COMMUNITY HEALTH NEEDS ASSESSMENT

2025-2027

ARH Harlan

TEAM UP
A Public Health Academic Practice Collaborative

Acknowledgements

This Community Health Needs Assessment (CHNA) report was prepared for Harlan 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 O. Harris

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

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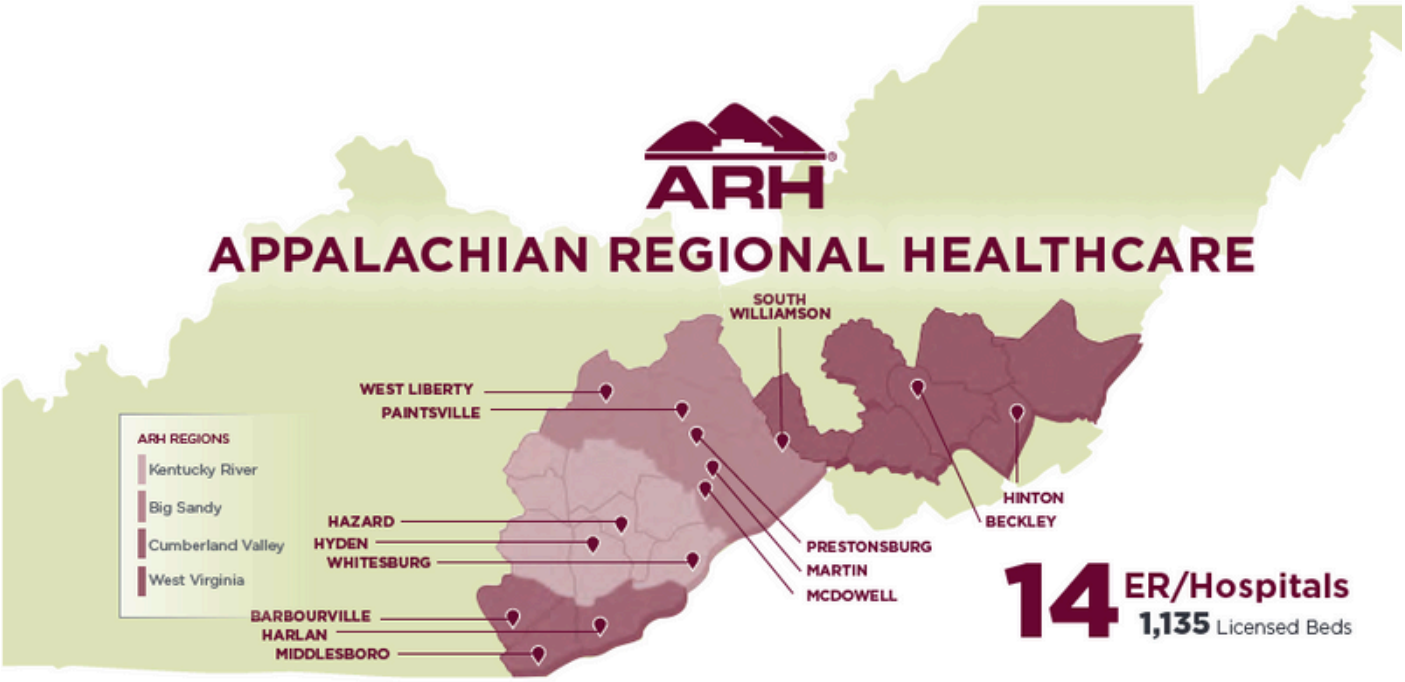
Introduction

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, Harlan 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

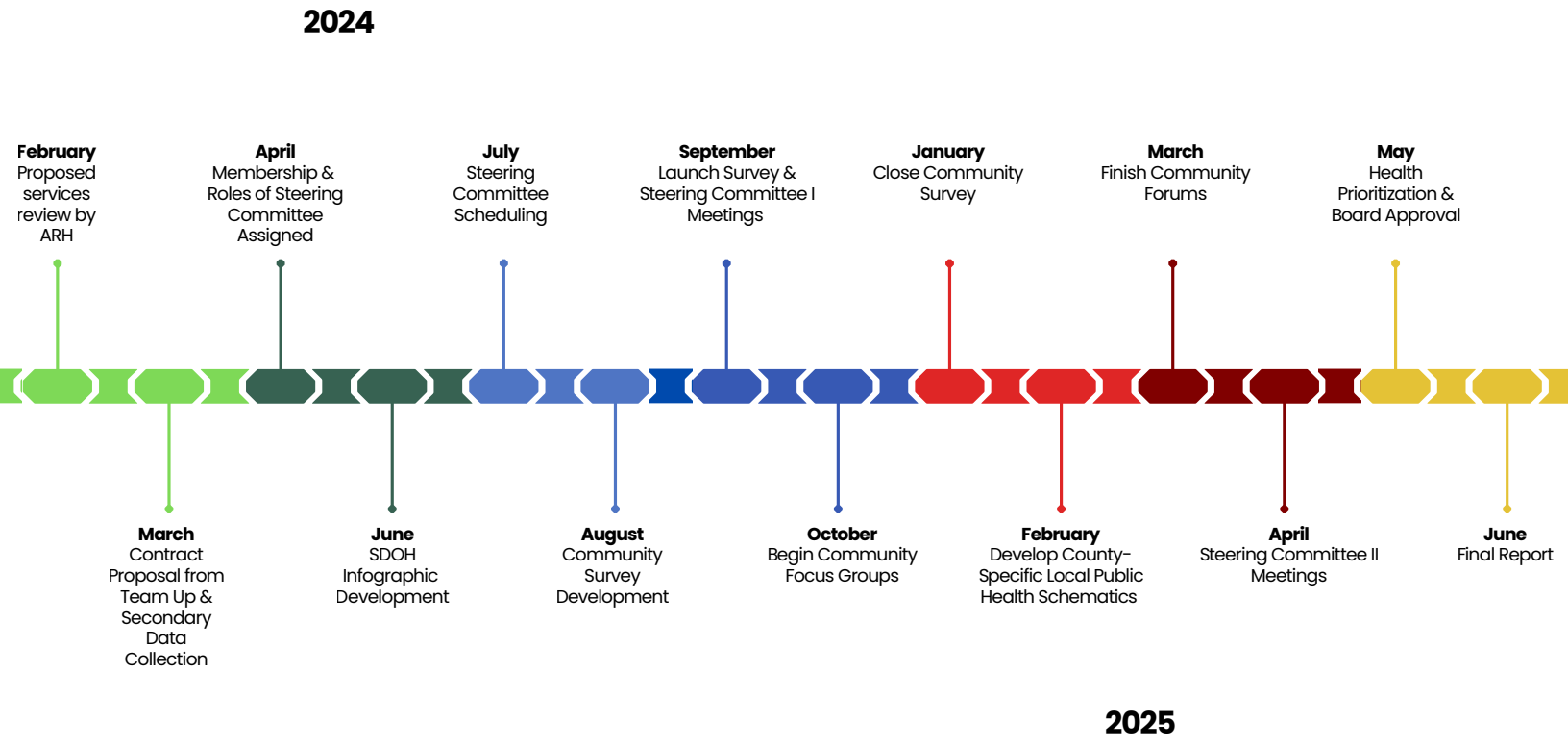
Community Health Needs Assessment (CHNA) steering committees are groups of key stakeholders assembled to guide the planning, development, and implementation of the CHNA process for non-profit hospitals. These committees typically include representatives from public health agencies, local government, 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 Harlan County

See the CHNA process timeline below.

CHNA Timeline



2022-2024 Implementation Successes

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

1. Drug Abuse/ Substance Use Disorder
2. Educational Programs and Behavioral Health Issues
3. Aging in Place and Other Senior-Oriented Services
4. Obesity and Healthy Eating Options

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

Goal 1

Address addiction and mental health issues through peer support, community partnerships, and education

Since 2022, Harlan ARH has addressed **addiction and mental health** by:

- In 2022, Harlan ARH launched the **Peer Support Program**, employing Certified Peer Support Coaches to work in our Emergency Department and throughout the community. Peer support coaches are people who have been successful in the SUD recovery process and can help others that are still in active addiction. Our coaches often respond to overdoses in our ED, refer people to treatment, provide resources for social needs, educate the community on SUD and overdose awareness, and more. Since 2022, Harlan ARH Peer Recovery Coaches have:
  - Engaged **763** patients
  - Referred **151** patients to treatment
  - Provided **155** Linkages to treatment
  - Assisted **39** individuals with attaining housing or employment

- Peer Recovery Coaches have worked with community partners to host many **community events** over the past three years. Events with a Substance Use Disorder /Drug Prevention focus include Harlan Kids Fest, Overdose Awareness Night, in-school SUD prevention programs each semester at Harlan County High School, Harlan County Drug Summit, and weekly Self Help meetings provided at the hospital.

- ARH Peer Support Coaches and Community Development staff also serve on many **coalitions, boards, and councils** that work to create drug-free communities. These include Operation Unite Coalition, Agencies for Substance Abuse Prevention, and the ARH-created Recovery Infrastructure Development Committee.

- ARH has also supported **NARCAN distribution efforts** and **Save A Life Roadshow** in partnership with KY Department of Public Health each year. Peer Recovery Coaches also provided Naloxone training to staff of Cumberland Hope Center, Harlan Recovery Services, LMU, and SEKRI.

- In an effort to **grow mental health services,** Harlan ARH has:
  - Successfully implemented mid-level providers in the Daniel Boone Clinic, which has increased access and capacity, generating an additional 3,000 visits since initiation in January 2023.
  - Developed and distributed “Meet the Provider" videos. These videos have been well-received and have played a crucial role in our outreach efforts.
  - Initiated virtual visits for post-discharge follow-up visits by our dedicated psychiatrist, which has resulted in an impressive 1,700 additional virtual visits since March of 2023.
  - Coordinated with a social worker to conduct monthly mental health educational events at the Harlan community senior center

Goal 2

Provide community education about healthy behavior, how to access health care and improve deicisonmaking skills among members of the community

Since 2022, Harlan ARH has **provided community education about healthy behavior, accessing healthcare, and improving decision making skills** by:

- Harlan ARH provided health education, preventative screenings, and disease awareness events broadly throughout the community from 2022-2024, including:
    - **Quarterly Lunch and Learns programs** in 2023-2024 for the community on topics of:
        - Cholesterol and heart disease
        - Stroke awareness and prevention
        - Healthy eating strategies
        - Controlling diabetes
    - **Three "Walk and Talk"** programs led by the facility cancer committee, oncology services and infusion suite nursing staff. Participants engaged in moderate exercise while discussing cancer specific topics (skin cancer, colon cancer).
    - **Four Fitness Fair events** at Harlan Elementary School, in which students are led through body strength, flexibility, and endurance testing and provided health education programming. This program is made possible through donations from Harlan ARH Auxiliary.
    - The **monthly Medical Explorers** is held at two middle schools in the Harlan area, focusing on a different area of medical science and education in each session. Classroom presentations and hospital facility tours are included throughout the year for both schools. Administrative staff of the county school district have reported the program has contributed to their students' higher level of performance in biology exams. The hospital's volunteer auxiliary also donated funds for teaching materials for the classes, which included an instructional video series, anatomical mannequins and charts, and presentation displays characteristic of health risks and medical conditions.
    - Two **medical inflatables**, a brain and heart, were purchased through grant funds and used at 20+ events throughout the service area since 2022. These 6ft high, 10ft long inflatables are replicas of the organs and teach about organ functions, various types of related disease, and some of the latest medical treatments for heart and brain issues.
    - Walk through medical inflatables of a colon and lung were also used in f**our educational events** in partnership with Kentucky Cancer Program. In particular, ARH's Love Your Lungs was a success in local schools. This program teaches the dangers of smoking and vaping on adolescent lungs.

- A total of **22 stroke awareness and educational programs** were held for the public between September 2022 and October 2024, reaching a total of 2,156 people. A dozen of these events were "Brain Saver/Brain Protector" programs taught in local school classrooms. Adult screening events were held at public venues including local festivals and ballgames.

Goal 3

Outreach and support for seniors and caregivers

Since 2022, Harlan ARH has **improved outreach and support for seniors and caregivers** by:

- In August 2022, the **Harlan County Committee on Aging**, which operates federally funded programs through the Older Americans Act and manages the affiliated senior citizens center programs, conducted a survey of its clients to gauge the level of interest in a variety of health topics. The results of the survey were used by ARH to schedule a monthly rotation of educational programs at their main congregate center in Harlan.

- Topics presented since 2022 include **cancer, hypertension, stroke, heart disease, respiratory disease, nutrition, fitness and exercise, obesity, tobacco risks, mental health risks, and substance abuse disorders**. Free screenings and health fairs were also provided twice per year. ARH staff organized over 90% of these activities over the past three years, with community partners managing the remainder. The center provides transportation to clients who are unable to drive themselves. Informational materials were made available for the senior center staff to provide to their clients who only receive home services.

Goal 4

Address obesity and its health consequences through work on root causes; food insecurity, physical inactivity, and lack of knowledge on healthy nutrition

Since 2022, Harlan ARH has addressed obesity and its health consequences by:

- **Providing free gym membership**s to all ARH employees at Core Fitness and subsidized discounted membership fees for family members.

- **Provided nutrition education** from an ARH dietitian during community events, such as Lunch and Learns.

- **Partnered with a new food service company**, Sodexo, to revamp cafeteria menus and meals for employees and patients. New menus include plant based options, higher protein, and education on caloric intake.

- Beginning in 2023, Harlan ARH engaged in partnership with the University of Kentucky, Grow Appalachia, and the Pine Mountain Settlement School to support local farms and food producers through a CSA program for employees. This program provided fresh produce during the summer months. Harlan's program **delivered 20 bags of produce bi-weekly from local growers.**

- Harlan ARH and the ARH Foundation **funded the delivery of fresh foods to 100 clients** of the University of Kentucky's Kentucky Homeplace program in Harlan County. In 2022 and 2023, a total of 100 qualified Homeplace clients were provided with a redeemable $25 voucher to Ropers Market in Harlan, which is a retail source of locally- and regionally grown fresh foods, specializing in produce. The program was expanded in 2024 to provide clients with monthly $25 vouchers to cover the spring, summer and fall harvest seasons. In addition to fresh produce, participants are also case managed and referred to social organizations or healthcare when necessary.

Community Served by Harlan ARH

Harlan 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 Harlan County (83.7%).

Secondary data for Harlan 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 Harlan County. An infographic containing data on the Social Determinants of Health can be located in Appendix A.

Population

Population	Harlan Co	Kentucky	US Overall
Population, 2024	25,052	4,588,372	340,110,988
Percent of Population Under 18 Years	23.8%	22.5%	21.7%
Percent of Population 65 Years+	19.9%	17.8%	17.7%
Percent of Population White	95.9%	86.7%	75.3%
Percent of Population Non-Hispanic Black	2.0%	8.8%	13.7%
Percent of Population American Indian & Alaska Native	0.3%	0.3%	1.3%
Percent of Population Asian	0.5%	1.8%	6.4%
Percent of Population Native Hawaiian/Other Pacific Islander	0.1%	0.1%	0.3%
Percent of Population Hispanic or Latino	1.2%	5.0%	19.5%
Two or More Races	1.2%	2.3%	3.1%
Percent of Population Female	51.9%	50.4%	50.5%

Source: US Census, 2024 QuickFacts

Social and Economic Factors

Social and Economic Factors	Harlan Co	Kentucky	US Overall
Percent Completed High School	79%	89%	89%
Bachelor's Degree or Higher	13%	27%	35%
Percent Unemployed	6.6%	4.2%	3.6%
Percent of People in Poverty	29.7%	16.4%	11.1%
Children in Poverty	35%	20%	16%
Number of Children in Single Parent Households	27%	25%	25%
Median Household Income	$36,900	$61,100	$77,700
Violent Crime Rate (per 100,000)	62.8	225.6	255.2
Child Care Cost Burden	29%	25%	28%
Food Insecurity Rate	24%	16%	14%

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

Health Behaviors

Heath Behaviors	Harlan Co	Kentucky	US Overall
Percent Adult Smoking	28%	18%	13%
Percent Adults with Obesity	45%	38%	34%
Percent of Physically Inactive Adults	36%	25%	23%
Adults (>65) with all Teeth Lost	24.1%		12.6%
Percent of Adults Receiving Flu Vaccination in the Last Year	22%	46%	48%
Teen Birth Rate (per 1,000)	39	24	16
Sexually Transmitted Infections per 100,000	171.5	406.8	495.0
Percent Excessive Drinking	13%	15%	19%
Number of Child Victims of Substantiated Abuse	100	17,917	-
Births to Mother who Smoked During Pregnancy	26.6%	12.6%	5%
Percent Driving Deaths with Alcohol Involvement	20%	26%	26%
Suicides Per 100,000 Population	17	18	14

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

Health Outcomes

Heath Outcomes	Harlan Co	Kentucky	US Overall
Life Expectancy (years)	65.7	73	77
Percent Adults with Diabetes	15%	13%	10%
Percent Adults with Hypertension	41.2%	-	29.6%
Adults with current Asthma	12.9%	-	9.9%
Percent Fair to Poor Health	31%	20%	17%
Avg Number of Physically Unhealthy Days	6.2	4.5	3.9
Avg Number of Mentally Unhealthy Days	6.4	5.0	5.1
Percent Low Birth Weight	10%	9%	8%
Percent with a Disability, under Age 65	22%	13%	9%

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

Access to Care

Access to Care	Harlan Co	Kentucky	US Overall
Primary Care Physicians	2,910:1	1,600:1	1,330:1
Mental Health Providers	1,690:1	320:1	300:1
Dentists	3,210:1	1,500:1	1,360:1
Preventable Hospital Stays per 100,000	5,625	3,336	2,666
Mammography Screening Rates	20%	43%	44%
Percent Uninsured	7%	7%	10%

Source: County Health Rankings (2025)

Physical Environment

Physical Environment	Harlan Co	Kentucky	US Overall
Severe Housing Problems	15%	13%	17%
Severe Housing Cost Burden	11%	12%	15%
Driving Alone to Work	75%	78%	70%
Long Commute to Work – Driving Alone	30%	31%	37%
Broadband Access	82%	87%	90%
Access to Parks	19%	29%	51%
Homeownership	71%	68%	65%
Air Pollution – Particulate Matter	7.0	8.0	7.3

Source: County Health Rankings (2025)

Invasive Cancer Incidence Rates

Age-Adjusted Rate	Harlan Co	Kentucky	US Overall
Total all sites (2017-2021)	531.4	513.7	444.4
Lung and Bronchus	112.8	84.5	53.1
Breast (Female)	106.3	129.2	129.8
Colon and Rectum	56.2	45.9	36.4
Urinary Bladder	22.2	21.7	18.8
Kidney and Renal Pelvis	12.8	21.4	17.3
Melanoma of the Skin	17.1	28.2	22.7

Source: National Cancer Institute: State Cancer Profiles

Hospital Utilization Data

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

Inpatient Hospital Discharges- Patient Origin*

Patient County	Inpatient Discharges	% of Total
Harlan-KY	6,391	83.7%
Bell-KY	383	5.0%
Whitley-KY	119	1.6%
Knox-KY	103	1.3%
Leslie-KY	76	1.0%
Lee-VA	72	0.9%
Letcher-KY	70	0.9%
Pike-KY	61	0.8%
Laurel-KY	55	0.7%
Floyd-KY	53	0.7%
Johnson-KY	49	0.6%
Clay-KY	47	0.6%
Perry-KY	33	0.4%
Jackson-KY	20	0.3%
Claiborne-TN	17	0.2%
Rockcastle-KY	14	0.2%
Magoffin-KY	13	0.2%
Mingo-WV	11	0.1%
Knott-KY	9	0.1%
Madison-KY	6	0.1%
Breathitt-KY	5	0.1%
Martin-KY	5	0.1%
Lee-KY	4	0.1%
Total	**7,636**	**100%**

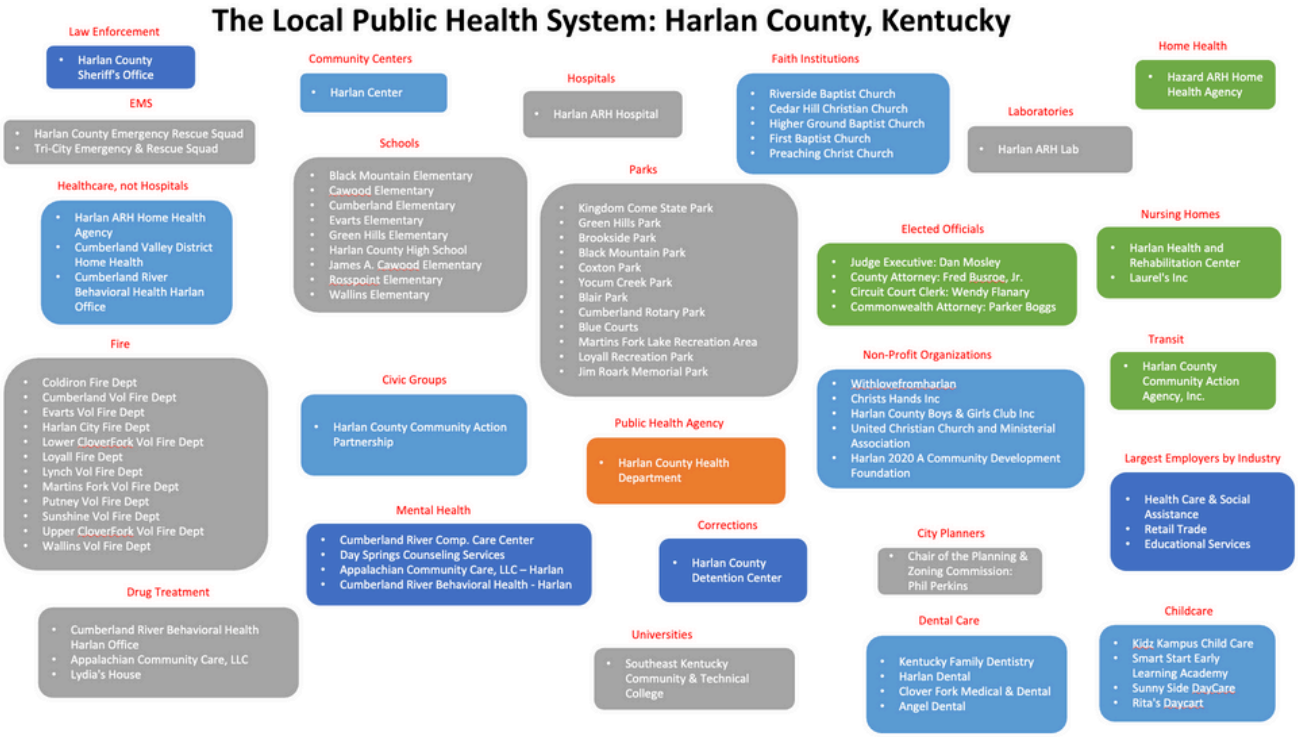
**Counties of residence accounting for >0.01% of the total are not listed. Numbers are still included in the total.*

Inpatient Hospital Discharges- Payer Mix

Payer Type	Inpatient Discharges	% of Total
Medicare (Excluding Medicare Managed Care)	2,003	26.2%
WellCare of Kentucky Medicaid Managed Care	1,713	22.4%
Medicare Managed Care	1,369	17.9%
Commercial- Anthem Health Plans of KY HMO Plan	546	7.2%
Humana Medicaid Managed Care	372	4.9%
Commercial- Anthem Health Plans of KY PPO Plan	339	4.4%
Anthem Medicaid Managed Care	196	2.6%
Passport Medicaid Managed Care	156	2.0%
Tricare (Champus)	154	2.0%
United Healthcare Medicaid Managed Care	152	2.0%
In State Medicaid	149	2.0%
Aetna Better Health of KY Medicaid Managed Care	130	2.7%
Other Facility	77	1.0%
Black Lung	47	0.6%
Out of State Medicaid	43	0.6%
Workers Compensation	41	0.5%
Self Pay	37	0.5%
Commercial- Other	31	0.4%
Commercial- United Healthcare POS Plan	25	0.3%
Commercial- Aetna Health HMO Plan	13	0.2%
Commercial- Humana PPO Plan	11	0.1%
Commercial- Cigna Health & Life FFS Plan	7	0.1%
Commercial- Aetna Health PPO Plan	7	0.1%
ChampVA	5	0.1%
Auto Insurance	5	0.1%
VA	4	0.1%
Care Source KY Commercial Plan	4	0.1%
Total	**7,636**	**100%**

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 Harlan County. An overview of this schematic can be seen below, see Appendix B for a larger font version.



Harlan 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 Harlan ARH leadership in late summer of 2024. On September 4, 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 2, 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 Harlan ARH to address.

Harlan County CHNA Steering Committee

Steering Committee Members

Name	Organization Represented
Laura Adkisson	Downtown Development Manager, City of Harlan Tourist and Convention Commission
Mark Bell	Patient and Family Engagement Leader, Harlan ARH
Stephanie Broersma	Harlan SWAP Director and Owner of Roper's Market
Bobbie Crider	Public Health Director, Harlan County Health Department
Ron Frazier	Vice President and Branch Operations Manager, Hearthside Bank Harlan
Anne Hensley	Harlan City Council Member
Jack Miniard	Administrator, Cloverfork Clinic
Matthew Nunez	DMD, Harlan Dental Clinic
Donna Pace	Executive Director, Harlan County Community Action Agency
Jonathan Price	Program Director Harlan Base Air-Evac Lifeteam
Janell Spurlock	Harlan County Committee on Aging
Christy Whitaker	RN, Harlan County School District Nurse

Community Focus Groups

After the initial steering committee meeting, 3 focus groups and 1 key informant interview were held to gain valuable feedback from community members and residents. 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.

Harlan ARH hosted forums with:

- Recovery Infrastructure Development Committee
- Harlan Senior Center
- UNITE Coalition

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 1.2: Chronic Disease

- Respiratory (COPD, Emphysema, Black Lung)
- Diabetes
- High cholesterol
- Obesity related disease
- Heart failure
- Substance use
- Mental health

Finding 1.1: Resource Challenges

- Lost OBGYN Unit
- Lack of transportation
- Lack of specialists
- Lack of after-hours care
- Inaccessible physical activity
- Lack of good jobs
- Lacking childcare
- Need re-entry services
- Homelessness

QUESTION 2: BARRIERS TO HEALTHCARE

Finding 2.1: Resource Barriers

- Poverty keeps people from accessing healthcare
- Lack of transportation
- Insurance cost for working families
- Lack of local providers
- Need medical detox
- Need harm reduction program

Finding 2.1: Resource Navigation

- Lack of health education
- Lack of knowledge of services available / difficult to navigate

"Well, we've got a lot of good, we do, but a lot is lacking. "

Focus Group Results

QUESTION 3: HEALTH BEHAVIORS

Finding 3.1: Obesity-related Behaviors

- Lack of physical activity opportunities, including fitness programs
- Sedentary lifestyles
- Food insecurity
- Poor diet

Finding 3.2: Substance Use

- Need education for at-risk youth
- Smoking
- Vaping (especially youth)
- Youth marijuana use
- Need for parental eduation on vaping and substance use

QUESTION 4: ADDITIONAL CONCERNS

Finding 4.1: Additional Resources Needed

- Affordable, safe housing
- Homeless assistance
- Postpartum depression education
- Help and education for grandparents raising grandchildren
- Diabetic shoe assistance
- Harm reduction
- Food insecurity programs
- Dental Care
- Aging population, youth leaving
- Programs outside of facility walls (churches, employers, schools)

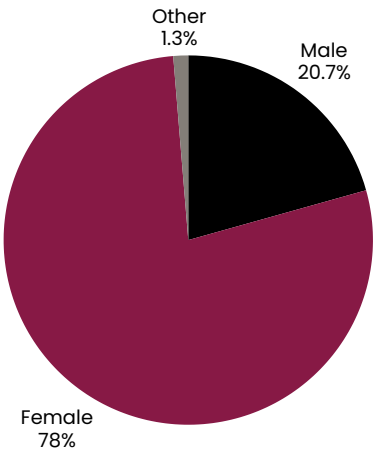
Community Survey Results

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=467

Gender



Education

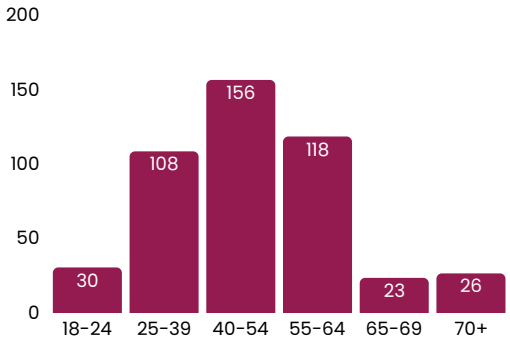
24% High School

6% Technical School

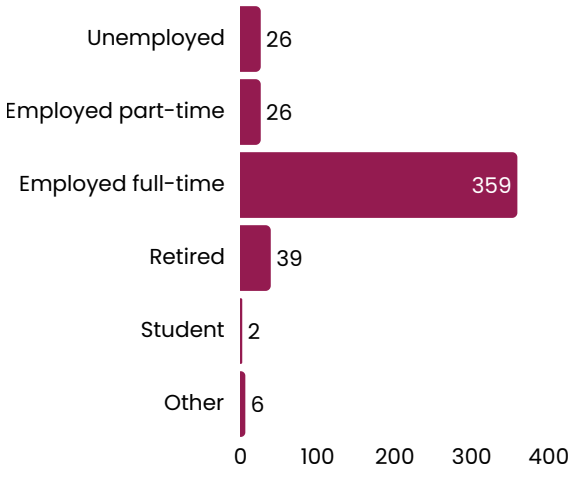
66% College or Above

4% Other

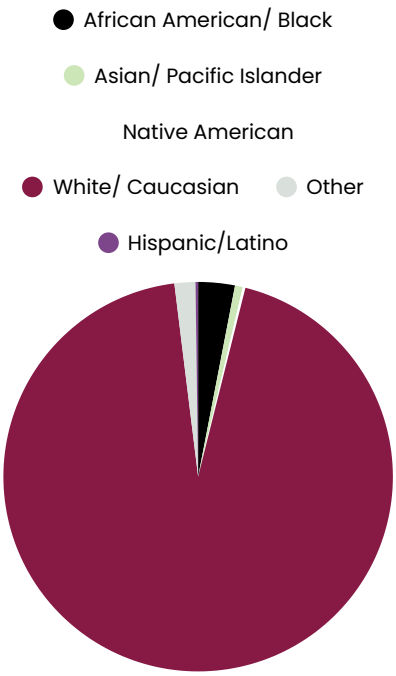
Age



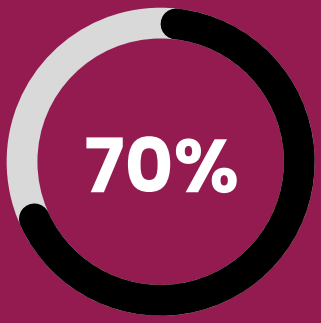
Employment Status



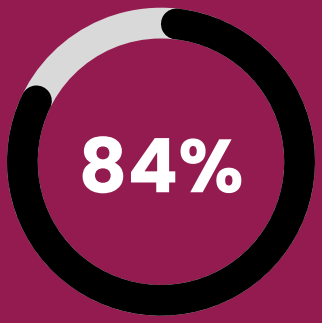
Race/ Ethnicity



Community Survey Results

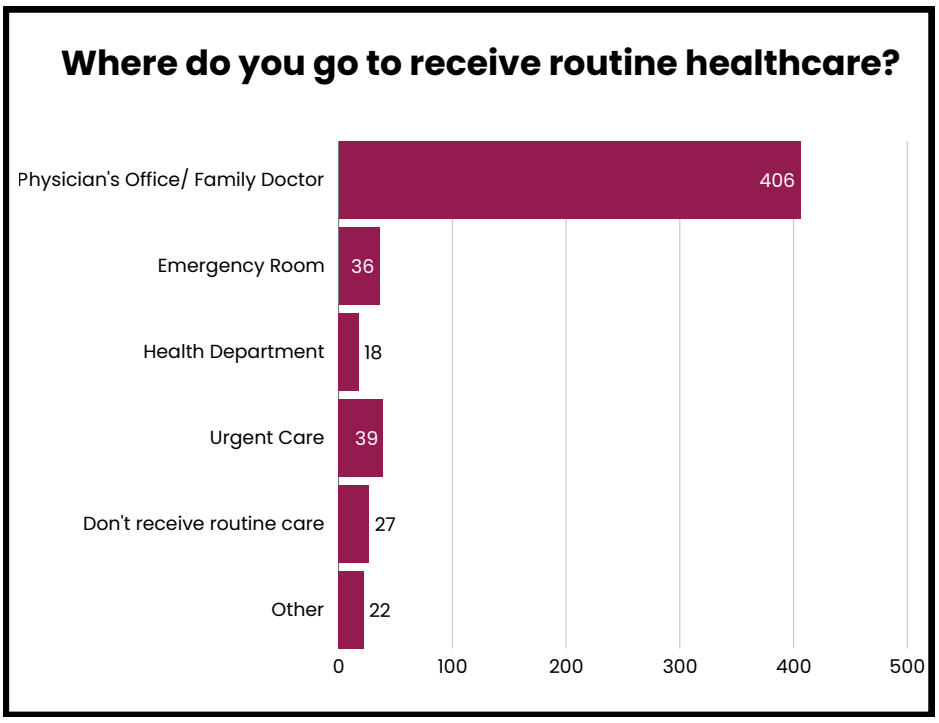


Are satisfied with the ability to access healthcare services in Harlan County.



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

Have delayed healthcare due to lack of money or insurance.

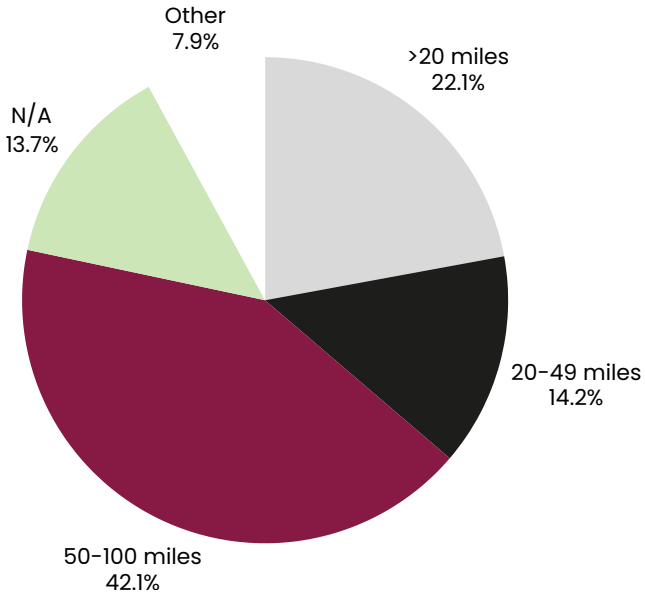


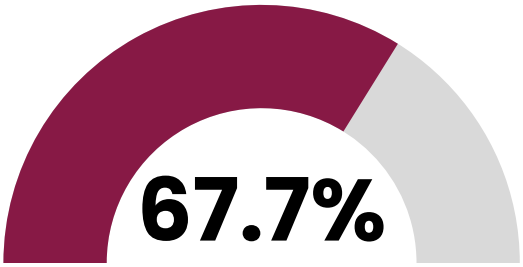
Top 5 barriers to receiving routine healthcare:

1. No barriers
2. Only visit the doctor when something is seriously wrong
3. Cannot take off work
4. Physician hours of operations
5. Months long wait times

Community Survey Results

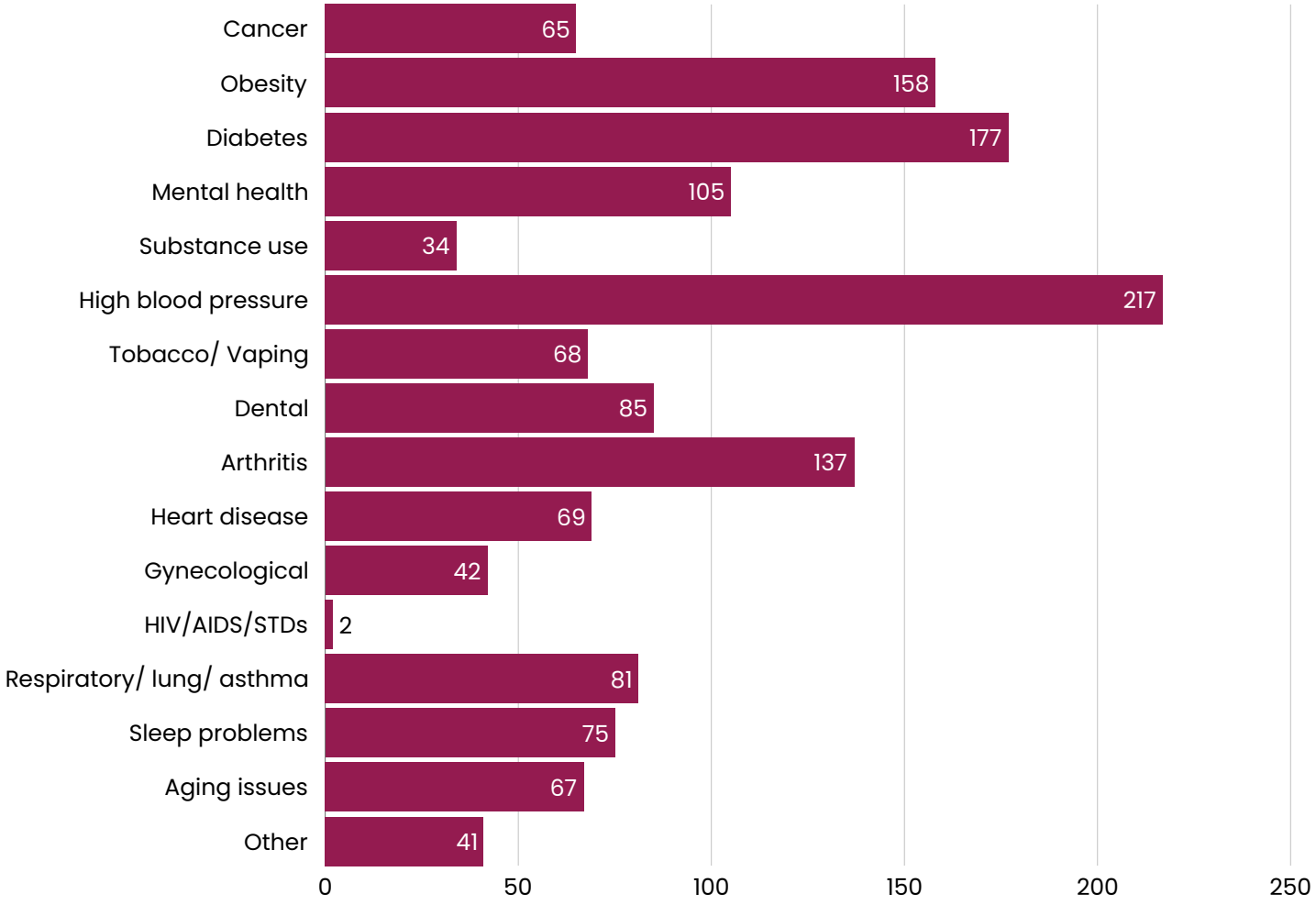
How far do you or your household travel to see a specialist?





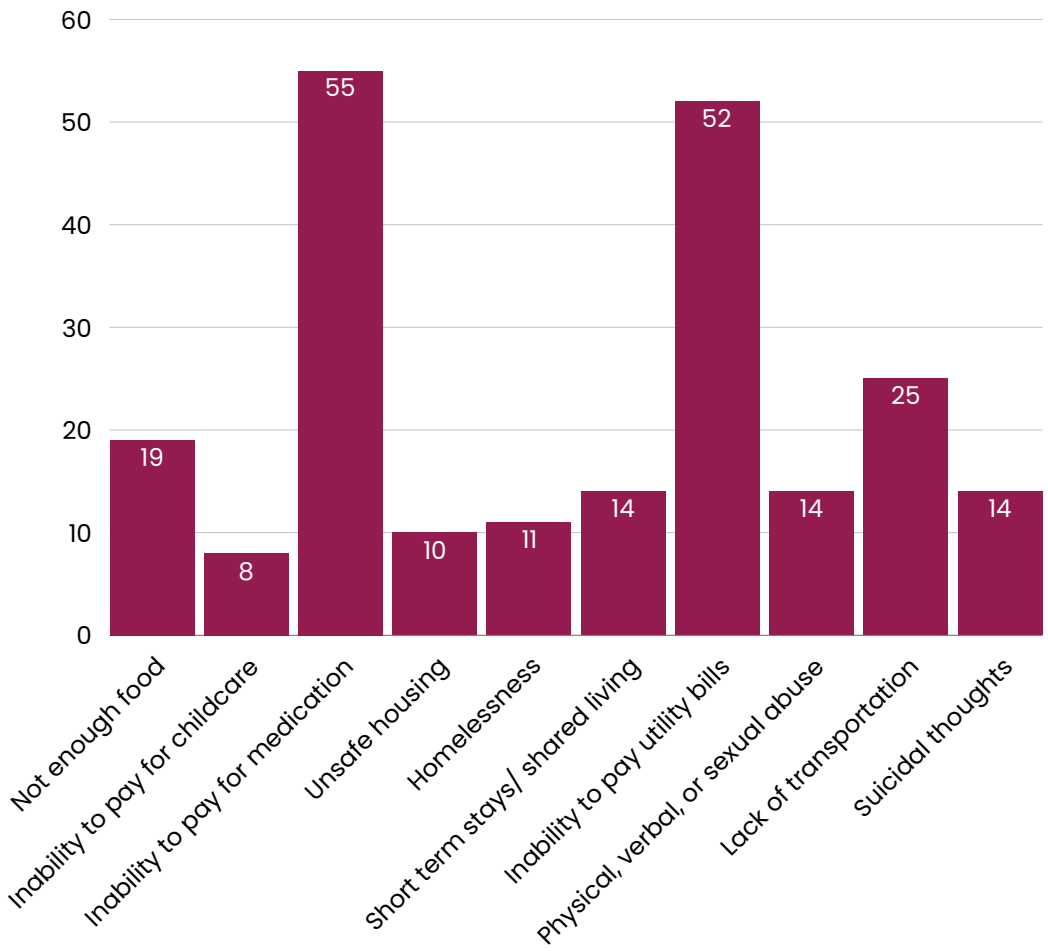
Are satisfied with the availability of mental health services in Harlan County.

Top 3 health challenges you/ your household face:



Community Survey Results

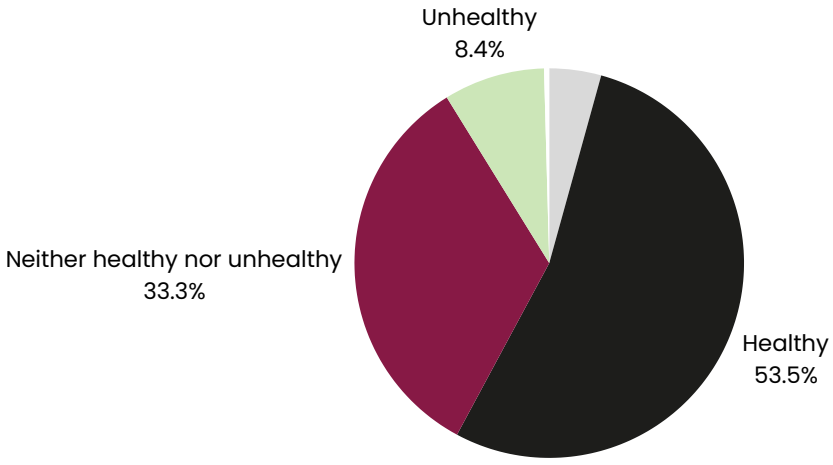
Have you or your household faced any of these issues in the past year?



How would you rate your overall health?

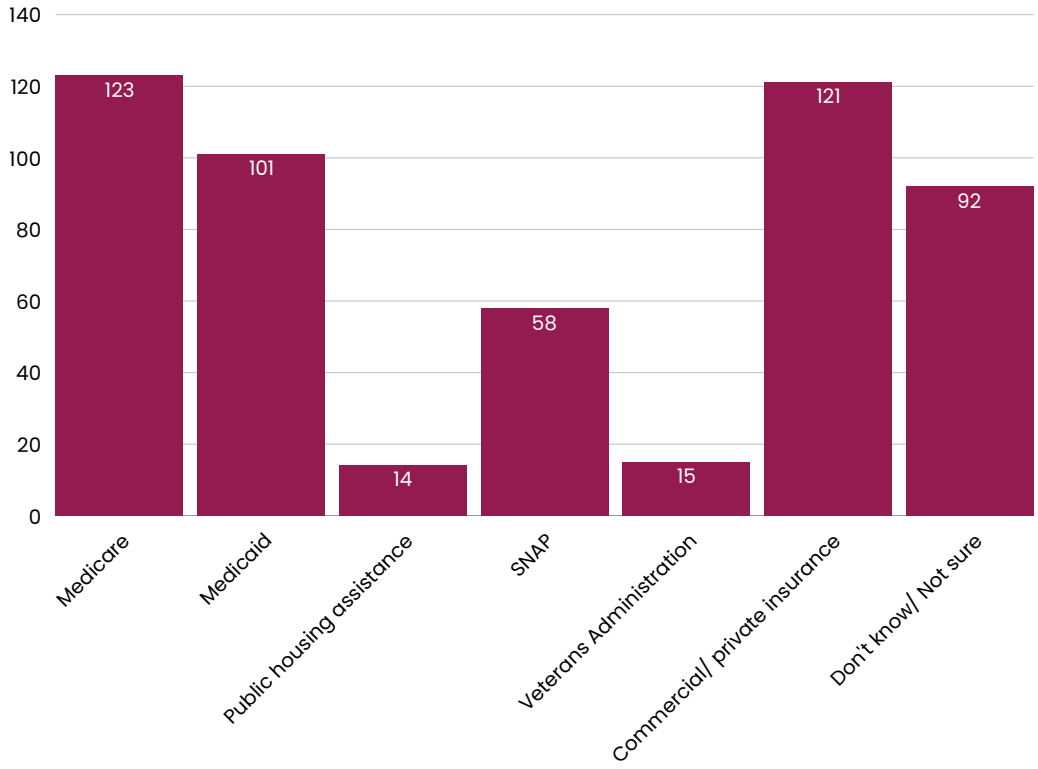
Top 3 risky behaviors you see in your community:

1. Drug use (369)
2. Tobacco or vaping use (229)
3. Poor eating habits (203)

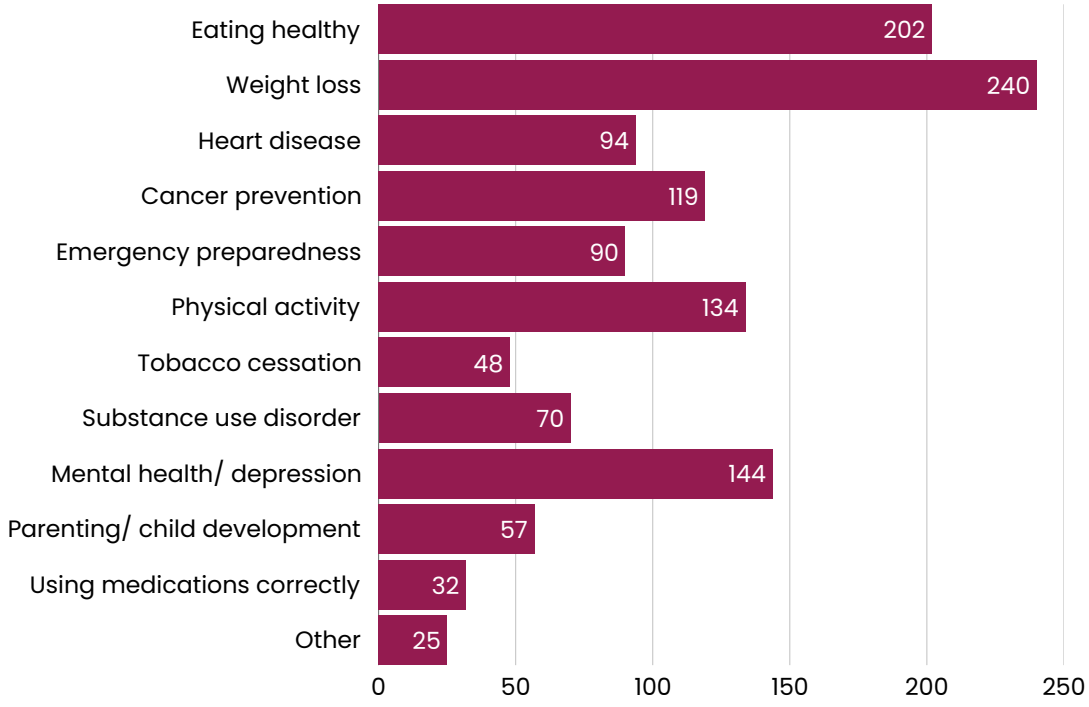


Community Survey Results

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

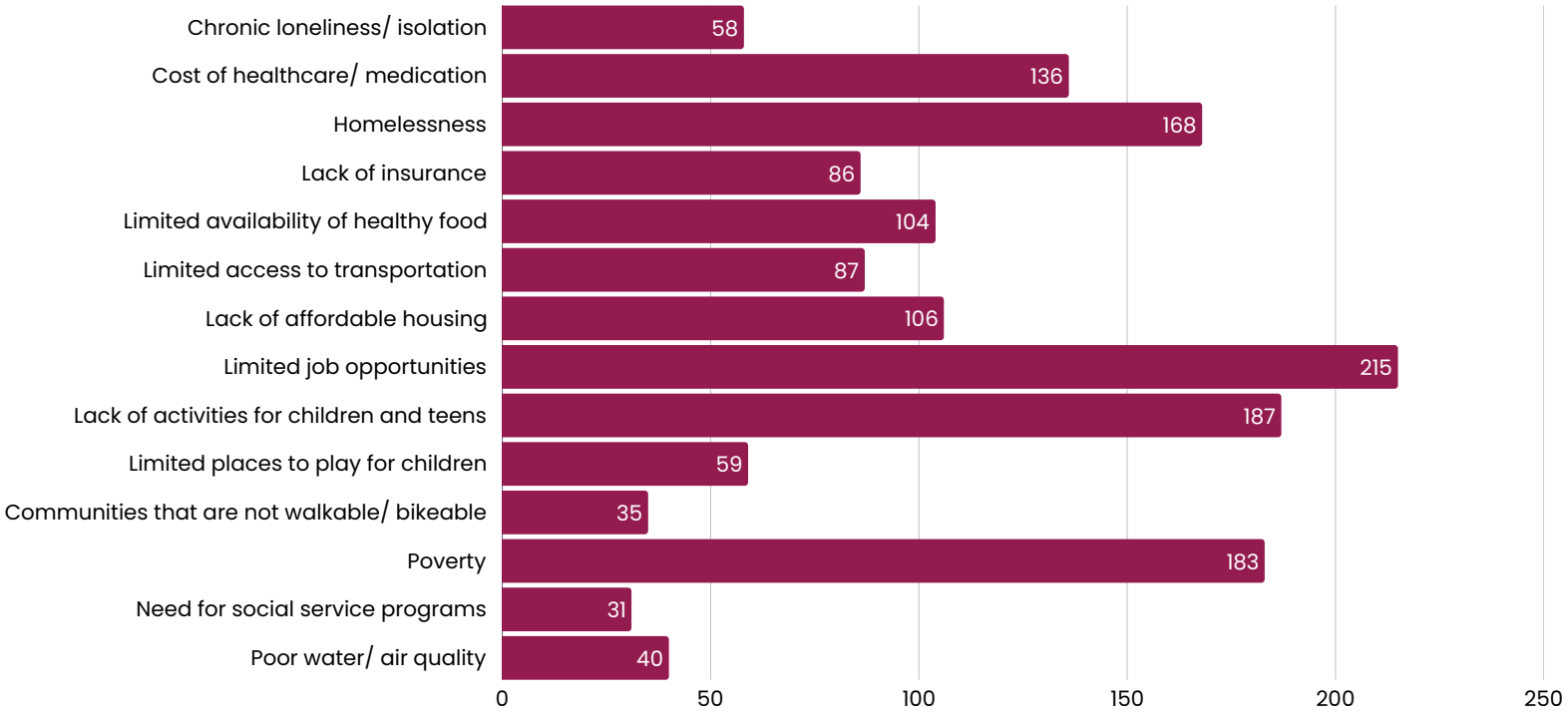


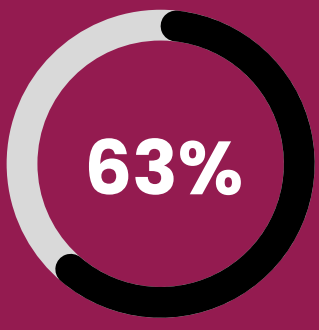
Health related topics respondents are interested in learning more about:



Community Survey Results

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





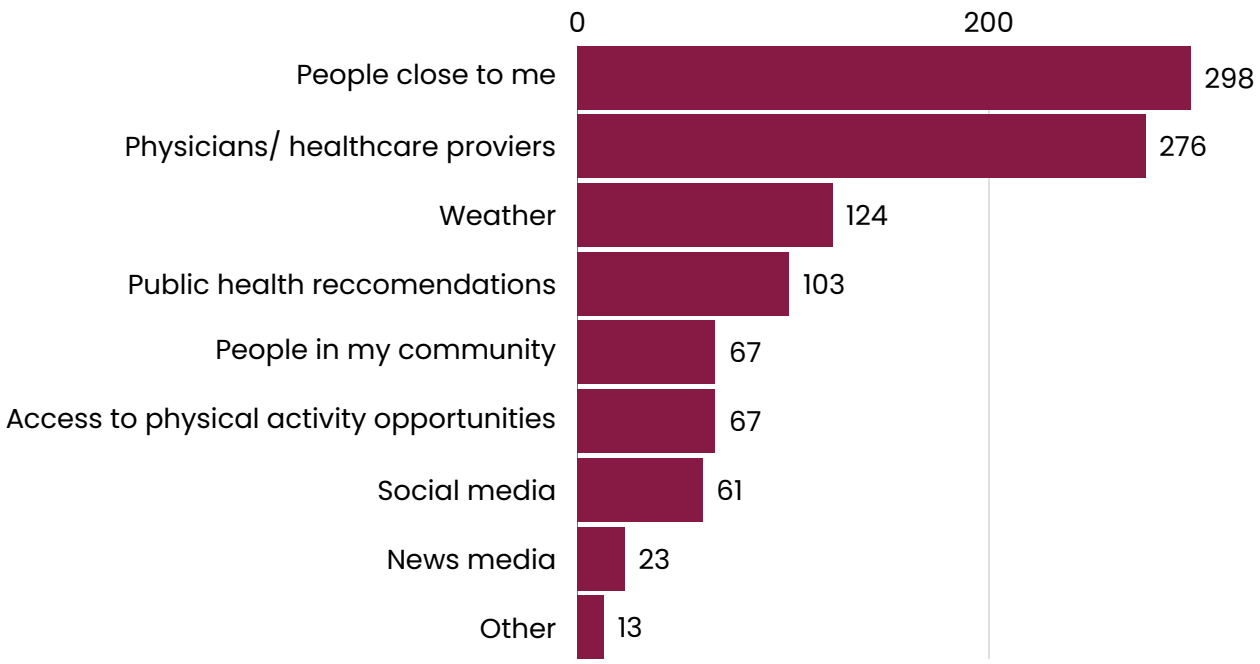
Have had a dental exam in the past year.

Have had a routine checkup in the past year.

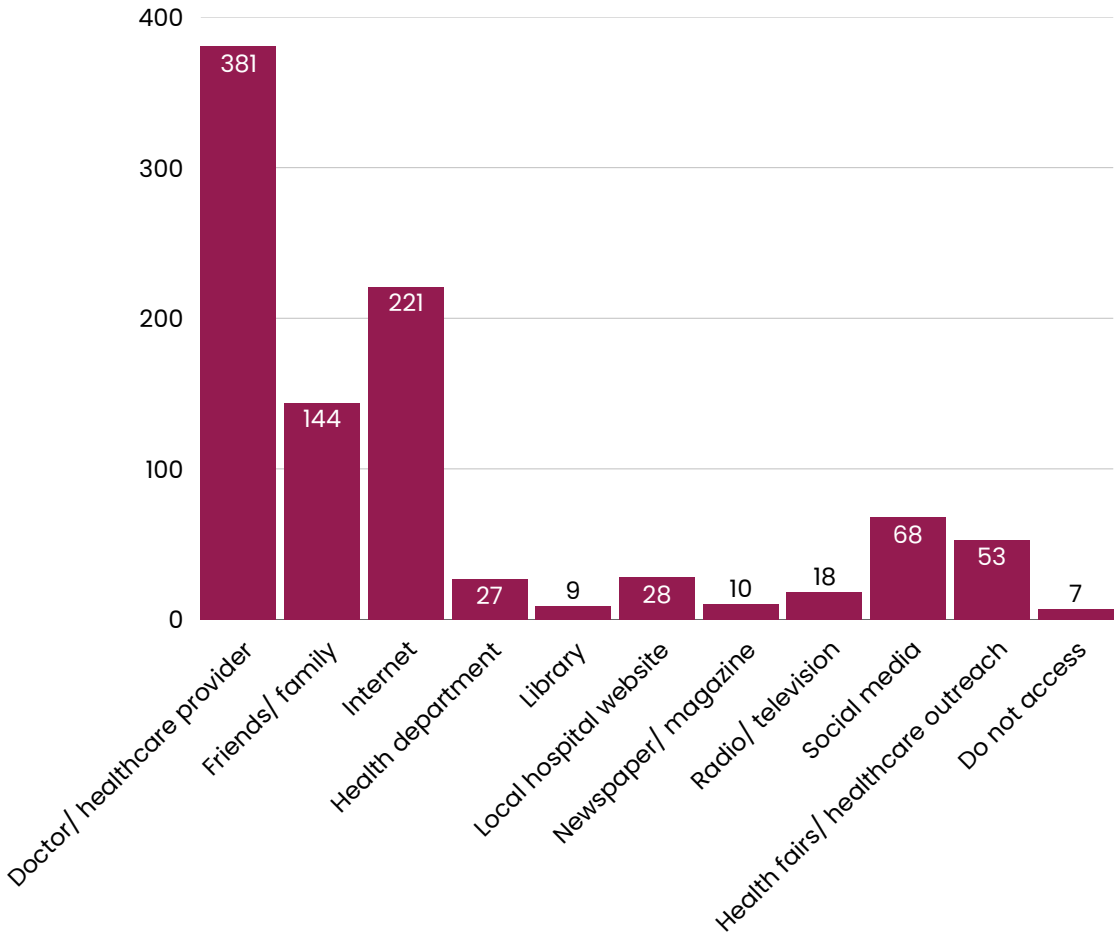
Believe mental illness is a medical condition.

Community Survey Results

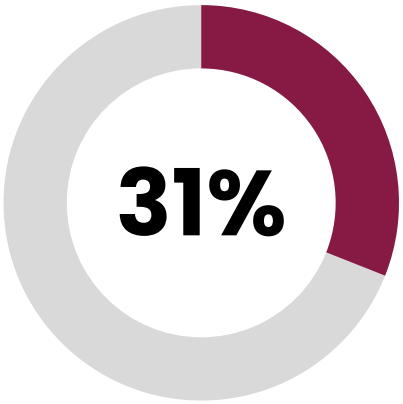
What factors influence your health choices?



Where do you get most of your healthcare information?

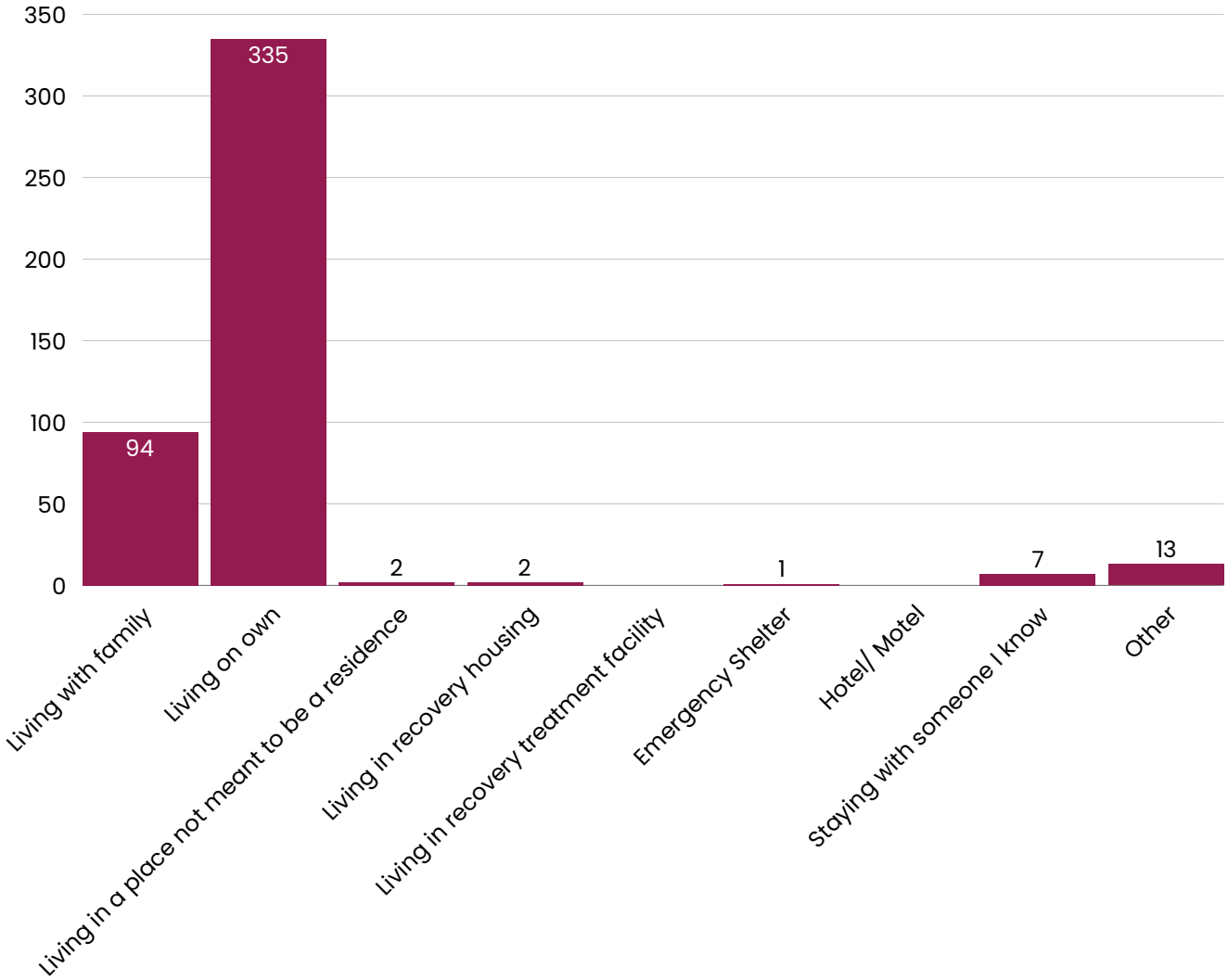


Community Survey Results



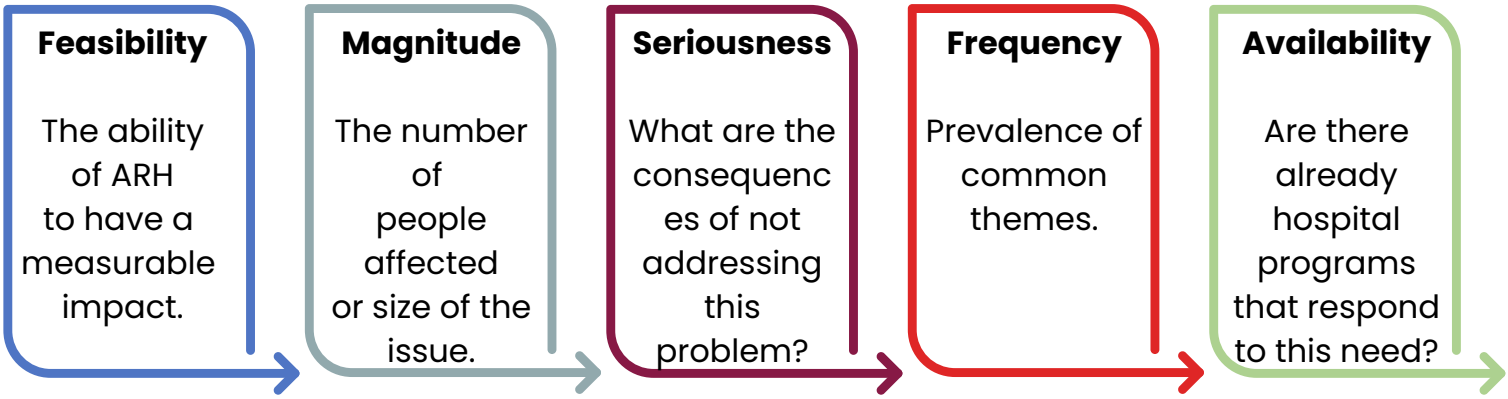
Have been told by a healthcare professional that they have high cholesterol.

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 5 health needs facing their community to be:

1. **Mental Health**
2. **Preventive Medicine and Health Literacy**
3. **Women's Health/ OBGYN**
4. **Senior Care**

Implementation Plan

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

Goal: Improve the mental health of our community members and reduce stigma associated with seeking treatment

Key Strategies

- Train staff and community members in Mental Health First Aid, a national program that teaches skills needed to respond to the signs of mental illness and substance use in patients as well as members of the community
- Increase outpatient behavior health services by hiring additional therapist and a case manager
- Renovate Inpatient Behavioral Health Unit to better serve more patients
- Provide mental health programming targeting youth and parents/caregivers, such as:
  - Suicide prevention and warning signs
  - Internet safety and cyber bullying
  - Youth Mental Health First Aid
  - Alcohol and SUD prevention
- Provide resources and mental health services for staff to include:
  - Online counseling services
  - Workplace stress events
  - Renovate break rooms to wellness rooms, incorporating stress relief activities and welcoming, restful environments
- Provide mental health-related community screenings and events such as:
  - Positive affirmation events targeting children and employees. Participants at facilities and on walking paths use sidewalk chalk to write encouragement and raise awareness of the importance of mental health
  - Anxiety and depression screenings
  - Educational events for area employers with mental health topics
- Increase Peer Support services by hiring additional staff and growing outreach services related to addiction and co-occuring mental health issues
  - Hosting overdose awareness events and Narcan trainings throughout the community
  - Creation of a HOPE hygiene closet for patients moving to treatment

Key Strategies	◦ Alcohol awareness events each April ◦ Advocate with local community for Harm Reduction/Needle Exchange program and actively participate as clinical provider + peer ◦ Implementation of recovery clinic and self-help support groups • Screen all patients for depression, referring to behavioral health when necessary

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

Key Strategies	• Host events that specifically promote cancer awareness, teach about early detection, and encourage preventative lifestyles. Examples include: ◦ Colon cancer educational or screening events where take-home colon cancer screening kits (FIT kits) were offered in partnership with Kentucky Cancer Link ◦ Community presentations about the early detection of lung cancer and low dose CT screenings provided by the ARH Lung Cancer Screening Program Manager. Include annual Lung Cancer Screening Days two Saturdays per year. ◦ Events educating about the early detection of breast cancer and importance of mammograms ◦ Targeted skin cancer events and screenings • Provide free, community-based clinical screenings ◦ Provide free or low cost clinical screenings throughout the community to include cholesterol checks, blood pressure, stroke risk, cardiac risk, mental health screenings, etc. • Nutrition interventions ◦ Expand in-school programming to include education about nutrition, especially on sugary and overly-caffeinated drinks ◦ Partner with UK Extension Service to provide cooking classes to the community ◦ Explore a partnership with Pine Mountain Settlement School that can include gardening education, farm-to-table events, children's activities, and more. ◦ Consider providing food boxes to those in need through an in-facility pantry program ◦ Continue and grow the Senior Produce Voucher Program with Kentucky Homeplace • Support opportunities for physical activity

Key Strategies	◦ Partner w/ fitness instructors or local gyms to provide fitness classes free to the community ◦ Monetarily support events that encourage physical activity – bike races, community health and wellness days, 5k events. ◦ Offer ARH-led gentle chair yoga classes throughout community ◦ Explore partnership with county fitness center for wellness programming ◦ Continue free gym memberships for staff at Core Fitness or other centers • Increase health literacy by educating the community on most relevant health topics ◦ Specifically focus on health issues with high rates of diagnosis in the county, such as hypertension, diabetes, and high cholesterol. ◦ Provide education to parents and caregivers about pressing topics such as dental health, maintaining well child visits, internet safety, and importance of physical activity • Educate youth through school-based programs ◦ Organize school-based programs that provide students with the knowledge and skills they need to make informed decisions about their health, such as: ▪ Love Your Lungs ▪ Rethink Your Drink ▪ Suicide Prevention ▪ Alcohol Awareness ▪ Fitness Fairs

Goal: Increase access to Women's Health with services and supports

Key Strategies	• Build Women's Health services at Harlan ◦ The recruitment of an additional women's health provider. ◦ Potentially offering women's health services via the ARH Mobile Clinic. ◦ Offering counseling services for perinatal mental health, including postpartum depression screenings. ◦ Ensure access to birth control options, sexually transmitted infection (STI) testing, and reproductive health counseling through trained primary care providers. • Partnerships and referrals ◦ Promote and refer to the Harlan County Health Department's Women's Health Programs ◦ Refer women in need to the Kentucky Women's Cancer Screening Program

Key Strategies	◦ Build a relationship with the Cumberland River KY Moms Program • Health education programs ◦ Utilize healthcare providers and Community Development staff to educate women on reproductive health, pregnancy care, breastfeeding support, and preventive screenings

Goal: Provide outreach and support for seniors and caregivers

Key Strategies	• Promotion and referrals to partner services ◦ Create a directory of available partner Senior services and distribute it at hospitals, clinics, and senior centers. ◦ Ensure healthcare providers, social workers, and community centers are equipped with referral information. Partners such as the Cumberland River ADD, Kentucky Homeplace, and Horizon Adult Daycare all have services to assist with senior care. • Monetarily support programs for senior connection, physical activity and general wellness, such as the Senior Games • Educational Sessions at Senior Centers ◦ Survey seniors to identify topics of interest (e.g., fall prevention, nutrition, financial planning) and organize regular workshops with healthcare professionals. • Continue the ARH Senior Produce Voucher Program, a partnership with Kentucky Homeplace and Ropers Produce that provides vouchers for food to seniors in need • Consider creating an Alzheimer's and Memory Caregiver Support Group ◦ Host monthly meetings (virtual or in-person) in collaboration with memory care specialists. Consider partnering with the Alzheimer's Association for resources and training

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

HARLAN COUNTY, KENTUCKY

POPULATION: 25,324

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:** Harlan 8.9% | Kentucky 3% | United States 2.4%
2	**Poverty Rate:** Harlan 26.9% | Kentucky 16.5% | United States 11.5%
3	**Population 16+ in Labor Force:** Harlan 39.6% | Kentucky 59.2% | United States 63.0%
4	Single Parent Households: Harlan 34.40% | Kentucky 31%
5	Households Spending at Least 30% of Income on Housing: Harlan 24.4% | Kentucky 23.9% | United States 22.8%
6	Population Without Access to Large Grocery Store: Harlan 6.2% | Kentucky 19.8% | United States 21.7%
7	**Children Living in Food Insecure Households:** Harlan 27.4% | Kentucky 15.2% | United States 16%

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

1	Students Graduating High School in 4 Years: Harlan 90.7% | Kentucky 91.4%
2	High School Graduates Enrolled in Post-Secondary Education Within 6 Months of Graduation: Harlan 63.93% | Kentucky 45.33%
3	8th Grade Students with Proficient or Distinguished on Reading State Assessment: Harlan 51% | Kentucky 45%
4	8th Grade Students with Proficient or Distinguished on Math State Assessment: Harlan 41% | Kentucky 37%
5	**Kindergarteners Ready to Learn:** Harlan 36% | Kentucky 46%
6	Students with an Individualized Education Plan (IEP): Harlan 31% | Kentucky 16%
7	4th Grade Students with Proficient or Distinguished on Reading State Assessment: Harlan 54% | Kentucky 47%
8	4th Grade Students with Proficient or Distinguished on Math State Assessment: Harlan 39% | Kentucky 42%

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

1	Visits to Doctor for Routine Checkup Within the Past Year: Harlan 72.1% | United States 71.8%
2	Children Under 19 With Health Insurance: Harlan 97.1% | Kentucky 96.1%
3	Number of TBI Emergency Department Cases: Harlan 97 | Kentucky 11,249
4	Adults With Recent Preventative Care Visit: Harlan 80.3% | Kentucky 80.7% | United States 74.6%
5	**Lung and Bronchus Cancer Incidence per 100,000 Population:** Harlan 123.6 | Kentucky 84.4 | United States 54
6	**Mammography Use Among Women Aged 50-74:** Harlan 64.1% | United States 77.8%
7	STIs per 100,000: Harlan 248.4 | Kentucky 410.3 | United States 495.5
8	Colon and Rectum Cancer Incidence per 100,000 Population: Harlan 60.4 | Kentucky 194.4 | United States 156.6
9	Children Enrolled in Medicaid or KY Children's Health Insurance Program Who Received Dental Services in Kentucky: Harlan 49% | Kentucky 51%
10	Population Under 65 Without Health Insurance: Harlan 7.1% | Kentucky 6.7% | United States 9.3%
11	Population With Limited English Proficiency: Harlan 0.0% - 1.7% | 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: Harlan 62.8 | Kentucky 225.6 | United States 204.5
2	Population with Access to Broadband: Harlan 93.3% | Kentucky 97% | United States 96.7%
3	**Percent of County Using SNAP:** Harlan 30.9% | Kentucky 16.3%
4	Air Quality Hazard: Harlan 0.40 | Kentucky 0.44 | United States 0.34
5	Vehicle Crash Fatality Rate per 100,000: Harlan 21.6 | Kentucky 51.5 | United States 17.5
6	**Population Within ½ Mile of Walkable Destinations**: Harlan 26.7% | Kentucky 33.9% | United States 34%
7	Walkability Score: Harlan 4.3 | Kentucky 7.2 | United States 6.1
8	Asthma Prevalence Among Adults 18+: Harlan 13.0% | United States 9.7%
9	**Adult Smoking Rate:** Harlan 32.1% | Kentucky 23.9% | United States 20.0%
10	Deaf and Hard of Hearing Population: Harlan 3,978 | Kentucky 705,533
11	**Prevalence of People with Disabilities:** Harlan 27.7% | Kentucky 21.1%

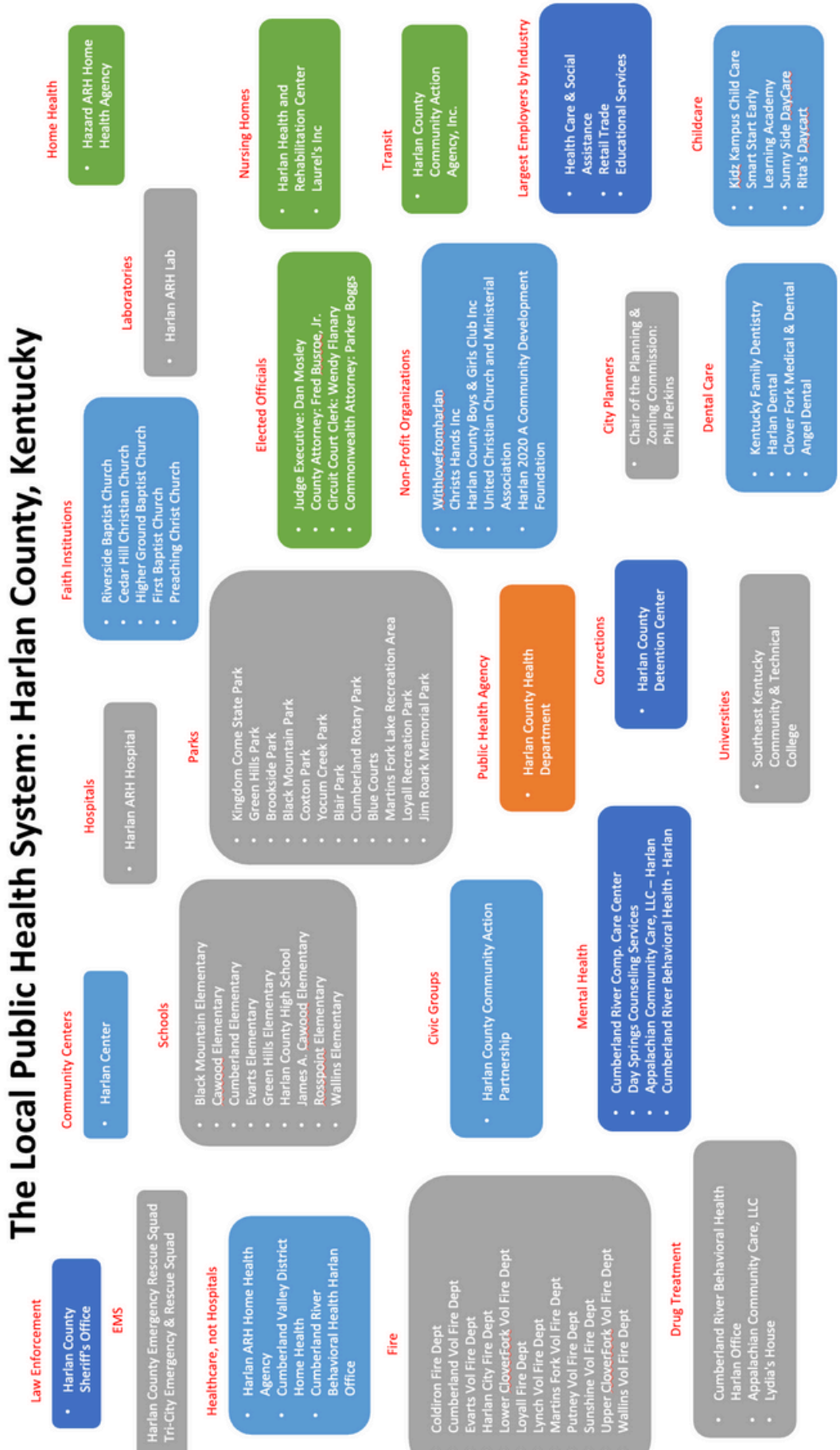
SOCIAL AND COMMUNITY CONTEXT: INCREASE SOCIAL AND COMMUNITY SUPPORT

1	Youth Incarcerated in the Juvenile Justice System Rate per 1,000 Youth: Harlan 17.9 | Kentucky 13.2
2	**Census Self- Response Rate:** Harlan 54.9% | Kentucky 63.50% | United States 65.80%
3	**Households With a Computer:** Harlan 85.7% | Kentucky 91.6% | 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 Harlan 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 Harlan 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.

TEAM UP
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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