COMMUNITY HEALTH NEEDS ASSESSMENT

2025-2027

ARH McDowell

TEAM UP
A Public Health Academic Practice Collaborative

Acknowledgements

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

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

Letter to the Community Member

Dear Community Members, Partners, and Stakeholders,

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

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

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

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

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

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

Sincerely,

Hollie P. Harris

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

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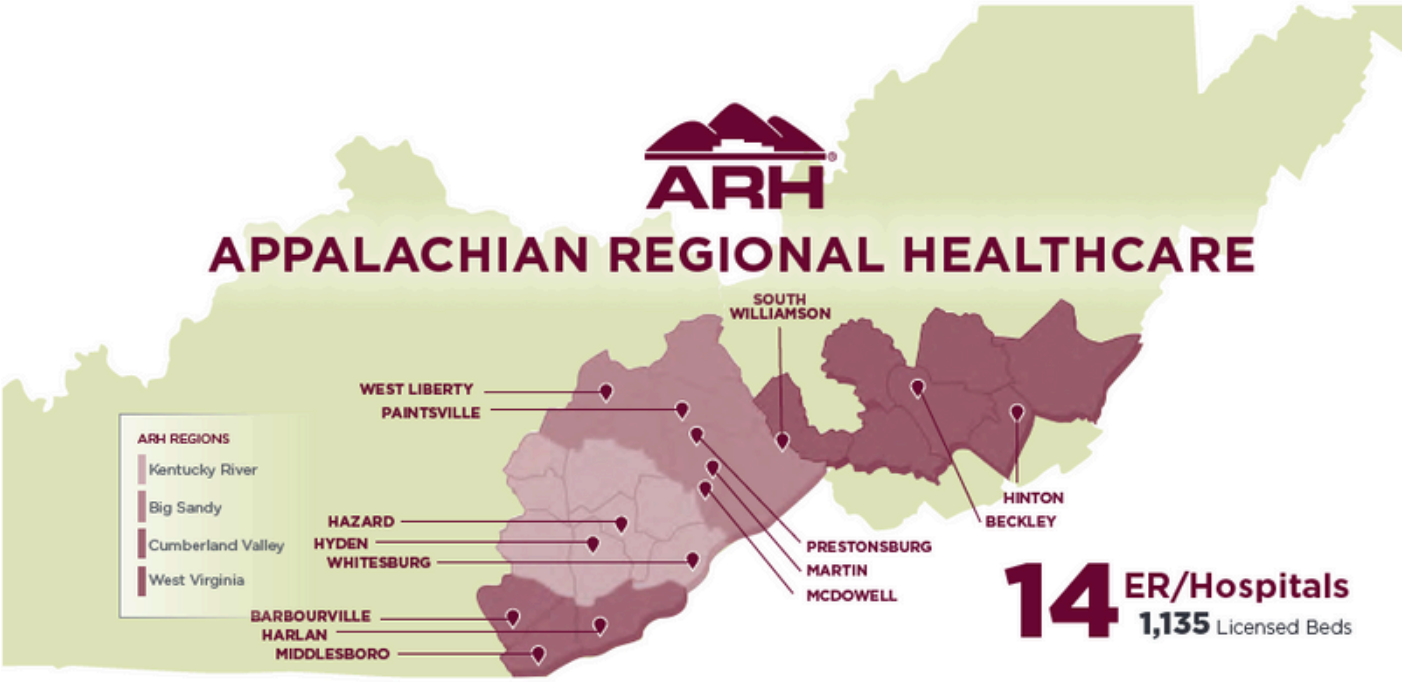
Introduction

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

ARH has always responded to the changing demands of rural healthcare. From building and acquiring new facilities, investing in medical technology, providing health education and support, and creating innovative community partnerships, we continue to meet the health needs of our Appalachian communities. As an ARH hospital, McDowell 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

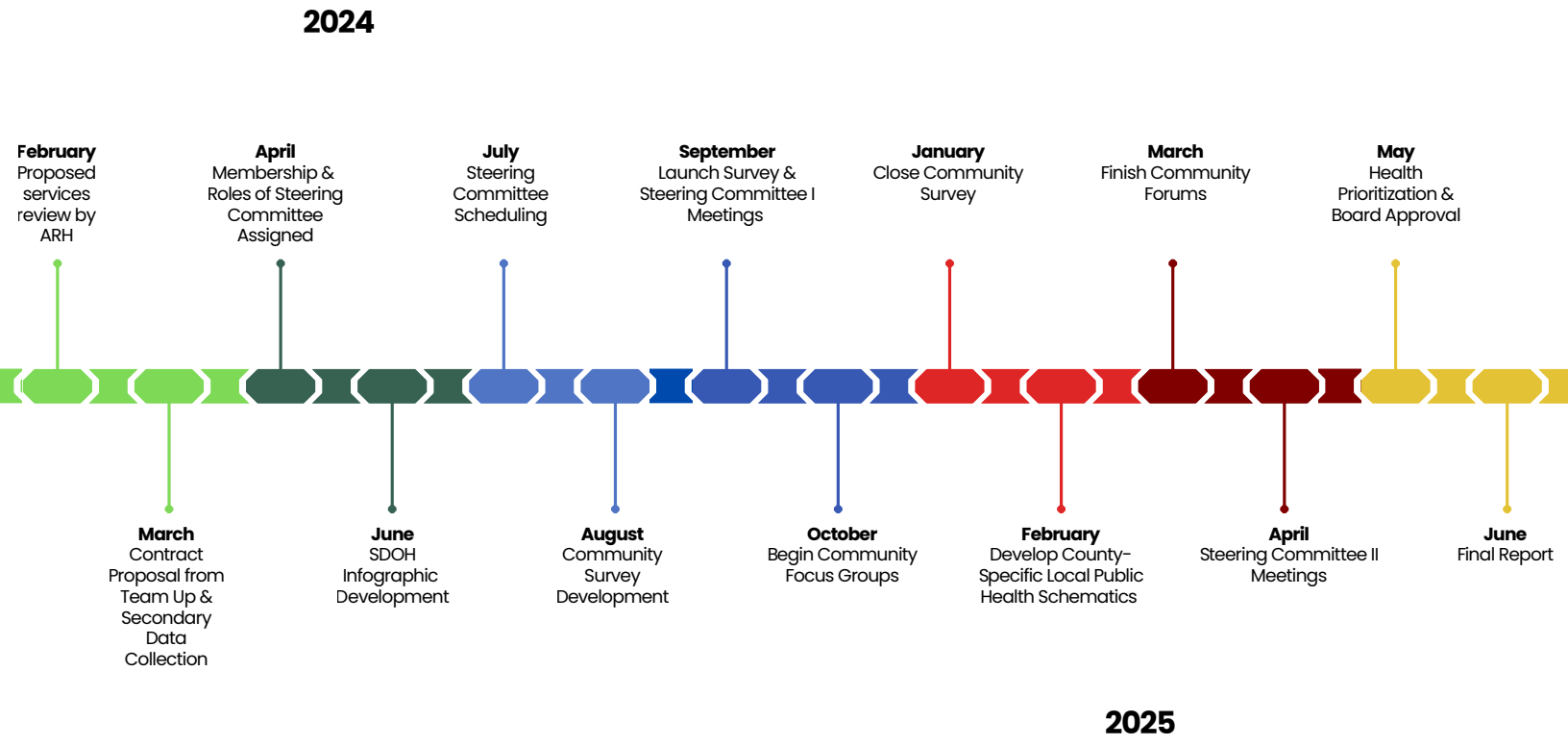
Community Health Needs Assessment (CHNA) steering committees are groups of key stakeholders assembled to guide the planning, development, and implementation of the CHNA process for non-profit hospitals. These committees typically include representatives from public health agencies, local government,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

See the CHNA process timeline below.

CHNA Timeline



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

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

Goal 1

Combat obesity through community education, opportunities for physical activity, promoting healthy nutrition, and supporting those that are food insecure.

Since 2022, McDowell ARH has **addressed obesity, food insecurity, and the need for nutrition education** by:

- 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 **30 boxes per month**. Food boxes contain ARH dietitian tips on healthiest use of foods included
- Participating in a research study with University of Kentucky Food as Health Alliance in which McDowell ambulatory patients with type 2 diabetes or hypertension could receive medically tailored meals for 12 weeks
- Hosting **13 monthly diabetes support group**s in Floyd County with diabetes-related topics and healthy cooking demonstrations each month (2022 start)
- Providing meals to those in need: monthly food donations to the Floyd County Homeless Shelter and hosting food drives and community picnics annually
- McDowell ARH also worked to educate and provide healthy nutrition to employees through a revamped cafeteria menu, which offers plant-based options

- ReThink Your Drink, a program that educates students and parents about the hazards of energy drinks, was presented to parents at the Floyd County Board of Education's SPARK event

Provided access to physical activity opportunities in our community by:

- As of 2022, free gym memberships to No Limits Fitness are available to all ARH employees
- Provided **563 free sports physicals** at local high schools at **12 sports physical clinics**. Students must have physicals before being permitted to play school sports
- Annually sponsored the Big Sandy Senior Games, which gives hundreds of seniors the chance to participate in indoor and outdoor sports competitions

Educated the McDowell community about healthy behaviors and obesity-related disease by:

- Providing 6 stroke risk assessment screening events throughout the McDowell community at area retail stores, grocery stores, senior centers, etc.
- Educated the community about diabetes prevention and management at the Floyd County Senior Center, Floyd Central High School, and McDowell Senior Center

Goal 2

Address addiction in our community through community partnerships and employee engagement

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

- Provided employees free access to Pelago Smoking Cessation App and in-person cessation support in our pharmacies
- Sponsored Operation Unite's **"Shoot Hoops, Not Drugs"** program, which promotes positive activities for local youth while providing education on drug prevention
- Community Development conducted **anti-vaping presentations** at Floyd Central High School and the Floyd County Board of Education
- Participated in many community coalitions that address SUD in our community, including **Communities Against Drug Addiction**, **UK HEALing Communities Imitative**, and **ASAP/Unite coalition**

Goal 3

Focus on bettering the mental health of our community members as we adjust to the COVID-19 pandemic.

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

- McDowell 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. **56** McDowell employees have been certified
- Reopened the **Senior Care Program** to provide older adults with quality behavioral healthcare. Along with social interaction and group therapy, participating seniors receive treatment from a multidisciplinary team including a **psychiatrist**, a **therapist,** and a **registered nurse** that develop individualized plans
- Presented twice to students about mental health issues at Adams Middle School and Floyd Central High School

Goal 4

Increase community, provider, and partner knowledge of services available

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

- Creating service flyers that include all McDowell ARH clinics, specialties, and providers
- Updated the overall ARH website with a new Kyruus system that allows for more accuracy and deeper search when researching providers and locations
- Contracted 14 billboards in Floyd County and three in the immediate community of McDowell
- On social media, posted at least 1x per week about services available in the Big Sandy Region and at least 2x a week about health education topics (urging routine healthcare, disease prevalence, etc.)
- Added large informational monitors to our clinics and in the hospital main lobby that play ARH service commercials and videos only
- Organized 17 provider visits to McDowell from other service regions (visits coordinated by physician liaisons to increase provider knowledge)
- Physician Liaison made visits to McDowell providers 3 times per month

Goal 5

Provide better access to care

Since 2022, McDowell ARH has **increased access to care** by:

- Recruiting two additional primary care providers: Kim Mosely, DO, and April Prater, APRN
- Extended hours of the After Hours Clinic to 8am-8pm seven says per week
- Became accredited as an Acute Stroke Ready Hospital
- Increased capacity and volume of the Swing Bed Program, keeping patients closer to home for longer-term care

Community Served by McDowell ARH

McDowell 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 Floyd County (82%).

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
Total all sites (2017-2021)	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 McDowell ARH inpatient hospital discharges from January 2022- September 2024.

Inpatient Hospital Discharges- Patient Origin

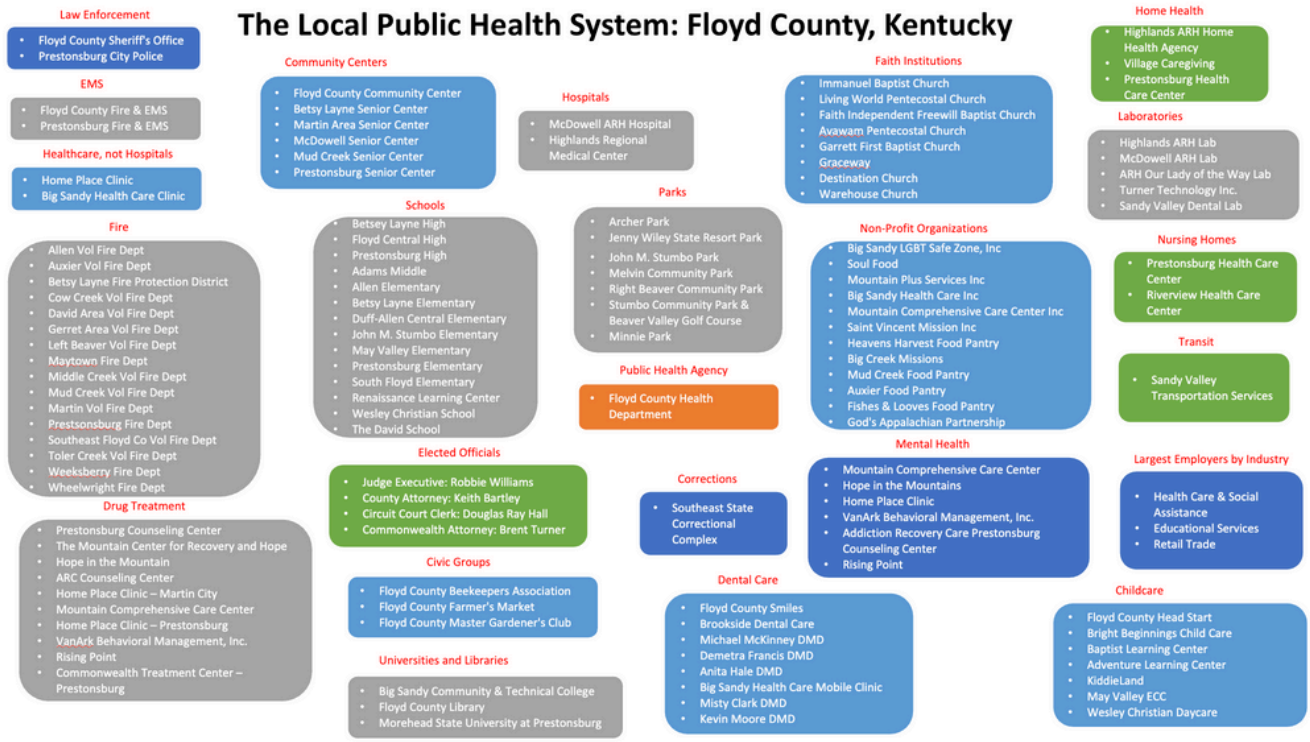
Patient County	Inpatient Discharges	% of Total
Floyd-KY	696	82.0%
Knott-KY	129	15.2%
Johnson-KY	7	0.8%
Leslie-KY	4	0.5%
Magoffin-KY	4	0.5%
Perry-KY	3	0.4%
Pike-KY	2	0.2%
Morgan-KY	1	0.1%
Martin-KY	1	0.1%
Breathitt-KY	1	0.1%
Mingo-WV	1	0.1%
Total	**843**	**100%**

Inpatient Hospital Discharges- Payer Mix

Payer Type	Inpatient Discharges	% of Total
Medicare (Excluding Medicare Managed Care)	223	26.3%
Medicare Managed Care	219	25.8%
WellCare of Kentucky Medicaid Managed Care	157	18.5%
Commercial- Anthem Health Plans of KY HMO Plan	69	8.1%
Commercial- Anthem Health Plans of KY PPO Plan	34	4.0%
Tricare (Champus)	31	3.7%
In State Medicaid	21	2.5%
Humana Medicaid Managed Care	20	2.4%
Black Lung	16	1.9%
Aetna Better Health of KY Medicaid Managed Care	13	1.5%
Passport Medicaid Managed Care	11	1.3%
United Healthcare Medicaid Managed Care	8	0.9%
Commercial- Aetna Health HMO Plan	8	10.9%
Anthem Medicaid Managed Care	8	0.9%
Commercial- Other	4	0.5%
Workers Compensation	2	0.2%
VA	1	0.1%
Out of State Medicaid	1	0.1%
Commercial- Cigna Health & Life FFS Plan	1	0.1%
Commercial- Humana PPO Plan	1	0.1%
Other Facility	1	0.1%
Total	**849**	**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 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 McDowell 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 McDowell 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.

McDowell ARH hosted forums with:

- Betsy Layne High School Students
- Head Start Parents
- Hope in the Mountains Staff and Program Participants

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

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

Finding 1.2: Communicable & Preventable Diseases & Behaviors

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

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 to walk places
- 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

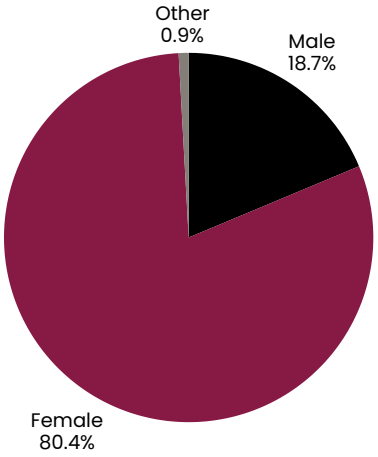
Community Survey Results

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

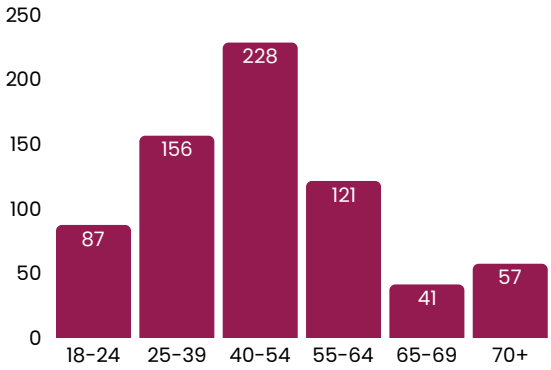
29% High School

6% Technical School

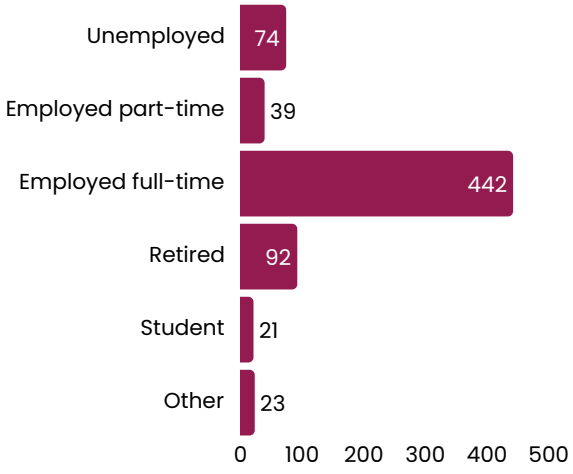
59% College or Above

7% Other

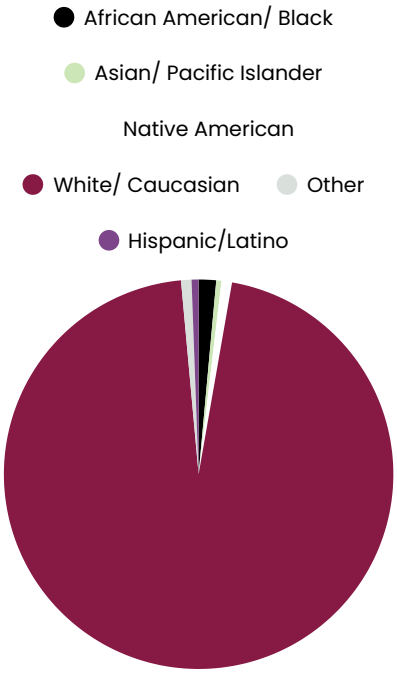
Age



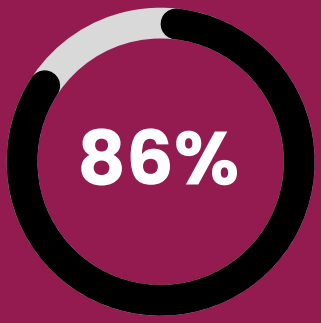
Employment Status



Race/ Ethnicity



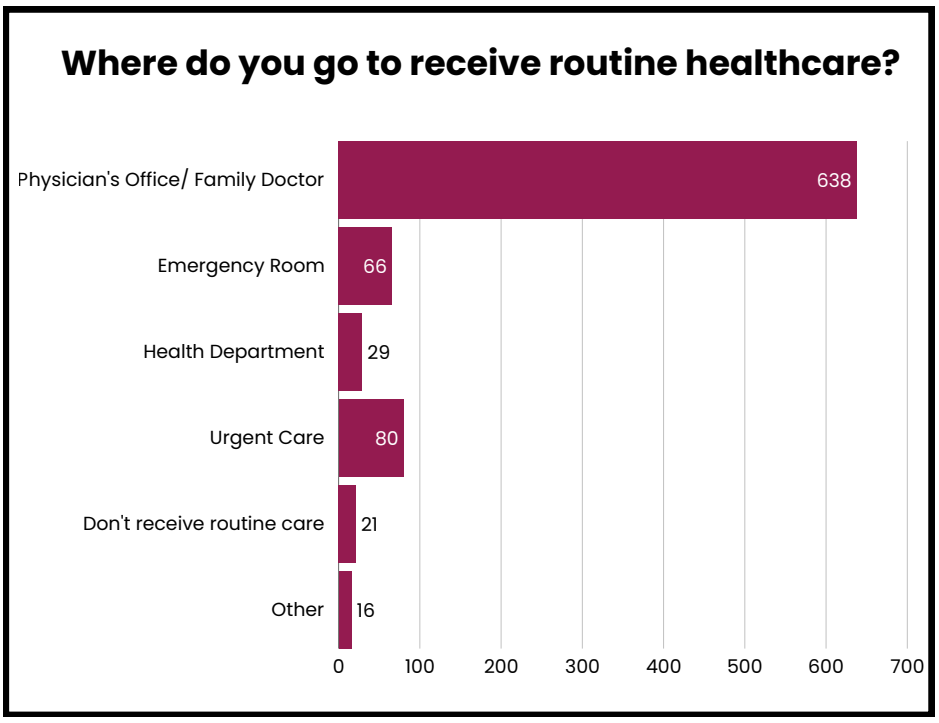
Community Survey Results



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.

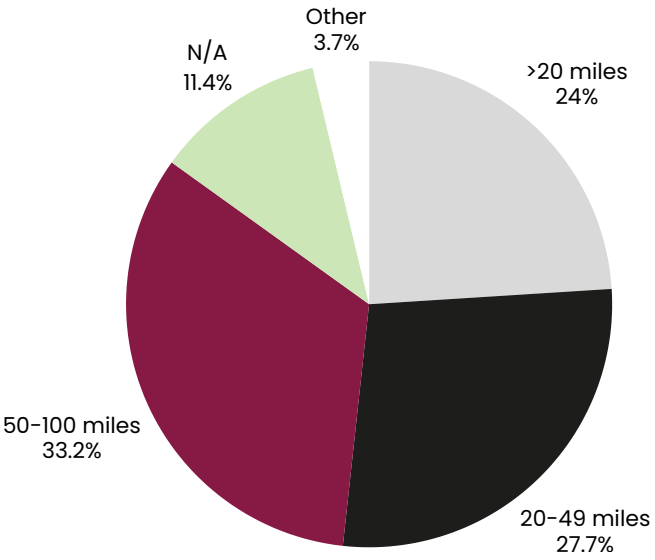


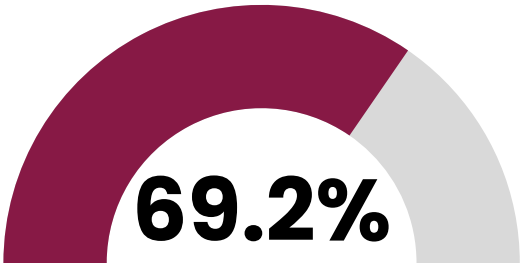
Top 5 barriers to receiving routine healthcare:

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

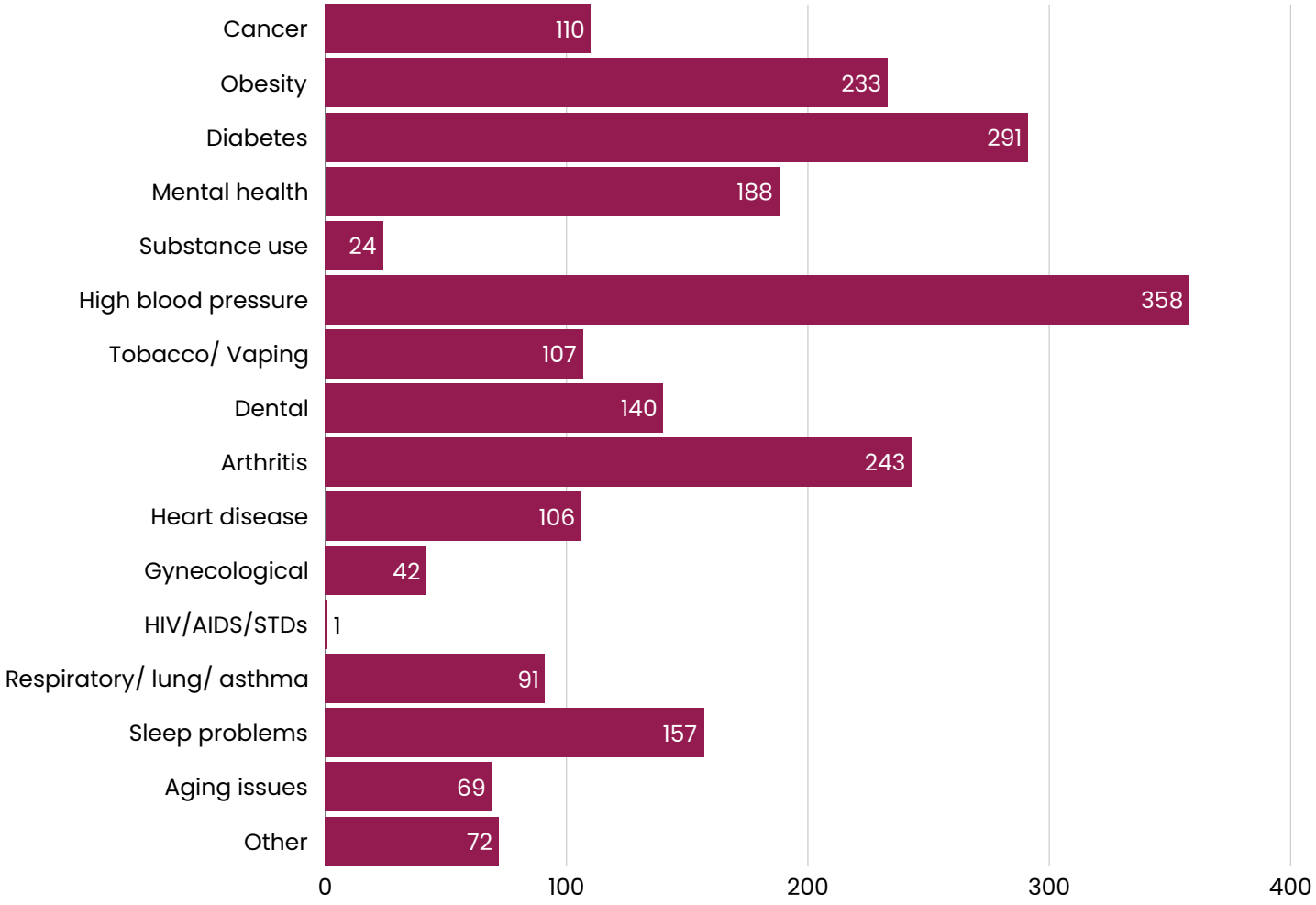
How far do you or your household travel to see a specialist?





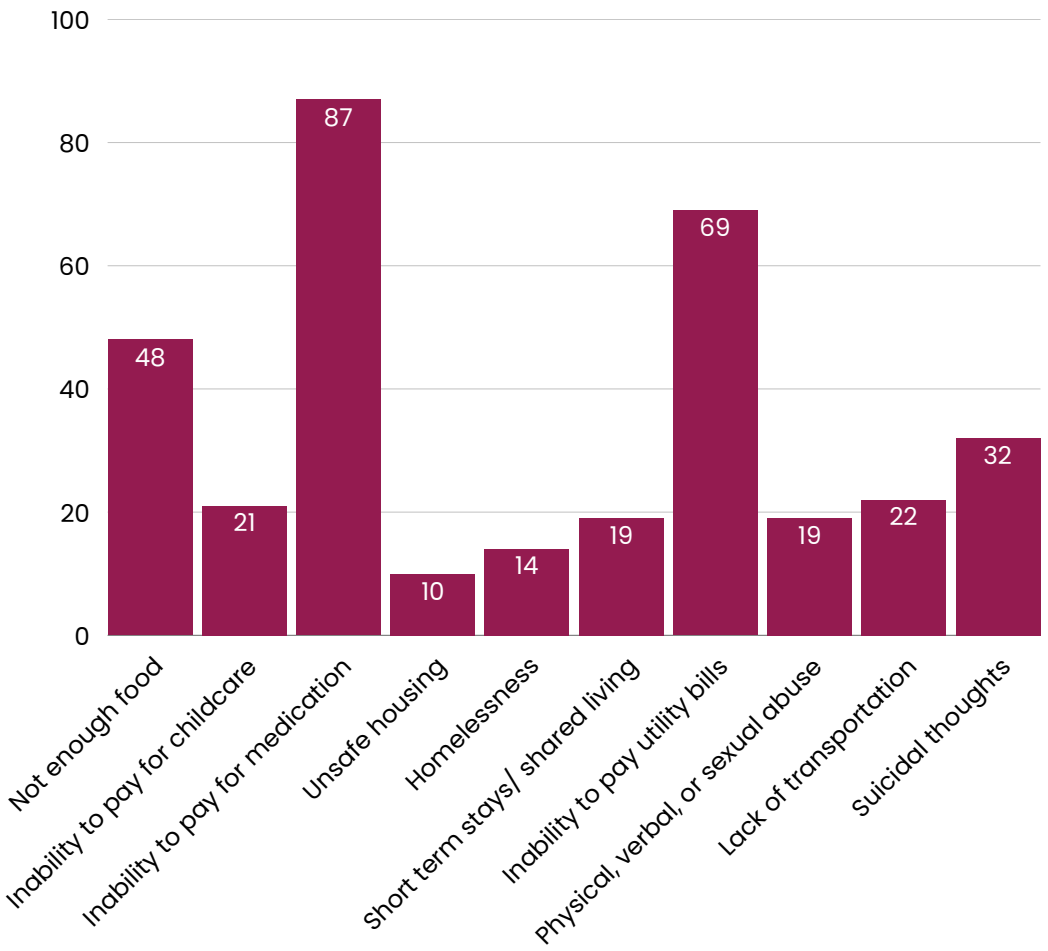
Are satisfied with the availability of mental health services in Floyd County.

Top 3 health challenges you/ your household face:

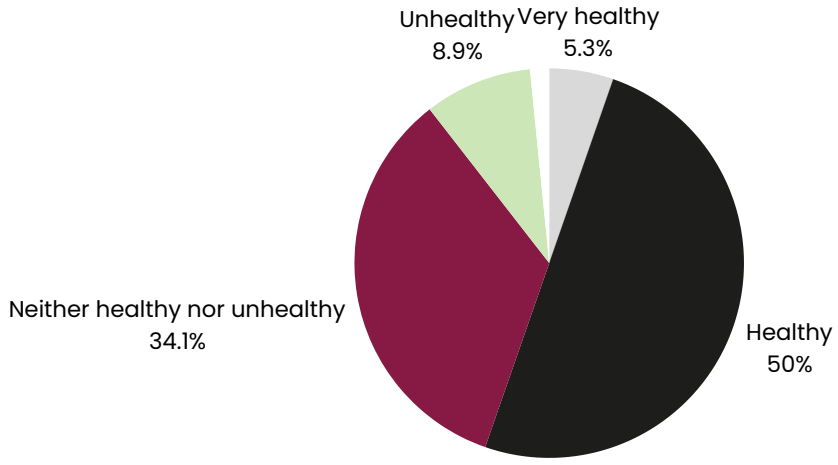


Community Survey Results

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



How would you rate your overall health?

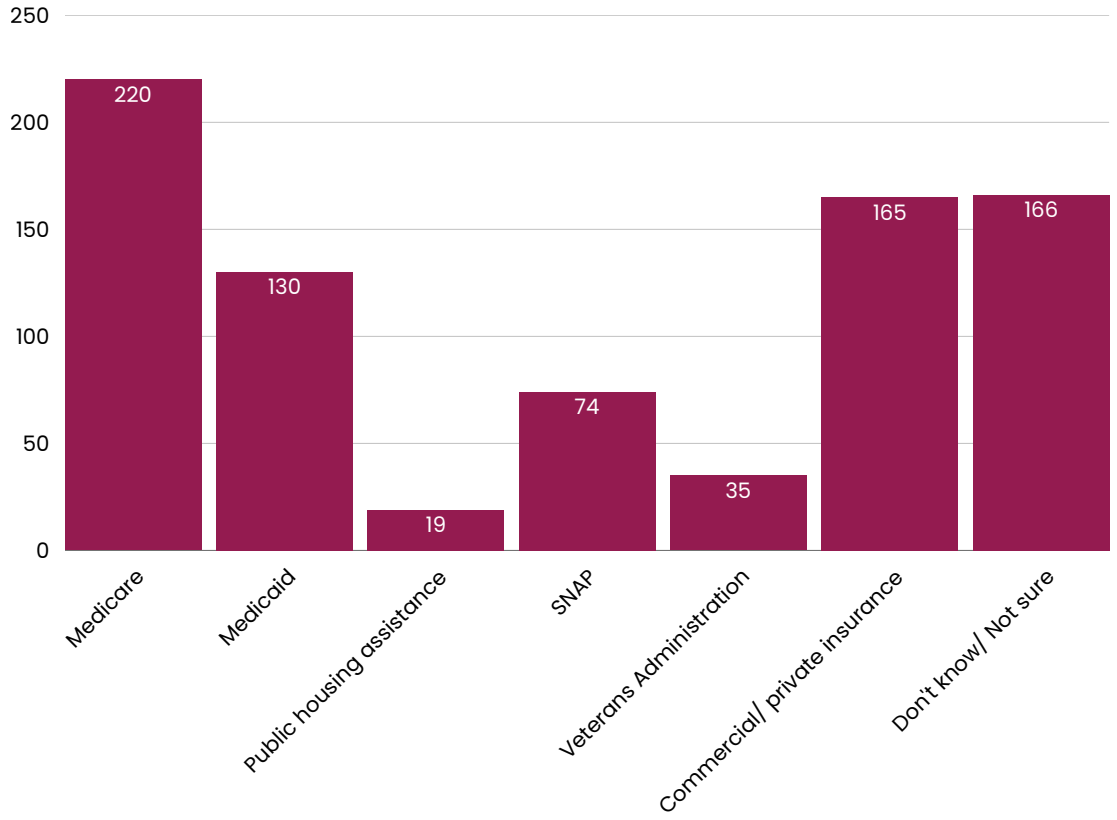


Top 3 risky behaviors you see in your community:

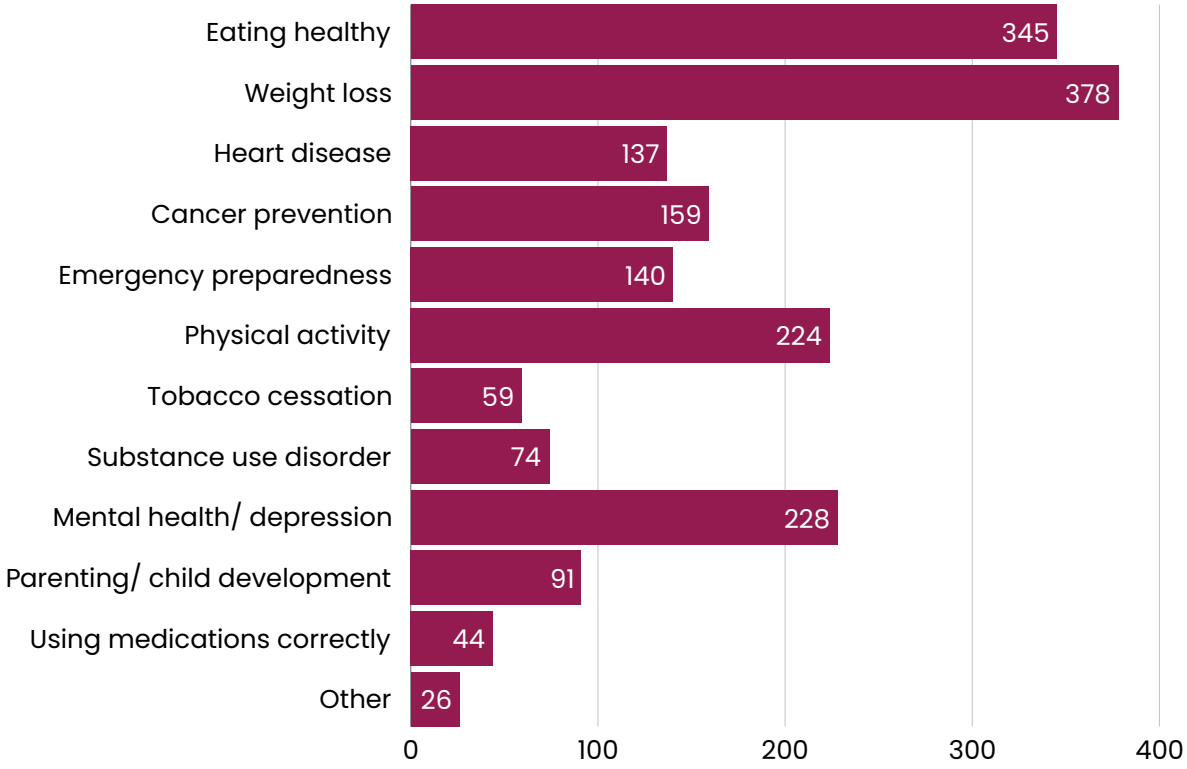
1. Drug use (475)
2. Tobacco/ Vaping (350)
3. Poor eating habits (323)

Community Survey Results

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

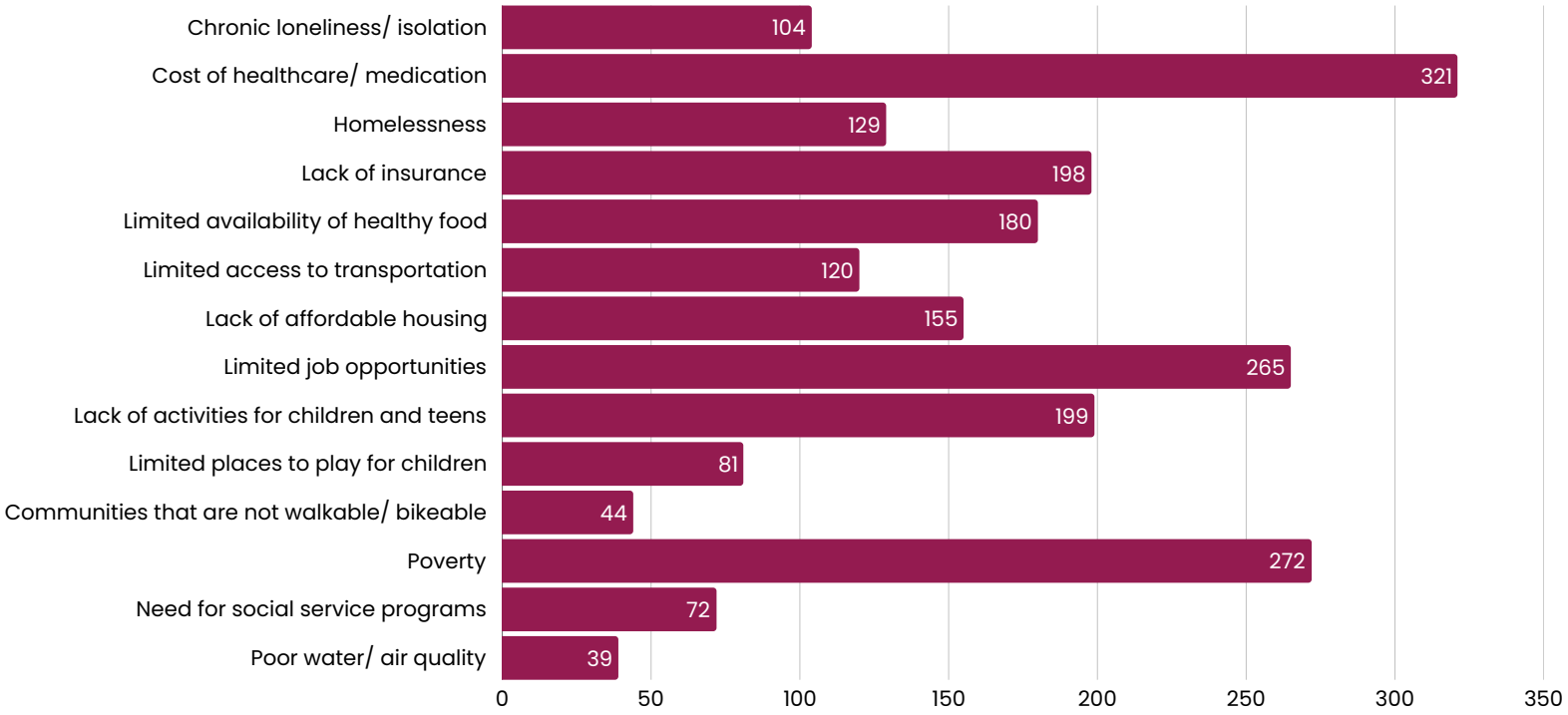


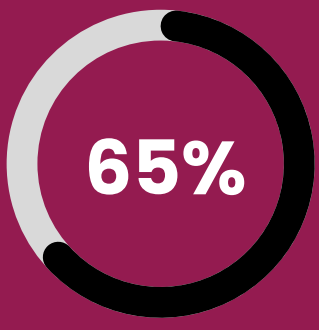
Health related topics respondents are interested in learning more about:



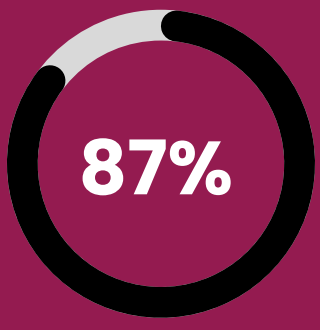
Community Survey Results

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

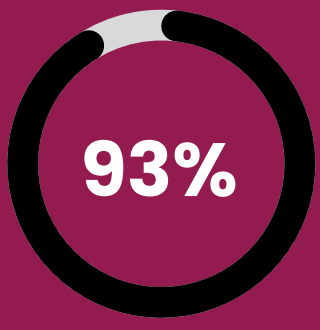




Have had a dental exam in the past year.



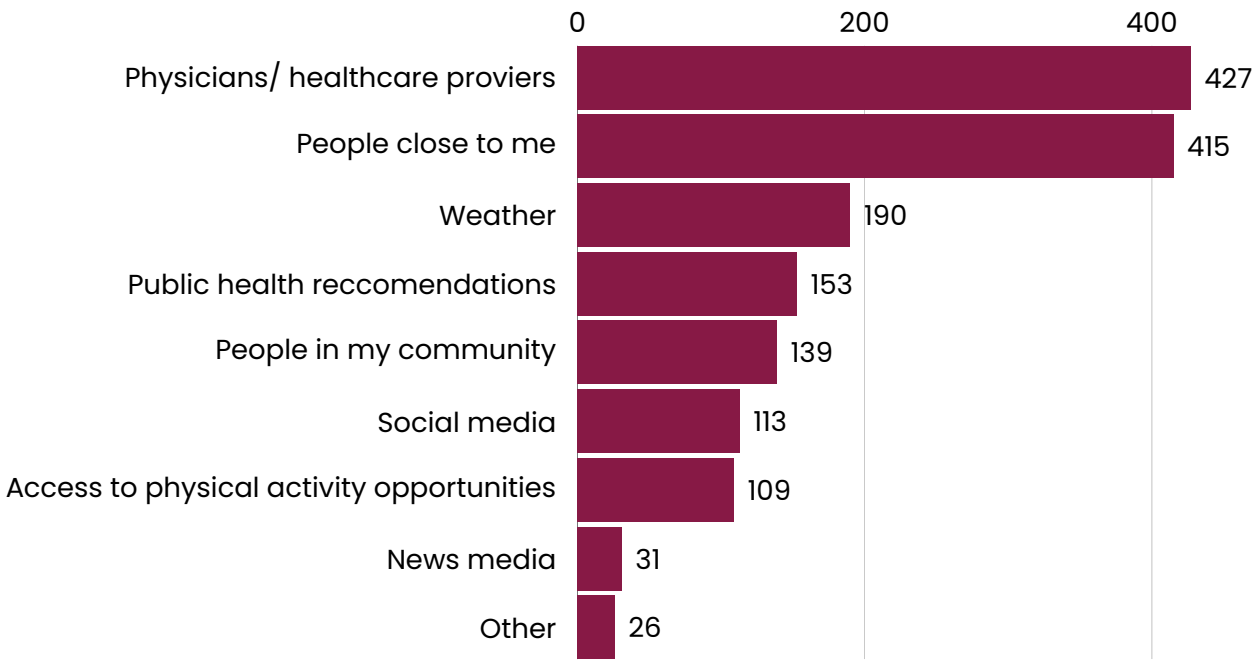
Have had a routine checkup in the past year.



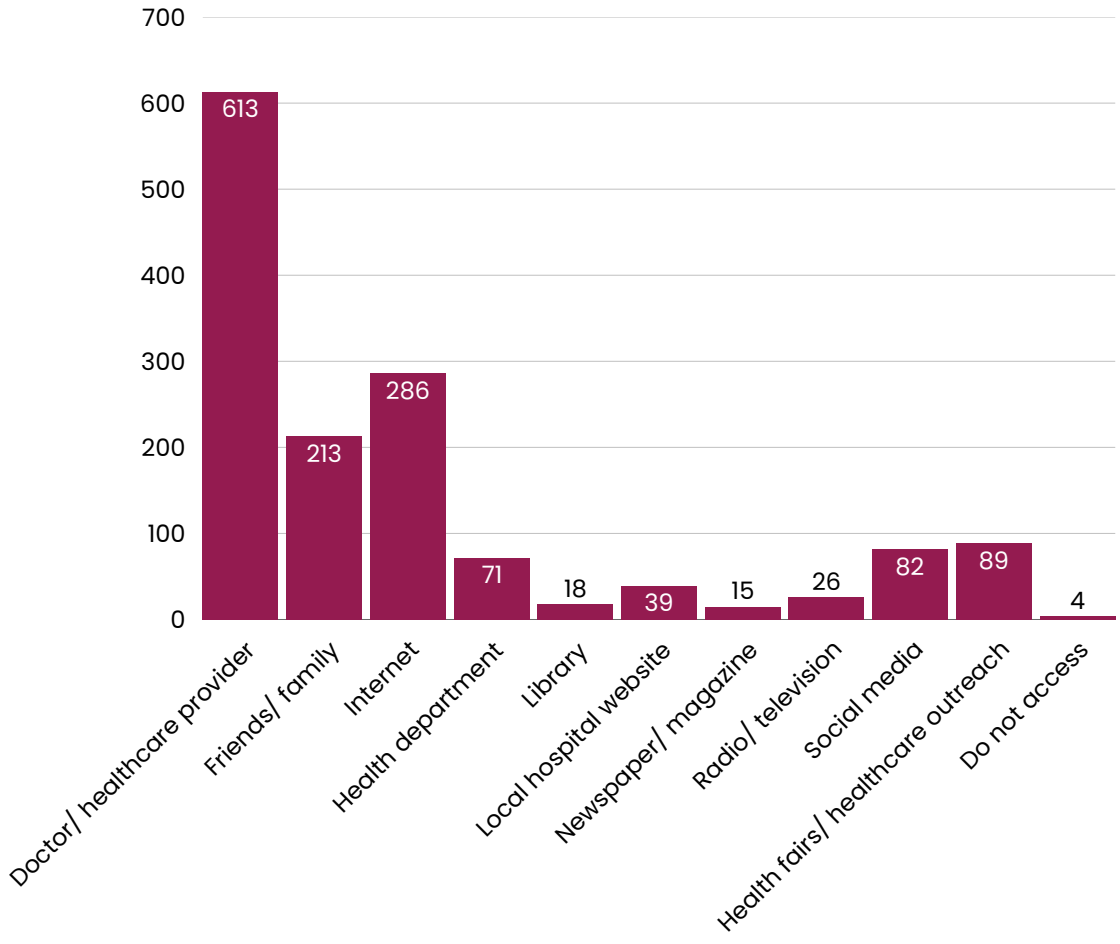
Believe mental illness is a medical condition.

Community Survey Results

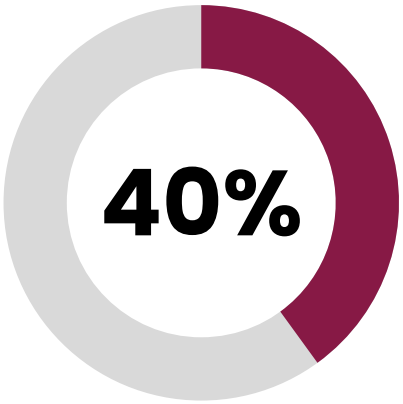
What factors influence your health choices?



Where do you get most of your healthcare information?

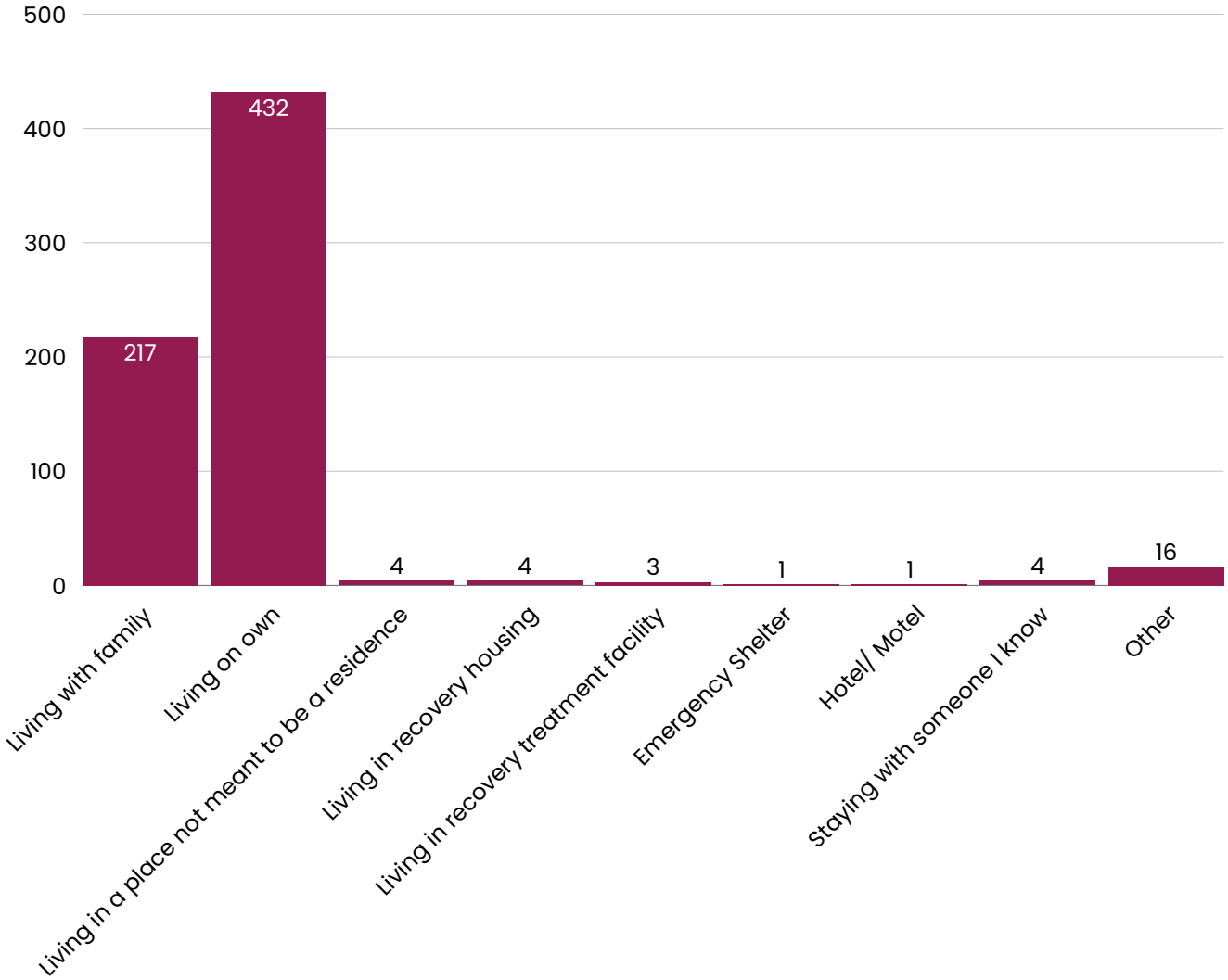


Community Survey Results



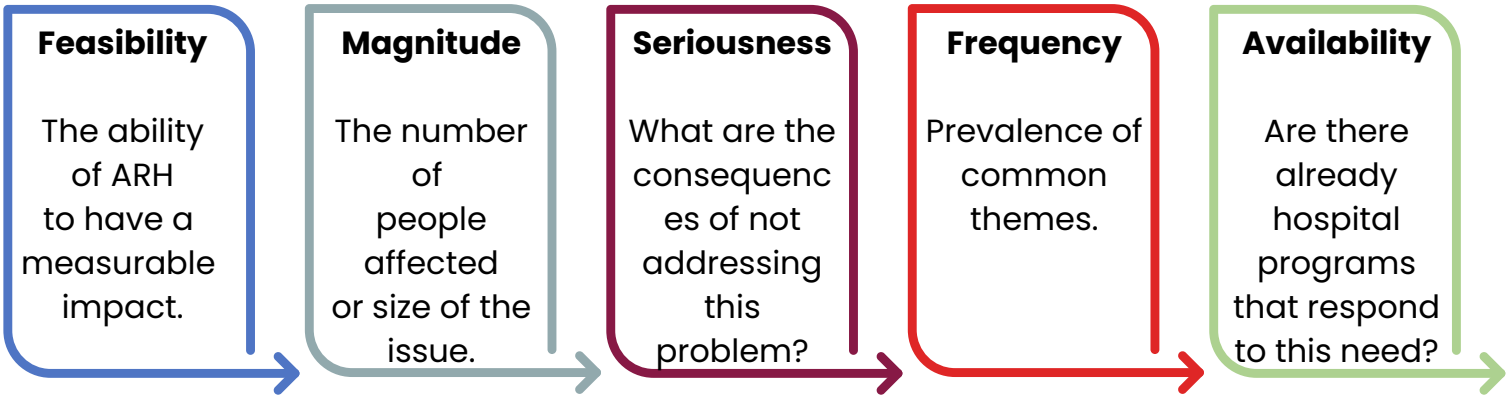
Have been told by a healthcare professional that they have high cholesterol.

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

McDowell 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	• 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, 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 interventions
	  ◦ Provide food to food insecure people through in-facility pantry programs, donations to homeless shelters and food banks
	  ◦ 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
	  ◦ Continue in-facility food pantry program, which distributes food boxes to patients that screen as food insecure

Key Strategies	• Physical Activity
	  ◦ Partner w/ fitness instructors or local gyms to provide fitness class in parts of the county that do not have walking tracks, gyms, or other physical activity opportunities
	  ◦ Reintroduce fitness fairs in local schools
	  ◦ Host annual "Biggest Loser" competitions for staff
	  ◦ 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
	• "Adopt" local children during the holidays through partnerships with local Family Resource Youth Service Centers

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
	  ◦ Provide cardiology services in a specialty clinic
	  ◦ Reopen Mobile MRI 1 day/week
	  ◦ Explore addition of 3D mammography and upgraded CT

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	**Poverty Rate**: Floyd 38.4% | Kentucky 16.6% | United States 17%
3	**Population 16+ in Labor Force**: Floyd 42% | Kentucky 59.1 % | United States 63.1%
4	Single Parent Households: Floyd 33.4% | Kentucky 31% | United States 7%
5	**Households spending at least 30% of income on housing:** Floyd 26.3% | 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	**Children Living in Food Insecure Households:** Floyd 23.3% | 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	**8th Grade Students with Proficient or Distinguished on Readings State Assessment:** Floyd 39% | Kentucky 44%
4	**8th Grade Students with Proficient or Distinguished on Math State Assessment:** Floyd 30% | Kentucky 46%
5	Kindergarteners Ready to Learn: Floyd 57% | Kentucky 44%
6	**Students with an Individualized Education Plan:** Floyd 20% | Kentucky 15%
7	**4th Grade Students with Proficient or Distinguished on Reading State Assessment:** Floyd 33% | Kentucky 46%
8	**4th Grade Students with Proficient or Distinguished on Math State Assessment:** Floyd 25% | 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	**Lung and Bronchus Incidence per 100,000 Population:** Floyd 125.5 | Kentucky 84.4 | United States 54

6	**Mammography Use Among Women Aged 50-74:** 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	**Percent of County Using SNAP:** 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	**Population Within ½ Mile of Walkable Destinations:** Floyd 9.5% | Kentucky 33.9% | United States 34%
7	**Walkability Index Score:** Floyd 4.7 | Kentucky 7.2 | United States 6.1
8	**Asthma Prevalence Among Adults 18+:** Floyd 12.3% | Kentucky 11.5% | United States 9.2%
9	**Adult Smoking Rate:** Floyd 31% | Kentucky 23.9% | United States 24.3%
10	Deaf and Hard of Hearing Population: Floyd 5,422 | Kentucky 705,533
11	**Prevalence of People with Disabilities:** Floyd 25.9% | Kentucky 21.1%

SOCIAL AND COMMUNITY CONTEXT: INCREASE SOCIAL AND COMMUNITY SUPPORT

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

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 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.

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