SULLIVAN COUNTY
COMMUNITY HOSPITAL

Sullivan County Community Hospital

2026 Community Health Needs Assessment

Approved by Board: May 19, 2026

Ovation Healthcare

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Executive Summary

Sullivan County Community Hospital ("SCCH" or the "Hospital") performed a Community Health Needs Assessment (CHNA) together in partnership with Ovation Healthcare ("Ovation") to assist in determining the health needs of the local community and an accompanying implementation plan to address the identified health needs. This CHNA report consists of the following information:

1) a definition of the community served by the Hospital and a description of how the community was determined;

2) a description of the process and methods used to conduct the CHNA;

3) a description of how the Hospital solicited and considered input received from persons who represent the broad interests of the community it serves;

4) commentary on the 2023 CHNA Assessment and Implementation Strategy efforts;

5) a prioritized description of the significant health needs of the community identified through the CHNA along with a description of the process and criteria used in identifying certain health needs as significant and prioritizing those significant health needs; and

6) a description of resources potentially available to address the significant health needs identified through the CHNA.

Data was gathered from multiple well-respected secondary sources to help build an accurate picture of the current community and its health needs. A broad community survey was performed to review and provide feedback on the prior CHNA and to support the determination of the Significant Health Needs of the community in 2026.

The health priorities identified by SCCH from this assessment are:

Chronic Disease Management

Affordability of Healthcare

Access to Healthcare Services

In the Implementation Strategy section of the report, the Hospital addresses these areas through identified programs and resources with intended impacts included for each health need to track progress towards improved community health outcomes.

Community Health Needs Assessment
Overview

CHNA Purpose

A CHNA is part of the required documentation of "Community Benefit" under the Affordable Care Act for 501(c)(3) hospitals and fulfills requirements for accreditation for many health and public health entities. However, regardless of status, a CHNA provides many benefits to an organization. This assessment provides comprehensive information about the community's current health status, needs, and disparities and offers a targeted action plan to address these areas, including programmatic development and partnerships.

Organizational Benefits

- Identify health disparities and social drivers to inform future outreach strategies
- Identify key service delivery gaps
- Develop an understanding of community members' perceptions of healthcare in the region
- Support community organizations for collaborations

CHNA Process

Survey the Community

Develop a CHNA survey to be deployed to the broad community in order to assess significant health priorities.

Data Analysis

Review survey data and relevant data resources to provide qualitative and quantitative feedback on the local community and market.

Determine Top Health & Social Needs

Prioritize community health and social needs based on the community survey, data from secondary sources, and facility input.

Implementation Planning

Build an implementation plan to address identified needs with actions, goals, and intended impacts on significant health needs.

Process & Methods

This assessment takes a comprehensive approach to determining community health needs and includes the following methodology:

- Several independent data analyses based on secondary source data
- Augmentation of data with community opinions through a community-wide survey
- Resolution of any data inconsistency or discrepancies by reviewing the combined opinions formed by local expert advisors and community members

Data Collection and Analysis

This assessment relies on secondary source data, which primarily uses the county as the smallest unit of analysis. Most data used in the analysis is available from public internet sources and proprietary data. Any critical data needed to address specific regulations or developed by the community members cooperating in this study are displayed in the CHNA report appendix.

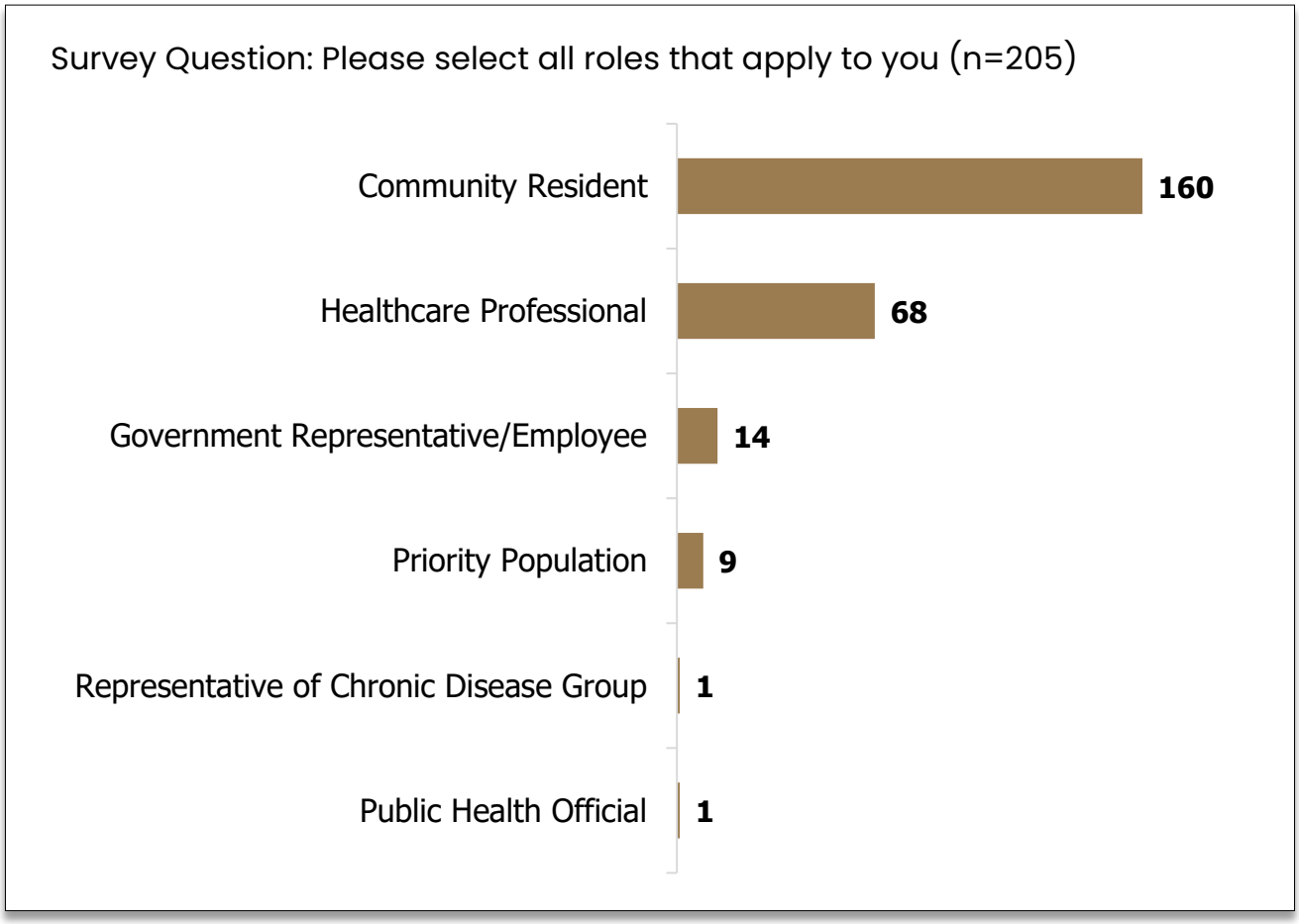
All data sources are detailed in the appendix of this report, with the majority of the data used in this assessment coming from:

- County Health Rankings 2025 Report
- Centers for Medicare & Medicaid Services – CMS
- Centers for Disease Control and Prevention – CDC

A standard process of gathering community input was utilized. In addition to gathering data from the above sources, a CHNA survey was deployed to local expert advisors and the general public to gain input on local health needs and the needs of priority populations. Local expert advisors were local individuals selected according to criteria required by the Federal guidelines and regulations and the Hospital's desire to represent the region's economic, racial, and geographically diverse population. 205 survey responses from community members were gathered in February 2026.

Community Input

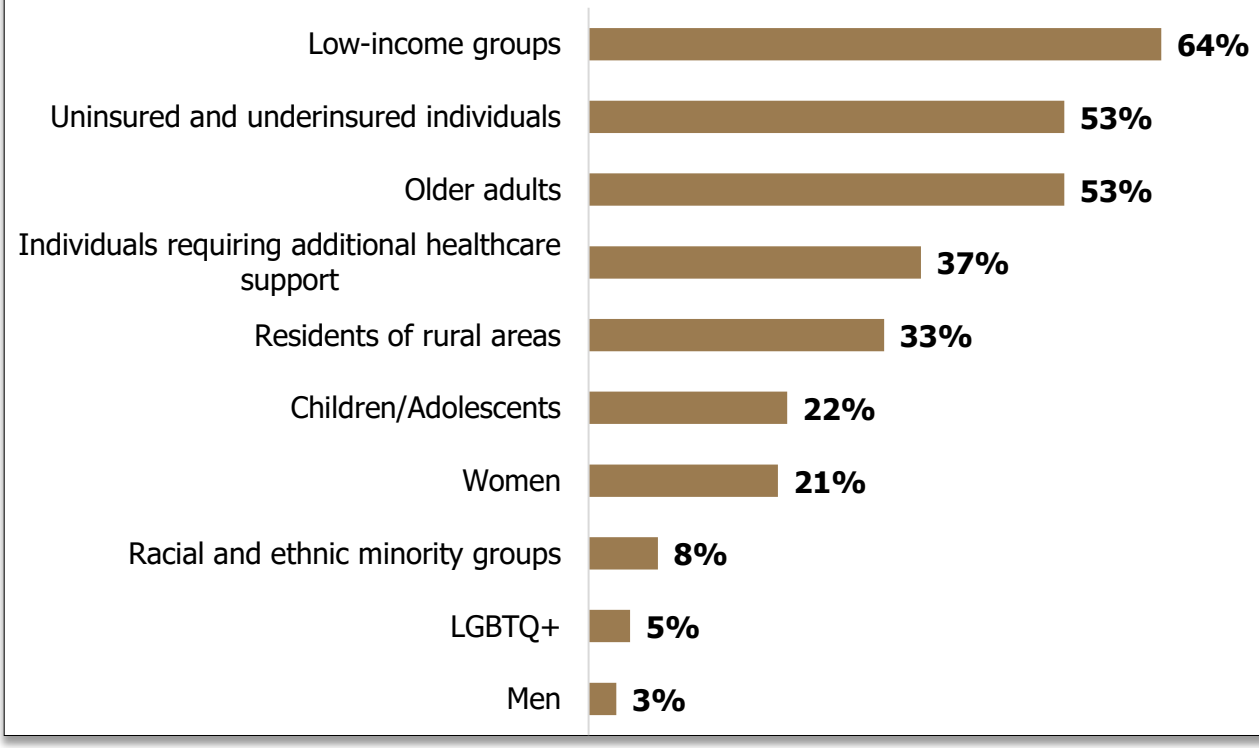
Input was obtained from the required three minimum federally required sources and expanded to include other representative groups. The Hospital asked all those participating in the written comment solicitation process to self-identify into any of the following representative classifications, which are detailed in the appendix to this report. Additionally, survey respondents were asked to identify their age, race/ethnicity, and income level to ensure a diverse range of responses were collected.



Priority Populations

Medically underserved populations are those who experience health disparities or face barriers to receiving adequate medical care because of income, geography, language, etc. The Hospital assessed what population groups in the community ("Priority Populations") would benefit from additional focus and asked survey respondents to elaborate on the key health challenges these groups face.

Survey Question: Which groups would you consider to have the greatest health needs (rates of illness, trouble accessing healthcare, etc.) in your community?



Local opinions of the needs of Priority Populations, while presented in their entirety in the appendix, were abstracted into the following key themes:

- The top three priority populations identified were low-income groups, uninsured and underinsured individuals, and older adults (65+)
- Summary of unique or pressing needs of the priority groups identified by the respondents:

Affordability of Healthcare | Adequate Transportation | Access to Specialty Care

Input on the Actions Taken Since the 2023 CHNA

SCCH considered written comments received on the prior CHNA and Implementation Strategy as a component of the development of the 2026 CHNA and Implementation Strategy. Comments were solicited from community members to provide feedback on any efforts and actions taken by SCCH since the 2023 CHNA and Implementation Plan were conducted. These comments informed the development of the 2026 CHNA and Implementation Plan and are presented in full in the appendix of this report. The health priorities identified in the 2023 CHNA are listed below with a selection of survey responses.

- Chronic Disease Management
- Behavioral Health
- Healthcare Affordability

"SCCH has increased providers for mental health as well as extending their services to younger children."

"Very happy to see the increase in family practice doctors in our local area. The hospital has done a great job of bringing new services to the area ie. total joint surgery, dedicated eye surgeons."

"I think SCCH does a fantastic job at promoting education for varying healthcare topics. They offer free classes for many of the diseases we see in our community. They started having the physicians go out into the community doing different lunch and learns/education. This is outstanding."

"Continues to add primary care providers, has Behavioral Health for all ages, actively pursues other service lines"

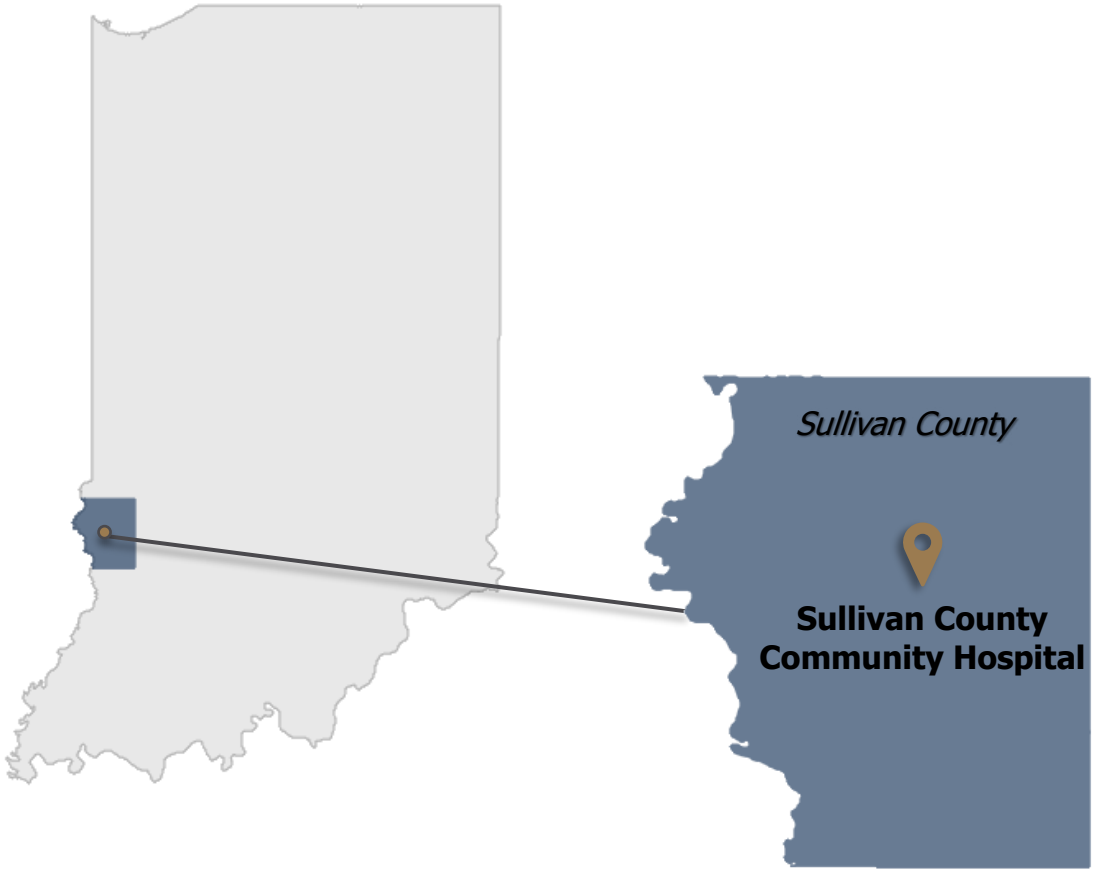
Community Served

For the purpose of this study, the service area is defined as Sullivan County in Indiana. The data presented in this report is based on this county-level service area and compared to state averages. Geographically, SCCH is centrally located in Sullivan County. SCCH is the only hospital in Sullivan County.

Service Area

Sullivan County

Total Population: **20,757**



Source: County Health Rankings 2025 Report, ArcGIS

Service Area Demographics

	Sullivan	Indiana
Demographics		
Total Population	20,757	6,862,199
Age		
Below 18 Years of Age	18.7%	23.1%
Ages 19 to 64	62.1%	59.7%
65 and Older	19.2%	17.2%
Race & Ethnicity		
Non-Hispanic White	91.1%	76.0%
Non-Hispanic Black	5.0%	10.0%
American Indian or Alaska Native	0.4%	0.5%
Asian	0.3%	2.9%
Native Hawaiian or Other Pacific Islander	0.1%	0.1%
Hispanic	2.0%	8.8%
Gender		
Female	45.1%	50.4%
Male	54.9%	49.6%
Geography		
Rural	76.6%	28.8%
Urban*	23.4%	71.2%
Income		
Median Household Income	$59,100	$69,500

*Notes: *Urban is defined by the US Census Bureau as census blocks that encompass at least 5,000 people or at least 2,000 housing units*
Source: County Health Rankings 2025 Report

Methods of Identifying Health Needs

Collect & Analyze

Analyze existing data and collect new data

737 indicators collected from data sources

205 surveys completed by community members

Evaluate

Evaluate indicators based on the following factors:

- Worse than benchmark
- Identified by the community
- Impact on health disparities
- Feasibility of being addressed

Select

Select priority health needs for implementation plan

Prioritizing Significant Health Needs

The survey respondents participated in a structured communication technique called the "Wisdom of Crowds" method. This approach relies on the assumption that the collective wisdom of participants is superior to the opinion of any one individual, regardless of their professional credentials.

In the Hospital's process, each survey respondent had the opportunity to prioritize community health needs. The survey respondents then ranked the importance of addressing each health need on a scale of 1 (not at all) to 5 (extremely), including the opportunity to list additional needs that were not identified.

The ranked needs were divided into "Significant Needs" and "Other Identified Needs." The determination of the breakpoint — "Significant" as opposed to "Other" — was a qualitative interpretation where a reasonable breakpoint in rank order occurred. The Hospital analyzed the health issues that received the most responses and established a plan for addressing them.

Ranked Health Priorities

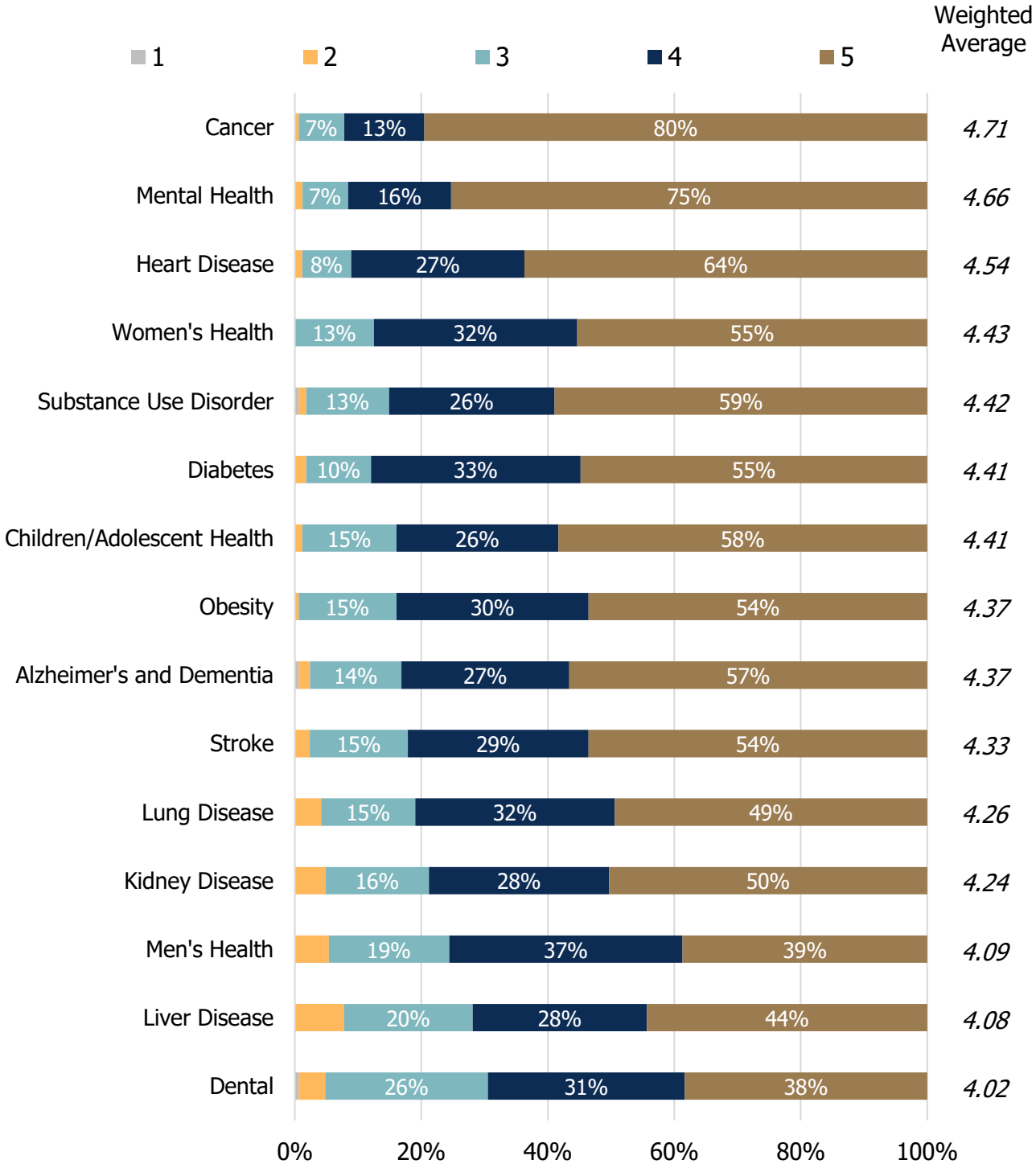
The health priority ranking process included an evaluation of health factors, community factors, and personal factors, given that they each uniquely impact the overall health and health outcomes of a community:

- Health factors include chronic diseases, health conditions, and the physical health of the population.
- Community factors are the social drivers that influence community health and health equity.
- Behavioral factors are the individual actions that affect health outcomes.

In our community survey, each broad factor was broken out into more detailed components, and respondents rated the importance of addressing each component in the community on a scale from 1 to 5. The results of the health priority rankings are outlined below:

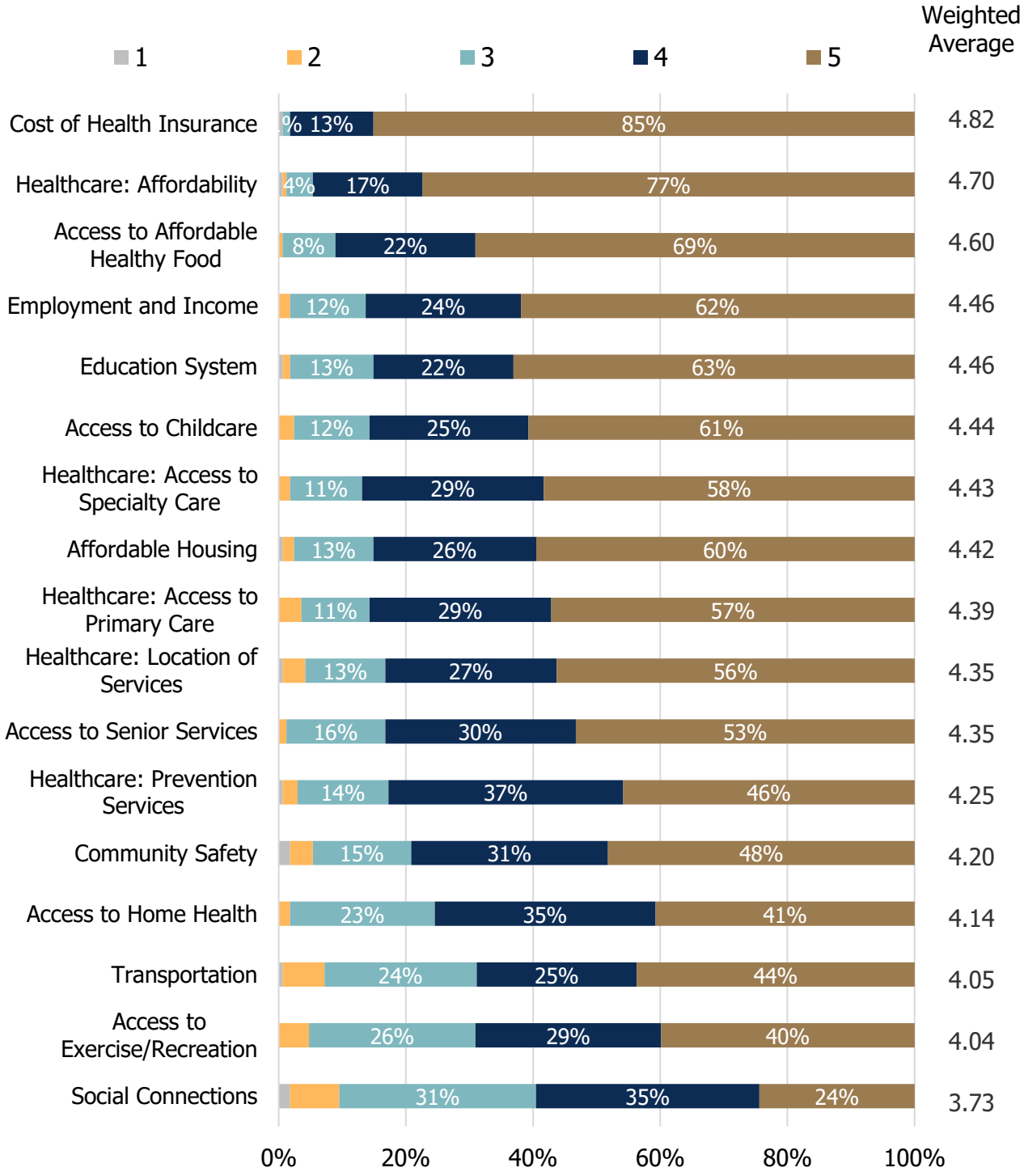
Health Factors

Survey Question: Please rate the importance of addressing each health factor on a scale of 1 (Not at all) to 5 (Extremely).



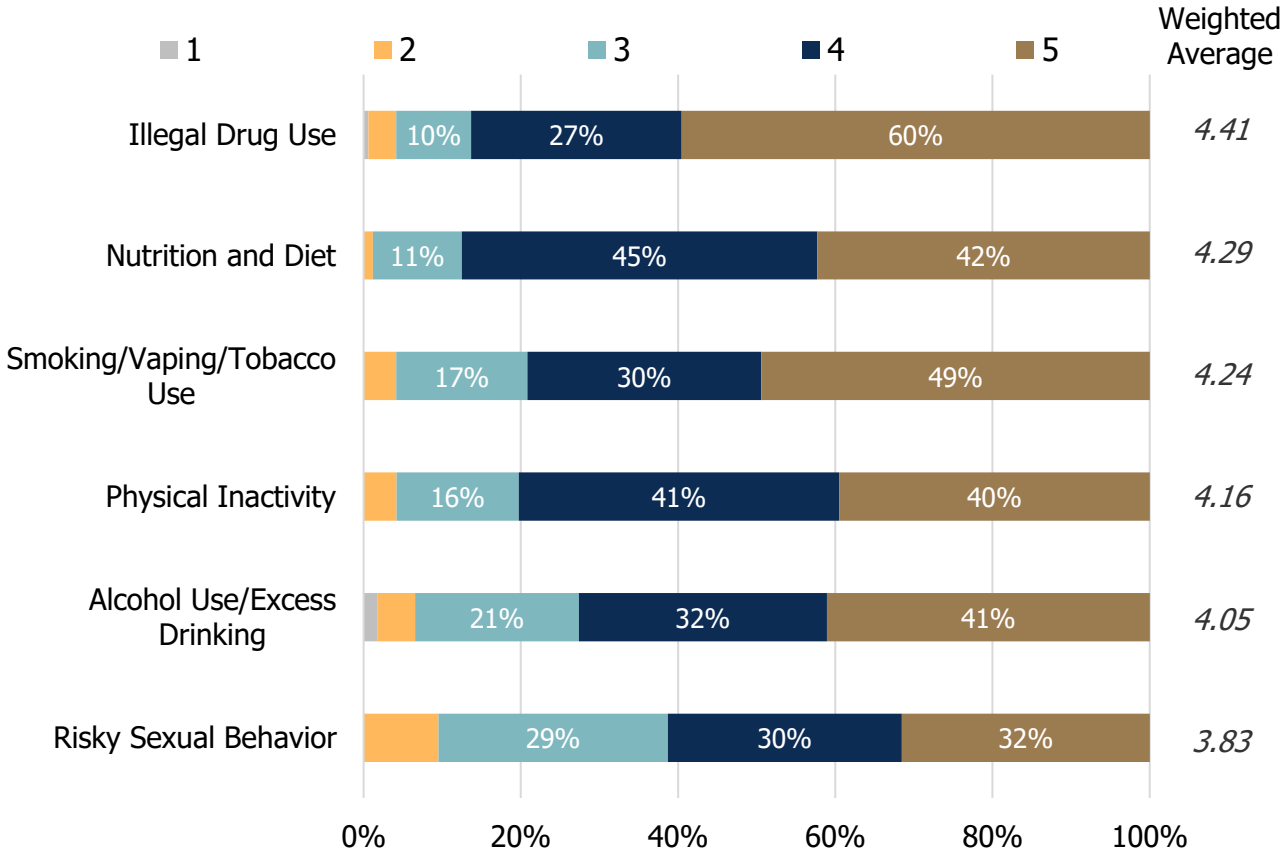
Community Factors

Survey Question: Please rate the importance of addressing each community factor on a scale of 1 (Not at all) to 5 (Extremely).



Behavioral Factors

Survey Question: Please rate the importance of addressing each behavioral factor in your community on a scale of 1 (Not at all) to 5 (Extremely).



Overall Health Priority Ranking (Top 10 Highlighted)

Health Issue	Weighted Average (out of 5)	Combined 4 (Important) and 5 (Extremely Important) Rating
Cost of Health Insurance	4.82	98.2%
Cancer	4.71	92.2%
Healthcare: Affordability	4.70	94.6%
Mental Health	4.66	91.6%
Access to Affordable Healthy Food	4.60	91.1%
Heart Disease	4.54	91.1%
Education System	4.46	85.1%
Employment and Income	4.46	86.3%
Access to Childcare	4.44	85.7%
Women's Health	4.43	87.5%
Healthcare: Access to Specialty Care	4.43	86.9%
Substance Use Disorder	4.42	85.1%
Affordable Housing	4.42	85.1%
Children/Adolescent Health	4.41	83.9%
Diabetes	4.41	88.0%
Illegal Drug Use	4.41	86.3%
Healthcare: Access to Primary Care	4.39	85.7%
Alzheimer's and Dementia	4.37	83.1%
Obesity	4.37	83.9%
Access to Senior Services	4.35	83.2%
Healthcare: Location of Services	4.35	83.2%
Stroke	4.33	82.1%
Nutrition and Diet	4.29	87.5%
Lung Disease	4.26	81.0%
Healthcare: Prevention Services	4.25	82.7%
Kidney Disease	4.24	78.8%
Smoking/Vaping/Tobacco Use	4.24	79.2%
Community Safety	4.20	79.2%
Physical Inactivity	4.16	80.2%
Access to Home Health	4.14	75.5%
Men's Health	4.09	75.6%
Liver Disease	4.08	71.9%
Transportation	4.05	68.9%

Survey Ranking Comparison from 2023 to 2026

Between 2023 and 2026, the community's identified health priorities shifted from a focus around mental health and chronic diseases in 2023 to a greater focus on healthcare affordability in 2026. The 2026 results provide a reliable and positive picture for community engagement due to the increase in survey participation (from 73 to 205 respondents). In 2026, many of the identified health priorities were ranked as more important to be addressed in the community than they were in 2023, particularly as it relates to affordability metrics and mental/behavioral health.

2026 SCCH Survey (n=205)	
Top 10 Health Priorities	Rank
Cost of Health Insurance	*4.82*
Cancer	*4.71*
Healthcare: Affordability	*4.70*
Mental Health	*4.66*
Access to Affordable Healthy Food	*4.60*
Heart Disease	*4.54*
Education System	*4.46*
Employment and Income	*4.46*
Access to Childcare	*4.44*
Women's Health	*4.43*

2023 SCCH Survey (n=73)	
Top 10 Health Priorities	Rank
Heart Disease	*4.63*
Mental Health	*4.61*
Cancer	*4.61*
Drug/Substance Abuse	*4.61*
Diabetes	*4.48*
Healthcare: Affordability	*4.48*
Obesity	*4.40*
Employment	*4.40*
Smoking/Vaping/Tobacco Use	*4.40*
Livable Wage	*4.40*

Community Health Characteristics

This section highlights health status indicators, outcomes, and relevant data on the health needs in Sullivan County. The data at the county level is supplemented with benchmark comparisons to the state data. The most recently available data is used throughout this report with trended data included where available. A scorecard that compares the population health data of the service area county to that of Indiana can be found in the report appendix.

Behavioral Health

Mental Health

Mental health was the #4 community-identified health priority, with 92% of respondents rating it as important to be addressed in the community (important is categorized as a 4 or 5 rating on the community survey). The suicide mortality rate in Sullivan County is 18.9, which is higher than the Indiana average.

While it's difficult to measure the true rate of mental illness in the community, the following data points give insight into the health priority:

	Sullivan	Indiana
Suicide Mortality Rate per 100,000 (2019-2023)	18.9	15.8
Poor Mental Health Days past 30 days (2023)	5.9	5.9
Population per 1 Mental Health Provider (2025)	1,600:1	440:1
Frequent Mental Distress (2023)	20%	19%

Note: "Frequent Mental Distress" indicates percentage of adults reporting 14 or more days of poor mental health per month
Source: NIH: HDPulse, County Health Rankings 2025 Report, PLACES: Local Data for Better Health, America's Health Rankings

Drug, Substance, and Alcohol Use

Sullivan County has a lower drug-related overdose death rate compared to Indiana (16 compared to 38 per 100,000 population, respectively). The prevalence of excessive drinking is slightly higher in Sullivan County than the state average, with alcohol-impaired driving deaths slightly lower than the state of Indiana. However, the adult smoking rate is higher in Sullivan County than the state of Indiana as a whole.

	Sullivan	Indiana
Drug-Related Overdose Deaths per 100,000 (2021-2023)	16.0	38.0
Excessive Drinking (2023)	18%	18%
Alcohol-Impaired Driving Deaths (2019-2023)	17%	19%
Adult Smoking (2023)	20%	18%

Source: CDC National Vital Statistics System, County Health Rankings 2025 Report

Chronic Diseases

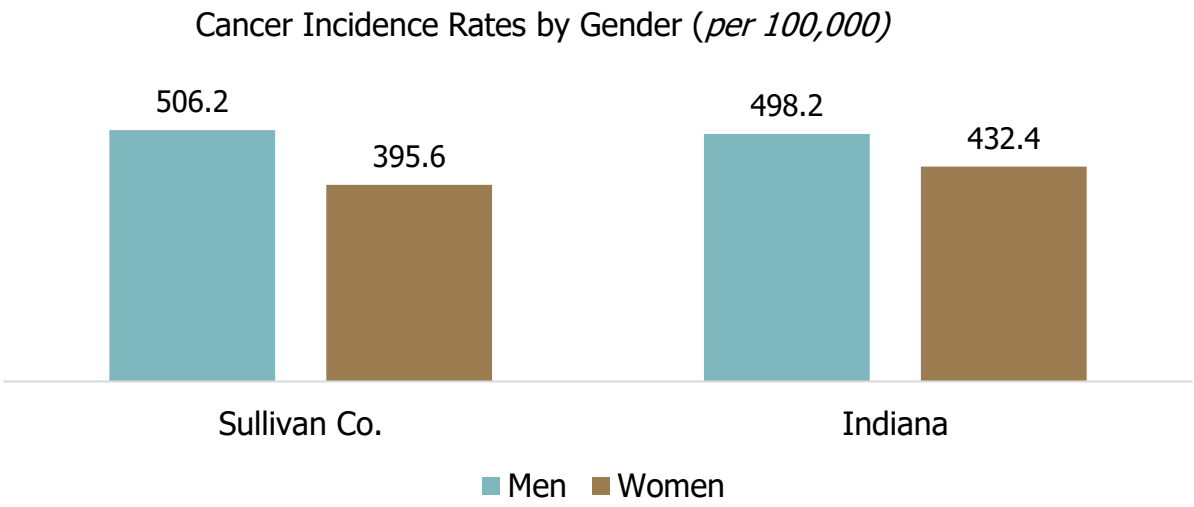
Cancer

Cancer was identified as the #2 community health concern, with 92% of survey respondents rating it as important to address in the community. Cancer is the 2nd leading cause of death in Sullivan County.

When evaluating health disparities across gender, men have higher incidence rates of cancer compared to women in the county and the state. This disparity can be due to a multitude of factors, including behavioral factors like tobacco use and diet, as well as healthcare utilization like preventative care and screening (CDC).

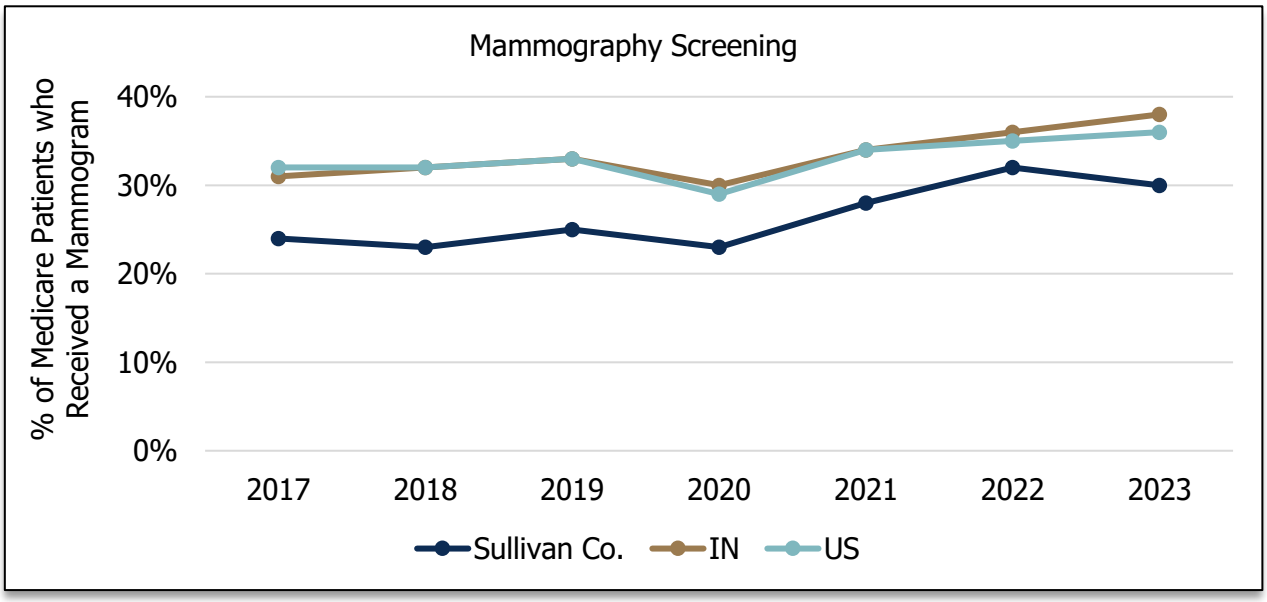
	Sullivan	Indiana
Cancer Incidence Rate Age-Adjusted per 100,000 (2019-2023)	440.9	458.2
Cancer Mortality Rate per 100,000 (2019-2023)	173.4	165.4

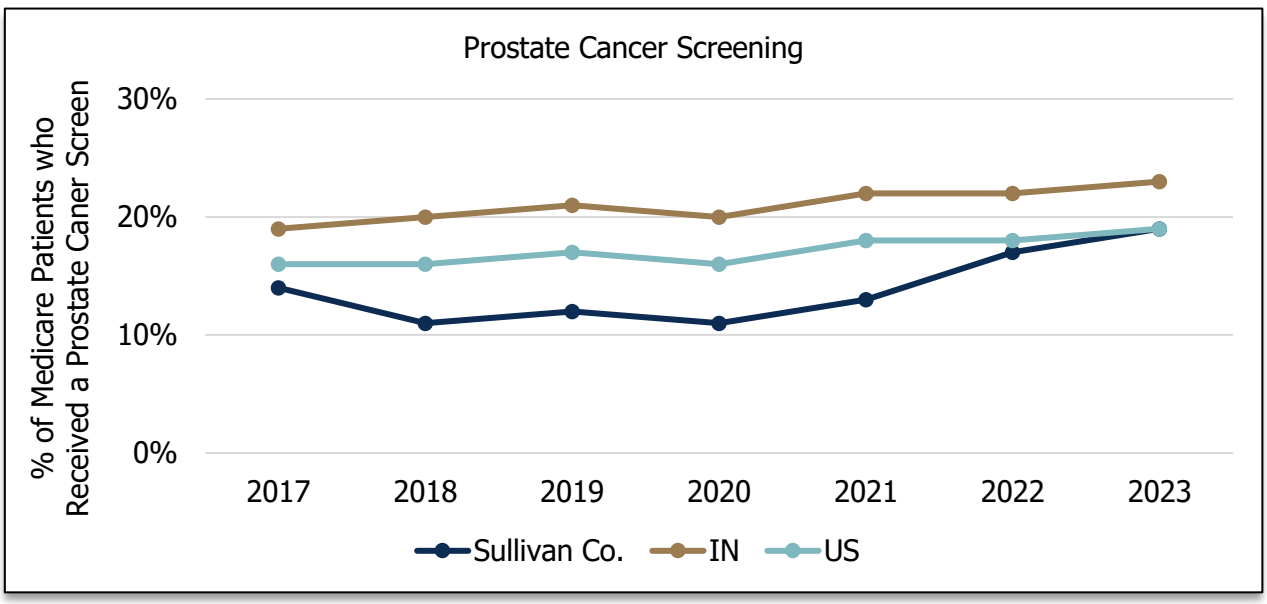
Source: NIH: HDPulse, National Cancer Institute



Source: National Cancer Institute

The rate of Medicare enrollees (women age 65+) who have received a mammogram in the past year is lower in Sullivan County than the state (30% and 38%, respectively). These rates have increased in recent years after a dip downward in 2020 during the COVID-19 pandemic. Among Medicare enrollees (men age 65+), Sullivan County has a lower rate of prostate cancer screening compared to the state (19 and 23%, respectively).





Source: Centers for Medicare & Medicaid Services: Mapping Medicare Disparities by Population

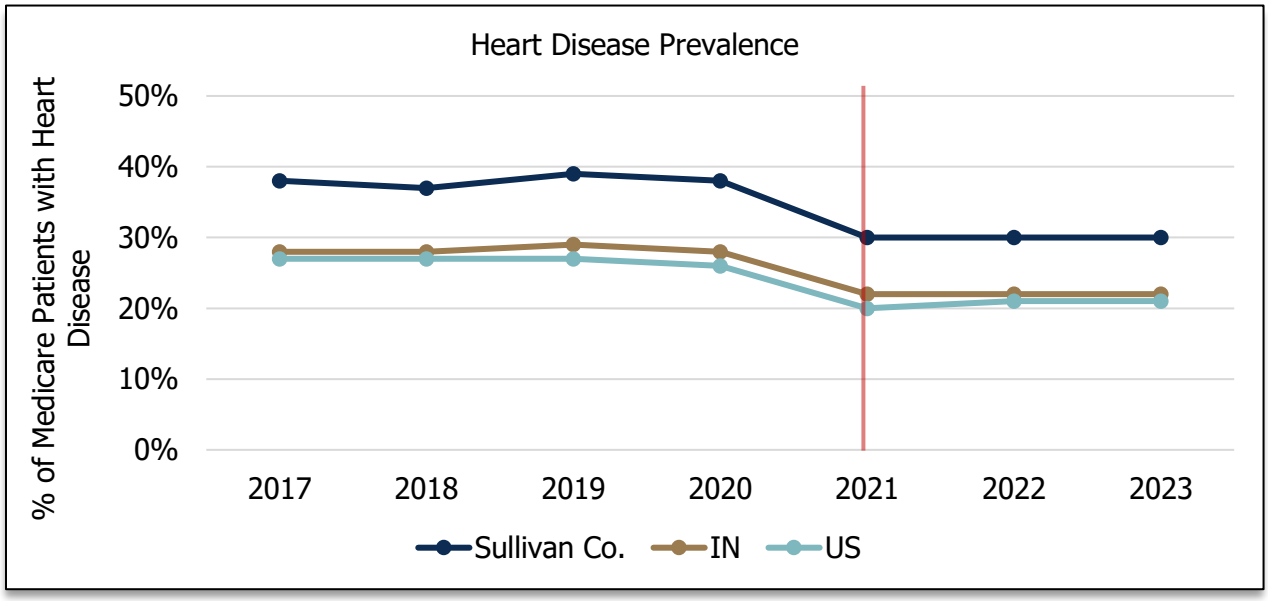
Cardiovascular Health

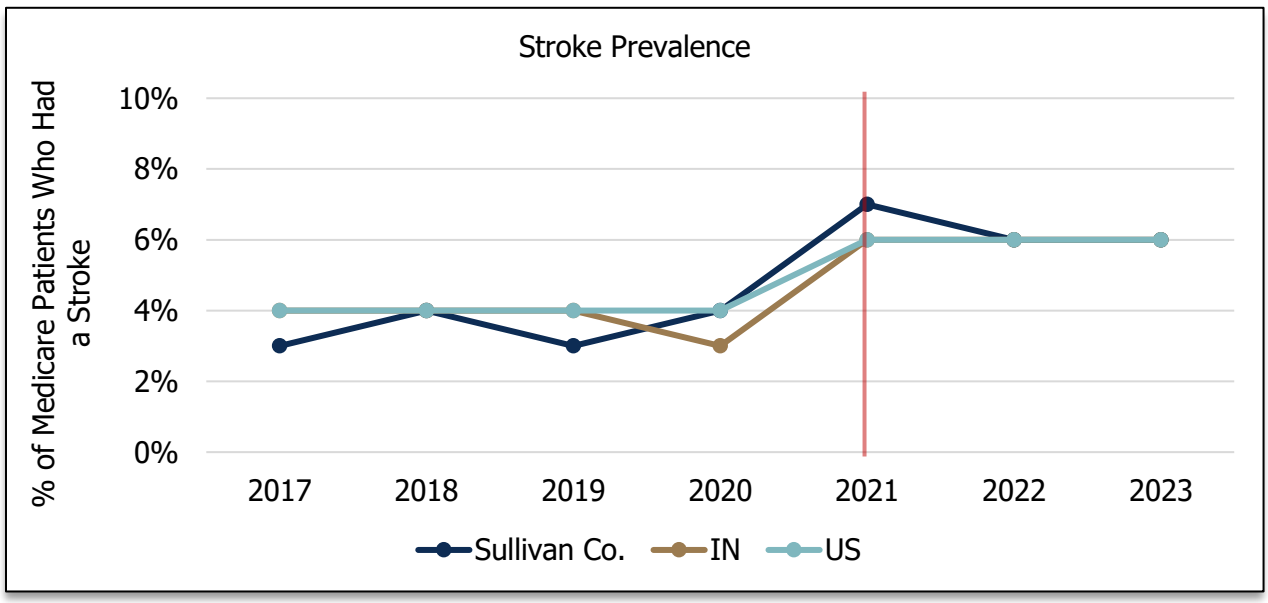
Heart disease is the leading cause of death in Sullivan County, and the county has a higher mortality rate for heart disease, but lower rate for stroke compared to state averages. Looking at risk factors for negative cardiovascular health, Sullivan County has a higher prevalence of high blood pressure compared to the Indiana average.

	Sullivan	Indiana
Heart Disease Mortality Rate per 100,000 (2019-2023)	247.5	186.7
Stroke Mortality Rate per 100,000 (2019-2023)	27.0	42.6
High Blood Pressure (2023)	41.1%	37.6%

Source: NIH: HDPulse, PLACES: Local Data for Better Health, America's Health Rankings

Within the Medicare population, Sullivan County has a higher prevalence of heart disease compared to the state (30% compared to 22%, respectively), and the prevalence of stroke is the same as the state (both 6%).





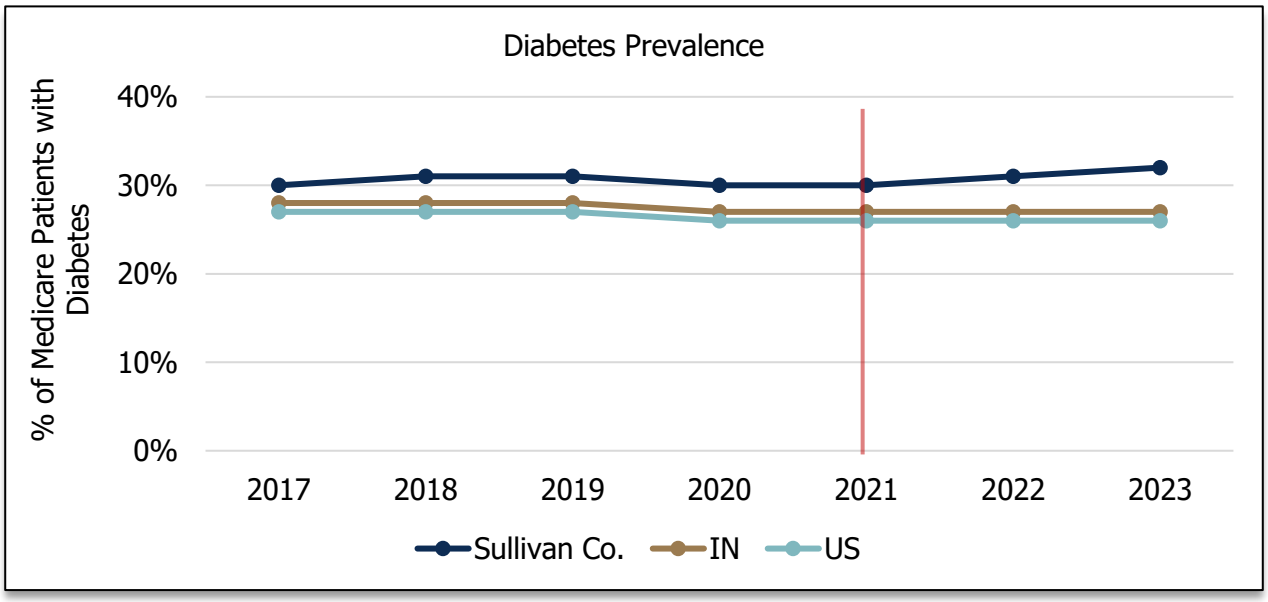
Note: There was a change in the algorithm of reported data in 2021 noted by a red bar.
Source: Centers for Medicare & Medicaid Services: Mapping Medicare Disparities by Population

Diabetes

The prevalence of diabetes in Sulivan County is comparable to the Indiana average, but the county sees a diabetes mortality rate higher than the state's. When evaluating the Medicare population, Sullivan County has a higher prevalence of diabetes compared to the state (32% and 27%, respectively), though rates have remained stable over the past decade.

	Sullivan	Indiana
Diabetes Mortality Rate per 100,000 (2019-2023)	32.5	28.8
Diabetes Prevalence (2023)	12%	11%

Source: NIH: HDPulse, County Health Rankings 2025 Report



Note: There was a change in the algorithm of reported data in 2021 noted by a red bar. Between 2018-2019 and 2021-2023 the State and National data overlap.
Sources: Centers for Medicare & Medicaid Services: Mapping Medicare Disparities by Population

Healthcare Access

Access & Affordability

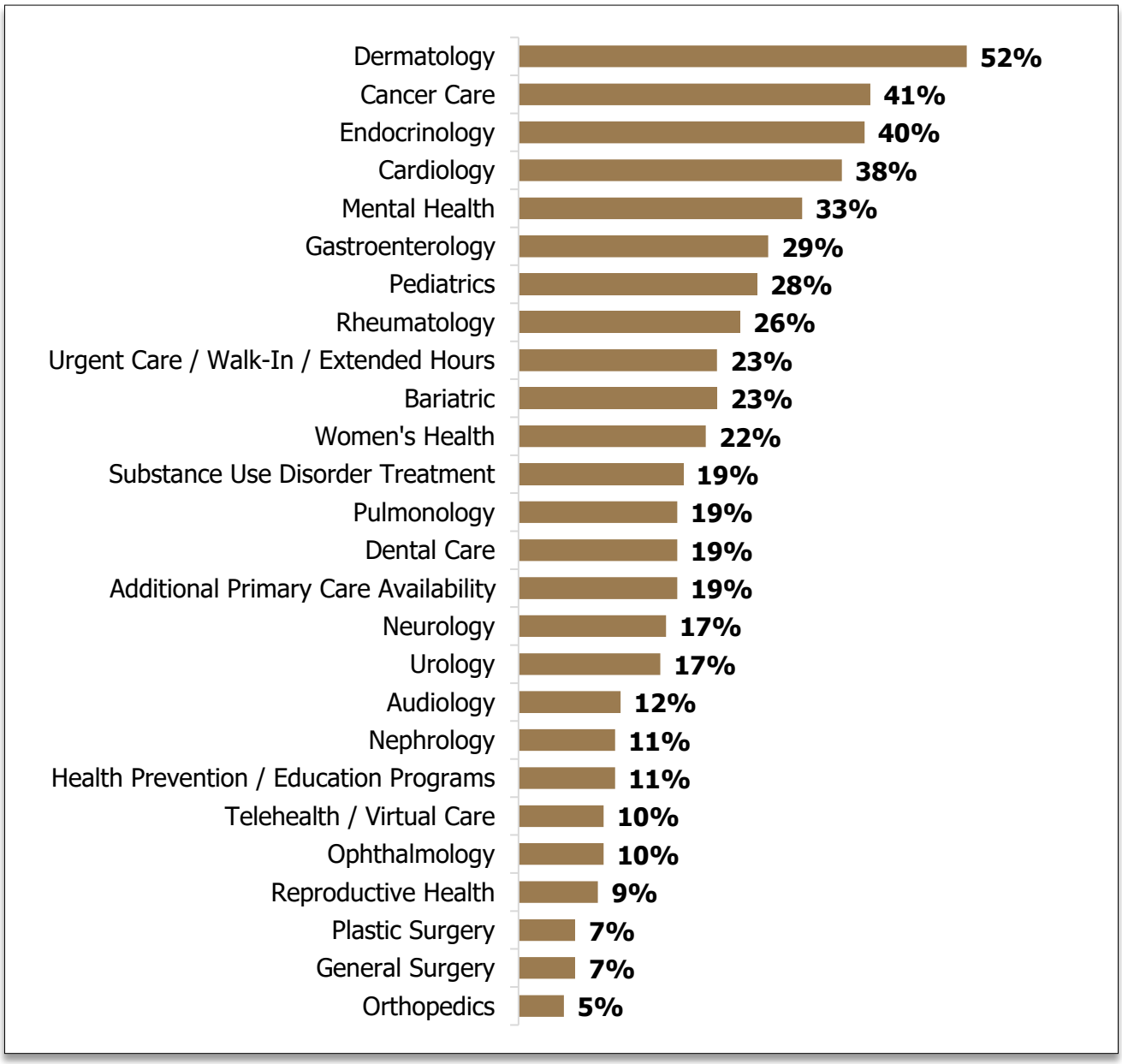
Access to affordable and quality healthcare services is a key driver of improved health outcomes, economic stability, and health equity. In the community survey, 19% of respondents said they would like to see additional primary care availability in the county. Sullivan County has a lower household income than the Indiana average and sees a similar uninsured population as the state. Sullivan County has 1 primary care physician (MD, DO) for every 2,580 residents, which indicates less access to primary care than the state average (1 physician for every 1,510 residents). Similarly, Sullivan County has less access to dental providers compared to Indiana on average.

	Sullivan	Indiana
Uninsured Population (2023)	8%	8%
Population per 1 Primary Care Physician (2022)	2,580:1	1,510:1
Population per 1 Primary Care Provider (APP) (2025)	1,040:1	700:1
Population per 1 Dentist (2023)	4,150:1	1,650:1

Source: County Health Rankings 2025 Report, PLACES: Local Data for Better Health

In the community survey, respondents were asked to identify what healthcare services and programs they would like to see available in their community. Dermatology was the top identified service need, with 52% of respondents saying they would like to see it available in their community, followed by Cancer Care (41%), Endocrinology (40%), Cardiology (38%), and Mental Health (33%)

Survey Question: What additional services/offerings would you like to see available locally? (select all that apply)



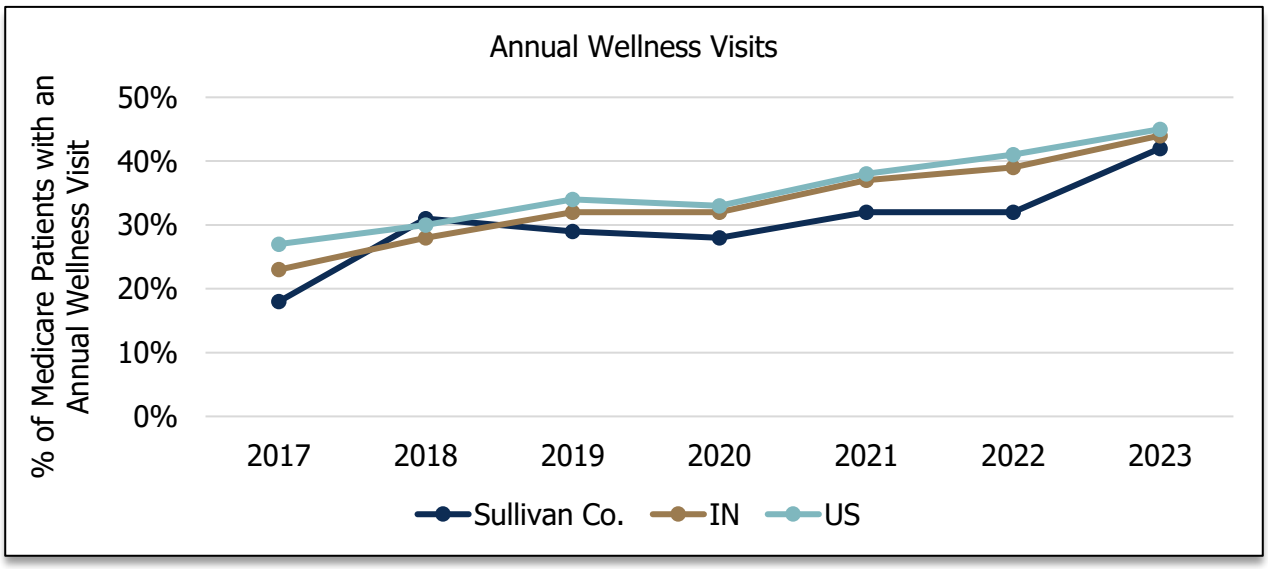
Prevention Services

Prevention services, including routine check-ups, health screenings, and education, can help prevent or detect diseases early when they are easier to treat. Preventive care reduces the burden on healthcare systems by preventing unnecessary hospital stays and costly care. In the community survey, 11% of respondents said they would like to see additional health prevention and education programs available in the community.

Sullivan County has lower flu vaccine adherence rates and lower mammography screening rates than the state. The county also has a higher rate of preventable hospital stays (hospital stays for ambulatory-care sensitive conditions). This rate represents the effectiveness of preventive care in a community, reflecting how well primary care services manage chronic conditions and prevent avoidable hospital admissions. Additionally, the rate of annual wellness visits in the Medicare population is lower in Sullivan County than the Indiana average, with rates increasing in recent years.

	Sullivan	Indiana
Preventable Hospital Stays per 100,000 (2023)	3,666	3,202
Mammography Screening (2023)	39%	49%
Flu Vaccination (2023)	43%	47%

Source: County Health Rankings 2025 Report



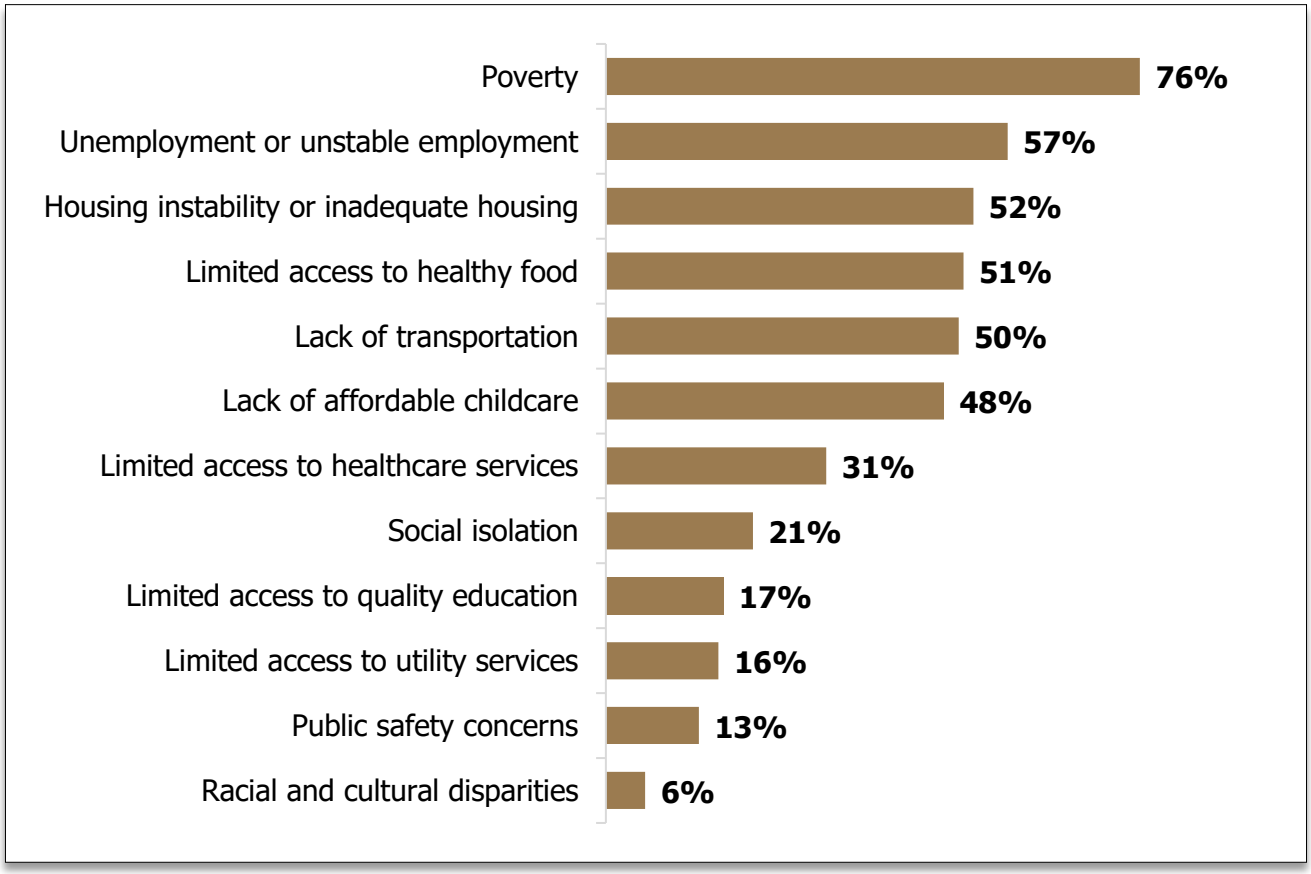
Source: Centers for Medicare & Medicaid Services: Mapping Medicare Disparities by Population

Social Determinants of Health

Social determinants of health, such as economic stability, education, and access to healthcare, significantly influence health outcomes by shaping individuals' living conditions, behaviors, and access to resources necessary for maintaining good health. These factors can lead to health disparities, with marginalized groups often experiencing worse health outcomes due to these determinants (Healthy People 2030).

Survey respondents were asked to identify the key social conditions that negatively impact the community. The top social condition identified was poverty, with 76% of survey respondents reporting it as negatively affecting the community's health, followed by unemployment and housing instability.

Survey Question: Please select the key social determinants that negatively impact the health of you or your community (select all that apply):



Housing

Access to affordable and safe housing influences a wide range of factors that contribute to physical and mental well-being. There is evidence that a lack of access to affordable and stable housing can lead to negative health outcomes such as mental illnesses and stress, exposure to environmental hazards, and financial instability (Center for Housing Policy). A slightly larger percentage of Sullivan County residents experience severe housing problems (overcrowding, high housing costs, lack of plumbing) compared to the state average. Additionally, 9% of Sullivan County residents spend 50% or more of their household income on housing.

	Sullivan	Indiana
Severe Housing Problems (2017-2021)	13%	12%
Severe Housing Cost Burden (2020-2024)	9%	12%
Broadband Access (2020-2024)	83%	90%

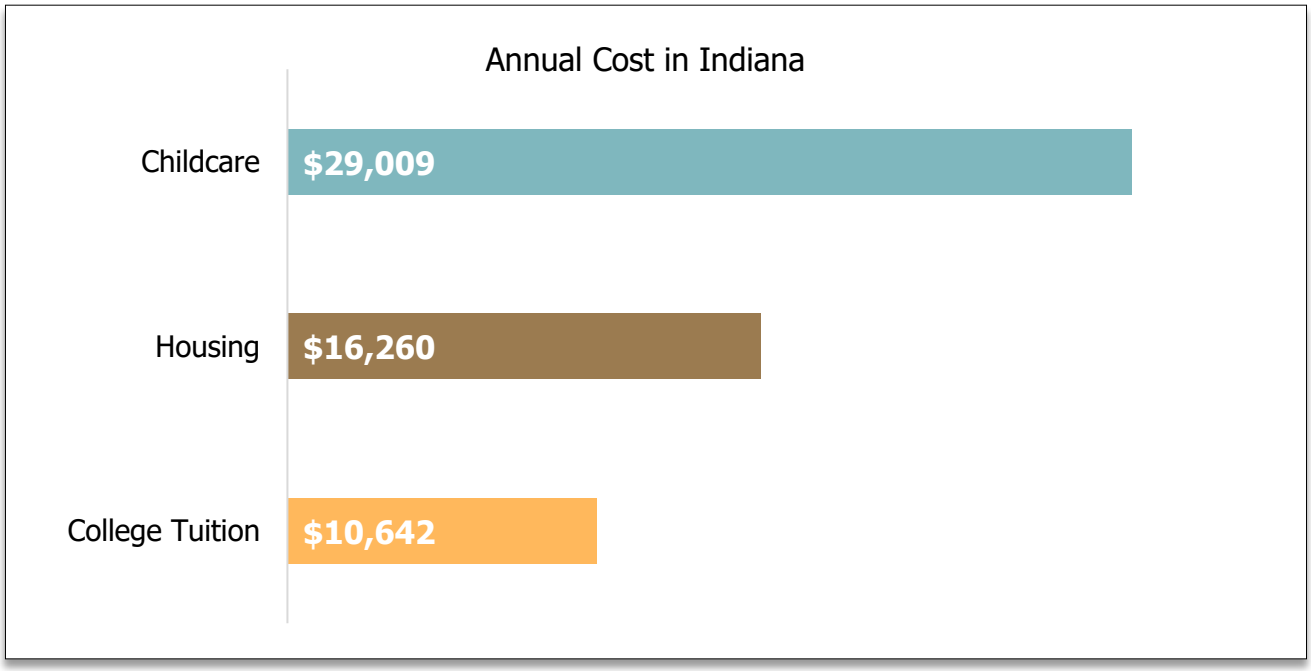
Source: County Health Rankings 2025 Report

Access to Childcare

The average yearly cost of infant care in Indiana is $9,508. The U.S. Department of Health and Human Services defines affordable childcare as being no more than 7% of a family's income (Economic Policy Institute). In Sullivan County, nearly 33% of household income is required for childcare expenses, and there are approximately 2 childcare centers for every 1,000 children under age 5 in the county, compared to 4 in the state.

	Sullivan	Indiana
Children in Single-Parent Households (2019-2023)	27%	24%
Child Care Cost Burden - % of HHI used for childcare (2023-2024)	33%	31%
Child Care Centers per 1,000 Under Age 5 (2010-2022)	2	4

Source: County Health Rankings 2025 Report



Note: Annual childcare price for 2 children (an infant and 4-year-old) in a center
Source: Child Care Aware (2024)

Income, Employment, and Education

Income, employment, and education play a role in the community's ability to afford healthcare and impact health outcomes through health literacy and access to health insurance. Educational attainment and employment impact mental health through poverty and unstable work environments, health behaviors like smoking, diet, and exercise, and access to health insurance (HealthAffairs). Additionally, these factors impact people's ability to afford services to live healthy and happy lives like safe housing, transportation, childcare, and healthy food.

	Sullivan	Indiana
Median Household Income (2023)	$59,100	$69,500
High School Completion (2019-2023)	88%	90%
Some College – Includes Those Who Had and Had Not Attained Degrees (2019-2023)	51%	63%
Unemployment (2024)	4.2%	4.2%
Children in Poverty (2019-2023)	19%	15%

Source: County Health Rankings 2025 Report

Evaluation Process

Worse than Benchmark Measure

Health needs were deemed "worse than the benchmark" if the supported county data was worse than the state and/or U.S. averages

Identified by the Community

Health needs expressed in the online survey and/or mentioned frequently by community members

Feasibility of Being Addressed

Growing health needs where interventions are feasible, and the Hospital could make an impact

Impact on Health Equity

Health needs that disproportionately affect vulnerable populations and can impact health equity if addressed

Health Need Evaluation	Worse than Benchmark	Identified by the Community	Feasibility	Impact on Health Equity
Cost of Health Insurance	✓	✓		✓
Cancer	✓	✓	✓	✓
Healthcare: Affordability	✓	✓	✓	✓
Mental Health	✓	✓	✓	✓
Access to Affordable Healthy Food		✓		✓
Heart Disease	✓	✓	✓	✓
Education System	✓	✓		✓
Employment and Income	✓	✓	✓	✓
Access to Childcare	✓	✓		✓
Women's Health	✓	✓	✓	✓

Implementation Strategy

Health Priority Selection Process

To determine the top health priorities for the community, a structured evaluation and selection process was conducted, where Hospital leaders reviewed both community survey findings and key secondary data indicators, comparing local health outcomes to state benchmarks to identify areas of concern. Each potential priority was assessed based on several criteria: the level of community concern (as reflected in survey responses), whether the issue showed worse-than-average performance compared to the state, the Hospital's capacity and resources to meaningfully address the need, and the alignment with the Hospital's strategic goals.

The top 3 health priorities identified by SCCH with the development of implementation strategies are:

Chronic Disease Management: Improve local management of chronic diseases by expanding access to appropriate care, strengthening prevention and education activities, and enhancing care coordination.

Factors/SDOH impacting need: Cancer, Mental Health, Heart Disease, Diabetes, Substance Use Disorder

Affordability of Healthcare: Reduce financial barriers to receiving necessary healthcare services by increasing access to low-cost care options and providing guidance on health system navigation and coverage options.

Factors/SDOH impacting need: Poverty, unemployment/unstable employment, cost of health insurance, affordable housing, lack of affordable childcare

Access to Healthcare Services: Improve access to care across Sullivan County by expanding service offerings and strengthening coordination with community partners

Factors/SDOH Impacting Need: Healthcare: access to specialty care, transportation, healthcare: location of services, healthcare: access to primary care, access to senior services, access to home health

Health Needs Not Addressed

SCCH acknowledges the significance of all health priorities identified through the community survey and overall assessment. While many of these needs are currently being addressed through existing programs, resources, and strategies led by other community organizations and the Hospital, SCCH has chosen to focus its future efforts on three top-priority areas where it can make the most meaningful impact in line with its strategic goals. By concentrating attention and resources on these key issues, the Hospital aims to strengthen outcomes through targeted programming and strategic collaboration with local partners.

Chronic Disease Management

SCCH Services and Programs Committed to Respond to This Need

- Specialty services: Cardiology, General Surgery, Nephrology, Oncology (intermittent), Orthopedics, Pulmonary, Podiatry, Chronic Pain Management
- Telehealth services in place, including tele-neurology, tele-cardiology, tele-hospitalist
- Mental/Behavioral Health services (through Turning Leaf facility):
    - Child through adult psychiatry
    - Geriatric psychiatry
    - Telehealth offerings
    - Onsite, group, and individualized counseling
    - Emergency referral readiness
    - Community health workers obtained psych certification
- Various screening services offered onsite, including low-dose CT, cardiac calcium scoring, 3D mammography, cervical cancer screening, sleep studies, PSA screening for prostate cancer, and colonoscopies/Cologuard testing
- Robust care coordination program available, including:
    - Access to health navigators and community health workers
    - Annual wellness visits
    - Transitional and chronic care management
    - Perinatal care coordination
    - Health education program
    - Managed care contracting
    - Connections to resources like food, clothing, and medication assistance
- Mammography screening specials in the month of October to promote Breast Cancer Awareness
- Social media, television, radio, and newspaper educational campaigns around chronic disease management
- Smoking cessation education and referral to classes
- Participation in Community Wellness Council
- Employer and community health fairs that include free screenings for BMI, blood pressure, and blood glucose
- Hospital provides free BMI screens, lipid panels, A1C, blood pressure, height & weight, and liver function tests to employees and spouses
- Participation in Silver Sneakers program for seniors
- Free glucometers are provided to newly diagnosed diabetes patients
- Cardio-pulmonary rehab program available to patients who have had a cardiac event or who have all the risk factors for an event
- Contract with Lincare Continuum to provide a 30-day in-home education program for just-released cardiac patients
- Electronic reminders for screening appointments

Chronic Disease Management

- Outpatient infusion services
- Employee wellness challenges to provide support in reaching healthy goals
- Respiratory therapy provides many outpatient services and testing

Goals and Future Actions to Address this Significant Health Need

- Prioritize recruitment of primary care, pulmonology, non-interventional cardiology, and urology providers
- Explore expansion of telehealth offerings in additional specialties/services
- Expand mental health services provided at Turning Leaf to include support groups
- Increase access to home-visits
- Enable audio-only visits where appropriate

Measures of Success for Planned Initiatives

- Recruitment/Access: number of providers recruited, appointment availability/wait times for new appointments across specialties
- Care Coordination: chronic care management referrals and caseload
- Mental/Behavioral Health: referrals to Turning Leaf, billed units, referrals to external partners (Harsha, Hamilton Center)

Other local organizations available to respond to this need

- Hamilton Center: https://www.hamiltoncenter.org/locations/sullivan-county/
- Harsha Behavioral Center (Terre Haute): https://www.harshacenter.com/
- Sullivan County Health Department: https://www.sullivancounty.in.gov/department/index.php?structureid=62
- Salvation Army: https://www.salvationarmyusa.org/usa-central-territory/indiana/sullivan/
- Pace Community Action Agency: https://www.pacecaa.org/sullivan-county
- Thrive West Central: https://thrivewestcentral.com/
- Sullivan County Community Hospital Foundation
- Indiana Geriatrics Society – West Central Chapter: https://www.indianageriatricssociety.org/
- Sullivan County Systems of Care

Affordability of Healthcare

SCCH Services and Programs Committed to Respond to This Need

- Financial Services Center and Financial Assistance Policy, including charity care
- Health insurance navigators available to assist patients of all ages
- Employer clinics for many local industries and employers
- Patients are connected to transportation services when needed
- Service discount opportunities provided, including tax time discounts and prompt pay discounts
- Participation in Back to School Blitz to provide education on resources to local students and parents
- Price estimations provided for services and price transparency available on hospital website
- Payment plans available
- Direct access testing offered at highly reduced rates
- Hospital foundation supports SDoH needs through funding and care coordination
- Breast and Cervical Cancer Program (BCCP) provides funding for breast and cervical cancer screenings services — screening services are contracted through Indiana medical providers and include clinical breast examinations, mammograms, and pap tests for eligible participants, as well as diagnostic testing for participants whose screening outcome is abnormal
- Funds are available through business donations for breast cancer patients who are unable to pay
- Participation in multiple community service programs to address community needs including Meals on Wheels, Brown Baggers, Coats for Kids, Our Father's Arms food pantry, and Casey's Kicks
- In-house pharmacy program for employees and families to get medicines at a deeply discounted rate and increased compliance
- Free echocardiograms offered to Sullivan County student athletes as well as discounted sports physicals
- Free triglyceride tests available to employees and spouses annually
- Part of GPO and contracts to support low-cost delivery and contain costs
- Participation in Connecting Kids to Coverage program assisting eligible children and teens in enrollment in insurance coverage
- Henry Bobe Foundation aids with employee emergencies (up to $800)
- Wellness clinic (Be Healthy) for hospital employees and spouses that include free labs (Lipid Panel, A1C, kidney and liver function) and wellness coaching; providing free membership to the fitness center to all department directors

Affordability of Healthcare

Goals and Future Actions to Address this Significant Health Need

- Explore partnership with on-campus independent dental office (Sullivan Family Dentistry) for free dental/healthcare days
- Host pop-up clinics in underserved communities across Sullivan County and the broader region on a semi-annual/quarterly basis
- Engage with grant-writing organization to secure grants supporting affordability programs
- Include care coordination/insurance navigation services at community events

Measures of Success for Planned Initiatives

- Continued tracking of charity care dollars
- Insurance navigator case loads
- Utilization of Henry Bobe Foundation employee emergency fund
- Donations to SCCH Foundation
- Track Be Healthy Clinic metrics and volumes

Other local organizations available to respond to this need

- West Central Indiana Partnership: https://www.westcentralpartnership.com/
- Thrive West Central: https://thrivewestcentral.com/
- Sullivan County Systems of Care
- Sullivan County Chamber of Commerce: https://sullivancountychamber.com/

Access to Healthcare Services

SCCH Services and Programs Committed to Respond to This Need

- Specialty services: Cardiology, General Surgery, Nephrology, Oncology (intermittent), Orthopedics, Pulmonary, Podiatry, Chronic Pain Management
- Various screening services offered onsite, including low-dose CT, cardiac calcium scoring, 3D mammography, cervical cancer screening, sleep studies, PSA screening for prostate cancer, and colonoscopies/Cologuard testing
- Home visits and telehealth/audio-only visits offered across various specialties (neurology, cardiology, hospitalist, care coordination)
- Addition of Health Annex clinic in 2025 with two family medicine physicians, one of whom also specializes in obstetrics
- Partnership with Thrive West Central for patient transportation support
- SCCH offers walk-in access through the Quick Care and Ortho Walk-In Clinic
- Patient Family Advisory Committee meets regularly to identify health needs and brainstorm solutions
- Collaboration with county health department for immunizations and screenings
- SCCH Dugger Clinic opening planned for May 2026; eliminating need for Dugger residents to leave town for routine services
- Added retinal detachment surgery onsite at SCCH

Goals and Future Actions to Address this Significant Health Need

- Recruit additional providers, including additional primary care, non-interventional cardiology, urology, and pulmonology
- Complete hospital modernization project to optimize and expand facility space
- Continue to explore grant opportunities for access-oriented programs and initiatives

Measures of Success for Planned Initiatives

- Number of providers recruited; availability of appointments for primary and specialty services
- Number of grants/grant dollars secured
- Care coordination caseload and referrals
- Referrals to Turning Leaf (mental/behavioral health access measure)
- Volume growth in surgical specialties, women’s health/OB

Access to Healthcare Services

Other local organizations available to respond to this need

- Sullivan County Health Department: https://www.sullivancounty.in.gov/department/index.php?structureid=62
- Salvation Army: https://www.salvationarmyusa.org/usa-central-territory/indiana/sullivan/
- Thrive West Central: https://thrivewestcentral.com/
- Greene County Health: http://www.gc-health.org/
- Valley Professionals: https://valleyprohealth.org/
- Sullivan County Systems of Care

Appendix

Community Data Tables

Leading Cause of Death

The Leading Causes of Death are determined by the official Centers for Disease Control and Prevention (CDC) final death total. The Leading Causes of Death are listed in the tables below in U.S. rank order. Sullivan County's mortality rates are compared to the Indiana state average, and whether the death rate was notably higher (red), or lower (green) compared to the state average.

	Sullivan	Indiana	U.S.
Heart Disease	247.5	186.7	168.9
Cancer	173.4	165.4	145.4
Chronic Lower Respiratory Disease	59.9	53.9	35.9
Accidents	51.3	67.3	59.7
Diabetes	32.5	28.8	23.9
Alzheimer's	28.2	31.0	30.8
Cerebrovascular Diseases (Stroke)	27.0	42.6	39.8
Kidney	19.1	18.0	13.4
Liver	19.0	13.9	13.1
Suicide	18.9	15.8	13.9
Blood Poisoning (Septicemia)	12.3	12.0	10
Pneumonia	N/A	9.7	10.7
Homicide	N/A	8.9	7.6

Source: NIH: HDPulse, CDC (2019-2023)

County Health Rankings

	Sullivan	Indiana	US Overall
Length of Life			
Premature Death*	**9,000**	9,500	8,100
Life Expectancy*	**76**	76	78
Quality of Life			
Poor or Fair Health	**23%**	21%	20%
Poor Physical Health Days	**4.8**	4.6	4.5
Poor Mental Health Days	**5.9**	5.9	5.7
Low Birthweight*	**8%**	8%	8%
Health Behaviors			
Adult Smoking	**20%**	18%	16%
Adult Obesity	**43%**	40%	38%
Limited Access to Healthy Foods	**5%**	9%	6%
Physical Inactivity	**27%**	26%	27%
Access to Exercise Opportunities	**33%**	76%	84%
Excessive Drinking	**18%**	18%	19%
Alcohol-Impaired Driving Deaths	**17%**	19%	26%
Drug Overdose Deaths*	**16**	38	32
Sexually Transmitted Infections*	**246**	491	492
Teen Births *(per 1,000 females ages 15-19)*	**30**	18	15
Clinical Care			
Uninsured	**8%**	8%	9%
Primary Care Physicians (MDs & DOs)	**2580:1**	1510:1	1310:1
Other Primary Care Providers (APPs)	**1040:1**	700:1	680:1
Dentists	**4150:1**	1650:1	1340:1
Mental Health Providers	**1600:1**	440:1	290:1
Preventable Hospital Stays*	**3,666**	3,202	2,769
Mammography Screening	**39%**	49%	46%
Flu Vaccinations	**43%**	47%	44%
Social & Economic Factors			
High School Completion	**88%**	90%	89%
Some College	**51%**	63%	68%
Unemployment	**4%**	4%	4.0%
Children in Poverty	**19%**	15%	16%
Children in Single-Parent Households	**27%**	24%	25%
Injury Deaths*	**81**	96	87
Child Care Cost Burden *(% of HHI used for childcare)*	**33%**	31%	28%
Child Care Centers *(per 1,000 under age 5)*	**2**	4	7
Physical Environment			
Severe Housing Problems	**13%**	12%	17%
Long Commute - Driving Alone *(> 30 min. commute)*	**36%**	32%	37%
Severe Housing Cost Burden *(50% or more of HHI)*	**9%**	12%	15%
Broadband Access	**83%**	90%	91%

Key (Legend)

Better than IN | Same as IN | Worse than IN

Source: County Health Rankings 2025 Report

Data and Inputs

Data Limitations

Rural communities and those with low population sizes face several data limitations including but not limited to:

- Small sample sizes: small populations reduce the statistical power and do not capture the full diversity of the community
- Data privacy: to ensure the confidentiality of individuals in small communities, data may be aggregated or withheld
- Data gaps: some events may happen less frequently in small populations leading to limited data and gaps in time
- Resource constraints: rural areas often have less funding for data collection and access to data collection technologies
- Underrepresentation in national surveys: many national level data sources focus on urban areas due to the higher population making access to data in small communities more limited

This assessment is meant to capture the health status of the service area at a specific point in time, combining both qualitative data from the local community through survey collection and quantitative data from multiple sources where the county is available as the smallest unit of analysis.

Local Expert Groups

Survey Respondents self-identify themselves into any of the following representative classifications:

1) Public Health Official – Persons with special knowledge of or expertise in public health
2) Government Employee or Representative – Federal, tribal, regional, State, or local health or other departments or agencies, with current data or other information relevant to the health needs of the community served by the Hospital
3) Chronic Disease Groups – Representative of or member of Chronic Disease Group or Organization, including mental and oral health
4) Community Resident – Individuals, volunteers, civic leaders, medical personnel, and others to fulfill the spirit of broad input required by the federal regulations
5) Priority Population – Persons who identify as medically underserved, low-income, racial and ethnic minority, rural resident, or LGBTQ+
6) Healthcare Professional – Individuals who provide healthcare services or work in the healthcare field with an understanding / education on health services and needs.
7) Other (please specify)

Data Sources

Source	Data Element	Date Accessed	Data Date
County Health Rankings 2025 Report	Assessment of health needs of the county compared to all counties in the state; County demographic data	February 2026	2014-2023
NIH: HDPulse – CDC	Leading causes of death, median household income	March 2026	2019-2023
PLACES: Local Data for Better Health	County level health, socioeconomic, and environmental data	February 2026	2024
America's Health Rankings	National and State level data for health, environmental, and socioeconomic measures	February 2026	2022
American Community Survey, US Census Bureau	Social, economic, housing, and demographic information for States	February 2026	2024
NIH National Cancer Institute	State cancer profiles; incidence rates	March 2026	2019-2023
Centers for Medicare & Medicaid Services: Mapping Medicare Disparities by Population	Health outcome measures and disparities in chronic diseases	March 2026	2023
American Diabetes Association	Type 2 diabetes risk factors	February 2026	2005
Centers for Disease Control and Prevention – CDC	Racial and ethnic disparities in heart disease	March 2025	2019
Healthy People 2030 – OASH	Social Determinants of Health	March 2026	n.d.
Center for Housing Policy	Impacts of affordable housing on health	February 2026	2015
Child Care Aware	Childcare costs	March 2026	2024
Health Affairs: Leigh, Du	Effects of low wages on health	February 2025	2022

Survey Results

Based on 205 survey responses gathered in February 2026.

Due to a high volume of survey responses, not all comments are provided in this report. All included comments are unedited and are contained in this report in the format they were received.

Q1: Your role in the community (select all that apply)

Answer Choices	Responses	
Community Resident	79.6%	160
Healthcare Professional	33.8%	68
Government Employee or Representative	7.0%	14
Priority Population	4.5%	9
Public Health Official	0.5%	1
Representative of Chronic Disease Group	0.5%	1
	Answered	201
	Skipped	4

Q2: Race/ethnicity (select all that apply)

Answer Choices	Responses	
White or Caucasian	99.5%	204
American Indian or Alaska Native	0.5%	1
Black or African American	0.0%	0
Hispanic or Latino	0.0%	0
Asian or Asian American	0.0%	0
Native Hawaiian or other Pacific Islander	0.0%	0
Prefer not to answer	0.0%	0
Other (please specify)	0.0%	0
	Answered	205
	Skipped	0

Q3: Age group

Answer Choices	Responses	
18-24	1.5%	3
25-34	13.2%	27
35-44	25.9%	53
45-54	22.9%	47
55-64	25.9%	53
65+	10.2%	21
Prefer not to answer	0.5%	1
	Answered	205
	Skipped	0

Q4: What ZIP code do you primarily live in?

Answer Choices		Responses	
47882	Sullivan, Indiana	51.0%	104
47879	Shelburn, Indiana	8.8%	18
47838	Jasonville, Indiana	7.4%	15
47441	Linton, Indiana	5.9%	12
47438	Bloomfield, Indiana	4.4%	9
47848	Carlisle, Indiana	4.4%	9
47861	Merom, Indiana	2.9%	6
47850	Dugger, Indiana	2.9%	6
47855	Hymera, Indiana	2.0%	4
47849	Farmersburg, Indiana	2.0%	4
All Others (3 or Less Responses Each)		8.3%	17
		Answered	204
		Skipped	1

Q5: Which groups would you consider to have the greatest health needs (rates of illness, trouble accessing healthcare, etc.) in your community? (please select your top 3 responses)

Answer Choices	Responses	
Low-income groups	63.9%	124
Older adults	53.1%	103
Uninsured and underinsured individuals	53.1%	103
Individuals requiring additional healthcare support	37.1%	72
Residents of rural areas	33.0%	64
Children/Adolescents	22.2%	43
Women	21.1%	41
Racial and ethnic minority groups	7.7%	15
LGBTQ+	4.6%	9
Men	3.1%	6
	Answered	194
	Skipped	11

What do you believe to be some of the specific needs of the groups selected above?

- Specifically with children/adolescents, potential opportunities to identify bone/joint or other issues that aren't found during a physical.
- Low income folks struggle with transportation and uninsured go without care.
- Pediatrician in the county would be great. Available transportation for older adults and rural areas.
- I believe that in our area the underinsured seeks less medical help. This group need d to be addressed so that illnesses can be caught at an earlier rate.
- Mental Health needs: Especially children. Uninsured people of all ages not getting the care they need for fear of inability to pay.
- Lack of transportation. Lack of funds to pay for services.
- Not really sure.....often I think people are reluctant to seek medical attention because of co-pays and/or deductibles that they have to pay. And I think some people don't use medical services because they have HSA's that their employers give to them if unused.
- I have a hard time finding AFFORDABLE heath care. I have insurance but my insurance doesn't cover the local doctors for women's needs.
- Not everyone has the luxury of family or friend as a health care advocate. This system is tough to navigate.
- OB care since local hospital unit is closing their operations, currently no outstanding pediatric physicians in our area, and personally, underinsured and not seeking healthcare due to expense-my deductible is ridiculous making it useless to even have health insurance
- Providers listening to the symptoms of those individuals who have serious issues and concerns.
- Transportation is an issue for a large number of residents.

- Older adults don't always have support to get to appointments or not get confused about health issues. Correctly taking meds etc. No insurance has kept me from seeking medical care for years at a time. I was low income and could not self pay.
- With the distinct possibility that many in the community will lose Medicaid and the benefits of the ACA. They will need a place to go for Healthcare. If they don't have that place their health will face dire consequences.
- I feel we need more assistance for under and uninsured to get prescriptions filled . I feel more people go without medications making their over all health worse.
- Older people need an advocate no one listens and everyone in a rush. I think most older people die due to healthcare not being easy to navigate
- Healthcare is too expensive, by the time they pay the monthly fee their deductible are insurmountable. A subscription health care plan would be ideal for this area.

Q6: Social drivers of health (SDoH) are conditions in the environments in which people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes. Please select the key social drivers that negatively impact the health of you or your community (select all that apply):

Answer Choices	Responses	
Poverty	76%	109
Unemployment or unstable employment	57%	82
Housing instability or inadequate housing	52%	75
Limited access to healthy food	51%	73
Lack of transportation	50%	72
Lack of affordable childcare	48%	69
Limited access to healthcare services	31%	45
Social isolation	21%	30
Limited access to quality education	17%	24
Limited access to utility services	16%	23
Public safety concerns	13%	19
Racial and cultural disparities	6%	8
Other (please specify)	2.8%	4
	Answered	143
	Skipped	62

Comments:

- Education on prevention, more health care rather than sick care. Functional Medicine, find the why behind the illness for each individual.
- Being able to afford to further our education
- High paying jobs
- Drugs

Q7: Please rate the importance of addressing each health factor on a scale of 1 (Not at all) to 5 (Extremely)

	1	2	3	4	5	Total	Weighted Average
Cancer	0	1	12	21	132	166	4.71
Mental Health	0	2	12	27	125	166	4.66
Heart Disease	0	2	13	46	107	168	4.54
Women's Health	0	0	21	54	93	168	4.43
Substance Use Disorder	1	2	22	44	99	168	4.42
Children/Adolescent Health	0	2	25	43	98	168	4.41
Diabetes	0	3	17	55	91	166	4.41
Alzheimer's and Dementia	1	3	24	44	94	166	4.37
Obesity	0	1	26	51	90	168	4.37
Stroke	0	4	26	48	90	168	4.33
Lung Disease	0	7	25	53	83	168	4.26
Kidney Disease	0	8	27	47	83	165	4.24
Men's Health	0	9	32	62	65	168	4.09
Liver Disease	0	13	34	46	74	167	4.08
Dental	1	7	43	52	64	167	4.02
Other (please specify)						3	
						Answered	168
						Skipped	37

Other:

- Chronic illnesses
- Pediatric mental health
- Elder care services, transitional care

Q8: Please rate the importance of addressing each community factor on a scale of 1 (Not at all) to 5 (Extremely)

	1	2	3	4	5	Total	Weighted Average
Cost of Health Insurance	1	0	2	22	143	168	4.82
Healthcare: Affordability	1	1	7	29	130	168	4.70
Access to Affordable Healthy Food	0	1	14	37	116	168	4.60
Education System	1	2	22	37	106	168	4.46
Employment and Income	0	3	20	41	104	168	4.46
Access to Childcare	0	4	20	42	102	168	4.44
Healthcare: Access to Specialty Care	0	3	19	48	98	168	4.43
Affordable Housing	1	3	21	43	100	168	4.42
Healthcare: Access to Primary Care	0	6	18	48	96	168	4.39
Access to Senior Services	0	2	26	50	89	167	4.35
Healthcare: Location of Services	1	6	21	45	94	167	4.35
Healthcare: Prevention Services	1	4	24	62	77	168	4.25
Community Safety	3	6	26	52	81	168	4.20
Access to Home Health	0	3	38	58	68	167	4.14
Transportation	1	11	40	42	73	167	4.05
Access to Exercise/Recreation	0	8	44	49	67	168	4.04
Social Connections	3	13	52	59	41	168	3.73
Other (please specify)						2	
						Answered Skipped	168 37

Other:

- Trade programs for low-income individuals
- Absolutely a need so many people request this

Q9: Please rate the importance of addressing each behavioral factor in your community on a scale of 1 (Not at all) to 5 (Extremely)

	1	2	3	4	5	Total	Weighted Average
Illegal Drug Use	1	6	16	45	100	168	4.41
Nutrition and Diet	0	2	19	76	71	168	4.29
Smoking/Vaping/Tobacco Use	0	7	28	50	83	168	4.24
Physical Inactivity	0	7	26	68	66	167	4.16
Alcohol Use/Excess Drinking	3	8	35	53	69	168	4.05
Risky Sexual Behavior	0	16	49	50	53	168	3.83
Other (please specify)						1	
						Answered Skipped	168 37

Other:

- Mental Health

Q10: Please provide feedback on any actions you've seen taken by Sullivan County Community Hospital to address the significant health needs in your community and what additional actions you would like to see.

- I appreciate the addition of more doctors & specialty clinics that sCCH is offering. I believe a pediatrician and cardiologists would be a great addition.
- Attempted a clinic for addiction (drug/substance abuse) but it failed. Most addicts are uninsured. We need something to help with mental health, especially our children.
- Very happy to see the increase in family practice doctors in our local area. The hospital has done a great job of bringing new services to the area ie. total joint surgery, dedicated eye surgeons.
- PR does a great job with Community involvement to educate about personal healthcare and services we offer. Offer more in school education. Send our staff into the schools to teach hygiene, dental, sex education. Start with basics in elementary and progress to more health issues that are advanced like heart lung kidney diseases and the risk factors that alcohol and drugs impact each system. Education from beyond the daily things teachers are doing.
- I think Turning Leaf should be awarded for all the hardworking they do. The Hamilton Center is literally a joke compared to Turning Leaf. I think that Turning Leaf is a huge asset to our community and addressing not only mental health needs but also factors like drug abuse and those listed previously.
- SCCH has increased providers for mental health as well as extending their services to younger children.
- I think SCCH does a fantastic job at promoting education for varying healthcare topics. They offer free classes for many of the diseases we see in our community. They started having the physicians go out into the community doing different lunch and learns/education. This is outstanding
- Several clinics that allow walk in so appointments and preplanning are not needed. I have not great ideas to support these areas.
- SCCH has brought in new doctors in family medicine and obstetrics. They also offer several specialties who are here once a week.
- They have diabetes classes at the hospital. Added more mental health services. Made things available to the community.
- I love that we offer the CT calcium scoring. I wish the heart disease and DM classes were offered more and more PCP providers offered/recommended these to patients for better buy in on the importance. Would love to see the fit days be more community events and not just hospital staff events
- They continue to add outpatient and specialty services. More specialty surgeries close to home.
- I haven't experienced any significant progress by SCCH in any of the above areas… especially in affordable care.
- We have a great hospital for the size of our community. They have specialty clinics which help for transportation of patients. The community has a bad drug problem which needs more help

- ACO has helped a lot of people with buying groceries and medications. They provide a lot of good information for resources those in the community can use. The fitness center is a great resource for the community. A childcare center for employees and those working in the comm would be helpful. Continued specialized training for therapists techniques would be beneficial to the community.
- Expanded access to mental health services by opening mental health counseling service line (children through adult). Offer up front estimates, prompt pay discounts, self-pay discounts, and write offs. Actively work on quality measure improvement for preventative services as well as Hgb A12 monitoring. Offer calcium scoring and lung cancer screens through Radiology Department.
- Continues to add primary care providers, has Behavioral Health for all ages, actively pursues other service lines

Q13: What additional services / offerings would you like to see available locally? (select all that apply)

Answer Choices	Responses	
Dermatology	52.3%	79
Cancer Care	41.1%	62
Endocrinology	40.4%	61
Cardiology	37.8%	57
Mental Health	33.1%	50
Gastroenterology	29.1%	44
Pediatrics	27.8%	42
Rheumatology	25.8%	39
Bariatric	23.2%	35
Urgent Care / Walk-In / Extended Hours	23.2%	35
Women's Health	21.9%	33
Substance Use Disorder Treatment	19.2%	29
Additional Primary Care Availability	18.5%	28
Dental Care	18.5%	28
Pulmonology	18.5%	28
Neurology	17.2%	26
Urology	16.6%	25
Audiology	11.9%	18
Health Prevention / Education Programs	11.3%	17
Nephrology	11.3%	17
Ophthalmology	9.9%	15
Telehealth / Virtual Care	9.9%	15
Reproductive Health	9.3%	14
General Surgery	6.6%	10
Plastic Surgery	6.6%	10
Orthopedics	5.3%	8
Other (please specify)		5
	Answered	151
	Skipped	54

Comments

- Childcare
- Functional Medicine Provider
- Access to free/affordable Wi-Fi and free breakfast and lunch in schools
- ENT
- None, there is access to all that

Q13: Where do you typically get most of your health information (advice about managing health conditions, wellness tips, information about treatment options, recommendations for preventive care)? (select all that apply)

Answer Choices	Responses	
Doctor/Healthcare Provider	84.7%	127
Websites/Internet (Google, WebMD, Mayo Clinic)	38.7%	58
Hospital or Clinic	36.7%	55
Family or Friends	34.0%	51
Word of Mouth	21.3%	32
Social Media (Facebook, Twitter, Instagram, TikTok)	19.3%	29
Workplace	17.3%	26
Public Health Agencies (Local Health Department, CDC, etc.)	14.7%	22
AI Platform (ChatGPT)	13.3%	20
Newspaper/Magazine (Online Publications)	10.0%	15
Other (please specify)		5
	Answered	150
	Skipped	55

Comments:

- Social media
- Chiropractor
- Medical journals
- Follow physicians on different platforms