

# COMMUNITY HEALTH NEEDS ASSESSMENT 2025-2027



# Acknowledgements

This Community Health Needs Assessment (CHNA) report was prepared for Highlands 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](mailto: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.

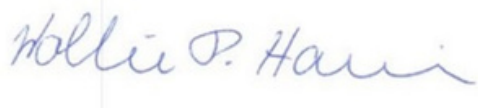
This CHNA is the result of extensive research, data collection, and direct community engagement. Through surveys, focus groups, and partnerships with local organizations, we have identified key health priorities affecting individuals and families. These insights drive our strategic initiatives, ensuring 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 Harris, MHA  
President and CEO Appalachian Regional Healthcare, Inc.



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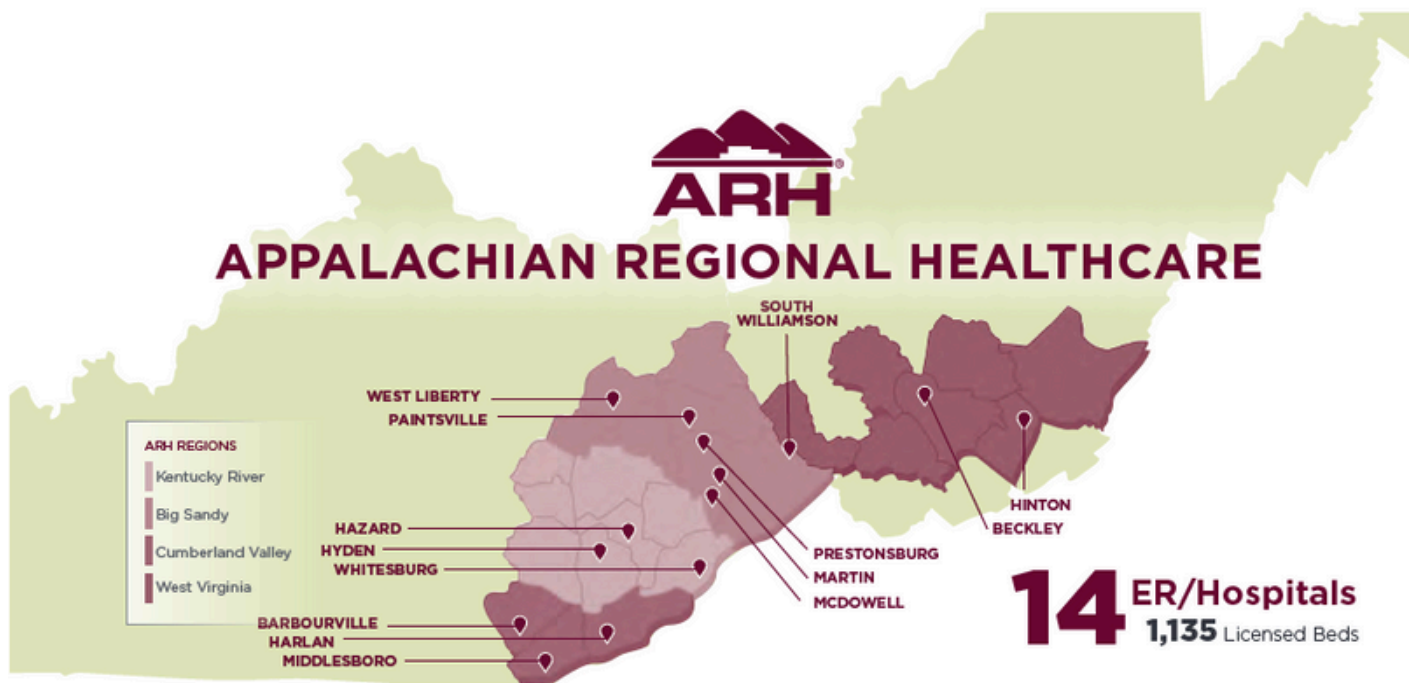
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# Introduction

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, Highlands 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.

<b>Method</b>	<b>Description</b>
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

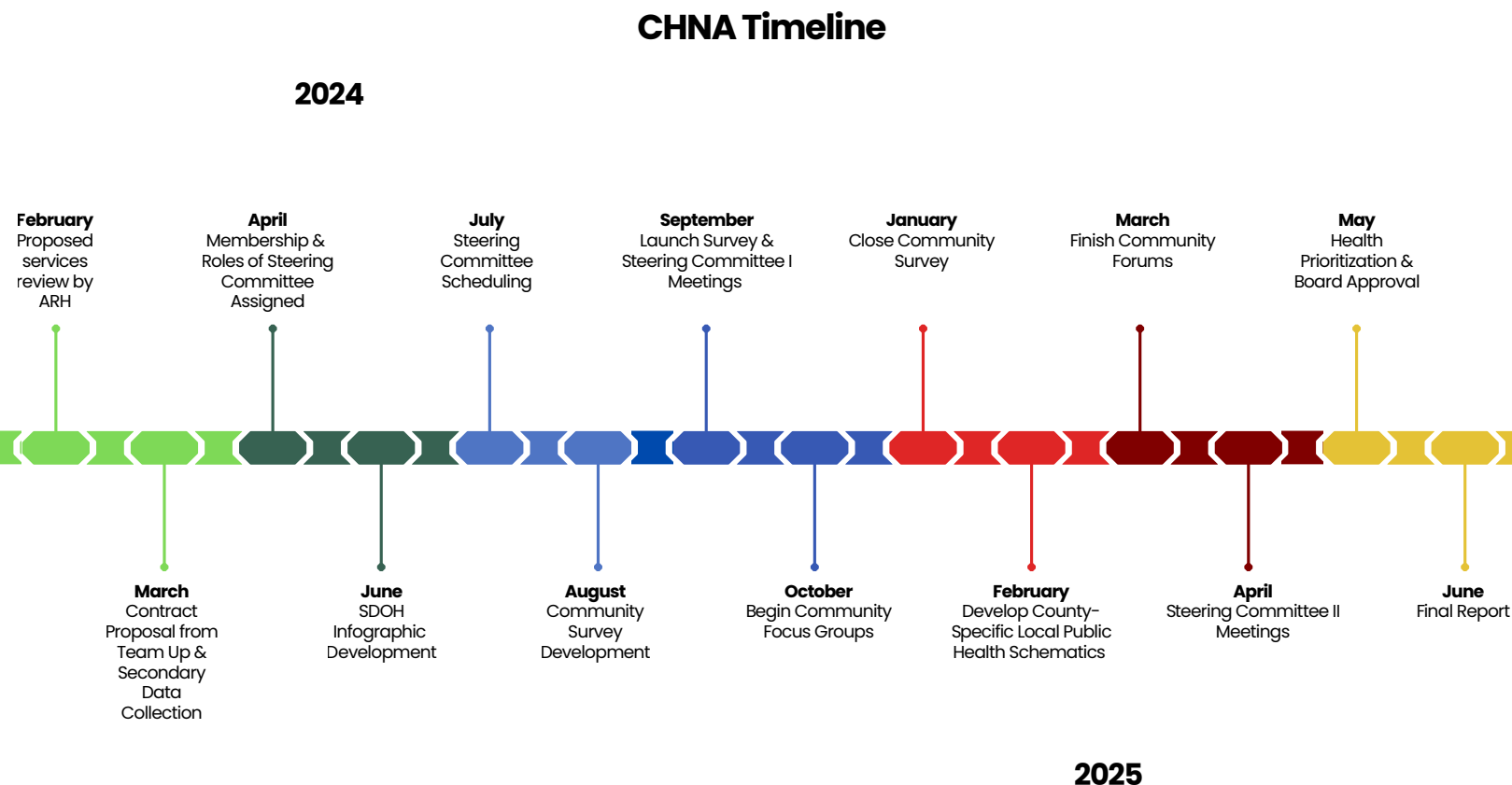
Secondary data is data that is collected by other entities and provides information on health status and demographics. Examples include vital statistics, censuses, reports from government agencies (such as the CDC), or information collected through studies and other organizations (such as County Health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





# 2022–2024 Implementation Successes

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

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

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

## Goal 1



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

Since 2022, Highlands ARH has **addressed food insecurity, physical inactivity, and the need for nutrition education** by:

- Providing **7 free cooking classes** with grocery gift card incentives in partnership with the Floyd County UK Extension Service
- Collaborating with God's Pantry Food Bank to provide nonperishable food boxes to patients identified as having a need in both the hospital and clinic environment; Distributing on average **40 boxes per month**
- Hosting **11 monthly diabetes support groups** in Floyd County with diabetes-related topics and healthy cooking demonstrations each month (2022 start)
- Participating in a research study with University of Kentucky Food as Health Alliance in which Highlands' ambulatory patients with type 2 diabetes or hypertension could receive medically tailored meals for 12 weeks
- Annual sponsorship of community feeding programs like the Bright Beginnings Community Thanksgiving Dinner, which **feeds 1000+ people** in Floyd County

- Creating a new program, **ReThink Your Drink**, which educates students on the harmful effects of sugary, overly caffeinated drinks (such as energy drinks). Community Development staff have presented this program 2 times in the community
- In 2023, an employee garden was created on-site, allowing space for employees to grow produce. Grown fruit and vegetables are available for employees to take home, and are often given to patients
- Highlands ARH also worked to educate and provide healthy nutrition to employees through a revamped cafeteria menu, which offers plant-based options
- Provided access to **physical activity opportunities** in our community by:
  - Sponsoring Mommy and Me fitness classes and Think Pink events annually with Foxy Fitness in Prestonsburg
  - As of 2022, free gym memberships to No Limits Fitness are available to all ARH employees
  - Sponsored numerous 5k races in the community, including those that benefit the local homeless shelter and animal shelter

## Goal 2



Address addiction through peer support, community partnerships, and education

Since 2022, Highlands ARH has **addressed addiction** in our community by:

- In 2022, Highlands 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 Hazard ARH Peer Recovery Coaches have:
  - Engaged **1873** patients
  - Referred **575** patients to treatment
  - Provided **488** Linkages to treatment
  - Assisted **90** individuals with attaining housing or employment
- ARH Peer Recovery Coaches and Community Development Managers have worked with community partners to host many community events over the past three years that work to reduce substance use.
  - Partnered with the KY Department of Public Health to host numerous Safe a Life Roadshow events, in which participants are provided with overdose awareness education, Narcan training and distribution, and referrals to treatment
    - Prestonsburg Food City 2023
    - Martin County Harvest Festival 2023
    - Prestonsburg Food City 2024
    - Martin County Harvest Festival 2024

- Love Your Lungs, an educational program on the dangers of smoking and vaping, was **presented to Floyd County schools 8 times** since 2022.
- Sponsored Operation Unite's "Shoot Hoops, Not Drugs" program, which promotes positive activities for local youth while providing education on drug prevention
- Beginning in 2023, the Highlands ARH pharmacy began in-person smoking cessation classes for employees, and online counseling is also available to all employees.
- ARH staff participated annually in Truth and Consequences, a program for all high school freshman and sophomores in the county. This program allows high school students to "experience" the harsh realities of substance abuse –from dangers to their health to incarceration—by walking through a scenario provided to each of them.

## Goal 3



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

Since 2022, Highlands ARH has **worked to improve mental health** in our community by:

- Highlands ARH provided **6 free Mental Health First Aid training** sessions for staff from 2023–2024. 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. Highlands 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. **72 Highlands employees have been certified**
- Presenting **Healthy Relationships programming** to Floyd Central, Prestonsburg High School, and Betsy Layne **high school students**. This program teaches critical thinking around qualities of healthy and unhealthy relationships, signs of abuse, and communication skills
- Through a partnership with Kentucky Education Development Corporation, ARH sponsored **art therapy "train the trainer" sessions for six area teachers**. The Thriving Through Art program teaches educators how to offer mental health art sessions in classrooms

## Goal 4



Increase community, provider, and partner knowledge of services available

Since 2022, Highlands ARH has **increased community, provider, and partner knowledge of services available** by:

- In order to break down silos, meet community health needs, and foster partnerships between health care organizations, ARH has actively participated in **14 councils, coalitions, and boards since 2022**. These groups work to better the health and wellness of Appalachians, but may also have community betterment and economic development goals
  - Floyd Co Diabetes Coalition, Fitness and Nutrition Coalition
  - Floyd/Pike Agencies on Substance Abuse Prevention
  - Big Sandy ADD Meetings
  - Big Sandy Council on Elder maltreatment
  - Elevate Early Learning Collaborative
  - Unite Coalition
  - Communities Against Drug Addiction
  - Floyd County Chamber of Commerce
  - Floyd County People Ready Communities
  - Big Sandy Diabetes Coalition
  - Floyd County Homeless Shelter Board of Directors
  - UK Healing Communities Initiative
  - KY SOS Bridge Program
  - Recovery Ready Communities
- Highlands ARH has also made **4,368 social media posts** from 2022–2023 promoting our services and educating on important health topics

## Goal 5



Increase access to care so community members do not have to travel for health services

Since 2022, Highlands ARH has **increased community, provider, and partner knowledge of services available** by:

- Highlands ARH improved access to care by increasing specialty services in
  - Nephrology – recruitment of Dr. Khan
  - Endocrinology – recruitment of Dr. Uy and Bonnie Ferguson, APRN for Endo clinic
  - General Surgery – recruitment of Dr. Kasum
  - Interventional Cardiology – recruitment of Dr. Talley

- Radiology – new 3D mammogram
  - Neonatal Care – 6 bed NICU opened in 2024
  - Robotic Surgery – added Davinci XI robot used by 4 general surgeons
  - Med/Surg – Added 12 additional beds and renovated unit
- Highlands ARH also launched an Internal Medicine Residency Program in an effort to recruit more providers to the area. The program opened with Four residents in year one.





# Community Served by Highlands ARH

Highlands 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 highest proportion of hospital discharges were residents of Floyd County (38.7%).

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

## Population

Population	Floyd Co	Kentucky	US Overall
Population, 2024	34,532	4,588,372	340,110,988
Percent of Population Under 18 Years	22.4%	22.5%	21.7%
Percent of Population 65 Years+	20.3%	17.8%	17.7%
Percent of Population White	97.8%	86.7%	75.3%
Percent of Population Non-Hispanic Black	0.8%	8.8%	13.7%
Percent of Population American Indian & Alaska Native	0.2%	0.3%	1.3%
Percent of Population Asian	0.3%	1.8%	6.4%
Percent of Population Native Hawaiian/Other Pacific Islander	*	0.1%	0.3%
Percent of Population Hispanic or Latino	0.9%	5.0%	19.5%
Two or More Races	0.9%	2.3%	3.1%
Percent of Population Female	50.9%	50.4%	50.5%

Source: US Census, 2024 QuickFacts

## Social and Economic Factors

Social and Economic Factors	Floyd Co	Kentucky	US Overall
Percent Completed High School	81%	89%	89%
Bachelor's Degree or Higher	15%	27%	35%
Percent Unemployed	6.0%	4.2%	3.6%
Percent of People in Poverty	26.5%	16.4%	11.1%
Children in Poverty	31%	20%	16%
Number of Children in Single Parent Households	25%	25%	25%
Median Household Income	\$40,600	\$61,100	\$77,700
Violent Crime Rate (per 100,000)	51.6	225.6	255.2
Child Care Cost Burden	32%	25%	28%
Food Insecurity Rate	23%	16%	14%

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

## Health Behaviors

Heath Behaviors	Floyd Co	Kentucky	US Overall
Percent Adult Smoking	23%	18%	13%
Percent Adults with Obesity	40%	38%	34%
Percent of Physically Inactive Adults	30%	25%	23%
Adults (>65) with all Teeth Lost	30.9%		12.6%
Percent of Adults Receiving Flu Vaccination in the Last Year	35%	46%	48%
Teen Birth Rate (per 1,000)	45	24	16
Sexually Transmitted Infections per 100,000	183	406.8	495.0
Percent Excessive Drinking	14%	15%	19%
Number of Child Victims of Substantiated Abuse	303	17,917	-
Births to Mother who Smoked During Pregnancy	22.4%	12.6%	5%
Percent Driving Deaths with Alcohol Involvement	16%	26%	26%
Suicides Per 100,000 Population	20	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	Floyd Co	Kentucky	US Overall
Life Expectancy (years)	67	73	77
Percent Adults with Diabetes	13%	13%	10%
Percent Adults with Hypertension	40.1%	-	29.6%
Adults with current Asthma	12.0%	-	9.9%
Percent Fair to Poor Health	25%	20%	17%
Avg Number of Physically Unhealthy Days	5.9	4.5	3.9
Avg Number of Mentally Unhealthy Days	6.1	5.0	5.1
Percent Low Birth Weight	11%	9%	8%
Percent with a Disability, under Age 65	20%	13%	9%

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

Access to Care

Access to Care	Floyd Co	Kentucky	US Overall
Primary Care Physicians	1,760:1	1,600:1	1,330:1
Mental Health Providers	30:1	320:1	300:1
Dentists	1,350:1	1,500:1	1,360:1
Preventable Hospital Stays per 100,000	5,492	3,336	2,666
Mammography Screening Rates	31%	43%	44%
Percent Uninsured	7%	7%	10%

Source: County Health Rankings (2025)

## Physical Environment

Physical Environment	Floyd Co	Kentucky	US Overall
Severe Housing Problems	14%	13%	17%
Severe Housing Cost Burden	14%	12%	15%
Driving Alone to Work	86%	78%	70%
Long Commute to Work – Driving Alone	32%	31%	37%
Broadband Access	83%	87%	90%
Access to Parks	4%	29%	51%
Homeownership	72%	68%	65%
Air Pollution – Particulate Matter	7.3	8.0	7.3

Source: County Health Rankings (2025)

## Invasive Cancer Incidence Rates

Age-Adjusted Rate	Floyd Co	Kentucky	US Overall
<b>Total all sites (2017-2021)</b>	606.6	513.7	444.4
Lung and Bronchus	123.6	84.5	53.1
Breast (Female)	132.2	129.2	129.8
Colon and Rectum	61.5	45.9	36.4
Urinary Bladder	21.7	21.7	18.8
Kidney and Renal Pelvis	28.0	21.4	17.3
Melanoma of the Skin	23.5	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 Highlands ARH inpatient hospital discharges from January 2022- September 2024.

## Inpatient Hospital Discharges- Patient Origin

Patient County	Inpatient Discharges	% of Total
Floyd-KY	4,394	38.7%
Johnson-KY	2,606	23.0%
Magoffin-KY	1,388	12.2%
Pike-KY	863	7.6%
Martin-KY	859	7.6%
Knott-KY	258	2.3%
Lawrence-KY	187	1.6%
Mingo-WV	139	1.2%
Morgan-KY	130	1.1%
Letcher-KY	103	0.9%
Perry-KY	84	0.7%
Wolfe-KY	40	0.4%
Leslie-KY	34	0.3%
Harlan-KY	28	0.2%
Breathitt-KY	26	0.2%
Clay-KY	21	0.2%
Bell-KY	17	0.1%
Buchanan-VA	16	0.1%
Laurel-KY	16	0.1%
Logan-WV	16	0.1%
Boyd-KY	11	0.1%
Rowan-KY	10	0.1%
Whitley-KY	10	0.1%
Knox-KY	9	0.1%
Menifee-KY	9	0.1%
Wise-VA	7	0.1%
Greenup-KY	7	0.1%
Rockcastle-KY	6	0.1%



Owsley-KY	6	0.1%
Montgomery-KY	6	0.1%
Elliott-KY	6	0.1%
Wyoming-WV	5	0.0%
Lee-KY	5	0.0%
McDowell-WV	4	0.0%
Madison-KY	4	0.0%
Jackson-KY	3	0.0%
Powell-KY	3	0.0%
Dickenson-VA	3	0.0%
Estill-KY	2	0.0%
Raleigh-WV	2	0.0%
Mercer-WV	1	0.0%
Lee-VA	1	0.0%
Fleming-KY	1	0.0%
Carter-KY	1	0.0%
Lewis-KY	1	0.0%
Webster-WV	1	0.0%
<b>Total</b>	<b>11,349</b>	<b>100%</b>

### Inpatient Hospital Discharges- Payer Mix

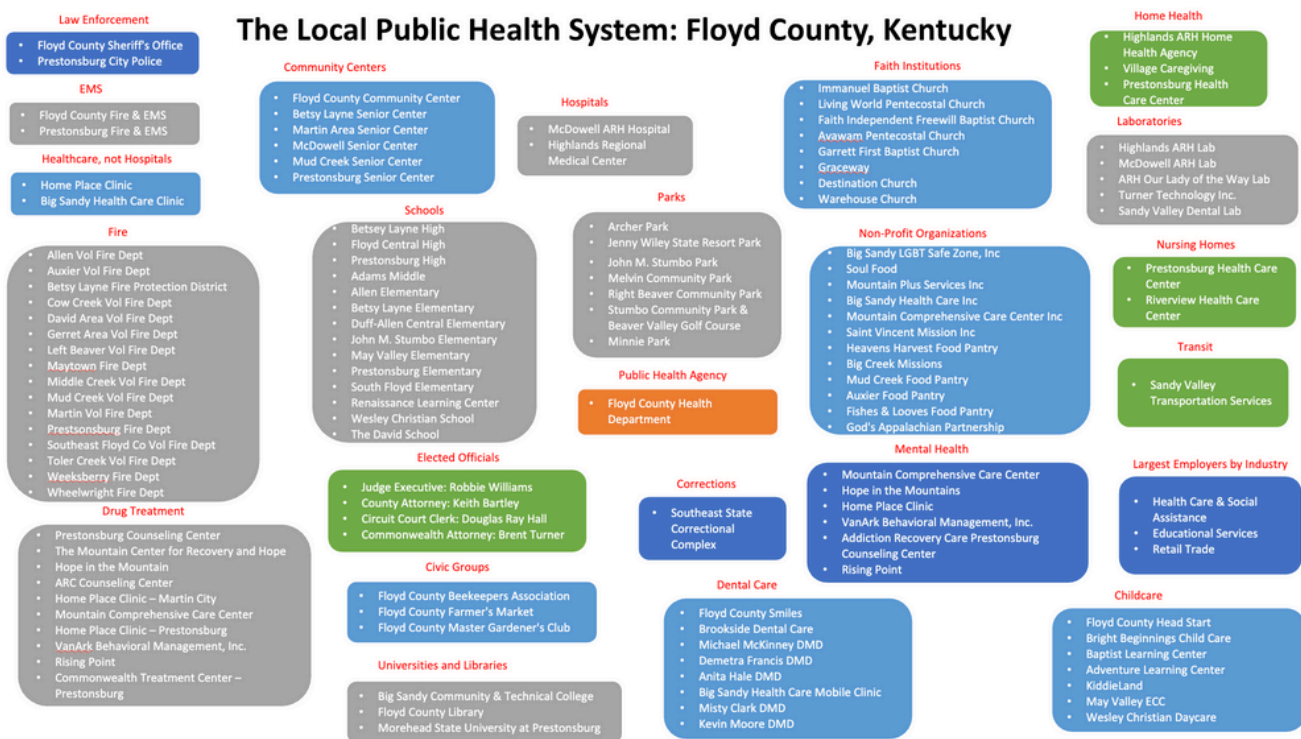
**Payer Type** **Inpatient Discharges** **% of Total**

WellCare of Kentucky Medicaid Managed Care	2,301	20.3%
Medicare (Excluding Medicare Managed Care)	2,091	18.4%
Medicare Managed Care	1,902	16.8%
Commercial- Anthem Health Plans of KY PPO Plan	905	8.0%
Commercial- Anthem Health Plans of KY HMO Plan	747	6.6%
Aetna Better Health of KY Medicaid Managed Care	696	6.1%
Humana Medicaid Managed Care	501	4.4%
Passport Medicaid Managed Care	374	3.3%
Anthem Medicaid Managed Care	354	3.1%
Other Facility	267	2.4%

Tricare (Champus)	260	2.3%
United Healthcare Medicaid Managed Care	244	2.1%
Self Pay	157	1.4%
In State Medicaid	126	1.1%
Commercial- Other	110	1.0%
Out of State Medicaid	97	0.9%
Commercial- Aetna Health HMO Plan	71	0.6%
Commercial- United Healthcare POS Plan	60	0.5%
Workers Compensation	22	0.2%
Commercial- Aetna Health PPO Plan	18	0.2%
Black Lung	18	0.2%
Auto Insurance	10	0.1%
VA	4	0.0%
ChampVA	4	0.0%
Commercial- Humana PPO Plan	3	0.0%
Care Source KY Commercial Plan	3	0.0%
Commercial- Cigna Health & Life FFS Plan	3	0.0%
Commercial- PPO	1	0.0%
<b>Total</b>	<b>11,349</b>	<b>100%</b>

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



# Floyd 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 Highlands ARH leadership in late summer of 2024. On September 23, 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 March 31, 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 Highlands ARH to address.



# Floyd County CHNA Steering Committee

## Steering Committee Members

Name	Organization Represented
Heather Samons	ARH
Danita Hampton	ARH- McDowell
Stacy Brown	Floyd County Schools
Michelle Keathley	Floyd County Schools
Jessica Adkins	Big Sandy Healthcare
Tammie Ratliff	Floyd County Health Department
Christina Tincher	Floyd County Health Department
Teresa Griffith	Floyd County Schools
Heather Coleman	Floyd County Extension Office
Andrea Slone	Floyd County Extension Office
Lauren Hurley	Big Sandy Healthcare
Jennifer Biddle	KCTCS
Terry Burchett	SOAR
Taylor Stumbo	University of Kentucky Student
Lynn Case	Community Member
Annette Harris	Floyd County Schools
Bethany Pigman	Floyd County Health Department
Kim Grubb	Floyd County Schools



# Community Focus Groups

After the initial steering committee meeting, 3 focus groups 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.

Highlands ARH hosted forums with:

- Betsy Layne High School Students
- Head Start Parents and Teachers
- Hope in the Mountains - Recovery Centric Group

## **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: Obesity & Related Disease

- Obesity
- Lack of access to physical activity
- Obesity-related disease (heart disease, diabetes, hypertension)
- Cancer
- Lack of access to healthy foods

### Finding 1.2: Communicable & Preventable Diseases & Behaviors

- Vaping
- Communicable illness
- Domestic violence
- Substance use (drugs & alcohol)
- Addiction

*"I can go buy a bag of chips cheaper than fruits and vegetables"*

## \* QUESTION 2: BARRIERS TO HEALTHCARE

### Finding 2.1: Resource Shortages

- Cost of healthcare
- Lack of transportation
- Cost of medications

### Finding 2.1: Contextual Barriers

- Lack of knowledge/ education on healthy lifestyles
- Lack of specialists
- Lack of dental care, especially for Medicaid population

# Focus Group Results

## \* QUESTION 3: HEALTH BEHAVIORS

### Finding 3.1: Substance Use

- Vaping
- Substance use
- Lack of extracurricular activities- contributing to substance use
- Tobacco use (smoking, vaping, chewing)

*"Ask someone in the high school bathroom and they will most likely have nicotine"*

### Finding 3.2: Social-Norm Health Behaviors

- Domestic violence
- Physical inactivity
- Sedentary lifestyle
- Not safe places to walk
- Feelings of hopelessness

## \* QUESTION 4: ADDITIONAL CONCERNS

### Finding 4.1: Additional Resources Needed

- Mental health
- Obesity resources
- Cancer care and education
- Poverty
- Transportation
- Lack of safe public parks
- Lack of daycare/ childcare
- Addiction
- Social issues: housing, transportation
- STD/STI education
- Narcan education
- Community activities
- Programs for children
- Single mothers

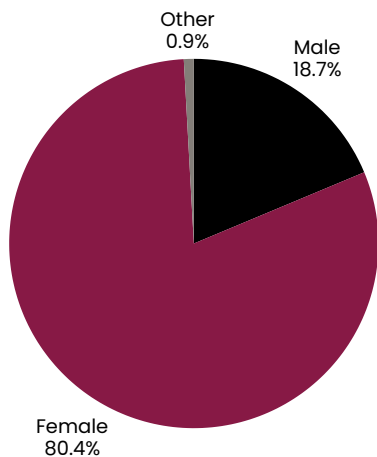
# Community Survey Results

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=700*

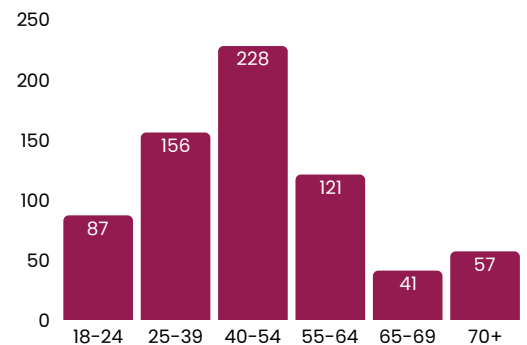
### Gender



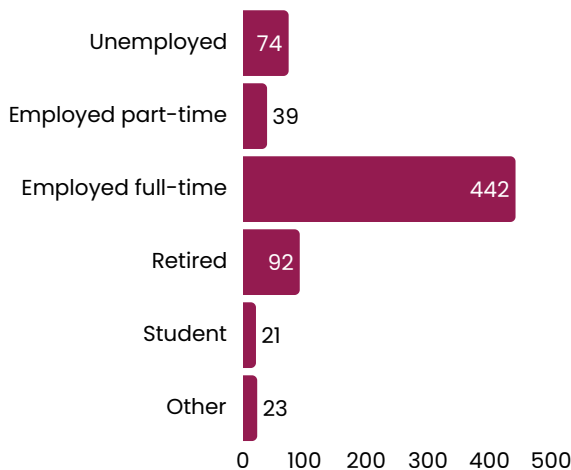
### Education

**29%** High School  
**6%** Technical School  
**59%** College or Above  
**7%** Other

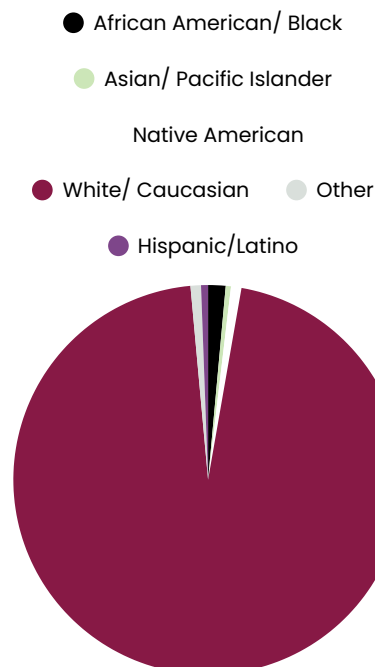
### Age



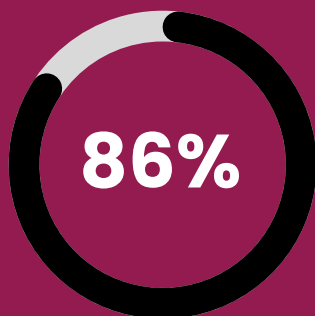
### Employment Status



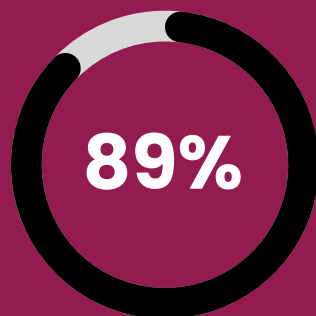
### Race/ Ethnicity



# Community Survey Results



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

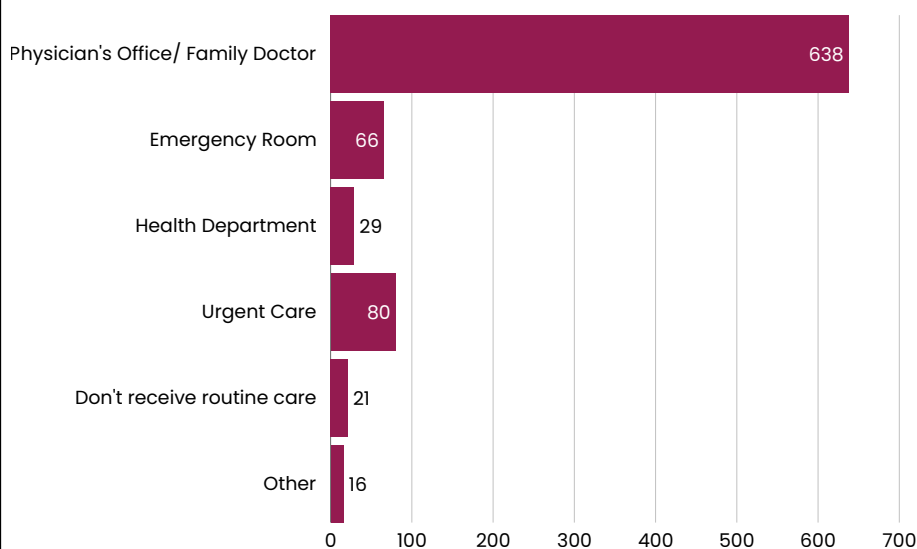


**Regularly receive preventive services such as vaccinations, screenings, and checkups.**



**Have delayed healthcare due to lack of money or insurance.**

## Where do you go to receive routine healthcare?

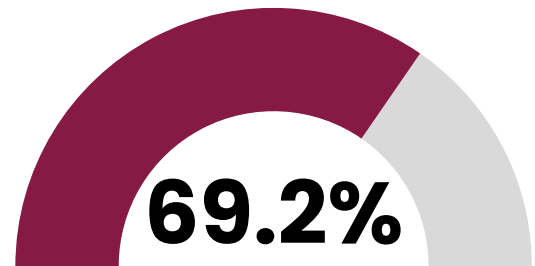
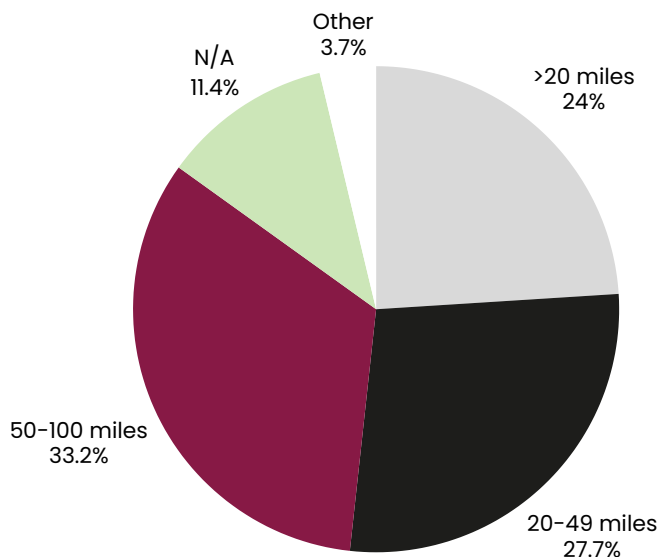


## Top 5 barriers to receiving routine healthcare:

1. No barriers
2. Only visit the doctor when something is seriously wrong
3. Physician hours of operation
4. Cannot take off work
5. Cannot afford it

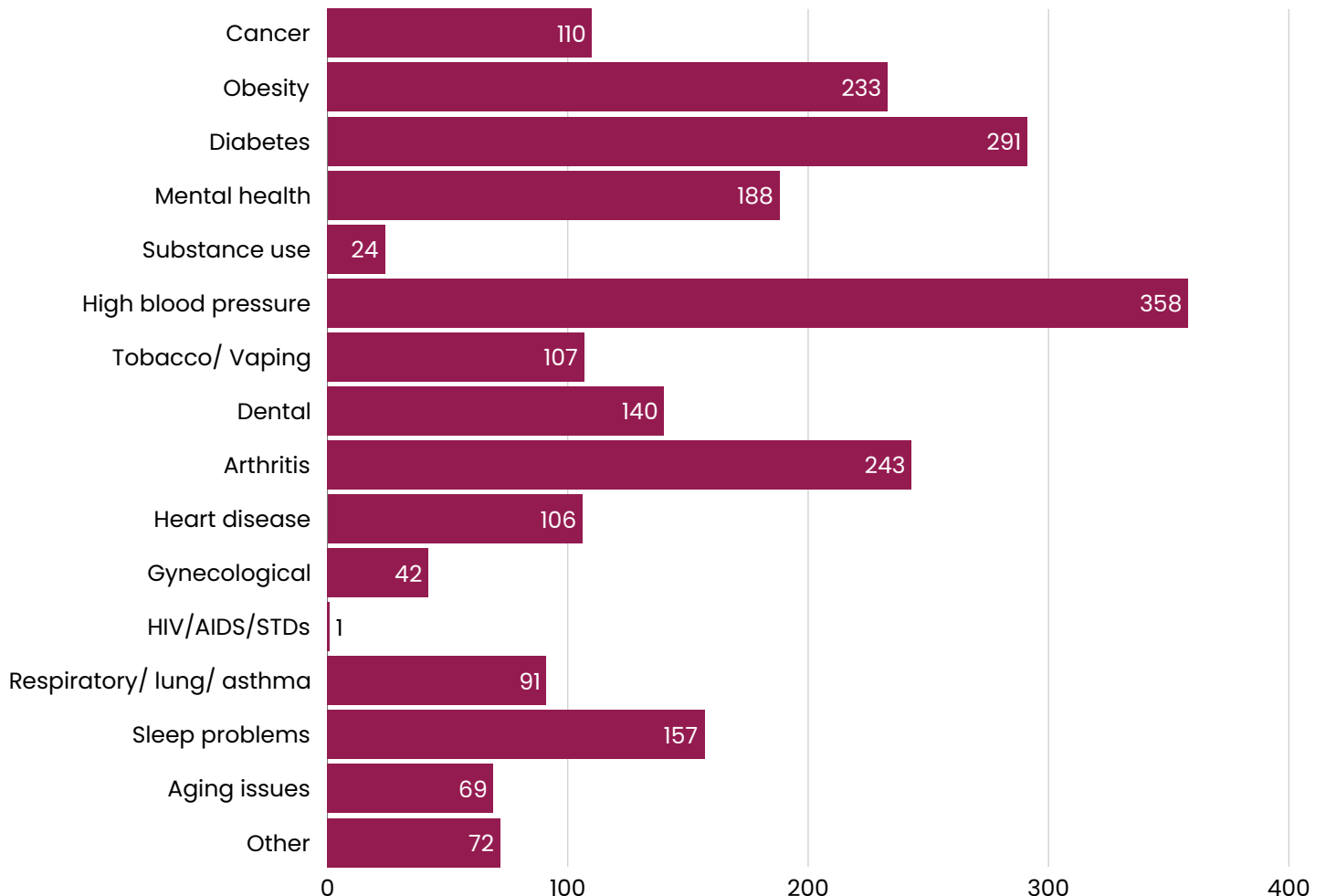
# Community Survey Results

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



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

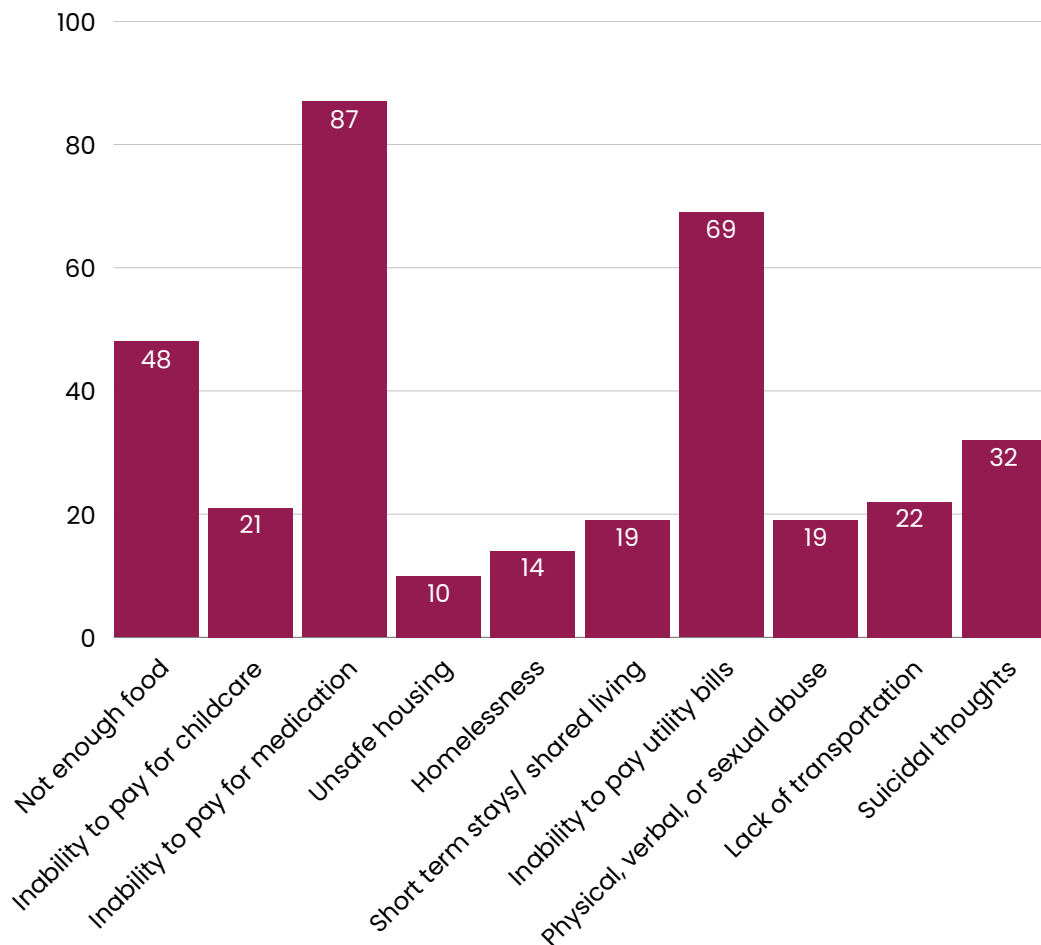
**Top 3 health challenges you/ your household face:**





# Community Survey Results

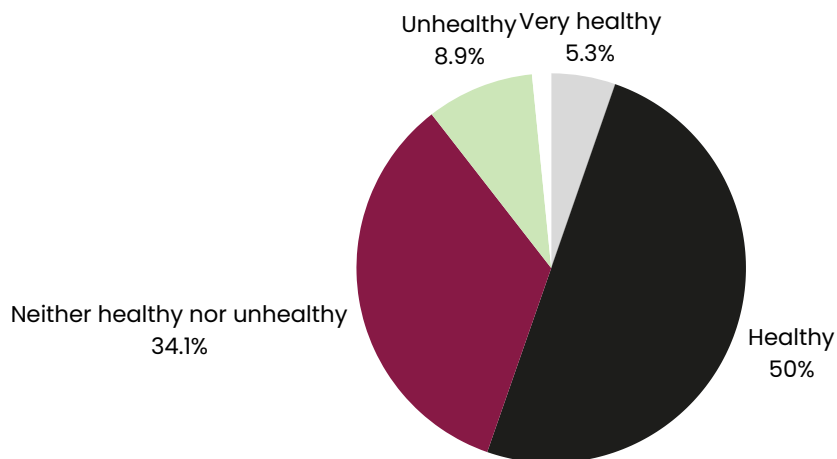
Have you or your household faced any of these issues in the past year?



How would you rate your overall health?

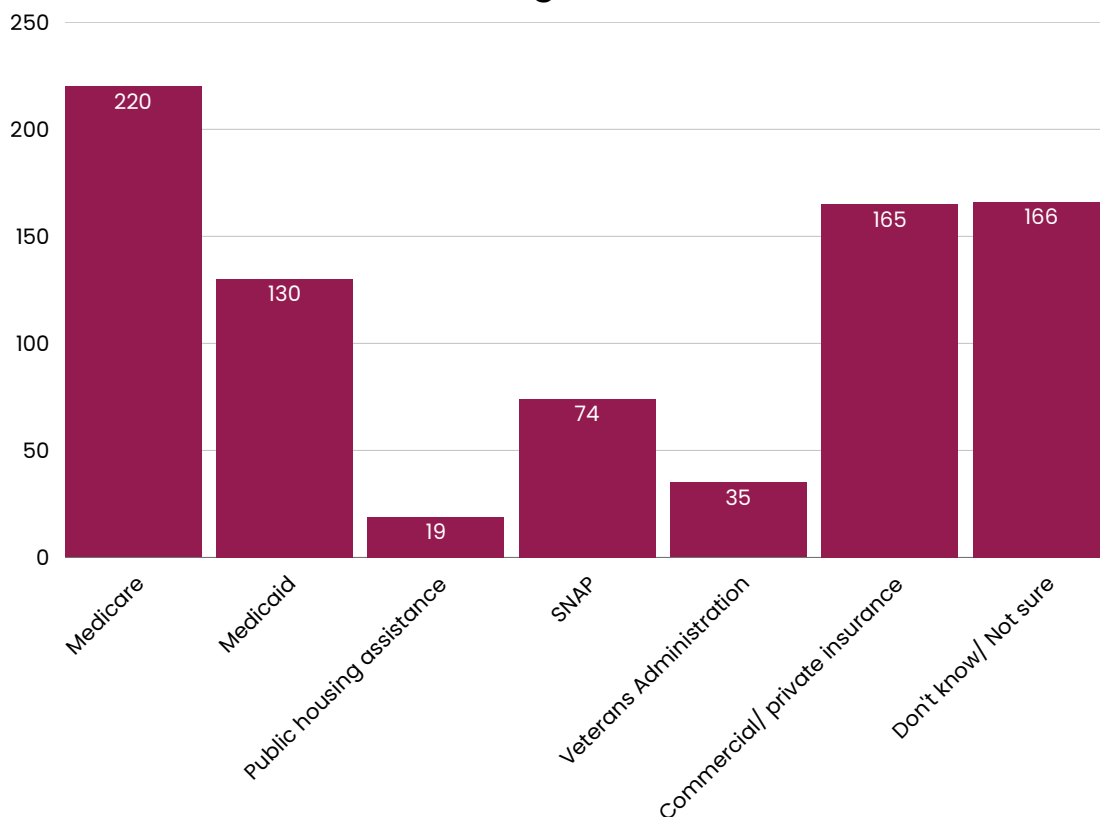
**Top 3 risky behaviors you see in your community:**

1. Drug use (475)
2. Tobacco/ Vaping (350)
3. Poor eating habits (323)

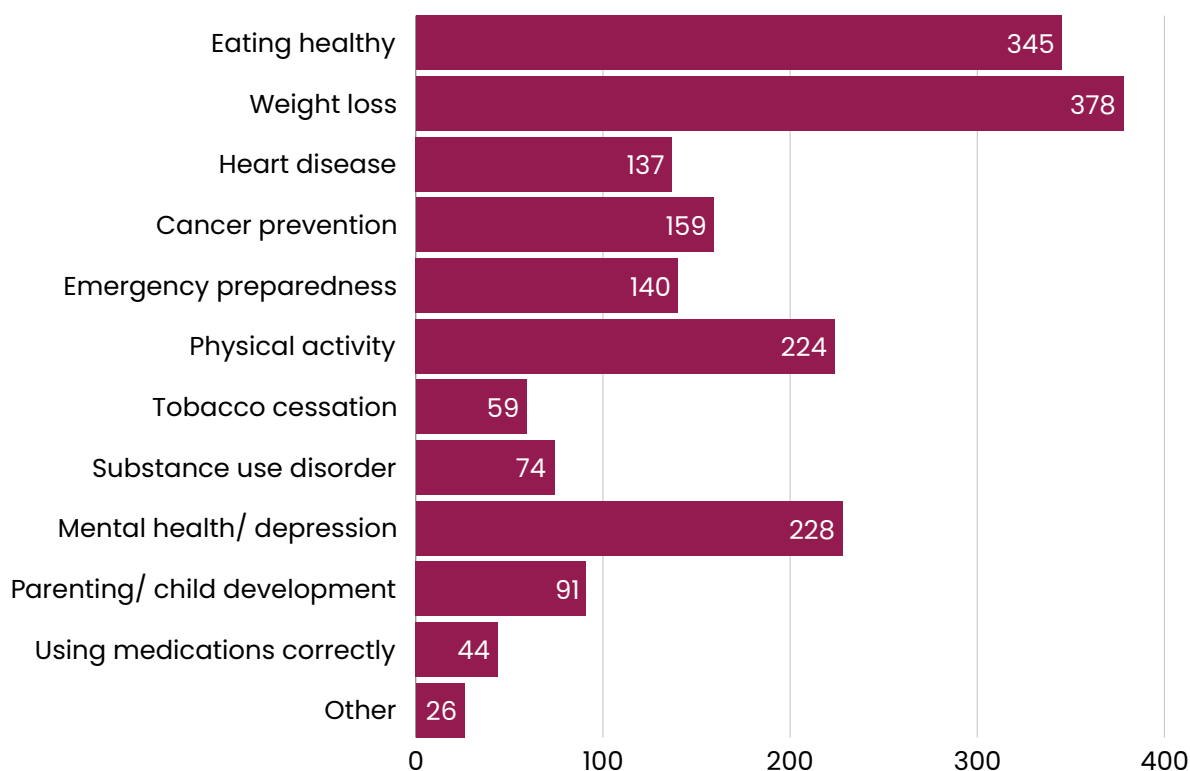


# Community Survey Results

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

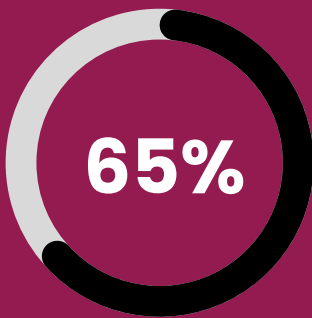
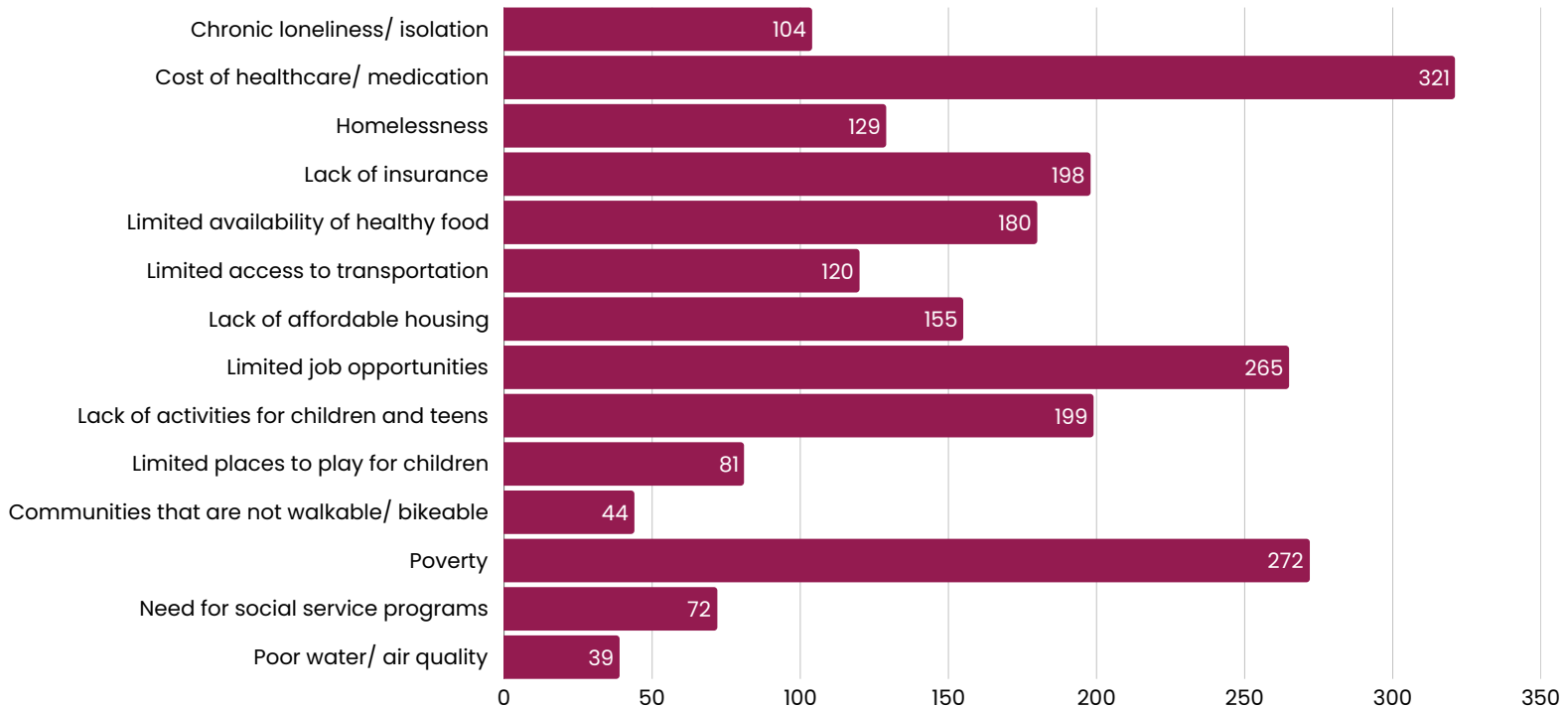


**Health related topics respondents are interested in learning more about:**

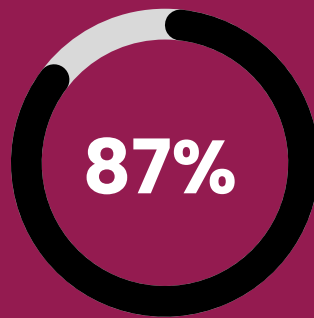


# Community Survey Results

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



**Have had a dental exam in the past year.**



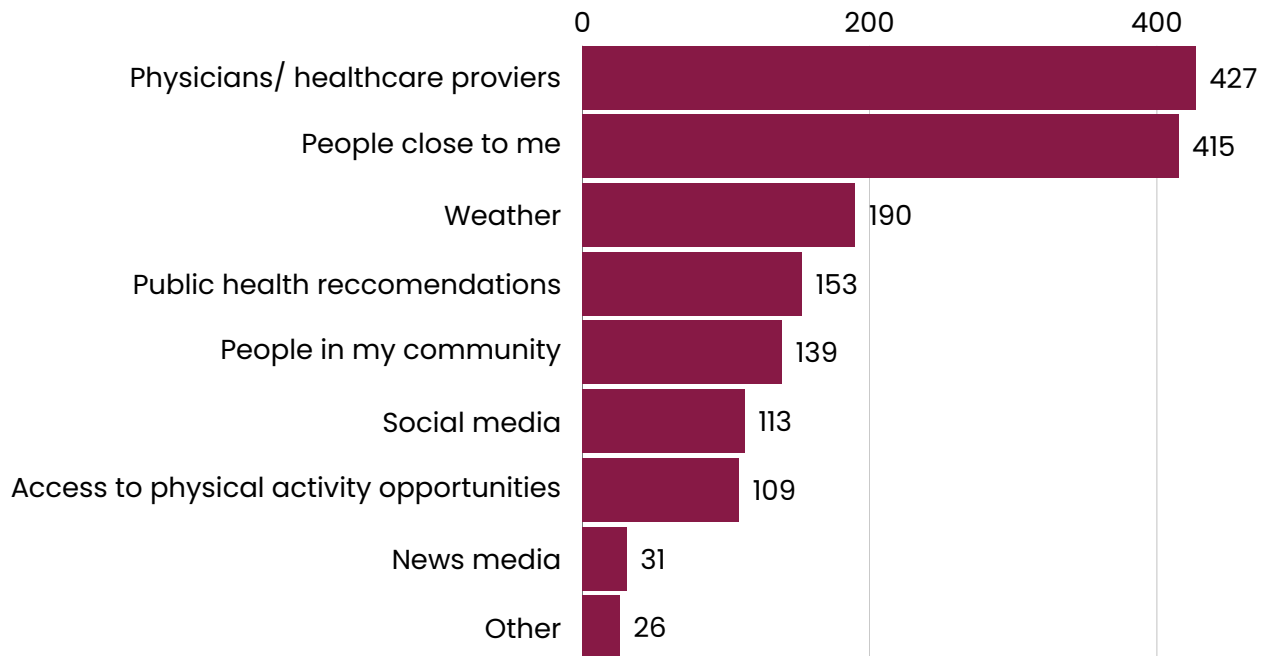
**Have had a routine checkup in the past year.**



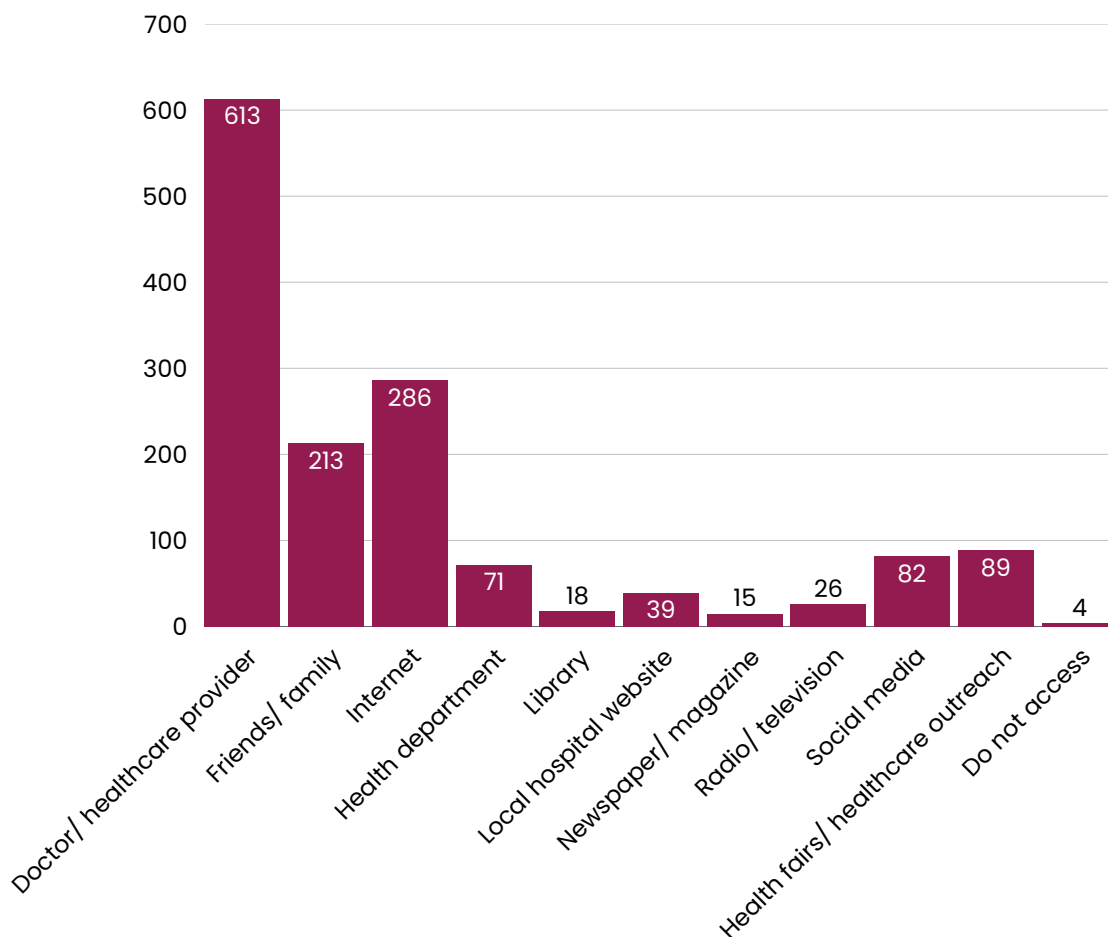
**Believe mental illness is a medical condition.**

# Community Survey Results

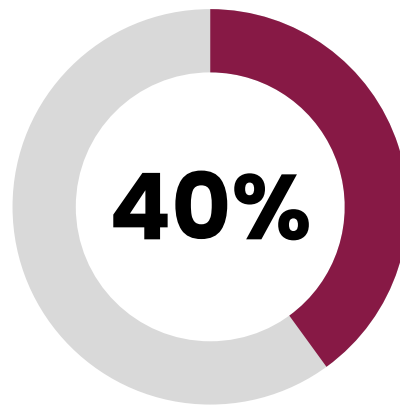
## What factors influence your health choices?



## Where do you get most of your healthcare information?

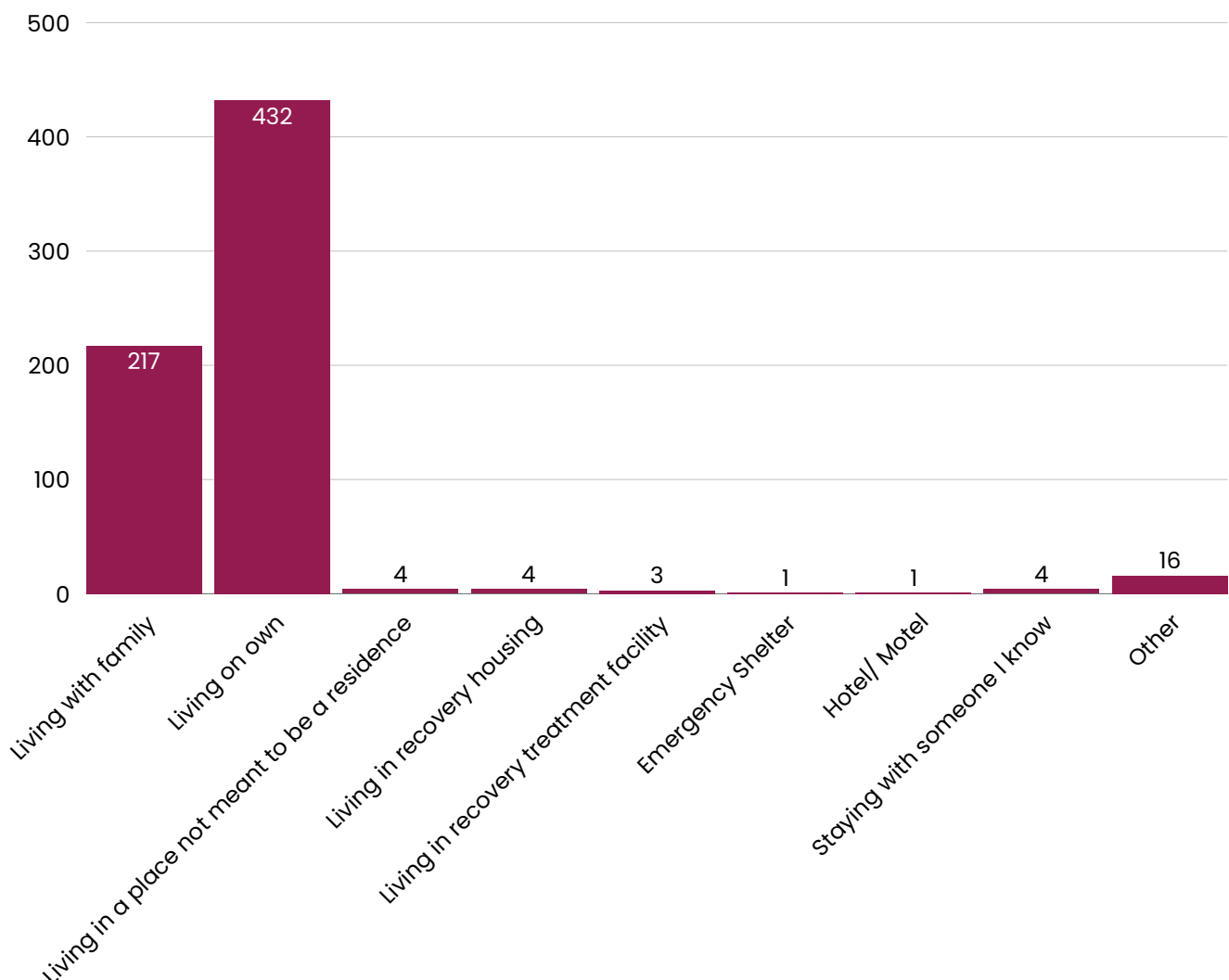


# Community Survey Results



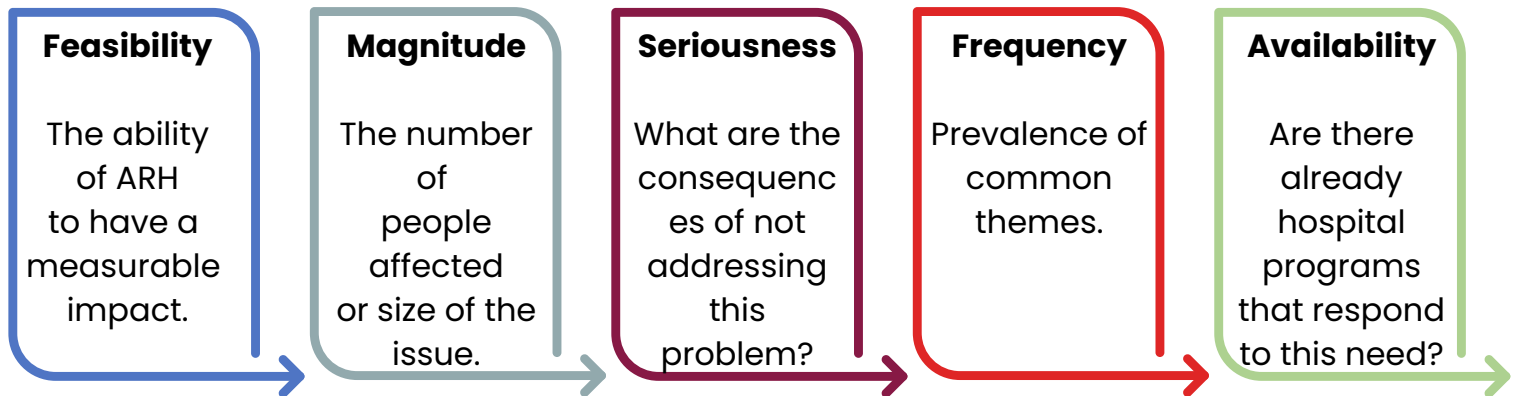
**Have been told by a healthcare professional that they have high cholesterol.**

## 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. Substance Use Disorder/ Addiction**
- 2. Obesity and Related Diseases**
- 3. Poverty and Meeting Basic Needs**
- 4. Transportation**



# Implementation Plan

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

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

## Key Strategies

- Continue to grow 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 (ARC board, ASAP, Unite, CADA)

**Goal: Lower rates of obesity through nutrition interventions, physical activity opportunities, and education about obesity-related diseases**

## Key Strategies

- Nutrition education
  - Expand in-school programming to include education about nutrition, especially on sugary and overly-caffeinated drinks
  - Grow partnership with UK Extension Service, expanding cooking classes to outlying communities, perhaps within faith-based community
  - Promote healthy cooking with ARH dietitian approved recipes at local farmer's markets and community events
  - Provide individual and group-based prevention and education efforts through the ARH Diabetes Education Program

### **Key Strategies**

- Physical Activity
  - Partner with local gyms and fitness clubs to host health and wellness events, physical activity classes, and experiences that promote healthy families
  - Offer gentle chair yoga classes throughout community
  - Monetarily support events that encourage physical activity – bike races, community health and wellness days, 5k events
- Screenings and education about obesity-related diseases
  - Educate about/provide screenings related to obesity-related diseases – heart disease, stroke, type 2 diabetes

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

### **Key Strategies**

- Continuing the 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 the Floyd County Homeless Shelter, Gods Pantry Food Bank, and Red Cross
- Provide basic needs during disaster relief
- 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

## Goal: Reduce transportation barriers to accessing health care

### Key Strategies

- Connect patients with transportation barriers with community resources
  - Provide gas funds as available to ARH patients
  - Increase referrals for medical taxi services and Sandy Valley Transportation
- Provide primary care in outlying communities with use of ARH Mobile Clinic
- Provide telehealth to students and staff of Floyd County Schools
- Continuously add new services locally so that patients do not have to travel for specialty care
  - Recruit providers in Cardiology, Infectious Disease, Pulmonology, Oncology
  - Upgrade and grow cath lab, oncology office, and MRI services
- Explore possibility of ARH supported transportation services

# 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

### FLOYD COUNTY, KENTUCKY

POPULATION: 34,423

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: Floyd 3.4%   Kentucky 3%   United States 2.4%
2	<b>Poverty Rate: Floyd 38.4%</b>   Kentucky 16.6%   United States 17%
3	<b>Population 16+ in Labor Force: Floyd 42%</b>   Kentucky 59.1%   United States 63.1%
4	Single Parent Households: Floyd 33.4%   Kentucky 31%   United States 7%
5	<b>Households spending at least 30% of income on housing: Floyd 26.3%</b>   Kentucky 23.9%   United States 22.8%
6	Population Without Access to Large Grocery Store: Floyd 6.4%   Kentucky 19.8%   United States 21.7%
7	<b>Children Living in Food Insecure Households: Floyd 23.3%</b>   Kentucky 16%   United States 15%

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



1	Students Graduating High School in 4 Years: Floyd 90.4%   Kentucky 91.4%
2	High School Graduates Enrolled in Post-Secondary Education Within 6 Months of Graduation: Floyd 44.3%   Kentucky 43.7%
3	<b>8th Grade Students with Proficient or Distinguished on Readings State Assessment: Floyd 39%</b>   Kentucky 44%
4	<b>8th Grade Students with Proficient or Distinguished on Math State Assessment: Floyd 30%</b>   Kentucky 46%
5	Kindergarteners Ready to Learn: Floyd 57%   Kentucky 44%
6	<b>Students with an Individualized Education Plan: Floyd 20%</b>   Kentucky 15%
7	<b>4th Grade Students with Proficient or Distinguished on Reading State Assessment: Floyd 33%</b>   Kentucky 46%
8	<b>4th Grade Students with Proficient or Distinguished on Math State Assessment: Floyd 25%</b>   Kentucky 46%

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



1	Adult with Recent Doctor Visit for Routine Checkup: Floyd 74.9%   Kentucky 76%   United States 73%
2	Children Under 19 with Health Insurance Coverage: Floyd 96.2%   Kentucky 96.1%
3	Number of TBI Emergency Department Cases: Floyd 46   Kentucky 11,249
4	Adults With Recent Preventative Care Visit: Floyd 79.5%   Kentucky 80.7%   United States 74.6%
5	<b>Lung and Bronchus Incidence per 100,000 Population: Floyd 125.5</b>   Kentucky 84.4   United States 54

6	<b>Mammography Use Among Women Aged 50-74:</b> Floyd 66.7%   Kentucky 75.2%-78.6%   United States 78.2%
7	STIs per 100,000 Population: Floyd 167.3   Kentucky 410.3   United States 495.5
8	Colon and Rectum Cancer Incidence per 100,000: Floyd 64.7   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: Floyd 61%   Kentucky 51%
10	Population Under 65 Without Health Insurance: Floyd 6.9%   Kentucky 7%   United States 13.5%
11	Population With Limited English Proficiency: Floyd 0-0.2%   Kentucky 2.1%   United States 9%

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



1	Violent Crime Rate per 100,000 Population: Floyd 51.6   Kentucky 2,233.4   United States 1,673.7
2	Population with Access to Broadband: Floyd 97%   Kentucky 97%   United States 96.7%
3	<b>Percent of County Using SNAP:</b> Floyd 26.3%   Kentucky 12.3%
4	Air Quality Hazard: Floyd 0.64   Kentucky 0.44   United States 0.34
5	Vehicle Crash Fatality Rate per 100,000: Floyd 23.7   Kentucky 51.5   United States 17.5
6	<b>Population Within ½ Mile of Walkable Destinations:</b> Floyd 9.5%   Kentucky 33.9%   United States 34%
7	<b>Walkability Index Score:</b> Floyd 4.7   Kentucky 7.2   United States 6.1
8	<b>Asthma Prevalence Among Adults 18+:</b> Floyd 12.3%   Kentucky 11.5%   United States 9.2%
9	<b>Adult Smoking Rate:</b> Floyd 31%   Kentucky 23.9%   United States 24.3%
10	Deaf and Hard of Hearing Population: Floyd 5,422   Kentucky 705,533
11	<b>Prevalence of People with Disabilities:</b> Floyd 25.9%   Kentucky 21.1%

#### SOCIAL AND COMMUNITY CONTEXT: INCREASE SOCIAL AND COMMUNITY SUPPORT



1	<b>Census Self- Response Rate:</b> Floyd 54.4%   Kentucky 63.5%   United States 65.8%
2	<b>Households With a Computer:</b> Floyd 86.3%   Kentucky 90.2%   United States 93.1%
3	Youth Incarcerated in the Juvenile Justice System per 1,000 Youth: Floyd <i>fewer than 6</i>   Kentucky 13.2



# Appendix B

## Local Public Health Schematic



# Appendix C

## Survey Instrument



### 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.

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

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

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

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

- |  |  |
|--|--|
| <input type="checkbox"/> Excessive alcohol use   | <input type="checkbox"/> Drug use                              |
| <input type="checkbox"/> Poor eating habits      | <input type="checkbox"/> Distracted driving                    |
| <input type="checkbox"/> Lack of exercise        | <input type="checkbox"/> Domestic violence                     |
| <input type="checkbox"/> Child abuse and neglect | <input type="checkbox"/> Other. Please specify below:<br>_____ |
| <input type="checkbox"/> Tobacco or vaping use   | _____  |
| <input type="checkbox"/> Unsafe sex              | _____  |

**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.

- |   |  |
|---|--|
| <input type="checkbox"/> Eating healthy         | <input type="checkbox"/> Substance use disorder (alcohol and/or drugs) |
| <input type="checkbox"/> Weight loss            | <input type="checkbox"/> Mental health/Depression                      |
| <input type="checkbox"/> Heart disease          | <input type="checkbox"/> Parenting / Child development                 |
| <input type="checkbox"/> Cancer prevention      | <input type="checkbox"/> Using my medications correctly                |
| <input type="checkbox"/> Emergency preparedness | <input type="checkbox"/> Other. Please specify below:                  |
| <input type="checkbox"/> Physical activity      | _____  |
| <input type="checkbox"/> Tobacco cessation      |  |

**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?**

- |   |   |
|---|---|
| <input type="checkbox"/> African American/Black | <input type="checkbox"/> Native American              |
| <input type="checkbox"/> Asian/Pacific Islander | <input type="checkbox"/> White/Caucasian              |
| <input type="checkbox"/> Hispanic/Latino        | <input type="checkbox"/> 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:

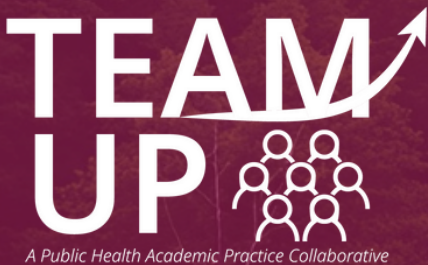
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**Q31.** What is your current employment status?

- ☐ 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 Floyd 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 Floyd 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.



## 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