COMMUNITY HEALTH NEEDS ASSESSMENT

2025-2027

TEAM UP
A Public Health Academic Practice Collaborative

Acknowledgements

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

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

Letter to the Community Member

Dear Community Members, Partners, and Stakeholders,

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

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

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

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

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

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

Sincerely,

Hollie O. Harris

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

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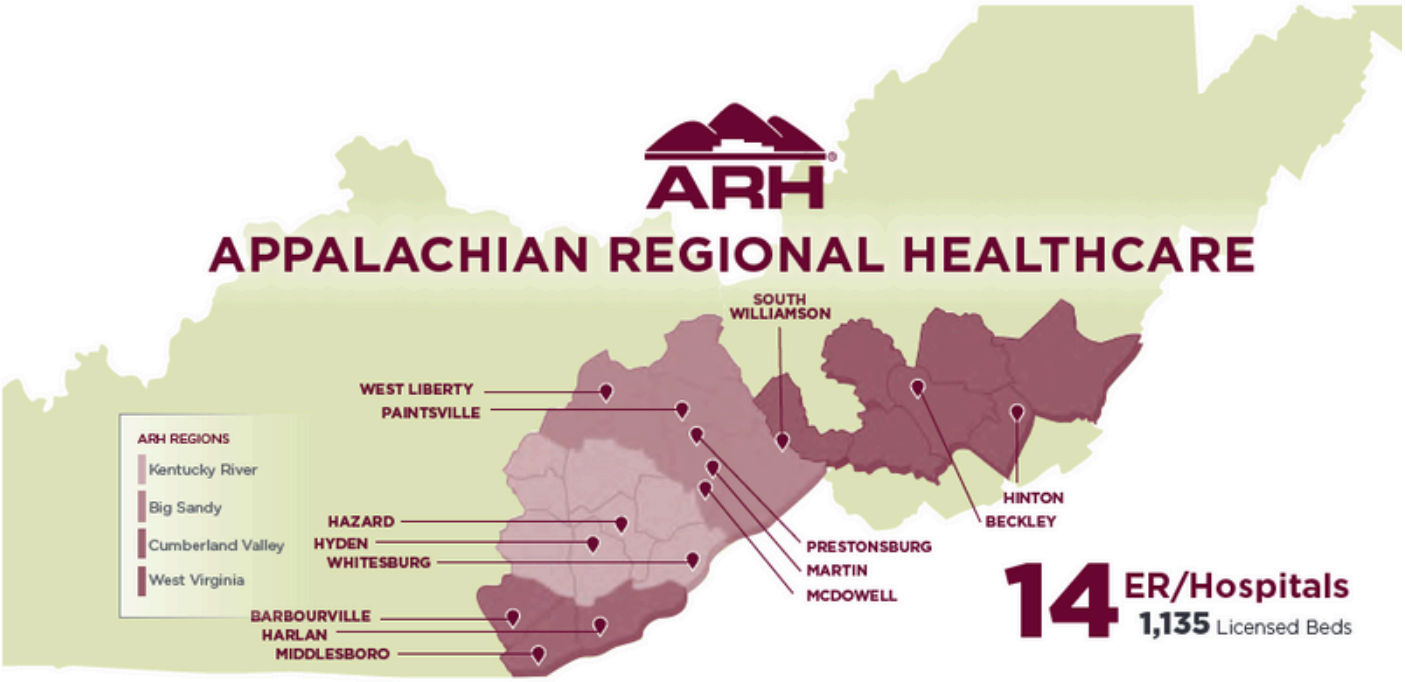
Introduction

Appalachian Regional Healthcare (ARH) is a not-for-profit health system operating 14 hospitals in Barbourville, Hazard, Harlan, Hyden, Martin, McDowell, Whitesburg, Whitesburg, Prestonsburg, West Liberty, Whitesburg, and South Williamson in Kentucky and Whitesburg 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, Whitesburg 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).

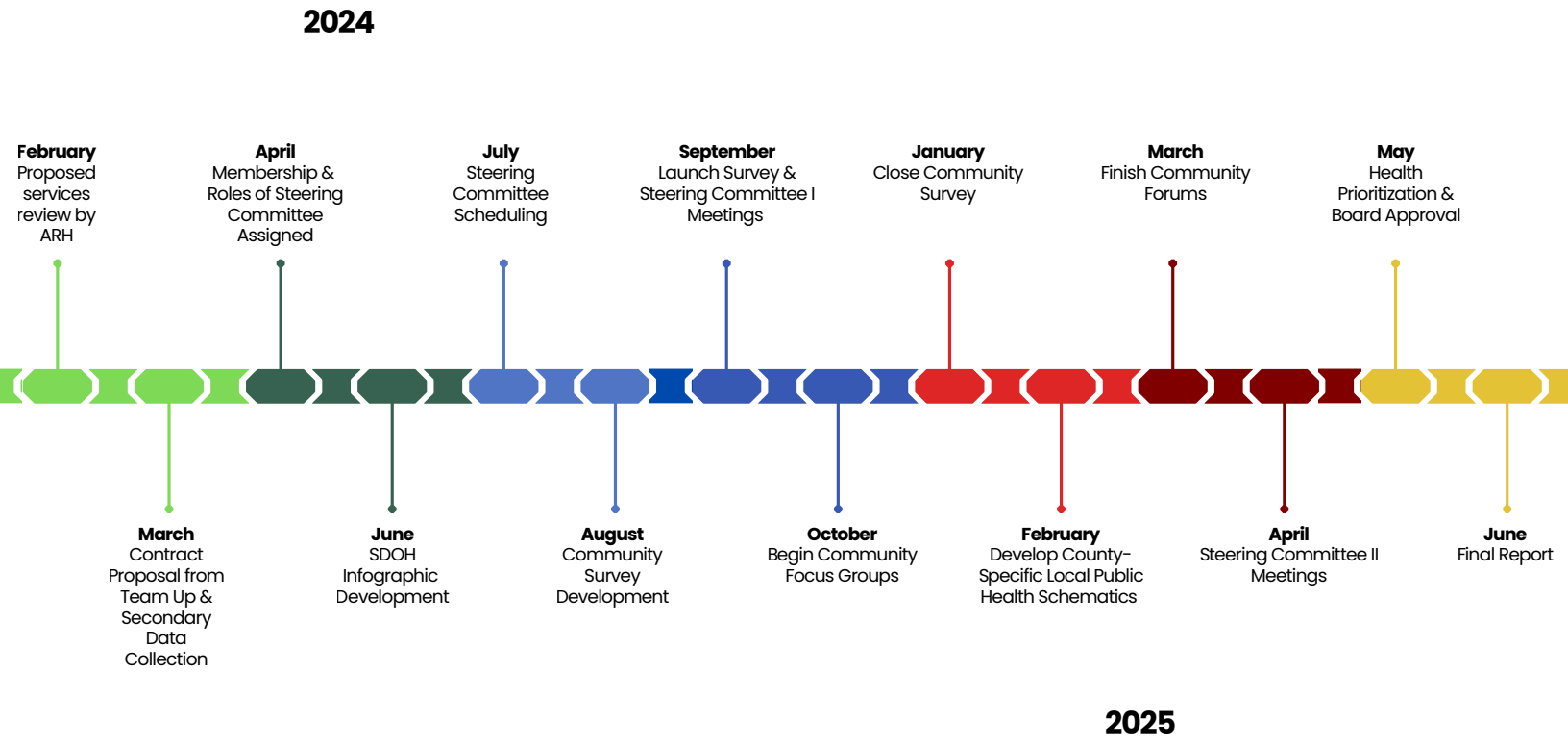
Steering Committees

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 Letcher County
See the CHNA process timeline below.

CHNA Timeline



2022-2024 Implementation Successes

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

1. Mental Health
2. Addiction/ Recovery
3. Food Insecurity
4. Education on Healthy Lifestyles

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

Goal 1

Increase the mental health of our community members and reduce stigma associated with seeking care

Since 2022, Whitesburg ARH has **improved the mental health landscape of our community** by:

- Providing quarterly free **Mental Health First Aid** trainings 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. Whitesburg 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. **20 Whitesburg ARH employees have been certified**

- Since 2022, Whitesburg ARH has tracked **3,303 behavioral health clinic visits**

- Mental health community events include:
  - Participation in the county Annual Child Abuse Awareness Walk, as well as child abuse resource events and activities led by local organizations. These events bring awareness to child abuse and the long term effects, as well as educate parents on coping techniques
  - ARH hosted the World Diabetes Day Celebration Health Fair in 2024 with an emphasis on mental health of patients with diabetes. A behavioral health nurse practitioner was the guest speaker
  - ARH has also partnered with a certified trauma instructor to host 2 Yoga and Mindfulness stress relief classes in Letcher county

Goal 2

Address addiction through peer support, community partnerships, and education

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

- Launching the **Peer Support Program** in 2020, employing Certified Peer Support Coaches to work in our Emergency Department and throughout the community. Peer support coaches are people who have been successful in the SUD recovery process and can help others that are still in active addiction. Our coaches often respond to overdoses in the ED, refer people to treatment, provide resources for social needs, educate the community on SUD and overdose awareness, and more. During this CHNA implementation period (2022-2024), Whitesburg ARH Peer Recovery Coaches have:
  - Engaged **406** patients
  - Referred **49** patients to treatment
  - Provided **36** linkages to treatment

- Peer Recovery Coaches have worked with community partners to host many community events over the past three years. Events with a Substance Use Disorder or Drug Prevention focus include:
  - **Weekly self-help group meetings** focusing on life skills, managing emotions, setting goals, etc. These are organized by ARH Peer Support
  - Sponsorship and participation in the **Recovery Central Walk**, **Recovery Central Resource Fair** and **Recovery Central Community Meal** since 2023
  - **Help End Addiction for Life (HEAL)** Event sponsorship

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

Goal 3

Address food insecurity in our community

Since 2022, Whitesburg ARH has **addressed 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 20 boxes per month

- Implementing a **farmer's market screening program** in which screening participants received a $10 voucher to spend fresh produce, meat, baked goods, and dairy items

- Implemented a 10-week **farmer's market walking program** in which community members could join the Saturday morning walking group or complete one mile on their own to receive a $10 voucher redeemable during the market season. On average, vouchers would be given to 25 participants each Saturday

Goal 4

Improve decision-making skills among members of the community by providing community education about healthy behaviors & accessing healthcare

Since 2022, Whitesburg ARH has **improved decision-making skills and healthy behaviors** in our community through:

- **Cancer prevention and early detection**
  - Since 2022, Whitesburg ARH has hosted **7 events** that specifically promote cancer awareness, teach about early detection, and encourage preventative lifestyles
    - **7** colon cancer screening events where take-home colon cancer screening kits (FIT kits) were offered in partnership with Kentucky Cancer Link. Many were held at local schools, targeting teachers during their work day
    - **5** community presentations about the early detection of lung cancer and low dose CT screenings provided by the ARH Lung Cancer Screening Program Manager
    - **3** breast cancer awareness luncheons or dinners provided free of cost to the community with breast cancer survivors and ARH provider speakers

- **Diabetes prevention and management**
  - Whitesburg ARH focused on diabetes prevention and management by:
    - Providing diabetes management education and A1C testing at Levitt Amp concerts, senior citizens center, and the Letcher County Diabetes Health Fair
    - Implementing monthly diabetes support groups in Letcher County with diabetes-related topics and healthy cooking demonstrations each month (**11** held since 2023 start)

- **Stroke and heart health**
  - Since 2022, our stroke and community development teams have excelled in community stroke education and screenings:
    - Provided **Brain Protectors** programming to **558 elementary school children** in **4 schools.** This program trains students to recognize the signs and symptoms of a stroke
    - In 2024, implemented **"Strike Out Stroke"** in partnership with our local little league and "Lets TACO-bout Stroke" cooking classes
    - Provided stroke risk assessments/screening events **16 times** throughout our community, including events at grocery stores, farmer's markets, and senior centers

- **Physical activity programming**
  - ARH has increased opportunities for physical activity in Letcher County and surrounding communities by:
    - Partnered with Letcher Co. Extension Office to provide incentives for their Drop It Like It's Hot exercise program
    - Implemented a 10-week farmer's market walking program in which community members could join the Saturday morning walking group or complete one mile on their own to receive a $10 voucher redeemable during the market season. On average, vouchers would be given to 25 participants each Saturday.

- **School-based programs**
  - ARH organizes many school-based programs that provide students with the knowledge and skills they need to make informed decisions about their health
    - **Love Your Lungs**, a programs that teaches the dangers associated with smoking and vaping, was taught in area schools 2 times since 2022. This program is a partnership with Kentucky Cancer Program
    - Provided **Brain Protectors programming** to 558 elementary school children in 5 schools. This program trains students to recognize the signs and symptoms of a stroke
    - 3 in-school programs teaching nutrition education using **MyPlate** material

- **Nutrition education**
  - Provided **3 free cooking classes** with in partnership with the Letcher County UK Extension Service. At many of these events, food or grocery gift cards are provided to participants
  - Partnered with the Letcher County Farmer's Market to provide health education, nutritional guidance, and health screenings at a minimum of one market per month
  - Provided a nutritional education session for kids on the Creek Camp at Cowan Community Center
  - Provided BMI measurement and nutrition education at Levitt Amp Music Festival

- **Health screening events**
  - ARH has organized health screening events broadly throughout the community since 2022. In total, **over 348 free health screenings** have been provided at health fairs, retail stores, area festivals, workplaces, etc.
    - **229** stroke risk screenings and blood pressure checks completed.
    - **30** cholesterol tests completed
    - **71** A1C tests completed
    - **18** FIT Kit referrals (colon cancer screenings)
  - Approximately **200 free vaccinations** provided to the community

Goal 5

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

Since 2022, Whitesburg ARH has **improved access to care in our community** by:

- Adding **new services** since 2022:
  - 3D mammography
  - New nuclear scanner
  - Upgraded our CT unit with more test capability
  - Added pain management program with pain management NP
  - Implemented Swing Beds program for patients that need extended recovery time
  - Added additional Speech Language Pathologist and Occupational Therapist
  - Expanded surgery offering to include podiatry
  - Expanded days for cataract surgery

- Earned **Acute Stroke Ready Center Certification** Feb 2022

Community Served by Whitesburg ARH

Whitesburg 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 Letcher County (63.0%).

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

Population

Population	Letcher Co	Kentucky	US Overall
Population, 2024	20,139	4,588,372	340,110,988
Percent of Population Under 18 Years	21.6%	22.5%	21.7%
Percent of Population 65 Years+	21.6%	17.8%	17.7%
Percent of Population White	97.7%	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	0.4%	1.8%	6.4%
Percent of Population Native Hawaiian/Other Pacific Islander	0%	0.1%	0.3%
Percent of Population Hispanic or Latino	0.8%	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	Letcher Co	Kentucky	US Overall
Percent Completed High School	79.8%	89%	89%
Bachelor's Degree or Higher	13.7%	27%	35%
Percent Unemployed	6.3%	4.2%	3.6%
Percent of People in Poverty	23.8%	16.4%	11.1%
Children in Poverty	29%	20%	16%
Number of Children in Single Parent Households	26%	25%	25%
Median Household Income	$41,700	$61,100	$77,700
Violent Crime Rate (per 100,000)	51.9	225.6	255.2
Child Care Cost Burden	31%	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	Letcher Co	Kentucky	US Overall
Percent Adult Smoking	21%	18%	13%
Percent Adults with Obesity	41%	38%	34%
Percent of Physically Inactive Adults	28%	25%	23%
Adults (>65) with all Teeth Lost	34.1%		12.6%
Percent of Adults Receiving Flu Vaccination in the Last Year	26%	46%	48%
Teen Birth Rate (per 1,000)	32	24	16
Sexually Transmitted Infections per 100,000	148.4	406.8	495.0
Percent Excessive Drinking	13%	15%	19%
Number of Child Victims of Substantiated Abuse	217	17,917	-
Births to Mother who Smoked During Pregnancy	23.5%	12.6%	5%
Percent Driving Deaths with Alcohol Involvement	16%	26%	26%
Suicides Per 100,000 Population	14	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	Letcher Co	Kentucky	US Overall
Life Expectancy (years)	67.7	73	77
Percent Adults with Diabetes	13%	13%	10%
Percent Adults with Hypertension	39.9%	-	29.6%
Adults with current Asthma	11.7%	-	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	6.4	5.0	5.1
Percent Low Birth Weight	9%	9%	8%
Percent with a Disability, under Age 65	23%	13%	9%

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

Access to Care

Access to Care	Letcher Co	Kentucky	US Overall
Primary Care Physicians	1,770:1	1,600:1	1,330:1
Mental Health Providers	1,070:1	320:1	300:1
Dentists	2,610:1	1,500:1	1,360:1
Preventable Hospital Stays per 100,000	8,833	3,336	2,666
Mammography Screening Rates	24%	43%	44%
Percent Uninsured	7%	7%	10%

Source: County Health Rankings (2025)

Physical Environment

Physical Environment	Letcher Co	Kentucky	US Overall
Severe Housing Problems	13%	13%	17%
Severe Housing Cost Burden	8%	12%	15%
Driving Alone to Work	74%	78%	70%
Long Commute to Work – Driving Alone	40%	31%	37%
Broadband Access	83%	87%	90%
Access to Parks	33%	29%	51%
Homeownership	73%	68%	65%
Air Pollution – Particulate Matter	6.8	8.0	7.3

Source: County Health Rankings (2025)

Invasive Cancer Incidence Rates

Age-Adjusted Rate	Letcher Co	Kentucky	US Overall
Total all sites (2017-2021)	500.4	513.7	444.4
Lung and Bronchus	87.0	84.5	53.1
Breast (Female)	108.9	129.2	129.8
Colon and Rectum	46.4	45.9	36.4
Urinary Bladder	16.7	21.7	18.8
Kidney and Renal Pelvis	21.3	21.4	17.3
Melanoma of the Skin	20.7	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 Whitesburg ARH inpatient hospital discharges from January 2022- September 2024.

Inpatient Hospital Discharges- Patient Origin

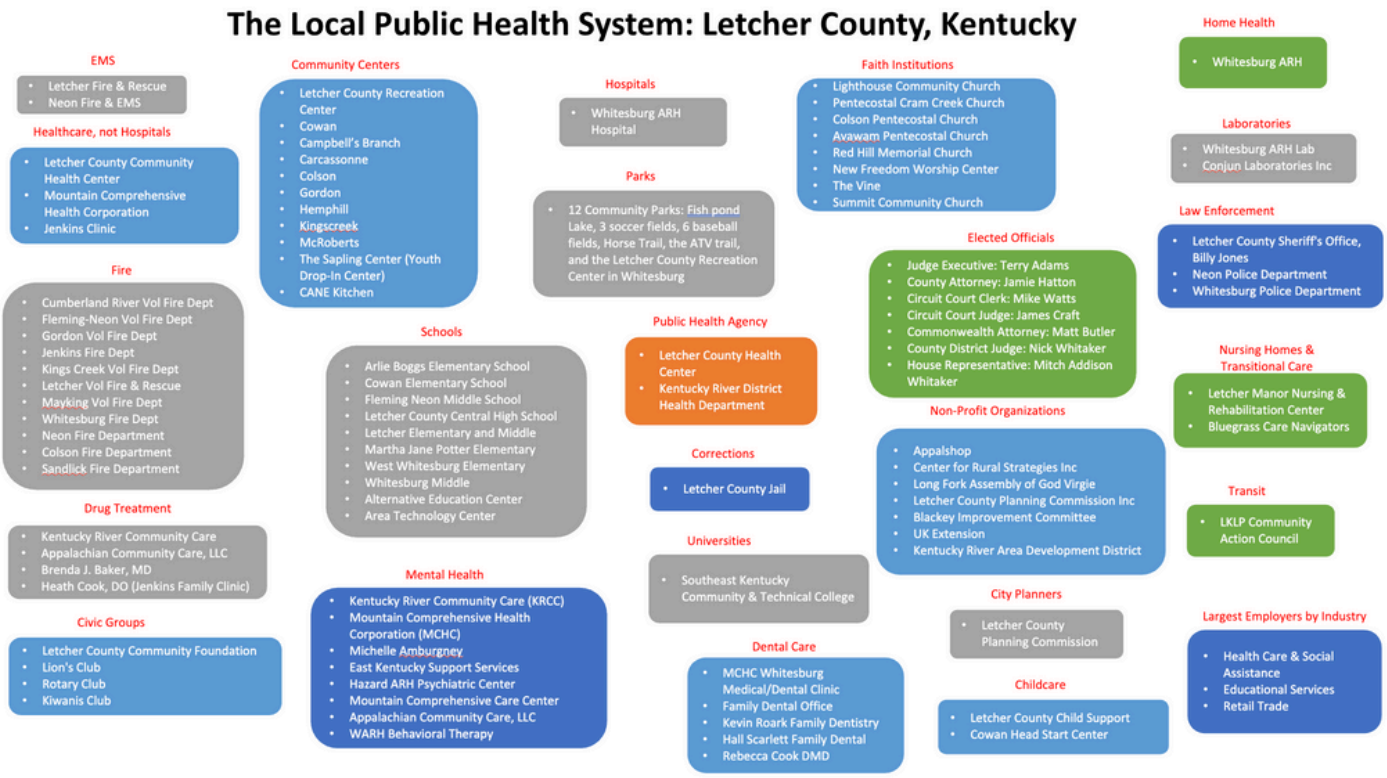
Patient County	Inpatient Discharges	% of Total
Letcher- KY	5,893	63.0%
Perry-KY	995	10.6%
Harlan-KY	924	9.9%
Knott-KY	714	7.6%
Pike-KY	266	2.8%
Wise-VA	180	1.9%
Leslie-KY	113	1.2%
Dickenson-VA	84	0.9%
Floyd-KY	68	0.7%
Breathitt-KY	51	0.5%
Lee-VA	11	0.1%
Whitley-KY	8	0.1%
Bell-KY	8	0.1%
Buchanan-VA	8	0.1%
Magoffin-KY	6	0.1%
Martin-KY	5	0.1%
Laurel-KY	4	0.0%
Madison-KY	3	0.0%
Wolfe-KY	3	0.0%
Johnson-KY	2	0.0%
Powell-KY	1	0.0%
Greenup-KY	1	0.0%
Knox-KY	1	0.0%
Morgan-KY	1	0.0%
Total	**9,350**	**100%**

Inpatient Hospital Discharges- Payer Mix

Payer Type	Inpatient Discharges	% of Total
WellCare of Kentucky Medicaid Managed Care	2,370	25.3%
Medicare (Excluding Medicare Managed Care)	1,729	18.5%
Medicare Managed Care	1,637	17.5%
Commercial- Anthem Health Plans of KY PPO Plan	1,038	11.1%
Commercial- Anthem Health Plans of KY HMO Plan	544	5.8%
Other Facility	338	3.6%
Anthem Medicaid Managed Care	206	2.2%
Humana Medicaid Managed Care	204	2.2%
Passport Medicaid Managed Care	202	2.2%
Tricare (Champus)	172	1.8%
Aetna Better Health of KY Medicaid Managed Care	148	1.6%
In State Medicaid	143	1.5%
United Healthcare Medicaid Managed Care	133	1.4%
Out of State Medicaid	104	1.1%
Black Lung	91	1.0%
Commercial-Other	87	0.9%
Workers Compensation	45	0.5%
Self Pay	43	0.5%
Commercial- Aetna Health HMO Plan	30	0.3%
Commercial- United Healthcare POS Plan	26	0.2%
Commercial- Cigna Health & Life FFS Plan	19	0.2%
Commercial- Humana PPO Plan	17	0.2%
Commercial- Aetna Health PPO Plan	11	0.1%
Auto Insurance	5	0.1%
Care Source KY Commercial Plan	4	0.0%
ChampVA	4	0.0%
Total	**9,350**	**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 Letcher County. An overview of this schematic can be seen below, see Appendix B for a larger font version.



Letcher 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 Whitesburg ARH leadership in late summer of 2024. On November 6, 2024, the group gathered to discuss the CHNA process, provide their view of health needs for clients they serve, and plan survey dissemination and focus groups. On April 2, 2025 and after months of data collection, the Steering Committee met again for their final meeting (image below). The group reviewed data and collaboratively recommended priority health needs for Whitesburg ARH to address.

Letcher County CHNA Steering Committee

Steering Committee Members

Name	Organization Represented
Melissa Slone	KY River District Health Department
Sherrie Stidham	KY River District Health Department
Alicia Cook	APRN
Matilda Park	Letcher Co Extension
Denise Yates	Letcher County Public Schools
Mimi Pickering	Appalshop/ WMMT
Candace Gentry	WARH
Ellen Wright	WARH CEO
Tristy Kincer	MCHC
Nanette Banks	Letcher Co Extension
Phillis Combs	KRCC Regional Prevention Center
Nicole Smith	ARH
Misty Combs	KY River District Health Department
Valerie Horn	Cowan Community Center
Josh Yonts	Asst. Superintendent- Letcher Co. Public Schools
Lisa Giles	Retired Teacher

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.

Whitesburg ARH hosted forums with:

- Young at Heart Seniors
- CANE Kitchen - Recovery Focused Group
- Head Start Parents and Staff

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: Chronic Disease

- Diabetes
- Heart disease
- Black lung and pukmonary issues
- Obesity-related disease
  - Heart Disease
  - Hypertension
- Liver disease
- Substance use

Finding 1.2: Trauma & Mental Health

- Aging population
- Mental health issues
- Flood recovery / disaster trauma
- Repercussions of SUD

"I fight to live every day, and you fight to die."

QUESTION 2: BARRIERS TO HEALTHCARE

Finding 2.1: Resource Challenges

- Long distance to visit doctor
- Transportation
- Poor quality home health care
- Long appointment wait times
- Lack of providers
- Lack of affordable insurance
- Working hours vs. office hours
- Lack of childcare
- Lack of specialists
- Shortage of first responders

Finding 2.1: Navigation & Communication

- Communication on services available
- Stigma against individuals in recovery
- Difficulty navigating resources

Focus Group Results

✳ QUESTION 3: HEALTH BEHAVIORS

Finding 3.1: Substance Use

- Tobacco use
  - Smoking
  - Vaping
- Substance use
  - Drugs (Rx and illicit)
  - Alcohol

Finding 3.2: Community Contextual Barriers

- Grandparents raising grandchildren
- Indoor tanning
- Lack of physical activity
- Vehicle crashes
- Lack of health education
- Poor diet
- Lack of well-paying jobs
- Lack of affordable produce

✳ QUESTION 4: ADDITIONAL CONCERNS

Finding 4.1: Additional Resources Needed

- Activities for children and teens
- Understanding/ navigating health system
- Well-paying jobs
- Childcare
- Alzheimer's or dementia programs
- Affordable housing
- Mental health programs and education
- Autism care
- Social media knowledge
- Resources on mental health for disaster relief
- Chane in cultural attitudes towards healthcare

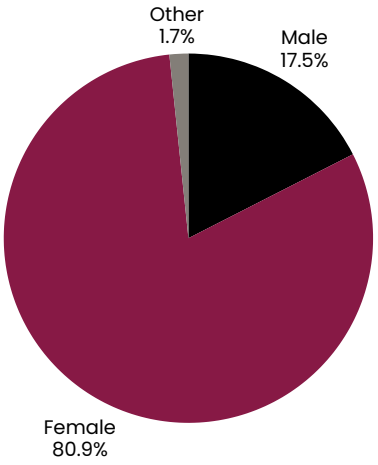
Community Survey Results

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=307

Gender



Education

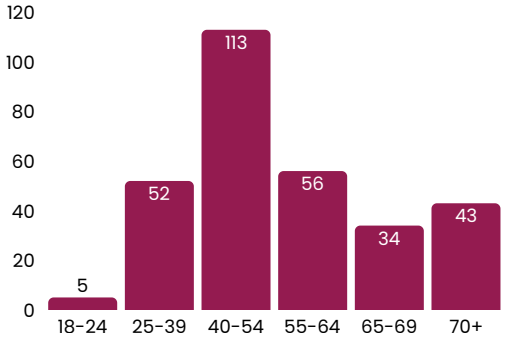
20% High School

9% Technical School

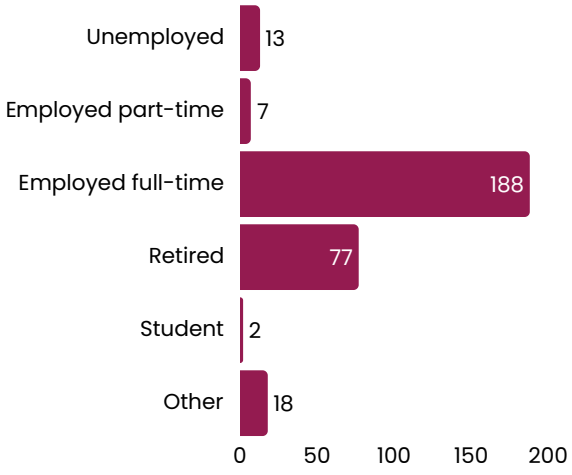
66% College or Above

5% Other

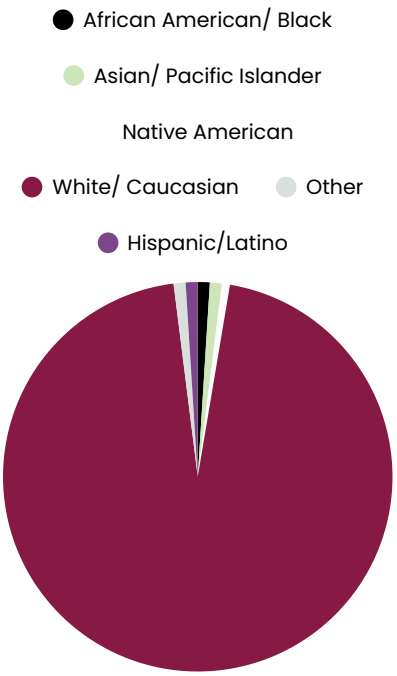
Age



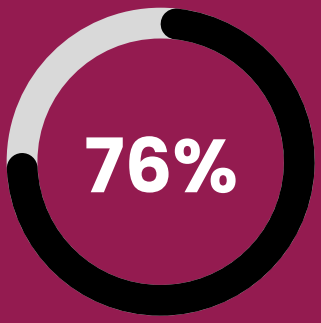
Employment Status



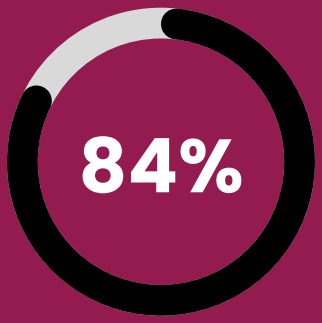
Race/ Ethnicity



Community Survey Results

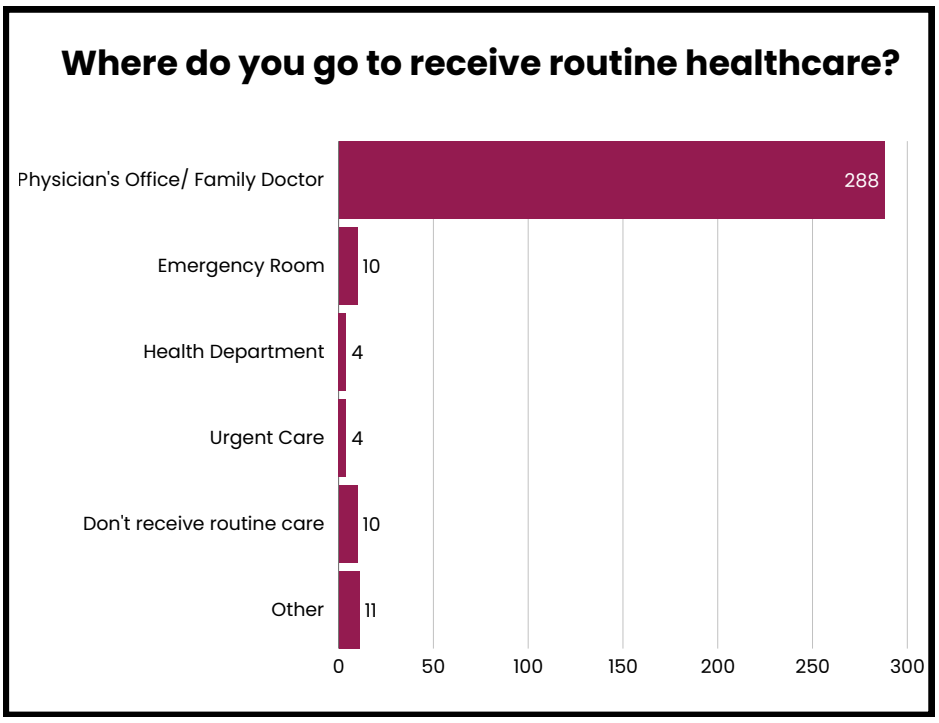


Are satisfied with the ability to access healthcare services in Letcher County.



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

Have delayed healthcare due to lack of money or insurance.

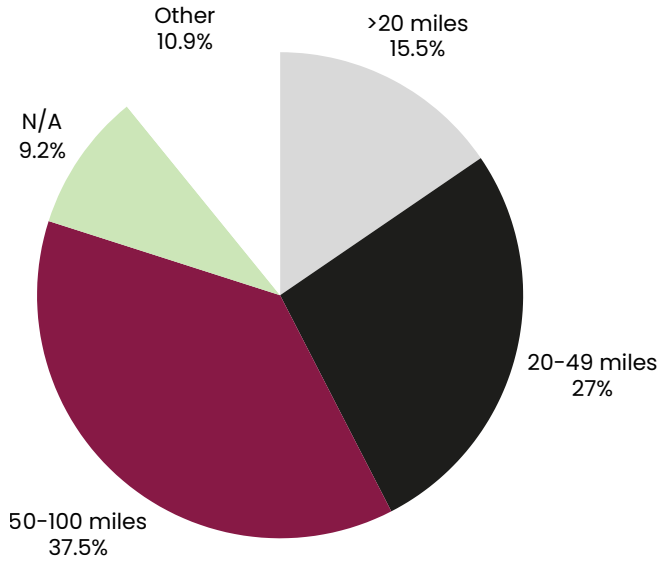


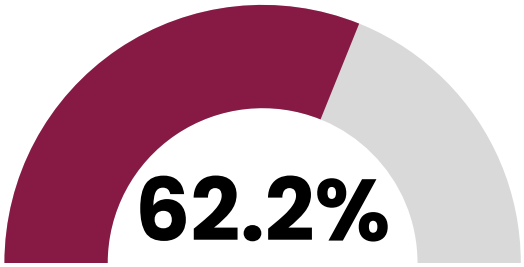
Top 5 barriers to receiving routine healthcare:

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

Community Survey Results

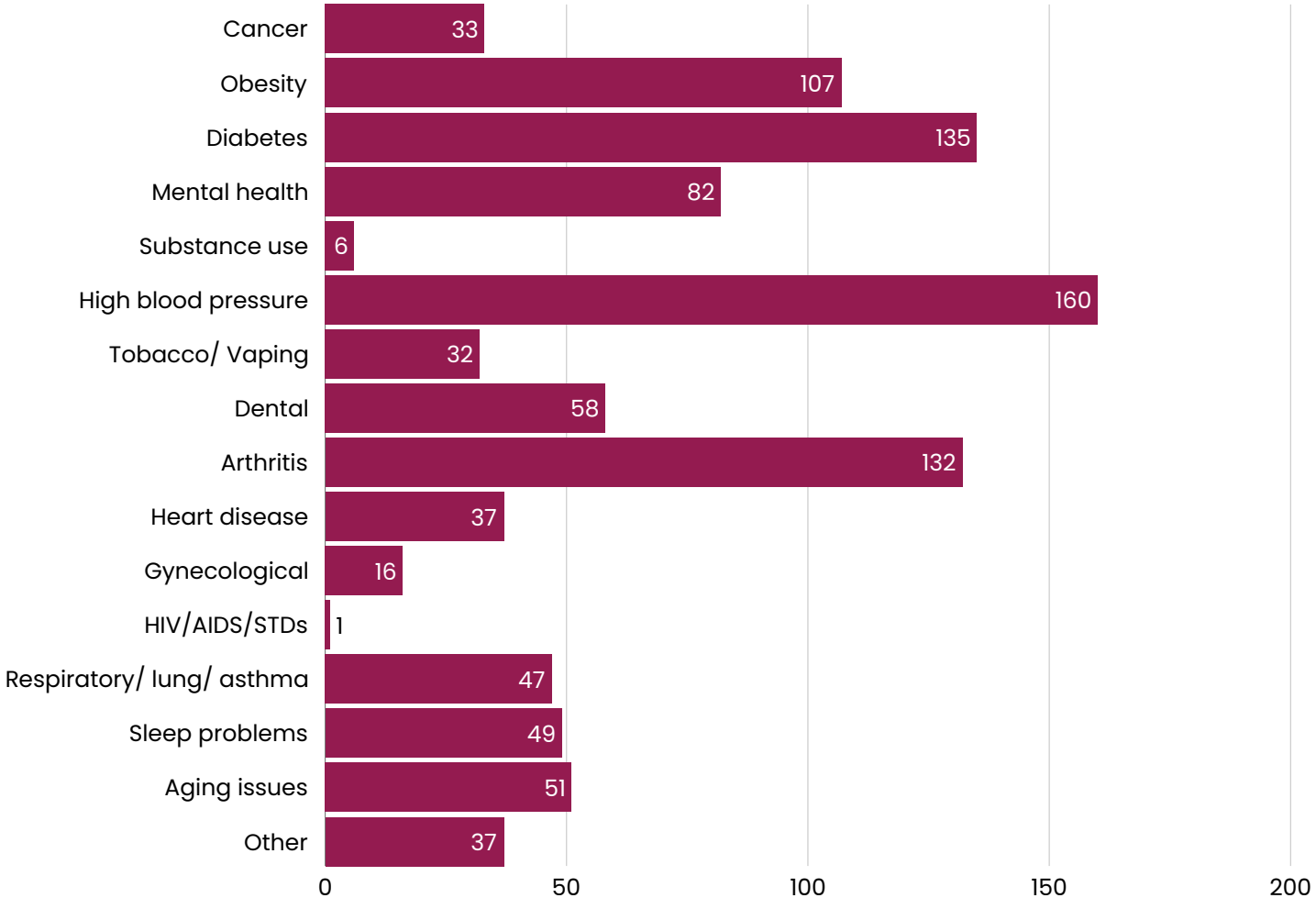
How far do you or your household travel to see a specialist?





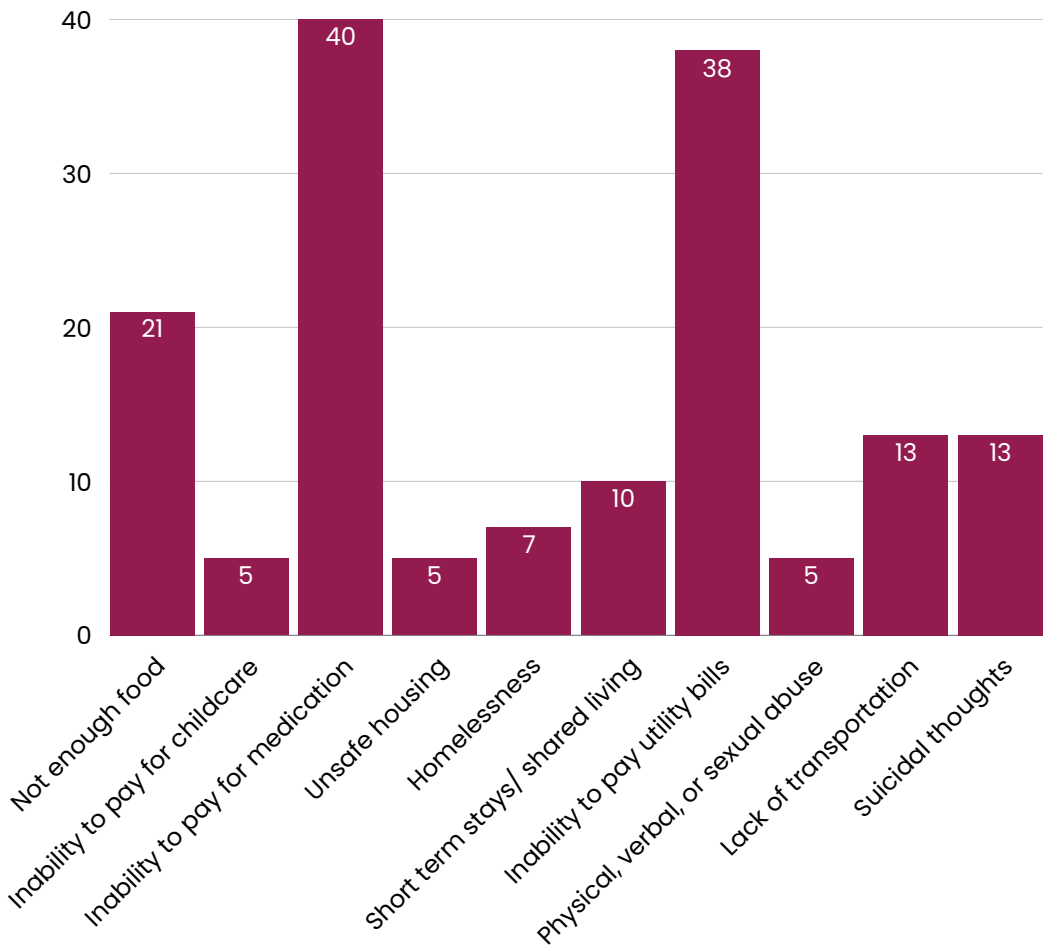
Are satisfied with the availability of mental health services in Letcher County.

Top 3 health challenges you/ your household face:

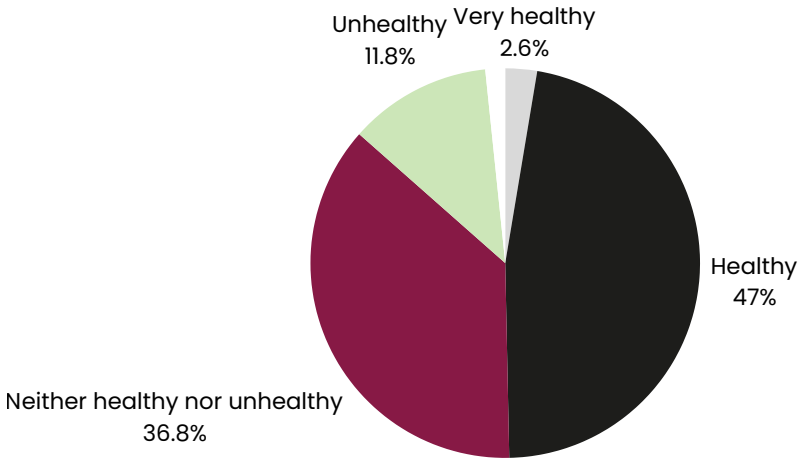


Community Survey Results

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



How would you rate your overall health?

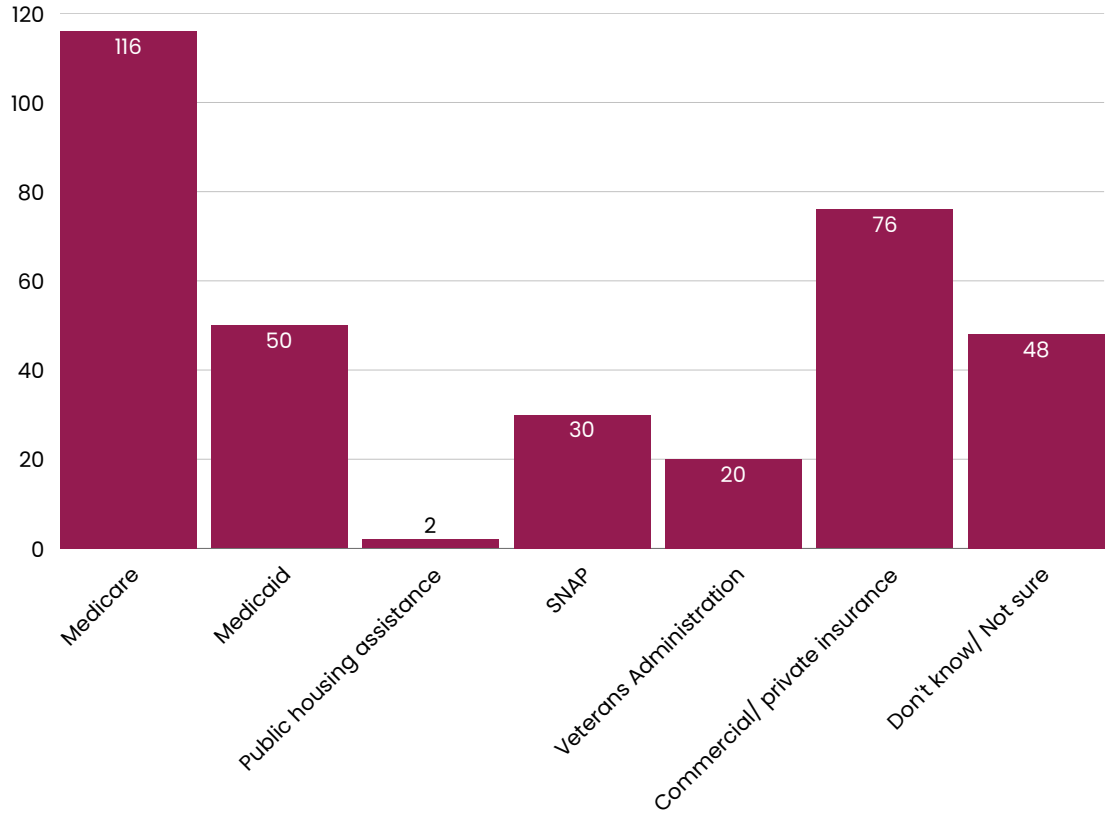


Top 3 risky behaviors you see in your community:

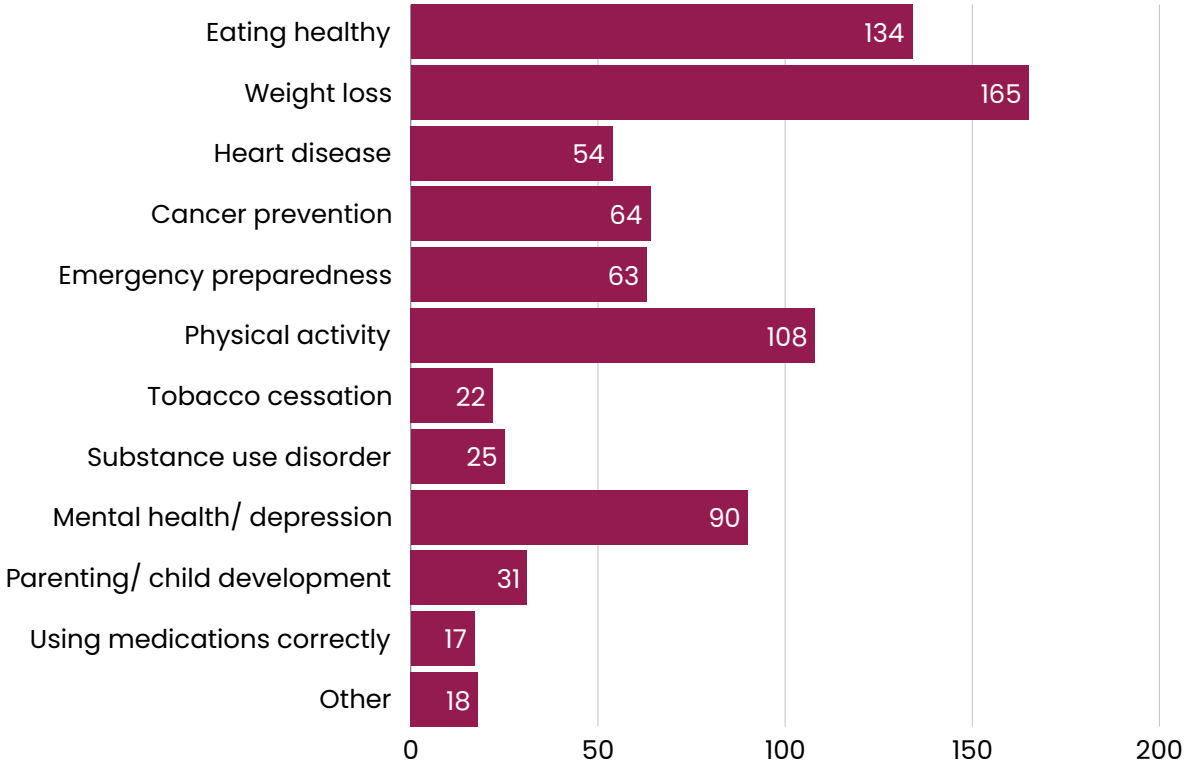
1. Drug use (224)
2. Poor eating habits (178)
3. Tobacco or vaping use (136)

Community Survey Results

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

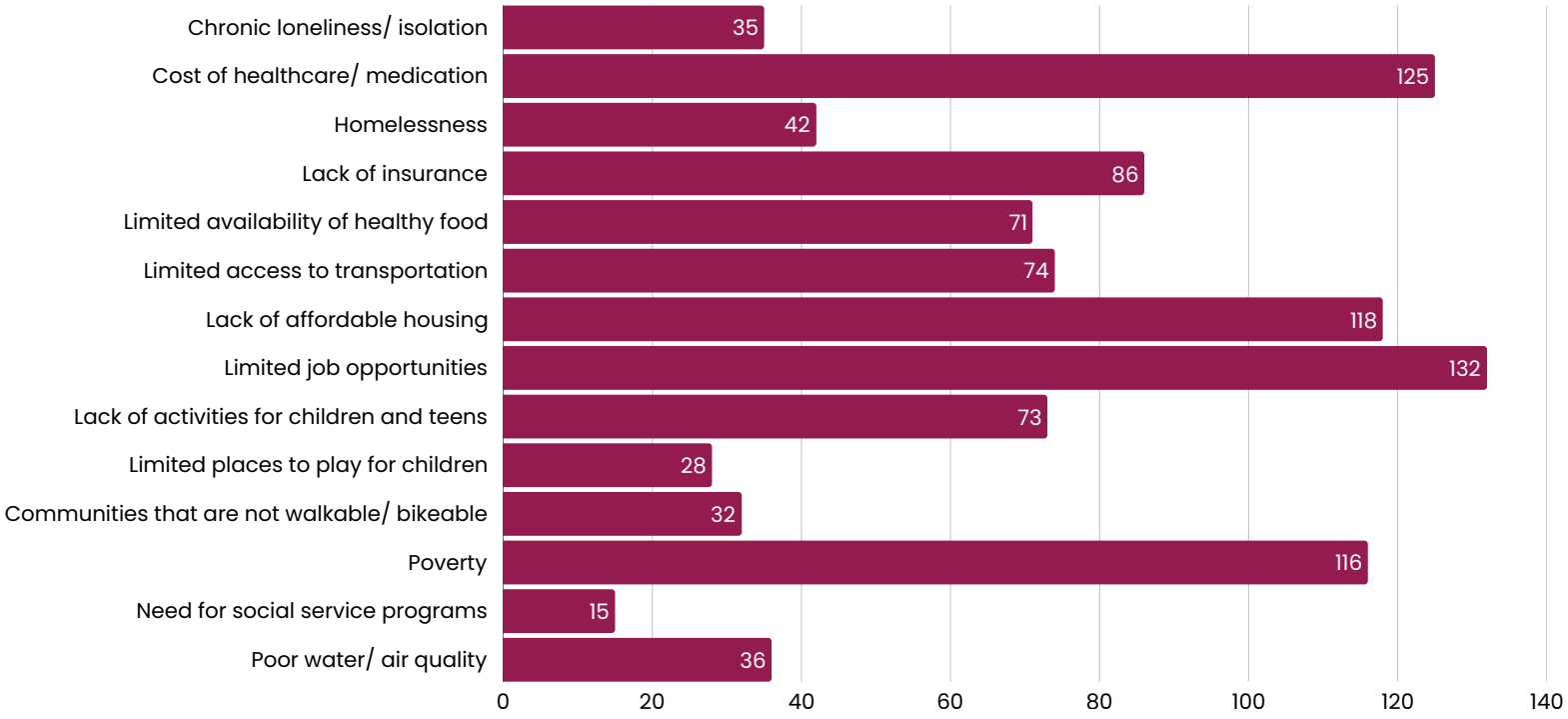


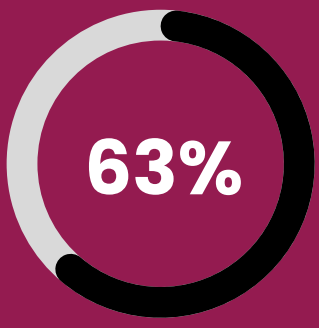
Health related topics respondents are interested in learning more about:



Community Survey Results

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





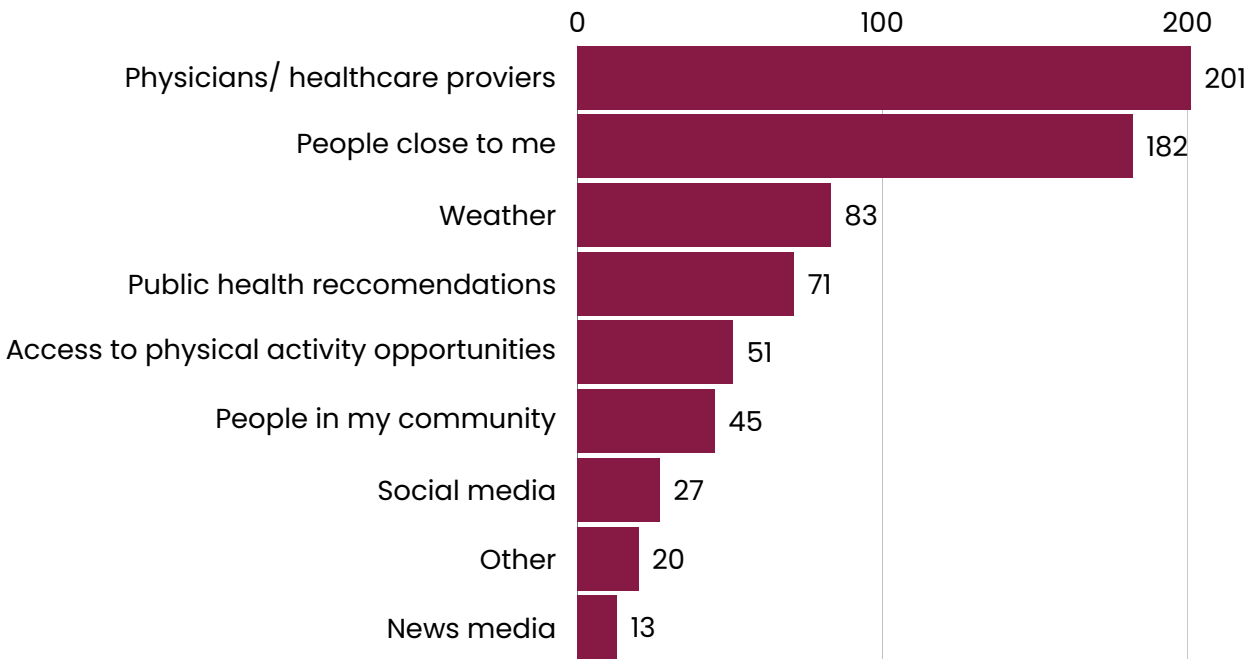
Have had a dental exam in the past year.

Have had a routine checkup in the past year.

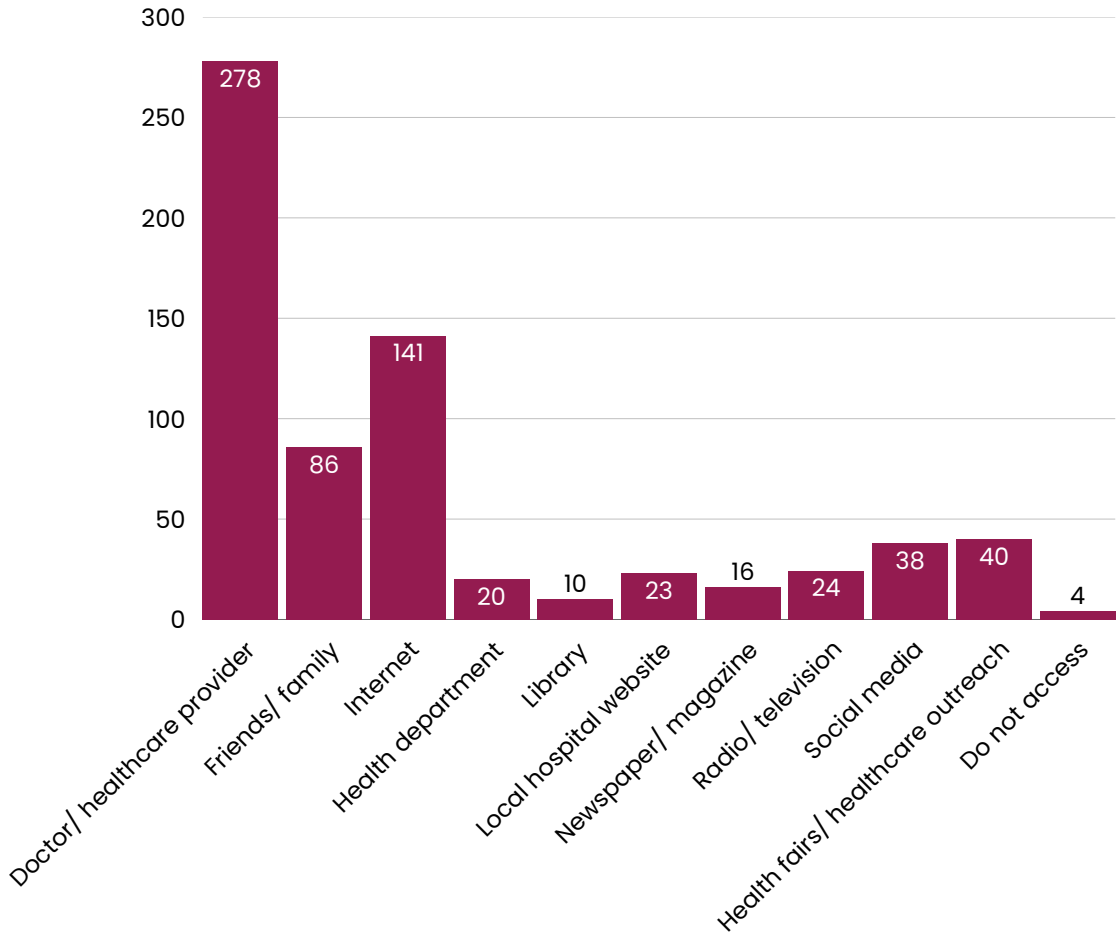
Believe mental illness is a medical condition.

Community Survey Results

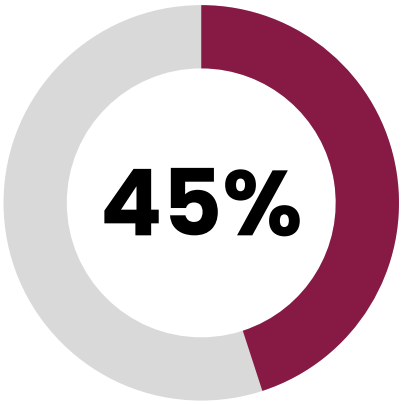
What factors influence your health choices?



Where do you get most of your healthcare information?

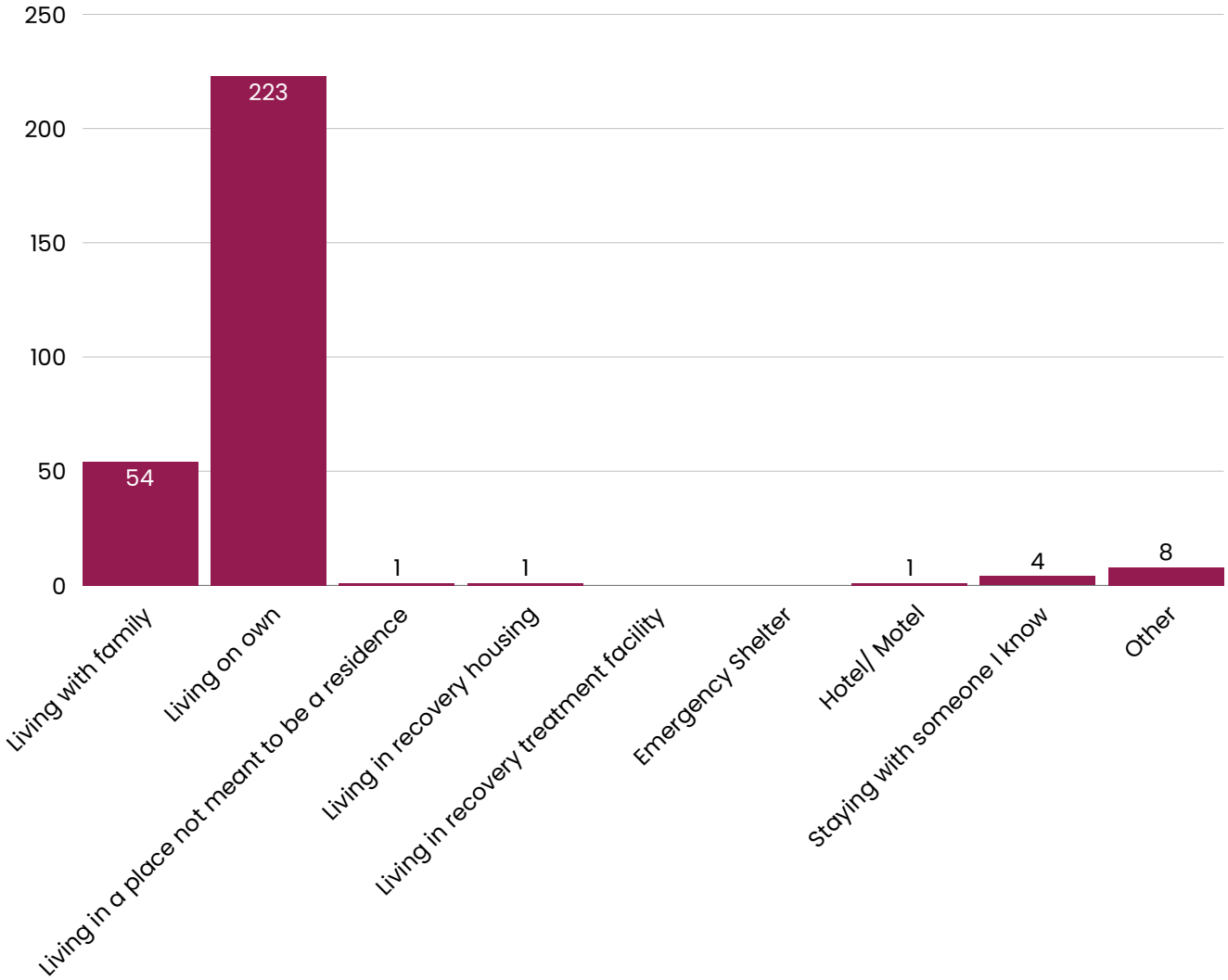


Community Survey Results



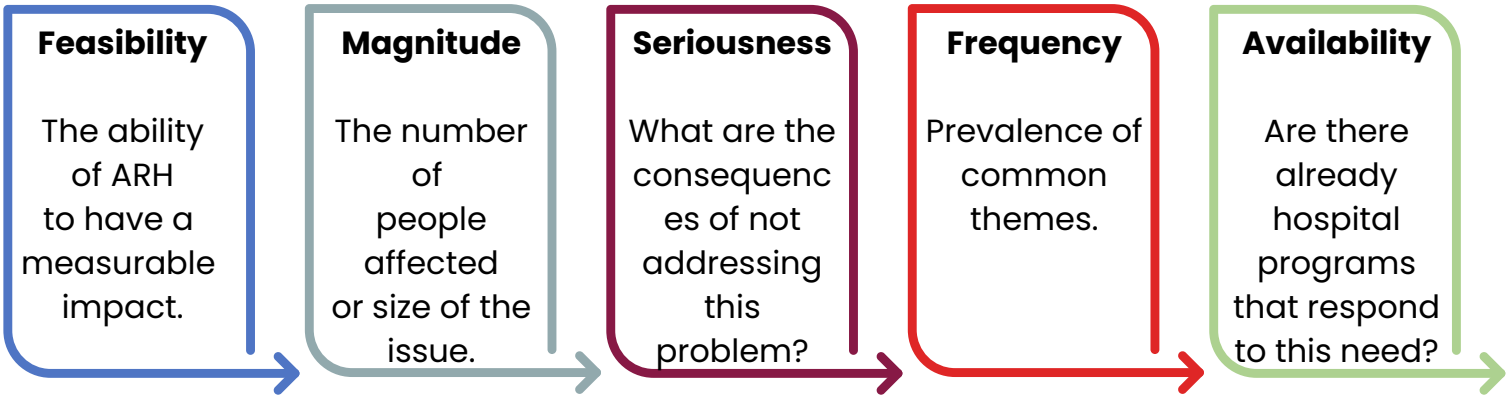
Have been told by a healthcare professional that they have high cholesterol.

What is your current living situation?



Health Needs Prioritization

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



Through this process, the Steering Committee synthesized and identified the top 5 health needs facing their community to be:

1. **Mental Health**
2. **Substance Use Disorder / Addiction**
3. **Healthy Lifestyles and Preventive Health**
4. **Lack of Specialists / Access to Care**
5. **Poverty and Meeting Basic Needs**

Implementation Plan

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

Goal: Address mental health issues through increased services, community education, and reduction of stigma

Key Strategies	• Grow outpatient behavioral health services, including:
	  ◦ Recruitment of additional therapists
	  ◦ Use of telehealth
	• Provide mental health programming targeting youth and parents/caregivers, such as:
	  ◦ Alcohol and SUD prevention
	  ◦ Suicide prevention and warning signs
	  ◦ Depression, anxiety, and coping strategies
	  ◦ Youth Mental Health First Aid
	  ◦ Social media impact
	  ◦ Targeted programs for grandparents raising grandchildren / relative care
	• Continue Mental Health First Aid trainings on-site for staff and community to include law enforcement and first responders
	• Provide resources and mental health services for staff to include:
	  ◦ Online counseling services
	  ◦ Workplace stress events
	  ◦ Explore possibility of green room / wellness space for staff
	• Provide mental health-related community screenings and events such as:
	  ◦ Partnership with Bluegrass Care Navigators to provide grief counseling to families of patients
	  ◦ Positive affirmation events targeting children and employees. Participants at facilities and on walking paths use sidewalk chalk to write encouragement and raise awareness of the importance of mental health
	  ◦ Anxiety and depression screenings
	  ◦ Educational events for area employers with mental health topics

Goal: Combat addiction (encompassing substance use disorder, tobacco, vaping, and alcohol) with multifaceted approaches

Key Strategies	• Continue to grow Peer Support Program. Peer support coaches are people who have been successful in the SUD recovery process and can help others that are still in active addiction. Peer Support coaches often respond to overdoses in the ED, refer people to treatment, provide resources for social needs, educate the community on SUD and overdose awareness, and more • Educate students and parents/caregivers about the dangers of alcohol, tobacco, nicotine, vaping, and illicit substances through targeted programming • Continue weekly Peer Recovery Self Help meetings that focus on developing like skills and coping strategies for people in SUD recovery process, including drug court treatment programming • Provide overdose awareness and education, along with trainings on Narcan and Naloxone, throughout the community • Partner with community organizations, councils and boards that support addiction prevention and treatment (HEAL, ASAP)

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 CancerScreening 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

Key Strategies	• 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 ARH Diabetes Education
	  ◦ Consider partnership with Cane Kitchen or Street Side Café for nutrition education or ARH-dietitian approved recipes on menus
	• 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 (Ex. Partner with KRADD to offer exercise classes for seniors, partner with UK extension offices to provide exercise programming for community: Bingocize, Yoga)
	  ◦ Offer gentle chair yoga classes throughout community
	  ◦ Continue partnership with Letcher County Farmers Market for incentivized walking program
	  ◦ Monetarily support events that encourage physical activity – bike races, community health and wellness days, 5k events
	  ◦ Consider implementing new programs such as:
	  ▪ "Hike with a Doc" or "Walk with a Doc" program
	  ▪ Swimming programs – lessons or pay for open swim
	  ▪ Sports camps at Cowan Community Center
	  ▪ Fall events that promote physical activity, such as a children's Halloween Dance or Spook Run 5k
	  ▪ Family Fun Fest incorporating health education, screenings, and children's activities
	  ◦ Seek funding partners for above programs (Partners for Rural Impact, Galen Nursing School)
	• 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
	  ▪ 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
	  ▪ Diabetes education and screening events

Goal: Grow services to better provide care and limit patient travel

Key Strategies	• Consider recruitment of specialists including Dermatology, GI, Endocrinology, Podiatry, Autism Care, Senior Care • Providing primary care in outlying communities with use of ARH Mobile Clinic • Move cardiac rehab to improve patient capacity • Development of pre-admission testing program to decrease surgery no-show rate and patient travel. • Streamline registration process for more efficient patient flow • Support services for caregivers of Autism patients – perhaps quarterly support group

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

Key Strategies	Access to affordable and clean housing, stable employment, quality education, and adequate food are vital for survival.
	• 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 Women's and Children's Shelter, Family Resource Youth Service Centers
	• 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
	• Provide primary care in outlying communities with use of ARH Mobile Clinic, thereby assisting patients with transportation barriers

Communication and Distribution Plan

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

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

Appendix A

Social Determinants of Health Infographic

LETCHER COUNTY, KENTUCKY

POPULATION: 20,423

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:** Letcher County 8.4% | Kentucky 3% | United States 2.4%
2	**Poverty Rate:** Letcher County 28.7% | Kentucky 16.5% | United States 11.5%
3	**Population 16+ in Labor Force:** Letcher County 43.6% | Kentucky 59.2 % | United States 63%
4	**Single Parent Households:** Letcher County 32.91% | Kentucky 31%
5	Households Spending at Least 30% Of Income on Housing: Letcher County 21.9% | Kentucky 23.9% | United States 22.8%
6	Population Without Access to Large Grocery Store: Letcher County *data not available* | Kentucky 19.8% | United States 21.7%
7	**Children Living in Food Insecure Households:** Letcher County 24% | 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:** Letcher County 90.4% | Kentucky 91.4%
2	High School Graduates Enrolled in Post-Secondary Education Within 6 Months of Graduation: Letcher County 47.31% | Kentucky 45.33%
3	**8th Grade Students with Proficient or Distinguished on Reading State Assessment:** Letcher County 46% | Kentucky 45%
4	**8th Grade Students with Proficient or Distinguished on Math State Assessment:** Letcher County 31% | Kentucky 37%
5	**Kindergarteners Ready to Learn:** Letcher County 10% | Kentucky 44%
6	**Students with an Individualized Education Plan (IEP):** Letcher County 28% | Kentucky 15%
7	**4th Grade Students with Proficient or Distinguished on Math State Assessment:** Letcher County 27% | Kentucky 47%
8	4th Grade Students with Proficient or Distinguished on Reading State Assessment: Letcher County 42% | 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: Letcher County 72.9% | United States 71.8%
2	Children Under 19 with Health Insurance Coverage: Letcher County 95.9% | Kentucky 96.1%
3	Number of TBI Emergency Department Cases: Letcher County 30 | Kentucky 11,249
4	Adults With Recent Preventative Care Visit: Letcher County 79.5% | Kentucky 80.7% | United States 74.6%
5	**Lung and Bronchus Incidence per 100,000 Population:** Letcher County 91.9 | Kentucky 84.4 | United States 54

6	**Mammography Use Among Women Aged 50-74:** Letcher County 64.7% | United States 77.8%
7	**STIs per 100,000:** Letcher County 122.3 | Kentucky 410.3 | United States 495.5
8	Colon and Rectum Cancer Incidence per 100,000: Letcher County 47.6 | 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: Letcher County 54% | Kentucky 51%
10	Population Under 65 Without Health Insurance: Letcher County 7.3% | Kentucky 6.7% | United States 9.3%
11	Population With Limited English Proficiency: Letcher County 0.0-1.9% | 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: Letcher County 51.9 | Kentucky 225.6 | United States 204.5
2	Population with Access to Broadband: Letcher County 98.3% | Kentucky 97% | United States 96.7%
3	**Percent of County Using SNAP:** Letcher County 25% | Kentucky 16.3
4	Air Quality Hazard: Letcher County 0.45 | Kentucky 0.44 | United States 0.34
5	Vehicle Crash Fatality Rate per 100,000: Letcher County 32.6 | Kentucky 51.5 | United States 17.5
6	**Population Within ½ Mile of Walkable Destinations:** Letcher County 11.2% | Kentucky 33.9% | United States 34%
7	Walkability Index Score: Letcher County 4.1 | Kentucky 7.2 | United States 6.1
8	Asthma Prevalence Among Adults 18+: Letcher County 12.7% | Kentucky 11.5% | United States 9.7%
9	**Adult Smoking Rate:** Letcher County 31.7% | Kentucky 23.9% | United States 24.3%
10	Deaf and Hard of Hearing Population: Letcher County 3,238 | Kentucky 705,533
11	**Prevalence of People with Disabilities:** Letcher County 31% | Kentucky 21.1%

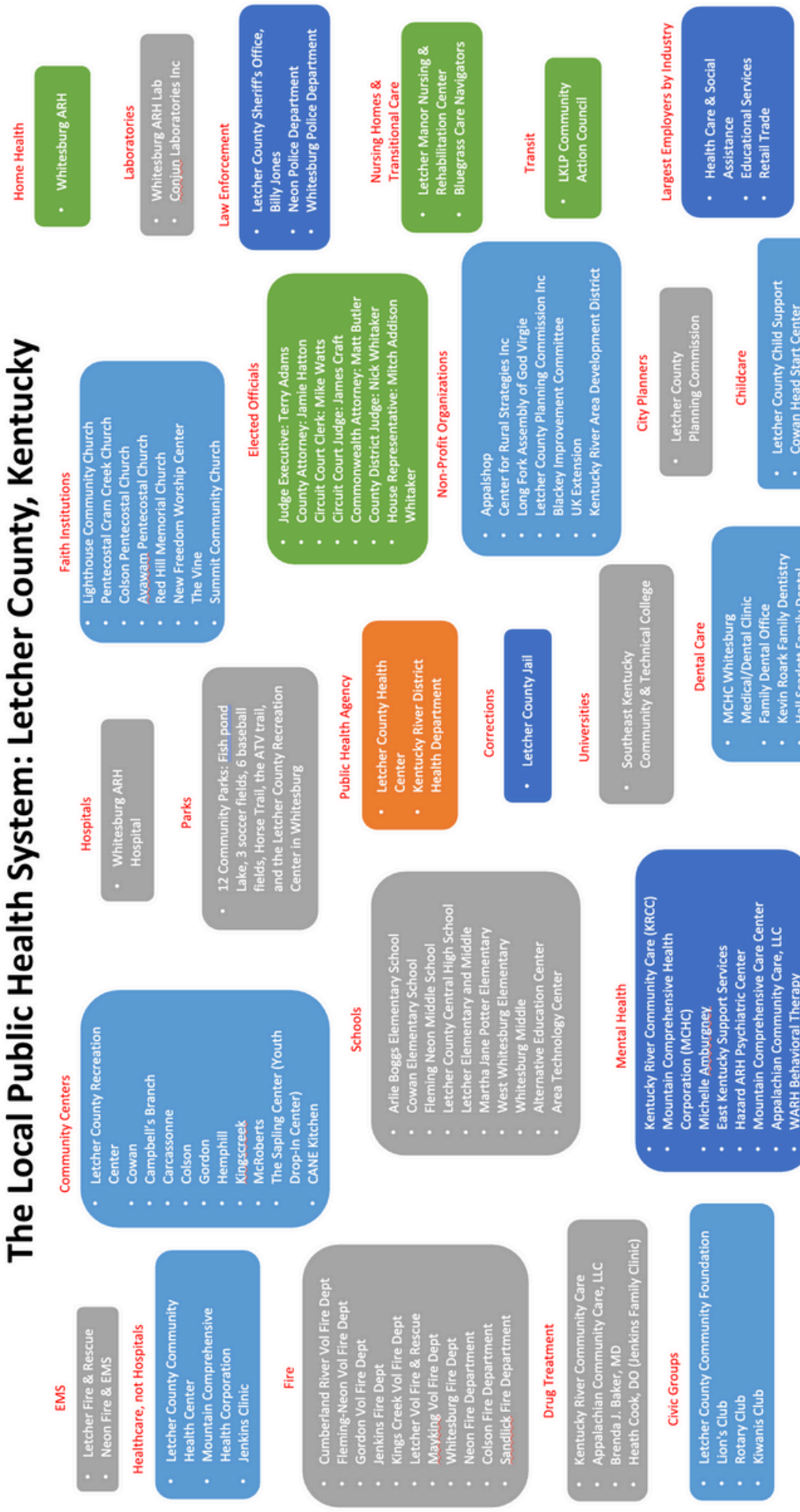
SOCIAL AND COMMUNITY CONTEXT: INCREASE SOCIAL AND COMMUNITY SUPPORT

1	Youth Incarcerated in the Juvenile Justice System per 1,000 Youth: Letcher County 7 | Kentucky 13.2
2	Census Self- Response Rate: Letcher County 60.1% | Kentucky 63.5% | United States 65.8%
3	**Households With a Computer:** Letcher County 85.2% | 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 Letcher 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 Letcher County residents face, but also the complex systems and context you operate within. With this information, we are able to create a more effective and comprehensive implementation plan to address these issues. Thanks to your dedication, we are able to work towards improving your selected health priority issues to create lasting, positive change.

TEAM UP
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Approval

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

BOT Chairperson Signature

7/28/25

Date