

Community Health Assessment (CHA)

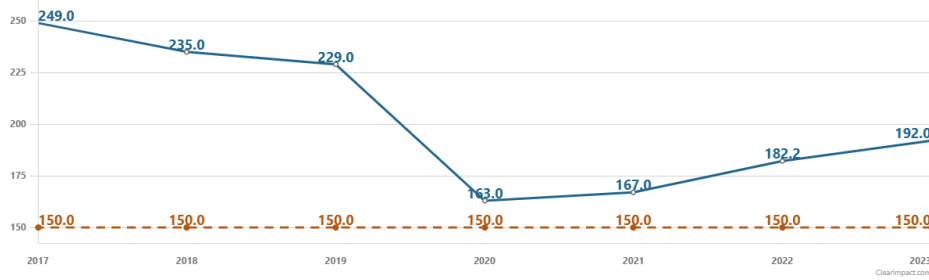
CA 2024 Community Health Assessment

Mental Health Issues (including depression, anxiety, suicidal thoughts, social isolation, loneliness)

R All people are living happy, healthy lives because Avery County has the ability to respond, withstand, and recover from adversity.

Most Recent Period	Current Actual Value	Current Trend	Baseline % Change
2023	192.0	↗ 3	-23% ↘
2022	182.2	↗ 2	-27% ↘
2021	167.0	↗ 1	-33% ↘
2020	163.0	↘ 3	-35% ↘
2019	229.0	↘ 2	-8% ↘
2018	235.0	↘ 1	-6% ↘
2017	249.0	↗ 1	0% →
2016	228.0	↘ 1	-8% ↘
2015	233.0	→ 1	-6% ↘

I NCDPH HNC2030 Incarceration Rate (Total) per 100,000 population aged 13 and older in North Carolina prisons



Story Behind the Curve

North Carolina's Incarceration Rate (TOTAL) per 100,000 population aged 13 or older decreased overall from 233.0 in 2014 to 192.0 in 2023.

Indicator Notes

Description:

Values for this measure were calculated based on data from the North Carolina Department of Adult Correction (NCDAC) and U.S. Census Bureau National Vintage Population Estimates - calculated by North Carolina Center for Health Statistics.

NCDAC is the agency responsible for corrections in the State of North Carolina. This department was formed as a cabinet level agency at the start of 2023, after it had been part of the North Carolina Department of Public Safety since 2012.

Why is this Important?

Incarceration leads to substantial negative consequences (health, social, and economic) for the imprisoned person and to their families and communities. Inequities of incarceration include disproportionate rates and harsher consequences for African American men. In addition, a large proportion of the imprisoned population is composed of individuals with mental illness (including substance misuse). [HNC2030]

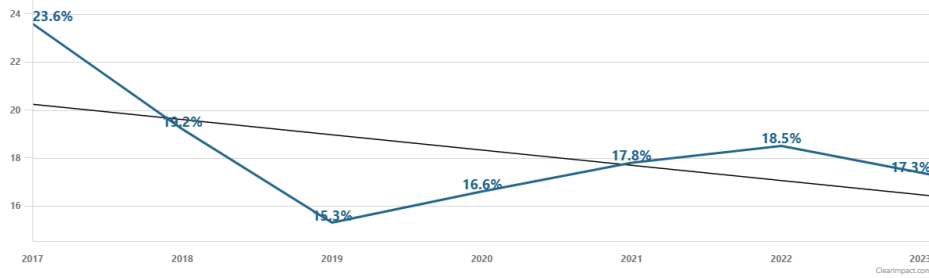
Additional Information:

The *Incarceration Rate* indicator is aligned with HNC2030.

For Further Information:

NC Department of Adult Correction <https://webapps.doc.state.nc.us/apps/asqExt/ASQ>
[HNC-REPORT-FINAL-Spread2.pdf](#)

2023	17.3%	↓ 1	-27% ↓
2022	18.5%	↑ 3	-22% ↓
2021	17.8%	↑ 2	-25% ↓
2020	16.6%	↑ 1	-30% ↓
2019	15.3%	↓ 2	-35% ↓
2018	19.2%	↓ 1	-19% ↓
2017	23.6%	→ 0	0% →



Story Behind the Curve

The National Survey of Children’s Health (NSCH) provides data on "multiple, intersecting aspects of children’s lives - including physical and mental health, access to and quality of health care, and the child’s family, neighborhood, school, and social context." [NSCH]

Two-year combined data pulled from interactive site: <https://www.childhealthdata.org/browse>

Indicator Notes

Definition:

Adverse Childhood Experiences (ACEs) are potentially traumatic events that occur in childhood.

Why is this Important?

Exposure to trauma, violence or neglect during childhood increases the future likelihood of poor physical and mental health. [CDC]

Additional Information:

The *Percent of Children with Two or More ACEs* indicator is aligned with HNC2030.

Link to References and Reports:

[HNC-REPORT-FINAL-Spread2.pdf](#)

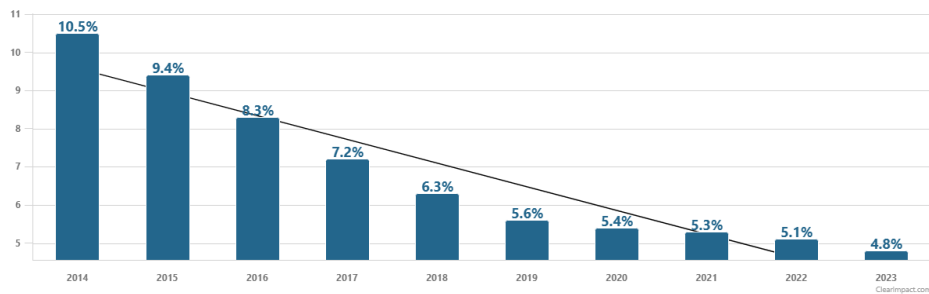
<https://www.childhealthdata.org/browse> (Interactive)

<https://www.childhealthdata.org/browse/survey/results?q=11266&r=1&r2=35> (North Carolina)

[About Child Abuse and Neglect | Child Abuse and Neglect Prevention | CDC](#)

<https://www.childhealthdata.org/learn-about-the-nsch/NSCH>

2023	4.8%	↓ 9	-54% ↓
2022	5.1%	↓ 8	-51% ↓
2021	5.3%	↓ 7	-50% ↓
2020	5.4%	↓ 6	-49% ↓
2019	5.6%	↓ 5	-47% ↓
2018	6.3%	↓ 4	-40% ↓
2017	7.2%	↓ 3	-31% ↓
2016	8.3%	↓ 2	-21% ↓
2015	9.4%	↓ 1	-10% ↓



Story Behind the Curve

The percent of North Carolina’s population aged 16 and older who are unemployed but seeking work has steadily decreased from 10.5% in 2014 to 4.8% in 2023. (Five-Year Rolling Estimate)

The disparity ratio between percent unemployed white and Black populations has not changed.

*Gender data are measured for ages 20 and older.

Indicator Notes

Definition:

The percentage of the population aged 16 years and older who are unemployed but seeking work.

Why is this Important?

Employment provides an important path toward economic security and societal engagement.

"Employment opportunities are vital to providing income and, for many, health insurance." [HNC2030]

Additional Information:

This indicator (*Unemployment (Total): Percent of Population in NC Aged 16 and Older Who Are Unemployed But Seeking Work*) is aligned with HNC 2030.

Two primary sources of unemployment data are:

1. The ACS (Table #S2301)*
2. The US Labor Department (<https://www.bls.gov/data/>)

*HNC2030 uses the ACS

State and County Level Data:

- State level data - available as annual data & five-year rolling estimate
- County level data - available as five-year rolling estimate (some larger jurisdictions may have annual data)

Follow Link Below for More Information:

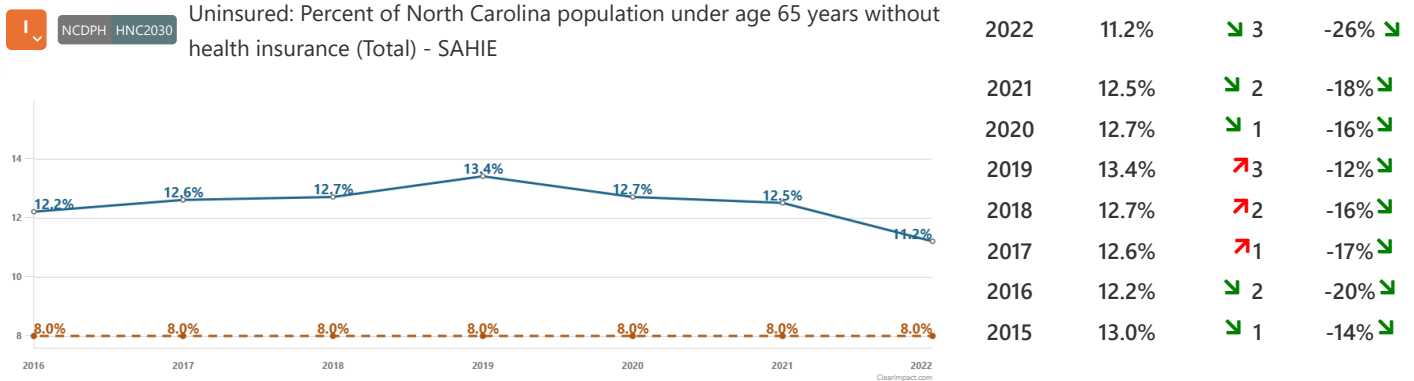
[HNC-REPORT-FINAL-Spread2.pdf](#)

[Databases, Tables & Calculators by Subject](#)

[3. Understanding and Using ACS Single-Year and Multiyear Estimates](#)

[S2301: Census Bureau Table](#)

[Unemployment | County Health Rankings & Roadmaps](#)



Story Behind the Curve

Small Area Health Insurance Estimates (SAHIE) are reported annually by the U.S. Census Bureau.

North Carolina expanded Medicaid eligibility on December 1, 2023, extending coverage to adults aged 19-64 years with incomes up to 138% of the federal poverty line, estimated to benefit around 600,000 people.

2022 data suggested that North Carolina was 11.2% uninsured with the target being 8%.

ADDITIONAL NOTES:

- From 2014-2020, data were only available for uninsured white/Black/Hispanic populations.
- Uninsured data for "All Other Races" were available only for the years 2021 & 2022.
- Anticipate 2023 data release summer 2025.

Indicator Notes

Definition:

Individuals who did not have health insurance coverage for the entire calendar year. [US Census]

Why is this Important?

Access to affordable, quality health care positively impacts individual health and well-being. Health insurance is the most common means of accessing affordable health care.

Uninsured individuals may be unable to access affordable health insurance. Lack of health insurance can result in poor health outcomes and create financial burdens, further impacting health and well-being. [HNC2030]

Additional Information:

- In 2023 the "Uninsured" data source changed from SCHS to SAHIE.
- Only white/Black/Hispanic population data were available for 2014-2020.
- Only 2021 & 2022 data are available for "All Other Race" group.

References and Links:

[HNC-REPORT-FINAL-Spread2.pdf](#)

[Small Area Health Insurance Estimates \(SAHIE\) Program \(census.gov\)](#)

P Community Education Campaign to Normalize Conversations

Most Recent Period	Current Actual Value	Current Trend	Baseline % Change
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Progress in 2025

November 2025 Baseline Survey Timeline – Comfort Discussing Mental Health

Start Date: November 2025

- 1. November 2025 – Launch**
 - Release the baseline survey across chosen channels (email, social media, workplaces, schools, community centers).
 - Initial push during the first 2 weeks to maximize early responses.
- 2. December 2025 – Reminder & Midpoint Check**
 - Send reminder messages to boost participation.
 - Midpoint review of # of responses to check progress toward target sample size.
- 3. January 2026 – Final Push**
 - Last call for responses with targeted outreach (partners, organizations, workplaces).
 - Consider offering small incentives (if appropriate) to encourage participation.
- 4. February 2026 – Survey Close**
 - Officially close the survey.
 - Document the total number of responses and demographics.
- 5. March 2026 – Data Analysis**
 - Analyze data: comfort levels across friends, family, colleagues.
 - Establish baseline percentages for future comparison.
- 6. April 2026 – Report & Dissemination**
 - Share key findings with stakeholders, partners, and the community.
 - Use insights to guide mental health awareness strategies.

PM	WNCHN ViewFromHereWNC	View From Here - Campaign Reach	Aug 2023	41,062	→ 0	0% →
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Story Behind the Curve

The "Story Behind the Curve" helps us understand the causes and forces at that work that explain the data behind **Campaign Reach**.

What's Helping What We Do? *These are the positive forces at work in View From Here that influence how much we do or how well we do it.*

- Consistent communications related to our priority health topics builds resident trust in public health.
- Hyper-local, tailored, story driven messages resonates with our communities in WNC.
- Social media communications is an effective way to spread health information to even our most rural communities.
- All communities throughout regions 1 and 2 communicating the same messages builds a surround sound effect that builds trust and supports positive behavior change.

What's Hurting What We Do? *These are the negative forces at work in View From Here that influence how much we do or how well we do it.*

- Our priority health topics can be met with stigmatizing public reactions.
- While this work is incredibly successful, it's also resource intensive and lack of ongoing funding raises the question of long-term sustainability.
- Because of capacity limitations, we aren't able to engage all of the community based partners we would like to include.

PM <small>How Much</small>	# of responses for baseline survey asking about their comfort discussing mental health with friends, family, and colleagues	—	—	—	—
PM <small>How Much</small>	Track the use of hashtags and "likes" on posts that debunk mental health myths	—	—	—	—

ST Build Community Connections to combat social isolation

Most Recent Period	Current Actual Value	Current Trend	Baseline % Change
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Progress in 2025

Personal Stories Timeline – Oct to Dec 2025

October 2025 – Launch & Collection

- Develop a call for stories (through schools, community centers, social media, faith groups).
- Begin collecting stories from community members.
- Track weekly # of submissions.
- Start selecting stories suitable for sharing (written, video, or audio).

November 2025 – Ongoing Collection & Sharing

- Continue outreach to increase submissions.
- Share first round of stories publicly (social media posts, newsletters, community bulletin boards).
- Track both # of stories collected and # shared.
- Highlight themes such as loneliness, resilience, and connection.

December 2025 – Final Push & Compilation

- Conduct final outreach push before year-end.
- Share remaining collected stories widely (community events, local news, holiday campaigns).
- Compile total # of stories collected and # shared during the 3-month period.
- Prepare a summary report highlighting the awareness raised and key messages.

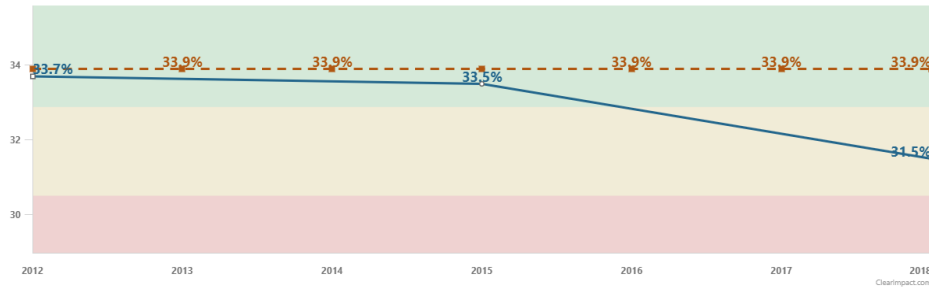
PM <small>How Much</small>	# of personal stories collected and shared to raise public awareness about the challenges of isolation and the positive impacts of building social connections	—	—	—	—
PM <small>How Much</small>	Track # of people participating in local clubs, classes, volunteer organizations, and other community events	—	—	—	—

Food Access & Availability

R All people in our community, at all times, have physical and economic access to sufficient safe and nutritious food that meets their dietary needs

Most Recent Period	Current Actual Value	Current Trend	Baseline % Change
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2018	31.5%	↘ 2	-7% ↘
2015	33.5%	↘ 1	-1% ↘
2012	33.7%	→ 0	0% →



Data Talking Points

Data Talking Points:

- **Data Source**

- PRC Community Health Survey (2012 & 2015 & 2018)
- Data is collected every 3 years
- Method Reminders:
 - Random Selection
 - Sampling levels allow for good local confidence intervals (N=3,300), but you should still keep in mind that error rates are larger at the county level than for WNC as a region
 - Results for WNC regional data have maximum error rate of $\pm 1.7\%$ at the 95% confidence level
 - Results for individual counties have maximum error rate of $\pm 5.6\%$ at the 95% confidence level

- Landline (94%) and Cell Phone (6%)
 - Survey instrument based largely on national survey models (e.g. CDC BRFSS)
- Data Interpretation Tools and Resources
- Phone Survey FAQs

- **Definition of "Healthy Weight"**

- PRC Survey Question:

Weight status (calculated from height, weight questions): Underweight (BMI < 18.5); Healthy Weight (18.5 ≤ BMI < 25.0); Overweight, Not Obese (25.0 ≤ BMI < 30.0); Obese (30 ≤ BMI)

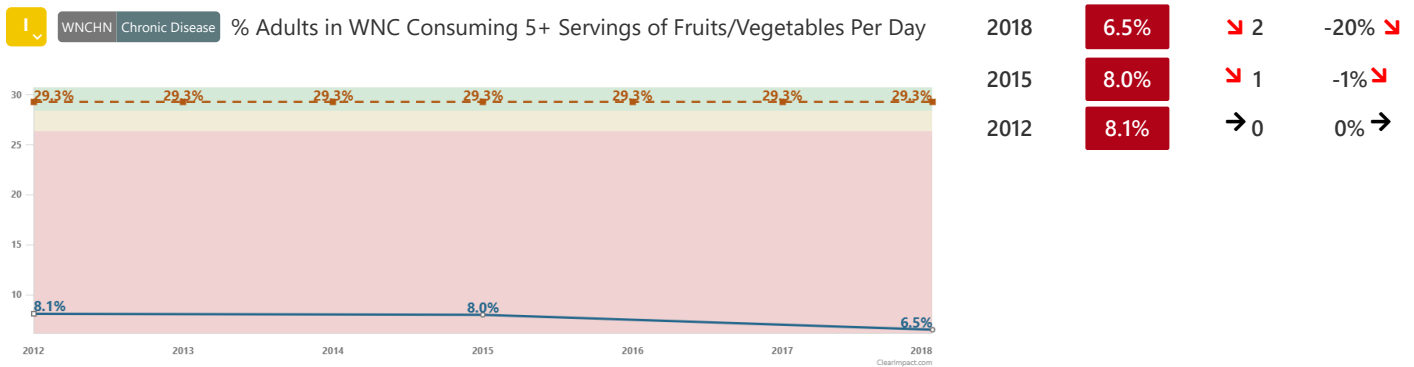
- US Department of Health and Human Services. Healthy People 2020. December 2010. <http://www.healthypeople.gov> [Objective NWS-8]
- The definition of healthy weight is having a body mass index (BMI), a ratio of weight to height (kilograms divided by meters squared), between 18.5 and 24.9.

- **Other Data Considerations**

- BMI is not a perfect measure, because it does not directly assess body fat. Muscle and bone are denser than fat, so an athlete or muscular person may have a high BMI, yet not have too much fat. But most people are not athletes, and for most people, BMI is a very good gauge of their level of body fat. [Source]
- Research has shown that BMI is strongly correlated with the gold-standard methods for measuring body fat. (2) And it is an easy way for clinicians to screen who might be at greater risk of health problems due to their weight. (3,4) [Source]
- It is important to note that we are not looking at individual level data, but at aggregated BMI data which is being used to monitor the health of an entire population.
- Some researchers have argued that BMI should be discarded in favor of measures such as waist circumference. (22) However, this is unlikely to happen given that BMI is easier to measure, has a long history of use-and most important, does an excellent job of predicting disease risk. [Source]

• **Examples of Talking Points**

- Based on self-reported heights and weights, 1 in 3 Western North Carolina adults (31.5%) is at a healthy weight
- Slight decrease in % adults in western North Carolina at healthy weight
- This is slightly below national findings (34.4% in 2015)
- Slightly below the Healthy People 2020 target (33.9% or higher)
- The continues a negative trend from 2012 to 2015 to 2018 survey results (decreasing percentage of WNC adults at a healthy weight)



Data Talking Points

Data Talking Points:

• **Data Source**

- PRC Community Health Survey (2012, 2015, 2018)
- Data is collected every 3 years
- Method Reminders:
 - Random Selection
 - Sampling levels allow for good local confidence intervals (N=3,300), but you should still keep in mind that error rates are larger at the county level than for WNC as a region—Results for WNC regional data have maximum error rate of $\pm 1.7\%$ at the 95% confidence level—Results for individual counties have maximum error rate of $\pm 5.6\%$ at the 95% confidence level Weights were added to enhance representativeness of data at county and regional levels
 - Landline (94%) and Cell Phone (6%)
 - Survey instrument based largely on national survey models (e.g. CDC BRFSS)
- Phone Survey FAQs
- Data Interpretation Tools and Resources

• **Definition of "Consuming 5+ Servings of Fruits/Vegetables Per Day"**

- PRC Survey Questions:

Comprised of the following questions:

Now I would like you to think about the food you ate during the past week. About how many 1-cup servings of fruit did you have in the past week? For example, one apple equals 1 cup.

And, NOT counting lettuce salad or potatoes, about how many 1-cup servings of vegetables did you have in the past week? For example, 12 baby carrots equal 1 cup.

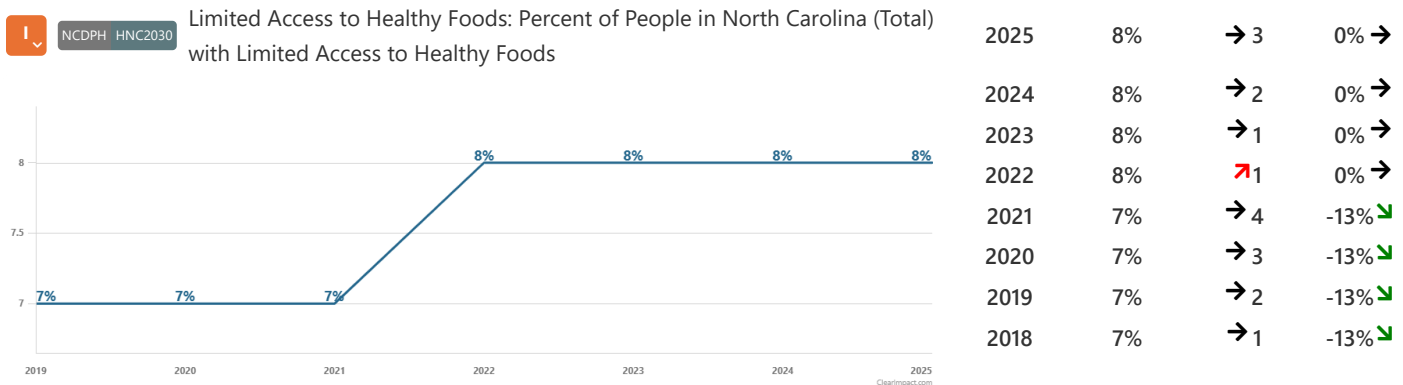
• Examples of Talking Points

- A total of 6.5% of WNC adults report eating five or more servings of fruits and/or vegetables per day.
- Fruit/vegetable consumption has decreased between 2012 and 2018.
- Those with lower incomes, Native Americans and Balcks are less likely to get the recommended servings of daily fruits/vegetables.
- Western North Carolina adults average 7.3 one-cup servings of fruits in the past week.
- Community members average 8.4 one-cup servings of vegetables in the past week (not including lettuce salad or potatoes).
- Both of these data points are statistically unchanged from 2012 survey results

Data Visualization & Communication Library:

• 521AlmostNone

- Printables
- Social Media Toolkit
 - 5 Social Media
 - 2 Social Media
 - 1 Social Media
 - Almost None Social Media



Story Behind the Curve

The trend from 2021-2025 reflects North Carolina population food insecurity from 2015-2019. The graph reflects a slight improvement in access to reliable food between 2015 and 2019 (as reported in 2025 County Health Rankings measures).*

*County Health Rankings *Annual Data Releases* for the years 2022-2025 used data from 2019 for this measure.

Indicator Notes

The HNC2030 indicator *Limited Access to Healthy Foods* includes *County Health Rankings* data. These numbers are not frequently updated; refer also to alternative indicator: *Food Insecurity*.

HNC 2030 target: decrease limited access to healthy foods to 5% by 2030.

County Health Rankings & Roadmaps discontinued this measure in 2020, rendering it inappropriate for measuring progress.

Definition of Limited Access to Healthy Foods:

The *Limited Access to Healthy Foods* indicator measures the percentage of population who are low-income and do not live close to a grocery store. The 2025 Annual Data Release used data from 2019 for this measure.

Why is this Important?

Living in a "food desert" (including lack of access to fresh produce) has been correlated with increased prevalence of obesity and premature death.

Supermarkets traditionally provide healthier options than convenience stores or smaller grocery stores.

Additional Information:

Limited Access to Healthy Foods indicator is aligned with HNC2030.

References and Links:

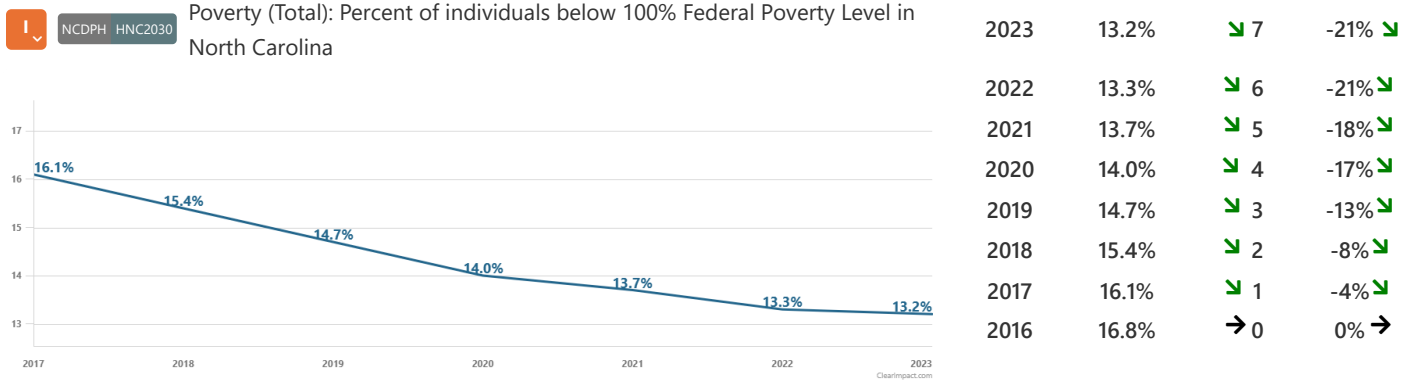
https://www.countyhealthrankings.org/health-data/north-carolina?year=2025&measure=Limited+Access+to+Healthy+Foods*

County level data is available at the following link: <https://www.countyhealthrankings.org/health-data/north-carolina/data-and-resources>

County Health Rankings (countyhealthrankings.org)

County Health Rankings and Roadmaps (CCR&R) - Business Analyst, Delorme map data, ESRI, & US Census Tiger line Files

*Should not compare ranked data from year to year



Story Behind the Curve

The percent of individuals below 100% of the Federal Poverty Level (FPL) in North Carolina steadily declined from 16.8% in 2016 to 13.2% in 2023.

Five-year rolling estimate

Indicator Notes

Definition:

The percentage of people who have incomes **below 100%** of the federal poverty level (FPL).

Why is this Important?

Poverty is a social determinant of health (SDOH). Families and individuals with incomes at or even somewhat above poverty level may have difficulty meeting basic needs such as housing, food, clothing, transportation, etc. [HNC2030]

For More Information:

Poverty (Total) Percent of individuals below 100% Federal Poverty Level in North Carolina from the American Community Survey (ACS,Table 1701)

Links:

[HNC-REPORT-FINAL-Spread2.pdf](#)

[SHA-REPORT-Final-2-24.pdf](#)

[How the Census Bureau Measures Poverty](#)

[3. Understanding and Using ACS Single-Year and Multiyear Estimates](#)

<https://www.census.gov/programs-surveys/acs/guidance/comparing-acs-data/2023.html>

<p>Strengthen Food Assistance Programs by working with School Nutrition Department and Community Food Pantries</p>	Most Recent Period	Current Actual Value	Current Trend	Baseline % Change

Progress in 2025

Food Assistance Program Feedback & Participation Timeline – November 2026

Week 1 (Nov 1-7) – Launch Feedback Collection

- Distribute surveys or conduct short interviews with program participants to gather feedback on:
 - Variety of food items available
 - Quality and freshness
 - Preferences or unmet needs
- Begin recording **# of individuals and families accessing food assistance.**

Week 2 (Nov 8-14) – Ongoing Tracking & Engagement

- Continue collecting participant feedback at distribution points or via online surveys.
- Track participation numbers daily or weekly to identify trends.
- Note any changes or spikes in new families accessing the program.

Week 3 (Nov 15-21) – Preliminary Analysis

- Compile feedback received so far.
- Identify common themes, preferred items, and gaps in food variety.
- Compare participation numbers to prior weeks to monitor trends.

Week 4 (Nov 22-30) – Final Compilation & Reporting

- Finalize collection of feedback for the month.
- Summarize total **# of participants and families served** in November.
- Prepare a brief report highlighting:
 - Food quality/variety insights
 - Participation trends and any increases
 - Recommendations for adjustments to better meet community needs.



How Well

Gather feedback on the variety and quality of food items available to ensure the program meets the needs and preferences of the community



Story Behind the Indicator

[Guidance: This section includes story you collect during your process.]

The "Story Behind the Curve" helps us understand why the data on [state the indicator in plain language, e.g. adults with diabetes, children born addicted to drugs, or people dying from drug overdoses] is the way that it is in our community. When we understand the root causes of our community problems, we have a better chance of finding the right solutions, together.

[Guidance: What is helping and what is hurting this issue? What conditions, policies, programs or other factors are helping us do as well as we are doing? What conditions, policies, programs or other factors are contributing to this problem and keeping us from doing better?

You could organize your What's Helping and What's Hurting by what do people most affected by this issue say? What do key stakeholders say? Challenge assumptions. Ask "why" to get to root-causes?

Story data can come from many sources: during Whole Distance Exercise with your coalition or work group; during listening sessions/focus groups with people affected by the issue; the Healthy Impact Key Informant Interview responses on your topic; interviews or surveys with key partners in your community; listening at meetings or community events; etc.

Recommended RBA tool for working on story behind the indicator, identifying partners, and thinking about what works (strategies): Population Turn-the-Curve Report]

What's Helping? *These are the positive forces at work in our community and beyond that influence this issue in our community.*

[Guidance: a prompting question can be, "Why are things as good as they are and not worse?" Ask "why?" multiple time to a single cause to get to root causes. Try to get input about what's help at the individual, organizational, environment and policy levels. You can also include additional number data/indicators that relate to your headline indicator as part of the story of what's helping.]

- Example 1
- Example 2
- Example 3

- Example 4

What's Hurting? *These are the negative forces at work in our community and beyond that influence this issue in our community.*

[Guidance: a prompting question can be, "Why are things as bad as they are and getting in the way of things getting better? Try to get input about what's hurting at the individual, organizational, environment and policy levels. You can also include additional number data/indicators that relate to your headline indicator as part of the story of what's hurting.]

- Example 1
- Example 2
- Example 3
- Example 4

PM How Much Track the # of individuals and families accessing the food assistance programs over time, noting any increases in participation - - - -

ST School-Based Programs to increase awareness and reduce stigma

Most Recent Period	Current Actual Value	Current Trend	Baseline % Change
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Progress in 2025

Assessment Tracking Timeline – Nov 2025 through Spring 2026

November–December 2025 – Preparation

- Finalize assessment tools (student, teacher, parent versions).
- Pilot test surveys/assessments in a small group.
- Establish baseline participation goals (# of assessments to complete per group).

January–February 2026 – Baseline Data Collection

- Conduct first full round of assessments with students, teachers, and parents.
- Track # completed by group and note participation rates.
- Store results in a centralized database or dashboard.

March–April 2026 – Continued Collection

- Administer additional assessments in schools/program sites not yet covered.
- Compare progress against baseline target numbers.
- Identify gaps in participation (e.g., low parent turnout) and adjust outreach.

May 2026 – Year-End Completion

- Finalize # of assessments completed across the year.
- Produce a comprehensive report showing how perceptions and behaviors changed.
- Use findings to guide next year’s programming and outreach.

PM <small>How Much</small>	# of assessments with students, teachers, and parents to gather detailed information about program's impact on perceptions and behavior	—	—	—	—
PM <small>How Well</small>	Record observations of students interactions to assess change in social behavior and overall inclusivity within the school	—	—	—	—

ST Expand Affordable Food Options by offering Community Gardens & Farming, bringing Mobile Markets/Food Trucks to underserved neighborhood		Most Recent Period	Current Actual Value	Current Trend	Baseline % Change
PM <small>How Much</small>	Track the number of community garden plots, farms, and mobile market stops in underserved areas	—	—	—	—
PM <small>How Much</small>	Count the number of active gardeners and the total number of families or individuals benefiting from plots	—	—	—	—
PM <small>Better Off</small>	Measure the volume of produce harvested from community farms and distributed through mobile markets	—	—	—	—
PM <small>Better Off</small>	Collect data on the low-income and older adult populations who are benefiting from these programs	—	—	—	—

CO Build Partnerships and Community Power with Non-Profits/Faith-Based Collaboration and forming Local Farmer Partnerships		Most Recent Period	Current Actual Value	Current Trend	Baseline % Change
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Progress in 2025

Partnership & Resource Sharing Tracking Timeline – Sept 2025 Onward

September–October 2025 – Launch & Baseline

- Identify potential partner organizations (nonprofits, schools, faith groups, businesses).
- Begin tracking **# of partnerships formed**.
- Document initial **shared resources** (staff, equipment, meeting spaces).
- Establish baseline metrics for network size and resource sharing.

November–December 2025 – Early Growth & Monitoring

- Continue forming and formalizing partnerships.
- Track monthly changes in **# of partnerships** and **resources shared**.
- Collect data on type and amount of resources successfully shared.

January–March 2026 – Midpoint Tracking

- Monitor ongoing partnership activity and resource utilization.
- Identify which partnerships are most active and effective.
- Track growth trends in network size and resource sharing.

April–June 2026 – Expanded Engagement

- Reach out to additional potential partners to expand the network.

- Continue tracking new partnerships formed and resources exchanged.
- Prepare a mid-year summary of partnership growth and resource sharing.

July–September 2026 – Annual Compilation

- Compile total **# of partnerships** formed over the year.
- Document cumulative resources shared among partners.
- Highlight key successes and lessons learned for future network expansion.

October 2026 Onward – Continuous Monitoring

- Continue tracking partnership growth and shared resources quarterly.
- Update metrics and analyze trends over time.
- Adjust strategies to strengthen the network and improve resource sharing.

PM <small>How Well</small>	Evaluate the percentage of community members who participate in events, volunteering, or other activities organized by the partnership	–	–	–	–
PM <small>How Much</small>	Number of partnerships formed to track growth in our network	–	–	–	–
PM <small>How Much</small>	Track the resources, such as staff, equipment, or meeting spaces, that are successfully shared among partners	–	–	–	–

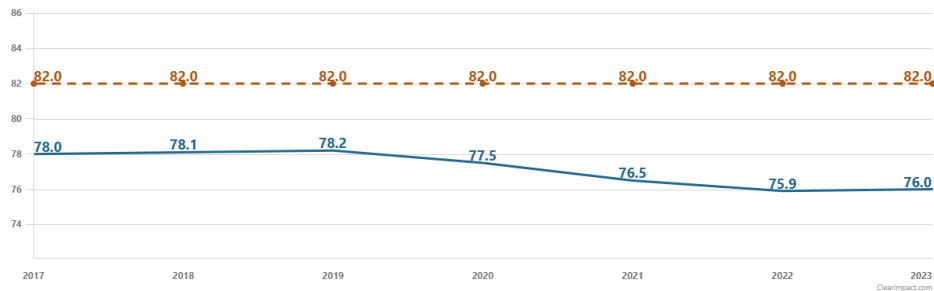
Affordable & Available Housing

The availability of safe, affordable, and accessible housing is critical to the economic and social well-being of our residents and the long-term prosperity of our county.



NCDPH HNC2030

Life Expectancy - ALL (Total) in NC - 3-Year Rolling: Avg. # of years of life remaining for people who have attained a given age



Most Recent Period	Current Actual Value	Current Trend	Baseline % Change
2023	76.0	↑ 1	-3% ↓
2022	75.9	↓ 3	-3% ↓
2021	76.5	↓ 2	-2% ↓
2020	77.5	↓ 1	-1% ↓
2019	78.2	↑ 2	0% →
2018	78.1	↑ 1	0% →
2017	78.0	↓ 1	0% →
2016	78.2	→ 0	0% →

Story Behind the Curve

North Carolina total life expectancy data - based on 3-year averages. Do not compare overlapping years.

Between 2016 and 2019, life expectancy (total) for North Carolina remained steady at just over 78 years.

Between 2019 and 2022, life expectancy dropped by over two years (from 78.1 to 75.9) and remained fairly level (at 76.0) in 2023. Potential contributors to this recent, retained drop include the COVID-19 pandemic and the rise in drug overdose deaths.

Indicator Notes

Definition:

Life Expectancy at Birth.

Life Expectancy (LE) is the average number of additional years that someone at a given age would be expected to live if current mortality conditions remained constant throughout their lifetime.

Life Expectancy figures for total NC population and disaggregated by gender are available annually and based on 3-year rolling averages.

County level disaggregated data (by race/ethnicity) are available for 3-year rolling averages.

Why is this Important?

Life Expectancy is a key health indicator and serves as a proxy measure for the total health of a population. [CDC, HNC2030]

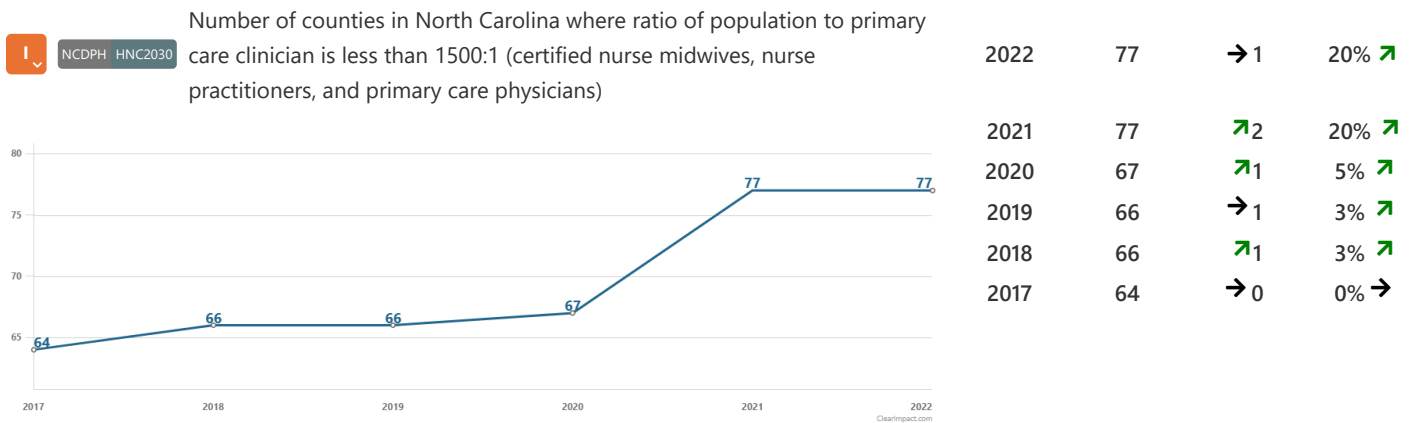
Additional Information:

County level disaggregated data (by race/ethnicity) are available for 3-year rolling averages

Links and References:

<https://www.cdc.gov/nchs/hus/atagance.htm>

HNC-REPORT-FINAL-Spread2.pdf



Story Behind the Curve

2024 data will be released in summer 2025.

Overall, the state is improving (i.e., there is an increasing number of counties with adequate number of providers).

The graph shows the percent of counties meeting the standard ratio of 1,500 or fewer people to 1 primary care clinician (i.e., county has sufficient primary care clinicians to meet population health needs).

Overall, the ratio for the state improved from 983:1 in 2017 to 808:1 in 2023. [Sheps Center]

NOTE: A significant # of physicians were issued temporary licenses during the pandemic (2021).

Indicator Notes

Definition:

"The primary care clinician index is a ratio of population to primary care clinicians, so a ratio with a higher value suggests lower access to primary care services...physicians, nurse practitioners, physician assistants, and certified nurse midwives as primary care clinicians." [Sheps Center]

Why is this indicator important?

Access to primary care can encourage preventive health care and improve health outcomes. Many rural areas of North Carolina lack adequate access to medical professionals, including those providing primary care.

Additional Information:

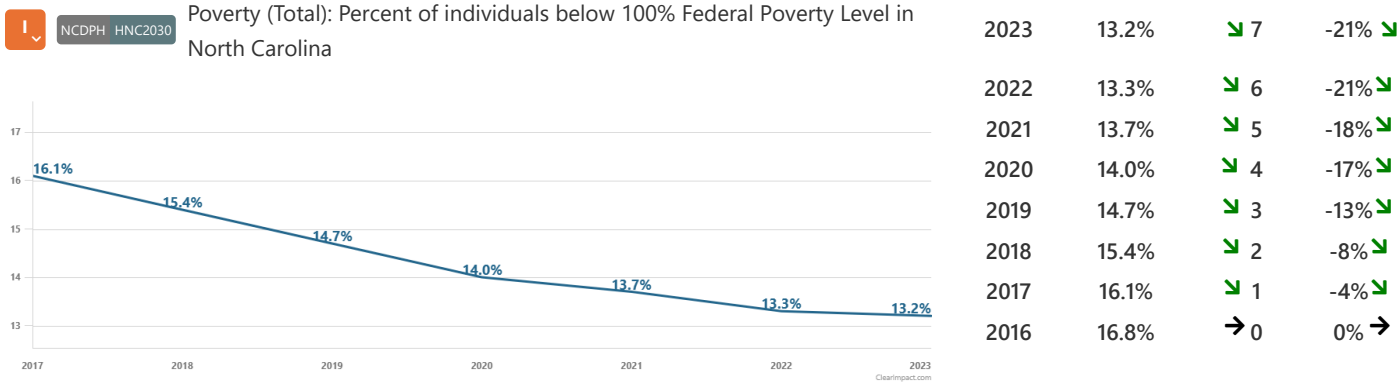
The indicator, *Number of counties in North Carolina where ratio of population to primary care clinician is less than 1500:1*, trends the percentage of the state's 100 counties with sufficient clinicians (i.e., population of 1,500 or fewer per provider, in order to meet population needs).

The indicator aligns with HNC2030.

For Further Information:

[HNC-REPORT-FINAL-Spread2.pdf](#)

<https://www.countyhealthrankings.org/health-data/health-factors/clinical-care/access-to-care/primary-care-physicians?year=2024>



Story Behind the Curve

The percent of individuals below 100% of the Federal Poverty Level (FPL) in North Carolina steadily declined from 16.8% in 2016 to 13.2% in 2023.

Five-year rolling estimate

Indicator Notes

Definition:

The percentage of people who have incomes **below 100%** of the federal poverty level (FPL).

Why is this Important?

Poverty is a social determinant of health (SDOH). Families and individuals with incomes at or even somewhat above poverty level may have difficulty meeting basic needs such as housing, food, clothing, transportation, etc. [HNC2030]

For More Information:

Poverty (Total) Percent of individuals below 100% Federal Poverty Level in North Carolina from the American Community Survey (ACS, Table 1701)

Links:

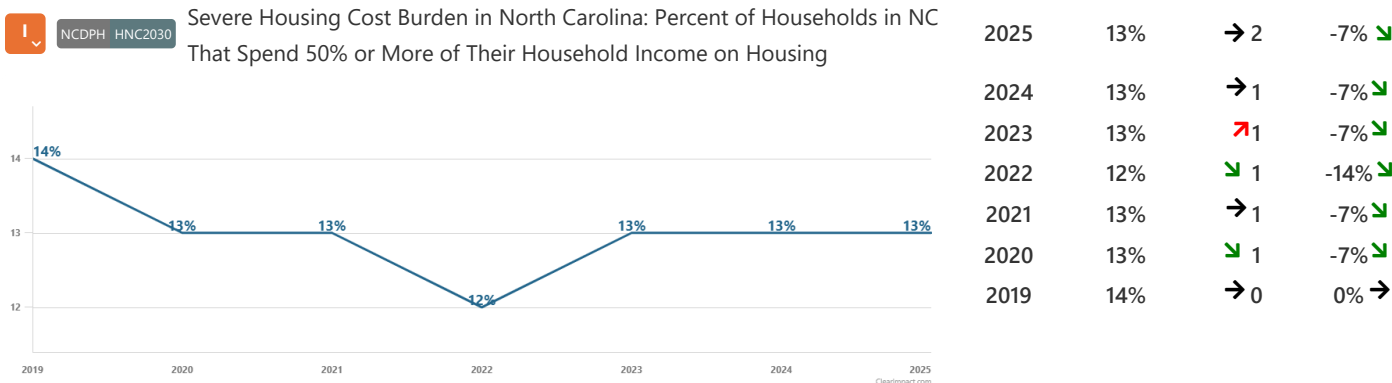
[HNC-REPORT-FINAL-Spread2.pdf](#)

[SHA-REPORT-Final-2-24.pdf](#)

[How the Census Bureau Measures Poverty.](#)

[3. Understanding and Using ACS Single-Year and Multiyear Estimates](#)

<https://www.census.gov/programs-surveys/acs/guidance/comparing-acs-data/2023.html>



Story Behind the Curve

Over the past few years, housing costs have increased faster than many household incomes which has increased pressure on individual families to meet basic needs (including health insurance, healthcare, healthy foods, utilities and transportation).

Important Note: These are five-year rolling estimates. Therefore, only compare non-overlapping years.

Indicator Notes

Definition:

Percent of Households in NC that Spend 50% or More of their Household Income on Housing

Why is this Important?

"Severe housing cost burden affects health and is linked to barriers to living long and well. Across counties in places where a higher share of households are severely cost burdened, there are also high rates of children in poverty and food insecurity, and more people in poor health."
[County Health Rankings]

Additional Information:

The U.S. Department of Housing and Urban Development (HUD) periodically receives "custom tabulations" of data from the U.S. Census Bureau that are largely not available through standard Census products. These data, known as the "CHAS" data (Comprehensive Housing Affordability Strategy), demonstrate the extent of housing problems and housing needs, particularly for low income households. The CHAS data are used by local governments to plan how to spend HUD funds and may also be used by HUD to distribute grant funds.

The *Percent of Households in NC that Spend 50% or More of their Household Income on Housing* indicator is aligned with HNC 2030.

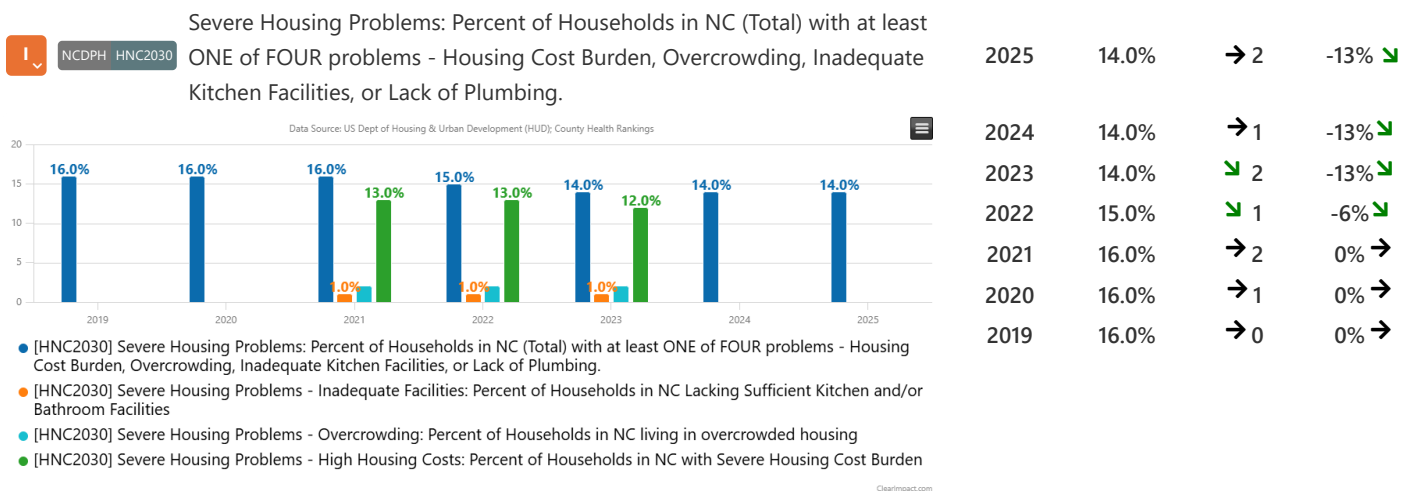
County Health Rankings and Roadmaps (CCR&R) - Business Analyst, Delorme map data, ESRI, & US Census Tiger line Files

References and Links:

https://www.countyhealthrankings.org/health-data/north-carolina?year=2025&measure=Severe+Housing+Cost+Burden*

<https://www.census.gov/programs-surveys/acs/about.html>

<https://www.huduser.gov/portal/datasets/cp.html>



Story Behind the Curve

Based on data from 2017-2021, 14% of North Carolina households experienced at least one of the following housing problems: High Cost Housing Costs, Overcrowding, Lack of Kitchen Facilities, or Lack of Plumbing. Percent of Severe Housing Problems ranged from 9% to 21% of households across counties in the state.

The 2025 Annual Data Release used data from 2017-2021 for this measure.

<https://www.countyhealthrankings.org/health-data/north-carolina?year=2025&measure=Severe+Housing+Problems>

Indicator Notes

Definition:

Percentage of households with at least one of four housing problems: overcrowding, high housing costs, lack of kitchen facilities, or lack of plumbing facilities.

Why is this Important?

Safe housing is fundamental to good health, and helps to protect individuals and families from harmful exposures while providing privacy, security, stability, and control.

Inadequate, poor quality housing can contribute to health problems (e.g., infectious and chronic disease and injuries) and interfere with healthy childhood development.

Severe housing costs can interfere with other basic needs (such as health insurance, healthcare, healthy foods, utilities and transportation).

[County Health Rankings]

Additional Information:

The *Percent of Households with at Least One of Four Problems* indicator is aligned with HNC2030.

References and Links:

County Health Rankings and Roadmaps (CCR&R) - Business Analyst, Delorme map data, ESRI, & US Census Tiger line Files

<https://www.countyhealthrankings.org/health-data/health-factors/physical-environment/housing-and-transit/severe-housing-problems?year=2024>

ST Improve Access & Equity by Streamlining Application Processes and Providing Housing Education to Seniors, Low-income families, and People with Disabilities

Most Recent Period	Current Actual Value	Current Trend	Baseline % Change
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Progress in 2025

Comprehensive Tracking & Evaluation Timeline (Sept 2025 – Sept 2027)

September–December 2025 – Program Launch & Baseline

- Start recording the **# of individuals from target populations** attending workshops or using online resources.
- Establish baseline demographic data.
- Introduce data collection system for follow-up housing stability checks (6, 12, 24 months).
- Begin scheduling first interviews with early graduates.

January–June 2026 – Early Participation & First Housing Stability Checks

- Continue monthly tracking of workshop attendance and online resource usage.
- Conduct **6-month follow-up checks** for Sept–Dec 2025 participants: % in stable housing.
- Interview a small sample of early graduates about applying knowledge to their housing situations.
- Share an interim participation and housing stability report.

July–December 2026 – Midpoint Monitoring

- Continue tracking # of participants.
- Conduct **12-month follow-up checks** for Sept–Dec 2025 participants.
- Conduct **6-month checks** for Jan–June 2026 participants.
- Schedule and conduct additional graduate interviews to capture successes and challenges.
- Compare housing outcomes across groups.

January–June 2027 – Expanded Analysis

- Continue tracking workshop and online participation.
- Conduct **24-month checks** for Sept–Dec 2025 participants, **12-month checks** for Jan–June 2026 participants, and **6-month checks** for July–Dec 2026 participants.
- Gather another round of graduate interviews, ensuring representation from multiple populations (youth, seniors, families, etc.).
- Prepare a cumulative mid-project report.

July–September 2027 – Final Review & Reporting

- Track last set of participation numbers for the two-year period.
- Conduct **final round of housing stability checks**:
 - 24-month for Jan–June 2026 participants
 - 12-month for July–Dec 2026 participants
 - 6-month for Jan–June 2027 participants
- Complete final set of graduate interviews.
- Compile a comprehensive two-year evaluation report:
 - Total # of individuals reached
 - Housing stability outcomes at 6, 12, and 24 months
 - Insights from graduate interviews on how knowledge/skills were applied

PM	How Much	Track the # of individuals from target populations who attend educational workshops or use online resources	–	–	–	–
PM	Better Off	Measure the percentage of participants who remain in stable housing for specific periods (e.g., 6, 12, or 24 months) after completing the education program	–	–	–	–
PM	Better Off	Conduct interviews with a sample of program graduates to understand how they applied their new knowledge and skills to their housing situations	–	–	–	–

ST Expand Community Partnerships by working with Nonprofits, Faith-Based Groups, Local Government, and Local Businesses to move people toward stability

Most Recent Period	Current Actual Value	Current Trend	Baseline % Change
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Progress in 2025

December 2025 – Tracking Individuals Served & Event Reach

Week 1 (Dec 1–7) – Launch Tracking

- Begin recording the **# of individuals served through referrals** or programs co-delivered with nonprofit partners.
- Document key partner organizations and type of services delivered.
- Start tracking outreach at scheduled events (job fairs, health clinics, workshops).

Week 2 (Dec 8–14) – Ongoing Data Collection

- Continue logging individuals served through referrals and co-delivered programs.
- Track **# of participants reached at events**, including demographic details if possible.
- Monitor trends in participation and identify gaps in outreach.

Week 3 (Dec 15–21) – Mid-Month Analysis

- Summarize preliminary totals for individuals served and event reach.
- Identify which programs or events had the highest engagement.
- Adjust outreach or scheduling as needed to reach more community members.

Week 4 (Dec 22–31) – Final Compilation & Reporting

- Finalize counts for **individuals served through referrals/co-delivered programs**.
- Compile total attendance for events held in December.

- Prepare a report showing:
 - # of individuals served through partnerships
 - # of people reached at community events
 - Insights for improving reach in the following months.

PM	How Much	Track the # of individuals served through referrals or programs co-delivered with nonprofit partners	-	-	-	-
PM	How Much	Count the # of people reached through events, such as job fairs or health clinics,	-	-	-	-
PM	How Much	Measure the # and dollar amount of grants secured as a direct result of the collaboration.	-	-	-	-

State of the County Health Reports (SOTCH)

SR 2025 SOTCH Report

SR 2026 SOTCH Report

SR 2027 SOTCH Report