Minnie Hamilton Health System

Community Health Implementation Plan 2026

Prepared for: Minnie Hamilton Health System

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1 Health Topic: Access to Care

1.1 Strategy One: Low-Cost Services

Priorities Targeted: Access to Care

Table 1: Low-Cost Services

Strategy	
Objectives	Increase access to affordable healthcare services by expanding awareness, utilization, and availability. This program is open to the community with no referral required.
Activities	• Low-Cost Lab Fairs • Veteran's Day Dental Services • 340B • Sliding Fee for Medical and Dental • Marketing/Advertising
Planning Partners	• Director of Business Development • Laboratory Supervisor • Outreach coordinator
Implementation Partners	• MHHS Dental Clinic • Certified Application counselor • Laboratory Supervisor • Director of Business Development
Resources	• Lab Fair flyers • 340 B information • Sliding Fee Information
Evaluation Activities	• # of Participants • Participant Retention • Feedback Surveys
Point of Contact	Director of Business Development

1.2 Strategy Two: Transportation Assistance

Priorities Targeted: Access to Care

Table 2: Transportation Assistance

Strategy	
Objectives	Improve patient access to healthcare services by developing and expanding transportation assistance for individuals who face barriers traveling or medical appointments or returning home after care.
Activities	• Provide transportation Information (brochures) • MHHS transport patients to appointments or home.
Planning Partners	• Associate Administrator/System Practice Administrator • Director of Facilities
Implementation Partners	• Minnie Hamilton Health System
Resources	• Modivcare brochure • Logisticare brochure • Little Kanawha Bus • Senior Center bus • MHHS Transportation Services
Evaluation Activities	• Number of transports made • Feedback surveys
Point of Contact	• Stephen Whited, CEO

2 Health Topic: Chronic Disease

2.1 Strategy Three: Diabetes Education Support Group

Priorities Targeted: Chronic Disease

This program supports diabetic patients who need additional education or support after receiving their diagnosis. This program is open to patients of MHHS.

Table 3: Diabetes Education Support Group

Strategy	
Objectives	Host one diabetes support group per month.
Activities	• Marketing • Plan for occasional guest speaker • Plan for topics for sessions • Plan expansion to offer lunch and learn sessions "Dining with Diabetes" in the future, one a month at noon
Planning Partners	• Director of Business Development • Community Outreach Coordinator • Clinical Care Managers
Implementation Partners	• Director of Business Development • Community Outreach Coordinator • Clinical Care Managers • Executive Assistant
Resources	• Educational materials/samples of health and personal hygiene products • Space for Group Meeting-Annex Basement lobby meeting room.
Evaluation Activities	• # groups held per year - (12) • # participants per group - (10)
Point of Contact	• Director of Business Development • Community Outreach Coordinator • Clinical Care Managers

2.2 Strategy Four: Smoking Cessation

Priorities Targeted: Chronic Disease

Smoking cessation classes will be offered to community members free of charge to support efforts to quit using tobacco or nicotine products.

Table 4: Smoking Cessation

Strategy	
Objectives	Group Smoking Cessation Classes will be offered to the community quarterly. These will be held in-person in the MHHS Annex basement lobby four times per year.
Activities	• Marketing -Director of Business Development • Contact referrals to sign up for group or individual tobacco cessation–Provider Recommendation • Accept self-referrals from the community • Participants initially meet with a provider then follow up with Education Coordinator for remainder of sessions • NP to follow through with some group sessions as available and as needed
Planning Partners	• Director of Business Development • Community Outreach Coordinator • Clinical Care Managers • Designated PCP
Implementation Partners	• Minnie Hamilton Health System • Community Outreach Coordinator
Resources	EMR-Intake questions–Nurse data collection
Evaluation Activities	• # of classes offered (4) per year • # of referrals for smoking/tobacco cessation (Run report in Athena) • # of participants– (Class size–No limit restrictions) • Feedback Surveys
Point of Contact	• Community Outreach Coordinator • Clinical Care Managers

3 Health Topic: Obesity

3.1 Strategy Five : FARMACY Program

Priorities Targeted: Obesity

MHHS has had previous success in the implementation of the FARMACY program, which is designed to improve health and access to fresh fruits and vegetables for patients in need. It is carried out in partnership with WVU Extention.

Table 5: Activity Five

Strategy	
Objectives	Hold one FARMACY program per year. The FARMACY program consists of 10 weekly sessions.
Activities	• Produce supply–Through Mountaineer Food Bank • Contact referrals with offer and schedule intake appointment if they verbalize commitment to FARMACY program • Confirm location for sessions and put session materials together for participants • Reminder calls for beginning of program • Communicate to providers who of their referrals signed up for FARMACY program • Enter pre/post data into WV Health Connections, Workshop Wizard • Share feedback data to providers • Possible cooking demonstrations (in conjunction with Calhoun County Extension, if possible)
Planning Partners	• Minnie Hamilton Health System • Director of Business Development • WVU Extension • Outreach Coordinator
Implementation Partners	• Minnie Hamilton Health System • WVU Extension FNP
Resources	• Produce to participants • Educational print materials • Recipes • Blood pressure cuffs • Notebooks • Logs for weight, blood pressure, and blood sugar • Bathroom scale as needed • Listing of local farmers markets' schedules • Reminder calls
Evaluation Activities	• # of participants (Year 1-28) Program can have up to 45 participants • Pre/post surveys

	• Pre/post Hgb, A1c, and cholesterol levels
Point of Contact	• Director of Business Development • Outreach Coordinator

3.2 Strategy Five: Wellness – Community Planning

Priorities Targeted: Obesity

This program is designed to target community members and MHHS employees to support and promote healthy lifestyle choices and to promote education and wellness events.

Table 6: Wellness – Community Planning

Strategy	
Objectives	Provide opportunities for community members and employees to promote healthy lifestyle through education and wellness events.
Activities	• Market Fitness Opportunities (Tracks, Weight Rooms, Swimming Pools, Zumba Dance Classes, etc.). • Monthly Wellness Challenges • Mountaineer Mile • Employee wellness programs (labs, fitness)
Planning Partners	• Director of Business Development • Community Outreach Coordinator • Clinical Care Managers • WVU Extension FNP
Implementation Partners	• MHHS- Director of Business Development • Community Outreach Coordinator • Calhoun/Gilmer County Wellness collation • MHHS-Medical Staff
Resources	• Marketing • Incentives for participants' steps/miles goals met • Overall challenge winners' prizes
Evaluation Activities	• # of programs offered • # of participants per activity per month • Participants steps/miles logged monthly with documented proof of step count.
Point of Contact	• Community Outreach Coordinator

3.3 Strategy Six: Stroke Smart

Table 6: Stroke Smart

Strategy	
Objectives	Stroke Smart is public health initiative designed to teach the public about the signs and symptoms of a stroke
Activities	• The 3 Questions that every West Virginian should be able to answer is: 1. What is a stroke? 2. What are the signs and symptoms of a stroke? 3. What should I do? • A single, statewide message for stroke recognition: BE FAST + CALL 911 • A multi-agency partnership (Health, EMS, Education, Aging, Public Safety) • Statewide activation in clinics, schools, and communities • A measurable plan aligned with Rural Health Transformation priorities • Clinics: BE FAST Fridays • Schools: curriculum integration • Community health fairs • Places of worship • QR codes • Partner recognition program • Continuous improvement
Planning Partners	• State and local EMS • Religious organizations • Schools • Media • Community partners • Governor
Implementation Partners	• State and local EMS • Religious organizations • Schools • Media • Community partners • Governor
Resources	• Time • Location

Evaluation Activities	• Quarterly metrics & reporting
Point of Contact	• MHHS Staff

In addition to the items listed above, MHHS is in the process of hiring a Community Health Worker to assist high-risk patients with care coordination in their homes and community. The hospital has also focused clinically on increasing access to care when it comes to behavioral health needs of their patients and community members.