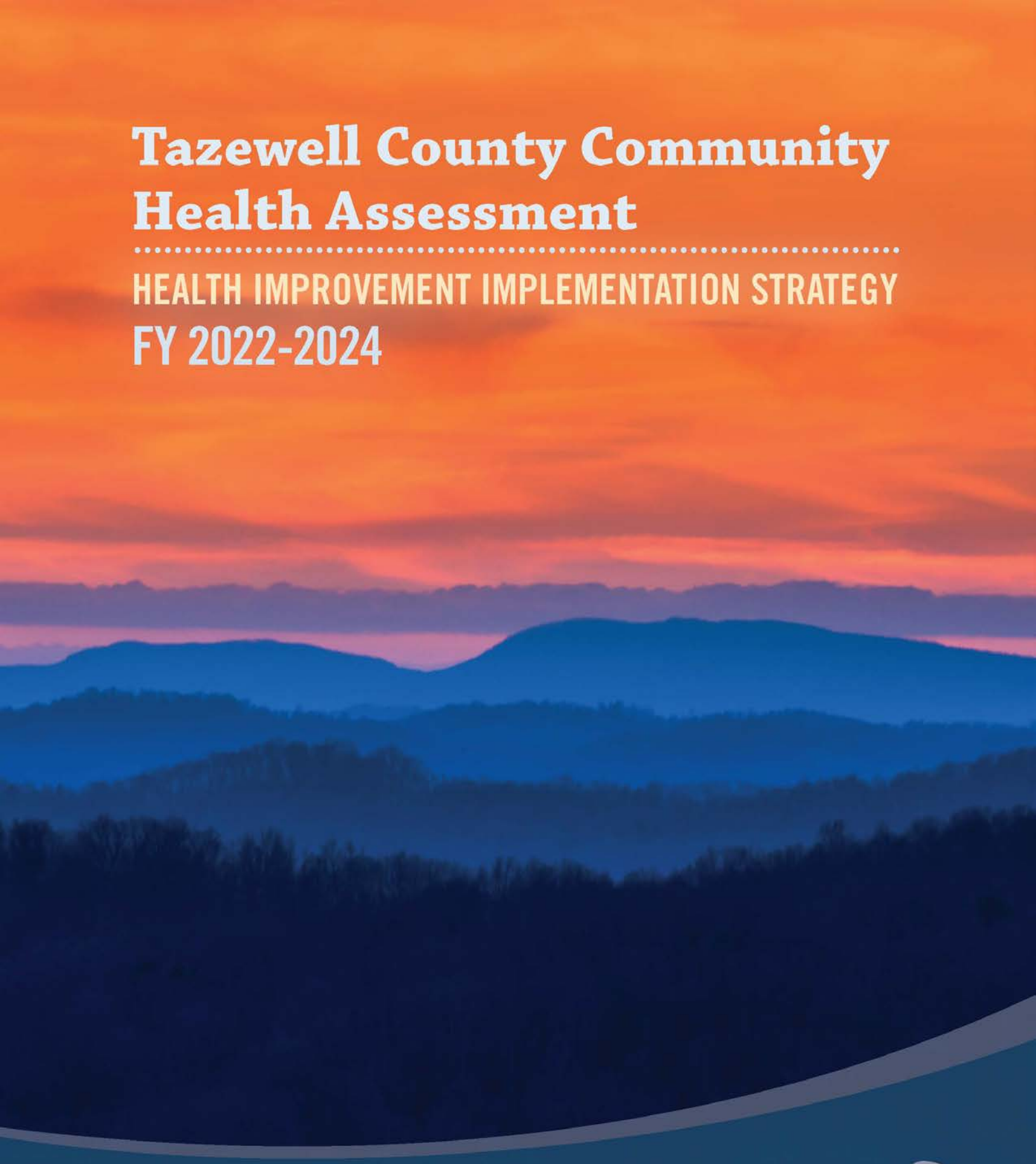
Tazewell County Community Health Assessment

HEALTH IMPROVEMENT IMPLEMENTATION STRATEGY FY 2022-2024



Carilion Tazewell Community Hospital

carilionclinic.org/community-health-assessments

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Carilion Tazewell Community Hospital Health Improvement Implementation Strategy

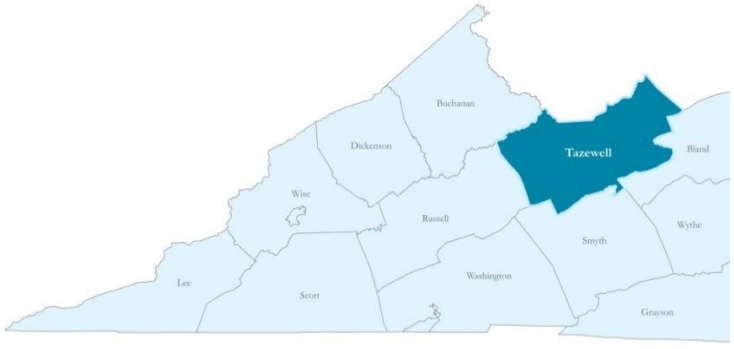
Executive Summary

Every three years, Carilion Tazewell Community Hospital (CTCH) conducts the Tazewell County Community Health Assessment (TCCHA) to determine focus areas across the region[1]. Through this collaborative process, we assess the needs of the community, prioritize them and develop a response to selected issues. The purpose of this implementation plan is to describe how CTCH plans to address the community health needs identified in the 2021 TCCHA.

Community Served

Tazewell County is nestled among the Appalachian Mountains in southwest Virginia and borders West Virginia to its north. Tazewell County has a land area of 518.85 square miles and about 86.9 persons per square mile[2]. Historically, what is now Tazewell County was a hunting ground for Native American tribes. The area's abundance of wild game was a source of frequent skirmishes among these tribes. Tazewell County was chartered on December 19, 1799, and included five towns: Bluefield, Richlands, Tazewell, Cedar Bluff and Pocahontas. The land for the county came from portions of the bordering Wythe and Russell Counties[3].

Today, Tazewell County is home to an outstanding array of hiking, biking and ATV trails, scenic drives (including "Back of the Dragon"), outdoor parks (including Cavitt's Creek Park), and venues for experiencing culture, art and history[4]. Tazewell also has a dedicated system of health and human service organizations that work to reduce the disparities in access to care and resources that still exist for many residents of the region.



The service areas for Carilion Clinic's Community Health Assessments (CHAs) are determined by 70-80% of unique patient origin of the hospital in each respective market. Focus is placed on areas that are considered Medically Underserved Areas and Health Professional Shortage Areas. The service area for the 2021 TCCHA includes Tazewell County, Virginia. In fiscal year

[1] Carilion Clinic began conducting Community Health Assessments prior to the IRS adoption of the 501(r)(3) which requires not-for-profit hospitals to conduct a Community Health Needs Assessment (CHNA) every three years. While meeting the CHNA requirement, Carilion maintains the longstanding formal name, Community Health Assessment, for our process and associated reports.

[2] US Census, Quick Facts, 2010

[3] Visit Tazewell County, Virginia. Retrieved from: http://visittazewellcounty.org/history/

[4] Visit Tazewell County, Virginia. Retrieved from: http://visittazewellcounty.org/

2020, CTCH served 5,943 unique patients. Patient origin data revealed that during this year, 82.72% of patients served by CTCH lived in Tazewell County.

The target population for Carilion Clinic's CHA projects consists of underserved/vulnerable populations disproportionately impacted by the social determinants of health, including poverty, race/ethnicity, education, access and/or lack of insurance. Populations are examined across the different life cycles, including parents of children and adolescents, women of child-bearing age, adults and the elderly. They are also studied across various race and ethnic groups and income levels. All patients are included in this assessment regardless of insurance payments or financial assistance eligibility.

Implementation Strategy Process

Carilion Clinic—with support of the Cumberland Plateau Health District—led the efforts to conduct the 2021 TCCHA. This process was community-driven and focused on high levels of community engagement involving health and human services leaders, stakeholders and providers, the target population, and the community as a whole.

An 11-member Community Health Assessment Team (CHAT) oversaw the planning activities. The CHAT consists of:

- Health and human service agency leaders
- Persons with special knowledge of or expertise in public health
- The local health department
- Leaders, representatives or members of medically underserved populations, low-income persons, minority populations and populations with chronic disease

Please see Appendix 1 for the CHAT Directory.

Beginning in October 2020, primary data collection included a Community Health Survey and a focus group with key CHAT stakeholders. Secondary data collected include demographic and socioeconomic indicators as well as health indicators addressing access to care, health status, prevention, wellness, risky behaviors and social environment.

After all primary and secondary data collection is complete, the CHAT reviews all data and participates in a prioritization activity. Each CHAT member selects and ranks the ten most pertinent community needs. The data are combined and priorities are selected based on the highest weighted score of each need. Please see Appendix 2 to view the prioritization worksheet.

Through this process, needs are prioritized by the CHAT members according to:

- The perceived burden, scope, severity or urgency of the health need
- The importance the community places on addressing the need through survey responses and other interactions
- Their own unique perspective on the health-related needs of the community

The 2021 TCCHA was approved by the CTCH Board of Directors and made publicly available in August 2021. The following plan was developed by the Carilion Clinic Community Benefit and Community Health and Outreach departments based on priority community health needs identified in the 2021 TCCHA. Input on the Implementation Strategy was solicited from CHAT members, the CTCH Board of Directors, Community Health and Outreach staff and key Carilion Clinic leadership.

Prioritized List of Significant Health Needs Identified in the 2021 TCCHA

The findings revealed 10 priority health-related issues in the community, identified by the CHAT after review of the data collected. Like-issues were grouped into categories to promote upstream and out-of-the-box thinking to address the top needs.

Top Needs	
Mental Health	Mental health problems (general)
	Alcohol and drug use
Socioeconomic Factors	High uninsured/underinsured population
	Poverty/low average household income
	Transportation/transit system
Culture	Culture: healthy behaviors not a priority
	Communication barriers with providers
Health Behaviors	High prevalence of chronic disease (general)
	Overweight/obesity
	Poor diet/poor eating habits

CTCH Action Plan

The foundation of Carilion's response is based on the following pillars:

- Commitment to mission
- Diversity, equity and inclusion
- Community partnerships
- Community grants

We will continue to respond to community health needs in innovative ways, including:

- Ensuring access to state-of-the-art health care close to home
- Creating and implementing community-wide strategies to reduce barriers, coordinate resources and enhance community strengths
- Providing community-based health and wellness programming

Commitment to Mission

Commitment to community service is evident at all levels of the organization. In 2020, Carilion committed more than $116 million toward activities that improve community health and social determinants of health. Carilion's commitment to community health is evidenced by a population health infrastructure including the Community Benefit and Community Health and Outreach departments dedicated to assessing and addressing community needs. These departments lead the community health improvement process, CHAs, the system's community grant process, community health education, community benefit collection and neighborhood health initiatives. With staff at the system level and at each community hospital, we work with each hospital's Board of Directors to create health improvement strategies. A Community Benefit Council provides oversight for Carilion Clinic as a whole, overseeing and strategically guiding Carilion's community health improvement work and community benefit strategy, collection and submission. Investing in community health is one component of Carilion Clinic's Vision 2025 strategic plan, showing an enduring commitment to improving the region's health.

Diversity, Equity and Inclusion

Carilion Clinic established the Office of Diversity, Equity and Inclusion in early 2021. With a focus on health equity and social justice, the office will collaborate with community leaders to better understand and address social and economic factors that influence health in our region, while also promoting diversity, equity and inclusion within the health system.

Community Partnerships

Carilion Clinic believes in the power of collaboration and understands that community health issues must be addressed together, with the community. To ensure lasting impact from the health assessment and community health improvement process, Carilion provides support to health coalitions that address needs across the region. Carilion also partners with multiple organizations on initiatives to improve health, wellness and the social determinants of health.

Community Grants

Carilion Clinic is committed to improving the health of the communities we serve by addressing key health priorities identified through our CHAs. Carilion fulfills this commitment in many ways, one of which is through targeted grants for community health improvement programs. Carilion provides a multitude of community grants and community health sponsorships helping local charitable organizations fulfill their missions as they relate to the health and well-being of our communities. Community grant dollars are allocated across the entire Carilion Clinic service area based on requests that align with the CHA priorities.

Priority Areas to be Addressed

Priority Area: Mental Health

Mental health problems (general); Alcohol and drug use

Actions	Anticipated Impact	Resources Committed	Collaboration
1) Explore establishment of a crisis receiving center 2) Support operation of office-based opioid treatment on hospital campus	1) Increase access to appropriate level of care and screening for those experiencing a behavioral health crisis 2) Increase access to outpatient treatment for substance use disorder	Financial and other assets such as staff time, leadership, physical space, provider credentialing and patient referrals	1) Cumberland Mountain Community Services Board 2) Southwest Virginia Community Health Systems

Priority Area: Socioeconomic Factors

High uninsured/underinsured population; Poverty/low average household income; Transportation/transit system

Actions	Anticipated Impact	Resources Committed	Collaboration
1) Assess eligibility and enroll patients in Medicaid 2) Implement the Unite Us platform for social service referrals and integrate with medical record system for clinical utilization. Support platform adoption by community partners. 3) Establish Bluefield virtual care center	1) Increase number of insured patients 2) Connect individuals to social service resources and decrease the prevalence of health-related social needs 3) Decrease impact of transportation as a barrier to care by bringing a telemedicine hub for primary care and specialty services close to home	Financial and other assets such as staff time and leadership	1) MedAssist 2) Virginia Hospital and Healthcare Association, Epic 3) Tazewell County, internal Carilion Clinic collaboration

Priority Areas: Culture and Health Behaviors

Culture: Healthy behaviors not a priority

Health Behaviors: High prevalence of chronic disease (general); Overweight/obesity; Poor diet/poor eating habits

Actions	Anticipated Impact	Resources Committed	Collaboration
1) Provide community health education and participate in community events such as health fairs, immunizations and health screenings	1) Increase knowledge of healthy behaviors, early detection of chronic disease and health management strategies	Staff time	1) Four Seasons YMCA

Other Initiatives Supporting a Culture of Community Health

Actions	Anticipated Impact	Resources Committed	Collaboration
1) Develop Community Health Investment Plan 2) Further develop community health infrastructure 3) Engage Carilion employees in supporting community partnerships 4) Leverage internal data to identify health disparities within employee and patient population	1) Increase deployment of assets for community health improvement 2) Increase in staffing to include peer recovery specialists, community health workers and community benefit staff 3) Increase support for community organizations through employee hours spent meeting community needs 4) Improve health-related outcomes and experiences through targeted interventions	Financial and other assets such as staff time and leadership	1) Planning and Community Development (PCD) and Finance divisions 2) PCD 3) PCD and Human Resources 4) PCD, Health Analytics, Human Resources

Priority Areas Not Being Addressed

Priority Area	Reason for Not Addressing
Communication barriers with providers	• Limited capacity to address with current resources. • Will continue to emphasize cultural competency across organization.

Implementation and Measurement

Carilion utilizes multiple systems to help manage data and track outcomes of our community work. Community health education programs and screenings will have program-level outcomes assigned based on the topic. These outcomes will be tracked with pre- and post-tests as well as through screening results. Community programs supported by Carilion grants will be responsible for reporting program outcomes regularly with grantee outcomes evaluated at least annually.

Scorecards have been developed with key secondary data points at the county level and are updated annually to track impact of community health initiatives. Carilion will track and measure impact on certain aligned indicators that contribute to the Robert Wood Johnson Foundation (RWJF) County Health Rankings. In addition to the RWJF rankings, we are utilizing a framework for viewing health and well-being through seven vital conditions. The WIN Network's Vital Conditions for Well-Being emphasize the health and well-being of people and places as a necessary component to thrive[5].

Progress on initiatives described in this document will be reported to the CTCH Board of Directors twice yearly.

Please visit https://carilionclinic.org/community-health-assessments to review the 2021 TCCHA. Learn more about Carilion Clinic Community Health and Outreach at https://www.carilionclinic.org/community-health-outreach.

This document was adopted on behalf of Carilion Tazewell Community Hospital on January 27, 2022.

[5] https://winnetwork.org/vital-conditions

About Us

Carilion Clinic is a not-for-profit, integrated health care system located among the Blue Ridge Mountains with its flagship hospital in the heart of the City of Roanoke, which serves as the largest urban hub in Western Virginia. Through a comprehensive network of hospitals, primary and specialty physician practices, wellness centers and other complimentary services, quality care is provided close to home for nearly 1 million Virginians. Carilion's roots go back more than a century, when a group of dedicated citizens came together and built a hospital to meet the community's health needs. Today, Carilion is a key institution focusing on more than health care—we are dedicated to our mission of improving the health of the communities we serve.

With an enduring commitment to the health of our region, care is advanced through clinical services, medical education, research and community health investments. Carilion believes in service, collaboration and caring for all. Through discovering and responding to our community's health needs comes the understanding that we must address health issues together to create change most effectively.

CTCH is a 56-bed hospital with extended care recovery through the swing bed program—a program that allows patients with skilled care needs to grow stronger before going home. CTCH offers 24/7 emergency care, diagnostic services including imaging, mammography, and physical and respiratory therapy. It also provides on-site primary care services through Carilion Clinic Family Medicine and the Tazewell Veteran's Outpatient Clinic[6].

[6] https://www.carilionclinic.org/locations/carilion-tazewell-community-hospital

Appendices

Appendix 1: Community Health Assessment Team

This list includes members that attended 50% (2) or more of the CHAT meetings.

Name	Organization	Expertise
Aaron Boush	Carilion Clinic	Healthcare
Alicia Bales	Carilion Tazewell Community Hospital	Hospital Administration
Jennifer Bourne	Clinch Valley Community Action	Families
Karen Mulkey	Carilion Clinic, CHO, CTCH	Health Education
Kendra Shelton	Carilion Clinic Home Care	Home Health
Kimberly Brown	Carilion Tazewell Community Hospital	Emergency Room
Manny Elswick	Main Street UMC, Project 13Three, Celebrate Recovery	Faith Community, Substance Use, Re-entry
Molly Roberts	Carilion Clinic	Public Health
Renae Matney	Four County Transit/Appalachian Agency for Senior Citizens	Transportation
Rene Steele	Labor of Love Mission	Poverty, Food Access
Susan White	Clinch Valley Community Action	Senior Outreach

Appendix 2: Community Health Need Prioritization Worksheet

Please rank from 1-10 the top 10 most pertinent community needs with 1 being the most pertinent.

Rank	Community Issue
Health Behavior Factors	
	Alcohol and drug use
	Culture: healthy behaviors not a priority
	Lack of exercise
	Lack of health literacy / lack of knowledge of healthy behaviors
	Lack of knowledge of community resources
	Poor diet / poor eating habits
	Risky sexual activity
	Tobacco use
	Access to healthy foods
	Stress
Clinical Care Factors	
	Access to primary care
	Access to dental care
	Access to mental / behavioral health services
	Access to specialty care (general)
	Access to substance use services
	Communication barriers with providers
	Coordination of care
	High cost of care
	High uninsured / underinsured population
	Quality of care
Social and Economic Health Factors	
	Child abuse / neglect
	Community safety / violence
	Domestic violence
	Educational attainment
	Lack of family / social support systems
	Poverty / low average household income
	Unemployment
Physical Environment Factors	
	Air quality
	Affordable / safe housing
	Injury prevention / safety of environment
	Outdoor recreation
	Transportation / transit system
	Water quality

Health Conditions / Outcomes	
	COVID-19
	Overweight / obesity
	Mental health problems
	Cancers
	Diabetes
	High blood pressure
	Heart disease and stroke
	High prevalence of chronic disease (general)
Write-in section	