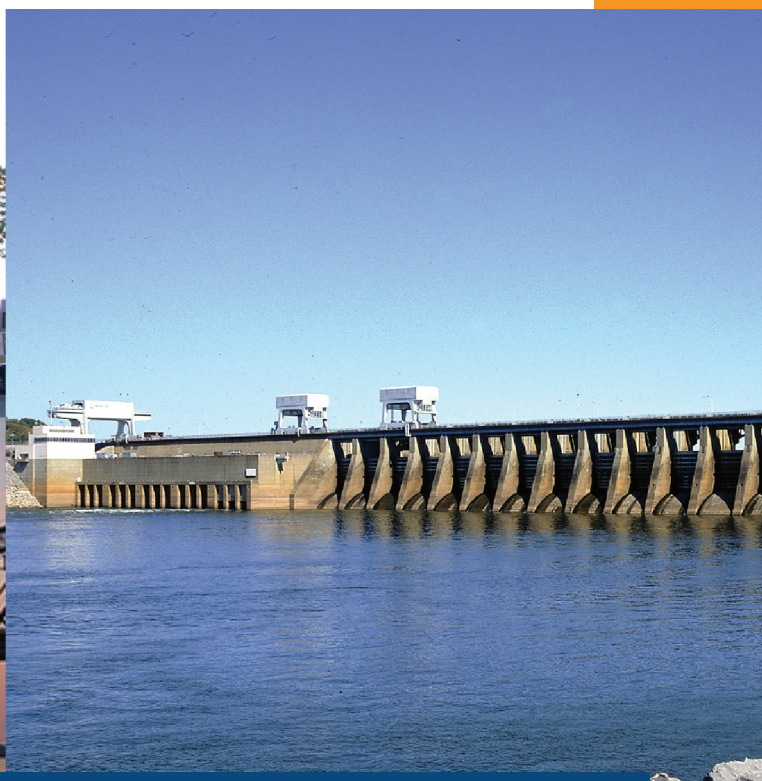
Marshall County Health Coalition

Holding the Fabric of a Healthy Community Together!

Planned Approach To Community Health



Marshall County Community Health Assessment and Community Health Improvement Plan

2026-2028

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About Marshall County

Marshall County is nestled in Western Kentucky and is one of eight counties that comprise the Purchase Region. As of 2023, the population is 31,744 individuals, with approximately 20% under age 18 and approximately 23% over age 65. The graphs on the following page depict the complete demographics of our area (sources: US Census and County Health Rankings). The county is composed of three primary municipalities: Benton, Hardin, and Calvert City. Other townships also include Gilbertsville and Aurora. The county has one public school district, consisting of one high school, two middle schools, and six elementary schools, as well as several private schools. According to ZipDataMaps, Marshall County ranks 10 out of 120 counties for our health ranking. The overall health ranking is derived from (1) Mortality – how long we live, and (2) Morbidity – how well we live. ZipDataMaps utilizes data from the County Health Rankings to rank counties across the state (County Health Rankings discontinued providing specific county rankings in 2021).

Total Population - 31,744

Race and Ethinicity

Non-Hispanic White	95.5%
Hispanic	2.1%
Non-Hispanic Black	0.6%
American Indian & Alaskan Native	0.3%
Asian	0.5%

Income And Poverty

Median Household Income	61,500
Individuals Living In Poverty	13.8%
Children Living In Poverty	17%

Languages Spoken

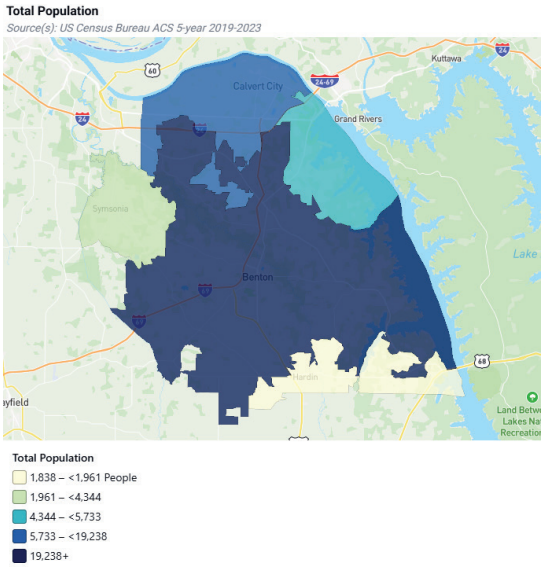
English	98.5%
Spanish	1.1%
Other Indo-European	0.14%
Asian -Pacific Islander	0.29%

Gender

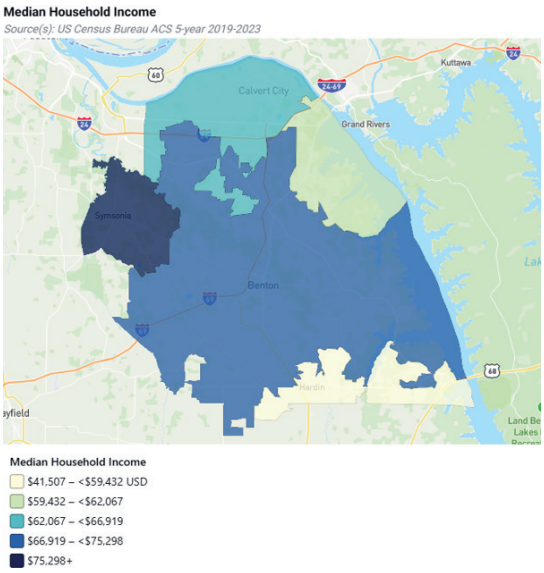
Male	49.9%
Female	50.1%

Educational Attainment

Less than 9th Grade	2.6%
9th to 12th Grade, No Diploma	5%
High School Degree	36.9%
Some College, No Degree	25.2%
Associate Degree	9.1%
Bachelor's Degree	12.5%
Graduate Degree	8.5%



Area and Color Categroy (Legend Class)	Population Range
Southern Marshall County (pale yellow)	1,838 - <1,961 People
North-Western Marshall County (pale green)	1, 961 - <4,344
North-Eastern Marshall County (light blue)	4,344 - <5,733
Northern Marshall County (medium blue)	5,733 - <19,238
Central Marshall County (dark blue)	19,238+



Area and Color Categroy (Legend Class)	Median Household Income Range
Southern Marshall County (pale yellow)	$41,507 - <$59,432 USD
North-Eastern Marshall County (pale green)	$59,432 - <$62,067
Northern Marshall County (light blue)	$62,067 - <$66,919
Central Marshall County (medium blue)	$66,919 - <$75,298
North-Western Marshall County (dark blue)	$75,298+

About the Process

The Community Health Assessment (CHA) is completed every three years in partnership with the Marshall County Hospital. This process is vital to keeping track of our community's health trends. This is the fourth CHA cycle we have completed, and it is the second cycle of using the most recent real-time data available to us.

The Marshall County Health Department (MCHD) formed a core team in the fall of 2024. This team led the process of using the Mobilizing for Action Through Planning and Partnerships (MAPP) 2.0 Framework. A steering committee was also formed at the beginning of 2025, comprising sectors that represent governmental institutions, healthcare, behavioral health, finance, the local public school system, law enforcement, and other organizations. The complete list of the organizations represented in the steering committee is:

Baptist Health Paducah

A regional healthcare system providing inpatient, outpatient, specialty medical services, and primary care to residents across Western Kentucky. *(Community Partner – General/Supporting Organization)*

Benton Family Resource Center

Serves local elementary students and families by addressing barriers to education and connecting households with food, clothing, and health resources. *(Community Partner – Represents Populations Disproportionately Affected by Poor Health Outcomes)*

CASA by the Lakes

Advocates for the best interests of children who have experienced abuse or neglect, providing support through trained community volunteers. *(Community Partner – Represents Populations Disproportionately Affected by Poor Health Outcomes)*

Community Financial Services Bank

A locally owned financial institution supporting community development and family financial stability initiatives. *(Community Partner – General/Supporting Organization)*

Family Resource Youth Service Center (FRYSC)

Coordinates services within middle and high schools to reduce non-academic barriers to student success and strengthen family well-being. *(Community Partner – Represents Populations Disproportionately Affected by Poor Health Outcomes)*

Four Rivers Behavioral Health

Provides comprehensive mental health, substance use, and developmental disability services throughout the Purchase Area Region. *(Community Partner – Represents Populations Disproportionately Affected by Poor Health Outcomes)*

Kentucky Lake Chamber of Commerce

Promotes local business growth, workforce development, and community engagement initiatives in Marshall County. *(Community Partner – General/Supporting Organization)*

KentuckyCare

A federally qualified health center offering affordable primary and preventive care to underserved and uninsured residents. *(Community Partner – Represents Populations Disproportionately Affected by Poor Health Outcomes)*

Marshall County Caring Needline

A nonprofit organization providing food assistance to individuals in need. *(Community Partner – Represents Populations Disproportionately Affected by Poor Health Outcomes)*

Marshall County Health Department

The local public health agency responsible for assessing community health needs, delivering core public health services, and coordinating population health improvement efforts. *(Governmental Public Health)*

Marshall County Hospital

A community-based hospital providing emergency, acute, and rehabilitative care, and partnering in countywide health improvement initiatives. *(Community Partner – General/Supporting Organization)*

Marshall County Public Library

Enhances community learning, access to technology, and public information through educational programs and outreach partnerships. *(Community Partner – Represents Populations Disproportionately Affected by Poor Health Outcomes)*

Marshall County Sheriff's Office

Provides law enforcement, safety education, and community outreach services to support a safe and healthy environment. *(Community Partner – General/Supporting Organization)*

Mercy Health

A regional healthcare system providing inpatient, outpatient, specialty medical services, and primary care to residents across Western Kentucky. *(Community Partner – General/Supporting Organization)*

Mountain Comprehensive Care Center

Provides behavioral health, substance use recovery, and community support programs for individuals and families across Kentucky. *(Community Partner – Represents Populations Disproportionately Affected by Poor Health Outcomes)*

Passport by Molina Healthcare

A managed care organization delivering Medicaid and Medicare services, with a focus on health equity and access for vulnerable populations. *(Community Partner – Represents Populations Disproportionately Affected by Poor Health Outcomes)*

United Way of Western Kentucky

Mobilizes resources and partnerships to address local needs in health, education, and financial stability for families across the region. *(Community Partner – Represents Populations Disproportionately Affected by Poor Health Outcomes)*

The Core Team and Steering Committee met regularly during 2025 to ensure the process was on track and that community partners were engaged and active throughout the process. The community forum was held in June 2025, and it was here that all of the analyzed data was presented to our community members and partners. The Core team then took the feedback from the forum and created our new health priorities in the late summer/early fall of 2025, which will be addressed in the Community Health Improvement Plan (CHIP).

Methodology

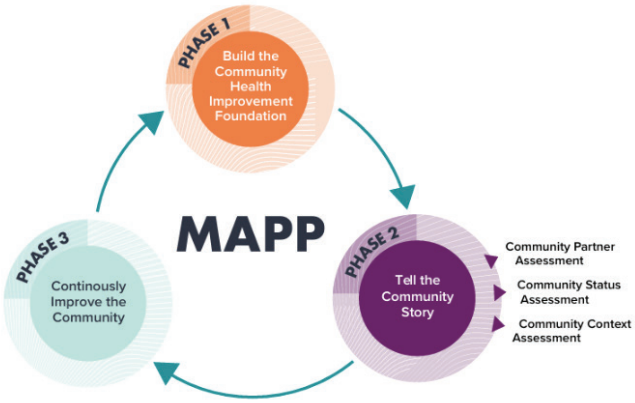
The current CHA process utilizes the MAPP 2.0 process to guide us. The MAPP 2.0 framework is an updated version of the framework developed by the National Association of County and City Health Officials (NACCHO).

The MCHD has traditionally utilized the MAPP framework, and this cycle chose to adopt the updated model. MAPP is generally facilitated by one or more organizations that complete the process with the guidance, input, and participation from many people and organizations who work, learn, live, and play in the community. MAPP 2.0 consisted of three phases, with Phase 2 comprising three assessments that facilitate data collection (see graphic below). Details of these three phases are expanded upon within the CHA.

The most important thing to remember about the MAPP 2.0 process and the CHA is that this is a community process. The CHA is led by, but not owned by, the MCHD or the Marshall County Hospital. The CHA is a community engagement initiative, fostering support and partnerships. The community map below shows how every sector plays an integral part in this process.

Community Sectors

- Schools
- Neighborhood Organizations
- Civic Groups
- Faith Institutions
- Non-Profit Organizations
- EMS
- Community Centers
- Hospitals
- Public Health Agency
- CHCs
- Doctors
- Employers
- Law Enforcement
- Corrections
- Tribal Health
- Elected Officials
- Transit
- Laboritories
- Fire
- Mental Health
- Nursing Homes
- Home Health



MAPP 2.0 Framework

Phase 1 - Build the Community Health Improvement Foundation

Phase 2 - Tell the Community Story
- Community Partner Assessment
- Community Status Assessment
- Community Context Assessment

Phase 3 - Continously Improve the Community

The Core CHA team started Phase 1 of the process with the Starting Point Assessment (SPA). The Team determined three core areas that went well last cycle and two areas where improvements could be made. The three strengths of the previous cycle were (1) the gathering of real-time data from a variety of local resources, (2) a diverse community partnership, and (3) the partnership with TN State University for the analysis and presentation of data. The two areas for improvement were (1) while significant progress was made in collecting local real-time data, gaps remained in areas such as coroner and ambulance data, as well as out-of-county data from our two largest area hospitals, and (2) preconceived ideas of community health concerns.

The ways we aimed to improve this cycle are (1) to identify root causes of health concerns within our community to better address priorities, (2) engage policy makers and individuals with lived experiences in health disparities to participate actively, and (3) gather additional local real-time data.

The next step was to form and onboard the Steering Committee, which was an integral part of the MAPP 2.0 process. We had members who participated in previous cycles, but we also gained several new members. With the changes from MAPP to MAPP 2.0, we wanted to ensure that all members were aware of the flow of the CHA process. The shift from the traditional MAPP framework to MAPP 2.0 was driven by a streamlined process that reduced six phases to three. It places greater emphasis on community voice and systems thinking, making it more adaptable and aligned with modern public health goals.

Steering Committee members first set a vision statement for our CHA process through a visioning exercise consisting of asking these three questions:

1. What does a healthy community mean to you?
2. What are the characteristics of a healthy community?
3. What needs to be in place for us to work together effectively to achieve our vision?

Through group discussions, the steering committee formed the following vision statement for our CHA:

> *"Our community envisions a future where everyone, regardless of background, has access to resources, support, and opportunities to thrive. We aim to educate beyond physical health, encompassing mental, emotional, and social well-being. By addressing the root causes of health disparities, fostering a sense of belonging, and building trust and transparency, we will empower individuals and families to reach their full potential while cultivating a community that prioritizes well-being for all."*

The steering committee was also deeply involved in identifying root cause health issues in our community based on survey data. These findings were used in the community forum activity with partners. As part of this process, we chose to focus more on root cause health priorities rather than traditional health concerns. Although health concerns will still be addressed as part of the CHIP, we made an effort to identify root causes this cycle. This will help us target disparities and health issues early, and over time, we will be more effective in creating a healthier community. This process will be detailed in the CHIP.

The Core committee also conducted the three assessments in phase 2 of MAPP 2.0: the Community Partner Assessment (CPA), Community Context Assessment (CTA), and Community Status Assessment (CSA). All three of these and the results are laid out in the following three sections.

Data Processes Analysis

The MCHD partnered with Dr. Miranda Terry from Tennessee State University and Drs. Elizabeth Gordon and Azaher Molla from Murray State University to conduct our data analysis. Both qualitative and quantitative data sets were gathered as part of this process including, but not limited to our CPA, community survey, visioning sessions, focus groups, and various quantitative sources, including the CDC, Kids Count Data Center, JobsEQ report, etc. (a complete list of data sources is listed at the conclusion of the CHA and on slide 70 of the data presentation in Appendix A). The qualitative data analysis employed inductive and two-cycle coding, while the quantitative data were reviewed, cleaned, and coded. The Statistical Package for the Social Sciences (SPSS) was then used, along with a descriptive and cross-tabulation approach, to analyze. More information on the specific data gathered is included later in the CHA.

Community Partner Assessment

The 2025 CPA drew responses from 28 organizations, achieving a strong 92.9% completion rate. Participants came from a range of roles, including front-line staff (21%), senior management/program leads (21%), administrative staff (14%), and community leaders (7%). This diversity of perspectives provided a well-rounded view of local organizational capacity, priorities, and challenges. The CPA was distributed in January of 2025 at our quarterly Health Coalition Meeting, where key community partners gather to network, share insights, and work on common community goals.

Participation and Collaboration

A majority of organizations (64%) have engaged in a community health improvement process before, and an even higher proportion (82%) have participated in or facilitated community-led driven decision-making. This reflects a robust base of experience in collaborative, community-driven work. Most organizations identify as non-profits (54%), with additional representation from public health, education, healthcare, grassroots organizing, and faith-based groups, suggesting a cross-sector network capable of addressing a wide range of health needs.

When asked about motivations for engaging in partnerships, respondents most often cited building networks (29%), enhancing communication among groups (21%), and accessing or providing services (21%). These priorities reflect an interest in strengthening relationships and resource-sharing, which are critical for sustainable community health improvements.

Populations Served

Many partners serve diverse and often underrepresented groups. Over two-thirds (69%) work with immigrants, refugees, and non-English-speaking populations, and nearly three-quarters (73%) provide general services accessible to LGBTQIA+ individuals. Just over half (54%) offer services or access for people with disabilities, and the others work with vulnerable populations not explicitly listed, such as those affected by socioeconomic barriers, housing instability, or justice system involvement.

Areas of Focus and Strengths

Organizations reported strong engagement across social determinants of health. Economic stability, education access, and healthcare access were most often identified as major focus areas. Neighborhood and built environment issues, along with social/community context, were somewhat less emphasized, suggesting potential areas for growth in cross-sector partnerships.

In terms of topic areas, healthcare access/utilization, education, food access, and public health were the most common fields of work (each cited by 54–62% of respondents). Mental and behavioral health was a priority for over half of the organizations, followed by tobacco/substance use prevention, chronic disease, and maternal/family health.

Capacity strengths include:

- Staff time for community engagement (63%)
- Physical meeting space (33%)
- Policy/advocacy skills (26%)
- Data analysis capacity (18–19%)

Community Engagement Practices

Half of organizations said their most common engagement approach is informing the community, with smaller portions prioritizing collaboration or direct involvement in planning. Social media, presentations, and community forums are the most frequent engagement tools, though deeper, shared decision-making approaches are less common.

Policy, Advocacy, and Communication

Policy work tends to focus on educating decision-makers (42%), responding to information requests (29%), and building relationships with elected officials (25%).

Communications capacity varies:

- 88% use social media outreach regularly.
- Around 40% use newsletters or media contact lists.
- Roughly 30% maintain active relationships with local journalists.

Data and Assessment Practices

Half of organizations conduct formal assessments, and one-third can share those with the MAPP 2.0 collaborative. Data collection most often involves surveys (77%), focus groups (32%), and feedback forms (27%). About 70% have needs assessment expertise, but fewer possess advanced analysis or mapping skills.

Interpretation

The survey reflects a community partner network with extensive expertise and strong community connections.

Strengthening cross-sector partnerships, providing resources for deeper engagement, and building shared capacity in policy advocacy will position the community for more impactful and inclusive health improvement efforts.

Community Context Assessment

Community Strengths and Assets

At the start of 2025, throughout the spring, the MCHD gathered qualitative data for our community health assessment. This included hosting focus groups with youth and adults with a focus on those living in poverty, senior citizens, and individuals in the LGBTQ+ community, along with visioning sessions with all of our local public schools and a cohort of youth from the resident treatment facility that is housed within Benton.

Marshall County residents describe their community as loyal, close-knit, and resilient. Strong family values, faith traditions, and small businesses with generational ties form the backbone of our community. People emphasize that while the area is rural, residents thrive through perseverance and mutual support.

The youth echoed these themes of connection and resilience. Students in both elementary and secondary schools envisioned healthy communities that foster kindness, caring, and helping others. Participants from the county's residential school, serving students experiencing psychological and behavioral health challenges, reinforced this message by identifying acceptance, empathy, and mutual support as the most important features of community health.

Marshall County, Kentucky, is also rich in tangible community assets that foster connection, health, and lifelong learning. The county has seen an increase in farmers' markets over the last several years, which has improved access to fresh, locally grown foods, supported small farmers, and strengthened community connections. Assets noted on the community survey included the county's parks and recreation system and the Marshall County Public Library, both of which play vital roles in community life. Parks and recreation continue to thrive, offering diverse outdoor opportunities that promote physical activity and social engagement, while the library system serves as a hub for education, creativity, and access to technology.

The Marshall County Health Coalition also continues to be a staple in our county by bringing together organizations and individuals who are assets to our community, such as our local school system, financial institutions, local government, civic organizations, and healthcare.

Challenges and Barriers

While strengths are deeply rooted, several challenges emerged. Focus group participants highlighted discrimination, prejudice, and a lack of safe spaces, particularly for LGBTQ residents. Experiences of exclusion and fear were described as driving some community members and visitors away, creating both social and economic losses. Participants also expressed a lack of mental health facilities, supportive churches, and affirming businesses as barriers to feeling safe and included.

Elementary and middle school students often focus on trash, pollution, and the lack of trees or parks, suggesting that the physical environment shapes their sense of health. High school students, meanwhile, emphasized larger structural challenges such as housing quality, transportation, and limited access to stores or healthcare resources. These insights align with the indirect context of rural living, where fewer providers, long travel distances, and limited infrastructure present persistent barriers.

Youth Visioning Results by School

The visioning sessions revealed school-level and age-specific priorities:

Benton Elementary School:

More trees and fruit trees, exercise spaces for kids, stores, and parks.

Calvert City Elementary School:

Clean environment, trees, and parks.

Central Elementary School:

Emphasis on God/prayer, clean environment, exercise opportunities, limits on screen time, and healthy food.

Jonathan Elementary School:

Clean environment, schools and teachers, hospitals, housing, and the importance of friends and helping one another.

Sharpe Elementary School:

Trees and fruit trees, hospitals, healthy food, exercise spaces, and litter-free surroundings.

South Marshall Elementary School:

Clean environment, trees and fruit trees, exercise spaces, parks, and hospitals.

High school students (276 participants) offered broader perspectives, with housing/neighborhoods (114 mentions), restaurants (112 mentions), and parks/stores (99 mentions) emerging as the most common features of a healthy community. Middle school students emphasized trees/fruit trees, clean environments, and access to essential services like hospitals and schools.

The residential school cohort treatment facility revealed a unique and vital perspective. Their responses emphasized social health over infrastructure, identifying helping others, being caring, kind, and accepting as the foundation of a healthy community.

Health Concerns

Across groups, mental health emerged as the most pressing concern. Residents noted a lack of affordable and accessible counseling, high out-of-pocket costs, and stigma associated with seeking help. Focus group participants linked untreated mental health needs to substance use, poor nutrition, and community instability.

Nutrition and food access were also recurring themes, along with limited options beyond Walmart and Dollar General, both of which stock foods high in preservatives and low in fresh, healthy options. During the visioning sessions, youth called for fruit trees, farmers' markets, and more opportunities for physical activity as ways to strengthen both health and community pride.

Aspirations for a Healthy Community

When asked to describe what a healthier Marshall County would look like, residents and youth envisioned:

- **Clean, green environments** with trees, fruit trees, and safe parks.
- **Inclusive spaces** where diversity is acknowledged and valued, and residents feel safe regardless of identity.
- **Expanded healthcare and social services,** especially mental health care, autism testing and support, veteran resources, and addiction recovery.
- **Opportunities for healthy living,** including gyms, walking trails, and access to affordable fresh food.
- **Communities built on kindness and empathy,** where helping neighbors is as important as infrastructure.

Indirect Context and Interpretation

These qualitative findings are shaped by the county's broader socioeconomic and geographic realities. Marshall County's aging population, rural environment, and reliance on a limited local economy intersect with the challenges voiced by participants. Transportation barriers make it harder to access distant providers, while housing and infrastructure pressures limit growth. At the same time, poverty and limited resources create affordability issues that compound unmet health needs.

Taken together, the voices of youth and adults present a nuanced picture: a community deeply proud of its resilience and values, but also ready to adapt by investing in inclusivity, mental health, and the physical environment. These qualitative insights complement the health status and demographic data, grounding the numbers in lived experience and highlighting priorities that address both the social and structural determinants of health.

Community Status Assessment

Introduction & Purpose

The Community Status Assessment (CSA) provides a comprehensive overview of the health status, conditions, and disparities within Marshall County. As part of the MAPP 2.0 framework, this assessment draws on quantitative health indicators, community survey results, and ZIP-code-level analyses to describe the current state of health and well-being. The CSA is designed to complement the Community Context Assessment by focusing on measurable health outcomes and access to services, while also incorporating community perceptions. Together, these assessments create the foundation for setting priorities in the Community Health Improvement Plan (CHIP).

Population & Demographics

Marshall County is home to approximately 31,744 residents, with nearly one in five under the age of 18 and almost one in four age 65 or older. This aging population highlights the importance of services for seniors, including chronic disease management and social support. The county is rural, with over 85% of its residents living outside Benton, the most populous city, with 4,726 residents.

The racial and ethnic composition is predominantly White, non-Hispanic (95.5%), with Hispanic/Latino residents making up 2.1% and Black, non-Hispanic residents accounting for less than 1%. While small in number, Latino families experience disproportionate economic challenges, with 26% of Latino children living in poverty compared to 17% of all children in the county.

Educational attainment remains strong, with 92% of adults completing high school and 65% completing some college, rates that slightly exceed state averages. Broadband access (84%) and homeownership (82%) are higher than both state and national averages, although 34% of residents report living with some form of functional limitation.

Social & Economic Context

The county's median household income is $61,500, which is similar to the state average but significantly lower than the national level. Income inequality is lower than Kentucky's overall, yet the gender pay gap persists, with women earning approximately $0.75 for every dollar earned by men. Unemployment remains steady at 4%.

Housing stability is generally strong, with high homeownership and relatively low housing cost burden. However, survey results show housing insecurity remains a concern for some residents, and young people frequently cited housing and neighborhood conditions as important to a healthy community. Transportation emerged as a recurring challenge: 79% of residents drive alone to work, commute times are long for nearly one-third of workers, and the county experiences higher rates of motor vehicle crash deaths compared to state and national averages. Residents in rural ZIP codes, particularly 42029 (Calvet City) and 42048 (Hardin), were more likely to cite transportation as a barrier to healthcare access.

Health Status & Outcomes

Marshall County faces notable challenges with chronic disease. Adult obesity remains high at 39%, and diabetes prevalence is 11%, both exceeding national benchmarks. Physical inactivity is improving, but still affects more than one in four adults. Preventive screenings vary by ZIP code, with residents in 42025 (Benton) reporting lower rates of routine check-ups and colon cancer screenings compared to 42044 (Gilbertsville).

Hospital utilization data indicate ongoing demand for treatment of respiratory infections, urinary tract infections, and chronic obstructive pulmonary disease (COPD). Mortality data reveal concerning patterns: in 2024, there were 162 deaths, with natural causes being the leading factor, followed by accidents, suicides, and drug-related deaths. Early 2025 data already show a continuation of these trends.

ZIP-level disparities are also evident. Gilbertsville has the highest rates of arthritis, cancer, coronary heart disease, and diabetes. Hardin reports the highest rates of obesity, low physical activity, and depression. By contrast, Benton, the most populous city, has comparatively lower rates of many chronic conditions but lags in preventive care.

Access to Care

Healthcare access remains a central issue. While only 6% of the population is uninsured, the uninsured rate among Latino residents is significantly higher at 17%. Provider shortages are pronounced, with ratios of one primary care provider for every 2,440 residents and one mental health provider for every 2,890 residents, far lower than state and national benchmarks. These gaps align closely with community survey results, where access to mental healthcare ranked as the top community priority, and physical healthcare access was also identified as a concern.

Survey respondents highlighted barriers, including the cost of services, the scarcity of providers, and transportation issues. Many residents noted difficulty affording out-of-pocket expenses, while others identified challenges in finding convenient appointment times or specialists. Elder care also emerged as an area of concern, reflecting both the aging population and service gaps.

Community Perceptions & Priorities

The 2025 community survey highlighted priorities that resonate with both quantitative data and community voices. Mental healthcare was ranked as the top priority, followed by access to healthy food, housing, transportation, and physical healthcare. Substance misuse was identified as the leading community risk factor, consistent with law enforcement data showing drug-related offenses as the top criminal charge.

Residents also pointed to strengths, including parks and recreation, safe neighborhoods, strong family life, and spiritual values, which were viewed as protective community assets. However, nearly half of the respondents described the community as somewhat unhealthy or very unhealthy, suggesting a recognition that systemic challenges outweigh strengths in many areas.

Youth voices added further context, identifying safe spaces, organized activities, and access to healthy food as critical needs. Survey data also indicated that discrimination, while not reported widely, was most often linked to age, gender, and body type.

ZIP-Code Disparities

Breaking results down by ZIP code reveals distinct differences within the county:

Benton (42025):

Largest population center, yet preventive screenings (check-ups and colonoscopies) are lower than in surrounding areas.

Calvert City (42029):

Smaller community with recurring transportation and food access concerns. Residents reported challenges aligning with rural infrastructure and limited-service availability.

Gilbertsville (42044):

Higher prevalence of cancer, coronary heart disease, arthritis, and diabetes. Despite this, residents reported stronger preventive screening participation.

Hardin (42048):

Highest rates of obesity, low physical activity, and depression, paired with lower access to screenings.

These disparities suggest that while Benton residents may have more access to providers, rural ZIPs such as Calvert City and Hardin face structural barriers that translate into poorer outcomes. Gilbertsville's high chronic disease burden underscores the need for targeted prevention and management programs.

Health Behaviors

Physical Activity and Nutrition

Physical activity and nutrition remain a defining health behavior challenge across Marshall County. Nearly one in four adults reports no leisure-time activity, and while access to exercise opportunities has improved to almost 60%, it continues to fall below state and national benchmarks. Adult obesity remains elevated at 39%, and diabetes prevalence is 11%. Community survey results show that poor eating habits have now surpassed lack of exercise as the most frequently reported health risk behavior. Limited access to healthy food options and affordability concerns were common themes, especially in Benton and Calvert City, where residents connected nutrition challenges directly to the cost of living. Youth participants echoed these concerns, expressing a desire for more accessible recreational spaces and healthy food choices within schools and neighborhoods.

Tobacco, Alcohol, and Substance Use

Tobacco use remains high, with nearly 19% of adults reporting current use, exceeding national rates. Alcohol consumption presents a mixed picture: while overall excessive drinking is near state averages, alcohol-impaired driving deaths are notably higher in Marshall County than state or national comparisons. Substance misuse continues to be a critical concern, with narcotics being the leading cause of arrest and overdose surveillance documenting nearly 100 suspected overdoses in 2024. Methamphetamine and fentanyl are the most reported substances, reflecting both availability and risk within the community.

Preventive Practices

Preventive health behaviors vary across the county. Rates of check-ups and screenings are highest in Gilbertsville (42044) but lowest in Benton (42025) and Hardin (42048). Barriers to preventive care identified in the community survey include cost, transportation, lack of providers, and long waits for services. Residents also expressed frustration with the affordability of dental care and gaps in behavioral health support.

Mental Health

Mental health is deeply tied to behavioral patterns. Nearly 18% of adults report frequent mental distress, and stress, anxiety, and depression were the top issues identified in youth surveys. Coping behaviors, including reliance on social media, were cited as risk factors, particularly among younger populations. Community survey respondents ranked access to mental healthcare as one of the top countywide priorities, highlighting both the prevalence of mental health challenges and the shortage of behavioral health providers.

ZIP-Code Disparities

Benton (42025):

As the county's largest and most populated area, Benton continues to identify substance misuse as a top health concern, along with poor eating habits and lack of exercise. Concern about cancer ranks third among the top health problems after obesity and mental health. Preventive check-ups remain lower than in neighboring ZIP codes, suggesting cost and convenience barriers influence utilization despite proximity to services.

Calvert City (42029):

Residents emphasized access to care and economic stability. The lack of a livable wage and the affordability of healthcare are growing concerns. Respondents also prioritized chronic conditions such as heart disease and cancer, signaling an increased focus on long-term health management.

Gilbertsville (42044):

Preventive care participation remains comparatively strong. Cancer and mental health are leading concerns, followed by diabetes and heart disease. Residents continue to report challenges with access to and affordability of healthy food, indicating that nutrition remains a persistent community issue.

Hardin (42048):

Hardin demonstrates the highest behavioral health and chronic disease burdens, with elevated rates of obesity, depression, and low physical activity. Substance misuse remains a concern among residents.

Disproportionate Impacts

Differences in geography, income, and access to care shape disproportionate impacts in Marshall County. While the county performs well on several measures compared to similar rural areas, distinct disparities emerge between ZIP codes and among specific populations. More rural residents face greater barriers to care, experience higher rates of chronic disease, and report fewer opportunities for physical activity and healthy food access.

Geographic differences are especially evident between more populated areas, such as Benton (42025), and smaller ZIP codes like Hardin (42048) and Calvert City (42029). Hardin consistently reports the highest rates of obesity, depression, and inactivity, while Gilbertsville (42044) has the highest prevalence of diabetes and chronic disease. In contrast, Benton residents report lower screening participation rates despite greater access to care, indicating that affordability and convenience also influence health behaviors.

Economic factors reinforce these geographic patterns. Families with lower incomes or limited transportation face greater difficulty obtaining care, food, and medication. Although overall insurance coverage is strong, uninsured rates among Latino residents are notably higher, and older adults and individuals with disabilities report increased challenges related to isolation and mobility. These disparities contribute to higher chronic disease rates, delayed preventive care, and poorer mental health outcomes among vulnerable populations.

Behavioral and lifestyle factors mirror these trends. Tobacco use and poor nutrition are more common in rural areas with higher poverty, while substance misuse remains a countywide concern. Mental health access is limited, and residents across all ZIP codes identified behavioral health as the top community priority. Youth surveys and partner input confirm that barriers such as stigma, transportation, and lack of affordable recreation or support services continue to limit opportunities for well-being.

Overall, the county's disproportionate impacts are rooted not only in individual behaviors but also in structural factors such as transportation, income, and service availability that influence the ability to achieve and maintain good health. Addressing these disparities through coordinated strategies that expand access, strengthen community connections, and invest in prevention will be essential to advancing health for all across Marshall County.

Data Presentation and Sources

On June 24, 2025, the community gathered for a comprehensive data presentation facilitated by Dr. Miranda Terry of Tennessee State University. This all-day forum included the review of quantitative and qualitative health data, small-group work sessions, and structured feedback from community partners. Participants examined trends in health status, social determinants of health, and identified disparities impacting Marshall County residents. For the full presentation, see Appendix A.

We would also like to extend our gratitude to the community partners, agencies, and residents who contributed to this process. Their time, expertise, and lived experiences provided context that made the data meaningful and ensured that the findings reflect the realities of our county. The following organizations were represented during the forum:

AmeriCorps

A national service program that engages volunteers in community-based projects, education, and public health initiatives. *(Community Partner – Represents Populations Disproportionately Affected by Poor Health Outcomes)*

Baptist Health

A regional healthcare system providing inpatient, outpatient, specialty medical services, and primary care to residents across Western Kentucky. *(Community Partner – General/Supporting Organization)*

Benton Family Resource Center

Serves local elementary students and families by addressing barriers to education and connecting households with food, clothing, and health resources. *(Community Partner – Represents Populations Disproportionately Affected by Poor Health Outcomes)*

City of Benton

The local municipal government serving the county seat of Marshall County, supporting infrastructure, safety, and community development. *(Government – Local/Municipal)*

City of Calvert

The city government for Calvert City, overseeing local services, public safety, and economic development. *(Government – Local/Municipal)*

Community Financial Services Bank

A locally owned financial institution supporting community development and family financial stability initiatives. *(Community Partner – General/Supporting Organization)*

Emerald Therapy

A behavioral health organization providing counseling, therapy, and mental health services for individuals and families.*(Community Partner – Represents Populations Disproportionately Affected by Poor Health Outcomes)*

Family Resource Youth Service Center (FRYSC)

Coordinates services within middle and high schools to reduce non-academic barriers to student success and strengthen family well-being. *(Community Partner – Represents Populations Disproportionately Affected by Poor Health Outcomes)*

Four Rivers Behavioral Health

Provides comprehensive mental health, substance use, and developmental disability services throughout the Purchase Area region. *(Community Partner – Represents Populations Disproportionately Affected by Poor Health Outcomes)*

Hope Clinic

A local nonprofit healthcare organization providing medical care, pregnancy services, and health education to families. *(Community Partner – Represents Populations Disproportionately Affected by Poor Health Outcomes)*

Horizon

A community-based organization focused on developmental and intellectual disability services, promoting independence and inclusion. *(Community Partner – Represents Populations Disproportionately Affected by Poor Health Outcomes)*

Kentucky Department of Public Health

The state agency responsible for protecting and improving the health of Kentuckians through statewide public health programs and policy. *(Governmental Public Health – State)*

KentuckyCare

A federally qualified health center offering affordable primary and preventive care to underserved and uninsured residents. *(Community Partner – Represents Populations Disproportionately Affected by Poor Health Outcomes)*

Kentucky Lake Chamber of Commerce

Promotes local business growth, workforce development, and community engagement initiatives in Marshall County. *(Community Partner – General/Supporting Organization)*

Lotus

A regional sexual assault and child advocacy center offering prevention education, advocacy, and trauma-informed support services. *(Community Partner – Represents Populations Disproportionately Affected by Poor Health Outcomes)*

Marshall County Health Department (MCHD)

The local public health agency responsible for assessing community health needs, delivering core public health services, and coordinating population health improvement efforts. *(Governmental Public Health)*

Marshall County Home Health

A division of Marshall County Hospital delivering skilled nursing and therapy services to residents in their homes. *(Community Partner – Represents Populations Disproportionately Affected by Poor Health Outcomes)*

Marshall County Hospital

A community-based hospital providing emergency, acute, and rehabilitative care, and partnering in countywide health improvement initiatives. *(Community Partner – General/Supporting Organization)*

Marshall County Public Library

Enhances community learning, access to technology, and public information through educational programs and outreach partnerships. *(Community Partner – Represents Populations Disproportionately Affected by Poor Health Outcomes)*

Mercy Health

A regional healthcare system providing inpatient, outpatient, specialty medical services, and primary care to residents across Western Kentucky. *(Community Partner – General/Supporting Organization)*

Mountain Comprehensive Care

Provides behavioral health, substance use recovery, and community support programs for individuals and families across Kentucky. *(Community Partner – Represents Populations Disproportionately Affected by Poor Health Outcomes)*

Office of Vocational Rehabilitation

A state agency that assists individuals with disabilities in achieving employment and independent living. *(Community Partner – Represents Populations Disproportionately Affected by Poor Health Outcomes)*

Tennessee State University

A public university providing academic programs, research, and community partnerships in health and social sciences. *(Community Partner – General/Supporting Organization)*

Primary Data

- **Visioning Sessions**

  Gathered perspectives from youth and adults on community strengths, needs, and health priorities.

- **Focus Groups**

  Collected in-depth qualitative feedback from residents and partners on lived experiences and barriers to health.

- **Community Survey**

  Countywide survey, including zip code analysis, to capture perceptions of health issues, behaviors, and access to care.

- **Community Partner Assessment**

  Input from local organizations to assess assets, gaps, and opportunities in public health collaboration.

Secondary Data

- **Graves County Health Department Syringe Exchange Program**
  Data on syringe distribution, return, and trends in substance use.
- **CASA by the Lakes**
  Insights on child advocacy cases and family resiliency challenges.
- **Centers for Disease Control and Prevention (CDC)**
  National health statistics and disease surveillance data for comparison.
- **Marshall County Family and Youth Resource Centers**
  School-based data on student needs, food insecurity, and family supports.
- **Marshall County Health Department**
  Local program data, communicable disease reports, and vital statistics.
- **Marshall County Hospital**
  Clinical data on admissions, emergency visits, and hospital-based community health indicators.
- **Overdose Detection Mapping Application Program (ODMAP)**
  Real-time data on overdose events and responses.
- **Kentucky Department for Public Health**
  Statewide health statistics, immunization rates, and chronic disease data.
- **Marshall County Coroner**
  Mortality data, including drug overdose and injury-related deaths.
- **Social Vulnerability Index (SVI)**
  Community-level indicators of social and economic vulnerability.
- **Marshall County Public Library**
  Community engagement and access data, including digital literacy and outreach programming.
- **Kentucky Injury Prevention and Research Center**
  Statewide injury surveillance and prevention data.
- **Kentucky Office of Drug Control Policy**
  Substance misuse, treatment, and recovery statistics.

- **Marcella's Kitchen**
  Local food insecurity and meal distribution data.
- **County Health Rankings & Roadmaps**
  Annual county-level health outcomes and factor rankings.
- **Kentucky Maternal and Infant Health**
  State data on maternal, prenatal, and infant health outcomes.
- **JobsEQ Reports –**
  Local workforce and economic trend data.
- **Purchase Area Health District**
  Regional health data and collaborative reports.
- **Salud Health Equity Report**
  Health equity indicators highlighting disparities across populations.
- **Merryman House**
  Data on domestic violence services and community safety.
- **Lotus**
  Sexual violence prevention and survivor support data.

Community Health Improvement Plan

As part of the CHA process, the Marshall County Health Department (MCHD), in partnership with Marshall County Hospital, hosted a community forum in June 2025. Following a presentation of local health data, participants were divided into groups to identify health priorities for this cycle.

Historically, our community has focused on three priorities: 1) Substance Misuse, 2) Obesity, and 3) Mental Health. While these are still relevant issues, this cycle sought to take a root cause approach. Prior to the data presentation, participants engaged in a "Penny for Your Thoughts" exercise. Each person was given ten pennies and asked to place them in designated cups representing what they believed were the top root causes of health issues in our community. Participants could distribute their pennies across several categories or place them all in one.

The list of potential root causes was developed in advance through discussions with both the Steering Committee and the Core Team. The Steering Committee provided oversight of the community's implementation of the MAPP 2.0 process and was composed of representatives from diverse community organizations. The Core Team, comprised of five MCHD staff members, laid the groundwork by devoting initial resources such as staff time and funding. They met regularly to support and lead the process, ensuring it progressed effectively and remained aligned with community needs.

After the data presentation, participants repeated the exercise. Results were totaled and shared before breaking into workgroups. Each group then discussed and identified what they believed to be the top three root causes and the associated health priorities. For example, "Family Resiliency" emerged as a root cause, with related priorities including mental health, substance misuse, and poverty.

When the workgroups reconvened, the following root causes and related health priorities were identified:

Family Resiliency

Trusted adult relationships, mental health, substance misuse, intimate partner and domestic violence, transportation, poverty, childcare, and programs for children

Low Income/Poverty

Mental health, transportation, and childcare

Engaging Our Aging Population

Increasing knowledge, addressing transportation barriers, reducing stigma, expanding senior centers, offering technology classes, and fostering intergenerational engagement

Education/Health Literacy

Access to healthy food, improved self-advocacy, reduced screen time, adequate sleep, life skills development, responsible social media use, mental health, and overall quality of life

To encompass the feedback from the forum, the Core Team met and determined the final CHIP goals for this cycle:

1. **Family Resiliency**
2. **Encouraging Education, Development, and Confidence for Personal Growth**
3. **Strengthening Community Connection**

Workgroups were then formed to lead implementation.

- **The Marshall County Public Library will oversee Family Resiliency.**
- **The MCHD will lead Encouraging Education, Development, and Confidence for Personal Growth, along with community partner participation.**
- **The MCHD will lead Strengthening Community Connection, along with community partner participation.**

The following sections outline the Specific, Measurable, Achievable, Relevant, and Time-Bound (SMART) goals developed to guide this CHIP cycle.

Priority Area:
Family Resiliency

Strong families are the foundation of a healthy community. In Marshall County, families face challenges such as financial stress, limited access to supportive services, and intergenerational barriers that can impact overall well-being. Building resiliency helps families adapt to adversity, maintain stability, and support positive development for children and youth. By working in partnership with local organizations, we aim to strengthen family supports, connect residents to available resources, and promote activities that enhance stability and resilience.

SMART Goal

By December 2028, strengthen family resiliency in Marshall County by partnering with community organizations to implement and promote programs, services, and resources that support families in adapting to challenges and thriving together.

SMART Objectives, Strategies & Performance Measures

Objective 1:

By December 2028, collaborate with at least 3 partner organizations annually to promote family-focused programs, services, or resources.

Strategies/Activities:

- Develop a shared system for partner organizations to submit information on family-focused programs (e.g., parenting classes, financial literacy, counseling, housing support).
- Promote programs through the Health Coalition's communication channels and partner networks.
- Include partner spotlights or success stories in newsletters or Coalition updates.

Performance Measures/Indicators:

- Number of partner organizations engaged annually (target: ≥3).
- Number of family-focused programs/services promoted annually (target: ≥3).

Objective 2:

By December 2028, support at least two collaborative family resiliency initiatives annually with community partners (e.g., workshops, family nights, resource fairs).

Strategies/Activities:

- Co-host events or attend events with partnering organizations such as schools, libraries, churches, and service providers.
- Provide staff or volunteer support through the Health Coalition to partner-led family events.

Performance Measures/Indicators:

- Number of collaborative family resiliency initiatives co-hosted or attended annually (target: ≥2).
- Attendance at events (baseline Year 1; target: increase annually).

Priority Area:
Encouraging Education, Development, and Confidence for Personal Growth

Access to education and personal development opportunities can help community members build confidence, increase job readiness, and improve overall well-being. By partnering with local organizations and leveraging the Marshall County Health Coalition, we aim to reduce barriers to learning and ensure that both youth and adults have access to meaningful opportunities for growth.

SMART Goal

By December 2028, increase the availability and promotion of personal growth and educational opportunities for adults and youth by hosting two events per year, and promoting existing opportunities in partnership with community organizations.

SMART Objectives, Strategies & Performance Measures

Objective 1:

By December 2026, develop a process to collect, compile, and share information from at least 5 partnering organizations to promote education and personal growth opportunities for community members.

Strategies/Activities:

- Establish a simple reporting tool (e.g., shared calendar, online form, or quarterly email) for partner organizations to submit event information.
- Disseminate a community event calendar through social media, flyers, and partner newsletters.

Performance Measures/Indicators:

- Number of partner organizations contributing event information (target: ≥5 per year).
- Number of educational/personal growth events promoted (target: ≥2 per year).

Objective 2:

By December 2026, the Marshall County Health Coalition will identify at least two areas of unmet needs annually and co-develop or promote programming to bridge those gaps.

Strategies/Activities:

- Work with Coalition partners to co-sponsor events in underserved areas or for priority groups.
- Secure volunteers or facilitators for workshops (e.g., financial literacy, job readiness, parenting skills, technology classes).

Performance Measures/Indicators:

- Number of unmet need areas identified (target: ≥2).
- Number of new or adapted programs/events developed to address gaps (target: ≥2).
- Attendance at new programs/events (baseline to be established Year 1).
- % of participants reporting increased confidence or knowledge (goal: ≥40%).

Priority Area:
Strengthening Community Connection

Building and maintaining strong connections within Marshall County is essential to health and well-being. Seniors in particular face barriers such as limited transportation, lack of accessible programming, and social isolation, while other residents may struggle to find opportunities to engage in meaningful community activities. Strengthening community connections for all residents not only improves health outcomes but also fosters intergenerational support, resilience, and a stronger sense of belonging. By partnering with existing organizations, promoting community events, and expanding outreach, the Health Coalition can help ensure that seniors and all community members remain socially active, connected to resources, and engaged in community life.

SMART Goal

Increase engagement of seniors and community members in health promotion and social connection activities by expanding outreach, promoting partner events, and strengthening partnerships across Marshall County by December 2028.

SMART Objectives, Strategies & Performance Measures

Objective 1:

Partner with Marcella's Kitchen to provide quarterly health information outreach, reaching at least 150 marginalized individuals and seniors quarterly. This will be on an annual basis throughout the duration of the CHIP through December 2028.

Strategies/Activities:

- Collaborate with Marcella's Kitchen to distribute printed health education materials (nutrition, preventive screenings, insurance resources, transportation options).
- Provide in-person presentations, information tables at quarterly meal events, or flyers to place with meal delivery.
- Track participant engagement using sign-in sheets, and distribution counts.

Performance Measures/Indicators:

- Number of outreach events held per year (target: 4).
- Number of seniors/marginalized individuals reached annually (target: ≥150).

Objective 2:

Co-host at least two activities annually with Marshall County Senior Citizens to foster social engagement, wellness, and healthy aging opportunities. This will be on an annual basis throughout the duration of the CHIP through December 2028.

Strategies/Activities:

- Collaborate with local senior citizen organizations to design quarterly events (e.g., health screenings, exercise demonstrations, social activities, technology training).
- Provide staff or volunteer support at community events geared toward seniors, in collaboration with community partners.
- Promote events through flyers, social media, and partner networks.

Performance Measures/Indicators:

- Number of senior participants attending events (target: 25–50 per event).
- Documentation of new or sustained partnerships resulting from activities (baseline to be established Year 1).

Objective 3:

Promote at least 12 community partner activities per year through the Health Department's and Health Coalition's communication channels to increase awareness and participation among Marshall County residents. This will be on an annual basis throughout the duration of the CHIP through December 2028.

Strategies/Activities:

- Develop a quarterly system to collect partner events (e.g., via email submissions, shared calendar, or coalition meeting updates).
- Share events through the Health Department's and Health Coalition's Facebook page, website, and flyers posted in high-traffic community locations.
- Highlight one partner activity per quarter on the Health Coalition's social media page.

Performance Measures/Indicators:

- Number of partner activities promoted annually (target: 12).
- Communication reach (social media impressions, flyer distribution). (baseline to be established Year 1)
- Number of community partners utilizing the promotion system (baseline Year 1; target: increase annually).

Reporting and Accountability

Implementation activities for this CHIP will be conducted continuously throughout the year in collaboration with community partners. To ensure accountability and transparency, progress will be formally reported each December. Reports will summarize accomplishments, barriers, and performance measures for each priority area, and will be shared with the Marshall County Health Coalition, governing entities, and community partners. This annual review process provides an opportunity for continuous quality improvement, ensuring that strategies remain responsive to community needs and aligned with the goals of the CHIP.

For additional copies or questions, please contact the Marshall County Health Department at 270-527-1496

Marshall County Health Coalition

Holding the Fabric of a Healthy Community Together!

Planned Approach To Community Health