2022 Community Health Needs Assessment

Highlands ARH Regional Medical Center

5000 KY-321, Prestonsburg, KY 41653 | Phone: (606) 886-8511

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This Community Health Needs Assessment (CHNA) report was prepared for Highlands ARH by the Community and Economic Development Initiative of Kentucky (CEDIK) at the University of Kentucky. CEDIK staff Melody Nall, Mercedes Fraser, Simona Balazs, Jennifer Clobes, Sarah Bowker and Alison Davis contributed to the information in this final report.

CEDIK works with stakeholders to build engaged communities and vibrant economies.
If you have questions about the assessment process, contact Melody Nall, CEDIK Extension Specialist Administrator: melody.nall@uky.edu or (859) 218-5949.

College of Agriculture, Food and Environment
Community and Economic Development Initiative of Kentucky
cedik.ca.uky.edu

Dear Community Member:

Appalachian Regional Healthcare has had a longstanding mission to *"promote the well-being of all people in Central Appalachia in partnership with our communities."*

Improving personal health and building healthier communities is about more than the care that is provided at the doctor's office or the hospital. To bring about true change and improvement requires listening to the needs of our community members and providing them with easily accessible opportunities to become healthier.

As ARH moves through its sixth decade of providing care, we are focusing on really putting our organizational mission into action by prioritizing overall wellness through an emphasis on preventative health screenings and good nutrition to improve the lives of the people we serve. To better meet the needs of these residents we asked the community to share their health concerns through surveys and focus groups during the 2022 Community Health Needs Assessment (CHNA).

The CHNA is an excellent opportunity for our community members to educate us on the health needs in their own homes, schools, and neighborhoods.

We use these results, along with secondary data collected by the Community and Economic Development Initiative of Kentucky (CEDIK) at the University of Kentucky, to help us to identify areas where we can better provide access to care, educate the community about healthy behaviors to reduce risk and symptoms of diseases, and provide resources that alleviate barriers to receiving care.

Within this report, you will find the community health goals identified based on this assessment for Highlands ARH Regional Medical Center for the next three years and our implementation successes from the last assessment completed in 2019.

We hope that this assessment will be used as a tool for our community, area leaders, and other organizations. Together, we can guide the appropriate use of resources and partner for new, innovative health initiatives to help build a healthier future for eastern Kentucky and southern West Virginia.

Sincerely,

Hollie Phillips

Hollie Phillips, MHA
President and Chief Executive Officer
Appalachian Regional Healthcare, Inc

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Introduction

Appalachian Regional Healthcare (ARH), the Healthcare System of Appalachia, and ranked as one of the Top 10 Employers in Kentucky by Forbes Magazine, is a not-for-profit health system operating 14 hospitals in Barbourville, Hazard, Harlan, Hyden, Martin, McDowell, Middlesboro, Paintsville, Prestonsburg, South Williamson, West Liberty and Whitesburg in Kentucky; as well as Beckley and Hinton in West Virginia, as well as multi-specialty physician practices, home health agencies, home medical equipment stores and retail pharmacies.

MISSION

To improve health and promote well-being of all people in Central Appalachia in partnership with our communities.

VISION

ARH will be the premier destination for quality care, a driver of advancement and development, and a leader in health for the communities we serve.

VALUES

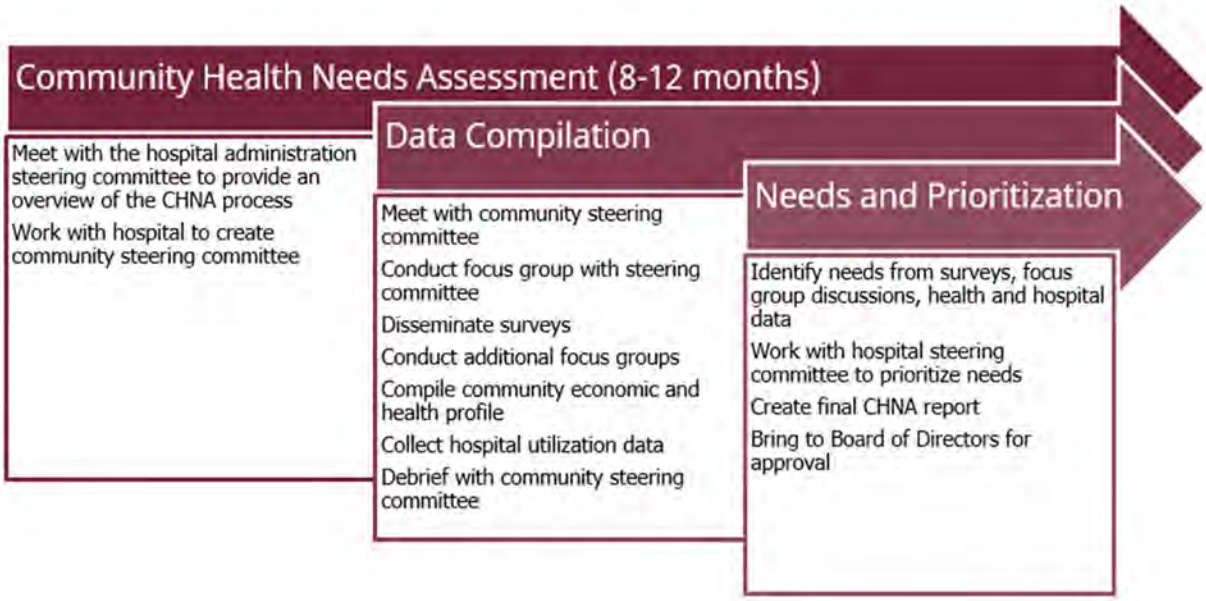
- Trust
- Innovation
- Collaboration
- Compassion
- Service

CHNA Process

Appalachian Regional Healthcare contracted with the Community and Economic Development Initiative of Kentucky (CEDIK) in the fall of 2021 to conduct a Community Health Needs Assessment (CHNA) for Highlands ARH in accordance with the Affordable Care Act. The Affordable Care Act, enacted March 23, 2010, added new requirements that hospital organizations must satisfy in order to be described in section 501(c)(3), as well as new reporting and excise taxes.

The IRS requires hospital organizations to complete a CHNA and adopt an implementation strategy at least once every three years. This CHNA was the fourth prepared by CEDIK for this organization; prior reports were completed in 2013, 2016 and 2019.

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



Highlands ARH Regional Medical Center

Appalachian Regional Healthcare

2019 community health needs... addressed!

✓ Goal: Provide additional health care after office hours and during office hours, by use of after hours clinics and telemedicine in our most rural service areas.

We opened an after hours clinic in Prestonsburg in Summer 2019 and expanded hours in Fall 2019. After hours clinic is still operational in Prestonsburg and numerous other clinics in the service area.

Although telemedicine is not available in Martin County Schools through ARH, we contracted to provide telemedicine to students and staff in Floyd County schools beginning in the 2021 school year.

Highlands ARH Regional Medical Center has improved access for community members in a number of ways. We have added beds for Inpatient Behavior Health services, as well as created a behavioral health wing so that patients no longer are held in ER. Our Emergency Department has remodeled triage and improved ER flow and wait times by implementing an alert system that goes to all managers.

We are pleased to report the addition of specialists including endocrinology, urology, gynecologic oncology, and teleneurology. We have added providers in orthopedics, anesthesiology, and ophthalmology. We have increased telemedicine availability during the COVID-19 pandemic. Highlands ARH has hired three care navigators that assist patients who are not able to afford prescriptions or need specialty care.

We have opened a drive-thru pharmacy, pharmacy delivery service, as well as a new specialty pharmacy. Retail pharmacies have been added in Harold and Martin.

Our lab services have been expanded, and ARH has leased numerous clinic spaces to community partners for their own growth and patient access.

We have implemented the Meditech EMR system for better communication between ARH clinics and hospitals.

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✓ Goal: Combat chronic disease through education, community screenings and patient centered approaches.

The Chronic Care Management Clinic was given new offices in the expanded pharmacy to better facilitate the growing program and increased patient volume. One pharmacist has been assigned to chronic care management at Highlands, and Chronic Care Management Clinic services have been expanded to Paintsville, Harold, and Martin areas. The scope of CCMC services was also broadened, with virtual visits added.

Pharmacy has added care navigators that enroll patients in programs with drug companies to cover costs of medicines they cannot afford or need assistance with. Pharmacy also has agreements with ARH cardiologists that assist in treatments of cardiac conditions such as aFib.

A System Diabetes Coordinator was hired to offer Diabetes Self Management Education in one-on-one sessions with patients. Although diabetes support groups had to stop during the COVID-19 pandemic, support groups were held in fall 2019 with 34 attendees. Diabetes awareness and education was also taught by Highlands ARH Youth Health Ambassadors in all presentations to elementary school students. Highlands is an active participant in the Big Sandy Diabetes Coalition and the Floyd County Diabetes Coalition, and has assisted in their planning and implementation of new programs. We have also welcomed a pulmonologist, endocrinologist, and diabetes-focused nurse practitioner to our staff.

✓ Goal: Implementation of employee wellness initiatives within Highlands Regional Medical Center and for area businesses.

Highlands ARH has prioritized efforts to better the health and wellness of employees. We created a walking track around the hospital and implemented a “Walk with a Manager” program. ARH now provides free wellness center memberships for employees and spouses. We have added calorie counts to foods sold in the cafeteria and added a healthy options menu. We created a new farmers market popup program every other week from spring to fall on campus, providing vouchers to the market for employees as prizes and incentives to eat healthy. Our facility has provided system-level health education webinars for staff on the following topics: lung cancer, diabetes, preventative health, heart disease, COVID-19, vaccines, and yoga.

Highlands ARH provided free employee biometrics (cholesterol checks, A1C, blood pressure, stroke screenings, BMI) for Big Sandy Community and Technical College, Appalachian Wireless, Christian Appalachian Project, Big Sandy RECC, Passport Health Plan, and Foothills Communications. We have provided COVID vaccination clinics for Floyd County School staff and teachers, Big Sandy RECC, Community Trust Bank, and at all high school open houses in the county.

Prior to COVID shutdown, offered lunch and learns at area businesses for their employees, including a quarterly event at Christian Appalachian Project and multiple events at Foothills Communications.

✓ Goal: Address the community's greatest health needs through education, outreach, support, and community partnerships.

Highlands ARH has participated in 10 community coalitions and councils, including those that work to decrease overdose deaths, prevent youth substance abuse, work to instate smoke-free environments, and educate on the risks of alcohol, tobacco, and prescription drug abuse.

In 2019 alone, Highlands ARH provided 793 free health screenings at 19 community events, including our free mammogram events (Mamms Day Out), Highlands Community Health Fair, and biometric screenings for area businesses. We provided 47 health educational classes or events with over 1300 attendees, including Youth Health Ambassador Presentations, Expressions of Courage cancer education to high school students, and lunch and learns for area businesses. Our staff planned and facilitated the Eastern Kentucky Maternal and Child Health Conference for the second time. We organized 6 disease awareness events, including Think Pink for breast cancer, Ladies in Red for women's heart health, and Colon Cancer Awareness Day. ARH hosted 10 support groups for diabetes.

Highlands ARH invites community members to the facility to share important health information.

Our facility conducts a Community Health Needs Assessment every three years. We are excited to share our progress from the last assessment, as we prioritize our next goals based on recent community input.

Thank you for your continued support of Highlands ARH Regional Medical Center.

Tim Hatfield
Highlands ARH Regional Medical Center Community CEO

Community Served by Highlands ARH

Highlands ARH determined its defined service area for this Community Health Needs Assessment by reviewing inpatient discharge data by county of residence in years 2020 and 2021. In 2020, eighty-three percent (83%) of Highlands ARH inpatients originated from Floyd County and in 2021, eighty-two percent (82%) of inpatients served were residents of Floyd County. These figures come from the Kentucky Hospital Association's market assessment data.

In this section publicly available data are presented for Floyd County. These data come from the *County Health Rankings & Roadmaps* website (https://www.countyhealthrankings.org/), *Kentucky Health Facts* website (https://www.kentuckyhealthfacts.org/). These data sites provide social, economic, and health data that is intended for use by communities to understand the multiple factors that influence a population's health. These data were accessed in March and April 2022.

Next, to provide more context to the ongoing health of the community, we present five year data trends (2016-2020) for Floyd County alongside the state average. These data come from the *County Health Rankings & Roadmaps* website and include selected health outcomes, health behaviors, and access to care as well as social, economic, and environmental factors that impact the health of Floyd County residents.

Last, we present recent data on invasive cancer incidence from the Kentucky Cancer Registry.

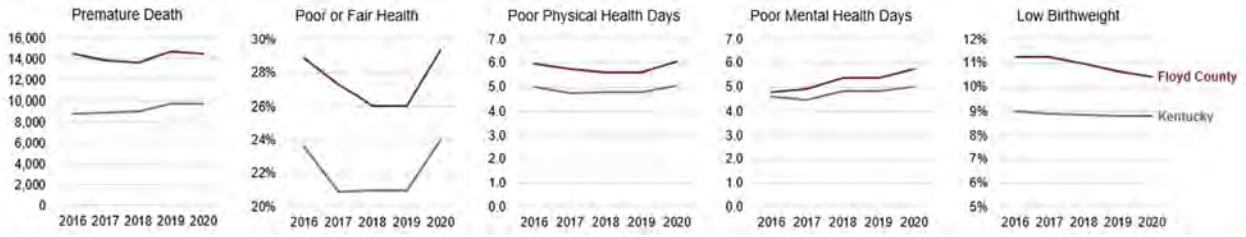
Population	Floyd County	Kentucky	US Overall
2019 Population	35,589	4,467,673	328,239,523
Percent of Population under 18 years	21.9%	22.4%	22.3%
Percent of Population 65 year and older	18.8%	16.8%	16.5%
Percent of Population Non-Hispanic Black	1.1%	8.2%	13.4%
Percent of Population American Indian & Alaska Native	0.2%	0.3%	1.3%
Percent of Population Asian	0.3%	1.6%	5.9%
Percent of Population Native Hawaiian/Other Pacific Islander	0.0%	0.1%	0.2%
Percent of Population Hispanic	0.9%	3.9%	18.5%
Percent of Population Non-Hispanic White	96.8%	84.1%	60.1%
Percent of Population not Proficient in English	0.2%	1.0%	8.3%
Percent of Population Female	51.2%	50.7%	50.8%
Percent of Population Rural	83.9%	41.6%	14%

Health Outcomes	Floyd County	Kentucky	US Overall
Years of Potential Life Lost Rate	14181	9505	6900
Percent Fair or Poor Health	31%	22%	17%
Average Number of Physically Unhealthy Days	6.5	4.6	3.7
Average Number of Mentally Unhealthy Days	6.4	5.0	4.1
Percent Low Birthweight	11%	9%	8%
Health Behaviors			
Percent Adults that are Diabetic	25.7%	13.3%	13%
Percent Adults with Hypertension	58.3%	40.1%	47%
Percent Adults with Tooth Loss	34.1%	22.6%	-
Percent Adults Consuming Recommended Fruit & Vegetable Intake	15.6%	12.1%	12.3%
Percent Smokers	29%	24%	17%
Percent Adults with Obesity	41%	35%	30%
Food Environment Index	6.2	6.9	7.8
Percent Physically Inactive	40%	29%	23%
Percent with Access to Exercise Opportunities	48%	71%	84%
Percent Excessive Drinking	13%	17%	19%
Percent Driving Deaths with Alcohol Involvement	10%	25%	27%
Chlamydia Rate	193.0	436.4	539.9
Teen Birth Rate	58	31	21
Access to Care			
Percent Uninsured	7%	7%	10%
Number of Primary Care Physicians	21	2,895	-
Primary Care Physicians Rate	59	65	-
Primary Care Physicians Ratio	1707:1	1543:1	1320:1
Number of Dentists	24	2,996	-
Dentist Rate	67	67	-
Dentist Ratio	1483:1	1491:1	1400:1
Number of Mental Health Providers	857	10,733	-
Mental Health Provider Rate	2408	240	-
Mental Health Provider Ratio	42:1	416:1	380:1

Social & Economic Factors	Floyd County	Kentucky	US Overall
Percent Completed High School	75%	86%	88%
Percent with Some College Education	47%	62%	66%
Number Unemployed	708	89,014	-
Number in Labor Force	11,048	2,072,597	-
Percent Unemployed	6.4%	4.3%	3.7%
80th Percentile Income	$70,954	$101,776	-
20th Percentile Income	$12,088	$20,248	-
Percent of Children in Poverty	34%	21%	17%
Number of Children in Single-Parent Households	2,184	265,296	-
Number of Children in Households	7,822	1,005,667	-
Percent of Children in Single-Parent Households	28%	26%	26%
Number of Associations	24	4,732	-
Social Association Rate	6.7	10.6	9.3
Annual Average Violent Crimes	20	9,824	-
Violent Crime Rate	52	222	386
Number of Injury Deaths	216	21,274	-
Injury Death Rate	118	96	72
Physical Environment			
Average Daily PM2.5	9.2	8.7	7.2
Presence of Water Violation	Yes	n/a	n/a
Percent with Severe Housing Problems	16%	14%	18%
Percent with Severe Housing Cost Burden	14%	11%	14%
Percent with Overcrowding	3%	2%	-
Percent with Inadequate Facilities	1%	1%	-
Percent that Drive Alone to Work	88%	82%	76%
Number of Workers who Drive Alone	10,359	1,949,184	-
Percent with Long Commute - Drives Alone	31%	31%	37%

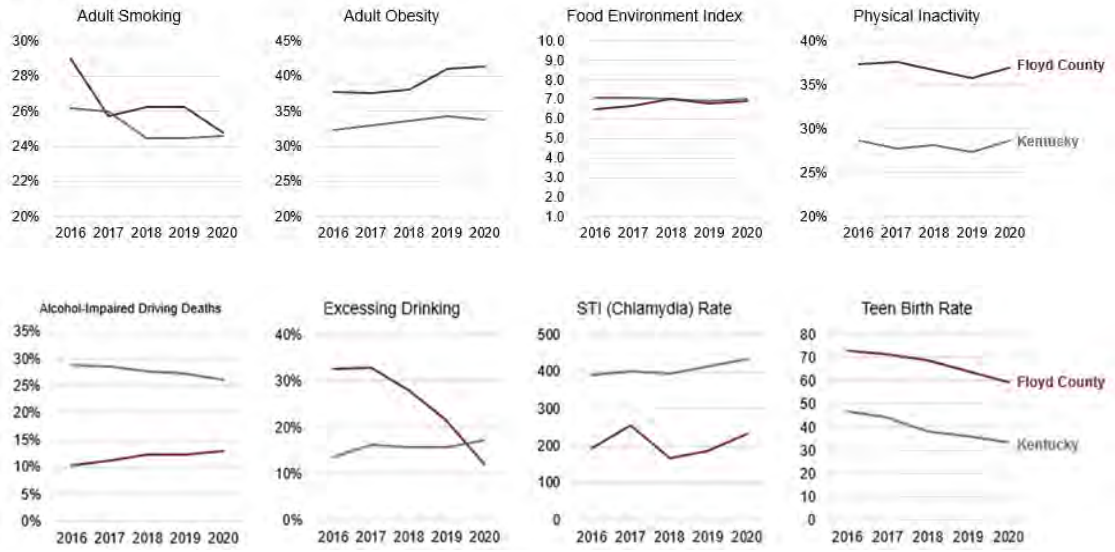
2016-2020 County Health Rankings Data Trends

Health Outcomes



- The middle three variables are based on self-reported data from BRFSS (Behavioral Risk Factor Surveillance System). All three are on an upward trend for the County.
- The County's low birthweight is on a downward trend.

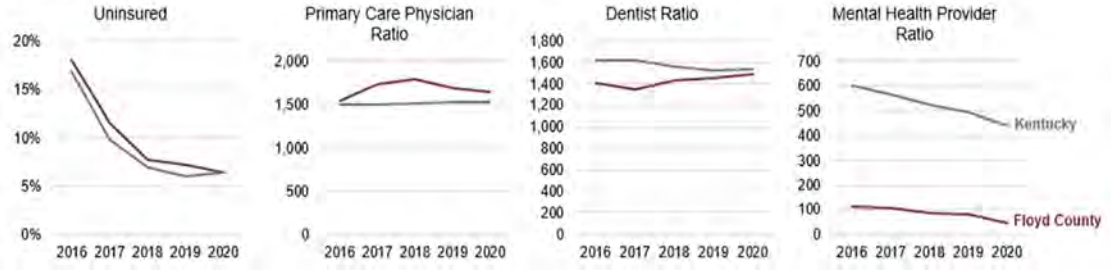
Health Behaviors



- Adult smoking in the County higher than the state, however is on a downward trend.
- Adult obesity in the County is trending upward and at a faster pace than the state trend.
- The higher the number on the USDA Food Environment Index (1-10) the better the Food Environment. The County has an improved score on the index over the five year trend.
- The County's rate of physical inactivity is higher than the state, and follows the state trend.
- There is a slight upward trend in alcohol-impaired driving deaths in the County.
- The data for excessive drinking in the County are trending downward.
- STI infections in the County are on a slight upward trend.
- The County's teen birth rates are trending downward.

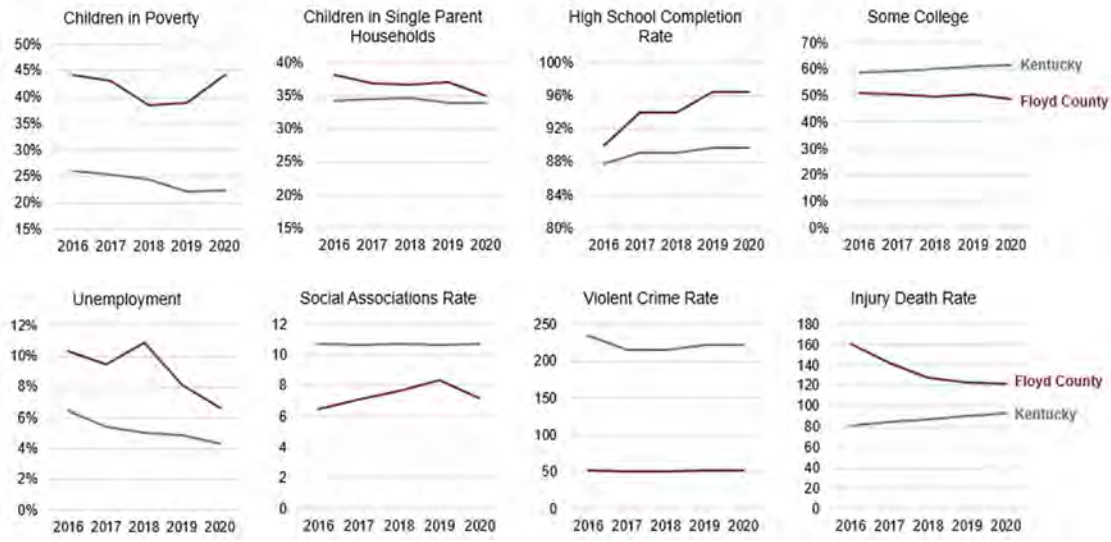
2016-2020 County Health Rankings Data Trends, continued

Access to Care



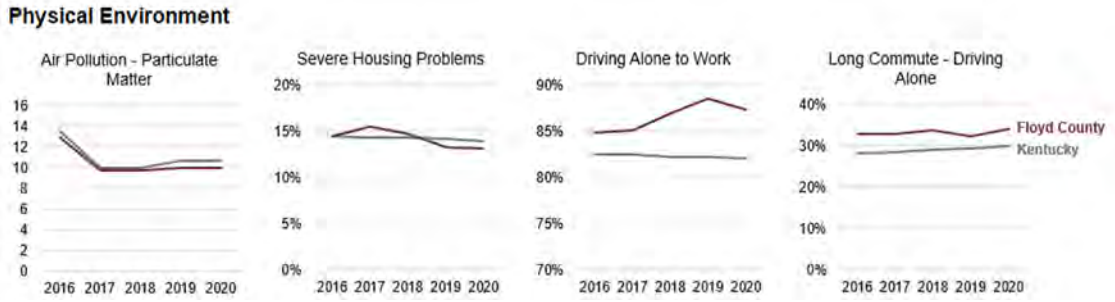
- The County's ratio of dentists and mental health providers is lower (more providers for population) compared to the state average. The County has a higher ratio of primary care physicians compared to the state average.
- County uninsurance rates are on par with the state.

Social & Economic Factors



- The County has a higher percentage of children in single parent households and in poverty compared to the state average. The year-to-year shifts in children in poverty make it difficult to pinpoint an overall trend. Children in single parent households appears to be trending downward for the County.
- County high school completion rates are above the state average, and percent of the County population with some college education is on a steady trend.
- While the unemployment rate is higher in the County, compared to the state, the rate of decline has accelerated (pre-pandemic).
- The County's rate of social associations has an overall upward trend.
- The County's violent crime rate is lower than the state average and has a steady trend.
- The County's injury death rate is higher than the state and has a downward trend.

2016-2020 County Health Rankings Data Trends, continued



- Air pollution in the County follows the state trend.
- The County's percentage of population with severe housing problems is on a downward trend.
- The County population driving alone to work has an overall upward trend, while the County population making long commutes driving alone is on a slight upward trend.

Top 10 Invasive Cancer Incidence Rates

All Genders, All Races	Floyd County	Crude Rate	Age-adjusted Rate
Total all sites over 5 years (2014-2018)	1472	797.3	622.4
Lung & Bronchus	336	182	129.5
Prostate (Males only)	133	147.3	112.5
Breast	180	97.5	80.4
Colon & Rectum	155	84	68.4
Corpus Uteri (Females only)	49	51.9	37.9
Kidney & renal pelvis	65	35.2	27.2
Thyroid	42	22.8	22.8
Melanoma of the Skin	49	26.5	22.8
Miscellaneous	48	26	21.9
Cervix uteri (Females only)	21	22.2	20.1

Note: All rates are per 100,000 population. All rates are age-adjusted to 2000 US Standard Million Population.

Hospital Utilization Data

The Tables below provide an overview of Highlands ARH's patients and in particular how they pay, and why they visited.

Hospital Usage, 1/1/2020 - 12/31/2020

Patient Status	Total
Inpatient Discharges	4,333
Outpatient Visits	68,748

Hospital Inpatient Payer Mix, 1/1/2020 - 12/31/2020

Payer	Discharges
Medicare (Excluding Medicare Managed Care)	1959
WellCare of Kentucky Medicaid Managed Care	723
Commercial - Anthem Health Plans of KY PPO Plan	413
Out of State Medicaid	263
Commercial - Other	239
Aetna Better Health of KY Medicaid Managed Care	227
In State Medicaid	154
Medicare Managed Care	117
Humana Medicaid Managed Care	57
Commercial - Anthem Health Plans of KY HMO Plan	39
Anthem Medicaid Managed Care	34
Passport Medicaid Managed Care	27
Other Facility	19
Tricare (Champus)	15
Self Pay	12
Commercial - United Healthcare POS Plan	8
Commercial - Aetna Health HMO Plan	7
Workers Compensation	6

Hospital Outpatient Payer Mix, 1/1/2020 - 12/31/2020

Payer	Visits
Medicare (Excluding Medicare Managed Care)	26462
WellCare of Kentucky Medicaid Managed Care	12483
Commercial - Anthem Health Plans of KY PPO Plan	11083
Aetna Better Health of KY Medicaid Managed Care	3729
Commercial - Other	3338
Out of State Medicaid	2796
Medicare Managed Care	2576
In State Medicaid	2154
Commercial - Anthem Health Plans of KY HMO Plan	894
Humana Medicaid Managed Care	648
Passport Medicaid Managed Care	508
Workers Compensation	381
Anthem Medicaid Managed Care	374
Commercial - United Healthcare POS Plan	294
Self Pay	203
Commercial - Humana PPO Plan	161
Other Facility	141
Tricare (Champus)	108
Care Source KY Commercial Plan	74
Commercial - Aetna Health HMO Plan	73
Commercial - Cigna Health & Life FFS Plan	56
Black Lung	46
Auto Insurance	45
Commercial - Aetna Health PPO Plan	40
Wellcare Health Commercial Plan	34
VA	29
ChampVA	16
Commercial - Wellcare Health Plans of KY HMO Plan	2

Hospital Inpatient Diagnosis Related Group, 1/1/2020 - 12/31/2020

DRG Description	Discharges
Psychoses	482
Vaginal delivery	303
Septicemia	191
Heart failure & shock	171
Simple pneumonia & pleurisy	161
Respiratory infections & inflammations	151
Cesarean section	141
Chronic obstructive pulmonary disease	126
Renal failure	118
Major joint replacement or reattachment of lower extremity	97

Community Steering Committee

The Community Steering Committee plays a vital role to the CHNA process. CEDIK provides a list of community leaders, agencies, and organizations to the hospital to assist them in the recruitment of members that facilitates broad community input.

These committee members represent organizations and agencies that serve the Floyd County population in a variety of areas that relate to the health of the population. By volunteering their time, the committee members enable the hospital to acquire input from residents that are often not engaged in conversations about their health needs. The steering committee provides both an expert view of the needs they see while working with the people and clients they serve and in extensive distribution of the community survey. Conducting this assessment during the COVID-19 pandemic added new challenges in accessing community input, however the community steering committee committed to the process both with promoting the survey through social media and encouraging organizations to share through email channels.

Floyd County is the location of three ARH facilities: Highlands ARH, McDowell ARH, and Our Lady of the Way ARH. Hospital leadership decided to have a joint steering committee and one community health needs survey for all Floyd ARH hospitals. ARH leadership in each community made recommendations for members to represent their community on the steering committee. CEDIK representatives scheduled and completed the first meeting on November 12, 2021 to introduce the assessment process, share the role of a committee member and to lead a focus group. A final steering committee meeting was held April 5, 2022, for the report of survey, focus group and key informant interview results along with selected secondary health data to inform and guide the prioritization process of the identified health needs. This resulted in the community steering committee making recommendations on the priority health needs for Highlands ARH to address over the next three years.

Floyd County Community Steering Committee

Name	Representing Organization
Andrea Slone	Floyd County UK Extension, Family and Consumer Science Agent
Bethany Pigman	Floyd County Health Department Dietitian
Christina Tincher	Floyd County Health Department Community Program Manager
Christy Hicks	Mountain Comprehensive Care Center, Addictions Program Director
Tiffany Hall	ARH Big Sandy Director of Behavioral Health
Missy Allen	Floyd County Fiscal Court
Kim Grubb	Floyd County Early Childhood, Director
Katherine Moore	ARH Our Lady of the Way, Chief Nursing Officer
Susan Ellis	Highlands ARH, Chief Nursing Officer
Libbi Hall	Community Advocate
Keith Hackworth	Floyd County UK Extension, Agriculture & Natural Resources Agent
Rebial Reynolds	Prestonsburg Elementary FRC
Jessica Hall	Big Sandy Region Clinic Administrator, ARH
Brittany Blankenship	Social Worker, ARH

Community Feedback

In November 2021, members of the Floyd County ARH facilities, including Highlands ARH, CHNA steering committee participated in a focus group for this community health needs assessment. The committee membership includes representation from the health department, behavioral health, public schools, family resource centers, cooperative extension, and community-based services. The members bring knowledge and expertise related to health needs of the populations they serve.

An additional five focus groups were conducted with the Floyd County Chamber of Commerce, Head Start program parents and staff, the Elder Maltreatment council, and a group of Prestonsburg High School students over a three-month time frame. Two key informant interviews were completed in early 2022. What follows is a summary of the responses that highlights the results of the conversations that identify strengths of the community and the healthcare system, challenges/barriers in the broader healthcare system and opportunities for improving the health of the community.

Focus Group Findings

Qualitative analysis of focus group responses revealed overarching themes across the focus groups. Findings across all groups consistently underscored challenging experiences that not only hindered community ability to access services, but also the need for expanded services. The key findings from each of the 5 questions posed to the focus groups are listed below:

- The community's vision for a healthy Floyd county involves community engagement, healthy lifestyles, and access to healthcare.
- The greatest health needs in Floyd County involve chronic diseases, unhealthy behaviors, and access to care. Social determinants of health particular to Floyd County heavily impact the community's view of the greatest health needs.
- Regarding the greater healthcare system, defined as hospital, health department, EMS, clinics, housing and food access; there is a comprehensive system in place that collaborates often, but there is still need for expanded access.
- To better meet health needs in Floyd County, there should be a healthcare approach and a community approach.
- There were positive and negative lasting impacts of COVID-19 on the community.

Finding 1: The community's vision for a healthy Floyd County involves community engagement, healthy lifestyles, and access to healthcare.

Focus group responses that contributed to this finding are listed below.

Community engagement

- Good jobs/wages/ insurance
- Good economy
- Safe community
- Good schools
- Engaged residents and elected leaders
- Clean communities and roadsides
- Improved broadband and affordable internet access
- Safe, affordable housing
- Recreation, affordable

Healthy lifestyles

- Healthy food choices
- Affordable, healthy food options
- Focus on prevention of disease
- Walking trails and indoor tracks
- Sportsplex for recreation Parks
- Social and physical activity for all ages

Access to health care

- Good hospitals and physicians
- Substance use prevention and treatment
- Reduced stigma for those seeking treatment for mental health issues and those in recovery from substance use disorders
- Increased health care workforce

Finding 2: The greatest health needs in Floyd County involve chronic diseases, unhealthy behaviors, and access to care. Social determinants of health particular to Floyd County heavily impact the community's view of the greatest health needs.

Focus group responses that contributed to this finding are listed below.

Unhealthy behaviors

- Tobacco use – smoking & chewing
- Vaping
- Lack of healthy, affordable foods
- Lack of healthy food preparation & nutrition knowledge
- Lack of exercise
- Hygiene – students may not have resources or knowledge
- Apathy about health care/ self care

Access to care

- Costs
- Long wait times for appointments
- Affordable vision & dental
- Substance use treatment
- Transportation
- Specialists
- EMS staffing shortages

Chronic disease

- Mental Health
- Diabetes
- Obesity – adult and child
- Heart disease
- COPD & lung diseases
- Cancer
- Substance use disorder

Social determinants of health particular to Floyd County that impact the greatest health needs in the community are:

Food Insecurity

There are many reasons for food insecurity in the community, and while some resources are available, not everyone is aware of them. The elderly, including those grandparents raising grandchildren, are particularly affected by this issue.

Economic Needs

The community is in need of economic development regarding job availability, workforce training, and efforts to retain youth.

Childcare

There is a current shortage of affordable childcare available in the community.

Transportation

Transportation to and from essential services, including healthcare is a barrier for people.

Housing

Homelessness is an issue. There is a need for quality, safe housing for lower to mid income families/individuals in Floyd County.

Finding 3: Regarding the greater healthcare system, defined as hospital, health department, EMS, clinics, housing and food access; there is a comprehensive system in place that collaborates often, but there is still need for expanded access.

Focus group responses that contributed to this finding are listed below.

Opportunities for System

- Mental health – youth counselors, more providers
- EMS – staffing shortage, lack of vehicles
- Transportation – public and medical
- Mobile health unit for smaller communities
- Health care navigators – insurance, clinics and hospitals
- Specialists – dermatology, vascular, rheumatologists, pediatrics, dentists
- Emphasis on prevention, preventative care & education
- Aftercare for long term recovery
- Support groups
- Retain current health care workforce
- Health care staffing shortages – nurses, EMS and some physicians

Strengths of System

- Organizations work together – hospitals & health department
- Telehealth
- Air ambulance
- Local food banks
- Access to care has been much improved
  - More primary care providers
  - More specialists
- Family Resource Centers – “amazing work!”
- 3 hospitals in our county - all in ARH network
- ARH working with Farmer’s Markets for fresh food availability

Finding 4: To better meet health needs in Floyd County, there should be a healthcare approach and a community approach.

Focus group responses that contributed to this finding are listed below.

Healthcare

- Retain healthcare providers – increases patient trust
- Increase mental health providers
- Drug treatment/detox/aftercare/long term recovery assistance
- Case manager/health navigator for primary care and follow up questions
- Recruit and retain more specialists – reduces travel and time away from work
- Telehealth
- Hospitals take education/screenings to communities
- Diabetes education and care – add endocrinologist
- One stop shop clinics – appointments and care in one location
- Resources and care for autism

Community

- Public transportation – for medical appointments, grocery, pharmacy
- Community resource education/promotion
- Increased healthy food options – affordable
- Nutrition education and cooking classes
- Community mental health education – reduce stigma, Mental Health First Aid
- Gym memberships – reduced cost
- Sportsplex or YMCA – indoor walking tracks
- More support for seniors and caregivers
- Support groups – grandparents raising grandchildren, chronic diseases
- Community gardens and ”how to garden” education

Finding 5: There were positive and negative lasting impacts of COVID-19 on the community.

Focus group responses that contributed to this finding are listed below.

Positives

- Communities came together to work together – brought out the best in people
- County officials, sheriff’s department and volunteer fire dept. provided well checks on elderly, home visits, food delivery
- Telehealth
- Technology – changed work, not necessary to travel for meetings
- More time at home with family – families slowed down, family dinners, gardening and cooking together
- “Don’t take the important things in life for granted.”
- Appreciate health care workers and teachers more
- Entrepreneurship and creativity – work pivoted

Negatives

- Mental health – depression, isolation, anxiety, difficulty with concentration (all ages)
- Schools and children – NTI difficult, isolation, anxiety, education and developmental delays, teacher stress and burn out
- Elderly – isolation, depression, fear, more shut ins as some haven’t left home in 2 years
- Grief – lost loved ones to COVID Increased substance use
- Postponed health screenings and health care
- Short staffed in health care – nurses, physicians, hospital staff leading to burn out and retirements
- Remote work – stacked meetings, no down time
- Social impact on other services – ex. Foster care – reduced placements
- Schools are “Safe Space” for many children – not being there didn’t allow eyes on students

Key Informant Interviews

As a mechanism to examine needs that surfaced in focus group discussions, hospital leadership and the CHNA steering committee provided contact information for key informant interviews to be conducted. One key informant was a city official, and the other was a leader in a regional health organization. A summary of their responses are below.

Challenges Faced by Residents

- The community is in need of economic development regarding jobs with a living wage.
- Residents feel isolated due to the geography of Eastern Kentucky.
- Substance use is an issue in the community.
- Smoking and cancer rates are very high in the area.
- There is a current shortage of paramedics and EMTs.
- The community would benefit from additional EMS providers.
- The community has not embraced a culture of wellness yet, there are still many unhealthy behaviors.
- The aging population faces many struggles, including technology.
- Transportation to essential services and specialty care is a barrier.
- There is a lack of knowledge on resources available to community members.
- Community members suffer from food insecurity and lack of access to healthy foods.
- There is sub-optimal housing available for all income levels.
- There is a lack of mental health providers and resources in the area. This includes psychiatric care.

Opportunities to Better the Healthcare System

- Additional sub-specialties, such as neurology, would benefit the community.
- Residents need more affordable housing.
- Education, including information on available resources, wellness, and prevention, is needed.
- Transportation to services.
- Improved access and experiences for elderly patients.

Strengths of the Community Healthcare System

- The community has collaborative organizations.
- School nurses provide access to medical care for children.
- ARH has invested in its facility and continues to invest in the community.
- There has been an increase in the healthcare base. More physicians are coming back to the community to practice and there has been an increase in specialty care.

Floyd County Survey Results

WINTER 2022

Respondent Demographics

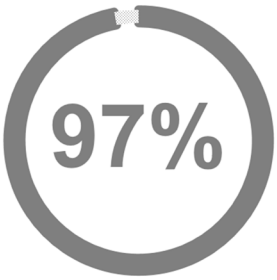
1,324 Respondents

Respondents are female.

Additional responses: Male (21%), Prefer not to answer (2%).

Respondents by age group:

18-24	2%
25-39	15%
40-54	33%
55-64	29%
65-69	11%
70 or older	10%

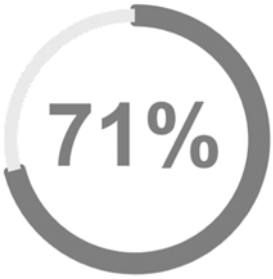


Respondents are white.

Additional responses: African American/Black (1%), Native American (1%), Other (1%).

Respondents by educational attainment:

College or above	57%
High School	28%
Technical school	9%
Other	3%



Respondents are living in their own home/ apartment.

Additional responses: Living with family (parent(s), guardian, grandparents or other relatives) (27%), Staying with someone I know (1%).

Respondents by employment status:

Employed full-time	50%
Retired	28%
Unemployed	11%
Employed part-time	5%
Student	1%
Other	6%

Where respondents go for routine healthcare:

Go to a Physician's office or their family doctor.

Respondents also use these options:

Emergency Room	9%
Urgent Care	7%
Health Department	2%
Do not receive routine healthcare	2%
Other	3%

Other providers due to insurance.

Barriers that keep respondents from receiving routine healthcare:

Do not have barriers that keep them from receiving routine healthcare.

Respondents identified these barriers:

Only visit doctor when something is seriously wrong	16%
Inconvenient Physician hours	10%
Cannot take off work	8%
Cannot afford it	6%
Fear/anxiety	5%
Poor Physician attitude/communication	5%

Other responses: No insurance (2%), No transportation (2%), Lack of childcare (2%) Respondents identified another 5% of barriers: no specialist, insurance not accepted, difficult to see the doctor.

Transportation to healthcare:

Travel more than 20 miles to see a specialist.

Respondents chose from these options:

Less than 20 miles	25%
20-49 miles	31%
50-100 miles	35%
Do not receive routine healthcare	2%

89% of respondents use their own vehicle, while 9% travel in a friend/family vehicle.

The top three health challenges respondent households face:

High blood pressure	21%
Arthritis/joint pain	15%
Diabetes	14%
Overweight/obesity	12%
Mental health issues	8%
Heart disease and stroke	7%
Respiratory/lung disease	5%
Cancer	4%
Tobacco use/vaping	3%
Asthma	3%
Substance use disorder (alcohol/drugs)	1%
HIV/AIDS/STDs	0.1%
Other	5%
Thyroid issues, anxiety/depression, kidney disease, autoimmune disorder, chronic pain	

Respondent households have delayed healthcare because of lack of money and/or insurance.

Respondent household eligibility:

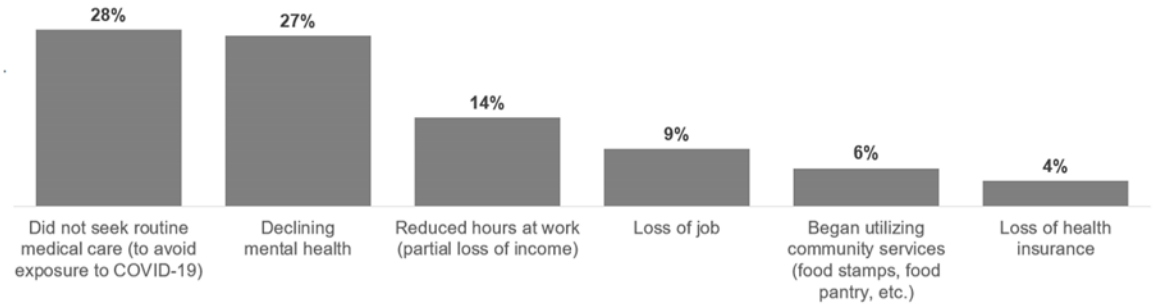
Medicare	33%
Medicaid	22%
Public Housing Assistance	3%
SNAP (Food stamp program)	11%
VA	3%
Commercial/private insurance	27%

Respondents used video calls (telemedicine) to see a provider in the last 12 months.

Specialty care services respondents are willing to use telemedicine:

Mental/Behavioral Health	20%
Cardiology	14%
Dermatology	13%
Gastroenterology	10%
Endocrinology	9%
Urology	8%
Pediatrics	7%
Pulmonology	6%
Oncology	6%
Nephrology	6%

Respondent household impacts due to COVID-19 pandemic:



Respondents identified another 9% of impacts due to COVID-19: isolation/anxiety and depression, loss of loved ones to COVID, overworked, loss of housing, postponed health care, less recreational activities/weight gain. 2% reported no impact.

The top three most important factors for a healthy community:

Easy to access healthcare	16%
Good jobs/healthy economy	15%
Low crime/safe neighborhood	13%
Good school systems	12%
Good place to raise children	10%
Religious/spiritual values	9%
Affordable housing	7%
Personal responsibility	5%
Community activities and events	3%
Transportation	3%
Low disease rate	2%
Parks and recreation	2%
Excellent race relationships	1%
Diverse community	1%

Respondents think Floyd County meets the above factors for a healthy community.

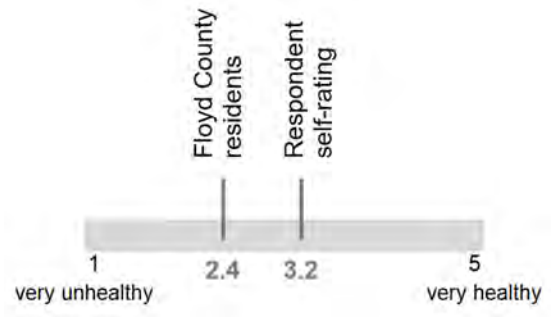
Which health related topics listed would you be interested in learning more about?

Weight loss	21%
Eating healthy	20%
Mental health/Depression	13%
Cancer prevention	10%
High blood pressure	10%
Heart disease	8%
Emergency preparedness	8%
Tobacco cessation	4%
Substance use disorder (alcohol &/or drugs)	3%
Using my medications correctly	2%

The top three risky behaviors seen most in the community:

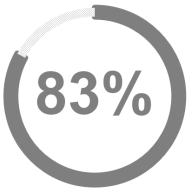
Drug abuse	26%
Being overweight/having poor eating habits and lack of exercise	22%
Tobacco Use	16%
Prescription drug use	15%
Alcohol use	13%
Dropping out of school	5%
Unsafe sex	3%

Respondents rate their own health, and the overall health of their community:



Respondent households have used ARH hospital services in the last 24 months.

Respondents would recommend their local ARH hospital to friends and family.



Respondents are satisfied with the ability to access healthcare services in Floyd County.

Respondent rating of their ARH facility in Floyd County:

Reasons respondents used a hospital other than an ARH facility in Floyd County:

Service I needed was not available	32%
My doctor referred me to another hospital	27%
I prefer larger hospitals	7%
My insurance required me to go somewhere else	6%
Other *Specialist at another hospital, better hospital/ doctors, closer to home/location, after hours clinic closed, billing issues*	28%

What factors influence your health choices?

Family	21%
Listening to physicians and other healthcare providers	21%
Spouse/Partner/Significant other	16%
Friends	10%
Public health recommendations/ guidelines (e.g. CDC)	8%
Weather (seasonal variation)	8%
Community	5%
Other people around me	4%
Access to parks/walking trails	4%
Social media	3%

Where do you get most of your healthcare information?

Doctor/healthcare provider	45%
Internet	22%
Friends/family	13%
Health Department	5%
Local hospital website	4%
Social media	4%
Newspaper/magazines	3%
Radio/television	3%
Library	1%
I do not access health information	1%

Prioritization of Identified Health Needs

Highlands ARH CHNA steering committee meeting was held in March 2022 to review findings from the community surveys, key informant interviews, focus groups and county specific secondary health data.

The process of priority selection followed the Association for Community Health Improvement (ACHI) recommendations to consider:

1. The ability of Highlands ARH to evaluate and measure outcomes.
2. The number of people affected by the issue or size of the issue.
3. The consequences of not addressing this problem.
4. Prevalence of common themes.
5. The existence of hospital programs which respond to the identified need.

CEDIK staff led a facilitated discussion with members of the steering committee after the data presentation and completed the process of prioritizing the identified health needs. The following represent the recommendations of the steering committee to Highlands ARH for addressing health needs in Floyd County and the hospital service area for the next three years.

Prioritized Needs

1. Obesity support related to food insecurity, physical inactivity, and lack of knowledge on healthy foods.
2. Addiction support (includes tobacco).
3. Mental health support.
4. Increasing community, provider, and partner knowledge of services available.
5. Increasing access to care.

Next Steps

Over the next three months, hospital administration, staff, and ARH regional community development managers along with community partners will develop an implementation plan that includes measurable goals, objectives, and action plan to address each identified priority health need in this community health needs assessment.

This Implementation Strategy will be rolled out over the next three years, from Fiscal Year 2022 through the end of Fiscal Year 2024.

Highlands ARH will kick off the implementation strategy by initiating collaborative efforts with community leaders to address each health priority identified through the assessment process.

Periodic evaluation of goals/objectives for each identified priority will be conducted to assure that we are on track to complete our plan as described.

At the end of Fiscal Year 2024, Highlands ARH will review the implementation strategy and report on the success experienced through the collaborative efforts of improving the health of the community.

Appendix

A. Secondary Data Sources

B. Highlands ARH CHNA Survey

C. Board Approval

2021 Secondary Data Sources

Population		Source	Years of Data
2019 Population	Total Population	Census Population Estimates	2019
Under 18 years	Percent of Population 18 years of age	Census Population Estimates	2019
65 years and older	Percent of Population 65 and older	Census Population Estimates	2019
Non-Hispanic Black	Percent of Population Non-Hispanic Black	Census Population Estimates	2019
American Indian & Alaska Native	Percent of Population American Indian & Alaska Native	Census Population Estimates	2019
Asian	Percent of Population Asian	Census Population Estimates	2019
Native Hawaiian/Other Pacific Islander	Percent of Population Native Hawaiian/Other Pacific Islander	Census Population Estimates	2019
Hispanic	Percent of Population Hispanic	Census Population Estimates	2019
Non-Hispanic White	Percent of Population Non-Hispanic White	Census Population Estimates	2019
Not Proficient in English	Percent of Population not Proficient in English	American Community Survey, 5-year estimates	2015-2019
Female	Percent of Population Female	Census Population Estimates	2019
Rural	Percent of Population Rural	Census Population Estimates	2010

Health Outcomes			
Premature death	Years of potential life lost before age 75 per 100,000 population (age-adjusted).	National Center for Health Statistics - Mortality Files	2017-2019
Poor or fair health	Percentage of adults reporting fair or poor health (age-adjusted).	Behavioral Risk Factor Surveillance System	2018
Poor physical health days	Average number of physically unhealthy days reported in past 30 days (age-adjusted).	Behavioral Risk Factor Surveillance System	2018
Poor mental health days	Average number of mentally unhealthy days reported in past 30 days (age-adjusted).	Behavioral Risk Factor Surveillance System	2018
Low birthweight	Percentage of live births with low birthweight (< 2,500 grams).	National Center for Health Statistics - Natality files	2013-2019

2021 Secondary Data Sources, continued

Health Behaviors		Source	Years of Data
Adult diabetes	Percent Adults that are Diabetic	Behavioral Risk Factor Surveillance System	2018-2020
Adult hypertension	Percent Adults with Hypertension	Behavioral Risk Factor Surveillance System	2017-2019
Adult dental health	Percent Adults with Tooth Loss	Behavioral Risk Factor Surveillance System	2016-2018
Food consumption	Percent Adults Consuming Recommended Fruit & Vegetable Intake	Behavioral Risk Factor Surveillance System	2017-2019
Adult smoking	Percentage of adults who are current smokers (age-adjusted).	Behavioral Risk Factor Surveillance System	2018
Adult obesity	Percentage of the adult population (age 20 and older) that reports a body mass index (BMI) greater than or equal to 30 kg/m2.	United States Diabetes Surveillance System	2017
Food environment index	Index of factors that contribute to a healthy food environment, from 0 (worst) to 10 (best).	USDA Food Environment Atlas, Map the Meal Gap from Feeding America	2015 & 2018
Physical inactivity	Percentage of adults age 20 and over reporting no leisure-time physical activity.	United States Diabetes Surveillance System	2017
Percent with Access to Exercise Opportunities	Access to exercise opportunities	Business Analyst, Delorme map data, ESRI, & US Census Tigerline Files	2010 & 2019
Excessive drinking	Percentage of adults reporting binge or heavy drinking (age-adjusted).	Behavioral Risk Factor Surveillance System	2018
Alcohol-impaired driving deaths	Percentage of driving deaths with alcohol involvement.	Fatality Analysis Reporting System	2015-2019
Sexually transmitted infections	Number of newly diagnosed chlamydia cases per 100,000 population.	National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention	2018
Teen births	Number of births per 1,000 female population ages 15-19.	National Center for Health Statistics - Natality files	2013-2019

Access to Care			
Access to Care	Uninsured	Small Area Health Insurance Estimates	2018
	Primary care physicians	Area Health Resource File/American Medical Association	2018
	Dentists	Area Health Resource File/National Provider Identification file	2019
Mental health providers	Mental health providers	CMS, National Provider Identification	2020

2021 Secondary Data Sources, continued

Social & Economic Factors		Source	Years of Data
Education	High school completion	American Community Survey, 5-year estimates	2015-2019
	Some college	American Community Survey, 5-year estimates	2015-2019
Employment	Unemployment	Bureau of Labor Statistics	2019
Income	Children in poverty	Small Area Income and Poverty Estimates	2019
	Income inequality	American Community Survey, 5-year estimates	2015-2019
Family and Social Support	Children in single-parent households	American Community Survey, 5-year estimates	2015-2019
	Social associations	County Business Patterns	2018
Community Safety	Violent crime	Uniform Crime Reporting - FBI	2014 & 2016
	Injury deaths	National Center for Health Statistics - Mortality Files	2015-2019
Physical Environment			
Environmental Quality	Air pollution - particulate matter	Environmental Public Health Tracking Network	2016
	Drinking water violations	Safe Drinking Water Information System	2019
Housing and Transit	Severe housing problems	Comprehensive Housing Affordability Strategy (CHAS) data	2013-2017
	Driving alone to work	American Community Survey, 5-year estimates	2015-2019
	Long commute - driving alone	American Community Survey, 5-year estimates	2015-2019

2016-2020 County Health Rankings Data Sources

Health Outcomes		Source	2016 Data	2020 Data
Premature death	Years of potential life lost before age 75 per 100,000 population (age-adjusted).	National Center for Health Statistics - Mortality Files	2011-2013	2016-2018
Poor or fair health	Percentage of adults reporting fair or poor health (age-adjusted).	Behavioral Risk Factor Surveillance System	2014	2017
Poor physical health days	Average number of physically unhealthy days reported in past 30 days (age-adjusted).	Behavioral Risk Factor Surveillance System	2014	2017
Poor mental health days	Average number of mentally unhealthy days reported in past 30 days (age-adjusted).	Behavioral Risk Factor Surveillance System	2014	2017
Low birthweight	Percentage of live births with low birthweight (< 2,500 grams).	National Center for Health Statistics - Natality files	2007-2013	2012-2018
Health Behaviors				
Adult smoking	Percentage of adults who are current smokers (age-adjusted).	Behavioral Risk Factor Surveillance System	2014	2017
Adult obesity	Percentage of the adult population (age 20 and older) that reports a body mass index (BMI) greater than or equal to 30 kg/m2.	CDC Diabetes Interactive Atlas, United States Diabetes Surveillance System	2012	2016
Food environment index	Index of factors that contribute to a healthy food environment, from 0 (worst) to 10 (best).	USDA Food Environment Atlas, Map the Meal Gap from Feeding America	2013	2015 & 2017
Physical inactivity	Percentage of adults age 20 and over reporting no leisure-time physical activity.	CDC Diabetes Interactive Atlas, United States Diabetes Surveillance System	2012	2016
Excessive drinking	Percentage of adults reporting binge or heavy drinking (age-adjusted).	Behavioral Risk Factor Surveillance System	2014	2017
Alcohol-impaired driving deaths	Percentage of driving deaths with alcohol involvement.	Fatality Analysis Reporting System	2010-2014	2014-2018
Sexually transmitted infections	Number of newly diagnosed chlamydia cases per 100,000 population.	National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention	2013	2017
Teen births	Number of births per 1,000 female population ages 15-19.	National Center for Health Statistics - Natality files	2007-2013	2012-2018

2016-2020 County Health Rankings Data Sources, continued

Access to Care		Source	2016 Data	2020 Data
Access to Care	Uninsured	Small Area Health Insurance Estimates	2013	2017
	Primary care physicians	Area Health Resource File/American Medical Association	2013	2017
	Dentists	Area Health Resource File/National Provider Identification file	2014	2018
Mental health providers	Mental health providers	CMS, National Provider Identification	2015	2019
Social & Economic Factors				
Education	High school completion	EDFacts, KY & WV Departments of Education	2012-2013	2016-2017
	Some college	American Community Survey, 5-year estimates	2010-2014	2014-2018
Employment	Unemployment	Bureau of Labor Statistics	2014	2018
Income	Children in poverty	Small Area Income and Poverty Estimates	2014	2018
Family and Social Support	Children in single-parent households	American Community Survey, 5-year estimates	2010-2014	2014-2018
	Social associations	County Business Patterns	2013	2017
Community Safety	Violent crime	Uniform Crime Reporting - FBI	2010 & 2012	2014 & 2016
	Injury deaths	CDC WONDER Mortality data, National Center for Health Statistics - Mortality Files	2009-2013	2014-2018
Physical Environment				
Environmental Quality	Air pollution - particulate matter	CDC WONDER Environmental data, Environmental Public Health Tracking Network	2011	2014
Housing and Transit	Severe housing problems	Comprehensive Housing Affordability Strategy (CHAS) data	2008-2012	2012-2016
	Driving alone to work	American Community Survey, 5-year estimates	2010-2014	2014-2018
	Long commute - driving alone	American Community Survey, 5-year estimates	2010-2014	2014-2018

Highlands ARH Regional Medical Center

Highlands ARH Regional Medical Center 2022 CHNA Survey

The Community and Economic Development Initiative of Kentucky (CEDIK), from the University of Kentucky was contracted by Appalachian Regional Healthcare (ARH) to conduct the Community Health Needs Assessments (CHNAs) for this hospital. We want to better understand your health needs and how the hospital and its partners can better meet those needs. Please take 10-15 minutes to fill out this survey. Please do not include your name anywhere. All responses will remain anonymous.

Q1. Please tell us your zip code:

_____

Q2. Are you or anyone in your household satisfied with the ability to access healthcare services in Floyd County?

- O Yes
- O No

Q3. Where do you go to receive routine healthcare? Select all that apply.

- O Physician's office/my family doctor
- O Emergency room
- O Health department
- O Urgent care
- O Other. Please specify below:

_____

- O I do not receive routine healthcare

Q4. Are there barriers that keep you from receiving routine healthcare? Select all that apply.

- O No insurance
- O Lack of child care
- O Physician hours of operation (inconvenient times)
- O Fear/anxiety
- O Poor physician attitudes or communication
- O I only visit the doctor when something is seriously wrong
- O No transportation
- O Cannot take off work
- O Cannot afford it
- O Other. Please specify below:

_____

- O No barriers

Q5. How far do you or anyone in your household travel to see a specialist?

- O Less than 20 miles
- O 20-49 miles
- O 50-100 miles
- O Other: _____
- O I do not receive routine healthcare

Q6. What do you or anyone in your household use for transportation when traveling for healthcare? Select all that apply.

- O My own vehicle
- O Friend/family vehicle
- O Taxi/cab
- O Other. Please specify below:

_____

Q7. Please select the TOP THREE **health challenges** you or anyone in your household face. Select only three.

- O Cancer
- O Diabetes
- O Mental health issues
- O Substance use disorder (alcohol/drugs)
- O High blood pressure
- O Tobacco use/vaping
- O Asthma
- O Arthritis/joint pain
- O Heart disease and stroke
- O HIV/AIDS/STDs
- O Overweight/obesity
- O Respiratory/lung disease
- O Other. Please specify below:

_____

Q8. Please select the TOP THREE **risky behaviors** you see <u>most</u> in your community. Select only three.

- O Alcohol use
- O Tobacco use
- O Unsafe sex
- O Prescription drug use
- O Being overweight/having poor eating habits and lack of exercise
- O Dropping out of school
- O Drug abuse
- O Other. Please specify below:

_____

Q9. Have you or someone in your household delayed healthcare because of lack of money and/or insurance?

- O Yes
- O No

Q10. Are you or members of your household currently eligible for any of the following services? Select all that apply.

- O Medicare
- O Medicaid
- O Public Housing Assistance
- O SNAP (Food stamp program)
- O VA
- O Commercial/private insurance

Q11. How would you rate your **own personal health**?

- O Very healthy
- O Healthy
- O Neither healthy nor unhealthy
- O Unhealthy
- O Very unhealthy

Q12. How would you rate the overall **health of Floyd County**?

- O Very healthy
- O Healthy
- O Neither healthy nor unhealthy
- O Unhealthy
- O Very unhealthy

Q13. Please select the TOP THREE most important factors for a **healthy community**. Select only three:

- O Good place to raise children
- O Low crime/safe neighborhood
- O Good school systems
- O Easy to access healthcare
- O Community activities and events
- O Affordable housing
- O Low disease rate
- O Personal responsibility
- O Excellent race relationships
- O Diverse community
- O Good jobs/healthy economy
- O Religious/spiritual values
- O Transportation
- O Parks and recreation
- O Other. Please specify below:

_____

Q14. Do you think Floyd County meets the factors you selected in question 13?

- O Yes
- O No

Q15. What could be done in Floyd County to better meet your health needs?

_____

_____

_____

_____

_____

Q16. Which health related topics would you be interested in learning more about? Select all that apply.

- O Eating healthy
- O Weight loss
- O Heart disease
- O Cancer prevention
- O Emergency preparedness
- O Tobacco cessation
- O Substance use disorder (alcohol and/or drugs)
- O Mental health/Depression
- O Using my medications correctly
- O Other. Please specify below:

_____

Q17. In what ways were you or your family affected by the COVID-19 pandemic? Select all that apply.

- O Loss of job
- O Loss of health insurance
- O Declining mental health
- O Reduced hours at work (partial loss of income)
- O Began utilizing community services (food stamps, food pantry, etc.)
- O Did not seek routine medical care (to avoid exposure to COVID-19)
- O Other. Please specify below:

_____

- O None of the above

Q18. Have you or anyone in your household used ARH hospital services in the past 24 months?

- O Yes
- O No

Q19. If you used a hospital other than Highlands ARH Regional Medical Center in the past 24 months, why? Select all that apply.

- O Service I needed was not available
- O My doctor referred me to another hospital
- O My insurance required me to go somewhere else
- O I prefer larger hospitals
- O Other. Please specify below:

_____

Q20. How would you rank Highlands ARH Regional Medical Center on a scale of 1 to 10, where 1 is *not very good* and 10 is *very good*? Please circle a number below.

1 2 3 4 5 6 7 8 9 10

Q21. Would you recommend your local ARH hospital to friends and family?

- O Yes
- O No

Q22. What factors influence your health choices? Select all that apply.

- O Family
- O Friends
- O Spouse/Partner/Significant other
- O Other people around me
- O Community
- O Listening to physicians and other healthcare providers
- O Public health recommendations/guidelines (example: CDC)
- O Social media
- O Access to parks/walking trails
- O Weather (seasons: Spring, Summer, Fall, Winter)
- O Other. Please specify below:

_____

Q23. Where do you get most of your healthcare information? Select all that apply.

- O Doctor/healthcare provider
- O Friends/family
- O Internet
- O Health department
- O Library
- O Local hospital website
- O Newspaper/magazines
- O Radio/television
- O Social media
- O I do not access health information

Q24. What is your current living situation?

- O Living with family (parent(s), guardian, grandparents or other relatives)
- O Living on your own (apartment or house)
- O Living in a place not meant to be a residence (outside, tent, homeless camp, car, abandoned building)
- O Living in recovery housing
- O Living in a recovery treatment facility
- O Staying in an emergency shelter or transitional living program
- O Living in a hotel or motel
- O Staying with someone I know

Q25. Have you used video calls (telemedicine) to see a provider in the last 12 months?

- O Yes
- O No

Q26. What specialty care services would you be willing to see using video calls (telemedicine)? Select all that apply.

- O Cardiology
- O Dermatology
- O Oncology
- O Urology
- O Nephrology
- O Gastroenterology
- O Pulmonology
- O Endocrinology
- O Pediatrics
- O Mental/Behavioral Health

Q27. What is your age?

- O 18 - 24
- O 25 - 39
- O 40 - 54
- O 55 - 64
- O 65 - 69
- O 70 or older

Q28. What is your gender?

- O Male
- O Female
- O Other _____
- O Prefer not to answer

Q29. What ethnic group do you identify with?

- O African American/Black
- O Asian/Pacific Islander
- O Hispanic/Latino
- O Native American
- O White/Caucasian
- O Other. Please specify below:

_____

Q30. What is the highest level of education you have completed?

- O High School
- O Technical school
- O College or above
- O Other. Please specify below:

_____

Q31. What is your current employment status?

- O Unemployed
- O Employed part-time
- O Employed full-time
- O Retired
- O Student
- O Other. Please specify below:

_____

Thank you for taking the time to participate in this survey.

Approval

This Community Health Needs Assessment was approved by the ARH Board of Trustees on May 12, 2022.