AdventHealth Hendersonville 2025 Community Health Needs Assessment

Extending the Healing Ministry of Christ

AdventHealth

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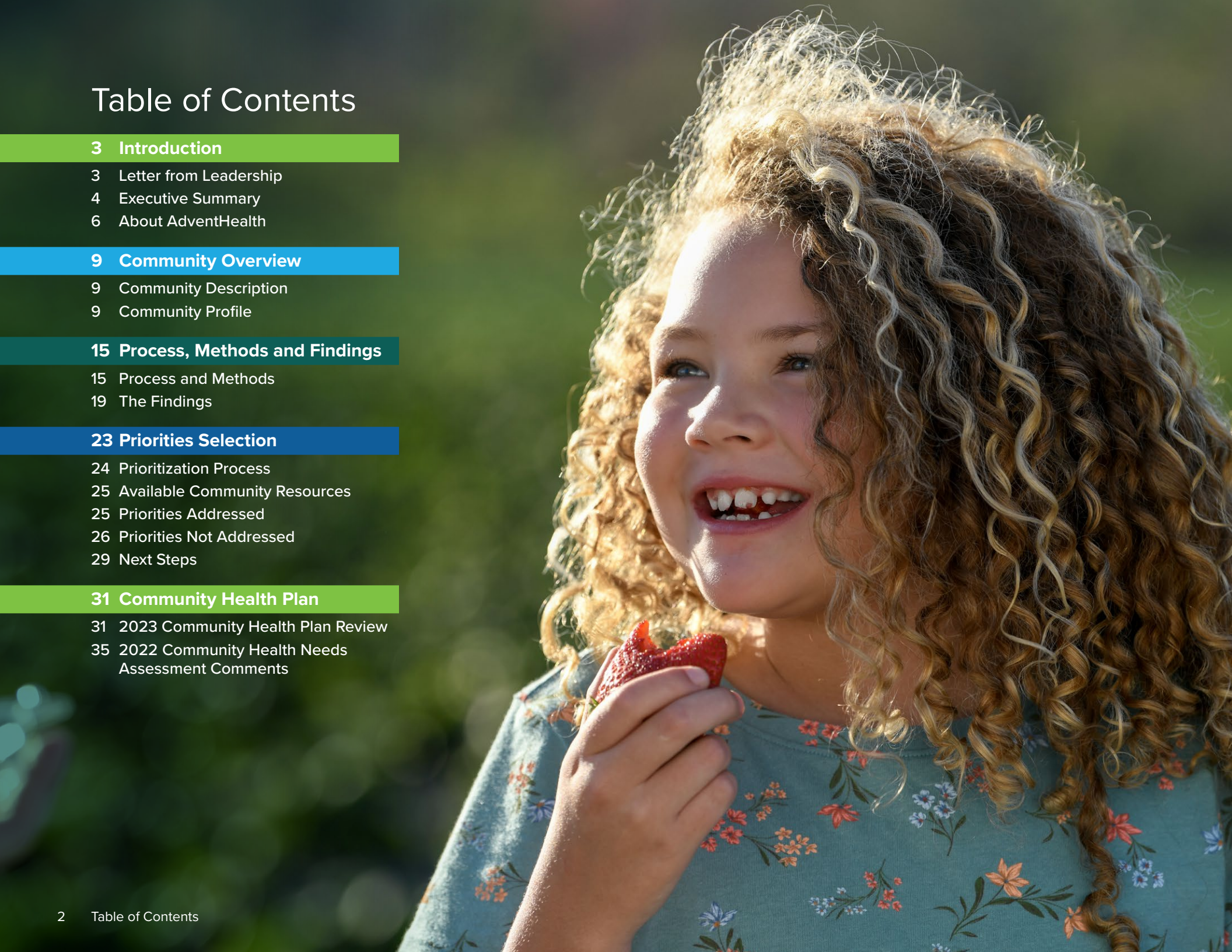


Letter from Leadership

At AdventHealth, we have a sacred mission of Extending the Healing Ministry of Christ. That obligation goes beyond our hospital walls and permeates into our communities. Our commitment is to address the health care needs of our community with a wholistic focus, one that strives to heal and restore the body, mind and spirit. We want to help our communities get well and stay well.

Every three years, AdventHealth hospitals across the nation complete a Community Health Needs Assessment. During this assessment, we talk and work with community organizations, public health experts and people like you who understand our communities best. This in-depth look at the overall health of our communities and the barriers to care they experience helps AdventHealth better understand the unique needs in the various communities we serve.

We use this information to create strategic plans that address the issues that impact our communities most. At AdventHealth, we know that a healthy community is not a “one size fits all” proposition—everyone deserves a whole health approach that meets them where they are and supports their individual health journey.

This work would not be possible without the partnership of public health experts, community organizations and countless community members who helped inform this report. Through these ongoing partnerships and collaborative efforts, AdventHealth will continue to create opportunities for better health in all the communities we serve.

In His service,

Daniel Tryon

Our commitment is to address the health care needs of our community with a wholistic focus, one that strives to heal and restore the body, mind and spirit.

Executive Summary

Fletcher Hospital, Inc. dba AdventHealth Hendersonville will be referred to in this document as AdventHealth Hendersonville "The Hospital." AdventHealth Hendersonville in Hendersonville, NC conducted a community health needs assessment from March 2024 to June 2025. The goals:

- Engage public health and community stakeholders, including low-income, minority and other underserved populations.
- Assess and understand the community's health issues and needs.
- Understand the health behaviors, risk factors and social determinants that impact health.
- Identify community resources and collaborate with community partners.
- Publish the Community Health Needs Assessment.
- Use the assessment findings to develop and implement a 2026–2028 Community Health Plan based on the needs prioritized in the assessment process.

Community Health Needs Assessment Committee

To ensure broad community input, AdventHealth Hendersonville took part in a Collaborative with Henderson County Department of Public Health (HCDPH) UNC Health Pardee, and the Henderson County Partnership for Health, to help guide the Hospital through the assessment process. The Collaborative included representation from the Hospital, public health experts and the broad community. This included intentional representation from low-income, minority and other underserved populations.

The Collaborative met three times in 2025. They reviewed primary and secondary data and helped to identify the top priority needs in the community.

See Prioritization Process for a list of Collaborative members.

Hospital Health Needs Assessment Committee

AdventHealth Hendersonville also convened a Hospital Health Needs Assessment Committee (HHNAC). The purpose of the HHNAC was to select the needs the Hospital would address due to the findings in the assessment. The HHNAC made this decision by reviewing the priority needs that were selected by the CHNAC and by the internal hospital resources available. With this information, the HHNAC was able to determine where the Hospital could most effectively support the community.

See Prioritization Process for a list of HHNAC members.

Data

Data used in the assessment came from Western North Carolina (WNC) Healthy Impact, a partnership and coordinated process between public health agencies, hospitals, and key partners in western North Carolina, working towards a vision of community health. Through WNC Healthy Impact, WNC Health Network compiles a comprehensive regional dataset to describe health challenges and opportunities in the 16 counties in the WNC Healthy Impact region. The regional dataset is a premier source of meaningful county-level health data in the region and is used to analyze and inform local and regional-level planning for community health. The dataset includes both primary (newly collected from the community) and secondary (existing) data. The primary data included community surveys, key informant interviews, and community meetings. Secondary data included internal hospital utilization data (inpatient, outpatient and emergency department). In addition, publicly available data from state and nationally recognized sources were used. Primary and secondary data was compiled and analyzed to identify the top 11 needs.

See Process, Methods and Findings for data sources.

Community Asset Inventory

The next step was to create a community asset inventory. This inventory was designed to help the Collaborative understand the existing community efforts being used to address the 11 needs

identified from the aggregate primary and secondary data. This inventory was also designed to prevent duplication of efforts.

See Available Community Resources for more.

Selection Criteria

The Collaborative participated in a prioritization process after a data review and facilitated discussion session. The identified needs were then ranked based on clearly defined criteria.

The HHNAC reviewed and discussed the needs identified by the Collaborative and the available resources to address them in the community. The HHNAC also considered the Hospital's current resources and strategies. Through these discussions the Hospital selected the needs it is best positioned to impact.

See Prioritization Process for more.

The following criteria were considered during the prioritization process:

A. Relevance

How important is this issue? (Size of the problem; Severity of problem; Focus on equity; Aligned with HNC 2030; Urgency to solve problem; Linked to other important issues)

B. Impact

What will we get out of addressing this issue? (Availability of solutions/proven strategies; Builds on or enhances current work; Significant consequences of not addressing issue now)

C. Feasibility

Can we adequately address this issue? (Availability of resources (staff, community partners, time, money, equipment) to address the issue; Political capacity/will; Community/social acceptability; Appropriate socio-culturally; Easily identifiable short-term wins)

Priorities to Be Addressed

The priorities to be addressed are:

- Dementias
- Mental Health
- Economic Stability — Housing

See Priorities Addressed for more.

Approval

On November 12, 2025, the AdventHealth Hendersonville board approved the Community Health Needs Assessment findings, priority needs and final report. A link to the 2025 Community Health Needs Assessment was posted on the Hospital's website prior to December 31, 2025.

Next Steps

AdventHealth Hendersonville will work with the CHNAC to develop a measurable implementation strategy called the 2026 – 2028 Community Health Plan to address the priority needs. The plan will be completed and posted on the Hospital's website on May 15, 2026.

About AdventHealth

AdventHealth Hendersonville is part of AdventHealth. With a sacred mission of Extending the Healing Ministry of Christ, AdventHealth strives to heal and restore the body, mind and spirit through our connected system of care. More than 100,000 talented and compassionate team members serve over 8 million patients annually. From physician practices, hospitals and outpatient clinics to skilled nursing facilities, home health agencies and hospice centers, AdventHealth provides individualized, whole-person care at more than 50 hospital campuses and hundreds of care sites throughout nine states.

Committed to your care today and tomorrow, AdventHealth is investing in new technologies, research and the brightest minds to redefine wellness, advance medicine and create healthier communities.

In a 2020 study by Stanford University, physicians and researchers from AdventHealth were featured in the ranking of the world's top 2% of scientists. These critical thinkers are shaping the future of health care.

Amwell, a national telehealth leader, named AdventHealth the winner of its Innovation Integration Award. This telemedicine accreditation recognizes organizations that have identified connection points within digital health care to improve clinical outcomes and user experiences. AdventHealth was recognized for its innovative digital front door strategy, which is making it possible for patients to seamlessly navigate their health care journey. From checking health documentation and paying bills to conducting a virtual urgent care visit with a provider, we're making health care easier—creating pathways to wholistic care no matter where your health journey starts.

AdventHealth is also an award-winning workplace aiming to promote personal, professional and spiritual growth with its team culture. Recognized by Becker's Hospital Review on its "150 Top Places to Work in Healthcare" several years in a row, this recognition is given annually to health care organizations that promote workplace diversity, employee engagement and professional growth. In 2024, the organization was named by Newsweek as one of the Greatest Workplaces for Diversity and a Most Trustworthy Company in America.

AdventHealth Hendersonville

Founded in 1910, AdventHealth Hendersonville is part of a connected, not-for-profit network of care that helps people feel whole – body, mind and spirit. As a proud member of AdventHealth since 1984, our wholistic approach to improving the health and prosperities of our Western North Carolina community is inspired by our mission of Extending the Healing Ministry of Christ.

Our team of more than 1,800 caregivers delivers compassionate, whole-person care through a growing network of services, including cardiac care and rehabilitation, emergency services, nationally accredited cancer care, state-of-the-art surgical care, full-service orthopedic care, an award-winning labor & delivery experience, and a full range of imaging services to help people across our region experience whole health.

AdventHealth Hendersonville is one of more than 2,000 care sites across the country that make up AdventHealth's national footprint, supported by more than 100,000 team members. Together, we care for nearly nine million people annually through hospitals, physician practices, outpatient clinics, home health and hospice agencies, and the AdventHealth app.

To learn more or find a provider, visit AdventHealthNC.com or call 855-774-LIFE (5433).

Our wholistic approach to improving the health and prosperities of our Western North Carolina community is inspired by our mission of Extending the Healing Ministry of Christ.

Community Overview

Community Description

Located in Hendersonville, North Carolina, AdventHealth Hendersonville defines its community as Henderson County.

According to the 2022 United States Census, the population in Henderson County is estimated to be 116,469 and has increased by 7,827 people since 2010.

Demographic and community profile data in this report are from publicly available data sources such as the U.S. Census Bureau and the Center for Disease Control and Prevention (CDC), unless indicated otherwise. Data are reported for Henderson County unless listed differently. Data are also provided to show how the community compares locally, in the state, and at a national level for some indicators.

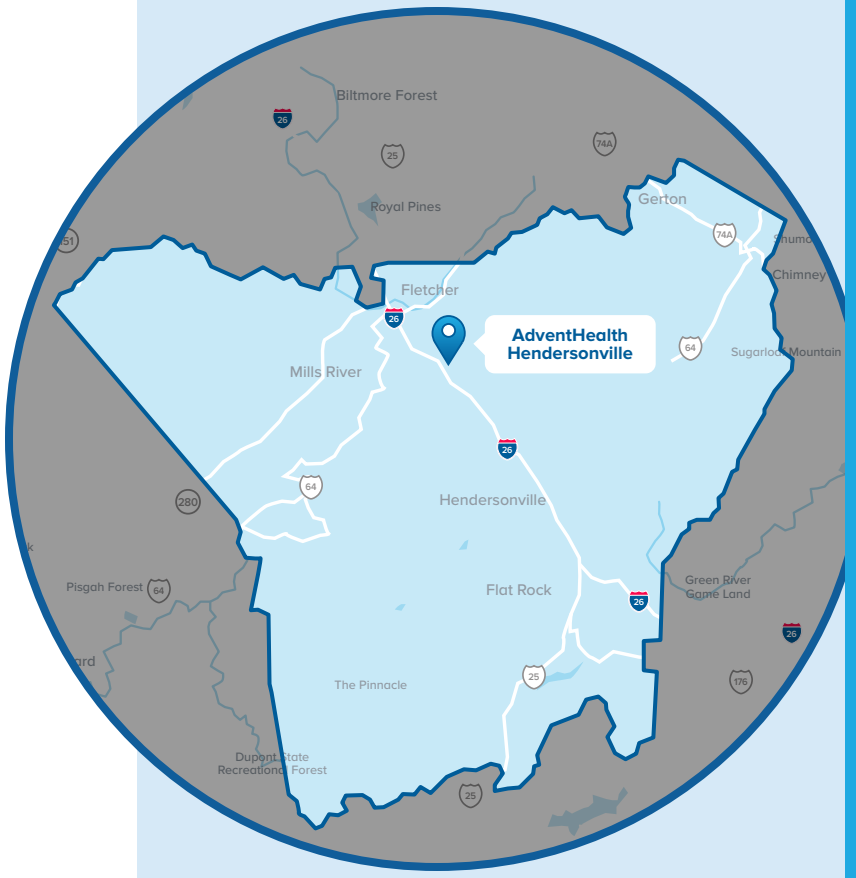
Community Profile

Age and Sex

The median age in the Hospital's community is 47.7, slightly higher than that of state which is 39.1 and the US, 39.2.

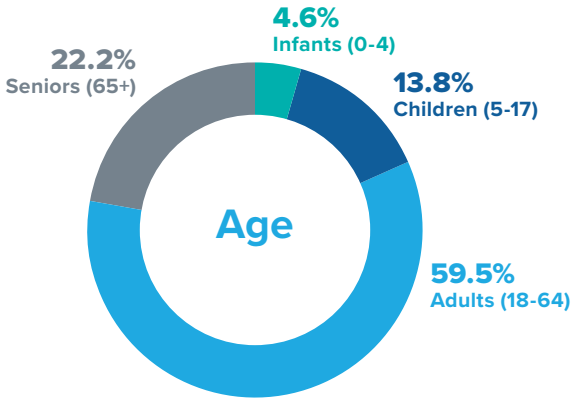
Females are the majority, representing 51.32% of the population. Middle-aged women, 40–64 are the largest demographic in the community at 16.7%.

Children make up 18.38% of the total population in the community. Infants, those zero to four, are 4.63% of that number. The community birth rate is 11.1 births per 1,000 women aged 15–50. This is lower than the U.S. average of 51.54, and lower than that of the state, 51.4. In the Hospital's community, 18.35% of children aged 0–4 and 16.78% of children aged 5–17 are in poverty.



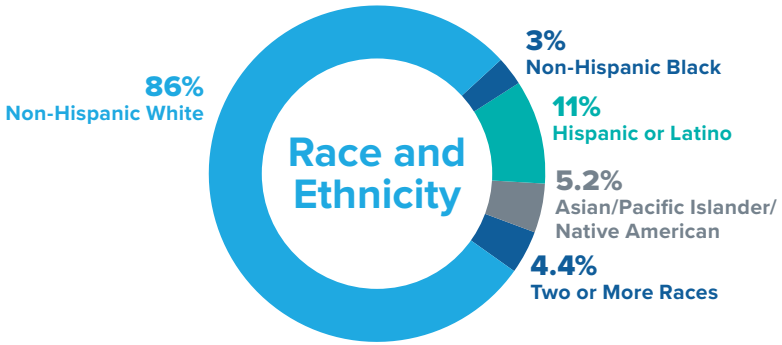
The population in Henderson County is estimated to be 116,469 and has increased by 7,827 people since 2010.

Seniors, those 65 and older, represent 22.2% of the total population in the community. Females are 55.4% of the total senior population.



Race and Ethnicity

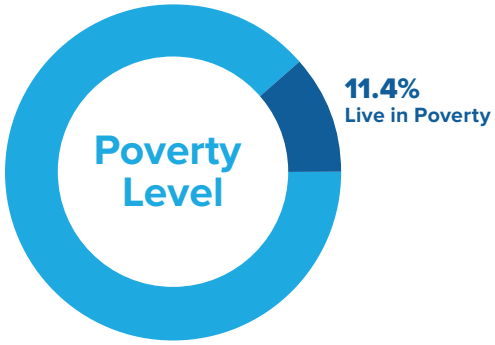
In the Hospital's community, 86% of the residents are non-Hispanic White, 3% are non-Hispanic Black and 11% are Hispanic or Latino. Residents who are of Asian or Pacific Islander descent represent or Native American make up a total of 5.2% of the population and 4.4% are two or more races. This sample consists solely of residents 18 years and older.



Economic Stability

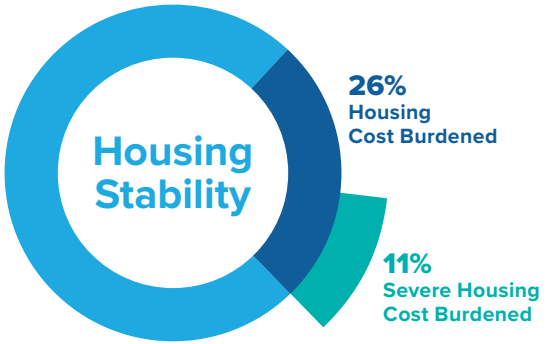
Income

The median household income in the Hospital's community is $65,508. This is below the median for both the state and the US. Although below the median, 11.4% of residents live in poverty, the majority of whom are under the age of 18.



Housing Stability

Increasingly, evidence is showing a connection between stable and affordable housing and health.[1] When households are cost burdened or severely cost burdened, they have less money to spend on food, health care and other necessities. Having less access can result in more negative health outcomes. Households are considered cost burdened if they spend more than 30% of their income on housing and severely cost burdened if they spend more the 50%. In the community 26% of residents are housing cost burdened while 11% are severely cost burdened.



1 Severe housing cost burden* | County Health Rankings & Roadmaps

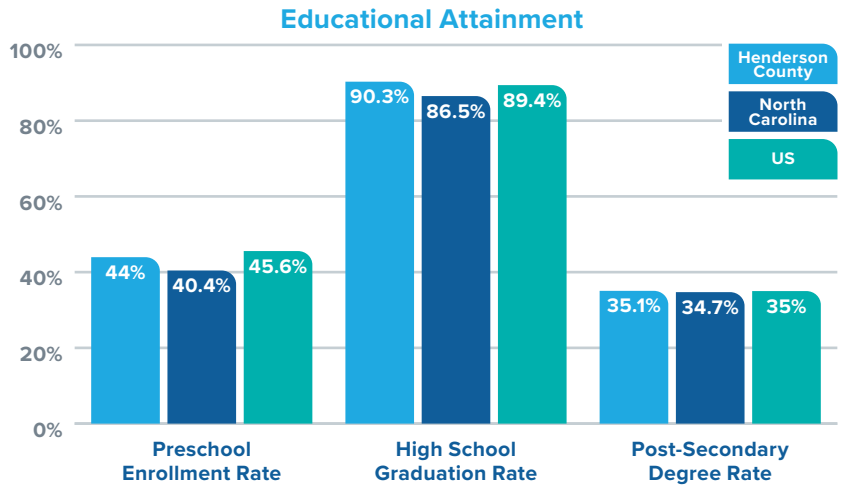
Education Access and Quality

Research shows that education can be a predictor of health outcomes, as well a path to address inequality in communities.[2] Better education can lead to people having an increased understanding of their personal health and health needs. Higher education can also lead to better jobs, which can result in increased wages and access to health insurance.

In the Hospital's community, there is a 90.3% high school graduation rate, which is higher than both the state, (86.5%) and national average (89.39%). The rate of people with a post-secondary degree is also higher in the Hospital's PSA than in both the state and nation.

Early childhood education is uniquely important and can improve children's cognitive and social development. It helps provide the foundation for long-term academic success, as well as improved health outcomes. Research on early childhood education programs shows that long-term benefits include improved health outcomes, savings in health care costs and increased lifetime earnings.[3]

In the Hospital's community, 43.95% of three- and four-year olds were enrolled in preschool. While slightly higher than the state (40.43%) but lower than the national (45.57%) average, there is still a large percentage of children in the community who may not be receiving these early foundational learnings.



2 The influence of education on health: an empirical assessment of OECD countries for the period 1995–2015 | Archives of Public Health | Full Text (biomedcentral.com)

3 Early Childhood Education | US Department of Health and Human Services

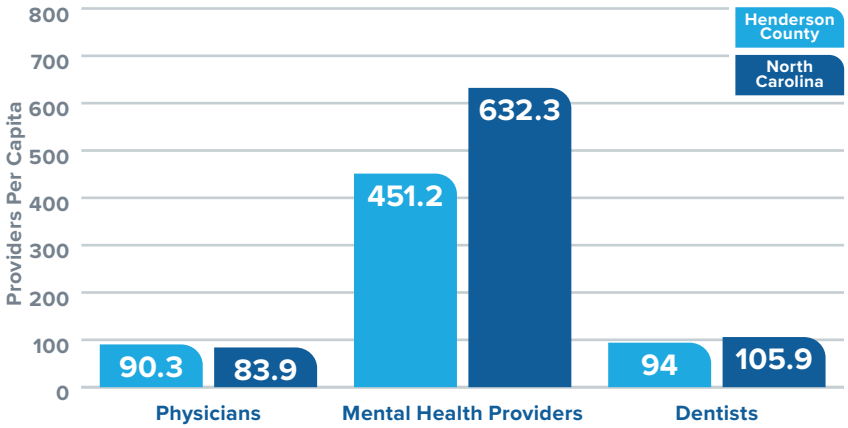
Health Care Access and Quality

In 2024, 22.7% of community members aged 18–64 were found to lack health insurance. Without access to health insurance, these individuals may experience delayed care, resulting in more serious health conditions and increased treatment costs. Although health insurance coverage levels can be a strong indicator of a person's ability to access care, there are other potential barriers that can delay care for many people.[4]

Accessing health care requires more than just insurance. There must also be health care professionals available to provide care. When more providers are available in a community access can be easier, particularly for those experiencing transportation challenges. In the counties served by the Hospital, both Buncombe and Henderson county have more physicians and dentists per capita than the state. However, Buncombe county has a significantly greater number of mental health providers per capita than the state, while Henderson county has less.

Routine checkups can provide an opportunity to identify potential health issues and when needed develop care plans. In the Hospital's community, 78.56% of people report visiting their doctor for routine care.

Available Health Care Providers

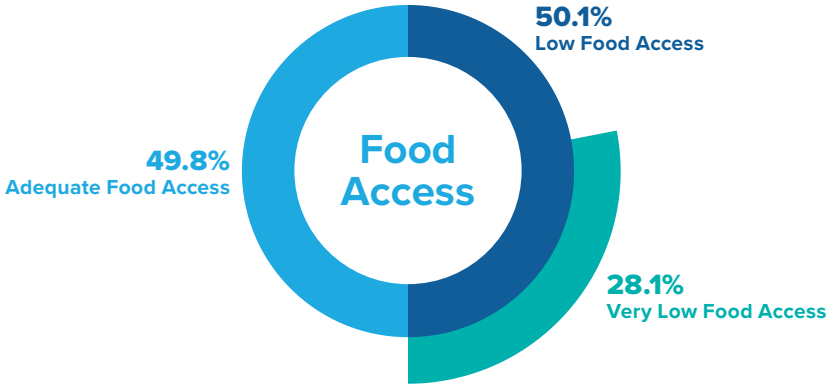


4 Health Insurance and Access to Care | CDC

Neighborhood and Built Environment

Increasingly, a community's neighborhoods and built environment are shown to impact health outcomes. If a neighborhood is considered to have low food access, which is defined as being more than ½ mile from the nearest supermarket in an urban area or ten miles in a rural area, it may make it harder for people to have a healthy diet. A very low food access area is defined as being more than one mile from your nearest supermarket in an urban area or 20 miles in a rural area.

A person's diet can have a significant impact on health, so access to healthy food is important. For example, the largest contributors to cardiovascular disease are obesity and type 2 diabetes, both of which can be impacted by diet.[5] In the Hospital's community, 50.9% of the community lives in a low food access area, while 28.1% live in a very low food access area.



People who are food insecure, who have reduced quality or food intake, may be at an increased risk of negative health outcomes. Studies have shown an increased risk of obesity and chronic disease in adults who are food insecure. Children who are food insecure have been found to have an increased risk of obesity and developmental problems compared to children who are not.[6] In 2021, 17% of households in Henderson County reported experiencing food insecurity.

Access to public transportation is also an important part of a built environment. For people who do not have cars, reliable public

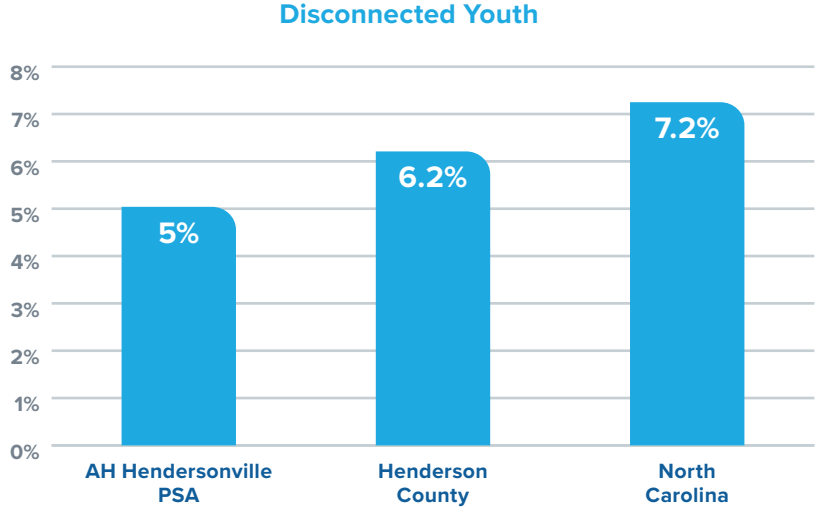
5 Heart Disease Risk Factors | CDC
6 Facts About Child Hunger | Feeding America

transportation can be essential to access health care, healthy food and steady employment. In the community, 4.86% of the households do not have an available vehicle.

Social and Community Context

People's relationships and interactions with family, friends, co-workers and community members can have a major impact on their health and well-being.[7] When faced with challenges outside of their control, positive relationships with others can help reduce negative impacts. People can connect through work, community clubs or others to build their own relationships and social supports. There can be challenges to building these relationships when people don't have connections to create them or there are barriers, like language.

In the community, 5.08% of youth aged 16-19 were reported as disconnected, meaning they were neither enrolled in school nor working at the time. The percentage of disconnected youth was highest in Henderson County at 6.21%.



Also, in the community 25.24% of seniors (age 65 and older) report living alone and 1.93% of residents report having limited English proficiency. All these factors can create barriers to feeling connected in the community.

7 Social and Community Context - Healthy People 2030 | U.S. Department of Health and Human Services

Social Determinants of Health

According to the CDC, social determinants of health (SDOH) are the conditions in the places where people live, learn, work and play that affect a wide range of health risks and outcomes. Social determinants of health are increasingly seen as the largest contributing factor to health outcomes in communities throughout the country.

The Hospital categorized and analyzed SDOH data following the Healthy People 2030 model. This approach was chosen so the Hospital could align its work with national efforts when addressing social determinants of health when possible. For the purposes of the CHNA, the Hospital will follow this model for reporting any related data.

The Healthy People 2030 place-based framework outlines five areas of SDOH:

Economic Stability

Includes areas such as income, cost of living and housing stability.

Education Access and Quality

This framework focuses on topics such as high school graduation rates, enrollment in higher education, literacy and early childhood education and development.

Health Care Access and Quality

Covers topics such as access to health care, access to primary care and health insurance coverage.

Neighborhood and Built Environment

Includes quality of housing, access to transportation, food security, and neighborhood crime and violence.

Social and Community Context

Focuses on topics such as community cohesion, civic participation, discrimination and incarceration.

Process, Methods and Findings

Process and Methods

The Process

The health of people living in the same community can be very different, because there are so many influencing factors. To understand and assess the most important health needs of its unique community and the people in it, the Hospital in partnership with a collaborative, HCDPH, solicited input directly from the community and from individuals who represent the broad interests of the community. A real effort was made to reach out to all members of the community to obtain perspectives across age, race and ethnicity, gender, profession, household income, education level and geographic location. The Collaborative also collected publicly available and internal hospital utilization data for review.

The Hospital partnered with local community organizations and stakeholders, including those in public health and those who represent the interests of medically underserved, low-income and minority community members, to form a Collaborative to guide the assessment process. The Collaborative is a regional effort through which health systems and departments of health spanning four counties work to improve community health by leading outcome driven initiatives addressing the needs found in the assessment. The Collaborative includes representation from the Henderson County Department of Public Health.

During data review sessions, community members of the Collaborative provided insight on how health conditions and areas of need were impacting those they represented. The Collaborative used the data review and discussion sessions to understand the most important health needs and barriers to health the community was facing and to guide the selection of needs to be addressed in the 2025 CHNA.

A real effort was made to reach out to all members of the community to obtain perspectives across age, race and ethnicity, gender, profession, household income, education level and geographic location.

Community Input

The Collaborative collected input directly from the community and from community stakeholders, including individuals working in organizations addressing the needs and interests of the community.

Input was collected through two different surveys: the WNC Healthy Impact Community Health Survey and the online key informant survey.

Community Health Survey

- The survey was conducted throughout the entire WNC Healthy Impact region, which includes the following 16 counties: Buncombe, Cherokee, Clay, Graham, Haywood, Henderson, Jackson, Macon, Madison, McDowell, Mitchell, Polk, Rutherford, Swain, Transylvania and Yancey.
- The survey was administered via a combination of telephone interviews (cell phone and landline) and an online survey to a random sample of adults.
- Telephone interviews were conducted in either English or Spanish, as preferred by respondents.
- The final sample included 5,898 random sample surveys, with 755 from Henderson County.

Online Key Informant Survey

- Online surveys were offered to local leaders and stakeholders as identified by PRC and a third-party provider.
- Participants include physicians and public health representatives. Participants were chosen because of their ability to identify primary concerns of the populations they work with.
- In all, 32 community stakeholders took part in the Online Key Informant Survey.

Public and Community Health Experts Consulted

A total of 55 stakeholders provided their expertise and knowledge regarding their communities, including:

Name	Organization	Role, Contribution
Alicia Evans	Council on Aging	CHA Forum
Amanda Goumas	Habitat for Humanity	CHA Forum
Angie Pena	Pisgah Legal Services, Latino Advocacy Coalition	CHA Forum
Belem Solanp	Interfaith Assistance Ministry	CHA Forum
Bridgette Thompson	Henderson County Parks and Recreation	CHA Forum
Charley Thompson	Blue Ridge Health, Partnership for Health	CHA Team, CHA Forum
Chira "Aser" Tandaira	Community Member	CHA Forum
Christopher Parker	Thrive, Partnership for Health	CHA Team, CHA Forum
Cindy Conner	AdventHealth Hendersonville	CHA Forum
Clint Holt	Children and Family Resource Center	CHA Forum
David Jenkins	Henderson County Department Public Health, Partnership for Health	CHA Team, CHA Data Team, CHA Forum
DeLaina Lewkowicz	AdventHealth Hendersonville, Partnership for Health	CHA Team, CHA Data Team, CHA Forum
Diana Curran	Henderson County Department Public Health	CHA Data Team
Donal Wilkie	Blue Ridge Health	CHA Data Team, CHA Forum
Ed Hudgins	Thrive	CHA Forum
Elizabeth Moss	Interfaith Assistance Ministry, Partnership for Health	CHA Team
Elizabeth Williams	Council on Aging, Partnership for Health	CHA Team, CHA Forum
Fabian Moreno	UNC MPH Student	CHA Forum
Graham Fields	AdventHealth Hendersonville, Partnership for Health	CHA Team, CHA Data Team

Name	Organization	Role, Contribution
Jamie Wiener	Children and Family Resource Center, Partnership for Health	CHA Data Team, CHA Forum
Jessica Perkins	The Free Clinics	CHA Forum
Jimmy Brissie	Henderson County Emergency Management	CHA Forum
Jodi Grabowski	Henderson County Department Strategic Behavioral Health, Partnership for Health	CHA Team, CHA Data Team, CHA Forum, Action Team Lead
Johanna Reed	Pardee UNC Health Care	CHA Forum
Jose Infanzon	UNETE, INC	CHA Forum
Joseph Knight	HandsOn! Children's Museum, Partnership for Health	CHA Team
Juliana Whitaker	Henderson County Department Public Health, Partnership for Health	CHA Lead, Author
Julie Huneycutt	Hope Coalition, Partnership for Health	CHA Team, Author
Kat Carlton	United Way of Henderson County, Partnership for Health	CHA Team, CHA Forum
Katrina McGuire	Hendersonville Family YMCA, Partnership for Health	CHA Team, CHA Forum
Kristen Bunch	Blue Ridge Community College	CHA Forum
Kylee Rose Frye	Boys and Girls Club	CHA Forum
Lauren Wilkie	Safelight, Partnership for Health	CHA Team, CHA Forum, Action Team Lead
Linda Saturno	Henderson County & Thermal Belt Habitat for Humanity, Partnership for Health	CHA Team, CHA Forum
Lorie Horne	Henderson County Department of Social Services, Partnership for Health	CHA Team, CHA Forum
Margaret Fenton Lebeck	Housing Assistance Corporation, Partnership for Health	CHA Team, CHA Forum
Martha Romero	Hendersonville Family YMCA	CHA Forum

Name	Organization	Role, Contribution
Mary Ellen Kustin	United Way of Henderson County	CHA Forum
Melisa Soto Escobar	True Ridge, Partnership for Health	CHA Team, CHA Data Team
Melissa Witmeier	Henderson County Department Public Health, Partnership for Health	CHA Team, CHA Forum, Action Team Lead
Michelle Geiser	Hope Coalition	CHA Data Team
Milton Butterworth	Pardee UNC Health Care, Partnership for Health	CHA Team, CHA Data Team, CHA Forum
Nancy Diaz	El Centro Hendersonville	CHA Forum
Noelle McKay	Housing Assistance Cooperation	CHA Forum
Pauline Carpenter	The Free Clinics, Partnership for Health	CHA Team, CHA Forum
Richard Hudspeth	Blue Ridge Health	CHA Forum
Roxanna Pepper	Children and Family Resource Center	CHA Forum
Sarah Kowalak	Henderson County Public Library	CHA Forum
Scott Galloway	Henderson County Sheriff's Office	CHA Forum
Shannon Auten	Henderson County Public Schools, Partnership for Health	CHA Team
Shawn Anderson	Community Member	CHA Forum
Sonya Jones	Henderson County Department Public Health, Partnership for Health	CHA Team, CHA Data Team, CHA Forum, Action Team Lead
Stacy Nash	Henderson County Department Public Health, Partnership for Health	CHA Team, CHA Data Team, CHA Forum
Tanya Blackford	Crossnore Communities for Children, Partnership for Health	CHA Team, CHA Forum
Trina Strokes	Blue Ridge Community College, Partnership for Health	CHA Team, CHA Forum

Secondary Data

To inform the assessment process, the Hospital collected existing health-related and demographic data about the community from public sources. This included data on health conditions, social determinants of health and health behaviors.

The most current publicly available data for the assessment was compiled and sourced from government and public health organizations including:

- US Census Bureau
- NC Department of Health and Human Services
- NC State Center for Health Statistics
- NC Division of Public Health
- NC State Departments

The Findings

To identify the top needs, the Collaborative analyzed the data collected across all sources. At the conclusion of the data analysis, there were 11 needs that rose to the top. These needs were identified as being the most prevalent in the community and frequently mentioned among community members and stakeholders.

The significant needs identified in the assessment process included:

Cancer

Cancer is the second leading cause of death in the United States. Healthy People 2030 focuses on promoting evidence-based cancer screening and prevention strategies—and on improving care and survivorship for people with cancer. 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.

Dementias

Alzheimer's disease is the most common cause of dementia and the sixth leading cause of death in U.S. adults. Nearly 6 million people in the United States have Alzheimer's, and that number will increase as the population ages. Healthy People 2030 focuses on improving care and quality of life for people with Alzheimer's and other causes 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.

Diabetes

More than 30 million people in the United States have diabetes, and it's the seventh leading cause of death. Healthy People 2030 focuses on reducing diabetes cases, complications, and deaths. 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.

Heart Disease and Stroke

Heart disease is the leading cause of death in the United States, and stroke is the fifth leading cause. Healthy People 2030 focuses on preventing and treating heart disease and stroke and improving overall cardiovascular health. 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.

Mental Health

About half of all people in the United States will be diagnosed with a mental disorder at some point in their lifetime. Healthy People 2030 focuses on the prevention, screening, assessment, and treatment of mental disorders and behavioral conditions. The Mental Health and Mental Disorders objectives also aim to improve health and quality of life for people affected by these conditions. 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

Overweight and Obesity

About 2 in 5 adults and 1 in 5 children and adolescents in the United States have obesity, and many others are overweight. Healthy People 2030 focuses on helping people eat healthy and get enough physical activity to reach and maintain a healthy weight. 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.

Respiratory Disease

Respiratory diseases affect millions of people in the United States. Healthy People 2030 focuses on increasing prevention, detection, and treatment of respiratory diseases. About 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.

Drug and Alcohol Use

More than 20 million adults and adolescents in the United States have had a substance use disorder in the past year. Healthy People 2030 focuses on preventing drug and alcohol misuse and helping people with substance use disorders get the treatment they need. 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.

Violence Prevention

Almost 20,000 people die from homicide every year in the United States, and many more people are injured by violence. Healthy People 2030 focuses on reducing different types of 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.

Economic Stability — Housing

People's homes can have a major impact on their health and well-being. Healthy People 2030 focuses on reducing health and safety risks in homes. Some homes have problems like lead paint or secondhand smoke, which can cause serious health issues. Other homes aren't accessible to people with disabilities and older adults. Both individual-level strategies and policy-level actions can help people stay safe and healthy at home. Some people also struggle to pay for their homes. This is linked to worse mental health and an increased risk of disease. Policies that make housing more affordable can help improve health and reduce the risk of homelessness.

Social and Community Context

People's relationships and interactions with family, friends, co-workers, and community members can have a major impact on their health and well-being. Healthy People 2030 focuses on helping people get the social support they need in the places where they are born, live, learn, work, play, worship, and age. Many people face challenges and dangers they can't control — like unsafe neighborhoods, discrimination, or trouble affording the things they need. This can have a negative impact on health and safety throughout life.

Positive relationships at home, at work, and in the community can help reduce these negative impacts. But some people — like children whose parents are in jail and adolescents who are bullied — often don't get support from loved ones or others. Interventions to help people get the social and community support they need are critical for improving health and well-being.

Priorities Selection

The Collaborative, through data review and discussion, narrowed the health needs of the community to a list of 11. Community partners on the Collaborative represented the broad range of interests and needs, from public health to the economic, of underserved, low-income and minority people in the community. During May 2025, the Collaborative met to review and discuss the collected data and select the top community needs.

Members of the Collaborative included:

Community Members

- Elizabeth Moss, Interfaith Assistance Ministry
- Donal Wilkie, Blue Ridge Health
- Jamie Wiener, Children and Family Resource Center
- Jerrie McFalls, Henderson County Department of Social Services
- Jodi Grabowski, Henderson County Department of Strategic Behavioral Health
- Julie Huneycutt, Hope Coalition
- Kat Carlton, United Way of Henderson County
- Mary Ellen Kustin, United Way of Henderson County
- Melisa Soto Escobar, True Ridge
- Milton Butterworth, UNC Health Pardee
- Michelle Geiser, Hope Coalition
- Shannon Auten, Henderson County Public Schools

AdventHealth Team Members

- DeLaina Lewkowicz, Director of Community Benefit, AdventHealth Hendersonville
- Graham Fields, Director of Governmental Relations, AdventHealth Hendersonville

Public Health Experts

- Melissa Witmeier, Henderson County Department of Public Health/ Partnership for Health
- Camden Stewart, Henderson County Department of Public Health

Community partners on the Collaborative represented the broad range of interests and needs, from public health to the economic, of underserved, low-income and minority people in the community.

- Diana Curran, MD, Henderson County Department of Public Health
- David Jenkins, Henderson County Department of Public Health
- Juliana Whitaker, Henderson County Department of Public Health
- Sonya Jones, Henderson County Department of Public Health
- Stacy Nash, Henderson County Department of Public Health

Prioritization Process

To identify the top needs the Collaborative participated in a prioritization session. During the session, the data behind each need was reviewed, followed by a discussion of the need, the impact it had on the community and the resources available to address it. Collaborative members used a modified Hanlon method to rate the needs. Then, using the criteria listed below, ranked the five needs from the #1 to #5 via an online Microsoft Form.

The following criteria were considered during the prioritization process:

A. Relevance

How important is this issue? (Size of the problem; Severity of problem; Focus on equity; Aligned with HNC 2030; Urgency to solve problem; Linked to other important issues)

B. Impact

What will we get out of addressing this issue? (Availability of solutions/proven strategies; Builds on or enhances current work; Significant consequences of not addressing issue now)

C. Feasibility

Can we adequately address this issue? (Availability of resources (staff, community partners, time, money, equipment) to address the issue; Political capacity/will; Community/social acceptability; Appropriate socio-culturally; Easily identifiable short-term wins)

The following needs rose to the top during the Collaborative's discussion and prioritization session.

- Dementias
- Mental Health
- Economic Stability—Housing

After a list of the top 11 health needs of the community had been voted on by the Collaborative, they were presented to the Hospital Health Needs Assessment Committee (HHNAC). The HHNAC met and reviewed the data behind the selected needs and the available resources to address them in the community. The HHNAC also considered the Hospital's current resources and strategies to find ways to most effectively address the needs. Through these discussions the Hospital selected the needs it is best positioned to impact.

Members of the HHNAC included:

- DeLaina Lewkowicz, Director of Community Benefit, AdventHealth Hendersonville
- Graham Fields, Director of Governmental Relations, AdventHealth Hendersonville
- Brandon Nudd, Pres CEO AdventHealth Waterman, AdventHealth Hendersonville
- Cindy Conner, Population Health Director, AdventHealth Hendersonville
- Jocely Shaw, Vice President of Mission and Ministry, AdventHealth Hendersonville
- Jennifer Taiwo, Executive Director of Operations (Phys Ent), AdventHealth Hendersonville
- Alicia Evans, Ambulatory Social Worker, AdventHealth Hendersonville
- Anna Hicks, MD, Geriatric Medicine PRN, AdventHealth Hendersonville

The HHNAC narrowed down the list to 3 priority needs:

- Dementias
- Mental Health
- Economic Stability—Housing

Available Community Resources

As part of the assessment process, a list of resources or organizations addressing the top needs in the community was created. Although not a complete list, it helped to show where there were gaps in support and opportunities for partnership in the community when the CHNAC chose which priorities to address.

Top Needs	Current Community Programs	Current Hospital Programs
Dementia	• Mountain Aging Partners	• Age-Friendly Programs • Age-Friendly IOP
Mental Health	• Department of Public Health • Blue Ridge Health • Love and Respect Community for Recovery and Wellness • Thrive • The Free Clinics	• Women's BH Inpatient Unit • Adolescent Girl BH Inpatient Unit • Outpatient HUB • Age-Friendly, Adult & Adolescent IOP
Economic Stability—Housing	• Habitat for Humanity • Thrive • Housing Assistance Corporation	• CommunityConnect (SDOH Screening Pilot)

Priorities Addressed

The priorities to be addressed include:

Dementias

By 2050, a significant portion of the population will be aged 65 and older, with 13.7% between 65–75, 11.6% between 75–84, and 6.7% aged 85 and above. Alzheimer's Disease remains a major concern, ranking as the 7th leading cause of death and showing a higher mortality rate among women. Dementia and cognitive decline were identified as moderate to major health issues by 96.6% of key informants. Additionally, unintentional falls pose a serious risk, with 233 deaths reported—94% of which occurred in individuals aged 65 and older—and 69% of key informants recognizing falls as a significant health problem.

Dementias, including Alzheimer's disease, are increasingly affecting the health and well-being of Henderson County residents. With a rapidly aging population and growing caregiver demands, the need for coordinated, compassionate dementia care and prevention has become a clear community priority.

Mental Health

Mental health and suicide continue to be pressing concerns in the community, with 100% of key informants identifying mental health and 96.8% identifying suicide as moderate to major health problems. Nearly a quarter (24.9%) of adults are currently receiving mental health treatment, while 16.5% reported unmet mental health needs in the past year—rates were notably higher among Hispanic (21.4%), Black (18.2%), and LGBTQ+ (31.5%) populations. Although 63.7% of adults report receiving adequate social/emotional support, 15.4% experienced more than seven days of poor mental health in the past month, and 10.3% expressed dissatisfaction with life. Alarmingly, 8.4% of adults considered suicide in the past year, with LGBTQ+ individuals disproportionately affected (31%). The suicide mortality rate stands at 19.0 per 100,000—nearly 41% higher than the state average—with males experiencing significantly higher rates than females. Between

2019 and 2023, eight children aged 10–17 died by suicide, three of whom were in 2023 alone, underscoring the urgent need for targeted mental health support.

Mental health is an essential component of overall well-being and is deeply interconnected with physical health, economic stability, and social functioning. In our community, the growing prevalence of mental health disorders, coupled with limited access to care and stigma, has made this issue a pressing public health concern. In the wake of a natural disaster, like Hurricane Helene, research shows the negative long-term effect can be exponential. Prioritizing mental health in the CHNA reflects both the community's voiced needs, the realities of recovering from what is being called "a once in a 1,000-year disaster," and the hospital's commitment to holistic, equitable care.

Economic Stability—Housing

Housing affordability and stability are major concerns in the community, identified as a 2021 CHA Health Priority and a Healthy NC 2030 Indicator. A significant portion of residents are financially burdened by housing costs, with 40.2% of renters and 25.8% of homeowners spending 30% or more of their income on housing. Fair market rent in 2024 ranges from $1,428 for a studio to $2,160 for a three-bedroom unit—among the highest in Western North Carolina. Housing stress disproportionately affects Hispanic (54.2%), Black (42.7%), and LGBTQ+ (20.6%) populations. Many adults reported living in unsafe conditions (13.9%), experiencing utility disruptions (11.1%), or facing housing emergencies that led them to stay with others (10.1%) or live in temporary shelters or on the streets (4%). In 2024, 176 individuals were counted as homeless, and in early 2025, Hurricane Helene caused damage to over 3,000 structures, with 296 completely destroyed, further exacerbating housing instability.

Housing is a foundational determinant of health, and its stability directly influences physical, mental, and social well-being. In our community, the intersection of economic hardship and housing insecurity has emerged as a critical barrier to achieving equitable health outcomes. Prioritizing Economic Stability – Housing in the CHNA reflects both the urgency of local needs and the hospital's commitment to addressing root causes of poor health outcomes.

Priorities Not Addressed

The priorities not to be addressed include:

Cancer

Cancer remains a significant health concern in the community, with a slight increase in the overall mortality rate to 144.7 per 100,000. The cancer incidence rate is notably higher than both the Western North Carolina (WNC) and North Carolina (NC) averages, making it the second leading cause of death in the area. Additionally, 90.3% of key informants identified cancer as a moderate to major health problem, highlighting its impact and the need for focused attention.

While cancer remains a significant health concern in Henderson County, it was not selected as a priority area in this CHNA. The hospital and its partners are always working toward stronger cancer screening, treatment, and support services. Local data shows that cancer-related outcomes are being actively addressed through existing initiatives. During community engagement, cancer was not consistently identified as a top concern compared to other emerging issues such as mental health, housing instability, and aging-related conditions. By focusing on areas with greater unmet needs and community urgency, the hospital aims to maximize its impact while continuing to support cancer care through ongoing programs and partnerships.

Diabetes

Diabetes continues to be a growing health concern in the community, identified as both a 2021 CHA Health Priority and a Healthy NC 2030 Indicator. Currently, 13.4% of adults report having borderline or pre-diabetes, while 9.1% have been diagnosed with diabetes—rates are notably higher among Hispanic (15.2%) and Black (13.5%)

populations compared to White adults (8.5%). The diabetes mortality rate has risen from 11.2 per 100,000 in 2015 to 16.9 per 100,000 in 2022, making it the ninth leading cause of death. Additionally, 96.8% of key informants identified diabetes as a moderate to major health issue, emphasizing the need for continued prevention and management efforts.

While diabetes continues to be a significant health issue in Henderson County, it was not selected as a priority in this CHNA. The hospital and its community partners already offer a range of diabetes prevention, education, and management programs that are addressing local needs. During community engagement, diabetes was not consistently identified as a top concern compared to other emerging issues such as mental health, housing instability, and aging-related conditions. The hospital will continue to emphasize the importance of diabetic prevention, education and treatment. By focusing on areas with greater unmet needs and community urgency, the hospital aims to maximize its impact while continuing to support diabetes care through existing initiatives.

Heart Disease and Stroke

Heart disease and stroke remain critical health concerns in the community, ranking as the first and fourth leading causes of death, respectively, with a combined mortality rate of 146.9 per 100,000. A significant 93.3% of key informants identified these conditions as moderate to major health problems. Mortality rates are disproportionately higher among men and Black/African American populations, with Black males experiencing the highest rate at 248.5 per 100,000. Additionally, 44% of adults reported having high blood pressure, and 38.8% reported high cholesterol—both major risk factors contributing to cardiovascular disease.

While the hospital continues to grow in services in support around heart disease and stroke prevention, it was not chosen as a priority because of community engagement, residents and stakeholders voicing greater concern for emerging issues such as mental health, housing instability, and aging-related conditions. By focusing on areas with growing unmet needs, the hospital aims to make the greatest impact on community well-being while continuing to support ongoing efforts in heart health through existing initiatives.

Overweight and Obesity

Obesity, physical inactivity, and food insecurity are major health concerns in the community, identified as a 2021 CHA Health Priority and a Healthy NC 2030 Indicator. Nearly all key informants (96.9%) recognized obesity as a moderate to major issue. Over one-fifth (21.7%) of adults reported no leisure-time physical activity in the past month, with particularly high rates among Black (74.4%) and Hispanic (37.7%) populations. Only 29% of adults meet physical activity guidelines, and 64.4% are overweight or obese, with 30.2% classified as obese—rates highest among Hispanic adults (41%). Nutrition remains a challenge, with just 4.5% of adults consuming five or more servings of fruits and vegetables daily. Food insecurity affects 24.1% of adults, disproportionately impacting Hispanic (53.3%), Black (45.9%), and LGBTQ+ (43.5%) individuals. Additionally, Hurricane Helene caused significant agricultural losses, including the destruction of 30 farms and over 54,000 apple trees, totaling an estimated $169 million in damages.

While overweight and obesity are important contributors to chronic disease, they were not selected as priority areas in this CHNA. The Hospital and its partners offer a variety of programs focused on nutrition, physical activity, and chronic disease prevention that address these concerns. By focusing on these emerging priorities, the Hospital aims to make the greatest impact while continuing to support healthy lifestyle initiatives through existing efforts.

Respiratory Disease

Chronic lower respiratory disease is the sixth leading cause of death in the community and has been identified as a 2021 CHA Health Priority. A significant portion of key informants view respiratory health as a concern, with 76.7% identifying chronic lung disease, 48% identifying respiratory disease, and 37% identifying asthma as moderate to major health problems. The prevalence of asthma and chronic obstructive pulmonary disease (COPD) has increased in Henderson County, alongside a rise in adult tobacco use, further contributing to respiratory health challenges.

While respiratory diseases such as asthma, COPD, and chronic bronchitis are important health concerns, they were not selected as priority areas in this CHNA. The Hospital has existing clinical programs and partnerships that are addressing respiratory health through prevention, treatment, and education efforts. Additionally, community feedback did not identify respiratory disease as a top concern when compared to more urgent issues such as mental health, housing instability, and aging-related conditions. The Hospital will continue to support respiratory care through ongoing services while focusing CHNA efforts on areas with unmet needs and community impact.

Drug and Alcohol Use

Substance use is a critical health issue in the community, identified as a Healthy NC 2030 Indicator and recognized by 100% of key informants as a moderate to major concern. Smoking and vaping rates have significantly increased since 2021, with 13.3% of adults currently smoking and 8.5% using vaping products—rates are especially high among Black adults. Alcohol misuse is prevalent, with 17.5% of adults reporting binge drinking and 22% engaging in excessive drinking, contributing to 31% of fatal vehicle crashes in 2023. Prescription opioid use affected 10% of adults in the past year, and nearly half (47.1%) reported that substance use—either their own or someone else's—negatively impacted their lives, with LGBTQ+ individuals most affected (73.2%). The unintentional poisoning mortality rate has reached its highest level at 30.1 per 100,000, and 84.4% of overdose deaths in 2023 involved illicit opioids, underscoring the urgent need for prevention and intervention efforts.

While drug and alcohol use remain serious public health concerns, they were not selected as priority areas in this CHNA. Community feedback and local data indicated that substance use, while important, can be closely related to overall mental health. Additionally, the Hospital and its partners support a range of substance use prevention and treatment programs, including behavioral health services and community-based initiatives. By focusing CHNA efforts on areas with greater gaps in care and community urgency, the Hospital aims to make the most meaningful impact while continuing to support substance use services through existing programs.

Violence Prevention

Injury and violence are recognized as significant health concerns in the community, with 76.7% of key informants identifying them as moderate to major issues. Safelight, a local crisis support organization, received 661 hotline calls and served 912 clients during FY 2022–2023, including 21% under the age of 18, 82% female, and 6% Hispanic. Additionally, 7.4% of CHA survey participants reported that someone in their household had experienced abuse or exploitation in the past three years. These issues are often exacerbated by disasters such as COVID-19 and Hurricane Helene, highlighting the need for continued support and prevention efforts.

While violence prevention is a critical component of public health, it was not selected as a priority in this CHNA. Community input and local data did not identify violence—such as domestic violence, youth violence, or crime—as a top concern compared to other pressing issues like mental health, housing instability, and aging-related conditions. Additionally, existing partnerships with law enforcement, schools, and social service agencies are actively addressing violence prevention through mature targeted programs. The hospital remains committed to supporting safe environments, partnerships with IPV prevention/support organizations, and trauma-informed care, while focusing CHNA efforts on areas with unaddressed health needs.

Social and Community Context

Community inclusivity and equity remain areas of concern, with 14.6% of adults expressing that the community is not welcoming to people of all races and ethnicities—this sentiment is especially pronounced among LGBTQ+ individuals (37.1%). Experiences of harassment and unfair treatment are also reported, with 5.9% of adults feeling threatened or harassed, and 4.5% treated unfairly when receiving medical care, particularly among Hispanic and LGBTQ+ populations. Unfair treatment in schools affected 3.7% of adults, with higher rates among Hispanic (10.2%) and Black (11.9%) individuals. These experiences have led to physical symptoms for 18.1% of adults, with race and appearance cited as the most common reasons for

discrimination. These findings highlight the need for continued efforts to promote equity, safety, and inclusion across all community settings.

While Community and Social Context were not included in the hospitals CHNA, the hospital is always prioritizing inclusivity in all facets. The hospital supports equity across all its partnerships and will continue with this work. While community and social context—including factors like social support, civic engagement, and discrimination—play a critical role in overall health, this area was not selected as a standalone priority in the CHNA. Many of the underlying issues related to social context are already being addressed through other prioritized areas such as housing, mental health, SDOH and aging. The hospital remains committed to fostering strong community connections and equity through its ongoing programs and partnerships, even as it focuses its CHNA efforts on areas with the most urgent and unmet needs.

Next Steps

The Collaborative will work with the Hospital and other community partners to develop a measurable Community Health Plan for 2026–2028 to address the priority needs. For each priority, specific goals will be developed, including measurable outcomes, intervention strategies and the resources necessary for successful implementation.

Evidence-based strategies will be reviewed to determine the most impactful and effective interventions. For each goal, a review of policies that can support or deter progress will be completed with consideration of opportunities to make an impact. The plan will be reviewed quarterly, with an annual assessment of progress. A presentation of progress on the plan will also be presented annually to the Hospital board.

A link to the Community Health Plan will be posted on AdventHealth.com prior to May 15, 2026.

Community Health Plan

2023 Community Health Plan Review

The Hospital evaluates the progress made on the implementation strategies from the Community Health Plan annually. The following is a summary of progress made on our most recently adopted plan. The full evaluation is available upon request.

Priority 1: Mental Health

In 2023, AdventHealth Hendersonville reaffirmed its commitment to addressing mental health challenges in Henderson County and surrounding region. The latest Community Health Needs Assessment painted a sobering picture: nearly one in five residents reported experiencing poor mental health for a week or more each month, and over 16% said they couldn't access the care they needed. Suicide remained a leading cause of death, especially among young adults aged 20 to 39.

In response, Henderson County launched a comprehensive plan aimed at improving access to mental and behavioral health services with a focus on reducing suicide deaths. The goal was clear—reduce the percentage of adults unable to receive needed care by nearly one full percentage point by the end of 2025. To achieve this, AdventHealth leaned into community collaboration, continuing its active role in the Henderson County Behavioral Health Action Team and hosting monthly meetings and to bring together local providers, educators, and advocates to bring awareness to available resources. The hospital sponsored the Mental Health First Aid Training in partnership with Henderson County Public Schools.

The plan emphasized outreach to underserved populations, including those living in poverty and individuals with severe mental illness. Partnerships with organizations including Thrive, The Free Clinics, and Henderson County Public Schools—were

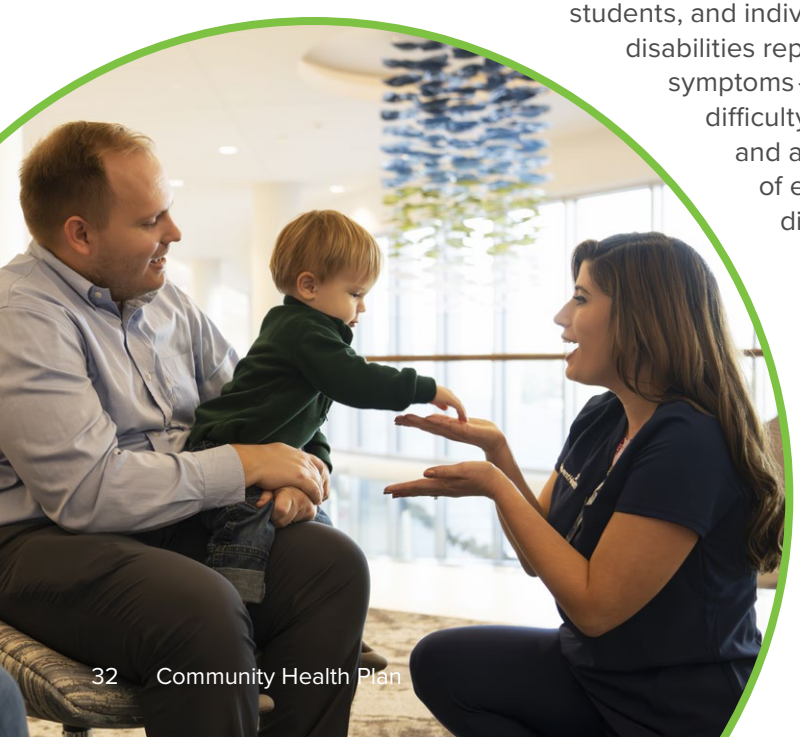
The Hospital evaluates the progress made on the implementation strategies from the Community Health Plan annually.

central to the strategy, creating a network of support that extended across the region. Thrive increased its clubhouse membership to 45 in 2024.

AdventHealth's FaithConnect created a movement aimed at teen suicide prevention. The hospital partnered with Henderson County Public Schools to show the documentary of Emma Benoit. The following week, the first annual "Light the Night 828" welcomed over 1,300 students and parents (supported by over 200 volunteers) to hear Emma talk about her attempted suicide and the hope she has now. Over 30 mental health responses were met by professional mental health providers.

The year also brought unexpected challenges. In September 2024, Hurricane Helene swept through Western North Carolina, leaving behind not just physical damage but emotional trauma. Our communities were deeply affected. In the wake of the storm, federal and state agencies mobilized quickly. Nearly $3 million in emergency funding was directed toward expanding crisis counseling services.

These counselors provided face-to-face outreach, emotional support, and referrals to behavioral health services. The impact was immediate and profound. First responders, college students, and individuals with disabilities reported heightened symptoms—nightmares, difficulty concentrating, and a sense of emotional disconnection. The hospital created walk-in clinics at the offices that were able to open in order to create access to care.



Despite these efforts, stigma remained a barrier. Many residents, especially in rural areas, hesitated to seek help. While Helene created unprecedented roadblocks for our community, The Free Clinics still served 4,817 patients in their Behavioral Health Program.

Together, the community's response to both ongoing mental health needs and the acute crisis brought on by Hurricane Helene demonstrated a growing awareness and commitment to mental well-being. The hospitals' health leaders, providers, and residents showed that even in the face of adversity, progress is possible when compassion and collaboration lead the way.

Priority 2: Substance Misuse

In 2023, AdventHealth Hendersonville took decisive steps to address the growing crisis of substance misuse in Henderson County. The Community Health Needs Assessment revealed troubling trends: rising rates of overdose deaths, increasing misuse of prescription medications, and a lack of accessible treatment options for those struggling with addiction. Slightly more than 42% of respondents to the CHA survey reported their life had been negatively impacted by substance misuse. These findings aligned with broader state-level concerns, as North Carolina continued to battle a complex and evolving overdose epidemic.

Recognizing the urgency, AdventHealth Hendersonville identified substance misuse as one of its top five health priorities. The hospital's Community Health Plan - in step with the County plan - laid out a multi-year strategy focused on prevention, education, and expanding access to care. The plan emphasized collaboration with community-based organizations, bringing together public health agencies, schools, law enforcement, and nonprofit organizations to form a united front against addiction.

One of the plan's core goals was to increase the availability of treatment and recovery services. This included supporting Medication-Assisted Treatment (MAT) programs, promoting safe prescription practices, and educating the public about the risks of opioid misuse.

The hospital donated funds to treatment organizations such as Asheville Buncombe Community Christian Ministries' (ABCCM) Steadfast House residential substance abuse program that served 203 women and children in 2024. AdventHealth made a donation to Hope Coalition, a foundational organization in the fight against substance misuse in Henderson County, to sponsor Hope Week in Henderson County Public Schools. This series of programs aims at educating students about the effects of substance use while implementing evidence based prevention tools.

Together, these initiatives created a more robust and responsive ecosystem for addressing substance misuse in Western North Carolina. AdventHealth Hendersonville's commitment to this priority reflected a broader shift toward treating addiction not just as a medical issue, but as a community-wide challenge requiring empathy, coordination, and sustained action.

Priority 3: Physical Activity and Nutrition

In 2023, AdventHealth Hendersonville launched a renewed effort to promote healthier lifestyles through its Community Health Plan, with physical activity and nutrition identified as one of the top five priorities. This decision was grounded in the findings of the 2022 Community Health Needs Assessment, which highlighted concerning trends in obesity, chronic disease, and limited access to healthy food and safe spaces for exercise—especially among low-income and underserved populations in Henderson County. A main goal was to close the gap in food insecurity across the area, with emphasis on healthy and nutritious options.

Collaborations with local food banks and nonprofits helped ensure that families in need could access nutritious meals without stigma or financial strain. The plan financially supported food banks like Interfaith Assistance Ministry (IAM), Asheville-Buncombe Community Christian Ministries (ABCCM), Western Carolina Rescue Ministries, and The Storehouse.

One of the key objectives was to create more opportunities for young people to get involved in physical activity early on. The Girls on the Run program in Western North Carolina had 431 girls participate in 2024 which was an increase of 143% from 2022.

Throughout the year, AdventHealth emphasized the importance of equity and inclusion, ensuring that interventions reached those most affected by health disparities. The plan also aligned with Healthy People 2030 goals and the North Carolina State Health Improvement Plan, reinforcing a statewide commitment to improving physical health through sustainable, community-driven solutions.

The hospital launched a program for the community that included walking with a provider once a month to encourage movement and discussions about the benefits of exercise for body and mind.

By the end of 2023, early indicators showed promising engagement from residents and community partners. While long-term outcomes will be evaluated annually, the foundation laid in 2023 marked a significant step toward building a healthier, more active, and better-nourished community in Henderson County and beyond.

Priority 4: Safe and Affordable Housing

In 2023, AdventHealth Hendersonville recognized that access to safe and affordable housing is a foundational determinant of health. The Community Health Needs Assessment revealed that many residents in Henderson County were burdened by housing costs, with a quarter of homeowners and 42.8% of renters paying over 30% of their income towards housing. These challenges were especially acute for low-income families, seniors, and individuals with disabilities.

To address this, in alignment with the County, AdventHealth included safe and affordable housing as a key priority in its Community Health Plan. The hospital's strategy focused on advocacy, partnership, and resource alignment to support housing stability and improve living conditions. Emergency housing support was indicated as a goal, and the hospital financially supported Western Carolina Rescue Ministries that provided 31,196 safe beds in 2024. The plan emphasized the importance of cross-sector collaboration, engaging local government, housing authorities, nonprofits, and health providers to create a more integrated response to housing insecurity.

One of the plan's central goals was to increase access to affordable housing options while supporting efforts to improve the quality and safety of existing housing. This included supporting initiatives that provided rental assistance, promoted affordable housing development, and reduced barriers to housing access—such as credit history or lack of documentation. The hospital financially supported Thrive's programs which served 526 clients with housing assistance in 2024.

The urgency of this work was underscored in the aftermath of Hurricane Helene. The storm caused widespread damage to homes and infrastructure, displacing families and exacerbating existing housing challenges. In Henderson County and surrounding areas, temporary shelters filled quickly, and many residents faced prolonged recovery periods due to limited affordable housing options. The disaster highlighted the fragility of the housing system and reinforced the need for resilient, safe, and affordable housing as a public health priority. In the wake of Helene, we continued to support Habitat for Humanity in their efforts to build and repair homes that were damaged. In 2024 Habitat completed 69 home repairs in the community.

AdventHealth's approach to this priority was not just about buildings—it was about people. By supporting housing as a health intervention, the hospital helped shift the narrative from crisis response to proactive community wellness. The plan laid the groundwork for future investments, policy advocacy, and deeper partnerships that would continue to shape the region's housing landscape.

Priority 5: Interpersonal Violence

AdventHealth Hendersonville identified interpersonal violence (IPV) as a critical health priority in its Community Health Plan, recognizing the profound and often hidden impact it has on individuals and families across Henderson County. The Community Health Needs Assessment revealed that many residents—particularly women, children, and individuals with disabilities—face elevated risks of physical, emotional, and sexual abuse, often without access to adequate support or intervention.

Interpersonal violence encompasses a wide range of harmful behaviors, including intimate partner violence, child maltreatment, elder abuse, and community violence such as bullying and assault. The plan acknowledged that IPV is not only a public safety issue but a public health crisis—one that contributes to long-term trauma, mental health disorders, substance misuse, and chronic physical conditions.

AdventHealth's strategy focused on prevention, education, and trauma-informed care. The hospital partnered with local organizations such as Helpmate, Safelight and Our Voice to strengthen referral networks and ensure survivors could access safe, confidential, and culturally competent services.

The hospital supported Our Voice, which served 520 survivors in 2024 through their programs. The hospital also partners with Safelight to provide financial and provider support for the Child Advocacy Center which conducted 263 child medical exams in 2024.

The urgency of this work was magnified in the aftermath of Hurricane Helene. Natural disasters often exacerbate interpersonal violence, as families face increased stress, displacement, and isolation. In Henderson County, shelters and temporary housing facilities reported a rise in domestic violence incidents following Hurricane Helene. The disruption of support systems and heightened economic insecurity created conditions where abuse could escalate unchecked. AdventHealth and its partners responded by reinforcing crisis intervention services and ensuring that survivors had access to safe spaces and trauma-informed care during recovery.

Through its commitment to addressing interpersonal violence, AdventHealth Hendersonville demonstrated a holistic understanding of health—one that includes safety, dignity, and the right to live free from harm. The 2023 plan laid the foundation for a more resilient and compassionate community, where healing is not only possible but prioritized.

2022 Community Health Needs Assessment Comments

We posted a link to the most recently-conducted CHNA and the most recently adopted implementation strategy, 2023 Community Health Plan on our hospital website as well as on AdventHealth.com prior to May 15, 2023 and have not received any written comments.

AdventHealth

Fletcher Hospital Inc. dba AdventHealth Hendersonville

CHNA Approved by the Hospital board on: November 12, 2025

For questions or comments, please contact
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