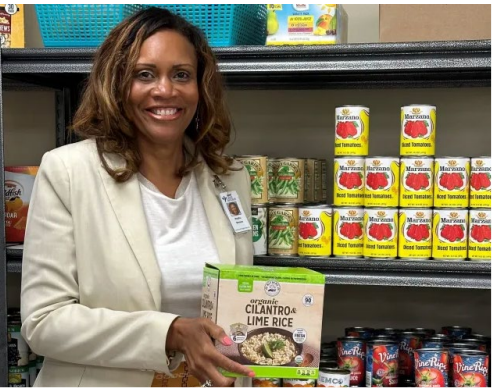
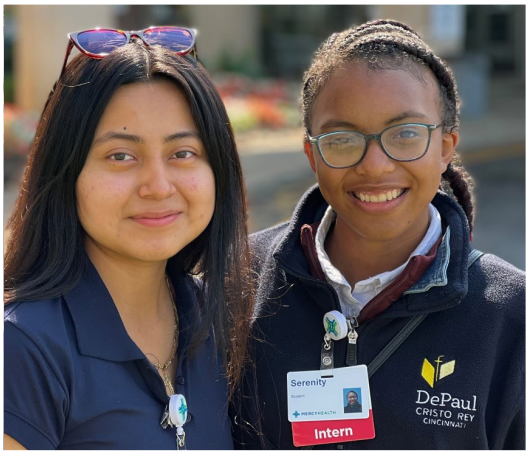
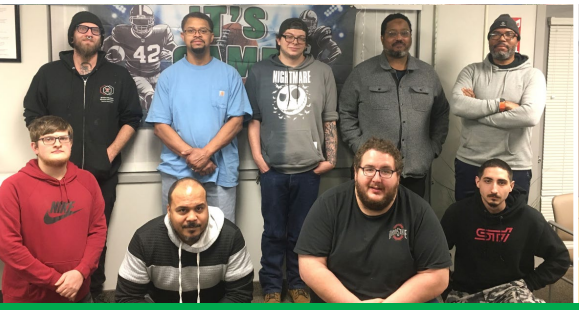
BON SECOURS MERCY HEALTH







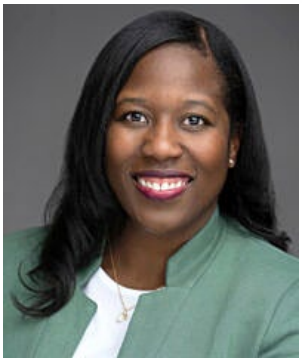
Community Health
Annual Report

2024

BON SECOURS MERCY HEALTH

Contents

Introduction



In 2024, we celebrated the 200th anniversary of the Sisters of Bon Secours. Building on the legacy of our founders, we continue to live our Mission of extending the compassionate ministry of Jesus, by caring for the sick, underserved and dying. As part of our efforts, we are proud to share the 2024 BSMH Community Health Annual Report, celebrating another year of partnership, programming and investment that focused on addressing the most pressing health and social needs in our communities.

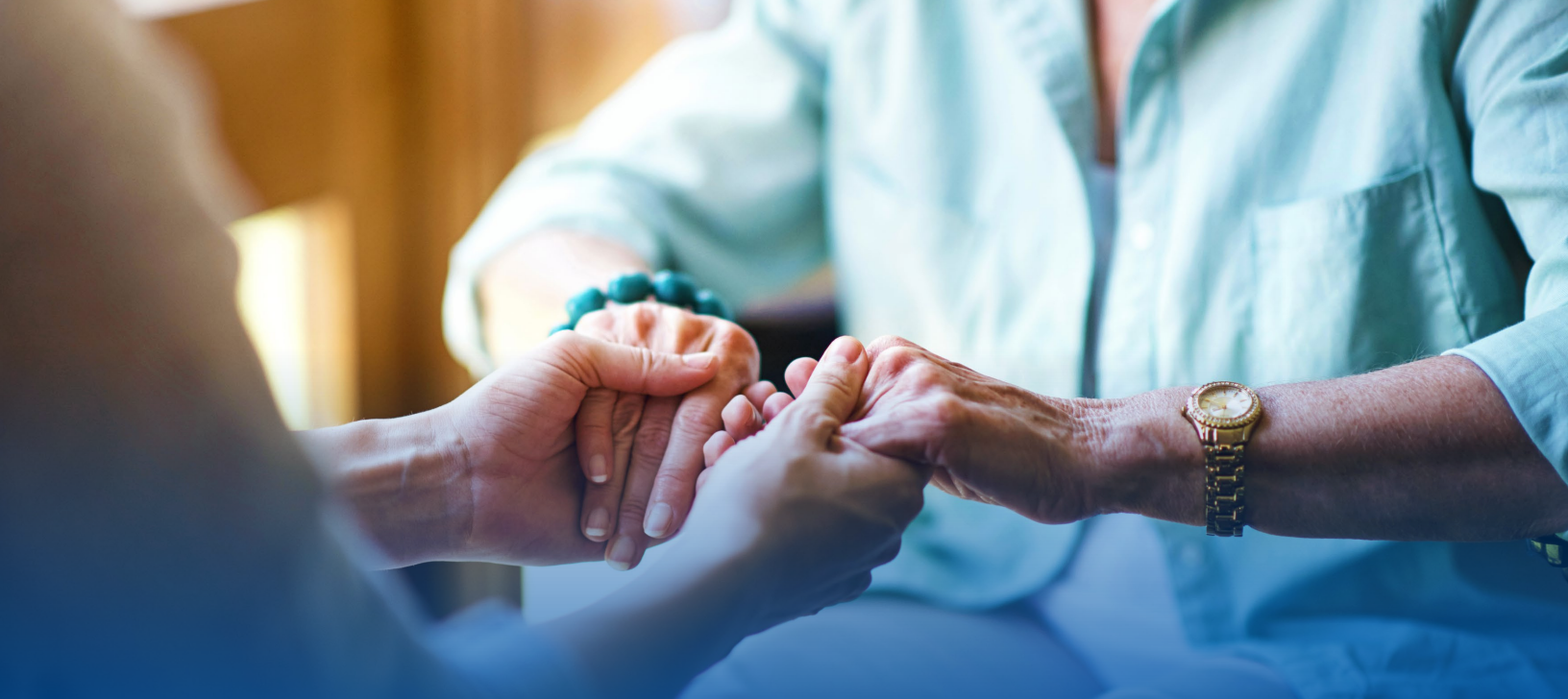
We continue to be thankful for the community residents, partner organizations, faith communities and numerous others who helped us build local capacity, drive innovative investments and deliver quality health programs and interventions. In 2024, we continued our efforts to improve data collection, integrate health equity approaches into our program development process, expand our scope of addressing social drivers and determinants of health by including areas such as community safety and community workforce needs and growing our local, regional and national partnerships to affect change. Serving more than 230,000 individuals in 2024, we continued to lean into opportunities to collaboratively serve the individuals and families that call the communities we serve home.

As we enter 2025, we are guided by a new Community Health Strategic Plan that focuses on supporting community and clinical alignment, improving health and well-being and innovating and collaborating to build scale and capacity. Also driving us is the opportunity for our ministry to revisit the community identified health and social needs of our Community Health Needs Assessments as we complete our triennial exercise, expanding our ongoing local community engagement efforts.

We again thank you, our partners in this work, for allowing us to work alongside you and support efforts to make sure our local communities thrive and the health and social needs of our patients and community members are well supported.

In good health,

Kendra N. Smith, AICP, MPH, MSUS
Vice President, Community Health
Bon Secours Mercy Health



Our Mission, Vision and Values

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.

Community Health

Community Health addresses the social dynamics and underlying factors that impact the health and well-being of the individuals and communities we serve in order to promote justice and health equity. We accomplish this by collaborating with internal and external partners and utilizing a mix of resources and assets.

Community Health Framework

Community Partnerships

BSMH continues to prioritize our commitment to engaging local, regional and national partners to support place-based work and initiatives. Utilizing the expertise of local residents and stakeholders, community-based organizations and regional and national policy partners, we continue to track the most immediate health and social needs of the communities within our footprint. In 2024, we continued expanding opportunities to build local partner capacity and invest in local partners and projects with the ability to reach BSMH patient populations and community members to address identified community needs.

Community Health continued to promote partnership development through evidence-based community engagement practices intended to solicit community voice, vision and preference on a range of health and community development related issues.

We extend our thanks to the many individual and organizational community partners who come along side us and for welcoming BSMH as a trusted partner in your communities.

In 2024, Bon Secours Mercy Health Community Health partnered with more than 300 community partners in offering 142 community programs to serve individuals and families.

Community Health Needs Assessment (CHNA) & Community Health Implementation Plans (CHIP)

Community Health Needs Assessment (CHNA)

As we seek to better understand the communities BSMH serves, the Community Health Needs Assessment is a valuable tool that elevates community voice and priorities in the areas of health and social needs. Created triennially, this report is a concrete reflection of the partnership between BSMH hospitals and local community including residents, organizations and various stakeholders. These groups come together to better understand, prioritize and document the main drivers of health outcomes in their community.

In 2024, Community Health directors began the 2025 CHNA process. 2025 CHNA documents will be board approved and publicly available by the end of 2025.

Community Health Implementation Plan (CHIP)

With 2025 CHNAs underway over the past year, a significant portion of 2024 was also spent implementing strategies of the 2023-2025 CHIP. Focused on opportunities to contribute to community health improvement, CHIPs identify the resources that BSMH can commit to addressing a community's prioritized needs and strengthening local partnerships. Including more than 150 strategies across the BSMH footprint and five cross-cutting topic areas, including behavioral/mental health, chronic disease management, access to health care, community safety and financial security, highlights of CHIP activity are included in the market sections of this report.

Community Benefit

Community Benefit reporting is one way the ministry demonstrates its commitment to community health improvement, documenting many of the operational investments made in our communities. Community Health leaders work closely with Finance and other teams to collect and analyze Community Benefit expense reports before they are reported to the Internal Revenue System (IRS). All activities and programs counted must address a community need (many of which are identified in the CHNA), improve access to health care services, enhance health of the community, advance medical or health knowledge or relieve or reduce the burden of government or other community efforts.

In 2024, BSMH invested more than $500 million in its communities across five states, ensuring that cost is not a barrier to health care for our patients in need. In addition to charity care, BSMH invests in programs that address chronic illness, affordable housing, access to healthy food, education and wellness programs, transportation support, workforce development and other social determinants and drivers of health that directly affect the communities we serve.

Community Benefit includes:

- Traditional Charity Care
- Unpaid cost of public programs
- Community health improvement services
- Health professions education
- Subsidized health services
- Research
- Cash and in-kind contributions
- Community building activities
- Community Benefit operations

Community Benefit — 2024

Community Benefit Categories	Dollars
Charity Care	$142,374,220
Medicaid Unpaid Cost	$217,070,534
Community Health Services	$31,597,885
Health Professions Education	$71,335,027
Subsidized Health Services	$40,903,902
Financial and In-Kind Contributions	$10,880,307
Community Building Activities	$3,865,511
Community Benefit Operations	$5,445,660
Research	$819,961
TOTAL Quantifiable Community Benefit	**$524,293,007**

Community Health Investment

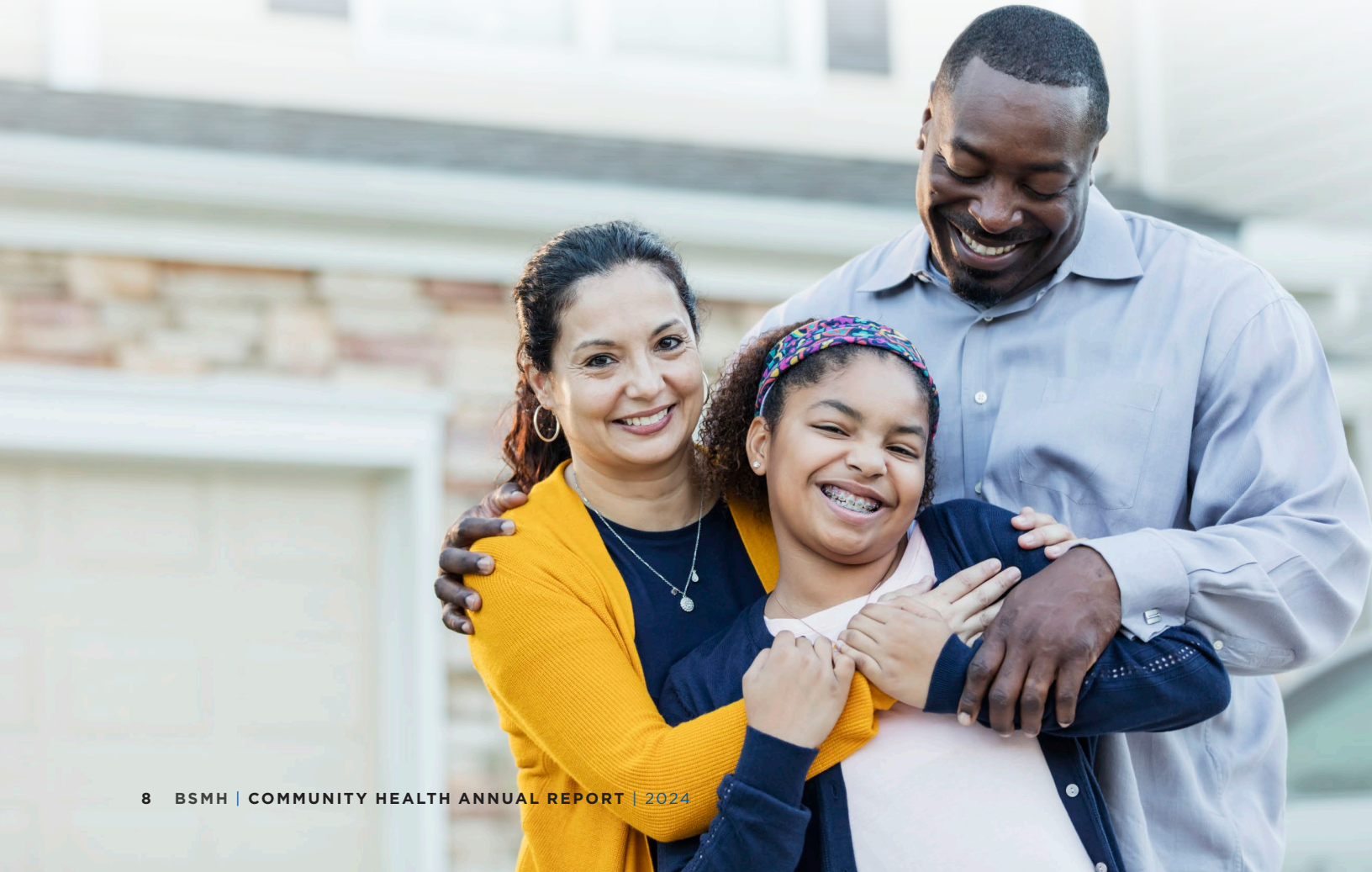
Bon Secours Mercy Health remains focused on supporting innovative and intentional investment into the people and places we serve. The investment program supports non-clinical interventions to address social drivers and determinants of health, using resources to improve community infrastructure, neighborhood conditions and quality of life.

Direct Community Investment (DCI)

The Direct Community Investment (DCI) program provides low interest loan capital in underserved and underinvested communities to address SDOH and promote social and racial equity. In partnership with the BSMH treasury team, capital has supported projects in areas including affordable housing development and retrofits, workforce development, local food systems, community infrastructure and neighborhood condition improvement. In 2024, the DCI program reviewed $7.5 million in loan capital and managed $47.4 million in capital across 90% of our ministry footprint.

Community Health Fund (CHF)

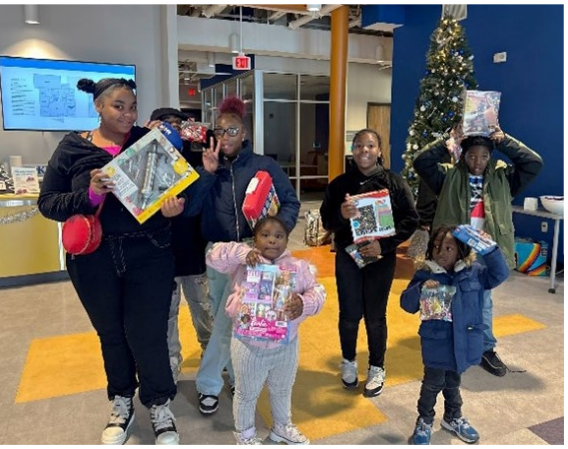
In addition to the DCI program, community investment also includes the Community Health Fund. Started in 2023, the Community Health Fund (CHF) utilizes resources to drive capacity building and partnership development to address social needs in local communities. In 2024, the Fund supported six projects, addressing local needs in permanent supportive housing, community center programming, health education for immigrant communities, intimate partner violence support, patient transportation infrastructure and social and health supports for individuals and families experiencing homelessness. The program will support six new projects in 2025, bringing the total number of projects to 16 since the program's inception. The community groups and organizations we work with are well-established in the community, with strong processes in place to make a difference for local residents.

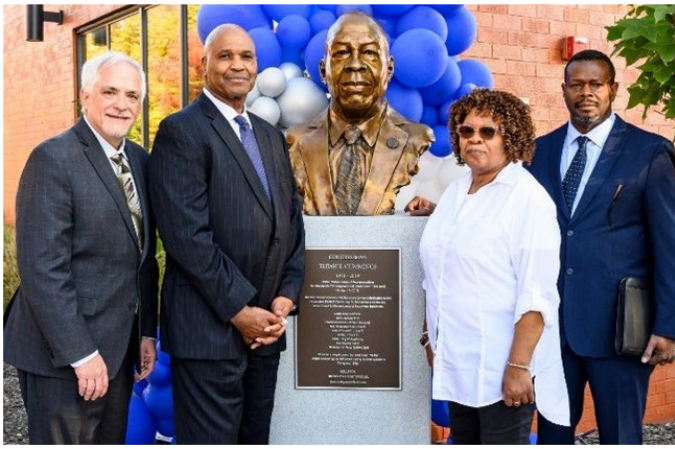


Community Health by Market

Our ministry is working each and every day to improve health equity and access in the communities we serve. Through our programs, partnerships and investments, we are community anchors recognized for high-quality, compassionate care that honors each individual mind, body and spirit and our wraparound services that impact the health and well-being of our neighbors.

In the pages that follow, see how our Mission comes alive in our markets through our Community Health work.





Baltimore (Bon Secours Community Works)

Bon Secours Community Works serves as a key community partner within West Baltimore, with a 30-year history of improving well-being and neighborhood conditions. Bon Secours Community Works' mission of enriching West Baltimore with programs and services that contribute to the long-term economic and social viability of neighborhoods is made possible by a strong commitment to community engagement in the development of programs and advancement of our place-based strategy.

We focus our efforts on 3 service delivery areas that meet unique community needs:

- Economic Development
- Youth & Family Services
- Housing & Community Development

Areas Served:

- Baltimore City
- Baltimore County

4,122 Lives Served

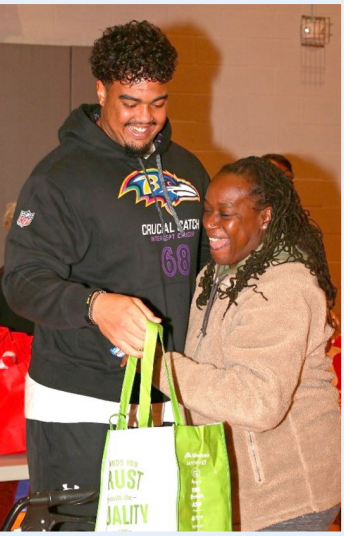
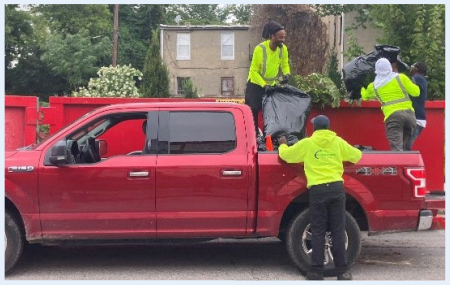
13 Community Health Programs

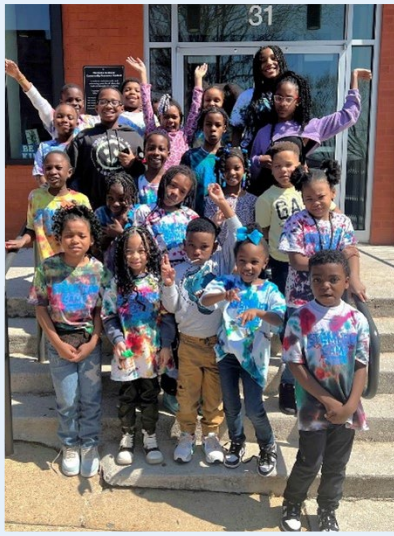
Community Identified Health Needs

- Youth and Family Services
- Housing and Community Development
- Economic Development

2025 Goals

- Complete the rooftop garden project at the Community Resource Center and begin programming that is focused on an intergenerational population.
- Complete the renovation of 20 vacant properties that will become part of a community homeowner program.
- Support 11 new and/or first-time homeowners with the sale of properties through the community homeowner program.
- Expand the Clean Corps Program to cover four large regional areas of West Baltimore, removing at least 100 tons of trash from these neighborhoods.
- Complete Certified Organization for Resident Engagement & Services (CORES) Certification for our resident services program at our affordable rental housing.





2024 **Program Highlights** | Baltimore

YOUTH & FAMILY SERVICE

Community Schools

Bon Secours Community Works partners with four local schools, placing a full-time community school coordinator in each to support the diverse needs of families and students and prioritizing the operation of a community hub for the neighborhood. In 2024, each school focused on increasing attendance. Through the implementation of a home visitation program and attendance incentives, there was a combined attendance increase of just over 5%.

Early Head Start Program

Through the development of an Early Head Start Teacher Training program, two new teachers have been hired and certified. This has allowed for an increase in enrollment, with 45 children enrolled. In 2024, 15 students from the three-year old program successfully transitioned to a certified Head Start program.

HOUSING & COMMUNITY DEVELOPMENT

Fulton Avenue Park

Bon Secours Community Works partnered with local community members in the Franklin Square neighborhood to plan, design and complete the initial build of a community park that transformed vacant dumping grounds into a green space with picnic tables, landscaping/tree cover, a stage and walking paths. With the addition of this park, Bon Secours Community Works has now transformed over 90,000 sq. ft of vacant land into community designed open space.

Bon Secours Apartments Consolidated

Renovations were completed on 117 family affordable rental housing units developed between 1997 and 2003. The extensive updates included new appliances, kitchens, bathrooms, floors, roofs, windows, diverse energy efficiencies and general site improvements.

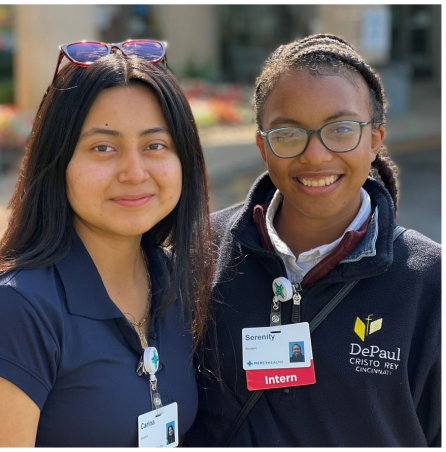
ECONOMIC DEVELOPMENT

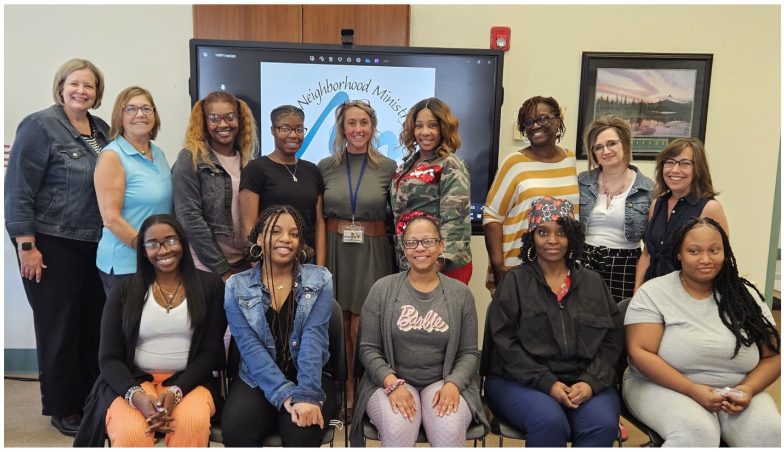
Food Access Program

The Food Delivery Program expanded to deliver food bags to 94 food insecure West Baltimore households, a 43.5% increase from 2023. The Bon Secours Community Works Food Access Program also supports healthy eating and food access in the neighborhood through the delivery of nutrition education workshops, hosting mobile market events and by providing garden plots to community members to learn how to grow their own food. More than 12 events were held in 2024.

Healthcare Training Program

This year, 93 community members were trained and certified to become certified nursing assistants. Forty-three of the certified students were placed in jobs in 2024. This program builds on the legacy of Bon Secours training nurses and creates a career pathway in the health care field.





Cincinnati

Operating six hospitals in Hamilton, Butler, Clermont and Warren counties, Mercy Health — Cincinnati serves a broad geography and works alongside communities to address underlying issues and barriers to health. Through programs and partnerships that are intentionally designed to promote health equity and reduce health disparities, the Mercy Health Community Health team here is changing health outcomes and improving the overall well-being of patients, families and communities across Greater Cincinnati.

Counties Served:

- Adams
- Brown
- Butler
- Clermont
- Hamilton
- Warren

40,843 Lives Served

3 Community Health Programs

Community Identified Health Needs

- Workforce Pipeline and Diversity
- Food Security and Housing
- Access to Services

2025 Goals

- Grow the volume and impact of community health worker referrals across the Cincinnati Market.
- Increase utilization of hospital accompaniment services for domestic violence and sexual assault survivors by strengthening partnerships with community-based advocates.
- Maintain 85% retention rate and improve post-service employment opportunities for Mercy Serves members.
- Establish one to two community food hubs in Clermont County.

2024 **Program Highlights** | Cincinnati

STRENGTHENING WORKFORCE DIVERSITY

Mercy Neighborhood Ministries Health Worker Readiness Program (HWRP)

HWRP launched in 2017 to address high turnover in health care and fill entry level positions. The program focuses on individuals who may have been overlooked or need additional guidance to jump start their path to gainful employment. It provides 54 hours of training over three weeks and prepares participants for early careers in health care. Graduates receive guaranteed interviews with Mercy Health — Cincinnati and priority job consideration. In 2024, 43 participants enrolled, 86% graduated and more than half became employed at Mercy Health.

DePaul Cristo Rey's Corporate Work Study (CWS) Program

DePaul Cristo Rey's CWS Program creates a pipeline of diverse, young talent for the community's future workforce while making private, college-prep education available to families who could not afford it otherwise. Mercy Health — Cincinnati provides tuition support and experiential learning opportunities for students at clinical sites across the Cincinnati market. For the 2023-2024 program year, five students received training in Mercy Health facilities.

ACCESS TO SERVICES

Women Helping Women (WHW)

In 2024, Mercy Health — Cincinnati leveraged funding from the Mercy Health Community Health Fund to help expand WHW's vital services to Clermont County. This marked a significant milestone in our shared mission to provide comprehensive support for survivors of dating violence, sexual violence, domestic violence and stalking. The partnership ensures that patients at Mercy Health – Clermont Hospital have access to community-based advocates and wrap-around resources. Since it's official expansion, 130 survivors have been served, with over 557 different services provided and 358 referrals to community-based organizations.

Dispensary of Hope (DOH)

Mercy Health — Cincinnati continues to strengthen its partnership with DOH, a charitable medication distributor that provides reliable access to essential medications at no cost. The partnership now provides prescriptions to uninsured patients at four different pharmacy locations across the market. This initiative not only addresses immediate medication needs but also fosters long-term health equity goals in the Cincinnati area. From January to December 2024, 1,025 patients were supported with 3,053 prescriptions valued at $213,290, representing a 70% year-over-year increase.

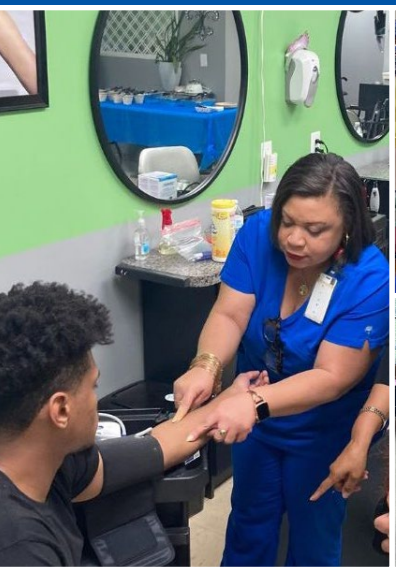
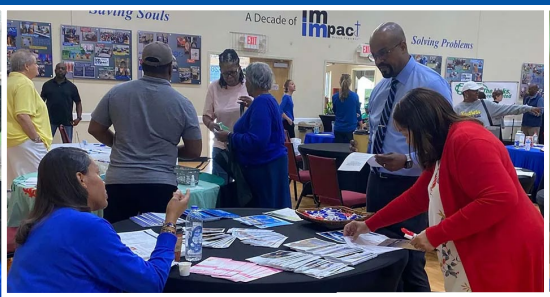
FOOD AND HOUSING

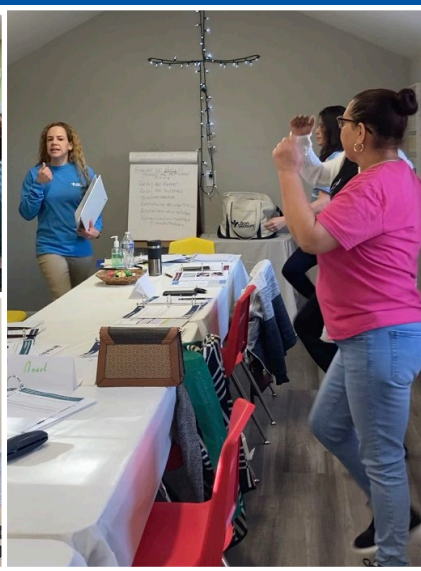
Community Health Workers (CHWs)

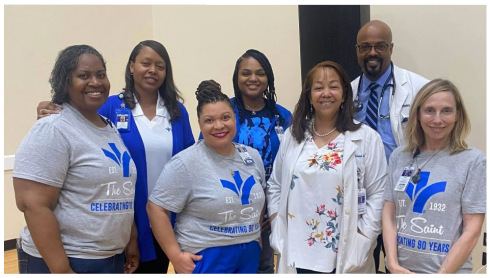
This year, Mercy Health — Cincinnati added three certified CHWs to their team, expanding support for patients and families with health-related social needs. The expansion doubles the number of CHWs currently employed by Mercy Health in Cincinnati and will more than double the number of patients supported by CHWs. In 2023, two CHWs supported 74 Black birthing individuals through the Perinatal Outreach Program. In 2024, a total of five CHWs have assisted nearly 583 patients.

Mercy Serves

Mercy Serves AmeriCorps Members join the Mercy Health Community Health team each September and serve an 11-month service term in Emergency Departments across the Market. The members support patients with substance use disorders and other health-related social needs, including housing instability, food insecurity, lack of transportation, unemployment and social isolation. The support extends compassionate care beyond immediate medical needs and helps patients on their path toward recovery. For the 2023-2024 program year, members conducted 3,513 SDOH screenings and provided 738 resources for SDOH. Mercy Serves is supported by ServeOhio, Ohio's commission on service and volunteerism.



Greenville

Bon Secours St. Francis Health System (BSSF) is one of the leading health care providers serving the health care needs of those in Greenville County, a rapidly growing and increasingly diverse county that spans 795 square miles in the Piedmont region of South Carolina. Greenville County now has both the largest population and highest population density of any county in the state.

The Greenville Market's Community Health team works with uninsured, underinsured and low-income residents to provide health education and services, help with chronic condition management, establish primary care homes and connect clients to other critical resources.

Area Served:

- **Greenville County**

24,413 Lives Served

4 Community Health Programs

Community Identified Health Needs

- **Affordable Housing and Homelessness**
- **Access to Care with an equity lens, including general access to care, access for the aging and access for those with chronic conditions.**
- **Behavioral and Mental Health**

2025 Goals

- Complete the final home of a 10-year, 10-build commitment to Habitat for Humanity.
- Offer at least three additional educational events that improve access to care.
- Create an advisory board for LifeWise with at least four members from the Greenville community, to help guide LifeWise's advocacy and educational efforts around access to care for senior adults.
- Using feedback from previous event attendees, schedule at least one provider or therapist for a "Walk with a Doc" session.
- Offer at least one "train the trainer" event in neighborhoods with an identified need to empower community partners to host their own mental/behavioral health educational events.

2024 **Program Highlights** | Greenville

AFFORDABLE HOUSING & HOMELESSNESS

United Ministries

In 2024, through the Community Health fund, Greenville Community Health helped support United Ministries' plan to increase housing units and wraparound services for families experiencing homelessness. The program provides stable living environments that allow families to transition to permanent housing and self-sustainability.

With the support from Bon Secours St. Francis Foundation, United Ministries was able to provide interim housing for an additional 26 families; GED tutoring for 157 adults, 31 of whom received their GEDs; financial assistance for rent/utility/ medications/ transportation/food for 1,929 families; help for 27 individuals in finding jobs; mental health coaching sessions for 350; financial coaching sessions for 1,194; matched savings for 31; and help meeting financial goals, like improving credit scores and opening a bank account, for 63% of individuals enrolled in financial coaching.

ACCESS TO CARE WITH AN EQUITY LENS

Ministries of Health

In 2024, the Community Health team delivered over 75 evidence-based classes that improved access to care for over 2,000 attendees. Many of these were hosted by community centers, faith-based organizations and other nonprofit organizations. The classes included Heart Health and Blood Pressure Management; Destination Health, a diabetes prevention program; Matter of Balance, a fall prevention program; Mental Health First Aid, a program designed to improve participants' ability to identify, understand and respond to mental and behavioral health issues; and Plant-Based Nutrition, which focused on encouraging participants to eat more fresh fruits and vegetables and less processed food.

In addition, professionals in a wide variety of disciplines and health care specialties provided presentations focused on senior adults' health and SDOH needs.

Access to Care for Senior Adults

As part of Community Health's work to improve knowledge of and access to health-related resources for senior adults, the LifeWise program offered nine classes and events focused on technology to over 150 participants. Topics included how to use smart phones and how to navigate MyChart.

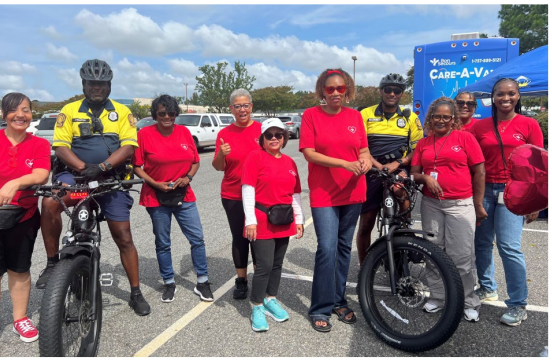
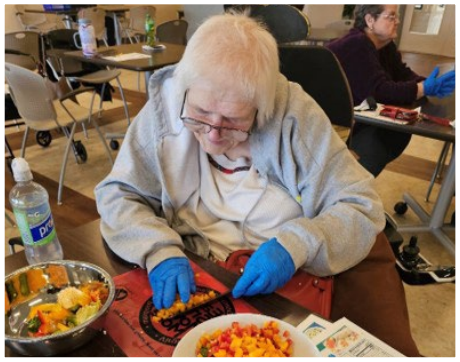
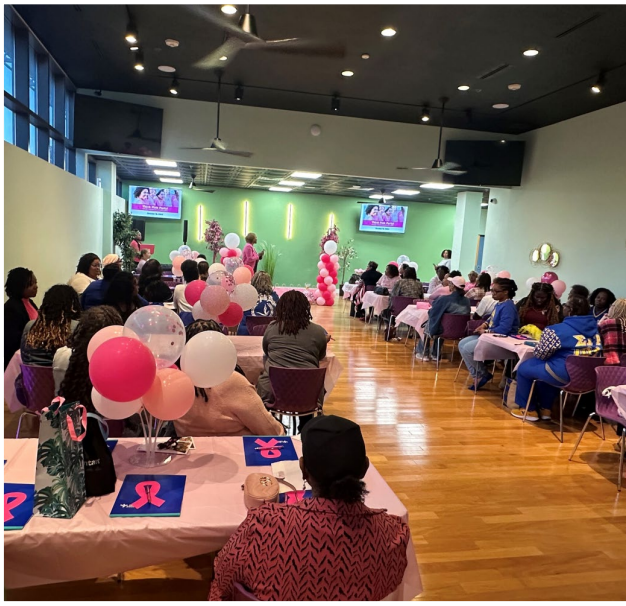
BEHAVIORAL & MENTAL HEALTH

Ministries of Health: Behavioral & Mental Health

Community Health team members presented nine Mental Health First Aid classes (four in Spanish) to over 100 individuals. Partners, including churches, community centers, the Lifelong Learning Center (adult education) and Just Say Something (substance use), provided space and helped recruit participants. Piedmont Health Foundation funded meals and materials for the classes taught in Spanish.

Two bilingual team members also presented NAMI classes to over 78 Spanish speaking community members. Ending the Silence helps participants learn the warning signs of mental health conditions and the steps to take if they or a loved one show symptoms of a mental health condition. Compartiendo Esperanza (Sharing Hope) is a three-part guided dialogue series rooted in sacred storytelling that facilitates discussion about mental health and wellness. The series was created by Hispanic/ Latin American communities for Hispanic/Latin American communities.

HeartMath, a stress and anxiety reduction program that incorporates elements of mindfulness and biofeedback, was delivered to over 1,400 community members. It was presented as a standalone class, as an addition to other physical and mental health classes and in partnership with Well Walkers, an exercise program sponsored by the Greenville Market.


Hampton Roads

Bon Secours Hampton Roads is committed to providing caring and exceptional health care. With medical centers, Bon Secours In Motion, where we provide physical therapy, speech therapy and occupational therapy and four hospitals including Bon Secours Mary Immaculate Hospital located in Newport News, Bon Secours Maryview Medical Center in Portsmouth, Bon Secours Southampton Medical Center in Franklin, and our newest facility, Bon Secours Harborview in Suffolk, scheduled to open in 2025, we meet community members where they are.

The Community Health team continues to be a valued partner in the community. Through our involvement in community events and additional programming, we offer health education programs and provide access through the Bon Secours Care-A-Van.

Counties Served:

- Hampton
- Portsmouth
- Chesapeake
- Virginia Beach
- Newport News
- Suffolk
- Norfolk
- Franklin

25,000 Lives Served

15 Community Health Programs

Community Identified Health Needs

- Violence in the Community
- Food Insecurity
- Mental Health and Substance Abuse
- Health Care Access

2025 Goals

- Expand Kidz-n-Grief programming to provide supportive grief, loss, trauma services at the Bon Secours Community Health in Portsmouth.
- Increase awareness of community-based addictions and behavioral health services in the community through programs hosted at the Bon Secours Hampton Roads Community Health HUB.
- Increase patient visits on the Care-A-Van and increase Passport to Health offerings at the HUB to improve access to services for those with chronic conditions.
- Partner with organizations to promote economic stability for individuals and families in the community.

2024 **Program Highlights** | Hampton Roads

ACCESS TO HEALTH

Care-A-Van (CAV)

For more than 14 years, the Bon Secours Hampton Roads CAV, a mobile medical unit, has delivered primary care services to underserved and uninsured individuals.

A significant portion of participants hail from underserved communities in Chesapeake, Newport News, Hampton, Portsmouth, Suffolk, Franklin and Norfolk. There, issues such as food insecurity and violence are prevalent in patients and participants living with diabetes, high blood pressure and other chronic conditions. Approximately 1,131 patients were served in 2024.

Wednesday Women's Wellness at The Mustard Seed Place

The Mustard Seed Place, a primary care clinic, is set to open in 2025 in Portsmouth. Leading up to the opening, Community Health is hosting monthly Wednesday Women's Wellness events. These events focus on celebrating women's health and well-being in a warm and supportive environment. A Think Pink Party focused on the importance of breast cancer screening and prevention included 75 participants.

EDUCATION

Diabetes Education

A new program focused on delivering diabetes education directly to the community, ensuring accessibility for individuals in their own environments. Classes on diabetes education have been held at various locations, including workforce centers, faith-based organizations, housing authorities and senior centers across different cities in Hampton Roads. In total, 14 community education classes have been conducted, with an overall participation of 151 individuals.

FOOD INSECURITY

Mobile Food Pantry

Transportation challenges make it difficult for many individuals to access food pantries, inspiring creation of the mobile food pantry. This initiative brings healthy food directly to underserved communities while offering education and access to Care-A-Van services. Since launching the Care-A-Van Mobile Food Pantry in early 2024, we've been able to support 3,860 family members.

MENTAL HEALTH & SUBSTANCE ABUSE

Alcoholics Anonymous (AA) Meetings

For this year, in addition to the Narcotics Anonymous meetings, we began regularly hosting AA meetings every Saturday evening. The program started with three participants and has grown to 15 individuals who now meet regularly.

Diaper Bank

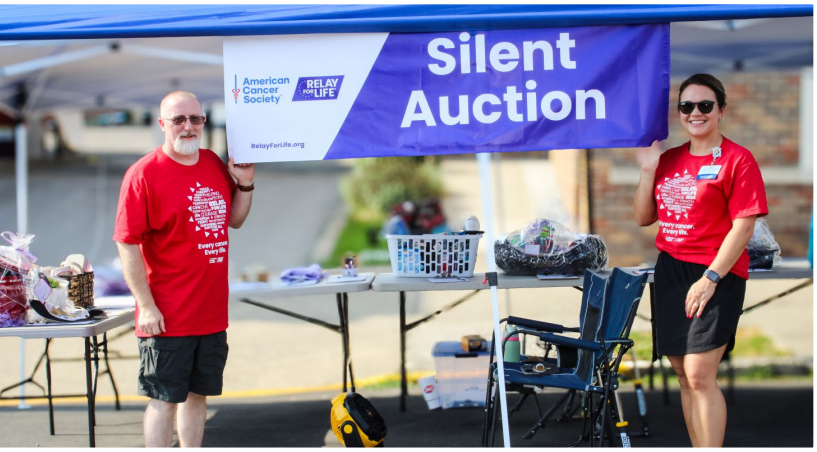
This new program is designed to address multiple goals, including financial and health needs of families with children, a significant segment of the community. The program also addresses significant challenges such as maternal depression and violence reduction in the community by preventing child abuse. In its first three months, the program served 93 families.

> Having access to diapers through the food pantry has been a huge blessing for our family. With three little ones at home, it's been hard to keep up with expenses. The support we've received has not only helped us financially, but has also given us peace of mind knowing our children have what they need. We're truly grateful.
>
> – A Grateful Family in Portsmouth, Va.

VIOLENCE IN THE COMMUNITY

Hispanic Circle of Parents

A national initiative focused on preventing child abuse through self-help groups has been introduced, successfully bringing together 60 family members, including adults and children, to strengthen parenting skills. The group meets weekly, co-facilitated by parents and trained professionals, fostering a supportive community. Participants have found reassurance in shared experiences, realizing that their family dynamics and children's behaviors are more common than they initially perceived. By both giving and receiving support, parents gain confidence in seeking assistance, recognizing it as a sign of strength rather than weakness.



Irvine

Mercy Health — Marcum and Wallace Hospital (MWH), a 25-bed Critical Access Hospital in Irvine, Ky., serves as the primary health care provider for four rural counties: Estill, Lee, Owsley and Powell. The hospital is committed to addressing the health care needs of patients, community partners and stakeholders by aligning its efforts with the CHNA and CHIP. Through these guiding frameworks, MWH ensures its resources and initiatives are focused on addressing the most critical health care challenges in the communities it serves.

Areas Served:

- Estill
- Lee
- Owsley
- Powell

8,862 Lives Served

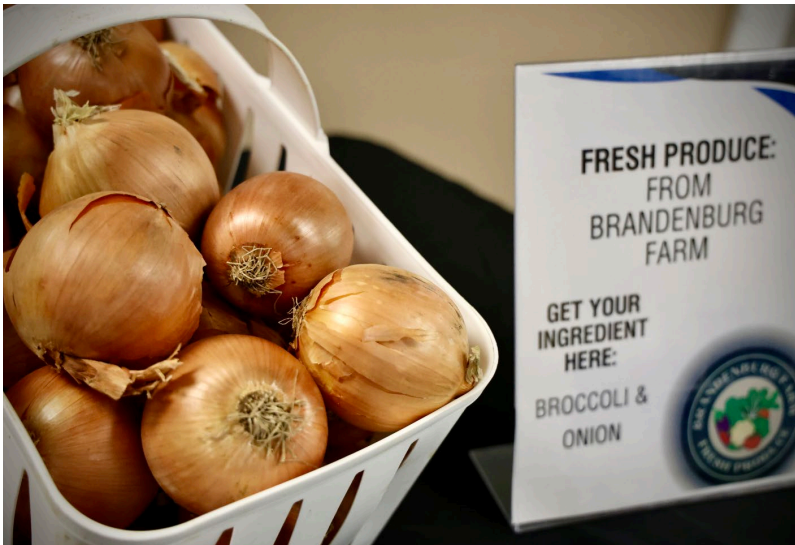
17 Community Health Programs

Community Identified Health Needs

- Food Security
- Addressing Chronic Diseases
- Medication Assistance
- Substance Use Disorder
- Mental Health

2025 Goals

- Food Security: Partner with Foundation for a Healthy Kentucky and Helping Hands Outreach.
- Addressing Chronic Diseases: Raise awareness and education on prevention and care.
- Medication Assistance: Expand delivery services for patients with transportation challenges.
- Mental Health: Implement Licensed Clinical Social Worker in Rural Health Clinics.
- Substance Use Disorder: Prevention education at local schools.



2024 **Program Highlights** | Irvine

FOOD SECURITY

Harvesting Health and Essential Food Support Programs

The Harvesting Health initiative promotes mental health, food security and medication assistance through partnerships with local Extension Services, farmers and fitness experts. With over 200 participants, 100 meal kits were distributed and 100% of recipients reported increased awareness of local food resources. The program equips families with tools for lasting health improvements while supporting local agriculture.

The Essential Food Support program has provided 280 kits to address food insecurity among underserved patients to provide immediate nutritional support and links to long-term resources and support in inpatient, primary care and Quick Response Team settings.

MEDICATION ASSISTANCE

Medication Assistance & Support Program

The medication assistance program supported 306 medication deliveries to homes and over 1,300 Meds2Beds prescriptions filled helping individuals with access to medications and maintaining their medication regimens.

ADDRESSING CHRONIC DISEASES

Diabetes Self-Management Support

The Lee County Diabetes Support Group, in partnership with the Lee County Diabetes Coalition, Kentucky River District Health Department, Lee County Cooperative Extension and Mercy Health — Marcum and Wallace Hospital, offers essential support for those living with diabetes. Over the past two years, 68% of participants improved their A1C levels, 94% prepared and shared healthy recipes at home and 100% reported better self-management of their condition. Additionally, Mercy Health — Lee and Powell County Primary Care clinics received excellence in quality awards for diabetes self-management education and support to better serve the needs of local diabetic patients.

SUBSTANCE USE DISORDER

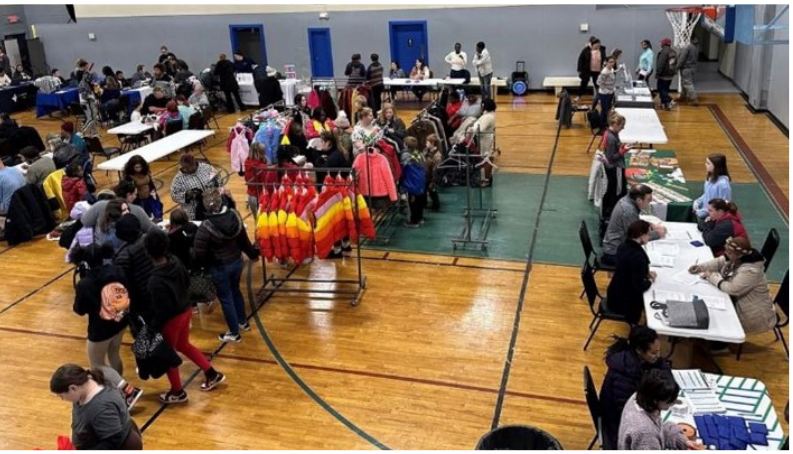
Quick Response Team (QRT)

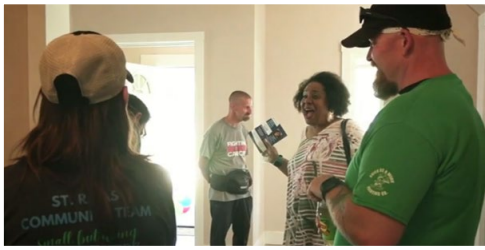
Funded by a KORE grant, the MWH QRT offers immediate support for individuals in substance use crises. Collaborating with local partners, the team has made125 visits, distributed 91 Narcan kits and facilitated treatment placement for 12 individuals, while prioritizing training to meet community needs effectively.

MENTAL HEALTH

Estill County Schools Suicide Awareness Training Program

The Estill County Schools Suicide Awareness Training Program, operated by the MWH Grants department, educates middle and high school students on mental health awareness and suicide prevention. Led by a Behavioral Health clinician and Chaplain/QPR certified trainer, the program includes psycho-educational sessions that encourage open discussions and offer essential resources. With a total of 1,045 participants — 935 students and 110 staff — the program conducted 15 sessions, creating a supportive environment for mental health awareness and equipping both students and staff with suicide prevention strategies.





Lima

For nearly two centuries, Mercy Health — Lima has been focused on the health and well-being of our patients and service to our community. Combining quality and compassion is what Mercy Health — St. Rita's Medical Center has been known for throughout the region. This longstanding commitment has evolved intentionally based on our communities most pressing health needs. The team at St. Rita's addresses these needs by ensuring resources for outreach, prevention, education and wellness are directed toward opportunities where the greatest impact can be realized. Through this we can reach those who are poor, dying, underserved and help to eliminate the many health disparities and barriers that directly impact our community's current greatest health needs.

Counties Served:

- Allen
- Auglaize
- Putnam

45,769 Lives Served

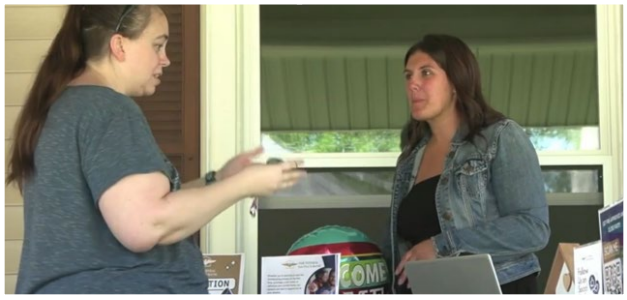
22 Community Health Programs

Community Identified Health Needs

- Housing and Community Conditions
- Access to Health Care
- Maternal Infant Health
- Chronic Disease
- Mental Health/Substance Abuse

2025 Goals

- Expand the Pathways Community HUB and Community Health Worker (CHW) model in the market to address health disparities aimed at reducing pre-term and low birth weight babies.
- Expand work as a OHIZ grantee in Census Tracts 129, 134 and 141 with the goal to launch an evidence-based program that improves health and clinical integration aligned to CHIP.
- Explore available avenues with community partners to help address adolescent behavioral health needs.
- Continue being a leader to help meet the needs of the nearly 2,000 immigrants and refugees who now call Lima home.



2024 **Program Highlights** | Lima

HOUSING & COMMUNITY CONDITIONS

Project 129

Census Tract (CT) 129, which is an area just north of the St. Rita's campus, was at high-risk of poor living and health conditions. Over the past few years, we've made a concentrated effort to invest in CT 129 allowing individuals the opportunity to have their home rehabbed and repaired, with the goal of them eventually becoming homeowners.

At the start of our work, over 67% of individuals that resided in Census Tract 129 were current renters and 45% were considered rent-burdened (over 60% of income spent on rent). In 2024, we have renovated 10 properties, have replaced three roofs and are also providing our employees up to $10,000 in down payment assistance to purchase a home in the neighborhood. In 2024, the program has increased home ownership by 2%. We've also developed a green space and reading park, provided events promoting homeownership and financial literacy, among others.

ACCESS TO HEALTH

Ohio Health Improvement Zone (OHIZ)

Through our work with the Ohio Department of Health (ODH) we've improved access to care in Census Tracts 129, 134 and 141 within Lima. Through this work, we've been able to add wrap-around services to improve access to care and meet people where they are while also supporting the community development work of Project 129. Access programming has included onsite screening events, home ownership events, cooking classes, educational events with our providers, neighborhood block parties, Walk with a Doc and more. In 2024, we completed 424 health needs assessments, completed a total of 64 mobile clinic stops, saw 229 patients, and provided 403 screenings; 205 referrals were then placed with 48.3% of participants having their needs met.

MATERNAL & INFANT HEALTH

Pathways Program

Through a grant secured from the Ohio Commission on Minority Health (OCMH) by the Hospital Council of Northwest Ohio, we were able to hire two Community Health Workers (CHWs) to support the Pathways HUB program in Allen County. Our CHWs act as care coordinators, guiding clients to essential services and resources for the best possible outcomes during pregnancy and post-partum. Through this program clients are offered personalized care coordination, providing access to community resources like car seats, cribs and diapers, support services and guidance on infant care and postpartum health.

In 2024, more than 36 referrals for at-risk mothers through the OBGYN Specialists of Lima were made and 41 mothers/patients enrolled in the Pathways HUB program.

CHRONIC DISEASE

Equity Beyond the 4 Walls

Equity Beyond the 4 Walls is a place-based program model that evaluates and increases access to care for underserved individuals within Allen County in an effort to decrease health disparities and identify gaps in health and social services for those most vulnerable in the community. In 2024, participant barriers to care and other SDOH needs were identified, including 22% needing housing assistance, 28% battling depression, 18% utilized tobacco and/or nicotine, 21% faced food insecurity, 26% not up to date or current with age specific preventive screenings. Of those 424 health needs assessments, a total of 205 referrals were made.

Tobacco Cessation

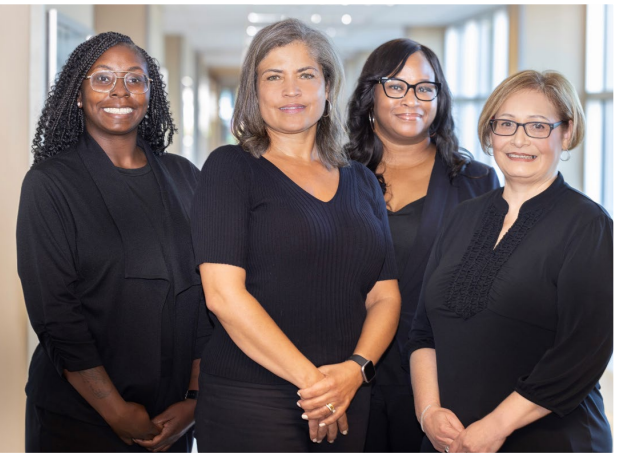
We offer a 12-week tobacco cessation program at no cost to patients. Participants can receive up to 10 weeks of nicotine replacement therapy. In 2024, we had 242 referrals and 80 patients who completed the 12-week program.

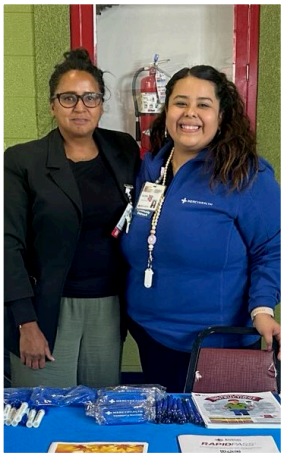
MENTAL HEALTH/ SUBSTANCE ABUSE

Mental Health and Our Community Health Improvement Plan

Adolescent behavioral health continues to be a very big need within the Lima community. For our CHIP, we have partnered with the Mental Health and Recovery Services of Allen, Auglaize and Hardin counties, in addition to Putnam County, to help increase the capacity for youth mental health programming by setting goals to increase the number of programs available and the number of screenings that are being provided. Between Allen, Auglaize and Putnam counties, there were seven different types of programs that were offered, which include: Daytime Crisis support, School Navigators, universal screenings and sports physicals, with 4,825 youth screenings that were provided, which included 85 immediate responses and 24 hospitalizations from those screenings that were provided.

We continue to explore how to best support our school personnel from a mental health perspective, as we are deploying focus groups to best understand what needs they may have in order to create a countywide dashboard that provides a map with all mental health services, where and how to contact and also to allow for tracking of on-going engagement and utilization.



Lorain

For more than 125 years, Mercy Health — Lorain has been dedicated to delivering high-quality, compassionate care to the residents of Lorain County. We are committed to ensuring that every individual in our community — regardless of their circumstances — has access to the care they need. Our two hospitals, Mercy Health – Lorain Hospital and Mercy Health – Allen Hospital in Oberlin, alongside specialized facilities like the Mercy Health — O'Brien Cancer Center and Mercy Health — Outpatient Rehabilitation and Therapy, provide a comprehensive range of services designed to meet the diverse needs of our community.

Improving the overall health and well-being of our neighbors, particularly those who are underserved, at-risk or in need of additional support is a core commitment to our Lorain County community. In line with our values, Mercy Health — Lorain places a strong emphasis on community engagement, offering programs that address key health disparities, promote wellness and provide education on health prevention activities. Our community health initiatives focus on tackling the root causes of poor health, such as chronic disease management, maternal and child health and access to preventive care.

County Served:

- Lorain

3,034 Lives Served

3 Community Health Programs

Community Identified Health Needs

- Chronic Disease
- Infant and Maternal Health
- Substance Use
- Behavioral Health
- Cancer
- Health Equity

2025 Goals

- Strengthen the foundation of health in the community by focusing on Chronic Disease measures (Hypertension, Diabetes, Knowing Your Numbers and Stroke Prevention).
- Provide emotional and social support for women and their children to strengthen their ability to thrive and survive.
- Work with partners to address substance use disorders by increasing access to education, treatment and support.
- Enhance mental health outcomes.
- Create a proactive cancer screening attitude providing access and education to prevention, screening, diagnosis and treatment.
- Remove barriers to ensure every person can achieve their best health and life.

2024 **Program Highlights** | Lorain

CHRONIC DISEASE

Know Your Numbers

Focusing on diabetes management, access to physical activity and promoting overall wellness, the "Know Your Numbers" campaign has empowered individuals to take control of their health. This initiative aligns with the American Heart Association's guidelines, educating participants about the importance of monitoring key health metrics such as blood pressure, cholesterol and BMI. This knowledge helps prevent serious conditions like heart disease and other chronic illnesses, fostering a healthier community.

In 2024, the "Know Your Numbers" campaign reached 663 individuals. A highlight of our outreach efforts included participation in Amherst Steele High School's Annual Wellness Week, where we engaged students through interactive sessions, teaching them the importance of knowing their health numbers at an early age. This kind of community outreach exemplifies our holistic approach to health — starting with education that promotes long-term wellness.

By focusing on prevention and education, our Chronic Disease program and Know Your Numbers continue to lay the foundation for a healthier, more resilient Lorain community.

INFANT AND MATERNAL HEALTH

Resource Mothers Program

For over 30 years, the Resource Mothers program has been a cornerstone of our commitment to supporting maternal and child health in the community. By providing comprehensive support to expectant mothers and their babies, the program promotes healthier pregnancies, safer deliveries and improved early childhood outcomes.

Since transitioning to the Pathways HUB model in 2022, the program has significantly enhanced its capacity to address the SDOH factors for at-risk mothers and infants. The Pathways Hub is a nationally recognized model that ensures holistic care by connecting individuals to critical services through coordinated pathways that meet their unique needs.

Since its inception, 545 clients have been enrolled in the program under the Pathways HUB model, including 252 new enrollments in 2024. Currently 179 clients are actively participating, receiving personalized support from our team of three Resource Mothers and one licensed social worker. These dedicated team members work closely with each client to address health and social needs through tailored pathways.

The Resource Mothers program achieved an impressive success rate in 2024. Out of the 2,722 pathways opened through the HUB, 2,561 were successfully completed, resulting in a success rate of 94%. This highlights the program's dedication to ensuring that clients receive the resources and support they need to overcome barriers and improve outcomes for both mothers and their families.

In 2024, the program has achieved remarkable outcomes, with 88% of babies delivered at or beyond 37 weeks gestation and 94.2% of infants born weighing more than 5 pounds, 8 ounces.

SUBSTANCE USE

Let's Get Real Referral Pipeline Program

Mercy Health – Lorain continues its commitment to addressing substance use disorders through a vital partnership with Let's Get Real, Inc., a 501(c)3 nonprofit Recovery Community Organization based in Lorain. Since 2013, Let's Get Real has provided critical recovery services and support to individuals and families affected by addiction, with a mission to offer education, resources and guidance through the recovery journey.

In 2024, Mercy Health – Lorain and Allen Hospitals have referred 468 individuals to Let's Get Real, connecting them to essential recovery services. Let's Get Real offers peer recovery services, family support groups, sober living resources and assistance in accessing detox and treatment options. The organization's unique approach, supported by Certified Peer Recovery Supporters, ensures that individuals are met where they are — whether in hospitals, jails, police stations or the Harm Reduction Clinic.

2024 **Program Highlights** | Lorain

Let's Get Real has expanded its services across Lorain and surrounding counties, including Huron County, providing holistic recovery support and eliminating barriers to care.

By partnering with Let's Get Real, Mercy Health – Lorain strengthens its commitment to providing a continuum of care for those struggling with substance use disorder. Together, we are working to ensure that recovery is not only possible but fully supported — giving individuals and families the tools and resources they need for long-term success.

CANCER SCREENING AND DETECTION

Promoting Cancer Screening and Early Detection

In 2024, Mercy Health – Lorain reinforced its commitment to cancer prevention and early detection through proactive screening programs. By providing access to life-saving tools such as Prostate-Specific Antigen (PSA) testing and mammograms, we continue to promote health equity and improve outcomes for our community.

PSA testing remains a cornerstone of our efforts to detect prostate cancer early. In 2024, a total of 6,425 PSA tests were conducted, ensuring that men in our community have access to preventive care and early intervention opportunities.

To address breast cancer prevention, our team facilitated 5,999 screenings in 2024. These screenings play a crucial role in detecting breast cancer at its earliest stages, significantly improving treatment outcomes and survival rates. Through outreach and partnerships, we have prioritized increasing awareness about the importance of regular mammograms and reducing barriers to access for women in our community.

The success of these initiatives is measured not only by the number of screenings conducted but also by their impact on community health. Both PSA tests and mammograms ensure individuals have access to preventive care, empowering them to take proactive steps toward better health.

HEALTH EQUITY

Addressing Social Drivers and Determinants of Health

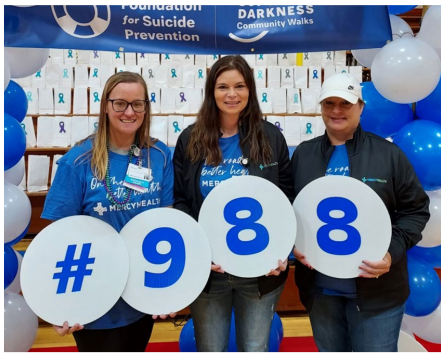
Mercy Health – Lorain's Community Health Team plays a critical role in addressing the SDOH that affect our most vulnerable populations — such as immigrants, migrants and low-income families. By providing resources that go beyond clinical care, we ensure that individuals and families receive the support they need to overcome barriers that impact their health outcomes.

In 2024, our team focused on addressing essential SDOH needs through the distribution of critical resources. This included 373 cans of formula, 12,668 diapers and wipes and 2,993 baby clothing items and blankets, helping families facing economic challenges. Additionally, 509 adult clothing and toiletry items and 173 pieces of furniture, including cribs and mattresses, were provided to meet basic living needs.

The team's efforts to reduce barriers to care extended to 1,440 encounters, providing direct support to help navigate health care access and address specific needs. We also provided 1,247 interpretation services to ensure language barriers did not prevent individuals from receiving care. These encounters directly address SDOH by providing access to vital health care services, regardless of linguistic challenges.

Our Community Health Team has been highly engaged, with 1,140 in-person encounters, 60 virtual encounters and 4,823 text-based encounters, ensuring continuous support and engagement. Through these interactions, we addressed a wide range of needs, from health education to service coordination. The team also made 617 referrals, further supporting individuals in accessing critical services.

By focusing on SDOH—such as housing stability, food security, transportation and health care access, Mercy Health – Lorain is committed to reducing health inequities and improving the overall well-being of our community. Through these efforts, we continue to drive positive outcomes by addressing the root causes of poor health and empowering individuals to live healthier lives.



Paducah

Mercy Health — Lourdes Hospital is a 359-bed, regional hospital located in Paducah, Ky., that is part of Mercy Health's Kentucky Market. It serves as a regional referral center for a wide geographic region, including more than a dozen counties in western Kentucky, southern Illinois, Southeast Missouri and northwest Tennessee. Its primary service area has a population of more than 200,000 people within seven counties and two states (Kentucky, Illinois). Lourdes is home to the region's largest multi-specialty physician network, Mercy Health Physicians — Kentucky, which consists of more than 100 providers serving in over 30 locations throughout Western Kentucky. Lourdes is proud to be one of the region's top three employers and treats more patients than any health care system in the region. The market's service area has a higher-than state average percentage of people over 65 years of age, living in poverty, with a disability and suffering from chronic illnesses.

Counties Served:

- McCracken County *
- Graves County *
- Livingston County
- Ballard County
- Marshall County *
- Massac County (IL)
- Calloway County

13,119 Lives Served

14 Community Health Programs

** CHNA Service Area Counties*

Community Identified Health Needs

- Financial Insecurity, including housing and homelessness and food insecurity
- Transportation
- Mental Health, with an emphasis on pediatrics
- Chronic Health Issues
- Substance Use

2025 Goals

- Continue providing free screenings and health education to the community, including adding new screening opportunities.
- Apply for Drug Free Community program through local health coalition, focused on youth substance misuse prevention and mental health within two public school systems.
- Maintain focus on health equity through community coalition grant program (HeartStrong Kentucky) and event partnerships, such as Alpha Cares Community Health Fair and Go Red Heart Luncheon.
- Implement new fresh food program with a local community partner.

2024 **Program Highlights** | Paducah

FINANCIAL INSECURITY
Housing, homelessness and food insecurity

Community Resource Kiosks

Made possible through funding from the BSMH Foundation's Mission Outreach Program, Mercy Health — Lourdes Hospital sponsored the installation of 11 new digital community resource kiosks across the region. The kiosks are located throughout seven counties in various public health departments and other community-accessible locations, providing easy access to vital resources. These kiosks connect individuals and families with essential resources, from basic needs like food and housing to medical assistance, financial and legal help and educational support. They also offer access to Kentucky's crisis lines and safe spaces. Since their installation in September, the 11 kiosks have been utilized a total of 680 times.

Warming Center Support

In each year since Paducah's Warming Center opened in 2021, Mercy Health — Lourdes Hospital has provided financial support to help Washington Street Baptist Church sustain this necessary shelter. The Warming Center is open nightly to those needing shelter when the temperature is below 40 degrees. During the four months it was open during the 2023-24 winter season, 136 people utilized the Warming Center.

TRANSPORTATION

Medical Transportation Program

Mercy Health continues to enhance its partnership with Heart USA, a non-profit organization located on Mercy Health — Lourdes Hospital's campus. Heart USA assists the community with prescription assistance, durable medical equipment, a food pantry and Certified Community Healthcare Workers (CHWs). Thanks to BSMH's Community Health Fund, Mercy Health was able to support Heart USA with starting a new Medical Transportation Program to provide free transportation to medical appointments for those who have no other transportation options. Since the program launched in mid-July, Heart USA has provided medical transportation to 42 clients.

Screening Outreach in Graves County

Mercy Health — Lourdes Hospital partnered with Graves County Health Department, KentuckyCare and Kentucky Cancer Program to support year-long breast cancer events in Mayfield and Graves County. The goal of these informative events was to help educate, provide resources and screen residents of Graves County for breast cancer, breaking down the transportation barrier while mammography services were unavailable in this county. During three events, 30 women received a free clinical breast exam.

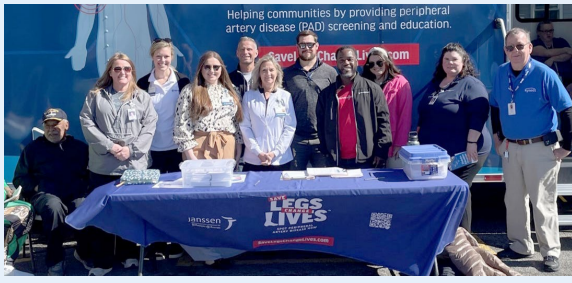
MENTAL HEALTH
Emphasis on pediatrics

Mural Partnership

Mercy Health was a proud sponsor of two Guess Anti-Bullying Foundation murals in downtown Paducah. Both murals feature mental health messaging on the side of Four Rivers Behavioral Health, including one dedicated to the 988 Suicide and Crisis Lifeline and the other featuring "You Are Not Alone" messaging. Alongside other community members, including some who have lost loved ones to suicide, 12 Mercy Health team members helped paint the murals in June. The project showcased a united, collaborative community effort towards reducing the stigma and creating a positive conversation around mental health.

Mental Health First Aid Trainings

In May, Lourdes supported two Mental Health First Aid trainings for individuals who work with adults and youth on how to deal with mental health crisis and substance use. Four Rivers Behavioral Health provided the training for free to representatives from education, law enforcement, health care, churches and more. In total, 17 individuals were trained in Youth and Adult Mental Health First Aid.



2024 **Program Highlights** | Paducah

CHRONIC HEALTH ISSUES

Peripheral Artery Disease Screening

In February, Mercy Health — Lourdes Hospital hosted no-cost Peripheral Artery Disease (PAD) screenings at the Paducah Community Kitchen, alongside KentuckyCare and the Janssen "Save Legs, Change Lives" mobile unit. The screening event aimed to raise awareness about PAD and help individuals assess their risk. If left untreated, PAD can result in serious health complications such as amputations. At the event, 53 people received an ABI (ankle brachial index) screening for PAD. Of those, 11 (21%) were deemed high risk and connected to KentuckyCare for follow up.

Free Flu Shot Program

To expand access to the influenza vaccine, Lourdes Hospital provided the flu vaccine throughout the region without charge, specifically targeting populations facing access barriers and challenges (such as lack of insurance or limited financial resources). Partnering organizations included local health departments, West Kentucky Community and Technical College, Purchase Area Diabetes Connection, county public libraries and local non-profit health care organizations. In 2024, four vaccine events were held across three counties in which 234 doses were administered. Additionally, 316 doses were donated to three non-profit health care organizations, impacting a total of 550 community members.

SUBSTANCE USE

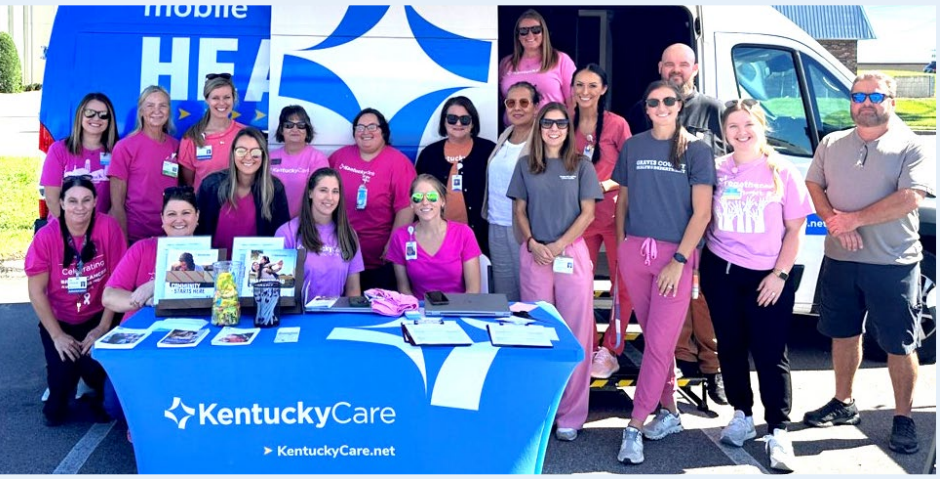
Peer Support Partnerships

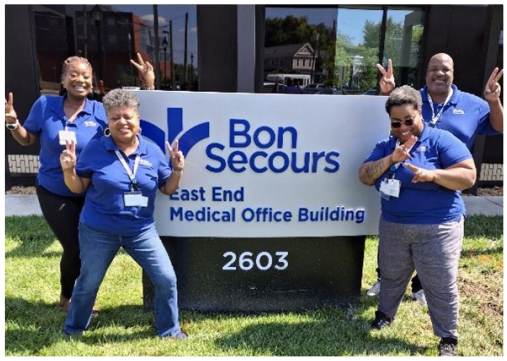
Mercy Health — Lourdes Hospital partners with two Peer Support Programs to connect patients struggling with substance misuse to a Peer Support Specialist (PSS). PSS have personal experience with substance use and can offer guidance and support from a unique, empathetic perspective. Mercy Health partnered with Turning Point Recovery Community Center's Quick Response Team (QRT) in 2023 and added an in-house PSS in April 2024 through StepWorks and the Kentucky Hospital Association's ED Bridge Program. In 2024, 223 total referrals were made to Peer Support Programs, with 95 of those accepting a referral to treatment.

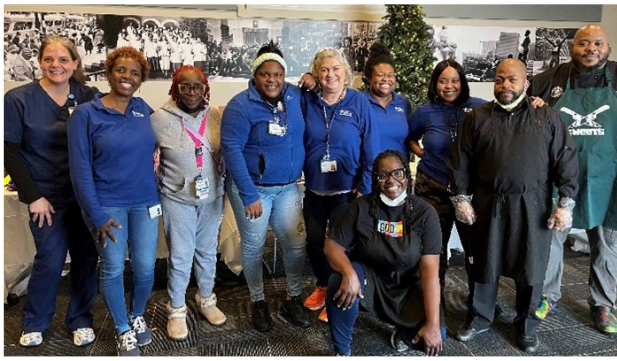
Harm Reduction Initiatives

Mercy Health partners with a variety of community organizations on harm reduction initiatives related to substance misuse. In 2024, results of those partnerships included:

- 2,250 Deterra bags distributed by retail pharmacy to patients receiving an opioid prescription.
- 295 Narcan kits were dispensed to patients receiving an opioid prescription or after an overdose.
- 293.6 pounds of unused prescription medication returned during DEA Take Back Days and through Emergency Department drop box for proper disposal.







Richmond

Bon Secours Richmond Health System provides compassionate medical care through a network of seven acute hospitals, primary and specialty care practices, ambulatory care sites and continuing care facilities across a diverse 24-locality region.

The Community Health team focuses on delivering services to the uninsured and/or marginalized, with an emphasis on being respectful of the cultures and previous life experiences patients bring to their health care encounters. With decades of building a foundation of trust, Community Health serves patients that may have difficulty accessing care through traditional health care venues. In partnership with community nonprofits and local churches, the Community Health work of Bon Secours Richmond has grown to include primary, specialty and preventative medicine and education, behavioral health and referral services, support to victims of interpersonal and community violence and community investments in organizations and programs that address SDOH, including: housing, transportation, food access, out-of-school time, financial literacy, pathways to sustainable careers and post incarceration re-entry.

Counties Served:

- Amelia
- Chesterfield
- Dinwiddie
- Goochland
- Hanover
- City of Hopewell
- King William
- Middlesex
- Northumberland
- Powhatan
- City of Richmond
- Surry
- Brunswick
- City of Colonial Heights
- City of Emporia
- Greensville
- Henrico
- King and Queen
- Lancaster
- New Kent
- City of Petersburg
- Prince George
- Southhampton
- Sussex

24,000 Lives Served

7 Community Health Programs

Community Identified Health Needs

- Chronic Disease and Prevention
- Mental Health
- Violence and Trauma
- Social and Economic Disparity
- Engagement and Inclusion

2025 Goals

- Expand access to primary and specialty health care for the uninsured by increasing services at existing clinic sites and bringing new clinic sites to new geographic areas with high levels of health disparities.
- Invest in and partner with community-based organizations who are providing innovative solutions towards addressing behavioral health needs, particularly in schools and among adolescents.
- Increase and deepen geographic footprint and provision of services to best care for victims of violence including additional support services for families experiencing community violence, gun violence and interpersonal violence.
- Expand community collaborations with trusted partners that support the socio-economic well-being of residents and build social cohesion.

2024 **Program Highlights** | Richmond

CHRONIC DISEASE & PREVENTION

Medical Home for the Uninsured

The Community Health Primary and Specialty Care team provides primary care, chronic disease management and preventative care to uninsured adults and children, lessening the burden on Emergency Departments and improving the quality of life of underserved neighborhoods. In 2024, Primary and Specialty Health Services opened a new state-of-the-art Community Health Clinic, in Richmond's Manchester neighborhood, allowing for more patients to be served. In 2024, Primary and Specialty Health Services served a total of 11,460 patients across our Manchester clinic and mobile clinic sites at various area congregations. The team also administered over 6,600 vaccines to underserved adults and children in the Greater Richmond area.

Hypertension Management Pilot with a Health Equity Focus

The Hypertension Management Program is a health equity pilot project launched in January 2024. The goal was to offer patients with uncontrolled hypertension the tools to become empowered in self-managing their hypertension in sustainable ways. Participants from Richmond's East End were selected because hypertension is the leading preventable risk factor for disease mortality in this neighborhood.

Growing out of a unique collaboration between Richmond's Medical Group, Community Health and Pharmacy teams, the program offers support with a multidisciplinary care team and has demonstrated early success. At the end of the program's first year, none of its 17 participants had an ED or Inpatient hospital visit due to their hypertension diagnosis and all participants achieved blood pressure control.

On average, each participant lost 4.3 lbs. in weight and decreased their BMI by 0.87%. In addition, the participant group's average A1c decreased from 7.1% to 6.8%.

MENTAL HEALTH

Boys to Men Mentoring

Teenage years are a critical time when young men make choices that affect the rest of their lives. Boys to Men Mentoring Network of Virginia (BTMVA) offers young men a safe place where they can talk about what is going on in their lives, as well as a community of mentors and peers to listen, believe in them and help them make better choices.

With the support of Community Health investments, BTMVA programs now serve over 500 boys in the Richmond/Petersburg area and making a measurable impact. Most notable, less unexcused absences, better grades and less suspensions are seen among participants. 74% incurred less than 10 unexcused absences and 60% passed all courses. Students new to the program showed a 12% decrease in out-of-school suspensions. Surveys of the boys reveal 80% satisfied with their friendships and a belief in helping others.

VIOLENCE & TRAUMA

New Violence Response Team Suite

The Violence Response Team (VRT) began serving patients experiencing violence in 1993 in the Richmond area. With the addition of Southside Medical Center to the Bon Secours Richmond Health System in 2020, the VRT began to expand their services to the Petersburg/Tri-Cities area. In September of 2024, the new Violence Response Team suite at Southside Medical Center was officially opened to ensure that patients could receive VRT services in their own community.

Additionally, in 2023, the VRT expanded its services to include victims of community violence. Identified individuals meet with a Community Health Worker (CHW) in the hospital and then receive post discharge resource referral and case management. Throughout 2024, the team has received 154 referrals and enrolled 34 patients into the hospital-based violence intervention program. This program gives enrollees a variety of violence intervention support, including SDOH screenings and referrals, telephone calls, accompaniment to medical appointments and home visits.

2024 **Program Highlights** | Richmond

SOCIAL & ECONOMIC DISPARITY

Economic Investments in Small Community Businesses

For 12 years, Bon Secours Richmond has conducted the S.E.E.D. (Supporting East End Entrepreneurship Development) Program now investing a total of over $1 million in 53 small businesses. As part of an effort to support an economically vibrant and diverse community, the program provides access to capital grant funds that can be elusive for most entrepreneurs. In addition to grants of up to $25,000, entrepreneurs also receive small business coaching, assistance in developing a small business plan and gain access to a network of other community partners focused on small business development.

As part of the criteria of the program, S.E.E.D. entrepreneurs are part of the fabric of their community and are committed to their business giving back. For some entrepreneurs this is evidenced by offering goods and services with accessible price points, intentionally hiring community residents and donating proceeds to the local schools

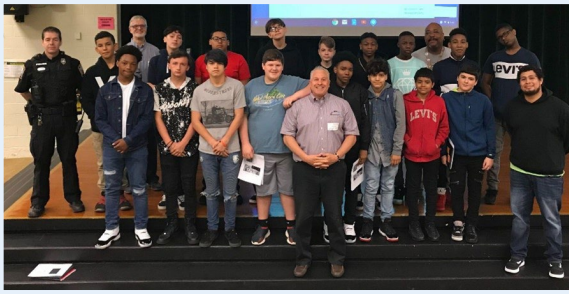
ENGAGEMENT & INCLUSION

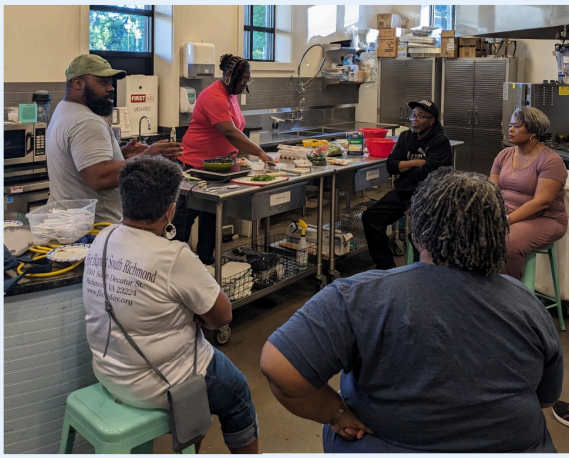
Engagement & Inclusion Powered by Community Health Workers

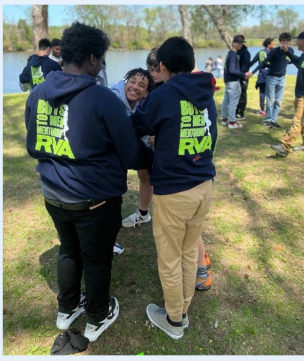
In partnership with the City of Richmond, Bon Secours Richmond on-boarded eight AmeriCorps CHWs. This diverse group of members bolstered efforts in engagement and inclusion by serving as a bridge between neighborhood residents and the health system. They canvassed the community, conducted 200+ surveys and interviews and ultimately planned community events in response to the feedback they received.

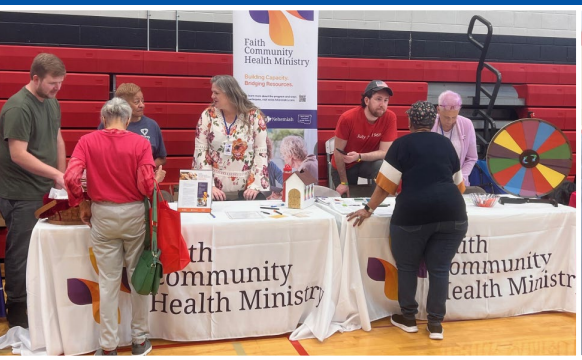
During their year-long service, members engaged over 300 community residents, created a database of resources and led events focused on the social determinants of health. Based on community feedback, they focused on housing, mental health, food access, fitness and overall wellness.

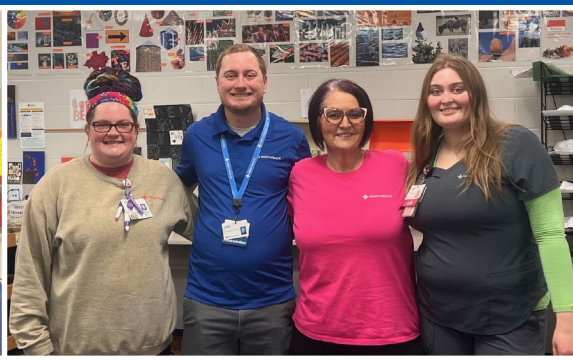
The program has also served as a pipeline for launching AmeriCorps members into full-time careers serving as CHWs. As a result of their service with Bon Secours, they receive training to become Certified Community Health Workers, and two have already transitioned into full-time CHW roles with our community partners.











Springfield

The Mercy Health — Springfield Market is served by Springfield Regional Medical Center, Urbana Hospital and Enon Emergency Department. These facilities serve the surrounding areas, including Springfield — Clark County, Urbana — Champaign County, Enon, Fairborn and nearby Greene County. Mercy Health — Springfield strives to ensure all residents of Clark, Champaign, Greene and surrounding communities have access to advanced medical technology and quality care.

Counties Served:

- Clark
- Champaign
- Greene

23,117 Lives Served

25 Community Health Programs

Community Identified Health Needs

- Access to Care: Primary care, women's health and appropriate point of care (non-emergent options: Urgent, palliative, paramedicine and virtual)
- Health Risk Prevention and SDOH, with focus on education, environmental, transportation and food access
- Behavioral Health: Including mental health, addiction (Including overdose deaths in Clark County) and trauma
- Chronic Disease: COPD, heart disease, stroke and cancer (with specific focus on breast, lung and bronchus, colon and rectum and melanoma/skin)
- Maternal, infant health and vitality

2025 Goals

- Develop the Springfield Market's Health Equity plan by establishing program goals to support new populations in the community and identifying at least two new areas of concern in 2025, such as: translation needs, navigation, expanded provider capacity.
- Move to a sustainable program model for the Faith Community Health Ministry Program.
- Launch a Mercy Serves AmeriCorps satellite site in the Springfield Market.
- Expand strategic Community Health outreach in Champaign County through paramedicine, outpatient nutrition and other support services.
- Support an expanded model for patient transportation needs in Champaign County.

2024 **Program Highlights** | Springfield

ACCESS TO CARE

Immigrant & Refugee Community Outreach

Mercy Health Springfield worked with the BSMH Foundation Community Health Fund to help support the growing Haitian population in Springfield and Clark County. Partnering with the Clark County Combined Health District, we have supported new initiatives, including refugee outreach, interpretation and translation support, and community navigation. Additionally, the fund has provided for the development of a multi-generational English learning support program called Micro Festa which also provides childcare and homework help for younger students. In 2024, Springfield's implementation of Micro Festa has served 83 adults and 37 children for a total of 120 English as Second Language (ESL) individuals and mobilized 114 volunteers from 24 different churches. Also underway, are 13 videos in Haitian Creole with focused topics on Health Literacy, Equity and Community Navigation. The collaboration has spurred helpful alignment across areas of business with new cross-cutting strategies to impact known community and patient needs, as well as have meaningful impact on patient health outcomes and clinical goals.

HEALTH RISK PREVENTION & SOCIAL DETERMINANTS OF HEALTH

Paramedicine Partnership & Community Outreach Collaboration for Champaign County

The Champaign County Paramedicine program, operated by Urbana Hospital, has continued its expansion throughout the county and with partner programming through Urbana Hospital. Support services such as Mercy REACH Tobacco Cessation, The Community Medication Assistance Program (Med Assist) and Mercy Health – Urbana Hospital's clinical dietitian have been partnering to have greater impact throughout the community's low income and senior living environments. More than 130 wellness checks and education included a blood pressure check, dietary support, tobacco cessation education and information on medication support. In addition, the Community Outreach team has served more than 2,200 meals to the local Youth Center, and more than 1,500 meals to the local Senior Center in 2024, often providing education, support programing and diabetes awareness education along with the snacks and meals they provide to the community in-kind.

Health Equity Spurs Collaborative Outcomes

The Springfield Market kicked off a new Health Equity Collaborative in 2024. With shared leadership from Mercy Health Community Health, Mission, Case Management and Quality departments, the collaborative includes representation from many service lines and core service areas of the Springfield Market. Seven subcommittees have formed, each highlighting pressing areas of care impact, including: Medical Group focus on blood pressure control and SDOH intervention, malnutrition continuum for patients experiencing food barriers, Race and ethnicity data accuracy at registration, transportation continuum for patients experiencing transportation barriers, hospital signage and wayfinding, maternal infant health equity, workforce/workplace for associates, Age-friendly measures, as well as the potential addition of Paramedicine and Faith Community Health Ministries. Each subgroup is working on a project plan with measurable goals and data showing progress in their respective areas based on patient barriers and needs. The collaboration has spurred helpful alignment across areas of business with new cross-cutting strategies to impact known community and patients' needs, as well as have meaningful impact on patient health outcomes and clinical goals.

2024 **Program Highlights** | Springfield

BEHAVIORAL HEALTH

Mercy REACH receives praise from patients

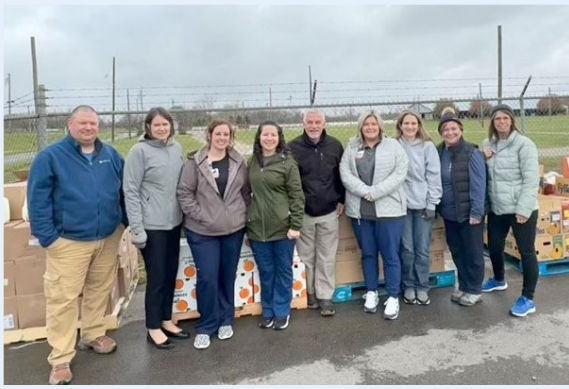
Mercy REACH — Recovery, Education, Advocacy, Care and Hope — provides outpatient alcohol, drug and tobacco treatment program services for adolescents and adults in Clark, Champaign and surrounding counties. In 2024, Mercy REACH served more than 8,400 patients, families and students in school-based education programs. Annually, patient satisfaction is evaluated through patient surveys.

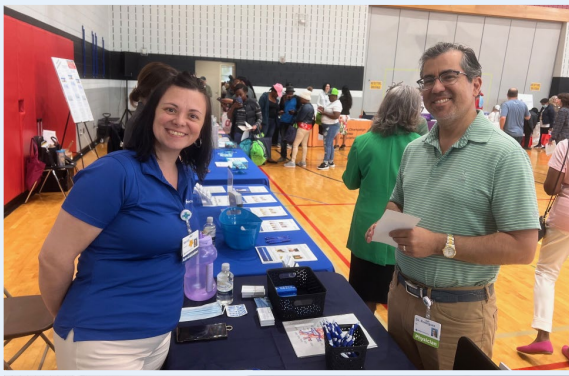
With an average of 93% patient satisfaction score, the REACH team has received comments from patients thanking staff for their life-saving compassionate care to help them pursue a life of sobriety and recovery, and thanks for helping patients see a new way of life.

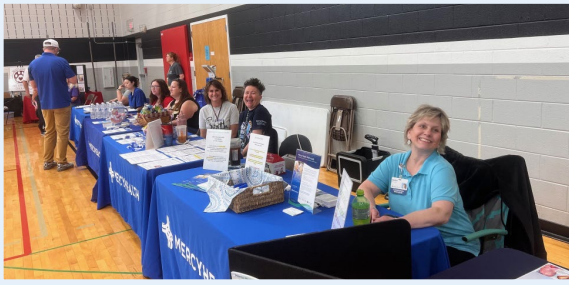
CHRONIC DISEASE

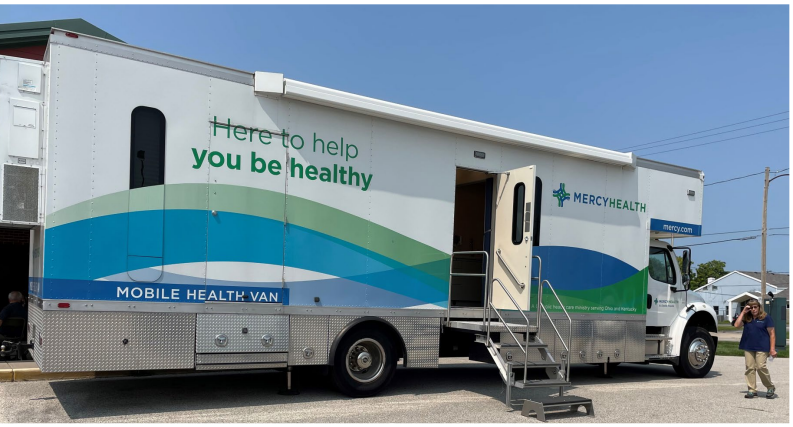
Community Medication Assistance Program expands to support malnutrition

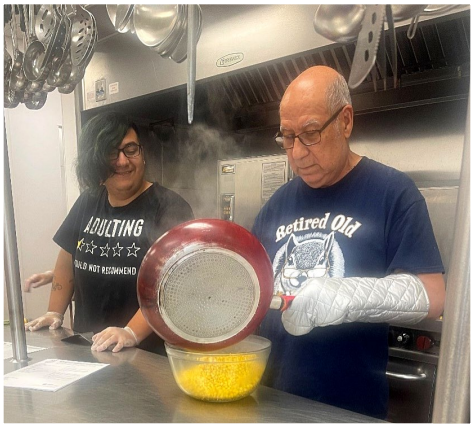
In 2024, the Community Medication Assistance Program (Med Assist) partnered with market Nutrition Services, Case Management and Nursing staff to expand support beyond medication, and to include nutritional supplements. A patient's diagnosis of malnutrition adds complications on top of other chronic diseases, which may make stabilization more difficult. Through the work of the team, patients are evaluated during their inpatient stay for malnutrition. Prior to discharge, they are referred to Med Assist, who support with review of options to receive supplements for their return home, if they qualify. They may also be referred to the onsite food bag program to support their recovery if supplements are not their preferred method of nutrition. Since the program launch in spring 2024, more than 948 patients have been screened for malnutrition and more than 250 patients have been referred to the program. Med Assist supported 8,748 patients with their medication and nutritional supplement needs in 2024.

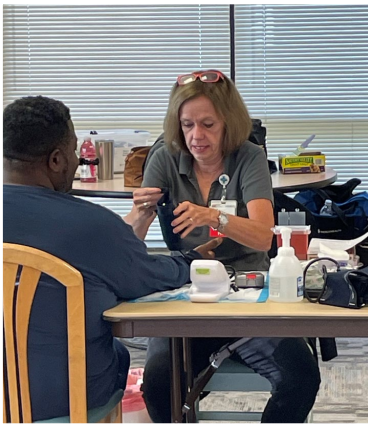
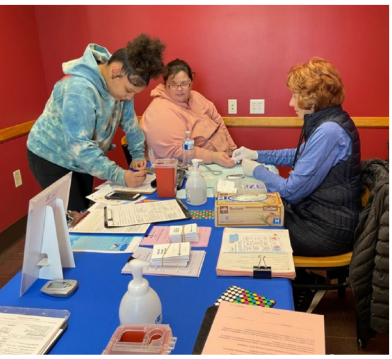
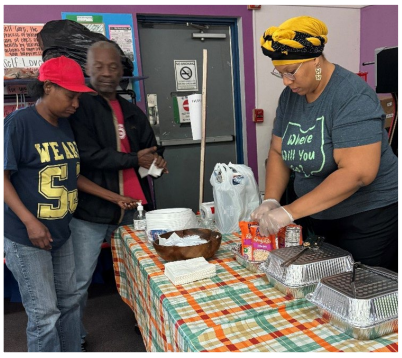
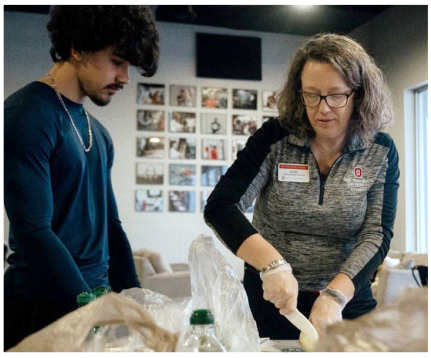
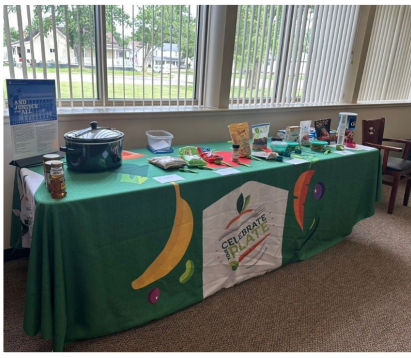










Toledo

Mercy Health — Toledo has served Northwest Ohio for more than 165 years. With a 20-county service area and seven hospitals located in Lucas, Wood, Defiance, Huron and Seneca counties, Mercy Health — Toledo remains committed to providing quality health care while also prioritizing the health of the communities we serve through neighborhood improvement, health education and community investment.

Community Identified Health Needs

- Access to Health Care Services
- Behavioral and Mental Health
- Health Education/Literacy
- Chronic Disease and Healthy Weight Status
- Financial Barriers

Counties Served:

- Lucas
- Defiance
- Seneca
- Wood
- Huron
- 15 additional surrounding counties

5,558 Lives Served

7 Community Health Programs

2025 Goals

- Expand Pathways HUB services to rural market.
- Partner with local community-based organizations to improve access to healthy food within the Toledo Market.
- Increase community health screenings by 10%.

2024 **Program Highlights** | Toledo

ACCESS TO HEALTH CARE SERVICES

Community Health Nursing Program

One of the many needs in health care today is bringing essential, targeted health care services to underserved communities. Since 1984, Mercy Health — St. Vincent Medical Center's Community Health Nursing program has been serving the underserved population within Northwest Ohio. The goals of the program are to provide community members access to health screenings, connect community members to primary care providers and educate community members of various chronic conditions through one day educational seminars and structured group classes. In 2024, 4,689 community members were served.

Mobile Health Van

The Mobile Health Van provides health screenings and services at various locations throughout the community. This allows providers and nurses to bring much needed services to underserved and rural communities. The mobile health van is equipped with an exam room and audiology booth. In 2024, the mobile health van provided services to 1,749 community members.

BEHAVIORAL AND MENTAL HEALTH

Mental Health First Aid

In 2023 the Community Health Nursing team completed Mental Health First Aid training which is an evidence-based, early-intervention course that teaches participants about mental health and substance use challenges. Each year, Community Health nurses encounter thousands of residents at various locations and events. In 2024, the team attended 369 events, meeting many individuals in need of mental health services or supports. Utilizing skills from the Mental Health First Aid training, they are able to be a better support to those attendees struggling with their mental health.

Senior Life Solutions

The Senior Life Solutions program at Mercy Health – Willard Hospital provides comprehensive psychiatric care for seniors in the community. This program offers both group and individual therapy sessions designed to support seniors dealing with depression, anxiety, grief or other emotional challenges. With a focus on improving mental health and overall well-being, participants receive intensive, compassionate care tailored to their unique needs. Currently they are serving five patients. Since opening in November of 2024, they have provided 17 individual counseling sessions, hosted 9 group days with a total of 16 group therapy sessions. Additionally, they have 286 community education touch points.

HEALTH EDUCATION AND LITERACY

Getting Healthy Zone

In 2018, Mercy Health — Toledo engaged residents in 43608, 43610 and 43620 neighborhoods to share their insights and experiences related to infant mortality. Infant mortality rate is not only seen as a measure of the risk of infant death, but it is used more broadly as a barometer of community health status, access to health care and the health and well-being of families. A strategic plan was developed with three goals: (1) connect residents with information and resources to increase infant vitality and to promote and/or improve their health (2) connect residents with living wage jobs and job training and (3) assist them with credit repair and home ownership. In 2024, the Getting Healthy Zone held over 150 events in the neighborhood to help connect residents to much needed resources.

Healthy Cooking Classes

Mercy Health sponsors and facilitates healthy cooking classes aimed at promoting better nutrition and wellness in the communities served. Classes provide participants with practical skills and knowledge to prepare nutritious meals that are both delicious and easy to make. The classes cover a variety of topics, including meal planning, understanding food labels and incorporating fresh, local ingredients into everyday cooking. This initiative reflects Mercy Health's strong commitment to enhancing overall health and well-being.

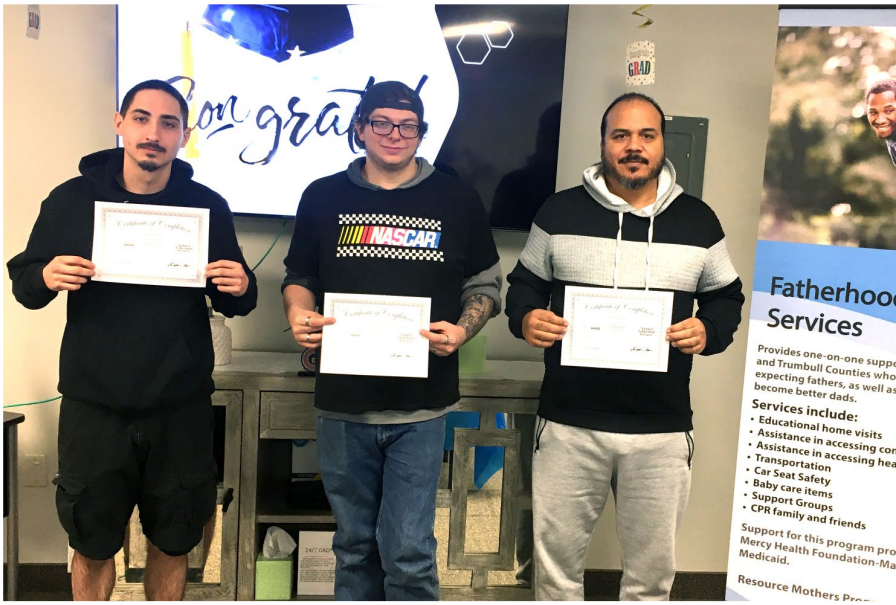
CHRONIC DISEASE AND HEALTHY WEIGHT STATUS

Diabetes Support Group

Mercy Health is dedicated to supporting the well-being of its community through comprehensive education initiatives including the Diabetes Support Group and Living Healthy with Diabetes classes. The Diabetes Support Group provides vital information and support for individuals managing diabetes, offering an interchange of ideas, questions and concerns amongst members and features guest speakers on topics related to diabetes management. Complementing this, the Living Healthy with Diabetes class offers instruction in preparing nutritious and delicious meals that align with diabetes-friendly dietary guidelines, empowering participants to make informed food choices and embrace healthier eating habits.

Starting Fresh

Mercy Health's Starting Fresh program is designed to provide participants with strategies to manage diabetes and other chronic diseases. The program consists of five weeks of classes and monthly support group sessions on various topics related to health and well-being. In 2024, 56 individuals completed the program, and 99 individuals participated in monthly support group sessions.



Youngstown

St. Elizabeth Youngstown Hospital (SEYH) is a tertiary care facility that draws patients from the tri-county area, including parts of Trumbull, Mahoning and Columbiana counties and is also a Level I Trauma Center serving as a trauma site for multiple counties in the surrounding primary service area. SEYH is licensed for 520 beds, 58 ICU beds and 48 Behavior Health beds.

St. Elizabeth Boardman Hospital (SEBH) is a community facility primarily serving residents of southern Mahoning and northern Columbiana counties. SEBH also offers Level III maternity services to surrounding counties. SEBH is licensed for 164 adult beds, 18 adult ICU beds, 51 Obstetric level III beds and 77 Newborn Care level I & II beds for a total of 310 beds.

St. Joseph Warren Hospital (SJWH) is a community facility primarily serving residents of Trumbull County. SJWH offers Level II maternity services. SJWH is licensed for 220 beds and a level III Trauma Center. SJWH offers ICU, Intermediate Care, Internal Medicine, Maternity, Surgery (specialty and general), Emergency Department, Community Care Ambulatory Center and a level II OB with a special care nursery.

Counties Served:

- Mahoning
- Trumbull
- Columbiana

22,014 **Lives Served**

12 **Community Health Programs**

Community Identified Health Needs

- **Mental Health Issues/Substance Use**
- **Community Conditions, Safety & Crime**
- **Access to Care, including access to health care, healthy foods and health care information and education**

2025 Goals

- To increase knowledge of services and programs available that address behavioral health and substance use issues through Community Health's participation in community-based events.
- Increasing access to treatment for uninsured individuals using the new Care-A-Van mobile medical clinic in order to meet community members where they are.
- Implementing a Hospital-Based Violence Intervention program.

2024 **Program Highlights** | Youngstown

ACCESS TO CARE & ACCESS TO HEALTHY FOOD

Mahoning Valley Mobile Market Voucher Program

Inflation and rising commodity costs have increased the number of people in Mahoning Valley experiencing hardship and struggling to access and afford healthy food, an important SDOH our partnership helps address. Mercy Health Foundation co-sponsored an opportunity for low to moderate income residents to access fresh food in their neighborhoods, mitigating transportation barriers and food insecurity. Those residents that qualify for assistance receive vouchers toward the purchase of healthy foods from a mobile market. Programming locations are carefully considered and selected to occur in ZIP codes in the tri-county area with lower median incomes and populations living in poverty. Large percentiles of marginalized communities are identified as underserved or underutilize in receiving health care or access to resources. These populations have higher rates of chronic illness identified by census data and health department statistics and are designated as urban and /or rural food deserts. In 2024, the Mahoning Valley Mobile Market redeemed a total of 7,000 food vouchers.

COMMUNITY CONDITIONS, SAFETY & CRIME

Hospital Based Violence Prevention Program (HVPP)

The Trauma/Injury Prevention, Community Health and Mission departments are currently working on the Human Trafficking committee. The team drafted a proposal for a new Hospital Based Violence Prevention Program to address cases of violence of identified or suspected victims that are brought into the Emergency Department. A grant application was submitted for the funding of a forensic nurse to be hired in year one and violence prevention specialists to be hired in year two for St. Elizabeth Youngstown, St. Elizabeth Boardman and St. Joseph in Warren. Members of HVPP will connect victims of assault to representatives of the Youngstown Community Initiative to Reduce Violence, community partners and services to initiate interventions to reduce incidences of repeat violence.

ACCESS TO CARE & ACCESS TO HEALTH INFORMATION AND EDUCATION

Empowering Moms, Fresh Start and 24/7 Dads

Our Resource Mothers and Fatherhood Support opened their Family Nurturing Center in 2023. In 2024, the Center provided various classes which enhance parenting skills. Classes include Fresh Start, Empowering Moms and 24/7 Dads.

24/7 Dads

The Fatherhood Support Community Health Worker/Facilitator is responsible for conducting community outreach, providing support for fathers through educational home visits and the 24/7 Dads' 8-week course series. The course explores the relationship with oneself, children and the mother of their children. Participating men gain valuable insight on how to move forward and be the dad his family needs him to be. All classes offer free transportation to and from the classes and Resource Mothers staff provide childcare during the classes to help participants concentrate on the education while attending classes at the Family Nurturing Center. There were 75 encounters for classes that were offered during 2024. During the final class, 15 out of 15 participants surveyed stated they would definitely recommend 24/7 Dads to other fathers.

Fresh Start

Fresh Start classes provide all the ingredients, equipment and kitchen items needed to prepare healthy meals. The program facilitators demonstrate and prepare the same meal as the participants, giving guided instruction. The facilitators meals are enjoyed by the participants. The meals the participants prepare are taken home to share with their family. They are also given the tools to prepare the meals at their home. Fresh Start has been able to adapt to the physical, emotional and nutritional needs of the participants and their families. In 2024, Fresh Start had 45 participant engagements.

> Thank you so much for all you guys do, I look forward to this every week.
>
> – Fresh Start Program Participant

Empowering Moms

Empowering Moms social support group provides a safe space for women to come together to eliminate isolation and develop relationships with other women who might be dealing with similar issues. The program facilitator helps moms address personal relationships with the father of their children. We take the moms and babies on educational field trips, not only promoting bonding activities with their children, but the moms are also able to enjoy fellowship with their peers creating a support system. They are empowered to meet some of their life goals by participating in arts and crafts as a way of fostering and building their self-esteem, managing their emotions and mental health. Some of our moms have been coming since the start of Empowering Moms 11 years ago. In 2024, 419 Empowering Moms' participants rated programs as 419 excellent and 58 participants rated as good.

Community Health Leadership

Shared Services Leadership

Kendra N. Smith, AICP, MPH, MSUS
Vice President
Community Health

Erin Hurlburt, MD
Chief Medical Officer, Population and Community Health

Shivonne L. Laird, PhD, MPH
System Director, Community Health Impact

Nancie Stover-Nicholson, MPH
Project Manager, Community Health

Patrick Schmidt
Program Manager, Community Benefit and CHNA

Market Leadership

Marilyn Alejandro-Rodriguez, BSAS, C-CHW
Director, Community Health
Lorain, Ohio

Leigh Ann Ballegeer
Director, Community Health
Paducah, Kentucky

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Director, Community Health
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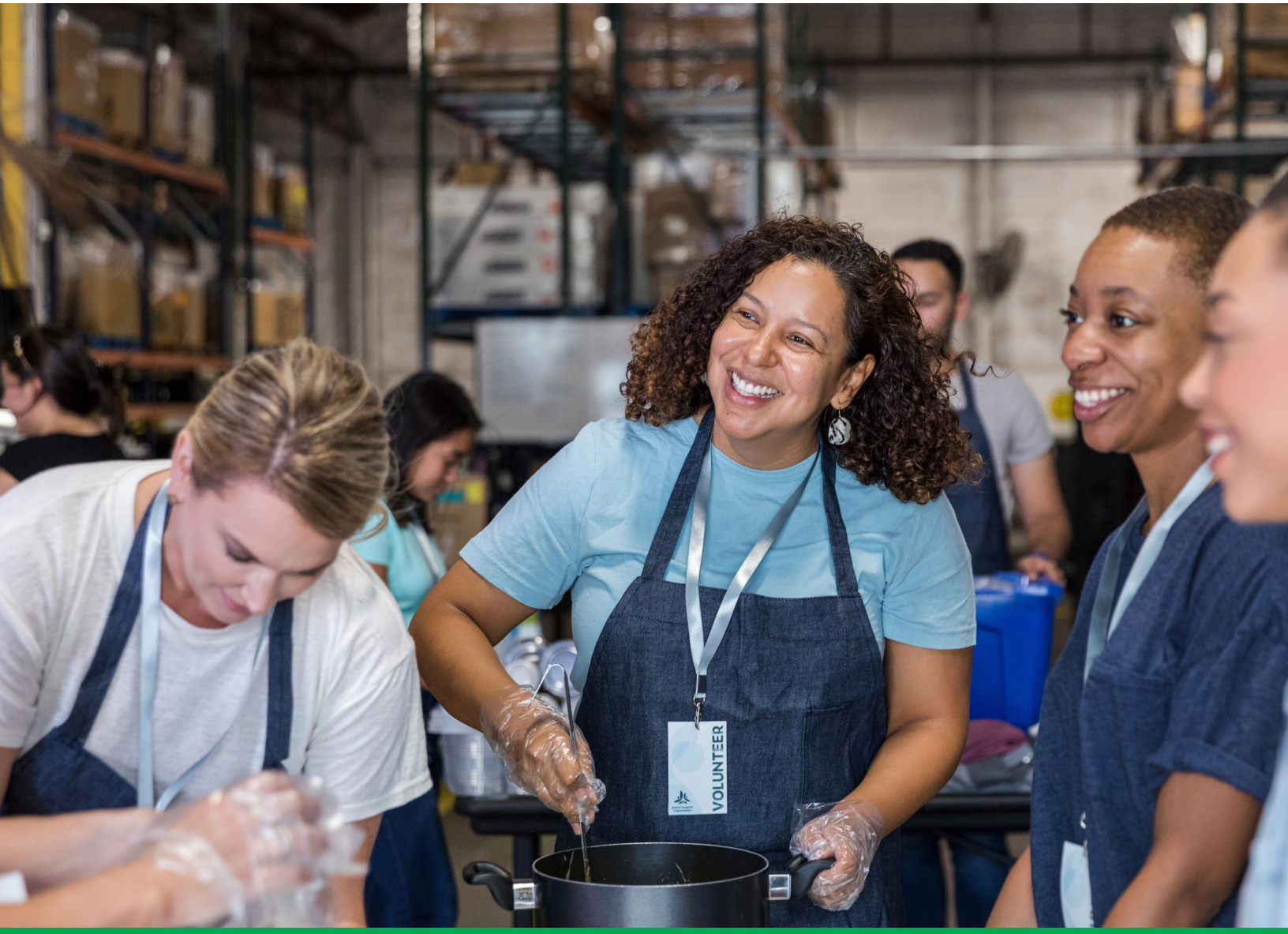
BON SECOURS MERCY HEALTH



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