MERCYHEALTH

2022 Community Health Needs Assessment – Implementation Plan

Mercy Health- Marcum and Wallace Hospital

2023 – 2025 Community Health Needs Assessment – Implementation Plan

Mercy Health – Marcum and Wallace Hospital

Adopted by the Marcum and Wallace Hospital Board of Trustees, April 24, 2023

Mercy Health- Marcum and Wallace Hospital

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Mercy Health CHIP Short Link: Bit.ly/MercyChip

Mercy Health has been committed to the communities it serves for nearly two centuries. This long-standing commitment has evolved intentionally, based on our communities' most pressing health needs.

The following document is a detailed Community Health Improvement Implementation Plan for Mercy Health- Marcum and Wallace Hospital. As a system, Mercy Health is dedicated to our Mission of extending the compassionate ministry of Jesus by improving the health and well-being of our communities and bringing good help to those in need, especially people who are poor, dying and underserved. We strive to create effective strategies to meet the health needs of our community.

Having identified the greatest needs in our community, the Community Health Improvement Implementation Plan ensures our resources for outreach, prevention, education, and wellness are directed towards opportunities where the greatest impact can be realized.

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Introduction

Mercy Health- Marcum and Wallace Hospital (Marcum or MWH) is a 25-bed Critical Access Hospital (CAH) located in Irvine, Kentucky (Estill County) which serves as the center of care for three other rural Kentucky counties, including Lee, Owsley, and Powell.

The detailed process, participants, and results are available in Mercy Health- Marcum and Wallace Hospital's Community Health Needs Assessment, which is available at Mercy.com

This Community Health Needs Assessment Implementation Plan will address the prioritized significant community health needs through the CHNA. The Plan indicates which needs Mercy Health- Marcum and Wallace Hospital will address and how, as well as which needs Mercy Health- Marcum and Wallace Hospital won't address and why.

Beyond programs and strategies outlined in the plan, Mercy Health- Marcum and Wallace Hospital will address the health care needs of the community by continuing to operate in accordance with its mission to extend the healing ministry of Jesus by improving the health of its communities with emphasis on the poor and underserved. This includes providing care for all individuals regardless of their ability to pay.

The strategies in this Implementation Plan will provide the foundation for addressing the community's significant needs between 2023 – 2025. However, Mercy Health- Marcum and Wallace Hospital anticipate that some strategies, and even the needs identified, will evolve over that period. Mercy Health- Marcum and Wallace Hospital plans a flexible approach to addressing the significant community needs that will allow adaptation to changes and collaboration with other community agencies.

Community Served by the Hospital
Estill County, Lee County, Owsley County, and Powell County.

Communities served by the hospital are defined as the primary service area: Estill County, Lee County, Owsley County, and Powell County. Patient data indicates that 90% of persons served at Mercy Health – Marcum and Wallace Hospital reside in the primary service area, based upon the county of residence of discharged inpatients during 2021.

Zip codes serving Estill, Lee, Owsley, and Powell counties

Estill County	Lee County	Owsley County	Powell County
40336	41311	41314	40380
40472			40312

Our Mission

As a system Mercy Health is dedicated to extending the compassionate ministry of Jesus by improving the health and well-being of our communities and bring good help to those in need, especially people who are poor, dying and underserved.

Our Vision

Inspired by God's hope for the world, we will be a ministry where associates want to work, clinicians want to practice, people seek wellness and communities thrive.

Our Values

Human Dignity

We commit to upholding the sacredness of life and being respectful and inclusive of everyone.

Integrity

We commit to acting ethically and modeling right relationships in all of our individual and organizational encounters.

Compassion

We commit to accompanying those we serve with mercy and tenderness, recognizing that "being with" is as important as "doing for."

Stewardship

We commit to promoting the responsible use of all human and financial resources, including Earth itself.

Service

We commit to providing the highest quality in every dimension of our ministry.

Executive Summary

Background and Process

MWH consulted with Community Economic Development Initiative of Kentucky (CEDIK) at the University of Kentucky College of Agriculture, Food and Environment to complete this CHNA. The CHNA process that CEDIK uses is based on IRS guidelines. CEDIK met with the internal hospital committee and designated CHNA lead to discuss the process and timeline. CEDIK provided a list of potential agencies and organizations to the hospital to aid in recruiting members to a Community Steering Committee that plays a vital role in the CHNA process, ensuring broad community input; and facilitating representation from all counties identified in the hospital service area. CEDIK guided the hospital to include individuals that would have knowledge of vulnerable and at-risk populations. This committee assisted in the collection of primary data for this assessment through the dissemination of a community health needs survey and in providing recommendations for focus group participants as well as participating in a focus group. The first steering committee meeting was held January 26, 2022, resulting in the survey launch and plans for future focus groups. The survey closed on March 15, 2022, resulting in a total of 716 responses. Five focus groups were completed with a total of 46 participants. Complete survey results and focus group data summaries are in the appendix of this report.

CEDIK team members collected and analyzed secondary health data from various sources, including hospital utilization data from the Kentucky Hospital Association, County Health Rankings, Kentucky Cancer Registry, Kentucky Health Facts and the Kentucky Injury Prevention and Research Center.

External sources

1. County Health Rankings (2021, www.countyhealthrankings.org)
2. Kentucky Cancer Registry (2014 – 2018, www.kcr.uky.edu)
3. Kentucky Health Facts (2016 – 2020, www.kentuckyhealthfacts.org)
4. Kentucky Injury Prevention and Research Center (2021, www.kiprc.uky.edu)

Identifying Significant Needs

The community steering committee met three times during the process. The initial meeting was held virtually on January 26, 2022, for the hospital and CEDIK to introduce the Community Health Needs Assessment (CHNA) process, roles, and responsibilities of the CHNA steering committee and to determine additional meeting dates to hold a focus group and for a final meeting to review all collected data and identify needs. The steering committee met a second time on March 10, 2022, to provide their input during a focus group. The committee met for a final time on April 22, 2022, to review primary and secondary data and to identify significant health needs.

The CEDIK team presented the following ACHI criteria for them to consider as they worked through the process:

1. Magnitude of the problem
2. Severity of the problem
3. Need among vulnerable populations
4. Community's capacity and willingness to act on the issue
5. Ability to have a measurable impact on the issue
6. Availability of hospital and community resources
7. Whether the issue is a root cause of other problem

Based on all data reviewed, the committee identified mental health, substance use disorder, chronic diseases, obesity, diabetes, prescription medication assistance/affordability, grief, access to healthy food, nutrition, and physical activity as the health needs. A list of health needs, gaps and issues was developed by the community partners steering committee, and each participant voted for their highest priority items. The committee determined to keep the top five health needs and issues with the highest vote count equivalent to half the number of participants voting remain on the list and all other health problems were eliminated. This was repeated twice to narrow the list and ensure agreement and prioritization of the needs. After discussing and completing this multi-vote process for prioritizing the needs, the committee recommended the following identified prioritized needs: food security, chronic diseases, substance use disorder, and mental health.

The internal hospital reviewed all data and recommendations with the following considerations:

- The ability of MWH to evaluate and measure outcomes.
- The number of people affected by the issue or the size of the issue
- The consequences of not addressing the problem
- Prevalence of common themes

After review and consideration, the internal hospital accepted the recommendations and added medication assistance as a priority need to be addressed.

No written comments were received on the Mercy Health- Marcum and Wallace Hospital's most recently conducted CHNA and most recently adopted implementation strategy.

Implementation Plan

Mercy Health- Marcum and Wallace Hospital is committed to addressing the prioritized significant health needs of the community through the strategies described in this Implementation Plan.

Prioritized Significant Health Needs

The table below lists the prioritized significant health needs that were identified through the CHNA and specifies which needs Mercy Health- Marcum and Wallace Hospital will address.

Prioritized Significant Health Needs	Hospital Addressing Need
Food Security (Including access to healthy foods and addressing obesity)	Yes
Addressing Chronic Diseases (Cardiac Disease/Diabetes)	Yes
Medication Assistance	Yes
Substance Disorder	Yes
Mental Health	Yes

Prioritized Significant Social Determinant of Health Needs Implementation Strategies:

Food Security (including access to healthy foods and addressing obesity)

Description
As detailed in the hospital's Community Health Needs Assessment Report:

In Estill, Lee, Owsley, and Powell County, there is a lack of accessible geographic locations that provide access to healthy foods, number of locations and assistance to maintain physical activity and lack of weight management/obesity services. This results in many Estill and surrounding county's residents traveling to other parts of the state for services.

Goals
1. Connect community members with food security resources
2. Increase physical fitness opportunities
3. Provide healthy food education

Expected impacts
1. Increase accessibility/awareness of resources available.
2. Address obesity and overall physical health through physical fitness opportunities.
3. Help people recognize and make healthy food and beverage choices, how to store and freeze food properly for cost-effective fresh food options and make healthy choices on a budget.

Targeted populations
Community-wide

Strategies
1. Provide up-to-date resource guides and food security bags to patients in hospital/primary care settings to increase accessibility to food security resources.
2. Increase opportunities available by funding Yoga certification of four MWH associates and education on use of existing equipment in communities.
3. Provide healthy food education at community events, partner with existing coalitions and organizations and provide education in schools to all grades
    - Develop monthly menu plans, monthly food tips and shopping lists to use and educate at planned events.

Strategic measures
1. Track number of resource guides and food bags distributed in Primary Care Clinics, ED, and Inpatient departments quarterly. Initial annual baseline is 200. Increase 10% by the end of each year.
2. Track the number of individuals yoga certified by the end of 2023. Initial baseline is 0.
3. Track number of educations provided on existing equipment. Initial baseline is 0. Establish baseline in year one, then increase at 10% by end of years two and three.
4. Track number of nutrition events attended or sponsored, then track number of individuals assisted by providing healthy food education. Initial annual event baseline is 20 and initial annual individual baseline is 0. Increase both by 10% by the end of each year.

Community collaborations
Mercy Health- Marcum and Wallace Hospital/Mercy Health Foundation-Irvine, local health departments, local extension agencies, schools, senior centers, farmers markets, libraries, primary care clinics, and other healthcare agencies.

Community resources available
The existing healthcare facilities and other resources in the community that are available to meet the prioritized need include:

Mercy Health- Marcum and Wallace Hospital, Estill County Community Food Bank, God's Outreach, Helping Hands, Meals on Wheels for Seniors, Lee County Helping Hands, God's Food Pantry, Powell County Emergency Food Bank, Operation Hands of Love Food Bank, Queen of All Saints Beattyville, and Cumberland Mountain Outreach Ministries, local health departments, local extension agencies, farmers markets and libraries.

Prioritized Significant Social Health Needs Implementation Strategies:

Medication Assistance

Description
As detailed in the hospital's Community Health Needs Assessment Report:

In Estill, Lee, Owsley, and Powell County, there is a high instance of poverty and accessibility to assistance that leads to medication non-compliance due to cost and low number of assistance opportunities burdened further by physical environment and cost of living fluctuations. This results in many Estill and surrounding county's residents having medical complications due to medication non-compliance.

Goals
1. Expand Meds2Beds program.
2. Provide medication assistance program education.
3. Provide medication assistance service in-house at Harness Health Pharmacy powered by Mercy Health.

Expected impacts
1. Increase availability and compliance to medications.
2. Increase awareness and use of MWH Medication Assistance program to increase access to and compliance with medications and other prescribed supplements.
3. Provide medication assistance option to patients internally.

Targeted populations
Patients Discharging from MWH (Inpatient, Outpatient or ED)
Service area primary care clinics, pharmacies, and patient population
Entire service area.

Strategies
1. Continue implementation of Meds2Beds (started in 2022) to increase use of Meds2Beds program.
2. Education on Medication Assistance program to target populations.
3. Establish and provide medication assistance at Harness Health Pharmacy.

Strategic measures
1. Track number of prescriptions filled with Meds2Beds. Initial baseline is 0. Establish baseline in year one, then increase at 10% by the end of years two and three.
2. Track number of group and individual educations, initial baseline is 0. Establish baseline in year one, then increase at 10% by the end of years two and three.
3. (a) Track establishment of medication assistance program at Harness Health Pharmacy. Initial baseline is no program. Establish program by March 2023. (b) Track the number of individuals assisted using program. Initial baseline is 0. Establish baseline in year one, then increase at 10% by the end of years two and three.

Community collaborations
Mercy Health- Marcum and Wallace Hospital/Mercy Health Foundation-Irvine, Kentucky Homeplace, Manufactures Assistance, 340B, area primary care clinics and area pharmacies.

Community resources available
The existing healthcare facilities and other resources in the community that are available to meet the prioritized need include:

- Mercy Health- Marcum and Wallace Hospital/Mercy Health Foundation-Irvine, Kentucky Homeplace, Manufactures Assistance, 340B.

Prioritized Significant Clinical Health Needs Implementation Strategies:

Addressing Chronic Diseases (including Diabetes & Cardiovascular Disease)

Description
As detailed in the hospital's Community Health Needs Assessment Report:

Significant numbers of residents have chronic disease, particularly diabetes/prediabetes and cardiovascular disease. Many programs and organizations work to provide treatment and prevention, but diabetes/pre-diabetes remains a major problem for the health of our community, with county averages exceeding that of the state up to 2-3 times

Goals
1. Increase awareness and education surrounding prevention and ongoing care of chronic diseases.
2. Increase access to in-person physical fitness opportunities.

Expected impacts
1. Increase holistic knowledge of chronic diseases.
2. Increase access and ability to address symptoms of chronic diseases due to lack of physical fitness.
3. Establish Cardiac and Pulmonary Rehabilitation at MWH.

Targeted populations
Adults

Strategies
1. Host or attended chronic disease-related educational events.
2. Provide free Yoga classes for community members.
   - Two classes monthly in each county (Estill, Lee, Owsley, Powell)
3. Seek and review potential for Cardiac and Pulmonary Rehabilitation in-house.
   - Review past and current data and financial ability to provide in-house Cardiac and Pulmonary Rehabilitation.

Strategic measures
1. Track number of educational events hosted or attended by applicable MWH staff. Initial annual baseline is 24. Increase by 10% by the end of each year.
2. Track number of free yoga classes held quarterly. Initial baseline is 0. Establish baseline in year one, then increase at 10% by the end of years two and three.
3. Establish in-house Cardiac and Pulmonary Rehabilitation program. Initial baseline is 0. Track established date of program.

Community collaborations
- Any community partner hosting or attending an MWH sponsored chronic disease education event.
- Local libraries, health departments, schools, and other community partners.

Community resources available
The existing healthcare facilities and other resources in the community that are available to meet the prioritized need include:

Relevant service providers include Mercy Health- Marcum and Wallace Hospital, Estill County Health Department, Lee County Health Department, Owsley County Health Department, Powell County Health Department, Baptist Health Richmond, Clark Regional Medical Center, Mercy Health- Irvine Primary Care, Estill Medical Clinic, Riverview Health Care, Whitehouse Clinic, Children's Clinic, Mercy Health- Lee County Primary Care, Beattyville Family Medical Clinic, Juniper Health- Lee County, United Clinics of Lee County, Family Practice Clinic, Owsley Medical Clinic, In-House Primary Care, Mercy Health- Powell County Primary Care, Stanton Family Clinic, Kentucky River Foothills, Sterling Healthcare-Stanton, Red River Healthcare and Clay City Pediatrics and Primary Care

Mental Health

Description
As detailed in the hospital's Community Health Needs Assessment Report:

In Estill County and surrounding counties, there is a lack of accessible geographic locations for mental health services, along with an inadequate number of behavioral health providers at the existing locations. This results in many Estill and surrounding county's residents traveling to other parts of the state or out of state for services.

Goals
1. Improve Mental Health among youth in service- area.
2. Provide education on mental health behaviors and resources.

Expected impact
1. Enhance or develop educational programs and best-practices to address mental health in youth.
2. Reduce mental health stigma and increase referrals to resources available.

Targeted populations
Youth, community-wide

Strategies
1. Support community organizations, through investments, partnerships, programming, and advocacy that contributes to delivery and access to mental health programs and services.
2. Increase partnerships and educational events attended/held targeted to youth.
3. Education on mental health behaviors and resources available to target populations at health events and attend meetings with community resources to align and increase efforts.

Strategic measures
1. Track number of events/educations held at schools or targeted to youth. Current annual baseline is 0. Establish baseline in year one, then increase at 10% by the end of years two and three.
2. Track number of partnerships/support of local school family resource centers. Current annual baseline is 0. Establish baseline in year one, then increase at 10% by the end of years two and three.
3. Track number of meetings/educations provided in community related to community health. Current annual baseline is 50. Increase 10% by the end of each year.

Community collaborations
Mercy Health- Marcum and Wallace Hospital/Mercy Health Foundation-Irvine, schools/FRCs in service-area, local businesses, primary care clinics in service area, spiritual and health care agencies

Community resources available
The existing healthcare facilities and other resources in the community that are available to meet the prioritized need include:

Mercy Health- Marcum and Wallace Hospital, Project Home Network, Baptist Health Richmond, New Vista, Kentucky River Foothills, Foothills Health & Wellness, Mountain Comprehensive Center, White House Clinics

Substance Use Disorder

Description
As detailed in the hospital's Community Health Needs Assessment Report:

There is a shortage of primary care providers, behavioral health specialists and drug treatment specialists to adequately serve and address the communities drug use. There has been a lot of collaborative work with area agencies to help address this at the school level with our youth, however, there is still a gap due to drug use increasing significantly over the past 10 years.

Goals
1. Increase access to Narcan
2. Partner with local school districts to provide substance use prevention education
3. Provide education and connection to resources available related to substance use disorder

Expected impacts
1. Increase the number of Narcan kits distributed to community at events, Harness Health Pharmacy and ED.
2. Support a comprehensive school-based strategy to help address substance use based issues.
3. Increase community engagements to share resources and provide education.

Targeted populations
Community-wide, youth

Strategies
1. Provide Narcan access.
2. Implement programs/procedures to support a peer support specialist program in schools.
3. Continue substance use disorder outreach efforts focused on; providing resource connections within the communities served and patient interactions.

Strategic measures
1. Track number of Narcan kits distributed (1) by Peer Support Specialists at community events/educations, (2) Harness Health Pharmacy, and (3) Emergency Department. Initial annual baseline is 200. Increase by 10% by the end of each year.
2. Track program development completion, then track number of events and support provided in schools. Current annual baseline is 0. Establish baseline in year one, then increase at 10% by the end of years two and three.
3. (a) Track number of events attended, sponsored and/or hosted, current annual baseline is 25, increase 10% by the end of each year. (b) Track number of referrals to external resources. Current annual baseline is 0. Establish baseline in year one, then increase at 10% by the end of years two and three.

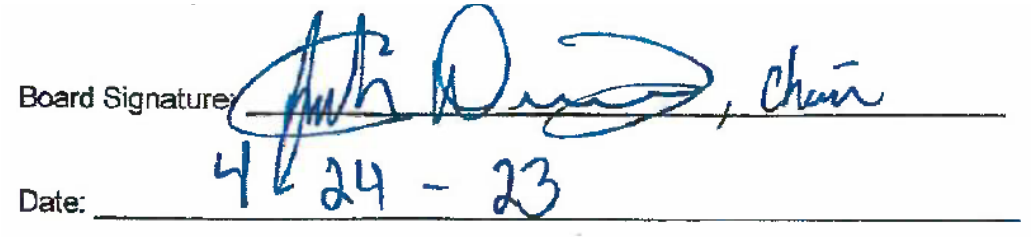
Community collaborations
Mercy Health- Marcum and Wallace Hospital/Mercy Health Foundation-Irvine, Project HOME, Estill County EMS, LEOs**,**

Community resources available
The existing healthcare facilities and other resources in the community that are available to meet the prioritized need include:

Mercy Health- Marcum and Wallace Hospital, Project Home Network, Baptist Health Richmond, New Vista, Kentucky River Foothills, Foothills Health & Wellness, Mountain Comprehensive Center, White House Clinics

Board Approval

The Mercy Health- Marcum and Wallace Hospital 2023 Community Health Improvement Plan was approved by the Marcum and Wallace Hospital Board of Trustees on April 24, 2023.



For further information or to obtain a hard copy of this CHIP please contact:

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Mercy Health CHIP Website: https://www.mercy.com/about-us/mission/giving-back/community-health-needs-assessment