COMMUNITY HEALTH NEEDS ASSESSMENT

2025-2027

ARH Beckley

TEAM UP
A Public Health Academic Practice Collaborative

Acknowledgements

This Community Health Needs Assessment (CHNA) report was prepared for Beckley ARH by Team Up: A Public Health Academic Practice Collaborative at the University of Kentucky College of Public Health. Team Up works with a variety of health organizations across Kentucky and Appalachia to bridge the gap between academia and practice by forming, encouraging, and sustaining collaborative partnerships. Team Up members Dr. Angela Carman and Mary Elizabeth Pendergrass, MPH contributed to the information in this final report. If you have questions about the assessment process or data collection methodology, contact Mary Elizabeth Pendergrass, Team Up Public Health Policy & Practice Apprentice: mepe242@uky.edu .

This CHNA report was commissioned and directed by Appalachian Regional Healthcare's Community Development Department. The Community Development Department exists to further the mission of ARH by creating new educational programs, funding opportunities, partnerships and coalitions that better the health and well-being of Appalachians. This department organizes awareness events, educational classes, free health screenings, health-related sponsorships, support groups, presentations, and more each year and tracks all these programs in community benefit.

Letter to the Community Member

Dear Community Members, Partners, and Stakeholders,

I am honored to present the 2025-2027 Community Health Needs Assessment (CHNA) report for Appalachian Regional Healthcare (ARH).

As the leading healthcare provider in Eastern Kentucky and southern West Virginia, ARH remains deeply committed to improving the health and well-being of our communities. Understanding the most pressing health challenges in our region is critical to our mission, and this report reflects our dedication to addressing these challenges through collaboration, innovation, and action.

This CHNA is the result of extensive research, data collection, and direct community engagement. Through surveys, focus groups, and partnerships with local organizations, we have identified key health priorities affecting individuals and families. These insights drive our strategic initiatives, ensuring that we provide accessible, high-quality care tailored to the evolving needs of our population.

Rural communities face unique healthcare challenges, particularly in access to services. ARH is committed to expanding medical services, removing barriers to care, and ensuring every community has equal access to quality healthcare.

This report highlights critical health concerns and outlines our strategies for 2025-2027. Real change happens when we work together. We are grateful to everyone who contributed to this assessment—your voices and perspectives are essential in shaping a healthier, better future.

I encourage you to explore this report and join us in our mission to make a lasting impact on the health of our region. Together, we can build a stronger, healthier future — one where every rural community has the access and care it deserves.

Sincerely,

Hollie P. Harris

Hollie Harris, MHA
President and CEO Appalachian Regional Healthcare, Inc.

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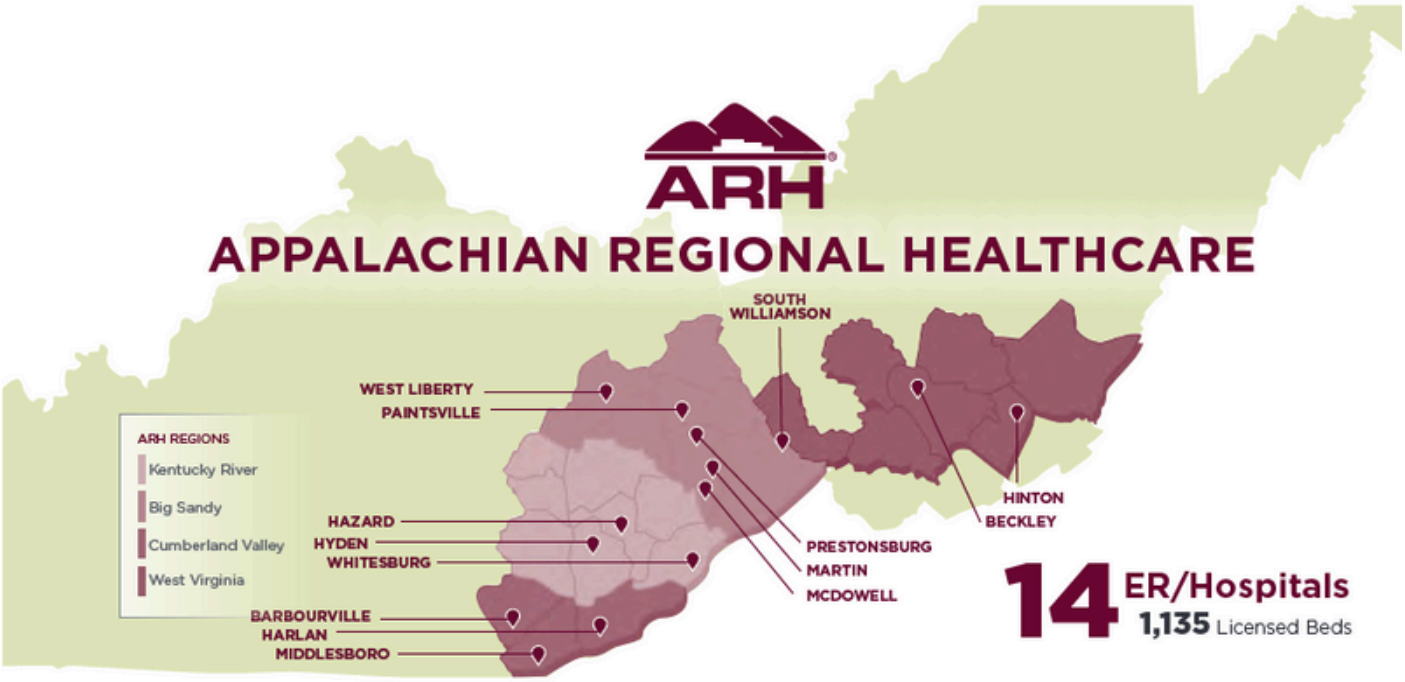
Introduction

Appalachian Regional Healthcare (ARH) is a not-for-profit health system operating 14 hospitals in Barbourville, Hazard, Harlan, Hyden, Martin, McDowell, Middlesboro, Paintsville, Prestonsburg, West Liberty, Whitesburg, and South Williamson in Kentucky and Beckley and Hinton in West Virginia, as well as multi-specialty physician practices, home health agencies, home medical equipment stores, retail pharmacies, and medical spas. ARH employs around 6,700 people with an annual payroll and benefits of $474 million generated into our local economies. ARH also has a network of more than 1,300 providers on staff across its multi-state system. ARH is the largest provider of care, the single largest employer in southeastern Kentucky, and the third-largest private employer in southern West Virginia.

ARH has always responded to the changing demands of rural healthcare. From building and acquiring new facilities, investing in medical technology, providing health education and support, and creating innovative community partnerships, we continue to meet the health needs of our Appalachian communities. As an ARH hospital, Beckley ARH is committed to these same goals for our service area. This CHNA report will outline the facility's efforts in meeting health improvement objectives from the last CHNA cycle, assessing current health needs, and creating new implementation plans for 2025-2027.



ARH Mission

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

ARH 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.

ARH Values

· Trust
· Innovation
· Collaboration
· Compassion
· Service

Culture Statement

At Appalachian Regional Healthcare our culture is defined by who we are – our history, our family, our traditions, and our story. A culture that embodies the resilient spirit of Appalachia.

SERVICE is our foundation; we honor our communities everyday by delivering healthcare that changes lives and an environment that promotes well-being for all.

TRUST is our core; every action is rooted in honesty, empathy, and integrity; fostering connections with one another, with our patients, and with our communities.

COMPASSION drives our purpose; It's not just treating people but how we treat each other that sets us apart. Enriching the collective strength of our team by bringing together a global workforce to provide local care.

COLLABORATION is our strength; we are one family taking care of all families. Committed to fostering an inclusive team full of unique perspectives, experiences, and talents at every level that enhances our service.

INNOVATION is our compass; we adapt the way we work and advance the way we care. Providing unique solutions to exceed the healthcare needs of the patients of our region.

Community Health Needs Assessment Process

Introduction to CHNA

Provisions in the Affordable Care Act (ACA) of 2010 require tax-exempt (non-profit) hospitals to conduct a Community Health Needs Assessment (CHNA) and develop a CHNA Implementation Plan at least every three years. The regulations for the CHNA include defining the hospital's service area, compiling demographics and analysis of health indicators; taking into account input from the broader community as served by the hospital facility.

The ACA requires that the CHNA must be made available to the public and must include input from individuals with special knowledge or expertise in public health. Accordingly, ARH contracted with experts from the UK College of Public Health to ensure equitable stakeholder representation and public health expertise throughout the CHNA process and final report.

Process

The Community Health Needs Assessment is a cyclical process that involves creating community steering committees, collecting primary and secondary health data, creating community profiles, prioritizing the greatest health needs for a geographical area, and creating a plan to meet those needs.

Over a three-year span, hospital facilities work to create healthier communities through programs and initiatives as guided by the CHNA. Prior to the start of a new CHNA cycle, facilities track and report on implementation successes (new health and wellness programs created, health care access improved, community members engaged, etc.).

Primary Data

Collecting primary data, or new data collected directly from the community, is a key part of the CHNA process. This type of data provides two valuable contributions:

1. Self-reported data about the health needs and strengths of community members
2. More engagement of the community in the process

Perhaps as important as a thorough data set, gathering local data provides opportunities for the community to be engaged through the community health needs assessment process and to ensure that the community members' voices are heard. Engagement at this stage can lead to stronger community support and involvement throughout the community health improvement efforts.

Primary data was collected in this CHNA through community surveys, focus groups, and key informant interviews.

Method	Description
Community Surveys	A traditional approach to gathering community input. Can include: written, telephone, web-based, or in-person.
Focus Groups	A traditional approach to gathering community input. Can include: written, telephone, web-based, or in-person.
Key Informant Interviews	In-depth one-on-one discussions to gather input from representative community members. Can be done with key community leaders or residents representing specific sub-populations.

Secondary Data

Secondary data is data that is collected by other entities and provides information on health status and demographics. Examples include vital statistics, censuses, reports from government agencies (such as the CDC), or information collected through studies and other organizations (such as County Health Rankings).

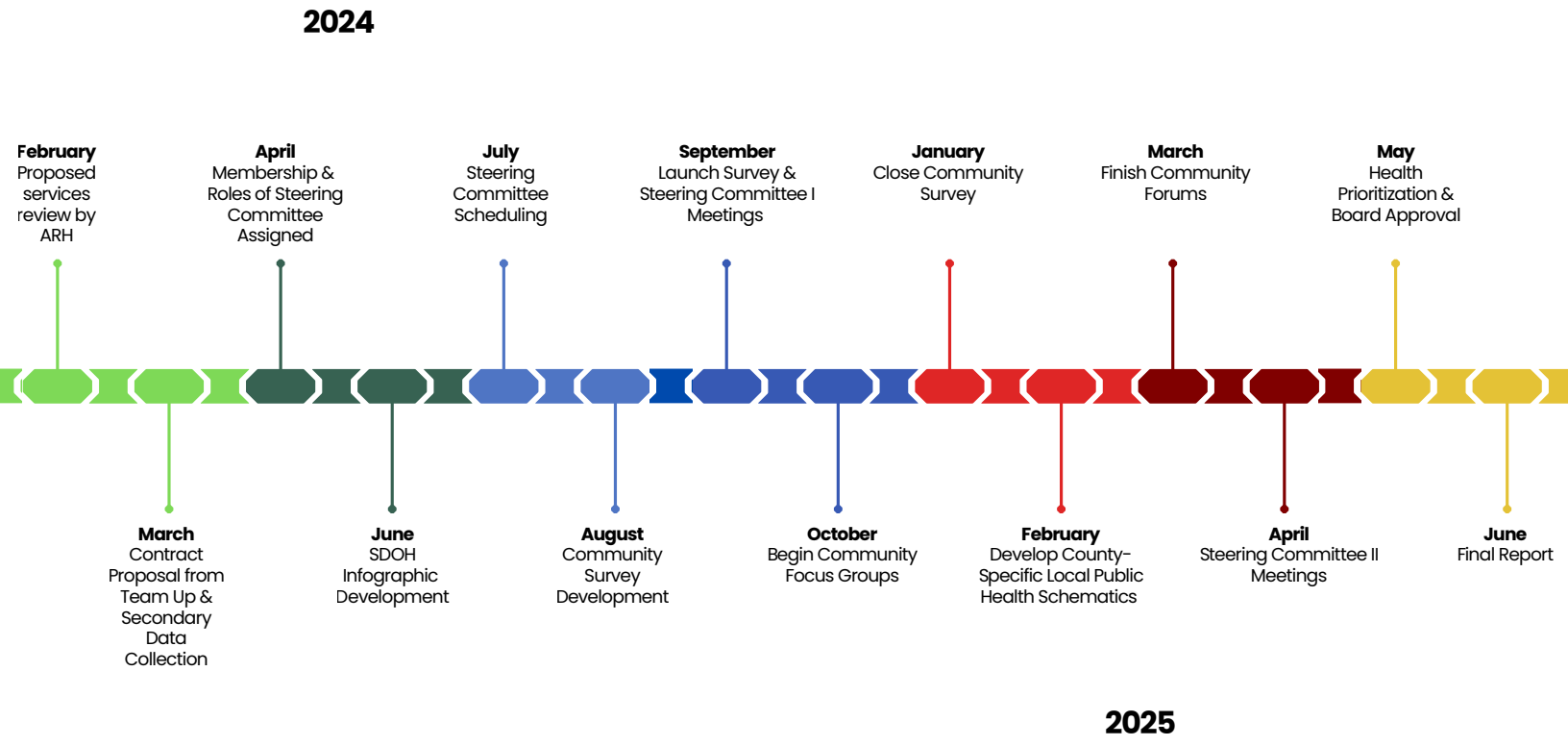
Steering Committees

Community Health Needs Assessment (CHNA) steering committees are groups of key stakeholders assembled to guide the planning, development, and implementation of the CHNA process for non-profit hospitals. These committees typically include representatives from public health agencies, local government, community organizations, healthcare providers, academic institutions, and members of the community, especially those who serve or represent medically underserved, low-income, or minority populations.

CHNA Timeline

Appalachian Regional Healthcare collaborated with Team Up at the University of Kentucky (UK) College of Public Health in the Summer of 2024 to begin conducting the 2025-2027 Community Health Needs Assessment (CHNA) for Raleigh County
See the CHNA process timeline below.

CHNA Timeline



2022-2024 Implementation Successes

During the 2022 CHNA process, the Raleigh County Steering Committee identified the following health needs:

1. Mental Health
2. Obesity
3. Culture of Health/ Healthy Lifestyle Education
4. Substance Use Disorder

Beckley ARH set forth goals and strategies to address each of the identified health needs, see these as well as successes below.

Goal 1

Educate our community on the importance of mental health and work to reduce stigma associated with seeking care

Since 2022, Beckley ARH has **educated our community on the importance of mental health and reduced associated stigma** by:

- Providing **2 free Mental Health First Aid trainings** for staff. Mental Health First Aid is an evidence-based, early intervention course that teaches participants about mental health and substance abuse challenges and how to assist those that may need help. Beckley ARH offered these trainings with the hope that the education would allow staff to better help our patients, but also their families, friends, and neighbors.

- Providing **7** mental health education and awareness events, including:
  - Positive affirmation sidewalk chalk events
  - Monthly Commission on Aging presentations on: Combating the Winter Blues, Exercising Your Brain, and many other topics
  - Mental Health Day at Beckley City Park
  - Causacon and Beckley Pride, both with a target audience of marginalized populations
  - Oak Hill and Beckley Family Days

- Managing and supervising the local Students Against Destructive Decisions (SADD) group. Since 2022, the group has:
  - Attended **15 events** targeting the K-12 population to discuss mental health topics and the National Suicide Crisis Hotline (988).

Goal 2

Address obesity through new services, nutrition education, and providing opportunities for physical activity

Since 2022, Beckley ARH has **addressed obesity** in our community by:

- Financially supporting Woodrow Wilson High School's Wetland Project, which includes plans for two 80-foot walking ramps connected by a 32 by 32 square-foot outdoor classroom, a wheelchair-accessible walking pavilion, and additional flora and fauna. This trail directly connects to the hospital parking lot, allowing for staff to use the walking path.

- Began hosting **monthly Diabetes Support Groups** in 2023, which offers healthy cooking demonstrations each month in addition to diabetic-centric education

- Developed a new program, **Rethink Your Drink**, that teaches children the harmful effects of sugary and caffeinated drinks. The program, which has been taught to area schools **5** times, encourages choosing healthier beverage options.

- Partnered with Active Southern West Virginia to host **4 Walk with a Doc events**, in which ARH providers walk with participants and discuss health-related issues. ARH has also partnered with Active Southern West Virginia to sponsor their community fun-runs and 5k races.

- Revamped the hospital's own cafeteria menu in partnership with Sodexo, promoting healthier options that are often plant-based

- Since 2023, Beckley ARH has provided **free gym memberships** to all **ARH employees** and hosted walking challenges at the start of each new year.

- In partnership with the American College of Lifestyle Medicine, BARH offered all staff the opportunity to be trained in **Food as Medicine Essentials** free of cost. Participants were trained on preventing, treating, and reversing diseases such as heart disease, diabetes, and certain cancers through proper diet.

- Community Development staff have also supported the local farmers market and provided ARH recipe cards with dietitian-approved recipes to attendees.

Goal 3

Provide community education about healthy behaviors in an effort to improve decision making skills

Since 2022, Beckley ARH has addressed the **culture of health & healthy lifestyle education** by:

- Providing **1,165 stroke risk assessments** at **17 community events**. These assessments include blood pressure checks, quick counseling sessions around stroke risk, family history, and modifiable risk factors.
- **5 Brain Protector programs** in local schools, in which students are taught to identify the signs of a stroke.
- Monthly support groups for Stroke Survivors and Caregivers and Diabetes
- **7 programs** centered around heart health education and free screenings, including:
  - Annual Free Heart Health Screening Days at the ARH Med Mall
  - Art with Heart painting classes with heart health speakers
  - Heart health education at local high schools
- **8 community presentations** on cancer prevention and early detection, including topics of lung cancer and the benefits of low-dose CT screenings, breast cancer and mammography, and colon cancer and colonoscopy importance
- **2** community diabetes education sessions
- **37 free CPR** and Basic Life Support trainings for the community
- New partnerships with Coalfield Coalition and Raleigh County Community Action to host annual health fairs / screening events
- ARH has provided free screening events in Beckley **19** times since 2022, which can include A1C, stroke risk assessments, EKG, blood pressure, cholesterol checks, and more. In total **1200 free screenings** have been provided to the community in this time.

Goal 4

Address drug, tobacco, and alcohol addiction through new services, community partnerships, and education

Since 2022, Beckley ARH has **addressed drug, tobacco, and alcohol addiction** by:

- Launching the Peer Support Program in 2022, employing Certified Peer Support Coaches to work in our Emergency Department and throughout the community. Peer coaches are people who have been successful in SUD recovery, and can help others by responding to overdoses in our ED, referring people to treatment, providing resources for social needs, educating the community on SUD, and more. Since 2022, Beckley ARH Peer Recovery Coaches have:
  - Engaged **3,801 patients**
  - Referred **651** patients to treatment
  - Provided **496** linkages to treatment
  - Completed **47,451** SBIRT screenings

- Peer recovery coaches & community development staff have worked with community partners to host many community events over the past 3 years, including:
  - Spread the Warmth
  - Open Hearts Outreach
  - Reach the Streets
  - International Overdose Awareness Day
  - Healing Appalachia
  - Safe a Life Day (with Narcan education & distribution)
  - National Drug Take Back Day

- ARH Peer Support Coaches and Community Development staff also serve on many coalitions, boards, and councils that work to create drug-free communities. Examples include the Raleigh County Prevention Coalition, Family Resource Network, and the ARH-managed Students Against Destructive Decisions group. Other addiction-focused collaborations include:
  - Collaborating with community partners to resume weekly, in person Alcoholics-Anonymous meetings in December 2024.
  - Catch My Breath, an evidence- based youth vape prevention program, is taught by ARH Community Development. CATCH My Breath's peer-led teaching approach empowers students with the knowledge and skills needed to make informed decisions about e-cigarettes and resist social pressures to vape.
  - ARH's Regional Community Development Manager became a **Generation Rx Ambassador** (2024) which provides research-based resources to help teach safe medication practices in your home, school, and local community.
  - **20 community educational sessions** and trainings on the administration of Naloxone

Goal 5

Better communication and collaboration among community partners

Since 2022, Beckley ARH has **improved communication and collaboration among community partners** by:

- Actively participating in many councils, coalitions, and boards that work to break down silos, meet community health needs, and foster partnerships between health care organizations. These include:
  - Human Rights Commission
  - Family Resource Network
  - WV Disability Caucus
  - REACH
  - Raleigh County Prevention Coalition
  - Rotary After Hours
  - Coalfields Healthcare Coalition
  - Valley College Advisory Council
  - ACT Advisory Council

- Beckley ARH has also partnered with Raleigh General Hospital annually to host the largest health fair in Southern West Virginia and for co-led blood drives.

Community Served by Beckley ARH

Beckley ARH defined its service area for this Community Health Needs Assessment by reviewing inpatient hospital discharge data for county of residence. From January 2022-September 2024, the majority of hospital discharges were residents of Raleigh County (60.2%).

Secondary data for Raleigh County are presented in this section. Data are presented at the County, State, and National level (where possible). These data come from a variety of sources listed below each table, and serve as indicators for social, economic, and health conditions in Raleigh County. An infographic containing data on the Social Determinants of Health can be located in Appendix A.

Population

Population	Raleigh Co	West Virginia	US Overall
Population, 2024	72,379	1,769,979	340,110,988
Percent of Population Under 18 Years	20.9%	19.9%	21.7%
Percent of Population 65 Years+	22.4%	21.5%	17.7%
Percent of Population White	88.9%	92.8%	75.3%
Percent of Population Non-Hispanic Black	7.8%	3.8%	13.7%
Percent of Population American Indian & Alaska Native	0.3%	0.3%	1.3%
Percent of Population Asian	0.7%	0.9%	6.4%
Percent of Population Native Hawaiian/Other Pacific Islander	*	*	0.3%
Percent of Population Hispanic or Latino	1.8%	2.2%	19.5%
Two or More Races	2.3%	2.1%	3.1%
Percent of Population Female	49.7%	50.1%	50.5%

Source: US Census, 2024 QuickFacts

Social and Economic Factors

Social and Economic Factors	Raleigh Co	West Virginia	US Overall
Percent Completed High School	86%	89%	89%
Bachelor's Degree or Higher	22%	23%	35%
Percent Unemployed	3.7%	3.9%	3.6%
Percent of People in Poverty	18.2%	16.7%	11.1%
Children in Poverty	21%	20%	16%
Number of Children in Single Parent Households	32%	24%	25%
Median Household Income	$53,500	$55,900	$77,700
Violent Crime Rate (per 100,000)	478.3	346.9	255.2
Child Care Cost Burden	35%	36%	28%
Food Insecurity Rate	17%	15%	14%

Source: US Census, 2024 QuickFacts, County Health Rankings (2025), U.S. News and World Report

Health Behaviors

Heath Behaviors	Raleigh Co	West Virginia	US Overall
Percent Adult Smoking	21%	22%	13%
Percent Adults with Obesity	40%	42%	34%
Percent of Physically Inactive Adults	32%	28%	23%
Adults (>65) with all Teeth Lost	21.5%	*	12.6%
Percent of Adults Receiving Flu Vaccination in the Last Year	42%	41%	48%
Teen Birth Rate (per 1,000)	28	23	16
Sexually Transmitted Infections per 100,000	363.6	250.7	495.0
Percent Excessive Drinking	16%	16%	19%
Number of Child Victims of Substantiated Abuse	*	*	-
Births to Mother who Smoked During Pregnancy	*	*	5%
Percent Driving Deaths with Alcohol Involvement	20%	26%	26%
Suicides Per 100,000 Population	21	20	14

Source: County Health Rankings (2025), CDC Places: Local Data for Better Health, KIDS Count Data Center (2020-2022) (2013)

Health Outcomes

Heath Outcomes	Raleigh Co	West Virginia	US Overall
Life Expectancy (years)	69.5	72.1	77
Percent Adults with Diabetes	14%	14%	10%
Percent Adults with Hypertension	39.2%	-	29.6%
Adults with current Asthma	13.2%	-	9.9%
Percent Fair to Poor Health	26%	23%	17%
Avg Number of Physically Unhealthy Days	5.7	5.2	3.9
Avg Number of Mentally Unhealthy Days	6.5	6.7	5.1
Percent Low Birth Weight	11%	10%	8%
Percent with a Disability, under Age 65	17%	13.8%	9%

Source: US Census, 2024 QuickFacts, County Health Rankings (2025), CDC Places Local Data for Better Health

Access to Care

Access to Care	Raleigh Co	West Virginia	US Overall
Primary Care Physicians	1,290:1	1,320:1	1,330:1
Mental Health Providers	340:1	510:1	300:1
Dentists	1,280:1	1,710:1	1,360:1
Preventable Hospital Stays per 100,000	4,958	3,938	2,666
Mammography Screening Rates	40%	42%	44%
Percent Uninsured	8%	7%	10%

Source: County Health Rankings (2025)

Physical Environment

Physical Environment	Raleigh Co	West Virginia	US Overall
Severe Housing Problems	16%	11%	17%
Severe Housing Cost Burden	16%	10%	15%
Driving Alone to Work	83%	79%	70%
Long Commute to Work – Driving Alone	25%	35%	37%
Broadband Access	75%	84%	90%
Access to Parks	9%	15%	51%
Homeownership	75%	74%	65%
Air Pollution – Particulate Matter	6.8	6.7	7.3

Source: County Health Rankings (2025)

Invasive Cancer Incidence Rates

Age-Adjusted Rate	Raleigh Co	West Virginia	US Overall
Total all sites (2017-2021)	485.5	489.8	444.4
Lung and Bronchus	75.8	76.1	53.1
Breast (Female)	118.7	124.7	129.8
Colon and Rectum	50.0	44.3	36.4
Urinary Bladder	17.1	21.3	18.8
Kidney and Renal Pelvis	20.0	21.5	17.3
Melanoma of the Skin	22.9	23.4	22.7

Source: National Cancer Institute: State Cancer Profiles

Hospital Utilization Data

The following data demonstrates the county of residence and payer mix of Beckley ARH inpatient hospital discharges from January 2022- September 2024.

Inpatient Hospital Discharges- Patient Origin

Patient County	Inpatient Discharges	% of Total
Raleigh-WV	8,314	60.2%
Fayette-WV	2,047	14.8%
Wyoming-WV	1,314	9.5%
Summers-WV	1,042	7.5%
Greenbrier-WV	323	2.3%
Mercer-WV	272	2.0%
Nicholas-WV	156	1.1%
McDowell-WV	152	1.1%
Monroe-WV	105	0.8%
Mingo-WV	31	0.2%
Boone-WV	26	0.2%
Logan-WV	18	0.1%
Webster-WV	14	0.1%
Boyd-KY	2	0.0%
Perry-KY	2	0.0%
Magoffin-KY	1	0.0%
Floyd-KY	1	0.0%
Pike-KY	1	0.0%
Total	**13,821**	**100%**

Inpatient Hospital Discharges- Payer Mix*

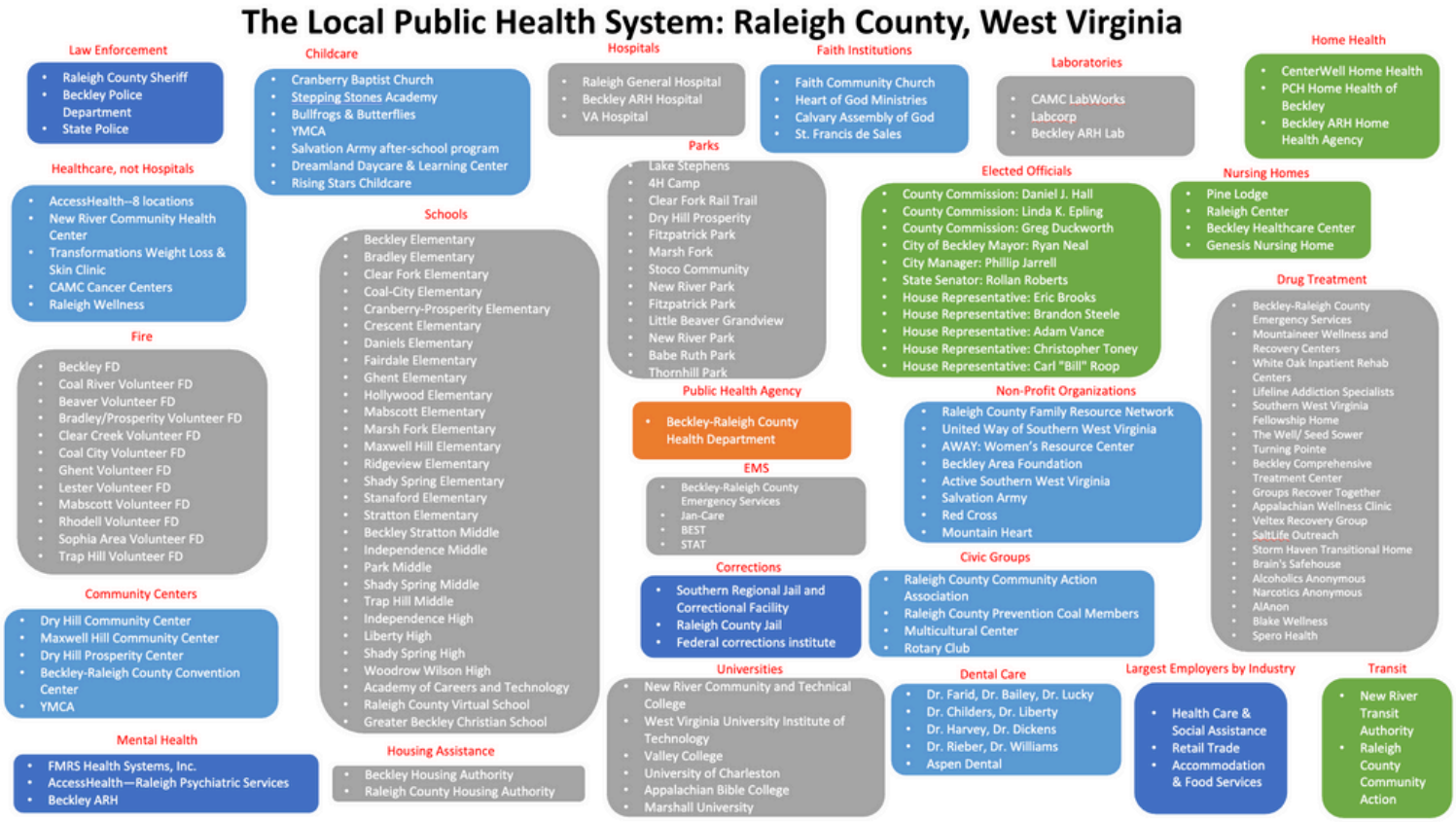
Payer Type	Inpatient Discharges	% of Total
Medicare A and B	3,555	25.7%
Humana Medicare HMO	1,685	12.2%
Aetna Medicare HMO/PPO	1,319	9.5%
Unicare MCD WV	1,177	8.5%
Aetna Better Health MCD WV	1,145	8.3%
West Virginia Medicaid	721	5.2%
Medicare/ UMWA	693	5.0%
VA Community Care Optum	677	4.9%
The Health Plan MCD WV	634	4.6%
Highmark Blue Cross WV	358	2.6%
UHC Medicare HMO	295	2.1%
Self-Pay	204	1.5%
UMR	189	1.4%
UMR/PEIA	97	0.7%
AARP Medicare HMO	87	0.6%
ARH Anthem	82	0.6%
The Health Plan Medicare HMO	80	0.6%
Highmark Blue Cross WV Federal	62	0.4%
Medicare Railroad	59	0.4%
Highmark WV Medicare HMO	48	0.3%
Aetna	47	0.3%
Cigna Health Plan	45	0.3%
United Healthcare	41	0.3%
Medicare Part A Only	40	0.3%
NAPHCARE	36	0.3%
Tricare East	33	0.2%
Black Lung Federal	31	0.2%
WV Senior Advantage	31	0.2%

Sharpe Hospital Diversion	26	0.2%
Medicare Inpt Part B Only	25	0.2%
The Health Plan	17	0.1%
Caresource Marketplace WV	17	0.1%
UMWA	15	0.1%
ChampVA	15	0.1%
Veteran Affairs Med Center	15	0.1%
Hospice of Southern WV	14	0.1%
Wexford Health Sources	14	0.1%
UHC Ohio Medicaid	10	0.1%
State/Co Inmate IP WV Medicaid	10	0.1%
West Virginia Senior Advantage	9	0.1%
SISCO	8	0.1%
Caresource Just 4 Me WV	7	0.1%
Sedgwick	7	0.1%
Seven Corners	7	0.1%
Total	**13,821**	**100%**

**List only includes payers comprising >0.1% of payer mix. Payers <0.1% not listed. Total includes payers not listed.*

Organizing Community Partners

Collaboration among organizations is an essential component of the CHNA process and community health improvement plan. One tool that can be utilized to map organizations that may influence health in the community is the Local Public Health Schematic. The Team Up team collaborated with local residents and members of the Steering Committee to produce a local public health schematic, custom to Raleigh County. An overview of this schematic can be seen below, see Appendix B for a larger font version.



Raleigh County CHNA Steering Committee

Community Health Needs Assessment (CHNA) steering committees typically include representatives from public health agencies, local government, community organizations, healthcare providers, academic institutions, and members of the community, especially those who serve or represent medically underserved, low-income, or minority populations. The steering committee plays an essential role in the CHNA process by providing expert input, aiding in community survey and focus group data collection, interpreting community results, and formulating an effective implementation plan.

Steering committee members were recruited by Beckley ARH leadership in late summer of 2024. On September 6, 2024, the group gathered to discuss the CHNA process, provide their view of health needs for clients they serve, and plan survey dissemination and focus groups. On April 4, 2025 and after months of data collection, the Steering Committee met again for their final meeting (image below).The group reviewed data and collaboratively recommended priority health needs for Beckley ARH to address.

Raleigh County CHNA Steering Committee

Steering Committee Members

Name	Organization Represented
Todd Howell	Beckley ARH
Mark Braskey	Beckley Fire Department
Chris Graham	Beckley Fire Department
Denise Southern	Beckey-Raleigh County Chamber of Commerce
Erin Jones	AWAY
Samantha Sizemore	AWAY
Michelle Kirby	Beckley-Raleigh County Health Department
Joey Preast	Beckley ARH
Danielle Stewart	Board Member, Raleigh County Community Action Association and Civil/ Community Rights Advocate
Rev. Dr. Susan Q Claytor	St. Stephen's Episcopal and Luke's Lutheran Churches
Cindy Whitlock	New River Health and Fayette County Board of Education
Danielle Harmon	ARH
Kelly Elkins	ARH

Community Focus Groups

After the initial steering committee meeting, 3 focus groups were held to gain valuable feedback from community members and residents. Additionally, 1 key informant interview was conducted with a youth from the community. Community members were asked questions regarding health challenges, barriers to accessing healthcare, health behaviors, and community highlights. Discussion in focus groups is fairly free flowing and open-ended, with Team Up staff noting recurring themes and the most pressing issues brought forth by participants.

Beckley ARH hosted forums with:

- Recovery Community Leaders
  - Staff who work with those in SUD recovery
- Beckley Council on Aging
  - Senior community members
- Faith Leaders
  - Leaders from a variety of faith organizations across the community

Sample Focus Group Discussion Questions

"What are your community's biggest health challenges?"

"Why do you think people in your community don't go to the doctor?"

"Are there barriers to accessing healthcare in your community?"

"What health behaviors do you see in your community that concern you?"

"What other concerns do you have?"

Focus Group Results

A qualitative thematic analysis was performed utilizing community forum responses. Recurring challenges and themes were isolated by each forum question (see table 2) and the resulting key findings are presented below:

QUESTION 1: COMMUNITY HEALTH CHALLENGES

Finding 1.1: Basic Needs

- Safety
- Quality of education
- Lack of transportation
- Internet access
- Insurance coverage gaps
- Homelessness
- Parenting skills
- Grandparents raising grandchildren

Finding 1.2: Substance Use & Addiction

- Substance use stigma
- Lack of needle exchange program
- Smoking
- Substance use
- Lack of re-entry housing
- Vaping
- Alcohol use

"What's the big deal? It's just prescription medication."

QUESTION 2: BARRIERS TO HEALTHCARE

Finding 2.1: Social Determinants of Health Barriers

- Transportation
- Traffic congestion
- Need to meet peopel where they are
- Poor quality providers
- Lack of access for seniors
- Lack of internet access
- Cost of care

Finding 2.1: Resource Shortage & Dissemination Barriers

- Lack of specialists
- Lack of dental care, especially for Medicaid population
- Provider communication
- Need resource guides

Focus Group Results

QUESTION 3: HEALTH BEHAVIORS

Finding 3.1: Substance Use

- Smoking
- Smoking during pregnancy
- Chewing tobacco
- Vaping (adults & youth)
- Lack of needle exchange program
- Drug use & overdose
- DUI
- Ramifications of addiction (kinship care, unemployment)

Finding 3.2: Access to Physical Activity

- Education around importance
- Obesity & related disease (diabetes, hypertension, heart disease)
- Lack of physical activity
- Safety
- Technology & social media

"Everything's uphill both ways." (discussing walking places)

QUESTION 4: ADDITIONAL CONCERNS

Finding 4.1: Additional Resources Needed

- Need affordable healthy meals
- Vitamins for low-income population
- Mental health
- Drinking more water
- Nutrition education
- Hearing care
- Resouces for grandparents raising grandchildren
- Lack of access to Chaplains
- Incorporation of faith organizations into outreach events

Key Informant Interview: Youth

HEALTH CONCERNS

- Distracted driving
- Pain clinics
- Sense of scarcity
- Lack of Women's Health
- Transportation barriers
- Cultural attitudes about accessing care
- Substance use
- Lack of generational wealth
- Unmet basic needs

"All of this is rooted in poverty"

BARRIERS TO HEALTHCARE

- Difficult to navigate system
- Lack of sex-education
- Poverty keeps people from seeking care
- Fear & anxiety

POSITIVES & COMMUNITY HIGHLIGHTS

- Mental health resources increasing
- Mental health stigma decreasing
- Want to make life in West Virginia more stable

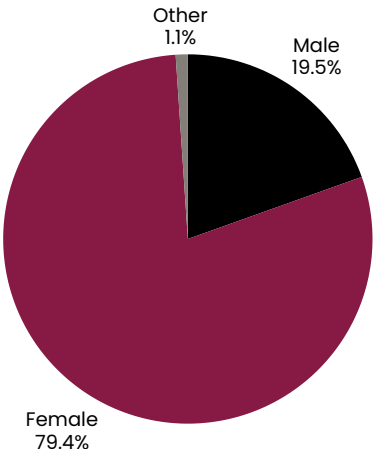
Community Survey Results

The community survey was developed and distributed online and via paper at various community events from October 2024-January 2025. Responses are anonymous. For the full survey instrument, see Appendix C.

Respondent Demographics

n=577

Gender



Education

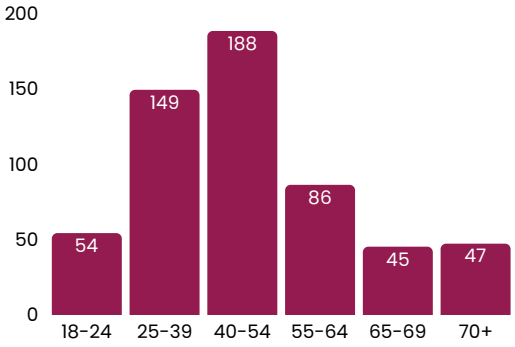
24% High School

9% Technical School

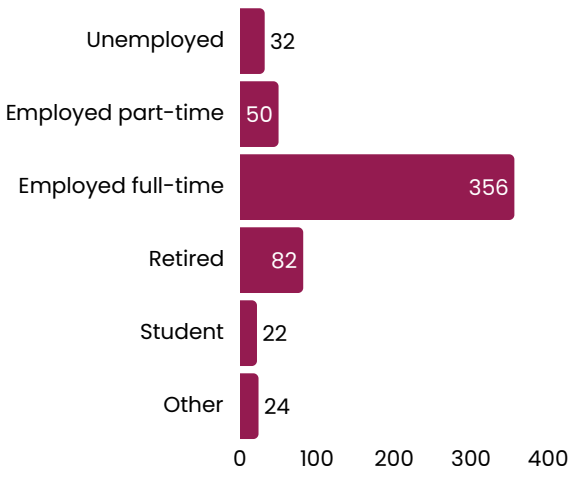
63% College or Above

3% Other

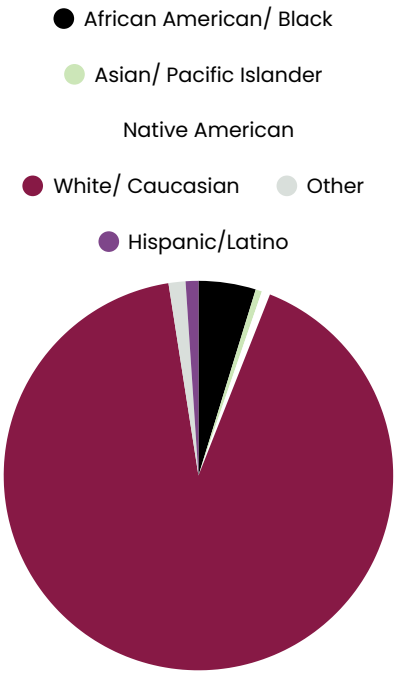
Age



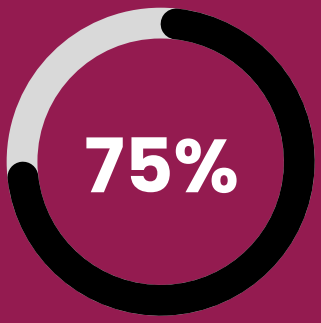
Employment Status



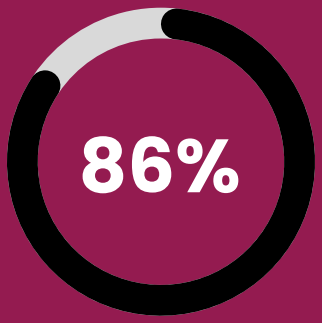
Race/ Ethnicity



Community Survey Results

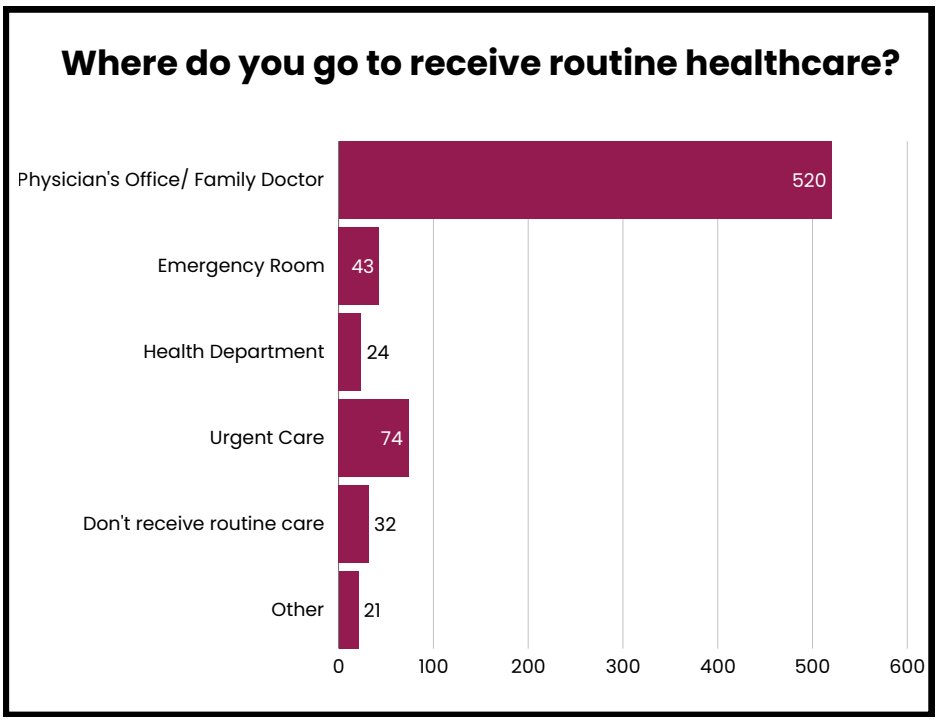


Are satisfied with the ability to access healthcare services in Raleigh County.



Regularly receive preventive services such as vaccinations, screenings, and checkups.

Have delayed healthcare due to lack of money or insurance.

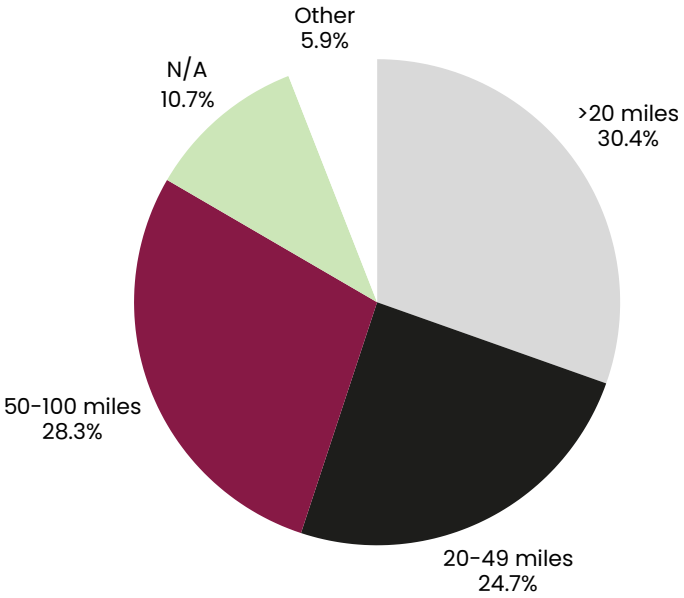


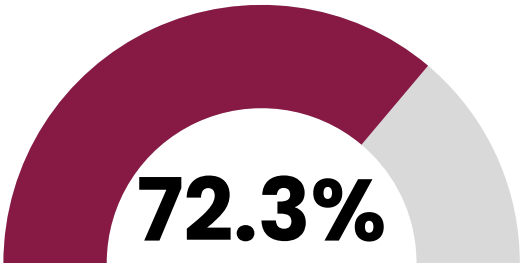
Top 5 barriers to receiving routine healthcare:

1. No barriers
2. Only visit the doctor when something is seriously wrong
3. Months long wait times
4. Physician hours of operation
5. Cannot afford it

Community Survey Results

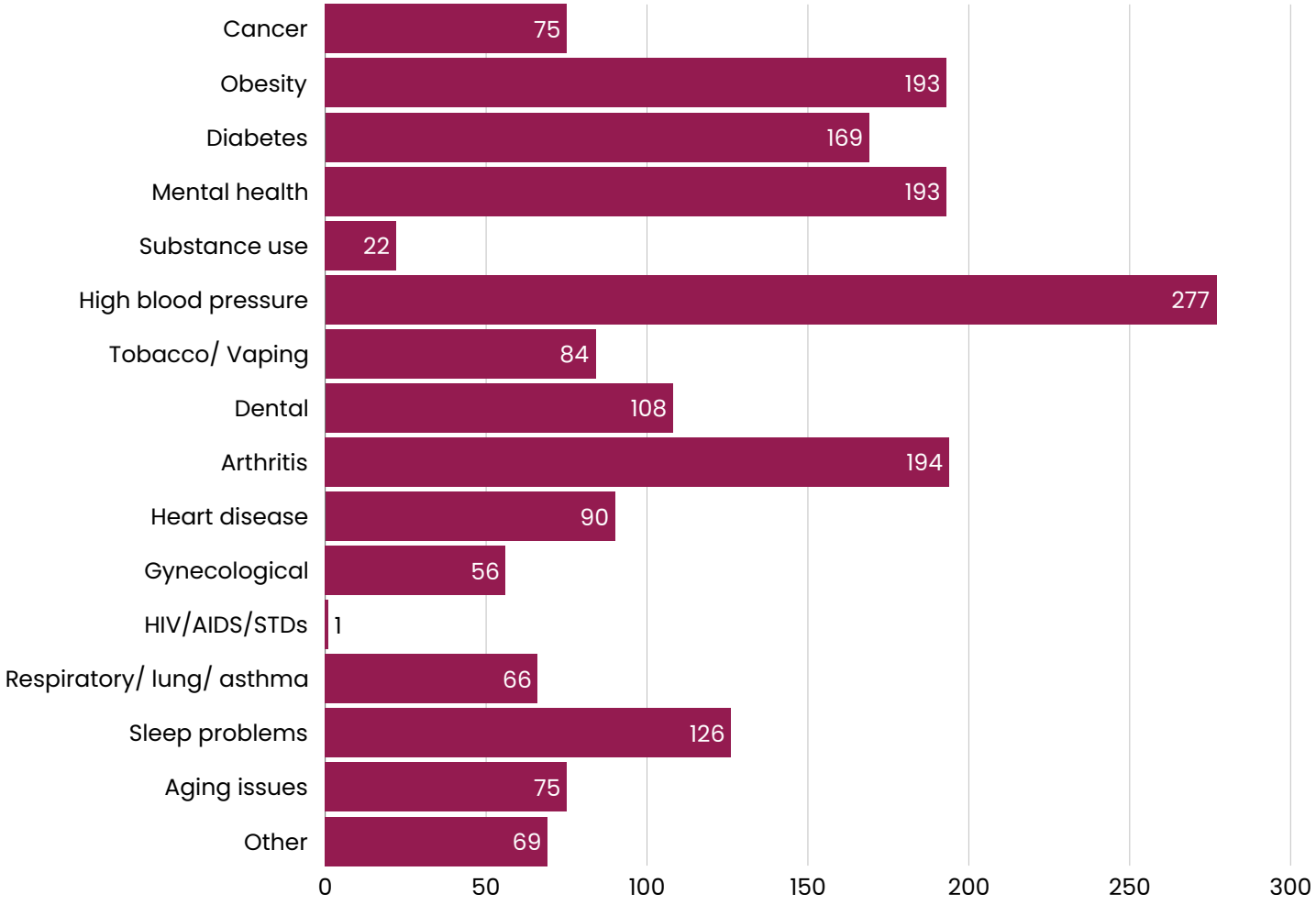
How far do you or your household travel to see a specialist?





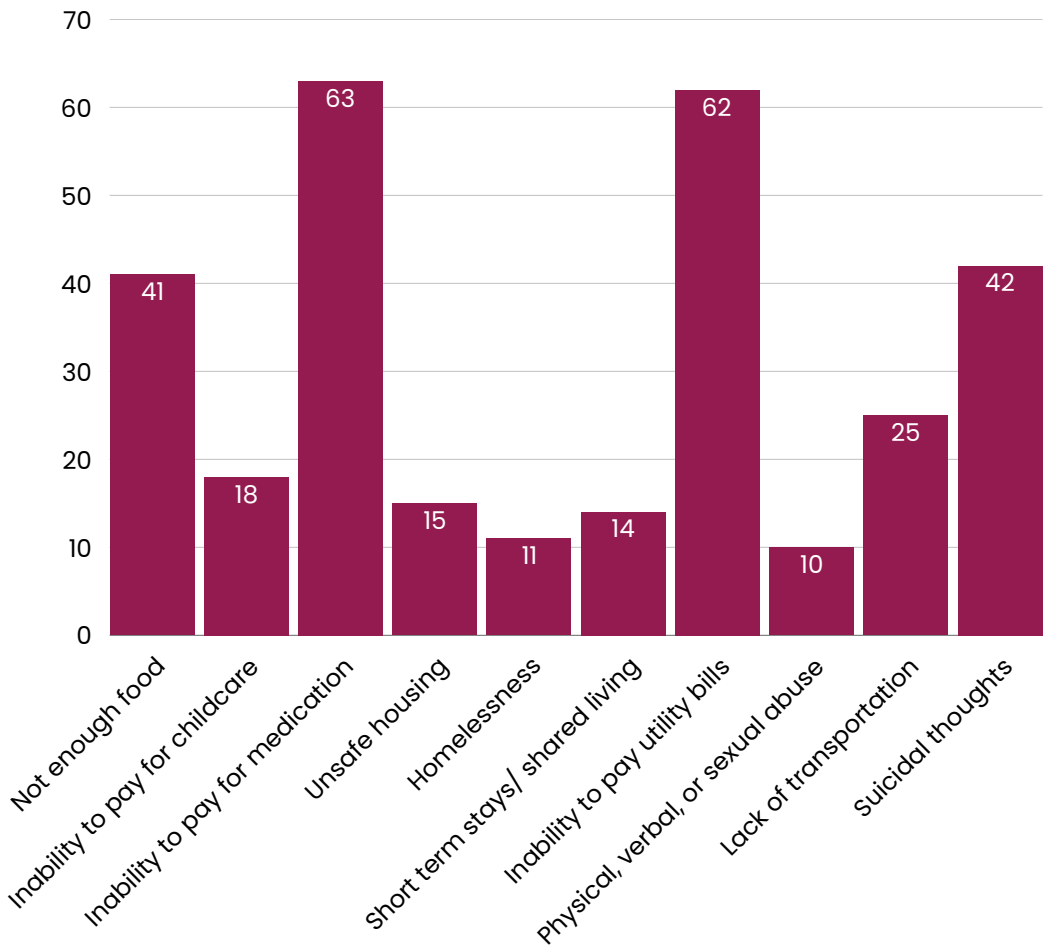
Are satisfied with the availability of mental health services in Raleigh County.

Top 3 health challenges you/ your household face:

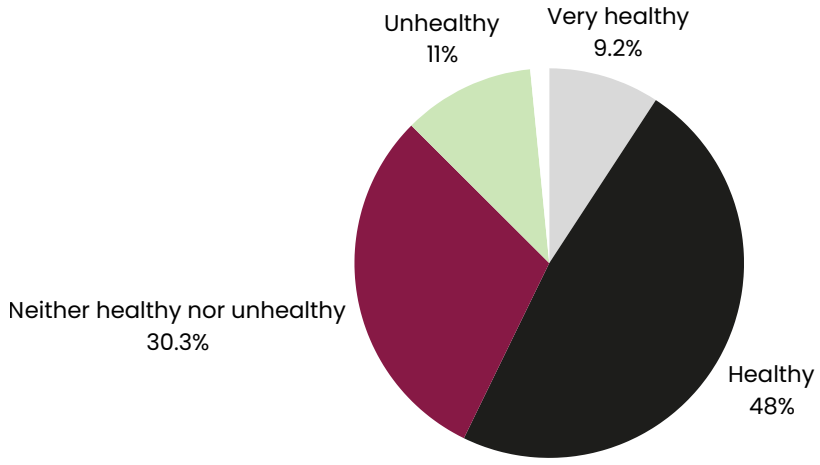


Community Survey Results

Have you or your household faced any of these issues in the past year?



How would you rate your overall health?

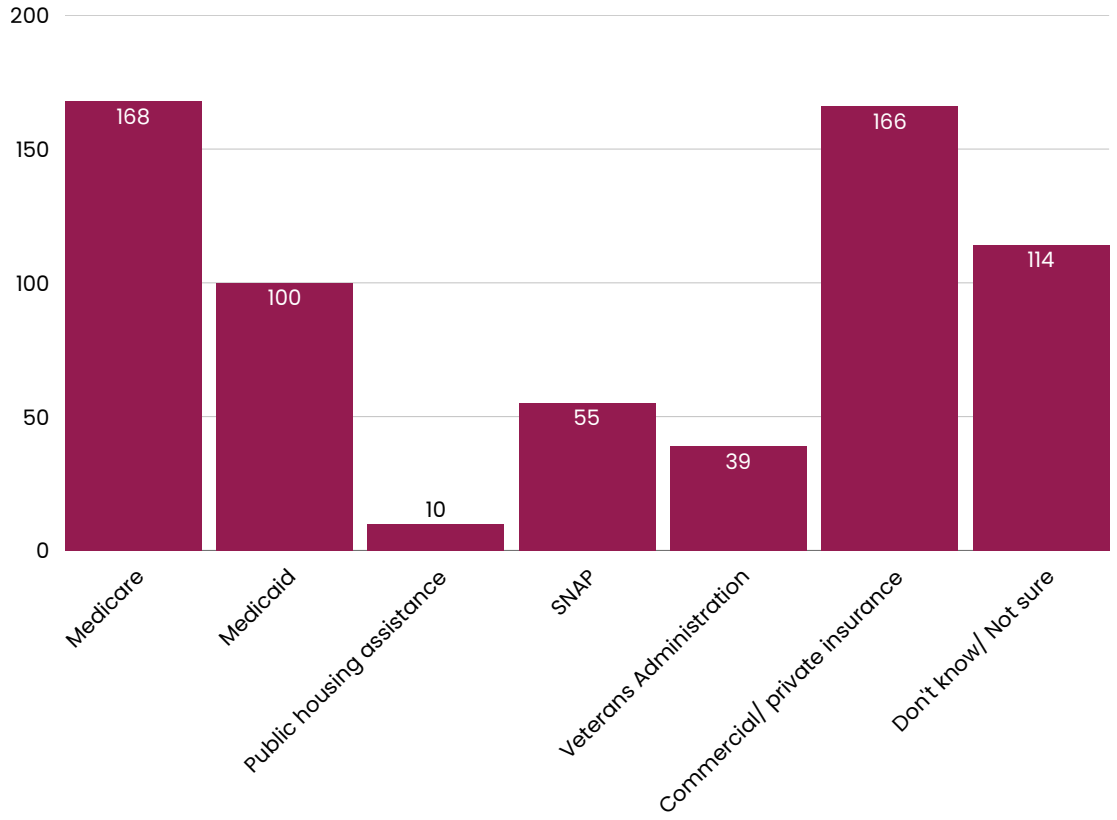


Top 3 risky behaviors you see in your community:

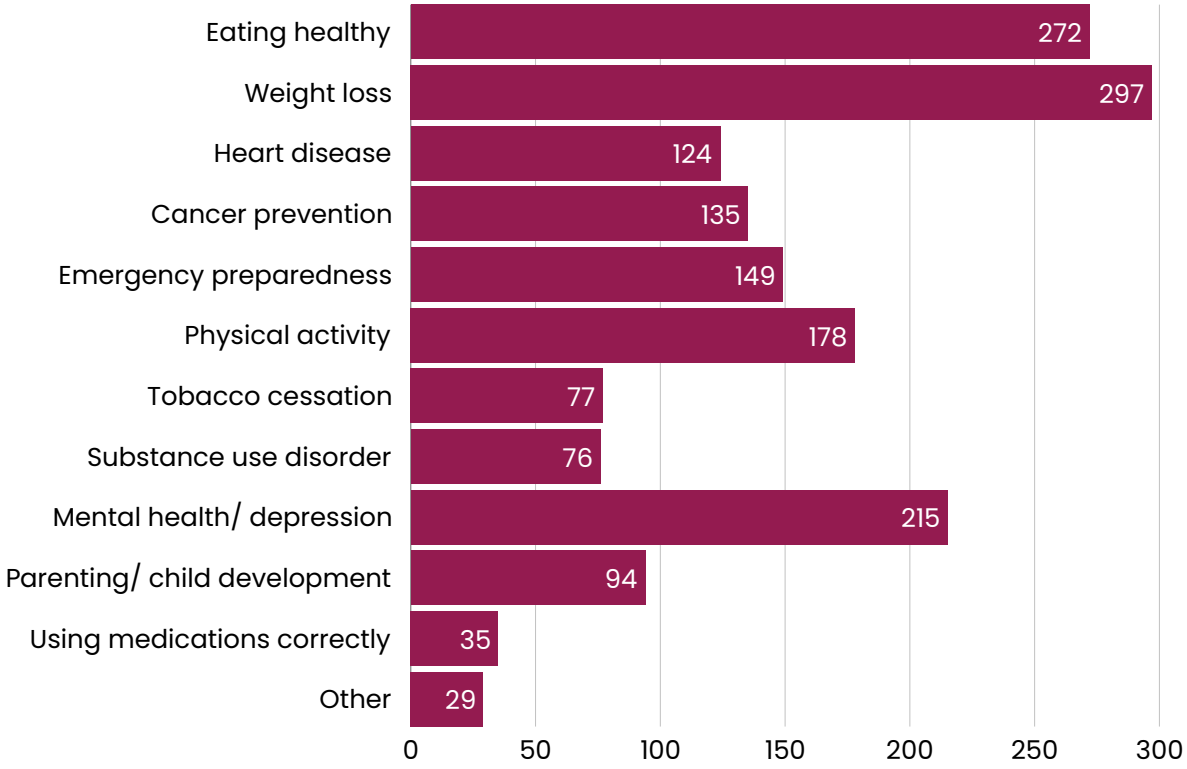
1. Drug Use (405)
2. Poor eating habits (293)
3. Lack of exercise (232)

Community Survey Results

Are you or members of your household currently eligible for any of the following services?

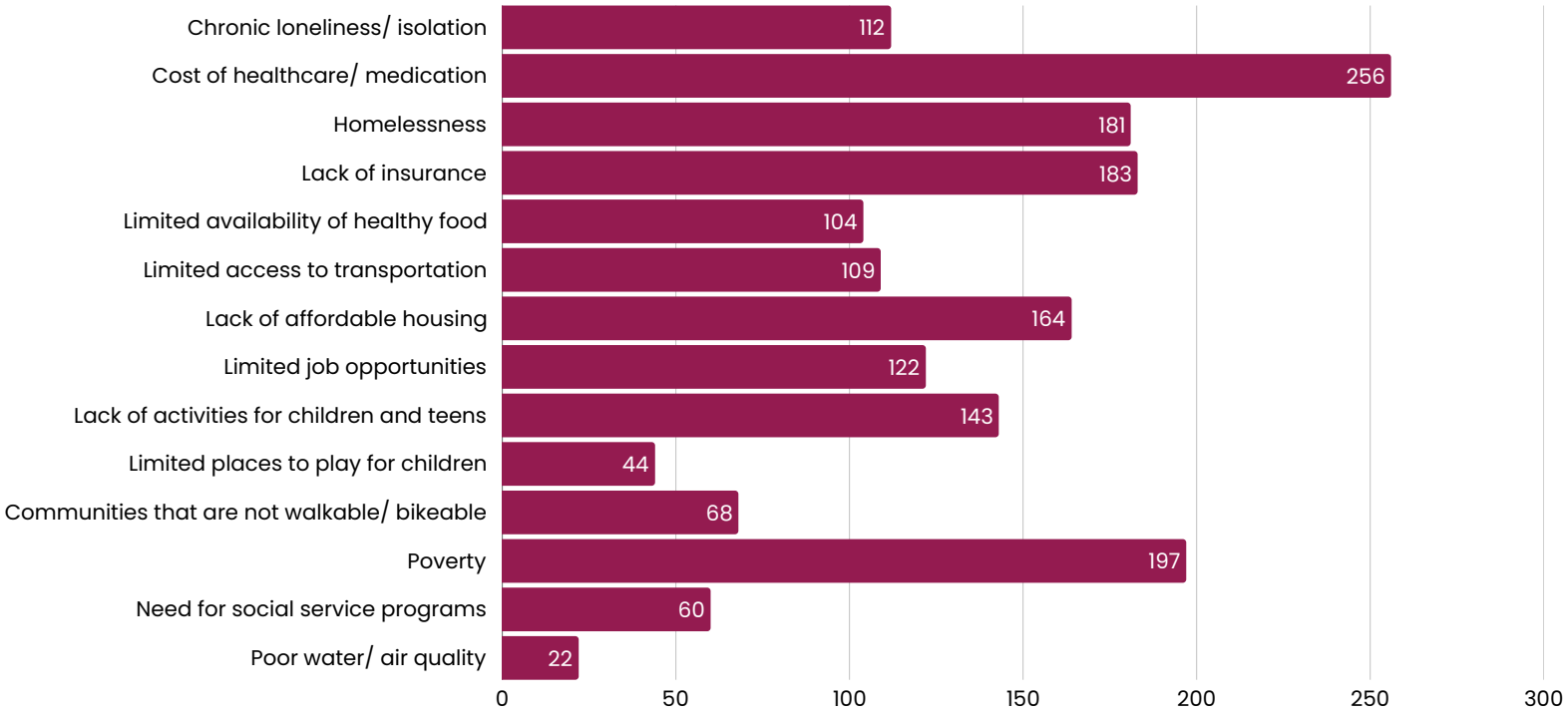


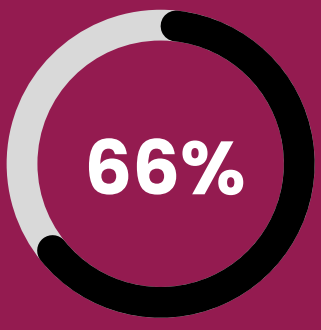
Health related topics respondents are interested in learning more about:



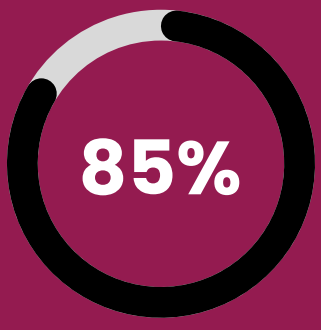
Community Survey Results

Most important problems related to quality of life & environment in Raleigh County:





Have had a dental exam in the past year.

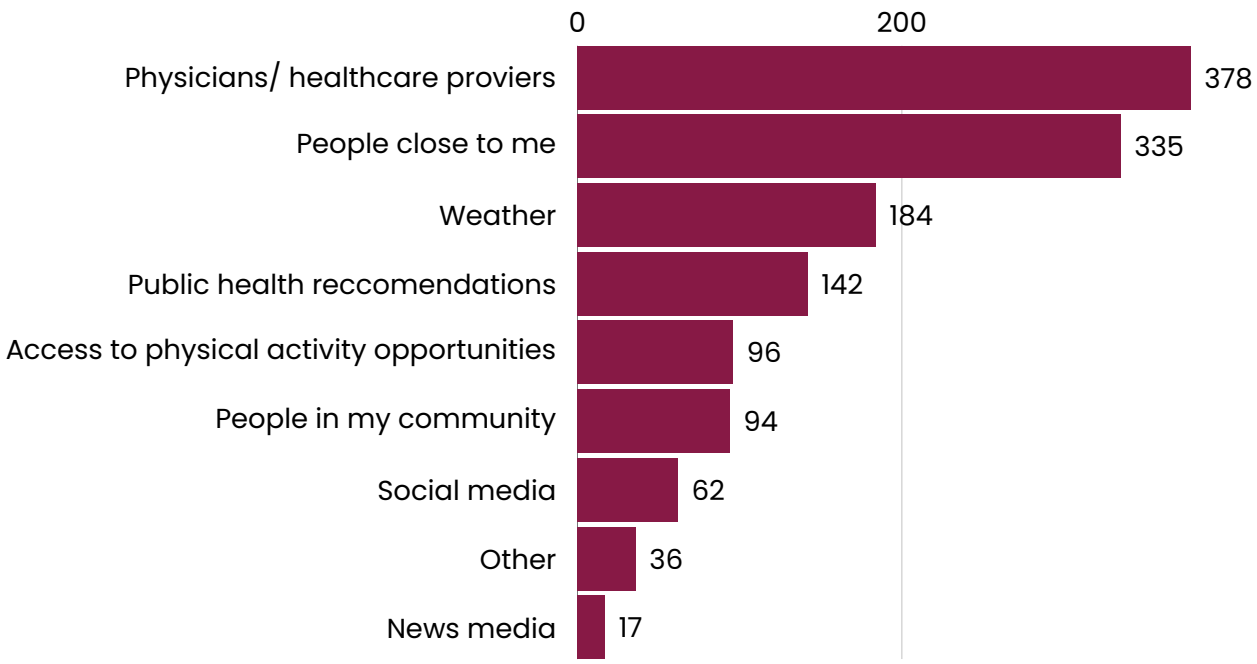


Have had a routine checkup in the past year.

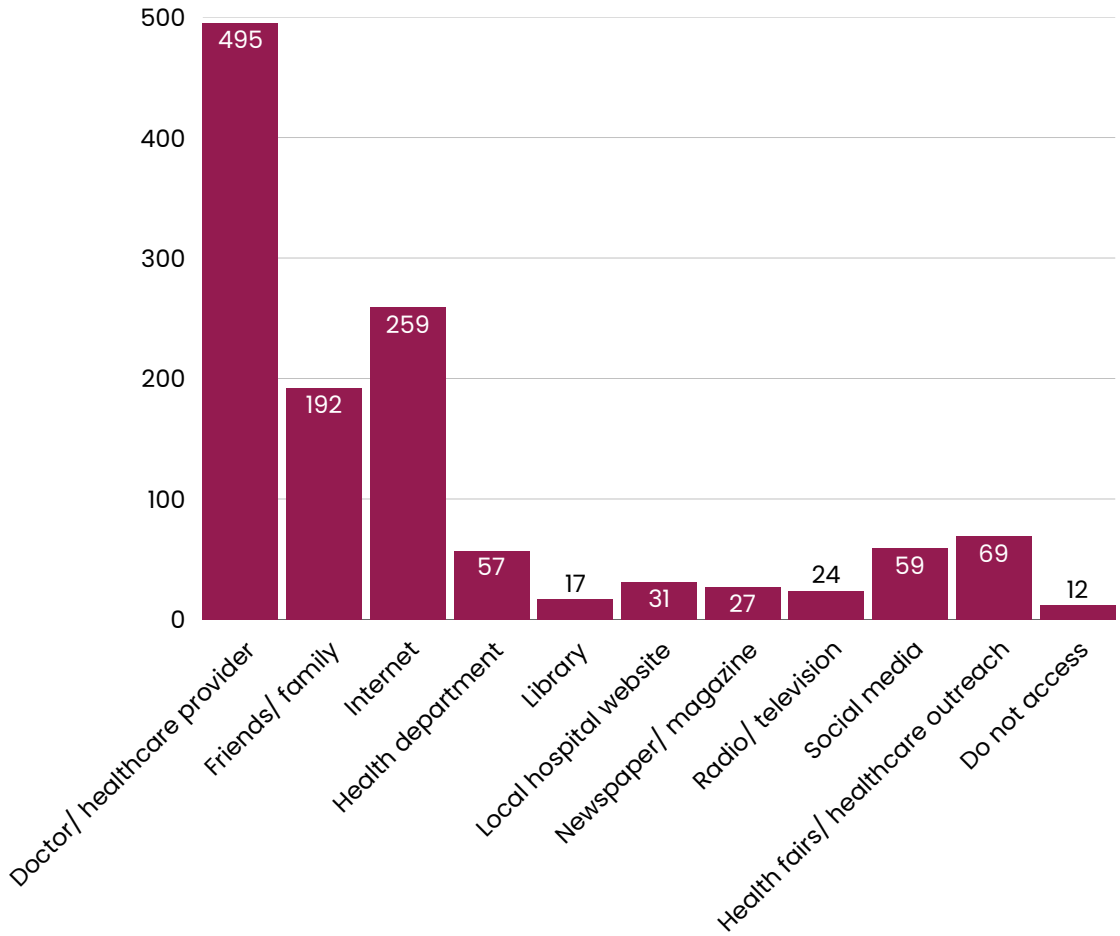
Believe mental illness is a medical condition.

Community Survey Results

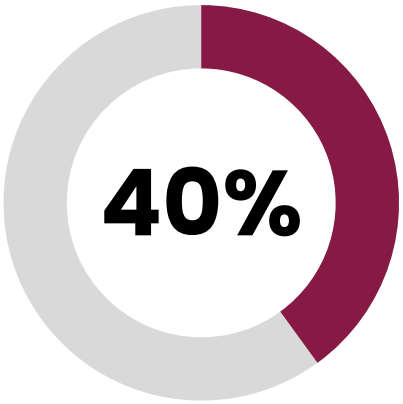
What factors influence your health choices?



Where do you get most of your healthcare information?

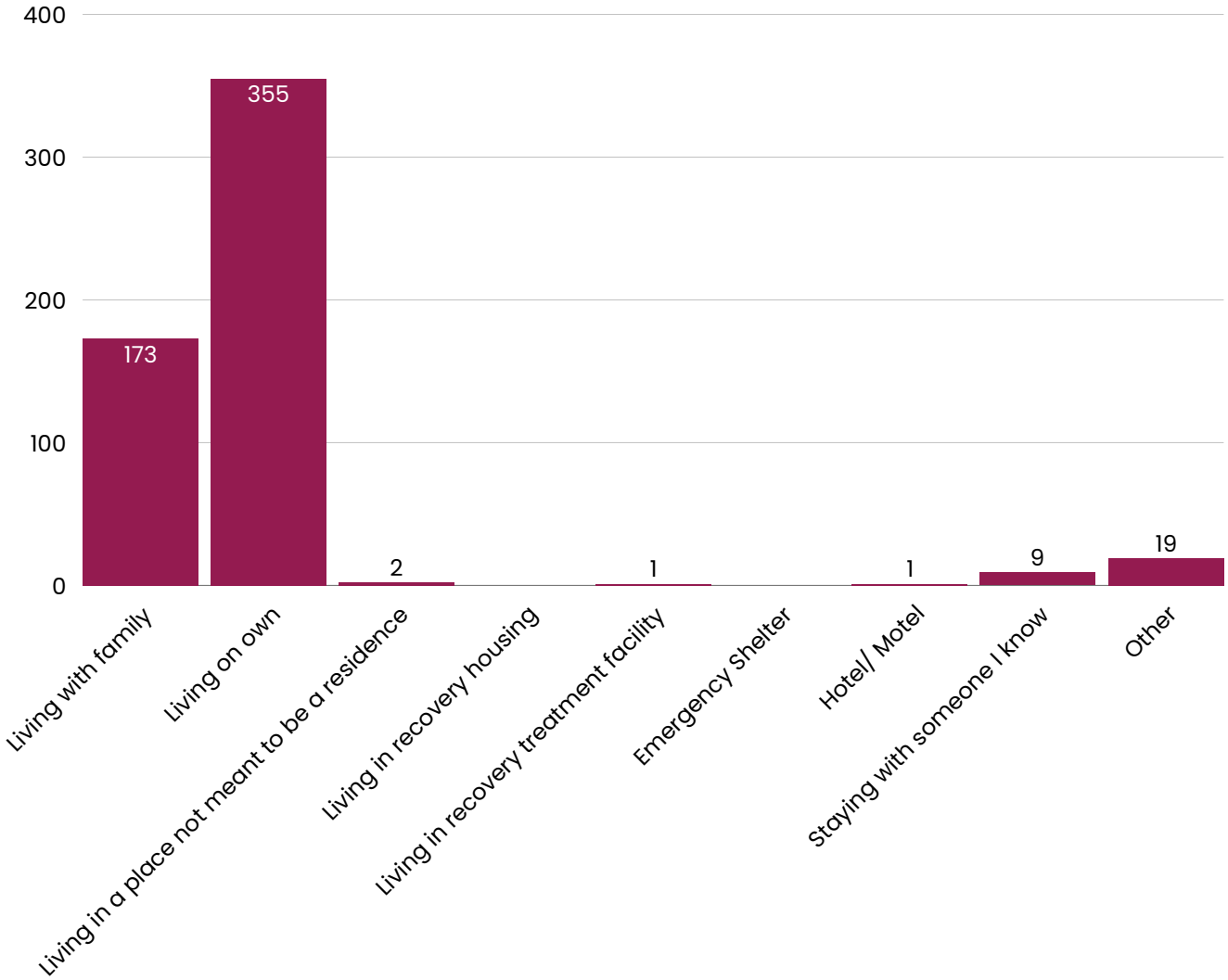


Community Survey Results



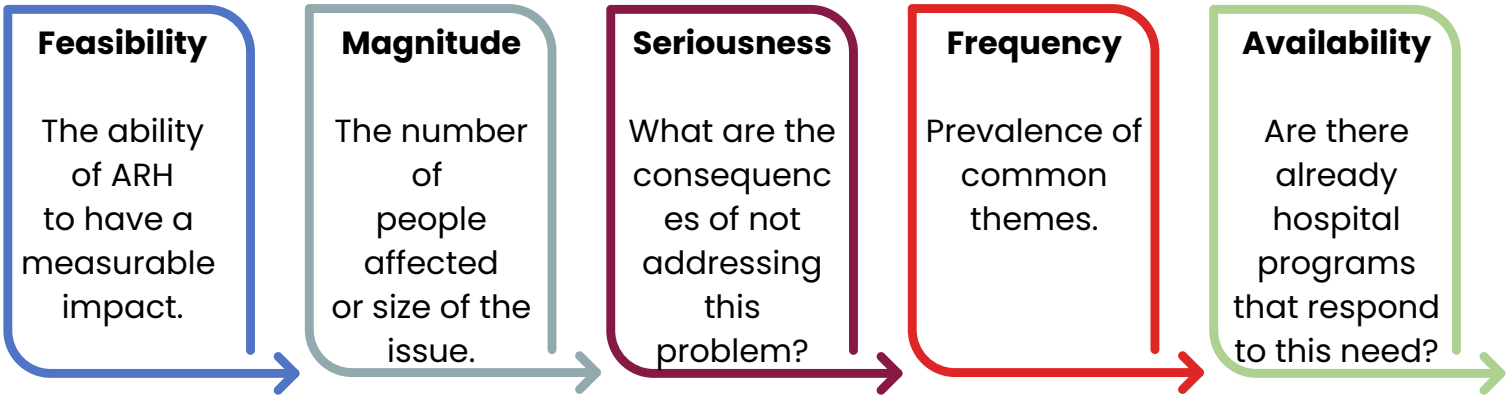
Have been told by a healthcare professional that they have high cholesterol.

What is your current living situation?



Health Needs Prioritization

After primary and secondary data were presented to the CHNA Steering Committee, the group set to prioritizing the top needs using the criteria below.



Through this process, the Steering Committee synthesized and identified the top 4 health needs facing their community to be:

1. **Education on healthy lifestyles and unhealthy behaviors**
2. **Substance use (includes SUD, alcohol, tobacco, and vaping)**
3. **Housing & homelessness**
4. **Basic needs (poverty, scarcity, food insecurity)**

Implementation Plan

Beckley ARH leadership collaborated with the Community Development Department to define the following goals and strategies to address the identified health needs.

Goal: Reduce the incidence and impact of disease by enhancing preventive care and offering healthy lifestyle education

Key Strategies	• Practice preventive medicine by hosting events that specifically promote cancer awareness, teach about early detection, and encourage preventive lifestyles. • Provide screenings and education about obesity-related diseases (heart disease, stroke, diabetes) broadly throughout the community. • Expand nutrition education efforts in collaboration with community partners. • Increase physical activity opportunities in collaboration with community partners.

Goal: Combat addiction through peer support, community collaboration, and education encompassing substance use disorders, tobacco, vaping, and alcohol

Key Strategies	• Continue to grow Beckley ARH's Peer Support Program. Peer support coaches are people who have been successful in the SUD recovery process and can help others that are still in active addiction. Peer Support coaches often respond to overdoses in the ED, refer people to treatment, provide resources for social needs, educate the community on SUD and overdose awareness, and more. • Educate students and parents/ caregivers about the dangers of alcohol, tobacco, nicotine, vaping, and illicit substances through targeted programming. • Provide overdose awareness and education, along with trainings on Naloxone and Narcan throughout the community. • Partner with community organizations, councils, and boards that support addiction prevention and treatment

Goal: Address homelessness and housing insecurity through patient referrals, community partnerships, and shared understanding

Key Strategies	• Increase patient screenings for homelessness (SDOH assessments) in the ambulatory, outpatient, and inpatient settings • Create a guide of community housing resources and a referral process for patients in need • Participate in community coalitions and councils that work to decrease homelessness and meet basic needs, strengthening partnerships with community-based organizations and nonprofits

Goal: Assist patients, employees, and community in meeting their basic needs and escaping poverty

Key Strategies	• Grow the number of patients screened in social drivers of health (homelessness, food insecurity, abuse) upon intake
	• Create an in-facility food pantry program, which provides boxes of shelf-stable food to patients that screen as food insecure in our hospital or clinics
	• Supporting community organizations that work to meet social or emergent needs, such as Red Cross, homeless shelters, domestic violence shelters, REACH food distribution
	• Promoting ARH workplace initiatives meant to assist employees and build communities from within:
	  ◦ Employee Assistance Program
	  ◦ Career Pathway and Training Programs
	• Refer patients to community and social services that can assist them with homelessness, utility assistance, food, etc. Creation of referral guides where they are lacking
	• Hosting employee-led food drives, coat drives, and animal shelter donation drives
	• Provide primary care in outlying communities with use of ARH Mobile Clinic, thereby assisting patients with transportation barriers

Communication and Distribution Plan

Nonprofit hospitals are required by the IRS to both communicate about and publicly distribute their Community Health Needs Assessments (CHNAs) and related Implementation Strategies (IS) to ensure transparency, community engagement, and compliance with federal regulations. To meet best practices and go beyond minimum requirements, ARH will focus on accessibility, outreach, and engagement. Here's how:

- Posting prominently on our ARH website
- Sharing with community partners
- Sharing with members of the steering committee and focus group participants
- Presenting implementation plans in area coalitions, councils, and boards
- Promoting on social media and hospital communications
- Incorporating CHNA in grant proposals and reports
- Providing progress reports and annual updates to the IRS and ARh Board of Trustees

Appendix A

Social Determinants of Health Infographic

RALEIGH COUNTY, WEST VIRGINIA

POPULATION: 72,356

HEALTHY PEOPLE 2030 GOALS AND SOCIAL DETERMINANTS OF HEALTH METRICS

ECONOMIC STABILITY: HELP PEOPLE EARN STEADY INCOMES THAT ALLOW THEM TO MEET THEIR HEALTH NEEDS

1	Idle Youth: Raleigh County 5.4% | West Virginia 3% | United States 2.4%
2	Poverty Rate: Raleigh County 19.6% | West Virginia 17.9% | United States 11.5%
3	**Population 16+ in Labor Force**: Raleigh County 47.8% | West Virginia 53.1% | 63.0%
4	Single Parent Households: Raleigh County 34.37%
5	Households spending at least 30% of income on housing: Raleigh County 22.8% | West Virginia 20.9% | United States 22.8%
6	Population Without Access to Large Grocery Store: Raleigh County 38.6% | West Virginia 38.6% | United States 21.7%
7	Child Food Insecurity Rate: Raleigh County 21.2% | West Virginia 20.3% | United States 15.2%

EDUCATION ACCESS AND QUALITY: INCREASE EDUCATIONAL OPPORTUNITIES AND HELP CHILDREN AND ADOLESCENT DO WELL IN SCHOOL

1	Students Graduating High School in 4 Years: Raleigh County 89.92% | West Virginia 92.53%
2	West Virginia College-Going Rate: Raleigh County 50.7% | West Virginia 52.6%
3	Middle School Students with Proficient or Distinguished on Reading State Assessment: Raleigh County 42%
4	Middle School Students with Proficient or Distinguished on Math State Assessment: Raleigh County 30%
5	Universal Pre-K Participation Rate: Raleigh County 81% | West Virginia 76%
6	Elementary School Students with Proficient or Distinguished on Reading State Assessment: Raleigh County 38%
7	Elementary School Students with Proficient or Distinguished on Math State Assessment: Raleigh County 33%

HEALTH CARE ACCESS AND QUALITY: INCREASE ACCESS TO COMPREHENSIVE HIGH QUALITY HEALTH CARE SERVICES

1	Adult with Recent Doctor Visit for Routine Checkup: Raleigh County 79.1% | United States 71.8%
2	Adults with Recent Preventive Care Visit: Raleigh County 78.7% | West Virginia 78.6% | United States 74.6%
3	Lung and Bronchus Incidence per 100,000 Population: Raleigh County 74.6 | West Virginia 75.7 | United States 54
4	Mammography Use Among Women Aged 50-74: Raleigh County 72.8% | United States 77.8%
5	**STIs per 100,000**: Raleigh County 387.7 | West Virginia 293.1 | United States 495.5
6	Colon and Rectum Cancer Incidence per 100,000: Raleigh County 47.6 | West Virginia 44.2 | United States 36.5
7	Population Under 65 Without Health Insurance: Raleigh County 7.2% | West Virginia 7.4% | United States 9.3%
8	Population With Limited English Proficiency: Raleigh County 0-4.8% | United States 8.3%

NEIGHBORHOOD AND BUILT ENVIRONMENT: CREATE NEIGHBORHOODS AND ENVIRONMENTS THAT PROMOTE HEALTH AND SAFETY

1	**Violent Crime Rate per 100,000 Population**: Raleigh County 478.3 | West Virginia 346.9 | United States 204.5
2	Population with Access to Broadband: Raleigh County 98.4% | West Virginia 90.5% | United States 96.7%
3	Population in County Using SNAP: Raleigh County 15,779
4	Air Quality Hazard: Raleigh County 0.32 | West Virginia 0.37 | United States 0.34
5	Vehicle Crash Fatality Rate per 100,000: Raleigh County 16.1 | West Virginia 44.3 | United States 17.5
6	**Population Within ½ Mile of Walkable Destinations**: Raleigh County 20.8% | West Virginia 28.7% | United States 34%
7	Walkability Index Score: Raleigh County 6.7 | West Virginia 6.3 | United States 6.1
8	Asthma Prevalence Among Adults 18+: Raleigh County 12.2% | United States 9.7%
9	Adult Smoking Rate: Raleigh County 25% | West Virginia 24.5% | United States 20.0%
10	Prevalence of People with Disabilities: Raleigh County 24.4%

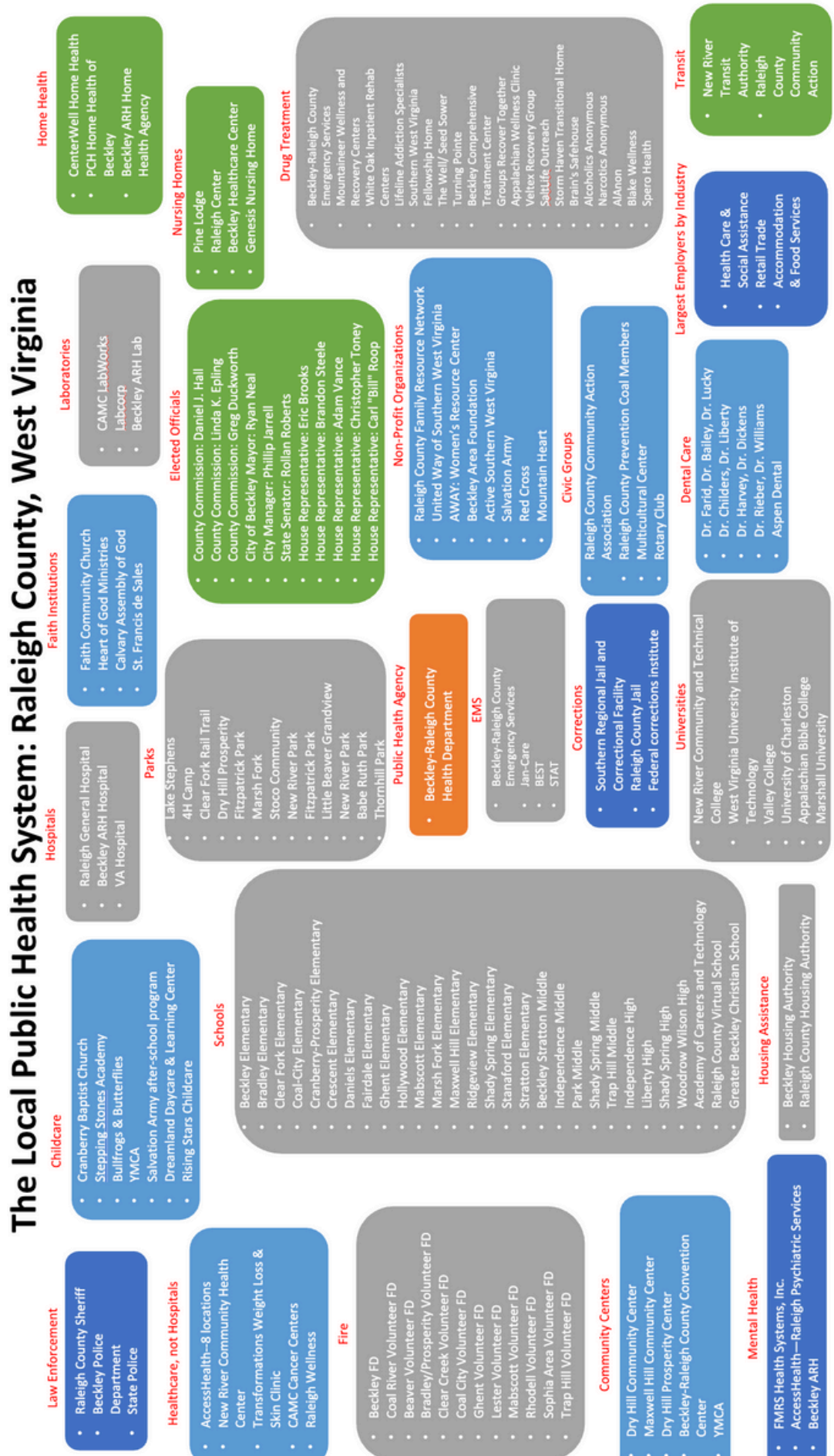
SOCIAL AND COMMUNITY CONTEXT: INCREASE SOCIAL AND COMMUNITY SUPPORT

1	Census Self-Response Rate: Raleigh County 61.3% | West Virginia 64.4% | United States 65.80%
2	Households with a Computer: Raleigh County 85.3% | West Virginia 88.8% | United States 94%

TEAM UP
A Public Health Academic Practice Collaborative

Appendix B

Local Public Health Schematic



Appendix C

Survey Instrument

Appalachian Regional Healthcare

ARH 2024 CHNA Survey

Please take 10-15 minutes to complete this survey. Please do not include your name anywhere. All responses will remain anonymous.

Q1. Please select the ARH facility closest to your home:

- ☐ ARH Our Lady of the Way Hospital, Floyd Co. KY (1)
- ☐ Highlands ARH Regional Medical Center, Floyd Co. KY (2)
- ☐ McDowell ARH Hospital, Floyd Co. KY (3)
- ☐ Morgan County ARH Hospital, Morgan Co. KY (4)
- ☐ Paintsville ARH Hospital, Johnson Co. KY (5)
- ☐ Tug Valley ARH Regional Medical Center, Pike Co. KY (6)
- ☐ Barbourville ARH Hospital, Knox Co. (7)
- ☐ Harlan ARH Hospital, Harlan Co. KY (8)
- ☐ Middlesboro ARH Hospital, Bell Co, KY (9)
- ☐ Hazard ARH Regional Medical Center, Perry Co. KY (10)
- ☐ Mary Breckinridge ARH Hospital, Leslie Co. KY (11)
- ☐ Whitesburg ARH Hospital, Letcher Co. KY (12)
- ☐ Beckley ARH Hospital, Raleigh Co. WV (13)
- ☐ Summers County ARH, Summers Co. WV (14)

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

- ☐ Yes
- ☐ No

Q3. Do you regularly receive preventative services such as vaccinations, screenings, and annual checkups?

- ☐ Yes
- ☐ No

Q4. Where do you go to receive routine healthcare? Select all that apply.

- ☐ Physician's office/my family doctor
- ☐ Emergency room
- ☐ Health department
- ☐ Urgent care
- ☐ I do not receive routine healthcare
- ☐ Other. Please specify below:

  _____

Q5. Are there barriers that keep you from receiving routine healthcare? Select all that apply.

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

Q6. How far do you or anyone in your household travel to see a specialist?

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

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

- ☐ Cancer
- ☐ Obesity
- ☐ Diabetes
- ☐ Mental health issues
- ☐ Substance use disorder (alcohol/drugs)
- ☐ High blood pressure
- ☐ Tobacco use/vaping
- ☐ Dental issues
- ☐ Arthritis/joint pain
- ☐ Heart disease and stroke
- ☐ Gynecological issues
- ☐ HIV/AIDS/STDs
- ☐ Respiratory/lung disease/asthma
- ☐ Sleep problems
- ☐ Aging issues
- ☐ Other. Please specify below:

  _____

Q8. Have you or anyone in your household faced any of these issues in the past year?

- ☐ Not enough food to feed your family
- ☐ Inability to pay for childcare
- ☐ Inability to pay for medications
- ☐ Unsafe housing
- ☐ Homelessness
- ☐ Shared Living / Short term stays with friends/others
- ☐ Inability to pay utility bills
- ☐ Physical, verbal, or sexual abuse
- ☐ Lack of transportation
- ☐ Suicidal thoughts
- ☐ None of the above

Q9. Please select the TOP THREE **risky behaviors related to personal choices** you see <u>most</u> in your community. Select only three.

- ☐ Excessive alcohol use
- ☐ Poor eating habits
- ☐ Lack of exercise
- ☐ Child abuse and neglect
- ☐ Tobacco or vaping use
- ☐ Unsafe sex
- ☐ Drug use
- ☐ Distracted driving
- ☐ Domestic violence
- ☐ Other. Please specify below:

  _____

  _____

Q10. Have you or someone in your household delayed healthcare because of lack of money and/or insurance?

- ☐ Yes
- ☐ No

Q11. 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

Q12. How would you rate your **overall health**?

- ☐ Very healthy / In excellent health
- ☐ Healthy
- ☐ Neither healthy nor unhealthy / Fair
- ☐ Unhealthy
- ☐ Very unhealthy

Q13. Are you satisfied with the availability of mental health services in your area (example: counselors, psychiatrists, etc.)?

- ☐ Yes
- ☐ No

  If no, why? _____

Q14. What could be done in your County to better meet your health needs?

Q15. 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
- ☐ Physical activity
- ☐ Tobacco cessation
- ☐ Substance use disorder (alcohol and/or drugs)
- ☐ Mental health/Depression
- ☐ Parenting / Child development
- ☐ Using my medications correctly
- ☐ Other. Please specify below:

_____

Q16. From the following list, which do you think are the 3 most important problems related to quality of life and environment in your county? Please choose ONLY 3

- ☐ Chronic loneliness or isolation
- ☐ Cost of health care and/or medications
- ☐ Homelessness
- ☐ Lack of health insurance or poor coverage
- ☐ Limited ability to get healthy food or enough food
- ☐ Limited access to transportation
- ☐ Lack of affordable housing
- ☐ Limited job opportunities
- ☐ Lack of activities for children and teens
- ☐ Limited places to play for children
- ☐ Communities that are not walkable/bikeable
- ☐ Poverty
- ☐ Need for social service programs
- ☐ Poor water or air quality

Q17. Have you had a dental exam in the past year?

- ☐ Yes
- ☐ No

Q18. Have you had a routine checkup in the past year?

- ☐ Yes
- ☐ No

Q19. Do you believe mental illness is a medical condition?

- ☐ Yes
- ☐ No

Q20. Have you been told by a healthcare professional that you have high cholesterol?

- ☐ Yes
- ☐ No

Q21. Have you or anyone in your household used ARH hospital services in the past 12 months?

- ☐ Yes
- ☐ No

Q22. If you used a hospital other than ARH in the past 12 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:

  _____

Q23. How would you rank 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

Q24. What factors influence your health choices? Select all that apply.

- ☐ People close to me (friends, family, spouse)
- ☐ People in my community
- ☐ Listening to physicians and other healthcare providers
- ☐ Public health recommendations/guidelines (example: CDC)
- ☐ Social media (Facebook, Instagram, etc.)
- ☐ Whether or not I have access to physical activity opportunities
- ☐ Weather (seasons: Spring, Summer, Fall, Winter)
- ☐ News media
- ☐ Other

Q25. 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 (Facebook, Instagram, etc.)
- ☐ Health fairs or other healthcare outreach
- ☐ I do not access health information

Q26. 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

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!

We would like to extend our most sincere gratitude to the Raleigh County community for your input and contributions to this Community Health Needs Assessment process. Because of your participation in this process, we were able to not only understand the health challenges that Raleigh County residents face, but also the complex systems and context you operate within. With this information, we are able to create a more effective and comprehensive implementation plan to address these issues. Thanks to your dedication, we are able to work towards improving your selected health priority issues to create lasting, positive change.

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Approval

This Community Health Needs Assessment and attached Implementation Plan was approved by the ARH Board of Trustees on May 9, 2025.

BOT Chairperson Signature

7/28/25

Date