



CENTERSTONE

TENNESSEE COMMUNITY NEEDS ASSESSMENT REPORT SUMMARY

MARCH 2024

This community needs assessment collects information about socioeconomic needs, barriers to healthcare, and poor health outcomes, which allows for development of recommendations to address significant needs. What we learn about access to care and health outcomes is shared to improve staffing and service delivery that meets the community's unique needs.

CONTENTS



HEALTH NEEDS

Overview of key behavioral and physical health challenges and priorities.



SOCIAL DETERMINANTS OF HEALTH

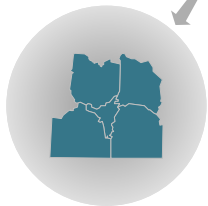
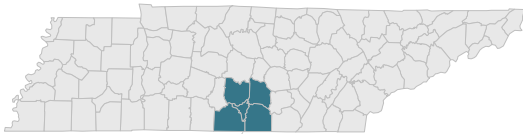
Summary of personal, social, and environmental factors that impact health.



SERVICE NEEDS

Assessment of healthcare service availability and gaps.

OVERVIEW OF TENNESSEE



COUNTIES:

Bedford, Coffee, Franklin,
Lincoln, Moore



44th

HEALTHIEST STATE

Top challenges where Tennessee ranked in the bottom three states include a high prevalence of frequent mental distress, high rates of multiple chronic conditions, and high rates of cigarette smoking. TN ranked in the bottom 10 states for population avoiding care due to cost (12.6% TN vs 10.1% US) and that are uninsured (9.3% TN vs 8.0% US),

KEY FINDINGS AND RECOMMENDATIONS

01

For behavioral health, all counties had high rates of suicide, especially Lincoln and Moore. High rates of drug overdose and alcohol-related mortality and related outpatient visits were observed, particularly for Bedford and Coffee. Recommendations include increasing preventive education and access to care (e.g., insurance) for adults with serious mental illness (SMI) and co-occurring disorders (COD) and youths with SED.

02

For physical health, high rates of adults smoking, physical inactivity, youth and adult obesity, and diabetes were observed along with limited access to exercise opportunities. Coffee, Lincoln, and Moore had low mammography screening rates. Child and infant mortality was high for Franklin and Lincoln. Recommendations include improving health literacy of physical and behavioral risk factors and collaborating with PCPs for preventive services.

03

Social determinant of health stressors include lacking health insurance, low-income and poverty, food insecurity, and transportation and broadband access. Socioeconomic disadvantages (i.e., based on income, education, employment, and housing quality) were notable in Bedford, Franklin, and Lincoln Counties. Recommendations include fostering partnerships with community support organizations to address needs.

HEALTH NEEDS



This section outlines the population's key health challenges, prevalent conditions, and overall health status, emphasizing areas where targeted interventions are most needed.

MENTAL HEALTH

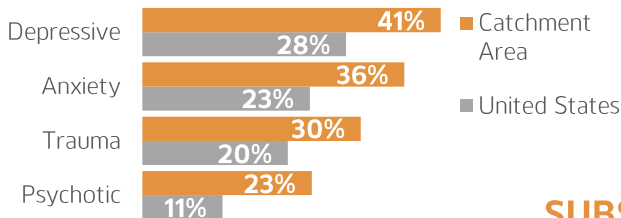


POOR MENTAL HEALTH DAYS

All counties had a slightly higher prevalence frequent mental distress than the state with an average of 5.3 unhealthy days.

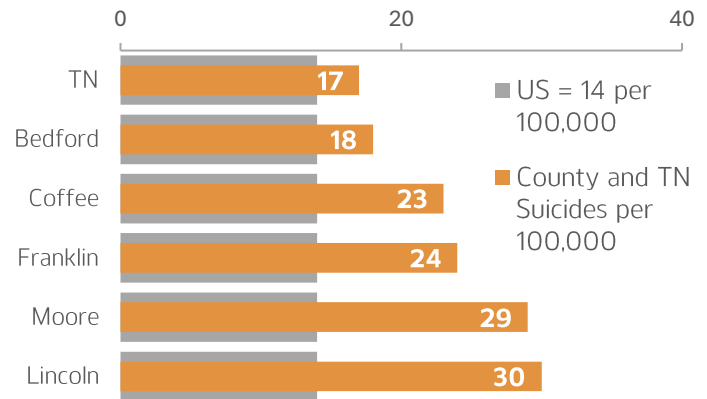
BEHAVIORAL HEALTH DIAGNOSES

Tullahoma clients had a higher proportion of diagnoses compared to national trends of individuals receiving behavioral health treatment.



HIGH SUICIDE MORTALITY RATES

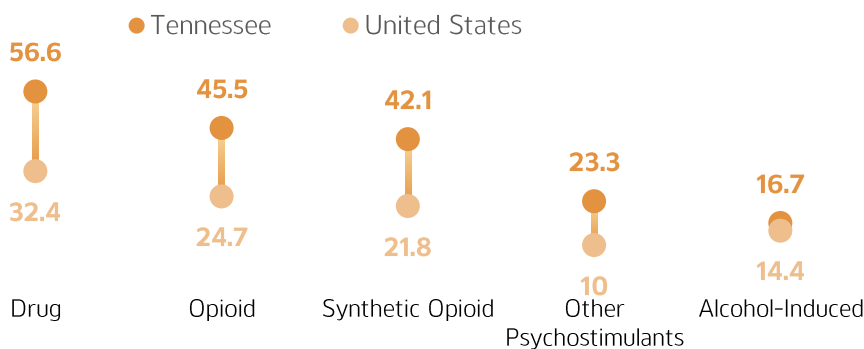
Suicide mortality per 100,000 population exceeded both the state and national averages for all counties.



SUBSTANCE USE

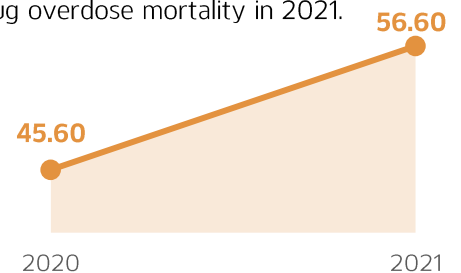
HIGH RATES OF SUBSTANCE USE-RELATED MORTALITY

Tennessee had higher rates of alcohol and substance use mortality per 100,000 population than the United States.



OVERDOSE MORTALITY PER 100K POPULATION

While steadily increasing over the last decade, Tennessee shifted from the 5th worst to the 2nd worst state for overall drug overdose mortality in 2021.



PHYSICAL HEALTH



POOR PHYSICAL HEALTH DAYS

Compared to Tennessee (3.3 days), average for all counties was slightly higher at 3.7 unhealthy days in the past 30 days.

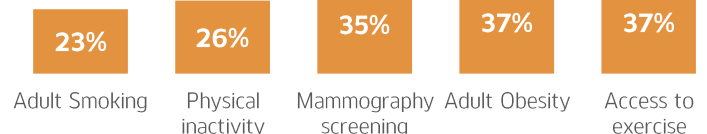
10,000
YLL
per 100,000


The catchment area had a high burden of premature death compared to national and state average (US 7,300 YLL; TN 9,900 YLL).

*YLL= Years of Life Lost

PHYSICAL HEALTH DISPARITIES

Compared to the state, the catchment area had high average smoking and physical inactivity, lower engagement in mammography screenings, and limited access to exercise opportunities, indicating key areas for health improvement. Average obesity rate was slightly higher.





SOCIAL DETERMINANTS OF HEALTH

This section explores the social and economic factors, such as income, education, housing, and access to resources, that shape health outcomes and contribute to disparities.

ACCESS TO HEALTH SERVICES

34%

AVOIDED CARE DUE TO COST

Of these 41 residents, **51%** went without prescription medications, **46%** went without physical care, and **44%** went without physical care.

48%

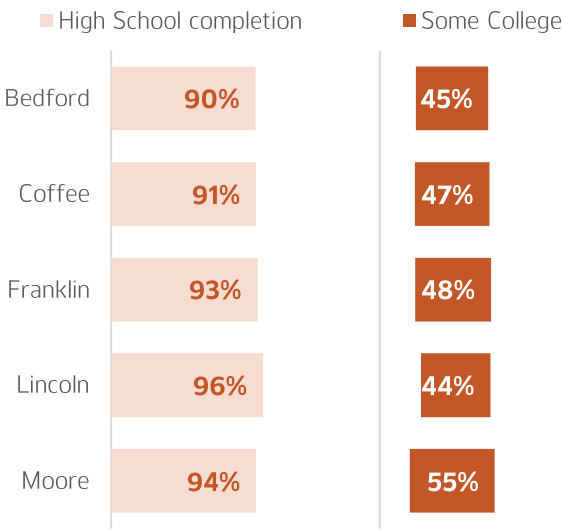
TELEHEALTH SERVICES

A large proportion (48%) of the residents are either **unfamiliar with telehealth service** or **do not have access**.

EDUCATIONAL ATTAINMENT

EDUCATIONAL WELL-BEING

Graduation rates were higher or followed closely with **Tennessee's rate of 89.9%** in our catchment area. Higher graduation rates are associated with better access to educational resources and employment options.



SOCIO-ECONOMIC STATUS



INCOME INEQUALITY

All counties had scores **less than or equal to 0.48** on the Gini Index of Income Inequality scale. This indicates a moderate level of inequality of the catchment area.



HOUSEHOLD CHARACTERISTICS

63% (n=83) of residents **indicated living with an individual with a disability**. 13% of them are caregivers to another adult



UNEMPLOYMENT

The catchment area is **performing better** than the state average in terms of **unemployment measuring at 3.7%**

HOUSING & FOOD INSECURITY

46%

COULD NOT ACCESS NECESSITIES

Nearly **half of residents** (n=83) **reported going without essentials** like food, clothing, or medication in the past year while **78% couldn't access necessities due to cost**.



SERIOUS HOUSING PROBLEMS

39% (n=83) of households **experienced serious housing problems** in the last 3 months with **majority spending more than 50%** of income on housing.



MAP THE MEAL GAP

Coffee and Franklin had the highest proportions of **all ages experiencing food insecurity and poverty rates** compared to other counties in the state.

SERVICE NEEDS

This section assesses the adequacy, accessibility, and availability of healthcare services to address identified health priorities and reduce barriers linked to social determinants.



ACCESS TO INTEGRATED AND WRAPAROUND SERVICES

Expand care for individuals with suicidal thoughts, particularly in Lincoln and Moore. Combat burden of premature deaths, low life expectancy, and multiple chronic conditions by developing community partnerships to provide comprehensive care.



EXPAND SUBSTANCE USE CARE

Increase access of outpatient substance use treatment and education, transitional services, recovery supports, and insurance coverage for services to address the opioid crisis.



STRENGTHEN COMMUNITY INTERVENTIONS

Contribute to educational and preventive initiatives to address youth mental health and risky sexual behaviors, including school-based programs and sexual education to address STIs and teen birth rates.

“

Advertise their services and access hope. Some in need may not know what Centerstone offers.

Centerstone Client

”

FUTURE DIRECTIONS



SUPPORT COMMUNITY EDUCATION AND PREVENTION

Educate the community about behavioral health and its importance for wellbeing to reduce stigma and encourage seeking help. Increase awareness of treatment options, especially for those with low-income or no insurance.



ADVANCE PARTNERSHIPS AND COMMUNITY OUTREACH

Collaborate with insurance providers to address coverage barriers. Develop community partnerships to alleviate financial and transportation barriers and provide support for justice-involved individuals.



INCREASE COLLABORATION AND DATA-SHARING

Local organizations suggest sharing flyers to promote available services, creating data-sharing agreements with drug court, and establishing two-way referral systems so they can follow-up with referrals to Centerstone.



IMPROVE CONSISTENCY AND QUALITY OF CARE

Consider staff feedback to improve quality care, including promoting treatment that does not prioritize medication, creating an app for clients to access information, and easier appointment scheduling.

Information from internal and external sources (e.g., Enlighten Analytics, SAMHSA, CDC), including feedback from Centerstone staff, clients, and community organizations (Nov 2023–Mar 2024), is shared to enhance care access, health outcomes, and tailored service delivery. This publication is supported by Grant Number SM089294 from SAMHSA. Its contents are solely the responsibility of the authors and do not represent the official views of SAMHSA.



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