# 2025 Community Health Needs Assessment

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- About our Community
- Key Health Indicators
- Community Input
- Prioritized Health Needs

# UK King's Daughters 2025 CHNA

Established in 1899 by a group of community leaders who saw a need for a hospital to serve the residents of Ashland, Kentucky and the surrounding areas, UK King's Daughters operated as an independent, non-profit healthcare organization until Dec. 2022, at which time it became part of the University of Kentucky.

Throughout its 125-year history, King's Daughters has remained committed to providing high-quality healthcare services to all who seek care. We listen carefully and continuously to the feedback of patients, families, and community organizations and adjust our efforts to better meet the community's needs.

As a healthcare organization, we recognize we have a duty not only to the people and communities of today, but also the people of tomorrow. In fulfillment of this, UK King's Daughters engages in or supports strategic planning, infrastructure improvement, workforce development, and primary, secondary, post-secondary, and graduate education.

We provide an array of programs to promote health and wellness throughout our region, including free and reduced-cost screening programs focusing on heart health, vascular health, cancer, stroke prevention, and bone and joint health. We offer programs to educate and reduce tobacco use and cessation; CPR training; substance use/abuse prevention and recovery; infant and child health and safety; and services to meet the needs of the elderly and/or homebound, including Meals on Wheels and our Transportation Ministry. Over the past five years, our organization has raised funds to purchase and donate more than 150 automated external defibrillators (AEDs) to first responders and non-profit organizations throughout our region to ensure this life-saving equipment is available when it is needed.

Members of our Leadership Team are active in dozens of community boards and organizations, helping us understand and stay connected to the needs outside the walls of the medical center. We value our relationships with community and public service organizations as these provide a depth of understanding and insight that would be difficult to achieve without them.

Our triennial Community Health Needs Assessment (CHNA) and CHNA Implementation Plan provide us with the opportunity to better understand the changing landscape of health, work with community leaders, and design and implement programs to address identified needs in alignment with King's Daughters' Mission, capabilities, and resources.

For the purposes of the 2025 CHNA, we defined our community as Boyd, Carter and Greenup counties in Kentucky and Lawrence County in Ohio. These four counties represent King's Daughters Primary Service Area and the majority of annual discharges.

# UK King's Daughters 2025 CHNA

The 2025 CHNA includes input from 204 community leaders representing public health, major employers, public schools, social services, hospital management, and medical professionals. Input from the broader community was obtained utilizing community forums, an online survey tool, and paper-and-pencil surveys. English and Spanish versions were available, and the general public was encouraged to participate through billboard, social media, and newspaper advertising.

Secondary data was assessed, including:

- Demographics (population, age, sex, race)
- Socioeconomic indicators (household income, poverty, unemployment, educational attainment)
- Key health indicators

Information gathered in the above steps was reviewed and analyzed to identify health needs and barriers such as accessibility, affordability, knowledge, and cultural beliefs. The process identified the following health issues, which are listed in alphabetical order.

- Access to health services/navigating healthcare services
- Childcare
- Chronic health conditions (high blood pressure, diabetes, heart disease, cancer, chronic pain)
- Poor Dental Health
- Food insecurity/lack of healthy nutrition
- Lack of affordable housing
- Mental health and depression
- Obesity
- Physical inactivity
- Poverty
- Preventative care
- Senior services
- Smoking/vaping
- Substance abuse
- Transportation
- Unintentional injury

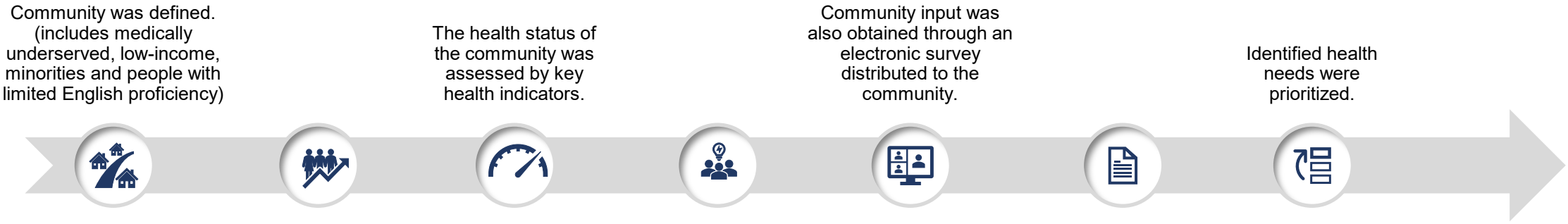
As part of the CHNA Implementation Plan, King's Daughters will identify areas within these priorities where it can effectively focus resources to achieve significant change.

# How the Assessment was Conducted

King's Daughters conducted a community health needs assessment (CHNA) to support its mission responding to the needs in the community it serves, to fulfill the requirements established by the Patient Protection and Affordable Care Act of 2010, and to comply with federal tax-exemption requirements. The goals were to:

- ✓ Identify and prioritize health issues in King's Daughters service area, particularly for vulnerable and under-represented populations.
- ✓ Ensure that programs and services closely match the priorities and needs of the community.
- ✓ Strategically address those needs to improve the health of the communities served by King's Daughters.

Based on current literature and other guidance from the U.S. Department of the Treasury, the following steps were conducted as part of King's Daughters CHNA:



# How the Assessment was Conducted

The community health needs assessment for King's Daughters supports the organization's mission *"To care. To serve. To heal."* This community health needs assessment was made possible because of the commitment toward addressing the health needs in the community. Many individuals across the organization devoted time and resources to the completion of this assessment.

King's Daughters would like to thank members of the 2025 CHNA Committee who provided leadership and oversight of the CHNA process and reporting.

- Sara Marks, President/CEO
- Elaine Corbitt, Executive Director, Communications/Community Engagement
- Scott Hill, Executive Director, Community Engagement
- Diva Justice, Director, Community Health
- Tom Dearing, Director, Integrated Communications
- Jennifer Sword, Data Analyst, Integrated Services

This community health needs assessment has been facilitated by Crowe LLP ("Crowe"). Crowe is one of the largest public accounting, consulting, and technology firms in the U.S. Crowe has significant healthcare experience including providing services to hundreds of large healthcare organizations across the country. For more information about Crowe's healthcare expertise visit www.crowe.com/industries/healthcare.

Written comments regarding the health needs that have been identified in the current community health needs assessment (CHNA) should be directed to:

**Elaine Corbitt**
Communications & Community Engagement
elaine.corbitt@kdmc.kdhs.us

# General Description of King's Daughters Medical Center

UK King's Daughters serves a catchment area of approximately 750,000 people in eastern Kentucky, southern Ohio, and western West Virginia. It includes the 455-bed Medical Center located in downtown Ashland, Ky. King's Daughters employs over 5,500 people, including more than 400 primary care and specialist physicians, advance practice providers and allied health professionals. King's Daughters provides intensive, intermediate and acute care services across a broad range of specialties including heart, vascular, orthopedics, oncology, gastroenterology, neurology, neurosurgery, maternity, pediatrics and neonatal care.

Services available at the UK KD Ashland Campus include:

- Comprehensive cardiac care, including cardiothoracic surgery, cardiac catheterization, structural heart, and electrophysiology. Our heart program has earned American College of Cardiology HeartCARE Center of Excellence designation continuously since 2022. We are a member of UK HealthCare's Gill Heart and Vascular Affiliate Network.
- Cancer Care & Infusion Services. Our program has earned Community Cancer Center designation from the Commission on Cancer of the American College of Surgeons and has been a member of UK HealthCare's Markey Cancer Network for more than 30 years.
- Emergency Services
- Gastroenterology/Digestive Health
- Orthopedics & Sports Medicine. Our program has recently earned Joint Commission Gold Seal of Approval Certification for advanced total hip and total knee replacement.
- Surgical Care, including board-certified physicians in general, breast, ENT, lung, neurosurgery, and vascular surgery.
- Inpatient Services, including acute, intermediate and intensive care; behavioral medicine; and pediatrics, maternity and NICU.

**Our Vision:**

- World-Class Care in our Communities

**Our Mission:**

- To Care. To Serve. To heal.

**Our iCARE Core Values:**

- Innovation
- Compassion
- Accountability
- Respect
- Excellence

# Community Overview

## Demographic Data

King's Daughters patients collectively come from a large geographic area. For purposes of this report, the community served by King's Daughters includes Boyd, Carter and Greenup counties in Kentucky, and Lawrence County, Ohio. Between July 1, 2023 and June 30, 2024, 74% of King's Daughters's inpatient discharges originated from patients residing in these four counties with approximately 28% of total patient discharges originating in Boyd County. To understand the profile of King's Daughters's CHNA community, demographic and health indicator data were analyzed for the population within the defined service area. Data was analyzed for the CHNA community as a whole as well each of the four counties within the CHNA community.

The CHNA community has a total population of 167,582 according to the U.S. Census Bureau American Community Survey 2019-2023 five-year estimates. The percentage of population by combined race and ethnicity is 93.9% Non-Hispanic White; 1.3% Non-Hispanic Black; 1.3% Hispanic or Latino; 2.8% Non-Hispanic multiple races; and 0.7% Non-Hispanic some other race. The demographic makeup of the CHNA community is shown below. The following socioeconomic indicators have significantly unfavorable rates for the CHNA community compared to state and national rates.

- Educational attainment is significantly lower for the CHNA community with 18% of people over the age of 25 obtaining a bachelor's degree or higher compared to 35% for the U.S. and 27% for the State of Kentucky.
- The labor force participation rate is significantly lower than state and national rates.
- The percentage of persons with disability is significantly higher than the state and national rates of 18% (Kentucky) and 13%, respectively.

**$89,008**
Average Family Income
U.S.: $130,215
KY: $103,036

**18%**
People 25+ with a Bachelor's Degree or Higher
U.S.: 35%
KY: 27%

**17.3%**
of people are living in poverty (28,406 persons)
U.S.: 12.4%
KY: 16.1%

**7.61%**
Adults age 18-64 without Health Insurance Coverage (7,222 persons)
U.S.: 11.24%
KY: 7.59%

**51%**
Population 16+ in Civilian Labor Force
U.S.: 64%
KY: 60%

**22%**
35,803 persons with a disability
U.S.: 13%
KY: 18%

# America's Health Rankings - Kentucky

America's Health Rankings evaluates a comprehensive set of health, environmental and socioeconomic data to illuminate both health challenges and successes; determine national and state health benchmarks; and enable stakeholders to take action to improve health. Annually, state-by-state analyses are prepared. Among the 50 states, Kentucky ranks 41st for health behaviors and 44th for health outcomes.

Below are highlights from Kentucky's 2023 report.

| Measures | | State Rank | State Value | U.S. Value |
|---|---|---|---|---|
| **Behaviors** | | **41** | **-0.662** | |
| **Nutrition and Physical Activity** | Exercise (% of adults) | 49 | 15.3% | 23.0% |
| | Fruit and Vegetable Consumption (% of adults) | 11 | 8.9% | 7.4% |
| | Physical Inactivity (% of adults) | 42 | 26.4% | 23.4% |
| **Sexual Health** | Chlamydia (Cases per 100,000 population) | 16 | 410.3 | 495.5 |
| | High-Risk HIV Behaviors (% of adults) | 16 | 5.5% | 5.7% |
| | Teen Births (Births per 1,000 females ages 15-19) | 45 | 22.3 | 13.9 |
| **Sleep Health** | Insufficient Sleep (% of adults) | 46 | 39.3% | 35.5% |
| **Tobacco Use** | Smoking (% of adults) | 46 | 17.4% | 14.0% |
| **Health Outcomes** | | **44** | **-0.514** | |
| **Behavioral Health** | Drug Deaths (Deaths per 100,000 population)* | 47 | 53.7 | 32.1 |
| | Excessive Drinking (% of adults) | 2 | 13.8% | 18.4% |
| | Frequent Mental Distress (% of adults) | 28 | 16.1% | 15.9% |
| | Non-medical Drug Use (% of adults) | 47 | 19.5% | 15.9% |
| **Mortality** | Premature Death (Years lost before age 75 per 100,000 population) | 44 | 13,356 | 9,478 |
| | Premature Death Racial Disparity (Ratio) | 6 | 1.2 | 1.6 |
| **Physical Health** | Frequent Physical Distress (% of adults) | 48 | 15.6% | 12.4% |
| | Low Birth Weight (% of live births) | 35 | 9.1% | 8.5% |
| | Low Birth Weight Racial Disparity (Ratio) | 11 | 1.8 | 2.1 |
| | Multiple Chronic Conditions (% of adults) | 49 | 17.0% | 11.2% |
| | Obesity (% of adults) | 40 | 37.7% | 33.6% |

## Strengths

- Low prevalence of excessive drinking
- High prevalence of colorectal cancer screening
- High supply of primary care providers

## Challenges

- High prevalence of multiple chronic conditions
- High occupational fatality rate
- High prevalence of insufficient sleep

# Access to Services

Data Tables

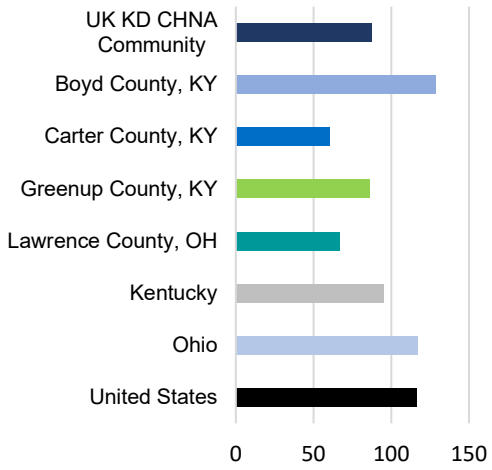
Limited access to care presents barriers to good health. The supply and accessibility of facilities and physicians affect access. As shown below, the rate of healthcare providers within King's Daughter's CHNA community depends on county of residence. Generally, Boyd County has higher rates of providers which are comparable to state and national rates. However, Carter, Greenup, and Lawrence counties have significantly fewer providers and rates that are unfavorable when compared to state and national rates, except for mental healthcare providers in Lawrence County.

The chart to the right reports the percentage of population that is living in a geographic area designated as a "Health Professional Shortage Area" (HPSA). Within the CHNA community, there are 66,235 people living in a HPSA. This represents approximately 39% of the total population.

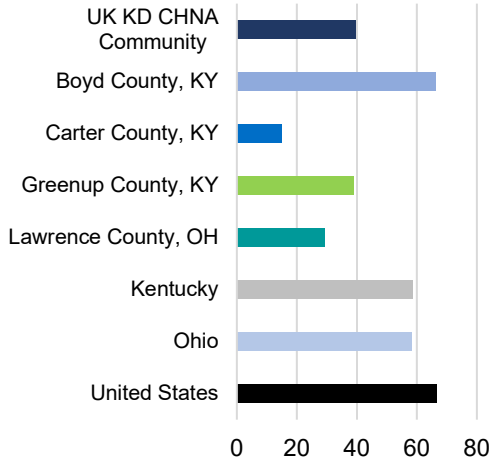
**Population Living in a Health Professional Shortage Area**

| | Total Population (ACS 2019 5-Year Estimates) | Population Living in an Area Affected by a HPSA | Percentage of Population Living in an Area Affected by a HPSA |
|---|---|---|---|
| **UK KD CHNA Community** | **170,580** | **66,235** | **38.83%** |
| Boyd County, KY | 47,682 | 17,100 | 35.86% |
| Carter County, KY | 27,159 | 12,976 | 47.78% |
| Greenup County, KY | 35,555 | 11,912 | 33.50% |
| Lawrence County, OH | 60,184 | 24,247 | 40.29% |
| Kentucky | 4,449,052 | 1,390,830 | 31.26% |
| Ohio | 11,655,397 | 1,839,506 | 15.78% |
| United States | 324,697,795 | 72,230,619 | 22.25% |

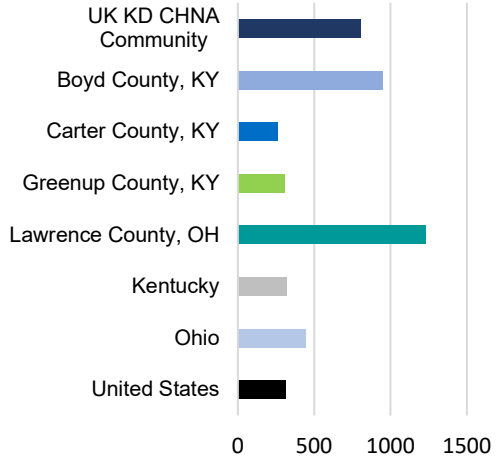
**148**
## Primary Care Providers
Rate per 100,000 Population




**67**
## Dental Health Providers
Rate per 100,000 Population




**1,355**
## Mental Health Providers
Rate per 100,000 Population




**76.6%**

of adults over age 18 had a routine checkup in the past year. *

**Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System- 2022.*

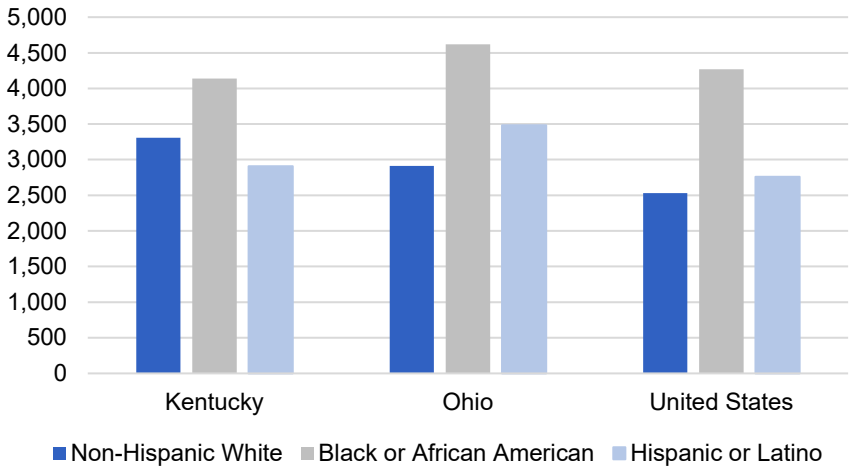
# Clinical Preventive Services

Rates of morbidity, mortality, and emergency hospitalizations can be reduced if community residents access services such as health screenings, routine tests, and vaccinations. Prevention indicators can call attention to a lack of access or knowledge regarding one or more health issues and can inform program interventions.

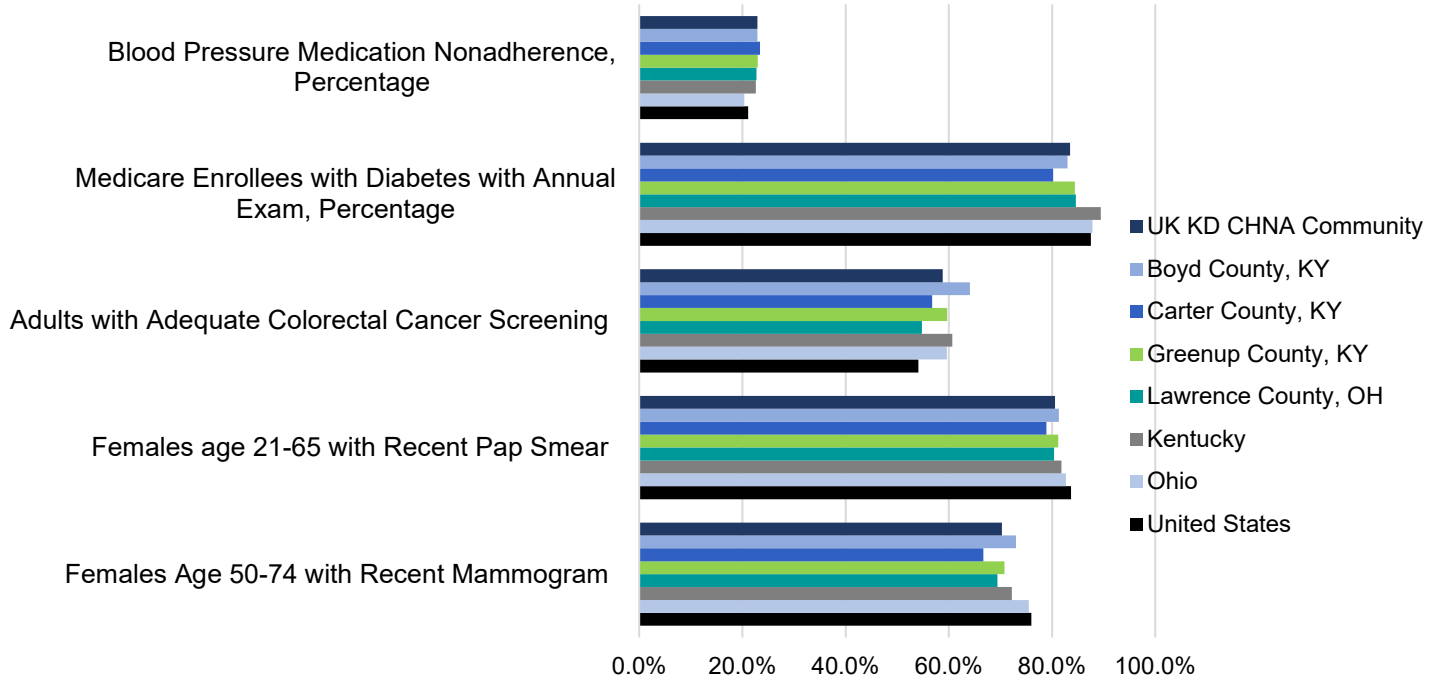
**35.9%** of women 65+ in the community are up-to-date with core preventative services compared to the national benchmark of 37.4%.

**43.3%** of men 65+ in the community are up-to-date with core preventative services compared to the national benchmark of 44.0%.

## Preventable Hospitalization Rate by Race and Ethnicity




## Preventive Services




Preventable hospitalizations include hospital admissions among Medicare beneficiaries for one or more of the following conditions: diabetes with short-term complications, diabetes with long-term complications, uncontrolled diabetes without complications, diabetes with lower-extremity amputation, chronic obstructive pulmonary disease, asthma, hypertension, heart failure, bacterial pneumonia, or urinary tract infection.

- The rate for preventable hospitalizations in the CHNA Community is unfavorable to state and national rates (4,821 per 100,000 population for the CHNA Community compared to 3,336 and 2,566 for Kentucky and National benchmarks, respectively).
- Preventable hospitalizations are significantly higher for Black or African American residents compared to Non-Hispanic White and Hispanic or Latino populations.
- Boyd County reports the highest rate of preventable hospitalizations among Medicare beneficiaries at 5,221 preventable hospitalizations per 100,000 Medicare beneficiaries. The rate for preventable hospitalizations for African American population is 7,788 in Boyd County.

Data Tables

# Health Outcomes & Mortality

King's Daughters community has a significant number of adults who have been diagnosed with chronic illnesses. The prevalence of chronic diseases in the King's Daughters community is fairly consistent with state rates and unfavorable to national percentages. Over 35% of the population, 47,114 adults, have high blood pressure.

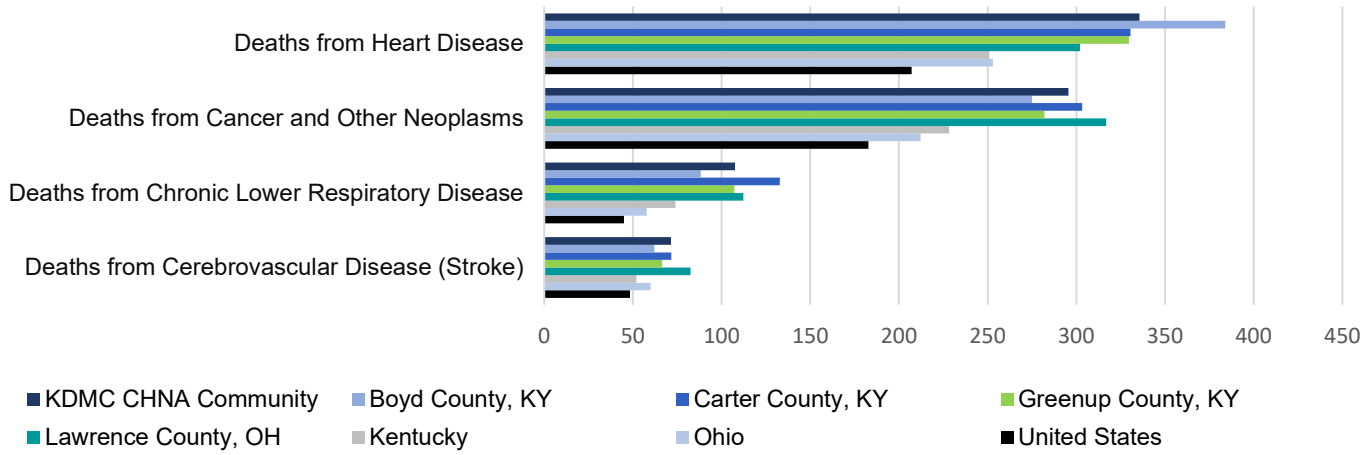
Coronary heart disease, cancer, lung disease and stroke are leading causes of death in the United States. Adjusted death rates for the community are unfavorable to state and national rates with deaths from heart disease, cancer and respiratory disease being significantly higher than national rates. Males have higher rates for deaths from heart disease and cancer compared to females.

Over 20% of the population age 65+ have poor dental health which means they have lost all of their natural teeth because of tooth decay or gum disease. Carter County has the highest percentage of poor dental health.

Data Tables

## Leading Causes of Death

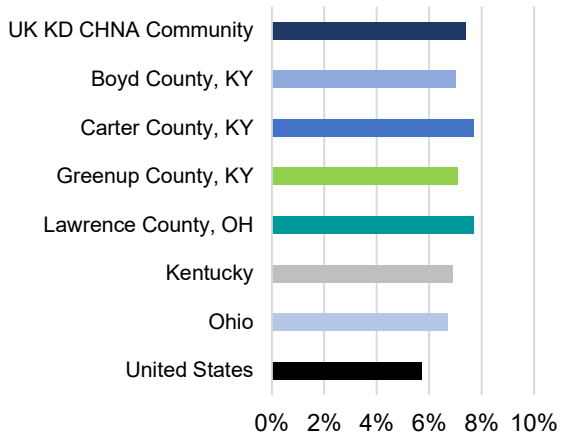
(Crude Death Rate - Per 100,000 Population)




**12,467**

## Adults Diagnosed with Coronary Heart Disease

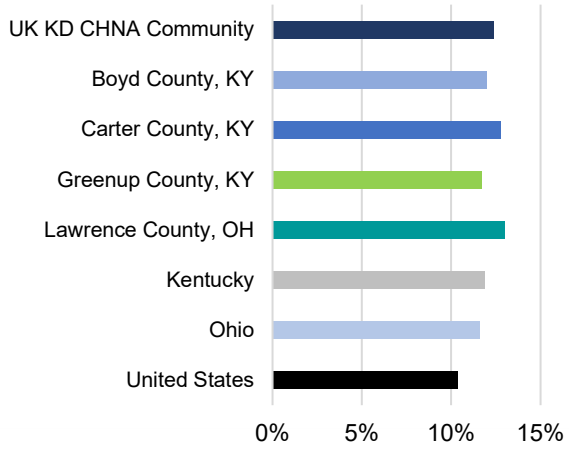
Age-Adjusted Percentage




**16,273**

## Adults with Diagnosed Diabetes

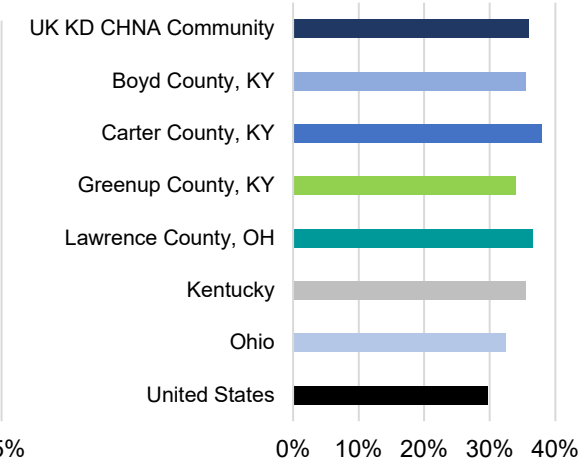
Age-Adjusted Percentage




**47,114**

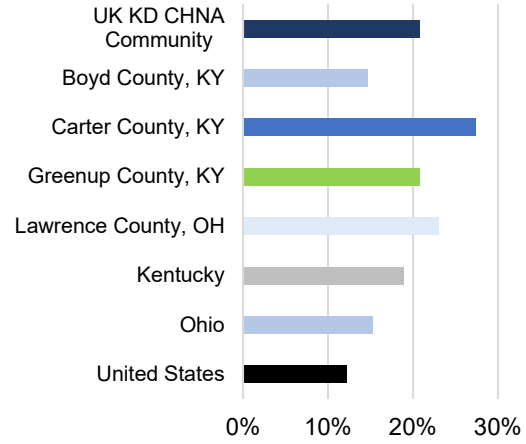
## Adults with High Blood Pressure

Age-Adjusted Percentage




## Adults Age 65+ with Poor Dental Health

Age-Adjusted Percentage



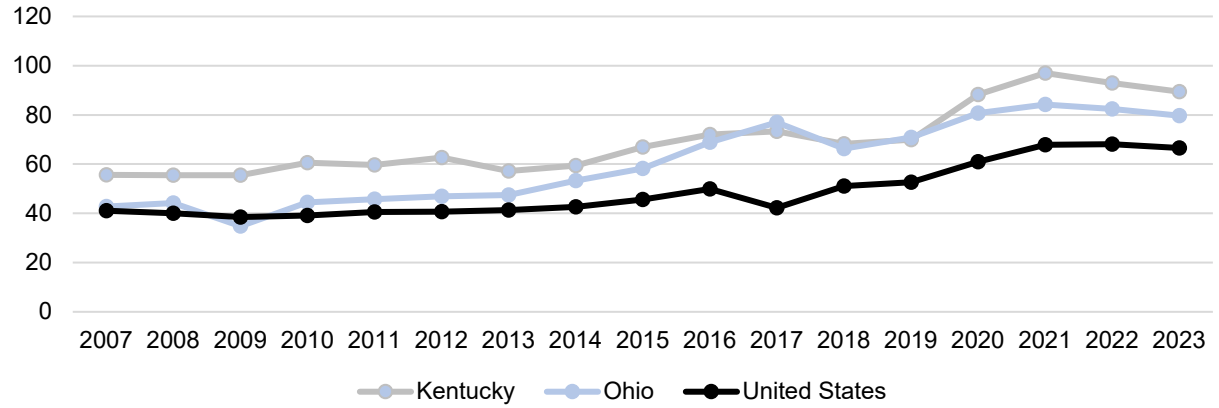
# Injury and Violence

Crime rates are very different in the CHNA Community, depending which county you live in. Carter and Greenup counties have very low crime rates compared to state and national rates. Boyd and Lawrence counties have have higher crime rates with Boyd County having crime rates consistent with state and national rates.

The five-year average rate of death due to unintentional injury (accident) for the King's Daughters CHNA community is nearly double the national average rate. This indicator is relevant because accidents are a leading cause of death in the United States. Deaths due to unintentional injury significantly increased starting in 2019 but have trended downward in the last few years.

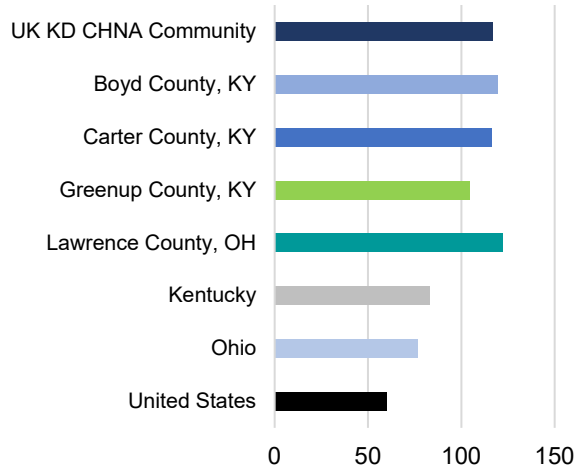
**Data Tables**

## Unintentional Injury (Accident) Mortality, Age-Adjusted Rate (Per 100,000 Pop.), Yearly Trend



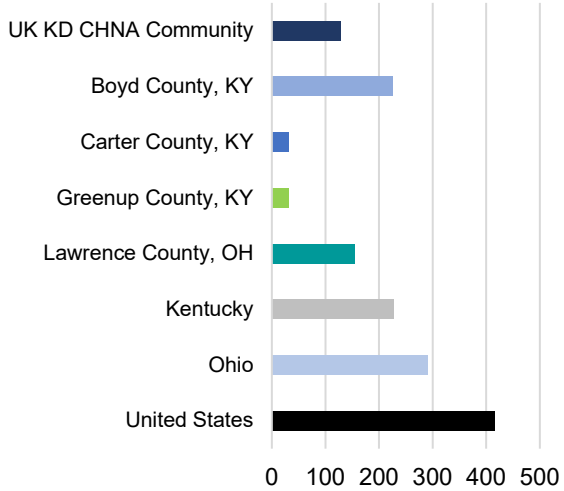

## Mortality - Unintentional Injury

Rate per 100,000 Population



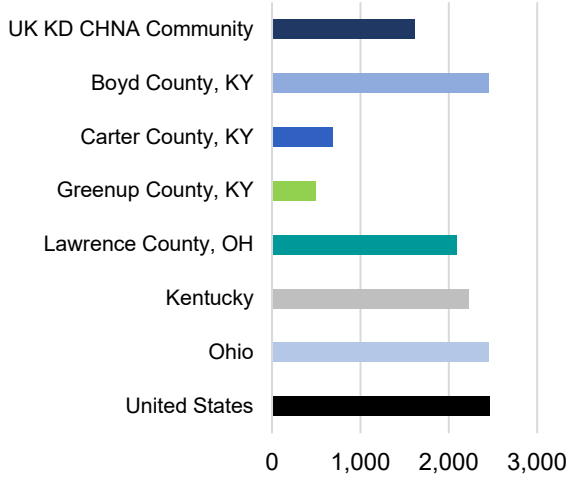

## Violent Crimes Annual Rate

Rate per 100,000 Population




## Property Crime Annual Rate

Rate per 100,000 Population



# Maternal, Infant, and Child Health

Engaging in prenatal care decreases the likelihood of maternal and infant health risks such as low birth weight. Rates for low birth weight are comparable to state and national rates with Lawrence County having the highest rate for low birth weight at 10%. Rates for low birth weight and infant mortality are significantly higher for the Non-Hispanic Black population.

In the report area, of the 4,878 total female population age 15-19, the 5-year average teen birth rate is 9.84 per 1,000, which is favorable to state rates in Kentucky and Ohio and consistent with the national rate. Lawrence County's teen birth rate is significantly higher at 27.81 per 1,000.

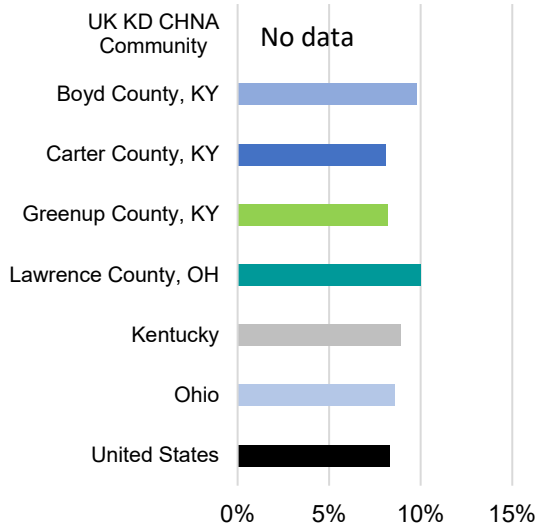
15.6% of women giving birth in the CHNA community had no prenatal care in the first trimester of pregnancy.

Approximately 20% of women giving birth in the CHNA community smoked during pregnancy.

**Data Tables**

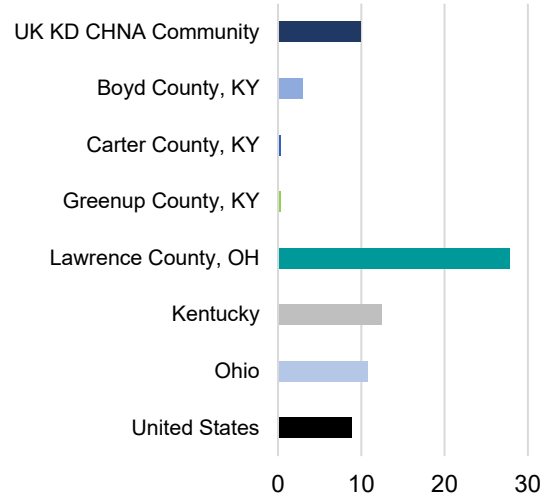
## Low Birth Weight

Percentage (2016-2022 Average)

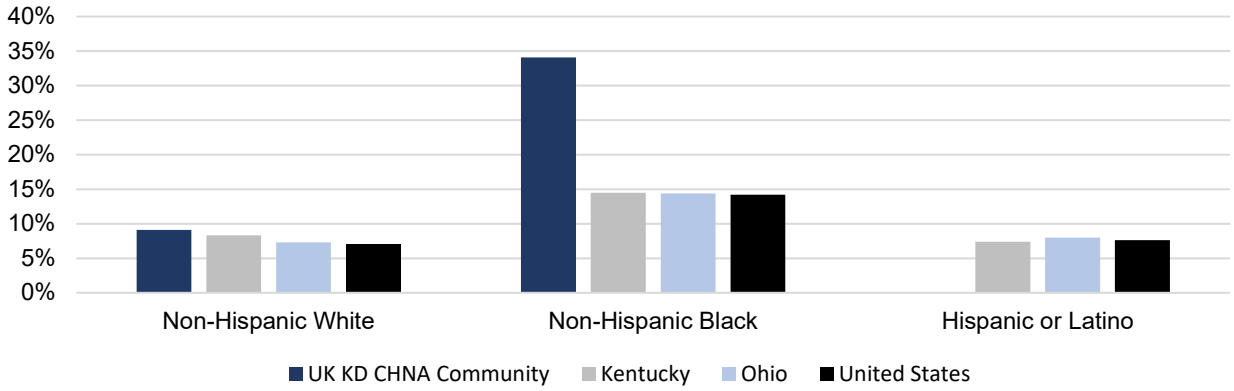



## Teen Birth Rate

Rate per 1,000 Teens
(2019-2023 Average)




## Low Birth Weight, Percent by Race / Ethnicity




**Women giving birth in the UK KD CHNA Community receiving prenatal care in the 1st Trimester.**

| | |
|---|---|
| **UK KD CHNA Community** | **84.4%** |
| Kentucky | 78.6% |
| Ohio | 77.9% |
| United States | 77.6% |

**Women giving birth in the UK KD CHNA Community who smoked during pregnancy.**

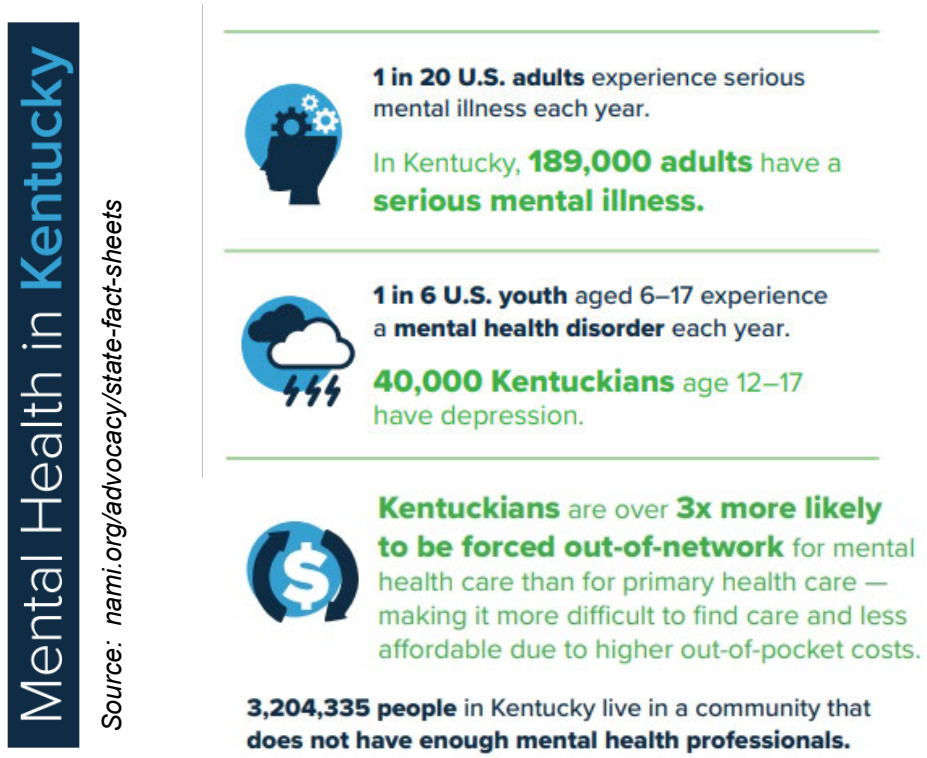
| | |
|---|---|
| **UK KD CHNA Community** | **19.8%** |
| Kentucky | 12.5% |
| Ohio | 9.6% |
| United States | 4.6% |

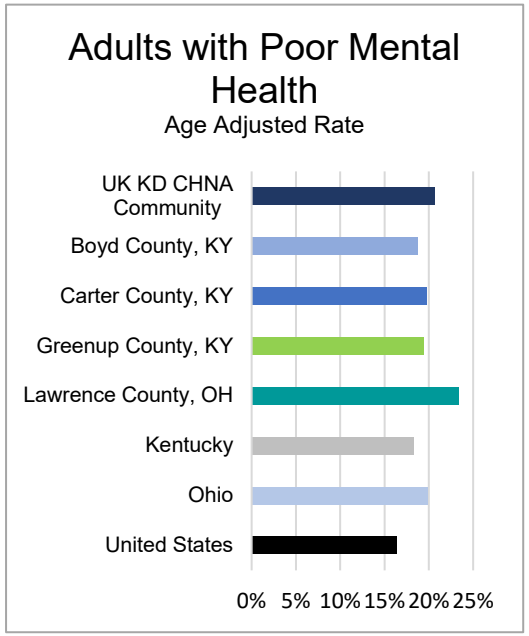
# Mental Health

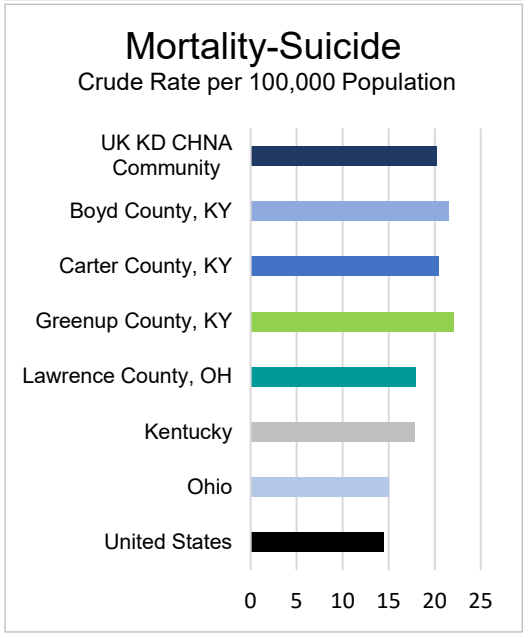
According to the National Alliance on Mental Illness, 189,000 adults in Kentucky have a serious mental illness and approximately 40,000 youth have depression.

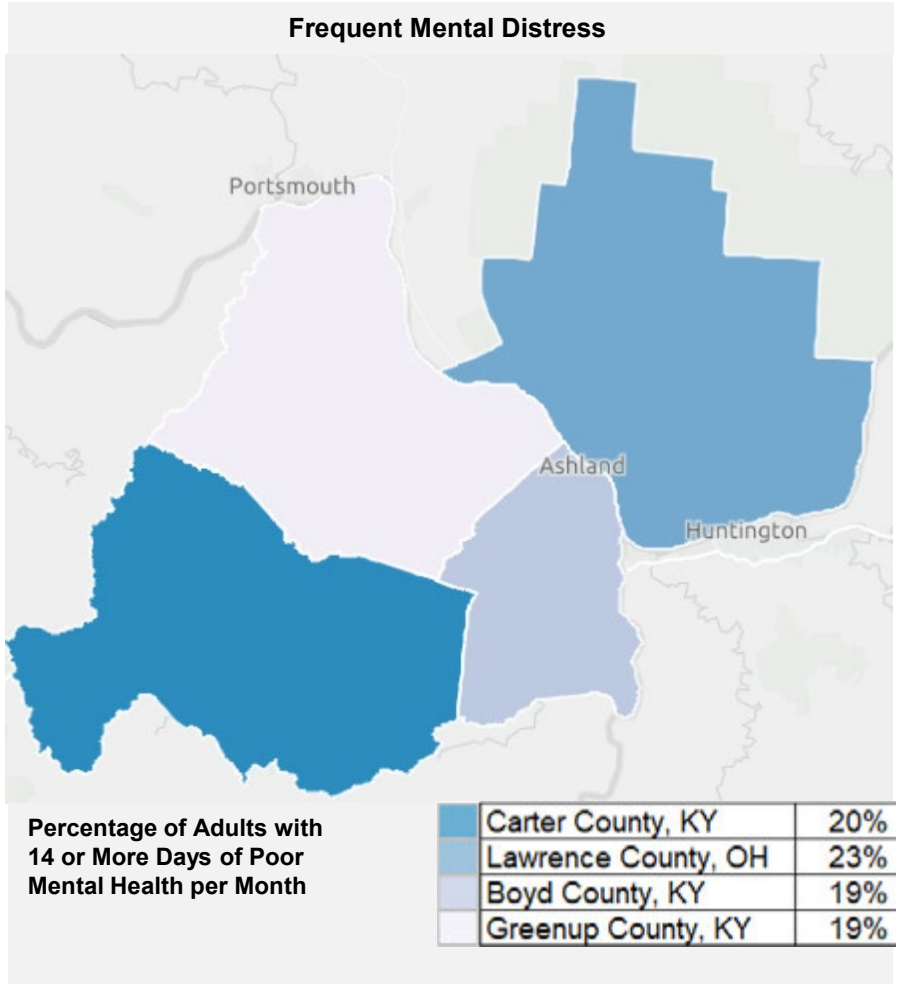
The map to the right reports the percentage of adults (ages 18 years and older) in the CHNA community reporting 14 days or more of poor mental health per month by county. In the CHNA community, it is estimated that approximately 27,000 adults have frequent mental distress.

**Data Tables**



# Nutrition, Physical Activity and Obesity

Healthy diets and physical activity contribute to healthy lifestyles and overall well-being. These factors are relevant because current behaviors are determinants of future health and well-being and these indicators may be linked to significant health issues, such as obesity and poor cardiovascular health.

- Over 18% of the population (30,790 persons) live with food insecurity in the CHNA community. The rate of food insecurity is higher for children and is 23.26%, which is approximately 8,400 children in the CHNA community.
- Approximately 50,000 persons, or 39% of adults, are obese in the CHNA community. Obesity rates have increased by 60% over the last 15 years.
- 28.3% of adults, age 20 and older, self-report no active leisure time physical activity. This is significantly higher than the national rate of 19.5%.
- Approximately 59% of public-school students in the CHNA Community are eligible for free or reduced-price lunch programs, which is higher than the U.S. rate of 54%.

The map to the right reports the percentage of the low-income population with low food access. Low food access is defined as living more than 1 mile (urban) or 10 miles (rural) from the nearest supermarket or large grocery store. The low-income population with low food access in the community is estimated to be 34,128 persons with Boyd County reporting the highest percentage (34.2%) of low-income population with low food access.

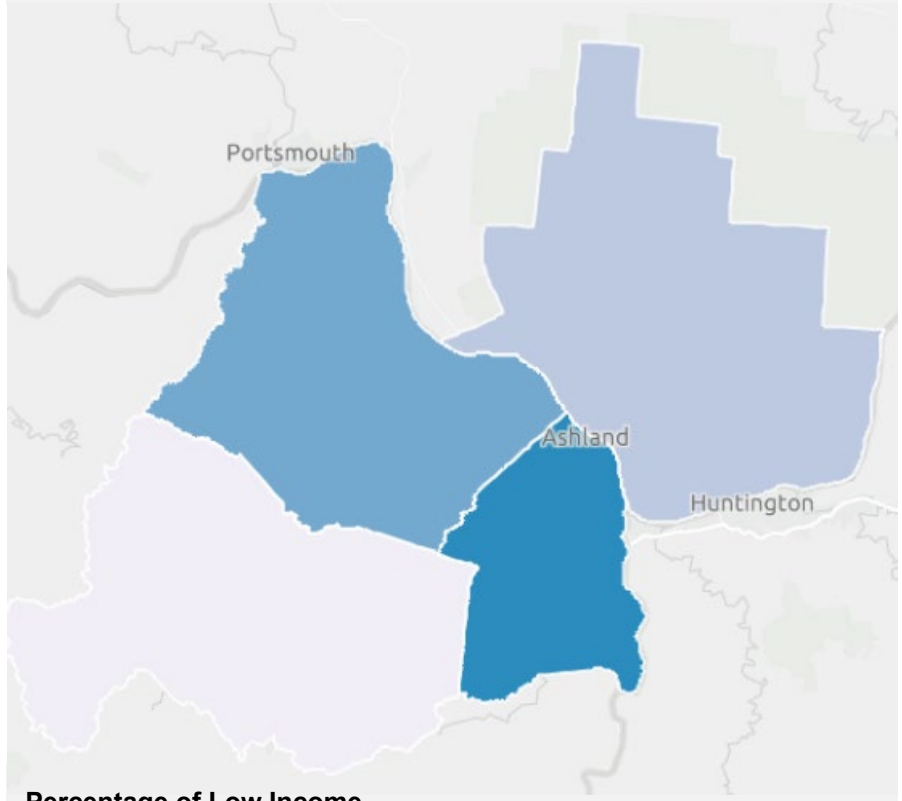
Data Tables

**30,790**
Food Insecure Population

**49,655**
Adults with BMI>30 (Obese)

**11,938**
Students Eligible for Free or Reduced- Price Lunch

**Population with Limited Food Access, Low Income Percent by County**




**Percentage of Low Income Population with Low Food Access**

| | |
|---|---|
| Boyd County, KY | 34% |
| Greenup County, KY | 20% |
| Lawrence County, OH | 12% |
| Carter County, KY | 8% |

# Physical Environment

The structure of housing and families and the condition and quality of housing units and residential neighborhoods are important because housing issues like overcrowding and affordability have been linked to multiple health outcomes, including infectious disease, injuries, and mental disorders.

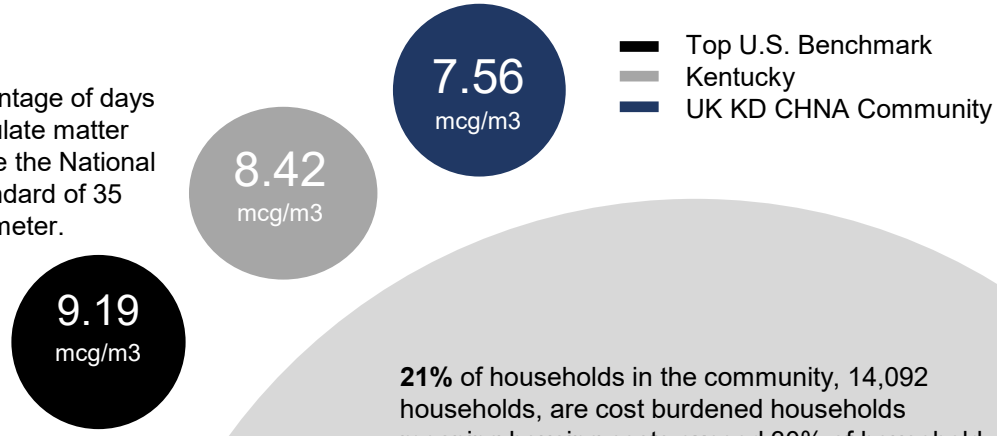
Within the community, 14,092 households, or 21%, have housing costs that are 30% or more of the total household income and are classified as "cost-burdened households."

A large number of seniors in the community, age 65+, live alone. This is important because older adults who live alone may have challenges meeting basic needs, including health services.

**Data Tables**

## Air Pollution-Fine Particulate Matter

Air pollution is the percentage of days per year with fine particulate matter 2.5 (PM2.5) levels above the National Ambient Air Quality Standard of 35 micrograms pers cubic meter.



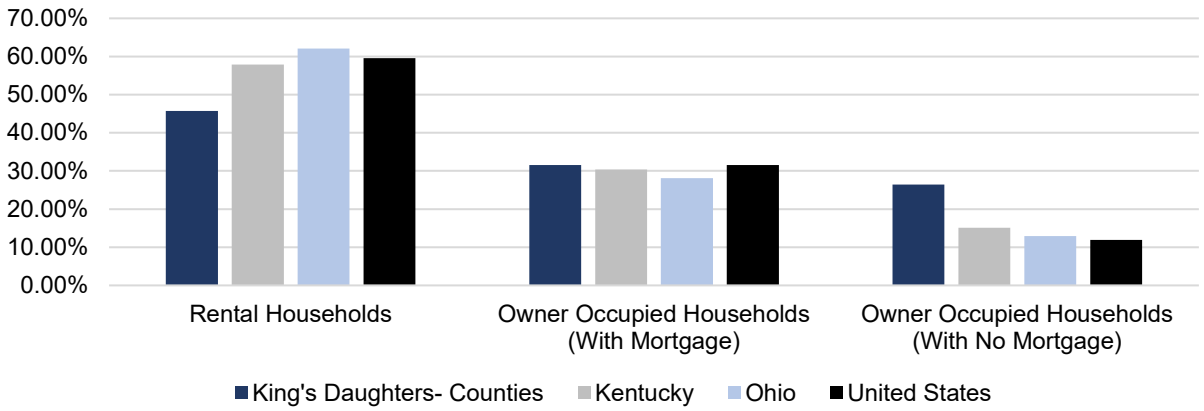

**21%** of households in the community, 14,092 households, are cost burdened households meaning housing costs exceed 30% of household income. **6,966** households have housing costs that **exceed 50%** of household income.

It is estimated that **16.5%** of households (10,938 households) within the community have no or slow internet.

**23%** housing units have one or more substandard conditions.

**10,185 Seniors** (age 65+) live alone.

## Severely Cost-Burdened Households



# Substance Use Disorder

The percentage of adults in the CHNA community who currently smoke is 20.7% and is unfavorable to state and national benchmarks. This indicator is relevant because tobacco use is linked to leading causes of death, such as cancer and cardiovascular disease.

Counties in the Appalachian region of the eastern United States have been disproportionately impacted by the epidemic of addiction. The death rate for opioid overdoses in Appalachian counties is 75% higher than non-Appalachian counties. The death rate for opioid overdoses in the CHNA community is more than triple the national rate.

Deaths of despair include deaths due to intentional self-harm (suicide), alcohol-related disease, and drug overdose. The rate for deaths of despair is two times the national rate, with Boyd County reporting the highest rates.

**Data Tables**

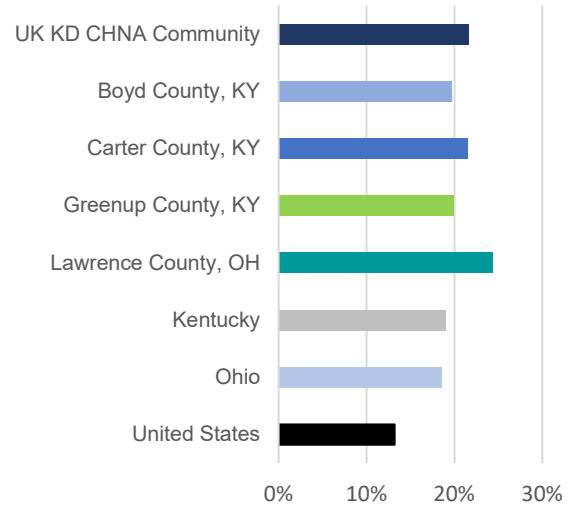
## *Behavioral Health Barometer*

**2021-2022 National Survey on Drug Use - Youth Substance Abuse**

| | 2021-2022 | | 2017-2019 | |
|---|---|---|---|---|
| | Kentucky | United States | Kentucky | United States |
| Cigarette Use Among youth Aged 12-17 | 1.77% | 1.45% | 6.00% | 2.70% |
| Marijuana Use among Youth Aged 12-17 | 4.54% | 6.25% | 6.00% | 6.80% |
| Alcohol Use among Youth Aged 12-17 | 5.87% | 7.03% | 10.70% | 9.40% |
| Illicit Drug Use among Youth Aged 12-17 | 6.42% | 7.44% | 6.50% | 8.20% |

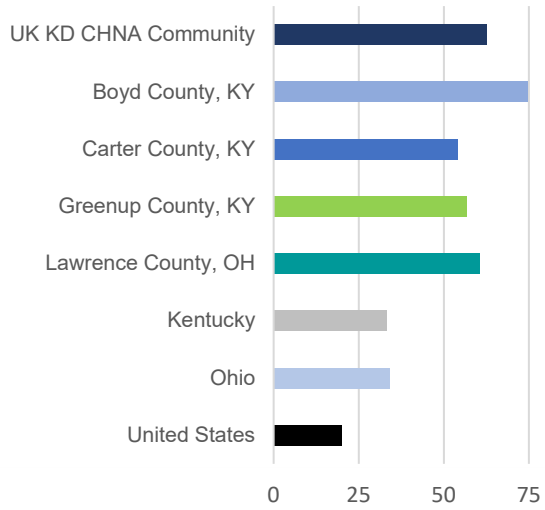
### Adult Current Smokers

Percentage (Crude)



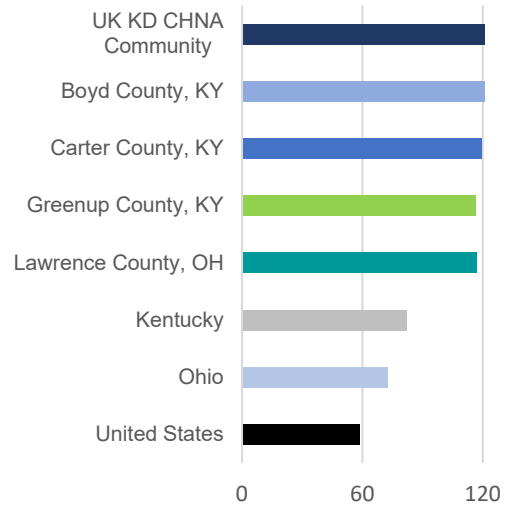

### Mortality-Opioid Overdose

Rate per 100,000 Population (Crude)




### Deaths of Despair

Rate per 100,000 Population (Crude)



# Community Forums

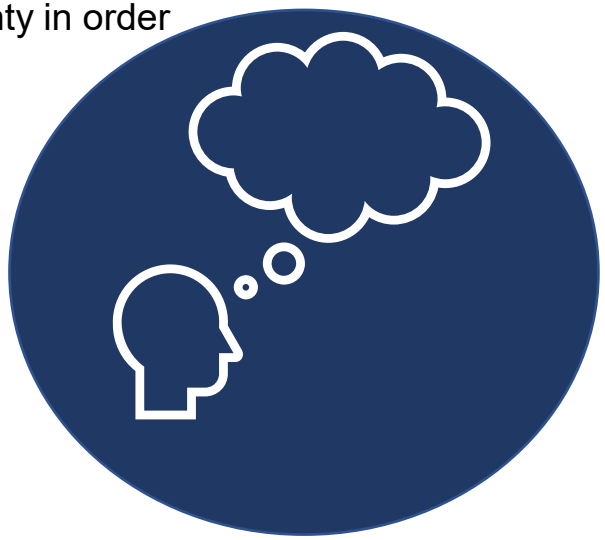
Community forums were conducted in each of the counties in the CHNA Community during January and February 2025. Each attendee was selected and encouraged to attend so the hospital could solicit input from the health department, community members, and members of underserved, low-income and minority populations.

Health department leaders provided relevant information to attendees and county health statistics were discussed as part of the community forums. The three questions below were discussed among the attendees and a content analysis was conducted for each question identifying the top needs that emerged.

1. What does a healthy county look like?
2. What are the county's biggest needs in order to be the healthy county that we envisioned?
3. What are the top health needs in our county?

The top needs that were identified were all listed out and each attendee had three votes to cast on what they believe was the biggest health need in the county. The items listed on the following page are the top needs by county in order of highest votes received.

| County | Date | Number of Participants |
|---|---|---|
| Boyd County, KY | January 23, 2025 | 29 |
| Carter County, KY | February 5, 2025 | 51 |
| Greenup County, KY | January 15, 2025 | 46 |
| Lawrence County, OH | February 25, 2025 | 23 |



# Community Forums

## What does a healthy county look like?

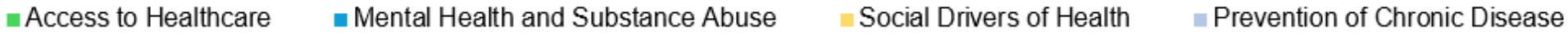
| Boyd, KY | Carter, KY | Greenup, KY | Lawrence, OH |
|---|---|---|---|
| More Dentists for All | Having an ER or Hospital | Access to Public Transportation | Youth Opportunities/Activities that are affordable |
| Access to Public Transportation | YMCA | Mental Health Checkups, annual screenings, stigma training, | Employment opportunities |
| Parenting Classes | Knowledge of Resources in the Community | Address general dental issues and in schools | Healthy eating |
| Mental Health Checkups, annual screenings, stigma training | Therapy for Kids | Safe housing for everyone | Education on drug use |
| Inpatient Mental Health | Homeless Shelter | Activities for the youth/teens | Social connectedness opportunities |
| Mental Health for Geriatric | Adult Day Care | Education out to everyone about resources available | Access to Public Transportation |
| Holistic Health | Access to Public Transportation | Access to healthy and affordable food | Strong faith community |
| End to Generational Poverty | Food Access | Low unemployment rate/higher median income | Obesity prevention programs/healthy habits |
| Access to Services | Dentist accepts all Insurance | Better access to care | Produce perks programs |

Access to Healthcare  Mental Health and Substance Abuse  Social Drivers of Health  Prevention of Chronic Disease

# Community Forums

## What are the county's biggest needs in order to be the healthy county that we envisioned?

| Boyd, KY | Carter, KY | Greenup, KY | Lawrence, OH |
|---|---|---|---|
| Mental Health Youth | Collaboration in the community | Transportation | Funding |
| Jobs/Economic Development | Education and better use of services provided | Dental Care for Medicaid/kids along with incentives for dental care, mobile dental, and dental insurance | Transportation |
| Access to Dentists for all | Better Infrastructure (Internet, technology, etc.) | Better access to care | Broadband expansion |
| Transportation | Economic and Budget | Mental Health Screenings | Positive mindset |
| Macro Plan/Vision | Youth Center with Activities and Services | Education on Vaping | Collaborative projects |
| Strengthen Families | Grant Writer | HIV Resources | Communication on events and programs |
| Social Work in Law Enforcement | Economic Developer | Food Stores | Resident participation |
| Reduce Mental Health Stigma | Better Jobs | Teen Events | Resources |
| Access to Healthy Activities/Tracks, etc. | Community Support | | Senior Services |



# Community Forums

## What are the top health needs in our County?

| Boyd, KY | Carter, KY | Greenup, KY | Lawrence, OH |
|---|---|---|---|
| Transportation | Emergency Department | Transportation | Mental Health and Substance Abuse |
| Mental Health (resources in school, and reducing stigma in regard to mental health) | YMCA | Mental Health (specifically standardized mental health screening for youth, pediatric mental health, and reducing stigma in regard to mental health) | Comprehensive School Health Programs |
| Access to Dental | Jail/Inmate Resources (Mental Health, parenting, religious resources) | Curb Influence of Social Media on kids and educate parents | School Health campaigns/mental health |
| Proactive Wellness | Resources List/Awareness | Dental | Access to care |
| Sexual/Dating Violence Education | Senior Services | Community Resource Education sent out on what is available | Developmentally disabled services |
| Health Insurance Barriers | Obesity | Affordable and Safe housing | Mobile virtual health |
| Child Care | Access to Therapy (BH, Trauma, Autism) | Youth/Teen Activities | |
| | Mobile Health (Dental, Vision, and Hearing) | Healthy Food Choices/food insecurity | |
| | Non-Emergency Transportation | HIV Resources | |

Access to Healthcare  Mental Health and Substance Abuse  Social Drivers of Health  Prevention of Chronic Disease

# Community Survey

In order to develop a broad understanding of community health needs, King's Daughters conducted a community survey November 13, 2024 to March 12, 2025. The survey was available in English and Spanish and a link to the survey was distributed via e-mail, social media and word of mouth to the community at-large. A total of 1,346 surveys were completed. Key findings from the community survey are reported on the following pages.

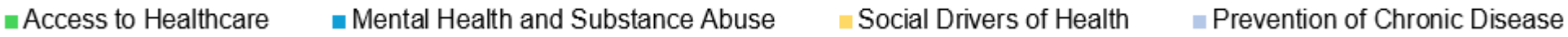
Link to Community Survey Summary

## Health Issues that Impact the Community Most

1. Access to Healthcare and Specialists
2. Mental Health and Substance Abuse Services
3. Transportation and Accessibility
4. Affordability and Insurance Issues
5. Housing and Social Determinants of Health
6. Emergency and Urgent Care Services
7. Preventive Care and Health Education
8. Concerns about Local Healthcare Facilities

## What do you believe are weaknesses in the community?

1. Poverty
2. Lack of Affordable Healthy Food
3. Affordable Housing
4. Access to Dentist
5. Transportation Services
6. Lack of Availability of Mental Health Care
7. Lack of Health Education
8. Access to Child Care Providers



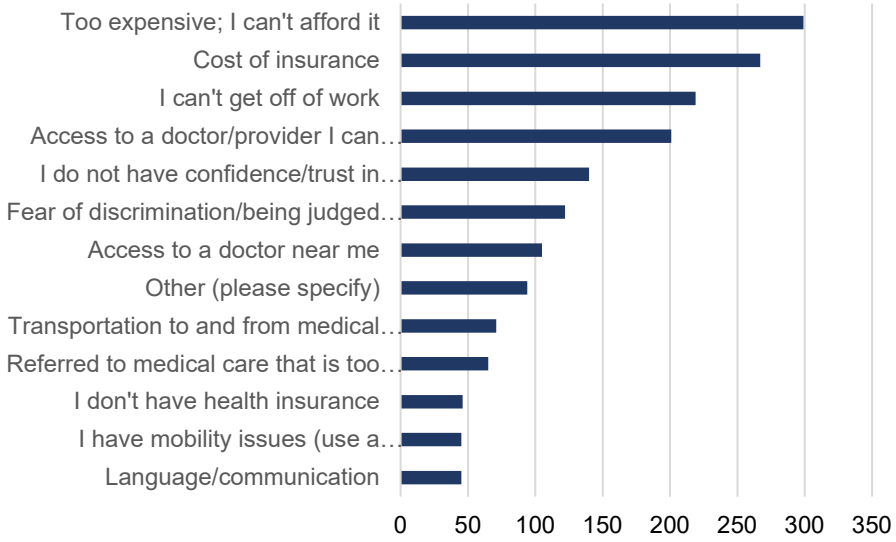
# Community Survey

Link to Community Survey Summary

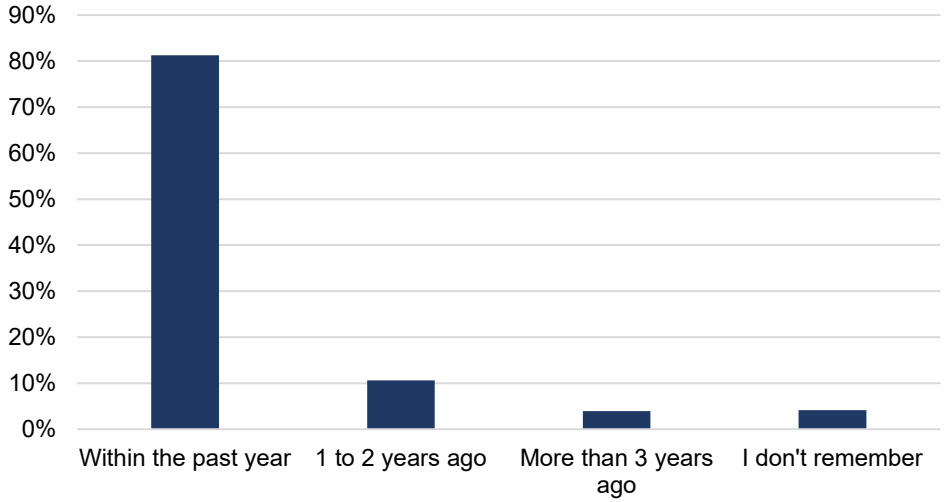
## Community Resources and Health Behaviors – Key Findings

- **82%** of the respondents have access to five fruits and vegetables each day.
- **39%** of the respondents exercise 30 minutes a day, three to five days a week.
- **79%** of the survey respondents said they have access to primary care physicians that are available in a timely manner.
- **33%** of survey respondents have delayed healthcare due to cost and/or lack of insurance. In 2022, this percentage was 28%.
- **91%** of survey respondents indicated they had access to transportation to/from medical appointments
- The health issues below impact survey respondents most.
  - High blood pressure 71%
  - Obesity/overweight 65%
  - Diabetes/sugar levels 49%
  - Mental Health 48%

### Barriers to Healthcare




### When was your last medical checkup?



# Professional Provider Survey

Summary of Provider Survey

King's Daughters obtained input from 55 medical professionals, including primary care providers, case managers, social workers, physician assistants and advanced practice registered nurses through a survey conducted in March 2025. A summary of findings from the provider survey is provided on the following pages.

## Most Prevalent Patient Health Concerns

Providers were asked to identify the five highest health concerns in their population. The health concerns listed below are the top health concerns in order from highest to lowest.

- Diabetes
- Adult obesity/overweight
- High blood pressure
- Depression
- Chronic pain
- Mental health conditions (other than depression)
- Aging concerns
- Cancer
- Physical disabilities such as mobility

## Community Services that Need Strengthening

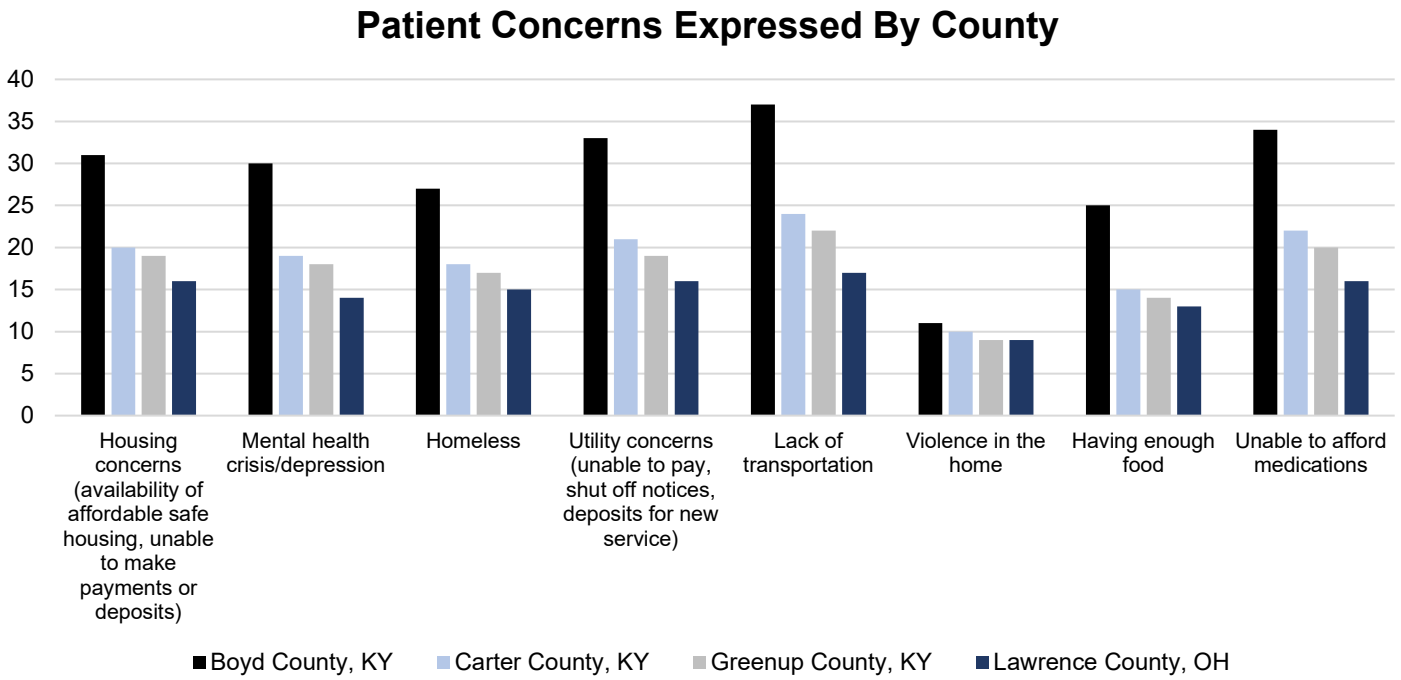
- Homeless services
- Behavioral health services
- Health care services for uninsured and underinsured
- Dental care/oral health services
- Food safety net
- Chronic pain management

## Most Common Barriers to Seeking Health Services

- Transportation
- Lack of inadequate coverage with health insurance
- Cost of insurance/co-pays
- Mobility issues (use a wheelchair, scooter, walker)
- Referred to medical provider that is too far away.

# Professional Provider Survey

## Social Determinants of Health




*"I absolutely cannot advocate for better transportation services to appointments enough! So many patients need further care now but are not getting it, van ministries and other rides to appointments are not plentiful enough."*

*"One of the most pressing health issues over the next 3-5 years is healthcare access disparities driven by Social Determinants of Health (SDOH), especially in rural and underserved communities. Barriers like economic instability, inadequate housing, food insecurity, and lack of transportation prevent many from accessing timely care, leading to worsening chronic conditions and preventable hospitalizations. Addressing these disparities requires expanding Medicaid, investing in Community Health Worker (CHW) programs, enhancing telehealth access, and integrating social care into healthcare. Prioritizing SDOH will improve health outcomes, reduce costs, and create more equitable, resilient communities."*

## What should King's Daughters address over the next three to five years?

Providers were asked to recommend the most important issue that King's Daughters should address over the next three to five years.

**Mental Health**

- Includes depression, bipolar disorder, ADHD, substance use, and lack of psychiatric services.
- Tied to other health and social issues like homelessness, substance abuse, chronic disease management, and non-compliance with treatment.

**Obesity & Chronic Disease**

- Includes obesity, type 2 diabetes, heart failure, COPD, and chronic pain.
- Need for weight loss support, including access to weight loss medications and addressing underlying causes (e.g., hormones, medications, social determinants of health).
- Emphasis on preventive care, health education, and early screening for chronic conditions.

**Social Determinants of Health (SDOH)**

- Critical barriers include:
  - Transportation access
  - Affordable food and medications
  - Insurance coverage gaps
  - Homelessness
  - Caregiver and elder care shortages
- These factors are described as rate-limiting and deeply interconnected with medical outcomes.

# Evaluation of the Impact of Actions Taken Since the Last CHNA – Access to Care

| Access to Care - Improve Access to Care | | | | |
|---|---|---|---|---|
| **Initiatives/Programs** | **Goals/Impact** | **FY 23** | **FY 24** | **FY 25 YTD** |
| Provide transportation for patients through the Van Ministry to medical visits (Monday – Friday) | Increase number of patients transported by 2% in FY 2023. FY 2022 baseline 1,296 patients served. Reevaluate goals for FY 2024-2025. | 1,439 people served | 1,533 people served | 677 people served |
| Provide Mammography and Healthy Heart with EKG services through our mobile health programs. | Mammography at least four new locations added per year 2023-2025. | 1) Mended Reeds Ironton<br>2) Dawson Bryant School<br>3) Big sandy<br>4) Elliot Nursing Home<br>5) Shelby Valley | 1) S.Webster OH<br>2) NECAO Olive Hill<br>3) Martin Co community health center<br>4) Hope Family services Salyersville<br>5) Cintas<br>6) Downtown Russell | 1) Shriners Olive Hill<br>2) YMCA<br>3) Camp Landing<br>4) Peoples Bank Jackson<br>5) Family Dollar<br>6) D. Lisa Cheek |
| Provide Mammography and Healthy Heart with EKG services through our mobile health programs. | Healthy Heart at least four new locations added per year 2023-2025. | 1) Lloyd Naz<br>2) Harbison Walker<br>3) AFD<br>4) Vertiv<br>5) Grayson Fire Dept. | 1) H Coal<br>2) Family care Portsmouth<br>3) Pavilion Russell<br>4) Prestonsburg senior center<br>5) Big Sandy | 1) Grayson Fire Dept.<br>2) Ramada Inn Paintsville<br>3) YMCA<br>4) Grayson Primary care<br>5) Ashland Credit union |
| Educate the community on availability of PCP providers. | Increase new patient PCP office visits by 3% per year. FY 2022 baseline 6,780. Revaluate goals for FY 2024. | 8,030 | 5,787 | 4,193 YTD |
| Educate the 45+ community on colorectal cancer screenings (Colonoscopy, FIT & Cologuard). Deena Stewart | At least 58% of Medicaid patients will receive a colorectal screening by 9/30/2025. | 53 | 57 | TBD |
| Educate providers and patients on the importance of statin therapy for patients with cardiovascular disease and diabetes. | Increase Medicaid statin usage by 20% by 9/30/2025. FY 2022 baseline 64.3%. Revaluate goal for FY 2024-25. | 71.6 | 85.9 | TBD |
| **Access to Care - Primary Care** | | | | |
| **Initiatives/Programs** | **Goals/Impact** | **FY 23** | **FY 24** | **FY 25 YTD** |
| Promote well care visits first 15 months and 3-6 years. | Increase in well visits for Medicaid patients by 3% per year for each age group. FY 2022 baseline: 0-15 months 49.6% 3-6 years 67.8%. Reevaluate goal for FY 2025. | 59 | 66.7 | TBD |
| Increase childhood immunizations status. | Increase in immunization status for Medicaid patients by 3% per year. FY 2022 baseline 23.2%. Reevaluate goal for FY 2025. | 24.9 | 22.9 | TBD |
| Educate the community on when to use Primary Care, Urgent Care and Emergency Department. | Number of people reached through education: Set baseline at end of FY 2023. Set goals for FY 2024-2025. | Cards and Provider Books Distributed 526 | Cards and Provider Books Distributed 673 | Cards and Provider Books Distributed 452 YTD |

# Evaluation of the Impact of Actions Taken Since the Last CHNA – Holistic Health

| Holistic Health | | | | |
|---|---|---|---|---|
| **Initiatives/Programs** | **Goals/Impact** | **FY 23** | **FY 24** | **FY 25 YTD** |
| ***Physical Health*** | | | | |
| Identify, promote and/or expand walking or other physical activity opportunities. | At least twelve events annually. | Promoted-<br>1) Iron ore Hiking trail<br>2) Greenbo state park<br>3) Tri state Racer<br>4) Carter caves park<br>5) 4C trial<br>6) Naturial Bridge<br>7) Shawnee State<br>8) Park loop Trail<br>9) Lampblack Trail<br>10) GCHD walking path<br>11) Russell park hiking trail<br>12) Dawkins Line Rail Trail | Face book post weekly on walking trails and opportunities<br>1) Grayson Lake<br>2) 8 mile beach<br>3) Lake Vesuvius<br>4) Backpack Trail<br>5) Jesse Stuart nature preserve<br>6) Lake Katharine trails<br>7) Ironton Walking path<br>8) Greenup Extension path<br>9) Fern Valley<br>10) Paven Rock Trail<br>11) Iron ore trail<br>12) Greenbo | Face book post Fridays YTD<br>1) Armco Park<br>2) Grayson Lake<br>3) Natural Bridge<br>4) .8 Hemelock<br>5) Lick falls<br>6) Raven Rock<br>7) East Park<br>8) Central Park<br>9) Red river gorge<br>10) Michael Tygart Loop<br>11) Carpenters Run Tail<br>12) Claylick loop |
| Identify individuals with food insecurities; partner with local food sources to provide healthy food to those in need including those with specific medical conditions. | Identify and implement a food box program for patients facing food insecurity for deliver/pickup. 100 boxes FY 2023. Set new matrix for 2024-25. | Food boxes distributed- 100 | Food boxes distributed -308Food Boxes distributed<br>1) GC Schools 200<br>2) Patients 52 serving 65 individuals | YTD Food boxes distributed Patients -26 serving 58 individuals |
| ***Mental Health*** | | | | |
| Promote Suicide Prevention Hotline. | Promote hotline number through at least six events and social media each year. | 1) Greenup Christian Church<br>2) Parade<br>3) Posters schools<br>4) Ashland<br>5) Boyd<br>6) Carter<br>7) Fairview<br>8) Greenup<br>9) Elliott | 1) Highlands Museum<br>2) Parades<br>3) Poage Landing Days<br>4) School program<br>5) Vertiv<br>6) Bridges out of addiction | 1) Neighborhood 2X month sttting Feb 2025<br>2) Healthy Hoopla event<br>3) YMCA Huddle for hunger<br>4) TBD<br>5) TBD<br>6) TBD |
| Educate and provide NARCAN to Behavioral Health Patients at discharge as appropriate. (BH- Trish Lewis) | Number of patients served. Establish benchmark 2022 Inpatient 256, Out patient 53, metrics for FY 2024. | Inpatient 91, Outpatient 49 | Inpatient 386, Outpatient 27 | Inpatient 341, Outpatient 96 |

# Evaluation of the Impact of Actions Taken Since the Last CHNA – Holistic Health

| Holistic Health (continued) | | | | |
|---|---|---|---|---|
| **Initiatives/Programs** | **Goals/Impact** | **FY 23** | **FY 24** | **FY 25** |
| ***Mental Health (continued)*** | | | | |
| Collaborate on two mental health awareness activities: (1) for the community and (2) for networking among providers. | At least two events. Attendance at programs, establish benchmark 2023. Set metrics FY 2024-25. | Dec- Greenup Christian Church | March- Bridges out of addiction, Self Harm education | Bridges out of addiction, Healthy Hoopla, Neighbors Helping Neighbors |
| Collaborate on two mental health awareness activities: (1) for the community and (2) for networking among providers. | At least two events. Attendance at programs, establish benchmark 2023. Set metrics FY 2024-25. | 1) Bridges out of addiction<br>2) Vertiv | 1)Bridges out of addiction<br>2)Self Harm education | 1) Bridges out of Addiction<br>2)Vertiv |
| Increase number of Certified Peer Support Specialists. | Establish additional peer support in FY 2023, set patient benchmark and set metrics to increase number of patients served in FY 2024-25. | 6 peer support specialist.<br>3 ED<br>1 inpatient medical units<br>1 on Mother Baby unit<br>1 in our OP office.<br>Patients seen by peer support-1,245 | 6 peer support specialist.<br>3 ED<br>1 inpatient medical units<br>1 on Mother Baby unit<br>1 in our OP office.<br>Patients seen by peer support-1,681 | 6 peer support specialist.<br>3 ED<br>1 inpatient medical units<br>1 on Mother Baby unit<br>1 in our OP office.<br>Patients seen by peer support-2,329 YTD |
| Promote mental health awareness at community events. | Promote through at least six events each year, 2023-2025. | 1) Summer Motion<br>2) Greenup Christian Church<br>3) Pride Picknic<br>4) Senior Citizens center<br>5) Poage Landing Days<br>6) Unity Baptist church Health fair | 1) Summer motion<br>2) Poage Landing days<br>3) Longest day of play<br>4) Safe Harbor<br>5) Veetiv<br>6) Smithfield health fair<br>7) LC health dept community health fair<br>8) Louisa community Health fair | 1) Vertiv<br>2) Smithfield<br>3) TBD<br>4) PRIDE event<br>5) Latin night<br>6) TBD |
| Reduce the number of high dose Opioid prescriptions from KD prescribers. | Decrease prescribing of high dose opioids to 3% overall by 9/302025. Baseline- | 4.9 | 1.0 | 1.5 YTD |
| ***Social Health*** | | | | |
| Provide free, interactive learning for children and adults. Topics may include, bullying, nicotine/vaping, SUD, suicide prevention, grief, depression etc. | At least eight programs per year. Set goal at end of FY 2023. | 1) monthly 21 Century afterschool program Ashland Schools<br>2) Dec- Alt school Ash. Vaping/Tobacco, MH<br>3) Raceland Schools<br>4) Greenup schools<br>5) GC Fair<br>6) Safe Harbor<br>7) Impact prevention<br>8) Fairview Schools | 1) Ashland Schools- Mental Health X3 events<br>2) GC schools summer camp<br>3) Safe Harbor<br>4) Poage landing days<br>5) Hill crest burce mission day care 6) Crabbe elem<br>7) 14th st community center<br>8) Raceland schools | 1) Family fun night<br>2) Fallsburg Teen Summit<br>3) Crabbe elem<br>4) |

# Evaluation of the Impact of Actions Taken Since the Last CHNA – Holistic Health

| Holistic Health (continued) | | | | |
|---|---|---|---|---|
| **Initiatives/Programs** | **Goals/Impact** | **FY 23** | **FY 24** | **FY 25** |
| ***Social Health (continued)*** | | | | |
| Provide free, interactive learning for children and adults. Topics may include, bullying, nicotine/vaping, SUD, suicide prevention, grief, depression etc. | At least eight programs per year. Set goal at end of FY 2023. | 1) 21ccentury monthly 10 months<br>2) Summer Camp GC schools | 1) Safe Harbor after school progam<br>2) 21 Century ten months<br>3) GC schools summer camp | 1) SOAR event Ashland<br>2) Safe Harbor, Vertiv, Smithfield |
| Provide social health programming for adults. Topics may include dealing with depression, active living, staying socially active, grief, diet & mental health, etc. | At least eight programs per year. Set goal at end of FY 2023. | 1) Senior Citizen center<br>2) faith works<br>3) Smithfield<br>4) Marathon<br>5) Vertiv<br>6) Poage Landig days<br>7) Summer Motion<br>8) Drug court event | 1) Marathon Stress<br>2) New boston<br>3) ACTC<br>4) Marathon<br>5) mega heart<br>6) Heritage Elementary staff event<br>7) Poage Landing<br>8) smithfield | 1) Vertiv<br>2) Smithfield<br>3) SOAR event TBD |
| Implement Social Determinants of Health screening protocol in Epic. | Implement SDH screening by end of FY 2023. | Implemented impatient screening 7/25/2023and Primary care screening on 12/26/2023 | Implemented Primary Ambilitray Pediatrics screening 10/28/2024 | Continuing screening |
| ***Faith Based Health*** | | | | |
| Rebuild the FaithWorks collaborative program to support community health initiatives. | Recruit at least six churches to provide health programming. Establish a FaithWorks phone number for questions, and appointments in FY 2023. Set goals for establishing new programs at in of FY 23. | Dedicated Phone number installed. Team members recruitment session Faith works event Jan 26, 2023 | May-Faithworks Dr. Friday speaker, Flu shots at churches, Unity baptist event, Fairview baptise community health fair, 10 chruches established | Flu shots,, Blood presures |

# Evaluation of the Impact of Actions Taken Since the Last CHNA – Social Determinants of Health

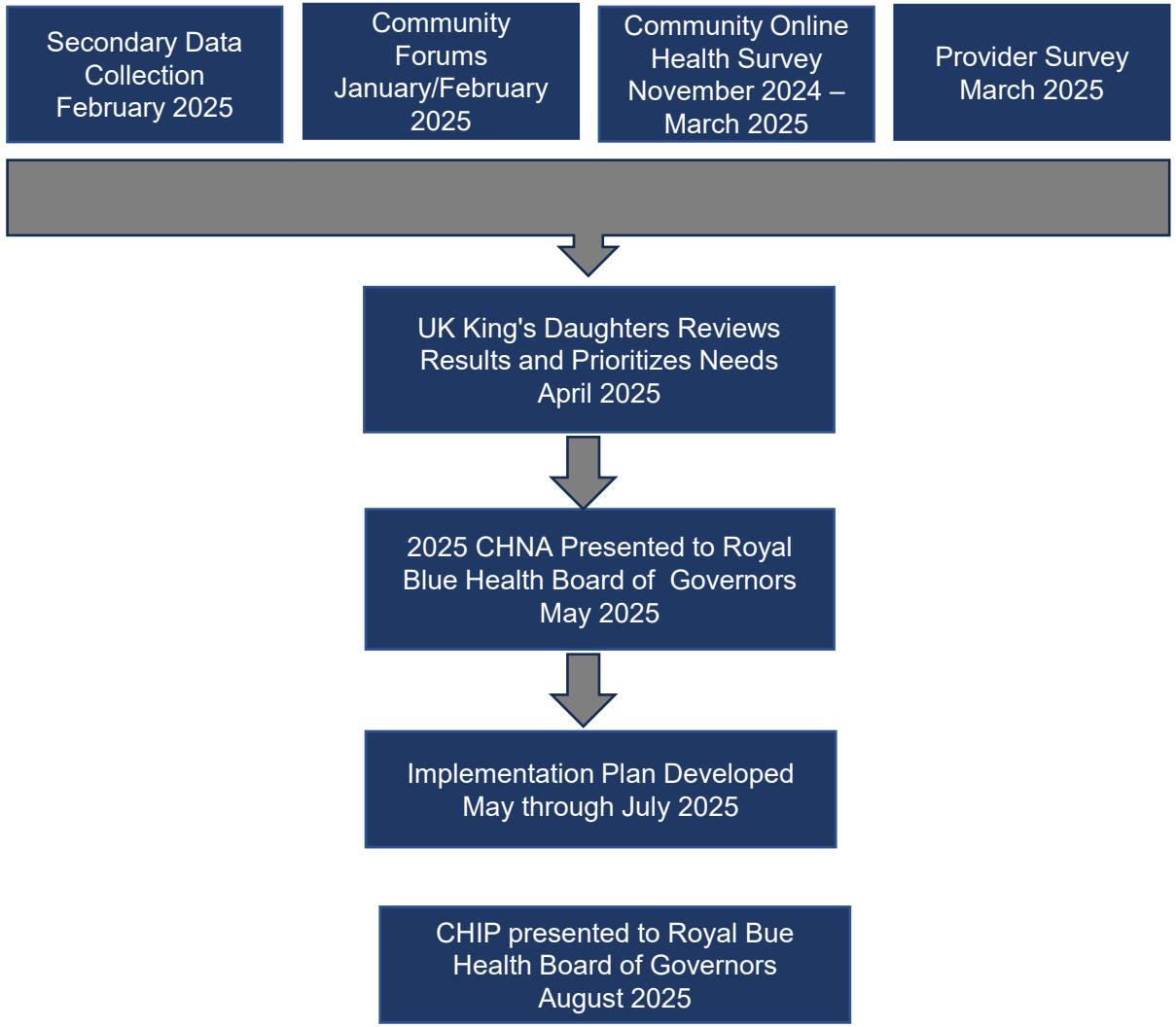
| Social Determinants of Health | | | | |
|---|---|---|---|---|
| **Initiatives/Programs** | **Goals/Impact** | **FY23** | **FY 24** | **FY 25 YTD** |
| ***Reduce the Impact of Social Determants of Health*** | | | | |
| Support organizations focused on assisting individuals facing issues associated with social determinants of health by supporting them to expand their services. Focus organizations are those providing, but not limited to food, clothing, shelter, housing, dental and social services. | Track number of organizations supported. | 1)GC Schools Snacksack weekend food program,<br>2)Ashland community Kitchen<br>3) NHN<br>4) Pathways 5) River city Harvest<br>6) YMCA | 1)NHN- Funding for programs,<br>2)Ashland community Kitchen<br>3) Hillcrest Bruce Mission<br>4)Ashland for Change<br>5) Safe Harbor<br>6) Hopes Place<br>7) Hands of Hope | 1) Ironton city Mission<br>2) Salvation Army<br>3)Hopes Place<br>4) Pathways<br>5) NHN<br>6) CARES<br>7) Salvation Army<br>8) Impact Prevention<br>9) The Dressing Room<br>10) ACK |

# Prioritization of Identified Health Needs

Primary and secondary data were gathered and compiled from November 2024 to March 2025. Based on the information gathered through the CHNA process, the following summary list of needs was identified. Identified health needs are listed in alphabetical order.

- Access to health services/navigating healthcare services
- Childcare
- Chronic health conditions
- Poor Dental Health
- Food insecurity/lack of healthy nutrition
- Lack of affordable housing
- Mental health and depression
- Obesity
- Physical inactivity
- Poverty
- Preventative care
- Senior services
- Smoking/vaping
- Substance abuse
- Transportation
- Unintentional injury

Based on the information gathered through this Community Health Needs Assessment, King's Daughters will work to identify areas where it can most effectively focus its resources to have significant impact and develop an implementation strategy for fiscal years ending 2026-2028.



# Appendix A

Return to Report

## Population by Age & Gender

| | Age 0-17 | Age 18-24 | Age 25-34 | Age 35-44 | Age 45-54 | Age 55-64 | Age 65+ | Total | Male | Female |
|---|---|---|---|---|---|---|---|---|---|---|
| **UK KD CHNA Community** | **36,345** | **12,555** | **19,371** | **20,200** | **22,172** | **23,429** | **33,510** | **167,582** | **82,721** | **84,861** |
| Boyd County, KY | 10,225 | 3,506 | 5,564 | 6,120 | 6,257 | 6,656 | 9,715 | 48,043 | 24,059 | 23,984 |
| Carter County, KY | 5,935 | 2,305 | 2,984 | 2,961 | 3,453 | 3,592 | 5,285 | 26,515 | 13,065 | 13,450 |
| Greenup County, KY | 7,646 | 2,484 | 3,927 | 4,211 | 4,664 | 5,001 | 7,706 | 35,639 | 17,470 | 18,169 |
| Lawrence County, OH | 12,539 | 4,260 | 6,896 | 6,908 | 7,798 | 8,180 | 10,804 | 57,385 | 28,127 | 29,258 |
| **State / National Benchmark** | | | | | | | | | | |
| Kentucky | 1,022,746 | 409,822 | 588,640 | 565,525 | 560,696 | 595,301 | 767,995 | 4,510,725 | 2,233,870 | 2,276,855 |
| Ohio | 2,610,179 | 1,046,523 | 1,550,140 | 1,459,379 | 1,429,147 | 1,581,635 | 2,103,043 | 11,780,046 | 5,809,077 | 5,970,969 |
| United States | 73,645,238 | 30,307,641 | 45,497,632 | 43,492,887 | 40,847,713 | 42,626,382 | 55,970,047 | 332,387,540 | 164,545,087 | 167,842,453 |

| | Age 0-17 | Age 18-24 | Age 25-34 | Age 35-44 | Age 45-54 | Age 55-64 | Age 65+ | Total | Male | Female |
|---|---|---|---|---|---|---|---|---|---|---|
| **UK KD CHNA Community** | **21.7%** | **7.5%** | **11.6%** | **12.1%** | **13.2%** | **14.0%** | **20.0%** | **100.0%** | **49.4%** | **50.6%** |
| Boyd County, KY | 21.3% | 7.3% | 11.6% | 12.7% | 13.0% | 13.9% | 20.2% | 100.0% | 50.1% | 49.9% |
| Carter County, KY | 22.4% | 8.7% | 11.3% | 11.2% | 13.0% | 13.5% | 19.9% | 100.0% | 49.3% | 50.7% |
| Greenup County, KY | 21.5% | 7.0% | 11.0% | 11.8% | 13.1% | 14.0% | 21.6% | 100.0% | 49.0% | 51.0% |
| Lawrence County, OH | 21.9% | 7.4% | 12.0% | 12.0% | 13.6% | 14.3% | 18.8% | 100.0% | 49.0% | 51.0% |
| **State / National Benchmark** | | | | | | | | | | |
| Kentucky | 22.7% | 9.1% | 13.0% | 12.5% | 12.4% | 13.2% | 17.0% | 100.0% | 49.5% | 50.5% |
| Ohio | 22.2% | 8.9% | 13.2% | 12.4% | 12.1% | 13.4% | 17.9% | 100.0% | 49.3% | 50.7% |
| United States | 22.2% | 9.1% | 13.7% | 13.1% | 12.3% | 12.8% | 16.8% | 100.0% | 49.5% | 50.5% |

Data Source: US Census Bureau, American Community Survey. 2019-23. Source geography: Tract

# Population by Race and Ethnicity

Return to Report

| | Non-Hispanic/ Latino | Hispanic/ Latino | Total | White | Black | Asian | Other Race | Multiple Races | Total |
|---|---|---|---|---|---|---|---|---|---|
| **UK KD CHNA Community** | **165,475** | **2,107** | **167,582** | **157,991** | **2,320** | **754** | **1,196** | **5,321** | **167,582** |
| Boyd County, KY | 47,227 | 816 | 48,043 | 44,676 | 1,029 | 159 | 530 | 1,649 | 48,043 |
| Carter County, KY | 26,226 | 289 | 26,515 | 25,357 | 120 | 42 | 118 | 878 | 26,515 |
| Greenup County, KY | 35,253 | 386 | 35,639 | 34,004 | 210 | 214 | 69 | 1,142 | 35,639 |
| Lawrence County, OH | 56,769 | 616 | 57,385 | 53,954 | 961 | 339 | 479 | 1,652 | 57,385 |
| **State / National Benchmark** | | | | | | | | | |
| Kentucky | 4,298,562 | 212,163 | 4,510,725 | 3,774,581 | 355,237 | 68,482 | 78,545 | 233,880 | 4,510,725 |
| Ohio | 11,242,487 | 537,559 | 11,780,046 | 9,167,192 | 1,446,466 | 288,117 | 207,897 | 670,374 | 11,780,046 |
| United States | 269,255,951 | 63,131,589 | 332,387,540 | 210,875,446 | 41,070,890 | 19,352,659 | 25,494,824 | 35,593,721 | 332,387,540 |

| | Non-Hispanic/ Latino | Hispanic/ Latino | Total | White | Black | Asian | Other Race | Multiple Races | Total |
|---|---|---|---|---|---|---|---|---|---|
| **UK KD CHNA Community** | **98.7%** | **1.3%** | **100.0%** | **94.3%** | **1.4%** | **0.4%** | **0.7%** | **3.2%** | **100.0%** |
| Boyd County, KY | 98.3% | 1.7% | 100.0% | 93.0% | 2.1% | 0.3% | 1.1% | 3.4% | 100.0% |
| Carter County, KY | 98.9% | 1.1% | 100.0% | 95.6% | 0.5% | 0.2% | 0.4% | 3.3% | 100.0% |
| Greenup County, KY | 98.9% | 1.1% | 100.0% | 95.4% | 0.6% | 0.6% | 0.2% | 3.2% | 100.0% |
| Lawrence County, OH | 98.9% | 1.1% | 100.0% | 94.0% | 1.7% | 0.6% | 0.8% | 2.9% | 100.0% |
| **State / National Benchmark** | | | | | | | | | |
| Kentucky | 95.3% | 4.7% | 100.0% | 83.7% | 7.9% | 1.5% | 1.7% | 5.2% | 100.0% |
| Ohio | 95.4% | 4.6% | 100.0% | 77.8% | 12.3% | 2.4% | 1.8% | 5.7% | 100.0% |
| United States | 81.0% | 19.0% | 100.0% | 63.4% | 12.4% | 5.8% | 7.7% | 10.7% | 100.0% |

Data Source: US Census Bureau, American Community Survey. 2019-23. Source geography: Tract

# Household Income and Poverty

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**Average Family Income**
This indicator reports average family income based on the latest 5-year American Community Survey estimates. A family household is any housing unit in which the householder is living with one or more individuals related to him or her by birth, marriage, or adoption. Family income includes the incomes of all family members age 15 and older.

**Children Eligible for Free/Reduced Price Lunch**
Free or reduced price lunches are served to qualifying students in families with income between under 185 percent (reduced price) or under 130% (free lunch) of the US federal poverty threshold as part of the federal National School Lunch Program (NSLP).

| | Population Below 100% FPL | Percentage of Population Below 100% FPL | Percentage of Population under Age 18 in Poverty | Average Family Income | Percentage of Children Eligible for Free/Reduced Price Lunch |
|---|---|---|---|---|---|
| **UK KD CHNA Community** | **28,406** | **17.38%** | **22.20%** | **$89,008** | **59.10%** |
| Boyd County, KY | 8,154 | 17.72% | 24.42% | $89,847 | 62.50% |
| Carter County, KY | 5,058 | 19.57% | 25.19% | $86,360 | 62.90% |
| Greenup County, KY | 5,292 | 15.10% | 18.57% | $98,051 | 55.90% |
| Lawrence County, OH | 9,902 | 17.52% | 21.18% | $83,754 | 52.50% |
| **State / National Benchmark** | | | | | |
| Kentucky | 707,480 | 16.14% | 20.86% | $103,036 | 57.50% |
| Ohio | 1,519,610 | 13.24% | 17.98% | $115,826 | 34.50% |
| United States | 40,390,045 | 12.44% | 16.32% | $130,215 | 53.50% |

Data Source: US Census Bureau, American Community Survey. 2019-23. Source geography: Tract

Free/Reduced Lunch Data Source: National Center for Education Statistics, NCES – Common Core Data. 2022-2023.

# Uninsured Adults

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**Uninsured Population**
This indicator reports the percentage of adults age 18 to 64 without health insurance coverage. This indicator is relevant because lack of insurance is a primary barrier to healthcare access including regular primary care, specialty care, and other health services that contributes to poor health status.

| | Total Population (For Whom Insurance Status is Determined) | Uninsured Population | Uninsured Population, Percent |
|---|---|---|---|
| **UK KD CHNA Community** | **94,881** | **7,222** | **7.6%** |
| Boyd County, KY | 26,665 | 1,839 | 6.9% |
| Carter County, KY | 14,751 | 1,301 | 8.8% |
| Greenup County, KY | 19,977 | 1,406 | 7.0% |
| Lawrence County, OH | 33,488 | 2,676 | 8.0% |
| **State / National Benchmark** | | | |
| Kentucky | 2,642,949 | 200,716 | 7.6% |
| Ohio | 6,878,056 | 558,057 | 8.1% |
| United States | 197,858,423 | 22,237,154 | 11.2% |

Data Source: US Census Bureau, Small Area Health Insurance Estimates. 2022. Source geography: County

# Population with a Disability

Return to Report

**Population with Any Disability**
This indicator reports the percentage of the total civilian non-institutionalized population with a disability. This indicator is relevant because disabled individuals comprise a vulnerable population that requires targeted services and outreach by providers.

| | Population with a Disability | Total Population (For Whom Disability Status Is Determined) | Percentage of Population with a Disability |
|---|---|---|---|
| **UK KD CHNA Community** | **35,803** | **164,511** | **21.8%** |
| Boyd County, KY | 10,089 | 46,284 | 21.8% |
| Carter County, KY | 5,640 | 26,237 | 21.5% |
| Greenup County, KY | 7,366 | 35,160 | 21.0% |
| Lawrence County, OH | 12,708 | 56,830 | 22.4% |
| **State / National Benchmark** | | | |
| Kentucky | 784,920 | 4,429,333 | 17.7% |
| Ohio | 1,646,041 | 11,612,784 | 14.2% |
| United States | 42,703,063 | 327,425,278 | 13.0% |

Data Source: US Census Bureau, American Community Survey. 2019-23. Source geography: Tract

# Educational Attainment

Return to Report

**Education**
Education metrics can be used to describe variation in population access, proficiency, and attainment throughout the education system, from access to pre-kindergarten through advanced degree attainment. These indicators are important because education is closely tied to health outcomes and economic opportunity.

| | Total Population Age 25+ | Population Age 25+ with No High School Diploma | Population Age 25+ with No High School Diploma, Percent | Population Age 25+ with Bachelor's Degree or Higher, Percent |
|---|---|---|---|---|
| **UK KD CHNA Community** | **118,682** | **13,426** | **11.3%** | **18.3%** |
| Boyd County, KY | 34,312 | 3,758 | 11.0% | 19.4% |
| Carter County, KY | 18,275 | 3,146 | 17.2% | 15.4% |
| Greenup County, KY | 25,509 | 2,476 | 9.7% | 18.3% |
| Lawrence County, OH | 40,586 | 4,046 | 10.0% | 18.6% |
| **State / National Benchmark** | | | | |
| Kentucky | 3,078,157 | 352,966 | 11.5% | 27.0% |
| Ohio | 8,123,344 | 680,554 | 8.4% | 31.0% |
| United States | 228,434,661 | 24,230,217 | 10.6% | 35.0% |

Data Source: US Census Bureau, American Community Survey. 2019-23. Source geography: Tract

# Areas Affected by a Health Professional Shortage Area (HPSA)

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**Areas Affected by a Health Professional Shortage Area**
This indicator reports the percentage of the population that is living in a geographic area designated as a "Health Professional Shortage Area" (HPSA), defined as having a shortage of primary medical care, dental or mental health professionals. This indicator is relevant because a shortage of health professionals contributes to access and health status issues.

| | Population Living in an Area Affected by a HPSA | Total Population (5-year estimate) | Percetage of Population Living in an Area Affected by a HPSA |
|---|---|---|---|
| **UK KD CHNA Community** | **66,235** | **170,580** | **38.8%** |
| Boyd County, KY | 17,100 | 47,682 | 35.9% |
| Carter County, KY | 12,976 | 27,159 | 47.8% |
| Greenup County, KY | 11,912 | 35,555 | 33.5% |
| Lawrence County, OH | 24,247 | 60,184 | 40.3% |
| **State / National Benchmark** | | | |
| Kentucky | 1,390,830 | 4,449,052 | 31.3% |
| Ohio | 1,839,506 | 11,655,397 | 15.8% |
| United States | 72,230,619 | 324,697,795 | 22.3% |

Data Source: US Department of Health & Human Services, Health Resources and Services Administration, HRSA - Health Professional Shortage Areas Database. 2024. Source geography: HPSA

# Access to Healthcare Services

Return to Report

| | Dental Care | | Mental Care | | Primary Care | |
|---|---|---|---|---|---|---|
| | Providers per 100,000 Population | Dental Health Providers | Providers per 100,000 Population | Mental Health Providers | Providers per 100,000 Population | Primary Care Providers |
| **UK KD CHNA Community** | **39.62** | **67** | **801.35** | **1,355** | **87.53** | **148** |
| Boyd County, KY | 66.31 | 32 | 946.93 | 457 | 128.47 | 62 |
| Carter County, KY | 15.02 | 4 | 262.89 | 70 | 60.09 | 16 |
| Greenup County, KY | 38.93 | 14 | 305.88 | 110 | 86.20 | 31 |
| Lawrence County, OH | 29.19 | 17 | 1,232.83 | 718 | 66.96 | 39 |
| **State / National Benchmark** | | | | | | |
| Kentucky | 58.57 | 2,639 | 319.87 | 14,413 | 94.81 | 4,272 |
| Ohio | 58.27 | 6,875 | 445.97 | 52,622 | 117.01 | 13,807 |
| United States | 66.47 | 222,511 | 312.48 | 1,045,976 | 116.28 | 389,218 |

Dental Care Data Source: Centers for Medicare and Medicaid Services, CMS - National Plan and Provider Enumeration System (NPPES). 2021. Source geography: Address

Mental and Primary Care Data Source: Centers for Medicare and Medicaid Services, CMS - National Plan and Provider Enumeration System (NPPES). Accessed via County Health Rankings. December 2024. Source geography: County

**Dental Care**
This indicator reports the number of oral healthcare providers with a CMS National Provider Identifier (NPI). Providers included in this summary are those who list "dentist," "general practice dentist," or "pediatric dentistry" as their primary practice classification, regardless of sub-specialty. Data are from the latest Centers for Medicare and Medicaid Services (CMS) National Provider Identifier (NPI) downloadable file.

**Mental Care**
This indicator reports the number of providers with a CMS National Provider Identifier (NPI) that specialize in mental health. Mental health providers include licensed clinical social workers and other credentialed professionals specializing in psychiatry, psychology, counseling, or child, adolescent, or adult mental health. Data are from the latest Centers for Medicare and Medicaid Services (CMS) National Provider Identifier (NPI) downloadable file.

**Primary Care**
This indicator reports the number of primary care physicians per 100,000 population. Doctors classified as "primary care physicians" by the AMA include General Family Medicine MDs and DOs, General Practice MDs and DOs, General Internal Medicine MDs and General Pediatrics MDs. Physicians aged 75 and over and physicians practicing sub-specialties within the listed specialties are excluded. This indicator is relevant because a shortage of health professionals contributes to access and health status issues.

# Preventive Services – Core Preventable Services

Return to Report

| | Percentage of Males age 65+ Up to Date on Core Preventative Services, Age-Adjusted | Percentage of Females age 65+ Up to Date on Core Preventive Services, Age-Adjusted |
|---|---|---|
| **UK KD CHNA Community** | **43.3%** | **35.9%** |
| Boyd County, KY | 45.2% | 37.2% |
| Carter County, KY | 43.0% | 33.0% |
| Greenup County, KY | 47.5% | 37.7% |
| Lawrence County, OH | 39.4% | 35.1% |
| **State / National Benchmark** | | |
| Kentucky | 45.4% | 39.4% |
| Ohio | 43.2% | 38.3% |
| United States | 44.0% | 37.4% |

Data Source: Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System. Accessed via the PLACES Data Portal. 2020. Source geography: Tract

**Male Preventive Services**
This indicator reports the percentage of males age 65 years and older who report that they are up to date on a core set of clinical preventive services. Services include: an influenza vaccination in the past year; a PPV ever; and either a fecal occult blood test (FOBT) within the past year, a sigmoidoscopy within the past 5 years and a FOBT within the past 3 years, or a colonoscopy within the past 10 years.

**Female Preventive Services**
This indicator reports the percentage of females age 65 years and older who report that they are up to date on a core set of clinical preventive services. Services include: an influenza vaccination in the past year; a pneumococcal vaccination (PPV) ever; either a fecal occult blood test (FOBT) within the past year, a sigmoidoscopy within the past 5 years and a FOBT within the past 3 years, or a colonoscopy within the previous 10 years; and a mammogram in the past 2 years.

# Preventive Services – Blood Pressure, Diabetes, and Preventable Hospitalizations

Return to Report

| | Blood Pressure Medication Nonadherence | Medicare Enrollees with Diabetes with Annual Exam | Preventable Hospitalizations per 100,000 Beneficiaries |
|---|---|---|---|
| **UK KD CHNA Community** | **22.9%** | **83.5%** | **4,821** |
| Boyd County, KY | 22.9% | 83.0% | 5,281 |
| Carter County, KY | 23.4% | 80.2% | 5,058 |
| Greenup County, KY | 23.0% | 84.4% | 4,541 |
| Lawrence County, OH | 22.7% | 84.6% | 4,584 |
| **State / National Benchmark** | | | |
| Kentucky | 22.6% | 89.4% | 3,336 |
| Ohio | 20.4% | 87.9% | 3,033 |
| United States | 21.1% | 87.5% | 2,666 |

Blood Pressure Medication Nonadherence Data Source: Centers for Disease Control and Prevention, CDC - Atlas of Heart Disease and Stroke 2019-2021. Source geography: County

Diabetes Annual Exam Data Source: Dartmouth College Institute for Health Policy & Clinical Practice, Dartmouth Atlas of Health Care. 2019. Source geography: County

Preventable Hospitalizations Data Source: Centers for Medicare and Medicaid Services, Mapping Medicare Disparities Tool. 2022. Source geography: County

**Blood Pressure**
This indicator reports the number and percentage of Medicare beneficiaries not adhering to blood pressure medication schedules. Nonadherence is defined having medication coverage days at less than 80%.

**Diabetes Annual Exam**
This indicator reports the percentage of diabetic Medicare patients who have had a hemoglobin A1c (hA1c) test, a blood test which measures blood sugar levels, administered by a health care professional in the past year. This indicator is relevant because engaging in preventive behaviors allows for early detection and treatment of health problems. This indicator can also highlight a lack of access to preventive care, a lack of health knowledge, insufficient provider outreach, and/or social barriers preventing utilization of services.

**Preventable Hospitalizations**
This indicator reports the preventable hospitalization rate among Medicare beneficiaries for the latest reporting period. Preventable hospitalizations include hospital admissions for one or more of the following conditions: diabetes with short-term complications, diabetes with long-term complications, uncontrolled diabetes without complications, diabetes with lower-extremity amputation, chronic obstructive pulmonary disease, asthma, hypertension, heart failure, bacterial pneumonia, or urinary tract infection. Rates are presented per 100,000 beneficiaries.

# Preventive Services – Cancer Screenings

Return to Report

| | Adults with Adequate Colorectal Cancer Screening, Age-Adjusted | Females Age 21-65 with Recent Pap Smear, Age-Adjusted | Females Age 50-74 with Recent Mammogram, Age-Adjusted |
|---|---|---|---|
| **UK KD CHNA Community** | **58.8%** | **80.6%** | **70.3%** |
| Boyd County, KY | 64.1% | 81.3% | 73.0% |
| Carter County, KY | 56.8% | 78.9% | 66.7% |
| Greenup County, KY | 59.7% | 81.2% | 70.8% |
| Lawrence County, OH | 54.8% | 80.4% | 69.4% |
| **State / National Benchmark** | | | |
| Kentucky | 60.7% | 81.8% | 72.2% |
| Ohio | 59.6% | 82.7% | 75.5% |
| United States | 54.1% | 83.7% | 76.0% |

Colorectal Cancer Screening Data Source: Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System. Accessed via the PLACES Data Portal. 2022.

Pap Smear Screening Data Source: Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System. Accessed via the PLACES Data Portal. 2020.

Mammogram Screening Data Source: Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System. Accessed via the PLACES Data Portal. 2022.

**Colorectal Cancer Screening**
This indicator reports the percentage of adults with adequate colorectal cancer screening.

**Pap Smear Screening**
This indicator reports the percentage of females age 21–65 years who report having had a Papanicolaou (Pap) smear within the previous 3 years.

**Mammogram Screening**
This indicator reports the percentage of females age 50-74 years who report having had a mammogram within the previous 2 years.

# Health Outcomes and Mortality – Cancer Incidence Rates

Return to Report

**Cancer Incidence Rates**
These indicators report the age adjusted incidence rate (cases per 100,000 population per year) of individuals with cancer adjusted to 2000 U.S. standard population age groups (Under Age 1, 1-4, 5-9, ..., 80-84, 85 and older).

| | Breast Cancer Incidence Rate (Per 100,000 Population) | Colorectal Cancer Incidence Rate (Per 100,000 Population) | Lung Cancer Incidence Rate (Per 100,000 Population) | Prostate Cancer Incidence Rate (Per 100,000 Population) |
|---|---|---|---|---|
| **UK KD CHNA Community** | **123.2** | **50.1** | **91.7** | **105.2** |
| Boyd County, KY | 121.7 | 46.9 | 93.8 | 110.5 |
| Carter County, KY | 97.2 | 58.2 | 97.3 | 92.6 |
| Greenup County, KY | 128.7 | 48.1 | 80.7 | 103.9 |
| Lawrence County, OH | 133.9 | 50.4 | 94.3 | 107.5 |
| **State / National Benchmark** | | | | |
| Kentucky | 126.7 | 45.9 | 84.4 | 108.3 |
| Ohio | 129.5 | 39.1 | 64.7 | 114.1 |
| United States | 127.0 | 36.5 | 54.0 | 110.5 |

Data Source: State Cancer Profiles. 2016-20. Source geography: County

# Health Outcomes and Mortality – Chronic Conditions

Return to Report

| | Percentage of Adults with Diagnosed Diabetes, Age-Adjusted | Percentage of Adults Ever Diagnosed with Coronary Heart Disease, Age-Adjusted | Percentage of Adults with High Blood Pressure, Age-Adjusted |
|---|---|---|---|
| **UK KD CHNA Community** | **12.4%** | **7.4%** | **35.9%** |
| Boyd County, KY | 12.0% | 7.0% | 35.4% |
| Carter County, KY | 12.8% | 7.7% | 37.9% |
| Greenup County, KY | 11.7% | 7.1% | 34.0% |
| Lawrence County, OH | 13.0% | 7.7% | 36.6% |
| **State / National Benchmark** | | | |
| Kentucky | 11.0% | 6.9% | 35.4% |
| Ohio | 11.6% | 6.7% | 32.4% |
| United States | 10.4% | 5.7% | 29.6% |

Coronary Heart Disease and Diabetes Data Source: Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System. Accessed via the PLACES Data Portal. 2022. Source geography: County

High Blood Pressure Data Source: Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System. Accessed via the PLACES Data Portal. 2021.

**Diabetes**
This indicator reports the number and percentage of adults age 18 and older who have ever been told by a doctor that they have diabetes. This indicator is relevant because diabetes is a prevalent problem in the U.S.; it may indicate an unhealthy lifestyle and puts individuals at risk for further health issues.

**Coronary Heart Disease**
This indicator reports the percentage of adults age 18 and older who report ever having been told by a doctor, nurse, or other health professional that they had angina or coronary heart disease.

**High Blood Pressure**
This indicator reports the percentage of adults age 18 who report ever having been told by a doctor, nurse, or other health professional that they have high blood pressure. Women who were told high blood pressure only during pregnancy and those who were told they had borderline hypertension were not included.

# Health Outcomes and Mortality – Mortality

Return to Report

**Cancer Deaths**
This indicator reports the 2019-2023 five-year average rate of death due to malignant neoplasm (cancer) per 100,000 population.

**Heart Disease Deaths**
This indicator reports the 2019-2023 five-year average rate of death due to heart disease (ICD10 Codes 120-125) per 100,000 population.

**Lung Disease Deaths**
This indicator reports the 2019-2023 five-year average rate of death due to chronic lower respiratory disease per 100,000 population.

| | Cancer Death Rate (Per 100,000 Population), Crude | Heart Disease Death Rate (Per 100,000 Population), Crude | Lung Disease Death Rate (Per 100,000 Population), Crude | Stroke Death Rate (Per 100,000 Population), Crude |
|---|---|---|---|---|
| **UK KD CHNA Community** | **295.5** | **335.6** | **107.6** | **71.5** |
| Boyd County, KY | 275.0 | 383.9 | 88.2 | 62.0 |
| Carter County, KY | 303.4 | 330.5 | 132.8 | 71.7 |
| Greenup County, KY | 282.0 | 329.7 | 107.2 | 66.4 |
| Lawrence County, OH | 316.9 | 302.0 | 112.2 | 82.4 |
| **State / National Benchmark** | | | | |
| Kentucky | 228.2 | 250.9 | 73.9 | 51.9 |
| Ohio | 212.2 | 253.0 | 57.7 | 58.9 |
| United States | 182.7 | 207.2 | 44.9 | 48.3 |

Data Source: Centers for Disease Control and Prevention, National Vital Statistics System. Accessed via CDC WONDER. 2019-2023. Source geography: County

# Injury and Violence – Unintentional Injury

Return to Report

**Death due to Unintentional Injury (Accident)**
This indicator reports the 2019-2023 five-year average rate of death due to unintentional injury (accident) per 100,000 population..

| | Unintentional Injury Death Rate (Per 100,000 Population), Crude | Five Year Total Deaths, 2019-2023 Total |
|---|---|---|
| **UK KD CHNA Community** | **122.7** | **1,024** |
| Boyd County, KY | 127.0 | 301 |
| Carter County, KY | 128.3 | 170 |
| Greenup County, KY | 112.9 | 199 |
| Lawrence County, OH | 122.6 | 354 |
| **State / National Benchmark** | | |
| Kentucky | 87.5 | 19,682 |
| Ohio | 79.6 | 46,715 |
| United States | 63.3 | 1,048,667 |

Data Source: Centers for Disease Control and Prevention, National Vital Statistics System. Accessed via CDC WONDER. 2019-2023. Source geography: County

# Injury and Violence – Violent Crime and Property Crime

Return to Report

**Violent Crime**
Violent crime includes homicide, rape, robbery, and aggravated assault.

**Property Crime**
This indicator reports the rate of property crime offenses reported by law enforcement per 100,000 residents. Property crimes include burglary, larceny-theft, motor vehicle theft, and arson. This indicator is relevant because it assesses community safety.

| | Violent Crimes, Annual Rate (Per 100,000 Pop.) | Violent Crimes, 3-year Total | Property Crimes, Annual Rate (Per 100,000 Pop.) | Property Crimes, Annual Average |
|---|---|---|---|---|
| **UK KD CHNA Community** | **129.1** | **671** | **1612.1** | **2,787** |
| Boyd County, KY | 225.6 | 326 | 2,443.8 | 1,182 |
| Carter County, KY | 32.0 | 26 | 683.6 | 185 |
| Greenup County, KY | 31.5 | 35 | 488.0 | 176 |
| Lawrence County, OH | 155.1 | 284 | 2,084.8 | 1,244 |
| **State / National Benchmark** | | | | |
| Kentucky | 226.5 | 30,445 | 2,226.8 | 98,512 |
| Ohio | 290.7 | 102,280 | 2,453.8 | 284,730 |
| United States | 416.0 | 4,579,031 | 2,466.1 | 7,915,583 |

Property Crime Data Source: Federal Bureau of Investigation, FBI Uniform Crime Reports. Additional analysis by the National Archive of Criminal Justice Data. Accessed via the Inter-university Consortium for Political and Social Research. 2014 & 2016. Source geography: County

Violent Crime Data Source: Federal Bureau of Investigation, FBI Uniform Crime Reports. Additional analysis by the National Archive of Criminal Justice Data. Accessed via the Inter-university Consortium for Political and Social Research. 2015-2017. Source geography: County

# Maternal, Infant, and Child Care – Infant Deaths, Low Weight Births, Birth Care

Return to Report

| | Infant Deaths per 1,000 Live Births | Low Birthweight Births, Percentage | Births with Late/No Care, Percentage | Births to Women Smoking During Pregnancy, Percentage |
|---|---|---|---|---|
| **UK KD CHNA Community** | **5.9** | **No data** | **No data** | **19.8%** |
| Boyd County, KY | 6.5 | 9.8% | No data | 22.1% |
| Carter County, KY | No data | 8.1% | No data | 19.1% |
| Greenup County, KY | No data | 8.2% | No data | 15.4% |
| Lawrence County, OH | 5.4 | 10.0% | No data | 20.4% |
| **State / National Benchmark** | | | | |
| Kentucky | 6.2 | 8.9% | 5.5% | 12.5% |
| Ohio | 7.1 | 8.6% | 6.1% | 9.6% |
| United States | 5.7 | 8.3% | 6.1% | 4.6% |

Infant Deaths Data Source: University of Wisconsin Population Health Institute, County Health Rankings. 2015-2021. Source geography: County

Low Birthweight Births Data Source: University of Wisconsin Population Health Institute, County Health Rankings. 2016-2022. Source geography: County

Births with Late/No Care Data Source: Centers for Disease Control and Prevention, National Vital Statistics System. Accessed via CDC WONDER. Centers for Disease Control and Prevention, Wide-Ranging Online Data for Epidemiologic Research. 2017-19. Source geography: County

Births to Women Smoking During Pregnancy Data Source: Health Resources & Services Administration, HRSA – Maternal and Child Health Bureau. 2020-2022.

**Infant Deaths**
This indicator reports information about infant mortality, which is defined as the number of all infant deaths (within 1 year) per 1,000 live births.

**Low Birthweight Births**
This indicator reports the percentage of live births where the infant weighed less than 2,500 grams (approximately 5 lbs., 8 oz.). These data are reported for a 7-year aggregated time period.

**Births with Late/No Care**
This indicator reports the percentage of women who did not obtain prenatal care until the 7th month (or later) of pregnancy or who didn't have any prenatal care, as of all who gave birth during the three-year period from 2017 to 2019. This indicator is relevant because engaging in prenatal care decreases the likelihood of maternal and infant health risks. This indicator can also highlight a lack of access to preventive care, a lack of health knowledge, insufficient provider outreach, and/or social barriers preventing utilization of services.

**Smoking During Pregnancy**
This indicator reports estimated percentage of live births where maternal cigarette smoking was reported during any trimester of pregnancy between 2020 and 2022.

# Mental Health – Adult Mental Health

Return to Report

| | Average Poor Mental Health Days per Month | Suicide Rate (Per 100,000 Population), Crude |
|---|---|---|
| **UK KD CHNA Community** | **6.0** | **20.5** |
| Boyd County, KY | 6.2 | 23.3 |
| Carter County, KY | 6.2 | 16.5 |
| Greenup County, KY | 6.0 | 22.1 |
| Lawrence County, OH | 5.7 | 19.1 |
| **State / National Benchmark** | | |
| Kentucky | 5.6 | 17.8 |
| Ohio | 5.5 | 15.1 |
| United States | 4.9 | 14.5 |

Poor Mental Health Data Source: Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System. Accessed via County Health Rankings. 2021. Source geography: Tract

Suicide Data Source: Centers for Disease Control and Prevention, National Vital Statistics System. Accessed via CDC WONDER. 2018-2022. Source geography: County

**Poor Mental Health**
This indicator reports the average number of self-reported mentally unhealthy days in past 30 days among adults.

**Suicides**
This indicator reports the 2018-2022 five-year average rate of death due to intentional self-harm (suicide) per 100,000 population.

# Nutrition, Physical Inactivity Obesity – Food Environment

Return to Report

**Food Deserts**
This indicator reports the number of neighborhoods in the report area that are within food deserts. The USDA Food Access Research Atlas defines a food desert as any neighborhood that lacks healthy food sources due to income level, distance to supermarkets, or vehicle access.

**Low Food Access**
This indicator reports the percentage of the population with low food access. Low food access is defined as living more than 1 mile (urban) or 10 miles (rural) from the nearest supermarket, supercenter, or large grocery store.

**SNAP Authorized Retailers**
This indicator reports the number of SNAP-authorized food stores as a rate per 10,000 population. SNAP-authorized stores include grocery stores as well as supercenters, specialty food stores, and convenience stores that are authorized to accept SNAP (Supplemental Nutrition Assistance Program) benefits.

| | | Food Desert | | Low Food Access | | SNAP Authorized Retailers | |
|---|---|---|---|---|---|---|---|
| | Total Population (2010) | Food Desert Population | Food Desert Population, Percent | Population with Low Food Access | Population with Low Food Access, Percent | Total SNAP-Authorized Retailers | SNAP-Authorized Retailers per 10,000 Population |
| **UK KD CHNA Community** | **176,622** | **22,558** | **12.8%** | **34,128** | **19.3%** | **201** | **14.41** |
| Boyd County, KY | 49,542 | 13,755 | 27.8% | 16,951 | 34.2% | 51 | 14.95 |
| Carter County, KY | 27,720 | 4,337 | 15.6% | 2,173 | 7.8% | 45 | 21.58 |
| Greenup County, KY | 36,910 | 3,037 | 8.2% | 7,436 | 20.1% | 42 | 11.58 |
| Lawrence County, OH | 62,450 | 1,429 | 2.3% | 7,568 | 12.1% | 63 | 13.05 |
| **State / National Benchmark** | | | | | | | |
| Kentucky | 4,339,367 | 571,751 | 13.2% | 858,468 | 19.8% | 4,618 | 14.37 |
| Ohio | 11,536,504 | 1,504,341 | 13.0% | 2,899,354 | 25.1% | 10,106 | 10.46 |
| United States | 308,745,538 | 39,074,974 | 12.7% | 68,611,398 | 22.2% | 262,606 | 10.77 |

Food Desert and Low Food Access Data Source: US Department of Agriculture, Economic Research Service, USDA - Food Access Research Atlas. 2019. Source geography: Tract
SNAP Authorized Retailers Data Source: US Department of Agriculture, Food and Nutrition Service, USDA - SNAP Retailer Locator. Additional data analysis by CARES. 2024. Source geography: Tract

# Nutrition, Physical Inactivity Obesity – Obesity and Physical Activity

Return to Report

| | | Obesity | | Physical Activity | |
|---|---|---|---|---|---|
| | Population Age 20+ | Adults with BMI > 30.0 | Adults with BMI > 30.0, Percent | Adults with No Leisure Time Physical Activity | Adults with No Leisure Time Physical Activity, Percent |
| **UK KD CHNA Community** | **127,732** | **49,655** | **38.8%** | **38,799** | **28.3%** |
| Boyd County, KY | 36,650 | 13,158 | 35.8% | 11,618 | 29.6% |
| Carter County, KY | 19,836 | 7,062 | 35.4% | 4,840 | 22.6% |
| Greenup County, KY | 27,322 | 10,118 | 37.0% | 7,978 | 27.1% |
| Lawrence County, OH | 43,924 | 19,317 | 43.9% | 14,363 | 30.7% |
| **State / National Benchmark** | | | | | |
| Kentucky | 3,378,007 | 1,078,014 | 31.8% | 811,155 | 22.9% |
| Ohio | 8,876,498 | 3,123,262 | 35.2% | 2,066,232 | 22.1% |
| United States | 232,759,569 | 70,168,831 | 30.1% | 47,072,403 | 19.5% |

Obesity Data Source: Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion. 2021. Source geography: County

Physical Activity Data Source: Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion. 2021. Source geography: County

**Obesity**
This indicator reports the number and percentage of adults aged 20 and older self-report having a Body Mass Index (BMI) greater than 30.0 (obese). Body mass index (weight [kg]/height [m]2) was derived from self-report of height and weight. Excess weight may indicate an unhealthy lifestyle and puts individuals at risk for further health issues.

**Physical Activity**
This indicator is based on the question: "During the past month, other than your regular job, did you participate in any physical activities or exercises such as running, calisthenics, golf, gardening, or walking for exercise?" This indicator is relevant because current behaviors are determinants of future health and this indicator may illustrate a cause of significant health issues, such as obesity and poor cardiovascular health.

# Physical Environment – Cost Burdened Households

Return to Report

**Cost Burdened Households**
This indicator reports the percentage of the households where housing costs are 30% or more total household income. This indicator provides information on the cost of monthly housing expenses for owners and renters. The information offers a measure of housing affordability and excessive shelter costs. The data also serve to aid in the development of housing programs to meet the needs of people at different economic levels.

| | Cost Burdened Households (30%) | Total Households | Percentage of Cost Burdened Households |
|---|---|---|---|
| **UK KD CHNA Community** | **14,092** | **66,488** | **21.2%** |
| Boyd County, KY | 4,447 | 19,016 | 23.4% |
| Carter County, KY | 1,845 | 10,371 | 17.8% |
| Greenup County, KY | 2,530 | 14,600 | 17.3% |
| Lawrence County, OH | 5,270 | 22,501 | 23.4% |
| **State / National Benchmark** | | | |
| Kentucky | 420,119 | 1,791,991 | 23.4% |
| Ohio | 1,158,956 | 4,829,571 | 24.0% |
| United States | 37,330,839 | 127,482,865 | 29.3% |

Data Source: US Census Bureau, American Community Survey. 2019-23. Source geography: Tract

# Physical Environment – Housing

Return to Report

| | Percentage of Households with No or Slow Internet | Percentage of Substandard Housing Conditions |
|---|---|---|
| **UK KD CHNA Community** | **16.5%** | **22.9%** |
| Boyd County, KY | 13.6% | 24.7% |
| Carter County, KY | 21.5% | 19.4% |
| Greenup County, KY | 18.0% | 19.3% |
| Lawrence County, OH | 15.5% | 25.2% |
| **State / National Benchmark** | | |
| Kentucky | 12.8% | 25.4% |
| Ohio | 11.2% | 25.6% |
| United States | 10.3% | 32.0% |

Internet Access Data Source: US Census Bureau, American Community Survey. 2019-23 Source geography: Tract

Substandard Housing Data Source: US Census Bureau, American Community Survey. 2019-23. Source geography: Tract

**Internet Access**
This indicator reports the percentage of households who either use dial-up as their only way of internet connection or have internet access but don't pay for the service, or have no internet access in their home, based on the 2019-2023 American Community Survey estimates.

**Substandard Housing**
This indicator reports the percentage of owner- and renter-occupied housing units having at least one of the following conditions: 1) lacking complete plumbing facilities, 2) lacking complete kitchen facilities, 3) with 1 or more occupants per room, 4) selected monthly owner costs as a percentage of household income greater than 30%, and 5) gross rent as a percentage of household income greater than 30%. Selected conditions provide information in assessing the quality of the housing inventory and its occupants. This data is used to easily identify homes where the quality of living and housing can be considered substandard.

# Substance Use Disorder – Adult Alcohol and Tobacco Use

Return to Report

| | Percentage of Adults Binge Drinking in the Past 30 Days, Age-Adjusted | Percentage of Adult Current Smokers, Age-Adjusted |
|---|---|---|
| **UK KD CHNA Community** | **16.0%** | **21.6%** |
| Boyd County, KY | 14.9% | 19.7% |
| Carter County, KY | 14.6% | 21.5% |
| Greenup County, KY | 16.3% | 19.9% |
| Lawrence County, OH | 17.5% | 24.4% |
| **State / National Benchmark** | | |
| Kentucky | 15.3% | 19.0% |
| Ohio | 19.6% | 18.6% |
| United States | 18.0% | 13.2% |

Data Source: Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System. Accessed via the PLACES Data Portal. 2022. Source geography: Tract

**Adult Alcohol Use**
This indicator reports the percentage of adults age 18 and older who report having five or more drinks (men) or four or more drinks (women) on an occasion in the past 30 days.

**Adult Tobacco Use**
This indicator reports the percentage of adults age 18 and older who report having smoked at least 100 cigarettes in their lifetime and currently smoke every day or some days.

# Substance Use Disorder – Opioid Overdose

Return to Report

**Opioid Overdose**
This indicator reports the 2018-2022 five-year average rate of death due to opioid drug overdose per 100,000 population. Rates are summarized for report areas from county level data, only where data is available. This indicator is relevant because opioid drug overdose is the leading cause of injury deaths in the United States, and they have increased dramatically in recent years.

| | Crude Death Rate (Per 100,000 Population) | Five Year Total Deaths, 2018-2022 Total |
|---|---|---|
| **UK KD CHNA Community** | **62.7** | **526** |
| Boyd County, KY | 74.8 | 177 |
| Carter County, KY | 54.1 | 72 |
| Greenup County, KY | 56.7 | 100 |
| Lawrence County, OH | 60.5 | 177 |
| **State / National Benchmark** | | |
| Kentucky | 33.2 | 7,458 |
| Ohio | 34.2 | 20,039 |
| United States | 20.1 | 331,211 |

Data Source: Centers for Disease Control and Prevention, National Vital Statistics System. Accessed via CDC WONDER. 2018-2022. Source geography: County

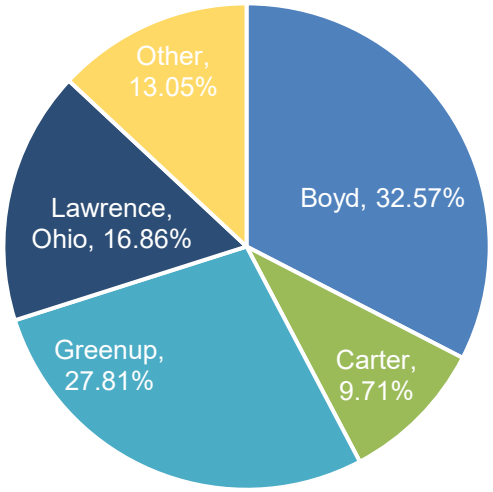
Return to Report

# Appendix B – Community Survey Summary – Demographics of Survey Respondents

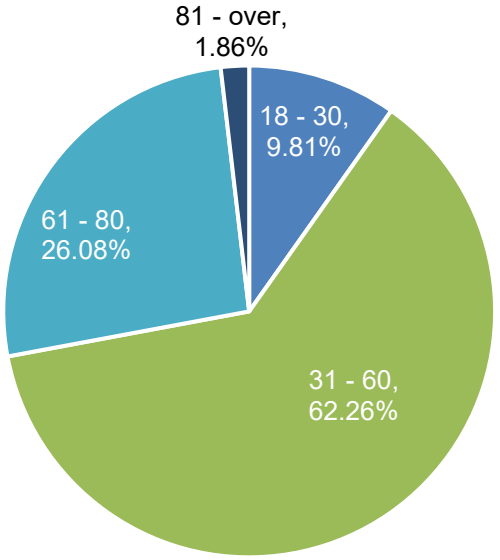
In order to develop a broad understanding of community health needs, King's Daughters conducted a community survey from November 13, 2024 to March 12, 2025. The survey was available in English and Spanish and a link to the survey was distributed via e-mail, social media and word of mouth to the community at-large. A total of 1,346 surveys were completed. The majority of respondents were White/Caucasian (95%), 2.5%of the respondents identified as Hispanic or Latino, 1.5% of the respondents identified as Black or African American and 1% identified as other racial or ethnic identities.

Other key characteristics of the surveyed population are provided below and on the following page.

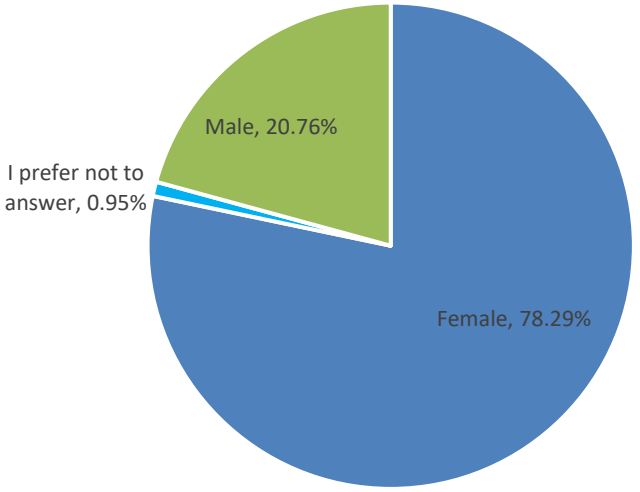
## County of Residence




## Age Group




## Sex Assigned at Birth

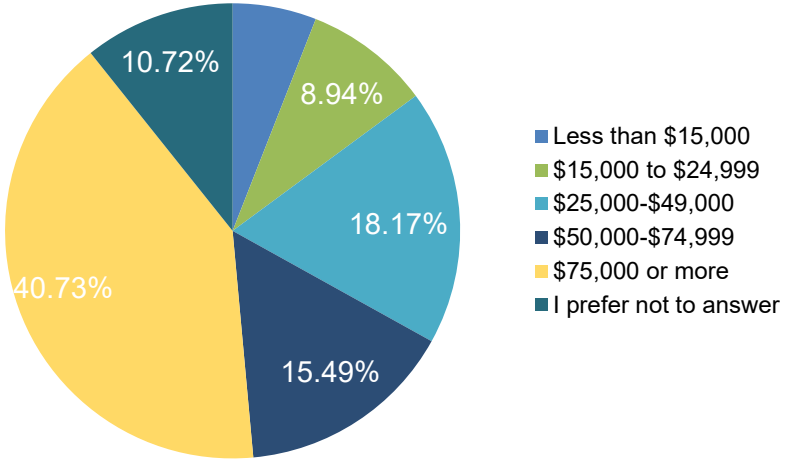



*Given the reported demographics above, care should be taken with interpreting the survey results. The gender of survey respondents do not match demographics for the CHNA Community.* Specifically, the survey reached more females compared to demographic information for the community.

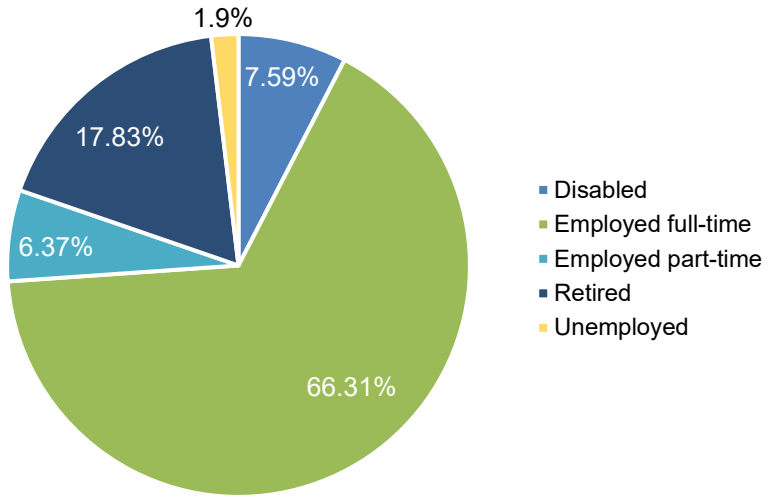
Return to Report

# Appendix B – Community Survey Summary – Demographics of Survey Respondents

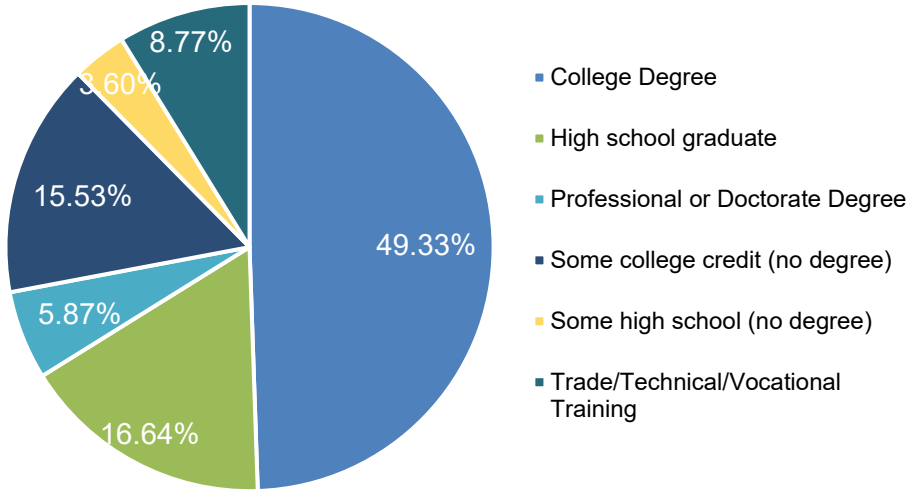
## Annual Household Income




## Employment Status



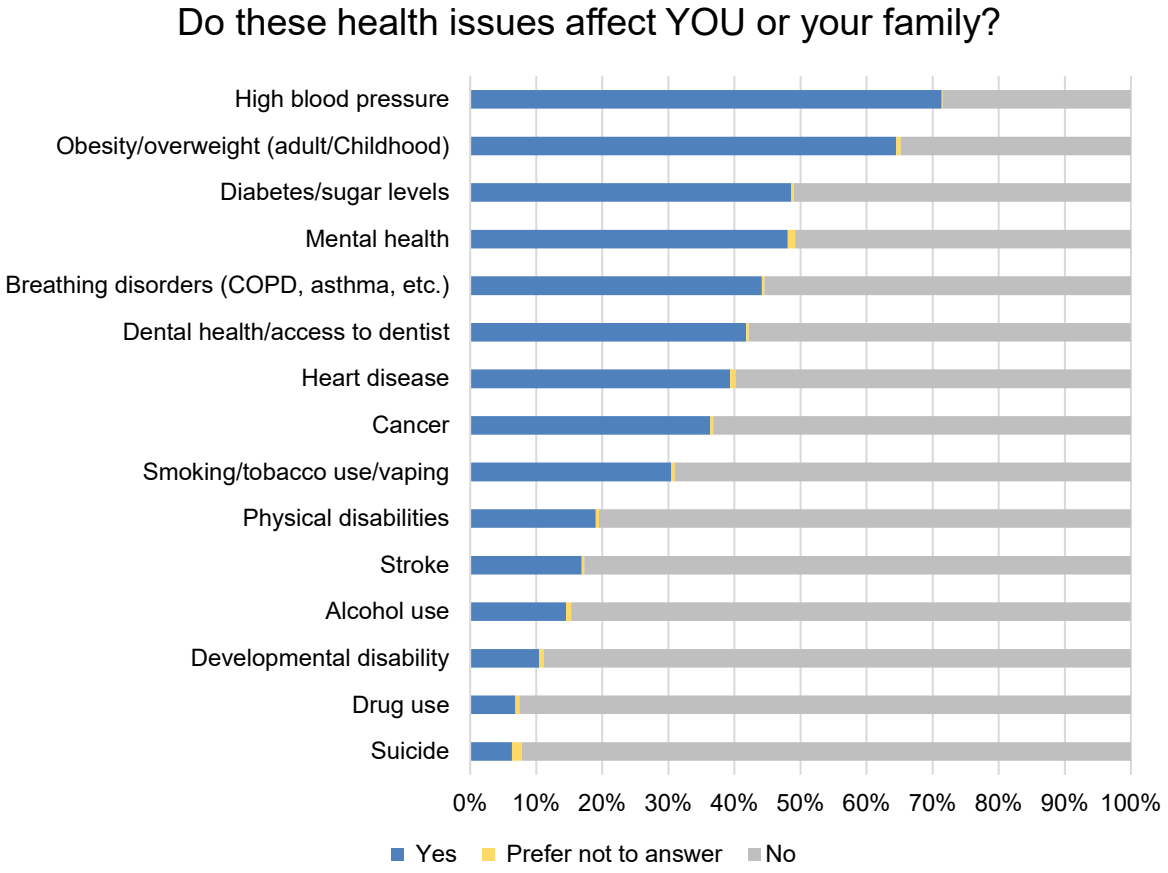

## Highest Degree or Level of School Completed



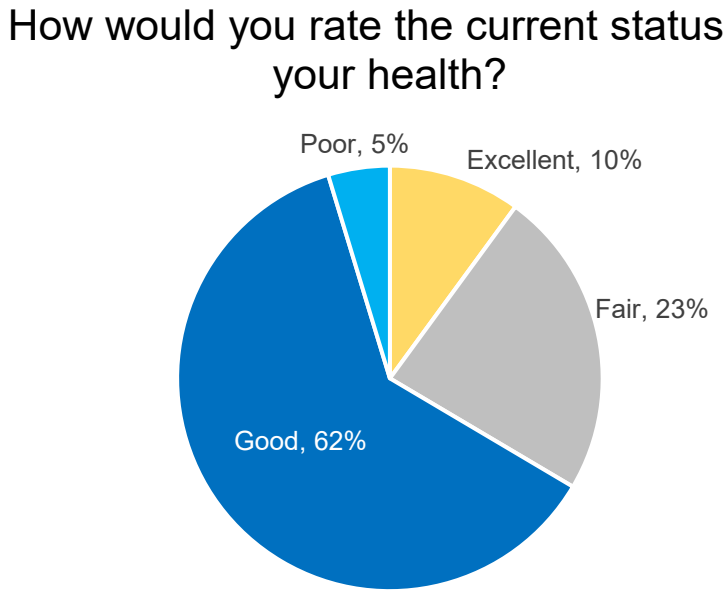
# Appendix B – Community Survey Summary

Return to Report

When asked about health issues that impact the respondent and their family, high blood pressure, obesity, diabetes and mental health were the issues that affected respondents most. The chart below summarizes all of the responses to this question.




Survey respondents were asked to rate the current status of their health. The majority of the respondents indicated the status of their health was good. A notable change from the previous community survey was the 5% of the respondents rated the current status of their health as "poor" compared to 1% in 2022.



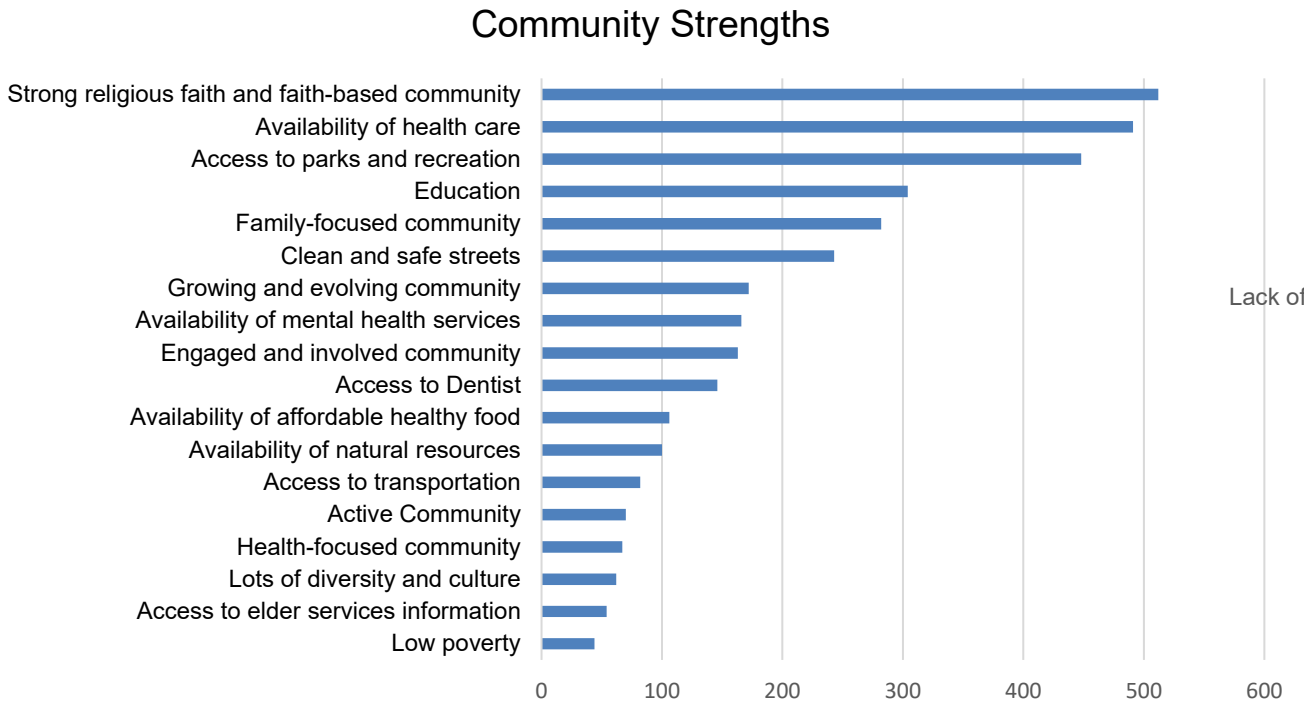
# Appendix B – Community Survey Summary

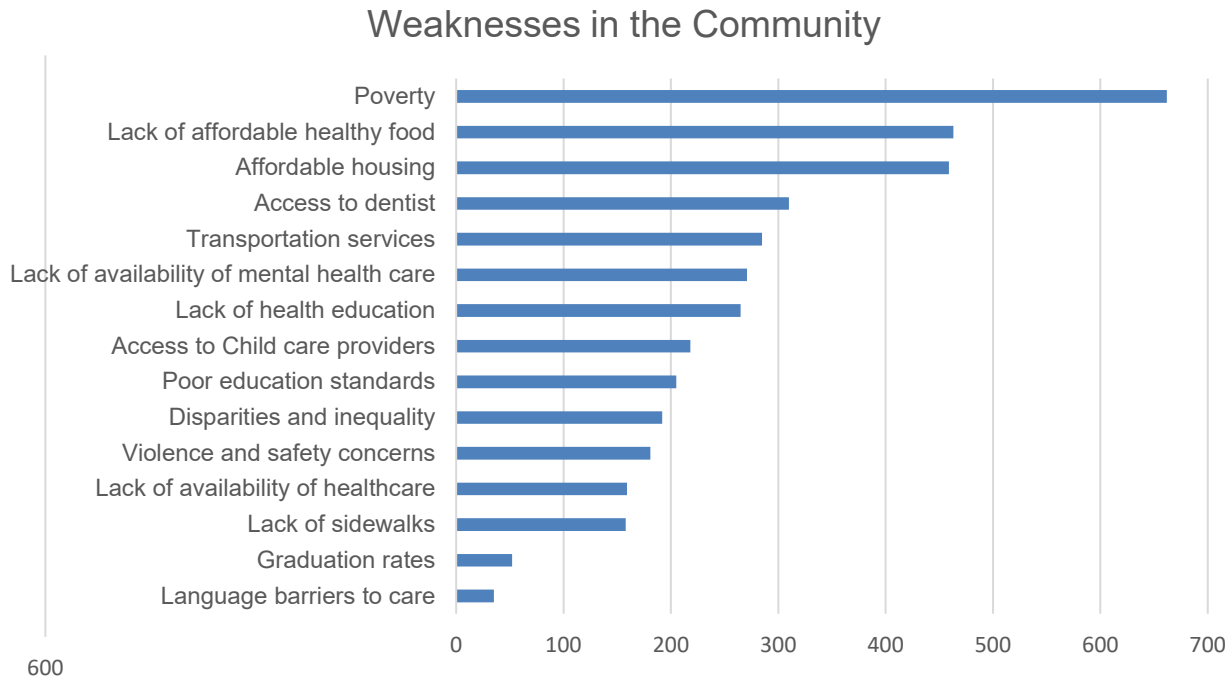
Return to Report

The survey asked the following two questions:

- What do you believe are the current STRENGTHS of your community?
- What do you believe are the WEAKNESSES in your community?

The survey provided predetermined responses that could be selected from the list. Below is a summary of strengths and weaknesses identified.

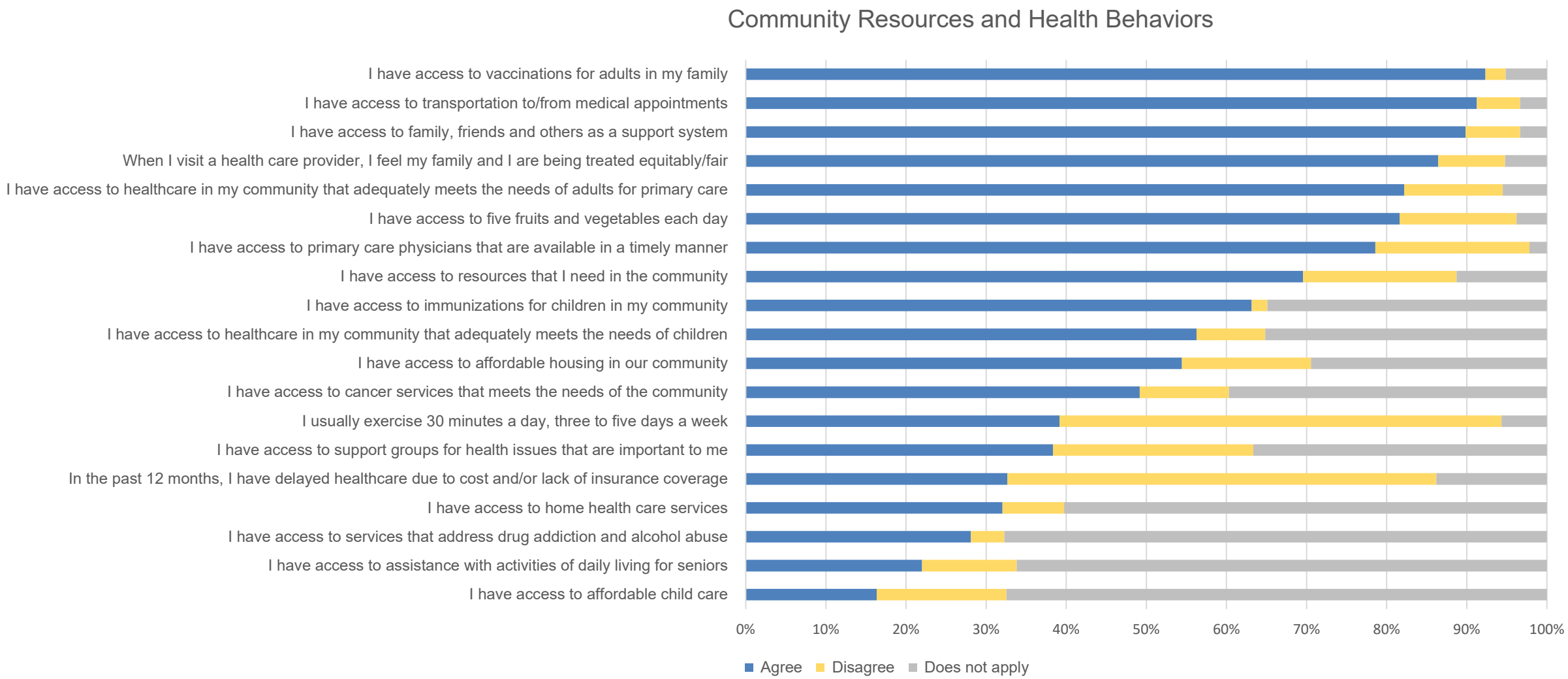


# Appendix B – Community Survey Summary

Return to Report

Below is summary of the survey results regarding specific statements regarding community resources and health behaviors.

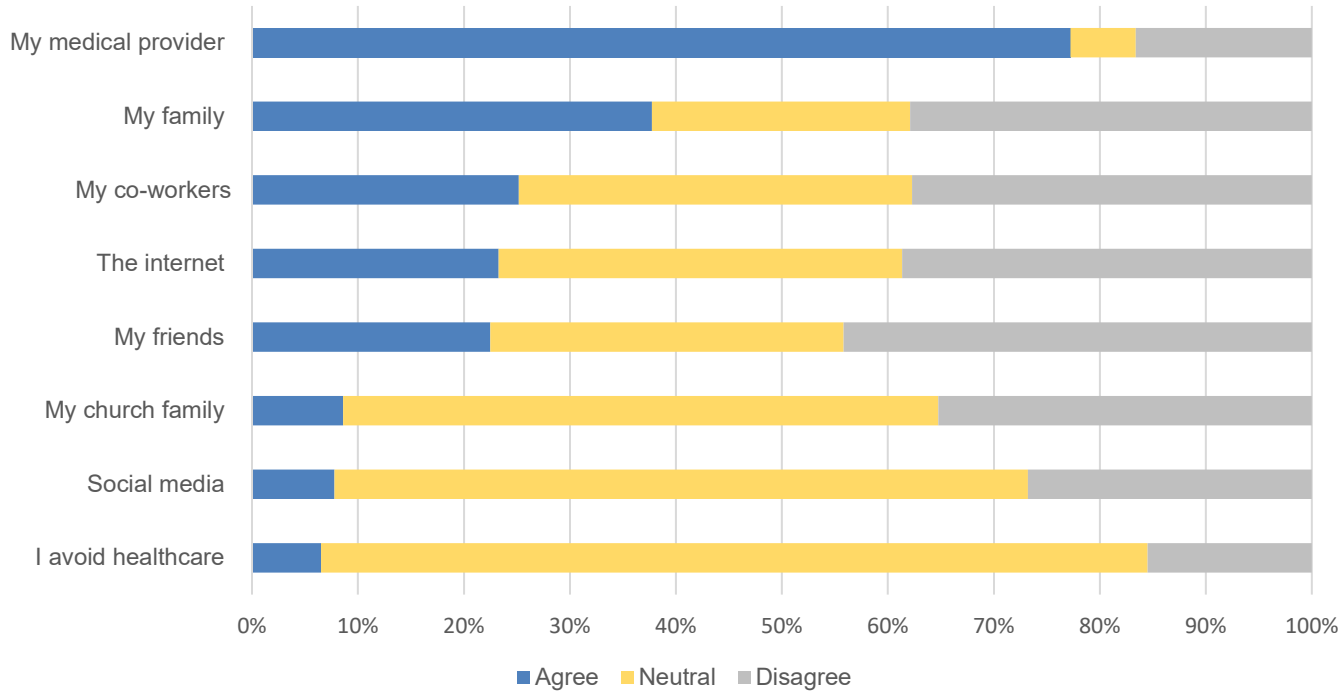


# Appendix B – Community Survey Summary

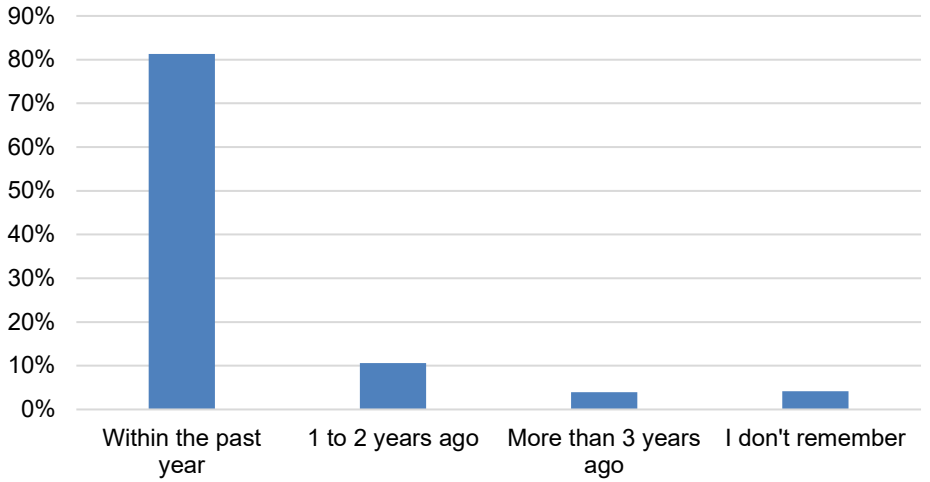
Return to Report

Several survey questions focused on personal healthcare. Responses to these questions are summarized on the following pages.

## Most of my healthcare support/advice comes from:

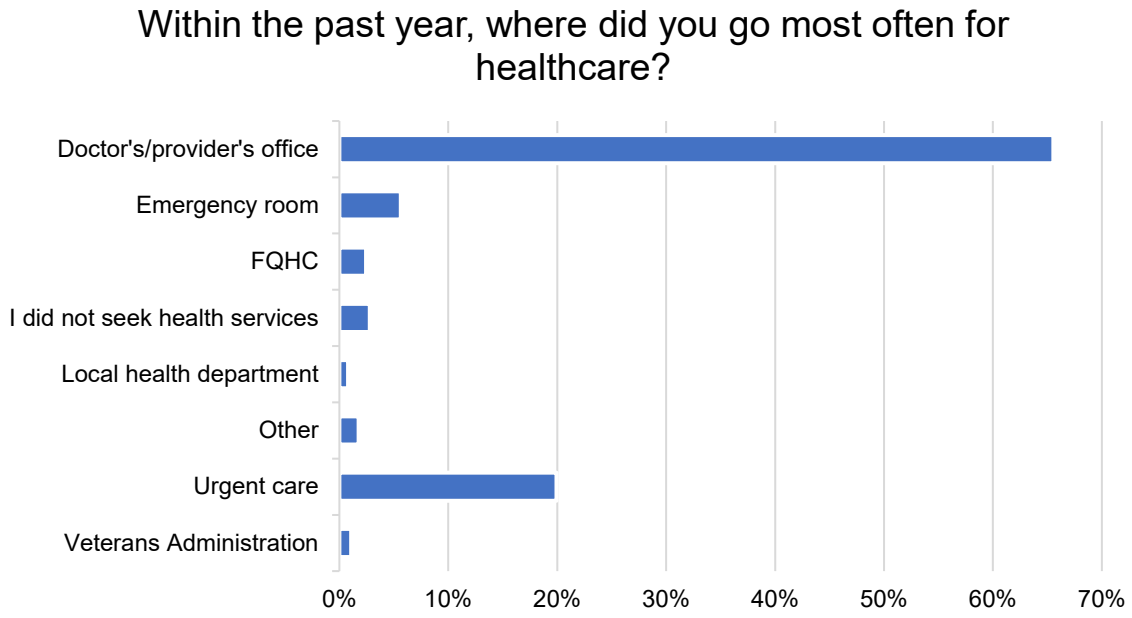


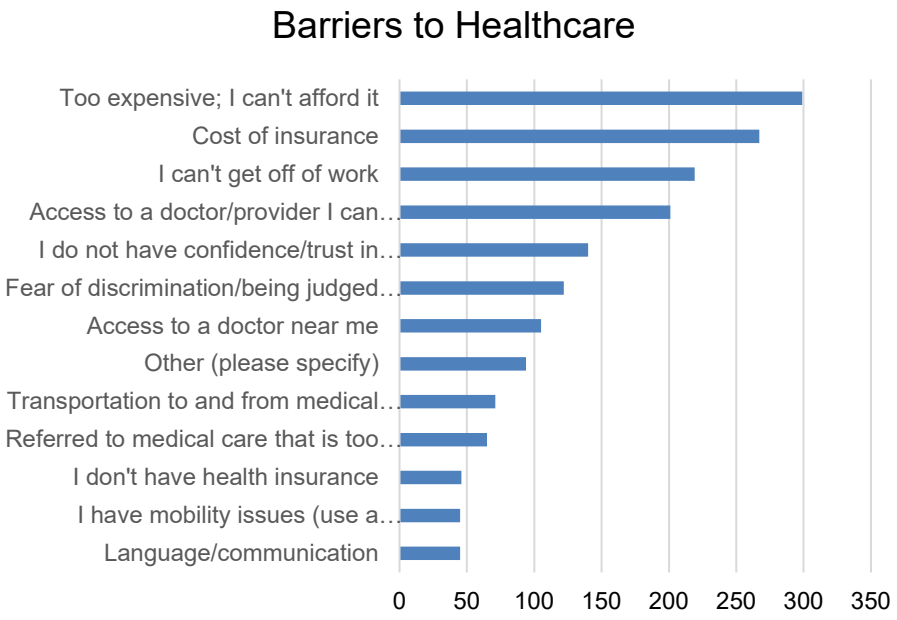

## When was your last medical checkup?



# Appendix B – Community Survey Summary

Return to Report



Return to Report

# Appendix B – Community Survey Summary

## Summary of Community Health Concerns

1. **Access to Healthcare & Specialists**
   - A shortage of primary care providers, pediatric specialists, and mental health professionals.
   - Limited dental care, especially for Medicaid patients, with long wait times and few available dentists.
   - Lack of urgent care and hospital facilities in rural areas, requiring long travel for care.
   - The need for women's health services, such as cervical cancer screenings and prenatal care.

2. **Mental Health & Substance Abuse Services**
   - Lack of mental health providers, especially for youth.
   - A need for drug rehabilitation programs and stricter regulations on methadone clinics.
   - Support groups for individuals struggling with addiction and their families.

3. **Transportation & Accessibility**
   - Many residents struggle to get to medical appointments due to lack of public transportation.
   - Requests for medical transport services for seniors and rural residents.
   - More walkable communities with sidewalks and bike lanes.

4. **Affordability & Insurance Issues**
   - High medical costs, copays, and prescription prices, even for those with insurance.
   - Frustration with Medicaid and Medicare coverage limitations.
   - Need for more affordable payment plans and financial assistance.

5. **Housing & Social Determinants of Health**
   - Lack of affordable housing and homeless shelters.
   - Difficulty for seniors and disabled individuals to find in-home care.
   - A need for healthy, affordable food options, with some unable to qualify for food assistance.

6. **Emergency & Urgent Care Services**
   - Long wait times in emergency rooms and lack of available urgent care options.
   - Concerns about ER staff being dismissive or overworked.
   - Calls for a regional trauma center closer to the community.

7. **Preventive Care & Health Education**
   - Interest in community programs for healthy eating, weight loss, and chronic disease prevention.
   - Need for school-based health programs, including nutrition, mental health education, and substance abuse prevention.
   - More screening services for cancer, diabetes, and heart disease.

8. **Concerns About Local Healthcare Facilities & Staffing**
   - Lack of trust in local hospitals and providers, leading many to seek care in larger cities.
   - Complaints about understaffing, long wait times for appointments, and difficulty scheduling tests.
   - Need for better-trained healthcare professionals and specialists

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# Appendix B – Community Survey Summary

## What has had a positive impact on the health of the community?

**1. Increased Access to Healthcare & Services**
- New healthcare clinics and urgent care centers opened, expanding local access.
- Expansion of UK King's Daughters Medical Center, adding more providers and specialists.
- Telehealth services made healthcare more accessible, especially for mental health.
- Improved healthcare facilities, including walk-in clinics and drive-thru lab services.
- Access to primary care and mental health providers in schools and workplaces.

**2. Preventative Health Measures & Screenings**
- Free health screenings for high blood pressure, diabetes, and cancer.
- COVID and flu vaccinations increased community-wide immunity.
- Low-cost lab tests provided access to important health data for early detection.
- More access to weight loss medications (e.g., GLP-1 agonists like Wegovy/Ozempic).

**3. Community & Social Support Initiatives**
- Mental health and substance use recovery programs expanded.
- Community health initiatives like blood drives and addiction recovery support.
- Farmers markets and healthy food initiatives helped improve nutrition access.
- Community-based health partnerships, including schools, hospitals, and businesses.

**4. Infrastructure & Accessibility Improvements**
- Better transportation services for medical appointments.
- More walking trails, outdoor exercise spaces, and recreational programs.
- Community health outreach programs helped connect people with resources.

## What has had a negative impact on the health of the community?

**1. COVID-19 Pandemic & Its Lasting Effects**
- Long-term health effects of COVID, including increased chronic conditions.
- Mental health decline, especially in youth, due to lockdowns and social isolation.
- Loss of jobs and healthcare coverage, making access to care more difficult.
- Misinformation and distrust in healthcare providers related to vaccines and treatment.

**2. Substance Abuse & Addiction Crisis**
- Increase in drug use (opioids, meth, heroin, fentanyl, vaping, tobacco, and alcohol abuse).
- Lack of effective addiction treatment and prevention programs.
- More drug treatment centers, but minimal focus on prevention and recovery support.

**3. Economic Challenges & Poverty**
- Loss of good-paying jobs, forcing many to live paycheck to paycheck.
- Inflation and the high cost of living, making healthcare, housing, and food less affordable.
- Financial barriers to healthcare, including high insurance premiums, deductibles, and out-of-pocket costs.
- Limited childcare options, making it harder for parents to work and support their families.

**4. Homelessness & Lack of Affordable Housing**
- More people experiencing homelessness, leading to higher health risks from exposure to harsh weather and unsafe environments.
- Limited affordable housing options, forcing families into unstable living situations.

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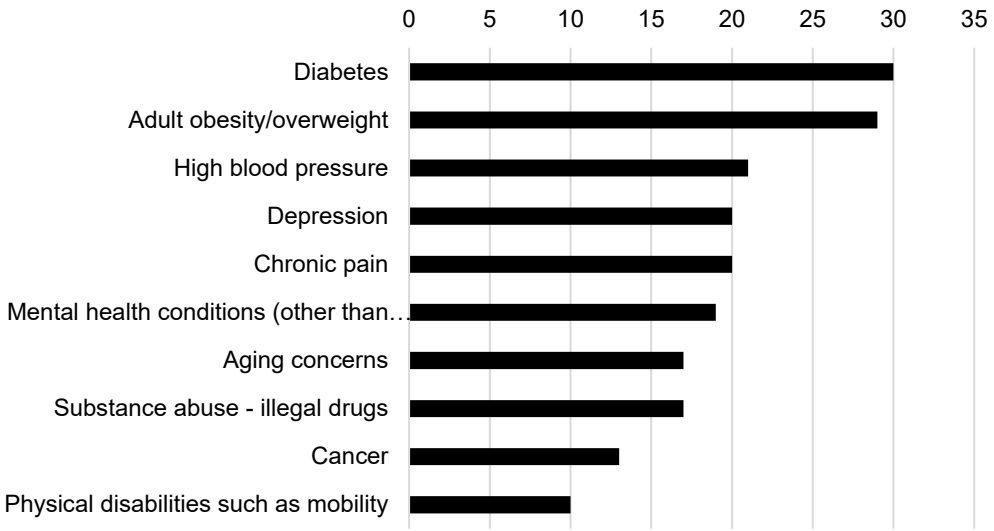
# Appendix C – Professional Provider Survey

The survey asked the following two questions:

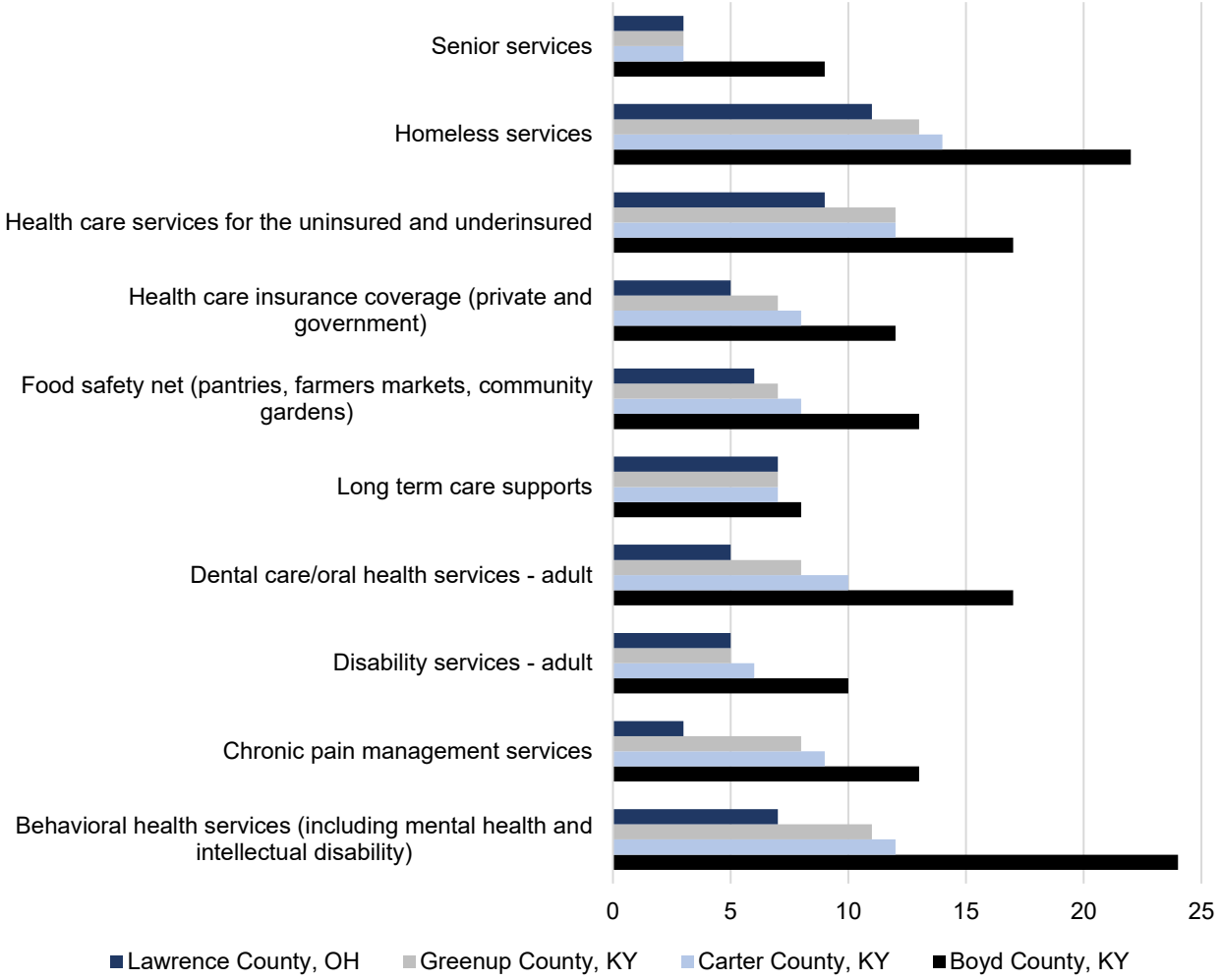
- What are the most prevalent patient health concerns in your scope of work? Based on your experience, please select the top 5 highest health concerns in your patient population. You may add additional items additional health concerns not listed
- Are there community services that need strengthening? The following is an alphabetical list of community services and supports. Please select the five services that you think need the most strengthening based on your patient population.

The survey provided predetermined responses that could be selected from the list. The following is a summary of the top 10 selected responses.

## Top 10 Most Prevalent Health Concerns




## Top 10 Community Services Need Strengthening by County



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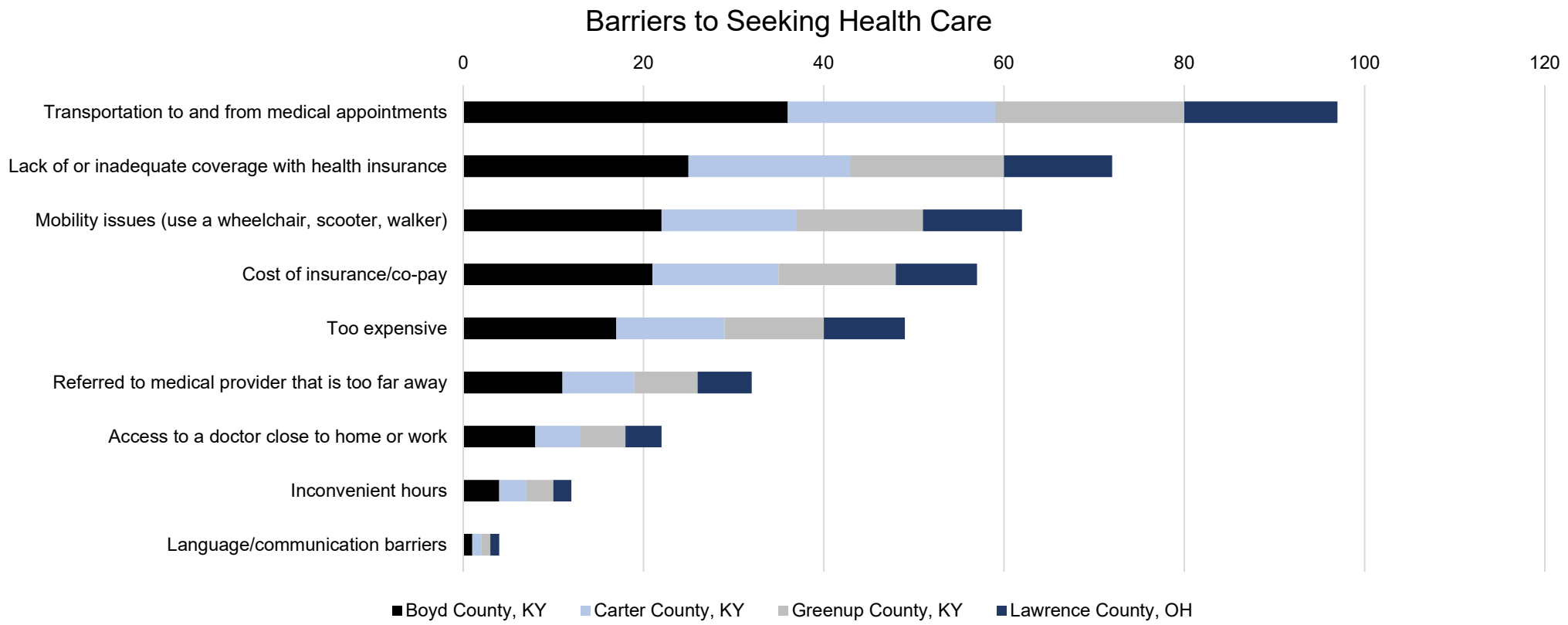
# Appendix C – Professional Provider Survey

The survey asked the following question:

- What are your patient's most common barriers to seeking health services? (Check all that apply.)

The survey provided predetermined responses that could be selected from the list. The following is a summary of the responses.



# Appendix D – Summary of Key Findings

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| Identified Health Need | Secondary Data | Community Forums | Community Survey | Professional Provider Survey |
|---|---|---|---|---|
| **Access to Health Services/Navigating Healthcare Services** | • 38.83% of the population (approximately 66,000 persons) live in an area affected by a health professional shortage area. | • Comprehensive school health programs were identified as a top health need. | • Access to healthcare and specialists was the top health issue that impacts the community most.<br>• Affordability and insurance issues was the 4th highest issue that impacts the community most.<br>• 33% of survey respondents have delayed healthcare due to cost and/or lack of insurance, which. In 2022, this percentage was 28%.<br>• **The biggest barriers to healthcare noted from survey respondents were healthcare is too expensive/can't afford it, cost of insurance and the inability to get off work for healthcare needs.** | • Lack of adequate health insurance coverage and cost of insurance were two of the most common barriers to seeking health services.<br>• Health care services for uninsured and underinsured were noted as a community service that needs strengthening. |
| **Childcare** | | • Childcare was noted as a top health need. | | • |
| **Chronic Health Conditions** | • Kentucky ranks 49th in 2023 America's Health Rankings for the percentage of adults that have multiple chronic conditions.<br>• The rates of death from heart disease, cancer and lower respiratory diseases are significantly higher for the CHNA Community compared to state and national benchmarks.<br>• Approximately 16, 200 persons have been diagnosed with diabetes in the CHNA Community.<br>• Over 47,000 persons in the CHNA community have high blood pressure. | | • Health issues that impact survey respondents most are high blood pressure, obesity and diabetes. | • Diabetes was one of the top five prevalent patient health concerns.<br>• High blood pressure was one of the top five prevalent patient health concerns.<br>• Recommended as a focus area for UK KD to address over the next three to five years. |
| **Dental Care** | • Over 20% of the population age 65+ have poor dental health which means they have lost all of their natural teeth because of tooth decay or gum disease. | • Access to dental care was noted as a top health need in 3 of the 4 counties served by UK KD. | • Access to dental care was the 4th ranked weakness noted in the community. | • Dental care/oral health services were noted as a community service that needs strengthening.<br>• Recommended as a focus area for UK KD to address over the next three to five years. |
| **Food Insecurity/Lack of Healthy Nutrition** | • Over 18% of the population (30,790 persons) live with food insecurity in the CHNA community. The rate of food insecurity is higher for children and is 23.26% which is approximately 8,400 children in the CHNA community. | • Healthy food choices was a top need identified in the Greenup County community forum. | • Lack of affordable healthy food was the 2nd biggest weakness noted in the community. | • Food safety net was noted as a community service that needs strengthening. |
| **Lack of Affordable Housing** | • 21% of households in the community, 14,092 households, are cost burdened households meaning housing costs exceed 30% of household income. | • Affordable and safe housing was a top need identified in the Greenup County community forum. | • Housing and social determinants of health was identified as the 5th highest health issue that impacts the community most.<br>• Affordable housing was the 3rd ranked weakness noted in the community. | • Homeless services were noted as the biggest community service that needs strengthening. |

# Appendix D – Summary of Key Findings

Return to Report

| Identified Health Need | Secondary Data | Community Forums | Community Survey | Professional Provider Survey |
|---|---|---|---|---|
| **Mental Health and Depression** | •20.7% of adults report frequent mental distress in the CHNA Community. | •Mental health was noted as a top health need in every county. | •Mental health and substance abuse services was identified as the 2nd highest health issue that impacts the community most. | •Depression was one of the top five prevalent patient health concerns.<br>•Behavioral health services were noted as a community service that needs strengthening.<br>•Recommended as a focus area for UK KD to address over the next three to five years. |
| **Obesity** | •Approximately 50,000 persons, or 39% of adults, are obese in the CHNA community. Obesity rates have increased by 60% over the last 15 years. | •Obesity was noted as a top health need. | •Obesity was the second ranked issue that impacts survey respondents. 65% of respondents indicated obesity/overweight impact them directly. | •One of the top five prevalent patient health concerns.<br>•Recommended as a focus area for UK KD to address over the next three to five years. |
| **Physical Inactivity** | •Kentucky ranks 49th in 2023 America's Health Rankings for exercise (% of adults) and 42nd in physical inactivity.<br>•28.3% of adults, age 20 and older, self-report no active leisure time physical activity. This is significantly higher than the national rate of 19.5%. | | •39% of respondents exercise 30 minutes a day, three to five days a week. | |
| **Poverty** | •17.38%, or 28,406 of the population in the CHNA Community live in households with income below the Federal Poverty Level.<br>•An estimated 7,862, or 22.2% of children under age 18 live in households with income below the Federal Poverty Level. | | •Poverty was identified as the biggest weakness in the community. | |
| **Preventive Care** | •The rate for preventable hospitalizations in the CHNA Community is unfavorable to state and national rates (4,821 per 100,000 population for the CHNA Community compared to 3,336 and 2,566 for Kentucky and National benchmarks, respectively. | •Proactive wellness and awareness of available resources was noted as a top health need. | | |
| **Senior Services** | | •Senior services were noted as a top health need. | | |

# Appendix D – Summary of Key Findings

Return to Report

| Identified Health Need | Secondary Data | Community Forums | Community Survey | Professional Provider Survey |
|---|---|---|---|---|
| **Smoking/Vaping** | • Kentucky ranks 46th in 2023 America's Health Rankings for adult smoking.<br>• 19.8% of women giving birth in the CHNA Community smoked during pregnancy, compared to 12.5% for Kentucky and 4.6% for the United States.<br>• The percentage of adults in the CHNA Community who currently smoke is 20.7% and is unfavorable to state and national rates. | | | |
| **Substance Abuse** | • Kentucky ranks 47th in drug related deaths and 47th in non-medical drug use (% of adults) in 2023 America's Health Rankings.<br>• The rate of deaths from opioid overdose is more than double the national rate and is nearly double the rates for Kentucky and Ohio. Boyd County has the highest rate for deaths from opioid overdose. | | | |
| **Transportation** | | • Transportation was noted as a top health need in 3 of the 4 counties. | • Transportation and accessibility were identified as the 3rd highest health issue that impacts the community most.<br>• Transportation services was the 5th ranked weakness noted in the community. | • The biggest barrier to seeking health services.<br>• Recommended as a focus area for UK KD to address over the next three to five years. |
| **Unintentional Injury** | • The rate for unintentional injuries in the CHNA Community is double the national rate and significantly higher than the rates for Kentucky and Ohio. | | | |

# Appendix E – Community Resources

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## General Resources

| Agency | Phone | Email |
|---|---|---|
| **Hillcrest-Bruce Mission**<br>Executive Director | (606) 324-5723<br>(606) 694-0504 | director@hillcrestbrucemission.com |
| **MyKy.Info**<br>Regional Resource Developer | (606) 465-9672 | dplantz@familyscholarhouse.org |
| **United Way - Northeast Kentucky**<br>CEO | (606) 325-1810<br>(606) 923-2590 | marshall@uwnek.org |
| **United Way - Northeast Kentucky**<br>Administrative Specialist & 211 Coordinator | (606) 325-1810 | uway@uwnek.org<br>211@uwnek.org |
| **United Way - Northeast Kentucky**<br>Resource Development Coordinator | (606) 325-1810 | development@uwnek.org |

# Appendix E – Community Resources

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## Food Resources

| Agency | Phone | Email |
|---|---|---|
| **Ashland Community Kitchen**<br>Director | 606-325-8144<br>606-686-0823 | ack@theneighborhood-ashland.org |
| **Ashland First UMC Food Pantry**<br>Pantry Coordinator | 606-324-6159<br>606-571-1174 | jolindaconley@hotmail.com |
| **Christ Temple Church** | 606-585-6074 | cccrockrel@gmail.com |
| **Church Without Walls** | 606-371-9350 | misfit.ministries@yahoo.com |
| **Community Assistance & Referral Service**<br>Executive Director | 606-324-2949<br>606-831-1333 | lynn@boydcountycares.org |
| **Hillcrest-Bruce Mission**<br>Pantry Coordinator | 606-324-5723<br>606-331-0977 | foodpantry@hillcrestbrucemission.com |
| **Seed & Feed** | 606-836-8944 | |
| **Seed Harvest Ministry** | 606-739-5966<br>606-585-4261 | ccofg374@gmail.com |
| **River Cities Harvest**<br>Executive Director | 606-324-3663<br>606-369-8023 | rivercitiesharvest@gmail.com |
| Meals on Wheels Greenup, Ashland | | |

# Appendix E – Community Resources

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## Housing/Shelter

| Agency | Phone | Email |
|---|---|---|
| **Ashland All Together Opportunity Center**<br>Street Outreach | (606) 324-6700 | Ashlei.felty@arccenters.com |
| **Ashland All Together Opportunity Center**<br>Street Outreach | (606) 324-6700<br>(606) 371-1621 | Keirsten.howell@arccenters.com |
| **Ashland Housing Authority**<br>Assisted Housing Specialist | (606) 385-3327 | anelson@ashlandky.gov |
| **Ashland Housing Authority**<br>Assisted Housing Specialist | (606) 385-3327<br>(606) 585-3738 | rconnor@ashlandky.gov |
| **Ashland Housing Authority**<br>Assisted Housing Specialist | (606) 385-3327 | twilks@ashlandky.gov |
| **Community Assistance & Referral Service**<br>Executive Director | (606) 324-2949<br>(606) 831-1333 | lynn@boydcountycares.org |
| **Frontier Housing**<br>President & CEO | (606) 784-2131 | t.manning-beavin@frontierky.org |
| **Frontier Housing**<br>Communications Manager | (606) 784-2131<br>(859) 967-7603 | s.ockerman@frontierky.org |
| **Mountain Comprehensive Care**<br>Mountain Haven Emergency Shelter Program Manager | (606) 784-3337<br>(606) 207-0916 | Teresa.forman@mtcomp.org |
| **Mountain Comprehensive Care**<br>Mountain Haven Emergency Shelter Case Manager | (606) 784-3337 | Sara.Lowe@mtcomp.org |
| **Oxford House**<br>Outreach Worker | (859) 953-7453 | Tara.fox@oxfordhouse.org |
| **Oxford House** | (417) 210-5791 | |
| **Safe Harbor**<br>Director | (606) 329-9304<br>(606) 923-9262 | APerkins@safeharborky.org |
| **Safe Harbor**<br>Volunteer & Communications Coordinator | (606) 329-9304<br>(606) 547-8366 | lday@safeharborky.org |
| **Salvation Army of Northeast Kentucky**<br>Corps Officer | (606) 329-2874<br>(606) 331-9014 | Jason.swain@uss.salvationarmy.org |
| **Salvation Army of Northeast Kentucky**<br>Social Worker | (606) 329-2874 | Katherine.marshall@uss.salvationarmy.org |
| **Welcome House**<br>Director of Regional Services | 606-407-1008 | bhill@welcomehouseky.org |
| **Welcome House**<br>Street Outreach Service Coordinator | 606-776-4445 | Jmarshall@welcomehouseky.org |

# Appendix E – Community Resources

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## Utility and Rent Assistance

| Agency | Phone | Email |
|---|---|---|
| **Community Assistance & Referral Service**<br>Executive Director | (606) 324-2949<br>(606) 831-1333 | lynn@boydcountycares.org |
| **Northeast Community Action Agency**<br>Community Service Block Grant Coordinator | (606) 393-1984 | angela.hall@northeastkycaa.net |
| **People Helping People**<br>Director | (606) 928-4646 | peoplehelpingpeople1@outlook.com |
| **Salvation Army of Northeast Kentucky**<br>Corps Officer | (606) 329-2874<br>(606) 331-9014 | Jason.swain@uss.salvationarmy.org |
| **Salvation Army of Northeast Kentucky**<br>Social Worker | (606) 329-2874 | Katherine.marshall@uss.salvationarmy.org |

# Appendix E – Community Resources

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## Medical Health

| Agency | Phone | Email |
|---|---|---|
| **Ashland-Boyd County Health Department**<br>Director | (606) 329-9444<br>(606) 571-4263 | Matthew.Anderson@ky.gov |
| **Ashland-Boyd County Healthy Department**<br>Community Outreach | (606) 329-9444 | tiffanied.buckner@ky.gov |
| **Carter County Health Department**<br>Health Education Coordinator | (606) 923-4456 | sldi236@uky.edu |
| **Hillcrest-Bruce Mission**<br>Health Specialist | (606) 324-5723<br>(606) 831-1001 | grants@hillcrestbrucemission.com |
| **Kentucky Homeplace - Greenup Co, Boyd Co**<br>Community Health Worker | (606) 473-6496<br>(606) 694-5194 | Misty.Rambo@uky.edu |
| **North West Labs**<br>Business Development | 304-634-9490 | chris.drummond@nwlabs.com |
| **North West Labs**<br>Business Development | 681-280-5854 | grant.thompson@nwlabs.com |
| **UK Cancer Program**<br>Regional Cancer Control Specialist (Big Sandy/FIVCO) | 606-259-6071 | Kaitlyne.Hackworth@uky.edu |
| **UKKD**<br>Director of Community Health | (606) 408-9307<br>(606) 922-7203 | diva.justice@kdmc.kdhs.us |
| **UKKD**<br>Certified Community Health Care Worker | (606) 408-0196 | tina.adkins@kdmc.kdhs.us |
| **UK - Region 8, Target 4 Project**<br>Health Education Coordinator | (740) 861-1324 | Carisa.Collins@uky.edu |
| **Greenup County Health Department Director** | (606)473-9838 | chrisg.crum@ky.gov |

# Appendix E – Community Resources

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## Behavioral Health and Substance Use

| Agency | Phone | Email |
|---|---|---|
| **Addiction Recovery Care**<br>Community Liaison - Boyd, Greenup, Lewis, Elliott | (740) 442-1538 | kelly.miller@arccenters.com |
| **Addiction Recovery Care**<br>Community Liaison - | (606) 371-4687 | lesha.elam@arccenters.com |
| **Addiction Recovery Care**<br>Case Manager | (606) 221-3251 | mannon.davis@arccenters.com |
| **AIM Behaviorial Health**<br>MD | (606) 618-0282 | drm@aimforchange.net |
| **AIM Behaviorial Health**<br>Practice Administrator | (606) 618-0282 | christa@aimforchange.net |
| **AIM Behaviorial Health**<br>ICCM | (606) 618-0282<br>(606) 571-1180 | candace@aimforchange.net |
| **AIM Behaviorial Health**<br>Targeted Case Manager | (606) 618-0282 | paige@aimforchange.net |
| **AIM Behaviorial Health**<br>Case Manager | (606) 618-0282<br>(606) 694-6713 | josh@aimforchange.net |
| **Bellefonte Hospital and Recovery Center**<br>Community CEO - Bellefonte Hospital | (304) 952-3197 | johnathan.frazier@arccenters.com |
| **Bellefonte Hospital and Recovery Center**<br>Patient Access Manager | (606) 369-0771<br>(606) 483-4404 | micki.arvin@arccenters.com |
| **Boyd County Jail**<br>Therapist | (606) 465-6169 | taylor@qualitycorrectional.com |
| **Boyd County Jail**<br>Therapist | | latrisha.duff@qualitycorrectional.com |
| **Contemplations Behavioral Health Services**<br>Counselor | (606) 405-0200 | dara.cyrus@contemplationsbhs.com |
| **Contemplations Behavioral Health Services** | (606) 492-8788 | amelia.keith@contemplationsbhs.com |
| **Crossroads Treatment Center**<br>Community Engagement Director | (408) 449-7666 | oandrews@ctc.care |
| **Crossroads Treatment Center**<br>Community Engagement (Kentucky) | (270) 349-2007 | darcher@ctc.care |
| **Fresh Start**<br>Targeted Case Manager | | jnichols@freshstarthealthcenters.com |
| **Groups Recover Together**<br>Regional Operations Supervisor | 859-201-1667 | shamekia.hampton@joingroups.com |
| **Groups Recover Together**<br>Operations Director (KY/WV) | 304-693-2919 | susan.coyer@joingroups.com |

# Appendix E – Community Resources

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## Behavioral Health and Substance Use

| Agency | Phone | Email |
|---|---|---|
| **Groups Recover Together**<br>Business Development Manager | (606) 309-1749 | pamela.bentley@joingroups.com |
| **Groups Recover Together**<br>Office Manager | (606) 309-1749<br>(606) 552 0921 | matt.hutchison@joingroups.com |
| **Groups Recover Together** | (606) 309-1749 | joshua.davis@joingroups.com |
| **Hillcrest-Bruce Mission**<br>Peer Support Specialist & Recovery Coach | (606) 324-5723<br>(722) 284-6351 | peersupport@hillcrestbrucemission.com |
| **Infinity Center**<br>Clinical Social Worker | 606-420-4070<br>606-369-8682 | erick.f@infinityctr.com |
| **Infinity Center**<br>Case Manager | 606-420-4070<br>606-254-7511 | beth@infinityctr.com |
| **Mountain Comprehensive HomePlace Clinic**<br>Clinic Coordinator | 606-393-3293 | sara.fry@mtcomp.org |
| **Mountain Comprehensive Safe Harbor Outpatient**<br>Targeted Case Manager | 606-393-3293<br>F 606-393-3912 | Mary.Lowe@mtcomp.org |
| **Mountain Comprehensive HomePlace Clinic**<br>Case Manager | 606-467-2650<br>F 606-467-2651 | rebekah.napier@mtcomp.org |
| **Mountain Comprehensive Safe Harbor Outpatient**<br>Billing Coordinator | 606-393-3293<br>F 606-393-3912 | staci.caudill@mtcomp.org |
| **Operation UNITE**<br>Coalition Coordinator | 606-889-0422<br>606-792-1085 | cbohon@operationunite.org |
| **OVP**<br>Operations Manager - Ashland | (304) 962-7168 | tsuman@ovp.healthcare |
| **OVP**<br>Case Manager - Ashland | (606) 329-0727<br>(606) 585-6645 | amurphy@ovp.healthcare |
| **Oxford House**<br>Outreach Worker | (859) 953-7453 | Tara.fox@oxfordhouse.org |
| **Oxford House** | (417) 210-5791 | |

# Appendix E – Community Resources

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## Behavioral Health and Substance Use

| Agency | Phone | Email |
|---|---|---|
| **Pathways**<br>CRRU | (606) 939-2488 | aellis@pathways-ky.org |
| **Pathways**<br>Youth Treatment Coordinator | | atackett@pathways-ky.org |
| **Pathways**<br>QRT Peer Support Specialist | (606) 324-1141<br>(606) 694-7618 | csammons@pathways-ky.org |
| **Pathways**<br>Pathways 2 Go Therapist/Supervisor | | dcheesbro@pathways-ky.org |
| **Pathways**<br>Prevention Specialist - Community Collaboration | 606-329-8588, Ext 4119 | dellis@pathways-ky.org |
| **Pathways**<br>SMVF, CRRU, QRT Peer Support Specialist | (606) 324-1141 | jgibson@pathways-ky.org |
| **Pathways**<br>Targeted Case Manager | 606-324-3005 | jvallance@pathways-ky.org |
| **Pathways**<br>QRT Peer Support Specialist | (606) 324-1141<br>(606) 939-3435 | mpatrick@pathways-ky.org |
| **Pathways**<br>QRT Peer Support Specialist | (606) 324-1141<br>(606) 615-5006 | rwilliamson@pathways-ky.org |
| **Pathways**<br>Chief Business Development Officer | (606) 329-8588 | rnunley@pathways-ky.org |
| **Pathways**<br>Tri-County KY-ASAP Coordinator | (606) 329-8588 | scastle@pathways-ky.org |
| **Pathways**<br>Dir of Business Development & Community Relations | (606) xxx-xxxx<br>(606) 483-4140 | smurphy@pathways-ky.org |
| **Ramey-Estep / Regroup**<br>VOCA Community Liaison | 606-255-1398 | savana.sparks@rameyestep.com |
| **Ramey-Estep / Regroup**<br>Director of Case Management Services | | trudmann@rameyestep.com |
| **The Ridge** | (859) 333-5510 | christine.jett@uhsinc.com |
| **Voices of Hope**<br>Recovery Coach | (859) 230-9783<br>(606) 371-0772 | shirley.wilks@voicesofhopelex.org |

# Appendix E – Community Resources

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## Youth

| Agency | Phone | Email |
|---|---|---|
| **Ashland-Boyd County Health Department (HANDS)**<br>Manager | (606) 329-9444<br>(606) 571-4263 | MaryE.Qualls@ky.gov |
| **Ashland-Boyd County Health Department (HANDS)** | (606) 329-9444 | nikkim.wilburn@ky.gov |
| **Ashland-Boyd County Health Department (HANDS)** | (606) 329-9444 | alecia.hall@ky.gov |
| **Court Appointed Special Advocates (CASA)**<br>Executive Director | (606) 739-2177 | jperkins@casaneky.org |
| **Court Appointed Special Advocates (CASA)**<br>Program Coordinator | (606) 739-2177 | abrowning@casaneky.org |
| **Court Appointed Special Advocates (CASA)**<br>Advocate & Case Coordinator | (606) 739-2177<br>(407) 405-0536 | mgraham@casaneky.org |
| **The Kentucky Early Intervention System**<br>Point of Entry Manager | (606) 929-9155<br>(606) 369-6038 | clorissad.mcconnell@ky.gov |
| **The Kentucky Early Intervention System**<br>Administrative Asst | (606) 929-9155<br>(606) 939-0076 | DonnaG.Chadwick@ky.gov |
| **Hope's Place Child Advocacy Center**<br>Counselor/Educator | (606) 325-4737 | cara@hopesplace.org |
| **Hope's Place Child Advocacy Center**<br>Victim Advocate | (606) 325-4737 | angela@hopesplace.org |
| **Pathways - "The Drop"**<br>Site Supervisor | 606-393-1522<br>606-922-6016 | teden@pathways-ky.org |
| **Pathways**<br>Transition Age Youth Coordinator | 606-324-3005 x4761<br>606-331-8029 | kmullins@pathways-ky.org |
| **Two Hearts Pregnancy**<br>Executive Director | 606-325-7654 | sandybellomy@twoheartspcc.org |
| **UK Kinship Care**<br>Peer Support | 606-615-3743 | lory.scarberry@uky.edu |

# Appendix E – Community Resources

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## Seniors

| Agency | Phone | Email |
|---|---|---|
| **Ashland Senior Center**<br>Director | 606-324-7323<br>606-831-0328 | clwspriggs@outlook.com |
| **Boyd County Senior Center**<br>Director | (606) 739-6349 | haley.mullins@northeastkycaa.net |
| **Legal Aid of the Bluegrass**<br>Long-Term Care Ombudsman | (606) 329-1321<br>(606) 780-2258 | ahamilton@lablaw.org |
| **FIVCO**<br>Director of Aging & Independent Living | (606)-929-1366 | nicole@fivco.org |
| **FIVCO**<br>Aging & Disability Resource Counselor | (606)-929-1366 | amy@fivco.org |
| **FIVCO**<br>Aging and Disability Vaccination Collaborative Coord | (606) 929-1366<br>(502) 496-3096 | donnal@fivco.org |

# Appendix E – Community Resources

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## Veterans

| Agency | Phone | Email |
|---|---|---|
| **VA**<br>Homeless Outreach | (304) 529-9142<br>(304) 544-9843 | Jazzy.Lowe@va.gov |
| **Kentucky Career Center**<br>Veteran Employment Counselor | (606) 356-7417 | albert.mabry@ky.gov |
| **Ky Dept of Veteran Affairs**<br>Field Representative | (606) 585-3833 | Rickiej.Hammond@ky.gov |
| **Pathways**<br>Service Members, Veterans, and Families Coordinator | (606) 324-1141 | jgibson@pathways-ky.org |
| **Volunteers of America Mid States SSVF**<br>Sustainability Case Manager | (606) 474-0200 | amandao@voamid.org |
| **Volunteers of America Mid States - SSVF**<br>Case Manager | (606) 474-0200 | bretts@voamid.org |
| **Volunteers of America Mid States - SSVF**<br>Case Manager | (606) 474-0200<br>(606) 939-8508 | catherinew@voamid.org |
| **Volunteers of America Mid States SSVF**<br>Case Manager | (606) 474-0200 | dwaynef@voamid.org |

# Limitations and Information Gaps

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As with all data collection efforts, there are several limitations related to the assessment's research methods that should be acknowledged. Years of the most current data available differ by data source. In some instances, 2024 may be the most current year available for data, while 2014 may be the most current year for other sources. Likewise, survey data based on self-reports, such as the Behavioral Risk Factor Surveillance Survey (BRFSS), should be interpreted with particular caution. In some instances, respondents may over or under report behaviors and illnesses based on fear of social stigma or misunderstanding the question being asked.

In addition, respondents may be prone to recall bias – that is, they may attempt to answer accurately, but they remember incorrectly. In some surveys, reporting and recall bias may differ according to a risk factor or health outcome of interest. Despite these limitations, most of the self-report surveys analyzed in this CHNA benefit from large sample sizes and repeated administrations, enabling comparison over time. Similarly, while the qualitative data collected for this study provide valuable insights, results are not statistically representative of a larger population due to nonrandom recruiting techniques and a small sample size. Data were collected at one point in time and among a limited number of individuals.

Therefore, findings, while directional and descriptive, should not be interpreted as definitive.