2026–2028 Community Health Implementation Plan

Mercy Health — Marcum and Wallace Hospital

IRVINE, KY

2026–2028 Community Health Implementation Plan

Mercy Health — Marcum and Wallace Hospital

Approved by the Mercy Health — Marcum and Wallace Hospital Board of Directors, April 27, 2026.

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, based on input from residents, businesses and other community members.

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

By listening to community voices from our partners and neighbors, Mercy Health — Marcum and Wallace Hospital has identified the greatest needs in our community. The Community Health Implementation Plan (CHIP) helps ensure our resources and strategies for outreach, prevention, education and wellness are directed where they can make the greatest impact.

We welcome written comments regarding the health needs identified in this CHIP. 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

60 Mercy Court
Irvine, KY 40336
606-723-2115

mercy.com

Mercy Health CHIP Short Link:
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Introduction

This Community Health Implementation Plan will address the prioritized significant community health needs listed through the Community Health Needs Assessment (CHNA). The Implementation Plan indicates which needs Mercy Health — Marcum and Wallace Hospital will address and how, as well as which prioritized needs will not be addressed and why.

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

The strategies in the Implementation Plan will provide the foundation for addressing the community's significant needs between 2026–2028. However, Mercy Health — Marcum and Wallace Hospital anticipates that some strategies and even the needs identified, may evolve over that period. Mercy Health — Marcum and Wallace Hospital plans a flexible approach to addressing the significant community identified needs that will allow for the adaptation of potential changes and collaboration with other community agencies and partners.

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Executive Summary

Background and Process

The 2025 Community Health Needs Assessment (CHNA) was conducted in partnership with Blueprint Kentucky following IRS guidelines. Blueprint Kentucky collaborated with the hospital's internal committee to establish the timeline, coordinate data collection and recruit a community steering committee representing Estill, Lee, Owsley and Powell counties, with inclusion of individuals knowledgeable about vulnerable and at-risk populations.

Primary data were collected through a community health survey (608 responses) and five focus groups (43 participants). Secondary data were analyzed from sources including the Kentucky Hospital Association, County Health Rankings, Kentucky Cancer Registry and Kentucky Injury Prevention and Research Center. Using Association for Community Health Improvement (ACHI) criteria, the steering committee met to review findings and collaboratively identify and prioritize the community's most significant health needs.

Identifying Significant Needs

Significant health needs were identified through a collaborative process involving the community steering committee, Blueprint Kentucky and the hospital's internal team. The committee reviewed both primary data (community surveys and focus groups) and secondary data from state and local sources to assess the overall health status of the service area.

During the final steering committee meeting, participants applied the ACHI criteria — including magnitude, severity, impact on vulnerable populations, community capacity, measurable impact and resource availability — to evaluate each identified issue. Through discussion and group consensus, the committee prioritized the most significant community health needs to guide the development of the 2026–2028 CHIP.

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
Health Literacy and Education	Yes
Addressing Chronic Diseases (including cancer screenings, cardiovascular disease and diabetes)	Yes
Mental Health (including pediatric and SUD)	Yes
Transportation	No

Implementation Strategies to Address Community-Level Social Determinant of Health Needs

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

Description

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 resources (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.

Goal

By 2028, improve awareness and consumption of local, nutritious and affordable foods among patients and community members identified as food insecure by 10% and promote sustainable dietary behaviors that reduce obesity and related chronic disease risk.

Strategies

- **Strategy 1:** Collaborate with clinical teams to increase screening for food insecurity and connect identified individuals to community nutrition resources through Food as Medicine referrals. The Food as Medicine program is new to the market and represents an expansion of existing community health and nutrition efforts. Building on the Harvesting Health program, which provided fresh meal kits and healthy recipes to address food insecurity, Food as Medicine expands services by allowing provider referrals to Community Health Workers and a registered dietitian trained to collaborate with clinical teams and coach patients on using food to improve health outcomes.
  - **Strategic Measures**
    - **Year 1 Strategic Measure (2026)**
      - Establish baseline % of patients screening positive for food insecurity or other indicators of unhealthy eating behaviors who are referred to Food as Medicine.
    - **Year 2 Strategic Measure (2027)**
      - Increase by 10% the % of individuals identified with food insecurity or unhealthy eating behaviors who receive Food as Medicine referrals.
      - Establish baseline % of participants reporting improved awareness and utilization of nutritious, affordable foods following follow-up with a dietitian or nutrition support provider.

- **Year 3 Strategic Measure (2028)**
  - Increase by 10% the percentage of those who receive Food as Medicine referrals and engage in nutrition education or support services after being identified with food insecurity or unhealthy eating behaviors.
  - Increase the % of participants reporting improved awareness and utilization of nutritious, affordable foods based on follow-up assessment.

Accountable Partners

- Mercy Health — Marcum and Wallace Hospital will work in partnership with the following accountable partners on the above listed strategy to address Food Security (including access to healthy foods and addressing obesity):
  - Internal Partners: Primary care clinics, dietitians and care coordination teams will identify patients experiencing food insecurity, provide referrals to established Food as Medicine program and support follow-up on nutrition and lifestyle interventions.
  - External Partners: Community-based organizations, local extension agencies, local public health departments and regional farms will provide access to nutrition resources, support educational programs and facilitate engagement with healthy, affordable food options for identified individuals.

These partnerships ensure a coordinated approach to screening, referral, education and follow-up, enhancing the hospital's ability to improve awareness and utilization of nutritious, affordable food, healthy eating behaviors and long-term chronic disease prevention.

Expected Impact of the Strategy

- Increased screening and identification of patients experiencing food insecurity or exhibiting unhealthy eating habits, with improved connection to community nutrition education and support resources.
- Expanded utilization of Food as Medicine referrals to encourage healthier, affordable food choices and reduce long-term risk of obesity and diet-related chronic diseases.

Targeted Populations

- Patients identified through clinical screening as food insecure or demonstrating unhealthy eating patterns.
- Community members at risk for obesity or diet-related chronic diseases (e.g., diabetes, hypertension).

Implementation Strategies to Address Individual Level Health Related Social Needs

Health Literacy and Education

Description

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.

Goal

Increase exposure to and knowledge gained from community health literacy education events, enabling community members to make more informed decisions about their health by 2028.

Strategies

- **Strategy 1:** Partner with primary care providers and care coordinators to connect patients and community members to targeted in-person health literacy education focused on preventive care, mental health, chronic disease management and vaccine education through community-based workshops and education sessions.
  - **Strategic Measures**
    - **Year 1 Strategic Measure (2026)**
      - Establish baseline number of health education classes offered by topic area (preventive care, mental health, chronic disease management and vaccine education).
      - Establish baseline % of participants who report increased understanding of the education topic following participation in a health education class or community-based health literacy education event.
      - Establish baseline % of participants who report applying learned information (e.g., screening, vaccination or provider visit) within 3–6 months after attending a health education class.
  - **Year 2 Strategic Measure (2027)**
      - Increase by 10% number of health education classes offered in each topic area
      - Increase the % of participants who report increased understanding of the education topic compared to the 2026 baseline.
      - Increase the % of participants who report applying learned information within 3–6 months after attending a health education class.

- **Year 3 Strategic Measure (2028)**
  - Increase by 10% the number of health education classes offered in each topic area compared to the 2026 baseline.
  - Increase by 10% the % of participants who report applying learned information following participation in a health education class.
  - Increase by 10% the percent of participants completing consistent follow-up with their primary care provider after participation in a health education class.

Accountable Partners

- Mercy Health — Marcum and Wallace Hospital will work in partnership with the following accountable partners on the above listed strategy to address Health Literacy and Education:
  - Internal Partners: Primary care clinics, care coordination teams and hospital educators will provide expertise, facilitate health education classes and education events and support follow-up with participants to encourage application of learned health information.
  - External Partners: Local extension agencies, public libraries, public health departments, primary care clinics and schools will host and promote educational events, provide venues and resources and assist in reaching diverse community members. Additional community-based organizations, such as senior centers and local civic groups, may also support outreach and education efforts.

These partnerships enable broad community engagement, ensure accurate and accessible health education and support participants in applying knowledge to preventive care, mental health, chronic disease management and primary care follow-up.

Expected Impact of the Strategy

- Increased knowledge and confidence among community members to make informed health decisions.
- Increased engagement with preventive care, mental health, chronic disease management and primary care follow-up.
- Strengthened collaboration between community members and primary care providers.

Targeted Populations

- Community members attending education sessions, especially those at risk for chronic disease or underutilizing preventive services.
- Patients with gaps in regular primary care who could benefit from education and follow-up support.

Implementation Strategies to Address Clinical Health Needs

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

Description

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.

Goal

By 2028, increase the percent of community members completing preventive screenings or engaging in chronic disease management education.

Strategies

- **Strategy 1:** Increase preventive screenings and chronic disease management participation through community outreach, education and referral partnerships with clinical teams.
  - **Strategic Measures**
    - **Year 1 Strategic Measure (2026)**
      - Increase the number of community events that include chronic disease education or screening opportunities.
      - Establish baseline percentage of event participants referred for preventive screenings (cancer, cardiovascular or diabetes).
      - Establish baseline percentage of referred participants who report completing a screening or follow-up appointment within 3–6 months.
    - **Year 2 Strategic Measure (2027)**
      - Increase by 10% the number of community outreach events that include chronic disease education or screening opportunities.
      - Increase by 10% the percentage of event participants referred for preventive screenings (cancer, cardiovascular or diabetes) from Year 1 baseline.
      - Increase by 10% the percentage of referred participants who report completing a screening or follow-up appointment within 3–6 months.
    - **Year 3 Strategic Measure (2028)**
      - Increase by 10% (from Year 2) the number of community outreach events that include chronic disease education or screening opportunities.
      - Increase by 10% (from Year 2) the percentage of event participants referred for preventive screenings (cancer, cardiovascular or diabetes).
      - Increase by 10% (from Year 2) the percentage of referred participants who report completing screenings or follow-up appointments within 3–6 months.

Accountable Partners

- Mercy Health — Marcum and Wallace Hospital will work in partnership with the following accountable partners on the above listed strategy to address Chronic Diseases (including cancer screenings, cardiovascular disease and diabetes):
  - Internal Partners: Primary care clinics, pharmacy, care coordination teams, dietitians and hospital educators will identify patients at risk for chronic diseases, provide education, facilitate referrals for screenings and support follow-up for adherence to care plans and medications.
  - External Partners: Local public health departments, primary care clinics, pharmacies, community organizations, businesses and educational institutions will assist in outreach, host screening and educational events and provide resources to promote chronic disease prevention and management in the community.

These partnerships ensure coordinated outreach, education and clinical follow-up, increasing preventive screenings, chronic disease knowledge and adherence to prescribed management plans.

Expected Impact of the Strategy

- Increased participation in preventive screenings and chronic disease education.
- Improved knowledge of chronic disease risk factors and self-management behaviors.
- Increased adherence to prescribed medications, supporting better health outcomes and reduced disease complications.

Targeted Populations

- Community members at risk for chronic diseases such as diabetes, cardiovascular disease and cancer.
- Patients with limited engagement in primary care who could benefit from preventive screenings, education and follow-up support.

Mental Health (including pediatric and SUD)

Description

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.

Goal

By 2028, increase community capacity to recognize and respond to mental health and substance use concerns through evidence-based training and education, reducing stigma and improving early intervention.

Strategies

- **Strategy 1:** Provide Adult and Youth MHFA (Mental Health First Aid), QPR (suicide prevention) and TIC (Trauma-Informed Care) training through community and school partnerships to strengthen early identification and response.
  - **Strategic Measures**
    - **Year 1 Strategic Measure (2026)**
      - Establish baseline number of community health events that include a mental health education or training component.
      - Establish baseline percentage of participants in MHFA, QPR and TIC trainings reporting increased confidence or ability to recognize/respond to mental health or suicide warning signs.
    - **Year 2 Strategic Measure (2027)**
      - Increase by 10% the number of community health events that include a mental health education or training component.
      - Increase by 10% the percentage of participants in MHFA, QPR and TIC trainings reporting increased confidence or ability to recognize/respond to mental health or suicide warning signs.
    - **Year 3 Strategic Measure (2028)**
      - Increase by 10% (from Year 2) the number of community health events that include a mental health education or training component.
      - Increase by 10% (from Year 2) the percentage of participants in MHFA, QPR and TIC trainings reporting increased confidence or ability to recognize/respond to mental health or suicide warning signs.

- **Strategy 2:** Provide substance use disorder (SUD) education through community and school partnerships to increase awareness, reduce stigma and improve early identification and intervention.
  - **Strategic Measures**
    - **Year 1 Strategic Measure (2026)**
      - Establish baseline number of community health events that include a SUD education component.
      - Establish baseline percentage of participants in SUD education reporting increased confidence or ability to recognize, intervene or report SUD.
    - **Year 2 Strategic Measure (2027)**
      - Increase by 10% the number of community health events that include a SUD education component.
      - Reporting increased confidence or ability to recognize, intervene or report SUD.
    - **Year 3 Strategic Measure (2028)**
      - Increase by 10% (from Year 2) the number of community health events that include a SUD education component.
      - Increase by 10% (from Year 2) the percentage of participants in SUD education reporting increased confidence or ability to recognize, intervene or report SUD.

Accountable Partners

- Mercy Health — Marcum and Wallace Hospital will work in partnership with the following accountable partners on the above listed strategy to address Mental Health (including pediatric and SUD):
  - Internal Partners: Licensed clinical counselors, peer support specialists, chaplains and certified educators will provide evidence-based training, facilitate workshops and support follow-up with participants to reinforce learning and ensure access to appropriate mental health resources.
  - External Partners: Local clinics, community-based organizations and advisory boards (e.g., Project Home) will assist with outreach, host and promote training sessions and support linkage to behavioral health services in the community.

These partnerships strengthen community capacity to identify and respond to mental health and substance use concerns, improve early intervention, reduce stigma and ensure participants have ongoing access to appropriate resources and support.

Expected Impact of the Strategy

- Increased community awareness, confidence and capacity to identify and respond to mental health and suicide concerns.
- Improved early intervention and referral to appropriate mental health resources.
- Reduced stigma around mental health and substance use disorders.

Targeted Populations

- Community members and students participating in education and training sessions.
- Educators, first responders and other community stakeholders who can function as first points of contact for mental health concerns.

Prioritized Needs Not Being Addressed

Transportation

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. 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.

Resources Available

Due to the considerable and complex nature of the prioritized needs, there are several organizations within the community that may be available to address one or more of the needs listed in this implementation plan:

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**
  - ood 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 and 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)

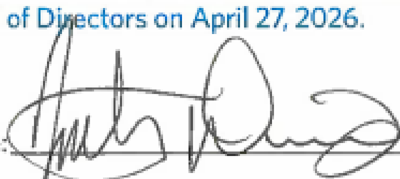
Other Local and National Resources

- **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)

Board Approval

The Mercy Health — Marcum and Wallace Hospital 2026-2028 Community Health Implementation Plan was approved by the Mercy Health — Marcum and Wallace Hospital Board of Directors on April 27, 2026.

Board Signature: 

Date: 4-27-26

For further information or to obtain a hard copy of this Community Health Implementation Plan, please contact:

Meghan Mills, *Director of Community Health*

Mercy Health — Marcum and Wallace Hospital
60 Mercy Court, Irvine, KY 40336

mlmills@mercy.com

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

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60 Mercy Court
Irvine, KY 40336
606-723-2115

mercy.com

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