CARTERET COUNTY

COMMUNITY HEALTH NEEDS ASSESSMENT

2024 CHNA REPORT

ACKNOWLEDGEMENTS

This Community Health Needs Assessment (CHNA) represents the culmination of work completed by multiple individuals and groups. Health ENC – a group of stakeholders who help find ways to collaborate and share resources to improve the health of the population in eastern North Carolina – served an integral role in making this comprehensive assessment possible. To provide focused guidance throughout the assessment process, Health ENC convened a smaller decision-making group, which will be referred to as the Steering Committee throughout this CHNA. The Steering Committee would like to extend its gratitude to all the focus groups participants, health leaders, and community members who provided information used in the development of this assessment.

The Health ENC CHNA Steering Committee

Name	Title	Organization
Lorrie Basnight	Executive Director	Eastern Area Health Education Center (AHEC)
Amanda Betts	Public Health Education Coordinator	Albemarle Regional Health Services (ARHS)
April Culver	Vice President, External Affairs	UNC Johnston Health
Caroline Doherty	Community Health Consultant	Roanoke Chowan Community Health Center (RCCHC)
Laura Ellis	Health Education	Halifax County Health Department
Sandra McMasters	Community Benefit Project Manager	Sentara Health
Claire Mills	Director	Eastern AHEC
Emmanuelle Quenum	Health Education Director	Greene County Department of Public Health (DPH)
Rose Ann Simmons	Administrator, Community Health Improvement	ECU Health
Michelle Wagner	Public Health Educator	Dare County Department of Health & Human Services (DHHS)

Carteret County CHNA Leadership

In addition to the Steering Committee, the Carteret County 2024 CHNA was developed in partnership with representatives from Carteret County Health Department (CCHD) and Carteret Health Care.

Carteret County CHNA Stakeholders

The Carteret County 2024 CHNA was also developed with input from additional representatives from local health providers, government officials, non-profit organizations, social service providers and community members, including:

- Carteret County Health and Human Services Board
- The community members who agreed to be surveyed and provided valuable information about the health of Carteret County
- Leo Mann Jr. Enrichment Center focus group participants
- Carteret Community College focus group participants
- Carteret County Unhoused focus group participants

- CCHD and Carteret Health Employee focus group participants
- Tameya Strayhorn, East Carolina University: Public Health intern for conducting surveys at various locations in the county
- Tommy Burns, Carteret County: County Manager for supporting the involvement of county staff in the Community Health Assessment process
- Carteret County Area Transportation: For providing transportation for the unhoused focus group
- Carteret Community College TRIO Student Support Service
- Leo Mann Enrichment Center Staff
- Hope Recovery Mission
- Veteran Services of the Carolinas

In addition, the Steering Committee would like to thank Ascendient Healthcare Advisors for directing the CHNA process and developing the content of this report.

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EXECUTIVE SUMMARY

A Community Health Needs Assessment (CHNA) helps health leaders evaluate the health and wellness of the community they serve and identify gaps and challenges that should be addressed through new programs, services and policy changes. This report was created in compliance with North Carolina Local Health Department Accreditation standards, as well as Internal Revenue Service requirements for not-for-profit hospitals.

The local health organizations who came together to help develop this CHNA included Carteret County Health Department and Carteret Health Care.

Secondary (existing) data is an important piece of the CHNA process. Key sources for secondary data included information provided by the Steering Committee and a variety of public data sources related to demographics, social and economic determinants of health, environmental health, health status and disease trends, mental/behavioral health trends, and individual health behaviors. Each data measure was also compared to state or national benchmarks to identify areas of specific concern for Carteret County. Top community needs identified through secondary data analysis included environmental quality, healthcare access and quality, length of life, tobacco use, and transportation and transit.

Primary (new) data were collected through focus groups and a web-based survey for community members, and included feedback from 461 people who live, work or receive healthcare in Carteret County. A total of four in-person focus groups were conducted, with a variety of community members from different backgrounds, age groups and life experiences. Primary data identified behavioral health (including mental health and substance use), the built environment, food access and security, healthcare access and quality, physical health (chronic diseases, cancer, obesity), and transportation and transit as top needs that impact the health and well-being of people living in Carteret County.

Representatives from Carteret County worked together to identify the priorities the county should focus on over the following three-year period. Leaders evaluated the primary and secondary data collected throughout the process to identify needs based on the size and scope, severity, the ability for hospitals or health departments to make an impact, associated health disparities, and importance to the community. Although it was not possible for every single area of potential need to be identified as a priority, Carteret County selected four top priority health needs (Chronic Health Conditions, Mental Health, Substance and Tobacco Use, and Family, Community, and Social Support), which are shown here in alphabetical order:

Carteret County also compiled a Health Resources Inventory, which describes a variety of resources available to help Carteret County residents meet their health and social needs.

Following completion of this report, health leaders throughout Carteret County will use its findings to collaborate with community organizations and local residents to develop effective health strategies, new implementation plans and interventions, and action plans to improve the communities they serve.

INTRODUCTION

Background

To illustrate its commitment to the health and well-being of the community, the Health ENC CHNA Steering Committee has completed this assessment to understand and document the greatest health needs currently faced by local residents. Guidance was also provided by local representatives from Carteret County Health Department and Carteret Health Care. These organizations helped gather the focus group and survey data that are detailed in this report. The CHNA process helps local leaders continuously evaluate how best to improve and promote the health of the community. It builds upon formal collaborations between the Steering Committee and other community partners to proactively identify and respond to the needs of Carteret County residents.

This report was created in compliance with the State of North Carolina's Local Health Department Accreditation (NCLHDA) Board's accreditation standards.[1] The accreditation process allows local health departments to assess how they are meeting national and state-specific standards for public health practice and provides opportunities to address any identified gaps. It also ensures that local health departments have the ability to deliver the 10 essential public health services, as described in **Figure I.1** below. In its demonstration of data and prioritization of Carteret County's community needs, this report aligns with all NCLHDA standards for accreditation, including the need to:

- Provide evidence of community collaboration in planning and conducting the assessment;
- Reflect the demographic profile of the population and describe socioeconomic, educational and environmental factors that affect health;
- Assemble and analyze secondary data to describe the health status of the community;
- Collect and analyze primary data to describe the health status of the community;
- Use scientific methods for collecting and analyzing data, including trend data to describe changes in community health status and in factors affecting health;
- Identify population groups at risk for health problems;
- Identify existing and needed health resources;
- Compare selected local data with data from other jurisdictions; and
- Identify leading community health problems.

[1] Source: NCLHDA Health Department Self-Assessment Instrument Interpretation Document 2024.

Figure I.1: The 10 Essential Public Health Services

Further, this process complies with Internal Revenue Service (IRS) requirements for not-for-profit hospitals to complete a CHNA every three years to maintain their tax exemption.[2] Specifically, the IRS requires that hospital facilities do the following:

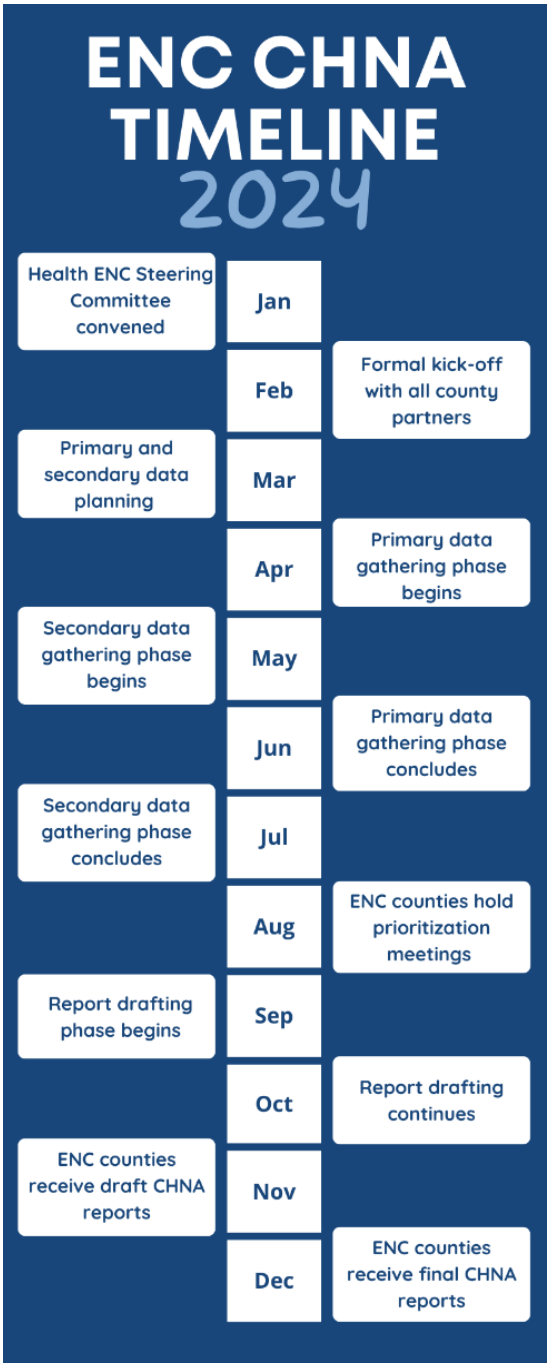
- Define the community it serves;
- Assess the health needs of that community;
- Through the assessment process, take into account input received from people who represent the community's broad interests, including those with special knowledge of or expertise in public health;
- Document the CHNA in a written report that is reviewed and adopted by the hospital facility's authorizing body; and
- Make the CHNA widely available to the public.

[2] Source: *Community Health Needs Assessment for Charitable Hospital Organizations – Section 501®(3)* (2023). Internal Revenue Service. Retrieved February 13th, 2024 from https://www.irs.gov/charities-non-profits/community-health-needs-assessment-for-charitable-hospital-organizations-section-501r3.

Timeline

The Health ENC 2024 CHNA process for all participating counties, including Carteret County, began in January 2024 with the convening of the Steering Committee and continued throughout the year. The process concluded in December 2024 with the delivery of final CHNA reports. A high-level summary of activities conducted throughout the year can be found in **Figure I.2** below.

Figure I.2: Health ENC 2024 CHNA Milestones



Process Overview

A significant amount of information has been reviewed during this planning process, and the Steering Committee has been careful to ensure that a variety of sources were used to deliver a truly comprehensive report. Both existing (secondary) data and new (primary) data were collected directly from the community throughout this process. It is also important to note that, although unique to Carteret County, the sources and methodologies used to develop this report comply with the current NCLHDA and IRS requirements for health departments and not-for-profit hospital organizations.

The purpose of this study is to better understand, quantify, and articulate the health needs of Carteret County residents. Key objectives of this CHNA include:

- Identify the health needs of Carteret County residents;
- Identify disparities in health status and health behaviors, as well as inequities in the factors that contribute to health challenges;
- Understand the challenges residents face when trying to maintain and/or improve their health;
- Understand where underserved populations turn for services needed to maintain and/or improve their health;
- Understand what is needed to help residents maintain and/or improve their health; and
- Prioritize the needs of the community and clarify/focus on the highest priorities.

There are ten phases in the CHNA process, as described in **Figure I.3** below. Results of the first seven phases are discussed throughout this assessment and the development of community health action plans and subsequent phases will take place after the completion of the CHNA report.

Figure I.3: The CHNA Process

Report Structure

The outline below provides detailed information about each section of the report.

1) *Methodology* – The methodology chapter provides an overall summary of how the priority health need areas were selected as well as how information was collected and incorporated into the development of this CHNA, including study limitations.

2) *County Profile* – This chapter details the demographic (such as age, gender, and race) and socioeconomic data of Carteret County residents.

3) *Priority Health Need Areas* – This chapter describes each identified priority health need area for Carteret County and summarizes the new and existing data that support these prioritizations. This chapter also describes the impact of health disparities among various sub-groups in Carteret County.

4) *Health Resource Inventory* – This chapter documents existing health resources currently available to the Carteret County community.

5) *Next Steps* – This chapter briefly summarizes the next steps that will occur to address the priority health need areas discussed throughout this document.

In addition, the appendices discuss all of the data used during the development of this report in detail, including:

1) *State of the County Health Report* – Detailed information about actions taken to address the priority health needs identified in previous CHNAs are presented in **Appendix 1.**

2) *Detailed Summary of Secondary Data Measures and Findings* – Existing data measures and findings used in the prioritization process are presented in **Appendices 2-3.**

3) *Detailed Summary of Primary Findings* – Summaries of new data findings from community member surveys as well as focus groups are presented in **Appendices 4-5.**

Evaluation of Prior CHNA Implementation Strategies

A CHNA is an ongoing process that begins with an evaluation of the previous CHNA. In 2021, Carteret County completed its previous assessment. Associated implementation strategies focused on three priority areas, as listed below:

Figure I.4: Carteret County 2021 Priorities

Local organizations developed goals and implementation plans to address these priority health needs. Below are brief summaries of each organization's most recent CHNA implementation plans.

Carteret County Health Department

Carteret County Health Department (CCHD) has served residents of Carteret County, North Carolina since 1937. The mission of the Carteret County Health Department, through its responsive and professional staff, is to preserve, promote and protect the health of the community by preventing disease, protecting the environment, and promoting healthy living. Carteret County Health Department provides a variety of preventive health care services, screenings, treatment, immunizations, environmental health services, animal control services, and health education/information. Carteret County Health Department's services

are grouped into the following overarching categories: Administration/Community Health; Animal Control; Case Management and Clinical Services; Dental; Environmental Health Services; Post Overdose Response, and Women, Infants, and Children (WIC).

Carteret Health Care

Carteret Hospital is an independent, not-for-profit, 135-bed community hospital serving Eastern North Carolina. Since 1967, Carteret Health Care has provided high-quality healthcare to residents of Carteret County and beyond. Carteret Health Care is a member of the Mayo Clinic Care Network, which means that doctors have access to Mayo Clinic knowledge, resources, and specialists so that patients can get the care they need, close to home, at no additional cost. Carteret Health Care offers a full range of acute care, diagnostic, and outpatient services, leading the way to healthier lives through innovations in safety, quality, service, and superior value. Carteret Health Care provides the community with valuable resources to help create healthy lifestyles and provides patients with optimal strategies to make informed decisions about their health. Carteret Health Care is committed to providing the community with safe, quality and equitable healthcare and strives toward a goal of zero serious safety events of patient harm every day.

Previous CHNA Priority: Chronic Disease

- **Diabetes Prevention Program:** Screening events took place in various locations across Carteret County including senior centers, faith-based organizations, and low-income housing communities to determine needs of individuals who may be at risk for developing Type 2 diabetes. The Diabetes Prevention Program screened 90 participants from July 2023 to July 2024.
- **Health Fairs:** The Health Education Team and Carteret Health Care collaborated to host seven health fairs to screen for cardiovascular disease and Type 2 diabetes during fiscal year (FY) 2023 to 2024.

Previous CHNA Priority: Equitable Access to Health

- **Community Events:** Health department staff comprising Clinical, Health Education, and Women, Infants, and Children attended community events such as “Stuff the Bus” and “National Night Out” to provide resources to individuals throughout the community.
- **Equitable Assess to Vaccines:** Health department staff provides access and information regarding vaccines, specifically the COVID vaccine, to historically marginalized groups and populations.
- **Equity Committee:** An equity committee has been established at the health department. The purpose of the committee is to address how to best serve all populations including marginalized groups and populations and discuss any issues the county is currently struggling with.
- **Hepatitis C Treatment Program:** Part of the Carteret Health Department’s adult health clinic, the Hepatitis C Treatment program enrolled 48 new clients during FY 2023 and 64% completed their treatment. In addition, a Hepatitis C bridge counselor connected with 67 clients throughout Region 10. The bridge counselor has connected with 58 additional clients from FY 2023 through FY 2025 so far.

Previous CHNA Priority: Substance Misuse

- **Post-Overdose Response Team (PORT):** A Post-Overdose Response Team was established in Carteret County to provide outreach, engagement, and resource navigation to individuals who have serious opioid and other substance use challenges. This may include experiencing overdose, substance use emergencies, relapse and other concerns. The team includes Certified Peer Support Specialists whose goal is to connect participants with the resources they need and support the individuals in moving towards the recovery pathway that works for them.
- **Operation Medicine Drops:** A semi-annual drug take-back event hosted in partnership with local law enforcement agencies.
- **Home Run for Health Substance Awareness and Resource Fair:** Hosted in April of 2023 in Smyrna.
- **Narcan:** Training events were held across the county.
- **National Fentanyl Awareness Day Event:** Roughly 130 to 150 community members came out to learn about resources and hear from survivors who were saved by Narcan. Additionally, 118 Narcan kits were distributed during the event.
- **Monthly Roundtable Events:** An opportunity for community organizations to come together.
- **Peer Support Groups**
- **Drug Prevention Curriculum:** High school students were administered and completed 396 pre-assessments and 437 post-assessments. Students who received the curriculum were 90% likely to misuse any illicit substances.
- **CATCH my Breath:** Nicotine vaping prevention program, CATCH my Breath, was taught in all Carteret County Middle Schools. Approximately 1,500 students were reached.

During each FY, there were health fairs and/or events to address the top health priorities in some capacity, including:

- 26 outreach community events during FY 2021 to 2022
- 17 outreach community events during FY 2022 to 2023
- Over 40 outreach community events during FY 2023 to 2024

Additional detail about previous implementation plans, as captured in the NCLHDA State of the County Health (SOTCH) report, can be found in **Appendix 1**.

Summary Findings: Carteret County 2024 Priority Health Need Areas

To achieve the study objectives in the 2024 assessment, both new and existing data were collected and reviewed. New data included information from web-based surveys of adults (18+ years) and focus groups; various local organizations, community members, and health service providers within Carteret County participated. Existing data included information regarding the demographics, health and healthcare resources, behavioral health, disease trends, and county rankings. The data collection and analysis process began in January 2024 and continued through July 2024.

Throughout Carteret County, significant variations in demographics and health needs exist within the county. At the same time, consistent needs are present across the whole county and serve as the basis for determining priority health needs at the county level. This document will discuss the priority health

need areas for Carteret County, as well as how the severity of those needs might vary across subpopulations based on the information obtained and analyzed during this process.

Through the prioritization process, the CHNA Steering Committee identified Carteret County's priority health need areas from a list of over 100 health indicators. Please note that the final priority needs were not ranked in any order of importance and county health leaders will engage in each of the four priority need areas. After looking at all relevant data and feedback from the CHNA Steering Committee, the Carteret focus areas identified as countywide priorities for the 2024 CHNA are Chronic Health Conditions; Family, Community, and Social Support; Mental Health; and Substance Use and Tobacco Use, as seen in **Figure I.5**.

Figure I.5: Carteret County 2024 Priority Health Needs

Health, healthcare and associated community needs are very much interrelated, and often impact each other. Although this CHNA process considered these areas separately, their impact on each other should be considered when planning for programs or services to address community needs.

Many health needs are also related to underlying societal and socioeconomic factors. Research has consistently shown that income, education, physical environment, and other such demographic and socioeconomic factors affect the health status of individuals and communities. This CHNA acknowledges that link and focuses on identifying and documenting the greatest health needs as they present themselves today. As plans are developed to address these needs, the Committee's goal is to work with other community organizations to address underlying factors that could drive long-term improvements to the county population's health.

For additional discussion of current priority needs and the data that supports those priorities, please see **Chapter 3**.

CHAPTER 1 | METHODOLOGY

Study Design

The process used to assess Carteret County's community needs, challenges, and opportunities included multiple steps. Both new and existing data were used throughout the study to paint a more complete picture of Carteret County's health needs. While the CHNA Steering Committee largely viewed the new and existing data equally, there were situations where one provided clearer evidence of community health need than the other. In these instances, the health needs identified were discussed based on the most appropriate data gathered. Data analysis, community feedback review, and stakeholder engagement were all used to identify key areas of need.

Specifically, the following data types were collected and analyzed:

New (Primary) Data

Public engagement and feedback were received through a web-based community member survey along with community focus groups and significant input and direction from the CHNA Steering Committee. The Steering Committee worked together to develop the survey questions for the web-based survey, and county leaders were provided with a set of target numbers based on their county population's race, ethnicity and age distribution to encourage recruitment of a representative sample of the community. Community members were asked to identify the most significant health and social needs in their community, as well as asked questions about topics specific to Carteret County, including access to care, physical health, and substance use disorders. Focus group participants were asked a standard set of questions about health and social needs, in order to identify trends across various groups and to highlight areas of concern for specific populations. In total, the input was gathered from nearly 500 Carteret County residents and other stakeholders. This included web survey responses from over 450 community members and four focus groups that included 42 community members and other people who live, work or receive healthcare in Carteret County.

For more information regarding specific questions asked as part of the focus groups and surveys, please refer to **Appendix 4**.

Existing (Secondary) Data

Key sources for existing data on Carteret County included information provided by the Steering Committee and a variety of public data sources related to demographics, social and economic determinants of health, environmental health, health status and disease trends, mental/behavioral health trends, and individual health behaviors. Key information sources leveraged during this process included:

- *North Carolina Data Portal*, a joint effort by the North Carolina Department of Health and Human Services and the University of Missouri Center for Applied Research and Engagement Systems

- *County Health Rankings*, developed in partnership by Robert Wood Johnson Foundation (RWJF) and University of Wisconsin Population Health Institute

- *The Opportunity Atlas*, developed in partnership by the U.S. Census Bureau, Harvard University, and Brown University
- *Food Access Research Atlas*, published by the U.S. Food and Drug Administration
- *Social Vulnerability Index*, developed by the CDC and the Agency for Toxic Substances and Disease Registry (ATSDR)
- *Environmental Justice Index*, developed by the CDC and the ATSDR
- *American Community Survey*, as collected and published by the U.S. Census Bureau
- Data provided by CHNA Steering Committee members and other affiliated organizations, including Community Health Assessment reports for Carteret County from 2018 and 2021.

For more information regarding data sources and data time periods, please refer to **Appendix 2**.

Comparisons

To understand the relevance of existing data collected throughout the process, each measure must be compared to a benchmark, goal, or similar geographic area. In other words, without being able to compare Carteret County to an outside measure, it would be impossible to determine how the county is performing. For this process, each data measure was compared to outside data as available, including the following:

- *County Health Rankings* Top Performers: This is a collaboration between the RWJF and the University of Wisconsin Population Health Institute that ranks counties across the nation by various health factors.
- State of North Carolina: The Steering Committee determined that comparisons with the state of North Carolina were appropriate.

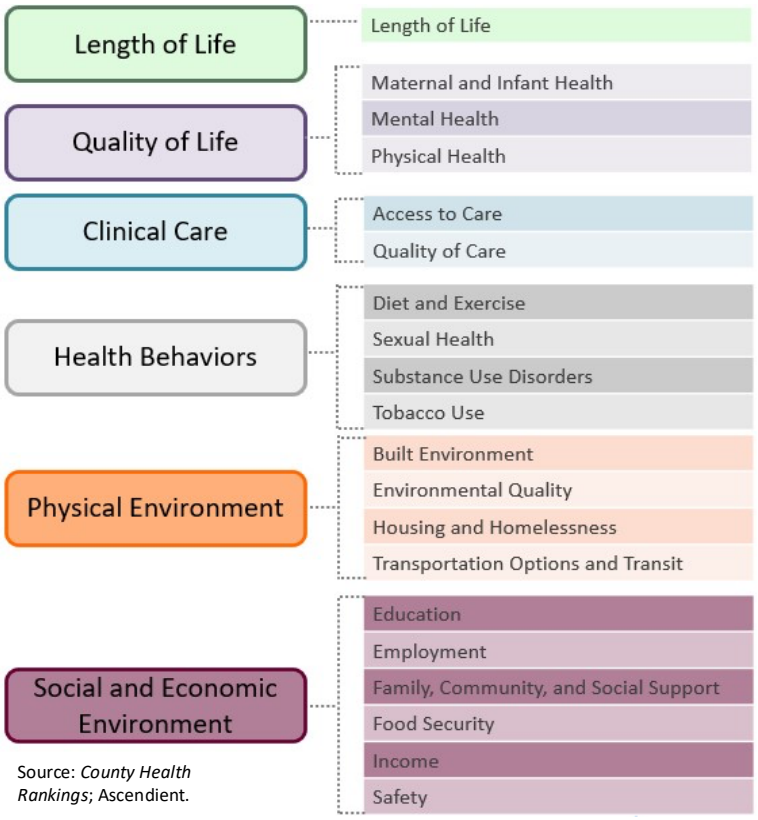
Population Health Framework

This assessment was developed in alignment with the RWJF population health framework, originally developed by the University of Wisconsin's Population Health Institute. Population health focuses on health status and outcomes among a specific group of people, and can be based on geographic location, health diagnoses or common health providers. The population health framework recognizes that the issues that affect health in a community are complex; there are many factors that have the potential to impact health outcomes, including both length and quality of life, within a population. Broadly, these factors include the clinical care available to community members, individual health behaviors, the physical environment, and the social and economic conditions in the community.

Using the population health framework as a guide for the CHNA process helps categorize many individual pieces of data in a way that connects the dots between health status and social drivers of health, in a way that helps local leaders better understand and address the health and well-being of the communities they

serve. This understanding is critical in identifying potential interventions to address priority needs in the community, and to helping develop partnerships across sectors that can help drive these interventions forward. **Figure 1.1** below illustrates the broad categories and sub-categories within the population health framework.

Figure 1.1: Population Health Framework



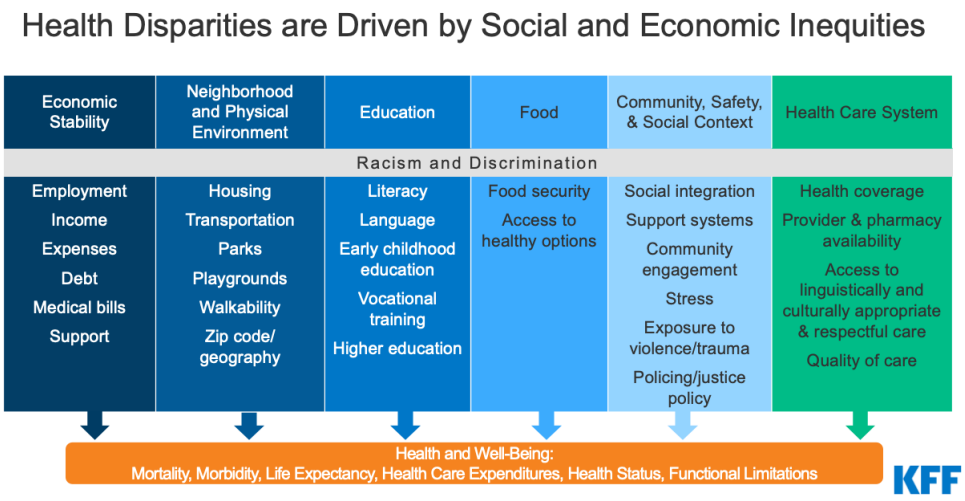
Source: *County Health Rankings*; Ascendient.

Throughout the process, the Steering Committee also considered *Healthy People 2030*'s "Social Determinants of Health and Health Equity." The CDC defines social determinants of health (SDoH) as the conditions in the environments where people are born, live, learn, work, play, worship and age that affect a wide range of health, functioning and quality of life outcomes and risks. These factors can include healthcare access and quality, neighborhood and built environment, social and community context, economic stability, and education access and quality, as outlined in **Figure 1.2**.[3]

Figure 1.2: Social Determinants of Health

Recognizing that SDoH have an impact on health disparities and inequities in the community was a key point the Steering Committee considered throughout the CHNA process. **Figure 1.3** describes the way various social and economic conditions may affect health and well-being.

Figure 1.3: SDoH and Health Disparities



Prioritization Process Overview and Results

The process of identifying the priority health needs for the 2024 CHNA began with the collection and analysis of hundreds of new and existing data measures. In order to create more easily discussable categories, all individual data measures were then grouped into six categories and 20 corresponding focus areas based on "common themes" that correspond to the Population Health Model, as seen in **Figure 1.1**. These focus areas are detailed further in **Appendix 2.**

[3] Source: CDC (2022). Social Determinants of Health at CDC. Accessed March 7th, 2024 via https://www.cdc.gov/about/sdoh/index.html

Since a large number of individual data measures were collected and analyzed to develop these 20 focus areas, it was not reasonable to make each of them a priority. The Steering Committee considered which focus areas had data measures of high need or worsening performance, priorities from the primary data, and how possible it is for health departments or hospitals to impact the given need to help determine which health needs should be prioritized.

Representatives from the Carteret County Health Department and Carteret Health Care met virtually to discuss to discuss the potential priority areas for the full Steering Committee to vote on, as well as the criteria for consideration and prioritization methodology. Prioritization occurred on September 23, 2024 at an in-person meeting at the Carteret County Health Department. During the meeting, participants used a dot sticker exercise for the first round of voting, narrowing down the 20 potential priority areas to 10. These 10 potential priority areas were then plotted on a PICK chart, assessing each priority area for its potential payoff (low vs. high) and difficulty implementing solutions to address the need (easy vs. difficult). Following the PICK chart exercise, participants held a facilitated discussion to affirm four priority need areas for Carteret County.

In the prioritization process, participants also considered the following factors:

- Size and scope of the health need;
- Severity and intensity of the health need;
- Whether possible interventions would be possible and effective;
- Health disparities associated with the need; and
- Importance the community places on addressing the need.

The final priority need areas were not ranked in any particular order of importance, and each will be addressed by the Steering Committee. The following four focus areas (Chronic Health Conditions; Family, Community and Social Support; Mental Health; and Substance Use and Tobacco Use) were identified as Carteret County's top priority health needs to be addressed over the next three years, as seen in **Figure 1.4** below:

Figure 1.4: Carteret County 2024 Priority Health Needs

Participants from the following organizations participated in the prioritization voting process:

- Coastal Community Action
- Carteret Community College Nursing Program
- Trillium
- Martha's Mission Cupboard, Inc.
- Leo Mann Enrichment Center
- Carteret County Department of Social Services
- Carteret School System
- Veterans of the Carolinas
- Carteret County Health Department Staff
- Carteret Health Care Staff

Study Limitations

Developing a CHNA is a long and time-consuming process. Because of this, more recent data may have been made available after the collection and analysis timeframe. Existing data typically become available between one and three years after the data is collected. This is a limitation, because the "staleness" of certain data may not depict current trends. For example, the U.S. Census Bureau's American Community Survey is a valuable source of demographic information, however data for a particular year is not published until late the following year. This means 2022 data on community characteristics, such as languages spoken at home, did not become available until late fall 2023. The Steering Committee tried to account for these limitations by collecting new data, including focus groups and web-based community member surveys. Another limitation of existing data is that, depending on the source, it may have limited demographic information, such as gender, age, race, and ethnicity.

Given the size of Carteret County in both population and geography, this study was limited in its ability to fully capture health disparities and health needs across racial and ethnic groups. Efforts were made to include diverse community members in survey efforts, which were largely successful. Roughly 87% of all respondents were White compared to 84% of the Carteret County population reported as being White. Another 6% of respondents were Black or African American, just exceeding the county population reported as being 5%. Nearly 5% of respondents identified as Hispanic, which is similar to the reported county population level of 5%. Although survey respondents could choose from multiple race categories, limited responses were received from these groups. This made it difficult for the Steering Committee to assess health needs and disparities for other racial minority groups in the community.

In addition, there are existing gaps in information for some population groups. Many available datasets are not able to isolate historically underserved populations, including the uninsured, low-income persons, and/or certain minority groups. Despite the lack of available data, attempts were made to include underserved sub-segments of the greater population through the new data gathered throughout the CHNA process. For example, the Steering Committee chose to focus on Spanish-speaking members of the community by providing a Spanish language version of the web-based community survey. Paper surveys were also distributed in an effort to reach as much of the community as possible. To increase future survey responses, members of the Steering Committee should consider working directly with partner organizations in the community who can connect directly with populations who are hard to access

through traditional outreach methods, including people with disabilities, the uninsured and people who are disengaged.

In the future, assessments should make efforts to include other underserved communities whose needs are not specifically discussed here because of data and input limitations during this CHNA cycle. Of note, residents in the disabled, blind, deaf, and hard-of-hearing communities can be a focus of future new data collection methods. Using a primarily web-based survey collection method might have also impacted response rates of community members with no internet access or low technological literacy. Additionally, more input from both patients and providers of SUD services would also be helpful in future assessments.

Finally, parts of this assessment have relied on input from community members and key community health leaders through web-based surveys and focus groups. Since it would be unrealistic to gather input from every single member of the community, the community members that participated have offered their best expertise and understanding on behalf of the entire community. As such, the CHNA Steering Committee has assumed that participating community members accurately and completely represented their fellow residents.

CHAPTER 2 | COUNTY PROFILE

Geography

Carteret County, referred to as the "Crystal Coast," is centrally located on the North Carolina coastline and bordered on the north by the Pamlico Sound and east and south by the Atlantic Ocean. With an average elevation of twelve feet above sea level, Carteret County is the southernmost portion of the Outer Banks region. There are eleven municipalities located within the county: Atlantic Beach, Beaufort (County Seat), Bogue, Cape Carteret, Cedar Point, Emerald Isle, Indian Beach, Morehead City, Newport, Peletier, and Pine Knoll Shores. Surrounding counties include Pamlico, Craven, Jones and Onslow. Geographically, the County is defined by water and is approximately 1,064 square miles with a land area of 506 square miles. Several protected areas can be found in Carteret County including Cape Lookout National Seashore, the Croatan National Forest, and Cedar Island Wildlife Refuge. Nearly one-third (30.6%) of Carteret County's population resides in rural areas.

Population

Population figures discussed throughout this chapter were obtained from Esri, a leading GIS provider that utilizes U.S. Census data projected forward using proprietary methodologies.

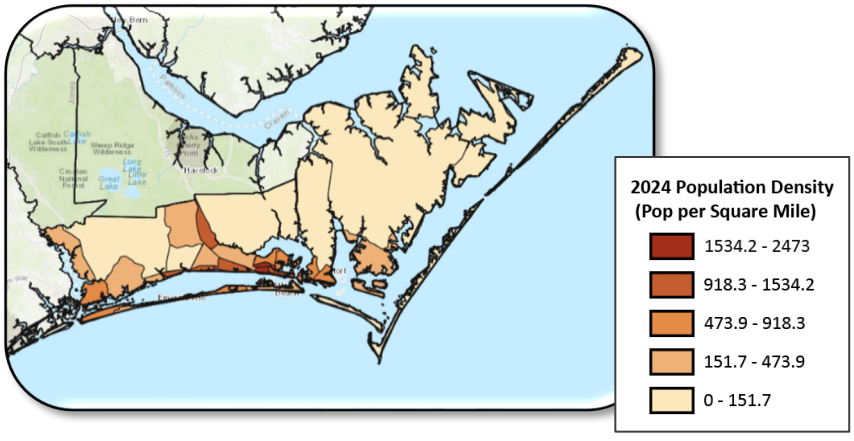
With a population of nearly 69,000, Carteret makes up less than 1% of the state's population.

Table 2.1: Total Population, 2023[4]

	Carteret County	North Carolina	United States
Population	68,761	10,765,678	337,470,185

Carteret County has a population density of 137.1 persons per square mile – lower than the population density for North Carolina (214.7 persons per square mile). Morehead City is the most densely populated area in the county.

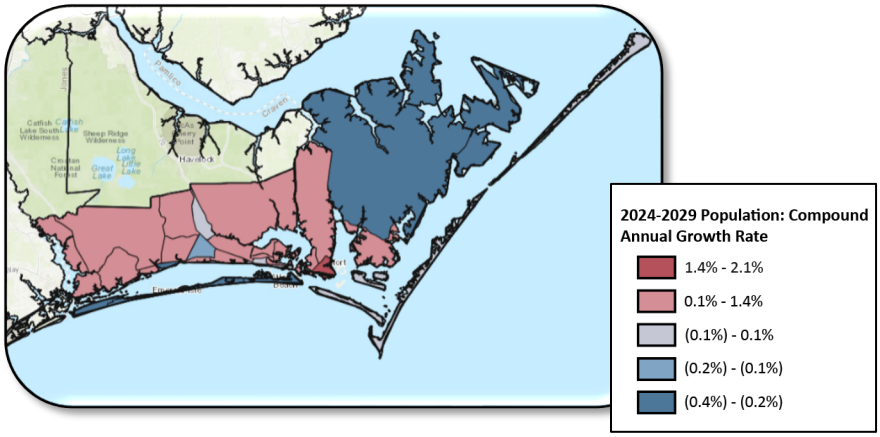
Figure 2.1: Carteret County Map: Population Density[4]



[4] Source: ESRI 2023

In total, the population of Carteret County is projected to grow 0.36% annually between 2024 and 2029. Areas in the western part of the county are experiencing greater growth.

Figure 2.2: Carteret County Map: Population Growth[4]



Age and Sex Distribution

Data on age and sex helps health providers understand who lives in the community and informs planning for needed health services. The age distribution of Carteret County skews older than that of the state and country, which means there may be an increasing demand for healthcare services to meet the specific needs of older adults, such as treatment for cancer or chronic illnesses.

Table 2.2: Age Distribution, 2023[4]

	Carteret County	North Carolina	United States
Percentage below 15	13.5%	17.9%	18.1%
Percentage between 15 and 44	31.6%	39.3%	39.5%
Percentage between 45 and 64	28.3%	25.1%	24.6%
Percentage 65 and older	26.6%	17.7%	17.8%

Carteret County's population distribution by sex is similar to that of the state of North Carolina.

Table 2.3: Sex Distribution, 2023[4]

	Carteret County		North Carolina		United States	
	Count	Pct. of Total	Count	Pct. of Total	Count	Pct. of Total
Female	35,319	51.4%	5,489,419	51.0%	170,118,720	50.4%
Male	33,442	48.6%	5,276,259	49.0%	167,351,465	49.6%

Race and Ethnicity

Data on race and ethnicity help us understand the need for healthcare services as well as cultural factors that can impact how care is delivered. Carteret County has a significantly higher proportion of White (Non-Hispanic) residents (85.4%) compared to both North Carolina (61.2%) and the United States (60.6%). In contrast, the Black (Non-Hispanic), Asian, AIAN (American Indian and Alaska Native), NHPI (Native Hawaiian and Pacific Islander) and multiracial populations represent a smaller share of the population in Carteret County compared to state and national levels. This suggests that Carteret County is less racially diverse than the broader North Carolina and U.S. populations.

Table 2.4: Racial Distribution, 2023[4]

	Carteret County		North Carolina		United States	
	Count	Pct. of Total	Count	Pct. of Total	Count	Pct. of Total
Black (Non-Hispanic)	3,363	4.9%	2,199,488	20.4%	42,132,758	12.5%
White (Non-Hispanic)	58,721	85.4%	6,590,161	61.2%	204,562,590	60.6%
Asian	673	1.0%	379,374	3.5%	21,088,177	6.2%
AIAN	327	0.5%	133,820	1.2%	3,831,126	1.1%
NHPI	68	0.1%	9,214	0.1%	712,229	0.2%
Some Other Race Alone	1,530	2.2%	677, 338	6.3%	29,432,586	8.7%
Two or More Races	4,079	5.9%	776,283	7.2%	35,710,719	10.6%

By ethnicity, nearly 5% of Carteret County's population is Hispanic. This figure is less than half that of the state (11.4%) and a quarter of the U.S. (19.4%).

Table 2.5: Ethnic Distribution, 2023[4]

	Carteret County		North Carolina		United States	
	Count	Pct. of Total	Count	Pct. of Total	Count	Pct. of Total
Non-Hispanic	65,375	95.1%	9,465,874	88.6%	271,934,049	80.6%
Hispanic	3,386	4.9%	1,299,804	11.4%	65,536,136	19.4%

The proportion of foreign-born individuals residing in Carteret County is significantly less than that of the state and the U.S, at less than 1%.

Table 2.6: Foreign Born Population, 2022[5,6]			
	Carteret County	North Carolina	United States
Foreign Born	0.3%	9%	13.9%

The diversity of Carteret County is reflected in the languages that residents speak at home. According to the most recent American Community Survey (ACS), over 5% of Carteret County residents speak a language other than English at home, compared to around 13% of North Carolina and 22% U.S. residents. A little over 3% of county residents speak Spanish at home.

Table 2.7: Language Spoken at Home, 2022[6]			
	Carteret County	North Carolina	United States
English Only	94.6%	87.3%	78%
Spanish	3.2%	7.9%	13.3%
Indo-European Languages	1.4%	2.1%	3.8%
Asian and Pacific Islander Languages	0.6%	1.9%	3.6%
Other Languages	0.2%	0.8%	1.2%

Disability Status[7]

Data on disabilities helps us understand how to create fair and equal opportunities for everyone in the county. In addition, individuals with disabilities may require targeted services and outreach by health and other service providers. The percent of the population in Carteret County with a disability is slightly lower than both the state and the U.S.

Table 2.8: Disability Status, 2022[5,6]			
	Carteret County	North Carolina	United States
Population with a Disability	11%	13.3%	12.9%

Veteran Status

Military veterans often need special services and support, so it is important to collect data about them to be better able to meet their specific needs. In Carteret County, the percentage of the population that are veterans (14.8%) is nearly twice the state and national averages.

[5] Source: US Census Bureau (2022)
[6] Source: American Community Survey 2018-2022 5-Year Estimates
[7] Disability status is classified in the ACS according to yes/no responses to questions about six types of disability concepts. For children under 5 years old, hearing and vision difficulty are used to determine disability status. For children between the ages of 5 and 14, disability status is determined from hearing, vision, cognitive, ambulatory, and self-care difficulties. For people aged 15 years and older, they are considered to have a disability if they have difficulty with any one of the six difficulty types.

Table 2.9: Veteran Status, 2022[5,6]			
	Carteret County	North Carolina	United States
Veterans	14.8%	7.8%	6.2%

Economic Indicators

In addition to demographic data, socioeconomic factors in the community such as income, poverty, and food scarcity play a significant role in identifying health-related needs. The median household income in Carteret County is $61,816, slightly lower than the median household income in North Carolina.

Table 2.10: Median Household Income, 2023[4]			
	Carteret County	North Carolina	United States
Median Household Income	$61,816	$64,316	$72,603

Poverty has a significant impact on health. Across the lifespan, people who live in impoverished communities have a higher risk of poor health outcomes, including mental illness, chronic diseases, higher mortality and lower life expectancy. Poverty is a concern across the lifespan; children who live in poverty are at risk for developmental delays, toxic stress and poor nutrition, and are likely to live in poverty as adults as well. Unmet social needs, including having low or no income, can also limit people's ability to access healthcare when they need it, or to provide for basic necessities needed to live healthy lives, such as safe housing or healthy food. In 2023, over 8% of Carteret County households were below the federal poverty level (FPL).

Table 2.11: Percent of Households Below the Federal Poverty Level, 2023[4]			
	Carteret County	North Carolina	United States
Percent Below FPL	8.4%	10.1%	9.5%

Higher than the percentage of households below the FPL, approximately 12% of Carteret County households received Food Stamps/SNAP (Supplemental Nutrition Assistance Program) in 2022. This is slightly lower than the state and national averages.

Table 2.12: Households Receiving Food Stamps/SNAP, 2022[6,8]			
	Carteret County	North Carolina	United States
Number of Households Receiving Food Stamps/SNAP	3,669	575,860	16,072,733
Total Number of Households	30,723	4,299,266	129,870,928
Percentage of Households receiving Food Stamps/SNAP	11.9%	13.4%	12.4%

[8] Source: North Carolina Department of Health and Human Services

In terms of educational attainment, the largest proportion of the population in Carteret County is individuals with some college/no diploma, representing just over a quarter of the population. This is higher than both North Carolina (21.1%) and the national average (14.6%).

Table 2.13: Educational Attainment, 2020[5,9]			
	Carteret County	North Carolina	United States
Less than 9th Grade	2.2%	6.0%	3.5%
Some High School/No Diploma	5.7%	5.5%	5.3%
High School Diploma	20.9%	21.2%	28.5%
GED/Alternative Credential	4.4%	4.3%	*[10]
Some College/No Diploma	26.6%	21.1%	14.6%
Associate's Degree	11.6%	9.9%	10.5%
Bachelor's Degree	17.0%	20.4%	23.4%
Graduate/ Professional Degree	11.5%	11.6%	14.2%

The total unemployment rate in Carteret (4.9%) is slightly lower than that of the state (5.1%), but one percentage point higher than the country (3.9%).

Table 2.14: Unemployment, 2022[6,11]			
	Carteret County	North Carolina	United States
Percentage unemployed ages 16 to 24	6.7%	12.4%	11.0%
Percentage unemployed ages 25 to 54	5.7%	4.7%	3.4%
Percentage unemployed ages 55 to 64	4.0%	3.3%	2.7%
Percentage unemployed ages 65 or more	3.3%	3.0%	2.9%
Total unemployment	4.9%	5.1%	3.9%

In Carteret County, the age group most likely to be uninsured is adults aged 19 to 34. One in five Carteret residents in this age group are uninsured, higher than the U.S and the state of North Carolina. The overall uninsured rate is lower than both the state and the U.S. rates.

[9] Source: North Carolina Office of State Budget and Management
[10] U.S. totals combine GED with High School Diploma
[11] Source: Federal Reserve Economic Data

Table 2.15: Health Insurance Status, 2022[6]			
	Carteret County	North Carolina	United States
Percentage uninsured ages 18 or below	6.0%	5.2%	5.4%
Percentage uninsured ages 19 to 34	20.2%	15.5%	13.6%
Percentage uninsured ages 35 to 64	15.1%	12.5%	9.9%
Total % Uninsured	10.1%	15.0%	12.0%

Social Determinants of Health

In addition to the considerations noted above, there are many other factors that can positively or negatively influence a person's health. The Steering Committee recognizes this and believes that, to portray a complete picture of the county's health status, it first must address the factors that impact community health. The Centers for Disease Control and Prevention (CDC) defines social determinants of health (SDoH) as the conditions in the environments where people are born, live, learn, work, play, worship and age that affect a wide range of health, functioning and quality of life outcomes and risks. According to the CDC's "Social Determinants of Health" from its *Healthy People 2030* public health priorities initiative, factors contributing to an individual's health status can include the following: healthcare access and quality, neighborhood and built environment, social and community context, economic stability, and education access and quality.

Figure 2.3: Social Determinants of Health

As seen in **Figure 2.3**, many of the factors that contribute to health are hard to control or societal in nature. As such, health and healthcare organizations need to consider many underlying factors that may impact an individual's health and not simply their current health conditions.

It is widely acknowledged that people with lower income, social status and levels of education find it harder to access healthcare services compared to people in the community with more resources. This lack of access is a factor that contributes to poor health status. Further, people in communities with fewer resources may also experience high levels of stress, which also contributes to worse health outcomes, particularly related to mental or behavioral health.

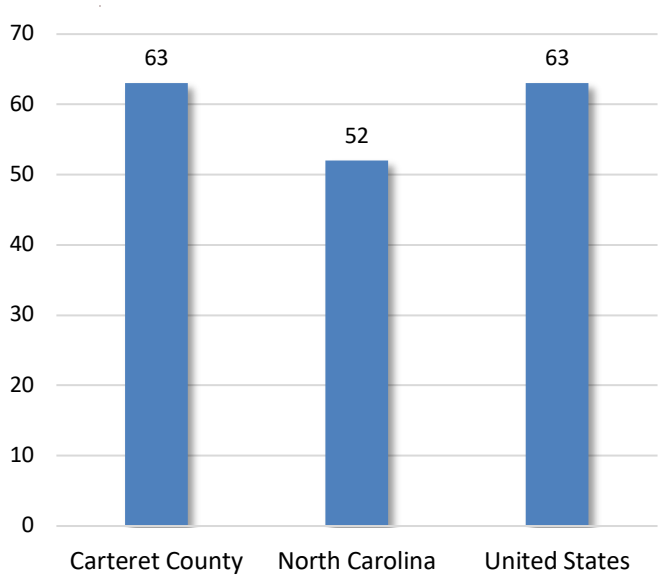
An analysis of the racial and geographic disparities that emerged in the information obtained and analyzed during this process is detailed below. The CHNA Steering Committee also collected new data via focus groups and surveys to ensure that residents and key community health leaders could provide input regarding the needs of their specific communities. This information will be presented in detail later in this report.

Disparities

Recognizing the diversity of Carteret County, as discussed above, the Steering Committee evaluated factors that may contribute to health disparities in its community. These included racial equity; racial segregation; financial barriers; nutrition; social, behavioral, and economic factors that influence health; and English language proficiency.

Residential segregation is measured by the index of dissimilarity, a demographic measure ranging from 0 to 100 that represents how evenly two demographic groups are distributed across a county's census tracts. Lower scores represent a higher level of integration. The rate of residential segregation in Carteret County is on par with that of the U.S and is higher than the state, as seen in **Figure 2.4**.

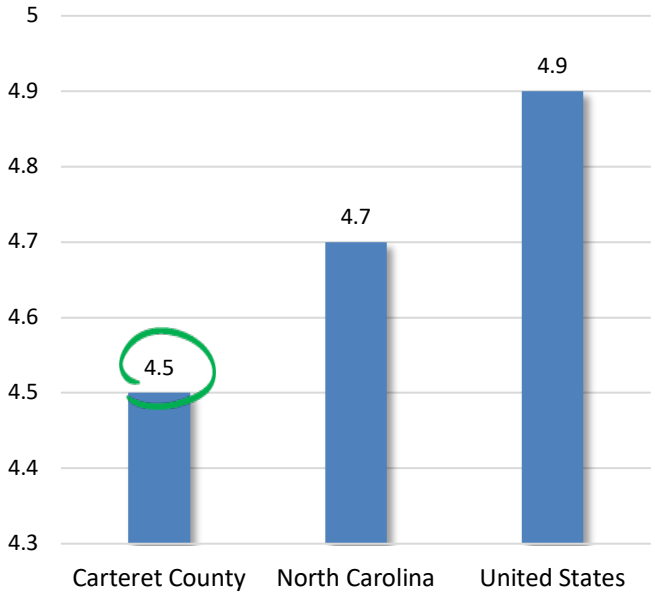
Figure 2.4: Residential Segregation[12]



Income inequality is measured as the ratio of household income at the 80th percentile to household income at the 20th percentile. Communities with greater income inequality may have worse outcomes on a variety of metrics, including mortality, poor health, sense of community, and social support. As seen in **Figure 2.5**, the income inequality ratio in Carteret County is lower than state and national figures.

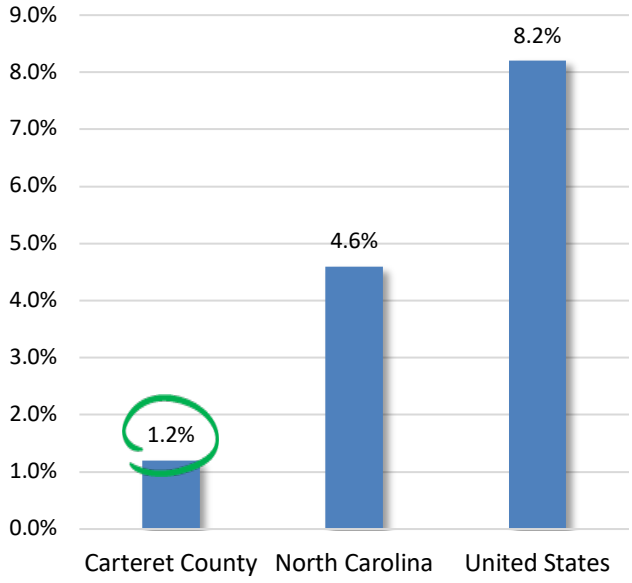
[12] Source: Robert Wood Johnson County Health Rankings 2024

Figure 2.5: Income Inequality Ratio[12]



People with limited English proficiency (LEP) may face challenges accessing care and resources that fluent English speakers do not. Language barriers may make it hard to access transportation, medical, and social services as well as limit opportunities for education and employment. Importantly, LEP community members may not understand critical public health and safety notifications, such as safety-focused communications during the COVID-19 pandemic. Fewer people are not fluent in English in Carteret compared to the state and country, as seen in **Figure 2.6**.

Figure 2.6: Percent of Population with Limited English Proficiency[6]

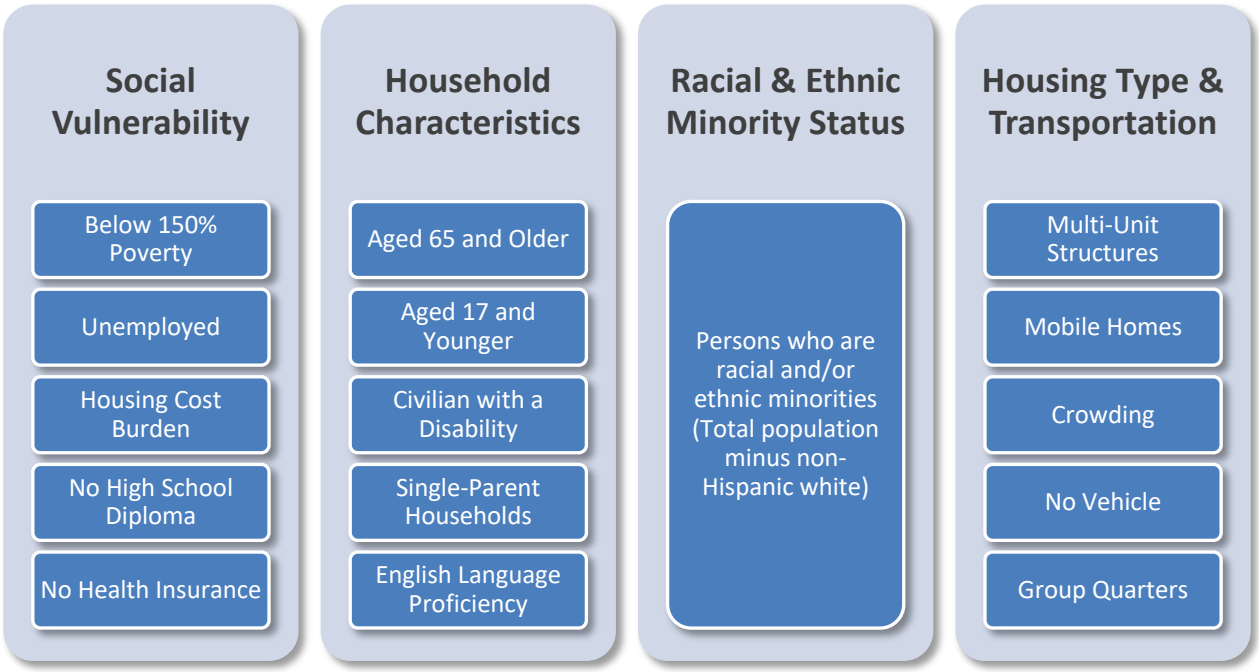


Social Vulnerability Index

One resource that can help show variation and disparities between geographic areas is the Social Vulnerability Index (SVI), which was developed by the CDC and the Agency for Toxic Substances and Disease Registry (ATSDR). Social vulnerability refers to negative effects communities may experience due to external stresses that impact human health, like natural or human-caused disasters, or disease outbreaks. Socially vulnerable populations are at especially high risk during public health emergencies.

The SVI uses 16 U.S. Census variables to help local officials identify communities that may need support before, during, or after a public health emergency.[13] Communities with a higher SVI score are generally at a higher risk for poor health outcomes. Instead of relying on public health data alone, the SVI accounts for underlying economic and structural conditions that affect overall health, including SDoH. SVI scores are calculated at the census tract level and based on U.S. Census variables across four related themes: socioeconomic status, household characteristics, racial and ethnic minority status, and housing type/transportation. **Figure 2.7** outlines the variables used to calculate SVI scores.

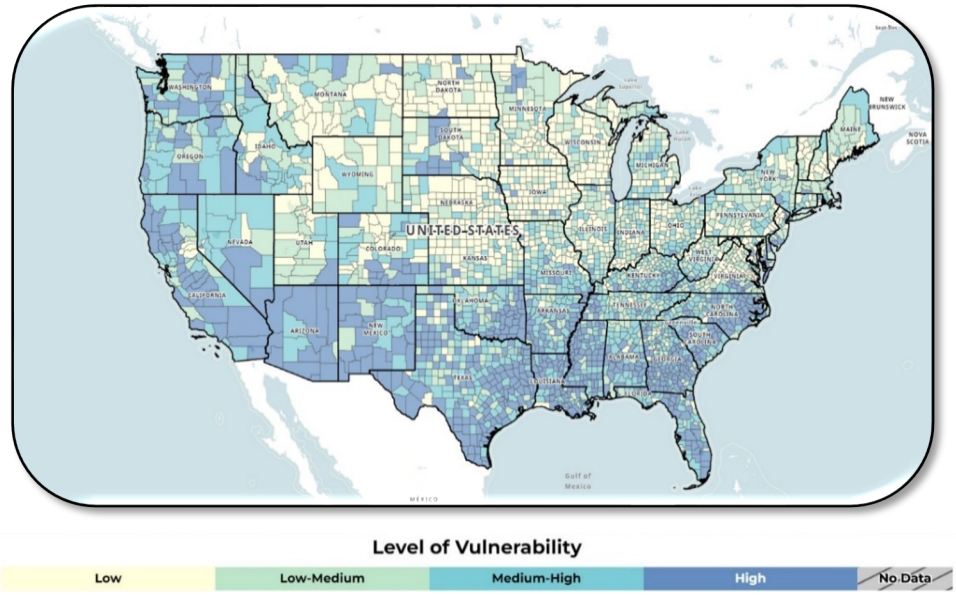
Figure 2.7: SVI Variables



The United States SVI by county is shown in **Figure 2.8** below. As shown, a lot of variation exists across the country, and even within individual states.

[13] CDC/ATSDR Social Vulnerability Index (SVI). Retrieved from https://www.atsdr.cdc.gov/placeandhealth/svi/index.html.

Figure 2.8: United States SVI by County, 2022



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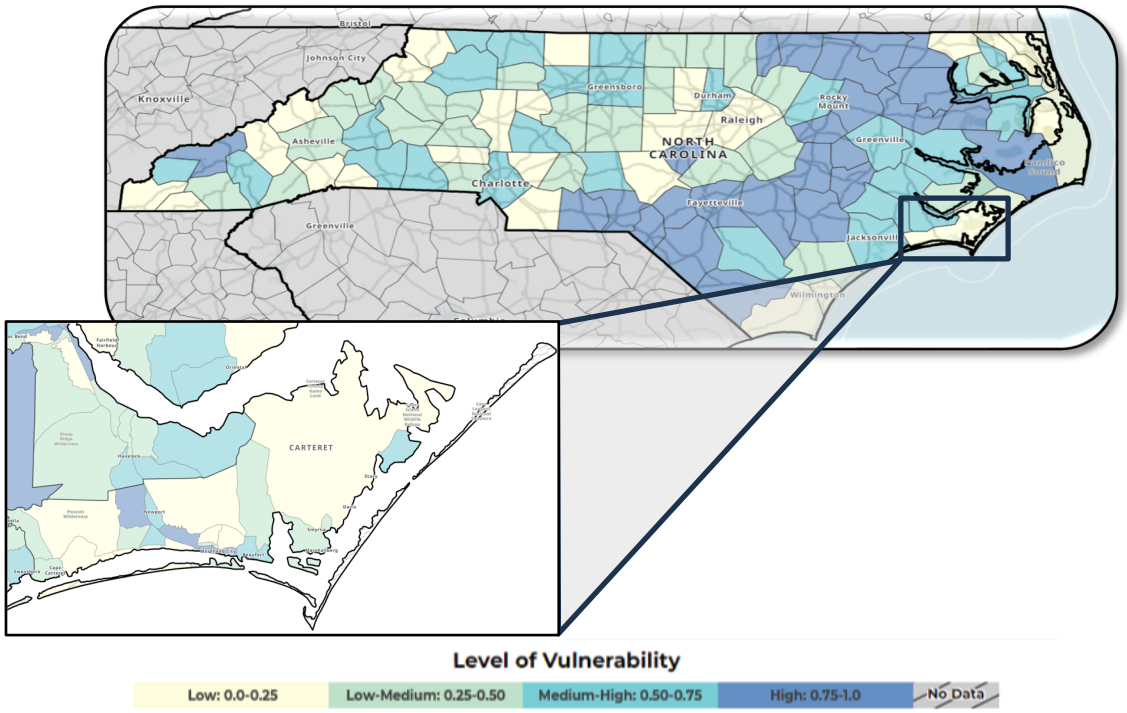
The 2022 SVI scores for Carteret County are shown in **Figure 2.9** below. Possible scores range from 0 (lowest vulnerability) to 1 (highest vulnerability), and these scores show a relative comparison with other counties and census tracts in North Carolina. The overall vulnerability of Carteret County is lower than average compared to the state. At the census tract level, vulnerability is variable across the county with the average being 0.11.

Figure 2.9: Carteret County SVI by Census Tract, 2022



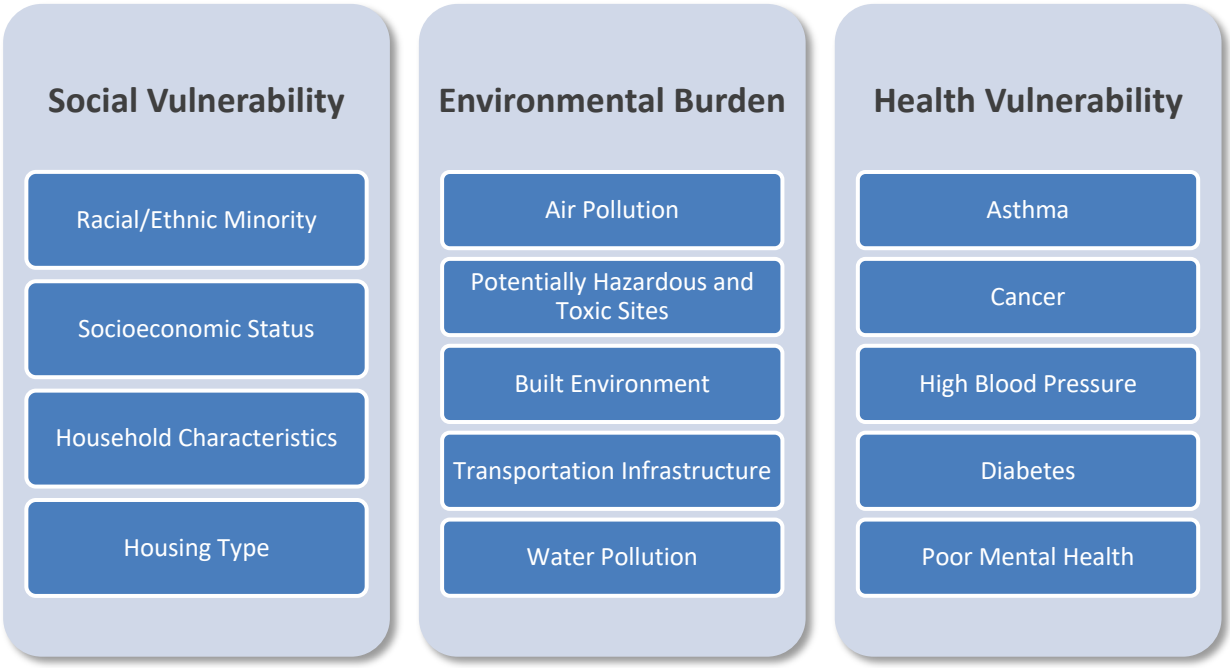
Environmental Justice Index

Environmental justice means the just treatment and meaningful involvement of all people, regardless of income, race, color, national origin, Tribal affiliation, or disability, in agency decision-making and other Federal activities that affect human health and the environment. It aims to protect everyone from disproportionate health and environmental risks, address cumulative impacts and systemic barriers, and provide equitable access to a healthy and sustainable environment for all activities and practices.[14]

The CDC/ATSDR EJI is a database that ranks the impact of environmental injustice on health. It uses data from the U.S. Census Bureau, the U.S. Environmental Protection Agency, the U.S. Mine Safety and Health Administration, and the CDC. The Index scores environmental burden and injustice at the census tract level in the U.S. based on multiple social, environmental, and health factors.

Over time, communities with a higher EJI score are generally shown to experience more severe impacts from environmental burden than communities in other census tracts. **Figure 2.10** outlines the variables used to calculate EJI scores.

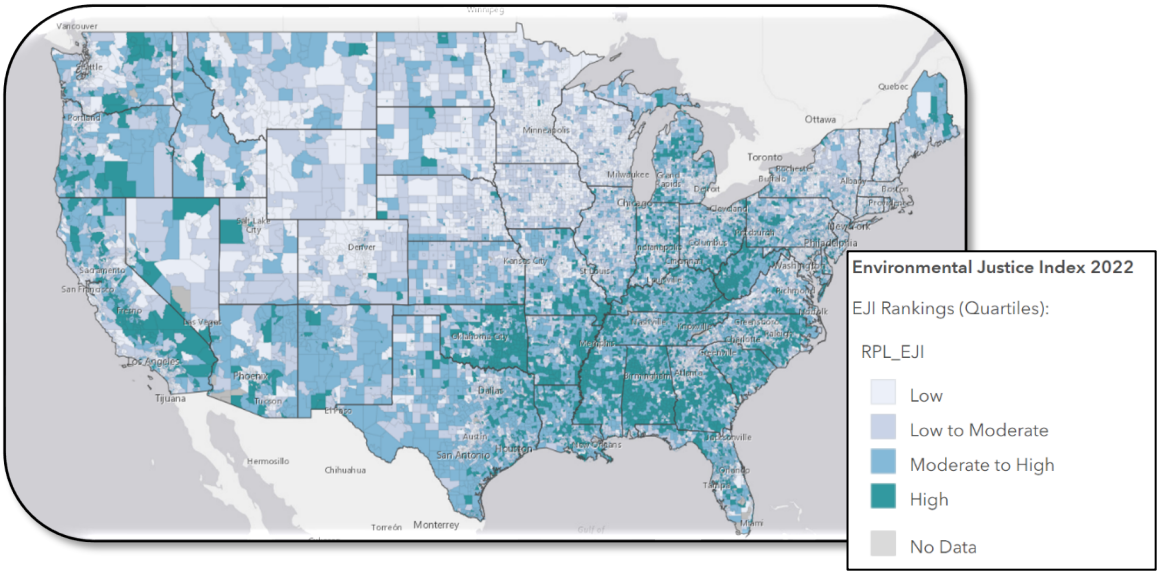
Figure 2.10: EJI Variables



[14] U.S. Environmental Protection Agency (2024). Retrieved from https://www.epa.gov/environmentaljustice

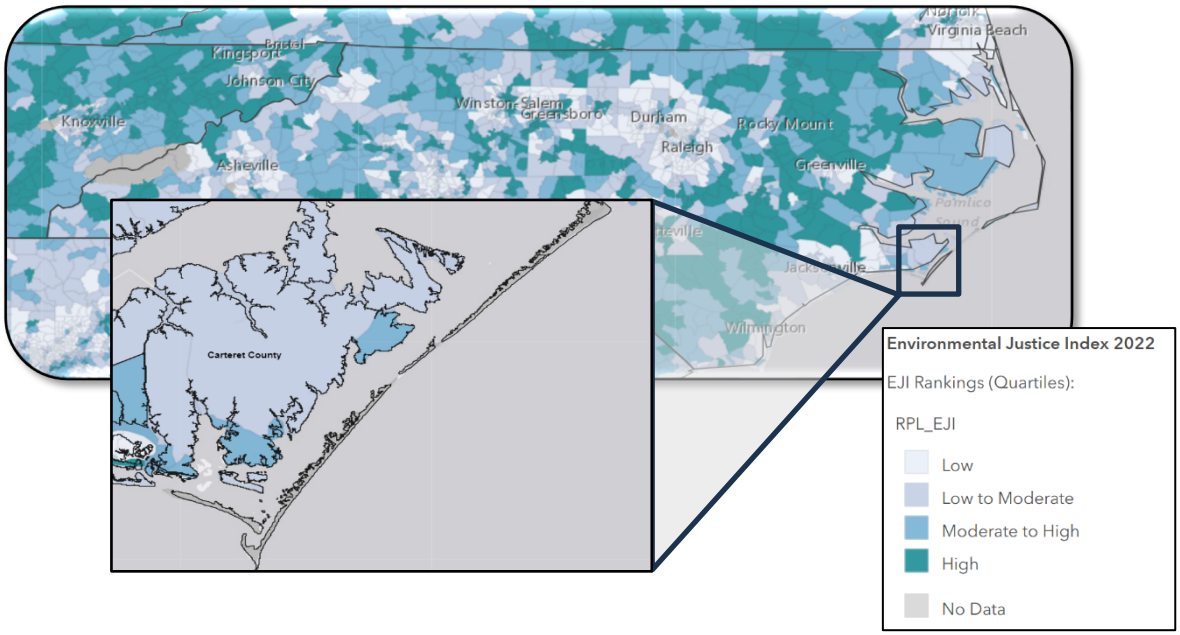
The United States EJI by county is shown in **Figure 2.11** below. As shown, a lot of variation exists across the country, and even within individual states.

Figure 2.11: United States EJI by Census Tract, 2022



The 2022 EJI scores for Carteret County are shown in **Figure 2.12** below. EJI scores use percentile ranking which represents the proportion of census tracts that experience environmental burden relative to other census tracts in North Carolina. The index ranges from 0-1 with higher scores indicating more environmental burden compared to other census tracts. Levels of environmental burden are variable across the county with the average being 0.34.

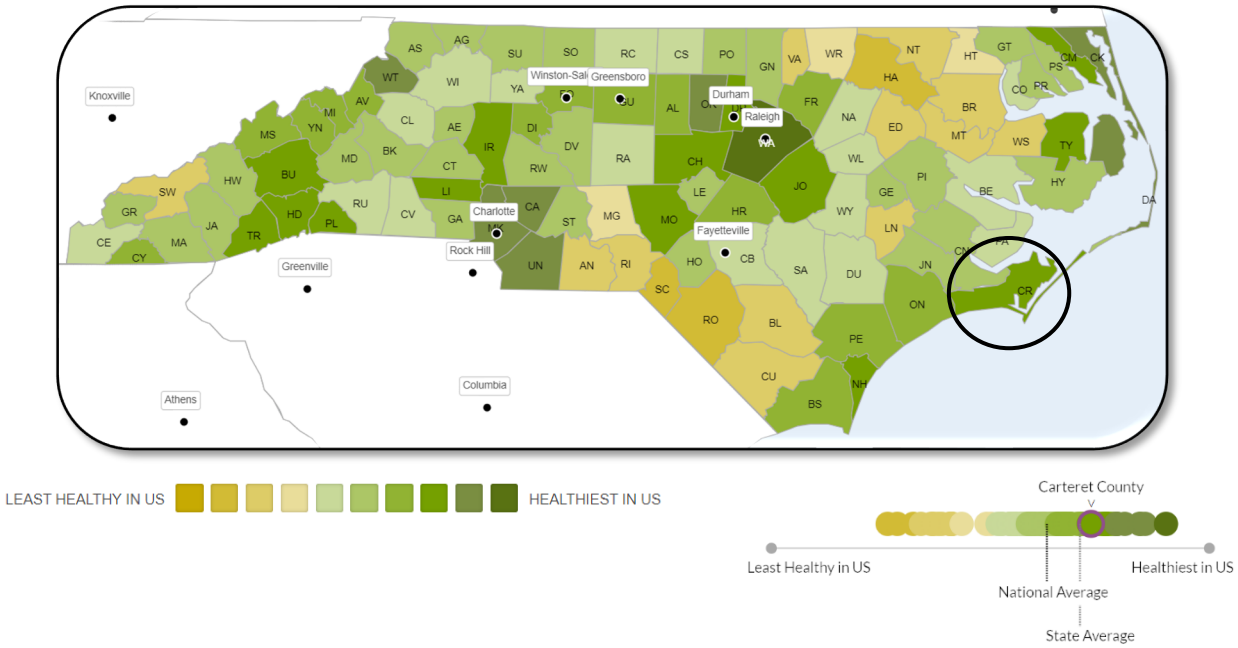
Figure 2.12: Carteret County EJI by Census Tract, 2022



Health Outcome and Health Factor Rankings

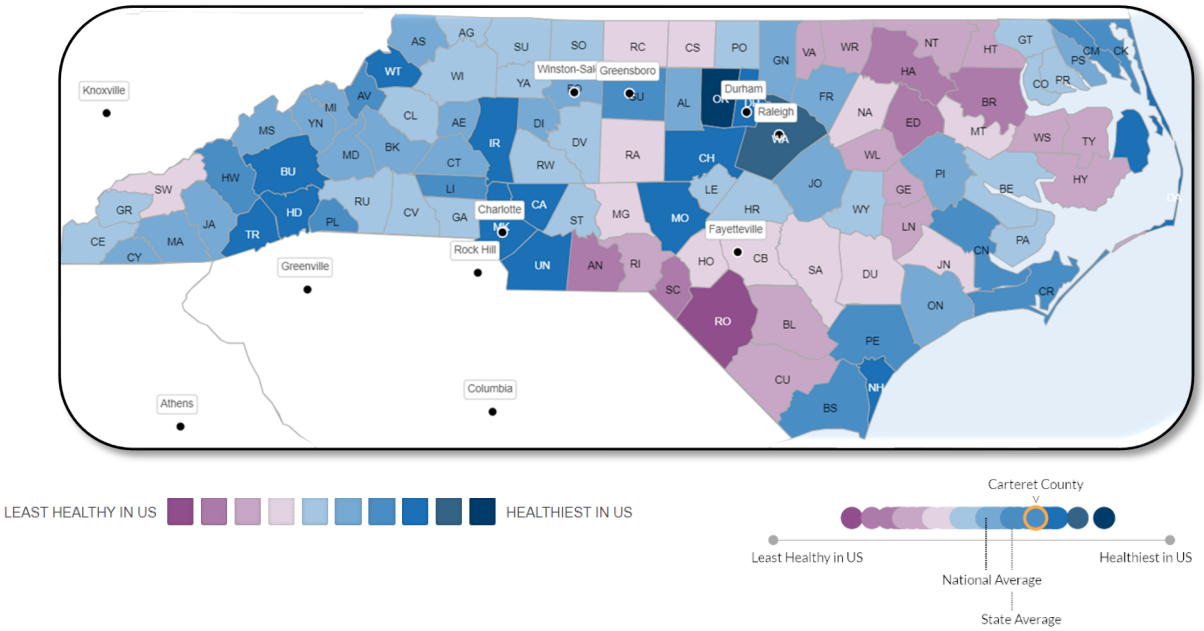
County leaders also reviewed and analyzed data from the Robert Wood Johnson Foundation and the University of Wisconsin County Health Rankings for the year 2024. The Health Outcomes measure looks at how long people in a community live and how physically and mentally healthy they are. These categories are discussed further in **Appendix 2** and **Appendix 3**. Carteret surpasses the average for the country and the state, which means people there may be healthier on average.

Figure 2.13: State Health Outcomes Rating Map[12]



The Health Factors measure looks at variables that affect people's health including health behaviors, clinical care, social & economic factors, and the physical environment they live in. More details about these indicators can be found in **Appendix 2** and **Appendix 3**. Similarly to the Health Outcome measure, Carteret surpasses the average for the country and the state.

Figure 2.14: State Health Factors Rating Map[12]



CHAPTER 3 | PRIORITY NEED AREAS

This chapter describes each of the four priority areas in more detail and discusses the data that supports each priority. The information in this section includes context and national perspective, secondary data findings, and primary data findings (including the community member survey and focus groups).

The prioritization process for Carteret County's 2024 Community Health Needs Assessment began with a virtual meeting between representatives from Carteret County Health Department (CCHD) and Carteret Health to discuss potential priority areas, criteria for consideration, and prioritization methodology.

The prioritization discussion was held on September 23rd, 2024 at CCHD. During this meeting, participants first engaged in a dot sticker exercise to narrow down a list of potential priorities from 20 to 10 areas. The remaining 10 priority areas were then evaluated using a PICK chart to assess each priority's potential payoff (low vs. high) and the difficulty of implementing solutions to address the need (easy vs. difficult). Following the PICK chart exercise, participants held a facilitated discussion to affirm the four priority areas determined to be most critical for Carteret County to focus on over the next three years.

As mentioned previously, these priority needs areas are not listed in any hierarchical order of importance and all will be addressed by the Carteret County leaders in health improvement plans guided by this CHNA. As noted in Chapter 1, county health leadership considered the following factors when determining the priority needs reported in this assessment:

- Size and scope of the health need;
- Severity and intensity of the health need;
- Estimated feasability and effectiveness of possible interventions;
- Health disparities associated with the need; and
- Importance the community places on addressing the need.

PRIORITY NEED: CHRONIC HEALTH CONDITIONS

Context and National Perspective

As society has changed and people live longer, chronic health conditions have become more common than communicable diseases like typhoid and cholera. As defined by the World Health Organization (WHO), chronic diseases are those with a long duration, that are influenced by a combination of genetic, environmental, psychological, or behavioral factors.[15] Chronic health conditions are extremely common

[15] Source: World Health Organization (WHO) (2023). *Noncommunicable diseases*. Retrieved September 10th, 2024, from: https://www.who.int/news-room/fact-sheets/detail/noncommunicable-diseases.

in the United States, with 6 in 10 Americans living with at least one chronic disease, such as diabetes, obesity, cancer, hypertension, or heart disease.[16]

Chronic diseases are the leading cause of death and disability in the United States.[15] According to the WHO, chronic health conditions kill 41 million people globally each year and are responsible for 7 in 10 deaths in the U.S. annually.[15] The number of individuals living with a chronic health condition is expected to increase as the U.S. population continues to age. The population over the age of 50 is expected to increase by 61% to 221.1 million people by 2050.[17] Among those 221 million, nearly two-thirds (142.7 million people) are expected to have at least one chronic health condition, with approximately 15 million people living with multiple chronic health conditions.[17]

Cancer is a group of diseases characterized by the uncontrolled growth and spread of abnormal cells that can result in death if not treated. While the risk of dying from cancer has declined significantly over the past 30 years, it remains the second most common cause of death in the U.S. Incidence of new cancer cases has continued to rise, with 2 million new cases expected to be identified in 2024.[18] This trend is largely affected by the aging and growth of the population and by a rise in diagnoses of 6 of the 10 most common cancers—breast, prostate, endometrial, pancreatic, kidney, and melanoma. Some research has attributed this rise to the impact of the obesity epidemic. [18] Cigarette smoking is another significant risk factor for cancer, and is responsible for about 20% of all cancers and 30% of cancer deaths in the U.S. each year.[19]

The CDC recommends four ways to prevent chronic conditions and maintain good physical health. Recommended healthy behaviors include stopping or refraining from smoking, eating low-fat whole food diets, exercising moderately for at least 150 minutes a week, and limiting or refraining from consuming alcohol.[20] Annual physicals with a primary care provider are also necessary to help prevent or treat chronic health conditions. Yearly screenings can allow providers to identify any warning signs for developing conditions and enable patients to correct or develop healthy behaviors to avoid developing a physical health condition. A CDC study noted that one-third of visits to health centers in 2020 were for preventive care.[21] For those living with chronic conditions, the CDC recommends some general steps people can take to manage their diseases. These include taking medications as prescribed by a provider, self-monitoring symptoms as needed (such as conducting home blood sugar checks), and regularly seeing a provider for check-ups.

As the population in North Carolina and the individual counties continues to collectively age, the prevalence of chronic disease grows. In fact, eight out of the top 10 deaths in North Carolina are related

[16] Source: CDC (2024). *National Center for Chronic Disease Prevention and Health Promotion*. Retrieved September 10th, 2024, from: https://www.cdc.gov/chronic-disease/about/index.html .

[17] Source: Ansah, J.P. & Chiu, T.C., (2022). Projecting the chronic disease burden among the adult population in the United States using a multi-state population model. *Frontiers in Public Health*. Retrieved September 10th, 2024, from: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC9881650/.

[18] Source: American Cancer Society (ACS) (2024). *ACS Fast & Figures 2024*. Retrieved September 10th, 2024, from https://www.cancer.org/research/acs-research-news/facts-and-figures-2024.html.

[19] ACS (2020). *Health Risks of Smoking Tobacco.* Retrieved September 10th , 2024 from https://www.cancer.org/cancer/risk-prevention/tobacco/health-risks-of-tobacco/health-risks-of-smoking-tobacco.html

[20] Source: CDC (2024). *Preventing chronic diseases: What you can do now.* Retrieved September 10th, 2024 from https://www.cdc.gov/chronic-disease/prevention/index.html

[21] Source: CDC (2022). *Characteristics of visits to health centers: United States, 2020*. Retrieved September 10th, 2024, from https://www.cdc.gov/nchs/products/databriefs/db438.htm.

to a chronic health condition[22], accounting for at least two-thirds (50,000) of all annual deaths.[23] Additionally, the population of North Carolina is largely rural, which hinders access to clinical care for these conditions. Finding ways to utilize existing resources for helping community members learn about and manage their chronic health conditions is key for improving health outcomes in these areas.

Secondary Data Findings

Secondary data identified various chronic health conditions as areas of concern for residents of Carteret County. The county has a higher rate of cardiovascular disease hospitalizations (14.2 per 1,000 population) compared to both the state (11.7) and national (10.4) averages. Similarly, the rate of ischemic stroke hospitalizations (9.9 per 1,000 population) exceeds both state (9.5) and national (8.0) figures. Cancer incidence rates in Carteret County (463.6 per 100,000 population) are comparable to the state average (464.4) but higher than the national rate (442.3). Emergency department utilization rates in the county (490 per 1,000 population) are lower than both state (563) and national (535) averages, suggesting potentially better management of chronic conditions in outpatient settings.

Table 3.1: Cardiovascular Disease and Ischemic Stroke Hospitalizations

Indicator	Carteret County	North Carolina	United States
Cancer Incidence (Rate per 100,000 Population)	463.6	464.4	442.3
Emergency Room Visits (Rate per 1,000 Population)	490	563	535
Cardiovascular Disease Hospitalizations (Rate per 1,000 Medicare Beneficiaries)	14.2	11.7	10.4
Ischemic Stroke Hospitalizations (Rate per 1,000 Medicare Beneficiaries)	9.9	9.5	8.0

However, Carteret County performs better than state and national averages on several chronic condition indicators. The percentage of adults with diagnosed diabetes in Carteret County (7.5%) is lower than both North Carolina (9.0%) and national (8.9%) rates. The county also has lower rates of adults with hypertension (28.5%) compared to the state (32.1%) and national (29.6%) averages. Adult obesity rates in the county (25.8%) are notably lower than both state (29.7%) and national (30.1%) figures.

[22] Source: CDC (2022). *North Carolina.* Retrieved October 3, 2024, from https://www.cdc.gov/nchs/pressroom/states/northcarolina/nc.htm

[23] Source: NCDHHS. (2023). *Chronic disease and injury.* Retrieved October 3, 2024, from https://www.dph.ncdhhs.gov/programs/chronic-disease-and-injury#:~:text=Chronic%20diseases%20and%20injuries%20are,of%20death%20in%20North%20Carolina.

Table 3.2: Chronic Disease Related Indicators			
Indicator	**Carteret County**	**North Carolina**	**United States**
Adults (Age 18+) with Asthma	9.4%	9.8%	9.7%
Adults (Age 20+) with Diagnosed Diabetes	7.5%	9.0%	8.9%
Adults (Age 18+) Ever Diagnosed with Coronary Heart Disease	5.3%	5.5%	5.2%
Adults (Age 18+) with Hypertension	28.5%	32.1%	29.6%
Adults (Age 18+) with High Cholesterol	31.0%	31.4%	31.0%
Adults (Age 18+) with Kidney Disease	2.7%	2.9%	2.7%
Adults (Age 18+) Ever Having a Stroke	2.7%	3.1%	2.8%
Adults with BMI > 30.0 (Obese)	25.8%	29.7%	30.1%
Adults (Age 18+) with Poor Dental Health	10.6%	12.0%	13.9%
Percent Reporting Poor or Fair Health	12.8%	14.4%	-

The county demonstrates mixed performance on factors that can impact chronic disease development and management. While Carteret County has a lower percentage of physically inactive adults (19.4%) compared to the state average (21.6%), it has fewer recreation and fitness facilities per 100,000 population (10.3) than both state (13.1) and national (14.7) averages. The county also has a lower walkability index score (6) compared to state (7) and national (10) figures, though a higher percentage of the population has access to exercise opportunities (83%) compared to the state average (73%).

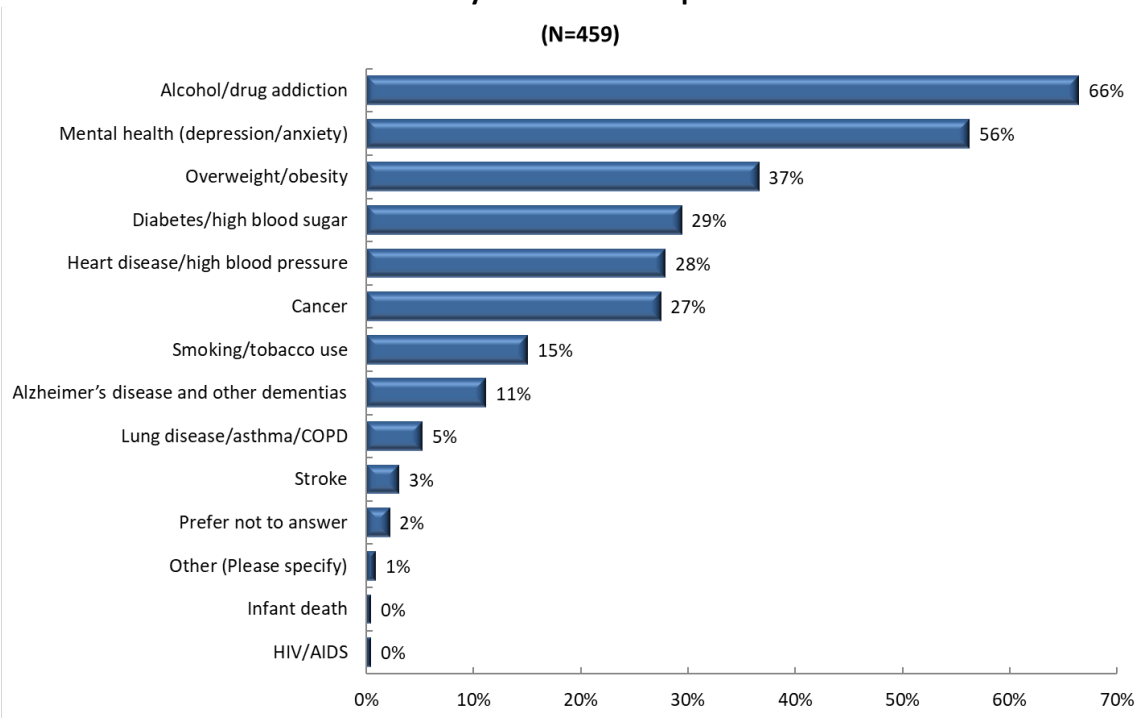
Table 3.3: Recreation and Fitness Facility Access			
Indicator	**Carteret County**	**North Carolina**	**United States**
Recreation and Fitness Facility Establishments, (Rate per 100,000 Population)	10.3	13.1	14.7
Walkability Index Score	6	7	10
% Physically Inactive	19.4	21.6	-
Percentage of Population with Access to Exercise Opportunities	83%	73%	84%

For additional detail on secondary data findings, see **Appendix 3**.

Primary Data Findings – Community Member Web Survey

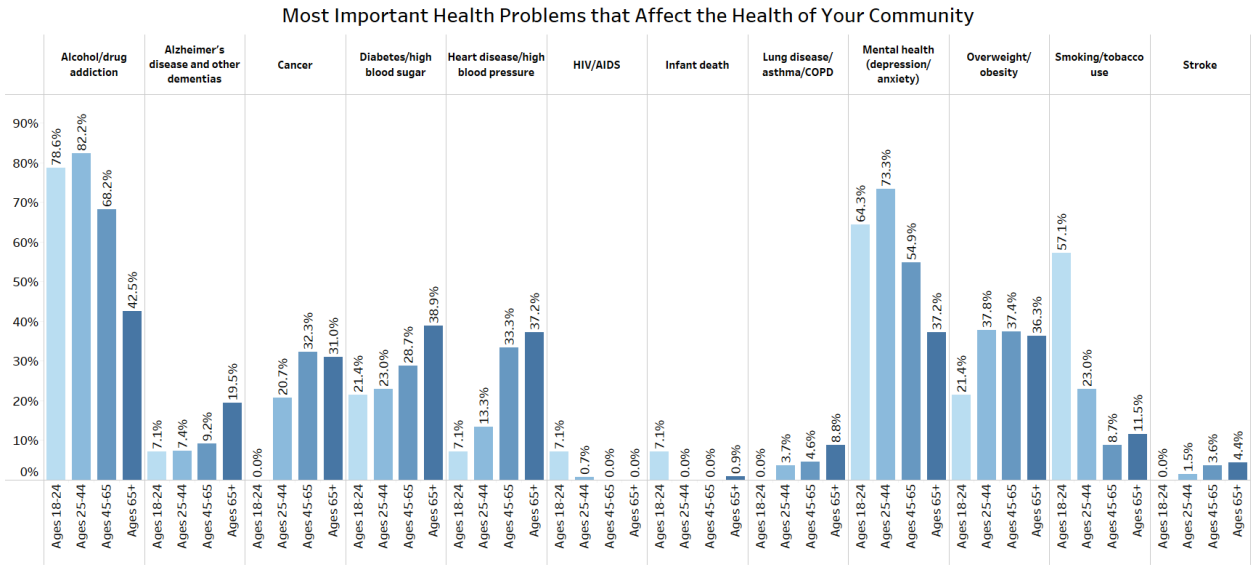
Nearly 460 Carteret residents responded to the web-based survey. Respondents identified several chronic health conditions of concern in the community. In fact, seven out of the top 10 most frequently identified community health needs were chronic health conditions with the top being overweight/obesity (37% of respondents), followed by diabetes/high blood sugar (29%) and heart disease/high blood pressure (28%).

Figure 3.1: What are the three most important health problems that affect the health of your community? Please select up to three.



When these results were examined by respondent demographics, responses varied. Older adults viewed diabetes and heart disease as more significant problems than younger respondents, as displayed in **Figure 3.2** below. Respondents identifying as Black or African American identified diabetes/high blood sugar more frequently than respondents identifying as White, while respondents identifying as White or all other races were more likely to identify heart disease/high blood pressure and obesity. Men were slightly more likely than women to identify diabetes and high blood sugar as an important community health problem, and women were slightly more likely to view heart disease and obesity as major concerns. Considering these differences in targeted efforts to address specific community health needs may be important.

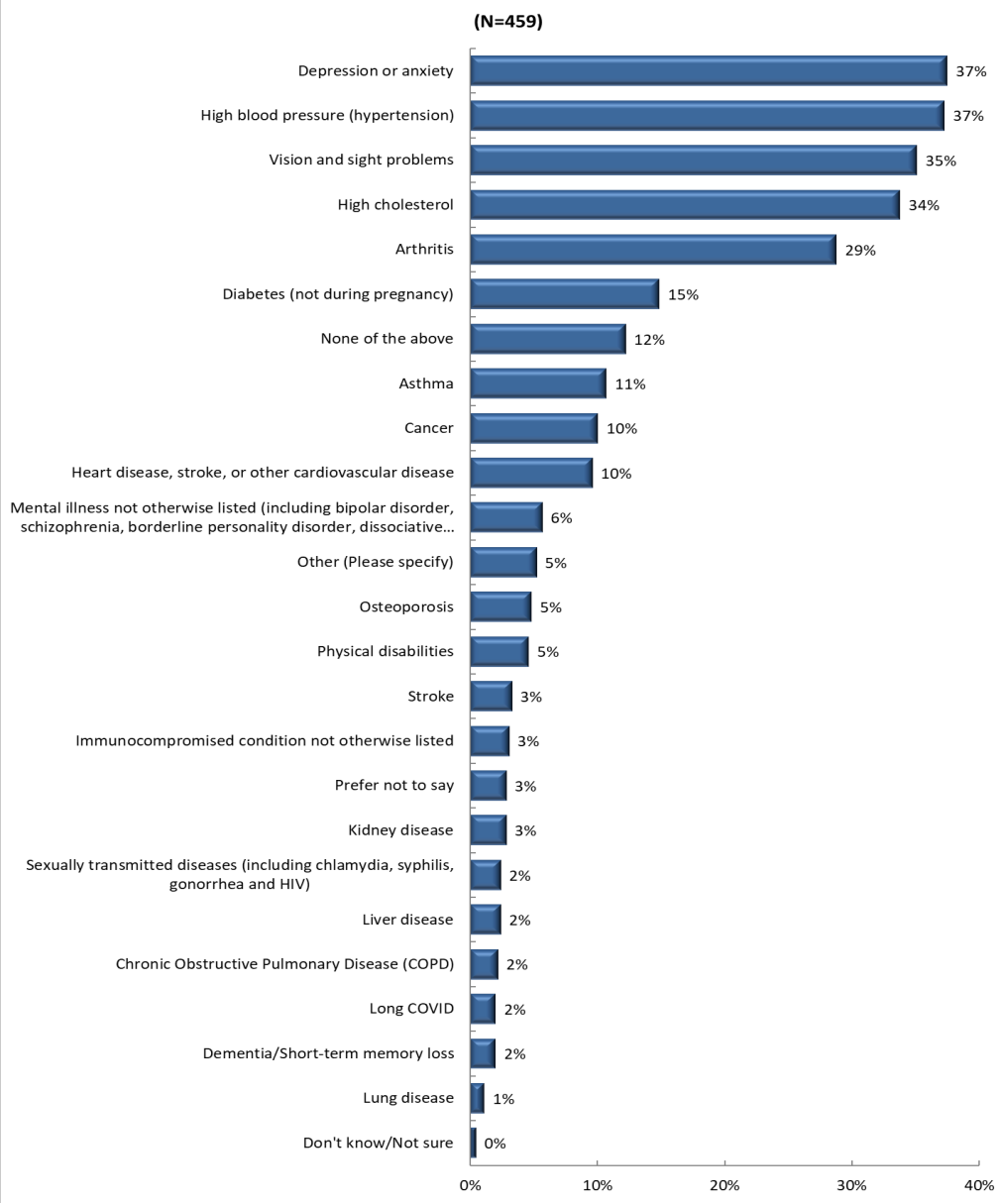
Figure 3.2: What are the three most important health problems that affect the health of your community? Please select up to three. (by age)



In terms of community perspectives on access to healthcare resources, one third of Carteret County respondents viewed availability/access to doctor's offices as an important social or environmental problem in the community. Regarding health behaviors and food security, an additional 14% cited limited access to healthy foods, and just 7% named limited places to exercise. Women were slightly more likely to view limited access to healthy foods (14% compared to 13% for men) and limited places to exercise (8% compared to 6% for men) as major concerns.

Carteret County respondents were also asked questions regarding their physical health. Nearly 40% of respondents reported having been informed by health professional that they have high blood pressure, with 34% reporting having been informed of high cholesterol, highlighting underlying factors for chronic disease in some residents in Carteret County.

Figure 3.3: Have you ever been told by a doctor, nurse, or other health professional that you have any of the following health conditions? Select all that apply.



For additional detail on survey findings, see **Appendix 5**.

Primary Data Findings – Focus Groups

In focus groups conducted in Carteret County, participants consistently identified chronic health conditions as a serious concern for the community. Focus group participants at Leon Mann Jr. Enrichment Center specifically highlighted obesity, heart disease, and diabetes as pressing health problems in their community. Healthcare workers at Carteret Health noted that chronic conditions like diabetes and

hypertension disproportionately impact unhoused and Hispanic/Latino populations in the county. The student focus group at Carteret Community College also raised concerns about diabetes, congestive heart failure, high blood pressure, and cancer. When asked what could help address these health issues, participants suggested expanding health education programs and increasing access to affordable healthy foods.

For a more detailed description of focus group findings, see **Appendix 5**.

PRIORITY NEED: FAMILY, COMMUNITY, AND SOCIAL SUPPORT

Context and National Perspective

Healthy People 2030 defines family, community, and social support as "people's relationships and interactions with family, friends, co-workers, and community members" and their subsequent health impact.[24] Addressing this need involves ensuring that neighborhoods are able to connect with each other socially and develop relationships with each other, families receive the economic and social resources they need to thrive, and the community has the overall resources it may need in order to ensure that each community member is able to live a healthy, safe life that aligns with positive health outcomes.

Lack of social support can have a negative health impact on individuals and can promote stress-inducing behaviors, which in turn can raise the risk for chronic and acute health conditions. Additionally, communities with low support levels are typically less healthy, and have higher rates of crime, further reducing positive health outcomes.[25]

There are many barriers to achieving healthy support in families and communities. Barriers to social support for families may include a lack of safety-net resources to help support them through a hard time, or they may live in an area where public and neighborhood events don't typically occur, and therefore have fewer opportunities to engage with their neighbors, especially if they are new to the area. For broader communities, barriers to support may include high crime rates, or a lack of public spaces where community members can meet for events such as parks, community centers, or local coffee shops.

In rural areas, community members and families may be closer knit as they are more reliant on each other for resources and activities. However, rural living can also have negative health impacts if the community does not have a strong sense of togetherness, or if an individual lives alone and is unable to engage with neighbors or other community members. NCDHHS community-based programs and social services in North Carolina are geared towards ensuring that families have the resources to be safe, happy, and healthy, with a particular focus on child neglect and abuse. Many community and social support programs are conducted either in the form of city and county festivals, fairs, social groups, and other events.

[24] Source: Office of Disease Prevention and Health Promotion. *Social and Community Context: Healthy People 2030.* Retrieved October 3, 2024 from https://health.gov/healthypeople/objectives-and-data/browse-objectives/social-and-community-context
[25] Source: County health Rankings. *Family and social support*. Retrieved October 3, 2024, from https://www.countyhealthrankings.org/health-data/health-factors/social-economic-factors/family-and-social-support

Secondary Data Findings

Secondary data analysis revealed several family, community and social support challenges in Carteret County. While childcare costs as a percentage of household income in Carteret County (24%) are lower than state (27%) and national (29%) averages, other social support indicators suggest areas of concern. The unemployment rate in Carteret County (3.1%) is currently lower than both state (3.7%) and national (3.9%) averages, with the average annual unemployment rate over the past decade (3.2%) also comparing favorably to state (3.5%) and national (3.6%) figures. However, median family income in the county ($86,312) shows a mixed picture, being higher than the state average ($82,890) but lower than the national figure ($92,646).

Table 3.4: Employment and Income Indicators

Indicator	Carteret County	North Carolina	United States
Employment - Unemployment Rate	3.1%	3.7%	3.9%
Average Annual Unemployment Rate, 2013-2023	3.2%	3.5%	3.6%
Median Family Income	$86,312	$82,890	$92,646
Childcare Costs, Percentage of Household Income (Median-Income Family)	24%	27%	29%

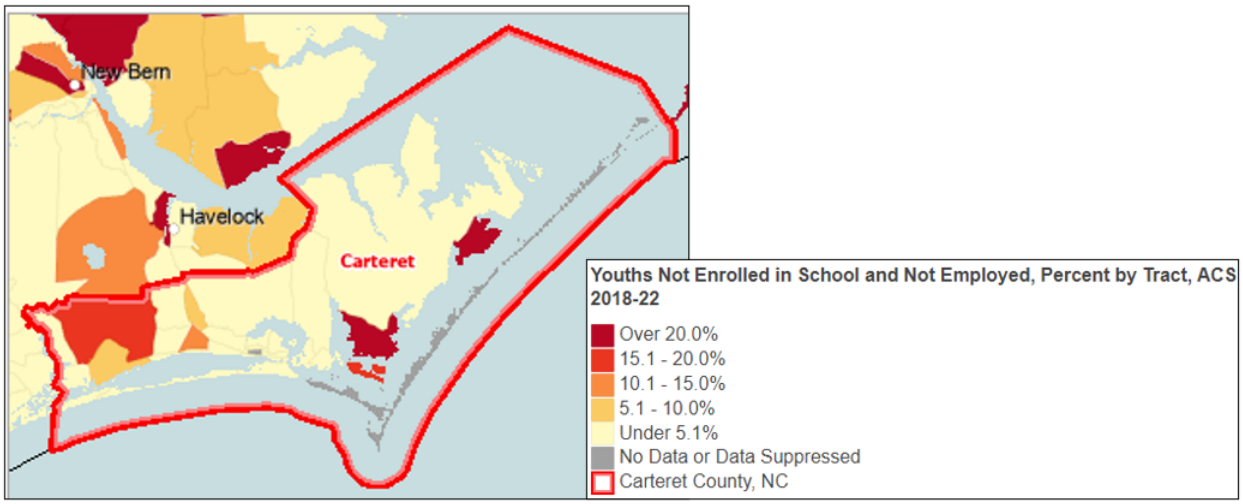
Housing indicators suggest some stability, with a lower percentage of households experiencing severe housing cost burden (11%) compared to state (12%) and national (14%) averages. The county also has a lower rate of homelessness among students (1%) compared to state (2%) and national (3%) figures.

Table 3.5: Housing and Homelessness

Indicator	Carteret County	North Carolina	United States
HUD-Assisted Units, Rate per 10,000 Housing Units	310.4	319.2	413.9
*Severely Burdened Households, Percent	11%	12%	14%
Homeless Students, Percent	1%	2%	3%
Percentage of Households with One or More Severe Problems	16%	16%	18%
Average Gross Rent	$970	$1,090	$1,366

The county's youth engagement metrics reveal areas of concern, with 6% of the population ages 16-19 neither in school nor employed, which is slightly better than state and national averages (both 7%). However, this figure varies significantly by census tract within the county, with some areas showing much higher concentrations of disconnected youth.

Figure 3.4: Youths Not Enrolled in School and Not Employed by Census Tract



Community safety indicators present a mixed picture. The county has a lower violent crime rate (176.8 per 100,000 population) compared to state (365.7) and national (416.0) averages. However, the rate of juvenile delinquency cases (18.0 per 1,000 juveniles) is higher than both state (16.0) and national (13.8) averages. Combined with data on disconnected youth presented above, this suggests a need for more programs and services targeted at young people in the community.

Table 3.6: Safety Indicators

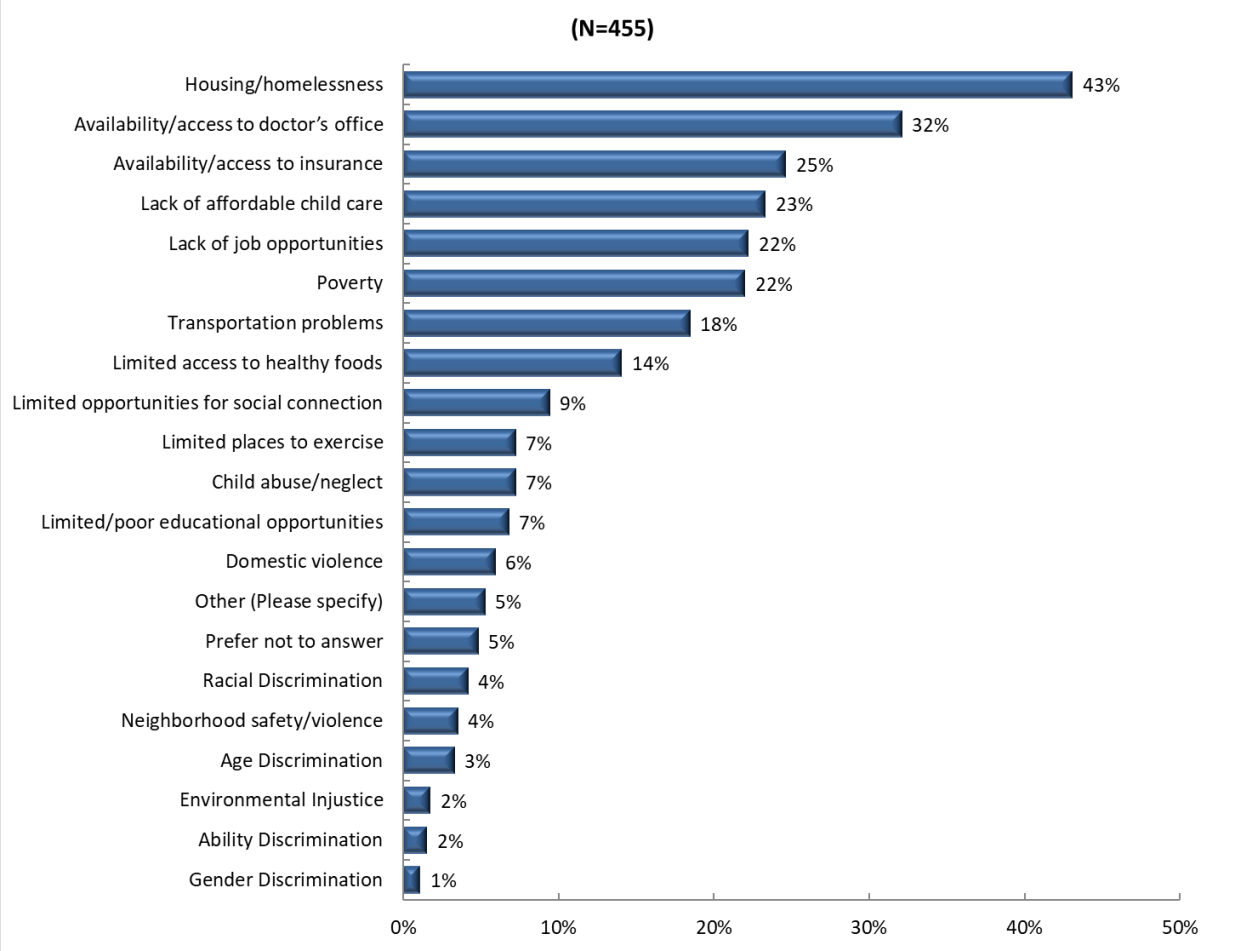
Indicator	Carteret County	North Carolina	United States
Incarceration Rate	1.1%	1.5%	1.3%
Rate of Delinquency Cases (Rate per 1,000 Juveniles)	18.0	16.0	13.8
Violent Crimes, Annual Rate (Rate per 100,000 Population)	176.8	365.7	416
Firearm Death Rate (Crude Rate per 100,000 Population)	16.4	15.5	13.4
Poisoning Death Rate (Crude Rate per 100,000 Population)	43.0	31.5	28.5

For additional detail on secondary data findings, see **Appendix 3.**

Primary Data Findings – Community Member Web Survey

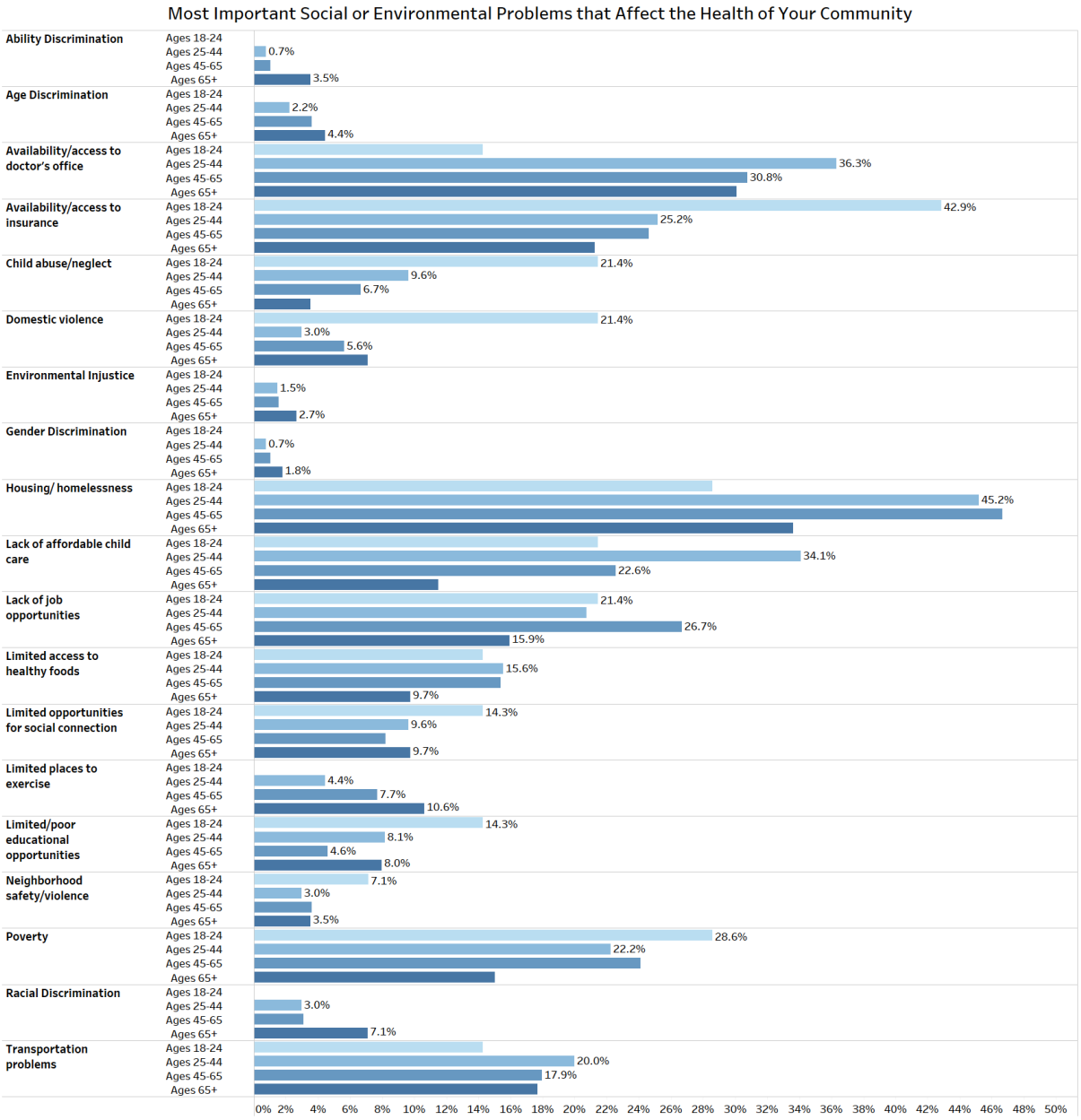
Carteret County respondents also highlighted family, community and social support community challenges in the web survey. Nearly 40% of respondents viewed housing/homelessness as an important social and environmental community problem, the most frequent response for this question, as displayed in **Figure 3.5** below. A quarter of respondents also identified lack of affordable childcare and lack of job opportunities. Other important social and environmental concerns included poverty (22%) and limited opportunities for social connection (9%).

Figure 3.5: What are the three most important social or environmental problems that affect the health of your community? Please select up to three.



There were differing responses based on the demographic characteristics of the respondents. Women (46%) were more likely to view housing and homelessness as a concern compared to men (34%), and more frequently identified poverty as an important social/environmental problem (23% vs. 17%). Older adults were also more likely to identify housing and homelessness as a top concern than younger respondents, as displayed in the figure below. Individuals in the 18 to 24 age group were more likely to identify poverty, child abuse/neglect, and domestic violence compared to the other age groups, as displayed in **Figure 3.6** below. Additionally, the youngest respondents more frequently cited limited opportunities for social connection as an important problem affecting the community.

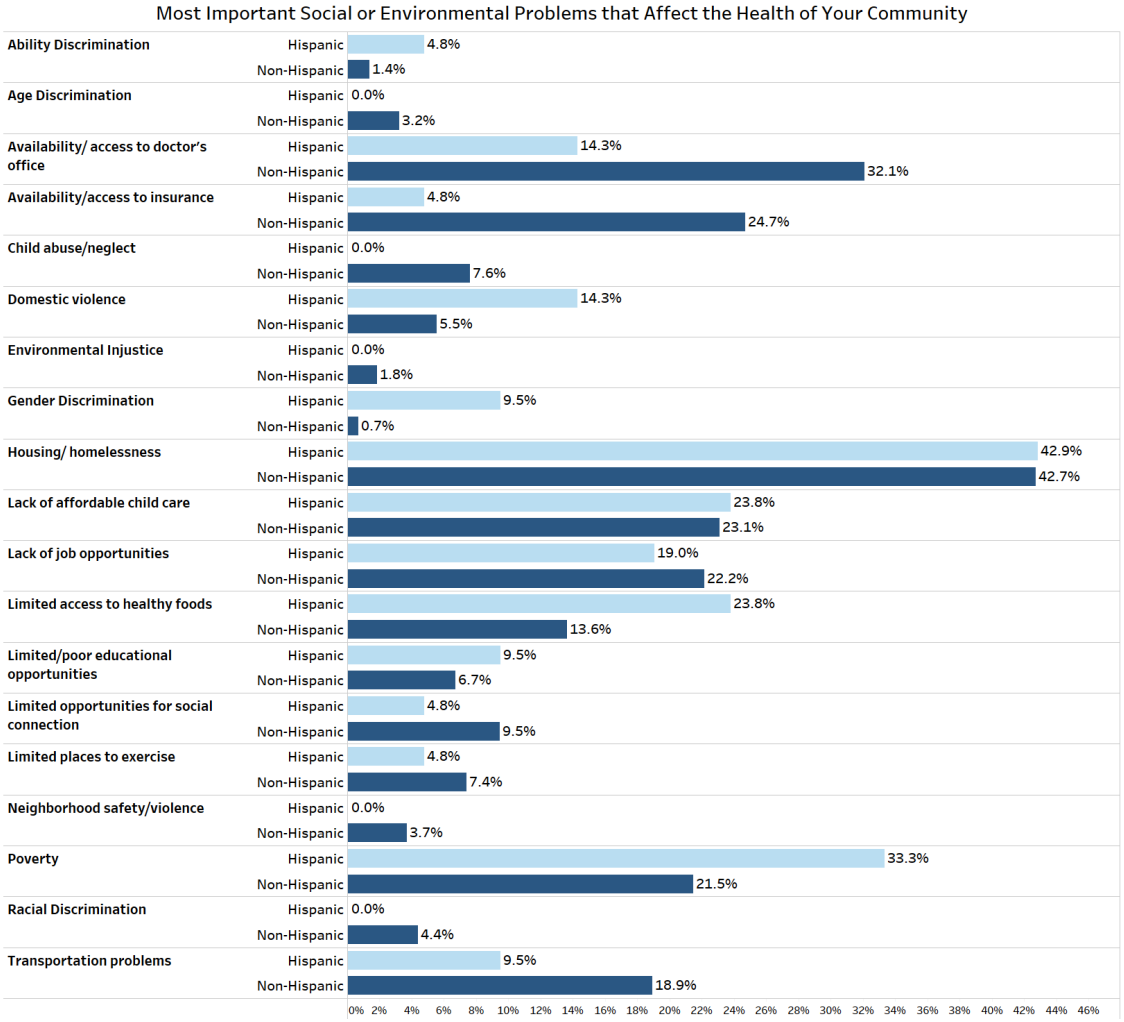
Figure 3.6: What are the three most important social or environmental problems that affect the health of your community? Please select up to three. (by age)



Respondents identifying as Hispanic were more likely to indicate poverty (33%) and domestic violence (14%) were top social and environmental concerns than those identifying as non-Hispanic (22%, 6%). Hispanic respondents also more frequently selected gender discrimination (10%) than non-Hispanics (1%), while non-Hispanics more frequently selected lack of job opportunities and limited opportunities for social

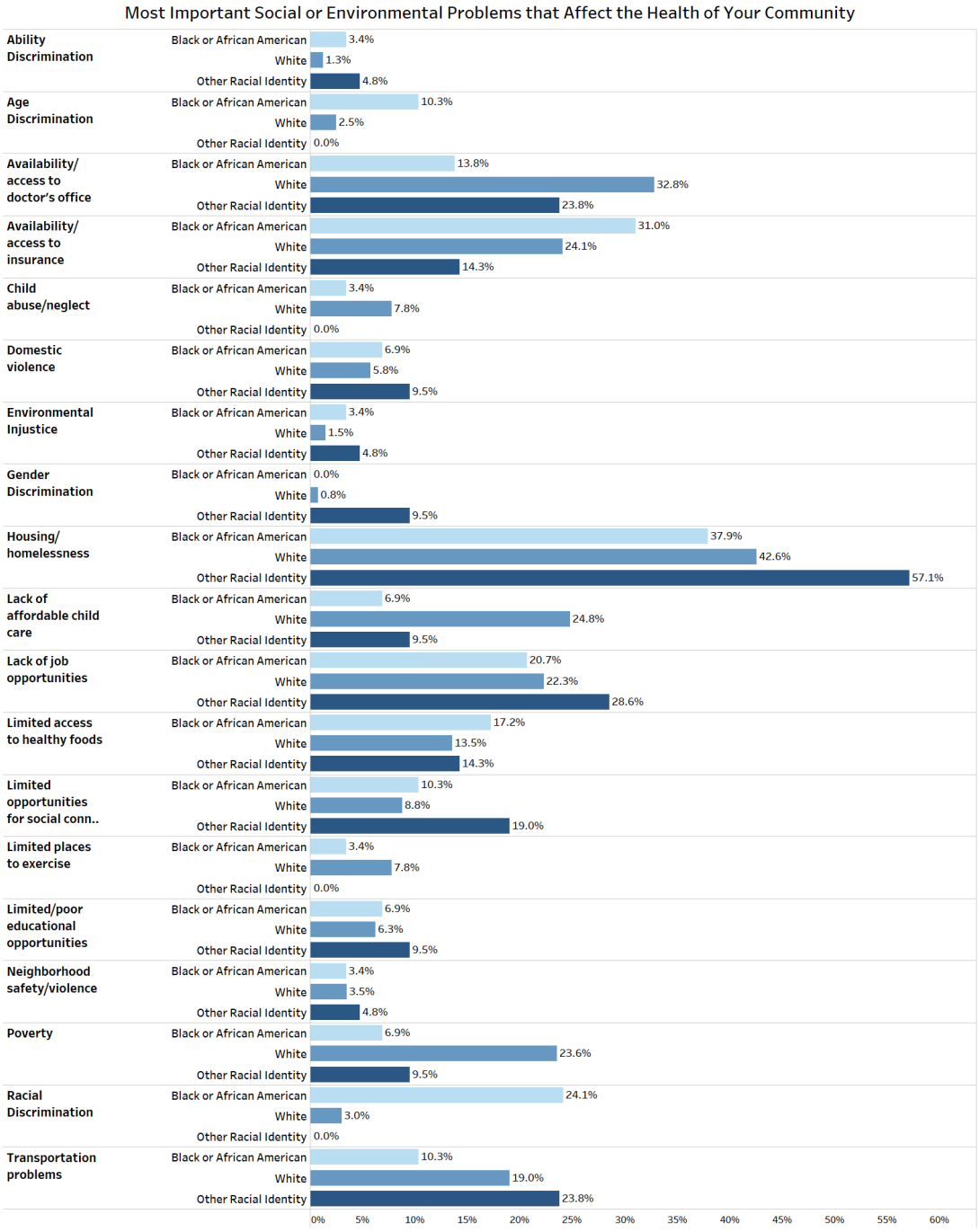
connection (22% and 10%) as social and environmental concerns more often than Hispanic community members who took the survey (19%, 5%).

Figure 3.7: What are the three most important social or environmental problems that affect the health of your community? Please select up to three. (by ethnicity)



Variations also occurred by race. Respondents identifying as Black or African American (24%) were more likely than those identifying as White (3%) or as another racial identify (0%) to indicate racial discrimination was a top social and environmental concern, as demonstrated in the figure below. Those identifying as another racial identify much more frequently cited housing and homelessness (57%), lack of job opportunities (29%), and limited opportunities for social connection (19%) compared to respondents identifying as White or Black. By contrast, respondents identifying as White were more likely to view poverty as a concern than the other racial groups (24% for White; 7% for Black or African American; 10% for Other).

Figure 3.8: What are the three most important social or environmental problems that affect the health of your community? Please select up to three. (by race)



For additional detail on survey findings, see **Appendix 5.**

Primary Data Findings – Focus Groups

Family, community and social support emerged as a significant theme across focus groups, though it should be noted that participants living in the "Down East" area may have been underrepresented in these discussions. Healthcare workers at Carteret Health emphasized the critical need for free or low-cost places where young people can gather outside of school hours and learn life skills. Focus group participants also noted that the lack of such spaces contributes to youth isolation and risk behaviors, further affirming the secondary data findings related to juvenile delinquency and disconnected youth. The student group at Carteret Community College highlighted how rising living costs are outpacing income and benefits, making it difficult for families to thrive. Participants praised existing community partnerships as a strength but indicated that there is a need for better communication about available resources and how to access them.

For a more detailed description of focus group findings, see **Appendix 5.**

PRIORITY NEED: MENTAL HEALTH

Context and National Perspective

The definition of behavioral health often describes conditions related to both mental health and substance use.[26] Mental health is defined as an emotional, psychological, and social state of well-being. Mental health impacts every stage of life and affects how one is able to handle their relationships, daily stressors, and health behaviors.[27] After evaluating data from a variety of sources including surveys and focus groups conducted throughout the assessment process, the Steering Committee identified mental health to be an area of urgent need within Carteret County.

Mental illnesses are common in the United States: in 2021, an estimated 57.8 million U.S. adults – nearly one in five – were living with a mental illness.[28] There is risk for developing a mental illness across the lifespan, with over one in five children and adults in the U.S. reported to have a mental illness, and nearly one in twenty-five adults currently coping with a serious mental illness (SMI) such as major depression, schizophrenia or bipolar disorder. [29]

Mental illness can occur due to multiple different factors, such as genetics, drug and/or alcohol usage, isolation, adverse childhood experiences, and chronic health conditions. Additionally, mental illness can act like other chronic health conditions, in that it can worsen or improve depending on the environment. Mental health services have evolved in the past five years, especially during the COVID-19 pandemic. However, accessing mental health care services can be challenging. According to the National Institute of Mental Health, less than half (47.2%) of adults with a common mental illness received any mental health

[26] Source: American Medical Association (2022). *What is behavioral health?* Retrieved September 13th, 2023, from https://www.ama-assn.org/delivering-care/public-health/what-behavioral-health.
[27] Source: CDC. (2024). About mental health. Retrieved October 1, 2024, from: https://www.cdc.gov/mentalhealth/learn/index.htm
[28] Source: National Institute of Mental Health (2023). *Mental Illness*. Retrieved September 13th, 2023, from https://www.nimh.nih.gov/health/statistics/mental-illness.
[29] Source: CDC. (2024). Mental health. Retrieved October 1, 2024, from https://www.cdc.gov/mentalhealth/learn/index.htm

services in 2021. Those who had an SMI were more likely (65.4%) to have received mental health services that same year.[30] While access to telehealth mental health services has increased, those living in rural areas may still find it difficult to access care. This is a particular concern among those who are low-income or experiencing homelessness, two groups at high risk for developing an acute or chronic mental health condition. As of 2023, over seven million people in the U.S. who reported having a mental illness lived in a rural area.[31]

Mental illness is a prevalent concern in North Carolina, with nearly 1.5 million adults reported to have a mental health condition in 2023. Additionally, that same year, 1 in 7 individuals who were identified as homeless also were living with an SMI. Access to mental health care in North Carolina is changing, however it is still unavailable to many. Specifically, over 452,000 individuals did not seek care in 2023, with 44.8% citing cost as the main reason. Additionally, those in live in North Carolina are seven times more likely to be pushed out of network of their behavioral health providers, than a primary care provider, furthering cost as a cause for stopping treatment. [32]

Access to services that address mental health is an ongoing challenge across the U.S. According to the Substance Abuse and Mental Health Services Administration (SAMHSA), in 2021, less than half (47.2%) of U.S. adults who reported having a mental illness utilized any type of mental health services, including inpatient, outpatient or telehealth services or prescription drug therapies. Demand for mental health services, particularly anxiety and depression treatment, remains high across the nation, while the prevalence of stress- and trauma-related disorders, along with substance use disorders, continues to grow. The American Psychological Association reports that the percentage of psychologists in the U.S. seeing more patients than they did before the pandemic increased from 15% in 2020 to 38% in 2021 to 43% in 2022. Further, 60% of psychologists reported having no openings for new patients and 38% maintained a waitlist for their services.

Secondary Data Findings

Secondary data analysis identified mental health as a significant concern for Carteret County residents across several measures. The county's crude death rate for deaths of despair (91.8 per 100,000 population) is substantially higher than both state (58.7) and national (55.9) averages, indicating a critical need for mental health intervention and support services. Similarly, the crude rate of suicide (21.1 per 100,000) also surpasses the state (14.0) and national rates (14.5).

[30] Source: National Institute of Mental Health. (2023). Mental Illness. Retrieved October 1, 2024, from https://www.nimh.nih.gov/health/statistics/mental-illness

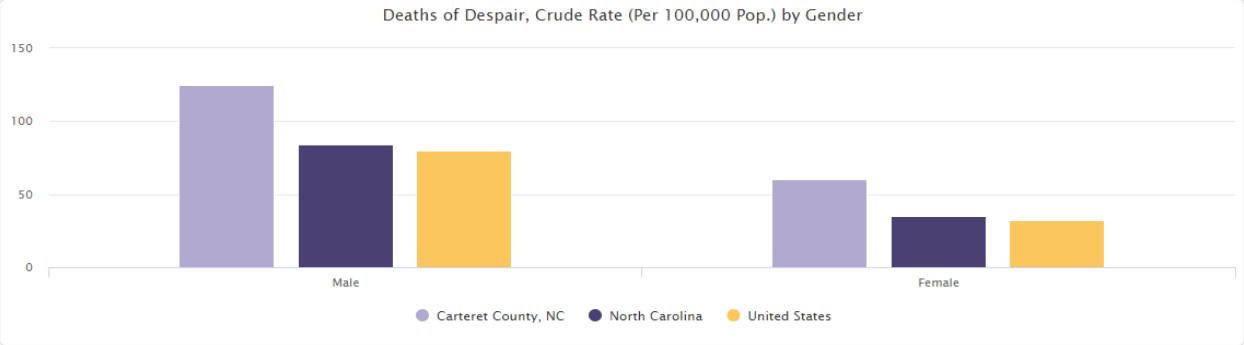
[31] RHI Hub. (2023). Rural mental health. Retrieved October 1, 2024 from: https://www.ruralhealthinfo.org/topics/mental-health

[32] Source: NAMI (2023). *Mental Health in North Carolina.* Retrieved October 10, 2024, from https://www.nami.org/wp-content/uploads/2023/07/NorthCarolinaStateFactSheet.pdf

Table 3.7: Mental Health Indicators			
Indicator	**Carteret County**	**North Carolina**	**United States**
Deaths of Despair (Crude Rate per 100,000 Population)	91.8	58.7	55.9
Suicide (Crude Rate per 100,000 Population)	21.1	14.0	14.5
Average Number of Poor Mental Health Days (per Month)	4.6	4.6	4.9

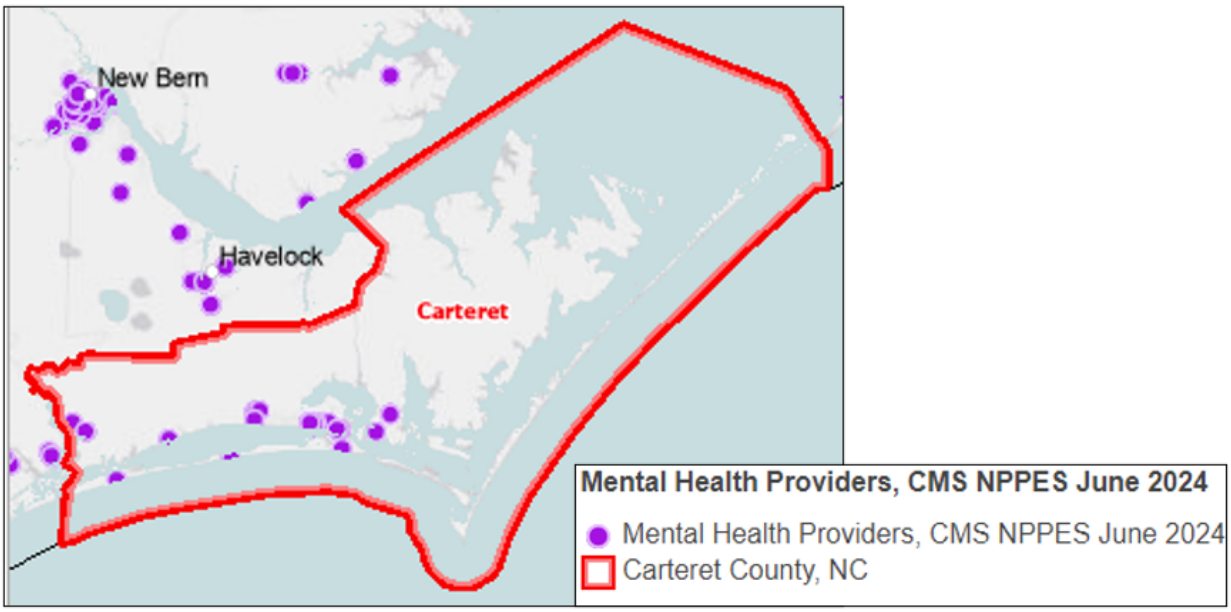
The average number of poor mental health days per month reported by county residents (4.6) matches the state average but is slightly better than the national average (4.9). However, significant gender disparities exist for deaths of despair, with males experiencing notably higher rates than females.

Figure 3.9: Deaths of Despair by Gender



Access to mental health care presents a significant challenge in the county. The rate of mental health providers (78.3 per 100,000 population) is substantially lower than both state (155.7) and national (178.7) averages, suggesting potential barriers to accessing mental health services. Provider distribution analysis shows these mental health professionals are concentrated in the southwestern portion of the county, indicating possible geographic disparities in access to care.

Figure 3.10: Mental Health Provider Distribution Map

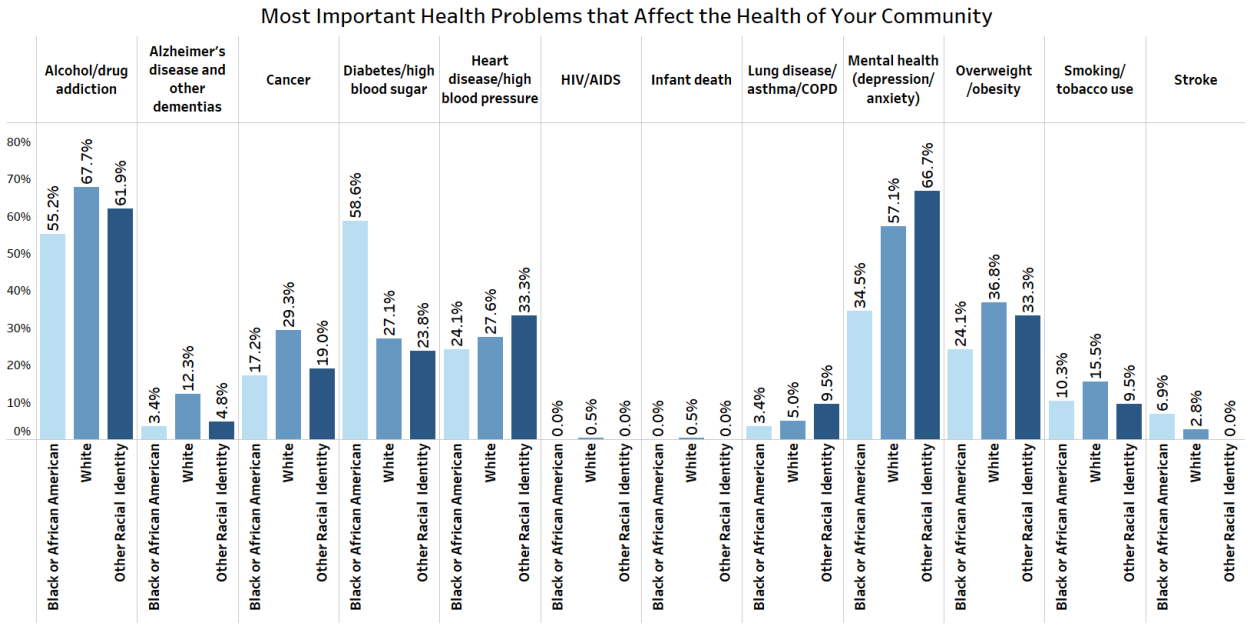


For additional detail on secondary data findings, see **Appendix 3**.

Primary Data Findings – Community Member Web Survey

Carteret County residents highlighted different aspects of mental health as areas of community concern on the web-based survey. When asked to identify the most important community health needs, 56% of these respondents identified (depression/anxiety), the second most frequently identified health need across all demographic groups. However, when this data was examined by the race of community member respondents, differences emerged. Those who identified as White (57%) or as all other races (67%) selected this as an important community health need more frequently than those who identified as Black or African American (34%), as displayed in the figure below.

Figure 3.11: What are the three most important health problems that affect the health of your community? Please select up to three. (by race)



Similarly, there were differences in responses across age groups. Younger people identified mental health as more significant than older respondents. Variations also emerged when analyzing responses by gender, with women (58%) were more likely to select mental health as an important problem in the community than men (50%). These perceived differences by demographic characteristics may be important in planning efforts to address mental health in the community.

When asked about overall health, 37% of respondents reported having been told by a health professional of depression or anxiety, with a further 6% who reported having been diagnosed with other mental illnesses (including bipolar disease, schizophrenia, borderline disorder, etc.), as previously shown in **Figure 3.3** in the Chronic Health Conditions section.

For additional detail on survey findings, see **Appendix 5.**

<u>Primary Data Findings – Focus Groups</u>

Mental health was consistently identified as a pressing concern across all four focus groups. Participants discussed high levels of anxiety, stress, depression, and social isolation affecting community members. The healthcare worker focus group noted cultural attitudes that prevent some individuals from seeking mental health support, while students emphasized the particular need for expanded youth mental health services. Focus group participants indicated that stigma around seeking help remains a significant barrier for many groups in the community. Both the healthcare worker and student groups recommended implementing free support groups for specific populations, such as survivors of domestic violence or veterans, while also expanding general mental health service availability throughout the county.

For a more detailed description of focus group findings, see **Appendix 5.**

PRIORITY NEED: SUBSTANCE USE/TOBACCO USE

Context and National Perspective

Substance use disorders (SUDs) are one of the fastest rising categories of behavioral health disorders. According to the American Psychiatric Association, SUDs are a complex condition in which there is uncontrolled use of a substance (such as alcohol or drugs), despite harmful consequences.[33] SUDs often occur in conjunction with other mental illness. In 2023, 16 million (46.9%) young adults aged 18-25 reported having either a SUD or Acute Mental Illness (AMI) in the past year. In that same year, 17.1% (48.5 million) of all U.S. adults were reported as having an SUD.[34] These trends have been increasing in recent years. According to the National Center for Drug Abuse Statistics, in 2018 (3.7%) of all adults aged 18 and older (9.2 million) had both an AMI and at least one SUD.[35] By 2021, this had increased to 13.5% of U.S. adults, with the highest incidence among Multiracial adults.

There are multiple common forms of SUD, such as alcohol use, cocaine use, cannabis use, opioid use, and methamphetamine use disorders. An individual living with one SUD can also be coping with another at the same time, such as co-occurring use of alcohol and cannabis.[36] Treatment for SUDs generally cannot follow a cookie-cutter approach, as each person receiving treatment will have different withdrawal and coping needs. Treatment is typically provided through various therapies, inpatient admissions, and forms of medication-assisted treatment such as methadone. Opioid overdoses are one of the most common types of deaths related to SUDs, and can be preventable and treatable if caught in time. Multiple efforts have been coordinated within the past two years to incorporate the storage of overdose reversing medications such as Naloxone in public facilities such as federal facilities, and over the counter, as was approved in 2023 by the FDA. This is critical, as in 2022, the number of opioid overdoses nationwide surpassed 81,051 – a 63% increase in overdoses since 2019.[37]

The pandemic impacted public mental health and well-being in many ways. Community members continue to grapple with the pandemic-related effects of isolation and loneliness, financial instability, long-term health impacts and grief, all of which are drivers for developing a substance use disorder. In addition, both drug overdose and suicide deaths have sharply increased over the past several years – often disproportionately impacting younger people and communities of color.[38]

[33] Source: American Psychiatric Association (2024). *Addiction and Substance Use Disorders*. Retrieved January 16, 2024, from https://www.psychiatry.org/patients-families/addiction-substance-use-disorders.

[34] Source: SAMHSA (2024). *Highlights from the 2023 National Survey on Drug Use and Health*. Retrieved October 10th, 2024 from https://www.samhsa.gov/data/sites/default/files/reports/rpt42731/2022-nsduh-main-highlights.pdf.

[35] Source: National Center for Drug Abuse Statistics (2023). *Drug Abuse Statistics*. Retrieved January 8th, 2024, from https://drugabusestatistics.org/.

[36] Source: Cleveland Clinic. (2024). Substance Use Disorder (SUD). Retrieved October 1, 2024, from https://my.clevelandclinic.org/health/diseases/16652-drug-addiction-substance-use-disorder-sud

[37] Source: KFF. (2023). Saunders, H., Rudowitz, R. (2023). Will the availability of Over-The-Counter Narcan increase access? Retrieved October 1, 2024 from https://www.kff.org/policy-watch/will-availability-of-over-the-counter-narcan-increase-access/

[38] Source: Panchal, N., Saunders H., Rudowitz, R. and Cox, C. (2023). The Implications of COVID-19 for Mental Health and Substance Use. *Kaiser Family Foundation*. Retrieved from https://www.kff.org/mental-health/issue-brief/the-implications-of-covid-19-for-mental-health-and-substance-use.

Substance use disorders have also had an impact in North Carolina. Over 36,000 overdose deaths occurred in the state between 2000 and 2022 – an average of more than 1,600 deaths each year.[39] Multiple programs have been developed in North Carolina to combat substance use disorder, notably surrounding opioid usage, which has led to an increase in access and usage of Medication Assisted Treatment (MAT) and methadone clinics within the state. Additionally, North Carolina launched the Opioid and Substance use action plan, which involved the development of multiple interventions, dashboards, and educational materials to help support counties and organizations with reducing not only overdose deaths, but the incidence of SUDs as well.

Secondary Data Findings

Secondary data analysis revealed substance use and tobacco use as significant areas of concern for Carteret County. While the county performed better than state and national averages on some indicators, several key measures highlighted the need for targeted interventions in substance use prevention and treatment.

Secondary data analysis revealed mixed findings regarding substance use disorders in Carteret County. While the percentage of adults reporting excessive drinking (17%) is slightly lower than both state and national averages (18%), the county faces significant challenges with opioid-related issues. The rate of emergency department visits for opioid use disorder (55 per 100,000 beneficiaries) is notably higher than both state (43) and national (41) averages. The county's opioid overdose death rate (34.1 per 100,000 population) is significantly higher than the state average (25.1), indicating a particular challenge with opioid-related substance use. However, the county performs better on alcohol-related metrics, with a lower rate of alcohol-involved crash deaths (2.4 per 100,000 population) compared to the state average (2.9).

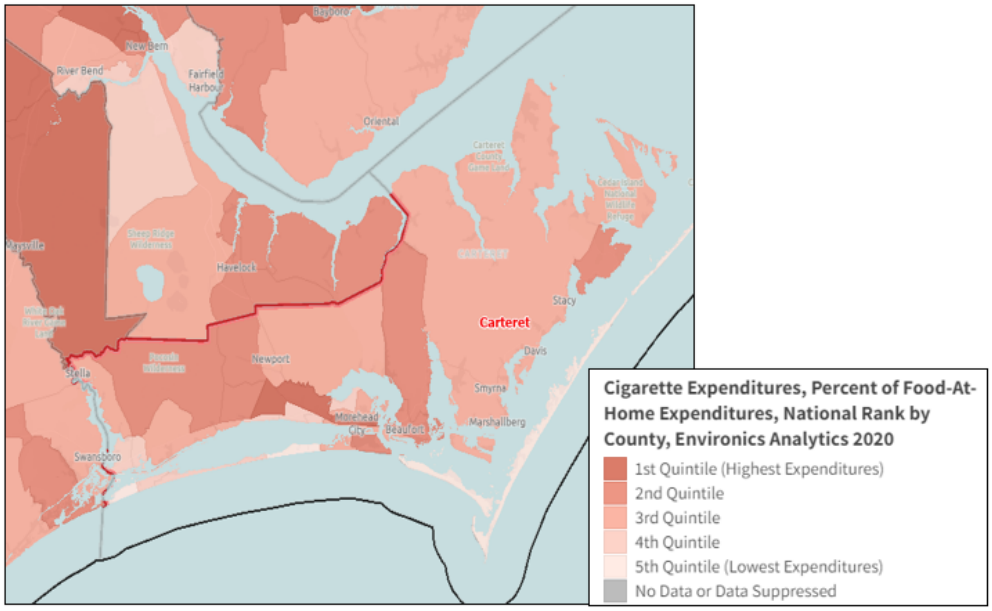
Table 3.8: Substance Use Disorder Indicators

Indicator	Carteret County	North Carolina	United States
Percentage of Adults Reporting Excessive Drinking	17%	18%	18%
Opioid Use Disorder Emergency Department Utilization (Rate per 100,000 Beneficiaries)	55	43	41
Alcohol-Involved Crash Deaths, Annual (Rate per 100,000 Population)	2.4	2.9	2.3
Opioid Overdose Death Rate (Crude Rate per 100,000 Population)	34.1	25.1	N/A

[39] Source: NCDHHS. (2022). *Overdose epidemic.* Retrieved October 3, 2024 from: https://www.ncdhhs.gov/about/department-initiatives/overdose-epidemic#:~:text=Combating%20North%20Carolina's%20Opioid%20Crisis,is%20devastating%20families%20and%20communities.

Regarding tobacco use, the percentage of adults reporting that they currently smoke in Carteret County (15.7%) is comparable to the state average (15.0%), though cigarette spending patterns vary significantly across different areas of the county.

Figure 3.12: Cigarette Expenditures, Percent of Food-At-Home Expenditures



The availability of substance use treatment resources shows room for improvement, with the rate of substance abuse providers (23.6 per 100,000 population) lower than both state (25.0) and national (27.9) averages.

Table 3.9: Substance Use Treatment Providers

Indicator	Carteret County	North Carolina	United States
Substance Abuse Providers (Rate per 100,000 Population)	23.6	25.0	27.9
Buprenorphine Providers (Rate per 100,000 Population)	11.5	15.2	15.5

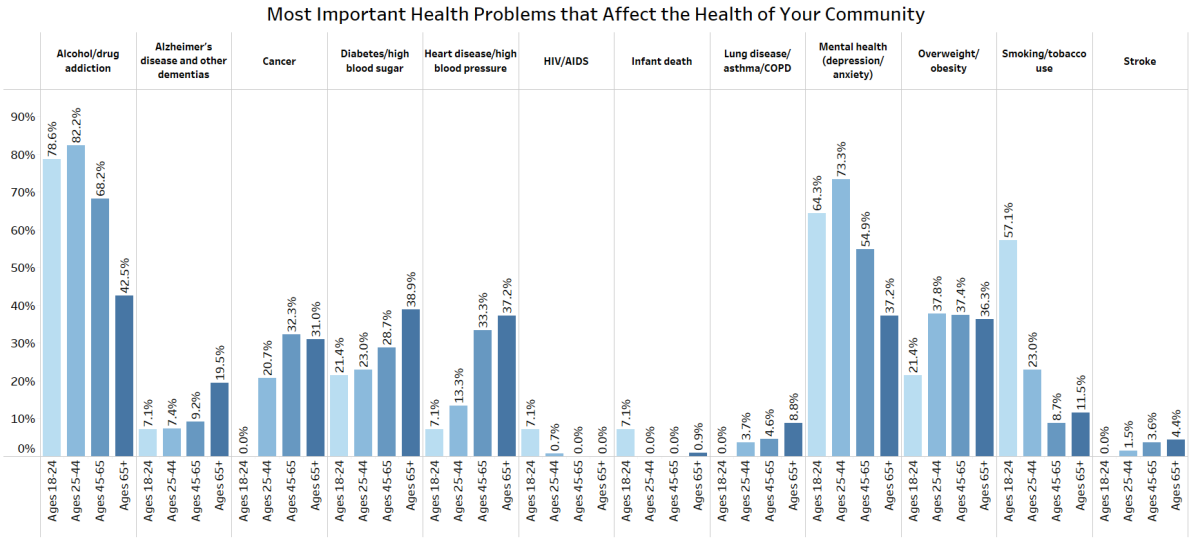
For additional detail on secondary data findings, see **Appendix 3.**

Primary Data Findings – Community Member Web Survey

Carteret County residents highlighted substance and tobacco use as areas of community concern on the web-based survey. When asked to identify the most important community health needs, 66% of respondents identified alcohol/drug addiction and 15% of respondents identified smoking/tobacco use. These were the first and seventh most frequent of all community health needs identified, respectively.

When these data were examined by the demographics of the community respondents, key differences emerged, especially by age. The second youngest cohort of respondents, ages 25 to 44, was more likely than all other age groups to identify alcohol/drug addiction as the most important health problem in the community, as displayed in the figure below. In fact, 83% of respondents in this age group identified alcohol/drug addiction as a top concern. By contrast, the very youngest cohort of respondents, ages 18-24, was more than twice as likely as all other age groups to view smoking/tobacco use as a significant health problem.

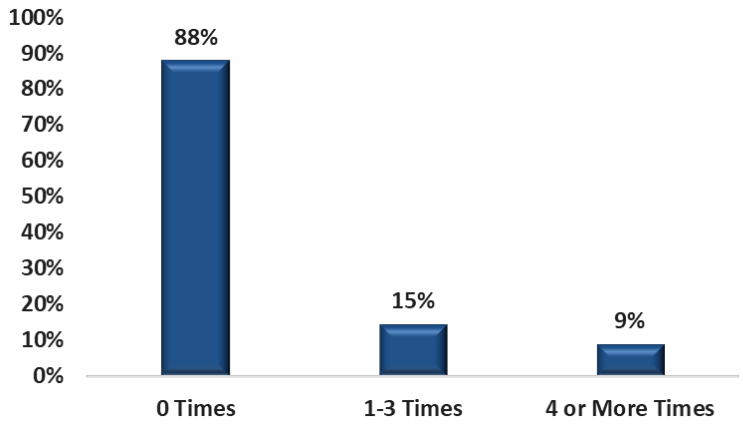
Figure 3.13: What are the three most important health problems that affect the health of your community? Please select up to three. (by age group)



Alcohol/drug addiction was more frequently identified by respondents who identified as White (68%) and all other races (61%) than those who identified as Black or African American (55%). Similarly, smoking/tobacco use was identified by respondents who identified as White (16%) more frequently than by those who identified as Black or African American (10%) or all other races (10%). These perceived differences by demographic characteristics may be important in planning efforts to address substance use in the community.

When respondents were asked about their own substance use, one-quarter of respondents reported drinking enough to meet the definition of "binge drinking" at least once in the past 30 days, with an average of one occasion of binge drinking in the past month among all respondents.

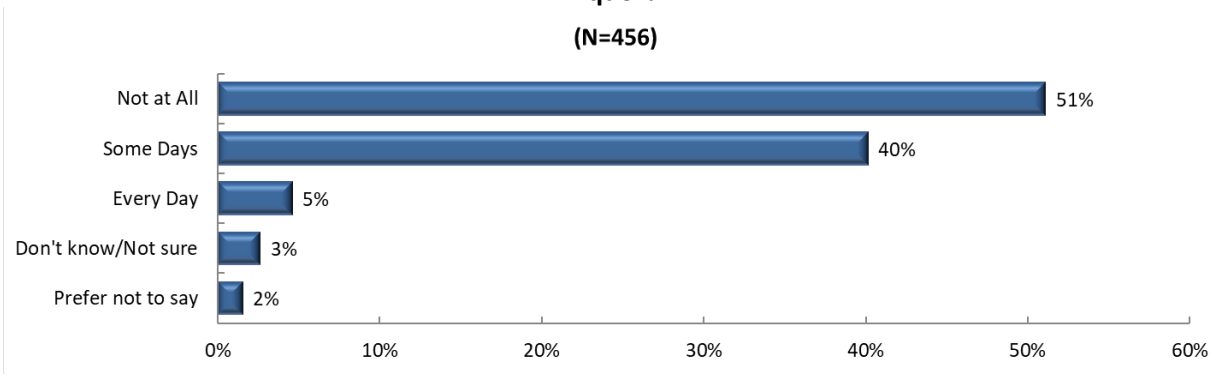
Figure 3.14: Considering all types of alcoholic beverages, how many times during the past 30 days did you have 4 (females)/ 5 (males) or more drinks on an occasion?



More than half of respondents reported no consumption of alcoholic products, with 40% of those indicating consumption of alcoholic products reporting a frequency of "some days".

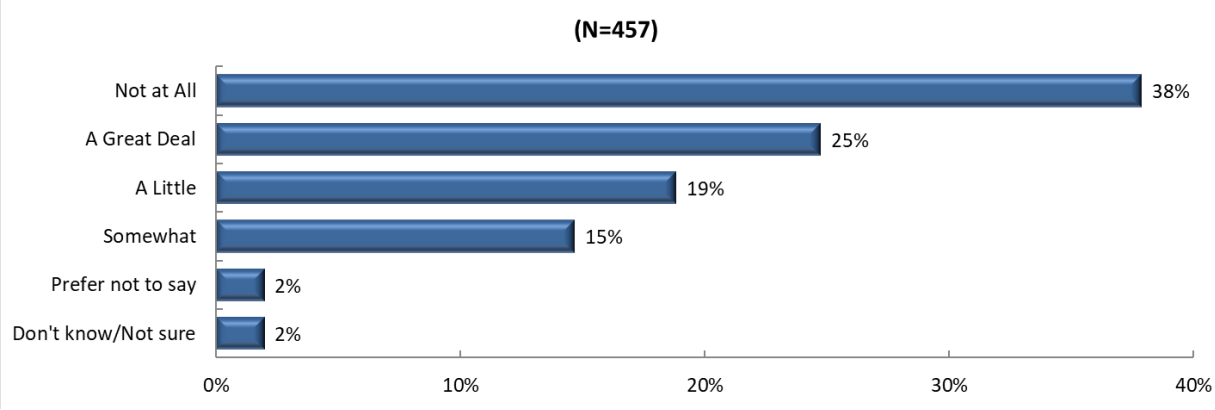
Figure 3.15: How often do you consume any kind of alcohol product, including beer, wine or hard liquor?

(N=456)



Over 90% of community member respondents reported no personal or household misuse of prescription drugs; however, when asked the degree to which their own or someone else's substance use negatively impacted their life, the majority of respondents stated they had been at least "somewhat" impacted. In fact, one-quarter of all respondents noted that they had been negatively impacted in this way "a great deal," further highlighting the presence of substance use issues in the community.

Figure 3.16: To what degree has your life been negatively affected by YOUR OWN or SOMEONE ELSE's substance abuse issues, including alcohol, prescription, and other drugs?



For additional detail on survey findings, see **Appendix 5.**

Primary Data Findings – Focus Groups

Substance use and tobacco use were highlighted as serious health problems by focus group participants, with specific concerns varying by group. The focus group of unhoused individuals at the Health Department discussed the way many community members use substances to self-medicate and cope with trauma, noting particularly high rates of smoking that contribute to chronic health conditions. The student focus group indicated that young people often turn to drugs and alcohol due to a lack of recreational activities and opportunities, while healthcare workers expressed concern that current drug and alcohol education programs in schools are ineffective. When asked about potential solutions, participants suggested expanding targeted substance use services for youth and creating more engaging activities and opportunities for young people in the community.

For a more detailed description of focus group findings, see **Appendix 5.**

CHAPTER 4 | HEALTH RESOURCE INVENTORY

NCLHDA requirements for local health departments and IRS requirements for nonprofit hospitals require the CHNA report to include a description of the resources available in a county to address the significant health needs identified in the assessment. This section includes information about local organizations in Carteret County that provide resources to address general community health needs, as well as the county's 2024 priority need areas: Chronic Health Conditions; Family, Community and Social Support; Mental Health; and Substance Use.

- Carteret County 2022 Resource Guide
- Carteret County Behavioral Health and Substance Use Resources

Category	Organization Name
County Resource Directories	• Parks and Recreation • Carteret Count Area Transportation System • Miles for Smile Dental Unit
Healthcare Facilities	• Carteret Landing • Crystal Bluffs • Brookdale • Croatan Ridge • Pruitt Health Crystal Coast • Carteret House • Cherry Point Bay
Community Services	• Leon Mann Jr. Enrichment Center
Priority Need: Chronic Health Conditions	• Carteret County Aging Services: Caregiver Resource Guide • North Carolina Cooperative Extension Carteret County • Carteret County Parks and Recreation • Carteret County Health Education Team • ENCPrevent Diabetes • Carteret Medical Group • PruittHealth • Carteret Healthcare Diabetes Program • Broad Street Community Clinic
Priority Need: Family, Community & Social Support	• Carteret County Department of Social Services • Carteret Healthcare Hospice Care • Carteret County Emergency Services • Women, Infants, and Children

	• Carteret County Case Management- Care Management for at Risk Children • HOPE Mission • Coastal Community Action
Priority Need: Mental Health	• Carteret County Behavioral Health/ Substance Abuse Resources List • Trillium • ICGH
Priority Need: Substance Use	• Carteret County Behavioral Health/ Substance Abuse Resources List • Post Overdose Response Team • Catch My Breath • HOPE Mission • Change in Recovery • Hope is Alive • Port Health • Dick's Crisis • Hope Recovery
Healthcare Facilities	• Carteret Landing • Crystal Bluffs • Brookdale • Croatan Ridge • Pruitt Health Crystal Coast • Carteret House • Cherry Point Bay
Community Services	• Leon Mann Jr. Enrichment Center

CHAPTER 5 | NEXT STEPS

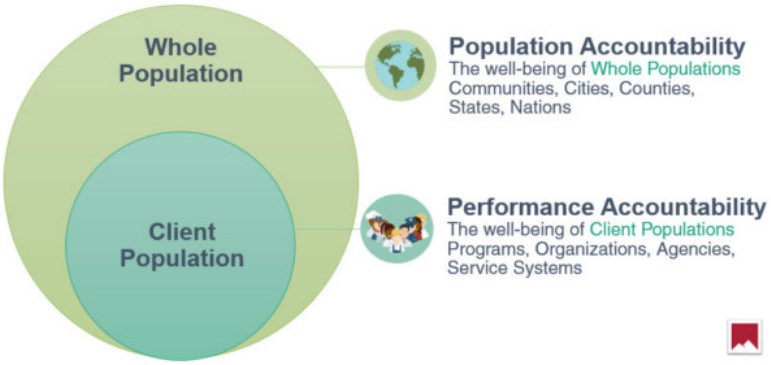
The CHNA findings are used to develop effective community health improvement strategies to address the priority needs identified throughout the process. The next and final step in the CHNA process is to develop community-based health improvement strategies and action plans to address the priorities identified in this assessment. Health leaders in Carteret County will leverage information from this CHNA to develop implementation and action plans for their local community, while also working together with other community partners to ensure the priority need areas are being addressed in the most efficient and effective way. Carteret County leaders recognize that the most effective strategies will be those that have the collaborative support of community organizations and residents. The strategies developed will include measurable objectives through which progress can be measured.

APPENDIX 1 | STATE OF THE COUNTY HEALTH REPORT

Results-Based Accountability Framework

To meet North Carolina accreditation requirements, LHDs are required to track progress on their implementation plans by publishing an annual State of the County Health Report (SOTCH). The SOTCH is guided by the Results-Based Accountability (RBA) Framework, and demonstrates that the LHD is tracking priority issues identified in the community health (needs) assessment process, identifying emerging issues, and implementing any relevant new initiatives to address community concerns.

Figure A1.1: Population vs. Performance Accountability



RBA provides a disciplined way of thinking about – and acting upon – complex social issues, with the goal of improving the lives of all members of the community. The framework is organized to recognize two distinct types of accountability: population and performance. Population accountability refers to the well-being of entire populations, and RBA recognizes that it is challenging, if not impossible, to hold individual organizations accountable for solving systemic problems. Conversely, performance accountability recognizes that individual organizations are accountable for the outcomes and impact of their programs, policies and practices as they relate to their client populations. **Figure A1.1** illustrates the way population and performance accountability interact.

In the CHIP process, RBA asks three key questions: how much did we do, how well did we do it, and is anyone better off? To more effectively answer these questions, and develop measurable strategies to address community health concerns, North Carolina LHDs use a software called Clear Impact Scorecard to develop their SOTCH and track progress against their goals. Clear Impact Scorecard is performance management and reporting software used by non-profit and government agencies to efficiently and effectively explain the impact of their work. The scorecard mirrors RBA and links results with indicators and programs with performance measures. Carteret County's most recent SOTCH is presented on the following pages.

State of the County Health Report

HNC 2030 Scorecard : Carteret County 2021-2024

The Community Health Assessment is an assessment by and for Carteret County residents to provide us with a true picture of the health and needs of Carteret County residents in order to equally and equitably guide decision-making, programs, and policies to improve health outcomes.

The Carteret County Health Department is excited to share the Healthy NC 2030 Scorecard for Carteret County. This Community Improvement Scorecard is an easy way to learn about some of the efforts currently underway in Carteret County to address the three health priorities identified in the 2021 Duplin County Community Health Assessment (CHA):

1. Chronic Disease
2. Equitable Access to Health Care
3. Substance Misuse

Below is the icon table that describes the key containers that are used to build the scorecard:

CH	**Community Health Assessment (CHA):** Local health departments are required to complete a health assessment at least every 48 months.
R	**Result:** Concise three-part statement that defines a condition of well-being for an entire population.
I	**Indicator:** How to quantify the achievement of a result.
P	**Program:** Evidence-informed implementation.
PM	**Performance Measure**: How to quantify the impact and effort of a program.
PY	**Policy:** A course of action that has been adopted or proposed by a government, business, or individual.
ST	**Strategy:** A plan of action designed to impact a performance measure or indicator.
CO	**Coalition:** A group of individuals from different organizations that agree to work together to impact a result.
TF	**Task Force:** A temporary group of individuals from different organizations that agree to work together to impact a result.
A	**Activity:** Any behavior or action that is not a program, policy, strategy, etc.
CC	**Clinical Care**: Anything related to the direct medical treatment or testing of patients.
S	**State of the County Health Report (SOTCH):** Annual report that is completed every year that a CHA is not completed.

Community Health Assessment

Community Health Assessment 2021	Time Period	Current Actual Value	Current Trend	Baseline % Change

Substance Misuse

All individuals and families in Carteret County with substance use disorder receive person-centered care incorporating evidence-based behavioral and pharmacological approaches.	Time Period	Current Actual Value	Current Trend	Baseline % Change
NCDPH HNC2030 Drug Overdose Death Rate in North Carolina: Drug Poisoning Deaths (Total) per 100,000 population	2022	42.1	↗ 4	205% ↗

Drug Poisoning Deaths (Counts) - Carteret County	2022	39	↗ 1	290% ↗
Drug Poisoning Deaths (Age-Adjusted Rates) - Carteret County	2022	68.4	↗ 1	378% ↗

New Coastal Coalition for Substance Awareness and Prevention (CCSAP)

Time Period	Current Actual Value	Current Trend	Baseline % Change

New Opioid/Narcan Education Training Event

Time Period	Current Actual Value	Current Trend	Baseline % Change

New Community Prevention Services

Time Period	Current Actual Value	Current Trend	Baseline % Change

New Carteret County Naloxone Kit Distributions

	Time Period	Current Actual Value	Current Trend	Baseline % Change
How Much Number of Kits Distributed	Q3 2022	78Kit	→ 0	0% →

Medication Take Back

	Time Period	Current Actual Value	Current Trend	Baseline % Change
How Much Pounds of Medication Collected	2022	153.0lb	→ 0	0% →

Equitable Access to Health Care

All people in Carteret County have access to comprehensive, high quality, healthcare, counseling services, affordable health insurance, housing and food

	Time Period	Current Actual Value	Current Trend	Baseline % Change
NCDPH Number of counties in North Carolina where the primary care clinician to population ratio is less than 1:1500 (certified nurse midwives, nurse practitioners, and primary care physicians)	2022	77	→ 1	20% ↗
NCDPH HNC2030 Primary Care Clinicians: Number of NC counties with a (full-time equivalent) "primary care workforce" to "county population" ratio of 1:1,500	2017	62:1	→ 0	0% →
Primary Care Clinicians Ratio for Carteret County	–	–	–	–
NCDPH HNC2030 Infant mortality rate in North Carolina: Rate of Infant Deaths (Total) per 1,000 Live Births	2022	6.8	→ 1	-3% ↘
Infant mortality rate in Carteret Rate of Infant Deaths (Total) per 1,000 Live Births	2022	2.0	→ 1	-62% ↘
NCDPH HNC2030 Uninsured: % of North Carolina population under age 65 without health insurance (Total) - SAHIE	2022	11.2%	↘ 3	-26% ↘
% of Carteret County population under age 65 without health insurance (SAHIE)	2022	12.3	↘ 1	0% →

Carteret County Rape Crisis Program

	Time Period	Current Actual Value	Current Trend	Baseline % Change
New Participants in Sexual Assault Awareness Events	2023	100	↗ 1	9900% ↗

Carteret County Domestic Violence Program

Time Period	Current Actual Value	Current Trend	Baseline % Change

How Much	Participants in Domestic Assault Awareness Events	2022	38	→ 0	0% →
New	Participants in Sexual Assault Awareness Events	2023	100	↗ 1	9900% ↗

Chronic Disease

All people in Carteret County have longer healthier lives, access to health care, better food choices and activities.

		Time Period	Current Actual Value	Current Trend	Baseline % Change
NCDPH HNC2030	Life Expectancy (Total) in North Carolina: Average number of years of life remaining for people who have attained a given age.	2022	76.2	↗ 1	-2% ↘

Minority Diabetes Prevention Program

		Time Period	Current Actual Value	Current Trend	Baseline % Change
How Much	# of people screened	–	–	–	–
How well	% of people completing MDPP	–	–	–	–
Better off	% of people at or below baseline A1C	–	–	–	–

SOTCH REPORTS

2022 SOTCH Report

Time Period	Current Actual Value	Current Trend	Baseline % Change

2023 SOTCH Report

Time Period	Current Actual Value	Current Trend	Baseline % Change

APPENDIX 2 | SECONDARY DATA METHODOLOGY AND SOURCES

Many individual secondary data measures were analyzed as part of the CHNA process. These data provide detailed insight into the health status and health-related behavior of residents in the county. These secondary data are based on statistics of actual occurrences, such as the incidence of certain diseases, as well as statistics related to SDoH.

Methodology

All individual secondary data measures were grouped into six categories and 20 corresponding focus areas based on "common themes." In order to draw conclusions about the secondary data for Carteret County, its performance on each data measure was compared to targets/benchmarks. If Carteret County's performance was more than five percent worse than the comparative benchmark, it was concluded that improvements could be needed to better the health of the community. Conversely, if an area performed more than five percent better than the benchmark, it was concluded that while a need is still present, the significance of that need relative to others is likely less acute. The most recently available data were compared to these targets/benchmarks in the following order (as applicable):

- For all available data sources, state and national averages were compared.

The following methodology was used to assign a priority level to each individual secondary data measure:

- If the data were more than 5 percent worse = High need
- If the data were within or equal to 5 percent (better or worse) = Medium need
- If the data were more than 5 percent better = Low need

These measures are noted with an asterisk.

Additionally, data measures were also viewed with regard to performance over time and whether the measure has improved or worsened compared to the prior CHNA timeframe.

Data Sources

The following tables are organized by each of the twenty focus areas and contain information related to the secondary data measures analyzed including a description of each measure, the data source, and most recent data time periods.

Table A2.1: Access to Care

Measure	Description	Data Source	Most Recent Data Year(s)
Primary Care Providers (per 100,000 population)	Number of providers with a CMS National Provider Identifier (NPI) that specialize in primary care. Primary health providers include practicing physicians specializing in general practice medicine, family medicine, internal medicine, and pediatrics.	Centers for Medicare and Medicaid Services (CMS) – National Plan and Provider Enumeration System (NPPES). Data accessed via the North Carolina Data Portal, June 2024.	2024
Mental Health Providers (per 100,000 population)	Number of providers with a CMS National Provider Identifier (NPI) that specialize in mental health. Mental health providers include licensed clinical social workers and other credentialed professionals specializing in psychiatry, psychology, counseling, or child, adolescent, or adult mental health.	CMS –NPPES. Data accessed via the North Carolina Data Portal, June 2024.	2024
Addiction/Substance Abuse Providers (per 100,000 population)	Number of providers who specialize in addiction or substance abuse treatment, rehabilitation, addiction medicine, or providing methadone. The providers include Doctors of Medicine (MDs), Doctors of Osteopathic Medicine (DOs), and other credentialed professionals with a Center for Medicare and Medicaid Services and a valid National Provider Identifier (NPI).	CMS –NPPES. Data accessed via the North Carolina Data Portal, June 2024.	2024
Buprenorphine Providers (per 100,000 population)	Number of providers authorized to treat opioid dependency with buprenorphine. Buprenorphine is the first medication to treat opioid dependency that is permitted to be prescribed or dispensed in physician offices, significantly increasing treatment access. Qualified physicians are required to acquire and maintain certifications to legally dispense or prescribe opioid dependency medications.	US Department of Health and Human Services (DHHS), Substance Abuse and Mental Health Services Administration. Data accessed via the North Carolina Data Portal, June 2024.	2023

Measure	Description	Data Source	Most Recent Data Year(s)
Dental Health Providers (per 100,000)	Number of oral health providers with a CMS National Provider Identifier (NPI). Providers included are those who list "dentist", "general practice dentist", or "pediatric dentistry" as their primary practice classification, regardless of sub-specialty.	CMS – NPPES. Data accessed via the North Carolina Data Portal, June 2024.	2024
Health Professional Shortage Areas - Dental Care	Percentage of the population that is living in a geographic area designated as a "Health Professional Shortage Area" (HSPA), defined as having a shortage of dental health professionals. This indicator is relevant because a shortage of health professionals contributes to access and health status issues.	U.S. Census Bureau, American Community Survey (ACS). Data accessed via the North Carolina Data Portal, June 2024.	2018-2022
Federally Qualified Health Centers (FQHCs)	Number of Federally Qualified Health Centers (FQHCs) in the community. This indicator is relevant because FQHCs are community assets that provide health care to vulnerable populations; they receive extra funding from the federal government to promote access to ambulatory care in areas designated as medically underserved.	U.S. DHHS, CMS, Provider of Services File. Data accessed via the North Carolina Data Portal, June 2024.	2023
Population Receiving Medicaid	Percentage of the population with insurance enrolled in Medicaid (or other means-tested public health insurance). This indicator is relevant because it assesses vulnerable populations which are more likely to have multiple health access, health status, and social support needs; when combined with poverty data, providers can use this measure to identify gaps in eligibility and enrollment.	U.S. Census Bureau, ACS. Data accessed via the North Carolina Data Portal, June 2024.	2018-2022
Uninsured Population (SAHIE)	Percentage of adults under age 65 without health insurance coverage. This indicator is relevant because lack of health insurance is a primary barrier to healthcare access including regular primary care, specialty care, and other health services that contribute to poor health status. The lack of health insurance is considered a *key driver* of health status.	U.S. Census Bureau, Small Area Health Insurance Estimates (SAHIE). Data accessed via the North Carolina Data Portal, June 2024.	2022

Table A2.2: Built Environment

Measure	Description	Data Source	Most Recent Data Year(s)
Broadband Access (Access to DL Speeds >= 25MBPS and UL Speeds >= 3 MBPS)	Percentage of population with access to high-speed internet. Data are based on the reported service area of providers offering download speeds of 25 MBPS or more and upload speeds of 3 MBPS or more. These data represent both wireline and fixed/terrestrial wireless internet providers. Cellular internet providers are not included.	Federal Communications Commission (FCC) FABRIC Data. Additional data analysis by CARES. Data accessed via the North Carolina Data Portal, June 2024.	2023
Broadband Access (Access to DL Speeds >= 100MBPS and UL Speeds >= 20 MBPS)	Percentage of population with access to high-speed internet. Data are based on the reported service area of providers offering download speeds of 100 MBPS or more and upload speeds of 20 MBPS or more. These data represent both wireline and fixed/terrestrial wireless internet providers. Cellular internet providers are not included.	FCC FABRIC Data. Additional data analysis by CARES. Data accessed via the North Carolina Data Portal, June 2024.	2023
Households with No Computer	Percentage of households who don't own or use any types of computers, including desktop or laptop, smartphone, tablet, or other portable wireless computer, and some other type of computer, based on the 2018-2022 American Community Survey estimates.	U.S. Census Bureau, ACS. Data accessed via the North Carolina Data Portal, June 2024.	2018-2022
Households with No or Slow Internet	Percentage of households who either use dial-up as their only way of internet connection or have internet access but don't pay for the service, or have no internet access in their home, based on the 2018-2022 American Community Survey estimates.	U.S. Census Bureau, ACS. Data accessed via the North Carolina Data Portal, June 2024.	2018-2022
Liquor Stores	Number of liquor stores per 100,000 population provides a measure of environmental influences on dietary behaviors and the accessibility of healthy foods. Note this data excludes establishments preparing and serving alcohol for consumption on premises (including bars and restaurants) or which sell alcohol as a secondary retail product (including gas stations and grocery stores).	U.S. Census Bureau, County Business Patterns. Additional data analysis by CARES. Data accessed via the North Carolina Data Portal, June 2024.	2022

Measure	Description	Data Source	Most Recent Data Year(s)
Adverse Childhood Experiences (ACEs)	Percentage of children in North Carolina (total) with two or more ACEs. ACEs are potentially traumatic events that occur in childhood (0-17 years), including experiencing violence, abuse, or neglect; witnessing violence in the home or community; and having a family member attempt or die by suicide. Also included are aspects of the child's environment that can undermine their sense of safety, stability, and bonding, such as substance abuse problems, mental health problems, instability due to parental separation, and instability due to household members being in jail or prison. Other traumatic experiences that impact health and well-being may include not having enough food to eat, experiencing homelessness or unstable housing, or experiencing discrimination. ACEs can have lasting effects on health and well-being in childhood and life opportunities well into adulthood, for example, education and job potential. These experiences can increase the risks of injury, sexually transmitted infections, teen pregnancy, suicide, and a range of chronic diseases including cancer, diabetes, and heart disease.	Clear Impact Healthy North Carolina (HNC) 2030 Scorecard, 2021-2024. Data accessed June 2024.	2022

Table A2.4: Diet and Exercise

Measure	Description	Data Source	Most Recent Data Year(s)
Physical inactivity (percent of adults that report no leisure time physical activity)	Percentage of adults ages 20 and over reporting no leisure-time physical activity in the past month. Examples of physical activities include running, calisthenics, golf, gardening, or walking for exercise. The method for calculating Physical Inactivity changed. Data for Physical Inactivity are provided by the CDC Interactive Diabetes Atlas which combines 3 years of survey data to	Behavioral Risk Factor Surveillance System. Data accessed via Robert Wood Johnson Foundation & University of Wisconsin Population Health Institute County Health Rankings & Roadmaps, June 2024.	2021

Measure	Description	Data Source	Most Recent Data Year(s)
	provide county-level estimates. In 2011, BRFSS changed their methodology to include cell phone and landline participants. Previously only landlines were used to collect data. Physical Inactivity is created using statistical modeling.		
Community Design - Walkability Index Score	The National Walkability Index (2021) is a nationwide index score developed by the Environmental Protection Agency (EPA) that ranks block groups according to their relative walkability using selected variables on density, diversity of land uses, and proximity to transit from the Smart Location Database. The block groups are assigned their final National Walkability Index scores on a scale of 1 to 20 where the higher a score, the more walkable the community is.	EPA – Smart Location Database. Data accessed via the North Carolina Data Portal, June 2024.	2021
Access to Exercise Opportunities	Percentage of individuals in the county who live reasonably close to a location for physical activity. Locations for physical activity are defined as parks or recreational facilities. The numerator is the 2020 total population living in census blocks with adequate access to at least one location for physical activity (adequate access is defined as census blocks where the border is a half-mile or less from a park, 1 mile or less from a recreational facility in an urban area, or 3 miles or less from a recreational facility in a rural area) and the denominator is the 2020 resident county population. This indicator is used in the 2024 County Health Rankings.	ArcGIS Business Analyst and Living Atlas of the World, YMCA & U.S. Census Tigerline Files. Data accessed via the North Carolina Data Portal, June 2024.	2023
Recreation and Fitness Facility Access (per 100,000 population)	Number of establishments primarily engaged in operating fitness and recreational sports facilities featuring exercise and other active physical fitness conditioning or recreational sports activities, such as swimming, skating, or racquet sports. Access to recreation and fitness facilities	U.S. Census Bureau, County Business Patterns. Additional data analysis by CARES. Data accessed via the North Carolina Data Portal, June 2024.	2022

Measure	Description	Data Source	Most Recent Data Year(s)
	encourages physical activity and other healthy behaviors.		
Sugar-Sweetened Beverage (SSB) Consumption Among Adults	Percentage of total adults reporting consumption of one or more SSBs per day.	Clear Impact. HNC2030 Scorecard, 2021-2024. Data accessed June 2024.	2022

Table A2.5: Education

Measure	Description	Data Source	Most Recent Data Year(s)
Population with Limited English Proficiency	Percentage of the population aged 5 and older who speak a language other than English at home and speak English less than "very well". This indicator is relevant because an inability to speak English well creates barriers to healthcare access, provider communications, and health literacy/education.	U.S. Census Bureau, ACS. Data accessed via the North Carolina Data Portal, June 2024.	2018-2022
High School Graduation Rate	Percentage of high school students who graduate within four years. The adjusted cohort graduation rate (ACGR) is a graduation metric that follows a "cohort" of first-time 9th graders in a particular school year, and adjusts this number by adding any students who transfer into the cohort after 9th grade and subtracting any students who transfer out, emigrate to another county, or pass away.	U.S. Department of Education, EDFacts. Additional data analysis by CARES. Data accessed via the North Carolina Data Portal, June 2024.	2020-2021
No High School Diploma	Percentage of the population aged 25 and older without a high school diploma (or equivalency) or higher. This indicator is relevant because educational attainment is linked to positive health outcomes.	U.S. Census Bureau, ACS. Data accessed via the North Carolina Data Portal, June 2024.	2018-2022
Student Math Proficiency (4th Grade)	Percentage of 4th grade students testing below the "proficient" level on the Math portion of state-specific standardized tests.	U.S. Department of Education, EDFacts. Additional data analysis by CARES. Data accessed via the North Carolina Data Portal, June 2024.	2020-2021
Student Reading Proficiency (4th Grade)	Percentage of 4th grade students testing below the "proficient" level on the English Language Arts portion of state-specific standardized tests.	US Department of Education, EDFacts. Additional data analysis by CARES. Data accessed	2020-2021

Measure	Description	Data Source	Most Recent Data Year(s)
		via the North Carolina Data Portal, June 2024.	
School Funding Adequacy	The average gap in dollars between actual and required spending per pupil among public school districts. Required spending is an estimate of dollars needed to achieve U.S. average test scores in each district.	School Finance Indicators Database. Data accessed via RWJF & UWPHI County Health Rankings & Roadmaps, June 2024.	2021
School Funding Adequacy – Spending per Pupil	Actual spending per pupil among public school districts.	School Finance Indicators Database. Data accessed via RWJF & UWPHI County Health Rankings & Roadmaps, June 2024.	2021

Table A2.6: Employment

Measure	Description	Data Source	Most Recent Data Year(s)
Unemployment Rate (percent of population age 16+ but unemployed)	Percentage of the civilian non-institutionalized population age 16 and older (non-seasonally adjusted) that is unemployed but seeking work. This indicator is relevant because unemployment creates financial instability and barriers to access including insurance coverage, health services, healthy food, and other necessities that contribute to poor health status.	U.S. Department of Labor, Bureau of Labor Statistics. Data accessed via the North Carolina Data Portal, June 2024.	2024
Average Annual Unemployment Rate, 2013-2023	Average yearly percentage across the given time period of the civilian non-institutionalized population age 16 and older (non-seasonally adjusted) that is unemployed but seeking work. This indicator is relevant because unemployment creates financial instability and barriers to access including insurance coverage, health services, healthy food, and other necessities that contribute to poor health status.	U.S. Census Bureau, ACS. Data accessed via the North Carolina Data Portal, June 2024.	2024

Table A2.7: Environmental Quality

Measure	Description	Data Source	Most Recent Data Year(s)
Climate and Health – Flood Vulnerability	Estimated number of housing units within the special flood hazard area (SFHA) per county. The SFHAs have	Federal Emergency Management Agency (FEMA), National Flood	2011

Measure	Description	Data Source	Most Recent Data Year(s)
	1% annual chance of coastal or riverine flooding.	Hazard Layer. Data accessed via the North Carolina Data Portal, June 2024.	
Air and Water Quality – Drinking Water Safety	Number of drinking water violations recorded in a two-year period. Health-based violations include incidents where either the amount of contaminant exceeded the maximum contaminant level (MCL) safety standard, or where water was not treated properly. In cases where a water system serves multiple counties and has a violation, each county served by the system is given a violation.	EPA. Data accessed via the North Carolina Data Portal, June 2024.	2023

Table A2.8: Family, Community, and Social Support

Measure	Description	Data Source	Most Recent Data Year(s)
Childcare Cost Burden	Childcare costs for a median-income household with two children as a percentage of household income. Data are included as part of the 2024 County Health Rankings.	The Living Wage Calculator, Small Area Income and Poverty Estimates. Data accessed via the North Carolina Data Portal, June 2024.	2023
Young People Not in School and Not Working	Percentage of youth ages 16-19 who are not currently enrolled in school and who are not employed.	U.S. Census Bureau, ACS. Data accessed via the North Carolina Data Portal, June 2024.	2018-2022

Table A2.9: Food Security

Measure	Description	Data Source	Most Recent Data Year(s)
Food Insecurity Rate	Estimated percentage of the population that experienced food insecurity at some point during the report year. Food insecurity is the household-level economic and social condition of limited or uncertain access to adequate food.	Feeding America. Data accessed via the North Carolina Data Portal, June 2024.	2021
Food Insecure Children	Estimated percentage of the population under age 18 that experienced food insecurity at some point during the report year. Food insecurity is the household-level economic and social condition of	Feeding America. Data accessed via the North Carolina Data Portal, June 2024.	2021

Measure	Description	Data Source	Most Recent Data Year(s)
	limited or uncertain access to adequate food.		
Low-Income and Low Food Access	Percentage of the low-income population with low food access. Low food access is defined as living more than 1 mile (urban) or 10 miles (rural) from the nearest supermarket, supercenter, or large grocery store. Data are from the April 2021 Food Access Research Atlas dataset. This indicator is relevant because it highlights populations and geographies facing food insecurity.	U.S. Department of Agriculture (USDA), Economic Research Service, USDA – Food Access Research Atlas. 2019. Data accessed via the North Carolina Data Portal, June 2024.	2019
Limited access to healthy foods	Percentage of population who are low-income and do not live close to a grocery store.	USDA Food Environment Atlas. Data accessed via RWJF & UWPHI County Health Rankings & Roadmaps, June 2024.	2019
Food Environment - Fast Food Restaurants (per 100,000 population)	Number of fast food restaurants per 100,000 population. The prevalence of fast food restaurants provides a measure of both access to healthy food and environmental influences on dietary behaviors. Fast food restaurants are defined as limited-service establishments primarily engaged in providing food services (except snack and nonalcoholic beverage bars) where patrons generally order or select items and pay before eating.	US Census Bureau, County Business Patterns. Additional data analysis by CARES. 2022. Data accessed via the North Carolina Data Portal, June 2024.	2022
Food Environment - Grocery Stores (per 100,000 population)	Number of grocery establishments per 100,000 population. Grocery stores are defined as supermarkets and smaller grocery stores primarily engaged in retailing a general line of food, such as canned and frozen foods; fresh fruits and vegetables; and fresh and prepared meats, fish, and poultry. Delicatessen-type establishments are also included. Convenience stores and large general merchandise stores that also retail food, such as supercenters and warehouse club stores, are excluded. Healthy dietary behaviors are supported by access to healthy	US Census Bureau, County Business Patterns. Additional data analysis by CARES. 2022. Data accessed via the North Carolina Data Portal, June 2024.	2022

Measure	Description	Data Source	Most Recent Data Year(s)
	foods, and grocery stores are a major provider of these foods.		

Table A2.10: Housing and Homelessness

Measure	Description	Data Source	Most Recent Data Year(s)
Renter Costs – Average Gross Rent	Average gross rent is the contract rent plus the estimated average monthly cost of utilities (electricity, gas, and water and sewer) and fuels (oil, coal, kerosene, wood, etc.) if these are paid by the renter (or paid for the renter by someone else). Gross rent provides information on the monthly housing cost expenses for renters. When the data is used in conjunction with income data, the information offers an excellent measure of housing affordability and excessive shelter costs. The data also serve to aid in the development of housing programs to meet the needs of people at different economic levels, and to provide assistance to agencies in determining policies on fair rent.	U.S. Census Bureau, ACS. Data accessed via the North Carolina Data Portal, June 2024.	2018-2022
Housing Cost Burden, Severe (50%)	Percentage of the households where housing costs are 50% or more total household income. This indicator provides information on the cost of monthly housing expenses for owners and renters. The information offers a measure of housing affordability and excessive shelter costs. The data also serve to aid in the development of housing programs to meet the needs of people at different economic levels.	U.S. Census Bureau, ACS. Data accessed via the North Carolina Data Portal, June 2024.	2018-2022
Housing & Urban Development (HUD)-Assisted Housing Units (per 10,000 households)	Number of HUD-funded assisted housing units available to eligible renters as well as the unit rate (per 10,000 total households).	U.S. Department of HUD. Data accessed via the North Carolina Data Portal, June 2024.	2017-2021
Substandard Housing, Severe	Percentage of owner- and renter-occupied housing units having at least one of the following conditions: 1) lacking complete plumbing facilities, 2) lacking complete kitchen	U.S. Census Bureau, ACS. Data accessed via the North Carolina Data Portal, June 2024.	2011-2015

Measure	Description	Data Source	Most Recent Data Year(s)
	facilities, 3) with 1.51 or more occupants per room, 4) selected monthly owner costs as a percentage of household income greater than 50%, and 5) gross rent as a percentage of household income greater than 50%. Selected conditions provide information in assessing the quality of the housing inventory and its occupants. This data is used to easily identify homes where the quality of living and housing can be considered substandard.		
Homeless Children and Youth	Number of homeless children and youth enrolled in the public school system during the school year 2019-2020. According to the data source definitions, homelessness is defined as lacking a fixed, regular, and adequate nighttime residence. Those who are homeless may be sharing the housing of other persons, living in motels, hotels, or camping grounds, in emergency transitional shelters, or unsheltered. Data are aggregated to the report-area level based on school-district summaries where three or more homeless children are counted.	US Department of Education, EDFacts. Additional data analysis by CARES. 2019-2020. Data accessed via the North Carolina Data Portal, June 2024.	2019-2020

Table A2.11: Income

Measure	Description	Data Source	Most Recent Data Year(s)
Median Family Income	Median family income based on the latest 5-year American Community Survey estimates. A family household is any housing unit in which the householder is living with one or more individuals related to him or her by birth, marriage, or adoption. Family income includes the incomes of all family members ages 15 and older.	U.S. Census Bureau, ACS. Data accessed via the North Carolina Data Portal, June 2024.	2018-2022
Gender Pay Gap	Ratio of women's median earnings to men's median earnings for all full-time, year-round workers, presented as "cents on the dollar." Data are	U.S. Census Bureau, ACS. Data accessed via the North Carolina Data Portal, June 2024.	2018-2022

Measure	Description	Data Source	Most Recent Data Year(s)
	acquired from the 2018-2022 ACS and are used in the 2024 County Health Rankings.		
Population Below 100% Federal Poverty Level (FPL)	Percentage of population living in households with income below the FPL. This indicator is relevant because poverty creates barriers to access including health services, healthy food, and other necessities that contribute to poor health status.	U.S. Census Bureau, ACS. Data accessed via the North Carolina Data Portal, June 2024.	2022
Population Below 200% FPL	Percentage of population living in households with income below 200% of the FPL. This indicator is relevant because poverty creates barriers to access including health services, healthy food, and other necessities that contribute to poor health status.	U.S. Census Bureau, ACS. Data accessed via the North Carolina Data Portal, June 2024.	2018-2022
Children Below 200% FPL	Percentage of children living in households with income below 200% of the FPL. This indicator is relevant because poverty creates barriers to access including health services, healthy food, and other necessities that contribute to poor health status.	U.S. Census Bureau, ACS. Data accessed via the North Carolina Data Portal, June 2024.	2018-2022
Population Receiving SNAP (SAIPE)	Average percentage of the population receiving SNAP benefits during the month of June during the most recent report year. The Supplemental Nutrition Assistance Program, or SNAP, is a federal program that provides nutrition benefits to low-income individuals and families that are used at stores to purchase food.	U.S. Census Bureau, Small Area Income and Poverty Estimates. Data accessed via the North Carolina Data Portal, June 2024.	2021
Children Eligible for Free/Reduced Price Lunch	Percentage of public school students eligible for the free or reduced price lunch program in the latest report year. Free or reduced price lunches are served to qualifying students in families with income between 185 percent (free lunch) and or 130 percent (reduced price) of the US federal poverty threshold as part of the federal National School Lunch Program (NSLP).	National Center for Education Statistics (NCES) – Common Core of Data. Data accessed via the North Carolina Data Portal, June 2024.	2022-2023

Table A2.12: Length of Life

Measure	Description	Data Source	Most Recent Data Year(s)
Premature Death (years of potential life lost before age 75 per 100,000 population age-adjusted)	Number of events (i.e., deaths, births, etc.) in a given time period (three-year period) divided by the average number of people at risk during that period. Years of potential life lost measures mortality by giving more weight to deaths at earlier ages than deaths at later ages. Premature deaths are deaths before age 75. All of the years of potential life lost in a county during a three-year period are summed and divided by the total population of the county during that same time period-this value is then multiplied by 100,000 to calculate the years of potential life lost under age 75 per 100,000 people. These are age-adjusted.	National Center for Health Statistics – Natality and Mortality Files; Census Population Estimates Program. Data accessed via RWJF & UWPHI County Health Rankings & Roadmaps, June 2024.	2019-2021
Premature Age-Adjusted Mortality	Number of deaths among residents under age 75 per 100,000 population (age-adjusted).	National Center for Health Statistics – Natality and Mortality Files; Census Population Estimates Program. Data accessed via RWJF & UWPHI County Health Rankings & Roadmaps, June 2024.	2019-2021
Life expectancy	Average life expectancy at birth (age-adjusted to 2000 standard). Data were from the National Center for Health Statistics - Mortality Files (2019-2021) and are used for the 2024 County Health Rankings.	National Center for Health Statistics – Natality and Mortality Files; Census Population Estimates Program. Data accessed via RWJF & UWPHI County Health Rankings & Roadmaps, June 2024.	2019-2021

Table A2.13: Maternal and Infant Health

Measure	Description	Data Source	Most Recent Data Year(s)
Births with no or late prenatal care	Percentage of women who did not obtain prenatal care until the 7th month (or later) of pregnancy or who didn't have any prenatal care, as of all who gave birth during the three-year period from 2017 to 2019. This	CDC – National Vital Statistics System (NVSS). CDC WONDER. CDC, Wide-Ranging Online Data for Epidemiologic Research. Data accessed	2017-2019

Measure	Description	Data Source	Most Recent Data Year(s)
	indicator is relevant because engaging in prenatal care decreases the likelihood of maternal and infant health risks. This indicator can also highlight a lack of access to preventive care, a lack of health knowledge, insufficient provider outreach, and/or social barriers preventing utilization of services.	via the North Carolina Data Portal, June 2024.	
Low birthweight (percent of live births with birthweight < 2500 grams)	Percentage of live births where the infant weighed less than 2,500 grams (approximately 5 lbs., 8 oz.). The numerator is the number of low birthweight infants born over a 7-year time span, while the denominator is the total number of births in a county during the same time.	National Center for Health Statistics – Natality Files. Data accessed via RWJF & UWPHI County Health Rankings & Roadmaps, June 2024.	2016-2022
Infant Mortality	Number of all infant deaths (within 1 year) per 1,000 live births. Data were from the National Center for Health Statistics - Mortality Files (2015-2021) and are used for the 2024 County Health Rankings.	National Center for Health Statistics – Natality and Mortality Files. Data accessed via RWJF & UWPHI County Health Rankings & Roadmaps, June 2024.	2015-2021

Table A2.14: Mental Health

Measure	Description	Data Source	Most Recent Data Year(s)
Poor Mental Health Days	Average number of self-reported mentally unhealthy days in past 30 days among adults (age-adjusted to the 2000 standard). Data are included as part of the 2024 County Health Rankings.	CDC, Behavioral Risk Factor Surveillance System (BRFSS). Data accessed via the North Carolina Data Portal, June 2024.	2021
Deaths of Despair (Suicide and Drug/Alcohol Poisoning) (per 100,000 population)	Average rate of death due to intentional self-harm (suicide), alcohol-related disease, and drug overdose, also known as "deaths of despair", per 100,000 population. Figures are reported as crude rates. Rates are re-summarized for report areas from county level data, only where data is available. This indicator is relevant because death of despair is an indicator of poor mental health.	CDC – NVSS. Data accessed via the North Carolina Data Portal, June 2024.	2018-2022
Suicide (per 100,000 population)	Five-year average rate of death due to intentional self-harm (suicide) per	CDC – NVSS. Data accessed via the North	2018-2022

Measure	Description	Data Source	Most Recent Data Year(s)
	100,000 population from 2018 to 2022. Figures are reported as crude rates. Rates are re-summarized for report areas from county level data, only where data is available. This indicator is relevant because suicide is an indicator of poor mental health.	Carolina Data Portal, June 2024.	

Table A2.15: Physical Health

Measure	Description	Data Source	Most Recent Data Year(s)
Poor or fair health (percent of adults reporting fair or poor health age-adjusted)	Percentage of adults in a county who consider themselves to be in poor or fair health. This measure is based on responses to the BRFSS question: "In general, would you say that your health is excellent, very good, good, fair, or poor?" The value reported in the County Health Rankings is the percentage of respondents who rated their health "fair" or "poor." Poor or Fair Health is age-adjusted. Poor or Fair Health estimates are created using statistical modeling.	Behavioral Risk Factor Surveillance System. Data accessed via RWJF & UWPHI County Health Rankings & Roadmaps, June 2024.	2021
Asthma Prevalence (Adult)	Percentage of adults ages 18 and older who answer "yes" to both of the following questions: "Have you ever been told by a doctor, nurse, or other health professional that you have asthma?" and the question "Do you still have asthma?"	CDC, BRFSS. Data accessed via the North Carolina Data Portal, June 2024.	2022
Heart Disease (Adult)	Percentage of adults ages 18 and older who report ever having been told by a doctor, nurse, or other health professional that they had angina or coronary heart disease.	CDC, BRFSS. Data accessed via the North Carolina Data Portal, June 2024.	2022
High Blood Pressure (Adult)	Percentage of adults ages 18 and older who report ever having been told by a doctor, nurse, or other health professional that they have high blood pressure (HTN). Women who were told high blood pressure only during pregnancy and those who were told they had borderline hypertension were not included.	CDC, BRFSS. Data accessed via the North Carolina Data Portal, June 2024.	2021
High Cholesterol (Adult)	Percentage of adults ages 18 and older who report having been told by a doctor, nurse, or other health	CDC, BRFSS. Data accessed via the North	2021

Measure	Description	Data Source	Most Recent Data Year(s)
	professional that they had high cholesterol.	Carolina Data Portal, June 2024.	
Diabetes Prevalence (Adult)	Percentage of adults ages 20 and older who have ever been told by a doctor that they have diabetes. This indicator is relevant because diabetes is a prevalent problem in the U.S.; it may indicate an unhealthy lifestyle and puts individuals at risk for further health issues.	CDC, National Center for Chronic Disease Prevention and Health Promotion. Data accessed via the North Carolina Data Portal, June 2024.	2021
Kidney Disease (Adult)	Percentage of adults ages 18 and older who report ever having been told by a doctor, nurse, or other health professional that they have kidney disease.	CDC, BRFSS. Data accessed via the North Carolina Data Portal, June 2024.	2021
Stroke (Adult)	Percentage of adults ages 18 and older who report ever having been told by a doctor, nurse, or other health professional that they have had a stroke.	CDC, BRFSS. Data accessed via the North Carolina Data Portal, June 2024.	2022
Obesity	Percentage of adults ages 20 and older self-report having a Body Mass Index (BMI) greater than 30.0 (obese). Respondents were considered obese if their BMI was 30 or greater. BMI (weight [kg]/height [m]2) was derived from self-report of height and weight. Excess weight may indicate an unhealthy lifestyle and puts individuals at risk for further health issues.	CDC, National Center for Chronic Disease Prevention and Health Promotion. Data accessed via the North Carolina Data Portal, June 2024.	2021
Poor Dental Health – Teeth Loss	Percentage of adults ages 18 and older who report having lost all of their natural teeth because of tooth decay or gum disease.	CDC, BRFSS. Data accessed via the North Carolina Data Portal, June 2024.	2022
Cancer Incidence – All Sites (per 100,000 population)	Age-adjusted incidence rate (cases per 100,000 population per year) of cancer (all sites) adjusted to 2000 U.S. standard population age groups (Under age 1, 1-4, 5-9, ..., 80-84, 85 and older).	State Cancer Profiles. Data accessed via the North Carolina Data Portal, June 2024.	2016-2020
Emergency Room (ER) Visits (per 100,000 Medicare beneficiaries)	Rate of ER visits among Medicare beneficiaries age 65 and older (per 100,000 beneficiaries). This indicator is relevant because ER visits are "high intensity" services that can burden on both health care systems and patients. High rates of ER visits "may indicate poor care management,	CMS – Geographic Variation Public Use File. Data accessed via the North Carolina Data Portal, June 2024.	2022

Measure	Description	Data Source	Most Recent Data Year(s)
	inadequate access to care or poor patient choices, resulting in ER visits that could be prevented".		
Hospitalizations – Heart Disease (per 1,000 Medicare beneficiaries)	Hospitalization rate for coronary heart disease among Medicare beneficiaries ages 65 and older for hospital stays occurring between 2018 and 2020.	CDC – Atlas of Heart Disease and Stroke. Data accessed via the North Carolina Data Portal, June 2024.	2018-2020
Hospitalizations – Stroke (per 1,000 Medicare beneficiaries)	Hospitalization rate for Ischemic stroke among Medicare beneficiaries ages 65 and older for hospital stays occurring between 2018 and 2020.	CDC – Atlas of Heart Disease and Stroke. Data accessed via the North Carolina Data Portal, June 2024.	2018-2020

Table A2.16: Quality of Care

Measure	Description	Data Source	Most Recent Data Year(s)
Seasonal Influenza Vaccine	Percentage of adults ages 18 and older who reported receiving an influenza vaccination in the past 12 months. These data are derived from responses to the 2019 BRFSS.	CDC – FluVaxView. Data accessed via the North Carolina Data Portal, June 2024.	2019
Hospitalizations – Preventable Conditions (per 100,000 Medicare beneficiaries)	Preventable hospitalization rate among Medicare beneficiaries for the latest reporting period. Preventable hospitalizations include hospital admissions for one or more of the following conditions: diabetes with short-term complications, diabetes with long-term complications, uncontrolled diabetes without complications, diabetes with lower-extremity amputation, chronic obstructive pulmonary disease, asthma, hypertension, heart failure, bacterial pneumonia, or urinary tract infection. Rate is presented per 100,000 beneficiaries.	CMS, Mapping Medicare Disparities Tool. Data accessed via the North Carolina Data Portal, June 2024.	2021
Readmissions – All Cause (Medicare Population)	Rate of 30-day hospital readmissions among Medicare beneficiaries ages 65 and older. Hospital readmissions are unplanned visits to an acute care hospital within 30 days after discharge from a hospitalization. Patients may have unplanned readmissions for any reason, however readmissions within 30 days	CMS – Geographic Variation Public Use File. Data accessed via the North Carolina Data Portal, June 2024.	2022

Measure	Description	Data Source	Most Recent Data Year(s)
	are often related to the care received in the hospital, whereas readmissions over a longer time period have more to do with other complicating illnesses, patients' own behavior, or care provided to patients after hospital discharge.		

Table A2.17: Safety

Measure	Description	Data Source	Most Recent Data Year(s)
Incarceration Rate	Percentage of individuals born in each census tract who were incarcerated at the time of the 2010 Census as estimated by Opportunity Atlas data.	Opportunity Insights. Data accessed via the North Carolina Data Portal, June 2024.	2018
Juvenile Arrest Rate (per 1,000 juveniles)	Rate of delinquency cases per 1,000 juveniles. Data are acquired from the 2021 Easy Access to State and County Juvenile Court Case Counts (EZACO) and are used in the 2024 County Health Rankings.	Office of Juvenile Justice and Delinquency Department, Easy Access to State and County Juvenile Court Case Counts (EZACO). Data accessed via the North Carolina Data Portal, June 2024.	2021
Violent Crime (per 100,000 people)	Annual rate of reported violent crimes per 100,000 people during the three-year period of 2015-2017. Violent crime includes homicide, rape, robbery, and aggravated assault.	Federal Bureau of Investigation (FBI), FBI Uniform Crime Reports. Additional analysis by the National Archive of Criminal Justice Data. Data accessed via the North Carolina Data Portal, June 2024.	2015-2017
Mortality – Firearm (per 100,000 population)	Five-year average rate of death due to firearm wounds per 100,000 population, which includes gunshot wounds from powder-charged handguns, shotguns, and rifles. Figures are reported as crude rates for the time period of 2018 to 2022. This indicator is relevant because firearm deaths are preventable, and are a cause of premature death.	CDC – National Vital Statistics System. Data accessed via the North Carolina Data Portal, June 2024.	2018-2022
Mortality – Poisoning (per 100,000 population)	Five-year average rate of death due to poisoning (including drug overdose) per 100,000 population. Figures are reported as crude rates	CDC – National Vital Statistics System. Data accessed via the North	2018-2022

Measure	Description	Data Source	Most Recent Data Year(s)
	for the time period of 2018 to 2022. Rates are re-summarized for report areas from county level data, only where data is available. This indicator is relevant because poisoning deaths, especially from drug overdose, are a national public health emergency.	Carolina Data Portal, June 2024.	

Table A2.18 Sexual Health

Measure	Description	Data Source	Most Recent Data Year(s)
Sexually transmitted infections (chlamydia rate per 100,000 population)	Number of newly diagnosed chlamydia cases per 100,000 population	National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention. Data accessed via RWJF & UWPHI County Health Rankings & Roadmaps, June 2024.	2021
HIV Incidence (rate per 100,000 population)	Incidence rate of HIV infection or infection classified as state 3 (AIDS) per 100,000 population. Incidence refers to the number of confirmed diagnoses during a given time period, in this case is January 1st and December 31st of the latest reporting year.	CDC, National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention. Data accessed via the North Carolina Data Portal, June 2024.	2022
Teen Births (per 1,000 female population age 15-19)	Seven-year average number of births per 1,000 female population age 15-19. Data were from the National Center for Health Statistics - Natality files (2016-2022) and are used for the 2024 County Health Rankings.	CDC – National Vital Statistics System. Data accessed via the North Carolina Data Portal, June 2024.	2016-2022

Table A2.19: Substance Use Disorders

Measure	Description	Data Source	Most Recent Data Year(s)
Excessive Drinking – Heavy Alcohol Consumption	Percentage of adults that self-report excessive drinking in the last 30 days. Data for this indicator were based on survey responses to the 2021 Behavioral Risk Factor Surveillance System (BRFSS) annual survey and are used for the 2024 County Health Rankings. Excessive drinking is defined as the percentage of the population who report at least one binge drinking	CDC, BRFSS. Data accessed via the North Carolina Data Portal, June 2024.	2021

Measure	Description	Data Source	Most Recent Data Year(s)
	episode involving five or more drinks for men and four or more for women over the past 30 days, or heavy drinking involving more than two drinks per day for men and more than one per day for women, over the same time period. Alcohol use is a behavioral health issue that is also a risk factor for a number of negative health outcomes, including: physical injuries related to motor vehicle accidents, stroke, chronic diseases such as heart disease and cancer, and mental health conditions such as depression and suicide. There are a number of evidence-based interventions that may reduce excessive/binge drinking; examples include raising taxes on alcoholic beverages, restricting access to alcohol by limiting days and hours of retail sales, and screening and counseling for alcohol abuse.		
Mortality - Motor Vehicle Crash – Alcohol-Involved (annual rate per 100,000 population)	Crude rate of persons killed in motor vehicle crashes involving alcohol as an annual rate per 100,000 population. Fatality counts are based on the location of the crash and not the decedent's residence. Motor vehicle crash deaths are preventable and are a leading cause of death among young persons.	U.S. Department of Transportation, National Highway Traffic Safety Administration, Fatality Analysis Reporting System. Data accessed via the North Carolina Data Portal, June 2024.	2018-2022
Opioid Use Disorder (per 100,000 Medicare beneficiaries)	Rate of emergency department utilization for opioid use and opioid use disorder among the Medicare population. Figures are reported as age-adjusted to year 2000 standard. Rates are re-summarized for report areas from county level data, only where data is available. This indicator is relevant because mental health and substance use is an indicator of poor health.	CMS, Mapping Medicare Disparities Tool. Data accessed via the North Carolina Data Portal, June 2024.	2021
Mortality – Opioid Overdose (per 100,000 population)	Five-year average rate of death due to opioid drug overdose per 100,000 population. Figures are reported as crude rates for the time period of 2018 to 2022. Rates are re-summarized for report areas from	CDC – NVSS. Data accessed via the North Carolina Data Portal, June 2024.	2018-2022

Measure	Description	Data Source	Most Recent Data Year(s)
	county level data, only where data is available. This indicator is relevant because opioid drug overdose is the leading cause of injury deaths in the United States, and they have increased dramatically in recent years.		

Table A2.20: Tobacco Use

Measure	Description	Data Source	Most Recent Data Year(s)
Adult smoking	Percentage of the adult population that currently smokes every day or most days and has smoked at least 100 cigarettes in their lifetime. Adult Smoking estimates are created using statistical modeling.	Behavioral Risk Factor Surveillance System. Data accessed via RWJF & UWPHI County Health Rankings & Roadmaps, June 2024.	2021

Table A2.21: Transportation Options and Transit

Measure	Description	Data Source	Most Recent Data Year(s)
Households with No Motor Vehicle	Percentage of households with no motor vehicle based on the latest 5-year American Community Survey estimates.	U.S. Census Bureau, ACS. Data accessed via the North Carolina Data Portal, June 2024.	2018-2022
Commuter Travel Patterns - Public Transportation	Percentage of population using public transportation as their primary means of commuting to work. Public transportation includes buses or trolley buses, streetcars or trolley cars, subway or elevated rails, and ferryboats.	U.S. Census Bureau, ACS. Data accessed via the North Carolina Data Portal, June 2024.	2018-2022
Community Design – Distance to Public Transit	Proportion of the population living within 0.5 miles of a GTFS (General Transit Feed Specification) or fixed-guideway transit stop. Transit data is available from over 200 transit agencies across the United States, as well as all existing fixed-guideway transit service in the U.S. This includes rail, streetcars, ferries, trolleys, and some bus rapid transit systems.	EPA – Smart Location Database. Data accessed via the North Carolina Data Portal, June 2024.	2021

APPENDIX 3 | SECONDARY DATA COMPARISONS

Description of Focus Area Comparisons

When viewing the secondary data summary tables, please note that the following color shadings have been included to identify how Carteret County compares to North Carolina and the national benchmark. If both statewide North Carolina and national data was available, North Carolina data was preferentially used as the target/benchmark value.

Secondary Data Summary Table Color Comparisons

Color Shading	Priority Level	Carteret County Description
	Low	Represents measures in which Carteret County scores are **more than five percent better** than the most applicable target/benchmark and for which a low priority level was assigned.
	Medium	Represents measures in which Carteret County scores are comparable to the most applicable target/benchmark scoring **within or equal to five percent**, and for which a medium priority level was assigned.
	High	Represents measures in which Carteret County scores are **more than five percent worse** than the most applicable target/benchmark and for which a high priority level was assigned.

Note: Please see the methodology section of this report for more information on assigning need levels to the secondary data.

Please note that to categorize each metric in this manner and identify the priority level, the Carteret County value was compared to the benchmark by calculating the percentage difference between the values, relative to the benchmark value:

(Carteret Co Value – Benchmark Value)/(Benchmark) x 100 = % Difference Used to Identify Priority Level

For example, for the % Limited Access to Healthy Foods metric, the following calculation was completed:

(7.7-7.5)/(7.5) x 100% = 2.7% = Displayed as **Medium Priority Level**, Shaded in Yellow

This metric indicates that the percentage of the population with limited access to healthy foods in Carteret County is 2.7 percent worse (or, in this case, higher) than the percentage of the population with limited access to healthy foods in the state of North Carolina.

Detailed Focus Area Benchmarks

Table A3.1: Access to Care

Measure	National Benchmark	North Carolina Benchmark	Carteret County Data	Most Recent Data Year	Carteret County Need
Primary Care Providers Ratio	112.4	101.1	75.4	2024	High
Mental Health Providers Ratio	178.7	155.7	78.3	2024	High
Addiction/Substance Abuse Providers Ratio	27.9	25.0	23.6	2024	High
Buprenorphine Providers Ratio	15.5	15.2	11.5	2023	High
Dental Health Providers Ratio	39.1	31.5	47.3	2024	Low
% Living in Health Professional Shortage Areas (HPSAs) – Dental Care	17.8%	34.0%	33.5%	2018-2022	Medium
Federally Qualified Health Centers (FQHCs)	3.5	4.1	0.0	2023	High
% Receiving Medicaid	22.3%	20.2%	16.3%	2018-2022	Low
% Uninsured	10.2%	12.5%	12.7%	2022	Medium

Table A3.2: Built Environment

Measure	National Benchmark	North Carolina Benchmark	Carteret County Data	Most Recent Data Year	Carteret County Need
Broadband Access (Access to DL Speeds >= 25MBPS and UL Speeds >= 3 MBPS)	93.8%	93.6%	99.3%	2023	Low
Broadband Access (Access to DL Speeds >= 100MBPS and UL Speeds >= 20 MBPS)	91.2%	90.4%	99.2%	2023	Low
Households with No Computer	6.1%	6.9%	4.6%	2018-2022	Low

Measure	National Benchmark	North Carolina Benchmark	Carteret County Data	Most Recent Data Year	Carteret County Need
Households with No or Slow Internet	11.7%	13.0%	8.9%	2018-2022	Low
Liquor Stores	13.3	6.2	11.8	2022	High
Adverse Childhood Experiences (ACEs)	N/A	N/A	Suppressed	2022	N/A

Table A3.3: Diet and Exercise

Measure	National Benchmark	North Carolina Benchmark	Carteret County Data	Most Recent Data Year	Carteret County Need
% Physically Inactive	N/A	21.6%	19.4%	2021	Low
Walkability Index Score	10	7	6	2021	High
% with Access to Exercise Opportunities	84.1%	73.0%	83.0%	2023	Low
Recreation and Fitness Facility Access	14.8	13.1	10.3	2022	High
Sugar-Sweetened Beverage (SSB) Consumption	N/A	N/A	Suppressed	2022	N/A

Table A3.4: Education

Measure	National Benchmark	North Carolina Benchmark	Carteret County Data	Most Recent Data Year	Carteret County Need
% Limited English Proficiency	8.2%	4.6%	1.2%	2018-2022	Low
High School Graduation Rate	81.1%	87.6%	85.0%	2020-2021	Medium
% with No High School Diploma	10.9%	10.6%	7.9%	2018-2022	Low
Student Math Proficiency	63.9%	65.8%	47.6%	2020-2021	Low
Student Reading Proficiency	60.1%	59.5%	48.9%	2020-2021	Low
School Funding Adequacy	N/A	-$4,742	$983	2021	Low
School Funding Adequacy –	N/A	$10,655	$11,366	2021	Low

Measure	National Benchmark	North Carolina Benchmark	Carteret County Data	Most Recent Data Year	Carteret County Need
Spending per pupil					

Table A3.5: Employment

Measure	National Benchmark	North Carolina Benchmark	Carteret County Data	Most Recent Data Year	Carteret County Need
Unemployment Rate	3.9%	3.7%	3.1%	2024	Low
Average Annual Unemployment Rate, 2013-2023	3.6%	3.5%	3.2%	2024	Low

Table A3.6: Environmental Quality

Measure	National Benchmark	North Carolina Benchmark	Carteret County Data	Most Recent Data Year	Carteret County Need
Flood Vulnerability	6.5%	4.9%	29.1%	2011	High
Drinking Water Safety	16,107	194	2	2023	Low

Table A3.7: Family, Community and Social Support

Measure	National Benchmark	North Carolina Benchmark	Carteret County Data	Most Recent Data Year	Carteret County Need
Childcare Cost Burden	28.8%	27.0%	24.0%	2023	Low
% Young People Not in School or Working	6.9%	7.5%	5.7%	2018-2022	Low

Table A3.8: Food Security

Measure	National Benchmark	North Carolina Benchmark	Carteret County Data	Most Recent Data Year	Carteret County Need
% Food Insecure	10.3%	11.4%	11.7%	2021	Medium
% Food Insecure Children	13.3%	15.3%	12.0%	2021	Low
% Low-Income and with Low Food Access	19.4%	21.3%	26.7%	2019	High
% Limited Access to Healthy Foods	N/A	7.5%	7.7%	2019	Medium
Fast Food Restaurants	96.2	77.4	90.1	2022	High
Grocery Stores	23.4	18.7	22.2	2022	Low

Table A3.9: Housing and Homelessness

Measure	National Benchmark	North Carolina Benchmark	Carteret County Data	Most Recent Data Year	Carteret County Need
Renter Costs – Average Gross Rent	$1,366	$1,090	$970	2018-2022	Low
% Severe Housing Cost Burden	14.1%	12.2%	10.6%	2018-2022	Low
Assisted Housing Units	413.9	319.2	310.4	2017-2021	Medium
% Severe Substandard Housing	18.5%	16.1%	15.6%	2011-2015	Medium
% Homeless Children	2.8%	1.9%	0.8%	2019-2020	Low

Table A3.10: Income

Measure	National Benchmark	North Carolina Benchmark	Carteret County Data	Most Recent Data Year	Carteret County Need
Median Family Income	$92,646	$82,890	$86,312	2018-2022	Low
Gender Pay Gap	81.0%	83.0%	82.0%	2018-2022	Medium
% Living Below 100% FPL	12.5%	13.3%	9.7%	2022	Low
% Living Below 200% FPL	28.8%	31.6%	26.5%	2018-2022	Low
% Children Living Below 200% FPL	37.2%	41.1%	30.8%	2018-2022	Low
% Receiving SNAP	12.4%	15.7%	10.8%	2021	Low
Children Eligible for Free/Reduced Price Lunch	51.7%	50.8%	72.0%	2022-2023	High

Table A3.11: Length of Life

Measure	National Benchmark	North Carolina Benchmark	Carteret County Data	Most Recent Data Year	Carteret County Need
Years of Potential Life Lost Rate	N/A	8,853	9,383	2019-2021	High
Premature Age-Adjusted Mortality	N/A	420	430	2019-2021	Medium
Life Expectancy	77.6	76.6	76.7	2019-2021	Medium

Table A3.12: Maternal and Infant Health

Measure	National Benchmark	North Carolina Benchmark	Carteret County Data	Most Recent Data Year	Carteret County Need
Births with Late or No Prenatal Care	6.1%	6.9%	Suppressed	2019	N/A
Low Birthweight	N/A	9.4%	7.5%	2016-2022	Low
Infant Mortality Rate	5.7	7.0	6.0	2015-2021	Low

Table A3.13: Mental Health

Measure	National Benchmark	North Carolina Benchmark	Carteret County Data	Most Recent Data Year	Carteret County Need
Poor Mental Health Days	4.9	4.6	4.6	2021	Medium
Deaths of Despair Rate	55.9	58.7	91.8	2018-2022	High
Suicide Death Rate	14.5	14.0	21.1	2018-2022	High

Table A3.14: Physical Health

Measure	National Benchmark	North Carolina Benchmark	Carteret County Data	Most Recent Data Year	Carteret County Need
% Poor or Fair Health	N/A	14.4%	12.8%	2021	Low
% Adults with Asthma	9.7%	9.8%	9.4%	2022	Medium
% Adults with Heart Disease	5.2%	5.5%	5.3%	2022	Medium
% Adults with High Blood Pressure	29.6%	32.1%	28.5%	2021	Low
% Adults with High Cholesterol	31.0%	31.4%	31.0%	2021	Medium
Diabetes Prevalence	8.9%	9.0%	7.5%	2021	Low
% Adults with Kidney Disease	2.7%	2.9%	2.7%	2021	Low
% Stroke	2.8%	3.1%	2.7%	2022	Low
Obesity	30.1%	29.7%	25.8%	2021	Low
% Teeth Loss	13.9%	12.0%	10.6%	2022	Low
Cancer Incidence Rate	442.3	464.4	463.6	2016-2020	Medium
Emergency Room Visits	535	563	490	2022	Low

Measure	National Benchmark	North Carolina Benchmark	Carteret County Data	Most Recent Data Year	Carteret County Need
Heart Disease Hospitalization Rate	10.4	11.7	14.2	2018-2020	High
Stroke Hospitalization Rate	8.0	9.5	9.9	2018-2020	Medium

Table A3.15: Quality of Care

Measure	National Benchmark	North Carolina Benchmark	Carteret County Data	Most Recent Data Year	Carteret County Need
Children/adults vaccinated annually against seasonal influenza	44.5%	45.6%	49.8%	2021	Low
Preventable Hospital Rate	2,752	2,957	3,052	2021	Medium
Readmissions Rate	18.1%	17.6%	15.0%	2022	Low

Table A3.16: Safety

Measure	National Benchmark	North Carolina Benchmark	Carteret County Data	Most Recent Data Year	Carteret County Need
Incarceration Rate	1.3%	1.5%	1.1%	2018	Low
Juvenile Arrest Rate	13.9	16.0	18.0	2021	High
Violent Crime	416.0	365.7	176.8	2015-2017	Low
Firearm Death Rate	13.4	15.5	16.4	2018-2022	High
Poisoning Death Rate	28.5	31.5	43.0	2018-2022	High

Table A3.17: Sexual Health

Measure	National Benchmark	North Carolina Benchmark	Carteret County Data	Most Recent Data Year	Carteret County Need
Chlamydia Rate	495.0	603.3	223.2	2021	Low
HIV Incidence Rate	12.7	15.5	9.9	2022	Low
Teen Births	16.6	18.2	N/A	2016-2022	N/A

Table A3.18: Substance Use Disorders

Measure	National Benchmark	North Carolina Benchmark	Carteret County Data	Most Recent Data Year	Carteret County Need
% Excessive Drinking	18.1%	18.2%	16.9%	2021	Low
% Driving Deaths with Alcohol	2.3	2.9	2.4	2018-2022	Low
Opioid Use Disorder Rate	41.0	43.0	55.0	2021	High
Opioid Drug Overdose Deaths	N/A	25.1	34.1	2018-2022	High

Table A3.19: Tobacco Use

Measure	National Benchmark	North Carolina Benchmark	Carteret County Data	Most Recent Data Year	Carteret County Need
% Smokers	14.5%	15.0%	15.7%	2021	Medium

Table A3.20: Transportation Options and Transit

Measure	National Benchmark	North Carolina Benchmark	Carteret County Data	Most Recent Data Year	Carteret County Need
% Households with No Motor Vehicle	8.3%	5.4%	3.9%	2018-2022	Low
% Public Transit	3.8%	0.8%	0.4%	2018-2022	High
% Living Near Public Transit	34.8%	10.9%	0.0%	2021	High

APPENDIX 4 | PRIMARY DATA METHODOLOGY AND SOURCES

Primary data were collected through focus groups, which were conducted in-person, and a web-based Community Member survey.

Methodologies

The methodologies varied based on the type of primary data being analyzed. The following section describes the various methodologies used to analyze the primary data, along with key findings.

Focus Groups

The following 4 focus groups were conducted in person between June 4th, 2024, and June 5th, 2024. These groups included representation from community members, with over 42 participants providing responses on their experiences living, working, or receiving healthcare in Carteret County.

- Leon Mann Jr. Enrichment Center
- Carteret Community College
- Carteret County Health Department
- Carteret Health

Input was gathered on the following topics:

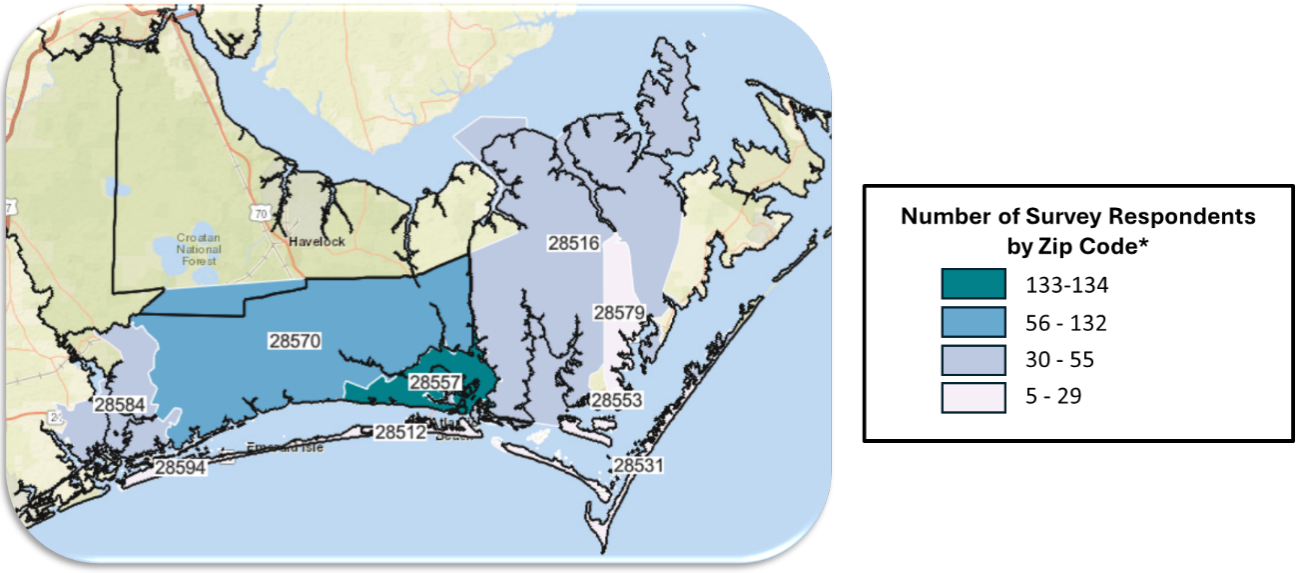
- Community health concerns
- Social and environmental concerns that may impact health
- Access to care
- Other topics of concern for Carteret County

The majority (71.4%) of participants identified as female, and the group was predominantly white (64.3%) and non-Hispanic/Latino (83.3%). Participants represented a wide range of ages, with nearly three-quarters (71.4%) of the group over the age of 40.

Community Member Web Survey

A total of 461 surveys were completed by individuals living, working or receiving healthcare in the Carteret County community. The survey was available in both English and Spanish, and approximately 1% were completed in Spanish. Consistent with one of the survey process goals, survey community member respondents were representative of a broad geographic area encompassing areas throughout the county. The map below provides additional information on survey respondents' ZIP code of residence.

Figure A4.1: Respondent Zip Code of Residence[40]



In general, survey questions focused on:

- Community health problems and concerns
- Community social/environmental problems and concerns
- Specific topics of interest to Carteret County:
    - Access to care
    - Physical health
    - Substance use disorders

The key findings from the Community Survey are detailed below:

- Alcohol/drug addiction, mental health, and weight issues were identified as the top 3 health problems affecting the community. Over one quarter of respondents also identified diabetes, heart disease/high blood pressure, and cancer as significant health problems in the community.
- Cost, insurance, and wait times were the top three barriers to receiving health care identified by the community.
- Housing, availability/access to doctor's offices, and availability/access to insurance were identified as the top three most important social or environmental problems that affect the health of the community. Over 20% of respondents also identified lack of affordable child care, lack of job opportunities, and poverty as significant problems.

[40] Zip codes with fewer than five respondents were not displayed for privacy reasons.

Information describing the respondents to the Community Member Survey are displayed below:

Figure A4.2: Respondents by Age

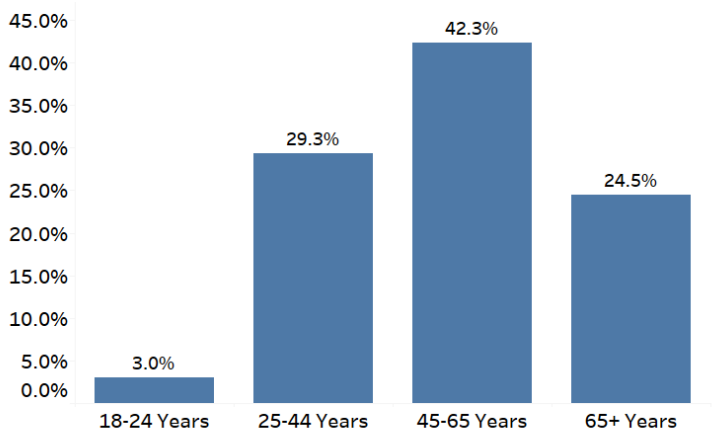


Figure A4.3: Respondents by Gender

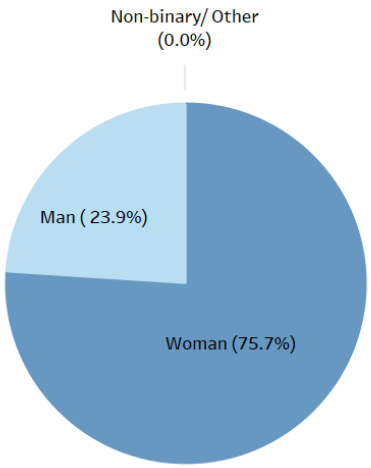


Figure A4.4: Respondents by Ethnicity

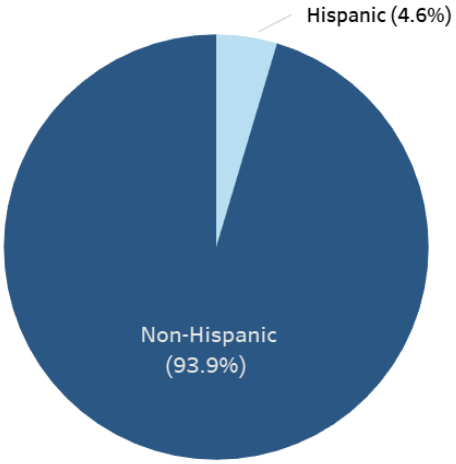
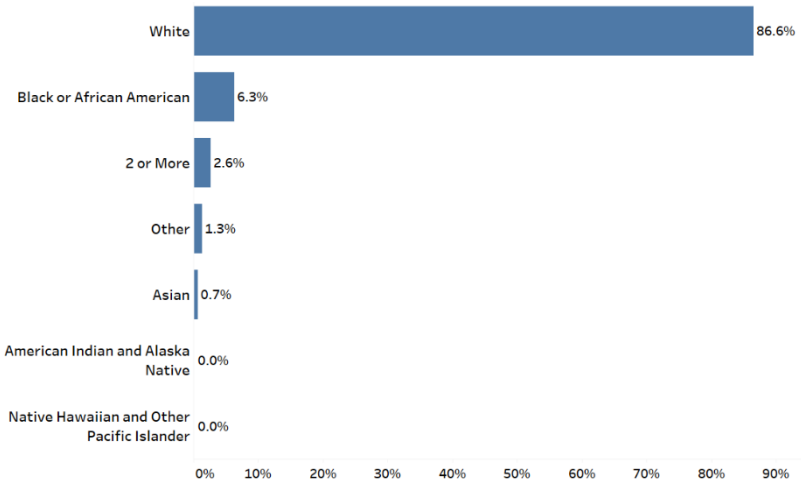


Figure A4.5: Respondents by Race



The questions administered via the Community Member Survey instrument are below. The survey instrument was also available in Spanish, and a copy of the Spanish language survey instrument is available on request.

Dear Community Member,

We invite you to participate in your county's Community Health Needs Survey.

Your responses to this optional survey are anonymous and will inform how hospitals and agencies work to improve health in your county. This is not a research survey. It will take less than 10 minutes to complete.

Instructions: You must be 18 years or older to complete this survey. Please answer all questions and return the survey as indicated.

For questions about this survey, contact Ascendient Healthcare Advisors: emilymccallum@ascendient.com

Thank you for your time and participation!

Topic: Demographics

1. What is the zip code where you currently live? _____

2. What is your age group?

□ 18-24
□ 25-44
□ 45-65
□ 65+
□ Don't know/ Not sure
□ Prefer not to say

3. Which of the following best describes your gender? *Select all that apply:*

□ Man
□ Woman
□ Non-binary, genderqueer, or gender nonconforming
□ Additional gender category: _____
□ Prefer not to say

4. How would you describe your race? *Select all that apply:*

   □ American Indian and Alaska Native
   □ Asian
   □ Black or African American
   □ Native Hawaiian and Other Pacific Islander
   □ White
   □ Other race: _____
   □ Don't know/Not sure
   □ Prefer not to say

5. Are you of Hispanic or Latino origin, or is your family originally from a Spanish speaking country?[41]

   □ Yes
   □ No
   □ Don't know/Not sure
   □ Prefer not to say

6. What is the highest grade or year of school you completed?

   □ Less than 9th grade
   □ 9-12th grade, no diploma
   □ High school graduate (or GED/equivalent)
   □ Some college (no degree)
   □ Associate's degree or vocational training
   □ Bachelor's degree
   □ Graduate or professional degree
   □ Don't know/Not sure
   □ Prefer not to say

7. Which language is most often spoken in your home? *Select one:*

   □ English
   □ Spanish
   □ Other, please specify: _____
   □ Don't know/Not sure
   □ Prefer not to say

[41] The U.S. Census Bureau defines "Hispanic or Latino" as "a person of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin regardless of race."

8. For employment, are you currently…*Select all that apply:*

□ Employed full-time (40+ hours per week)
□ Employed part-time (under 40 hours per week)
□ Retired
□ Student
□ Armed forces/military
□ Self-employed
□ Homemaker
□ Temporarily unable to work due to illness or injury
□ Unemployed for less than one year
□ Unemployed for more than one year
□ Permanently unable to work
□ Prefer not to answer

9. Which category best describes your yearly household income before taxes? Do not give the dollar amount, just give the category. Include all income received from employment, social security, support from family, welfare, Aid to Families with Dependent Children (AFDC), bank interest, retirement accounts, rental property, investments, etc.

□ Less than $15,000
□ $15,000 - $24,999
□ $25,000 - $34,999
□ $35,000 - $49,999
□ $50,000 - $74,999
□ $75,000 - $99,999
□ $100,000 - $149,999
□ $150,000 - $199,999
□ $200,000 or more
□ Prefer not to say

Topic: Community Health Opinion Questions

10. What are the **three** most important health problems that affect the health of your community? *Please select up to three:*

□ Alcohol/drug addiction
□ Alzheimer's disease and other dementias
□ Mental health (depression/anxiety)
□ Cancer
□ Diabetes/high blood sugar
□ Heart disease/high blood pressure
□ HIV/AIDS
□ Infant death
□ Lung disease/asthma/COPD
□ Stroke
□ Smoking/tobacco use
□ Overweight/obesity
□ Other (please specify): _____
□ Prefer not to answer

11. What are the **three** most important social or environmental problems that affect the health of your community? *Please select up to three:*

□ Availability/access to doctor's office
□ Availability/access to insurance
□ Child abuse/neglect
□ Age Discrimination
□ Ability Discrimination
□ Gender Discrimination
□ Racial Discrimination
□ Domestic violence
□ Housing/homelessness
□ Lack of affordable childcare
□ Lack of job opportunities
□ Limited access to healthy foods
□ Limited places to exercise
□ Neighborhood safety/violence
□ Limited opportunities for social connection
□ Poverty
□ Limited/poor educational opportunities
□ Transportation problems
□ Environmental injustice
□ Other (please specify): _____
□ Prefer not to answer

12. What are the **three** most important reasons people in your community do not get health care? *Please select up to three:*

□ Cost – too expensive/can't pay
□ Wait is too long
□ No health insurance
□ No doctor nearby
□ Lack of transportation
□ Insurance not accepted
□ Language barriers
□ Cultural/religious beliefs
□ Other (please specify):
□ Prefer not to answer

Topic: Access to Care

13. DURING THE PAST 12 MONTHS, were you told by a health care provider or doctor's office that they did not accept your health care coverage?

□ Yes
□ No
□ Don't know
□ Prefer not to answer

14. Where do you USUALLY go when you are sick or need advice about your health? *Select all that apply:*

□ Doctor's office, clinic or health center
□ Urgent care or minute clinic
□ Hospital emergency room
□ Some other place [please specify]: _____
□ Don't go to one place most often
□ Don't know
□ Prefer not to answer

15. There are many reasons people delay getting medical care. Have you delayed getting care for any of the following reasons in the PAST 12 MONTHS? *Select all that apply:*

□ Didn't have transportation
□ You live in a rural area where distance to the health care provider is too far
□ You were nervous about seeing a health care provider
□ Couldn't get time off work
□ Couldn't get childcare
□ You provide care to an adult and could not leave him/her
□ Couldn't afford the copay
□ Your deductible was too high/could not afford the deductible
□ You had to pay out of pocket for some or all of the visit/procedure
□ I did not delay care for any reason
□ Other *(please specify)*: _____
□ Prefer not to answer

16. DURING THE PAST 12 MONTHS, was there any time when you needed any of the following, but didn't get it because you couldn't afford it? *Select all that apply:*

□ Prescription medicines
□ Mental health care or counseling
□ Emergency care
□ Dental care (including checkups)
□ Eyeglasses
□ To see a regular doctor or general health provider (in primary care, general practice, internal medicine, family medicine)
□ To see a specialist
□ Follow-up care
□ None of the above
□ Prefer not to answer

17. If you get sick or have an accident, how worried are you that you will be able to pay your medical bills?

□ Very worried
□ Somewhat worried
□ Not at all worried
□ Don't know
□ Prefer not to answer

18. How much do you agree or disagree with the following statements about telehealth? Telehealth means connecting virtually with a medical provider using a smartphone, tablet or computer. 1 = Strongly disagree; 2 = somewhat disagree; 3 = neither agree nor disagree; 4 = somewhat agree; 5 = strongly agree

	1	2	3	4	5	Don't know	Prefer not to say
7. I have access to the resources I need to access telehealth (internet, smartphone, tablet, computer, etc.)	☐	☐	☐	☐	☐	☐	☐
b. I have used telehealth to access care from my doctor or other provider in the past	☐	☐	☐	☐	☐	☐	☐
c. I am open to using telehealth to access medical care in the future	☐	☐	☐	☐	☐	☐	☐
d. I am comfortable using a phone, tablet or computer to communicate with my doctor or other provider	☐	☐	☐	☐	☐	☐	☐
e. I am comfortable using an online patient portal (i.e. MyChart, My CarolinaEast Care, myOMH, etc.) to communicate with my doctor or other provider	☐	☐	☐	☐	☐	☐	☐

Topic: Physical Health

19. Considering your physical health overall, would you describe your health as…

□ Excellent
□ Very Good
□ Good
□ Fair
□ Poor
□ Don't know/Not sure
□ Prefer not to say

20. Within the past year (anytime less than one year ago), have you:

	Yes	No	Don't Know	Prefer not to say
a. Had a routine/annual physical or check-up?	□	□	□	□
b. Been to the dentist/dental hygienist?	□	□	□	□

21. Have you ever been told by a doctor, nurse, or other health professional that you have any of the following health conditions? *Select all that apply:*

□ Arthritis
□ Asthma
□ Cancer
□ Chronic Obstructive Pulmonary Disease (COPD)
□ Dementia/Short-term memory loss
□ Depression or anxiety
□ Diabetes (not during pregnancy)
□ Heart disease, stroke, or other cardiovascular disease
□ High blood pressure (hypertension)
□ High cholesterol
□ Immunocompromised condition not otherwise listed
□ Kidney disease
□ Liver disease
□ Long COVID
□ Lung disease
□ Osteoporosis
□ Physical disabilities
□ Mental illness not otherwise listed (including bipolar disorder, schizophrenia, borderline personality disorder, dissociative identity disorder)
□ Sexually transmitted diseases (including chlamydia, syphilis, gonorrhea and HIV)
□ Stroke
□ Vision and sight problems
□ Other *(please specify)*:
□ None of the above
□ Don't know/Not sure
□ Prefer not to say

22. What do you need to be able to manage your current health conditions (for example, heart conditions, high blood pressure, stroke, diabetes, asthma, cancer, COPD, congestive heart failure, arthritis, HIV, depression, anxiety, other mental health condition, etc.) to stay healthy? *Please select all that apply:*

    □ I don't have a current health condition to manage
    □ Health insurance to cover the care I need
    □ Assistance finding a doctor
    □ Assistance making and keeping appointments with my doctor(s)
    □ Assistance understanding all the directions from my doctor(s)
    □ Information to understand how to take my medication(s)
    □ Assistance paying for my prescription(s)/medication(s) or medical equipment
    □ Health care in my home
    □ Coordination of my overall care among multiple health care providers
    □ Access to healthy foods
    □ Access to places to exercise safely
    □ Transportation assistance
    □ Financial assistance for co-pays, deductibles
    □ Home modification assistance (for example, installing a wheelchair ramp or a handicapped-accessible shower)
    □ Other *(please specify)*: _____
    □ None
    □ Don't know
    □ Prefer not to say

Topic: Substance Use Disorders

23. Considering all types of alcoholic beverages, how many times during the past 30 days did you have 4 (females)/ 5 (males) or more drinks on an occasion?

    □ Number of drinks: _____

24. How often do you consume any kind of alcohol product, including beer, wine or hard liquor?

    □ Every Day
    □ Some Days
    □ Not at all
    □ Don't know/not sure
    □ Prefer not to say

25. In the past year, have you or a member of your household intentionally misused any form of prescription drugs (e.g. used without a prescription, used more than prescribed, used more often than prescribed, or used for any reason other than a doctor's instructions)?

    □ Yes
    □ No
    □ Don't know/not sure
    □ Prefer not to say

26. To what degree has your life been negatively affected by YOUR OWN or SOMEONE ELSE's substance abuse issues, including alcohol, prescription, and other drugs? Would you say:

    □ A Great Deal
    □ Somewhat
    □ A Little
    □ Not at All
    □ Don't know/Not sure
    □ Prefer not to say

APPENDIX 5 | DETAILED PRIMARY DATA FINDINGS

Focus Groups

Key findings from the focus groups are summarized below.

Focus Groups Summary

As part of the 2024 CHNA process, Carteret County hosted four focus groups in order to better understand the issues impacting residents and solutions they feel would help people live healthier lives. Across the four focus groups, five major themes emerged. Firstly, participants noted built environment as a challenge to healthy living, including lack of sidewalks impacting safety and walkability, lack of high-speed internet across the county, and need for free/low-cost recreation opportunities for young people. Additionally, the participants focused on food access and security and how the cost of healthy foods, scarcity of grocery stores in some areas of the county, and general lack of time to cook healthy foods negatively impacted overall health. The participants noted healthcare access and quality was a challenge in the county. Specifically, they said there was stigma around seeking help, high cost of care, insurance challenges, lack of dental and mental health services, and challenges with language barriers such as lack of translators/interpreters for LEP patients. Mental health was another concern among each focus group, noting the high prevalence of anxiety, stress, depression, and social isolation among community members. Lastly, transportation and transit was a common barrier to care identified by all four focus groups. There are limited public transportation options in the county and existing options are cost prohibitive.

Focus Group 1 Unique Insights: Older Adults

The first focus group was held at Leon Mann Jr. Enrichment Center. Ten of the twelve participants identified as women and eleven identified as white. All were over the age of 50. In addition to the aforementioned themes, this focus group identified three additional health or social/environmental barriers to healthy living in Carteret County. Community safety was a major concern in this group, specifically traffic safety. They agreed that infrastructure in the county has not kept up with population growth and has led to motor vehicle accidents and pedestrian injuries. This group also aligned on a need for additional education among seniors on topics such as avoiding internet scams and fraud. Lastly, this group identified some physical health challenges such as obesity, heart disease, diabetes, and macular degeneration.

When asked what they would like to see local health leaders do to address their concerns, the group suggested improving access to primary care and health education, offer more holistic markets and workshops out in the community, and expand the menu of health-focused activities at the senior center.

Focus Group 2 Unique Insights: Students

The second focus group conducted in Carteret County was hosted by the Carteret County Community College and consisted of 11 students. Ten of these students identified as women and ranged in age from 18 to 39. Over half of this group identified as a race other than white. Their top concerns were education, employment and income, physical health, and substance use. Specifically, they were concerned with young people not receiving adequate education about physical and sexual health. Additionally, they noted the cost of living is rising faster than income or benefits and it is challenging to find high paying work close to home. Some physical health concerns in this group were inactivity, anemia, diabetes, congestive heart failure, high blood pressure, and cancer. Related to inactivity, the students noted that many young people turn to drugs and alcohol because there is a lack of activities for them to participate in within the county.

When asked what they think local health leaders should do to address these concerns and improve the health and well-being of county residents, the students aligned on a need to better advertise available programs and services and expand mental health substance use services for young people. Additionally, they suggested implementing free support groups for specific populations such as survivors of domestic abuse or veterans.

Focus Group 3 Unique Insights: Unhoused Population

The third focus group conducted by Carteret County was held at Carteret County Health Department and consisted of seven men who were unhoused. These men ranged in age from 40 to mid-60s and mostly identified as white. The men in this group offered a unique perspective into the lives and challenges of the unhoused population in Carteret County. The main health and social/environmental barriers to health they faced included community safety, environmental quality, health equity, substance use, and tobacco use. These men aligned on the perception that shelters and encampments can be dangerous and that there is a lack of available sanitary resources such as public trashcans and clean water for drinking and bathing. Additionally, they noted that stigma against unhoused persons contributed to feeling the need to isolate themselves from the community. Further, they noted that substance and tobacco use was highly prevalent in their community, particularly as a self-medication technique to cope with trauma and the challenges of being unhoused, and these substances were contributing to poor physical health outcomes such as cancer.

When asked what they would like local leaders to do to improve the health of their community, the participants all said there needs to be more public resources such as restrooms, clean water sources, electricity sources, and trash disposal. Additionally, the men agreed that there needs to be a less adversarial relationship with law enforcement. Lastly, this focus group suggested a need to address transportation issues and food deserts.

Focus Group 4 Unique Insights: Healthcare Workers

The fourth and final focus group conducted in Carteret County was held at Carteret Health. This group consisted of 12 healthcare workers, ten of whom were women and about half of which identified as white. They ranged in age from approximately 30 to mid-70 years of age. This group identified several health and social/environmental barriers to health in Carteret County. One issue identified was a lack of free or low-cost places for young people to gather outside of school hours and to learn life skills. The group reported this lack of youth space contributed to the high use of substances among young people in the community. The group also noted that there is a lack of health literacy (i.e., lack of understanding the healthcare and insurance systems) in the community and a lack of interpreter services for LEP patients. The healthcare workers in this focus group noted the prevalence of several physical health issues such as diabetes and hypertension, noting specifically that these chronic conditions disproportionately impact unhoused and Hispanic populations.

The healthcare workers had several suggestions for local health leaders working to improve health and well-being in the county. First, they suggested collaborating with local businesses that could provide funding for new programs and services. The group also suggested more training for language interpreters and hiring more bilingual staff in healthcare settings to address the language barriers many patients face. Lastly, the group recognized a need for high level collaboration on making housing more affordable.

Community Member Web Survey

Charts detailing key findings from the Community Member Survey are displayed below:

Topic: Additional Demographic Information

Figure A5.1: What is the highest grade or year of school you completed?

(N=460)

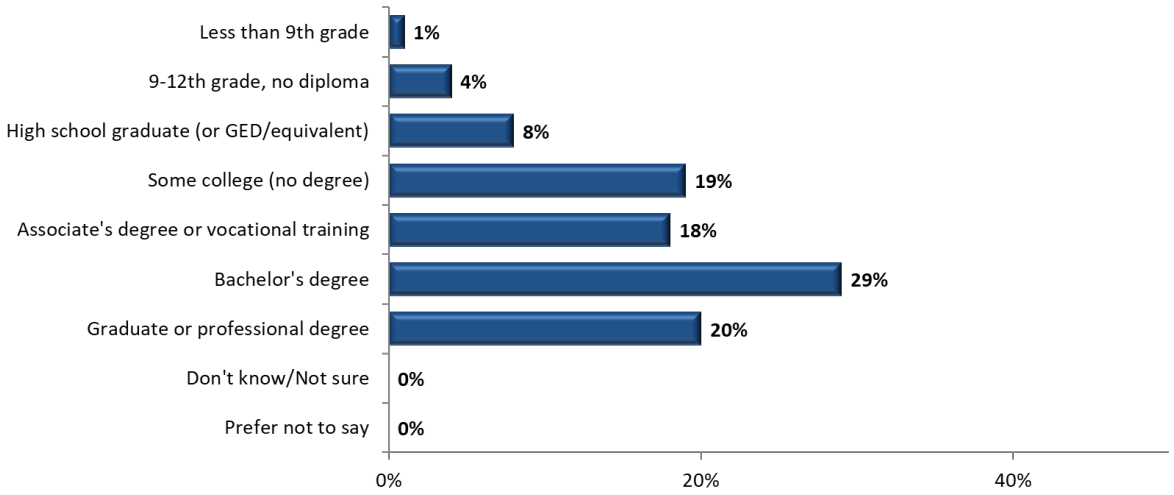


Figure A5.2: Which language is most often spoken in your home? (choose one)

(N=461)

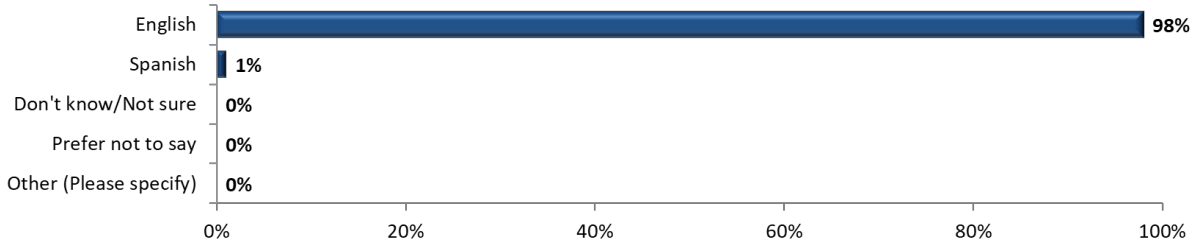


Figure A5.3: For employment, are you currently… (select all that apply.)

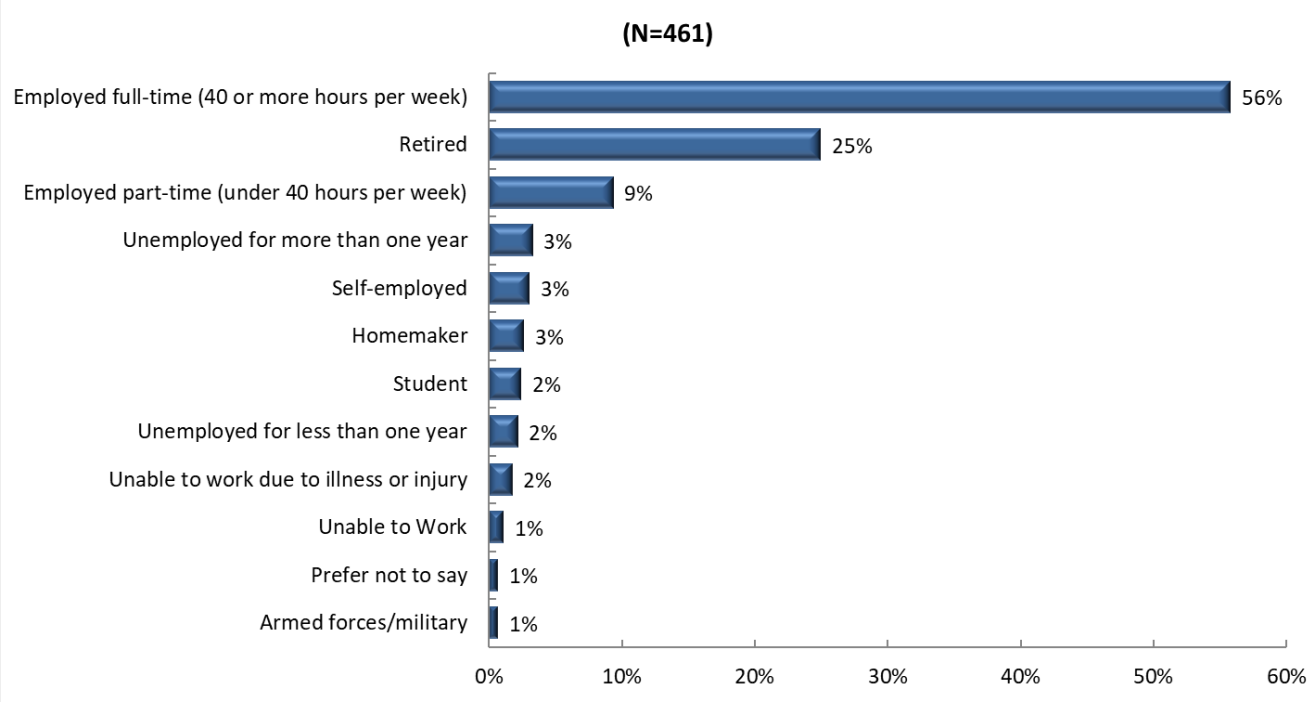
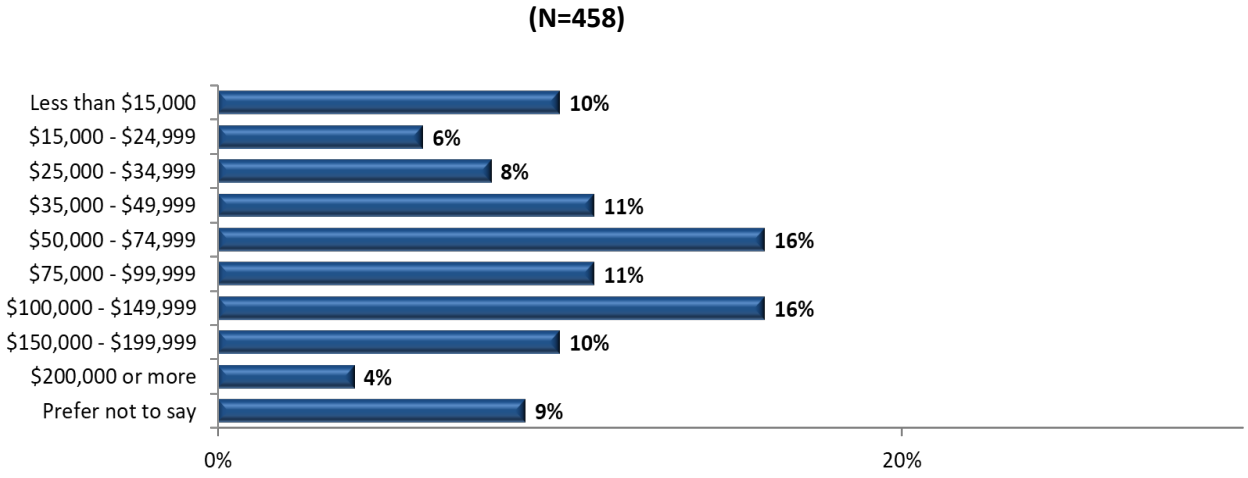


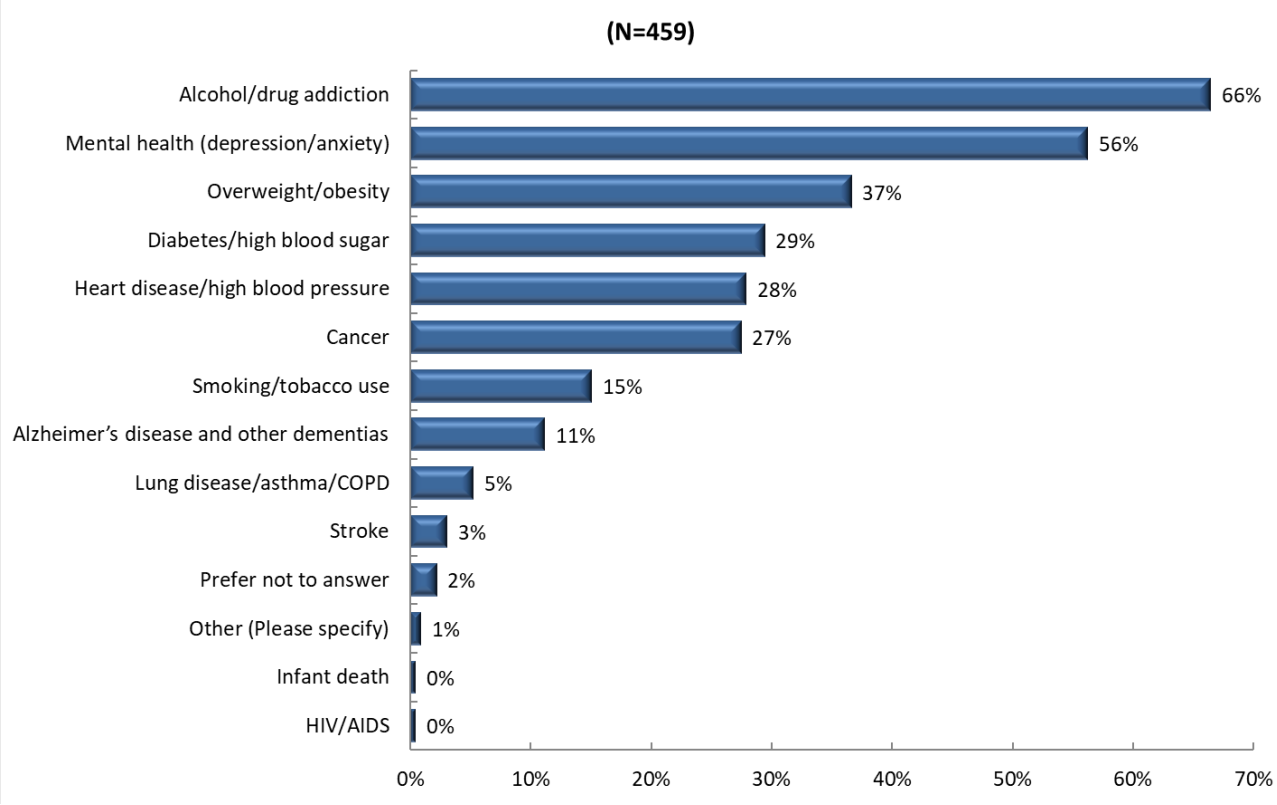
Figure A5.4: Which category best describes your yearly household income before taxes?

Respondents were asked to include all income received from employment, social security, support from children or other family, welfare, aid to families with dependent children (AFDC), bank interest, retirement accounts, rental property, investments, etc.



Topic: Health Conditions, Barriers to Care, and Social Determinants of Health

Figure A5.5: What are the three most important health problems that affect the health of your community? Please select up to three.



Other (please specify):

- "Not enough housing I/DD adults"
- "Rheumatoid Arthritis"
- "Kid Needs Dib"
- "Miscarriages"

Figure A5.6: What are the three most important health problems that affect the health of your community? Please select up to three. (by age)

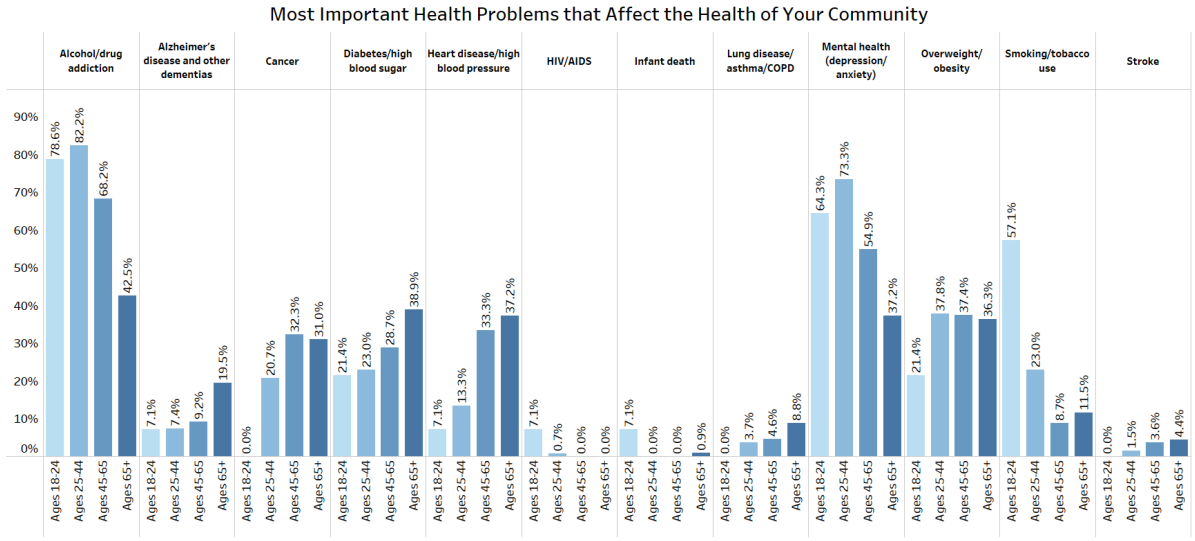


Figure A5.7: What are the three most important health problems that affect the health of your community? Please select up to three. (by gender)

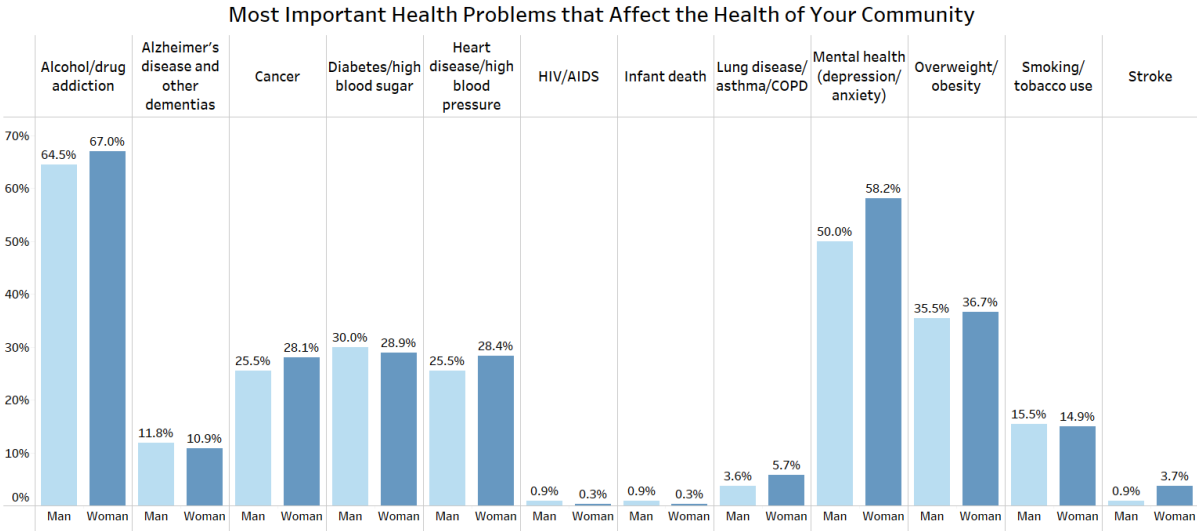


Figure A5.8: What are the three most important health problems that affect the health of your community? Please select up to three. (by race)

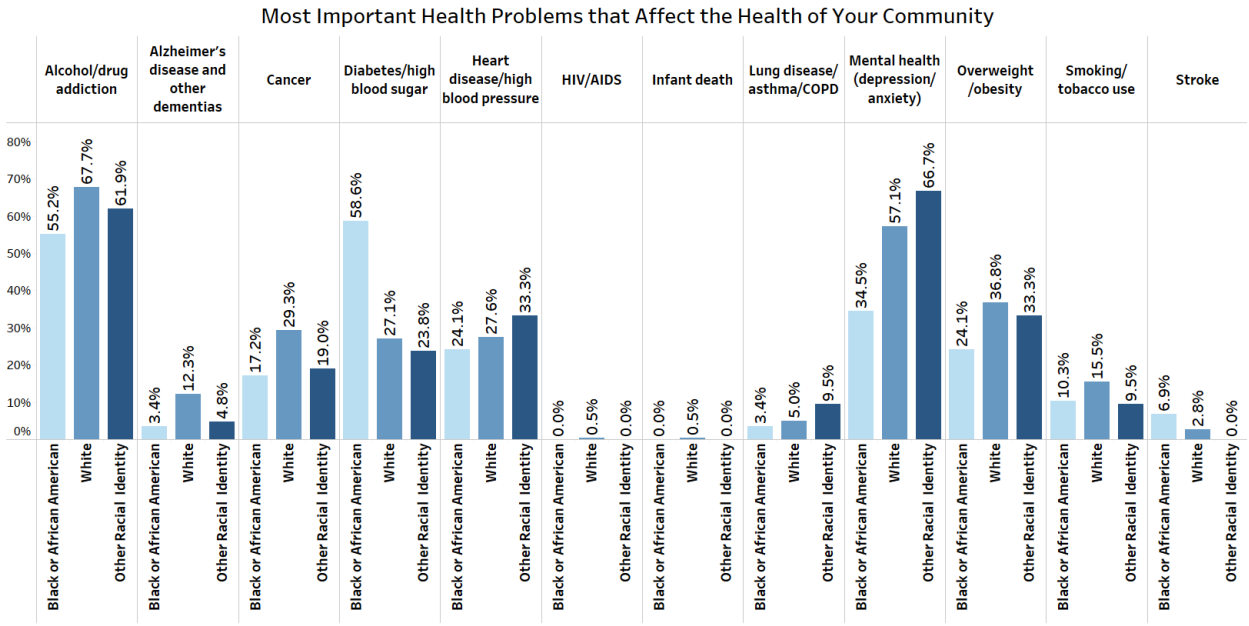


Figure A5.9: What are the three most important health problems that affect the health of your community? Please select up to three. (by ethnicity)

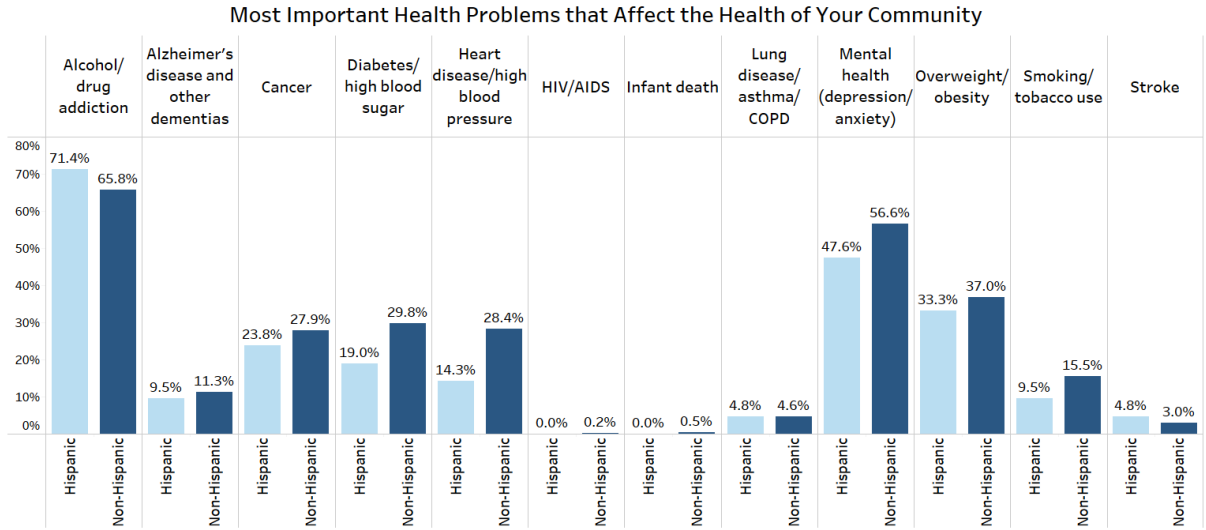
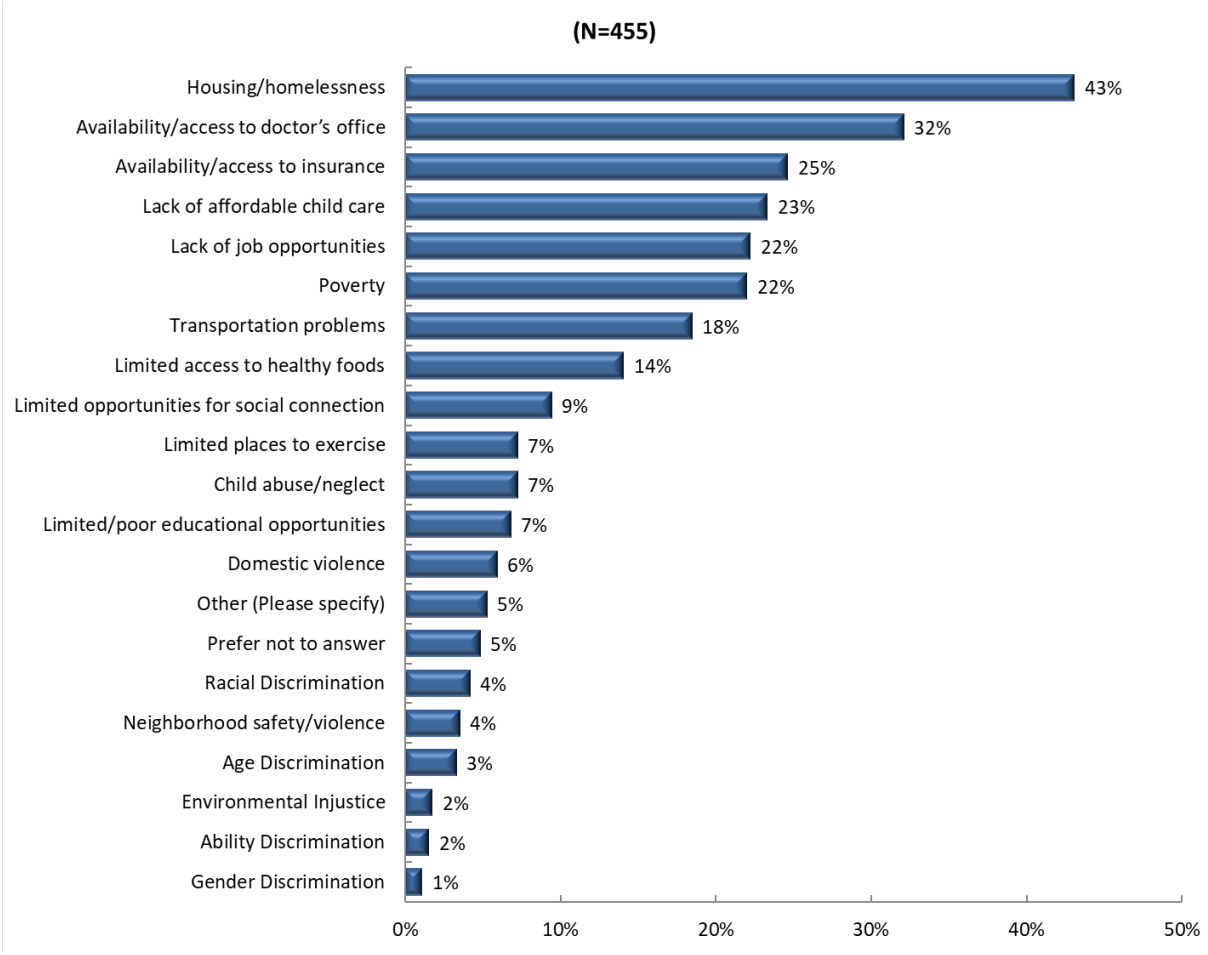


Figure A5.10: What are the three most important social or environmental problems that affect the health of your community? Please select up to three.



Other (Please Specify):

- "Vacation homes"
- "Affordable and attainable housing"
- "Cost of receiving medical care"
- "DEI and "Environmental justice, absolutely ridiculous waste of time, money and energy."
- "Drug Dealers"
- "Growth without good planning for effects on community and environment"
- "I truly don't think we have any of these problems in my county on a large scale. I cannot identify any of these as being a serious problem here."
- "Lack of affordable housing and lack of access to mental healthcare"
- "Lack of inpatient and outpatient Veteran and general mental health services including alcohol and addiction programs"
- "Lack of Knowledge of resources available"

- "Lack of motivation and affordable health care"
- "Meeting place refused"
- "Mental Health"
- "Mental health treatment availability especially for children"
- "Need bike path connectivity"
- "Parents not wanting to be parents"
- "re-entry/ jail diversia"
- "Sea level rise, loss of wetlands, overdevelopment"
- "shelters"
- "Some people do not care to take care of themselves"

Figure A5.11: What are the three most important social or environmental problems that affect the health of your community? Please select up to three. (by age)

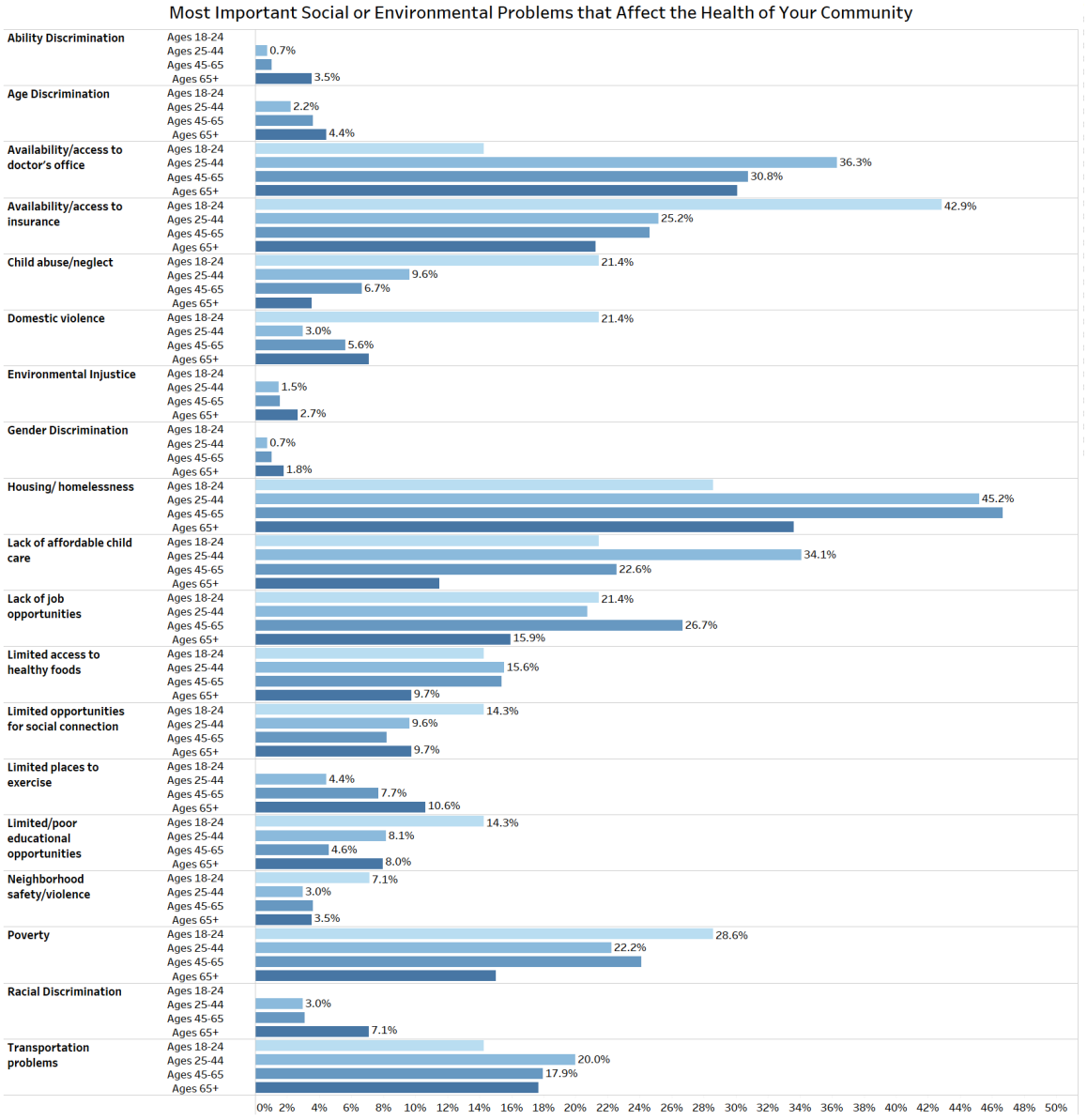


Figure A5.12: What are the three most important social or environmental problems that affect the health of your community? Please select up to three. (by gender)

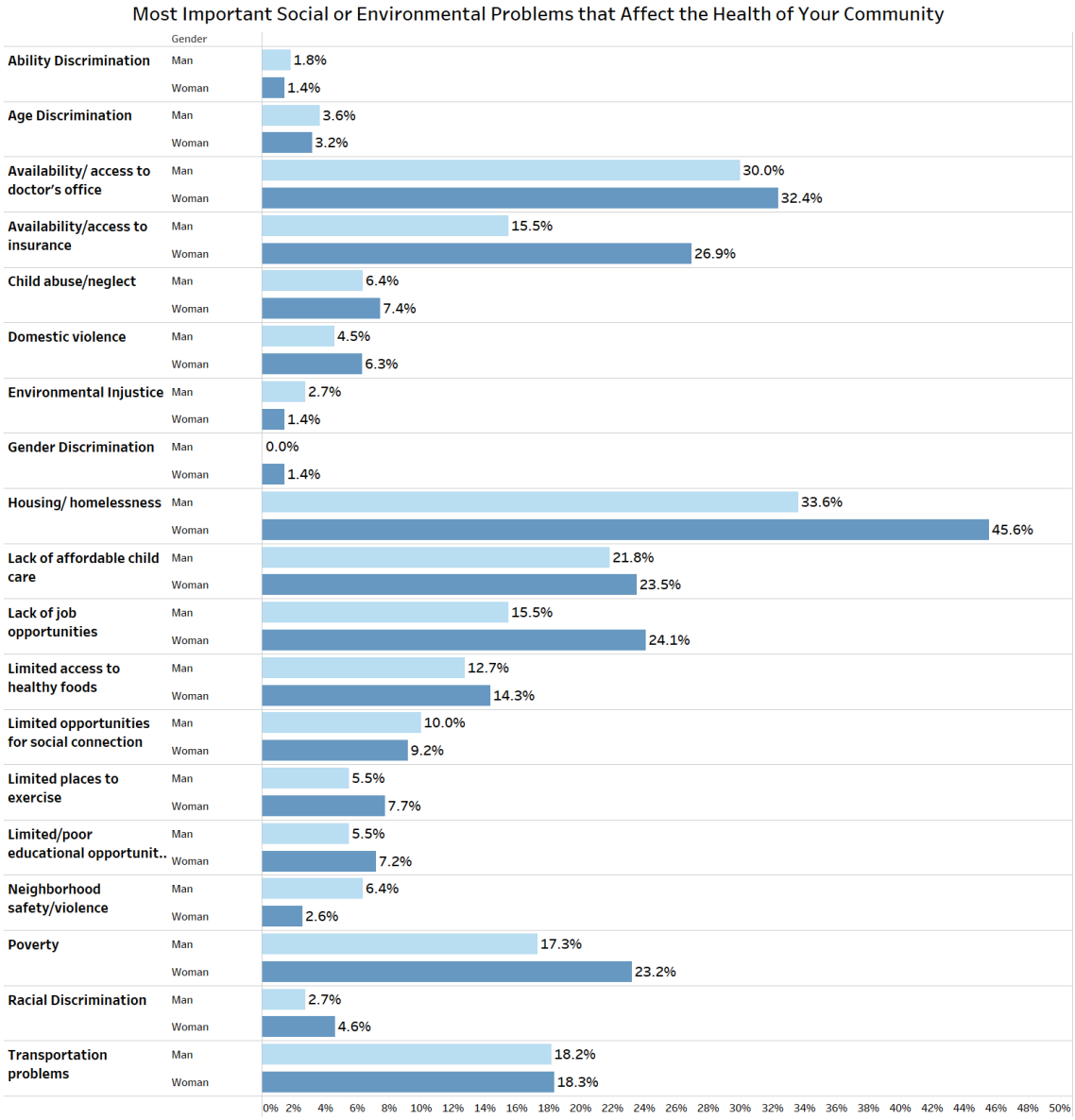


Figure A5.13: What are the three most important social or environmental problems that affect the health of your community? Please select up to three. (by race)

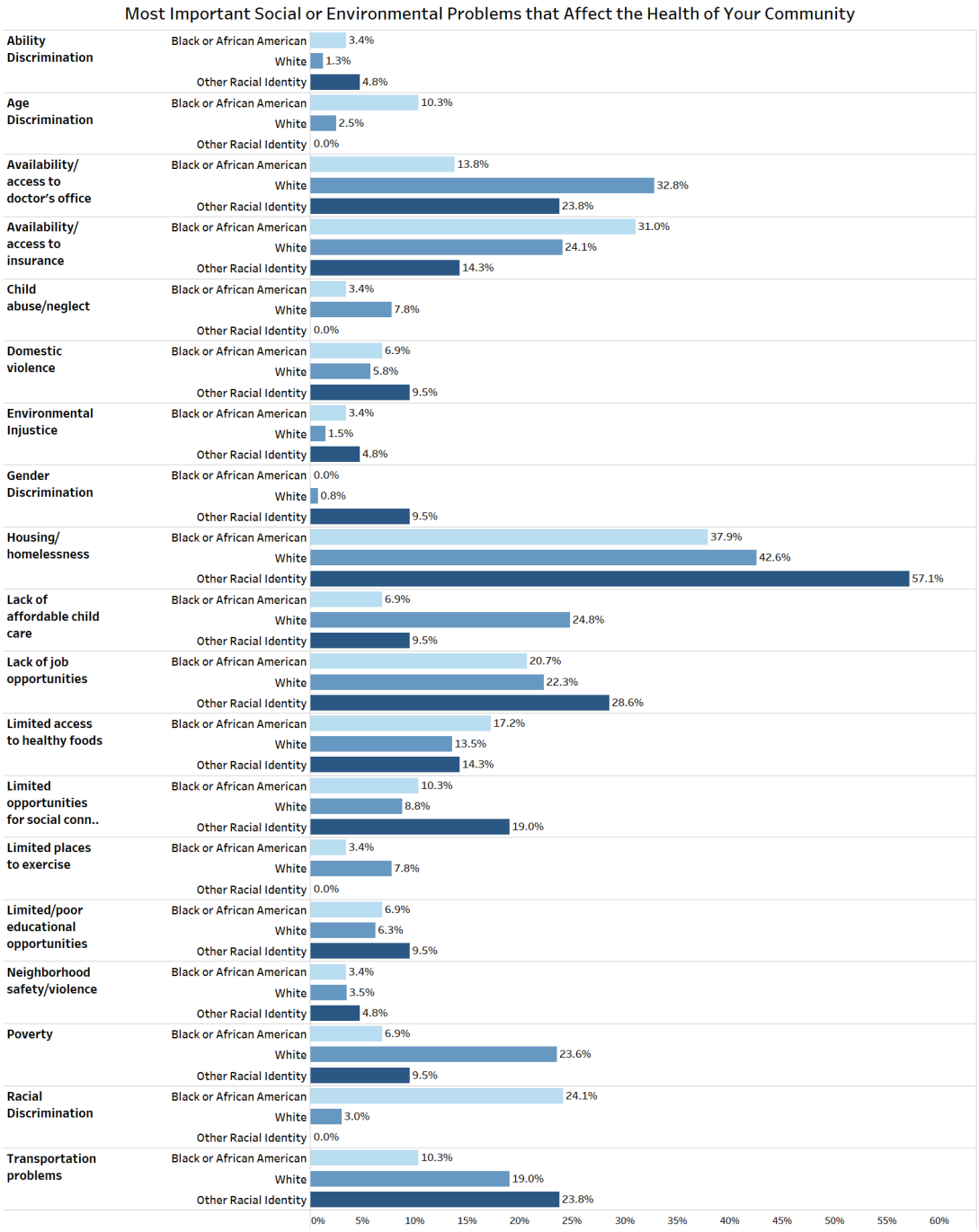


Figure A5.14: What are the three most important social or environmental problems that affect the health of your community? Please select up to three. (by ethnicity)

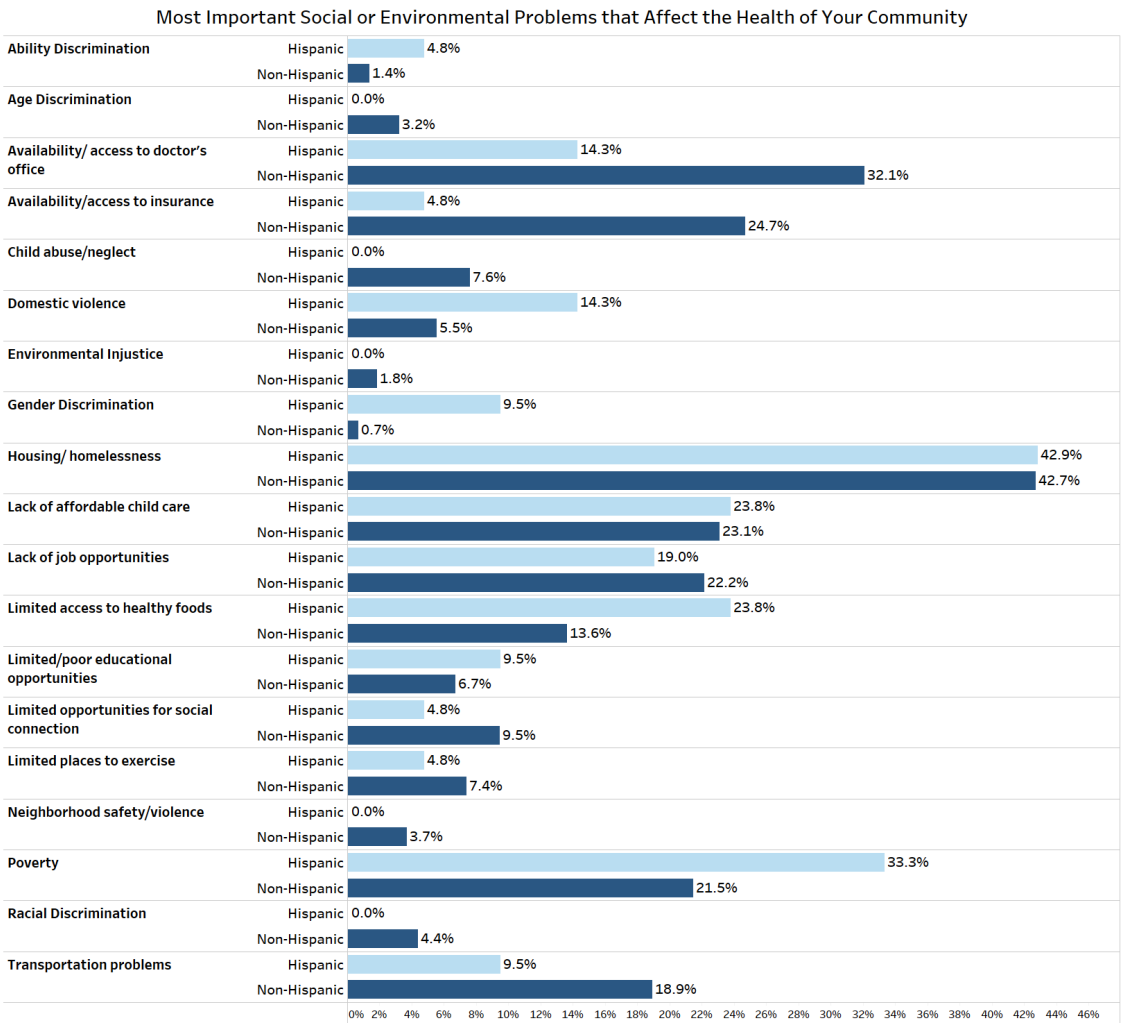
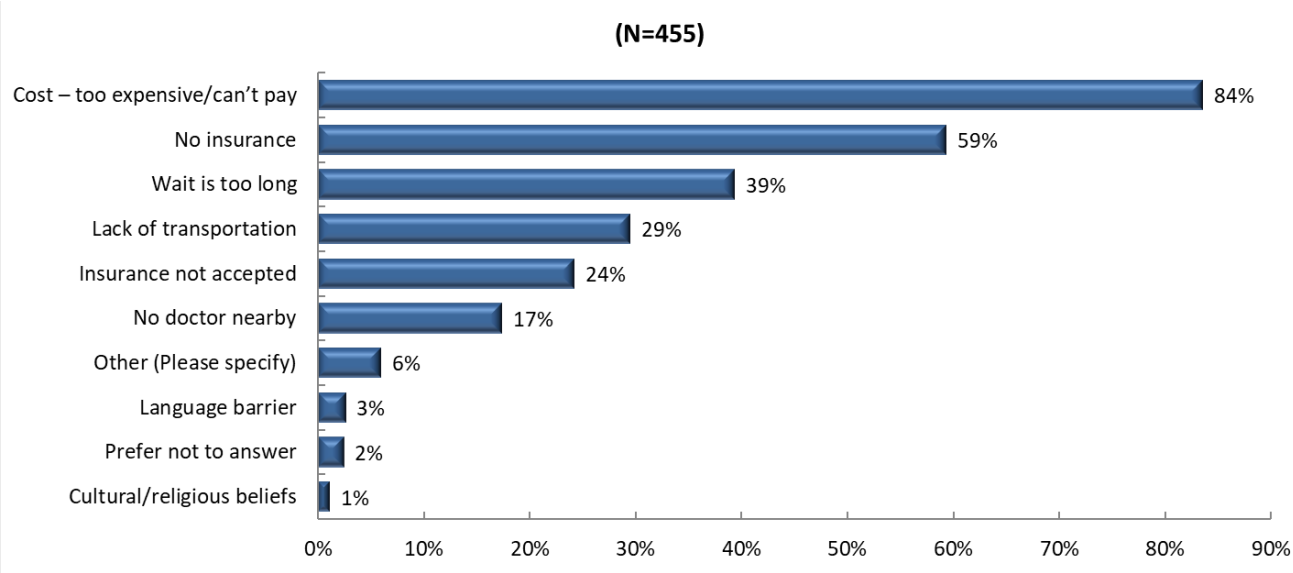

Most Important Social or Environmental Problems that Affect the Health of Your Community
Ability Discrimination
Hispanic 4.8%
Non-Hispanic 1.4%
Age Discrimination
Hispanic 0.0%
Non-Hispanic 3.2%
Availability/ access to doctor's office
Hispanic 14.3%
Non-Hispanic 32.1%
Availability/access to insurance
Hispanic 4.8%
Non-Hispanic 24.7%
Child abuse/neglect
Hispanic 0.0%
Non-Hispanic 7.6%
Domestic violence
Hispanic 14.3%
Non-Hispanic 5.5%
Environmental Injustice
Hispanic 0.0%
Non-Hispanic 1.8%
Gender Discrimination
Hispanic 9.5%
Non-Hispanic 0.7%
Housing/ homelessness
Hispanic 42.9%
Non-Hispanic 42.7%
Lack of affordable child care
Hispanic 23.8%
Non-Hispanic 23.1%
Lack of job opportunities
Hispanic 19.0%
Non-Hispanic 22.2%
Limited access to healthy foods
Hispanic 23.8%
Non-Hispanic 13.6%
Limited/poor educational opportunities
Hispanic 9.5%
Non-Hispanic 6.7%
Limited opportunities for social connection
Hispanic 4.8%
Non-Hispanic 9.5%
Limited places to exercise
Hispanic 4.8%
Non-Hispanic 7.4%
Neighborhood safety/violence
Hispanic 0.0%
Non-Hispanic 3.7%
Poverty
Hispanic 33.3%
Non-Hispanic 21.5%
Racial Discrimination
Hispanic 0.0%
Non-Hispanic 4.4%
Transportation problems
Hispanic 9.5%
Non-Hispanic 18.9%
0% 2% 4% 6% 8% 10% 12% 14% 16% 18% 20% 22% 24% 26% 28% 30% 32% 34% 36% 38% 40% 42% 44% 46%

Figure A5.15: What are the three most important reasons people in your community do not get health care when they need it? Please select up to three.



Other (please specify):

- "Criminal record"
- "Do not take off work to seek care.
- "docs push too many meds/pharma dispensing"
- "Education"
- "Knowledge deficit"
- "lack of education"
- "Lack of trust in healthcare"
- "Lack of trust. "
- "limited number of health care providers"
- "limited specialty practitioners"
- "Limited understanding of preventative care"
- "Mental health care unavailable"
- "No desire to change"
- "no one is going to tell them what they can and can't do"
- "No primary care doctors accepting new patients"
- "Not enough mental health providers"
- "Our local hospital is not so trustworthy and we have to travel 40 miles or more. Also, my husband is insured by the VA and our hospital will not work with the VA. If there is ever an emergency, we can't call an ambulance because they will only take us to the one hospital we cannot trust."
- "Perception that the hospital is the better option"
- "Poor health knowledge, unhealthy habits"
- "poor healthcare in county"
- "Poor quality of care from local providers"
- "They do not care until it is too late"
- "They don't get it because they don't want it. But then blame socialite for not having got."
- "Unknowledgeable medical professionals/subpar"

Figure A5.16: What are the three most important reasons people in your community do not get health care when they need it? Please select up to three. (by age)

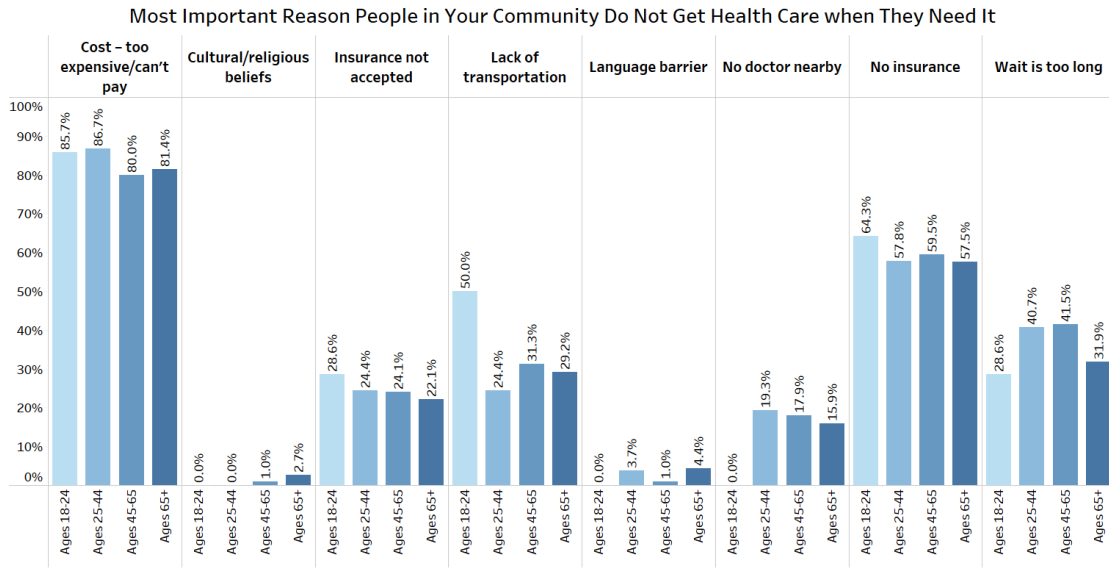


Figure A5.17: What are the three most important reasons people in your community do not get health care when they need it? Please select up to three. (by gender)

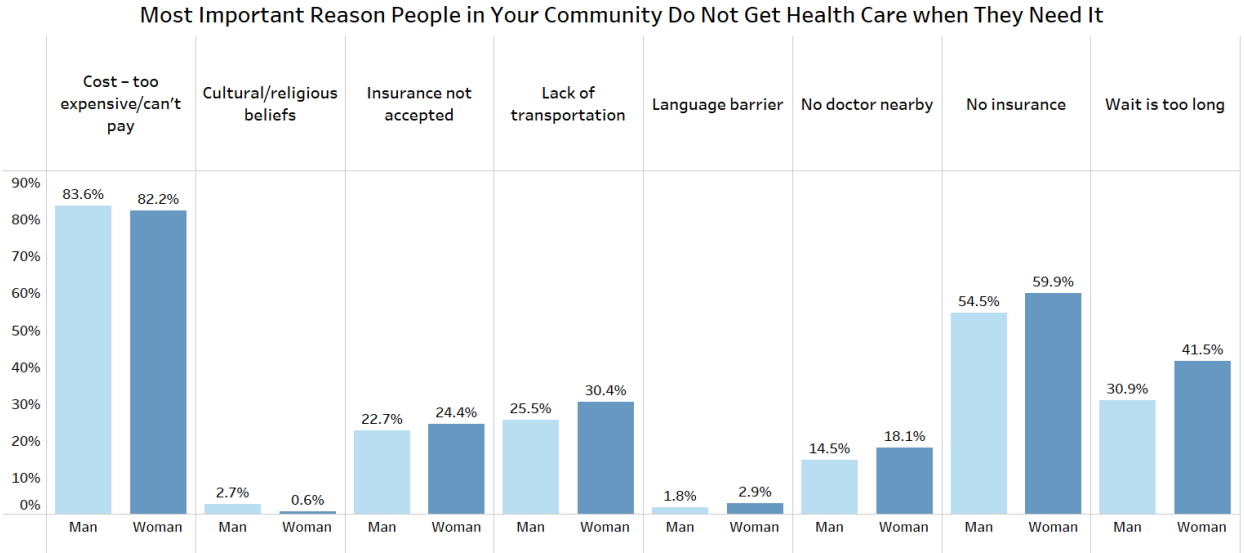


Figure A5.18: What are the three most important reasons people in your community do not get health care when they need it? Please select up to three. (by race)

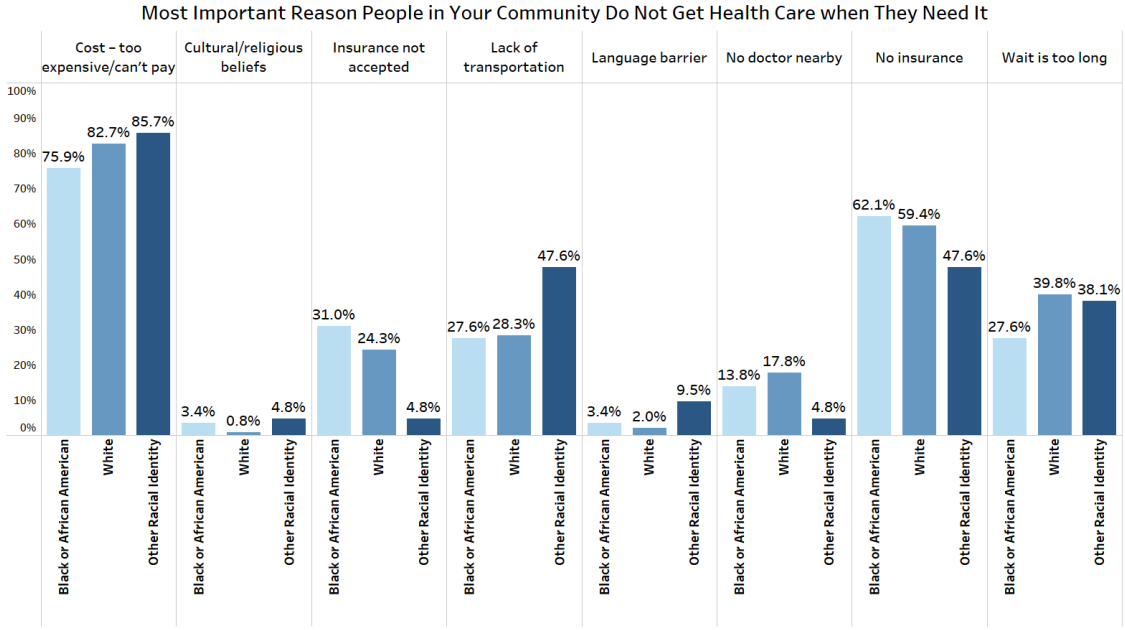
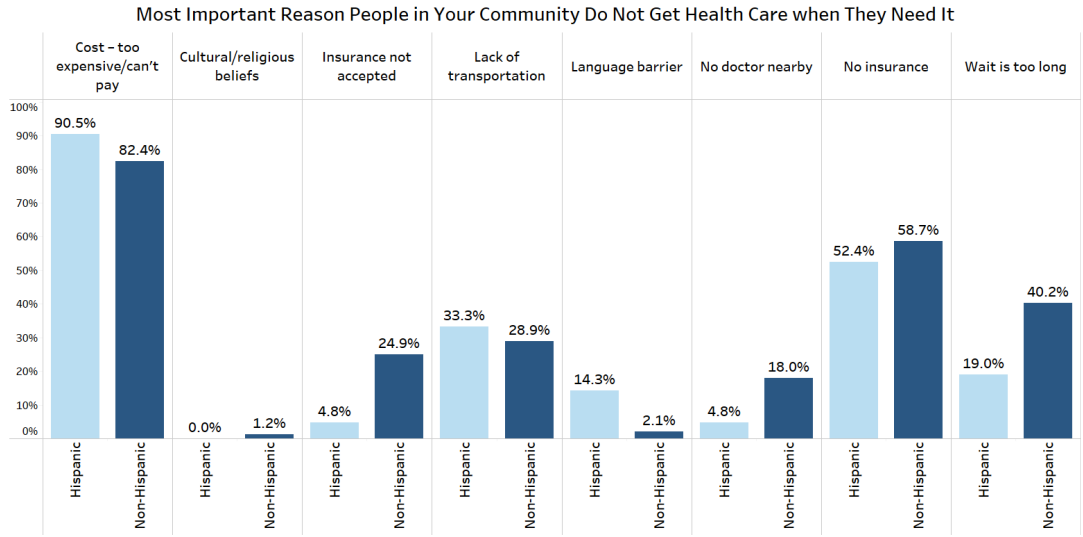


Figure A5.19: What are the three most important reasons people in your community do not get health care when they need it? Please select up to three. (by ethnicity)



Topic: Access to Care

Figure A5.20: DURING THE PAST 12 MONTHS, were you told by a health care provider or doctor's office that they did not accept your health care coverage?

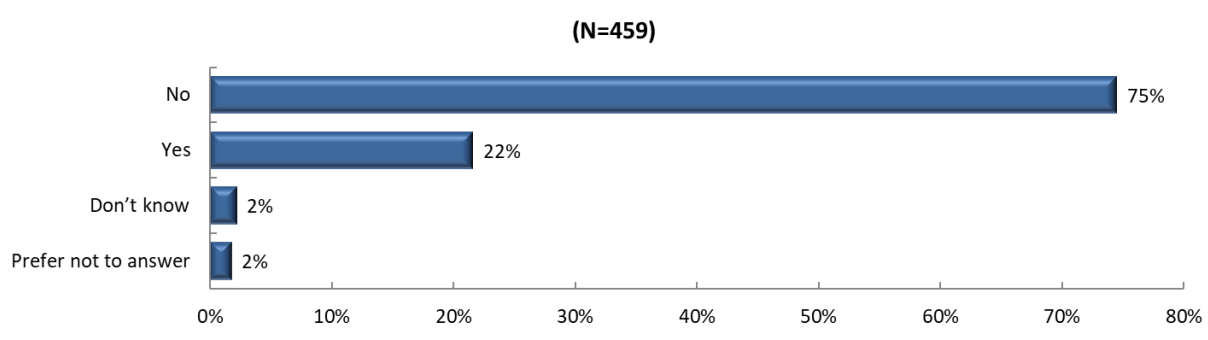
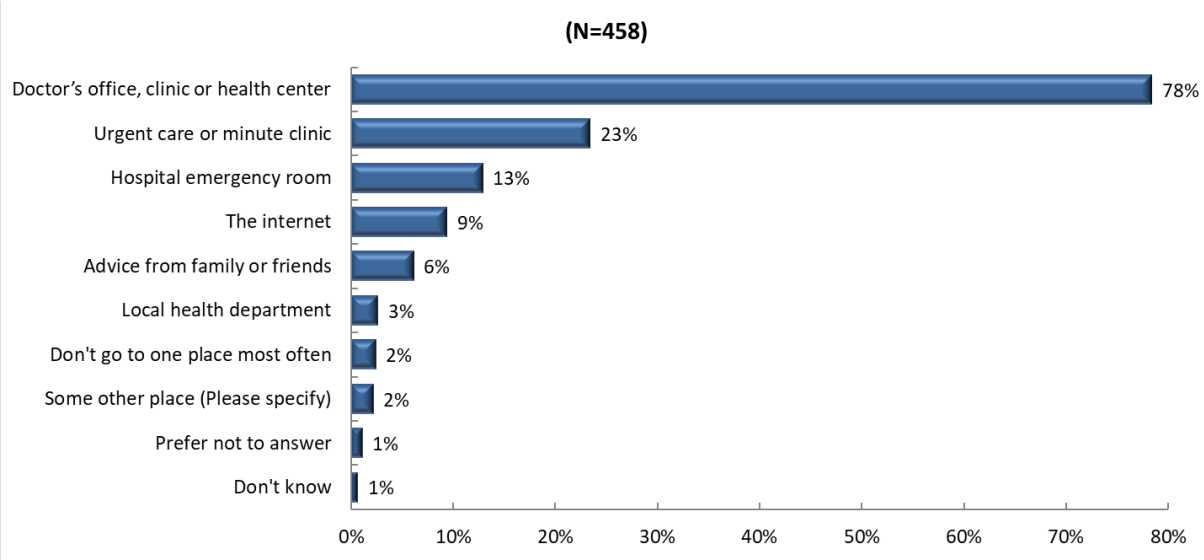


Figure A5.21: Where do you USUALLY go when you are sick or need advice about your health?



Other (please specify):

- "I can't afford insurance and therefore can't afford to get dental and regular health care"
- "Naval Clinic"
- "Doctor online" "Teledoc" or "Telehealth" (3x)
- "The Base"
- "VA" (2x)

Figure A5.22: There are many reasons people delay getting medical care. Have you delayed getting care for any of the following reasons in the PAST 12 MONTHS?

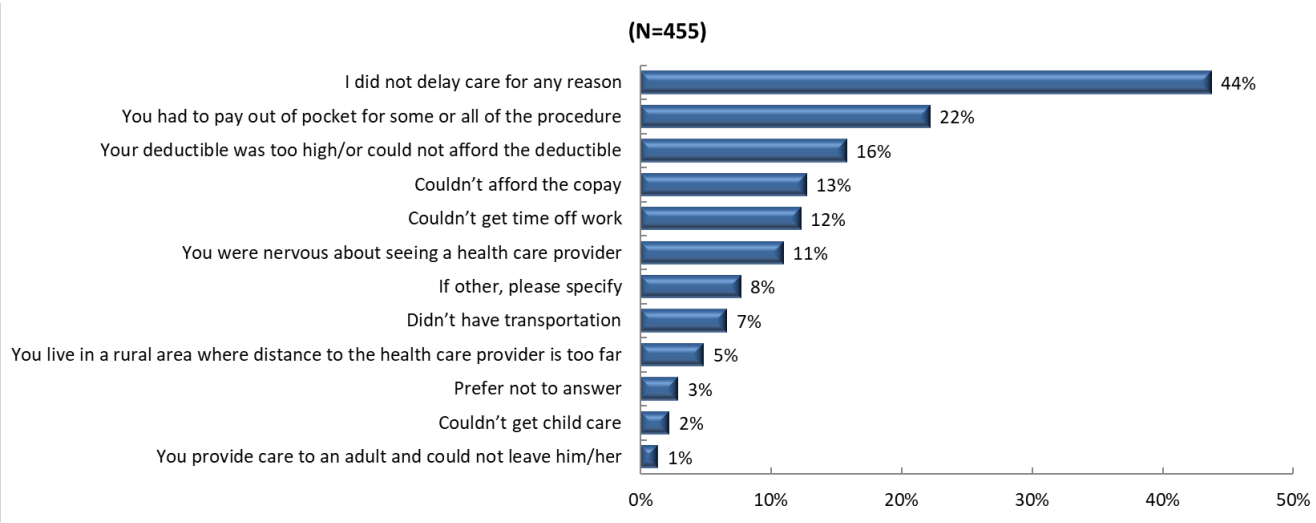


Figure A5.23: DURING THE PAST 12 MONTHS, was there any time when you needed any of the following, but didn't get it because you couldn't afford it?

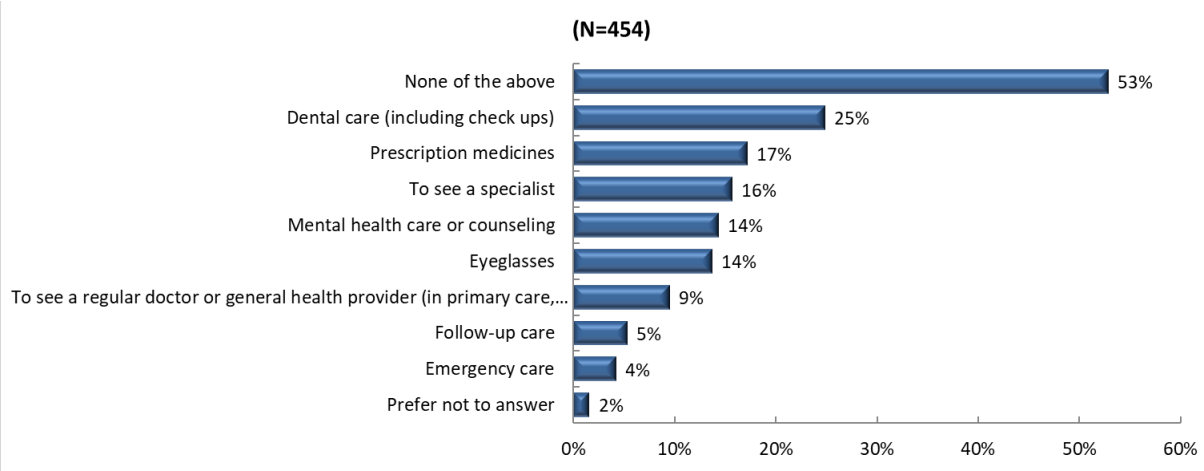


Figure A5.24: If you get sick or have an accident, how worried are you that you will be able to pay your medical bills?

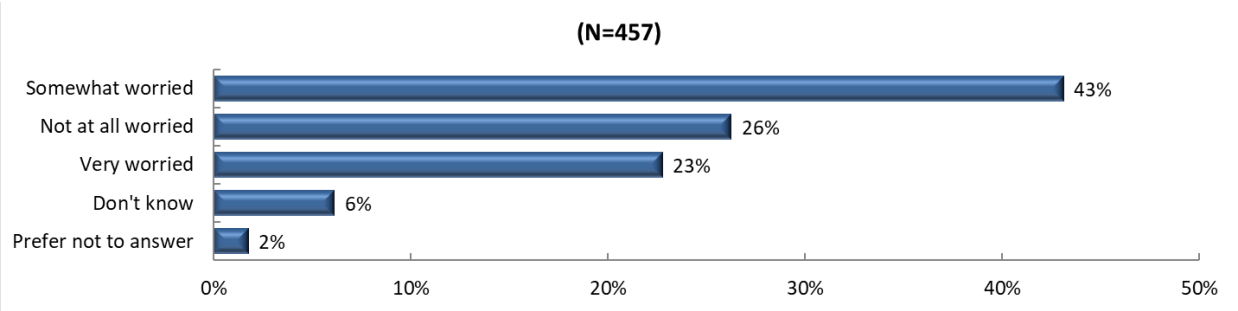
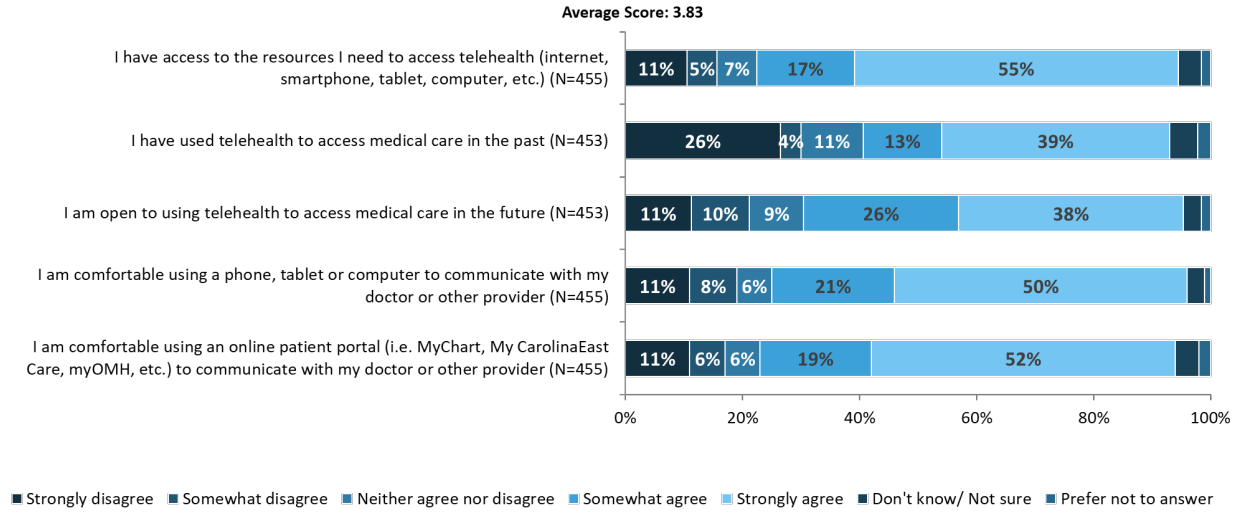


Figure A5.25: How much do you agree or disagree with the following statements about telehealth? Telehealth means connecting virtually with a medical provider using a smartphone, tablet or computer.

Rated on a scale from 1 to 5 with 1 being "strongly disagree" and 5 being "strongly agree"



Topic: Physical Health

Figure A5.26: Considering your physical health overall, would you describe your health as…

Scale from 1 to 5 with 1 being "poor" and 5 being "excellent"

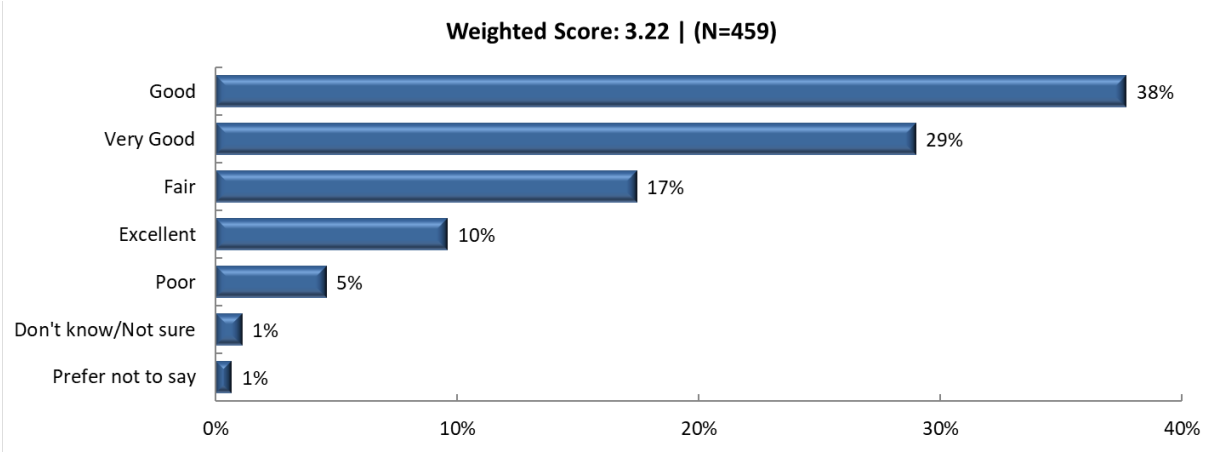


Figure A5.27: Within the past year (anytime less than one year ago), have you:

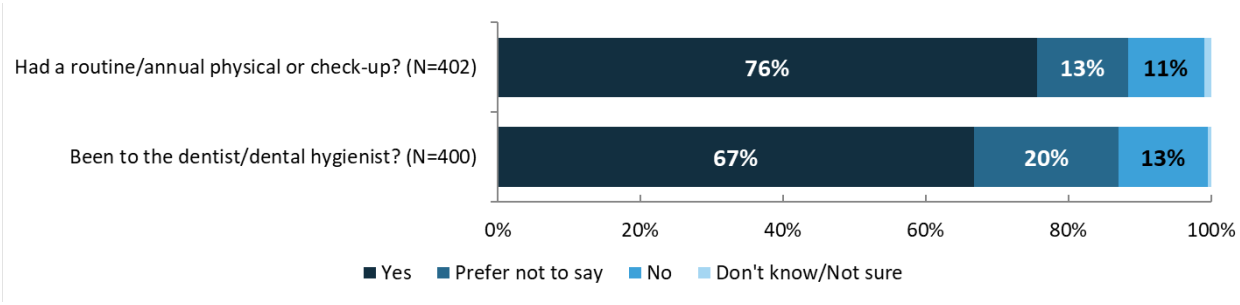
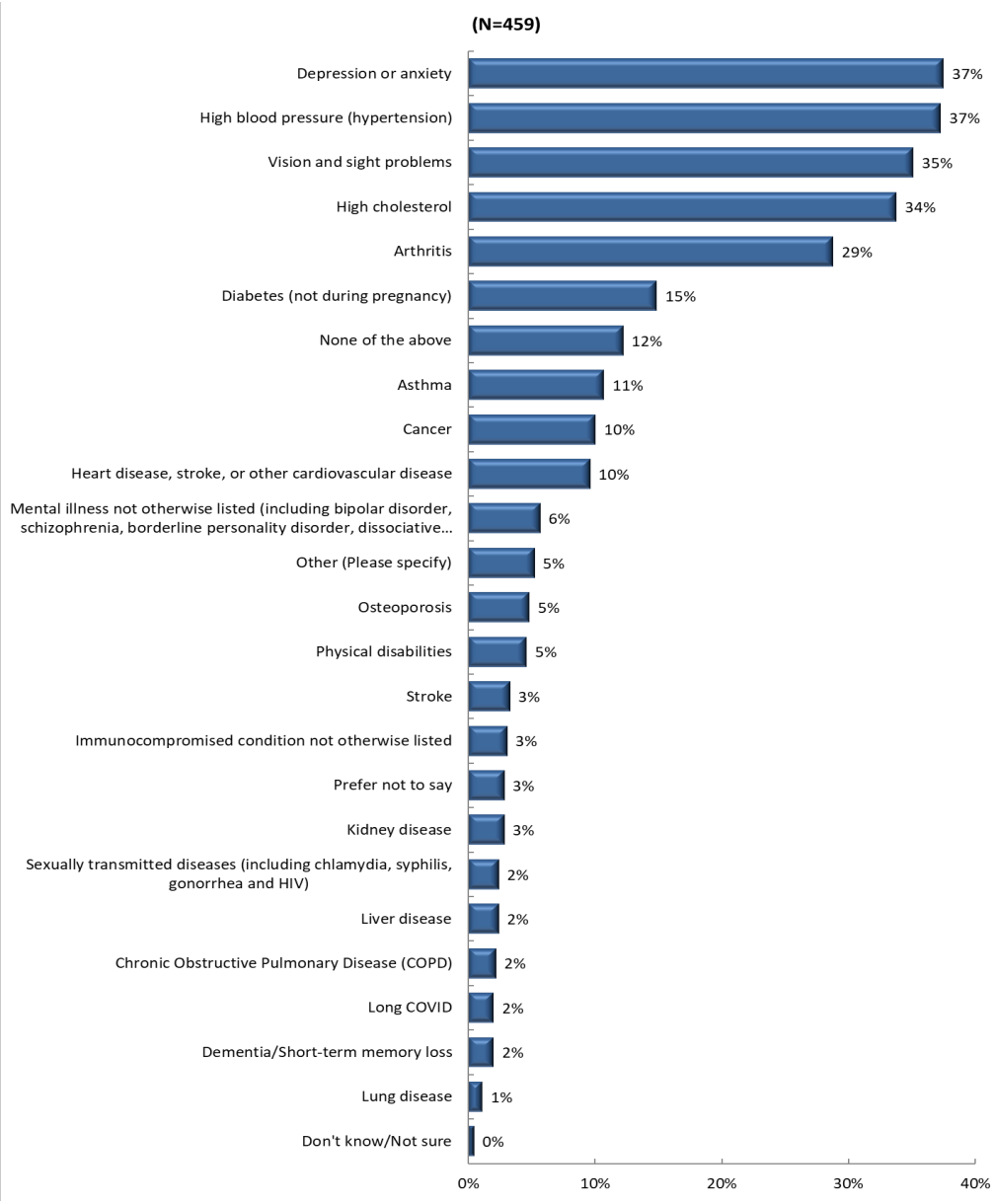


Figure A5.28: Have you ever been told by a doctor, nurse, or other health professional that you have any of the following health conditions? Select all that apply

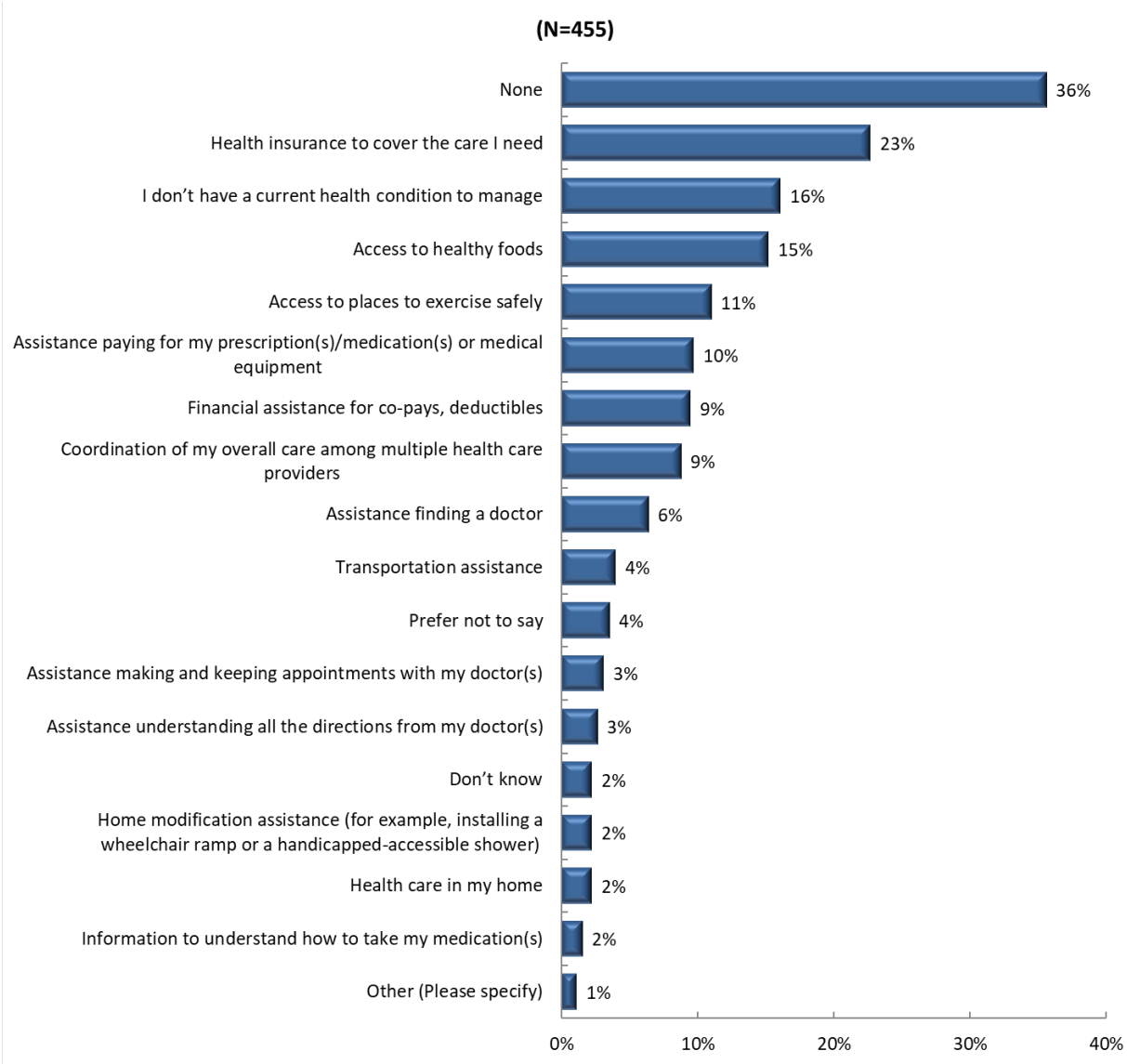


Other (please specify):

- "Anemia, Prediabetic"
- "AS"
- "Boarder Line Blood Pressure"
- "Chronic Pain"
- "Eczema
- "Epilepsy"
- "Fibromyalgia"
- "Gastro Issues"
- "Hearing Loss" (3x), "Deafness", "Hearing Impaired"
- "HPV"
- "I Have Tavor Heart Valve"

- “Kidney Stones”
- “Lyme Disease, Recurrent Mono”
- “Obesity”
- “Parkinson Disease”
- “Polycystic Ovarian Syndrome”
- “Pulmonary Fibrosis”
- “Skin Cancer - Basal Cell”
- “The Stroke Was a Mini Stroke”
- “Thyroid Issues, and Prediabetes”
- “Thyroid Issues/ Obesity”

Figure A5.29: What do you need to be able to manage your current health conditions (for example, heart conditions, high blood pressure, stroke, diabetes, asthma, cancer, COPD, congestive heart failure, arthritis, HIV, depression, anxiety, other mental health condition, etc.) to stay healthy? (Select all that apply.)



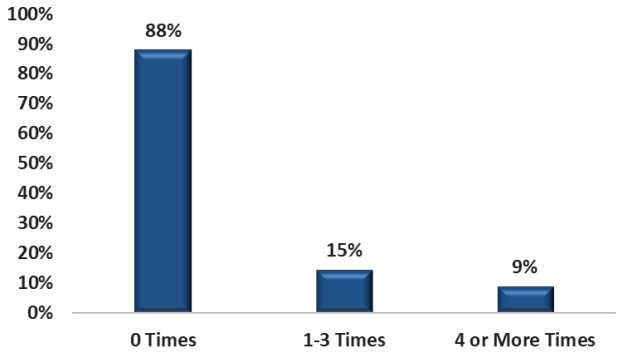
Other (please specify):

- "Better work life balance"
- "Chiropractic care and massage therapy"
- "Cleaning apartment"
- "Hearing Aids"
- "Motivation to eat better and exercise consistently"

Topic: Substance Use

Figure A5.30: Considering all types of alcoholic beverages, how many times during the past 30 days did you have 4 (females)/ 5 (males) or more drinks on an occasion?

(N=441)



Measure	Value
Mean (Standard Deviation)	1 (4)
Median	0
Mode	0
Minimum-Maximum	0-25

Figure A5.31: How often do you consume any kind of alcohol product, including beer, wine or hard liquor?

(N=456)

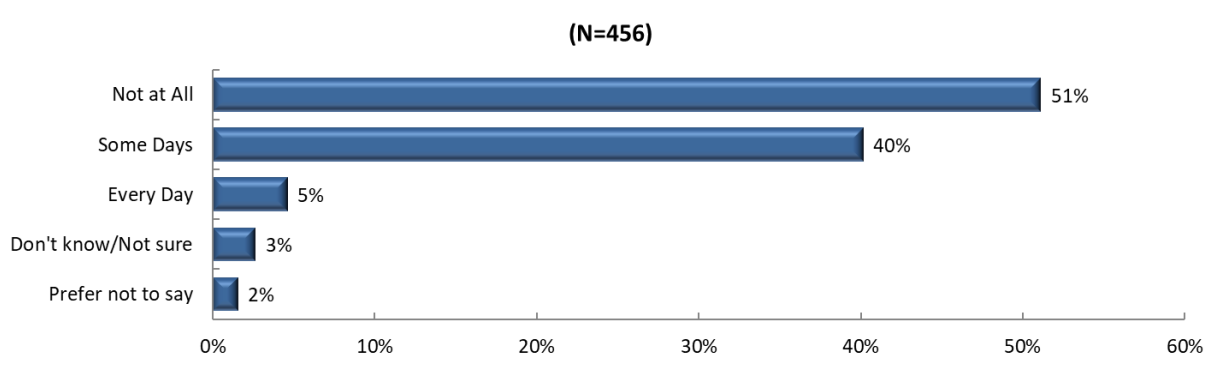


Figure A5.32: In the past year, have you or a member of your household misused any form of prescription drugs (e.g. used without a prescription, used more than prescribed, used more often than prescribed, or used for any reason other than a doctor's instructions)?

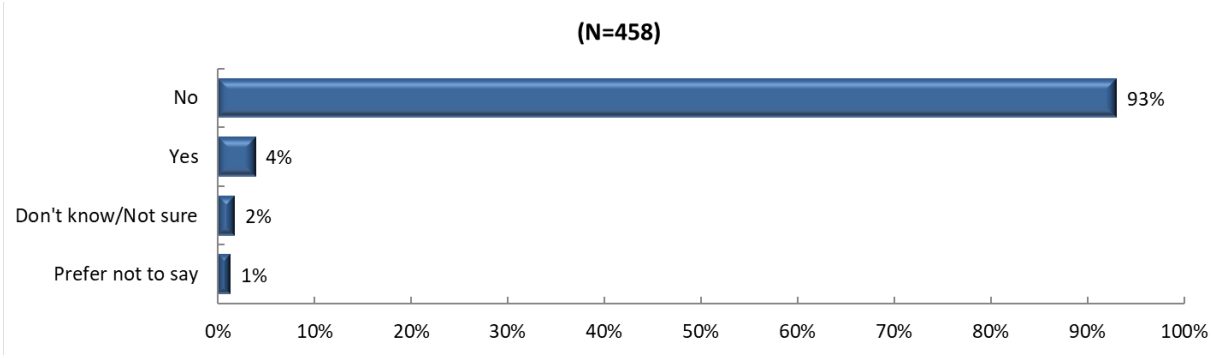
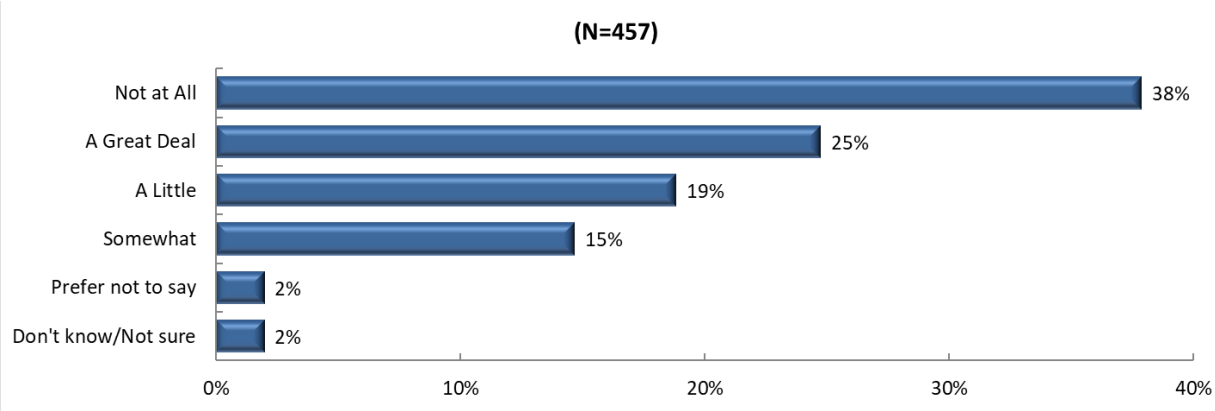


Figure A5.33: To what degree has your life been negatively affected by YOUR OWN or SOMEONE ELSE's substance abuse issues, including alcohol, prescription, and other drugs?



APPENDIX 6 | SUMMARY OF DATA FINDINGS ACROSS SOURCES

Primary and Secondary data findings are summarized in full by the table below.[42]

Priority Area	Secondary Data	Community Survey	Focus Group 1	Focus Group 2	Focus Group 3	Focus Group 4
Behavioral Health: Mental Health		✓	✓	✓	✓	✓
Behavioral Health: Substance Use		✓		✓	✓	✓
Built Environment			✓	✓	✓	✓
Community Safety			✓		✓	
Diet & Exercise						
Education			✓	✓		
Employment & Income				✓		
Environmental Quality	✓				✓	
Family, Community & Social Support						✓
Food Access & Security			✓	✓	✓	✓
Healthcare: Access & Quality	✓	✓	✓	✓	✓	✓
Health Equity & Literacy					✓	✓
Housing & Homelessness		✓				
Length of Life	✓					
Maternal & Infant Health						
Physical Health (Chronic Diseases, Cancer, Obesity)		✓	✓	✓		✓
Sexual Health						✓
Tobacco Use	✓				✓	
Transportation & Transit	✓		✓	✓	✓	✓

[42] Survey results captured here reflect major findings from the Community Health Opinion Survey questions. Red boxes indicate categories identified as high need consistently across data sources.