



# 2025 COMMUNITY HEALTH NEEDS ASSESSMENT

Flaget Memorial Hospital Service Area  
Nelson County, Kentucky

Sponsored by  
**Flaget Memorial Hospital**



Adopted May 20, 2025

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# 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 Flaget Memorial Hospital (FMH). 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

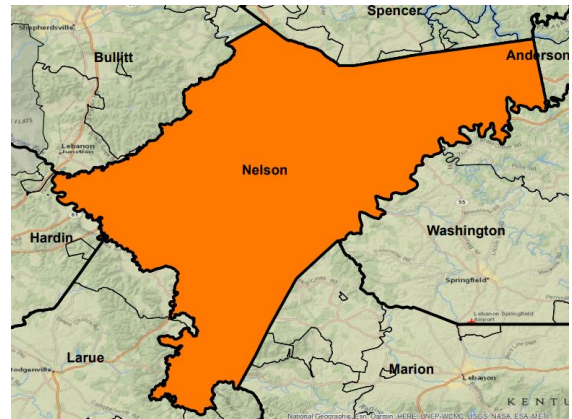
The hospital's commitment to engaging with the community, assessing priority needs, and helping to address them with community partners is in keeping with its mission. As CommonSpirit Health, we make the healing presence of God known in our world by improving the health of the people we serve, especially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

## CHNA Collaborators

Flaget Memorial Hospital is the sole sponsor of this assessment, and no other hospitals serve our area. This assessment was conducted on behalf of Flaget Memorial 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

Flaget Memorial Hospital is located at 4305 New Shepherdsville Road, Bardstown, KY, 40004. 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 Nelson County, which includes the following ZIP Codes: 40004, 40008, 40012, 40013, 40048, 40051, and 40107.



## 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. **SUBSTANCE USE** ▶ Key informants identified this as a top concern in the community. Existing data revealed a relatively high rate of unintentional drug-induced deaths.
2. **MENTAL HEALTH** ▶ Key informants identified this as a top concern in the community. Existing data revealed needs relative to suicide and the availability of mental health providers. Survey findings revealed needs related to treatment for mental health issues.
3. **CANCER** ▶ Key informants identified this as a top concern in the community. Existing data show this to be a leading cause of death and revealed needs relative to cancer deaths (including lung, prostate, and colorectal cancer deaths), as well as new cancer diagnoses (including lung and colorectal cancer incidence).
4. **TOBACCO USE** ▶ There is a high rate of lung disease deaths in the community. Key informants identified this as a top concern in the community.
5. **HEART DISEASE** ▶ Heart disease is a leading cause of death. Survey data reveal a high prevalence of high blood pressure and overall cardiovascular risk.

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

- INFANT HEALTH & FAMILY PLANNING
- ACCESS TO HEALTH CARE SERVICES
- NUTRITION, PHYSICAL ACTIVITY & WEIGHT
- INJURY & VIOLENCE
- DISABLING CONDITIONS

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 CHI Saint Joseph Health Board of Directors on May 20, 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 e-mail to [Sherri.Craig@commonspirit.org](mailto: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
<b>Part V Section B Line 3a</b> A definition of the community served by the hospital facility	9
<b>Part V Section B Line 3b</b> Demographics of the community	29
<b>Part V Section B Line 3c</b> Existing health care facilities and resources within the community that are available to respond to the health needs of the community	112
<b>Part V Section B Line 3d</b> How data was obtained	7
<b>Part V Section B Line 3e</b> The significant health needs of the community	14
<b>Part V Section B Line 3f</b> Primary and chronic disease needs and other health issues of uninsured persons, low-income persons, and minority groups	Addressed Throughout
<b>Part V Section B Line 3g</b> The process for identifying and prioritizing community health needs and services to meet the community health needs	24
<b>Part V Section B Line 3h</b> The process for consulting with persons representing the community's interests	10
<b>Part V Section B Line 3i</b> The impact of any actions taken to address the significant health needs identified in the hospital facility's prior CHNA(s)	117



# ASSESSMENT PROCESS & METHODS

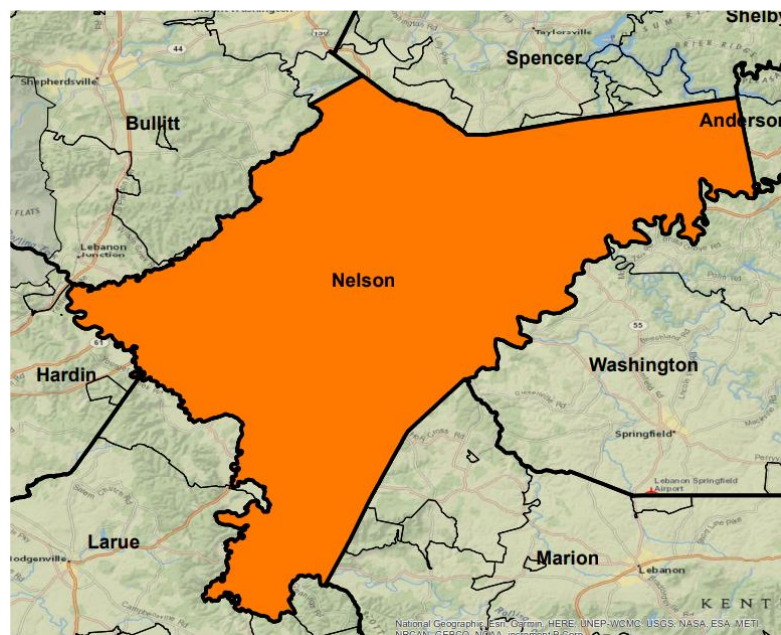
## PRC Community Health Survey

### 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 “Flaget Memorial Hospital Service Area” or “FMH” in this report), determined based on the ZIP Codes of residence of recent patients of Flaget Memorial Hospital, includes Nelson County 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 random sample of 172 individuals age 18 and older in the Flaget Memorial 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 172 respondents is  $\pm 8.0\%$  at the 95 percent confidence level.

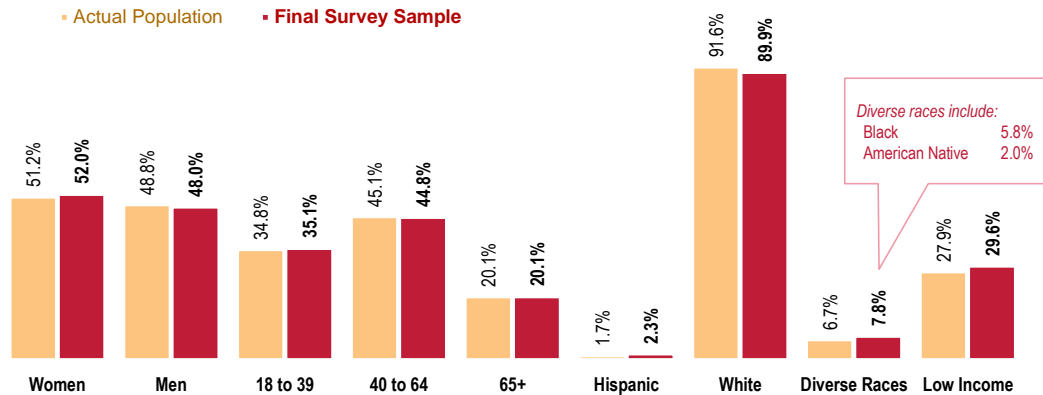


## Sample Characteristics

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 Flaget Memorial 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.]

**Population & Survey Sample Characteristics**  
(FMH Service Area, 2025)



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.

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, 39 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
Public Health Representatives	6
Health Providers	2
Social Services Providers	1
Other Community Leaders	30

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
- BIPOC
- Disabled
- Disabled students
- Elderly
- Hispanics
- Homeless
- Immigrants/refugees
- LGBTQIA+
- Low income
- Medicare/Medicaid patients
- Pregnant women
- Single parents
- Those who are incarcerated
- Those with HIV/AIDS/hepatitis
- Those with language barriers
- Those with mental health issues
- Those with substance abuse issues
- Those without childcare
- Those without transportation
- Undocumented
- Uninsured/underinsured
- Youth

Final participation included representatives of the organizations outlined below.

- Bardstown City Schools
- Bernheim Forest and Arboretum
- City of Bardstown
- Communicare
- Hite Law Group
- Kentucky Courts
- Lincoln Trail District Health Department
- Nelson County Government
- Nelson County Schools
- Sisters of Charity of Nazareth
- St. Vincent de Paul Outreach
- Tri-County Kentucky United Way
- US Senate



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 Flaget Memorial 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](http://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 its most recent CHNA reports and implementation strategies both in the documents and on its 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, Flaget Memorial 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 Flaget Memorial 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	FMH Service Area	FMH SERVICE AREA vs. BENCHMARKS		
		vs. KY	vs. US	vs. HP2030
Linguistically Isolated Population (Percent)	1.1		 0.0	
Population in Poverty (Percent)	9.7	 16.1	 12.4	 8.0
Children in Poverty (Percent)	13.6	 20.9	 16.3	 8.0
No High School Diploma (Age 25+, Percent)	8.1	 11.5	 10.6	
Unemployment Rate (Age 16+, Percent)	4.3	 5.1	 3.9	
% Unable to Pay Cash for a \$400 Emergency Expense	29.0		 34.0	
% Worry/Stress Over Rent/Mortgage in Past Year	33.9		 45.8	
% Unhealthy/Unsafe Housing Conditions	13.8		 16.4	
Population With Low Food Access (Percent)	3.9	 19.8	 22.2	
% Food Insecure	29.6		 43.3	





better



similar



worse

OVERALL HEALTH	FMH Service Area	FMH SERVICE AREA vs. BENCHMARKS		
		vs. KY	vs. US	vs. HP2030
% "Fair/Poor" Overall Health	22.3	 21.9	 15.7	






better




































similar










worse

ACCESS TO HEALTH CARE	FMH Service Area	FMH SERVICE AREA vs. BENCHMARKS		
		vs. KY	vs. US	vs. HP2030
% [Age 18-64] Lack Health Insurance	9.7	 4.5	 8.1	 7.6
% Difficulty Accessing Health Care in Past Year (Composite)	44.5		 52.5	
% Cost Prevented Physician Visit in Past Year	13.9	 10.0	 21.6	
% Cost Prevented Getting Prescription in Past Year	13.5		 20.2	
% Difficulty Getting Appointment in Past Year	26.8		 33.4	
% Inconvenient Hrs Prevented Dr Visit in Past Year	12.4		 22.9	
% Difficulty Finding Physician in Past Year	15.9		 22.0	
% Transportation Hindered Dr Visit in Past Year	8.9		 18.3	
% Language/Culture Prevented Care in Past Year	0.0		 5.0	
% Stretched Prescription to Save Cost in Past Year	13.3		 19.4	
% Typically Travel Over 25 Miles for Health Care Services	21.3			
% Traveled for Health Care 4+ Times in the Past Year	28.0			
Primary Care Doctors per 100,000	64.2	 94.8	 116.3	
% Have a Specific Source of Ongoing Care	68.6		 69.9	 84.0
% Routine Checkup in Past Year	78.3	 78.6	 65.3	
% Two or More ER Visits in Past Year	22.0		 15.6	




ACCESS TO HEALTH CARE (continued)	FMH Service Area	FMH SERVICE AREA vs. BENCHMARKS		
		vs. KY	vs. US	vs. HP2030
% Rate Local Health Care "Fair/Poor"	17.3		 11.5	
				
		better	similar	worse








CANCER	FMH Service Area	FMH SERVICE AREA vs. BENCHMARKS		
		vs. KY	vs. US	vs. HP2030
Cancer Deaths per 100,000	259.5	 228.6	 182.5	 122.7
Lung Cancer Deaths per 100,000	66.8	 64.8	 39.8	 25.1
Female Breast Cancer Deaths per 100,000	26.5	 27.6	 25.1	 15.3
Prostate Cancer Deaths per 100,000	24.1	 19.1	 20.1	 16.9
Colorectal Cancer Deaths per 100,000	26.0	 21.3	 16.3	 8.9
Cancer Incidence per 100,000	524.7	 506.8	 442.3	
Lung Cancer Incidence per 100,000	82.6	 84.4	 54.0	
Female Breast Cancer Incidence per 100,000	117.0	 126.7	 127.0	
Prostate Cancer Incidence per 100,000	103.7	 108.3	 110.5	
Colorectal Cancer Incidence per 100,000	50.8	 45.9	 36.5	
% Cancer	10.0	 12.6	 7.4	
% [Women 50-74] Breast Cancer Screening	79.4		 64.0	 80.5




CANCER (continued)	FMH Service Area	FMH SERVICE AREA vs. BENCHMARKS		
		vs. KY	vs. US	vs. HP2030
% [Women 21-65] Cervical Cancer Screening	79.1		 75.4	 84.3
% [Age 45-75] Colorectal Cancer Screening	85.9		 71.5	 74.4








 better     
  similar     
  worse

CLIMATE, NATURE & HEALTH	FMH Service Area	FMH SERVICE AREA vs. BENCHMARKS		
		vs. KY	vs. US	vs. HP2030
% Consider Climate and Health Risk to be Connected	72.3			
% Health/Well-Being Impacted by Weather in the Past 3 Years	21.8			
% Access to Nature, Parks, or Greenspaces is "Fair/Poor"	7.3			
% Visit Nature, Parks, or Greenspaces Less Than Monthly	43.0			

 better     
  similar     
  worse

DIABETES	FMH Service Area	FMH SERVICE AREA vs. BENCHMARKS		
		vs. KY	vs. US	vs. HP2030
Diabetes Deaths per 100,000	28.8	 37.8	 30.5	
% Diabetes/High Blood Sugar	16.5	 14.8	 12.8	
% Borderline/Pre-Diabetes	13.7		 15.0	
Kidney Disease Deaths per 100,000	28.1	 26.3	 26.3	

 better     
  similar     
  worse

DISABLING CONDITIONS	FMH Service Area	FMH SERVICE AREA vs. BENCHMARKS		
		vs. KY	vs. US	vs. HP2030
% 3+ Chronic Conditions	49.9		 38.0	
% Activity Limitations	29.9		 27.5	
% [With Limitations] Serious Difficulty Walking/Climbing Stairs	60.8			
% [With Limitations] Difficulty Dressing or Bathing	22.3			
% High-Impact Chronic Pain	27.3		 19.6	 6.4
Alzheimer's Disease Deaths per 100,000	34.5	 34.6	 35.8	
% Caregiver to a Friend/Family Member	29.1		 22.8	


















better



similar



worse

HEART DISEASE & STROKE	FMH Service Area	FMH SERVICE AREA vs. BENCHMARKS		
		vs. KY	vs. US	vs. HP2030
Heart Disease Deaths per 100,000	196.2	 257.1	 209.5	 127.4
% Heart Disease	9.2	 9.5	 10.3	
Stroke Deaths per 100,000	43.6	 52.7	 49.3	 33.4
% Stroke	4.9	 4.6	 5.4	
% High Blood Pressure	57.2	 39.9	 40.4	 42.6
% High Cholesterol	38.9		 32.4	
% 1+ Cardiovascular Risk Factor	94.4		 87.8	










better

















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
worse

		FMH SERVICE AREA vs. BENCHMARKS		
INFANT HEALTH & FAMILY PLANNING	FMH Service Area	vs. KY	vs. US	vs. HP2030
Teen Births per 1,000 Females 15-19	21.8	 25.7	 16.6	
Low Birthweight (Percent of Births)	7.3	 8.9	 8.3	
Infant Deaths per 1,000 Births	5.8	 5.8	 5.6	 5.0

 better     
  similar     
  worse

		FMH SERVICE AREA vs. BENCHMARKS		
INJURY & VIOLENCE	FMH Service Area	vs. KY	vs. US	vs. HP2030
Unintentional Injury Deaths per 100,000	93.5	 94.3	 67.8	 43.2
Motor Vehicle Crash Deaths per 100,000	16.2	 17.5	 13.3	 10.1
Homicide Deaths per 100,000	3.6	 8.2	 7.6	 5.5
% Victim of Violent Crime in Past 5 Years	2.9		 7.0	
% Victim of Intimate Partner Violence	22.7		 20.3	

 better     
  similar     
  worse

MENTAL HEALTH	FMH Service Area	FMH SERVICE AREA vs. BENCHMARKS		
		vs. KY	vs. US	vs. HP2030
% "Fair/Poor" Mental Health	25.8		 24.4	
% Diagnosed Depression	37.0	 25.8	 30.8	
% Symptoms of Chronic Depression	48.7		 46.7	
% Typical Day Is "Extremely/Very" Stressful	15.0		 21.1	
Suicide Deaths per 100,000	24.6	 18.1	 14.7	 12.8
Mental Health Providers per 100,000	149.8	 319.9	 312.5	
% Receiving Mental Health Treatment	35.8		 21.9	
% Unable to Get Mental Health Services in Past Year	13.5		 13.2	















better



similar



worse

NUTRITION, PHYSICAL ACTIVITY & WEIGHT	FMH Service Area	FMH SERVICE AREA vs. BENCHMARKS		
		vs. KY	vs. US	vs. HP2030
% "Very/Somewhat" Difficult to Buy Fresh Produce	19.4		 30.0	
% No Leisure-Time Physical Activity	32.4	 26.4	 30.2	 21.8
% Meet Physical Activity Guidelines	17.9	 15.3	 30.3	 29.7
% Overweight (BMI 25+)	73.3	 71.8	 63.3	
% Obese (BMI 30+)	40.9	 37.7	 33.9	 36.0








better














similar












worse




		FMH SERVICE AREA vs. BENCHMARKS		
ORAL HEALTH	FMH Service Area	vs. KY	vs. US	vs. HP2030
% Have Dental Insurance	78.2		 72.7	 75.0
% Dental Visit in Past Year	61.0	 60.3	 56.5	 45.0














 better     
  similar     
  worse

		FMH SERVICE AREA vs. BENCHMARKS		
RESPIRATORY DISEASE	FMH Service Area	vs. KY	vs. US	vs. HP2030
Lung Disease Deaths per 100,000	71.0	 72.3	 43.5	
Pneumonia/Influenza Deaths per 100,000	21.1	 17.8	 13.4	
% Asthma	16.9	 10.8	 17.9	
% COPD (Lung Disease)	14.3	 11.7	 11.0	

 better     
  similar     
  worse

		FMH SERVICE AREA vs. BENCHMARKS		
SEXUAL HEALTH	FMH Service Area	vs. KY	vs. US	vs. HP2030
HIV Prevalence per 100,000	93.0	 222.5	 386.6	
Chlamydia Incidence per 100,000	257.7	 381.9	 492.2	
Gonorrhea Incidence per 100,000	67.0	 134.4	 179.0	

 better     
  similar     
  worse

SUBSTANCE USE	FMH Service Area	FMH SERVICE AREA vs. BENCHMARKS		
		vs. KY	vs. US	vs. HP2030
Alcohol-Induced Deaths per 100,000	16.2	 14.7	 15.7	
Cirrhosis/Liver Disease Deaths per 100,000	25.3	 20.2	 16.4	 10.9
% Excessive Drinking	15.0	 13.8	 34.3	
Unintentional Drug-Induced Deaths per 100,000	45.0	 48.9	 29.7	
% Used an Illicit Drug in Past Month	8.4		 8.4	
% Used a Prescription Opioid in Past Year	20.6		 15.1	
% Ever Sought Help for Alcohol or Drug Problem	11.7		 6.8	
% Personally Impacted by Substance Use	42.8		 45.4	









better



similar



worse

TOBACCO USE	FMH Service Area	FMH SERVICE AREA vs. BENCHMARKS		
		vs. KY	vs. US	vs. HP2030
% Smoke Cigarettes	23.3	 17.4	 23.9	 6.1
% Someone Smokes at Home	18.1		 17.7	
% Use Vaping Products	13.9	 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	SUBSTANCE USE	<ul style="list-style-type: none"> <li>Unintentional Drug-Induced Deaths</li> <li>Key Informants: <i>Substance Use</i> ranked as a top concern.</li> </ul>
2	MENTAL HEALTH	<ul style="list-style-type: none"> <li>Suicide Deaths</li> <li>Mental Health Provider Ratio</li> <li>Receiving Treatment for Mental Health</li> <li>Key Informants: <i>Mental Health</i> ranked as a top concern.</li> </ul>
3	CANCER	<ul style="list-style-type: none"> <li>Leading Cause of Death</li> <li>Cancer Deaths                             <ul style="list-style-type: none"> <li>Including Lung Cancer, Prostate Cancer, Colorectal Cancer Deaths</li> </ul> </li> <li>Cancer Incidence                             <ul style="list-style-type: none"> <li>Including Lung Cancer, Colorectal Cancer</li> </ul> </li> <li>Key Informants: <i>Cancer</i> ranked as a top concern.</li> </ul>
4	TOBACCO USE	<ul style="list-style-type: none"> <li>Lung Disease Deaths</li> <li>Key Informants: <i>Tobacco Use</i> ranked as a top concern.</li> </ul>
5	HEART DISEASE & STROKE	<ul style="list-style-type: none"> <li>Leading Cause of Death</li> <li>High Blood Pressure Prevalence</li> <li>Overall Cardiovascular Risk</li> </ul>



Other health needs identified in this assessment include:

- INFANT HEALTH & FAMILY PLANNING
- ACCESS TO HEALTH CARE SERVICES
- NUTRITION, PHYSICAL ACTIVITY & WEIGHT
- INJURY & VIOLENCE
- DISABLING CONDITIONS

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

## Hospital Implementation Strategy

Flaget Memorial 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 Flaget Memorial Hospital Service Area, the focus of this Community Health Needs Assessment, includes Nelson County. It encompasses 418.69 square miles and houses a total population of 47,102 residents, according to latest census estimates.

The Flaget Memorial Hospital Service Area is predominantly rural.

Note the following demographic makeup of our community.

## Core Demographic Summary

	FMH Service Area	
Urbanization	65.2% Rural	
Total Population Size	47,102	
Race & Ethnicity	<i>Hispanic</i>	2.7%
	<i>White</i>	89.5%
	<i>Black</i>	5.1%
	<i>Asian</i>	0.5%
	<i>American Indian or Alaska Native</i>	0.1%
Median Household Income	\$67,888	
Percent of Population Living in Poverty (Below 100% FPL)	9.7%	
Unemployment Rate (December 2024)	4.3%	
Percent of People Age 5 and Older Who are Non-English Speaking	1.1%	
Percent of People Without Health Insurance	5.4%	
Percent of People with Medicaid	22.9%	
Health Professional Shortage Area	No	
Medically Underserved Areas/Populations	Yes	
Medically Underserved, Low Income, or Minority Populations	Multiple	
Number of Other Hospitals Serving the Community	0	





# 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

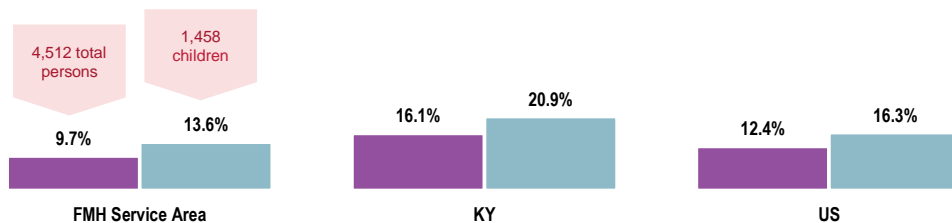
The following chart outlines the proportion of our population below the federal poverty threshold in comparison to state and national proportions.

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.

### Percent of Population in Poverty (2019-2023)

Healthy People 2030 = 8.0% or Lower

■ Total Population ■ Children



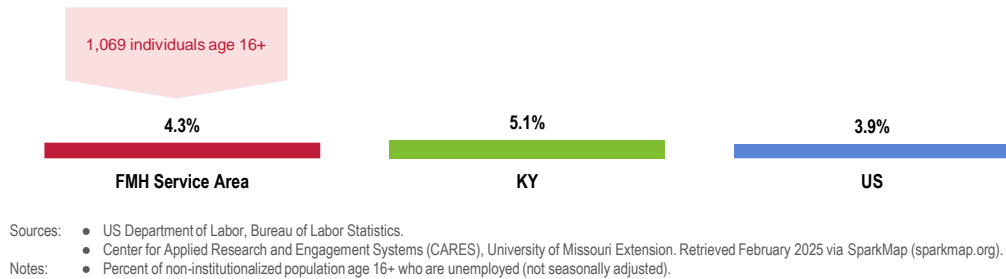
Sources: • US Census Bureau American Community Survey, 5-year estimates.  
 • Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved February 2025 via SparkMap ([sparkmap.org](https://sparkmap.org)).  
 • US Department of Health and Human Services. Healthy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

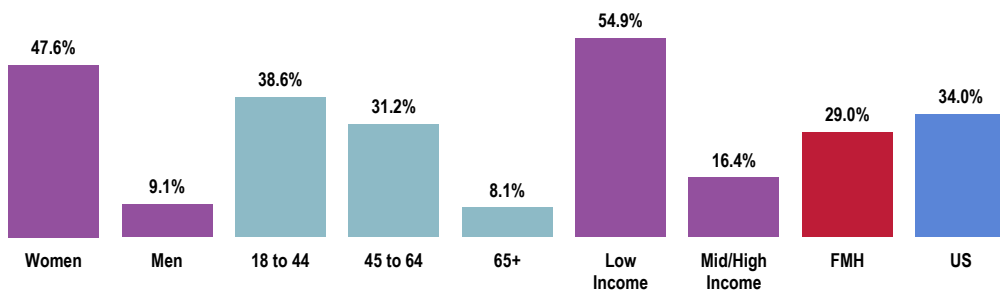


## Financial Resilience

**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 Flaget Memorial Hospital Service Area in comparison to benchmark data, as well as by basic demographic characteristics (such as gender, age groupings, and income [based on poverty status]).

### Do Not Have Cash on Hand to Cover a \$400 Emergency Expense (FMH 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

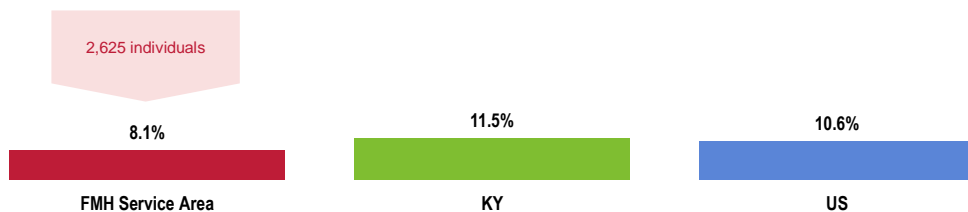
**INCOME** ► Income categories used to segment survey data in this report are based on administrative poverty thresholds determined by the US Department of Health & Human Services. These guidelines define poverty status by household income level and number of persons in the household (e.g., the 2024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

**RACE & ETHNICITY** ► While the survey data are representative of the full racial and ethnic makeup of the population, samples were not of sufficient size for independent analysis by race and/or ethnicity.

## 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.

### Population With No High School Diploma (Adults Age 25 and Older; 2019-2023)



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](https://sparkmap.org)).

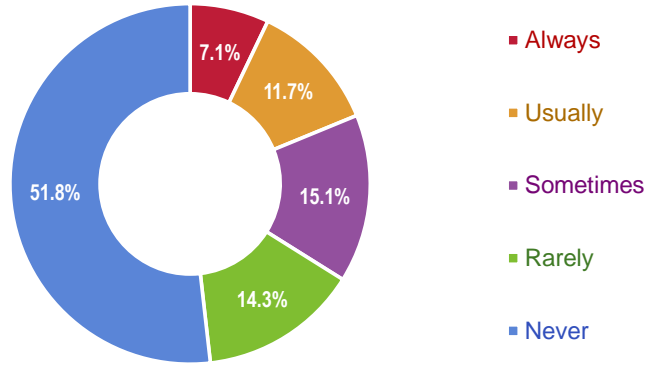


# Housing

## 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 Over Paying Rent or Mortgage in the Past Year (FMH Service Area, 2025)

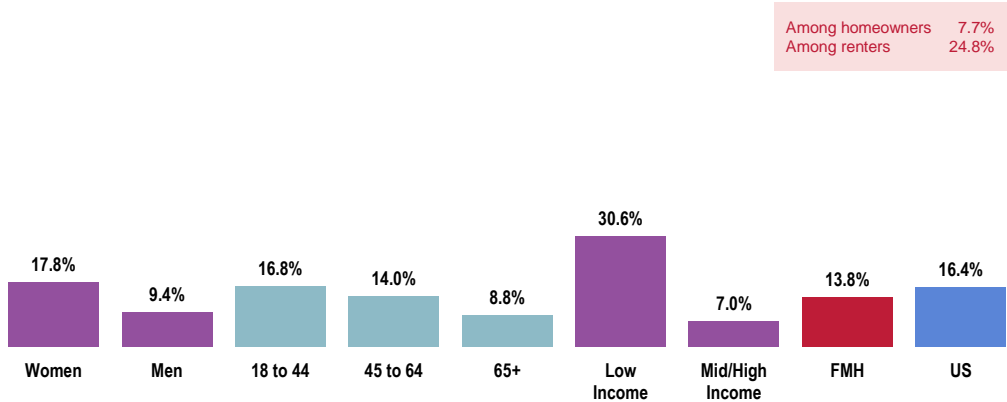


Sources: • 2025 PRC Community Health Survey, PRC, Inc. [Item 56]  
Notes: • Asked of all respondents.

## 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 (FMH Service Area, 2025)



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.



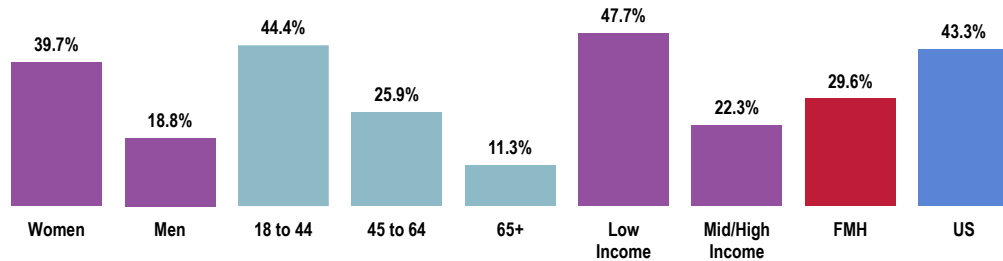
# Food Insecurity

**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.

## Food Insecure



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

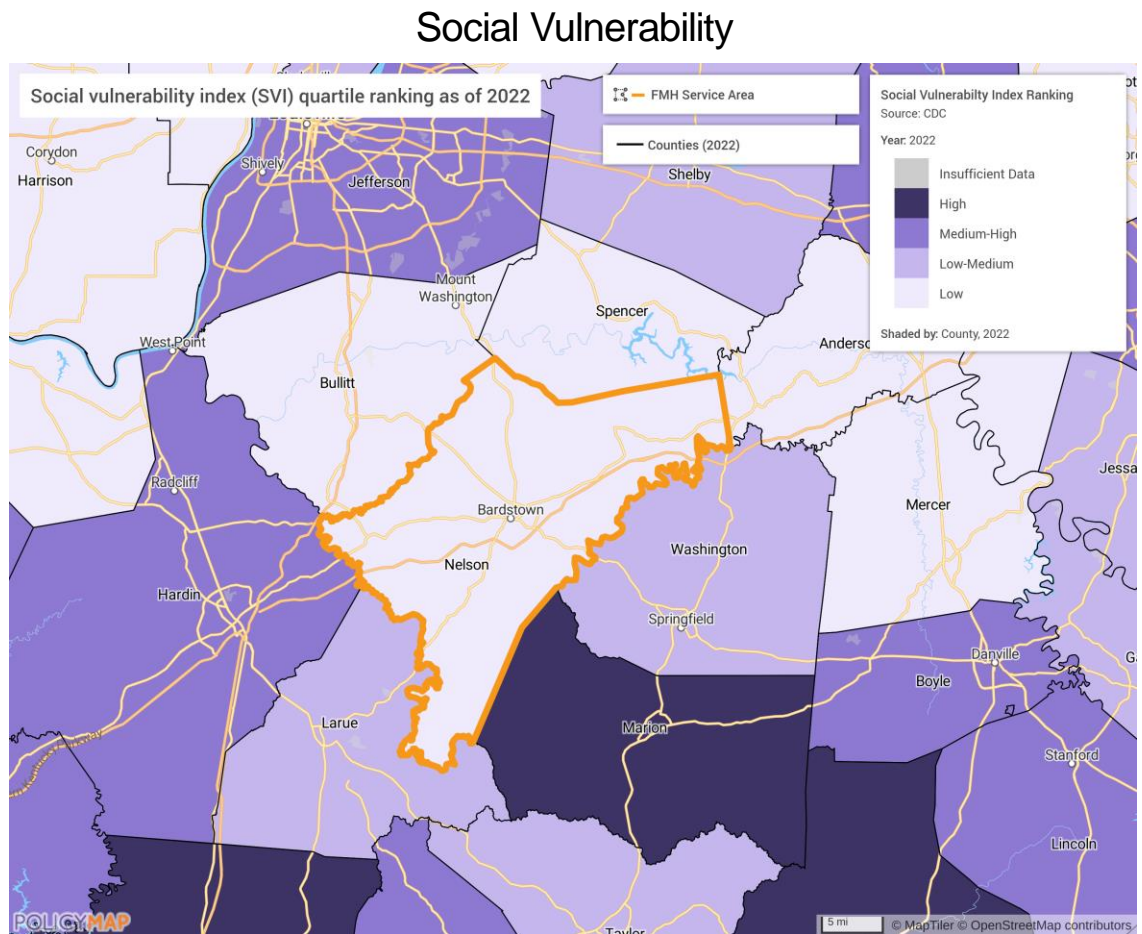
Social vulnerability refers to the potential negative effects on communities caused by external stresses on human health. Such stresses include natural or human-caused disasters, or disease outbreaks. Reducing social vulnerability can decrease both human suffering and economic loss.

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 Flaget Memorial Hospital Service Area with the highest social vulnerability.

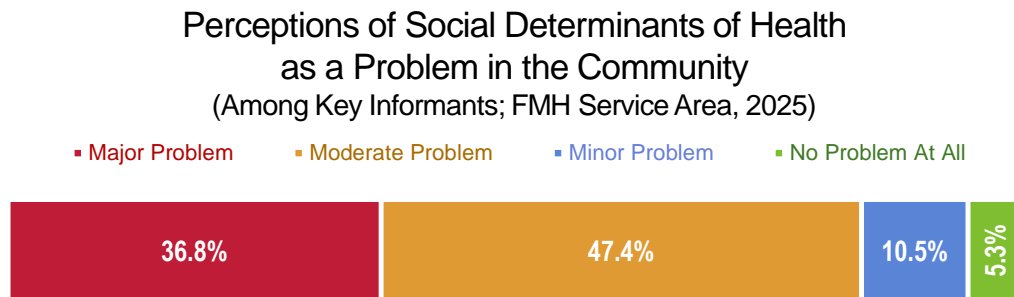


Source: Agency for Toxic Substances and Disease Registry, Centers for Disease Control and Prevention (CDC). Accessed via PolicyMap.



# 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:



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:

## Housing

The concept of housing first has to be taken seriously by local leaders and local employers. Until people have stable housing, finding a job or engaging in health care isn't important or even feasible. — Public Health Representative

There is a huge shortage of public housing and housing in general in our area. — Community Leader

Housing is a major issue. There are no resources, and the Section 8 wait list is horrific. There are concerns for the poverty line and livable wages, as well as ongoing affordable education for working parents. — Community Leader

Housing is a major issue that many groups are talking about right now. There is not a lot of attention to environmental issues in the area. — Community Leader

## Income/Poverty

Poverty is extremely high/lack of resources. — Public Health Representative

Economic stability, social support, access to healthy affordable foods, related health risks, depending on how the person lives, type of work, discrimination based on race, sex, religion, gender, ethnicity, social background, — Community Leader

Low income prevents citizens from taking the meds the doctors order, Insufficient housing. It's a generational issue in our community. — Community Leader

## Impact on Quality of Life

An individual's health is not going to improve until the barriers they experience with SDOH are removed or reduced. — Public Health Representative

## Access to Affordable Healthy Food

Economic challenges – limited access to healthy food, safe housing and health care. Job opportunities – limited good, quality-paying jobs. Limited transportation. Lack of internet for ease of access for online opportunities in rural areas. Lack of public transportation. Chronic disease due to lifestyle factors, such as living in rural areas with less opportunities for work, healthy food choices, and transportation. — Community Leader

## Denial/Stigma

Stigma, transportation, income, housing, cost of living, etc. All these things are problems in seeking assistance. Pride. — Community Leader

## Vulnerable Populations

Large amount of unhoused population, no public transportation, relatively few food resources. — Health Care Provider



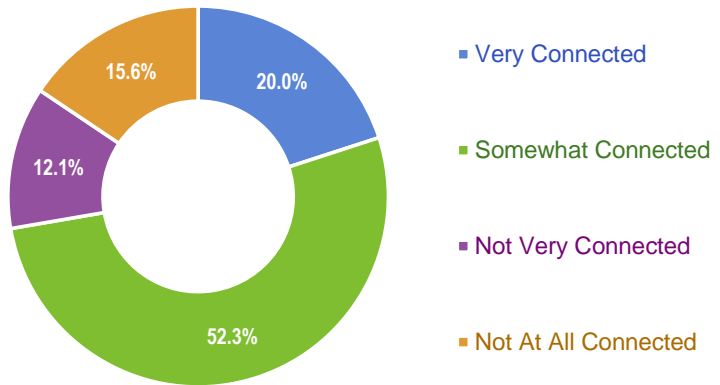
# CLIMATE, NATURE & HEALTH

## 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.

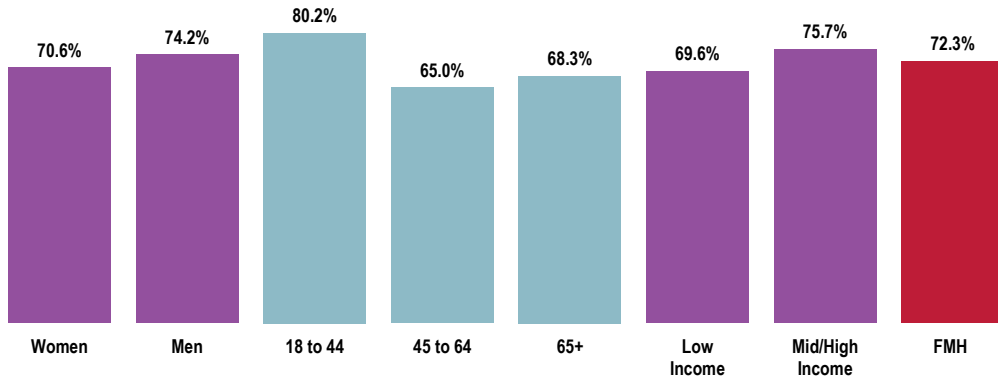
**PRC SURVEY** ▶ “To what extent do you feel that climate is connected to health risks? Would you say it is very connected, somewhat connected, not very connected, or not at all connected?”

Perception of Climate’s Connection to Health Risks  
(FMH 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”  
(FMH Service Area, 2025)

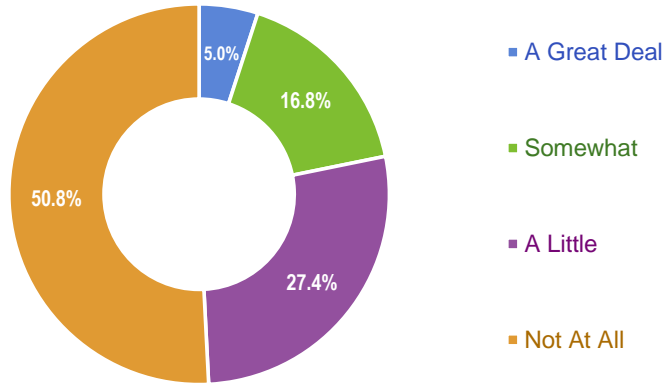


Sources: • 2025 PRC Community Health Survey, PRC, Inc. [Item 306]  
 Notes: • Asked of all respondents.  
 • In this case, climate refers to general weather conditions in an area or over a long period of time, such as storms, tornadoes, extreme heat, flooding, or drought.



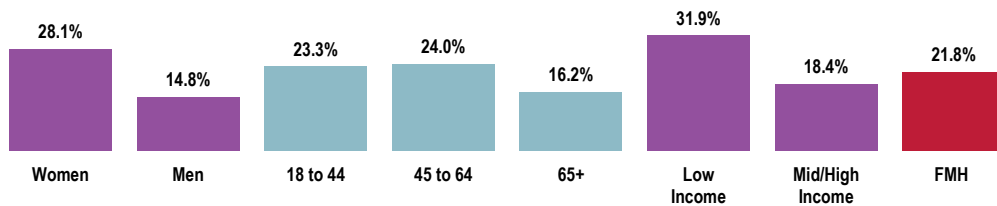
**PRC SURVEY** ▶ “In the past three years, to what extent has your health or well-being been impacted by weather events? Would you say a great deal, somewhat, a little, or not at all?”

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



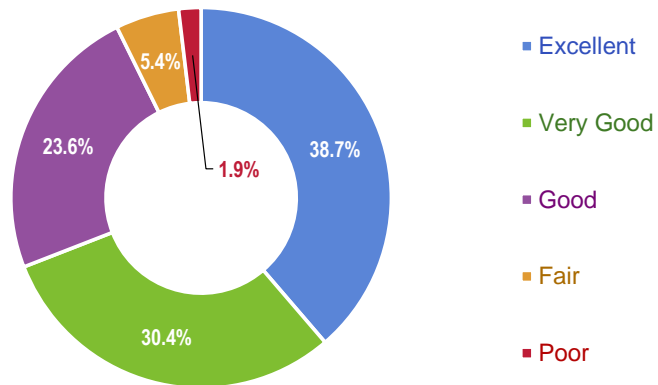
Sources: • 2025 PRC Community Health Survey, PRC, Inc. [Item 307]  
 Notes: • Asked of all respondents.



# Access to Nature, Parks & Greenspaces

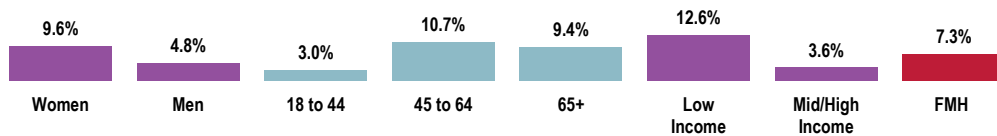
**PRC SURVEY** ▶ “How would you rate access to nature, parks, or greenspaces in your area?  
Would you say excellent, very good, good, fair, or poor?”

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

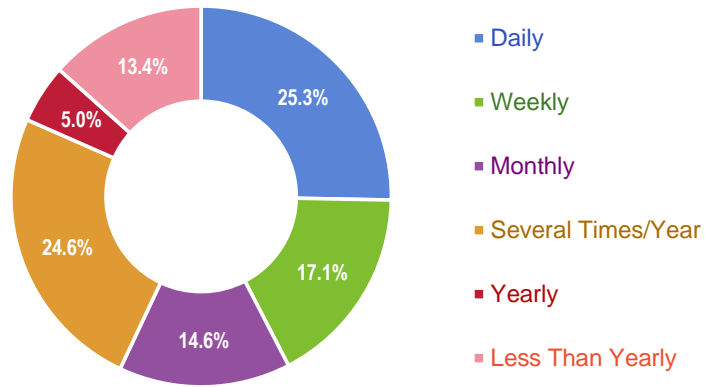


Sources: • 2025 PRC Community Health Survey, PRC, Inc. [Item 308]  
Notes: • Asked of all respondents.



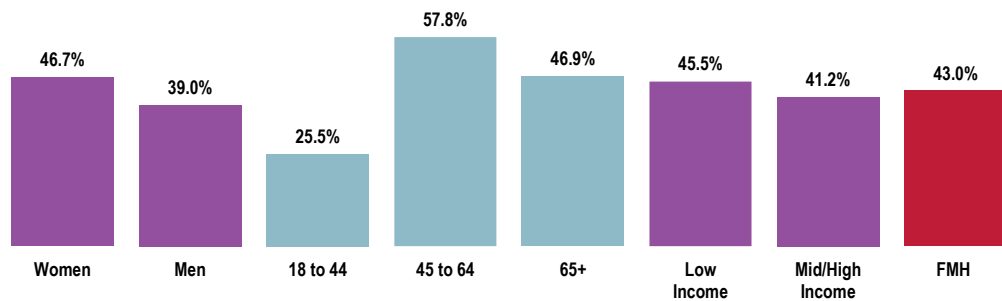
**PRC SURVEY** ▶ “How often do you spend time in nature, parks, or greenspaces in your area?”

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



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

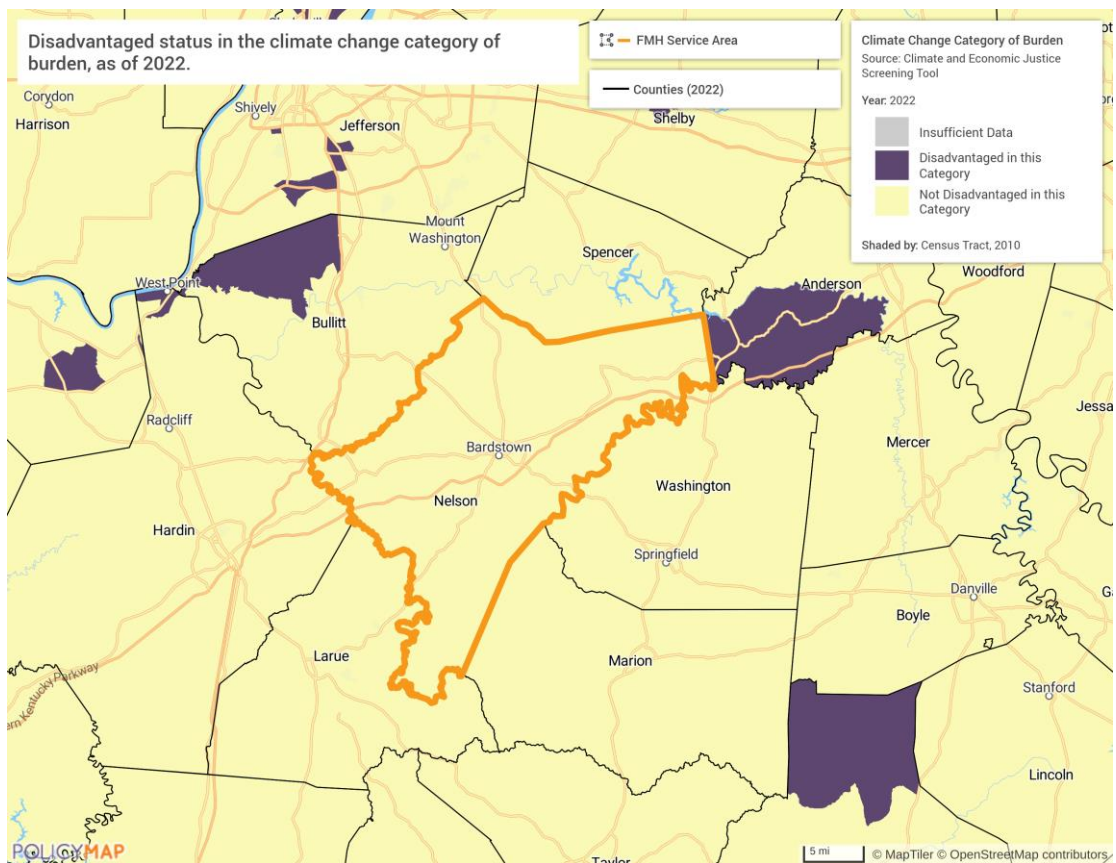


# Climate Change Burden

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 Flaget Memorial 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.

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.

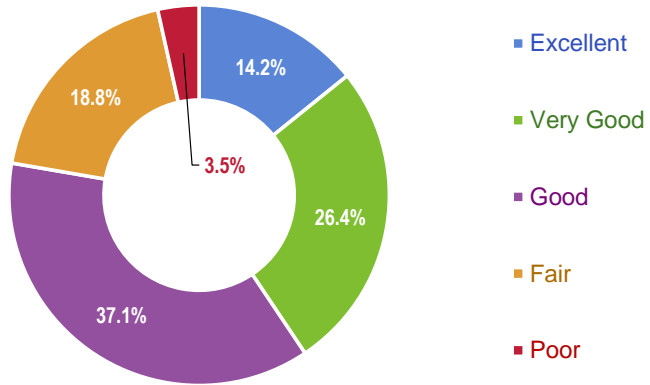


# HEALTH STATUS

## Overall Health

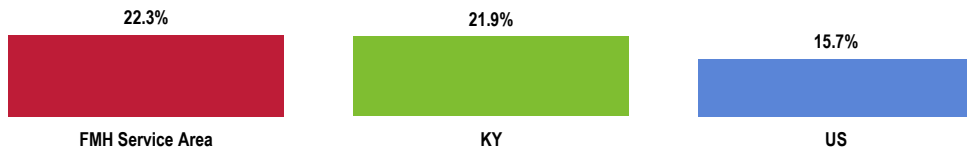
**PRC SURVEY** ▶ “Would you say that in general your health is: excellent, very good, good, fair, or poor?”

Self-Reported Health Status  
(FMH Service Area, 2025)



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

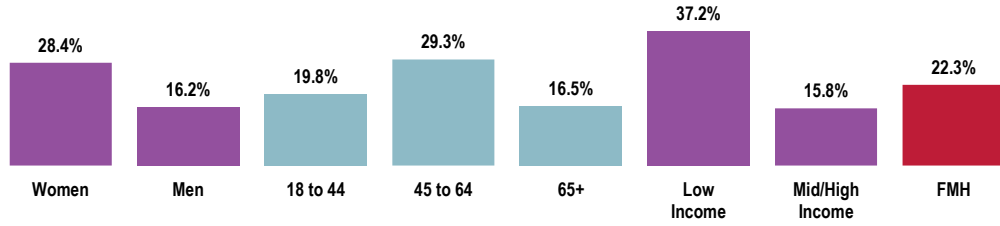
## Experience “Fair” or “Poor” Overall Health



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 (FMH 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.

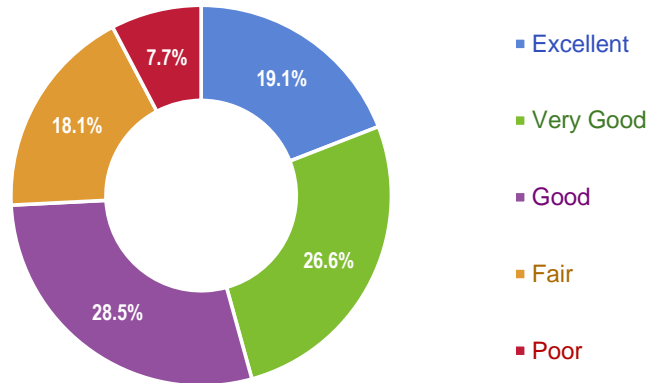
In addition, mental health and physical health are closely connected. Mental disorders like depression and anxiety can affect people's ability to take part in healthy behaviors. Similarly, physical health problems can make it harder for people to get treatment for mental disorders. Increasing screening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

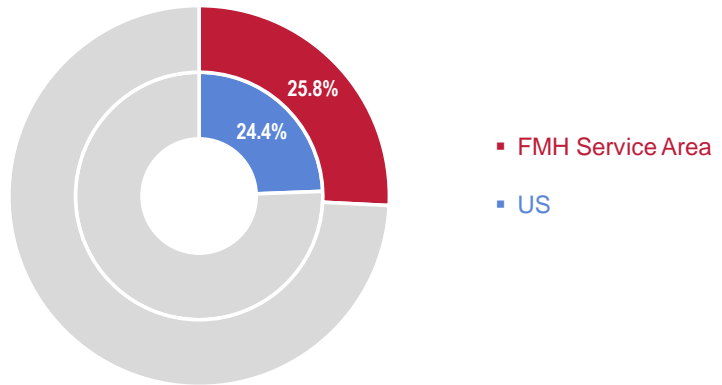
Self-Reported Mental Health Status  
(FMH Service Area, 2025)



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



## Experience “Fair” or “Poor” Mental Health



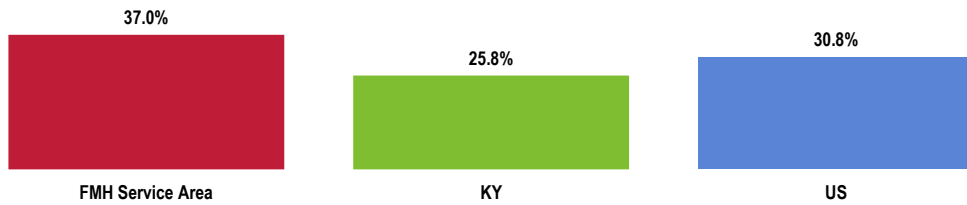
Sources: • 2025 PRC Community Health Survey, PRC, Inc. [Item 77]  
 • 2023 PRC National Health Survey, PRC, Inc.  
 Notes: • Asked of all respondents.

## 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



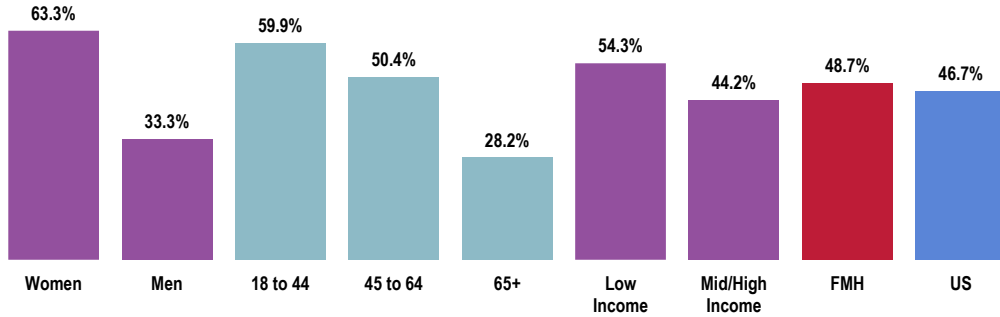
Sources: • 2025 PRC Community Health Survey, PRC, Inc. [Item 80]  
 • Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2022 Kentucky data.  
 • 2023 PRC National Health Survey,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



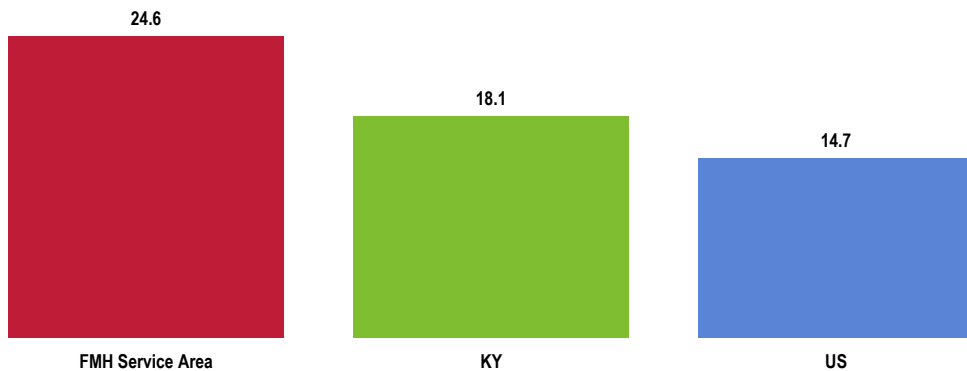
Sources: • 2025 PRC Community Health Survey, PRC, Inc. [Item 78]  
• 2023 PRC National Health Survey, PRC, Inc.

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.

Notes: • US Department of Health and Human Services. Healthy People 2030. <https://health.gov/healthypeople>  
• 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.

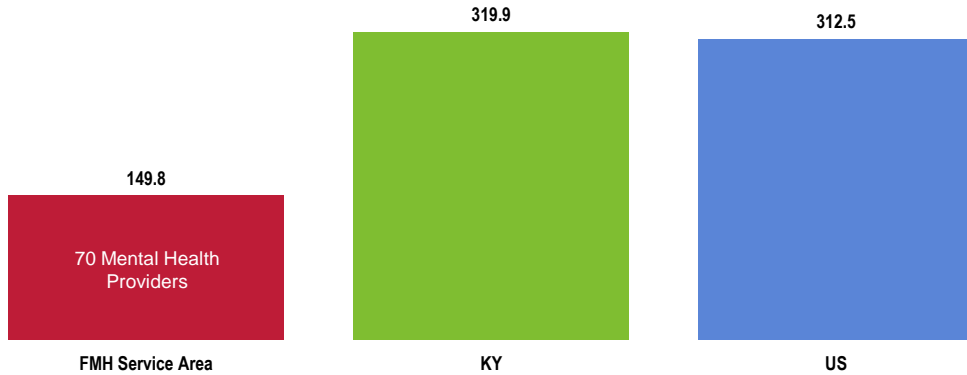


## Mental Health Treatment

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.

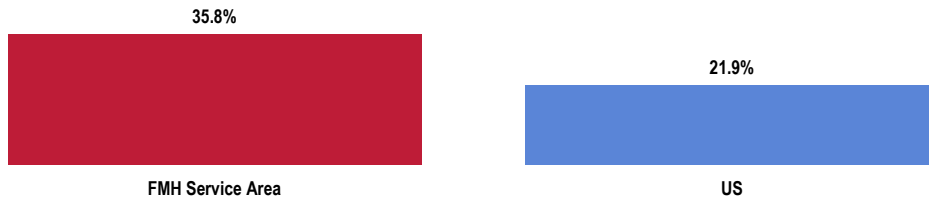
Number of Mental Health Providers per 100,000 Population (2024)



- 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

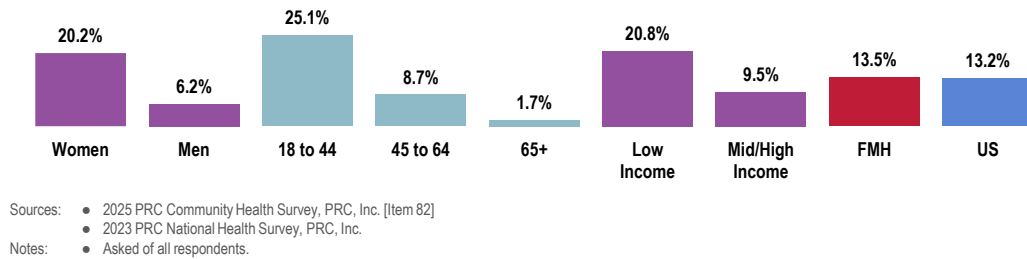


- Sources:
- 2025 PRC Community Health Survey, PRC, Inc. [Item 81]
  - 2023 PRC National Health Survey, PRC, Inc.
- Notes:
- Asked of all respondents.
  - Includes individuals now taking medication or otherwise receiving treatment for any type of mental health condition or emotional problem.



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

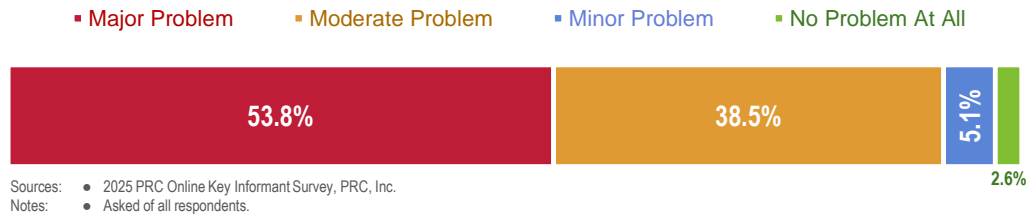
### Unable to Get Mental Health Services When Needed in the Past Year (FMH Service Area, 2025)



### Key Informant Input: Mental Health

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

### Perceptions of Mental Health as a Problem in the Community (Among Key Informants; FMH Service Area, 2025)



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

#### Access to Care/Services

- Residents continue to struggle with their mental health. Access, transportation, cost, and stigma. — Community Leader
- Access to resources. Continued medical coverage. — Community Leader
- Wait time for an appointment. — Public Health Representative
- Lack of access to mental health professionals. Stigma for treatment. — Community Leader
- Lack of resources and support. Wait lists for all providers, or lack of accepting insurances. It makes it challenging for people who want to receive help. — Community Leader
- Access to care that is consistent and timely. Provider burnout creates gaps in care and mistrust among those that need care. — Public Health Representative
- Lack of mental health providers. — Public Health Representative
- Access to mental health services and stigma of mental health challenges. — Public Health Representative



Access to care and stigma. — Health Care Provider

## Denial/Stigma

Stigma around mental health and asking for help. Lack of affordable counseling services. — Public Health Representative

## Diagnosis/Treatment

Finding the treatment for their symptoms. This is a major issue. Those who have mental inquest warrants have to go outside the county for treatment. — Community Leader

## Housing

Basic, everyday living like keeping housing, affordability, drugs, being unemployed, hereditary, criminal activity, and lack of affordable medication. — Community Leader

## Impact on Quality of Life

People with mental health concerns struggle with daily life tasks: employment, maintaining proper care/treatment for their mental health needs. They often resort to alcohol and drugs to cope, and they struggle with their physical health (obesity, heart problems, etc.). — Community Leader

## Disease Management

People with mental health issues tend to stop taking their medication once they start feeling better, or they do not feel that they have an issue to seek out treatment. — Community Leader



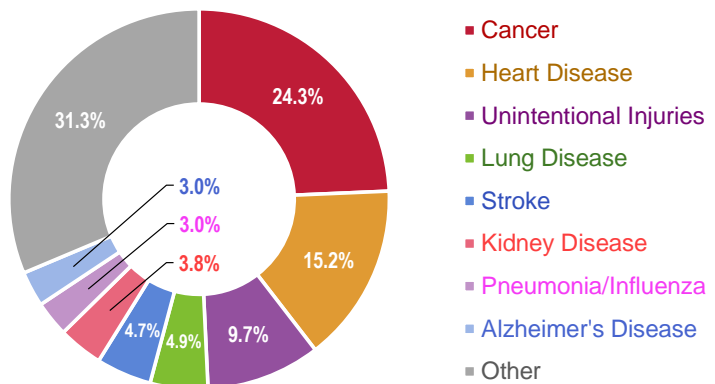
# DEATH, DISEASE & CHRONIC CONDITIONS

## Leading Causes of Death

### Distribution of Deaths by Cause

The following outlines leading causes of death in the community.

Leading Causes of Death  
(FMH Service Area, 2023)



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)

	FMH Service Area	KY	US	Healthy People 2030
<b>Cancers (Malignant Neoplasms)</b>	259.5	228.6	182.5	122.7
<b>Heart Disease</b>	196.2	257.1	209.5	127.4*
<b>Unintentional Injuries</b>	93.5	94.3	67.8	43.2
<b>Lung Disease (Chronic Lower Respiratory Disease)</b>	71.0	72.3	43.5	—
<b>Unintentional Drug-Induced Deaths</b>	45.0	48.9	29.7	—
<b>Stroke (Cerebrovascular Disease)</b>	43.6	52.7	49.3	33.4
<b>Alzheimer's Disease</b>	34.5	34.6	35.8	—
<b>Diabetes</b>	28.8	37.8	30.5	—
<b>Kidney Disease</b>	28.1	26.3	16.9	—
<b>Cirrhosis/Liver Disease</b>	25.3	20.2	16.4	10.9
<b>Suicide</b>	24.6	18.1	14.7	12.8
<b>Pneumonia/Influenza</b>	21.1	17.8	13.4	—
<b>Alcohol-Induced Deaths</b>	16.2	14.7	15.7	—
<b>Motor Vehicle Crashes</b>	16.2	17.5	13.3	10.1
<b>Homicide [2019-2023]</b>	3.6	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.

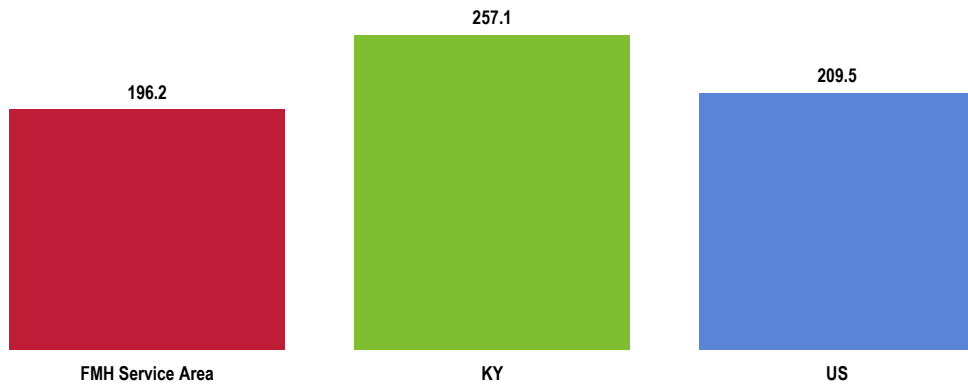
– Healthy People 2030 (<https://health.gov/healthypeople>)

## 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.

**Heart Disease Mortality**  
(2021-2023 Annual Average Deaths per 100,000 Population)  
Healthy People 2030 = 127.4 or Lower (Adjusted)

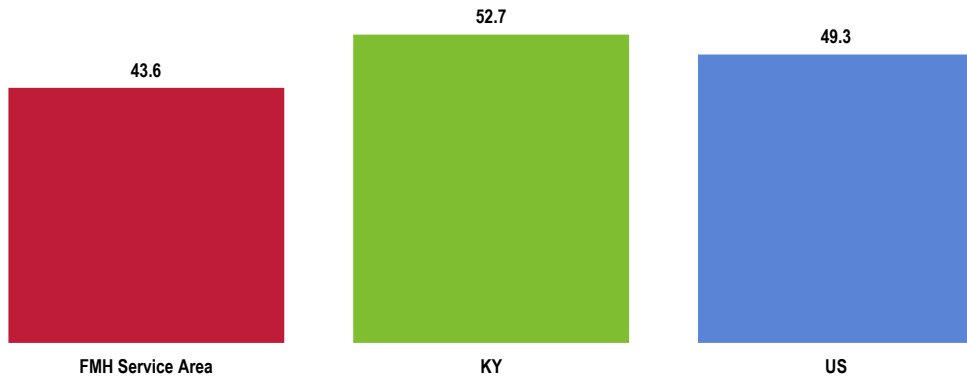


- Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted February 2025.
  - US Department of Health and Human Services. Healthy People 2030. <https://health.gov/healthypeople>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

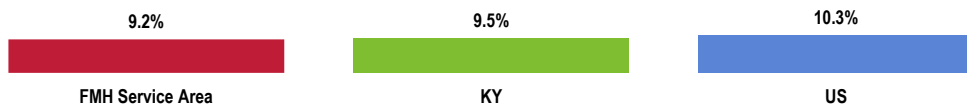
Notes: 

- 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.

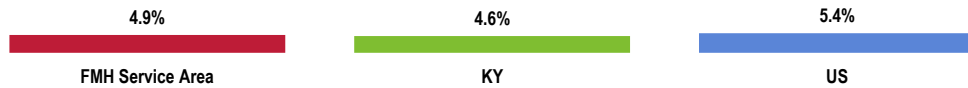
Notes: 

- 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

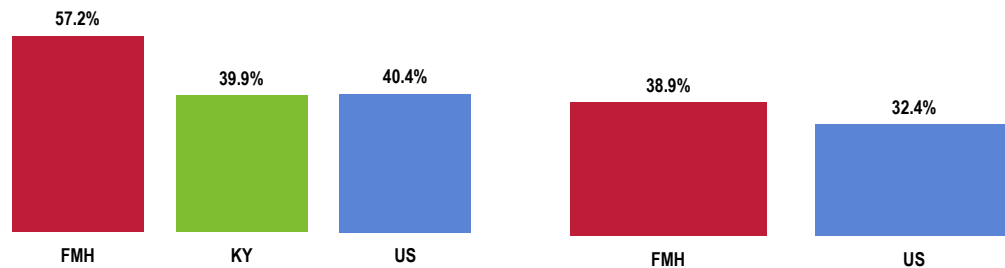
### Blood Pressure & Cholesterol

**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:

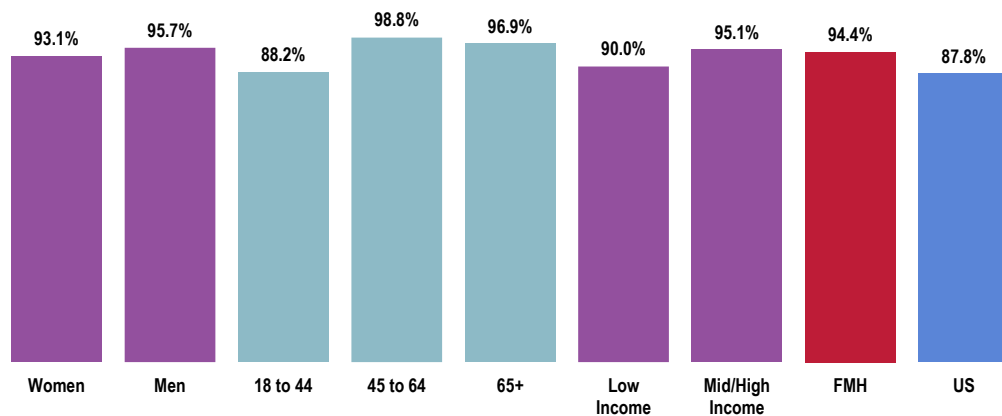
- High Blood Pressure
- High Blood Cholesterol
- Cigarette Smoking
- Physical Inactivity
- Overweight/Obesity

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 Flaget Memorial 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**  
(FMH Service Area, 2025)



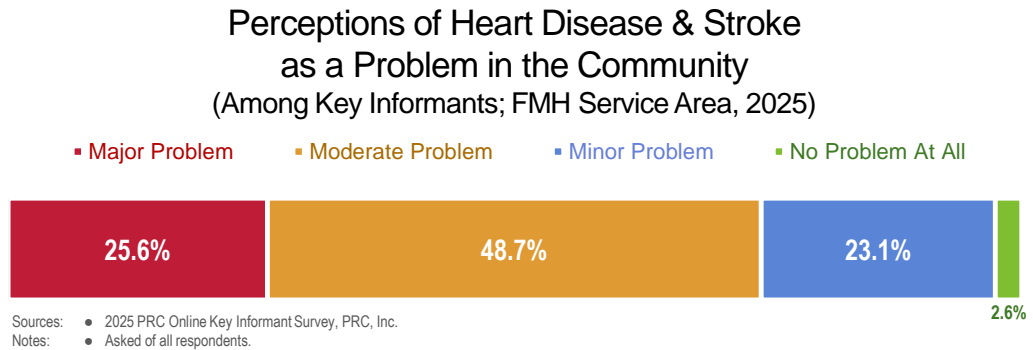
Sources: • 2025 PRC Community Health Survey, PRC, Inc. [Item 100]  
• 2023 PRC National Health Survey, PRC, Inc.

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:

### Incidence/Prevalence

- I know of several people who have either died of heart disease and stroke or who have ongoing problems with their heart and neurological issues. — Community Leader
- The sheer number of people I know who are on blood pressure medicine and/or have to have stints installed to deal with these problems is excessive in my mind. — Community Leader
- They are in every community. — Community Leader
- Unknown cause, but high prevalence of cardiac and stroke care needs for our patients. — Community Leader
- I have attended several funerals in 2024 from death of stroke or cardiac arrest. — Public Health Representative

### Tobacco Use

- Smoking and obesity are prevalent in our area, which lead to heart disease and stroke. Lack of exercise and availability of healthy foods lead to heart disease and stroke. — Public Health Representative

### Access to Care/Services

- With stroke, time is a factor. Hospitals need to have round-the-clock staffing to deal with strokes in an effective manner. — Community Leader
- One reason is people can't afford the cardiologist or the food to control it. — Community Leader



# Cancer

## ABOUT CANCER

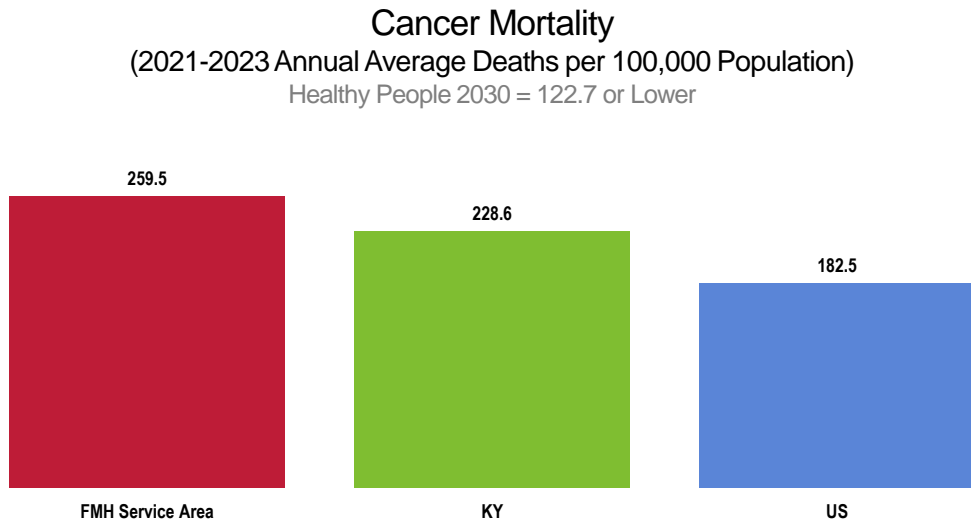
Cancer is the second leading cause of death in the United States. ...The cancer death rate has declined in recent decades, but over 600,000 people still die from cancer each year in the United States. Death rates are higher for some cancers and in some racial/ethnic minority groups. These disparities 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)

	FMH Service Area	KY	US	Healthy People 2030
<b>ALL CANCERS</b>	<b>259.5</b>	<b>228.6</b>	<b>182.5</b>	<b>122.7</b>
<b>Lung Cancer</b>	<b>66.8</b>	<b>64.8</b>	<b>39.8</b>	<b>25.1</b>
<b>Female Breast Cancer</b>	<b>26.5</b>	<b>27.6</b>	<b>25.1</b>	<b>15.3</b>
<b>Colorectal Cancer</b>	<b>26.0</b>	<b>21.3</b>	<b>16.3</b>	<b>8.9</b>
<b>Prostate Cancer</b>	<b>24.1</b>	<b>19.1</b>	<b>20.1</b>	<b>16.9</b>

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>

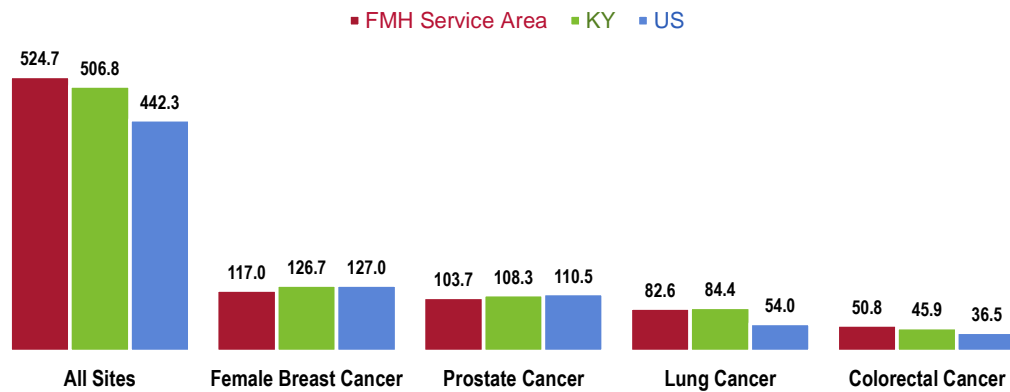
Notes: 

- 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 (2016-2020)



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](http://sparkmap.org)).

Notes: 

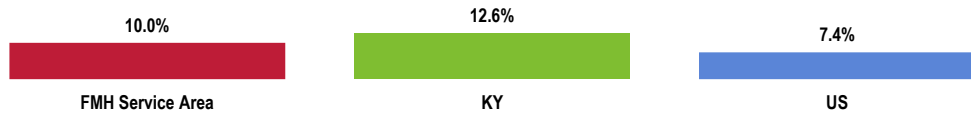
- This indicator reports the incidence rate (cases per 100,000 population per year) for select cancers.



## Prevalence of Cancer

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

### Prevalence of Cancer



- Sources:
- 2025 PRC Community Health Survey, PRC, Inc. [Item 24]
  - 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

### 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.



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

### 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?”

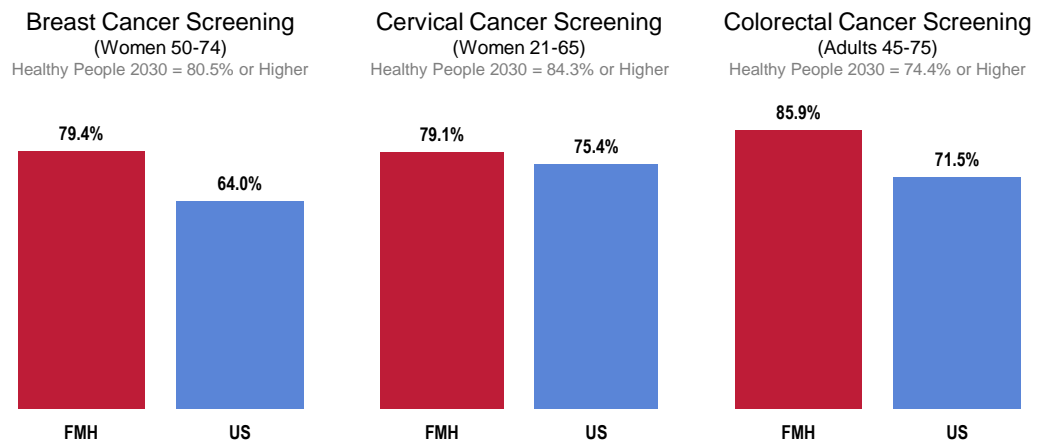
“Appropriate cervical cancer screening” includes Pap smear testing (cervical cytology) every three years in women age 21 to 29 and Pap smear testing and/or HPV testing every 5 years in women age 30 to 65.

### 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.

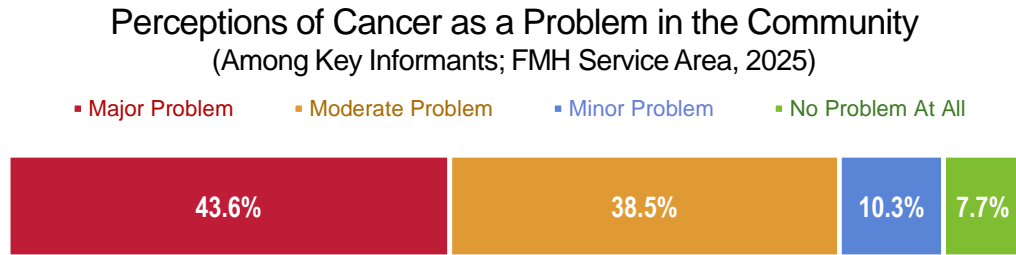


Sources: ● 2025 PRC Community Health Survey, PRC, Inc. [Items 101-103]  
 ● 2023 PRC National Health Survey, PRC, Inc.  
 ● US Department of Health and Human Services. Healthy People 2030. <https://health.gov/healthypeople>  
 Notes: ● Each indicator is shown among the gender and/or age group specified.  
 ● 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:



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

- Cancer appears to be widespread, more in our community than others. For example. I am from a family of four. My parents, brother, and I have all been diagnosed with cancer. Both of my parents died from it, and I have had it twice in the last 15 years. I know of many families with records like this. — Community Leader
- Seems like cancer touches everyone in some way, and there's no cure. — Community Leader
- Kentucky has one of the highest rates of new cancers and death from cancer in the nation. — Community Leader
- There are many Nelson County residents who have been diagnosed with cancer. — Community Leader
- I have had numerous friends and family, both young and old, pass away or have undergone treatment for cancer. — Community Leader
- Seems to me that more people are getting diagnosis younger and younger. — Public Health Representative
- Just seems to be an ongoing issue and rise in the number of ill residents. — Community Leader
- In my opinion, it affects our citizens across the board, including the poor and wealthy. — Community Leader
- High rates of colon cancer. — Community Leader
- I see many more people diagnosed with cancer and a lot of people with brain cancer. — Community Leader

### Transportation

- Affects many individuals, as well as their families. Need for transportation to chemo and treatments, as well as other doctor appointments. Long battle with minimum support in our local communities. — Community Leader



# 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.

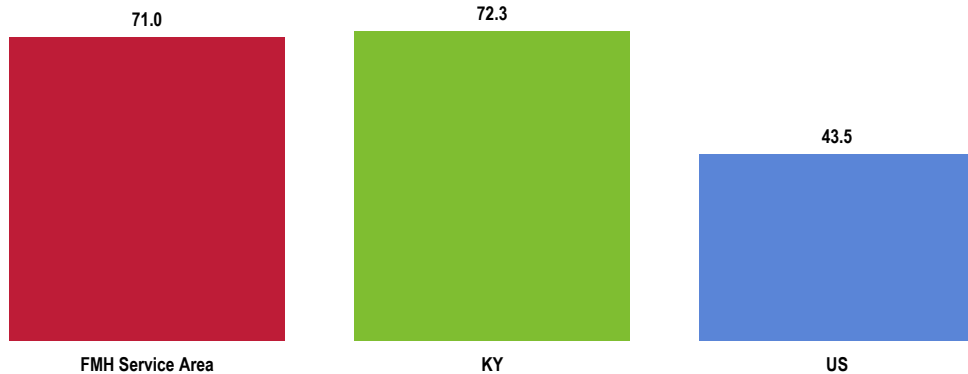
– Healthy People 2030 (<https://health.gov/healthypeople>)

## 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.

**Lung Disease Mortality**  
(2021-2023 Annual Average Deaths per 100,000 Population)



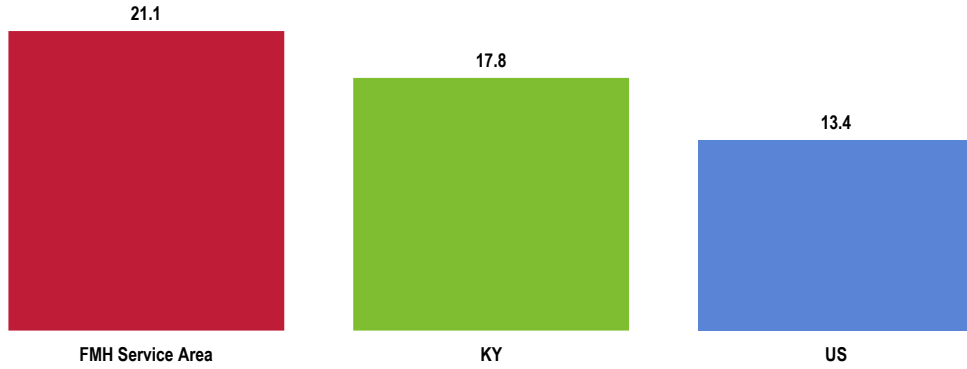
- Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted February 2025.
- Notes:
- Deaths are coded using the Tenth Revision of the International Statistical Classification 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.

### Pneumonia/Influenza Mortality (2021-2023 Annual Average Deaths per 100,000 Population)



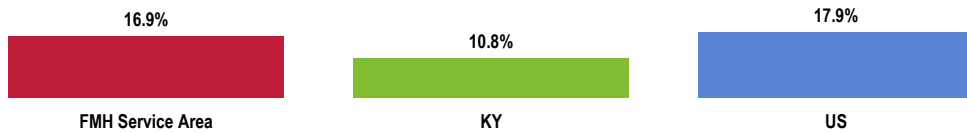
- Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted February 2025.
- Notes:
- Deaths are coded using the Tenth Revision of the International Statistical Classification 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?”

### Prevalence of Asthma



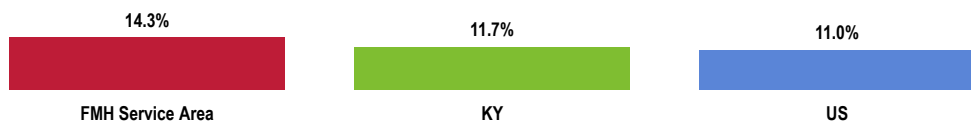
- Sources:
- 2025 PRC Community Health Survey, PRC, Inc. [Item 26]
  - Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2022 Kentucky data.
  - 2023 PRC National Health Survey,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



## 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?”

### Prevalence of Chronic Obstructive Pulmonary Disease (COPD)

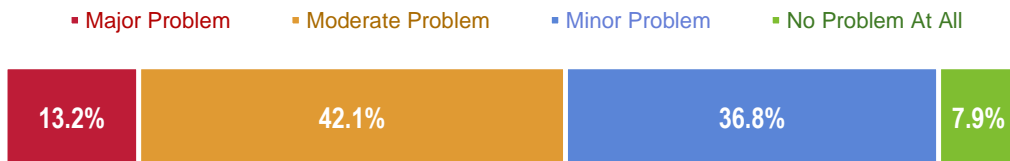


- Sources:
- 2025 PRC Community Health Survey, PRC, Inc. [Item 21]
  - Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2022 Kentucky data.
  - 2023 PRC National Health Survey,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

### Perceptions of Respiratory Disease as a Problem in the Community (Among Key Informants; FMH 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:

#### Tobacco Use

Breathing is essential for life. Kentucky has a large population of smokers and, therefore, lung cancer patients. COVID-19 hit nonsmokers who otherwise were at risk. — Community Leader

#### Incidence/Prevalence

I believe our community had a larger-than-average number of deaths related to COVID and now the same for the population that smokes. — 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.

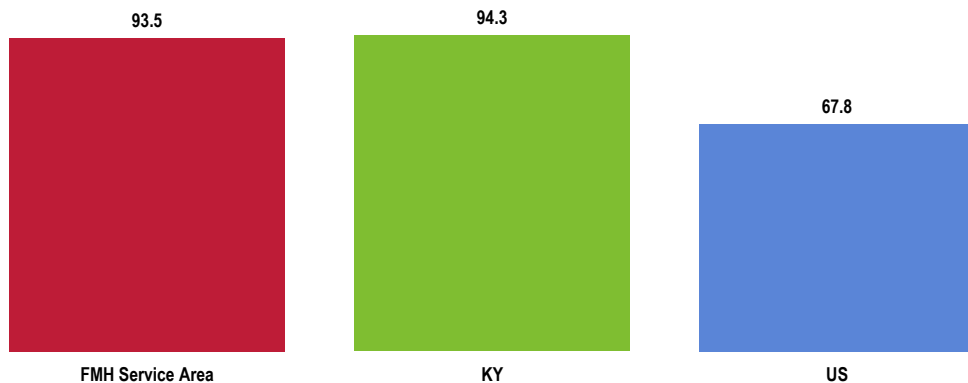
– Healthy People 2030 (<https://health.gov/healthypeople>)

## Unintentional Injury

### Unintentional Injury Deaths

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

**Unintentional Injury Mortality**  
(2021-2023 Annual Average Deaths per 100,000 Population)  
Healthy People 2030 = 43.2 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: 

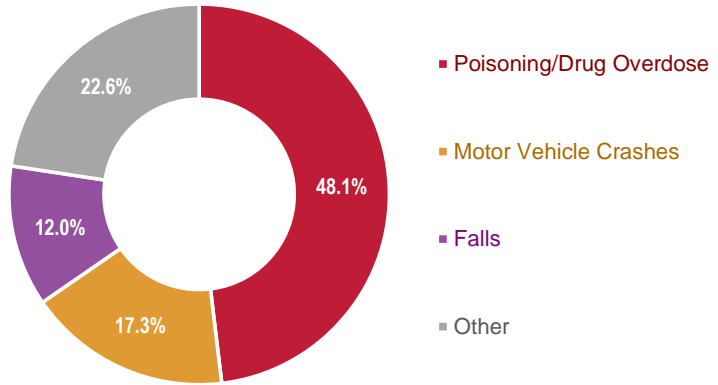
- Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
- Rates are per 100,000 population.



## Leading Causes of Unintentional Injury Deaths

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

### Leading Causes of Unintentional Injury Deaths (FMH Service Area, 2021-2023)



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.

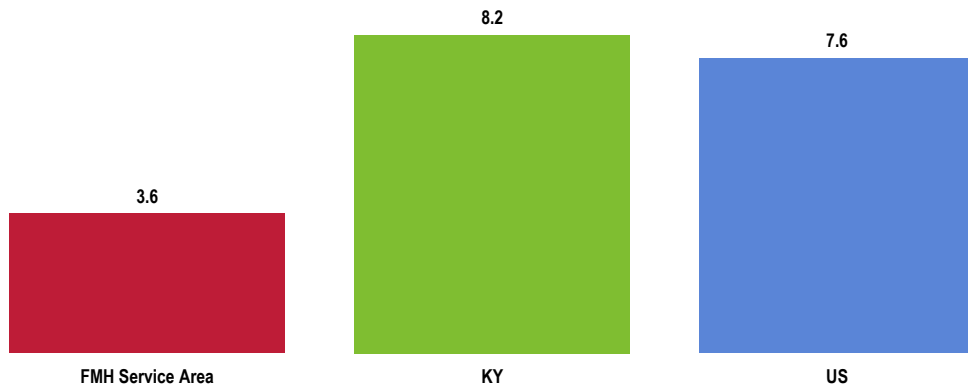
**RELATED ISSUE**  
For more information about unintentional drug-induced deaths, see also *Substance Use* in the **Modifiable Health Risks** section of this report.

## Intentional Injury (Violence)

### Homicide Deaths

Mortality attributed to homicide is shown in the following chart.

### Homicide Mortality (2019-2023 Annual Average Deaths per 100,000 Population) Healthy People 2030 = 5.5 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.

Notes: • US Department of Health and Human Services. Healthy People 2030. <https://health.gov/healthypeople>  
• 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.

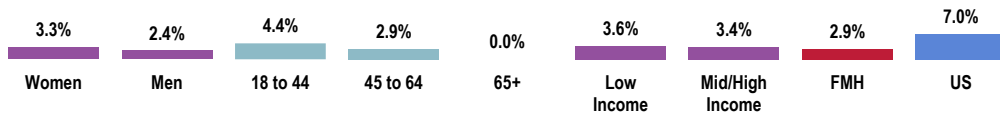
**RELATED ISSUE**  
See also *Mental Health (Suicide)* in the **General Health Status** section of this report.



## 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 (FMH Service Area, 2025)

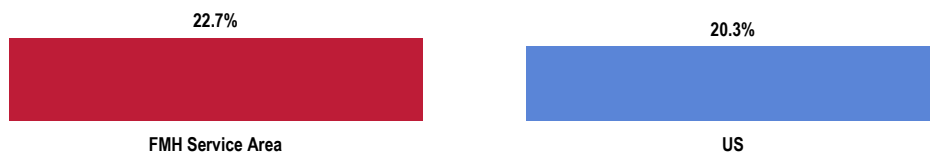


Sources: • 2025 PRC Community Health Survey, PRC, Inc. [Item 32]  
• 2023 PRC National Health Survey, PRC, Inc.  
Notes: • Asked of all respondents.

## 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



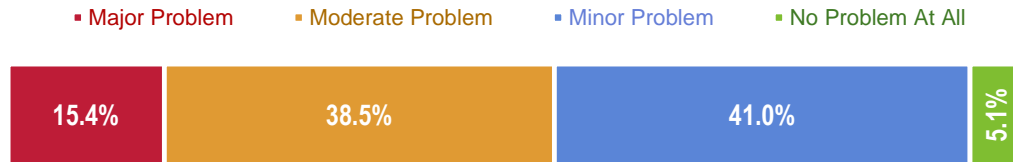
Sources: • 2025 PRC Community Health Survey, PRC, Inc. [Item 33]  
• 2023 PRC National Health Survey, PRC, Inc.  
Notes: • Asked of all respondents.



## Key Informant Input: Injury & Violence

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

### Perceptions of Injury & Violence as a Problem in the Community (Among Key Informants; FMH 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:

#### Incidence/Prevalence

Injury deaths are higher than the state and national rates. — Public Health Representative

Injury is a very broad topic, but I believe that involves everything from motor vehicle accidents and suicide to falls and overdoses. Hospital billing charges for injuries in Nelson County reached well into the millions over the past three years, especially in the over-65 population. — Public Health Representative

#### Diagnosis/Treatment

The quality of care received within the community for this, I would assume is not great. I think we are just not equipped to handle such an issue. — Community Leader



# Diabetes

## ABOUT DIABETES

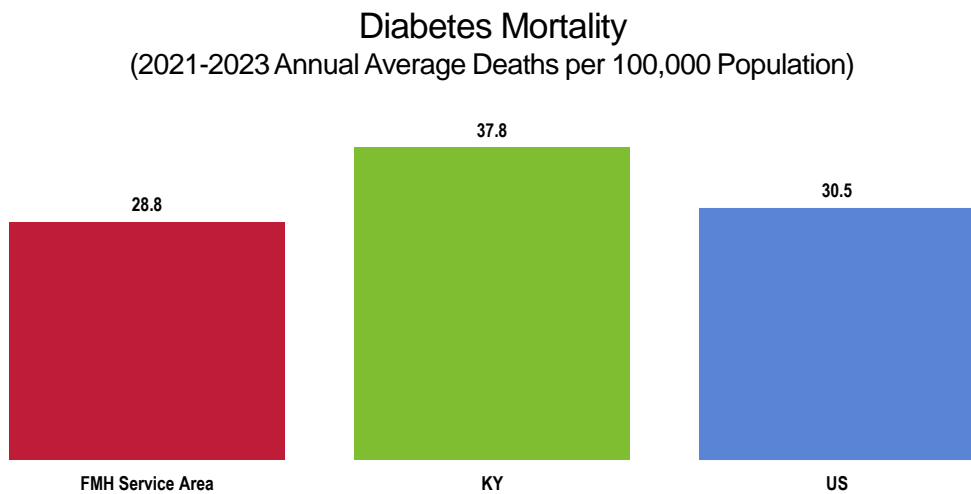
More than 30 million people in the United States have diabetes, and it's the seventh leading cause of death. ...Some racial/ethnic minorities are more likely to have diabetes. And many people with diabetes don't know they have it.

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.

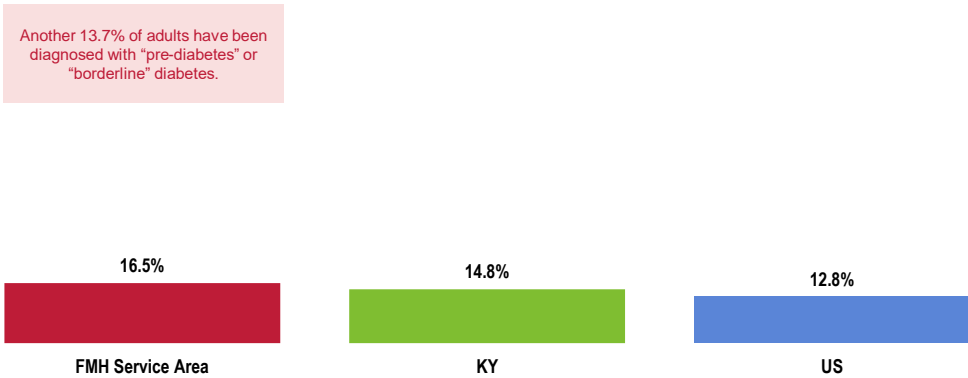


## Prevalence of Diabetes

**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?”

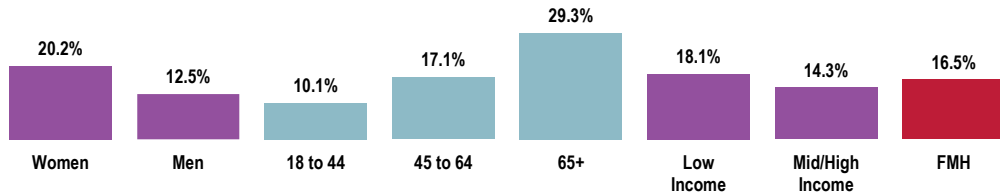
### Prevalence of Diabetes



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 (FMH Service Area, 2025)

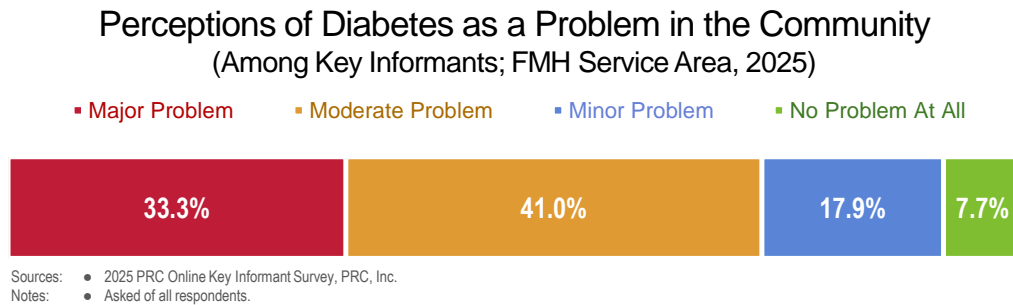


Sources: • 2025 PRC Community Health Survey, PRC, Inc. [Item 106]  
 Notes: • Asked of all respondents.  
 • Excludes gestational diabetes (occurring only during pregnancy).



## 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

- Low income to purchase healthier foods and access because of travel and age. — Community Leader
- Nutritious food is often the most expensive. Cost of supplies is very expensive. — Public Health Representative
- Healthy food options, dieticians, and physical activities for the elderly population. — Community Leader

### Nutrition & Physical Activity

- Diet, lack of physical activity and lack of education. — Community Leader
- Dietary guidance. — Community Leader
- Nutrition and physical activity. — Health Care Provider
- Food choices. Education about food choices and then making those appropriate choices. — Community Leader

### Affordable Medications/Supplies

- Access to the medication, being able to afford the medication, the foods available and affordable to maintain said condition. — Community Leader
- Insulin costs and costs of healthy food. — Community Leader

### Obesity

- Obesity affects diabetes and heart issues. — Community Leader

### Disease Management

- Self-sufficiency. — Public Health Representative

### Generational

- Many people with diabetes are from families who have been unhealthy, and this disease has become generational in many families. — Community Leader

### Lack of Providers

- No pediatric endocrinologist. — Public Health Representative



# Disabling Conditions

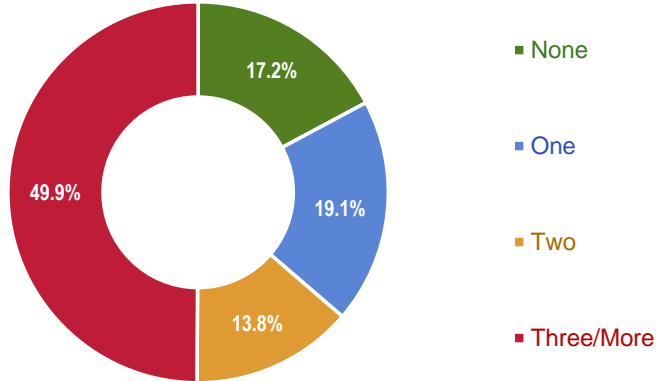
## Multiple Chronic Conditions

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.

For the purposes of this assessment, chronic conditions include:

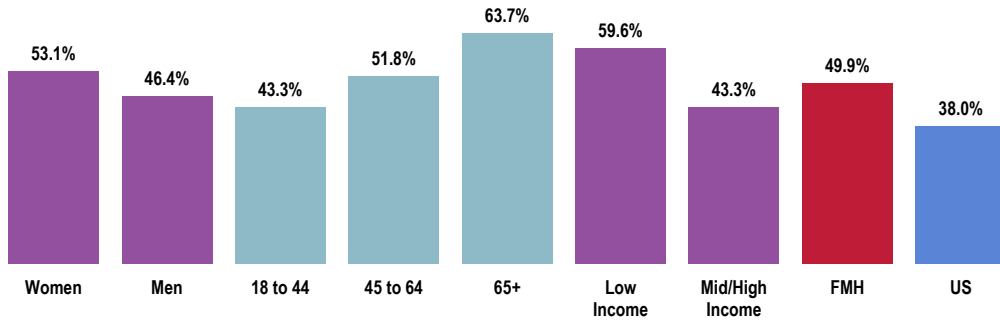
- Asthma
- Cancer
- Chronic pain
- Diabetes
- Diagnosed depression
- Heart disease
- High blood cholesterol
- High blood pressure
- Lung disease
- Obesity
- Stroke

**Number of Current Chronic Conditions  
(FMH 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  
(FMH 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.

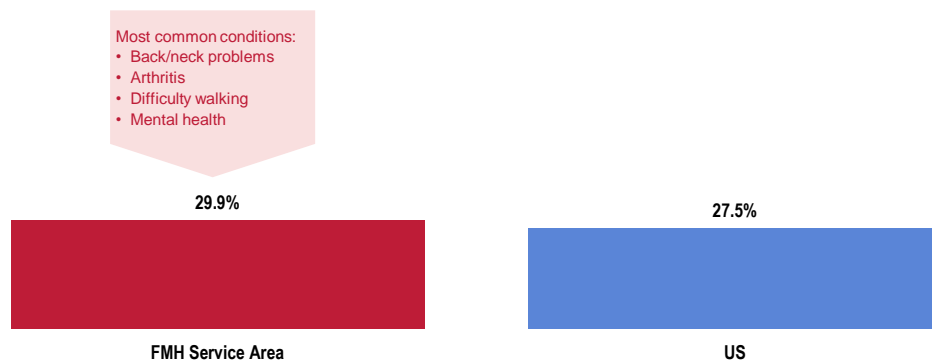
In addition, people with disabilities may have trouble finding a job, going to school, or getting around outside their homes. And they may experience daily stress related to these challenges. Efforts to make homes, schools, workplaces, and public places easier to access can help improve quality of life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



Sources: 

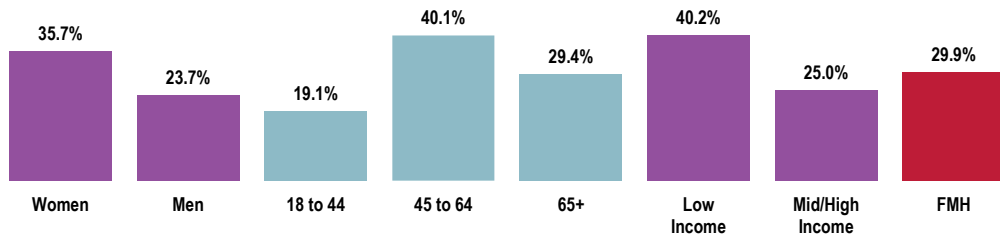
- 2025 PRC Community Health Survey, PRC, Inc. [Items 83-84]
- 2023 PRC National Health Survey, PRC, Inc.

Notes: 

- Asked of all respondents.



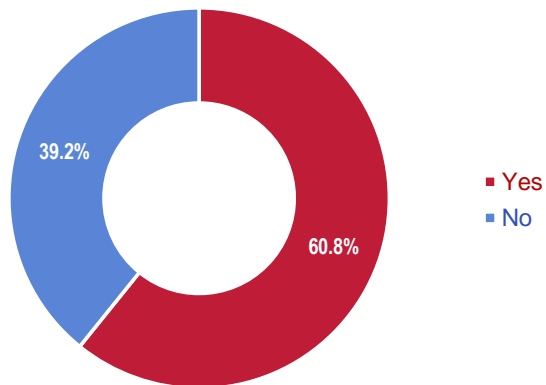
## Limited in Activities in Some Way Due to a Physical, Mental, or Emotional Problem (FMH Service Area, 2025)



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?”**

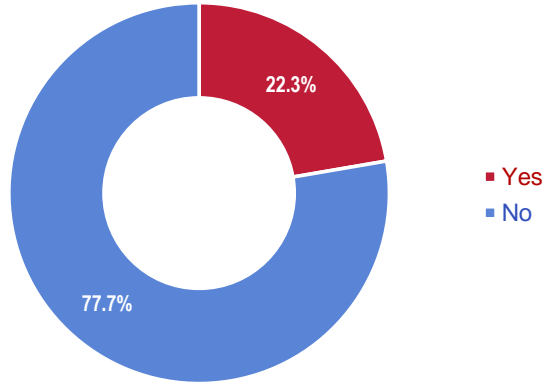
## Have Serious Difficulty Walking or Climbing Stairs (Respondents With Activity Limitations, 2025)



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



### Experience Difficulty Dressing or Bathing (Respondents With Activity Limitations, 2025)



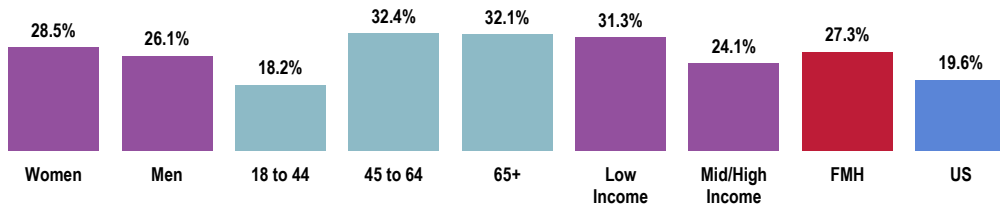
Sources: • 2025 PRC Community Health Survey, PRC, Inc. [Item 311]  
 Notes: • Asked of all respondents.

### 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.”)

### Experience High-Impact Chronic Pain (FMH Service Area, 2025)

Healthy People 2030 = 6.4% or Lower



Sources: • 2025 PRC Community Health Survey, PRC, Inc. [Item 311]  
 • 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.

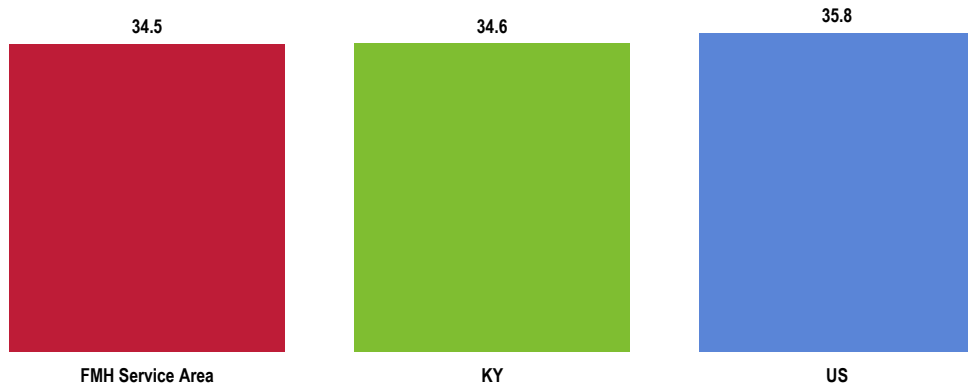
While there's no cure for Alzheimer's disease, early diagnosis and supportive care can improve quality of life. And efforts to make sure adults with symptoms of cognitive decline — including memory loss — are diagnosed early can help improve health outcomes in people with dementia. Interventions to address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

**Alzheimer's Disease Mortality**  
(2021-2023 Annual Average Deaths per 100,000 Population)



- 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.

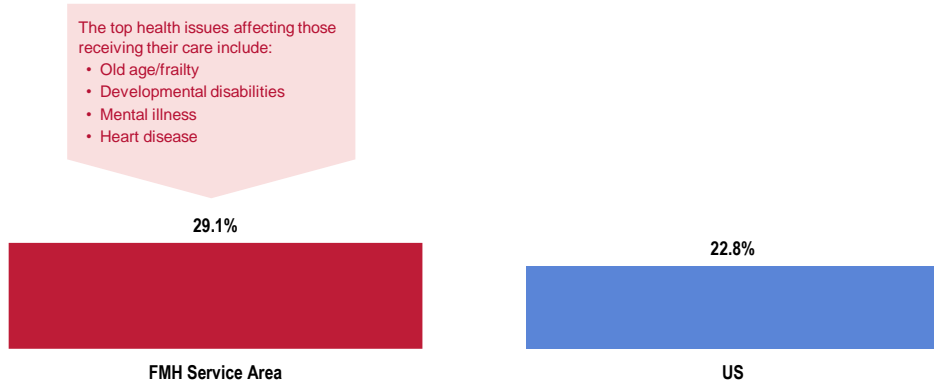


## Caregiving

**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?”

### Act as Caregiver to a Friend or Relative with a Health Problem, Long-Term Illness, or Disability

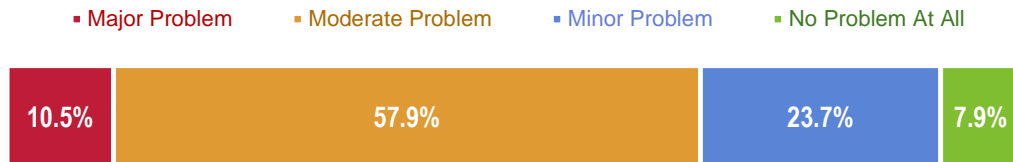


Sources: • 2025 PRC Community Health Survey, PRC, Inc. [Items 85-86]  
 • 2023 PRC National Health Survey, PRC, Inc.  
 Notes: • Asked of all respondents.

## Key Informant Input: Disabling Conditions

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

### Perceptions of Disabling Conditions as a Problem in the Community (Among Key Informants; FMH 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 Care/Services

Most vendors and community partners do not have handicap accessibility. The pending pool arena will be a great resource. — Community Leader

#### Awareness/Education

It’s hard to get out and receive the service, and a lot of people are not educated on the resources or education available. — Community Leader



## Insurance Issues

Physical therapy is often limited to a certain number of visits by insurance companies, and only if the person is progressing and getting better. Most older patients are not going to show great improvements but still need the physical therapy to maintain their mobility. Medicare does not pay for glasses or hearing aids, which are desperately needed for individuals' safety and quality of life. There is not much training for families that are caring for loved ones with dementia. Facilities that care specifically for dementia patients are expensive. Hiring a caregiver to stay with dementia patients so that their family members can work is also very costly. — Public Health Representative



# 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.

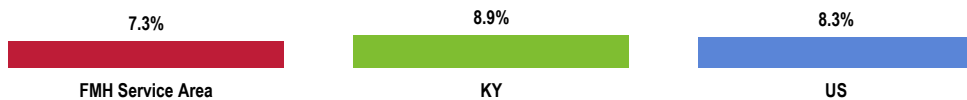
– Healthy People 2030 (<https://health.gov/healthypeople>)

## 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.

Low-Weight Births  
(Percent of Live Births, 2016-2022)

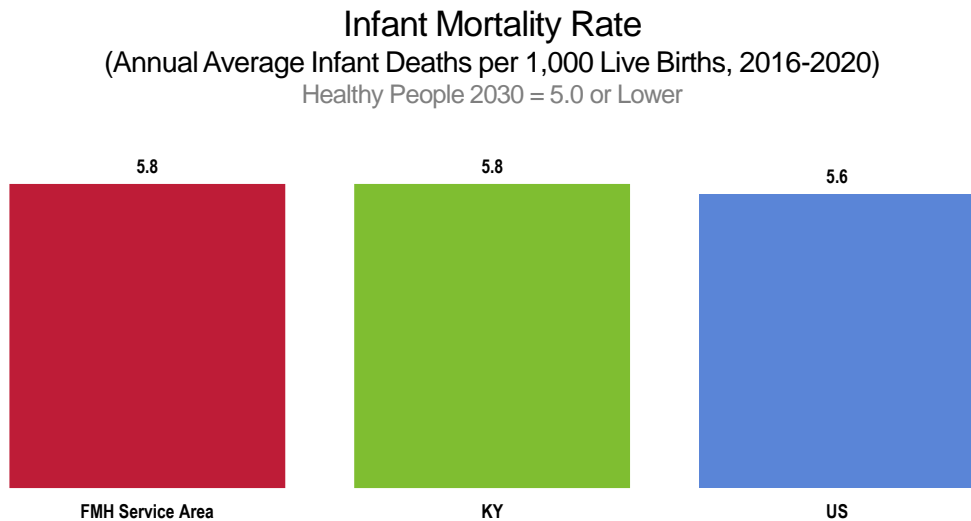


Sources: • University of Wisconsin Population Health Institute, County Health Rankings.  
Note: • This indicator reports the percentage of total births that are low birth weight (Under 2500g).



## 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>)

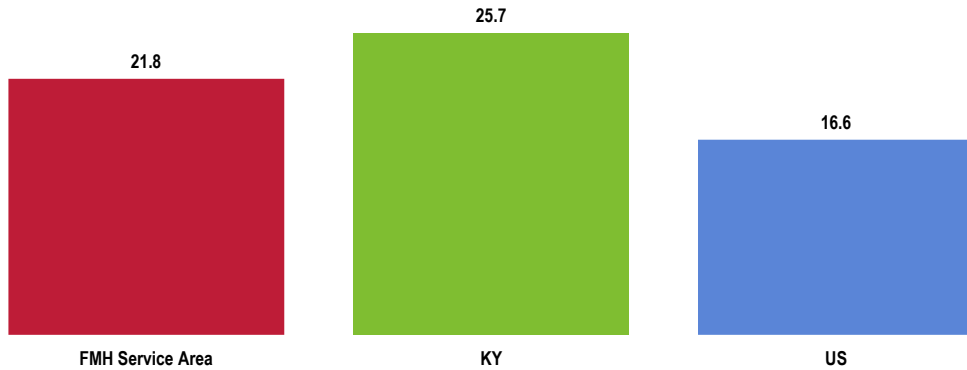


## Births to Adolescent Mothers

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.

**Teen Birth Rate**  
(Births to Adolescents Age 15-19 per 1,000 Females Age 15-19, 2016-2022)



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).

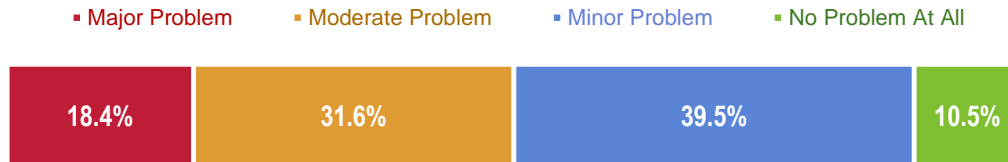
  
Notes: 

- 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:

**Perceptions of Infant Health & Family Planning as a Problem in the Community**  
(Among Key Informants; FMH 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 Care/Services

Infant and family health need to be accessible in a timely manner. Having to drive an hour to Louisville or Elizabethtown takes time away from work or family life. — Community Leader

As someone who has been pregnant here within the last year, the options and quality of care overall for people who are planning a family are slim to none. I personally had to travel outside of NC to find care that was up to my standards when regarding the delivery of a child/prenatal care (especially with gestational diabetes). — Community Leader

### Awareness/Education

No education on safe sex or safe pregnancy practices. — Public Health Representative



## Prenatal Care

I think a lot of women don't follow through with prenatal care. Many families with babies do not have insurance or do not qualify for Medicaid. — Community Leader

## Teen Pregnancy

Teen births are still higher than average, above the nation. And increasing positive childhood experiences is another major concern. Infant deaths are not above average at this time. — Public Health Representative

## Housing

Families continue to struggle with the cost of living as prices increase. A family of three can barely survive, let alone a family of five when just simply buying groceries. — Community Leader



# 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.

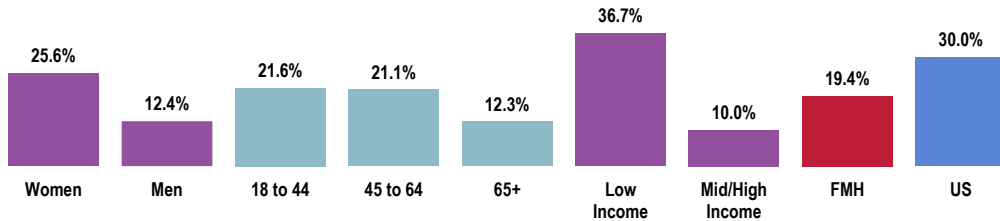
Some people don't have the information they need to choose healthy foods. Other people don't have access to healthy foods or can't afford to buy enough food. Public health interventions that focus on helping everyone get healthy foods are key to reducing food insecurity and hunger and improving health.

– 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  
(FMH Service Area, 2025)



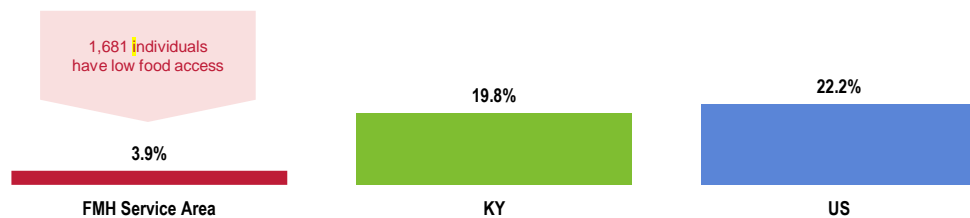
Sources: • 2025 PRC Community Health Survey, PRC, Inc. [Item 66]  
• 2023 PRC National Health Survey, PRC, Inc.  
Notes: • Asked of all respondents.



## 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.

### Population With Low Food Access (2019)



- 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.

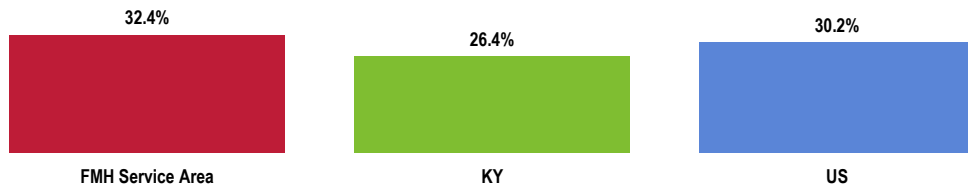
– Healthy People 2030 (<https://health.gov/healthypeople>)

## 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.

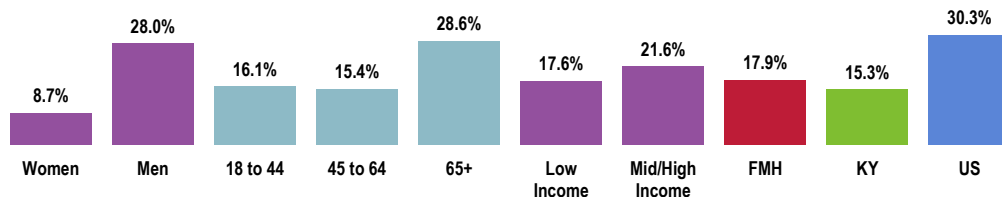
Respondents were also asked about strengthening exercises:

**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

(FMH 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.



# 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<sup>2</sup>)] 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  $\geq 30 kg/m^2$ . 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  $\geq 30 kg/m^2$ , 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	$\geq 30.0$

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.

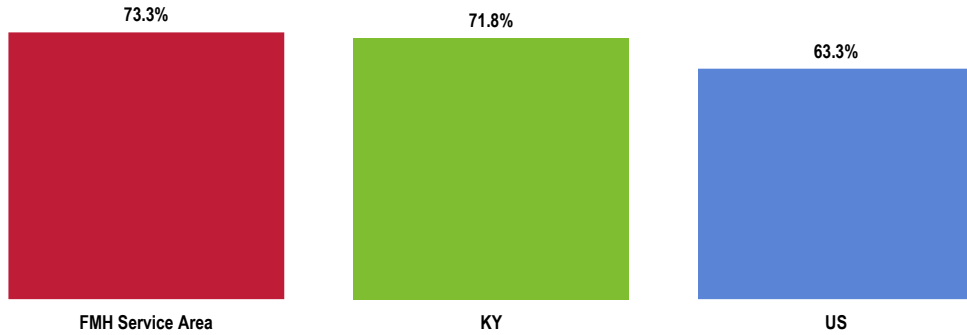


**PRC SURVEY ▶ “About how much do you weigh without shoes?”**

**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).

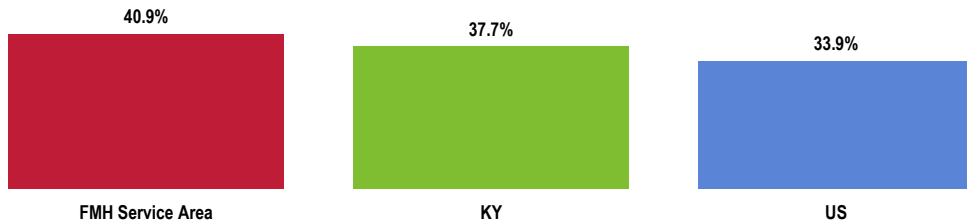
### Prevalence of Total Overweight (Overweight and Obese)



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

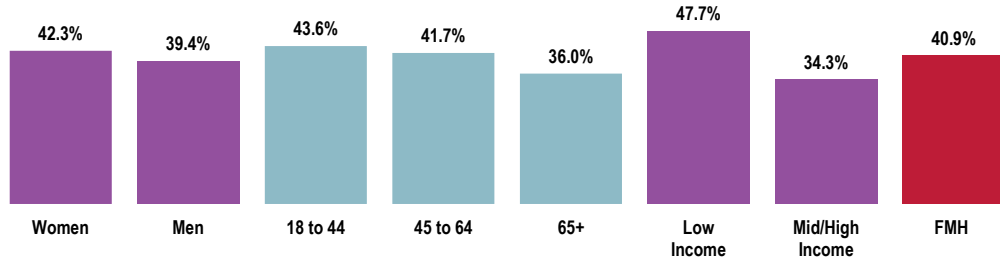


Sources: ● 2025 PRC Community Health Survey, PRC, Inc. [Item 112]  
● Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2022 Kentucky data.  
● 2023 PRC National Health Survey,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

Healthy People 2030 = 36.0% or Lower

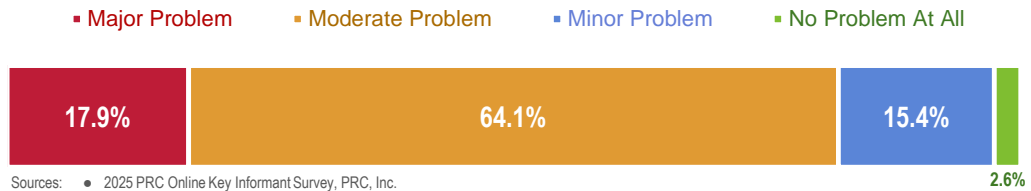


Sources: • 2025 PRC Community Health Survey, PRC, Inc. [Item 112]  
 • US Department of Health and Human Services. Healthy People 2030. <https://health.gov/healthypeople>  
 Notes: • Based on reported heights and weights, asked of all respondents.  
 • The definition of obesity is having a body mass index (BMI), a ratio of weight to height (kilograms divided by meters squared), greater than or equal to 30.0, regardless of gender.

### 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; FMH 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

- Access to affordable and nutritious food. — Public Health Representative
- Ease of fast food, lack of nutritious affordable foods, lack of education on importance of nutrition and exercise. — Public Health Representative

#### Nutrition

- Not understanding good nutrition that leads to better weight management. Lack of time and motivation to exercise. — Community Leader

#### Access to Care/Services

- Lack of activities available for recreation. — Community Leader



# 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.

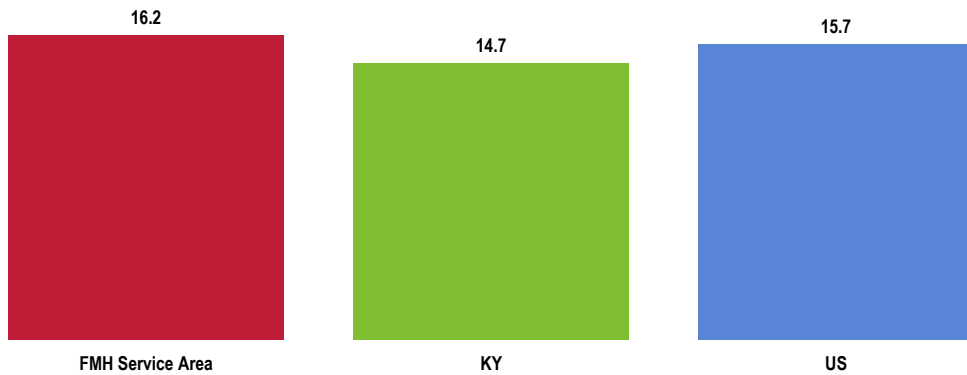
– Healthy People 2030 (<https://health.gov/healthypeople>)

## Alcohol

### Alcohol-Induced Deaths

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

**Alcohol-Induced Mortality**  
(2021-2023 Annual Average Deaths per 100,000 Population)



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

**Excessive drinking** includes heavy and/or binge drinkers:

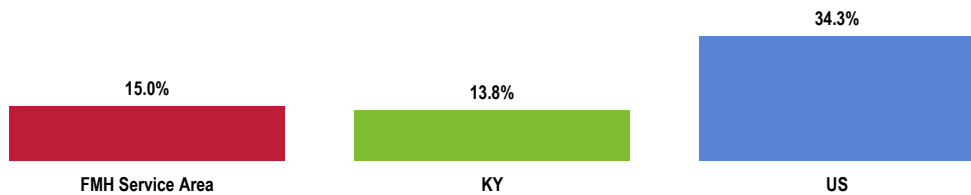
- **HEAVY DRINKING** ▶ men reporting 2+ alcoholic drinks per day or women reporting 1+ alcoholic drink per day in the month preceding the interview.
- **BINGE DRINKING** ▶ men reporting 5+ alcoholic drinks or women reporting 4+ alcoholic drinks on any single occasion during the past month.

**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?”

## 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.

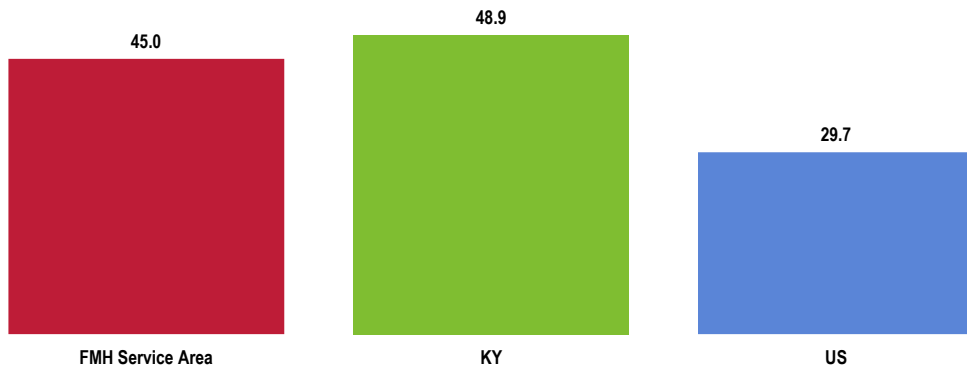


## Drugs

### 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.

**Unintentional Drug-Induced Mortality**  
(2021-2023 Annual Average Deaths per 100,000 Population)



- 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?”

#### Illicit Drug Use in the Past Month



- Sources:
- 2025 PRC Community Health Survey, PRC, Inc. [Item 40]
  - 2023 PRC National Health Survey, PRC, Inc.
- Notes:
- Asked of all respondents.

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.

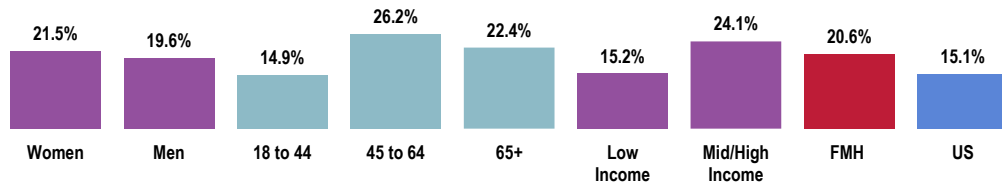


## Use of Prescription Opioids

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 (FMH Service Area, 2025)



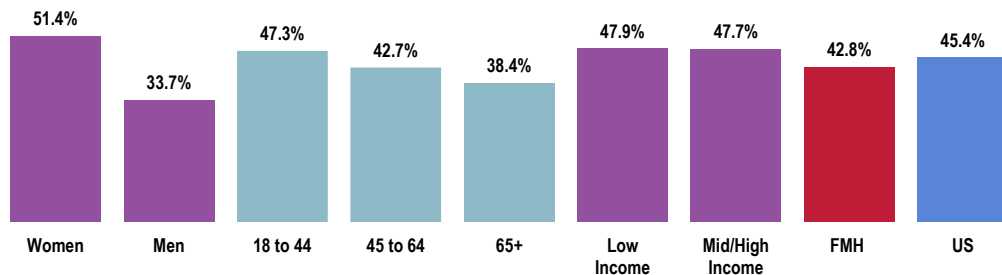
Sources: ● 2025 PRC Community Health Survey, PRC, Inc. [Item 41]  
● 2023 PRC National Health Survey, PRC, Inc.

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) (FMH 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:

### Perceptions of Substance Use as a Problem in the Community (Among Key Informants; FMH Service Area, 2025)

■ Major Problem   ■ Moderate Problem   ■ Minor Problem   ■ No Problem At All



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

- Limited treatment facilities, stigma and fear of judgment, cost, transportation, long wait list, family challenges. — Community Leader
- Substance abuse treatment is more available than ever before. We in the court system are very aware of the resources available to treat substance abuse. — Community Leader
- We need more options, more accountability, more structure in a lot of the substance abuse treatment facilities. We need to correlate with the jail and court systems to where people aren't sitting around waiting for treatment and random drug testing and welfare checks need to be a priority. — Community Leader
- The Affordable Care Act has helped tremendously. We now have available treatment beds that we didn't have for many years. Citizens had to wait too long to get in for needed treatment. — Community Leader
- The greatest barriers to obtaining substance abuse treatment are the lack of local treatment facilities, financial barriers to services, and transportation. — Community Leader

#### Denial/Stigma

- Stigma from all areas of the community. — Public Health Representative
- Stigma. — Health Care Provider
- There are a lot of treatment programs in our area. I think the stigma of substance abuse is a deterrent for some seeking help. Education, communication, and privacy are important concerns. — Community Leader
- Stigma around substance use and asking for help, ease of availability in our community, lack of treatment options. — Public Health Representative
- Stigma and readiness. — Public Health Representative

#### Affordable Care/Services

- I believe that the greatest barrier to accessing needed substance use is financial burden. Some insurances will pay for 30 days, but anyone who knows someone who has substance use disorder knows that 30 days isn't enough. To pay for extended time would cost more money for the individual or their family. One of our other barriers is that some, possibly most, of those with substance use disorder do not want to go to treatment. — Community Leader
- Cost, availability, support systems within families. — Public Health Representative
- Cost and space. — Public Health Representative

#### Awareness/Education

- Education and transportation. Challenges with filing Casey's Law, including evaluations and funds. — Community Leader
- Fentanyl poisoning awareness and education and response. Understanding of the instant mental health decline and patient and families lack of awareness. People are unknowingly being given illicit fentanyl in the form of fake pills or having it laced into illicit drugs without knowledge or consent. and they become addicted and/or die. — Community Leader



## Disease Management

The individuals that are addicted have to want to get treatment and buy in for treatment and 12-step programs. There is apparently a major supply of illegal drugs available throughout Central Kentucky. — Community Leader

## Transportation

Transportation, education, pride, embarrassment, income, mental health. — Community Leader

## Fear

Fear of being arrested. — 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.

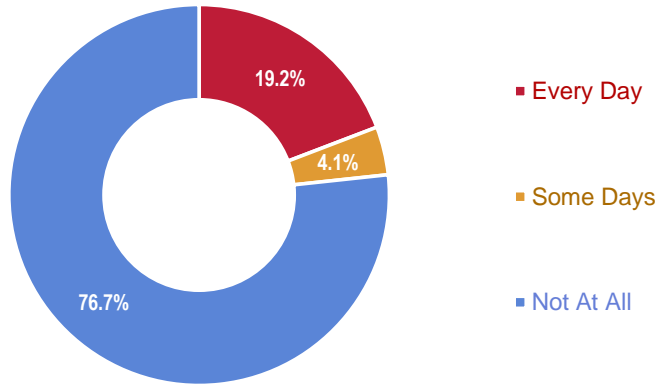
– Healthy People 2030 (<https://health.gov/healthypeople>)



# Cigarette Smoking

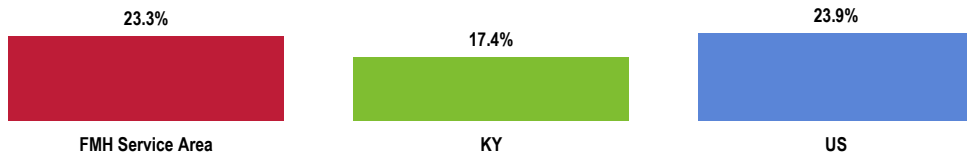
**PRC SURVEY** ▶ “Do you currently smoke cigarettes every day, some days, or not at all?”  
 (“Currently Smoke Cigarettes” includes those smoking “every day” or on “some days.”)

### Prevalence of Cigarette Smoking (FMH Service Area, 2025)



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).

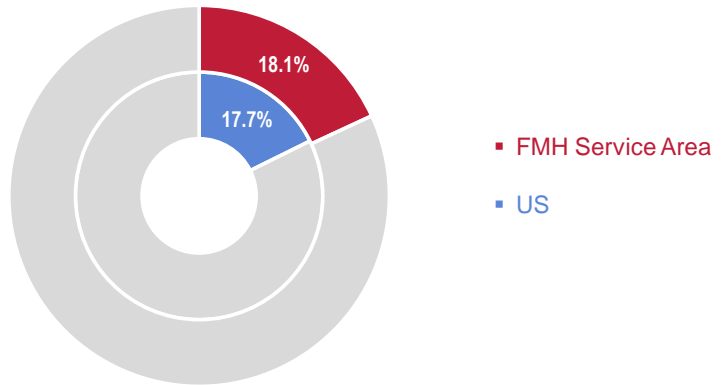


## Environmental Tobacco Smoke

**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.

### Member of Household Smokes at Home



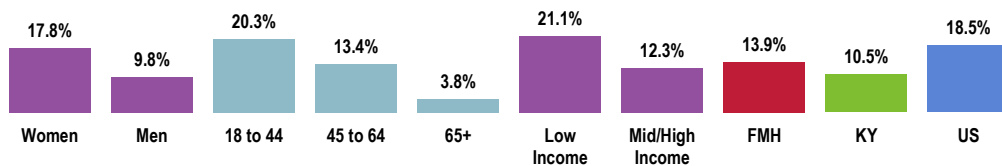
- Sources:
- 2025 PRC Community Health Survey, PRC, Inc. [Item 35]
  - 2023 PRC National Health Survey, PRC, Inc.
- Notes:
- Asked of all respondents.
  - “Smokes at home” refers to someone smoking cigarettes, cigars, or a pipe in the home an average of four or more times per week in the past month.

## 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.”)

### Currently Use Vaping Products (FMH Service Area, 2025)



- 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:

### Perceptions of Tobacco Use as a Problem in the Community (Among Key Informants; FMH Service Area, 2025)

■ Major Problem   ■ Moderate Problem   ■ Minor Problem   ■ No Problem At All



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

- Approximately 18.7% of the population of Nelson County uses tobacco. — Community Leader
- High levels of lung cancer in our area. — Community Leader
- Widespread tobacco use and vaping. — Health Care Provider

#### E-Cigarettes

- I believe that tobacco use is a major problem in my community because of the vape usage. Everywhere you go, you see people hitting their vapes. The young people surveyed in our public schools show that a large percentage of them have vaped before the age of 21. — Community Leader
- Vaping and smoking are rampant among teens and younger adults. — Community Leader
- Vaping use has increased among youth. Schools have difficulty with this problem and don't have the resources to help students in need of intervention. Kids are influenced by their family and other peers. — Community Leader

#### Generational

- It is a habit that has been passed down from generation to generation. Many children who see their parents smoke often pick up the habit. It is also a way people cope with stress, which goes back to the mental health issue. Secondhand smoke is also a problem for many children in our area. — Public Health Representative
- Generation after generation of smokers in families. Vaping has added to the problem. — Community Leader

#### Teen/Young Adult Usage

- Younger and younger youth are accessing these items, causing the use to start earlier and earlier. Easy access to obtain. Social media and targeting younger populations. — Community Leader
- Many youths are using tobacco. Even with all the information about cancer. — Community Leader

#### Impact on Quality of Life

- Leads to health problems with use. — Public Health Representative

#### Easy Access

- It's easily accessible. Even for youth because some gas stations are selling to underage children. — Community Leader

#### Cessation Education

- Because there are not enough options for people who wish to quit smoking, as well as not enough education on the risk factors associated with smoking. Vaping has become a status among the younger generations. — Community Leader

#### Addiction

- It contains nicotine, a highly addictive substance. — Public Health Representative



# 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).

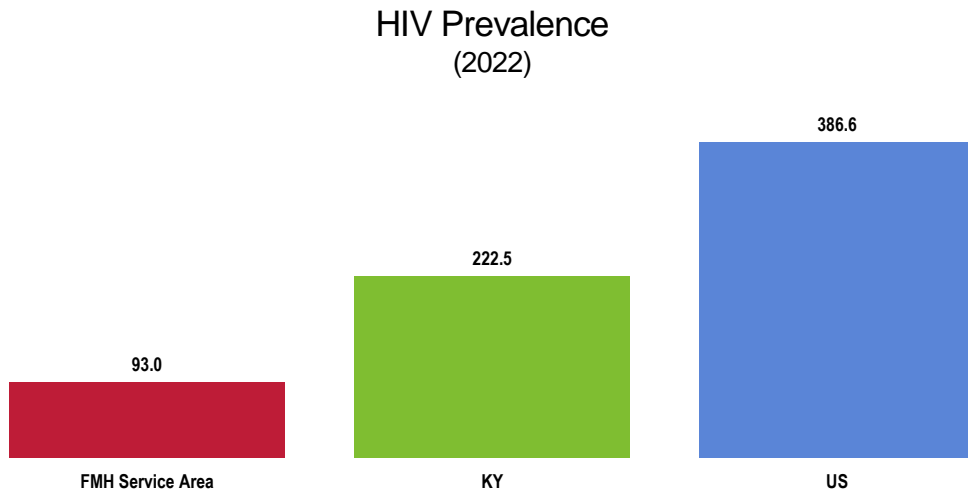
Adolescents, young adults, and men who have sex with men are at higher risk of getting STIs. And people who have an STI may be at higher risk of getting HIV.

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](https://sparkmap.org)).



# Sexually Transmitted Infections (STIs)

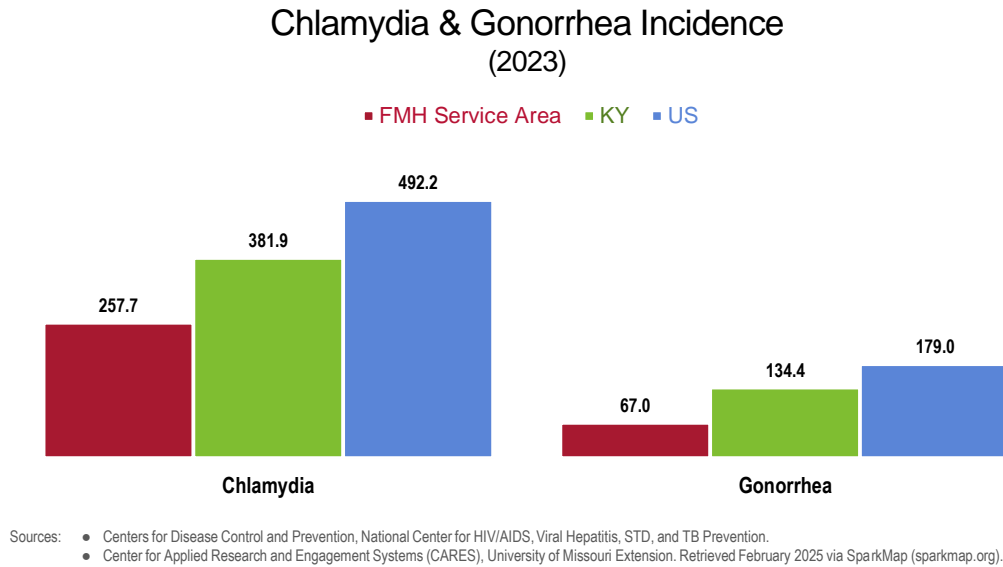
## Chlamydia

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

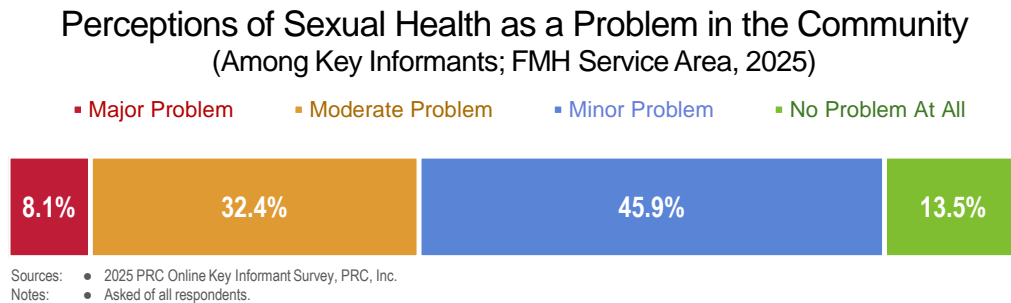
Anyone who is sexually active can get gonorrhea. Gonorrhea can be cured with the right medication; left untreated, however, gonorrhea can cause serious health problems in both women and men.

The following chart outlines local incidence for these STIs.



## Key Informant Input: Sexual Health

The following chart outlines key informants' perceptions of the severity of *Sexual 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

Lack of access to care, lack of sexual health education in schools, high-risk behavior, stigma, and lack of widespread testing. — Health Care Provider



## Awareness/Education

Educational issues in school that are not realistic in teaching children healthy sexual care. — Community Leader

## Alcohol/Drug Use

If someone is addicted to drugs or alcohol and they can't afford the drugs or alcohol, they tend to get them by any means necessary, including trading sex. Some will even allow their significant others to trade them in exchange for a place to stay due to lack of housing. Lack of education is another problem. People fail to disclose their status and pass diseases around. The affordability of services is another problem. — Community Leader



# 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

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

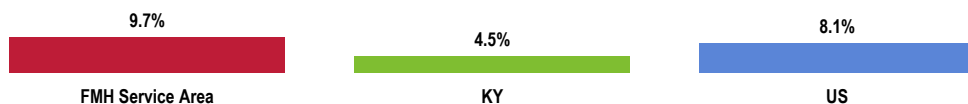
**PRC SURVEY** ▶ “Do you have any government-assisted health care coverage, such as Medicare, Medicaid, or VA/military benefits?”

**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?”

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.

### Lack of Health Care Insurance Coverage (Adults 18-64)

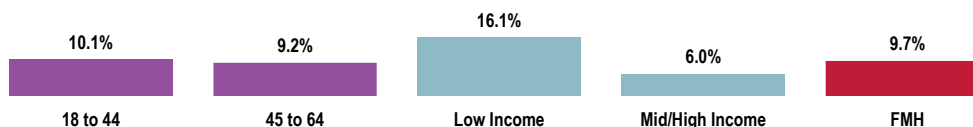
Healthy People 2030 = 7.6% or Lower



- 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; FMH 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?”

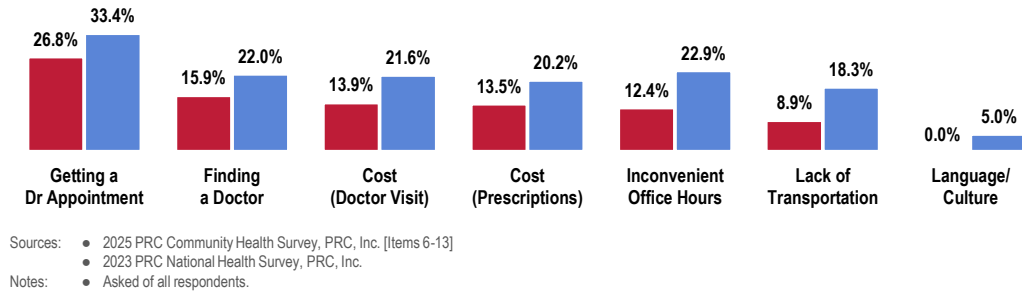


The percentages shown in the following chart reflect the total population, regardless of whether medical care was needed or sought.

## Barriers to Access Have Prevented Medical Care in the Past Year

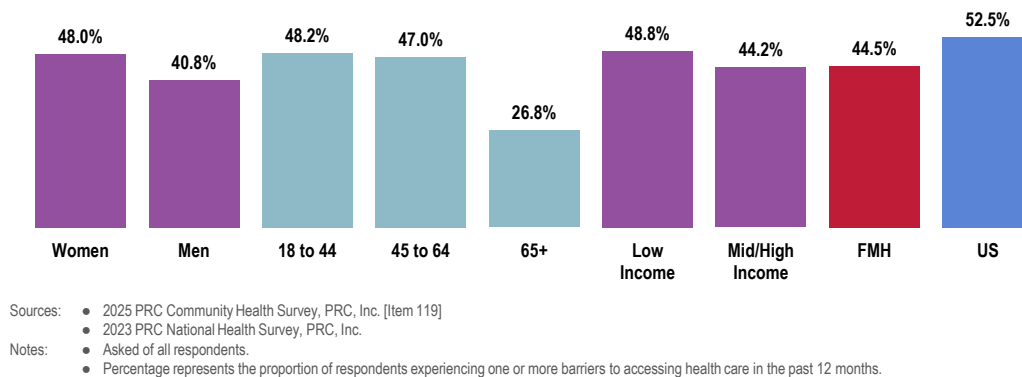
■ FMH Service Area ■ US

In addition, 13.3% of adults have skipped doses or stretched a needed prescription in the past year in order to save costs.



The following charts reflect the composite percentage of the total population experiencing problems accessing health care in the past year (indicating one or more of the aforementioned barriers), again regardless of whether they needed or sought care.

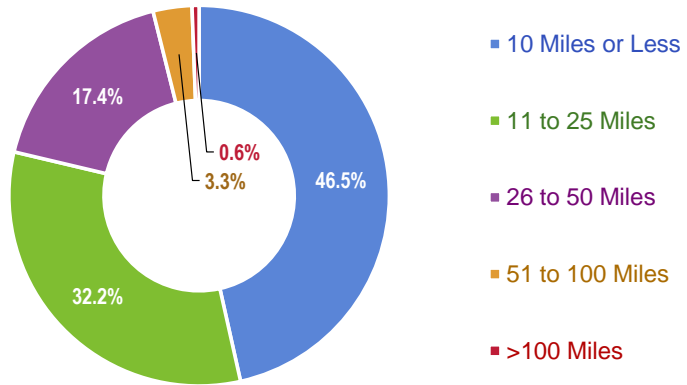
## Experienced Difficulties or Delays of Some Kind in Receiving Needed Health Care in the Past Year (FMH Service Area, 2025)



## Outmigration for Health Care Services

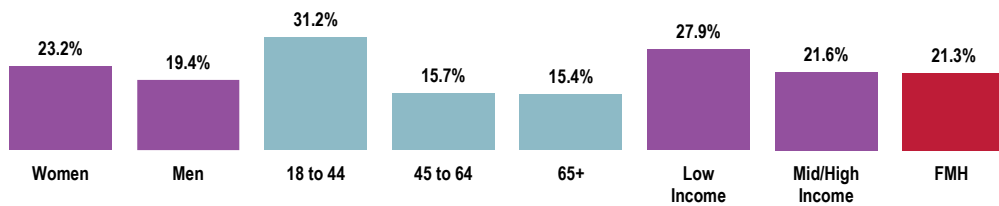
PRC SURVEY ► “In general, how far do you typically travel for health care?”

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

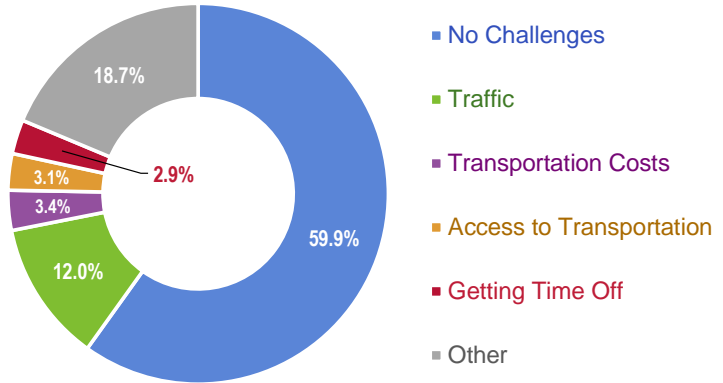


Sources: ● 2025 PRC Community Health Survey, PRC, Inc. [Item 302]  
Notes: ● Asked of all respondents.



**PRC SURVEY** ▶ “What is the biggest challenge, if any, that you have when traveling for health care?”

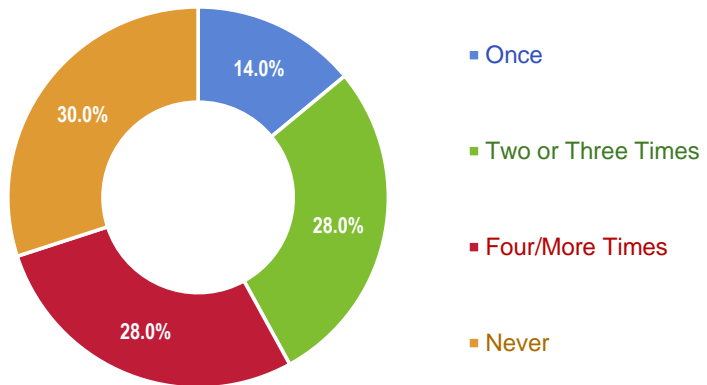
**Biggest Challenge When Traveling for Health Care**  
(FMH Service Area, 2025)



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?”

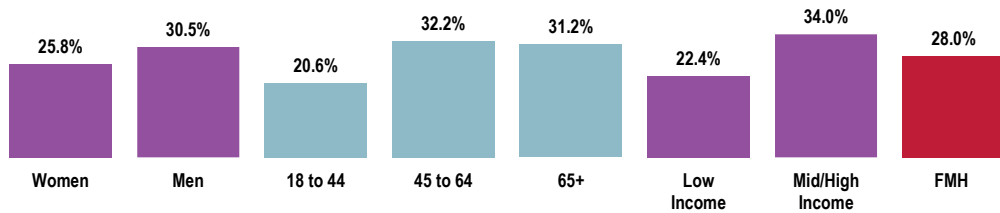
**Frequency of Leaving the Community for Health Care in the Past Year**  
(FMH Service Area, 2025)



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



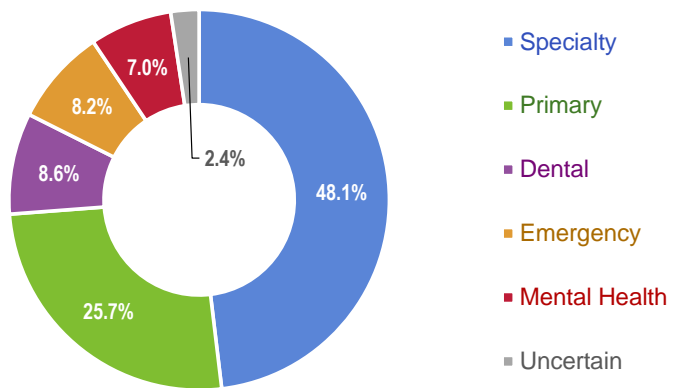
## Left the Community for Health Care Four or More Times in the Past Year (FMH Service Area, 2025)



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?”

## Type of Care Needed When Leaving the Community for Services (Respondents Who Left the Community for Care in the Past Year, 2025)

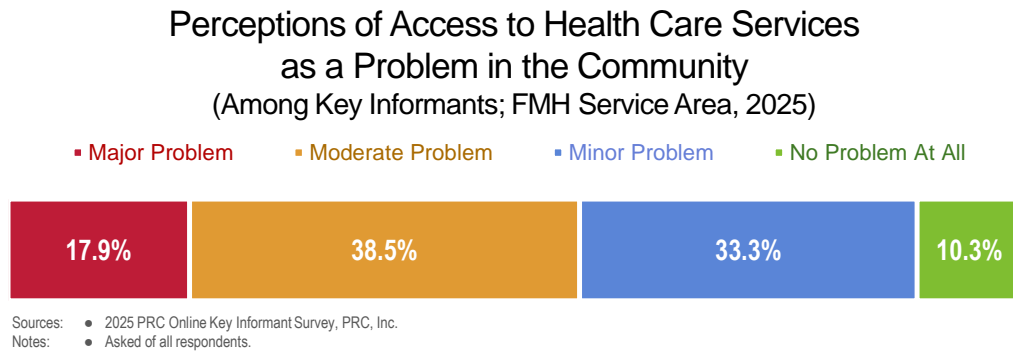


Sources: • 2025 PRC Community Health Survey, PRC, Inc. [Item 305]  
 Notes: • Asked of all respondents who left the community for health care services at least once in the past year.



## 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:

### Transportation

A lot of people lack transportation, affording the insurance or copays for insurance, lack of insurance, or the availability of the services needed. — Community Leader  
Transportation and financial stability. — Community Leader

### Access to Care for Uninsured/Underinsured

Mental health care is lacking. Health care for those who are uninsured is a big problem. — Community Leader  
I think making sure everyone has health insurance is the biggest challenge, and then finding providers that take that insurance. It is very difficult to find dentists that take Medicaid. — Community Leader

### Lack of Providers

Having sufficient doctors and testing equipment in Nelson County so that patients don't have to go to Elizabethtown or Louisville for health services but can be cared for close to home. — Community Leader

### Vision Care

Vision care. Eye doctors are expensive. The insurance doesn't cover certain things, and a lot of people can't afford to get their prescriptions updated. All insurance make it impossible to afford eyeglasses or contacts, and the upkeep is expensive, as well. — Community Leader



# 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.

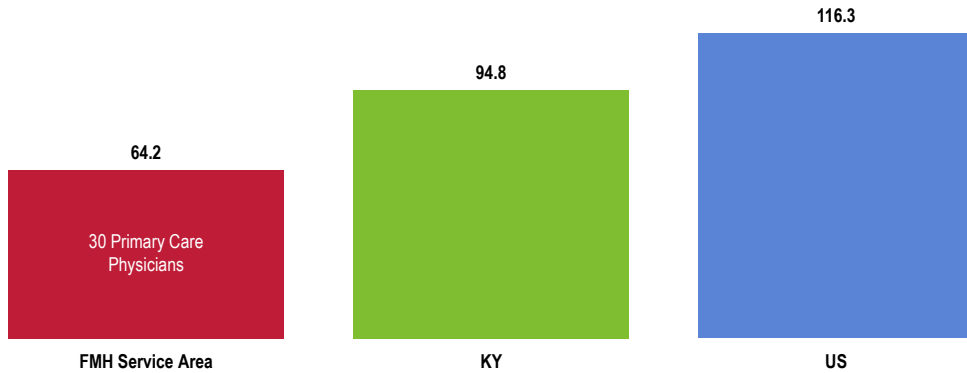
– Healthy People 2030 (<https://health.gov/healthypeople>)

## Access to Primary Care

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.

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.

### Number of Primary Care Physicians per 100,000 Population (2024)



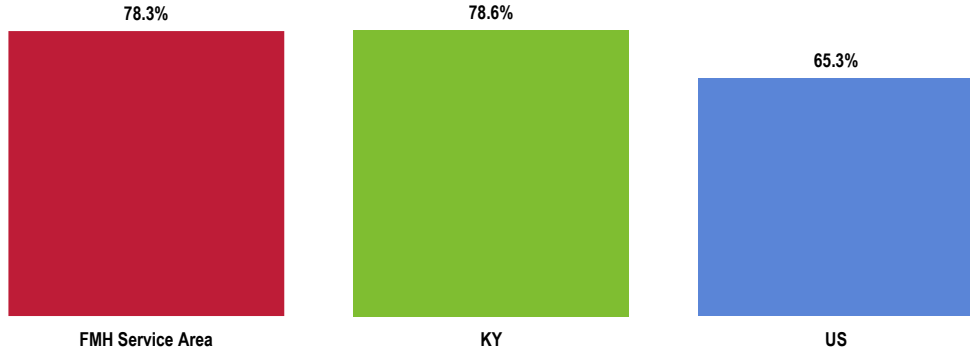
- Sources:
- Centers for Medicare and Medicaid Services, National Plan and Provider Enumeration System (NPPES).
  - Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved February 2025 via SparkMap ([sparkmap.org](http://sparkmap.org)).
- Notes:
- Doctors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

### Have Visited a Physician for a Checkup in the Past Year



- 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.



# 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.

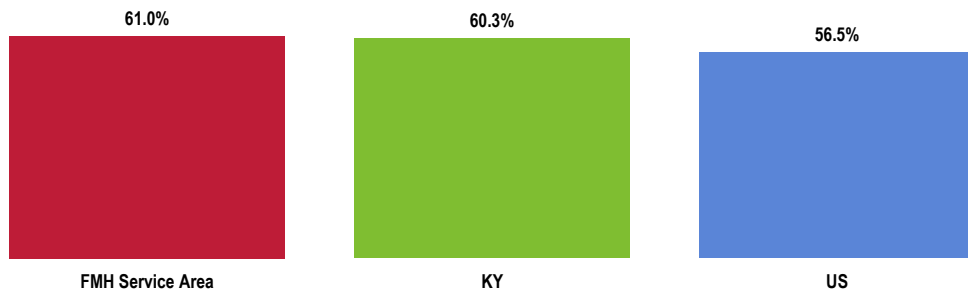
– Healthy People 2030 (<https://health.gov/healthypeople>)

## Dental Care

**PRC SURVEY** ▶ “About how long has it been since you last visited a dentist or a dental clinic for any reason?”

### Have Visited a Dentist or Dental Clinic Within the Past Year

Healthy People 2030 = 45.0% or Higher



- 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.



## Key Informant Input: Oral Health

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

### Perceptions of Oral Health as a Problem in the Community (Among Key Informants; FMH Service Area, 2025)

■ Major Problem   ■ Moderate Problem   ■ Minor Problem   ■ No Problem At All



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:

#### Affordable Care/Services

Dental insurance costs entirely too much, then the cost of procedures and the procedures themselves are entirely way too expensive. Not all insurances cover certain procedures. — Community Leader

#### Access for Medicare/Medicaid Patients

Poor coverage of dental care with Medicaid, lack of dentists who accept Medicaid. — Health Care Provider

#### Alcohol/Drug Use

Poor dental care due to tobacco and/or substance use and lack of providers accepting Medicaid patients. — Public Health Representative

#### Lack of Providers

Lack of providers overall and Medicaid-eligible. — Public Health Representative

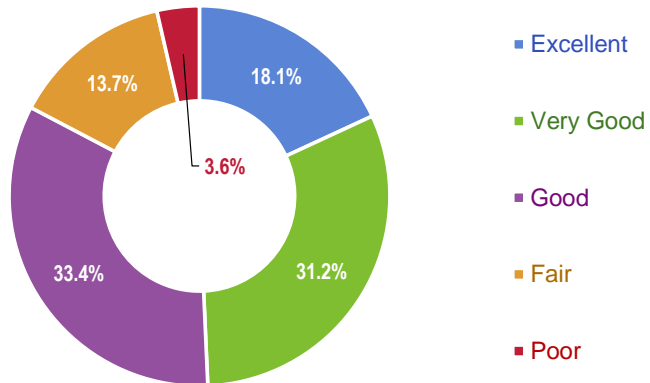


# LOCAL RESOURCES

## 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?”

Ratings of Local Health Care Services  
(FMH Service Area, 2025)



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

- Baptist Health
- Community Action Kentucky
- Community Action Council
- Community Action Transportation Services
- Community Family Clinic
- Department of Community Based Services
- Flaget Cancer Center
- Flaget Memorial Hospital
- Lincoln Trail District Health Department
- Rehab Facilities
- St. Vincent de Paul
- Stepworks Intensive Health Mobile Unit
- Urgent Care Centers

## Cancer

- American Cancer Society
- Baptist Health
- Baptist Health Hardin
- Cancer Support Group
- City/County Government
- Community Clinic for Nelson County
- Cooperative Extension
- Doctors' Offices
- Flaget Cancer Center
- Flaget Memorial Hospital
- Health Department
- Hospitals
- Kentucky Cancer Program
- School System

## Diabetes

- Community Health Center
- Diabetes and Nutrition Management of Bardstown
- Diabetes Care Solutions PLLC
- Doctors' Offices
- Farmers' Markets
- Feeding America Truck
- Flaget Memorial Hospital

- Food Stamps
- Guthrie Opportunity Center
- Lincoln Trail District Health Department
- Nelson County Community Clinic
- Stepworks Intensive Health Mobile Unit
- Women, Infants, and Children

## Disabling Conditions

- Area Agency on Aging
- Lions Club

## Heart Disease & Stroke

- Baptist East Family Medicine
- Baptist Health Bardstown Medical Plaza
- Bread of Life Food Pantry
- Doctors' Offices
- Flaget Memorial Hospital
- Food Stamps
- Medicaid
- Nelson County Health Department
- Quit Now
- Serendipity Massage

## Infant Health & Family Planning

- Baptist Health Medical Group Family Medicine
- Bread of Life Food Pantry
- Flaget Memorial Hospital
- Health Access Nurturing Development Services Program
- Kentucky Moms MATR
- Lincoln Trail District Health Department
- New Life Center
- Women, Infants, and Children



## Injury & Violence

Bethany Haven  
Community Action Kentucky  
Intensive Health  
Lincoln Trail District Health Department  
New Life Center  
United Way  
University of Kentucky

## Mental Health

988  
Astra Behavioral Health  
Bardstown Health and Healing  
Bethany Haven  
Communicare  
Counseling Services  
Credible Minds  
Family Resource Center  
Flaget Memorial Hospital  
Heartland Village  
Lemon-Aid Mental Health Services  
Lincoln Trail Behavioral Health  
Lincoln Trail District Health Department  
NeICARE  
Nelson County Health Department  
Our Lady of Peace Hospital  
REACH  
Room at the Inn  
School System  
Stepworks Intensive Health Mobile Unit  
Zocdoc

## Nutrition, Physical Activity & Weight

Farmers' Markets  
Fitness Centers/Gyms  
Flaget Memorial Hospital  
Food Stamps  
Libraries  
Women, Infants, and Children

## Oral Health

Community Health Center  
Nelson County Community Clinic

## Respiratory Diseases

Advanced ENT and Allergists  
Doctors' Offices  
Family Allergy and Asthma  
Flaget Memorial Hospital

## Sexual Health

Lincoln Trail District Health Department  
Stepworks Intensive Health Mobile Unit

## Social Determinants of Health

Bernheim Forest and Arboretum  
Bethany Haven  
Career Center  
Community Action Kentucky  
Community Action Transportation Services  
Flaget Memorial Hospital  
Food Banks/Pantries  
Housing Authorities  
Lincoln Trail District Health Department  
NeICARE  
Nelson County Community Action  
Nelson County Community Clinic  
New Pioneers for a Sustainable Future  
Parks and Recreation  
Public Housing  
Room at the Inn  
State Legislation

## Substance Use

AA/NA  
Addiction Recovery Care (ARC)  
Ascension Center for Recovery  
Astra Behavioral Health  
Bardstown Police Department  
Bardstown Total Care  
Communicare  
Crown Recovery Center  
Family Resource Center  
Find Help Now  
Flaget Memorial Hospital  
Impact Outpatient  
Isaiah House  
Kentucky Moms MATR  
Lexington Addiction Center  
Lincoln Trail Behavioral Health  
Lincoln Trail District Health Department  
Lincoln Trail Mobile Health Unit  
NeICARE



Nelson County Health Department  
Police Department  
REACH  
Rehab Facilities  
School System  
Stepworks Intensive Health Mobile Unit  
United for Recovery

### **Tobacco Use**

Counseling Services  
Doctors' Offices  
Family Resource Center  
Flaget Memorial Hospital  
Lincoln Trail District Health Department  
NeICARE  
Nelson County Health Department  
Nelson County Tobacco and Vaping  
Prevention  
Pharmacies  
Police Department  
Quit Now  
Quitline  
School System  
Stepworks Intensive Health Mobile Unit  
UofL Health - Brown Cancer Center  
United for Recovery Resource Directory





# APPENDIX

# EVALUATION OF PAST ACTIVITIES

## 2023-2025 Community Health Needs Assessment Flaget Memorial 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.	<p>Substance Use Disorders were identified as a legislative priority for the Kentucky General Assembly in 2023, 2024 and 2025.</p> <p>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.</p> <p>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.</p> <p>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)</p> <p>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)</p> <p>Joined coalition with American Cancer Society to advocate for \$10M annually for Kentucky Tobacco Prevention &amp; Cessation Program. (2024)</p>

System	Expand pharmacist-driven initiation of medications for opioid use disorder.	<p>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)</p> <p>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)</p> <p>In FY23:</p> <ul style="list-style-type: none"> <li>● 93% of providers received education</li> <li>● 20% reduction in pain scores among patients</li> <li>● 10% reduction in MME burden among patients</li> <li>● 47% reduction in co-prescription of oral benzodiazepines with oral opioid</li> </ul>
Flaget Memorial Hospital	Support local groups and events that have a mission to prevent and/or treat substance use disorders and increase patient access to substance use and other community resources by developing and disseminating a resource list.	<p>3 partnerships to address substance use disorder</p> <ul style="list-style-type: none"> <li>● Nelson County Drug Coalition - Member: Tabitha Yates, ED Manager</li> <li>● Smoke Free Nelson County - Member: Sarah Gabehart, Oncology Manager</li> <li>● ARC Advisory Council - Member: Netta Nusz</li> </ul> <p>Expanded UofL Peace Hospital agreement to provide level of care assessments and psychiatric evals both in the ED and on our inpatient units. Psychiatrist and Psych NP will be credentialed as of 8/1/23. Psych Evals to be offered after 8/1/23. .</p> <p>Violence prevention program in Nelson County</p> <ul style="list-style-type: none"> <li>● 1 mini grant for vape detectors in local high school</li> <li>● 630 students received training</li> <li>● 4 high schools and 1 middle school participate</li> </ul> <p>Out of the Darkness Fundraiser - Partnered with the Twin Ponds Ranch Team to help raise awareness for suicide prevention by hosting a bake sale. All the proceeds went directly to the American Foundation for Suicide Prevention's Out of the Darkness Walk. The Out of the Darkness walk benefits the American Foundation of Suicide Prevention by raising awareness on suicide and depression, raising money for research and education to prevent suicide from taking place, and providing assistance and a safe outlet for survivors of suicide.</p> <p>Sponsorship towards local high schools Project Graduation. Project Graduation is held for seniors after they graduate to celebrate in a no alcohol/drug free night.</p>

		Conducted introductory meetings with Intensive Health through Stepworks to be able to use them as a resource for our behavioral health patients to receive comprehensive medical care in a recovery-friendly environment. Their services offer primary care, medication-assisted treatment, and behavioral healthcare. Will be connecting them with ED and CM.
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## 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.	<p>Mental Health &amp; Mental Disorders were identified as legislative priorities for the Kentucky General Assembly in 2023, 2024 and 2025.</p> <p>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</p> <p>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.</p> <p>50 attendees at Catholic Conference of Kentucky Health Summit to heighten awareness about mental health issues and build a coalition of supporters. (2022)</p> <p>Advocated in D.C. with the Central KY Policy Group to increase resources for mental health treatment and research. (2023)</p>

<p>Flaget Memorial Hospital</p>	<p>Support local groups that have a mission to promote mental wellbeing and collaborate to develop and disseminate a list of mental health and other community resources.</p>	<p>Have connected with multiple treatment facilities in an effort to get up to date information on services offered in order to provide accurate info on resources to the emergency dept and care coordination team.</p> <p>Psych Evals to be offered to ED and inpt services after 8/1/23. Expanded Peace agreement to provide not only level of care assessments but also psychiatric evals both in the ED and on our inpatient units. Psychiatrist and Psych NP will be credentialed as of 8/1/23</p> <p>Violence prevention program in Nelson County (FY 23)</p> <ul style="list-style-type: none"> <li>• 630 students received training</li> <li>• 4 high schools and 1 middle school participate</li> </ul> <p>Suicide Awareness - Invited OLOP to set up a table at Flaget to share behavioral health fact sheets and program information.</p> <p>Bake sale at Flaget to raise money for the American Foundation of Suicide Prevention.</p>
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## 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.	<p>Weight Status, Physical Activity &amp; Nutrition were identified as legislative priorities for the Kentucky General Assembly in 2023, 2024 and 2025.</p> <p>Legislature enacted 3 new laws in 2023: SB 9 Hazing, SB 229 Child Abuse, SB 80 Sex Offenders</p> <p>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.</p>
Flaget Memorial Hospital	Educate community members on the risk factors for obesity and chronic diseases and provide screening at local events.	<p>Community Health Improvement Grant (2024)</p> <ul style="list-style-type: none"> <li>● \$10,000 St.Vincent dePaul Outreach</li> <li>● \$18,500 Bernheim Arboretum and Research Forest</li> </ul> <p>Community Health Improvement Grant (2025)</p> <ul style="list-style-type: none"> <li>● \$10,000 St.Vincent dePaul Outreach</li> <li>● \$19,500 Bernheim Arboretum and Research Forest</li> </ul> <p>Events:</p> <ul style="list-style-type: none"> <li>● March 4, 2023 - Green Dot Trot 5k</li> <li>● Flaget Cancer Center participated in a community health fair on May 18, 2023 to provide cancer education.</li> <li>● Flaget participated in Sisters of Charity of Nazareth 5K on 5/30/23.</li> <li>● Flaget partnered with the Nelson County Co-op Extension Service to highlight a mindfulness walk on our walking trail - June, 2023</li> <li>● Flaget hosted a bike safety event on campus for kids/grandkids of employees to promote exercise/well being - June 2023.</li> <li>● March 2, 2024 - Green Dot Trot 5k</li> <li>● Flaget hosted health fair for the Sisters of Nazareth of Charity - 11/23</li> <li>● Flaget participated in health fair for Nazareth Village residents - 8/22/24</li> <li>● Flaget sponsored and participated in the United Way's annual Spirit 5K and Tri-County Trifecta - 10/12/24</li> </ul>