MERCYHEALTH

2025 Community Health Needs Assessment

Mercy Health — Marcum and Wallace Hospital

IRVINE, KY

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Adopted by the Mercy Health — Marcum and Wallace Hospital Board of Directors
October 27, 2025

As part of Bon Secours Mercy Health, Mercy Health — Marcum and Wallace Hospital is honored to uphold nearly two centuries of dedication to the communities we serve. This commitment has continually evolved to address the most pressing needs in each community as identified by the input of residents, businesses and other community members.

Every three years, we reaffirm this dedication, in part by conducting a comprehensive Community Health Needs Assessment (CHNA). The most recent assessment, completed by Mercy Health — Marcum and Wallace Hospital, incorporates robust quantitative and qualitative data. This process guides our strategic planning, community investment and community benefit initiatives. The following document provides a detailed CHNA specific to Mercy Health — Marcum and Wallace Hospital.

Guided by our Mission to extend the compassionate ministry of Jesus, Mercy Health remains steadfast in improving the health and well-being of our communities and bringing good help to those in need — especially people who are poor, underserved and dying.

Mercy Health — Marcum and Wallace Hospital has identified the greatest needs within our community by listening to its local voices. Through open forums, surveys and additional engagement strategies, we diligently seek input from our partners and neighbors. This ensures that we strategically align our resources for outreach, prevention, education and wellness to deliver the greatest impact.

We welcome written comments regarding the health needs identified in this CHNA. Please direct your feedback to Meghan Mills, Mercy Health — Marcum and Wallace Hospital, Director of Community Health at 606-726-8185 or mlmills@mercy.com.

Mercy Health — Marcum and Wallace Hospital

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Mercy Health CHNA Short Link:
Mercy Health CHNAs

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Executive Summary

Market Summary

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

Collaborating Partners

Mercy Health — Marcum and Wallace Hospital thanks the following organizations for their collaboration as part of the process of conducting the needs assessment:

- Estill County Area Technology Center
- Estill County Board of Education
- Estill County Chamber of Commerce
- Estill County Cooperative Extension Office
- Estill County Emergency Medical Services
- Estill County Health Department
- Estill County Judge Executive Office
- Estill County Sheriff's Department
- Estill Development Alliance
- Helping Hands Outreach
- Holy Family Catholic Church
- Housing Authority of Irvine
- Interfaith Wellness Ministry, Inc.
- Irvine City Hall
- Kentucky Regional Health Information Organization
- Lee County Health Department
- Owsley County Action Team
- Owsley County Health Department
- Powell County Health Department
- Powell County High School
- Powell County Public Library

Overview

Mercy Health — Marcum and Wallace Hospital consulted with Blueprint Kentucky (formerly the Community & Economic Development Initiative of Kentucky or CEDIK) at the University of Kentucky Martin-Gatton College of Agriculture, Food and Environment to complete this Community Health Needs Assessment.

Blueprint Kentucky facilitated the process of primary data collection through a community survey, focus groups and key informant interviews to support Mercy Health — Marcum and Wallace in creating the community health needs assessment and an implementation plan to address identified health needs. In addition, they gathered county-specific secondary data (County Health Rankings 2024, Kentucky Cancer Registry 2018-2022, Centers for Disease Control 2019-2022 and Kentucky Injury Prevention Research Center 2023) to help examine specific health indicators and the social determinants of health.

Throughout the process, Blueprint Kentucky prioritized obtaining input from populations that are often not engaged in conversations about their health needs or gaps in service. Blueprint Kentucky presented primary and secondary data results to the community steering committee and led a prioritization process utilizing a multi-voting technique guided by the criteria from the American Hospital Association (AHA) and Association for Community Health Improvement (ACHI).

The significant health needs identified by the community steering committee are mental health and substance use disorders, transportation, health literacy and education, food access and security, chronic disease management (diabetes, cardiovascular health and cancer), and obesity and weight control.

The Blueprint Kentucky consultant presented a summary of the primary and secondary data collected for the MWH CHNA and compiled the significant health needs identified by the community steering committee to the MWH Internal Committee. After a discussion of the findings and a review of the guidance from the ACHI on considerations when prioritizing health needs, a vote was held to prioritize the needs to address for the next three years. To confirm the agreement, the consultant asked for a verbal consensus from the committee members. Below is the list of the prioritized health needs.

Determining Prioritized Needs

Based on data presented and reviewed, the community steering committee identified transportation, mental health, substance use disorder (SUD), chronic disease management (including diabetes, cardiovascular health and cancer), obesity, food access and security, and health literacy and education as the highest health needs. Other needs mentioned but not deemed significant to all committee members included elderly support, poverty, access to physical activity and affordable youth programs.

A facilitated discussion of the health needs, resource gaps and issues identified by the community partners steering committee followed. Then, each participant voted for their highest priority items. The votes of the committee determined to keep the top six health needs and issues. The remaining identified needs received one vote per need, and those were eliminated. After regrouping to ensure agreement and prioritization of the needs, the committee reached consensus and recommended the following identified prioritized needs: transportation, mental health, substance use disorder, chronic disease management (including diabetes, cardiovascular health, cancer and obesity), food access and security, and health literacy and education.

The internal hospital committee reviewed and accepted the steering committee's recommendations except for transportation, as at least five other organizations in the region are addressing transportation issues. The hospital will be included in conversations to identify actionable strategies to address transportation barriers.

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

Prioritized Health Needs

- Food Security
  (including access to healthy foods and addressing obesity)
- Health Literacy and Education
- Addressing Chronic Diseases
  (including cancer screenings, cardiovascular disease and diabetes)
- Mental Health (including pediatric and SUD)

Our Mission

Our mission is to extend 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.

Facilities Description

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

Community Served by Hospital

The community served by the hospital is defined as the counties within the primary service area containing the residential address for equal to or greater than 90% of the patients discharged during the most recently completed calendar year for which data is available at the beginning of the community health needs assessment process.

The community served by the hospital and defined as the primary service area includes Estill County, Lee County, Owsley County and Powell County. Patient data indicates that over 93% of persons served at Mercy Health — Marcum and Wallace Hospital reside in the primary service area, based on the county of residence of discharged inpatients during 2023.

ZIP Codes serving Estill, Lee, Owsley and Powell Counties

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

Process and Methods

Process and Methods to Conduct the Community Health Needs Assessment

The CHNA process that Blueprint Kentucky uses is based on the IRS guidelines. Blueprint Kentucky meets with the internal hospital committee and the designated CHNA lead to discuss the process and determine the timeline. Blueprint Kentucky provides a list of potential agencies and organizations to the hospital to aid in the recruitment of members to a community steering committee. This committee plays a vital role in the CHNA process, ensuring broad community input and facilitating representation from all counties identified in the hospital service area. Blueprint Kentucky guided the hospital to include individuals with knowledge of vulnerable and at-risk populations. The committee assisted in collecting primary data for this assessment through the dissemination of a community health needs survey and providing recommendations for focus group participants, as well as participating in a focus group.

The first steering committee meeting was held on July 31, 2024, resulting in the survey launch and plans for future focus groups. The survey closed on Dec. 20, 2024, resulting in a total of 608 responses. Five focus groups were completed with a total of 43 participants. Complete survey results and focus group data summaries are in the appendix of this report. Blueprint Kentucky team members collected and analyzed secondary health data from a variety of sources, including hospital utilization data from the Kentucky Hospital Association, County Health Rankings, Kentucky Cancer Registry, and the Kentucky Injury Prevention and Research Center.

The community steering committee met two times during the process. The initial meeting was held on July 31, 2024, at the Estill County Extension Office. The hospital and Blueprint Kentucky introduced the Community Health Needs Assessment (CHNA) process, roles and responsibilities of the CHNA steering committee, launched the survey and held a focus group. The committee met for a final time on Feb. 28, 2025, at the Estill County Public Library, to review primary and secondary data and to identify significant health needs. The Blueprint Kentucky consultant presented the following Association for Community Health Improvement (ACHI) criteria for the committee to consider as they worked through the process of identifying and prioritizing health needs:

- Magnitude of the problem
- Severity of the problem
- Need among vulnerable populations
- Community's capacity and willingness to act on the issue
- Ability to have a measurable impact on the issue
- Availability of hospital and community resources
- Whether the issue is a root cause of other problems

External Sources

- County Health Rankings & Roadmaps (2024, www.countyhealthrankings.org)
- Kentucky Cancer Registry (2018 - 2022, www.kcr.uky.edu)
- Centers for Disease Control (2019-2022, data.cdc.gov)
- Kentucky Injury Prevention and Research Center (2023, kiprc.uky.edu)

Demographics	Kentucky	Estill County	Lee County	Owsley County	Powell County
2022 Population	4,512,310	14,044	7,261	3,929	13,083
% Less than 18 Years of Age	22.3	21.3	17.8	22.7	23.8
% 65 and Over	17.6	19.2	18.3	20.7	16.9
% Black	8.4	0.5	3.2	0.8	1.1
% American Indian & Alaska Native	0.3	0.3	0.5	0.4	0.3
% Asian	1.8	0.1	0.4	0.1	0.3
% Native Hawaiian/ Other Pacific Islander	0.1	0.0	0.1	0.1	0.0
% Hispanic	4.3	1.6	2.8	2.2	1.6
% Non-Hispanic White	83.2	96.2	91.7	95.3	95.5
% Not Proficient in English	1.1	0.9	0.1	0.0	0.1
% Female	50.3	50.0	43.6	51.1	49.9
% Rural	41.3	71.6	100.0	100.0	100.0

2024 County Health Rankings Data, countyhealthrankings.org

Health Outcomes	Kentucky	Estill County	Lee County	Owsley County	Powell County
Years of Potential Life Lost Rate	11,055	15,158	16,393	22,153	15,994
% Fair or Poor Health	21	27	31	28	23
Average Number of Physically Unhealthy Days	4.5	5.6	6.1	5.7	5.0
Average Number of Mentally Unhealthy Days	5.5	6.3	6.6	6.4	5.9
% Low Birthweight	9	8	8	10	9

Health Behaviors	Kentucky	Estill County	Lee County	Owsley County	Powell County
% Adult Smokers	20	29	32	30	24
% Adults with Obesity	41	42	41	44	40
Food Environment Index	6.8	6.9	6.6	6.0	7.6
% Physically Inactive	30	36	40	37	32
% With Access to Exercise Opportunities	70	61	80	84	87
% Excessive Drinking	15	13	13	13	15
% Driving Deaths with Alcohol Involvement	26	36	0	40	25
Chlamydia Rate	410.3	290.9	147.6	151.8	335.0
Teen Birth Rate	26	35	48	27	55

Access to Care	Kentucky	Estill County	Lee County	Owsley County	Powell County
% Uninsured	7	8	7	8	6
# Primary Care Physicians	2,816	3	N/A	N/A	1
Primary Care Physicians Rate	62	21	N/A	N/A	8
Primary Care Physicians Ratio	1,601:1	4,697:1	N/A	N/A	13,133:1
# Dentists	3,005	7	1	2	4
Dentist Rate	67	50	14	51	31
Dentist Ratio	1,502:1	2,006:1	7,261:1	1,965:1	3,271:1
# Mental Health Providers	13,211	15	9	6	13
Mental Health Provider Rate	293	107	124	153	99

Social and Economic Factors	Kentucky	Estill County	Lee County	Owsley County	Powell County
% Completed High School	88	76	73	71	82
% Completed Some College	63	47	38	36	51
# Unemployed	79,950	249	113	74	217
Labor Force	2,048,078	5,189	2,081	1,075	5,265
% Unemployed	3.9	4.8	5.4	6.9	4.1
% Children in Poverty	21	25	45	44	32
80th Percentile Income	$119,690	$85,354	$60,667	$81,635	$97,974
20th Percentile Income	$24,295	$14,334	$12,904	$12,884	$13,966
# Children in Single-Parent Households	256,978	992	373	266	607
# Children in Households	1,008,670	3,072	1,487	751	3,156
% Children in Single-Parent Households	25	32	25	35	19
# Associations	4,622	15	3	0	7
Social Association Rate	10.2	10.6	4.0	0.0	5.3
# Injury Deaths	23,759	118	68	48	88
Injury Death Rate	106	167	190	222	141

Physical Environment	Kentucky	Estill County	Lee County	Owsley County	Powell County
Average Daily PM2.5	8.2	7.9	7.7	7.6	7.8
Presence of Water Violation		No	No	No	No
% Severe Housing Problems	13	14	14	15	14
% Severe Housing Cost Burden	11	12	9	11	10
% Overcrowding	2	2	2	1	5
% Inadequate Facilities	1	3	3	3	2
% Drive Alone to Work	79	76	76	77	88
# Workers who Drive Alone	1,993,847	4,572	2,232	1,091	4,637
% Long Commute — Drives Alone	31	48	43	36	46

Prevalence and Mortality Rates	Kentucky	Estill County	Lee County	Owsley County	Powell County	Years	Data Source
Asthma Prevalence (adults)	10.8	11.8	12	11.8	11.6	2022	BRFSS
Diabetes Prevalence (adults)	13.0	13.2	16	13.7	12	2022	BRFSS
Hypertension Prevalence (adults)	55.2	38	41.3	39	35.4	2021	BRFSS
Heart Disease Deaths per 100K	398.1	442.9	522.3	631.3	571.9	2019 - 2021	CDC
Stroke Deaths per 100K	84.4	100.7	104.1	86.6	105.3	2019 - 2021	CDC
All Sites Cancer Deaths per 100K	181.3	211.8	213.6	249.6	224.4	2016 - 2020	KIPRC
Lung and Bronchus	54.4	61.9	61.2	98.5	85.1	2016 - 2020	KIPRC
Prostate (males only)	18.6	17.5	15.5		12.4	2016 - 2020	KIPRC
Colon and Rectum	16.1	15.1	18.4		30.6	2016 - 2020	KIPRC
Breast	11.8	15.1			10	2016 - 2020	KIPRC
Pancreas	11.4	11.5		18.5	11.6	2016 - 2020	KIPRC
Liver and Intrahepatic Bile Duct	6.4				9.2	2016 - 2020	KIPRC
Non-Hodgkin Lymphoma	5.9	7.7				2016 - 2020	KIPRC
Ovary (females only)	5.7	7.7				2016 - 2020	KIPRC
Urinary and Bladder	5	6.5			6.8	2016 - 2020	KIPRC
Esophagus	4.5	6.1				2016 - 2020	KIPRC

KIPRC 2023 Data	Kentucky	Estill County	Lee County	Owsley County	Powell County
Any Drug-Involved Fatal Overdose (rate per 100K population)	44.0	193.7	150.8	N/A	123.3
Any Drug-Involved Non-Fatal Overdose (rate per 100K population)	326.9	617.1	370.2	299.9	470.2
ED Visit with a SUD Diagnosis (rate per 100K population)	1,790	2,497	3,332	5,174	2,829
Any Drug-Involved Fatal Overdose (count)	1,990	27	11	5	16
Any Drug-Involved Non-Fatal Overdose (count)	14,798	86	27	12	61
ED Visit with a SUD Diagnosis (count)	81,009	348	243	207	367

Community Input

Collaborating Partners

The Mercy Health — Marcum and Wallace Hospital thanks the following organizations for their collaboration as part of the process of conducting the needs assessment:

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- Estill County Board of Education
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- Estill County Emergency Medical Services
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- Powell County Public Library

Information and Data Considered in Identifying Potential Need

Community Survey — Primary Data Collection

This community health needs assessment (CHNA) included three approaches to the collection of primary data. A community survey of adults within Estill, Lee, Owsley and Powell Counties, focused discussion groups in each of the four counties in the service area and additional key informant interviews based on high need topics. To create the community survey, leaders and an internal workgroup from Mercy Health — Marcum and Wallace Hospital met to discuss sources of valid and reliable survey questions that would be appropriate for assessing the health status and health needs of community members. Based on input from the planning committee, the Blueprint Kentucky consultant composed drafts of the community survey with 27 questions. The targeted population for the survey consisted of adults 19 and over living in Estill, Lee, Owsley and Powell Counties. Surveys were distributed in-person from July 2024–December 2024 via organized group meetings, housing authorities, and wide-spread distribution and collection by community partners. Surveys were made available online for completion.

Community Survey — Identified Health Challenges and Needs

The community survey revealed that 37% of respondents have delayed health care due to lack of money and/or insurance. High blood pressure, diabetes, mental illness, pulmonary (lung) diseases and cancer are the top five conditions that respondents have received treatment for at Mercy Health — Marcum and Wallace Hospital. The top challenges identified by the respondents include high blood pressure, overweight/obesity, diabetes, mental health issues, dental health, and heart disease and stroke. Responses for how the hospital could better meet identified health needs include expanded medical services, such as additional mental health services, educational programs, after-hours access and outpatient services. Additional health care services that would be beneficial to the community include mental and behavioral health services, more specialists, alcohol and drug use programming, and homeless shelter and health care services. When asked what drug and alcohol services are needed, respondents chose mental health counseling, job opportunities, housing, life skills training, treatment facilities (inpatient, sober living facilities and faith-based approach) and medication-assisted therapy (see Appendix).

Focus Group — Unmet Needs

Focus groups were conducted in November 2024 in Estill, Lee, Powell and Owsley Counties to discuss the health needs of populations with unmet health needs and to deepen the understanding of the health challenges they face. Participants were recruited through local health departments, community organizations and partner agencies, ensuring representation from residents with lived experience of unmet health needs. Individuals were identified based on factors such as age group, income level, geographic location, and connection to populations facing health disparities in Estill, Lee, Powell and Owsley Counties. Focus groups revealed

unmet needs among children, youth, senior populations and low-income and/or under-resourced residents. Common concerns across these populations include diabetes, heart disease, high blood pressure, obesity (adult and child), substance use disorder, cancer and mental health issues. Unhealthy behaviors that contribute to poor health include lack of physical activity, tobacco use (smoking, chewing and vaping), poor nutrition (by choice or lack of available healthy foods and lack of food preparation knowledge). Barriers to care include transportation issues (that affect physician appointments, pharmacy/medications, and essential needs such as food and utilities), travel to other locations for specialty care and the need for more mental health providers. Every focus group discussed social determinants of health, such as housing, poverty, food insecurity, transportation and lack of childcare.

Secondary Data — Trends and Rankings

Secondary data from external sources for Estill, Lee, Owsley and Powell Counties were included in the previous section of the report. The data is considered representative of the county and state population due to how they were collected and reported by the agencies. In addition, these data sets were reviewed for accuracy with the community steering committee and the internal hospital committee.

Secondary data provides additional support to the community input, allowing for further identification of areas of concern. As the data depicts, all four counties have a higher number of mentally unhealthy days, a higher percentage of smokers and a higher percentage of physically inactive population than Kentucky. In addition, Estill, Lee and Owsley Counties have a higher percentage of adults with obesity than the state average. The highest cancer death rates in the state are lung and bronchus, prostate (males), colon and rectum, breast, pancreas and liver. All four counties have higher overall cancer death rates than the state.

Public Health Departments	Date of Data/Information
Estill County Health Department	July 31, 2024, steering committee participated in focus group Feb. 28, 2025, steering committee prioritized needs
Lee County Health Department	July 31, 2024, steering committee participated in focus group Nov. 13, 2024, focus group Feb. 28, 2025, steering committee prioritized needs
Powell County Health Department	July 31, 2024, steering committee participated in focus group Feb. 28, 2025, steering committee prioritized needs

Community, Organization and Stakeholder Input*	Date of Data/ Information	Nature and Extent of Input	At Risk, Medically Underserved, Low-Income or Minority Populations Represented by Organization
Kentucky Rural Health Information Organization	Nov. 14, 2024 Feb. 6, 2025	Focus group participant — in Powell County, Key informant interview	At risk, low-income, medically underserved populations
Estill County Area Technology Center	Nov. 14, 2024	Focus group — Estill and Powell	Students and health career instructors
Estill County EMS	July 31, 2024 Feb. 28, 2025	Steering committee member, Focus group participant	All community residents
Estill County — UK Cooperative Extension	Feb. 6, 2025	Key informant interview	At risk and low-income populations
Estill County Development Alliance and Chamber of Commerce	July 31, 2024 Feb. 28, 2025	Steering committee member, Focus group participant	Community leaders
Estill County Health Department	July 31, 2024 Feb. 28, 2025	Steering committee member, Focus group participant	At risk, low-income, medically underserved populations
Estill County Board of Education	July 31, 2024 Feb. 28, 2025	Steering committee member, Focus group participant	At risk and low-income populations, students
Interfaith Wellness Council	July 31, 2024 Feb. 28, 2025	Steering committee member, Focus group participant	At risk, medically underserved, low-income populations
Powell County Public Library	Nov. 14, 2024	Focus group participant	At risk, medically underserved, low-income populations
Powell County Public Schools	Nov. 14, 2024	Focus group participant	At risk, medically underserved, low-income populations
Sterling Health Care — FQHC	Nov. 14, 2024	Focus group participant	At risk, medically underserved, low-income populations
Mountain Comprehensive Health Corporation	Nov. 13, 2024	Focus group participant	At risk, medically underserved, low-income populations
Owsley County Emergency Management	Nov. 13, 2024	Focus group participant	All community members, including at risk and low-income populations
Kentucky River District Health Department — Lee and Owsley counties	July 31, 2024 Nov. 13, 2024 Feb. 28, 2024	Steering committee member, Focus group participant	At risk, medically underserved, low-income populations
Owsley County Community Action Team and Workforce Assistance	Nov. 14, 2024	Focus group participant and host — Owsley County	At risk, medically underserved, low-income populations

Significant Community Identified Health Needs

Social Determinants of Health Needs — Community Level Needs that Impact Health and Well-being

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

Capacity and adequacy of service levels

Food security continues to be a critical need across Estill, Lee, Owsley and Powell Counties. The United States Department of Agriculture defines food security as access to enough food for an active, healthy life for all people at all times. This remains a challenge in our service area, exacerbated by factors such as limited access to full-service grocery stores, lack of transportation to food sources (including food banks) and poverty, which impacts the ability to purchase healthy foods. Focus group participants across the four counties reported these barriers as significant contributors to food insecurity.

Data indicates that all counties in our service area have obesity rates higher than the Kentucky state average of 41%, except Powell County, which is slightly lower. Additionally, these counties report higher than average physically unhealthy days per month, with a figure above Kentucky's average of 4.5 days, signaling the need for improved access to healthier food and physical wellness. The food environment index, which measures access to healthy food sources, was recorded as follows: Estill County at 6.9, Lee County at 6.6, Owsley County at 6.0, Powell County at 7.6 and the state of Kentucky at 6.8 (CHR, 2024).

Various services, including food banks, meal programs and farmers markets, address food security, but their capacity is limited. Transportation barriers hinder access to food banks, while meal programs provide temporary relief but don't fully meet ongoing needs. Farmers markets offer fresh produce, but geographic limitations and short operating seasons restrict their reach. Current services cannot fully address food security, with transportation and limited fresh produce being key challenges. There is also a need for expanded nutritional education to combat obesity and promote healthier eating habits.

Transportation

Capacity and adequacy of service levels

In a study by the Robert Wood Johnson Foundation, transportation barriers, which disproportionately affect individuals and families with low incomes, were found to create access barriers to care and can be detrimental to long-term health. One in five adults who did not have access to a vehicle or public transportation reported skipping necessary health care

appointments. Focus group findings for Estill, Lee, Owsley and Powell Counties echo this study with health care providers reporting patients missing appointments and finding it difficult to seek specialty care due to a lack of transportation. Patients often postpone seeking care until an issue warrants a visit to the emergency department.

An interview with the Nutrition Education Program at Estill County Extension Office revealed that classes on how to prepare nutritious and affordable foods are often not attended due to lack of transportation. Transportation impacts the ability to purchase food at grocery stores or to pick up food from the available food pantries.

Social Health Needs — Individual Level Non-Clinical Needs

Health Literacy and Education

Capacity and adequacy of service levels

According to the CDC Healthy People 2030, personal health literacy is defined as the degree to which individuals have the ability to find, understand, and use information and services to inform health-related decisions and actions for themselves and others. In addition, organizational health literacy is the degree to which organizations equitably enable individuals to find, understand, and use information and services to inform health-related decisions and actions for themselves and others. (ODPHP) (https://odphp.health.gov/healthypeople/priority-areas/health-literacy-healthy-people-2030)

The impact of low health literacy on access to care and health outcomes illustrates that persons with low health literacy are more likely to visit an emergency room, have more hospital stays, are less likely to follow treatment plans and have higher mortality rates. Focus group findings identified health literacy as a priority health need related to understanding health insurance coverage, including Medicare, managing health systems to make medical appointments, and following treatment and medication plans after appointments. Improved health literacy can result in improved health outcomes for chronic disease management, appropriate use of medications and can potentially increase appropriate cancer screenings.

Qualitative data gathered during focus groups and key informant interviews revealed that patients often do not know the available health or community services that exist in the county. In addition, health information can be confusing, and patients or caregivers do not know how to ask appropriate follow-up questions to gain clarity on a treatment plan from a physician or the hospital.

Significant Clinical Health Needs

Addressing Chronic Diseases (including cancer screenings, cardiovascular disease and diabetes)

Capacity and adequacy of service levels

The CDC defines chronic diseases as "conditions that last one year or more and require ongoing medical attention or limit activities of daily living or both." The top leading causes of death are heart disease, cancer and diabetes. Community input from the survey and focus groups identify high blood pressure/cardiac issues, cancer, obesity, mental health and diabetes as the top issues that affect health in Estill, Lee, Powell and Owsley Counties.

Secondary data from external sources further supports these findings. With very few exceptions, the four counties in the primary service area for Mercy Health — Marcum and Wallace Hospital have higher heart disease and stroke death rates, higher percentage of adults with diabetes and higher cancer death rates than the state average. According to the CDC, cardiovascular diseases and Type 2 diabetes significantly impact the region MWH serves.

Mental Health (including pediatric and SUD)

Capacity and adequacy of service levels

Mental health includes our emotional, psychological and social well-being. It helps determine how we handle stress, relate to others and make choices. It is important at every stage of life, from childhood through adulthood. According to the National Institute of Mental Health, nearly one-in-five adults live with mental illness.
(https://www.samhsa.gov/mental-health/what-is-mental-health)

The community survey revealed that 20% of the respondents depicted mental health issues as one of their top health challenges. Mental health was one of the common concerns identified through the focus groups, as well. In addition, when asked what the hospital could do to better meet the community's health needs, participants in the surveys and focus groups emphasized the need for additional mental health services and programming in the area.

Secondary data indicate the average number of mentally unhealthy days reported in Estill, Lee, Owsley and Powell Counties was higher than for Kentucky. The primary service area counties for MWH also have a higher ratio of population to mental health providers compared to the state average. County Health Ranking (CHR) findings suggest that areas with more mentally unhealthy days tend to have higher unemployment and poverty rates, and a higher percentage of people with substance use disorders. The drug-involved fatal overdose per 100K population and the rate of nonfatal overdose-related visits to the hospital with a SUD diagnostic were above the state average (KIPRC, 2023) for all four counties.

Resources Available

Due to the considerable and complex nature of the community identified significant health needs, there are several organizations that may be available to address one or more of the needs:

Health Care Facilities and Services:

- Mercy Health — Marcum and Wallace Hospital
  - Food Security (including access to healthy foods and addressing obesity), Health Literacy and Education, Addressing Chronic Diseases (including cancer screenings, cardiovascular disease and diabetes), Mental Health (including pediatric and SUD)
- Mercy Health — Irvine Primary Care
  - Food Security (including access to healthy foods and addressing obesity), Health Literacy and Education, Addressing Chronic Diseases (including cancer screenings, cardiovascular disease and diabetes), Mental Health (including pediatric and SUD)
- Mercy Health — Powell County Primary Care
  - Food Security (including access to healthy foods and addressing obesity), Health Literacy and Education, Addressing Chronic Diseases (including cancer screenings, cardiovascular disease and diabetes), Mental Health (including pediatric and SUD)
- Estill Medical Clinic
  - Addressing Chronic Diseases (including cancer screenings, cardiovascular disease and diabetes), Mental Health (including pediatric and SUD)
- Riverview Health Care Center
  - Addressing Chronic Diseases (including cancer screenings, cardiovascular disease and diabetes)
- White House Clinics
  - Food Security (including access to healthy foods and addressing obesity), Health Literacy and Education, Addressing Chronic Diseases (including cancer screenings, cardiovascular disease and diabetes), Mental Health (including pediatric and SUD)
- Children's Clinic
  - Food Security (addressing obesity), Health Literacy and Education, Addressing Chronic Diseases (diabetes), Mental Health (including pediatric)
- A+ Pediatrics
  - Food Security (addressing obesity), Health Literacy and Education, Addressing Chronic Diseases (diabetes), Mental Health (including pediatric)
- Juniper Health – Lee County
  - Food Security (including access to healthy foods and addressing obesity), Health Literacy and Education, Addressing Chronic Diseases (including cancer screenings, cardiovascular disease and diabetes), Mental Health (including pediatric and SUD)
- United Clinics of Kentucky – Lee County
  - Addressing Chronic Diseases (including cancer screenings, cardiovascular disease and diabetes), Mental Health (including pediatric and SUD)

- Beattyville Family Medical Clinic (Lee)
  - Addressing Chronic Diseases (including cancer screenings, cardiovascular disease and diabetes), Mental Health (including pediatric and SUD)
- Family Practice Clinic of Booneville
  - Addressing Chronic Diseases (including cancer screenings, cardiovascular disease and diabetes), Mental Health (including pediatric and SUD)
- Owsley County Medical Clinic
  - Addressing Chronic Diseases (including cancer screenings, cardiovascular disease and diabetes), Mental Health (including pediatric and SUD)
- In House Primary Care
  - Addressing Chronic Diseases (including cancer screenings, cardiovascular disease and diabetes), Mental Health (including pediatric and SUD)
- Stanton Family Clinic, LLC
  - Addressing Chronic Diseases (including cancer screenings, cardiovascular disease and diabetes), Mental Health (including pediatric and SUD)
- Kentucky River Foothills (Estill and Powell)
  - Food Security (including access to healthy foods and addressing obesity), Health Literacy and Education, Addressing Chronic Diseases (including cancer screenings, cardiovascular disease and diabetes), Mental Health (including pediatric and SUD)
- Sterling Healthcare – Stanton
  - Food Security (including access to healthy foods and addressing obesity), Health Literacy and Education, Addressing Chronic Diseases (including cancer screenings, cardiovascular disease and diabetes), Mental Health (including pediatric and SUD)
- Red River Healthcare
  - Addressing Chronic Diseases (including cancer screenings, cardiovascular disease and diabetes), Mental Health (including pediatric and SUD)
- Clay City Pediatrics & Primary Care
  - Food Security (addressing obesity), Health Literacy and Education, Addressing Chronic Diseases (diabetes), Mental Health (including pediatric)

Health Departments:

- Estill County Health Department
  - Health Literacy and Education, Addressing Chronic Diseases (including cancer screenings, cardiovascular disease and diabetes), Mental Health (including pediatric and SUD)
- Lee County Health Center (KRDHD)
  - Food Security (including access to healthy foods and addressing obesity), Health Literacy and Education, Addressing Chronic Diseases (including cancer screenings, cardiovascular disease and diabetes), Mental Health (including pediatric and SUD)
- Owsley County Health Care Center (KRDHD)
  - Food Security (including access to healthy foods and addressing obesity), Health Literacy and Education, Addressing Chronic Diseases (including cancer screenings, cardiovascular disease and diabetes), Mental Health (including pediatric and SUD)

- Powell County Health Department
  - Health Literacy and Education, Addressing Chronic Diseases (including cancer screenings, cardiovascular disease and diabetes), Mental Health (including pediatric and SUD)

Other Local and National Resources:

- Senior Life Solutions of Psychiatric Medical Care at Mercy Health — Marcum and Wallace Hospital
  - Mental Health
- New Vista
  - Mental Health (including SUD)
- Trinity Health Group, LLC
  - Mental Health (including pediatric and SUD)
- Mountain Comprehensive Care Center
  - Mental Health (including pediatric and SUD)
- Bourbon Behavioral Health
  - Mental Health (including pediatric and SUD)
- The Ridge Behavioral Health System
  - Mental Health (including pediatric and SUD)
- 988 Suicide and Crisis Lifeline (Nationwide)
  - Mental Health (including pediatric and SUD)
- Estill County Community Food Bank
  - Food Security (including access to healthy foods and addressing obesity)
- God's Outreach – Estill County Food Pantry
  - Food Security (including access to healthy foods and addressing obesity)
- Helping Hands Outreach
  - Food Security (including access to healthy foods and addressing obesity), Mental Health (including pediatric and SUD)
- Lee County Helping Hands Food Bank
  - Food Security (including access to healthy foods and addressing obesity)
- Operation Hands of Love Food Bank
  - Food Security (including access to healthy foods and addressing obesity)
- Community Action Food Pantry
  - Food Security (including access to healthy foods and addressing obesity)
- Powell County Homeless Coalition
  - Health Literacy and Education, Food Security (including access to healthy foods and addressing obesity)
- Kentucky Homeplace
  - Health Literacy and Education, Addressing Chronic Diseases (including cancer screenings, cardiovascular disease and diabetes)

Prioritization of Health Needs

The internal committee for Mercy Health — Marcum and Wallace Hospital, including administration and clinical/provider representation, participated in the prioritization for Mercy Health — Marcum and Wallace Hospital on March 6, 2025. Based on the 2025 CHNA, the external or community steering committee identified six significant health needs (mental health and substance use disorder, transportation, health literacy and education, food access and security, chronic disease management for diabetes, cardiovascular health, and cancer, obesity and weight control). The internal committee composed and ranked all six significant health needs by magnitude, the seriousness of the consequence and the feasibility of correcting the problem. This method allows for health needs to be ranked as objectively as possible based on the data. After the ranking, the committee voted and determined the top four health issues that may be addressed through hospital-wide efforts as follows: 1. Food Security 2. Health Literacy and Education 3. Addressing Chronic Diseases (diabetes, cardiovascular disease and cancer) 4. Mental Health (including pediatrics and substance use disorder). The remaining health concerns identified through the community assessment process may be addressed individually by the focused efforts of community organizations and partnerships.

Prioritized Health Needs

Based on the above information and processes, the prioritized health needs of the community served by the hospital are listed below.

Social Determinant of Health — Community Level

Needs that Impact Health and Well-being

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

Food security remains a significant concern across Estill, Lee, Owsley and Powell Counties due to limited access to grocery stores, poverty and transportation barriers. Increasing access to healthy foods is essential to improve quality of life and reduce chronic conditions like obesity, diabetes, and cardiovascular disease.

Social Health Need — Individual Level Non-Clinical Needs

Health Literacy and Education

Low health literacy continues to impact access to care, chronic disease management and appropriate use of health care services. Improving patients' ability to understand health information and navigate care systems can lead to better outcomes and reduce unnecessary utilization.

Significant Clinical Health Needs

Addressing Chronic Diseases (including cancer screenings, cardiovascular disease and diabetes)

Chronic conditions such as heart disease, diabetes and cancer remain leading causes of poor health and death across the region. Local data and community input consistently point to these as top concerns requiring ongoing attention and intervention.

Mental Health (including pediatric and SUD)

Mental health concerns, including access to care and high rates of unmet needs, remain a top priority across the service area. Community input and data show elevated rates of mental distress, limited provider access, and strong overlap with substance use disorder and poverty.

Significant Health Needs Not Prioritized

Transportation

Transportation is a complex issue that requires a multi-organizational approach to move toward improvement or solutions. It was stated during the discussion phase of prioritizing needs that five regional organizations have identified transportation as a significant need and are working to improve the ability of residents to access transportation. Mercy Health — Marcum and Wallace Hospital administration and appropriate staff members will work with those organizations and support their efforts. Currently, it is not feasible for the hospital to commit to addressing the issue on its own.

Progress and Impact

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

Strategies	Progress
Track number of resource guides/ food bags given to Primary Care, ED, Med. Unit patients	In response to food insecurity, by 2025, over 550 food bags with updated resource guides were distributed to patients across Primary Care, the ED and the Medical Unit, surpassing goals. Bag contents were reviewed for nutritional value, and resource guides were regularly updated to ensure patients had access to current community support.
Track number of individuals provided with equipment use education	In 2023, we established a baseline of 61 individuals receiving equipment use education, with a goal to increase by 10% annually. We exceeded this target, reaching over 106 individuals by 2025. This strategy promotes the use of free or low-cost physical activity equipment in parks, schools and recreational areas to support healthier lifestyles.
Track number of nutrition events attended or sponsored	We exceeded our goals for nutrition-focused events by 2025 — participating in 64 events. These efforts helped promote healthy eating habits and improved access to nutrition education across the community.
Track number of students and staff provided with healthy food education	To support healthy food education, our dietitian participated in both hospital-hosted and community partner events, tailoring education to audiences ranging from first graders at the Teddy Bear Fair to adults at Carhartt employee lunch & learns. We established a baseline in 2023 and set a 10% growth goal for 2024 and 2025, which we surpassed with 1,228 individuals reached from 2023–2025. Staff received targeted, age-appropriate healthy food education.
Yoga certification by four individuals	In 2023, we successfully certified four individuals in yoga instruction — three Mercy Health associates and one community member — expanding our capacity to offer accessible, wellness-focused movement opportunities across the community.

Addressing Chronic Diseases (cardiac disease and diabetes)

Strategies	Progress
Track number of educational events hosted or attended by MWH staff	To address chronic diseases, such as cardiac conditions and diabetes, MWH staff hosted or participated in events that offered resources and screenings to the community. We established a baseline goal of 26 events in 2023 and set a 10% growth target for 2024 and 2025. Staff participated in over 95 chronic disease-focused events.
Track number of yoga classes hosted at no cost in the community	To increase access to in-person physical fitness opportunities and support those managing chronic disease symptoms, MWH began offering no-cost yoga classes in 2023, establishing a baseline of 12 classes. A growth goal of 10% was set for 2024 and 2025 and exceeded with 27 total classes offered.
Track established date of cardiac and pulmonary rehabilitation programs	Our original goal was to establish a full cardiac and pulmonary rehabilitation program at MWH. In 2024, the strategy was refined to focus on establishing a Cardiac Clinical Program — better reflecting the current needs and available resources in our service area. Program development is underway, with the established date to be tracked and full implementation expected by 2025.

Medication Assistance

Strategies	Progress
Track number of prescriptions filled using Meds2Beds	To expand access to prescription support at discharge, MWH tracked the number of prescriptions filled through the Meds2Beds program. In 2023, 1,539 prescriptions were filled, establishing a strong baseline. In 2024, 1,323 prescriptions were filled — bringing the combined total to over 2,800. While we did not meet our 2024 goal of 1,693 due to factors like inpatient discharge volume, off-campus location, limited weekend availability and ED discharge timing, our 36.7% fulfillment rate remains above the national average of 34.6%. We continue to improve access through curbside pickup for patients wishing to receive medications after discharge.
Track number of medication assistance program educations provided	To improve access to affordable medications, MWH provided education on medication assistance programs to patients, providers and pharmacies across the communities we serve. In 2023, we established a baseline with 11 education encounters. A goal of 10% growth was set — and far exceeded — with 68 individuals and organizations receiving direct support and guidance.
Track establishment of medication assistance program	To ensure sustainable access to essential medications, MWH successfully established an in-house medication assistance program at Harness Health Pharmacy powered by Mercy Health. This service provides direct support to eligible patients, reducing financial barriers to care. The program was fully implemented and marked complete in 2023.
Track number of individuals assisted using medication assistance program	To reduce financial barriers and improve medication access, MWH established an in-house medication assistance program. In 2023, we assisted 86 individuals, setting our baseline. A goal of 10% growth was set — and surpassed — with 130 individuals receiving support through the program.

Substance Use Disorder

Strategies	Progress
Track number of Narcan kits distributed by peer support specialists and Harness Health Pharmacy	To support harm reduction and overdose prevention, MWH tracked the number of Narcan kits distributed by Peer Support Specialists through community events, Harness Health Pharmacy and the Emergency Department. In 2023, 281 kits were distributed, exceeding the goal of 220. A 10% growth was set and exceeded with 223 kits distributed, helping equip individuals and families with life-saving tools and education.
Track establishment of program in schools	To promote early intervention and prevention, MWH partnered with local school districts to provide substance use prevention education. In 2023, a vape counseling program was successfully established, meeting our initial goal. We expanded our reach by providing 23 school-based prevention programs, surpassing the goal of 10% growth.
Track number of SUD events and programs provided in schools	To support youth substance use prevention, MWH partnered with local school districts to deliver targeted education through in-school events and programs. We established a baseline of eight in 2023 and set a goal of 10% growth — exceeding it with 22 programs delivered across the school year.
Track number of SUD events attended, sponsored or hosted	To increase awareness and access to substance use disorder resources, MWH tracked events attended, sponsored or hosted. In 2023, we participated in 27 events — just shy of our goal of 28. We more than doubled 10% growth goal by engaging in 65 events, expanding our reach and deepening community connections.
Track number of referrals to external resources	To connect individuals with necessary support, MWH tracked referrals to external substance use disorder resources. We established a baseline of 12 referrals in 2023 and set a goal of 10% growth. We exceeded this goal by providing 36 referrals, significantly increasing access to critical resources for those in need.

Mental Health

Strategies	Progress
Track number of educational events and programs held at schools or targeted to youth	To support youth mental health, MWH hosted or participated in educational events and programs aimed at raising awareness and providing resources in schools. We established a baseline of six events in 2023 and set a goal of 10% growth. We surpassed that goal with 47 events, significantly expanding our reach and impact on youth mental health in the community.
Track number of partnerships with local school family resource centers	To enhance youth mental health, MWH partnered with local school family resource centers to provide support and resources. In 2023, we established a baseline with four partnerships and set a goal of 10% growth. We exceeded that goal with 17 partnerships, strengthening our collaboration and impact on the mental well-being of youth in our service area.
Track number of meetings and educational events provided in community	To promote mental health awareness, MWH provided education on mental health behaviors and available resources through community meetings and events. In 2023, we established a baseline with 38 events and set a goal of 10% growth. We surpassed this goal, reaching 49 events, expanding our educational efforts and support across the community.

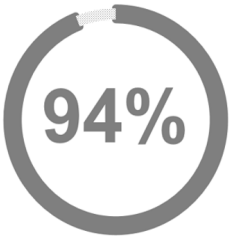
Appendix

- Appendix A: Mercy Health — Marcum and Wallace Hospital Survey Results
- Appendix B: Mercy Health — Marcum and Wallace Hospital 2024 CHNA Survey
- Appendix C: Mercy Health — Marcum and Wallace Hospital Focus Group and Key Informant Interviews
- Appendix D: Mercy Health — Marcum and Wallace Hospital Usage Data

Appendix A

Mercy Health — Marcum and Wallace Hospital Survey Results

WINTER 2024
Respondents Demographics | 608 Respondents*



Have a primary care provider.

Regularly visit primary care provider for check-ups.

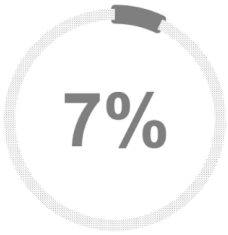
Respondent households have delayed health care due to cost/lack of money.

Additional Responses: Difficulty scheduling appointment, Lack of insurance, Transportation, Other, Lack of emotional support, Afraid loved one will find out.

Respondent households receiving treatment for:	
Diabetes	20%
High Blood Pressure/Heart Disease	40%
Cancer	7%
Mental Illness	17%
Drug/Alcohol Abuse	1%
Tobacco/Vaping	2%
Pulmonary (Lung) Diseases	9%
Liver Disease	4%

Top four health challenges respondent households face:	
High blood pressure	**20%**
Overweight/obesity	**19%**
Mental health issues	**12%**
Diabetes	**12%**
Dental health	9%
Heart disease and stroke	7%
Smoking/vaping	6%
Respiratory/lung disease	5%
Cancer	5%
Drugs/alcohol addiction or Substance Use Disorder (SUD)	1%
Liver disease	1%
HIV/AIDS/STDs	0.1%
Child abuse/neglect	0.1%
Other	3%

** Survey results in the Appendix are based on the number of responses for each question, which may differ from the number of respondents.*



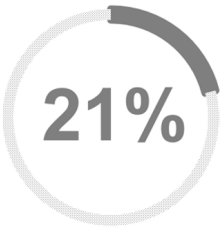
Households report not having health insurance.

Respondent household eligibility:

Medicare	43%
Medicaid	32%
Snap Food Stamp Program	17%
Public Housing Assistance	8%

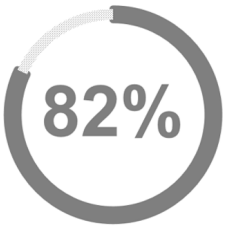
Respondents by living situation:

Living on your own	75%
Living with family	24%
Staying with someone I know	1%
Living in recovery treatment	0.2%
Living in a hotel/motel	0.2%



Regularly impacted by natural disasters.

Impacts from natural disasters limit access to primary care for 9% of respondents.



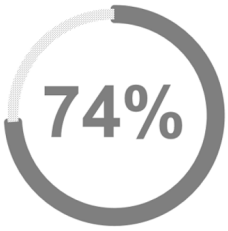
Respondents returned to care management after being impacted by natural disasters.

94% returned to regular management within one month.

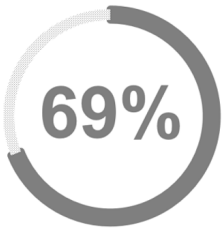
Reasons respondents did not return to regular management:

Distance to appropriate care	44%
Cost of transportation	28%
No appointment availability for my primary care provider	22%
Other	6%

Respondent Interactions with Hospitals



Respondent households have used the services of a hospital in the past 12 months.



Respondent households have used the services of Marcum and Wallace Hospital.

Respondent households used the services of another hospital.

Hospital services respondent households used:

Emergency Room for Life-Threatening Issue	7%
Emergency Room for Non-Life-Threatening Issue	27%
Outpatient Services	52%
Inpatient Services	12%
Post-Acute Care	2%

Services used in the last 12 months by respondent households:

	At Mercy Health	At Other Facility
Cardiology	9%	8%
Obstetrics/Gynecology	0.5%	9%
Radiology	26%	12%
Neurology	2%	5%
Psychiatry	1%	5%
Oncology Cancer Care	1%	4%
Urology	1%	5%
Orthopedics	2%	9%
Pulmonology Lung Care	2%	4%
Pediatrics	1%	6%
Dietary/Nutrition	2%	2%
Primary Care	23%	10%
Drug/Alcohol Abuse	0.1%	0.4%
Outpatient Services - Laboratory	23%	14%
Outpatient Services - Therapeutic	4%	5%
Infusion Therapy	2%	2%
Cardiac Rehabilitation	0.1%	1%
Advanced Care Planning/Spiritual Care	0.5%	0.3%

Most important qualities while receiving care at a hospital:

Effective Treatment	25%
Physician Interaction with Patients	20%
Nursing Care	17%
Comfort of the Hospital/Environment	13%
Explanation Of Diagnosis	12%
Close To Family/Home	11%
Other	2%

Respondent satisfaction with overall experience at Marcum and Wallace:

Very Satisfied	59%
Satisfied	34%
Dissatisfied	5%
Very Dissatisfied	2%

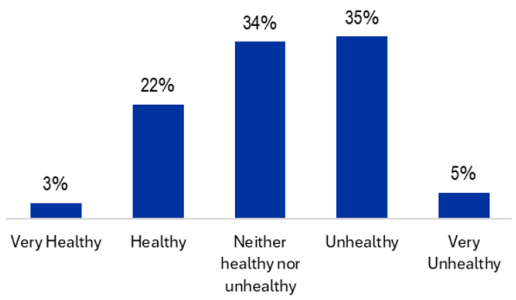
Other hospitals where respondents used services:

Baptist Health	43%
University of Kentucky	20%
Clark Regional Medical Center	15%
St. Joseph Health	13%
Kentucky River Medical Center	2%
Other *(VA Hospital, Lexington Clinic)*	7%

Reasons respondents used a different hospital:

Service I Needed Was Not Available	42%
My Doctor Referred Me To Another Hospital	26%
Prior Services Did Not Meet My Expectations	10%
My Insurance Requires Me To Go Somewhere Else	7%
Other (*distance, cost*)	15%

Respondent rating of the overall health of the community:



Ways for the hospital to better meet the community's health needs:

Mental health	20%
Educational programs	19%
After-hours access	18%
Outpatient services	16%
Community activities and events	14%
Substance Use Disorder (SUD) services	11%
Other (*Mobile health care/access to health care, Specialty Services, Reduced cost/payment options)*	4%

Top other health care services respondents feel should be provided in their community:

Mental & Behavioral Health	14%
Specialists & Specialty Services	12%
Alcohol & Drugs Programming	8%
Homeless Shelter & Health Care	7%
Nutrition/Exercise Aid & Programming	6%
Services Dedicated to Low-income Patients	5%
Senior Citizen Support & Activities	5%
Urgent Care/Other After-Hours Services	5%
Women's Health Services	5%
Community Health Education & Programming; Closer Hospital Services; Peer Support Services; Rehab & Therapies (PT/OT/Cardio); Dialysis	4%

Services used in the last 12 months by respondent households:

More mental health counseling services	11%
Job opportunities	11%
Opportunities for housing	10%
Opportunities for skills training and education	9%
Life skills training	8%
Residential treatment facilities	8%
Medication assisted therapy	8%
Sober living facilities	8%
Detoxification treatment	7%
Recovery community	6%
Spiritual care	6%
Peer support	5%
Hepatitis C treatment	3%
Other	0.4%

Appendix B

Mercy Health — Marcum and Wallace Hospital 2024 CHNA Survey

We want to better understand your health needs and how the hospital and its partners can better meet those needs. Please take 5-10 minutes to fill out this survey. Please do not include your name anywhere.

All responses will remain anonymous.

Q1. Please tell us your zip code:

Q2. Do you have a primary care provider?

- ☐ Yes
- ☐ No

Q3. Do you regularly visit your primary care provider for a check-up?

- ☐ Yes
- ☐ No

Q4. Have you or someone in your household used the services of a hospital in the past 12 months?

- ☐ Yes
- ☐ No

Q5. Did you use the services of Marcum and Wallace Hospital?

- ☐ Yes
- ☐ No

Q6. Did you use the services of another hospital?

- ☐ Yes
- ☐ No

Q7. If you used services at another facility, which hospital did you use?

- ☐ Kentucky River Medical Center
- ☐ Clark Regional Medical Center
- ☐ Baptist Health
- ☐ University of Kentucky
- ☐ St. Joseph Health
- ☐ Other. Please Specify:

Q8. What services did you use?

- ☐ Emergency room for life-threatening issues
- ☐ Emergency room for non-life-threatening issues
- ☐ Outpatient services (radiology, laboratory, therapy, etc.)
- ☐ Inpatient services (overnight hospitalization)
- ☐ Post-acute care (swing bed, skilled nursing facility, etc.

Q9. Why did you or someone in your household go to a hospital other than Marcum and Wallace Hospital?

- ☐ Service I needed was not available at Marcum and Wallace
- ☐ My doctor referred me to another hospital
- ☐ My insurance requires me to go somewhere else
- ☐ Prior services did not meet my expectations
- ☐ Other. Please specify:

Q10. If you received care at Marcum and Wallace Hospital how satisfied were you with your overall experience?

- ☐ Very Satisfied
- ☐ Satisfied
- ☐ Dissatisfied
- ☐ Very Dissatisfied

Q11. While receiving care in a hospital, what is the most important thing to you? **Please select only three.**

- ☐ Nursing Care
- ☐ Comfort of the hospital/environment
- ☐ Close to family/home
- ☐ Physician interaction with patients
- ☐ Explanation of diagnosis
- ☐ Effective treatment
- ☐ Other. Please Specify:

Q12. Have you or someone in your household used any of the services below in the past 12 months?

Select all that apply.

	At Mercy Health	At Other Facility
Cardiology	☐	☐
Obstetrics/Gynecology	☐	☐
Radiology	☐	☐
Neurology	☐	☐
Psychiatry	☐	☐
Oncology (Cancer Care)	☐	☐
Urology	☐	☐
Orthopedics	☐	☐
Pulmonology (Lung Care)	☐	☐
Pediatrics	☐	☐
Dietary/Nutrition	☐	☐
Primary Care	☐	☐
Drug/Alcohol Abuse	☐	☐
Outpatient Services - Laboratory	☐	☐
Outpatient Services - Physical Therapy, Occupational or Speech Therapy	☐	☐
Infusion Therapy	☐	☐
Cardiac Rehabilitation	☐	☐
Advanced Care Planning/Spiritual Care	☐	☐

Q13. Are you or anyone in your household without health insurance currently?

☐ Yes
☐ No

Q14. Have you or someone in your household delayed health care for the following reasons? **Select all that apply.**

- ☐ Cost/lack of money
- ☐ Lack of insurance
- ☐ Transportation
- ☐ Afraid loved one will find out
- ☐ Lack of emotional support
- ☐ Difficulty scheduling appointment
- ☐ Other. Please specify:

Q15. Do you or someone in your household receive treatment for any of the following conditions? **Select all that apply.**

- ☐ Diabetes
- ☐ High blood pressure/heart disease
- ☐ Cancer
- ☐ Mental illness
- ☐ Drug/alcohol abuse
- ☐ Tobacco/vaping
- ☐ Pulmonary (lung) diseases
- ☐ Liver disease

Q16. Are you or members of your household currently eligible for any of the services listed below? **Select all that apply.**

- ☐ Medicare
- ☐ Medicaid
- ☐ Public housing assistance
- ☐ SNAP (food stamp program)

Q17. What is your current living situation?

- ☐ Living with family (parent(s), guardian, grandparents, or other relatives)
- ☐ Living on your own (apartment or house)
- ☐ Living in a place not meant to be a residence (outside, tent, car, homeless camp, abandoned building)
- ☐ Living in recovery housing
- ☐ Living in recovery treatment facility
- ☐ Living in a hotel or motel
- ☐ Staying in an emergency shelter or transitional living program
- ☐ Staying with someone I know

Q18. Please select the TOP FOUR health challenges you or anyone in your household face.
Select only four.

- ☐ Cancer
- ☐ Diabetes
- ☐ Mental health issues
- ☐ Heart disease and stroke
- ☐ High blood pressure
- ☐ HIV/AIDS/STDs
- ☐ Overweight/obesity
- ☐ Respiratory/lung disease
- ☐ Drugs/alcohol addiction or Substance Use Disorder
- ☐ Dental health
- ☐ Child abuse/neglect
- ☐ Liver disease
- ☐ Smoking/vaping
- ☐ Other. Please specify:

Q19. How would you rate the overall health of your community?

- ☐ Very healthy
- ☐ Healthy
- ☐ Neither healthy nor unhealthy
- ☐ Unhealthy
- ☐ Very unhealthy

Q20. What could the hospital do to better meet the community's health needs?
Select all that apply.

- ☐ Educational programs
- ☐ After-hours access
- ☐ Outpatient services
- ☐ Substance Use Disorders (SUD) services
- ☐ Community activities and events
- ☐ Mental health
- ☐ Other. Please Specify:

Q21. What other drug/alcohol treatment services do you think are needed in the community? **Select all that apply.**

- ☐ More mental health counseling services
- ☐ Medication assisted therapy (medication, used in combination with counseling and behavioral therapies, to treat substance use disorders)
- ☐ Residential treatment facilities (treatment in a controlled accountable environment)
- ☐ Detoxification treatment (inpatient)
- ☐ Opportunities for housing (housing for those in recovery and/or homeless)
- ☐ Opportunities for skills training and education (GED, vocational, college)
- ☐ Job opportunities (jobs for individuals in recovery)
- ☐ Spiritual care (faith-based treatment options)
- ☐ Life skills training
- ☐ Sober living facilities (accountability program)
- ☐ Peer support
- ☐ Recovery community (sober community)
- ☐ Hepatitis C treatment
- ☐ Other. Please specify:

Q22. What other health care services do you feel should be provided in your community?

Q23. Are you regularly impacted by natural disasters: floods, wildfires, winter weather, tornadoes, etc.?

- ☐ Yes
- ☐ No

Q24. Do the impacts from natural disasters limit your access to your primary care provider?

- ☐ Yes
- ☐ No

Q25. Were you able to efficiently return to managing chronic conditions and medications after being impacted by natural disasters?

- ☐ Yes
- ☐ No

Q26. If yes, how long before you were able to return to regular management of chronic conditions?

- ☐ Less than one week
- ☐ More than one week, but less than one month
- ☐ More than one month
- ☐ I still haven't returned to regular management of chronic conditions

Q27. If no, what stopped you from returning to regular management of chronic conditions?

- ☐ No appointment availability for my primary care provider
- ☐ Distance to appropriate care
- ☐ Cost of transportation
- ☐ Other. Please specify:

Appendix C

Mercy Health — Marcum and Wallace Hospital Focus Group and Key Informant Interviews

Focus Group and Key Informant Questions

What are your community's strengths and assets? (Tell me what makes you proud of your community/county, including your available health care system.)

What are the most pressing issues/problems that affect health and quality of life in the county? (Identify ages that are most impacted, if appropriate.)

What are the barriers to addressing these issues?

Perception of the current greater health care system (including hospitals, health departments, clinics, EMS and essential services). What is working well? What could be improved or added?

What can be done to address the identified or current health needs/issues over the next three years?

Focus Group and Key Informant Interview Findings

Community Strengths

Community Spirit and Collaboration

- Supportive, caring community
- Collaboration, communication, partnership, support: active collaboration and partnerships are present across the four-county region (Estill, Lee, Powell, Owsley)
- Demonstrated ability to recognize and respond to the needs of individuals and organizations
- Strong partnerships — hospital, health departments, extension, local officials, civic and faith organizations, schools

Community Resources and Infrastructure

- Strong schools
- Farmers markets — access to local produce through farmers markets
- Food pantry and soup kitchen — available to address food insecurity
- Library services and programs
- Availability of local community parks

Healthy Lifestyle Opportunities and Environment

- Access to outdoor activities in all counties
- Outdoor recreation, walking trails
- Natural amenities attract tourists and provide recreational opportunities
- Lee County — walkability assessment completed
- Lee County smoke-free policy

Access to Care

- Access — for a small community, there is some level of access to health care
- Hospital, health department, clinics, dental and chiropractic care (all in Estill County)
- Estill County is the hub for a range of health care services
- Health care resource availability varies across the counties
- Recovery services (response and treatment) in all counties
- Facilities for long-term care and rehabilitation exist

Greatest Health Needs

Chronic disease

- Cancer — breast, lung, liver
- Cardiac issues
- Diabetes
- Obesity
- Mental health

Improve healthy choices

- Vaping and tobacco use
- Substance misuse — alcohol, drugs (including prescriptions)
- Access to healthy foods and nutrition knowledge
- Health literacy

Economic security and community vitality

- Housing — affordable and quality
- Job opportunities
- Clothing access
- Poverty and generational poverty
- Inadequate childcare opportunities

- Laundry mat
- Transportation — to essential services and medical
- Children raised by relatives, not parents

Food access

- Healthy food and meals
- Food security
- Access to healthier snacks
- Additional full-service grocery stores
- Improve farmers markets — more access to fresh fruit and vegetables
- Transportation

Improve access to health care

- Increase available mental health appointments (including school counselors)
- Gaps in Medicare services for seniors — dental, vision and hearing
- Access to specialists
- Transportation
- Additional EMS services — Powell and Lee Counties
- Health literacy — including Medicare and insurance

Perceptions of Current Health Care System

What is working well?

Access to primary care

- Mountain Comprehensive Health Care clinics — take walk-ins, open first Saturday
- Rural Health Clinics — billing on sliding fee scale
- Local services — labs, ultrasound, pediatrics, optometrist
- Emergency Department in Irvine — excellent care
- Walk-in clinics
- Evening and weekend primary care provider access
- Urgent care access (Powell and Estill Counties)
- Great/strong EMS

Public Health Department services

- HANDS program — free for expectant mothers and infants
- Home health
- Women's health services on a sliding fee scale
- Diabetes education
- Homeless health care

Mental health and substance use disorder services

- Medication Assisted Treatment (MAT) for substance use disorders
- Bed placement for SUD treatment
- Mental health services

Additional strengths

- Food availability, blessing boxes, food banks — community supported
- Physical therapy
- Retail pharmacy, meds to beds, delivery
- Elderly services (adult day care)

Opportunities for improvement

- Expand substance use disorder services
- Enhance access to specialists
- Improve transportation to health care
- Increase preventive health efforts for chronic diseases
- Expand mental health services
- Promote health literacy
- Continue to foster collaboration and partnerships
- Address food insecurity
- Recruitment and retention of health care professionals

Barriers to health care and essential services

- Poverty
- Transportation — no public transportation for essential services (grocery, pharmacy, medical appointments, educational offerings, recreation for youth)

How to Better Meet Health Needs

Health care

- Access to specialty services — oncology, cardiovascular, pediatrics
- Rehabilitation services in Estill County
- More mental health programs — during school and continuing into the summer
  - Counselors
  - Outreach and education
  - Coping skills
- More funding for EMS (Lee and Powell Counties)
- Homeless shelter
- Health care provider consortium — continuing education on available services
- Lack of internet access in areas of the county makes telehealth a barrier
- Domestic violence shelter and support
- Increase accountability for businesses that sell to underage youth — liquor, nicotine

Community

- Basic needs met — transportation, affordable housing, food security, and mobile laundry, showers and hygiene unit
- Improve workforce opportunities
- Childcare — affordable and quality
- Youth activities and opportunities — improved mental health
- Addition of full-service grocery
- Fitness and nutrition programs with accountability (for all ages)
- Permanent, covered location for the Farmer's Market
- "Clean up Kentucky" increases pride in home and community, including recycling

Appendix D

Mercy Health — Marcum and Wallace Hospital Usage Data

Hospital Usage, CY 2023

Patient Status	Total
Inpatient Discharges	765
Outpatient Discharges	31,891

Hospital Inpatient Payer Mix, CY 2023

Payor	Discharges
Commercial	51
Medicaid	118
Medicare	573
Other	12
Self-Pay and Charity	11

Top Hospital Inpatient Diagnosis-Related Group, CY 2023

DRG Description	Visits
Signs and Symptoms	106
Simple Pneumonia and Pleurisy	84
Septicemia	66
Respiratory Infections and Inflammations	52
Kidney and Urinary Tract Infections	49
Chronic Obstructive Pulmonary Disease	48
Heart Failure and Shock	47
Renal Failure	30
Cellulitis	29
Nutritional and Miscellaneous Metabolic Disorders	25

Mercy Health — Marcum and Wallace Hospital

CHNA Community Steering Committee

Marcum and Wallace Hospital 2024 CHNA External Stakeholders			
Organization	**County**	**First Name**	**Last Name**
Estill County EMS	Estill	Darren	Muncie
Estill County Health Department	Estill	Elizabeth	Walling
Estill County Chamber of Commerce	Estill	Joe	Crawford
Estill County Judge Executive Office	Estill	Donnie	Watson
Estill County Schools	Estill	Melinda	Barnett
Estill County Sheriff's Department	Estill	Chris	Flynn
Estill Action Group	Estill	Jessica	Stevens
Estill Development Alliance	Estill	Ethan	Moore
Housing Authority of Irvine	Estill	Debra	Rogers
Interfaith Wellness Ministry	Estill	Donna	Crow
Lee County Health Department	Lee	Kristin	Brandenburg
Holy Family Catholic Church	Owsley	Sister	Angie
Owsley County Action Team	Owsley	Donna	Hardin
Kentucky Rural Health Information Organization (KRHIO)	Powell	Scott	Lilley
Kentucky Rural Health Information Organization (KRHIO)	Powell	Leandra	Knox
Powell County Health Department	Powell	Stacy	Crase
Powell County Senior Citizens Center	Powell	Sheila	Thomas

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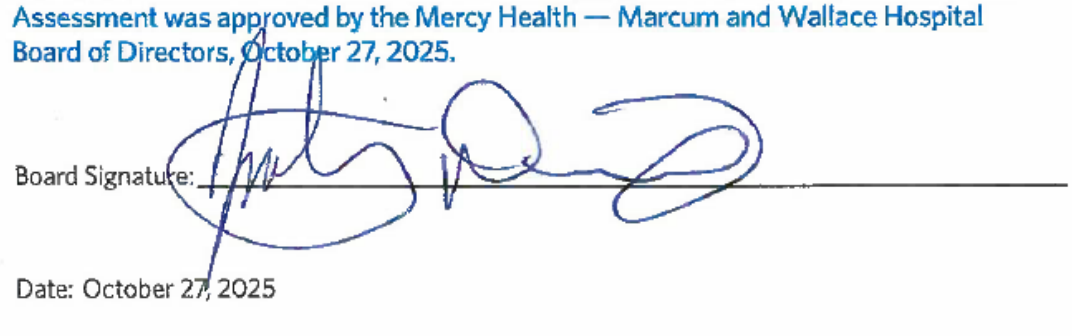
Board Approval

The Mercy Health — Marcum and Wallace Hospital 2025 Community Health Needs Assessment was approved by the Mercy Health — Marcum and Wallace Hospital Board of Directors, October 27, 2025.



For further information or to obtain a hard copy of this Community Health Needs Assessment (CHNA), please contact:

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

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Mercy Health CHNA Short Link: Mercy Health CHNAs

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