2024 Community HEALTH NEEDS Assessment

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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 group 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)
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The Nash County 2024 Community Health Needs Assessment (CHNA) would not have been possible without the help and support of many individuals and groups who work, live, play, and pray in Nash County. Nash County Health Department, UNC Health Nash, and the CHNA planning team would like to thank the following individuals and groups for their support during this assessment. We know we do it better together.

- The Community Health Needs Assessment team, Nash County Health Department (NCHD) staff, and UNC Health Nash staff for their hard work and support in making the assessment a team effort.
- The Health Education team at Nash County Health Department and Kirby Slade, Community Development Director at UNC Health Nash, for leading the process and encouraging the involvement of staff and community organizations to participate in the Community Health Need Assessment process.
- The Nash County Human Services Board for their support.
- The Harrison Family YMCA for providing space to distribute paper copies of the Community Health Needs Assessment surveys.
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- Boice-Willis Clinic and Carolina Family Health Centers, Inc. staff for sharing valuable input during the focus group discussion.
- Nash County Public Schools English as Second Language (ESL)-Migrant Education employees for hosting a focus group for the assessment.
- Health ENC and Ascendient for conducting the Community Health Needs Assessment survey.
- Ascendient for analyzing data and all their support and training throughout the process.
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- The community members who agreed to be surveyed and provided valuable information about Nash County.
- The many community members and organizations for their assistance in the needs assessment prioritization process.

In addition, the Nash County 2024 CHNA was developed with input from the following individuals and organizations who participated in the prioritization process.

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Kathleen Fleming	UNC Health Nash Foundation
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EXECUTIVE SUMMARY

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 developed as part of the Health ENC coalition's collaborative, regional 2024 CHNA process. 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. The report adheres to North Carolina Local Health Department Accreditation standards, as well as Internal Revenue Service requirements for not-for-profit hospitals.

Vision Statement

Through collaborative efforts between the Health ENC Steering Committee, Nash County Health Department, and UNC Health Nash, the 2024 CHNA process aspires to create a healthier eastern North Carolina where data-driven decision making, shared resources, and community engagement converge to address health inequities and build resilient, thriving communities for all Nash County residents.

Nash County CHNA Leadership

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

Nash County CHNA Partnerships

The 2024 CHNA process for Nash County included a variety of different stakeholders who assisted with community engagement activities, provided feedback, and participated in the prioritization process. A summary of the partner organizations who participated in the process is below.

Type of Partner Organization	Number of Partners
Public Health Agency	1
Hospital/Health Care System(s)	1
Healthcare Provider(s)	4
Behavioral Healthcare Provider(s)	3
EMS Provider(s)	1
Pharmacy/Pharmacy Community Organization(s)	1

Community Organization(s)	14
Educational Institution(s)	6
Public/Private/Charter School System(s)	1
Government/Public Agencies	4
Public Member	2

The Health ENC Steering Committee and Nash County CHNA Leadership contracted with Ascendient Healthcare Advisors to coordinate the regional CHNA process, including primary and secondary data analysis, relevant trainings for county partners and development of the contents of this report.

Nash County CHNA Timeline and Process

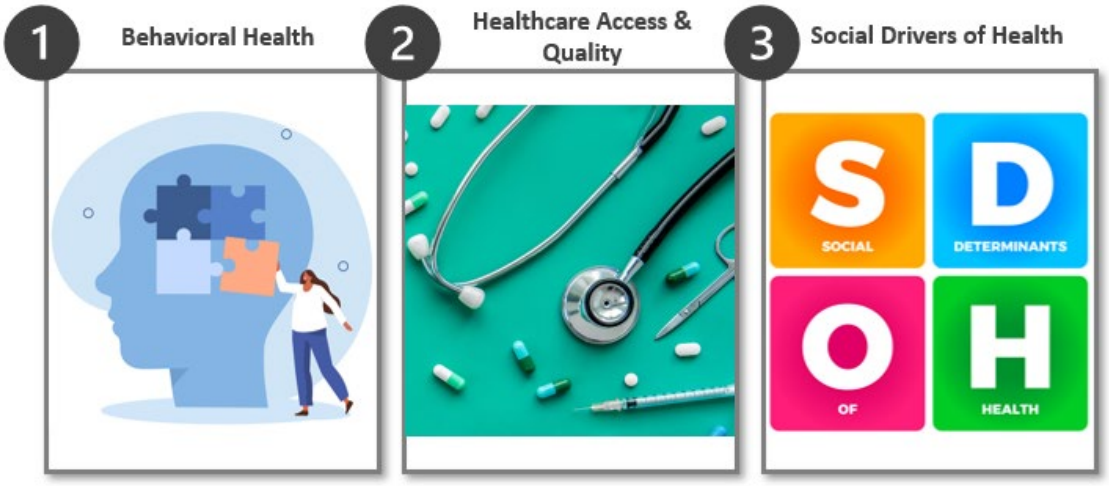
The Health ENC 2024 process formally kicked off with a collaborative meeting of all participating counties on February 8th, 2024. It concluded with the delivery of final CHNA reports to all 34 counties on December 20th, 2024. A summary of key process milestones is shown below.

Secondary (existing) data came from various public sources related to demographics, social determinants of health, environmental health, disease trends, behavioral health trends, and individual health behaviors. Data was evaluated using the Robert Wood Johnson Foundation's population health framework and compared to state or national benchmarks to identify areas of concern. Top community needs identified through secondary data analysis included health concerns related to physical and behavioral health, and social or environmental concerns such as education, employment and income, environmental quality, and family, community, and social support, among others.

Primary (new) data were collected through focus groups and a web-based survey for community members, and included feedback from 553 people who live, work or receive healthcare in Nash County. A total of two 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), employment and income, healthcare access and quality, housing and homelessness, and physical health (chronic diseases, cancer, obesity) as top needs that impact the health and well-being of people living in Nash County.

Representatives from Nash 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, three top priorities were identified by Nash County (in alphabetical order): Behavioral Health, Healthcare Access and Quality, and Social Drivers of Health – Economic Stability.



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

Following completion of this report, health leaders throughout Nash 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

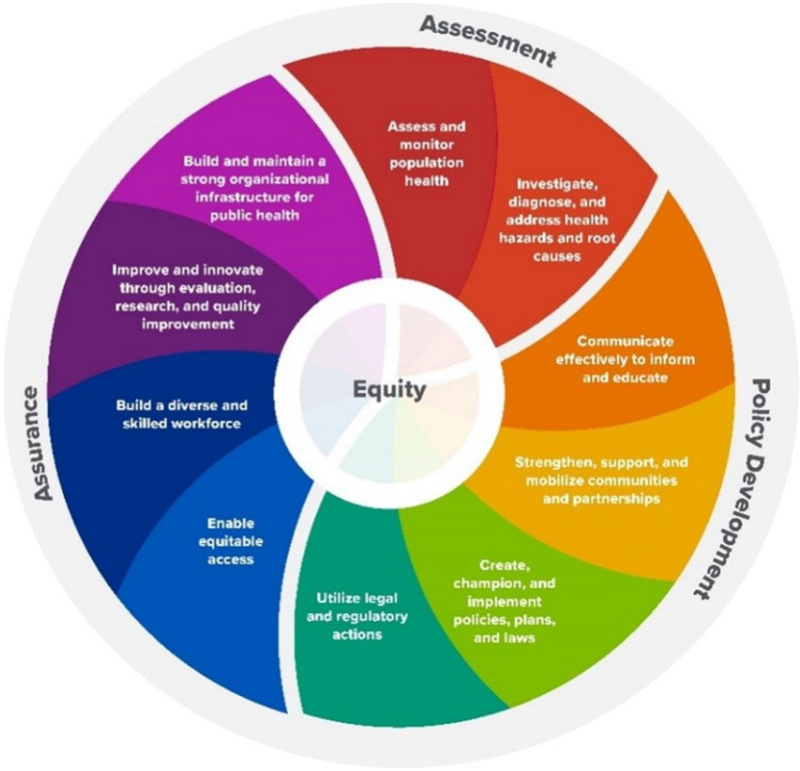
To illustrate its commitment to the health and well-being of the community, the Health ENC CHNA Steering Committee has completed this assessment to understand and document the greatest health needs currently faced by local residents. Guidance was also provided by local representatives from Nash County Health Department and UNC Health Nash. These organizations helped gather the focus group and survey data 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 Nash 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 1** below. In its demonstration of data and prioritization of Nash 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 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:

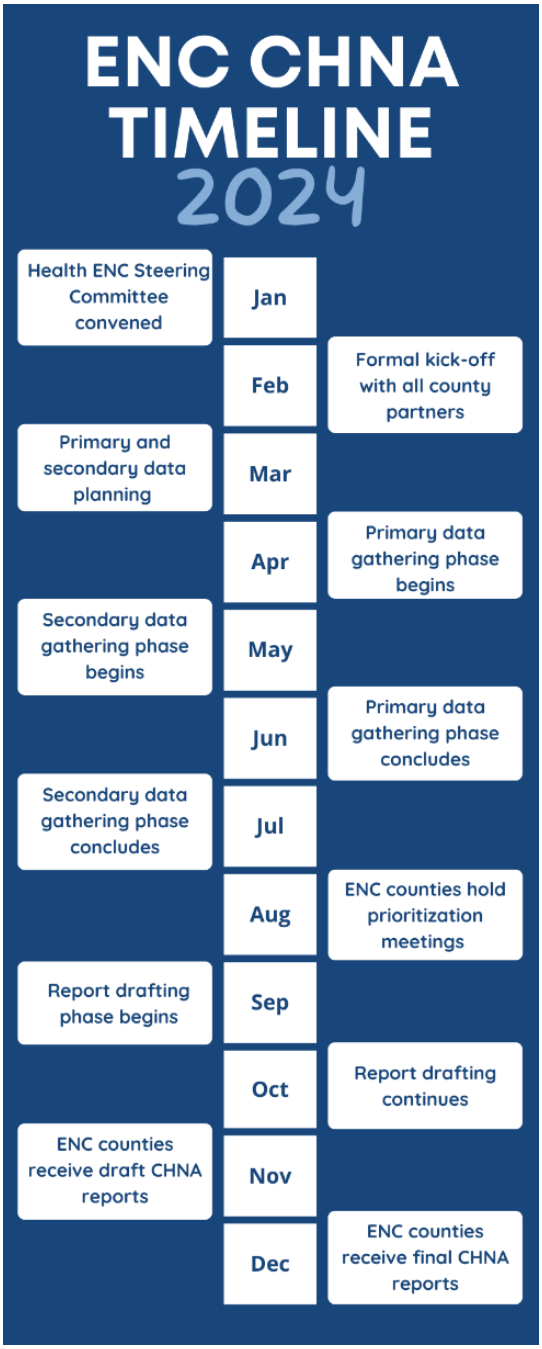
- Define the community it serves;
- Assess the health needs of that community;
- Through the assessment process, take into account input received from people who represent the community's broad interests, including those with special knowledge of or expertise in public health;
- Document the CHNA in 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 Nash 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 2** below.

Figure 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 Nash 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 Nash County residents. Key objectives of this CHNA include:

- Identify the health needs of Nash 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 twelve phases in the CHNA process, as shown in **Figure 3** below, beginning with pre-planning and assessing organizational capacity and ending with an evaluation of the process. Once the CHNA process is complete, county leaders must develop community health action plans to describe the specific activities they will implement to address the health and social needs identified in the CHNA.

Figure 3: The Community Health Assessment Process[3]

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 Nash County residents.

3) *Priority Health Need Areas* – This chapter describes each identified priority health need area for Nash 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 Nash County.

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

[3] Source: NCDHHS Division of Public Health (2024). *North Carolina Community Health Assessment Guidebook*. Accessed April 7th, 2025 from https://schs.dph.ncdhhs.gov/units/ldas/docs/chaguidebook/NC-CHA-GuidebookOnlineRev1.pdf

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, Nash County completed its previous assessment. Associated implementation strategies focused on three priority areas, as listed below:

Figure 4: Nash County 2021 Priority Need Areas

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.

Nash County Health Department

The Nash County Health Department (NCHD) offers many services and programs to keep residents in the community healthy. Services are available to all individuals, whether they are patients or recipients of community outreach programs or environmental health services. The NCHD has two clinics throughout the community to serve residents – one in Nashville and the other in Rocky Mount. Care managers and social workers are located at the hospital campus office. The NCHD collaborates with community

resources to create synergy and a bigger impact in Nash County. The goal of the NCHD is to make the county a healthy and thriving community for all citizens, enabling all individuals who live, work, go to school, play and pray to have valuable resources to help them achieve complete physical, mental, and social well-being.

UNC Health Nash

UNC Health Nash is a nonprofit hospital affiliate of UNC Health, a leading national health care system. Through a diverse team of approximately 200 physicians on active medical staff at UNC Nash, patients have access to a wide range of locally available care and services at home, including a total of 345 beds across four facilities: Nash General Hospital, Nash Day Hospital, Coastal Plain Hospital, and Bryant T. Aldridge Rehabilitation Center. UNC Nash refined its mission to focus on improving the health and wellbeing of the community. By collaborating with a diverse board of commissioners, robust medical staff, a national health care system, and key stakeholders in the community, UNC Health Nash is well-positioned to respond to the community's unique health needs in a meaningful, measurable way.

Previous CHNA Priority: Metabolic Syndrome

- The Nash County Health Department Deputy Health Director and Lead Health Educator met with the Upper Coastal Plain Council of Government Area Agency on Aging to discuss lay-leader training. Two Health Department health education staff members were subsequently trained in the Self-Management in Chronic Disease four-day lay-leader training program.
- The Nash County Health Department and Nash UNC Health-Women Center collaborated to provide glucometers and sphygmomanometers (blood pressure cuffs) to qualified patients who attended a Maternity clinic.
- The UNC Nash Heart Center conducts quarterly community education initiatives as part of its Chest Pain Center Accreditation, covering topics like heart attack care, CPR, hypertension, and lifestyle changes. It also hosts annual heart fairs to offer free screenings and heart health education in a welcoming setting.
- The UNC Nash Community Paramedic program supports qualifying patients post-discharge by reinforcing heart disease and diabetes education, assisting with medication planning, and facilitating outpatient referrals.
- UNC Nash enhances community health awareness by sponsoring and participating in educational opportunities to combat metabolic syndrome (heart disease/stroke/diabetes/obesity).

Previous CHNA Priority: Poverty

- The Nash County Health Department met with Blue Cross Blue Shield Healthy Blue staff and received funding to initiate a car seat and pack & play bank for county residents who cannot afford these items.
- The Nash County Health Department continued to provide clinical services on a sliding fee schedule to ensure access to healthcare for all Nash County residents.
- UNC Health Nash has taken actions to combat low income/poverty through several key initiatives:
    - **Economic Empowerment & Workforce Development** – Gradually increasing the minimum wage to $16/hour for employees, partnering with local agencies for job training and professional networking, and exposing children to career paths in healthcare.

- **Education & Career Support** – Providing healthcare-related internships and supporting education programs at local colleges to strengthen workforce readiness.
- **Financial & Medical Assistance** – Screening patients for financial strain, assisting with Medicaid and financial aid applications, and evaluating eligibility for UNC Nash Foundation's Patient Assistance Funds to aid with medical costs, transportation, home safety modifications, and more.
- **Food Security Initiatives** – Operating a hospital-based food pantry for food-insecure patients and partnering with local organizations to provide continued food access.
- **Community Health Support** – Offering at-home follow-up care through the Community Paramedic Program to reduce readmissions and unnecessary ER visits, as well as connecting uninsured patients with primary care and medication assistance programs.

Previous CHNA Priority: Behavioral Health

- Nash County hired a new County Assistant Manager, Tia Foula, to oversee the Opioid Settlement Funds for Nash County.
- The Health Education team, along with one of our interpreters, presented to 28 parents and staff involved with Migrant Education and the English as a Second Language program to address concerns about teen mental health issues. Two Health Education staff members attended the "Light the Flame: Igniting Hope for NC's Youth – Youth Suicide Prevention" conference to learn about valuable resources to help serve youth in the community better.
- Teen Mental Health First Aid training was arranged for Nash County Health Department staff, who were encouraged to attend.
- The Nash County Health Department began distributing Narcan at local health department locations.
- Nash County and UNC Health Nash partner with the Coalition for Addiction Recovery Education (C.A.R.E.) and its efforts to provide education, prevention assistance, and resources for individuals who struggle with addiction, as well families and loved ones of those addicted.
- The UNC Nash Foundation invested in Peer Support Specialist services to enable Emergency Department and at-home care for patients struggling with substance and mental health issues.
- Medication-assisted treatment (MAT) for opioid misuse is available through UNC Nash's Emergency Department along with coordination of care services with local provider partners.

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

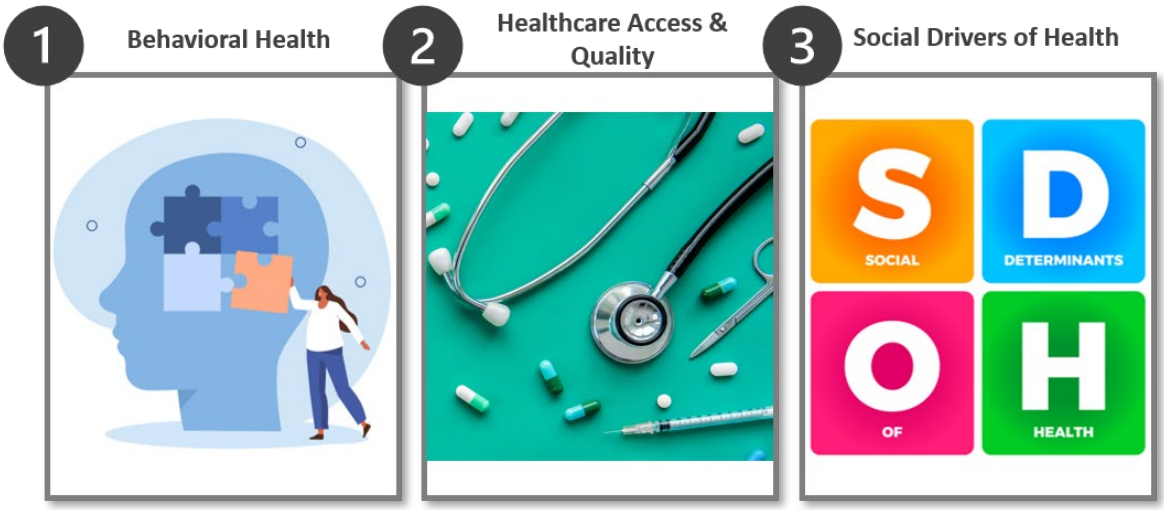
Summary Findings: Nash County 2024 Priority Health Need Areas

To achieve the study objectives in the 2024 assessment, both new and existing data were collected and reviewed. New data included information from paper and web-based surveys of adults (18+ years) and focus groups; various local organizations, community members, and health service providers within Nash County participated. Existing data included information regarding 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 Nash County, significant variations in demographics and health needs exist. 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 Nash 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 Nash 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 three priority need areas. After looking at all relevant data and feedback from the CHNA Steering Committee, the Nash focus areas identified as countywide priorities for the 2024 CHNA are Behavioral Health, Healthcare Access & Quality, and Social Drivers of Health, as seen in **Figure 5**.

Figure 5: Nash County 2024 Priority Health Needs[4]



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 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 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**.

[4] Note: All graphics in this image were licensed from Adobe Stock

CHAPTER 1 | METHODOLOGY

Study Design

The process used to assess Nash 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 Nash 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 needs 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 paper and web-based community member survey, 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 Nash County, including access to care, income, mental health, 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. This process gathered input from numerous Nash County residents and other stakeholders. This included paper and web survey responses from over 550 community members and two focus groups that featured community members and other people who live, work or receive healthcare in Nash County.

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

Existing (Secondary) Data

The primary source for existing data on Nash County was the North Carolina Data Portal. This website is a joint effort by NCDHHS and the University of Missouri Center for Applied Research and Engagement Systems (CARES), which includes over 120 data indicators focused on demographics, health status and social determinants of health. In addition to information from the North Carolina Data Portal, a variety of other sources were leveraged in this assessment process, including:

- *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 previous CHNAs for Nash County in 2019 and 2021-2022.

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 Nash 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.

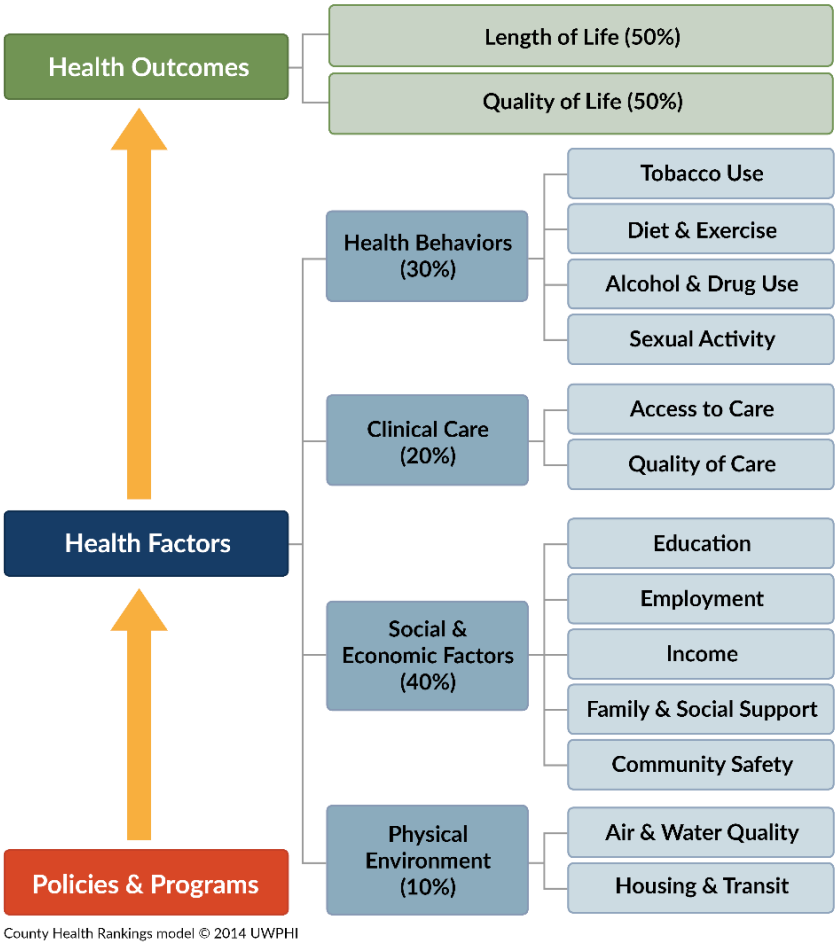
Population Health Framework

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

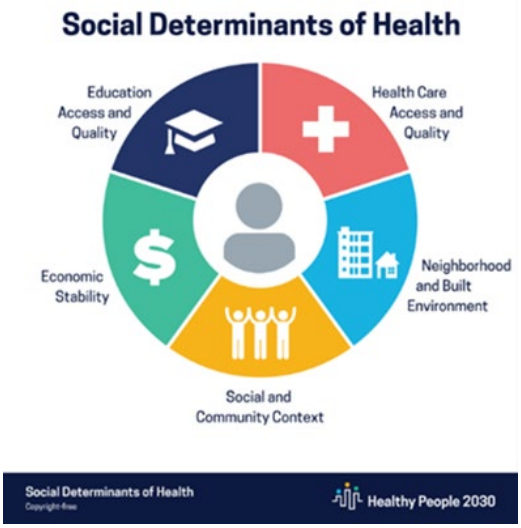
forward. **Figure 6** below illustrates the broad categories and sub-categories within the population health framework.

Figure 6: Population Health Framework[5]



[5] Source: University of Wisconsin Population Health Institute (2024). County Health Rankings & Roadmaps. www.countyhealthrankings.org.

Figure 7: Social Determinants of Health[6]



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 7**.

Recognizing that SDoH have an impact on health disparities and inequities in the community was a key point Nash County leaders considered throughout the CHNA process. **Figure 8** describes the way various social and economic conditions may affect health and well-being.

Figure 8: SDoH and Health Disparities[7]

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

[7] Source: Kaiser Family Foundation (2024). Disparities in Health and Health Care: 5 Key Questions and Answers. Accessed December 30, 2024 via https://www.kff.org/racial-equity-and-health-policy/issue-brief/disparities-in-health-and-health-care-5-key-question-and-answers/

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 6**. These focus areas are detailed further in **Appendix 2**.

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 individuals and organizations participating in the CHNA process 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.

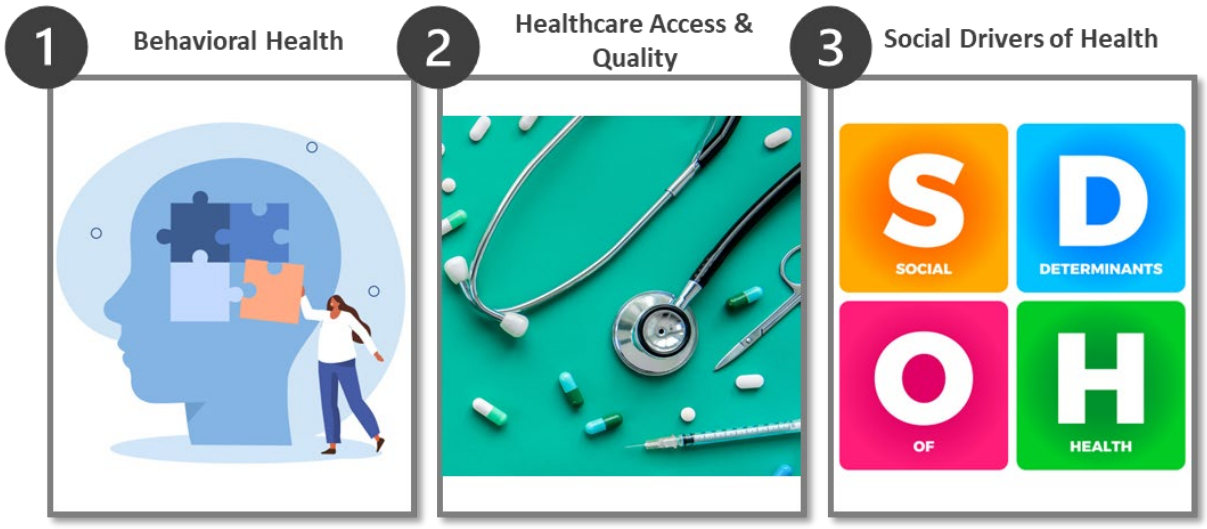
Participating individuals and organizations utilized the multi-voting technique to determine Nash County's priority need areas, while considering the following factors:

- 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.

Specifically, the prioritization process participants ranked the top 10 potential priority need areas based on the primary and secondary data and discussion. Next, this big group was divided into small groups to share expertise and rank the top 10 potential priority need areas. The smaller groups were brought back together for discussion to narrow the list of potential priorities. Next, from the condensed list of potential priority need areas, participants were given three dot stickers to vote for their top three concerns. Following voting, a brief discussion occurred to finalize the priority need areas for Nash County.

The final priority need areas were not ranked in any particular order of importance, and each will be addressed by the CHNA leadership in Nash County. The following three focus areas (Behavioral Health: Mental Health & Substance Use, Healthcare Access & Quality, and Social Drivers of Health with Emphasis on Economic Stability) were identified as Nash County's top priority health needs to be addressed over the next three years, as seen in **Figure 9** below:

Figure 9: Nash County 2024 Priority Health Needs



The following organizations participated in the prioritization voting process:

- Area L AHEC
- Boice Willis
- Candid Screening
- Carolina Family Health Centers, Inc.
- City of Rocky Mount
- Communities in Schools of the Rocky Mount Region INC
- Community Peer Support Specialist
- County Commissioner
- Cross River Therapy
- Down East Partnership for Children
- Nash County DSS
- Dynamik Learning
- East Coast Migrant Head Start Project
- ECU Nursing (Student)
- Emergency Management Services
- Nash County Farmers Market
- Halifax Community College
- Health Department
- Lakeside Church
- Nash Community College
- Nash County EMS
- Nash County Government
- Nash County Health Department
- Nash County Public Schools
- Nash County Senior Center

- NC Cooperative Extension
- OIC Healthcare
- Ripple Effects
- Rocky Mount Housing Authority
- Spaulding Family Resource Center
- Trillium Health Resources
- UNC Health Nash
- UNC Health Nash/Twin Co. Partnership for Healthier Communities
- UNC Nash Foundation
- United Way Tar River region
- Ward Specialty Pharmacy
- North Carolina Wesleyan University
- Wright Center
- Harrison Family YMCA

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 Nash 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. Resource limitations meant that county leaders relied on convenience sampling to engage with the community via the web-based survey. This method of survey sampling may fail to capture a truly representative cross-section of the community, resulting in overrepresentation of some demographic groups and underrepresentation of others. This can lead to findings that don't accurately reflect the health needs and perspectives of the entire community, particularly those from underrepresented or marginalized groups. Efforts were made to include diverse community members in survey efforts, and overall, the composition of survey respondents in terms of race and ethnicity were similar to that of the county as a whole. Roughly 47% of all respondents identified as White compared to 48% of Nash County as a whole. Additionally, 40% of all respondents identified as Black or African American compared, which slightly exceeded the total population of the county that identifies as Black or African American (39%). Roughly 8% of respondents identified as Hispanic, which mirrored the percentage of the overall county population. There were also respondents who identified with other races and multiple races. Furthermore, the overall positive survey response rate increased the ability of the CHNA Steering Committee to assess health needs and disparities across community groups, including racial/ethnic minority groups.

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

Nash County is located in the Inner Coastal Plain region of North Carolina, characterized by low-lying areas, winding rivers, and rolling hills. It covers 542 square miles, including 540 square miles of land and 2 square miles of water. Nash is comprised of 12 municipalities: Town of Whitakers, Town of Momeyer, Corinth, City of Rocky Mount, Town of Bailey, Town of Castalia, Town of Dortches, Town of Middlesex, Town of Nashville (County Seat), Town of Red Oak, Town of Spring Hope, and Town of Sharpsburg. Nearly half (49.7%) of Nash 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.

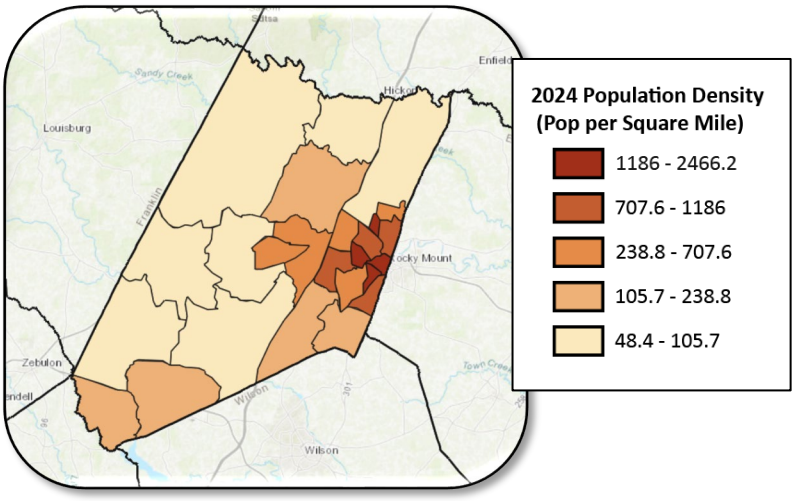
Nash County has a population of 95,699, making up approximately 0.9% of North Carolina's total population.

Table 1: Total Population, 2023[8]

	Nash County	North Carolina	United States
Population	95,699	10,765,678	337,470,185

Nash County has a population density of 177.6 persons per square mile – lower than the population density for North Carolina (214.7 persons per square mile). Rocky Mount is the most densely populated area in the county.

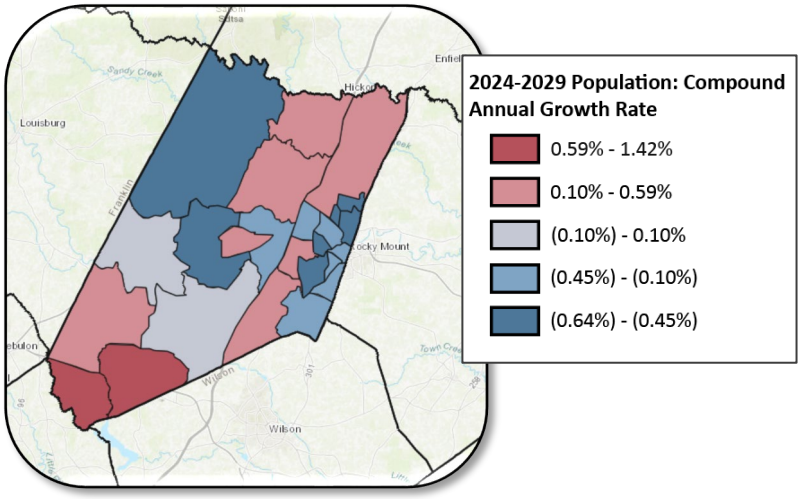
Figure 10: Nash County Map: Population Density[8]



[8] Source: Esri. Throughout this report, maps and demographic estimates (unless otherwise noted) were developed using ArcGIS® software by Esri. ArcGIS® and ArcMap™ are the intellectual property of Esri and are used herein under license. Copyright © Esri. All rights reserved. For more information about Esri® software, please visit www.esri.com.

In total, the population of Nash County is projected to grow 0.05% annually between 2024 and 2029. Areas in the southern parts of the county are experiencing the greatest growth.

Figure 11: Nash County Map: Population Growth[8]



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 Nash County skews older than the state. The county has a slightly lower percentage of residents below 15 (17.2%) compared to North Carolina (17.9%). The percentage of residents between 15 and 44 (36.0%) is lower than the state average (39.3%). However, the county has higher proportions of residents ages 45 to 64 (27.0% vs. 25.1% state) and 65 and older (19.8% vs. 17.7% state).

Table 2: Age Distribution, 2023[8]

	Nash County	North Carolina	United States
Percentage below 15	17.2%	17.9%	18.1%
Percentage between 15 and 44	36.0%	39.3%	39.5%
Percentage between 45 and 64	27.0%	25.1%	24.6%
Percentage 65 and older	19.8%	17.7%	17.8%

Like North Carolina overall, Nash County has more female than male residents. Females make up 51.9% of the county's residents while males comprise 48.1%, a distribution similar to the state's ratio.

Table 3: Sex Distribution, 2023[8]

	Nash County		North Carolina		United States	
	Count	Pct. of Total	Count	Pct. of Total	Count	Pct. of Total
Female	49,688	51.9%	5,489,419	51.0%	170,118,720	50.4%
Male	46,011	48.1%	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. Nash County's racial composition differs from state averages. Non-Hispanic Black residents comprise 39.0% of the population, nearly double the state average (20.4%). Non-Hispanic White residents make up 49.1% of the population, lower than North Carolina's 61.2%. The county has lower percentages of Asian (0.5% vs. 3.5% state) and American Indian Alaskan Native (AIAN) (0.8% vs. 1.2% state) populations.

Table 4: Racial Distribution, 2023[8]

	Nash County		North Carolina		United States	
	Count	Pct. of Total	Count	Pct. of Total	Count	Pct. of Total
Black (Non-Hispanic)	37,325	39.0%	2,199,488	20.4%	42,132,758	12.5%
White (Non-Hispanic)	47,006	49.1%	6,590,161	61.2%	204,562,590	60.6%
Asian	1,019	0.5%	379,374	3.5%	21,088,177	6.2%
AIAN	766	0.8%	133,820	1.2%	3,831,126	1.1%
NHPI	44	0.0%	9,214	0.1%	712,229	0.2%
Some Other Race Alone	5,003	5.2%	677, 338	6.3%	29,432,586	8.7%
Two or More Races	4,536	4.7%	776,283	7.2%	35,710,719	10.6%

By ethnicity, 8.2% of the county's population is Hispanic, lower than the North Carolina average (11.4%).

Table 5: Ethnic Distribution, 2023[8]

	Nash County		North Carolina		United States	
	Count	Pct. of Total	Count	Pct. of Total	Count	Pct. of Total
Non-Hispanic	87,848	91.8%	9,465,874	88.6%	271,934,049	80.6%
Hispanic	7,851	8.2%	1,299,804	11.4%	65,536,136	19.4%

The proportion of foreign-born individuals residing in Nash County is 4.1%, less than half of North Carolina's 9%.

Table 6: Foreign Born Population, 2022[9]

	Nash County	North Carolina	United States
Foreign Born	4.1%	9%	13.9%

The diversity of Nash County is reflected in the languages that residents speak at home. According to the most recent American Community Survey (ACS), approximately 7% of Nash County residents speak a language other than English at home, compared to around 13% of North Carolina and 22% U.S. residents. Spanish is spoken by 6.2% of the population, lower than the state average (7.9%).

Table 7: Language Spoken at Home, 2022[9]

	Nash County	North Carolina	United States
English Only	92.5%	87.3%	78%
Spanish	6.2%	7.9%	13.3%
Indo-European Languages	0.3%	2.1%	3.8%
Asian and Pacific Islander Languages	0.4%	1.9%	3.6%
Other Languages	0.6%	0.8%	1.2%

Disability Status[10]

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. Nash County's disability rate (13.0%) is nearly equivalent to the state average of 13.3%.

Table 8: Disability Status, 2022[9]

	Nash County	North Carolina	United States
Population with a Disability	13.0%	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. The veteran population in Nash County (6.4%) is lower than the state average of 7.8%,

[9] Source: U.S. Census Bureau. "Selected Social Characteristics in the United States." *American Community Survey, ACS 5-Year and 1-Year Estimates Data Profiles, Table DP02,* 2022, https://data.census.gov. Accessed on April 1, 2024.
[10] 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 9: Veteran Status, 2022[9]

	Nash County	North Carolina	United States
Veterans	6.4%	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 Nash County is $58,220, lower than the median for North Carolina.

Table 10: Median Household Income, 2023[8]

	Nash County	North Carolina	United States
Median Household Income	$58,220	$64,316	$72,603

In 2023, approximately 11% of Nash County households were below the federal poverty level (FPL) – slightly higher than the state overall. 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.

Table 11: Percent of Households Below the Federal Poverty Level, 2023[8]

	Nash County	North Carolina	United States
Percent Below FPL	11.2%	10.1%	9.5%

Approximately one in five Nash County households received Food Stamps/SNAP (Supplemental Nutrition Assistance Program) in 2022. This is notably higher than the proportion for broader North Carolina.

Table 12: Households Receiving Food Stamps/SNAP, 2022[11,12]

	Nash County	North Carolina	United States
Number of Households Receiving Food Stamps/SNAP	8,294	575,860	16,072,733
Total Number of Households	39,677	4,299,266	129,870,928
Percentage of Households receiving Food Stamps/SNAP	20.9%	13.4%	12.4%

In Nash County, 28.2% of the population has completed high school alone, higher than the state average (21.2%). The county has lower percentages of residents with less than 9th grade education (4.8% vs. 6.0% state) but higher percentages with some high school but no diploma (8.8% vs. 5.5% state). Nash has a slightly lower rate of residents with some college education (19.6% vs. 21.1% state) but higher rates of associate's degrees (11.7% vs. 9.9% state). However, the county shows lower rates of advanced education, with bachelor's degrees (14.6%) lower than the state average (20.4%) and graduate/professional degrees (6.5%) at less than half of North Carolina's rate (11.6%).

Table 13: Educational Attainment, 2020[13,14]

	Nash County	North Carolina	United States
Less than 9th Grade	4.8%	6.0%	3.5%
Some High School/No Diploma	8.8%	5.5%	5.3%
High School Diploma	28.2%	21.2%	28.5%
GED/Alternative Credential	5.7%	4.3%	*[15]
Some College/No Diploma	19.6%	21.1%	14.6%
Associate's Degree	11.7%	9.9%	10.5%
Bachelor's Degree	14.6%	20.4%	23.4%
Graduate/ Professional Degree	6.5%	11.6%	14.2%

The overall unemployment rate in Nash County (6.4%) is higher than both state (5.1%) and national (3.9%) averages. Young people between ages 16 and 24 face higher unemployment (14.2%) compared to North

[11] Source (for County): North Carolina Department of Health and Human Services. FNS Cases and Participants (March 2024). https://www.ncdhhs.gov/divisions/social-services/program-statistics-and-reviews/fns-caseload-statistics-reports. Note: county household estimate is from Esri (2023).
[12] Source (for North Carolina and United States): U.S. Census Bureau. "Food Stamps/Supplemental Nutrition Assistance Program (SNAP)." *American Community Survey, ACS 1-Year Estimates Subject Tables, Table S2201*, 2022, https://data.census.gov/table/ACSST1Y2022.S2201?q=s2201&g=010XX00US_040XX00US37&moe=false. Accessed on April 1, 2024.
[13] Source (for County and North Carolina): U.S. Census Bureau. "Educational Attainment for the Population 25 Years and Over." *American Community Survey, ACS 5-Year Estimates Detailed Tables, Table B15003,* 2020, https://data.census.gov/table/ACSDT5Y2020.B15003?q=b15003&g=040XX00US37,37$0500000&moe=false. Accessed on April 1, 2024.
[14] Source (for United States): U.S. Census Bureau. "Educational Attainment in the United States: 2022." Table 1, All Races. https://www.census.gov/data/tables/2022/demo/educational-attainment/cps-detailed-tables.html
[15] U.S. totals combine GED with High School Diploma

Carolina's rate (12.4%). The unemployment rate for ages 25 to 54 (7.1%) is also higher than the state figure (4.7%). However, the county shows lower rates for workers ages 55 to 64 (2.5% vs. 3.3% state) and those 65 or more (0.8% vs. 3.0% state). This data indicates employment challenges particularly among younger and working-age adults.

Table 14: Unemployment, 2022[16,17]

	Nash County	North Carolina	United States
Percentage unemployed ages 16 to 24	14.2%	12.4%	11.0%
Percentage unemployed ages 25 to 54	7.1%	4.7%	3.4%
Percentage unemployed ages 55 to 64	2.5%	3.3%	2.7%
Percentage unemployed ages 65 or more	0.8%	3.0%	2.9%
Total unemployment	6.4%	5.1%	3.9%

Nash County's overall uninsured rate (11.6%) is lower than the state average (15.0%). The county shows slightly higher uninsured rates for those 18 and below (5.6%) compared to the state average (5.2%). The uninsured rate for ages 19 to 34 (20.7%) is notably higher than North Carolina's 15.5%. The county's uninsured rate for ages 35 to 64 (13.3%) is also higher than the state's 12.5%. This data suggests that while Nash County performs better overall in terms of insurance coverage, residents across all age groups face challenges in accessing health insurance, with particularly high rates among young adults.

Table 15: Health Insurance Status, 2022[18]

	Nash County	North Carolina	United States
Percentage uninsured ages 18 or below	5.6%	5.2%	5.4%
Percentage uninsured ages 19 to 34	20.7%	15.5%	13.6%
Percentage uninsured ages 35 to 64	13.3%	12.5%	9.9%
Total % Uninsured	11.6%	15.0%	12.0%

[16] Source (for County and North Carolina): U.S. Census Bureau. "Employment Status." *American Community Survey, ACS 5-Year Estimates Subject Tables, Table S2301,* 2022, https://data.census.gov/table/ACSST5Y2022.S2301?q=S2301&g=040XX00US37,37$0500000&moe=false. Accessed on April 1, 2024.

[17] Source (for United States): Federal Reserve Bank of Saint Louis. Federal Reserve Economic Data - FRED (March 2024). https://fred.stlouisfed.org/

[18] Source: U.S. Census Bureau. "Selected Characteristics of Health Insurance Coverage in the United States." *American Community Survey, ACS 5-Year Estimates Subject Tables, Table S2701,* 2022, https://data.census.gov/table/ACSST5Y2022.S2701?q=s2701&g=010XX00US_040XX00US37,37$0500000&moe=false. Accessed on April 1, 2024.

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 12: Social Determinants of Health

As seen in **Figure 12**, 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.

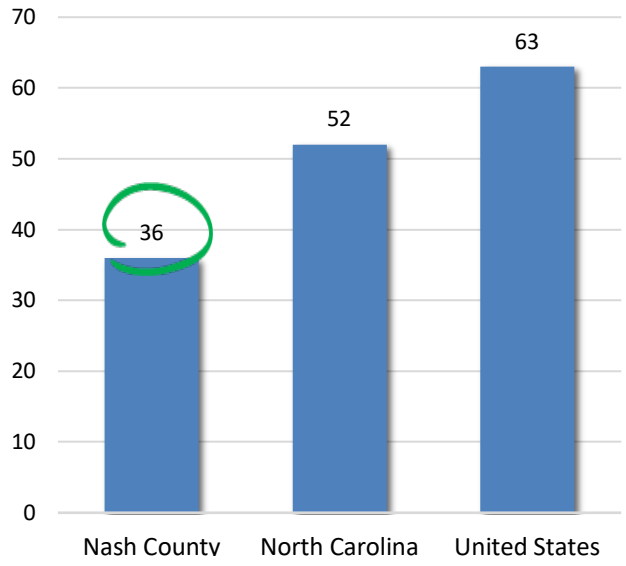
<u>Disparities</u>

Recognizing the diversity of Nash 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

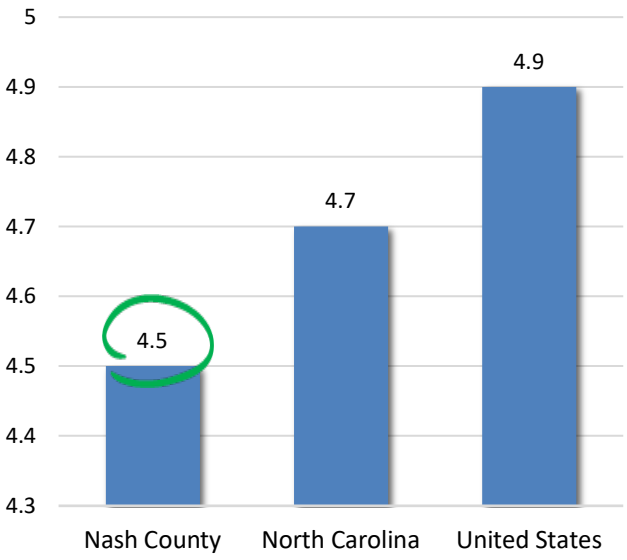
tracts. Lower scores represent a higher level of integration. There is less residential segregation in Nash compared to the state and country, as seen in **Figure 13**.

Figure 13: Residential Segregation[5]



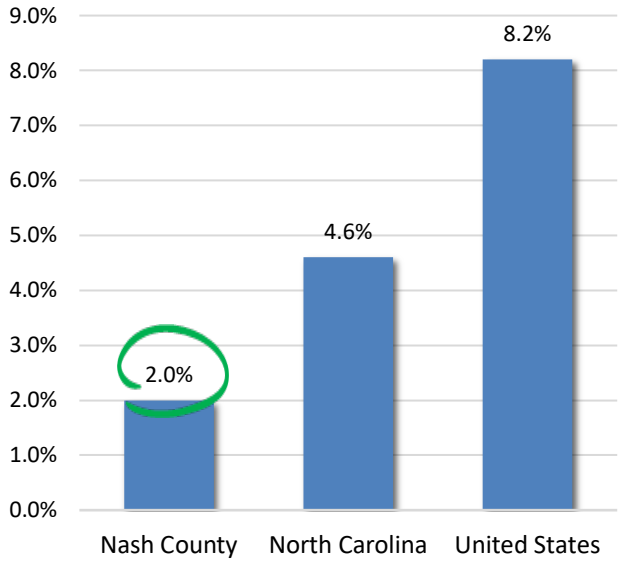
Income inequality is measured as the ratio of household income at the 80th percentile to household income at the 20th percentile. Communities with greater income inequality may have worse outcomes on a variety of metrics, including mortality, poor health, sense of community, and social support. As seen in **Figure 14**, the income inequality ratio in Nash County is lower than state and national figures.

Figure 14: Income Inequality Ratio[5]



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 Nash compared to the state and country, as seen in **Figure 15**.

Figure 15: Percent of Population with Limited English Proficiency[9]



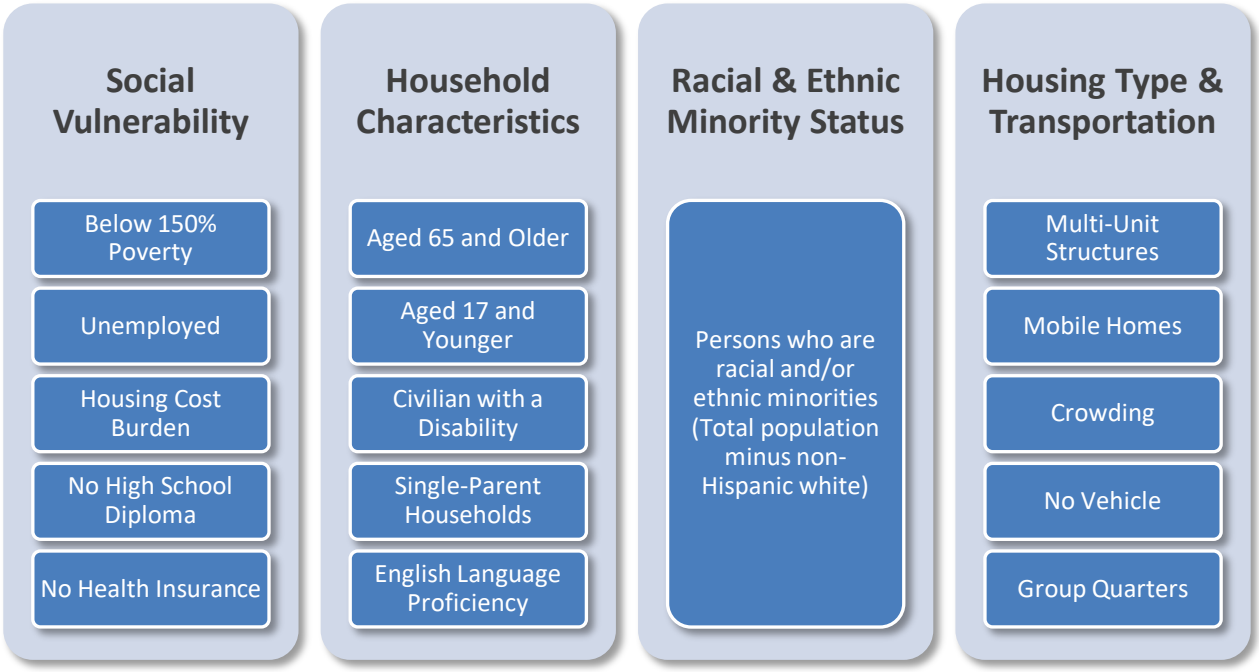
Social Vulnerability Index

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.[19] 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 16** outlines the variables used to calculate SVI scores.

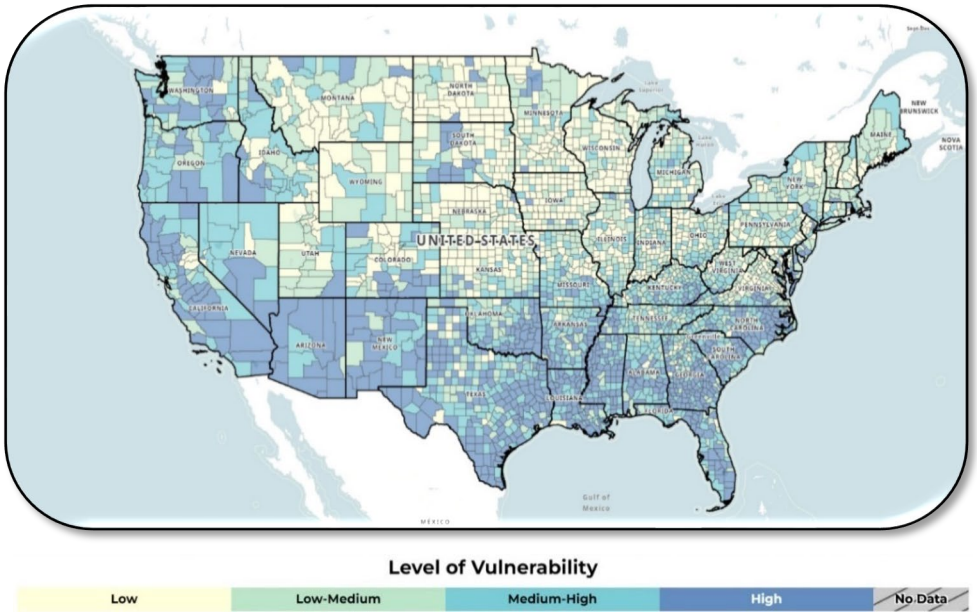
[19] Source: Centers for Disease Control and Prevention (2024). Social Vulnerability Index. https://www.atsdr.cdc.gov/place-health/php/svi/index.html

Figure 16: SVI Variables



The United States SVI by county is shown in **Figure 17** below. As shown, a lot of variation exists across the country, and even within individual states.

Figure 17: United States SVI by County, 2022



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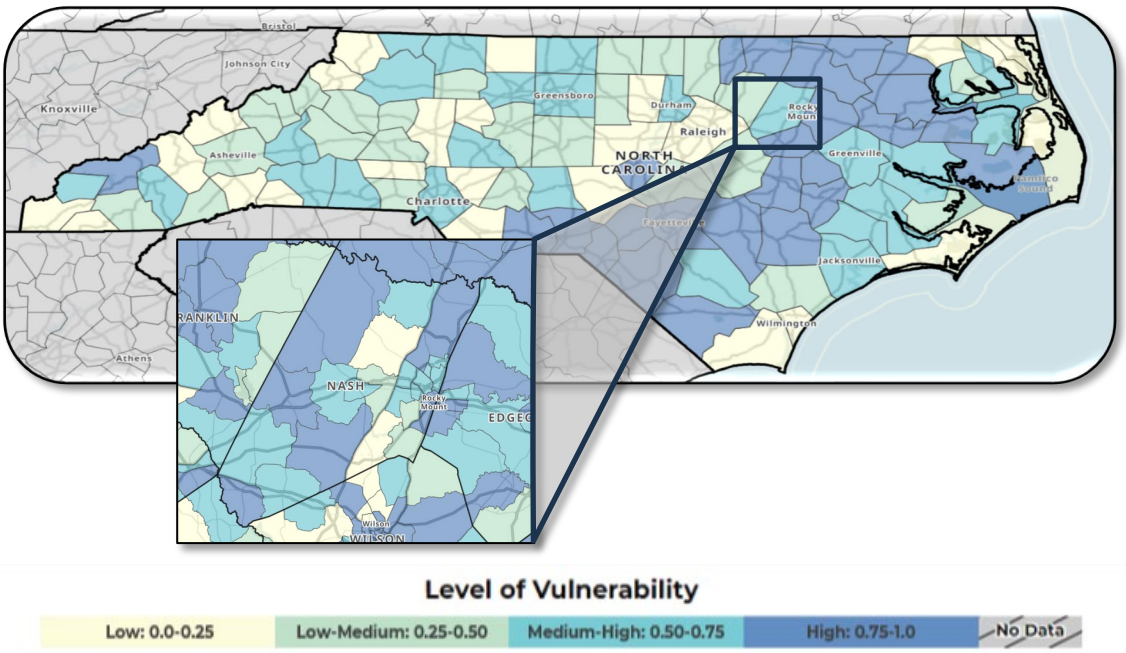
The 2022 SVI scores for Nash County are shown in **Figure 18** below. Possible scores range from 0 (lowest vulnerability) to 1 (highest vulnerability), and these scores show a relative comparison with other counties and census tracts in North Carolina. The vulnerability of Nash County overall is higher than average compared to the state. Levels of vulnerability are variable across the county with the average being 0.75.

Figure 18: Nash County SVI by Census Tract, 2022



Environmental Justice Index

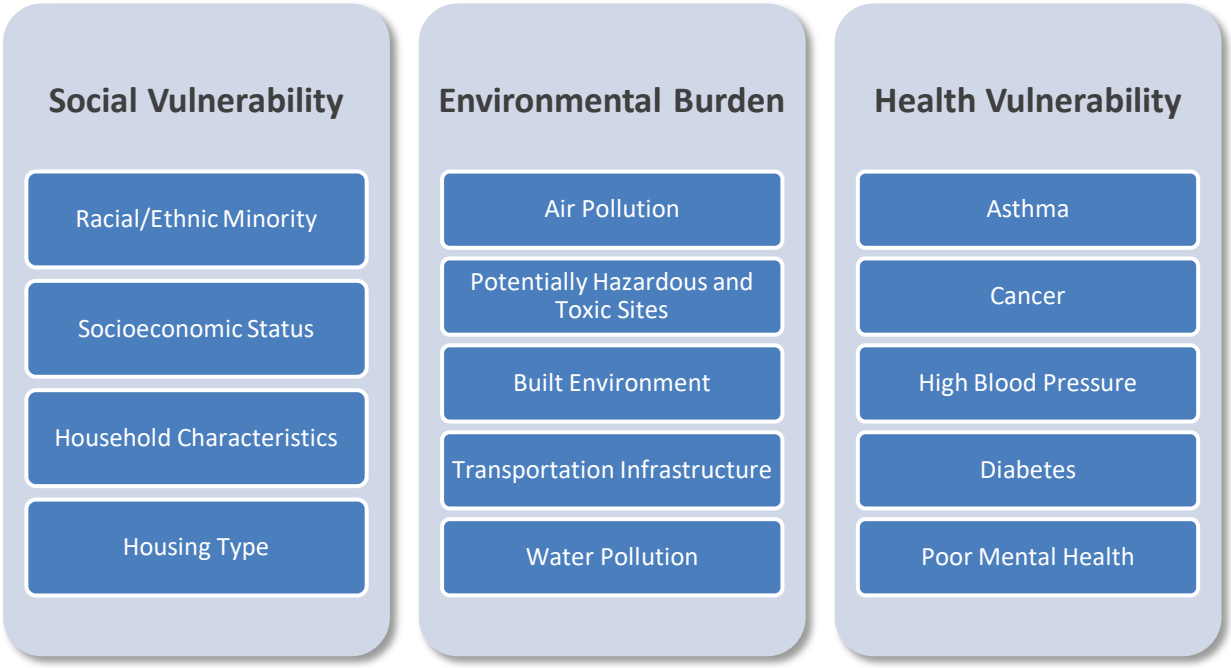
Environmental justice means the just treatment and meaningful involvement of all people, regardless of income, race, color, national origin, Tribal affiliation, or disability, in agency decision-making and other Federal activities that affect human health and the environment. It aims to protect everyone 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.[20]

The CDC/ATSDR Environmental Justice Index (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 U.S. Centers for Disease Control and Prevention. 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 19** outlines the variables used to calculate EJI scores.

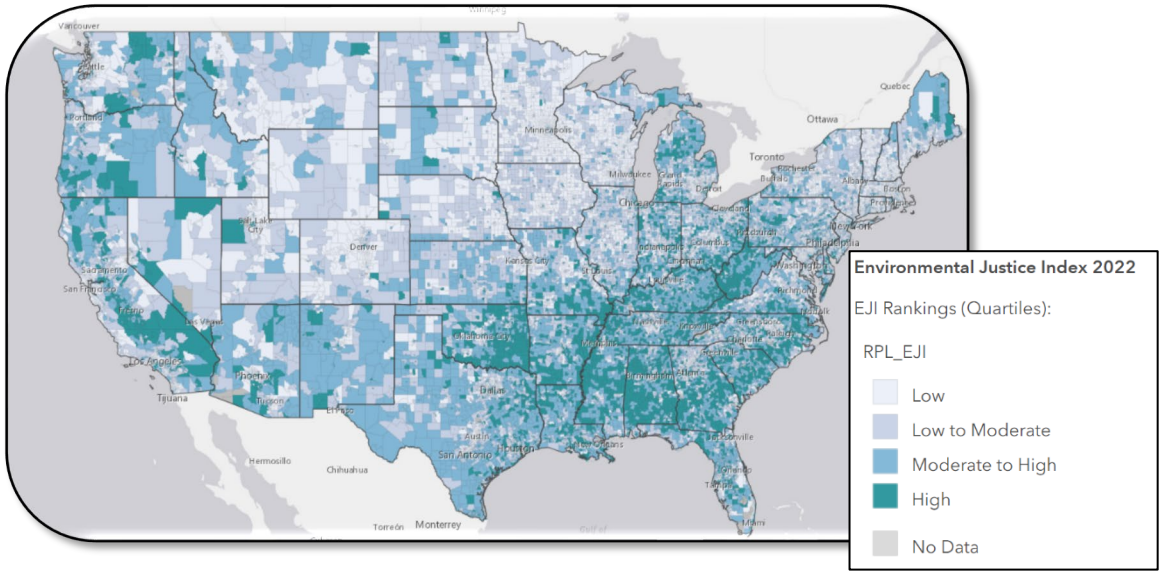
[20] Source: Centers for Disease Control and Prevention (2024). Environmental Justice Index. https://www.atsdr.cdc.gov/place-health/php/eji/index.html#cdc_generic_section_3-eji-tools-and-resources

Figure 19: EJI Variables



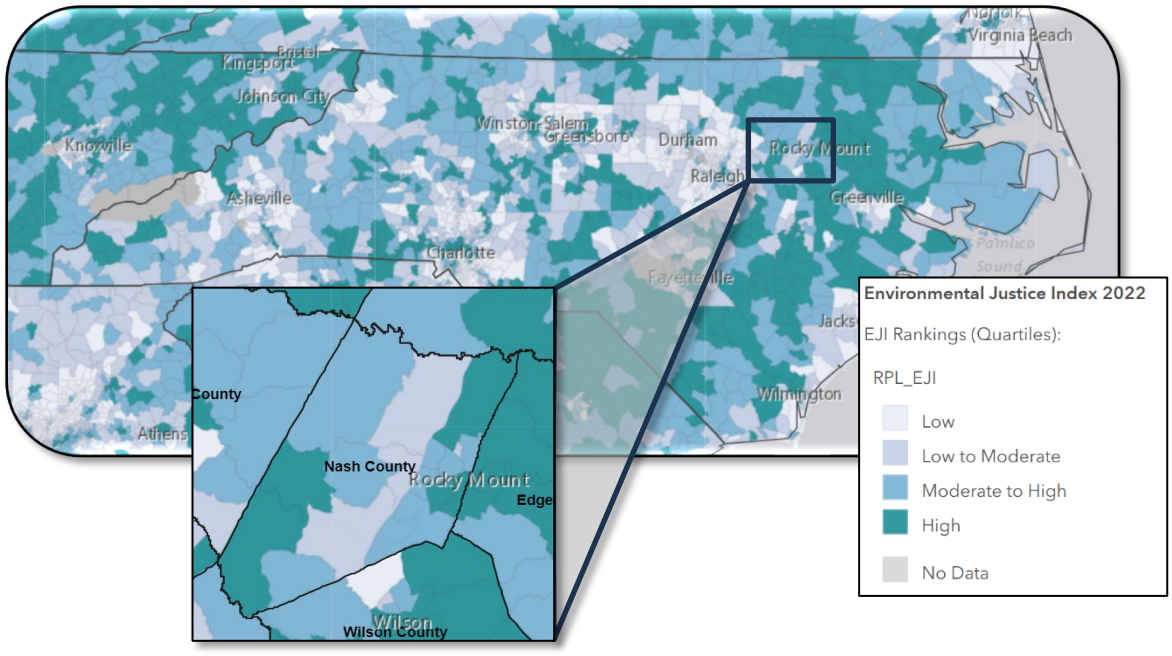
The United States EJI by county is shown in **Figure 20** below. As shown, a lot of variation exists across the country, and even within individual states.

Figure 20: United States EJI by Census Tract, 2022



The 2022 EJI scores for Nash County are shown in **Figure 21** 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 0.66.

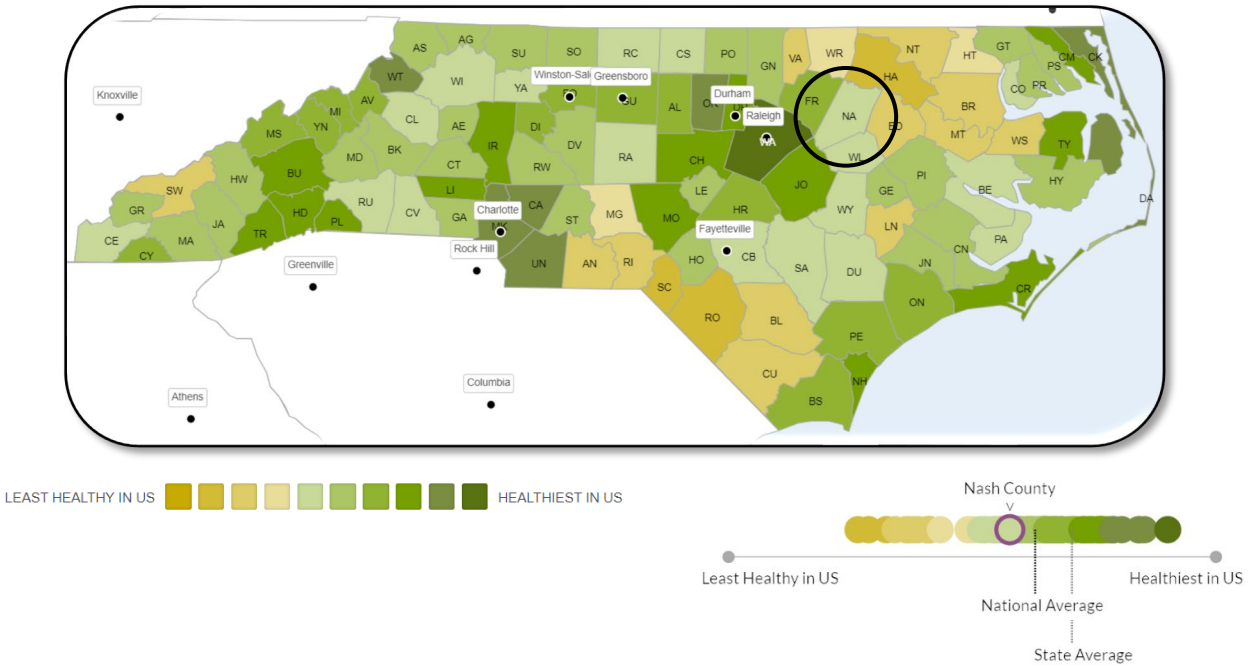
Figure 21: Nash County EJI by Census Tract, 2022



Health Outcome and Health Factor Rankings

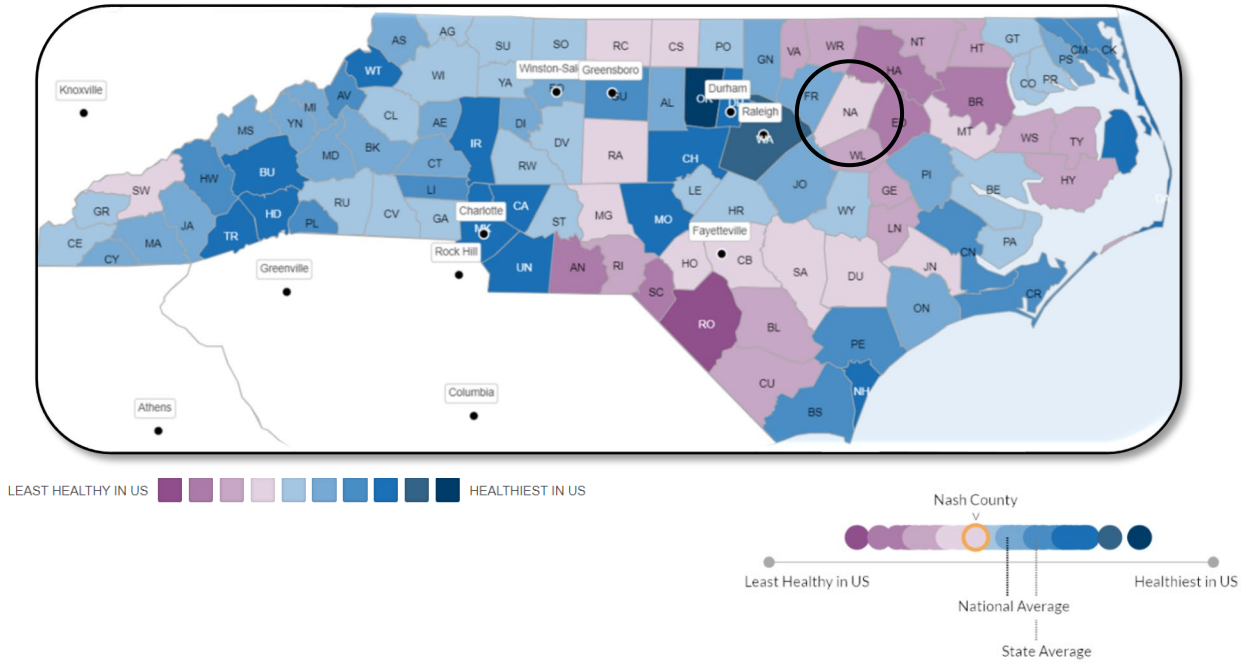
County leaders also reviewed and analyzed data from the Robert Wood Johnson Foundation and the University of Wisconsin County Health Rankings for the year 2024. The Health Outcomes measure looks at how long people in a community live and how physically and mentally healthy they are. These categories are discussed further in **APPENDIX 2 | SECONDARY** DATA METHODOLOGY AND SOURCES. Nash is behind the average for the country and the state, which means people there may be less healthy on average.

Figure 22: State Health Outcomes Rating Map[5]



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 | SECONDARY** DATA METHODOLOGY AND SOURCES. Similarly to the Health Outcome measure, Nash falls behind the average for the country and the state.

Figure 23: State Health Factors Rating Map[5]



CHAPTER 3 | PRIORITY NEED AREAS

This chapter describes each of the three 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). As previously described in **CHAPTER 1 |** METHODOLOGY, secondary data was primarily sourced using the North Carolina Data Portal. For additional descriptive information on data sources and methodology, please see **APPENDIX 2** | SECONDARY DATA METHODOLOGY AND SOURCES.

This chapter describes each of the three 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 key leader survey, community member survey, and focus groups).

As mentioned previously, these priority needs areas are not listed in any hierarchical order of importance and all will be addressed by the Nash County leaders in health improvement plans guided by this CHNA. As noted in **CHAPTER 1** | METHODOLOGY, 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: ACCESS TO QUALITY HEALTHCARE

Context and National Perspective

Access to care means patients are able to get high quality, affordable healthcare in a timely fashion to achieve the best possible health outcomes. It includes several components, including coverage (i.e. insurance), a physical location where care is provided, the ability to receive timely care, and enough providers in the workforce. The CHNA Steering Committee identified access to care as a high priority need for residents of Nash County

From a national perspective, according to Healthy People 2030, approximately one in ten people in the U.S. do not have health insurance, which means they are less likely to have a primary care provider or to

be able to afford the services or medications they need.[21] Access is a challenge even for those who are insured.[22]

The availability and distribution of health providers in the U.S. contributes to healthcare access challenges. According to the Association of American Medical Colleges (AAMC), there is estimated to be a shortage of 13,500 to 86,000 physicians in the U.S. by 2036, which will impact both primary and specialty care.[23] Access issues are anticipated to increase in coming years. Growing shortages of both nurses and doctors are being driven by several factors, including population growth, the aging U.S. population requiring higher levels of care, provider burnout (physical, mental and emotional exhaustion) made worse by the COVID-19 pandemic, and a lack of clinical training programs and faculty – particularly for nurses.[24] The aging of the current physician workforce is also driving anticipated personnel shortages. In North Carolina, 30.6% of actively practicing physicians were over the age of 60 in 2020.[25] Access is also impacted by the number of actively practicing physicians overall. In 2020, there were just 9,211 primary care physicians in North Carolina, with 27,650 physicians actively practicing overall.[26]

The ability to access healthcare is not evenly distributed across groups in the population. Groups who may have trouble accessing care include the chronically ill and disabled (particularly those with mental health or substance use disorders), low-income or homeless individuals, people located in certain geographical areas (rural areas; tribal communities), members of the LGBTQIA+ community, and certain age groups – particularly the very young or the very old.[27] In addition, individuals with limited English proficiency (LEP) face barriers to accessing care, experience lower quality care and have worse outcomes for health concerns. LEP is known to worsen health disparities and can make challenges related to other SDoH (access to housing, employment, etc.) worse.[28] Both primary and secondary data resources analyzed for this report highlight the need for greater access to health services within Nash County.

Secondary Data Findings

Access to quality health care is a significant concern for Nash County. The county's performance on multiple healthcare access and quality metrics was worse than state and national averages, indicating a high need in this area. Nash County faces significant challenges in terms of healthcare provider availability.

[21] Source: U.S. Department of Health and Human Services Office of Disease Prevention and Health Promotion (2023). *Healthy People 2030: Health Care Access and Quality*. Retrieved September 9th, 2024 from https://health.gov/healthypeople/objectives-and-data/browse-objectives/health-care-access-and-quality.

[22] Source: Phillips, K.A., Marshall, D.A., Adler, L., Figueroa, J., Haeder, S.F., Hamad, R., Hernandez, I., Moucheraud, C., Nikpay, S. (2023). Ten health policy challenges for the next ten years. *Health Affairs Scholar*. Retrieved from: https://academic.oup.com/healthaffairsscholar/article/1/1/qxad010/7203673.

[23] Source: Association of American Medical Colleges (AAMC) (2024). *The complexities of physician supply and demand: Projections from 2021 to 2036*. Retrieved from: https://www.aamc.org/media/75236/download?attachment .

[24] Source: Association of American Medical Colleges (AAMC) (2024). *State of US Nursing Report 2024*. Retrieved, from https://www.incrediblehealth.com/wp-content/uploads/2024/03/2024-Incredible-Health-State-of-US-Nursing-Report.pdf .

[25] Source: AAMC (2021). *North Carolina physician workforce profile*. Retrieved September 9, 2024, from: https://www.aamc.org/media/58286/download.

[26] Source: AAMC (2021). *North Carolina physician workforce profile*. Retrieved September 9, 2024, from: https://www.aamc.org/media/58286/download

[27] Source: Joszt, L. (2018). 5 Vulnerable Populations in Healthcare. *American Journal of Managed Care*. Retrieved September 9, 2024 from https://www.ajmc.com/view/5-vulnerable-populations-in-healthcare.

[28] Source: Espinoza, J. and Derrington, S. (2021). How Should Clinicians Respond to Language Barriers That Exacerbate Health Inequity? *AMA Journal of Ethics*. Retrieved from: https://journalofethics.ama-assn.org/article/how-should-clinicians-respond-language-barriers-exacerbate-health-inequity/2021-02.

The rate of primary care providers per 100,000 population in Nash County (84.2) is lower than both the state (101.1) and national (112.4) averages. This shortage of primary care professionals may contribute to difficulties in accessing timely and appropriate care for various health concerns.

Table 16: Healthcare Provider Rates

Indicator	Nash County	North Carolina	United States
Substance Abuse Providers (Rate per 100,000 Population)	17.9	25.0	27.9
Buprenorphine Providers (Rate per 100,000 Population)	7.4	15.2	15.5
Dental Providers (Rate per 100,000 Population)	31.6	31.5	39.1
Mental Health Providers (Rate per 100,000 Population)	74.8	155.7	178.7
Primary Care Providers (Rate per 100,000 Population)	84.2	101.1	112.4

The disparity is even more pronounced for other types of healthcare providers. Nash County has a lower rate of substance abuse providers (17.9 per 100,000 population) compared to the state rate of 25.0 and the national rate of 27.9. In addition, the rate of buprenorphine providers (7.4 per 100,000 population) is half of the North Carolina (15.2) and national rate (15.5). The rate of dental providers (31.6 per 100,000 population) is comparable to the state average (31.5) but lower than the national average (39.1). Additionally, 40% of Nash County's population lives in an area designated as a Dental Health Professional Shortage Area (HPSA), compared to 34% in North Carolina and 18% nationally.

In terms of healthcare quality indicators, Nash County results indicate that, while the 30-day hospital readmission rate in Nash County (18%) is on par with the state and national averages, the county has a significantly higher rate of preventable hospitalizations (3,503 per 100,000 Medicare beneficiaries) compared to the state average (2,957) and national average (2,752). This could indicate issues with access to primary care or preventive services that can help keep people out of the hospital.

Table 17: Healthcare Quality Indicators

Indicator	Nash County	North Carolina	United States
Percentage of Population Living in an Area Affected by a Dental Care HPSA	40%	34%	18%
Percent of Insured Population Receiving Medicaid	24%	20%	22%
Rate of Federally Qualified Health Centers (Rate per 100,000 Population)	3.2	4.0	3.5
Percentage of Adults with Recent Influenza Immunization	39%	46%	45%

Preventable Hospitalizations, (Rate per 100,000 Beneficiaries)	3,503	2,957	2,752
30-Day Hospital Readmissions, Rate	18%	18%	18%

Nash County has higher Medicaid enrollment rates compared to state and national averages. The percentage of the insured population receiving Medicaid in Nash County is 24%, compared to 20% in North Carolina and 22% nationally. This higher Medicaid enrollment rate could indicate a higher level of need for affordable healthcare options in the county.

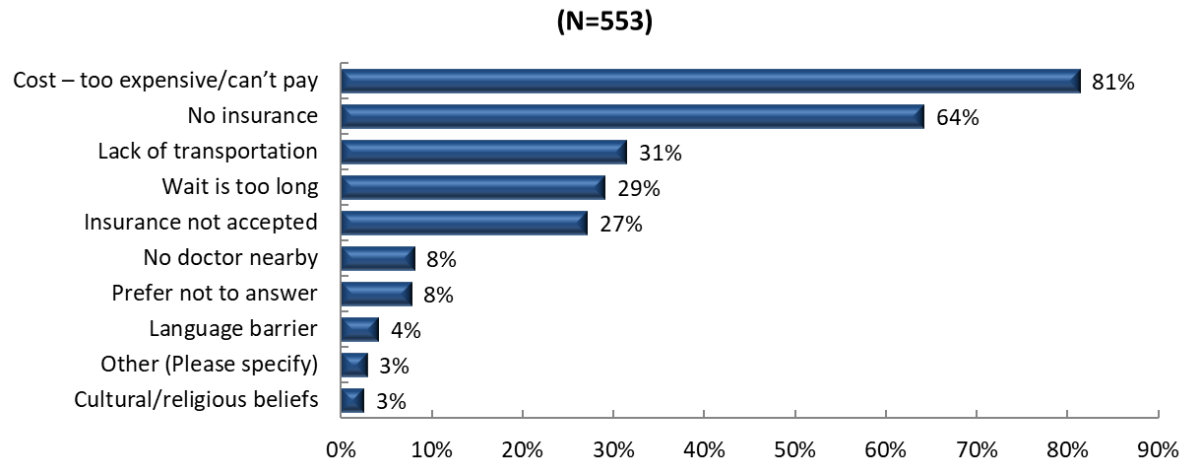
These data suggest that Nash County faces significant challenges in healthcare access and quality, particularly in terms of healthcare provider availability across various specialties. The lower rates of healthcare providers, combined with higher rates of preventable hospitalizations and lower rates of preventive care, indicate a pressing need for improved access to and quality of healthcare in the county.

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

Primary Data Findings – Community Member Web Survey

Over 550 Nash residents responded to the web-based survey. Respondents identified several access to care needs in Nash County. In the survey, community members were asked to identify the top barriers to receiving healthcare. Cost (81%), no insurance (64%), lack of transportation (31%) and wait times (29%) were the top four identified reasons why people in the community are not getting care when they need it. Another one-third (27%) of respondents indicated that their insurance not being accepted was also a top barrier.

Figure 24: 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.

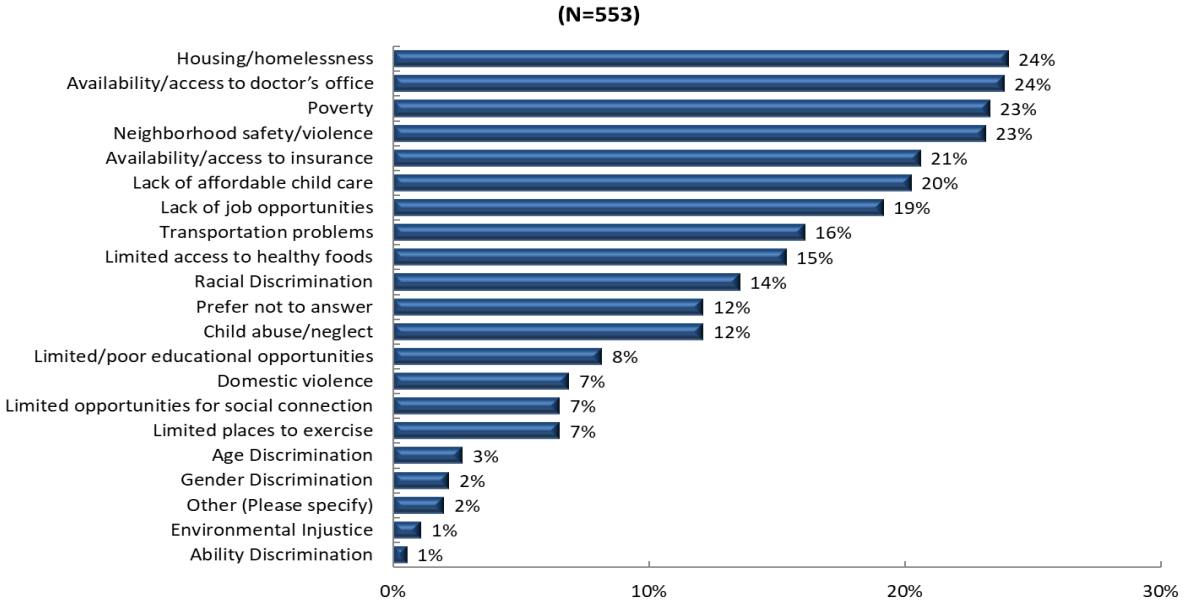


When these data were examined by demographics, top barriers were ranked similarly across all age groups genders, race, and ethnicity. Those over the age of 65 were the least likely to indicate cost and lack of insurance as top barriers to care (78%, 52%). However, while disparities were not indicated as

significant in the community survey, other secondary and primary data indicated a need for more equitable care for minorities and other vulnerable populations.

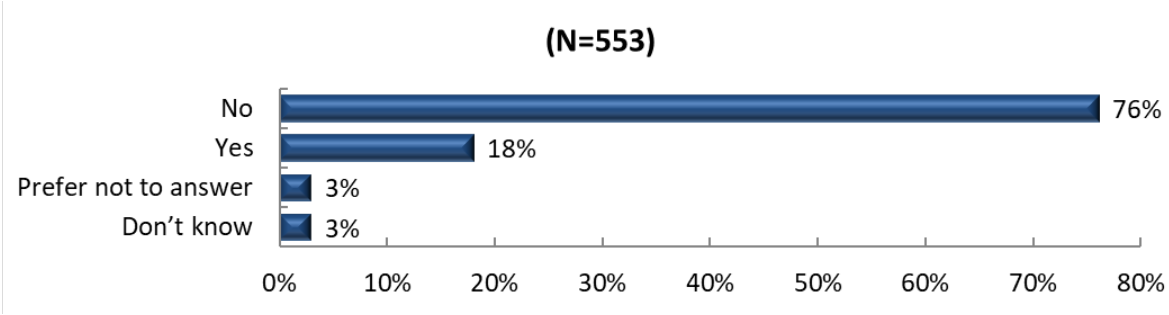
Nash County residents were also asked to identify the top social and environmental problems that impact the health and wellbeing of their community. Availability and accessibility to their provider's office was the second highest ranked concern, identified by nearly one quarter (24%) of residents. When data was viewed by demographic characteristics, those between the ages of 45 and 65 were most likely (28%) to identify this as a concern. Additionally, over one-third (32%) of White respondents cited access to their doctor's office as a problem, compared to just 17% of Black/African American respondents. The most significant demographic disparity was among non-Hispanic/Latino residents, who were significantly (26%) more likely to identify access to a doctor's office as a major concern, compared to just 11% of Hispanic/Latino respondents.

Figure 25: What are the three most important social or environmental problems that affect the health of your community? Please select up to three.



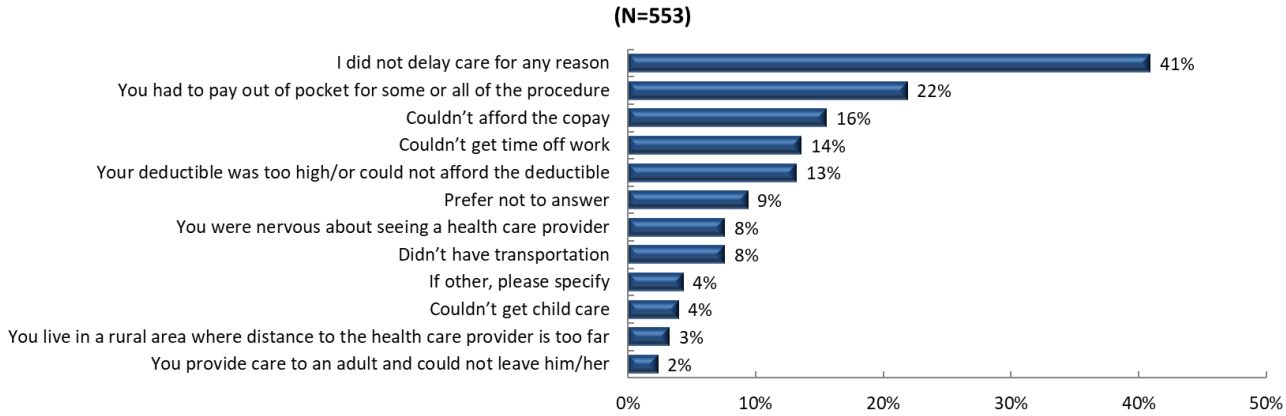
Nash County community survey respondents were also asked if there was a time during the past 12 months that they were told by their healthcare provider that their insurance was not accepted. While the majority of respondents (78%) answered "no," 18% noted that they were told their insurance was not accepted by their provider.

Figure 26: 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?



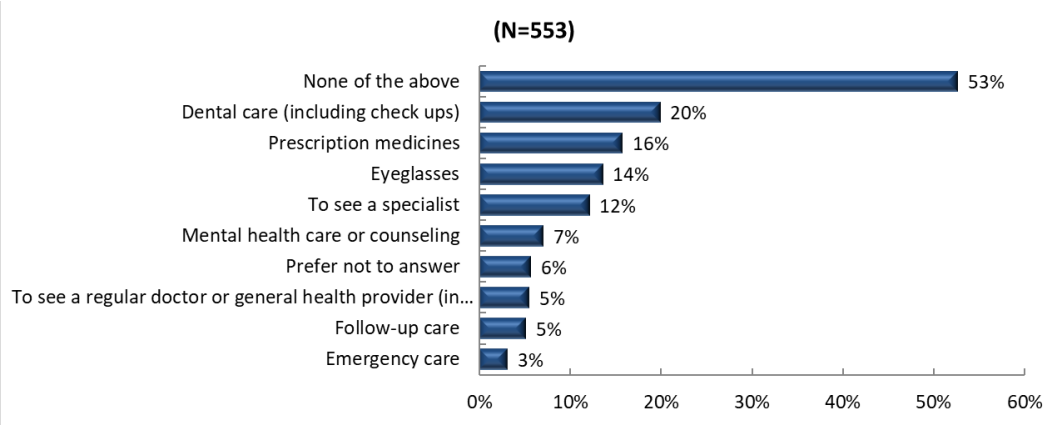
Nash County community survey respondents were also asked if there was a time during the past 12 months that they put off getting specific types of care and, if so, why that care was delayed. Nearly half (41%) of respondents indicated that they did not need to delay care for any reason. However, 22% cited that they delayed care due to the out-of-pocket cost, and 16% cited not being able to afford the copay.

Figure 27: 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?



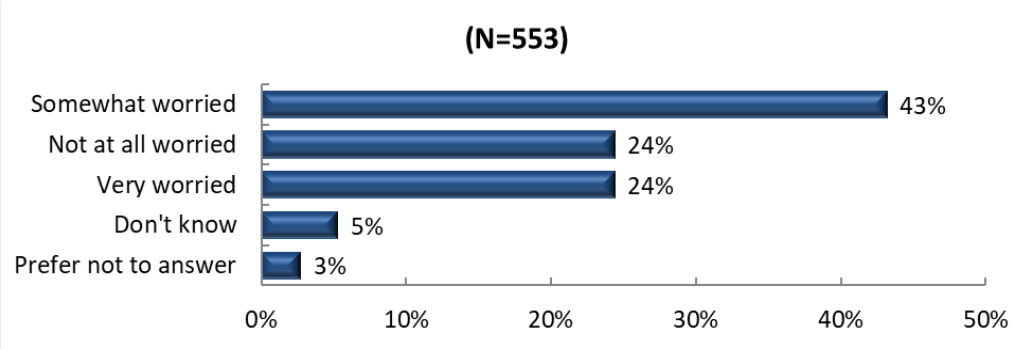
Nash County community survey respondents were also asked if there was a time during the past 12 months that they needed specific medical care or health-related items and were unable to receive it due to the cost. While over half (53%) of respondents indicated that they were not impacted in this way, 20% cited not receiving dental care, and 16% were not able to afford their prescription medications.

Figure 28: 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?



Respondents were also asked if they were worried about being able to afford an unexpected medical bill should they fall ill or become injured. As displayed in **Figure 29** below, 67% of respondents indicated being at least somewhat worried about a surprise medical bill, further supporting cost as the top-ranked barrier to care.

Figure 29: If you get sick or have an accident, how worried are you that you will be able to pay your medical bills?



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

Primary Data Findings – Focus Groups

Access to quality healthcare emerged as a key concern across focus groups in Nash County. Participants highlighted several challenges, including a significant shortage of healthcare providers and specialists in the area. This shortage often requires residents to travel outside the county for care, which is particularly challenging due to the transportation issues the groups also described. The lack of insurance and the high cost of care were cited as major obstacles for many residents seeking medical care. Language barriers and a lack of interpreter services were mentioned as additional challenges for the Hispanic/Latino population. Participants expressed concerns about the quality of available healthcare services, with some mentioning

long wait times for appointments. It was noted that school schedules are not conducive to working families seeking healthcare, disproportionately affecting lower-income households.

To address these issues, participants suggested implementing more mobile health services, especially in rural areas, offering extended hours for working families, and creating a comprehensive resource guide describing available healthcare services in the community. Recommendations also included creating more partnerships with churches and other faith-based groups to improve healthcare access and quality.

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

PRIORITY NEED: BEHAVIORAL HEALTH (MENTAL HEALTH AND SUBSTANCE USE)

Context and National Perspective

The definition of behavioral health often describes conditions related to both mental health and substance use.[29] 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.[30] After evaluating data from a variety of sources including surveys and focus groups conducted throughout the assessment process, the Steering Committee identified behavioral health, including both mental health and substance use, to be an area of urgent need within Nash 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.[31] 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. [32]

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 services in 2021. Those who had an SMI were more likely (65.4%) to have received mental health services that same year.[33] 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

[29] 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.

[30] Source: CDC. (2024). About mental health. Retrieved October 1, 2024, from: https://www.cdc.gov/mentalhealth/learn/index.htm

[31] Source: National Institute of Mental Health (2023). *Mental Illness*. Retrieved September 13th, 2023, from https://www.nimh.nih.gov/health/statistics/mental-illness.

[32] Source: CDC. (2024). Mental health. Retrieved October 1, 2024, from https://www.cdc.gov/mentalhealth/learn/index.htm

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

condition. As of 2023, over seven million people in the U.S. who reported having a mental illness lived in a rural area.[34]

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 who live in North Carolina are seven times more likely to be pushed out of the network of their behavioral health providers than a primary care provider, furthering cost as a cause for stopping treatment. [35]

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.[36] SUDs often occur in conjunction with other mental illnesses. 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.[37] 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.[38] 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.[39] Treatment of 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 of causes of death 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.[40]

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

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

[36] 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.

[37] 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.

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

[39] 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

[40] 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/

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.[41] 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.

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.[42]

Access to services that address mental health and substance use 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 findings indicate that behavioral health, encompassing both mental health and substance use, is a significant concern for Nash County. The county's performance on several key behavioral health metrics was worse than state and national averages, highlighting a high level of need in this area.
Nash County faces challenges in terms of mental health outcomes. Residents report a higher average number of poor mental health days each month (5.1 days) compared to the North Carolina state average (4.6 days) and the national average (4.9 days). This indicates that residents of Nash County are experiencing more frequent mental health challenges than their counterparts across the state and nation.

[41] 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.

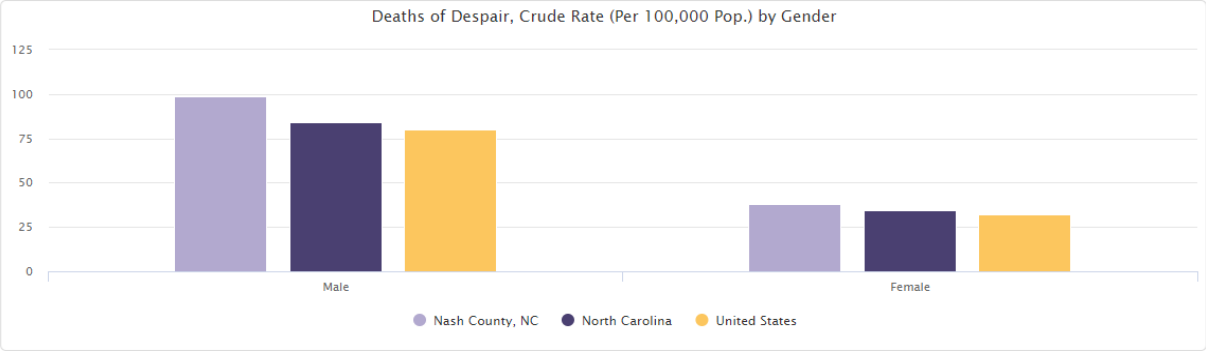
[42] Source: Panchal, N., Saunders H., Rudowitz, R. and Cox, C. (2023). The Implications of COVID-19 for Mental Health and Substance Use. *Kaiser Family Foundation*. Retrieved from https://www.kff.org/mental-health/issue-brief/the-implications-of-covid-19-for-mental-health-and-substance-use.

Table 18: Mental Health Indicators

Indicator	Nash County	North Carolina	United States
Crude Deaths of Despair (Rate per 100,000 Population)	67.3	58.7	55.9
Suicide (Rate per 100,000 Population)	12.7	14.0	14.5
Average Number of Poor Mental Health Days (per Month)	5.1	4.6	4.9

The county also has a higher crude death rate for deaths of despair (67.3 per 100,000 population) compared to both the state (58.7) and national (55.9) averages. Deaths of despair include deaths from suicide, drug overdose, and alcohol-related causes, and are often indicative of underlying mental health and substance use issues in a community. Notably, there is a substantial gender disparity in deaths of despair in Nash County, with men experiencing significantly higher rates than women.

Figure 30: Deaths of Despair by Gender in Nash County



In terms of mental health provider availability, Nash County faces significant shortages. The rate of mental health providers per 100,000 population in Nash County (74.8) is substantially lower than both the state (155.7) and national (178.7) averages. This shortage of mental health professionals may contribute to difficulties in accessing timely and appropriate care for mental health concerns. As previously described in the Access to Care section and indicated in **Table 16**, Nash County has a lower rate of substance abuse providers (17.9 per 100,000 population) and buprenorphine providers (7.4 per 100,000 population).

Regarding substance use, Nash County shows some positive indicators. The percentage of adults reporting excessive drinking in Nash County (16%) is lower than the state and national averages (18% for both). However, the county has a significantly higher rate of alcohol-involved crash deaths (7.8 per 100,000 population) compared to the state average (2.9) and the national average (2.3), suggesting that while overall excessive drinking rates may be lower, there are still significant issues related to alcohol use in the county.

Table 19: Substance Use Indicators

Indicator	Nash County	North Carolina	United States
Percentage of Adults Reporting Excessive Drinking	16%	18%	18%
Opioid Use Disorder Emergency Department Utilization (Rate per 100,000 Beneficiaries)	38	43	41
Alcohol-Involved Crash Deaths, Annual (Rate per 100,000 Population)	7.8	2.9	2.3
Opioid Overdose Death Rate (Crude Rate per 100,000 Population)	25.3	25.1	N/A

These data suggest that while Nash County is performing slightly better in some substance use measures, there are significant challenges in mental health outcomes and access to mental health services. The higher rates of deaths of despair, particularly among men, the higher number of poor mental health days, and the lower availability of mental health providers indicate a pressing need for increased focus on behavioral health services and interventions in the county.

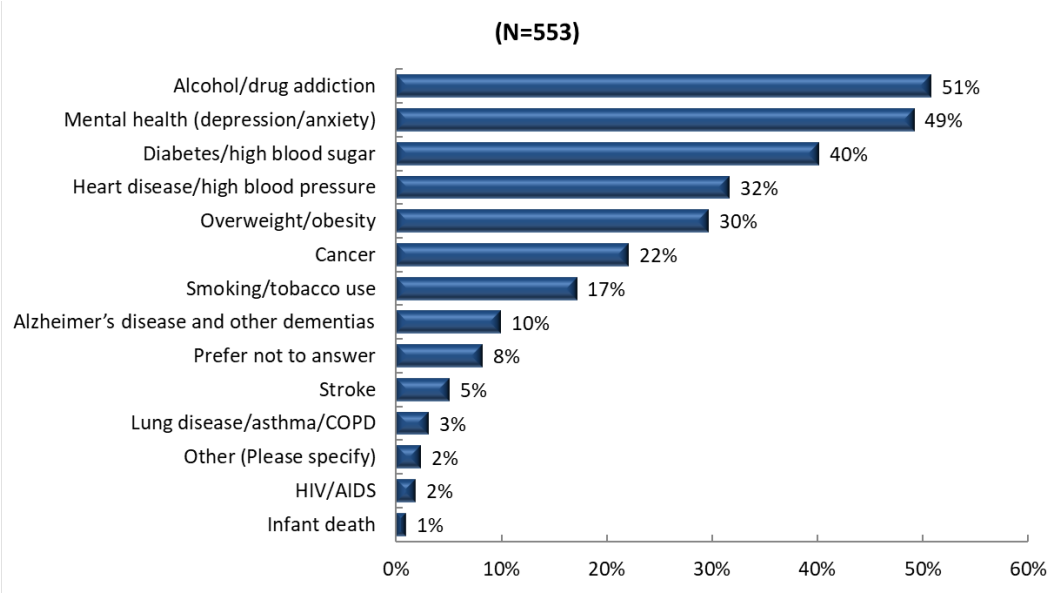
For additional detail on secondary data findings, see **Appendix 3**.

Primary Data Findings – Community Member Web Survey

Nash County residents highlighted mental health and substance use as top concerns in the community member web survey. When asked to identify the most important community health needs, alcohol and substance use emerged as the highest concern by 51% of all respondents. Mental health emerged as the second highest concern identified by 37% of all respondents.

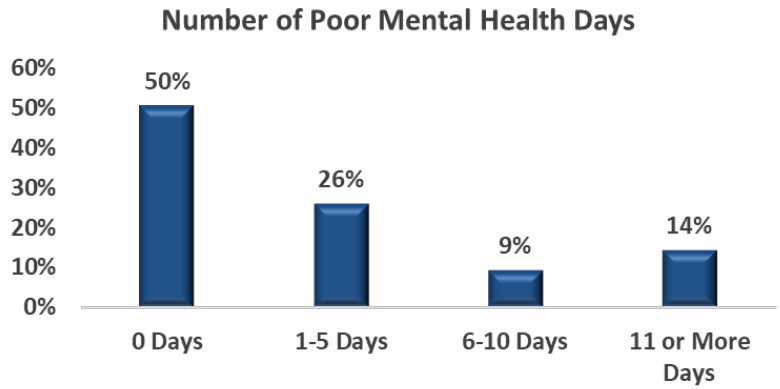
With regard to substance use, respondents ages 25 to 44 were most likely (54%) to identify substance use as a top health problem, compared to those over the age of 65 (40%). Additionally, the 45 to 65 age cohort most frequently (56%) indicated substance use as a health problem, compared to just 19% of those over the age of 65. A sizeable racial disparity was noted in the way alcohol and substance use were rated. Over half of White respondents (59%) indicated substance use as a top concern, compared to just one-third (35%) of “Other race” community members.

Figure 31: What are the three most important health problems that affect the health of your community? Please select up to three.



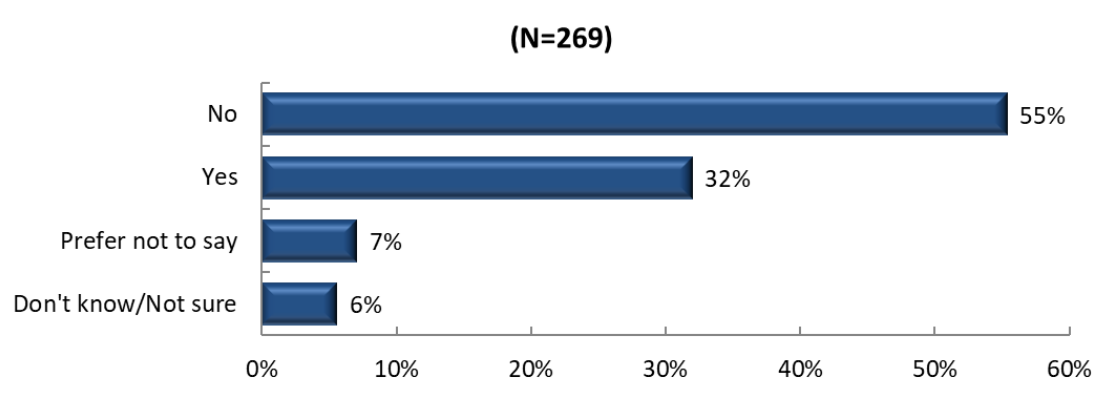
When respondents were asked about their own mental health, nearly half (49%) of respondents indicated they had experienced one or more poor mental health days in the past 30 days, with an average of five poor mental health days across these respondents. Half of respondents indicated that they had not had any poor mental health days in the prior month.

Figure 32: Now thinking about your mental health, which includes stress, depression, and problems with emotions, for how many days during the past 30 days was your mental health not good? (N=547)



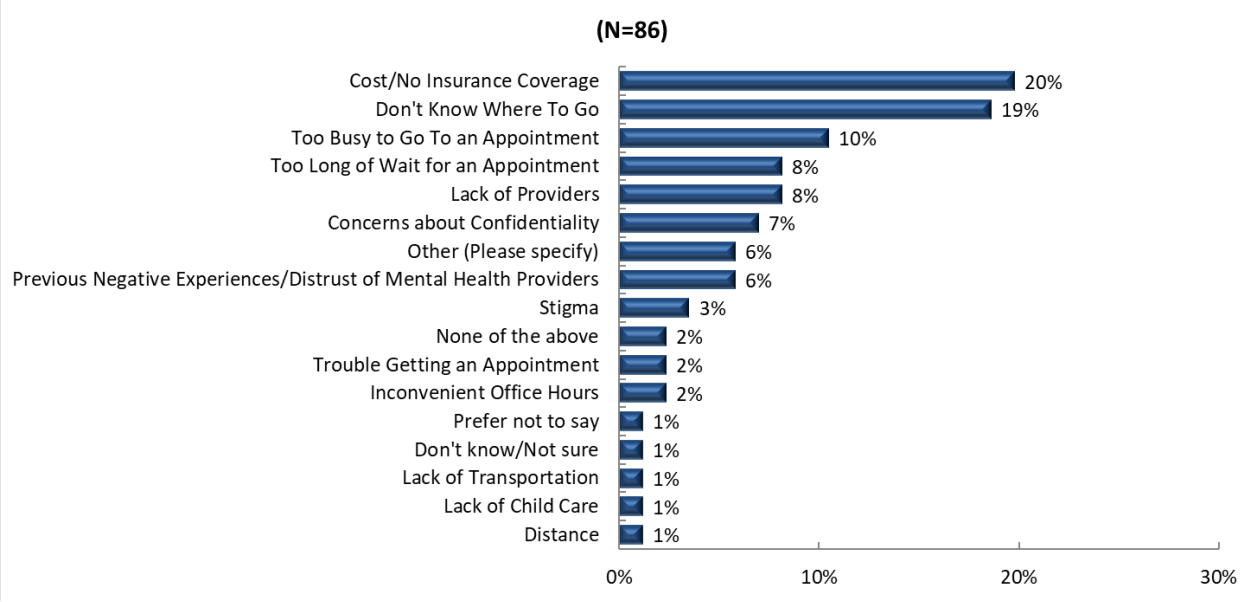
Community member respondents who indicated they experienced at least one poor mental health day in the previous month were also asked if there was a time in the past 12 months when they needed mental healthcare or counseling but did not get it at that time. One-third (32%) of these respondents answered yes.

Figure 33: Was there a time in the past 12 months when you needed mental health care or counseling, but did not get it at that time?



The top responses for why this group did not receive needed mental health care included high costs and lack of insurance (20%), a lack of knowledge of where to go (19%), and not having the time to go to an appointment (10%).

Figure 34: What was the main reason you did not get mental health care or counseling?

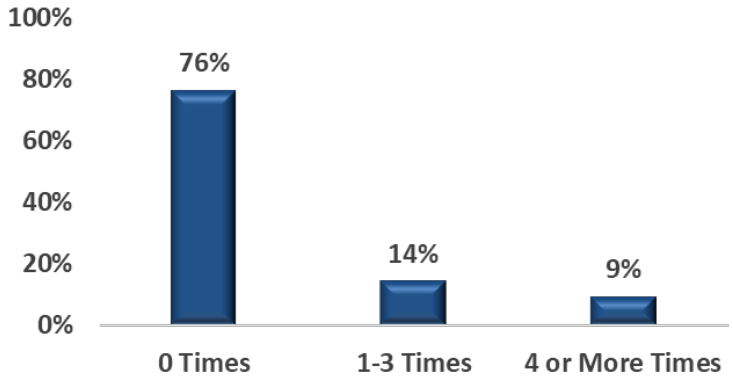


Community members were also asked about their experiences regarding alcohol and substance use. Alcohol substance use was the highest-ranked community health issue by survey respondents. Despite this, many community survey respondents had positive responses to more targeted questions about substance use. However, concerns were identified regarding behaviors surrounding alcohol usage, prescription drug misuse, and secondary impact from other individuals coping with substance use.

Community members were asked to identify the number of times they consumed enough drinks to meet the definition of “binge drinking” on a single occasion in the prior month. Two-thirds (76%) reported that

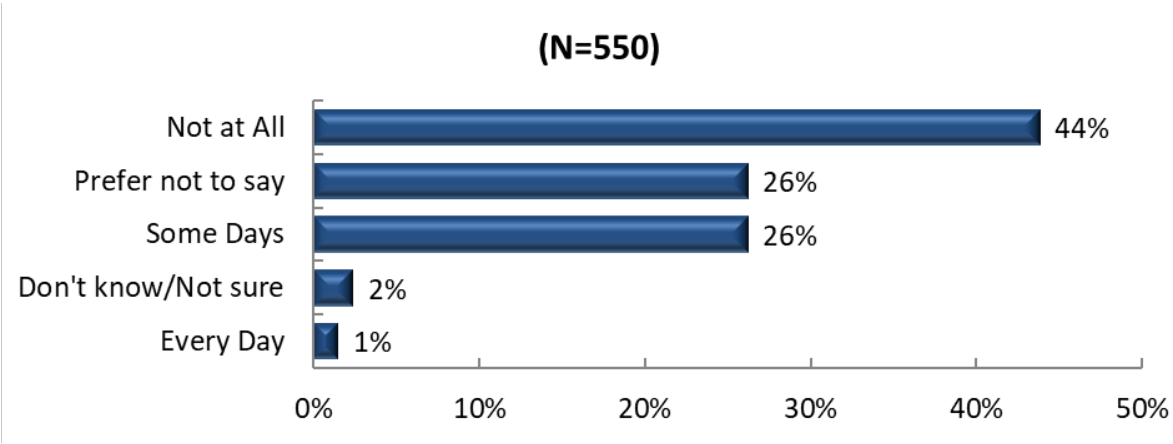
they did not consume an excessive amount (4 drinks for females and 5 drinks for males) on any occasion in the past 30 days. However, nearly one-quarter (23%) of respondents identified having consumed over that threshold one or more times in the past month.

Figure 35: 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=549)



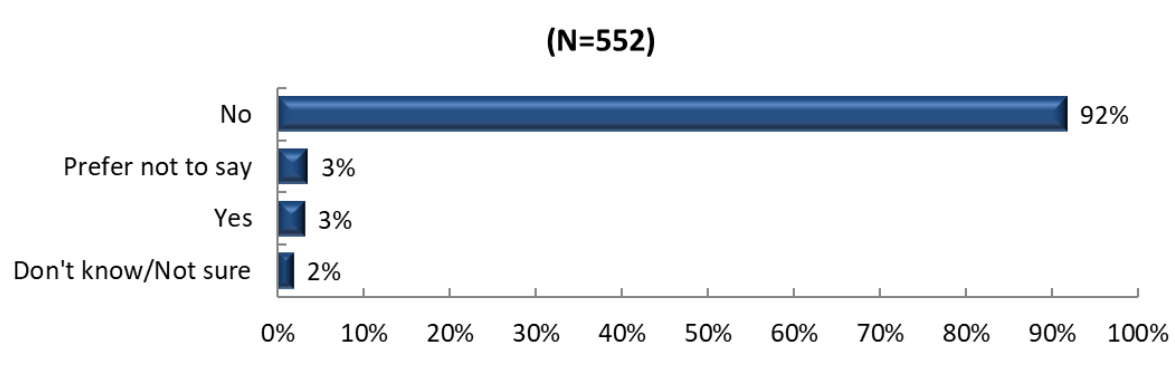
Community members were further asked how often they consume any alcohol, with 44% of respondents reporting that they do not drink at all, and 27% of respondents stating that they did drink at least some days. However, it is important to note that nearly one-third of respondents (28%) chose not to respond to the question or were unsure about their alcohol use.

Figure 36: How often do you consume any kind of alcohol product, including beer, wine or hard liquor?



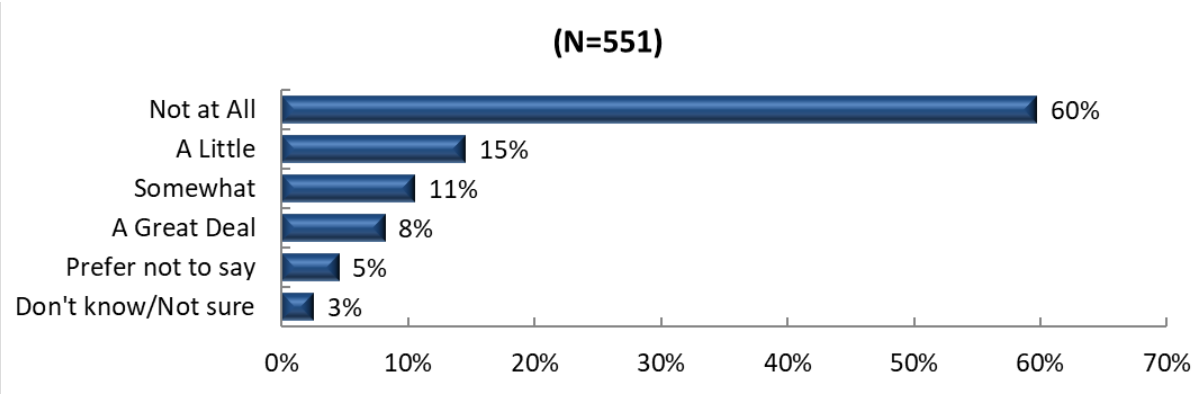
Just three percent of participants reported that they or a member of their household had misused any prescription medications in the prior year.

Figure 37: 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)?



While many substance use-related survey responses were positive, over one-third (34%) of respondents indicated that their lives have been negatively impacted by their own or someone else's substance use.

Figure 38: 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 details on survey findings, see **Appendix 5**.

Primary Data Findings – Focus Groups

Focus group participants in Nash County identified behavioral health, encompassing both mental health and substance use, as a significant concern affecting community health. Participants highlighted the limited availability of mental health services in the county, noting a significant shortage of mental health providers and specialists. This shortage was seen as particularly problematic given the growing prevalence of mental health issues in the community. Participants recognized the interconnectedness of mental health and substance use issues, emphasizing the need for comprehensive services that address both areas. Substance use, especially drug and alcohol addiction, was identified as a major health problem

affecting the community. Participants noted a lack of bilingual mental health providers, which presents an additional barrier for the Hispanic/Latino population.

Groups suggested implementing more education programs to raise awareness about mental health and substance use and proposed developing more community-based programs to support individuals struggling with these issues. Participants emphasized the need for more equitable resource distribution, noting that behavioral health concerns disproportionately impact people of color and minority populations.

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

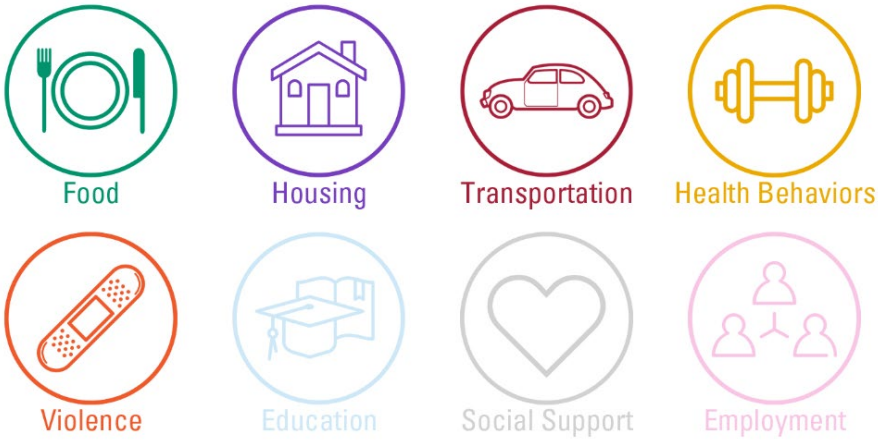
PRIORITY NEED: SOCIAL DRIVERS OF HEALTH – ECONOMIC STABILITY

Context and National Perspective

The World Health Organization defines SDoH as the non-medical factors that influence health outcomes. These are the conditions in which people are born, grow, work, live and age, and the wider set of external forces and systems shaping the conditions of daily life. Examples of SDoH that can influence health status and health equity in positive or negative ways include income, education, unemployment/job security, food insecurity, housing, early childhood development, social inclusion or non-discrimination, structural conflict and access to affordable, high-quality healthcare.[43]

As seen in **Figure 39**, the American Hospital Association categorizes SDoH factors into the following domains: food, housing, transportation, health behaviors, violence, education, social support and employment.

Figure 39: Social Drivers of Health[44]



[43] Source: WHO (2024). *Social Determinants of Health*. Retrieved September 9th, 2024, from https://www.who.int/health-topics/social-determinants-of-health#tab=tab_1.
[44] Source: American Hospital Association (2024). Social Determinants of Health Series. https://www.aha.org/social-determinants-health/populationcommunity-health/community-partnerships

SDoH are not experienced equally by all people and are often linked to one another. The impacts of SDoH on populations are profound, can persist across generations, and often drive health inequities based on race, ethnicity or socioeconomic status. When health systems use their resources to address SDoH among patient populations, it can strengthen the quality of the care they provide while reducing health inequities.[45] Evidence-based SDoH programs that can be adopted by hospitals or health systems that may reduce healthcare costs and improve outcomes include supportive housing for individuals with chronic health conditions, food and nutrition access, patient transportation services, cash payment or income support for individuals with disabilities, and multidisciplinary patient care coordination teams.[46] Research published in JAMA suggests that collecting patient data on social adversity and health-related social needs (HRSN) can be used to develop better trust and support for their patients and help identify broader community social needs.[47]

Local health departments can impact SDOH health outcomes by facilitating community interventions. Health departments can also obtain funding and resources that may not be accessible to others for community outreach, thereby increasing the value of their partnerships with healthcare facilities. Resources such as health education, community partnerships, and leadership help local health departments develop interventions that address SDOH. [48]

Throughout the primary and secondary data findings below, various SDoH emerged as areas of priority need that impact Nash County residents' ability to live healthy lives or access medical care. Specifically, based on these findings, key concerns include dynamics related to economic stability, employment, housing and homelessness, and food insecurity. Nash County health leaders will continue to evaluate their potential to impact these domains in the years to come.

Secondary Data Findings

Social determinants of health, particularly those related to economic stability, are significant concerns for Nash County. The county's performance on multiple socioeconomic indicators was worse than state and national averages, highlighting a high need in this area.

Nash County faces significant challenges in terms of income and poverty. The median family income in Nash County ($69,593) is lower than the state ($82,890) average. Additionally, 11% of households in Nash County are below the Federal Poverty Level (FPL), which is higher than the state average of 10%. The disparity is even more pronounced when looking at the population living below 200% of the FPL, with 35% of Nash County's population falling into this category compared to 32% in North Carolina and 29% nationally.

[45] Source: American Medical Association (2022). *What are social determinants of health?* Retrieved September 9, 2024, from https://www.ama-assn.org/delivering-care/health-equity/what-are-social-determinants-health.
[46] Source: Whitman, A., De Lew, N., Chappel, A., Aysola, V., Zuckerman, R. & Sommers, B. (2022). *Addressing Social Determinants of Health: Examples of Successful Evidence-Based Strategies and Current Federal Efforts*. Retrieved from https://aspe.hhs.gov/sites/default/files/documents/e2b650cd64cf84aae8ff0fae7474af82/SDOH-Evidence-Review.pdf.
[47] Chen, A., Gwynn, K. & Schmidt, S. (2023). Addressing health-related social needs in the clinical, community, and policy domains. *JAMA Network*. Retrieved September 9, 2024 from: https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2804105.
[48] Source: Emery, Kyle J., Durocher, B., et.al, (2023). *Health departments' role in addressing Social Determinants of Health in collaboration with multisector community partnerships.* Retrieved from https://www.ncbi.nlm.nih.gov/pmc/articles/PMC9812476/

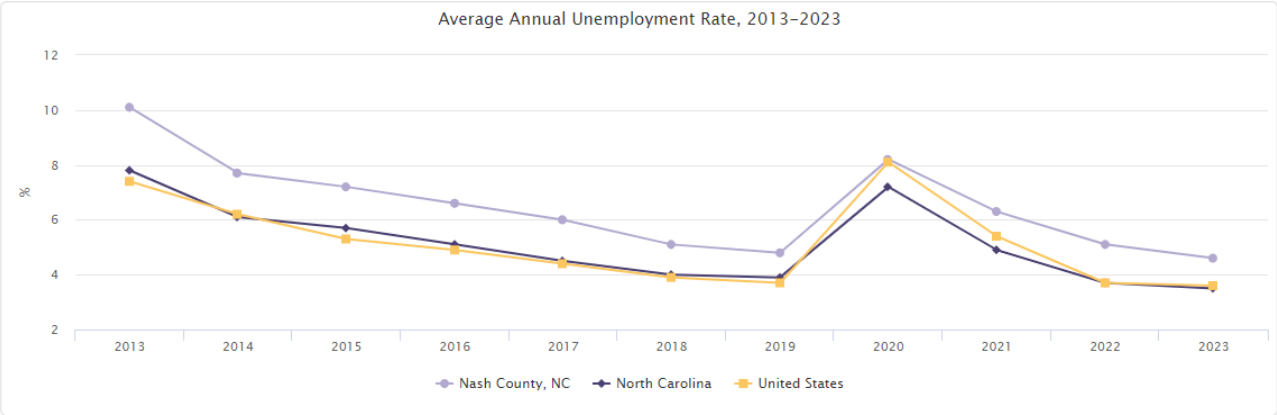
Table 20: Income and Poverty Indicators

Indicator	Nash County	North Carolina	United States
Population Under Age 18 Below 200% FPL, Percent	47%	41%	37%
Children Eligible for Free or Reduced Price Lunch by Eligibility	47%	46%	37%
Population in Poverty, Percent	15%	13%	13%
Population with Income Below 200% FPL, Percent	35%	32%	29%
Population Receiving SNAP Benefits, Percent	20%	16%	12%
Ratio of Female vs. Male Median Earnings	75%	83%	81%
Median Family Income	$69,593	$82,890	$92,646

Child poverty is a particular concern in Nash County. The percentage of children eligible for free or reduced-price lunch (47%) is higher than both the state (46%) and national (37%) averages. This indicator suggests that many children in the county may be experiencing economic hardship.

Employment is another area where Nash County faces challenges. The unemployment rate in Nash County (6.4%) is higher than both the state (5.1%) and national averages. Looking at long-term trends, the average annual unemployment rate from 2013 to 2023 in Nash County (4.6%) has consistently been higher than state (3.5%) and national (3.6%) averages.

Figure 40: Unemployment Rate Trends, 2013-2023



Food insecurity is also a significant issue in Nash County. The overall food insecurity rate in the county (12%) is higher than both the state (11%) and national (10%) averages. The disparity is even more pronounced for child food insecurity, with 21% of children in Nash County experiencing food insecurity compared to 15% in North Carolina and 13% nationally.

Housing affordability presents mixed results. While the average gross rent in Nash County ($844) is lower than state ($1,090) and national ($1,366) averages, 12% of households in the county are severely cost-burdened, meaning they spend 50% or more of their monthly income on housing costs. This rate is equal to the state average but lower than the national average of 14%.

Table 21: Housing Affordability Indicators

Indicator	Nash County	North Carolina	United States
HUD-Assisted Units, Rate per 10,000 Housing Units	349.7	319.2	413.9
Severely Cost-Burdened Households, Percent*	12%	12%	14%
Homeless Students, Percent	2.2%	1.9%	2.8%
Percentage of Households with One or More Severe Problems	17%	16%	18%
Average Gross Rent	$844	$1,090	$1,366

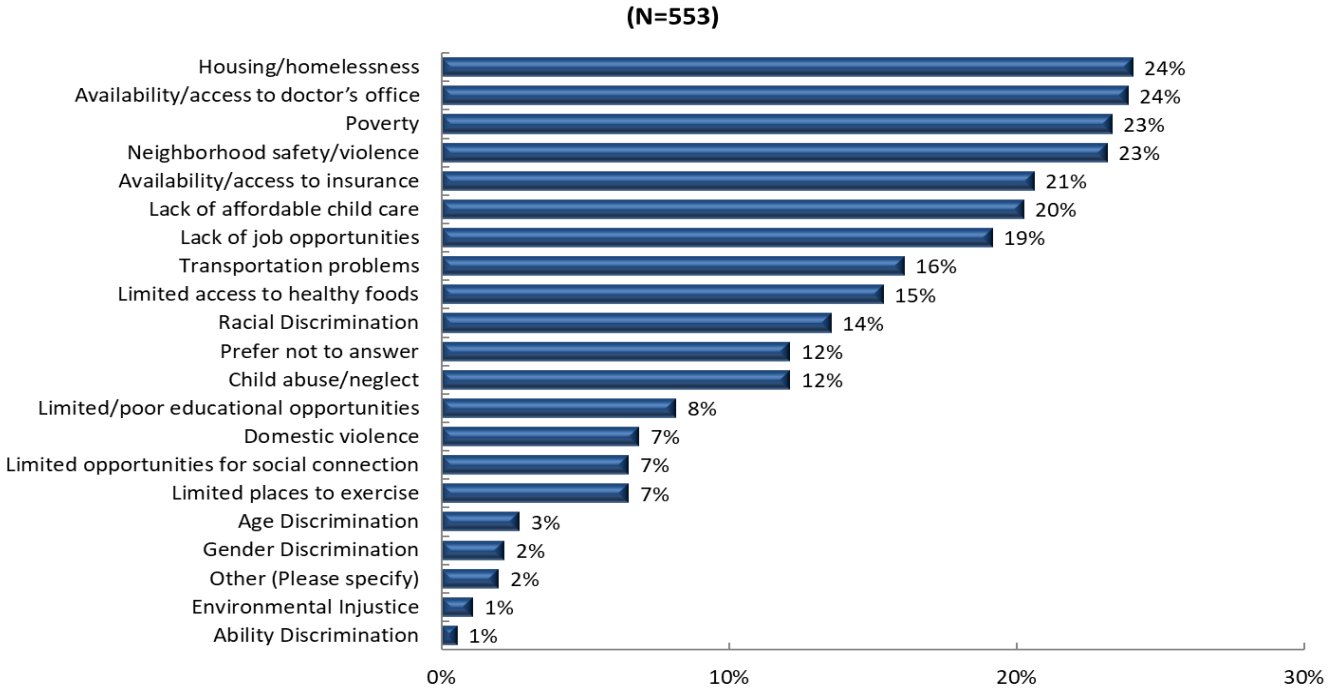
These data suggest that Nash County faces significant challenges related to economic stability, a key social driver of health. The lower median income, higher rates of poverty (especially child poverty), higher unemployment rates, and higher rates of food insecurity indicate a pressing need for interventions that address these social and economic factors to improve overall community health.

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

Primary Data Findings – Community Member Web Survey

Nash County community members who responded to the survey also highlighted various SDoH as social and environmental problems in their communities. Housing and homelessness was the highest ranked social and environmental problem, identified by nearly one-quarter (24%) of respondents. Poverty and neighborhood safety were also rated closely at 23%, highlighting a need for increased access to social services in the community. In addition, 20% of respondents selected the lack of affordable childcare and 19% selected a lack of job opportunities as significant social or environmental concerns in Nash County.

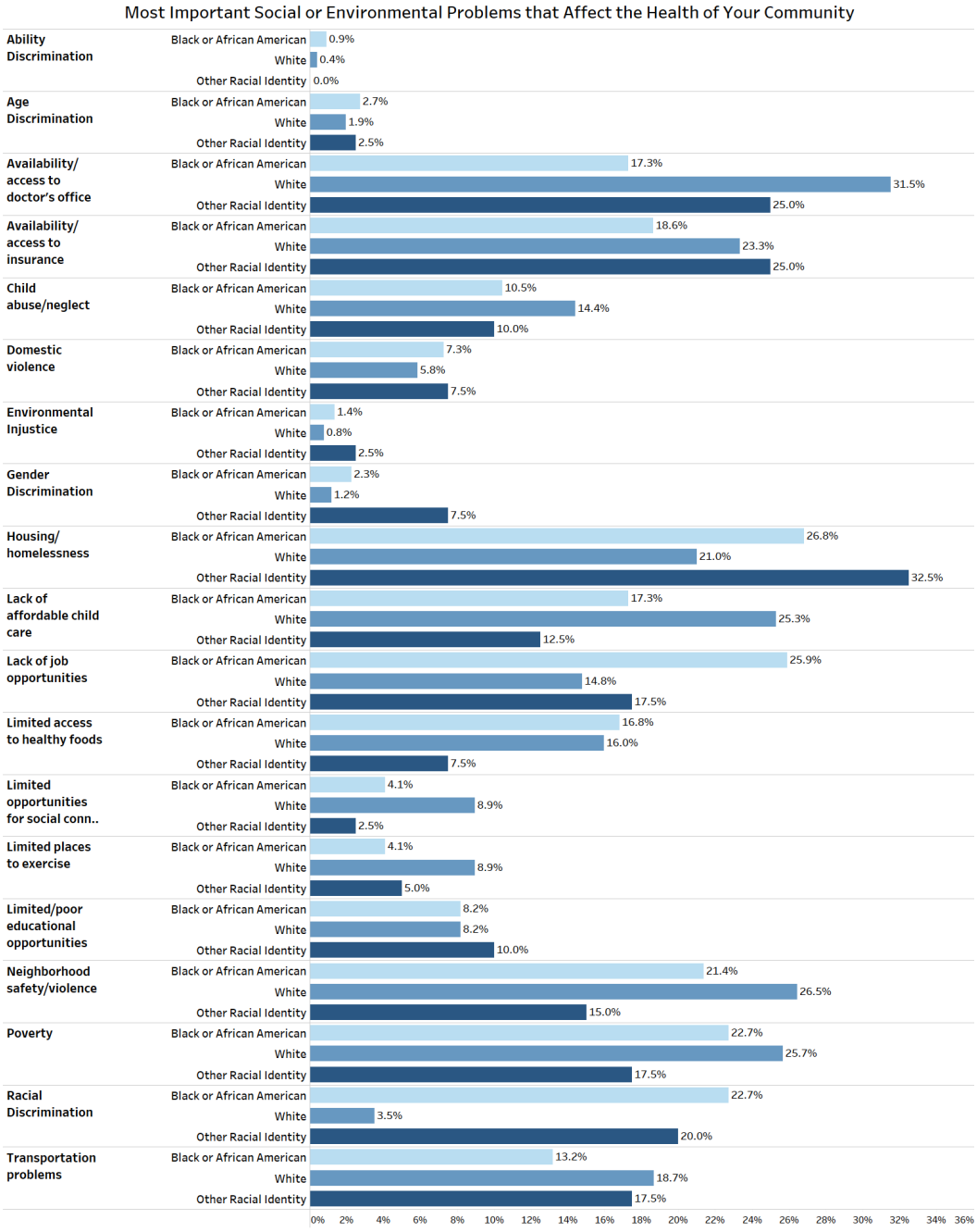
Figure 41: What are the three most important social or environmental problems that affect the health of your community? Please select up to three.



When data from different age groups were examined, disparities were noted. When housing and homelessness was reviewed, the most common population to rate it highest were those between the ages of 25 and 44 (26%). However this population also was the least likely to identify poverty and neighborhood safety (17%) as primary concerns. Conversely, those aged 45 to 64 were the most likely to rank poverty and neighborhood safety (29%) as key concerns.

Differences between racial groups were also identified. The racial group most likely to select housing and homelessness as a primary concern were those who identified as an "other" race (33%), compared to 21% of White respondents. "Other Race" respondents were also the least likely to indicate poverty and neighborhood safety as key concerns (18%, 15%). Black/African American respondents (26%) selected a lack of job opportunities as an important concern more often than White respondents (15%). Regarding a lack of affordable childcare, White respondents were most likely (25%) to cite it as a problem compared to other racial groups.

Figure 42: 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 details on the survey findings, see **Appendix 5**.

Primary Data Findings – Focus Groups

Focus groups in Nash County identified various social determinants of health, with a particular emphasis on economic stability, as significant factors affecting community well-being. Food access and security were major concerns, with participants describing Nash County as a "food swamp" with limited access to affordable healthy foods. It was noted that people are no longer growing their own food as they did in the past, contributing to reduced access to fresh, healthy foods.

Employment and income issues were also highlighted, with participants mentioning the high overall cost of living and limited, expensive childcare options as barriers to economic stability. Housing and homelessness were also identified as challenges, with participants citing poor housing conditions and a lack of affordable, quality housing. The need for more comprehensive health education programs, including nutrition education, was emphasized, which could indirectly impact economic stability by promoting healthier lifestyles and potentially reducing healthcare costs. Participants noted that these social and economic challenges disproportionately affect people of color, minority populations, and low-income families.

To address these issues, suggestions included encouraging stores to stock fresh produce, promoting community gardens, and creating more partnerships with local organizations to address food insecurity and economic instability.

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 Nash County that provide resources to address general community health needs and the county's 2024 priority need areas: Behavioral Health, Healthcare Access & Quality, and Social Drivers of Health.

Category	Organization Name
County Resources Directories	• Nash County Health Department Nash County Community Resources Brochure

Healthcare Facilities	• Duke University Medical Center-Durham
	  ○ 919-684-8111
	• ECU Health Medical Center (Greenville Hospital)
	  ○ 252-847-4100
	• Wake Medical Center (Raleigh)
	  ○ 919-350-8000
	• University of NC Hospital, Chapel Hill
	  ○ 984-974-1000
	• Nash County Health Department
	  ○ Nashville Office
	  ▪ 214 S. Barnes Street – PO Box 849, Nashville, NC 27856
	  ▪ 252-459-9819
	  ○ Rocky Mount Office
	  ▪ 322 S. Franklin Street, Rocky Mount, NC 27804
	  ▪ 252-446-0027
	  ○ Hospital Campus Case Management Services
	  ▪ 500 Medical Arts Mall Suite 144, Rocky Mount, NC 27804
	  ▪ 252-459-1358
	  ○ Services: Communicable Disease Control, Child Health, CMARC, Family Planning, Health Education, Immunization, Maternal Health, Pregnancy Care Management and Women's Health Watch
	• Eastern North Carolina Medical Group, P.L.L.C.
	  ○ Rocky Mount: 252-451-2700
	  ○ Nashville: 252-459-7769
	  ○ Full-service family medical practice serving children and adults

Other Healthcare Services	**Mental Health and Substance Use Services** • HOPE Initiative of Nash County ○ 252-450-0513

	○ Assist individuals with substance abuse disorder to find treatment options and to get into recovery • Nash County Recovery Alliance Center ○ 252-231-1618 ○ Supports individuals and their families who are in or seeking recovery from substance use/addiction • Rocky Mount Treatment Center ○ 252-972-4357 ○ Heroin and opioid drug treatment center • CARE of Nash County/Syringe Exchange Program ○ 252-289-5601 ○ Services: Biohazard collection, injection drug user health peer support, detox referrals, treatment referrals, naloxone access & information, overdose prevention training, Hepatitis C education & referral and advocacy • Trillium ○ 877-685-2415 ○ Services: Mental health, substance use, and intellectual/developmental disability services
Community Services	**Social Services** • Department of Social Services ○ 252-459-9818 ○ Services: Medicaid, adoption and foster care, food and nutrition, work first, services for elderly disabled, emergency financial aid, transportation, protective services, child support, child care assistance, and support services • Nash Edgecombe Wilson Community Action, Inc (NEW CA, Inc.) ○ 252-442-8081 ○ Services: Head Start, USDA Food Service, Rental Assistance, Family Development • NC Division of Vocational Rehabilitation ○ 252-316-4400 ○ 877-699-7573 ○ Support services for individuals with disabilities • Telamon ○ 919-851-7611 ○ Services for migrant and seasonal farm workers, early childhood and family support, workforce and career services, housing and financial support **Housing and Shelter Services** • Bassett Center ○ 252-985-0078 ○ Shelter for families • United Community Ministries ○ 252-985-0078

  - Shelter for individuals with no children
  - Community kitchen and food pantry
  - Have access to Spanish services
- Christian Fellowship Home of Nash-Edgecombe Counties
  - 252-977-1273
  - Halfway program for men

Family and Children Services

- Down East Partnership for Children
  - 252-985-4300
  - Family services, referrals, quality childcare/day care assistance, and information
- Your Choice Resource Center
  - 252-446-2273
  - 24/7 Hotline: 800-712-4357
  - Services: Medical assistance, Pregnancy tests, ultrasounds, baby equipment, educational classes, counseling, maternity clothes, and STD checks via mobile unit (services are free and confidential)
- Williford Family Resource Center
  - 252-462-2851
  - Services: Parent support meetings, food pantry, clothing, school supplies, health education classes

Community Support Services

- Faith Christian Ministries
  - 252-459-7977
  - Provides gently used clothing, furnishings and household goods
- Nash County Cooperative Extension
  - 252-459-9810
  - Services: Nutrition education, farmers market, and agriculture
- Salvation Army
  - 252-446-4496
  - Services: Clothing, food, jobs, rent, fuel, utilities, medicine
  - W.A.R.M. (Heating assistance program for City of Rocky Mount utilities customers; must meet eligibility requirements)

Legal Services

- Legal Aid of North Carolina
  - 866-219-5262
- Senior Legal Helpline (60 years+)
  - 877-579-7562

Insurance

- Health Insurance Marketplace
  - 800-318-2596
  - Website: www.healthcare.gov

	24/7 Hotlines and Helplines
	• Alcohol/Drug Council of NC
	  ○ 800-688-4232
	• Cleft Palate (ACPA)
	  ○ 919-933-9044
	• Disability Hotline
	  ○ 480-3287
	• HIV/STD Hotline
	  ○ 800-232-4636
	• HIV/AIDS Hotline
	  ○ 888-227-8922
	• Medication Assistance (MAP)
	  ○ 866-331-1348
	• National Runaway Safeline
	  ○ 800-786-2929
	  ○ Email: info@1800runaway.org
	  ○ Text: 6608
	• NC Quit Line
	  ○ 800-QUIT-NOW (800-784-8669)
	  ○ Website: QuitlineNC.com
	• Susan G. Komen Breast Cancer Helpline
	  ○ 877-465-6636
	  ○ Website: www.Komen.org
	• U.S. Citizenship and Immigration Services
	  ○ 800-375-5283

Priority Need: Behavioral Health	• See Mental Health and Substance Use resources above
Priority Need: Healthcare Access and Quality	• See Healthcare Facilities and Services sections above
Priority need: Social Drivers of Health	• See Community Services above

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 Nash 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. Nash 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 Clear Impact 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.[49]

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.

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. Nash County's most recent SOTCH is presented on the following pages.

[49] Clear Impact (2022). *Results-Based Accountability™: A Framework to Help Communities Get From Talk to Action*. Retrieved from: https://clearimpact.com/wp-content/uploads/2022/02/Clear-Impact-Results-Based-Accountability-Brochure-2022.pdf. Note: Clear Impact has exclusive and worldwide rights to use Results-Based Accountability™ (RBA), including all of proprietary and intellectual property rights represented by RBA. RBA intellectual property is free for use (with attribution) by government and nonprofit or voluntary sector organizations, as well as small consulting firms representing the interests of these organizations.

State of the County Health Report

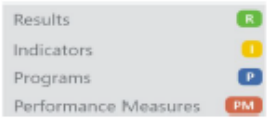
HNC 2030 Scorecard: Nash County (2021-2023)

Scorecard is an online platform used as a performance measurement system to reduce gaps in health services and report on community programs resulting in better health outcomes. In 2021, Nash County community health partners adopted the platform to report progress on the top three health priorities of the Community Health Needs Assessment. For years, Nash County organizations have been utilizing a collaborative approach to make a collective impact on addressing physical, social, and environmental issues. Scorecard allows Nash County community health partners to pool information in a single report to enhance programs and services toward meeting goals and objectives. **The three health priorities identified in the CHNA include:**

- **Metabolic Syndrome (Focus on Heart Disease, Cardiovascular Disease/Stroke, Diabetes, & Obesity)**
- **Poverty (Focus on Access and Low Income)**
- **Behavioral Health (Focus on Substance Use)**

For each priority, the Scorecard highlights:

- A Results Statement, a picture of where we would like to be
- Important local Indicators, or measures of how we are doing
- Select Programs or activities
- Key Performance Measures that show how these programs are making an impact



Ths Scorecard also contains the annual Nash County States of the County Health reports or SOTCH.

Instructions: Click anywhere on the scorecard to learn more about the programs and initiatives taking place to improve health outcomes in Nash County.

Nash County Health Department

Health ENC
Working Together for a Healthier Eastern North Carolina

Community Health Needs Assessment

2021-2022 CHNA

	Time Period	Current Actual Value	Current Trend

Metabolic Syndrome (Focus on Heart Disease, Cardiovascular Disease/Stroke, Diabetes, & Obesity)

All people who work, live, play and pray in Nash County have various opportunities to access of health and wellness programs.

	Time Period	Current Actual Value	Current Trend
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

NCDPH HNC2030	Sugar-Sweetened Beverage (SSB) Consumption Among Adults in NC: % of Adults (Total) reporting consumption of one or more sugar-sweetened beverages (SSBs) per day.	2022	36.8%	↗ 1

Diabetes Awareness Program

		Time Period	Current Actual Value	Current Trend
How much	Number of adults who attended the Diabetes Awareness Program	2022	60.0	↗ 1
Better OFF	Percent of Diabetes Awareness Program participants reporting 5% or greater weight loss and/or improved blood glucose	2021	40.0%	↗ 1

DEPC - Faithful Families Program

		Time Period	Current Actual Value	Current Trend
How much	Number of program participants	2022	1,298.0	→ 0
Better OFF	Percentage of program participants reporting healthy eating and physical activity	2023	88.0%	↗ 1

Harrison Family YMCA Health and Wellness Programs

		Time Period	Current Actual Value	Current Trend
How much	Number of program participants utilizing the Blood Pressure Self-Monitoring Program	2022	8.0	→ 0
Better OFF	Percentage of the Blood Pressure-Self Monitoring participants reporting controlled blood pressure	2022	100.0%	→ 0
How much	Number of program participants in the Enhance Fitness Program	2022	39.0	→ 0
How much	Number of program participants in the Walk with Ease Program	2022	8.0	→ 0
Better OFF	Percentage of the Enhance Fitness program engaged in regular physical activity	2022	92.0%	→ 0

Healthy Communities Program

		Time Period	Current Actual Value	Current Trend
How much	Number of community health fair program participants	2022	700	↗ 1
How much	Number of social media messages about healthy eating and physical activity	2022	18.0%	↗ 1
How much	Number of MyPlate programs offered in community settings	2022	7.0	↗ 1
Better OFF	Number of faith-based organizations and non-profits adopting healthy foods and physical activity policies	2022	2.0%	↗ 1

Poverty (Focus on Access and Low Income)

All people in Nash County have equitable opportunities to address their conditions and causes of poverty through education and partnership program services to increase self-sufficiency.

		Time Period	Current Actual Value	Current Trend
NCDPH HNC2030	Percent of individuals below 100% Federal Poverty Level in NC by race/ethnicity (Black)	2022	20.5%	↘ 6
NCDPH HNC2030	Third Grade Reading Proficiency: Percent of children in NC (Total) who are proficient in reading at end of Third Grade	2023	47.7%	↗ 2
NCDPH HNC2030	Uninsured: % of North Carolina population under age 65 without health insurance (Total) - SAHIE	2022	11.2%	↘ 3
NCDPH HNC2030	Unemployment (Total): Percent of population in NC aged 16 and older who are unemployed but seeking work	2022	5.1%	↘ 8

Cooperative Extension Financial Literary Program

Time Period	Current Actual Value	Current Trend

How much	Number of program participants attending Financial Literacy Program	2022	104.0	→ 0
Better OFF	Number of individuals reporting improved financial planning	2022	124.0%	→ 0
Better OFF	Number of individuals reporting an increased knowledge and/or skills about family economic security (such as how to access: SNAP benefits, SHIP, Medicare Part D, food cost management, cos comparison skills, shop for reverse mortgages and select long-term care insurance)	2022	11	→ 0

DEPC - Gardening and Nutrition Support Program

		Time Period	Current Actual Value	Current Trend
How much	Number of individuals who reported access to healthy foods	2022	894.0	→ 0
How much	Number of community garden volunteers	2022	0.0	→ 0

Harrison Family YMCA Food Box Program

		Time Period	Current Actual Value	Current Trend
Better OFF	Number of opportunities for Healthy Food Box Program	2022	50.00	→ 0
How much	Number of program participants	2022	135.0	→ 0

Ripe Revival Fresh Fruits and Vegetables Mobile Market

		Time Period	Current Actual Value	Current Trend
Better OFF	Number of opportunities for fresh fruits and vegetables	2022	17.0	→ 0
How much	Number of program participants	2022	620.0	→ 0

Nash County Senior Services Wellness Programs

		Time Period	Current Actual Value	Current Trend
How much	Number of individuals participated in fitness and education programs	2022	536.0	→ 0
How much	Number of Home Delivered Meals	2022	150.0	→ 0
How much	Number of individuals accessed transportation services for programs	2022	15.0	→ 0
Better OFF	Number of new Caregiver Support Program Clients	2022	145.0	→ 0
Better OFF	Number of Project Lifesaver participants	2022	38.0	→ 0

Behavioral Health (Focus on Substance Use)

All people in Nash County have equitable access to increased behavioral health/substance use services to promote well-being and decrease stigma.

		Time Period	Current Actual Value	Current Trend
NCDPH HNC2030	Drug Overdose Death Rate in North Carolina: Drug Poisoning Deaths (Total) per 100,000 population	2022	42.1	↗ 4
	Drug Poisoning Deaths - Nash County (Age Adjusted Rate per 100,000 population))	2020	31.9	↗ 1
	Drug Poisoning Deaths - Nash County (Counts)	2020	28	↗ 1
NCDPH HNC2030	Percent of Middle School Youth Using Tobacco in North Carolina (Total)	2019	10.4%	↘ 2
NCDPH HNC2030	Percent of High School Youth Using Tobacco in North Carolina (Total)	2019	27.3%	↘ 1
NCDPH HNC2030	Percent of Adults Using Tobacco in North Carolina (Total)	2022	21.6%	↗ 1

Empowering Youth and Families Program (EYFP) through Cooperative Extension

		Time Period	Current Actual Value	Current Trend
How much	Number of program participants	2022	0.0	→ 0

Better OFF	Individuals reporting increased knowledge about substance use prevention awareness	2022	0.0	→ 0

Substance Use Programs | C.A.R.E

		Time Period	Current Actual Value	Current Trend
How much	Number of program participants utilizing the Medication Assisted Treatment Services	2022	24.0	→ 0
Better OFF	Number of Peer Support Program certified trainers	2022	0.0	→ 0
How much	Number of community mental health fair events	2022	10.0	→ 0
How much	Number of Naloxone distribution	2022	60.0	→ 0

Tobacco Prevention and Education

		Time Period	Current Actual Value	Current Trend
How much	Number of individuals receiving tobacco education	2022	15.0	→ 0
How much	Number of media messages throughout the county about the dangers of tobacco use	2022	12.0	→ 0

SOTCH REPORTS

2022 Nash County SOTCH

Time Period	Current Actual Value	Current Trend

2023 Nash County SOTCH

Time Period	Current Actual Value	Current Trend

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 county residents. They 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." To draw conclusions about the secondary data for Nash County, its performance on each data measure was compared to targets/benchmarks. If Nash County's performance was more than five percent worse than the comparative benchmark, it was concluded that improvements could be needed to better the community's health. Conversely, if an area performed more than five percent better than the benchmark, it was concluded that while a need is still present, its significance 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 in terms of performance over time and whether they have 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 22: 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

Measure	Description	Data Source	Most Recent Data Year(s)
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
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

Measure	Description	Data Source	Most Recent Data Year(s)
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 23: 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 >=	Percentage of population with access to high-speed internet. Data are	FCC FABRIC Data. Additional data analysis	2023

Measure	Description	Data Source	Most Recent Data Year(s)
100MBPS and UL Speeds >= 20 MBPS)	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.	by CARES. Data accessed via the North Carolina Data Portal, June 2024.	
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
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		2022

Measure	Description	Data Source	Most Recent Data Year(s)
	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.	

Table 24: 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 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.	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
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	EPA – Smart Location Database. Data accessed via the North Carolina Data Portal, June 2024.	2021

Measure	Description	Data Source	Most Recent Data Year(s)
	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.		
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 encourages physical activity and other healthy behaviors.	U.S. Census Bureau, County Business Patterns. Additional data analysis by CARES. Data accessed via the North Carolina Data Portal, June 2024.	2022
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 25: 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	U.S. Census Bureau, ACS. Data accessed via the	2018-2022

Measure	Description	Data Source	Most Recent Data Year(s)
	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.	North Carolina Data Portal, June 2024.	
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 via the North Carolina Data Portal, June 2024.	2020-2021
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 26: 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 27: 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 1% annual chance of coastal or riverine flooding.	Federal Emergency Management Agency (FEMA), National Flood Hazard Layer. Data accessed via the North Carolina Data Portal, June 2024.	2011
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 28: 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 29: 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 limited or uncertain access to adequate food.	Feeding America. Data accessed via the North Carolina Data Portal, June 2024.	2021
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

Measure	Description	Data Source	Most Recent Data Year(s)
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 foods, and grocery stores are a major provider of these foods.	US Census Bureau, County Business Patterns. Additional data analysis by CARES. 2022. Data accessed via the North Carolina Data Portal, June 2024.	2022

Table 30: 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	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)
	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.		
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 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.	U.S. Census Bureau, ACS. Data accessed via the North Carolina Data Portal, June 2024.	2011-2015
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	US Department of Education, EDFacts. Additional data analysis by CARES. 2019-2020. Data accessed via the	2019-2020

Measure	Description	Data Source	Most Recent Data Year(s)
	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.	North Carolina Data Portal, June 2024.	

Table 31: 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 acquired from the 2018-2022 ACS and are used in the 2024 County Health Rankings.	U.S. Census Bureau, ACS. Data accessed via the North Carolina Data Portal, June 2024.	2018-2022
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	U.S. Census Bureau, ACS. Data accessed via the	2018-2022

Measure	Description	Data Source	Most Recent Data Year(s)
	because poverty creates barriers to access including health services, healthy food, and other necessities that contribute to poor health status.	North Carolina Data Portal, June 2024.	
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 32: 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

Measure	Description	Data Source	Most Recent Data Year(s)
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 33: 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 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.	CDC – National Vital Statistics System (NVSS). CDC WONDER. CDC, Wide-Ranging Online Data for Epidemiologic Research. Data accessed via the North Carolina Data Portal, June 2024.	2017-2019
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	National Center for Health Statistics –	2015-2021

Measure	Description	Data Source	Most Recent Data Year(s)
	from the National Center for Health Statistics - Mortality Files (2015-2021) and are used for the 2024 County Health Rankings.	Natality and Mortality Files. Data accessed via RWJF & UWPHI County Health Rankings & Roadmaps, June 2024.	

Table 34: 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 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.	CDC – NVSS. Data accessed via the North Carolina Data Portal, June 2024.	2018-2022

Table 35: 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	Behavioral Risk Factor Surveillance System. Data accessed via RWJF & UWPHI County Health Rankings & Roadmaps, June 2024.	2021

Measure	Description	Data Source	Most Recent Data Year(s)
	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.		
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 professional that they had high cholesterol.	CDC, BRFSS. Data accessed via the North Carolina Data Portal, June 2024.	2021
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	CDC, BRFSS. Data accessed via the North Carolina Data Portal, June 2024.	2022

Measure	Description	Data Source	Most Recent Data Year(s)
	health professional that they have had a stroke.		
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, inadequate access to care or poor patient choices, resulting in ER visits that could be prevented".	CMS – Geographic Variation Public Use File. Data accessed via the North Carolina Data Portal, June 2024.	2022
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 36: 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 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.	CMS – Geographic Variation Public Use File. Data accessed via the North Carolina Data Portal, June 2024.	2022

Table 37: 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

Measure	Description	Data Source	Most Recent Data Year(s)
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 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.	CDC – National Vital Statistics System. Data accessed via the North Carolina Data Portal, June 2024.	2018-2022

Table 38: 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	2021

Measure	Description	Data Source	Most Recent Data Year(s)
		Rankings & Roadmaps, June 2024.	
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 39: 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 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	CDC, BRFSS. Data accessed via the North Carolina Data Portal, June 2024.	2021

Measure	Description	Data Source	Most Recent Data Year(s)
	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 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.	CDC – NVSS. Data accessed via the North Carolina Data Portal, June 2024.	2018-2022

Table 40: 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	Behavioral Risk Factor Surveillance System. Data accessed via RWJF & UWPHI County Health	2021

Measure	Description	Data Source	Most Recent Data Year(s)
	Smoking estimates are created using statistical modeling.	Rankings & Roadmaps, June 2024.	

Table 41: 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 Nash County compares to North Carolina and the national benchmark. If both statewide North Carolina and national data were available, North Carolina data was preferentially used as the target/benchmark value.

Secondary Data Summary Table Color Comparisons

Color Shading	Priority Level	Nash County Description
	Low	Represents measures in which Nash 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 Nash 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 Nash 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 Nash County value was compared to the benchmark by calculating the percentage difference between the values, relative to the benchmark value:

(Nash 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:

(5.5-7.5)/(7.5) x 100% = -26.7% = Displayed as **Low Priority Level**, Shaded in Green

This metric indicates that the percentage of the population with limited access to healthy foods in Nash County is 26.7 percent better (or, in this case, lower) than the percentage of the population with limited access to healthy foods in the state of North Carolina.

Detailed Focus Area Benchmarks

Table 42: Access to Care

Measure	National Benchmark	North Carolina Benchmark	Nash County Data	Most Recent Data Year	Nash County Need
Primary Care Providers Ratio	112.4	101.1	84.2	2024	High
Mental Health Providers Ratio	178.7	155.7	74.8	2024	High
Addiction/Substance Abuse Providers Ratio	27.9	25.0	17.9	2024	High
Buprenorphine Providers Ratio	15.5	15.2	7.4	2023	High
Dental Health Providers Ratio	39.1	31.5	31.6	2024	Medium
% Living in Health Professional Shortage Areas (HPSAs) – Dental Care	17.8%	34.0%	40.0%	2018-2022	High
Federally Qualified Health Centers (FQHCs)	3.5	4.1	3.2	2023	High
% Receiving Medicaid	22.3%	20.2%	24.0%	2018-2022	High
% Uninsured	10.2%	12.5%	13.9%	2022	High

Table 43: Built Environment

Measure	National Benchmark	North Carolina Benchmark	Nash County Data	Most Recent Data Year	Nash County Need
Broadband Access (Access to DL Speeds >= 25MBPS and UL Speeds >= 3 MBPS)	93.8%	93.6%	89.1%	2023	Medium
Broadband Access (Access to DL Speeds >= 100MBPS and UL Speeds >= 20 MBPS)	91.2%	90.4%	82.5%	2023	High
Households with No Computer	6.1%	6.9%	9.2%	2018-2022	High

Measure	National Benchmark	North Carolina Benchmark	Nash County Data	Most Recent Data Year	Nash County Need
Households with No or Slow Internet	11.7%	13.0%	18.3%	2018-2022	High
Liquor Stores	13.3	6.2	11.6	2022	High
Adverse Childhood Experiences (ACEs)	N/A	N/A	Suppressed	2022	N/A

Table 44: Diet and Exercise

Measure	National Benchmark	North Carolina Benchmark	Nash County Data	Most Recent Data Year	Nash County Need
% Physically Inactive	N/A	21.6%	25.6%	2021	High
Walkability Index Score	10	7	8	2021	Low
% with Access to Exercise Opportunities	84.1%	73.0%	55.0%	2023	High
Recreation and Fitness Facility Access	14.8	13.1	4.2	2022	High
Sugar-Sweetened Beverage (SSB) Consumption	N/A	N/A	36.8%	2022	N/A

Table 45: Education

Measure	National Benchmark	North Carolina Benchmark	Nash County Data	Most Recent Data Year	Nash County Need
% Limited English Proficiency	8.2%	4.6%	2.0%	2018-2022	Low
High School Graduation Rate	81.1%	87.6%	89.0%	2020-2021	Medium
% with No High School Diploma	10.9%	10.6%	13.4%	2018-2022	High
Student Math Proficiency	63.9%	65.8%	84.2%	2020-2021	High
Student Reading Proficiency	60.1%	59.5%	72.0%	2020-2021	High
School Funding Adequacy	N/A	-$4,742	-$11,703	2021	High
School Funding Adequacy –	N/A	$10,655	$10,270	2021	Medium

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

Table 46: Employment

Measure	National Benchmark	North Carolina Benchmark	Nash County Data	Most Recent Data Year	Nash County Need
Unemployment Rate	3.9%	3.7%	4.3%	2024	High
Average Annual Unemployment Rate, 2013-2023	3.6%	3.5%	4.6%	2024	High

Table 47: Environmental Quality

Measure	National Benchmark	North Carolina Benchmark	Nash County Data	Most Recent Data Year	Nash County Need
Flood Vulnerability	6.5%	4.9%	3.4%	2011	Low
Drinking Water Safety	16,107	194	6	2023	Low

Table 48: Family, Community and Social Support

Measure	National Benchmark	North Carolina Benchmark	Nash County Data	Most Recent Data Year	Nash County Need
Children Cost Burden	28.8%	27.0%	29.0%	2023	High
% Young People Not in School or Working	6.9%	7.5%	10.6%	2018-2022	High

Table 49: Food Security

Measure	National Benchmark	North Carolina Benchmark	Nash County Data	Most Recent Data Year	Nash County Need
% Food Insecure	10.3%	11.4%	11.6%	2021	Medium
% Food Insecure Children	13.3%	15.3%	20.9%	2021	High
% Low-Income and with Low Food Access	19.4%	21.3%	15.2%	2019	Low
% Limited Access to Healthy Foods	N/A	7.5%	5.5%	2019	Low
Fast Food Restaurants	96.2	77.4	77.9	2022	Medium
Grocery Stores	23.4	18.7	22.1	2022	Low

Table 50: Housing and Homelessness

Measure	National Benchmark	North Carolina Benchmark	Nash County Data	Most Recent Data Year	Nash County Need
Renter Costs – Average Gross Rent	$1,366	$1,090	$844	2018-2022	Low
% Severe Housing Cost Burden	14.1%	12.2%	11.5%	2018-2022	Low
Assisted Housing Units	413.9	319.2	349.7	2017-2021	High
% Severe Substandard Housing	18.5%	16.1%	16.6%	2011-2015	Medium
% Homeless Children	2.8%	1.9%	2.2%	2019-2020	High

Table 51: Income

Measure	National Benchmark	North Carolina Benchmark	Nash County Data	Most Recent Data Year	Nash County Need
Median Family Income	$92,646	$82,890	$69,593	2018-2022	High
Gender Pay Gap	81.0%	83.0%	75.0%	2018-2022	High
% Living Below 100% FPL	12.5%	13.3%	14.5%	2022	High
% Living Below 200% FPL	28.8%	31.6%	35.1%	2018-2022	High
% Children Living Below 200% FPL	37.2%	41.1%	46.6%	2018-2022	High
% Receiving SNAP	12.4%	15.7%	19.9%	2021	High
Children Eligible for Free/Reduced Price Lunch	51.7%	50.8%	50.0%	2022-2023	Medium

Table 52: Length of Life

Measure	National Benchmark	North Carolina Benchmark	Nash County Data	Most Recent Data Year	Nash County Need
Years of Potential Life Lost Rate	N/A	8,853	10,652	2019-2021	High
Premature Age-Adjusted Mortality	N/A	420	509	2019-2021	High
Life Expectancy	77.6	76.6	74.4	2019-2021	Medium

Table 53: Maternal and Infant Health

Measure	National Benchmark	North Carolina Benchmark	Nash County Data	Most Recent Data Year	Nash County Need
Births with Late or No Prenatal Care	6.1%	6.9%	Suppressed	2019	N/A
Low Birthweight	N/A	9.4%	10.8%		High
Infant Mortality Rate	5.7	7.0	8.0	2015-2021	High

Table 54: Mental Health

Measure	National Benchmark	North Carolina Benchmark	Nash County Data	Most Recent Data Year	Nash County Need
Poor Mental Health Days	4.9	4.6	5.1	2021	High
Deaths of Despair Rate	55.9	58.7	67.3	2018-2022	High
Suicide Death Rate	14.5	14.0	12.7	2018-2022	Low

Table 55: Physical Health

Measure	National Benchmark	North Carolina Benchmark	Nash County Data	Most Recent Data Year	Nash County Need
% Poor or Fair Health	N/A	14.4%	17.2%	2021	High
% Adults with Asthma	9.7%	9.8%	10.6%	2022	High
% Adults with Heart Disease	5.2%	5.5%	5.8%	2022	High
% Adults with High Blood Pressure	29.6%	32.1%	35.9%	2021	High
% Adults with High Cholesterol	31.0%	31.4%	31.0%	2021	Medium
Diabetes Prevalence	8.9%	9.0%	10.8%	2021	High
% Adults with Kidney Disease	2.7%	2.9%	3.2%	2021	High
% Stroke	2.8%	3.1%	3.5%	2022	High
Obesity	30.1%	29.7%	30.2%	2021	Medium
% Teeth Loss	13.9%	12.0%	15.0%	2022	High
Cancer Incidence Rate	442.3	464.4	434.6	2016-2020	Low
Emergency Room Visits	535	563	621	2022	High

Measure	National Benchmark	North Carolina Benchmark	Nash County Data	Most Recent Data Year	Nash County Need
Heart Disease Hospitalization Rate	10.4	11.7	11.7	2018-2020	Medium
Stroke Hospitalization Rate	8.0	9.5	11.4	2018-2020	High

Table 56: Quality of Care

Measure	National Benchmark	North Carolina Benchmark	Nash County Data	Most Recent Data Year	Nash County Need
Children/adults vaccinated annually against seasonal influenza	1.3%	1.5%	39.1%	2021	High
Preventable Hospital Rate	13.8	16.0	3,503	2021	High
Readmissions Rate	416.0	365.7	17.7%	2022	Medium

Table 57: Safety

Measure	National Benchmark	North Carolina Benchmark	Nash County Data	Most Recent Data Year	Nash County Need
Incarceration Rate	1.3%	1.5%	1.5%	2018	Medium
Juvenile Arrest Rate	13.8	16.0	10.0	2021	Low
Violent Crime	416.0	365.7	457.6	2015-2017	High
Firearm Death Rate	13.4	15.5	18.6	2018-2022	High
Poisoning Death Rate	28.5	31.5	32.3	2018-2022	Medium

Table 58: Sexual Health

Measure	National Benchmark	North Carolina Benchmark	Nash County Data	Most Recent Data Year	Nash County Need
Chlamydia Rate	495.0	603.3	740.7	2021	High
HIV Incidence Rate	12.7	15.5	19.8	2022	High
Teen Births	16.6	18.2	23.2	2016-2022	High

Table 59: Substance Use Disorders

Measure	National Benchmark	North Carolina Benchmark	Nash County Data	Most Recent Data Year	Nash County Need
% Excessive Drinking	18.1%	18.2%	16.2%	2021	Low
% Driving Deaths with Alcohol	2.6	3.3	7.8	2018-2022	High
Opioid Use Disorder Rate	41.0	43.0	38.0	2021	Low
Opioid Drug Overdose Deaths	16.0	19.5	25.3	2018-2022	Medium

Table 60: Tobacco Use

Measure	National Benchmark	North Carolina Benchmark	Nash County Data	Most Recent Data Year	Nash County Need
% Smokers	14.5%	15.0%	18.0%	2021	High

Table 61: Transportation Options and Transit

Measure	National Benchmark	North Carolina Benchmark	Nash County Data	Most Recent Data Year	Nash County Need
% Households with No Motor Vehicle	8.3%	5.4%	6.9%	2018-2022	High
% Public Transit	3.8%	0.8%	0.6%	2018-2022	High
% Living Near Public Transit	34.8%	10.9%	30.1%	2021	Low

APPENDIX 4 | PRIMARY DATA METHODOLOGY AND SOURCES

Primary data were collected through focus groups, which were conducted in-person, and a paper and 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 two focus groups were conducted in person during June 2024. These groups included representation from community members, with participants providing responses on living, working, or receiving healthcare in Nash County.

- Twin Counties Partnership for Healthier Communities
- Nash County ESL and Migrant Education School Employees and Interpreters

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 Nash County

The focus group discussion guide questions are below:

FACILITATOR INTRODUCTION:

"Thank you for being a part of today's focus group! My name is [NAME] and I'm here on behalf of [ORGANIZATION]. We are conducting a community health needs assessment to find out more about some of the health and social issues facing residents in [COUNTY NAME]. The results of this focus group will be used to help health leaders throughout [COUNTY NAME] develop programs and services to address some of the issues we'll be talking about today. We may record today's discussion to assist with notetaking, but we will not be using any identifying information, like participant names, in our results. We would also like to ask you to fill out this demographic form, so we can understand a little bit more about who is participating in this focus group."

PARTICIPANT INTRODUCTIONS

1. Please tell us your first name, how long you've lived in [COUNTY NAME] and something you like about living here.

HEALTH AND WELLNESS

2. What are some of the issues that keep residents in [COUNTY NAME] from living healthy lives?
3. What are the most serious health problems facing people who live in [COUNTY NAME]?
    a. Are there particular groups of people (i.e. race, ethnicity, age, LGBTQ+, etc.) who are more affected by these problems than others?
    b. Are there particular areas in the county that are more affected by these problems than others?
4. Thinking about the health problems you described, what do you think could be done to address these issues?

SOCIAL DETERMINANTS OF HEALTH

5. What are some of the environmental and/or social conditions that affect quality of life for people living in [COUNTY NAME]?
    a. Examples of social and environmental issues that negatively impact health: availability or access to health insurance, domestic violence, housing problems, homelessness, lack of job opportunities, lack of affordable childcare, limited access to healthy food, neighborhood safety/ street violence, poverty, racial/ethnic discrimination, limited/poor educational opportunities.
6. Thinking about the social and environmental issues you described, how do you think these issues could be addressed?

ACCESS TO CARE

7. What are some reasons people in [COUNTY NAME] do not get health care when they need it? How can these issues be addressed?
8. What do you think about the health-related services that are available in your community, including medical care, dental care and behavioral health care?
    a. Are there enough locations providing these types of care for people who need it?
    b. Can you find medical, dental or behavioral health care within a reasonable timeframe when you need it?
    c. Are your experiences with providers (doctors, dentists, nurses, therapists, emergency personnel, etc.) more positive or negative, and why?

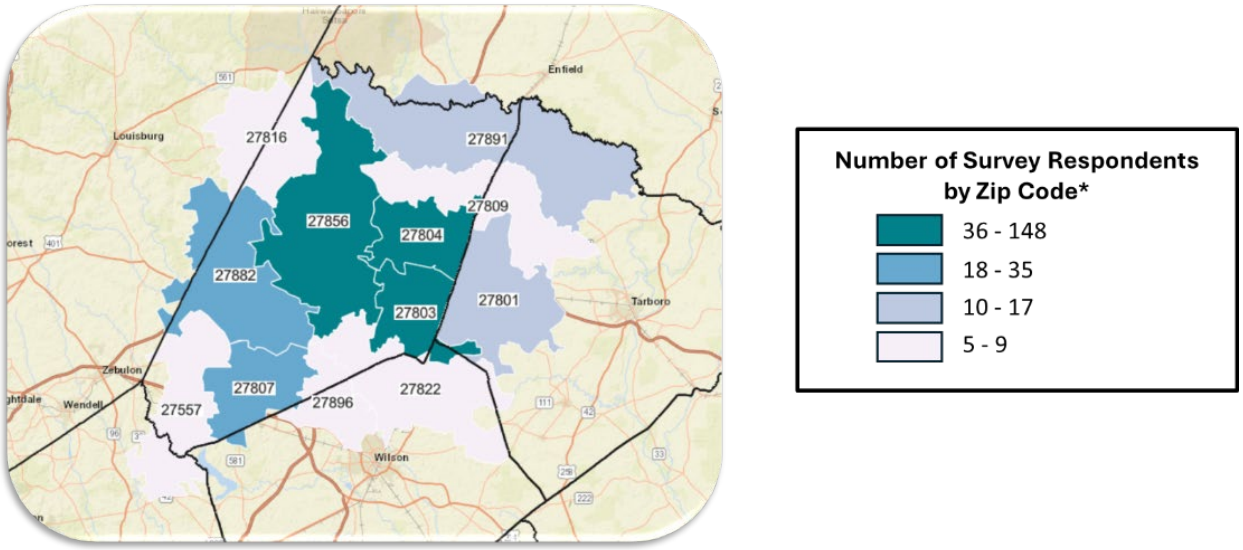
SUGGESTIONS

9. What are some of the strengths or community assets in [COUNTY NAME] that can help residents live healthier lives?
10. What do you think local health leaders should do to improve health and quality of life in [COUNTY NAME]? What do you want local health leaders to know?
11. What actions can local residents take to help improve the health of the community?

Community Member Web Survey

A total of 553 surveys were completed by individuals living, working or receiving healthcare in the Nash County community. The survey was available in both English and Spanish, and approximately 3% 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 43: Respondent Zip Code of Residence[50]



In general, survey questions focused on:

- Community health problems and concerns
- Community social/environmental problems and concerns
- Specific topics of interest to Nash County:
  - Access to care
  - Income

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

- Mental health
- Physical health
- Substance use disorders

The key findings from the Community Survey are detailed below:

- Alcohol/drug addiction, mental health (e.g., depression and anxiety), and diabetes/high blood sugar were identified as the top three health problems affecting the community. About one-third of respondents also identified heart disease/high blood pressure and weight/obesity as important health problems.
- Cost, not having insurance, and lack of transportation were the top three barriers to receiving health care identified by the community.
- Availability and access to doctor's offices, housing, and poverty were identified as the top three most important social or environmental problems that affect the health of the community. Neighborhood safety, insurance, and lack of affordable childcare were also identified by almost one in four respondents.

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

Figure 44: Respondents by Age Group

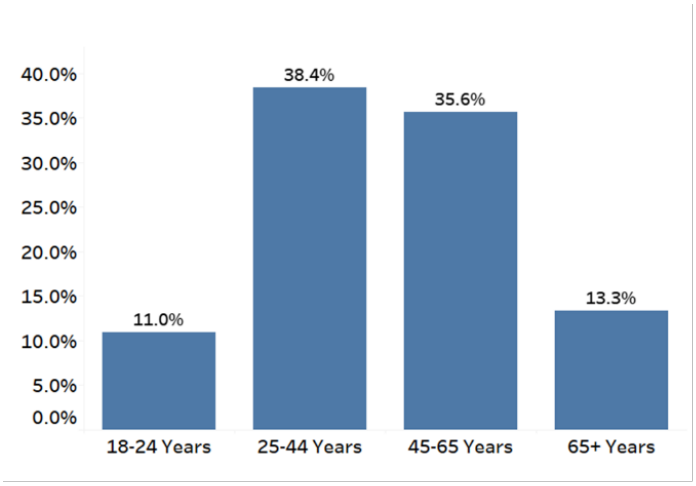


Figure 45: Respondents by Gender

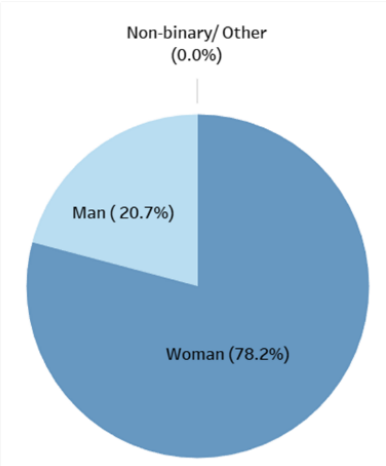


Figure 46: Respondents by Race

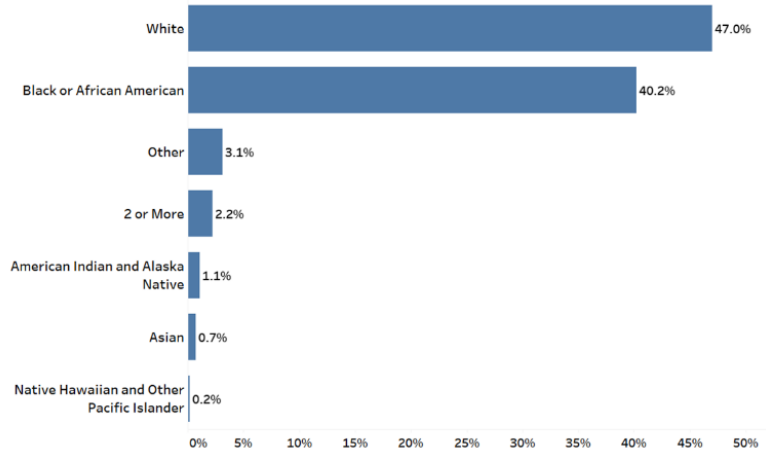
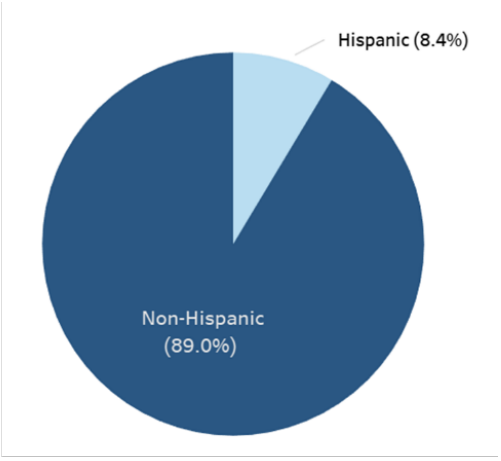


Figure 47: Respondents by Ethnicity



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?[51]

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

[51] 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."

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

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
a. 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: Income

19. How often do you have someone you can rely on to help with the following items, as needed? 1 = Always; 2 = Usually; 3 = Sometimes; 4 = Rarely; 5 = Never

	1	2	3	4	5	Prefer not to say
a. Food	□	□	□	□	□	□
b. Transportation	□	□	□	□	□	□
c. Childcare	□	□	□	□	□	□
d. Other support	□	□	□	□	□	□

20. In the past year, did you have any of the following assistance needs NOT met? *Select all that apply.*

□ Access and safety modifications to your home (ex. ramp, handrail)
□ Clothing for yourself and your family
□ Critical house repairs
□ Food for yourself and your family
□ Household goods (furniture, a stove or refrigerator)
□ Medical or adaptive equipment not covered by Medicaid or private insurance
□ None of the above
□ Don't know/Not sure
□ Prefer not to say

Topic: Mental Health

21. Now thinking about your MENTAL health, which includes stress, depression, and problems with emotions, for how many days during the past 30 days was your mental health NOT good?

□ Number of days: _____

22. Was there a time in the past 12 months when you needed mental health care or counseling, but did not get it at that time?

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

23. If you answered 'Yes' to the previous question, what was the MAIN reason you did not get mental health care or counseling?

□ Cost/No insurance coverage
□ Distance
□ Don't know where to go
□ Concerns about confidentiality
□ Inconvenient office hours
□ Lack of childcare
□ Lack of providers
□ Lack of transportation
□ Previous negative experiences/Distrust of mental health providers
□ Stigma
□ Too busy to go to an appointment
□ Too long of wait for an appointment
□ Trouble getting an appointment
□ Other *(please specify)*: _____
□ None of the above
□ Don't know/Not sure
□ Prefer not to say

24. Are you currently taking medication or receiving treatment, therapy, or counseling from a health professional for any type of MENTAL or EMOTIONAL HEALTH NEED?

□ Yes
□ No
□ Prefer not to say

Topic: Physical Health

25. 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

26. 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?	□	□	□	□

27. 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

28. 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

29. 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

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?

□ Number of drinks: _____

31. 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

32. 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

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? 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 Group General Findings

Two focus groups were conducted in Nash County in June 2024 to gather insights on residents' experiences. The groups identified several common health concerns and barriers to care. First, they highlighted community safety issues, noting that certain areas in the county do not feel safe. Second, food access and security were identified as concerns, with the county being described as a "food swamp" with limited access to affordable healthy foods. The third common theme was healthcare access and quality, including issues such as lack of compassionate providers, limited appointment availability, and high care costs. Additionally, housing and homelessness were identified as challenges, specifically poor housing conditions and lack of affordable quality housing. Physical health issues, particularly chronic conditions like diabetes, heart disease, and high blood pressure, were also top concerns. Lastly, the focus groups identified transportation and transit as significant barriers to accessing healthcare and other needed services.

Focus Group 1 Unique Insights: Twin Counties Partnership for Healthier Communities

Participants in this focus group identified several key health and social/environmental concerns beyond the common themes. Employment and income were significant issues, with participants noting the high overall cost of living, limited and expensive childcare options, and school schedules that are not conducive to working families. Health equity was another concern, specifically regarding the lack of equitable resource distribution across the county, which disproportionately impacts people of color and minority populations. Substance use, particularly drug use in the community, was also identified as a concern.

Participants had several suggestions for addressing these health concerns and barriers to care in their community. They recommended offering more surveys and public input meetings, especially for parks and recreation. They also suggested encouraging stores like Dollar General to stock fresh produce and promoting more community gardens and nutrition education, particularly for young children.

Focus Group 2 Unique Insights: ESL School Employees and Interpreters

Focus group two included 6 participants. The majority (4) of the group identified as female, and four identified as white. Nearly all (5) of the participants identified as Hispanic or Latino. All participants were over the age of 30, with 4 falling within the 50-64 age group. One group member chose not to provide demographic information. The ESL Migrant Employees highlighted mental health as a significant concern for the community. While they noted that there seem to be enough mental health providers in the area, there is a lack of bilingual providers. They also identified a need for urgent care services specifically for mental health issues.

When asked what they would like local health leaders in Nash County to do to improve well-being, participants suggested providing more education about available resources and creating more partnerships with churches and other faith-based groups. They also emphasized the need for more translators and proposed creating a "Health Week" event with partners from all over the county. Lastly, the group suggested utilizing mobile units to improve access to healthcare services.

Both focus groups agreed that improving access to information and resources, as well as engaging with the community more directly, are essential steps towards a healthier Nash County.

Community Member Web Survey

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

Topic: Additional Demographic Information

Figure 48: What is the highest grade or year of school you completed?

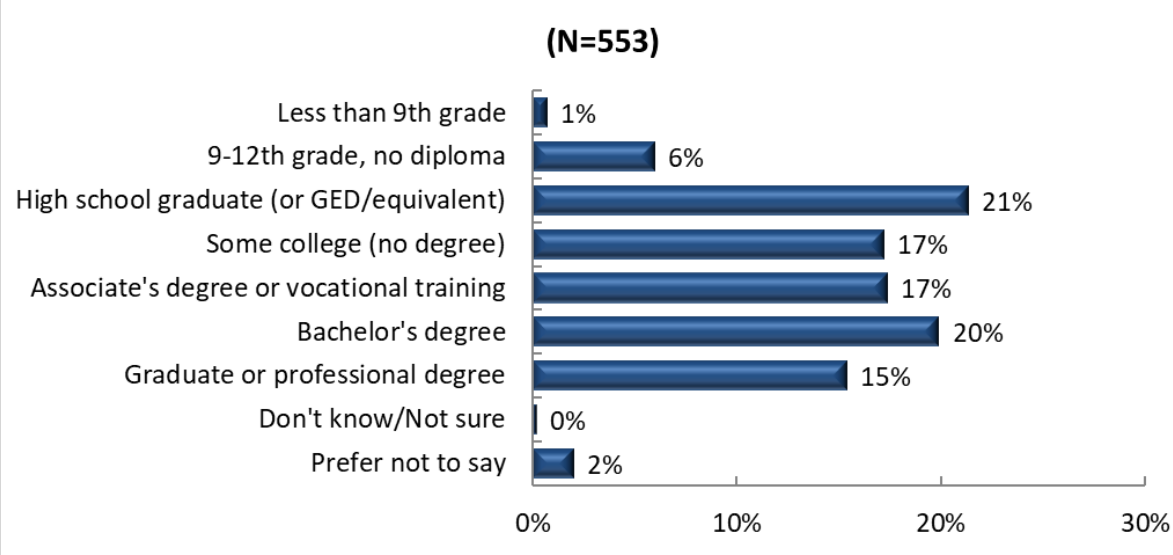


Figure 49: Which language is most often spoken in your home? (Choose one)

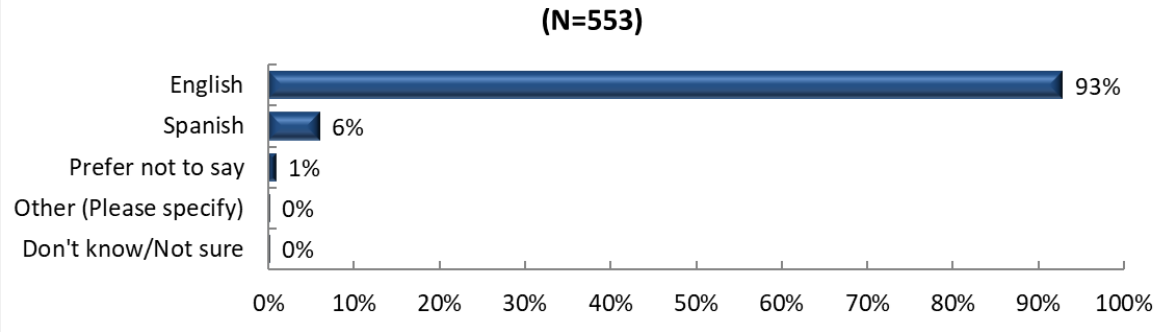


Figure 50: For employment, are you currently... (Select all that apply.)

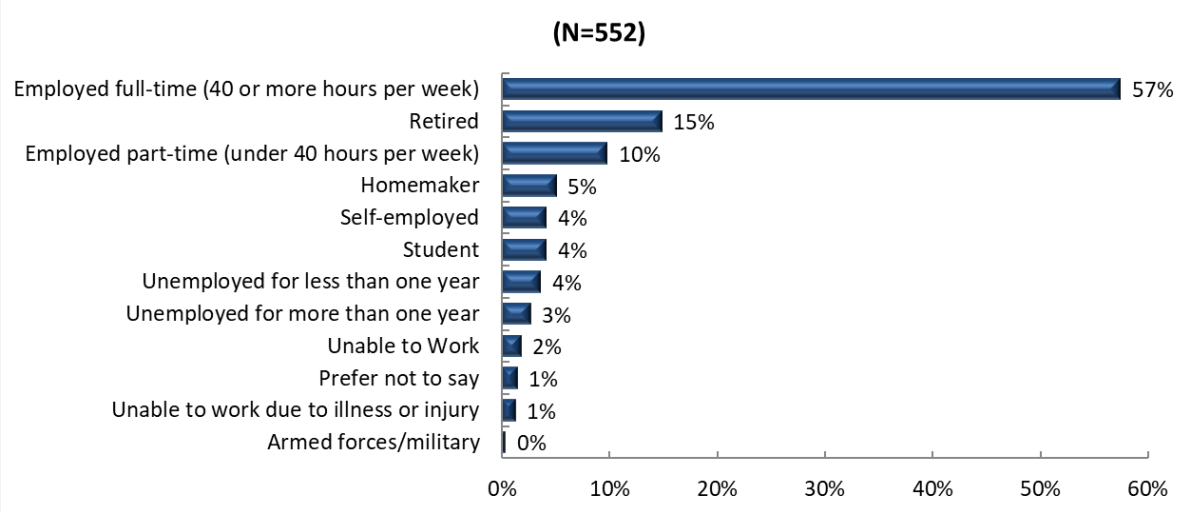
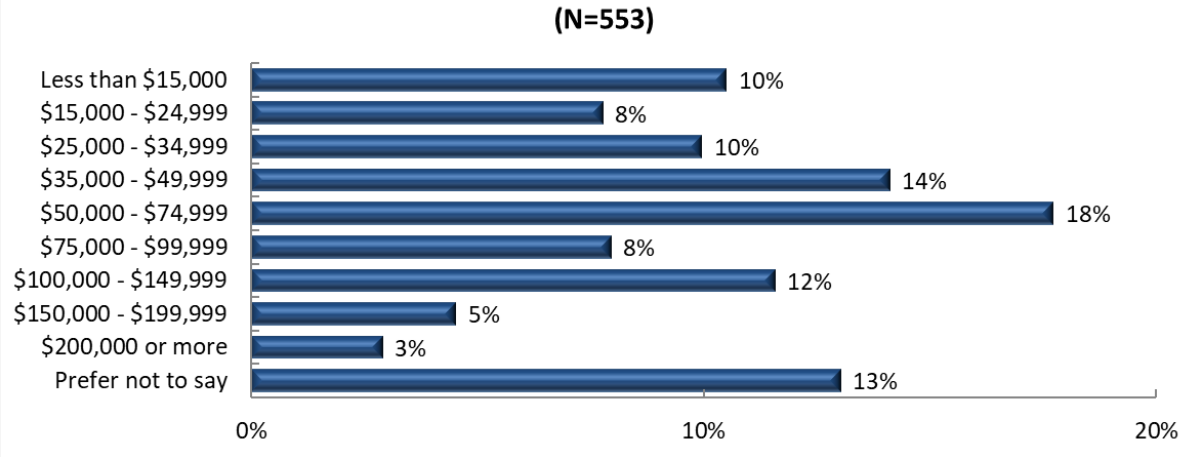


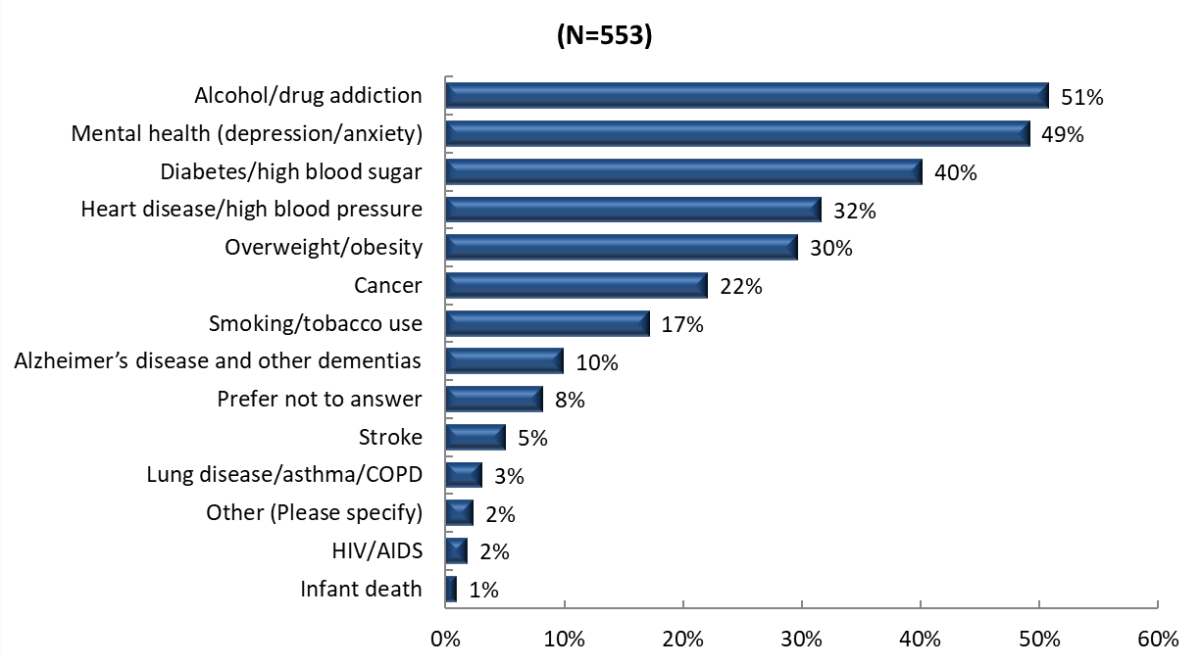
Figure 51: Which category best describes your yearly household income before taxes?

Do not give the dollar amount, just give the category. Include all income received from employment, social security, support from children or other family, welfare, Aid to Families with Dependent Children (AFDC), bank interest, retirement accounts, rental property, investments, etc.



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

Figure 52: What are the three most important health problems that affect the health of your community? Please select up to three.



Other (please specify):

- "Asthma"
- "Food Scarcity"
- "gangs"
- "Gun violence"
- "Microscopic collagenous colitis"
- "RACISM"
- "Social determinants of health"
- "std"

Figure 53: What are the three most important health problems that affect the health of your community? Please select up to three. (by age)

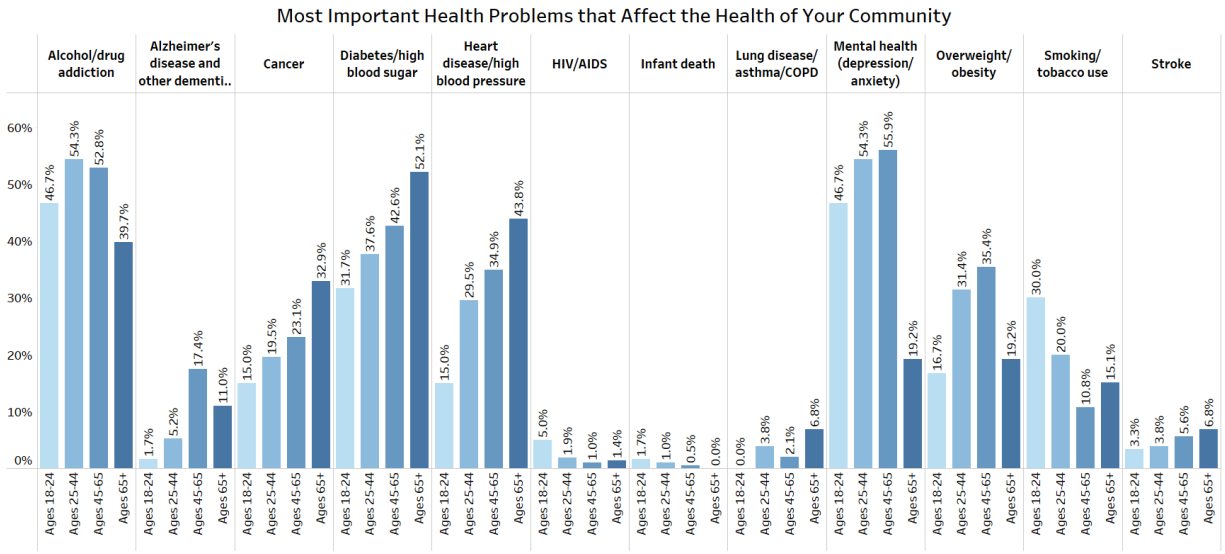


Figure 54: What are the three most important health problems that affect the health of your community? Please select up to three. (by gender)

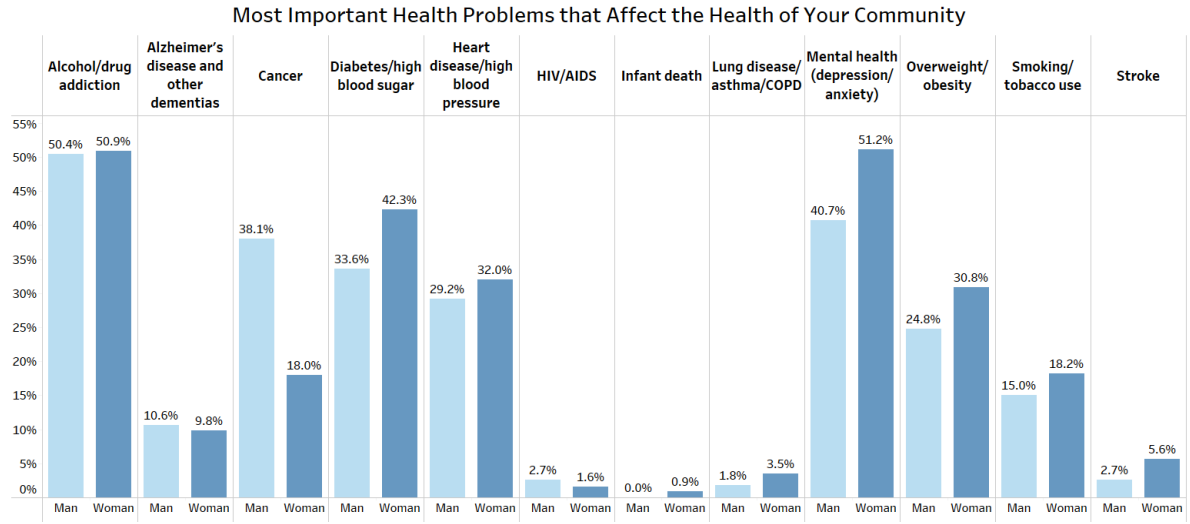


Figure 55: What are the three most important health problems that affect the health of your community? Please select up to three. (by race)

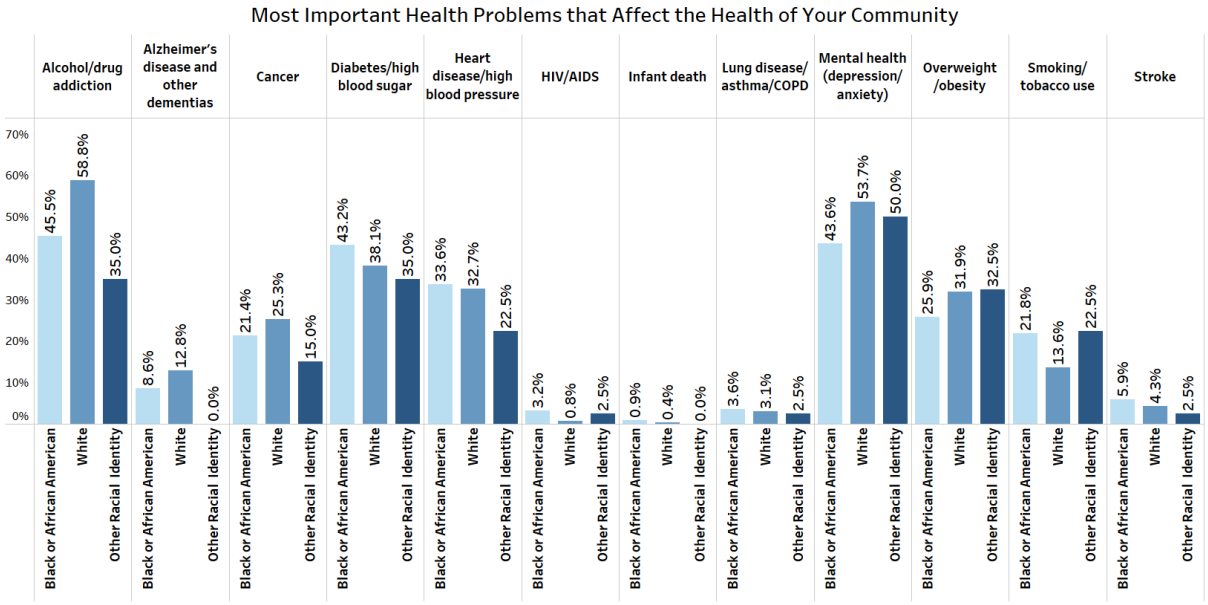


Figure 56: What are the three most important health problems that affect the health of your community? Please select up to three.

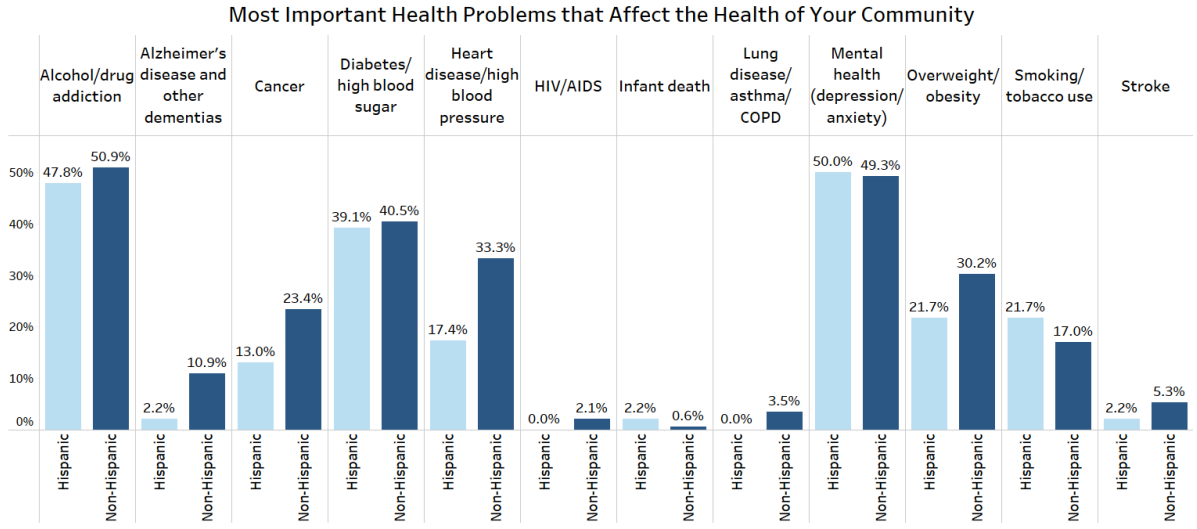
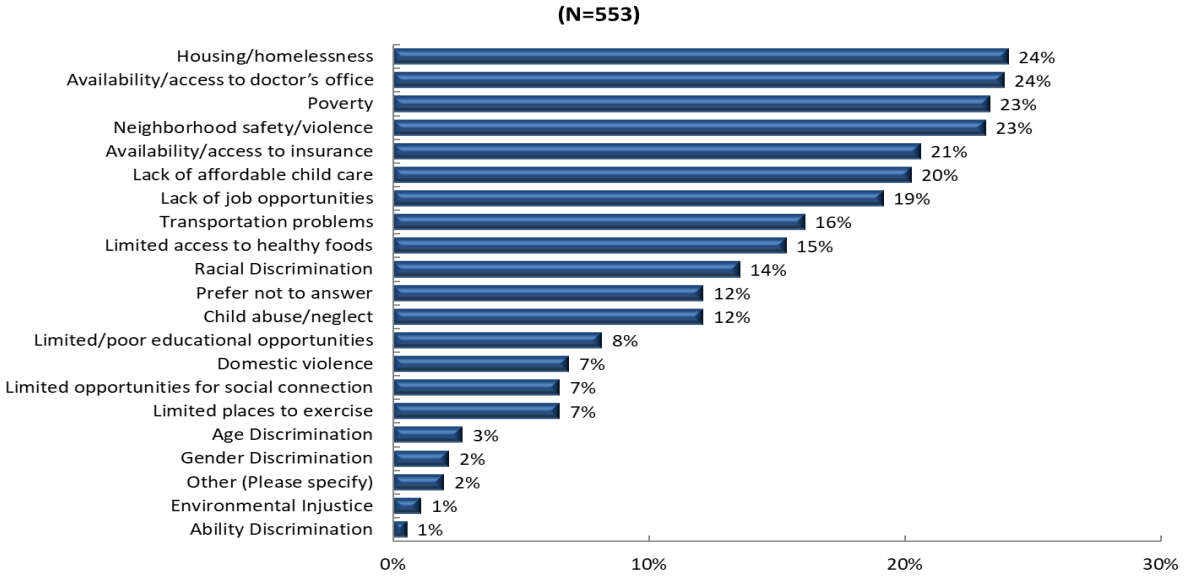


Figure 57: What are the three most important social or environmental problems that affect the health of your community? Please select up to three.



Other (please specify):

- "Access in general"
- "cost of dental"
- "Lack of informative resources"
- "Not enough high quality job opportunities."
- "People have gotten lazy since Covid. Hard for companies to find people to work and that can pass a drug test."
- "The medical system is a joke. Primary don't do anything. Every appt takes 3 months. Primary don't treat acute issues any more. You have to go to immediate care or ER. The system is broken. They say the bill is X, you agree, then get bills x,y,z, a, b,c"
- "timely doctor's appointment"
- "Water"

Figure 58: What are the three most important social or environmental problems that affect the health of your community? Please select up to three. (by age)

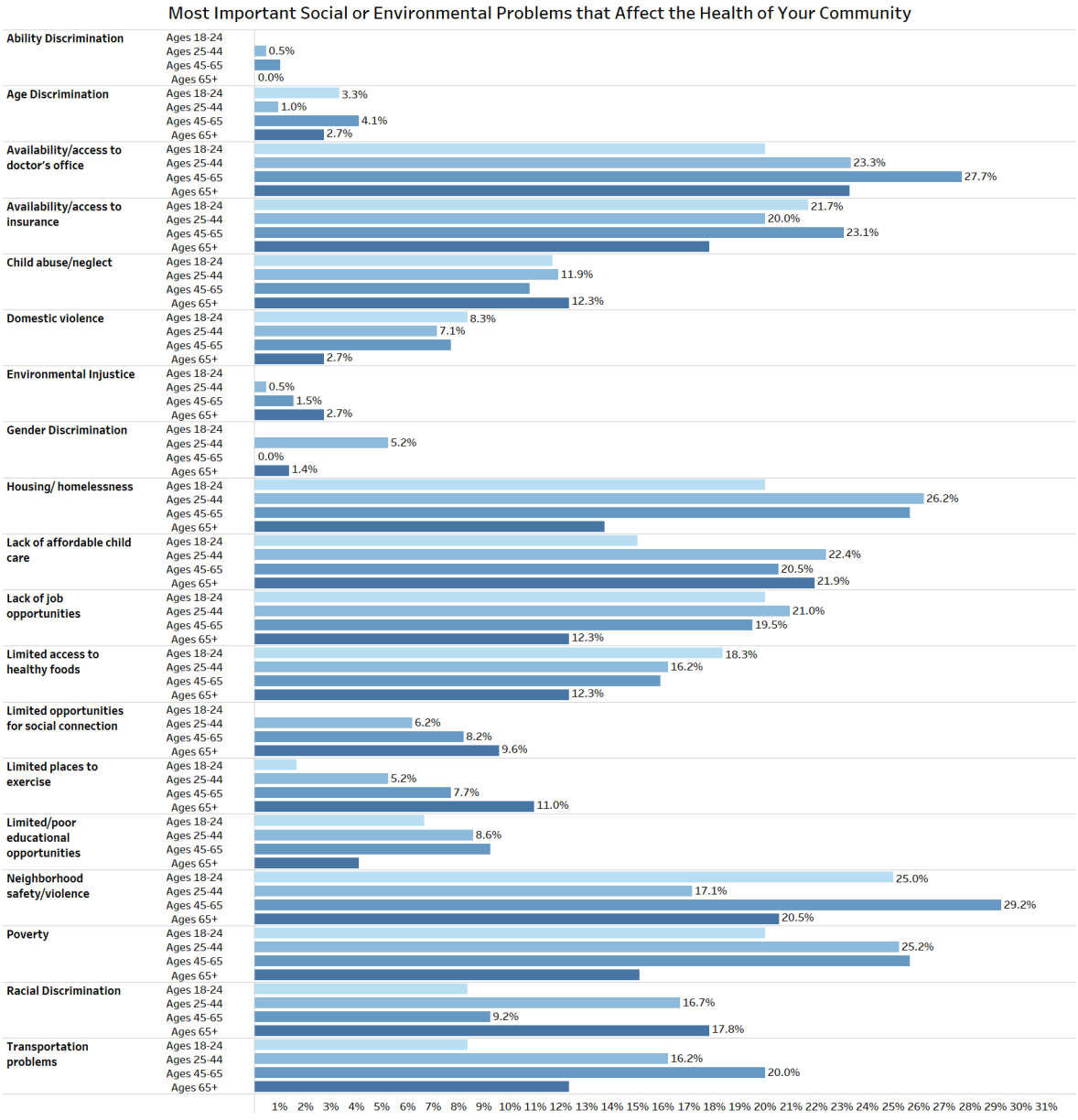


Figure 59: What are the three most important social or environmental problems that affect the health of your community? Please select up to three. (by gender)

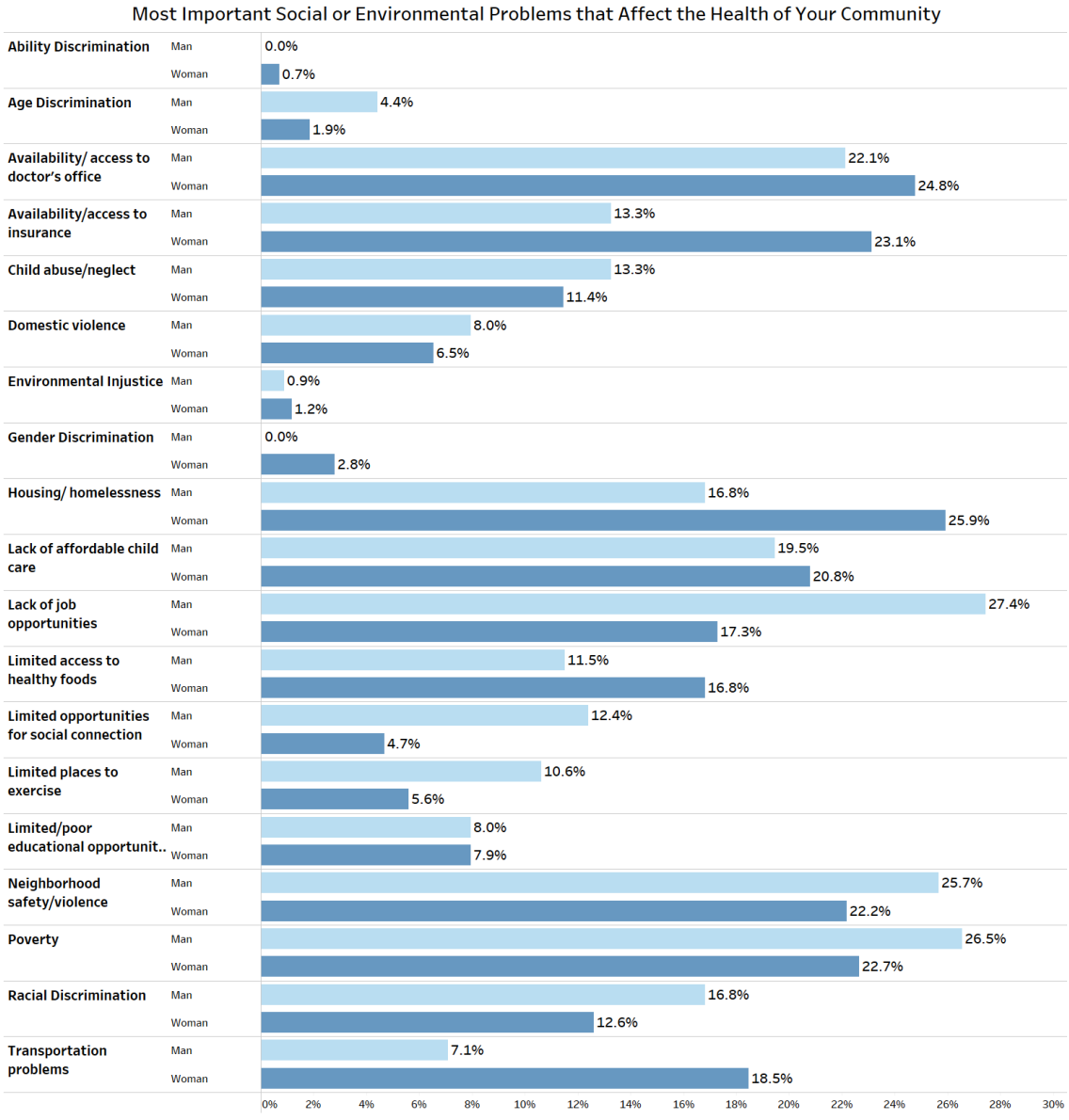


Figure 60: What are the three most important social or environmental problems that affect the health of your community? Please select up to three.

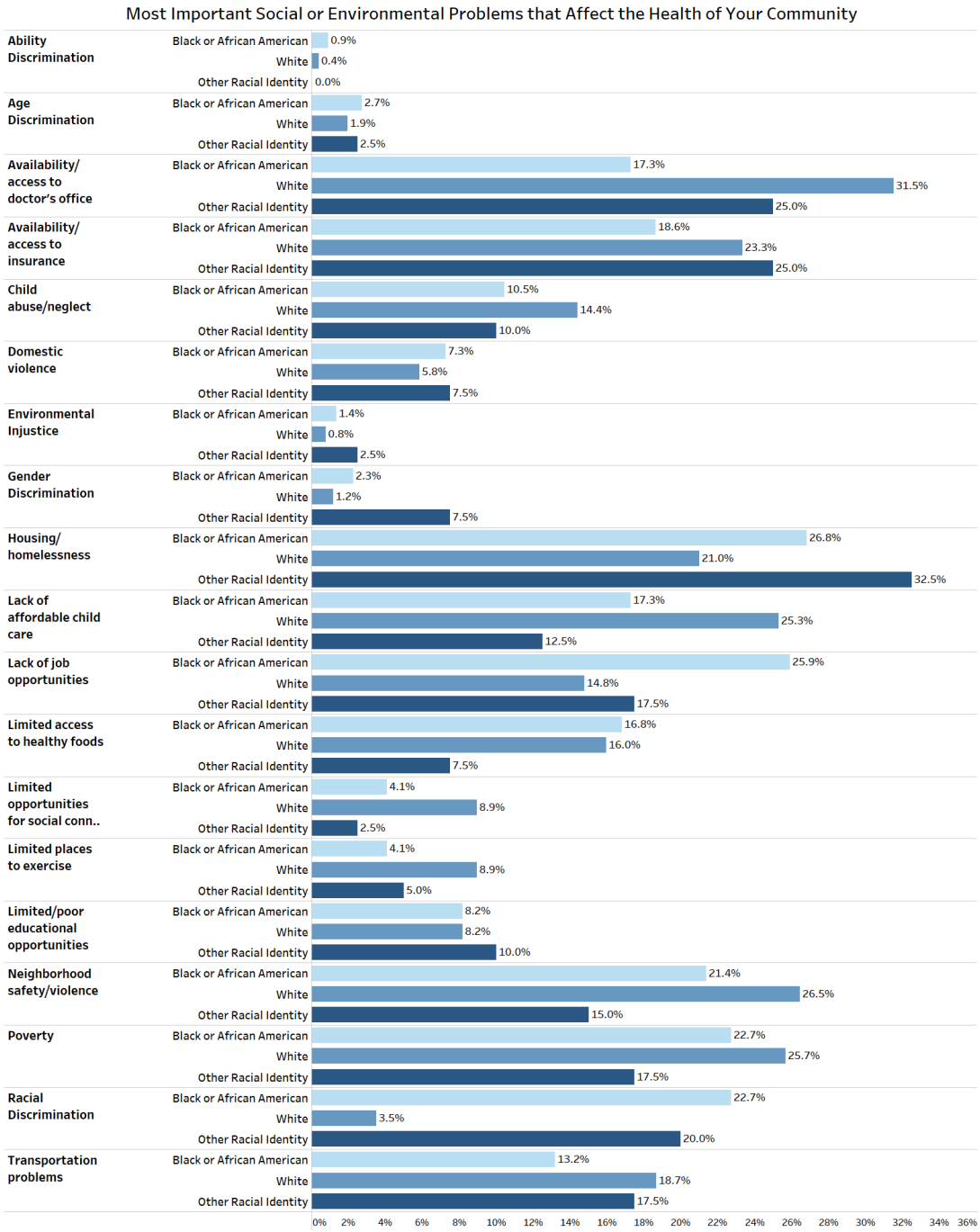


Figure 61: What are the three most important social or environmental problems that affect the health of your community? Please select up to three.

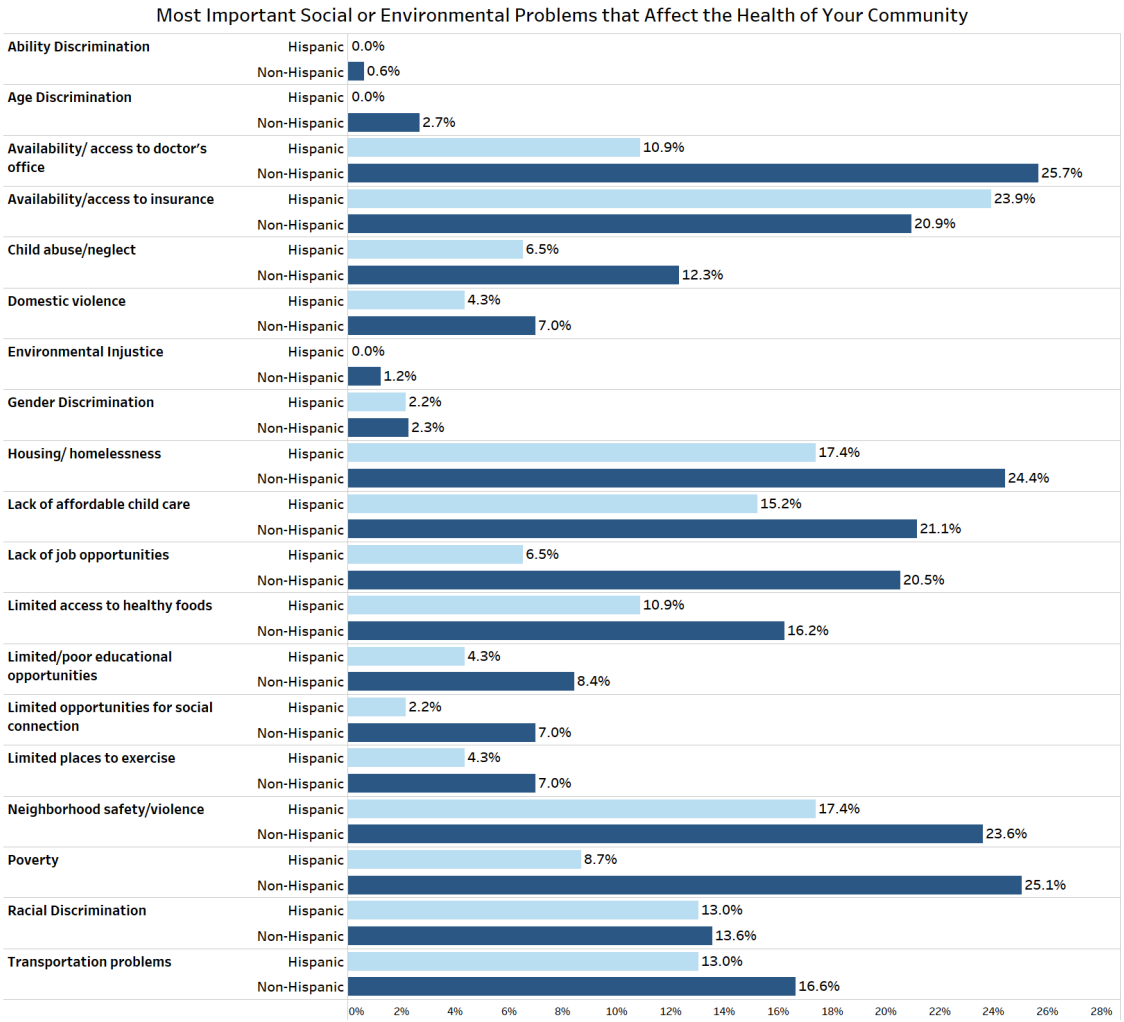
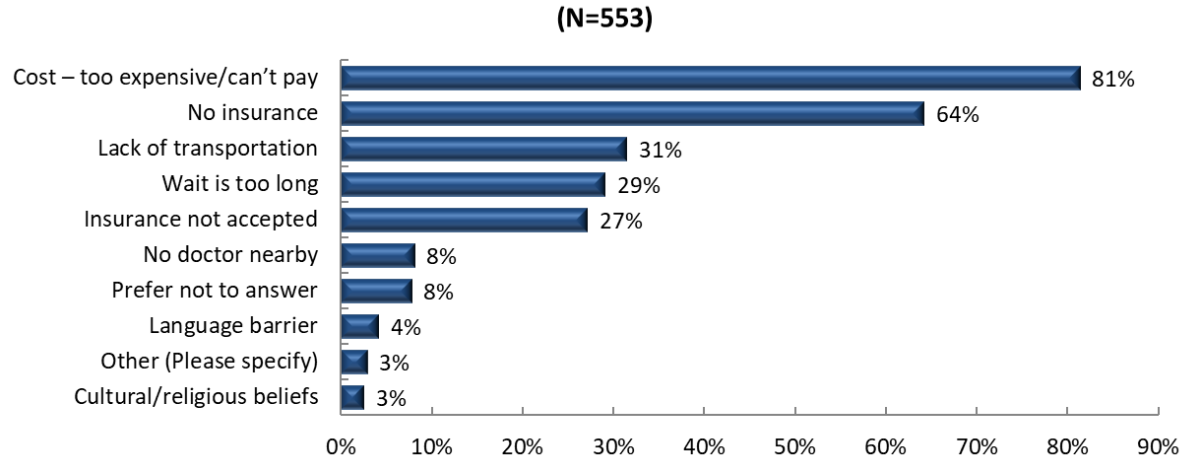


Figure 62: What are the three most important reasons people in your community do not get health care when they need it? Please select up to three.



Other (please specify):

- "After hours or weekend services without going to the hospital"
- "Do not like the providers in the county"
- "Doctors not accepting new patients"
- "Inform citizens about various health resources"
- "Lack of health literacy"
- "Lack of Information"
- "Lack of knowledge of insurance available."
- "Lack of knowledge related to conditions"
- "Lack of personal connection with a doctor."
- "Lack of trust in health care system"
- "No job"
- "No time off work/after hours/weekend clinics"
- "The offices are so inefficient and ineffective. Nurses are unprofessional. Doctors contradict one another."

Figure 63: 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)

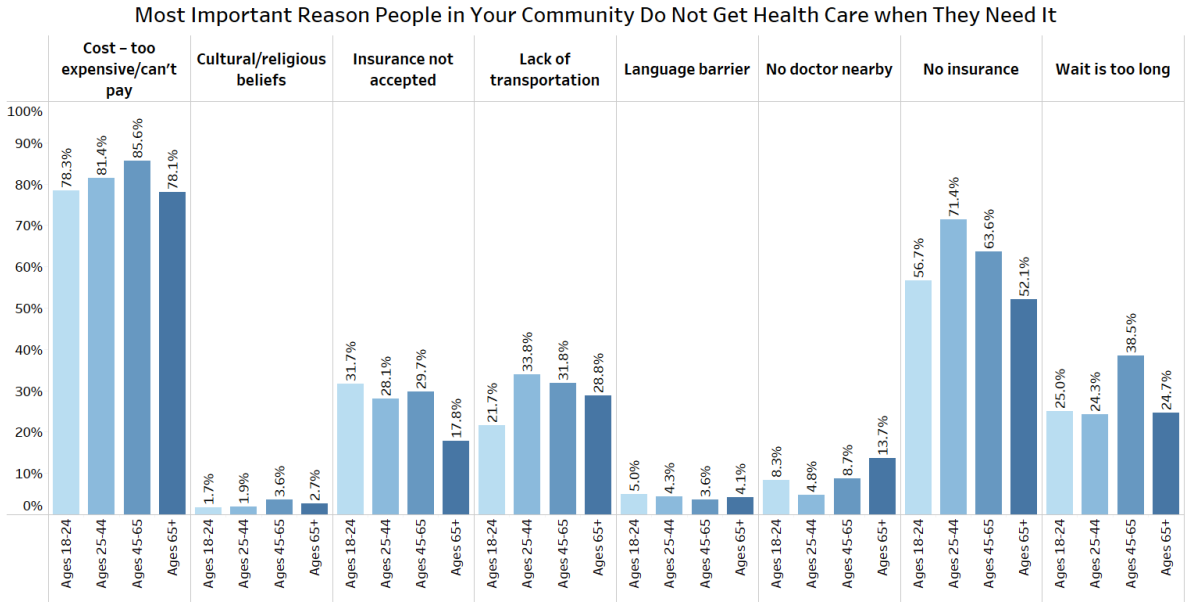


Figure 64: What are the three most important reasons people in your community do not get health care when they need it? Please select up to three. (by gender)

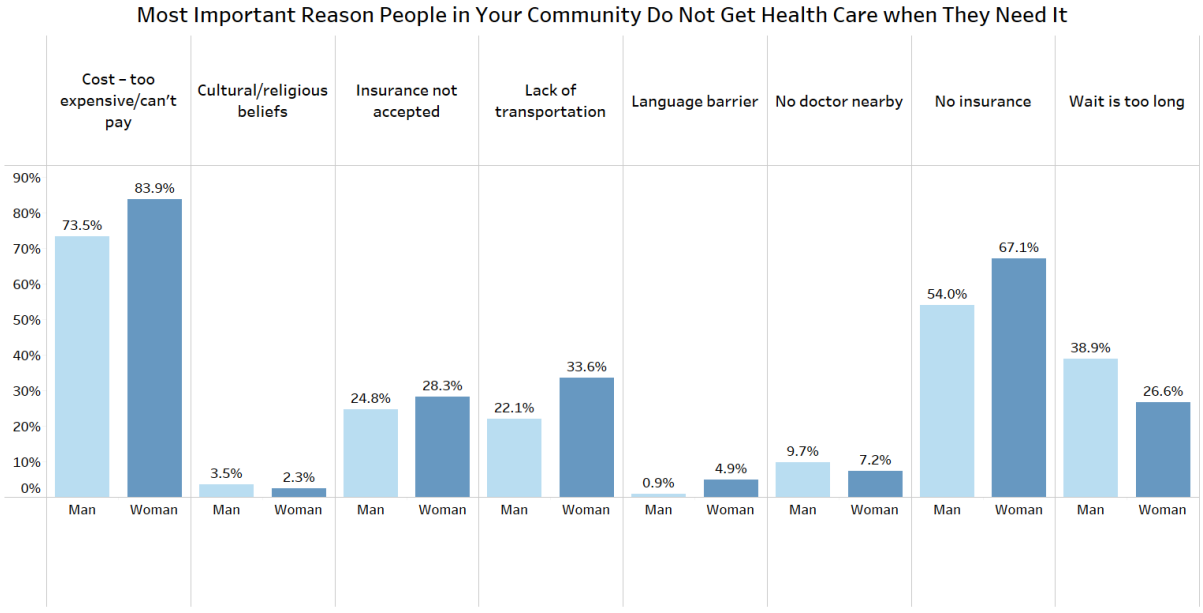


Figure 65: What are the three most important reasons people in your community do not get health care when they need it? Please select up to three. (by race)

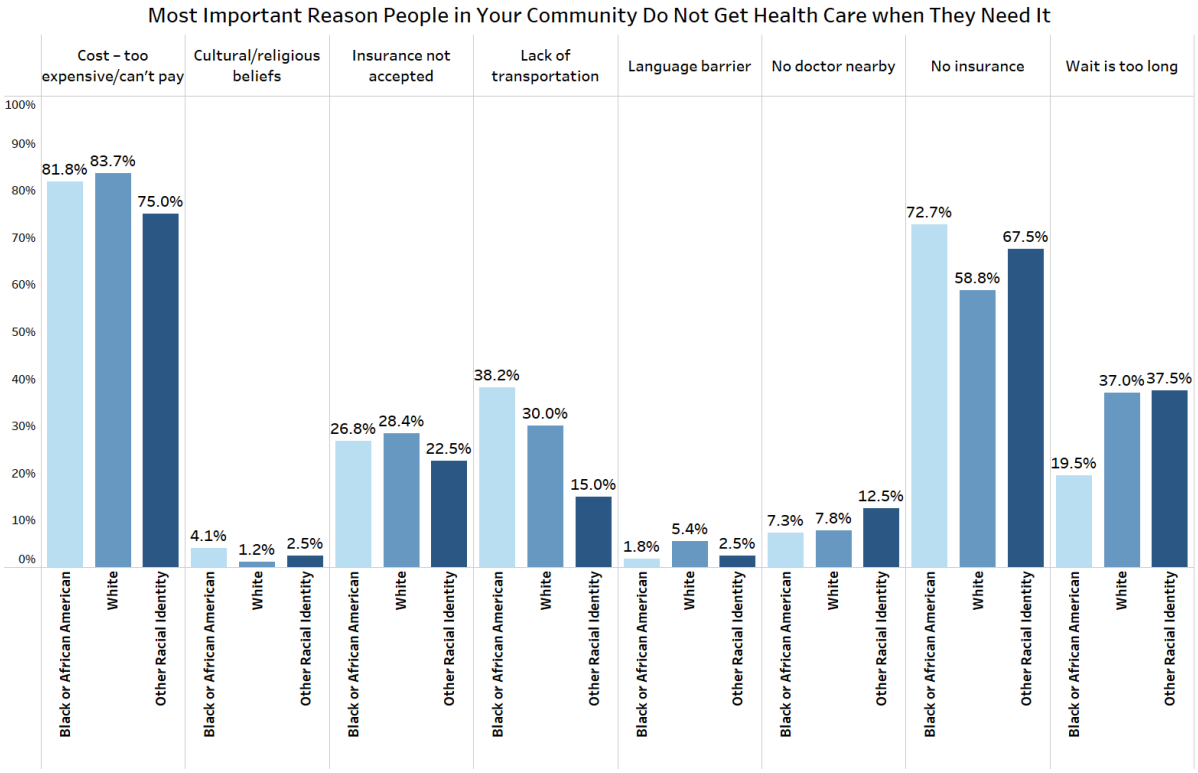
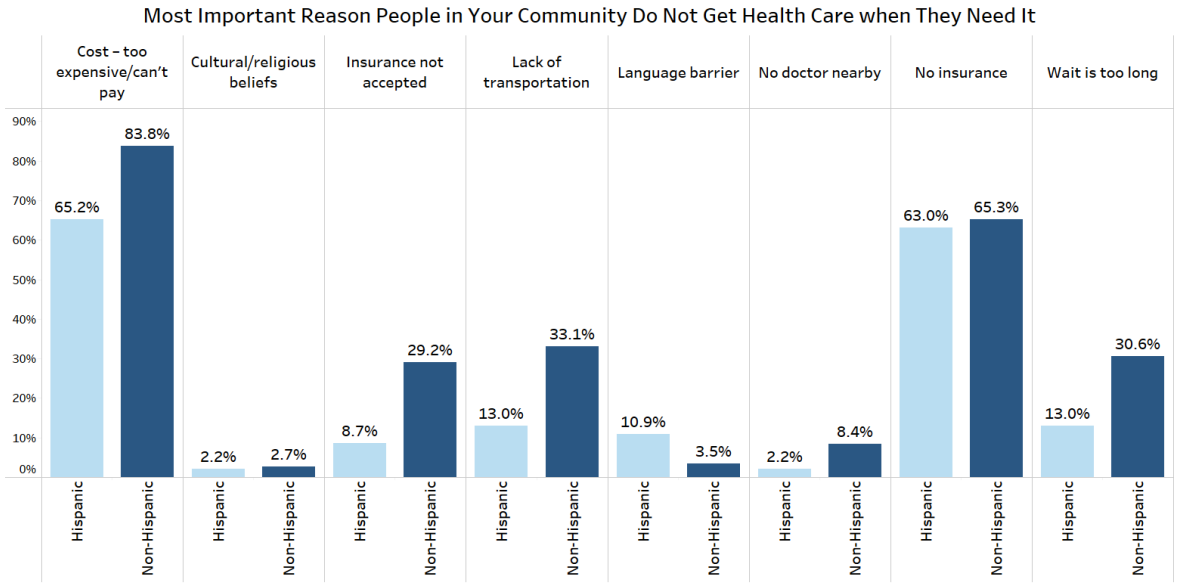


Figure 66: What are the three most important reasons people in your community do not get health care when they need it? Please select up to three. (by ethnicity)



Topic: Access To Care

Figure 67: 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?

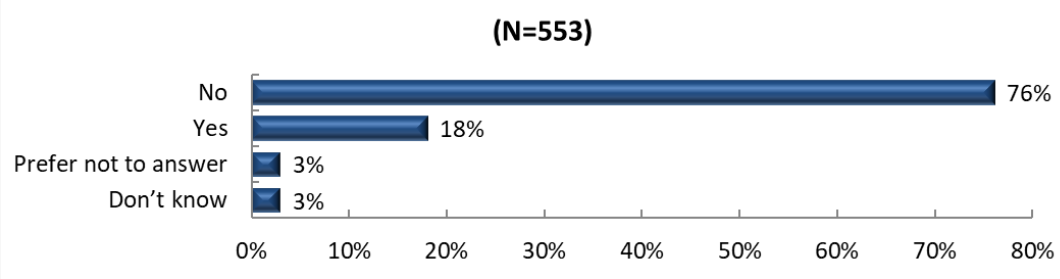
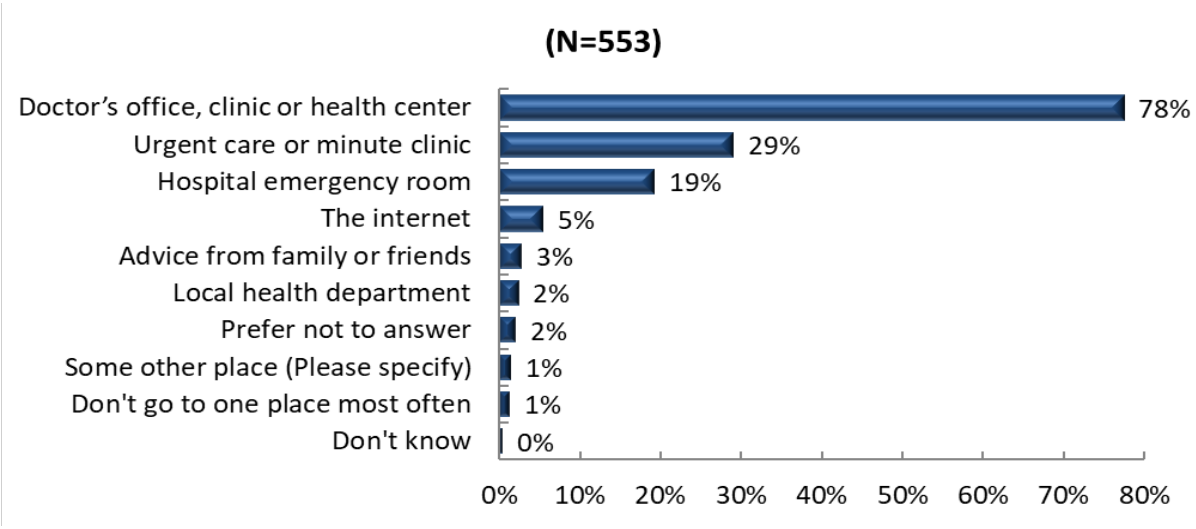


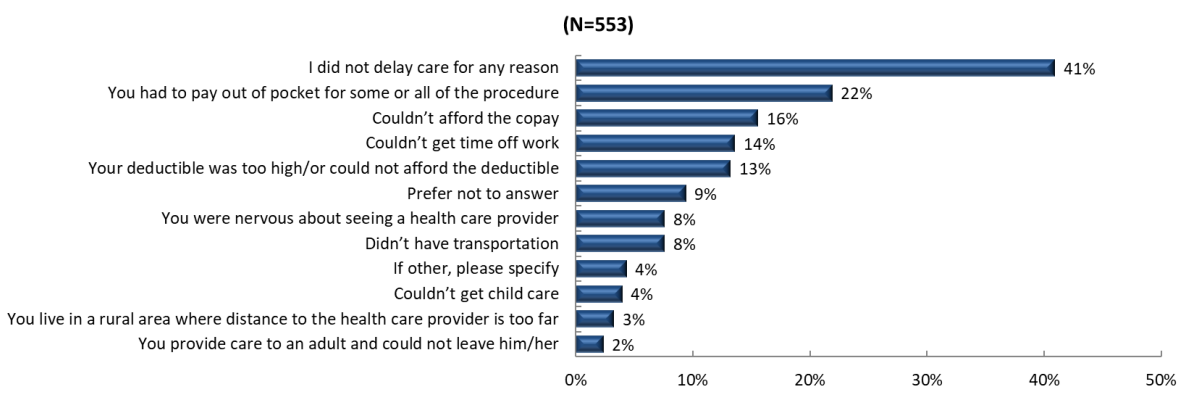
Figure 68: Where do you USUALLY go when you are sick or need advice about your health?



Other (please specify):

- "I don't."
- "Knightdale for after work appt"
- "Primeravaz aku en USA"
- "Raleigh"
- "Tele Med" / "Teledoc" (4 responses)

Figure 69: 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?



Other (please specify):

- "Can't be seen for 3 months, not bad enough for ER. Urgent/immediate care didn't couldn't do anything."
- "Coverage free but in another state"
- "Doctor did not have availability in schedule."
- "doesn't apply to me"
- "Frustration with local healthcare providers responsiveness."
- "I needed to get a new PCP and doctors schedule out so far, I had to wait several months, even as a new patient"
- "Lack of providers, waiting list to get app"
- "MD office said no appointments were available"
- "No"
- "No appointment in timely manner."
- "No availability"
- "no available providers"
- "No contestan el telefon para hacercita"
- "No doctors accepting new patients with medicaid"
- "No insurance"
- "Said I was not CPAP compliant, when CPAP machine was recalled and a DO NOT USE order was issued by the FDA."
- "sick"
- "To many bums living off the governmet, overcrowding the doctors office!"
- "Too long of wait, lack of quality care"
- "Unable to get appt"
- "Work schedule"

Figure 70: 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?

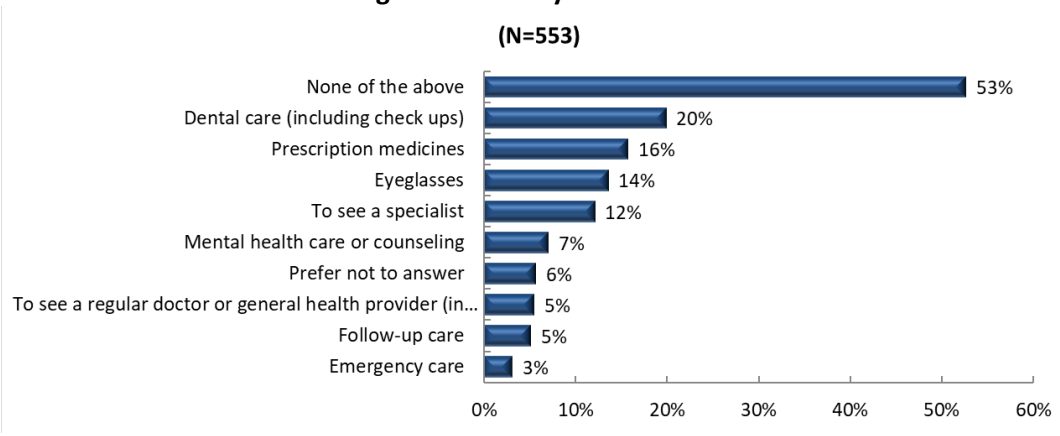


Figure 71: If you get sick or have an accident, how worried are you that you will be able to pay your medical bills?

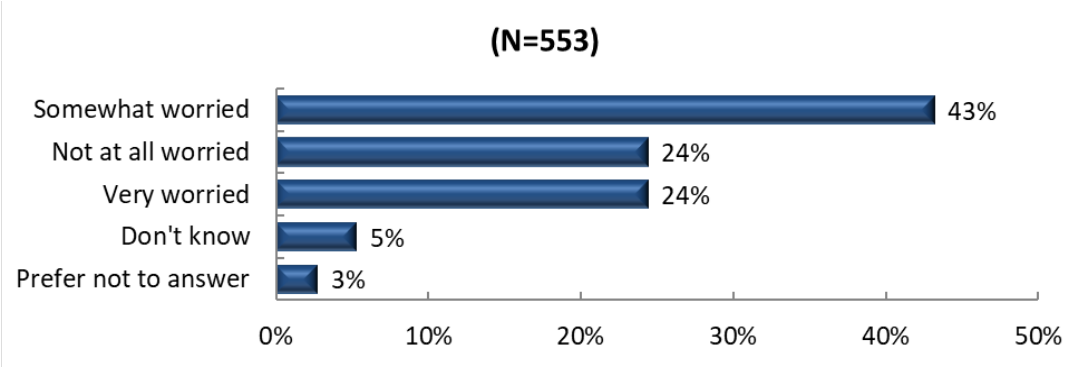
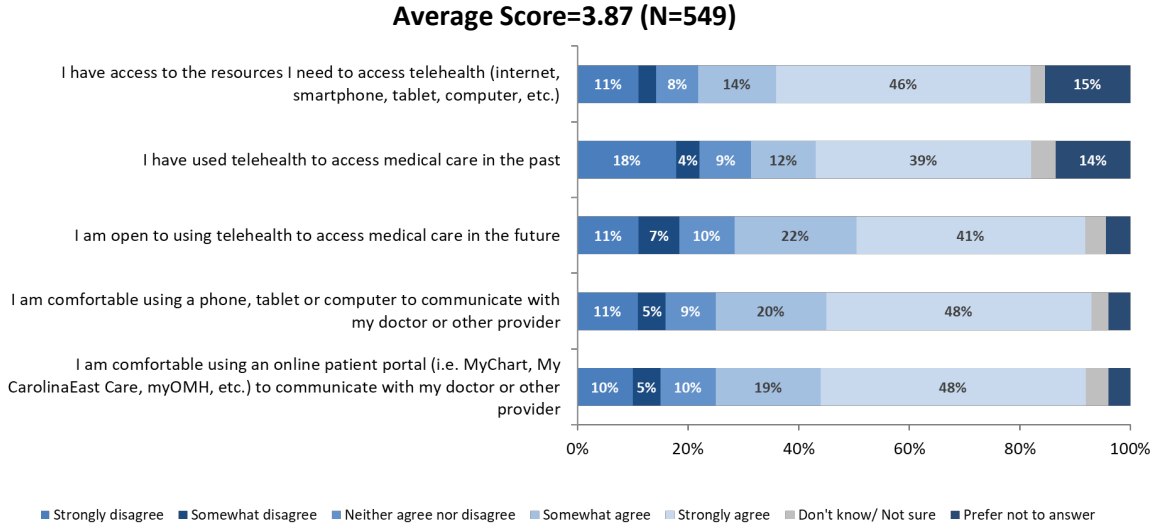


Figure 72: How much do you agree or disagree with the following statements about telehealth? Telehealth means connecting virtually with a medical provider using a smartphone, tablet or computer.

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



Topic: Income

Figure 73: How often do you have someone you can rely on to help with the following items, as needed?

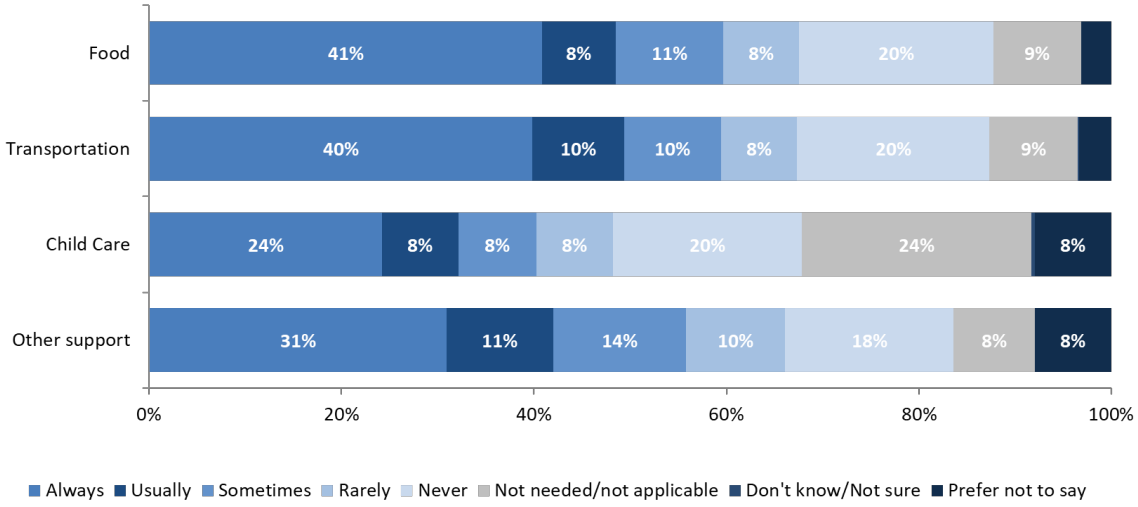
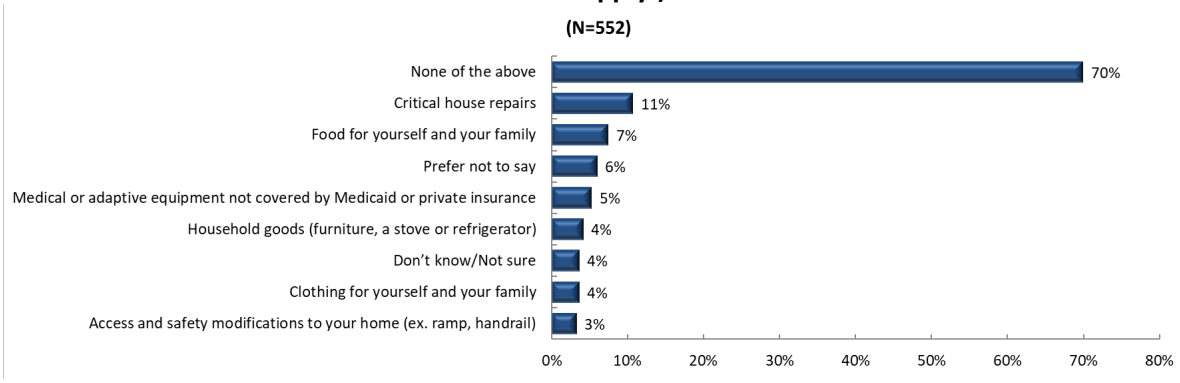


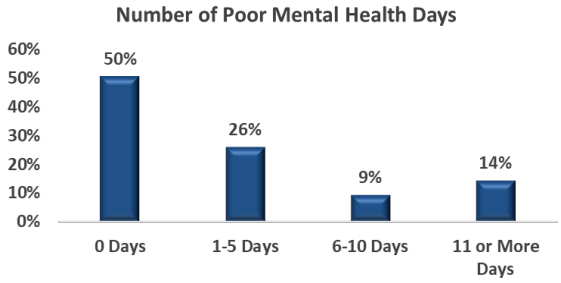
Figure 74: In the past year, did you have any of the following assistance needs NOT met? (Select all that apply.)



Topic: Mental Health

Figure 75: Now thinking about your MENTAL health, which includes stress, depression, and problems with emotions, for how many days during the past 30 days was your mental health NOT good?

(N=547)



Measure	Value
Mean (Standard Deviation)	5 (8)
Median	0
Mode	0
Minimum-Maximum	0-30

Figure 76: Was there a time in the past 12 months when you needed mental health care or counseling, but did not get it at that time?

Note: only participants who indicated experiencing one or more poor mental health days in previous question were asked the current question

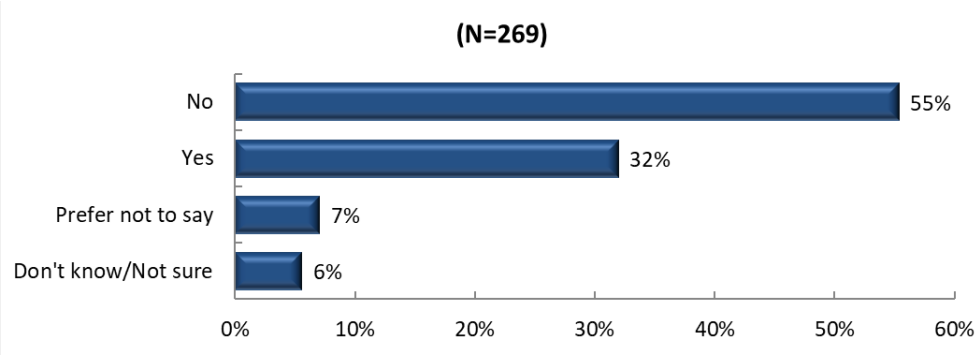
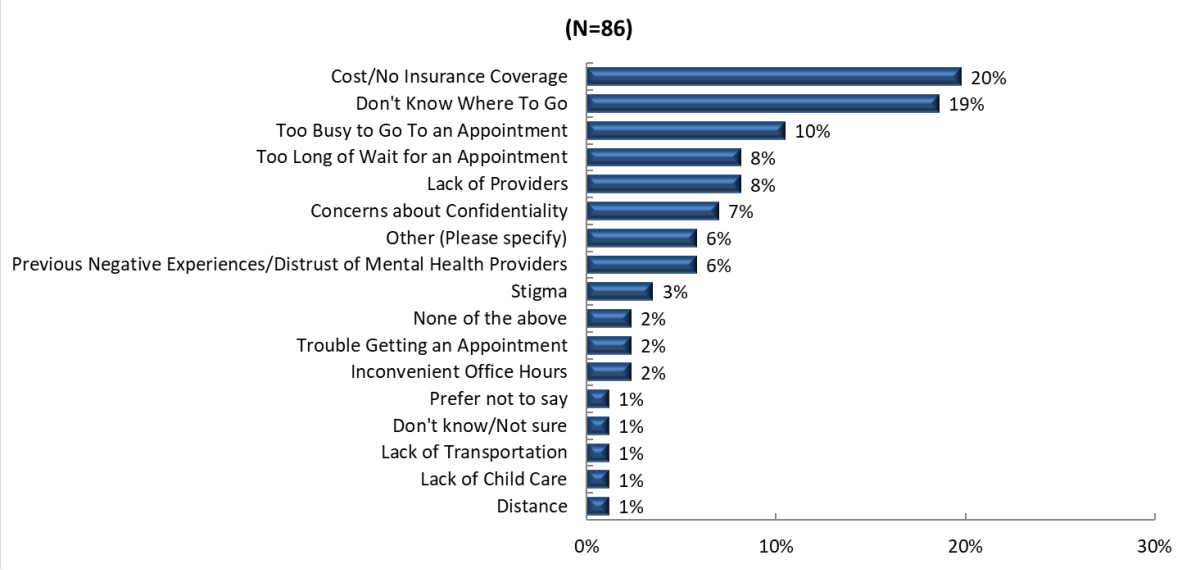


Figure 77: What was the MAIN reason you did not get mental health care or counseling?

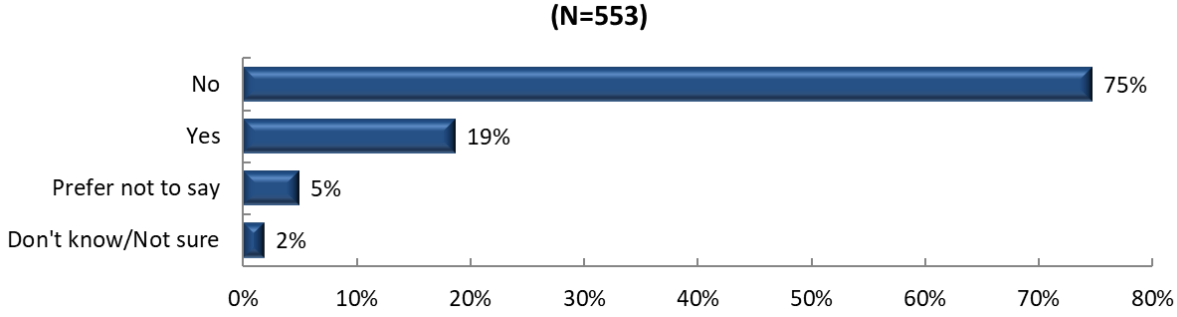
Note: only participants who responded "yes" to previous question were asked the current question



Other (please specify):

- "Couldn't get off work"
- "Coverage is in another state"
- "Lack of support from employer"
- "Not wanting to take off work to go"
- "Work"

Figure 78: Are you currently taking medication or receiving treatment, therapy, or counseling from a health professional for any type of MENTAL or EMOTIONAL HEALTH NEED?



Topic: Physical Health

Figure 79: Considering your physical health overall, would you describe your health as…

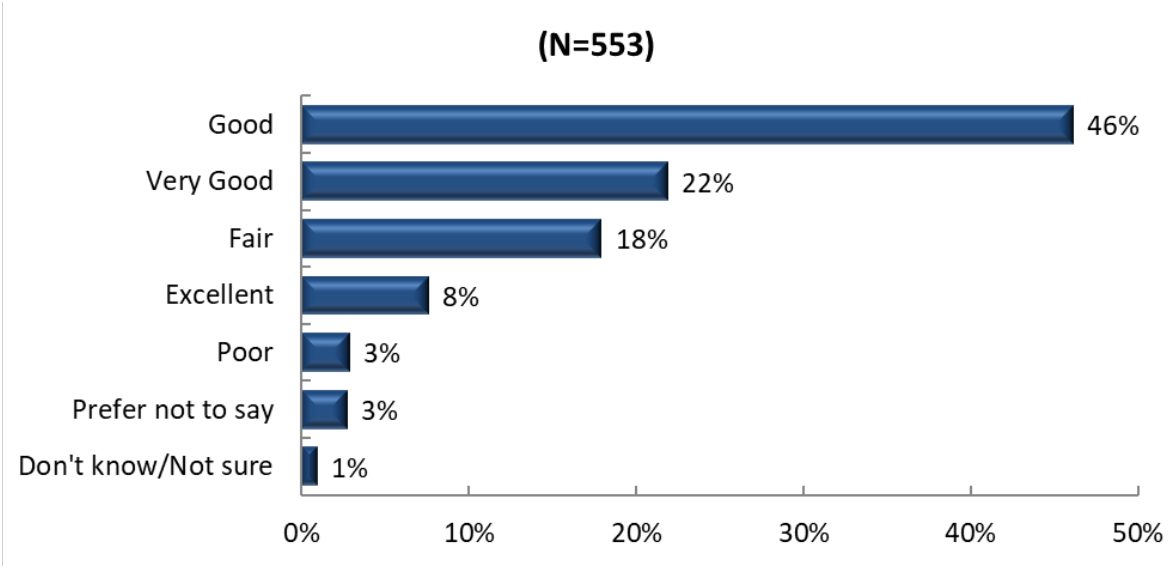


Figure 80: Within the past year (anytime less than one year ago), have you:

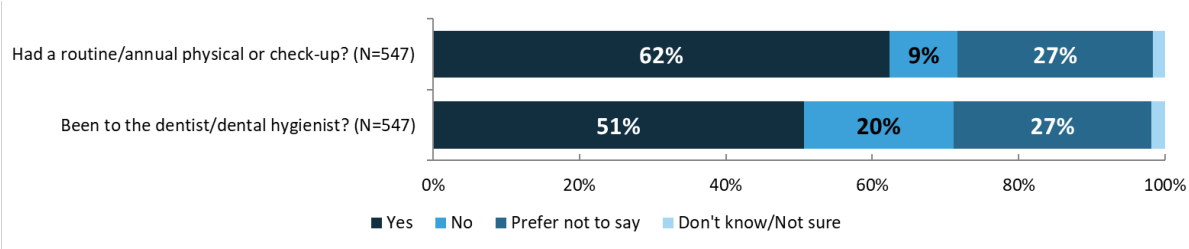
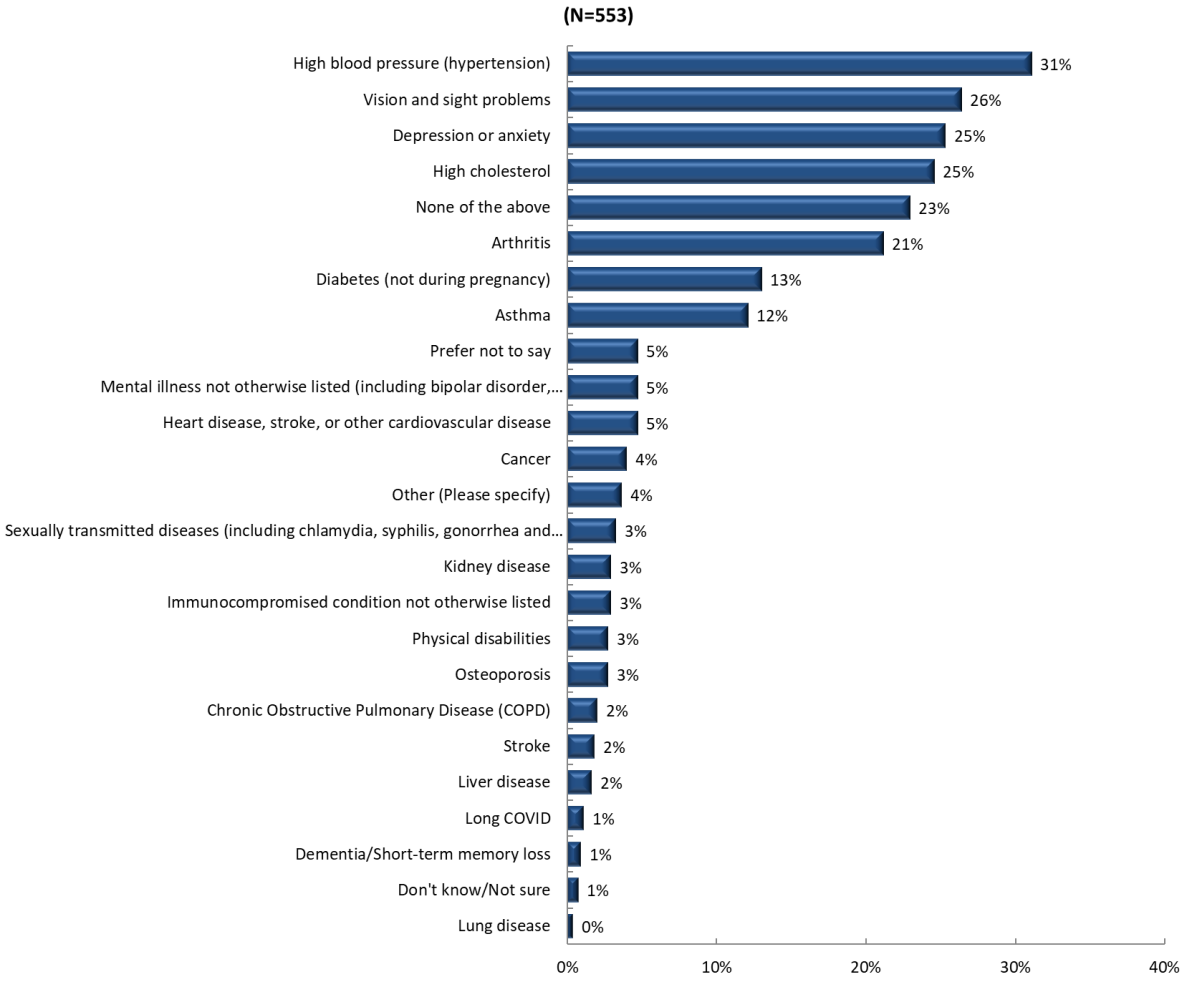


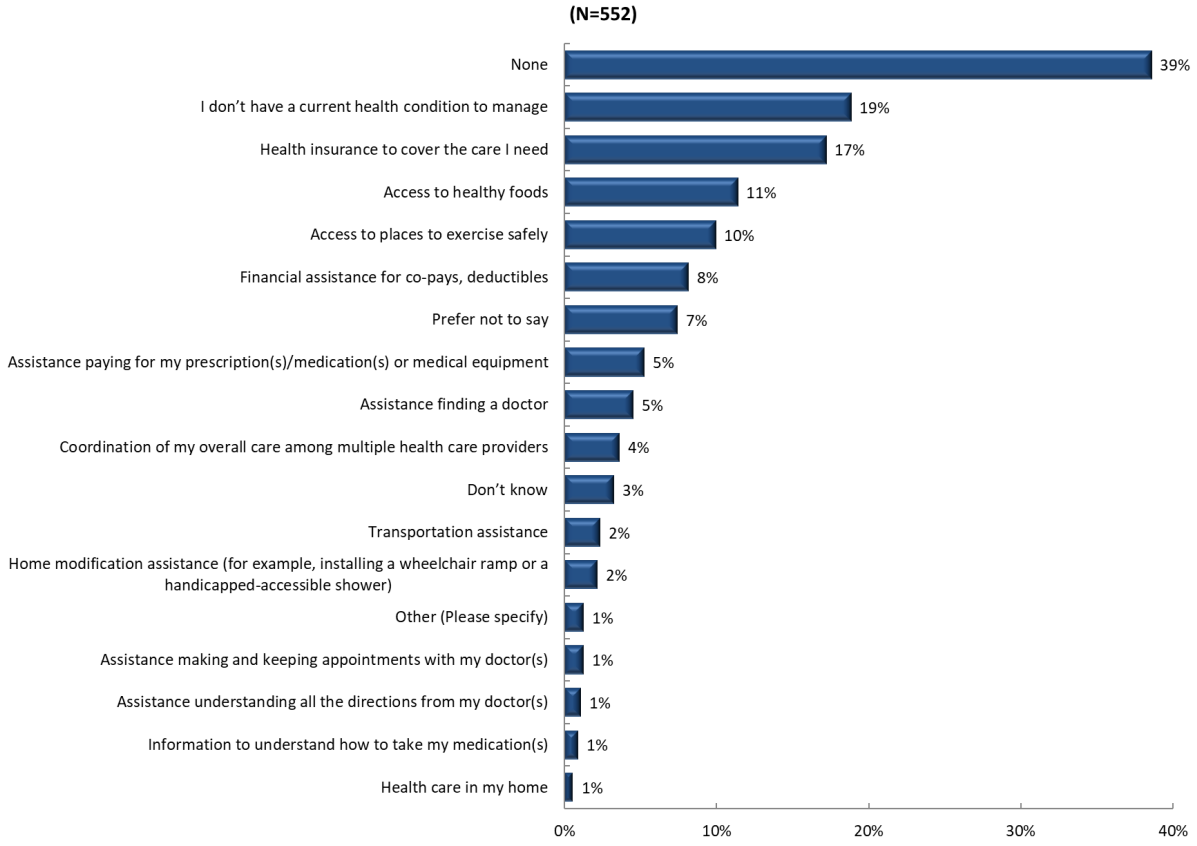
Figure 81: Have you ever been told by a doctor, nurse, or other health professional that you have any of the following health conditions? Select all that apply



Other (please specify):

- "Acid reflux"
- "ADHD"
- "Autism"
- "Dental"
- "Digestive Problem"
- "Factor V Lydon"
- "Hypothyroidism"
- "knee replaced"
- "left eye ache & pressure"
- "MIGRAINES, ALLERGIES, ADD"
- "obesity" (2 responses)
- "OBESITY/PCOS"
- "Prediabetes"
- "PTSD"
- "PVCs"
- "scoliosis"
- "Sleep Apnea"
- "weight

Figure 82: 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.)



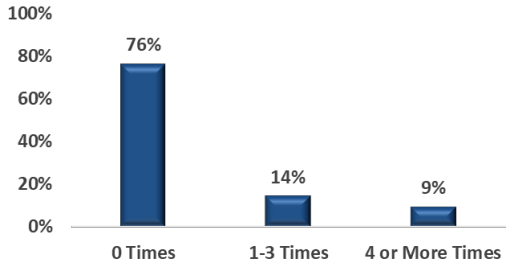
Other (please specify):

- "A doctors office that's not full of people!"
- "Employer support and understanding of how mental health works"
- "I have what I need"
- "money"
- "The ability to get off work for appointments"
- "Time off work"
- "Weight Loss"

Topic: Substance Use Disorders

Figure 83: 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=549)



Measure	Value
Mean (Standard Deviation)	1 (3)
Median	0
Mode	0
Minimum-Maximum	0-30

Figure 84: How often do you consume any kind of alcohol product, including beer, wine or hard liquor?

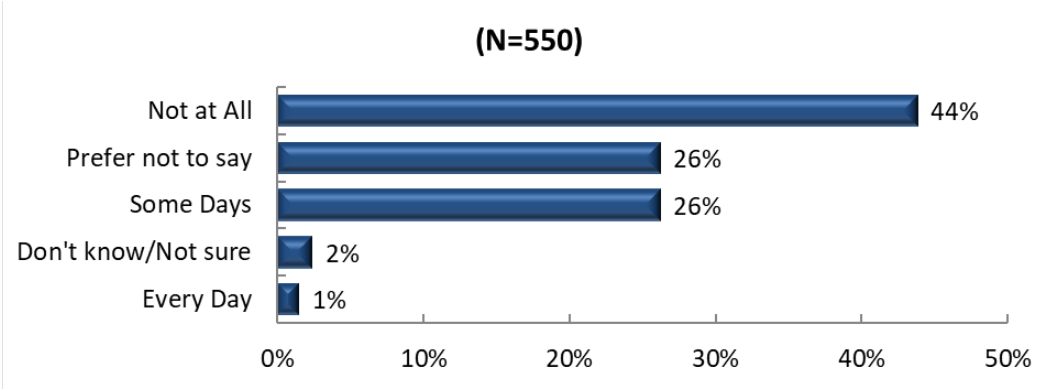


Figure 85: In the past year, have you or a member of your household misused any form of prescription drugs (e.g. used without a prescription, used more than prescribed, used more often than prescribed, or used for any reason other than a doctor's instructions)?

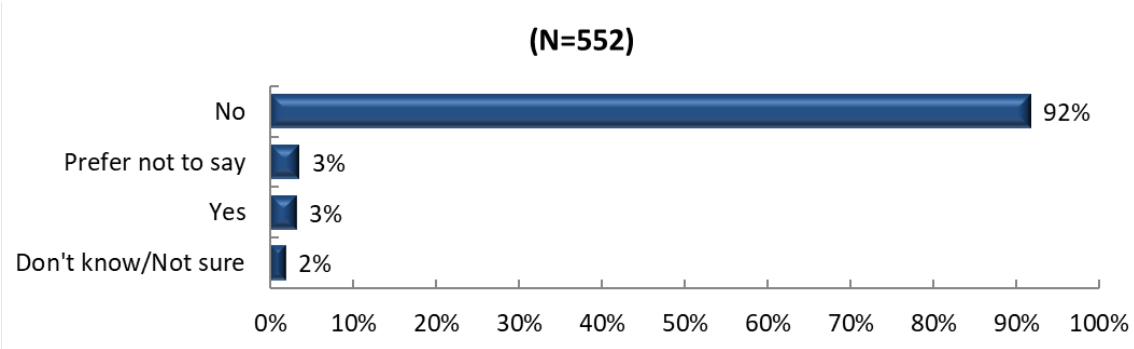
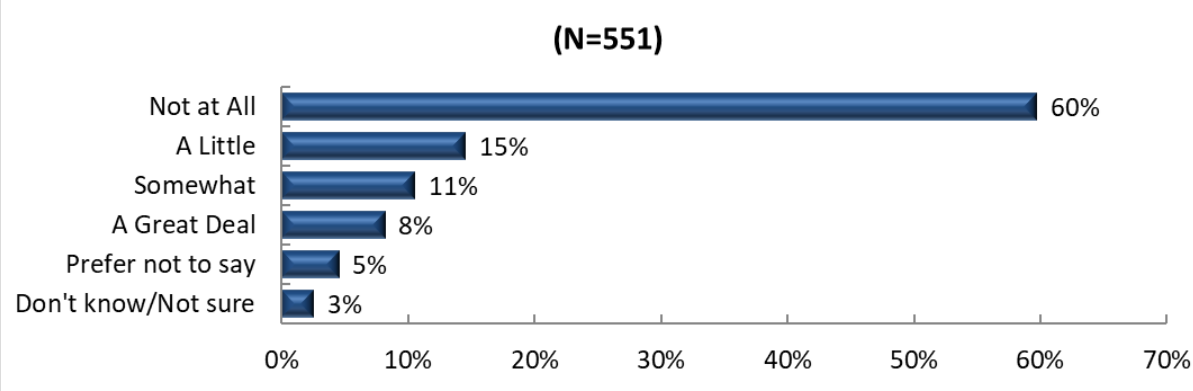


Figure 86: To what degree has your life been negatively affected by YOUR OWN or SOMEONE ELSE's substance abuse issues, including alcohol, prescription, and other drugs?



APPENDIX 6 | SUMMARY OF DATA FINDINGS ACROSS SOURCES

Primary and Secondary data findings are summarized in full by the table below.[52]

Priority Area	Secondary Data	Community Survey	Focus Group 1	Focus Group 2
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	✓		✓	✓

[52] 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.