



2026–2028 Community Health Implementation Plan

Mercy Health — Tiffin Hospital
TIFFIN, OH

2026–2028 Community Health Implementation Plan

Mercy Health — Tiffin Hospital

Approved by the Mercy Health — Toledo Board of Directors, April 21, 2026

As part of Bon Secours Mercy Health, Mercy Health — Tiffin 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.

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.

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

We welcome written comments regarding the health needs identified in this CHIP. Please direct your feedback to Jessica Henry, Director, Community Health at Jessica_Henry@mercy.com

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Mercy Health CHIP
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Introduction

This Community Health Implementation Plan will address the prioritized significant community health needs listed through the CHNA. The Plan indicates which needs Mercy Health — Tiffin Hospital will address and how, as well as which needs Mercy Health — Tiffin Hospital will not address and why.

Beyond the programs and strategies outlined in this plan, Mercy Health — Tiffin 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 — Tiffin Hospital anticipates that some strategies and even the needs identified, may evolve over that period. Mercy Health — Tiffin 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

From April 2024 through March 2025, Mercy Health — Tiffin Hospital (in collaboration with Seneca County General Health District) conducted a community health needs assessment (CHNA) that utilized a comprehensive, mixed-methods approach to identify priority community health needs. The process combined secondary (existing) data collection, community engagement to collect primary (new) data, quantitative and qualitative data analysis and stakeholder input to ensure a well-rounded understanding of local health challenges. The needs assessment was conducted in partnership with Moxley Public Health, LLC. The CHNA included the following components:

1. Secondary (Existing) Data Collection and Analysis

Publicly available health statistics were gathered from sources such as the U.S. Census, the Centers for Disease Control and Prevention (CDC), health interview surveys, state and local health departments. These data sources helped establish trends in demographics, social determinants of health, health conditions, disparities and service gaps. Previous CHNA reports were also reviewed.

2. Primary Data Collection and Analysis

The assessment incorporated direct input from community members and key stakeholders through various engagement methods:

A. Community Member Surveys

- A community-wide survey collected from April 2024 through March 2025, 193 responses from Seneca County. The survey was also utilized to collect CHNA data for Defiance, Huron, Lucas and Wood Counties and collected 965 responses in total.
- Topics included ranking health needs, health status, access to care, chronic diseases, mental health and social determinants of health (e.g., housing, transportation, food security).

B. Focus Groups

- Four focus groups were conducted from April 2024 through October 2024, with a total of 47 participants from priority populations:
 - Seniors - 20 participants
 - Mental health - 10 participants
 - LGBTQ+ - 8 participants
 - Youth - 9 participants
- The focus groups identified emerging health issues affecting sub-populations, existing resources and ideas for community health improvement.

C. Key Informant Interviews

- 12 community leaders were interviewed from April 2024 through October 2024 representing sectors such as health care, housing, mental health, education, local government, libraries, senior services and local businesses.
- The interviews identified emerging health issues, sub-populations most affected, existing resources and ideas for community health improvement.

Identifying Significant Needs

Community and stakeholder data were synthesized to determine the top health concerns based on:

- Relevance - Level of importance to community members.
- Severity - Magnitude and urgency of the issue.
- Health Disparities - Impact on marginalized populations.
- Feasibility - Availability of solutions and resources.

The process followed the MAPP 2.0 (Mobilizing for Action through Planning and Partnerships) framework, ensuring a community-driven, equity-focused approach.

Validation and Final Selection

The preliminary health priorities were discussed in a prioritization meeting on March 14, 2025, where key decision-makers reviewed data and selected priority health needs to address in the next Implementation Strategy. The market and hospital presidents identified key decision-makers.

The CHNA's comprehensive data collection and prioritization process ensured that the final health priorities reflected both statistical evidence and real-life community experiences, forming the foundation for the next Implementation Strategy.

Implementation Plan

Mercy Health — Tiffin 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 — Tiffin Hospital will address

Prioritized Significant Health Needs	Hospital Addressing Need
Access to Health Care	Yes
Behavioral Health	No
Maternal, Infant and Child Health	Yes
Chronic Diseases	Yes

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

Access to Health Care

Description

Survey responses from community members highlight health care access as a predominant concern, with 43% identifying it as a priority need. Specific gaps identified include specialist care (36%), dental care access (19%), primary health care (12%), vision care (12%) and hospital and emergency services (7%). Financial and logistical barriers compound these access issues. Five percent of respondents lack health insurance due to cost concerns and five percent do not have an established primary care provider. This leads 15% to rely on urgent care clinics as their usual source of care. Care delays and unmet needs are widespread, with 29%

postponing or forgoing medical care due to appointment unavailability, 5% missing appointments due to transportation challenges, 28% not receiving dental care for over a year, 21% reporting unmet dental needs and 19% unable to obtain necessary prescription medications.

Goal

Increase health coverage for Medicaid, eligible Mercy Health — Tiffin Hospital patients by utilizing a community health worker (CHW) to help connect them to coverage.

Strategies

Strategy

Utilize Community Health Worker Program (CHW) to connect eligible patients with Medicaid insurance coverage.

Strategic Measures

Mercy Health — Tiffin Hospital will measure the number of completed referrals to community health worker for Medicaid-eligible patients.

- **Year 1 Strategic Measure**
 - Establish a baseline of Medicaid-eligible patients referred to CHW.
- **Year 2 Strategic Measure**
 - Increase number of completed referrals by 5% from the baseline.
- **Year 3 Strategic Measure**
 - Increase number of completed referrals by 5% from year two.

Accountable Partners

Mercy Health — Tiffin Hospital will work in partnership with the following accountable partners on the above listed strategy to address access to health care:

- Mercy Health Physicians
- Mercy Health — Tiffin Hospital

Expected Impact of the Strategy

Increase number of Medicaid-eligible patients with insurance coverage.

Targeted Populations

Seneca County residents without insurance, eligible for Medicaid.

Implementation Strategies to Address Clinical Health Needs

Maternal, Infant and Child Health

Description

In the 2025 Mercy Health — Tiffin Hospital CHNA, 46% of survey respondents say that maternal and child health is a top concern. Seneca County's infant mortality rate per 1,000 births was 7, on par with Ohio's and above 5, the HP 2030 target. Maternal and child health services represent a significant priority for nearly half of community members, with 46% of survey respondents identifying addressing maternal and child health as a top community concern. Geographic disparities emerged as a particular concern, with focus group members specifically noting that rural areas are disproportionately affected by these service gaps, likely reflecting the challenges of accessing specialized maternal and child health services in more remote parts of the county, where transportation and provider availability may be additional limiting factors.

Goal

Reduce the incidence of low-birth-weight births among participants in the Pathways Program to 20% in 3 years.

Strategies

Strategy

Early entry into Pathways Program, increase the percentage of program participants enrolled in the first and second trimester to 70% and 70% of babies born at a healthy weight by end of CHIP cycle. The Pathway Program will reduce the incidence of low-birth-weight births in Seneca County through achieving the following objectives:

- Early Entry into prenatal care
- Attendance of regular prenatal visits
- Birth weight of baby is 5 lbs. 8 oz. or greater
- Attendance of a post-partum visit 21 to 56 days after delivery
- The infant is connected to a medical home and attends a one-month well-baby visit

Strategic Measures

Mercy Health — Tiffin Hospital will track what stage of pregnancy expectant mothers are enrolled in the program and the weight of baby at birth.

- **Year 1 Strategic Measure**
 - Have 60% of participants enroll in the 1st and 2nd trimester.
 - 60% of babies born at a healthy weight.
- **Year 2 Strategic Measure**
 - Have 65% of participants enroll in the 1st and 2nd trimester.
 - 65% of babies born at a healthy weight.
- **Year 3 Strategic Measure**
 - Have 70 % of participants enroll in the 1st and 2nd trimester.
 - 70% of babies born at a healthy weight.

Accountable Partners

Mercy Health — Tiffin Hospital will work in partnership with the following accountable partners on the above listed strategy to address Maternal, Infant and Child Health:

- Northwest Ohio Pathways HUB
- Mercy Health — Tiffin Hospital
- Mercy Health Physicians

Expected Impact of the Strategy

Lower the incidence of low-birth-weight babies in Seneca County.

Targeted Populations

Pregnant population in Seneca County.

Chronic Disease

Description

Chronic diseases represent the overwhelming health priority for community members, with 85% of survey respondents identifying chronic diseases as a top community health need. The most cited conditions include diabetes, heart disease, cancer and obesity, reflecting both the prevalence and perceived impact of these conditions on community well-being. The personal impact is substantial, as 40% of survey respondents report having at least one chronic health condition or disability, indicating that two in five community members are directly affected by

ongoing health challenges. Nine percent of respondents report that a lack of provider awareness or education about their health condition prevents community members from accessing appropriate care.

Goal

Decrease the prevalence of Seneca County residents with chronic health conditions by increasing the rate of patients referred to Mercy Health PCPs and achieving identified metrics

Strategies

Strategy

Increase the referral rate of patients without a PCP presenting to the Emergency Department with at least one uncontrolled metric to Mercy Health PCPs. Achieve at least one of the identified metric(s): Blood pressure under 140/90 mmHg, HgbA1c under 9.0, BMI less than 30, or no longer using tobacco products.

Strategic Measures

By the end of the CHIP cycle, achieve 50% referral rate of identified patients to a Mercy Health PCP. 20% of referred patients achieving at least one identified metric:

- BP under 140/90 mmHg
- HgbA1c under 9.0
- BMI less than 30
- No longer using tobacco products

- **Year 1 Strategic Measure**
 - Achieve 40% referral rate of identified patients to a Mercy Health PCP.
 - 10% of referred patients achieving identified metrics.
- **Year 2 Strategic Measure**
 - Achieve 45% referral rate of identified patients to a Mercy Health PCP.
 - 15% of referred patients achieving identified metrics.
- **Year 3 Strategic Measure**
 - Achieve 50% referral rate of identified patients to a Mercy Health PCP.
 - 20% of referred patients achieving identified metrics.

Accountable Partners

Mercy Health — Tiffin Hospital will work in partnership with the following accountable partners on the above listed strategy to address Chronic Disease:

- Mercy Health Physicians
- Mercy Health — Tiffin Hospital
- Mercy Health — Tiffin Hospital Social Work Department

Expected Impact of the Strategy

Decrease the number of patients in Seneca County with chronic health conditions.

Targeted Populations

Adults aged 40 years and over with hypertension and/or at least one of the following co-morbidities: diabetes, obesity, or tobacco use.

Prioritized Needs Not Being Addressed

Behavioral Health

Mercy Health — Tiffin Hospital will not address this prioritized need in the 2026–2028 CHIP due to resource constraints and other organizations that are more equipped to address this need. They will support the efforts of National Alliance on Mental Illness (NAMI) of Seneca County.

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

- Mental Health and Recovery Services Board of Seneca, Ottawa, Sandusky and Wyandot
 - Access to health care, mental health
- Mercy Health — Tiffin
 - Access to health care, chronic diseases, maternal, infant and child health, mental health
- National Alliance on Mental Illness (NAMI) of Seneca County
 - Mental health support
- OhioRISE (Resilience through Integrated Systems and Excellence)
 - Access to health care, mental health
- ProMedica
 - Access to health care, chronic diseases, maternal, infant and child health, mental health

Health Departments

- Seneca County General Health District
 - Access to health care, chronic diseases, maternal, infant and child health, mental health

Other Local and National Resources

- Ravens Care
 - Access to health care
- Tiffin YMCA
 - All prioritized needs

Board Approval

The Mercy Health — Tiffin Hospital 2026–2028 Community Health Implementation Plan was approved by the Mercy Health — Tiffin Hospital Board of Directors on April 21, 2026.



Board Signature: _____

Date: 04/30/2026 _____

For further information or to obtain a hard copy of this Community Health Implementation Plan, please contact Jessica Henry, Director, Community Health at Jessica_Henry@mercy.com

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

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