# 2022 Community Health Needs Assessment

## McDowell ARH Hospital

9879 KY-122, McDowell, KY 41647 | Phone: (606) 377-3400

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This Community Health Needs Assessment (CHNA) report was prepared for McDowell 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 McDowell ARH Hospital 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
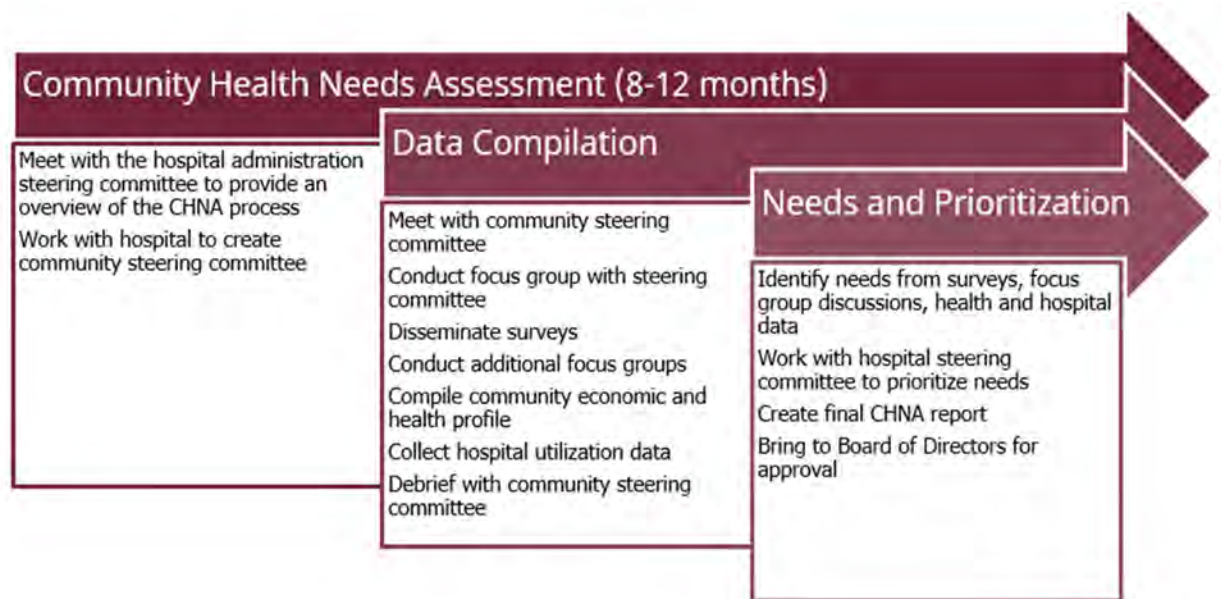- Collaboration
- Compassion
- Service

# 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 McDowell 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:

## Community Health Needs Assessment (8-12 months)

Meet with the hospital administration steering committee to provide an overview of the CHNA process

Work with hospital to create community steering committee

### Data Compilation

Meet with community steering committee

Conduct focus group with steering committee

Disseminate surveys

Conduct additional focus groups

Compile community economic and health profile

Collect hospital utilization data

Debrief with community steering committee

### Needs and Prioritization

Identify needs from surveys, focus group discussions, health and hospital data

Work with hospital steering committee to prioritize needs

Create final CHNA report

Bring to Board of Directors for approval

# McDowell ARH

## 2019 community health needs... addressed!

✓ Goal: Promote local Needle Exchange Program, provide drug education in local schools and during community events, educate and provide resources on mental health and help reduce the negative stigma of addiction.

In conjunction with UK Center on Drug and Alcohol Research, we joined the Floyd County HEALing Communities Study Task Force, with the aim to reduce Opioid related overdose deaths by 40% over 3 years. **The goal of this group is to collaborate with state and community partners to implement evidence-based interventions to save lives, help people receive recovery support services and inform the nation of what strategies will help us heal from the Opioid crisis.** During the past two years, we addressed various drug addiction/needle exchange programs, discussed ways to reduce the negative stigma of addiction by getting these addicts "clean", providing them with constant support after their programs end and getting them back in the workforce. We have done many advertising campaigns. We have installed billboards and banners, and shared flyers and mailers in our hospital and in the community.

ARH sponsored an Opioid Summit at Floyd Central High School in 2019. Vendors from all over the region sat up booths, staff from ARC (Addiction Recovery Center) and individuals in recovery spoke to the students, sharing their personal stories of addiction and information of offered services.

**We continue testing for Hepatitis C in our ER.** We refer all positive results to KEYTREAT in Hazard for proper treatment.

To address the mental health needs of our community, we hosted a bi-monthly webinar (open to the public) on Alzheimer's education. This program was sponsored by UK Healthcare, UK Sanders Brown Center on Aging, and the Alzheimer's Association.

Due to the mental stress of the pandemic, we offered mental health assistance & direct phone contact for our employees.

We shared various educational messages on COVID-19, healthy tips on how to avoid the infection, the benefits of COVID vaccines and boosters, along with various information and healthy tips on COVID, via television ads, social media, etc. ARH offered free virtual yoga classes, nutritional classes and various health related web-based series.

**Since 2019, McDowell ARH has contributed $502,075 in community benefits to our service area.**

✓ Goal: Educate the community, especially the younger population on the unforeseen health issues of vaping, and reduce the number of people vaping in our area.

Prior to the pandemic, we sponsored an educational event at Floyd Central High School for the entire staff of Floyd Central and South Floyd that focused on smoking and emphasizing vaping as the new area of concern for students. Staff spoke to the group and answered many questions about the prevalence of vaping and the "unknown" future effects of vaping. The event was very successful with great interaction, interest and concern from the school staff.

✓ Goal: Educate the community/schools on the risks of obesity in adults and children in our area, host fitness fairs in local schools beginning with the 2019-2020 school year, promote walking clubs to get people to exercise.

McDowell ARH co-sponsored and participated in a Health and Fitness program, sponsored by the Floyd County Health Department in 2019, where many of our employees and community members met to walk in our local "Walking Club" at the local Minnie Park most evenings after work.

ARH and our local staff participated and promoted a virtual 5K, benefiting the ARH Employee Assistance Fund, and emphasizing a healthy activity in our community.

COVID-19 caused McDowell ARH to postpone plans for in-person programming in the school system.



*Local student visits with McDowell ARH staff at Career Day.*

✓ **Goal: Recruit more specialists to service our community needs and increase community knowledge of available specialty services in our clinic.**

**Over the past 2-3 years, ARH has recruited various specialists that have traveled to McDowell for clinics once or twice/month or who see patients via telemedicine visits.** We currently have Teleradiology, Teleneurology, Telecardiology, plus low acuity admissions have been made via telemedicine.

We now have the privilege of having many Advanced ICU providers that are available 24 hours a day, 7 days a week on a moment's notice for our ICU patients.

McDowell ARH now has extenders in Cardiology, Brooke Bays, APRN; Dr. Christopher Clement, Podiatry and Dr. Peter Kummant, General Surgery; who are all available for personal visits in our McDowell clinic each month.

✓ **Goal: Keep the public updated and informed about all current and new services/ providers.**

Advertisements and announcements of new and expanded services available at McDowell ARH are on social media, local television, and billboards.

## From our CEO:

During the past three years, our McDowell team had to refocus our efforts to contend with a global pandemic that touched every facet of our existence. Our team responded in a heroic fashion by taking care of our community, each other, and our patients who were in need of life saving treatment.

We also witnessed an outpouring of support from our community. It was amazing to see the McDowell team and community in action supporting and encouraging each other during this difficult time. I am proud to be serving alongside such a caring team!

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 McDowell ARH.**

Danita Hampton
McDowell ARH Community CEO

# Community Served by McDowell ARH

McDowell 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 McDowell 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**
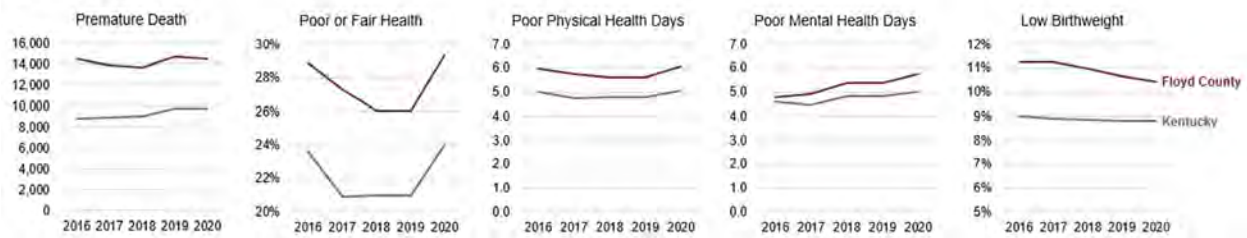


- The middle three variables are based on self-reported data from BRFSS (Behavioral Risk Factor Surveillance System). All three are on an upward trend for the County.

- The County's low birthweight is on a downward trend.

**Health Behaviors**
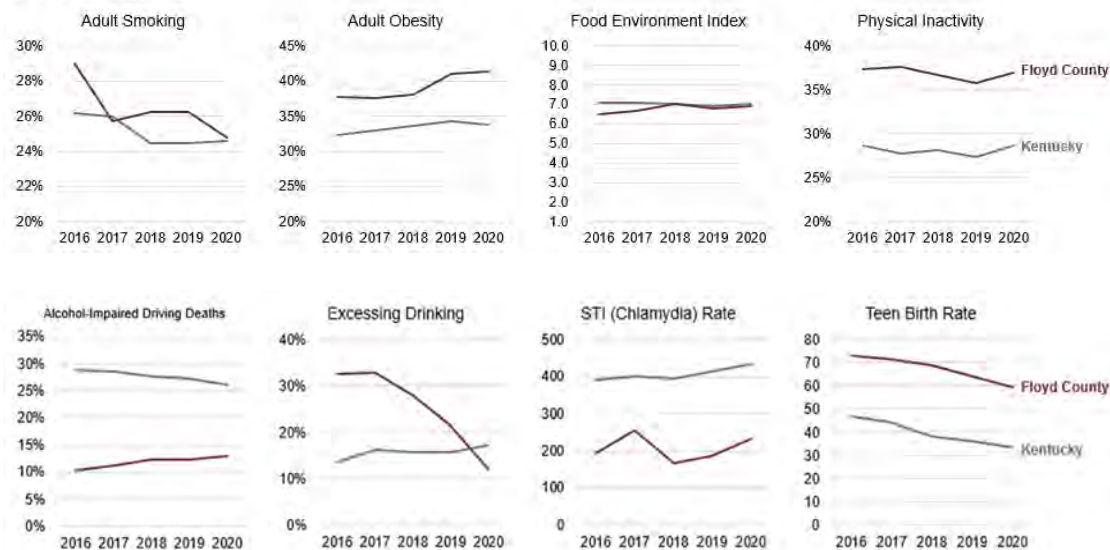


- Adult smoking in the County higher than the state, however is on a downward trend.

- 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**
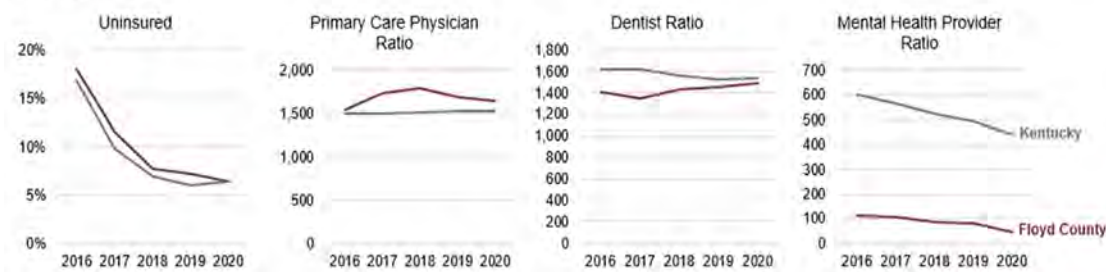


- The County's ratio of dentists and mental health providers is lower (more providers for population) compared to the state average. The County has a higher ratio of primary care physicians compared to the state average.

- County uninsurance rates are on par with the state.

**Social & Economic Factors**
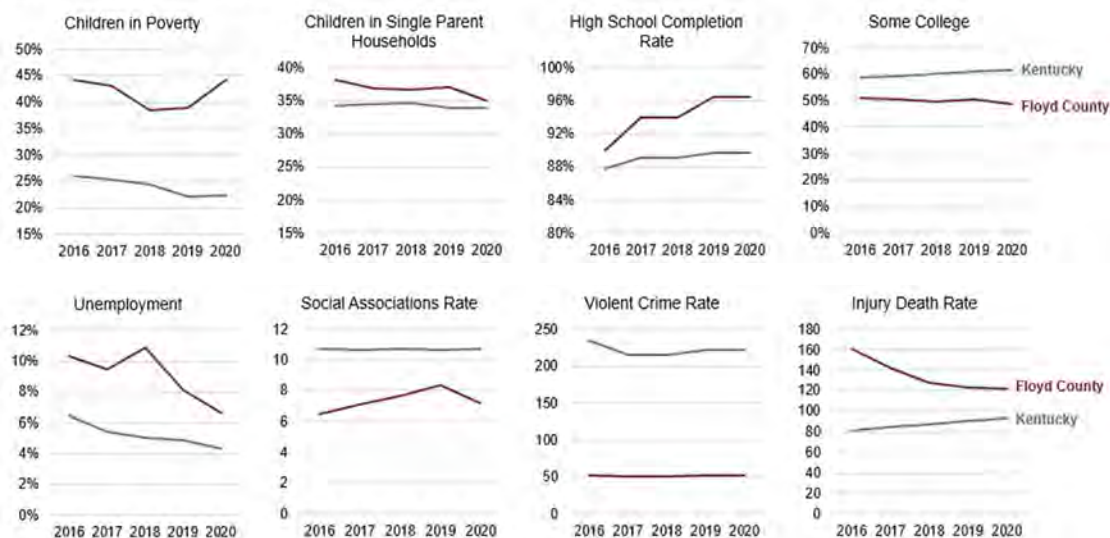


- The County has a higher percentage of children in single parent households and in poverty compared to the state average. The year-to-year shifts in children in poverty make it difficult to pinpoint an overall trend. Children in single parent households appears to be trending downward for the County.

- 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

**Physical Environment**
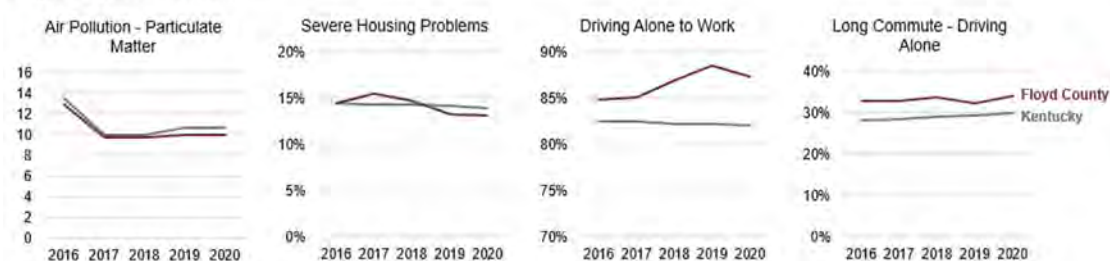


- Air pollution in the County follows the state trend.
- The County's percentage of population with severe housing problems is on a downward trend.
- The County population driving alone to work has an overall upward trend, while the County population making long commutes driving alone is on a slight 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 McDowell 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 | 238 |
| Outpatient Visits | 26,072 |

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

| Payer | Discharges |
| --- | --- |
| Medicare (Excluding Medicare Managed Care) | 134 |
| WellCare of Kentucky Medicaid Managed Care | 36 |
| Medicare Managed Care | 17 |
| Commercial - Anthem Health Plans of KY HMO Plan | 12 |
| Commercial - Anthem Health Plans of KY PPO Plan | 9 |
| Aetna Better Health of KY Medicaid Managed Care | 5 |
| Anthem Medicaid Managed Care | 4 |
| Passport Medicaid Managed Care | 4 |
| Commercial - Other | 3 |
| Humana Medicaid Managed Care | 3 |
| VA | 3 |
| Tricare (Champus) | 2 |
| Workers Compensation | 2 |
| Black Lung | 1 |
| Care Source KY Commercial Plan | 1 |
| Commercial - United Healthcare POS Plan | 1 |
| In State Medicaid | 1 |

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

| Payer | Visits |
| --- | --- |
| WellCare of Kentucky Medicaid Managed Care | 8977 |
| Medicare (Excluding Medicare Managed Care) | 6086 |
| Medicare Managed Care | 2735 |
| Commercial - Anthem Health Plans of KY PPO Plan | 2260 |
| Humana Medicaid Managed Care | 844 |
| In State Medicaid | 836 |
| Commercial - Anthem Health Plans of KY HMO Plan | 754 |
| Passport Medicaid Managed Care | 629 |
| Anthem Medicaid Managed Care | 586 |
| Aetna Better Health of KY Medicaid Managed Care | 514 |
| Workers Compensation | 480 |
| Self Pay | 454 |
| Commercial - Other | 220 |
| Commercial - United Healthcare POS Plan | 155 |
| Auto Insurance | 85 |
| Commercial - Aetna Health HMO Plan | 76 |
| Tricare (Champus) | 75 |
| Commercial - Humana PPO Plan | 68 |
| Other Facility | 51 |
| Black Lung | 43 |
| Care Source KY Commercial Plan | 40 |
| Commercial - Aetna Health PPO Plan | 26 |
| Wellcare Health Commercial Plan | 22 |
| ChampVA | 19 |
| Commercial - Cigna Health & Life FFS Plan | 18 |
| VA | 14 |
| Commercial - PPO | 3 |
| Out of State Medicaid | 2 |

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

| DRG Description | Discharges |
| --- | --- |
| Chronic Obstructive Pulmonary Disease | 34 |
| Kidney & Urinary Tract Infections | 27 |
| Simple Pneumonia & Pleurisy | 20 |
| Septicemia | 20 |
| Cellulitis | 16 |
| Respiratory Infections & Inflammations | 15 |
| Heart Failure & Shock | 15 |
| Esophagitis Gastroent & Misc Digest Disorders | 9 |
| Nutritional & Misc Metabolic Disorders | 7 |
| Disorders Of Pancreas Except Malignancy | 4 |

# 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 in November 2021 to introduce the assessment process, share the role and duties of a committee member and to conduct a facilitated discussion in a focus group format. A final steering committee was held in April 2022 for the reporting 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 results in the community steering committee making recommendations as to the priority health needs for Floyd County ARH facilities including McDowell 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 Co 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 McDowell 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

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

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*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

76%
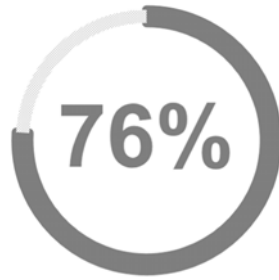
### Respondents are female.

*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% |

97%
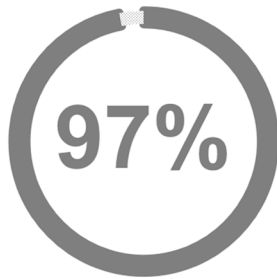
### Respondents are white.

*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% |

71%
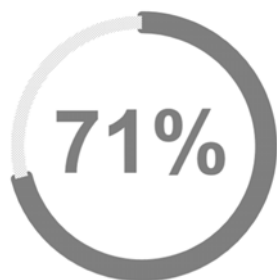
### Respondents are living in their own home/ apartment.

*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:
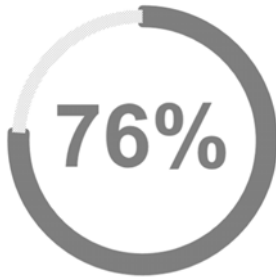
**76%** Go to a Physician's office or their family doctor.

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:

**39%** 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:

**66%** 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 household eligibility:

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

**56%**

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% |

**37%**

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

## Respondent household impacts due to COVID-19 pandemic:

| Did not seek routine medical care (to avoid exposure to COVID-19) | Declining mental health | Reduced hours at work (partial loss of income) | Loss of job | Began utilizing community services (food stamps, food pantry, etc.) | Loss of health insurance |
|---|---|---|---|---|---|
| 28% | 27% | 14% | 9% | 6% | 4% |
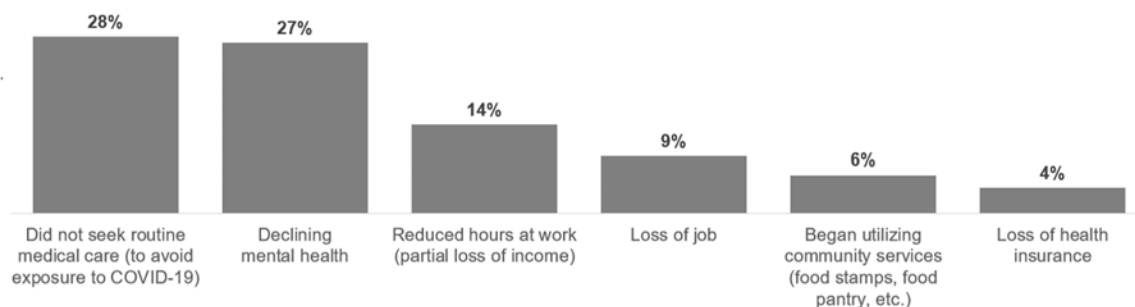
*Respondents identified another 9% of impacts due to COVID-19: isolation/anxiety and depression, loss of loved ones to COVID, overworked, loss of housing, postponed health care, less recreational activities/weight gain. 2% reported no impact.*

## 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% |

## 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% |

**35%**

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

## 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:

Floyd County residents — 2.4

Respondent self-rating — 3.2

1 very unhealthy ... 5 very healthy

**88%**
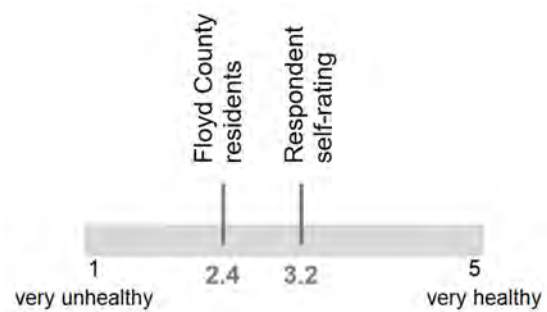
Respondent households have used ARH hospital services in the last 24 months.

**82%**

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

**83%**
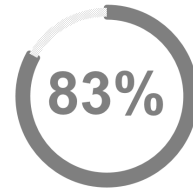
Respondents are satisfied with the ability to access healthcare services in Floyd County.

## Respondent rating of their ARH facility in Floyd County:

Average rating

1
not very good

8.3

10
very good

## 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 | 28% |

*Specialist at another hospital, better hospital/ doctors, closer to home/location, after hours clinic closed, billing issues*

## 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

McDowell 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 McDowell 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 McDowell 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.

McDowell 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, McDowell 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. McDowell 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

| | | Source | Years of Data |
|---|---|---|---|
| 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

| | | Source | Years of Data |
|---|---|---|---|
| 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

| | | Source | 2016 Data | 2020 Data |
|---|---|---|---|---|
| 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

| 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

| | | Source | 2016 Data | 2020 Data |
|---|---|---|---|---|
| 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

| | | Source | 2016 Data | 2020 Data |
|---|---|---|---|---|
| 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 |

# McDowell ARH 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?

○ Yes

○ No

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

○ Physician's office/my family doctor

○ Emergency room

○ Health department

○ Urgent care

○ Other. Please specify below:

_____

○ I do not receive routine healthcare

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

○ No insurance

○ Lack of child care

○ Physician hours of operation (inconvenient times)

○ Fear/anxiety

○ Poor physician attitudes or communication

○ I only visit the doctor when something is seriously wrong

○ No transportation

○ Cannot take off work

○ Cannot afford it

○ Other. Please specify below:

_____

○ No barriers

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

○ Less than 20 miles

○ 20-49 miles

○ 50-100 miles

○ Other: _____

○ 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.

○ My own vehicle

○ Friend/family vehicle

○ Taxi/cab

○ Other. Please specify below:

_____

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

○ Cancer

○ Diabetes

○ Mental health issues

○ Substance use disorder (alcohol/drugs)

○ High blood pressure

○ Tobacco use/vaping

○ Asthma

○ Arthritis/joint pain

○ Heart disease and stroke

○ HIV/AIDS/STDs

○ Overweight/obesity

○ Respiratory/lung disease

○ Other. Please specify below:

_____

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

○ Alcohol use

○ Tobacco use

○ Unsafe sex

○ Prescription drug use

○ Being overweight/having poor eating habits and lack of exercise

○ Dropping out of school

○ Drug abuse

○ Other. Please specify below:

_____

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

○ Yes

○ No

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

○ Medicare

○ Medicaid

○ Public Housing Assistance

○ SNAP (Food stamp program)

○ VA

○ Commercial/private insurance

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

○ Very healthy

○ Healthy

○ Neither healthy nor unhealthy

○ Unhealthy

○ Very unhealthy

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

○ Very healthy

○ Healthy

○ Neither healthy nor unhealthy

○ Unhealthy

○ Very unhealthy

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

○ Good place to raise children

○ Low crime/safe neighborhood

○ Good school systems

○ Easy to access healthcare

○ Community activities and events

○ Affordable housing

○ Low disease rate

○ Personal responsibility

○ Excellent race relationships

○ Diverse community

○ Good jobs/healthy economy

○ Religious/spiritual values

○ Transportation

○ Parks and recreation

○ Other. Please specify below:

_____

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

○ Yes

○ 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.

○ Eating healthy

○ Weight loss

○ Heart disease

○ Cancer prevention

○ Emergency preparedness

○ Tobacco cessation

○ Substance use disorder (alcohol and/or drugs)

○ Mental health/Depression

○ Using my medications correctly

○ Other. Please specify below:

_____

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

○ Loss of job

○ Loss of health insurance

○ Declining mental health

○ Reduced hours at work (partial loss of income)

○ Began utilizing community services (food stamps, food pantry, etc.)

○ Did not seek routine medical care (to avoid exposure to COVID-19)

○ Other. Please specify below:

_____

○ None of the above

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

○ Yes

○ No

**Q19.** If you used a hospital other than McDowell ARH in the past 24 months, why? Select all that apply.

○ Service I needed was not available

○ My doctor referred me to another hospital

○ My insurance required me to go somewhere else

○ I prefer larger hospitals

○ Other. Please specify below:

_____

**Q20.** How would you rank McDowell ARH 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?

○ Yes

○ No

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

○ Family

○ Friends

○ Spouse/Partner/Significant other

○ Other people around me

○ Community

○ Listening to physicians and other healthcare providers

○ Public health recommendations/guidelines (example: CDC)

○ Social media

○ Access to parks/walking trails

○ Weather (seasons: Spring, Summer, Fall, Winter)

○ Other. Please specify below:

_____

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

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

**Q24.** What is your current living situation?

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

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

- ○ Yes
- ○ No

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

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

**Q27.** What is your age?

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

**Q28.** What is your gender?

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

**Q29**. What ethnic group do you identify with?

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

_____

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

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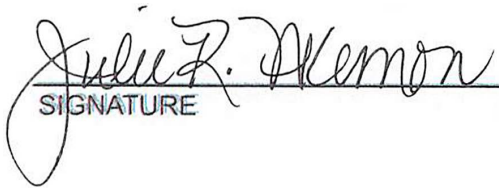
_____

**Q31**. What is your current employment status?

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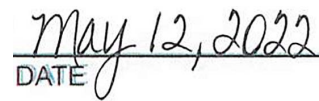- ○ Student
- ○ Other. Please specify below:

**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.

_Julie R. Akemon_
SIGNATURE

_May 12, 2022_
DATE