

Community Health Assessment (CHA)

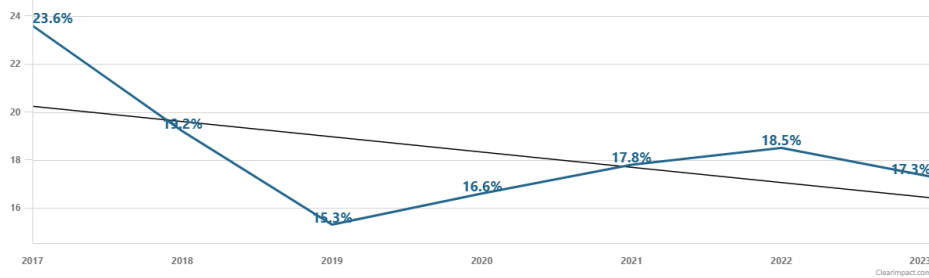
CA 2024 Community Health Assessment

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

R All people have the resources accessible that they need to live a healthy, happy, productive life.

Most Recent Period	Current Actual Value	Current Trend	Baseline % Change
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% →

I NCDPH HNC2030 Adverse Childhood Experiences (ACEs): Percent of children in NC (Total) with 2 or more ACEs



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](#)

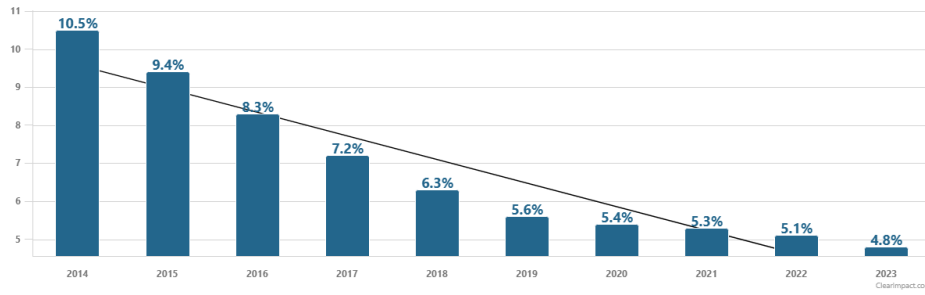
<https://www.childhealthdata.org/browse> (Interactive)

<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](#)

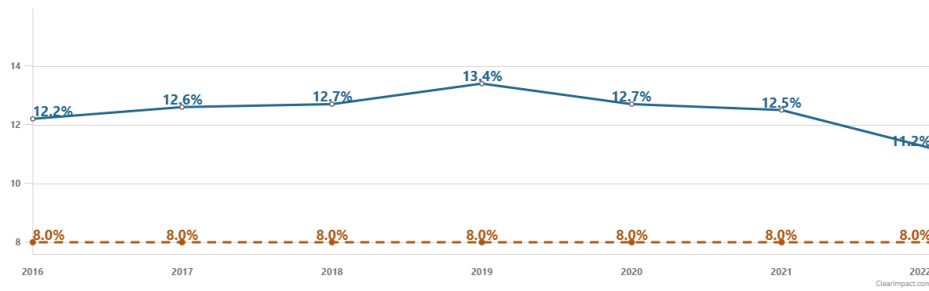
[3. Understanding and Using ACS Single-Year and Multiyear Estimates](#)

[S2301: Census Bureau Table](#)

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

Uninsured: Percent of North Carolina population under age 65 years without health insurance (Total) - SAHIE

2022	11.2%	↘ 3	-26%
2021	12.5%	↘ 2	-18%
2020	12.7%	↘ 1	-16%
2019	13.4%	↗ 3	-12%
2018	12.7%	↗ 2	-16%
2017	12.6%	↗ 1	-17%
2016	12.2%	↘ 2	-20%
2015	13.0%	↘ 1	-14%



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.

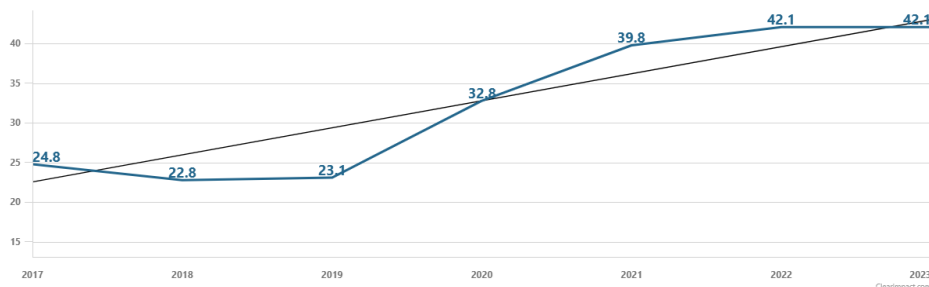
References and Links:

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

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

Drug Poisoning Death Rate in North Carolina (Total): Drug Poisoning Deaths per 100,000 population (age-adjusted rates)

2023	42.1	→ 1	205%
2022	42.1	↗ 4	205%
2021	39.8	↗ 3	188%
2020	32.8	↗ 2	138%
2019	23.1	↗ 1	67%
2018	22.8	↘ 1	65%
2017	24.8	↗ 3	80%
2016	19.8	↗ 2	43%
2015	15.8	↗ 1	14%



Story Behind the Curve

Along with the rest of the country, North Carolina experienced a sharp increase in drug overdose deaths since 2019, largely due to the opioid epidemic, and more recently involving a preponderance of poisonings from illegally manufactured fentanyl.

The drug overdose death rate nearly tripled from 2014 (13.8) to 2023 (42.1).

Indicator Notes

Definition:

Number of persons in North Carolina who die as a result of drug poisoning per 100,000 population, adjusted by age.

Why is this Important?

Substance misuse is a chronic condition, requiring ongoing care and treatment for individuals to regain and maintain health and recovery.

This chronic condition affects the individual's relationship with family and community. It can impair ability to attend school or work and negatively impacts both physical and mental health. It can also lead to social complications and negative interactions with the justice system. [HNC2030]

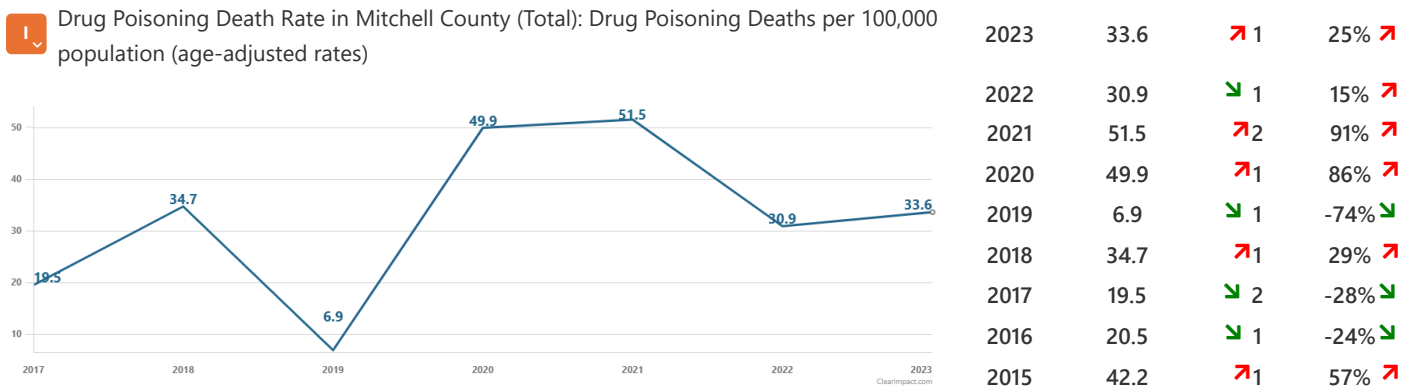
Additional Information:

The *Drug Poisoning Death Rate* indicator is aligned with HNC2030.

References and Links:

[North Carolina's Opioid and Substance Use Action Plan | NCDHHS](#)

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



Story Behind the Indicator

The "Story Behind the Indicator" helps us understand why the data on unintentional opioid deaths in Mitchell County 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.

The story behind the indicator is that Mitchell County has a strong sense of pride in their youth. The Substance Abuse Task Force has a strong youth program in the schools that helps the children learn the dangers of substance abuse and teaches them how to properly combat issues revolving around substance abuse. This group uses their youth to youth program to educate the children and young adults in the area and this in turn could hopefully pay off by seeing a decrease in the frequency of drinking and other drugs that the youth in Mitchell County participate in.

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

- Substance Abuse Task Force
- Youth to Youth Groups in Schools
- Mitchell Community Health Partnership

These three groups are of great help to the Mitchell County Community. Through these three factors there are multiple organizations that band together to help Mitchell County achieve a higher quality of life for the county. With multiple organizations coming together multiple times a month to tackle a growing concern in the county it is incredible the things that can get done with these two meetings that then help the youth to youth leaders know what to focus on for the children.

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

- Small Community with Limited Resources for Youth
- Easy Access to Alcohol and other Substances

A barrier that Mitchell County faces is the fact that the youth in the county don't have many activities to participate in. This is a reason for the importance of youth to youth and other things that are attempting to get our youth involved in the community. Children in the community also have easy access to substances such as alcohol and prescription drugs because of the lack of education in the community concerning the harm that this can cause youth.

Partners with a Role to Play

Partners in our Community Health Improvement Process:

- Partners Aligned Toward Health
- Mitchell-Yancey Substance Abuse Task Force
- Blue Ridge Regional Hospital
- Mountain Community Health Partnership
- WNC Healthy Impact

These partners in the community work diligently to improve the health of our county and are valuable partners with the health department. With the help of the community we believe we will reach our goals concerning this particular health issue.

Partners with a Role in Helping Our Community Do Better on This Issue:

- Mitchell-Yancey Substance Abuse Task Force
- Blue Ridge Regional Hospital

The two specific partners listed work closely with the health department and help us move forward on the issues presented by partnering in events, meetings, and other activities to improve the health of the community.

Strategies Considered and Process

The following actions have been identified by our partners and community members as ideas for what can work for our community to make a difference on substance abuse and mental health.

Actions and Approaches Identified by Our Partners *These are actions and approaches that our partners think can make a difference on substance abuse.*

- Prevention Oriented Community
- Expansion of Alternative Pain Methods
- Drug Take Back Day

These actions have been selected by our partners as a way to greatly impact substance abuse in Mitchell County. Becoming a prevention oriented community and expanding the alternative pain methods could give relief to the community. Staring and continuing a drug take back day and having it regularly could also greatly impact the lives of the community by decreasing the prescription pills in the area.

What is Currently Working in Our Community *These are actions and approaches that are currently in place in our community to make a difference on substance abuse.*

- Needle Drop boxes in Health Departments
- Drug Lockboxes
- Tonier Cane Event (Creating Community Awareness)

The above approaches are currently working in the community and we believe will either begin making an impact or continue making an impact among the citizens.

Evidence-Based Strategies *These are actions and approaches that have been shown to make a difference on substance abuse.*

Name of Strategy Reviewed	Level of Intervention
Community Reinforcement Approach	Individual Level
Family Behavior Therapy	Interpersonal Level
Multisystemic Therapy	Interpersonal Level

What Community Members Most Affected by Substance Abuse Say These are the actions and approaches recommended by members of our community who are most affected by substance abuse.

- Breaking Down Barriers among Recovering Addicts and the Community
- Continue growing recovery community and continue educating community professionals

The following was selected by community members as what they believe could help them and the community in general the most. The community sees a large barrier among recovering addicts and the community and repairing this barrier could help those who are trying to put their life back together after having broken apart from addiction. Continuing growing the recovery community and educating professionals on how to better help was also seen as something that would help our community.

Process for Selecting Priority Strategies

This list was prioritized in a multitude of ways. The process for making this list included speaking to community partners and gaining their input on what they believe is being done currently and what could be done in the future. It also includes input from recovering addicts who know what the population needs and what will help the community grow. This process finally included looking back over the last health assessments and action plans and finding what had an effect on the community and what needs to be continued and what didn't have as large of an impact and could be discontinued.

Community Education Campaign to Normalize Conversations

Most Recent Period	Current Actual Value	Current Trend	Baseline % Change
Aug 2023	41,062	→ 0	0% →

WNCHN ViewFromHereWNC View From Here - Campaign Reach



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 School-Based Programs to increase awareness and reduce stigma

Most Recent Period	Current Actual Value	Current Trend	Baseline % Change
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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 Build Community Connections to combat social isolation

Most Recent Period	Current Actual Value	Current Trend	Baseline % Change
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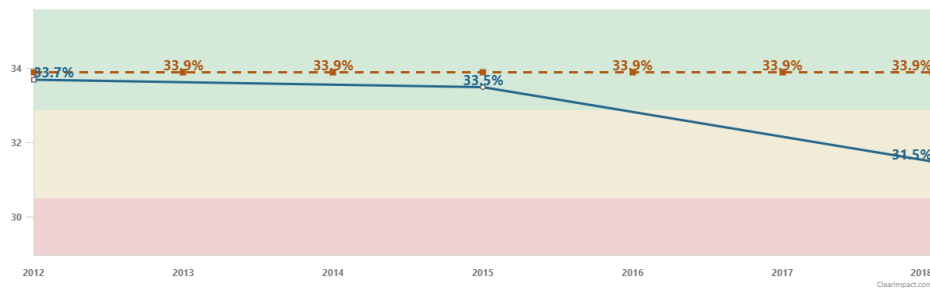
PM <small>How Much</small>	# of personal stories collected and shared to raise public awareness about the challenges of isolation and the positive impacts of building social connections	-	-	-	-
PM <small>How Much</small>	Track # of people participating in local clubs, classes, volunteer organizations, 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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I WNCN Chronic Disease % Adults in WNC at a Healthy Weight



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)

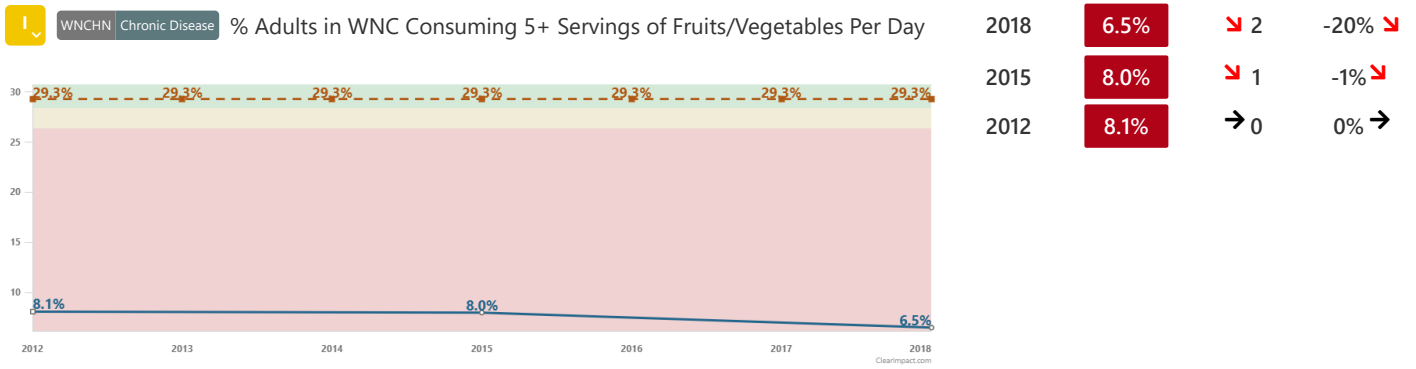
- US Department of Health and Human Services. Healthy People 2020. December 2010. <http://www.healthypeople.gov> [Objective NWS-8]
- The definition of healthy weight is having a body mass index (BMI), a ratio of weight to height (kilograms divided by meters squared), between 18.5 and 24.9.

- **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.

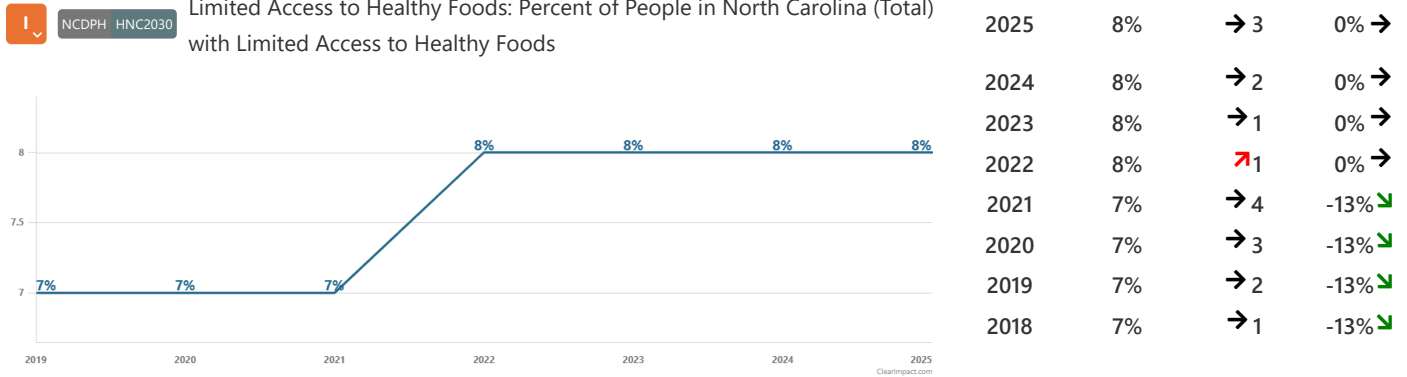
- **Examples of Talking Points**

- 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 Blacks 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*

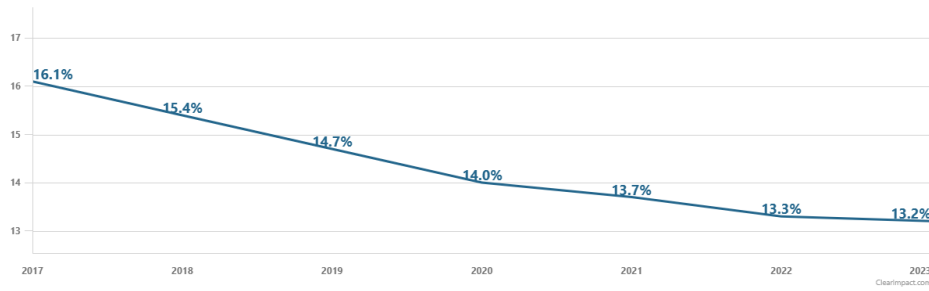
County level data is available at the following link: <https://www.countyhealthrankings.org/health-data/north-carolina/data-and-resources>

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

2023	13.2%	↓ 7	-21% ↓
2022	13.3%	↓ 6	-21% ↓
2021	13.7%	↓ 5	-18% ↓
2020	14.0%	↓ 4	-17% ↓
2019	14.7%	↓ 3	-13% ↓
2018	15.4%	↓ 2	-8% ↓
2017	16.1%	↓ 1	-4% ↓
2016	16.8%	→ 0	0% →



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>

ST Strengthen Food Assistance Programs by working with School Nutrition Department and Community Food Pantries

Most Recent Period	Current Actual Value	Current Trend	Baseline % Change
—	—	—	—

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 <small>How Much</small>	Track the # of individuals and families accessing the food assistance programs over time, noting any increases in participation	—	—	—	—
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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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PM <small>How Well</small>	Evaluate the percentage of community members who participate in events, volunteering, or other activities organized by the partnership	—	—	—	—
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PM <small>How Much</small>	Number of partnerships formed to track growth in our network	—	—	—	—
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PM <small>How Much</small>	Track the resources, such as staff, equipment, or meeting spaces, that are successfully shared among partners	—	—	—	—
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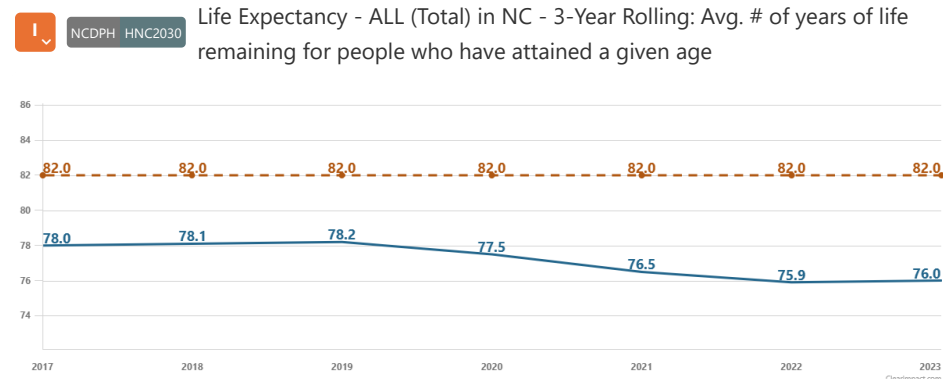
ST **Expand Affordable Food Options by offering Community Gardens & Farming, bringing Mobile Markets/Food Trucks to underserved neighborhood**

Most Recent Period	Current Actual Value	Current Trend	Baseline % Change
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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	—	—	—	—

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.



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

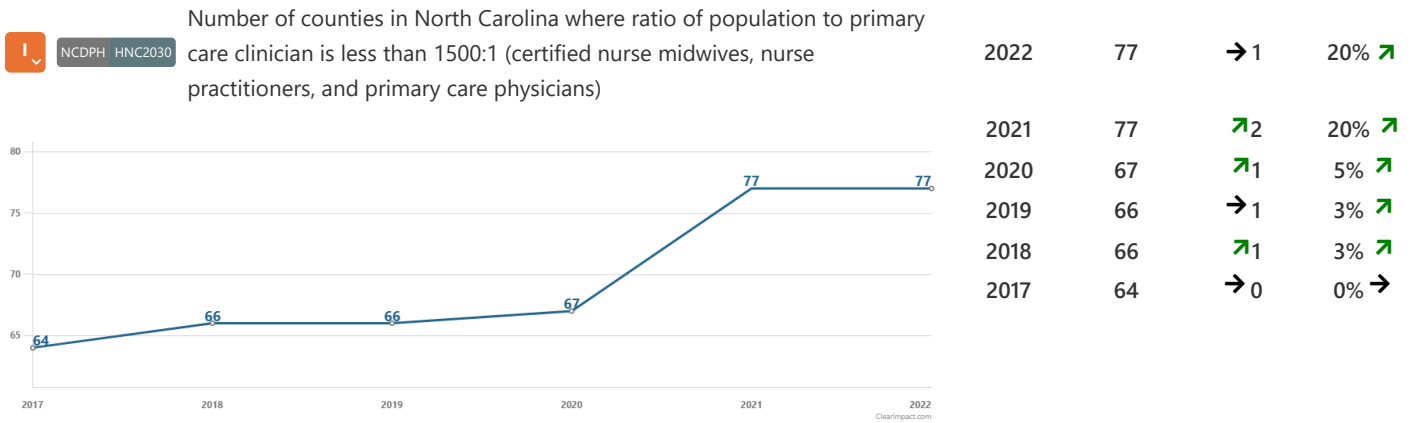
Additional Information:

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

Links and References:

<https://www.cdc.gov/nchs/atus/ataglance.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:

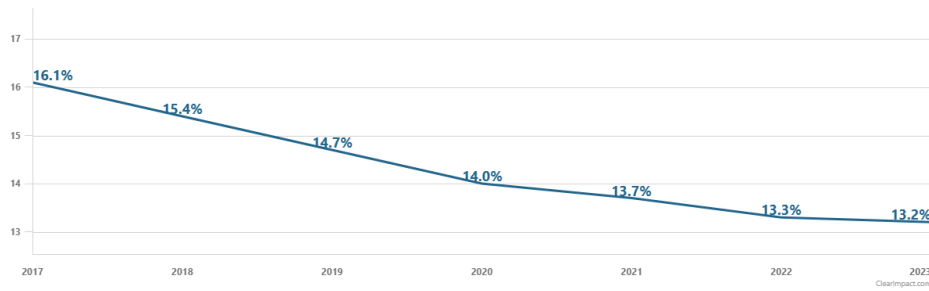
[HNC-REPORT-FINAL-Spread2.pdf](#)

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

https://nchealthworkforce.unc.edu/blog/pcc_index_2023/#:~:text=Guided%20by%20the%20recommendations%20of,to%20meet%20population%20health%20needs.

Poverty (Total): Percent of individuals below 100% Federal Poverty Level in North Carolina

2023	13.2%	↘ 7	-21% ↘
2022	13.3%	↘ 6	-21% ↘
2021	13.7%	↘ 5	-18% ↘
2020	14.0%	↘ 4	-17% ↘
2019	14.7%	↘ 3	-13% ↘
2018	15.4%	↘ 2	-8% ↘
2017	16.1%	↘ 1	-4% ↘
2016	16.8%	→ 0	0% →



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](#)

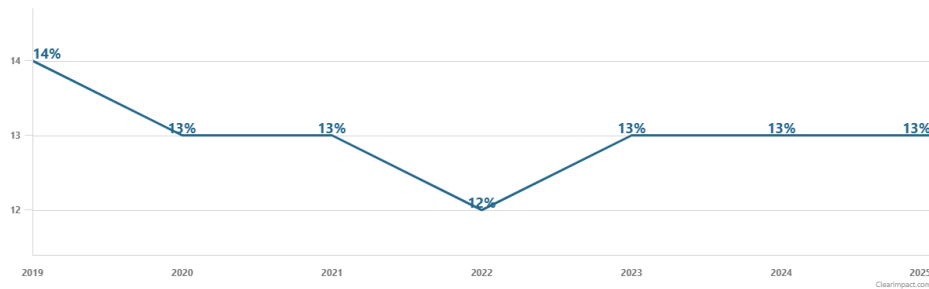
[How the Census Bureau Measures Poverty](#)

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

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

Severe Housing Cost Burden in North Carolina: Percent of Households in NC That Spend 50% or More of Their Household Income on Housing

2025	13%	→ 2	-7% ↘
2024	13%	→ 1	-7% ↘
2023	13%	↗ 1	-7% ↘
2022	12%	↘ 1	-14% ↘
2021	13%	→ 1	-7% ↘
2020	13%	↘ 1	-7% ↘
2019	14%	→ 0	0% →



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.

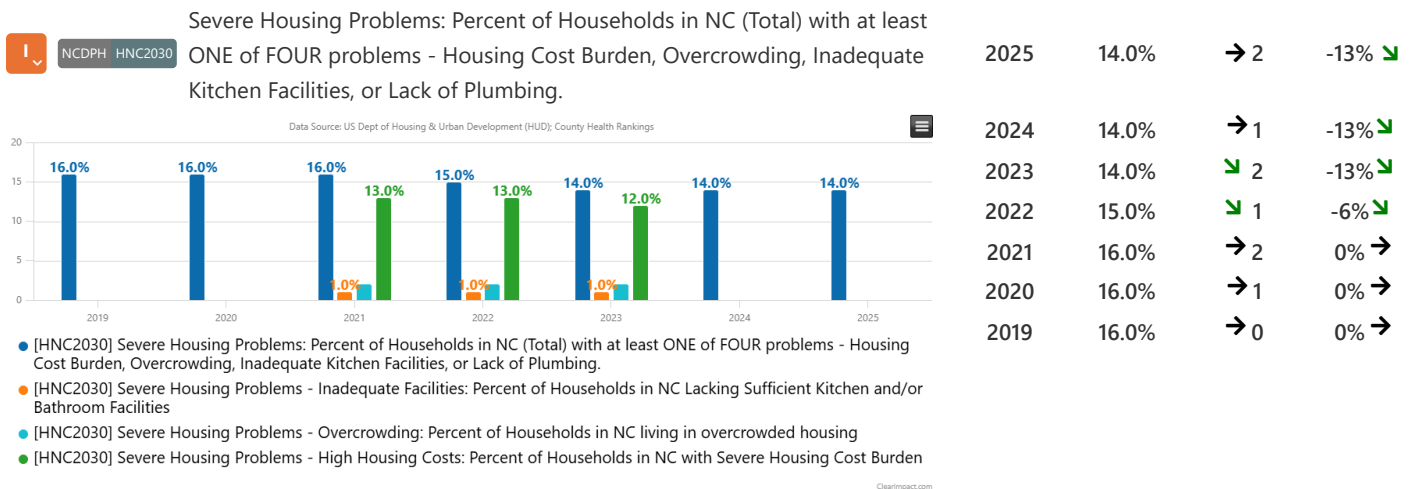
County Health Rankings and Roadmaps (CCR&R) - Business Analyst, Delorme map data, ESRI, & US Census Tiger line Files

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.

The 2024 Annual Data Release used data from 2016-2020 for this measure. [County Health Rankings]

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>

Improve Access & Equity by Streamlining Application Processes and

ST 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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PM **How Much** Track the # of individuals from target populations who attend educational workshops or use online resources

—	—	—	—
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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

—	—	—	—
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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

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

ST

Most Recent Period	Current Actual Value	Current Trend	Baseline % Change
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PM **How Much** Track the # of individuals served through referrals or programs co-delivered with nonprofit partners

—	—	—	—
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PM **How Much** Count the # of people reached through events, such as job fairs or health clinics,

—	—	—	—
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PM **How Much** Measure the # and dollar amount of grants secured as a direct result of the collaboration.

—	—	—	—
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State of the County Health Reports (SOTCH)

SR 2025 SOTCH Report

SR 2026 SOTCH Report