BON SECOURS
MERCY HEALTH

2025 Community Health

Annual Report

BON SECOURS MERCY HEALTH

Introduction

BSMH Community Health is proud to celebrate another year of partnership and investment in the communities, individuals and families we serve across our multistate footprint. This year centered on completing the 2025 Community Health Needs Assessment. Our local teams engaged more than 16,000 community members in surveys and focus groups designed to identify the most pressing clinical and social needs in their communities.

Additionally, we continued to live our Mission of extending the compassionate ministry of Jesus through a variety of community health programs, initiatives and collaborations that increased knowledge, access and sustainability through tools and relationships to improve health and well-being. Many of those efforts are highlighted here, in the 2025 BSMH Community Health Annual Report.

As we enter 2026, we remain thankful to the community residents, partner organizations, faith communities and numerous others who have helped define our path to improving health and well-being through increased capacity, operational sustainability, innovative investments and quality programming. Our team will continue its efforts to align our clinical and community workflows, improve our data collection and impact reporting tools, expand our ability to address social drivers of health, and continue to build local, regional and national partnerships to affect a changing health care landscape.

We again thank our many partners in this work for coming together to support thriving communities, as well as health and social needs of our patients and community members.

Contents

3 Our Mission, Vision, Values
4 Community Health Overview
5 Partnerships
6 Community Health Investment
7 Community Health Needs Assessment (CHNA)
7 Community Health Improvement Plan (CHIP)
8 Ministry-wide Priorities
9 Community Benefit
10 Market Highlights
- 11 Baltimore
- 17 Cincinnati
- 23 Greenville
- 28 Hampton Roads
- 33 Irvine
- 37 Lima
- 43 Lorain
- 51 Paducah
- 57 Richmond
- 62 Springfield
- 67 Toledo
- 72 Youngstown

78 Community Health Leadership

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. We accomplish this work by collaborating with internal and external partners and utilizing a mix of resources and assets.

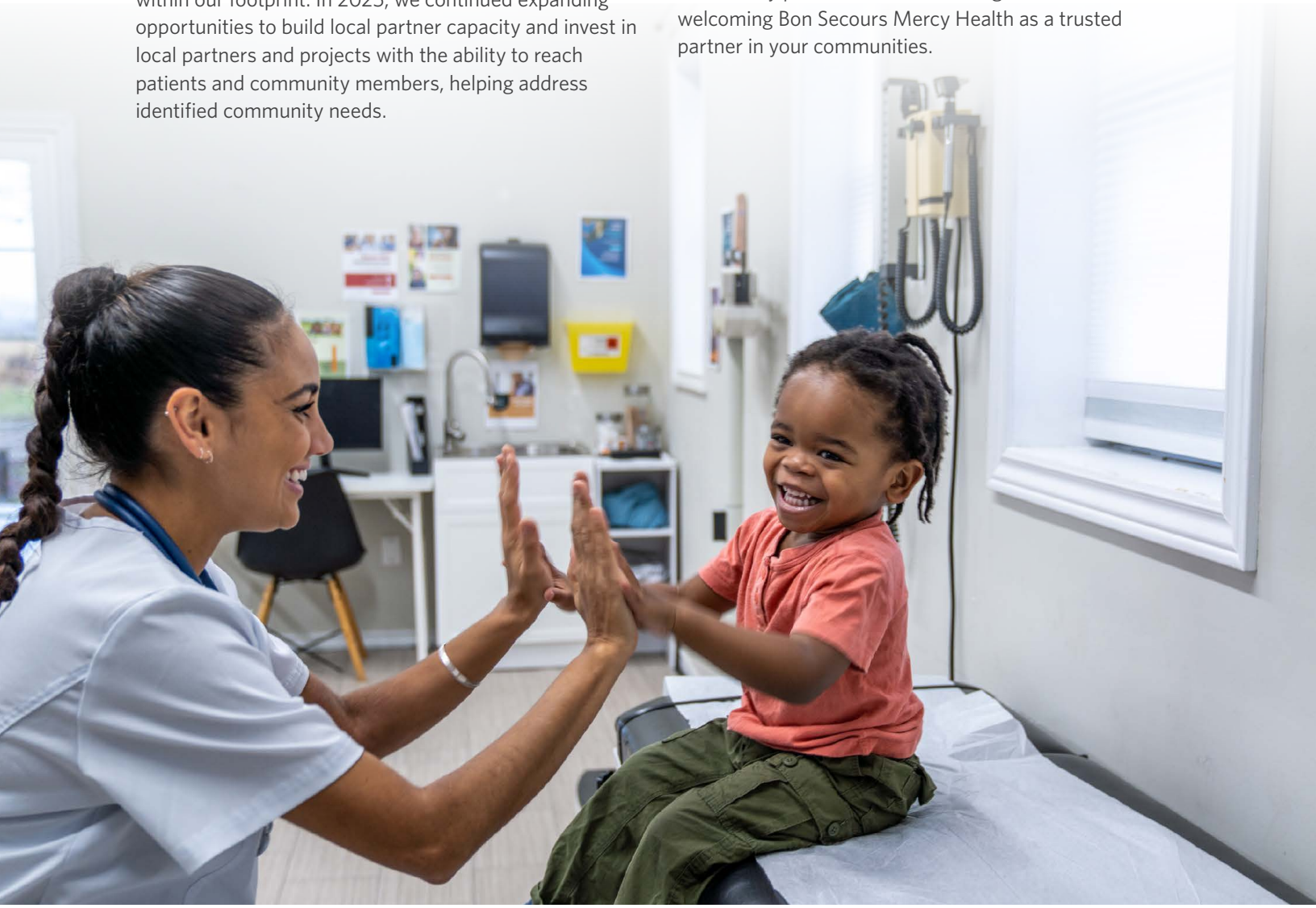
Community Health Framework

Community Partnerships

Bon Secours Mercy Health continues to prioritize our commitment to engaging local, regional and national partners to support place-based work and initiatives. Using 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 2025, we continued expanding opportunities to build local partner capacity and invest in local partners and projects with the ability to reach patients and community members, helping address identified community needs.

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

We thank the many individual and organizational community partners who work alongside us and for welcoming Bon Secours Mercy Health as a trusted partner in your communities.



In 2025, Bon Secours Mercy Health Community Health engaged more than 1,000 community partners to advance the work of Community Health across the Ministry.

Community Health Investment

Bon Secours Mercy Health remains focused on supporting intentional investment and low-cost capital for projects that support the people and places we serve. The investment program supports nonclinical 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 social drivers and determinants of health. In partnership with the Bon Secours Mercy Health treasury team, such capital has supported projects in areas that include affordable housing development and retrofits, workforce development, local food systems, community infrastructure and neighborhood condition improvement. In 2025, the DCI program deployed $2 million in new low-interest loan capital and managed $49.4 million in capital across 90% of our ministry's footprint.

Community Health Fund (CHF)

In addition to the DCI program, community investment included the final year of a three-year pilot for the Community Health Fund (CHF). Started in 2023, the CHF utilized resources to build capacity and develop partnerships to address social needs in local communities. In 2025, the CHF supported six projects addressing local needs in rural food systems access, small business development, expanded care sites for uninsured populations, urban agriculture and gardening, and nonprofit partner capacity building. In three years, the CHF invested more than $3 million across 16 projects. 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 Needs Assessment (CHNA) & Community Health Implementation Plans (CHIP)

Community Health Needs Assessment (CHNA)

Conducted every three years, the Community Health Needs Assessment (CHNA) is a collaborative activity between Bon Secours Mercy Health, local residents, community organizations and leaders. Since we know that listening is one component of improving health, the CHNA is an opportunity to engage with and listen to patients and community members who interact with our Community Health programming or with our care teams. We collect their feedback, concerns and suggestions through a series of surveys, town hall meetings, focus groups and key informant interviews. These are a significant source of information in our program planning and program improvement strategies.

Community Health Implementation Plan (CHIP)

With the completion of the 2025 CHNA, BSMH Community Health teams will create specific strategies that we will undertake to help drive community health improvements in each market. These strategies will be documented in the 2026–2028 Community Health Implementation Plan (CHIP).

Driven by the priorities identified throughout the 2025 CHNA process, the CHIP outlines how we will respond to the community's most pressing health-related concerns through targeted programs, investments and partnerships. Local Bon Secours Mercy Health markets began the CHIP process in 2025, and all documents will be board-approved and publicly available by May 15, 2026.

There were over 16,000 total engagements for the 2025 CHNA cycle, including: over 15,000 survey responses received, 87 focus groups conducted with more than 900 participants, and over 150 interviews with various community members held.

Internally, local market teams use the final CHNA report for strategic decision-making and resource allocation for clinical and social needs. Communities also use the CHNA reports to encourage collaboration on ways to further address community-identified priorities.

All 2025 CHNAs are publicly available on the Bon Secours and Mercy Health websites.

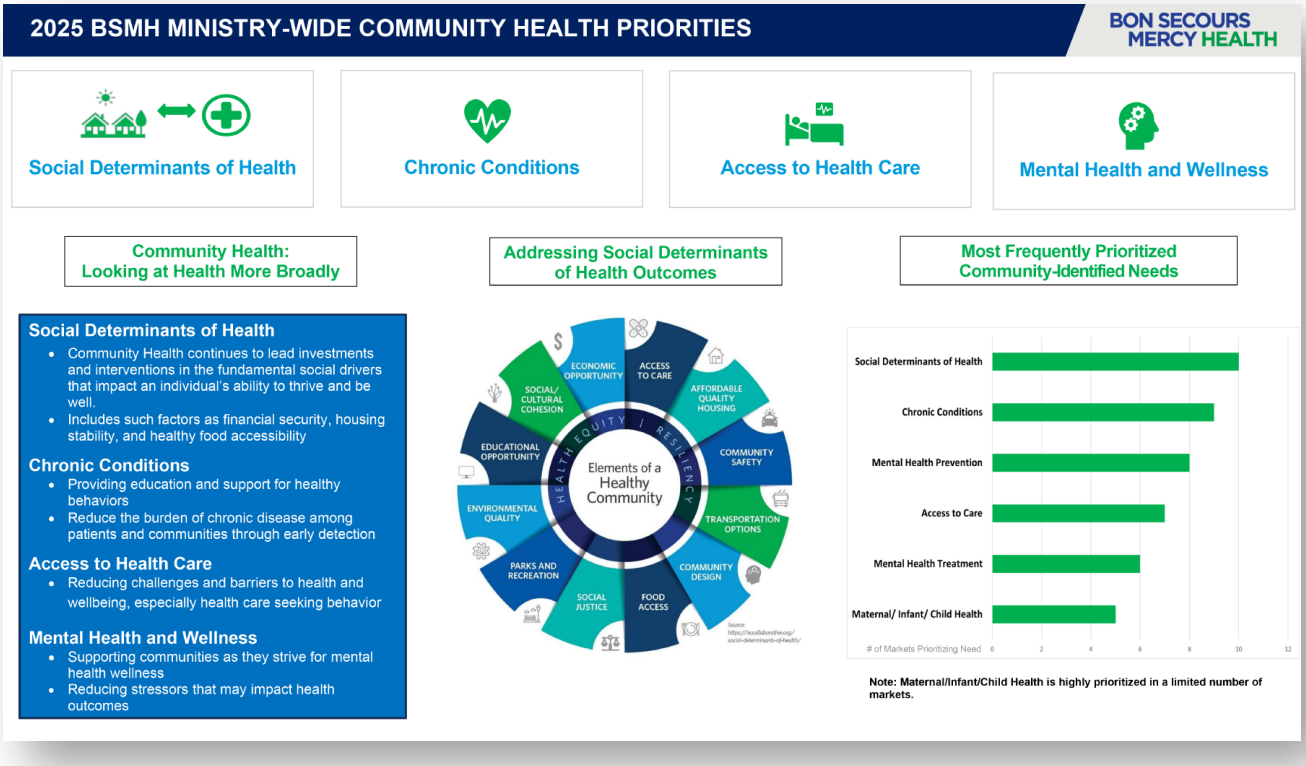
Bon Secours CHNAs
bonsecours.com/about-us/community-commitment/community-health-needs-assessment

Mercy Health CHNAs
mercy.com/about-us/mission/giving-back/community-health-needs-assessment

BSMH Ministry-Wide Priorities

As a result of the 2025 Community Health Needs Assessments, we have identified the following prioritized areas of focus for enhanced resources and implementation:

- Social Drivers of Health
- Chronic Conditions
- Access to Health Care
- Mental Health and Wellness



Community Benefit

Community Benefit reporting is one of the many ways our ministry demonstrates its commitment to community health improvement, documenting many of our operational investments in our communities. 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 community health, advance medical or health knowledge, or relieve or reduce the burden of government or other community efforts.

In 2025, Bon Secours Mercy Health provided more than $400 million dollars in community benefit expenses across five states. This number includes funds that ensure cost is not a barrier to health care for our patients in need. In addition, it includes Bon Secours Mercy Health investments in community-facing programs that address chronic illness, affordable housing, access to healthy food, education and wellness programs, transportation, workforce development and other social drivers and determinants 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 — 2025

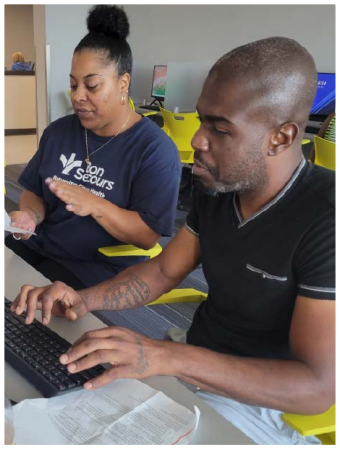
Community Benefit Categories	Dollars
Charity Care	$144,270,213
Medicaid Unpaid Cost	$95,484,694
Community Health Services	$29,620,798
Health Professions Education	$84,195,270
Subsidized Health Services	$37,671,526
Financial and In-Kind Contributions	$12,227,599
Community Building Activities	$5,172,660
Community Benefit Operations	$6,178,665
Research	$868,690
TOTAL Quantifiable Community Benefit	**$415,690,115**

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

Community Identified Health Needs

Youth and Family Services

Housing and Community Development

Economic Development

Bon Secours Community Works (BSCW) is a key community partner throughout the City of Baltimore. Building on its 30-year history, BSCW actively addresses the social dynamics and underlying factors that impact the health and well-being of individuals and communities. This focus contributes to the long-term economic and social viability of neighborhoods and is made possible by a strong commitment to intentional engagement and the advancement of our place-based strategy.

We focus our efforts on three service delivery areas, which serve as upstream interventions to meet unique community needs and tackle the root causes of historic inequities:

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

2025 Goals

- Graduate 175 individuals with industry-certified training, preparing them for employment and earning a living wage. **[Accomplished]**
- Provide financial capabilities training to 275 people, enabling them to budget their income and build their credit. **[Accomplished]**
- Serve 60 children though the Early Head Start program, preparing children for kindergarten and enabling parents to work. **[Accomplished]**
- Provide high-quality affordable housing to 1,200 people. **[Accomplished]**
- Complete the renovation of five vacant properties for sale to increase homeownership rates and community property values. **[Accomplished]**

2026 Goals

- Maintain the graduation rate of industry-certified training program participants.
- Reduce participation in financial capabilities training by 25.
- Provide credit building loans to 350 individuals through a new partnership that enables participants to build their credit and work toward asset development.
- Maintain funding for the Early Head Start program, preparing children for kindergarten and enabling parents to work.
- Maintain high-quality, affordable housing for 1,200 people, investing in infrastructure and making structural improvements.
- Complete the renovation of 20 vacant properties for sale by June 2026 to increase homeownership rates and increase property value in the community.

Early Head Start Program

Community Health System-Wide Priority Area: Social Determinants/Drivers of Health

Program Description

Early Head Start (EHS) serves children from 6 weeks up to three years of age. The program provides measurable benefits for children and their families, especially those from low-income backgrounds. Children in EHS show improved cognitive, language and social-emotional development by age 3 when compared to similar children not enrolled in the program. These improvements include better problem-solving, communication skills and emotional regulation.

Program Impact and Outcomes

- **Reach:** EHS serves 60 children.
- **Outcomes:** EHS has an 85% average attendance rate and a 100% immunization rate.
- **Community value:** Children in EHS show improved cognitive, language and social-emotional development by age 3 when compared to similar children not enrolled in the program. These improvements include better problem-solving, communication skills and emotional regulation. EHS participation correlates with reduced child abuse and neglect after leaving the program, highlighting its impact on family well-being. Children and families in EHS also have increased access to vaccinations, regular medical and dental screenings, and health education.

Program Highlights/Success Stories

EHS offered childcare to parents and caregivers who work and/or attend school at least 30hrs weekly. Thanks to the continued generous support of the Maryland Family Network, this expansion will give working parents and caregivers the stability and peace of mind to better support their families.

Program Future Plans/Next Steps

In 2026, we plan to expand EHS programming to serve up to 68 children.

2025 **Program Highlights** | Baltimore

Homeownership Program

Community Health System-Wide Priority Area: Financial Security

Program Description

Transforming vacant properties into homes for sale has significant positive impacts on neighborhoods and communities. This transformation stabilizes and revitalizes neighborhoods by reducing the negative effects of vacancy and abandonment, which include declining property values, decreased property tax revenues, increased crime, and higher public safety and maintenance costs. By converting vacant properties into homes for sale in West Baltimore, communities increase local property values, generate property tax revenues that fund public services, improve neighborhood safety and morale, and encourage community engagement and investment.

Additionally, transforming vacant properties into homes for sale helps address the shortage of affordable and quality housing in West Baltimore, providing opportunities for homeownership across income levels. This transformation also mitigates the negative social and economic impacts of disinvestment, abandonment and blight, fostering stronger, healthier communities. Bon Secours Community Works (BSCW) partners with city and state entities, community associations and private philanthropy to acquire, rehab and sell properties to benefit the community. The impact of this program revitalizes neighborhoods, enhances local economies, ensures safer communities, increases homeownership opportunities and improves quality of life for West Baltimore residents.

Program Impact and Outcomes

- **Reach:** Twenty vacant properties are under construction in the Union Square and Carrollton Ridge neighborhoods.
- **Outcomes:** The first home was listed and sold within one week.
- **Community Value**: Neighborhood residents have been clear that they want fewer abandoned houses on their blocks and more opportunities for their neighbors to own homes. Every abandoned house that BSCW rehabs and sells to a new homeowner is one less eyesore on the block, one less safety concern for families and one more neighbor who has a stake in our community's future.
- This impact extends beyond individual properties. When we increase homeownership in West Baltimore, we're building the foundation for lasting neighborhood improvement. Property values stabilize, tax revenues increase to support better services and residents look out for one another more.

Program Highlights/Success Stories

The first home was sold in November 2025. The state of Maryland also awarded BSCW up to $5 million to acquire and transform approximately 140 vacant properties in West Baltimore.

Program Future Plans/Next Steps

Complete the renovation of 20 vacant properties for sale by June 2026 to increase homeownership rates and increase property values in the community.

2025 **Program Highlights** | Baltimore

Workforce Development Program

Community Health System-Wide Priority Area: Financial Security

Program Description

In the Workforce Development Programs, 110 individuals graduated with industry-certified CNA and GNA training, preparing them for employment and earning a living wage in the health care sector. When we provide industry credentials to our neighbors, this leads to higher employment rates and increased earnings. Obtaining an industry-recognized credential can boost earnings by more than $10,000 within two years of program completion.

Impact and Outcomes

- **Reach:** Enroll 140 people (80%).
- **Outcomes:** Graduate 175 people with industry credentials.
- **Community Value:** Industry-aligned CNA and GNA credentials help individuals transition into the health care sector and foster upward economic mobility. Our staff work directly with employers to ensure training is relevant to local labor demands, strengthening job placement outcomes. Staff provide wraparound supports, such as transportation, childcare and career counseling, which promote program completion and success, particularly for women and other groups facing participation barriers.
- The Workforce Development Program promotes economic stability and reduces poverty by raising household incomes. Our graduates are local role models, spreading positive impacts through peer networks and community engagement.

Program Highlights/Success Stories

The program has placed 76 people in jobs with an average wage of $17.50 per hour (15.5% higher than the living wage for an individual in Baltimore).

Program Future Plans/Next Steps

We plan to graduate 175 individuals with industry-certified training, preparing them for employment and earning a living wage.

2025 **Program Highlights** | Baltimore

Financial Capabilities Program

Community Health System-Wide Priority Area: Financial Security

Program Description

Financial literacy workshops have measurable positive impacts on participants' financial knowledge and behavior. Our workshops significantly increase participants' self-reported knowledge of money management and their understanding of credit. Program participants experience greater confidence in controlling their spending and paying bills on time.

Program Impact and Outcomes

- **Reach:** The program provided financial literacy workshops to 275 people.
- **Outcomes:** Through the program, 400 people have received financial literacy workshops, exceeding our goal of 275 people.
- **Community Value:** Financial literacy workshops bring measurable value to communities by promoting financial confidence, self-sufficiency and stability among residents. Our program helps individuals understand budgeting and build savings, creating more resilient households that are less dependent on emergency assistance. Our workshops also promote broader access to banking services, making it easier for families to achieve security and pursue opportunities such as homeownership. As residents gain control of their finances, the entire community benefits from a stronger and more reliable local economy.

Program Highlights/Success Stories

Through our program, 400 people have benefited from financial literacy workshops, surpassing our annual goal by 44%.

Program Future Plans/Next Steps

Through a new partnership with a local community development financial institution, we will provide credit-building loans to 30 people. These loans will help such individuals build their credit and work toward purchasing a personal vehicle, starting a small business or purchasing a home.

Affordable Housing Program

Community Health System-Wide Priority Area: Community Safety

Program Description

The Affordable Housing Program provides 1,200 people with high-quality, affordable housing.

We own and operate 800 affordable housing units, which serve approximately 1,200 residents across nine apartment buildings. Six apartment buildings serve seniors, while the remaining three serve working families. These apartments provide safe, high-quality housing and have an average occupancy rate of 95%, which aligns with the national average.

Program Impact and Outcomes

- **Reach:** We own and operate 800 high-quality, affordable rental units.
- **Outcomes:** We maintain a 92% occupancy rate.
- **Community Value:** The Low-Income Housing Tax Credit (LIHTC) program expands affordable rental housing opportunities for low-income families in Baltimore. Our program enforces crucial tenant protections, including good-cause eviction rules and fair housing regulations, promoting social inclusion and ensuring everyone has the respect and opportunities they deserve.

Program Highlights/Success Stories

Our current occupancy rate is 92%, which meets the industry standard.

Program Future Plans/Next Steps

We will continue to invest in properties to ensure we provide high-quality rental housing in Baltimore.



Cincinnati

Community Identified Health Needs

Workforce Pipeline and Diversity

Food Security and Housing

Access to Services

With six hospitals serving Hamilton, Butler, Clermont and Warren counties, Mercy Health — Cincinnati works alongside community partners to address underlying social factors that influence health. Guided by our Values to serve with Compassion and uphold the Dignity of every person, our Community Health efforts are shaped through listening, trust-building and collaboration with community leaders. By expanding access to care, supporting whole-person well-being, and strengthening partnerships, we are improving the overall well-being of families and communities across Greater Cincinnati.

2025 Goals

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

2026 Goals

- Demonstrate improved health efficacy for patients that Community Health Workers support.
- Increase the number of patients with financial hardships who have access to free and reduced cost medications.
- Increase the number of pregnant women enrolled in Mercy Health's Perinatal Outreach Program prior to their third trimester.
- Leverage AmeriCorps volunteers to increase connections between emergency departments and community-based supports.

Perinatal Outreach Program Supports Eviction Prevention and Housing Stability

Community Health System-Wide Priority Area: Social Determinants/Drivers of Health

Program Description

Mercy Health's Perinatal Outreach Program is a team of Community Health Workers (CHWs) who provide education, advocacy and support aimed at reducing preterm births and infant mortality. Rising housing costs and a shortage of affordable housing units have left many of their pregnant clients at risk of eviction and homelessness, directly undermining pregnancies and birth outcomes. In response, Mercy Health — Cincinnati partnered with Housing Opportunities Made Equal (HOME) to support participants in the Perinatal Outreach Program who experience housing instability. The program's CHWs build trusted relationships, identify and assess housing needs and refer participants to HOME for counseling, landlord mediation and guidance on housing rights. If needed, the program provides targeted emergency financial assistance to prevent eviction and maintain stable housing. CHWs continue to offer wraparound support that builds self-efficacy, fosters resilience against future crises and promotes long-term stability for families at a defining period in life.

Program Impact/Outcomes

The Perinatal Outreach Program served 127 pregnant clients in 2025. Among the participants who were provided with financial assistance for housing, 100% were stably housed at the time of delivery and remained stable three months later.

Program Highlights/Success Stories

A first-time mom who was 33 weeks pregnant with twins enrolled with a Mercy Health Perinatal Outreach Program CHW. She was $1,500 behind on her rent and utilities and at risk of eviction, despite working full time throughout her entire pregnancy. With her induction date only three weeks away, many of the community resources to which she had applied were unavailable. The CHW connected her to HOME's tenant advocate, who provided education and emergency financial assistance. The client delivered two healthy baby girls and was able to focus on healing, bonding with her babies and becoming a mom with the continued support of her CHW.

Program Future Plans/Next Steps

The 2025 Community Health Needs Assessment identified housing as one of the three prioritized health needs. The Mercy Health CHW programs will continue to deepen trust with patients and clients, as well as proactively identify housing needs early. These goals will create greater opportunities for timely tenant advocacy, maximize emergency assistance resources and provide holistic support to perinatal participants.

Mercy Health Partnership Program Grows to Support More Patients with Health-Related Social Needs

Community Health System-Wide Priority Area: Access to Health Care

Program Description

Frequent and consistent visits to primary care are integral to a patient's health and well-being. Yet, their ability to access health care relies on their social circumstances, such as food security, housing stability and access to transportation. In the most recent Regional Community Health Needs Assessment, three out of every 10 community respondents reported economic strain, highlighting significant barriers to care. The Mercy Health Partnership Program provides comprehensive support to primary care patients with complex social circumstances. Certified Community Health Workers (CHWs) address social barriers to care, including food, housing, transportation, insurance and medical bills. By providing education, advocacy and in-depth support, the program aims to improve access to essential services and overall patient outcomes.

Program Impact/Outcomes

The Mercy Health Partnership Program saw a 17% year-over-year increase in the number of patients it served and addressed 601 social barriers (an average of seven per patient), including food, housing and transportation, in 2025.

Program Highlights/Success Story

A patient with a rising A1C of 6.3 and a possible new cardiac diagnosis was unable to manage her health due to financial strain and homelessness following her eviction related to domestic violence. Through consistent relationship building and five home visits, a CHW helped her access medications, secure affordable housing and furniture, and navigate the health system. As a result, the patient's A1C decreased to 5.9. She also expressed renewed confidence, optimism and plans for a higher-income career path as she and her child entered a more stable chapter.

Program Future Plans/Next Steps

The 2025 Community Health Needs Assessment identified cardiovascular health as one of the three prioritized health needs. The Mercy Health Partnership Program will continue to increase its impact by supporting blood pressure screenings, monitoring and education, as well as reducing barriers to care.

Mercy Serves Supports Mission-Minded Leaders of the Future

Community Health System-Wide Priority Area: Mental/Behavioral Health

Program Description

Mercy Serves trains and places AmeriCorps members in Mercy Health emergency departments (ED) to screen patients for substance use disorders and social needs, as well as to offer compassionate connections to community resources. Member development is a core component of the program, which strengthens the quality of support that members provide in the ED and cultivates leaders in health care and social services. Members receive robust training through Bon Secours Mercy Health's Culture and Learning modules, earn certifications in mental health first aid and psychological first aid, receive motivational interviewing training from Bon Secours Mercy Health behavioral health experts and are supported in pursuing additional credentials, such as Community Health Worker and Peer Recovery Support certifications. This service-learning model allows members to apply new skills in real time, enhancing their growth while meaningfully contributing to compassionate, patient-centered care.

Program Impact/Outcomes

- Through the program, 2,271 patients were screened for substance use disorders and social needs.
- Among graduating members of the 2024–2025 cohort, 100% agreed or strongly agreed that Mercy Serves improved their career prospects or technical skills; 100% agreed or strongly agreed that they are better leaders today than before joining the program.

Program Future Plans/Next Steps

The 2025 Community Health Needs Assessment identified mental health treatment and prevention as one of the three prioritized health needs. Mercy Serves AmeriCorps will continue preparing the next generation of leaders while strengthening its role as a bridge between the ED and community-based supports, ensuring patients receive timely follow-up care and continuity of behavioral health and recovery services.

Collaborative Partnerships to Expand Rural Food Access

Community Health System-Wide Priority Area: Social Determinants/Drivers of Health

Program Description

Mercy Health — Cincinnati's longstanding partnership with Produce Perks Midwest continues to support patients and community members who experience food insecurity and nutrition-related illnesses. The partnership incentivizes healthy choices with a 1:1 SNAP match, which individuals can use to purchase healthy produce from local redemption sites and nutrition prescriptions that provide households with biweekly produce vouchers or delivery boxes. This year, the partnership grew to include a new redemption site offered in collaboration with the UFC Food System and Clermont Metropolitan Housing Authority. The new flagship food hub increases affordable access to healthy food for more rural residents. This hub has the capacity to help feed over 100 unique individuals and families monthly. It also supports local Ohio farmers, who provide most of the food offered through the hub.

Program Impact/Outcomes

Produce Perks incentives supported 4,805 individuals and nearly $90,000 in fresh, locally sourced food purchases for SNAP beneficiaries. Among the 92 Mercy Health patients currently active in a PRx program, 23 are pregnant women. Participants report an improvement in overall health, food security, biometric outcomes and birth outcomes.

Program Highlights/Success Stories

- The partnership opened a new food hub in Clermont County in collaboration with the UFC Food System and Clermont Metropolitan Housing Authority.
- The food hub offered free food boxes that feed a family of four, with a choice of meat included, in Clermont County during November, when SNAP benefits lapsed for many.

Program Future Plans/Next Steps

In 2026, we will continue our partnerships with Produce Perks Midwest and the UFC Food System, as well as extend our reach to serve more community members who experience food insecurity.

Amplifying Lived Experience to Improve Care

Community Health System-Wide Priority Area: Maternal/Infant Health

Program Description

Mama Certified is an equity-focused birthing hospital certification in Cincinnati, OH. It is dedicated to improving care for moms and babies throughout Greater Cincinnati. One key achievement of Mama Certified is the launch of Mercy Health's Queens Village Hospital Advisory Board, a community-led body designed to elevate the lived experiences, insights and leadership of women and families most affected by adverse pregnancy and birth outcomes. The board meets quarterly with Mercy Health clinical and programmatic leaders to discuss what culturally grounded care and positive birthing experiences should look and feel like, identify where current systems fall short and co-develop meaningful improvements. Together, the group works to reimagine policies, practices and programs to authentically reflect the priorities and values of women and families. By positioning women as co-creators of strategies to improve maternal and infant health, this partnership promises to strengthen accountability, alignment and lasting impact.

Program Impact/Outcomes

Mercy Health — Anderson Hospital achieved Leader badges across all categories of Mama Certified, including Infant Health, Maternal Health and Community Care. This is the highest possible badge, demonstrating over 90% competency across assessed areas.

Program Highlight/Success Stories

"I've witnessed hospital leaders lean in with real authenticity, and I've watched everyday community members step into their voices and their power and be met with affirmation and partnership. Together, we are building relationships and an understanding that is transforming care."

— Josselyn Okorodudu
Director of Community Strategy, Cradle Cincinnati

Program Future Plans/Next Steps

Mercy Health and the Queens Village Hospital Advisory Board will strategize, co-create and launch a campaign that makes it easier for women of childbearing age to access and keep trusted primary care providers before, during and after pregnancy.


Greenville

Community Identified Health Needs

Affordable Housing and Homelessness

Access to Care, including aging individuals and those with chronic conditions

Behavioral and Mental Health

Bon Secours St. Francis Health System, located in Greenville, SC, is one of the leading health care providers serving the needs of those in Greenville County. This county is rapidly growing and increasingly diverse, spanning 795 square miles in the Piedmont region of South Carolina. Greenville County now has the largest population and highest population density of any county in the state.

Bon Secours St. Francis Health System includes hospitals in downtown Greenville and at Eastside; a neuroscience institute, cancer center and other facilities on the Millennium campus; a medical campus in Simpsonville, which includes a freestanding emergency room; and a medical center in Fountain Inn.

The Greenville Market's Community Health team works with uninsured 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.

2025 Goals

- Complete the final home of a 10-year, 10-build commitment to Habitat for Humanity. **[Accomplished]**
- Offer at least three additional educational events that improve access to care. Associates provided 79 educational events for 2025.**[Accomplished]**
- Create an advisory board for LifeWise with at least four members from the Greenville community, which will help guide LifeWise in advocacy and educational efforts regarding access to care for senior adults. The advisory board was completed in 2024, ahead of schedule, and met twice in 2025. **[Accomplished]**
- Using feedback from previous event attendees (senior adults), schedule at least one provider or therapist session on a topic of interest. LifeWise offered a well-attended session on brain health to an engaged audience. **[Accomplished]**
- Offer at least one "train the trainer" event in neighborhoods with an identified need to empower community partners to host their own mental and behavioral health educational events. A community partner and nonprofit leader was trained in HeartMath, a stress and anxiety reduction program. **[Accomplished]**

2026 Goals

- Increase the ability of community members to recognize and know when to seek help for mental and behavioral health issues through education (Mental Health First Aid and National Alliance on Mental Illness classes).
- Increase the number of low-income, uninsured individuals who have access to health care services through community screenings and education.
- Improve food and nutrition security through comprehensive education, programming, and food donations.
- Improve community members' chances of achieving self-sustainability and becoming housed through partnership with and support of Greenville Housing Authority's Moving to Work program.

Improving Access to Mental/ Behavioral Health Tools

Community Health System-Wide Priority Area: Mental/Behavioral Health

Program Description

Four Community Health associates are certified to teach Mental Health First Aid (MHFA); two of the four teach in both English and Spanish. The instructors taught a total of nine MHFA classes at faith-based organizations and community centers, with the purpose of giving individuals the tools to recognize mental and behavioral health issues and to know when to seek help for themselves or their family members. The free classes are eight hours long and include lunch.

Program Impact/Outcomes

One hundred fifty-four community members completed MHFA classes through Q3 of 2025 (six classes).

Program Highlights/Success Stories

"I am really still sad from my husband's suicide, and people tell me to just get over it," said one older adult at a community center. "This was really helpful and made me feel loved."

MHFA classes are helping the Latino community normalize mental health discussions. The community communication is shifting from asking, "What's wrong with you?" to "What has happened to you?" This approach promotes healing with dignity, understanding and respect.

Program Future Plans/Next Steps

Due to the overwhelming number of requests for MHFA classes, associates have scheduled classes through the summer of 2026. They plan to offer nine classes in 2026.

Fall Prevention

Community Health System-Wide Priority Area: Access to Health Care

Program Description

The Bon Secours St. Francis LifeWise program offers health and social drivers and determinants of health-related programming for adults 55 and older. In 2025, LifeWise presented several events and opportunities focused on fall prevention. The LifeWise coordinator taught Matter of Balance classes, offered a large fall prevention event with internal and external partners and worked with Bob Jones University's health science faculty at their state-of-the-art balance lab. The coordinator also organized a fall prevention work group that includes several local and regional partners. The work group's purpose is to raise community awareness and offer educational programs that help older adults identify choices that support their independence, free from falls. Community Health associates also provided community outreach to support the injury prevention education needs that the Bon Secours St. Francis trauma team identified, including fall prevention.

Program Impact/Outcomes

Over 180 community members were reached through fall prevention classes and events. Falls that are unrelated to any previous condition are the most common reason for patients' trauma-related visits to Bon Secours St. Francis' emergency department; the average age of those patients is around 70. While health systems often focus much of their fall prevention work on patients who have been admitted to hospitals, LifeWise focuses on keeping senior adults out of the emergency department or hospital when possible. Event and class attendees indicated that they better understand the causes of falls and feel that they are better prepared to avoid them.

Program Highlights/Success Stories

"I think of what I learned in the [Matter of Balance course] every day. It has been so helpful in my daily life," a LifeWise member and Matter of Balance participant said.

Program Future Plans/Increasing Access

LifeWise will provide fall prevention awareness and solutions to senior adults, including those with barriers to participating in classes and exercise programs, through evidence-based fall prevention programs: Stay Active and Independent for Life (SAIL Fitness), Matter of Balance and Tai Chi for Falls.

2025 **Program Highlights** | Greenville

Women's Health Events

Community Health System-Wide Priority Area: Access to Health Care

Program Description

In 2025, Bon Secours St. Francis Community Health completed three women's health events that were sponsored by a Bon Secours Mercy Health Foundation Mission Outreach Program award. Each of the three events offered mammograms, pelvic exams + Pap smears, STI testing and blood glucose + lipid profile tests at no charge to 25 uninsured community members. Partner organizations that provided locations for the events included Lifelong Learning and two local faith-based organizations.

Program Impact/Outcomes

In 2025, 75 women received no-cost exams and tests (in addition to 75 women in 2024). For many of these women, this was their first opportunity to receive mammograms and Pap smears. These events allowed staff to identify health issues early, after which Community Health team members provided follow-up referrals to local providers and assisted with health care sponsorship applications.

Program Highlights/Success Stories

Although these were women's events, two men asked to receive mammograms because they had found lumps in their chests. The mobile unit wasn't able to accommodate these men, but associates referred them to the appropriate providers. The men may never have visited a provider if these events had not been offered.

Program Future Plans/Next Steps

The Community Health team will continue to work with the mobile mammography unit and Best Chance Network to provide mammograms for women in under-resourced communities in Greenville County.

Women's and Maternal Health Event

Community Health System-Wide Priority Area: Access to Health Care

Program Description

Bon Secours St. Francis Community Health team members held a Women's and Maternal Health event. This event brought together internal and external partners to educate expectant and new mothers about topics such as lactation, nutrition, infant CPR, car seat usage and the role of doulas in the birth process. The event helped build a strong partnership between Women's Services and Community Health and included presentations from a retired OB-GYN physician and a doula. It concluded with lunch for all and a community baby shower for mothers in need. Associates, community members, Bon Secours St. Francis provider offices and local and national organizations donated new and gently used items for the baby shower. Greenville Awareness and Community Engagement (GACE), the Greenville chapter of the NAACP, New Horizon Family Health and a local faith-based organization were presenting partners.

Program Impact/Outcomes

The Women's and Maternal Health event drew over 150 engaged participants. New and expectant mothers, along with their families, visited 21 vendors, including multiple health care providers, and learned how to perform infant CPR, safely transport their babies, support themselves and their infants through healthy eating and navigate common issues with breastfeeding. The event had strong representation from under-resourced women and women of color, which was especially important given the high rates of infant mortality among these populations. Mothers in need left the event with diapers, wipes and clothing. Thirteen women also received mammograms during the event.

Program Highlights/Success Stories

One young couple visited the event with a baby in a stroller. The man seemed a little withdrawn. His partner asked if he could shop, too, because he had a little girl, so the team provided him with a ticket for the community baby shower. When he stopped to pick up lunch at the end, associates had to do a double-take to ensure that they were looking at the same person. He was beaming and smiling from ear to ear and also said "thank you" several times. He had been treated with care and respect, which made a difference in his life.

Program Future Plans/Next Steps

Bon Secours St. Francis plans to offer an annual Women's and Maternal Health event to fill the substantial need in the Greenville community.

Hampton Roads

Community Identified Health Needs

- Violence in the Community
- Chronic Disease
- Mental Health

Rooted in a Mission of compassion and excellence, Bon Secours Hampton Roads continues to advance health and healing throughout the region. With four hospitals, including Bon Secours Maryview Medical Center in Portsmouth, Bon Secours Harbor View Medical Center in Suffolk, Bon Secours Southampton Medical Center in Franklin and Bon Secours Mary Immaculate Hospital in Newport News, we provide high-quality, patient-centered care to individuals and families throughout Hampton Roads.

Complementing our hospitals, we operate 17 In Motion outpatient locations, 44 primary and specialty care locations, eight imaging centers, three mobile imaging service locations and one free-standing cancer treatment center to ensure that care is accessible and convenient.

Our Community Health team works hand in hand with community partners to advance health equity and improve access to care. By offering education, preventive services and outreach through programs like the Bon Secours Care-A-Van, we bring the ministry of Bon Secours to neighborhoods where it's needed most.

2025 Goals

- Expand Kidz-N-Grief programming to provide supportive grief, loss and trauma services at the Bon Secours Community Health location in Portsmouth. **[Accomplished]**
- 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. **[Accomplished]**
- 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. **[Accomplished]**
- Partner with organizations to promote economic stability for individuals and families in the community. **[Accomplished]**

2026 Goals

- Strengthen and expand the Kidz-N-Grief program through partnerships with faith-based and grassroots community organizations, the addition of two after-school programs in Portsmouth and pop-up sessions.
- Reduce the burden of chronic disease by increasing health education through faith-based partnerships and improving access to medications via Dispensary of Hope, Care-A-Van's new prescription program.
- Increase utilization and access to behavioral health resources by raising community awareness, reducing stigma and strengthening referrals.
- Develop a network of faith-based organizations that host healthy living programs and wellness conversations to promote nutritious eating and reduce chronic diseases.

Care-A-Van

Community Health System-Wide Priority Area: Access to Health Care

Program Description

The Bon Secours Care-A-Van continues to deliver compassionate, high-quality care to communities across the region, covering an estimated 250 square miles. Providing free primary care services to uninsured adults and children, the Care-A-Van reaches individuals and families in Chesapeake, Hampton, Newport News, Norfolk, Portsmouth, Suffolk and Virginia Beach. From wellness checks to lab work, the team treats chronic conditions like diabetes and hypertension, as well as minor illnesses and injuries ranging from heartburn, rashes and headaches to respiratory and urinary infections. The Care-A-Van isn't just a mobile clinic; it's a health care home on wheels, staffed by registered nurses, licensed practical nurses, physicians, patient technicians and community outreach workers. The team also partners with a Bon Secours mobile food pantry and provides screenings and health education at various community events throughout the year.

Program Impact/Outcomes

- As of December 2025, 1,532 total patients visited the Care-A-Van.
- As of December 2025, the Care-A-Van provided 840 health screenings.

Mental Health Referrals

To support patients with behavioral health needs, the Care-A-Van will partner with Pearl Counseling and local community service boards to provide mental health referrals and ongoing support for patients who require additional care.

Abbott's Compassionate Care Program

Abbott's Compassionate Care will allow the Care-A-Van mobile clinic to purchase continuous glucose monitor sensors and readers at a reduced cost for diabetic patients requiring closer diabetes management. The monitors and readers will be provided free of charge to patients. Combined with patient education, these will improve participants' diabetes management and A1c.

Kids-N-Grief

Community Health System-Wide Priority Area: Community Safety

Program Description

Kidz-N-Grief (Portsmouth) is a unique program for grieving children. It provides compassionate support to children coping with grief and loss, many of whom have been impacted by community violence or sudden trauma. Trained facilitators and dedicated volunteers implement the program. Through age-appropriate peer group meetings, participants learn coping skills, rebuild trust and develop emotional resilience in a safe and nurturing environment.

The program's key partners are the Bon Secours Community Health Hub, Portsmouth Public Schools family engagement liaisons, local youth programs and faith-based organizations.

Program Impact/Outcomes

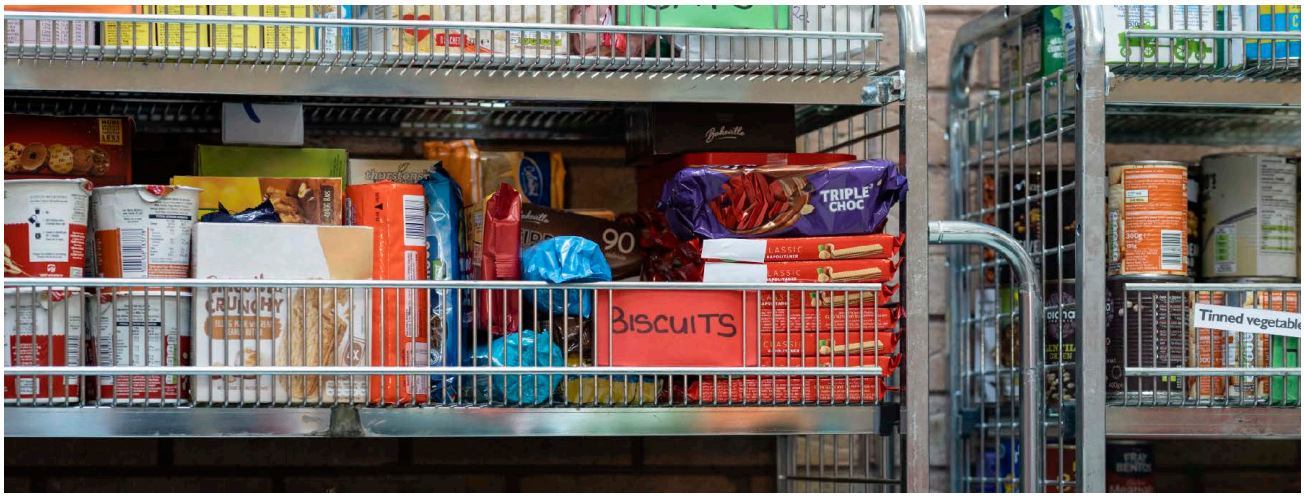
- **Reach:** The program serves 78 students and youth.
- **Outcomes:** Children and teens demonstrate improved emotional expression and grief regulation, including reduced feelings of isolation, anxiety and unresolved sadness.
- **Community Value:** The program serves youth who may not otherwise have access to grief support, eliminates cost and transportation barriers, and normalizes stages of grief and emotions.

Program Highlights/Success Stories

The Kidz-N-Grief program continues to grow in Portsmouth, providing compassionate support for children coping with loss. Through partnerships with local schools, three active groups now meet in elementary after-school programs, creating safe spaces for students to share and heal together. This year, the program introduced a special session to reach middle and high school students, fostering emotional resilience and connection among youth at a critical stage in their development.

Program Future Plans/Next Steps

The program will partner with community-based organizations to host pop-up Kidz-N-Grief sessions for participants aged 5 to 18 years.



Mobile Food Pantry — "Food as Medicine"

Community Health System-Wide Priority Area: Social Determinants/Drivers of Health

Program Description

The Mobile Food Pantry addresses food insecurity by bringing healthy, fresh food directly to underserved communities throughout Hampton Roads. In collaboration with the Care-A-Van, the pantry follows a strategic route with more than 60 annual deployments across six key neighborhoods, which the program identifies through demographic mapping, health data and community surveys. The pantry delivers nutritious food, recipe cards and chronic disease education materials. In addition, health care providers prescribe Food as Medicine for patients managing diabetes, hypertension and obesity.

The program also partners with faith-based organizations throughout the region to reach more families experiencing food insecurity and chronic health conditions. These partnerships extend pantry services into churches and community centers, where participants receive educational materials and opportunities to enroll in Passport to Health, diabetes education and other wraparound programs, which are often hosted directly at their own locations. This collaborative approach improves participants' access to healthy food and strengthens trust, cultural connections and long-term engagement across communities.

The pantry's key partners are the Bon Secours Care-A-Van, the Foodbank of Southeastern Virginia, Food Lion, Operation Blessing and local faith-based organizations.

Program Impact/Outcomes

- **Reach:** The Mobile Food Pantry served over 2,400 families with an average household size of 3.5 people, or 8,400 individuals. We deployed over 60 times annually based on data, surveys and demographic mapping.
- **Outcomes:** Over 10% of families participated in one or more of our wraparound services, such as Passport to Health, diabetes education, Care-A-Van services and community activities. All participating families received educational materials.
- **Community Value:** All participants improved nutrition access designated for underserved residents.

Program Highlights/Success Stories

"The pantry helped me control my diabetes better. I didn't just get food; I learned how to eat differently," shared one participant in Portsmouth.

Program Future Plans/Next Steps

The program will expand its partnership with faith-based organizations, adding new locations for deployments based on data, mapping and surveys. We will also add digital referral capabilities and include more materials and resources for our homeless population, which is present in all our deployments.

Mental Health and Substance Abuse "Saved by the Blood" Community Event

Community Health System-Wide Priority Area: Mental/Behavioral Health

Program Description

The Community Health team hosted a community book presentation featuring Belinda Wynch, a community member whom the team first met through the Bon Secours Hampton Roads Food Pantry and who is now a published author. Belinda shared her inspiring journey of overcoming addiction, navigating mental health challenges and finding hope through recovery. The event provided a safe space for individuals in recovery to discuss mental health stigma and learn about the Community Health HUB's resources, including Narcotics Anonymous, Alcoholics Anonymous and the Healthy Food Pantry.

Program Impact/Outcomes

- **Reach:** Fifty community members attended the event.
- **Outcomes:** The event increased awareness of local recovery and mental health supports.
- **Community Value:** The event strengthened connections between faith-based and clinical services.

Program Highlights/Success Stories

"Through faith and the support I found at the HUB, I realized my story could help others heal,"
Belinda Wynch shared.

Program Future Plans/Next Steps

- Host quarterly mental health and recovery forums.
- Develop peer support and mentorship opportunities.
- Further integrate recovery resources with weekly Community Health HUB services.

Passport to Health: Building Sustainable Healthy Lifestyles

Community Health System-Wide Priority Area: Chronic Disease

Program Description

Passport to Health (PTH) is a comprehensive wellness program that addresses key social drivers and determinants of health through monthly education, screenings, behavior tracking and incentives. The program focuses on five core areas: health care access, nutrition education, physical activity, mental health and financial literacy. In 2025, Portsmouth, Newport News and Norfolk offered the program, which included a Spanish-language version. Participants engaged in health assessments, nutrition workshops, exercise sessions and goal-setting activities supported by health care professionals. To reinforce long-term healthy lifestyle habits, the program also connects participants to the Mobile Food Pantry, Healthy Food Pantry, Care-A-Van services and additional HUB wraparound services.

Program Impact/Outcomes

- **Reach:** Eighty-five participants completed a six-month cycle with an 85% attendance rate.
- **Outcomes:** Among participants, 80% reported lack of knowledge as a barrier pre-program; 100% felt confident post-program.

Irvine

Community Identified Health Needs

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

Mercy Health — Marcum and Wallace Hospital (MWH), a 25-bed critical access hospital in Irvine, KY, serves as the primary provider of acute and outpatient care for Estill, Lee, Owsley and Powell counties. MWH operates hospital-based services in Irvine and primary care clinics in Estill and Powell counties. The Community Health Needs Assessment (CHNA) and Community Health Implementation Plan (CHIP) guide the MWH, which focuses its resources and programs on addressing the most pressing health care challenges across the communities it serves.

2025 Goals

- Food Security: Partner with the Foundation for a Healthy Kentucky and Helping Hands Outreach. **[Accomplished]**
- Addressing Chronic Diseases: Raise awareness and education on prevention and care. **[Accomplished]**
- Medication Assistance: Expand delivery services for patients with transportation challenges. **[In progress]**
- Mental Health: Implement licensed clinical social workers in rural health clinics. **[In progress]**
- Substance Use Disorder: Provide prevention education at local schools. **[Accomplished]**

2026 Goals

- Increase access to nutritious foods and address obesity through the Food as Medicine and Harvesting Health initiatives.
- Improve community understanding of preventive care and chronic disease management through targeted education.
- Increase participation in preventive screenings and chronic disease education to support early detection.
- Strengthen community responses to mental health needs through Mental Health First Aid (MHFA), Question, Persuade, Refer (QPR) and Trauma Informed Care (TIC) trainings.

2025 **Program Highlights** | Irvine

Cardiac Health Program

Community Health System-Wide Priority Area: Chronic Disease

Program Description

The Cardiac Health Program at Mercy Health — Marcum and Wallace Hospital (MWH) focuses on improving cardiovascular health outcomes through prevention, education and early intervention for residents across Estill, Lee, Owsley and Powell counties. The program promotes heart health through community outreach, education and screenings designed to raise awareness of cardiovascular risk factors and support early detection. Each February, MWH hosts Heart to Heart, an annual event that includes interactive learning stations such as blood pressure checks, carotid scans, nutrition and physical therapy guidance, medication management and stroke risk screenings. In 2025, MWH earned Joint Commission's Acute Heart Attack Ready certification following a comprehensive review of its clinical practices and emergency response processes, affirming the hospital's commitment to excellence in cardiac care. The hospital also earned recognition from the American Heart Association's Get With The Guidelines (GWTG) program for quality achievement in coronary artery disease care, receiving Rural Coronary Artery Disease NSTE-ACS Bronze, STEMI Silver and STEMI Referring Center Bronze Plus awards. These achievements reflect strong collaboration among hospital departments, emergency medical services, the American Heart Association and regional health partners to enhance cardiac care delivery across rural communities.

Program Impact and Outcomes

- **Reach:** In 2025, 500+ community members participated in Heart to Heart and other cardiac health initiatives.
- **Outcomes:** The Cardiac Health Program earned the Acute Heart Attack Ready certification and multiple American Heart Association GWTG awards, demonstrating improved adherence to evidence-based cardiac care protocols and enhanced response times for heart attack patients. The program increased community awareness of cardiovascular risk factors through education and on-site screenings.
- **Community Value:** The program improved access to advanced cardiac care in a rural setting, strengthened coordination between hospital teams and EMS, and empowered community members to take proactive steps toward heart health and disease prevention.

Program Highlights/Success Stories

"Our team's dedication and collaboration have elevated the standard of cardiac care available right here in our community," shared **Trena Stocker**, president of Mercy Health — Marcum and Wallace Hospital. Participants at Heart to Heart and other community events featuring cardiac education and screenings expressed appreciation for the personalized guidance they received. Many participants reported that they scheduled follow-up appointments as a result of this guidance, demonstrating the program's real-world impact on early detection and prevention.

Program Future Plans/Next Steps

Building on these successes, Mercy Health — Marcum and Wallace Hospital is pursuing Joint Commission's Disease-Specific Care certification as an Acute Stroke Ready Hospital and participating in the GWTG-Stroke program to strengthen the continuum of cardiovascular and cerebrovascular care. The program will continue to expand community education, screenings and partnerships to further reduce the challenges of chronic diseases and improve long-term heart health outcomes across our region.

2025 **Program Highlights** | Irvine

25th Annual Teddy Bear Fair

Community Health System-Wide Priority Area: Community Well-being (Health Equity)

Program Description

The Teddy Bear Fair is an annual educational and community outreach event hosted by Mercy Health — Marcum and Wallace Hospital, now celebrating its 25th year. The program primarily serves first-grade students from Estill, Lee, Owsley and Powell County elementary schools, along with homeschooled students in each county, providing a fun, hands-on introduction to health care and emergency services. Each student receives a teddy bear, names it and takes it through interactive stations that explore hospital departments, EMS, fire and police services. Key activities include health screenings, ambulance and fire equipment demonstrations, a puppet show and an Air Methods educational visit. The event helps reduce children's anxieties about medical settings while teaching foundational health and safety concepts. Key partners include Estill County EMS, the Estill County Sheriff's Department, the Irvine Fire Department, Estill County ATC health sciences students, the hospital auxiliary and the Mercy Health Foundation Irvine, which sponsors teddy bears for all participants. Volunteers and staff provide hands-on guidance, modeling compassion and patient-centered care. The program fosters early health education, community engagement and long-term relationships between local families and the hospital.

Impact and Outcomes

- **Reach:** During the event, 450 first-grade students from Estill, Lee, Owsley and Powell counties participated in hands-on health education.
- **Outcomes:** Students gained familiarity with hospital and emergency services, reducing their anxiety about medical settings and increasing their awareness of basic health, safety and emergency procedures.
- **Community Value:** The event strengthened connections among families, schools and Mercy Health, promoted early health literacy and positive experiences with health care providers, and reinforced community spirit through volunteer and multigenerational involvement.

Program Highlights/Success Stories

This year, the Teddy Bear Fair celebrated four generations of one family who have volunteered, worked or attended the event over the years, a true testament to the program's lasting impact and the strength of our community. The family's multigenerational involvement highlights how the event fosters connection, education and a sense of belonging for families and the broader community.

Program Future Plans/Next Steps

The Teddy Bear Fair will continue its traditional, beloved activities while expanding opportunities in each department to provide students with even more interactive, hands-on learning experiences. To further support early health education in 2026 and beyond, the program aims to enhance engagement, introduce new educational stations and strengthen partnerships with community organizations.

Called to Care: Teen Volunteer Program

Community Health System-Wide Priority Area: Community Well-being (Health Equity)

Program Description

The Called to Care program is a summer volunteer initiative at Mercy Health — Marcum and Wallace Hospital that introduces high school students to careers in health care. The program serves students interested in exploring health professions and developing professional skills while giving back to the community. During the summer, participants volunteer across multiple hospital departments, including the emergency room, primary care, lab, imaging and more. Key activities include hands-on volunteering, mentorship from hospital staff and exposure to various clinical and nonclinical roles. Hospital staff and community volunteers support the program by providing guidance and supervision. This support fosters skill development and compassion in future health care professionals.

Program Impact/Outcomes

- **Reach:** Eighteen high school students participated in the program, contributing over 675 volunteer hours.
- **Outcomes:** Students gained real-world experience in health care settings, explored potential careers and developed professional skills such as teamwork, communication and patient interaction.
- **Community Value:** The program strengthened connections between local youth and the hospital, inspired future health care professionals and fostered a culture of service and compassion.

Program Highlights/Success Stories

"It was inspiring to see these students step into our hospital and truly embrace what it means to serve others with heart and purpose," said Director of Community Health **Meghan Mills**. The program gave students hands-on experience while showcasing the next generation of compassionate health care professionals.

Future Plans/Next Steps

After a successful first year, the Called to Care program will continue in 2026 with plans to expand participant numbers, increase departmental opportunities and deepen mentorship experiences, providing more students with meaningful exposure to health care careers.

Lima

Community Identified Health Needs

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

For nearly two centuries, Mercy Health — Lima has focused on the health and well-being of our patients and service to our community. Mercy Health — St. Rita's Medical Center has been known for combining quality and compassion 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 that achieve the greatest impact. Through this work, we can reach those who are poor, dying or underserved, helping to eliminate the many health disparities and barriers that directly impact our communities' greatest health needs.

2025 Goals

- Expand work as an Ohio Health Improvement Zone (OHIZ) grantee in Census Tracts 129, 134 and 141, with the goal of launching an evidence-based program that improves health and clinical integration aligned with the Community Health Implementation Plan (CHIP). **[Accomplished]**
- Expand the Pathways Community HUB and Community Health Worker (CHW) model in the market to address health disparities that will reduce the number of preterm and low-birth-weight babies. **[Accomplished]**
- Explore available avenues with community partners to help address adolescent behavioral health needs. **[Accomplished]**
- Continue being a leader to help meet the needs of the nearly 2,000 immigrants and refugees who now call Lima home. **[Accomplished]**

2026 Goals

- Increase access to social support services by expanding screening and resource navigation for patients with identified social drivers and determinants of health.
- Reduce avoidable emergency department utilization by enrolling high-risk patients in the Community Paramedicine program and improving patient health literacy.
- Improve maternal and infant health outcomes by increasing participation in the Mom RX and Pathways programs and reducing low-birth-weight deliveries among enrolled mothers.
- Improve access to timely behavioral health care for youth by implementing a Partial Hospitalization Program and strengthening transitions to outpatient and step-down services.
- Strengthen rural care coordination by implementing targeted initiatives from Rural HEALTH Connect in Putnam and Van Wert counties.

2025 **Program Highlights** | Lima

Pathways HUB Program

Community Health System-Wide Priority Area: Maternal/Infant Health

Program Description

After securing a grant from the Ohio Commission on Minority Health through the Health Council of Northwest Ohio, we have two Community Health Workers (CHWs) to help support the Northwest Ohio Pathways HUB in Allen County. The HUB is a regional care coordination system that uses a network of trained CHWs to support low-income residents, with an emphasis on pregnant women and other high-risk populations. Our CHWs identify and engage individuals who experience both health and social risk factors. They perform a comprehensive assessment of a client's needs, which covers medical and behavioral health issues as well as social drivers and determinants of health. Our CHWs then open a "pathway" for each identified risk factor, which has a defined target outcome requiring CHW intervention. They work one-on-one with the client to help them overcome barriers and connect to community resources. Our CHWs collaborate with other stakeholders (health care providers, social service agencies and the HUB network) to ensure the client receives a coordinated set of services rather than fragmented help.

In 2025, 62 referrals were made for at-risk mothers through the OB-GYN Specialists of Lima, and 46 mothers/patients were enrolled in the Pathways HUB program.

Program Impact and Outcomes

A total of 62 active clients were referred to the Pathways HUB program, while 46 patients were enrolled in the Pathways HUB program.

Program Highlights/Success Stories

The Pathways HUB program recently received additional funding that will support essential supplies for new mothers and infants. We are also expanding our marketing efforts to increase awareness and improve access to transportation.

Program Future Plans/Next Steps

In 2026, the Pathways HUB program will continue with an enhanced focus on care coordination and intentional referral growth, aligning closely with Help Me Grow, Early Intervention and OB-GYN Specialists of Lima to proactively build a sustainable pipeline for increased Medicaid maternity patients.

2025 **Program Highlights** | Lima

Equity Beyond the 4 Walls

Community Health System-Wide Priority Area: Social Determinants and Drivers of Health

Program Description

Equity Beyond the 4 Walls is an initiative that extends the hospital's Mission into the community by addressing the root causes of health disparities and improving access to care in the neighborhoods facing the greatest health needs. The program serves residents in Census Tracts 129, 134 and 141, with a focus on individuals and families experiencing barriers such as poverty, chronic illness, food insecurity and limited access to preventive health services.

Through a comprehensive outreach model, the program brings health and wellness directly to meet people where they are. Key activities include mobile health clinic outreach in collaboration with Ohio Northern University at recurring community stops, the Walk with a Doc program promoting physical activity and provider engagement, neighborhood block parties that foster trust and connection, café conversations that create safe spaces for dialogue on health and community issues, and pop-up parties that deliver accessible health education in informal, family-friendly settings. Additionally, the initiative offers homeownership and financial literacy classes, empowering residents to build long-term stability.

In 2025, participant barriers to care and other needs related to social drivers and determinants of health (SDOH) were identified by administering 220 health needs assessments, in which a total of 98 referrals for SDOH/Access were provided. Of those 98 referrals, 51 (52%) were for primary care providers, 29 (29%) were for tobacco cessation support, nine (9%) were to the Pathways HUB program, three (3%) were for mammograms and one (1%) was for weight management.

Program Highlights/Success Stories

Through strong partner collaboration, we identified key gaps and areas of need, leveraged the grant framework to define clear next steps for partner engagement and implemented a streamlined referral tracking process across teams.

Program Future Plans/Next Steps

In 2026, we will continue the initiative's work as an approach to identifying SDOH needs and related barriers to care, building programs and establishing relationships with community partners.

Tobacco Cessation

Community Health System-Wide Priority Area: Chronic Disease

Program Description

The Tobacco Use Prevention (TUP) grant through the Ohio Department of Health is a comprehensive community initiative to reduce tobacco and nicotine use among youth and adults across Allen County and the surrounding region. The program targets residents in high Social Vulnerability Index (SVI) areas who face disproportionate rates of nicotine dependence and tobacco-related illness.

The initiative's three central goals are to build community infrastructure and leadership to reduce tobacco use; decrease adult nicotine use through the promotion of the Ohio Tobacco Quit Line and implementation of policy, systems and environmental (PSE) changes; and reduce youth nicotine use through school-based education, media outreach and youth engagement in collaboration with Activate Allen County.

The Health and Pharmacy Systems Change Project was a cornerstone of the program, in which St. Rita's partnered with the Institute of Orthopaedic Surgery (IOS) and Health Partners of Western Ohio to integrate the Ask, Advise, Refer framework into clinical workflows. These collaborations have expanded access to cessation support, including on-site dispensing of Nicotine Replacement Therapy (NRT) and increased referrals to the Ohio Tobacco Quit Line and St. Rita's Tobacco Cessation Program.

The program also emphasized outreach to behavioral health populations, who represent roughly 40% of tobacco use nationally. Collaborating with Coleman Behavioral Health, Specialized Alternatives for Families and Youth (SAFY) and Cornerstone of Hope, St. Rita's worked to develop referral pathways, strengthen smoke-free policies and implement on-site cessation education. Additionally, the program provided compliance checks for retailers in partnership with law enforcement. It also worked to deliver school-based prevention and community engagement activities, including safe vape collection and disposal efforts (such as the disposal of eight pounds of confiscated e-cigarettes and vapes).

The St. Rita's Tobacco Cessation Program is a 12-week, evidence-based initiative offered at no cost to participants. The program combines group education, personalized counseling and up to 10 weeks of NRT. In 2025, we had 250 referrals and 25 patients who completed the 12-week program.

Program Impact/Outcomes

In 2025, St. Rita's Tobacco Cessation Program received 250 referrals, reflecting strong integration of the Ask, Advise, Advise, Refer (AAR) framework across clinical and community settings. The 12-week, evidence-based program provides group education, individualized counseling and up to 10 weeks of NRT at no cost to participants.

Eighteen Participants successfully completed the full program in 2025, with additional participants achieving meaningful reductions in tobacco use and short-term abstinence milestones. For those unable to complete all 12 weeks, continued follow-up ensured access to counseling and quit-support resources, reinforcing sustained engagement and long-term behavioral change.

Program Highlights/Success Stories

We collaborated with Health Partners of Western Ohio (HPWO) and the Institute for Orthopaedic Surgery (IOS) to enhance tobacco-use screening and cessation workflows. We also implemented Ask, Advise, Refer, establishing referral pathways and integrating Nicotine Replacement Therapy (NRT) through Health Partners Pharmacy, thereby improving access to evidence-based treatments.

Program Future Plans/Next Steps

The Tobacco Use Prevention (TUP) grant continues into 2026, enabling prevention efforts focused on youth and adult tobacco use. We will focus on coalition and capacity building to help address county outreach and efforts, emphasizing zoning and large-scale events.

Rural HEALTH Connect

Community Health (System) Priority Area: Access to Health Care

Program Description

Rural HEALTH Connect is a collaborative coalition established through an HRSA Rural Health Network Development Grant to help strengthen rural health systems across Putnam and Van Wert counties. The initiative unites local organizations, health care providers and community leaders to identify service gaps and develop coordinated strategies that address chronic disease, mental health and other priority needs.

Serving as a regional network, Rural HEALTH Connect's primary audience includes community-based organizations, public health agencies, hospitals, schools and social service providers working to improve the health and well-being of rural residents. Key activities include convening monthly coalition meetings, conducting data collection and SWOT analyses, sharing partner insights and collaboratively building a comprehensive strategic plan that will guide future implementation efforts.

Mercy Health — St. Rita's Medical Center supports the coalition by providing administrative oversight through a project director, as well as leadership for on-the-ground coordination, partnership engagement and data analysis through a network director. Although Mercy Health serves as the fiscal and administrative lead, the coalition operates on behalf of its member organizations and the communities they represent.

Program Impact and Outcomes

The coalition successfully convened a multi-sector rural health network across Putnam and Van Wert counties, engaging health care, public health, social services, education and community-based partners. Additionally, it established a shared governance structure to help advance care coordination and ensure alignment among partners.

Program Future Plans/Next Steps

The HRSA Rural Health Network Development Grant continues into 2026. Our goal is to apply for a three-year implementation grant to begin implementing initiatives and priorities identified in the strategic plan with Rural HEALTH Connect stakeholders.

2025 **Program Highlights** | Lima

Census Tract 129

Community Health (System) Priority Area: Access to Health Care

Program Description

Census Tract (CT) 129 is an area just north of St. Rita's campus. Work in this area is vital and aligns with the Equity Beyond the 4 Walls program, which is a care coordination and community connection strategy linking individuals in CT 129 with the medical, social and economic resources necessary to improve their overall well-being. In 2025, Mercy Health — St. Rita's hosted the Third Annual Here's to Your Health Neighborhood Block Party, which brought together 220 participants and a broad network of community and internal partners. At the event, 92 Health Needs Assessments (HNAs) were completed, six individuals enrolled in the Pathways HUB program, three were scheduled for mammograms, nine were enrolled in insurance through Molina, one was connected to weight management services, one was established with primary care and six were enrolled with Buckeye insurance.

The work within this neighborhood directly aligns with the initiative's Mission to bridge gaps between clinical care and community-based resources, addressing the social drivers and determinants of health that most impact residents. Within CT 129, the initiative's partnership with Project 129, LLC — a joint effort between St. Rita's Medical Center, Project 129, LLC, Superior Credit Union and Greater Lima Region, Inc. — focuses on increasing access to affordable housing while ensuring residents receive wraparound health care and support services to eliminate barriers to care. Together, these collaborative efforts reflect a holistic, community-driven approach to advancing health equity and building healthier, more resilient neighborhoods across Lima.

We also worked with the Red Cross to install a total of 36 smoke alarms in homes within CT 129.

Since the inception of Project 129 in 2023, the program has increased CT 129 homeownership from 175 owner-occupied houses to 198, representing a 13% increase. Additionally, the program has renovated eight single-family homes and one two-family home within that time frame.

Program Future Plans/Next Steps

Work will continue in CT 129 with a focus on moving individuals who have been connected to resources to a long-term sufficiency and sustainability plan. Additionally, on-site programming in the neighborhood will continue to build trusting relationships with residents.

Lorain

Community Identified Health Needs

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

Mercy Health — Lorain continues to advance its Mission of extending the compassionate ministry of Jesus by improving the health and well-being of individuals and families throughout Lorain County. Guided by the 2023–2025 Community Health Needs Assessment (CHNA), the Community Health Department focuses on addressing six key priorities: chronic disease, maternal and infant health, behavioral health, substance use, cancer prevention and health equity.

In 2025, the department led seven coordinated programs and initiatives designed to meet people where they are in neighborhoods, clinics, schools and faith communities to reduce health disparities and strengthen community well-being. These efforts combine clinical care, education and social support to create meaningful, measurable change.

The team's work reflects an integrated model of service that addresses both clinical and nonclinical drivers of health. Through programs such as Resource Mothers, community social work services, community health screenings, Community Health Worker (CHW) integration in primary care and the Health Education Series, Mercy Health — Lorain provided individualized support and vital resources to residents across Lorain County. Additional initiatives planned for the 2026 – 2028 Community Health Improvement Plan (CHIP) cycle incudes support groups for new mothers, implementation of the 24:7 Dad Fatherhood Program, community exercise classes and preparations for the 2026 launch of a hospital-based food pantry in partnership with Second Harvest Food. Together, these efforts reflect a continued focus on whole-person care and addressing practical needs that impact health.

Through strong collaborations with partners such as Lorain County Public Health, Catholic Charities, El Centro de Servicios Sociales, local schools, congregations and community-based organizations, the department continues to expand access to care, improve care coordination and reduce barriers for individuals and families. Together, these programs and partnerships ensure that Mercy Health — Lorain's presence extends beyond hospital walls, bringing compassionate care, dignity and opportunity to every person served.

2025 **Program Highlights** | Lorain

2025 Goals

- Strengthen the foundation of health in the community by focusing on chronic disease measures (hypertension, diabetes, knowing your numbers and stroke prevention). **[In progress]**
- Provide emotional and social support for women and their children to strengthen their ability to thrive and survive. **[Accomplished]**
- Work with partners to address substance use disorders by increasing access to education, treatment and support. **[In progress]**
- Enhance mental health outcomes. **[In progress]**
- Create a proactive cancer screening attitude by providing access and education concerning prevention, screening, diagnosis and treatment. **[In progress]**
- Remove barriers to ensure every person can achieve their best health and life. **[In progress]**

2026 Goals

- **Dispensary of Hope**
  Improve access to prescription medications for individuals experiencing barriers to care.
- **Community Health Fair**
  Increase community awareness of available health care services and preventive care resources through community outreach.
- **24:7 Dad National Fatherhood Initiative**
  Implement and sustain a fatherhood and family support initiative to strengthen parenting skills, promote healthy relationships and support family stability.
- **Community Health Screenings**
  Provide community-based chronic disease screenings and education to support early identification of health risks and connection to preventive and primary care.
- **Food Pantry Program**
  Operate a food access initiative to support individuals experiencing food insecurity and improve access to nutritious food.
- **Safe Sleep Program**
  Promote safe sleep practices through education and access to safe sleep resources.
- **Car Seat Safety Program**
  Support child passenger safety through education and car seat distribution.

Community Health Screenings

Community Health System-Wide Priority Area: Chronic Disease

Program Description

Mercy Health — Lorain's Community Health team provided no-cost blood pressure, cholesterol, glucose, and BMI screenings throughout Lorain County, targeting underserved residents who may lack access to preventive care. Screenings were conducted at churches, schools and community centers due to strong partnerships with Catholic Charities, the Coalition of Hispanic Issues and Progress (CHIP), El Centro de Servicios Sociales, local faith-based organizations and other community-based organizations.

Each participant received personalized education about their screening results, resources for healthy lifestyle management and referrals to primary care providers, behavioral health support or social service agencies as needed. Each screening also included a social drivers and determinants of health (SDOH) and behavioral health assessment, ensuring participants received a holistic evaluation of their needs.

Impact and Outcomes

Reach:

- Across Lorain County, 306 individuals received Community Health screenings.
- Participants ranged in age from 19 to 91 years old. Nearly half of these participants were 55 years or older, a key demographic for chronic disease prevention.
- Screenings were conducted in five Lorain County cities, with the highest participation in Elyria and Lorain.

Outcomes:

- 215 participants (70%) had elevated or high blood pressure.
- 74 participants (24%) had high cholesterol levels.
- 71participants (23%) had glucose levels above the normal range.
- 49 participants (23%) reported no primary care provider or no visit in the past year, and they were referred to a provider for follow-up.
- All participants received verbal and written counseling on maintaining healthy numbers, healthy eating habits and regular physical activity.

2025 **Program Highlights** | Lorain

Community Value:

- This initiative promotes the early detection of chronic diseases, reducing preventable hospitalizations and improving access to care. By linking participants to primary care, the program bridges community-based prevention and clinical follow-up while reinforcing Mercy Health's Mission to serve poor, underserved and marginalized populations.

Program Highlights/Success Stories

At one of our community health screenings, a gentleman discovered for the first time that his cholesterol levels were high. Until that moment, he had no idea he was at risk for heart disease. After receiving his results and guidance from our team, he scheduled a follow-up visit with his primary care provider, who confirmed his elevated levels and discussed the possibility of starting medication.

This information motivated the man to begin making lifestyle changes before turning to medication. He is now working closely with a dietitian to improve his eating habits and has already started lowering his cholesterol naturally. His experience reflects how our community health screenings empower individuals to take ownership of their health, turning awareness into action and prevention into lasting change.

Program Future Plans/Next Steps

Looking ahead to 2026, the Community Health team will expand outreach to 800 residents annually, prioritizing areas identified through our Community Health Needs Assessment. Plans include:

- Strengthening referral tracking to measure referral follow-up
- Implementing post-screening surveys to assess participant satisfaction
- Collaborating with local schools, parishes and employers to reach additional populations

These next steps will deepen the program's impact by combining screening, education and sustained follow-up, ensuring Lorain County residents have equitable opportunities to know their numbers and improve their health.

Cancer Screenings

Community Health System-Wide Priority Area: Access to Health Care

Program Description

Mercy Health — Lorain continues to advance cancer prevention and early detection through accessible prostate-specific antigen (PSA) and mammogram screenings offered across hospital and outpatient facilities. These screenings serve adults throughout Lorain County, with an emphasis on reaching uninsured, underinsured and transportation-limited residents who may otherwise delay preventive care.

Through a close partnership between the Mercy Health Cancer Team and the Community Health Department, staff collaborate to ensure a consistent presence at community events where residents can learn about the importance of regular screenings and early detection. The Mercy Health Cancer Team directly contacts individuals who express interest in scheduling a personalized follow-up appointment. This shared approach ensures that education leads to action and that each participant has a clear path to care.

Program Impact and Outcomes

Reach:

- In 2025, 6,988 PSA screenings and 7,809 mammogram screenings were completed across Mercy Health — Lorain facilities.
- The Mercy Health Cancer Team and Community Health staff attended multiple community events throughout Lorain County, offering hundreds of residents preventive care education.

Outcomes:

- There was increased participation in cancer screenings among previously unscreened adults.
- Coordination improved between the Mercy Health Cancer Team and clinical scheduling, ensuring that residents who expressed interest received a follow-up call for appointment scheduling.
- Consistent engagement and accessible health education have strengthened community trust.

2025 **Program Highlights** | Lorain

Community Value:

- Mercy Health — Lorain ensured the early detection of cancer through proactive outreach and accessible screening opportunities, enabling earlier diagnosis and improved outcomes. Such opportunities reduced barriers — such as cost, language and transportation — by meeting residents in neighborhoods, churches and community centers. The screenings strengthened community trust in Mercy Health by connecting awareness with real access to care, empowering residents to take proactive steps toward prevention and long-term health.

Program Highlights/Success Stories

At a recent Community Health event, several residents expressed interest in mammograms after learning about the importance of early detection. One woman shared that she was a breast cancer survivor but had fallen behind on her annual screening after changing employers and insurance plans. She explained that she had not taken the time to establish care or understand her new benefits.

The Mercy Health team explained that preventive mammograms are covered 100% under most insurance plans and offered to arrange a follow-up call from the scheduling team. Within 48 hours, she received a call and was scheduled for her mammogram within two weeks of the event. She later shared that she was grateful for the support and appreciated the outreach that helped her return to compliance with her annual screening.

This woman's story illustrates how combining education with personalized follow-up helps individuals overcome barriers, stay engaged in their preventive care and maintain their health after surviving cancer.

Program Future Plans/Next Steps

Looking ahead to 2026, Mercy Health — Lorain will expand access to preventive cancer screenings across Lorain County, with a focus on high-need areas identified through the Community Health Needs Assessment. Plans include:

- Launching a mobile Mammo-Van to provide on-site mammography in underserved neighborhoods
- Strengthening referral tracking systems to measure follow-up completion rates for both PSA and mammogram participants
- Expanding outreach through community events in partnership with churches, nonprofits and employers to promote early detection and preventive care

These next steps will deepen the program's impact by bringing cancer screening and education directly into the community, reducing barriers to care and ensuring that every resident has equitable access to early detection and lifesaving treatment.

Resource Mothers

Community Health (System) Priority Area: Maternal/Infant Health

Program Description

The Resource Mothers program provides individualized home visiting and case management for pregnant women and families with infants up to one year old. The program focuses on improving maternal and infant health outcomes through education, social support and connections to medical and community resources.

Each mother is paired with a Community Health Worker (CHW) who provides consistent support throughout pregnancy and the postpartum period. The CHW educates families on topics such as prenatal care, safe sleep, breastfeeding and immunizations while helping them overcome barriers to care, such as transportation or insurance coverage. Referrals come from Mercy Health OB-GYNs and pediatric practices as well as community partners.

The Resource Mothers program operates under the Mercy Health Community Health Department, emphasizing trust, relationship-building and continuity of care to promote healthy pregnancies and thriving infants.

Program Impact/Outcomes

Reach:

- The program served 261 pregnant or postpartum women and infants across Lorain County through home and virtual visits.
- The program provided maternal education on prenatal health, safe sleep, postpartum recovery and early childhood development.

Outcomes:

- Among infants, 85% were born at or beyond 37 weeks of gestation, reflecting continued improvement while highlighting opportunities for enhanced prenatal engagement and early identification of high-risk pregnancies.
- Among infants, 91% were born weighing 5 lbs 8 oz or more, demonstrating significant progress toward healthy birth weight outcomes.

- Immunization completion and first-birthday outcomes are actively being tracked for 2025 infants and will be finalized in early 2026.
- Consistent engagement and accessible health education have strengthened community trust.

Community Value:

- Resource Mothers improved maternal and infant health by providing consistent, trusted support throughout pregnancy and early parenthood. The program reduced barriers to care by connecting families to medical, social and educational resources. Moreover, it empowered mothers with the confidence, knowledge and tools to nurture their children and create safe, stable home environments.

Program Highlights/Success Stories

One mother in the program had just given birth to a premature baby and was preparing for discharge from the hospital when our team learned that she and her family were living in a garage. Before she and her newborn could safely leave the hospital, the Resource Mothers team urgently worked to help her find emergency shelter.

The challenges that followed revealed much more than the mother's need for housing; these challenges revealed her deep mistrust of the health care system, discomfort in an unfamiliar environment and cultural differences in how she approached infant care. For her, the shelter's rules felt restrictive, the metal detector at the entrance triggered fear and she was frustrated by not being able to cook traditional meals for her family.

Instead of labeling the mother as resistant, the Resource Mothers team offered her patience, empathy and respect. The team clearly explained the shelter's expectations, listened to her concerns and connected her with another Spanish-speaking family to ease her transition. When she attempted to give her baby water, the CHW gently explained why that practice can be unsafe for newborns and offered alternatives.

Through compassion and cultural humility, trust slowly began to develop. This experience reminded the team that behind every challenging situation is a mother doing her best in an unfamiliar system. By choosing understanding over judgment, the Resource Mothers program transformed a moment of crisis into an opportunity for connection, learning and healing.

Program Future Plans/Next Steps

Looking ahead to 2026, the Resource Mothers team will continue strengthening outcomes and expanding its capacity to serve more families. Plans include:

- Increasing annual enrollment numbers
- Collaborating with Lorain County Public Health to ensure car seat safety and safe sleep education
- Expanding prenatal care to include blood pressure monitoring and the importance of understanding blood pressure changes during pregnancy

These next steps will deepen the program's impact by advancing maternal and infant health outcomes, reinforcing Mercy Health's Mission to serve with compassion and excellence.

Paducah

Community Identified Health Needs

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

Mercy Health — Lourdes Hospital is a 359-bed regional hospital located in Paducah, KY, and 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. The hospital's primary service area has a population of more than 200,000 people within seven counties and two states (Kentucky and Illinois). Lourdes is home to the region's largest multispecialty 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 percentage of people over 65 years of age, living in poverty, living with a disability and living with chronic illnesses than the state average.

2025 Goals

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

2026 Goals

- Complete the construction and opening of the Client Choice Food Pantry at Paducah Cooperative Ministry.
- Continue to expand free screenings and health education to the community.
- Increase use of harm reduction initiatives, including the distribution of free Deterra bags.
- Increase use of medical transportation partnership programs.

Free Flu Shot Program

Community Health System-Wide Priority Area: Chronic Disease; Access to Health Care; Community Well-Being (Health Equity)

Program Description

To expand access to the influenza vaccine, Lourdes provides the flu shot throughout the region without charge, specifically targeting populations facing access barriers and challenges, such as a lack of insurance or limited financial resources. In 2025, Lourdes administered vaccines through four events across three counties. Doses were also provided to three nonprofit health care organizations. In total, Mercy Health provided 550 flu shot doses (500 regular doses and 50 senior doses) and partnered with a variety of community organizations to connect individuals attending events to additional resources.

Impact and Outcomes

- Mercy Health provided 550 flu shot doses (500 regular doses and 50 senior doses).
- Mercy Health administered flu shots at four community events in three counties and through three health care nonprofits.
- Among flu shot event attendees, 20% indicated that they did not have health insurance.
- Thanks to community partners, 13 attendees also received pneumonia vaccines and 39 received free HIV screenings.
- Over the past six years, Mercy Health has provided 3,476 free flu shots through this program.

Program Highlights/Success Stories

"The flu shot is critical in keeping our community healthy and significantly decreases flu-related hospitalizations in our area," said Mercy Health Director of Community Health **Leigh Ann Ballegeer**. "Over the past six years, Mercy Health has provided over 3,476 no-cost flu shots throughout the region. This program aims to increase access to the flu vaccine, targeting populations who may not otherwise get the flu shot. This year, we were thrilled to have additional partners join us to provide our community with additional resources to stay healthy."

Program Future Plans/Next Steps

The program will continue in 2026.

Client Choice Food Pantry

Community Health System-Wide Priority Area: Social Determinants and Drivers of Health; Financial Security; Community Well-Being (Health Equity); Mental/Behavioral Health

Program Description

In February, the Bon Secours Mercy Health Community Health Fund, selected Paducah Cooperative Ministry (PCM) as an awardee to establish the Client Choice Food Pantry, the first of its kind in the region. This innovative initiative is designed to combat food insecurity, promote healthier eating options and restore dignity to those in need. This solution will address the increased need for food assistance while providing healthier food options to improve the community's overall health and well-being. This groundbreaking food pantry model reduces the waste that often occurs when clients cannot self-select food items, allows for healthier dietary choices and education to support food preparation changes, and restores dignity to the food pantry experience by promoting more positive self-esteem and mental health.

Impact and Outcomes

- Philanthropic investment to drive the project forward
- PCM provided 4,782 sets of groceries to families in 2025, including serving 769 new families through their food programs.

Program Highlights/Success Stories

"PCM is grateful for community partners such as Mercy Health, who help make our vision a reality," said Executive Director of Paducah Cooperative Ministry **Lacy Boling**. "PCM experienced a 41% increase in grocery requests from 2022 to 2023. In 2024, we received approximately 800 requests per month for food assistance. The goal of our new Client Choice Food Pantry is to transform the food pantry experience for our neighbors in need by creating a grocery store-like environment to empower people to make informed choices about their food and restore dignity."

Program Future Plans/Next Steps

Construction for the pantry has begun, with an opening date in summer 2026.

Transportation Program

Community Health System-Wide Priority Area: Social Determinants and Drivers of Health; Community Well-Being (Health Equity); Financial Security

Program Description

Mercy Health continues to partner with and support Heart USA, a local nonprofit that celebrated 20 years of serving the community in 2025. To mark this milestone, they publicly launched their new medical transportation program, which the 2023 BSMH Community Health Fund made possible. This program serves clients who need transportation to essential medical appointments and do not qualify for other transportation benefits. Heart USA (Healthcare Equipment and Resource Tools, Inc.) is located on Mercy Health's Paducah Medical Campus and provides prescription medication assistance, certified Community Health Workers (CHW), durable medical equipment and supplies, and an on-site food pantry. For two decades, Heart USA has successfully saved clients a total of $115,178,031 on medications through 68,819 volunteer-facilitated orders. Heart USA remains the model for the statewide Kentucky Prescription Assistance Program (KPAP).

Impact and Outcomes

- 198 trips provided to medical appointments in 2025
- In 2025, Heart USA hit an all-time record of over $15 million in prescription savings for its clients

Program Highlights/Success Stories

"A lot of times, when clients come in the door, they have their heads hung low, and they've never asked for help before," Heart USA Executive Director **Gractia Wilburn** shared. "We try to uplift them and let them know that they are taking empowering steps to manage their health by coming to us and allowing us to work with their doctor to make sure that they're following the doctor's orders, and also making it to their appointments."

Program Future Plans/Next Steps

The program will continue in 2026.

Feminine Hygiene Product Program

Community Health System-Wide Priority Area: Financial Security; Community Well-Being (Health Equity); Mental/Behavioral Health

Program Description

Mercy Health relaunched its Feminine Hygiene Product Program after the Mercy Health Foundation Lourdes received a donation from the Charity League of Paducah to support it. Started in 2022, this initiative expands access to essential feminine hygiene products to local youth in need. With this new grant funding, items were purchased and provided to all high, middle and intermediate schools within McCracken County Public Schools and Paducah Public Schools and nonprofit partners. With this support, Mercy Health can continue to combat the stigma surrounding menstrual health, promote female empowerment, expand access to these costly products and encourage positive mental health among our youth.

Impact and Outcomes

The following items were distributed in 2025:

- 7,500 tampons
- 4,320 maxi pads
- 500 toiletry bags

Items were distributed to the following organizations:

- Eight high, middle and intermediate schools within McCracken County Public Schools and Paducah Public Schools
- McKinney-Vento liaisons (homeless student outreach) at both school systems
- Oscar Cross Boys & Girls Club of Paducah
- Paducah Cooperative Ministry's Fresh Start Village shelter

Program Highlights/Success Stories

"Thank you for serving our students experiencing homelessness with feminine hygiene items. These items are crucial for my students, as they cannot afford to purchase them themselves. Period poverty causes anxiety, stress and discomfort that impacts school attendance and overall well-being. Your program provides a sense of dignity and well-being for my students, which ultimately helps them succeed in school. It provides self-esteem, confidence, educational equity, health, safety and dignity."

— **Heather Anderson**, *Paducah Public Schools*

Program Future Plans/Next Steps

Thanks to additional funding from the Bon Secours Mercy Health Foundation, in 2026, this program can greatly expand into outlying Community Health Needs Assessment service area counties (Marshall and Graves), providing products and education to more schools and local nonprofits.

2025 **Program Highlights** | Paducah

Free Community Education and Trainings

Community Health System-Wide Priority Area: Mental/Behavioral Health; Access to Health Care

Program Description

In collaboration with community partners, Mercy Health helped provide multiple free training opportunities to the community and Mercy Health employees. These trainings aligned with Community Health Needs Assessment priorities and included Bridges Out of Poverty, Adult and Youth Mental Health First Aid, Darkness 2 Light for child abuse prevention, Question, Persuade, Refer (QPR) for suicide prevention, the Immunization Summit and the Substance Prevention and Recovery Knowledge (S.P.A.R.K.) Summit. The community members who attended trainings included representatives from education, law enforcement, health care, churches, local nonprofits and more. These free educational programs enhance community health and employee knowledge, creating a more informed, compassionate and effective network of resources.

Trainings included the following:

- Bridges Out of Poverty is a framework and set of resources designed to help communities address poverty by providing professionals and organizations with a deeper understanding of the challenges and strengths of individuals experiencing poverty.
- Mental Health First Aid trainings teach participants how to deal with mental health crises and substance misuse. These trainings target individuals who work with adults or youth.
- Darkness 2 Light is an evidence-informed, award-winning training that teaches adults to prevent, recognize and react responsibly to child sexual abuse.
- QPR is an emergency mental health intervention to identify and interrupt mental health crises as well as direct individuals to proper care.
- The Immunization Summit is an educational event that brings together health care professionals and public health experts to address timely issues surrounding vaccinations in western Kentucky and beyond.
- The S.P.A.R.K. Summit covers evidence-based topics on the illicit drug supply, transmissible diseases, the link between oral health and substance use, the impacts substance use may have on youth, substance-induced mental health states, deflection strategies and innovative programs within local organizations.

Impact and Outcomes

- 99 attendees (Bridges Out of Poverty)
- 12 attendees (Adult Mental Health First Aid)
- 11 attendees (Youth Mental Health First Aid)
- 7 attendees (Darkness 2 Light)
- 10 attendees (QPR)
- 100 attendees (Immunization Summit)
- 130 attendees (S.P.A.R.K. Summit)

Program Highlights/Success Stories

In collaboration with many community partners, 369 health care and community service professionals received free education, increasing the community's overall knowledge on a variety of important topics. This education created a more informed, compassionate and effective network of resources to assist those who need it most.

Program Future Plans/Next Steps

The program will continue in 2026.

Richmond

Community Identified Health Needs

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

The Bon Secours Richmond Health System provides compassionate medical care through a network of seven acute care hospitals, primary and specialty care practices, ambulatory care sites and continuing care facilities across a diverse 28-locality region.

The Community Health team focuses on delivering services to the uninsured and/or marginalized, with an emphasis on respect for the cultures and the previous life experiences that patients bring to their health care encounters. With decades of building a foundation of trust, Community Health serves patients who may have difficulty accessing health care through traditional venues. In partnership with community nonprofits and local faith-based communities, Bon Secours Richmond's Community Health work has grown to include primary, specialty and preventive medicine and education, behavioral health and referral services, support for victims of interpersonal and community violence. Additionally, Bon Secours provides direct financial investments to community organizations and programs that address social determinants of health, including housing, transportation, food access, out-of-school time, financial literacy, pathways to sustainable careers and post incarceration reentry.

2025 Goals

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

2026 Goals

- To increase early identification and referral to mental health supports of adults affected by interpersonal violence by implementing a new screening exploring childhood trauma exposure and referring patients who screen positive to appropriate community based mental health services.
- To support and foster the expansion of collaborative programs and initiatives that provide systemic community-based responses to SDOH needs in the community.
- To increase health related social need referrals by 15% over the 2025 baseline and connect at least 80% of patients to appropriate community resources.
- To expand the rural footprint of the Bon Secours Care-A-Van, working to increase the percentage of rural patients served by the Bon Secours Care-A-Van by 20% as compared with the 2025 baseline of rural patients.

Medically Tailored Meals

Community Health System-Wide Priority Area: Social Determinants and Drivers of Health

Program Description

Located in Petersburg, VA, Bon Secours Southside Medical Center serves a community that is ranked lowest overall among 133 localities in Virginia for many health outcomes and health conditions. Petersburg has a life expectancy of 64.9 years (13.2 years lower than the state average) and a food insecurity rate of 16% (double the state average). In partnership with the Feed More regional food bank and the local Walnut Hill Pharmacy, Bon Secours Community Health collaborated with the hospital staff to launch a Medically Tailored Meal (MTM) program to address food and nutrition insecurity among patients discharging from the hospital. Funded with a grant from the Bon Secours Community Benefit Investment program, the MTM program was designed to ease the burden of recovery for food-insecure patients lacking reliable transportation.

During their acute hospital stay, chronic disease patients who identify as food insecure are referred to Feed More to enroll in the MTM program. When enrolled patients are discharged home, Walnut Hill Pharmacy delivers eight weeks of medically tailored meals, medically tailored groceries, disease management recipes and nutrition and health information.

The lessons learned from this pilot program will help to understand the staffing and partnerships required to bring this innovative program to other Bon Secours hospitals.

Program Impact and Outcomes

- 22 Patients Served

Program Highlights or Success Stories

Quotes from program participants:

- *"The program came to me right on time — a good transition from the hospital."*
- *"I'm walking [and] eating better. My stomach feels better, and my [blood] sugar is better."*
- *"For the first time, I had some good, decent meals [and] the vitamins that I needed."*

Program Future Plans/Next Steps

In 2026, this program will continue with a focus on enhancing the referral and tracking processes between the hospital and community partners.

Hope in a Backpack (Partnership with Dignity Grows)

Community Health System-Wide Priority Area: Community Well-Being (Health Equity)

Program Description

Bon Secours Richmond has partnered with the nonprofit Dignity Grows to address period poverty in Petersburg, VA, through the Hope in a Backpack program. Period poverty impacts students' ability to attend school. By the end of the twelfth grade, girls could miss up to 145 days of school, leaving them nearly a full school year behind. The Hope in a Backpack partnership addresses community needs by embedding reliable access to hygiene within the school ecosystem. The program provides every sixth through twelfth grade female student with essential menstrual hygiene products for use at home throughout the school year with the Bon Secours Petersburg Center for Healthy Living serving as the hub for packing and distributing the backpacks.

By normalizing access and removing stigma, the program eliminates a preventable barrier to attendance and participation, allowing students to focus on learning rather than managing scarcity. The Hope in a Backpack initiative is an actionable path to eradicate Period Poverty and strengthen communities from within.

Program Impact and Outcomes

- 7,000 backpacks distributed to Petersburg High School students

Program Highlights/Success Stories

Responses from the girls are overwhelmingly positive. As one Vernon Johns Middle School Hope in a Backpack recipient said, "The backpack was really nice and so helpful. It was comforting to know that the things I need to be clean and fresh are all here."

Program Future Plans/Next Steps

Recognizing that the long-term goal of the Hope in the Backpack program is to ensure that girls in Petersburg can achieve their academic goals, Dignity Grows is expanding it to include all Petersburg middle schools.

Petersburg Center for Healthy Living

Community Health System-Wide Priority Area: Access to Health Care

Program Description

Bon Secours' Care-A-Van began almost 30 years ago as an innovative way to bring health care services to uninsured patients who lack reliable transportation options. This mobile medical home model continues to serve the uninsured in the community, but transportation continues to be a significant challenge for extending this ministry to more locations in the region. This year, Bon Secours opened the Petersburg Center for Community Health, bringing community-based health services to uninsured residents in the southern reaches of Bon Secours Richmond's 24-county service area.

Converted from a former medical office space, the center was designed to offer a flexible clinical, meeting and health programming space. Most critically, the center has enabled the Care-a-Van team to extend its mobile health clinics and vaccination services to reach more uninsured patients without requiring an additional mobile clinic vehicle.

Local residents can now access free flu vaccines, health screenings, primary health care for the uninsured and victim services. Bon Secours providers, nurses and service providers staff the center, and it is a gathering place for prevention, education and referral services. The center's programs include the Care-A-Van, IVNA Wellness, the Violence Response Team and Community Nutrition Services.

Impact and Outcomes

- 12,700 patient visits to the Care-A-Van in 2025
- 9,900 vaccines administered by Community Health in 2025

Program Highlights/Success Stories

As Southside Regional Hospital President Brenda Woodcock said, "The City of Petersburg and [the] surrounding region are going to benefit from the removal of longtime barriers like transportation, education and insufficient income. The Center for Healthy Living promises to be a great partner to other health initiatives offered in the hospital setting."

Program Future Plans/Next

The Petersburg Center for Healthy Living now has a dedicated healthy communities coordinator to lead the expansion of health and wellness programming and forge new collaborations with community organizations.

Parsley's Kitchen at the Sarah Garland Jones Center

Community Health System-Wide Priority Area: Community Well-Being (Health Equity)

Program Description

Since 2017, Bon Secours' Sarah Garland Jones Center has operated Parsley's Kitchen, which offers nutrition education, cooking classes, community access and food-based small business supports for families in East Richmond. Capable of holding up to 16 people at a time, the kitchen is a hub for our Food is Medicine programs, which are aimed at reducing disparities in chronic disease. In 2025, residents of all ages built relationships while learning how to prepare healthy foods in a safe environment. The kitchen has a wide range of partners, including schools, after-school programs, nonprofits and government entities, who use the kitchen to increase community members' knowledge and skills concerning healthy food preparation.

The kitchen is fully equipped with stoves, sinks, a walk-in refrigerator, freezers, dishwashing stations, industrial mixers, an icemaker, preparation stations and storage. It also offers access to pans, cooking utensils, cutting boards, cleaning supplies, aprons and more. The kitchen is designed for easy use, including additional power capacity for connecting hot plates in workstations.

During 2025, the kitchen hosted monthly community cooking classes that were open to all adult residents, the RVA C.O.O.K.S. program for teens in partnership with the Richmond Police Department, the Produce Rx program (focused on heart disease prevention), the Her Table, Her Budget program (focused on affordable cooking for single parents) and more.

Parsley's Kitchen also serves as a commissary kitchen for 14 minority-owned, food-based small businesses. Since the space is available for only $20 an hour with no minimum contract, the kitchen offers a pathway into entrepreneurship for local small businesses. Poverty is one of the most stubborn social drivers of health, so creating pathways for building wealth through entrepreneurship can promote opportunities for financial stability.

Program Impact and Outcomes

- 136 small business bookings
- 109 nutrition education program and cooking class sessions
- 15 small business and commissary partners
- 630.75 hours of programs and services

Program Highlights/Success Stories

The 2025 canning class was the highlight of the year! Our senior participants enjoyed learning the art of canning to preserve their produce and extend its life cycle. While it was a refresher course for some, reminding them of what they learned from their parents or grandparents, it was a new experience for others. The class included story telling from participants deeply rooted in history and culture.

Program Future Plans/Next Steps

In 2026, the Parsley's Kitchen team is excited to roll out a full slate of healthy cooking and community building programs, including:

1. Her table, Her Budget is a 6-week class that will teach women in underserved communities' financial literacy, and we will be teaching/ making budget friendly health-conscious meals in partnership with the City of Richmond's Office of Community Wealth Building, Truist Bank, and the Richmond Police Department. The class was piloted in 2025 but will be offered with expanded partnerships and deeper capacity in 2026.
2. RVA C.O.O.K.S is an 8-week program held quarterly for teens to learn social emotional learning and basic cooking techniques and will continue to be offered for 3-4 cycles in 2026.

Springfield

Community Identified Health Needs

Access to Care, including primary care, women's health and appropriate points of care

Health Risk Prevention and SDOH, with a focus on education, environment, transportation and food access

Behavioral Health, such as mental health, addiction and trauma

Chronic Disease

Maternal Health, infant health and vitality

For more than 150 years, Mercy Health — Springfield has served Clark and Champaign counties with compassionate, high-quality care that is anchored by our two hospitals: Springfield Regional Medical Center and Mercy Health — Urbana Hospital.

Over 150 physicians and 58 practice locations power the Springfield Market, ensuring care is accessible across urban and rural communities. From primary care to specialty services, we continue to expand our reach and deepen our impact.

In 2025, Community Health initiatives focused on addressing barriers to wellness, such as chronic disease, maternal and infant health, and social drivers and determinants of health, including food insecurity. We prioritize partnerships with schools, nonprofits and local agencies to deliver education, screenings and support services that meet people where they are.

A commitment to health equity and investing in programs that promote access and dignity for all is central to all our programs. Our overarching goal is for Mercy Health — Springfield to remain steadfast in its Mission to serve with compassion and excellence — today and for generations to come.

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 and expanded provider capacity. **[Accomplished]**
- Move the Faith Community Health Ministry Program to a sustainable program model. **[Accomplished]**
- Launch a Mercy Serves AmeriCorps satellite site in the Springfield Market. **[Accomplished]**
- Expand strategic Community Health outreach in Champaign County through paramedicine, outpatient nutrition and other support services. **[Accomplished]**
- Support an expanded model for patient transportation needs in Champaign County. **[Accomplished]**

2026 Goals

- Strengthen transportation access for patients in Clark and Champaign counties through localized collaboration, advocacy, education and awareness. Build on the existing transportation partnership with TAC Industries and expand access to more than 50 patients.
- Growth and Develop the Garden of Mercy and McAuley Memorial Garden. Enhance malnutrition screening and supplement support by collaborating with the Community Medication Assistance Program and Nutrition Services.
- Leverage data on the impact of health equity through health equity subcommittees dedicated to targeted, market-wide interventions on topics such as the diabetes continuum of care.
- Cross-train three Community Medication Assistance team members as Community Health Workers and launch expanded care interventions for patients' social health needs.

Mercy REACH Provides Cessation in a Changing Landscape

Community Health System-Wide Priority Area: Mental/Behavioral Health

Program Description

The Mercy REACH program continues to provide comprehensive outreach, education and cessation services targeting tobacco, vaping and marijuana use across Clark and Champaign counties. In 2025, the program conducted over 90 educational presentations and sessions for schools, juvenile courts, prenatal groups and adult/adolescent populations. School-based outreach was particularly robust, with over 1,000 student encounters addressing the risks of nicotine and THC vaping. Juvenile court presentations reached nearly 400 youth, focusing on substance use prevention and behavioral health.

Prenatal cessation sessions supported expecting mothers through over 40 encounters, emphasizing the dangers of nicotine and THC during pregnancy. Adult and adolescent cessation services engaged participants in over 200 encounters, offering personalized support and resources. Community engagement was strong, with participation in multiple health fairs and resource events, including the Minority Health Fair, Overdose Awareness and the Screenagers Resource Fair, which collectively reached hundreds of residents.

The program also facilitated tobacco support groups and Alternative to Suspension (ATS) education, reinforcing long-term behavioral change. Through consistent outreach and tailored education, Mercy REACH is a vital resource in promoting healthier lifestyles and reducing substance use in the community.

Program Impact/Outcomes

- 2,134 patient encounters in 2025
- More than 86 events provided education and information to the public
- Overall outpatient program satisfaction rating as "good" or "very good": 95% for the Therapeutic Services program; 94% for Mercy REACH

Program Highlights/Success Stories

Anonymous patient feedback from satisfaction surveys:

- *"Would recommend. Very nice staff and very helpful. I am thankful for my time here, and it has helped me better myself and my life. Thank you."*
- *"I am very happy with this program. They did a very good job [of] taking care of me. Everything about this program was great. All staff worked with me and opened my eyes to the importance of going through the process."*

Program Future Plans/Next Steps

Mercy REACH, particularly its tobacco, vaping and marijuana cessation education component, is focused on expanding support for participants in the Maternal/Infant Health program.

Springfield Health Equity Committee Creates Meaningful Impact

Community Health System-Wide Priority Area: Community Well-Being (Health Equity)

Program Description

The Springfield Market Health Equity Committee works with clinical and nonclinical departments across the Mercy Health — Springfield region. The committee serves our community, including patients, visitors and staff, with a Mission to advance equitable health outcomes. Co-led through a hybrid model of quality, mission, community health and case management, the committee fosters collaboration across disciplines. It supports a wide range of subgroups, including:

- The Medical Group
- The Malnutrition Continuum
- Accurate Race and Ethnicity Data Collection at Registration
- Champaign County Transportation Continuum
- Hospital Signage Communication and Wayfinding
- Maternal Infant Health
- Workforce and Workplace
- Age-Friendly Measures
- The Chronic Disease Continuum

The committee engages diverse stakeholders from departments such as nursing, pharmacy, behavioral health, nutrition, OB-GYN, the Birthing Center, the emergency department, and Mercy Health Safety and Police. It also includes support from human resources, clinical education, volunteer services, community relations and the Community Medication Assistance Program. Through this value-driven structure, the committee drives systemic improvements in health equity across the region. Its work is grounded in data-informed strategies, community engagement and culturally responsive care.

Program Impact and Outcomes

- The committee includes ten subcommittees with engagement from more than 13 departments.
- The committee enabled the creation of important wayfinding materials in multiple languages, including English, Spanish and Haitian Creole. Deliverables included new campus maps and isolation signage for patient rooms, which included Spanish and Haitian Creole.
    - Isolation signage was identified as a critical patient and visitor concern for illnesses such as tuberculosis, COVID and flu.
- The committee completed a quality check and process revision regarding processes and procedures for patient registration to accurately gather data during patient registration.
    - This process revision helped ensure the Springfield Market team was eliminating barriers and appropriately providing responses to patients with critical needs.
- The committee launched a support transportation partnership between Mercy Health — Urbana Hospital and TAC Industries to provide rides for Mercy Health patients who do not have one. **This service assisted 45 patients in its first months of operation!**

Program Highlights/Success Stories

Staff serving visitors and patients identified the creation of wayfinding materials and isolation signage as a critical issue. Springfield is currently serving a more diverse community than ever before. Isolation signage directs visitors to check in at a nurse's station before entering a room, ensuring visitor safety and the containment of critical illness through appropriate measures.

Program Future Plans/Next Steps

The Health Equity Committee continues to be data-driven, responding to the pressing needs of the community as they arise. Of the original eight work groups, three have concluded with new topics up for discussion. Presently, the Springfield Health Equity Committee includes six active subgroups, with two pending additions for group consideration.

Local Small Business Development Center Partnership Achieves Community Impact

Community Health System-Wide Priority Area: Social Determinants and Drivers of Health

Program Description

Established in 2023 through a partnership with the Springfield Small Business Development Center (SBDC), the Mercy Health Revolving Loan Fund (RLF) provides accessible financing to small businesses in Clark and Champaign counties. The program primarily serves women-owned, veteran-owned and minority-owned businesses, as well as enterprises addressing social drivers and determinants of health — groups that often face barriers to traditional lending. As the first RLF available to Champaign County residents, the program offers more than capital; every loan recipient receives ongoing coaching, technical assistance and certified credit counseling through the SBDC.

Key activities include microloans, mentoring, business workshops and pipeline development. Partnerships with banks and community development financial institutions support these activities. Since the fund's inception, 17 loans have been issued, creating a cycle of reinvestment that strengthens local economies. In 2025, the fund supported Urbana Tomorrow, a Champaign County small business focused on revitalizing downtown areas by renovating retail spaces, hiring staff and establishing a real estate group for continued expansion. Across all 17 clients, the fund leveraged $387,900 in owner investment and spurred nearly $3 million in capital infusion, producing $2.94 million in new sales, creating 62 jobs and preserving 101 jobs. With 237 hours of direct engagement, the program continues to empower entrepreneurs and foster vibrant, resilient communities.

Program Impact/Outcomes

Since the program's inception:

- 5 new businesses were launched
- 17 loans were issued (3 in 2023, 13 in 2024, 1 in 2025)
  - Loan funds are reissued as they are repaid
  - All 17 businesses that were loaned RLF funds receive ongoing coaching and technical assistance from the SBDC
- 62 new jobs were created
- 101 jobs were preserved
- $1,071,200 in funds were loaned to businesses (more than the initial allocation), thanks to borrowers' strong repayment history
- Over $2.94 million in additional capital was unlocked from banks and owner investments

Program Highlights/Success Stories

The Mercy Health Revolving Loan Fund has become a vital tool in advancing community health by addressing economic stability as a key social determinant. By expanding access to opportunities, the program continues to promote wellness beyond clinical care, reinforcing our commitment to holistic community health.

Beyond the numbers are the following stories of resilience and gratitude:

- *"I am grateful for the chance that Mac and the SBDC took on me … if you need ANYTHING, please let me know!"*
  — **Mark Bloemhard**, *Founder and CEO, Bolder and Co. Creative Studios*
- *"I am grateful for the assistance I received, and I encourage others who are considering starting a business to take advantage of all the resources the SBDC has to offer."*
  — **Dionna Stephens**, *Owner, CPR and More, LLC*

These voices remind us that community health is about more than just access to care; it's about access to opportunity. The Mercy Health Revolving Loan Fund continues to act as a catalyst for both.

Program Future Plans/Next Steps

In 2026, we will continue our commitment to investing in the local community through our partnership with the SBDC and the revolving loan fund.

Malnutrition Collaboration Improves Patient Outcomes

Community Health System-Wide Priority Area: Social Determinants and Drivers of Health

Program Description

The Community Medication Assistance Program (Med Assist) has expanded to address malnutrition among hospitalized patients, thanks to a collaborative effort between the Med Assist team, Case Management and Nutrition Services. This initiative ensures that patients with financial needs who are being discharged home receive nutritional supplements to support their recovery. The Mercy Health Foundation of Clark and Champaign counties generously funds these supplements. The program targets individuals who were diagnosed with malnutrition while hospitalized and recognizes the significant impact of nutrition on patients' overall health and healing.

For patients transitioning to local care facilities, the program provides education to those facilities — including the local Senior Center — about the importance of nutrition and the impact of malnutrition. This outreach aims to raise awareness and promote better nutritional practices in post-acute care settings. By bridging the gap between hospital care and home or facility-based recovery, Med Assist helps improve patient outcomes and supports long-term wellness by providing medication assistance, financial assistance for durable medical equipment and community navigation to support services for those who qualify.

Program Impact and Outcomes

- Patients served: 3,502
- Patients screened positive for malnutrition:
  - 2024: 1063
  - 2025: 1,236
- Patients referred to the malnutrition pathway:
  - 2024: 377
  - 2025: 376
- Patients readmitted with malnutrition:
  - 2024: Home: 179; Skilled Nursing Facility: 150; Other: 26
  - 2025: Home: 109; Skilled Nursing Facility: 158; Other: 3

Through our coordination of care, we've seen an overall decrease in the number of individuals readmitted with malnutrition in 2025.

Program Highlights/Success Stories

Capturing malnutrition data has allowed us to develop a program that reaches all parts of the care continuum, improving circumstances for our patients. Through our internal processes and the referral to Med Assist, we're ensuring patients receive the support they need to be discharged home. Our partnership with United Senior Services provides education to the community, allowing us to pair our expertise with a community organization that regularly interacts with the largest population of individuals diagnosed with malnutrition — those over the age of 55. In addition, through education and partnership with local skilled nursing facilities, we've been able to create a better care continuum to facilitate improved outcomes for individuals who have been recently hospitalized.

Program Future Plans/Next Steps

Looking ahead, we are committed to deepening our impact by expanding the malnutrition pathway to include current patients of our cancer center, in addition to expanding our local food bag program to include condition-specific options, hygiene essentials and broader social determinant supports. These enhancements will ensure that individuals receive both nourishment and the tools to thrive. We are also strengthening education and outreach, partnering with our local senior centers to equip staff and programs with resources that promote better health outcomes. Our ongoing collaboration with skilled nursing facilities (SNF) will focus on improving malnutrition monitoring and helping patients transition from hospital, to SNF and then home safely. Together, these next steps reflect our dedication to holistic care and a healthier, more resilient community.

Toledo

Community Identified Health Needs

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

Mercy Health — Toledo has served Northwest Ohio for 170 years, with seven hospitals located in Lucas, Wood, Defiance, Huron and Seneca counties. In addition to the market's overall commitment to quality health care, Community Health continued to prioritize the health of the communities we serve through neighborhood improvements and addressing community-identified needs.

2025 Goals

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

2026 Goals

- Establish a Pathways HUB program in Tiffin, creating a referral network in OB-GYN clinics and the Labor and Delivery unit to establish a baseline of clients.
- Expand programming at the Mercy Senior Wellness Center.
- Launch Nature Rx, a programming partnership with Metroparks Toledo.

Community Health Nursing Program

Community Health System-Wide Priority Area: Access to Health Care

Program Description

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 Northwest Ohio's underserved population. The program's goals are to provide community members access to health screenings, connect community members to primary care providers and educate community members about various chronic conditions through one-day educational seminars and structured group classes. In 2025, the program served 4,642 community members.

Program Impact and Outcomes

- 4,553 adults were screened in Northwest Ohio.
  - 4,553 total blood pressure screenings, 2,606 abnormal
  - 4,553 total blood glucose, 666 abnormal
  - 691 total cholesterol, 111 abnormal
- The number of adult screenings stayed consistent from 2024 to 2025.
- The program provided residents with opportunities to know their biometric numbers.

Program Future Plans/Next Steps

- Expand screenings within Wood County.
- Hold two screening events in Defiance County.

Healthy Cooking with Chronic Conditions

Community Health System-Wide Priority Area: Chronic Disease

Program Description

Mercy Health sponsors and facilitates healthy cooking classes aimed at promoting better nutrition and wellness in the communities it serves. Classes provide participants with practical skills and knowledge to prepare nutritious meals that are 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.

Program Impact and Outcomes

- 127 participants completed the program.
- 95% of participants indicated that the program provided value.
- The program provides participants with the opportunity to increase their knowledge of food and healthy eating.

Program Highlights/Success Stories

- One of the healthy cooking class series took place at a local community center and the focus of the cooking classes was eating healthy with food pantry staples. Healthy recipes utilizing pantry staples were made including brownies made with black beans. All the participants were amazed at how delicious the brownies were and stated they never knew food pantry staples could be prepared so delicious. One participant stated, "I didn't think I liked black beans!

Program Future Plans/Next Steps

- Continue work for 2026.
- Update the evaluation process to gauge changes in participants' knowledge after completing the program.
- Incorporate biometric numbers as a measure of success.

Getting Healthy Zone

Community Health System-Wide Priority Area: Maternal/Infant Health

Program Description

The Getting Healthy Zone is a community-driven initiative that works to increase infant vitality, improve the health of residents and create a community where people want to live, work and visit. The Getting Healthy Zone serves the neighborhoods along the Cherry Street Corridor. The initiative aims to increase infant vitality, improve health, improve economic stability, beautify and preserve the neighborhood, increase safety, decrease crime and increase positive activity, care and support.

Program Impact and Outcomes

2,245 residents in the Getting Healthy Zone participated in programs and/or received services through the initiative.

Program Highlights/Success Stories

- Mercy Health and the Toledo Police Department joined forces to open a substation on the campus of Mercy Health — St. Vincent Medical Center which enhanced neighborhood safety and accessibility. This move allows offers to respond more quickly to emergencies in the neighborhood.
- In August, the Getting Healthy Zone hosted, "Let's Get a Healthy Start Back-to-School" event were 385 families benefited from backpacks, school supplies, and health resources thanks to a generous donation from SSOE.

Program Future Plans/Next Steps

- Explore the possibility of hiring a Community Health Worker (CHW) dedicated to working in the Getting Healthy Zone.
- Continue work for 2026.

Mercy Health Senior Wellness Center

Community Health System-Wide Priority Area: Chronic Disease

Program Description

The Mission of the Mercy Health Senior Wellness Center is to be the community health and wellness hub that keeps seniors' minds, bodies and spirits healthy. Mercy Health offers expertise in the field of health and wellness to enable seniors to live healthier lives. The center offers a variety of programming that focuses on health and wellness. These programs include Zumba Gold classes, chair yoga, health education classes and Senior Smiles (a dental cleaning program for seniors).

Impact and Outcomes

- In 2025, the center had 15 programs and served 445 seniors in Northwest Ohio.

Program Highlights/Success Stories

- A senior stated she initially joined the Mercy Health Senior Wellness center to socialize while exercising at the Tabata class. She stated that since joining the program she has increased her upper body strength and greatly improved her balance. She loves that the center not only offers senior friendly exercise classes but it also offers programs and information on chronic disease such as diabetes, the importance of reading food labels and Alzheimer's disease. Since joining the center two years ago she has lost 18 pounds naturally. She loves everything about the center especially Ms. Tiffany who is always there to support program participants.

Program Future Plans/Next Steps

- Expand the number of programs offered to pre-COVID offerings of 30.
- Increase the number of participants by 5%.

Franklin Avenue Financial Opportunity Center

Community Health System-Wide Priority Area: Financial Security

Program Description

Mercy Health — Toledo continues to partner with the Local Initiatives Support Coalition (LISC) and NeighborWorks to provide an on-site Financial Opportunity Center (FOC) on the campus of Franklin Avenue Medical Center. The FOC staff are qualified, expertly trained job coaches, HUD-certified housing counselors and financial coaches. The FOC provides patients, associates and community members with services and support to achieve financial freedom.

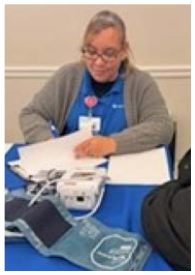
Program Impact and Outcomes

- 302 clients engaged in coaching, tax prep, or workshops in 2025.
- 23% of clients increased income
- 22% of clients increased their net worth
- 5% of clients increased their FICO credit score

Program Future Plans/Next Steps

Mercy Health — Toledo plans to continue the partnership and work of the FOC into 2026 and beyond.





Youngstown

Community Identified Health Needs

Mental Health Issues/Substance Use

Community Conditions, Safety and Crime

Access to Care, including access to health care, healthy foods, and health care information and education

Our goal is to create a healthier community, one member at a time. With the primary support of our Mercy Health — Youngstown Market, Mercy Health — Youngstown Foundation and grants from local foundations, our Community Health team can provide no-cost screenings, programs, preventive health education and supportive services. Through partnerships with local community health programs, community and faith-based organizations, and local and county health districts, our trained staff offer health services or resources to address needs in underserved or targeted neighborhoods identified in the Community Health Needs Assessment. The market serves the greater Mahoning, Trumbull and Columbiana counties, extending the ministry of Jesus by improving and serving the needs of our community.

2025 Goals

- Increase knowledge of available services and programs that address behavioral health and substance use issues through Community Health's participation in community-based events. **[Accomplished]**
- Increase access to treatment for uninsured individuals by using the new Care-A-Van mobile medical clinic to meet community members where they are. **[In progress]**
- Implement a Hospital-Based Violence Intervention program. **[In progress]**

2026 Goals

- Improving client access and experience to programs and services through transitioning to a more spacious and modernized location.
- Expand community health screenings, including hosting quarterly on-site health events.
- Launch the Care-A-Van in early 2026 to extend services directly into the community.
- Expand the Centering Pregnancy program to the St. Joseph Tod Avenue site.

2025 **Program Highlights** | Youngstown

Community Health Events

Community Health System-Wide Priority Area: Community Well-Being (Health Equity)

Program Description

The Community Health Education (CHE) program provides nutrition facts, food tips, preparation demos, healthy living education, referrals to services and resources, health screenings, motivational interviewing and support through participation in community-sponsored events and presentations. CHE programming is specifically designed to target community members at risk for food insecurity and those who may have trouble accessing resources that may put them at risk for adverse health outcomes.

Program Data/Outcomes

- Blood pressure screenings: 815 (year to date)
- Cholesterol screenings: 123 (year to date)
- Diabetes screenings: 123 (year to date)
- Total participants in Healthy Eating hands-on cooking classes, demonstrations and speaking engagements: 1,946 (year to date)

Program Highlights/Success Stories

Maintaining and expanding our offerings to partnerships with community organizations — such as Inspiring Minds Youngstown, the public library systems of Trumbull and Mahoning counties, and the Trumbull Neighborhood Partnership — has gone well, as has expanding our screenings and outreach to previous Neighborhood Health Watch sites. Requests for partnership with other community organizations have steadily increased, allowing education and screening programs to expand to new populations and organizations throughout the community, including United Returning Citizens and Youngstown State University's (YSU) Guin Fit program.

Program Future Plans/Next Steps

The goal of CHE programming is to improve participants' health outcomes by providing health screenings as well as educational and inspirational programs, which address the most pressing health needs identified in the Community Health Needs Assessment for the Mahoning Valley.

Stepping Out Program

Community Health System-Wide Priority Area: Chronic Disease

Program Description

The Stepping Out Program (SOP) was created to promote health and wellness throughout the community and to address obesity and diabetes. The SOP is currently serving 24 sites, including community centers, churches and senior living complexes. Nine contracted instructors provide free fitness classes at community partner sites.

Program Impact and Outcomes

St. Angela Merici Parish is one of the program's most successful and well-utilized sites. In 2022, we began our partnership with the parish to provide fitness activities and fitness assessments, with the goal of providing safe places to exercise. We teach fitness and health classes to the participants, educating them on movement and self-care topics such as blood pressure, diabetes, heart disease, healthy eating, yoga, yogalates, Pilates, aerobics, chair aerobics, personal fitness, motivational interviewing and more.

Throughout 2025 at St. Angelia Merici Parish, we taught 70 classes with a combined total of 1,280 attendees. SOP has provided 189 screening assessments, including 68 blood pressure, 11 cholesterol, 11 diabetes, 55 pulse and 55 pulse oximetry screenings.

Program Future Plans/Next Steps

The Mercy Health Stepping Out Program provides and continues to address various plans to implement and evaluate healthy promotional activities.

Trumbull County Women, Infants and Children Program

Community Health System-Wide Priority Area: Maternal/Infant Health

Program Description

The Women, Infants and Children (WIC) national program provides healthy food and support services for pregnant women, new mothers and children up to age five. Participants live in Trumbull County, meet WIC income guidelines and satisfy nutritional or health-risk requirements. The primary purpose of the Mercy Health — Youngstown Trumbull County WIC program is to improve the health status of and prevent health problems for income-eligible pregnant and breastfeeding women, women who recently had a baby, infants and children who are at health risk due to inadequate or inappropriate nutrition.

Program Impact and Outcomes

We provide nutrition and breastfeeding education, as well as counseling, to our target populations. The program's goal is to improve pregnancy outcomes, provide education and support to achieve full-term pregnancies, reduce infant mortality, decrease incidences of low birth weight, increase breastfeeding rates among newborns and give infants and children a healthy start in life by providing access to nutritious foods.

Year to date (January 2025 to December 2025), WIC dietitians have conducted 13,453 visits consisting of educational sessions with pregnant, breastfeeding and postpartum women in our WIC clinics. Our current caseload of active participants is 3,550. Our most recent breastfeeding initiation rate is 73.79%, outranking the current average breastfeeding rate of 32.47%.

Program Notable Highlights/Success Stories

We held the Third Annual Baby Shower for Breastfeeding Awareness Month in August 2025. The event was attended by the breastfeeding and expectant moms who are currently enrolled in our program. WIC staff, the Mercy Health Community Health team and lactation consultants from St. Joe's Hospital donated baby items that the participants received. Participants received vital education on following the ABCs of safe sleep, received supportive community resources, played intermittent games and enjoyed refreshments. We hosted 23 WIC moms, two dads, many babies and a couple of older siblings.

Program Future Plans/Next Steps

We will implement the state WIC initiative to provide education on "urgent maternal warning signs," raising awareness of the need to seek medical care if any of the indicated symptoms are present.

Hispanic Health Program

Community Health System-Wide Priority Area: Social Determinants and Drivers of Health

Program Description

The Mercy Health Hispanic Health Program (HHP) was initiated to assist communities in Mahoning and Columbiana counties, especially individuals whose first language is not English. Many of the clients we serve have cultural and linguistic barriers that prevent them from accessing necessary health care. In 2025, the HHP provided 55 families with a variety of fresh fruits and vegetables, dry goods and personal care products. Our bilingual staff helps connect patients to medical care, social services and resources while addressing social determinants that may put clients at risk for unmet medical needs. Our team provides health classes and screenings, helps schedule provider appointments and offers interpretive services during appointments. In 2025, the HHP provided 11,407 interpretive services and assisted patients in navigating and understanding their billing statements.

Program Impact and Outcomes

- **Reach:**
  - 25,945 interactions
  - 11,407 interpretations
  - 8,721 participants served
  - 5,232 financial assistance interactions
- **Outcomes:**
  - 3,667 participants engaged in basic health education classes and presentations
  - 4,720 total health screenings
- **Community Value:**
  - The services the Hispanic Health Program provides to the community matters because these services remove real barriers to care, language, cost and lack of information, so the community members can detect health issues early, understand how to manage them, access needed resources, and make informed decisions that improve long term health outcomes.

Program Notable Highlights/Success Stories

Project Connect was our last event of the year, created to address the needs of individuals facing homelessness or instability. This event was held at the Organización Cívica y Cultural Hispana Americana and provided access for clients whose first language is Spanish. The HHP provided vital screenings to the participants. Among the 150 event attendees, 38 (25%) of the participants took advantage of the screenings, which included cardio checks as well as blood pressure and pulse oximetry screenings. One participant expressed how grateful she was for the free services we provide, and how caring and respectful we were. Another client received help to become established with Mercy Health as a new patient. After identifying that one participant had significantly elevated blood pressure, we took time to explain the seriousness of hypertension and the importance of following up with a primary care provider. We also educated the patient about where to go for urgent care, walk-in and emergency room assistance.

Program Future Plans/Next Steps

The HHP is planning to increase its screening, education and resource interventions in communities most in need. By shifting from a heavy focus on interpreting, the HHP will be able to direct more efforts toward reaching those who do not have a medical home or primary care provider. The HHP can assist clients in becoming aware of and understanding their health screening status, as well as the steps needed to address potential health concerns.

Community Health Leadership

Shared Services Leadership

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

Phyllita Bolden, MPH
Director, Community Health
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Ruben Chandrasekar
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Becky Clay Christensen
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Richmond, Virginia

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Director, Community Health
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