2024 Community Health Needs Assessment

Lee County Community Hospital

BalladHealth™

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Acknowledgements

Ballad Health sincerely thanks the members of the Regional Steering Committee and its collaborative partners for their dedication and collaboration during this assessment process. Dr. Paula Masters, chief health disparities officer at Ballad Health, is the senior executive sponsor for the assessment process.

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Executive Summary

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

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

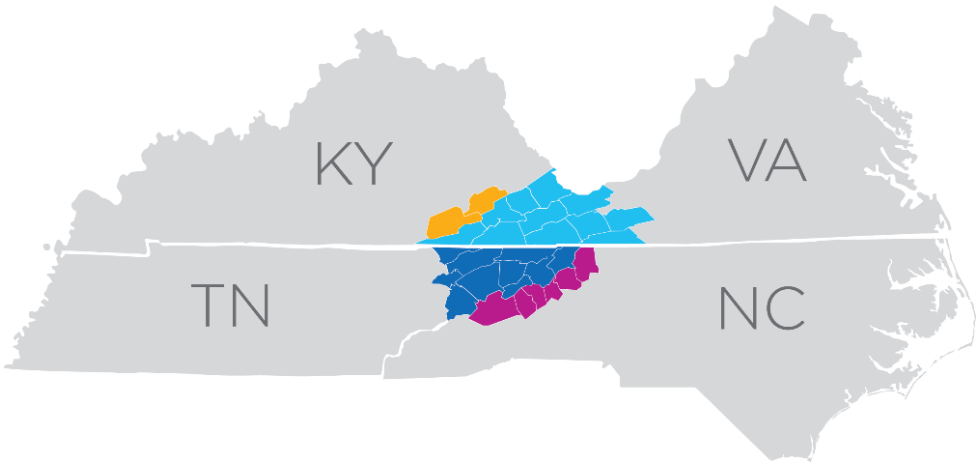
To assess the health of those living in our service area, Ballad Health utilized the Mobilizing for Action through Planning and Partnerships (MAPP 2.0) framework. This comprehensive assessment was conducted from summer 2023 through spring 2024. We gathered primary data through surveys with community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

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

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

Ballad Health

Introduction



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

Ballad Health Hospitals

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

Nearly

1 million

residents across the Ballad Health service area

13,000+

team members

Ballad Health

Mission

Honor those we serve by delivering the best possible care

Vision

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

Values

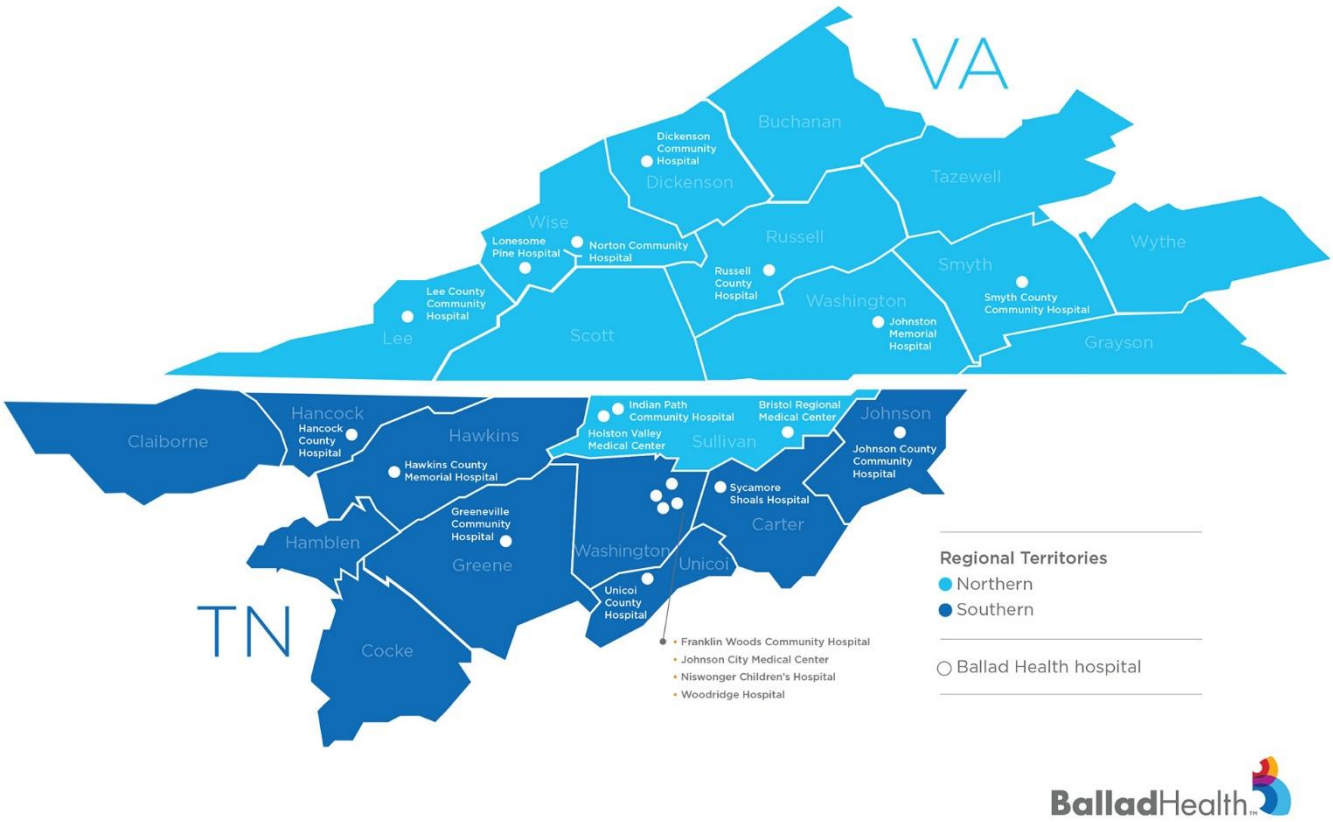
- Caring
- Creativity
- Faith
- Honesty
- Quality
- Respect

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

Ballad Health

Territory

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



Facility Description

Lee County Community Hospital

Opened in 2021, after a successful community effort to bring hospital services back to Pennington Gap, Virginia, Lee County Community Hospital is a critical access hospital that has been specifically designed to meet the needs of its community. The hospital offers acute and emergency services available 24/7, diagnostic radiology and lab services, outpatient cardiology and additional rotating clinics for specialty care and telehealth access, and it also serves as an access point to the hospitals, services and specialties of Ballad Health. Learn more about Lee County Community Hospital at www.balladhealth.org/LCCH.

Scope of services

- Emergency services
- Diagnostic imaging and testing services
- Telemedicine services
- Inpatient care unit
- Inpatient physical therapy services
- Respiratory therapy services
- Outpatient cardiology
- Rotating clinic or telemedicine access to specialty care consultants
- Mobile health services for preventative screenings
- Care coordination services
- Access to a behavioral health network of services through a coordinated system of care
- Community-based education, prevention and disease management services for prioritized programs of emphasis

Lee County Community Hospital's primary service area covers Lee County in Southwest Virginia.

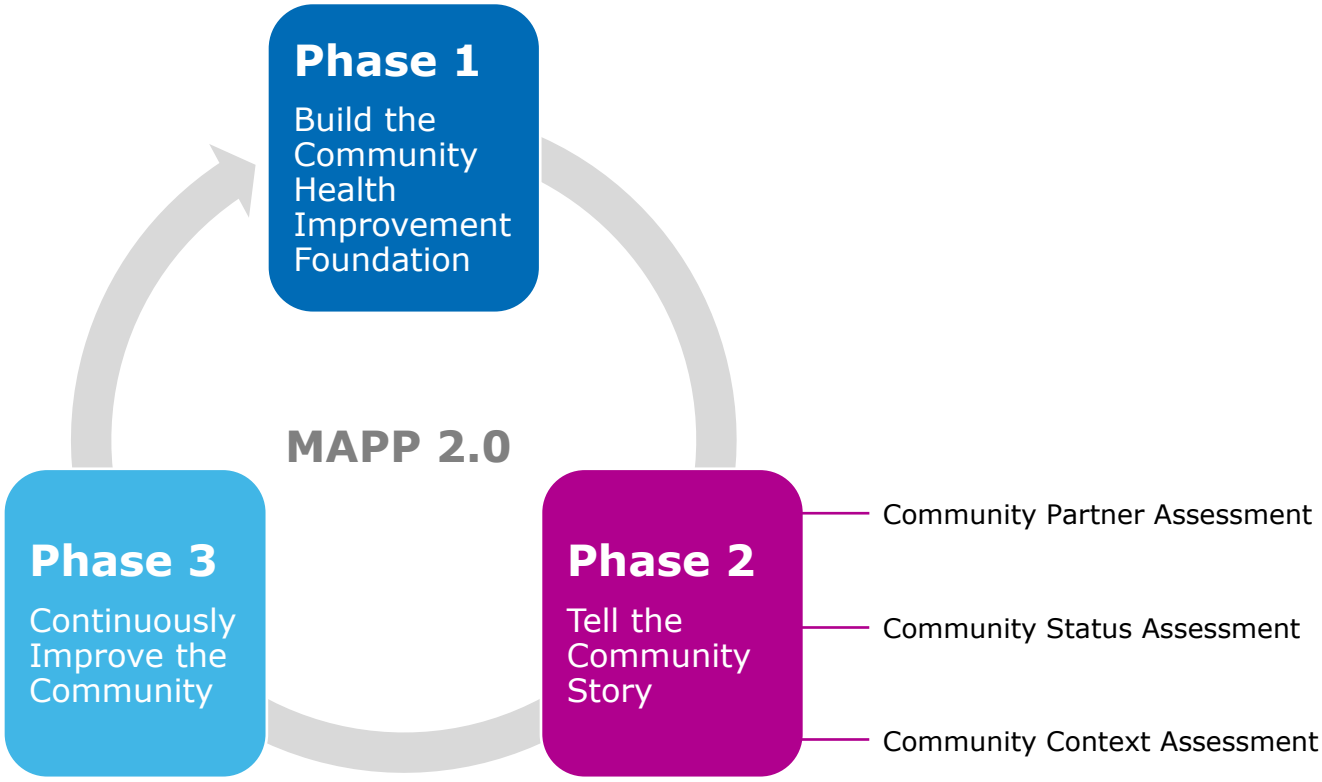
Evaluation model

Model selection : MAPP 2.0

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

MAPP 2.0: Model overview

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



MAPP 2.0: Phases

Phase 1 : Build the Community Health Improvement Foundation

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

Phase 2 : Tell the Community Story

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

Community Partner Assessment

Data and conversations about partnerships and organizational capacities.

Community Status Assessment

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

Community Context Assessment

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

Phase 3 : Continuously Improve the Community

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

Methodology

Methodology

Phase 1 : Build the Community Health Improvement Foundation

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

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

Phase 1: Build the Community Health Improvement Foundation

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

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

Phase 1: Community Health Improvement Foundation

Mission

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

Vision

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

Values

Phase 2: Tell the Community Story

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

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

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

Phase 2: Tell the Community Story

Community Status Assessment (CSA)

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

Primary Data Collection

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

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

Secondary Data Collection

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

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

Phase 2: Tell the Community Story

Community Partner Assessment (CPA)

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

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

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

Community Context Assessment (CCA)

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

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

Phase 3: Continuously Improve the Community

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

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

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

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

Results

Community Status Assessment:
Community Profiles

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

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

Community Status Assessment:
Community Demographic Profile

Data Indicator	Lee	Ballad Health GSA	Virginia	USA
Total Population	22,287	947,632	8,624,511	331,097,593
Total Population by Age Groups, Percent				
Age 0-4	4.4%	4.7%	5.6%	5.7%
Age 5-17	14.1%	14.4%	16%	16.4%
Age 18-24	6.7%	8.5%	9.6%	9.5%
Age 25-34	12.1%	11.6%	13.5%	13.7%
Age 35-44	11.9%	11.4%	12.9%	12.9%
Age 45-54	13.5%	13.4%	12.6%	12.4%
Age 55-64	14.2%	14.5%	13%	12.9%
Age 65+	21.7%	21.5%	16%	16.5%
Total Population by Gender, Percent				
Female, Percent	47%	50.2%	50.5%	50.4%
Male, Percent	52.2%	49.3%	48.9%	49.1%
Total Population by Race Alone, Percent				
American Indian or Alaska Native	0.1%	0.2%	0.3%	0.8%
Asian	0.2%	0.7%	6.9%	5.8%
Black	4%	2.5%	18.6%	12.4%
Multiple Race	2.6%	4.5%	8.2%	10.2%
Multiple Races	2.1%	3.2%	6.9%	8.8%
Native Hawaiian or Pacific Islander	0%	0.1%	0.1%	0.2%
Some Other Race	0.1%	0.7%	3.5%	6.1%
White	92.6%	90.5%	60.4%	61.6%
Families with Children (Age 0-17),Percent of Total Households	25.2%	26.1%	30.5%	29.9%
Hispanic Population, Percent	2.1%	3.1%	10%	18.7%
Median Age	45.2	44.5	38.7	38.5
Net Migration Rate - Total Population (2010-2020)	-1.8%	1.8%	-0.9%	0%
Non-Citizen, Percent	0.9%	1.2%	5.6%	6.5%
People of Color (Not Non-Hispanic White)		8.7%	40%	41.1%
People of Color (Not Non-Hispanic White), Percent	7.9%			
People of Color by Gender, Percent	16.4%	45.5%	49.1%	49.5%
Population Age 5+with Limited English Proficiency,Percent	1.2%	1.1%	5.9%	8.2%
Population with Any Disability by Disability Status, Percent of Total Population	11.7%	12.4%	2.2%	2.4%
Population with Any Disability, Percent	29.7%	21.8%	12.1%	12.9%
Urban and Rural Population (2020), Percent				
Rural Population, Percent	100%	52.8%	24.4%	20%
Urban Population, Percent	0%	47.2%	75.6%	80%
Veteran Population, Percent	7.8%	8.3%	9.9%	6.6%

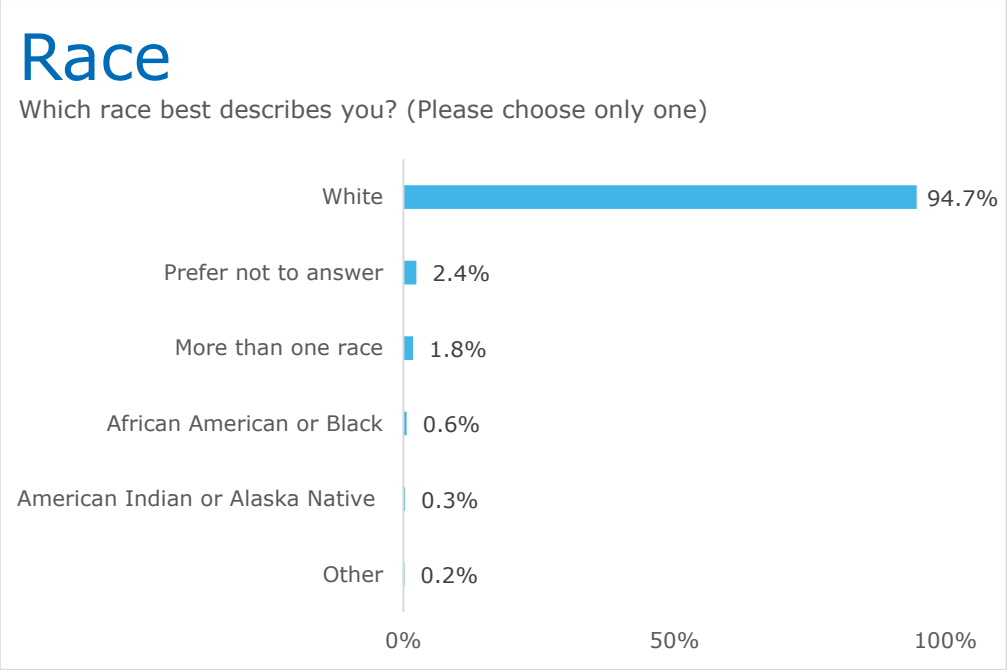
Community Status Assessment:
Community Social Determinants of Health Profile

Social Determinants of Health (SDOH)				
Data Category	Lee	Ballad Health GSA	Virginia	USA
Education				
Access - Childcare Centers - Rate of Childcare Centers per 1,000 (Population <5)	11	10.16	7	8
Access - Childcare Cost Burden - % of Household Income	30.0%	29.2%	26.0%	28.8%
Access - Head Start Programs, Rate per 10,000 Children Under Age 5	45.49	24.88	8.79	10.53
Access - Preschool Enrollment (Age 3-4), Percent	27.2%	30.5%	45.8%	45.6%
Attainment - Overview, Percent				
Associate's Degree	7.3%	8.6%	7.8%	8.7%
Bachelor's Degree	8.5%	13.2%	23.1%	20.9%
Graduate or Professional Degree	3.1%	7.7%	17.9%	13.4%
High School Only	36.7%	36.7%	23.9%	26.4%
No High School Diploma	18.3%	13.3%	8.9%	10.9%
Some College	26.2%	20.5%	18.5%	19.7%
Housing and Families				
Affordable Housing				
Units Affordable at 100% AMI (Area Median Income)	64.8%	63.7%	60.2%	59.5%
Units Affordable at 50% AMI (Area Median Income)	32.2%	24.9%	20.9%	20.7%
Housing Costs - Cost Burden (30%), Percent of Households	21.8%	21.9%	28.2%	30.5%
Housing Costs - Cost Burden, Severe (50%), Percent	12.5%	9.7%	12.4%	14.1%
Substandard Housing: Number of Substandard Conditions Present, Percentage of Total Occupied Housing Units				
One Condition	21.9%	21.4%	27.2%	29.9%
Two or Three Conditions	0.6%	0.7%	1.2%	1.8%
Four Conditions	0.0%	0.0%	0.0%	0.0%
No Conditions	77.6%	77.9%	71.6%	68.3%
Income and Economics				
Employment - Unemployment Rate	3.1%	3.1%	2.4%	3.9%
Households by Household Income Levels, Percent				
Under $25,000	35.0%	24.8%	13.0%	15.7%
$25,000 - $49,999	21.1%	24.8%	15.7%	18.1%
$50,000 - $99,999	30.2%	29.7%	27.3%	28.9%
$100,000 - $199,999	11.5%	16.9%	28.5%	25.9%
$200,000+	2.3%	3.8%	15.6%	11.4%
Income - Median Household Income	$41,619	No data	$87,249	$75,149
Poverty - Children Below 100% FPL, Percent	45.0%	24.8%	12.8%	16.7%
Poverty - Children Below 200% FPL, Percent	67.9%	49.5%	29.8%	37.2%
Poverty - Population Below 200% FPL	48.0%	39.5%	23.4%	28.8%
Other Social & Economic Factors				
Food Insecure Children, Percent of Children	20.0%	14.6%	8.8%	13.3%
Food Insecurity Rate - Percent of Total Population	17.9%	14.1%	7.7%	10.3%
Households with No Motor Vehicle, Percent of Households	9.0%	5.9%	6.1%	8.3%
Housing + Transportation Costs, Percent of Total Income				
Housing + TransportationCosts % Income	62.0%	55.0%	45.0%	48.0%
Incarceration Rate, Percent of Total Population	1.7%	1.7%	1.7%	1.3%
Insurance - Uninsured Population (ACS), Percent of Total Population	10.8%	9.6%	7.4%	8.7%
Racial Segregation (Interaction Index) - (0 = Low Segregation, 1 = High Segregateion)	0.77	No data	No data	No data
Social Vulnerability Index (SoVI) - (0 = Low Vulnerability, 1 = High Vulnerability)	0.88	0.61	0.4	0.58
Violent Crime - Total - Annual Rate per 100,000	97	315.9	207.8	416
Physical Environment				
Food Environment - Low Food Access, Percent	0.0%	22.0%	20.4%	22.2%
Households with No or Slow Internet, Percent	37.3%	20.0%	11.3%	11.7%
Work Force, Rate per 100,000				
Addiction/Substance Abuse Providers	0	7.5	6.77	27.85
Dental Health Providers	18.04	26.53	38.44	39.06
Mental Health Providers	22.55	92.26	116.47	178.73
Primary Care Providers	58.63	118.57	107.63	112.36

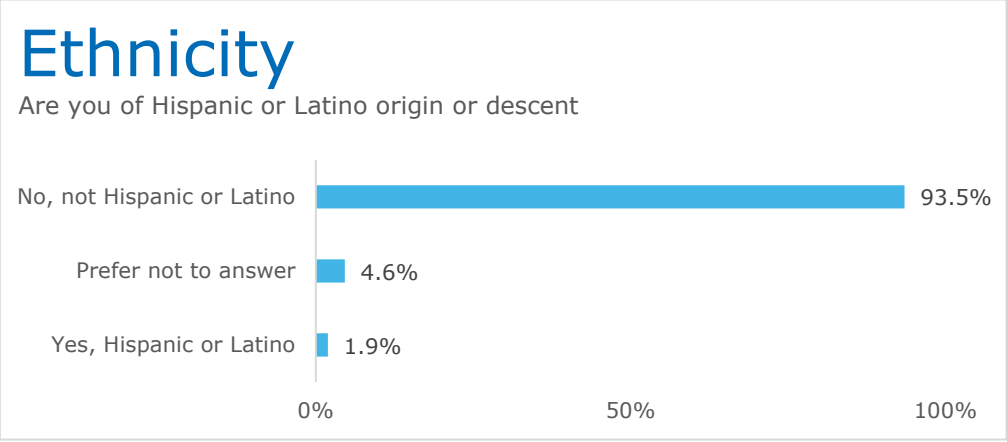
Community Status Assessment:
Community Member Survey Southwest Virginia

Total Respondents

A total of **656** community members living in Southwest Virginia participated in Ballad Health's community member survey.



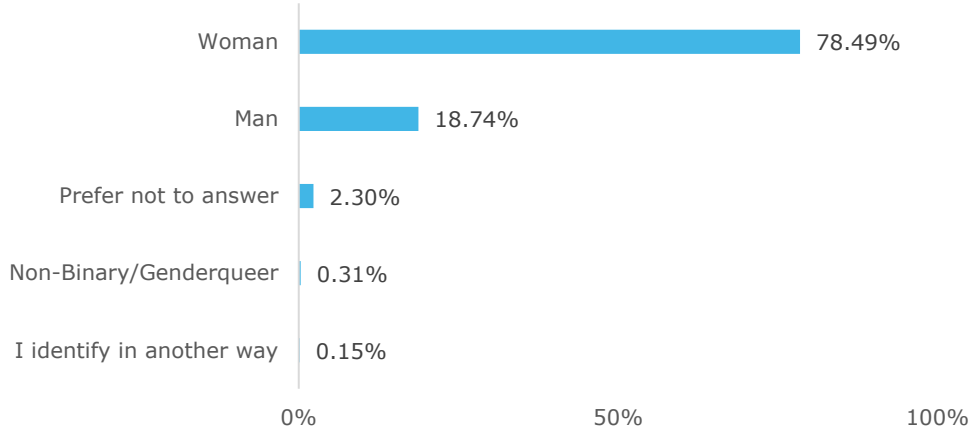
Among Southwest Virginia respondents, the majority (94.7%) were White. This was followed by respondents preferring not to answer (2.4%) then more than one race (1.8%).



Additionally, 93.5% of respondents identified as not Hispanic or Latino, 4.6% preferred not to answer and 1.9% identified as Hispanic or Latino.

Gender identity

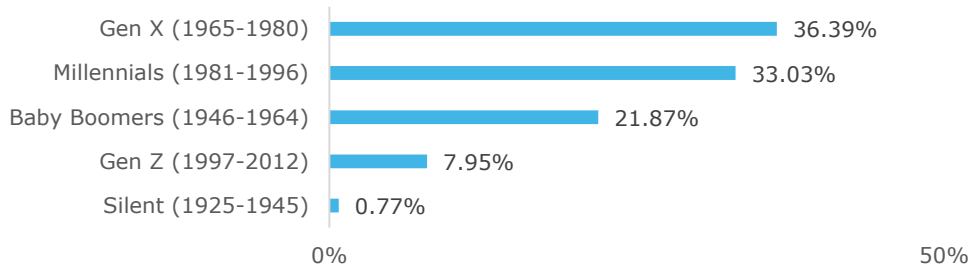
What is your current gender identity? (Please choose only one)



The majority of Southwest Virginia community members who answered the survey identified as women (78.49%). This was followed by men (18.74%).

Age

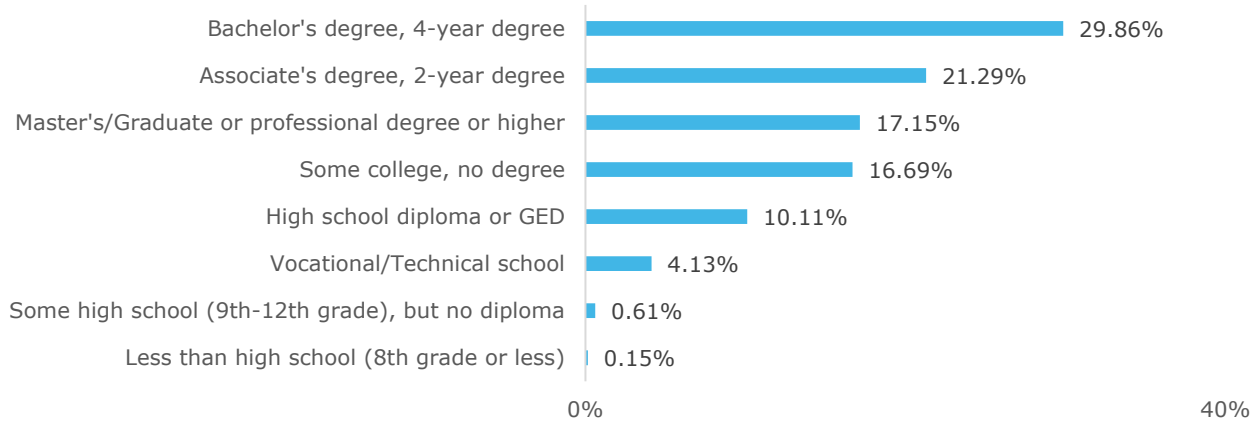
Which age generation group are you in?



Survey respondents were asked to identify their generational group, resulting in 36% identifying as Gen X, 33% as Millennials, and 22% as Baby Boomers.

Education

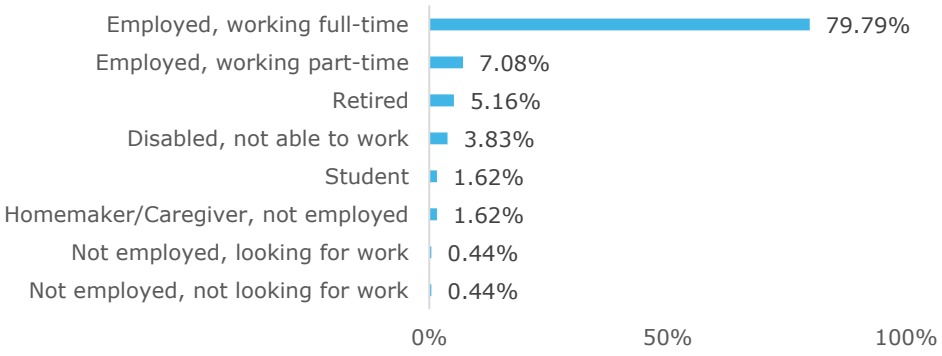
What is the highest level of school that you have completed?



Additionally, 30% of respondents have a bachelor’s degree, 21% have an associate's degree and 17% have a master's/graduate degree.

Employment

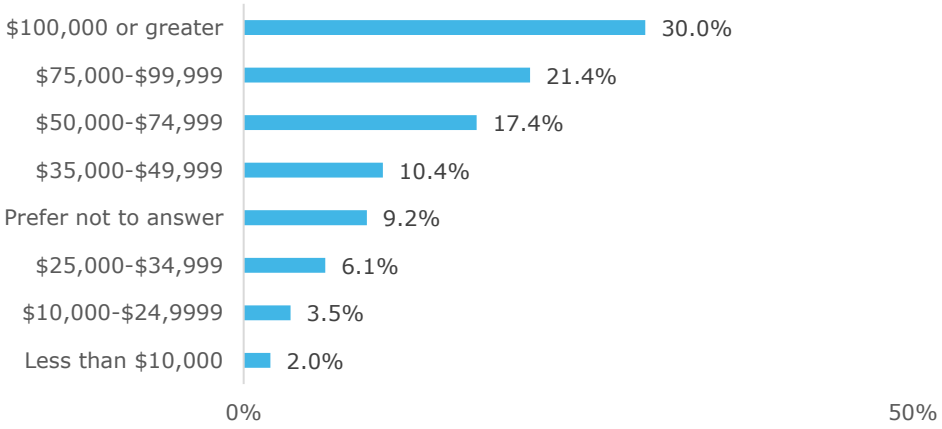
Which of the following categories best describes your employment status? (Choose all that apply)



Survey respondents were asked to provide their current employment status. 80% of respondents were employed, working full-time, 7% employed, working part time and 5% were retired.

Household income

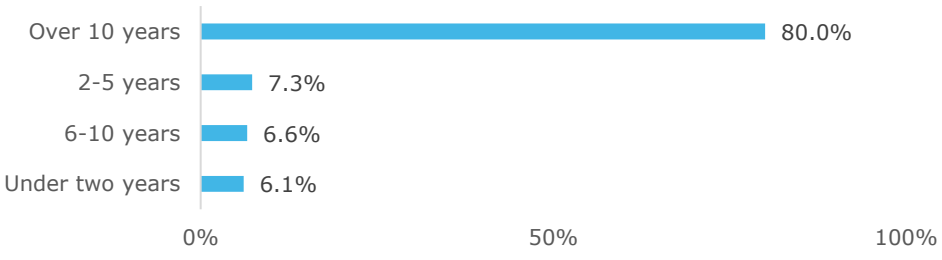
How much total combined income did all people living in your home earn last year?



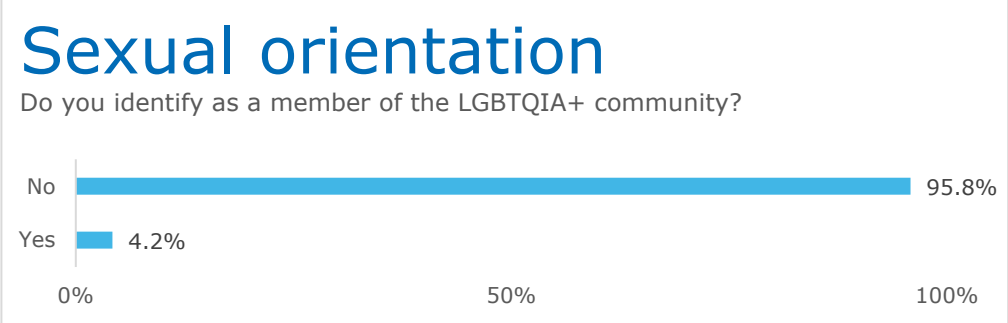
Among respondents to the community health needs assessment from Southwest Virginia, 30% households make $100,000 or greater, 21.4% make $75,000 - $99,999, and 17.4% make $50,000 - $74,999.

Community resident

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



In Southwest Virginia , 80% of survey respondents have been a community member for over 10 years, 7% for 2-5 years, and 7% for 6-10 years.

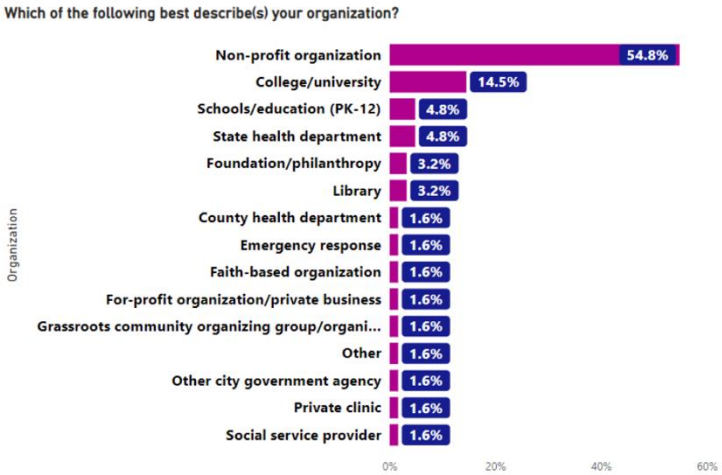


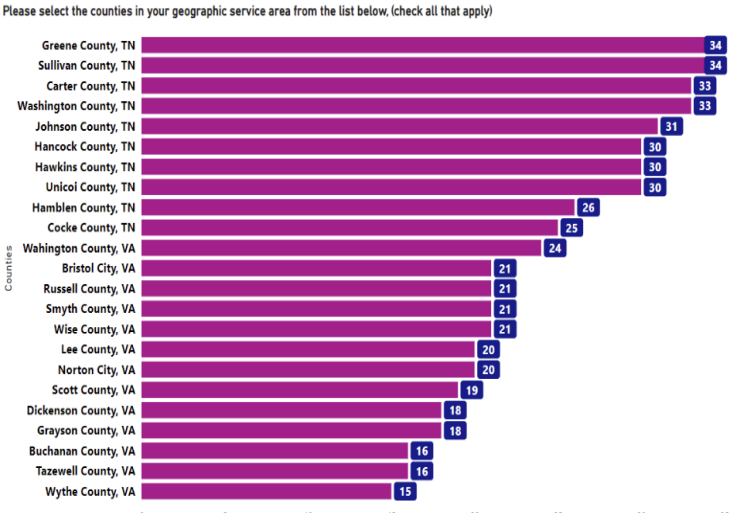
When survey respondents were asked if they identify as members of the LGBTQIA+ community, 4% indicated that they do.

Community Partner Assessment:
Community Partner Survey

Organization Type

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

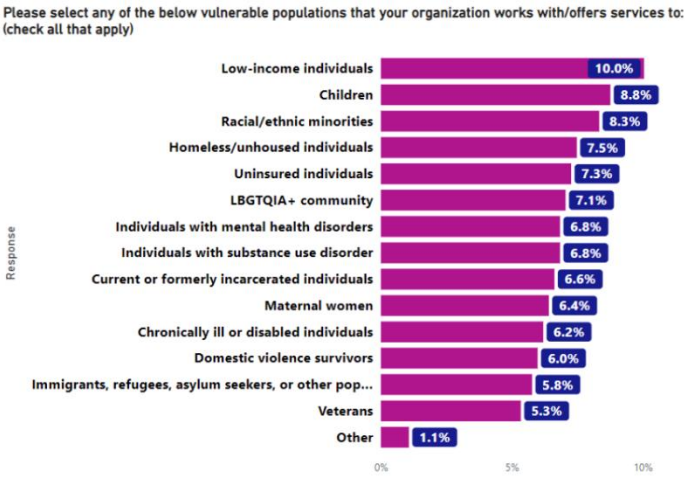




Each county in Tennessee and Virginia within Ballad Health's service area is served by at least 15 organizations that responded to the Community Partner Survey, ensuring the survey's geographic representation of the region. Thirty-four of organizations who responded to the survey serve both Greene and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

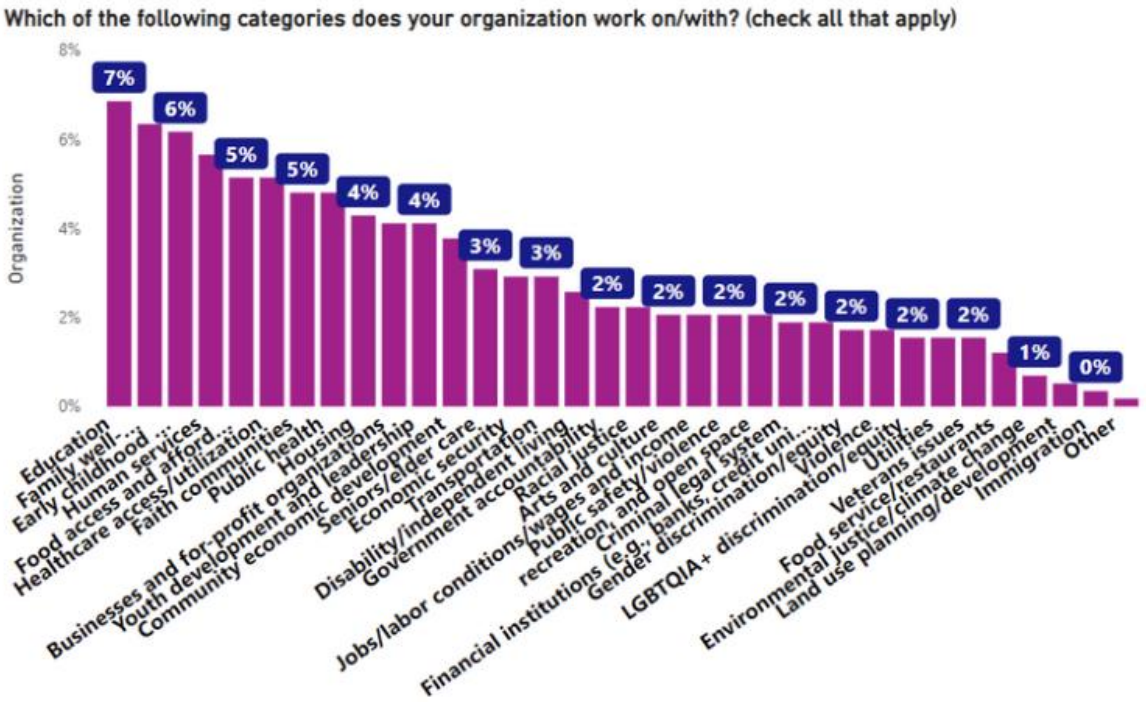
Vulnerable Populations Served

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



Community Partner Assessment:
Community Partner Survey

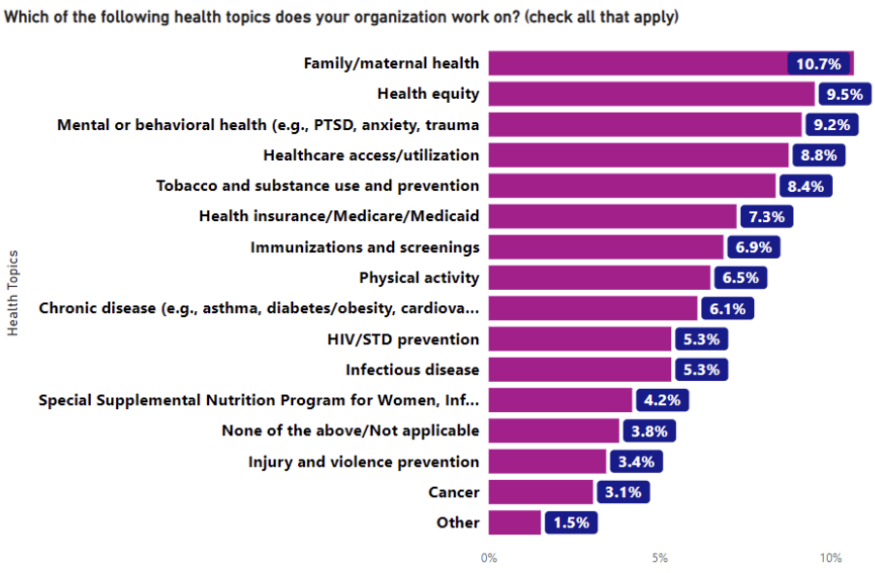
Service Categories



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

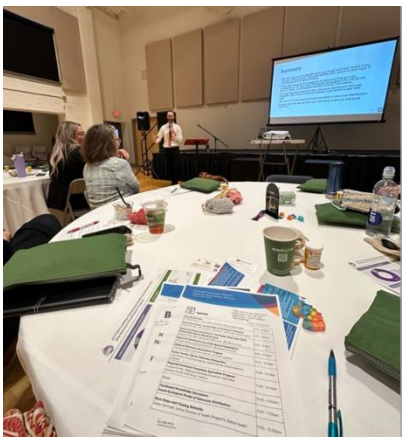
Health Topics

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



Community Context Assessment:
Regional Stakeholder Convening - Substance Use

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



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

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

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

Community Context Assessment:
Regional Stakeholder Convening - Substance Use

Social-Ecological Model for Naloxone Distribution

Organizational

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

Community

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

INTRApersonal

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

INTERpersonal

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

Policy

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

Community Context Assessment:
Regional Stakeholder Convening – Early Literacy

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

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

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

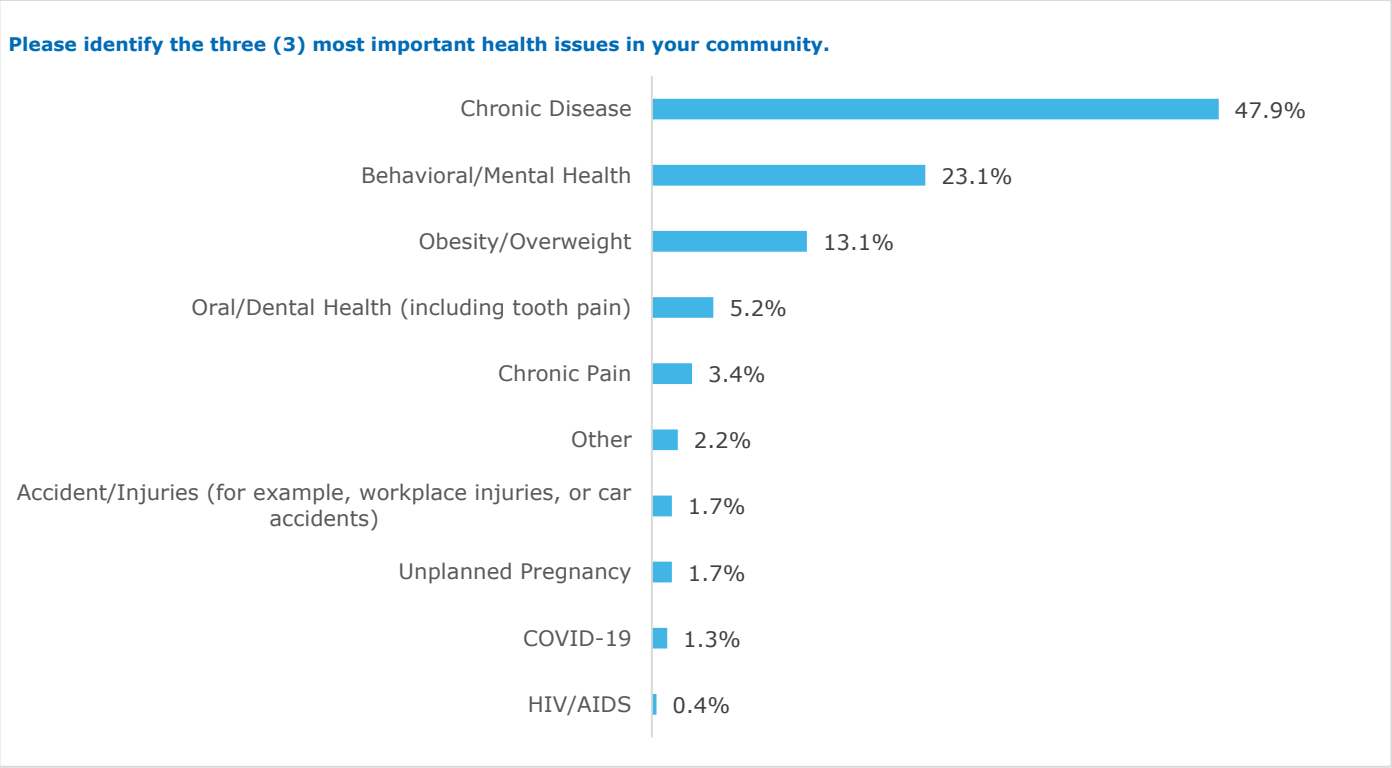
- **Needs**: Stakeholders identified essential requirements or gaps that must be addressed to improve early literacy, including the need for a more collective impact approach that includes a focus on social determinants of health and adverse childhood experiences.
- **Opportunities:** Participants explored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

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

Health Priorities

Health Priorities in Southwest Virginia

Residents who participated in the community member survey were asked to identify the three most important health issues in their community from a provided list. The results indicated that the most important health issues were chronic diseases (48%), behavioral/mental health (23%) and obesity/overweight (13%).



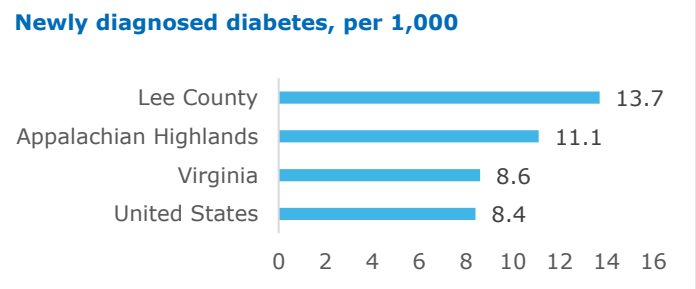
Chronic Disease in Lee County

Diabetes

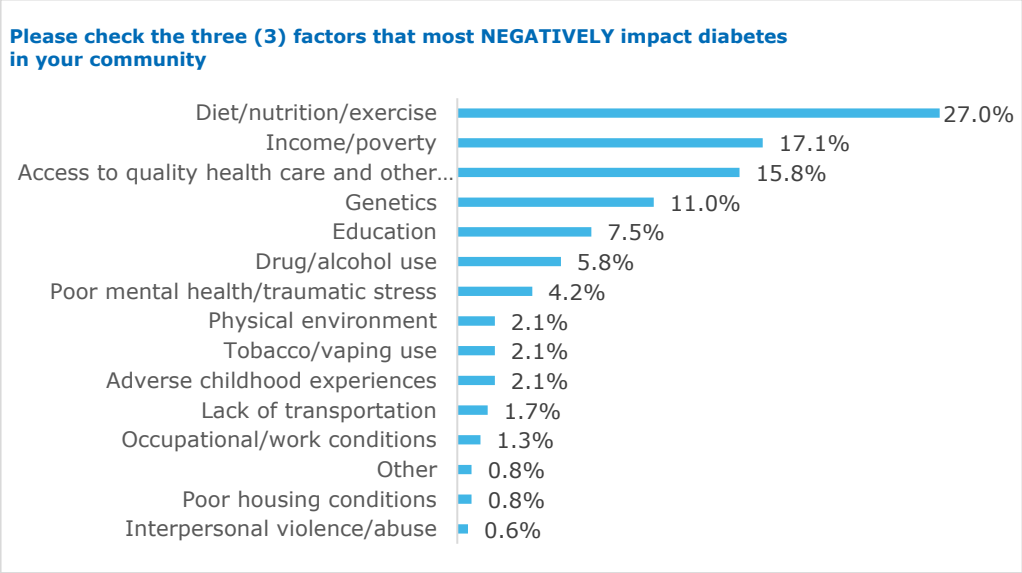
Diabetes is a major public health issue due to its widespread prevalence and severe health impacts. It can lead to serious complications like cardiovascular disease, nerve damage, kidney failure and blindness. Effective management through lifestyle changes, medication and regular monitoring is crucial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

10.2%
of adults in Lee County have diabetes

Lee County has a higher rate of newly diagnosed diabetes cases among adults (20+) each year (13.7 per 1,000) compared to Virginia (8.6 per 1,000) and the United States (8.4 per 1,000).



Root Causes



Survey participants were asked to identify the three factors that most negatively impact diabetes in their community, essentially pinpointing root causes. The results highlighted diet/nutrition/exercise (27%), income/poverty (17%) and access to quality healthcare (16%). Understanding these root causes is crucial because they directly influence the prevalence and management of diabetes. Poor diet and lack of exercise are primary contributors to obesity and metabolic disorders, which significantly increase diabetes risk. Income and poverty levels affect individuals' ability to afford nutritious food, healthcare and other resources necessary for diabetes prevention and management. Access to quality healthcare ensures timely diagnosis, effective treatment and education about managing diabetes, which are vital for controlling the disease and preventing complications. Identifying and addressing these root causes can lead to more effective interventions and improved health outcomes for the community.

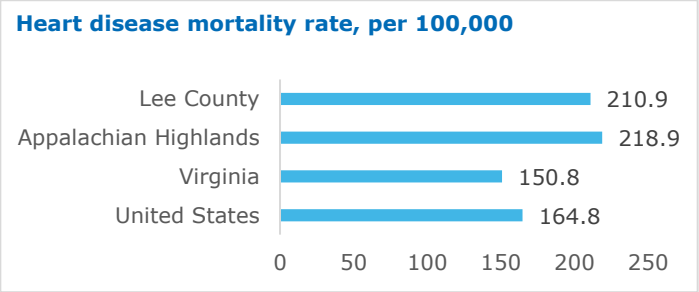
Chronic Disease in Lee County

Heart Disease

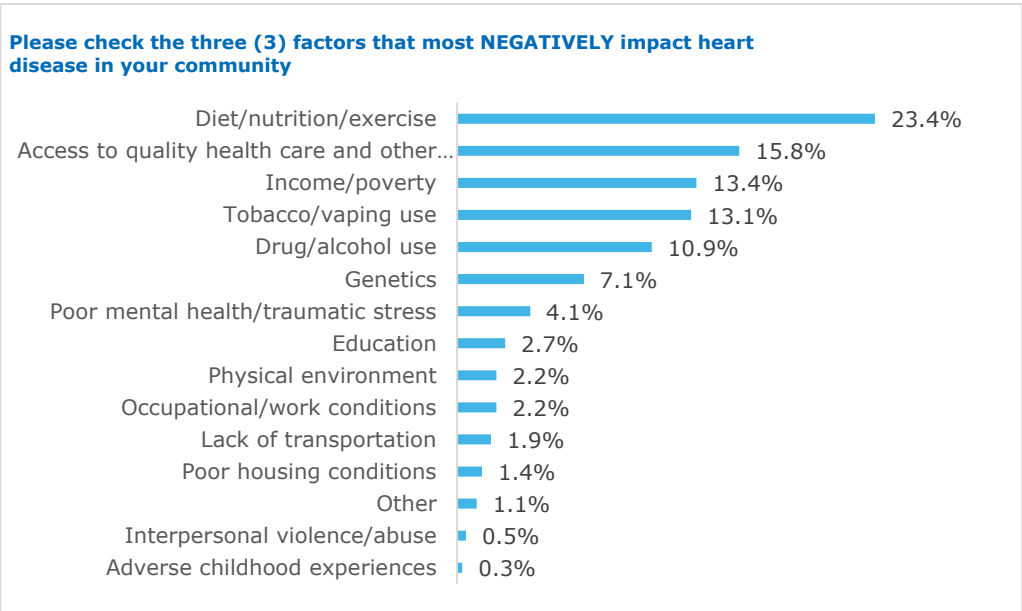
Heart disease is a critical public health issue, being the leading cause of death worldwide. It includes conditions such as coronary artery disease, heart failure and arrhythmias, which significantly impact health and quality of life. Preventing and managing heart disease through a healthy diet, regular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

7%
of adults in Lee County have been diagnosed with heart disease

Lee County has a higher heart disease mortality rate per 100,000 than the national and state average.



Root Causes

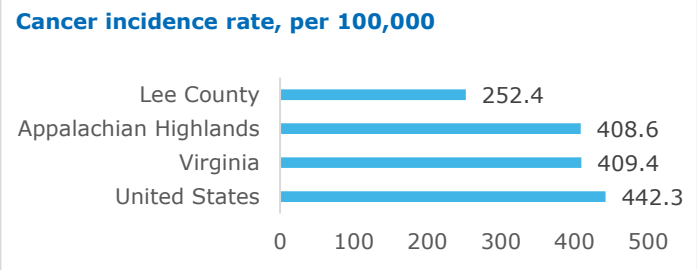


Survey participants were asked to identify the three factors that most negatively impact heart disease in their community, essentially pinpointing root causes. The results highlighted diet/nutrition/exercise (23%), access to quality healthcare (16%) and income/poverty (13%). These root causes crucial because they directly influence the prevalence and severity of heart disease. Poor diet and lack of exercise are well-known risk factors that can lead to obesity, hypertension, and high cholesterol, all of which increase the risk of heart disease. Limited access to quality healthcare can prevent individuals from receiving early diagnosis, effective treatment, and ongoing management of heart conditions, thereby worsening their cardiovascular health. Income and poverty levels affect individuals' ability to access nutritious food, healthcare, and other resources necessary for preventing and managing heart disease. Addressing these root causes through public health initiatives can lead to more effective interventions, improved health outcomes and reduced heart disease rates in the community.

Chronic Disease in Lee County

Cancer

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

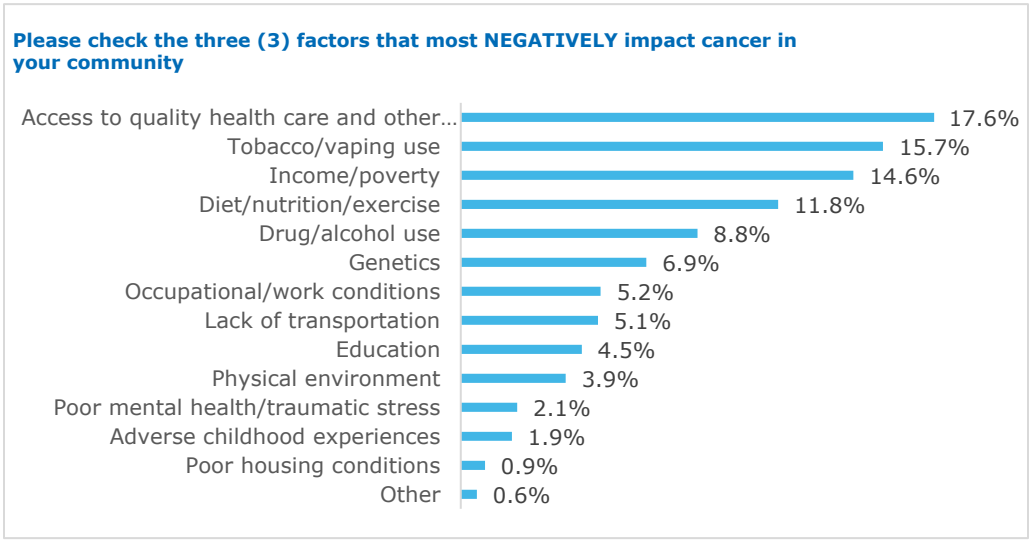


In Lee County, the cancer incidence rate for all sites is 252.4 per 100,000 population, lower than Virginia at 409.4, the Appalachian Highlands at 408.6 and the United States at 442.3.

Rate of cancer incidence, per 100,000

65.7 Breast	41.9 Prostate	54.3 Lung	18.4 Colon and Rectum	Suppressed Cervical

Root Causes



Survey participants were asked to identify the three factors that most negatively impact cancer in their community, essentially pinpointing root causes. The results highlighted access to quality healthcare (17.6%), tobacco/vaping use (15.7%) and income/poverty (14.6%) as primary contributors. Understanding these root causes is crucial because they directly influence cancer outcomes. Limited access to quality healthcare prevents early detection, timely treatment and effective management of cancer, leading to poorer prognosis and higher mortality rates. Tobacco and vaping use are significant risk factors for various cancers, particularly lung cancer, due to the carcinogenic substances they introduce to the body. Income and poverty levels affect individuals' ability to afford preventive measures, screenings and treatments, exacerbating health disparities. Addressing these root causes through public health initiatives can lead to more effective cancer prevention, improved access to care and better health outcomes for the community. Suppressed Data: Certain data points or values have been intentionally omitted or masked in this report to protect privacy, maintain confidentiality and ensure compliance with relevant legal and ethical standards. This practice helps prevent the identification of individuals and safeguards sensitive information.

Overall cancer mortality **181.7** per 100,000 population in Lee County

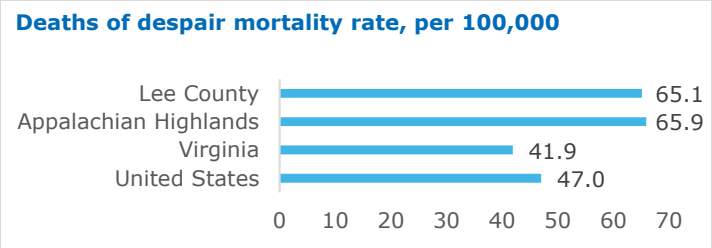
Behavioral/Mental Health in Lee County

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

41%
of adults in Lee County suffer from either mental health or substance use conditions

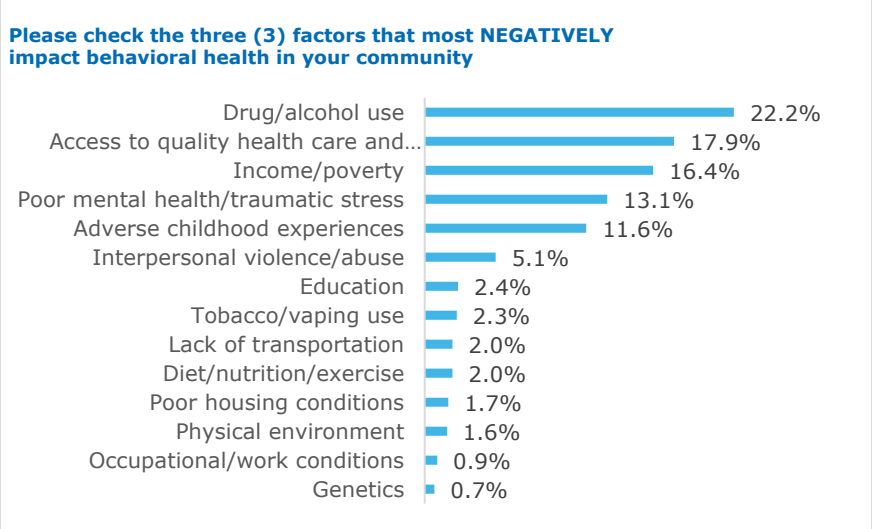
6.2
is the average number of poor mental health days per month for residents in Lee County

Suicide mortality rate is **21** per 100,000 population in Lee County



In Lee County the mortality rate for deaths of despair, which include suicide and drug/alcohol overdose deaths, is 65.1 per 100,000 population. This rate is lower than the rate for the Appalachian Highlands, which stands at 65.9 per 100,000 population. Comparatively, Virginia as a whole has a mortality rate of 41.9 per 100,000 for deaths of despair, while the national rate in the United States is slightly higher at 47 per 100,000 population.

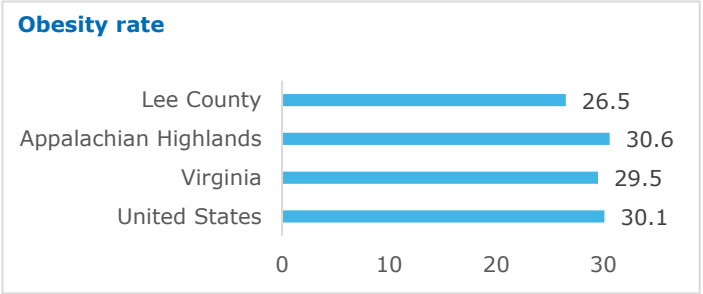
Root Causes



Survey participants were asked to identify the three factors that most negatively impact behavioral and mental health in their community, essentially pinpointing root causes. The results indicated drug and alcohol use (22%), access to quality healthcare (18%) and income/poverty (16%) as primary contributors. Understanding these root causes is crucial because they directly influence mental health outcomes. Substance abuse can exacerbate mental health disorders, leading to a cycle of dependency and deteriorating mental well-being. Limited access to quality healthcare prevents individuals from receiving timely and effective treatment, exacerbating mental health issues. Economic hardship and poverty can lead to chronic stress, anxiety and depression, further impacting mental health. Addressing these root causes through comprehensive public health strategies can lead to more effective interventions, improved access to care and overall better mental health outcomes in the community.

Overweight/Obesity in Lee County

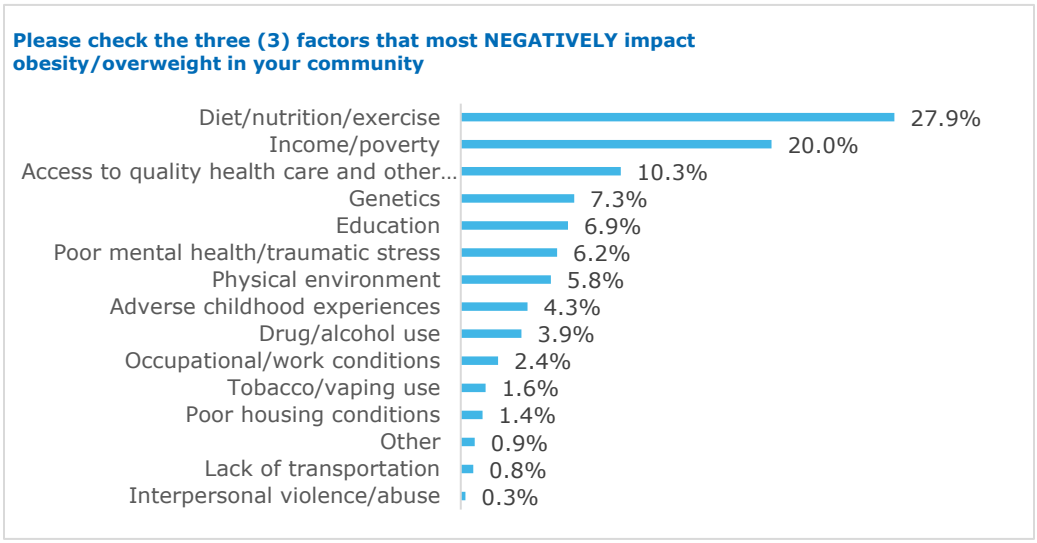
Obesity is a significant public health issue because it is associated with numerous chronic diseases, including heart disease, diabetes and certain cancers, leading to reduced quality of life and increased healthcare costs. The leading causes of obesity include poor diet, lack of physical activity, genetic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



Lee County has a lower obesity rate, affecting 26.5% of the population, compared to the Appalachian Highlands at 30.6%, Virginia overall at 29.5% and the United States at 30.1%.

35.0% have access to exercise opportunities	**24.0%** live within a 1/2 mile from a park	**0.0%** have low access to food	**26.8%** of men are obese	**26.3%** of women are obese	**4** Walkability score (1=Not walkable, 20=Very walkable)

Root Causes



Survey participants were asked to identify the top factors negatively impacting overweight and obesity in their community, highlighting root causes. The results were access to diet/nutrition/ exercise (28%), income/poverty (20%) and access to quality healthcare (10%). These root causes are crucial because limited access to healthy food and exercise leads to poor dietary habits and sedentary lifestyles, major contributors to obesity. Income and poverty restrict the ability to afford nutritious food and exercise opportunities, while access to quality healthcare is essential for effective weight management and addressing related health issues. Addressing these factors through public health initiatives can lead to better interventions and improved health outcomes for the community.

Conclusion

Conclusion

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

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

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

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

Appendix

Appendix

Secondary Data Tables

Demographics				
Data Indicator	Lee	Ballad Health GSA	Virginia	USA
Total Population	22,287	947,632	8,624,511	331,097,593
Total Population by Age Groups, Percent				
Age 0-4	4.4%	4.7%	5.6%	5.7%
Age 5-17	14.1%	14.4%	16%	16.4%
Age 18-24	6.7%	8.5%	9.6%	9.5%
Age 25-34	12.1%	11.6%	13.5%	13.7%
Age 35-44	11.9%	11.4%	12.9%	12.9%
Age 45-54	13.5%	13.4%	12.6%	12.4%
Age 55-64	14.2%	14.5%	13%	12.9%
Age 65+	21.7%	21.5%	16%	16.5%
Total Population by Gender, Percent				
Female, Percent	47%	50.2%	50.5%	50.4%
Male, Percent	52.2%	49.3%	48.9%	49.1%
Total Population by Race Alone, Percent				
American Indian or Alaska Native	0.1%	0.2%	0.3%	0.8%
Asian	0.2%	0.7%	6.9%	5.8%
Black	4%	2.5%	18.6%	12.4%
Multiple Race	2.6%	4.5%	8.2%	10.2%
Multiple Races	2.1%	3.2%	6.9%	8.8%
Native Hawaiian or Pacific Islander	0%	0.1%	0.1%	0.2%
Some Other Race	0.1%	0.7%	3.5%	6.1%
White	92.6%	90.5%	60.4%	61.6%
Families with Children (Age 0-17),Percent of Total Households	25.2%	26.1%	30.5%	29.9%
Hispanic Population, Percent	2.1%	3.1%	10%	18.7%
Median Age	45.2	44.5	38.7	38.5
Net Migration Rate - Total Population (2010-2020)	-1.8%	1.8%	-0.9%	0%
Non-Citizen, Percent	0.9%	1.2%	5.6%	6.5%
People of Color (Not Non-Hispanic White)		8.7%	40%	41.1%
People of Color (Not Non-Hispanic White), Percent	7.9%			
People of Color by Gender, Percent	16.4%	45.5%	49.1%	49.5%
Population Age 5+with Limited English Proficiency,Percent	1.2%	1.1%	5.9%	8.2%
Population with Any Disability by Disability Status, Percent of Total Population	11.7%	12.4%	2.2%	2.4%
Population with Any Disability, Percent	29.7%	21.8%	12.1%	12.9%
Urban and Rural Population (2020), Percent				
Rural Population, Percent	100%	52.8%	24.4%	20%
Urban Population, Percent	0%	47.2%	75.6%	80%
Veteran Population, Percent	7.8%	8.3%	9.9%	6.6%

Appendix

Secondary Data Tables

Housing and Families				
Data Indicator	Lee	Ballad Health GSA	Virginia	USA
Affordable Housing				
Units Affordable at 100% AMI, Percent of Units	64.8%	63.7%	60.2%	59.5%
Units Affordable at 50% AMI, Percent of Units	32.2%	24.9%	20.9%	20.7%
Average Monthly Owner Costs	$639	$822	$1,774	$1,604
Average Monthly Renter Costs	$442	$692	$1,482	$1,366
Household Structure - Older Adults Living Alone				
Percentage of Senior Households	34.6%	39.3%	37.2%	37.2%
Percentage of Total Households	13.4%	14.7%	11.2%	11.5%
Housing Costs - Cost Burden (30%), Percent of Households	21.8%	21.9%	28.2%	30.5%
Housing Costs - Cost Burden, Severe (50%), Percent of Households	12.5%	9.7%	12.4%	14.1%
Housing Quality - Severe Substandard Housing, Percent of Occupied Units	14.2%	13.1%	15.2%	18.5%
Housing Quality - Substandard Housing, Percent of Occupied Units	22.5%	22.1%	28.4%	31.7%
Housing Stock - Median Household Value	$95,800	No data	$339,800	$281,900
Housing Stock - Median Year Structures Built	1977	No data	1983	1979
Housing Stock - Modern Housing (Built after 1999), Percent of Houses	14.2%	18.4%	23.9%	22.3%
Housing Stock - New Building Permits, Rate per 10,000 Housing Units	14.75	54.92	107.84	122.27
Housing Stock - Older Housing (Built before 1960), Percent of Houses	29.2%	24.4%	19.7%	26.5%
Housing Units - Overview (2020)				
Occupied, Percent	83.7%	87.7%	91.8%	90.3%
Vacant, Percent	16.3%	12.3%	8.2%	9.7%
Percent of Householders who Own their Home by Age Group				
Age 15-24	44.7%	21.9%	13.8%	15.8%
Age 25-34	64.4%	47.7%	41.1%	40.3%
Age 35-44	65.6%	63.8%	61.8%	60.1%
Age 45-54	69.6%	73.6%	72.2%	69.4%
Age 55-64	72.4%	78.5%	77.7%	75.1%
Age 65-74	74.8%	83.8%	81.6%	79.4%
Age 75-84	83.7%	86.3%	82.8%	79.5%
Age 85+	96.7%	82.7%	71.9%	70.5%
Percent of Householders who Own their Home by Race				
American Indian or Alaska Native	0.0%	56.3%	58.7%	55.0%
Asian	100.0%	56.0%	69.4%	61.6%
Black	24.0%	43.0%	48.6%	43.1%
Multiple Races	33.3%	50.6%	56.9%	54.5%
Some Other Race	No data	46.0%	49.0%	45.1%
White	72.9%	73.4%	73.1%	71.1%
Percent of Housing Units Overcrowded	1.7%	1.5%	3.0%	4.7%
Percentage of Children in Single-Parent Households	32.2%	26.0%	23.6%	24.9%
Substandard Housing: Households Lacking Complete Kitchen Facilities, Percent	8.7%	4.9%	2.0%	2.4%
Substandard Housing: Households Lacking Complete Plumbing Facilities, Percent	0.1%	0.3%	0.3%	0.4%
Substandard Housing: Households Lacking Telephone Service, Percent	0.7%	1.3%	0.9%	1.1%
Vacant Housing Units (ACS), Percent	23.7%	14.8%	9.3%	10.8%

Appendix

Secondary Data Tables

Health Behaviors				
Data Indicator	Lee	Ballad Health GSA	Virginia	USA
Adults with No Leisure-Time Physical Activity by Gender, 2021				
Female, Percent	31.2%	24.0%	19.1%	21.1%
Male, Percent	27.4%	20.8%	15.8%	17.8%
Alcohol - Adults Age 18+ Binge Drinking in the Past 30 Days (Age-Adjusted), Percent	16.3%	15.7%	16.8%	16.7%
Alcohol - Adults Reporting Excessive Drinking, Percent	14.8%	14.4%	17.8%	18.1%
HIV Prevalence Rate by Race / Ethnicity				
American Indian or Alaska Native	Suppressed	0	88.2	160.3
Asian	Suppressed	0	73	98.9
Black or African American	Suppressed	673.1	975.6	1245.1
Hispanic or Latino	0	274.3	384.2	517.6
Multiracal	Suppressed	899.7	738.4	1063.9
White	96.1	102	144.7	178.6
Insufficient Sleep - Adults Age 18+ Sleeping Less Than 7 Hours on Average (Age-Adjusted), Percent	39.1%	36.3%	34.7%	33.3%
Percentage of Adults Physically Inactive, 2021	29.2%	22.4%	17.5%	19.5%
STI - Chlamydia Incidence				
Chlamydia Infections	34	2598	40409	1644416
Chlamydia Infections,Rate per 100,000 Pop.	154.66	274.46	467.57	495.50
STI - Gonorrhea Incidence				
Gonorrhea Infections	12	1125	14323	710151
Gonorrhea Infections,Rate per 100,000 Pop.	54.6	118.8	165.7	214
STI - HIV Incidence				
HIV / AIDS Infections,Rate per 100,000 Pop.	Suppressed	6.21	10.8	12.7
Total HIV / AIDS Infections	Suppressed	27	792	35716
STI - HIV Prevalence				
Population with HIV / AIDS	20	1027	24411	1071005
Population with HIV / AIDS,Rate per 100,000 Pop.	104.4	125.36	333.9	382.2
Tobacco Usage - Adults Age 18+ as Current Smokers (Age-Adjusted), Percent	24.8%	22.1%	14.1%	13.8%
Walking or Biking to Work Age 16+, Percent	0.5%	1.4%	2.4%	2.9%

Appendix

Secondary Data Tables

Physical Environment				
Data Indicator	Lee	Ballad Health GSA	Virginia	USA
Access to Exercise Opportunities				
Percentage of Population with Access to Exercise Opportunities	35.0%	64.0%	84.0%	84.1%
Air & Water Quality - Drinking Water Safety				
Total Violations	0	28	140	16107
Air & Water Quality - Particulate Matter 2.5				
Average Daily Ambient Particulate Matter 2.5	7.7	7.45	7.65	8.64
Broadband Access, Percent by Time Period				
December, 2023	96.9%	92.5%	88.7%	93.8%
Built Environment - Households with No Computer				
Households with No Computer, Percent	17.8%	12.1%	6.0%	6.1%
Built Environment - Households with No or Slow Internet	37.3%	20.0%	11.3%	11.7%
Climate & Health - Climate-Related Mortality Impacts				
Estimated Climate Change Impacts (% GDP)	7.8%	No data	8.199999%	9.5%
Climate & Health - Flood Vulnerability				
Percentage of Housing Units Within a FEMA Designated Special Flood Hazard Area	6.82%	No data	4.84%	6.45%
Community Design - Park Access (CDC)				
Percent Within 1/2 Mile of a Park	24.0%	33.0%	55.0%	61.0%
Community Design - Walkability Index Score				
Walkability Index Score	4	6	9	10
Food Environment - Low Food Access	0.0%	22.0%	20.4%	22.2%
Food Environment - Low Income & Low Food Access	0.0%	20.9%	17.4%	19.4%
Population with Low or No Healthy Food Access by Race/Ethnicity, Percent				
Hispanic or Latino	0.0%	35.1%	52.6%	55.0%
Multiple Race	0.0%	45.6%	48.4%	53.6%
Non-Hispanic American Indian or Alaska Native	0.0%	49.4%	50.3%	54.6%
Non-Hispanic Asian	0.0%	40.1%	43.3%	51.3%
Non-Hispanic Black	0.0%	44.0%	54.7%	64.2%
Non-Hispanic Other	0.0%	39.7%	47.6%	57.9%
Non-Hispanic White	0.0%	45.2%	43.6%	49.3%
Population with Low or No Healthy Food Access, Racial Disparity Index				
Disparity Index Score (0 = No Disparity; 1 - 15 = Some Disparity; Over 15 = High Disparity)	0	23.56	13.91	16.59
Population without a Computer or an Internet Subscription by Employment Status				
Employed withNo Computer orInternet Subscription,Percent	28.0%	9.3%	6.0%	6.1%
Unemployed withNo Computer orInternet Subscription,Percent	28.6%	14.9%	9.3%	8.8%

Appendix

Secondary Data Tables

Clinical Care and Prevention				
Data Indicator	Lee	Ballad Health GSA	Virginia	USA
Annual Wellness Exam (2021), Percent	30.0%	45.0%	41.0%	
Annual Wellness Exam by Race and Ethnicity, Percent				
American Indian/Alaska native	No data	No data	38%	
Black or African American	No data	38.0%	38.0%	
Hispanic or Latino	No data	28.0%	29.0%	
Non-Hispanic White	30.0%	48.0%	42.0%	
Blood Pressure Medication Nonadherence by Race/Ethnicity, Percent				
Black or African American	No data	25.5%	26.3%	
Hispanic or Latino	No data	No data	25%	
Non-Hispanic White	22.7%	21.4%	19.6%	
Cancer Screening - Cervical - Females Age 21-65 with recent Pap Smear, Percent	79.0%	81.6%	84.3%	83.7%
Cancer Screening - Mammogram (Adult) - Age 50-74, Percent	68.8%	71.8%	75.8%	77.8%
Cancer Screening - Sigmoidoscopy or Colonoscopy - Age 50-75, Percent	65.4%	69.7%	73.1%	70.6%
Dental Care - Adults Age 18+ with Recent Dental Visit, Percent	54.6%	55.5%	68.3%	64.5%
Hospitalizations - Heart Disease - Cardiovascular Disease Hospitalizations, Rate per 1,000	14.8	13	10.7	10.4
Hospitalizations - Ischemic Stroke Hospitalizations, Rate per 1,000	9	9.2	9.1	
Hospitalizations - Preventable Hospitalizations, Rate per 100,000 Beneficiaries	4268	3258	2591	2752
Late or No Prenatal Care - Percent of Births	Suppressed	4.9%	4.8%	
Opioid Drug Claims, Percent of Total Claims	6.2%	5.0%	3.9%	
Prevention - Adults with Recent Influenza Immunization, Percent	42.7%	44.1%	48.7%	
Prevention - Cholesterol Screening - Adults Age 18+ with Recent Cholesterol Screening (Age-Adjusted), percent	80.6%	83.3%	86.2%	
Prevention - Core Preventative Services for Men - Age 65+ Up to Date on Core Preventative Services (Age-Adjusted), Percent	41.0%	42.2%	48.5%	
Prevention - Core Preventative Services for Women - Age 65+ Up to Date on Core Preventative Services (Age-Adjusted), Percent	36.0%	37.8%	42.6%	
Prevention - High Blood Pressure Management (Adult) - Age 18+ with HTN Who Take Medicine for HTN (Age-Adjusted), Percent	63.3%	62.4%	61.5%	
Prevention - Recent Primary Care Visit (Adult) - Age 18+ with Routine Checkup in Past 1 Year (Age-Adjusted), Percent	73.5%	74.5%	74.9%	
Readmissions - Chronic Obstructive Pulmonary Disease - 30 Day Readmission, Percent	Suppressed	19.7%	19.7%	
Readmissions - Heart Attack - 30 Day Readmission, Percent	Suppressed	16.2%	15.3%	
Readmissions - Heart Failure - 30 Day Readmission, Percent	Suppressed	22.6%	21.1%	
Readmissions - Pneumonia - 30 Day Readmission, Percent	Suppressed	17.5%	16.6%	

Appendix

Secondary Data Tables

Other Social and Economic Factors				
Data Indicator	Lee	Ballad Health GSA	Virginia	USA
Food Insecurity - Food Insecure Population Ineligible for SNAP Assistance				
Food Insecure Children Ineligible for Assistance, Percent	10.0%	17.1%	23.8%	26.6%
Food Insecure Population Ineligible for Assistance, Percent	8.9%	29.9%	30.1%	36.8%
Food Insecurity - Percent of Children that are Food Insecure	20.0%	14.6%	8.8%	13.3%
Food Insecurity Rate, Percent of Total Population	17.9%	14.1%	7.7%	10.3%
Gender Pay Gap: Ratio of Female vs. Male Median Earnings	0.89	0.81	0.8	0.81
Homeless Children & Youth: Homeless Students, Percent	0.3%	1.9%	1.4%	2.8%
Households Receiving SNAP Benefits by Race/Ethnicity, Percent				
American Indian or Alaska Native	0.0%	32.4%	13.4%	22.9%
Asian	0.0%	4.6%	5.0%	7.9%
Black	76.0%	26.2%	18.2%	24.6%
Multiple Race	45.8%	22.0%	10.5%	16.9%
Non-Hispanic White	24.4%	14.1%	5.4%	7.1%
Some Other Race	No data	16.9%	10.5%	19.5%
Households with No Motor Vehicle, Percent	9.0%	5.9%	6.1%	8.3%
Housing + Transportation Affordability Index (H+T Index)				
Housing + Transportation Costs,Percent of Income	62.0%	55.0%	45.0%	48.0%
Housing Costs, Percent of Income	25.0%	25.0%	26.0%	26.0%
Transportation Costs, Percent of Income	37.0%	30.0%	19.0%	21.0%
Incarceration Rate, Percent of Total Population	1.7%	1.7%	1.7%	1.3%
Insurance - Insured Population and Provider Type				
Percentage with Private Insurance	53.3%	64.5%	80.5%	74.0%
Percentage with Public Insurance	65.0%	51.2%	33.9%	39.3%
Insurance - Population Receiving Medicaid, Percent of insured Population	36.4%	26.1%	15.5%	22.3%
Insurance - Uninsured Adults				
Pop. Age 18-64 w/ Insurance, Percent	88.6%	86.5%	90.7%	87.9%
Pop. Age 18-64 w/o Insurance, Percent	11.4%	13.5%	9.3%	12.1%
Insurance - Uninsured Children				
Pop. Age 0-18 w/ Insurance, Percent	95.7%	96.0%	95.7%	94.7%
Pop. Age 0-18 w/o Insurance, Percent	4.3%	4.0%	4.4%	5.3%

Appendix

Secondary Data Tables

Other Social and Economic Factors				
Data Indicator	Lee	Ballad Health GSA	Virginia	USA
Opportunity Index - Dimension Scores (0=Low Opportunity, 100=High Opportunity)				
Community	34.1	42.2	50.4	47.6
Economy	46	52.6	61.1	55.4
Education	34.3	51.5	60.3	55.2
Health	43.2	43.6	56	54
Opportunity Index (0=Low Opportunity, 100=High Opportunity)	39.4	47.5	57	53.1
Racial Segregation (Interaction Index) - (0 = Low Segregation, 1 = High Segregation)	0.77	No data	No data	No data
SNAP Benefits - Households Receiving SNAP (ACS), Percent	25.0%	14.6%	8.3%	11.5%
Social Capital - Voter Participation, Percent	51.5%	57.7%	72.6%	68.8%
Social Vulnerability Index (SoVI) - (0 = low Vulnerability, 1 = High Vulnerability)	0.2	0.22	0.37	0.48
Teen Births, Rate per 1,000 Female Population Age 15-19	34.4	26.4	13.5	16.6
Uninsured Population by Ethnicity Alone				
Hispanic or Latino, Percent	2.4%	27.1%	22.4%	17.6%
Not Hispanic or Latino, Percent	10.9%	9.1%	5.8%	6.6%
Uninsured Population by Race, Percent				
American Indian or Alaska Native	50.0%	25.9%	16.3%	19.3%
Asian	0.0%	8.9%	6.7%	6.1%
Black or African American	0.0%	13.5%	8.0%	9.8%
Multiple Race	0.0%	13.8%	11.0%	12.6%
Native Hawaiian or Pacific Islander	No data	18.5%	8.9%	11.5%
Non-Hispanic White	11.1%	8.9%	4.9%	5.9%
Some Other Race	100.0%	34.2%	27.8%	19.8%
Violent Crime - Assaults, Rate per 100,000	62.9	246.9	117	261.2
Violent Crime - Rape, Rate per 100,000	30	38.9	32.1	38.6
Violent Crime - Robbery, Rate per 100,000	4.1	25.7	53.4	110.9
Young People, Age 16-19, Not in School and Not Working, Percent	6.7%	9.9%	5.9%	6.9%

Appendix

Secondary Data Tables

Special topics - Covid-19				
Data Indicator	Lee	Ballad Health GSA	Virginia	USA
COVID-19 Fully Vaccinated Adults				
Estimated Percent of Adults Hesitant About Receiving COVID-19 Vaccination	8.0%	11.6%	5.6%	10.3%
Percent of Adults Fully Vaccinated	60.1%	59.4%	66.5%	72.9%
Vaccine Coverage Index	0.65	0.56	0.2	0.44
COVID-19 - Mortality				
Deaths, Rate per 100,000 Population	556.48	569.06	277.85	337.86
COVID-19 - Confirmed Cases				
Confirmed Cases, Rate per 100,000 Population	36009.52	37500.38	26908.14	31100.91

Work Force				
Data Indicator	Lee	Ballad Health GSA	Virginia	USA
Addiction/Substance Abuse Providers				
Providers, Rate per 100,000 Population	0	7.5	6.77	27.85
Dental Health Providers				
Providers, Rate per 100,000 Population	18.04	26.53	38.44	39.06
Federally Qualified Health Centers				
Rate of Federally Qualified Health Centers per 100,000	40.59	6.45	2.06	3.49
Mental Health Providers				
Providers, Rate per 100,000 Population	22.55	92.26	116.47	178.73
Population Living in a Health Professional Shortage Area				
Percentage of HPSA Population Underserved	67.5%	28.6%	35.6%	53.1%
Percentage of Population Living in an Area Affected by a Primary Care HPSA	1	43.8%	19.9%	23.5%
Primary Care Providers				
Providers, Rate per 100,000 Population	58.63	118.57	107.63	112.36

Appendix

Secondary Data Tables

Social Determinants of Health (SDOH)				
Data Category	Lee	Ballad Health GSA	Virginia	USA
Education				
Access - Childcare Centers - Rate of Childcare Centers per 1,000 (Population <5)	11	10.16	7	8
Access - Childcare Cost Burden - % of Household Income	30.0%	29.2%	26.0%	28.8%
Access - Head Start Programs, Rate per 10,000 Children Under Age 5	45.49	24.88	8.79	10.53
Access - Preschool Enrollment (Age 3-4), Percent	27.2%	30.5%	45.8%	45.6%
Attainment - Overview, Percent				
Associate's Degree	7.3%	8.6%	7.8%	8.7%
Bachelor's Degree	8.5%	13.2%	23.1%	20.9%
Graduate or Professional Degree	3.1%	7.7%	17.9%	13.4%
High School Only	36.7%	36.7%	23.9%	26.4%
No High School Diploma	18.3%	13.3%	8.9%	10.9%
Some College	26.2%	20.5%	18.5%	19.7%
Housing and Families				
Affordable Housing				
Units Affordable at 100% AMI (Area Median Income)	64.8%	63.7%	60.2%	59.5%
Units Affordable at 50% AMI (Area Median Income)	32.2%	24.9%	20.9%	20.7%
Housing Costs - Cost Burden (30%), Percent of Households	21.8%	21.9%	28.2%	30.5%
Housing Costs - Cost Burden, Severe (50%), Percent	12.5%	9.7%	12.4%	14.1%
Substandard Housing: Number of Substandard Conditions Present, Percentage of Total Occupied Housing Units				
One Condition	21.9%	21.4%	27.2%	29.9%
Two or Three Conditions	0.6%	0.7%	1.2%	1.8%
Four Conditions	0.0%	0.0%	0.0%	0.0%
No Conditions	77.6%	77.9%	71.6%	68.3%
Income and Economics				
Employment - Unemployment Rate	3.1%	3.1%	2.4%	3.9%
Households by Household Income Levels, Percent				
Under $25,000	35.0%	24.8%	13.0%	15.7%
$25,000 - $49,999	21.1%	24.8%	15.7%	18.1%
$50,000 - $99,999	30.2%	29.7%	27.3%	28.9%
$100,000 - $199,999	11.5%	16.9%	28.5%	25.9%
$200,000+	2.3%	3.8%	15.6%	11.4%
Income - Median Household Income	$41,619	No data	$87,249	$75,149
Poverty - Children Below 100% FPL, Percent	45.0%	24.8%	12.8%	16.7%
Poverty - Children Below 200% FPL, Percent	67.9%	49.5%	29.8%	37.2%
Poverty - Population Below 200% FPL	48.0%	39.5%	23.4%	28.8%
Other Social & Economic Factors				
Food Insecure Children, Percent of Children	20.0%	14.6%	8.8%	13.3%
Food Insecurity Rate - Percent of Total Population	17.9%	14.1%	7.7%	10.3%
Households with No Motor Vehicle, Percent of Households	9.0%	5.9%	6.1%	8.3%
Housing + Transportation Costs, Percent of Total Income				
Housing + TransportationCosts % Income	62.0%	55.0%	45.0%	48.0%
Incarceration Rate, Percent of Total Population	1.7%	1.7%	1.7%	1.3%
Insurance - Uninsured Population (ACS), Percent of Total Population	10.8%	9.6%	7.4%	8.7%
Racial Segregation (Interaction Index) - (0 = Low Segregation, 1 = High Segregateion)	0.77	No data	No data	No data
Social Vulnerability Index (SoVI) - (0 = Low Vulnerability, 1 = High Vulnerability)	0.88	0.61	0.4	0.58
Violent Crime - Total - Annual Rate per 100,000	97	315.9	207.8	416
Physical Environment				
Food Environment - Low Food Access, Percent	0.0%	22.0%	20.4%	22.2%
Households with No or Slow Internet, Percent	37.3%	20.0%	11.3%	11.7%
Work Force, Rate per 100,000				
Addiction/Substance Abuse Providers	0	7.5	6.77	27.85
Dental Health Providers	18.04	26.53	38.44	39.06
Mental Health Providers	22.55	92.26	116.47	178.73
Primary Care Providers	58.63	118.57	107.63	112.36

Appendix

Secondary Data Tables

Education				
Data Indicator	Lee	Ballad Health GSA	Virginia	USA
Access - Childcare Centers - Rate of Childcare Centers per 1,000 (Population <5)	11	10.16	7	8
Access - Childcare Cost Burden - % of Household Income	30.0%	29.2%	26.0%	28.8%
Access - Head Start Programs, Rate per 10,000 Children Under Age	45.49	24.88	8.79	10.53
Access - Preschool Enrollment (Age 3-4), Percent	27.2%	30.5%	45.8%	45.6%
Attainment - Overview, Percent				
Associate's Degree	7.3%	8.6%	7.8%	8.7%
Bachelor's Degree	8.5%	13.2%	23.1%	20.9%
Graduate or Professional Degree	3.1%	7.7%	17.9%	13.4%
High School Only	36.7%	36.7%	23.9%	26.4%
No High School Diploma	18.3%	13.3%	8.9%	10.9%
Some College	26.2%	20.5%	18.5%	19.7%
Chronic Absence Rate	12.3%	14.2%	10.9%	20.9%
Chronic Absence Rate by Race / Ethnicity				
American Indian or Alaska Native	0	59.0%	13.0%	39.0%
Asian	0	8.0%	3.0%	10.0%
Black or African American	12.0%	24.0%	18.0%	33.0%
Hispanic / Latino	12.0%	16.0%	13.0%	25.0%
Native Hawaiian/Other Pacific Islander	No data	39.0%	11.0%	56.0%
Two or More Races	11.0%	22.0%	11.0%	27.0%
White	12.0%	14.0%	8.0%	16.0%
Employment Rate by Educational Attainment				
Bachelor's or Higher	98.0%	97.7%	97.9%	97.2%
High School Only	99.0%	93.5%	95.1%	94.1%
No High School Diploma	96.6%	90.1%	93.1%	92.2%
Some College or Associate's	92.7%	95.3%	95.9%	95.3%
High School Graduation Rate by Student Race and Ethnicity				
Black or African American	No data	88.0%	86.5%	83.6%
Hispanic or Latino	No data	88.7%	75.2%	78.5%
White	82.1%	92.4%	92.9%	90.8%
Proficiency - Student Math Proficiency (4th Grade)				
Students Scoring 'Not Proficient' or Worse, Percent	51.4%	55.6%	48.1%	63.9%
Students Scoring 'Proficient' or Better, Percent	48.6%	44.4%	51.9%	36.1%
Proficiency - Student Reading Proficiency (4th Grade)				
Students Scoring 'Not Proficient' or Worse, Percent	32.2%	49.8%	35.7%	60.1%
Students Scoring 'Proficient' or Better, Percent	67.8%	50.2%	64.3%	39.9%
Public School Expenditures				
Expenditures Per Student ($)	$13,530	$11,988	$15,290	$17,001
Expenditures Spent on Capital Outlay (%)	5.24	6.33	7.51	10.07
Expenditures Spent on Instruction (%)	53.18	56.59	55.15	50.31
Expenditures Spent on Non-Elementary/Secondary Education (%)	7.0%	70.0%	36.0%	90.0%
Expenditures spent on Support Services (%)	36.02	30.67	32.47	29.77
Total Expenditures (Millions)	41	1490	19066	827605
School Funding Adequacy				
Actual Spending Per Pupil	$12,742	$11,071	$13,835	$14,116
Gap between Actual and Required Spending	$-2,716	$-1,571	$-806	$-1,337
Required Spending Per Pupil	$15,458	$12,642	$14,641	$15,453

Appendix

Secondary Data Tables

Income and Economics				
Data Indicator	Lee	Ballad Health GSA	Virginia	USA
Average Public Assistance Dollars Received				
Aggregate Public Assistance Dollars Received	$881,500	$29,861,400	$287,830,900	$14,167,234,100
Average Public Assistance Received (in USD) by Households Receiving Public Assistance	$3,082	$2,927	$3,961	$4,242
Children in Poverty by Race, Percent				
American Indian or Alaska Native	No data	41.5%	14.3%	29.1%
Asian	100.0%	5.1%	6.7%	10.2%
Black or African American	No data	38.3%	25.0%	30.6%
Multiple Race	52.6%	38.6%	11.6%	17.7%
Native Hawaiian or Pacific Islander	No data	28.9%	10.2%	23.4%
Some Other Race	No data	44.6%	22.2%	25.5%
Commuter Travel Patterns - Overview				
PercentBicycle or Walk	0.5%	1.4%	2.4%	2.9%
PercentCarpool	7.0%	7.6%	8.3%	8.5%
PercentDrive Alone	83.2%	83.1%	70.9%	71.7%
PercentPublic Transportation	0.3%	0.2%	3.0%	3.8%
PercentTaxi or Other	1.3%	1.2%	1.4%	1.4%
PercentWork at Home	7.7%	6.4%	14.0%	11.7%
Commuter Travel Patterns - Overview 2				
% Workers Travelling < 10 mins	13.5%	16.0%	10.3%	12.5%
% Workers Travelling > 60 mins	8.5%	6.2%	9.5%	8.9%
% Workers Travelling between 10 and 30 mins	53.8%	53.3%	49.0%	49.6%
% Workers Travelling between 30 and 60 mins	24.2%	24.5%	31.2%	29.0%
Debt - Any Debt in Collections				
Median Debt in Collections	$1,512	No data	$1,647	$1,739
Share with Any Debt in Collections	40.9%	34.0%	24.6%	26.2%
Debt - Student Loan Debt				
Median Monthly Student Loan Payment	No data	No data	$178	$160
Median Student Loan Debt	$19,651	No data	$22,856	$20,108
Share with Any Student Loan Debt	8.6%	9.8%	15.6%	15.2%
Employment - Unemployment Rate	3.1%	3.1%	2.4%	3.9%
Employment Rate by Disability Status, Percent				
Population w/ Disability Employed, Percent	89.5%	88.1%	90.6%	88.5%
Population w/o Disability Employed, Percent	92.0%	94.8%	95.9%	95.1%
Families with Income Over $75,000 by Race Alone, Percent				
American Indian or Alaska Native	No data	29.6%	59.4%	42.5%
Asian	100.0%	70.6%	76.9%	70.5%
Black or African American	0.0%	27.8%	49.4%	42.5%
Multiple Race	33.3%	29.6%	64.7%	53.2%
Native Hawaiian or Pacific Islander	No data	0.0%	67.0%	55.8%
Some Other Race	No data	38.5%	48.3%	42.7%
White	35.9%	43.9%	70.6%	64.2%
Households by Household Income Levels, Percent				
Under $25,000	35.0%	24.8%	13.0%	15.7%
$25,000 - $49,999	21.1%	24.8%	15.7%	18.1%
$50,000 - $99,999	30.2%	29.7%	27.3%	28.9%
$100,000 - $199,999	11.5%	16.9%	28.5%	25.9%
$200,000+	2.3%	3.8%	15.6%	11.4%
Income - Families Earning Over $75,000				
Percent Families with Income Over $75,000	35.9%	43.4%	66.3%	60.0%
Income - Inequality (GINI Index)	0.49	No data	0.47	0.48
Income - Median Family Income				
Average Family Income	$68,825.12	$84,999	$142,105.92	$124,529.93
Median Family Income	$56,954	No data	$107,504	$92,646
Income - Median Household Income				
Average Household Income	$58,253.52	$70,152	$120,553.30	$105,833.04
Median Household Income	$41,619	No data	$87,249	$75,149

Appendix

Secondary Data Tables

Income and Economics				
Data Indicator	Lee	Ballad Health GSA	Virginia	USA
Income - Per Capita Income				
Per Capita Income ($)	$23,257	$29,890	$47,209	$41,261
Median Family Income by Family Composition				
Married-Couple Families with Children	$71,250	No data	$138,758	$119,934
Married-Couple Families without Children	$65,878	No data	$118,916	$104,323
Single Females with Children	No data	No data	$40,021	$35,779
Single Females without Children	$24,592	No data	$66,295	$62,044
Single-Males with Children	$34,000	No data	$60,670	$55,671
Single-Males without Children	$68,143	No data	$81,932	$73,433
Population in Poverty by Ethnicity Alone				
Hispanic or Latino, Percent	37.1%	33.7%	13.2%	17.2%
Not Hispanic or Latino, Percent	25.9%	16.8%	9.6%	11.5%
Population in Poverty by Race Alone, Percent				
American Indian or Alaska Native	100.0%	34.6%	11.7%	22.6%
Asian	8.5%	14.4%	7.0%	10.1%
Black or African American	86.9%	29.8%	16.5%	21.5%
Multiple Race	49.0%	29.2%	10.3%	14.8%
Native Hawaiian or Pacific Islander	No data	33.6%	9.9%	17.0%
Some Other Race	0.0%	30.8%	16.9%	18.6%
White	25.2%	16.5%	8.0%	10.1%
Poverty - Children Below 100% FPL, Percent	45.0%	24.8%	12.8%	16.7%
Poverty - Children Below 200% FPL, Percent	67.9%	49.5%	29.8%	37.2%
Poverty - Poverty Profile				
101%-150%	11.4%	11.3%	6.3%	8.0%
151% - 200%	10.7%	10.9%	7.1%	8.3%
201% - 500%	40.3%	43.4%	38.2%	40.3%
50% or Less	10.8%	No data	4.9%	5.8%
51% - 100%	15.2%	9.7%	5.1%	6.7%
Over 500%	11.6%	17.1%	38.4%	30.9%

Appendix

Community Member Survey Results: Demographics

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

Which race best describes you? (Please choose only one)	Percentage
White	94.7%
Prefer not to answer	2.4%
More than one race	1.8%
African American or Black	0.6%
American Indian or Alaska Native	0.3%
Other	0.2%
Total	100.0%

Are you of Hispanic or Latino origin or descent?

Are you of Hispanic or Latino origin or descent?	Percentage
No, not Hispanic or Latino	93.5%
Prefer not to answer	4.6%
Yes, Hispanic or Latino	1.9%
Total	100.0%

Which generation group are you in?

Response	Percentage
Gen X (1965-1980)	36.39%
Millennials (1981-1996)	33.03%
Baby Boomers (1946-1964)	21.87%
Gen Z (1997-2012)	7.95%
Silent (1925-1945)	0.76%
Total	100.00%

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

Response	Percentage
Woman	78.49%
Man	18.74%
Prefer not to answer	2.30%
Non-Binary/Genderqueer	0.31%
I identify in another way	0.15%
Total	100.00%

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

Response	Percentage
No	95.8%
Yes	4.2%
Total	100.0%

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

Education	Percentage
Bachelor's degree, 4-year degree	29.9%
Associate's degree, 2-year degree	21.3%
Master's/Graduate or professional degree or higher	17.2%
Some college, no degree	16.7%
High school diploma or GED	10.1%
Vocational/Technical school	4.1%
Some high school (9th-12th grade), but no diploma	0.6%
Less than high school (8th grade or less)	0.2%
Total	100.0%

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

Response	Percentage
$100,000 or greater	30.0%
$75,000 - $99,999	21.4%
$50,000 - $74,999	17.4%
$35,000 - $49,999	10.4%
Prefer not to answer	9.2%
$25,000 - $34,999	6.1%
$10,000 - $24,999	3.5%
Less than $10,000	2.0%
Total	100.0%

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

How many people live in your home? (Including yourself)	Percentage
2	36.95%
3	23.66%
4	16.95%
1	11.30%
5	6.26%
6	3.51%
7	1.07%
8	0.15%
9+	0.15%
Total	100.00%

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

Response	Percentage
Private/Commercial)	75.95%
Medicare)	11.17%
Medicaid)	9.90%
Do not have health insurance)	1.98%
TRICARE)	0.99%
Total	100.00%

Appendix

Community Member Survey Results: Community Perceptions

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

Response	Percent
Religious or spiritual opportunities	16.0%
Safe neighborhoods/Low rates of crime and violence	14.2%
Good access to parks and recreation	13.0%
A clean and healthy environment	8.0%
Access to health care	6.0%
Welcoming supportive community	6.0%
Access to arts music and cultural events	5.8%
Good internet access	5.4%
Low rates of homelessness	4.9%
Well-funded, local, 24-hour police fire and rescue services for emergencies	4.9%
Walkable bike-able community	4.7%
Access to affordable healthy foods in the community	2.5%
Access to affordable housing for everyone	2.2%
Other	1.6%
Access to programs activities and support for the senior community	1.5%
Plenty of jobs and a healthy economy	1.3%
Access to programs activities and support for youth and teens during non-school hours	1.2%
The community appreciates social and cultural diversity	0.6%
Total	100.0%

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

Response	Percentage
Unplanned pregnancy	1.7%
Other	2.2%
Oral/dental health (including tooth pain	5.2%
Obesity/overweight	13.1%
HIV/AIDS	0.4%
COVID-19	1.3%
Chronic pain	3.4%
Chronic Disease	47.9%
Behavioral/Mental health	23.1%
Accident/injuries (for example, workplace injuries, or car accidents	1.7%
Total	100.0%

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

Responses	Percentage
Diet/nutrition/exercise	27.0%
Income/poverty	17.1%
Access to quality health care and other services	15.8%
Genetics	11.0%
Education	7.5%
Drug/alcohol use	5.8%
Poor mental health/traumatic stress	4.2%
Adverse childhood experiences	2.1%
Physical environment	2.1%
Tobacco/vaping use	2.1%
Lack of transportation	1.7%
Occupational/work conditions	1.3%
Other	0.8%
Poor housing conditions	0.8%
Interpersonal violence/abuse	0.6%
Total	100.0%

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

Response	Percentage
Access to quality health care and other services	17.6%
Tobacco/vaping use	15.7%
Income/poverty	14.6%
Diet/nutrition/exercise	11.8%
Drug/alcohol use	8.8%
Genetics	6.9%
Occupational/work conditions	5.2%
Lack of transportation	5.1%
Education	4.5%
Physical environment	3.9%
Poor mental health/traumatic stress	2.1%
Adverse childhood experiences	1.9%
Poor housing conditions	0.9%
Other	0.6%
Interpersonal violence/abuse	0.4%
Total	100.0%

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

Response	Percentage
Diet/nutrition/exercise	23.4%
Access to quality health care and other services	15.8%
Income/poverty	13.4%
Tobacco/vaping use	13.1%
Drug/alcohol use	10.9%
Genetics	7.1%
Poor mental health/traumatic stress	4.1%
Education	2.7%
Occupational/work conditions	2.2%
Physical environment	2.2%
Lack of transportation	1.9%
Poor housing conditions	1.4%
Other	1.1%
Interpersonal violence/abuse	0.5%
Adverse childhood experiences	0.3%
Total	100.0%

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

Response	Percentage
Drug/alcohol use	22.2%
Access to quality health care and other services	17.9%
Income/poverty	16.4%
Poor mental health/traumatic stress	13.1%
Adverse childhood experiences	11.6%
Interpersonal violence/abuse	5.1%
Education	2.4%
Tobacco/vaping use	2.3%
Diet/nutrition/exercise	2.0%
Lack of transportation	2.0%
Poor housing conditions	1.7%
Physical environment	1.6%
Occupational/work conditions	0.9%
Genetics	0.7%
Other	0.4%
Total	100.0%

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

Response	Percentage
Drug/alcohol use	22.4%
Poor mental health/traumatic stress	22.4%
Income/poverty	17.1%
Interpersonal violence/abuse	7.9%
Access to quality health care and other services	6.6%
Physical environment	6.6%
Poor housing conditions	3.9%
Adverse childhood experiences	2.6%
Lack of transportation	2.6%
Tobacco/vaping use	2.6%
Diet/nutrition/exercise	1.3%
Education	1.3%
Genetics	1.3%
Other	1.3%
Total	100.0%

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

Response	Percentage
Diet/nutrition/exercise	27.9%
Income/poverty	20.0%
Access to quality health care and other services	10.3%
Genetics	7.3%
Education	6.9%
Poor mental health/traumatic stress	6.2%
Physical environment	5.8%
Adverse childhood experiences	4.3%
Drug/alcohol use	3.9%
Occupational/work conditions	2.4%
Tobacco/vaping use	1.6%
Poor housing conditions	1.4%
Other	0.9%
Lack of transportation	0.8%
Interpersonal violence/abuse	0.3%
Total	100.0%

Appendix

Community Member Survey Results: Community Perceptions

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

Question	A few times a month	A few times a year	At least once a week	Never	Total
People act as if they are afraid of you.	2.99%	9.68%	1.23%	86.09%	100.00%
People act as if they think you are not smart.	7.73%	30.76%	5.80%	55.71%	100.00%
People criticize your accent or the way you speak.	7.57%	29.23%	3.52%	59.68%	100.00%
You are threatened or harassed.	2.81%	13.51%	1.93%	81.75%	100.00%
You are treated with less courtesy or respect than other people.	14.56%	33.68%	9.47%	42.28%	100.00%
You receive poorer service than other people at restaurants or stores.	7.41%	25.22%	3.17%	64.20%	100.00%

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

Response	Percentage
Your rural/country designation	27.7%
Your sex	13.1%
Your age	12.5%
Your weight	8.7%
Your income level	7.1%
Some other aspect of your physical appearance	6.0%
Your ancestry or national origin	5.3%
Your education level	4.9%
Your religion	3.6%
Your gender identity	3.2%
Your height	2.2%
Your race	2.1%
A disability	1.9%
Your sexual orientation	1.8%
Total	100.0%

Please indicate your level of agreement for the following statements:

Attribute	Agree	Disagree	Total
Community members are able to get healthy and affordable food easily.	30.1%	69.9%	100.0%
I feel safe in my community.	91.3%	8.7%	100.0%
I have received information/resources related to emergency preparedness and response for my community.	38.9%	61.1%	100.0%
Illegal drug use/prescription medicine abuse is a problem in my community.	91.0%	9.0%	100.0%
My community is a good place to have a baby and raise children.	81.3%	18.7%	100.0%
My community is a good place to live.	88.7%	11.3%	100.0%
My community is good place to grow old/retire.	78.5%	21.5%	100.0%
Public transportation is easy to get to for those who need it.	19.8%	80.2%	100.0%
The quality of health care is good in my community.	32.9%	67.1%	100.0%
There are affordable places to live in my community.	30.4%	69.6%	100.0%
There are plenty of jobs available for those who want them.	33.8%	66.2%	100.0%
There are plenty of opportunities for social engagement in my community.	47.4%	52.6%	100.0%
We have great parks and recreational facilities.	67.3%	32.7%	100.0%

Appendix

Community Member Survey Results: Access to Care

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

Response	Percentage
Doctors Office	44.3%
Urgent Care	31.7%
Emergency Department (ER	11.4%
I dont seek medical attention	6.9%
Homeopathic/Herbal Medicine	2.1%
Free Clinic or Community Health Center	1.8%
Other	1.3%
Health Department	0.4%
Total	100.0%

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

Attribute	Agree	Disagree	Total
People can access a medical specialist (Cardiologist, Dermatologist, etc.) when needed.	30.0%	70.0%	100.0%
People can access a primary care doctor (Family Doctor, Pediatrician etc.), including nurse practitioners and physician assistants, when needed.	58.6%	41.4%	100.0%
There are enough dental care providers in my community.	31.9%	68.1%	100.0%
There are enough health care providers in my community that speak more than one language.	23.6%	76.4%	100.0%
There are enough mental health care providers in my community.	17.7%	82.3%	100.0%
There are enough providers accepting Medicaid in my community.	43.3%	56.7%	100.0%
There are enough providers accepting Medicare in my community.	53.6%	46.4%	100.0%
There are enough substance use disorder treatment providers in my community.	22.9%	77.1%	100.0%

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

Attribute	No	Yes	Total
Dental Care	73.7%	26.3%	100.0%
Medical Care	76.6%	23.4%	100.0%
Mental Health Care	84.0%	16.0%	100.0%
Prescription Medicine	76.5%	23.5%	100.0%

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

Response	Percentage
Unable to afford to pay for prescriptions	32.19%
Manufacturing shortage	27.40%
Other	14.38%
Do not have insurance to cover my prescription medications	12.33%
Pharmacy does not have convenient hours	6.85%
Unable to find a pharmacy that takes my insurance	4.11%
Transportation challenges	2.74%
Total	100.00%

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

Response	Percentage
Unable to schedule an appointment when needed	27.73%
Doctors office does not have convenient hours	17.27%
Unable to afford to pay for care	15.00%
Cannot take time off work	11.82%
Other	9.09%
Unable to find a doctor who takes my insurance	7.73%
Do not have insurance to cover medical	3.18%
Transportation challenges	2.73%
Unable to find someone to watch my child(ren	2.73%
Unable to find a doctor who knows or understands my culture, identity, or beliefs	1.36%
Unsure how to find a doctor	1.36%
Total	100.00%

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

Response	Percentage
Unable to schedule an appointment when needed	14.16%
Unable to find a doctor / counselor who takes my insurance	13.24%
Unable to afford to pay for care	12.33%
Unsure how to find a doctor/counselor	10.50%
Cannot take time off work	9.59%
Doctor/counselors office does not have convenient hours	9.59%
Afraid of what people might think	8.68%
Other	5.94%
Do not have insurance to cover mental health care	5.02%
Unable to find a doctor/counselor who knows or understands my culture, identity, or beliefs	4.57%
Transportation challenges	3.20%
Unable to find someone to watch my child(ren	3.20%
Total	100.00%

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

Response	Percentage
Unable to schedule an appointment when needed	22.0%
Unable to afford to pay for care	17.5%
Unable to find a dentist who takes my insurance	17.5%
Dentists office does not have convenient hours	16.4%
Cannot take time off work	9.3%
Do not have insurance to cover dental care	6.3%
Other	4.1%
Transportation challenges	2.2%
Unable to find someone to watch my child(ren	2.2%
Unsure how to find a dentist	1.5%
Unable to find a dentist who knows or understands my culture, identity, or beliefs	0.7%
Total	100.0%

Appendix

Community Member Survey Results: Personal Health and Well-Being

How often do you have a drink containing alcohol?

Response	Percentage
Never	49.24%
Monthly or less	31.49%
2 to 4 times a month	11.07%
2 to 3 times a week	5.34%
4 or more times a week	2.86%
Total	100.00%

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

Response	Percentage
Never	84.53%
4 or more times a week	12.08%
Monthly or less	1.89%
2 to 4 times a month	0.94%
2 to 3 times a week	0.57%
Total	100.00%

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

Response	Percentage
Regular Physical Exam	17.7%
Blood Pressure and Cholesterol Check	16.4%
Blood Glucose Diabetes Screening	12.1%
Pap Smear	11.3%
Breast/Mammography Exam	10.7%
Thyroid Testing	7.8%
Depression/Anxiety Screening	7.0%
Colonoscopy/Colorectal Cancer Screening	6.4%
Skin Cancer Screening	4.2%
Sexually Transmitted Infection Screening	2.3%
Heart Shape Screening/Calcium Scoring	2.1%
Low Dose CT Scan (Lung Cancer Screening	1.1%
Prostate Exam	0.9%
Total	100.0%

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

Response	Percentage
Had trouble sleeping or concentrating	27.76%
Felt down, depressed, or hopeless	21.26%
Lost interest in activities that you used to enjoy	16.16%
Felt isolated or alone	14.02%
Taken any medication for a mental health condition	14.02%
Been diagnosed with a mental health condition	4.09%
Had thoughts of harming yourself or others	2.23%
Been hospitalized for a mental health condition	0.46%
Total	100.00%

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

Response	Percentage
Yes	94.32%
No	5.68%
Total	100.00%

Appendix

Community Member Survey Results: Personal Health and Well-Being

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

Response	Never True	Often True	Refused to Answer	Sometimes True	Total
Home bug infestation	93.5%	0.6%	1.9%	4.0%	100.0%
Inadequate air conditioning in home	89.1%	2.3%	1.7%	6.9%	100.0%
Inadequate heat in home	88.2%	2.5%	1.5%	7.8%	100.0%
Lead paint or pipes in home	95.0%	0.4%	2.1%	2.5%	100.0%
Mold in home	88.2%	1.1%	1.7%	9.0%	100.0%
No or not working smoke detectors in home	91.8%	0.8%	2.1%	5.3%	100.0%
Oven or stove not working in home	96.0%	1.1%	1.9%	1.0%	100.0%
Paying my bills	45.7%	20.0%	3.0%	31.2%	100.0%
Running out of food before you got money to buy more	78.5%	5.5%	1.5%	14.5%	100.0%
Safe and stable housing	85.9%	5.9%	1.9%	6.3%	100.0%
Transportation issues that keep you from medical appointments, work, or things needed for daily living	85.8%	3.3%	1.7%	9.2%	100.0%
Water leaks in home	81.0%	1.3%	1.9%	15.8%	100.0%

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

Response	Percentage
Yes	97.4%
No	2.6%
Total	100.0%

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

Response	Percentage
Yes	96.8%
No	3.2%
Total	100.0%

Appendix

Community Member Survey Results: Child Health and Well-Being

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

Response	Percentage
Dental care	14.80%
Mental or behavioral health/suicide prevention	12.99%
Healthy food/nutrition	10.36%
Neurodiversity (ADHD, ADD, Autism, Dyslexia, etc.	7.73%
Drug or alcohol use/exposure (including cigarettes and vaping	7.57%
Special needs (physical/chronic/behavioral/developmental/emotional	7.24%
Accidents and injuries	7.07%
Eye/vision health	6.58%
Immunizations (for example, common childhood vaccines, like mumps, measles, chicken pox, etc.	5.92%
Obesity/physical inactivity	5.92%
Respiratory health (for example, asthma, RSV, cystic fibrosis	3.62%
Complex medical needs	2.63%
Safe sex practices and teen pregnancy	2.14%
Diabetes	1.64%
Infectious diseases (including COVID-19	1.32%
Healthy pregnancies and childbirth (not teen pregnancy	1.15%
Gender/sexual identity of child	0.82%
Other	0.49%
Total	100.00%

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

Response	Percentage
Teen (12-18 years)	35.23%
Grade School (5-12 years)	31.88%
Toddler (1-3 years)	15.44%
Preschool (3-5 years)	13.42%
Infant (less than 1 year)	4.03%
Total	100.00%

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

Response	Percentage
Yes	80.00%
No	20.00%
Total	100.00%

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

Response	Percentage
I am unhappy with my current child care option.	26.47%
Other	35.29%
I am unable to find child care or am on waitlist(s).	38.24%
Total	100.00%

Appendix

Community Partner Survey Results: Organizational Information

Which best describes your position or role in your organization?

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

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

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

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

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

How many people are currently employed at your organization?

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

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

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

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

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

Appendix

Community Partner Survey Results

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

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

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

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

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

Appendix

Community Partner Survey Results

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

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

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

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

Appendix

Community Partner Survey Results: Technology in Health

Technology in Health

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

Response	Percentage
Yes	97.7%
No	2.3%
Total	100.0%

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

Response	Percentage
No	45.5%
Yes	54.5%
Total	100.0%

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

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

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

Response	Percentage
No	53.5%
Yes	46.5%
Total	100.0%

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

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

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

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

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

Response	Percentage
Yes	77.8%
No	22.2%
Total	100.0%

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

Response	Percentage
Yes	79.5%
No	20.5%
Total	100.0%

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

Response	Percentage
Yes	51.1%
No	48.9%
Total	100.0%

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

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

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

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

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

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

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

Response	Percentage
Yes	72.1%
No	27.9%
Total	100.0%

Appendix

Community Partner Survey Results: Technology in Health

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

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

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

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

Organizational Commitment To Equity

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

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

Appendix

Community Partner Survey Results: Organizational Accountability

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

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

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

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

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

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

Appendix

Community Partner Survey Results: Data Access and Systems

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

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

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

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

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