



# 2020-2022 Community Health Needs Assessment — Implementation Plan

Adopted by the Mercy Health- Marcum and Wallace Hospital Board of Trustees, October 28, 2019

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## Introduction

Mercy Health- Marcum and Wallace Hospital (Marcum or MWH) is a 25-bed Critical Access Hospital (CAH) located in Irvine, Kentucky (Estill County) who serves as the center of care for three other rural Kentucky counties, including Lee, and Powell. The detailed process, participants and results are available in Irvine Community Health Needs Assessment Report which is available at [mercy.com](http://mercy.com).

This Community Health Needs Assessment Implementation Plan will address the significant community needs identified through the CHNA. The Plan indicates which needs Mercy Health- Marcum and Wallace Hospital will address and how, as well as which needs Mercy Health- Marcum and Wallace Hospital won't address and why.

Beyond the programs and strategies outlined in this plan, Mercy Health- Marcum and Wallace Hospital will address the health care needs of the community by continuing to operate in accordance with its mission to extend the healing ministry of Jesus by improving the health of its communities with emphasis on the poor and under-served. This includes providing care for all individuals regardless of their ability to pay.

The strategies and tactics of this Implementation Plan will provide the foundation for addressing the community's significant needs between 2020 and 2022. However, Mercy Health- Marcum and Wallace Hospital anticipates that some of the strategies, tactics and even the needs identified will evolve over that period. Mercy Health- Marcum and Wallace Hospital plans a flexible approach to addressing the significant community needs that will allow for adaption to changes and collaboration with other community agencies.

## **COMMUNITY SERVED BY HOSPITAL**

Mercy Health- Marcum and Wallace Hospital (Marcum or MWH) is a 25-bed Critical Access Hospital (CAH) located in Irvine, Kentucky (Estill County) who serves as the center of care for three other rural Kentucky counties, including Lee, and Powell. Like other rural communities, residents in the defined service area on average are more likely to suffer from chronic illness than their urban counterparts, but have limited access to healthcare services, lower incomes and insurance coverage, and fewer physicians per capita. Barriers to access to healthcare continue to be a major issue for people of this region, particularly those without adequate health insurance and at the lower end of the socioeconomic ladder. Although uninsured rates are improving with the expansion of Medicaid, the average uninsured rate, Medicaid rate, poverty and unemployment are all considerably higher in this region as compared to the rest of the nation (Table 1).

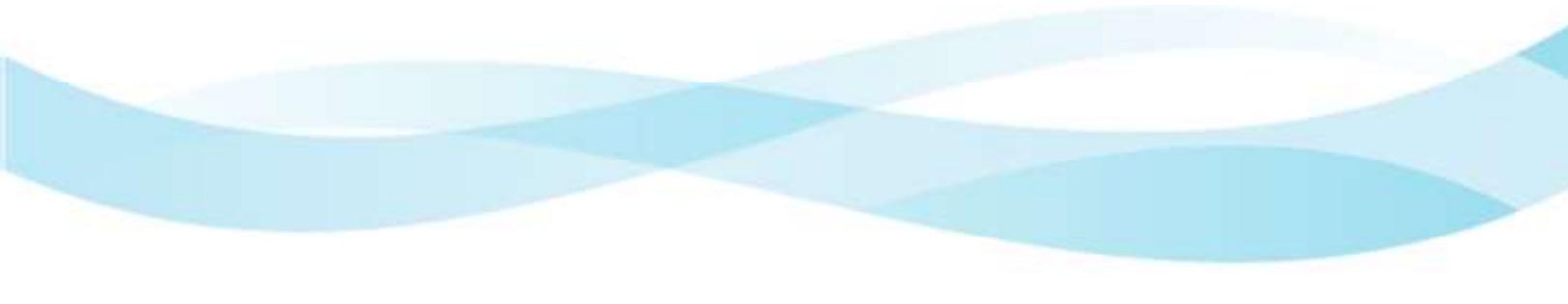


Table 1 Socio-economic factors in Service Area.

	<b>Estill</b>	<b>Lee</b>	<b>Powell</b>	<b>Kentucky</b>
Median Household Income	\$34,096	\$28,672	\$35,817	\$48,332
Population	14,277	6,570	12,374	4,454,189
%65 older	18.5%	18.4%	15.5%	16.0%
Unemployment	6.0%	8.9%	6.6%	4.9%
Child Poverty	30%	39%	35%	22%
Data Source: County Health Rankings, 2019				

The underinsured population in this region is larger than the Kentucky state average which has several negative consequences. First, individuals are not receiving preventative health care and are either visiting the emergency room for routine illnesses or prolonging receiving medical care until it becomes an emergency. Second, health care providers are often uncompensated for the care they receive thus weakening the financials of the regional hospitals and clinics. Finally, it is also difficult to recruit health care professionals to an area with a large share of underinsured households.

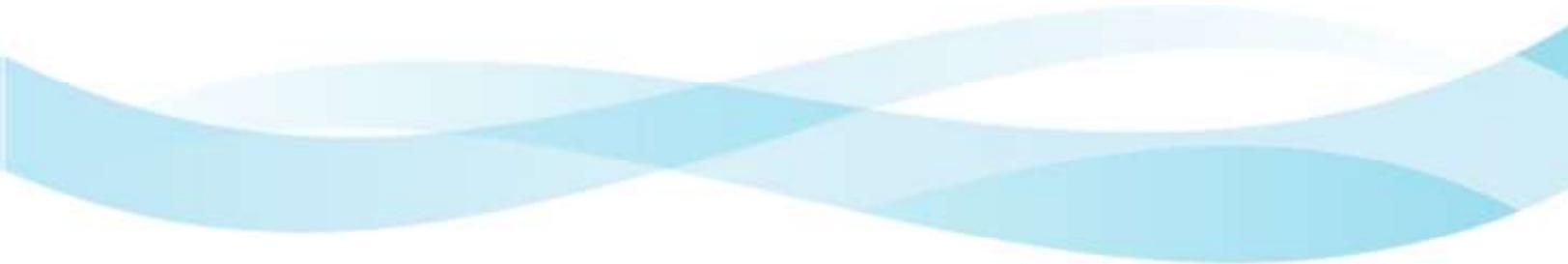
Table 2 Health Access Factors for Service Area.

	<b>Estill</b>	<b>Lee</b>	<b>Powell</b>	<b>Kentucky</b>
Medicaid	32%	40%	33%	20%
Physician Ratio	1/2142	1/2666	1/2283	1/500
HPSA/MUA Designation	HPSA	HPSA	HPSA	

As expected, areas with high underinsured rates will experience higher than average rates of chronic diseases, cancer deaths, and diabetes. This is reflective in the overall health status of individuals living in the four-county service area compared to statistics for the Commonwealth of Kentucky and the United States. Behavioral conditions such as smoking, obesity, lacking physical activity and oral health are quite high in this area. As a potential result of lacking adequate health insurance and have high incidence rates of diabetes, heart disease, and cancer death rates.

Geographic Identifiers: Estill, Lee, and Powell Counties

Zip Codes: 40336, 41311, 40380



## **MISSION**

We extend the healing ministry of Jesus by improving the health of our communities with emphasis on people who are poor and under-served.

Mercy Health's Mission and culture are expressed through the organization's core values:

Compassion

*Our commitment to serve with mercy and tenderness*

Excellence

*Our commitment to be the best in the quality of our services and the stewardship of our resources*

Human Dignity

*Our commitment to value the diversity of all persons and to be respectful and inclusive of everyone*

Justice

*Our commitment to act with integrity, honesty and truthfulness*

Sacredness of Life

*Our commitment to reverence all life and creation*

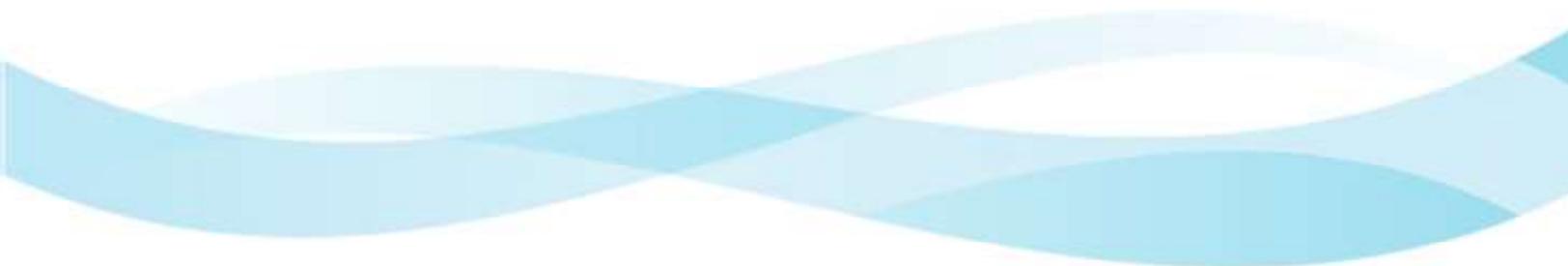
Service

*Our commitment to respond to those in need*

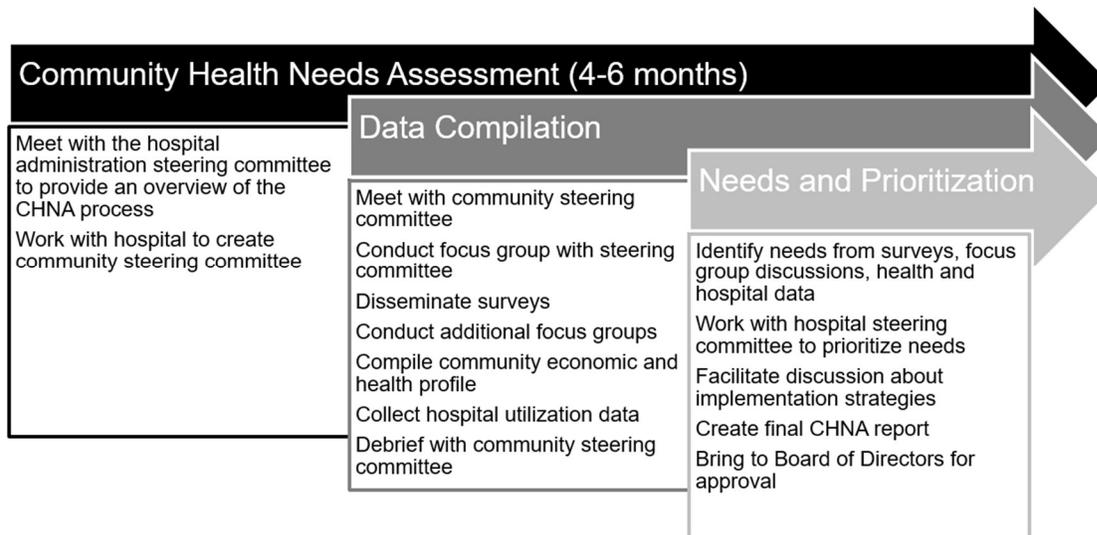
## **Executive Summary**

### **BACKGROUND AND PROCESS**

Mercy Health- Marcum and Wallace Hospital contracted with the Community and Economic Development Initiative of Kentucky (CEDIK) with the University of Kentucky in the summer of 2019 to conduct a Community Health Needs Assessment (CHNA) in accordance with the Affordable Care Act (ACA). This CHNA was the third prepared by CEDIK for this organization; prior reports were completed in 2013 and 2016.



Here is an overview of the CHNA process that CEDIK uses based on the IRS guidelines:



**Community Steering Committee**

The Community Steering Committee met twice as a group and each time a hospital representative opened the meetings with appreciation of the members’ service, the purpose of the CHNA and the importance of the members’ active involvement and input. CEDIK presented the CHNA process at the first meeting and the important role of the steering committee in the distribution and collection of the community surveys (including a shareable mobile survey link and paper surveys), identifying locations and contacts for potential focus groups. The Community Steering Committee includes individuals that represent organizations and agencies from the defined service area. This enabled the hospital to get input from populations not often engaged in conversations about their health needs. Representatives included those servicing the local health department, EMS, public housing, senior citizens and other healthcare providers and a representative of small businesses.

**Data Sources**

The assessment process included collecting secondary data related to the health of the community. Social and economic data as well as health outcomes and providers data were collected from secondary sources to help provide context for the community, using 2019 County Health Rankings ([www.countyhealthrankings.org](http://www.countyhealthrankings.org)), retrieved October 2019. In addition, CEDIK compiled hospital utilization data to better understand who was using the facility and for what services. Finally, with the assistance of the Community Steering

Committee, input from the community was collected through focus group discussions and surveys.

A survey was developed with Mercy Health- Marcum and Wallace staff and the Community Steering Committee and was available in paper form and online. The mobile survey was used to increase survey responses. Each member of the steering committee was responsible for distributing and collecting surveys and sharing the mobile link with coworkers and the populations they served. The surveys were available at MWH, public health departments, the Interfaith Wellness Ministry, Estill County Schools and Carhartt, Inc. 483 surveys were completed and returned.

Focus groups and surveys both included questions that asked respondents how they felt the hospital could address the health needs of the community.

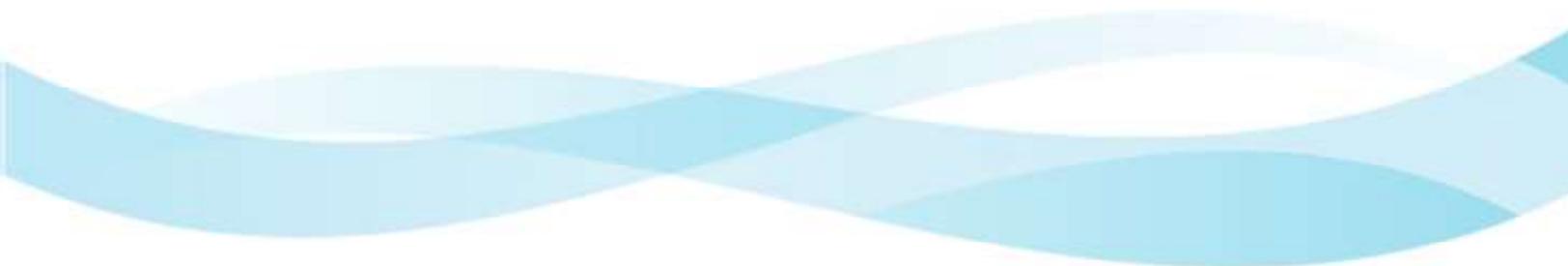
The CHNA relied heavily on input from local residents and health-related organizations. The primary sources of data included one-on-one interviews with numerous local stakeholders, a variety of local focus groups and survey data gathered from people within the service area. Combined input was received from local public health departments, social agencies, healthcare providers and local employers within the service region. Much of the secondary data came from the Kentucky Department of Vital Statistics, U.S. Census, U.S. Centers for Disease Control, Kentucky Hospital Association and [countyhealthrankings.org](http://countyhealthrankings.org).

## Identifying significant needs

The Community Steering Committee met to review the results of surveys and input received from community focus groups. They compared the survey and focus group data to the various health data and made recommendations to MWH for CHNA health priorities to be addressed.

After reviewing community input and survey and focus group results from the CHNA process, MWH ranked the identified needs in order of priority to be addressed by the hospital. To facilitate prioritization of identified health needs, a ranking process was used. Health needs were ranked based on five factors:

- The ability of MWH to evaluate and measure outcomes.
- The number of people affected by the issue or the size of the issue
- The consequences of not addressing the problem
- Prevalence of common themes



- The existence of hospital programs which respond to the identified need.

Health needs were then prioritized by their overall ranking, the degree to which MWH can influence long-term change and the impact on the identified health needs on overall health.

## Implementation Plan

Mercy Health- Marcum and Wallace Hospital is continuing to work with other county agencies and is committed to developing a county-wide Community Health Improvement Plan. While that plan is still being finalized, Mercy Health- Marcum and Wallace Hospital is committed to addressing the health needs of the community through the strategies and tactics described in this Implementation Plan, which will be in alignment with the overall Community Health Improvement Plan.

### PRIORITIZED SIGNIFICANT COMMUNITY HEALTH NEEDS

The table below lists the significant community needs that were identified through the CHNA and specifies which needs Mercy Health- Marcum and Wallace Hospital will address.

Prioritized significant community health need	Addressed by hospital
Substance Abuse	Yes
Mental Health	Yes
Obesity	Yes

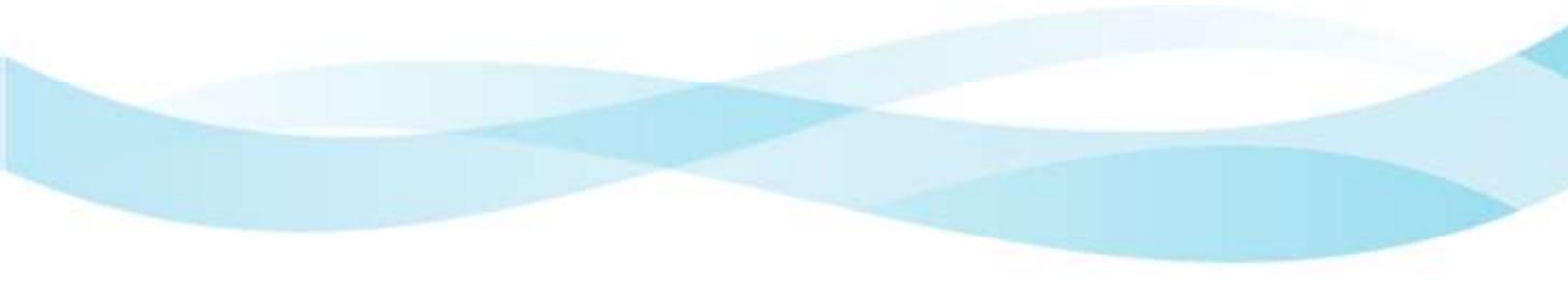
### IMPLEMENTATION STRATEGIES TO ADDRESS SIGNIFICANT COMMUNITY HEALTH NEEDS

#### PRIORITIZED HEALTH NEED NAME 1: SUBSTANCE ABUSE

##### Description

As detailed in Mercy Health- Marcum and Wallace’s Community Health Needs Assessment Report:

Based on the community survey results conducted for this CHNA, 31% of respondents identified substance abuse disorder services as a way the hospital could better meet the needs of the community. Secondary data also identifies this as a community issue. CDC data from 2017 lists Estill County as one of the highest opioid prescribing rates in Kentucky. Focus group feedback



collected for the CHNA also identified substance abuse as an issue. The Mercy Health- Marcum and Wallace Hospital service area has limited resources for community education, awareness and prevention. The hospital has identified a need to increase substance abuse education and awareness within the community.

### **Goal**

Increase substance abuse education and awareness of treatment resources within the community ensuring prevention and recognition of substance abuse.

### **Targeted populations**

All populations within the hospital's service area.

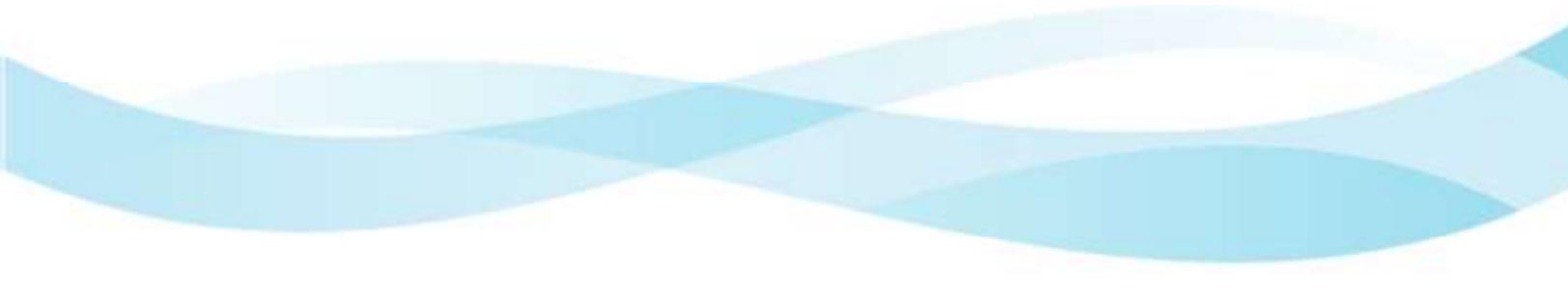
### **Strategies**

- Partner with local school districts to conduct substance abuse prevention education within school systems in hospital service area.
- Investigate opportunities to increase local access to substance abuse services within the hospital's service area.
- Enhance partnerships with local boards and civic organizations through increased staff and leader memberships.
- Collaborate with potential partners to increase community awareness of substance abuse and prevention and treatment resources.

### **Strategic measures**

- Track the completion of substance abuse prevention education events.
- Number of new staff and leadership memberships.
- Increase awareness of substance abuse prevention and treatment resources available in the service area.
- Collaborate with KY-ASAP to complete an event promoting community awareness and education about substance abuse.

### **Community collaborations and available resources**

- School Districts in Estill, Lee and Powell Counties
  - Civic organizations such as Kiwanis
  - Eastern Kentucky Areas Substance Abuse Council.
  - Estill County EMS
  - West Care
  - Project Home Network
- 

## **PRIORITIZED HEALTH NEED NAME 2: MENTAL HEALTH**

### **Description**

As detailed in the hospital's Community Health Needs Assessment Report: Kentucky ranked 19<sup>th</sup> in the country for suicide with a rate of 15.5 per 100,00 making it the tenth leading cause of death overall. Studies indicate including behavioral and mental health services in primary care remove stigma, provide continuity of care and increase the overall compliance of treatment. Additionally, behavioral health treatments and targets can assist with compliance of medical treatments such as smoking cessation, healthy heart and eating habits as well as the

### **Goal**

Increase awareness and improve access to mental and behavioral health services within the service area.

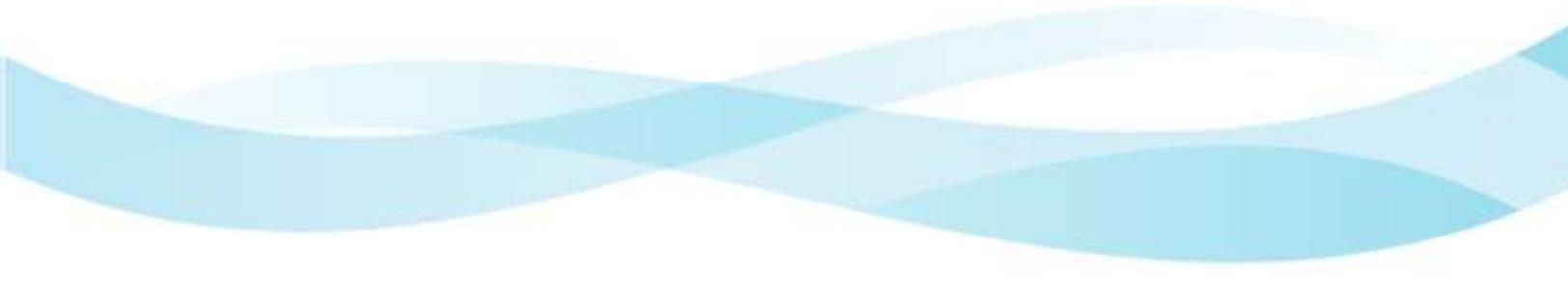
### **Targeted populations**

All populations within the hospital service area.

### **Strategies**

- Investigate opportunities to provide behavioral health services to patients within MWH ED and primary care clinics.
- Increase community awareness of behavioral health issues and resources available to address behavioral health needs.
- Increase early intervention treatments
- Implementation of Mental Health/ Behavioral Health project through Project Home Network.
- Ensure MWH representation on community advocacy boards and groups.

### **Strategic measures**

- Number of early interventions
  - Number of telehealth encounters conducted in the ED and Primary Care Clinics
  - Number of opportunities for discussion and communication with community leaders
  - Increased number of community board involvements of MWH leaders
- 

### **Community collaborations and resources available**

- School Districts
- Local Employers
- Civic Groups/ Organizations
- Faith Based Organizations
- Spark Organization
- Project Home Network

### **PRIORITIZED HEALTH NEED NAME 3: OBESITY**

#### **Description**

As detailed in the hospital's Community Health Needs Assessment Report: Based on the community survey results conducted for this CHNA, 20% of respondents identified overweight/obesity as a health challenge their household faces. Secondary data also identifies this as a community issue. In Estill and Lee Counties, nearly 40% of the adult population is obese, according to data from the 2019 County Health Rankings ([www.countyhealthrankings.org](http://www.countyhealthrankings.org)). Focus group feedback collected for the CHNA also identified obesity as an issue.

#### **Goal**

Increase awareness of the impact obesity has on one's overall health including impact on chronic illness and encourage health heating habits and an active lifestyle.

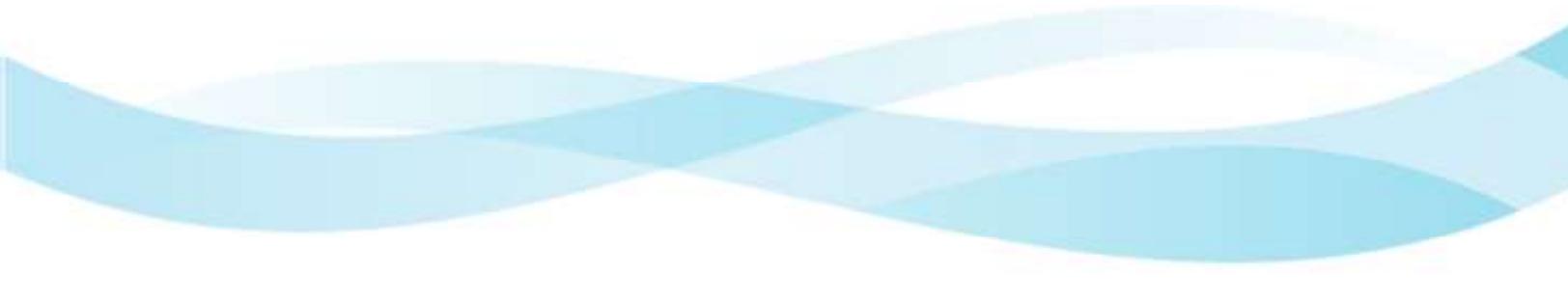
#### **Targeted populations**

All populations within the hospitals service area.

#### **Strategies**

- Promote increased physical activity and proper nutrition to fight obesity, with an emphasis on childhood obesity.
- Collaboration with partners to offer educational community-based events.
- Implementation of population health management clinic within the hospital service area

#### **Strategic measures**

- Decreased readmissions
  - Access to care through population health management clinic
  - Number of visits in population health management clinic.
- 

**Community collaborations and resources available**

- School Districts
- Pediatric Providers
- Local Employers
- Civic Groups/ Organizations

