2024 Community Health Needs Assessment

Sycamore Shoals Hospital

BalladHealth™

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The Core Team, supported by the Community Engagement Team, conducted the assessment and prepared this report.

Senior Executive Sponsor
Paula Masters | Ballad Health

Core Team
Paezha McCartt | Ballad Health
Brianna Gorsky Robbins | Ballad Health
Gaffar Solihu | Ballad Health

Community Engagement Team
Rachel Stiltner | Ballad Health
Jessica Harmon | Ballad Health
Emily Wells | Ballad Health
Maria Mitchell | Ballad Health
Paula Masters | Ballad Health

Collaborative Partners
David Driscoll | Healthy Appalachian Institute

Regional Steering Committee

Paula Masters | Ballad Health
Paezha McCartt | Ballad Health
Casey Carringer | Ballad Health
Mark Cruise | STRONG ACC
Brittany Boles | STRONG ACC
Tyler Wright | Tennessee Department of Health
Jamie Hensley | Tennessee Department of Health
Caroline Chinouth | Tennessee Department of Health
Ada Sloop | Tennessee Department of Health
Maiah Morris | Virginia Department of Health
Donna Surber | Virginia Department of Health
Allison Phillips | Virginia Department of Health
Dan Hunsucker | Virginia Department of Health
Resa Sloce | Virginia Department of Health

Executive Summary

Ballad Health is deeply committed to the health and well-being of our communities. By merging two legacy health systems, we have strengthened our focus on understanding and addressing the socioeconomic factors that impact health. We recognize that health is influenced by more than genetics — access to care and health literacy are vital. As the region’s largest employer, we are dedicated to collaborating with our communities to create lasting health improvements that will benefit future generations.

Ballad Health and its hospitals have pledged to improve the health of our service area counties by focusing on access, quality and population health measures. These metrics enable Ballad Health to collaborate with our communities and address the region's health disparities and access challenges. Through the Community Health Needs Assessment (CHNA) process, we have gained valuable insights into the health disparities within our communities and prioritized the most pressing issues in each hospital's service area. This collaborative approach helps us educate and drive meaningful change, ensuring better health outcomes for all.

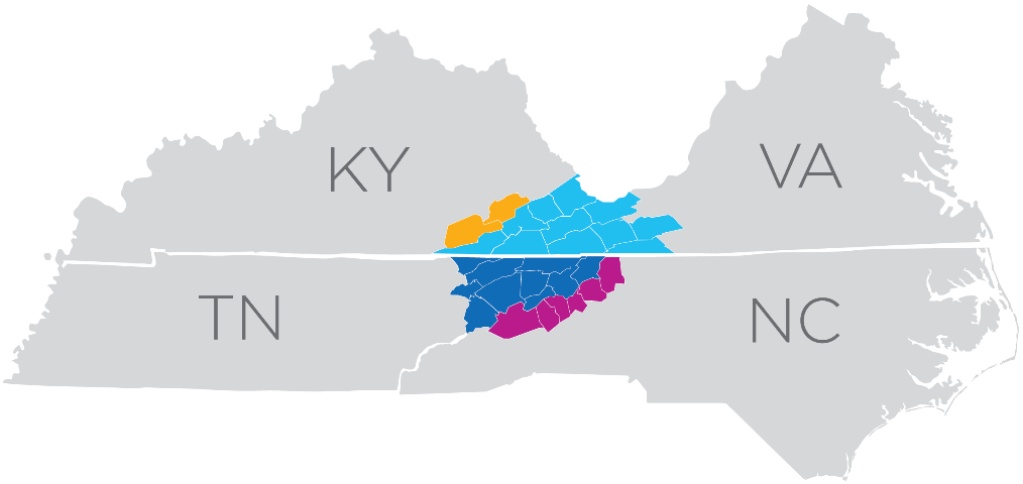
To assess the health of those living in our service area, Ballad Health utilized the Mobilizing for Action through Planning and Partnerships (MAPP 2.0) framework. This comprehensive assessment was conducted from summer 2023 through spring 2024. We gathered primary data through surveys with community partners and members, as well as stakeholder meetings. Additionally, we compiled secondary data from national, state, regional and county sources. This thorough approach helps us understand and address the unique health needs of our communities.

Throughout the community health needs assessment process, we focused on identifying health priorities and disparities within each community. Community members ranked the top three health issues in their area, providing valuable local insights. Combining these perspectives with county, state and national data gives us a comprehensive view of the region's health. This foundation helps us develop effective solutions to improve health outcomes for all.

The community health needs assessment identified chronic disease, behavioral and mental health and obesity and overweight as the top three health priorities in Northeast Tennessee, especially in Carter County. These issues emerged as the most pressing health concerns based on data from various sources, including local perspectives and community surveys. Addressing these critical areas allows us to focus efforts on improving overall health outcomes and quality of life in the region.

Ballad Health

Introduction



Ballad Health is an integrated community health improvement organization serving 29 counties of the Appalachian Highlands in Northeast Tennessee, Southwest Virginia, Northwest North Carolina and Southeast Kentucky. Our system of 20 hospitals, post-acute care and behavioral health services, and a large multi-specialty group physician practice works closely with an active independent medical community and community stakeholders to improve the health and well-being of close to one million people. By leading in the adoption of value-based payments, addressing health-related social needs, funding clinical and health systems research and committing to long-term investments in strong children and families in our region, Ballad Health is striving to become a national model for rural health and healthcare.

Ballad Health Hospitals

- Bristol Regional Medical Center
- Dickenson Community Hospital
- Franklin Woods Community Hospital
- Greeneville Community Hospital
- Hancock County Hospital
- Hawkins County Memorial Hospital
- Holston Valley Medical Center
- Indian Path Community Hospital
- Johnson City Medical Center
- Johnson County Community Hospital
- Johnston Memorial Hospital
- Lonesome Pine Hospital
- Lee County Community Hospital
- Niswonger Children's Hospital
- Norton Community Hospital
- Russell County Hospital
- Smyth County Hospital
- Sycamore Shoals Hospital
- Unicoi County Hospital
- Woodridge Hospital

Nearly

1 million

residents across the Ballad Health service area

13,000+

team members

Ballad Health

Mission

Honor those we serve by delivering the best possible care

Vision

To build a legacy of superior health by listening to and caring for those we serve

Values

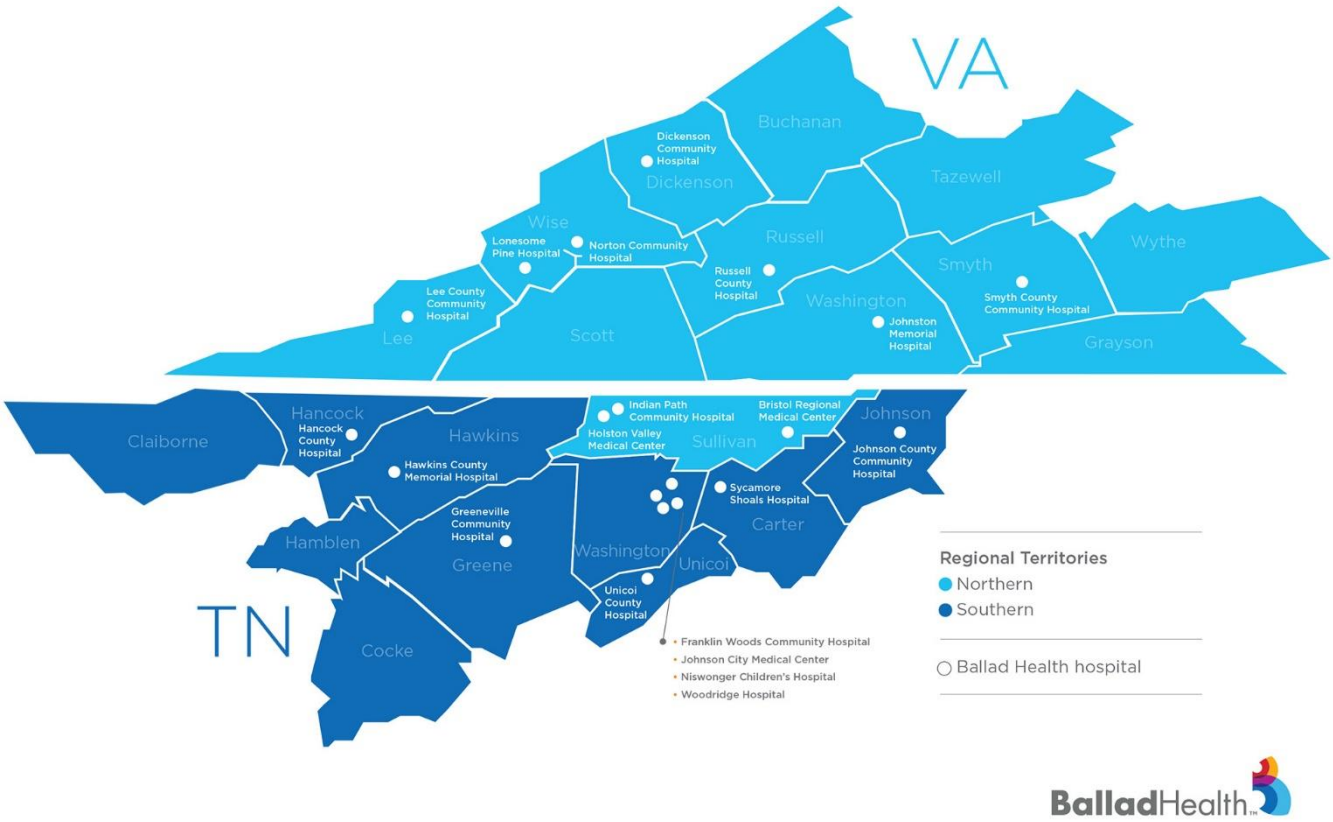
- Caring
- Creativity
- Faith
- Honesty
- Quality
- Respect

Ballad Health was created to address local health needs. We understand that good health is about more than healthcare – it's the story of people's lives. Located in the Appalachian Highlands, Ballad Health honors the traditions and stories that shape our community. We also seek new ways to partner with individuals and communities to make our region a healthier place to live and work.

Ballad Health

Territory

Ballad Health is the region's largest healthcare provider. Our primary service area includes 21 counties in Northeast Tennessee and Southwest Virginia, with a secondary area extending to six counties in Western North Carolina and two in Southeastern Kentucky.



Facility Description

Sycamore Shoals Hospital

Located in Elizabethton, Tennessee, Sycamore Shoals Hospital is a 121-bed not-for-profit hospital. Sycamore Shoals Hospital provides complete inpatient and outpatient surgical services, including general surgery, surgical oncology and orthopedics. In addition to comprehensive primary care and specialist coverage, the hospital offers a regional cancer center. Sycamore Shoals also has a chest pain center, emergency care, diagnostic imaging and more. The hospital's chest pain and heart failure programs are certified by The Joint Commission for delivering quality care to patients. Learn more about Sycamore Shoals Hospital at www.balladhealth.org/SSH.

Scope of services

Sycamore Shoals Hospital is a 121-bed facility on a 27-acre medical campus comprised of several medical office buildings. The facility offers 24/7 emergency services, as well as complete inpatient and outpatient services including:

- General surgery
- Surgical oncology
- Orthopedics (including hand and extremities)
- Plastic surgery
- Gynecology
- Heart care
- Cancer care
- Breast cancer services
- Emergency care
- Tele-medicine
- Behavioral health/gero-psych
- Lab services

Sycamore Shoals Hospital's primary service area covers Carter County in Northeast Tennessee.

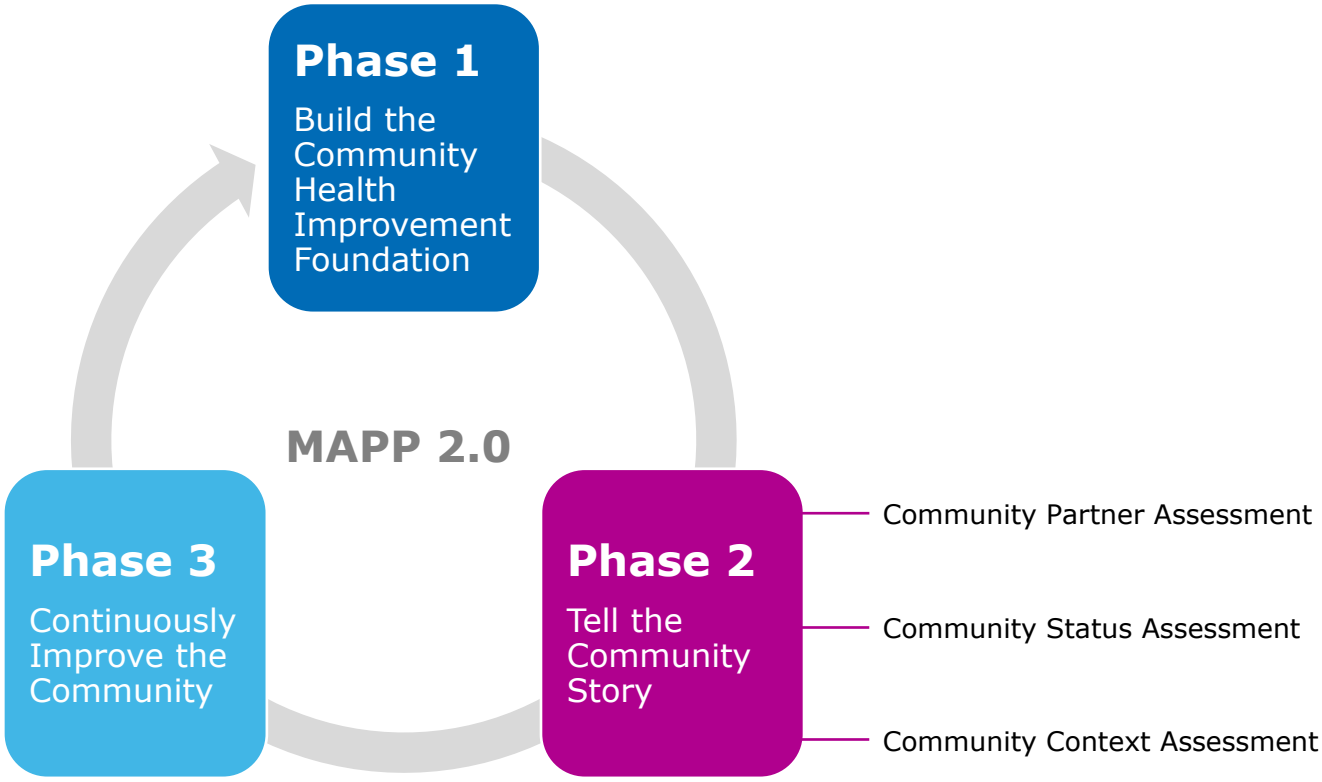
Evaluation model

Model selection : MAPP 2.0

For the Community Health Needs Assessment (CHNA) of Sycamore Shoals Hospital, we adopted the MAPP 2.0 model developed by the National Association of County and City Health Officials (NACCHO). This updated framework, released in July 2023, builds on our successful use of the original MAPP in 2021. MAPP 2.0 enhances community health planning by integrating modern practices and tools to address current public health challenges. It emphasizes equity, partnerships and data-driven decision-making, making it ideal for our assessment efforts. By implementing MAPP 2.0, we aimed to build on our previous successes, produce actionable insights and foster sustainable improvements in community health outcomes.

MAPP 2.0: Model overview

Mobilizing for Action through Planning and Partnerships (MAPP), developed by NACCHO in 2001, is a respected community health improvement framework. This strategic planning process helps communities evaluate public health needs, prioritize issues and create strategies for a unified health improvement plan. In 2019, NACCHO updated the framework to MAPP 2.0, incorporating best practices and feedback from experts. Tested by fifteen diverse health departments, MAPP 2.0 emphasizes community engagement, data-driven assessments and health equity. It streamlines the process from six phases to three, with new tools and resources. MAPP 2.0 empowers communities to identify health priorities, develop effective strategies and mobilize partnerships, fostering sustainable and equitable health solutions.



MAPP 2.0: Phases

Phase 1 : Build the Community Health Improvement Foundation

This phase sets the stage for the MAPP process. It includes guidance to build strategic relationships based on a Stakeholder and Power Analysis, conduct a Starting Point Assessment to take inventory of resources and set goals for process improvement, cultivate a shared mission and vision for MAPP and develop a common understanding of how MAPP can be used to achieve health equity.

Phase 2 : Tell the Community Story

This phase results in a comprehensive, accurate and timely community assessment of health and wellbeing based upon findings from three assessment tools. It maintains the need for data and information from several perspectives, including qualitative and quantitative, with a greater emphasis on understanding health inequities.

Community Partner Assessment

Data and conversations about partnerships and organizational capacities.

Community Status Assessment

Quantitative data about community, including demographics, health status, SDOH, health equity indicators, and across all of these variables, existing inequities.

Community Context Assessment

Qualitative data about community strengths and assets, built environment, and current and historical forces of change.

Phase 3 : Continuously Improve the Community

This phase includes steps to address the social determinants of health (SDOH) and health equity through transformational strategies. It encourages strategic partnerships for sustained action, through partner profiles and a power analysis that best position partners to address inequity as it relates to each community health improvement plan (CHIP) goal. This phase also employs methods of continuous quality improvement and rapid cycle improvement to promote sustained, data-driven action which allows for building an evidence base through small-scale improvements on existing strategies and small-scale testing on new, innovative strategies for health equity action.

Methodology

Methodology

Phase 1 : Build the Community Health Improvement Foundation

In the first phase of MAPP 2.0, Ballad Health leadership focused on identifying key stakeholders and community partners essential for the assessment efforts. To maximize collaboration and minimize survey fatigue among community members, Ballad Health aimed to integrate efforts with other organizations conducting similar assessments. This collaborative approach ensured a unified effort rather than multiple, redundant inquiries. Stakeholders were identified through existing partnerships and a comprehensive stakeholder analysis, ensuring broad and effective community engagement. By fostering these collaborations, Ballad Health created a Regional Steering Committee that was tasked with overseeing the assessment efforts, from design to implementation.

The Regional Steering Committee was comprised of 15 members and included representation from Ballad Health, Tennessee Department of Health, Virginia Department of Health, and the regional STRONG Accountable Care Community (ACC), which represents over 400 member organizations.

Phase 1: Build the Community Health Improvement Foundation

In July 2023, Ballad Health organized a comprehensive, full-day, in-person Kick-Off Retreat for the Regional Steering Committee. This retreat set the foundation for a thorough and inclusive community health improvement process. During this retreat, committee members did the following:

- Conducted a Starting Point Assessment as prescribed by MAPP 2.0
- Collaboratively developed the mission, vision, and values to guide the assessment efforts
- Identified key primary and secondary data metrics to be included
- Formulated questions for a community-wide survey
- Devised a strategy for collecting qualitative data

Phase 1: Community Health Improvement Foundation

Mission

This group exists to include the voices of all groups within the community, especially those experiencing health inequities, to improve population health.

Vision

A committed collective to build on the strengths of our communities, develop goals to overcome our challenges, and inspire our neighbors to work together for a healthier next generation.

Values

Phase 2: Tell the Community Story

As outlined in Phase 1 of MAPP 2.0, the Regional Steering Committee played a crucial role in guiding Ballad Health's approach to conducting the three MAPP 2.0 assessments. This committee was responsible for determining the necessary data to be collected and the methods for gathering this information. Their input ensured that the assessments would capture a comprehensive and accurate picture of community health needs.

Additionally, the steering committee contributed to the design of the assessment instruments, ensuring they were effective and comprehensive. Through a series of collaborative discussions and workshops, the committee identified key metrics and data sources that would provide valuable insights. They also worked on tailoring the instruments to reflect the unique characteristics and needs of the community, making sure to include metrics that are often overlooked in traditional Community Health Needs Assessments (CHNAs).

The committee's involvement extended beyond data collection and instrument design. They also played a vital role in strategizing the dissemination of the surveys and assessments, leveraging their networks to ensure broad and diverse participation.

Phase 2: Tell the Community Story

Community Status Assessment (CSA)

The Community Status Assessment (CSA) involved both primary data collection and the compilation of secondary data.

Primary Data Collection

Ballad Health conducted a community member survey to gather primary data. The survey was developed using evidence-based questions identified through an extensive literature review of community-wide surveys. After discussions and guided exercises with the Steering Committee to finalize the questions, the resulting survey comprised 44 questions covering demographics, community perceptions, access to care, child health and wellbeing, personal health and wellbeing, adverse childhood experiences, and resiliency. The survey was available in both online and paper formats, and a Spanish version was also offered. It was tested among Ballad Health team members before its launch in December 2023 and remained open through March 2024.

The survey was distributed through various channels. Ballad Health marketing and communications assisted with distribution through emails to Ballad Health team members encouraging them to participate and share the survey with friends and family and posts on Ballad Health's social media pages. The STRONG ACC provided the survey to over 400 member organizations for further dissemination among their staff, clients, and contacts. Lastly, Steering Committee members assisted in spreading the survey through their respective organizations. For example, the Virginia Department of Health assisted in the distribution of the survey through taking the paper version of the survey into low-income housing developments.

Secondary Data Collection

The Regional Steering Committee played a vital role in selecting secondary data elements for the assessment. They focused on highlighting metrics often omitted from Community Health Needs Assessments (CHNAs), ensuring comprehensive coverage through discussions and guided exercises. The secondary data compilation involved various sources, including the Centers for Disease Control and Prevention (CDC), National Institutes of Health (NIH), Tennessee and Virginia Health Departments, Tennessee and Virginia Departments of Education, and the United States Census.

Data was collected at the county level to create specific data packages covering topics such as demographics, health behaviors, health outcomes, social and economic factors, physical environment, and the healthcare workforce. For comparison purposes, regional averages for the Appalachian Highlands, state, and national levels were also provided. The compiled regional data packages were not only used in the assessments but also circulated to Ballad Health's community partners for presentations, grant writing, and other purposes.

Phase 2: Tell the Community Story

Community Partner Assessment (CPA)

As a second avenue for primary data collection, Ballad Health launched a Community Partner Assessment. This assessment was based on the Community Partner Survey from the MAPP 2.0 Handbook developed by NACCHO, which was slightly modified to better suit the specific needs and context of Ballad Health's Community Health Needs Assessment (CHNA) process.

The Community Partner Survey, which was 37 questions in length, explored several key topics, including Organizational Information, Populations Served, Technology in Health, Organizational Commitment to Health Equity, Organizational Accountability, and Data Access and Systems. These topics were chosen to provide a comprehensive understanding of the capacities, challenges, and focus areas of community partners involved in health improvement efforts.

The survey was open from March 2024 to May 2024 and was distributed to various stakeholders, including STRONG ACC's 400 member organizations, Ballad Health's Community Health Improvement Sites, and other community partners identified by the Steering Committee. This wide distribution ensured a broad and representative collection of insights from diverse organizations working towards health improvement in the community.

Community Context Assessment (CCA)

The Community Context Assessment involved collecting primary, qualitative data to support the assessment process. Ballad Health accomplished this by hosting two stakeholder convenings on special topics identified through ongoing discussions with community partners. Each convening adopted an action-driven approach. Ballad Health compiled data and literature findings to illustrate the severity of the issues under discussion, ensuring stakeholders had the necessary foundational and contextual information before group discussions.

At the start of each convening, Ballad Health presented the relevant data and findings. Stakeholders then engaged in guided exercises and discussions to generate potential solutions and action items to address the identified problems. These discussions also aimed to identify synergies and paths for collaboration among community partners. The topics explored in these stakeholder convenings were substance use and early literacy.

Phase 3: Continuously Improve the Community

Phase 3 of the MAPP 2.0 framework focuses on the continuous improvement of the community. As part of this phase, presentations on Ballad Health's Community Health Needs Assessment (CHNA) process were provided to each of the hospital boards to promote engagement and secure buy-in ahead of the development of Community Health Improvement Plans (CHIPs). These presentations aimed to ensure that hospital leadership fully understood the CHNA process and were committed to the subsequent steps.

The CHIPs will be developed by each facility based on the CHNA findings and will involve collaboration between hospital leadership and community partners in their design and implementation. Each CHIP will outline specific, actionable strategies tailored to address the priority health issues identified in the CHNA. These strategies will include measurable objectives, timelines, and assigned responsibilities to ensure accountability and progress tracking.

Recognizing the complexity of the identified health issues, Ballad Health emphasizes the importance of collaboration, ensuring that all partners have a seat at the table. This inclusive approach is essential for addressing the multifaceted health challenges that no single entity can manage alone. By fostering strong partnerships and collective action, Ballad Health aims to create effective and sustainable health improvement strategies for the community.

Furthermore, the development of CHIPs will include regular progress reviews and updates to adapt to emerging needs and challenges. This dynamic process ensures that the plans remain relevant and effective over time, continually improving health outcomes in the community. Through these comprehensive and collaborative efforts, Ballad Health is committed to making meaningful and lasting improvements in community health.

Results

Community Status Assessment:
Community Profiles

Including community demographics and social determinants of health (SDOH) data in CHNAs is crucial because it provides a comprehensive understanding of the factors influencing health outcomes in a community. Demographic data, such as age, race, income, and education levels, helps identify vulnerable populations and disparities in health status. SDOH data, which includes factors like access to healthcare, housing, transportation, and social services, offers insight into the broader context affecting community health. This information is essential for identifying health priorities, allocating resources effectively, and developing targeted interventions that address both immediate health needs and underlying causes of health inequities. By integrating these data, CHNAs can better inform public health strategies and policies, ultimately leading to more equitable and effective health outcomes.

In order to provide the necessary context for the remainder of the CHNA findings, secondary data related to demographics, SDOH, and health outcomes are provided in the following tables. More robust community profiles for Carter County, Tennessee are provided in the appendix.

Community Status Assessment:
Community Demographic Profile

Data Indicator	Carter	Ballad Health GSA	Tennessee	USA
Total Population	56,315	947,632	6,923,772	331,097,593
Total Population by Age Groups, Percent				
Age 0-4	4.3%	4.7%	5.8%	5.7%
Age 5-17	13.7%	14.4%	16.2%	16.4%
Age 18-24	7.3%	8.5%	9.2%	9.5%
Age 25-34	11.3%	11.6%	13.7%	13.7%
Age 35-44	10.7%	11.4%	12.6%	12.9%
Age 45-54	13.6%	13.4%	12.7%	12.4%
Age 55-64	14.8%	14.5%	13.1%	12.9%
Age 65+	22.1%	21.5%	16.7%	16.5%
Total Population by Gender, Percent				
Female, Percent	50.9%	50.2%	50.9%	50.4%
Male, Percent	48.8%	49.3%	48.7%	49.1%
Total Population by Race Alone, Percent				
American Indian or Alaska Native	0.2%	0.2%	0.2%	0.8%
Asian	0.4%	0.7%	1.9%	5.8%
Black	1.3%	2.5%	15.8%	12.4%
Multiple Race	4.6%	4.5%	6%	10.2%
Multiple Races	2.3%	3.2%	4.7%	8.8%
Native Hawaiian or Pacific Islander	0%	0.1%	0.1%	0.2%
Some Other Race	0.5%	0.7%	2%	6.1%
White	92.6%	90.5%	72.2%	61.6%
Families with Children (Age 0-17),Percent of Total Households	24.6%	26.1%	29.5%	29.9%
Hispanic Population, Percent	2.7%	3.1%	6%	18.7%
Median Age	46	44.5	38.9	38.5
Net Migration Rate - Total Population (2010-2020)	2.3%	1.8%	4.1%	0%
Non-Citizen, Percent	1.4%	1.2%	3.2%	6.5%
People of Color (Not Non-Hispanic White)	7.1%	8.7%	27.4%	41.1%
People of Color by Gender, Percent	45.8%	45.5%	48.7%	49.5%
Population Age 5+with Limited English Proficiency,Percent	0.8%	1.1%	3.1%	8.2%
Population with Any Disability by Disability Status, Percent of Total Population	13%	12.4%	2.9%	2.4%
Population with Any Disability, Percent	22.2%	21.8%	15.3%	12.9%
Urban and Rural Population (2020), Percent				
Rural Population, Percent	40.7%	52.8%	33.8%	20%
Urban Population, Percent	59.3%	47.2%	66.2%	80%
Veteran Population, Percent	8.6%	8.3%	7.7%	6.6%

Community Status Assessment:

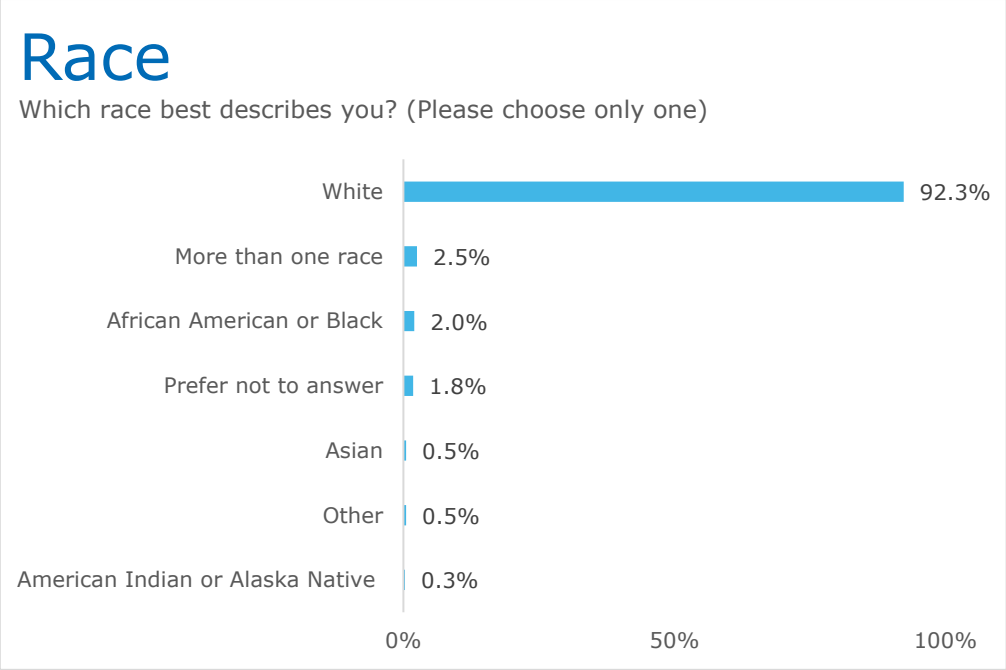
Community Social Determinants of Health Profile

Social Determinants of Health (SDOH)				
Data Category	Carter	Ballad Health GSA	Tennessee	USA
Education				
Access - Childcare Centers - Rate of Childcare Centers per 1,000 (Population <5)	12	10.16	9	8
Access - Childcare Cost Burden - % of Household Income	28.0%	29.2%	26.0%	28.8%
Access - Head Start Programs, Rate per 10,000 Children Under Age 5	29.6	24.88	10.32	10.53
Access - Preschool Enrollment (Age 3-4), Percent	28.1%	30.5%	38.6%	45.6%
Attainment - Overview, Percent				
Associate's Degree	8.2%	8.6%	7.7%	8.7%
Bachelor's Degree	13.5%	13.2%	18.7%	20.9%
Graduate or Professional Degree	7.6%	7.7%	11.0%	13.4%
High School Only	36.7%	36.7%	31.5%	26.4%
No High School Diploma	12.6%	13.3%	10.7%	10.9%
Some College	21.4%	20.5%	20.4%	19.7%
Housing and Families				
Affordable Housing				
Units Affordable at 100% AMI (Area Median Income)	62.6%	63.7%	57.9%	59.5%
Units Affordable at 50% AMI (Area Median Income)	23.6%	24.9%	21.7%	20.7%
Housing Costs - Cost Burden (30%), Percent of Households	21.5%	21.9%	26.3%	30.5%
Housing Costs - Cost Burden, Severe (50%), Percent	8.7%	9.7%	11.6%	14.1%
Substandard Housing: Number of Substandard Conditions Present, Percentage of Total Occupied Housing Units				
One Condition	21.0%	21.4%	25.7%	29.9%
Two or Three Conditions	0.4%	0.7%	1.0%	1.8%
Four Conditions	0.0%	0.0%	0.0%	0.0%
No Conditions	78.6%	77.9%	73.2%	68.3%
Income and Economics				
Employment - Unemployment Rate	3.1%	3.1%	3.0%	3.9%
Households by Household Income Levels, Percent				
Under $25,000	26.2%	24.8%	18.2%	15.7%
$25,000 - $49,999	25.4%	24.8%	21.2%	18.1%
$50,000 - $99,999	29.9%	29.7%	30.8%	28.9%
$100,000 - $199,999	16.1%	16.9%	22.4%	25.9%
$200,000+	2.4%	3.8%	7.3%	11.4%
Income - Median Household Income	$47,994	No data	$64,035	$75,149
Poverty - Children Below 100% FPL, Percent	27.4%	24.8%	19.2%	16.7%
Poverty - Children Below 200% FPL, Percent	55.1%	49.5%	42.1%	37.2%
Poverty - Population Below 200% FPL	41.3%	39.5%	32.6%	28.8%
Other Social & Economic Factors				
Food Insecure Children, Percent of Children	15.6%	14.6%	13.2%	13.3%
Food Insecurity Rate - Percent of Total Population	15.3%	14.1%	11.3%	10.3%
Households with No Motor Vehicle, Percent of Households	5.9%	5.9%	5.3%	8.3%
Housing + Transportation Costs, Percent of Total Income				
Housing + TransportationCosts % Income	51.0%	55.0%	51.0%	48.0%
Incarceration Rate, Percent of Total Population	1.2%	1.7%	1.9%	1.3%
Insurance - Uninsured Population (ACS), Percent of Total Population	12.9%	9.6%	10.1%	8.7%
Racial Segregation (Interaction Index) - (0 = Low Segregation, 1 = High Segregateion)	0.93	No data	No data	No data
Social Vulnerability Index (SoVI) - (0 = Low Vulnerability, 1 = High Vulnerability)	0.65	0.61	0.56	0.58
Violent Crime - Total - Annual Rate per 100,000	215.2	315.9	633.7	416
Physical Environment				
Food Environment - Low Food Access, Percent	47.0%	22.0%	27.2%	22.2%
Households with No or Slow Internet, Percent	21.6%	20.0%	14.3%	11.7%
Work Force, Rate per 100,000				
Addiction/Substance Abuse Providers	0	7.5	7.44	27.85
Dental Health Providers	26.62	26.53	33.41	39.06
Mental Health Providers	33.71	92.26	132.83	178.73
Primary Care Providers	58.56	118.57	90.09	112.36

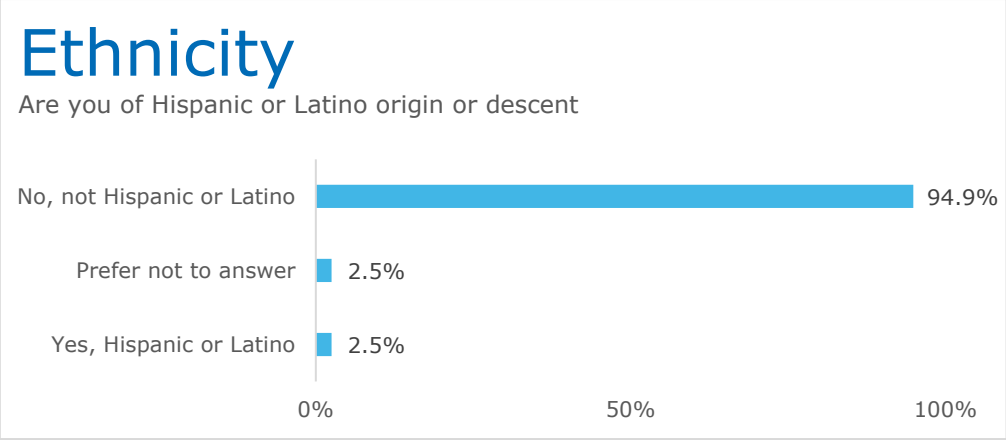
Community Status Assessment:
Community Member Survey Northeast Tennessee

Total Respondents

A total of **1,130** community members living in Northeast Tennessee participated in Ballad Health's community member survey.



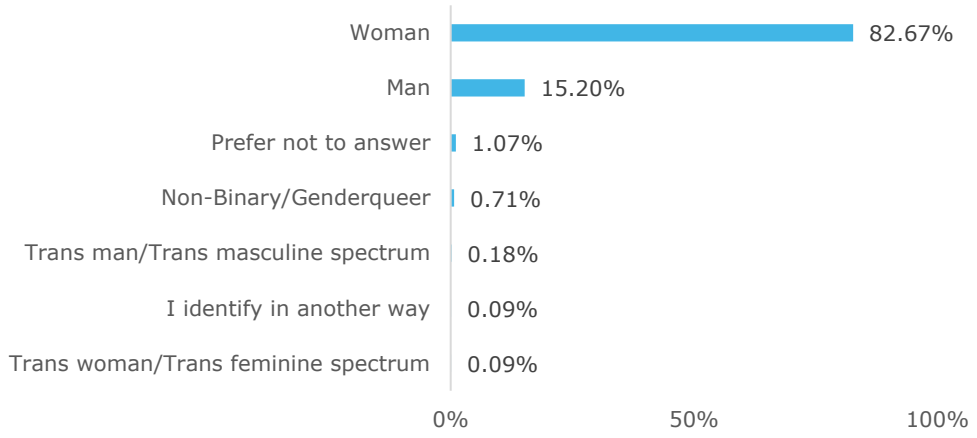
Among Northeast Tennessee respondents the majority (92%) were White. This was followed by more than one race (2.5%), and African American or Black (2.05%).



Additionally, 95% of respondents identified as not Hispanic or Latino, 2.5% preferred not to answer, and 2.5% identified as Hispanic or Latino.

Gender identity

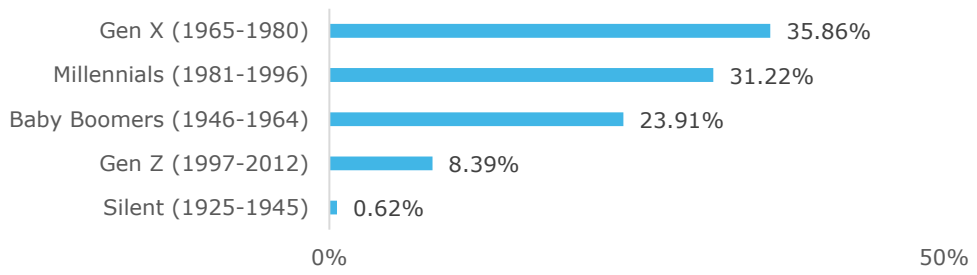
What is your current gender identity? (Please choose only one)



The majority of Northeast Tennessee community members that answered the survey identified as women (83%). This was followed by Men (15%).

Age

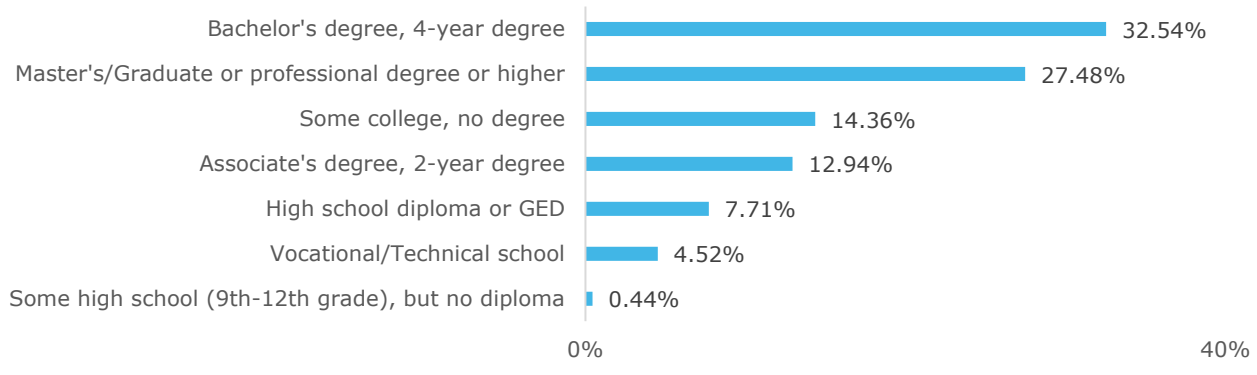
Which age generation group are you in?



Survey respondents were asked to identify their generational group, resulting in 36% identifying as Gen X, 31% as Millennials, and 24% as Baby Boomers.

Education

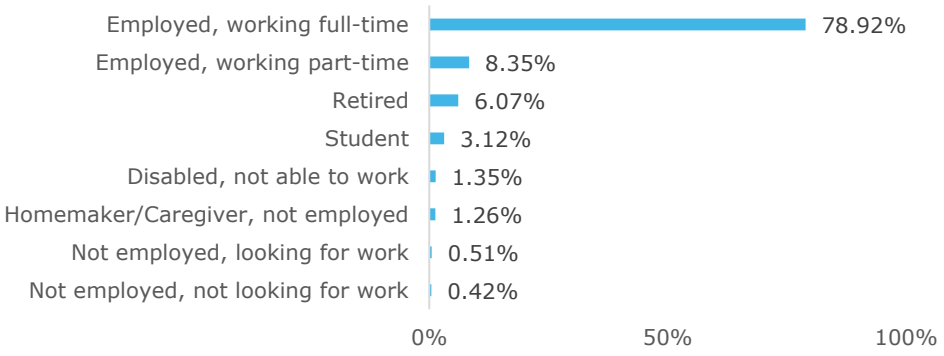
What is the highest level of school that you have completed?



Additionally, 33% of respondents have a bachelor's degree, 27% have a master's/graduate degree, and 14% have some college, no degree.

Employment

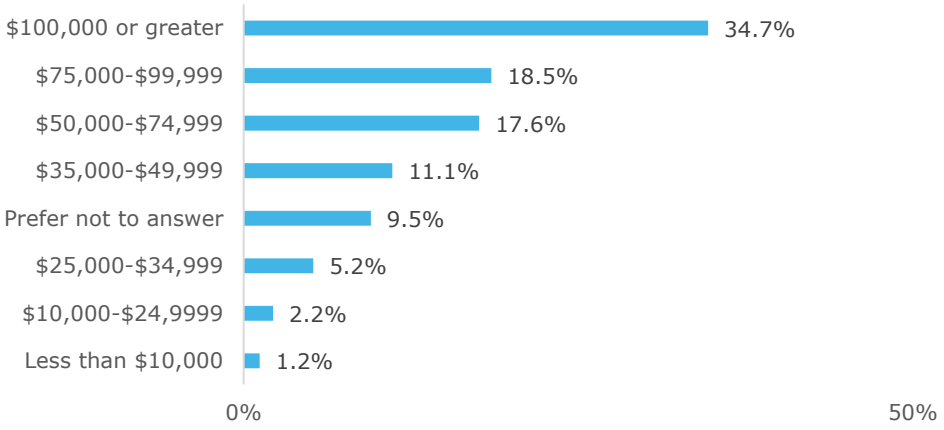
Which of the following categories best describes your employment status? (Choose all that apply)



Survey respondents were asked to provide their current employment status. Seventy-nine percent (79%) of respondents were employed, working full-time, 8% employed, working part-time, and 6% were retired.

Household income

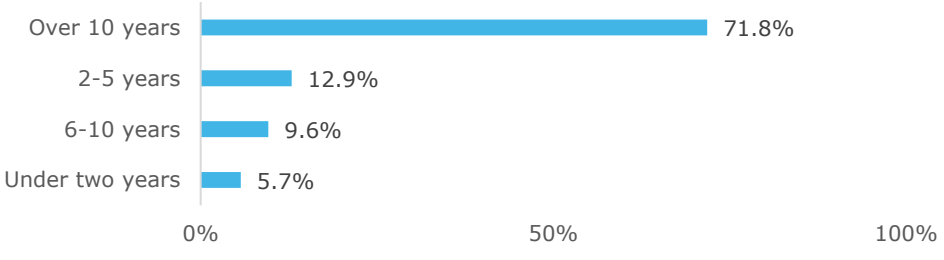
How much total combined income did all people living in your home earn last year?



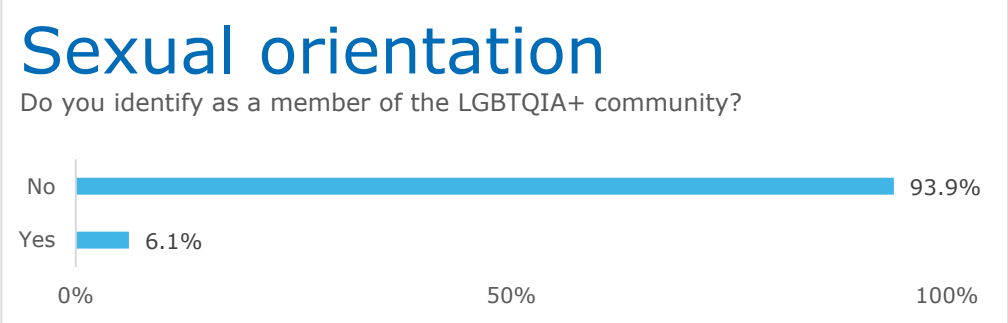
Among respondents to the community health needs assessment from Northeast Tennessee, 35% households make $100,000 or greater, 18.54% make $75,000 - $99,999, and 17.57% make $50,000 - $74,999.

Community resident

How long have you been a member of the community that you currently live in?



In Northeast Tennessee, 72% of survey respondents have been a community member for over 10 years, 13% for 2-5 years, and 10% for 6-10 years.

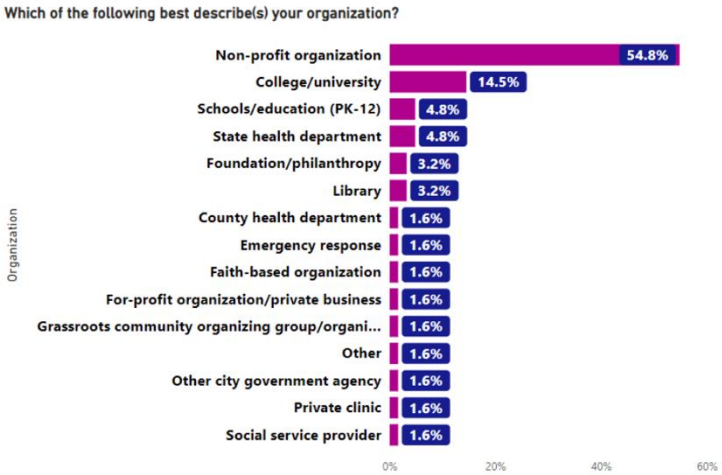


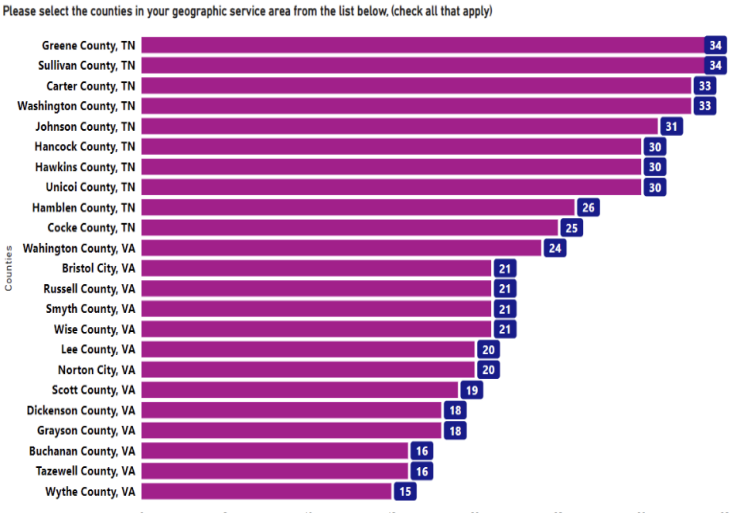
When survey respondents were asked if they identify as members of the LGBTQIA+ community, 6% indicated that they do.

Community Partner Assessment:
Community Partner Survey

Organization Type

Ballad Health's Community Partner Survey received responses from 54 distinct organizations. The majority (55%) were non-profit organizations. This was followed by colleges and universities (15%), schools and educational institutions (PK-12) (5%) and state health departments (5%).

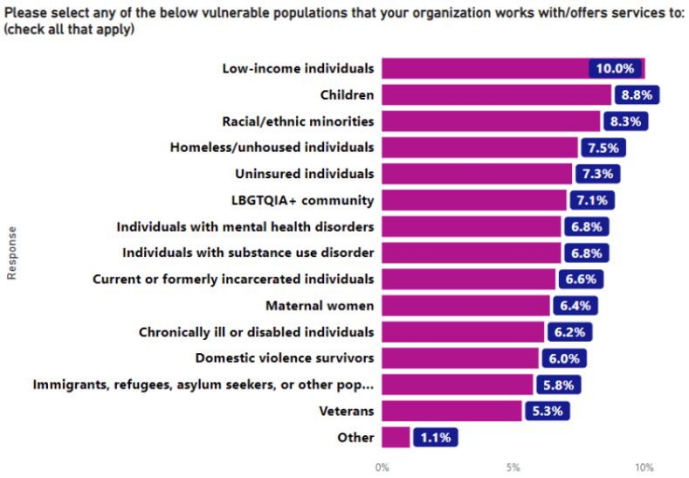




Each county in Tennessee and Virginia within Ballad Health's service area is served by at least 15 organizations that responded to the Community Partner Survey, ensuring the survey's geographic representation of the region. Thirty-four of organizations who responded to the survey serve both Greene and Sullivan County, making them the two counties most represented.

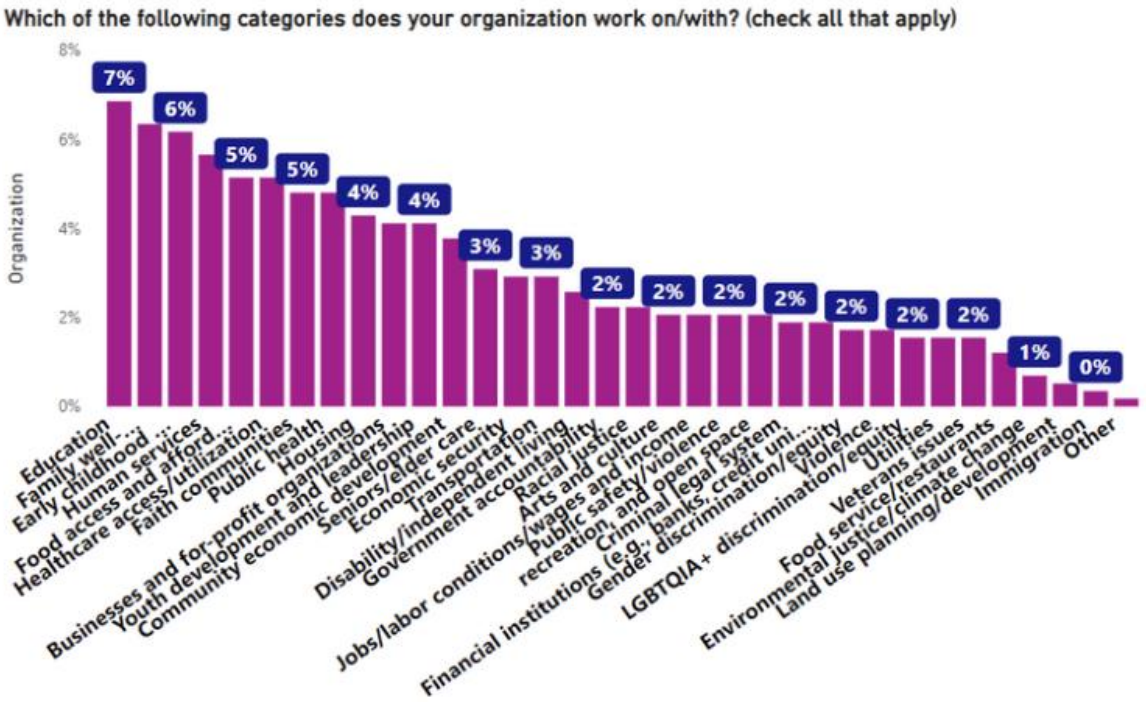
Vulnerable Populations Served

The organizations that responded to the survey serve a wide range of vulnerable populations, which is vital to ensuring that the needs of the most marginalized individuals in our community are represented in these survey findings. Specifically, 10% of the organizations work with low-income individuals, 9% with children, 8% with racial and ethnic minorities, 7% with homeless/unhoused individuals, 7% with uninsured individuals and 7% with the LGBTQIA+ community.



Community Partner Assessment:
Community Partner Survey

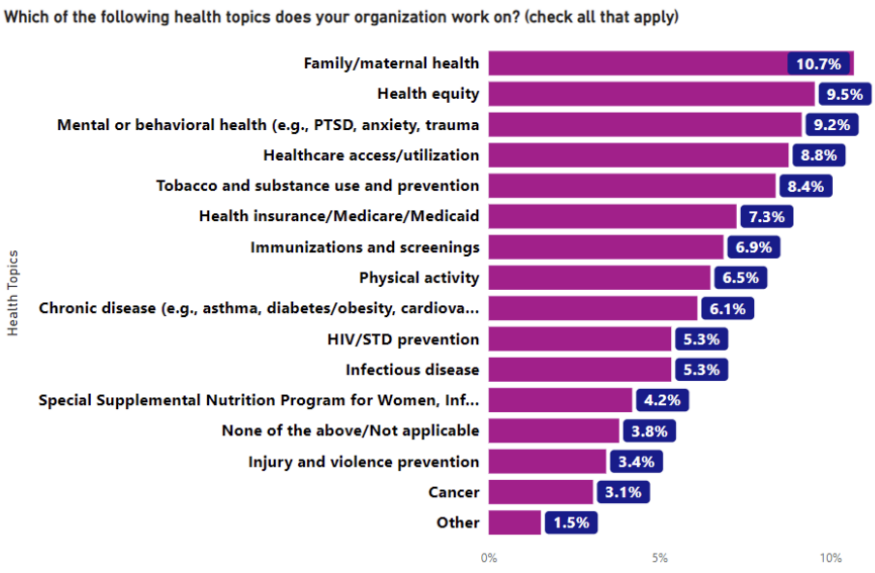
Service Categories



The organizations that responded to the survey operate across a diverse range of categories, including education (7%), family well-being (6%), early childhood development (6%), human services (5%), food access and affordability (5%), healthcare utilization (5%) and faith communities (5%).

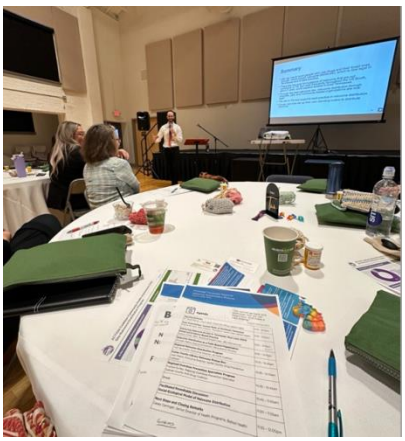
Health Topics

The organizations that responded to the survey address various health topics, which is essential for fostering strong relationships between the health system and community partners. The key areas of focus include: family/maternal health (11%), health equity (10%), mental or behavioral health (9%), healthcare access/utilization (9%) and tobacco and substance use prevention (8%).



Community Context Assessment:
Regional Stakeholder Convening - Substance Use

On February 28th, 2024, a significant Stakeholders Convening on Substance Use was held at the Langston Centre in Johnson City, Tennessee. The event gathered 55 attendees representing 25 organizations including healthcare providers, community leaders, policymakers and representatives from various local groups. The primary focus was on naloxone distribution, a crucial intervention for preventing opioid overdose deaths.



The convening featured six insightful presentations. Attendees were provided an overview of substance use trends and the impact of naloxone in the region. Discussions included new laws that facilitate evidence-based practices for naloxone distribution and the role of faith-based groups in making naloxone accessible to their communities. The regional program's strategies and successes in distributing naloxone were highlighted, along with an innovative approach where library boxes serve as pickup points for naloxone kits. Additionally, the work of specialists dedicated to overdose prevention and response in the region was detailed.

The event also included a facilitated roundtable discussion guided by a socio-ecological model of naloxone distribution, developed by Ballad Health from an extensive review of literature. This model considers the complex interplay between individual, relationship, community and societal factors in effectively distributing naloxone and preventing overdoses.

The convening provided a platform for stakeholders to share knowledge, discuss challenges and collaborate on strategies to enhance naloxone access and distribution. It underscored the community's commitment to addressing substance use issues through innovative and evidence-based approaches, aiming to save lives and improve public health outcomes.

Community Context Assessment:
Regional Stakeholder Convening - Substance Use

Social-Ecological Model for Naloxone Distribution

Organizational

- Lack of training on the importance of naloxone
- Lack of educational training on naloxone administration (nasal spray and injection)
- Lack of collaboration with local services such as fire department, law enforcement, schools and community centers for naloxone distribution
- Misinformation about naloxone within organizations, e.g. (the availability of this medication encourages drug use, efficacy after expiration, lengthy training requirements)
- Lack of on-site supplies of naloxone for "rescue" dosing in case of opioid overdose
- Lack of standardization in prescribing practices for naloxone
- Lack of adequate time for healthcare professionals to educate patients
- Lack of data and tracking for naloxone distribution, especially at the local level
- Lack of prioritization of naloxone in financial budgets/plans for organizations that sere individuals that use drugs

Community

- Societal stigma around carrying naloxone
- Community attitude towards individuals with SUD
- Limited access to naloxone in communities, especially those lacking adequate health facilities and pharmacies
- Lack of engagement with local community groups, churches and schools in opioid overdose education
- Inadequate awareness and training among the general public regarding the identification and management of opioid overdoses
- Widespread misinformation
- Rurality
- Lack of Take Home naloxone (THN) Programs
- Lack of knowledge and stigma around low-cost naloxone options
- Lack of naloxone distribution directly to impacted individuals; e.g. (family members of individuals at risk); misalignment of priorities for at-risk individuals

INTRApersonal

- Demographics (age, race, environment)
- Fear of legal action as someone with SUD
- Limited knowledge about what naloxone is and how it can be used, e.g. (efficacy after expiration, training requirements)
- Confusion around insurance coverage for naloxone or an inability to pay
- Lack of awareness of how and where to get naloxone
- Fear of discrimination
- Lack of trust in Health Professionals
- Fear and experience of side-effects

INTERpersonal

- No support system or reluctant to reach out for help
- Strained relationships with family, peers, and providers
- Provider bias and beliefs about naloxone and SUD
- Belief that providing naloxone would lead to continued or riskier opioid use in the future (family or peers)
- Lack of knowledge of legal liability related to naloxone administration
- Lack of knowledge about overdose, such as indications for use, and prevention
- Lack of confidence or competence in using naloxone
- Misinformation about needing lengthy training in order to administer naloxone

Policy

- Lack of policymaker's support for free naloxone distribution in some high opioid consumption regions
- Lack of legislation addressing the deficit in naloxone manufacturing is making the drug more scarce across the country
- Regulatory barriers that restrict who can distribute and administer naloxone
- Affordability of naloxone
- Lack of data and tracking for naloxone distribution, especially at the local level
- Lack of family-friendly naloxone distribution and outreach
- Packaging/portability of nasal naloxone

Community Context Assessment:
Regional Stakeholder Convening – Early Literacy

Literacy in the Appalachian Highlands is a pressing issue, with social determinants of health, access to basic needs and strategic management all playing a role. During this convening, held on April 3, 2024 at Bristol Regional Medical Center, emphasis was placed on collaboration among organizations to better serve children, remove barriers, improve family engagement and strengthen partnerships. There were 44 stakeholders in attendance, composed of community partners who address early literacy and early childhood development.

At the regional stakeholder convening for early literacy, stakeholders were first presented with data illustrating the current state of early literacy in the Appalachian Highland region. The data included information on third-grade reading levels, the negative impacts of poor early literacy skills, Adverse Childhood Experiences (ACEs) and the racial and socioeconomic disparities in the relationship between children's early literacy skills and third-grade outcomes.

Stakeholders were then asked to participate in a N.O.I.S.E. analysis. N.O.I.S.E. stands for Needs, Opportunities, Improvements, Strengths and Exceptions. This strategic planning technique helps to identify what works well and determine areas for improvement. Here's how it was used in the convening:

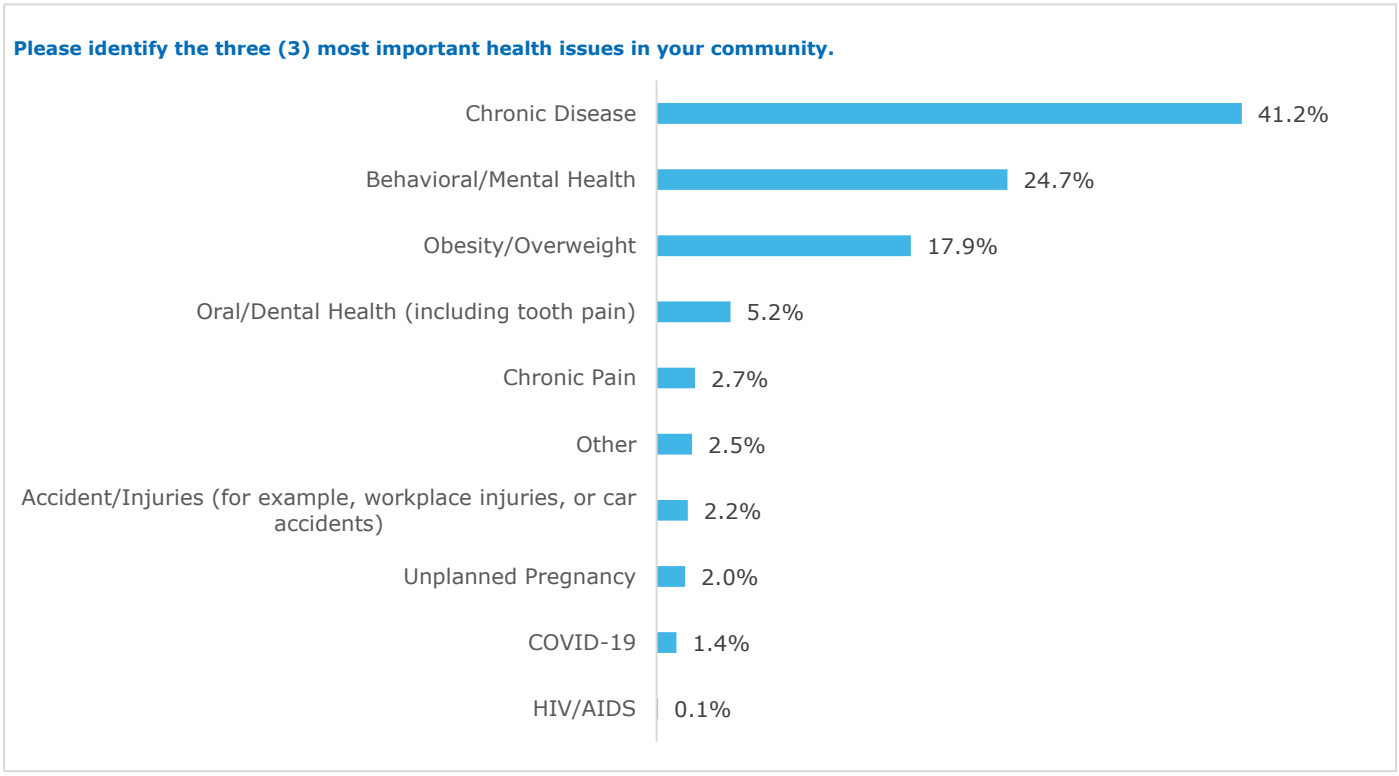
- **Needs**: Stakeholders identified essential requirements or gaps that must be addressed to improve early literacy, including the need for a more collective impact approach that includes a focus on social determinants of health and adverse childhood experiences.
- **Opportunities:** Participants explored potential areas for growth or positive change, such as new community partnerships or funding opportunities to support literacy programs.
- **Improvements**: The group discussed current processes and practices that could be enhanced, such as strengthening the literacy workforce and increasing access to early childhood education resources.
- **Strengths**: Stakeholders recognized existing advantages and resources within the region, such as dedicated educators and supportive community organizations that could be leveraged to advance literacy initiatives.
- **Exceptions**: Unique factors or circumstances were also considered, such as the need for a cultural shift that values literacy.

By conducting a N.O.I.S.E. analysis, stakeholders gained a comprehensive understanding of the current landscape and collaboratively developed actionable strategies to enhance early literacy outcomes in the Appalachian Highland region.

Health Priorities

Health Priorities in Northeast Tennessee

Residents who participated in the community member survey were asked to identify the three most important health issues in their community from a provided list. The results indicated that the most important health issues were chronic diseases (41%), behavioral/mental health (25%) and obesity/overweight (18%).



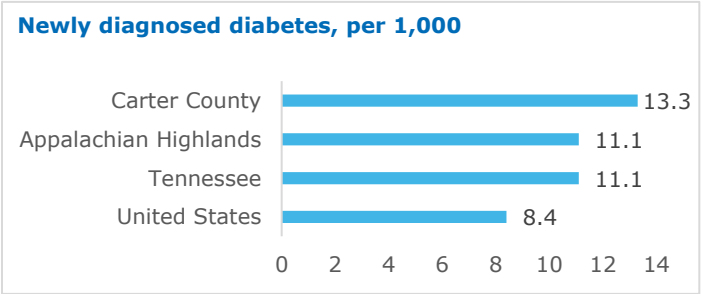
Chronic Disease in Carter County

Diabetes

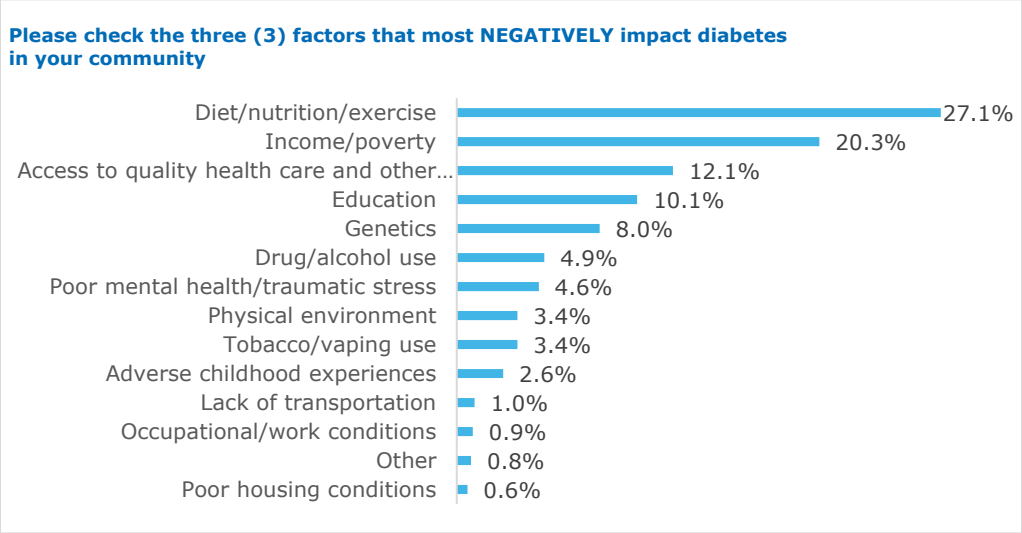
Diabetes is a major public health issue due to its widespread prevalence and severe health impacts. It can lead to serious complications like cardiovascular disease, nerve damage, kidney failure and blindness. Effective management through lifestyle changes, medication and regular monitoring is crucial to prevent these complications. Public health initiatives focusing on healthy eating, physical activity and accessible healthcare can significantly reduce the burden of diabetes, improve quality of life and prevent related health issues.

11.5%
of adults in Carter County have diabetes

Carter County has a higher rate of newly diagnosed diabetes cases among adults (20+) each year (13.3 per 1,000) compared to the Appalachian Highlands (11.1 per 1,000), Tennessee (11.1 per 1,000) and the United States (8.4 per 1,000).



Root Causes



Survey participants were asked to identify the three factors that most negatively impact diabetes in their community, essentially pinpointing root causes. The results highlighted diet/nutrition/exercise (27%), income/poverty (20.27%) and access to quality healthcare (12%). Understanding these root causes is crucial because they directly influence the prevalence and management of diabetes. Poor diet and lack of exercise are primary contributors to obesity and metabolic disorders, which significantly increase diabetes risk. Income and poverty levels affect individuals' ability to afford nutritious food, healthcare and other resources necessary for diabetes prevention and management. Access to quality healthcare ensures timely diagnosis, effective treatment and education about managing diabetes, which are vital for controlling the disease and preventing complications. Identifying and addressing these root causes can lead to more effective interventions and improved health outcomes for the community.

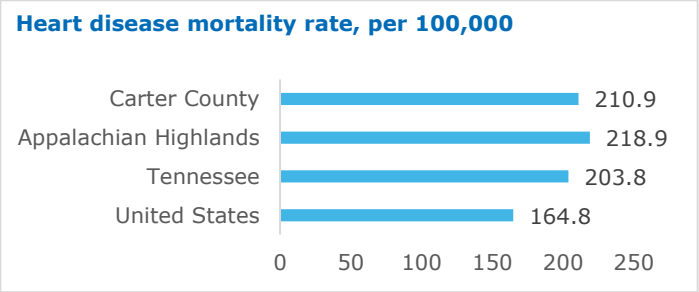
Chronic Disease in Carter County

Heart Disease

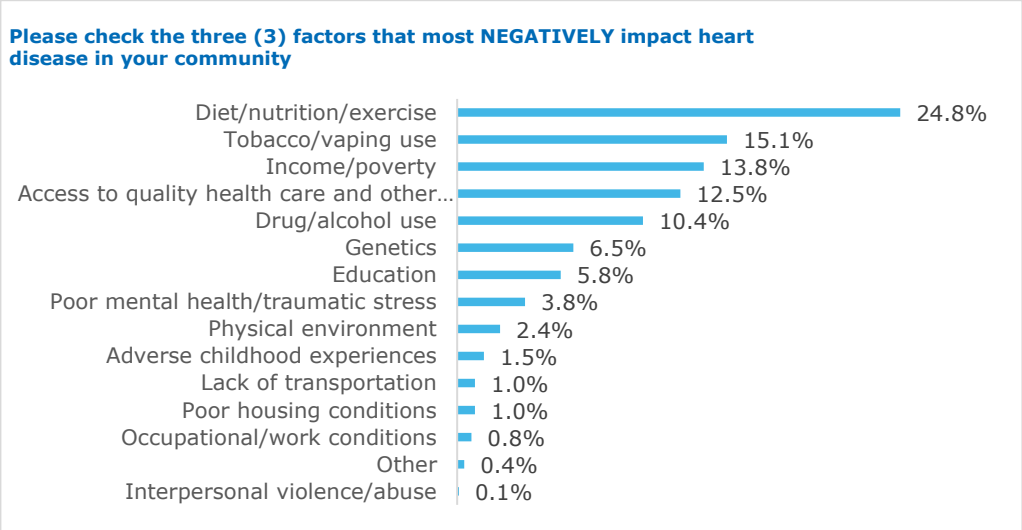
Heart disease is a critical public health issue, being the leading cause of death worldwide. It includes conditions such as coronary artery disease, heart failure and arrhythmias, which significantly impact health and quality of life. Preventing and managing heart disease through a healthy diet, regular exercise, smoking cessation and controlling risk factors like hypertension and diabetes are essential. Effective public health initiatives can reduce the incidence of heart disease, save lives and improve overall community health.

6.8%
of adults in Carter County have been diagnosed with heart disease

While Carter County has a higher heart disease mortality rate per 100,000 than the national and state average, it remains lower than the mortality rates for the Appalachian Highland Region. This suggests that while the county faces significant challenges related to heart disease, it performs better relative to the broader region.



Root Causes

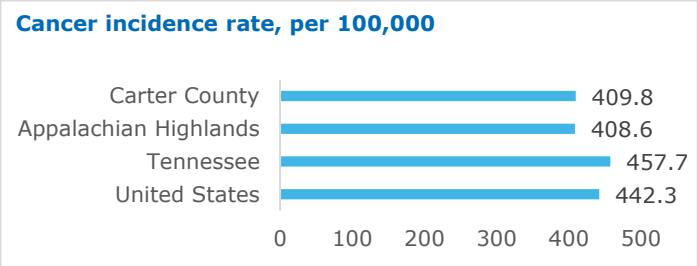


Survey participants were asked to identify the three factors that most negatively impact heart disease in their community, essentially pinpointing root causes. The results highlighted diet/nutrition/exercise (25%), tobacco/vaping use (15%) and income/poverty (14%). Understanding these root causes is crucial because they directly influence the prevalence and severity of heart disease. Poor diet and lack of exercise are well-known risk factors that can lead to obesity, hypertension, and high cholesterol, all of which increase the risk of heart disease. Tobacco use and vaping are significant contributors to cardiovascular problems, exacerbating heart disease through damage to blood vessels and reduced oxygen supply to the heart. Income and poverty levels affect individuals' ability to access nutritious food, healthcare, and other resources necessary for preventing and managing heart disease. Addressing these root causes through public health initiatives can lead to more effective interventions, improved health outcomes, and reduced heart disease rates in the community.

Chronic Disease in Carter County

Cancer

Cancer is significant public health concern because it is one of the leading causes of death worldwide. profoundly affecting individuals and communities. The leading types of cancer include lung, breast, colorectal, prostate and stomach cancer. Public health initiatives can prevent and ease the burden of cancer through strategies such as promoting healthy lifestyles, implementing screening and early detection programs and providing effective treatments and education about risk factors.

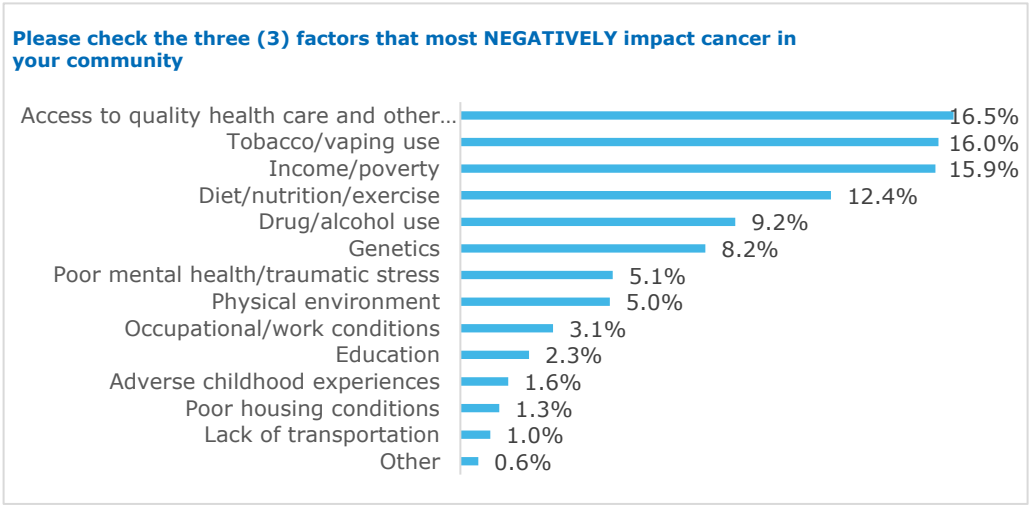


In Carter County, the cancer incidence rate for all sites is 409.8 per 100,000 population, slightly higher than the Appalachian Highlands at 408.6, but lower than Tennessee's rate of 457.7 and the United States Rate of 442.3.

Rate of cancer incidence, per 100,000

105.0	71.2	69.0	27.3	Suppressed
Breast	Prostate	Lung	Colon and Rectum	Cervical

Root Causes



Survey participants were asked to identify the three factors that most negatively impact cancer in their community, essentially pinpointing root causes. The results highlighted access to quality healthcare (17%), tobacco/vaping use (16%) and income/poverty (16%) as primary contributors. Understanding these root causes is crucial because they directly influence cancer outcomes. Limited access to quality healthcare prevents early detection, timely treatment and effective management of cancer, leading to poorer prognosis and higher mortality rates. Tobacco and vaping use are significant risk factors for various cancers, particularly lung cancer, due to the carcinogenic substances they introduce to the body. Income and poverty levels affect individuals' ability to afford preventive measures, screenings and treatments, exacerbating health disparities. Addressing these root causes through public health initiatives can lead to more effective cancer prevention, improved access to care and better health outcomes for the community. Suppressed Data: Certain data points or values have been intentionally omitted or masked in this report to protect privacy, maintain confidentiality and ensure compliance with relevant legal and ethical standards. This practice helps prevent the identification of individuals and safeguards sensitive information.

Overall cancer mortality **159** per 100,000 population in Carter County

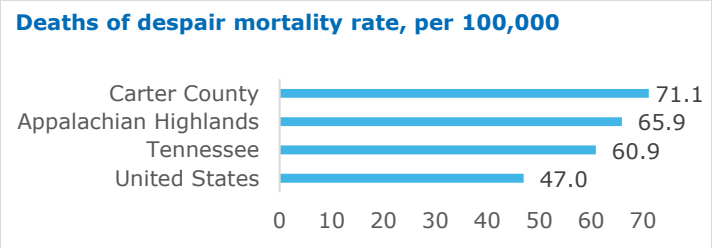
Behavioral/Mental Health in Carter County

Mental and behavioral health, including suicide prevention, is crucial for community well-being. Mental health conditions like depression and anxiety can severely impact daily life and physical health. Behavioral health issues, including substance use disorders, are essential to address for fostering resilience and improving relationships. Suicide, a significant consequence of untreated mental health issues, is a leading cause of death globally, particularly among youth. Addressing these issues through accessible mental health services, education and support systems is vital for early intervention, effective treatment and recovery, reducing the incidence of crises and suicides and promoting healthier communities.

40%
of adults in Carter County suffer from either mental health or substance use conditions

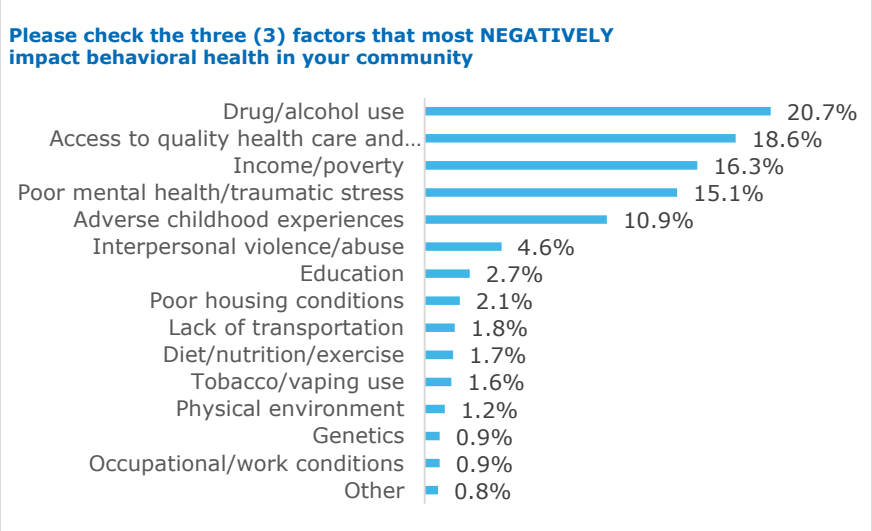
6.4
is the average number of poor mental health days per month for residents in Carter County

Suicide mortality rate is **21.2** per 100,000 population in Carter County



In Carter County, the mortality rate for deaths of despair, which include suicide and drug/alcohol overdose deaths, is 71.1 per 100,000 population. This rate is higher than the rate for the Appalachian Highlands, which stands at 65.9 per 100,000 population. Comparatively, Tennessee as a whole has a mortality rate of 60.9 per 100,000 for deaths of despair, while the national rate in the United States is significantly lower at 47 per 100,000 population.

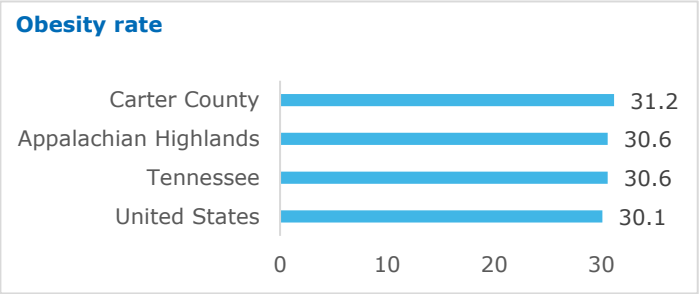
Root Causes



Survey participants were asked to identify the three factors that most negatively impact behavioral and mental health in their community, essentially pinpointing root causes. The results indicated drug and alcohol use (21%), access to quality healthcare (19%) and income/poverty (16%) as primary contributors. Understanding these root causes is crucial because they directly influence mental health outcomes. Substance abuse can exacerbate mental health disorders, leading to a cycle of dependency and deteriorating mental well-being. Limited access to quality healthcare prevents individuals from receiving timely and effective treatment, exacerbating mental health issues. Economic hardship and poverty can lead to chronic stress, anxiety and depression, further impacting mental health. Addressing these root causes through comprehensive public health strategies can lead to more effective interventions, improved access to care and overall better mental health outcomes in the community.

Overweight/Obesity in Carter County

Obesity is a significant public health issue because it is associated with numerous chronic diseases, including heart disease, diabetes and certain cancers, leading to reduced quality of life and increased healthcare costs. The leading causes of obesity include poor diet, lack of physical activity, genetic factors and environmental influences. Preventing and reducing obesity involves promoting healthy eating, encouraging regular physical activity, implementing county-wide health programs and providing education on maintaining a healthy lifestyle. Rurality plays a role in obesity rates due to factors such as limited access to healthy food options, fewer opportunities for physical activity and socioeconomic challenges, making tailored interventions in rural areas essential.



Carter County, TN has a higher obesity rate, affecting 31.2% of the population, compared to the Appalachian Highlands at 30.6%, Tennessee overall at 30.6%, and the United States at 30.1%

87.0% have access to exercise opportunities

75.0% live within a 1/2 mile from a park

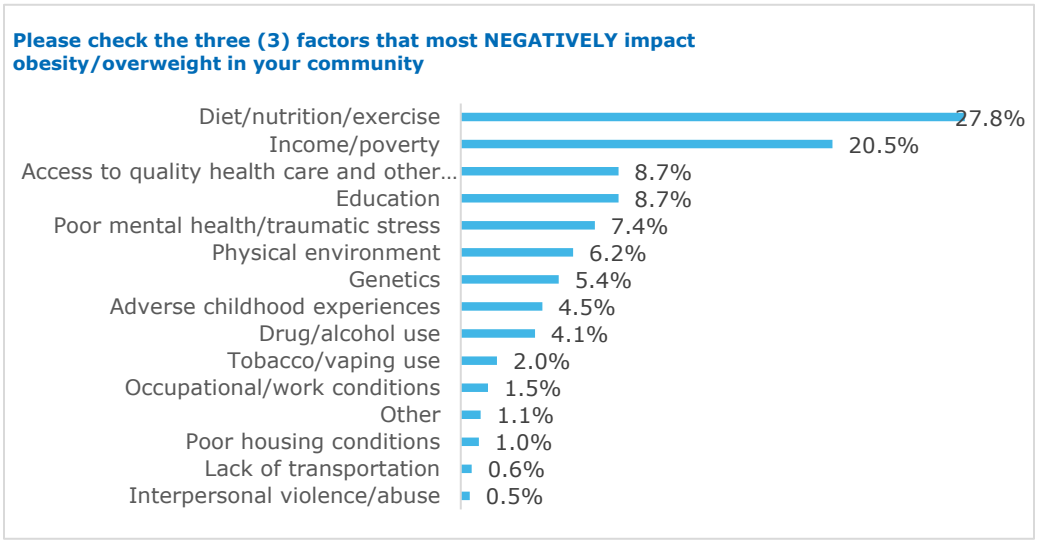
47.0% have low access to food

31.5% of men are obese

30.9% of women are obese

5 Walkability score (1=Not walkable, 20=Very walkable)

Root Causes



Survey participants were asked to identify the top factors negatively impacting overweight and obesity in their community, highlighting root causes. The results were access to diet/nutrition/exercise (28%), income/poverty (21%) and access to quality healthcare (9%). These root causes are crucial because limited access to healthy food and exercise leads to poor dietary habits and sedentary lifestyles, major contributors to obesity. Income and poverty restrict the ability to afford nutritious food and exercise opportunities, while access to quality healthcare is essential for effective weight management and addressing related health issues. Addressing these factors through public health initiatives can lead to better interventions and improved health outcomes for the community.

Conclusion

Conclusion

The Community Health Needs Assessment (CHNA) for Carter County has provided a comprehensive overview of the most pressing health issues faced by residents. Utilizing the MAPP 2.0 framework, Ballad Health effectively gathered and analyzed primary data from community member surveys, partner surveys and stakeholder convenings, alongside secondary data from national, state, regional and county-specific sources.

The assessment identified Chronic Disease, Behavioral/Mental Health and Obesity/Overweight as the top health priorities, reflecting the community's immediate health concerns. These issues not only affect a significant portion of the population but also have far-reaching implications for the overall well-being and economic stability of the region. While other health challenges exist, these three priorities stand out based on the extensive data collected and analyzed.

By prioritizing these health issues, Ballad Health and its partners can tailor interventions and allocate resources more effectively to address the root causes and improve health outcomes. The community's input has been invaluable in shaping this assessment, ensuring that the strategies developed will be relevant and impactful.

Moving forward, the collaborative efforts of healthcare providers, community organizations and residents will be crucial in tackling these health priorities. Through continued engagement, data-driven decision- making and targeted initiatives, we can work towards a healthier, more vibrant community for all residents of Northeast Tennessee. This CHNA serves as a foundational document, guiding future health initiatives and fostering a shared commitment to enhancing the health and well-being of our communities.

Appendix

Appendix

Secondary Data Tables

Demographics				
Data Indicator	Carter	Ballad Health GSA	Tennessee	USA
Total Population	56,315	947,632	6,923,772	331,097,593
Total Population by Age Groups, Percent				
Age 0-4	4.3%	4.7%	5.8%	5.7%
Age 5-17	13.7%	14.4%	16.2%	16.4%
Age 18-24	7.3%	8.5%	9.2%	9.5%
Age 25-34	11.3%	11.6%	13.7%	13.7%
Age 35-44	10.7%	11.4%	12.6%	12.9%
Age 45-54	13.6%	13.4%	12.7%	12.4%
Age 55-64	14.8%	14.5%	13.1%	12.9%
Age 65+	22.1%	21.5%	16.7%	16.5%
Total Population by Gender, Percent				
Female, Percent	50.9%	50.2%	50.9%	50.4%
Male, Percent	48.8%	49.3%	48.7%	49.1%
Total Population by Race Alone, Percent				
American Indian or Alaska Native	0.2%	0.2%	0.2%	0.8%
Asian	0.4%	0.7%	1.9%	5.8%
Black	1.3%	2.5%	15.8%	12.4%
Multiple Race	4.6%	4.5%	6%	10.2%
Multiple Races	2.3%	3.2%	4.7%	8.8%
Native Hawaiian or Pacific Islander	0%	0.1%	0.1%	0.2%
Some Other Race	0.5%	0.7%	2%	6.1%
White	92.6%	90.5%	72.2%	61.6%
Families with Children (Age 0-17),Percent of Total Households	24.6%	26.1%	29.5%	29.9%
Hispanic Population, Percent	2.7%	3.1%	6%	18.7%
Median Age	46	44.5	38.9	38.5
Net Migration Rate - Total Population (2010-2020)	2.3%	1.8%	4.1%	0%
Non-Citizen, Percent	1.4%	1.2%	3.2%	6.5%
People of Color (Not Non-Hispanic White)	7.1%	8.7%	27.4%	41.1%
People of Color by Gender, Percent	45.8%	45.5%	48.7%	49.5%
Population Age 5+with Limited English Proficiency,Percent	0.8%	1.1%	3.1%	8.2%
Population with Any Disability by Disability Status, Percent of Total Population	13%	12.4%	2.9%	2.4%
Population with Any Disability, Percent	22.2%	21.8%	15.3%	12.9%
Urban and Rural Population (2020), Percent				
Rural Population, Percent	40.7%	52.8%	33.8%	20%
Urban Population, Percent	59.3%	47.2%	66.2%	80%
Veteran Population, Percent	8.6%	8.3%	7.7%	6.6%

Appendix

Secondary Data Tables

Housing and Families				
Data Indicator	Carter	Ballad Health GSA	Tennessee	USA
Affordable Housing				
Units Affordable at 100% AMI, Percent of Units	62.6%	63.7%	57.9%	59.5%
Units Affordable at 50% AMI, Percent of Units	23.6%	24.9%	21.7%	20.7%
Average Monthly Owner Costs	$744	$822	$1,192	$1,604
Average Monthly Renter Costs	$650	$692	$1,052	$1,366
Household Structure - Older Adults Living Alone				
Percentage of Senior Households	40.3%	39.3%	38.0%	37.2%
Percentage of Total Households	15.0%	14.7%	11.5%	11.5%
Housing Costs - Cost Burden (30%), Percent of Households	21.5%	21.9%	26.3%	30.5%
Housing Costs - Cost Burden, Severe (50%), Percent of Households	8.7%	9.7%	11.6%	14.1%
Housing Quality - Severe Substandard Housing, Percent of Occupied Units	15.1%	13.1%	15.1%	18.5%
Housing Quality - Substandard Housing, Percent of Occupied Units	21.4%	22.1%	26.8%	31.7%
Housing Stock - Median Household Value	$145,000	No data	$232,100	$281,900
Housing Stock - Median Year Structures Built	1978	No data	1986	1979
Housing Stock - Modern Housing (Built after 1999), Percent of Houses	16.8%	18.4%	27.4%	22.3%
Housing Stock - New Building Permits, Rate per 10,000 Housing Units	64.38	54.92	186.64	122.27
Housing Stock - Older Housing (Built before 1960), Percent of Houses	28.1%	24.4%	18.2%	26.5%
Housing Units - Overview (2020)				
Occupied, Percent	87.5%	87.7%	90.5%	90.3%
Vacant, Percent	12.5%	12.3%	9.5%	9.7%
Percent of Householders who Own their Home by Age Group				
Age 15-24	24.4%	21.9%	16.9%	15.8%
Age 25-34	42.9%	47.7%	42.8%	40.3%
Age 35-44	69.2%	63.8%	61.4%	60.1%
Age 45-54	73.6%	73.6%	72.0%	69.4%
Age 55-64	81.4%	78.5%	77.1%	75.1%
Age 65-74	81.6%	83.8%	81.9%	79.4%
Age 75-84	90.3%	86.3%	84.1%	79.5%
Age 85+	88.1%	82.7%	77.6%	70.5%
Percent of Householders who Own their Home by Race				
American Indian or Alaska Native	22.2%	56.3%	55.6%	55.0%
Asian	18.8%	56.0%	60.1%	61.6%
Black	47.4%	43.0%	43.6%	43.1%
Multiple Races	47.3%	50.6%	53.0%	54.5%
Some Other Race	62.1%	46.0%	45.0%	45.1%
White	74.7%	73.4%	73.1%	71.1%
Percent of Housing Units Overcrowded	1.2%	1.5%	2.5%	4.7%
Percentage of Children in Single-Parent Households	24.4%	26.0%	27.9%	24.9%
Substandard Housing: Households Lacking Complete Kitchen Facilities, Percent	4.5%	4.9%	3.3%	2.4%
Substandard Housing: Households Lacking Complete Plumbing Facilities, Percent	0.0%	0.3%	0.3%	0.4%
Substandard Housing: Households Lacking Telephone Service, Percent	2.1%	1.3%	1.3%	1.1%
Vacant Housing Units (ACS), Percent	14.1%	14.8%	11.1%	10.8%

Appendix

Secondary Data Tables

Physical Environment				
Data Indicator	Carter	Ballad Health GSA	Tennessee	USA
Access to Exercise Opportunities				
Percentage of Population with Access to Exercise Opportunities	87.0%	64.0%	67.0%	84.1%
Air & Water Quality - Drinking Water Safety				
Total Violations	0	28	112	16107
Air & Water Quality - Particulate Matter 2.5				
Average Daily Ambient Particulate Matter 2.5	7	7.45	8.25	8.64
Broadband Access, Percent by Time Period				
December, 2023	91.0%	92.5%	94.4%	93.8%
Built Environment - Households with No Computer				
Households with No Computer, Percent	12.4%	12.1%	7.7%	6.1%
Built Environment - Households with No or Slow Internet	21.6%	20.0%	14.3%	11.7%
Climate & Health - Climate-Related Mortality Impacts				
Estimated Climate Change Impacts (% GDP)	7.1%	No data	17.2%	9.5%
Climate & Health - Flood Vulnerability				
Percentage of Housing Units Within a FEMA Designated Special Flood Hazard Area	7.69%	No data	2.98%	6.45%
Community Design - Park Access (CDC)				
Percent Within 1/2 Mile of a Park	75.0%	33.0%	34.0%	61.0%
Community Design - Walkability Index Score				
Walkability Index Score	5	6	7	10
Food Environment - Low Food Access	47.0%	22.0%	27.2%	22.2%
Food Environment - Low Income & Low Food Access	49.9%	20.9%	24.8%	19.4%
Population with Low or No Healthy Food Access by Race/Ethnicity, Percent				
Hispanic or Latino	58.3%	35.1%	48.9%	55.0%
Multiple Race	62.0%	45.6%	50.0%	53.6%
Non-Hispanic American Indian or Alaska Native	72.0%	49.4%	50.7%	54.6%
Non-Hispanic Asian	66.2%	40.1%	50.3%	51.3%
Non-Hispanic Black	77.2%	44.0%	58.5%	64.2%
Non-Hispanic Other	93.3%	39.7%	49.6%	57.9%
Non-Hispanic White	59.7%	45.2%	47.6%	49.3%
Population with Low or No Healthy Food Access, Racial Disparity Index				
Disparity Index Score (0 = No Disparity; 1 - 15 = Some Disparity; Over 15 = High Disparity)	17.41	23.56	20.03	16.59
Population without a Computer or an Internet Subscription by Employment Status				
Employed withNo Computer orInternet Subscription,Percent	11.0%	9.3%	7.3%	6.1%
Unemployed withNo Computer orInternet Subscription,Percent	16.8%	14.9%	12.6%	8.8%

Appendix

Secondary Data Tables

Clinical Care and Prevention				
Data Indicator	Carter	Ballad Health GSA	Tennessee	USA
⊞ Annual Wellness Exam (2021), Percent	50.0%	45.0%	43.0%	
⊟ Annual Wellness Exam by Race and Ethnicity, Percent				
American Indian/Alaska native	No data	No data	37%	
Black or African American	0.0%	38.0%	37.0%	
Hispanic or Latino	No data	28.0%	28.0%	
Non-Hispanic White	50.0%	48.0%	44.0%	
⊟ Blood Pressure Medication Nonadherence by Race/Ethnicity, Percent				
Black or African American	No data	25.5%	30.0%	
Hispanic or Latino	No data	No data	26.9%	
Non-Hispanic White	21.2%	21.4%	21.4%	
⊞ Cancer Screening - Cervical - Females Age 21-65 with recent Pap Smear, Percent	81.3%	81.6%	83.2%	83.7%
⊞ Cancer Screening - Mammogram (Adult) - Age 50-74, Percent	70.1%	71.8%	73.5%	77.8%
⊞ Cancer Screening - Sigmoidoscopy or Colonoscopy - Age 50-75, Percent	69.5%	69.7%	71.6%	70.6%
⊞ Dental Care - Adults Age 18+ with Recent Dental Visit, Percent	50.5%	55.5%	57.4%	64.5%
⊞ Hospitalizations - Heart Disease - Cardiovascular Disease Hospitalizations, Rate per 1,000	17.8	13	13.2	10.4
⊞ Hospitalizations - Ischemic Stroke Hospitalizations, Rate per 1,000	9	9.2	9.9	
⊞ Hospitalizations - Preventable Hospitalizations, Rate per 100,000 Beneficiaries	3618	3258	2897	2752
⊞ Late or No Prenatal Care - Percent of Births	Suppressed	4.9%	6.5%	
⊞ Opioid Drug Claims, Percent of Total Claims	3.5%	5.0%	5.1%	
⊞ Prevention - Adults with Recent Influenza Immunization, Percent	42.8%	44.1%	43.0%	
⊞ Prevention - Cholesterol Screening - Adults Age 18+ with Recent Cholesterol Screening (Age-Adjusted), percent	83.2%	83.3%	85.2%	
⊞ Prevention - Core Preventative Services for Men - Age 65+ Up to Date on Core Preventative Services (Age-Adjusted), Percent	41.5%	42.2%	40.4%	
⊞ Prevention - Core Preventative Services for Women - Age 65+ Up to Date on Core Preventative Services (Age-Adjusted), Percent	33.5%	37.8%	38.9%	
⊞ Prevention - High Blood Pressure Management (Adult) - Age 18+ with HTN Who Take Medicine for HTN (Age-Adjusted), Percent	63.4%	62.4%	63.1%	
⊞ Prevention - Recent Primary Care Visit (Adult) - Age 18+ with Routine Checkup in Past 1 Year (Age-Adjusted), Percent	74.7%	74.5%	75.8%	
⊞ Readmissions - Chronic Obstructive Pulmonary Disease - 30 Day Readmission, Percent	22.4%	19.7%	19.6%	
⊞ Readmissions - Heart Attack - 30 Day Readmission, Percent	No data	16.2%	15.6%	
⊞ Readmissions - Heart Failure - 30 Day Readmission, Percent	22.4%	22.6%	21.9%	
⊞ Readmissions - Pneumonia - 30 Day Readmission, Percent	18.9%	17.5%	17.1%	

Appendix

Secondary Data Tables

Special topics - Covid-19				
Data Indicator	Carter	Ballad Health GSA	Tennessee	USA
COVID-19 Fully Vaccinated Adults				
Estimated Percent of Adults Hesitant About Receiving COVID-19 Vaccination	14.0%	11.6%	12.6%	10.3%
Percent of Adults Fully Vaccinated	47.6%	59.4%	63.1%	72.9%
Vaccine Coverage Index	0.92	0.56	0.65	0.44
COVID-19 - Mortality				
Deaths, Rate per 100,000 Population	661.92	569.06	424.14	337.86
COVID-19 - Confirmed Cases				
Confirmed Cases, Rate per 100,000 Population	38327.63	37500.38	35577.98	31100.91

Work Force				
Data Indicator	Carter	Ballad Health GSA	Tennessee	USA
Addiction/Substance Abuse Providers				
Providers, Rate per 100,000 Population	0	7.5	7.44	27.85
Dental Health Providers				
Providers, Rate per 100,000 Population	26.62	26.53	33.41	39.06
Federally Qualified Health Centers				
Rate of Federally Qualified Health Centers per 100,000	1.77	6.45	2.47	3.49
Mental Health Providers				
Providers, Rate per 100,000 Population	33.71	92.26	132.83	178.73
Population Living in a Health Professional Shortage Area				
Percentage of HPSA Population Underserved	4.3%	28.6%	32.8%	53.1%
Percentage of Population Living in an Area Affected by a Primary Care HPSA	40.7%	43.8%	34.9%	23.5%
Primary Care Providers				
Providers, Rate per 100,000 Population	58.56	118.57	90.09	112.36

Appendix

Secondary Data Tables

Health Behaviors				
Data Indicator	Carter	Ballad Health GSA	Tennessee	USA
Adults with No Leisure-Time Physical Activity by Gender, 2021				
Female, Percent	21.9%	24.0%	22.8%	21.1%
Male, Percent	19.2%	20.8%	19.3%	17.8%
Alcohol - Adults Age 18+ Binge Drinking in the Past 30 Days (Age-Adjusted), Percent	15.3%	15.7%	15.5%	16.7%
Alcohol - Adults Reporting Excessive Drinking, Percent	13.8%	14.4%	16.9%	18.1%
HIV Prevalence Rate by Race / Ethnicity				
American Indian or Alaska Native	0	0	50.7	160.3
Asian	Suppressed	0	78.9	98.9
Black or African American	Suppressed	673.1	1051.1	1245.1
Hispanic or Latino	Suppressed	274.3	409.4	517.6
Multiracal	Suppressed	899.7	1013.1	1063.9
White	72.7	102	147.1	178.6
Insufficient Sleep - Adults Age 18+ Sleeping Less Than 7 Hours on Average (Age-Adjusted), Percent	36.4%	36.3%	35.0%	33.3%
Percentage of Adults Physically Inactive, 2021	20.6%	22.4%	21.1%	19.5%
STI - Chlamydia Incidence				
Chlamydia Infections	168	2598	39227	1644416
Chlamydia Infections,Rate per 100,000 Pop.	299.28	274.46	562.38	495.50
STI - Gonorrhea Incidence				
Gonorrhea Infections	98	1125	18768	710151
Gonorrhea Infections,Rate per 100,000 Pop.	174.6	118.8	269.1	214
STI - HIV Incidence				
HIV / AIDS Infections,Rate per 100,000 Pop.	Suppressed	6.21	14.1	12.7
Total HIV / AIDS Infections	Suppressed	27	831	35716
STI - HIV Prevalence				
Population with HIV / AIDS	42	1027	18738	1071005
Population with HIV / AIDS,Rate per 100,000 Pop.	85.1	125.36	318.1	382.2
Tobacco Usage - Adults Age 18+ as Current Smokers (Age-Adjusted), Percent	23.5%	22.1%	19.9%	13.8%
Walking or Biking to Work Age 16+, Percent	1.0%	1.4%	1.3%	2.9%

Appendix

Secondary Data Tables

Other Social and Economic Factors				
Data Indicator	Carter	Ballad Health GSA	Tennessee	USA
Food Insecurity - Food Insecure Population Ineligible for SNAP Assistance				
Food Insecure Children Ineligible for Assistance, Percent	13.0%	17.1%	22.2%	26.6%
Food Insecure Population Ineligible for Assistance, Percent	39.6%	29.9%	46.4%	36.8%
Food Insecurity - Percent of Children that are Food Insecure	15.6%	14.6%	13.2%	13.3%
Food Insecurity Rate, Percent of Total Population	15.3%	14.1%	11.3%	10.3%
Gender Pay Gap: Ratio of Female vs. Male Median Earnings	0.83	0.81	0.81	0.81
Homeless Children & Youth: Homeless Students, Percent	2.7%	1.9%	2.0%	2.8%
Households Receiving SNAP Benefits by Race/Ethnicity, Percent				
American Indian or Alaska Native	5.6%	32.4%	18.7%	22.9%
Asian	0.0%	4.6%	5.4%	7.9%
Black	41.5%	26.2%	23.4%	24.6%
Multiple Race	15.4%	22.0%	14.7%	16.9%
Non-Hispanic White	14.9%	14.1%	8.9%	7.1%
Some Other Race	10.3%	16.9%	14.2%	19.5%
Households with No Motor Vehicle, Percent	5.9%	5.9%	5.3%	8.3%
Housing + Transportation Affordability Index (H+T Index)				
Housing + Transportation Costs,Percent of Income	51.0%	55.0%	51.0%	48.0%
Housing Costs, Percent of Income	23.0%	25.0%	25.0%	26.0%
Transportation Costs, Percent of Income	28.0%	30.0%	26.0%	21.0%
Incarceration Rate, Percent of Total Population	1.2%	1.7%	1.9%	1.3%
Insurance - Insured Population and Provider Type				
Percentage with Private Insurance	62.2%	64.5%	74.2%	74.0%
Percentage with Public Insurance	52.6%	51.2%	40.2%	39.3%
Insurance - Population Receiving Medicaid, Percent of insured Population	26.1%	26.1%	21.8%	22.3%
Insurance - Uninsured Adults				
Pop. Age 18-64 w/ Insurance, Percent	83.5%	86.5%	85.4%	87.9%
Pop. Age 18-64 w/o Insurance, Percent	16.5%	13.5%	14.6%	12.1%
Insurance - Uninsured Children				
Pop. Age 0-18 w/ Insurance, Percent	96.3%	96.0%	95.4%	94.7%
Pop. Age 0-18 w/o Insurance, Percent	3.7%	4.0%	4.6%	5.3%
Opportunity Index - Dimension Scores (0=Low Opportunity, 100=High Opportunity)				
Community	38.6	42.2	44.5	47.6
Economy	44.5	52.6	54.9	55.4
Education	48.6	51.5	53.3	55.2
Health	41.4	43.6	44.9	54
Opportunity Index (0=Low Opportunity, 100=High Opportunity)	43.2	47.5	49.4	53.1
Racial Segregation (Interaction Index) - (0 = Low Segregation, 1 = High Segregation)	0.93	No data	No data	No data
SNAP Benefits - Households Receiving SNAP (ACS), Percent	15.4%	14.6%	11.7%	11.5%
Social Capital - Voter Participation, Percent	53.9%	57.7%	60.8%	68.8%
Social Vulnerability Index (SoVI) - (0 = low Vulnerability, 1 = High Vulnerability)	0.12	0.22	0.48	0.48
Teen Births, Rate per 1,000 Female Population Age 15-19	26.1	26.4	24.2	16.6
Uninsured Population by Ethnicity Alone				
Hispanic or Latino, Percent	36.7%	27.1%	30.9%	17.6%
Not Hispanic or Latino, Percent	12.3%	9.1%	8.8%	6.6%
Uninsured Population by Race, Percent				
American Indian or Alaska Native	0.0%	25.9%	18.3%	19.3%
Asian	14.3%	8.9%	9.6%	6.1%
Black or African American	10.9%	13.5%	11.5%	9.8%
Multiple Race	18.8%	13.8%	16.3%	12.6%
Native Hawaiian or Pacific Islander	0.0%	18.5%	20.3%	11.5%
Non-Hispanic White	12.3%	8.9%	8.1%	5.9%
Some Other Race	63.7%	34.2%	33.3%	19.8%
Violent Crime - Assaults, Rate per 100,000	181	246.9	468.3	261.2
Violent Crime - Rape, Rate per 100,000	10.1	38.9	42.2	38.6
Violent Crime - Robbery, Rate per 100,000	19.7	25.7	115.7	110.9
Young People, Age 16-19, Not in School and Not Working, Percent	7.0%	9.9%	7.3%	6.9%

Appendix

Secondary Data Tables

Social Determinants of Health (SDOH)				
Data Category	Carter	Ballad Health GSA	Tennessee	USA
⊟ Education				
⊞ Access - Childcare Centers - Rate of Childcare Centers per 1,000 (Population <5)	12	10.16	9	8
⊞ Access - Childcare Cost Burden - % of Household Income	28.0%	29.2%	26.0%	28.8%
⊞ Access - Head Start Programs, Rate per 10,000 Children Under Age 5	29.6	24.88	10.32	10.53
⊞ Access - Preschool Enrollment (Age 3-4), Percent	28.1%	30.5%	38.6%	45.6%
⊟ Attainment - Overview, Percent				
Associate's Degree	8.2%	8.6%	7.7%	8.7%
Bachelor's Degree	13.5%	13.2%	18.7%	20.9%
Graduate or Professional Degree	7.6%	7.7%	11.0%	13.4%
High School Only	36.7%	36.7%	31.5%	26.4%
No High School Diploma	12.6%	13.3%	10.7%	10.9%
Some College	21.4%	20.5%	20.4%	19.7%
⊟ Housing and Families				
⊟ Affordable Housing				
Units Affordable at 100% AMI (Area Median Income)	62.6%	63.7%	57.9%	59.5%
Units Affordable at 50% AMI (Area Median Income)	23.6%	24.9%	21.7%	20.7%
⊞ Housing Costs - Cost Burden (30%), Percent of Households	21.5%	21.9%	26.3%	30.5%
⊞ Housing Costs - Cost Burden, Severe (50%), Percent	8.7%	9.7%	11.6%	14.1%
⊟ Substandard Housing: Number of Substandard Conditions Present, Percentage of Total Occupied Housing Units				
One Condition	21.0%	21.4%	25.7%	29.9%
Two or Three Conditions	0.4%	0.7%	1.0%	1.8%
Four Conditions	0.0%	0.0%	0.0%	0.0%
No Conditions	78.6%	77.9%	73.2%	68.3%
⊟ Income and Economics				
⊞ Employment - Unemployment Rate	3.1%	3.1%	3.0%	3.9%
⊟ Households by Household Income Levels, Percent				
Under $25,000	26.2%	24.8%	18.2%	15.7%
$25,000 - $49,999	25.4%	24.8%	21.2%	18.1%
$50,000 - $99,999	29.9%	29.7%	30.8%	28.9%
$100,000 - $199,999	16.1%	16.9%	22.4%	25.9%
$200,000+	2.4%	3.8%	7.3%	11.4%
⊞ Income - Median Household Income	$47,994	No data	$64,035	$75,149
⊞ Poverty - Children Below 100% FPL, Percent	27.4%	24.8%	19.2%	16.7%
⊞ Poverty - Children Below 200% FPL, Percent	55.1%	49.5%	42.1%	37.2%
⊞ Poverty - Population Below 200% FPL	41.3%	39.5%	32.6%	28.8%
⊟ Other Social & Economic Factors				
⊞ Food Insecure Children, Percent of Children	15.6%	14.6%	13.2%	13.3%
⊞ Food Insecurity Rate - Percent of Total Population	15.3%	14.1%	11.3%	10.3%
⊞ Households with No Motor Vehicle, Percent of Households	5.9%	5.9%	5.3%	8.3%
⊟ Housing + Transportation Costs, Percent of Total Income				
Housing + TransportationCosts % Income	51.0%	55.0%	51.0%	48.0%
⊞ Incarceration Rate, Percent of Total Population	1.2%	1.7%	1.9%	1.3%
⊞ Insurance - Uninsured Population (ACS), Percent of Total Population	12.9%	9.6%	10.1%	8.7%
⊞ Racial Segregation (Interaction Index) - (0 = Low Segregation, 1 = High Segregateion)	0.93	No data	No data	No data
⊞ Social Vulnerability Index (SoVI) - (0 = Low Vulnerability, 1 = High Vulnerability)	0.65	0.61	0.56	0.58
⊞ Violent Crime - Total - Annual Rate per 100,000	215.2	315.9	633.7	416
⊟ Physical Environment				
⊞ Food Environment - Low Food Access, Percent	47.0%	22.0%	27.2%	22.2%
⊞ Households with No or Slow Internet, Percent	21.6%	20.0%	14.3%	11.7%
⊟ Work Force, Rate per 100,000				
⊞ Addiction/Substance Abuse Providers	0	7.5	7.44	27.85
⊞ Dental Health Providers	26.62	26.53	33.41	39.06
⊞ Mental Health Providers	33.71	92.26	132.83	178.73
⊞ Primary Care Providers	58.56	118.57	90.09	112.36

Appendix

Secondary Data Tables

Education				
Data Indicator	Carter	Ballad Health GSA	Tennessee	USA
Access - Childcare Centers - Rate of Childcare Centers per 1,000 (Population <5)	12	10.16	9	8
Access - Childcare Cost Burden - % of Household Income	28.0%	29.2%	26.0%	28.8%
Access - Head Start Programs, Rate per 10,000 Children Under Age	29.6	24.88	10.32	10.53
Access - Preschool Enrollment (Age 3-4), Percent	28.1%	30.5%	38.6%	45.6%
Attainment - Overview, Percent				
Associate's Degree	8.2%	8.6%	7.7%	8.7%
Bachelor's Degree	13.5%	13.2%	18.7%	20.9%
Graduate or Professional Degree	7.6%	7.7%	11.0%	13.4%
High School Only	36.7%	36.7%	31.5%	26.4%
No High School Diploma	12.6%	13.3%	10.7%	10.9%
Some College	21.4%	20.5%	20.4%	19.7%
Chronic Absence Rate	16.3%	14.2%	17.7%	20.9%
Chronic Absence Rate by Race / Ethnicity				
American Indian or Alaska Native	67.0%	59.0%	80.0%	39.0%
Asian	No data	8.0%	12.0%	10.0%
Black or African American	38.0%	24.0%	28.0%	33.0%
Hispanic / Latino	31.0%	16.0%	22.0%	25.0%
Native Hawaiian/Other Pacific Islander	No data	39.0%	65.0%	56.0%
Two or More Races	27.0%	22.0%	25.0%	27.0%
White	17.0%	14.0%	14.0%	16.0%
Employment Rate by Educational Attainment				
Bachelor's or Higher	96.3%	97.7%	97.9%	97.2%
High School Only	92.2%	93.5%	94.5%	94.1%
No High School Diploma	90.6%	90.1%	91.3%	92.2%
Some College or Associate's	93.3%	95.3%	95.7%	95.3%
High School Graduation Rate by Student Race and Ethnicity				
Black or African American	66.7%	88.0%	85.1%	83.6%
Hispanic or Latino	85.7%	88.7%	81.1%	78.5%
White	89.5%	92.4%	93.7%	90.8%
Proficiency - Student Math Proficiency (4th Grade)				
Students Scoring 'Not Proficient' or Worse, Percent	81.1%	55.6%	70.4%	63.9%
Students Scoring 'Proficient' or Better, Percent	18.9%	44.4%	29.6%	36.1%
Proficiency - Student Reading Proficiency (4th Grade)				
Students Scoring 'Not Proficient' or Worse, Percent	69.8%	49.8%	71.0%	60.1%
Students Scoring 'Proficient' or Better, Percent	30.2%	50.2%	29.0%	39.9%
Public School Expenditures				
Expenditures Per Student ($)	$11,434	$11,988	$11,795	$17,001
Expenditures Spent on Capital Outlay (%)	6.83	6.33	7.92	10.07
Expenditures Spent on Instruction (%)	58.74	56.59	54.21	50.31
Expenditures Spent on Non-Elementary/Secondary Education (%)	76.0%	70.0%	74.0%	90.0%
Expenditures spent on Support Services (%)	28.83	30.67	30.82	29.77
Total Expenditures (Millions)	85	1490	11549	827605
School Funding Adequacy				
Actual Spending Per Pupil	$10,555	$11,071	$10,422	$14,116
Gap between Actual and Required Spending	$-1,538	$-1,571	$-2,125	$-1,337
Required Spending Per Pupil	$12,093	$12,642	$12,547	$15,453

Appendix

Secondary Data Tables

Income and Economics				
Data Indicator	Carter	Ballad Health GSA	Tennessee	USA
Average Public Assistance Dollars Received				
Aggregate Public Assistance Dollars Received	$3,547,700	$29,861,400	$191,731,600	$14,167,234,100
Average Public Assistance Received (in USD) by Households Receiving Public Assistance	$3,530	$2,927	$3,426	$4,242
Children in Poverty by Race, Percent				
American Indian or Alaska Native	0.0%	41.5%	39.0%	29.1%
Asian	0.0%	5.1%	8.3%	10.2%
Black or African American	84.5%	38.3%	34.3%	30.6%
Multiple Race	21.2%	38.6%	24.3%	17.7%
Native Hawaiian or Pacific Islander	No data	28.9%	15.8%	23.4%
Some Other Race	60.8%	44.6%	32.1%	25.5%
Commuter Travel Patterns - Overview				
PercentBicycle or Walk	1.0%	1.4%	1.3%	2.9%
PercentCarpool	7.1%	7.6%	8.5%	8.5%
PercentDrive Alone	84.0%	83.1%	78.8%	71.7%
PercentPublic Transportation	0.2%	0.2%	0.5%	3.8%
PercentTaxi or Other	1.5%	1.2%	1.2%	1.4%
PercentWork at Home	6.2%	6.4%	9.7%	11.7%
Commuter Travel Patterns - Overview 2				
% Workers Travelling < 10 mins	13.4%	16.0%	11.8%	12.5%
% Workers Travelling > 60 mins	4.5%	6.2%	6.8%	8.9%
% Workers Travelling between 10 and 30 mins	53.1%	53.3%	52.2%	49.6%
% Workers Travelling between 30 and 60 mins	29.1%	24.5%	29.2%	29.0%
Debt - Any Debt in Collections				
Median Debt in Collections	$1,933	No data	$1,892	$1,739
Share with Any Debt in Collections	35.4%	34.0%	31.6%	26.2%
Debt - Student Loan Debt				
Median Monthly Student Loan Payment	$139	No data	$154	$160
Median Student Loan Debt	$18,231	No data	$19,984	$20,108
Share with Any Student Loan Debt	10.0%	9.8%	14.7%	15.2%
Employment - Unemployment Rate	3.1%	3.1%	3.0%	3.9%
Employment Rate by Disability Status, Percent				
Population w/ Disability Employed, Percent	88.3%	88.1%	88.7%	88.5%
Population w/o Disability Employed, Percent	93.5%	94.8%	95.5%	95.1%
Families with Income Over $75,000 by Race Alone, Percent				
American Indian or Alaska Native	No data	29.6%	47.9%	42.5%
Asian	36.7%	70.6%	68.6%	70.5%
Black or African American	9.5%	27.8%	37.7%	42.5%
Multiple Race	47.1%	29.6%	45.2%	53.2%
Native Hawaiian or Pacific Islander	No data	0.0%	36.9%	55.8%
Some Other Race	50.0%	38.5%	36.3%	42.7%
White	39.5%	43.9%	56.8%	64.2%
Households by Household Income Levels, Percent				
Under $25,000	26.2%	24.8%	18.2%	15.7%
$25,000 - $49,999	25.4%	24.8%	21.2%	18.1%
$50,000 - $99,999	29.9%	29.7%	30.8%	28.9%
$100,000 - $199,999	16.1%	16.9%	22.4%	25.9%
$200,000+	2.4%	3.8%	7.3%	11.4%
Income - Families Earning Over $75,000				
Percent Families with Income Over $75,000	39.1%	43.4%	53.5%	60.0%
Income - Inequality (GINI Index)	0.45	No data	0.48	0.48
Income - Median Family Income				
Average Family Income	$76,259.82	$84,999	$105,921.13	$124,529.93
Median Family Income	$61,776	No data	$80,258	$92,646
Income - Median Household Income				
Average Household Income	$62,878.85	$70,152	$89,266.59	$105,833.04
Median Household Income	$47,994	No data	$64,035	$75,149
Income - Per Capita Income				
Per Capita Income ($)	$28,320	$29,890	$36,040	$41,261

Appendix

Secondary Data Tables

Income and Economics				
Data Indicator	Carter	Ballad Health GSA	Tennessee	USA
Median Family Income by Family Composition				
Married-Couple Families with Children	$76,393	No data	$104,477	$119,934
Married-Couple Families without Children	$67,050	No data	$90,448	$104,323
Single Females with Children	$32,067	No data	$32,580	$35,779
Single Females without Children	$49,508	No data	$52,404	$62,044
Single-Males with Children	$51,826	No data	$47,807	$55,671
Single-Males without Children	$43,409	No data	$61,813	$73,433
Population in Poverty by Ethnicity Alone				
Hispanic or Latino, Percent	31.6%	33.7%	22.1%	17.2%
Not Hispanic or Latino, Percent	17.8%	16.8%	13.4%	11.5%
Population in Poverty by Race Alone, Percent				
American Indian or Alaska Native	10.5%	34.6%	24.3%	22.6%
Asian	0.8%	14.4%	9.0%	10.1%
Black or African American	51.0%	29.8%	22.8%	21.5%
Multiple Race	29.0%	29.2%	19.5%	14.8%
Native Hawaiian or Pacific Islander	0.0%	33.6%	17.8%	17.0%
Some Other Race	31.5%	30.8%	23.9%	18.6%
White	17.2%	16.5%	11.5%	10.1%
Poverty - Children Below 100% FPL, Percent	27.4%	24.8%	19.2%	16.7%
Poverty - Children Below 200% FPL, Percent	55.1%	49.5%	42.1%	37.2%
Poverty - Poverty Profile				
101%-150%	12.5%	11.3%	9.1%	8.0%
151% - 200%	10.7%	10.9%	9.5%	8.3%
201% - 500%	44.8%	43.4%	43.0%	40.3%
50% or Less	6.5%	No data	6.3%	5.8%
51% - 100%	11.7%	9.7%	7.6%	6.7%
Over 500%	13.9%	17.1%	24.4%	30.9%

Appendix

Community Member Survey Results: Demographics

Which race best describes you? (Please choose only one)

Which race best describes you? (Please choose only one)	Percentage
White	92.3%
More than one race	2.5%
African American or Black	2.0%
Prefer not to answer	1.8%
Asian	0.5%
Other	0.5%
American Indian or Alaska Native	0.3%
Total	100.0%

Are you of Hispanic or Latino origin or descent?

Are you of Hispanic or Latino origin or descent?	Percentage
No, not Hispanic or Latino	94.9%
Prefer not to answer	2.5%
Yes, Hispanic or Latino	2.5%
Total	100.0%

Which generation group are you in?

Response	Percentage
Gen X (1965-1980)	35.86%
Millennials (1981-1996)	31.22%
Baby Boomers (1946-1964)	23.91%
Gen Z (1997-2012)	8.39%
Silent (1925-1945)	0.62%
Total	100.00%

What is your current gender identity? (Please choose only one)

Response	Percentage
Woman	82.67%
Man	15.20%
Prefer not to answer	1.07%
Non-Binary/Genderqueer	0.71%
Trans Man/Trans Masculine Spectrum	0.18%
I identify in another way	0.09%
Trans Woman/Trans Feminine Spectrum	0.09%
Total	100.00%

Do you identify as a member of the LGBTQIA+ community?

Response	Percentage
No	93.9%
Yes	6.1%
Total	100.0%

What is the highest level of school that you have completed?

Education	Percentage
Bachelor's degree, 4-year degree	32.5%
Master's/Graduate or professional degree or higher	27.5%
Some college, no degree	14.4%
Associate's degree, 2-year degree	12.9%
High school diploma or GED	7.7%
Vocational/Technical school	4.5%
Some high school (9th-12th grade), but no diploma	0.4%
Total	100.0%

How much total combined money did all people living in your home earn last year?

Response	Percentage
$100,000 or greater	34.7%
$75,000 - $99,999	18.5%
$50,000 - $74,999	17.6%
$35,000 - $49,999	11.1%
Prefer not to answer	9.5%
$25,000 - $34,999	5.2%
$10,000 - $24,999	2.2%
Less than $10,000	1.2%
Total	100.0%

How many people live in your home? (Including yourself)

How many people live in your home? (Including yourself)	Percentage
2	40.14%
3	23.18%
4	14.83%
1	12.97%
5	6.57%
6	1.69%
7	0.27%
9+	0.27%
8	0.09%
Total	100.00%

How long have you been a member of the community that you currently live in?

Response	Percentage
Over 10 years	72.3%
2 - 5 years	12.7%
6 - 10 years	9.0%
Under two years	6.0%
Total	100.0%

What type of health insurance do you have, if any? (Choose all that apply)

Response	Percentage
Private/Commercial)	78.82%
Medicare)	11.48%
Medicaid)	5.64%
Do not have health insurance)	2.70%
TRICARE)	1.35%
Total	100.00%

Appendix

Community Member Survey Results: Community Perceptions

Select three (3) of your community's greatest strengths.

Response	Percent
Good access to parks and recreation	17.7%
Religious or spiritual opportunities	16.2%
Safe neighborhoods/Low rates of crime and violence	11.0%
Access to health care	7.7%
Good internet access	7.0%
Access to arts music and cultural events	6.2%
Well-funded, local, 24-hour police fire and rescue services for emergencies	6.1%
A clean and healthy environment	5.8%
Welcoming supportive community	4.4%
Walkable bike-able community	4.1%
Access to programs activities and support for the senior community	3.5%
Plenty of jobs and a healthy economy	2.4%
Access to programs activities and support for youth and teens during non-school hours	1.9%
Access to affordable healthy foods in the community	1.9%
Low rates of homelessness	1.5%
Other	1.2%
The community appreciates social and cultural diversity	0.7%
Access to affordable housing for everyone	0.7%
Total	100.0%

Please identify the three (3) most important health issues in your community.

Response	Percentage
Chronic Disease	41.2%
Behavioral/Mental health	24.7%
Obesity/overweight	17.9%
Oral/dental health (including tooth pain	5.2%
Chronic pain	2.7%
Other	2.5%
Accident/injuries (for example, workplace injuries, or car accidents	2.2%
Unplanned pregnancy	2.0%
COVID-19	1.4%
HIV/AIDS	0.1%
Total	100.0%

Please check the three (3) factors that most NEGATIVELY impact diabetes in your community.

Responses	Percentage
Diet/nutrition/exercise	27.1%
Income/poverty	20.3%
Access to quality health care and other services	12.1%
Education	10.1%
Genetics	8.0%
Drug/alcohol use	4.9%
Poor mental health/traumatic stress	4.6%
Physical environment	3.4%
Tobacco/vaping use	3.4%
Adverse childhood experiences	2.6%
Lack of transportation	1.0%
Occupational/work conditions	0.9%
Other	0.8%
Poor housing conditions	0.6%
Total	100.0%

Please check the three (3) factors that most NEGATIVELY impact cancer in your community.

Response	Percentage
Access to quality health care and other services	16.5%
Tobacco/vaping use	16.0%
Income/poverty	15.9%
Diet/nutrition/exercise	12.4%
Drug/alcohol use	9.2%
Genetics	8.2%
Poor mental health/traumatic stress	5.1%
Physical environment	5.0%
Occupational/work conditions	3.1%
Lack of transportation	2.9%
Education	2.3%
Adverse childhood experiences	1.6%
Poor housing conditions	1.3%
Other	0.6%
Total	100.0%

Please check the three (3) factors that most NEGATIVELY impact heart disease in your community.

Response	Percentage
Diet/nutrition/exercise	24.8%
Tobacco/vaping use	15.1%
Income/poverty	13.8%
Access to quality health care and other services	12.5%
Drug/alcohol use	10.4%
Genetics	6.5%
Education	5.8%
Poor mental health/traumatic stress	3.8%
Physical environment	2.4%
Adverse childhood experiences	1.5%
Lack of transportation	1.0%
Poor housing conditions	1.0%
Occupational/work conditions	0.8%
Other	0.4%
Interpersonal violence/abuse	0.1%
Total	100.0%

Please check the three (3) factors that most NEGATIVELY behavioral health in your community.

Response	Percentage
Drug/alcohol use	20.7%
Access to quality health care and other services	18.6%
Income/poverty	16.3%
Poor mental health/traumatic stress	15.1%
Adverse childhood experiences	10.9%
Interpersonal violence/abuse	4.6%
Education	2.7%
Poor housing conditions	2.1%
Lack of transportation	1.8%
Diet/nutrition/exercise	1.7%
Tobacco/vaping use	1.6%
Physical environment	1.2%
Genetics	0.9%
Occupational/work conditions	0.9%
Other	0.8%
Total	100.0%

Please check the three (3) factors that most NEGATIVELY suicide in your community.

Response	Percentage
Poor mental health/traumatic stress	19.6%
Adverse childhood experiences	16.8%
Drug/alcohol use	16.8%
Access to quality health care and other services	15.1%
Income/poverty	15.1%
Interpersonal violence/abuse	8.4%
Poor housing conditions	4.5%
Education	1.1%
Physical environment	1.1%
Genetics	0.6%
Lack of transportation	0.6%
Other	0.6%
Total	100.0%

Please check the three (3) factors that most NEGATIVELY impact obesity/overweight in your community.

Response	Percentage
Diet/nutrition/exercise	27.8%
Income/poverty	20.5%
Access to quality health care and other services	8.7%
Education	8.7%
Poor mental health/traumatic stress	7.4%
Physical environment	6.2%
Genetics	5.4%
Adverse childhood experiences	4.5%
Drug/alcohol use	4.1%
Tobacco/vaping use	2.0%
Occupational/work conditions	1.5%
Other	1.1%
Poor housing conditions	1.0%
Lack of transportation	0.6%
Interpersonal violence/abuse	0.5%
Total	100.0%

Appendix

Community Member Survey Results: Community Perceptions

In your day-to-day life how often have any of the following things happened to you?

Question	A few times a month	A few times a year	At least once a week	Never	Total
People act as if they are afraid of you.	3.03%	10.02%	1.67%	85.28%	100.00%
People act as if they think you are not smart.	11.69%	32.25%	7.31%	48.75%	100.00%
People criticize your accent or the way you speak.	6.92%	24.11%	4.51%	64.47%	100.00%
You are threatened or harassed.	3.13%	22.36%	2.93%	71.58%	100.00%
You are treated with less courtesy or respect than other people.	16.39%	38.94%	12.94%	31.73%	100.00%
You receive poorer service than other people at restaurants or stores.	5.75%	30.51%	4.81%	58.93%	100.00%

What do you think is the main reason(s) for these experiences? (Choose all that apply)

Response	Percentage
Your rural/country designation	17.7%
I have not had these experiences	15.3%
Your sex	13.4%
Your age	10.8%
Your weight	7.4%
Some other aspect of your physical appearance	5.9%
Your income level	5.6%
Your education level	4.9%
Your ancestry or national origin	4.3%
Your race	3.2%
Your religion	3.1%
Your gender identity	2.7%
Your height	2.4%
Your sexual orientation	1.7%
A disability	1.5%
Total	100.0%

Please indicate your level of agreement for the following statements:

Attribute	Agree	Disagree	Total
Community members are able to get healthy and affordable food easily.	31.1%	68.9%	100.0%
I feel safe in my community.	85.5%	14.5%	100.0%
I have received information/resources related to emergency preparedness and response for my community.	38.2%	61.8%	100.0%
Illegal drug use/prescription medicine abuse is a problem in my community.	89.0%	11.0%	100.0%
My community is a good place to have a baby and raise children.	83.2%	16.8%	100.0%
My community is a good place to live.	90.2%	9.8%	100.0%
My community is good place to grow old/retire.	83.2%	16.8%	100.0%
Public transportation is easy to get to for those who need it.	22.6%	77.4%	100.0%
The quality of health care is good in my community.	42.6%	57.4%	100.0%
There are affordable places to live in my community.	22.0%	78.0%	100.0%
There are plenty of jobs available for those who want them.	50.7%	49.3%	100.0%
There are plenty of opportunities for social engagement in my community.	59.4%	40.6%	100.0%
We have great parks and recreational facilities.	81.9%	18.1%	100.0%

Appendix

Community Member Survey Results: Access to Care

When you get sick, where do you go? (Choose all that apply)

Response	Percentage
Doctors Office	43.5%
Urgent Care	35.2%
Emergency Department (ER	10.1%
I dont seek medical attention	6.4%
Homeopathic/Herbal Medicine	2.3%
Other	1.5%
Health Department	0.5%
Free Clinic or Community Health Center	0.5%
Total	100.0%

Please indicate your level of agreement with the following statements about access to care in your community:

Attribute	Agree	Disagree	Total
People can access a medical specialist (Cardiologist, Dermatologist, etc.) when needed.	41.2%	58.8%	100.0%
People can access a primary care doctor (Family Doctor, Pediatrician etc.), including nurse practitioners and physician assistants, when needed.	67.9%	32.1%	100.0%
There are enough dental care providers in my community.	48.4%	51.6%	100.0%
There are enough health care providers in my community that speak more than one language.	28.7%	71.3%	100.0%
There are enough mental health care providers in my community.	15.7%	84.3%	100.0%
There are enough providers accepting Medicaid in my community.	37.1%	62.9%	100.0%
There are enough providers accepting Medicare in my community.	47.6%	52.4%	100.0%
There are enough substance use disorder treatment providers in my community.	17.2%	82.8%	100.0%

In the last year, was there a time when you needed any of the following types of care but were not able to get it?

Attribute	No	Yes	Total
Dental Care	72.7%	27.3%	100.0%
Medical Care	75.0%	25.0%	100.0%
Mental Health Care	82.1%	17.9%	100.0%
Prescription Medicine	74.8%	25.2%	100.0%

If you were not able to get prescription medicine, why not? (Choose all that apply)

Response	Percentage
Unable to afford to pay for prescriptions	37.55%
Manufacturing shortage	25.29%
Other	13.03%
Do not have insurance to cover my prescription medications	10.73%
Pharmacy does not have convenient hours	6.13%
Unable to find a pharmacy that takes my insurance	4.60%
Transportation challenges	2.30%
Unsure how to find a pharmacy	0.38%
Total	100.00%

If you were not able to get medical care, why not? (Choose all that apply)

Response	Percentage
Unable to schedule an appointment when needed	25.00%
Unable to afford to pay for care	16.26%
Cannot take time off work	14.08%
Doctors office does not have convenient hours	13.83%
Other	9.47%
Unable to find a doctor who takes my insurance	8.01%
Do not have insurance to cover medical	4.61%
Unable to find a doctor who knows or understands my culture, identity, or beliefs	3.16%
Unable to find someone to watch my child(ren	2.67%
Unsure how to find a doctor	2.18%
Transportation challenges	0.73%
Total	100.00%

If you were not able to receive mental-health services, why not? (Choose all that apply)

Response	Percentage
Unable to afford to pay for care	15.70%
Unable to schedule an appointment when needed	13.92%
Doctor/counselors office does not have convenient hours	12.91%
Cannot take time off work	12.41%
Unable to find a doctor / counselor who takes my insurance	11.65%
Do not have insurance to cover mental health care	6.58%
Other	6.08%
Unsure how to find a doctor/counselor	6.08%
Afraid of what people might think	5.32%
Unable to find a doctor/counselor who knows or understands my culture, identity, or beliefs	5.06%
Unable to find someone to watch my child(ren	3.54%
Transportation challenges	0.76%
Total	100.00%

If you were not able to get dental care, why not? (Choose all that apply)

Response	Percentage
Unable to afford to pay for care	22.8%
Unable to schedule an appointment when needed	20.5%
Dentists office does not have convenient hours	13.0%
Unable to find a dentist who takes my insurance	13.0%
Cannot take time off work	11.9%
Do not have insurance to cover dental care	7.7%
Other	4.4%
Unable to find someone to watch my child(ren	2.6%
Unsure how to find a dentist	2.1%
Unable to find a dentist who knows or understands my culture, identity, or beliefs	1.4%
Transportation challenges	0.7%
Total	100.0%

Appendix

Community Member Survey Results: Personal Health and Well-Being

How often do you have a drink containing alcohol?

Response	Percentage
Never	42.51%
Monthly or less	33.84%
2 to 4 times a month	13.47%
2 to 3 times a week	7.23%
4 or more times a week	2.96%
Total	100.00%

How often do you use tobacco products (dip/chew, cigarettes, vaping, etc.)?

Response	Percentage
Never	88.77%
4 or more times a week	7.56%
Monthly or less	2.34%
2 to 3 times a week	0.89%
2 to 4 times a month	0.44%
Total	100.00%

In the past 5 years, please select any of the following preventative screenings you have received from a healthcare professional. (Choose all that apply)

Response	Percentage
Regular Physical Exam	17.5%
Blood Pressure and Cholesterol Check	15.8%
Pap Smear	11.5%
Breast/Mammography Exam	11.4%
Blood Glucose Diabetes Screening	11.3%
Depression/Anxiety Screening	8.0%
Thyroid Testing	6.9%
Colonoscopy/Colorectal Cancer Screening	6.9%
Skin Cancer Screening	5.3%
Sexually Transmitted Infection Screening	2.1%
Heart Shape Screening/Calcium Scoring	1.9%
Prostate Exam	0.9%
Low Dose CT Scan (Lung Cancer Screening	0.5%
Total	100.0%

Within the last year, have you experienced any of the following? (Choose all that apply)

Response	Percentage
Had trouble sleeping or concentrating	27.31%
Felt down, depressed, or hopeless	21.56%
Lost interest in activities that you used to enjoy	15.47%
Felt isolated or alone	14.04%
Taken any medication for a mental health condition	13.63%
Been diagnosed with a mental health condition	5.07%
Had thoughts of harming yourself or others	2.68%
Been hospitalized for a mental health condition	0.24%
Total	100.00%

Do you have people in your life you can rely on for support?

Response	Percentage
Yes	94.64%
No	5.36%
Total	100.00%

Appendix

Community Member Survey Results: Personal Health and Well-Being

In the past 12 months, how often have you been concerned with any of the following?

Response	Never True	Often True	Refused to Answer	Sometimes True	Total
Home bug infestation	91.7%	1.1%	1.7%	5.5%	100.0%
Inadequate air conditioning in home	88.8%	2.6%	1.7%	6.9%	100.0%
Inadequate heat in home	88.0%	2.5%	1.6%	7.9%	100.0%
Lead paint or pipes in home	94.2%	1.0%	2.0%	2.8%	100.0%
Mold in home	86.4%	2.7%	1.7%	9.2%	100.0%
No or not working smoke detectors in home	90.8%	2.0%	1.9%	5.3%	100.0%
Oven or stove not working in home	94.2%	1.4%	1.9%	2.5%	100.0%
Paying my bills	44.6%	19.9%	2.0%	33.5%	100.0%
Running out of food before you got money to buy more	78.4%	6.0%	1.6%	13.9%	100.0%
Safe and stable housing	84.0%	6.1%	1.4%	8.4%	100.0%
Transportation issues that keep you from medical appointments, work, or things needed for daily living	84.9%	2.7%	1.7%	10.7%	100.0%
Water leaks in home	78.9%	2.9%	1.9%	16.3%	100.0%

Does anyone living in your household have access to a smart phone?

Response	Percentage
Yes	97.9%
No	2.1%
Total	100.0%

Do you have internet in your home (or where you live)? For example, can you watch YouTube?

Response	Percentage
Yes	97.2%
No	2.8%
Total	100.0%

Appendix

Community Member Survey Results: Child Health and Well-Being

Select the three (3) most important HEALTH needs for children in your community.

Response	Percentage
Mental or behavioral health/suicide prevention	15.10%
Dental care	12.18%
Healthy food/nutrition	9.74%
Neurodiversity (ADHD, ADD, Autism, Dyslexia, etc.	8.89%
Drug or alcohol use/exposure (including cigarettes and vaping	8.53%
Immunizations (for example, common childhood vaccines, like mumps, measles, chicken pox, etc.	7.92%
Special needs (physical/chronic/behavioral/developmental/emotional	6.33%
Accidents and injuries	5.97%
Obesity/physical inactivity	5.60%
Respiratory health (for example, asthma, RSV, cystic fibrosis	4.38%
Eye/vision health	3.78%
Safe sex practices and teen pregnancy	3.65%
Healthy pregnancies and childbirth (not teen pregnancy	2.56%
Gender/sexual identity of child	1.71%
Infectious diseases (including COVID-19	1.58%
Complex medical needs	1.10%
Diabetes	0.73%
Other	0.24%
Total	100.00%

How old are your children? (Choose all that apply)

Response	Percentage
Grade School (5-12 years)	33.96%
Teen (12-18 years)	33.42%
Toddler (1-3 years)	14.61%
Preschool (3-5 years)	13.40%
Infant (less than 1 year)	4.60%
Total	100.00%

Do you currently have a child care option that meets your child care needs?

Response	Percentage
Yes	80.08%
No	19.92%
Total	100.00%

Which statement best describes why you are in need of non-parental child care?

Response	Percentage
I am planning for future children or have just started looking.	2.17%
I am unhappy with my current child care option.	21.74%
I am unable to find child care or am on waitlist(s).	36.96%
Other	39.13%
Total	100.00%

Appendix

Community Partner Survey Results: Organizational Information

Which best describes your position or role in your organization?

Response	Percentage
Senior management level/unit or program lead	31.7%
Leadership team	25.4%
Supervisor (not senior management)	14.3%
Administrative staff	12.7%
Other	12.7%
Front line staff	3.2%
Total	100.0%

Has your organization ever participated in a community health improvement process?

Response	Percentage
Yes	55.74%
Unsure	34.43%
No	9.84%
Total	100.00%

Does the leadership and management of your organization reflect the demographics of the community you serve?

Response	Percentage
Yes	75.81%
No	16.13%
Unsure	8.06%
Total	100.00%

How many people are currently employed at your organization?

Response	Percentage
1 - 10	32.26%
More than 100	29.03%
11 - 50	27.42%
51 - 100	11.29%
Total	100.00%

Does the administrative/frontline staff and others in your organization reflect the demographics of the community you serve?

Response	Percentage
Yes	77.42%
No	14.52%
Unsure	6.45%
Not applicable	1.61%
Total	100.00%

Which of the following best describe(s) your organization?

Response	Percentage
Non-profit organization	54.84%
College/university	14.52%
Schools/education (PK-12)	4.84%
State health department	4.84%
Foundation/philanthropy	3.23%
Library	3.23%
County health department	1.61%
Emergency response	1.61%
Faith-based organization	1.61%
For-profit organization/private business	1.61%
Grassroots community organizing group/organization	1.61%
Other	1.61%
Other city government agency	1.61%
Private clinic	1.61%
Social service provider	1.61%
Total	100.00%

Appendix

Community Partner Survey Results

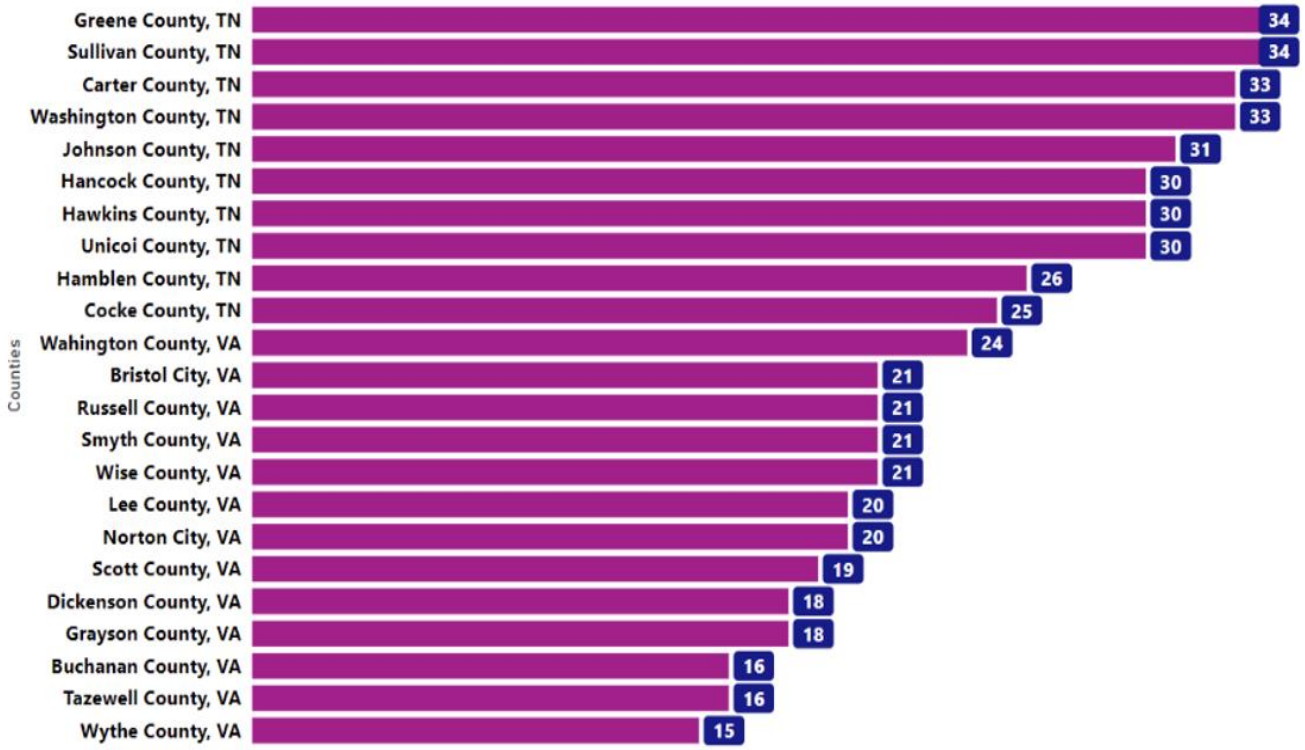
Please select any of the below vulnerable populations that your organization works with/offers services to: (check all that apply)

Response	Percentage
Low-income individuals	10.0%
Children	8.8%
Racial/ethnic minorities	8.3%
Homeless/unhoused individuals	7.5%
Uninsured individuals	7.3%
LBGTQIA+ community	7.1%
Individuals with mental health disorders	6.8%
Individuals with substance use disorder	6.8%
Current or formerly incarcerated individuals	6.6%
Maternal women	6.4%
Chronically ill or disabled individuals	6.2%
Domestic violence survivors	6.0%
Immigrants, refugees, asylum seekers, or other populations who speak English as a second language	5.8%
Veterans	5.3%
Other	1.1%
Total	100.0%

Which of the following health topics does your organization work on? (check all that apply)

Response	Percentage
Family/maternal health	10.7%
Health equity	9.5%
Mental or behavioral health (e.g., PTSD, anxiety, trauma	9.2%
Healthcare access/utilization	8.8%
Tobacco and substance use and prevention	8.4%
Health insurance/Medicare/Medicaid	7.3%
Immunizations and screenings	6.9%
Physical activity	6.5%
Chronic disease (e.g., asthma, diabetes/obesity, cardiovascular disease	6.1%
HIV/STD prevention	5.3%
Infectious disease	5.3%
Special Supplemental Nutrition Program for Women, Infants, and Children (WIC/food stamps	4.2%
None of the above/Not applicable	3.8%
Injury and violence prevention	3.4%
Cancer	3.1%
Other	1.5%
Total	100.0%

Please select the counties in your geographic service area from the list below, (check all that apply)



Appendix

Community Partner Survey Results

Which of the following categories does your organization work on/with? (check all that apply)

Response	Percentage
Education	7%
Family well-being	6%
Early childhood development/childcare	6%
Human services	6%
Food access and affordability (e.g., food bank	5%
Healthcare access/utilization	5%
Faith communities	5%
Public health	5%
Housing	4%
Businesses and for-profit organizations	4%
Youth development and leadership	4%
Community economic development	4%
Seniors/elder care	3%
Economic security	3%
Transportation	3%
Disability/independent living	3%
Government accountability	2%
Racial justice	2%
Arts and culture	2%
Jobs/labor conditions/wages and income	2%
Public safety/violence	2%
recreation, and open space	2%
Criminal legal system	2%
Financial institutions (e.g., banks, credit unions	2%
Gender discrimination/equity	2%
Violence	2%
LGBTQIA+ discrimination/equity	2%
Utilities	2%
Veterans issues	2%
Food service/restaurants	1%
Environmental justice/climate change	1%
Land use planning/development	1%
Immigration	0%
Other	0%
Total	100%

Please review the following statements. For each one, select: Agree, Disagree, Unsure.

Attribute	Agree	Disagree	Unsure	Total
Advancing equity/addressing inequities is included in all or most staff job requirements.	59.57%	31.91%	8.51%	100.00%
We have a team dedicated to advancing equity/addressing inequities in our organization.	48.94%	48.94%	2.13%	100.00%
We have at least one person in our organization dedicated to addressing diversity, equity, and inclusion internally in our organization.	63.27%	30.61%	6.12%	100.00%
We have at least one person in our organization dedicated to addressing inequities externally in our community.	56.25%	35.42%	8.33%	100.00%

Appendix

Community Partner Survey Results

Technology in Health

Would receiving appointment reminders and medication alerts via text or email be useful to those you serve?

Response	Percentage
Yes	97.7%
No	2.3%
Total	100.0%

Are those you serve interested in using wearable devices (e.g., fitness trackers, smartwatches) to monitor their health?

Response	Percentage
No	45.5%
Yes	54.5%
Total	100.0%

How important is it to those you serve to be able to message their health provider securely?

Response	Percentage
Neutral	36.4%
Very important	29.5%
Important	18.2%
Very unimportant	13.6%
Unimportant	2.3%
Total	100.0%

How important is it to those you serve to access virtual support groups to manage chronic conditions or specific health concerns?

Response	Percentage
Neutral	48.9%
Important	20.0%
Unimportant	17.8%
Very important	11.1%
Very unimportant	2.2%
Total	100.0%

How likely would those you serve be to using a mobile app to communicate with health provider?

Response	Percentage
Neutral	44.9%
Likely	24.5%
Unlikely	20.4%
Very likely	8.2%
Very unlikely	2.0%
Total	100.0%

Do you feel that those you serve would be willing to share data from wearable devices with their health provider for monitoring purposes?

Response	Percentage
No	53.5%
Yes	46.5%
Total	100.0%

Would those you serve like to access their medical records online?

Response	Percentage
Yes	79.5%
No	20.5%
Total	100.0%

Do the majority of those you serve have reliable internet access at home?

Response	Percentage
Yes	51.1%
No	48.9%
Total	100.0%

Are those you serve interested in telemedicine/video consultations for non-emergency medical issues?

Response	Percentage
Yes	77.8%
No	22.2%
Total	100.0%

How comfortable do you feel those you serve are with using technology for health purposes?

Response	Percentage
Neutral	46.9%
Comfortable	28.6%
Uncomfortable	14.3%
Very uncomfortable	8.2%
Very comfortable	2.0%
Total	100.0%

Would those you serve prefer to schedule appointments online or over the phone?

Response	Percentage
No preference (either option is fine)	42.9%
Over the phone	38.8%
Online	18.4%
Total	100.0%

How important is it to those you serve to access virtual support groups to manage chronic conditions or specific health concerns?

Response	Percentage
Neutral	48.9%
Important	20.0%
Unimportant	17.8%
Very important	11.1%
Very unimportant	2.2%
Total	100.0%

Would those you serve use online resources (e.g., videos, articles) for health education and self-care information?

Response	Percentage
Yes	72.1%
No	27.9%
Total	100.0%

Appendix

Community Partner Survey Results: Technology in Health

What concerns do those you serve have, if any, about using technology for health purposes?

Response	Percentage
Hesitation due to prior frustrating experience(s with technology	29.17%
Privacy concerns	26.04%
Risk of miscommunication	15.63%
Lack of human interactions	14.58%
Other	8.33%
Incorrect data leading to wrong diagnosis/treatment plan	6.25%
Total	100.00%

What types of technology do those you serve regularly use? (check all that apply)

Response	Percentage
Smartphones	42.7%
Computers/Laptops	29.1%
Tablets	24.5%
Other	3.6%
Total	100.0%

Organizational Commitment To Equity

Please review the following statements. For each one, select: Agree, Disagree, Unsure.

Attribute	Agree	Disagree	Unsure	Total
Advancing equity/addressing inequities is included in all or most staff job requirements.	59.57%	31.91%	8.51%	100.00%
We have a team dedicated to advancing equity/addressing inequities in our organization.	48.94%	48.94%	2.13%	100.00%
We have at least one person in our organization dedicated to addressing diversity, equity, and inclusion internally in our organization.	63.27%	30.61%	6.12%	100.00%
We have at least one person in our organization dedicated to addressing inequities externally in our community.	56.25%	35.42%	8.33%	100.00%

Appendix

Community Partner Survey Results: Organizational Accountability

Please select whether your organization regularly does the following activities. (check all that apply)

Response	Percentage
Community Engagement and Partnerships: My organization works to strengthen, support, and mobilize communities and partnerships to improve health and well-being.	17.3%
Communication and Education: My organization works to communicate effectively to inform and educate people about health or well-being, factors that influence well-being, and how to improve it.	13.5%
Workforce: My organization supports workforce development and can help build and support a diverse, skilled workforce.	12.2%
Assessment: My organization conducts assessments of living and working conditions and community needs and assets.	10.5%
Organizational Infrastructure: My organization is helping build and maintain a strong organizational infrastructure for health and well-being.	10.1%
Policies, Plans, Laws: My organization works to create, champion, and apply policies, plans, and laws that impact health and well-being.	9.7%
Access to Care: My organization provides healthcare and social services to individuals or works to ensure equitable access and an effective system of care and services.	9.3%
Evaluation And Research: My organization conducts evaluation, research, and continuous quality improvement and can help improve or innovate functions.	9.3%
Investigation of Hazards: My organization investigates, diagnoses, and addresses health problems and hazards affecting the population.	4.2%
Legal and Regulatory Authority: My organization has legal or regulatory authority to protect health and well-being and uses legal and regulatory actions to improve and protect the publics health and well-being.	3.8%
Total	100.0%

Which of the following methods of community engagement does your organization use most often? (check all that apply)

Response	Percentage
Presentations	10.3%
Social media	9.6%
Customer/patient satisfaction surveys	8.3%
Community forums/events	7.3%
Memorandums of understanding (MOUs with community-based organizations	7.0%
Surveys	6.6%
Advocacy	6.3%
Community organizing	5.6%
Fact sheets	5.6%
Interactive workshops	5.0%
Community-driven planning	4.6%
Focus groups	4.3%
Videos	4.0%
Open houses	3.6%
Public comment	3.3%
Citizen advisory committees	2.6%
Billboards	2.0%
Consensus building	1.0%
House meetings	1.0%
Open planning forums with citizen polling	1.0%
Other	0.3%
Participatory action research	0.3%
Polling	0.3%
Total	100.0%

Does your organization have sufficient capacity to meet the needs of your clients/members? For example, do you have enough staff/funding/support to do your work?

Response	Percentage
No	57.45%
Unsure	23.40%
Yes	19.15%
Total	100.00%

Appendix

Community Partner Survey Results: Data Access and Systems

What data does your organization collect? (check all that apply)

Response	Percentage
Demographic information about clients or members	24.3%
Evaluation, performance management, or quality improvement information about services and programs offered	18.1%
Access and utilization data about services provided and to whom	16.0%
Data about conditions and social determinants of health (e.g., housing, education, or other conditions	13.2%
Data about health status	12.5%
Data about health behaviors	10.4%
We dont collect data	4.2%
Data about systems of power, privilege, and oppression	0.7%
Other	0.7%
Total	100.0%

How does your organization collect data? (check all that apply)

Attribute	Percentage
Surveys	22.6%
Data tracking systems	13.7%
Feedback forms	12.9%
Focus groups	10.5%
Interviews	10.5%
Secondary data sources	9.7%
Notes from community meetings	8.9%
Electronic health records	8.1%
Other	2.4%
Videos	0.8%
Total	100.0%

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