2025 COMMUNITY HEALTH NEEDS ASSESSMENT

Continuing Care Hospital Service Area

Bath, Bourbon, Clark, Estill, Fayette, Franklin, Jessamine, Madison, Montgomery, Powell, Rockcastle, Scott, Whitley & Wolfe Counties, Kentucky

Sponsored by

Continuing Care Hospital

CHI Saint Joseph Health
A member of CommonSpirit

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Prepared by
www.PRCExcellence.com

TABLE OF CONTENTS

INTRODUCTION

EXECUTIVE SUMMARY

CHNA Purpose

The purpose of this Community Health Needs Assessment (CHNA) is to identify and prioritize significant health needs in the community served by Continuing Care Hospital (CCH). The priorities identified in this report help to guide the hospital's community health improvement programs and community benefit activities, as well as its collaborative efforts with other organizations that share a mission to improve health. This CHNA report meets requirements of the Patient Protection and Affordable Care Act that not-for-profit hospitals conduct a community health needs assessment at least once every three years.

CommonSpirit Health Commitment & Mission

The hospital's commitment to engaging with the community, assessing priority needs, and helping to address them with community partners is in keeping with its mission. As CommonSpirit Health, we make the healing presence of God known in our world by improving the health of the people we serve, especially those who are vulnerable, while we advance social justice for all.

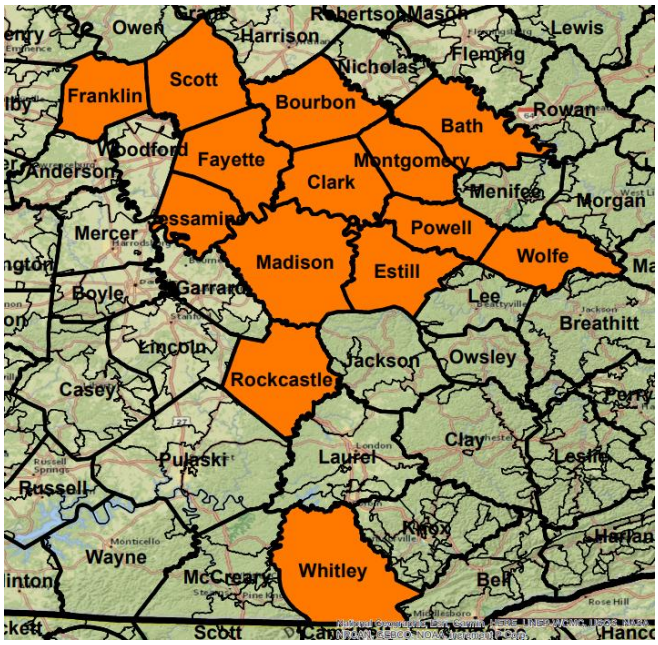
CHNA Collaborators

Continuing Care Hospital is the sole sponsor of this assessment, although 15 other hospitals also serve our area. This assessment was conducted on behalf of Continuing Care Hospital by PRC, a nationally recognized health care consulting firm with extensive experience conducting Community Health Needs Assessments in hundreds of communities across the United States since 1994.

Community Definition

Continuing Care Hospital is located at 1 Saint Joseph Drive, 3rd and 4th Floors, Lexington, KY, 40504. The hospital tracks ZIP Codes of origin for all patient admissions and includes all who received care without regard to insurance coverage or eligibility for financial assistance. The hospital defines its primary service area as including 64 ZIP Codes in these Kentucky counties: Bath, Bourbon, Clark, Estill, Fayette, Franklin, Jessamine, Madison, Montgomery, Powell, Rockcastle, Scott, Whitley, and Wolfe.

These service area counties include the following ZIP Codes: 40004, 40012, 40013, 40020, 40048, 40051, 40107, 40385, 40403, 40404, 40405, 40475, 40334, 40337, 40353, 40358, 40360, 40366, 40371, 40374, 40701, 40702, 40741, 40745, 40759, 40763, 40769, 40324, 40336, 40340, 40356, 40370, 40379, 40390, 40391, 40502, 40503, 40504, 40505, 40506, 40507, 40508, 40509, 40510, 40511, 40512, 40513, 40514, 40515, 40516, 40517, 40575, 40601, 40312, 40348, 40361, 40380, 40409, 40456, 40460, 41301, 41332, 41360, and 41365.



Assessment Process & Methods

This assessment incorporates data from multiple sources, including primary research (through the PRC Community Health Survey and PRC Online Key Informant Survey), as well as secondary research (vital statistics and other existing health-related data). It also allows for comparison to benchmark data at the state and national levels.

Primary Data Collection. Primary data represent the most current information provided in this assessment. The PRC Community Health Survey provides an aggregate snapshot of the health experience, behaviors, and needs of residents in the community. The PRC Online Key Informant Survey allows key community leaders and providers in the area an opportunity to give extensive qualitative input about what they see as the most pressing issues in the populations they serve.

Secondary Data Collection. Secondary data provide information from existing data sets (e.g., public health records, census data, etc.) that complement the primary research findings.

Identifying & Prioritizing Significant Health Needs

Significant health needs for the community were identified through a review of the data collected for this assessment. These were determined after consideration of various criteria, including: standing in comparison with benchmark data (particularly national data); the preponderance of significant findings within topic areas; the magnitude of the issue in terms of the number of persons affected; and the potential health impact of a given issue. These also take into account those issues of greatest concern to the key informants giving input to this process.

Prioritization of the health needs was determined based on a prioritization exercise conducted among providers and other community leaders (representing a cross-section of community-based agencies and organizations) as part of the Online Key Informant Survey.

This process yielded the following prioritized list of community health needs:

1. **MENTAL HEALTH** ► Key informants identified this as a top concern in the community. Survey findings revealed needs related to depression, stress, and difficult obtaining needed services for mental health.
2. **SUBSTANCE USE** ► Key informants identified this as a top concern in the community. Existing data revealed needs relative to unintentional drug-induced deaths. Survey findings revealed needs related to use of prescription opioids and the impact of substance use in peoples' lives.
3. **DIABETES** ► Key informants identified this as a top concern in the community. Survey findings revealed needs related to diabetes prevalence.
4. **NUTRITION, PHYSICAL ACTIVITY & WEIGHT** ► Key informants identified this as a top concern in the community. Survey findings revealed needs related to meeting physical activity guidelines and the prevalence of adult overweight/obesity.
5. **HEART DISEASE & STROKE** ► Existing data show cardiovascular disease to be a leading cause of death. Survey findings revealed needs related to high blood pressure prevalence, high blood cholesterol prevalence, and overall cardiovascular risk.

Other health needs identified (through a combination of survey findings, key informant input, and/or other health data) include:

- TOBACCO USE
- CANCER
- DISABLING CONDITIONS
- INFANT HEALTH & FAMILY PLANNING
- RESPIRATORY DISEASE
- ACCESS TO HEALTH CARE SERVICES
- INJURY & VIOLENCE

Further, the **social determinants of health** are an important lens through which to understand and address all of these health issues.

Resources Potentially Available to Meet Significant Health Needs

Measures and resources (such as programs, organizations, and facilities in the community) potentially available to address the significant health needs were identified by key informants giving input to this process. While not exhaustive, this list — which includes many potential resources — draws on the experiences and wide knowledge base of those directly serving our community.

Report Adoption, Availability & Comments

This CHNA report was adopted by the Continuing Care Hospital Board of Directors on May 14, 2025.

The report is widely available to the public at CHI Saint Joseph Health's website on the Healthy Communities page. Written comments on this report can be submitted to CHI Saint Joseph Health, Healthy Communities, 1451 Harrodsburg Road, Suite A-410, Lexington, KY 40504, or by email to Sherri.Craig@commonspirit.org.

IRS FORM 990, SCHEDULE H COMPLIANCE

For nonprofit hospitals, a Community Health Needs Assessment (CHNA) also serves to satisfy certain requirements of tax reporting, pursuant to provisions of the Patient Protection & Affordable Care Act of 2010. To understand which elements of this report relate to those requested as part of hospitals' reporting on IRS Schedule H (Form 990), the following table cross-references related sections.

IRS FORM 990, SCHEDULE H	See Report Page
Part V Section B Line 3a A definition of the community served by the hospital facility	9
Part V Section B Line 3b Demographics of the community	31
Part V Section B Line 3c Existing health care facilities and resources within the community that are available to respond to the health needs of the community	123
Part V Section B Line 3d How data was obtained	7
Part V Section B Line 3e The significant health needs of the community	15
Part V Section B Line 3f Primary and chronic disease needs and other health issues of uninsured persons, low-income persons, and minority groups	Addressed Throughout
Part V Section B Line 3g The process for identifying and prioritizing community health needs and services to meet the community health needs	26
Part V Section B Line 3h The process for consulting with persons representing the community's interests	11
Part V Section B Line 3i The impact of any actions taken to address the significant health needs identified in the hospital facility's prior CHNA(s)	129

ASSESSMENT PROCESS & METHODS

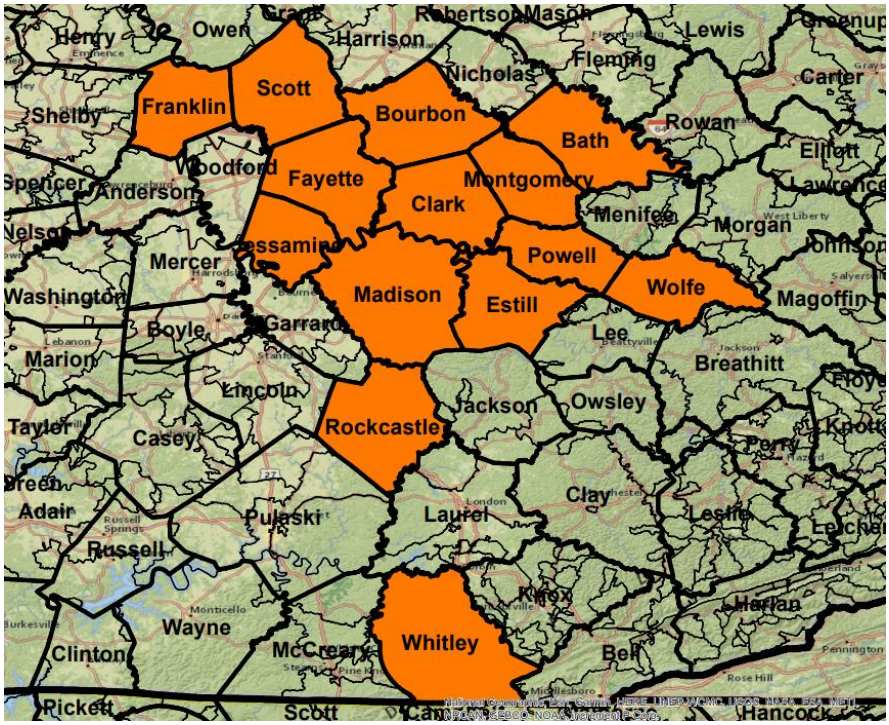
PRC Community Health Survey

Survey Instrument

The survey instrument used for this study is based largely on the Centers for Disease Control and Prevention (CDC) Behavioral Risk Factor Surveillance System (BRFSS), as well as various other public health surveys and customized questions addressing gaps in indicator data relative to health promotion and disease prevention objectives and other recognized health issues. The final survey instrument was developed by CHI Saint Joseph Health and PRC.

Community Definition

The study area for this assessment (referred to as “Continuing Care Hospital Service Area” or “CCH” in this report), determined based on the ZIP Codes of residence of recent patients of Continuing Care Hospital, includes Bath, Bourbon, Clark, Estill, Fayette, Franklin, Jessamine, Madison, Montgomery, Powell, Rockcastle, Scott, Whitley, and Wolfe counties in Kentucky, as illustrated in the following map.



Sample Approach & Design

A precise and carefully implemented methodology is critical in asserting the validity of the results gathered in the PRC Community Health Survey. Thus, to ensure the best representation of the population surveyed, a mixed-mode methodology was implemented. This included surveys conducted via telephone (landline and cell phone), as well as through online questionnaires. The surveys were administered September through December 2024.

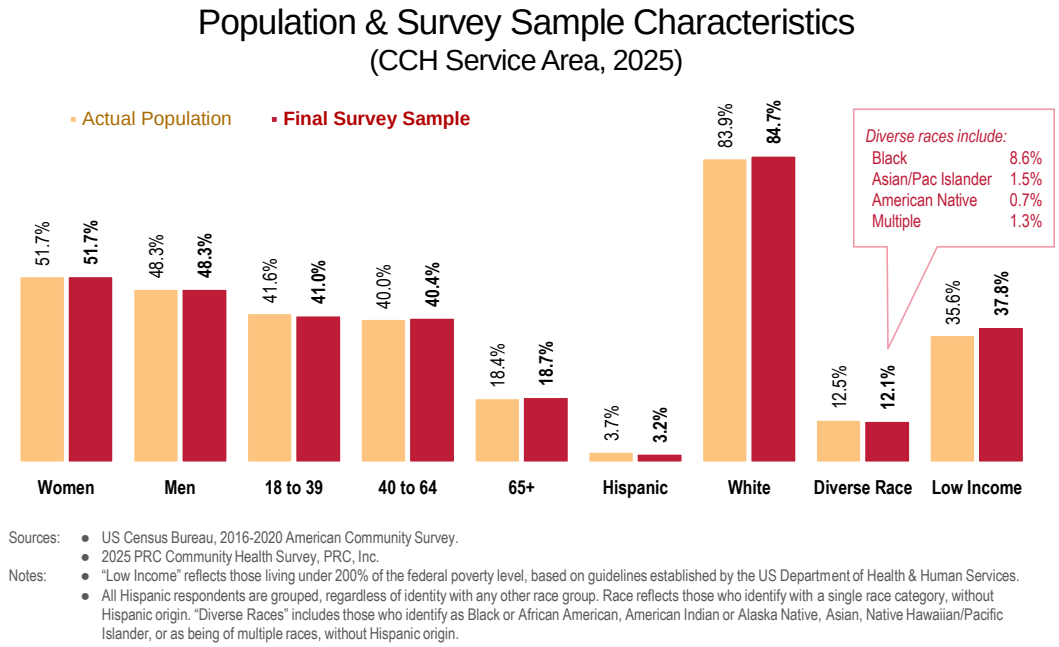
The sample design used for this effort consisted of a stratified random sample of 973 individuals age 18 and older in the Continuing Care Hospital Service Area. Once the interviews were completed, these were weighted in proportion to the actual population distribution so as to appropriately represent the service area as a whole. All administration of the surveys, data collection, and data analysis was conducted by PRC.

For statistical purposes, the maximum rate of error associated with a sample size of 973 respondents is ±3.1% at the 95 percent confidence level.

Sample Characteristics

To accurately represent the population studied, PRC strives to minimize bias through application of a proven telephone methodology and random-selection techniques. While this random sampling of the population produces a highly representative sample, it is a common and preferred practice to "weight" the raw data to improve this representativeness even further. This is accomplished by adjusting the results of a random sample to match the geographic distribution and demographic characteristics of the population surveyed (poststratification), so as to eliminate any naturally occurring bias. Specifically, once the raw data are gathered, respondents are examined by key demographic characteristics (namely sex, age, race, ethnicity, and poverty status), and a statistical application package applies weighting variables that produce a sample which more closely matches the population for these characteristics. Thus, while the integrity of each individual's responses is maintained, one respondent's responses might contribute to the whole the same weight as, for example, 1.1 respondents. Another respondent, whose demographic characteristics might have been slightly oversampled, might contribute the same weight as 0.9 respondents.

The following chart outlines the characteristics of the Continuing Care Hospital Service Area sample for key demographic variables, compared to actual population characteristics revealed in census data. [Note that the sample consisted solely of area residents age 18 and older; data on children were given by proxy by the person most responsible for that child's health care needs, and these children are not represented demographically in this chart.]



Sources:
- US Census Bureau, 2016-2020 American Community Survey.
- 2025 PRC Community Health Survey, PRC, Inc.

Notes:
- "Low Income" reflects those living under 200% of the federal poverty level, based on guidelines established by the US Department of Health & Human Services.
- All Hispanic respondents are grouped, regardless of identity with any other race group. Race reflects those who identify with a single race category, without Hispanic origin. "Diverse Races" includes those who identify as Black or African American, American Indian or Alaska Native, Asian, Native Hawaiian/Pacific Islander, or as being of multiple races, without Hispanic origin.

The sample design and the quality control procedures used in the data collection ensure that the sample is representative. Thus, the findings may be generalized to the total population of community members in the defined area with a high degree of confidence.

Online Key Informant Survey

To solicit input from key informants, those individuals who have a broad interest in the health of the community, an Online Key Informant Survey also was implemented in January and February 2025, as part of this process. A list of recommended participants was provided by CHI Saint Joseph Health; this list included names and contact information for physicians, public health representatives, other health professionals, social service providers, and a variety of other community leaders. Potential participants were chosen because of their ability to identify primary concerns of the populations with whom they work, as well as of the community overall. (Note that geographic coverage for this Online Key Informant Survey differed slightly from the CCH Service Area and included the following counties: Anderson, Clark, Estill, Fayette, Franklin, Jackson, Jessamine, Laurel, Madison, Montgomery, Scott, Whitley, and Woodford.)

Key informants were contacted by email, introducing the purpose of the survey and providing a link to take the survey online; reminder emails were sent as needed to increase participation. In all, 73 community representatives took part in the Online Key Informant Survey, as outlined in the table that follows:

ONLINE KEY INFORMANT SURVEY PARTICIPATION	
KEY INFORMANT TYPE	NUMBER PARTICIPATING
Physicians	1
Public Health Representatives	5
Other Health Providers	4
Social Services Providers	17
Other Community Leaders	46

Through this process, input was gathered from individuals whose organizations work with low-income, minority, or other medically underserved populations. These populations include:

- African-Americans
- All populations
- Caregivers of disabled
- Disabled
- Disabled students
- Domestic violence survivors
- Elderly
- Families with no preparedness plan
- Hispanics
- Homeless
- Immigrants/refugees
- LGBTQIA+
- Low income
- Low income students
- Medicare/Medicaid patients
- People of color
- Pregnant women
- Rural
- Those who need respite care
- Those who need specialty care
- Those with dementia
- Those with language barriers
- Those with mental health issues
- Those with sickle cell
- Those with substance abuse issues
- Those without established care
- Title 1 schools
- Undocumented
- Unemployed/underemployed
- Uninsured/underinsured
- Vulnerable adults
- West Africans
- Women caregivers for those with dementia
- Youth

Final participation included representatives of the organizations outlined below.

- 5/3 Bank
- Aging and Disability Resource Center
- Alzheimer's Association, Greater Kentucky & Southern Indiana
- American Red Cross
- Bluegrass Care Navigators
- Bluegrass Community & Technical College
- Catholic Conference of Kentucky
- Catholic Diocese of Lexington
- Community Inspired Lexington
- Consolidated Baptist Church
- Council on Postsecondary Education
- Department for Behavioral Health
- Department for Community Based Services
- Fayette County Public Schools
- FoodChain
- God's Food Pantry
- Habitat for Humanity
- HealthFirst Bluegrass
- Jessamine County Government
- Jessamine County Health Department
- Kentucky Equal Justice Center
- Kentucky Legislature
- Kentucky Refugee Ministry
- Kentucky State University
- LexArts
- Lexington-Fayette Urban County Government
- Lexington Fire Department
- Lexington Rescue Mission
- Lexington-Fayette County Health Department
- LFUCG Office of Homelessness Prevention and Intervention
- Lincoln Memorial University
- Mission Lexington
- New Vista
- Office of Drug Control Policy
- Refuge for Women
- Sisters of Charity of Nazareth
- Southland Christian Church
- Surgery on Sunday
- The Hope Center
- The Nature Conservancy
- The Nest
- Transylvania University
- U of L Health
- US Senate
- University of Kentucky
- Voices of Hope Lexington
- YMCA of Central Kentucky

In the online survey, key informants were asked to rate the degree to which various health issues are a problem in their own community. Follow-up questions asked them to describe why they identify problem areas as such and how these might better be addressed. Results of their ratings, as well as their verbatim comments, are included throughout this report as they relate to the various other data presented.

Public Health, Vital Statistics & Other Data

A variety of existing (secondary) data sources was consulted to complement the research quality of this Community Health Needs Assessment. Data for the Continuing Care Hospital Service Area were obtained from the following sources (specific citations are included with the graphs throughout this report):

- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension, SparkMap (sparkmap.org)
- Centers for Disease Control & Prevention, Office of Infectious Disease, National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention
- Centers for Disease Control & Prevention, Office of Public Health Science Services, National Center for Health Statistics
- National Cancer Institute, State Cancer Profiles
- US Census Bureau, American Community Survey
- US Census Bureau, County Business Patterns
- US Census Bureau, Decennial Census
- US Department of Agriculture, Economic Research Service
- US Department of Health & Human Services
- US Department of Health & Human Services, Health Resources and Services Administration (HRSA)
- US Department of Justice, Federal Bureau of Investigation
- US Department of Labor, Bureau of Labor Statistics

Benchmark Comparisons

Kentucky Data

State-level findings are provided where available as an additional benchmark against which to compare local findings. For survey indicators, these are taken from the most recently published data from the CDC's Behavioral Risk Factor Surveillance System (BRFSS). For other indicators, these draw from vital statistics, census, and other existing data sources.

National Data

National survey data, which are also provided in comparison charts, are taken from the *2023 PRC National Health Survey*; these data may be generalized to the US population with a high degree of confidence. National-level findings (from various existing resources) are also provided for comparison of secondary data indicators.

Healthy People 2030 Objectives

Healthy People provides 10-year, measurable public health objectives — and tools to help track progress toward achieving them. Healthy People identifies public health priorities to help individuals, organizations, and communities across the United States improve health and well-being. Healthy People 2030, the initiative's fifth iteration, builds on knowledge gained over the first four decades.

The Healthy People 2030 framework was based on recommendations made by the Secretary's Advisory Committee on National Health Promotion and Disease Prevention Objectives for 2030. After receiving feedback from individuals and organizations and input from subject matter experts, the US Department of Health and Human Services (HHS) approved the framework which helped guide the selection of Healthy People 2030 objectives.

Determining Significance

Differences noted in this report represent those determined to be significant. For survey-derived indicators (which are subject to sampling error), statistical significance is determined based on confidence intervals (at the 95 percent confidence level), using question-specific samples and response rates. For the purpose of this report, "significance" of secondary data indicators (which do not carry sampling error but might be subject to reporting error) is determined by a 15% variation from the comparative measure.

Information Gaps

While this assessment is quite comprehensive, it cannot measure all possible aspects of health in the community, nor can it adequately represent all possible populations of interest. It must be recognized that these information gaps might in some ways limit the ability to assess all of the community's health needs.

For example, certain population groups — such as the homeless, institutionalized persons, or those who only speak a language other than English or Spanish — are not represented in the survey data. Other population groups — for example, pregnant women, LGBTQ+ residents, undocumented residents, and members of certain racial/ethnic or immigrant groups — while included in the overall findings, might not be individually identifiable or might not comprise a large-enough sample for independent analyses.

In terms of content, this assessment was designed to provide a comprehensive and broad picture of the health of the overall community. However, there are certainly medical conditions that are not specifically addressed.

Public Comment

CHI Saint Joseph Health invited written comments on the most recent CHNA report and implementation strategies both in the documents and on the website, where they are widely available to the public. Seven comments were received; these comments were taken into account when planning this assessment.

SUMMARY OF FINDINGS

Summary Tables: Comparison With Benchmark Data

Reading the Summary Tables

- In the following tables, Continuing Care Hospital Service Area results are shown in the larger, gray column.
- The columns to the right of the service area column provide comparisons between local data and any available state and national findings, and Healthy People 2030 objectives. Symbols indicate whether the Continuing Care Hospital Service Area compares favorably (🌞), unfavorably (🌧), or comparably (🌤) to these external data.

Note that blank table cells signify that data are not available or are not reliable for that area and/or for that indicator.

Tip: Indicator labels beginning with a "%" symbol are taken from the PRC Community Health Survey; the remaining indicators are taken from secondary data sources.

SOCIAL DETERMINANTS	CCH Service Area	CCH SERVICE AREA vs. BENCHMARKS vs. KY	vs. US	vs. HP2030
Linguistically Isolated Population (Percent)	2.2		0.0	
Population in Poverty (Percent)	15.8	16.1	12.4	8.0
Children in Poverty (Percent)	19.5	20.9	16.3	8.0
No High School Diploma (Age 25+, Percent)	9.9	11.5	10.6	
Unemployment Rate (Age 16+, Percent)	4.4	5.1	3.9	
% Unable to Pay Cash for a $400 Emergency Expense	40.8		34.0	
% Worry/Stress Over Rent/Mortgage in Past Year	41.2		45.8	
% Unhealthy/Unsafe Housing Conditions	19.4		16.4	
Population With Low Food Access (Percent)	19.2	19.8	22.2	
% Food Insecure	41.6		43.3	
		better	similar	worse

OVERALL HEALTH	CCH Service Area	CCH SERVICE AREA vs. BENCHMARKS vs. KY	vs. US	vs. HP2030
% "Fair/Poor" Overall Health	21.0	21.9	15.7	
		better	similar	worse

ACCESS TO HEALTH CARE	CCH Service Area	CCH SERVICE AREA vs. BENCHMARKS		
		vs. KY	vs. US	vs. HP2030
% [Age 18-64] Lack Health Insurance	**5.8**	4.5	8.1	7.6
% Difficulty Accessing Health Care in Past Year (Composite)	**53.9**		52.5	
% Cost Prevented Physician Visit in Past Year	**18.5**	10.0	21.6	
% Cost Prevented Getting Prescription in Past Year	**22.7**		20.2	
% Difficulty Getting Appointment in Past Year	**29.1**		33.4	
% Inconvenient Hrs Prevented Dr Visit in Past Year	**21.2**		22.9	
% Difficulty Finding Physician in Past Year	**17.4**		22.0	
% Transportation Hindered Dr Visit in Past Year	**17.6**		18.3	
% Language/Culture Prevented Care in Past Year	**1.7**		5.0	
% Stretched Prescription to Save Cost in Past Year	**20.9**		19.4	
% Difficulty Getting Child's Health Care in Past Year	**6.4**		11.1	
% Typically Travel Over 25 Miles for Health Care Services	**10.8**			
% Traveled for Health Care 4+ Times in the Past Year	**17.5**			
Primary Care Doctors per 100,000	**107.4**	94.8	116.3	
% Have a Specific Source of Ongoing Care	**74.4**		69.9	84.0
% Routine Checkup in Past Year	**71.6**	78.6	65.3	

ACCESS TO HEALTH CARE SERVICES (continued)	CCH Service Area	CCH SERVICE AREA vs. BENCHMARKS vs. KY	vs. US	vs. HP2030
% [Child 0-17] Routine Checkup in Past Year	**84.0**		77.5	
% Two or More ER Visits in Past Year	**20.5**		15.6	
% Rate Local Health Care "Fair/Poor"	**12.3**		11.5	
		better	similar	worse

CANCER	CCH Service Area	CCH SERVICE AREA vs. BENCHMARKS vs. KY	vs. US	vs. HP2030
Cancer Deaths per 100,000	**198.7**	228.6	182.5	122.7
Lung Cancer Deaths per 100,000	**53.1**	64.8	39.8	25.1
Female Breast Cancer Deaths per 100,000	**25.2**	27.6	25.1	15.3
Prostate Cancer Deaths per 100,000	**17.3**	19.1	20.1	16.9
Colorectal Cancer Deaths per 100,000	**17.7**	21.3	16.3	8.9
Cancer Incidence per 100,000	**491.5**	506.8	442.3	
Lung Cancer Incidence per 100,000	**79.1**	84.4	54.0	
Female Breast Cancer Incidence per 100,000	**132.3**	126.7	127.0	
Prostate Cancer Incidence per 100,000	**109.4**	108.3	110.5	
Colorectal Cancer Incidence per 100,000	**41.2**	45.9	36.5	

CANCER (continued)	CCH Service Area	CCH SERVICE AREA vs. BENCHMARKS vs. KY	vs. US	vs. HP2030
% Cancer	13.2	12.6	7.4	
% [Women 50-74] Breast Cancer Screening	77.3		64.0	80.5
% [Women 21-65] Cervical Cancer Screening	64.2		75.4	84.3
% [Age 45-75] Colorectal Cancer Screening	73.0		71.5	74.4
		better	similar	worse

CLIMATE, NATURE & HEALTH	CCH Service Area	CCH SERVICE AREA vs. BENCHMARKS vs. KY	vs. US	vs. HP2030
% Consider Climate and Health Risk to be Connected	67.6			
% Health/Well-Being Impacted by Weather in the Past 3 Years	32.2			
% Access to Nature, Parks, or Greenspaces is “Fair/Poor”	13.3			
% Visit Nature, Parks, or Greenspaces Less Than Monthly	38.4			
		better	similar	worse

DIABETES	CCH Service Area	CCH SERVICE AREA vs. BENCHMARKS vs. KY	vs. US	vs. HP2030
Diabetes Deaths per 100,000	27.2	37.8	30.5	
% Diabetes/High Blood Sugar	18.7	14.8	12.8	
% Borderline/Pre-Diabetes	13.4		15.0	
Kidney Disease Deaths per 100,000	21.6	26.3	26.3	
		better	similar	worse

DISABLING CONDITIONS	CCH Service Area	CCH SERVICE AREA vs. BENCHMARKS vs. KY	vs. US	vs. HP2030
% 3+ Chronic Conditions	51.7		38.0	
% Activity Limitations	36.4		27.5	
% [With Limitations] Serious Difficulty Walking/Climbing Stairs	48.4			
% [With Limitations] Difficulty Dressing or Bathing	22.7			
% High-Impact Chronic Pain	27.6		19.6	6.4
Alzheimer's Disease Deaths per 100,000	35.4	34.6	35.8	
% Caregiver to a Friend/Family Member	24.5		22.8	
		better	similar	worse

HEART DISEASE & STROKE	CCH Service Area	CCH SERVICE AREA vs. BENCHMARKS vs. KY	vs. US	vs. HP2030
Heart Disease Deaths per 100,000	224.0	257.1	209.5	127.4
% Heart Disease	9.6	9.5	10.3	
Stroke Deaths per 100,000	50.9	52.7	49.3	33.4
% Stroke	4.5	4.6	5.4	
% High Blood Pressure	52.1	39.9	40.4	42.6
% High Cholesterol	38.3		32.4	
% 1+ Cardiovascular Risk Factor	91.8		87.8	
		better	similar	worse

INFANT HEALTH & FAMILY PLANNING	CCH Service Area	CCH SERVICE AREA vs. BENCHMARKS vs. KY	vs. US	vs. HP2030
No Prenatal Care in First 6 Months (Percent of Births)	4.6	5.5	6.1	
Teen Births per 1,000 Females 15-19	21.3	25.7	16.6	
Low Birthweight (Percent of Births)	8.9	8.9	8.3	
Infant Deaths per 1,000 Births	5.4	5.8	5.6	5.0
		better	similar	worse

INJURY & VIOLENCE	CCH Service Area	CCH SERVICE AREA vs. BENCHMARKS vs. KY	vs. US	vs. HP2030
Unintentional Injury Deaths per 100,000	**96.0**	94.3	67.8	43.2
Motor Vehicle Crash Deaths per 100,000	**14.2**	17.5	13.3	10.1
Homicide Deaths per 100,000	**6.9**	8.2	7.6	5.5
Violent Crimes per 100,000			0.0	
% Victim of Violent Crime in Past 5 Years	**5.7**		7.0	
% Victim of Intimate Partner Violence	**24.6**		20.3	
		better	similar	worse

MENTAL HEALTH	CCH Service Area	CCH SERVICE AREA vs. BENCHMARKS vs. KY	vs. US	vs. HP2030
% "Fair/Poor" Mental Health	**34.7**		24.4	
% Diagnosed Depression	**45.4**	25.8	30.8	
% Symptoms of Chronic Depression	**54.5**		46.7	
% Typical Day Is "Extremely/Very" Stressful	**25.0**		21.1	
Suicide Deaths per 100,000	**17.0**	18.1	14.7	12.8
Mental Health Providers per 100,000	**392.7**	319.9	312.5	
% Receiving Mental Health Treatment	**38.4**		21.9	
% Unable to Get Mental Health Services in Past Year	**16.4**		13.2	

NUTRITION, PHYSICAL ACTIVITY & WEIGHT	CCH Service Area	CCH SERVICE AREA vs. BENCHMARKS		
		vs. KY	vs. US	vs. HP2030
% "Very/Somewhat" Difficult to Buy Fresh Produce	**30.0**		30.0	
% No Leisure-Time Physical Activity	**32.5**	26.4	30.2	21.8
% Meet Physical Activity Guidelines	**22.9**	15.3	30.3	29.7
% [Child 2-17] Physically Active 1+ Hours per Day	**42.1**		27.4	
Recreation/Fitness Facilities per 100,000			0.0	
% Overweight (BMI 25+)	**75.3**	71.8	63.3	
% Obese (BMI 30+)	**47.5**	37.7	33.9	36.0
% [Child 5-17] Overweight (85th Percentile)	**31.0**		31.8	
% [Child 5-17] Obese (95th Percentile)	**17.6**		19.5	15.5
		better	similar	worse

ORAL HEALTH	CCH Service Area	CCH SERVICE AREA vs. BENCHMARKS		
		vs. KY	vs. US	vs. HP2030
% Have Dental Insurance	**78.5**		72.7	75.0
% Dental Visit in Past Year	**56.6**	60.3	56.5	45.0
% [Child 2-17] Dental Visit in Past Year	**78.8**		77.8	45.0
		better	similar	worse

RESPIRATORY DISEASE	CCH Service Area	CCH SERVICE AREA vs. BENCHMARKS vs. KY	vs. US	vs. HP2030
Lung Disease Deaths per 100,000	**60.7**	72.3	43.5	
Pneumonia/Influenza Deaths per 100,000	**16.3**	17.8	13.4	
% Asthma	**18.4**	10.8	17.9	
% [Child 0-17] Asthma	**9.1**		16.7	
% COPD (Lung Disease)	**10.0**	11.7	11.0	
		better	similar	worse

SEXUAL HEALTH	CCH Service Area	CCH SERVICE AREA vs. BENCHMARKS vs. KY	vs. US	vs. HP2030
HIV Prevalence per 100,000	**252.8**	222.5	386.6	
Chlamydia Incidence per 100,000	**463.4**	381.9	492.2	
Gonorrhea Incidence per 100,000	**129.4**	134.4	179.0	
		better	similar	worse

SUBSTANCE USE	CCH Service Area	CCH SERVICE AREA vs. BENCHMARKS		
		vs. KY	vs. US	vs. HP2030
Alcohol-Induced Deaths per 100,000	**15.8**	14.7	15.7	
Cirrhosis/Liver Disease Deaths per 100,000	**18.3**	20.2	16.4	10.9
% Excessive Drinking	**20.6**	13.8	34.3	
Unintentional Drug-Induced Deaths per 100,000	**59.1**	48.9	29.7	
% Used an Illicit Drug in Past Month	**6.5**		8.4	
% Used a Prescription Opioid in Past Year	**19.5**		15.1	
% Ever Sought Help for Alcohol or Drug Problem	**11.4**		6.8	
% Personally Impacted by Substance Use	**52.1**		45.4	
		better	similar	worse

TOBACCO USE	CCH Service Area	CCH SERVICE AREA vs. BENCHMARKS		
		vs. KY	vs. US	vs. HP2030
% Smoke Cigarettes	**26.9**	17.4	23.9	6.1
% Someone Smokes at Home	**24.1**		17.7	
% Use Vaping Products	**25.9**	10.5	18.5	
		better	similar	worse

Prioritized Description of Significant Community Health Needs

Identification of Significant Health Needs

The following represent the significant health needs of the community, based on the information gathered through this Community Health Needs Assessment. From these data, opportunities for health improvement exist in the area with regard to the following health issues (see also the summary tables presented in the preceding section).

The significant health needs were determined after consideration of various criteria, including: standing in comparison with benchmark data (particularly national data); the preponderance of significant findings within topic areas; the magnitude of the issue in terms of the number of persons affected; and the potential health impact of a given issue. These also take into account those issues of greatest concern to the key informants giving input to this process.

Community Feedback on Prioritization

Prioritization of the health needs identified in this assessment was determined based on a prioritization exercise conducted among providers and other community leaders (representing a cross-section of community-based agencies and organizations) as part of the Online Key Informant Survey.

In this process, these key informants were asked to rate the severity of a variety of health issues in the community. Insofar as these health issues were identified through the data above and/or were identified as top concerns among key informants, their ranking of these issues informed the following priorities:

PRIORITIZED LIST OF SIGNIFICANT HEALTH NEEDS

Priority	Significant Health Need	Key Supporting Evidence
#1	MENTAL HEALTH	▪ "Fair/Poor" Mental Health ▪ Diagnosed Depression ▪ Symptoms of Chronic Depression ▪ Stress ▪ Receiving Treatment for Mental Health ▪ Difficulty Obtaining Mental Health Services ▪ Key Informants: *Mental Health* ranked as a top concern.
#2	SUBSTANCE USE	▪ Unintentional Drug-Induced Deaths ▪ Use of Prescription Opioids ▪ Personally Impacted by Substance Use ▪ Key Informants: *Substance Use* ranked as a top concern.
#3	DIABETES	▪ Diabetes Prevalence ▪ Key Informants: *Diabetes* ranked as a top concern.
#4	NUTRITION, PHYSICAL ACTIVITY & WEIGHT	▪ Meeting Physical Activity Guidelines ▪ Overweight & Obesity [Adults] ▪ Key Informants: *Nutrition, Physical Activity & Weight* ranked as a top concern.
#5	HEART DISEASE & STROKE	▪ Leading Cause of Death ▪ High Blood Pressure Prevalence ▪ High Blood Cholesterol Prevalence ▪ Overall Cardiovascular Risk

Other health needs identified in this assessment include:

- TOBACCO USE
- CANCER
- DISABLING CONDITIONS
- INFANT HEALTH & FAMILY PLANNING
- RESPIRATORY DISEASE
- ACCESS TO HEALTH CARE SERVICES
- INJURY & VIOLENCE

Key informants also expressed significant concern about **Social Determinants of Health**, which impact all of the aforementioned health issues.

Hospital Implementation Strategy

Continuing Care Hospital will use the information from this Community Health Needs Assessment to develop an Implementation Strategy to address the significant health needs in the community. While the hospital will likely not implement strategies for all of the health issues listed above, the results of this prioritization exercise will be used to inform the development of the hospital's action plan to guide community health improvement efforts in the coming years.

Note: An evaluation of the hospital's past activities to address the needs identified in prior CHNAs can be found as an appendix to this report.

COMMUNITY DESCRIPTION

DEMOGRAPHIC SUMMARY

The Continuing Care Hospital Service Area, the focus of this Community Health Needs Assessment, includes Bath, Bourbon, Clark, Estill, Fayette, Franklin, Jessamine, Madison, Montgomery, Powell, Rockcastle, Scott, Whitley, and Wolfe counties. It encompass 3,810.29 square miles and houses a total population of 763,590 residents, according to latest census estimates.

The Continuing Care Hospital Service Area is predominantly urban.

Note the following demographic makeup of our community.

Core Demographic Summary

	CCH Service Area
Urbanization	71.4% Urban
Total Population Size	763,590
Race & Ethnicity — *Hispanic*	6.0%
White	79.6%
Black	8.3%
Asian	2.3%
American Indian or Alaska Native	0.1%
Native Hawaiian/Pacific Islander	0.1%
Average Household Income	$91,246
Percent of Population Living in Poverty (Below 100% FPL)	15.8%
Unemployment Rate (December 2024)	4.4%
Percent of People Age 5 and Older Who are Non-English Speaking	2.2%
Percent of People Without Health Insurance	6.2%
Percent of People with Medicaid	26.7%
Health Professional Shortage Area	Yes
Medically Underserved Areas/Populations	Yes
Medically Underserved, Low Income, or Minority Populations	Multiple
Number of Other Hospitals Serving the Community	15

DATA CHARTS & KEY INFORMANT INPUT

The following sections present data from multiple sources, including the population-based PRC Community Health Survey, public health and other existing data sets (secondary data), as well as qualitative input from the Online Key Informant Survey.

Data indicators from these sources are intermingled and organized by health topic. To better understand the source data for specific indicators, please refer to the footnotes accompanying each chart.

SOCIAL DETERMINANTS OF HEALTH

ABOUT SOCIAL DETERMINANTS OF HEALTH

Social determinants of health (SDOH) are the conditions in the environments where people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks.

Social determinants of health (SDOH) have a major impact on people's health, well-being, and quality of life. Examples of SDOH include:

- Safe housing, transportation, and neighborhoods
- Racism, discrimination, and violence
- Education, job opportunities, and income
- Access to nutritious foods and physical activity opportunities
- Polluted air and water
- Language and literacy skills

SDOH also contribute to wide health disparities and inequities. For example, people who don't have access to grocery stores with healthy foods are less likely to have good nutrition. That raises their risk of health conditions like heart disease, diabetes, and obesity — and even lowers life expectancy relative to people who do have access to healthy foods.

Just promoting healthy choices won't eliminate these and other health disparities. Instead, public health organizations and their partners in sectors like education, transportation, and housing need to take action to improve the conditions in people's environments.

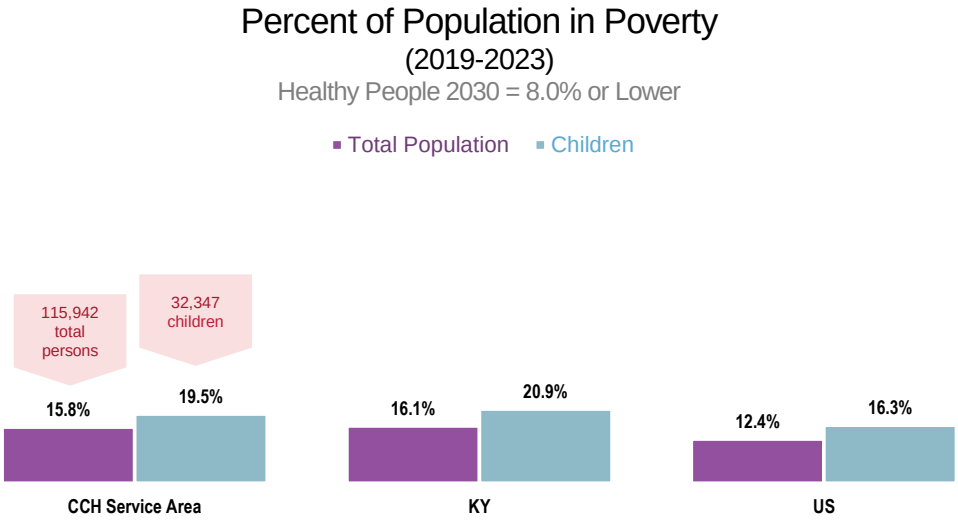
– Healthy People 2030 (https://health.gov/healthypeople)

Income & Poverty

Poverty

Poverty is considered a key driver of health status because it creates barriers to accessing health services, healthy food, and other necessities that contribute to health status.

The following chart outlines the proportion of our population below the federal poverty threshold in comparison to state and national proportions.

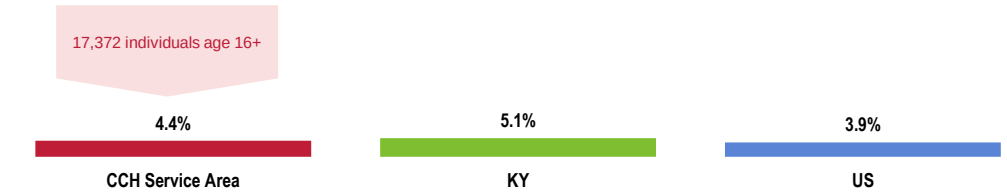


Sources:
- US Census Bureau American Community Survey, 5-year estimates.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved February 2025 via SparkMap (sparkmap.org).
- US Department of Health and Human Services. Healthy People 2030. https://health.gov/healthypeople

Employment

Note the following unemployment data derived from the US Department of Labor.

Unemployment Rate
(As of December 2024)



Sources:
- US Department of Labor, Bureau of Labor Statistics.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved February 2025 via SparkMap (sparkmap.org).

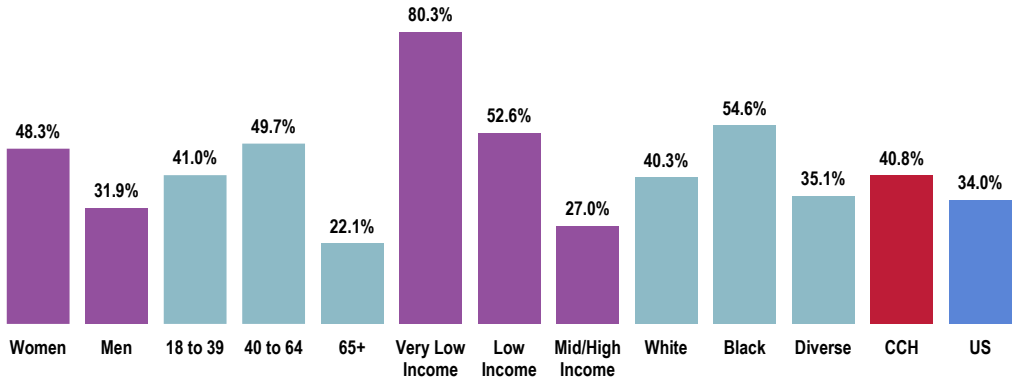
Notes:
- Percent of non-institutionalized population age 16+ who are unemployed (not seasonally adjusted).

Financial Resilience

PRC SURVEY ► "Suppose that you have an emergency expense that costs $400. Based on your current financial situation, would you be able to pay for this expense either with cash, by taking money from your checking or savings account, or by putting it on a credit card that you could pay in full at the next statement?"

The following chart details "no" responses in the Continuing Care Hospital Service Area in comparison to benchmark data, as well as by basic demographic characteristics (such as gender, age groupings, income [based on poverty status], and race/ethnicity).

Do Not Have Cash on Hand to Cover a $400 Emergency Expense
(CCH Service Area, 2025)



Sources:
- 2025 PRC Community Health Survey, PRC, Inc. [Item 53]
- 2023 PRC National Health Survey, PRC, Inc.

Notes:
- Asked of all respondents.
- Includes respondents who say they would not be able to pay for a $400 emergency expense either with cash, by taking money from their checking or savings account, or by putting it on a credit card that they could pay in full at the next statement.

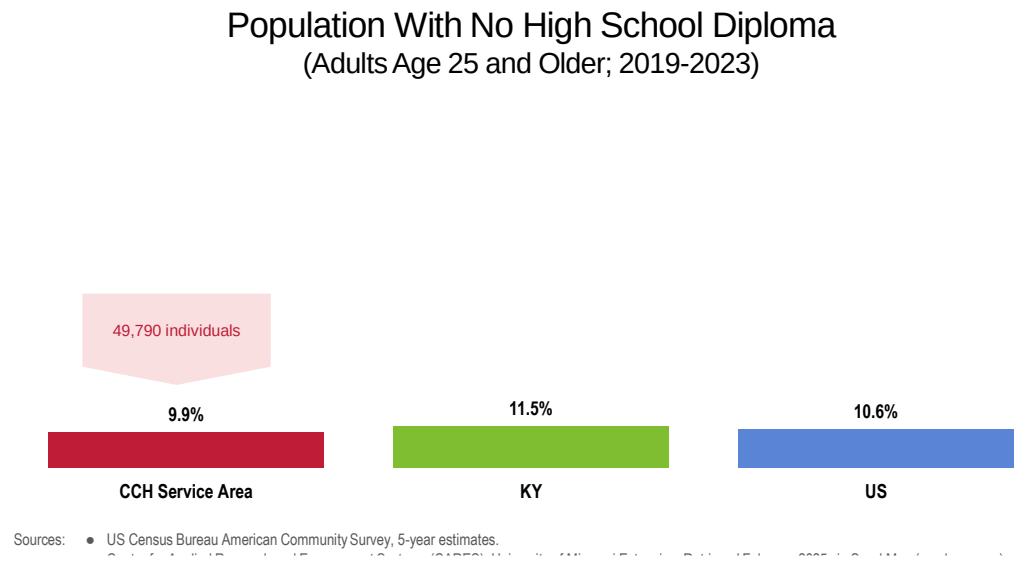
INCOME & RACE/ETHNICITY

INCOME ► Income categories used to segment survey data in this report are based on administrative poverty thresholds determined by the US Department of Health & Human Services. These guidelines define poverty status by household income level and number of persons in the household (e.g., the 2024 guidelines place the poverty threshold for a family of four at $30,700 annual household income or lower). In sample segmentation: “very low income” refers to community members living in a household with defined poverty status; “low income” refers to households with incomes just above the poverty level and earning up to twice (100%-199% of) the poverty threshold; and “mid/high income” refers to those households living on incomes which are twice or more (≥200% of) the federal poverty level.

RACE & ETHNICITY ► In analyzing survey results, mutually exclusive race and ethnicity categories are used. “White” reflects those who identify as White alone, without Hispanic origin. “Black” reflects those who identify as Black alone, without Hispanic origin. “Diverse” includes those who identify as American Indian or Alaska Native, Asian, Native Hawaiian/Pacific Islander, and/or as being Hispanic or of multiple races.

Education

Education levels are reflected in the proportion of our population without a high school diploma. This indicator is relevant because educational attainment is linked to positive health outcomes.

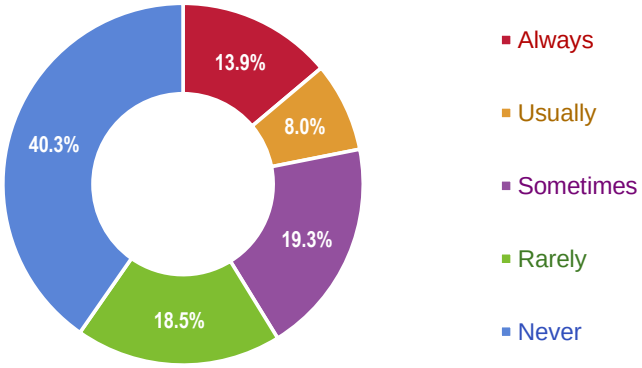


Housing

Housing Insecurity

PRC SURVEY ► "In the past 12 months, how often were you worried or stressed about having enough money to pay your rent or mortgage? Would you say you were worried or stressed: always, usually, sometimes, rarely, or never?"

Frequency of Worry or Stress
About Paying Rent or Mortgage in the Past Year
(CCH Service Area, 2025)



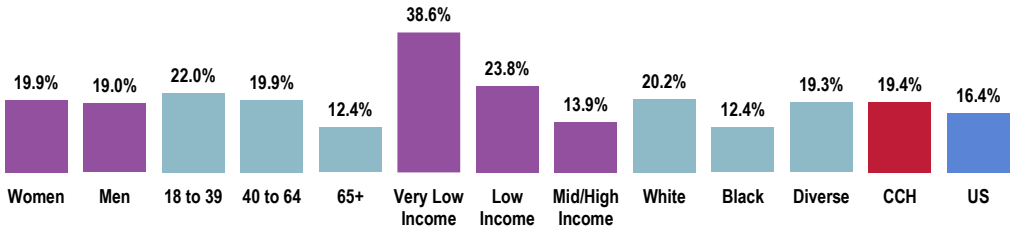
Sources: ● 2025 PRC Community Health Survey, PRC, Inc. [Item 56]
Notes: ● Asked of all respondents.

Unhealthy or Unsafe Housing

PRC SURVEY ► "Thinking about your current home, over the past 12 months have you experienced ongoing problems with water leaks, rodents, insects, mold, or other housing conditions that might make living there unhealthy or unsafe?"

Unhealthy or Unsafe Housing Conditions in the Past Year
(CCH Service Area, 2025)

Among homeowners	11.2%
Among renters	28.9%



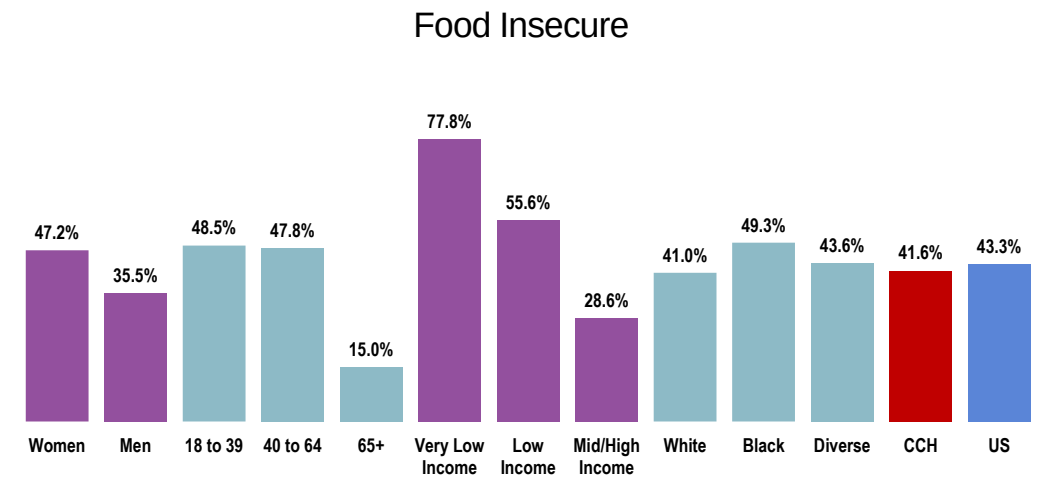
Sources: ● 2025 PRC Community Health Survey, PRC, Inc. [Item 55]
● 2023 PRC National Health Survey, PRC, Inc.
Notes: ● Asked of all respondents.
● Includes respondents who say they experienced ongoing problems in their current home with water leaks, rodents, insects, mold, or other housing conditions that might make living there unhealthy or unsafe.

Food Insecurity

PRC SURVEY ► "Now I am going to read two statements that people have made about their food situation. Please tell me whether each statement was 'often true,' 'sometimes true,' or 'never true' for you in the past 12 months.

- 'I worried about whether our food would run out before we got money to buy more.'
- 'The food that we bought just did not last, and we did not have money to get more.'"

Agreement with either or both of these statements ("often true" or "sometimes true") defines food insecurity for respondents.



Sources:
- 2025 PRC Community Health Survey, PRC, Inc. [Item 98]
- 2023 PRC National Health Survey, PRC, Inc.

Notes:
- Asked of all respondents.
- Includes adults who A) ran out of food at least once in the past year and/or B) worried about running out of food in the past year.

Social Vulnerability Index

Social vulnerability refers to the potential negative effects on communities caused by external stresses on human health. Such stresses include natural or human-caused disasters, or disease outbreaks. Reducing social vulnerability can decrease both human suffering and economic loss.

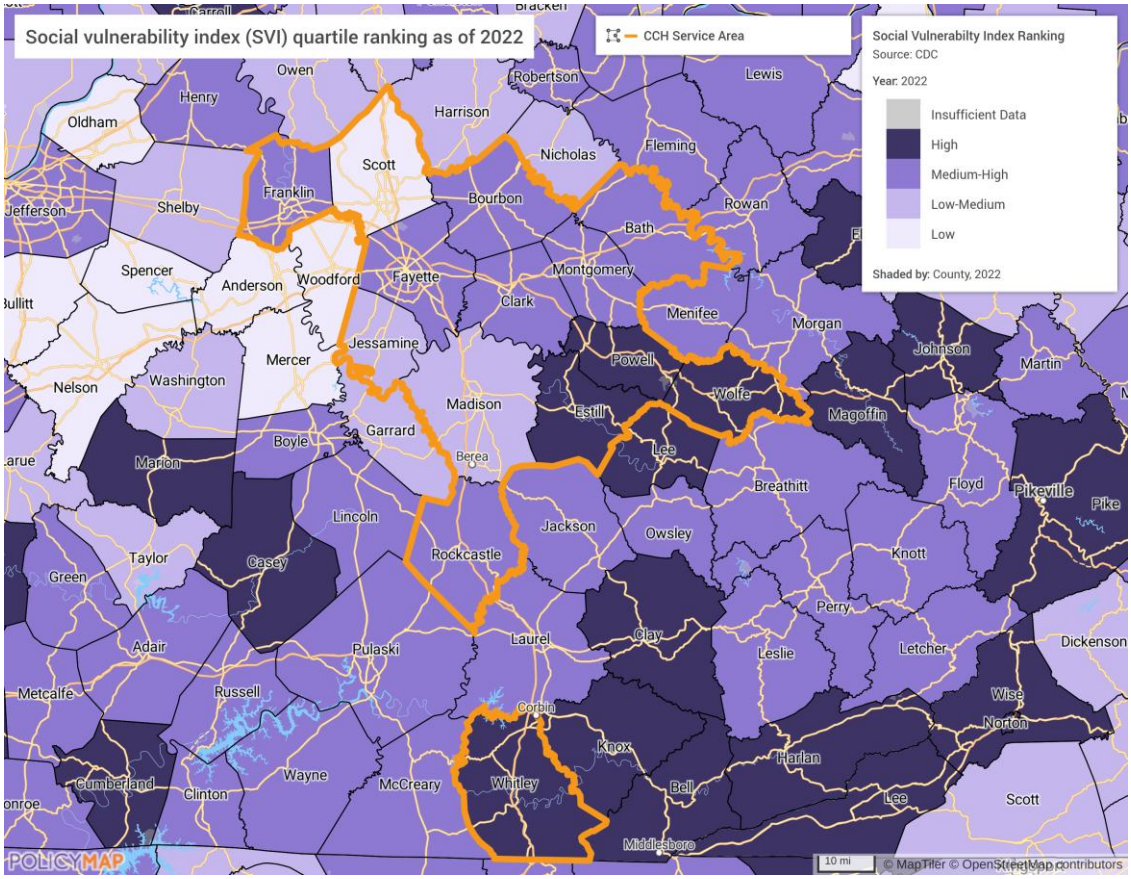
The CDC/ATSDR Social Vulnerability Index (CDC/ATSDR SVI) uses 16 US census variables to help local officials identify communities that may need support before, during, or after disasters.

The degree to which a community exhibits certain social conditions, including high poverty, low percentage of vehicle access, or crowded households, may affect that community's ability to prevent human suffering and financial loss in the event of disaster. These factors describe a community's social vulnerability.

The social vulnerability index is a measure of the degree of social vulnerability in counties and neighborhoods across the United States, where a higher score indicates higher vulnerability.

The following illustrates those census tracts in the Continuing Care Hospital Service Area with the highest social vulnerability.

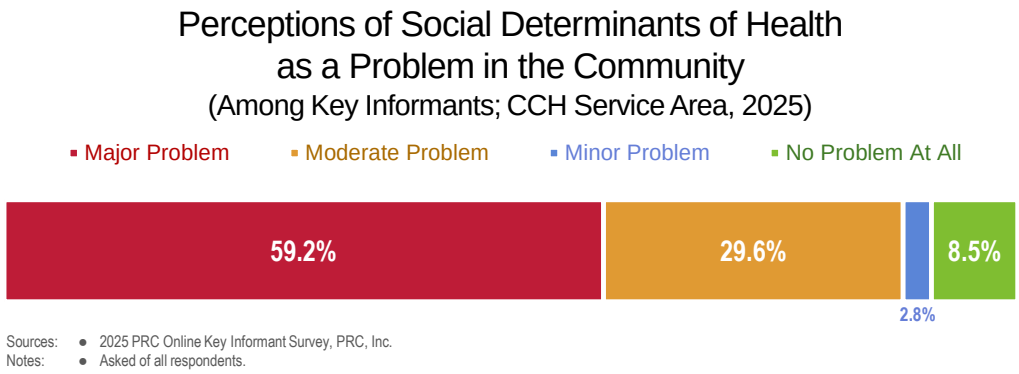
Social Vulnerability



Source: Agency for Toxic Substances and Disease Registry, Centers for Disease Control and Prevention (CDC). Accessed via PolicyMap.

Key Informant Input: Social Determinants of Health

The following chart outlines key informants' perceptions of the severity of *Social Determinants of Health* as a problem in the community:



Among those rating this issue as a "major problem," reasons related to the following:

Housing

> The lack of affordable housing is a primary concern for many of the clients we work with. Many apartments require 3x the income to be able to qualify and for people on SSI/SSDI, that typically is not possible. We have many people who are working full time at less than a living wage that are not able to obtain appropriate housing. — Social Services Provider
>
> There is a lack of access to affordable housing, causing seniors, families, and individuals finding themselves in first time homeless situations. — Community Leader
>
> Housing is a major crunch with rent prices being high and taking up too much share of people's income, leaving people with less resources for nutritious food, medical co-pays, and other needs. Discrimination also makes some people avoid healthcare. — Social Services Provider
>
> Affordable Housing is a major problem in our community and across our country. I believe the Minimum Wage and a True Living Wage for many single parents and those that struggle for sufficient housing, in addition to more affordable housing units is needed to start addressing the gap, however the gap is large. — Community Leader
>
> Housing insecurity is a major problem within Lexington, and the lack of affordable housing. — Social Services Provider
>
> There is a definite lack of affordable housing in our community. Also, there is great fear among the immigrant and refugee community (especially the Spanish community) about deportation and family separation. This causes much stress, and also keep those communities in hiding so they don't venture out for health care contacts as much as before. — Community Leader
>
> I believe the economy has made it extremely difficult for families to afford safe, dependable housing options. Some residents are also not taking the opportunity to seek higher education for better paying jobs. Higher education is also not affordable for many. — Health Care Provider
>
> Housing stability, transportation. — Physician
>
> There isn't enough housing, the price of higher education is expensive, food deserts, no sidewalks. — Community Leader
>
> Lack of adequate affordable housing, low paying jobs decreased education levels/dropouts, community environments and the mindset of those living there. — Community Leader
>
> Lack of affordable housing in the community. Everything is so expensive. — Social Services Provider
>
> The social determinants as listed above are exactly as they are termed: these factors play a major factor in quality of life. A roof over one's head that can be counted on, a steady, predictable income, access to quality schools, absence of environmental problems like water and air quality, safe streets and access to good parks. Minus any one of these factors, it is nearly impossible to maintain a healthy lifestyle. — Community Leader
>
> Housing shortage, low-income region, less educational funding, resource extraction industries that damage the environment, LGBTQ+ and racial discrimination. — Social Services Provider

> I would say that SDH is more of an issue in our rural eastern and southern counties more that the counties specific to this survey. In Central KY we do have better access to care and job opportunities. I will say that affordable housing is a major issue and transportation too. Public transportation is non-existent in most of these counties (except Fayette) which makes getting from place to place a huge challenge. Hence the reason we need more walkable/bikeable communities.
> — Public Health Representative

Income/Poverty

> Disparity between those with financial resources and those without are clear in terms of everything from diet, knowledge, access to care, access to transportation. — Community Leader

> When unavailability of finances combines with a lack of education you have struggles. — Community Leader

> Health is a function of finances. Folks that have less money to spend on living a healthier lifestyle have less favorable health outcomes. That includes education that impacts income, that income determines where they can afford to live which normally means areas with no health care facilities readily available. Sometimes these areas can have higher crime rates. Lack of social capital limits the access to information and people that could help mitigate these challenges. — Community Leader

> Social determinants of health are a major issue in the community because factors like poverty, education, housing, and access to healthcare create significant disparities in health outcomes, leading to higher rates of chronic illness and reduced life expectancy for marginalized populations. These systemic barriers limit opportunities for individuals to achieve optimal health, reinforcing cycles of inequality and increasing the burden on social and healthcare systems. — Community Leader

> Factors such as income, education, housing, food security, employment, and access to healthcare create disparities that can lead to chronic illnesses, mental health struggles, and lower life expectancy. For example, individuals in low-income communities may face barriers to nutritious food, safe housing, and medical care, increasing their risk for preventable diseases. Additionally, systemic inequities, including racial and socioeconomic discrimination, further widen health gaps, making it harder for marginalized populations to achieve well-being. Consider Maslow's hierarchy of needs, if people can't get their basic needs met they are unable to properly thrive in society and it can create issues that span for generations. — Social Services Provider

Affordable Care/Services

> Patients must prioritize what they spend money on and often dental care, medications, preventive checkups, care for themselves when paying for care for their children make care out of reach. — Health Care Provider

Access to Care/Services

> Services do not exist. — Community Leader

Access to Care for Uninsured/Underinsured

> Lack of access to healthcare for those without insurance or higher deductibles. Housing is expensive if you live in the city of Lexington, in comparison to smaller towns surrounding Lexington. Education can make an individual more qualified for certain job positions, therefore lack of education can play a role in finding a job. Etc. — Public Health Representative

Diagnosis/Treatment

> People cannot care for their physical health conditions, if basic needs are going unmet. — Health Care Provider

Impact on Quality of Life

> Social determinants are often the catalyst for lack of services and opportunities in the community. — Community Leader

Employment

> Social determinants of health limit workforce participation, access to education and create social isolation. Our community will never be all that it could be without appropriate resources to address all of these issues. This problem accelerates in rural areas. — Social Services Provider

Incidence/Prevalence

> Because of the calls and walk-ins, I get from families/individuals in need of assistance and resources, especially housing. — Community Leader

Childcare

> Childcare is a big issue. — Community Leader

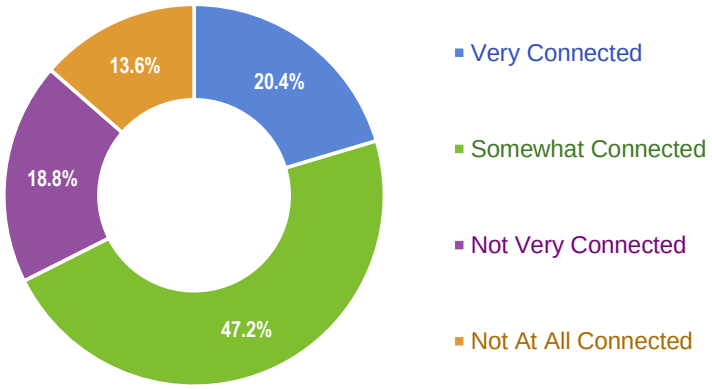
CLIMATE, NATURE & HEALTH

Climate/Health Connection

In this context, climate refers to general weather conditions in an area or over a long period of time, such as storms, tornadoes, extreme heat, flooding, or drought.

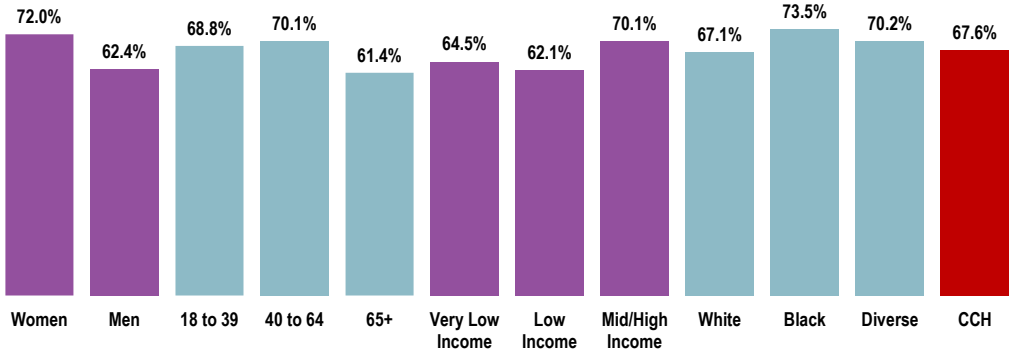
PRC SURVEY ► "To what extent do you feel that climate is connected to health risks? Would you say it is very connected, somewhat connected, not very connected, or not at all connected?"

Perception of Climate's Connection to Health Risks
(CCH Service Area, 2025)



Sources: ● 2025 PRC Community Health Survey, PRC, Inc. [Item 306]
Notes: ● Asked of all respondents.
● In this case, climate refers to general weather conditions in an area or over a long period of time, such as storms, tornadoes, extreme heat, flooding, or drought.

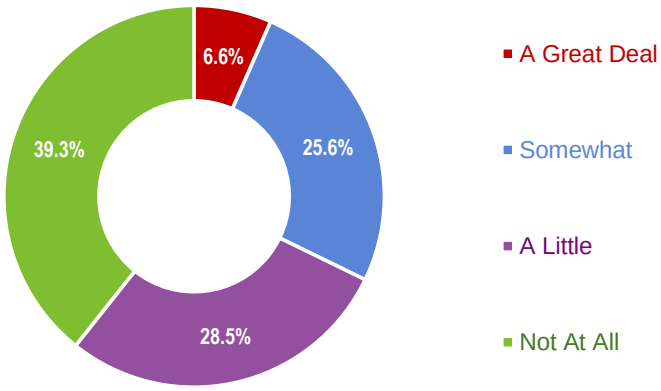
Climate and Health Risk Are "Very/Somewhat Connected"
(CCH Service Area, 2025)



Sources: ● 2025 PRC Community Health Survey, PRC, Inc. [Item 306]
Notes: ● Asked of all respondents.
● In this case, climate refers to general weather conditions in an area or over a long period of time, such as storms, tornadoes, extreme heat, flooding, or drought.

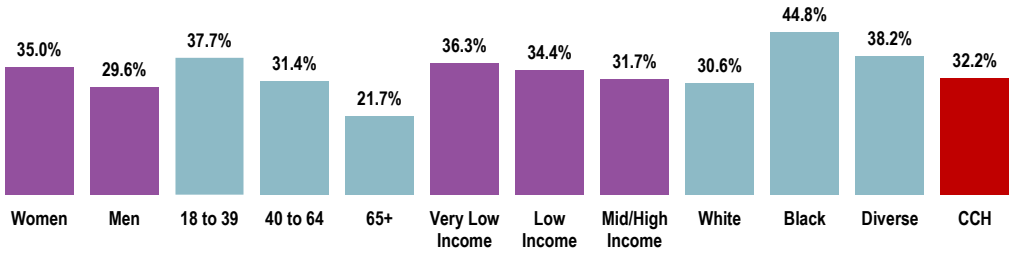
PRC SURVEY ► "In the past three years, to what extent has your health or well-being been impacted by weather events? Would you say a great deal, somewhat, a little, or not at all?"

Health or Well-Being Has Been Impacted by Weather in the Past Three Years
(CCH Service Area, 2025)



Sources: ● 2025 PRC Community Health Survey, PRC, Inc. [Item 307]
Notes: ● Asked of all respondents.

Health or Well-Being Has Been Impacted "A Great Deal/Somewhat" by Weather in the Past Three Years
(CCH Service Area, 2025)

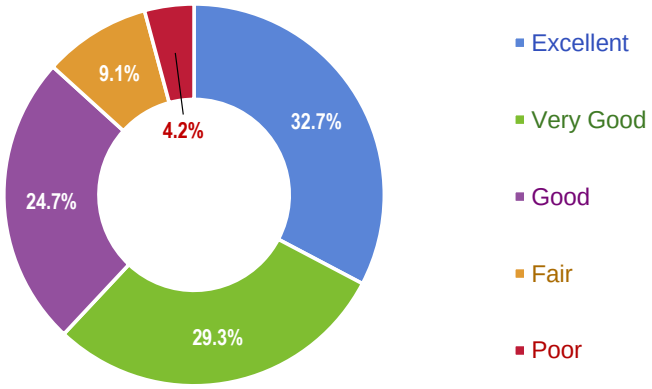


Sources: ● 2025 PRC Community Health Survey, PRC, Inc. [Item 307]
Notes: ● Asked of all respondents.

Access to Nature, Parks & Greenspaces

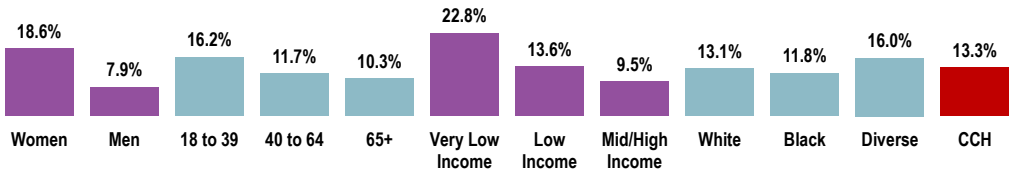
PRC SURVEY ► "How would you rate access to nature, parks, or greenspaces in your area? Would you say excellent, very good, good, fair, or poor?"

Rating of Access to Nature, Parks, or Greenspaces
(CCH Service Area, 2025)



Sources: ● 2025 PRC Community Health Survey, PRC, Inc. [Item 308]
Notes: ● Asked of all respondents.

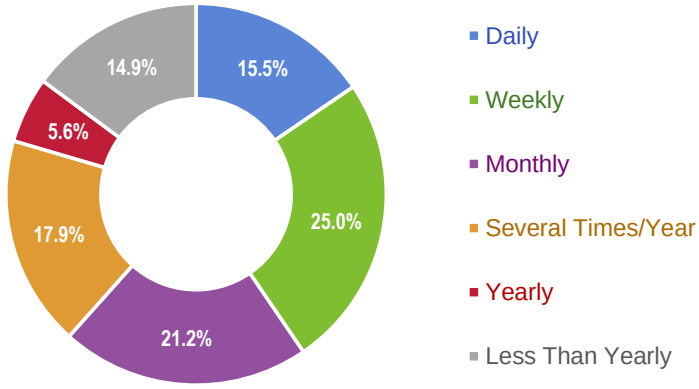
Access to Nature, Parks, or Greenspaces is "Fair" or "Poor"
(CCH Service Area, 2025)



Sources: ● 2025 PRC Community Health Survey, PRC, Inc. [Item 308]
Notes: ● Asked of all respondents.

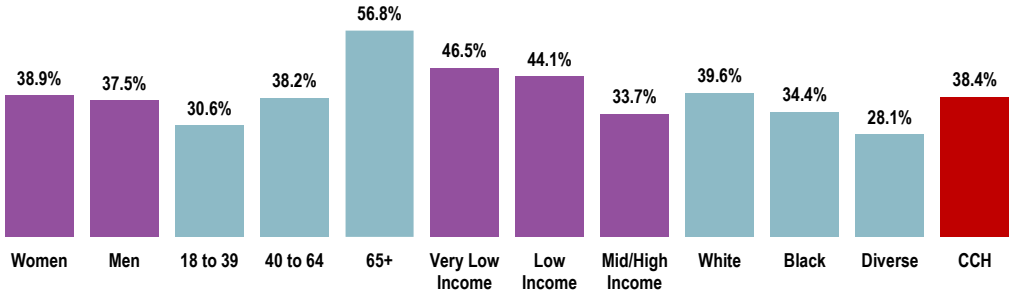
PRC SURVEY ► "How often do you spend time in nature, parks, or greenspaces in your area?"

Frequency of Time Spent in Nature, Parks, or Greenspaces
(CCH Service Area, 2025)



Sources: ● 2025 PRC Community Health Survey, PRC, Inc. [Item 309]
Notes: ● Asked of all respondents.

Visit Nature, Parks, or Greenspaces Less Than Monthly
(CCH Service Area, 2025)



Sources: ● 2025 PRC Community Health Survey, PRC, Inc. [Item 309]
Notes: ● Asked of all respondents.

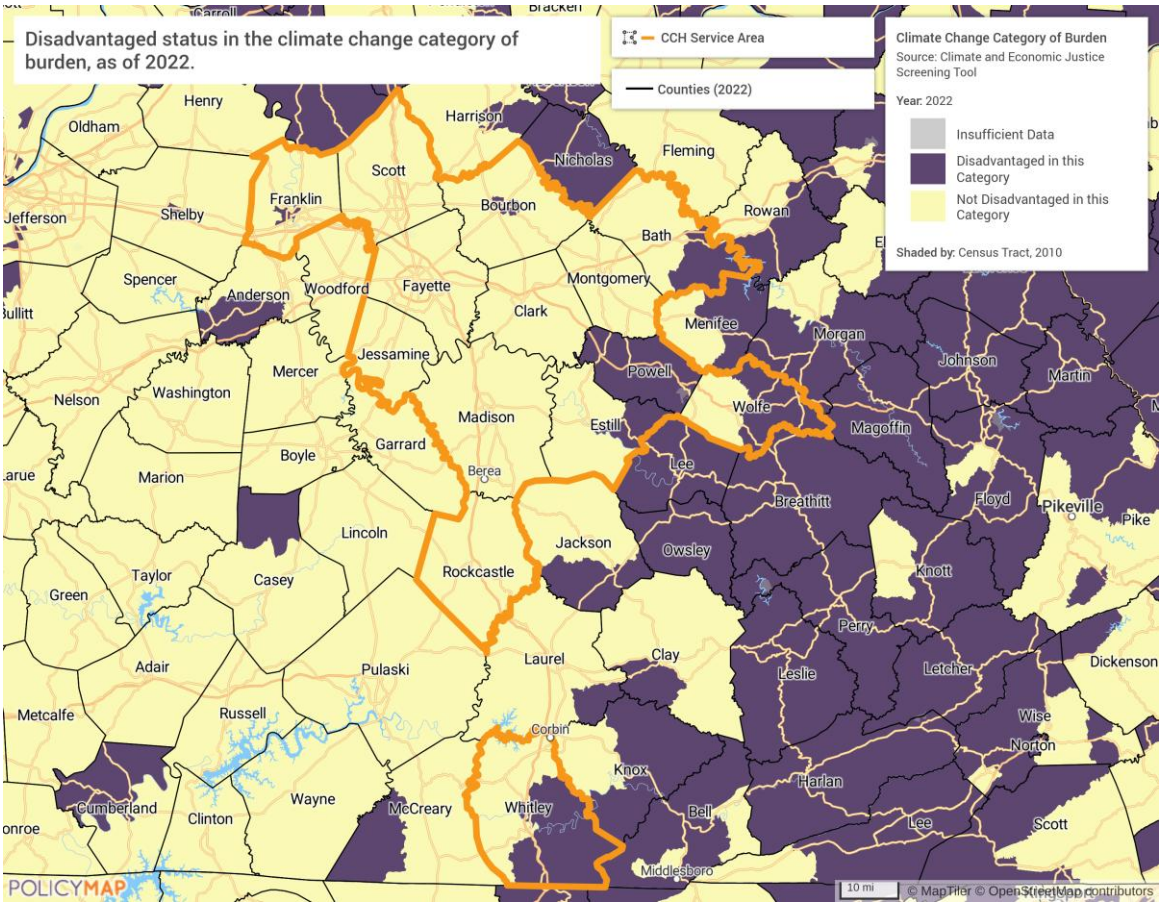
Climate Change Burden

The Climate and Economic Justice Screening Tool (CEJST) was developed by the Council on Environmental Quality to identify disadvantaged communities that face burdens across eight categories: climate change, energy, health, housing, legacy pollution, transportation, water and wastewater, and workforce development. CEJST combines a number of publicly available national datasets to identify disadvantaged communities.

Census tracts are considered disadvantaged if they meet the thresholds for at least one of the CEJST categories of burden or if they are on land within the boundaries of Federally Recognized Tribes. Meeting one of the CEJST categories of burden requires that a tract be at or above specified thresholds for one or more environmental, climate, housing, health or other burdens and be at or above the threshold for an associated socioeconomic burden (e.g., low income or low educational attainment). Additionally, a census tract that is completely surrounded by disadvantaged communities and is at or above the 50th percentile for low income is also considered disadvantaged.

The following illustrates those census tracts in the Continuing Care Hospital Service Area with the highest burden relative to climate change.

Disadvantaged Status for Climate Change Category of Burden

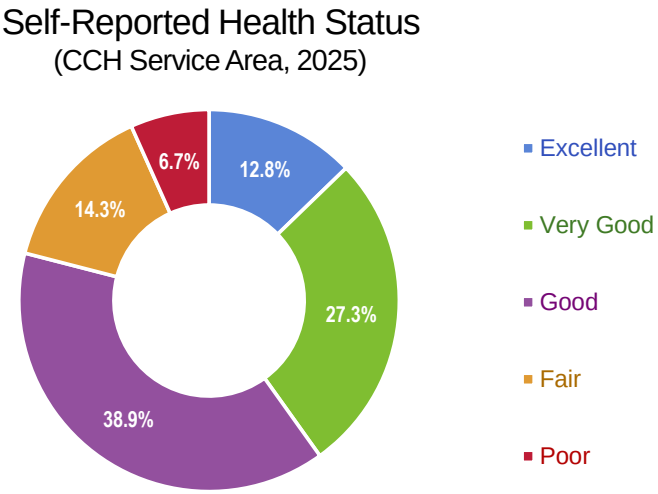


Source: Council on Environmental Quality, Climate and Economic Justice Screening Tool (CEJST). Accessed via PolicyMap.

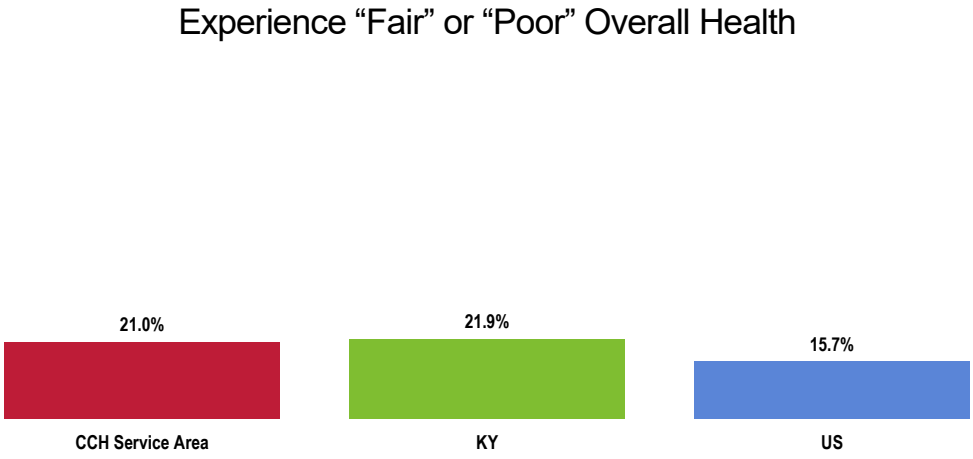
HEALTH STATUS

Overall Health

PRC SURVEY ► "Would you say that in general your health is: excellent, very good, good, fair, or poor?"

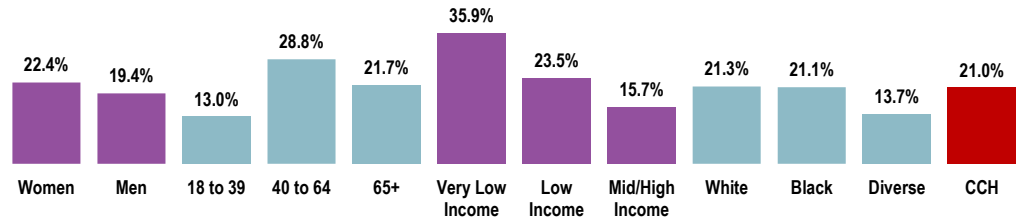


Sources: ● 2025 PRC Community Health Survey, PRC, Inc. [Item 4]
Notes: ● Asked of all respondents.



Sources: ● 2025 PRC Community Health Survey, PRC, Inc. [Item 4]
● Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2022 Kentucky data.
● 2023 PRC National Health Survey, PRC, Inc.
Notes: ● Asked of all respondents.

Experience “Fair” or “Poor” Overall Health
(CCH Service Area, 2025)



Sources: • 2025 PRC Community Health Survey, PRC, Inc. [Item 4]
Notes: • Asked of all respondents.

Mental Health

ABOUT MENTAL HEALTH & MENTAL DISORDERS

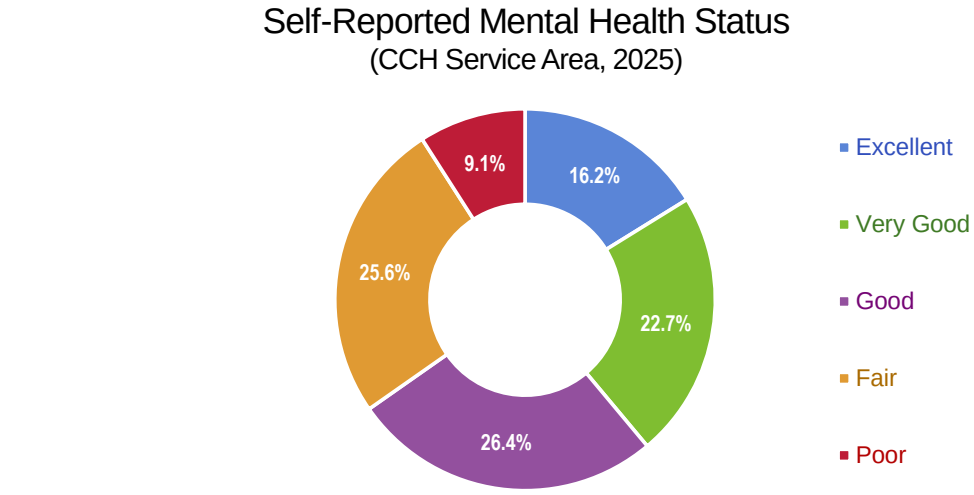
About half of all people in the United States will be diagnosed with a mental disorder at some point in their lifetime. …Mental disorders affect people of all age and racial/ethnic groups, but some populations are disproportionately affected. And estimates suggest that only half of all people with mental disorders get the treatment they need.

In addition, mental health and physical health are closely connected. Mental disorders like depression and anxiety can affect people's ability to take part in healthy behaviors. Similarly, physical health problems can make it harder for people to get treatment for mental disorders. Increasing screening for mental disorders can help people get the treatment they need.

– Healthy People 2030 (https://health.gov/healthypeople)

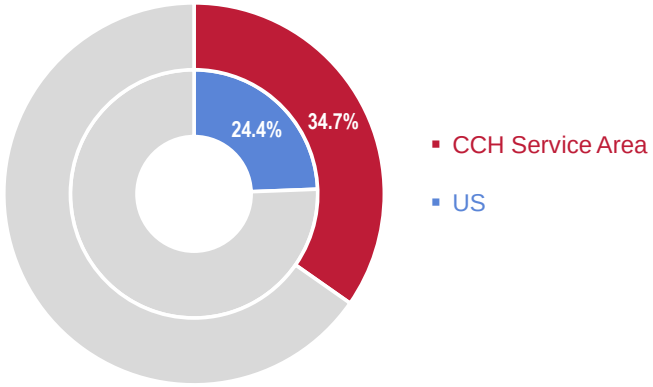
Mental Health Status

PRC SURVEY ► "Now thinking about your mental health, which includes stress, depression, and problems with emotions, would you say that, in general, your mental health is: excellent, very good, good, fair, or poor?"



Sources: ● 2025 PRC Community Health Survey, PRC, Inc. [Item 77]
Notes: ● Asked of all respondents.

Experience “Fair” or “Poor” Mental Health



Sources:
- 2025 PRC Community Health Survey, PRC, Inc. [Item 77]
- 2023 PRC National Health Survey, PRC, Inc.

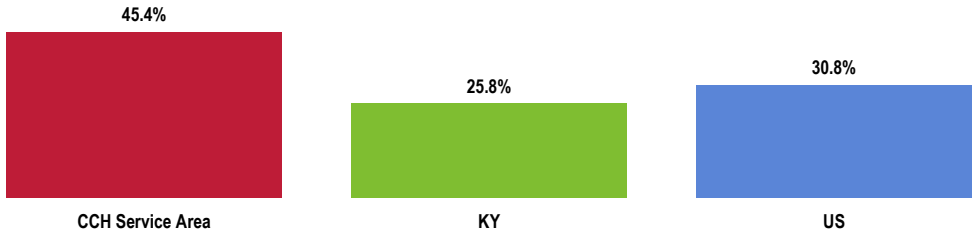
Notes:
- Asked of all respondents.

Depression

Diagnosed Depression

PRC SURVEY ► “Has a doctor, nurse, or other health professional ever told you that you have a depressive disorder, including depression, major depression, dysthymia, or minor depression?”

Have Been Diagnosed With a Depressive Disorder



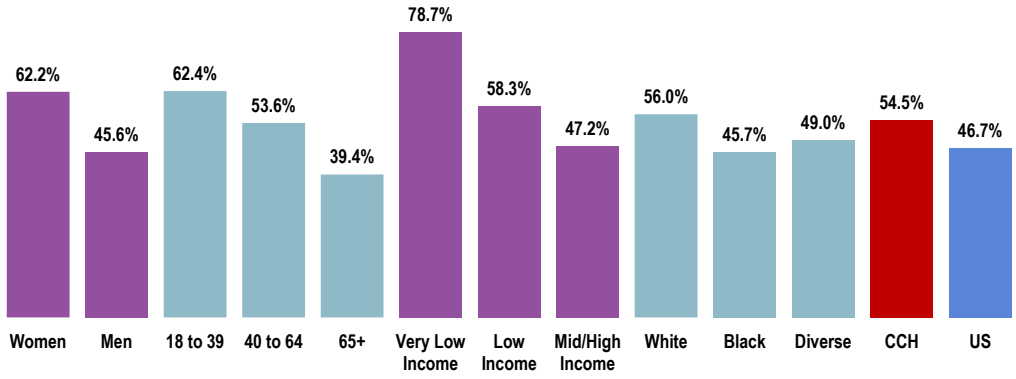
Sources:
- 2025 PRC Community Health Survey, PRC, Inc. [Item 80]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2022 Kentucky data.
- 2023 PRC National Health Survey, PRC, Inc.

Notes:
- Asked of all respondents.
- Depressive disorders include depression, major depression, dysthymia, or minor depression.

Symptoms of Chronic Depression

PRC SURVEY ► "Have you had two years or more in your life when you felt depressed or sad most days, even if you felt okay sometimes?"

Have Experienced Symptoms of Chronic Depression
(CCH Service Area, 2025)



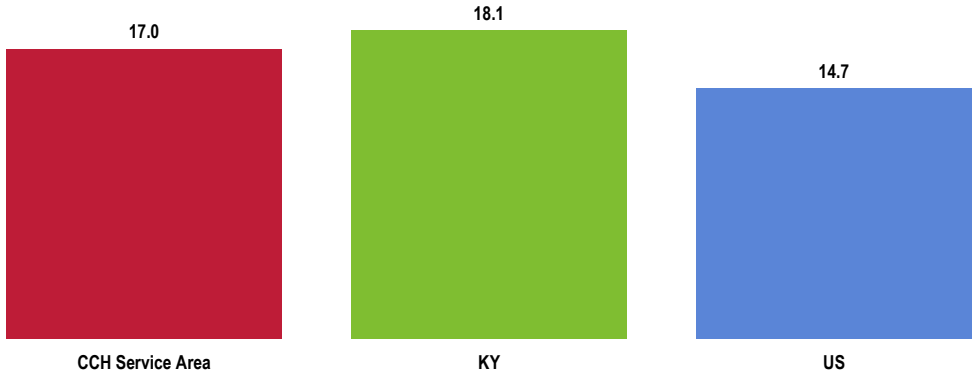
Sources:
- 2025 PRC Community Health Survey, PRC, Inc. [Item 78]
- 2023 PRC National Health Survey, PRC, Inc.

Notes:
- Asked of all respondents.
- Chronic depression includes periods of two or more years during which the respondent felt depressed or sad on most days, even if (s)he felt okay sometimes.

Suicide

The following chart outlines the most current mortality rates attributed to suicide in our population.

Suicide Mortality
(2021-2023 Annual Average Deaths per 100,000 Population)
Healthy People 2030 = 12.8 or Lower



Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted February 2025.
- US Department of Health and Human Services. Healthy People 2030. https://health.gov/healthypeople

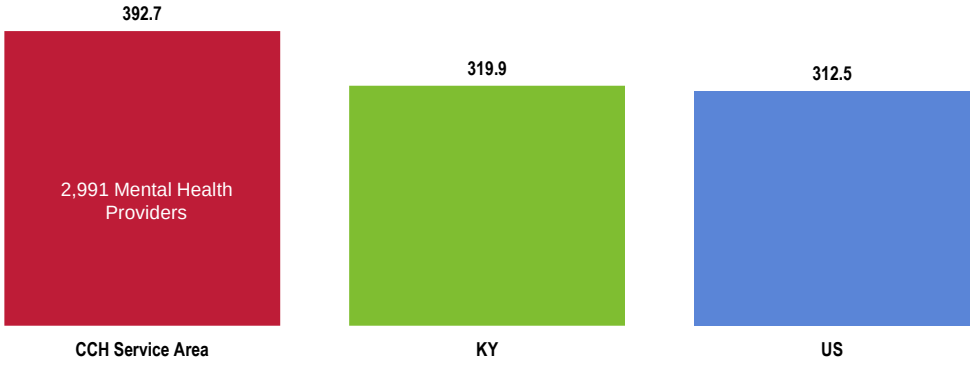
Notes:
- Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
- Rates are per 100,000 population.

Mental Health Treatment

Note that this indicator only reflects providers practicing within the study area and residents within the study area; it does not account for the potential demand for services from outside the area, nor the potential availability of providers in surrounding areas.

The following chart outlines access to mental health providers, expressed as the number of providers (psychiatrists, psychologists, clinical social workers, and counsellors who specialize in mental health care) per 100,000 residents.

Number of Mental Health Providers per 100,000 Population
(2024)

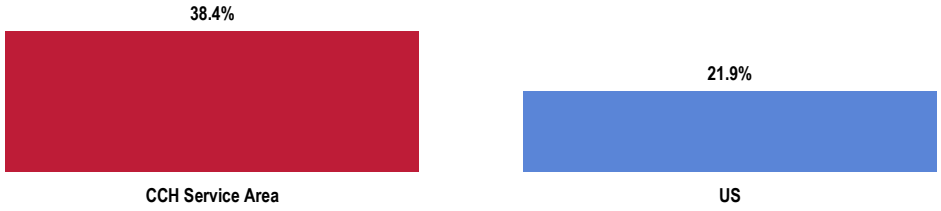


Sources:
- Centers for Medicare and Medicaid Services, National Plan and Provider Enumeration System (NPPES).
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved February 2025 via SparkMap (sparkmap.org).

Notes:
- This indicator reports the rate of the county population to the number of mental health providers, including psychiatrists, psychologists, clinical social workers, and counselors that specialize in mental health care.

PRC SURVEY ► "Are you now taking medication or receiving treatment from a doctor, nurse, or other health professional for any type of mental health condition or emotional problem?"

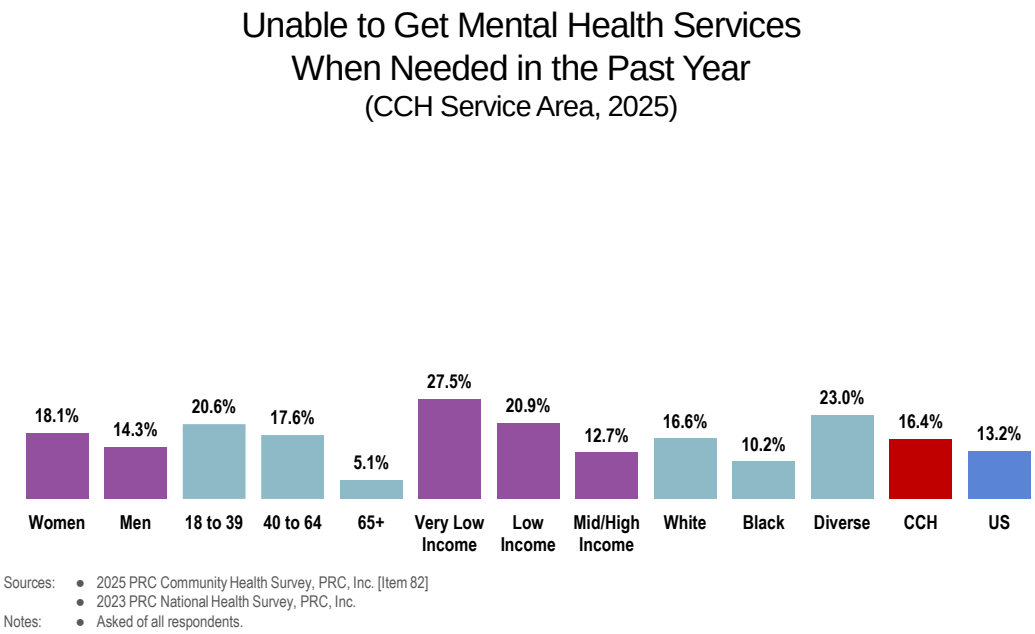
Currently Receiving Mental Health Treatment



Sources:
- 2025 PRC Community Health Survey, PRC, Inc. [Item 81]
- 2023 PRC National Health Survey, PRC, Inc.

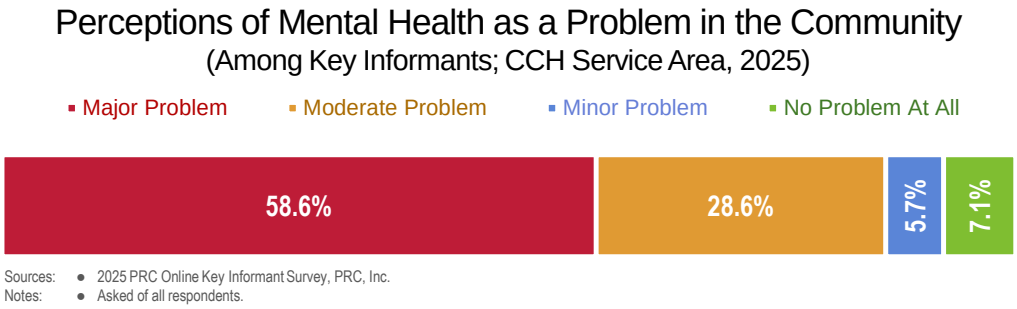
Notes:
- Asked of all respondents.
- Includes individuals now taking medication or otherwise receiving treatment for any type of mental health condition or emotional problem.

PRC SURVEY ► "Was there a time in the past 12 months when you needed mental health services but were not able to get them?"



Key Informant Input: Mental Health

The following chart outlines key informants' perceptions of the severity of *Mental Health* as a problem in the community:



Among those rating this issue as a "major problem," reasons related to the following:

Access to Care/Services

> Availability of care and support to keep them compliant. — Health Care Provider
>
> Accessing care and resources. Consequential negative outcomes for people with mental health issues, such as homelessness, lack of employment, lack of education. — Community Leader
>
> There are several major concerns. The availability of prescribers is a definite problem. We often see people discharged from hospitals or jails with a short supply of medicine and cannot get into see another prescriber before that expires, so they either stop the medicine or return to the ER to get more. Also, the length of time it takes to get appointments or finding therapists who take Medicaid can be an obstacle. The need for more crisis level care for those that don't meet hospitalization criteria. — Social Services Provider

> Access! And insurance coverage. A specific example — my son needed help with anxiety — providers who would accept his insurance had insane wait times. Concierge mental health providers are also booked — and very expensive. The health care model for mental health really limits who can get help. — Social Services Provider
>
> Many data sources show that mental health is on the rise, especially post-Covid. The biggest challenge is access to care and stigma. — Public Health Representative
>
> Wait time of over 6 months to see someone. With wait times this long, when patients are referred, the accepting office often cancels the referral due to lack of physicians and appointments. The EmPath unit is a great response for those in crisis, but for folks with not a severe issue when seeking help the EmPath unit isn't what they are looking for. There also needs to be more training for police on how to deal with mental health crises because they are often the first ones called. — Social Services Provider
>
> Services do not exist. — Community Leader
>
> Struggle with where to go to receive care. — Community Leader
>
> How many people go undiagnosed due to lack of access to care or stigma. — Public Health Representative
>
> Access and affordable. — Community Leader
>
> Accessing timely outpatient and crisis services. — Physician
>
> Access to treatment, access to a variety of treatment options, ability to pay for treatment. — Health Care Provider
>
> Don't have access to appropriate resources and/or counseling. — Community Leader
>
> Access to care, no insurance, and not enough providers in the state. — Community Leader

Denial/Stigma

> I believe the Stigma is getting better, however affordable access (many providers/counselors) do not take insurance, and it is private pay. Also, the homeless population is stricken with this disease, and we are using incarceration in lieu of mental health treatment, which is not addressing the problem. — Community Leader
>
> Stigma and health access. — Community Leader
>
> Stigma and access to mental health resources. Lack of access to basic resources, employment, housing, food insecurity, transportation all causing stress and complication to healthy living. Youth mental health coming out of the pandemic has been largely identified by the Fayette County Health Department and Public Schools System. Youth in essence lost 2 years of education and social engagement which has had a lasting impact on their development. — Community Leader
>
> The stigma associated with asking for help. — Health Care Provider
>
> There is a huge stigma around mental health, there is limited access to mental health, it is expensive and if you have Medicaid. The community mental health centers are so overwhelmed, the therapist's burnout constantly. — Social Services Provider
>
> The stigma around seeking treatment is a major problem. But beyond that, it is often more difficult to find the right provider who can help meet your needs, or even know where to begin to look for the right provider, than for other medical treatment. — Community Leader
>
> Stigma, cost and challenges in finding the right provider. — Community Leader

Follow-Up/Support

> When people can't see a mental health professional, they have difficulty making their follow up appointments. There are many factors involved in this, but a chief one is transportation. Many folks with mental health problems need to rely upon public transportation, and the public transportation system is not adequate for someone who is already suffering from depression or other mental health issues. — Community Leader
>
> The biggest challenges for people with mental health problems is consistent follow up and follow through. Many times, people are not able to make it to appointments or track time. They are unable to manage finances, making it difficult to maintain housing, pay bills, navigate other services and physical health issues. — Social Services Provider

Diagnosis/Treatment

> Untreated mental health issues and long commutes to providers depending on what side of town you are in. — Public Health Representative

Awareness/Education

> Lack of knowledge around mental health issues, resources available. — Community Leader

Alcohol/Drug Use

> Seems as if mental health isn't the causing factor, however, substance use, violence, negative family influences, poverty and housing crisis lead to overwhelming an individual and poor mental health. — Social Services Provider

Co-Occurrences

> Often, we see more severe mental health issues coinciding with substance use issues. We also see a lot of mental health issues come up during and after pregnancies as new moms battle postpartum depression, isolation, and usually financial instability/hardship. Culturally there is a lot of stigma surrounding mental health, many of our immigrants and non-English speakers don't seek assistance for fear of what their community will say. This is seen even clearer in cases of domestic violence as women who immigrated here with a partner are entirely shut off from their communities and struggle here due to lack of awareness, language barriers and stigma. Alternatively, the impact of long term/generational poverty can have serious ripple effects on a family's mental health. — Social Services Provider

Homelessness

> Homelessness. — Community Leader

Loneliness

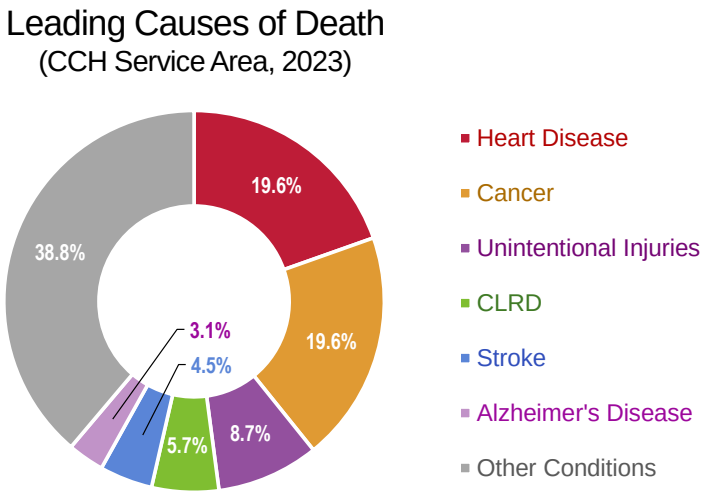
> Loneliness, we are learning more and more about the impact of this on health. — Community Leader

DEATH, DISEASE & CHRONIC CONDITIONS

Leading Causes of Death

Distribution of Deaths by Cause

The following outlines leading causes of death in the community.



Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted February 2025.

Notes:
- Lung disease includes deaths classified as chronic lower respiratory disease.

Death Rates for Selected Causes

For infant mortality data, see *Birth Outcomes & Risks* in the **Births** section of this report.

Here, deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10). Rates are per 100,000 population.

The following chart outlines annual average death rates per 100,000 population for selected causes of death.

Death Rates for Selected Causes
(2021-2023 Deaths per 100,000 Population)

	CCH Service Area	KY	US	Healthy People 2030
Heart Disease	224.0	257.1	209.5	127.4*
Cancers (Malignant Neoplasms)	198.7	228.6	182.5	122.7
Unintentional Injuries	96.0	94.3	67.8	43.2
Lung Disease (Chronic Lower Respiratory Disease)	60.7	72.3	43.5	—
Unintentional Drug-Induced Deaths	59.1	48.9	29.7	—
Stroke (Cerebrovascular Disease)	50.9	52.7	49.3	33.4
Alzheimer's Disease	35.4	34.6	35.8	—
Diabetes	27.2	37.8	30.5	—
Kidney Disease	21.6	26.3	16.9	—
Cirrhosis/Liver Disease	18.3	20.2	16.4	10.9
Suicide	17.0	18.1	14.7	12.8
Pneumonia/Influenza	16.3	17.8	13.4	—
Alcohol-Induced Deaths	15.8	14.7	15.7	—
Motor Vehicle Crashes	14.2	17.5	13.3	10.1
Homicide [2019-2023]	6.9	8.2	7.6	5.5

Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted February 2025.
- US Department of Health and Human Services. Healthy People 2030. https://health.gov/healthypeople.

Note:
- *The Healthy People 2030 coronary heart disease target is adjusted here to account for all diseases of the heart.
- Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
- Rates are per 100,000 population.

Cardiovascular Disease

ABOUT HEART DISEASE & STROKE

Heart disease is the leading cause of death in the United States, and stroke is the fifth leading cause. …Heart disease and stroke can result in poor quality of life, disability, and death. Though both diseases are common, they can often be prevented by controlling risk factors like high blood pressure and high cholesterol through treatment.

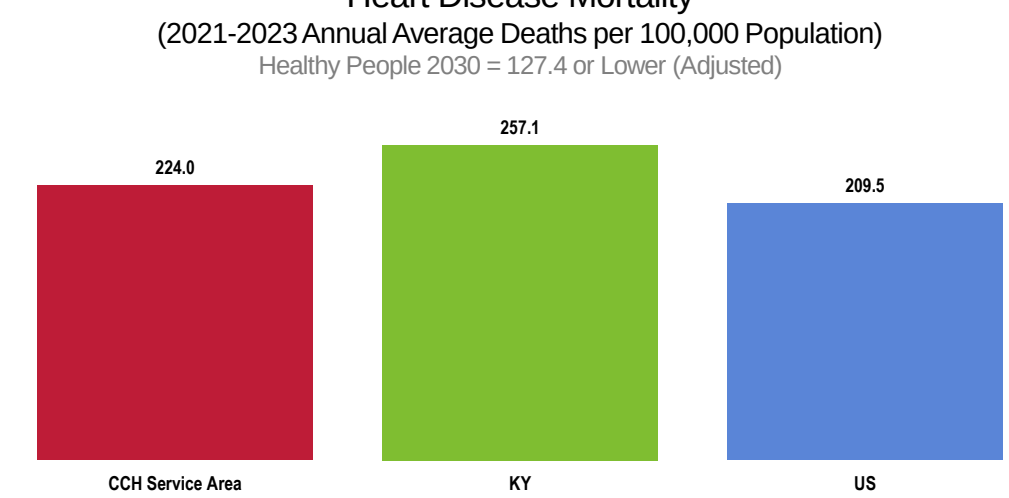
In addition, making sure people who experience a cardiovascular emergency — like stroke, heart attack, or cardiac arrest — get timely recommended treatment can reduce their risk for long-term disability and death. Teaching people to recognize symptoms is key to helping more people get the treatment they need.

– Healthy People 2030 (https://health.gov/healthypeople)

Heart Disease & Stroke Deaths

The following charts outline mortality rates for heart disease and for stroke in our community.

The greatest share of cardiovascular deaths is attributed to heart disease.



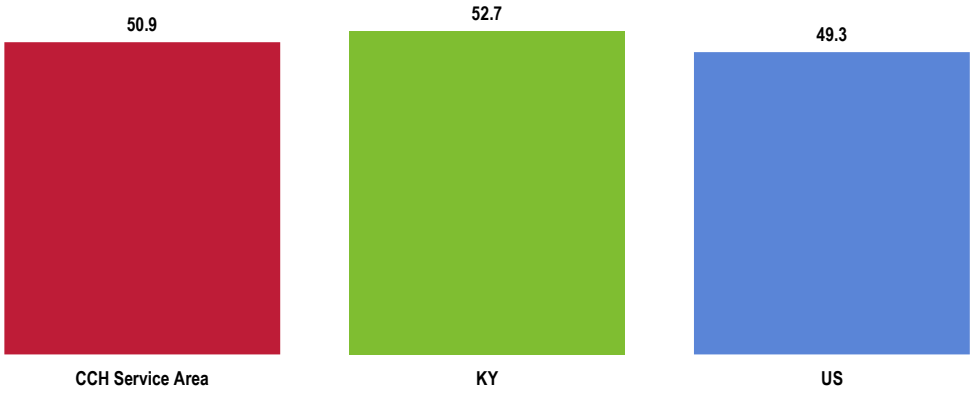
Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted February 2025.
- US Department of Health and Human Services. Healthy People 2030. https://health.gov/healthypeople

Notes:
- The Healthy People 2030 coronary heart disease target is adjusted here to account for all diseases of the heart.
- Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
- Rates are per 100,000 population.

Stroke Mortality

(2021-2023 Annual Average Deaths per 100,000 Population)

Healthy People 2030 = 33.4 or Lower



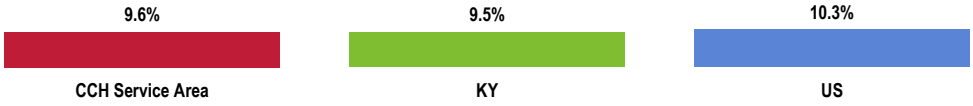
Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted February 2025.
- US Department of Health and Human Services. Healthy People 2030. https://health.gov/healthypeople

Notes:
- Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
- Rates are per 100,000 population.

Prevalence of Heart Disease & Stroke

PRC SURVEY ► "Have you ever suffered from or been diagnosed with heart disease, including heart attack or myocardial infarction, angina, or coronary heart disease?"

Prevalence of Heart Disease

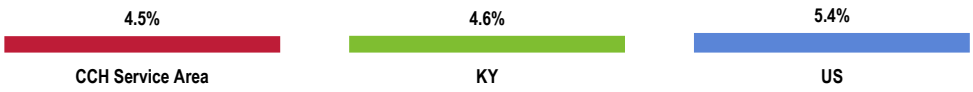


Sources:
- 2025 PRC Community Health Survey, PRC, Inc. [Item 22]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2022 Kentucky data.
- 2023 PRC National Health Survey, PRC, Inc.

Notes:
- Asked of all respondents.
- Includes diagnoses of heart attack, angina, or coronary heart disease.

PRC SURVEY ► "Have you ever suffered from or been diagnosed with a stroke?"

Prevalence of Stroke



Sources:
- 2025 PRC Community Health Survey, PRC, Inc. [Item 23]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2022 Kentucky data.
- 2023 PRC National Health Survey, PRC, Inc.

Notes:
- Asked of all respondents.

Cardiovascular Risk Factors

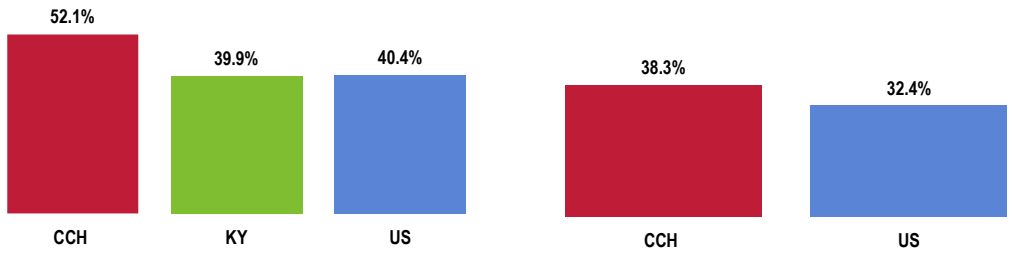
Blood Pressure & Cholesterol

PRC SURVEY ► "Have you ever been told by a doctor, nurse, or other health care professional that you had high blood pressure?"

PRC SURVEY ► "Blood cholesterol is a fatty substance found in the blood. Have you ever been told by a doctor, nurse, or other health care professional that your blood cholesterol is high?"

Prevalence of
High Blood Pressure
Healthy People 2030 = 42.6% or Lower

Prevalence of
High Blood Cholesterol



Sources:
- 2025 PRC Community Health Survey, PRC, Inc. [Items 29-30]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2022 Kentucky data.
- 2023 PRC National Health Survey, PRC, Inc.
- US Department of Health and Human Services. Healthy People 2030. https://health.gov/healthypeople

Notes:
- Asked of all respondents.

Total Cardiovascular Risk

Total cardiovascular risk reflects the individual-level risk factors which put a person at increased risk for cardiovascular disease, including:

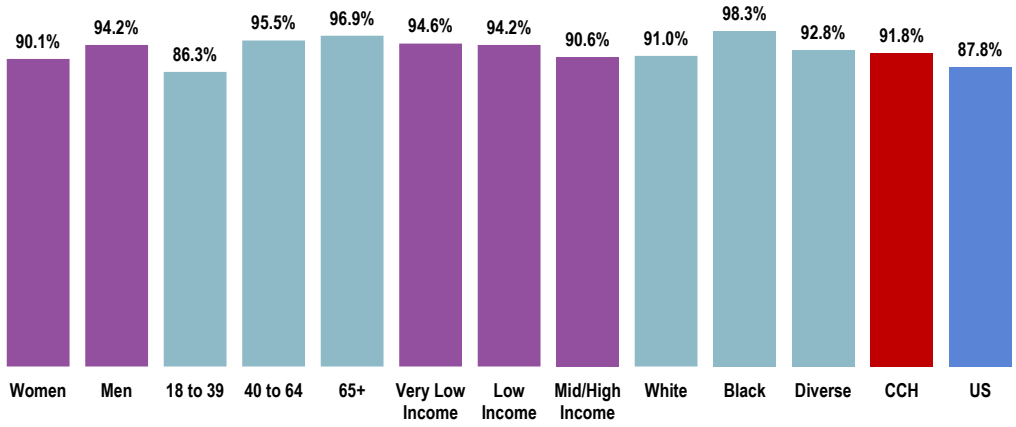
- High Blood Pressure
- High Blood Cholesterol
- Cigarette Smoking
- Physical Inactivity
- Overweight/Obesity

Modifying these behaviors and adhering to treatment for high blood pressure and cholesterol are critical both for preventing and for controlling cardiovascular disease.

RELATED ISSUE
See also *Nutrition, Physical Activity & Weight* and *Tobacco Use* in the **Modifiable Health Risks** section of this report.

The following chart reflects the percentage of adults in the Continuing Care Hospital Service Area who report one or more of the following: being overweight; smoking cigarettes; being physically inactive; or having high blood pressure or cholesterol.

Exhibit One or More Cardiovascular Risks or Behaviors
(CCH Service Area, 2025)

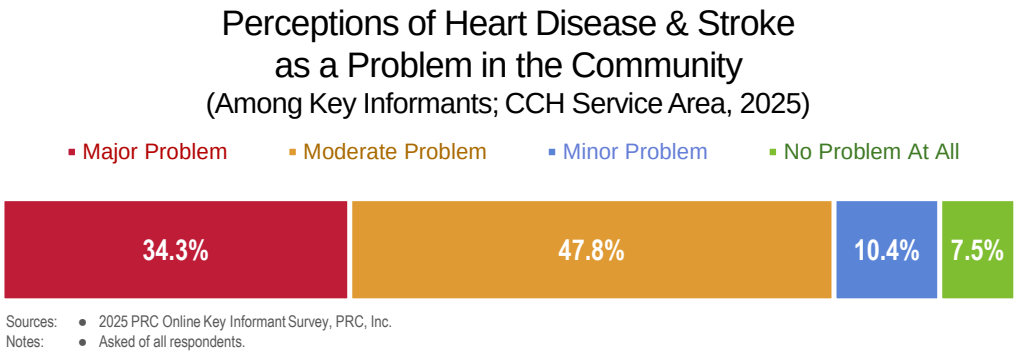


Sources:
- 2025 PRC Community Health Survey, PRC, Inc. [Item 100]
- 2023 PRC National Health Survey, PRC, Inc.

Notes:
- Reflects all respondents.
- Cardiovascular risk is defined as exhibiting one or more of the following: 1) no leisure-time physical activity; 2) regular/occasional cigarette smoking; 3) high blood pressure; 4) high blood cholesterol; and/or 5) being overweight/obese.

Key Informant Input: Heart Disease & Stroke

The following chart outlines key informants' perceptions of the severity of *Heart Disease & Stroke* as a problem in the community:



Among those rating this issue as a "major problem," reasons related to the following:

Lifestyle

> Poor diet, excessive weight, diabetes, and other comorbidities. — Community Leader
>
> High smoking and vaping rates, unhealthy eating habits, lack of physical activity, and limited preventative health care. — Social Services Provider
>
> Lifestyle in the state as we get away from Lexington result in unhealthy habits. — Community Leader
>
> Obesity, lack of access to healthy foods. — Community Leader

Incidence/Prevalence

> Heart disease and stroke are associated with diabetes or other chronic diseases. Many people have some types of chronic diseases which have the potential to develop heart disease. Early prevention is critical. — Community Leader
>
> Chronic diseases such has obesity, heart disease, diabetes are very prevalent in Kentucky. Many people suffer from a metabolic disorder that increases the risk of heart disease and stroke because of the multi-diagnosis of conditions. — Public Health Representative
>
> It is the number one and number three killer of Americans and both are preventable in 90% of the cases. Education is the key, and education is not happening on a widespread grass roots level. — Community Leader
>
> Number of people we know with heart issues. — Community Leader

Obesity

> Again, this is attributed to the poor health and overweight statistics of residents of Kentucky. High population of smokers in the state. — Community Leader
>
> The numbers are there to prove this. Much of this is a factor of obesity, hypertension and diabetes. Underlying much of this is poverty. — Community Leader

Tobacco Use

> Heart disease and stroke are linked to smoking, nutrition and exercise, all huge issues in our state and in the areas you described. — Social Services Provider

Access to Care/Services

> It is difficult to find. — Community Leader

Awareness/Education

> The lack of health education and the food deserts that exists within certain communities within our city. — Health Care Provider

Access to Affordable Healthy Food

> Our community still has significant barriers to healthy food options. There are food deserts in the area north of our downtown. This results in limited choices of healthy food options. Access to these specialties in the healthcare setting is a barrier for a significant portion of our residents. Access is limited by availability of appointments, transportation, etc. — Community Leader

Affordable Medications/Supplies

> Because so many with heart related problems cannot afford medications and medical problems get worse untreated. — Health Care Provider

Cancer

ABOUT CANCER

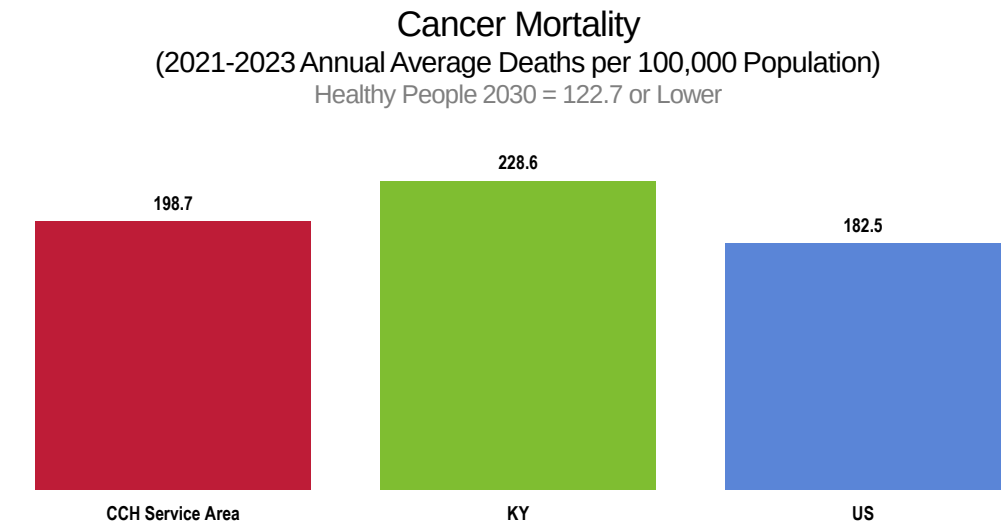
Cancer is the second leading cause of death in the United States. …The cancer death rate has declined in recent decades, but over 600,000 people still die from cancer each year in the United States. Death rates are higher for some cancers and in some racial/ethnic minority groups. These disparities are often linked to social determinants of health, including education, economic status, and access to health care.

Interventions to promote evidence-based cancer screenings — such as screenings for lung, breast, cervical, and colorectal cancer — can help reduce cancer deaths. Other effective prevention strategies include programs that increase HPV vaccine use, prevent tobacco use and promote quitting, and promote healthy eating and physical activity. In addition, effective targeted therapies and personalized treatment are key to helping people with cancer live longer.

– Healthy People 2030 (https://health.gov/healthypeople)

Cancer Deaths

The following chart illustrates cancer mortality (all types).



Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted February 2025.
- US Department of Health and Human Services. Healthy People 2030. https://health.gov/healthypeople

Notes:
- Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
- Rates are per 100,000 population.

Lung cancer is by far the leading cause of cancer deaths.

Cancer Death Rates by Site
(2021-2023 Annual Average Deaths per 100,000 Population)

	CCH Service Area	KY	US	Healthy People 2030
ALL CANCERS	198.7	228.6	182.5	122.7
Lung Cancer	53.1	64.8	39.8	25.1
Female Breast Cancer	25.2	27.6	25.1	15.3
Colorectal Cancer	17.7	21.3	16.3	8.9
Prostate Cancer	17.3	19.1	20.1	16.9

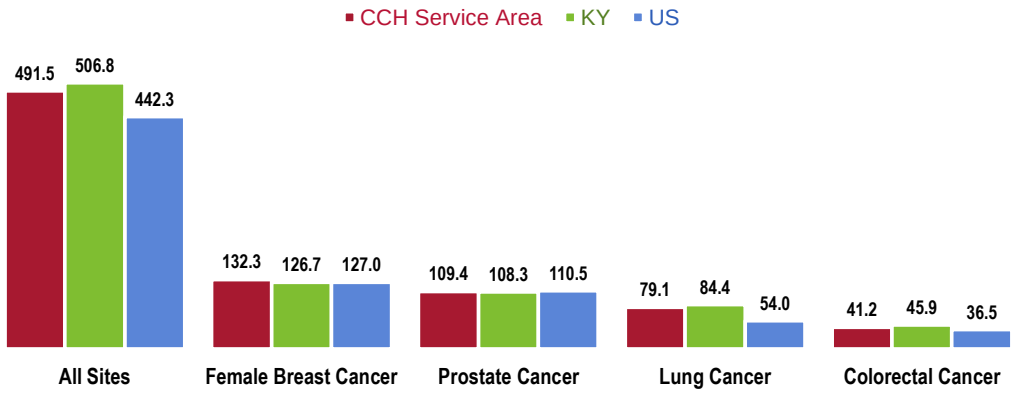
Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted February 2025.
- US Department of Health and Human Services. Healthy People 2030. https://health.gov/healthypeople

Notes:
- Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
- Rates are per 100,000 population.

Cancer Incidence

"Incidence rate" or "case rate" is the number of newly diagnosed cases in a given population in a given year, regardless of outcome. It is usually expressed as cases per 100,000 population per year.

Cancer Incidence Rates by Site
(2021-2023)



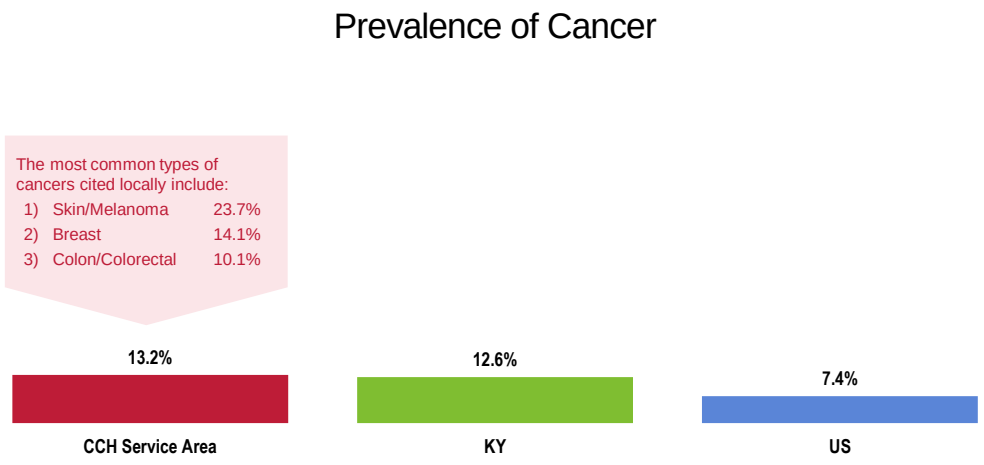
Sources:
- National Cancer Institute, State Cancer Profiles.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved February 2025 via SparkMap (sparkmap.org).

Notes:
- This indicator reports the incidence rate (cases per 100,000 population per year) for select cancers.

Prevalence of Cancer

PRC SURVEY ► "Have you ever suffered from or been diagnosed with cancer?"

PRC SURVEY ► "Which type of cancer were you diagnosed with? (If more than one past diagnosis, respondent was asked about the most recent.)



Sources:
- 2025 PRC Community Health Survey, PRC, Inc. [Items 24-25]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2022 Kentucky data.
- 2023 PRC National Health Survey, PRC, Inc.

Notes:
- Asked of all respondents.

Cancer Screenings

Screening levels in the community were measured in the PRC Community Health Survey relative to the following cancer sites:

FEMALE BREAST CANCER

The US Preventive Services Task Force (USPSTF) recommends biennial screening mammography for women age 50 to 74 years.

CERVICAL CANCER

The US Preventive Services Task Force (USPSTF) recommends screening for cervical cancer every 3 years with cervical cytology alone in women age 21 to 29 years. For women age 30 to 65 years, the USPSTF recommends screening every 3 years with cervical cytology alone, every 5 years with high-risk human papillomavirus (hrHPV) testing alone, or every 5 years with hrHPV testing in combination with cytology (cotesting). The USPSTF recommends against screening for cervical cancer in women who have had a hysterectomy with removal of the cervix and do not have a history of a high-grade precancerous lesion (i.e., cervical intraepithelial neoplasia [CIN] grade 2 or 3) or cervical cancer.

COLORECTAL CANCER

The US Preventive Services Task Force (USPSTF) recommends screening for colorectal cancer starting at age 45 years and continuing until age 75 years.

– US Preventive Services Task Force, Agency for Healthcare Research and Quality, US Department of Health & Human Services

Note that other organizations (e.g., American Cancer Society, American Academy of Family Physicians, American College of Physicians, National Cancer Institute) may have slightly different screening guidelines.

Breast Cancer Screening

PRC SURVEY ► "A mammogram is an x-ray of each breast to look for cancer. How long has it been since you had your last mammogram?"

Breast cancer screening is calculated here among women age 50 to 74 who indicate mammography within the past 2 years.

Cervical Cancer Screening

PRC SURVEY ► "A Pap test is a test for cancer of the cervix. How long has it been since you had your last Pap test?"

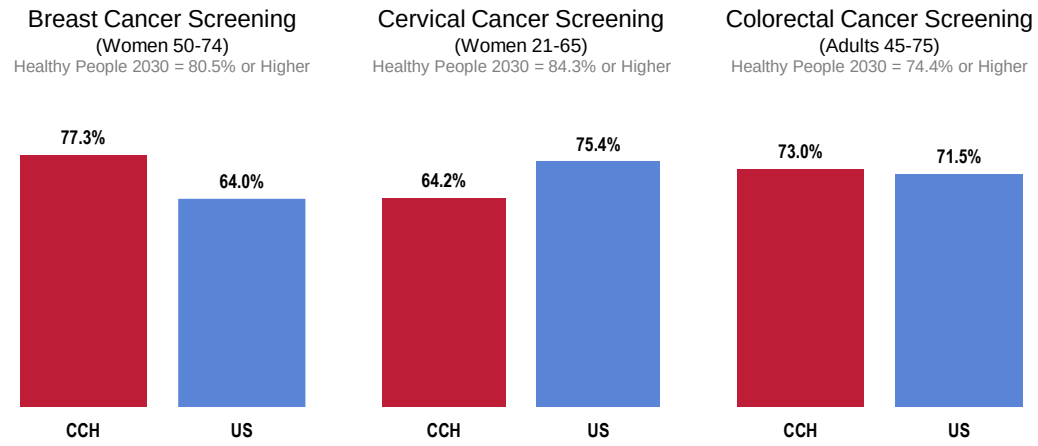
"Appropriate cervical cancer screening" includes Pap smear testing (cervical cytology) every three years in women age 21 to 29 and Pap smear testing and/or HPV testing every 5 years in women age 30 to 65.

Colorectal Cancer Screening

PRC SURVEY ► "Sigmoidoscopy and colonoscopy are exams in which a tube is inserted in the rectum to view the colon for signs of cancer or other health problems. How long has it been since your last sigmoidoscopy or colonoscopy?"

PRC SURVEY ► "A blood stool test is a test that may use a special kit at home to determine whether the stool contains blood. How long has it been since you had your last blood stool test?"

"Appropriate colorectal cancer screening" includes adults age 45 to 75 with a fecal occult blood test within the past year and/or lower endoscopy (sigmoidoscopy or colonoscopy) within the past 10 years.

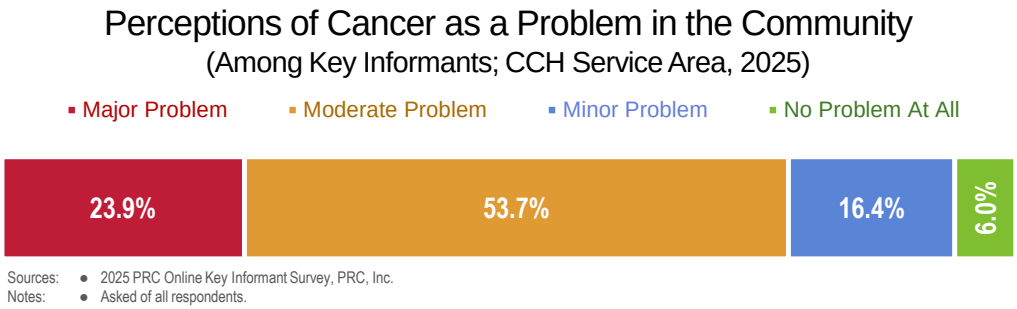


Sources:
- 2025 PRC Community Health Survey, PRC, Inc. [Items 101-103]
- 2023 PRC National Health Survey, PRC, Inc.
- US Department of Health and Human Services. Healthy People 2030. https://health.gov/healthypeople

Notes:
- Each indicator is shown among the gender and/or age group specified.
- Note that national data for colorectal cancer screening reflect adults ages 50 to 75.

Key Informant Input: Cancer

The following chart outlines key informants' perceptions of the severity of *Cancer* as a problem in the community:



Among those rating this issue as a "major problem," reasons related to the following:

Incidence/Prevalence

> Based on the current individuals that I know who are dealing with or have dealt with cancer. — Health Care Provider
>
> It seems as though most people deal with some form of cancer in their lifetime if they live past a certain age. The foods and other influencing factors can increase the likelihood that cancer occurs earlier in life. Not everyone in the community has access to healthy foods and preventative activities and education about healthy living. The prevalence of cancer-causing environmental factors including substance abuse increases the chances of cancer in our region. — Community Leader
>
> Kentucky overall is at risk for cancer. everyone I know either has a cancer or knows someone who has a cancer. — Community Leader
>
> We see an increase in the number of cancer diagnosis, especially breast cancer. — Community Leader
>
> The incidence of lung cancer is the worst in the US. — Community Leader
>
> Chronic disease such as obesity, heart disease, diabetes, can lead to cancer. Kentucky has a very high rate of these conditions. — Public Health Representative
>
> Number of cases continue to rise. — Community Leader
>
> It is my understanding that our state has a high percentage of cancer health outcomes and unfortunately socio and economic factors are limiting to a subset of the population that seeks appropriate and affordable care and preventive actions and knowledge. — Community Leader
>
> KY ranks in the top three states in America for Cancer incidence and mortality for colon cancer and breast cancer, two very preventable cancers with regular screening. This should never be the case in 2025 and is an embarrassment to our state and to Fayette County. — Community Leader
>
> The age of those diagnosed with cancer is dropping. — Community Leader
>
> Based on the number of people we know who have cancer. — Community Leader

Diagnosis/Treatment

> Cancer is major problem when it is found in stage four, which can't be treated. — Community Leader
>
> The ability to determine the best approach to receiving the needed care. — Community Leader

Environmental Contributors

> Poor water quality, high rates of smoking and vaping, toxin exposures and general poverty. — Social Services Provider

Social Norms/Community Attitude

> It's difficult to "unlink" these determinants of health — smoking, substance abuse, environment — all link to cancer. I suspect it would be impossible to find a family that has not been impacted by cancer. The cost of treating it, the mental health impact on the patient and their family cannot be adequately measured. — Social Services Provider

Respiratory Disease

ABOUT RESPIRATORY DISEASE

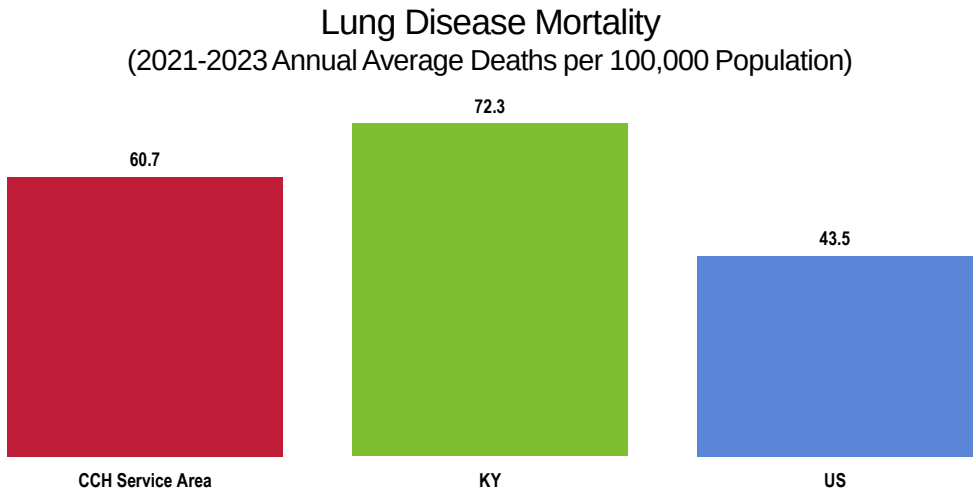
Respiratory diseases affect millions of people in the United States. …More than 25 million people in the United States have asthma. Strategies to reduce environmental triggers and make sure people get the right medications can help prevent hospital visits for asthma. In addition, more than 16 million people in the United States have COPD (chronic obstructive pulmonary disease), which is a major cause of death. Strategies to prevent the disease — like reducing air pollution and helping people quit smoking — are key to reducing deaths from COPD.

– Healthy People 2030 (https://health.gov/healthypeople)

Respiratory Disease Deaths

Lung Disease Deaths

Chronic lower respiratory diseases (CLRD) are diseases affecting the lungs; the most deadly of these is chronic obstructive pulmonary disease (COPD), which includes emphysema and chronic bronchitis. Mortality for lung disease is illustrated in the charts that follow.

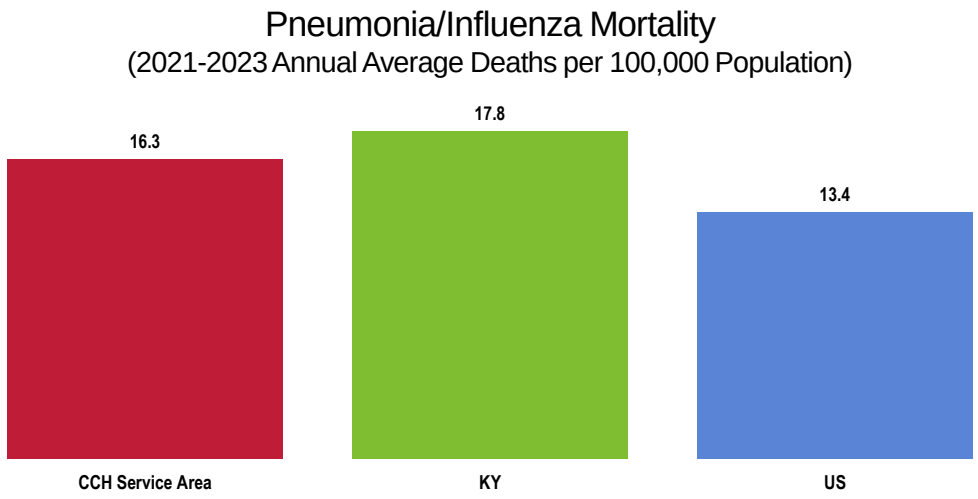


Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted February 2025.

Notes:
- Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
- Rates are per 100,000 population.
- Here, lung disease reflects chronic lower respiratory disease (CLRD) deaths and includes conditions such as emphysema, chronic bronchitis, and asthma.

Pneumonia/Influenza Deaths

Pneumonia and influenza mortality is illustrated here.



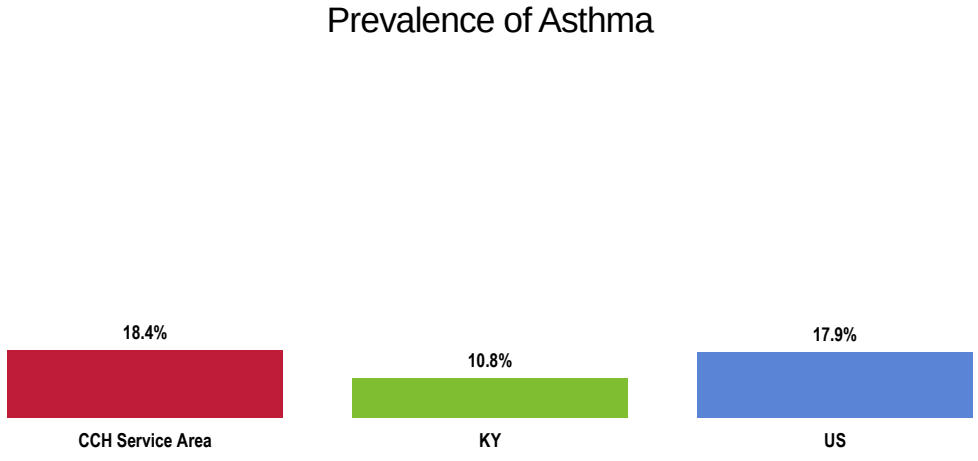
Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted February 2025.

Notes:
- Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
- Rates are per 100,000 population.

Prevalence of Respiratory Disease

Asthma

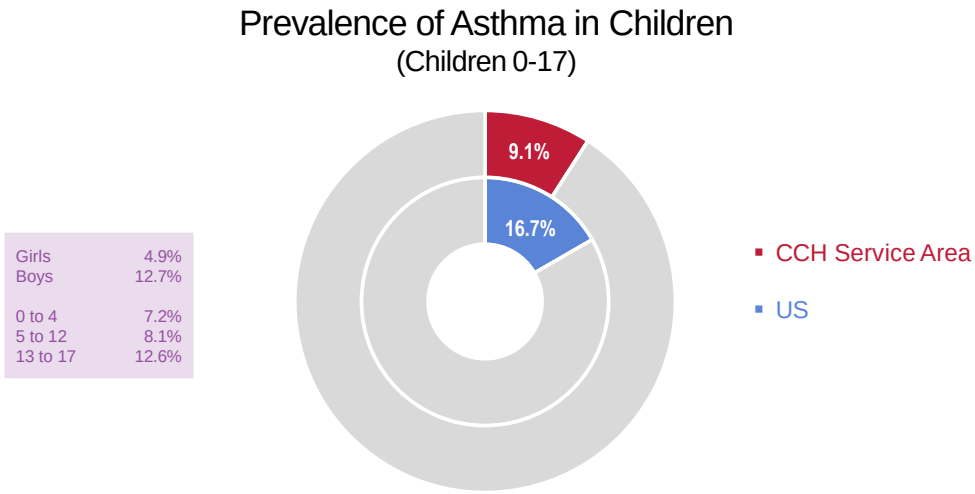
PRC SURVEY ► "Do you currently have asthma?"



Sources:
- 2025 PRC Community Health Survey, PRC, Inc. [Item 26]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2022 Kentucky data.
- 2023 PRC National Health Survey, PRC, Inc.

Notes:
- Asked of all respondents.

PRC SURVEY ► [Among parents of children age 0-17] **"Has a doctor, nurse, or other health professional ever told you that this child had asthma?"**

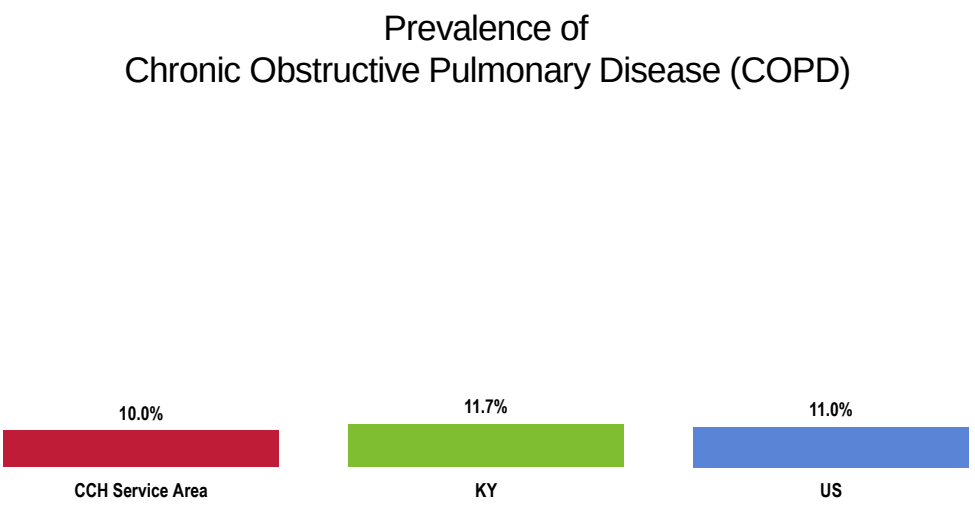


Sources:
- 2025 PRC Community Health Survey, PRC, Inc. [Item 92]
- 2023 PRC National Health Survey, PRC, Inc.

Notes:
- Asked of all respondents with children 0 to 17 in the household.

Chronic Obstructive Pulmonary Disease (COPD)

PRC SURVEY ► **"Would you please tell me if you have ever suffered from or been diagnosed with COPD or chronic obstructive pulmonary disease, including bronchitis or emphysema?"**

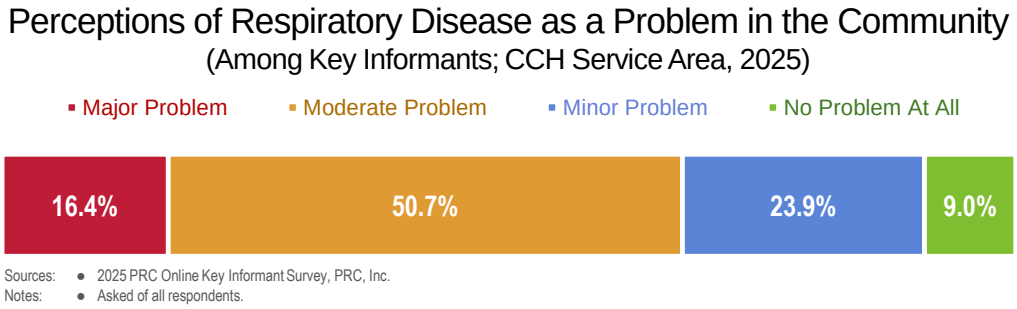


Sources:
- 2025 PRC Community Health Survey, PRC, Inc. [Item 21]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2022 Kentucky data.
- 2023 PRC National Health Survey, PRC, Inc.

Notes:
- Asked of all respondents.
- Includes conditions such as chronic bronchitis and emphysema.

Key Informant Input: Respiratory Disease

The following chart outlines key informants' perceptions of the severity of *Respiratory Disease* as a problem in the community:



Among those rating this issue as a "major problem," reasons related to the following:

Tobacco Use

> Historically being a tobacco state, we have a large portion of the population that smokes. — Community Leader
>
> Smoking decision when faced with lifestyle choices. — Community Leader

Environmental Contributors

> COPD is so common among our elderly population due to being exposed to smoking, coal runoff and ash, and other toxic exposures. — Social Services Provider

Incidence/Prevalence

> I moved here three years ago, and you can't go anywhere without someone coughing. Employees don't stay home; they don't mask up and they do not get flu shots. I also think there is a lot of people who smoke here that do not realize the consequences vs other states. — Community Leader

Impact on Quality of Life

> I consider COPD in this category, along with the virus-borne illnesses. Life-limiting illnesses that keep people out of the workforce and dependent on social programs and family support for survival. — Social Services Provider

Access to Care/Services

> Services do not exist. — Community Leader

Injury & Violence

ABOUT INJURY & VIOLENCE

INJURY ► In the United States, unintentional injuries are the leading cause of death in children, adolescents, and adults younger than 45 years. …Many unintentional injuries are caused by motor vehicle crashes and falls, and many intentional injuries involve gun violence and physical assaults. Interventions to prevent different types of injuries are key to keeping people safe in their homes, workplaces, and communities.

Drug overdoses are now the leading cause of injury deaths in the United States, and most overdoses involve opioids. Interventions to change health care providers' prescribing behaviors, distribute naloxone to reverse overdoses, and provide medications for addiction treatment for people with opioid use disorder can help reduce overdose deaths involving opioids.

VIOLENCE ► Almost 20,000 people die from homicide every year in the United States, and many more people are injured by violence. …Many people in the United States experience physical assaults, sexual violence, and gun-related injuries. Adolescents are especially at risk for experiencing violence. Interventions to reduce violence are needed to keep people safe in their homes, schools, workplaces, and communities.

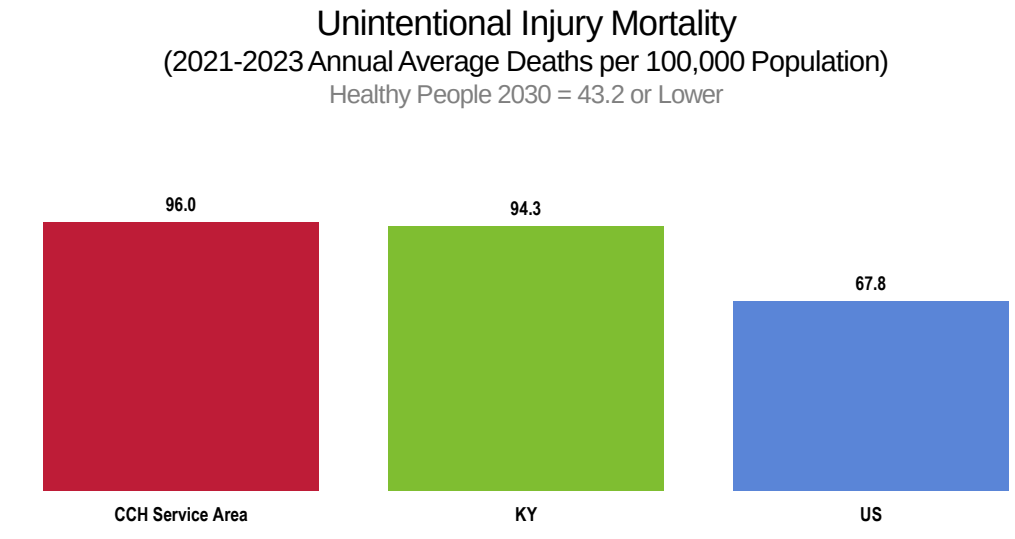
Children who experience violence are at risk for long-term physical, behavioral, and mental health problems. Strategies to protect children from violence can help improve their health and well-being later in life.

– Healthy People 2030 (https://health.gov/healthypeople)

Unintentional Injury

Unintentional Injury Deaths

The following chart outlines mortality rates for unintentional injury in the area.



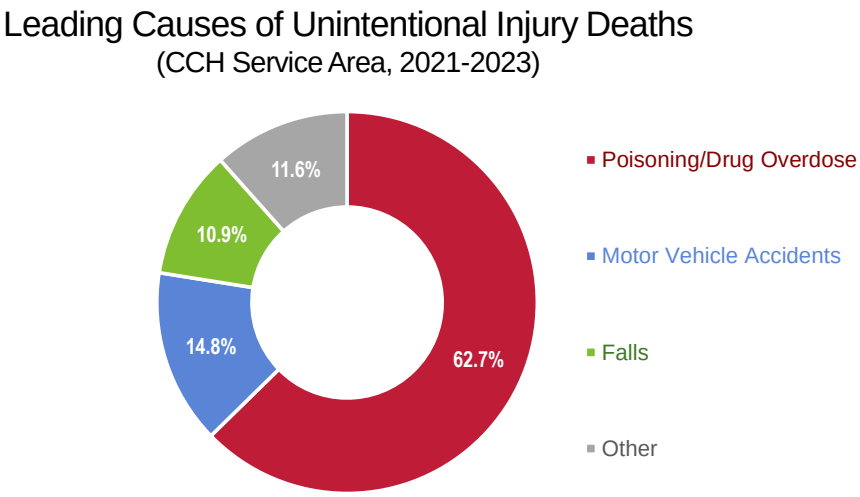
Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted February 2025.
- US Department of Health and Human Services. Healthy People 2030. https://health.gov/healthypeople

Notes:
- Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
- Rates are per 100,000 population.

Leading Causes of Unintentional Injury Deaths

RELATED ISSUE
For more information about unintentional drug-induced deaths, see also *Substance Use* in the **Modifiable Health Risks** section of this report.

The following outlines leading causes of accidental death in the area.



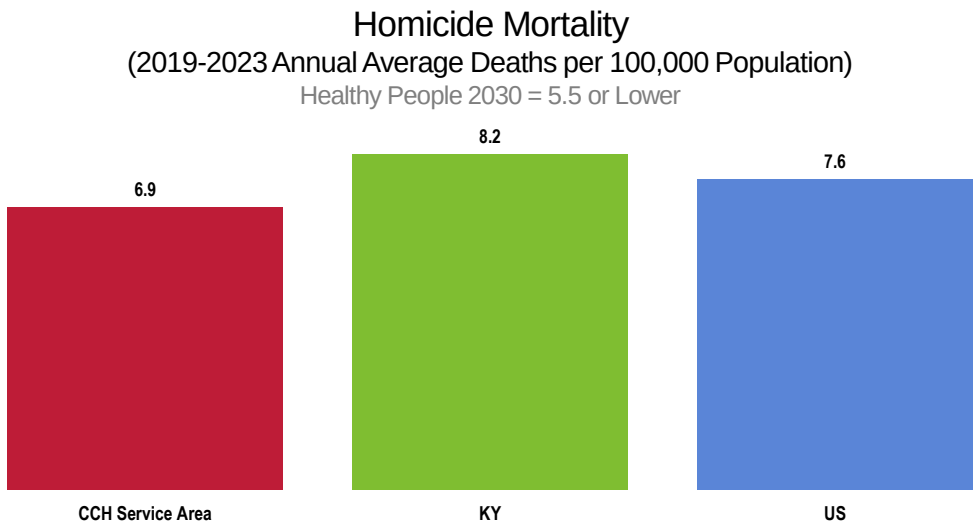
Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted February 2025.

Intentional Injury (Violence)

Homicide Deaths

RELATED ISSUE
See also *Mental Health (Suicide)* in the **General Health Status** section of this report.

Mortality attributed to homicide is shown in the following chart.



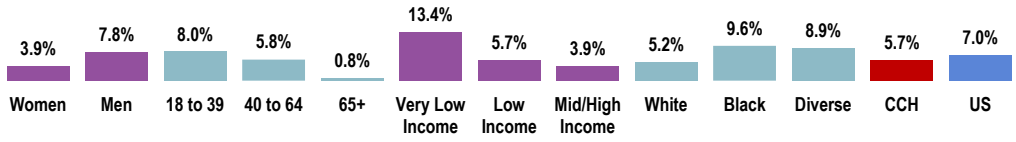
Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted February 2025.
- US Department of Health and Human Services. Healthy People 2030. https://health.gov/healthypeople

Notes:
- Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
- Rates are per 100,000 population.

Violent Crime Experience

PRC SURVEY ► "Thinking about your own personal safety, have you been the victim of a violent crime in your area in the past 5 years?"

Victim of a Violent Crime in the Past Five Years
(CCH Service Area, 2025)



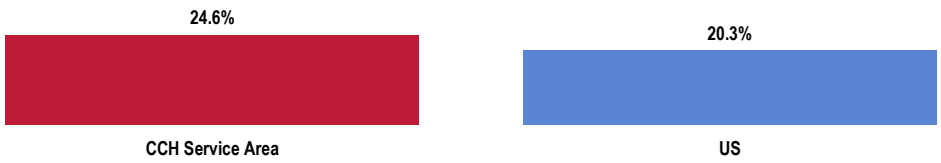
Sources:
- 2025 PRC Community Health Survey, PRC, Inc. [Item 32]
- 2023 PRC National Health Survey, PRC, Inc.

Notes:
- Asked of all respondents.

Intimate Partner Violence

PRC SURVEY ► "The next question is about violence in relationships with an intimate partner. By an intimate partner, I mean any current or former spouse, boyfriend, or girlfriend. Someone you were dating, or romantically or sexually intimate with, would also be considered an intimate partner. Has an intimate partner ever hit, slapped, pushed, kicked, or hurt you in any way?"

Have Ever Been Hit, Slapped, Pushed, Kicked, or Hurt in Any Way by an Intimate Partner

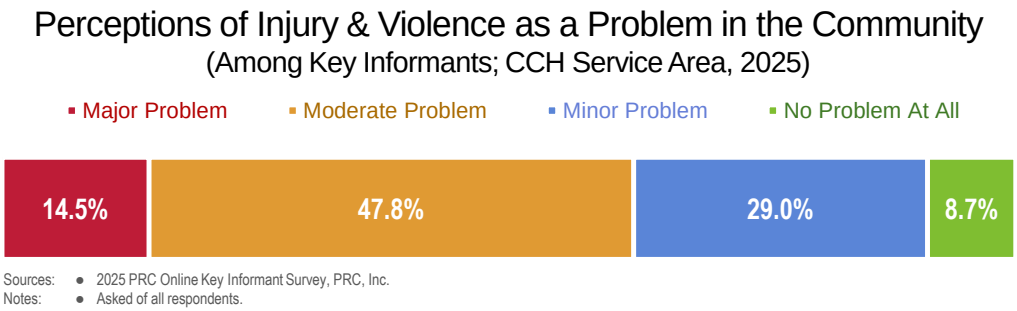


Sources:
- 2025 PRC Community Health Survey, PRC, Inc. [Item 33]
- 2023 PRC National Health Survey, PRC, Inc.

Notes:
- Asked of all respondents.

Key Informant Input: Injury & Violence

The following chart outlines key informants' perceptions of the severity of *Injury & Violence* as a problem in the community:



Among those rating this issue as a "major problem," reasons related to the following:

Gun Violence

> Gun violence in Fayette County is pretty well documented. The work of one lex and other community partners in the past couple of years has helped a lot with youth violence. However, it is still a consistent fight. — Social Services Provider
>
> I see too many young people involved in violent activity these days. Gun violence in every aspect of life, the streets, schools and everywhere. Gun violence has become the new version of conflict resolution. — Community Leader

Incidence/Prevalence

> In a community like Lexington, bigger cities are more prone to having acts of violence. The bigger the population, the bigger the chances are of injuries occurring. — Public Health Representative

Access to Care/Services

> Services do not exist. — Community Leader

Work-Related

> People work in unsafe conditions at high-risk jobs without insurance. There are shootings daily, people are not living in safe housing. — Social Services Provider

Diabetes

ABOUT DIABETES

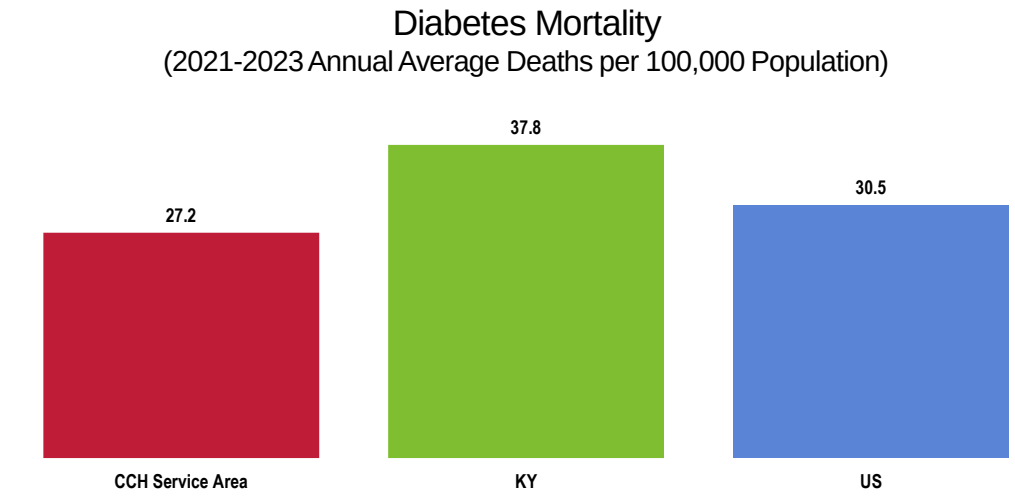
More than 30 million people in the United States have diabetes, and it's the seventh leading cause of death. …Some racial/ethnic minorities are more likely to have diabetes. And many people with diabetes don't know they have it.

Poorly controlled or untreated diabetes can lead to leg or foot amputations, vision loss, and kidney damage. But interventions to help people manage diabetes can help reduce the risk of complications. In addition, strategies to help people who don't have diabetes eat healthier, get physical activity, and lose weight can help prevent new cases.

– Healthy People 2030 (https://health.gov/healthypeople)

Diabetes Deaths

Diabetes mortality for the area is shown in the following chart.



Sources: ● CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted February 2025.

Notes: ● Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
● Rates are per 100,000 population.

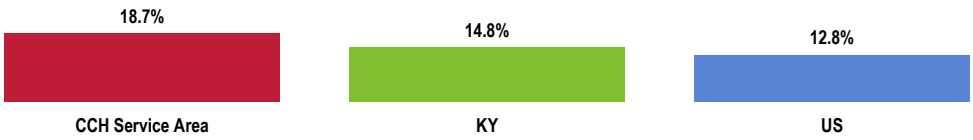
Prevalence of Diabetes

PRC SURVEY ► "Have you ever been told by a doctor, nurse, or other health professional that you have diabetes, not counting diabetes only occurring during pregnancy?"

PRC SURVEY ► "Other than during pregnancy, have you ever been told by a doctor, nurse, or other health professional that you have pre-diabetes or borderline diabetes?"

Prevalence of Diabetes

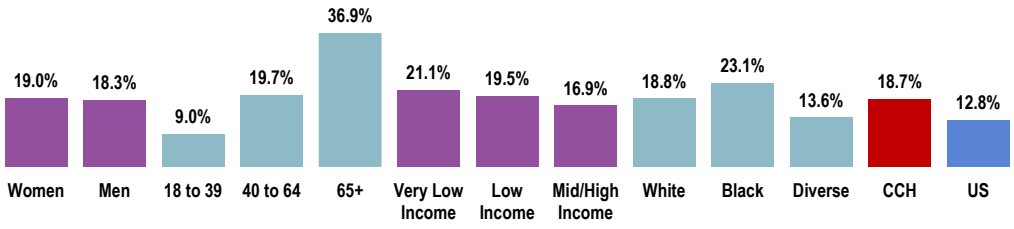
Another 13.4% of adults have been diagnosed with "pre-diabetes" or "borderline" diabetes.



Sources:
- 2025 PRC Community Health Survey, PRC, Inc. [Item 106]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2022 Kentucky data.
- 2023 PRC National Health Survey, PRC, Inc.

Notes:
- Asked of all respondents. Excludes gestational diabetes (occurring only during pregnancy).

Prevalence of Diabetes
(CCH Service Area, 2025)

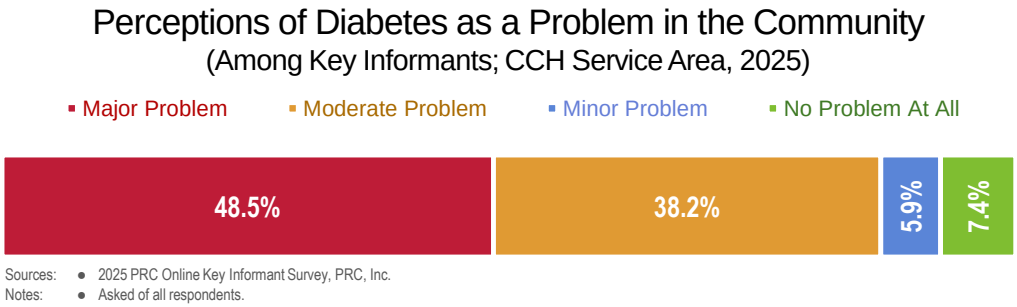


Sources:
- 2025 PRC Community Health Survey, PRC, Inc. [Item 106]

Notes:
- Asked of all respondents.
- Excludes gestational diabetes (occurring only during pregnancy).

Key Informant Input: Diabetes

The following chart outlines key informants' perceptions of the severity of *Diabetes* as a problem in the community:



Among those rating this issue as a "major problem," reasons related to the following:

Access to Affordable Healthy Food

> Access to nutritious foods and communities that are walkable. — Community Leader
>
> Access to appropriate food, nutrition information, exercise support program. — Social Services Provider
>
> Access to affordable healthy food. Inability to pay for needed medication, such as insulin, as people are underinsured and on fixed incomes and may not be able to afford the medication. Ability to arrange transportation to get to needed medical services. — Social Services Provider
>
> Lack of access to nutritious food. — Community Leader
>
> Access to better food options, sidewalks for exercising, and healthcare. — Community Leader
>
> Living a diabetic friendly lifestyle can be expensive- consistent access to fresh food due to cost, transportation or location is often a problem. Folks often have to choose convenience over health. High calorie low quality food is cheaper and more readily available. — Community Leader
>
> For many people, the budget doesn't afford healthy eating, and obesity sets in at a young age. Given this, weight becomes a significant problem. There is a great need for nutrition education. For some people, there is a long familial history of diabetes and people feel a strong sense of inevitability. For low-income people, managing diabetes, the time it takes and the money it costs, is nearly impossible. — Community Leader
>
> Nutrition on a budget due to very low income and weightless when disabled or with limitations. — Social Services Provider
>
> Accessing health foods. — Social Services Provider

Nutrition & Physical Activity

> Poor diet, poor self-care. — Community Leader
>
> Diet and nutrition. Clients may be educated on diabetes but don't always have the proper diet and nutrition resources to be compliant. — Community Leader
>
> The typical diet leads to such an increased risk of diabetes, which then leads to major chronic complications. These chronic issues require a great deal of ongoing management, and that is very difficult for people of limited means or with limited family support. — Community Leader

Awareness/Education

> Understanding the proper diet requirements and adhering to their application. — Community Leader
>
> People didn't see the importance of changing diets to control diabetes. A lack of understanding of nutrition, eating habits, and minimum exercise contribute to it. — Community Leader
>
> People lack a general understanding of things like eating healthy, exercise, and counting macros. — Health Care Provider

Affordable Medications/Supplies

> The cost of insulin. Education on how to properly eat as dietary changes are necessary to make improvements. Ability to afford healthy groceries. A lack of education about the disease. — Social Services Provider
>
> Buying medications and testing materials. I see many patients rationing medications due to cost, which leads to extended periods of high blood sugars and compounding medical issues. — Health Care Provider

> Access to affordable and holistic care. — Community Leader
>
> Access to medication and blood monitoring devices. — Community Leader
>
> Cost of insulin, access to transportation to pick up the medications. — Social Services Provider
>
> Access to medication and assistance with payment. — Community Leader

Obesity

> We have a large percentage of overweight individuals with poor diets and other contributing factors. Access to affordable medicine, care and nutrition information and food are barriers here. — Community Leader
>
> Chronic disease such as obesity can lead to increased prevalence of diabetes. Kentucky has a significant rate of obesity plus lack of physical activity opportunities. — Public Health Representative

Disease Management

> Compliance related to knowledge of care and the disease, cost of supplies and healthy food access. — Community Leader
>
> Control. — Community Leader

Diagnosis/Treatment

> Diagnosis, treatment and monitoring of diabetes. — Community Leader
>
> Early diagnosis and follow up care. — Health Care Provider

Foreign-Born

> For those who do not have insurance because they are undocumented, treatment is expensive. Needles and insulin are ridiculously priced. Health facilities that operate on a sliding scale have long waits if someone has just moved to Kentucky. — Public Health Representative

Access to Care/Services

> Access to healthcare, medicine and healthy food choices. — Community Leader

Disabling Conditions

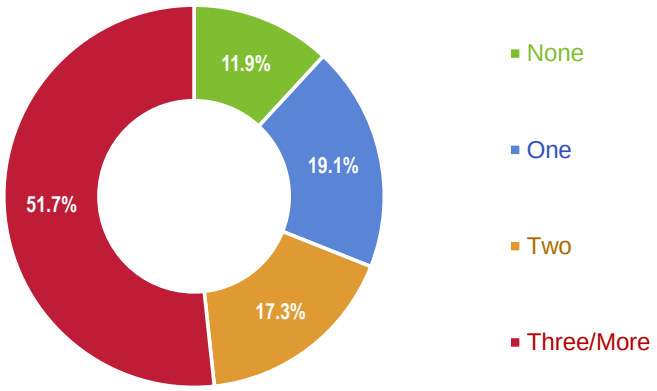
Multiple Chronic Conditions

For the purposes of this assessment, chronic conditions include:

- Asthma
- Cancer
- Chronic pain
- Diabetes
- Diagnosed depression
- Heart disease
- High blood cholesterol
- High blood pressure
- Lung disease
- Obesity
- Stroke

The following charts outline the prevalence of multiple chronic conditions among surveyed adults, taking into account all of the various conditions measured in the survey.

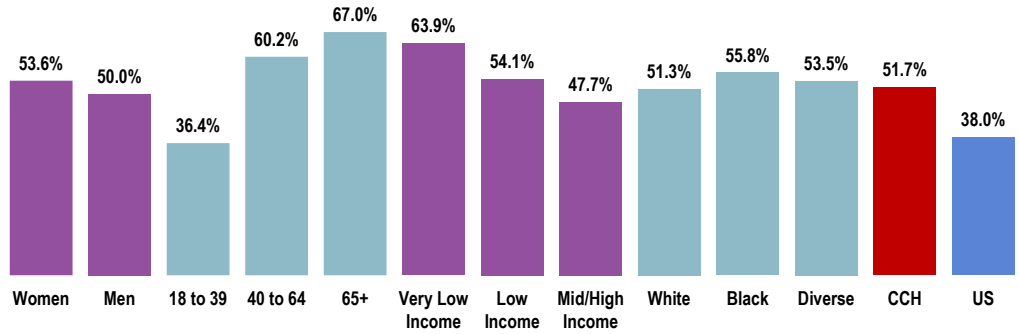
Number of Current Chronic Conditions
(CCH Service Area, 2025)



Sources:
- 2025 PRC Community Health Survey, PRC, Inc. [Item 107]

Notes:
- Asked of all respondents.
- In this case, chronic conditions include lung disease, cancer, heart attack/angina, stroke, asthma, high blood pressure, high blood cholesterol, diabetes, high-impact chronic pain, obesity, and/or diagnosed depression.

Have Three or More Chronic Conditions
(CCH Service Area, 2025)



Sources:
- 2025 PRC Community Health Survey, PRC, Inc. [Item 107]
- 2023 PRC National Health Survey, PRC, Inc.

Notes:
- Asked of all respondents.
- In this case, chronic conditions include lung disease, cancer, heart attack/angina, stroke, asthma, high blood pressure, high blood cholesterol, diabetes, high-impact chronic pain, obesity, and/or diagnosed depression.

Activity Limitations

ABOUT DISABILITY & HEALTH

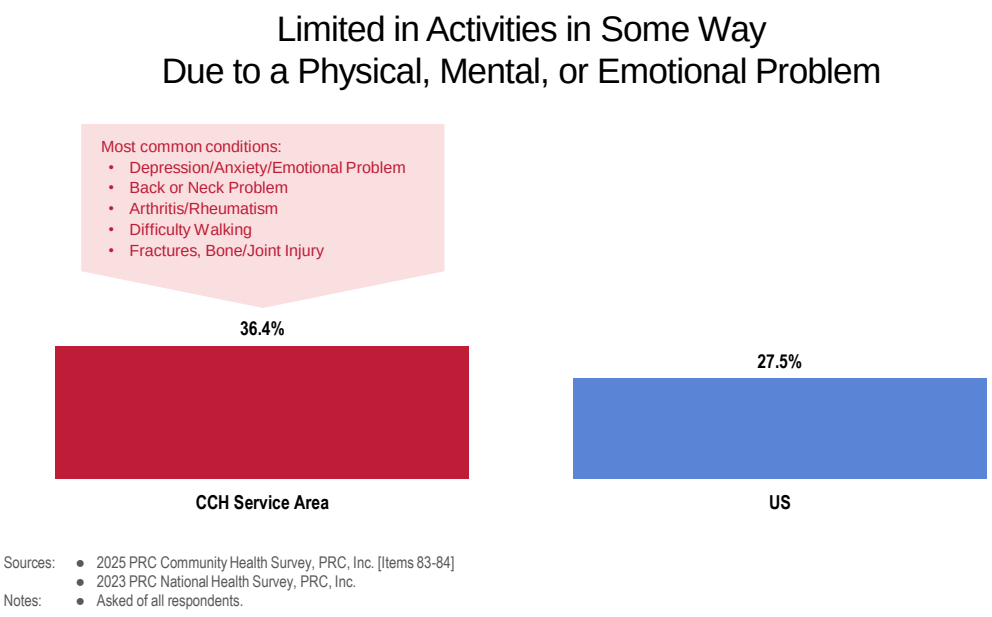
Studies have found that people with disabilities are less likely to get preventive health care services they need to stay healthy. Strategies to make health care more affordable for people with disabilities are key to improving their health.

In addition, people with disabilities may have trouble finding a job, going to school, or getting around outside their homes. And they may experience daily stress related to these challenges. Efforts to make homes, schools, workplaces, and public places easier to access can help improve quality of life and overall well-being for people with disabilities.

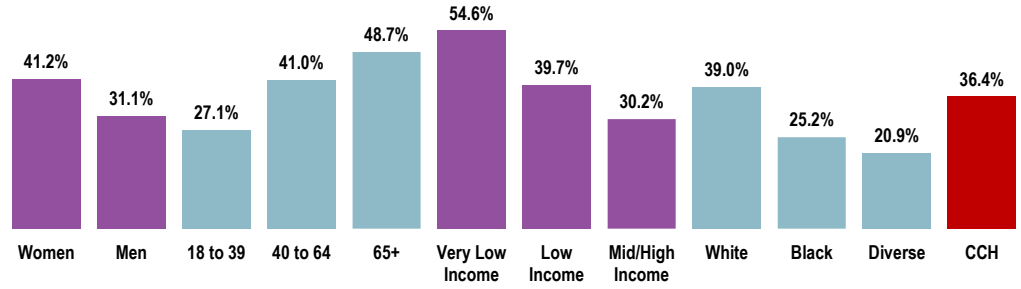
– Healthy People 2030 (https://health.gov/healthypeople)

PRC SURVEY ► "Are you limited in any way in any activities because of physical, mental, or emotional problems?"

PRC SURVEY ► [Adults with activity limitations] **"What is the major impairment or health problem that limits you?"**



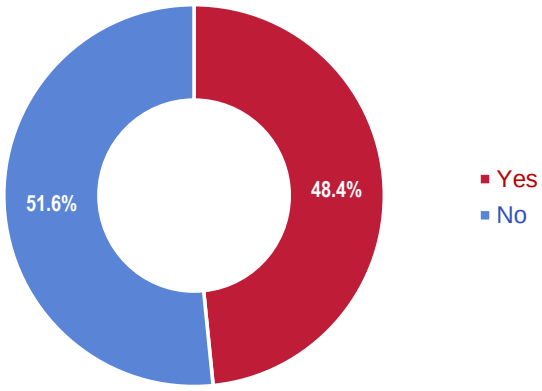
Limited in Activities in Some Way Due to a Physical, Mental, or Emotional Problem
(CCH Service Area, 2025)



Sources: ● 2025 PRC Community Health Survey, PRC, Inc. [Item 83]
Notes: ● Asked of all respondents.

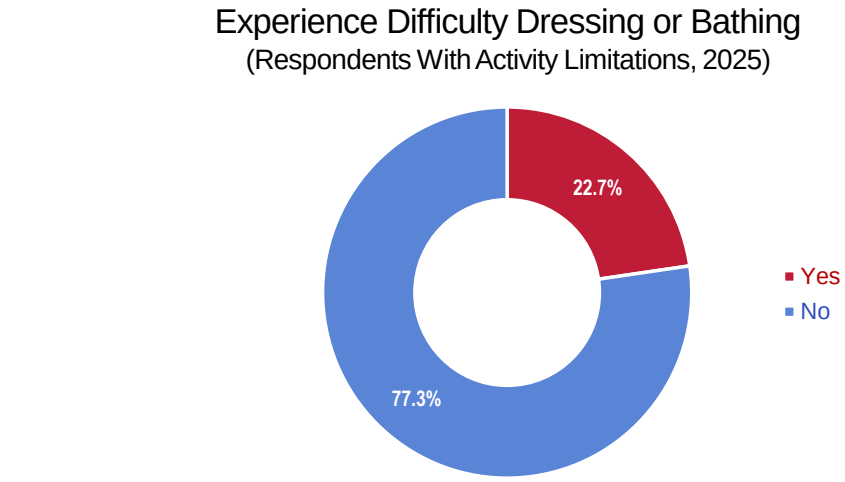
PRC SURVEY ► [Adults with activity limitations] **"Do you have serious difficulty walking or climbing stairs?"**

Have Serious Difficulty Walking or Climbing Stairs
(Respondents With Activity Limitations, 2025)



Sources: ● 2025 PRC Community Health Survey, PRC, Inc. [Item 310]
Notes: ● Asked of all respondents.

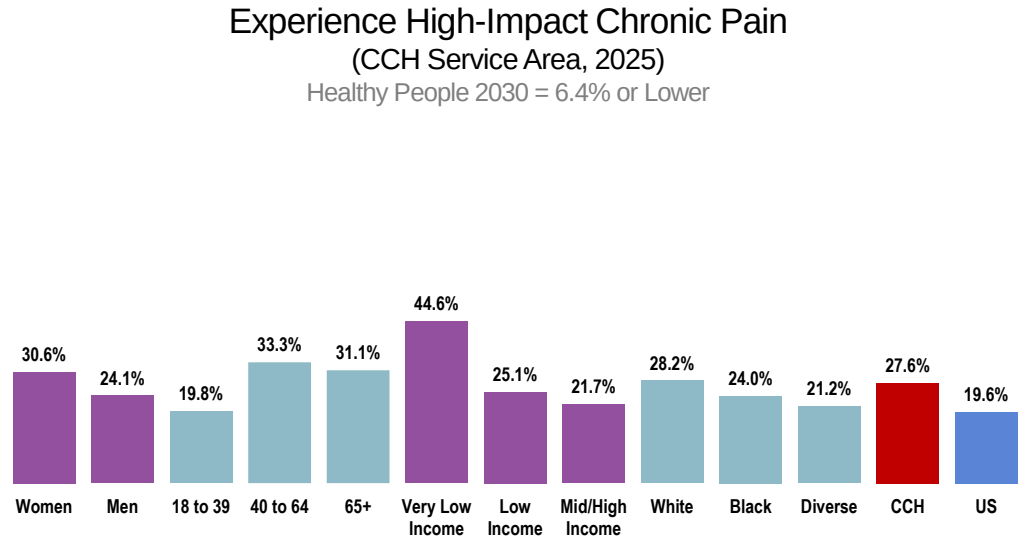
PRC SURVEY ► [Adults with activity limitations] **"Do you have difficulty dressing or bathing?"**



Sources: ● 2025 PRC Community Health Survey, PRC, Inc. [Item 311]
Notes: ● Asked of all respondents.

High-Impact Chronic Pain

PRC SURVEY ► **"Over the past six months, how often did physical pain limit your life or work activities? Would you say: never, some days, most days, or every day?"** (Reported here among those responding "most days" or "every day.")



Sources: ● 2025 PRC Community Health Survey, PRC, Inc. [Item 31]
● 2023 PRC National Health Survey, PRC, Inc.
● US Department of Health and Human Services. Healthy People 2030. https://health.gov/healthypeople
Notes: ● Asked of all respondents.
● High-impact chronic pain includes physical pain that limits life or work activities on "most days" or "every day" of the past six months.

Alzheimer’s Disease

ABOUT DEMENTIA

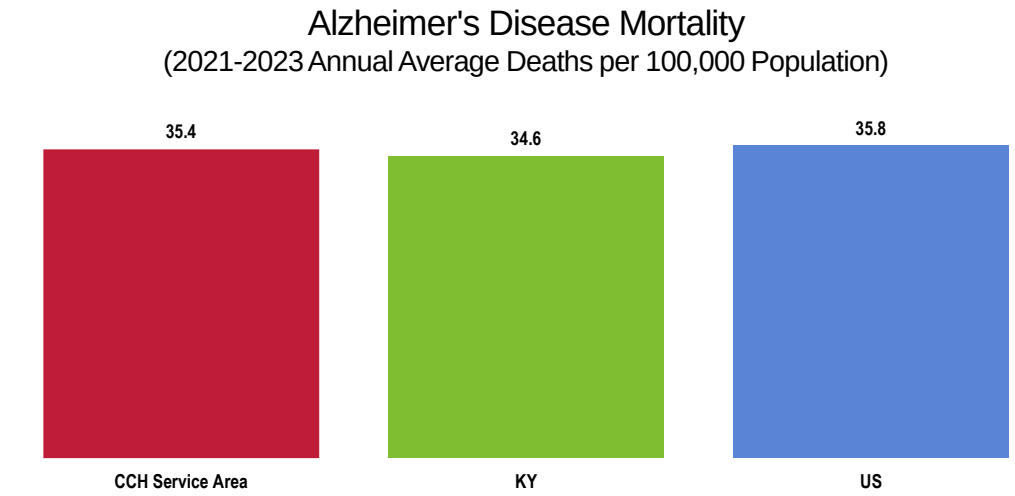
Alzheimer’s disease is the most common cause of dementia… . Dementia refers to a group of symptoms that cause problems with memory, thinking, and behavior. People with dementia are more likely to be hospitalized, and dementia is linked to high health care costs.

While there’s no cure for Alzheimer’s disease, early diagnosis and supportive care can improve quality of life. And efforts to make sure adults with symptoms of cognitive decline — including memory loss — are diagnosed early can help improve health outcomes in people with dementia. Interventions to address caregiving needs can also help improve health and well-being in people with dementia.

– Healthy People 2030 (https://health.gov/healthypeople)

Alzheimer’s Disease Deaths

Alzheimer’s disease mortality is outlined in the following chart.



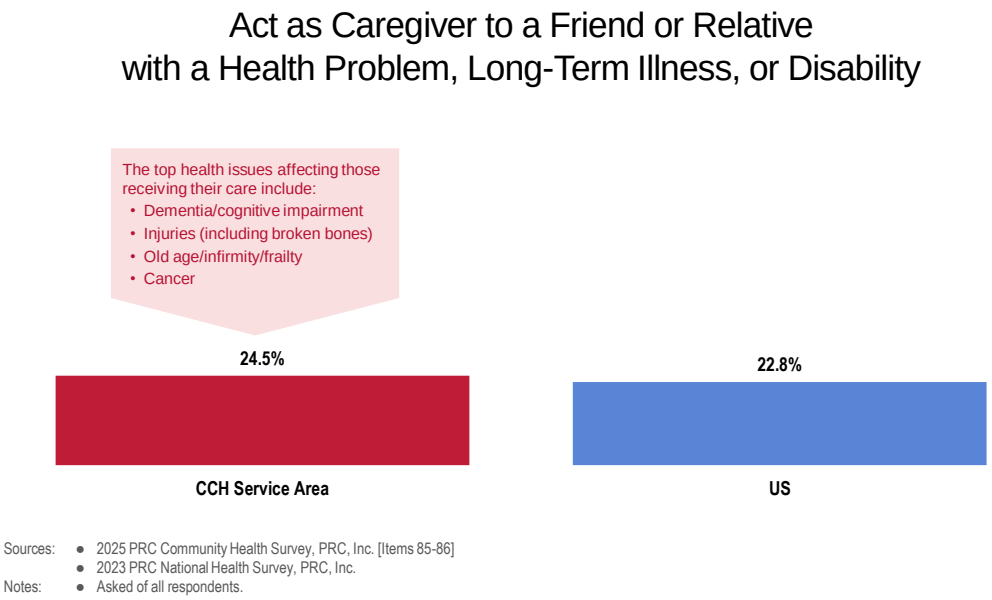
Sources: ● CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted February 2025.

Notes: ● Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
● Rates are per 100,000 population.

Caregiving

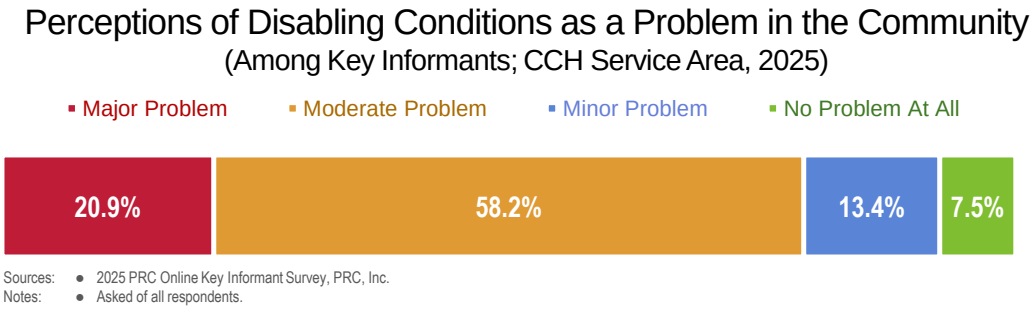
PRC SURVEY ► "People may provide regular care or assistance to a friend or family member who has a health problem, long-term illness, or disability. During the past 30 days, did you provide any such care or assistance to a friend or family member?"

PRC SURVEY ► [Among those providing care] **"What is the main health problem, long-term illness, or disability that the person you care for has?"**



Key Informant Input: Disabling Conditions

The following chart outlines key informants' perceptions of the severity of *Disabling Conditions* as a problem in the community:



Among those rating this issue as a "major problem," reasons related to the following:

Transportation

> One of the primary concerns is the reliability of transportation services, Lexington has the Wheels program, but we have heard reports of the bus being late or simply not coming, making it difficult for users to attend medical appointments, work, and other essential activities. Clients with chronic pain and other disabling issues have a hard time maintaining a job and steady income leading to ensure housing and food situations for our families, some clients have been denied disability multiple times despite having protected conditions and severe health issues. — Social Services Provider
>
> They limit the ability to be part of social events and access to transportation assistance is limited. — Community Leader

> We have many homebound people, public transportation programs for the disabled are expensive, many public and commercial buildings are not accessible for the disabled. Sidewalks are in poor order. Snow removal isn't enforced. — Community Leader

Incidence/Prevalence

> Disability and conditions like the ones mentioned above are problems for our community and that it limits the ability for individuals who are facing these various health conditions to fully participate in that they are living. Their conditions also impact their family members in terms of the caregiving that may be required. — Health Care Provider

> High rates of dementia, disability, hearing and vision loss not covered by Medicare. — Social Services Provider

Impact on Quality of Life

> Disabling conditions are major problems because dementia doesn't only affect the person living cognitive decline. Some issues that stem from this issue include financial and legal problems, physical and emotional well-being, safety concerns for caregivers, and can create loneliness and isolation which lead to lower quality of life for everyone involved. — Social Services Provider

> Preventing quality of life. — Community Leader

Access to Care/Services

> Services are not available. — Community Leader

Aging Population

> Aging, dementia, access to services and general support in homes. — Community Leader

Follow-Up/Support

> It takes years to get ahead of the trauma before the body can catch up. Trying to address the mental and physical takes time and most programs release them before they are able to get ahead of them. — Social Services Provider

Homelessness

> There is a significant homeless population with needs that go unattended or undiagnosed. — Community Leader

Vulnerable Populations

> It compounds the problem of poverty. We see patients anxious to return to work, but a health condition, such as a hernia, cataracts, limb injuries, etc. keep them from working, and availability of care can be out of reach. — Health Care Provider

BIRTHS

ABOUT INFANT HEALTH

Keeping infants healthy starts with making sure women get high-quality care during pregnancy and improving women's health in general. After birth, strategies that focus on increasing breastfeeding rates and promoting vaccinations and developmental screenings are key to improving infants' health. Interventions that encourage safe sleep practices and correct use of car seats can also help keep infants safe.

The infant mortality rate in the United States is higher than in other high-income countries, and there are major disparities by race/ethnicity. Addressing social determinants of health is critical for reducing these disparities.

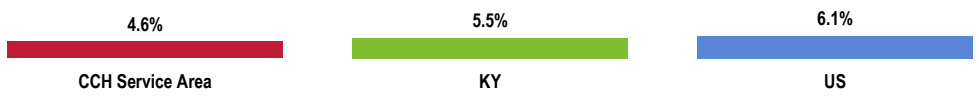
– Healthy People 2030 (https://health.gov/healthypeople)

Prenatal Care

Early and continuous prenatal care is the best assurance of infant health.

This indicator reports the percentage of women who did not receive prenatal care during their first six months of pregnancy. This indicator can signify a lack of access to preventive care, a lack of health knowledge, or other barriers to services.

Lack of Prenatal Care in the First Six Months of Pregnancy
(Percentage of Live Births, 2017-2019)

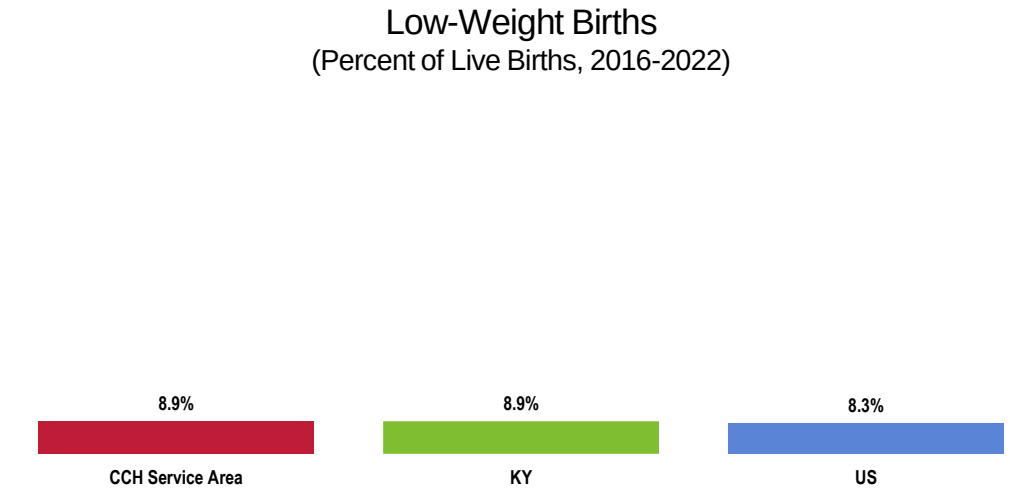


Sources: ● Centers for Disease Control and Prevention, National Vital Statistics System. Accessed via CDC WONDER.
Note: ● This indicator reports the percentage of women who do not obtain prenatal care before the seventh month of pregnancy (if at all).

Birth Outcomes & Risks

Low-Weight Births

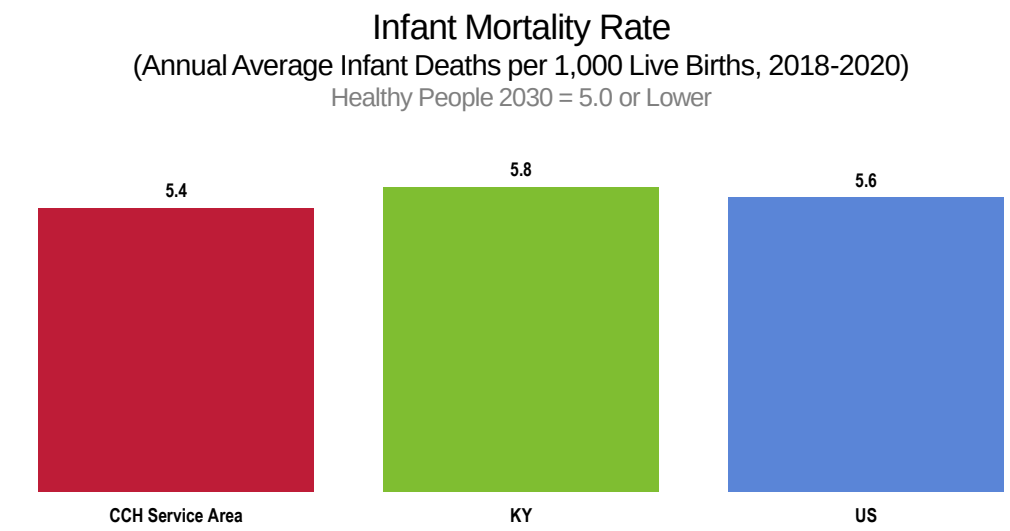
Low birthweight babies, those who weigh less than 2,500 grams (5 pounds, 8 ounces) at birth, are much more prone to illness and neonatal death than are babies of normal birthweight. Largely a result of receiving poor or inadequate prenatal care, many low-weight births and the consequent health problems are preventable.



Sources: ● University of Wisconsin Population Health Institute, County Health Rankings.
Note: ● This indicator reports the percentage of total births that are low birth weight (Under 2500g).

Infant Mortality

Infant mortality rates reflect deaths of children less than one year old per 1,000 live births. High infant mortality can highlight broader issues relating to health care access and maternal/child health.



Sources: ● CDC WONDER Online Query System. Centers for Disease Control and Prevention, National Center for Health Statistics, Division of Vital Statistics. Data extracted February 2025.
● US Department of Health and Human Services. Healthy People 2030. https://health.gov/healthypeople
Notes: ● This indicator reports deaths of children under 1 year old per 1,000 live births.

Family Planning

ABOUT FAMILY PLANNING

Nearly half of pregnancies in the United States are unintended, and unintended pregnancy is linked to many negative outcomes for both women and infants. …Unintended pregnancy is linked to outcomes like preterm birth and postpartum depression … family planning services can help increase the length of time between pregnancies, which can improve health for women and their infants.

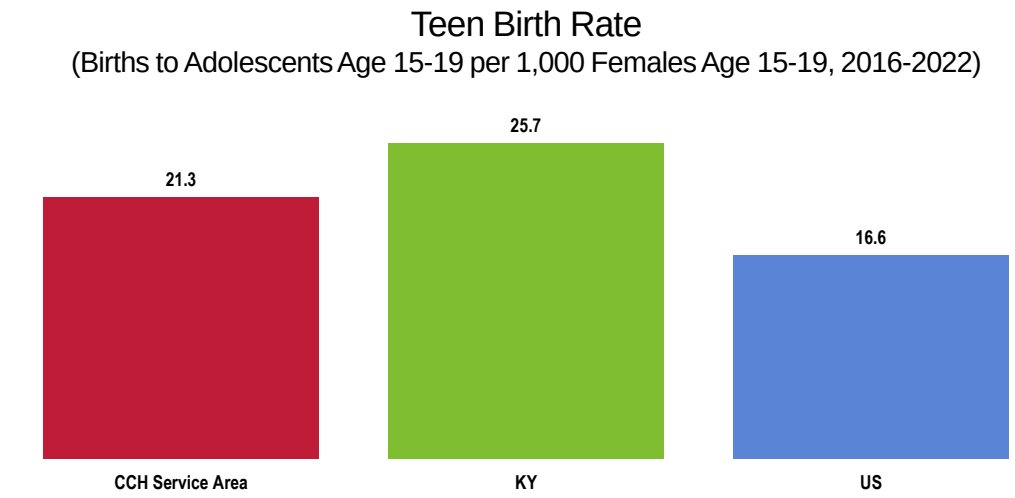
Adolescents are at especially high risk for unintended pregnancy. Although teen pregnancy and birth rates have gone down in recent years, close to 200,000 babies are born to teen mothers every year in the United States. Linking adolescents to youth-friendly health care services can help prevent pregnancy and sexually transmitted infections in this age group.

– Healthy People 2030 (https://health.gov/healthypeople)

Births to Adolescent Mothers

Here, teen births include births to women age 15 to 19 years old, expressed as a rate per 1,000 female population in this age cohort.

The following chart outlines local teen births, compared to the state and nation. In many cases, teen parents have unique health and social needs. High rates of teen pregnancy might also indicate a prevalence of unsafe sexual behavior.

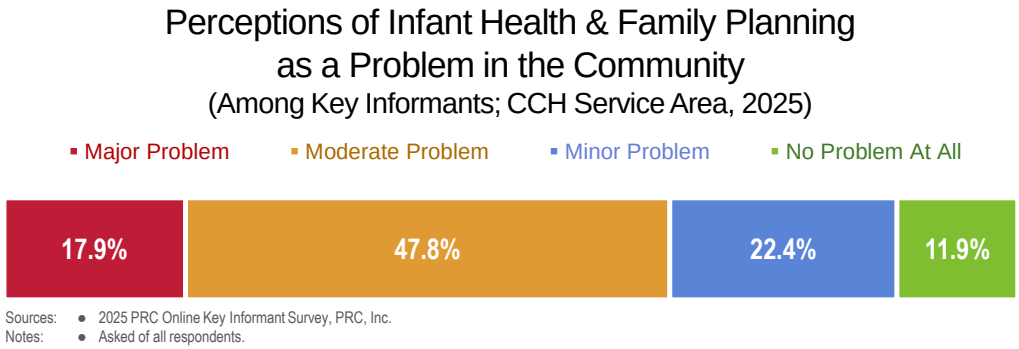


Sources:
- Centers for Disease Control and Prevention, National Vital Statistics System.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved February 2025 via SparkMap (sparkmap.org).

Notes:
- This indicator reports the rate of total births to women under the age of 15-19 per 1,000 female population age 15-19.

Key Informant Input: Infant Health & Family Planning

The following chart outlines key informants' perceptions of the severity of *Infant Health & Family Planning* as a problem in the community:



Among those rating this issue as a "major problem," reasons related to the following:

Awareness/Education

> I think that the folks that are in the underserved populations are not aware of what services are available. — Community Leader
>
> Lack of education and immigrant needs cause unfamiliarity with available care. — Community Leader

Access to Care/Services

> Services do not exist. — Community Leader
>
> There are a lot of first-time parents in Fayette County, and they might need help, either emotional and/or financial. There are programs such as Hands available from the Health Department to help in these types of situations. — Public Health Representative

Incidence/Prevalence

> Because of the calls and walk-ins, I get from families and individuals in need of assistance and resources. — Community Leader

Vulnerable Populations

> Limited access to prenatal healthcare for low-income mothers. — Community Leader

Vaccine Skepticism

> Vaccine skepticism- we are seeing viruses and illnesses become more prevalent due to individuals not vaccinating themselves and their children. A lot of misinformation that gets repeated about vaccines is creating harmful and dangerous situations for diseases we thought were eradicated. — Social Services Provider

MODIFIABLE HEALTH RISKS

Nutrition

ABOUT NUTRITION & HEALTHY EATING

Many people in the United States don't eat a healthy diet. …People who eat too many unhealthy foods — like foods high in saturated fat and added sugars — are at increased risk for obesity, heart disease, type 2 diabetes, and other health problems. Strategies and interventions to help people choose healthy foods can help reduce their risk of chronic diseases and improve their overall health.

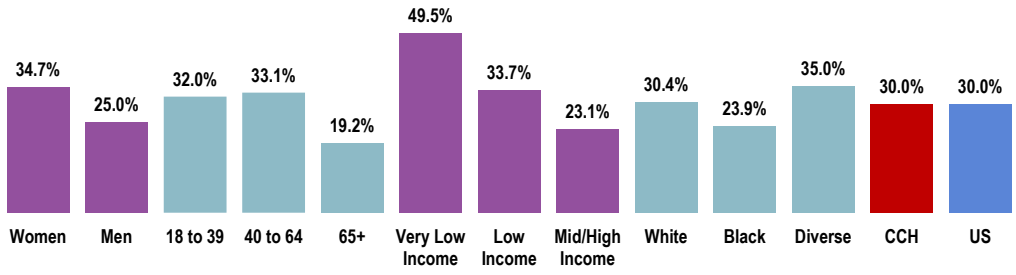
Some people don't have the information they need to choose healthy foods. Other people don't have access to healthy foods or can't afford to buy enough food. Public health interventions that focus on helping everyone get healthy foods are key to reducing food insecurity and hunger and improving health.

– Healthy People 2030 (https://health.gov/healthypeople)

Access to Fresh Produce

PRC SURVEY ► "How difficult is it for you to buy fresh produce like fruits and vegetables at a price you can afford — would you say: very difficult, somewhat difficult, not too difficult, or not at all difficult?"

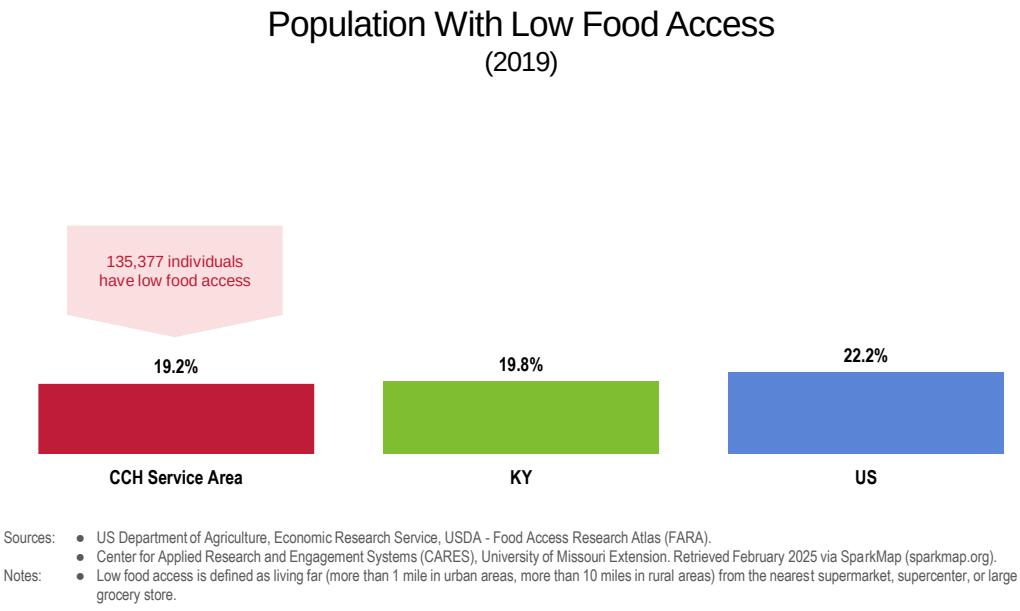
Find It "Very" or "Somewhat"
Difficult to Buy Affordable Fresh Produce
(CCH Service Area, 2025)



Sources: ● 2025 PRC Community Health Survey, PRC, Inc. [Item 66]
● 2023 PRC National Health Survey, PRC, Inc.
Notes: ● Asked of all respondents.

Low Food Access

Low food access is defined as living more than one mile from the nearest supermarket, supercenter, or large grocery store in urban areas (10 miles in rural areas). This related chart is based on US Department of Agriculture data.



Sources:
- US Department of Agriculture, Economic Research Service, USDA - Food Access Research Atlas (FARA).
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved February 2025 via SparkMap (sparkmap.org).

Notes:
- Low food access is defined as living far (more than 1 mile in urban areas, more than 10 miles in rural areas) from the nearest supermarket, supercenter, or large grocery store.

Physical Activity

ABOUT PHYSICAL ACTIVITY

Physical activity can help prevent disease, disability, injury, and premature death. The Physical Activity Guidelines for Americans lays out how much physical activity children, adolescents, and adults need to get health benefits. Although most people don't get the recommended amount of physical activity, it can be especially hard for older adults and people with chronic diseases or disabilities.

Strategies that make it safer and easier to get active — like providing access to community facilities and programs — can help people get more physical activity. Strategies to promote physical activity at home, at school, and at childcare centers can also increase activity in children and adolescents.

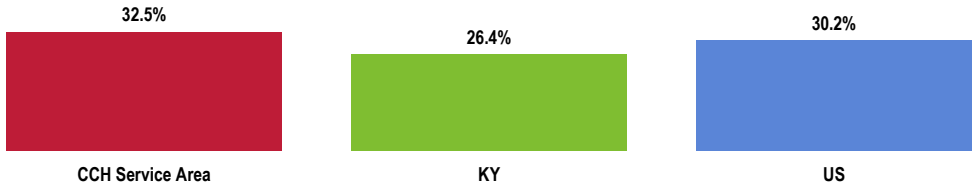
– Healthy People 2030 (https://health.gov/healthypeople)

Leisure-Time Physical Activity

PRC SURVEY ► "During the past month, did you participate in any physical activities or exercises, such as running, calisthenics, golf, gardening, or walking for exercise?"

No Leisure-Time Physical Activity in the Past Month

Healthy People 2030 = 21.8% or Lower



Sources:
- 2025 PRC Community Health Survey, PRC, Inc. [Item 69]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2022 Kentucky data.
- 2023 PRC National Health Survey, PRC, Inc.
- US Department of Health and Human Services. Healthy People 2030. https://health.gov/healthypeople

Notes:
- Asked of all respondents.

Meeting Physical Activity Recommendations

ADULTS: RECOMMENDED LEVELS OF PHYSICAL ACTIVITY

"Meeting physical activity recommendations" includes adequate levels of both aerobic and strengthening activity:

- **Aerobic activity** is at least 150 minutes per week of light-to-moderate activity, 75 minutes per week of vigorous physical activity, or an equivalent combination of both;
- **Strengthening activity** is at least 2 sessions per week of exercise designed to strengthen muscles.

– 2013 Physical Activity Guidelines for Americans, US Department of Health and Human Services. www.cdc.gov/physicalactivity

To measure physical activity frequency, duration and intensity, respondents were asked:

PRC SURVEY ► "During the past month, what type of physical activity or exercise did you spend the most time doing?"

PRC SURVEY ► "And during the past month, how many times per week or per month did you take part in this activity?"

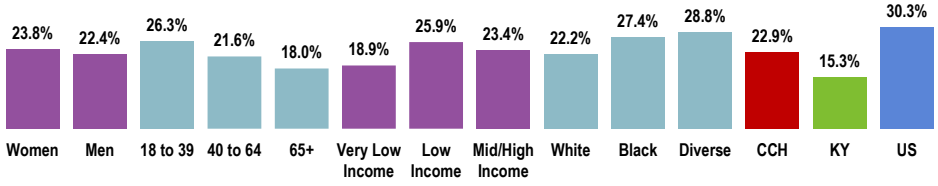
PRC SURVEY ► "And when you took part in this activity, for how many minutes or hours did you usually keep at it?"

Respondents could answer the above series for up to two types of physical activity. The specific activities identified (e.g., jogging, basketball, treadmill, etc.) determined the intensity values assigned to that respondent when calculating total aerobic physical activity hours/minutes.

Respondents were also asked about strengthening exercises:

PRC SURVEY ► "During the past month, how many times per week or per month did you do physical activities or exercises to strengthen your muscles? Do not count aerobic activities like walking, running, or bicycling. Please include activities using your own body weight, such as yoga, sit-ups, or push-ups, and those using weight machines, free weights, or elastic bands."

Meets Physical Activity Recommendations
(CCH Service Area, 2025)
Healthy People 2030 = 29.7% or Higher



Sources:
- 2025 PRC Community Health Survey, PRC, Inc. [Item 110]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2022 Kentucky data.
- 2023 PRC National Health Survey, PRC, Inc.
- US Department of Health and Human Services. Healthy People 2030. https://health.gov/healthypeople

Notes:
- Asked of all respondents.
- Meeting both guidelines is defined as the number of persons age 18+ who report light or moderate aerobic activity for at least 150 minutes per week or who report vigorous physical activity 75 minutes per week (or an equivalent combination of moderate and vigorous-intensity activity) *and* who also report doing physical activities specifically designed to strengthen muscles at least twice per week.

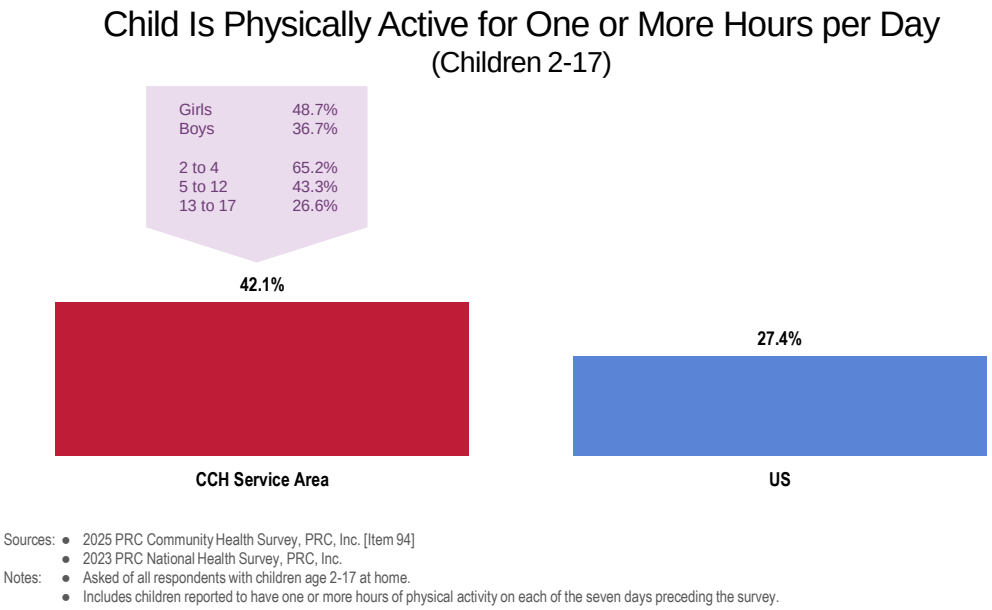
Children's Physical Activity

CHILDREN: RECOMMENDED LEVELS OF PHYSICAL ACTIVITY

Children and adolescents should do 60 minutes (1 hour) or more of physical activity each day.

– 2013 Physical Activity Guidelines for Americans, US Department of Health and Human Services. www.cdc.gov/physicalactivity

PRC SURVEY ► [Among parents of children age 2-17] **"During the past 7 days, on how many days was this child physically active for a total of at least 60 minutes per day?"**



Sources:
- 2025 PRC Community Health Survey, PRC, Inc. [Item 94]
- 2023 PRC National Health Survey, PRC, Inc.

Notes:
- Asked of all respondents with children age 2-17 at home.
- Includes children reported to have one or more hours of physical activity on each of the seven days preceding the survey.

Weight Status

ABOUT OVERWEIGHT & OBESITY

Obesity is linked to many serious health problems, including type 2 diabetes, heart disease, stroke, and some types of cancer. Some racial/ethnic groups are more likely to have obesity, which increases their risk of chronic diseases.

Culturally appropriate programs and policies that help people eat nutritious foods within their calorie needs can reduce overweight and obesity. Public health interventions that make it easier for people to be more physically active can also help them maintain a healthy weight.

– Healthy People 2030 (https://health.gov/healthypeople)

Body Mass Index (BMI), which describes relative weight for height, is significantly correlated with total body fat content. The BMI should be used to assess overweight and obesity and to monitor changes in body weight. In addition, measurements of body weight alone can be used to determine efficacy of weight loss therapy. BMI is calculated as weight (kg)/height squared (m^2). To estimate BMI using pounds and inches, use: [weight (pounds)/height squared ($inches^2$)] x 703.

In this report, overweight is defined as a BMI of 25.0 to 29.9 kg/m^2 and obesity as a BMI ≥30 kg/m^2. The rationale behind these definitions is based on epidemiological data that show increases in mortality with BMIs above 25 kg/m^2. The increase in mortality, however, tends to be modest until a BMI of 30 kg/m^2 is reached. For persons with a BMI ≥30 kg/m^2, mortality rates from all causes, and especially from cardiovascular disease, are generally increased by 50 to 100 percent above that of persons with BMIs in the range of 20 to 25 kg/m^2.

– Clinical Guidelines on the Identification, Evaluation, and Treatment of Overweight and Obesity in Adults: The Evidence Report. National Institutes of Health. National Heart, Lung, and Blood Institute in Cooperation With The National Institute of Diabetes and Digestive and Kidney Diseases. September 1998.

Adult Weight Status

CLASSIFICATION OF OVERWEIGHT AND OBESITY BY BMI	BMI (kg/m^2)
Underweight	<18.5
Healthy Weight	18.5 – 24.9
Overweight	25.0 – 29.9
Obese	≥30.0

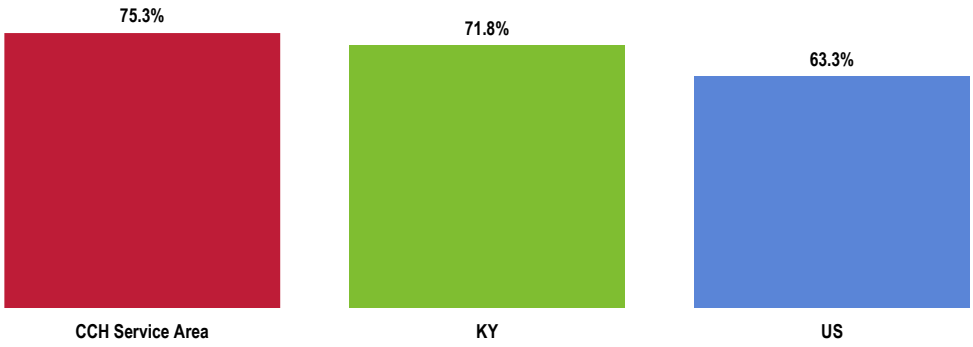
Source: Clinical Guidelines on the Identification, Evaluation, and Treatment of Overweight and Obesity in Adults: The Evidence Report. National Institutes of Health. National Heart, Lung, and Blood Institute in Cooperation With The National Institute of Diabetes and Digestive and Kidney Diseases. September 1998.

PRC SURVEY ► "About how much do you weigh without shoes?"

PRC SURVEY ► "About how tall are you without shoes?"

Reported height and weight were used to calculate a Body Mass Index or BMI value (described above) for each respondent. This calculation allows us to examine the proportion of the population who is at a healthy weight, or who is overweight or obese (see table above).

Prevalence of Total Overweight (Overweight and Obese)

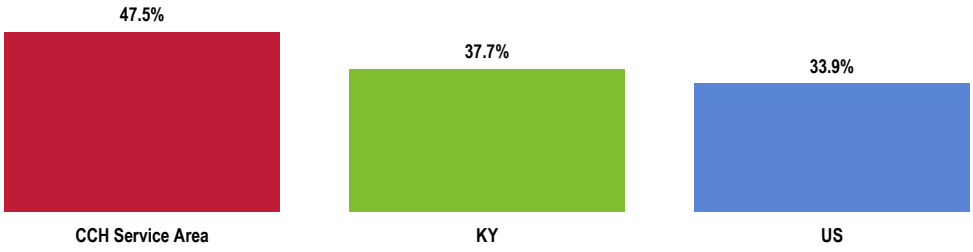


Sources:
- 2025 PRC Community Health Survey, PRC, Inc. [Item 112]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2022 Kentucky data.
- 2023 PRC National Health Survey, PRC, Inc.

Notes:
- Based on reported heights and weights, asked of all respondents.
- The definition of overweight is having a body mass index (BMI), a ratio of weight to height (kilograms divided by meters squared), greater than or equal to 25.0. The definition for obesity is a BMI greater than or equal to 30.0.

Prevalence of Obesity

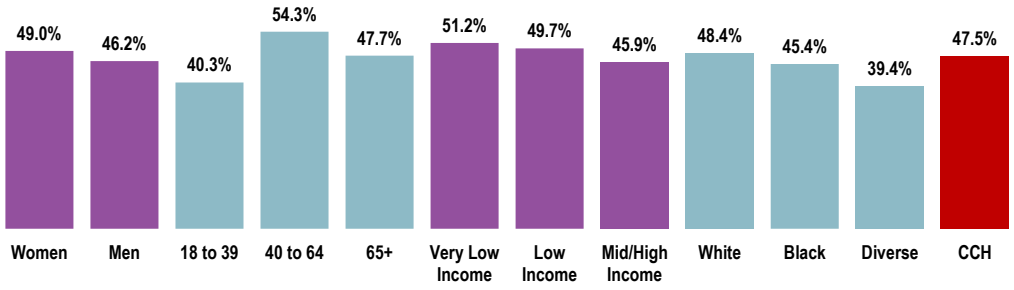
Healthy People 2030 = 36.0% or Lower



Sources:
- 2025 PRC Community Health Survey, PRC, Inc. [Item 112]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2022 Kentucky data.
- 2023 PRC National Health Survey, PRC, Inc.
- US Department of Health and Human Services. Healthy People 2030. https://health.gov/healthypeople

Notes:
- Based on reported heights and weights, asked of all respondents.
- The definition of obesity is having a body mass index (BMI), a ratio of weight to height (kilograms divided by meters squared), greater than or equal to 30.0.

Prevalence of Obesity
(CCH Service Area, 2025)
Healthy People 2030 = 36.0% or Lower



Sources:
- 2025 PRC Community Health Survey, PRC, Inc. [Item 112]
- US Department of Health and Human Services. Healthy People 2030. https://health.gov/healthypeople

Notes:
- Based on reported heights and weights, asked of all respondents.
- The definition of obesity is having a body mass index (BMI), a ratio of weight to height (kilograms divided by meters squared), greater than or equal to 30.0, regardless of gender.

Children's Weight Status

ABOUT WEIGHT STATUS IN CHILDREN & TEENS

In children and teens, body mass index (BMI) is used to assess weight status – underweight, healthy weight, overweight, or obese. After BMI is calculated for children and teens, the BMI number is plotted on the CDC BMI-for-age growth charts (for either girls or boys) to obtain a percentile ranking. Percentiles are the most commonly used indicator to assess the size and growth patterns of individual children in the United States. The percentile indicates the relative position of the child's BMI number among children of the same sex and age.

BMI-for-age weight status categories and the corresponding percentiles are shown below:

- Underweight <5th percentile
- Healthy Weight ≥5th and <85th percentile
- Overweight ≥85th and <95th percentile
- Obese ≥95th percentile

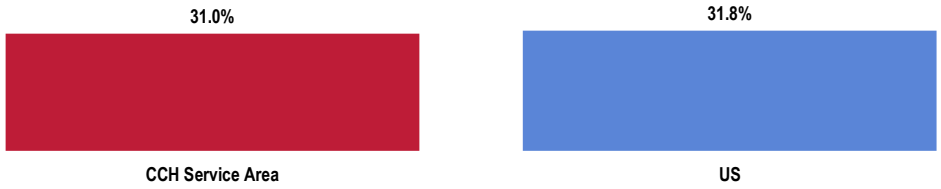
– Centers for Disease Control and Prevention

The following questions were used to calculate a BMI value (and weight classification as noted above) for each child represented in the survey:

PRC SURVEY ► [Among parents of children age 5-17] **"How much does this child weigh without shoes?"**

PRC SURVEY ► [Among parents of children age 5-17] **"About how tall is this child?"**

Prevalence of Overweight in Children
(Children 5-17)



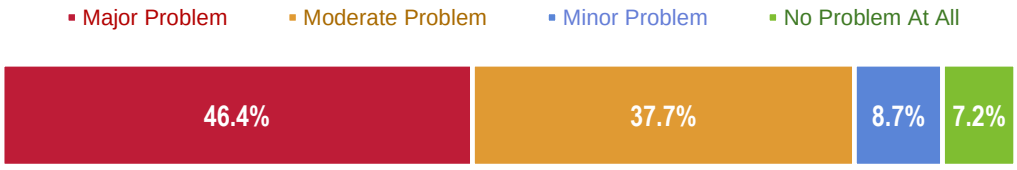
Sources:
- 2025 PRC Community Health Survey, PRC, Inc. [Item 113]
- 2023 PRC National Health Survey, PRC, Inc.

Notes:
- Asked of all respondents with children age 5-17 at home.
- Overweight among children is determined by children's Body Mass Index status at or above the 85th percentile of US growth charts by gender and age.

Key Informant Input: Nutrition, Physical Activity & Weight

The following chart outlines key informants' perceptions of the severity of *Nutrition, Physical Activity & Weight* as a problem in the community:

Perceptions of Nutrition, Physical Activity & Weight as a Problem in the Community
(Among Key Informants; CCH Service Area, 2025)



Sources:
- 2025 PRC Online Key Informant Survey, PRC, Inc.

Notes:
- Asked of all respondents.

Among those rating this issue as a "major problem," reasons related to the following:

Access to Affordable Healthy Food

> It is difficult for people with a low household income to buy healthy food, it's expensive and finding time for an exercise program. Some neighborhoods are not safe for walking, the same with parks. Obesity is the natural outcome of these challenges. — Community Leader
>
> Healthy food limitations. — Community Leader
>
> Cost of healthy foods. Education surrounding healthy food choices. Education on creative physical activity that can be done at home, in nearby parks, etc. for no cost. — Social Services Provider
>
> For nutrition and weight, access to healthy foods. Physical activity, lack of resources and education, familial tendencies. — Community Leader
>
> Prices of being able to eat healthy food and the options for people that are in poverty. — Social Services Provider
>
> No access or limited access to affordable healthy foods. People on a fixed income and/or with SNAP benefits cannot afford non-processed meals. Gym memberships are extremely expensive and not affordable to the average person. — Social Services Provider

Obesity

> Obesity. starting from the chemicals that are allowed to be in our food. School lunches that offer many carb options and little healthy protein choices. Kids that start school at 6 years old but are therefore cut off from WIC services at age 5 and there is a gap. — Public Health Representative
>
> We have a very overweight population that has contributed to the health outcomes for the State. Again, portions of the State and the population do not have access to healthy food, medication or counseling to help them overcome their current physical conditions. — Community Leader
>
> Weight- obesity is on the rise. Nutrition- access to fresh, affordable, healthy and good for your foods. Most grocery stores only accessible by car or takes forever on the bus. This leads to convenience foods being consumed increasingly. Something to also keep in mind is the idea of "time poverty" where individuals do not have the time to access good nutrition (no time to shop, prepare foods) or have time to build in physical activity. Something we've been focusing on lately is the "sustainable square model" where no matter where you live, you can access the things you need within one square mile. If our focus is on increasing sustainable square models in our cities, we could see, as a result, nutrition and physical activity increase, and weight decrease as we see more people walking to places instead of driving long distances. — Social Services Provider

Nutrition

> Poor diet, lack of exercise, lack of knowledge, bad habits. — Community Leader
>
> Food insecurity, lack of education. — Community Leader
>
> Addiction to sugar and junk foods, easily accessible unhealthy foods, but more expensive to purchase healthier options, sedentary lifestyles and hard to overcome those. — Social Services Provider

Awareness/Education

> Again, people do not understand how to eat healthy, especially when on a strict budget or SNAP. — Health Care Provider

Lifestyle

> Changing lifelong habits and less expensive access to fresh foods. While we are fortunate in Lexington to have such access, more rural areas pay higher prices and have more limited access. — Social Services Provider
>
> Addiction to electronic devices. We have to start talking about this. Screen time leads to sedentary lifestyles, social isolation, exposure to access points for addictive substances. — Social Services Provider

Disease Management

> Non-compliance with medical recommendations and the need for many of the public to stop idealizing TV personalities. We need to start looking at ourselves as individuals and not as a group in the health area. — Community Leader
>
> Lack of motivation, indifference and lack of effective education. — Community Leader

Access to Care/Services

> Services do not exist. — Community Leader

Income/Poverty

> Limited funds to purchase healthier foods. [Fitness centers] cost money to join, not to mention having reliable transportation to get to and from. Consistent access to medical care. — Community Leader

Built Environment

> Our built environment is a big issue as we have very little walkable/bikeable space especially in the more rural areas. Also, our culture has evolved so that we are eating out more and not eating "real" homecooked foods. Families are eating way more processed foods now then 30 years ago it's affecting our weight dramatically. — Public Health Representative

Substance Use

ABOUT DRUG & ALCOHOL USE

More than 20 million adults and adolescents in the United States have had a substance use disorder in the past year. …Substance use disorders can involve illicit drugs, prescription drugs, or alcohol. Opioid use disorders have become especially problematic in recent years. Substance use disorders are linked to many health problems, and overdoses can lead to emergency department visits and deaths.

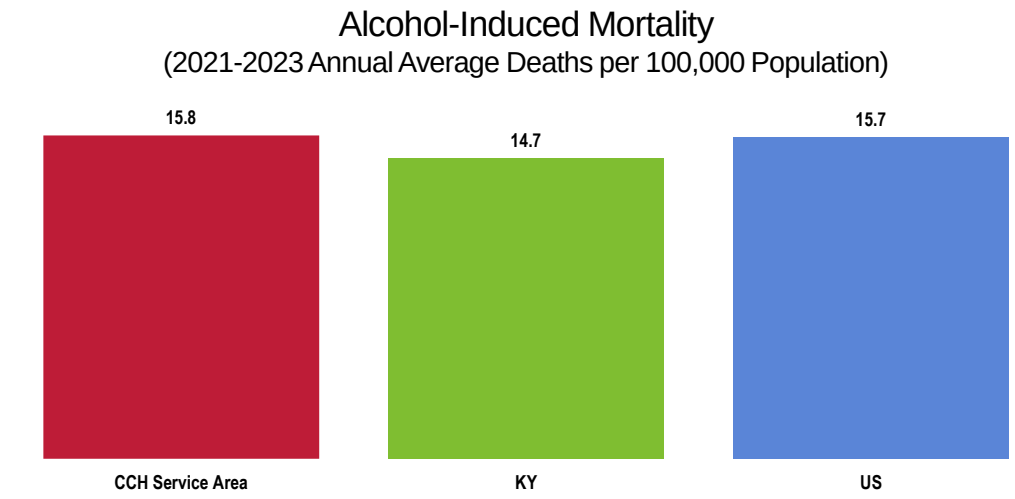
Effective treatments for substance use disorders are available, but very few people get the treatment they need. Strategies to prevent substance use — especially in adolescents — and help people get treatment can reduce drug and alcohol misuse, related health problems, and deaths.

– Healthy People 2030 (https://health.gov/healthypeople)

Alcohol

Alcohol-Induced Deaths

The following chart outlines alcohol-induced mortality in the area.



Sources: ● CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted February 2025.

Notes: ● Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
● Rates are per 100,000 population.

Excessive Drinking

PRC SURVEY ► "During the past 30 days, on how many days did you have at least one drink of any alcoholic beverage such as beer, wine, a malt beverage, or liquor?"

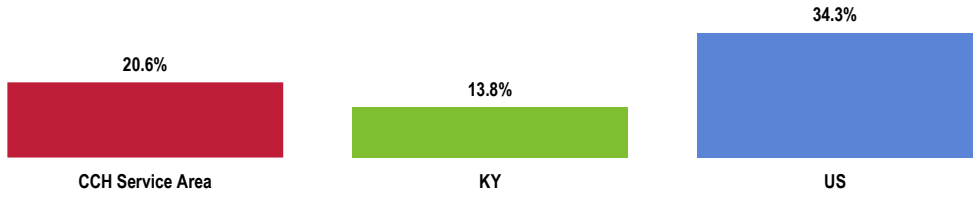
PRC SURVEY ► "On the day(s) when you drank, about how many drinks did you have on average?"

PRC SURVEY ► "Considering all types of alcoholic beverages, how many times during the past 30 days did you have 5 (if male)**/4** (if female) **or more drinks on an occasion?"**

Excessive drinking includes heavy and/or binge drinkers:

- HEAVY DRINKING ► men reporting 2+ alcoholic drinks per day or women reporting 1+ alcoholic drink per day in the month preceding the interview.
- BINGE DRINKING ► men reporting 5+ alcoholic drinks or women reporting 4+ alcoholic drinks on any single occasion during the past month.

Engage in Excessive Drinking



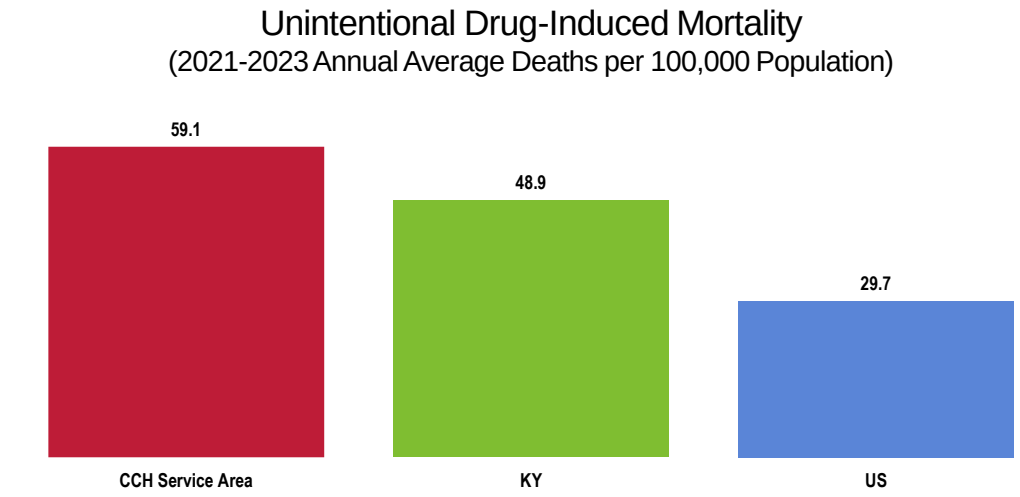
Sources:
- 2025 PRC Community Health Survey, PRC, Inc. [Item 116]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2022 Kentucky data.
- 2023 PRC National Health Survey, PRC, Inc.

Notes:
- Asked of all respondents.
- Excessive drinking reflects the percentage of persons age 18 years and over who drank more than two drinks per day on average (for men) or more than one drink per day on average (for women) OR who drank 5 or more drinks during a single occasion (for men) or 4 or more drinks during a single occasion (for women) during the past 30 days.

Drugs

Unintentional Drug-Induced Deaths

Unintentional drug-induced deaths include all deaths, other than suicide, for which drugs are an underlying cause. A "drug" includes illicit or street drugs (e.g., heroin and cocaine), as well as legal prescription and over-the-counter drugs; alcohol is not included. The following chart outlines local mortality for unintentional drug-induced deaths.



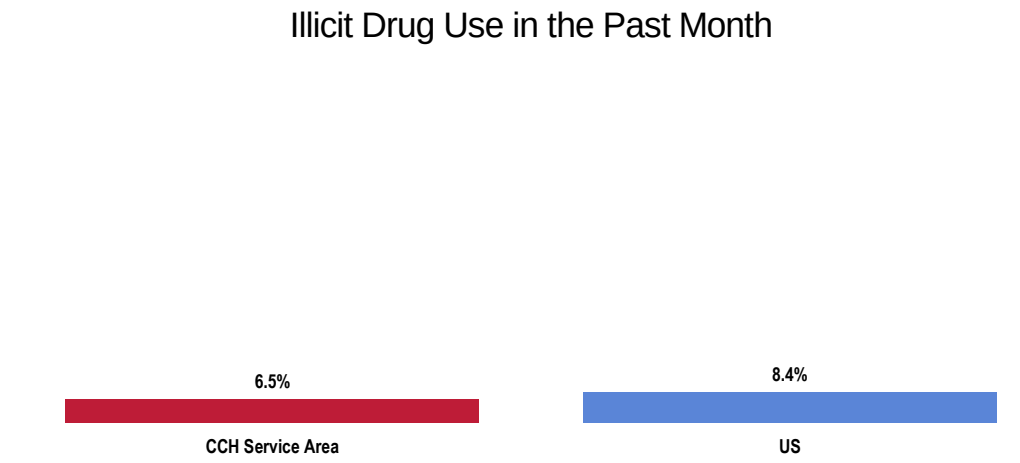
Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted February 2025.

Notes:
- Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
- Rates are per 100,000 population.

Illicit Drug Use

PRC SURVEY ► "During the past 30 days, have you used an illegal drug or taken a prescription drug that was not prescribed to you?"

Note: As a self-reported measure – and because this indicator reflects potentially illegal behavior – it is reasonable to expect that it might be underreported, and that actual illicit drug use in the community is likely higher.



Sources:
- 2025 PRC Community Health Survey, PRC, Inc. [Item 40]
- 2023 PRC National Health Survey, PRC, Inc.

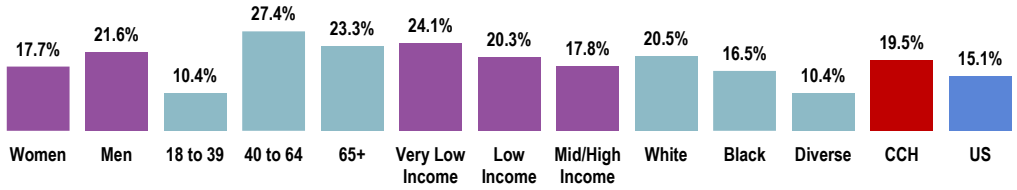
Notes:
- Asked of all respondents.

Use of Prescription Opioids

Opioids are a class of drugs used to treat pain. Examples presented to respondents include morphine, codeine, hydrocodone, oxycodone, methadone, and fentanyl. Common brand name opioids include Vicodin, Dilaudid, Percocet, OxyContin, and Demerol.

PRC SURVEY ► "Opiates or opioids are drugs that doctors prescribe to treat pain. Examples of prescription opiates include morphine, codeine, hydrocodone, oxycodone, methadone, and fentanyl. In the past year, have you used any of these prescription opiates?"

Used a Prescription Opioid in the Past Year
(CCH Service Area, 2025)



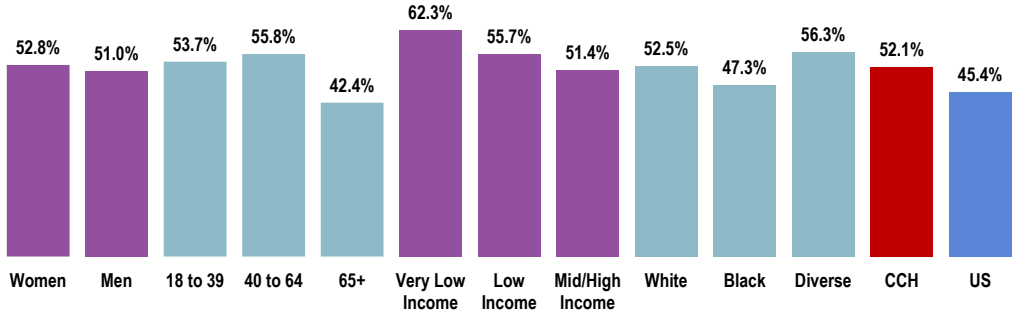
Sources:
- 2025 PRC Community Health Survey, PRC, Inc. [Item 41]
- 2023 PRC National Health Survey, PRC, Inc.

Notes:
- Asked of all respondents.

Personal Impact From Substance Use

PRC SURVEY ► "To what degree has your life been negatively affected by your own or someone else's substance use issues, including alcohol, prescription, and other drugs? Would you say: a great deal, somewhat, a little, or not at all?"

Life Has Been Negatively Affected by Substance Use (by Self or Someone Else)
(CCH Service Area, 2025)

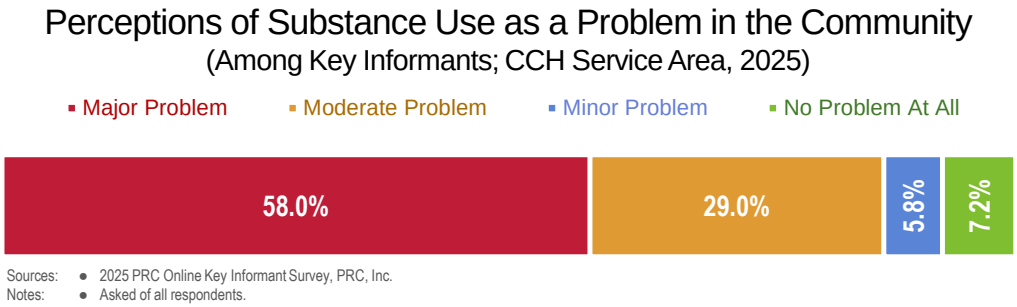


Sources:
- 2025 PRC Community Health Survey, PRC, Inc. [Item 43]
- 2023 PRC National Health Survey, PRC, Inc.

Notes:
- Asked of all respondents.
- Includes response of "a great deal," "somewhat," and "a little."

Key Informant Input: Substance Use

The following chart outlines key informants' perceptions of the severity of *Substance Use* as a problem in the community:



Among those rating this issue as a "major problem," reasons related to the following:

Access to Care/Services

> Access and awareness. — Community Leader
>
> Ease of access. — Community Leader
>
> Availability. Willingness to seek help. Cost, insurance restrictions and transportation. — Social Services Provider
>
> Access to centers to help with withdrawals or other resources needed for mental health. — Public Health Representative
>
> Lack of free centers, lack of preventative programs and education in the beginning, and most often people who need this care are uninsured. — Community Leader
>
> Lack of facilities and programs, access to entry points for treatment. — Community Leader
>
> Services do not exist. — Community Leader

Denial/Stigma

> Stigma and inability to afford treatment. — Health Care Provider
>
> Alienation from family and friends, stigma, poor insight and grasp of having a problem, fear of the justice system, navigating where and how to seek help and cost barriers. — Community Leader
>
> Stigma. — Public Health Representative
>
> Stigma and lack of immediate access to medication for opioid use disorder for those post overdose. — Physician

Awareness/Education

> Knowledge, not everyone knows what is available to them. — Community Leader
>
> Awareness of resources, transportation, costs and insurance. Addictive nature of drugs available. — Community Leader
>
> Lack of awareness, lack of a way to afford the time needed to get clean, and untreated mental health. — Health Care Provider

Disease Management

> Addiction is notoriously hard to overcome, and people often don't want to stop or don't believe they can do so or try and fail. — Social Services Provider
>
> The first barrier is the want to go to treatment. There is a large population of people who do not want treatment. transportation is a barrier. Another barrier is follow-through once a person does go to treatment. — Health Care Provider
>
> There is a good amount of availability but getting people to agree to enter those programs can be a huge barrier. More programs that engage people soon after an overdose or hospitalization would be helpful. — Social Services Provider

Affordable Care/Services

> Cost, transportation, stigma, childcare and housing. — Social Services Provider

Diagnosis/Treatment

> Effective treatment, self-serving treatment centers, lack of oversight for treatment programs. — Community Leader

Transportation

> Several barriers, including transportation, stigma related to seeking treatment, childcare, comorbidities, cost, access to appropriate treatment facilities. — Community Leader

> Transportation, stigma, mental health issues. — Community Leader

Follow-Up/Support

> Recovery looks different for everyone. In working with a lot of different programs, trying to re-enter society and be a part of a community when you are a member of the recovery community is hard. There are also quite a few unregulated programs which can take advantage of those trying to change their lives and outcomes. There are also just a lot of limited beds in some programs. If someone in the middle of the night decides they want to get clean- who do they call and where can they go? There is definitely a stigma around substance use in our community. — Social Services Provider

Fear

> Scared and we need to meet people where they are at. — Public Health Representative

Incidence/Prevalence

> The rate of it. — Community Leader

Access for Medicare/Medicaid Patients

> Finding access for those who are on Medicare with co-occurring mental health, or physical disabilities. — Community Leader

Funding

> Funding. — Community Leader

Tobacco Use

ABOUT TOBACCO USE

More than 16 million adults in the United States have a disease caused by smoking cigarettes, and smoking-related illnesses lead to half a million deaths each year.

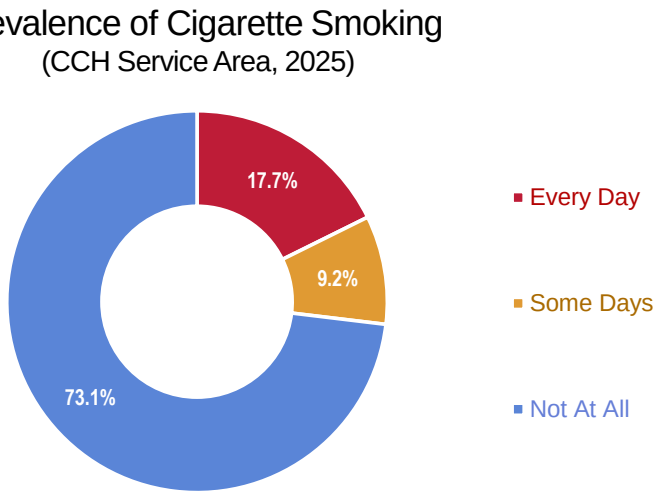
Most deaths and diseases from tobacco use in the United States are caused by cigarettes. Smoking harms nearly every organ in the body and increases the risk of heart disease, stroke, lung diseases, and many types of cancer. Although smoking is widespread, it's more common in certain groups, including men, American Indians/Alaska Natives, people with behavioral health conditions, LGBT people, and people with lower incomes and education levels.

Several evidence-based strategies can help prevent and reduce tobacco use and exposure to secondhand smoke. These include smoke-free policies, price increases, and health education campaigns that target large audiences. Methods like counseling and medication can also help people stop using tobacco.

– Healthy People 2030 (https://health.gov/healthypeople)

Cigarette Smoking

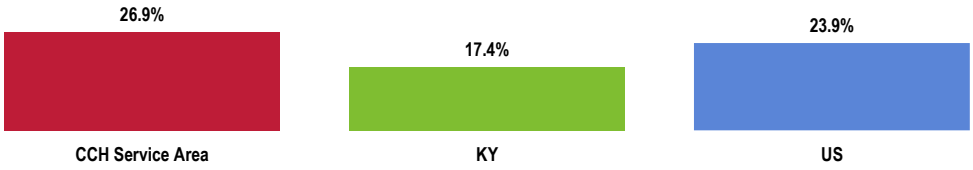
PRC SURVEY ► "Do you currently smoke cigarettes every day, some days, or not at all?"
("Currently Smoke Cigarettes" includes those smoking "every day" or on "some days.")



Sources: ● 2025 PRC Community Health Survey, PRC, Inc. [Item 34]
Notes: ● Asked of all respondents.

Currently Smoke Cigarettes

Healthy People 2030 = 6.1% or Lower



Sources:
- 2025 PRC Community Health Survey, PRC, Inc. [Item 34]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2022 Kentucky data.
- 2023 PRC National Health Survey, PRC, Inc.
- US Department of Health and Human Services. Healthy People 2030. https://health.gov/healthypeople

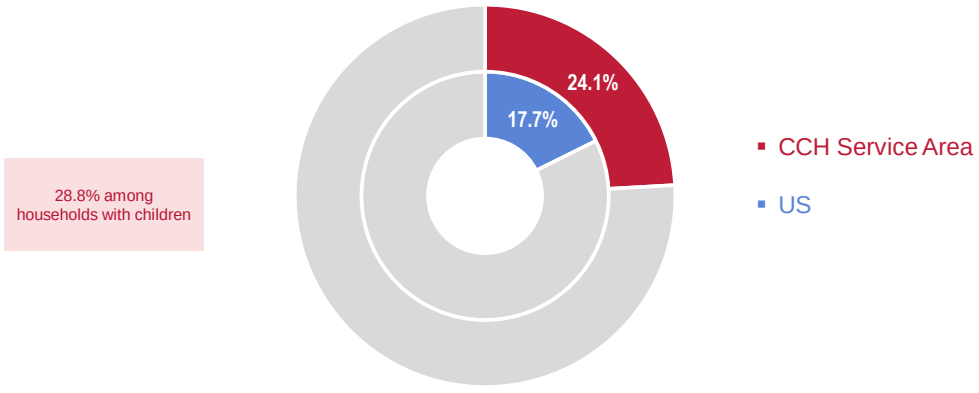
Notes:
- Asked of all respondents.
- Includes regular and occasional smokers (those who smoke cigarettes every day or on some days).

Environmental Tobacco Smoke

PRC SURVEY ► "In the past 30 days, has anyone, including yourself, smoked cigarettes, cigars, or pipes anywhere in your home on an average of four or more days per week?"

The following chart details these responses among the total sample of respondents, as well as among only households with children (age 0-17).

Member of Household Smokes at Home



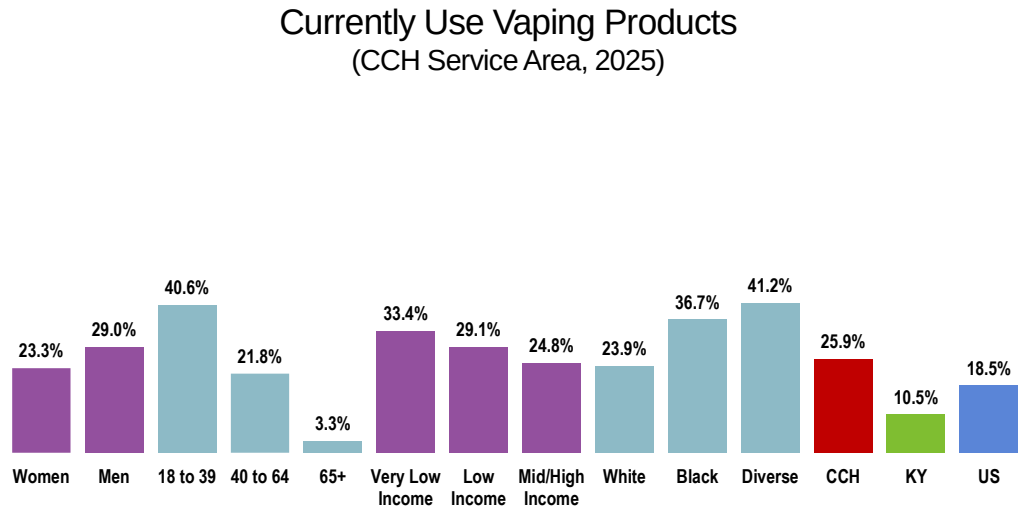
Sources:
- 2025 PRC Community Health Survey, PRC, Inc. [Items 35, 114]
- 2023 PRC National Health Survey, PRC, Inc.

Notes:
- Asked of all respondents.
- "Smokes at home" refers to someone smoking cigarettes, cigars, or a pipe in the home an average of four or more times per week in the past month.

Use of Vaping Products

PRC SURVEY ► "Electronic vaping products, such as electronic cigarettes, are battery-operated devices that simulate traditional cigarette smoking but do not involve the burning of tobacco. Do you currently use electronic vaping products, such as electronic cigarettes, every day, some days, or not at all?"

("Currently Use Vaping Products" includes use "every day" or on "some days.")

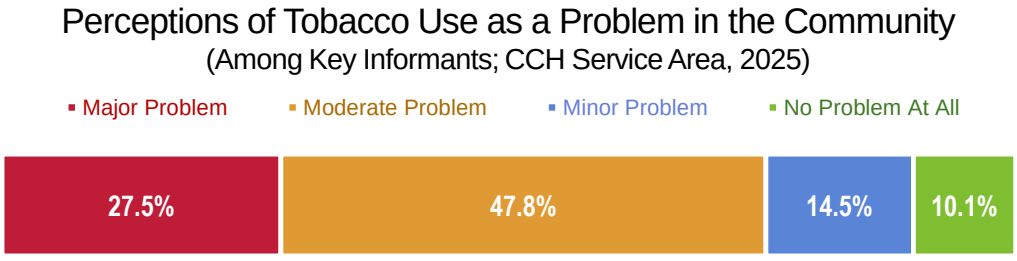


Sources:
- 2025 PRC Community Health Survey, PRC, Inc. [Item 36]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2022 Kentucky data.
- 2023 PRC National Health Survey, PRC, Inc.

Notes:
- Asked of all respondents.
- Includes regular and occasional users (those who smoke e-cigarettes every day or on some days).

Key Informant Input: Tobacco Use

The following chart outlines key informants' perceptions of the severity of *Tobacco Use* as a problem in the community:



Sources:
- 2025 PRC Online Key Informant Survey, PRC, Inc.

Notes:
- Asked of all respondents.

Among those rating this issue as a “major problem,” reasons related to the following:

Incidence/Prevalence

> Too many smoking or vaping and the number of lung cancer patients. — Community Leader
>
> I see everyone smoking, especially under 25 years of age, and it stands out. — Community Leader
>
> Smoking rates are not decreasing with continued hospitalizations related to respiratory status. — Community Leader
>
> High rates of smoking and vaping. — Social Services Provider

E-Cigarettes

> Although cigarette smoking rates have decreased over the years, vaping has skyrocketed. We are seeing more youth engaging in vaping and they are being fed misinformation about the dangers of vaping. Many smokers have switched to vaping as a "healthy alternative" which studies have shown are false. Health issues related to vaping are on the rise and starting at a younger age then cigarettes. — Public Health Representative
>
> I think this has improved, but vaping has just become a whole different issue. Tobacco use leads to all those chronic illnesses previously covered, such as respiratory, cancer, etc. It’s still an addictive product. — Social Services Provider

Social Norms/Community Attitude

> Tobacco was historically the major cash crop for the state. Tobacco use stemmed from that earlier access and position. The addictive nature of tobacco is also a determinant of quitting. — Community Leader
>
> Tradition in Kentucky. — Public Health Representative

Impact on Quality of Life

> It contributes to a wide range of unfavorable health outcomes and is widely available. It is also more prominent in lower income levels and more rural areas. — Social Services Provider
>
> For the well-known health problems tobacco causes, the expense of this and it being prioritized over other important household expenses. — Community Leader

Co-Occurrences

> Tobacco is one of the first things a person starts using, that often leads to vaping or use of other drugs. — Health Care Provider

Sexual Health

ABOUT HIV & SEXUALLY TRANSMITTED INFECTIONS

Although many sexually transmitted infections (STIs) are preventable, there are more than 20 million estimated new cases in the United States each year — and rates are increasing. In addition, more than 1.2 million people in the United States are living with HIV (human immunodeficiency virus).

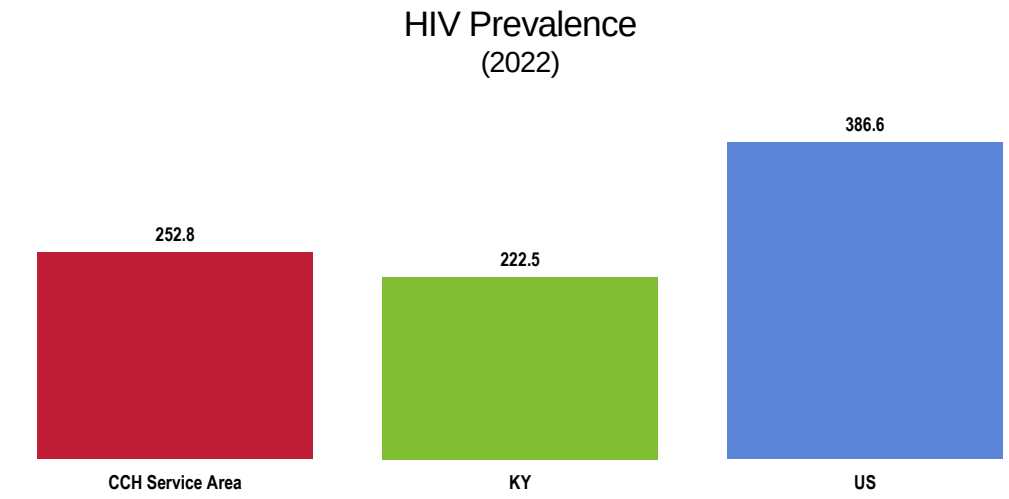
Adolescents, young adults, and men who have sex with men are at higher risk of getting STIs. And people who have an STI may be at higher risk of getting HIV.

Strategies to increase screening and testing for STIs can assess people's risk of getting an STI and help people with STIs get treatment, improving their health and making it less likely that STIs will spread to others. Getting treated for an STI other than HIV can help prevent complications from the STI but doesn't prevent HIV from spreading.

– Healthy People 2030 (https://health.gov/healthypeople)

HIV

The following chart outlines prevalence (current cases, regardless of when they were diagnosed) of HIV per 100,000 population in the area.



Sources:
- Centers for Disease Control and Prevention, National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved February 2025 via SparkMap (sparkmap.org).

Sexually Transmitted Infections (STIs)

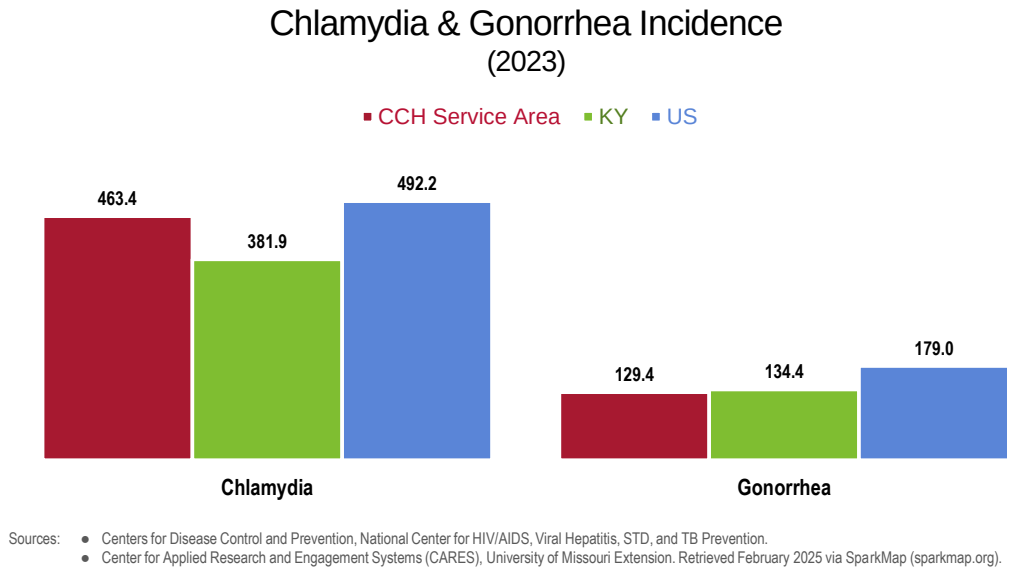
Chlamydia

Chlamydia is the most commonly reported STI in the United States; most people who have chlamydia are unaware, since the disease often has no symptoms.

Gonorrhea

Anyone who is sexually active can get gonorrhea. Gonorrhea can be cured with the right medication; left untreated, however, gonorrhea can cause serious health problems in both women and men.

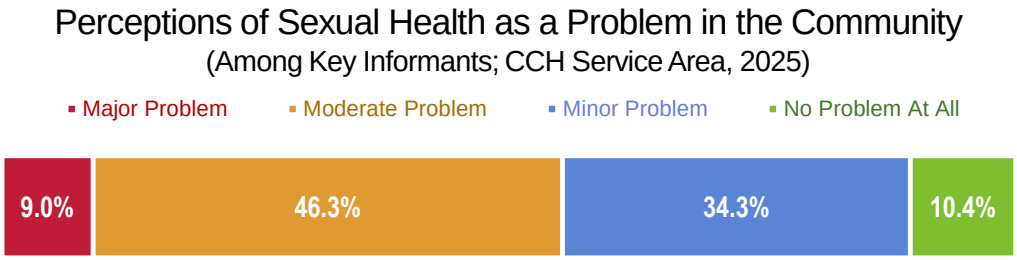
The following chart outlines local incidence for these STIs.



Sources:
- Centers for Disease Control and Prevention, National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved February 2025 via SparkMap (sparkmap.org).

Key Informant Input: Sexual Health

The following chart outlines key informants' perceptions of *Sexual Health* as a problem in the community:



Sources: 2025 PRC Online Key Informant Survey, PRC, Inc.
Notes: Asked of all respondents.

Among those rating this issue as a "major problem," reasons related to the following:

Access to Care/Services

> Services do not exist. — Community Leader

Awareness/Education

> The lack of education on how to protect themselves, also lack of resources. — Public Health Representative

ACCESS TO HEALTH CARE

ABOUT HEALTH CARE ACCESS

Many people in the United States don't get the health care services they need. …About 1 in 10 people in the United States don't have health insurance. People without insurance are less likely to have a primary care provider, and they may not be able to afford the health care services and medications they need. Strategies to increase insurance coverage rates are critical for making sure more people get important health care services, like preventive care and treatment for chronic illnesses.

Sometimes people don't get recommended health care services, like cancer screenings, because they don't have a primary care provider. Other times, it's because they live too far away from health care providers who offer them. Interventions to increase access to health care professionals and improve communication — in person or remotely — can help more people get the care they need.

– Healthy People 2030 (https://health.gov/healthypeople)

Difficulties Accessing Health Care

Lack of Health Insurance Coverage

Here, lack of health insurance coverage reflects respondents age 18 to 64 (thus, excluding the Medicare population) who have no type of insurance coverage for health care services – neither private insurance nor government-sponsored plans.

Survey respondents were asked a series of questions to determine their health care insurance coverage, if any, from either private or government-sponsored sources.

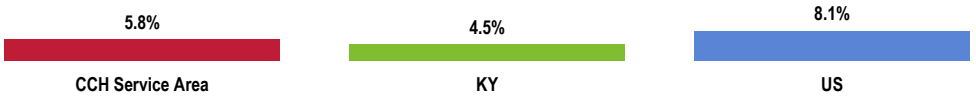
PRC SURVEY ► "Do you have any government-assisted health care coverage, such as Medicare, Medicaid, or VA/military benefits?"

PRC SURVEY ► "Do you currently have: health insurance you get through your own or someone else's employer or union; health insurance you purchase yourself or get through a health insurance exchange website; or, you do not have health insurance and pay entirely on your own?"

Lack of Health Care Insurance Coverage

(Adults 18-64)

Healthy People 2030 = 7.6% or Lower



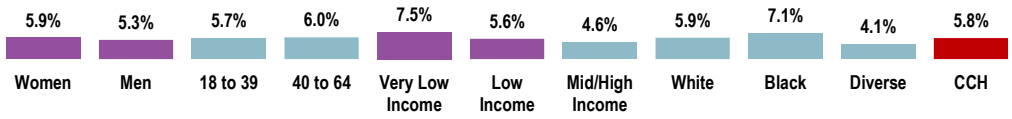
Sources:
- 2025 PRC Community Health Survey, PRC, Inc. [Item 117]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2022 Kentucky data.
- 2023 PRC National Health Survey, PRC, Inc.
- US Department of Health and Human Services. Healthy People 2030. https://health.gov/healthypeople

Notes:
- Reflects respondents age 18 to 64.

Lack of Health Care Insurance Coverage

(Adults Age 18-64; CCH Service Area, 2025)

Healthy People 2030 = 7.6% or Lower



Sources:
- 2025 PRC Community Health Survey, PRC, Inc. [Item 117]
- US Department of Health and Human Services. Healthy People 2030. https://health.gov/healthypeople

Notes:
- Asked of all respondents under the age of 65.

Barriers to Health Care Access

To better understand health care access barriers, survey participants were asked whether any of the following barriers to access prevented them from seeing a physician or obtaining a needed prescription in the past year.

PRC SURVEY ► "Was there a time in the past 12 months when you needed medical care but had difficulty finding a doctor?"

PRC SURVEY ► "Was there a time in the past 12 months when you had difficulty getting an appointment to see a doctor?"

PRC SURVEY ► "Was there a time in the past 12 months when you needed to see a doctor but could not because of the cost?"

PRC SURVEY ► "Was there a time in the past 12 months when a lack of transportation made it difficult or prevented you from seeing a doctor or making a medical appointment?"

PRC SURVEY ► "Was there a time in the past 12 months when you were not able to see a doctor because the office hours were not convenient?"

PRC SURVEY ► "Was there a time in the past 12 months when you needed a prescription medicine but did not get it because you could not afford it?"

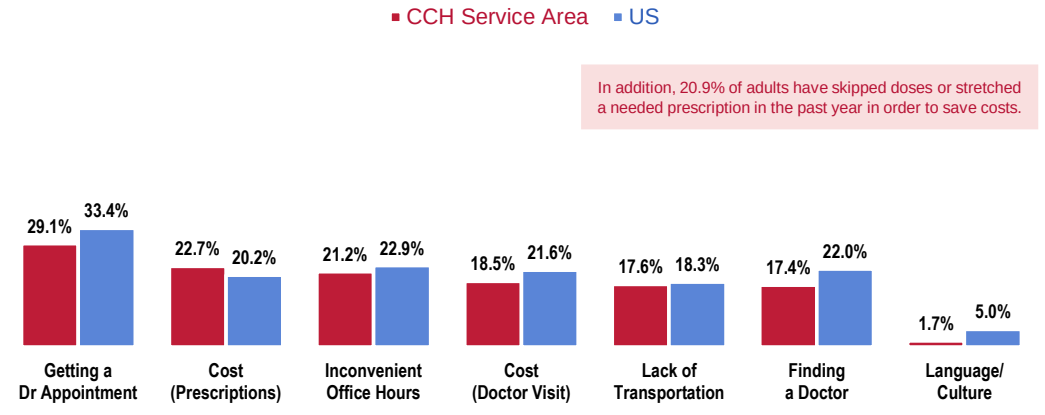
PRC SURVEY ► "Was there a time in the past 12 months when you were not able to see a doctor due to language or cultural differences?"

Also:

PRC SURVEY ► "Was there a time in the past 12 months when you skipped doses or took smaller doses in order to make your prescriptions last longer and save costs?"

The percentages shown in the following chart reflect the total population, regardless of whether medical care was needed or sought.

Barriers to Access Have Prevented Medical Care in the Past Year



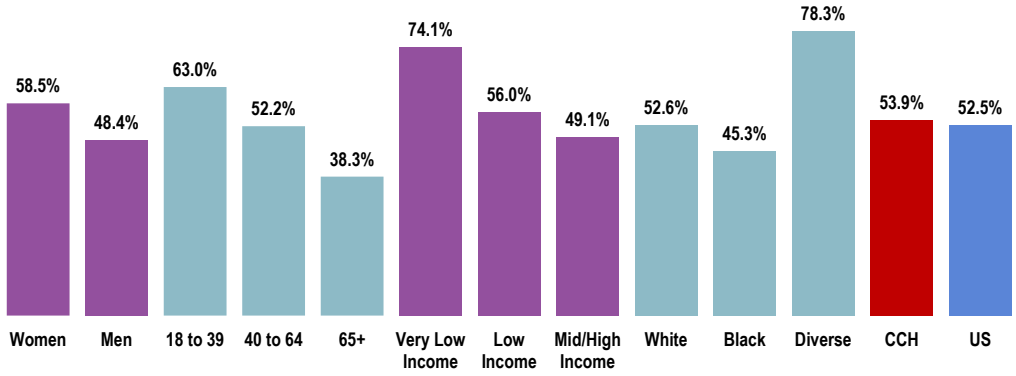
Sources:
- 2025 PRC Community Health Survey, PRC, Inc. [Items 6-13]
- 2023 PRC National Health Survey, PRC, Inc.

Notes:
- Asked of all respondents.

The following chart reflects the composite percentage of the total population experiencing problems accessing health care in the past year (indicating one or more of the aforementioned barriers or any other problem not specifically asked), again regardless of whether they needed or sought care.

Experienced Difficulties or Delays of Some Kind in Receiving Needed Health Care in the Past Year

(CCH Service Area, 2025)



Sources:
- 2025 PRC Community Health Survey, PRC, Inc. [Item 119]

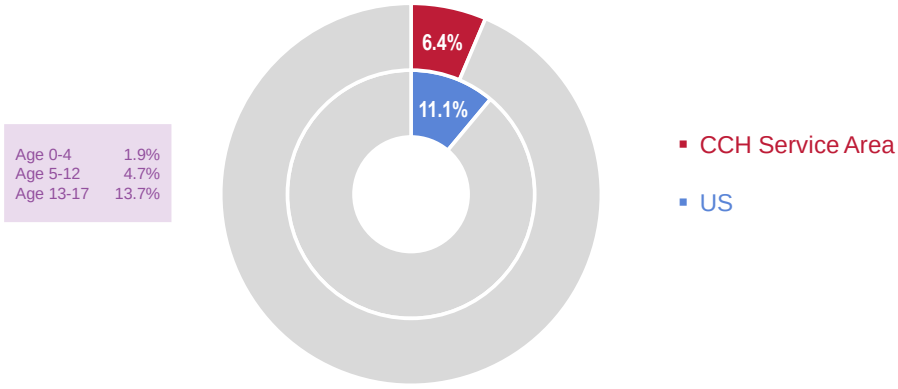
Notes:
- Asked of all respondents.
- Percentage represents the proportion of respondents experiencing one or more barriers to accessing health care in the past 12 months.

Accessing Health Care for Children

Surveyed parents were also asked if, within the past year, they experienced any trouble receiving medical care for a randomly selected child in their household.

PRC SURVEY ► [Among parents of children age 0-17] **"Was there a time in the past 12 months when you needed medical care for this child but could not get it?"**

Had Trouble Obtaining Medical Care for Child in the Past Year
(Parents of Children 0-17)

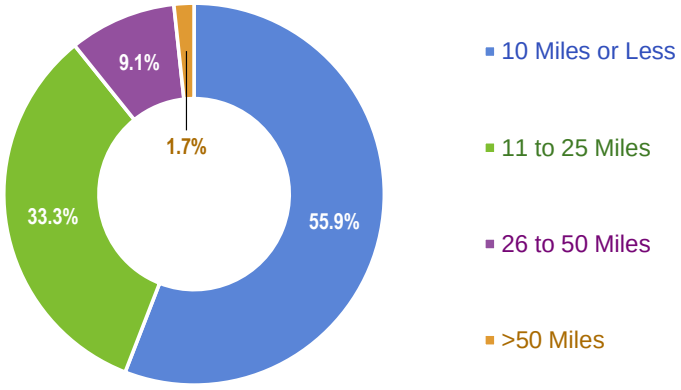


Sources: ● 2025 PRC Community Health Survey, PRC, Inc. [Item 90]
● 2023 PRC National Health Survey, PRC, Inc.
Notes: ● Asked of all respondents with children 0 to 17 in the household.

Outmigration for Health Care Services

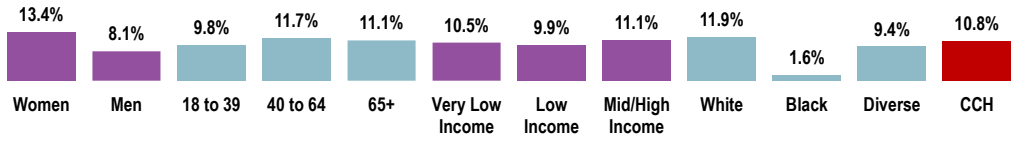
PRC SURVEY ► **"In general, how far do you typically travel for health care?"**

Distance Traveled for Health Care Services
(CCH Service Area, 2025)



Sources: ● 2025 PRC Community Health Survey, PRC, Inc. [Item 302]
Notes: ● Asked of all respondents.

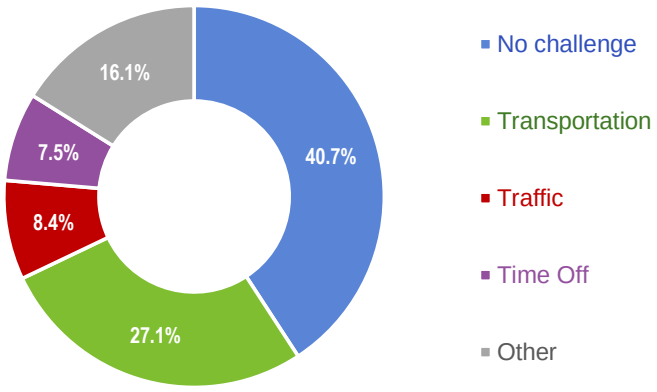
Typically Travel Over 25 Miles for Health Care Services
(CCH Service Area, 2025)



Sources: ● 2025 PRC Community Health Survey, PRC, Inc. [Item 302]
Notes: ● Asked of all respondents.

PRC SURVEY ► "What is the biggest challenge, if any, that you have when traveling for health care?"

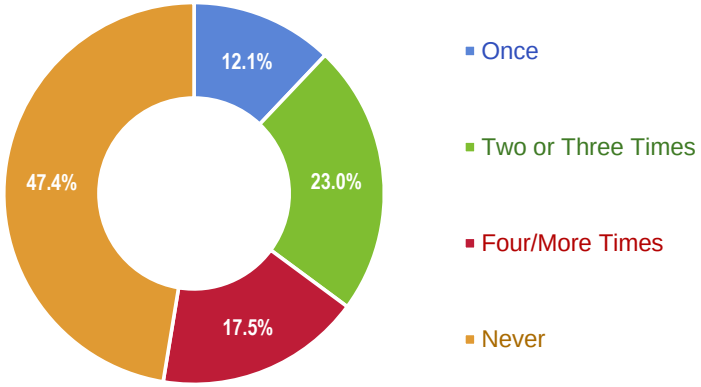
Biggest Challenge When Traveling for Health Care
(CCH Service Area, 2025)



Sources: ● 2025 PRC Community Health Survey, PRC, Inc. [Item 303]
Notes: ● Asked of all respondents.

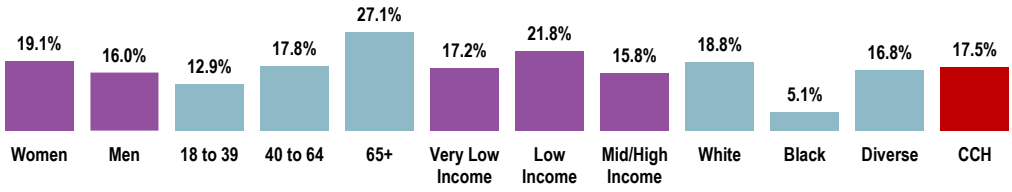
PRC SURVEY ► "In the past 12 months, about how many times have you traveled outside of your community for health care? Would you say once, two or three times, more than three times, or never?"

Frequency of Leaving the Community for Health Care in the Past Year
(CCH Service Area, 2025)



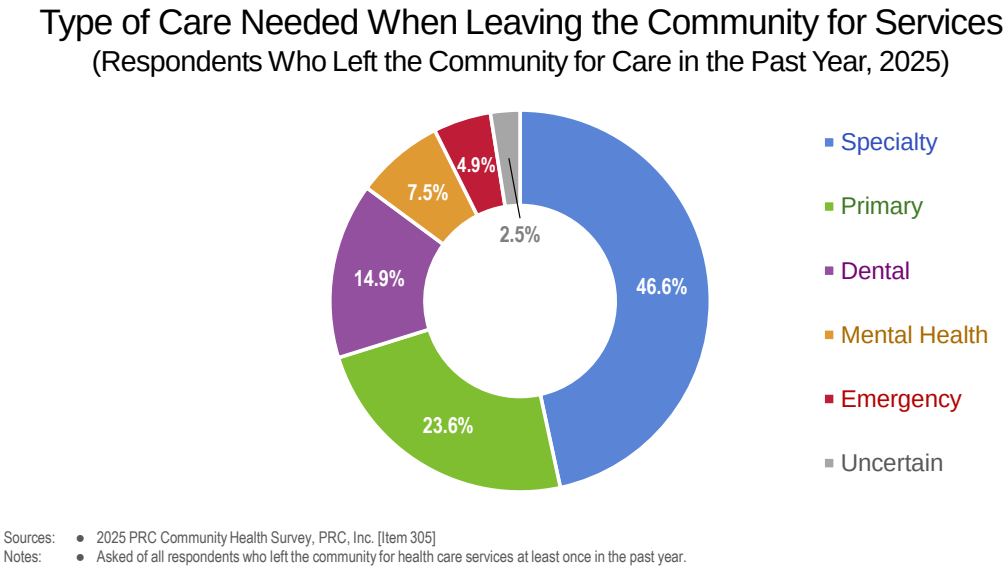
Sources: ● 2025 PRC Community Health Survey, PRC, Inc. [Item 304]
Notes: ● Asked of all respondents.

Left the Community for Health Care Four or More Times in the Past Year
(CCH Service Area, 2025)



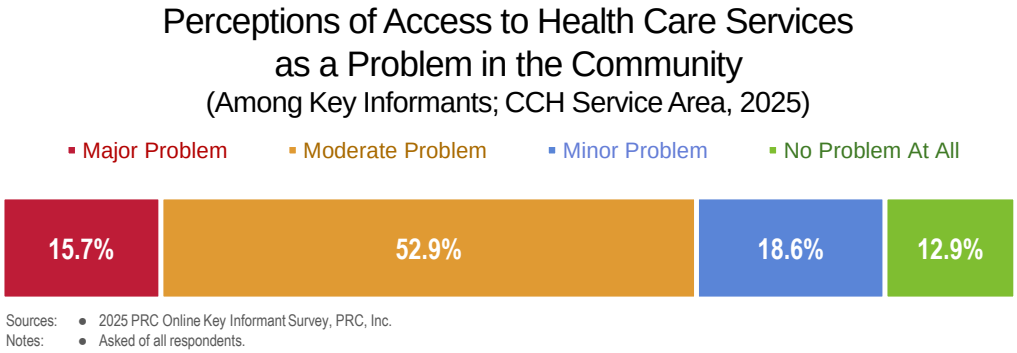
Sources: ● 2025 PRC Community Health Survey, PRC, Inc. [Item 304]
Notes: ● Asked of all respondents.

PRC SURVEY ► [Among those leaving the community for care] **"For which type of health care do you most often travel outside of your community?"**



Key Informant Input: Access to Health Care Services

The following chart outlines key informants' perceptions of the severity of *Access to Health Care Services* as a problem in the community:



Among those rating this issue as a "major problem," reasons related to the following:

Vulnerable Populations

> Accessibility, economically depressed neighborhoods struggle to have access to adequate health care, food and employment. Increasing opportunities in all these areas will positively impact outcomes. — Community Leader
>
> Equitable access to care for LGBTQ populations. — Physician

Affordable Care/Services

> Cost. There are too many patients uninsured or underinsured which causes dramatic delays in seeking care which then results in small problems becoming bigger problems. Deductibles can be prohibitive for patients. Our free or sliding scale clinics are very overwhelmed. — Health Care Provider
>
> Affordability is one of the biggest challenges in accessing services and not all patients are eligible for financial assistance at local hospitals. There are a handful of Free Clinics in our community, but all have waiting lists, and most aren't for acute needs. — Social Services Provider

Transportation

> Transportation to appointments is a huge concern, having enough providers, and access to affordable insurance. — Social Services Provider

Access to Care/Services

> Financial constraints, language barriers, lack of insurance, and limited transportation options are some of the more common barriers our clients face. The high cost of medical care, even with insurance, often makes it difficult for families to prioritize their health needs over other essentials like food and housing. Language barriers and limited health literacy further complicate access, making it challenging for some families to navigate the healthcare system or understand medical instructions. Childcare responsibilities and inflexible work schedules also prevent parents from attending appointments. For some, fear of judgment or discrimination, particularly among marginalized communities, discourages them from seeking care. These obstacles create significant gaps in healthcare access, often leading to untreated conditions and worsening health outcomes. — Social Services Provider
>
> I would say access and affordability. — Community Leader
>
> 1. Cost. 2. Language barriers for non-English speakers 3. location of medical services and transportation 4. mindset- many folks only seek medical care when it is absolutely necessary, therefor chronic conditions like diabetes, heart disease, high blood pressure go untreated for years. — Community Leader
>
> Easy access to needed services for everyone. Not being financially able to afford. — Community Leader

Awareness/Education

> People don't know where to go for their specific need. Healthcare is not available when they are off work. No childcare. — Public Health Representative

Diagnosis/Treatment

> The biggest problem I see is getting an accurate and timely diagnosis of cognitive decline, including Alzheimer's and dementia. This not only affects the person living with the disease, but also the caregiver and support system around the person with dementia. It has a large ripple effect that can have a lasting impact on the overall community as well. — Social Services Provider

Primary Care Services

ABOUT PREVENTIVE CARE

Getting preventive care reduces the risk for diseases, disabilities, and death — yet millions of people in the United States don't get recommended preventive health care services.

Children need regular well-child and dental visits to track their development and find health problems early, when they're usually easier to treat. Services like screenings, dental check-ups, and vaccinations are key to keeping people of all ages healthy. But for a variety of reasons, many people don't get the preventive care they need. Barriers include cost, not having a primary care provider, living too far from providers, and lack of awareness about recommended preventive services.

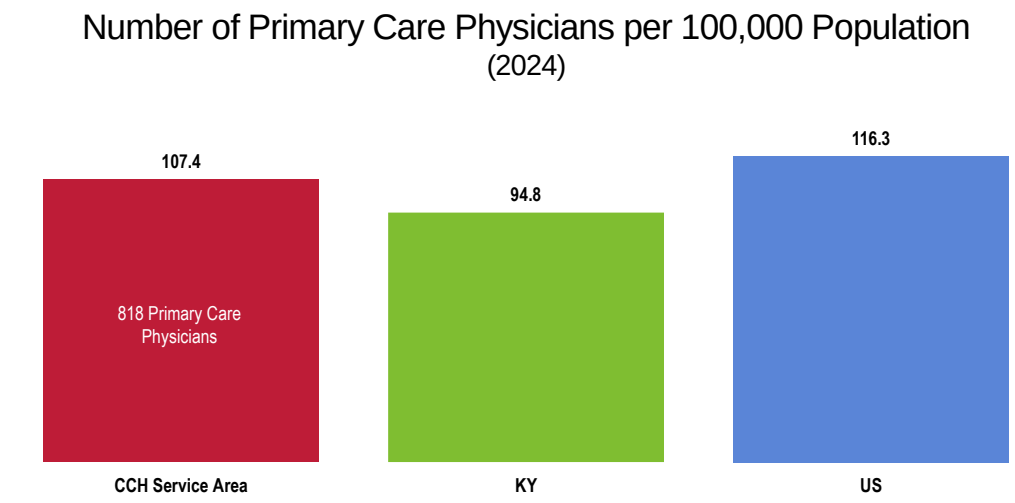
Teaching people about the importance of preventive care is key to making sure more people get recommended services. Law and policy changes can also help more people access these critical services.

– Healthy People 2030 (https://health.gov/healthypeople)

Access to Primary Care

Note that this indicator takes into account *only* primary care physicians. It does not reflect primary care access available through advanced practice providers, such as physician assistants or nurse practitioners.

The following chart shows the number of active primary care physicians per 100,000 population. This indicator is relevant because a shortage of health professionals contributes to access and health status issues.

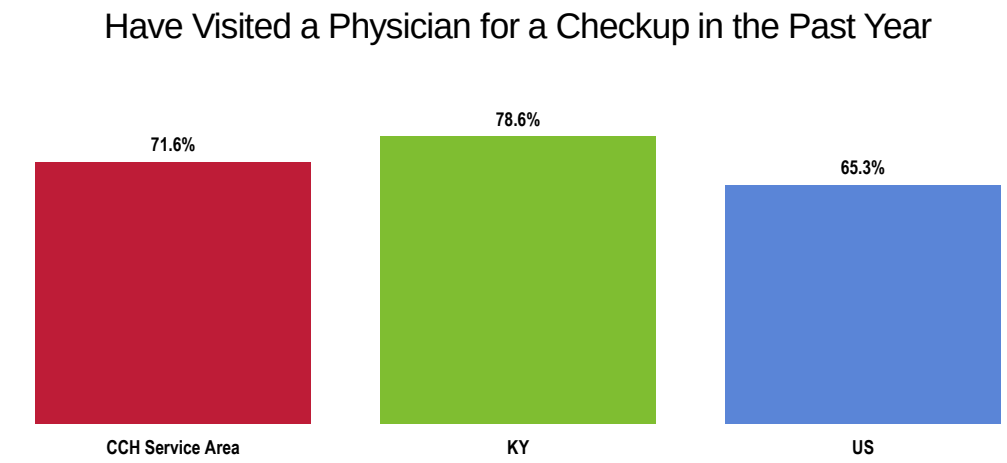


Sources:
- Centers for Medicare and Medicaid Services, National Plan and Provider Enumeration System (NPPES).
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved February 2025 via SparkMap (sparkmap.org).

Notes:
- 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 age 75 and over and physicians practicing sub-specialties within the listed specialties are excluded.

Utilization of Primary Care Services

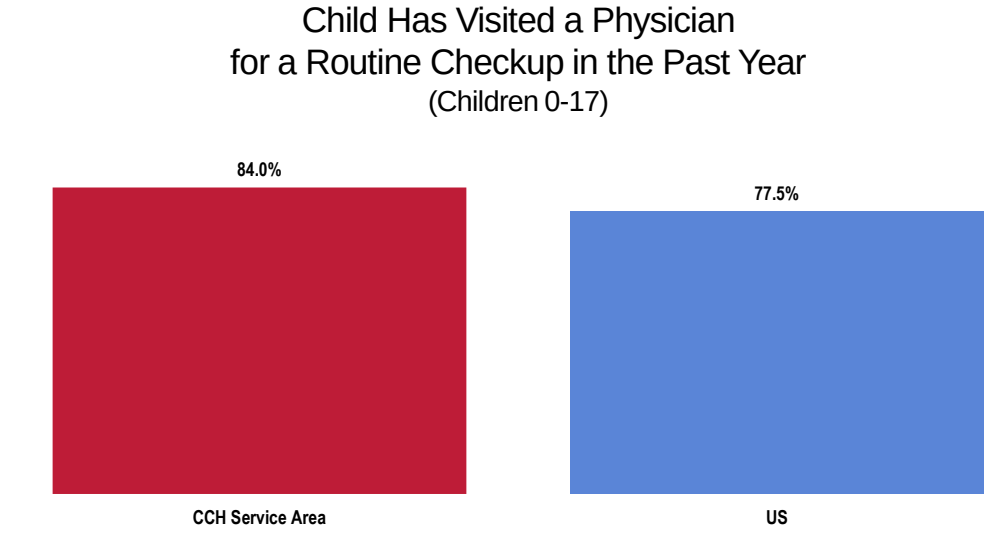
PRC SURVEY ► "A routine checkup is a general physical exam, not an exam for a specific injury, illness, or condition. About how long has it been since you last visited a doctor for a routine checkup?"



Sources:
- 2025 PRC Community Health Survey, PRC, Inc. [Item 16]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2022 Kentucky data.
- 2023 PRC National Health Survey, PRC, Inc.

Notes:
- Asked of all respondents.

PRC SURVEY ► [Among parents of children age 0-17] "About how long has it been since this child visited a doctor for a routine checkup or general physical exam, not counting visits for a specific injury, illness, or condition?"



Sources:
- 2025 PRC Community Health Survey, PRC, Inc. [Item 91]
- 2023 PRC National Health Survey, PRC, Inc.

Notes:
- Asked of all respondents with children age 0 to 17 in the household.

Oral Health

ABOUT ORAL HEALTH

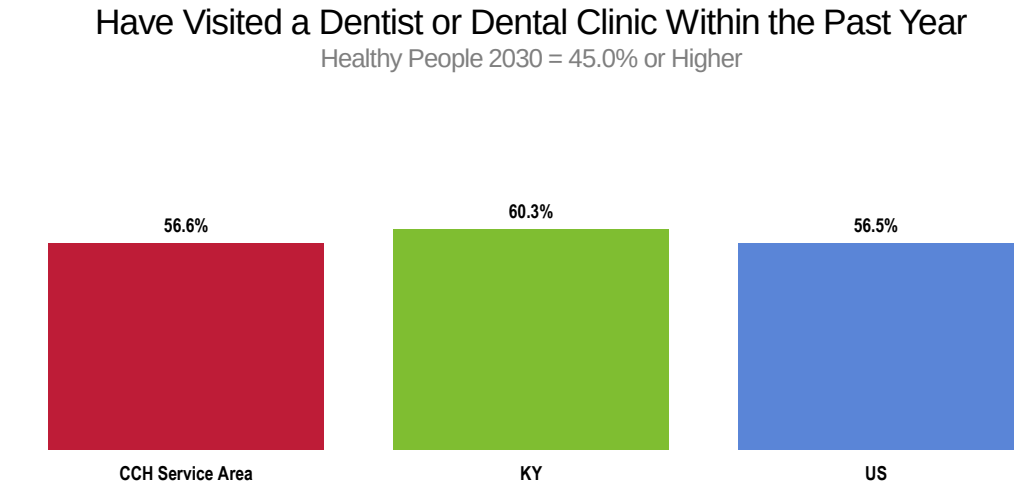
Tooth decay is the most common chronic disease in children and adults in the United States. …Regular preventive dental care can catch problems early, when they're usually easier to treat. But many people don't get the care they need, often because they can't afford it. Untreated oral health problems can cause pain and disability and are linked to other diseases.

Strategies to help people access dental services can help prevent problems like tooth decay, gum disease, and tooth loss. Individual-level interventions like topical fluorides and community-level interventions like community water fluoridation can also help improve oral health. In addition, teaching people how to take care of their teeth and gums can help prevent oral health problems.

– Healthy People 2030 (https://health.gov/healthypeople)

Dental Care

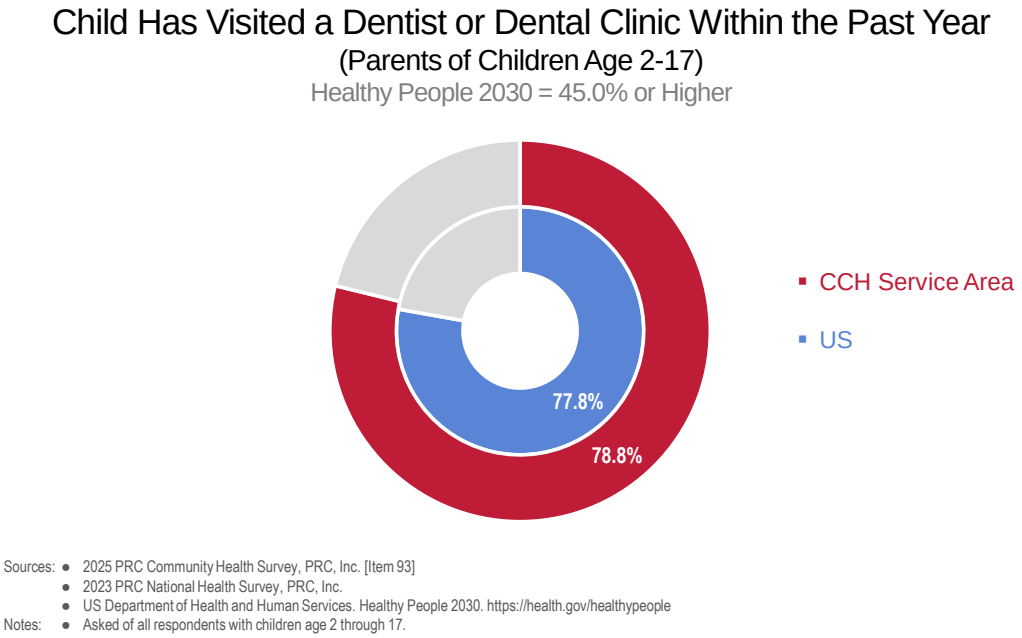
PRC SURVEY ► "About how long has it been since you last visited a dentist or a dental clinic for any reason?"



Sources:
- 2025 PRC Community Health Survey, PRC, Inc. [Item 17]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2022 Kentucky data.
- 2023 PRC National Health Survey, PRC, Inc.
- US Department of Health and Human Services. Healthy People 2030. https://health.gov/healthypeople

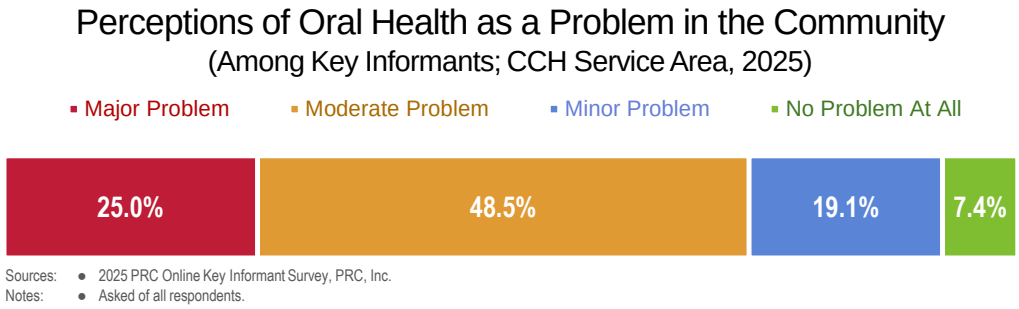
Notes:
- Asked of all respondents.

PRC SURVEY ► [Among parents of children age 2-17] **"About how long has it been since this child visited a dentist or dental clinic?"**



Key Informant Input: Oral Health

The following chart outlines key informants' perceptions of the severity of *Oral Health* as a problem in the community:



Among those rating this issue as a "major problem," reasons related to the following:

Affordable Care/Services

> Very hard to access for low-income and uninsured individuals. Long wait times for some of the clinics that makes it hard to access. Even for those with insurance, oral health is expensive if you have a major problem, and more and more folks forego the dentist to afford other necessities.
> — Social Services Provider
>
> Oral healthcare is incredibly expensive, so when choosing between rent, food, gas for the car, prescriptions, oral health is often put on the backburner. Many in our community are unable to afford dental care and do not have dental insurance. — Social Services Provider
>
> Oral health is a significant community issue because lack of access to affordable dental care leads to untreated cavities, gum disease, and other serious health problems, disproportionately affecting low-income and underserved populations. Poor oral health can also impact overall well-being, including nutrition, self-esteem, employment opportunities, and increased risks of chronic diseases like diabetes and heart disease. — Community Leader

Impact on Quality of Life

> Oral health is connected to a person's overall well-being and quality of life. Poor oral health can contribute to chronic pain, infections, and serious conditions like heart disease and diabetes, disproportionately affecting vulnerable populations who already struggle with access to healthcare. Individuals facing poverty, homelessness, or lack of insurance often go without dental care, leading to worsening health issues and financial burdens. Additionally, oral health effects self-esteem, employability, and social interactions—missing or damaged teeth can create stigma, making it harder to secure jobs or build relationships. For children, untreated dental issues can impact school performance and development, perpetuating cycles of disadvantage. — Social Services Provider
>
> Surgery on Sunday gets weekly calls about providing dental care. Oral health can lead to major medical issues and since cost is out of reach, patients choose to eat and not see a dentist. — Health Care Provider

Access for Medicare/Medicaid Patients

> Limited dental care, not covered by most insurance, including Medicaid and Medicare. If someone has coverage by an Advantage plan, there are only a few providers, and they are not close. — Social Services Provider

Access to Care/Services

> Services do not exist. — Community Leader
>
> We have a walk-in clinic that is always packed. — Health Care Provider

Incidence/Prevalence

> There are many systemic issues that begin with poor oral health. One can assess the issues in an area by observing the directed commercials in the media. So many oral health commercials and offerings because the demand is present. — Community Leader

Vulnerable Populations

> In the homeless community, it has been a major issue as many medical clinics will not treat oral or dental health needs, or the free clinics have several month's wait. Those with emergency dental needs often are not able to access assistance. — Community Leader

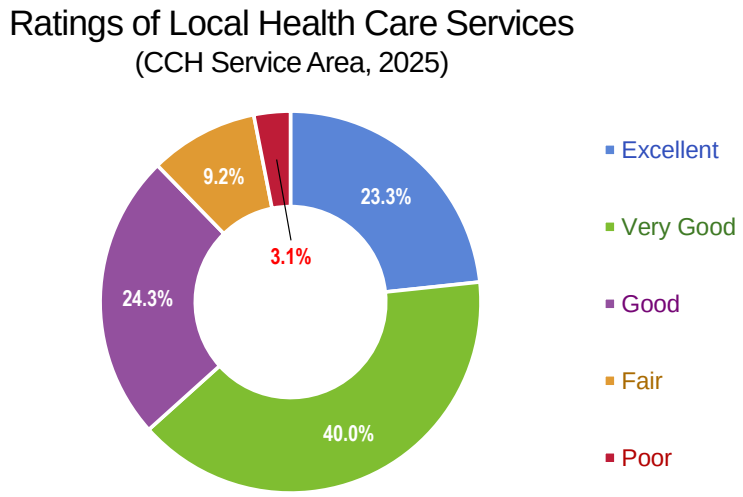
Income/Poverty

> The problem occurs more in Southeastern Kentucky because of financial resource priority of needs. — Community Leader

LOCAL RESOURCES

Perceptions of Local Health Care Services

PRC SURVEY ► "How would you rate the overall health care services available to you? Would you say: excellent, very good, good, fair, or poor?"



Sources: ● 2025 PRC Community Health Survey, PRC, Inc. [Item 5]
Notes: ● Asked of all respondents.

Resources Available to Address Significant Health Needs

The following represent potential measures and resources (such as programs, organizations, and facilities in the community) identified by key informants as available to address the significant health needs identified in this report. This list only reflects input from participants in the Online Key Informant Survey and should not be considered to be exhaustive nor an all-inclusive list of available resources.

Access to Health Care Services

- Alzheimer's Association
- Baby Health Outreach Program
- Bluegrass Community Health
- Centro de San Juan Diego
- CHI Saint Joseph Health
- Doctors' Offices
- Faith Pharmacy
- Health Department
- HealthFirst Bluegrass
- Immigration Clinics
- Kentucky Cancer Program
- Kentucky Homecare
- Medicaid
- Mission Lexington
- New Vista
- Public Transportation
- Refuge Clinic
- Salvation Army
- Senior Citizens Center
- State Health Insurance Assistance Program
- Surgery on Sunday
- Urgent Care Centers

Cancer

- American Cancer Association
- American Cancer Society
- American Lung Association
- Baptist Health
- Baptist Health Cancer Center
- Cancerlink
- Central Baptist Hospital
- CHI Saint Joseph Health, Cancer Care Center
- Cologuard/Non-Invasive Cancer Screenings
- Health Department
- Health Systems
- Hospice of the Bluegrass
- Hospitals
- Kentucky Cancer Program
- Lexington Clinic
- Lexington Fayette County Health Department
- Markey Cancer Center
- Medicaid
- Saint Joseph
- School System
- Screenings
- Susan G. Komen Foundation
- Tobacco Prevention and Cessation Program
- University of Kentucky
- White House Clinic
- YMCA

Diabetes

- American Diabetes Association
- Baptist Health
- Baptist Health Lexington
- Barnstable Brown Diabetes Center
- Bluegrass Community and Technical College
- Central Baptist Hospital
- CHI Saint Joseph Health, Diabetes and Nutrition Care
- Churches
- Commercial Advertising
- Community Health Center
- Diabetes Advocacy Associations
- Diabetes Center
- Diabetes Classes
- Doctors' Offices
- Faith Pharmacy
- Family Members
- Farmers' Markets
- Fayette County Health Department
- Food Banks/Pantries
- God's Pantry
- Health Department
- Health Fairs
- HealthFirst Bluegrass
- Home Health
- Hospitals
- KC Wellness
- Kentucky Diabetes Prevention and Control Program
- Lexington Fayette County Health Department
- Libraries
- Medicaid

- Mobile Market
- Neighborhood Clubs
- New Lexington Clinic
- Paramedicine Team
- Refuge Clinic
- School System
- Senior Citizens Center
- University of Kentucky
- YMCA

Disabling Conditions

- Aging and Disability Resource Centers
- Alzheimer's Association
- Cardinal Hill
- Catholic Action Center
- Centers for Independent Living
- CHI Saint Joseph Health
- Hope Center
- Hospice of the Bluegrass
- Kentucky Council of the Blind
- Kentucky Hears
- Lexington Senior Center
- LexTran's Wheels Program
- Lions Club
- Meals on Wheels
- Sanders Brown Center on Aging
- Surgery on Sunday
- Wheels Paratransit Program

Heart Disease & Stroke

- American Heart Association
- Baptist Health
- CHI Saint Joseph Health
- Churches
- Faith Pharmacy
- Gill Heart Institute
- Health Department
- Health Systems
- Hospitals
- Lexington Clinic
- Lexington Senior Center
- Parks and Recreation
- Pharmacies
- Refuge Clinic
- School System
- Tobacco Prevention and Cessation Program
- University of Kentucky
- Urgent Care Centers
- YMCA

Infant Health & Family Planning

- All Options Help Line
- Baby Health Outreach Program
- CHI Saint Joseph Health
- Cabinet for Health and Family Services
- Central Baptist Hospital
- Community Collaborations for Children
- Doctors' Offices
- Extension Office
- Family Resource Center
- First Steps
- Health Access Nurturing Development Services Program
- Health Department
- HealthFirst Bluegrass
- Planned Parenthood
- School System
- The Nest
- University of Kentucky
- Women, Infants, and Children

Injury & Violence

- CIL Summer Camp
- Gun Laws
- Health Department
- Hope Center
- Housing and Urban Development
- Law Enforcement
- Mayor's Office
- One Lexington
- Operation Making a Change
- Police Athletic League
- Rehab Facilities
- Social Services
- The Nest
- Unions
- Women's Shelters

Mental Health

- 988
- Altavista
- ARC
- Athena Women's Counseling
- Baptist Health Behavioral Health
- Betterhelp
- Bluegrass Community Health
- Catholic Action Center
- Catholic Charities
- Center for Grieving Children and Families
- Chrysalis House
- Community Action Council

- Community Perception
- Doctors' Offices
- Eastern State
- EmPATH
- Fayette County Health Department
- Federally Qualified Health Centers
- Health Department
- Health Systems
- HealthFirst Bluegrass
- Hope Center
- Hospitals
- Isaiah House
- Kentucky Center for Grieving Children and Families
- Lionheart Trauma
- Medicaid
- Mission Lexington
- Mountain Comprehensive Care
- National Alliance on Mental Illness
- New Beginnings
- New Vista
- Private Counselors
- Refuge Clinic
- Resolutions Therapy
- Samaritan Hospital
- School System
- Southland Christian Counseling Referral
- The Nest
- The Ridge
- University of Kentucky
- Veterans Health Administration
- Voices of Hope
- White House Clinic

Nutrition, Physical Activity & Weight

- Cabinet for Health and Family Services
- Churches
- Community Health Workers
- Community Inspired Lexington Food Pantry
- Culture
- Doctors' Offices
- Extension Office
- Fayette County Health Department
- Fitness Centers/Gyms
- FoodChain
- Free Lunch Programs
- God's Pantry
- Health Department
- Hospitals
- Lexington Northside Library Food Bank
- Mobile Market
- Nutrition Counseling
- Obesity Action Coalition
- Online Resources
- Parks and Recreation
- PROMATx Health Club
- Self-Regulation
- Senior Citizens Center
- Social Services
- University of Kentucky
- Weight Watchers
- YMCA

Oral Health

- Health Department
- HealthFirst Bluegrass
- Mission Health
- Mission Lexington
- Refuge Clinic
- School Smiles
- University of Kentucky
- White House Clinic

Respiratory Diseases

- American Heart Association
- Health Department
- Health Systems
- Home Health
- Smoking Bans in Public Places

Sexual Health

- Bluegrass Community Health
- College Campus Medical Clinics
- Health Department
- Lexington Fayette County Health Department
- Planned Parenthood
- Rape Crisis Centers
- School System

Social Determinants of Health

- Adult Education Centers
- American Civil Liberties Union of Kentucky
- Baby Health Outreach Program
- Bluegrass Community and Technical College
- BUILD Network
- Catholic Action Center
- Churches
- City/County Government
- Community Action Council
- Community Action Kentucky

- Community and Residential Services
- Community Health Workers
- Community Response Coalition of Kentucky
- Department for Children and Families
- Department of Community Based Services
- Environmental Protection Agency
- Family Care Center
- Family Resource Center
- Food Banks/Pantries
- Goodwill Opportunity Center
- Greenhouse 17
- Habitat for Humanity
- Health Department
- HealthFirst Bluegrass
- Homeless and Housing Coalition of Kentucky
- Hope Center
- Hospitals
- Housing Authorities
- Lexington Fayette County Health Department
- Lexington Housing Authority
- Lexington Public Library
- Lexington Rescue Mission
- Mary Queen of the Holy Rosary Church
- Mayor's Office
- Mobile Market
- Non-Profits
- Office of Homelessness Prevention and Intervention
- Parks and Recreation
- Pride Center
- Private Business Donations
- Programs to Reduce Violence
- Rental Assistance Programs
- Sage Mental Health
- Saint Leo Church
- Saint Paul Church
- Salvation Army
- School System
- Section 8 Housing
- Senior Citizens Center
- Social Services
- St. James Place
- United Way
- Urban League
- Work Force Development

Substance Use

- 2nd Chance Clinic
- AA/NA
- Agency for Substance Abuse Policy
- ARC
- Bluegrass
- Bluegrass Community Health
- BUILD Network
- Caise Place
- Catholic Action Center
- Chrysalis House
- City of Lexington
- Community Mental Health Centers
- Counseling Services
- Doctors' Offices
- Good Samaritan
- HealthFirst Bluegrass
- Hope Center
- Isaiah House
- Jessamine County Emergency Medical Services
- Level Up
- Lexington Fayette County Health Department
- Mental Health Court
- New Vista
- Outpatient Facilities
- Private For-Profit and Non-Profit Treatment Centers
- Recovery Housing
- Rehab Facilities
- Residential Rehab Programs
- Schwartz Center
- Shepherds House
- Sober Living Houses
- Substance Use Disorder Intervention Program
- The Ridge
- UK Bridge Clinic
- University of Kentucky
- Voices of Hope

Tobacco Use

- American Cancer Society
- American Heart Association
- American Lung Association
- Doctors' Offices
- Health Department
- Lexington Fayette County Health Department
- Peer Groups for Cessation Support
- Tobacco Prevention and Cessation Program
- University of Kentucky

APPENDIX

EVALUATION OF PAST ACTIVITIES

2023-2025 Community Health Needs Assessment
Continuing Care Hospital
Impact of Action Taken

SUBSTANCE USE DISORDERS
GOAL: Reduce disease and death associated with substance use disorders through evidence-based prevention and treatment efforts

System / Hospital	Strategy	Key Accomplishments / Highlights
System	Advocate for public policies aimed at reducing use of tobacco products.	Substance Use Disorders were identified as a legislative priority for the Kentucky General Assembly in 2023, 2024 and 2025. Legislature enacted 4 new laws in 2023: HB 248 Recovery Housing, HB 148 Substance Abuse or Mental Health Treatment Benefits, HB 353 Narcotic Drug Testing Products, HB 544 Hemp-Derived Products. Legislature enacted 5 new laws in 2024: HB 11 prohibiting a retailer from selling certain products to persons under 21; HB142 banning tobacco, alternative nicotine and vapor products in public schools; HB 293 regulating kratom; HB 534 and SB 71 related to addiction treatment; and HB 462 providing a framework for certification of recovery residences. Advocated for Congressional reauthorization of the Comprehensive Addiction Recovery through Effective Employment and Reentry (CAREER) Act, which makes available competitive grants to treatment and recovery service providers to carry out evidence-based programs focused on supporting independent living and workforce participation among individuals in SUD treatment or recovery. (2023) Advocated in D.C. with the Central KY Policy Group to support federal efforts to curb the drug epidemic through prevention, treatment and criminal justice reforms. (2023) Joined coalition with American Cancer Society to advocate for $10M annually for Kentucky Tobacco Prevention & Cessation Program. (2024)

System	Expand pharmacist-driven initiation of medications for opioid use disorder.	Haley Busch, Manager, Performance Excellence-Opioid Program, worked with the system clinical informatics department to automate initiation of medications for opioid use disorder with an order set. Annual education for providers is given regarding use and ease of the order set. Education is also provided to case management across the system regarding longitudinal resources for patients with opioid use disorder. (FY23/FY24) The Kentucky Statewide Opioid Stewardship Program awarded Saint Joseph London and Saint Joseph Mount Sterling $50,000 each to participate in the ED Bridge Program, which recognizes that EDs have an opportunity to make opioid use disorder treatment accessible to all on a 24/7 basis. In addition to financial resources to establish a new position within both hospital EDs, KY SOS provided education on opioid stewardship best practices, support and coordination on the program, and access to clinical advisors and subject matter experts to guide the program towards sustainability. A peer support specialist was hired in 2024. (FY23/FY24) In FY23: ● 93% of providers received education ● 20% reduction in pain scores among patients ● 10% reduction in MME burden among patients ● 47% reduction in co-prescription of oral benzodiazepines with oral opioid
Continuing Care Hospital	Enhance services for the medically complex IV drug use population in Fayette County.	CCH is in the final stages of developing a new model care for the medically complex IV substance abuse patients. It will integrate substance abuse treatment with medical treatment in our Long Term Acute Care Hospital. ● 30 beds will be added at Saint Joseph East ● 40 new caregiver positions will be created ● $1.5 million in capital being invested

MENTAL HEALTH & MENTAL DISORDERS
GOAL: Increase access to mental health services, enabling improved mental health outcomes for Kentucky residents

System / Hospital	Strategy	Key Accomplishments / Highlights
System	Advocate for public policies aimed at improving mental health outcomes.	Mental Health & Mental Disorders were identified as legislative priorities for the Kentucky General Assembly in 2023, 2024 and 2025. Legislature enacted 4 new laws in 2023: HB 248 Recovery Housing, HB 148 Substance Abuse or Mental Health Treatment Benefits, SB 9 Hazing, SB 135 Postpartum Depression Care Legislature enacted 3 new laws in 2024: HB385 allowing a patient's friend to make a health care decision when a patient lacks decisional capacity and has not executed a living will or advanced directive; HB 30 creating a suicide prevention program for service members, veterans and their families; SB 74 establishing the Kentucky Maternal Psychiatry Access Program which provides access to appropriate mental health services through a dedicated hotline and the Kentucky Maternal and Infant Health Collaborative to improve the quality and treatment of perinatal mental health disorders. 50 attendees at Catholic Conference of Kentucky Health Summit to heighten awareness about mental health issues and build a coalition of supporters. (2022) Advocated in D.C. with the Central KY Policy Group to increase resources for mental health treatment and research. (2023)
Continuing Care Hospital	Increase patient access to mental health and other community resources by developing and disseminating a resource list.	CCH is in the final stages of developing a new model care for the medically complex IV substance abuse patients. It will integrate substance abuse treatment with medical treatment in our Long Term Acute Care Hospital. ● 30 beds will be added at Saint Joseph East ● 40 new caregiver positions will be created ● $1.5 million in capital being invested 102 (2023) and 151 (2024) patients in Lexington that screened positive for "feeling alone" were connected with community resources.

WEIGHT STATUS, PHYSICAL ACTIVITY & NUTRITION

GOAL: Improve health and quality of life among community members by promoting healthy eating and regular physical activity

System / Hospital	Strategy	Key Accomplishments / Highlights
System	Advocate for initiatives that address the risk factors that lead to obesity and chronic disease in children.	Weight Status, Physical Activity & Nutrition were identified as legislative priorities for the Kentucky General Assembly in 2023, 2024 and 2025. Legislature enacted 3 new laws in 2023: SB 9 Hazing, SB 229 Child Abuse, SB 80 Sex Offenders Legislature enacted 1 new law in 2024: SB 74 supporting the Health Access Nurturing Development Services (HANDS) program which provides information related to lactation and breastfeeding.
Continuing Care Hospital	Support local groups and events that have a mission to promote healthy diet and exercise to prevent negative health outcomes.	60 (2023) and 69 (2024) patients in Lexington that screened positive for food insecurities were given emergency food boxes.