Tazewell County Community Health Needs Assessment

FINAL REPORT

JULY 26, 2016

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Table of Contents

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This document has been produced to benefit the community. Carilion Clinic encourages use of this report for planning purposes and is interested in learning of its utilization. Comments and questions are welcome and can be submitted to Amy Michals (almichals@carilionclinic.org), Carilion Clinic Community Outreach Planning Analyst.

Members of the Project Management team reviewed all documents prior to publication and provided critical edits. Every effort has been made to ensure the accuracy of the information presented in this report, however accuracy cannot be guaranteed. Members of the Tazewell County Community Health Assessment Team cannot accept responsibility for any consequences that result from the use of any information presented in this report.

Acknowledgements

Success of the Tazewell County Community Health Needs Assessment was due to the strong leadership and participation of its Project Management Team and the Community Health Assessment Team. Thank you to all of the community members who participated in the Community Health Survey and focus groups.

Members of these teams included:

Project Management Team

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Community Health Assessment Team (CHAT)

Carilion Clinic's CHNAs are community-driven projects and success is highly dependent on the involvement of citizens, health and human service agencies, businesses, and community leaders. Community stakeholder collaborations known as "Community Health Assessment Teams" (CHAT) lead the CHNA projects. The CHATs consists of health and human service agency leaders, persons with special knowledge of or expertise in public health, the local health department, and leaders, representatives, or members of medically underserved populations, low-income persons, minority populations and populations with chronic disease.

CHAT Members

Name	Organization
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Aaron Boush	Carilion Clinic
Kimberly Brown	Carilion Tazewell Community Hospital
George Brown	Tazewell County Public Schools
Jack Casey	Tazewell Police Department
Dr. Kevin Combs	Carilion Tazewell Community Hospital
Shenika Dillard	Carilion Clinic
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Denise Farmer	Four Seasons YMCA
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Jim Talbert	Richlands News Press
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Executive Summary

Many and varied organizations are involved in the essential work of improving and maintaining the health of any given community. It is important to assess the health concerns of each community periodically to ensure that current needs are being addressed. A Community Health Needs Assessment (CHNA) every three years will uncover issues, indicate where improvement goals are needed, and track and promote progress in key areas, so that there is demonstrated, ongoing improvement. The work of conducting this CHNA and the public availability of its findings is intended to enable the community to plan effectively the vital work of maintaining and improving health.

This report contains the findings of the 2016 Tazewell County Community Health Needs Assessment (TCCHNA), including data on the target population and service area, as well as primary and secondary data.

Method

A 19-member Community Health Assessment Team (CHAT) oversaw the planning activities. The service area included those living in Tazewell County. The target population included the low-income, uninsured and/or underinsured, and those living with chronic illness.

Beginning in April 2016, primary data collection included a Community Health Survey, focus groups with key stakeholders and providers, and focus groups with target populations. Secondary data was collected including demographic and socioeconomic indicators as well as health indicators addressing access to care, health status, prevention, wellness, risky behaviors and the social environment.

Findings

The findings of the Community Health Needs Assessment revealed an older, poorer, more racially homogeneous and unhealthy county, when compared to the state of Virginia as a whole. Poverty rates were higher, academic attainment rates were lower, and unemployment rates continue to be greater than statewide averages impacting the social determinants of health. Health statistics revealed higher death rates and prevention quality indicators for preventable, chronic diseases. Teen pregnancy rates in the Tazewell County continue to be much higher than rates in Virginia. More adults in Tazewell are obese with limited physical activity and more people die from chronic diseases. There are also much higher drug/poison and prescription drug deaths.

Many of the respondents to the Community Health Survey and focus group participants, whether insured or uninsured, noted that the cost of services keeps them from accessing preventive care and services. Often individuals self-treat or delay treatment due to cost. Access to affordable oral health services for uninsured and low-income adults continues to be a major need in the service area. Respondents reported suffering from depression and anxiety and the need to “talk to someone.” Stakeholders cited poor health literacy among the target

population including limited basic health knowledge, no value placed on preventive care and chronic disease management, lack of trust in the current healthcare system, and little awareness of existing resources in the community. There is a need to develop a "Culture of Wellness" with an emphasis on health education, access to healthy foods, and increased physical activity.

Response

In July 2016, the CHAT participated in a prioritization activity to determine the greatest needs in the service area based on the primary and secondary data collected during the assessment period. The top ten priority areas that emerged from these findings include:

1. Access to primary care
2. Access to mental health counseling / substance abuse
3. High prevalence of obesity / overweight individuals
4. Lack of reliable transportation
5. Access to specialty care / specialist physicians
6. High uninsured population
7. Chronic disease (diabetes, cardiovascular disease, hypertension, asthma)
8. High prevalence of substance abuse (alcohol, illegal & prescription drugs)
9. Value not placed on preventive care and chronic disease management
10. Lack of exercise / physical activity

The CHAT participated in strategic planning on July 19, 2016. It reviewed the top priorities and compared data from the 2016 needs assessment to the 2013 needs assessment, analyzed existing resources and community work around these priority needs, and determined community level strategies to work on over the next three years.

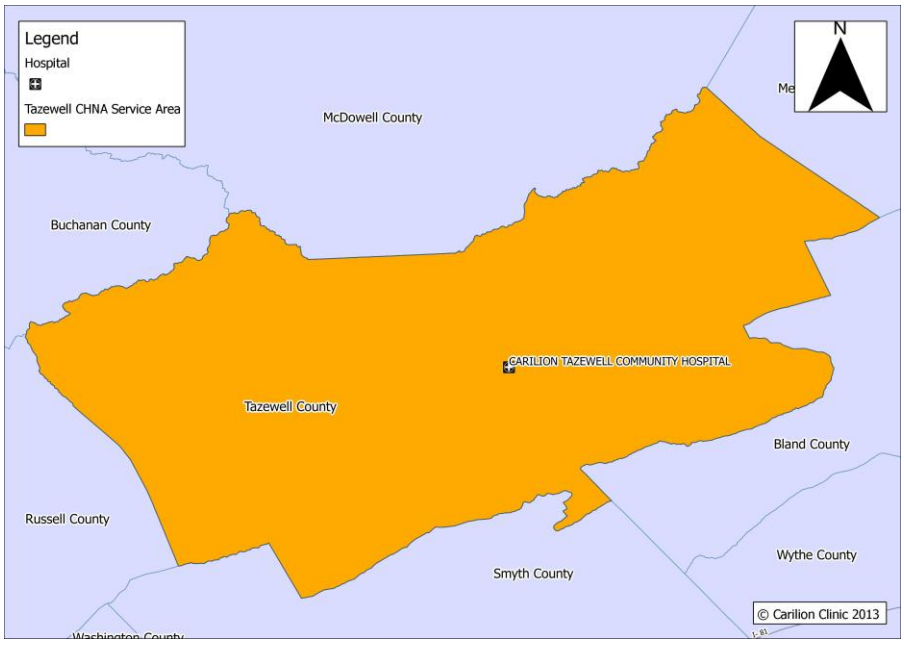
Carilion Clinic will work in the summer and fall of 2016 to develop an implementation strategy. Carilion Clinic and many of the CHAT members hope to continue collaborating to actively address community health needs in Tazewell County.

Target population

The target populations for Carilion's CHNA projects consist of the following groups: low-income individuals, uninsured and under-insured individuals, those that face barriers to accessing care and available resources, and users of existing health care safety net organizations. Populations are examined across the different life cycles including women of child-bearing age, adults, and elderly as well as across various race and ethnic groups.

Service Area

The service areas for each CHNA are determined by at least 70% of unique patient origin of the Carilion Clinic hospital in each respective market. There is a focus placed on areas that are considered Medically Underserved Areas (MUAs), Health Professional Shortage Areas (HPSA), and Food Deserts.



Carilion Tazewell Community Hospital (CTCH) is located in Tazewell, Virginia. In fiscal year 2015, CTCH served 7,915 unique patients (inpatient and outpatient). Patient origin data revealed that in fiscal year 2015, 81.42% of patients served by CTCH lived in Tazewell County.

Tazewell County is located in rural Southwest Virginia and contains portions of the Ridge and Valley Appalachians and the Cumberland Plateau. It has a land area of 518.85 square miles and about 86.9 persons per square mile. [1]

The service area for the Tazewell County Community Health Needs Assessment includes all of Tazewell County, which is classified as a Medically Underserved Area.

[1] US Census, Quick Facts, 2010

Community Health Improvement Process

Carilion Clinic's community health improvement process was adapted from Associates in Process Improvement's the Model for Improvement and the Plan-Do-Study-Act (PDSA) cycle developed by Walter Shewhart[2]. It consists of five distinct steps: (1) conducting the CHNA, (2) strategic planning, (3) creating the implementation strategy, (4) program implementation, and (5) evaluation. This cycle is repeated every three years to comply with IRS requirements. Each step in the process is explained below. Please see Appendix 1 for the Carilion Clinic Community Health Improvement Process diagram.

Step 1: Conduct CHNA.

The first step of conducting a CHNA is to create a Gantt chart. This tool is a timeline that documents the upcoming tasks needed to conduct the CHNA, who is responsible for each task, start and end dates for each task, and the completion percentage for each task. The Gantt Chart for the Tazewell County CHNA can be found in Appendix 2.

The CHAT leads the CHNA and oversees primary and secondary data collection. Primary data includes a community health survey (CHS), target population focus groups, and a stakeholder survey and focus groups.

Community Health Survey (CHS)

The CHS consists of forty questions for adults about access and barriers to healthcare, general health questions, and demographic information. The survey mirrors Healthy People 2020 goals as well as many other national health surveys that do not collect health care data at the county or zip code level. This survey is not a scientific survey and uses oversampling techniques of the target population. See Appendix 3 for Carilion Clinic's CHS. A Data Collection and Tracking Committee provides recommendations for future improvements on the CHS with input from the CHAT and community members. An incentive for completing the CHNA was provided to encourage participation in the CHS.

Target Population Focus Groups

Focus groups are conducted with the target population. The goal of the focus groups is to identify barriers to care and gaps in services for primary care, dental and mental health/substance abuse services for the population. Focus group participants represent each lifecycle (woman of child-bearing age, adults, and elderly). Focus groups targeting special populations will be determined by the CHAT if needed.

For each focus group, there is a maximum of sixteen participants. A facilitator and scribe(s) conduct the focus group meeting and the audio of the meetings are recorded and later transcribed. Snacks and beverages are provided for participants. Consent forms must be signed prior to each meeting (to inform participants regarding format and to ensure confidentiality).

[2] Science of Improvement: How to Improve. (2014). Institute for Healthcare Improvement. Retrieved from http://www.ihi.org/resources/Pages/HowtoImprove/ScienceofImprovementHowtoImprove.aspx

The groups are held in convenient, neutral locations and/or in sites where participants already congregate.

The script for the focus groups is simple and consists of five open-ended questions:

1. In one or two words, how would you describe good health?
2. What do you, or your family and friends, do when you need a check-up or are sick?
3. What do you, or your family and friends, do when you have a toothache or need your teeth cleaned?
4. What do you, or your family and friends, do when you need to talk to someone about your nerves/stress/depression or need help with alcohol or drug addiction?
5. Is there anything else you would like to tell us about your health or the health of others in Tazewell County?

Data is analyzed and themes are identified using the focus group transcripts.

Stakeholder Survey

The final primary research as part of the CHNA is a stakeholder survey and stakeholder focus groups. This survey is administered to any stakeholders identified by the CHAT or Carilion Clinic. Results of stakeholder surveys and focus groups are combined. See Appendix 4 for the stakeholder survey tool.

Secondary Data Collection

Secondary data is collected as part of the CHNA. Data is benchmarked with Healthy People 2020 and other national best measures and trends are analyzed. Carilion uses the data metrics suggested by the Catholic Health Association.

Prioritization

After all primary and secondary data collection is complete, the CHAT reviews all data and participates in a prioritization activity. This consists of each CHAT member picking the ten most pertinent community needs and ranking them on a scale of one to ten, with one being the most pertinent. Then, only for those top ten, the CHAT members rate the feasibility and potential impact of the needs on a scale of one to five, with one being the most feasible and having the most impact. Please see Appendix 7: Community Health Needs Assessment Prioritization Worksheet. This data is combined and overall ranking and feasibility and potential impact scores are determined.

CHNA Report

The last step of the CHNA is publishing and analyzing the primary and secondary data into a final CHNA report. These reports must be published in the same fiscal year as the CHNA and made widely available to the community. Carilion publishes the CHNAs on its website at www.carilionclinic.org/about/chna and has print copies available through the Community Outreach department. CHAT members and partner organizations may also publish data on their websites.

Step 2: Strategic Planning

After the completion of the CHNA and the identification of the priority areas (needs), the CHAT enters the strategic planning phase of the process. During strategic planning, the CHAT first reviews data for the top priorities, comparing data from the current needs assessment to results from the prior needs assessment conducted three years earlier. CHAT members then identify and analyze existing community resources and initiatives addressing the priority issues. Analysis of existing work and resources is completed using a SWOT analysis, identifying areas of strength and weakness and factors that could create opportunities for success or threaten success in solving community health needs. Through this process, CHAT members identify alignment opportunities between organizations, identify system changes that are likely to lead to improvement, and select new or existing evidence-based strategies for the community that are most likely to succeed in addressing the needs.

Step 3: Implementation Strategy

After the CHNA is completed, Carilion Clinic develops a written implementation strategy that specifies what health needs were identified in the CHNA, what needs the organization plans to address, and what needs the organization does not plan to address and reasons for each.

Included in the document are expected outcomes for each community issue being addressed, proposed evidence-based interventions with goals and objectives that will be tracked over time (both process measures and outcome measures). The document must be formally approved by the organization's Board of Directors and filed on the organizations 990 tax return. Carilion Clinic will integrate the implementation strategy with existing organizational and community plans and host an event in the community to present the CHNA results and the corresponding implementation strategy.

Step 4: Program Implementation

Carilion Clinic Community Outreach and the CHAT will establish and monitor new community health programs implemented to respond to the community health needs identified in the CHNA. New programs will be piloted on a small scale first and will be continually assessed and improved using the PDSA cycle. The goal of the PDSA cycle is to make small, sustained improvements over time. Relevant data is collected and analyzed for each program. After successful implementation of the pilot, the program can be implemented on a larger scale throughout Carilion Clinic or to other organizations in the community. The PDSA cycle is on-going for existing community health improvement programs.

Step 5: Evaluation

Community health programs and metrics associated with the expected outcome in the implementation strategy will be monitored by Carilion Clinic Community Outreach.

Progress will be reported bi-annually to Carilion Clinic's Board of Directors for each community health need identified in the last CHNA cycle for each community. In addition, the Board will be informed of community grant awards giving by Carilion Clinic to fund health safety net programs in the community. Decisions on funding of health safety net programs will be based on available resources and the impact on addressing a documented community health need identified in the CHNA. For more information, see https://www.carilionclinic.org/about/community-outreach.

Finally, Carilion Clinic will update progress made on each community health need identified in the most resent CHNA cycle annually on the organization's 990 tax form.

Community Collaboration and Collective Impact

Carilion Clinic fosters community development in its CHNA process and community health improvement process by using the Strive Collective Impact Model for the CHAT. This evidence-based model focuses on "the commitment of a group of important players from different sectors to a common agenda for solving a specific social problem(s)[3]" and has been proven to lead to large-scale changes. It focuses on relationship building between organizations and the progress towards shared strategies. Collective impact focuses on four conditions for success:

1. A Shared Community Vision: a broad set of cross-sector community partners come together in an accountable way to implement a vision for a healthier community and communicate that vision effectively.
2. Evidence-based Decision Making: The integration of professional expertise and data to make decisions about how to prioritize a community's efforts to improve health outcomes.
3. Collaborative Action: the process by which networks of appropriate cross-sector services/providers use data to continually identify, adopt and scale practices that improve health outcomes.
4. Investment & Sustainability: There is broad community ownership for building civic infrastructure and resources are committed to sustain the work of the partnership to improve health outcomes.

Collective Impact also suggests having a neutral anchor institution to serve as the convening body for the CHAT. The role of the anchor institution is to listen to/support the community as a convener in identifying and aligning around the community's shared aspirations. The anchor institution pulls together and staffs a coalition of key organizations and individuals to achieve that change including: (1) organize meetings of the full partnership; (2) facilitate work groups to guide the development and implementation of specific activities; (3) manage and strengthen relationships with individuals and organizations; (4) engage a broad spectrum of stakeholders in developing community change strategies and mobilizing the community's resources to implement them; (5) build public will and catalyze action; (6) create a policy agenda; (7) use data to inform all decisions[4].

[3] Kania, J., & Kramer, M. (2011). Collective Impact. Stanford Social Innovation Review. Retrieved from http://www.ssireview.org/images/articles/2011_WI_Feature_Kania.pdf

[4] Kania, J., & Kramer, M. (2011). Collective Impact. Stanford Social Innovation Review. Retrieved from http://www.ssireview.org/images/articles/2011_WI_Feature_Kania.pdf

Description of the Community

Tazewell County is nestled among the Appalachian Mountains in southwest Virginia and borders West Virginia to its north. Since it contains portions of the Ridge and Valley Appalachians, and the Cumberland Plateau, Tazewell County has very distinct and beautiful geologic areas.

Historically, what is now Tazewell County was a hunting ground for the Cherokee and Shawnee tribes. The area's abundance of wild game was a source of frequent skirmished among these tribes. Tazewell County was created on December 20, 1799. The land for the county was taken from portions of the bordering Virginia counties of Wythe and Russell.

Carilion Tazewell Community Hospital is a not-for-profit, 56-bed hospital owned by Carilion Clinic. CTCH is located in the Town of Tazewell in Tazewell County, Virginia and offers a medical facility with imaging, therapy services, and a physician clinic within the facility. CTCH utilized a unique model of care, with emergency/hospitalist physicians caring for patients across the continuum of emergency and inpatient care. Despite these amenities and the presence of key safety net providers in this region including the hospital system, a federally qualified health center, the health department and other service agencies, there are thousands of low income and uninsured residents who do not have access to affordable primary health care. Emergency departments are burdened by inappropriate use of their services for non-urgent primary care.

Carilion Tazewell Community Hospital is wholly owned by Carilion Clinic, a not-for-profit healthcare organization based in Roanoke, Virginia. Through a comprehensive network of hospitals, primary and specialty physician practices and other complementary services, quality care is provided close to home for more than 870,000 Virginians. With an enduring commitment to the health of the region, care is advanced through medical education and research and assistance is provided to help the community to stay healthy. Carilion Clinic employs 685 physicians representing more than 70 specialties who provide care at 241 practice sites.

Carilion Tazewell Community Hospital

To advance education of health professionals, Jefferson College of Health Sciences, within Carilion Medical Center, is a professional health sciences college offering Associate's, Bachelor's, and Master's degree programs. During fiscal year 2015, 800 undergraduate and 262 graduate students were enrolled.

The Virginia Tech Carilion School of Medicine enrolled 165 students and there were 706 appointed faculty members during fiscal year 2015. Carilion Clinic and Virginia Tech Carilion School of Medicine provides graduate medical education to 260 medical residents and fellows. There are 13 accredited residency programs (Carilion / OMNEE Emergency Medicine Dermatology, General Hospital Dentistry, Emergency Medicine, Family Medicine, Internal Medicine, Neurosurgery, Obstetrics/Gynecology, Pediatrics, Plastic Surgery, Podiatry, Psychiatry and Surgery) and 11 accredited fellowship programs (Addiction Psychology, Adult Joint Reconstruction, Cardiovascular Disease, Child and Adolescent Psychiatry, Gastroenterology, Geriatric Medicine, Geriatric Psychiatry, Hospice and Palliative Care, Infectious Disease, Interventional Cardiology, and Pulmonary Critical Care).

Advanced clinical technology and programs include CyberKnife Stereotactic Radiosurgery, DaVinci Robotic Surgical System, 60 bed neonatal intensive care unit, hybrid operating room, Carilion Clinic Children's Hospital, Cancer Center, Spine Center, and comprehensive cardiothoracic, vascular and orthopedic surgery programs. Carilion Roanoke Memorial Hospital serves as a Level One Trauma Center with EMS services that include three EMS helicopters, six first-response vehicles and 38 Advanced Life Support Ambulances.

An additional benefit to the community is Carilion Clinic's economic contribution to the region. As the area's largest employer, jobs are provided for more than 12,100 residents of the region. Research conducted at the Virginia Tech Carilion Research Institute (VTCRI) creates a bridge between basic science research at Virginia Tech and clinical expertise at Carilion Clinic and increases translational research opportunities for both partners. Research conducted by scientists at the institute is aimed at understanding the molecular basis for health and disease, and development of diagnostic tools, treatments, and therapies that will contribute to the prevention and solution of existing and emerging problems in contemporary medicine. Research areas of emphasis which presently align with areas of strength and active research at Virginia Tech include inflammation, infectious disease, neuroscience, and cardiovascular science and cardiology.

Primary Data and Community Engagement

Stakeholder Survey Results

During the CHNA process, community stakeholders and providers were encouraged to complete the stakeholder survey (see Appendix 4: Stakeholder Survey for the survey tool). This survey was completed online, in print, and administered to stakeholders during various meetings. When this survey was physically administered at meetings, the project management team used this tool to spark conservation about community health need in the service area. Please see Appendix 5: 2015 Stakeholder Survey Locations for a complete list of locations where the survey was administered. In total, 17 participants completed the stakeholder survey. Fifteen (15) surveys were completed during stakeholder meetings, 2 surveys were completed online.

Needs and Barriers

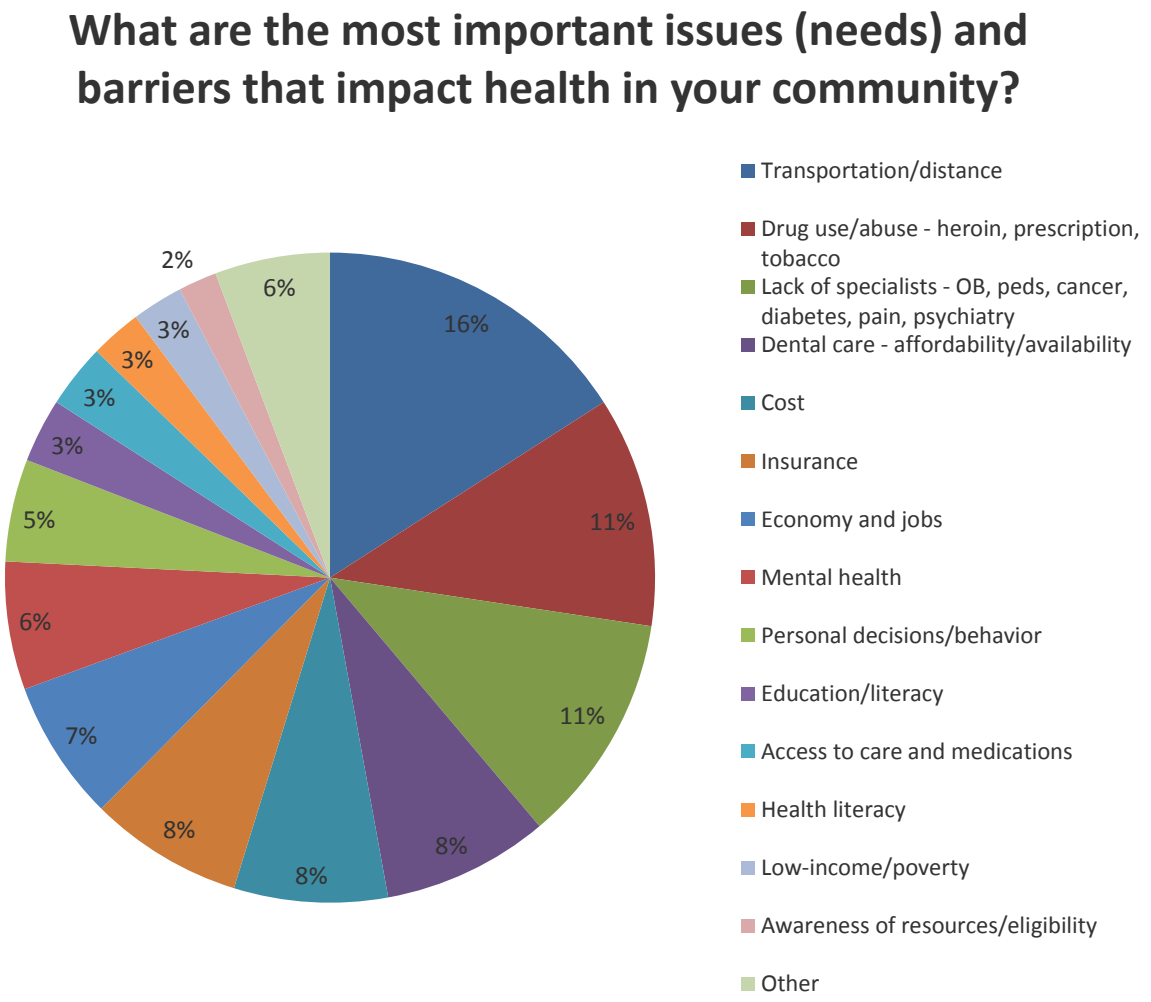
Stakeholders were asked to respond to the following questions addressing the health needs and barriers in Tazewell County.

- ***What are the most important issues (needs) that impact health in Tazewell?***
- ***What are the barriers to health for the populations you serve in Tazewell?***

A total of 157 responses from 17 individuals were collected addressing the "Needs and Barriers" and 20 categories were identified:

- Transportation/distance to travel
- Drug use/abuse
- Lack of specialists
- Dental Care – affordability/availability
- Cost
- Insurance
- Economy and jobs
- Mental Health
- Personal decisions/behavior
- Education/literacy
- Access to care and medication
- Healthy literacy
- Poverty/low income
- Resource awareness
- No elder care/elder abuse and neglect
- Interconnectedness of all problems
- Lack of enough ambulances and lack of funding for EMS
- Overburdened caregivers
- Traditions/culture
- Graduation rates

To determine which “Needs and Barriers” categories were identified most often by the focus groups, the responses for each category are presented as a percentage of the total responses.



Respondents identified “Transportation and Distance” as the greatest need/barrier that impacts health.

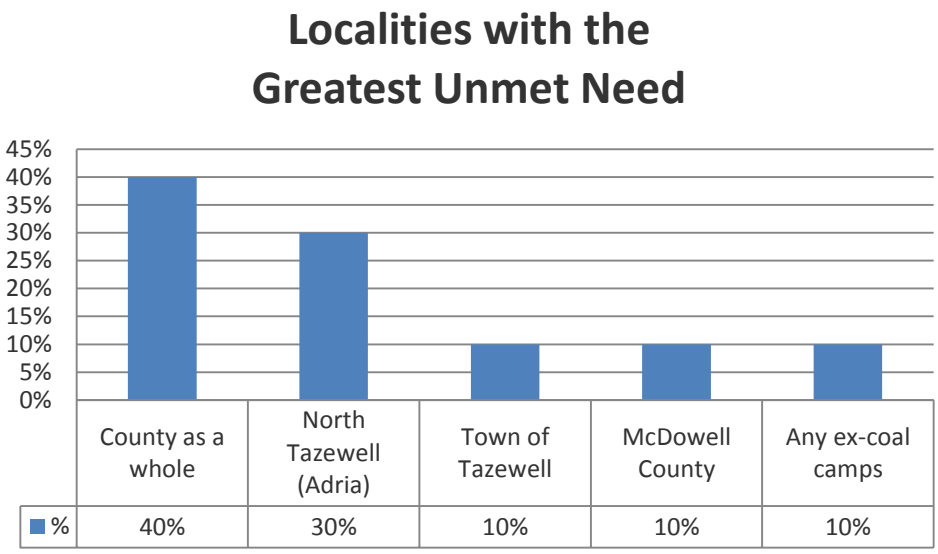
The second greatest needs and barriers impacting health in the service area included drug use and abuse. Specifically, prescription drug abuse, general illegal drug abuse and heroin were the top three types of substance abuse identified by participants. Tobacco use was also included as an issue.

Localities with the Greatest Unmet Need

In addition to the "Needs and Barriers" that impact health, participants were asked:

- ***Is there one locality/neighborhood with greatest unmet need in Tazewell?***

The majority of respondents agreed that there is unmet need throughout Tazewell County as a whole. Of the 10 responses, the following localities/neighborhoods were identified:



Populations with the Greatest Unmet Need

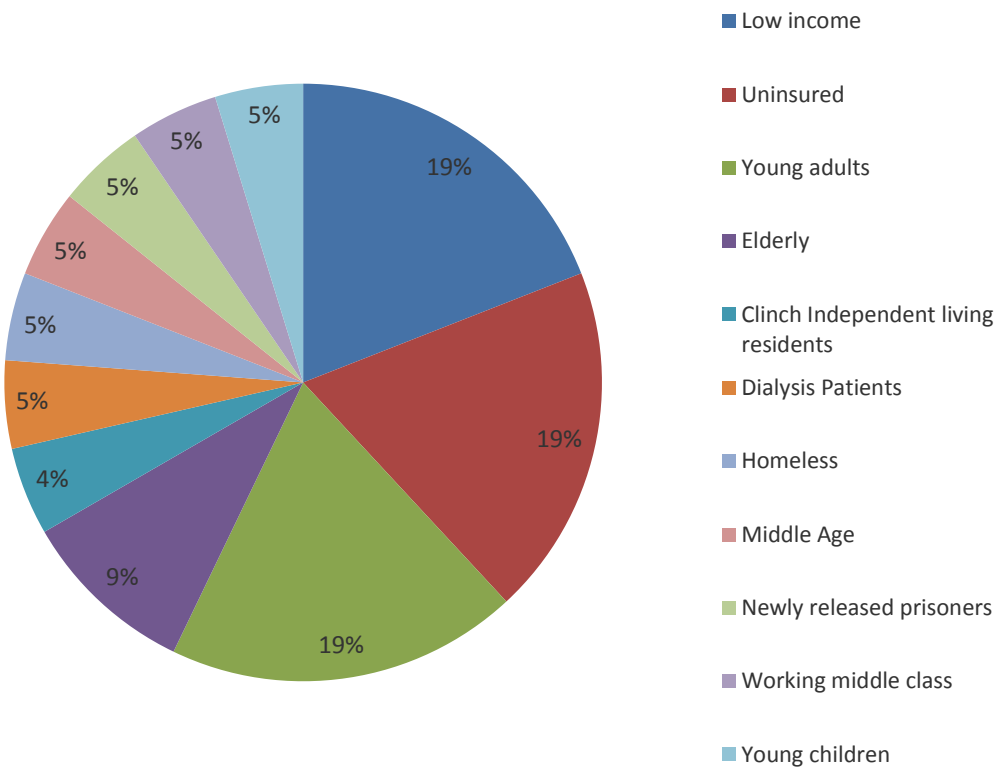
Next participants were asked:

- ***Is there one population with greatest unmet need in Tazewell?***

The top response from participants identified low income, uninsured and young adult individuals as all having the greatest unmet need, followed by the elderly.

Category	# of Responses	% of Responses
Low income/poor	4	19.05%
Uninsured	4	19.05%
Young adults	4	19.05%
Elderly	2	9.52%
Clinch Independent Living residents	1	4.76%
Dialysis patients	1	4.76%
Homeless	1	4.76%
Middle aged	1	4.76%
Newly released prisoners	1	4.76%
Working middle class	1	4.76%
Young children	1	4.76%
Total	21	100%

Is there one population group with the greatest unmet need?



Resources

Stakeholder survey participants were asked to respond to the following question addressing the available resources in the Tazewell area.

- ***What are the health resources for the populations you serve in Tazewell***?

A total of 35 responses were collected addressing the "Resources" and 15 categories identified, including:

- Community Resources
- Community Resources- Access to Food
- Community Resources- Education
- Community Resources, Coordination of Care
- Community Resources, Information & Referral
- Information
- Prescriptions
- Public Health
- Services- Behavioral Health
- Services- Health System
- Services- Healthcare
- Services- Primary care
- Services- Public Health
- Services- Workforce Training
- Services- School-based care

The complete list of community resources, as identified by community stakeholders, can be found in Appendix 6: Community Resources.

Initiatives and Changes

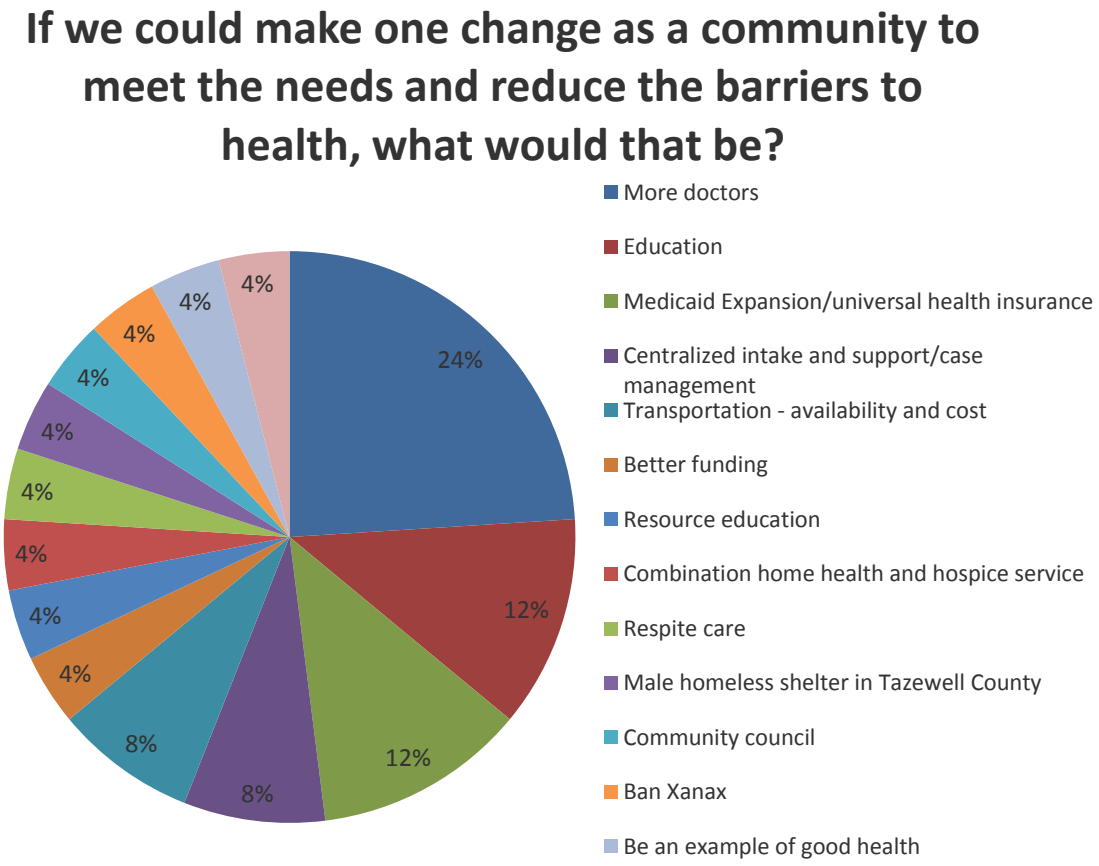
Stakeholder survey participants were asked to respond to the following question:

- ***<u>If we could make one change as a community to meet the needs and reduce the barriers to health in Tazewell, what would that be</u>***?

A total of 25 responses were collected addressing the "Initiatives and Changes" and 14 categories identified:

- More doctors
- Education
- Medicaid Expansion/universal health insurance
- Centralized intake and support/case management
- Transportation – improve availability and cost
- Better funding
- Educate people on resources/options available
- Offer a combination of home health and hospice service
- Respite care
- Male homeless shelter in Tazewell County
- Community Council
- Ban Xanax
- Be an example of good health
- More jobs

To determine which "Changes and Initiatives" categories were identified most often by the participants, the responses for each category are presented as a percentage of the total responses.



Stakeholders recommended advocating for “access to services” and healthcare as a right for all including universal health insurance and Medicaid expansion. Along with access to specialty care, chronic disease initiatives were identified as having the greatest potential impact on health.

Target Population Focus Group Results

Three focus group meetings with target populations living in the Tazewell area were conducted from May 19 through June 21, 2016 to address the healthcare needs for, and address barriers to, affordable comprehensive services including primary care, oral health, and mental health and substance abuse services.

The CHAT identified participants for the focus group meetings by reviewing programs and organizations in Tazewell County that offer services to the uninsured and under-insured, the low-income, minority, and chronically ill groups across the lifecycles and special populations (homeless and public housing residents). All attempts were made to conduct focus groups at sites where existing, intact groups already met and/or at sites that served the target population.

Focus Group Locations

Organization	Women of Childbearing Age	Adults	Seniors	Site/Group
Cumberland Mountain		✓	✓	Seniors/Veterans
Four Seasons YMCA		✓	✓	Chair Aerobics Class
Labor of Love	✓	✓	✓	Client Group

Cumberland Mountain Community Services (CMCSB): Veterans Group

CMCSB is one of 40 Community Service Boards in the Commonwealth of Virginia. CMCSB provides a variety of child and family, intellectual disability, mental health and substance abuse services to residents of Tazewell, Buchanan and Russell Counties. For more information, you can visit the website at http://www.cmcsb.com/.

A focus group was conducted with Cumberland Mountain Community Service's Veterans group.

Four Seasons YMCA

The Four Seasons YMCA serves Tazewell and Russell Counties. They serve people of all ages, races and religions. They offer financial assistance to those who otherwise could not afford membership, services or programs at the YMCA. For more information, you can visit the website at http://fsymca.org/.

A focus group was conducted with participants in a Chair Aerobics class at the YMCA.

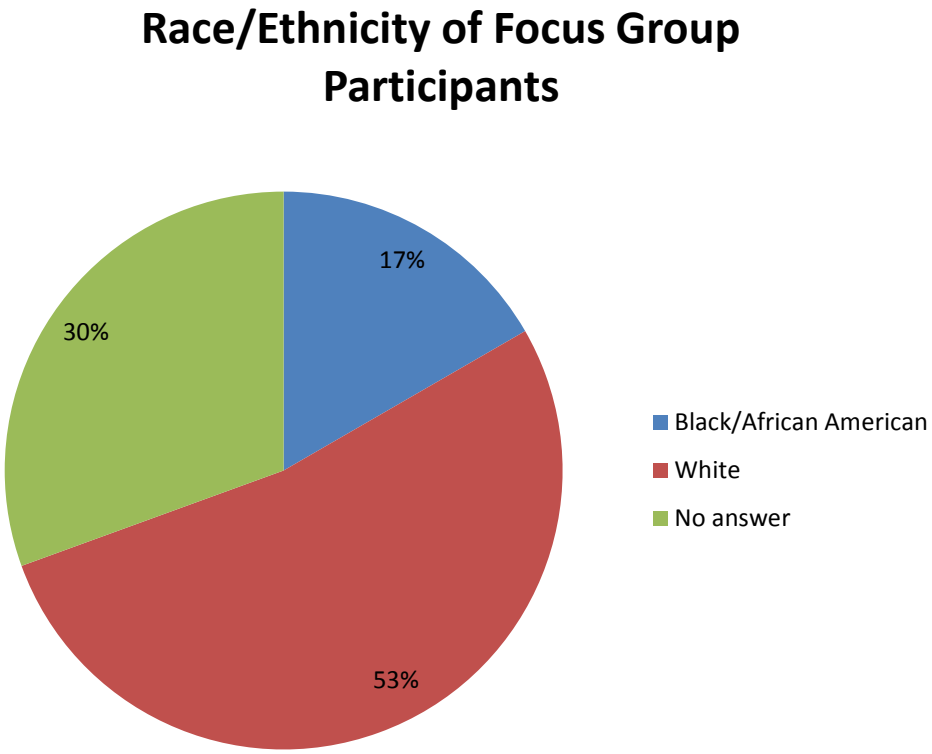
Labor of Love Mission

Labor of Love mission is a nonprofit organization located in Tazewell, Virginia, focused on providing relief free of charge for the poor, the distressed, and the underprivileged. They distribute food, commodities and clothing all year long, provide Christmas to children, help those without prescription insurance access prescribed medications, provide school age children with haircuts, and help provide furniture and other items to all in need. For more information, visit the website at http://www.laboroflovemission.org/.

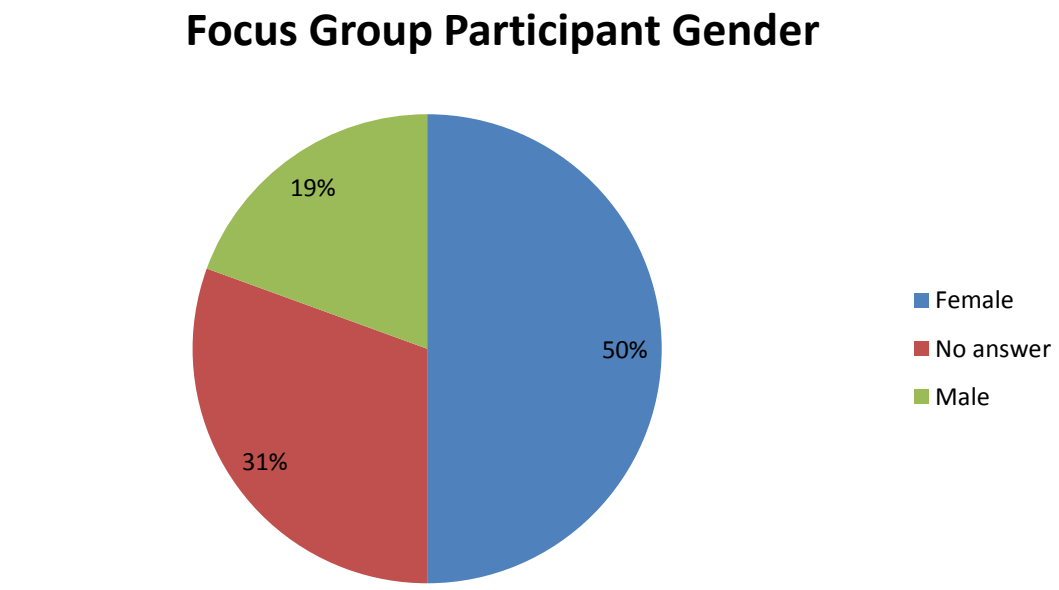
A focus group was conducted with Labor of Love clients.

Focus Group Demographics

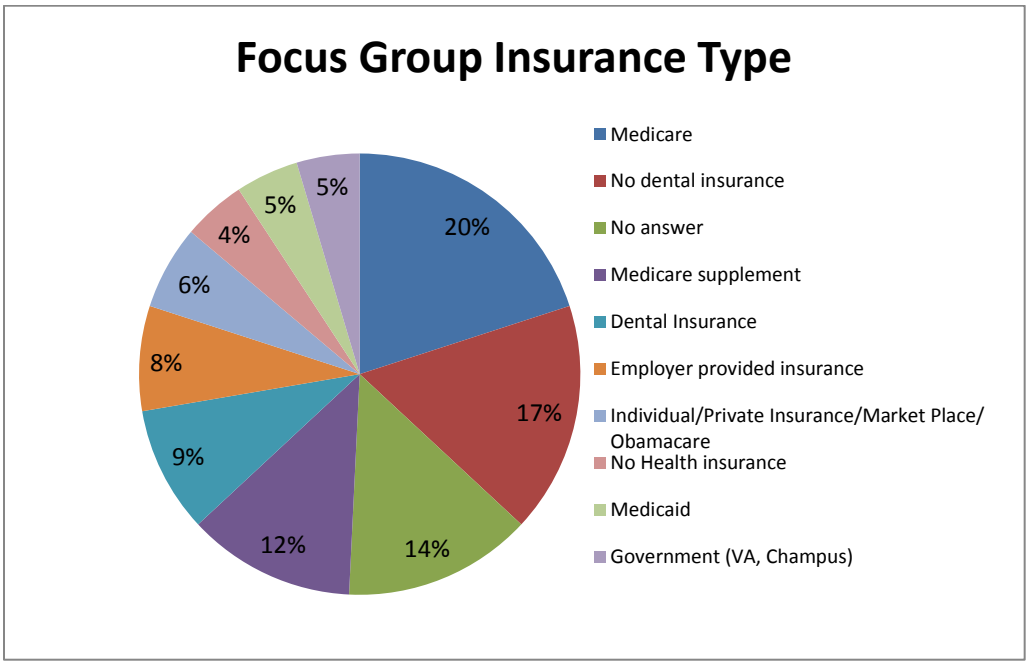
A total of 36 individuals participated in the focus group meetings. Of the participants, 53% were Caucasian, 17% African American, and 30% gave no answer to this question.



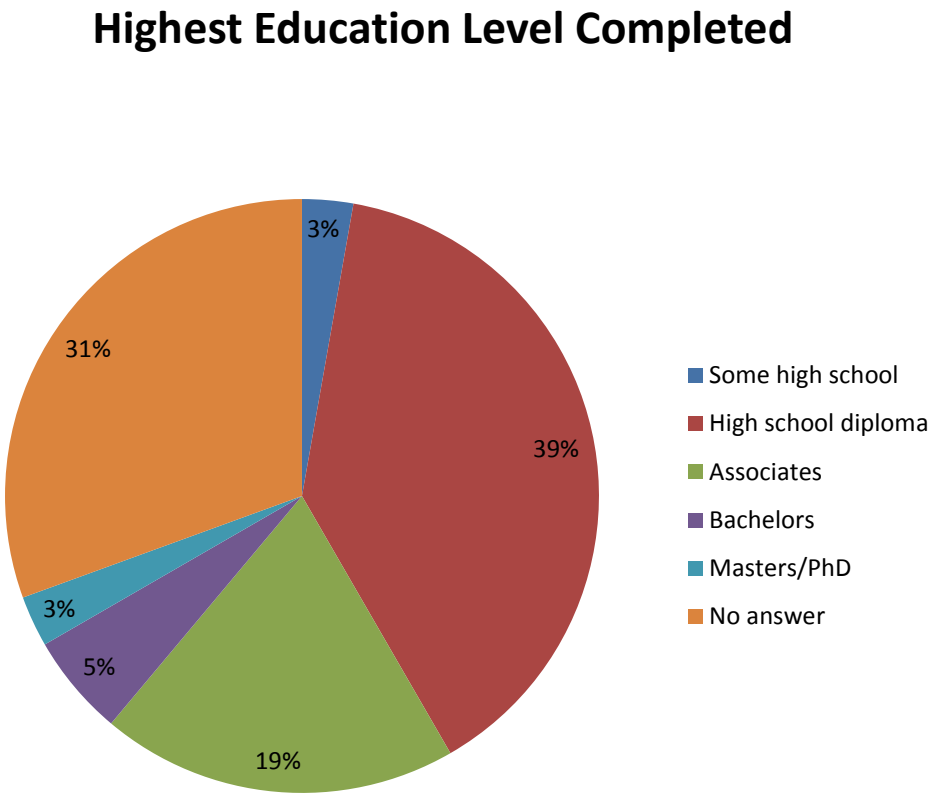
The majority of participants were women (50%), with 31% men and 19% gave no answer.



More participants reported having Medicare (20%) compared to employer provided insurance (8%) or market place plans (6%). More participants had no dental insurance (17%) compared to those having dental insurance (9%).



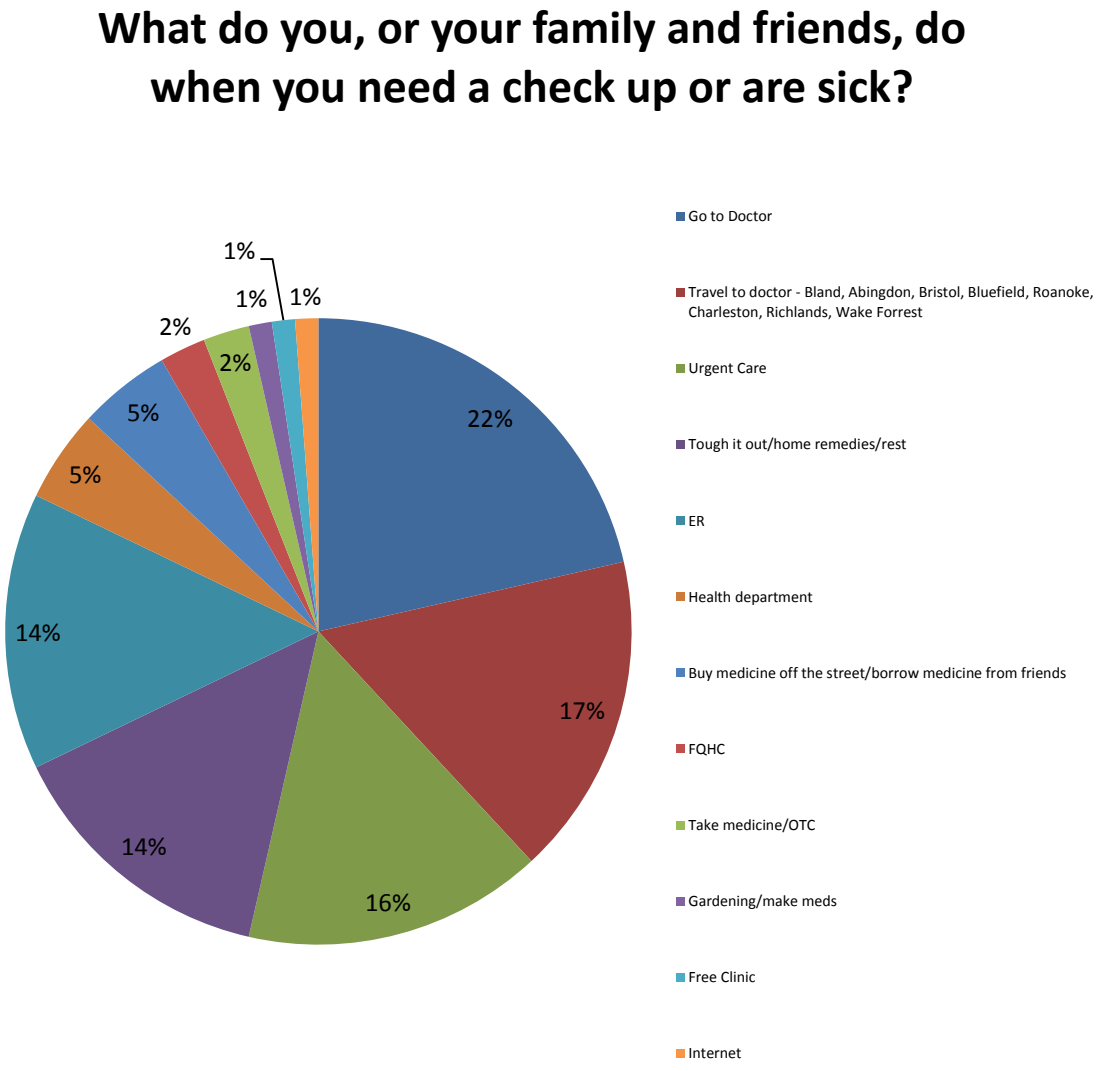
Three percent (3%) of focus group participants had some high school, 39% had a high school diploma, 19% had an Associate's degree, 5% had a Bachelor's degree, 3% had a Master's degree and 31% did not answer this question.



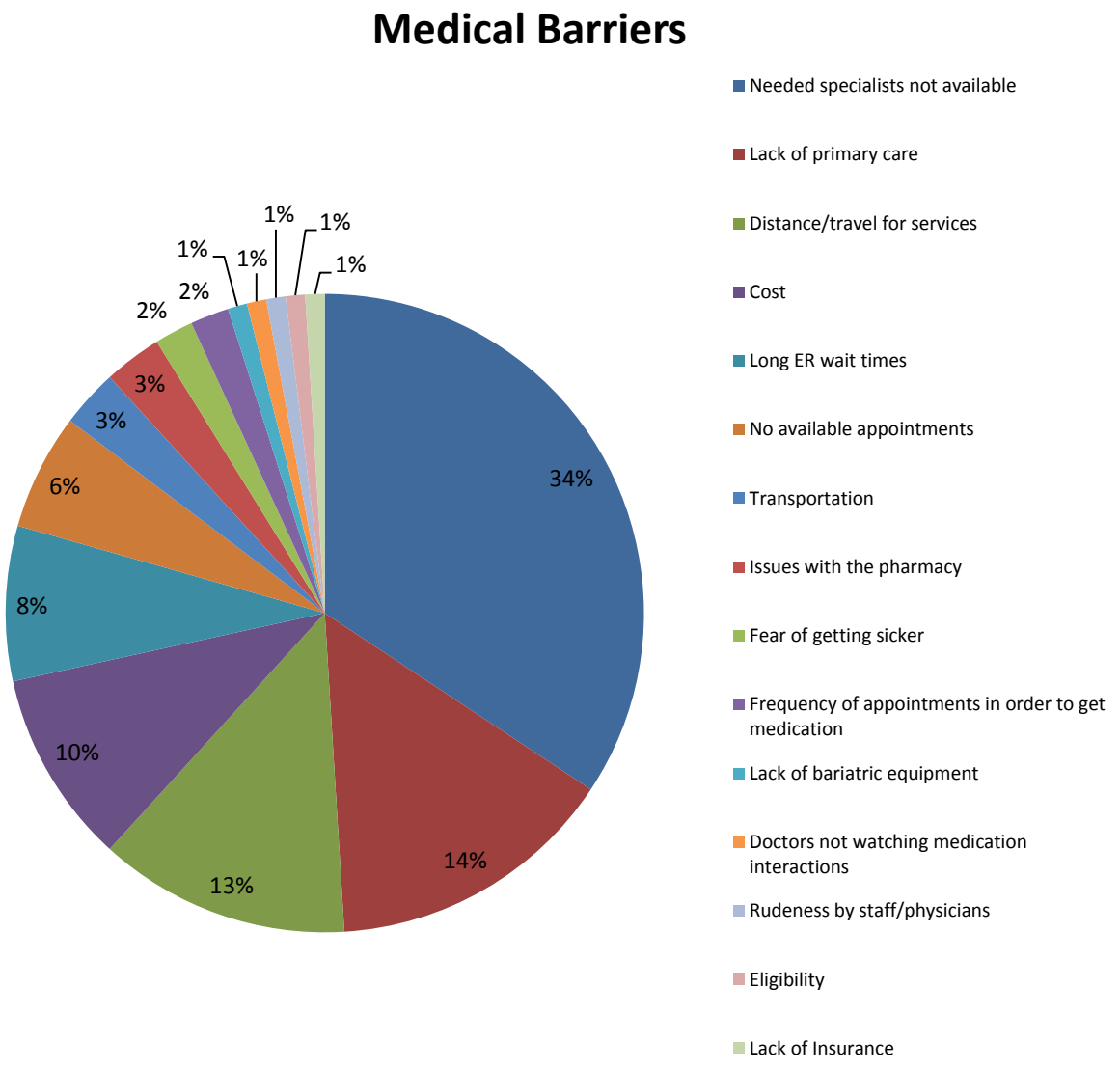
Focus Group Results

At the beginning of each meeting, participants were asked “What is good health?”. Responses addressed participants’ perceptions of health status, wellness and prevention, social networks, and access to services. A word cloud was created to show results from this question. The more a term was used, the larger that word is in the cloud.

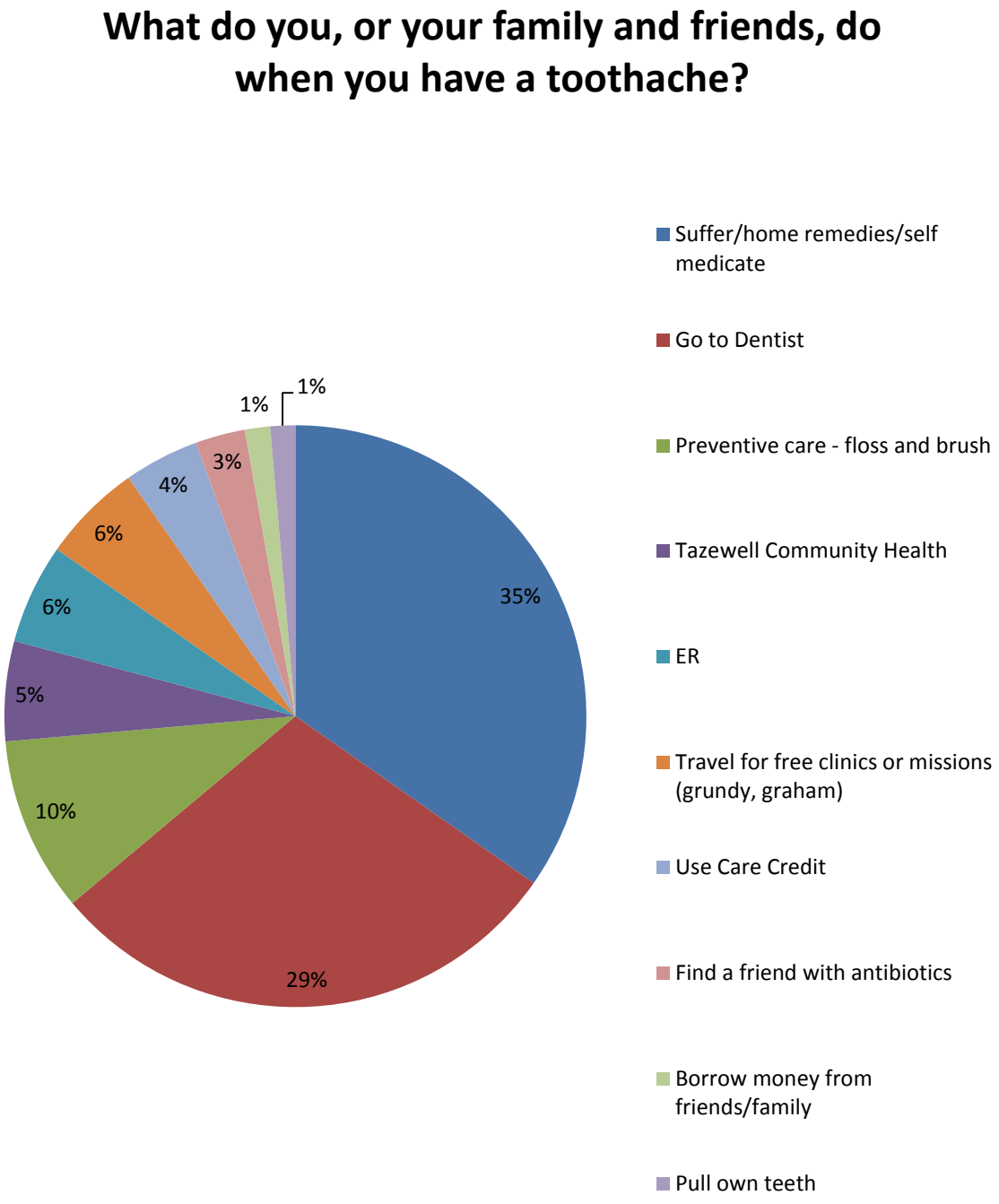
Participants were then asked “What do you, or your family and friends, do when you need a check-up or are sick?” Only 22% of participants identified that they use the doctor’s office, 39% when combined with travelling to a doctor’s office (Bland, Abingdon, Bristol, etc.) (17%).



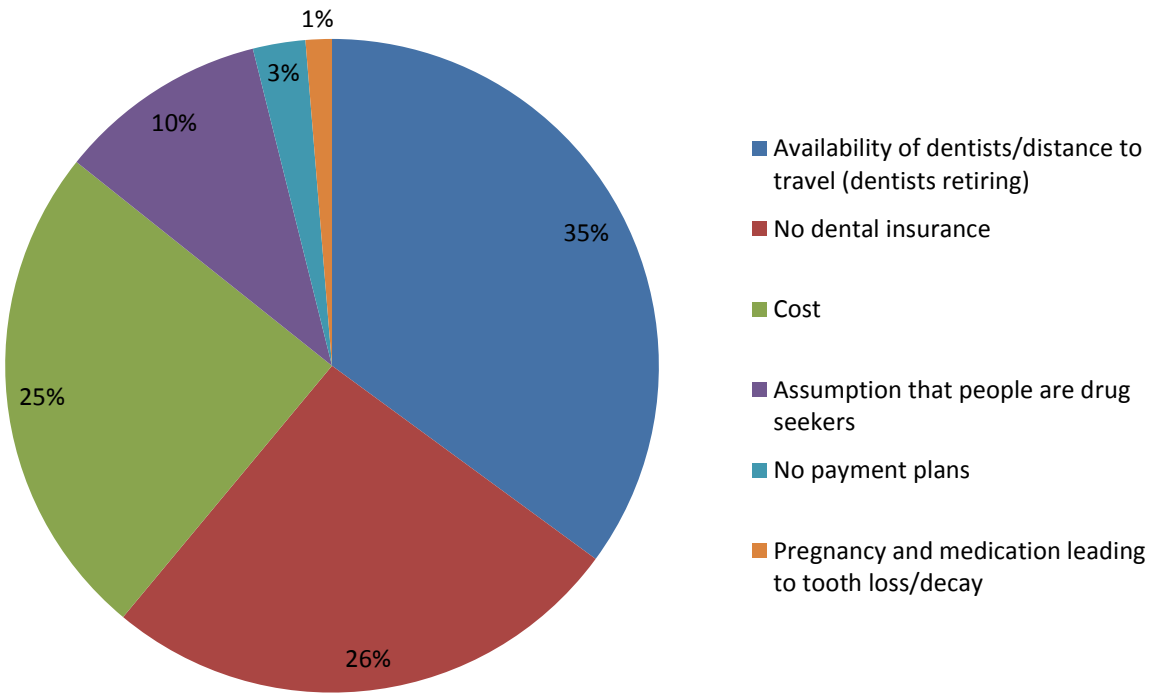
Medical care barriers identified during the focus group included lack of availability of specialists (34%), lack of primary care (14%), distance/travel for services (13%), and cost (10%).



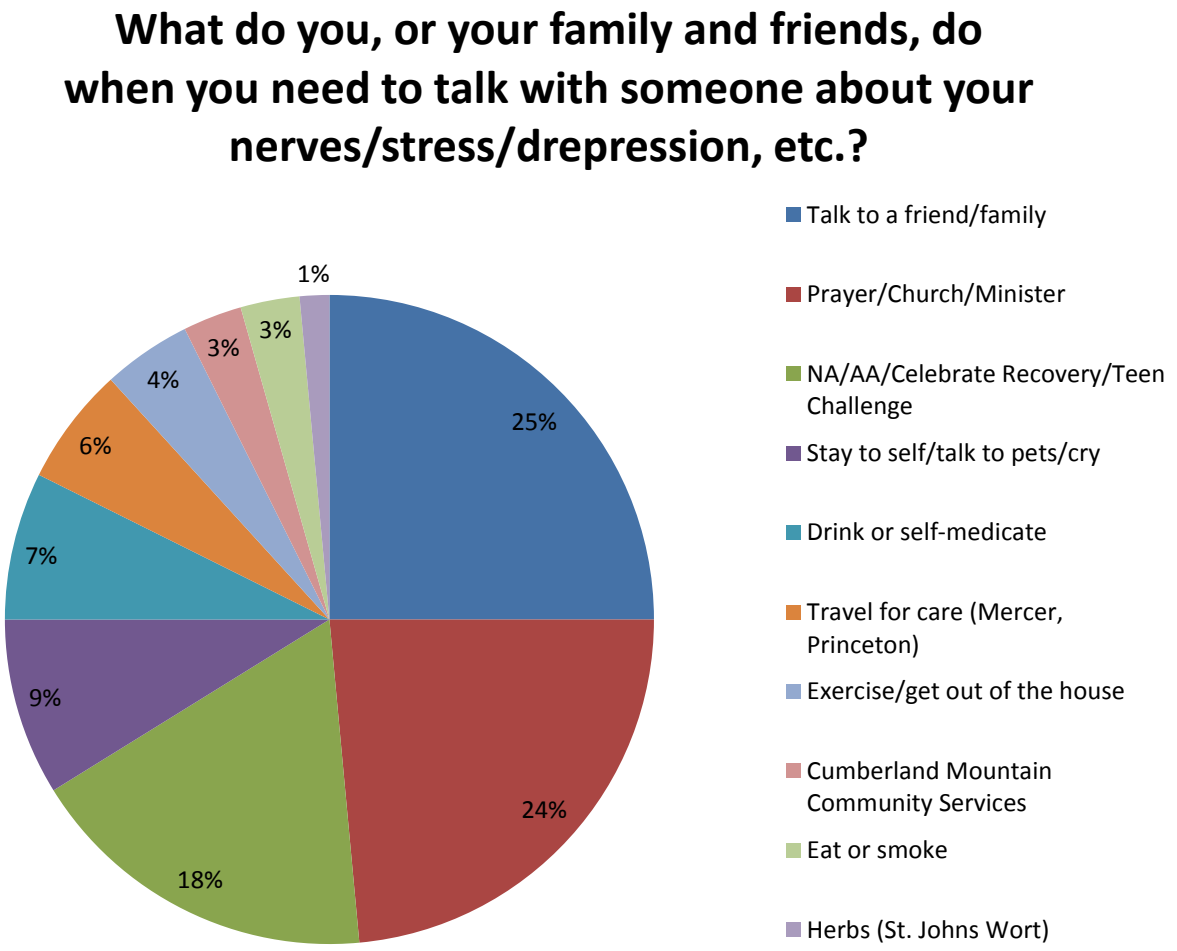
Next, participants were asked, “What do you, or your family and friends, do when you have a toothache or need your teeth cleaned?” The top response was to suffer, use home remedies or self-medicate (35%), followed by going to the dentist (29%), and preventive care – floss and brush (10%).



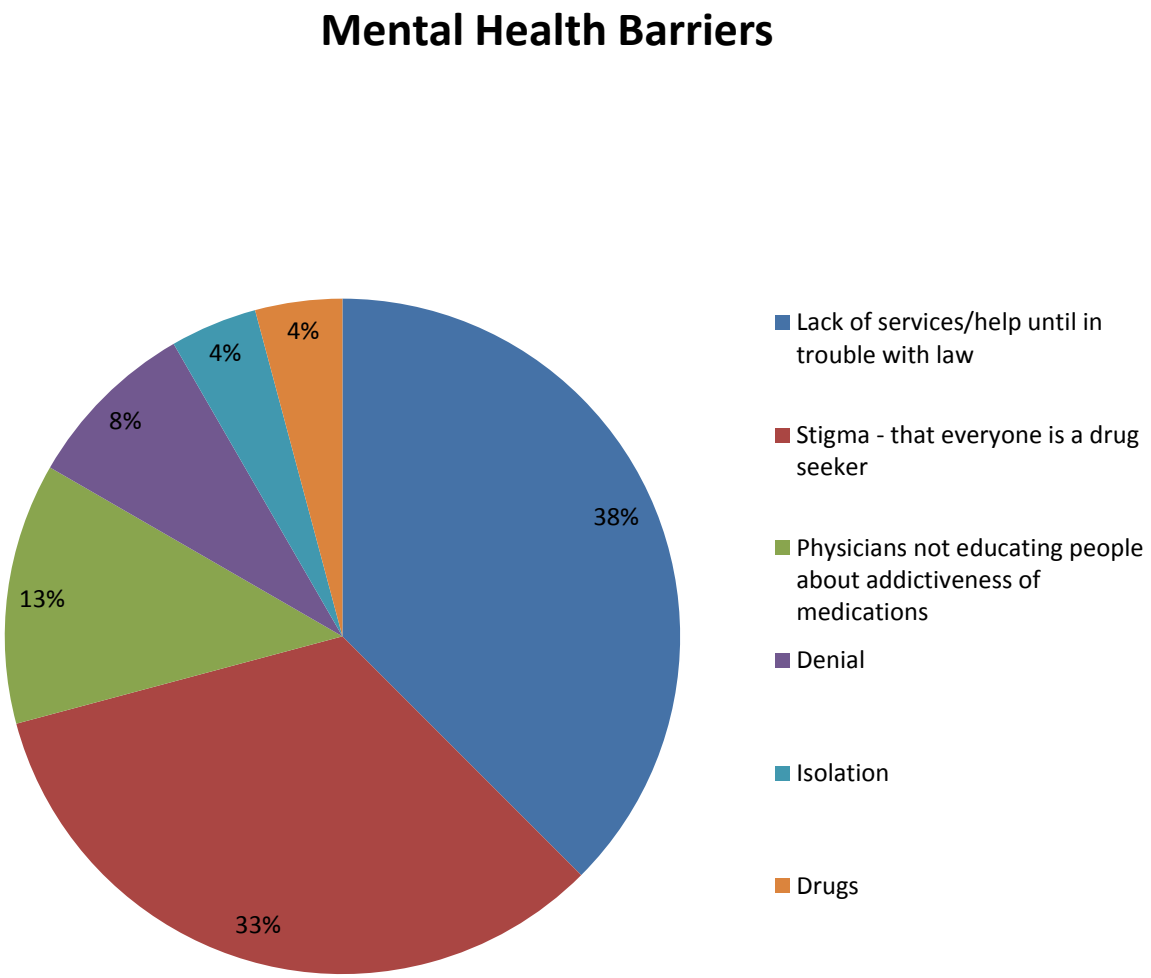
Dental care barriers included lack of availability of local dentists (35%), lack of dental insurance (26%) and cost (25%).



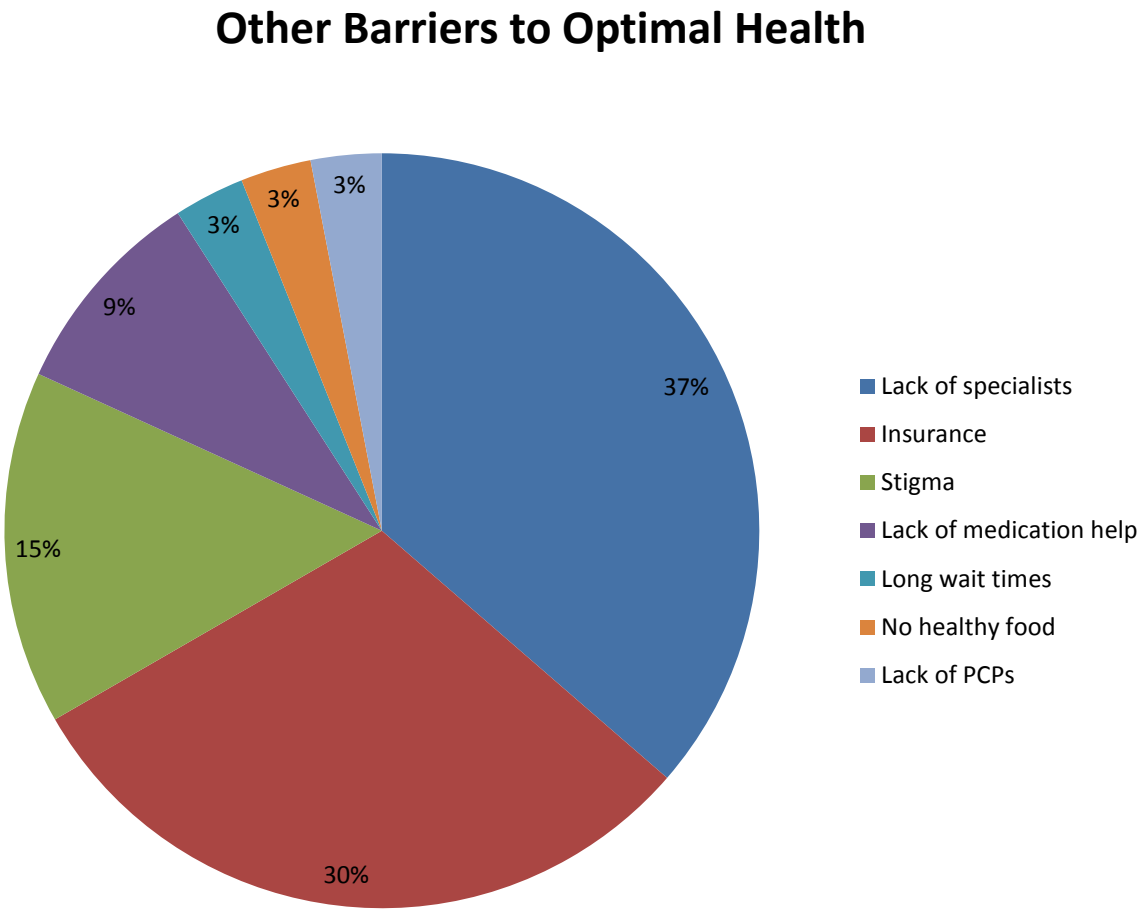
Participants were asked, “What do you, or your family and friends, do when you need to talk to someone about mental health or substance abuse issues?” The top responses were talk to a friend or family (25%), pray, go to church or talk to a minister (24%) and go to NA, AA, Celebrate Recovery or the Teen Challenge program (18%).



Mental health barriers included lack of service or help until you are in trouble with law (38%), stigma – particularly the assumption that everyone is seeking drugs (33%), and physicians not educating people about addictiveness of medications (13%).



Finally, participants were asked, “Is there anything else we need to know about the health care need in the community?” The top responses indicated a lack of specialists (37%), insurance (30%), and stigma (15%).



Tazewell Community Health Survey

Methodology

A Community Health Survey was conducted as part of the Tazewell Community Health Needs Assessment. This survey was used to gauge the health of the community and identify potential areas to target improvements. Input and oversight of survey development was provided by the Community Health Assessment Management Team.

The survey was developed using community survey samples from the following:

- National Association of County and City Health Officials' Mobilizing for Action through Planning and Partnerships Community Themes and Strengths Assessments;
- YMCA's Community Healthy Living Index;
- Center for Disease Control's Behavioral Risk Factor Surveillance System;
- Center for Disease Control's National Health Interview Survey;
- Center for Disease Control's Youth Risk Behavior Surveillance System (YRBSS);
- Community Health Surveys from Montgomery and Giles County, Virginia;
- Martin County Community Health Assessment, Martin County, North Carolina; and
- Carilion Clinic Community Health Needs Assessment, 2012.

A 40-question survey was developed that asked questions about an individual's access to medical, dental and mental health care. The survey also asked questions about chronic illness, healthy and risky behaviors, insurance status, and basic demographic information. Both an English and Spanish version of the survey was available. (The survey tool is included in Appendix 3: Community Health Survey).

Populations targeted for the survey were residents 18 years of age and older and included:

- General Population
  - All residents in the CHNA service area of Tazewell County
- Target Populations
  - Low-income and/or uninsured residents; minority populations; and residents living with chronic illness

A nonprobability sampling method, which does not involve random selection of respondents, was used.[5] This method is often used for social research. Although surveys were made available to all residents living in Tazewell County, oversampling of the target populations occurred through targeted outreach efforts. Oversampling methodologies involve data collection for particular subgroups of the population that may be underrepresented in a random sample survey.

[5] Research Methods- Knowledge Base, Nonprobability Sampling, Web Center for Social Research Methods, www.socialresearchmethods.net/kb/sampnon/php

The CHAT identified target populations, collection sites and mode(s) of distribution of the surveys. Surveys were distributed beginning April through June 2016. Over 20 organizations, agencies, and community members assisted in the distribution of the surveys. In total, 328 surveys were collected.

The survey was distributed via the following methods:

- Survey Monkey link (www.surveymonkey/com/r/2016CHNA)
- Phone line 888-964-6620
- Flyers and posters distributed throughout the community with survey URL and phone line information
- Paper surveys (collected by CHAT members and volunteers and/or staff of partner agencies)

A drawing for a $50 Food Lion gift card was offered as an incentive to those who completed the survey (one survey per person).

Outreach strategies for survey distribution included:

- Media coverage by the local newspaper announcing the URL for the survey
- Face-to-face survey interviews at sites/agencies that serve the target populations using volunteers and/or staff
- Flyer and poster distributed at sites/agencies that serve the general community and target populations
- Survey URL posted on partner agency websites

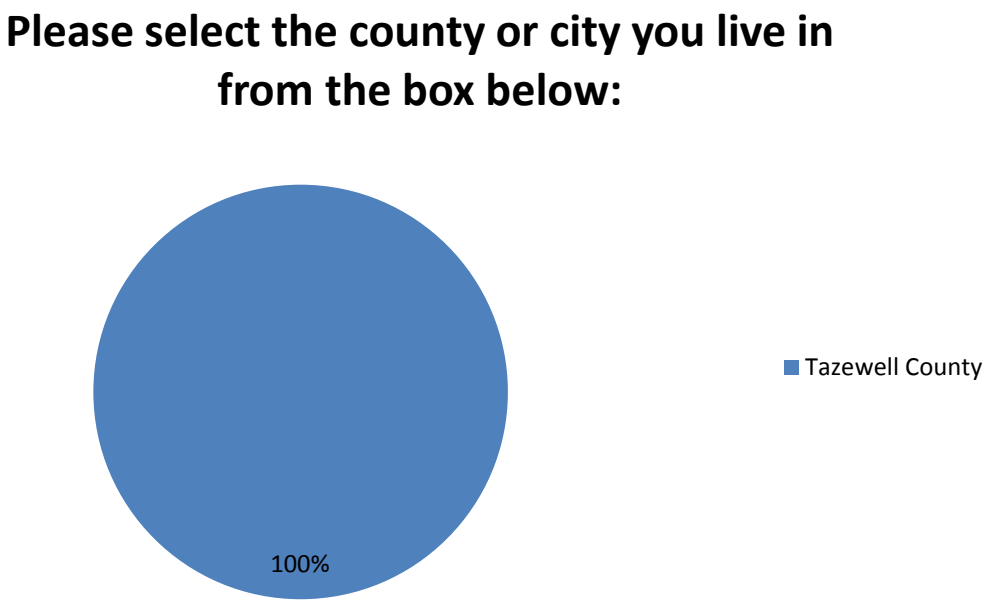
Surveys were analyzed and reported using Survey Monkey and Microsoft Excel. All responses were entered into Survey Monkey either directly by the respondents or by Carilion Direct who entered responses from paper or phone surveys.

Survey Results

Access and Barriers to Healthcare

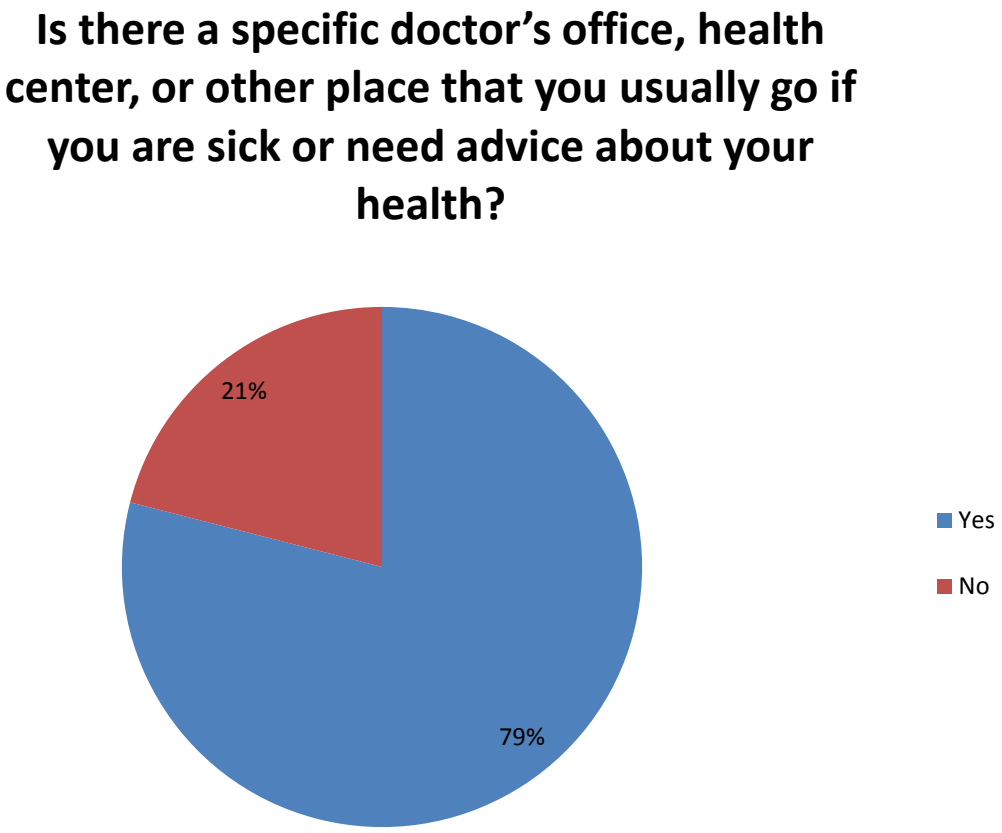
Please select the county or city you live in from the box below:

Answer Options	Response Percent	Response Count
Tazewell County	98.2%	322
	answered question	328
	skipped question	0



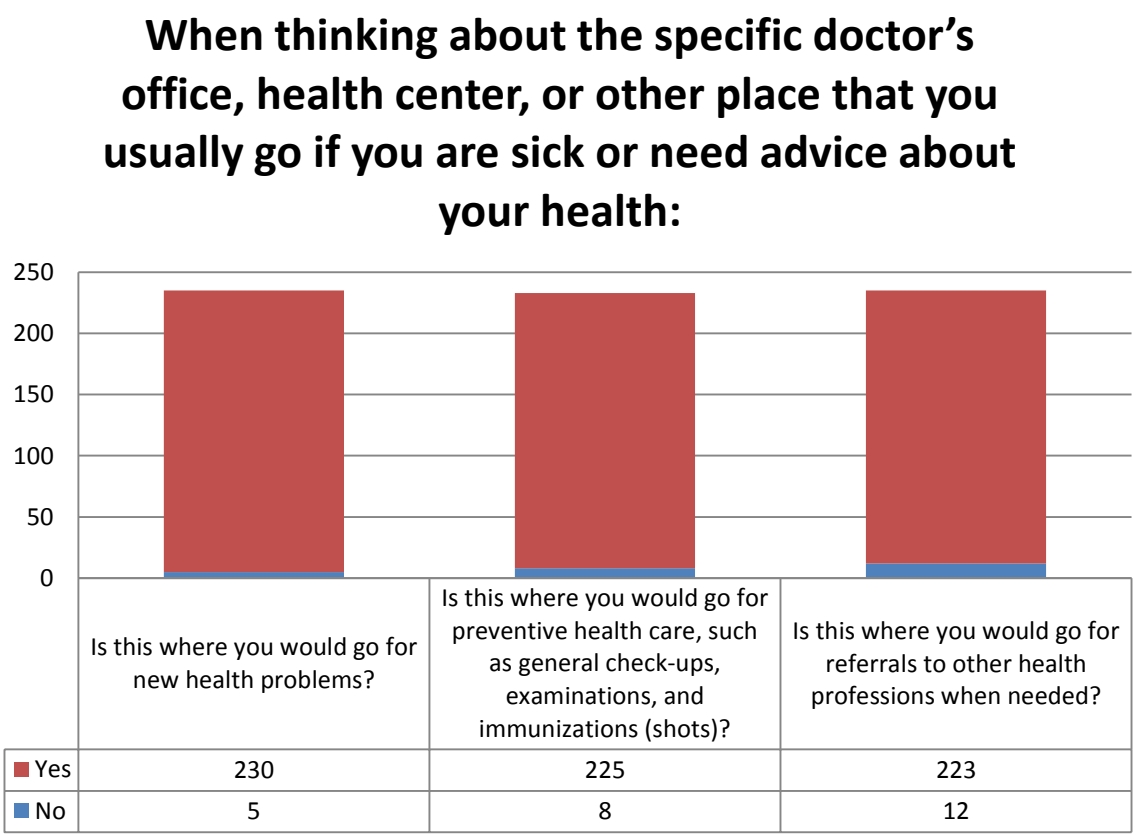
Question 1: Is there a specific doctor's office, health center, or other place that you usually go if you are sick or need advice about your health?

Answer Options	Response Percent	Response Count
Yes	79.0%	249
No	21.0%	66
	answered question	315
	skipped question	13



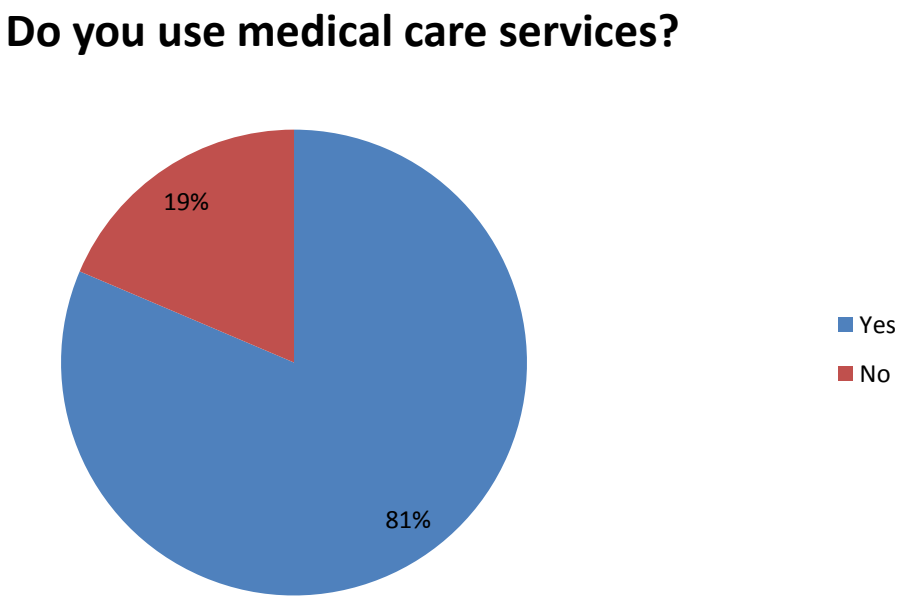
When thinking about the specific doctor's office, health center, or other place that you usually go if you are sick or need advice about your health:

Answer Options	Yes	No	Response Count
Is this where you would go for new health problems?	230	5	235
Is this where you would go for preventive health care, such as general check-ups, examinations, and immunizations (shots)?	225	8	233
Is this where you would go for referrals to other health professions when needed?	223	12	235
		answered question	241
		skipped question	87



Question 2: Do you use medical care services?

Answer Options	Response Percent	Response Count
Yes	81.4%	249
No	18.6%	57
answered question		306
skipped question		22

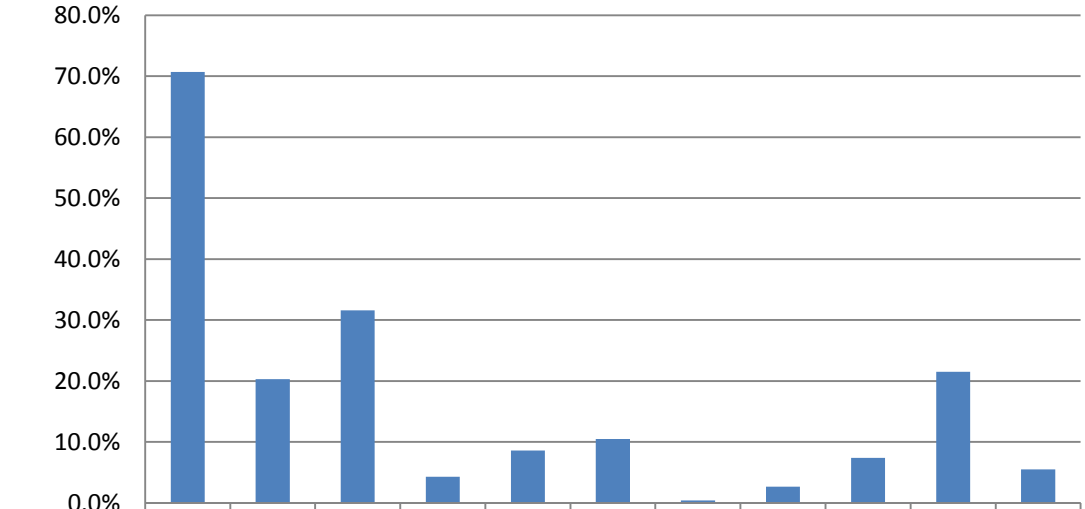


Where do you go for medical care? (Check all that apply)

Answer Options	Response Percent	Response Count
Doctor's Office	70.7%	181
Carilion Clinic Family Medicine - Tazewell	20.3%	52
Emergency Room	31.6%	81
Free Clinic	4.3%	11
Health Department	8.6%	22
Nurse Practitioner's Office	10.5%	27
Pharmacy Clinic	0.4%	1
Salem VA Medical Center	2.7%	7
Tazewell Community Health	7.4%	19
Urgent Care / Walk in Clinic	21.5%	55
Other (please specify)	5.5%	14
	answered question	256
	skipped question	72

Number	Other (please specify)
1	Bluefield, WV
2	Bland Clinic
3	Bland Medical Center
4	CVCC
5	BRMC
6	Beckley/Princeton
7	Johnston Memorial
8	Roanoke Memorial
9	Bluefield Regional Medical Center
10	Bluefield
11	Duke
12	Tazewell Family Physicians
13	Bland County Medical Clinic
14	Med-Express

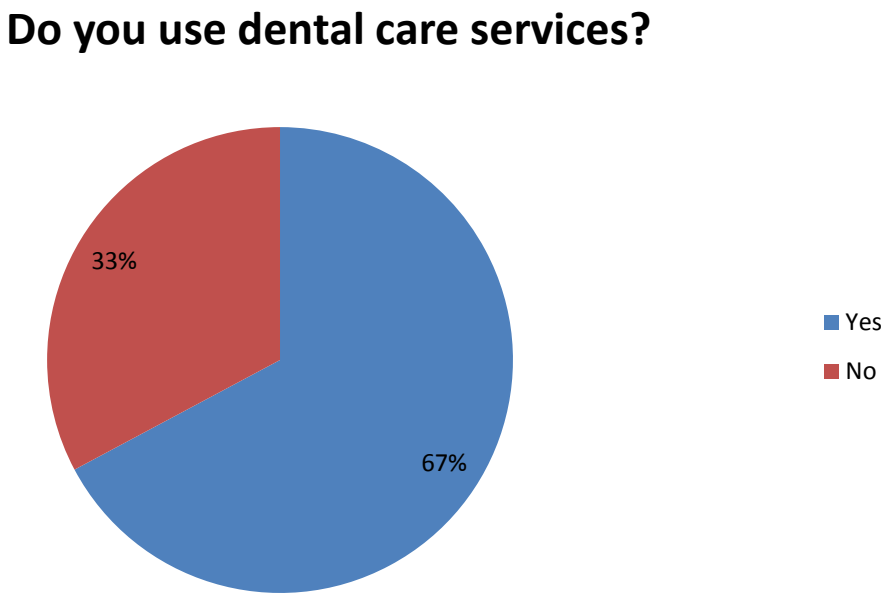
Where do you go for medical care?



	Doctor's Office	Carilion Clinic Family Medicine – Tazewell	Emergency Room	Free Clinic	Health Department	Nurse Practitioner's Office	Pharmacy Clinic	Salem VA Medical Center	Tazewell Community Health	Urgent Care / Walk in Clinic	Other (please specify)
Response Percent	70.7%	20.3%	31.6%	4.3%	8.6%	10.5%	0.4%	2.7%	7.4%	21.5%	5.5%

Question 3: Do you use dental care services?

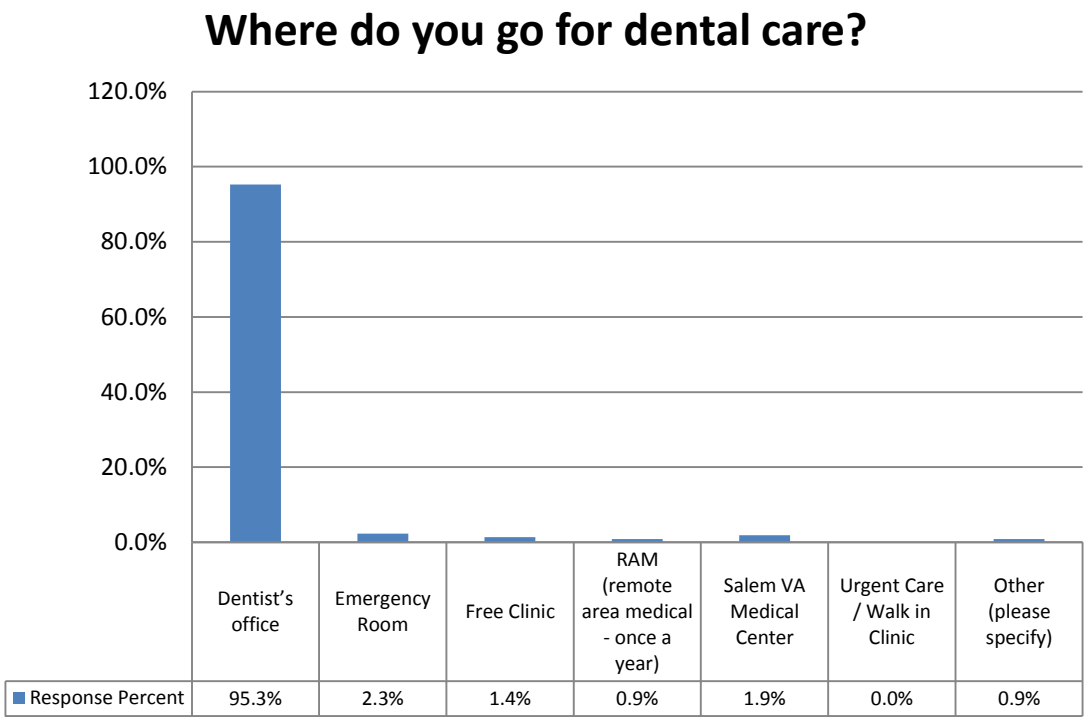
Answer Options	Response Percent	Response Count
Yes	67.2%	211
No	32.8%	103
	answered question	314
	skipped question	14



Where do you go for dental care? (Check all that apply)

Answer Options	Response Percent	Response Count
Dentist's office	95.3%	204
Emergency Room	2.3%	5
Free Clinic	1.4%	3
RAM (remote area medical - once a year)	0.9%	2
Salem VA Medical Center	1.9%	4
Urgent Care / Walk in Clinic	0.0%	0
Other (please specify)	0.9%	2
	answered question	214
	skipped question	114

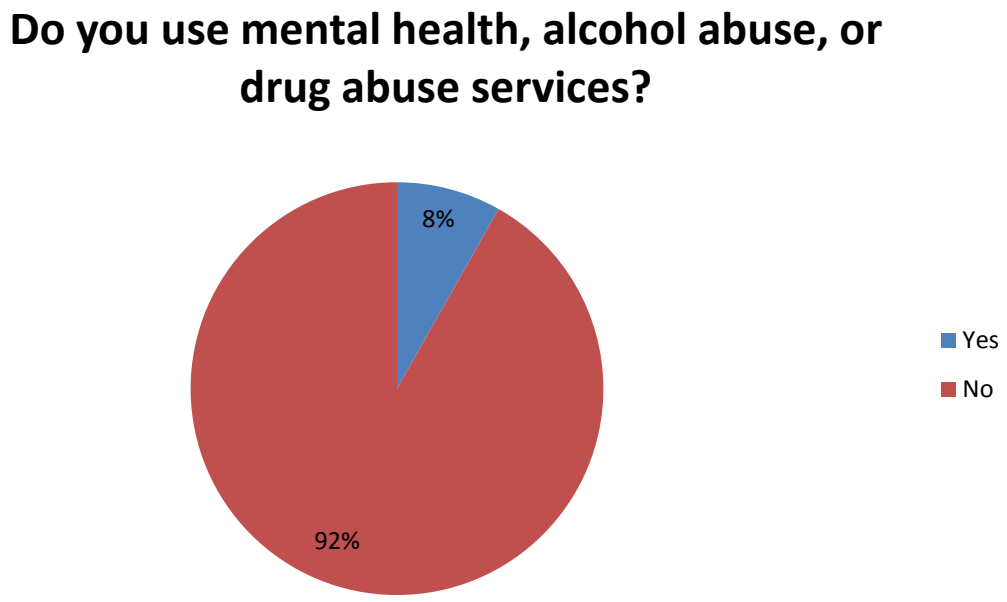
Number	Other (please specify)
1	Lhtzs
2	New River Valley Clinic



Question 4: Do you use mental health, alcohol abuse, or drug abuse services?

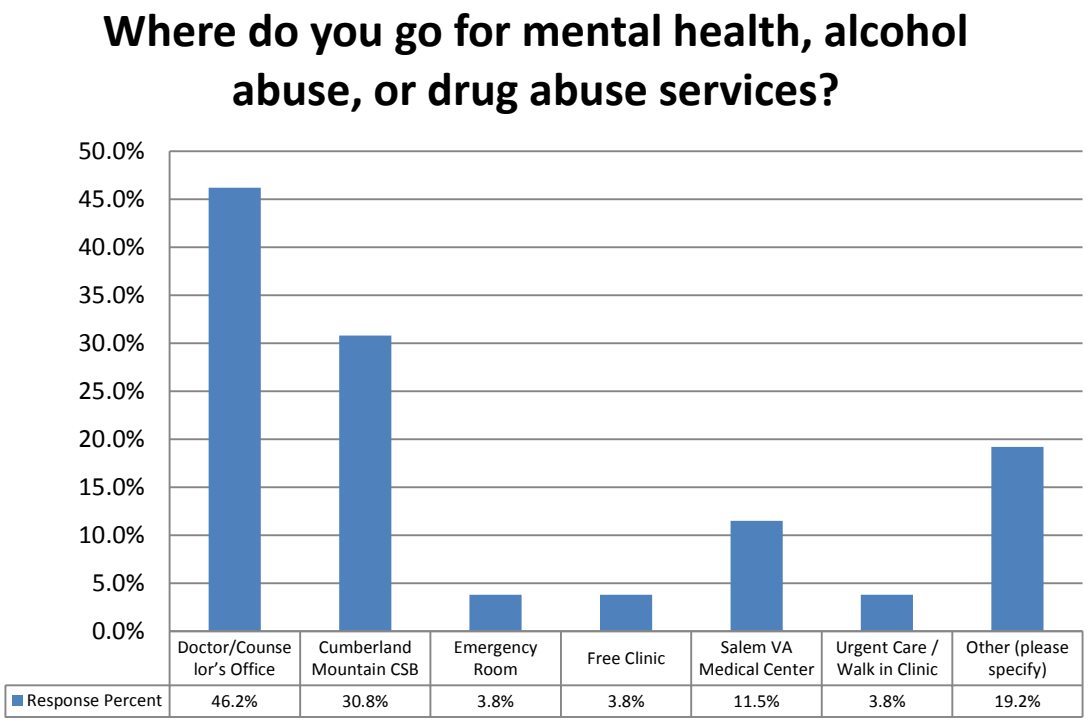
Answer Options	Response Percent	Response Count
Yes	8.2%	26
No	91.8%	292
answered question		318
skipped question		10

Number	Other (please specify)
1	Healing Waters
2	Beckly WVA
3	Counseling Service outside the area
4	CBOC - Wytheville
5	Bill Haynes



Where do you go for mental health, alcohol abuse, or drug abuse services? (Check all that apply)

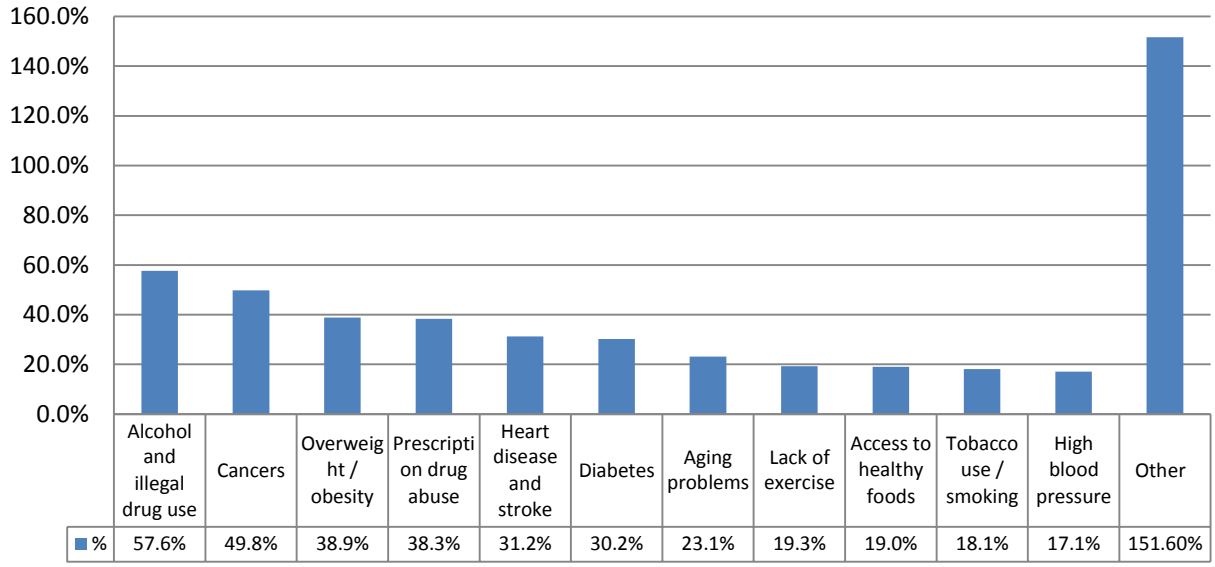
Answer Options	Response Percent	Response Count
Doctor/Counselor's Office	46.2%	12
Cumberland Mountain CSB	30.8%	8
Emergency Room	3.8%	1
Free Clinic	3.8%	1
Salem VA Medical Center	11.5%	3
Urgent Care / Walk in Clinic	3.8%	1
Other (please specify)	19.2%	5
answered question		26
skipped question		302



Question 5: What do you think are the five most important issues that affect health in our community? (Please check five)

Answer Options	Response Percent	Response Count
Alcohol and illegal drug use	57.6%	185
Cancers	49.8%	160
Overweight / obesity	38.9%	125
Prescription drug abuse	38.3%	123
Heart disease and stroke	31.2%	100
Diabetes	30.2%	97
Aging problems	23.1%	74
Lack of exercise	19.3%	62
Access to healthy foods	19.0%	61
Tobacco use / smoking	18.1%	58
High blood pressure	17.1%	55
Child abuse / neglect	15.6%	50
Cell phone use / texting and driving / distracted driving	15.3%	49
Stress	14.3%	46
Mental health problems	14.0%	45
Poor eating habits	14.0%	45
Dental problems	11.5%	37
Accidents in the home (ex. falls, burns, cuts)	10.6%	34
Domestic violence	9.0%	29
Lung disease	9.0%	29
Bullying	7.2%	23
Environmental health (e.g. water quality, air quality, pesticides, etc.)	5.0%	16
Teenage pregnancy	4.0%	13
Not getting “shots” to prevent disease	3.7%	12
Unsafe sex	3.4%	11
Suicide	3.1%	10
Sexual assault	2.5%	8
Not using seat belts / child safety seats / helmets	2.2%	7
Other (please specify)	1.9%	6
HIV / AIDS	1.6%	5
Neighborhood safety	1.6%	5
Gang activity	1.2%	4
Homicide	0.9%	3
Infant death	0.0%	0
answered question		321
skipped question		7

What do you think are the five most important issues that affect health in our community?

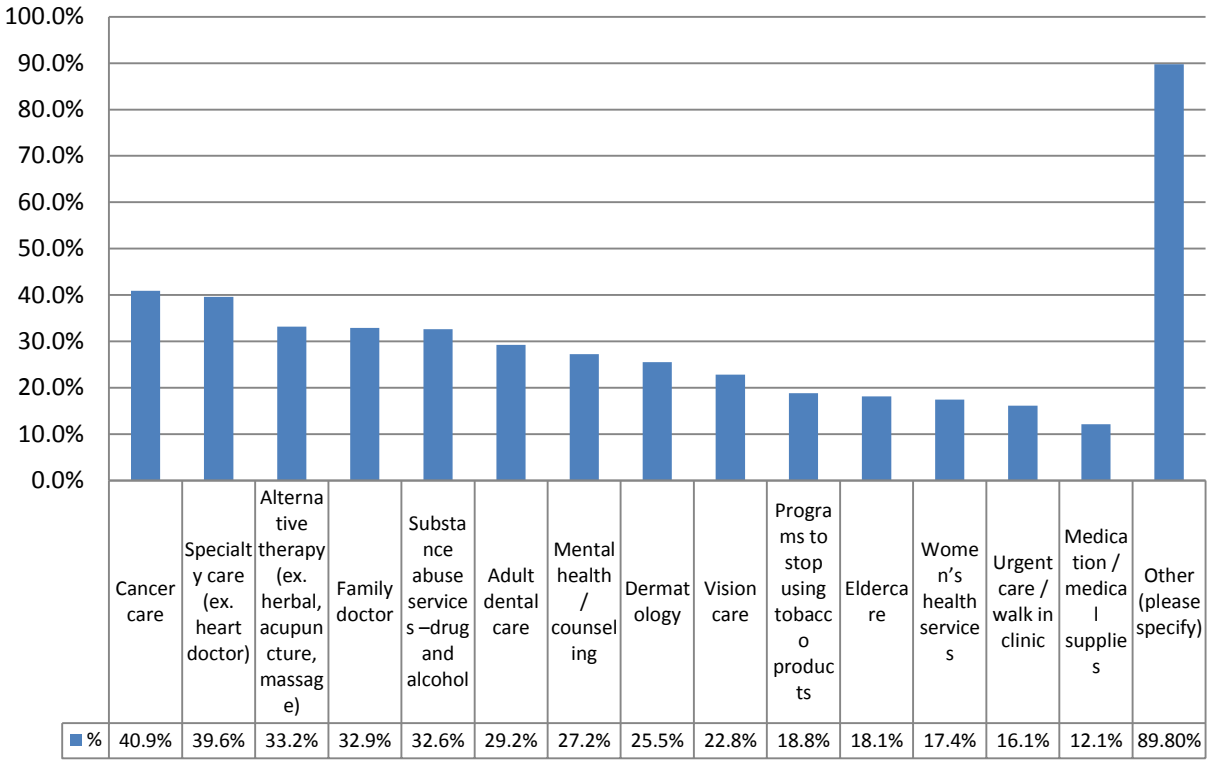


	Alcohol and illegal drug use	Cancers	Overweight / obesity	Prescription drug abuse	Heart disease and stroke	Diabetes	Aging problems	Lack of exercise	Access to healthy foods	Tobacco use / smoking	High blood pressure	Other
%	57.6%	49.8%	38.9%	38.3%	31.2%	30.2%	23.1%	19.3%	19.0%	18.1%	17.1%	151.60%

Question 6: Which health care services are hard to get in our community? (Check all that apply)

Answer Options	Response Percent	Response Count
Cancer care	40.9%	122
Specialty care (ex. heart doctor)	39.6%	118
Alternative therapy (ex. herbal, acupuncture, massage)	33.2%	99
Family doctor	32.9%	98
Substance abuse services –drug and alcohol	32.6%	97
Adult dental care	29.2%	87
Mental health / counseling	27.2%	81
Dermatology	25.5%	76
Vision care	22.8%	68
Programs to stop using tobacco products	18.8%	56
Eldercare	18.1%	54
Women's health services	17.4%	52
Urgent care / walk in clinic	16.1%	48
Medication / medical supplies	12.1%	36
Preventive care (ex. yearly check-ups)	9.7%	29
Domestic violence services	9.1%	27
Child dental care	8.4%	25
Inpatient hospital	8.1%	24
Lab work	7.7%	23
Ambulance services	6.0%	18
Emergency room care	6.0%	18
End of life / hospice / palliative care	6.0%	18
Family planning / birth control	6.0%	18
Physical therapy	6.0%	18
X-rays / mammograms	4.7%	14
Chiropractic care	4.0%	12
None	3.4%	10
Other (please specify)	3.4%	10
Immunizations	1.3%	4
answered question		298
skipped question		30

Which health care services are hard to get in our community?

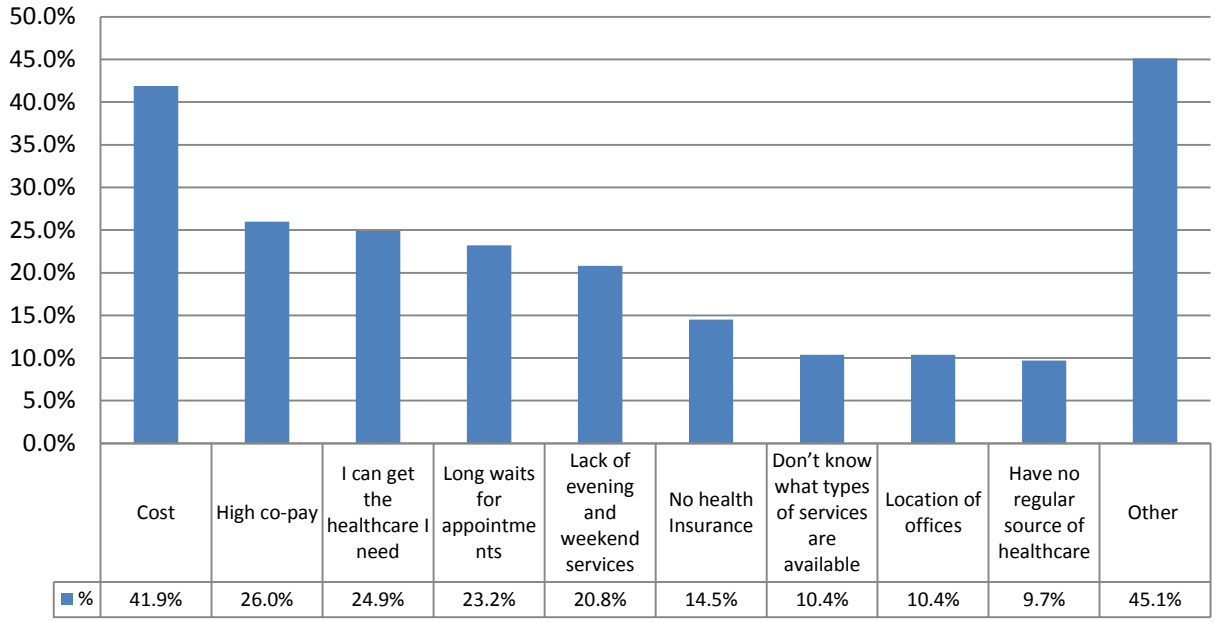


	Cancer care	Specialty care (ex. heart doctor)	Alternative therapy (ex. herbal, acupuncture, massage)	Family doctor	Substance abuse services –drug and alcohol	Adult dental care	Mental health / counseling	Dermatology	Vision care	Programs to stop using tobacco products	Eldercare	Women's health services	Urgent care / walk in clinic	Medication / medical supplies	Other (please specify)
%	40.9%	39.6%	33.2%	32.9%	32.6%	29.2%	27.2%	25.5%	22.8%	18.8%	18.1%	17.4%	16.1%	12.1%	89.80%

Question 7: What do you feel prevents you from getting the healthcare you need? (Check all that apply)

Answer Options	Response Percent	Response Count
Cost	41.9%	121
High co-pay	26.0%	75
I can get the healthcare I need	24.9%	72
Long waits for appointments	23.2%	67
Lack of evening and weekend services	20.8%	60
No health Insurance	14.5%	42
Don't know what types of services are available	10.4%	30
Location of offices	10.4%	30
Have no regular source of healthcare	9.7%	28
Can't find providers that accept my Medicaid insurance	7.3%	21
No transportation	7.3%	21
Other (please specify)	7.3%	21
Afraid to have check-ups	6.6%	19
Don't trust doctors / clinics	6.2%	18
Can't find providers that accept my Medicare insurance	3.1%	9
Childcare	2.8%	8
Language services	2.4%	7
Don't like accepting government assistance	2.1%	6
answered question		289
skipped question		39

What do you feel prevents you from getting the healthcare you need?



	Cost	High co-pay	I can get the healthcare I need	Long waits for appointments	Lack of evening and weekend services	No health Insurance	Don't know what types of services are available	Location of offices	Have no regular source of healthcare	Other
%	41.9%	26.0%	24.9%	23.2%	20.8%	14.5%	10.4%	10.4%	9.7%	45.1%

General Health Questions

Question 8: Please check one of the following for each statement:

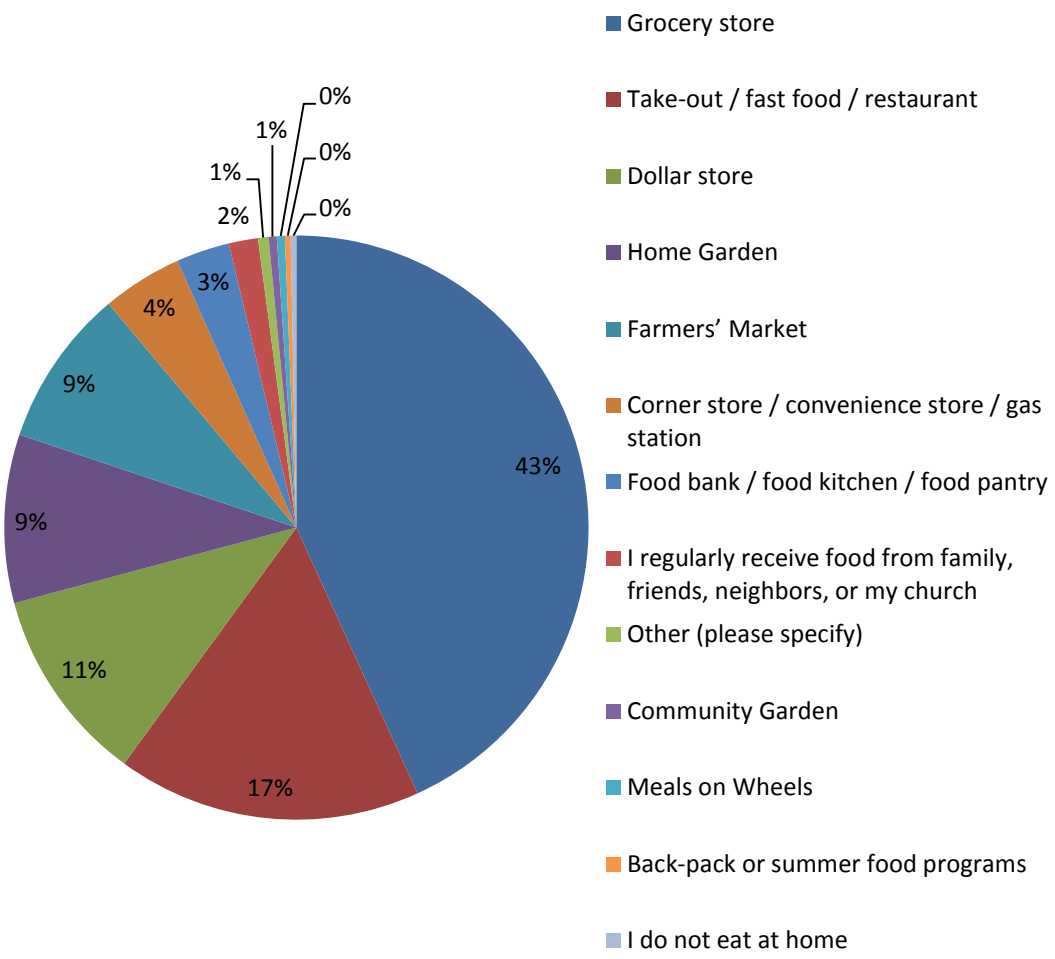
Please check one of the following for each statement							
Answer Options	**Yes**	**%**	**No**	**%**	**Not applicable**	**%**	**Response Count**
I have had an eye exam within the past 12 months.	168	55.45%	133	43.89%	2	0.66%	303
I have had a mental health / substance abuse visit within the past 12 months.	28	9.33%	219	73.00%	53	17.67%	300
I have had a dental exam within the past 12 months.	155	51.67%	140	46.67%	5	1.67%	300
I have been to the emergency room in the past 12 months.	111	36.63%	189	62.38%	3	0.99%	303
I have been to the emergency room for an injury in the past 12 months (e.g. motor vehicle crash, fall, poisoning, burn, cut, etc.).	46	15.28%	249	82.72%	6	1.99%	301
Have you been a victim of domestic violence or abuse in the past 12 months?	11	3.65%	279	92.69%	11	3.65%	301
My doctor has told me that I have a long-term or chronic illness.	87	28.90%	207	68.77%	7	2.33%	301
I take the medicine my doctor tells me to take to control my chronic illness.	116	39.46%	90	30.61%	88	29.93%	294
I can afford medicine needed for my health conditions.	156	53.61%	87	29.90%	48	16.49%	291
I am over 21 years of age and have had a Pap smear in the past three years (if male or under 21, please check not applicable).	138	45.85%	99	32.89%	64	21.26%	301
I am over 40 years of age and have had a mammogram in the past 12 months (if male or under 40, please check not applicable).	88	29.33%	102	34.00%	110	36.67%	300
I am over 50 years of age and have had a colonoscopy in the past 10 years (if under 50, please check not applicable).	80	26.76%	110	36.79%	109	36.45%	299

Does your neighborhood support physical activity? (e.g. parks, sidewalks, bike lanes, etc.)	146	48.99%	149	50.00%	3	1.01%	298
Does your neighborhood support healthy eating? (e.g. community gardens, farmers' markets, etc.)	182	60.47%	113	37.54%	6	1.99%	301
In the area that you live, is it easy to get affordable fresh fruits and vegetables?	181	60.33%	117	39.00%	2	0.67%	300
Have there been times in the past 12 months when you did not have enough money to buy the food that you or your family needed?	91	30.33%	203	67.67%	6	2.00%	300
			answered question				**305**
			skipped question				**23**

Question 9: Where do you get the food that you eat at home? (Check all that apply)

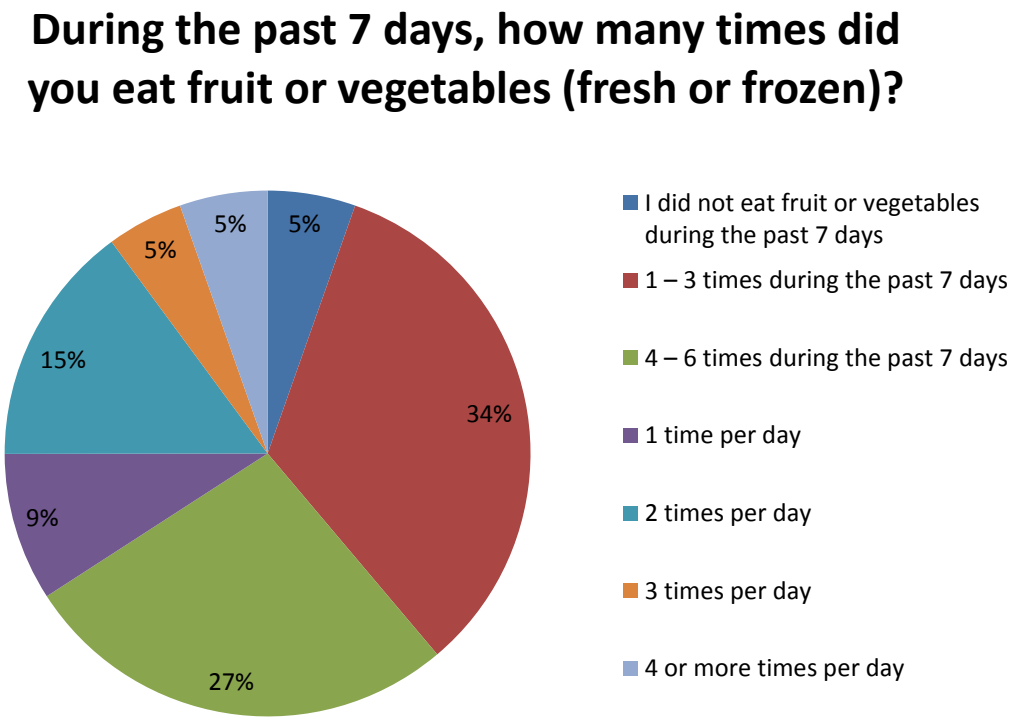
Answer Options	Response Percent	Response Count
Grocery store	96.4%	292
Take-out / fast food / restaurant	37.6%	114
Dollar store	24.1%	73
Home Garden	20.8%	63
Farmers' Market	19.5%	59
Corner store / convenience store / gas station	9.9%	30
Food bank / food kitchen / food pantry	6.6%	20
I regularly receive food from family, friends, neighbors, or my church	3.6%	11
Other (please specify)	1.3%	4
Community Garden	1.0%	3
Meals on Wheels	1.0%	3
Back-pack or summer food programs	0.7%	2
I do not eat at home	0.7%	2
answered question		303
skipped question		25

Where do you get the food that you eat at home?



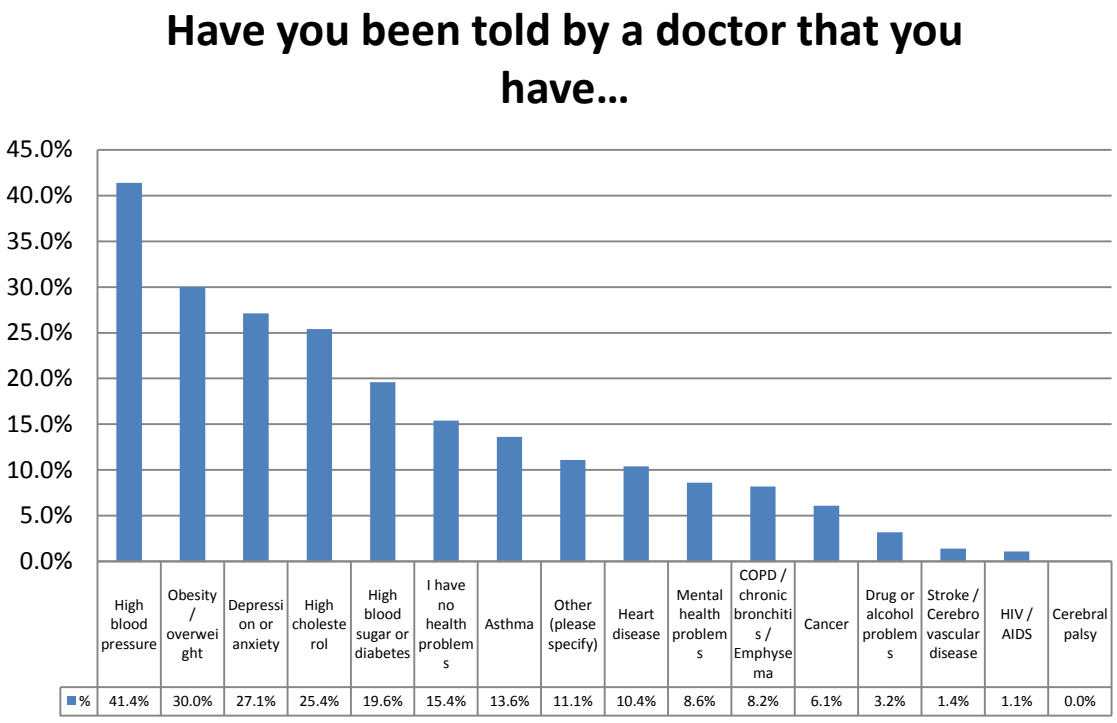
Question 10: During the past 7 days, how many times did you eat fruit or vegetables (fresh or frozen)? Do not count fruit or vegetable juice. (Please check one)

Answer Options	Response Percent	Response Count
I did not eat fruit or vegetables during the past 7 days	5.4%	16
1 - 3 times during the past 7 days	33.4%	99
4 - 6 times during the past 7 days	27.0%	80
1 time per day	9.1%	27
2 times per day	14.9%	44
3 times per day	4.7%	14
4 or more times per day	5.4%	16
	answered question	296
	skipped question	32



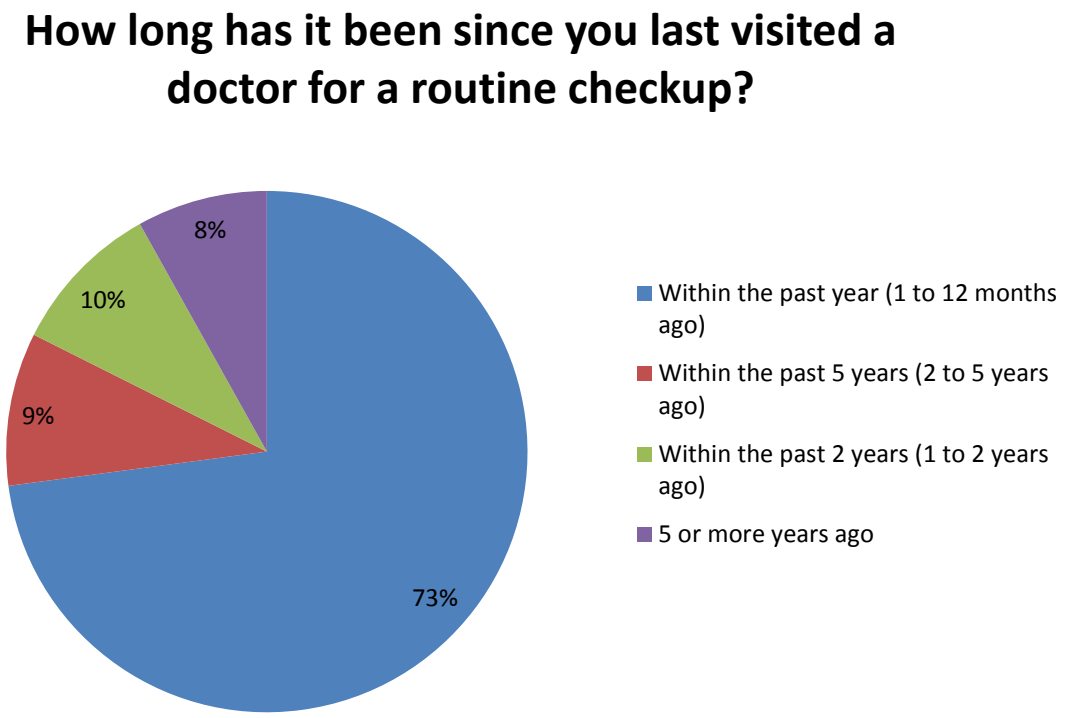
Question 11: Have you been told by a doctor that you have… (Check all that apply)

Answer Options	Response Percent	Response Count
High blood pressure	41.4%	116
Obesity / overweight	30.0%	84
Depression or anxiety	27.1%	76
High cholesterol	25.4%	71
High blood sugar or diabetes	19.6%	55
I have no health problems	15.4%	43
Asthma	13.6%	38
Other (please specify)	11.1%	31
Heart disease	10.4%	29
Mental health problems	8.6%	24
COPD / chronic bronchitis / Emphysema	8.2%	23
Cancer	6.1%	17
Drug or alcohol problems	3.2%	9
Stroke / Cerebrovascular disease	1.4%	4
HIV / AIDS	1.1%	3
Cerebral palsy	0.0%	0
answered question		280
skipped question		48



Question 12: How long has it been since you last visited a doctor for a routine checkup? (Please check one)

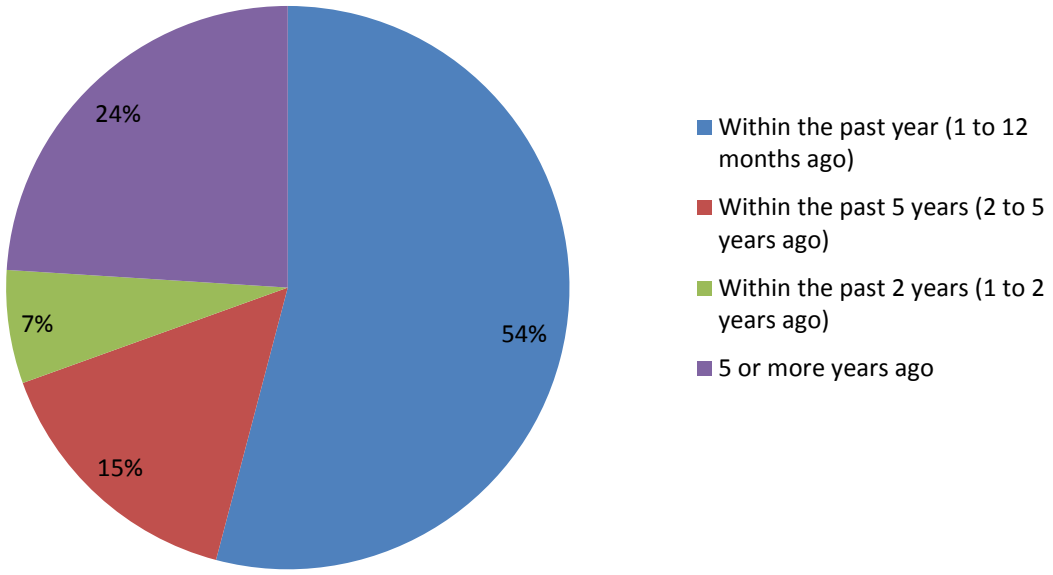
Answer Options	Response Percent	Response Count
Within the past year (1 to 12 months ago)	72.9%	215
Within the past 5 years (2 to 5 years ago)	9.5%	28
Within the past 2 years (1 to 2 years ago)	9.5%	28
5 or more years ago	8.1%	24
	answered question	295
	skipped question	33



Question 13: How long has it been since you last visited a dentist or a dental clinic for any reason? Include visits to dental specialists, such as orthodontists. (Please check one)

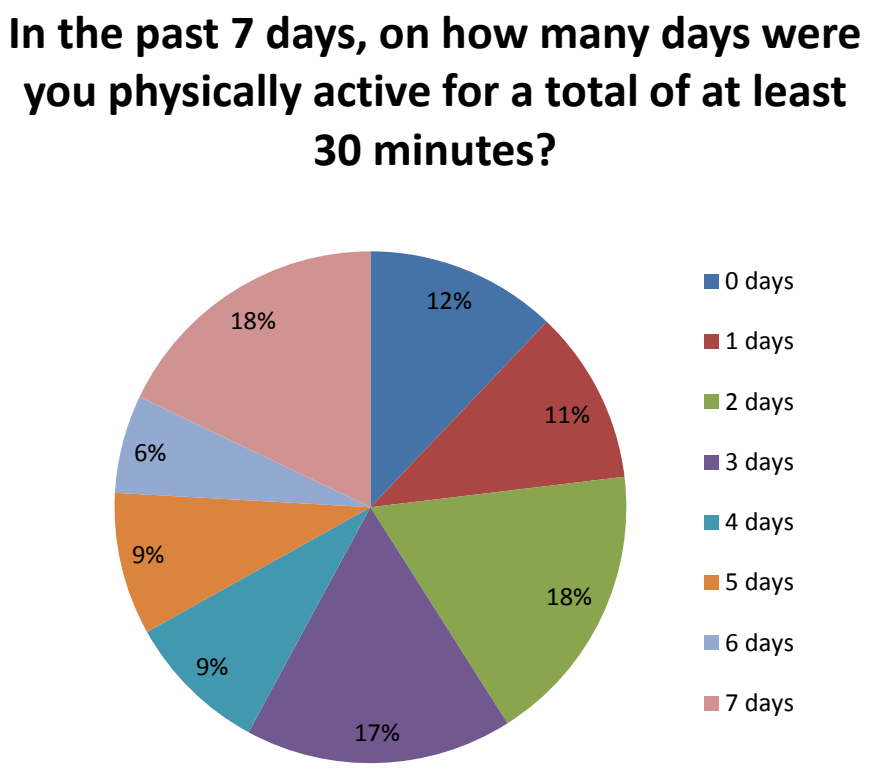
Answer Options	Response Percent	Response Count
Within the past year (1 to 12 months ago)	54.1%	158
Within the past 5 years (2 to 5 years ago)	15.4%	45
Within the past 2 years (1 to 2 years ago)	6.5%	19
5 or more years ago	24.0%	70
answered question		292
skipped question		36

How long has it been since you last visited a dentist or a dental clinic for any reason?



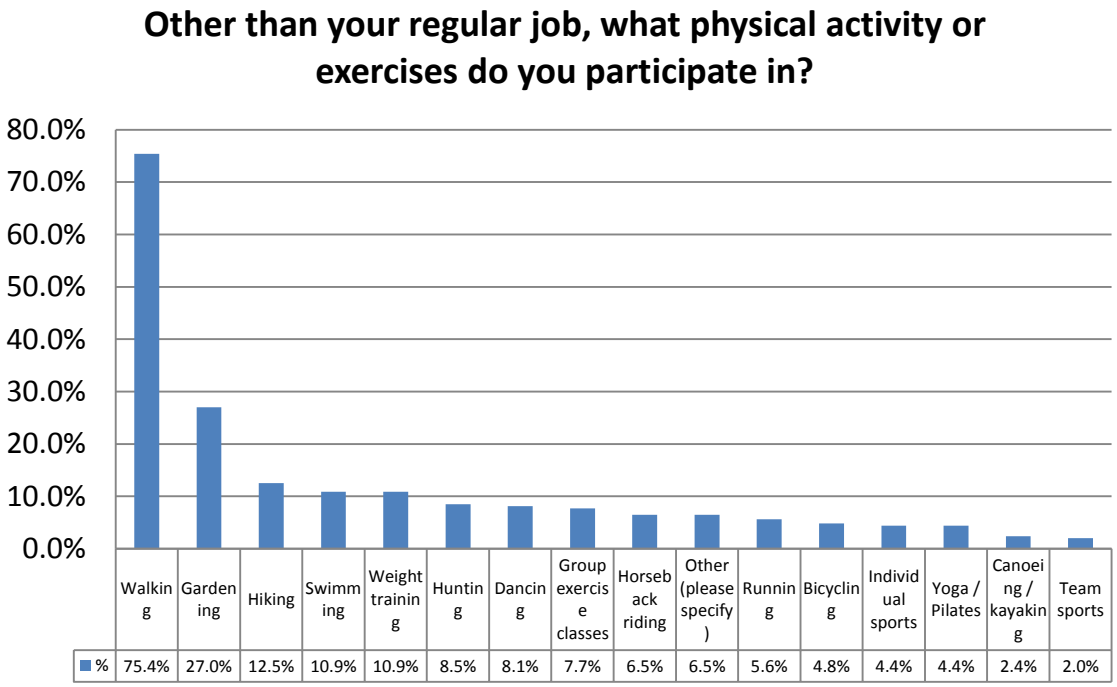
Question 14: In the past 7 days, on how many days were you physically active for a total of at least 30 minutes? (Add up all the time you spent in any kind of physical activity that increased your heart rate and made you breathe hard for some of the time.)

Answer Options	Response Percent	Response Count
0 days	12.1%	35
1 days	11.0%	32
2 days	17.9%	52
3 days	16.9%	49
4 days	9.0%	26
5 days	9.0%	26
6 days	6.2%	18
7 days	17.9%	52
answered question		290
skipped question		38



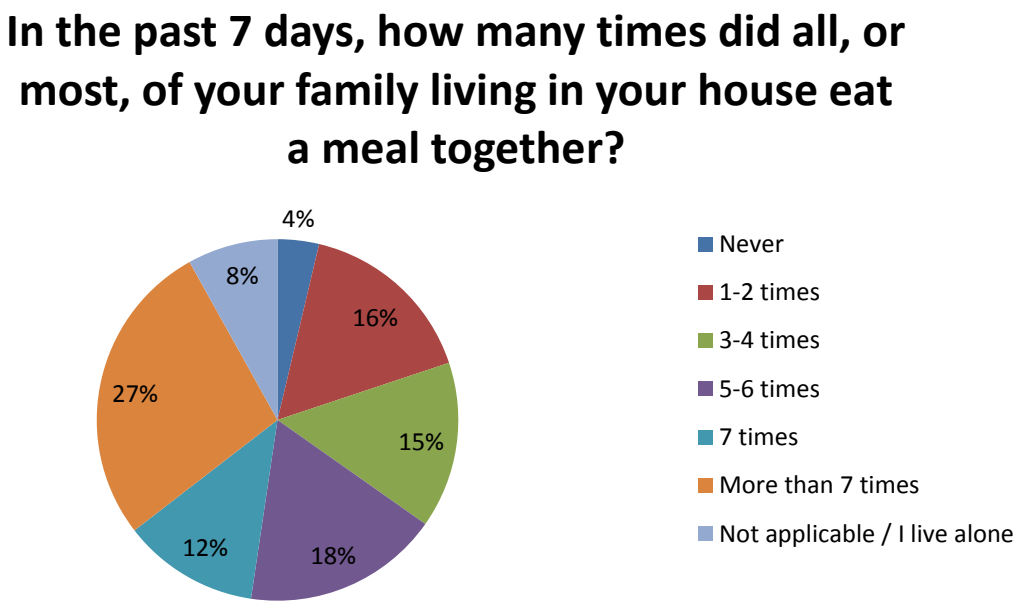
Question 15: Other than your regular job, what physical activity or exercises do you participate in? (Check all that apply)

Answer Options	Response Percent	Response Count
Walking	75.4%	187
Gardening	27.0%	67
Hiking	12.5%	31
Swimming	10.9%	27
Weight training	10.9%	27
Hunting	8.5%	21
Dancing	8.1%	20
Group exercise classes	7.7%	19
Horseback riding	6.5%	16
Other (please specify)	6.5%	16
Running	5.6%	14
Bicycling	4.8%	12
Individual sports	4.4%	11
Yoga / Pilates	4.4%	11
Canoeing / kayaking	2.4%	6
Team sports	2.0%	5
answered question		248
skipped question		80



Question 16: In the past 7 days, how many times did all, or most, of your family living in your house eat a meal together?

Answer Options	Response Percent	Response Count
Never	3.7%	11
1-2 times	16.2%	48
3-4 times	14.9%	44
5-6 times	17.6%	52
7 times	12.2%	36
More than 7 times	27.4%	81
Not applicable / I live alone	8.1%	24
answered question		296
skipped question		32



Question 17: Thinking about your physical health, which includes physical illness and injury, for how many days during the past 30 days was your physical health not good?

Answer Options	Response Average
	7 days
answered question	249
skipped question	79

Question 18: Thinking about your mental health, which includes stress, depression, and problems with emotions, for how many days during the past 30 days was your mental health not good?

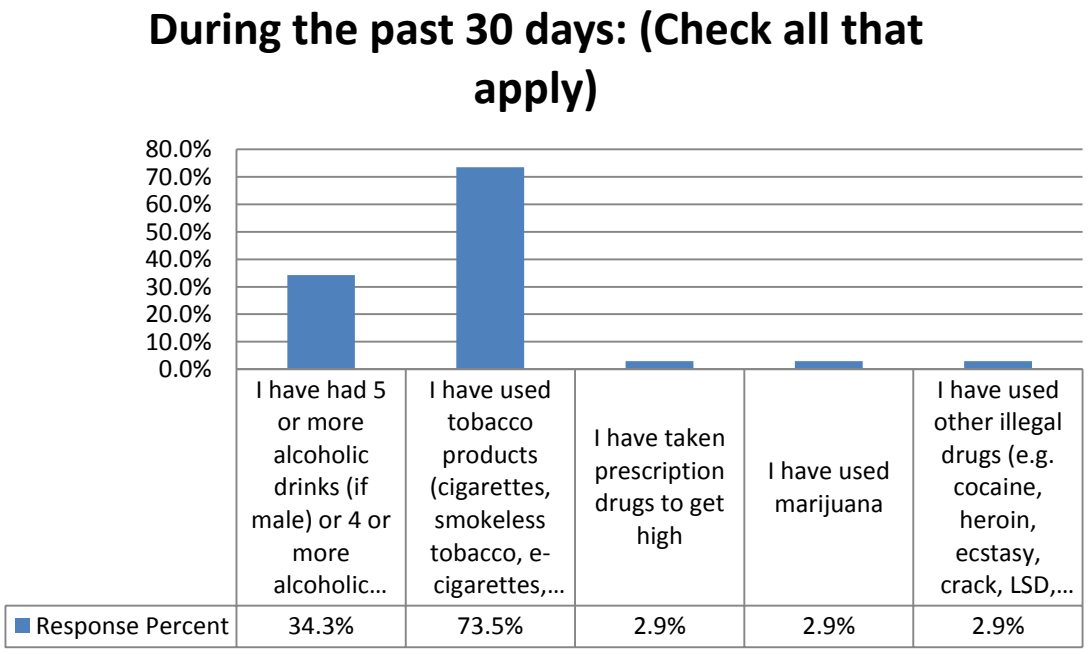
Answer Options	Response Average
	7 days
answered question	243
skipped question	85

Question 19: During the last 30 days, how many days did you miss work or school due to pain or illness (physical or mental)?

Answer Options	Response Average
	1 day
answered question	224
skipped question	104

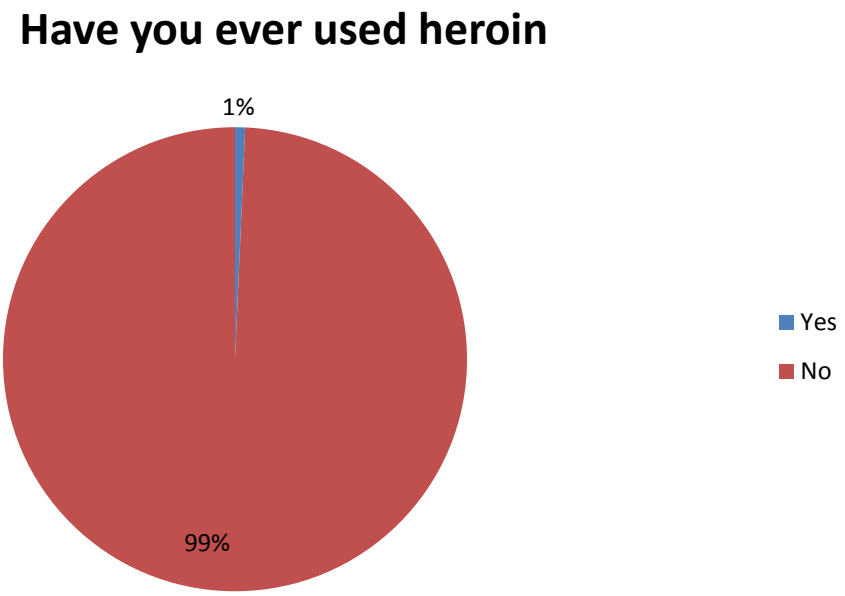
Question 20: During the past 30 days: (Check all that apply)

Answer Options	Response Percent	Response Count
I have had 5 or more alcoholic drinks (if male) or 4 or more alcoholic drinks (if female) during one occasion.	34.3%	35
I have used tobacco products (cigarettes, smokeless tobacco, e-cigarettes, etc.)	73.5%	75
I have taken prescription drugs to get high	2.9%	3
I have used marijuana	2.9%	3
I have used other illegal drugs (e.g. cocaine, heroin, ecstasy, crack, LSD, etc.)	2.9%	3
answered question		102
skipped question		226



Question 21: Have you ever used heroin?

Answer Options	Response Percent	Response Count
Yes	0.7%	2
No	99.3%	291
	answered question	293
	skipped question	35

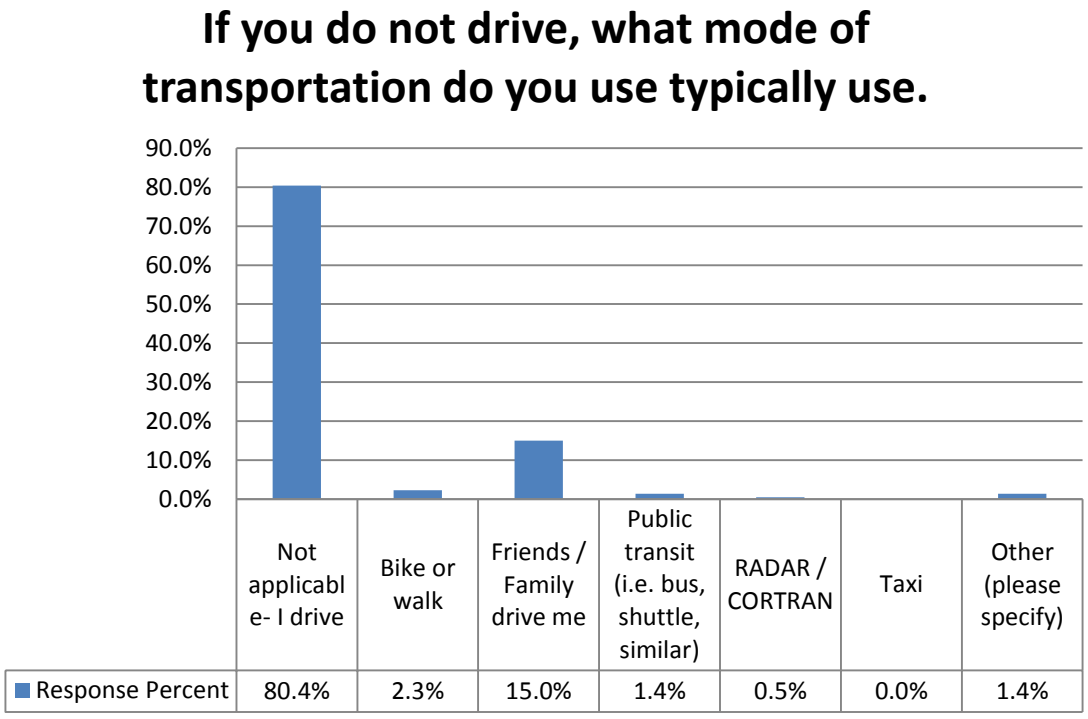


Question 22: How many vehicles are owned, leased, or available for regular use by you and those who currently live in your household? Please be sure to include motorcycles, mopeds and RVs

Answer Options	Response Average
	2
answered question	278
skipped question	50

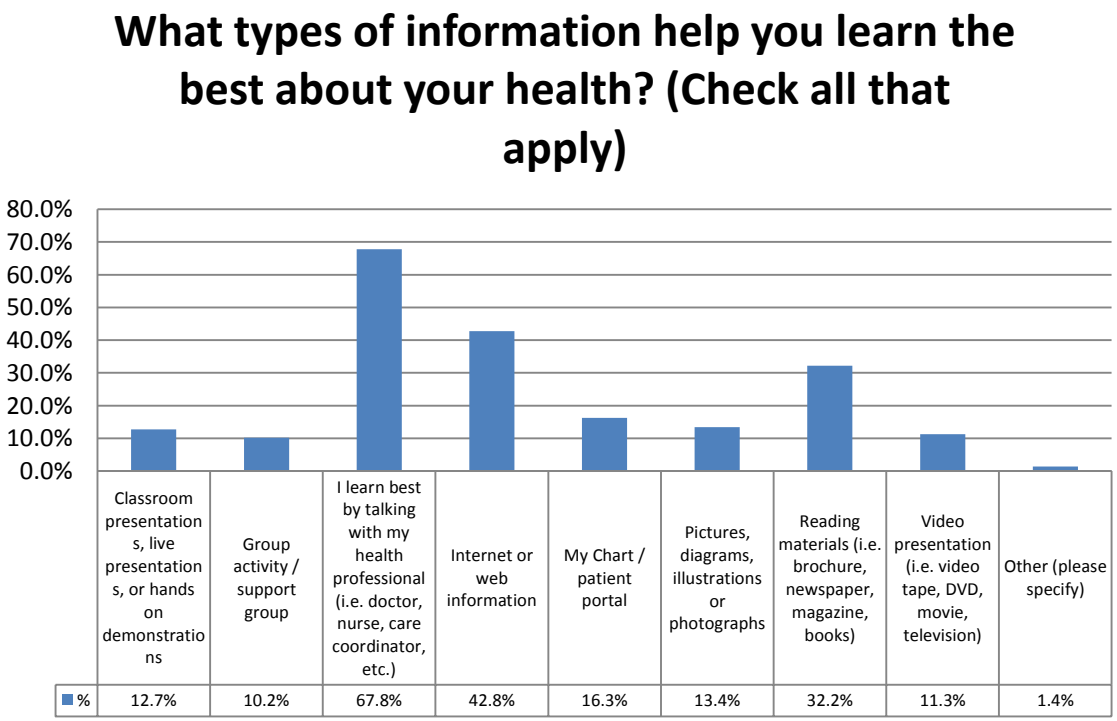
Question 23: If you do not drive, what mode of transportation do you typically use.

Answer Options	Response Percent	Response Count
Not applicable- I drive	80.4%	172
Bike or walk	2.3%	5
Friends / Family drive me	15.0%	32
Public transit (i.e. bus, shuttle, similar)	1.4%	3
RADAR / CORTRAN	0.5%	1
Taxi	0.0%	0
Other (please specify)	1.4%	3
answered question		214
skipped question		114



Question 24: What types of information help you learn the best about your health? (Check all that apply)

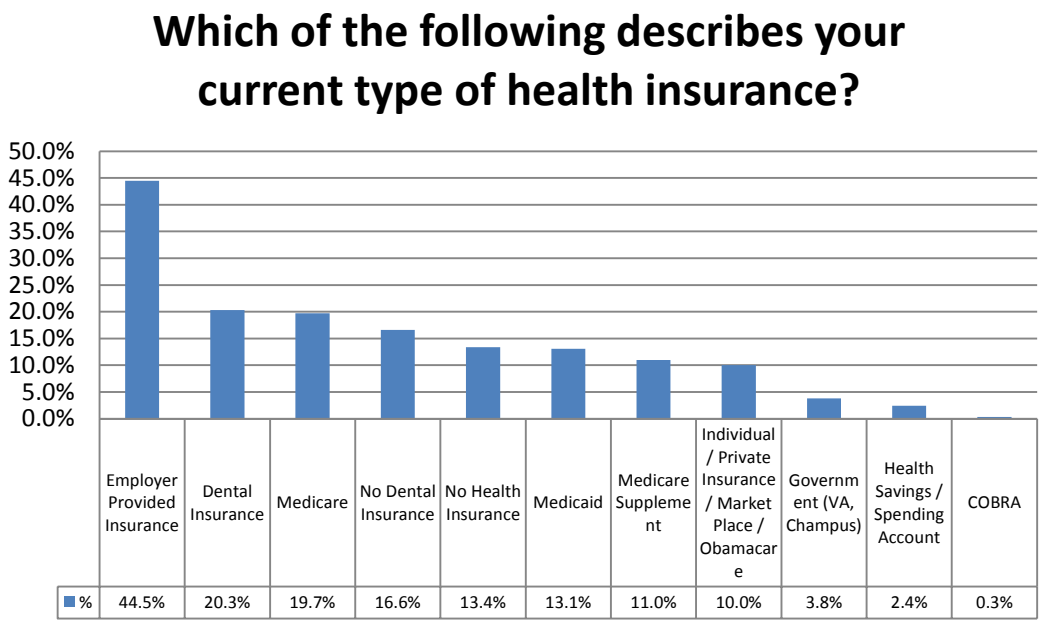
Answer Options	Response Percent	Response Count
Classroom presentations, live presentations, or hands on demonstrations	12.7%	36
Group activity / support group	10.2%	29
I learn best by talking with my health professional (i.e. doctor, nurse, care coordinator, etc.)	67.8%	192
Internet or web information	42.8%	121
My Chart / patient portal	16.3%	46
Pictures, diagrams, illustrations or photographs	13.4%	38
Reading materials (i.e. brochure, newspaper, magazine, books)	32.2%	91
Video presentation (i.e. video tape, DVD, movie, television)	11.3%	32
Other (please specify)	1.4%	4
	answered question	283
	skipped question	45



Demographic Information and Health Insurance

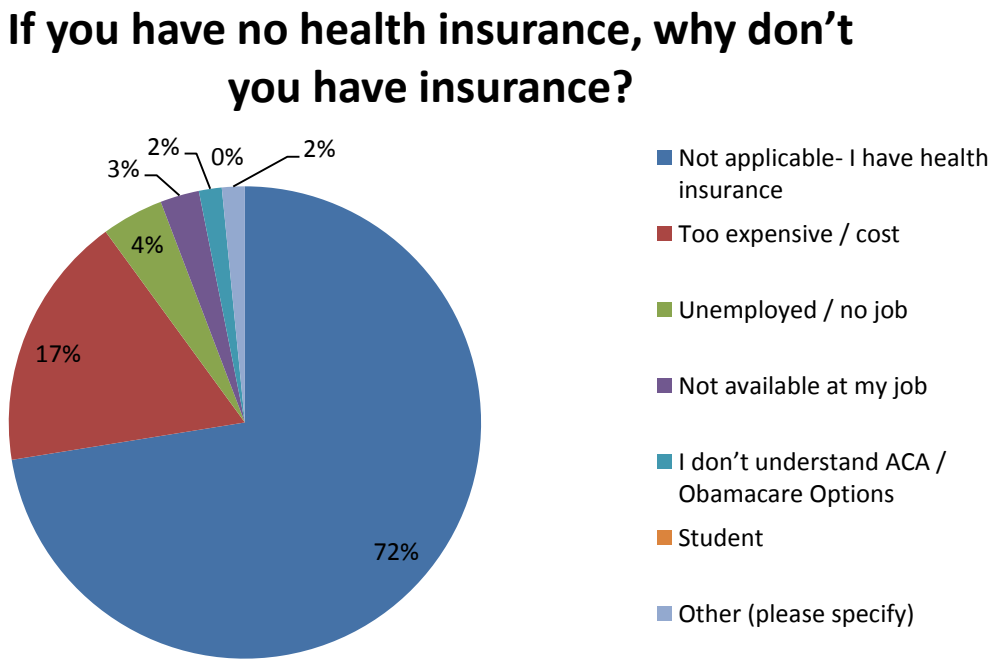
Question 25: Which of the following describes your current type of health insurance? (Check all that apply)

Answer Options	Response Percent	Response Count
Employer Provided Insurance	44.5%	129
Dental Insurance	20.3%	59
Medicare	19.7%	57
No Dental Insurance	16.6%	48
No Health Insurance	13.4%	39
Medicaid	13.1%	38
Medicare Supplement	11.0%	32
Individual / Private Insurance / Market Place / Obamacare	10.0%	29
Government (VA, Champus)	3.8%	11
Health Savings / Spending Account	2.4%	7
COBRA	0.3%	1
answered question		290
skipped question		38



Question 26: If you have no health insurance, why don't you have insurance? (Check all that apply)

Answer Options	Response Percent	Response Count
Not applicable- I have health insurance	78.7%	137
Too expensive / cost	19.0%	33
Unemployed / no job	4.6%	8
Not available at my job	2.9%	5
I don't understand ACA / Obamacare Options	1.7%	3
Student	0.0%	0
Other (please specify)	1.7%	3
answered question		174
skipped question		154



Question 27: What is your ZIP code?

What is your ZIP code?			
Location	**Answer Options**	**Response Count**	**Response Percent**
Tazewell, Tazewell Co.	24651	117	37.9%
North Tazewell, Tazewell Co.	24630	91	29.4%
Bluefield, VA- Tazewell Co.	24605	19	6.1%
Cedar Bluff, Tazewell Co.	24609	19	6.1%
Richlands, Tazewell Co.	24641	17	5.5%
Bandy, Tazewell Co.	24602	12	3.9%
Pounding Mill, Tazewell Co.	24637	10	3.2%
Raven, Tazewell Co.	24639	3	1.0%
Boones Mill, Franklin Co.	24065	2	0.6%
Lebanon, Russell Co.	24266	2	0.6%
Boissevian, Tazewell Co.	24606	2	0.6%
Peterstown, WV- Monroe Co.	24963	2	0.6%
Rosedale, Russell Co.	24280	1	0.3%
Bastian, Bland Co.	24314	1	0.3%
Max Meadows, Wythe Co.	24360	1	0.3%
Rocky Gap, Bland Co.	24366	1	0.3%
Tannersville, Tazewell Co.	24377	1	0.3%
Amonate, Tazewell Co.	24601	1	0.3%
Bishop, WV- McDowell Co.	24604	1	0.3%
Falls Mill, Tazewell Co.	24613	1	0.3%
Raven, Tazewell Co.	24640	1	0.3%
Wolfe, WV- Mercer Co.	24751	1	0.3%
Ballard, WV- Monroe Co.	24918	1	0.3%
Lindside, WV- Monroe Co.	24951	1	0.3%
Union, WV- Monroe Co.	24983	1	0.3%
answered question		309	
skipped question		19	

Question 28: What is your street address (optional)?

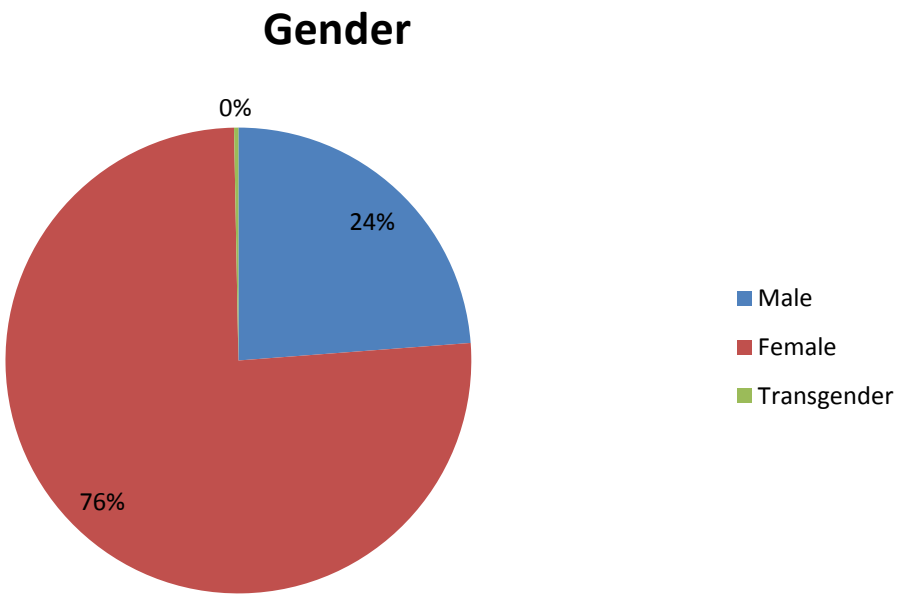
Results are not public and will be used for community health improvement initiatives

Question 29: What is your age?

Answer Options	Response Average
	49 years
answered question	277
skipped question	51

Question 30: What is your gender?

Answer Options	Response Percent	Response Count
Male	23.8%	68
Female	75.9%	217
Transgender	0.3%	1
answered question		286
skipped question		42



Question 31 and Question 32: What is your height, weight, and BMI calculation

What is your height?	
Answer Options	**Response Average**
Feet	5.27
Inches	4.93
answered question	**279**
skipped question	**49**

What is your weight?	
Answer Options	**Response Average**
Pounds	192.93
answered question	**268**
skipped question	**60**

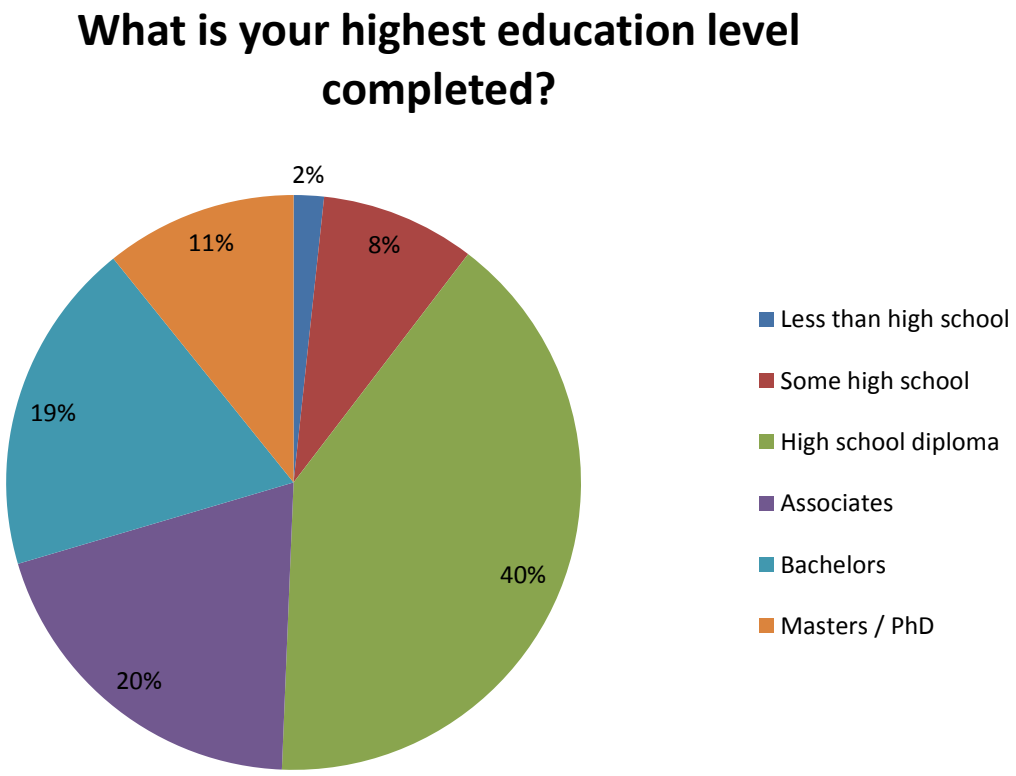
BMI Calculation	
Average BMI	29.40
answered question	**268**
skipped question	**60**

Question 33: How many people live in your home (including yourself)?

Answer Options	Response Average	Response Total	Response Count
Number who are 0 - 17 years of age:	1.49	293	197
Number who are 18 - 64 years of age :	2.08	523	252
Number who are 65 years of age or older:	.69	109	159
		answered question	**283**
		skipped question	**45**

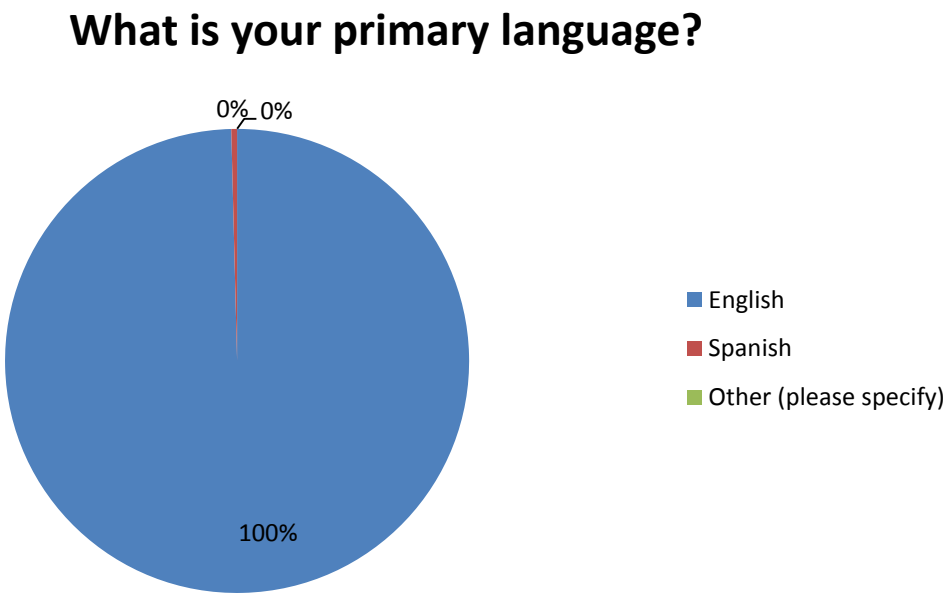
Question 34: What is your highest education level completed?

Answer Options	Response Percent	Response Count
Less than high school	1.7%	5
Some high school	8.7%	25
High school diploma	40.3%	116
Associates	19.8%	57
Bachelors	18.8%	54
Masters / PhD	10.8%	31
	answered question	288
	skipped question	40



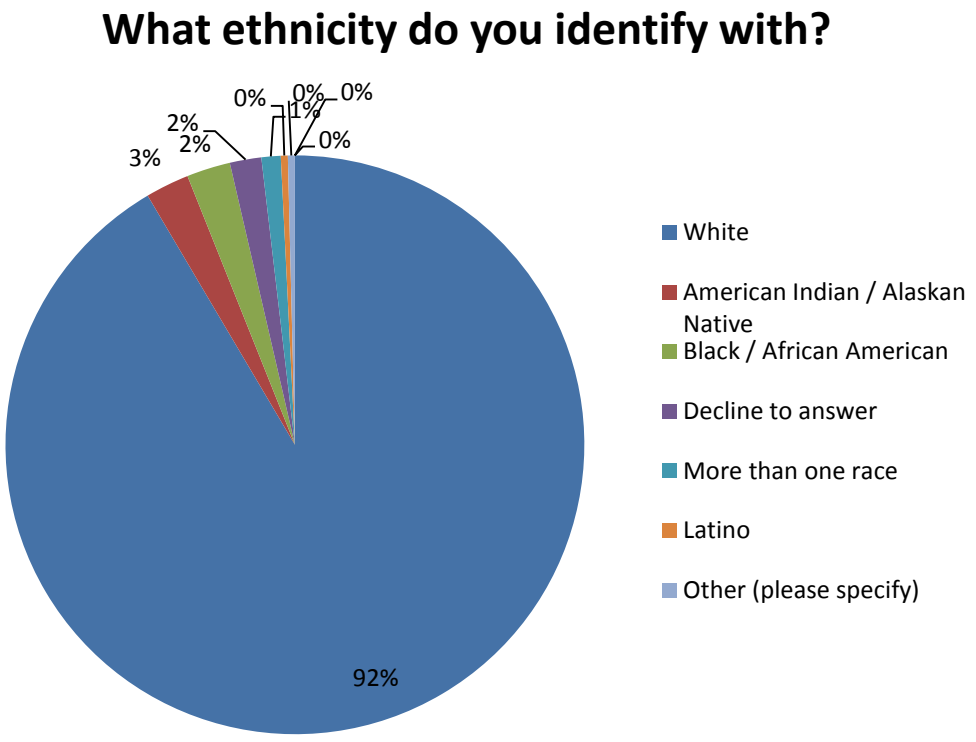
Question 35: What is your primary language?

Answer Options	Response Percent	Response Count
English	99.6%	283
Spanish	0.4%	1
Other (please specify)	0.0%	0
answered question		284
skipped question		44



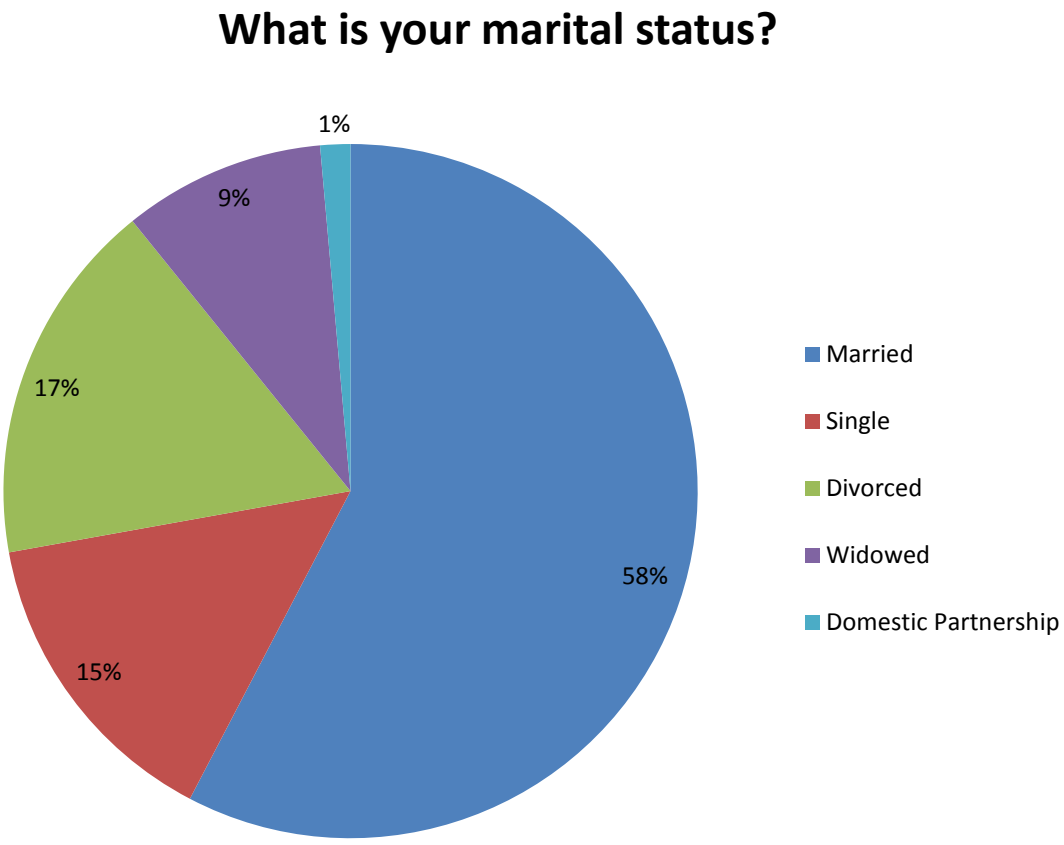
Question 36: What ethnicity do you identify with? (Check all that apply)

Answer Options	Response Percent	Response Count
White	93.7%	266
American Indian / Alaskan Native	2.5%	7
Black / African American	2.5%	7
Decline to answer	1.8%	5
More than one race	1.1%	3
Latino	0.4%	1
Other (please specify)	0.4%	1
Asian	0.0%	0
Native Hawaiian / Pacific Islander	0.0%	0
answered question		284
skipped question		44



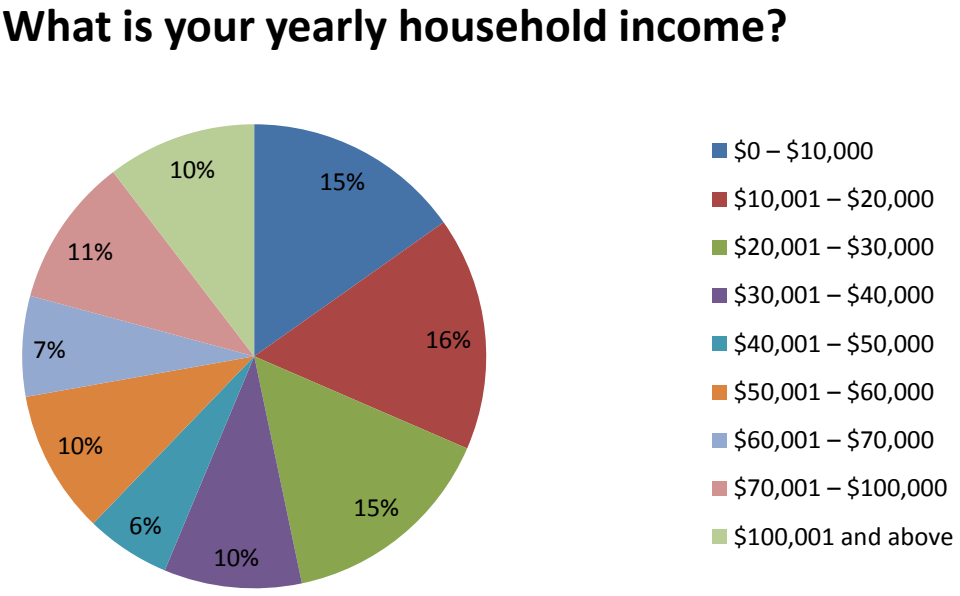
Question 37: What is your marital status?

Answer Options	Response Percent	Response Count
Married	57.6%	159
Single	14.5%	40
Divorced	17.0%	47
Widowed	9.4%	26
Domestic Partnership	1.4%	4
answered question		276
skipped question		52



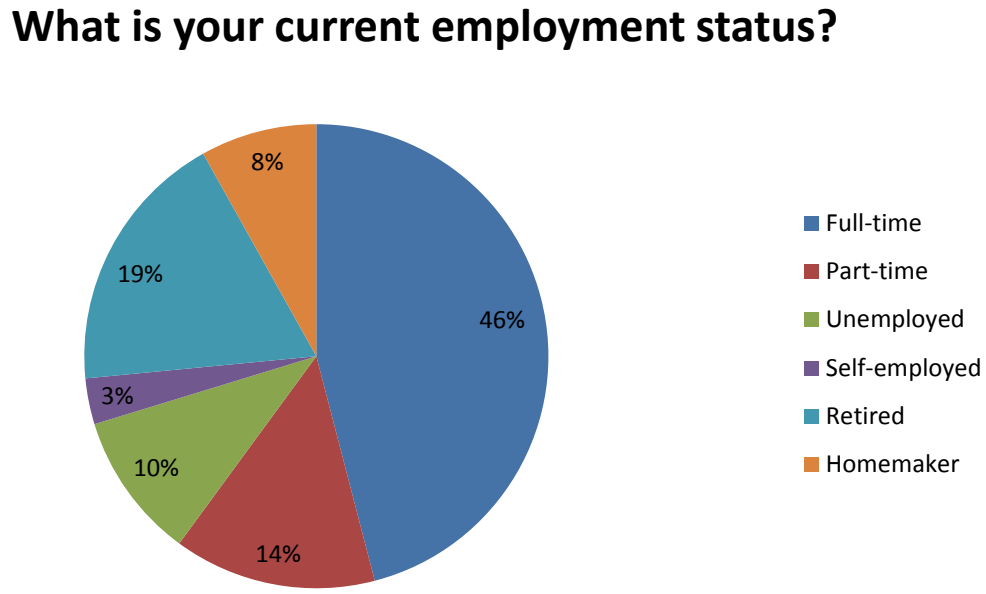
Question 38: What is your yearly household income?

Answer Options	Response Percent	Response Count
$0 - $10,000	15.2%	41
$10,001 - $20,000	16.3%	44
$20,001 - $30,000	15.2%	41
$30,001 - $40,000	9.6%	26
$40,001 - $50,000	5.9%	16
$50,001 - $60,000	10.0%	27
$60,001 - $70,000	7.0%	19
$70,001 - $100,000	10.4%	28
$100,001 and above	10.4%	28
	answered question	270
	skipped question	58



Question 39: What is your current employment status?

Answer Options	Response Percent	Response Count
Full-time	45.9%	130
Part-time	14.1%	40
Unemployed	10.2%	29
Self-employed	3.2%	9
Retired	18.4%	52
Homemaker	8.1%	23
answered question		283
skipped question		45



Secondary Data

Demographics and socioeconomic status

Social Determinants of Health

In the same way a person's DNA is the cornerstone of their individuality, social determinants of health shape wellbeing for billions of humans across the globe. The Center for Disease Control defines social determinants of health as "the circumstances in which people are born, grow up, live, work, and age, as well as the systems put in place to deal with illness[6]". These circumstances change over time as a person grows and moves around the living world. For this reason, social determinants of health are often used to identify at-risk populations and analyze what determinants impact their lives more than people not considered to be at-risk[6].

Individuals don't have complete control over social determinants of health. In fact, they are heavily influenced by large-scale processes like politics, economic change, and culture[6]. These forces also have power in deciding what health care systems are operational in a geographic area. Higher-income areas are commonly buzzing with private care physicians and health services while the lower-income areas depend heavily on charity and government-subsidized services as treatment. This keeps social mobilization from occurring, and the poor areas become sicker as the rich areas see improvement in health issues[7].

Healthy People 2020 has identified five main social determinants of health that need to be addressed in some way. Economic stability, education, social and community context, health and health care, and neighborhood and built environment have been named as the focus for governmental and organizational health system and wellbeing improvement by the year 2020 in the United States[8]. These five overarching topics include several subcategories that serve to direct specific actions and policy across the nation. Once the social determinants of health are identified in any context, the next important step is to devise a strategy for addressing the determinants and, ultimately, minimizing the negative impact that they have on the nation's most at-risk groups. No single strategy has been identified as the best or most effective for this task, but trial and error by social groups and government bodies has already brought much needed change to some of the needs areas[8].

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[6] Centers for Disease Control and Prevention. (2015). Social Determinants of Health. Retrieved from http://www.cdc.gov/socialdeterminants/

[7] World Health Organization. (n.d.-a) Social Determinants of Health: Key Concepts. Retrieved from http://www.who.int/social_determinants/thecommission/finalreport/key_concepts/en/

[8] Healthy People 2020. (2015-a). Social Determinants of Health. Retrieved from

A central task in analyzing social determinants of health is the process of discovering health disparities between subgroups in the same geographical area[9]. Health disparities are differences in physical and mental health or wellbeing that stem from differences in factors like race, ethnicity, and socioeconomic status[10]. When connections can be drawn between certain population subgroups, income levels, and the burden that illness places on the community, social disparities emerge as the problems that can be fixed. Social determinants of health provide the context needed to identify what issues need to be addressed and where improvement efforts should begin.

Population, gender, race and age

From 2010 to 2020, the U.S. Census Bureau projects population growth of 1.08% in Tazewell County. In comparison, Virginia will experience a 13.02% increase in its population and there will be a 10.6% increase in the United States as a whole. There were 44,334 residents who lived in Tazewell County in 2014.

[9] Robert Wood Johnson Foundation. (n.d.). Social Determinants of Health. from – http://www.rwjf.org/en/our-topics/topics/social-determinants-of-health.html

[10] Robert Wood Johnson Foundation. (n.d.). Social Determinants of Health. from – http://www.rwjf.org/en/our-topics/topics/social-determinants-of-health.html

Total Population by Geographic Location

(U.S. Census Bureau, 2010-2014 5-Year American Community Survey, Table S0101. Retrieved from http://factfinder.census.gov/faces/nav/jsf/pages/searchresults.xhtml?refresh=t#none)

Geography	Total Population
Virginia	8,185,131
Tazewell	44,331

Population Change Estimates, 2010 – 2040

(U.S. Census Bureau, Virginia Employment Commission. (2016). Community Profiles. Retrieved from http://data.virginialmi.com/gsipub/index.asp?docid=342.)

Geography	2010	% Change	2020	% Change	2030	% Change	2040	% Change
Virginia	8001024	13.02	8811512	10.13	9645281	9.46	10530229	9.17
Tazewell County	45078	1.08	45300	0.49	45436	.3	45535	.22

In the County of Tazewell, 50.1% of the population is female and 49.9% is male.[11]
The median age in the county of Tazewell is 43.1 years, which is slightly higher than the median age in Virginia as a whole (37.6).

Median Age by Geographic Location

(U.S. Census Bureau, 2010-2014 5-Year American Community Survey, Table S0101. Retrieved from http://factfinder.census.gov/faces/nav/jsf/pages/searchresults.xhtml?refresh=t#none)

Geography	Median Age (years)
Virginia	37.6
Tazewell	43.1

[11] US Census, Table QT-P1, Age Groups and Sex, 2010

Estimates of Population by Lifecycle, 5-Year Estimates, 2010 - 2014

(U.S. Census Bureau, 2010-2014 5-Year American Community Survey, Table S0101. Retrieved from http://factfinder.census.gov/faces/nav/jsf/pages/searchresults.xhtml?refresh=t#none)

	Under 5	5-14 years	15-17 years	18-64 years	Over 65 years
Virginia	6.30%	12.70%	3.90%	40.90%	12.60%
Tazewell County	5.2%	11%	3.6%	62.1%	18.1%

In the county of Tazewell, 95.09% of the population is white, 2.96% is black, and .296% is Hispanic.

Race and Ethnicity, 5-Year Estimate, 2010-2014

(U.S. Census Bureau, 2010-2014 5-Year American Community Survey, Table DP05. Retrieved from http://factfinder.census.gov/faces/nav/jsf/pages/searchresults.xhtml?refresh=t#none)

	White	Black	American Indian and Alaskan Native	Asian	Native Hawaiian and Other Pacific Islander	Some other race	Two or more races	Hispanic or Latino Origin	Not Hispanic or Latino
Tazewell County	95.1%	2.96%	.126%	.641%	.013%	.217%	.947%	.657%	99.34%
Virginia	69.50%	19.40%	0.30%	5.70%	0.10%	2.20%	2.90%	8.10%	91.90%

Tazewell County Public Schools Race/Ethnicity, 2013-2016

(Virginia Department of Education (2016). Fall Membership Reports. Retrieved from http://bi.vita.virginia.gov/doe_bi/rdPage.aspx?rdReport=Main&subRptName=Fallmembership)

School Year	School Type	Hispanic	American Indian/ Alaskan Native	Asian	Black, not of Hispanic origin	White	Native Hawaiian/ Other	2 or more
2013-2014								
	Elementary Schools	0.56%	0.00%	0.91%	2.38%	93.71%	0.00%	2.44%
	Middle Schools	0.41%	0.14%	1.03%	2.67%	93.29%	0.00%	2.46%
	High Schools	0.32%	0.005	0.75%	2.51%	95.63%	0.00%	0.80%
	District Grand Total	0.45%	0.03%	0.89%	2.48%	94.19%	0.00%	1.95%
2014-2015								
	Elementary Schools	0.67%	0.04%	0.78%	3.32%	92.51%	0.00%	2.68%
	Middle Schools	0.43%	0.00%	1.07%	1.70%	94.82%	0.00%	1.99%
	High Schools	0.33%	0.05%	0.71%	2.89%	94.77%	0.00%	1.25%
	District Grand Total	0.51%	0.03%	0.82%	2.82%	93.73%	0.00%	2.09%
2015-2016								
	Elementary Schools	0.56%	0.04%	0.52%	3.11%	92.89%	0.00%	2.89%
	Middle Schools	0.28%	0.00%	1.13%	1.90%	95.06%	0.00%	1.62%
	High Schools	0.49%	0.11%	0.75%	2.43%	94.07%	0.00%	2.16%
	District Grand Total	0.47%	.05%	0.74%	2.61%	93.77%	0.00%	2.36%

In the County of Tazewell 1.40% of the population 5 years and over speaks a language other than English at home compared 15.20% in Virginia and 20.8% in the United States.

Population 5 years and over whom speak a language other than English at home, 5-Year Estimate, 2010-2014

(U.S. Census Bureau, 2010-2014 5-Year American Community Survey, Table S1601. Retrieved from http://factfinder.census.gov/faces/nav/jsf/pages/searchresults.xhtml?refresh=t#none)

Locality	#	%
Tazewell	581	1.40%
Virginia	1,164,892	15.20%

Academic Attainment

There is a direct link to educational attainment, health literacy, and positive health outcomes. According to the Virginia Health Equity report, Virginians who don't attend, or complete, high school are more likely to die of heart disease, cancer and a dozen other leading causes of death than those who earn a diploma.

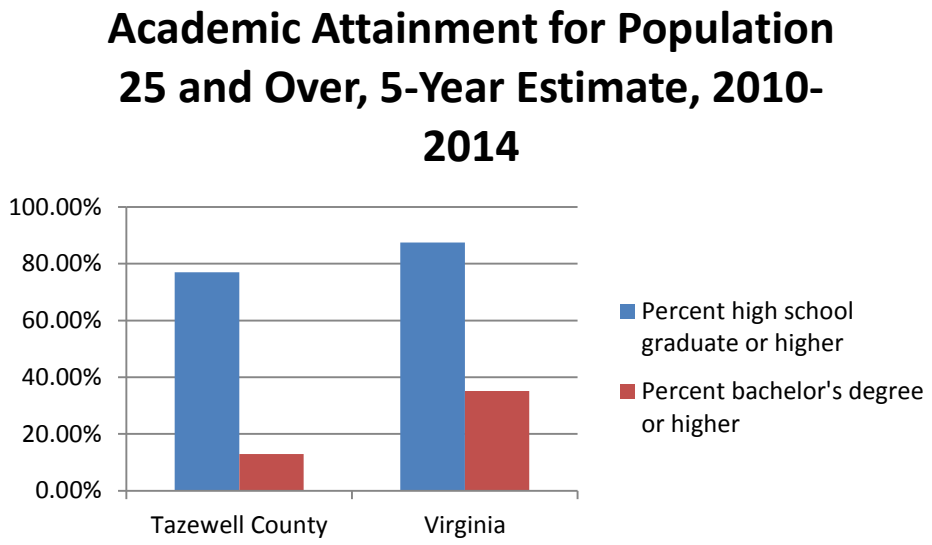
In the County of Tazewell, there is one public school division, Tazewell County Public Schools consisting of eight elementary, four middle, and three high schools.

Seventy eight percent (78.40%) of the population 25 years and over in Tazewell County has a high school diploma while only 12.80% have a Bachelor's Degree or higher.

Academic Attainment for Population 25 and Over, 5-Year Estimate, 2010-2014

(U.S. Census Bureau, 2010-2014 5-Year American Community Survey, Table S1501. Retrieved from http://factfinder.census.gov/faces/nav/jsf/pages/searchresults.xhtml?refresh=t#none)

	Percent high school graduate or higher	Percent bachelor's degree or higher
Tazewell County	77.00%	12.90%
Virginia	87.50%	35.20%



On Time Graduation Rates, Tazewell County

(Virginia Department of Education, Virginia Cohort Reports, Retrieved from http://www.doe.virginia.gov/statistics_reports/graduation_completion/cohort_reports/.)

MSA Localities	2013	2014	2015
Tazewell County	84.50%	84.90%	84.20%
Virginia	90.20%	90.90%	90.50%

On Time Graduation Rates, Tazewell County High Schools

(Virginia Department of Education, Virginia Cohort Reports, Retrieved from http://www.doe.virginia.gov/statistics_reports/graduation_completion/cohort_reports/.)

	2013	2014	2015
Graham High	90.10%	86.80%	91.50%
Richlands High	84.70%	84.80%	80.00%
Tazewell High	78.80%	83.20%	83.60%
Virginia	90.10%	89.90%	90.50%

Dropout Rates

(Virginia Department of Education, Annual Dropout Statistics, Retrieved from http://doe.virginia.gov/statistics_reports/graduation_completion/index.shtml)

MSA Localities	2013	2014	2015
Tazewell County	8.50%	6.60%	7.60%
Virginia	6.50%	5.40%	5.20%

Dropout Rates, Tazewell County High Schools

(Virginia Department of Education, Virginia Cohort Reports, Retrieved from http://www.doe.virginia.gov/statistics_reports/graduation_completion/cohort_reports/.)

	2013	2014	2015
Graham High	5.90%	6.60%	2.60%
Richlands High	10.00%	7.00%	10.00%
Tazewell High	9.60%	6.20%	8.60%
Virginia	6.50%	5.40%	5.20%

Income and Poverty Status

Median Household Income, 5-Year Estimates, 2009-2013 & 2010-2014

(U.S. Census Bureau, 2010-2014 5-Year American Community Survey, Table S1901. Retrieved from http://factfinder.census.gov/faces/nav/jsf/pages/searchresults.xhtml?refresh=t#none)

Location	Median Income 2009-2013	Median Income 2010-2014
Tazewell County	35,693	36,248
Virginia	63,907	64,792

The Federal Poverty Guidelines (FPL) is used to determine eligibility for many local, state, and federal assistance programs. It is based on an individual's or family's annual cash income before taxes. Updated yearly by the Census Bureau, the 2013, 2014, and 2015 guidelines are provided below as a reference.[12]

2014 Federal Poverty Guidelines for the 48 Contiguous States and the District of Columbia	
Persons in Family/household	Poverty Guideline
1	11,670
2	15,730
3	19,790
4	23,850
5	27,910
6	31,970
7	36,030
8	40,090
For families/household with more than eight persons, add $4,060 for each additional person.	

(Federal Register. *2014 Poverty Guidelines for the 48 Contiguous States and the District of Columbia.* Vol. 79, January 22, 2014, pp. 3593-3594. Retrieved from https://federalregister.gov/a/2014-01303)

[12] http://aspe.hhs.gov/poverty/13poverty.cfm

2015 Federal Poverty Guidelines for the 48 Contiguous States and the District of Columbia	
Persons in Family/household	Poverty Guideline
1	11,770
2	15,930
3	20,090
4	24,250
5	28,410
6	32,570
7	36,730
8	40,890
For families/household with more than eight persons, add $4,160 for each additional person.	

(Federal Register. *2015 Poverty Guidelines for the 48 Contiguous States and the District of Columbia.* Vol. 80, January 22, 2015, pp. 3236-3237. Retrieved from https://federalregister.gov/a/2015-01120)

2016 Federal Poverty Guidelines for the 48 Contiguous States and the District of Columbia	
Persons in Family/household	Poverty Guideline
1	11,880
2	16,020
3	20,160
4	24,300
5	28,440
6	32,580
7	36,730
8	40,890
For families/household with more than eight persons, add $4,160 for each additional person.	

(Federal Register. 2016 Poverty Guidelines for the 48 Contiguous States and the District of Columbia. Vol. 81, January 22, 2016, pp. 3236-3237. Retrieved from https://federalregister.gov/a/2016-01120)

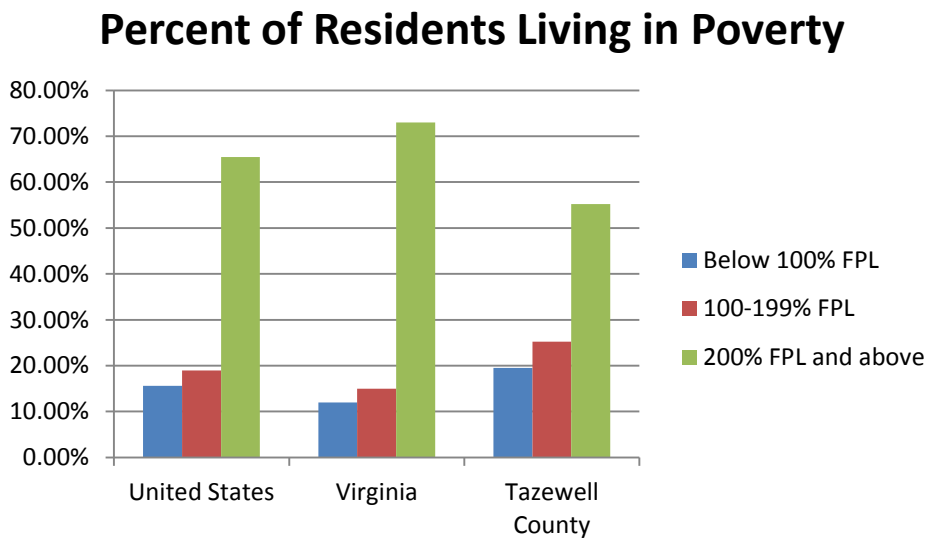
The guidelines reflect 100% of the FPL. To calculate 200% of the FPL, multiply the listed income level by two.

In the County of Tazewell, 44.76% of residents for whom poverty was determined live below 200% of the FPL as compared to 27.0% in Virginia and 34.54% in the United States.

Number of Residents Living in Poverty, 2010-2014

(U.S. Census Bureau, 2010-2014 5-Year American Community Survey, Table C17002. Retrieved from http://factfinder.census.gov/faces/nav/jsf/pages/searchresults.xhtml?refresh=t#none)

	Below 100% FPL		100-199% FPL		200% FPL and above		Total	
	#	%	#	%	#	%	#	%
United States	47,75,606	15.59%	58,017,801	18.95%	200,452,987	65.46%	306,226,394	100%
Virginia	914,237	12.00%	1,227,921	15.00%	5,797,174	73.00%	7,939,332	100%
Tazewell County	8,375	19.51%	10,839	25.25%	23,708%	55.24%	42,922	100%



In the county of Tazewell a disproportionate number of children less than 6 years of age (60.65%) and 6-17 years of age (50.99%) live below 200% of FPL.

Ratio of Income by Poverty Status by Age, Tazewell

(American Community Survey 5-Year Estimates, U.S. Census Bureau, ,Table B17024, 2010-2014. Retrieved from http://factfinder.census.gov/faces/nav/jsf/pages/searchresults.xhtml?refresh=t#none)

< 6 years of age						
	Below 100% FPL		100-199% FPL		200% FPL & over	
	#	%	#	%	#	%
United States	5859390	24.71%	5469940	23.07%	12379706	52.22%
Virginia	106060	17.44%	119773	19.69%	382384	62.87%
Tazewell County	848	30.22%	854	30.43%	1104	39.34%

6-17 years						
	Below 100% FPL		100-199% FPL		200% FPL & over	
	#	%	#	%	#	%
United States	10048005	20.54%	10739094	21.95%	28141750	57.52%
Virginia	173299	14.11%	285855	23.27%	830912	67.63%
Tazewell County	1466	25.16%	1505	25.83	2856	49.01%

Of adults 18-64 years of age, 40.91% who live in the County, live below 200% of the FPL as compared to 24.57% in Virginia, and 31.61% in the United States.

Almost half the seniors 65 years of age and older in the Tazewell area (47.5%), live below 200% of poverty as compared to 26.5% statewide, and 31.2% nationally.

18-64 years						
	Below 100% FPL		100-199% FPL		200% FPL & over	
	#	%	#	%	#	%
United States	27921695	14.57%	32653021	17.04%	131142249	68.42%
Virginia	555771	10.97%	688952	13.60%	3823182	75.44%
Tazewell County	5034	19.03%	5786	21.88%	15630	59.09%

65 years & >						
	Below 100% FPL		100-199% FPL		200% FPL & over	
	#	%	#	%	#	%
United States	3926219	9.38%	9155746	21.87%	28789282	68.76%
Virginia	79107	7.64%	194821	18.82%	760993	73.53%
Tazewell County	1027	13.10%	2694	34.37%	4118	52.53%

In the county of Tazewell more whites live in poverty (19%) as compared to Virginia (9.20%). More blacks live in poverty in the city (34.9%) as compared to the statewide averages (20.10%) as well.[13]

Poverty Status in the Past 12 Months by Race/Ethnicity, 2010-2014

(U.S. Census Bureau, 2010-2014 5-Year American Community Survey, Table S1701. Retrieved from http://factfinder.census.gov/faces/nav/jsf/pages/searchresults.xhtml?refresh=t#none)

Geography	White			Black/African American		
	Population	Number in Poverty	Percent	Population	Number in Poverty	Percent
Virginia	5,520,140	505,667	9.20%	1,501,394	301,972	20.10%
Tazewell County	41,108	7,888	19%	813	284	34.90%

Geography	American Indian/Alaskan Native			Asian			Native Hawaiian and Other Pacific Islander		
	Population	Number in Poverty	Percent	Population	Number in Poverty	Percent	Population	Number in Poverty	Percent
Virginia	22,245	3,094	13.90%	467,627	38,712	8.30%	4,966	544	11.00%
Tazewell County	47	0	0.00%	163	38	23%	0	0	0.00%

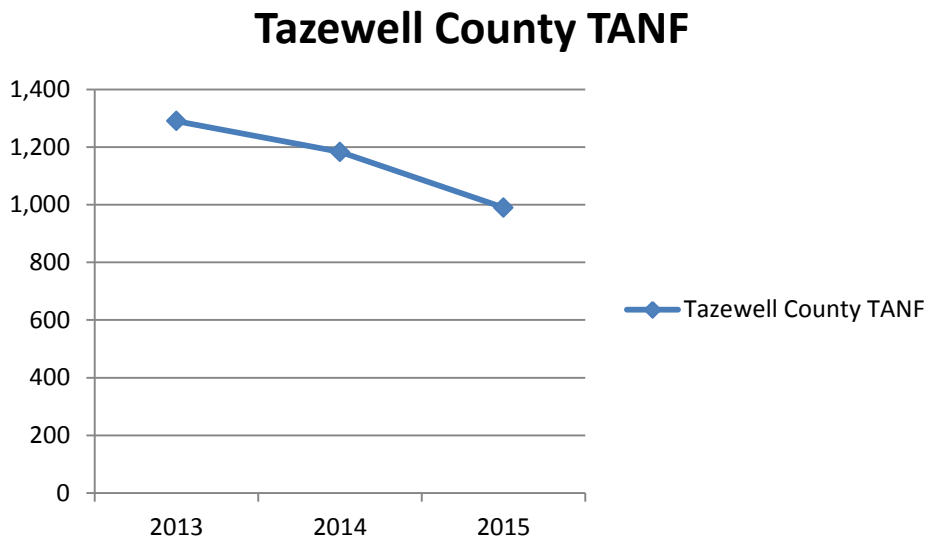
Geography	Some Other Race			Two or More Races		
	Population	Number in Poverty	Percent	Population	Number in Poverty	Percent
Virginia	175,067	30,181	17.20%	247,893	31,067	13.70%
Tazewell County	11	11	100.00%	780	154	19.70%

[13] US Census Bureau, American Community Survey, 1-year estimates, 2010

Number of TANF Recipients for Tazewell County, 2013-2015

(Virginia Department of Social Services. Local Departments of Social Services Profile Report. Local Agency Caseload & Expenditure, SFY 2013-2015. Retrieved from http://www.dss.virginia.gov/geninfo/reports/agency_wide/ldss_profile.cgi

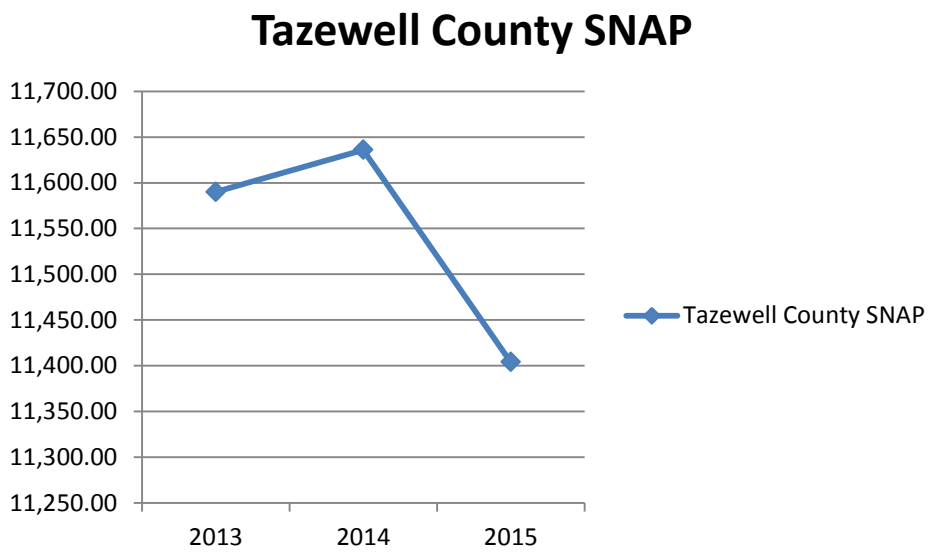
	2013	2014	2015
Tazewell County	1290	1183	990



Number of SNAP Recipients for Tazewell County, 2013-2015

(Virginia Department of Social Services. Local Departments of Social Services Profile Report. Local Agency Caseload & Expenditure, SFY 2013-2015. Retrieved from http://www.dss.virginia.gov/geninfo/reports/agency_wide/ldss_profile.cgi

	2013	2014	2015
Tazewell County	11590	22636	11404



In the county of Tazewell, 52.88% of children and adolescents are eligible for the Free and Reduced Lunch Program, as compared to 41.2% for Virginia school districts as a whole.[14]

Students Eligible for Free and Reduced Lunch Program, 2012-2015

(Virginia Department of Education, Office of School Nutrition Programs. Free and Reduced Price Eligibility Report, Division Level. Retrieved from http://www.doe.virginia.gov/support/nutrition/statistics/.)

Locality	% Eligible for Free or Reduced Lunch 2013	% Eligible for Free or Reduced Lunch 2014	% Eligible for Free or Reduced Lunch 2015	% Eligible for Free or Reduced Lunch 2016
Tazewell County	51.06%	51.97%	52.37%	52.88%
Virginia	40.10%	41.19%	41.95%	41.20%

Tazewell County Public Schools Free and Reduced Lunch Eligibility, 2015-2016

(Virginia Department of Education, Office of School Nutrition Programs. Free and Reduced Price Eligibility Report, School/Site Level. Retrieved from http://www.doe.virginia.gov/support/nutrition/statistics/.)

	SNAP Membership	Free Lunch Eligible	%Free Lunch Eligible	Reduced Lunch Eligible	%Reduced Lunch Eligible	Total F/R Lunch Eligible	% Total F/R Lunch Eligible
Elementary Schools							
Abbs Valley-Boissevian	168	98	58.33%	21	12.50%	119	70.83%
Cedar Bluf	420	180	42.86%	32	7.62%	212	50.48%
Dudley Primary	267	118	44.19%	22	8.24	140	52.43%
Graham Intermediate	296	105	35.47%	20	6.76%	125	42.23%
North Tazewell	299	183	61.20%	25	8.36%	208	69.57%
Raven	139	116	83.45%	3	2.16%	119	85.61%
Richlands	568	326	57.39%	28	4.93%	354	62.32%
Springville	130	60	46.15%	20	15.38%	80	61.54%
Tazewell	538	267	49.63%	45	8.36%	213	57.99%
Middle Schools							
Graham	404	141	34.90%	30	7.43%	171	42.33%
Richlands	577	261	45.23%	40	6.93%	301	52.17%
Tazewell	435	206	47.36%	32	7.36%	238	54.71%
High Schools							
Graham	564	186	32.98%	42	7.45%	228	40.43%
Richlands	686	274	39.94%	31	4.52%	305	44.46%
Tazewell	583	249	42.71%	51	8.75%	300	51.46%

[14]Virginia Department of Education, Office of School Nutrition Program,National School Lunch Program Free & Reduced Price Eligibility Report, October 31, 2011

Tazewell County Public Schools Free and Reduced Lunch Eligibility, 2014-2015

(Virginia Department of Education, Office of School Nutrition Programs. Free and Reduced Price Eligibility Report, School/Site Level. Retrieved from http://www.doe.virginia.gov/support/nutrition/statistics/.)

	SNAP Membership	Free Lunch Eligible	%Free Lunch Eligible	Reduced Lunch Eligible	%Reduced Lunch Eligible	Total F/R Lunch Eligible	% Total F/R Lunch Eligible
Elementary Schools							
Abbs Valley-Boissevian	160	84	52.50%	30	18.75%	114	71.25%
Cedar Bluf	439	186	42.37%	24	5.47%	210	47.84%
Dudley Primary	295	126	42.71%	22	7.46%	148	50.17%
Graham Intermediate	302	106	35.10%	26	8.61%	132	43.71%
North Tazewell	311	206	66.24%	23	7.40%	229	73.635
Raven	192	143	74.78%	10	5.21%	153	79.69%
Richlands	591	323	54.65%	37	6.26%	360	60.91%
Springville	132	63	47.73%	12	9.09%	75	56.82%
Tazewell	542	252	46.49%	40	7.38%	292	53.87%
Middle Schools							
Graham	403	148	36.72%	31	7.69%	179	44.42%
Richlands	549	246	44.81%	39	7.10%	285	51.91%
Tazewell	542	252	46.49%	40	7.38%	292	53.87%
High Schools							
Graham	546	171	31.32%	42	7.69%	213	39.01%
Richlands	665	259	38.95%	32	4.81%	291	43.76%
Tazewell	607	259	42.67%	46	7.58%	305	50.25%

Households and Marital Status

Marital Status, Population 15 years and over, 2010-2014, Percentage

(U.S. Census Bureau, 2010-2014 5-Year American Community Survey, Table S1201. Retrieved from http://factfinder.census.gov/faces/nav/jsf/pages/searchresults.xhtml?refresh=t#none)

Geography	Now Married (except separated)	Widowed	Divorced	Separated	Never Married
Virginia	50.40%	5.60%	10.00%	2.50%	31.50%
Tazewell County	54.80%	9.60%	11.50%	2.60%	21.50%

Percent of Children Living in Single Parent Households, 2010, by Race/Ethnicity

(U.S. Census Bureau, 2010 Census Summary File 1, Table P31, P31A, P31B, P31H. Retrieved from http://factfinder.census.gov/faces/nav/jsf/pages/searchresults.xhtml?refresh=t#none)

Geography	Total Child Population	White	African American	Hispanic or Latino
Virginia	23.97%	17.73%	44.70%	24.03%
Tazewell County	23.06%	22.16%	43.78%	22.35%

*Note: Refers to population of children (< 18 years) living in their own parents' households. Excludes minors who are heads of households, spouses, or other relatives (e.g., grandchildren) living in the household as well as children living in institutionalized settings. Hispanic origin is not mutually exclusive of race.

There are many more families (14.20%) in the county of Tazewell that live below 100% of poverty as compared to those statewide (8.20%). This disparity is even greater for families living in poverty with children under 18 years of age where 24.70% of families in the county of Tazewell live below 100% of FPL, almost two and a half times the number of families statewide (13.00%). In Tazewell, over half of families (51.90%) with a female head of household and children less than 18 years of age live below 100% FPL, compared to 34.40% in Virginia as a whole.

Families Living in Poverty

(U.S. Census Bureau, 2009-2013 and 2010-2014 5-Year American Community Survey, Table S1702. Retrieved from http://factfinder.census.gov/faces/nav/jsf/pages/searchresults.xhtml?refresh=t#none)

Geography	Percent 2009-2013	Percent 2010-2014	Percent Change
Virginia	8.00%	8.20%	2.50%
Tazewell County	14.10%	14.20%	0.70%

Families Living in Poverty with Related Children Under 18 Years

(U.S. Census Bureau, 2008-2012 and 2009-2013 5-Year American Community Survey, Table S1702. Retrieved from http://factfinder.census.gov/faces/nav/jsf/pages/searchresults.xhtml?refresh=t#none)

Geography	2009-2013	2010-2014	Percent Change
Virginia	12.60%	13.00%	3.17%
Tazewell County	23.80%	24.70%	3.78%

Female Head of Household with Related Children Under 18 Years Living in Poverty

(U.S. Census Bureau, 2009-2014 5-Year American Community Survey, Table S1702. Retrieved from http://factfinder.census.gov/faces/nav/jsf/pages/searchresults.xhtml?refresh=t#none)

Geography	2009-2013	2010-2014	Percent Change
Virginia	33.20%	34.40%	3.61%
Tazewell County	52.90%	51.90%	-1.00%

Percent of Grandparents Living with Grandchildren who are Responsible for their Grandchildren with No Parent of the Grandchild Present

(U.S. Census Bureau, 2009-2014 5-Year American Community Survey, Table S1002. Retrieved from http://factfinder.census.gov/faces/nav/jsf/pages/searchresults.xhtml?refresh=t#none)

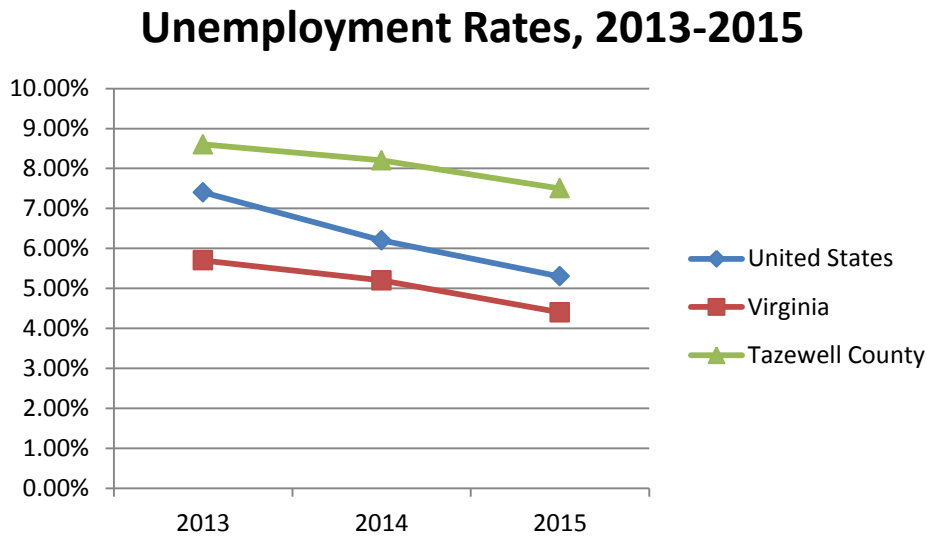
Geography	2009-2013	2010-2014	Percent Change
Virginia	13.00%	12.60%	-3.08%
Tazewell County	28.60%	26.20%	-8.39%

Employment Status

Unemployment Rates for Tazewell, Virginia, and U.S. 2013-2015

(Virginia Employment Commission, Local Area Unemployment Statistics, Retrieved from https://data.virginialmi.com/gsipub/index.asp?docid=342)

	2013	2014	2015
Tazewell County	8.60%	8.20%	7.50%
Virginia	5.70%	5.20%	4.40%
United States	7.40%	6.20%	5.30%



Transportation

In Tazewell County, 8.5% of people live in housing without an available vehicle as compared to the state's average (6.4%).[15]

Occupied Housing Units with No Vehicles Available, Tazewell, 2010-2014

(U.S. Census Bureau, 2010-2014 5-Year American Community Survey, Table DP04. Retrieved from http://factfinder.census.gov/faces/nav/jsf/pages/searchresults.xhtml?refresh=t#none)

	#Occupied housing units with no vehicles available	%Occupied housing units with no vehicles available
Virginia	194,153	6.40%
Tazewell County	1553	8.50%

Lack of access to reliable transportation is one of the most pervasive barriers to regular health care for families and individuals. The result is missed opportunities for preventive and routine care. Target Population Focus Group participants noted a reliance on friends and family for doctors' appointments which is an unreliable mode of transportation, given the lack of "control" over their arrivals and departures.

[15] US Census Bureau American Community Survey 5-year estimates, 2006-2010

Access to health care

Access to health services is one of Healthy People 2020's Leading Health Indicators and its goal is to improve access to comprehensive, quality health care services. Objectives related to this goal include:

- Increase the proportion of persons with a usual primary care provider (AHS-3)
- Increase the number of practicing primary care providers (AHS-4)
- Increase the proportion of persons who have a specific source of ongoing care (AHS-5)
- Reduce the proportion of individuals who are unable to obtain or delay in obtaining necessary medical care, dental care, or prescription medicines (AHS-6)[16]

Disparities in access to health services directly affect quality of life and are impacted by having health insurance and ongoing sources of primary care. Individuals who have a medical home tend to receive preventive health care services, are better able to manage chronic disease conditions, and decrease emergency room visits for primary care services.[17]

Health staffing shortages and designations

Tazewell County is designated Medically Underserved Areas (MUA). Health Professional Shortage Areas (HPSA) are present for Primary Care, Dental, Mental Health providers and are outlined in the following table.

[16] US Department of Health & Human Services, Healthy People 2020, Topics and Objectives, www.healthypeople.gov

[17] Closing the Divide: How Medical Homes Promote Equity in Health Care: Results from the Commonwealth Fund 2006 Health Care Quality Survey, Volume 62, June 27, 2007

Tazewell Health Professional Shortage Areas

(Find Shortage Areas: HPSA by State & Country.(2014).U.S. Department of Health and Human Services: Health Resources and Services Administration. Retrieved from http://hpsafind.hrsa.gov/HPSASearch.aspx. Find Shortage Areas: MUA/P by State & County. (2014). U.S. Department of Health and Human Services: Health Resources and Services Administration. Retrieved from http://muafind.hrsa.gov/index.aspx)

Geography	MUA	Primary Care HPSA	Dental HPSA	Mental Health HPSA
Tazewell County	Tazewell Service Area	Low Income- Tazewell County; Bluefield Internal Medicine; Clinch Valley Physicians, Inc.; Merit Medical Rural Health Clinic Richland's	Low Income- Tazewell County	Cumberland Mountain Service Area (Tazewell); Pocahontas State Correctional Center

Health Services Professionals

There is a direct relationship between the number of primary care providers in a community and improved health outcomes. Having an adequate supply of primary care providers is a measure of access to care and can be determined by calculating the ratio of the population to one Full-time Equivalent (FTE) provider. It is important to note that this information may at times under- or over-estimate the number of providers in the area; does not take into account patient satisfaction, how care is provided and utilization of services by the patients; and finally this measure does not reflect how care is coordinated within a community.[18]

[18] County Health Rankings, 2012 Data and Methods, http://www.countyhealthrankings.org/health-factors/access-care accessed 8/18/12

Primary Care Providers Population Ratio, 2013

(HRSA Area Resource File. (2013). Retrieved from http://www.countyhealthrankings.org/app/virginia/2016/measure/factors/4/map)

Geography	#PCP	PCP Rate	PCP Ratio
Virginia	6,216	75	1329:1
Tazewell	34	77	1297:1

Primary Care Providers Population Ratio, 2012

(HRSA Area Resource File. (2012). Retrieved from http://www.countyhealthrankings.org/app/virginia/2015/measure/factors/4/map)

Geography	#PCP	PCP Rate	PCP Ratio
Virginia	6,091	74	1344:1
Tazewell	38	86	1165:1

Primary Care Providers Population Ratio, 2011

(HRSA Area Resource File. (2011). Retrieved from http://www.countyhealthrankings.org/app/virginia/2014/measure/factors/4/map))

Geography	#PCP	PCP Rate	PCP Ratio
Virginia	6,021	74	1345:1
Tazewell	39	87	1147:1

Mental Health Providers Population Ratio, 2015

(HRSA Area Resource File. (2015). Retrieved from http://www.countyhealthrankings.org/app/virginia/2016/measure/factors/4/map)

Geography	#MHP	MHP Rate	MHP Ratio
Virginia	12,162	146	685:1
Tazewell	60	138	724:1

Mental Health Providers Population Ratio, 2014

(HRSA Area Resource File. (2014). Retrieved from http://www.countyhealthrankings.org/app/virginia/2015/measure/factors/4/map)

Geography	#MHP	MHP Rate	MHP Ratio
Virginia	11,406	138	724:1
Tazewell	56	127	788:1

Mental Health Providers Population Ratio, 2013

(HRSA Area Resource File. (2013). Retrieved from http://www.countyhealthrankings.org/app/virginia/2014/measure/factors/4/map)

Geography	#MHP	MHP Rate	MHP Ratio
Virginia	8,205	100	998:1
Tazewell	23	52	1925:1

Dentist Population Ratio, 2014

(HRSA Area Resource File. (2014). Retrieved from http://www.countyhealthrankings.org/app/virginia/2016/measure/factors/4/map)

Geography	#Dentists	Dentist Rate	Dentist Ratio
Virginia	5,303	64	1570:1
Tazewell	17	39	2556:1

Dentist Population Ratio, 2013

(HRSA Area Resource File. (2013). Retrieved from http://www.countyhealthrankings.org/app/virginia/2015/measure/factors/4/map)

Geography	#Dentists	Dentist Rate	Dentist Ratio
Virginia	5127	62	1611:1
Tazewell	15	34	2940:1

Dentist Population Ratio, 2012

(HRSA Area Resource File. (2012). Retrieved from http://www.countyhealthrankings.org/app/virginia/2014/measure/factors/4/map)

Geography	#Dentists	Dentist Rate	Dentist Ratio
Virginia	4951	60	1653:1
Tazewell	15	34	2951:1

Source of Primary Care and Cost of Services

Primary care services are the center of modern health care systems. According to Healthy People 2020, there are three main steps in accessing primary health care services. First, an individual needs to enter the health care system. This may happen in several different ways. For example, entry can occur as a new patient in a private practice, community health center or as an emergency room patient. Next, the individual needs to access location where the health care services they need are provided. This could be through a referral, a discharge from the hospital to another location, or from independent research. Finally, the individual needs to find a health care provider in the location they have chosen that they trust with their wellbeing and are able to communicate with. This is often the lengthiest part of the process, as doctors often have long wait times for appointments. Cultural differences and language barriers also contribute to the complicated process. Once these three steps are completed, a patient is defined as having successfully accessed the health system[19].

Currently, one in fifteen American citizens depend on government-provided primary health services. This reliance on community health services has forced public health to grow rapidly in order to accommodate the nearly 22 million patients that utilize health centers today[20]. The wide range of services provided by primary care professionals makes it a cornerstone of the entire U.S. health care system. In order to make sure the services rendered to patients are high-quality and utilize new technology, access to primary care needs the support of a hefty budget[42]. The transition to electronic medical records has already occurred in nearly 90 percent of federally qualified health centers. This technological innovation has made it easier and faster to integrate new patients into health centers everywhere[41].

Improving the accessibility of primary care health services in this country is an expensive and somewhat lengthy process, but the benefits of Americans having a primary care health professional to monitor their wellbeing outweigh the cost.

Having a usual source of care and cost of services greatly impacts an individual's ability to access primary care especially the low-income and uninsured populations living in a community. In Tazewell County 19% of people reported that they could not see a doctor due to cost which is much higher than in Virginia as a whole.

[19] Healthy People 2020. (2015). Access To Health Services. Retrieved from http://www.healthypeople.gov/2020/topics-objectives/topic/Access-to-Health-Services

[20] Health Resources and Services Administration. (n.d.). Health Center Program: What Is A Health Center? Retrieved from http://bphc.hrsa.gov/about/what-is-a-health-center/index.html

Percent of People Who Could Not See a Doctor Due to Cost, 2006-2012

(HRSA Area Resource File. (2006-2012). Retrieved from http://www.countyhealthrankings.org/app/virginia/2015/measure/factors/4/map)

Geography	% Couldn't Access 2006-2012
Virginia	11.50%
Tazewell County	19.40%

Insurance Status

There is a greater number of uninsured individuals (15%), Medicaid (20%), and Medicare (25%) recipients in the Tazewell County as compared to statewide. There are fewer individuals with employer based insurance plans (48.4%).

Health Insurance Status, 2010-2014

(http://factfinder.census.gov/faces/tableservices/jsf/pages/productview.xhtml?pid=ACS_14_5YR_S2701&prodType=table)

Insurance Type	Virginia		Tazewell	
	#	%	#	%
Medicaid	865,073	10.90%	8,625	20%
Medicare	1,180,282	14.80%	10,862	25.10%
Private	5,944,729	74.60%	25,458	58.80%
Direct-Purchase	1,042.55	13.10%	4,946	11.40%
Employer Based	4,799,029	60.20%	20,928	48.40%
Uninsured	968,444	12.10%	6,482	15.00%

Less Than 200% FPL Health Insurance Status by Age, Virginia

(U.S Census Bureau, American Community Survey 2011-2013, 3-Year Estimates, Table B27016. Retrieved from http://factfinder.census.gov/faces/nav/jsf/pages/searchresults.xhtml?refresh=t#none)

2013	< 18 Years		18-64		65+		All Ages	
With health insurance	573569	90.74%	774657	61.42%	269020	98.60%	1617246	74.66%
Employer-based health insurance	161325	25.52%	392888	31.15%	60121	22.04%	614334	28.36%
Direct-purchase health insurance	33268	5.26%	119231	9.45%	94883	34.78%	247382	11.42%
Medicare	11901	1.88%	96393	7.64%	265435	97.29%	373729	17.25%
Medicaid	369825	58.51%	218111	17.29%	57610	21.12%	645546	29.80%
No health insurance	58519	9.26%	486662	38.58%	3810	1.40%	548991	25.34%
Total Number < 200% FPL	632088		1261319		272830		2166237	

Less Than 200% FPL Health Insurance Status by Age, Tazewell County

(U.S Census Bureau, American Community Survey 2011-2013, 3-Year Estimates, Table B27016. Retrieved from http://factfinder.census.gov/faces/nav/jsf/pages/searchresults.xhtml?refresh=t#none)

	< 18 Years		18-64		65+		All Ages	
	#	%	#	%	#	%	#	%
With health insurance	4005	88.18%	7060	64.20%	3695	98.69%	14760	76.54%
Employer-based health insurance	841	18.52%	2476	22.52%	947	25.29%	4264	22.11%
Direct-purchase health insurance	144	3.17%	763	6.94%	856	22.86%	1763	9.14%
Medicare	0	0	1971	17.92%	3689	98.53%	5660	29.35%
Medicaid	3320	73.10%	2896	26.33%	906	24.20%	7122	36.93%
No health insurance	537	11.82%	2733	24.85%	49	1.31%	3319	17.21%
Total Number < 200% FPL	4542		10997		3744		19283	

Health status of the population

Percent of Adults Reporting Fair to Poor Health and the Number of Poor Physical Health Days in the Past Month, 2014

(Behavioral Risk Factor Surveillance System (2014). Retrieved from http://www.countyhealthrankings.org/app/virginia/2016/downloads)

	Poor or Fair Health	Poor Physical Health Days
Geography	% Poor or Fair Health	Physically Unhealthy Days
Virginia	17	3.5
Tazewell County	16	3.9

Percent of Adults Reporting Fair to Poor Health and the Number of Poor Physical Health Days in the Past Month, 2006-2012

(Behavioral Risk Factor Surveillance System (2006-2012). Retrieved from http://www.countyhealthrankings.org/app/virginia/2015/downloads)

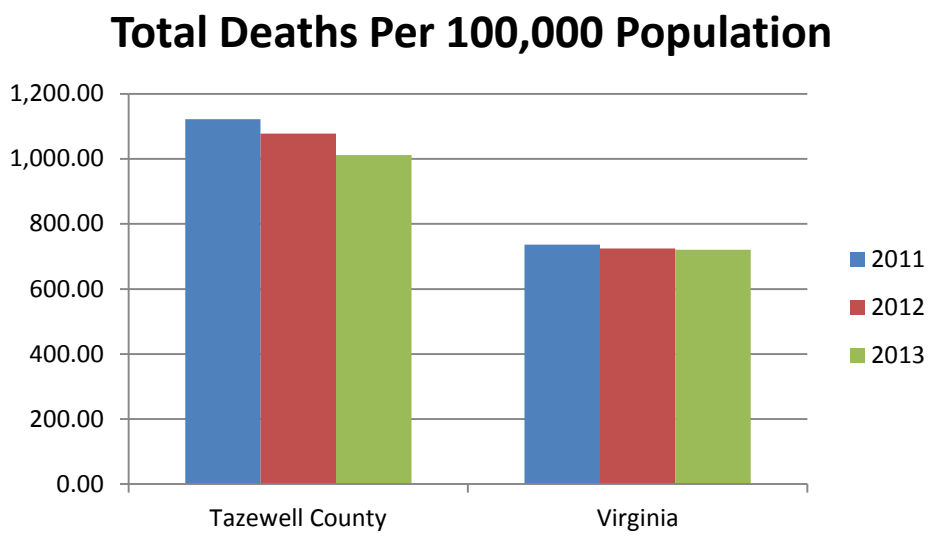
	Poor or Fair Health	Poor Physical Health Days
Geography	% Poor or Fair Health	Physically Unhealthy Days
Virginia	14	3.2
Tazewell County	29	5.9

Death Rates

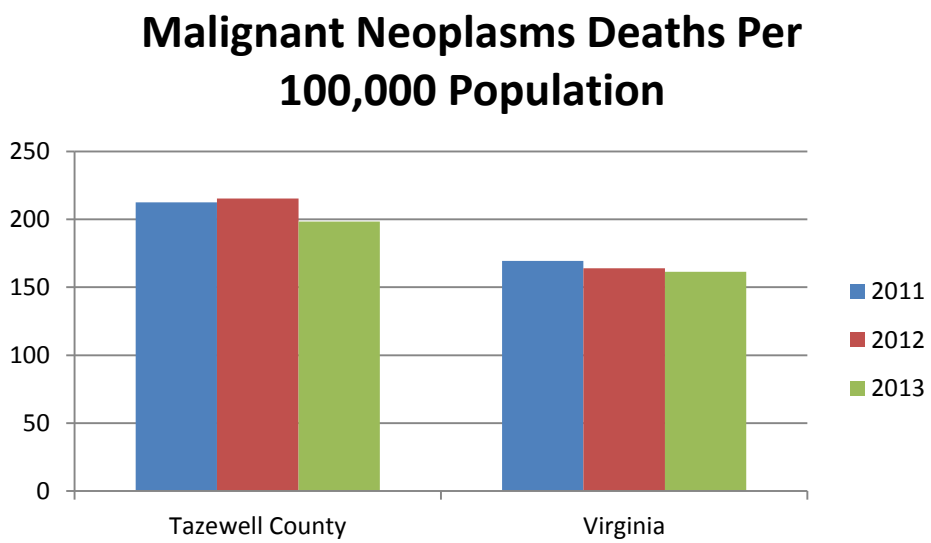
Tazewell County Statistical Area Deaths Age-Adjusted Rates per 100,000

(Statistical Reports and Tables (2014). Virginia Department of Health: Division of Health Statistics. Retrieved from http://www.vdh.virginia.gov/healthstats/stats.htm#pop)

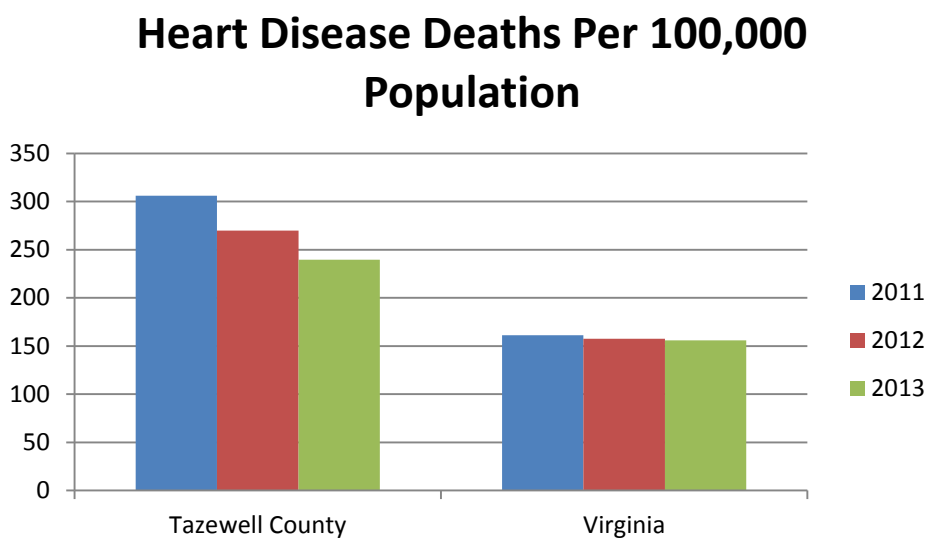
Geography	2011	2012	2013
Tazewell County	1,122.40	1,078.10	1,011.70
Virginia	735.8	724.9	720.1



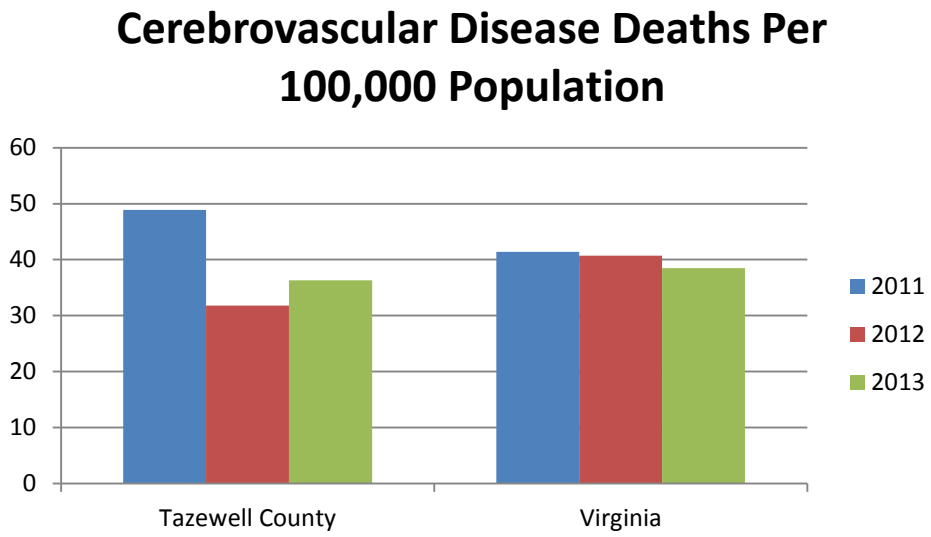
Malignant Neoplasms Deaths per 100,000 Population			
Geography	2011	2012	2013
Tazewell County	212.5	215.4	198.3
Virginia	169.5	164.1	161.3



Heart Disease Deaths per 100,000 Population			
Geography	2011	2012	2013
Tazewell County	306.1	270.0	239.6
Virginia	161.3	157.4	155.9

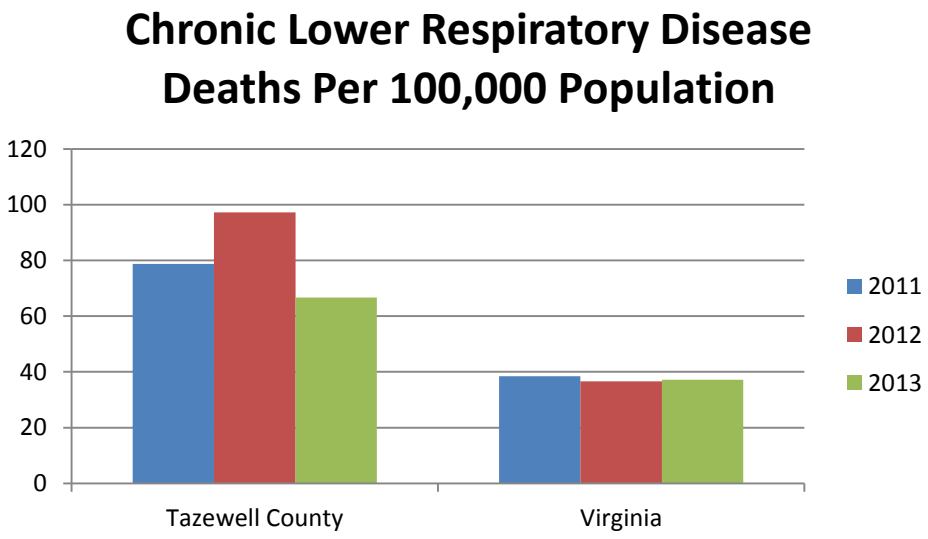


Cerebrovascular Disease Deaths per 100,000 Population			
Geography	2011	2012	2013
Tazewell County	48.9	31.8	36.3
Virginia	41.4	40.7	38.5

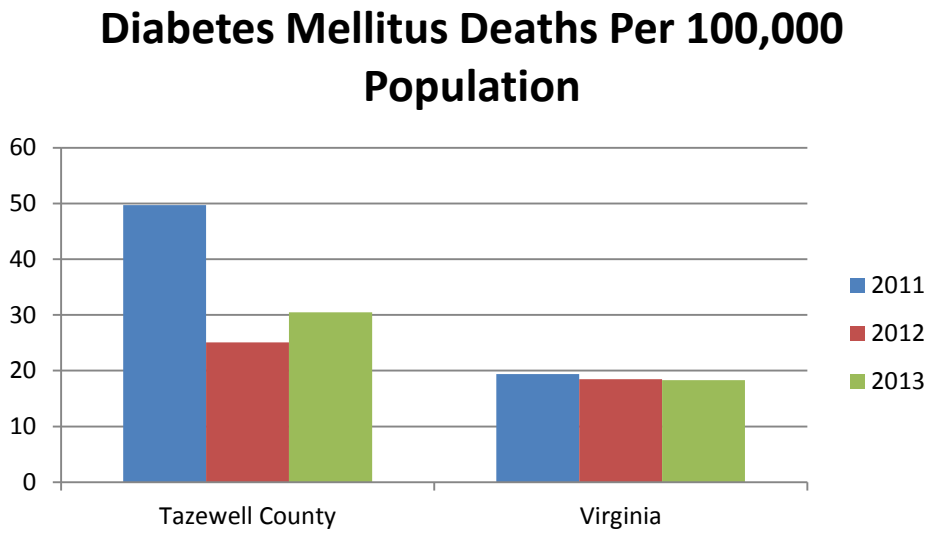


Chronic Lower Respiratory Disease Deaths per 100,000 Population

Geography	2011	2012	2013
Tazewell County	78.8	97.2	66.7
Virginia	38.4	36.6	37.2



Diabetes Mellitus Deaths per 100,000 Population			
Geography	2011	2012	2013
Tazewell County	49.7	25.1	30.5
Virginia	19.4	18.5	18.3



Prevention Quality Indicators

Prevention Quality Indicators (PQI) identify quality of care for ambulatory sensitive conditions, conditions for which good outpatient care can prevent hospitalization or which early intervention can prevent complications and severe disease.

Tazewell County Statistical Area Age Adjusted Discharge Rates per 100,000

(Virginia Atlas of Community Health, Atlas Data, HPD6, 2013, Retrieved from http://atlasva.com/)

Age-Adjusted Discharge Rate per 100,000	Tazewell County	Virginia Total
Adult Asthma PQI Discharges	N/A	14.60
Angina PQI Discharges	88.90	7.50
Bacterial Pneumonia PQI Discharges	487.50	186.70
Chronic Obstructive Pulmonary Disease (COPD) PQI Discharges	514.20	181.80
Congestive Heart Failure PQI Discharges	275.70	237.50
Diabetes PQI Discharges	140.90	141.50
Hypertension PQI Discharges	N/A	38.60

Mental Health and Substance Abuse

At any moment, there are millions of people across the nation suffering from mental health and substance abuse problems. The American Psychological Association estimates that one-fourth of American citizens do not have access to any kind of mental health services. Without access to mental health services, many Americans are rendered incapable of living a healthy, productive life. Even the individuals with health insurance are at risk due to the fact that several insurance companies do not cover mental health and substance abuse services under their policies[21]. As the media continues to report crimes committed by people with poor mental health occurring every day, it is the nation's responsibility to increase access to mental health services for all.

The Affordable Care Act has recognized the need and responded with measures to widen access to all Americans. The key in the ACA's guidelines is the need to identify and treat mental illness early and effectively. More than 5,000 health care professionals across the nation are being supported by a part of the ACA that sends social workers and psychologists into schools in order to improve the overall social and behavioral atmosphere among at risk adolescents. The ACA is also investing in the creation of new hubs and websites that Americans can access to locate the services they need. By entering a few details such as location and the health issue they want to treat, people will be able to bypass the lengthy referral process that makes accessing mental health services so difficult[22]. The Affordable Care Act is a key player in the improvement of mental health services across the nation.

Accessing mental health and substance abuse services is a need seen across races, ages, genders, and geographic region. While the public works to fight the negative stigma that is associated with seeking help for mental health crises, health organizations need to commit their money and time to connecting those who are suffering to the resources they need and deserve to heal and rebuild their lives.

Number of Mentally Unhealthy Days in the Past Month

(Behavioral Risk Factor Surveillance System. (2006-2012). Retrieved from http://www.countyhealthrankings.org/app/virginia/2015/downloads and http://www.countyhealthrankings.org/app/virginia/2016/downloads)

Geography	Mentally Unhealthy Days in the Past Month, 2006-2012	Mentally Unhealthy Days in the Past Month, 2014
Virginia	3.10	3.30
Tazewell County	6.30	3.60

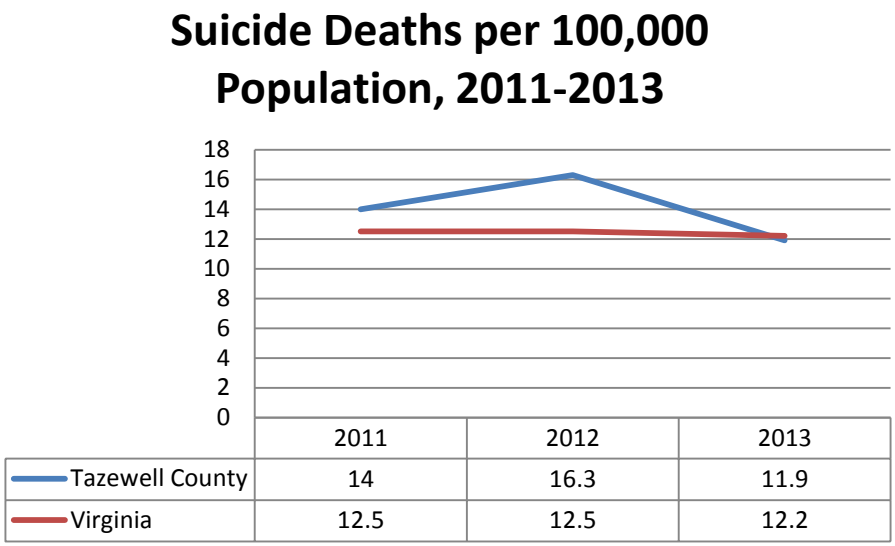
[21] American Psychological Association. (n.d.). Access To Mental Health Care. Retrieved from http://www.apa.org/health-reform/access-mental-health.html

[22] The White House Blog. (2013). Increasing Access To Mental Health Services. Retrieved from https://www.whitehouse.gov/blog/2013/04/10/increasing-access-mental-health-services

Tazewell County Statistical Suicide Deaths per 100,000 Population, 2011-2013

(Statistical Reports and Tables (2015). Virginia Department of Health: Division of Health Statistics. Retrieved from http://www.vdh.virginia.gov/healthstats/stats.htm#pop

Geography	2011	2012	2013
Tazewell County	14.0	16.3	11.9
Virginia	12.5	12.5	12.2



Tazewell County Statistical Unintentional Injury Death Rate per 100,000 Population, 2011-2013

(Statistical Reports and Tables (2015). Virginia Department of Health: Division of Health Statistics. Retrieved from http://www.vdh.virginia.gov/healthstats/stats.htm#pop)

Geography	2011	2012	2013
Tazewell	81.0	73.0	52.3
Virginia	33.4	33.3	33.0

Tazewell County Statistical Area Drug/Poison Deaths (age adjusted rates per 100,000), 2014

(Virginia Department of Health, Office of Chief Medical Examiner's Annual Report, 2013, Table 5.8, 5.11 and 5.15, Retrieved from http://www.vdh.virginia.gov/medExam/documents/pdf/Annual%20Report%202013.pdf)

Drug/Poison (deaths per 100,000 population)	Tazewell	Virginia Total
Drug/Poison	39.10	11.40
Prescription Drugs (FHMO)	32.20	6.40

Oral Health

All too often, the importance of oral health maintenance is overshadowed by larger scale health care issues. For about 47 million people in the United States, these issues are left untreated until emergency care is required[23]. In fact, nearly 830,000 emergency room visits during 2009 could have been prevented if underserved populations had access to regular dental services in their community (The White House Blog, 2013). According to the Center for Disease Control, Non-Hispanic Blacks, Hispanics, and American Indians have the worst overall oral health in the nation[24]. In order to mend the oral health issues in this nation, it is absolutely necessary to change the way the public, government, and elected officials view dental health services.

The American Dental Association is leading the charge for transitioning the way oral health is prioritized in the U.S. They have found that nearly one fourth of American children don't have access to oral health services and have devised several strategies to begin opening the right pathways for intervention. They are teaming up with community centers across the nation to implement programs to provide dental care and educate the underserved population about how to maintain their oral health[25]. A central goal in improving access to oral health services is increasing the prevalence of oral health literacy among all populations in the country.

Great strides have already been seen in child and adolescent oral health. New programs are being implemented across the nation that use school and after-school care centers to reach the vulnerable children without regular access to oral health services. New school-based dental sealant programs have stemmed from Healthy People 2020 initiatives[26].

These programs recognize that tooth decay is a huge issue in underserved populations, and provide the thin plastic seals on chewing teeth that help children to minimize the number of dental caries they will face without regular oral care. Other regions are focusing on making every public water source in the nation contain the fluoride that is suggested for strong, healthy teeth[47].

Eliminating oral health disparities requires medical professionals, medical supply companies, and local venues to volunteer their resources and expertise in order to care for the populations with poor oral health.

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[23] The White House Blog. (2013). Increasing Access To Mental Health Services. Retrieved from https://www.whitehouse.gov/blog/2013/04/10/increasing-access-mental-health-services

[24] Centers for Disease Control and Prevention. (2015-b). Disparities in Oral Health. Retrieved from http://www.cdc.gov/oralhealth/oral_health_disparities/index.htm

[25] American Dental Association. (2015). Action For Dental Health: Breaking Down Barriers. Retrieved from http://www.ada.org/en/public-programs/action-for-dental-health/breaking-down-barriers

[26] Healthy People 2020. (2015-b). Access To Health Services. Retrieved from http://www.healthypeople.gov/2020/topics-objectives/topic/Access-to-Health-Services

Adults age 18+ with No Dental Visit in the Last Year, 2013

(Virgina Atlas of Communty Health, 2013, , Retrieved from http://www.atlasva.com/)

	Tazewell County	Virginia Total
Percent Adults age 18+ with No Dental Visit in the Last Year	20%	22%

Youth (age 0-17) with No Dental Visit in the Last Year, 2013

(Virgina Atlas of Communty Health, 2013, , Retrieved from http://www.atlasva.com/)

	Tazewell County	Virginia Total
Percent Youth age 18+ with No Dental Visit in the Last Year	19%	21%

Youth (age 0-17) with Dental Caries in their Primary or Permanent Teeth, 2013

(Virgina Atlas of Communty Health, 2013, , Retrieved from http://www.atlasva.com/)

	Tazewell County	Virginia Total
Percent Youth (age 0-17) with Dental Caries in their Primary or Permanent Teeth	15%	18%

Youth (age 0-17) with Teeth in Fair/Poor Condition, 2013

(Virgina Atlas of Communty Health, 2013, , Retrieved from http://www.atlasva.com/)

	Tazewell County	Virginia Total
Percent Youth (age 0-17) with Teeth in Fair/Poor Condition	5%	6%

Prevention and Wellness

Well-being is a concept whose definition varies greatly between individuals. Essentially, well-being involves the ability to see your own life in a positive way and feeling good. Well-being and wellness are interchangeable terms, and encompass different aspects of a person's life. Some specific aspects of well-being include physical, psychological, developmental, and emotional well-being[27]. In health care, measuring wellness is done by collecting data in order to evaluate community behaviors, determine the average life span and top causes of death, study regional access to healthy food and individual activity levels, and many other categories involving the way humans live[28].

Wellness in America is at a historical low in several areas. Obesity runs rampant across almost every race and region in the country[49]. Food deserts, or areas where there is virtually no access to healthy and local food choices, are becoming a normal presence in urban areas across the nation. People continue to partake in risky health behaviors like binge-drinking and drug use despite knowing the negative impact it has on the body as a whole[48]. In order to reverse the negative trend that well-being is following, individuals and organizations alike must change everything about the way the average person spends their day. Learning what a healthy lifestyle is can take countless different forms, whether it is a class or a festival or a school presenter[49]. As communities embrace the concept that they have the power to change their state of wellness, it will become easy to implement the right programs and initiatives for the area. Wellness is core to human life and the task of monitoring and improving it is highly important in order to ensure that future generations will have the opportunity to thrive.

County Health Rankings

Beginning in 2010, the County Health Rankings have analyzed localities in all 50 states using measures to determine how healthy people are and how long they live. These measures include (1) health outcomes which look at how long people live (mortality) and how healthy people feel while alive (morbidity); and (2) health factors which represent what influences the health of a county including health behaviors, clinical care, social and economic factors, and physical environment.[29] The lower the overall ranking is, the healthier the community.

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[27] Centers for Disease Control and Prevention. (2015-e). Health-Related Quality Of Life: Well-Being Concepts. Retrieved from http://www.cdc.gov/hrqol/wellbeing.htm

[28] U.S. Department of Health and Human Services. (2015-b). Prevention. Retrieved from http://www.hhs.gov/safety/

[29] University of Wisconsin Population Health Institute & the Robert Wood Johnson Foundation, County Health Rankings, www.countyhealthrankings.org, 2012

From 2014 to 2016 Tazewell Health Outcomes ranking has improved while its health factors ranking has worsened.

County Health Rankings--Health Outcomes (out of 133)			
Locality	**2014 Rank**	**2015 Rank**	**2016 Rank**
Tazewell	132	133	126

County Health Rankings--Health Factors (out of 133)			
Locality	**2014 Rank**	**2015 Rank**	**2016 Rank**
Tazewell	104	96	110

Health Risk Factors

Low education levels in the region and high poverty rates result in the inability for many to understand the complexities of health care resulting in poor compliance with disease management goals, preventive services and screenings, and follow-up with providers.

High blood pressure and high cholesterol are two of the controllable risk factors for heart disease and stroke. Reducing the proportion of adults with hypertension to 26.9% (HDS-5) and high blood cholesterol levels to 13.5% (HDS-7) are two targets for the Healthy People 2020 goal to improve cardiovascular health. In Tazewell County a similar percentage of adults reported having hypertension or high blood cholesterol levels as compared statewide.[30]

Virginia Behavior Risk Factor Surveillance System Health Risk Factors- High Blood Pressure and Cholesterol, 2013

(Risk Profiles HPD2 http://atlasva.org/data/)

Adult Age 18+ Health Risk Profile	Tazewell	Virginia
High Blood Pressure (told by a doctor or other health professional)	31.00%	30%
High Cholesterol (told by a doctor or other health professional)	34.00%	35%

One of the Healthy People 2020 Leading Health Indicators addresses the effects of tobacco and a goal to "reduce illness, disability, and death related to tobacco use and secondhand smoke exposure". One of its key objectives is to reduce the number of adults who are current smokers to 12% (TU-1).

Virginia Behavior Risk Factor Surveillance System Health Risk Factors- Adult Smoking

(Behavioral Risk Factor Surveillance System. (2006-2012). Retrieved from http://www.countyhealthrankings.org/app/virginia/2015/downloads and http://www.countyhealthrankings.org/app/virginia/2016/downloads)

Geography	% Adults who smoke daily or most days, 2006-2012	% Adults who smoke daily or most days, 2014
Virginia	18%	20%
Tazewell County	21%	19%

[30] Virginia Department of Health, Office of Family Health Services, Behavior Risk Factor Surveillance System, 2010

Nutrition, Weight Status, and Physical Activity

A healthy body weight, good nutrition, and physical activity are positive predictors of good health and are a Healthy People 2020 Leading Health Indicator. The prevalence of overweight and obesity has increased tremendously in the past 30 years and is at epidemic proportions in the United States. These increasing rates raise concern because of their implications on health and their contribution to obesity-related diseases like diabetes and hypertension.

Virginia Behavior Risk Factor Surveillance System Health Risk Factors- Obesity and Physical Inactivity

(National Center for Chronic Disease Prevention and Health Promotion, Division of Diabetes Translation. (2010). Retrieved from http://www.countyhealthrankings.org/app/virginia/2015/downloads) (CDC Diabetes Interactive Atlas. (2011). Retrieved from http://www.countyhealthrankings.org/app/virginia/2015/downloads)

	2010		2011		2012	
Geography	**% Obese**	**% No Leisure Time Physical Activity**	**% Obese**	**% No Leisure Time Physical Activity**	**% Obese**	**% No Leisure Time Physical Activity**
Virginia	28%	23%	28%	22%	27%	22%
Tazewell County	31%	34%	30%	31%	29%	31%

The presence of recreational facilities in a community can influence a person's ability to engage in physical activity.

Access to Recreational Facilities, 2014

(United States Department of Agriculture. 2014. Food Environment Atlas: Data Access and Documentation Downloads. Economic Research Service. Retrieved from http://ers.usda.gov/data-products/food-environment-atlas/data-access-and-documentation-downloads.aspx)

Access to Recreational Facilities		
Geography	Rec. Facs.	Rec. Fac. Rate
Tazewell	2	4.52%
Virginia	10	N/A

Fast Food Restaurant Rate per 1,000 population

(USDA Food Environment Index. (2012) Retrieved from http://ers.usda.gov/data-products/food-environment-atlas/data-access-and-documentation-downloads.aspx)

Geography	Rate of Fast Foods per 1,0000 population	Number of Fast Food Restaurants
Virginia		
Tazewell County	0.70	36

Access to healthy foods directly impacts an individual's (and community's) ability to consume fruits, vegetables and whole grains. Increasing the proportion of Americans who have access to a food retail outlet that sells a variety of foods encouraged by the Dietary Guidelines is an objective of Healthy People 2020 (NWS-4).

Despite the prevalence of food deserts in the United States, there is no universally recognized definition of a "food desert". The U.S. Department of Agriculture (USDA) and the Department of Health and Human Services (HHS) define food deserts as "a census tract with a substantial share of residents who live in low-income areas that have low levels of access to a grocery store or healthy, affordable food retail outlet[31]". Food deserts and food insecurity go hand-in-hand; individuals living in food deserts are often food insecure.

Individuals who are food insecure are unsure where their food will come from and are more likely to have low access to healthy, nutritious foods, such as fruits and vegetables, whole grains, and dairy[32]. Fruit and vegetable consumption, in particular, is a key component of disease prevention. Individuals who consume more fruits and vegetables are more likely to maintain a healthy body weight and are less likely to develop chronic diseases, such as diabetes, heart disease, or cancer[33]. However, national studies have consistently shown that lower-income individuals consume fewer servings of fruits and vegetables than higher-income individuals[34] with the most often cited barrier being cost[35]. These health behaviors not only fuel disparities in chronic disease prevalence, but are driven by preexisting disparities in income, education, and access to food.

[31] U.S. Department of Agriculture. "Food deserts". Updated 2014. Accessed January 23, 2015. Retrieved from http://apps.ams.usda.gov/fooddeserts/fooddeserts.aspx.
[32] Food Deserts in Virginia, Recommendations from the Food Desert Task Force. Virginia Tech and Virginia State University, January 2014.
[33] U.S. Department of Health and Human Services, U.S. Department of Agriculture. Dietary Guidelines for Americans. 7th Ed. U.S. Government Printing Office; Washington, D.C.: December 2010.
[34] Centers for Disease Control and Prevention. State-specific trends in fruit and vegetable consumption among adults – United States, 2000-2009. MMWR, Morb Mortal Wkly Rep. 2010; 59:1125-1130.
[35] Larson NI, Story MT, and Nelson MC. Experimental analysis of neighborhood effects. Econometrica. 2009, 75(1):83-119.

Recently, studies have indicated that individuals with better access to a supermarket or large grocery store are more likely to eat healthier foods[36]. Furthermore, researchers have shown that fruit and vegetable intake in low-income, low food access areas increases when access to healthy foods increases, such as at the opening of a new grocery store or modified corner store[37]. In addition to increased consumption of fruits and vegetables, better access to large grocery stores or supermarkets is also associated with decreased risk of obesity while better access to convenience stores is associated with a higher risk of obesity and obesity-related chronic diseases, such as diabetes and heart disease[52]. Similar results have been associated with increased access to farmer's markets. In one study of adolescent girls, greater access to farmer's markets and produce vendors was associated with decreased risk of overweight and obesity over a three-year period[38].

Decreasing hunger, food insecurity, and food deserts in the United States has been repeatedly prioritized in federal and local initiatives including *Healthy People 2020*, First Lady Michelle Obama's *Let's Move* campaign, and more recently, First Lady of Virginia Dorothy McAuliffe's childhood nutrition and food security initiative. Despite this, the U.S. Department of Agriculture's Economic Research Service estimates that 14.3% of American households, or 43.5 million people, were food insecure at some point in 2013[39] [40] with 23.5 million people (7.5%), including 6.5 million children, living in food deserts[41]. In Virginia, food deserts exist in all regions of the state, though some regions are more severely affected than others. In 2012, 12.7% of Virginians were food insecure though many localities, particularly those situated in Central and Southwestern Virginia, reported food insecurity rates much higher than the state average. Similarly, many localities in Central and Southwestern Virginia reported low-access rates, the number of people that live more than a mile from a supermarket in urban areas or 10 miles in rural areas, greater than the state average of 17.8% or the national average of 7.3%[57].

[36] Larson NI, Story MT, and Nelson MC. Experimental analysis of neighborhood effects. Econometrica. 2009, 75(1):83-119.
[37] Economic Research Service. Access to Affordable and Nutritious Foods: Measuring and Understanding Food Deserts and Their Consequences, Report to Congress, U.S. Department of Agriculture, June 2009.
[38] Leung CW, Laraia BA, Kelly M, Nickleach D, Adler NE, Kushi LH, Yen IH. The influence of neighborhood food stores on change in young girls' body mass index. Am J Prev Med 2011; 41(1):43-51.
[39] Coleman-Jenson A, Gregory C, and Singh A. Household food security in the United States in 2013, ERR-173, U.S. Department of Agriculture, Economic Research Service, September 2014.
[40] U.S. Census Bureau. State and County Quickfacts: USA. Updated December 2014. Accessed January 25, 2015. Retrieved from http://quickfacts.census.gov/qfd/states/00000.html.
[41] Food Deserts in Virginia, Recommendations from the Food Desert Task Force. Virginia Tech and Virginia State University, January 2014.

Access to Healthy Foods-2010

(USDA Food Environment Atlas, Map the Meal Gap. (2010). Retrieved from http://www.countyhealthrankings.org/app/virginia/2016/downloads)

Geography	# Limited Access	% Limited Access
Tazewell	3122	7%
Virginia	295610	4%

Food deserts are defined as an area where residents are poor, lack transportation and have no supermarkets to supply healthy food choices. There are three Census Tracts classified as food deserts in Tazewell County.

Census Tract Food Deserts

(United States Department of Agriculture, Economic Research Service, Food Access Research Atlas, 2013, Retrieved from http://www.ers.usda.gov/data-products/food-access-research-atlas/download-the-data.aspx)

Locality	Census Tract	Total Population	Percentage of people with low access to a supermarket or large grocery store	Number of people with low access to a supermarket or large grocery store	Percentage of total population that is low-income and has low access to a supermarket or large grocery store	Number of low-income people with low access to a supermarket or large grocery store
Tazewell	202	5354	88.28%	4726.39	6.18%	1731.45
Tazewell	205	3152	74.98%	2363.32	8.01%	1246.65
Tazewell	210	4234	50.32%	2130.75	4.01%	885.14
*People at 1 mile--an urban tract with at least 500 people or 33% percent of the population living at least 1 mile from the nearest supermarket, supercenter, or large grocery store						

Clinical Preventive Screenings

According to the National Cancer Institute, deaths can be greatly reduced for breast, cervical, colon, and rectal cancer through early detection and screening tests. In Tazewell, more women 18 years and older had no PAP test in the past 3 years as compared statewide and adults 50 years of age and older had fewer colorectal screenings within the past two years.

Virginia Behavior Risk Factor Surveillance System Health Risk Factors-Cancer Screenings, 2013

(Risk Profiles HPD2 http://atlasva.org/data/)

Adult age 18+ Health Risk Profile	Tazewell	Virginia
Percent of women with no Pap test in the past 3 years	18.00%	16.00%
Percent of women 40 and older with no mammogram in past 2 years	28.00%	28.00%
Percent of adults 50 and older with no sigmoidoscopy or colonoscopy	36.00%	28.00%

Maternal, Infant, and Child health

Prenatal and Perinatal Health Indicators

Maternal and child health is a Healthy People 2020 Leading Health Indicator with the goal to "improve the health and well-being of women, infants, children and families". Infant mortality is affected by many factors including the socio-economic status and health of the mother, prenatal care, birth weight of the infant, and quality of health services delivered to both the mother and child and is a key predictor of the health of a community.

Healthy People 2020 Objectives and targets are as follows:

MICH- 1.3: Reduce the rate of infant deaths (within 1 year) to 6.0 infant deaths per 1,000 live births

MICH- 8.1: Reduce low birth weight (LBW) to 7.8% of live births

MICH- 10.1: Increase the proportion of pregnant women who receive early and adequate prenatal care to 77.9%

Late Entry into Prenatal Care, Tazewell , 2013

(Virginia Department of Health, Statistical Reports and Tables, 2011-2013, Retrieved from http://www.vdh.virginia.gov/HealthStats/stats.htm, http://www.vdh.virginia.gov/HealthStats/documents/2010/pdfs/VDHS13.pdf)

Prenatal & Perinatal Health Indicators	Tazewell	Virginia
Late entry into prenatal care (entry after first trimester) Percent of all births	17.10%	13.20%

Prenatal & Perinatal Health Indicators, Tazewell, 2013

(Virginia Department of Health, Statistical Reports and Tables, 2011-2013. Retrieved from http://www.vdh.virginia.gov/HealthStats/stats.htm)

	Tazewell	Virginia
Low Birth Weight Rate	7.9	7.9
Infant Mortality Rate (Number per 1,000 births)	6.7	6.2

Infant Mortality Rates per 1,000 live births			
	2011	2012	2013
Tazewell	9.6	6.6	6.7
Virginia	6.7	6.3	6.2

Prenatal & Perinatal Health Indicators, Tazewell, 2013

(Virginia Department of Health, Statistical Reports and Tables, 2013, Retrieved from http://www.vdh.virginia.gov/HealthStats/stats.htm)

Total Live Births Rates by Race, 2013	Tazewell	Virginia
Total Live Birth Rates per 1,000	10.2	12.3
Live Birth Rates per 1,000 (White)	10.3	10.9
Live Birth Rates per 1,000 (Black)	4.8	12.8
Live Birth Rates per 1,000 (Other)	18.2	25.4

Total Infant Deaths by Race, 2013	Tazewell	Virginia
Infant Death Rates per 1,000	6.7	6.2
Infant Death Rates per 1,000 (White)	7	5.2
Infant Death Rates per 1,000 (Black)	No data	12.2
Infant Death Rates per 1,000 (Other)	No data	2.2

Teen Pregnancy Rate, 2013

(Virginia Department of Health, Statistical Reports and Tables, 2013, Retrieved from http://www.vdh.virginia.gov/HealthStats/stats.htm)

Pregnancy Rate per 1,000 Females 10-19 (per 1,000 births)	Total	White	Black	Other
Tazewell County	24.8	22	25.2	No data
Virginia	14.4	22.6	10.8	20.4

Preventive Screenings

Reported Number of Children Tested for Elevated Blood Lead Levels under 36 months

(Virginia Department of Health, Lead-Safe Virginia Program, 2014, Retrieved from http://166.67.66.226/leadsafe/documents/pdf/2014%20Surveillance%20Report.pdf)

	Tazewell	Virginia
Population <36 Months	1360	303439
Number Confirmed Elevated	0	185

Infectious diseases

HIV Infection Prevalence and Other Sexually Transmitted Infections Rate

One of the Healthy People 2020 goals is to "promote healthy sexual behaviors, strengthen community capacity, and increase access to quality services to prevent sexually transmitted diseases in their complications".

The HIV infection prevalence and the rates of early syphilis, gonorrhea, and chlamydia are much lower in Tazewell as compared to the state as a whole.

Tazewell HIV Infection Prevalence, 2013

(Virginia Department of Health. (2015). Virginia HIV Surveillance Annual Report. Retrieved from http://www.vdh.virginia.gov/epidemiology/DiseasePrevention/Programs/HIV-AIDS/SurveillanceProgram/documents/pdf/Annual_Report_2015.pdf)

	Tazewell	VA
Rate of all cases of HIV disease (per 100,000)	92.1	298.5

Tazewell Sexually Transmitted Infection Rates (per 100,000), 2014

(Virginia Department of Health. (2014). Virginia STI Surveillance Annual Report. Retrieved from http://www.vdh.virginia.gov/epidemiology/DiseasePrevention/DAta/QuarterlySurveillanceReport2_Q_15.htm#TES)

Geography	Early Syphilis	Gonorrhea	Chlamydia
Tazewell County	0	2.3	140.6
Virginia	6.7	98.4	426.7

Tazewell Number of Reported Tuberculosis (TB) Rates per 100,000 2013-2014

(Virginia Department of Health, TB Surveillance Reports, 2010-2014, Retrieved from http://www.vdh.virginia.gov/TB/EpidemiologyandSurveillance.htm)

Geography	2013	2014
Tazewell	0	0
Virginia	2.2	2.9

Social environment

Tazewell Rate of Child Abuse and Neglect (per 1,000 children), 2012-2013

(Virginia Department of Social Services, Child Protective Reports & Studies, 2012-2013, Retrieved from http://www.dss.virginia.gov/geninfo/reports/children/cps/all_other.cgi)

Rate of Child Abuse and Neglect (per 1,000 children)		
Geography	2012	2013
Tazewell County	1.89	0.78

Community Health Need Prioritization

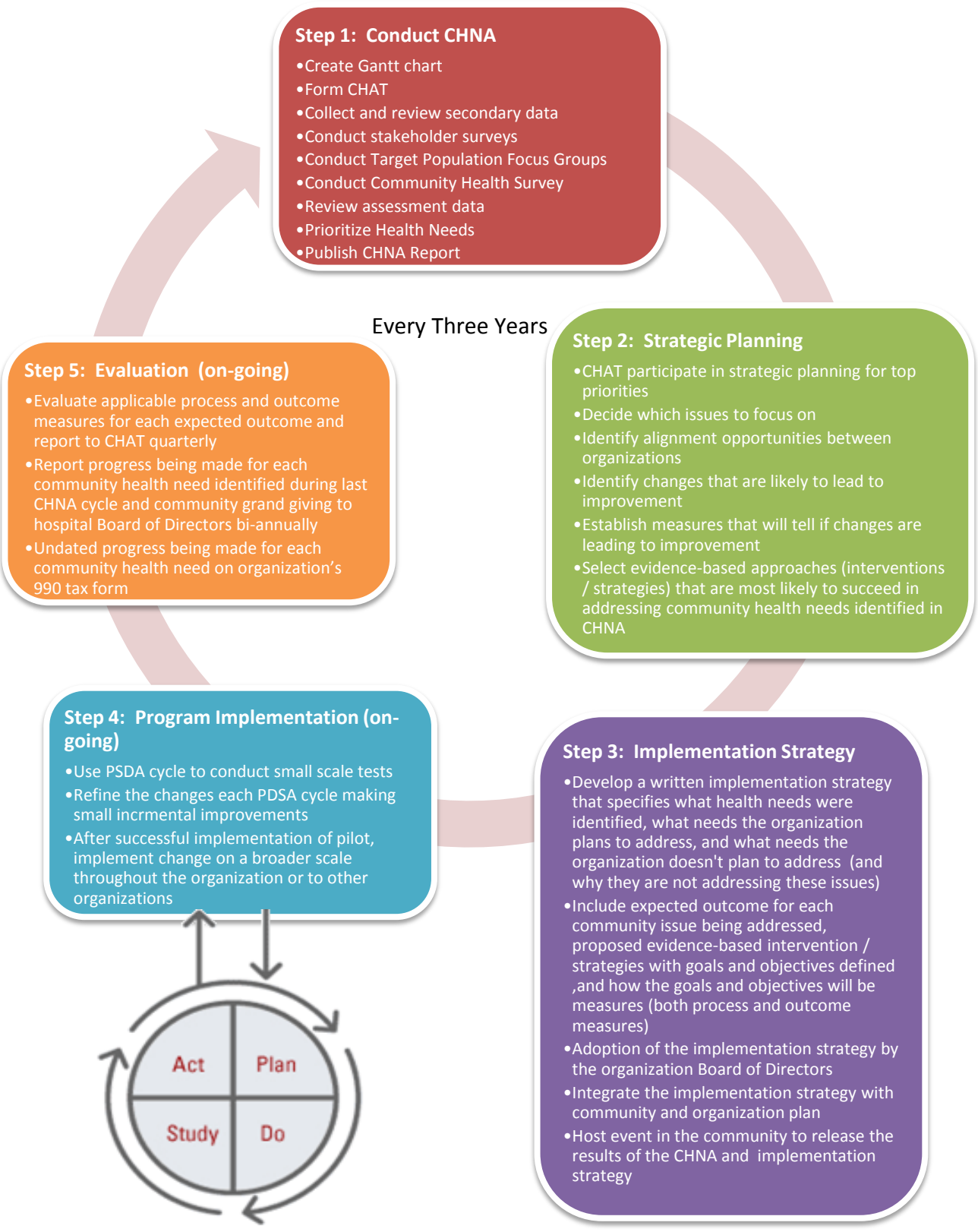
CHAT members participated in a prioritization activity in July 2016 after all primary and secondary data was presented. To quantitatively determine health needs, CHAT members were asked to rank the top ten pertinent community needs, with one being the most pertinent. Next, on a scale of 1-5, CHAT members were ask to assign a feasibility and potential impact score for each of the ranked needs. This information is used to inform strategic planning. See Appendix 7: Prioritization Worksheet for an example of the tool used.

The results of the prioritization activity found the following issues as the top prioritized need for the service area:

2016 Tazewell County Community Health Needs Assessment Prioritization of Needs	Rank Frequency	Rank Average	Feasibility Average	Potential impact Average
Access to primary care	9	2.9	2.3	1.8
Access to mental health counseling / substance abuse	9	3.4	2.6	1.7
High prevalence of obesity / overweight individuals	9	4.9	1.9	1.3
Lack of reliable transportation	9	5.7	3.5	1.8
Access to specialty care/specialist physicians	7	4.4	2.2	1.0
High uninsured population	6	4.2	1.8	1.3
Chronic disease (diabetes, cardiovascular disease, hypertension, asthma)	6	4.8	2.3	1.0
High prevalence of substance abuse (alcohol, illegal & prescription drugs)	6	5.5	3.0	2.7
Value not placed on preventive care and chronic disease management	6	5.7	2.0	1.3
Lack of exercise / physical activity	5	7.4	2.0	1.6

Appendices

Appendix 1: Community Health Improvement Process



Appendix 2: Gantt Chart

Tasks	Assigned To:	Start Date	End Date	Duration (working days)	% complete
2016 Tazewell CHNA		03-29 Tue	07-22 Fri	83	84%
Create Gantt Chart	Amy	04-04 Mon	04-04 Mon		100%
Update CHAT Contact List	Kathren	03-29 Tue	04-12 Tue	1	50%
Collect Secondary Data for CHNA	Amy + Interns	04-04 Mon	06-10 Fri	49	100%
Pre-CHAT #1 Work	Amy + Aaron	04-04 Mon	04-18 Mon	10	100%
Schedule ALL Meetings	Kenya	04-04 Mon	04-08 Fri	4	100%
CHAT #1 Meeting	CHAT - Amy + Aaron	05-02 Mon	05-02 Mon	1	100%
Survey Distribution	All	04-25 Mon	06-01 Wed	27	100%
Focus Groups	Amy + Shenika + Aaron	04-29 Fri	06-21 Tue	37	100%
CHAT #2 Meeting	CHAT	05-31 Tue	05-31 Tue	1	100%
Analyze Survey Data	Amy	06-01 Wed	07-01 Fri	22	100%
CHAT Meeting #3- Data and Prioritization	CHAT	07-06 Wed	07-06 Wed	1	100%
Management Team Meeting	Management Team	07-06 Wed	07-06 Wed	1	100%
Final CHNA Report	Carilion Clinic	06-21 Tue	07-18 Mon	1	98%
CHAT Strategic Plan	CHAT	07-19 Tue	07-19 Tue	1	
Create Implementation Strategy	Carilion Clinic	06-17 Fri	07-11 Mon	16	
Communication Plan and Community Forum	Carilion Clinic	07-11 Mon	07-22 Fri	9	

Appendix 3: Community Health Survey

TAZEWELL COUNTY COMMUNITY HEALTH SURVEY

ACCESS and BARRIERS TO HEALTHCARE

1. Is there a specific doctor's office, health center, or other place that you usually go if you are sick or need advice about your health? ❒ Yes ❒ No

- ***Skip to question 2 if you answered <u>No</u>***
- ***If you answered <u>Yes</u>***
  - Is this where you would go for new health problems? ❒ Yes ❒ No
  - Is this where you would go for preventive health care, such as general check-ups, examinations, and immunizations (shots)? ❒ Yes ❒ No
  - Is this where you would go for referrals to other health professions when needed? ❒ Yes ❒ No

2. Do you use medical care services? ❒ Yes ❒ No

- ***If yes, where do you go for medical care? (Check <u>all</u> that apply)***

❒ Doctor's Office
❒ Carilion Clinic Family Medicine - Tazewell
❒ Emergency Room
❒ Free Clinic
❒ Health Department
❒ Nurse Practitioner's Office
❒ Salem VA Medical Center
❒ Tazewell Community Health
❒ Urgent Care / Walk in Clinic
❒ Other: _____

3. Do you use dental care services? ❒ Yes ❒ No

- ***If yes, where do you go for dental care? (Check <u>all</u> that apply)***

❒ Dentist's office
❒ Emergency Room
❒ Free Clinic
❒ Salem VA Medical Center
❒ RAM (remote area medical – once a year)
❒ Urgent Care / Walk in Clinic
❒ Other: _____

4. Do you use mental health, alcohol abuse, or drug abuse services? ❒ Yes ❒ No

- ***If yes, where do you go for mental health, alcohol abuse, or drug abuse services? (Check <u>all</u> that apply)***

❒ Doctor/Counselor's Office
❒ Cumberland Mountain CSB
❒ Emergency Room
❒ Free Clinic
❒ Salem VA Medical Center
❒ Urgent Care / Walk in Clinic
❒ Other: _____

5. What do you think are the <u>five most important issues</u> that affect health in our community? (*Please check <u>five</u>*)

❒ Access to healthy foods
❒ Accidents in the home (ex. falls, burns, cuts)
❒ Aging problems
❒ Alcohol and illegal drug use
❒ Bullying
❒ Cancers
❒ Cell phone use / texting and driving / distracted driving
❒ Child abuse / neglect
❒ Dental problems
❒ Diabetes
❒ Domestic violence
❒ Environmental health (e.g. water quality, air quality, pesticides, etc.)
❒ Gang activity
❒ Heart disease and stroke
❒ High blood pressure
❒ HIV / AIDS
❒ Homicide
❒ Infant death
❒ Lack of exercise
❒ Lung disease
❒ Mental health problems
❒ Neighborhood safety
❒ Not getting "shots" to prevent disease
❒ Not using seat belts / child safety seats / helmets
❒ Overweight / obesity
❒ Poor eating habits
❒ Prescription drug abuse
❒ Sexual assault
❒ Stress
❒ Suicide
❒ Teenage pregnancy
❒ Tobacco use / smoking
❒ Unsafe sex
❒ Other:_____

6. Which health care services are hard to get in our community? *(Check all that apply)*

- ❒ Adult dental care
- ❒ Alternative therapy (ex. herbal, acupuncture, massage)
- ❒ Ambulance services
- ❒ Cancer care
- ❒ Child dental care
- ❒ Chiropractic care
- ❒ Dermatology
- ❒ Domestic violence services
- ❒ Eldercare
- ❒ Emergency room care
- ❒ End of life / hospice / palliative care
- ❒ Family doctor
- ❒ Family planning / birth control
- ❒ Immunizations
- ❒ Inpatient hospital
- ❒ Lab work
- ❒ Medication / medical supplies
- ❒ Mental health / counseling
- ❒ Physical therapy
- ❒ Preventive care (ex. yearly check-ups)
- ❒ Programs to stop using tobacco products
- ❒ Specialty care (ex. heart doctor)
- ❒ Substance abuse services –drug and alcohol
- ❒ Urgent care / walk in clinic
- ❒ Vision care
- ❒ Women's health services
- ❒ X-rays / mammograms
- ❒ None
- ❒ Other:_____

7. What do you feel prevents you from getting the healthcare you need? *(Check all that apply)*

- ❒ Afraid to have check-ups
- ❒ Can't find providers that accept my Medicaid insurance
- ❒ Can't find providers that accept my Medicare insurance
- ❒ Childcare
- ❒ Cost
- ❒ Don't know what types of services are available
- ❒ Don't like accepting government assistance
- ❒ Don't trust doctors / clinics
- ❒ Have no regular source of healthcare
- ❒ High co-pay
- ❒ Lack of evening and weekend services
- ❒ Language services
- ❒ Location of offices
- ❒ Long waits for appointments
- ❒ No health Insurance
- ❒ No transportation
- ❒ I can get the healthcare I need
- ❒ Other:_____

GENERAL HEALTH QUESTIONS

8. Please check one of the following for each statement	**Yes**	**No**	**Not applicable**
I have had an eye exam within the past 12 months.	❒	❒	
I have had a mental health / substance abuse visit within the past 12 months.	❒	❒	
I have had a dental exam within the past 12 months.	❒	❒	
I have been to the emergency room in the past 12 months.	❒	❒	
I have been to the emergency room for an injury in the past 12 months (e.g. motor vehicle crash, fall, poisoning, burn, cut, etc.).	❒	❒	
Have you been a victim of domestic violence or abuse in the past 12 months?	❒	❒	
My doctor has told me that I have a long-term or chronic illness.	❒	❒	
I take the medicine my doctor tells me to take to control my chronic illness.	❒	❒	❒
I can afford medicine needed for my health conditions.	❒	❒	❒
I am over 21 years of age and have had a Pap smear in the past three years (if male or under 21, please check not applicable).	❒	❒	❒
I am over 40 years of age and have had a mammogram in the past 12 months (if male or under 40, please check not applicable).	❒	❒	❒
I am over 50 years of age and have had a colonoscopy in the past 10 years (if under 50, please check not applicable).	❒	❒	❒
Does your neighborhood support physical activity? (e.g. parks, sidewalks, bike lanes, etc.)	❒	❒	
Does your neighborhood support healthy eating? (e.g. community gardens, farmers' markets, etc.)	❒	❒	
In the area that you live, is it easy to get affordable fresh fruits and vegetables?	❒	❒	
Have there been times in the past 12 months when you did not have enough money to buy the food that you or your family needed?	❒	❒	

9. Where do you get the food that you eat at home? *(Check all that apply)*

- ❒ Back-pack or summer food programs
- ❒ Community Garden
- ❒ Corner store / convenience store / gas station
- ❒ Dollar store
- ❒ Farmers' Market
- ❒ Food bank / food kitchen / food pantry
- ❒ Grocery store
- ❒ Home Garden
- ❒ I do not eat at home
- ❒ I regularly receive food from family, friends, neighbors, or my church
- ❒ Meals on Wheels
- ❒ Take-out / fast food / restaurant
- ❒ Other: _____

10. During the past 7 days, how many times did you eat fruit or vegetables (fresh or frozen)? Do not count fruit or vegetable juice. *(Please check one)*

- ❒ I did not eat fruit or vegetables during the past 7 days
- ❒ 1 – 3 times during the past 7 days
- ❒ 4 – 6 times during the past 7 days
- ❒ 1 time per day
- ❒ 2 times per day
- ❒ 3 times per day
- ❒ 4 or more times per day

11. Have you been told by a doctor that you have… *(Check all that apply)*

- ❒ Asthma
- ❒ Cancer
- ❒ Cerebral palsy
- ❒ COPD / chronic bronchitis / Emphysema
- ❒ Depression or anxiety
- ❒ Drug or alcohol problems
- ❒ Heart disease
- ❒ High blood pressure
- ❒ High blood sugar or diabetes
- ❒ High cholesterol
- ❒ HIV / AIDS
- ❒ Mental health problems
- ❒ Obesity / overweight
- ❒ Stroke / Cerebrovascular disease
- ❒ I have no health problems
- ❒ Other: _____

12. How long has it been since you last visited a doctor for a routine checkup? *(Please check one)*

- ❒ Within the past year (1 to 12 months ago)
- ❒ Within the past 5 years (2 to 5 years ago)
- ❒ Within the past 2 years (1 to 2 years ago)
- ❒ 5 or more years ago

13. How long has it been since you last visited a dentist or a dental clinic for any reason? Include visits to dental specialists, such as orthodontists. *(Please check one)*

- ❒ Within the past year (1 to 12 months ago)
- ❒ Within the past 5 years (2 to 5 years ago)
- ❒ Within the past 2 years (1 to 2 years ago)
- ❒ 5 or more years ago

14. In the past 7 days, on how many days were you physically active for a total of at least 30 minutes? (Add up all the time you spent in any kind of physical activity that increased your heart rate and made you breathe hard for some of the time.)

❒ 0 days ❒ 1 days ❒ 2 days ❒ 3 days ❒ 4 days ❒ 5 days ❒ 6 days ❒ 7 days

15. Other than your regular job, what physical activity or exercises do you participate in? *(Check all that apply)*

- ❒ Bicycling
- ❒ Canoeing / kayaking
- ❒ Dancing
- ❒ Gardening
- ❒ Group exercise classes
- ❒ Hiking
- ❒ Horseback riding
- ❒ Hunting
- ❒ Individual sports
- ❒ Running
- ❒ Swimming
- ❒ Team sports
- ❒ Walking
- ❒ Weight training
- ❒ Yoga / Pilates

16. In the past 7 days, how many times did all, or most, of your family living in your house eat a meal together?

- ❒ Never
- ❒ 1-2 times
- ❒ 3-4 times
- ❒ 5-6 times
- ❒ 7 times
- ❒ More than 7 times
- ❒ Not applicable / I live alone

17. Thinking about your physical health, which includes physical illness and injury, for how many days during the past 30 days was your physical health not good? _____ Days

18. Thinking about your mental health, which includes stress, depression, and problems with emotions, for how many days during the past 30 days was your mental health not good? _____ Days

19. During the last 30 days, how many days did you miss work or school due to pain or illness (physical or mental)? _____ Days

20. During the past 30 days: *(Check all that apply)*

- ❒ I have had 5 or more alcoholic drinks (if male) or 4 or more alcoholic drinks (if female) during one occasion.
- ❒ I have used tobacco products (cigarettes, smokeless tobacco, e-cigarettes, etc.)
- ❒ I have taken prescription drugs to get high
- ❒ I have used marijuana
- ❒ I have used other illegal drugs (e.g. cocaine, heroin, ecstasy, crack, LSD, etc.)

21. Have you ever used heroin? ❒ Yes ❒ No

22. How many vehicles are owned, leased, or available for regular use by you and those who currently live in your household? Please be sure to include motorcycles, mopeds and RVs. _____ vehicles

23. If you do not drive, what mode of transportation do you use typically use.

- ❒ Not applicable- I drive
- ❒ Bike or walk
- ❒ Friends / Family drive me
- ❒ Public transit (i.e. bus, shuttle, similar)
- ❒ RADAR / CORTRAN
- ❒ Taxi
- ❒ Other:_____

24. What types of information help you learn the best about your health? *(Check <u>all</u> that apply)*

- ❒ Classroom presentations, live presentations, or hands on demonstrations
- ❒ Group activity / support group
- ❒ I learn best by talking with my health professional (i.e. doctor, nurse, care coordinator, etc.)
- ❒ Internet or web information
- ❒ My Chart / patient portal
- ❒ Pictures, diagrams, illustrations or photographs
- ❒ Reading materials (i.e. brochure, newspaper, magazine, books)
- ❒ Video presentation (i.e. video tape, DVD, movie, television)
- ❒ Other _____

DEMOGRAPHIC INFORMATION and HEALTH INSURANCE

25. Which of the following describes your current type of health insurance? (*Check <u>all</u> that apply*)

❒ COBRA
❒ Dental Insurance
❒ Employer Provided Insurance
❒ Government (VA, Champus)
❒ Health Savings / Spending Account
❒ Individual / Private Insurance / Market Place / Obamacare
❒ Medicaid
❒ Medicare
❒ Medicare Supplement
❒ No Dental Insurance

26. No Health Insurance**<u>If you have no health insurance</u>, why don't you have insurance? (*Check <u>all</u> that apply)***

❒ Not applicable- I have health insurance
❒ I don't understand ACA / Obamacare Options
❒ Not available at my job
❒ Student
❒ Too expensive / cost
❒ Unemployed / no job

27. Other: _____

28. What is your ZIP code? _____

29. What is your street address (optional)? _____

30. What is your age? _____

31. What is your gender? ❒ Male ❒ Female ❒ Transgender

32. What is your height? _____

33. What is your weight? _____

34. How many people live in your home (including yourself)?

Number who are 0 – 17 years of age _____
Number who are 18 – 64 years of age _____
Number who are 65 years of age or older _____

35. What is your highest education level completed?

❒ Less than high school ❒ Some high school ❒ High school diploma ❒ Associates ❒ Bachelors ❒ Masters / PhD

36. What is your primary language? ❒ English ❒ Spanish ❒ Other_____

37. What ethnicity do you identify with? *(Check all that apply)*

❒ Native Hawaiian / Pacific Islander ❒ Asian ❒ Black / African American ❒ White
❒ American Indian / Alaskan Native ❒ Latino ❒ More than one race ❒ Decline to answer ❒ Other:_____

38. What is your marital status? ❒ Married ❒Single ❒Divorced ❒Widowed ❒Domestic Partnership

39. What is your yearly household income?

❒ $0 – $10,000 ❒ $10,001 – $20,000 ❒ $20,001 – $30,000 ❒ $30,001 – $40,000 ❒ $40,001 – $50,000
❒ $50,001 – $60,000 ❒ $60,001 – $70,000 ❒ $70,001 – $100,000 ❒ $100,001 and above

40. What is your current employment status?

❒ Full-time ❒ Part-time ❒ Unemployed ❒ Self-employed ❒ Retired ❒ Homemaker

41. Is there anything else we should know about your (or someone living in your home) health care needs in Tazewell County?

_____
_____
_____
_____
_____

Appendix 4: Stakeholder Survey

Tazewell County Professional Informant Survey

Barriers and Challenges Faced by Residents and Health and Human Services Agencies

An online version of this survey is available at https://www.surveymonkey.com/r/CHNAProviderSurvey

Responses will not be identified, either in written material or verbally, by name or organization.

Please return to: Amy Michals, Carilion Clinic Community Outreach, 1202 Third Street, S.W., Roanoke, VA 24016. Thank you!

1. Your name, organization, and title:

NAME: _____

ORGANIZATION:_____

TITLE: _____

2. What are the most important issues (needs) that impact health in Tazewell County?

_____
_____
_____
_____
_____
_____

3. What are the barriers to health for the populations you serve?

_____
_____
_____
_____
_____
_____

4. Is there one locality / neighborhood with the greatest unmet need? If so, why?

_____
_____
_____
_____
_____
_____

5. Is there one population group with the greatest unmet need? If so, why?

6. What are the resources for health for the populations you serve?

7. If we could make one change as a community to meet the needs and reduce the barriers to health in Tazewell County, what would that be?

Thank you for your input!

Please return to: Amy Michals, Carilion Clinic Community Outreach, 1202 Third Street, S.W., Roanoke, VA 24016.

Questions: Please contact Amy Michals at 540-983-4046 or almichals@carilionclinic.org

Appendix 5: 2016 Stakeholder Survey Locations

Organization	Site/Group
Tazewell County	Bluefield Rescue Squad
Carilion Tazewell Community Hospital	CTCH Employees
2016 CHNA CHAT	Meeting #2

Appendix 6: Community Resources

Organization	Categories	Website
Churches	Community Resource	
Labor of Love	Community Resource	http://www.laboroflovemission.org/
YMCA	Community Resource	http://fsymca.org/
Appalachia Agency on Aging	Community Resource - Information and Referral, Services for older adults	https://scaccess.communityos.org/zf/profile/agency/id/57845
Backpack program	Community Resource – Access to Food	http://www.foodbankonline.org/HowWeWork/ChildNutritionPrograms/BackPackProgram.aspx
EBT	Community Resource – Access to Food	https://www.connectebt.com/ebtcard/vaebt/index.jsp
Farmers Market	Community Resource – Access to Food	http://www.virginia.org/listings/Shopping/TazewellFarmersMarket/
Good Samaritan Food Pantry	Community Resource – Access to Food	http://www.foodpantries.org/li/good_samaritan_food_pantry_62901
WIC	Community Resource – Access to Food,	http://www.tazewellhealth.org/maternalchild-health/wic-program.html
Camp Joy	Community Resource – Education	http://www.clinchvalleycaa.org/index.php/cvca-programs/camp-joy
Headstart	Community Resource – Education	http://www.acf.hhs.gov/programs/ohs
Cumberland Mountain Services	Community Resource, Coordination of Care	http://www.cmcsb.com/
Libraries	Community Resource, Education	https://tcplweb.org/
Clinch Valley Independent Living Services	Community Resource, Information and Referral	http://www.accessva.org/CILAccessible.html
State funded programs	Community Resource, Information and Referral	http://www.financialhelpresources.com/details/tazewell_county_department_of_social_services.html
Internet	Information	
Pharmacies	Prescriptions	http://www.whitepages.com/business/VA/Tazewell/Pharmacies

Health Department	Public Health, Services – Healthcare, Information and Referral	http://www.tazewellhealth.org/
Clinch Valley Community Action	Service – Health, Education, Outreach	http://www.clinchvalleycaa.org/
FQHC	Service - Healthcare	https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/fqhcfactsheet.pdf
Local ERs	Service - Healthcare	https://www.carilionclinic.org/hospitals/carilion-tazewell-community-hospital
Medicaid Taxi	Service - Healthcare	http://easyaccess.virginia.gov/transportation.shtml
Outpatient clinic	Service - Healthcare	https://www.carilionclinic.org/locations/family-medicine-tazewell
Schools	Service - School-based Care	http://www.tazewell.k12.va.us/?PN=Schools2
VA Cares Reentry program	Service, Education – Rehabilitation, Workforce Training, Information and Referral, Behavioral Health	http://www.vacares.org/
Drop box for drug takeback	Services	http://rxdrugdropbox.org/
Celebrate recovery	Services – Behavioral Health	http://www.mainstreettazewell.com/
Destiny Outreach	Services – Behavioral Health	http://www.domtoday.com/
Urgent care	Services - Healthcare	http://www.vitals.com/urgent-care/va/north-tazewell
Various hospitals	Services - Healthcare	https://www.carilionclinic.org/hospitals/carilion-tazewell-community-hospital
Primary care physicians	Services – Healthcare	http://www.docspot.com/d/TN/new-tazewell/primary-care.html
Tazewell Community Health	Services – Healthcare / Health System	http://svchs.com/about/
Sentara drug testing kit	Services – Public Health, Healthcare	https://drugtestsinbulk.com/drug-test-cards-c-65.html?gclid=CjwKEAjw8Jy8BRCE0pOC9qzRhkMSJABC1pvJ8M4lVGzPLfUTWK168sIcRRk97dXnoVrYaHt2Vjh1ShoCKQXw_wcB

Appendix 7: Prioritization Worksheet

Community Health Needs Assessment Prioritization

Please pick 10 of the most pertinent community needs and rank on a scale of 1 - 10, with 1 being the most pertinent.

For only those top 10, on a scale of 1 - 5, please rate the feasibility and potential impact of those needs, with 1 being the most feasible and having the most impact.

Rank	Community Need	Feasibility	Potential Impact
	Access to adult dental care		
	Access to alternative therapies		
	Access to dental care for children		
	Access to hospice services		
	Access to mental health counseling / substance abuse		
	Access to primary care		
	Access to psychiatry services		
	Access to services for the elderly		
	Access to specialty care		
	Access to vision care		
	Alcohol and illegal drug use		
	Births without prenatal care		
	Child abuse / neglect		
	Chronic disease (diabetes, cardiovascular disease, hypertension, asthma)		
	Coordination of care		
	Domestic violence		
	Dropping out of school		
	High cost of living and preferences for necessities		
	High cost of services for insured (co-pay, deductible, premium)		
	High cost of services for Medications		
	High cost of services for uninsured		
	High prevalence of angina		
	High prevalence of asthma		
	High prevalence of cardiovascular disease		
	High prevalence of COPD		
	High prevalence of diabetes		
	High prevalence of hypertension		
	High prevalence of mental health (depression, anxiety) disorders		
	High prevalence of obesity / overweight individuals		
	High prevalence of pneumonia		
	High prevalence of substance abuse (alcohol, illegal & prescription drugs)		
	High uninsured population		
	In home health care		
	Inappropriate utilization of ED/urgent care for primary care, dental, and mental health services		
	Individual self-treatment for medical conditions		
	Lack of exercise / physical activity		
	Lack of knowledge of community resources		
	Lack of knowledge of health care		
	Lack of reliable transportation		
	Lack of trust in health care services		
	Language barriers and services		
	Need for urgent care services		
	Need for weekend and extended hours for health care services		
	Not accessing regular preventive care for adult dental care		
	Not accessing regular preventive care for primary care		
	Not accessing regular preventive care for vision		
	Not taking medications for chronic conditions		
	Poor eating habits / lack of nutrient dense foods in diet		
	Prescription drug abuse		
	Services that are hard to get in our community:		
	Stigma with mental health and substance abuse services		
	Teenage pregnancy		
	Tobacco use		
	Unable to understand what provider is saying		
	Unsafe sex		
	Value not placed on preventive care and chronic disease management		

Community Need

- Magnitude/ Prevalence
- Severity
- Impact on vulnerable populations
- Health disparities
- Urgency
- Historical trends
- Public concern
- Economic burden

Feasibility

- Alignment with hospital mission and strategic priorities
- Falls within existing hospital capabilities
- Ease of solution implementation
- Barriers to implementation (social, cultural, economic)
- Ease of obtaining additional needed resources, fundraising

Potential Impact

- Preventability
- Presence of existing alternative resources
- Effectiveness of solutions
- Effect on other health needs