COMMUNITY HEALTH NEEDS ASSESSMENT

2025-2027

ARH
Mary Breckinridge

TEAM UP
A Public Health Academic Practice Collaborative

Acknowledgements

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

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

Letter to the Community Member

Dear Community Members, Partners, and Stakeholders,

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

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

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

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

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

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

Sincerely,

Hollie P. Harris

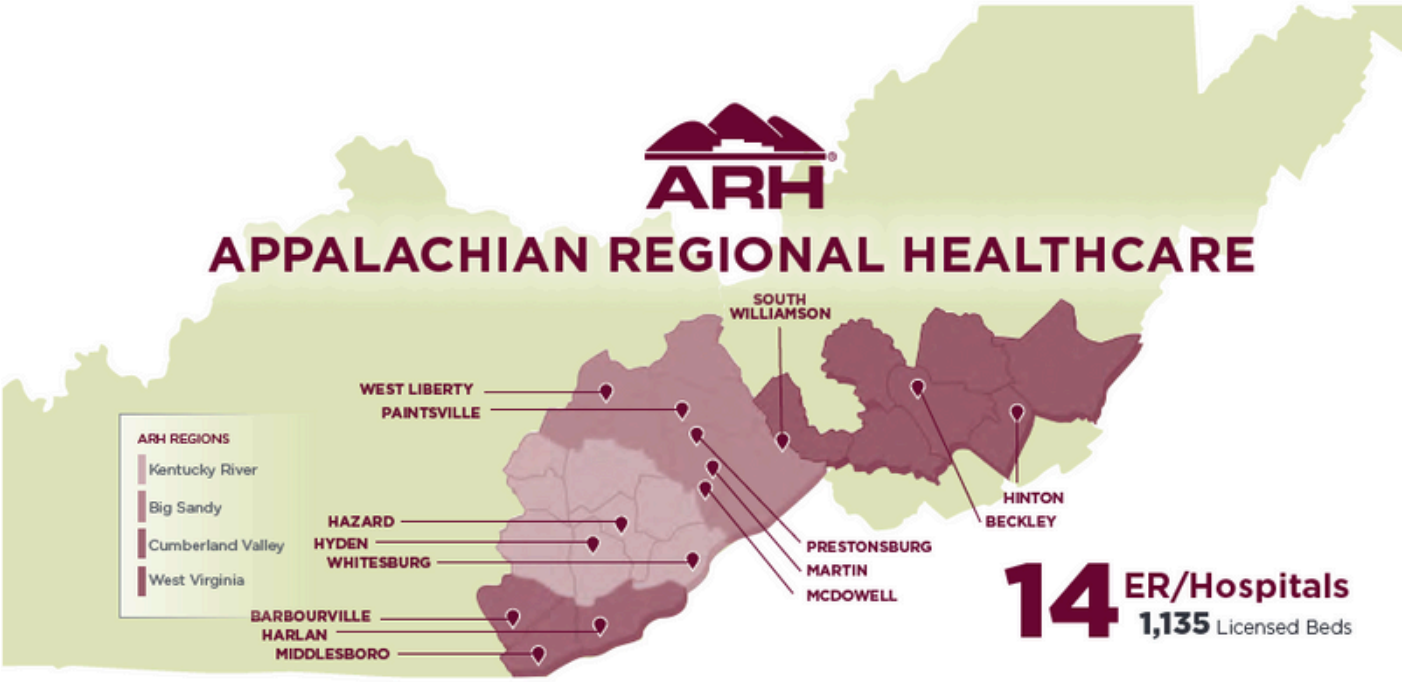
Hollie Harris, MHA
President and CEO Appalachian Regional Healthcare, Inc.

Table of Contents

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, Mary Breckenridge 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.

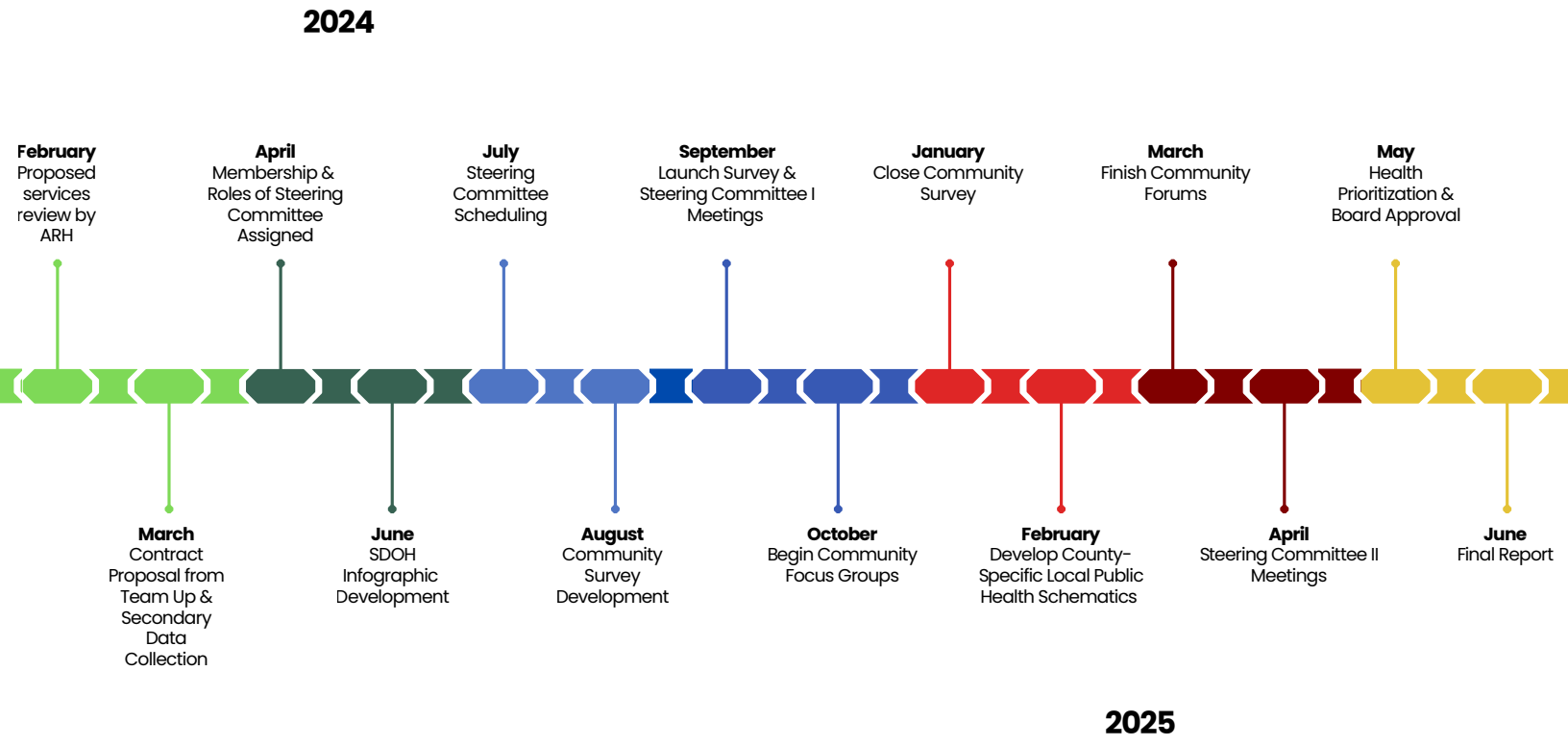
Method	Description
Community Surveys	A traditional approach to gathering community input. Can include: written, telephone, web-based, or in-person.
Focus Groups	A traditional approach to gathering community input. Can include: written, telephone, web-based, or in-person.
Key Informant Interviews	In-depth 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 Mary Breckenridge ARH. See the CHNA process timeline below.

CHNA Timeline



2022-2024 Implementation Successes

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

1. Substance use disorder
2. Mental health
3. Access to health care- after hours & urgent care
4. Transportation
5. Health education - healthy eating and food preparation, reducing hypertension, diabetes, childhood obesity, tobacco use and vaping

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

Goal 1 ✓ Provide community education and support related to drug, tobacco, and alcohol addiction

Since 2022, Mary Breckenridge ARH has **provided community education and support** by:

- Launching the Peer Support program in 2022, which employs Peer Support Coaches to work in our Emergency Departments 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, Mary Breckinridge ARH Peer Recovery Coaches have:
  - **65** patient encounters with peer recovery coach
  - **9,674** SBIRT screenings completed
  - Implemented "**Too Good for Drugs**" Class at WB Muncy Elementary
  - Served on Operation Unite Leslie County Coalition
  - Peer Recovery Coaches have provided "Too Good for Drugs" programming to middle school age students in Leslie County Schools

- Supporting Narcan distribution efforts and Save A Life Roadshow in partnership with KY Department of Public Health

- Sponsorship of weekly AA/NA meetings held at Rockhouse Baptist Church

- Partnership with the Leslie County Health Department to offer smoking cessation classes to community members and education on the harmful effects to smoking

- ARH Employee smoking cessation service including free online counseling and nicotine replacement therapies

Goal 2

Improve the mental health of our community members and reduce mental health stigma

Since 2022, Mary Breckenridge ARH has **improved mental health in our community** by:

- Growing outpatient behavioral health services as well as community engagement from our behavioral health team in many ways:
  - The facility added a psychiatric mental health nurse practitioner to its staff that provides needed services for all age groups.
  - A behavioral health satellite clinic has opened once per month in Big Creek, KY, in addition to the clinic in Hyden.
  - The MPHNP also provides telehealth visits
  - Behavioral health staff have attended community events to educate about anxiety, depression, bullying, and many other mental health topics as requested from the community.

- Reopening the Mary Breckenridge Senior Care Program in 2023. ARH Senior Care provides older adults with quality behavioral healthcare. Patients that come to the program typically have Medicare Part B and a diagnosis such as Major Depressive Disorder, Generalized Anxiety Disorder, and other mental health diagnoses. The staff at ARH Senior Care utilizes a multidisciplinary treatment team including a psychiatrist, a therapist, and a registered nurse to develop an individualized plan of treatment for each patient. Our Goal is to provide a safe environment for our patients to come and share their feelings with others that are experiencing similar issues. Patients receive transportation to and from the program

Goal 3

Increase access to care

Since 2022, Mary Breckenridge ARH has **addressed access to care** by:

- Adding many new services that would otherwise require patient travel, including:
  - Hepatitis C Treatment in the Hyden Rural Health Clinic
  - Outpatient pulmonary rehabilitation, a program that helps people with lung disease improve their function and quality of life through exercise and education. The program is tailored to each individual's needs and abilities, and is supervised by a team of health professionals
  - A Podiatry clinic in Hyden, offering a much-needed service for our diabetic patients

- In 2024, the facility received certification from DNV as an Acute Stroke Ready Center, affirming the hospital's readiness to handle strokes and stroke related medical problems. The advantage of an Acute Stroke Ready certified program is that these stroke centers usually serve communities where access to a larger, more equipped hospital is too far for patients to reach in limited time.

Goal 4

Provide health education and preventive screening events broadly throughout the community

Since 2022, Mary Breckenridge ARH has **provided health education and preventive screening** in our community through:

- Partnering with the Leslie County Extension Office to host 25 cooking classes in which participants learn to cook a nutritious meal and are provided a grocery gift card for participation

- Hosting 22 ARH-led Diabetes Support Groups with diabetes-related education and diabetic-friendly meal demonstrations. 60 free A1C screenings have been completed at these groups and throughout the community

- Providing screenings and education monthly at the Leslie County Farmers Market, including stroke risk screenings, A1C testing, diabetes education, lung cancer screening education, nutritional programs, and more. ARH also monetarily supported the farmers market by providing Carrot Cash vouchers, market t-shirts and market totes

- Hosting 13 stroke-related programs and events that educate the community about stroke risk, recognizing a stroke, importance of blood pressure management. These include new programs such as
  - Strike Out Stroke with local little leagues
  - Taco-Bout Stroke cooking classes
  - 351 free stroke risk assessments completed for participants at community screening events held at pharmacies, retail stores, and for staff in local schools

- Promoting the importance of preventative breast cancer screenings and early detection by hosting annual breast cancer awareness luncheons with survivor speakers. ARH also offers a $50 mammogram special each October that covers the screening mammogram and radiologist's reading. This program allows women to self-schedule mammograms without a physician's order, and is an affordable option for women without insurance

- Partnering with Kentucky Cancer Program to host Colon Cancer Awareness and Educational events each year in March, including visits to local schools, registrations for take-home colon cancer screening kits, and walk-through tours of The Incredible Colon, a 12-ft educational, medical inflatable

- In an effort to increase youth literacy and physical activity, Mary Breckinridge ARH partnered with the city of Hyden to sponsor the Children's Story Walk. The facility also provides bags of educational coloring books and other promo items for each child that participates

- ARH staff and providers have spoken on health topics at events throughout the community, including events for the Leslie County Chamber of Commerce, Leslie County Schools, Leslie County Extension office, and more

- Sponsored the Carrot Cash program for Leslie County Farmers Market, providing vouchers for children to spend on fresh fruits and vegetables

- Mary Breckinridge ARH hosts a community meal annually to kick off the Mary Breckinridge Festival, and includes health education and free health screenings each year

Community Served by Mary Breckenridge ARH

Mary Breckenridge 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 Leslie County (58.1%).

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

Population

Population	Leslie Co	Kentucky	US Overall
Population, 2024	9,729	4,588,372	340,110,988
Percent of Population Under 18 Years	21.3%	22.5%	21.7%
Percent of Population 65 Years+	20.2%	17.8%	17.7%
Percent of Population White	97.8%	86.7%	75.3%
Percent of Population Non-Hispanic Black	0.6%	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%	0.1%	0.3%
Percent of Population Hispanic or Latino	0.9%	5.0%	19.5%
Two or More Races	1.1%	2.3%	3.1%
Percent of Population Female	49.9%	50.4%	50.5%

Source: US Census, 2024 QuickFacts

Social and Economic Factors

Social and Economic Factors	Leslie Co	Kentucky	US Overall
Percent Completed High School	81%	89%	89%
Bachelor's Degree or Higher	10%	27%	35%
Percent Unemployed	6.9%	4.2%	3.6%
Percent of People in Poverty	26.7%	16.4%	11.1%
Children in Poverty	31%	20%	16%
Number of Children in Single Parent Households	21%	25%	25%
Median Household Income	$39,900	$61,100	$77,700
Violent Crime Rate (per 100,000)	37.7	225.6	255.2
Child Care Cost Burden	32%	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	Leslie Co	Kentucky	US Overall
Percent Adult Smoking	23%	18%	13%
Percent Adults with Obesity	44%	38%	34%
Percent of Physically Inactive Adults	32%	25%	23%
Adults (>65) with all Teeth Lost	25.8%		12.6%
Percent of Adults Receiving Flu Vaccination in the Last Year	24%	46%	48%
Teen Birth Rate (per 1,000)	24	24	16
Sexually Transmitted Infections per 100,000	118.9	406.8	495.0
Percent Excessive Drinking	14%	15%	19%
Number of Child Victims of Substantiated Abuse	36	17,917	-
Births to Mother who Smoked During Pregnancy	26.1%	12.6%	5%
Percent Driving Deaths with Alcohol Involvement	38%	26%	26%
Suicides Per 100,000 Population	22	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	Leslie Co	Kentucky	US Overall
Life Expectancy (years)	68.7	73	77
Percent Adults with Diabetes	14%	13%	10%
Percent Adults with Hypertension	40.9%	-	29.6%
Adults with current Asthma	11.9%	-	9.9%
Percent Fair to Poor Health	27%	20%	17%
Avg Number of Physically Unhealthy Days	6.0	4.5	3.9
Avg Number of Mentally Unhealthy Days	6.0	5.0	5.1
Percent Low Birth Weight	11%	9%	8%
Percent with a Disability, under Age 65	25.6%	13%	9%

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

Access to Care

Access to Care	Leslie Co	Kentucky	US Overall
Primary Care Physicians	5,140:1	1,600:1	1,330:1
Mental Health Providers	1,640:1	320:1	300:1
Dentists	5,050:1	1,500:1	1,360:1
Preventable Hospital Stays per 100,000	4,309	3,336	2,666
Mammography Screening Rates	24%	43%	44%
Percent Uninsured	5%	7%	10%

Source: County Health Rankings (2025)

Physical Environment

Physical Environment	Leslie Co	Kentucky	US Overall
Severe Housing Problems	16%	13%	17%
Severe Housing Cost Burden	11%	12%	15%
Driving Alone to Work	86%	78%	70%
Long Commute to Work – Driving Alone	59%	31%	37%
Broadband Access	79%	87%	90%
Access to Parks	100%	29%	51%
Homeownership	83%	68%	65%
Air Pollution – Particulate Matter	6.9	8.0	7.3

Source: County Health Rankings (2025)

Invasive Cancer Incidence Rates

Age-Adjusted Rate	Leslie Co	Kentucky	US Overall
Total all sites (2017-2021)	492.2	513.7	444.4
Lung and Bronchus	114.6	84.5	53.1
Breast (Female)	98.2	129.2	129.8
Colon and Rectum	54.5	45.9	36.4
Urinary Bladder	-	21.7	18.8
Kidney and Renal Pelvis	-	21.4	17.3
Melanoma of the Skin	29.6	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 Mary Breckenridge ARH inpatient hospital discharges from January 2022- September 2024.

Inpatient Hospital Discharges- Patient Origin

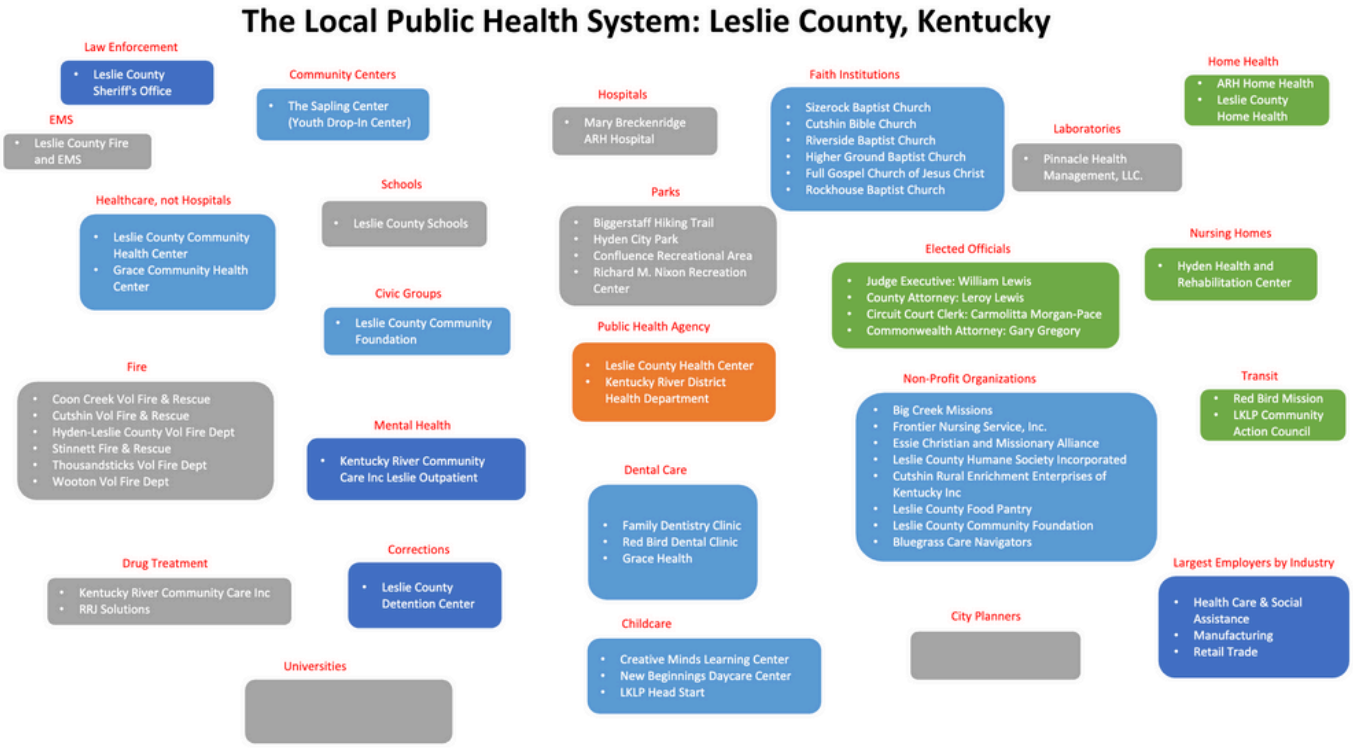
Patient County	Inpatient Discharges	% of Total
Leslie-KY	730	58.1%
Perry-KY	314	25.0%
Harlan-KY	50	4.0%
Clay-KY	46	3.7%
Breathitt-KY	30	2.4%
Knott-KY	26	2.1%
Letcher-KY	18	1.4%
Floyd-KY	8	0.6%
Jackson-KY	5	0.4%
Bell-KY	4	0.3%
Owsley-KY	4	0.3%
Lee-KY	4	0.3%
Laurel-KY	4	0.3%
Wolfe-KY	3	0.2%
Pike-KY	2	0.2%
Madison-KY	2	0.2%
Magoffin-KY	2	0.2%
Whitley-KY	2	0.2%
Johnson-KY	1	0.1%
Elliott-KY	1	0.1%
Total	**1,256**	**100%**

Inpatient Hospital Discharges- Payer Mix

Payer Type	Inpatient Discharges	% of Total
Medicare (Excluding Medicare Managed Care)	415	33.0%
Medicare Managed Care	309	24.6%
Commercial- Anthem Health Plans of KY HMO Plan	186	14.8%
In State Medicaid	175	13.9%
Other Facility	44	3.5%
WellCare of Kentucky Medicaid Managed Care	40	3.2%
Commercial- Anthem Health Plans of KY PPO Plan	19	1.5%
Black Lung	14	1.1%
Workers Compensation	11	0.9%
Humana Medicaid Managed Care	11	0.9%
Passport Medicaid Managed Care	6	0.5%
Auto Insurance	5	0.4%
United Healthcare Medicaid Managed Care	4	0.3%
Self Pay	4	0.3%
Anthem Medicaid Managed Care	3	0.2%
Commercial- Other	3	0.2%
Tricare (Champus)	3	0.2%
Aetna Better Health of KY Medicaid Managed Care	2	0.2%
Commercial- Aetna Health HMO Plan	1	0.1%
Out of State Medicaid	1	0.1%
Total	**1,256**	**100%**

Organizing Community Partners

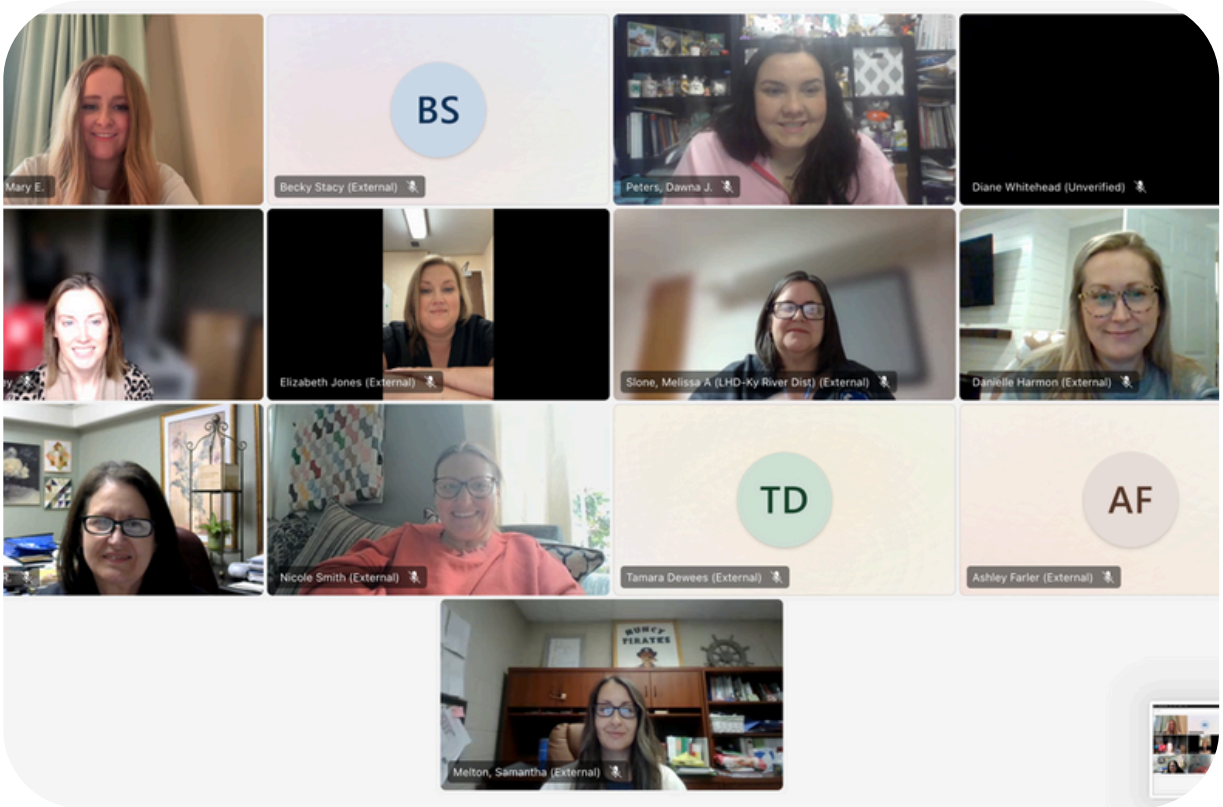
Collaboration among organizations is an essential component of the CHNA process and community health improvement plan. One tool that can be utilized to map organizations that may influence health in the community is the Local Public Health Schematic. The Team Up team collaborated with local residents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



Leslie 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 Mary Breckenridge ARH leadership in late summer of 2024. On September 25, 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 7, 2025 and after months of data collection, the Steering Committee met again for their final meeting (image below). As a result of severe weather, the second steering committee meeting was held virtually. The group reviewed data and collaboratively recommended priority health needs for Mary Breckenridge ARH to address.



Leslie County CHNA Steering Committee

Steering Committee Members

Name	Organization Represented
Ashley Farler	Bluegrass Care Navigators
Danielle Harmon	ARH
Dawna Jace Peters	Leslie County 4-H
Nicole Smith	ARH
Tara Dewees	ARH
Becky Stacy	Appalachian Early Childhood Network
Ashley Teague	Kentucky Cancer Program
Melissa Slone	KY River District Health Department
Elizabeth Jones	Mary Breckenridge ARH
Samantha Melton	Principal, WB Muncy Elementary
Vicki Boggs	Leslie County Extension Family and Consumer Sciences

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.

Mary Breckenridge ARH hosted forums with:

- Leslie County Chamber of Commerce - Business owners
- Cooking Through the Calendar group - Community members
- Leslie County LKLP Staff - Representing low income individuals

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: Social Determinants of Health Barriers to Healthy Lifestyle

- Lack of transportation
- Lack of affordable housing
- Access and cost of healthy food
- Not enough well-paying jobs
- Lack of access to physical activity opportunities
- Cost of healthcare and/or insurance
- Lack of childcare

Finding 1.2: Need for Health Education

- Obesity & related disease
  - Heart disease, diabetes, cancer
  - Nutrition education
- Vaping, especially youth
- Substance use prevention
- Mental health awareness
- Behavioral issues
- Dental care and education

QUESTION 2: BARRIERS TO HEALTHCARE

Finding 2.1: Resource Challenges

- Need assistance programs for Rx costs
- Lack of specialists
- Lack of primary care providers
- Transportation assistance
- Knowledge of resources available

Finding 2.1: Navigation & Communication

- Long travel distance to access specialty care
- Long wait times for appointments
- Need for health literacy and patient navigation

Focus Group Results

QUESTION 3: HEALTH BEHAVIORS

Finding 3.1: Substance Use

- Tobacco use
  - Smokeless
  - Vaping and the misconception that it is safer
  - Traditional cigarettes
- Substance use - Rx and Illicit

Finding 3.2: Healthy Lifestyle Barriers

- Parental Education
- Walkability challenges
- Lack of healthy lifestyle education
- Consumption of energy drinks
- Technology & social media safety

"Technology is now used as a babysitter."

QUESTION 4: ADDITIONAL CONCERNS

Finding 4.1: Additional Resources Needed

- Water quality & quantity
- Increased pay to match cost of living
- Dental care
- Food insecurity resources
- Quality produce
- Higher quality health providers
- Obesity education and resources
- Access to healthy foods
- Help for kinship families
- Diabetes management and care

"We need more for people with diabetes."

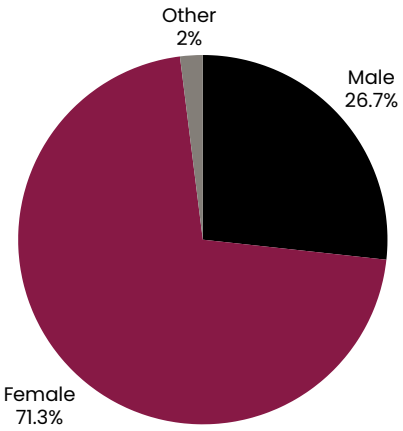
Community Survey Results

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=240

Gender



Education

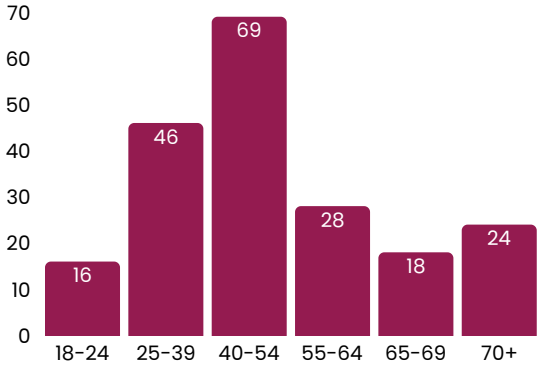
26% High School

9% Technical School

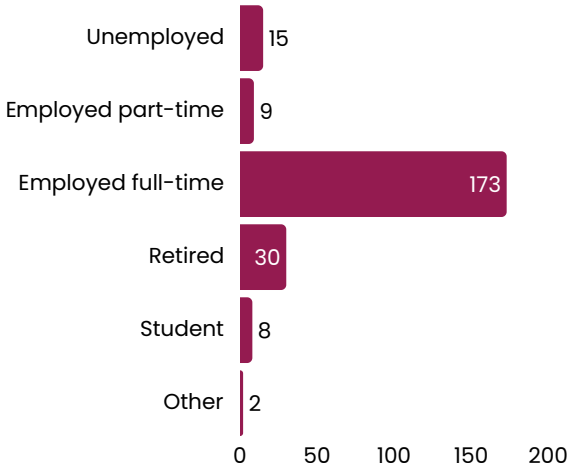
55% College or Above

9% Other

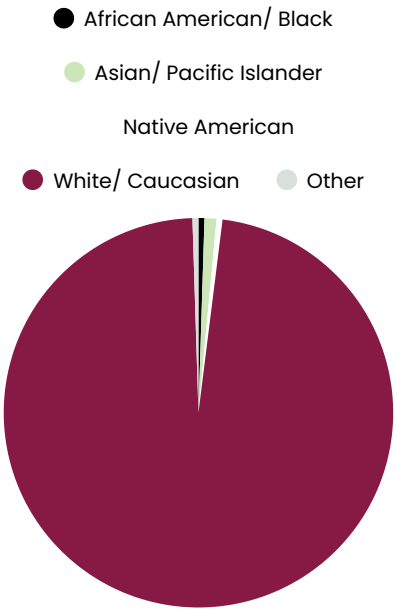
Age



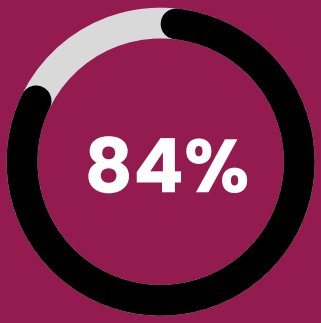
Employment Status



Race/ Ethnicity



Community Survey Results

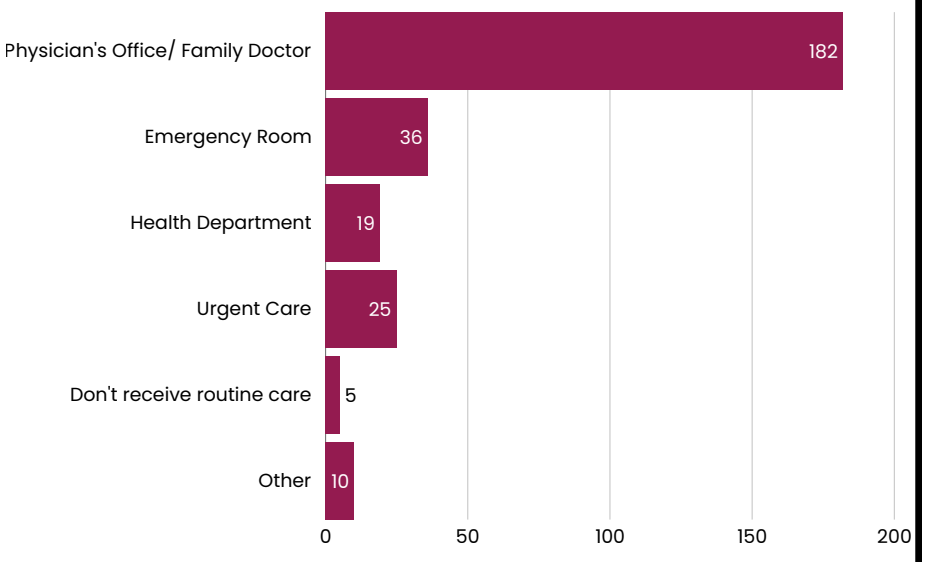


Are satisfied with the ability to access healthcare services in Leslie County.

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?

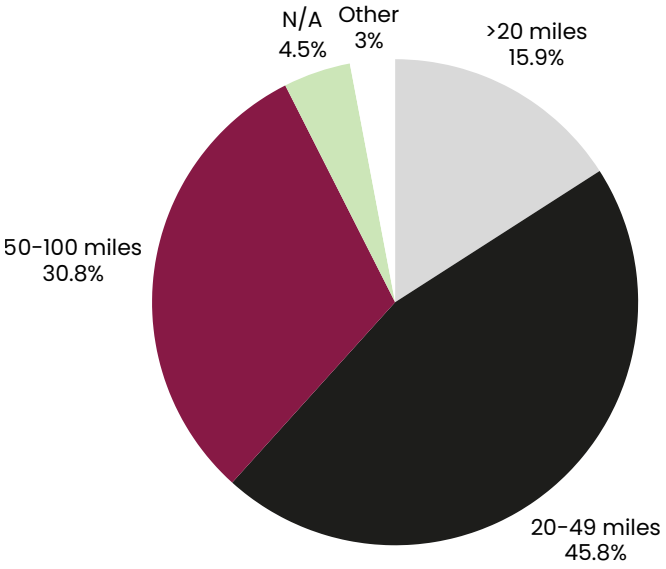


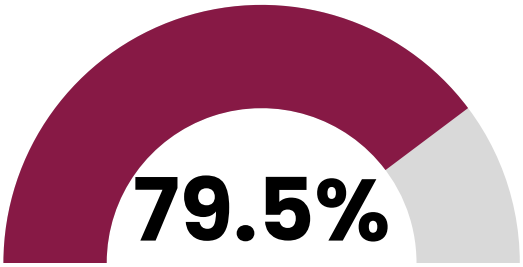
Top 5 barriers to receiving routine healthcare:

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

Community Survey Results

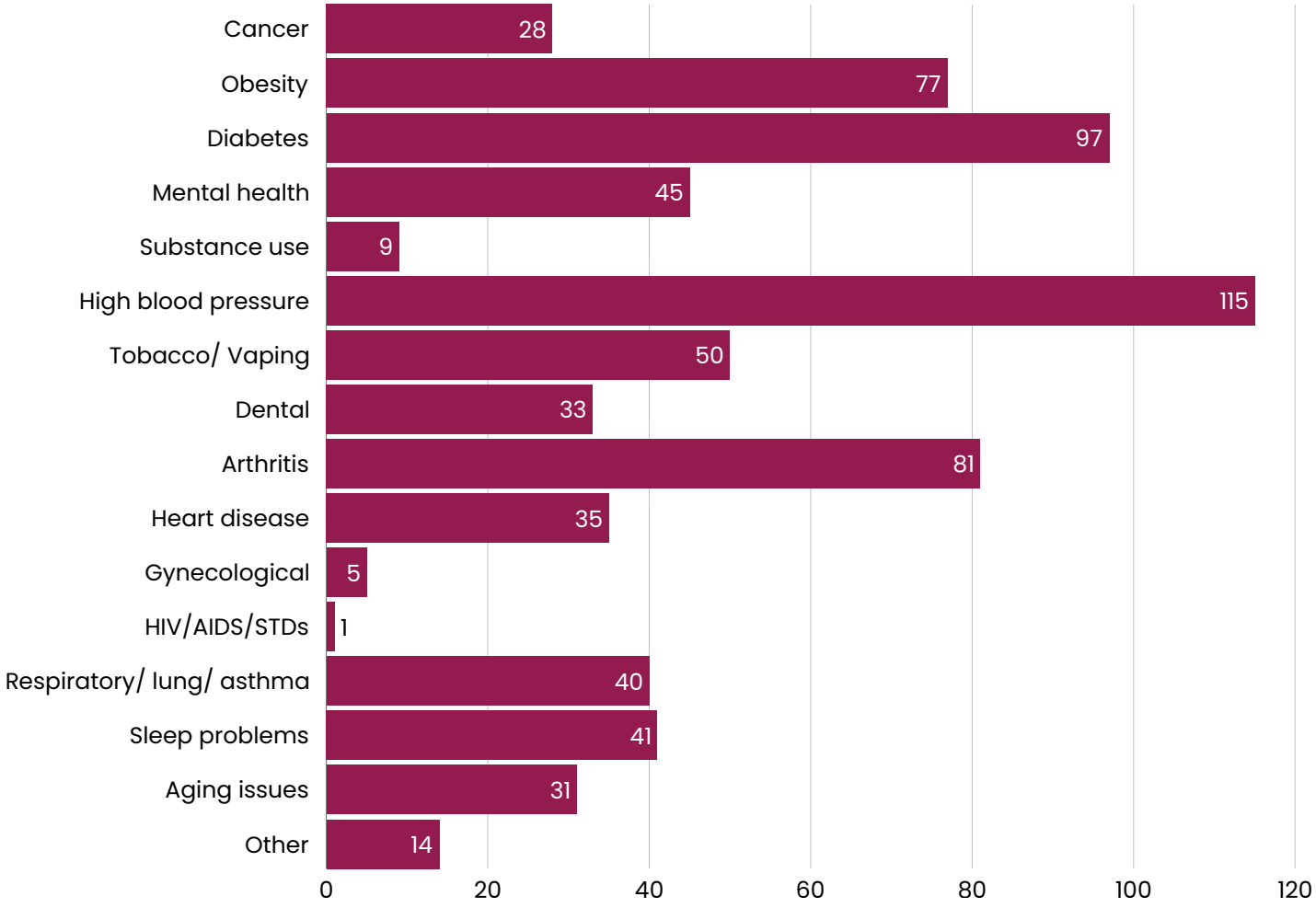
How far do you or your household travel to see a specialist?





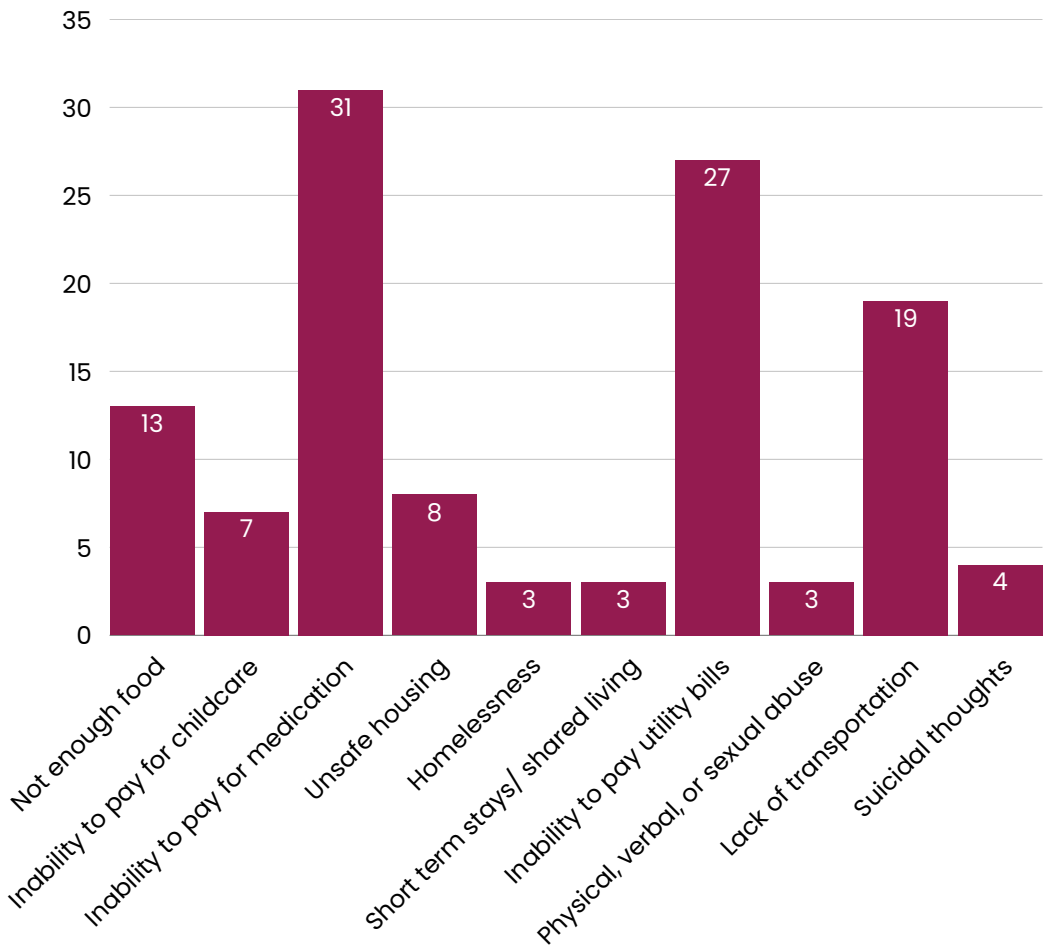
Are satisfied with the availability of mental health services in Leslie County.

Top 3 health challenges you/ your household face:

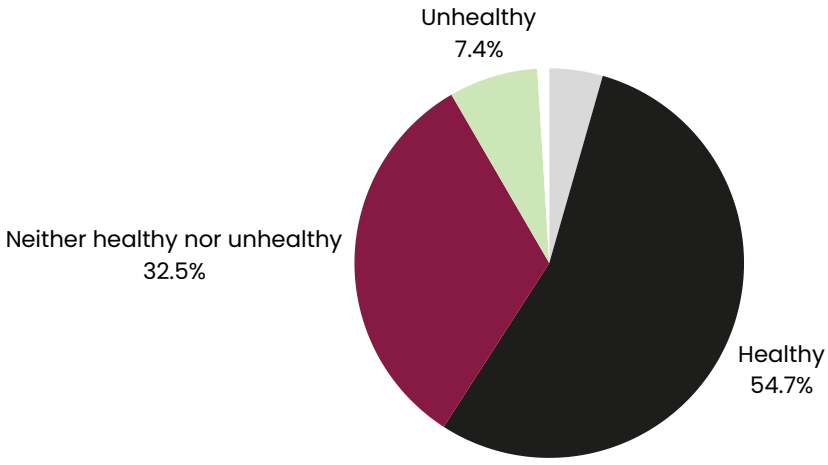


Community Survey Results

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



How would you rate your overall health?

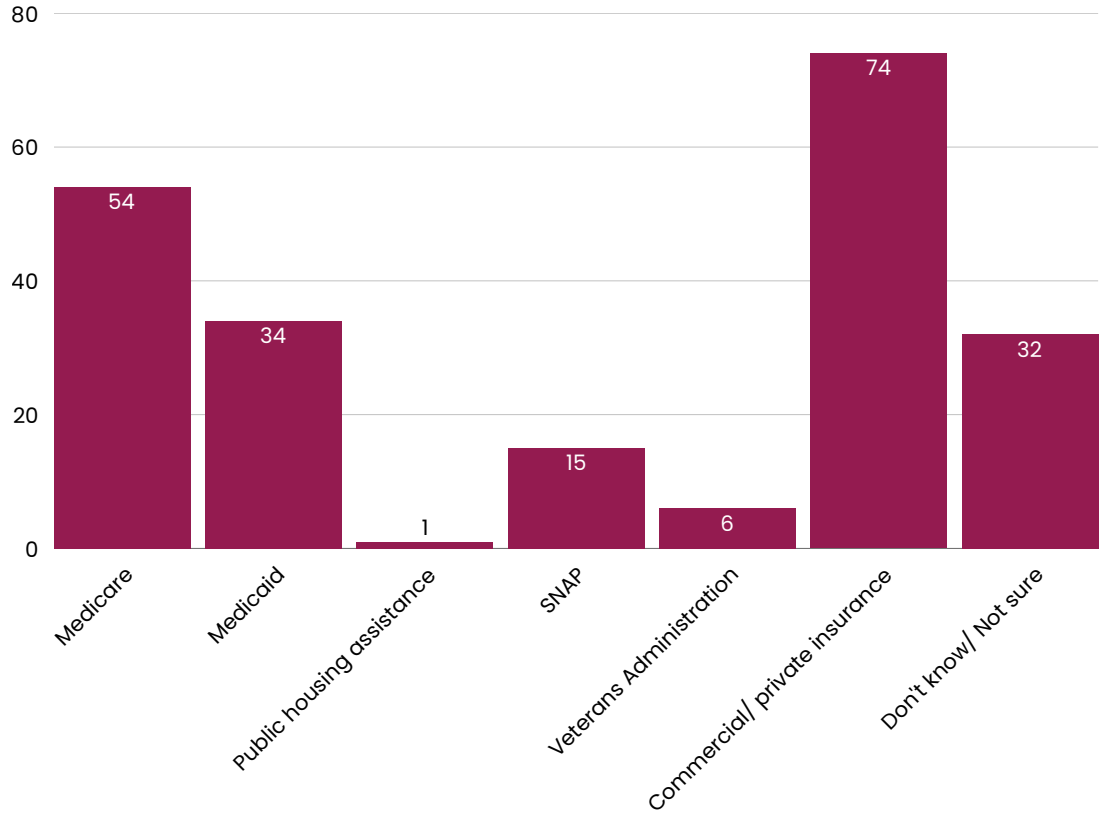


Top 3 risky behaviors you see in your community:

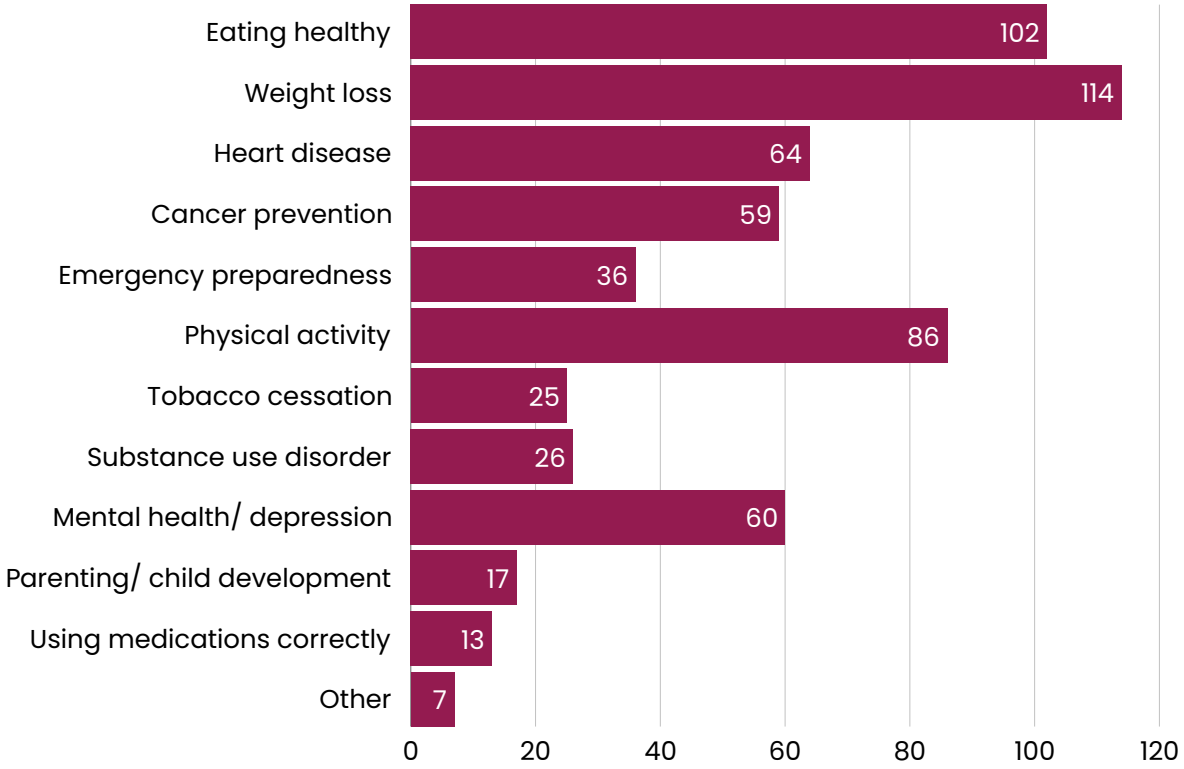
1. Drug use (185)
2. Tobacco or vaping use (125)
3. Poor eating habits (97)

Community Survey Results

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

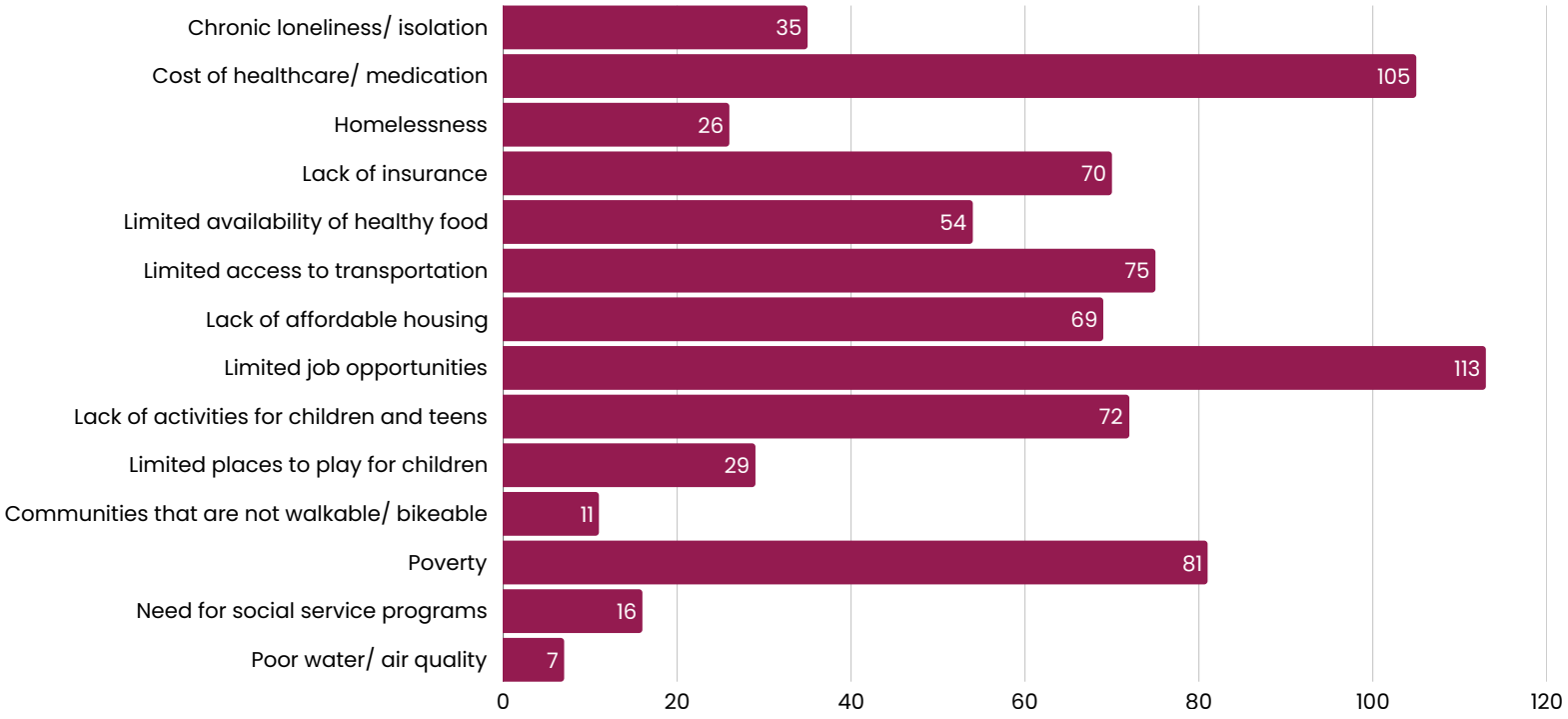


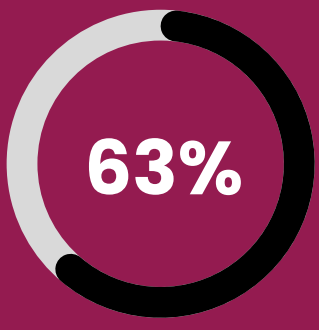
Health related topics respondents are interested in learning more about:



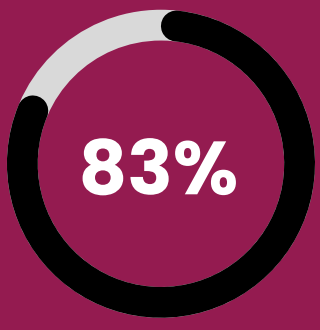
Community Survey Results

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





Have had a dental exam in the past year.

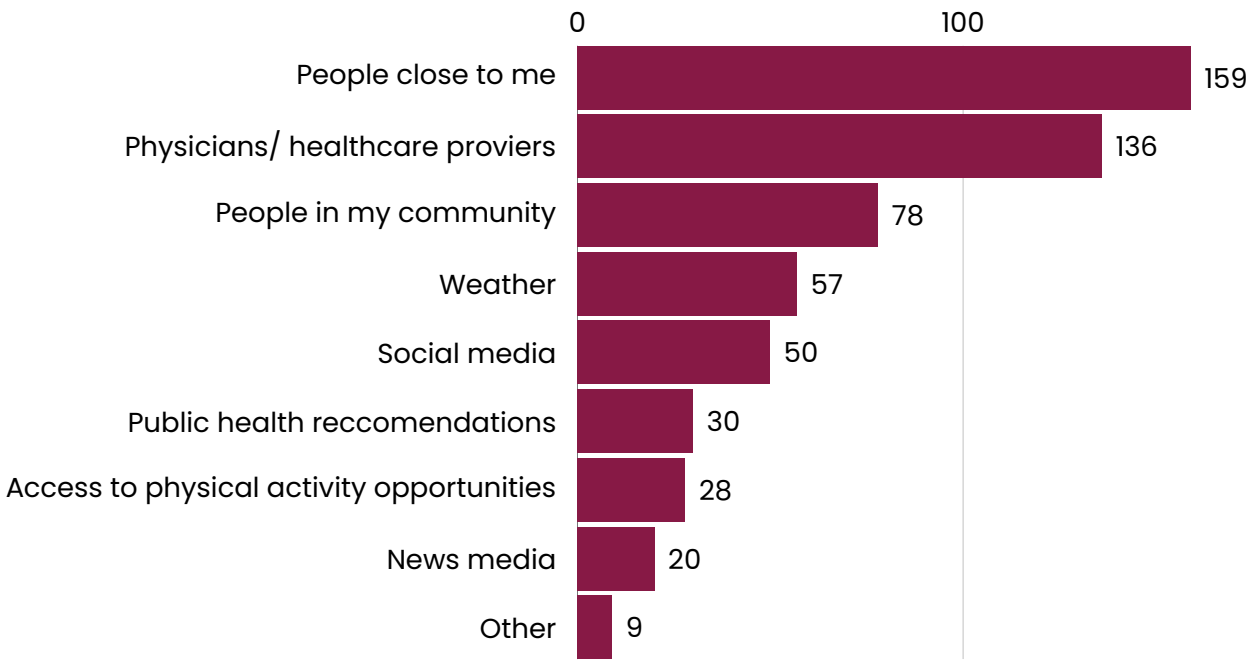


Have had a routine checkup in the past year.

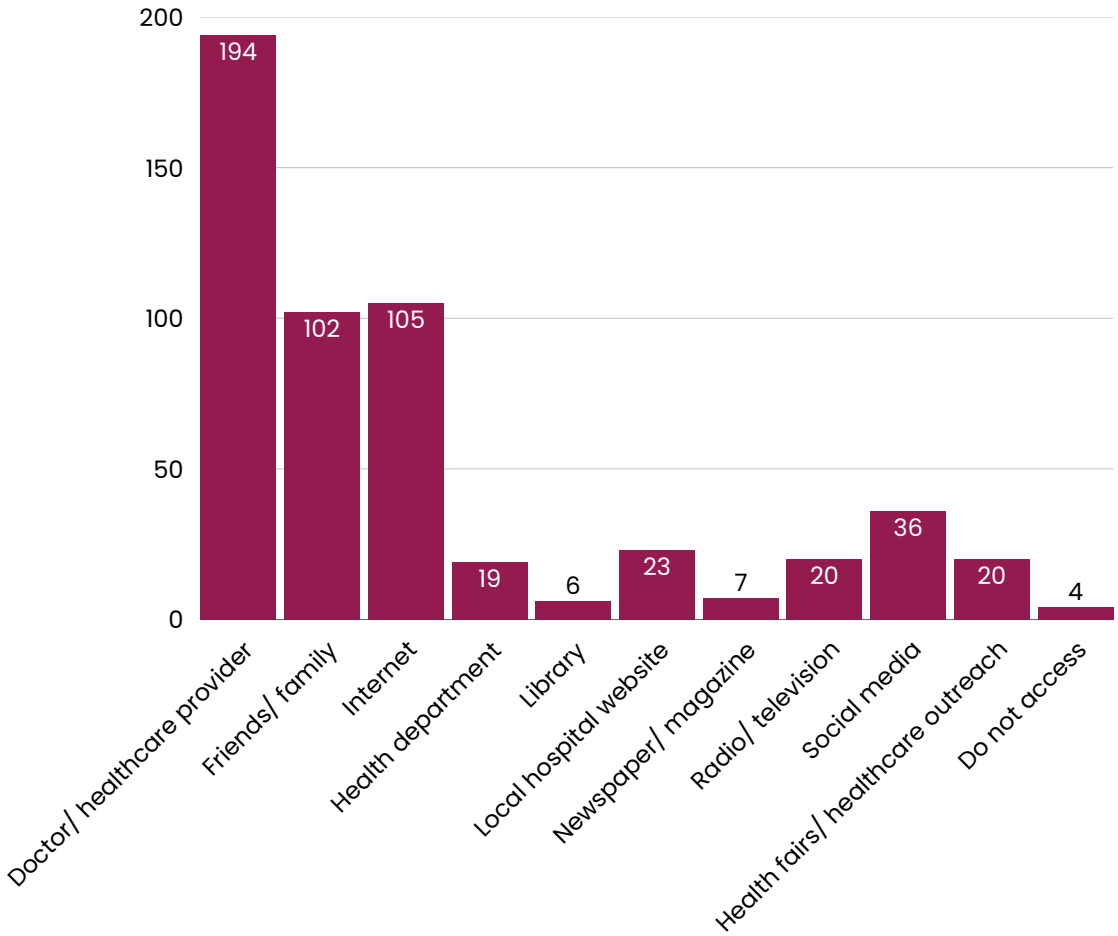
Believe mental illness is a medical condition.

Community Survey Results

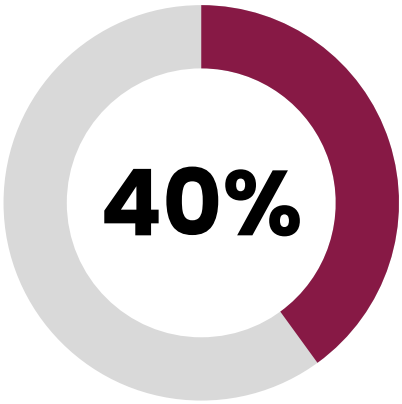
What factors influence your health choices?



Where do you get most of your healthcare information?

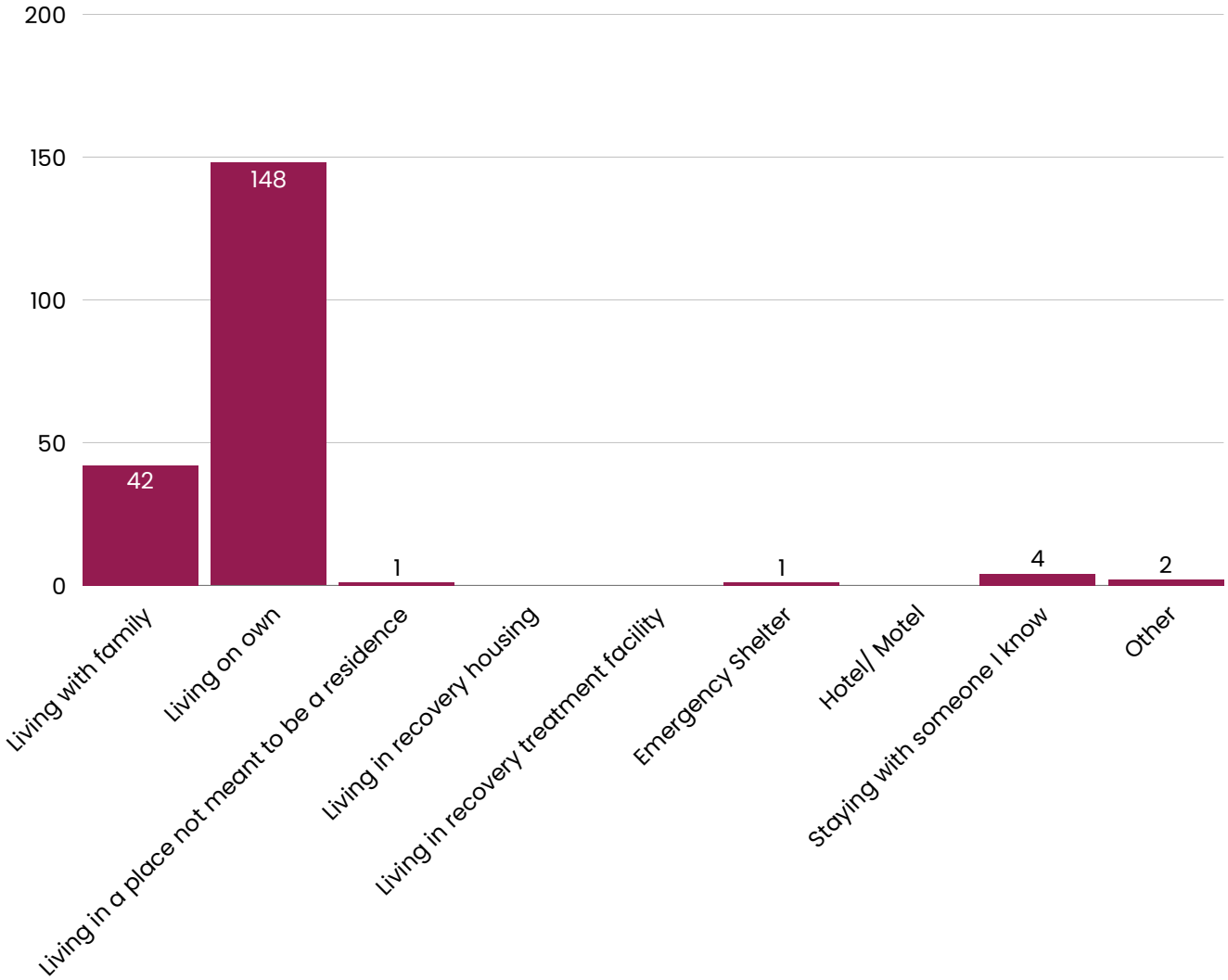


Community Survey Results



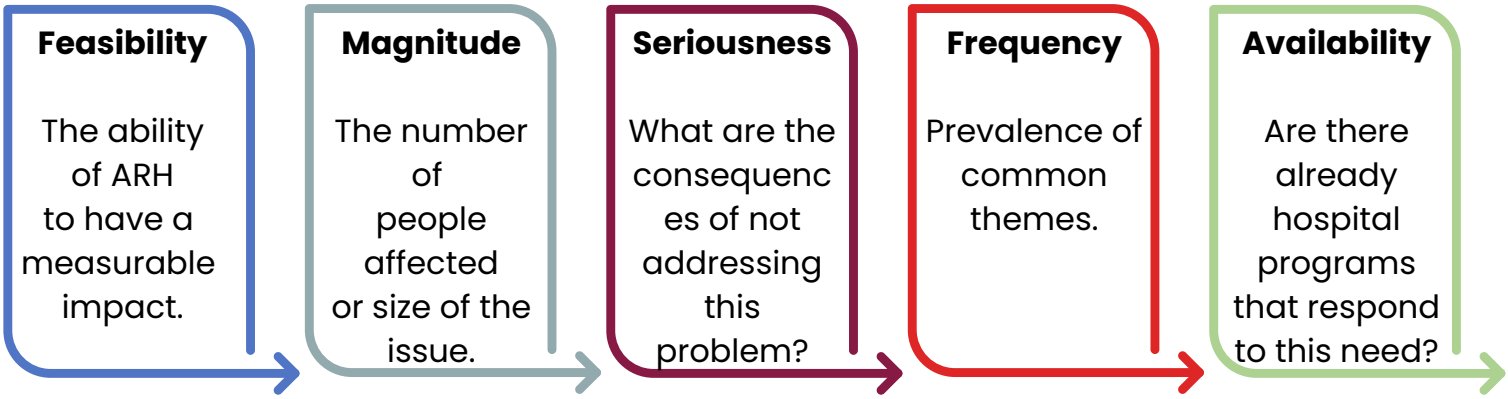
Have been told by a healthcare professional that they have high cholesterol.

What is your current living situation?



Health Needs Prioritization

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



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

1. **Substance Use (tobacco, vaping, alcohol, re-entry)**
2. **Nutrition (access to food, energy drinks)**
3. **Obesity & related disease**
4. **Basic needs (water, safety, jobs, trash, housing, food insecurity, transportation)**

Implementation Plan

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

Goal: Address addiction through peer support, community partnerships, and education

Key Strategies	• Build a 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 and substance abuse through targeted programming • Partner with community organizations, councils and boards that support addiction prevention and treatment (Leslie County Drug Awareness Coalition, Celebrate Recovery, ASAP, Unite) • Explore the creation of a stigma and recovery biases program for area employers • Support Harm Reduction/Needle Exchange with local health department through referrals, increasing community knowledge, and distributing needle disposal boxes • Create an in-facility Hope Closet that provides basic hygiene needs for patients moving from our ER into treatment • Provide Mental Health First Aid training to department managers, staff, and community

Goal: Promote nutritional health and improve access to healthy foods

Key Strategies	• Grow partnership with UK Extension Service, expanding cooking classes to outlying communities and different target audiences (i.e. head start parents, faith-based community), incentivize classes with grocery store gift cards. • Expand in-school programming to include education about nutrition, especially on sugary and overly-caffeinated drinks • Sponsor / monetarily support programs that provide access to healthy foods (i.e. Veggie Bucks, Double Dollars program, school backpack food programs, food donations to Celebrate Recovery)

Key Strategies	• Provide individual and group-based prevention and education efforts through the ARH Diabetes Education Program, to include Healthy Habits Challenges • Support farmer's markets through ARH participation in market days for health education, healthy recipe samples, and monetary donations. Explore incentivizing physical activity with farmer's market vouchers • Continue in-facility food pantry program, which distributes food boxes to patients that screen as food insecure • Staff volunteerism at local food bank, Big Creek Mission

Goal: Lower rates of obesity through physical aactivity opportunities and education about obesity-related diseases

Key Strategies	• Physical activity opportunities:
	  ◦ Partner with local fitness instructors and community organizations to host health and wellness events, free fitness classes, and experiences that promote healthy families
	  ◦ Explore partnership with Leslie County Farmers Market for incentivized walking program
	  ◦ Monetarily support events that encourage physical activity – bike races, community health and wellness days, 5k events.
	  ◦ Sponsor and participate in the city's Story Walk for children, which encourages physical activity and health literacy in children
	  ◦ Consider programs like "Hike with a Doc" or community hikes and walks at local walking tracks or Bigger Staff Trail.
	  ◦ Offer gentle chair yoga classes throughout community and on site through Senior Care
	  ◦ "Walk across Leslie County" program
	  ◦ Partner with Big Creek Missions to host Pool Days for the community – an opportunity for physical activity, education on skin cancer, sunscreen, water safety, and healthy nutrition
	• Screenings and education about obesity-related disease:
	  ◦ Educate about/provide screenings related to obesity-related diseases broadly throughout the community – heart disease, stroke, type 2 diabetes

Key Strategies	▪ Explore a partnership with LKLP to provide educational programming and free screening opportunities for parents of children enrolled in Head Start ▪ Stroke Programming – Strike Out Stroke, TACO-bout stroke cooking classes, Brain Protector programs ▪ Cardiac education and cardiac risk assessments ▪ Provide local employers with employee screening events and education – sheriff's office, Hyden Citizens Bank, Medicine Shoppe, Hometown Rx ▪ Educate and screen first responders through a First Responders Health and Wellness Picnic

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

Key Strategies	• Grow the number of patients screened in social drivers of health (homelessness, food insecurity, abuse) upon intake • 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 Family Resource Youth Service Centers, faith-based organizations • 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, holiday giveaways, coat drives, back to school giveaways, and animal shelter donation drives • Provide primary care in outlying communities with use of ARH Mobile Clinic, thereby assisting patients with transportation barriers • Participate in community clean ups and free dump days, promote to employees and on social media • Provide basic needs through a blessing box on-site to include hygiene items, toothpaste, soap, deodorant, food, etc.

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
	• Nutrition education
	  ◦ Expand in-school programming to include education about nutrition, especially on sugary and overly-caffeinated drinks (ReThink Your Drink)
	  ◦ 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
	• Physical activity opportunities
	  ◦ Partner with local fitness instructors and community organizations to host health and wellness events, free fitness classes, and experiences that promote healthy families
	  ◦ Offer gentle chair yoga classes throughout community
	  ◦ Continue partnership with Perry County Farmers Market for incentivized walking program
	  ◦ 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 broadly throughout the community – heart disease, stroke, type 2 diabetes

Key Strategies	• Use of HeartCorp program to implement Hypertension Hubs in community spaces, such as the Perry County Library. HeartCorp member can also counsel patients and community members on self-monitoring blood pressure, cardiac risk, nutrition, and more • Explore a partnership with LKLP to provide educational programming and free screening opportunities for parents of children enrolled in Head Start • Stroke Programming – Strike Out Stroke, TACO-bout stroke cooking classes, Brain Protector programs • Cardiac education and cardiac risk assessments

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

LESLIE COUNTY, KENTUCKY

POPULATION: 9,864

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: Leslie County 10% | Kentucky 3% | United States 2.4%
2	**Poverty Rate:** Leslie County 30.1% | Kentucky 16.5% | United States 11.5%
3	**Population 16+ in Labor Force:** Leslie County 43.8% | Kentucky 59.2 % | United States 63%
4	Single Parent Households: Leslie County 17.01% | Kentucky 31%
5	Households Spending at Least 30% Of Income on Housing: Leslie County 24.6% | Kentucky 23.9% | United States 22.8%
6	Population Without Access to Large Grocery Store: Leslie County 8.4% | Kentucky 19.8% | United States 21.7%
7	**Children Living in Food Insecure Households:** Leslie County 25.9% | 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:** Leslie County 84.8% | Kentucky 91.4%
2	High School Graduates Enrolled in Post-Secondary Education Within 6 Months of Graduation: Leslie County 41.1% | Kentucky 45.33%
3	8th Grade Students with Proficient or Distinguished on Reading State Assessment: Leslie County 51% | Kentucky 45%
4	8th Grade Students with Proficient or Distinguished on Math State Assessment: Leslie County 40% | Kentucky 37%
5	Kindergarteners Ready to Learn: Leslie County 67% | Kentucky 44%
6	**Students with an Individualized Education Plan (IEP):** Leslie County 25% | Kentucky 15%
7	4th Grade Students with Proficient or Distinguished on Reading State Assessment: Leslie County 41% | Kentucky 47%
8	4th Grade Students with Proficient or Distinguished on Math State Assessment: Leslie County 50% | Kentucky 42%

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

1	Adults with Recent Doctor Visit for Routine Checkup: Leslie County 73.7% | United States 71.8%
2	Children Under 19 with Health Insurance Coverage: Leslie County 96.4% | Kentucky 96.1%
3	Number of TBI Emergency Department Cases: Leslie County 12 | Kentucky 11,249
4	Adults With Recent Preventative Care Visit: Leslie County 79.7% | Kentucky 80.7% | United States 74.6%
5	**Lung and Bronchus Incidence per 100,000 Population**: Leslie County 115.7 | Kentucky 84.4 | United States 54

6	**Mammography Use Among Women Aged 50-74:** Leslie County 66.7% | United States 77.8%
7	STIs per 100,000: Leslie County 136.2 | Kentucky 410.3 | United States 495.5

8	Colon and Rectum Cancer Incidence per 100,000: Leslie County 50.3| 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: Leslie County 50% | Kentucky 51%
10	Population Under 65 Without Health Insurance: Leslie County 6.8% | Kentucky 6.7% | United States 9.3%
11	Population With Limited English Proficiency: Leslie County 0-0.1% | 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: Leslie County 37.3 | Kentucky 225.6 | United States 204.5
2	**Population with Access to Broadband:** Leslie County 89.2% | Kentucky 97% | United States 96.7%
3	**Percent of County Using SNAP:** Leslie County 24% | Kentucky 16.3
4	Air Quality Hazard: Leslie County 0.46 | Kentucky 0.44 | United States 0.34
5	Vehicle Crash Fatality Rate per 100,000: Leslie County 23.6 | Kentucky 51.5 | United States 17.5
6	**Population Within ½ Mile of Walkable Destinations:** Leslie County 3.1% | Kentucky 33.9% | United States 34%
7	Walkability Index Score: Leslie County 3.3 | Kentucky 7.2 | United States 6.1
8	Asthma Prevalence Among Adults 18+: Leslie County 12.2% | Kentucky 11.5% | United States 9.7%
9	**Adult Smoking Rate:** Leslie County 33.1% | Kentucky 23.9% | United States 24.3%
10	Deaf and Hard of Hearing Population: Leslie County 1,564| Kentucky 705,533
11	Prevalence of People with Disabilities: Leslie County 28% | Kentucky 21.1%

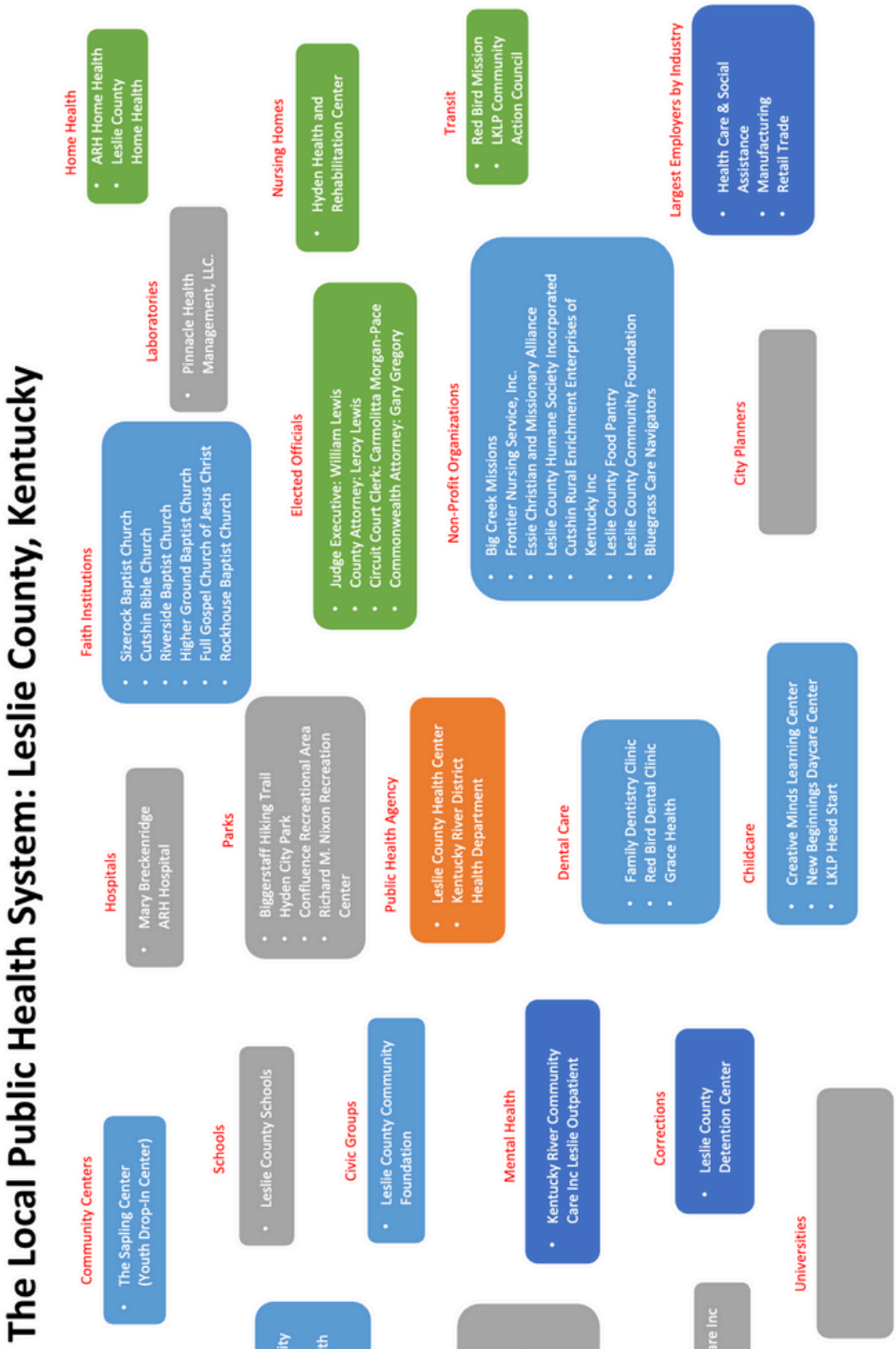
SOCIAL AND COMMUNITY CONTEXT: INCREASE SOCIAL AND COMMUNITY SUPPORT

1	Youth Incarcerated in the Juvenile Justice System per 1,000 Youth: Leslie County 9 | Kentucky 13.2
2	**Census Self- Response Rate:** Leslie County 54% | Kentucky 63.5% | United States 65.8%
3	**Households With a Computer:** Leslie County 81.4% | Kentucky 90.2% | United States 93.1%

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 Leslie 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 Leslie 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
A Public Health Academic Practice Collaborative

ARH®
Appalachian Regional Healthcare

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