeman Health System

- Freeman West Hospital
- Freeman Neosho Hospital
- Freeman Fort Scott Hospital
- Freeman Clinics
- Ozark Center

Mercy

- Mercy Hospital Joplin
- Mercy Hospital Carthage
- Mercy Hospital Columbus
- Mercy Hospital Pittsburg
- Mercy Specialty Hospital of Southeast Kansas
- Mercy-GoHealth
- Mercy Clinics

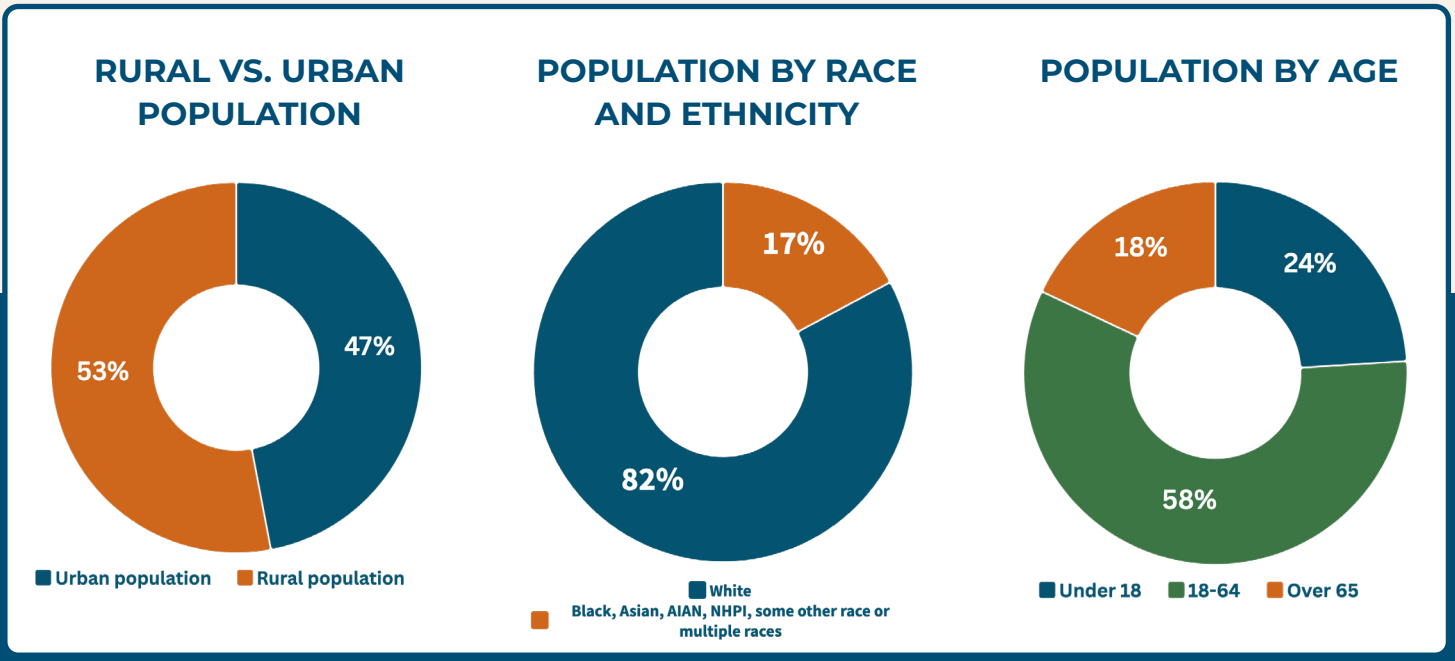
Local Public Health Agencies (LPHAs)

- Joplin City Health Department
- Jasper County Health Department
- Newton County Health Department
- McDonald County Health Department
- Barton County Health Department
- Vernon County Health Department
- Cherokee County Health Department
- Crawford County Health Department
- Labette County Health Department
- Delaware County Health Department
- Ottawa County Health Department

Population overview

The OHC noted several important demographic and population trends within the Tri-State Community. The area is home to 386,399 residents and is an estimated 30% of the OHC region's total population. From 2010-2020, the population declined by 0.7%. This decline led to concerns about aging populations, job losses, declining tax revenues and shrinking schools and neighborhoods. Hispanic populations had the greatest population increase and White populations had the greatest population decrease in the overall community. Other population changes varied across counties and people from racial and ethnic minority groups.

Of the Tri-State Community population, 53% is classified as rural and 47% is classified as urban. Seven out of ten counties are classified as more than 50% rural. Three of these counties are greater than 99% rural. Residents of the community mostly identify as White (82%), while approximately 17% identify as Black, Asian, American Indian or Alaska Native (AIAN), Native Hawaiian or Pacific Islander (NHPI), some other race or multiple races. The Tri-State Community is home to larger populations of AIAN (5%), NHPI (1%), and multiple race populations (8%) compared to the OHC region, states and national racial and ethnic populations.



Nearly 24% of residents are minors under the age of 18, while approximately 18% are over the age of 65. This means on average the population is older than both the OHC region and the nation. Older residents are more likely to be living with chronic illnesses and require access to more health services. Rural counties account for higher percentages of populations over the age of 65. Further, approximately 58% of residents are age 18-64, which drives the workforce in the community.

Approximately 17% of the total population is living with a disability, which is roughly the same as the OHC region but higher than the national rate of about 13%. This may contribute to access to care difficulties and disparities among community members with disabilities.

Populations of interest

Health disparities are the result of inequities rooted in social, racial/ethnic and economic injustice. Communities disproportionately affected by health disparities—such as residents of rural areas, people experiencing poverty, people from racial and ethnic minority groups and older adults—often experience higher rates of chronic illness and worse health outcomes. Utilizing health equity as a guiding priority, root causes of health outcomes were the focus in identifying people from the Tri-State Community who are disproportionately affected by health disparities.

Economic stability

Across the lifespan, people experiencing poverty are at increased risk for poor mental health, chronic disease, higher mortality and lower life expectancy.[1] Children experiencing poverty are at increased risk of developmental delays, toxic stress, chronic illness and nutritional deficits.[2] Individuals who experience childhood poverty are more likely to experience poverty into adulthood, which creates generational cycles. Community survey results showed the most prevalent challenge for community members not accessing health care and mental health care for children and adults, including access to medication, are financial reasons or cost concerns.

Education access and quality

Not completing high school is linked to many factors that can negatively impact health, including limited employment opportunities, low wages and poverty.[3] Factors related to individual students as well as broader institutional factors can affect a student's ability to graduate.[4, 5] Limited language and low literacy skills are associated with lower educational attainment and worse health outcomes.[6] High school graduation rates (86%), unemployment rates (4%), poverty rates (18%), and populations with limited English proficiency (2%) are factors that negatively impact the Tri-State Community greater than the OHC region, states, and nationally.

Health care access and quality

Inadequate health insurance coverage is one of the largest barriers to health care access and uninsured adults are less likely to receive preventive services for chronic conditions such as diabetes, cancer and heart disease.[7, 8] Another access barrier is the limited availability of health care resources, particularly in rural communities and Health Professional Shortage Areas (HPSAs).[9,10] Unavailable or unreliable transportation can also contribute to negative outcomes by limiting access to health care resources.

Q: What is your biggest barrier to better health?

A:

"Affordable insurance."
"Timely appointments without massive wait times."
"Difficulty getting appointments"
"Waiting months for an appointment"
"Lack of providers in the area."

- Community Survey Answers, 2024

Neighborhood and built environment

Housing quality refers to the physical conditions of a person's home and the quality of the environment where the housing is located.[11] The Tri-State Community reports approximately 15% of households with one or more severe problems and describes 3.3% of housing units as overcrowded. Poor housing quality and inadequate living conditions, including the presence of lead, mold or asbestos, poor air quality and overcrowding can contribute to increases in chronic diseases and injuries.[12,13]

Social and community context

Community relationships are important for physical and mental health and well-being. High levels of social support from family, friends or organizations like churches can positively influence health outcomes through behavioral and psychological pathways.[14] Social isolation is an area of concern for older adults and has led to increases in mortality.[15] Approximately 15% of households in the Tri-State Community include seniors living alone, which is higher than region and state averages, and higher rates of isolated older adults are reflected in counties that are mostly rural.

Rural populations

Residents of rural areas are more likely to experience some of the contributing SDOH factors that impact health and can be compounded by additional barriers, such as availability of transportation and limited access to healthy food. Rural communities also experience SDOH factors in prenatal care, childcare and educational opportunities.[16,17]

Health indicator improvements

Over the past three years, the Tri-State Community has made significant strides in improving various health indicators. Notable improvements include:

Insurance coverage

There has been a marked increase in insurance coverage for individuals aged 18-64. In 2019, 20% of adults were uninsured. This decreased to 17% in 2022. Insurance coverage for individuals under 18 fell from 8% in 2019 to 6% in 2022. This improvement is crucial for enhancing access to healthcare services and reducing financial barriers to care.

Women's health

The rate of mammogram screenings increased from 67% in 2018 to 70% in 2022 for adult females aged 50-74. Mammograms contribute to early detection and treatment of breast cancer, which is vital for improving survival rates. Alternately, opportunity exists in improving access to cervical cancer screening. Tri-State saw a 2% decrease in women aged 21-65 receiving recommended cervical cancer screening. This reflects a rate of cervical cancer (13.3 per 100,000) that is higher than the OHC region, state and nation.

Diabetes screening and management

Enhanced diabetes screening efforts have led to earlier diagnosis and management of diabetes, helping to prevent complications and improve quality of life for affected individuals. Hospital data

reports rates of diabetes are lower than region and state rates. Annual A1c testing among Medicare enrollees has been consistently increasing since 2008, with 82% of Medicare enrollees with diabetes receiving their annual exam. With these improvements there are many areas of opportunity for a complex disease such as diabetes. Efforts towards programs and increased access should continue to grow.

Preventable hospitalizations

There has been a reduction in preventable hospitalizations of approximately 5% per year from 2012 to 2021 among Medicare beneficiaries, indicating better management of chronic conditions and improved access to primary care services. However, the Tri-State community reports a higher rate than the OHC region, indicating further opportunity in this area.

Annual wellness visits

The number of annual wellness visits in adults aged 18 and older has returned to pre-COVID-19 pandemic rates. While the overall rate for the Tri-State Community is still lower than surrounding areas at around 73%, there has been significant progress in overcoming some of the barriers caused by the pandemic.

While these improvements are encouraging, it is important to acknowledge that some of these factors are still below state and regional rates and vary in severity across urban and rural areas. However, the positive trends observed suggest that continued efforts and focused interventions can further bridge these gaps bringing us to the health priorities reflected in this report.

Methodology

The Tri-State Community steering committee members—represented by the Joplin Health Department, Jasper County Health Department, Freeman Health System and Mercy—formed a work group to identify priority health issues, analyze quantitative and qualitative data and guide the prioritization process for community partners. Analysis focused on root cause factors associated with health outcomes. Building on the methodology developed by the OHC, the work group began analysis of partner and community survey response data and public health data through a series of meetings from September to October 2024. Methodologies used in survey development and a comprehensive list of comparison tables can be found in the OHC Regional Report. Aggregated public health data, using the SDOH framework, revealed health factors and health indicators that were compared to community feedback and categorized into seven top health issues of concern (cancer, chronic disease, dental care, infectious disease, behavioral health, nutrition and physical activity, and unintentional injury). Health system data was not yet available during the time of this analysis.

Information from the Community Toolbox,[18] National Association of County and City Health Officials (NACCHO),[19] and Association of State and Territorial Health Officials (ASTHO) [20] were used as guides in the prioritization process for assessed health issues. A simplified prioritization matrix was implemented for each identified health issue with size of the problem, seriousness of the problem, feasibility, disparities, available expertise and importance to the community adopted as criteria categories based on the Hanlon Method.[21] A scoring system of Low (1), Medium (2), or High (3) was utilized and each criteria category was rated with equal importance. A supplemental instruction sheet accompanied the prioritization matrix with additional questions for community partners to consider for each category when scoring identified health issues. Average scores for each criterion were calculated and a final score was developed from the overall average for each health issue.

The Tri-State Community convened a special meeting of the Tri-State Community Health Collaborative (CHC) to assess and prioritize identified health issues through primary and secondary data sources and further incorporate community feedback. Representatives from public agencies,

nonprofit organizations, local collaboratives and coalitions, CHC members and community leaders were invited to a hybrid in-person/virtual meeting in Joplin. Based on the seven health issues identified by the work group, contributors convened to further consider top priorities.

Prior to the meeting date, the work group drafted supplemental fact sheets and a summary data table (to provide context surrounding prioritization matrix criteria for each identified health issue) from root cause analysis findings. To provide a comprehensive overview of identified health issues, and to aid in discussion and informed decision making for each evaluation criteria, these additional documents were emailed to all meeting invitees prior to the meeting date. Feasibility criteria was left to community representatives to assess and determine based on their perspectives, resources and capabilities for their respective organizational or individual goals.

On October 11, 2024, 47 community partners and collaborators representing health care, education, public health, libraries, law enforcement, community-based organizations and court systems gathered to discuss and prioritize the top seven identified health issues. Printed copies of supplemental data sheets were provided to participants. Following an overview of the OHC's methodology for the regional report and presentation of instructions and expectations, work group representatives presented each health issue. They highlighted community input and associated health factors and outcomes in which the Tri-State Community experienced worse rates than the OHC region, state and national rates. Health system data was not available at the time of this meeting and is unlikely to have affected the prioritization results. For each health issue, the presenter facilitated open-forum discussion before moving on. These discussions included two question prompts:

- Does anything from the presentation, notes or handouts stand out to you?
- Do you feel we can do something about this?

Following a final summary and discussion, an anonymous, electronic, live vote—utilizing the established prioritization matrix—elevated the top three health priorities.

Identified health issue	Average score
Behavioral health	2.5
Chronic disease	2.5
Nutrition and physical activity	2.5
Cancer	2.2
Infectious disease	2.2
Dental care	2.1
Unintentional injury	2.0

PART 2

Community health priorities

CHRONIC DISEASE

BEHAVIORAL HEALTH

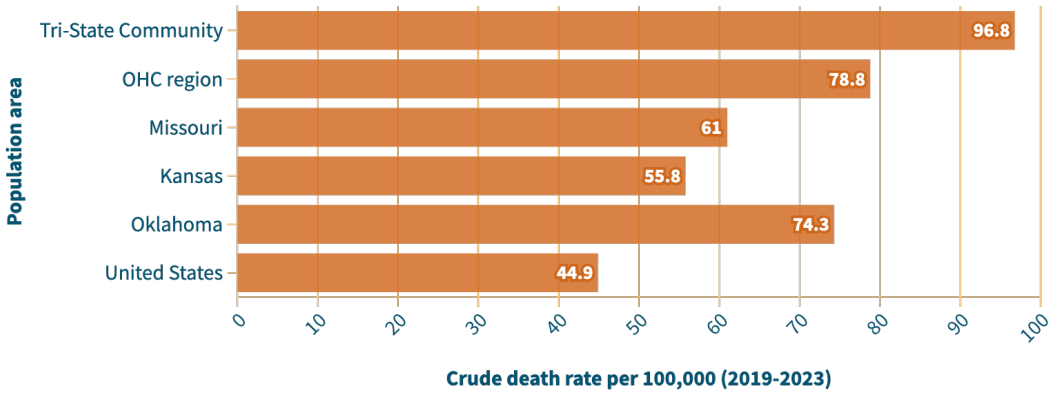
NUTRITION AND PHYSICAL EXERCISE

COMMUNITY HEALTH PRIORITY

Chronic disease

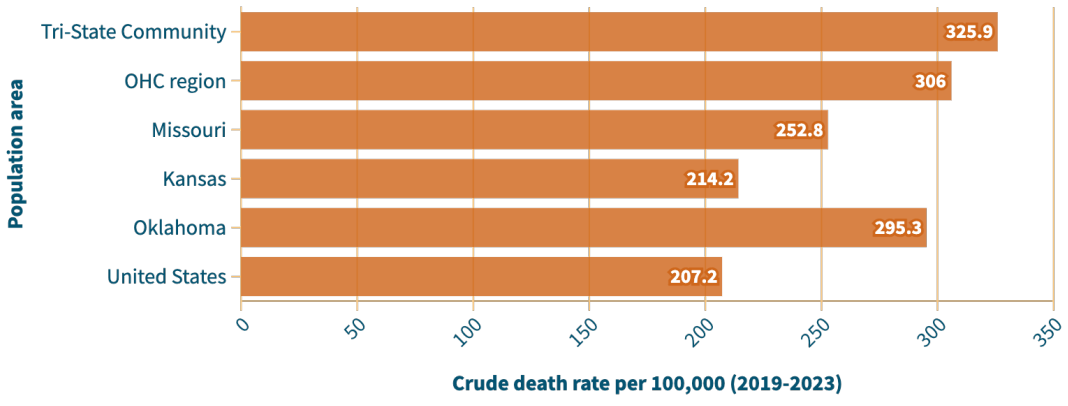
Chronic diseases are broadly defined as conditions that last one year or more, such as heart disease, cancer and diabetes. They require ongoing medical attention, limit activities of daily living or both.[22] Chronic disease affects a large part of the population and management is expensive. These conditions require ongoing medical care, medications and sometimes hospitalizations. Limited access to preventive care services and health care resources can negatively affect chronic disease outcomes, particularly for communities experiencing disadvantages because of health disparities. The high needs of managing chronic disease can also affect mental health, leading to conditions such as depression and anxiety.

LUNG DISEASE MORTALITY



In the Tri-State Community, heart disease, lung disease, stroke and cancer mortality are higher than the OHC region, states (Kansas, Missouri and Oklahoma) and U.S. rates. Hospital data shows chronic disease or chronic disease indicators in the top 7 out of 10 condition rates, including hypertension, diabetes and heart disease. The community survey did not directly address specific conditions, although feedback from community partners and residents indicated barriers in access to care. Respondents indicated the top three reasons for not accessing medical care as financial, scheduling and insurance. Surveyed community partners also indicated barriers in access to healthy food options and physical activity opportunities, which are contributing factors to chronic disease.

HEART DISEASE MORTALITY



The rate of available primary care providers is 74.24 per 100,000 population, which is lower than the OHC region, states and national rates and is insufficient to meet the needs of the Tri-State Community, according to community response. Approximately 14% of residents do not have health insurance, which limits access to care needed to prevent and manage chronic conditions. Of people with lower incomes, about 64% experience low food access, which can contribute to poor nutrition. Housing barriers are also contributing factors to increased rates of chronic diseases and are a significant health factor in the Tri-State Community. Households with structural problems and overcrowded housing situations impact overall health and well-being.

Another major risk factor for several chronic diseases is smoking, and in the Tri-State Community approximately 23% of adults indicate they are current smokers. Further, about 16% of adults report excessive alcohol use. Physical activity is a critical component of chronic disease prevention, and 25% of adults report no leisure time activity. This, along with about 40% of residents not having access to exercise opportunities, shows there are barriers preventing participation in physical activity.

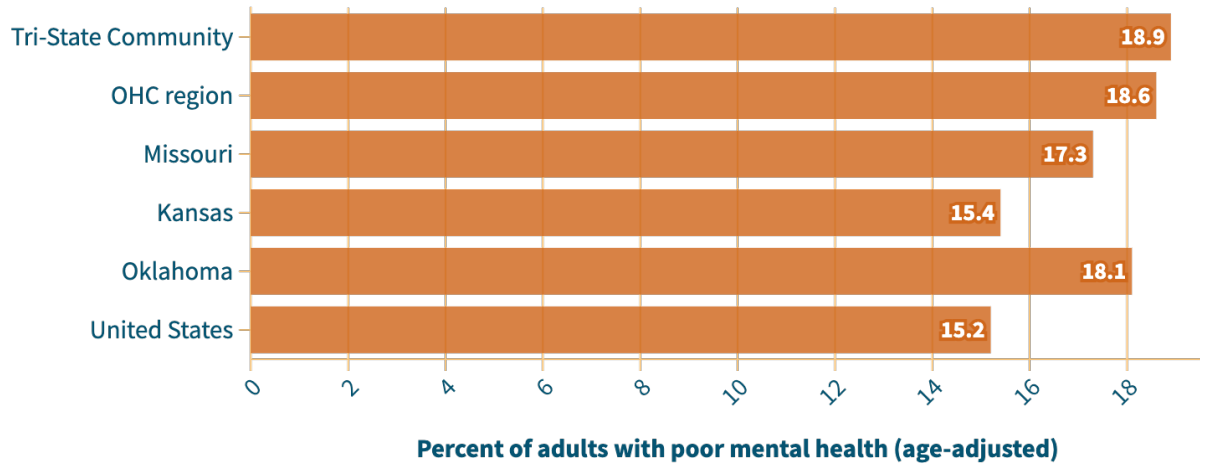
Hospital data shows chronic disease or chronic disease indicators in the top 7 out of 10 condition rates, including hypertension, diabetes and heart disease.

COMMUNITY HEALTH PRIORITY

Behavioral health

Behavioral health refers to a state of mental, emotional and social well-being and is a key part of overall health. Behavioral health also includes behaviors and actions that affect wellness and is used to describe support systems that promote well-being, prevent mental stress and provide access to treatments and services for mental health conditions.[23] During the prioritization process, mental health and substance use disorders were identified as separate health issues. Through further analysis, findings indicated multiple similarities in contributing factors and populations of focus, so they were combined under the definition of behavioral health for this assessment.

ADULTS 18+ WITH POOR MENTAL HEALTH

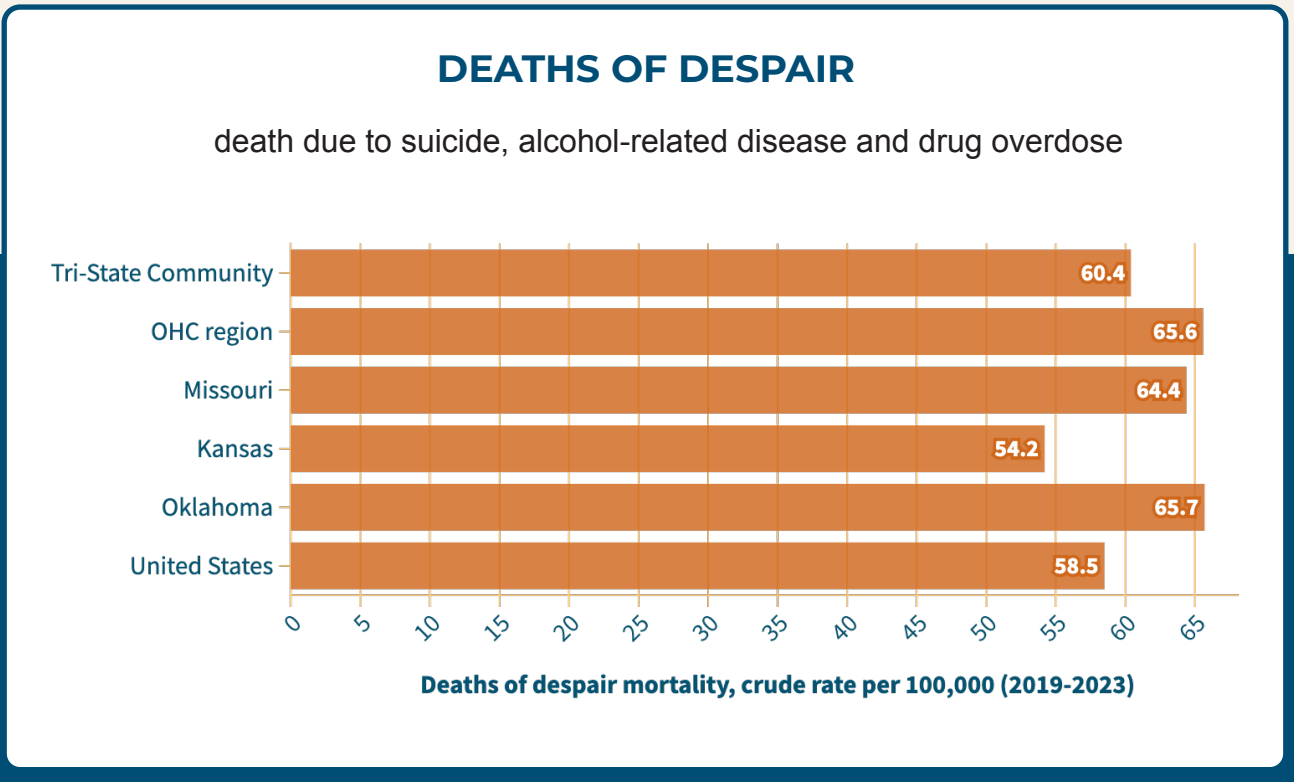


Mental health

Mental health is important at every stage of life and has many influencing factors including brain chemistry, life experiences and family history. Mental health is also closely linked to physical health. For example, depression increases the risk of chronic conditions like diabetes, heart disease and stroke. Mental health is not only the absence of a mental health condition, but also the presence of well-being and the ability to thrive. A mental health condition is an illness or disorder that affects a person's thinking, feeling, behavior or mood. Nearly one out of four adults in the U.S. live with a mental health condition.[24] Anyone can face challenges to their mental health, regardless of whether they have a mental health condition or not.

Substance use

People may sometimes turn to drugs, alcohol and other substances to help them cope with stress, trauma or mental distress. Substance use refers to the use of alcohol, tobacco products, illicit drugs and/or other substances and can result in substance use disorders, which often co-occur with mental health conditions. For this report, substance use does not include accidental poisoning from carbon monoxide, pesticides, animals or plants. Substance use is a major public health concern because of high prevalence, high rates of associated death and disability, and impact on health inequities. It is linked to several health issues including liver disease, heart disease, lung disease and mental health conditions. Substance use can also increase the risk of accidents, injuries and violence that also contribute to rates of death and disability.



Poor mental health can be both a cause and consequence of substance use.

In the Tri-State Community, behavioral health is an area of concern with multiple contributing factors and barriers. Although the rate of mental health providers in the community is higher than the OHC region, states and national rates, this indicator does not match up with rates of adults with poor mental health (19%) and suicide mortality rates (18.96 per 100,000 population). The differences between counties and disproportionate coverage of mental health providers between rural and urban counties indicates a significant lack of access or accessibility, which was reflected in feedback from the partner and community surveys. While secondary data shows the Tri-State Community as roughly the same or better than the OHC region in most measures of associated factors and outcomes, importance to the community, continuous increase in yearly trends, and significant disparities among contributing factors prioritizes behavioral health as a focused health issue.

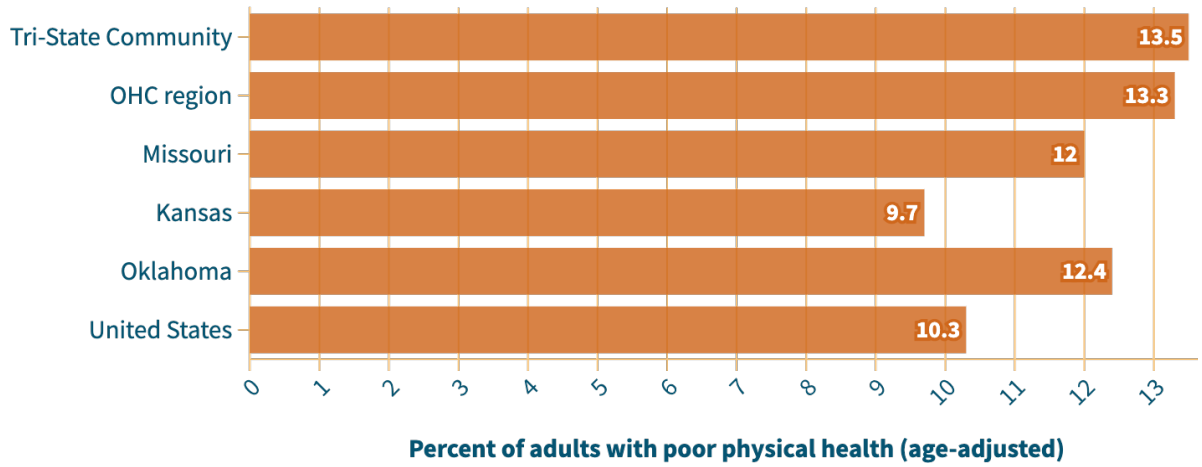
Poor mental health can be both a cause and consequence of substance use. People experiencing poverty also experience increased stress and limited access to resources, increasing likelihood of substance use as a coping mechanism. Higher poverty rates in people from racial and ethnic minority groups, despite only accounting for 17% of the community population, indicates a significant disparity. Lower levels of education contribute due to limitations in job opportunities for people without high school diplomas, creating economic instability. Further, an estimated 4% of students in the Tri-State Community experience homelessness, which significantly impacts education attainment and increases chronic stress. In some communities, there may be cultural acceptance of substance use, making it more prevalent. Social circles and peer pressure can further influence engagement in substance use. Co-occurrence of mental health conditions and substance use disorders creates severe complications for treatment and recovery, especially in areas where availability of resources is limited.

COMMUNITY HEALTH PRIORITY

Nutrition and physical activity

Healthy eating, physical activity, adequate sleep and stress reduction are important to achieving optimal health. Good nutrition is important across all life stages and reduces risk for serious health problems such as heart disease, type 2 diabetes and obesity.[25] Physical activity is one of the best things people can do to improve their health, and for people with chronic diseases, physical activity can help manage some conditions and complications.[26] Nutrition and physical activity also contribute to overall well-being and behavioral health.

ADULTS 18+ WITH POOR PHYSICAL HEALTH

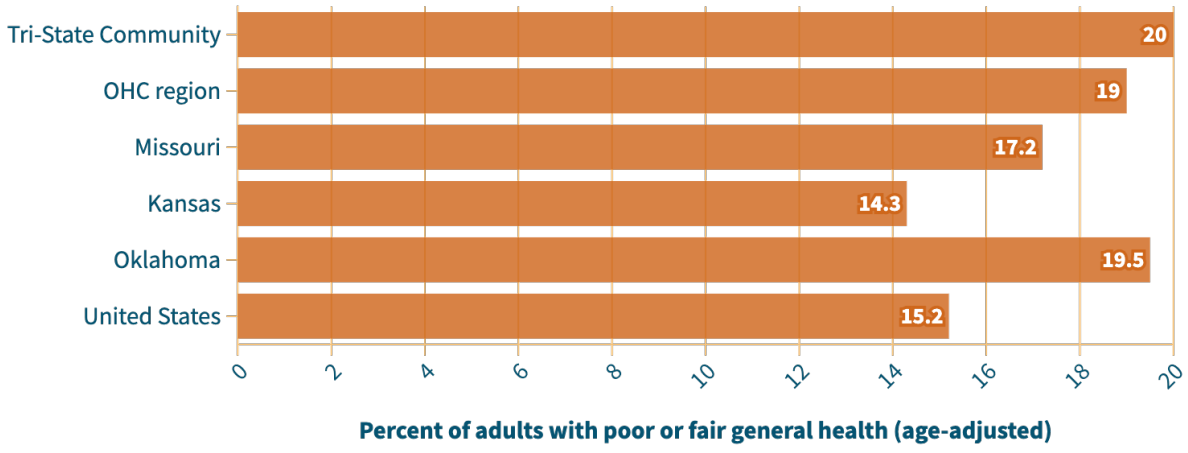


In the Tri-State Community, the rate of adult residents with obesity is 34%, which is higher than the OHC region, states and national rates. Primary data from the community indicated time, interest, finances and access as the top reasons not to engage in physical activity or improve nutrition. Secondary data indicates only 60% of the population in the Tri-State Community have access to exercise opportunities, and only 25% of the population has adequate access to healthy food options. Hospital data further indicates a higher rate of disordered eating in the community compared to the region, which could further indicate the severity of food insecurity and lack of nutritional resources. These barriers are greater for people in rural communities, who experience additional barriers related to health behaviors and higher instances of chronic disease.

High cost of living limits access to healthy food and physical activity opportunities by reducing the amount of disposable income for healthy food and recreational activities. The Tri-State Community has limited transportation resources (0% of the population is within walking distance to public transit) and low walkability (7 on a scale of 1 to 20) making it difficult for residents to access areas for physical activity. Less than 30% of the population in the community lives within a half mile of a park. This lack of access is further limited for people experiencing poverty or homelessness and people living with disabilities.

Health insurance coverage is an additional factor that can affect access. Without health insurance, or with inadequate coverage, limited access to health resources such as nutrition counseling or physical therapy can contribute to poor outcomes. Of adults in the community, 20% report poor or fair general health, which can be influenced by poor nutrition and physical inactivity. Behavioral health factors also are a significant driver of maintaining good nutrition and participating in physical activities.

ADULTS 18+ WITH POOR OR FAIR GENERAL HEALTH



COMMUNITY HEALTH PRIORITIES

Interconnectivity

These priorities are deeply interconnected, with several overlapping causal factors contributing to their prevalence and impact on the community. Shared causal factors like limited access to care, socioeconomic challenges, behavioral risks (e.g., smoking, substance use), and environmental barriers (e.g., lack of exercise opportunities, food insecurity) emphasize how these interconnected factors contribute to the community's health needs.

PART 3

Conclusion

While this overview of health in the Tri-State Community is not comprehensive, it gives an important glimpse into health priorities reflected in both data and community feedback. The 2025 assessment will be used to inform public health and health care initiatives. These initiatives will be outlined in a forthcoming Community Health Improvement Plan.

Dissemination

The OHC regional report and all community-level reports are available to the public through various channels.

Websites

Ozarks Health Commission
www.ozarkshealthcommission.org

CoxHealth
www.coxhealth.com

Freeman Health System
freemanhealth.com

Mercy Hospital
mercy.net

Printed copies

Printed copies will be available by request through health care partners and LPHAs. Please refer to organization websites or contact an organization directly.

Social media

CHNA and CHIP announcements will be made via social media channels.

CoxHealth
facebook.com/coxhealth/

x.com/CoxHealth

Freeman Health System
facebook.com/freemanhealthsystem

x.com/freemancares4u

Jasper County Health Department
facebook.com/jaspercountyhealthdept

Joplin Health Department
facebook.com/joplinhealthdepartment

Mercy Southwest Missouri and Southeast Kansas Communities
facebook.com/mercyhospitaljoplin

facebook.com/mercypittsburg

facebook.com/mercycarthage

facebook.com/mercycolumbusks

Health services available

Access Family Care
accessfamilycare.org

Barton County Health Department
Bchdhealth.com

Cherokee County Health Department
Cherokeecountyks.gov/main/departments/health-department

Community Clinic of Southwest Missouri
joplinclinic.org

Community Health Center of Southeast Kansas
chcsek.org

CoxHealth
Doctors.coxhealth.com

Crawford County Health Department
crawfordcountykansas.org/health-department

Delaware and Ottawa County Health Departments
oklahoma.gov/health/county-health-departments

Find Help
Findhelp.org

Freeman Health System
freemanhealth.com/find-a-provider

Kansas Community Resources
mercy.net/content/dam/mercy/en/pdf/SoutheastKansas-Resource-List.pdf

Labette County Health Department
labettecounty.com/health-dept

Macdonald County Health Unit
Mcdonaldcountyhealth.com

Mercy
mercy.net/search/doctor

Missouri Community Resources
freemanhealth.com/community-resource-directory

Newton County Health Department
newtoncountyhealth.org

Oklahoma Community Resources
Navigateresources.net/hlok

United Way
211.org

Vernon County Health Department
http://www.vernoncohd.com

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Access data

www.ozarkshealthcommission.org/explore-data

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Citations

[1] Khullar, Dhruv, and Dave Chokshi. “Health, income and poverty: Where we are and what could help.” Health Affairs Health Policy Brief (October 4, 2018). https://doi.org/https://doi.org/10.1377/hpb20180817.901935.

[2] Evans, Gary W., and Pilyoung Kim. “Childhood Poverty, Chronic Stress, Self-Regulation, and Coping.” Child Development Perspectives 7, no. 1 (2013): 43–48. https://doi.org/10.1111/cdep.12013.

[3] Magnani, J. W., H. Ning, J. T. Wilkins, D. M. Lloyd-Jones, and N. B. Allen. “Educational Attainment and Lifetime Risk of Cardiovascular Disease.” JAMA Cardiol 9, no. 1 (2024): 45-54. https://doi.org/10.1001/jamacardio.2023.3990.

[4] Freudenberg, Nicholas, and Jessica Ruglis. “Reframing School Dropout as a Public Health Issue.” Preventing Chronic Disease 4, no. 4 (2007): A107. Published electronically September 15, 2007. https://www.cdc.gov/pcd/issues/2007/oct/07_0063.htm.

[5] LaVeist, Thomas A., Eliseo J. Pérez-Stable, Patrick Richard, Andrew Anderson, Lydia A. Isaac, Riley Santiago, Celine Okoh, Nancy Breen, Tilda Farhat, Assen Assenov, and Darrell J. Gaskin. “The Economic Burden of Racial, Ethnic, and Educational Health Inequities in the US.” JAMA 329, no. 19 (2023): 1682-1692. https://doi.org/10.1001/jama.2023.5965.

[6] Gulati, Reeti K., and Kevin Hur. “Association Between Limited English Proficiency and Healthcare Access and Utilization in California.” Journal of Immigrant and Minority Health 24, no. 1 (2022): 95–101. https://doi.org/10.1007/s10903-021-01224-5.

[7] Lazar, Malerie, and Lisa Davenport. “Barriers to Health Care Access for Low Income Families: A Review of Literature.” Journal of Community Health Nursing 35, no. 1 (2018): 28-37. https://doi.org/10.1080/07370016.2018.1404832.

[8] Horne, Gabrielle, Amber Gautam, and Dmitry Tumin. “Short- and Long-Term Health Consequences of Gaps in Health Insurance Coverage among Young Adults.” Population Health Management 25, no. 3 (2022): 399-406. https://doi.org/10.1089/pop.2021.0211.

[9] Rural Health Information Hub. “Healthcare Access in Rural Communities.” Rural Health Information Hub. 2024. https://www.ruralhealthinfo.org/topics/healthcare-access.

[10] Southwest Rural Health Research Center. Rural Healthy People 2030. College Station, TX: Texas A&M University, 2023. https://srhrc.tamu.edu/documents/rural-healthy-people-2030.pdf.

[11] Swope, Carolyn B., and Diana Hernández. “Housing as a Determinant of Health Equity: A Conceptual Model.” Social Science & Medicine 243 (2019): 112571. https://doi.org/10.1016/j.socscimed.2019.112571.

[12] Marí-Dell’Olmo, Marc, Ana M. Novoa, Lluís Camprubí, Andrés Peralta, Hugo Vásquez-Vera, Jordi Bosch, Jordi Amat, Fernando Díaz, Laia Palència, Roshanak Mehdipanah, Maica Rodríguez-Sanz, Davide Malmusi, and Carme Borrell. “Housing Policies and Health Inequalities.” International Journal of Health Services 47, no. 2 (2017): 207-232. https://doi.org/10.1177/0020731416684292.

[13] Boch, Samantha J., Danielle M. Taylor, Melissa L. Danielson, Deena J. Chisolm, and Kelly J. Kelleher. "'Home is Where the Health Is': Housing Quality and Adult Health Outcomes in the Survey of Income and Program Participation." Preventive Medicine 132 (2020): 105990. https://doi.org/10.1016/j.ypmed.2020.105990.

[14] Strine, Tara W., Daniel P. Chapman, Lina Balluz, and Ali H. Mokdad. "Health-Related Quality of Life and Health Behaviors by Social and Emotional Support: Their Relevance to Psychiatry and Medicine." Social Psychiatry and Psychiatric Epidemiology 43, no. 2 (2008): 151-159. https://doi.org/10.1007/s00127-007-0277-x.

[15] Holt-Lunstad, Julianne, Timothy B. Smith, Mark Baker, Tyler Harris, and David Stephenson. "Loneliness and Social Isolation as Risk Factors for Mortality: A Meta-Analytic Review." Perspectives on Psychological Science 10, no. 2 (2015): 227-237. https://doi.org/10.1177/1745691614568352.

[16] Rural Health Information Hub. "Rural Health Disparities." Rural Health Information Hub. 2022. https://www.ruralhealthinfo.org/topics/rural-health-disparities.

[17] Rural Health Information Hub. "Social Determinants of Health." Rural Health Information Hub. 2024. https://www.ruralhealthinfo.org/topics/social-determinants-of-health.

[18] Center for Community Health and Development, University of Kansas. "Assessing Community Needs and Resources." Community Toolbox. 2024. https://ctb.ku.edu/en/assessing-community-needs-and-resources.

[19] National Association of County and City Health Officials. Guide to Prioritization Techniques. Washington, D.C.: NACCHO, 2013. https://www.naccho.org/uploads/downloadable-resources/Gudie-to-Prioritization-Techniques.pdf.

[20] Association of State and Territorial Health Officials. "Public Health Assessment." Association of State and Territorial Health Officials. 2024. https://www.astho.org/topic/public-health-infrastructure/assessment/.

[21] National Association of County and City Health Officials. Guide to Prioritization Techniques. Washington, D.C.: NACCHO, 2013. https://www.naccho.org/uploads/downloadable-resources/Gudie-to-Prioritization-Techniques.pdf.

[22] Centers for Disease Control and Prevention. "About Chronic Diseases." Centers for Disease Control and Prevention. 2024. https://www.cdc.gov/chronic-disease/about/index.html.

[23] Centers for Disease Control and Prevention. "About Behavioral Health." Centers for Disease Control and Prevention. 2024. https://www.cdc.gov/mental-health/about/about-behavioral-health.html.

[24] Centers for Disease Control and Prevention. "About Mental Health." Centers for Disease Control and Prevention. 2024. https://www.cdc.gov/mental-health/about/index.html.

[25] Centers for Disease Control and Prevention. "About Nutrition." Centers for Disease Control and Prevention. 2023. https://www.cdc.gov/nutrition/php/about/.

[26] Centers for Disease Control and Prevention. "About Physical Activity." Centers for Disease Control and Prevention. 2024. https://www.cdc.gov/physical-activity/php/about/.

OZARKS HEALTHCOMMISSION

2025 Community Health Needs Assessment