Albemarle Regional Health Services
Partners in Public Health

Sentara

CAMDEN COUNTY

COMMUNITY HEALTH NEEDS ASSESSMENT

2024 CHNA REPORT

ACKNOWLEDGEMENTS

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

The Health ENC CHNA Steering Committee

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

Camden County CHNA Leadership

In addition to the Steering Committee, the Camden County 2024 CHNA was developed in partnership with representatives from the following organizations.

- Albemarle Regional Health Services
- Sentara Albemarle Medical Center
- ECU Health Chowan Hospital
- ECU Health Bertie Hospital
- ECU Health Roanoke Chowan Hospital
- Healthy Carolinians of the Albemarle
- Gates Partners for Health
- Three Rivers Healthy Carolinians

Camden County CHNA Stakeholders

The Camden County 2024 CHNA was also developed with input from the following individuals and organizations who participated in the prioritization process:

Name	Organization
Kellen Long	Albemarle Regional Health Services
Matt Sabin	Albemarle Regional Health Services
Amy Underhill	Albemarle Regional Health Services
Molly Brown	Albemarle Regional Health Services
Wanda Stallings	Albemarle Regional Health Services
Teresa Beardsley	Albemarle Regional Health Services
Kellie Lane	Albemarle Regional Health Services
Gabi Corprew	Albemarle Regional Health Services
Bill Blake	Albemarle Area United Way
Erin Burke	Camden County
Lisa Higgins	Catholic Charities
Yvonne Mullen	Community Member
Robin Harris	College of the Albemarle
Deborah Malenfant	Elizabeth City Downtown
Bryan Spence	Elizabeth City State University
Lenore Jarvis- Makey	River City Community Development Corp
Mandy Hall	Roanoke Chowan Community Health Center
Bobie Lowe	Trillium
Tracey Webster	Trillium

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

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EXECUTIVE SUMMARY

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

Several local health organizations came together to help develop this CHNA, including Albemarle Regional Health Services and Sentara Healthcare.

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

Primary (new) data were collected through a focus group and a web-based survey for community members, and included feedback from 131 people who live, work or receive healthcare in Camden County. The focus group was conducted in person and featured community members from different backgrounds, age groups and life experiences. Primary data identified behavioral health (specifically substance use) and healthcare access and quality as top needs that impact the health and well-being of people living in Camden County.

Representatives from Camden 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, Camden County selected three top priority health needs (Access to Healthcare, Behavioral Health, and Healthy Living), which are shown here in alphabetical order:

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

Following completion of this report, health leaders throughout Camden 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

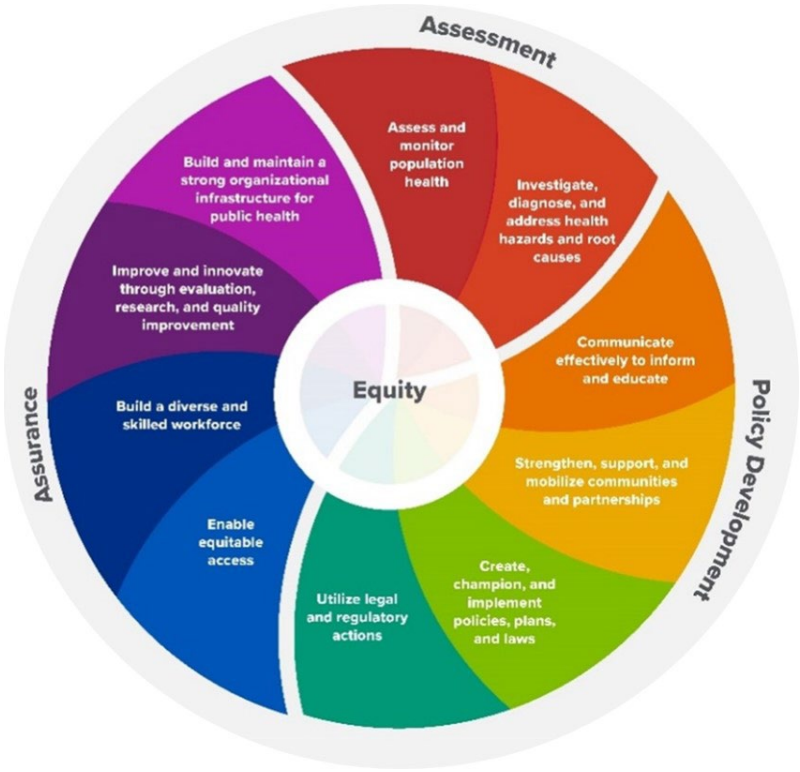
To illustrate its commitment to the health and well-being of the community, the Health ENC CHNA Steering Committee has completed this assessment to understand and document the greatest health needs currently faced by local residents. Guidance was also provided by local representatives from Albemarle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

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

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

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

Figure I.1: The 10 Essential Public Health Services



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

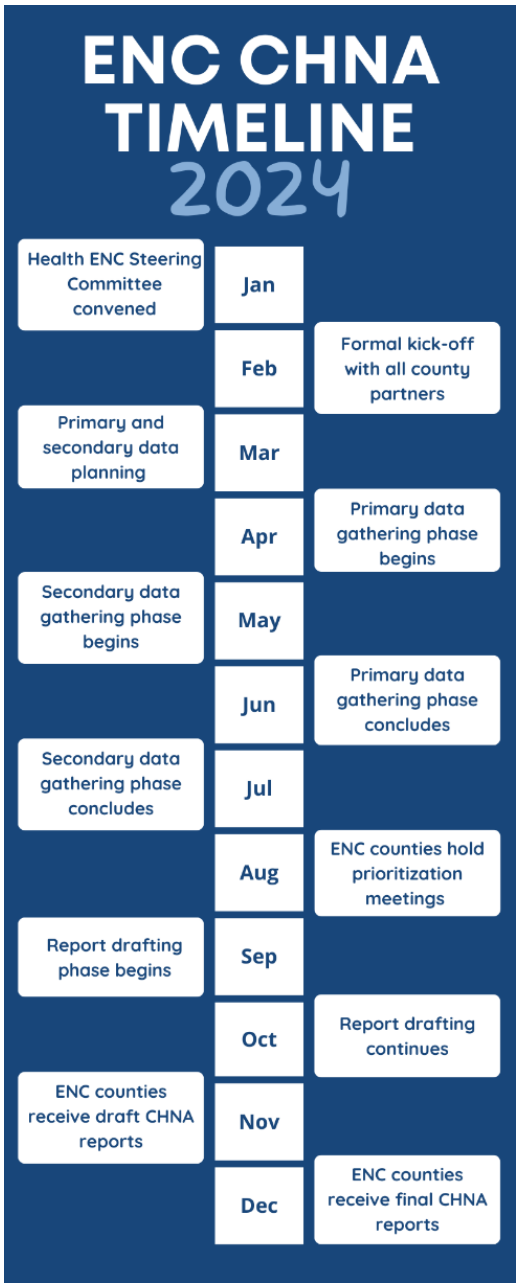
- Define the community it serves;
- Assess the health needs of that community;
- Through the assessment process, take into account input received from people who represent the community's broad interests, including those with special knowledge of or expertise in public health;
- Document the CHNA in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

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

Timeline

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

Figure I.2: Health ENC 2024 CHNA Milestones



Process Overview

A significant amount of information has been reviewed during this planning process, and the Steering Committee has been careful to ensure that a variety of sources were used to deliver a truly comprehensive report. Both existing (secondary) data and new (primary) data were collected directly from the community throughout this process. It is also important to note that, although unique to Camden 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 Camden County residents. Key objectives of this CHNA include:

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

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

Figure I.3: The CHNA Process

Report Structure

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

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

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

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

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

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

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

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

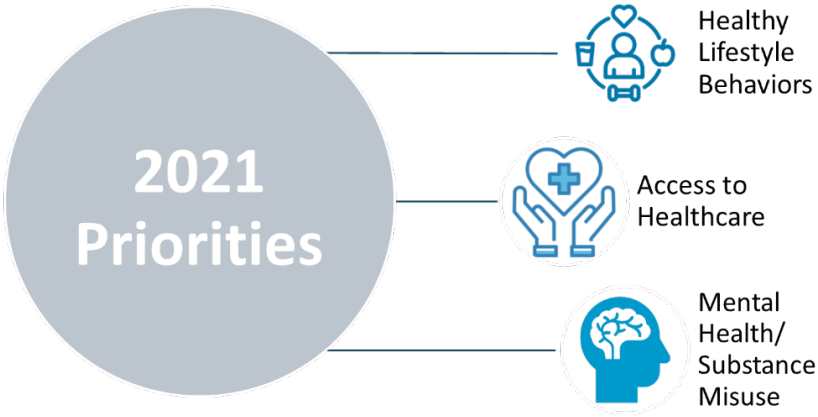
2) *Detailed Summary of Secondary Data Measures and Findings* – Existing data measures and findings used in the prioritization process are presented in **Appendices 2-3.**

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

Evaluation of Prior CHNA Implementation Strategies

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

Figure I.4: ARHS 2021 Priority Need Areas – Camden County



ARHS and other 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.

Albemarle Regional Health Services

Albemarle Regional Health Services (ARHS) is a district health department serving northern North Carolina. The ARHS district model serves as a shining example of regionalization and what true public health champions can accomplish when they work together. This district model would not be possible if it were not for its eight member counties: Bertie, Camden, Chowan, Currituck, Gates, Hertford, Pasquotank, and Perquimans. The mission & vision of ARHS serves to inspire people to lead healthy lives. The public health professionals and programs of ARHS are dedicated to disease prevention and the promotion of a healthy environment to reduce morbidity, mortality, and disability through quality service, education, and advocacy. ARHS partnerships stretch far and wide, and many agencies serve as public health champions throughout its communities. These agencies range from school systems to cooperative extension, colleges and universities, other county agencies, and many more.

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

Sentara Albemarle Medical Center (SAMC) completed its most recent CHNA in 2022, covering Camden, Currituck, Pasquotank, and Perquimans counties. This assessment was focused on the following three priority areas:

Figure I.5: SAMC 2022 Priority Need Areas – Camden County

A description of the organization and a summary of activities undertaken to address these priorities can be found below.

Sentara Healthcare – Sentara Albemarle Medical Center

SAMC is located in Elizabeth City, North Carolina and serves northeastern North Carolina with a caring team of approximately 650 employees and 150 medical providers. The 182-bed facility features 25 specialties including emergency, maternity, orthopedics, medical, and surgical care in addition to outpatient laboratory, imaging, and comprehensive breast services. Sentara Healthcare (Sentara) cares about advancing health equity and ensuring that all members of its communities have access to the necessary resources to live their healthiest and most fulfilling lives. Sentara is guided by the understanding

that overall health is greatly influenced by where people are born and where people live, learn, work, play, worship, and age. Sentara is proud of its longstanding commitment to the communities served by SAMC.

Previous CHNA Priority: Behavioral Health

- Sentara offers inpatient treatment services through telepsychiatry. In addition, Sentara's adult and senior behavioral health inpatient programs provide diagnostic services and treatment for people 18 and older who are in crisis due to mental illness, emotional distress or destructive behavior patterns. Because these treatment facilities are located within hospitals, patients have access to the full range of both psychiatric and medical care. Sentara will continue to partner with community mental health programs to identify alternate placement options for Behavioral Health Emergency Department patients.
- In 2023, SAMC partnered with multiple counties to increase and improve physical activity opportunities to promote the development of effective stress management and coping skills. SAMC also partnered with community organizations to reduce the number of Veteran suicides and to help offer both mental and physical help by creating a network of support for Veterans to fall back on when needed. SAMC partnered with Children's Hospital of The King's Daughters, Inc. by providing funding support to increase the mental health program to provide needed mental health services to all local children who need it. To increase community awareness and reduce stigma, Sentara partnered with Virginia Stage Company to support an inspirational play about mental health. "Every Brilliant Thing" is an intimate, interactive performance which continues to be brought to communities throughout Virginia and North Carolina.

Previous CHNA Priority: Chronic Disease

- SAMC worked with multiple community partners to increase health education and resources to communities. SAMC partnered with Port Discover STEM and local colleges to provide health education and resources to youth and families. SAMC worked with local religious groups to ensure all residents have access and opportunity to the same high level of healthcare, improving health equity for all residents. SAMC staff worked at multiple community events to provide health education and screening opportunities including the addition of a mobile mammography vehicle to bring cancer screening opportunities to vulnerable populations without access to timely care.

Previous CHNA Priority: Social Determinants of Health

- Each hospital has implemented the use of Unite Us, a cross-sector collaboration software establishing a new standard of care that identifies social needs in communities, manages enrollment of individuals in services, and leverages meaningful outcomes data and analytics to further drive community investment. SAMC is also working with North Carolina CARE 360, a statewide network that unites health care and human services organizations to better provide resources to communities. To increase economic growth, job security, and educational opportunities, SAMC continues to collaborate with multiple colleges and universities to provide fellowships, internships and preceptorships for healthcare professionals and students.

A vital phase of the Community Health Needs Assessment (CHNA) involves reporting out to the communities being served and to those residents who participated in the data gathering process. Community health presentations were held to provide the opportunity for community residents and key stakeholders to learn about the health–related primary and secondary data from the 2021 CHNA process. The data was presented by ARHS, SAMC, and ECU Health through presentations geographically dispersed throughout the Albemarle Region.

The presentations were widely promoted through email invitations, newspaper announcements, the ARHS website, social media outlets, and by partnering organizations in an effort to bring the community together and strengthen an environment where the individuals were empowered in the decisions highlighted through the prioritization process.

Summary Findings: Camden County 2024 Priority Health Need Areas

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

Throughout Camden County, significant variations in demographics and health needs exist within the county. At the same time, consistent needs are present across the whole county and serve as the basis for determining priority health needs at the county level. This document will discuss the priority health need areas for Camden 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 Camden 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 Camden focus areas identified as countywide priorities for the 2024 CHNA are Access to Healthcare, Behavioral Health, and Healthy Living, as seen in **Figure I.6**.

Figure I.6: Camden County 2024 Priority Health Needs

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

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

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

CHAPTER 1 | METHODOLOGY

Study Design

The process used to assess Camden 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 Camden County's health needs. While the CHNA Steering Committee largely viewed the new and existing data equally, there were situations where one provided clearer evidence of community health need than the other. In these instances, the health needs identified were discussed based on the most appropriate data gathered. Data analysis, community feedback review, and stakeholder engagement were all used to identify key areas of need.

Specifically, the following data types were collected and analyzed:

New (Primary) Data

Public engagement and feedback were received through a web-based community member survey along with community focus groups and significant input and direction from the CHNA Steering Committee. The Steering Committee worked together to develop the survey questions for the web-based survey, and county leaders were provided with a set of target numbers based on their county population's race, ethnicity and age distribution to encourage recruitment of a representative sample of the community. Community members were asked to identify the most significant health and social needs in their community, as well as asked questions about topics specific to Camden County, including access to care, healthy lifestyle, housing and homelessness, mental health, physical health, substance use disorders, and transportation and transit. Focus group participants were asked a standard set of questions about health and social needs, in order to identify trends across various groups and to highlight areas of concern for specific populations. In total, the input was gathered from numerous Camden County residents and other stakeholders. This included web survey responses from over 130 community members and one focus group that included several community members and other people who live, work or receive healthcare in Camden County.

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

Existing (Secondary) Data

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

- *North Carolina Data Portal*, a joint effort by the North Carolina Department of Health and Human Services and the University of Missouri Center for Applied Research and Engagement Systems
- *County Health Rankings*, developed in partnership by Robert Wood Johnson Foundation (RWJF) and University of Wisconsin Population Health Institute

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

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

Comparisons

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

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

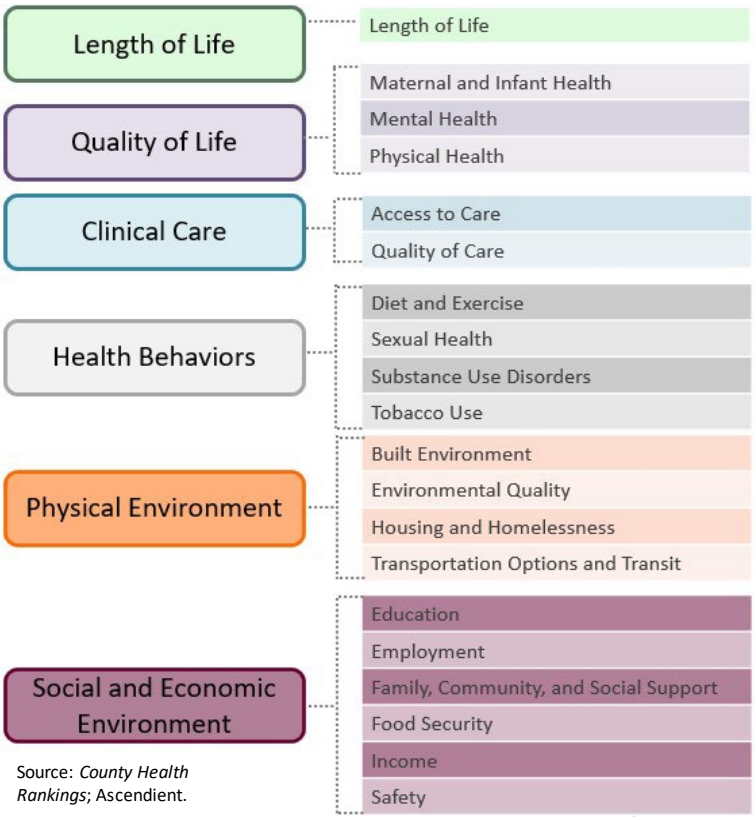
Population Health Framework

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

Using the population health framework as a guide for the CHNA process helps categorize many individual pieces of data in a way that connects the dots between health status and social drivers of health, in a way

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

Figure 1.1: Population Health Framework



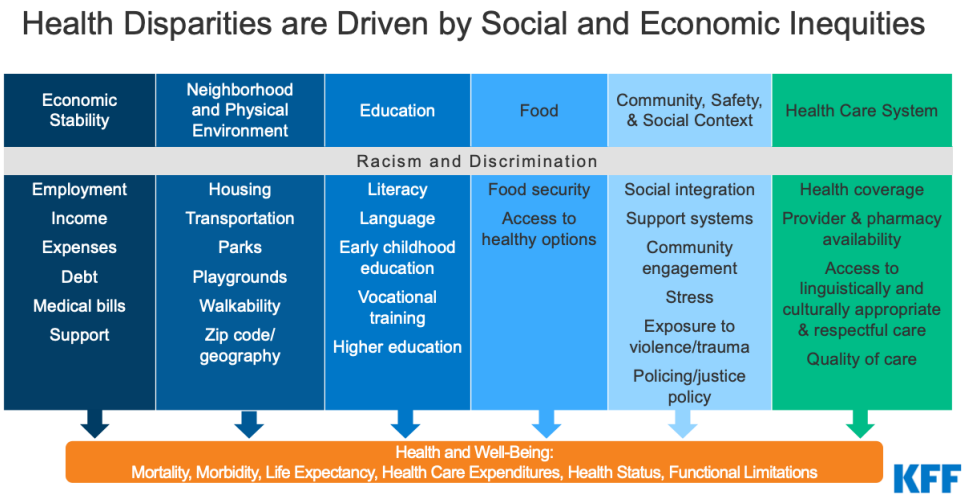
Source: *County Health Rankings*; Ascendient.

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

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

Figure 1.2: Social Determinants of Health

Figure 1.3: SDoH and Health Disparities



Prioritization Process Overview and Results

The process of identifying the priority health needs for the 2023-2024 CHNA began with the collection and analysis of hundreds of new and existing data measures. In order to create more easily discussable categories, all individual data measures were then grouped into six categories and 20 corresponding focus areas based on "common themes" that correspond to the Population Health Model, as seen in **Figure 1.1**. These focus areas are detailed further in **Appendix 2.**

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

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

The Steering Committee utilized the multi-voting technique to determine Camden 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.

Group discussion was held to assemble a list of priority areas. After discussion, all Steering Committee participants voted to identify the top three priority areas. Once the votes were tallied, another discussion was held to finalize the priority need areas.

The final priority need areas were not ranked in any particular order of importance, and each will be addressed by the Steering Committee. The following three focus areas (Access to Healthcare, Behavioral Health: Mental Health/Substance Misuse, and Healthy Living) were identified as Camden County's top priority health needs to be addressed over the next three years, as seen in **Figure 1.4** below:

Figure 1.4: Camden County 2024 Priority Health Needs

The list of organizations below had members that participated in the prioritization voting process.

- Albemarle Area United Way
- Albemarle Regional Health Services
- Camden County
- Catholic Charities
- Citizen
- College of the Albemarle
- Elizabeth City State University
- Elziabeth City Downtown
- River City Community Development Corp
- Roanoke Chowan CHC
- Trillium

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 Camden County in both population and geography, this study was limited in its ability to fully capture health disparities and health needs across racial and ethnic groups. Efforts were made to include diverse community members in survey efforts, and overall, the composition of survey respondents in terms of race and ethnicity indicates that diverse community members were oversampled, which ensures the Steering Committee was able to assess health needs and disparities across racial/ethnic minority groups in the community. Roughly 56% of all respondents identified as White compared to 78% of Camden County as a whole, and 25% of all respondents identified as Black or African American compared to 10% of the county as a whole. Roughly 16% of respondents identified as Hispanic, which was much higher than the percentage of the population of the county as a whole (4%).

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

Camden County, the first and only city-county[4] in the state of North Carolina, is in the Outer Coastal Plain region of North Carolina. Camden County is adjacent to Pasquotank and Gates counties to the west, Currituck County to the northeast, the Albemarle Sound to the south, and the state of Virginia to the north. It covers a total of 310 square miles, including 65 square miles of waterfront along the Pasquotank and North rivers and the Albemarle Sound. Camden County is comprised of 3 townships: South Mills Township, Courthouse Township of Camden, and Shiloh Township. Nearly all (95%) of Camden County's population resides in rural areas.

Population

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

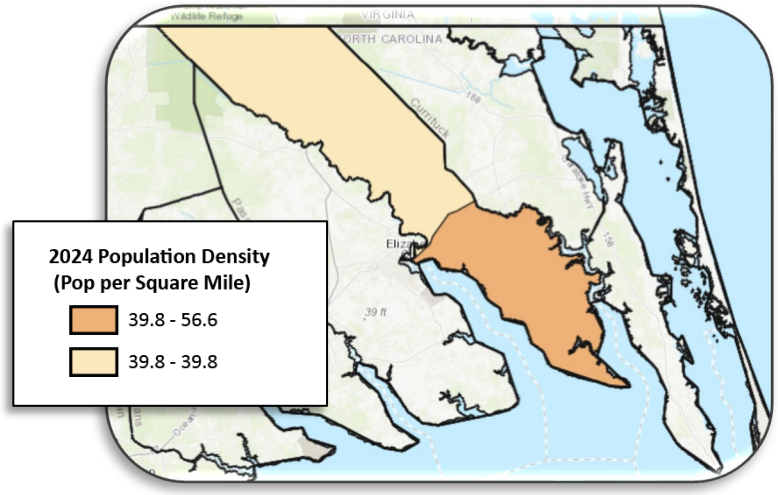
With a population of just over 10,500, Camden makes up less than 0.1% of the state's population.

Table 2.1: Total Population, 2023[5]

	Camden County	North Carolina	United States
Population	10,562	10,765,678	337,470,185

Camden County has a population density of 46.1 persons per square mile – substantially lower than the population density for North Carolina (214.7 persons per square mile). The southern half of the county is most densely populated.

Figure 2.1: Camden County Map: Population Density

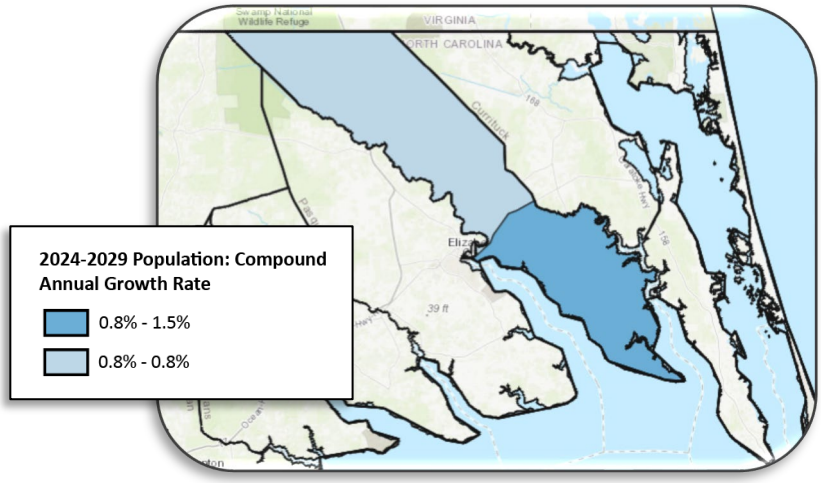


[4]Any county where the largest municipality in the county has been abolished and its powers, duties, rights, privileges and immunities consolidated with those of the county

[5] Source: Esri 2023

In total, the population of Camden County is projected to grow 1.11% annually between 2024 and 2029. The southern part of the county is experiencing faster growth.

Figure 2.2: Camden County Map: Population Growth



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 Camden County skew older than that of the state and country, with a higher percentage of adults aged 45 to 64 than both state and national averages.

Table 2.2: Age Distribution, 2023[5]

	Camden County	North Carolina	United States
Percentage below 15	17.2%	17.9%	18.1%
Percentage between 15 and 44	34.8%	39.3%	39.5%
Percentage between 45 and 64	30.0%	25.1%	24.6%
Percentage 65 and older	18.0%	17.7%	17.8%

Unlike the State of North Carolina and the country, Camden County has a slightly higher percentage of male compared to female residents.

Table 2.3: Sex Distribution, 2023[5]

	Camden County		North Carolina		United States	
	Count	Pct. of Total	Count	Pct. of Total	Count	Pct. of Total
Female	5,243	49.6%	5,489,419	51.0%	170,118,720	50.4%
Male	5,319	50.4%	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. Over 10% of Camden residents identify as Black (Non-Hispanic), making this the largest minority group in the county. Additionally, Camden has lower proportions of residents who identify as Asian and American Indian & Alaska Native (AIAN) compared to the state and the U.S.

Table 2.4: Racial Distribution, 2023[5]

	Camden County		North Carolina		United States	
	Count	Pct. of Total	Count	Pct. of Total	Count	Pct. of Total
Black (Non-Hispanic)	1,087	10.3%	2,199,488	20.4%	42,132,758	12.5%
White (Non-Hispanic)	8,401	79.5%	6,590,161	61.2%	204,562,590	60.6%
Asian	135	1.3%	379,374	3.5%	21,088,177	6.2%
AIAN	52	0.5%	133,820	1.2%	3,831,126	1.1%
NHPI[6]	2	0.1%	9,214	0.1%	712,229	0.2%
Some Other Race Alone	130	1.2%	677, 338	6.3%	29,432,586	8.7%
Two or More Races	755	7.1%	776,283	7.2%	35,710,719	10.6%

By ethnicity, 3.5% of Camden County's population is Hispanic. This figure is significantly lower than that of the state and the U.S.

Table 2.5: Ethnic Distribution, 2023[5]

	Camden County		North Carolina		United States	
	Count	Pct. of Total	Count	Pct. of Total	Count	Pct. of Total
Non-Hispanic	10,190	96.5%	9,465,874	88.6%	271,934,049	80.6%
Hispanic	372	3.5%	1,299,804	11.4%	65,536,136	19.4%

The proportion of foreign-born individuals residing in Camden County is less than 2%, compared to 9% of North Carolina's residents.

Table 2.6: Foreign Born Population, 2022[7,8]

	Camden County	North Carolina	United States
Foreign Born	1.7%	9%	13.9%

[6] Native Hawaiian and Pacific Islander

[7]Source: U.S. Census Bureau (2022)

[8] Source: American Community Survey (ACS) 2018-2022 5-Year Estimates

The diversity of Camden County is reflected in the languages that residents speak at home. According to the most recent American Community Survey (ACS), approximately 2.8% of Camden County residents speak a language other than English at home, compared to around 13% of North Carolina and 22% of U.S. residents.

Table 2.7: Language Spoken at Home, 2022[8]			
	Camden County	North Carolina	United States
English Only	97.2%	87.3%	78%
Spanish	0.7%	7.9%	13.3%
Indo-European Languages	0.7%	2.1%	3.8%
Asian and Pacific Islander Languages	0.8%	1.9%	3.6%
Other Languages	0.7%	0.8%	1.2%

Disability Status[9]

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. Compared to North Carolina and the U.S, Camden has more residents with disabilities at nearly 15%.

Table 2.8: Disability Status, 2022[7,8]			
	Camden County	North Carolina	United States
Population with a Disability	14.8%	13.3%	12.9%

Veteran Status

Military veterans often need special services and support, so it is important to collect data about them to be better able to meet their specific needs. In Camden, the percentage of the population that are veterans (15%) is twice that of the state (7.8%) and the U.S (6.2%).

Table 2.9: Veteran Status, 2022[7,8]			
	Camden County	North Carolina	United States
Veterans	15%	7.8%	6.2%

[9] 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.

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 Camden County is $72,388, comparable to the national statistic.

Table 2.10: Median Household Income, 2023[5]			
	Camden County	North Carolina	United States
Median Household Income	$72,388	$64,316	$72,603

In 2023, a little over 4% of Camden County households were below the federal poverty level (FPL) – lower than the state or nation. 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 2.11: Percent of Households Below the Federal Poverty Level, 2023[5]			
	Camden County	North Carolina	United States
Percent Below FPL	4.1%	10.1%	9.5%

Higher than the percentage of households below the FPL, over 10% of Camden County households received Food Stamps/SNAP (Supplemental Nutrition Assistance Program) in 2022. This is lower than both state and national figures.

Table 2.12: Households Receiving Food Stamps/SNAP, 2022[8,10]			
	Camden County	North Carolina	United States
Number of Households Receiving Food Stamps/SNAP	422	575,860	16,072,733
Total Number of Households	3,964	4,299,266	129,870,928
Percentage of Households receiving Food Stamps/SNAP	10.6%	13.4%	12.4%

In Camden County, nearly two-thirds of residents had earned less than a college degree—notably higher than both the state (58.1%) and the country (51.9%).

[10] Source: North Carolina Department of Health and Human Services, Social Service Division

Table 2.13: Educational Attainment, 2020[11]			
	Camden County	North Carolina	United States
Less than 9th Grade	7.8%	6.0%	3.5%
Some High School/No Diploma	4.8%	5.5%	5.3%
High School Diploma	27.8%	21.2%	28.5%
GED/Alternative Credential	4.4%	4.3%	*[12]
Some College/No Diploma	21.8%	21.1%	14.6%
Associate's Degree	13.4%	9.9%	10.5%
Bachelor's Degree	13.5%	20.4%	23.4%
Graduate/ Professional Degree	6.4%	11.6%	14.2%

The unemployment rate in Camden County (5.7%) is slightly higher than that of the state (5.1%) and the U.S. (3.9%).

Table 2.14: Unemployment, 2022[8,13]			
	Camden County	North Carolina	United States
Percentage unemployed ages 16 to 24	15.0%	12.4%	11.0%
Percentage unemployed ages 25 to 54	5.7%	4.7%	3.4%
Percentage unemployed ages 55 to 64	4.2%	3.3%	2.7%
Percentage unemployed ages 65 or more	0.0%	3.0%	2.9%
Total unemployment	5.7%	5.1%	3.9%

In Camden County, the age group most likely to be uninsured is adults aged 35-64. This is unlike both the U.S and the state of North Carolina, where adults aged 19-34 are more likely to be uninsured. Overall, Camden County has more uninsured than both the state and the country.

Table 2.15: Health Insurance Status, 2022[8]			
	Camden County	North Carolina	United States
Percentage uninsured ages 18 or below	0.2%	5.2%	5.4%
Percentage uninsured ages 19 to 34	4.7%	15.5%	13.6%
Percentage uninsured ages 35 to 64	7.1%	12.5%	9.9%
Total % Uninsured	16.0%	15.0%	12.0%

[11] Source: North Carolina Office of State Budget and Management

[12] U.S. Totals combine GED with High School Diploma

[13] Source: Federal Reserve Economic Data (FRED)

Social Determinants of Health

Figure 2.3: 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.

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

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

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

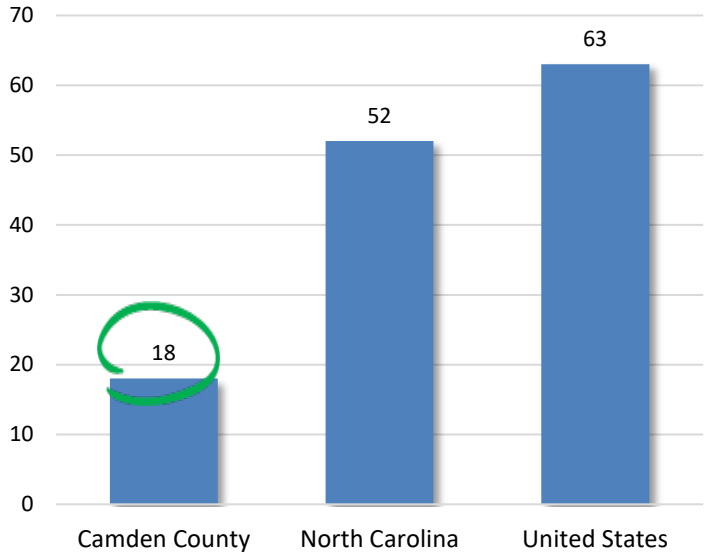
<u>Disparities</u>

Recognizing the diversity of Camden 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

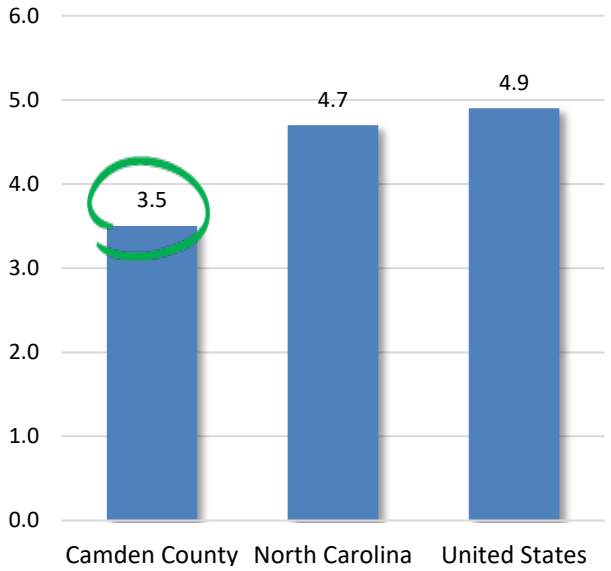
tracts. Lower scores represent a higher level of integration. There is significantly less residential segregation in Camden County compared to the state and country, as seen in **Figure 2.4**.

Figure 2.4: Residential Segregation[14]



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

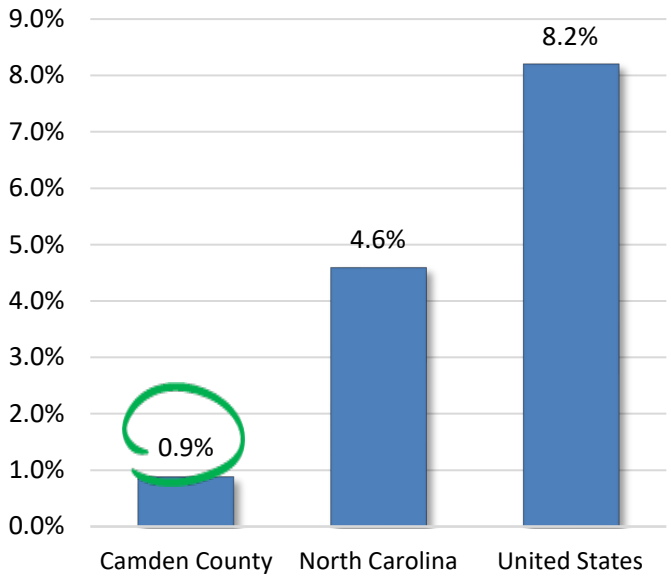
Figure 2.5: Income Inequality Ratio[14]



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

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. Less than 1% of Camden's population is not proficient in English, as seen in **Figure 2.6**.

Figure 2.6: Percent of Population with Limited English Proficiency[8]



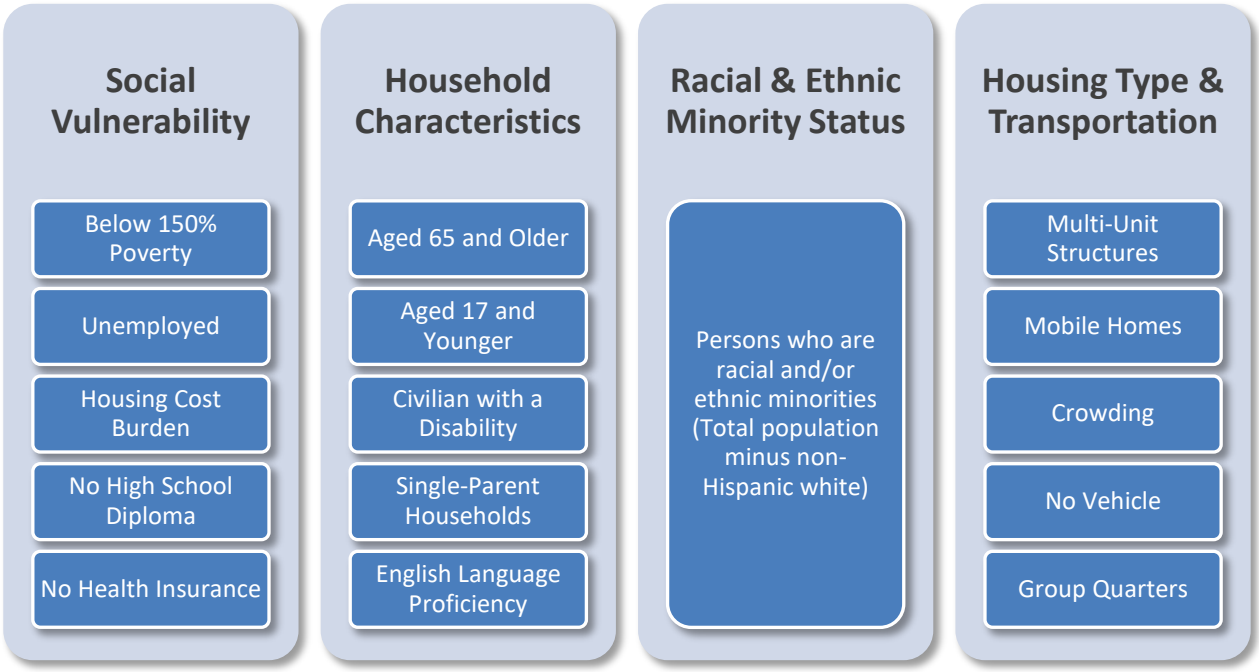
Social Vulnerability Index

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.[15] Communities with a higher SVI score are generally at a higher risk for poor health outcomes. Instead of relying on public health data alone, the SVI accounts for underlying economic and structural conditions that affect overall health, including SDoH. SVI scores are calculated at the census tract level and based on U.S. Census variables across four related themes: socioeconomic status, household characteristics, racial and ethnic minority status, and housing type/transportation. **Figure 2.7** outlines the variables used to calculate SVI scores.

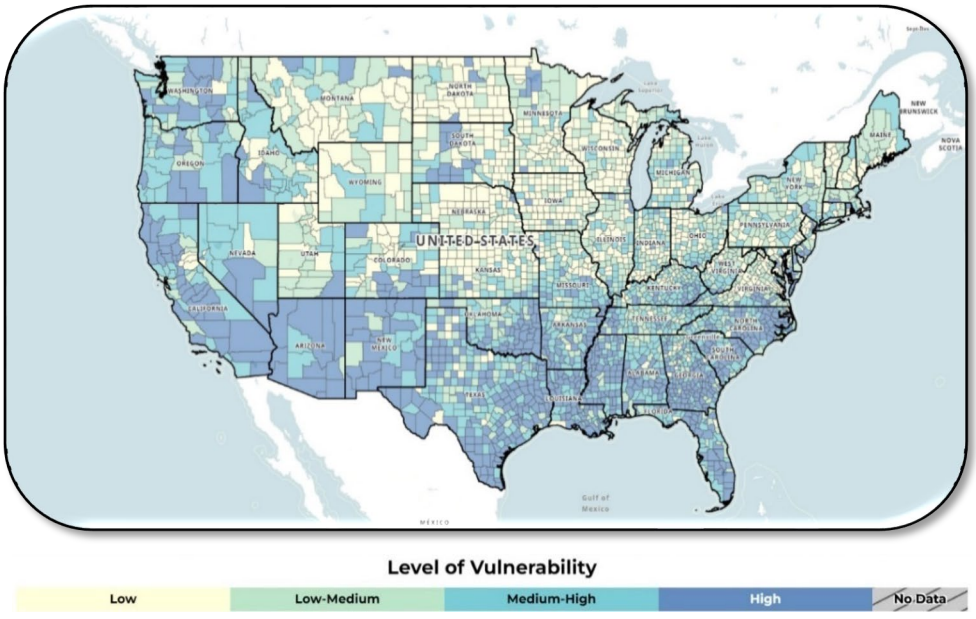
[15] CDC/ATSDR Social Vulnerability Index (SVI). Retrieved from https://www.atsdr.cdc.gov/placeandhealth/svi/index.html.

Figure 2.7: SVI Variables



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

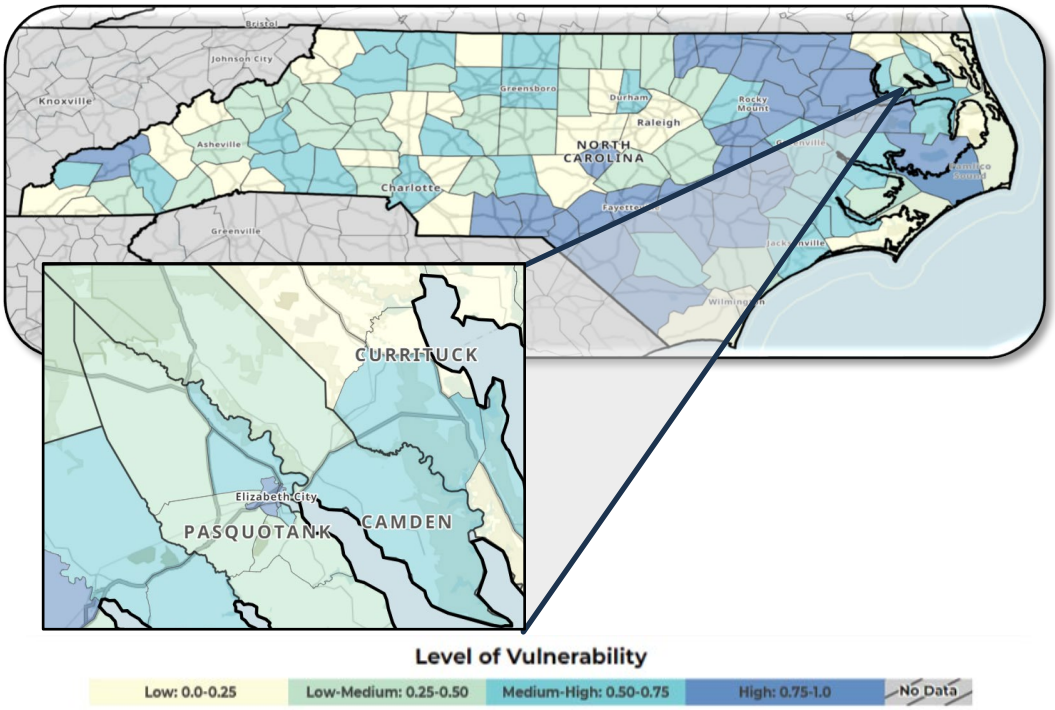
Figure 2.8: United States SVI by County, 2022



The 2022 SVI scores for Camden County are shown in **Figure 2.9** below. Possible scores range from 0 (lowest vulnerability) to 1 (highest vulnerability), and these scores show a relative comparison with other counties and census tracts in North Carolina. The vulnerability of Camden County overall is lower than

average compared to the state. At the census tract level, vulnerability is variable across the county with the average score being 0.25.

Figure 2.9: Camden County SVI by Census Tract, 2022



Environmental Justice Index

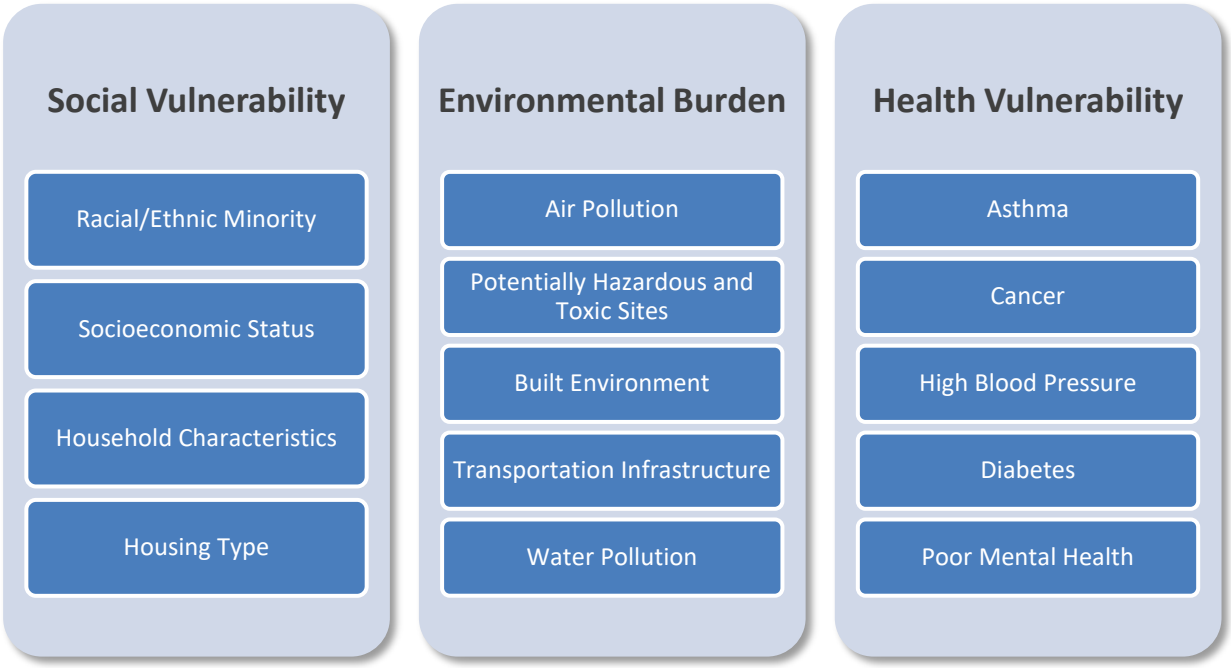
Environmental justice means the just treatment and meaningful involvement of all people, regardless of income, race, color, national origin, Tribal affiliation, or disability, in agency decision-making and other Federal activities that affect human health and the environment. It aims to protect everyone 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.[16]

The CDC/ATSDR EJI is a database that ranks the impact of environmental injustice on health. It uses data from the U.S. Census Bureau, the U.S. Environmental Protection Agency, the U.S. Mine Safety and Health Administration, and the 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 2.10** outlines the variables used to calculate EJI scores.

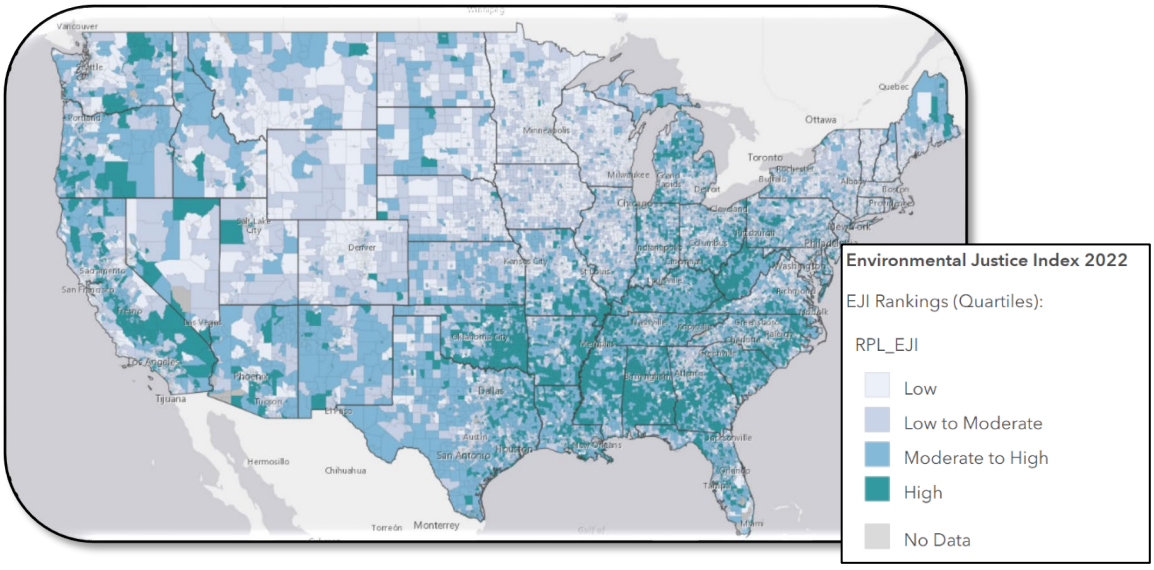
[16] U.S. Environmental Protection Agency (2024). Retrieved from https://www.epa.gov/environmentaljustice

Figure 2.10: EJI Variables



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

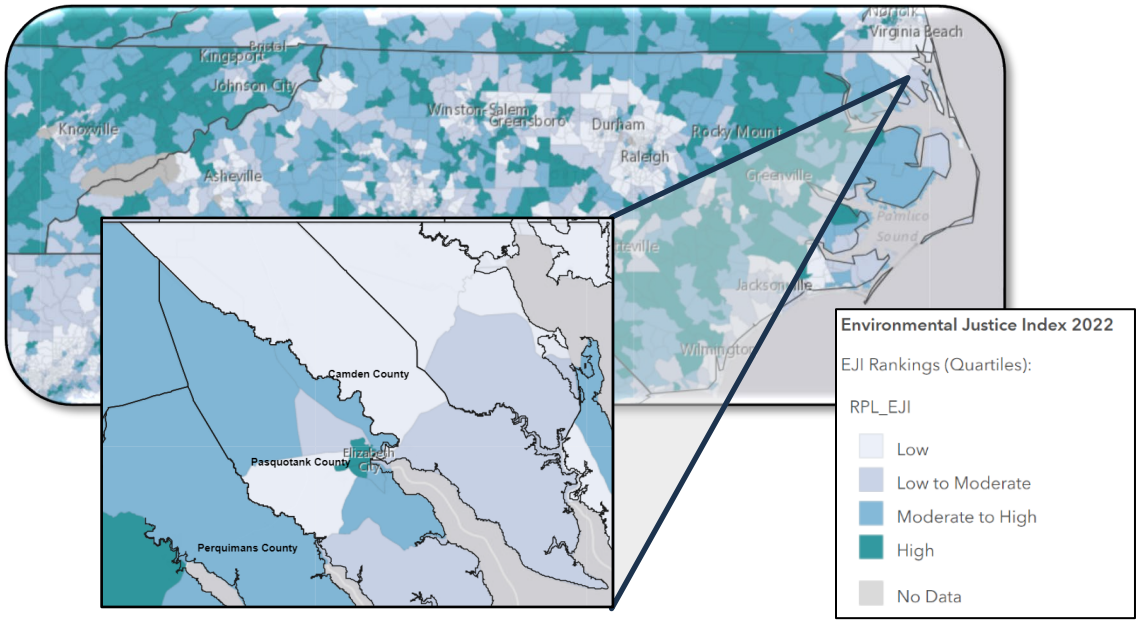
Figure 2.11: United States EJI by Census Tract, 2022



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

environmental burden compared to other census tracts. Levels of environmental burden are variable across the county with the average being 0.21.

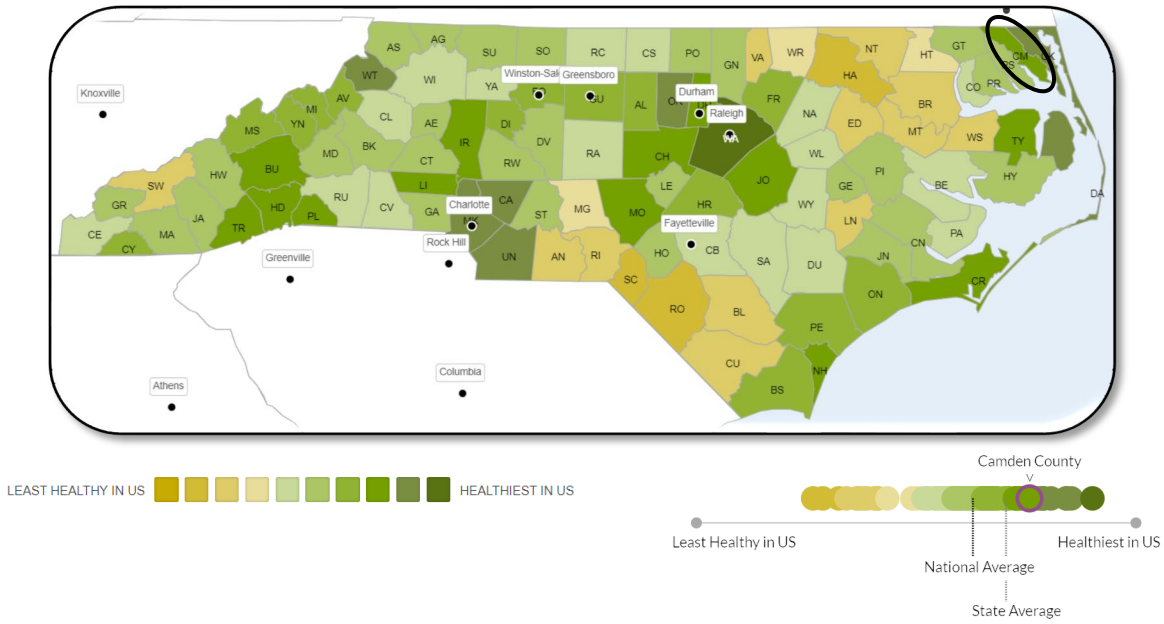
Figure 2.12: Camden County EJI , 2022



Health Outcome and Health Factor Rankings

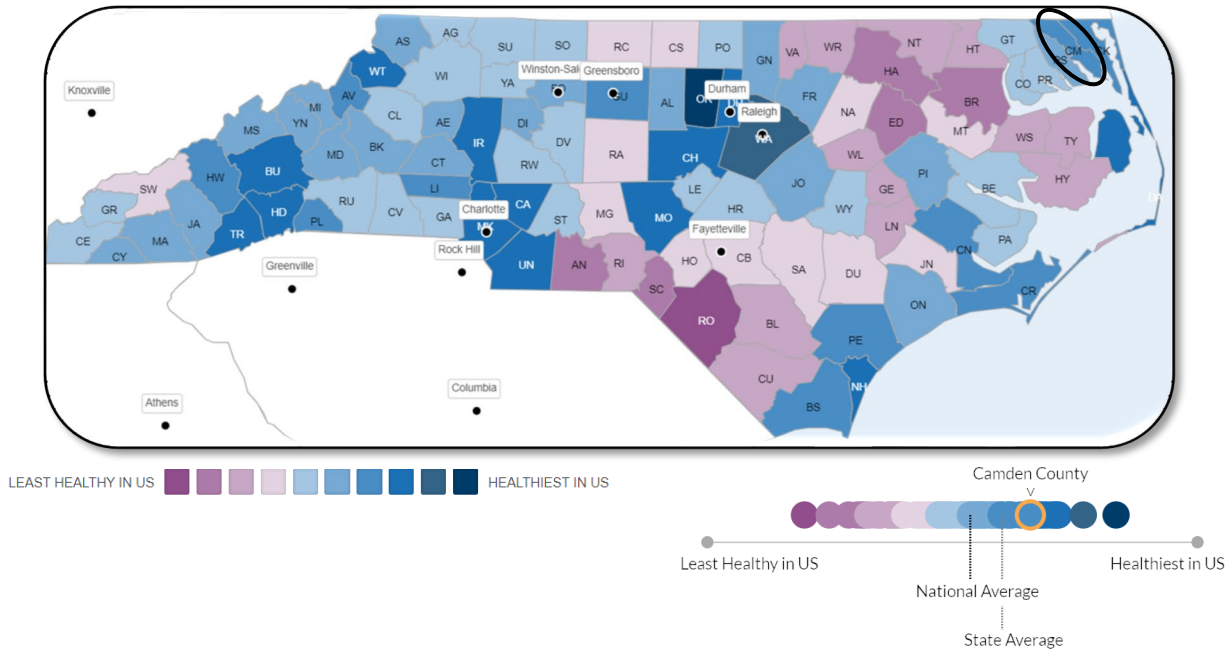
County leaders also reviewed and analyzed data from the Robert Wood Johnson Foundation and the University of Wisconsin County Health Rankings for the year 2024. The Health Outcomes measure looks at how long people in a community live and how physically and mentally healthy they are. These categories are discussed further in Appendices 2 through 4. Camden surpasses the average for the country and the state, which means people there may be healthier on average.

Figure 2.13: State Health Outcomes Rating Map[14]



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 Appendices 2 through 4. Similarly to the Health Outcome measure, Camden surpasses the average for the country and the state.

Figure 2.14: State Health Factors Rating Map[14]



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).

On August 16, 2024, Camden County conducted its Community Health Needs Assessment prioritization meeting at the Elizabeth City/Pasquotank Senior Center in Elizabeth City, North Carolina. The meeting brought together stakeholders representing a diverse range of organizations including Albemarle Regional Health Services, Trillium, Albemarle Area United Way, Roanoke Chowan Community Health Center, and community members. The multi-voting technique was used to determine priorities, with participants first engaging in group discussion to assemble a list of priority areas, followed by individual voting where everyone selected their top three priorities. After tallying the votes, another discussion was held to ensure the selected priorities were feasible for the community to address.

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

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

PRIORITY NEED: ACCESS TO 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 Camden 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.[17] Access is a challenge even for those who are insured.[18]

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.[19] 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.[20] 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.[21] 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.[22]

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.[23] 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.[24] Both primary and secondary data resources analyzed for this report highlight the need for greater access to health services within Camden County.

Secondary Data Findings

Various factors contribute to healthcare access, not all of which were determined to be of high need for Camden County, as detailed in **Appendix 3**. As displayed in the table below, Camden County has fewer

[17] 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.

[18] 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.

[19] 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 .

[20] 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 .

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

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

[23] 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.

[24] 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.

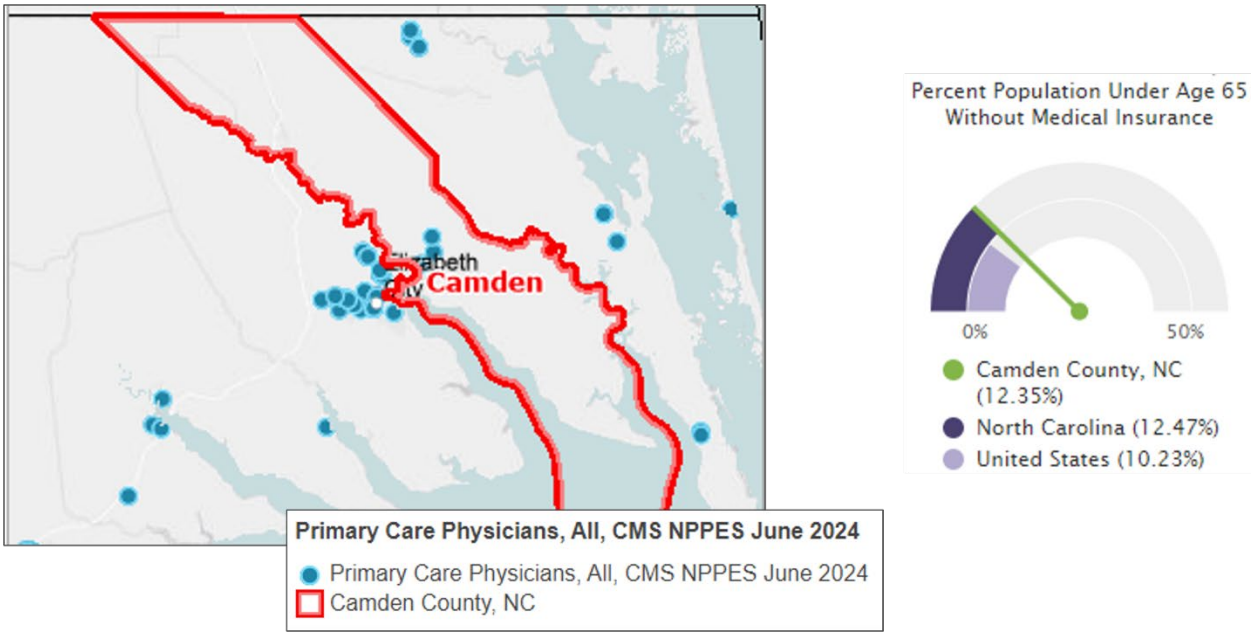
health professionals of all types compared to the state and national averages, highlighting challenges in access to care. Further, Camden County does not have any substance abuse providers, Buprenorphine providers, or dental providers, and nearly all Camden County residents live in an area that has been federally designated as a Dental Care Health Professional Shortage Area (HPSA), confirming a shortage of dental health professionals exist in the community. Additionally, there are no Federally Qualified Health Centers in Camden County. However, just 12 percent of insured Camden County residents receive Medicaid, suggesting a higher rate of private insurance relative to the state of North Carolina and the U.S.

Table 3.1: Access to Care Indicators

Indicator	Camden County	North Carolina	United States
Substance Abuse Providers (Rate per 100,000 Population)	0.0	25.0	27.9
Buprenorphine Providers (Rate per 100,000 Population)	0.0	15.2	15.5
Dental Providers (Rate per 100,000 Population)	0.0	31.5	39.1
Mental Health Providers (Rate per 100,000 Population)	9.7	155.7	178.7
Primary Care Providers (Rate per 100,000 Population)	19.3	101.1	112.4
Percentage of Population Living in an Area Affected by a Dental Care HPSA	99%	34%	18%
Percent of Insured Population Receiving Medicaid	12%	20%	22%
Rate of Federally Qualified Health Centers (Rate per 100,000 Population)	N/A	4.0	3.5

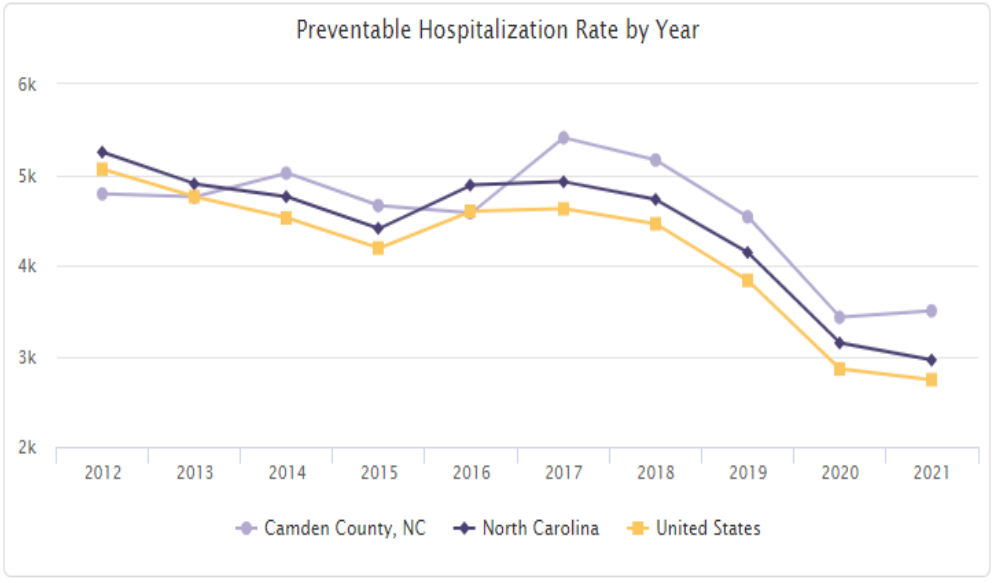
The map in **Figure 3.1** below shows that the primary care providers practicing in the county are concentrated near Elizabeth City, suggesting access challenges for residents in the outlying areas of the county. The graphic in **Figure 3.1** demonstrates that nearly 13 percent of the population under age 65 is without medical insurance in the county, a similar percentage compared to the state and a higher percentage compared to the nation. This suggests additional barriers to accessing care may exist in the community. While Medicaid coverage can support access to care, gaps in access can persist, particularly for specific provider types. Additionally, these residents may face greater difficulty finding a provider that accepts Medicaid compared to private insurance.

Figure 3.1: Primary Care Access in Camden County



Another access-related indicator of concern for Camden County was the number of preventable hospital stays for ambulatory care-sensitive conditions per 100,000 Medicare enrollees. While there has been a general downward trend in preventable hospital stays, the rate in Camden County remains higher than state and national averages.

Figure 3.2: Annual Preventable Hospital Stays



Slight health disparities for preventable hospital stays exist in Camden County. The rate among Black or African American Medicare beneficiaries in Camden County was higher compared to non-Hispanic White Medicare beneficiaries, as displayed in the table below. Hospitalizations for diagnoses that are usually treatable in ambulatory or outpatient settings suggest that residents of Camden County may experience difficulty accessing high-quality outpatient or primary care to prevent unneeded inpatient stays.

Table 3.2: Preventable Hospital Stays by Race/Ethnicity	
Preventable Hospital Stays (per 100,000 Medicare Beneficiaries)	**Camden County Rate**
Preventable Hospital Stays	3,499
Black or African American Medicare Beneficiaries	3,547
White Medicare Beneficiaries	3,385

Additionally, access to care may not be equitable across all county populations, particularly those with socioeconomic or transportation-related challenges. A lack of access to reliable transportation or transit is a key barrier that can prevent someone from being able to see their provider and can influence their ability to thrive in other areas of their life as well (such as getting to school or work). While Camden County has a lower percentage of households with no car compared to the state of North Carolina and the U.S. overall, there is no public transit option available for commuting. This suggests some residents may face transportation challenges.

Table 3.3: Transportation Options and Transit			
Indicator	**Camden County**	**North Carolina**	**United States**
Households with No Motor Vehicle, Percent	1.3%	5.4%	8.3%
Percent Population Using Public Transit for Commute to Work	0.0%	0.8%	3.8%
Percentage of Population within Half Mile of Public Transit	0.0%	10.9%	34.8%

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

Primary Data Findings – Community Member Web Survey

Almost 130 Camden residents responded to the web-based survey. Respondents identified several access to care needs in Camden County. In the survey, community members were asked to identify the top barriers to receiving healthcare. Cost (79%), no insurance (56%), and long wait times (41%) were the top three identified reasons why people in the community are not getting care when they need it. Other top barriers to care identified were lack of transportation (24%), insurance not accepted (21%), and a lack of nearby doctors (18%)

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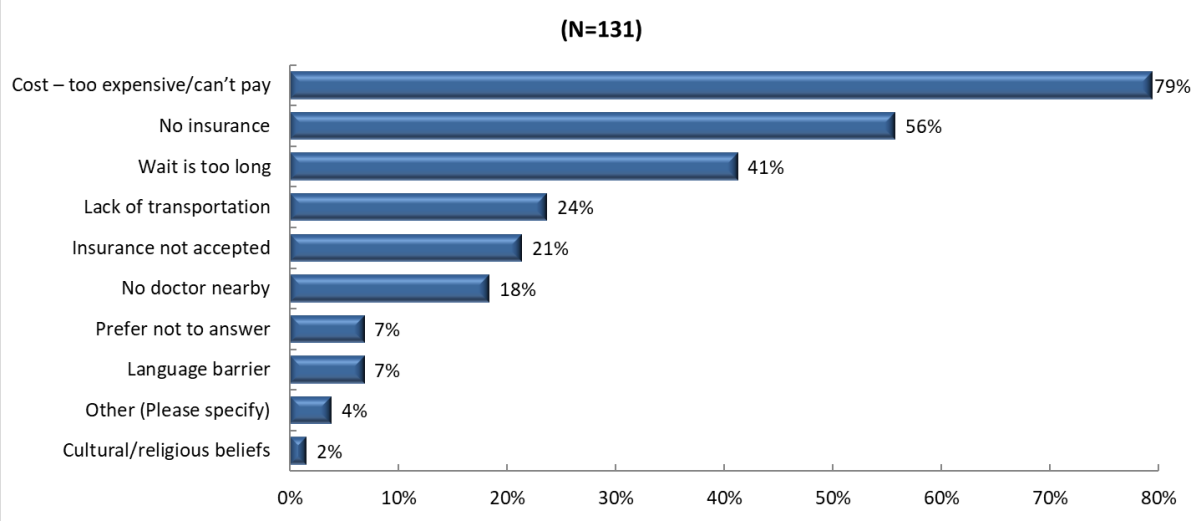
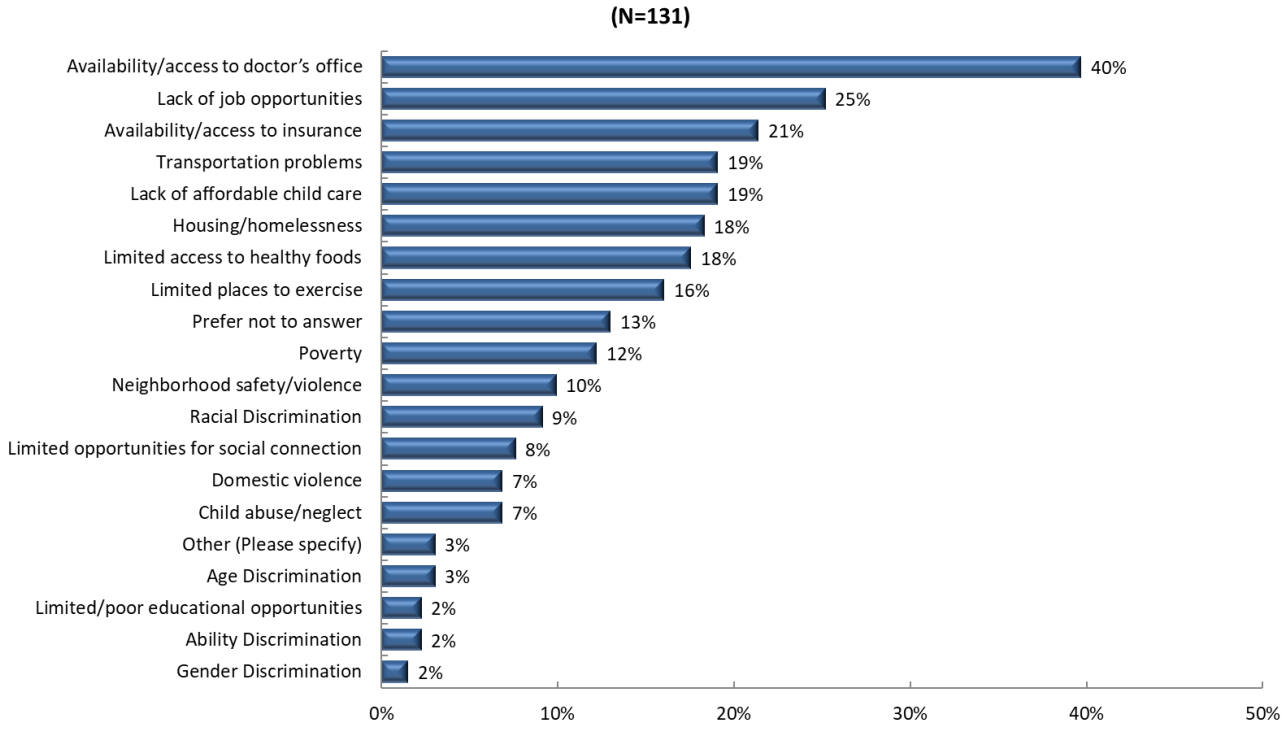
Figure 3.3: What are the three most important reasons people in your community do not get health care when they need it? Please select up to three.



Community members were also asked to identify the most important social or environmental problems that affect the health of the community. As displayed in the figure below, the most frequent problem identified was availability/access to doctor's offices (40%), which is supported by the secondary data findings and highlights access to care challenges within the community. Another 25% of respondents identified lack of job opportunities which can impact the ability for individuals and families to have health insurance coverage and to access healthcare. In fact, another 21% of respondents identified availability/access to insurance as a top social or environmental problem. About one in five respondents also identified transportation issues as a significant problem.

Figure 3.4: What are the three most important social or environmental problems that affect the health of your community? Please select up to three.



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

Primary Data Findings – Focus Groups

One focus group was conducted during the CHNA process. Focus group participants highlighted the lack of healthcare providers and dentists in the community. Additionally, focus group participants discussed health insurance coverage limitations, overwhelmed providers, and long wait times. Transportation was also noted as a barrier to accessing healthcare services.

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

PRIORITY NEED: BEHAVIORAL HEALTH

Context and National Perspective

The definition of behavioral health often describes conditions related to both mental health and substance use.[25] 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

[25] 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.

stressors, and health behaviors.[26] 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 Camden 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.[27] 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. [28]

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.[27] While access to telehealth mental health services has increased, those living in rural areas may still find it difficult to access care. This is a particular concern among those who are low-income or experiencing homelessness, two groups at high risk for developing an acute or chronic mental health condition. As of 2023, over seven million people in the U.S. who reported having a mental illness lived in a rural area.[29]

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 that live in North Carolina are seven times more likely to be pushed out of network of their behavioral health providers, than a primary care provider, furthering cost as a cause for stopping treatment. [30]

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.[31] SUDs often occur in conjunction with other mental illness. In 2023, 16 million (46.9%) young adults aged 18-25 reported having either a SUD or Acute Mental Illness (AMI) in the past year. In that same year, 17.1% (48.5

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

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

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

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

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

[31] 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.

million) of all U.S. adults were reported as having an SUD.[32] 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.[33] 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.[34] Treatment SUDs generally cannot follow a cookie-cutter approach, as each person receiving treatment will have different withdrawal and coping needs. Treatment is typically provided through various therapies, inpatient admissions, and forms of medication-assisted treatment such as methadone. Opioid overdoses are one of the most common types of deaths related to SUDs, and can be preventable and treatable if caught in time. Multiple efforts have been coordinated within the past two years to incorporate the storage of overdose reversing medications such as Naloxone in public facilities such as federal facilities, and over the counter, as was approved in 2023 by the FDA. This is critical, as in 2022, the number of opioid overdoses nationwide surpassed 81,051 – a 63% increase in overdoses since 2019.[35]

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.[36] 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.[37]

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[32] 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.

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

[34]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

[35] 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/

[36] 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.

[37] 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.

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 collected through the CHNA process identified behavioral health, including both mental health and substance use, as an area of concern for residents of Camden County. As demonstrated in the table below and the previous Access to Care section, Camden County has significantly less access to mental health providers compared to the state and U.S. overall. Further, Camden County does not have any local substance abuse providers or Buprenorphine providers.

Table 3.4: Access to Mental Health Care Indicators

Indicator	Camden County	North Carolina	United States
Substance Abuse Providers (Rate per 100,000 Population)	0.0	25.0	27.9
Buprenorphine Providers (Rate per 100,000 Population)	0.0	15.2	15.5
Mental Health Providers (Rate per 100,000 Population)	9.7	155.7	178.7

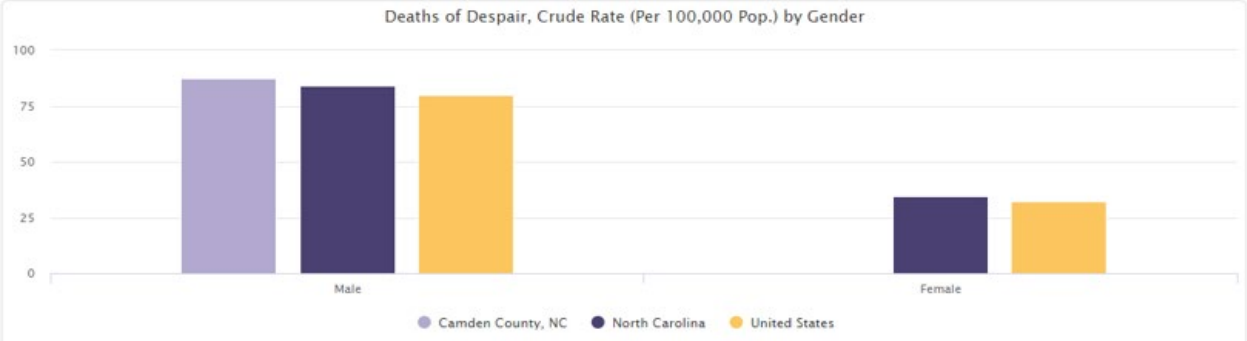
As displayed in the table below, Camden County's behavioral health indicators are on par with North Carolina and the U.S. overall, including the crude rate deaths of despair, as well as the average number of poor mental health days per month reported by residents.[38] Suicide mortality data was not available due to the small size of the county.

[38] Deaths of despair includes deaths by intentional self-harm (suicide), alcohol-related conditions and drug poisoning.

Table 3.5: Behavioral Health Indicators			
Indicator	**Camden County**	**North Carolina**	**United States**
Deaths of Despair (Crude Rate per 100,000 Population)	56.9	58.7	55.9
Suicide (Crude Rate per 100,000 Population)	N/A	13.4	13.8
Average Number of Poor Mental Health Days (per Month)	4.8	4.6	4.9

Deaths of despair are much more common among men compared to women. The figure below highlights this gender disparity, although county-level data for women was not available.

Figure 3.5: Crude Rate of Deaths of Despair by Gender



In terms of substance use disorder indicators, Camden County has a slightly higher rate of excessive drinking among residents and lower rates of opioid-related emergency department visits and death due to alcohol-involved vehicle crashes compared to state and national averages.

Table 3.6: Substance Use Disorder Indicators			
Indicator	**Camden County**	**North Carolina**	**United States**
Percentage of Adults Reporting Excessive Drinking	19%	18%	18%
Opioid Use Disorder Emergency Department Utilization (Rate per 100,000 Beneficiaries)	25	43	41
Alcohol-Involved Crash Deaths, Annual (Rate per 100,000 Population)	0.0	3.3	2.6

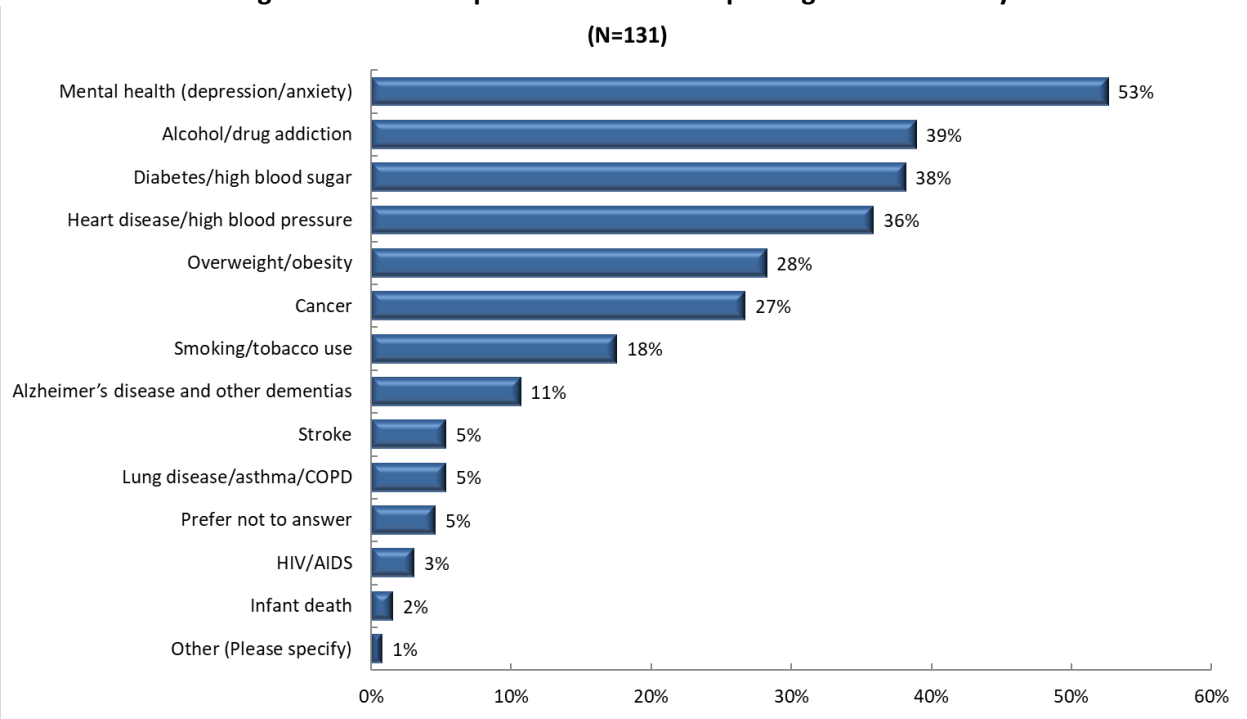
Opioid Overdose Death Rate (Crude Rate per 100,000 Population)	N/A	25.1	N/A

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

Primary Data Findings – Community Member Web Survey

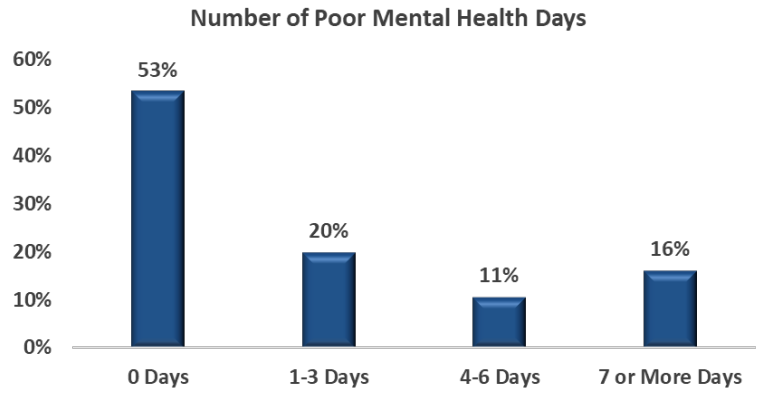
When asked to identify the most important community health needs, more than half (53%) of Camden County residents surveyed identified mental health (depression/anxiety). In fact, mental health (depression/anxiety) was the most top community health need identified through the survey.

Figure 3.6: Most Important Problems Impacting the Community



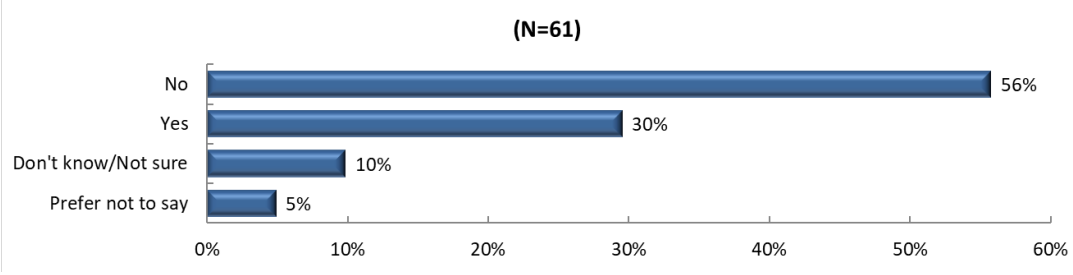
As seen in **Figure 3.7**, responses related to individual mental health concerns were largely positive, with 53% of respondents reporting that they had not experienced any poor mental health days in the prior 30-day period. Nearly one-third of respondents reported that they had experienced six or fewer poor mental health days in the previous month (31%), while 16% reported having poor mental health on seven days or more. While just over half of Camden County residents reported no poor mental health days in the last month, a significant proportion of residents (16%) spent a week or more experiencing mental health concerns.

Figure 3.7: Number of Poor Mental Health Days in the Last Month



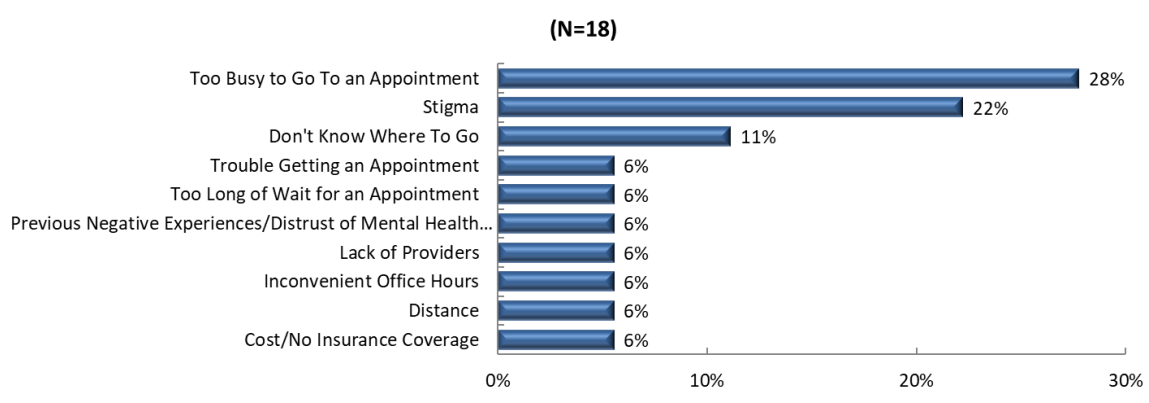
Community member respondents who indicated they experienced at least one poor mental health day in the previous month were also asked if there was a time in the past 12 months when they needed mental healthcare or counseling but did not get it at that time. One-third (30%) of these respondents answered yes.

Figure 3.8: 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?



Camden County residents were further asked why they chose to delay mental health care. The top reason given was that they were too busy to go to their appointment (28%), followed by stigma (22%), and just over one tenth (11%) stated a lack of knowledge of where to go.

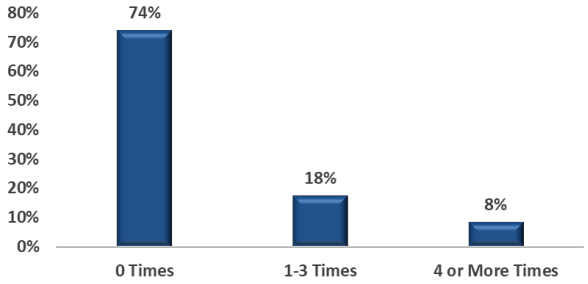
Figure 3.9: What was the MAIN reason you did not get mental health care or counseling?



Community members were also asked about their experiences regarding alcohol and substance use. Alcohol usage and substance use was the second highest ranked health issue by survey respondents, as indicated in **Figure 3.6** above. 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 a substance use disorder.

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. Two-thirds of respondents (74%) reported that they did not consume an excessive amount (4 drinks for females and 5 drinks for males) on at least one occasion in the past 30 days. However, one-quarter (26%) of respondents identified that they had consumed more than that threshold one or more times in the past month.

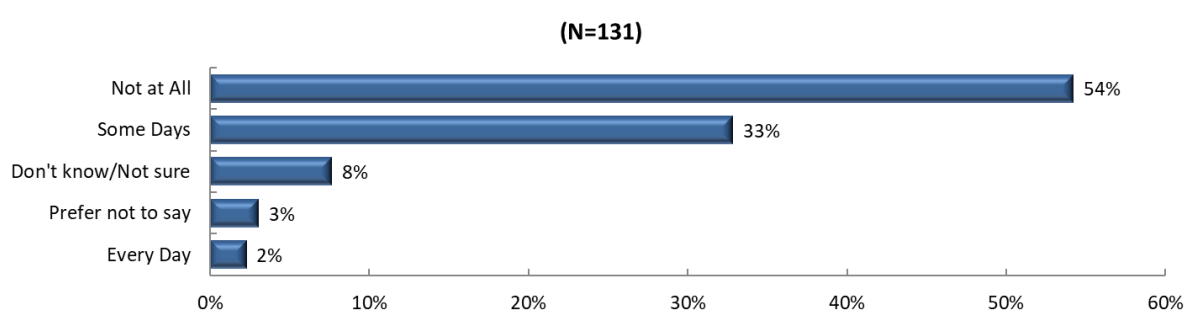
Figure 3.10: Considering all types of alcoholic beverages, how many times during the past 30 days did you have 4 (females)/ 5 (males) or more drinks on an occasion?



Measure	Value
Mean (Standard Deviation)	1 (3)
Median	0
Mode	0
Minimum-Maximum	0-24

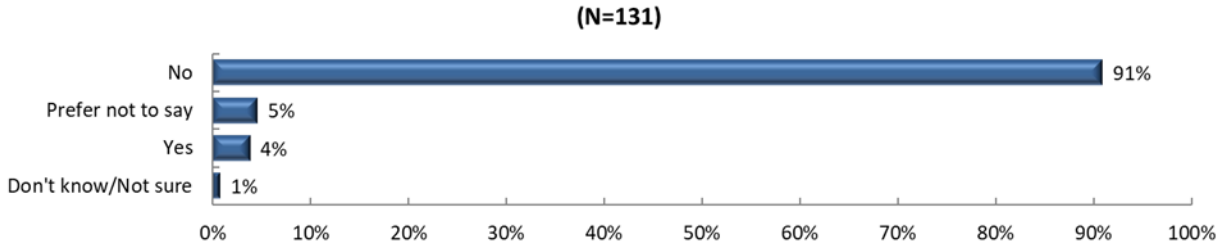
A similar trend was noted when community members were further asked the frequency at which they did consume any alcohol, with over half (54%) of respondents reporting that they do not drink at all, and 35% of respondents stating that they did drink at least some days.

Figure 3.11: How often do you consume any kind of alcohol product, including beer, wine or hard liquor?



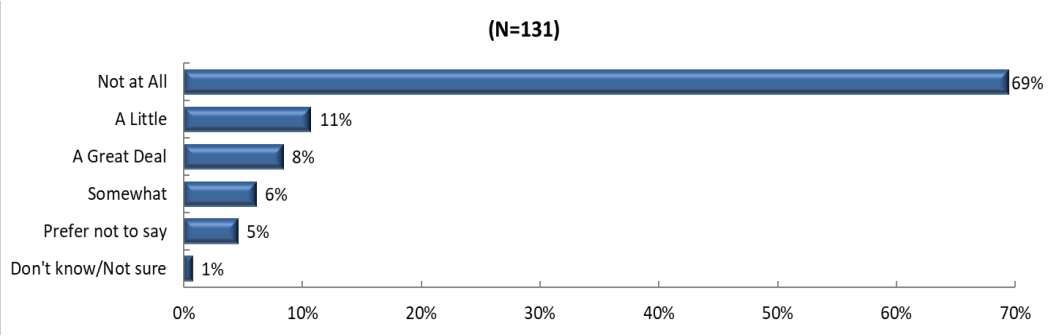
Additionally, just four percent of Camden County residents report that they or a member of their household had misused any prescription medications in the prior year.

Figure 3.12: 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)?



Finally, community members were asked to indicate what degree their life had been negatively impacted by either their own or someone else's substance use. While nearly two thirds (69%) of individuals indicated no negative impact, one quarter (25%) stated that their life had been at least a little impacted, and nearly one in ten (8%) indicated that their life had been impacted a great deal.

Figure 3.13: To what degree has your life been negatively affected by your own or someone else's substance abuse issues, including alcohol, prescription, and other drugs?



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

Primary Data Findings – Focus Groups

In the focus group conducted at Ebenezer Baptist Church, participants identified drug use as an issue of concern in the community. They also discussed homelessness, the lack of safe and affordable housing, and the need for more resources to address housing issues in the community, all of which may be impacted by mental health and wellbeing. The lack of healthcare providers was also cited as a concern.

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

PRIORITY NEED: HEALTHY LIVING

Context and National Perspective

Focus on a healthy lifestyle is critical for maintaining one's physical health – the monitoring and maintenance of the human body. There are many factors involved in an individual's overall physical health status, such as disease prevention, timely access to primary and preventive healthcare, exercise, and maintaining a healthy diet. Living a healthy lifestyle is not a one size fits all approach, and many individuals choose to incorporate different healthy behaviors at different times, slowly building more and more healthy habits. The CDC recommends multiple healthy behaviors that can be integrated for healthier living, such as getting enough sleep, moving more and sitting less, limiting alcohol intake, and eating healthy food. Sleep needs can vary from person to person; however, the CDC recommends that an adult gets at least 7 hours of regular sleep. Another healthy behavior that can be incorporated is movement, starting at least 20 minutes a day with some light activity, such as walking or dancing. [39]

Another form of healthy living and disease prevention is taking a proactive role in preventative health care, which can often start with one's diet. According to experts, losing just 5-10 % of one's current weight can lower the risk for multiple chronic conditions such as diabetes, arthritis, cancer, and high blood pressure. When speaking with a primary doctor, or a nutritionist about creating a healthy diet, it is important to have some information prepared, such as food allergies, health goals, the types of medication taken, and any other health concerns that one may have. When considering a diet for weight loss, ensuring that the diet is both filling and matches a daily activity level is key. When implementing a new diet, there are a few recommendations for success. First, eating when hungry and stopping when full is key, and choosing to eat filling foods that one might enjoy, such as one's favorite vegetables, fruit, or lean protein. Secondly, seasoning the food with different herbs and spices, and reducing the amount of salt and sugar in a recipe if possible. Finally, drinking enough water throughout the day helps with digestion and other body functions.[40]

When considering healthy living in rural communities, research has shown that just one in four adults in rural areas are consistently performing at least four healthy behaviors.[41] Rural areas often have fewer or less diverse grocery stores, with many relying on smaller general stores, which may not always have fresh produce and meat. Additionally, these areas may also not have safe places to walk or exercise, such as sidewalks, recreation centers, or parks.

In North Carolina, over half (52%) of adults do not get at least two and a half hours of moderate exercise per week, and over 70% don't meet weekly muscle strengthening recommendations. However, 84% of adults eat at least one vegetable a day, and over 60% eat fruit at least once a day.[42] North Carolina's

[39] Source: Centers for Disease Control and Prevention. (2023). *Taking care of your body.* Retrieved October 3, 2024 from: https://www.cdc.gov/howrightnow/taking-care/index.html

[40] Source: U.S. Department of Veterans Affairs. (2023). *Healthy living overview.* Retrieved October 10th, 2024 from https://www.prevention.va.gov/Healthy_Living/index.asp

[41] Source: CDC (n.d.) *Health behaviors in rural America.* Retrieved October 3, 2024 from https://www.cdc.gov/rural-health/php/public-health-strategy/public-health-considerations-for-health-behaviors-in-rural-america.html#:~:text=People%20living%20in%20rural%20areas,and%20getting%20regular%20health%20screenings.

[42] Source: Eat Smart Move More North Carolina. (2017). *The roles of nutrition and physical activity in Chronic Disease in North Carolina.* Retrieved

Department of Health and Human Services has implemented several workshops and classes that individuals can take to learn healthy habits, such as Living Healthy workshops. Additionally, several nonprofits have implemented programs to help individuals learn healthy behaviors, and North Carolina also has an extensive WIC program, as well as the NCCARE360 program, which seeks to connect individuals with all necessary resources for living a healthier life.

Secondary Data Findings

Secondary data collected through the CHNA process also identified healthy living as a priority concern area for residents living in Camden County. Camden County residents had a slightly lower rate of physical inactivity than the state overall, but Camden County underperformed relative to the state and the U.S. in walkability and access to exercise opportunities. These indicators can impact physical health and increase the risk of various chronic health conditions.

Table 3.7: Exercise Indicators

Indicator	Camden County	North Carolina	United States
Recreation and Fitness Facility Establishments (Rate per 100,000 Population)	N/A	13.1	14.7
Walkability Index Score	4	7	10
% Physically Inactive	20.4	21.6	-
Percentage of Population with Access to Exercise Opportunities	32%	73%	84%

Camden County experience lower rates of food insecurity, with less than one in ten (9%) of residents experiencing this issue, compared to state (11%) and national (10%) averages. Furthermore, the child food insecurity rate is marginally lower (11%) than the state and national averages (15% and 13% respectively). Overall, food insecurity is trending positively, with just 3% of the low-income population citing low food access, compared to North Carolina (21%) and the United States (19%).

Table 3.8: Food Security Indicators			
Indicator	**Camden County**	**North Carolina**	**United States**
Food Insecurity Rate	9%	11%	10%
Child Food Insecurity Rate	11%	15%	13%
Percent Low Income Population with Low Food Access	3%	21%	19%
Food Environment - Fast Food Restaurants Establishments (Rate per 100,000 Population)	29.0	77.4	96.2
Food Environment - Grocery Stores Establishments (Rate per 100,000 Population)	N/A	18.7	23.4

Camden County also performed worse on emergency department visits, cardiovascular disease hospitalizations, and ischemic stroke hospitalizations, confirming the need for a continued focus on healthy living in the county. The cancer incidence rate in Camden County was lower than in North Carolina and the U.S. overall.

Table 3.9: Cancer Incidence and Cardiovascular Disease and Stroke Hospitalizations			
Indicator	**Camden County**	**North Carolina**	**United States**
Cancer Incidence (Rate per 100,000 Population)	343.1	464.4	442.3
Emergency Room Visits (Rate per 1,000 Population)	616	563	535
Cardiovascular Disease Hospitalizations (Rate per 1,000 Medicare Beneficiaries)	16.5	11.7	10.4
Ischemic Stroke Hospitalizations (Rate per 1,000 Medicare Beneficiaries)	10.3	9.5	8

However, Camden County has lower percentages of adults living with various chronic health conditions, compared to incidence rates for North Carolina and the U.S. overall.

Table 3.10: Chronic Health Conditions			
Indicator	**Camden County**	**North Carolina**	**United States**
Adults (Age 18+) with Asthma	9.5%	9.8%	9.7%
Adults (Age 20+) with Diagnosed Diabetes	7.3%	9.0%	8.9%
Adults (Age 18+) Ever Diagnosed with Coronary Heart Disease	5.3%	5.5%	5.2%
Adults (Age 18+) with Hypertension	30.3%	32.1%	29.6%
Adults (Age 18+) with High Cholesterol	30.5%	31.4%	31.0%
Adults (Age 18+) with Kidney Disease	2.7%	2.9%	2.7%
Adults (Age 18+) Ever Having a Stroke	2.8%	3.1%	2.8%
Adults with BMI > 30.0 (Obese)	17.7%	29.7%	30.1%
Adults (Age 18+) with Poor Dental Health	12.0%	12.0%	13.9%
Percent Reporting Poor or Fair Health	13.2%	14.4%	-

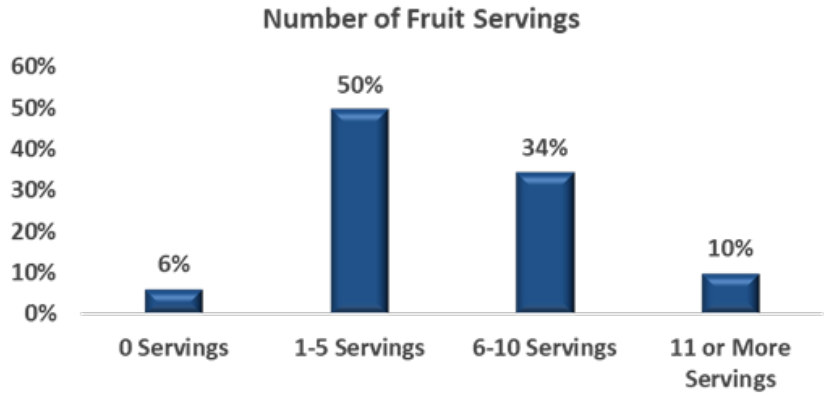
For additional detail on secondary data findings, see **Appendix 3.**

Primary Data Findings – Community Member Web Survey

Camden County residents identified several healthy living concerns in the community in the web survey. As previously identified in **Figure 3.4** in the Access to Healthcare section, 17% of community respondents indicated limited access to healthy foods and 16% indicated limited places to exercise were top social or environmental problems affecting the health of the community.

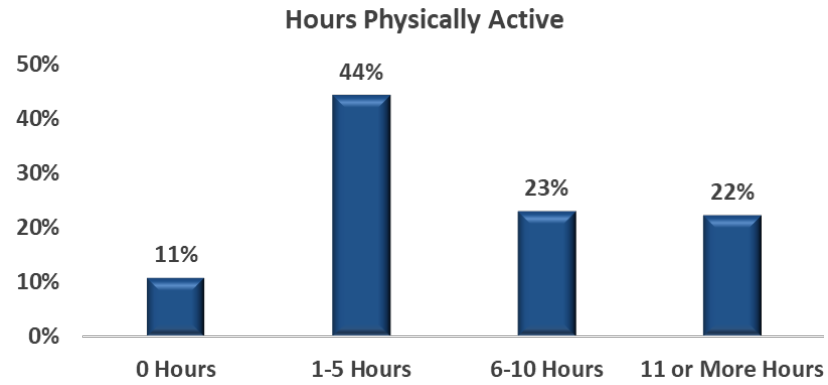
When respondents were asked how many servings of fruit they ate in the past week, 6% indicated none, while 50% indicated they ate between one and five servings. On average, community member respondents in Camden County ate six servings of fruit over the past week. Responses for vegetables were similar, suggesting opportunities for increasing healthy food consumption in the community.

Figure 3.14: Think about the food you ate during the past week. On average, how many servings of fruit did you eat, not including juices? (For example, one serving equals a medium apple, a small banana, or 7 strawberries)



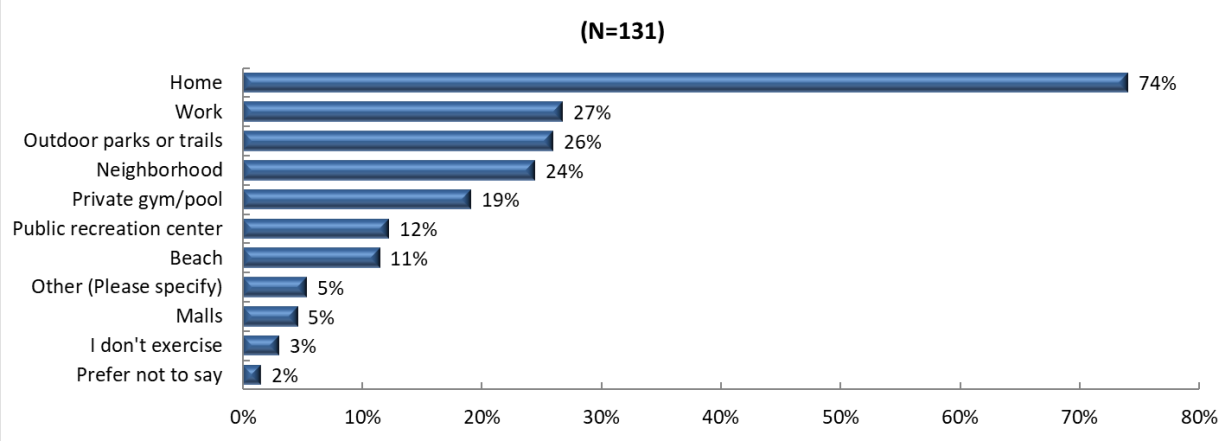
When respondents were asked how often they were physically active outside of their jobs in the last month, 11% indicated they were not active at all, while 44% indicated they were active between one and five hours. On average, community member respondents in Camden County were active 10 hours each week in the last month, suggesting opportunities for increasing physical activity in the community.

Figure 3.15: During the past month, approximately how much time (in hours) per week were you physically active outside of your regular job?



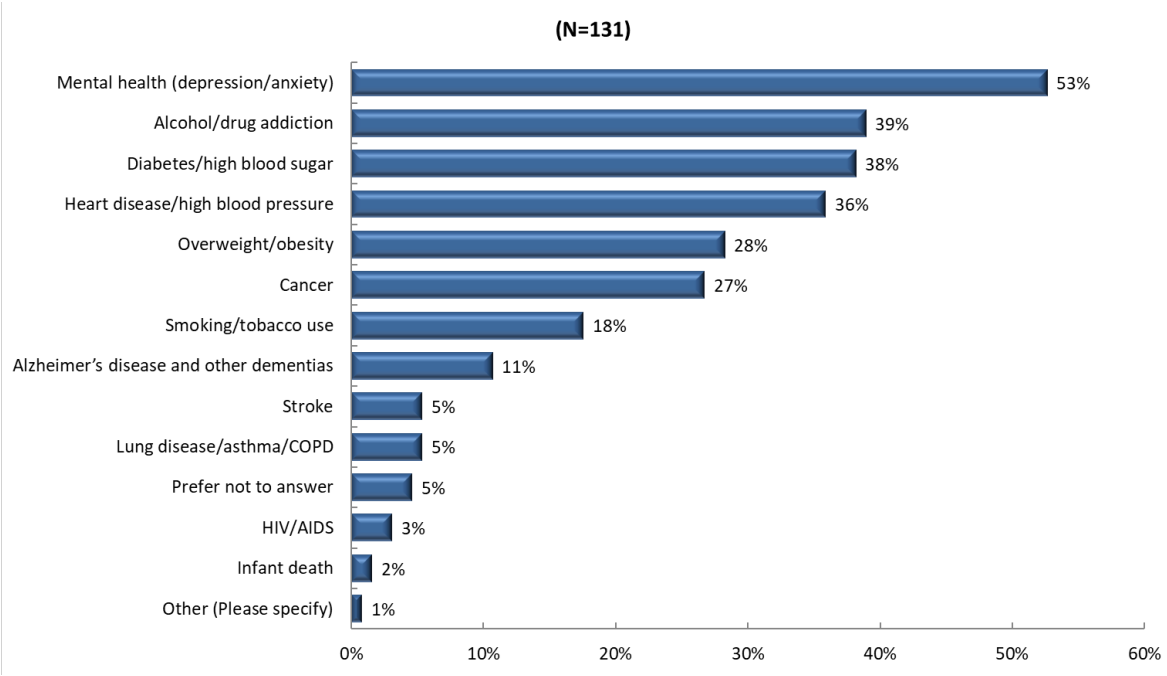
When survey participants were asked where they engage in exercise or physical activities in the community, the majority indicated at home (74%) with roughly one-quarter also indicating work, outdoor parks or trails, or a neighborhood.

Figure 3.16: When you are active, where do you engage in exercise or physical activities? (Select all that apply.)



In addition to healthy living concerns, Camden County respondents also highlighted chronic health conditions as top community concerns in the survey. Diabetes/high blood sugar, heart disease/high blood pressure, and overweight/obesity were identified as some of the most significant health problems affecting the community. In addition, 27% of respondents identified cancer as a top problem.

Figure 3.17: What are the three most important health problems that affect the health of your community? Please select up to three.



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

Primary Data Findings – Focus Groups

Healthy living concerns emerged in the focus group conducted in Camden County. Food access and security was a significant theme, with participants discussing both the cost and availability of healthy foods as a community challenge, particularly the lack of grocery stores that makes purchasing healthy food difficult. A reliance on farmer's markets and local stands for fresh produce was described. Participants also discussed the need for a food bank in the community and more places to exercise. Participants suggested community gardens and other shared food resources as a potential way for local leaders to improve community health. Community safety, specifically domestic violence, was also cited as a concern.

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 Camden County that provide resources to address general community health needs, as well as the county's 2024 priority need areas: Access to Healthcare, Behavioral Health, and Healthy Living.

For a comprehensive list of existing resources, facilities, and programs, please refer to Camden County Community Resource Directories and Guides.

Category	Organization Name
County Resource Directories	**Camden County Health Department** • The Health Department offers clinical services such as adult health, child health, immunizations, general communicable disease, sexually transmitted disease, women's preventive health, and maternal health. Other services are Women, Infants and Children (WIC), Diabetes Care, Health Education and Health Promotion, Environmental Health Services, Public Health Preparedness and Response, Inter-County Public Transportation Authority (ICPTA), and Children's Developmental Services Agency. **Law Enforcement** • Camden County Sheriff's Office **Fire Departments** • South Camden Fire Department • South Mills Volunteer Fire Department **Public Libraries:** There are two public libraries that serve the people of Camden County • Camden County Library • Pasquotank-Camden Public Library **Albemarle Smart Start Partnership Community Resource Guide:** Searchable directory of programs and services available throughout the Albemarle Region. Currently catalogs annotated listings for 125 local and regional agencies and organizations. Also available as a printable version—scroll down to Resource Guide PDF to view the Community Resource Guide below or download it. **North Carolina Arts Council:** Maintains a resource list of cultural, arts, and civic organizations that is searchable by county.

	Elizabeth City/Pasquotank County Economic Development Commission **Elizabeth City Chamber of Commerce** **Parks and Recreation Department**

Healthcare Facilities	**Hospitals**:
	• Bertie County – Vidant Bertie Hospital
	• Chowan County – Vidant Chowan Hospital
	• Dare County – The Outer Banks Hospital, Inc.
	• Hertford County – Vidant Roanoke-Chowan Hospital
	• Martin County – Martin General Hospital
	• Pasquotank County – Sentara Albemarle Medical Hospital
	• Washington County – Washington County Hospital
	
	Primary Care, Clinics, & Other Facilities
	• Vidant Family Medicine – Windsor
	• Vidant Pediatrics – Edenton
	• Vidant Family Medicine – Edenton
	• Vidant Internal Medicine & Cardiology – Edenton
	• Vidant Women's Care – Edenton
	• Vidant General Surgery – Edenton
	• Cancer Care
	• Pitt County – Vidant Medical Center
	• Pasquotank-Camden Emergency Medical Service
	• Gateway Community Health Center – Tyner Clinic
	  ○ This clinic provides primary care to patients 18 years old and up. Services include sick visits, wellness and preventative visits, chronic disease management, health education, and laboratory testing. Staff includes a full time Adult Nurse Practitioner, a Registered Nurse, and support personnel.
	• Gateway Community Health Center of Gatesville
	  ○ This clinic provides primary and minor emergency care for patients of all ages, including babies and children. Services include sick visits, wellness and preventative visits, chronic disease management, health education, stitches, X-rays, and laboratory and EKG testing. Staff includes a full time Family Practitioner medical doctor, a Family Nurse Practitioner, nurses, and support personnel
	• Colerain Primary Care
	• Adolescent Care Clinic
	  ○ This clinic provides primary care to students 10 to 19 years old and school faculty. Services include sick visits, wellness and preventative visits, chronic disease management, sports physicals, mental health counseling, health education, and

	laboratory testing. Staff includes a halftime Family Nurse Practitioner, a Registered Nurse, and a Licensed Practical Nurse.
	• Chesapeake Regional Primary Care
	• Michelle Creech, Speech-Language Pathology
	• Delaine Tanis, Speech-Language Pathology
	
	Mental Health/Substance Use
	• Trillium
	  ○ Manages Medicaid for mental health, substance use/abuse, and intellectual/development disability services in a 27-county area. Trillium has a network of agencies with licensed therapists to offer services and support to people in need within their community.
	• Trillium Access Point
	  ○ Anonymous, evidence-based, self-conducted screenings online 24hrs a day for depression, bipolar disorder, post-traumatic stress disorder, eating disorders, and alcohol use disorders.
	• Martha Goodman, Counseling
	• East Carolina Behavioral Health
	
	Long-Term Care Facilities
	• Needham Adult Care Home
	
	Dental Care
	• Dr. Francis A. Bald & Associates
	• Physicians-Oral Surgeons
	• Regis Dandar
	• Morgan Family Dentistry
	• Currituck Dental Clinic
	• Elizabeth City Dental
	• Robert T. Gillam, III, D.D.S.
	• Dental Transformations
	• Dentist and Sleep Specialist
	• Complete Dental Care: Jones Jr Clifford B D.D.S
	• Griffin Jr. Lloyd E D.D.S.

Other Healthcare Services	• Community Care of Eastern North Carolina (CCPEC)/Carolina Access • Lynn Olsefski, Social Work • Albemarle Pregnancy resource Center and Clinic
Community Services	• Camden County Senior Center • Social Services • NC Cooperative Extension

- Camden County Center
- Albemarle Alliance for Children and Families (formerly Albemarle Smart Start Partnership, INC.)
    - Mission: Albemarle Alliance for Children and Families builds the capacity of families, communities and schools, to prepare the next generation for academic, emotional, social and economic success in a global world. Learn more and get involved.
    - Vision Statement: All Albemarle children are given the support needed to reach their full potential as adults, thereby ensuring the long-term economic vitality of the region's families, communities and companies in a globally competitive world.
- Albemarle Hopeline: a private, non-profit organization in the Albemarle region, with outreach through four satellite offices (Chowan, Currituck, Gates and Perquimans counties), a shelter/direct service facility, and a thrift store. The agency is guided by the mission of "providing comprehensive direct and preventive services to victims of family violence, sexual assault and teen dating violence" in the counties of Camden, Chowan, Currituck, Gates, Pasquotank and Perquimans.
    - Services include: 24-hour crisis line; emergency Hope House shelter; food, clothing and transportation; crisis intervention; court advocacy; individual and group counseling for adults and children; Displaced Homemaker Program; information and referral; outreach; and prevention through awareness and education to school, church and civic groups and the community-at-large. Since the opening of an enlarged 14,200 square foot Hope House facility in 2006, Hopeline has been able to consolidate services to both residential and non-residential victims and improve coordination and effectiveness. All services are designed to meet basic safety needs of victims of domestic and sexual violence, empowering them to establish and maintain healthy, violence-free lives.
- Kids First Inc.: Evaluation and treatment services for children who have been abused or neglected.
- Nuestra Casa de la Communidad Hispana
    - This center provides assistance and health programing focused on the local farm worker and Hispanic communities. Services include medical field clinics with a bilingual Case Manager, Outreach Worker and Registered Nurse/Family Nurse Practitioner providing health assessments and immunizations as well as HIV testing and TB skin testing; assistance in accessing existing health resources from both public agencies and private organizations; case management; interpretation services; advocacy; health education; and a tutoring program for grades K-5.

CHAPTER 5 | NEXT STEPS

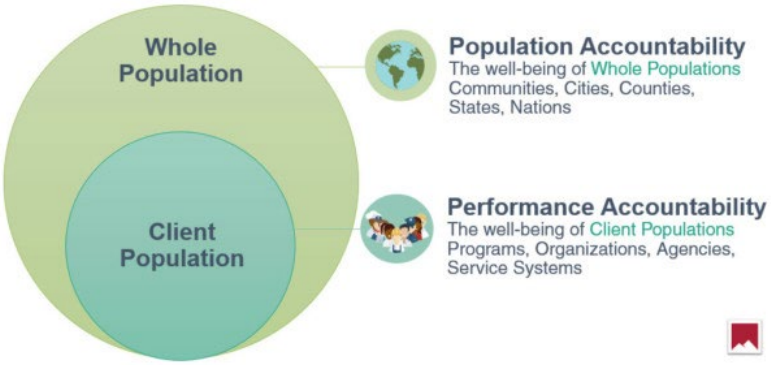
The CHNA findings are used to develop effective community health improvement strategies to address the priority needs identified throughout the process. The next and final step in the CHNA process is to develop community-based health improvement strategies and action plans to address the priorities identified in this assessment. Health leaders in Camden 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. Camden County leaders recognize that the most effective strategies will be those that have the collaborative support of community organizations and residents. The strategies developed will include measurable objectives through which progress can be measured.

APPENDIX 1 | STATE OF THE COUNTY HEALTH REPORT

Results-Based Accountability Framework

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

Figure A1.1: Population vs. Performance Accountability



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

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

State of the County Health Report

HNC 2030 Scorecard: Albemarle Regional Services - 2021-2023

Albemarle Regional Health Services
Partners in Public Health

Albemarle Regional Health Services is excited to share the Healthy NC 2030 Scorecard for the eight counties in our district health department. This Community Health Improvement Scorecard is an easy way to learn about some of the efforts currently underway to address three health priorities identified in the (CHA):

- ***Healthy Lifestyle Behaviors***
- ***Access to Healthcare***
- ***Mental Health/Substance Misuse***

This Scorecard also serves as **ARHS's** community health improvement plan (CHIP), fulfilling the **NC Local Health Department Accreditation** requirements that local health departments complete two CHIPs following the CHA submission and a State of the County's Health Report for **ARHS** on years when not completing the CHA.

For each priority, this Scorecard spotlights:

- A Result Statement, a picture of where we would like to be,
- Important local Indicators or measures of how we are doing linked to Healthy NC2030 indicators and
- Select Programs or activities and
- Key Performance Measures that show how those programs are making an impact.

Instructions: Click anywhere on the scorecard to learn more about programs and partners that are working together to improve health. The letters below represent key components of the Scorecard.

Results	R
Indicators	I
Programs	P
Performance Measures	PM

Use the icons to expand items and the icons to read more. This scorecard is not intended to be a complete list of all the programs and partners who are working on these issues in **ARHS**.

Community Health Assessment

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

Access to Healthcare

All individuals and families in the ARHS service area have access to equitable, comprehensive care.	Time Period	Current Actual Value	Current Trend	Baseline % Change
NCDPH HNC2030 Uninsured: % of North Carolina population under age 65 without health insurance (Total) - SAHIE	2022	11.2%	↘ 3	-26% ↘
NCDPH HNC2030 Life Expectancy (Total) in North Carolina: Average number of years of life remaining for people who have attained a given age.	2022	76.2	↗ 1	-2% ↘
NCDPH HNC2030 Primary Care Clinicians: Number of NC counties with a (full-time equivalent) "primary care workforce" to "county population" ratio of 1:1,500	2017	62:1	→ 0	0% →

ARHS Primary Care clinic	Time Period	Current Actual Value	Current Trend	Baseline % Change
How Much # of primary care visits at ARHS	2023	987	↗ 2	98% ↗

Healthy Lifestyle Behaviors

All Individuals and families in the ARHS service area live a healthy lifestyle.	Time Period	Current Actual Value	Current Trend	Baseline % Change
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	12% ↗
NCDPH HNC2030 Life Expectancy (Total) in North Carolina: Average number of years of life remaining for people who have attained a given age.	2022	76.2	↗ 1	-2% ↘
NCDPH HNC2030 Infant mortality rate in North Carolina: Rate of Infant Deaths (Total) per 1,000 Live Births	2022	6.8	→ 1	-3% ↘
NCDPH HNC2030 Teen Birth Rate: Number of births in NC per 1,000 population (Total) to females aged 15-19	2023	14.8	↘ 8	-37% ↘

Albemarle GetFit!	Time Period	Current Actual Value	Current Trend	Baseline % Change
How Much Number of individuals enrolled in program	2023	86	↗ 1	87% ↗
How Well % of GetFit! participants self reporting that they engage in at least 150 minutes of fitness each week	2023	38.0%	↗ 1	9% ↗

New Healthy Food Initiatives	Time Period	Current Actual Value	Current Trend	Baseline % Change
How Much Number of individuals reached	2023	422	→ 0	0% →
How Much Numbers of individuals receiving nutrition education	2023	222	→ 0	0% →
How Well % of Individuals that self report they have increased their fruit/vegetable consumption	2023	18.0%	→ 0	0% →

New Faithful Families	Time Period	Current Actual Value	Current Trend	Baseline % Change
How Much Number of individuals enrolled in program	2023	30	→ 0	0% →
How Well % of Individuals that self report they have increased their fruit/vegetable consumption	2023	18.0%	→ 0	0% →

Chronic Disease Prevention and Management	Time Period	Current Actual Value	Current Trend	Baseline % Change
How Well % of individuals receiving chronic disease education who self report positive behavior changes	2023	20%	→ 0	0% →
How Much Number of individuals receiving chronic disease management through support groups	2023	45	↘ 1	-21% ↘
How Much Number of individuals receiving chronic disease prevention education	2023	570	↘ 1	146% ↗

Mental Health/Substance Misuse

All individuals and families in the ARHS service area have wellness and resiliency, free from stigma of mental illness and substance misuse.	Time Period	Current Actual Value	Current Trend	Baseline % Change
NCDPH HNC2030 Percent of Adults Using Tobacco in North Carolina (Total)	2022	21.6%	↗ 1	-10% ↘
NCDPH HNC2030 Percent of High School Youth Using Tobacco in North Carolina (Total)	2019	27.3%	↘ 1	-1% ↘
NCDPH HNC2030 Percent of Middle School Youth Using Tobacco in North Carolina (Total)	2019	10.4%	↘ 2	-10% ↘
NCDPH HNC2030 Drug Overdose Death Rate in North Carolina: Drug Poisoning Deaths (Total) per 100,000 population	2022	42.1	↗ 4	205% ↗
NCDPH HNC2030 Suicide Rate (TOTAL) in North Carolina (per 100,000)	2022	14.4	↗ 1	11% ↗

ARHS Behavioral Health Program	Time Period	Current Actual Value	Current Trend	Baseline % Change
How Much # of behavioral health visits at ARHS	2023	2,426	↗ 1	346% ↗

Tobacco Prevention and Education	Time Period	Current Actual Value	Current Trend	Baseline % Change
How Much # of counties or municipalities that adopt tobacco free policies	2023	1	→ 0	0% →
How Much # of individuals receiving tobacco education	2023	2,130	↗ 2	647% ↗
How Much # of individuals utilizing QuitlineNC	2023	114	↘ 1	-28% ↘
How Much # of media messages provided throughout region	2023	100	↘ 1	-38% ↘

Substance Misuse Awareness and Prevention	Time Period	Current Actual Value	Current Trend	Baseline % Change
How Much # of education outreach activities	2023	74	↘ 1	-21% ↘
How Much # of community partners promoting NENC Connect website	2022	100	→ 0	0% →
How Much # of individuals accessing NENC Connect website	2022	460	↗ 1	130% ↗
How Much # of medication take back events held	2023	3	↗ 1	200% ↗

New Suicide Prevention Training	Time Period	Current Actual Value	Current Trend	Baseline % Change
How Much # of individuals trained in suicide prevention	2023	90	→ 0	0% →
How Well % of individuals trained that self report utilizing skills learned	2023	0	→ 0	0% →

SOTCH REPORTS

2022 SOTCH Report	Time Period	Current Actual Value	Current Trend	Baseline % Change

2023 SOTCH Report	Time Period	Current Actual Value	Current Trend	Baseline % Change

APPENDIX 2 | SECONDARY DATA METHODOLOGY AND SOURCES

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

Methodology

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

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

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

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

These measures are noted with an asterisk.

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

Data Sources

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

Table A2.1: Access to Care

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

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

Table A2.2: Built Environment

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

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

Table A2.4: Diet and Exercise

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

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

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

Table A2.5: Education

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

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

Table A2.6: Employment

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

Table A2.7: Environmental Quality

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

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

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

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

Table A2.9: Food Security

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

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

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

Table A2.10: Housing and Homelessness

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

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

Table A2.11: Income

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

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

Table A2.12: Length of Life

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

Table A2.13: Maternal and Infant Health

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

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

Table A2.14: Mental Health

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

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

Table A2.15: Physical Health

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

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

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

Table A2.16: Quality of Care

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

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

Table A2.17: Safety

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

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

Table A2.18 Sexual Health

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

Table A2.19: Substance Use Disorders

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

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

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

Table A2.20: Tobacco Use

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

Table A2.21: Transportation Options and Transit

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

APPENDIX 3 | SECONDARY DATA COMPARISONS

Description of Focus Area Comparisons

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

Secondary Data Summary Table Color Comparisons

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

(Camden 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:

(1.0-7.5)/(7.5) x 100% = -86.7% = Displayed as **Low Priority Level**, Shaded in Green

This metric indicates that the percentage of the population with limited access to healthy foods in Camden County is 86.7 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 A3.1: Access to Care

Measure	National Benchmark	North Carolina Benchmark	Camden County Data	Most Recent Data Year	Camden County Need
Primary Care Providers Rate	112.4	101.1	19.3	2024	High
Mental Health Providers Rate	178.7	155.7	9.7	2024	High
Addiction/Substance Abuse Providers Rate	27.9	25.0	0.0	2024	High
Buprenorphine Providers Rate	15.5	15.2	0.0	2023	High
Dental Health Providers Rate	39.1	31.5	0.0	2024	High
% Living in Health Professional Shortage Areas (HPSAs) – Dental Care	17.8%	34.0%	99.1%	2018-2022	High
Federally Qualified Health Centers (FQHCs)	3.5	4.1	0.0	2023	High
% Receiving Medicaid	22.3%	20.2%	11.6%	2018-2022	Low
% Uninsured	10.2%	12.5%	12.4%	2022	Medium

Table A3.2: Built Environment

Measure	National Benchmark	North Carolina Benchmark	Camden County Data	Most Recent Data Year	Camden County Need
Broadband Access (Access to DL Speeds >= 25MBPS and UL Speeds >= 3 MBPS)	93.8%	93.6%	79.8%	2023	High
Broadband Access (Access to DL Speeds >= 100MBPS and UL Speeds >= 20 MBPS)	91.2%	90.4%	75.5%	2023	High
Households with No Computer	6.1%	6.9%	5.3%	2018-2022	Low

Measure	National Benchmark	North Carolina Benchmark	Camden County Data	Most Recent Data Year	Camden County Need
Households with No or Slow Internet	11.7%	13.0%	7.1%	2018-2022	Low
Liquor Stores	13.3	6.2	Suppressed	2022	N/A
Adverse Childhood Experiences (ACEs)	N/A	N/A	Suppressed	2022	N/A

Table A3.3: Diet and Exercise

Measure	National Benchmark	North Carolina Benchmark	Camden County Data	Most Recent Data Year	Camden County Need
% Physically Inactive	N/A	21.6%	20.4%	2021	Low
Walkability Index Score	10	7	4	2021	High
% with Access to Exercise Opportunities	84.1%	73.0%	32.0%	2023	High
Recreation and Fitness Facility Access	14.8	13.1	Suppressed	2022	N/A
Sugar-Sweetened Beverage (SSB) Consumption	N/A	N/A	36.8	2022	N/A

Table A3.4: Education

Measure	National Benchmark	North Carolina Benchmark	Camden County Data	Most Recent Data Year	Camden County Need
% Limited English Proficiency	8.2%	4.6%	0.9%	2018-2022	Low
High School Graduation Rate	81.1%	87.6%	92.3%	2020-2021	Low
% with No High School Diploma	10.9%	10.6%	7.7%	2018-2022	Low
Student Math Proficiency	63.9%	65.8%	43.7%	2020-2021	Low
Student Reading Proficiency	60.1%	59.5%	38.3%	2020-2021	Low
School Funding Adequacy	N/A	-$4,742	$1,512	2021	Low
School Funding Adequacy –	N/A	$10,655	$11,025	2021	Medium

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

Table A3.5: Employment

Measure	National Benchmark	North Carolina Benchmark	Camden County Data	Most Recent Data Year	Camden County Need
Unemployment Rate	3.9%	3.7%	2.8%	2024	Low
Average Annual Unemployment Rate, 2013-2023	3.6%	3.5%	3.3%	2024	Low

Table A3.6: Environmental Quality

Measure	National Benchmark	North Carolina Benchmark	Camden County Data	Most Recent Data Year	Camden County Need
Flood Vulnerability	6.5%	4.9%	41.9%	2011	High
Drinking Water Safety	16,107	194	0	2023	Low

Table A3.7: Family, Community and Social Support

Measure	National Benchmark	North Carolina Benchmark	Camden County Data	Most Recent Data Year	Camden County Need
Childcare Cost Burden	28.8%	27.0%	18.0%	2023	Low
% Young People Not in School or Working	6.9%	7.5%	0.0%	2018-2022	Low

Table A3.8: Food Security

Measure	National Benchmark	North Carolina Benchmark	Camden County Data	Most Recent Data Year	Camden County Need
% Food Insecure	10.3%	11.4%	9.4%	2021	Low
% Food Insecure Children	13.3%	15.3%	11.2%	2021	Low
% Low-Income and with Low Food Access	19.4%	21.3%	3.4%	2019	Low
% Limited Access to Healthy Foods	N/A	7.5%	1.1%	2019	Low
Fast Food Restaurants	96.2	77.4	29.0	2022	Low
Grocery Stores	23.4	18.7	Suppressed	2022	N/A

Table A3.9: Housing and Homelessness

Measure	National Benchmark	North Carolina Benchmark	Camden County Data	Most Recent Data Year	Camden County Need
Renter Costs – Average Gross Rent	$1,366	$1,090	$1,018	2018-2022	Low
% Severe Housing Cost Burden	14.1%	12.2%	10.0%	2018-2022	Low
Assisted Housing Units	413.9	319.2	86.9	2017-2021	Low
% Severe Substandard Housing	18.5%	16.1%	14.8%	2011-2015	Low
% Homeless Children	2.8%	1.9%	0.0%	2019-2020	Low

Table A3.10: Income

Measure	National Benchmark	North Carolina Benchmark	Camden County Data	Most Recent Data Year	Camden County Need
Median Family Income	$92,646	$82,890	$88,953	2018-2022	Low
Gender Pay Gap	81.0%	83.0%	80.0%	2018-2022	Medium
% Living Below 100% FPL	12.5%	13.3%	5.9%	2022	Low
% Living Below 200% FPL	28.8%	31.6%	19.2%	2018-2022	Low
% Children Living Below 200% FPL	37.2%	41.1%	20.8%	2018-2022	Low
% Receiving SNAP	12.4%	15.7%	9.1%	2021	Low
Children Eligible for Free/Reduced Price Lunch	51.7%	50.8%	19.0%	2022-2023	Low

Table A3.11: Length of Life

Measure	National Benchmark	North Carolina Benchmark	Camden County Data	Most Recent Data Year	Camden County Need
Years of Potential Life Lost Rate	N/A	8,853	7,555	2019-2021	Low
Premature Age-Adjusted Mortality	N/A	420	365	2019-2021	Low
Life Expectancy	77.6	76.6	77.6	2019-2021	Medium

Table A3.12: Maternal and Infant Health

Measure	National Benchmark	North Carolina Benchmark	Camden County Data	Most Recent Data Year	Camden County Need
Births with Late or No Prenatal Care	6.1%	6.9%	Suppressed	2019	N/A
Low Birthweight	N/A	9.4%	8.5%	2016-2022	Low
Infant Mortality Rate	5.7	7.0	Suppressed	2015-2021	N/A

Table A3.13: Mental Health

Measure	National Benchmark	North Carolina Benchmark	Camden County Data	Most Recent Data Year	Camden County Need
Poor Mental Health Days	4.9	4.6	4.8	2021	Medium
Deaths of Despair Rate	55.9	58.7	56.9	2018-2022	Medium
Suicide Death Rate	14.5	14.0	N/A	2018-2022	N/A

Table A3.14: Physical Health

Measure	National Benchmark	North Carolina Benchmark	Camden County Data	Most Recent Data Year	Camden County Need
% Poor or Fair Health	N/A	14.4%	13.2%	2021	Low
% Adults with Asthma	9.7%	9.8%	9.5%	2022	Medium
% Adults with Heart Disease	5.2%	5.5%	5.3%	2022	Medium
% Adults with High Blood Pressure	29.6%	32.1%	30.3%	2021	Low
% Adults with High Cholesterol	31.0%	31.4%	30.5%	2021	Medium
Diabetes Prevalence	8.9%	9.0%	7.3%	2021	Low
% Adults with Kidney Disease	2.7%	2.9%	2.7%	2021	Low
% Stroke	2.8%	3.1%	2.8%	2022	Low
Obesity	30.1%	29.7%	17.7%	2021	Low
% Teeth Loss	13.9%	12.0%	12.0%	2022	Medium
Cancer Incidence Rate	442.3	464.4	343.1	2016-2020	Low
Emergency Room Visits	535	563	616	2022	High

Measure	National Benchmark	North Carolina Benchmark	Camden County Data	Most Recent Data Year	Camden County Need
Heart Disease Hospitalization Rate	10.4	11.7	16.5	2018-2020	High
Stroke Hospitalization Rate	8.0	9.5	10.3	2018-2020	High

Table A3.15: Quality of Care

Measure	National Benchmark	North Carolina Benchmark	Camden County Data	Most Recent Data Year	Camden County Need
Children/adults vaccinated annually against seasonal influenza	44.5%	45.6%	44.6%	2021	Medium
Preventable Hospital Rate	2,752	2,957	3,499	2021	High
Readmissions Rate	18.1%	17.6%	18.1%	2022	Medium

Table A3.16: Safety

Measure	National Benchmark	North Carolina Benchmark	Camden County Data	Most Recent Data Year	Camden County Need
Incarceration Rate	1.3%	1.5%	1.0%	2018	Low
Juvenile Arrest Rate	13.8	16.0	N/A	2021	N/A
Violent Crime	416.0	365.7	54.5	2015-2017	Low
Firearm Death Rate	13.4	15.5	N/A	2018-2022	N/A
Poisoning Death Rate	28.5	31.5	N/A	2018-2022	N/A

Table A3.17: Sexual Health

Measure	National Benchmark	North Carolina Benchmark	Camden County Data	Most Recent Data Year	Camden County Need
Chlamydia Rate	495.0	603.3	276.9	2021	Low
HIV Incidence Rate	12.7	15.5	Suppressed	2022	N/A
Teen Births	16.6	18.2	N/A	2016-2022	N/A

Table A3.18: Substance Use Disorders

Measure	National Benchmark	North Carolina Benchmark	Camden County Data	Most Recent Data Year	Camden County Need
% Excessive Drinking	18.1%	18.2%	19.0%	2021	Medium
% Driving Deaths with Alcohol	2.3	2.9	0.0	2018-2022	Low
Opioid Use Disorder Rate	41.0	43.0	25.0	2021	Low
Opioid Drug Overdose Deaths	N/A	25.1	N/A	2018-2022	N/A

Table A3.19: Tobacco Use

Measure	National Benchmark	North Carolina Benchmark	Camden County Data	Most Recent Data Year	Camden County Need
% Smokers	14.5%	15.0%	15.9%	2021	High

Table A3.20: Transportation Options and Transit

Measure	National Benchmark	North Carolina Benchmark	Camden County Data	Most Recent Data Year	Camden County Need
% Households with No Motor Vehicle	8.3%	5.4%	1.3%	2018-2022	Low
% Public Transit	3.8%	0.8%	0.3%	2018-2022	High
% Living Near Public Transit	34.8%	10.9%	0.0%	2021	High

APPENDIX 4 | PRIMARY DATA METHODOLOGY AND SOURCES

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

Methodologies

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

Focus Groups

One focus group was conducted in person on June 5th, 2024. This group included multiple community members who provided responses on health and social needs as well as their experiences living, working or receiving healthcare in Camden County.

- Ebenezer Baptist Church

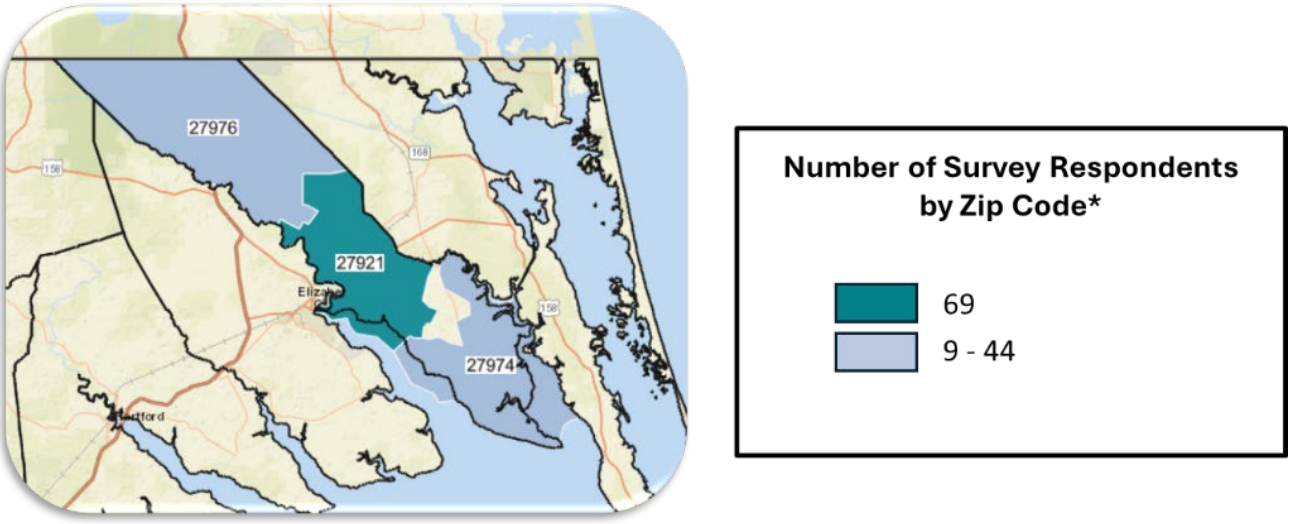
Input was gathered on the following topics:

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

Community Member Web Survey

A total of 131 surveys were completed by individuals living, working or receiving healthcare in the Camden County community. The survey was available in both English and Spanish, and approximately 11% were completed in Spanish. Consistent with one of the survey process goals, survey community member respondents were representative of a broad geographic area encompassing areas throughout the county. The map below provides additional information on survey respondents' ZIP code of residence.

Figure A4.1: Respondent Zip Code of Residence[43]



In general, survey questions focused on:

- Community health problems and concerns
- Community social/environmental problems and concerns
- Specific topics of interest to Camden County:
    - Access to care
    - Healthy lifestyle (Diet and Exercise)
    - Housing and homelessness
    - Mental health
    - Physical health
    - Substance use disorders
    - Transportation and transit

The key findings from the Community Survey are detailed below.

- Mental health, diabetes/high blood sugar, and alcohol/drug addiction were identified as the top three health problems affecting the community. Over one-third of respondents also identified heart disease/high blood pressure as a significant health problem in the community.
- Cost, insurance, and wait times were the top three barriers to receiving health care identified by the community.
- Availability/access to doctor's offices, lack of job opportunities, and availability/access to insurance were identified as the top three most important social or environmental problems that affect the

[43] Zip codes with fewer than 5 respondents were not displayed for privacy reasons

health of the community. About one in five respondents also identified transportation issues as a significant problem.

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

Figure A4.2: Respondents by Gender

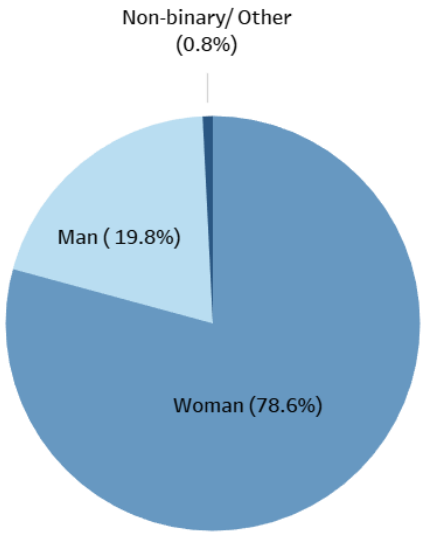


Figure A4.3: Respondents by Age

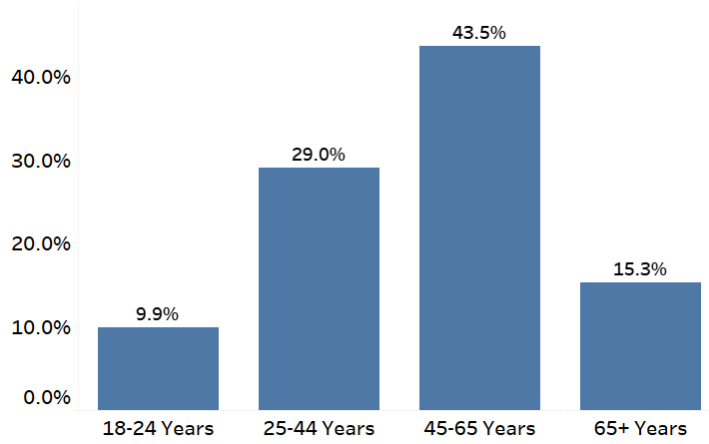


Figure A4.4: Respondents by Race

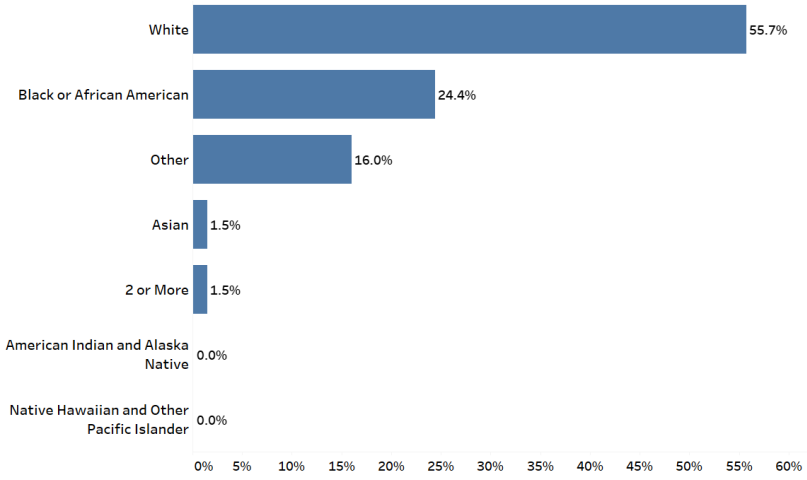
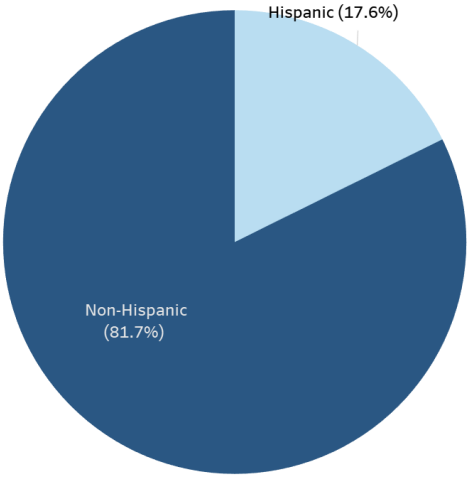


Figure A4.5: Respondents by Ethnicity



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?[44]

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

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

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

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

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

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

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

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

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

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

Topic: Community Health Opinion Questions

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

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

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

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

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

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

Topic: Access to Care

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

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

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

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

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

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

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

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

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

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

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

	1	2	3	4	5	Don't know	Prefer not to say
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: Diet & Exercise

19. Think about the food you ate during the past week. On average, how many servings of fruit did you eat, not including juices? (For example, one serving equals a medium apple, a small banana, or 7 strawberries.)

□ Number of servings: _____

20. On average, how many servings of vegetables did you eat, not including potatoes? (For example, one serving equals 6 baby carrots, small bell pepper, or half of a large squash or zucchini.)

□ Number of servings: _____

21. About how many cans, bottles, or glasses of sugar-sweetened beverages, such as regular sodas, sugar sweetened tea, or energy drinks, do you drink each day?

□ Number of drinks: _____

22. During the past month, approximately how much time (in hours) per week were you physically active outside of your regular job?

□ Number of hours: _____

23. When you are active, where do you engage in exercise or physical activities? *Select all that apply:*

□ Beach
□ Home
□ Malls
□ Neighborhood
□ Private gym/pool
□ Public recreation center
□ Outdoor parks or trails
□ Work
□ Other (please specify): _____
□ I don't exercise
□ Don't know
□ Prefer not to answer

Topic: Housing and Homelessness

24. In the past 12 months, were there times when you:

	Yes	No	Don't Know	Prefer not to say
a. Were worried about having enough money to pay your rent or mortgage?	□	□	□	□
b. Did not have electricity, water, or heating in your home?	□	□	□	□

25. In the PAST THREE YEARS, were there times when you:

	Yes	No	Don't Know	Prefer not to say
a. Had to live with a friend or relative because of a housing emergency, even if this was only temporary?	□	□	□	□
b. Were evicted or displaced from your home?	□	□	□	□
c. Were living on the street, in a car, or in a temporary shelter?	□	□	□	□

26. Think about the place where you live. Do you have problems with any of the following? *Select all that apply:*

□ Bug infestation
□ Mold
□ Lead paint or pipes
□ Inadequate heat
□ Inadequate cooling (air conditioning)
□ Holes in the floor
□ Oven or stove not working
□ No or not working smoke detector
□ Water leaks
□ None of the above
□ Prefer not to say

Topic: Mental Health

27. 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: _____

28. 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

29. 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

30. 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

31. 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

32. 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?	□	□	□	□

33. 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

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

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

Topic: Substance Use Disorders

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?

□ Number of drinks: _____

36. 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

37. 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

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

Topic: Transportation and Transit

39. In a typical week, what kinds of transportation do you use the most? *Select all that apply:*

□ Car
□ Bus
□ Walk
□ Taxi, Uber, or Lyft
□ Ride with someone
□ Bike
□ Motorcycle
□ Paying for rides from family or friends
□ Other, please specify: _____
□ Prefer not to say

40. In the past 12 months has lack of transportation kept you from medical appointments, meetings, work, or getting things for daily living? *Select all that apply:*

□ Yes, it has kept me from medical appointments or getting medications
□ Yes, it has kept me from non-medical meetings, appointments, work, or getting things that I need
□ No
□ Prefer not to say

41. Do you put off or neglect going to the doctor because of distance or transportation?

□ Yes
□ No
□ 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 Summary

As part of the 2024 CHNA process, Camden County hosted one focus group at the Ebenezer Baptist Church to find out more about issues directly impacting community members. This focus group identified several key health and social/environmental issues preventing Camden County residents from living healthier lives. The participants described concerned related to the built environment, specifically a need for more places to exercise; community safety, particularly around domestic violence; food access and security, including the high cost and lack of availability of healthy foods; healthcare access and quality (e.g., high cost of care, insurance issues, and overwhelmed providers); housing and homelessness, specifically a need for more HUD-assisted housing units; substance use in the community; and transportation and transit (i.e., lack of transportation creating barriers to healthcare, healthy food, and employment).

Participants in the group noted a few strengths in the community including community gardens and neighbors sharing resources. Some suggestions for improving the health of the community included adding more senior centers and greater availability of health screening programs for adults.

Community Member Web Survey

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

Topic: Additional Demographic Information

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

(N=131)

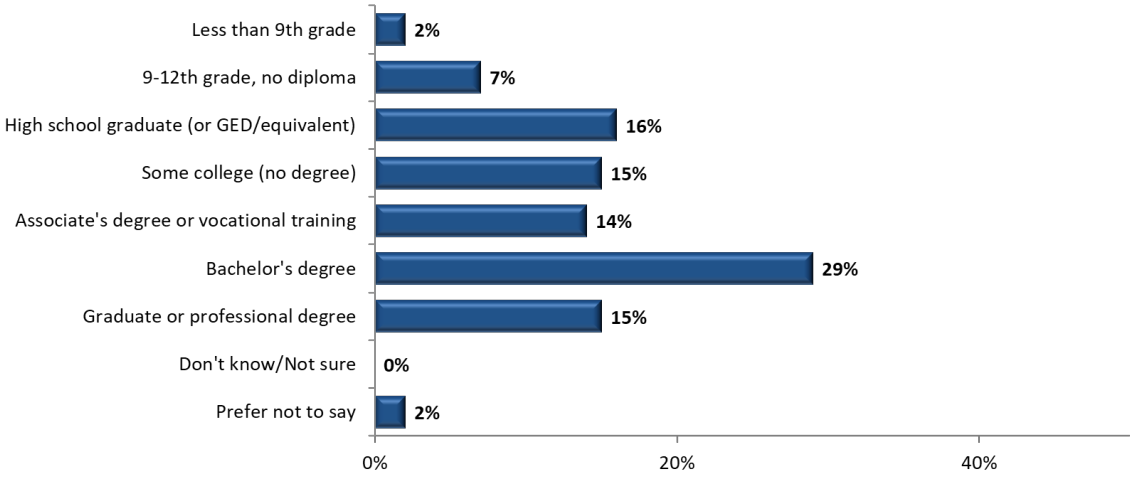


Figure A5.2: Which language is most often spoken in your home? (Choose one)
(N=131)

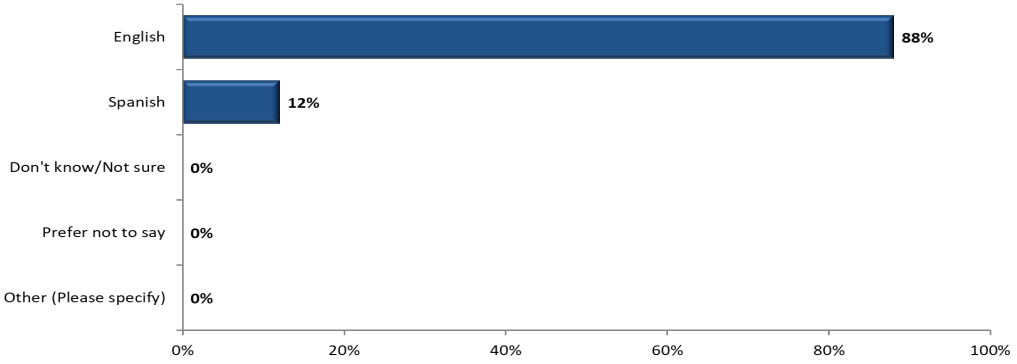


Figure A5.3: For employment, are you currently... (Select all that apply.)

(N=130)

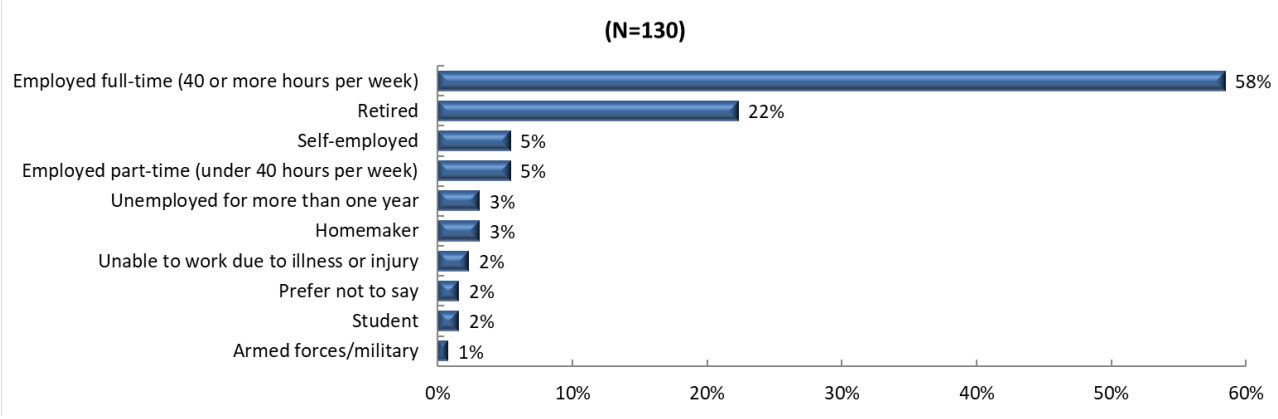
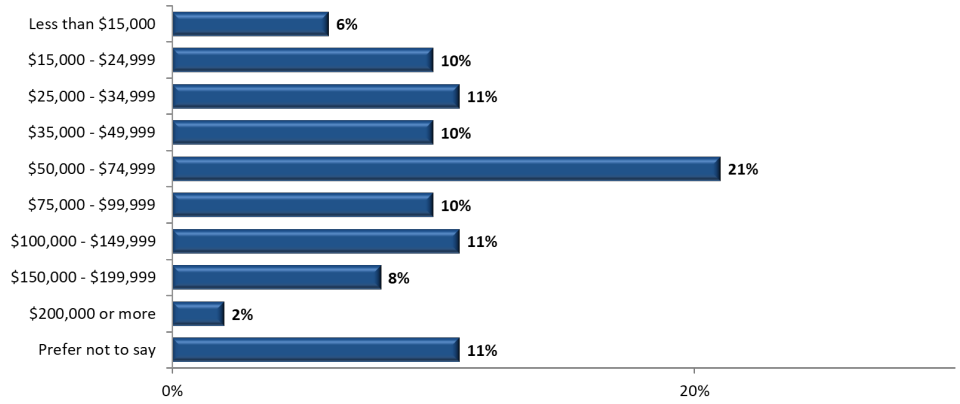


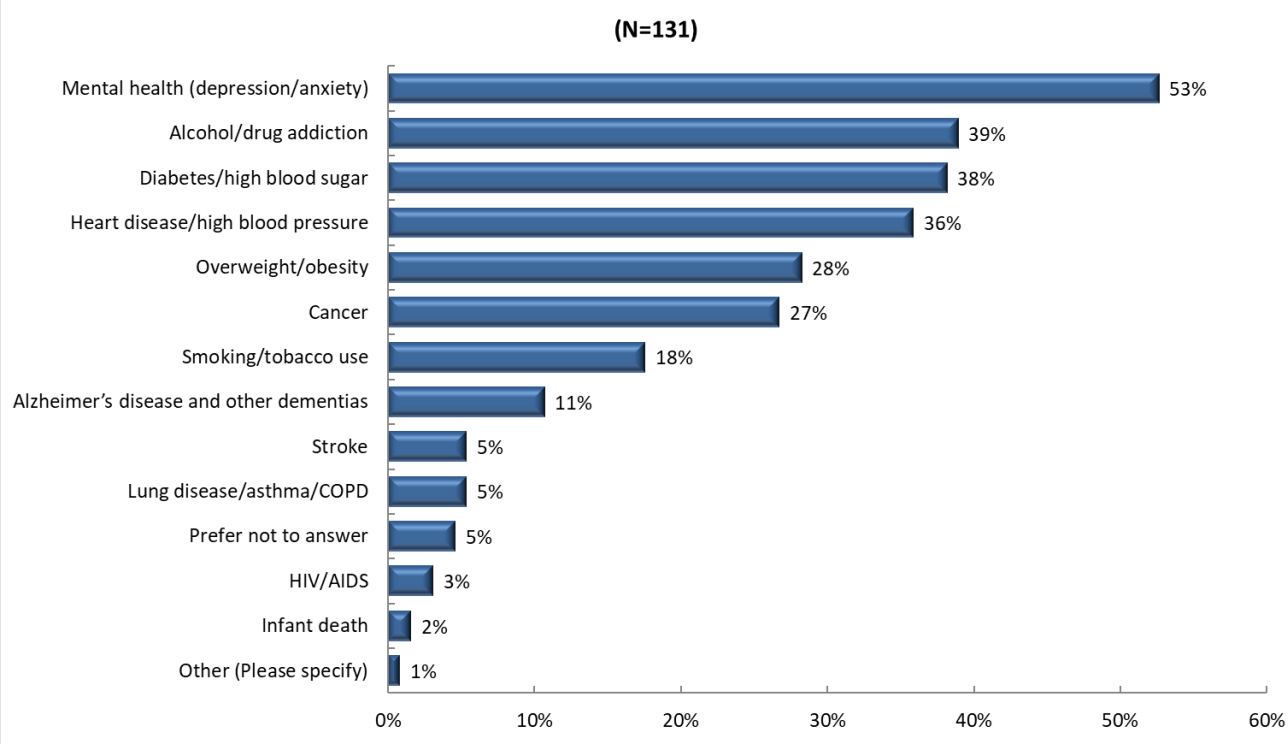
Figure A5.4: Which category best describes your yearly household income before taxes?

(N=131)



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

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



Other (please specify):

- "Opioids"

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

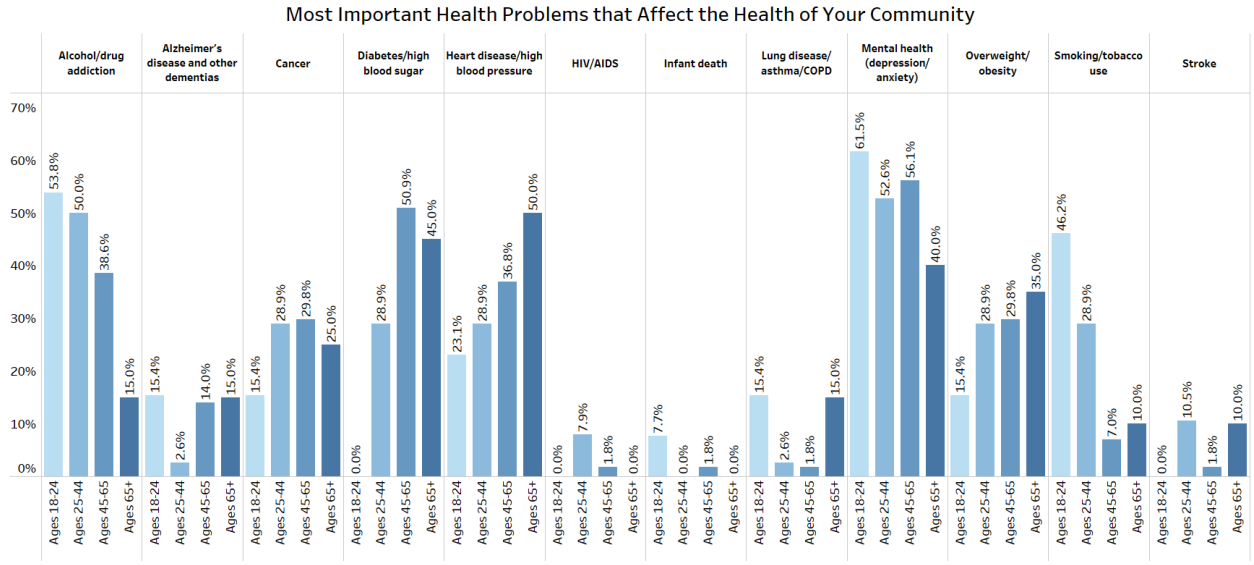


Figure A5.7: What are the three most important health problems that affect the health of your community? Please select up to three. (by gender)

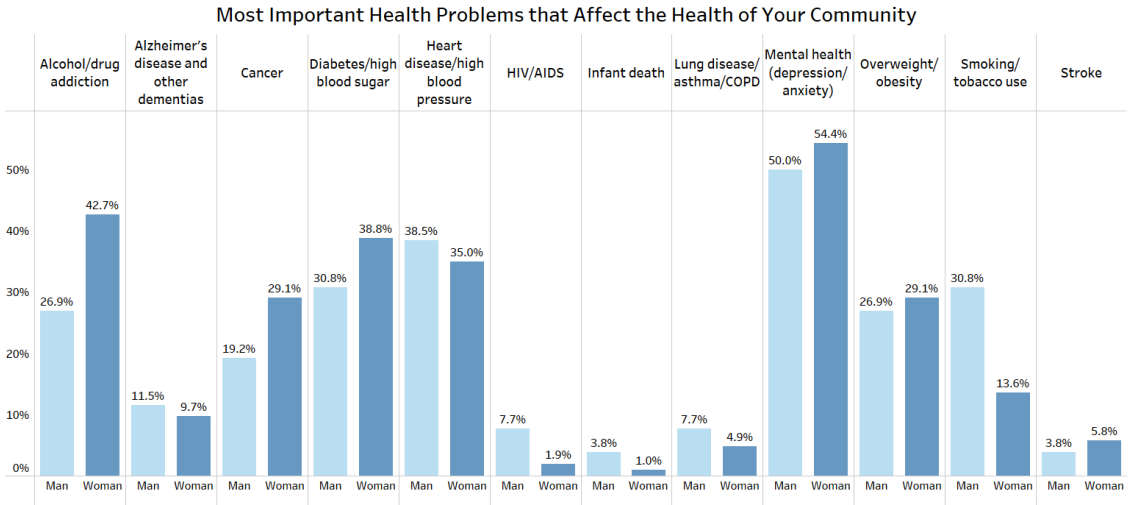


Figure A5.8: What are the three most important health problems that affect the health of your community? Please select up to three. (by race)

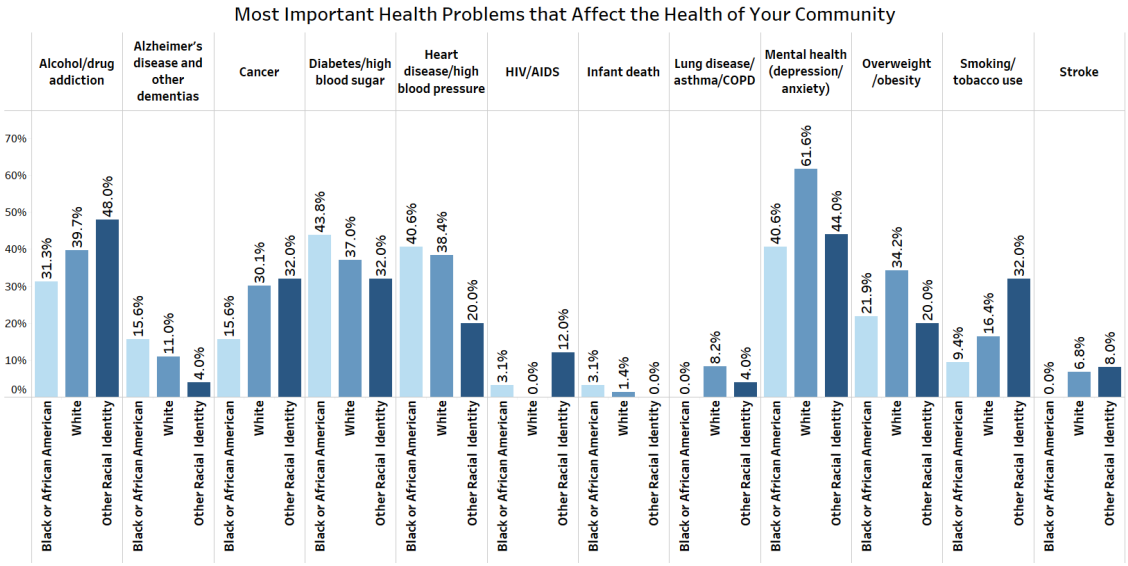


Figure A5.9: What are the three most important health problems that affect the health of your community? Please select up to three. (by ethnicity)

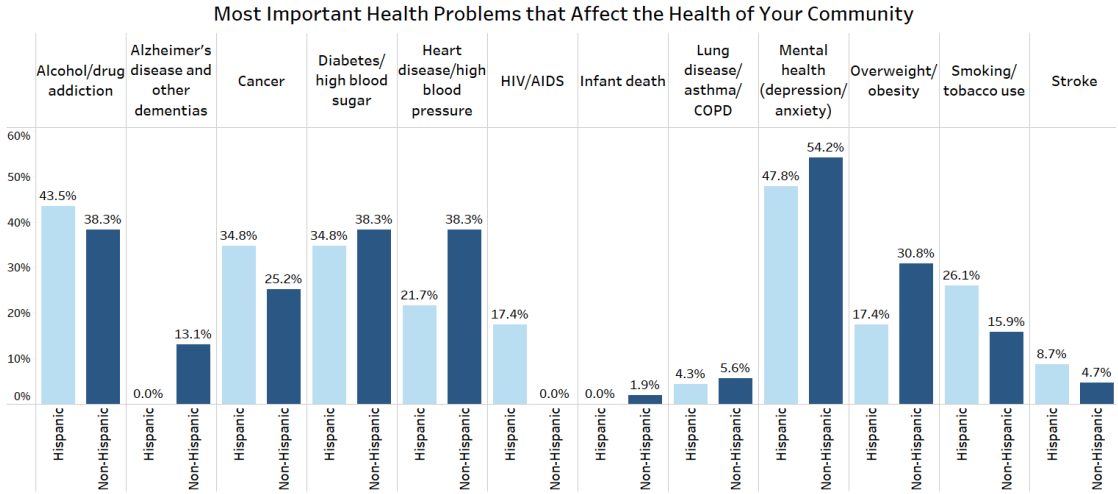
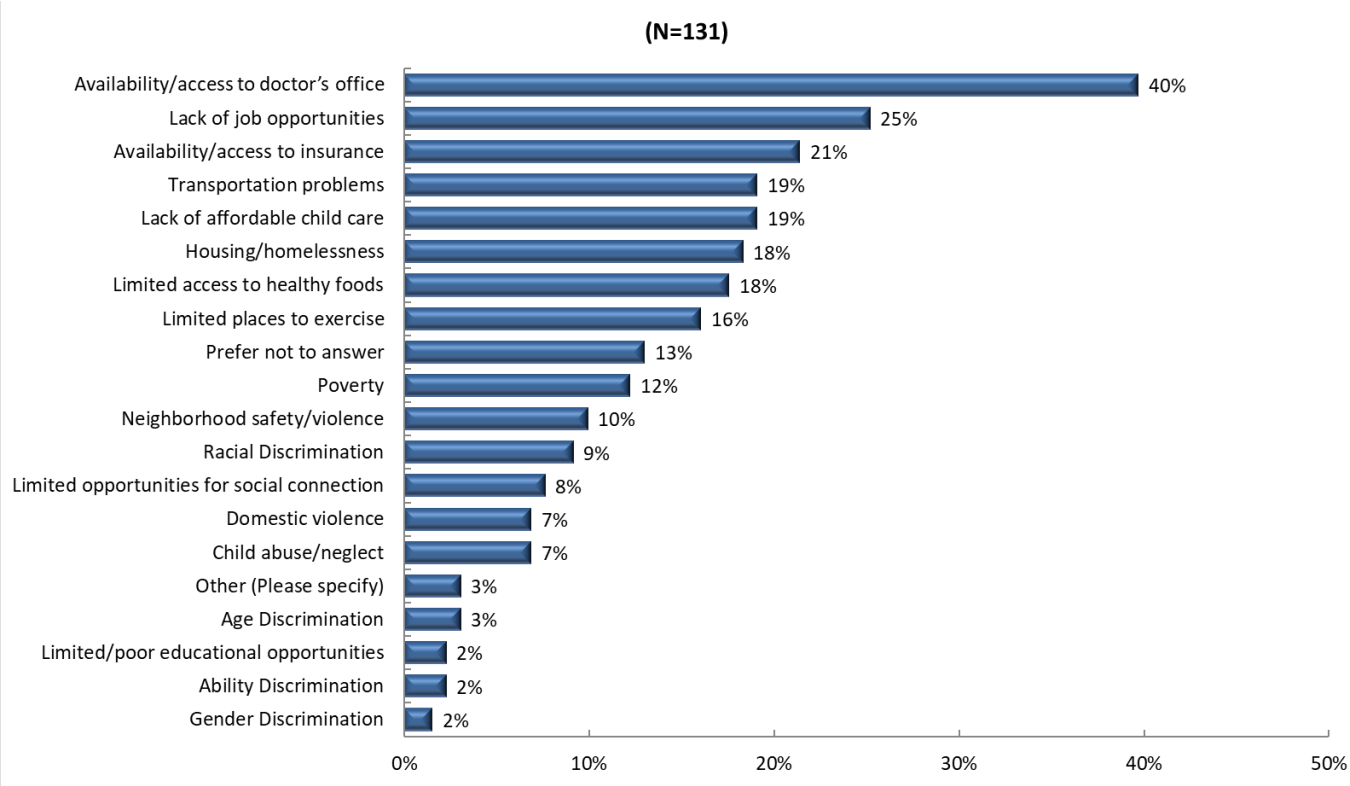


Figure A5.10: What are the three most important social or environmental problems that affect the health of your community? Please select up to three.



Other (please specify):

- "Not enough resources"
- "Opioids addiction"

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

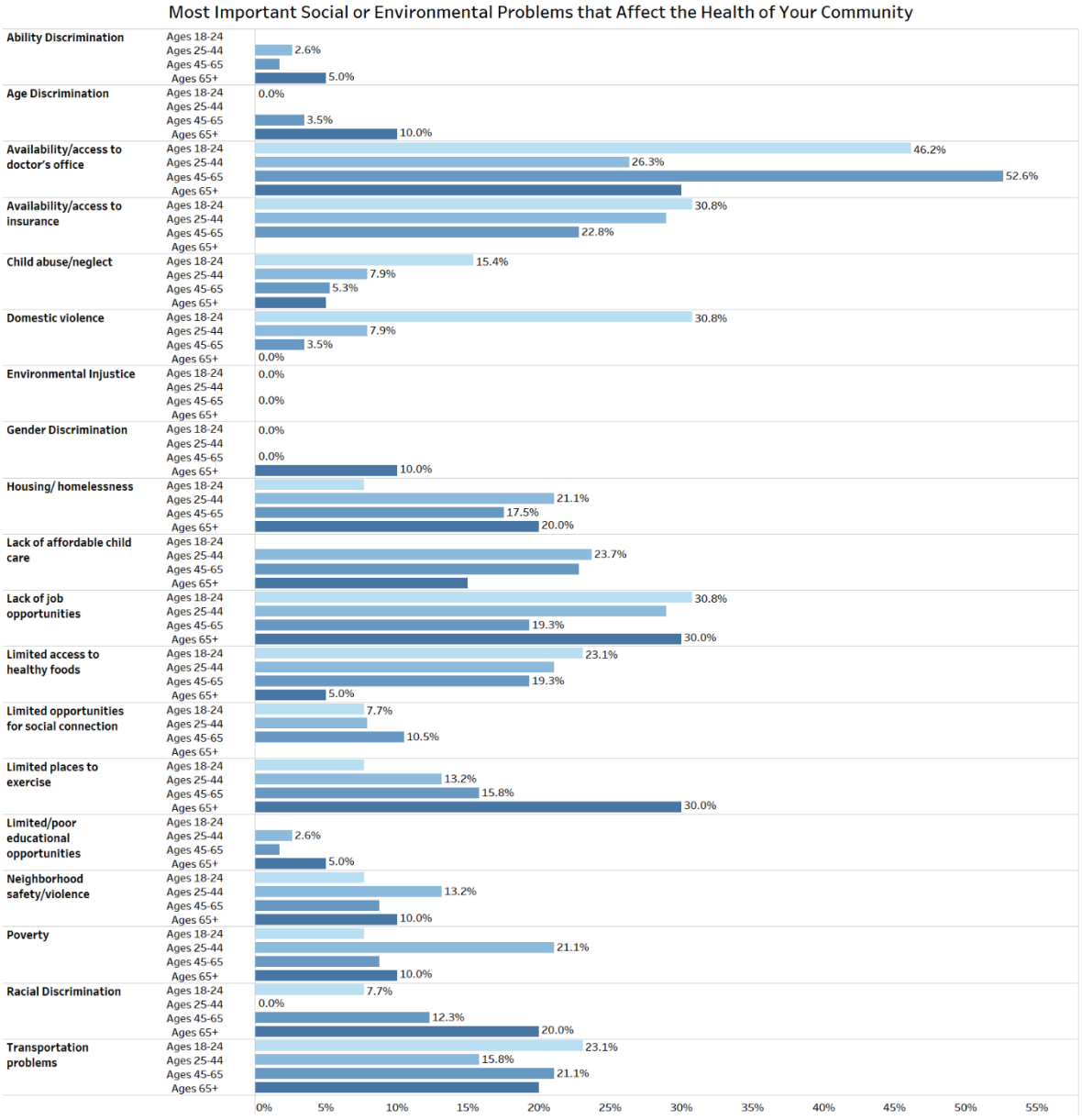


Figure A5.12: What are the three most important social or environmental problems that affect the health of your community? Please select up to three. (by gender)

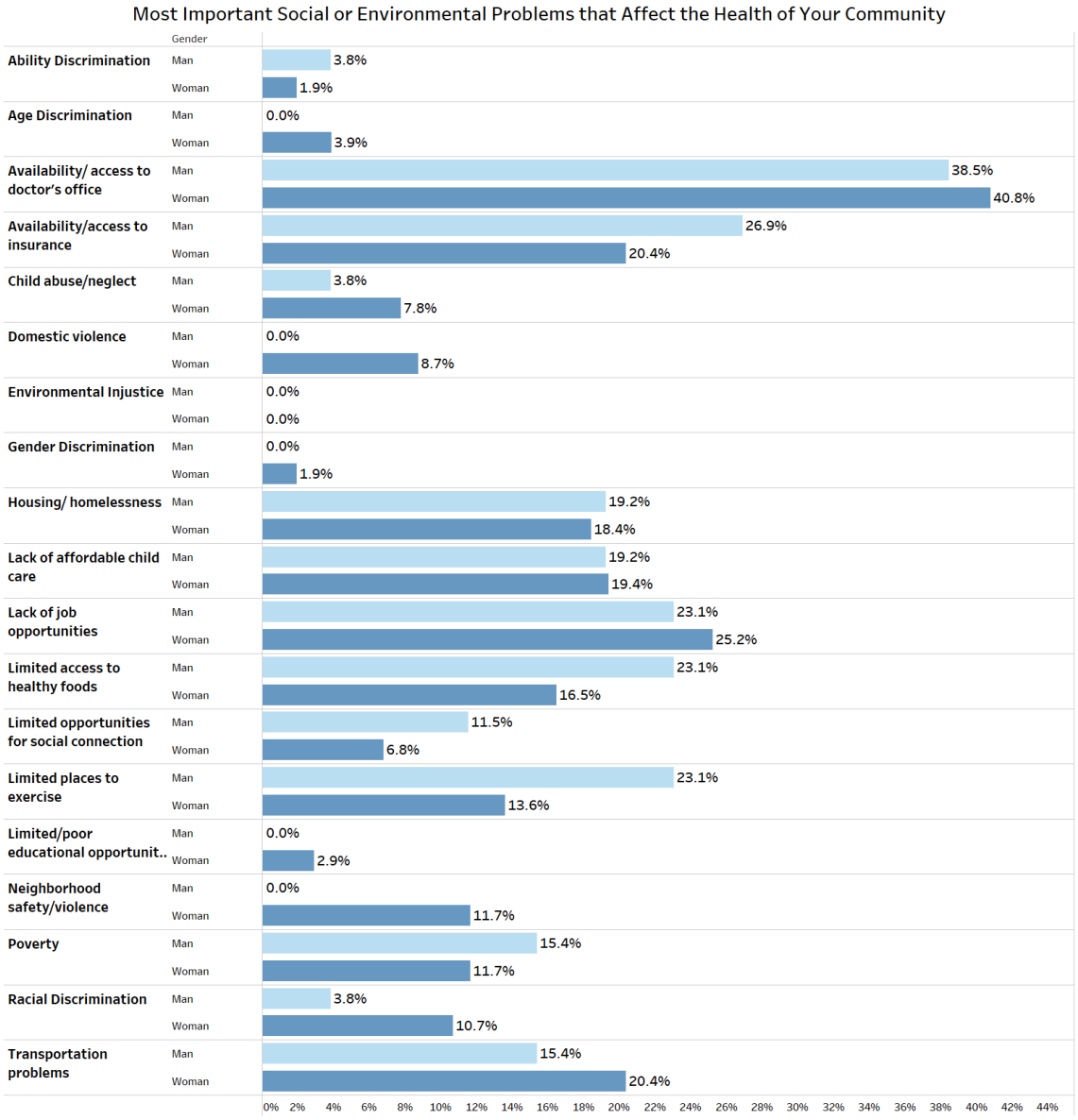


Figure A5.13: What are the three most important social or environmental problems that affect the health of your community? Please select up to three. (by race)

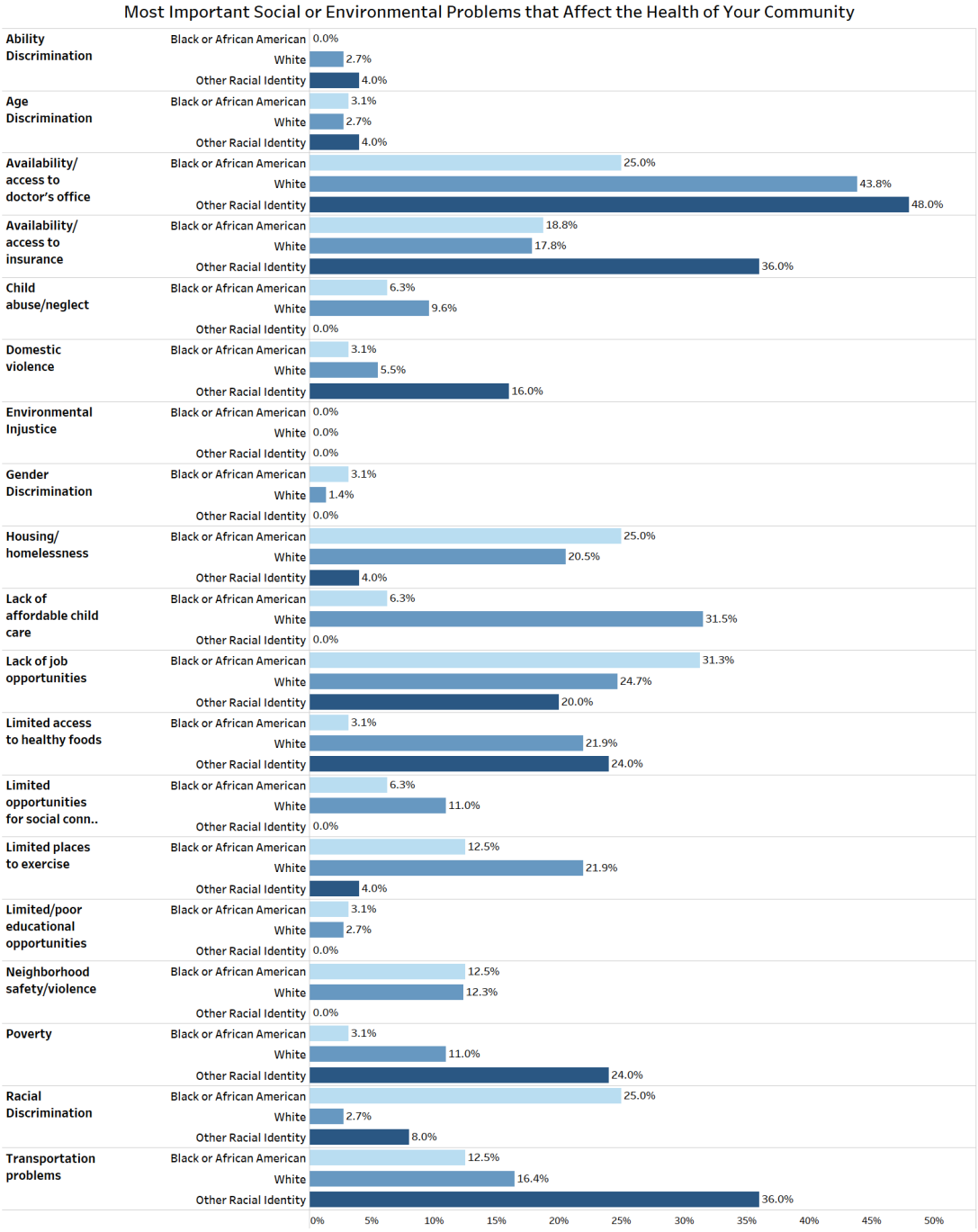


Figure A5.14: What are the three most important social or environmental problems that affect the health of your community? Please select up to three. (by ethnicity)

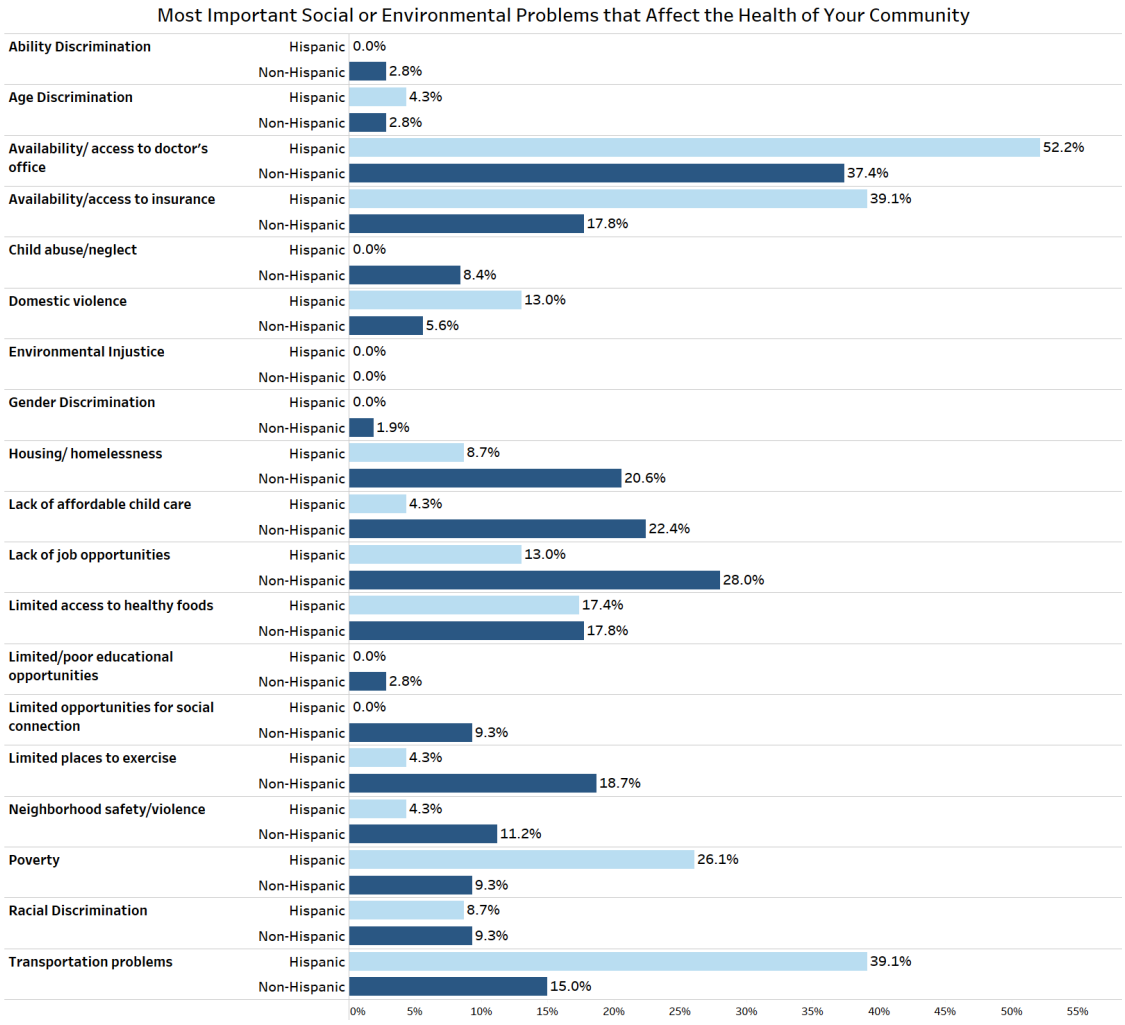
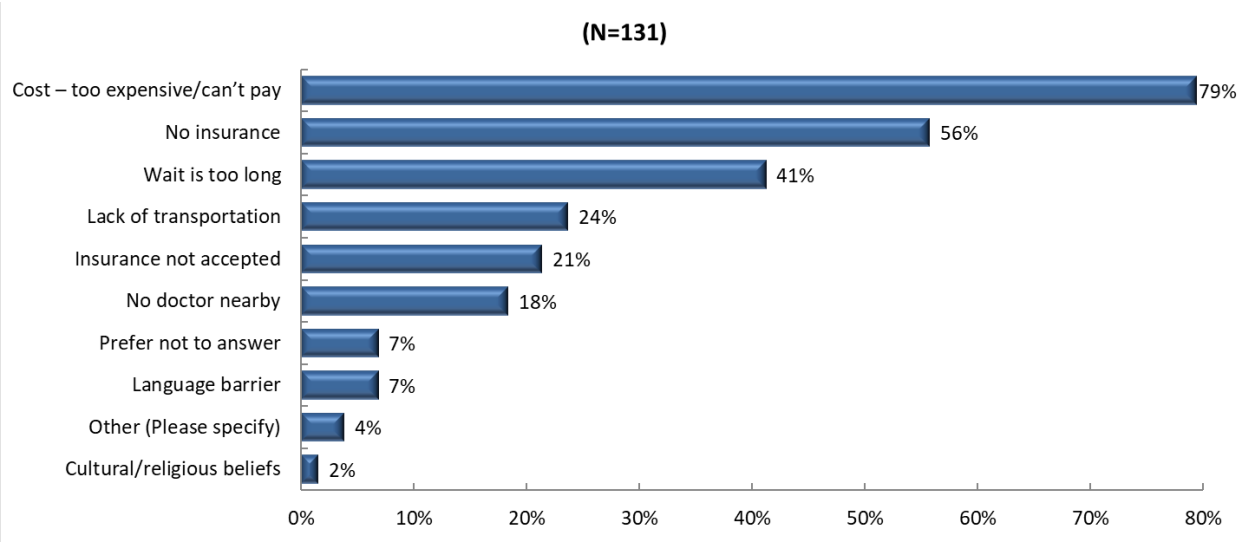


Figure A5.15: What are the three most important reasons people in your community do not get health care when they need it? Please select up to three.



Other (please specify):

- "Fear of not being heard"
- "Missed work"
- "Not enough providers in the area"
- "Procrastination"

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

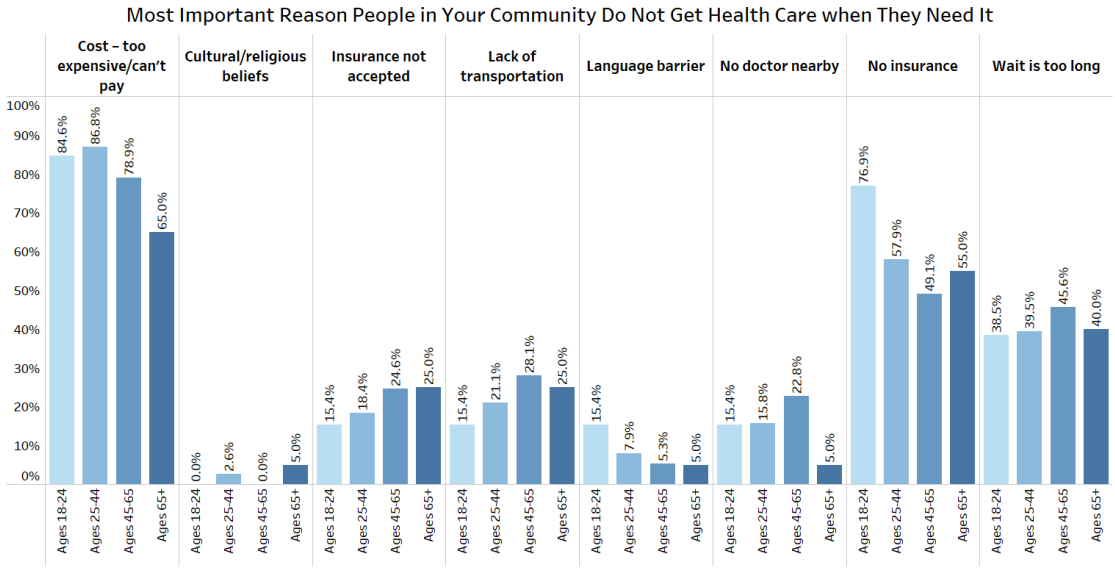


Figure A5.17: What are the three most important reasons people in your community do not get health care when they need it? Please select up to three. (by gender)

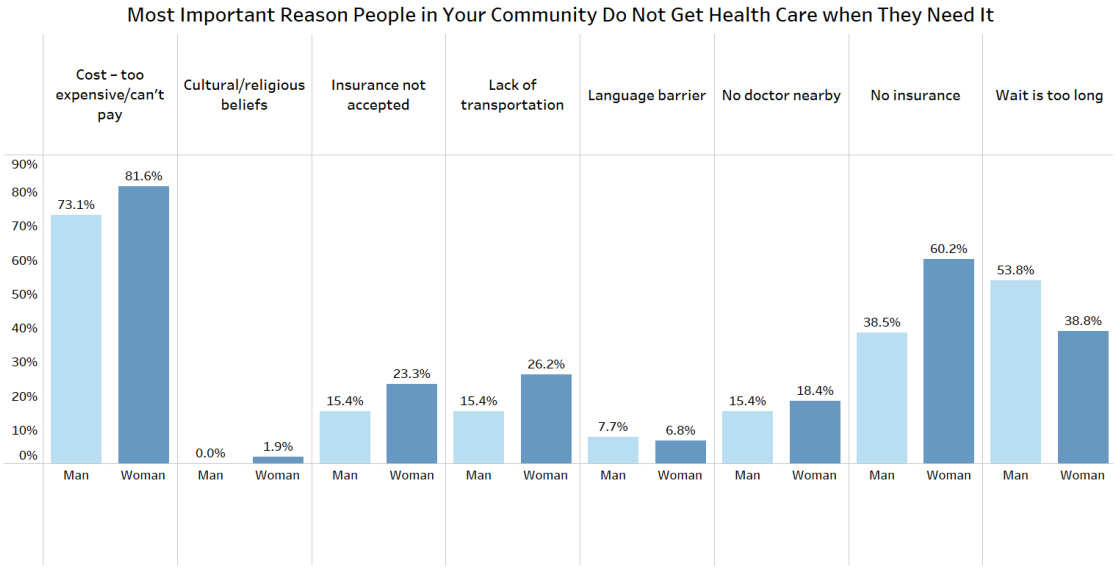


Figure A5.18: What are the three most important reasons people in your community do not get health care when they need it? Please select up to three. (by race)

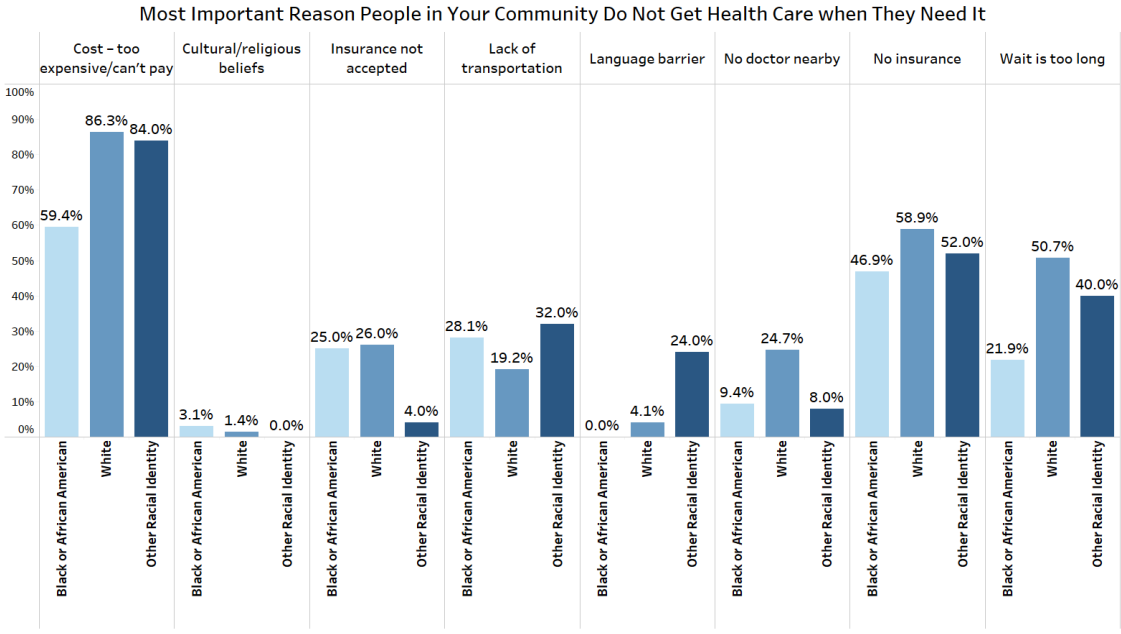
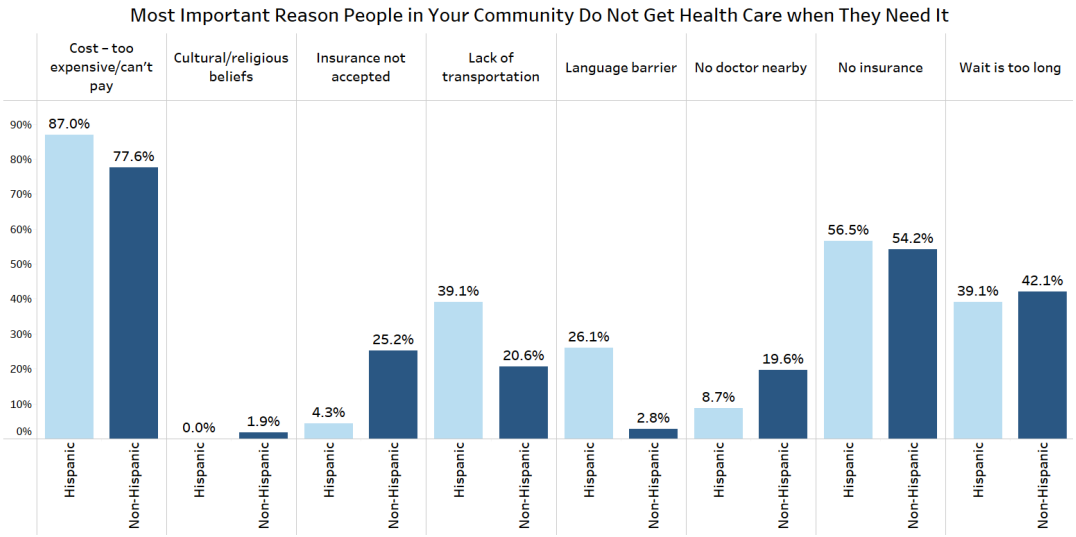


Figure A5.19: What are the three most important reasons people in your community do not get health care when they need it? Please select up to three. (by ethnicity)



Topic: Access to Care

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

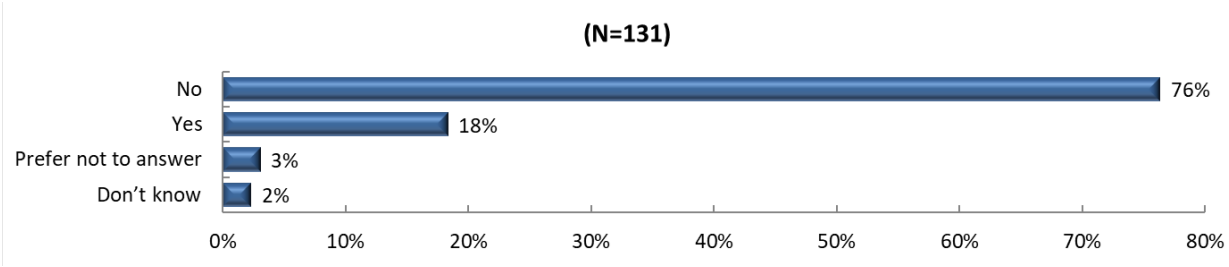
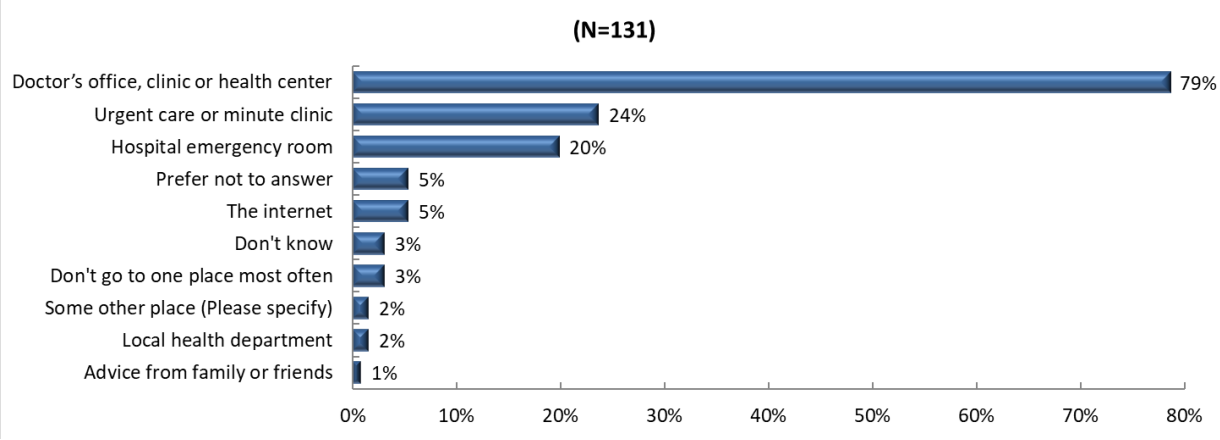


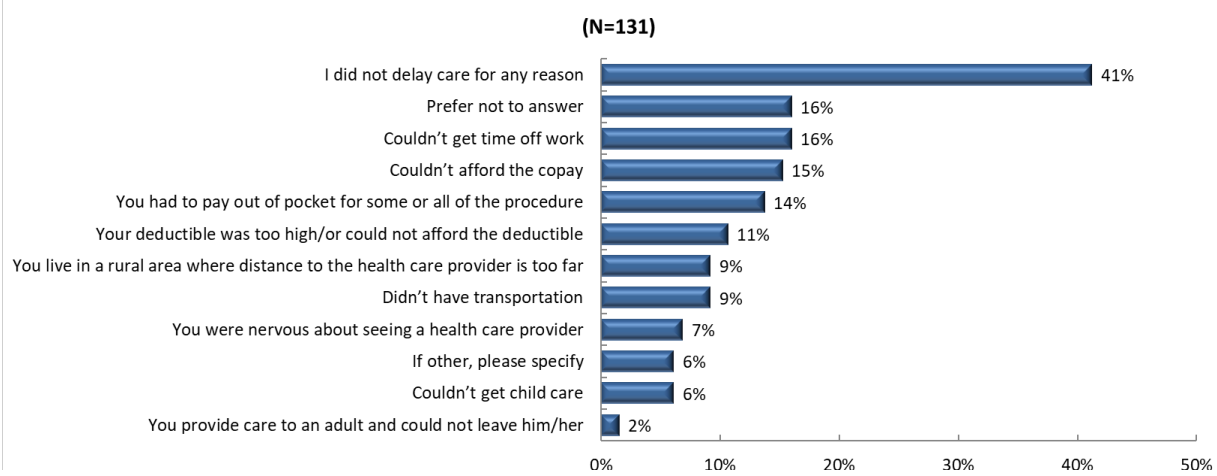
Figure A5.21: Where do you USUALLY go when you are sick or need advice about your health?



Other (Please specify)

- "Telehealth" / "MD Live"

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



Other (please specify):

- "Age discrimination - was treated as irreverent and not listened to"
- "Insurance denied 3 times for heart problems"
- "Long wait for specialist in Virginia"
- "Lost faith in medical field"
- "Not taking new patients"

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

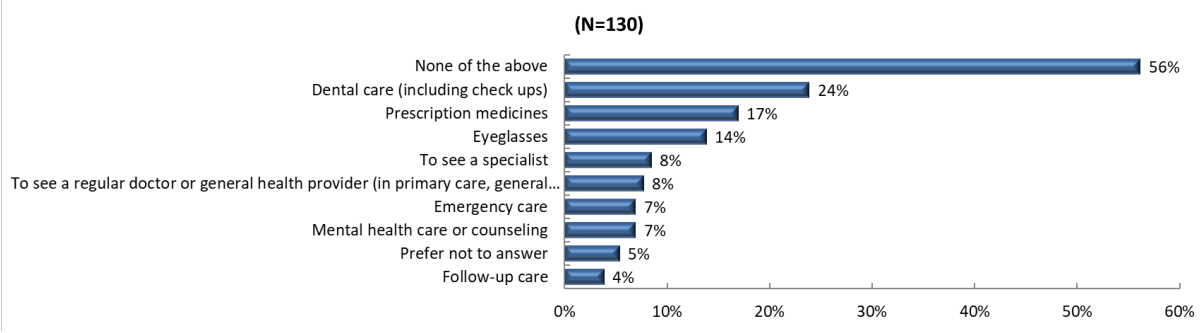


Figure A5.24: If you get sick or have an accident, how worried are you that you will be able to pay your medical bills?

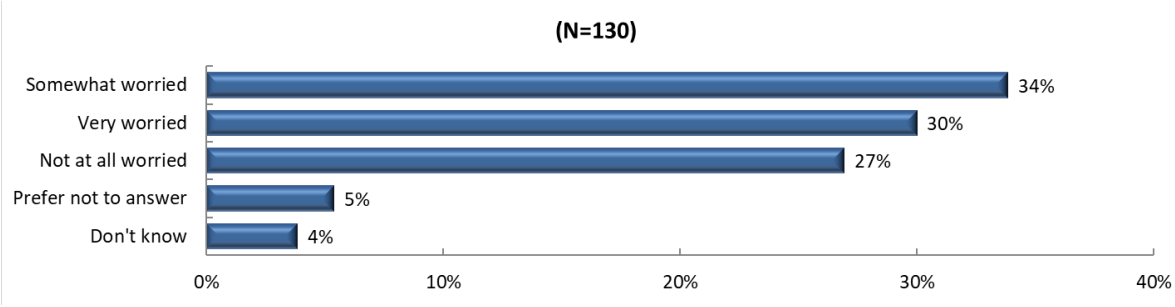
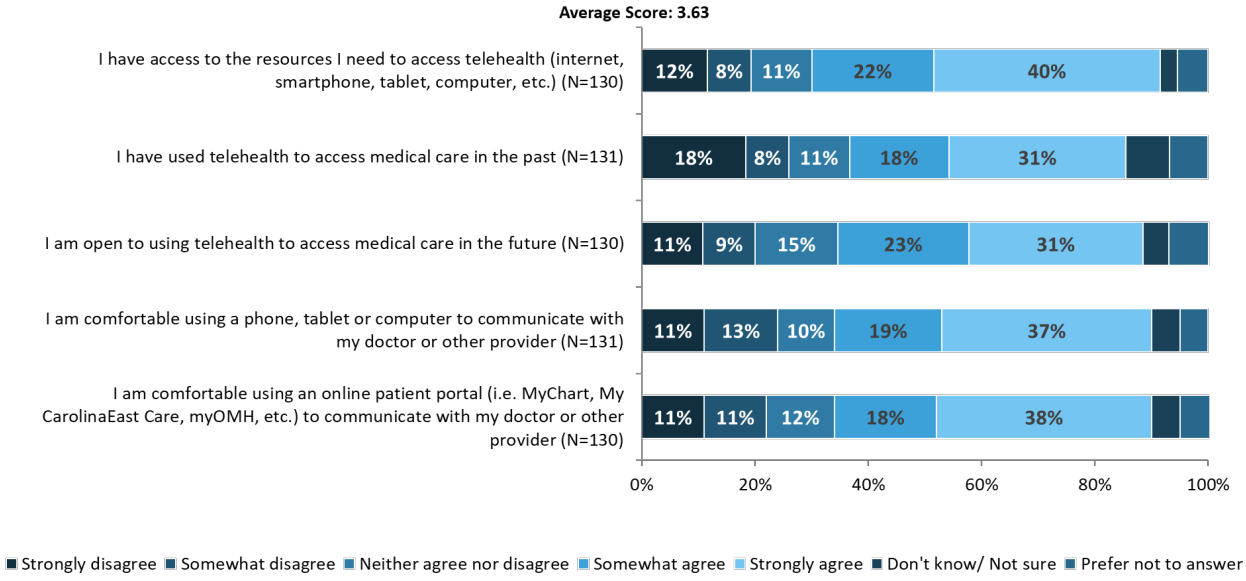


Figure A5.25: How much do you agree or disagree with the following statements about telehealth? Telehealth means connecting virtually with a medical provider using a smartphone, tablet or computer.

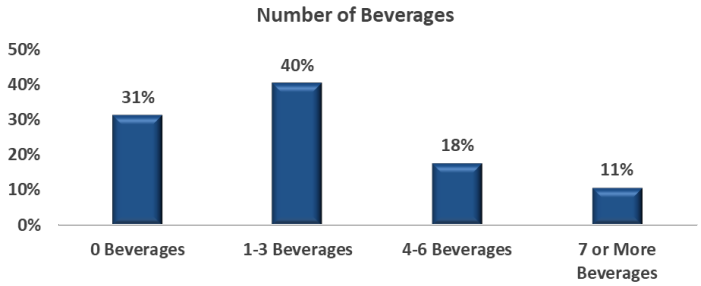
Scale from 1 to 5 with 1 being "strongly disagree" and 5 being "strongly agree"



Topic: Healthy Lifestyle (Diet and Exercise)

Figure A5.26: Think about the food you ate during the past week. On average, how many servings of fruit did you eat, not including juices? (For example, one serving equals a medium apple, a small banana, or 7 strawberries)

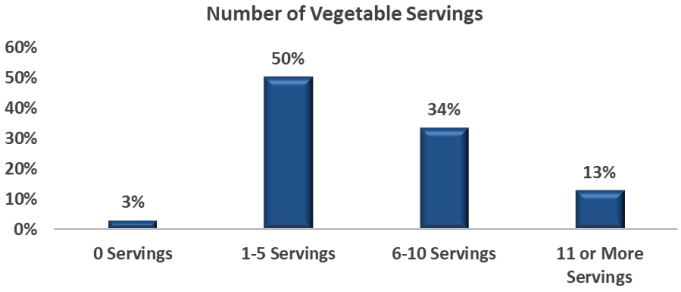
(N=131)



Measure	Value
Mean (Standard Deviation)	2 (3)
Median	2
Mode	0
Minimum-Maximum	0-12

Figure A5.27: Think about the food you ate during the past week. On average, how many servings of vegetables did you eat, not including potatoes? (For example, one serving equals 6 baby carrots, small bell pepper, or half of a large squash or zucchini)

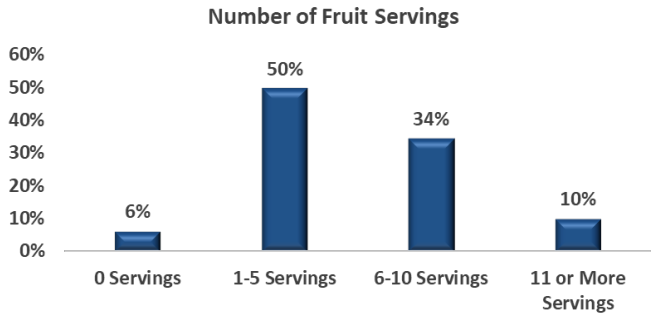
(N=131)



Measure	Value
Mean (Standard Deviation)	6 (6)
Median	5
Mode	3
Minimum-Maximum	0-42

Figure A5.28: About how many cans, bottles, or glasses of sugar-sweetened beverages, such as regular sodas, sugar-sweetened tea, or energy drinks, do you drink each day?

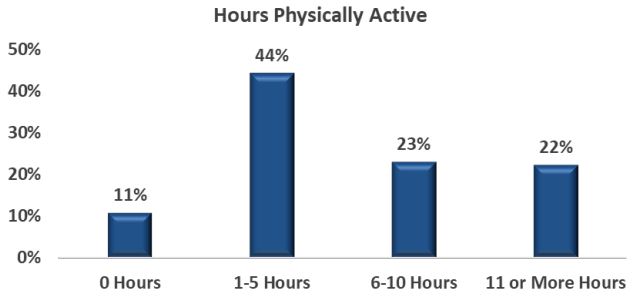
(N=131)



Measure	Value
Mean (Standard Deviation)	6 (5)
Median	5
Mode	3
Minimum-Maximum	0-25

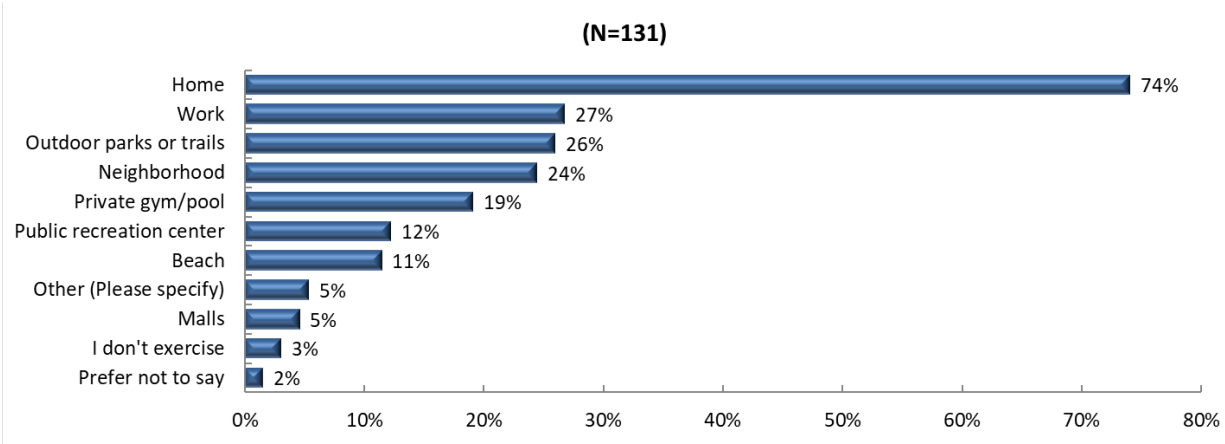
Figure A5.29: During the past month, approximately how much time (in hours) per week were you physically active outside of your regular job?

(N=131)



Measure	Value
Mean (Standard Deviation)	10 (15)
Median	5
Mode	2
Minimum-Maximum	0-100

Figure A5.30: When you are active, where do you engage in exercise or physical activities? (Select all that apply.)



Other (please specify):

- "House cleaning"
- "University track"
- "Walking"
- "Yard"

Topic: Housing and Homelessness

Figure A5.31: In the past 12 months, were there times when you:

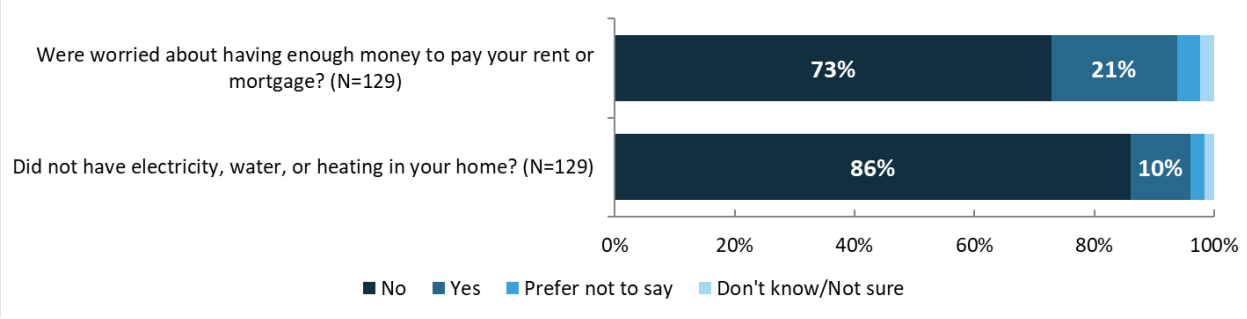


Figure A5.32: In the PAST THREE YEARS, were there times when you:

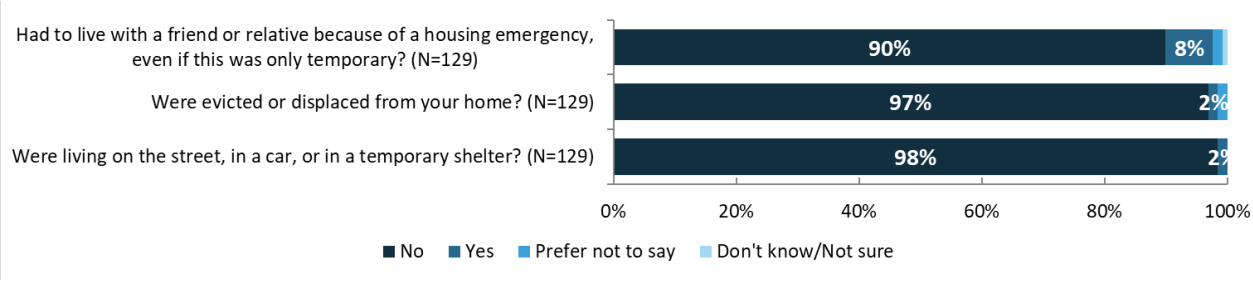
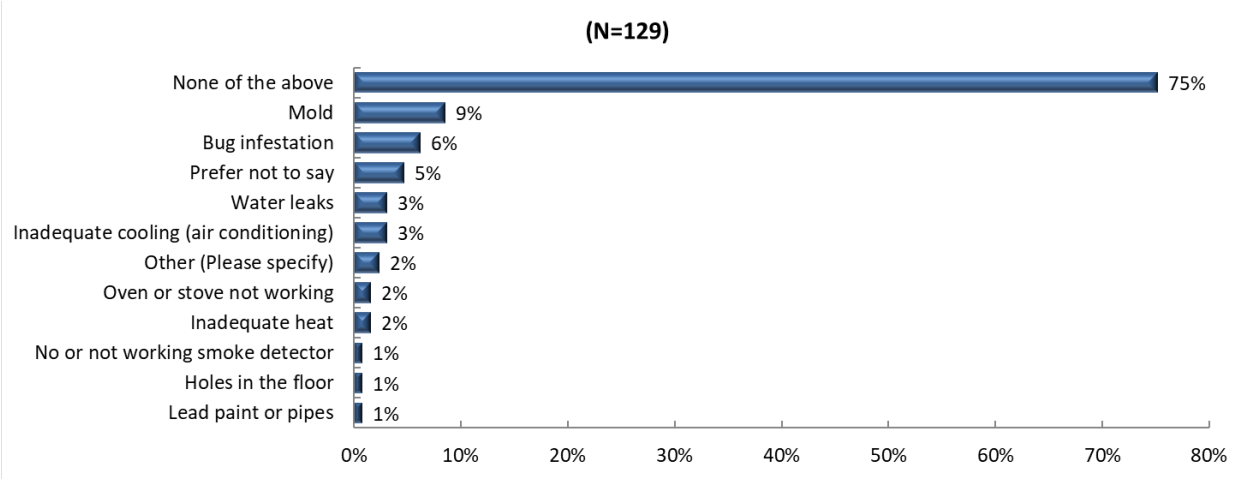


Figure A5.33: Think about the place you live. Do you have problems with any of the following? (Check all that apply.)



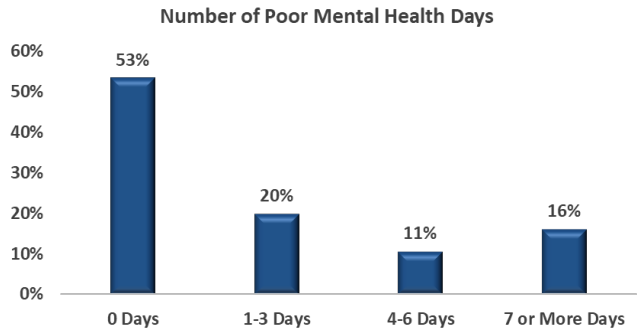
Other (please specify)

No responses given

Topic: Mental Health

Figure A5.34: 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=131)



Measure	Value
Mean (Standard Deviation)	3 (6)
Median	0
Mode	0
Minimum-Maximum	0-30

Figure A5.35: 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 respondents who indicated one or more poor mental health day were asked this question

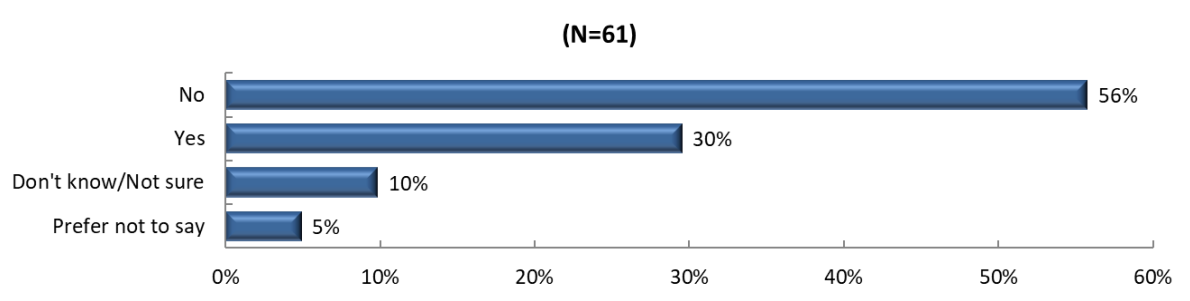


Figure A5.36: What was the MAIN reason you did not get mental health care or counseling?

Note: only respondents who answered "yes" to the previous question were asked this question

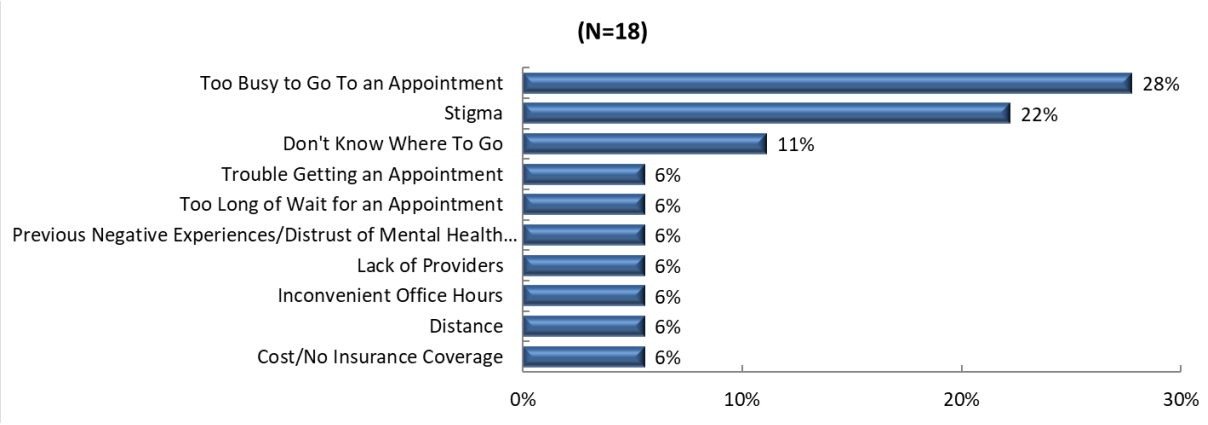
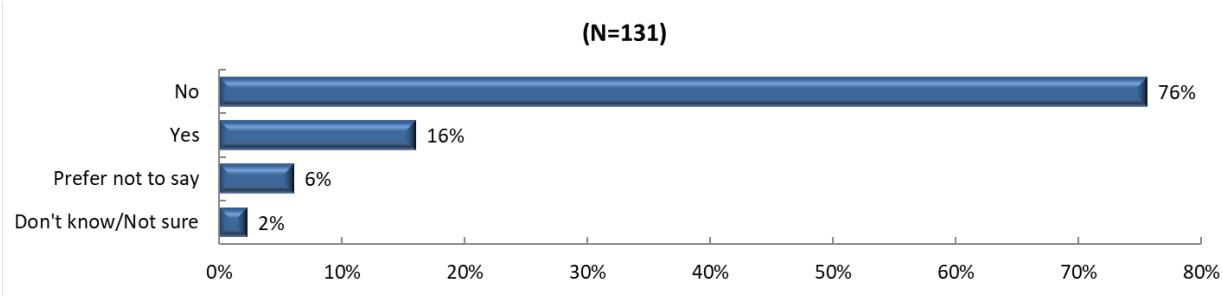


Figure A5.37: Are you currently taking medication or receiving treatment, therapy, or counseling from a health professional for any type of MENTAL or EMOTIONAL HEALTH NEED?



Topic: Physical Health

Figure A5.38: Considering your physical health overall, would you describe your health as…

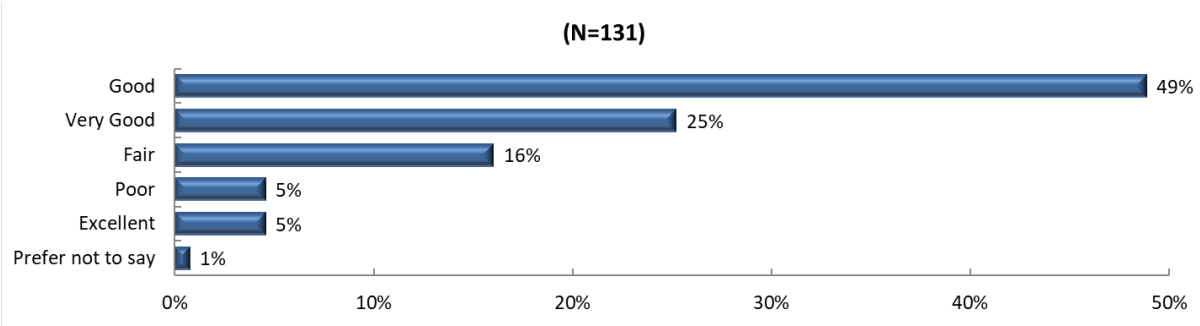


Figure A5.39: Within the past year (anytime less than one year ago), have you:

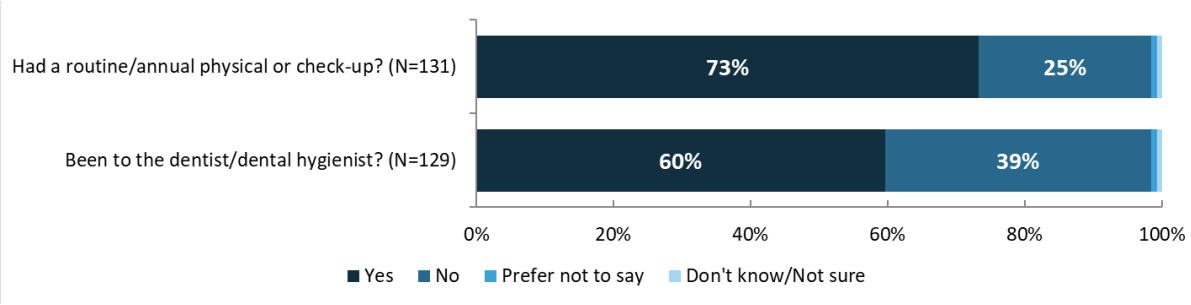
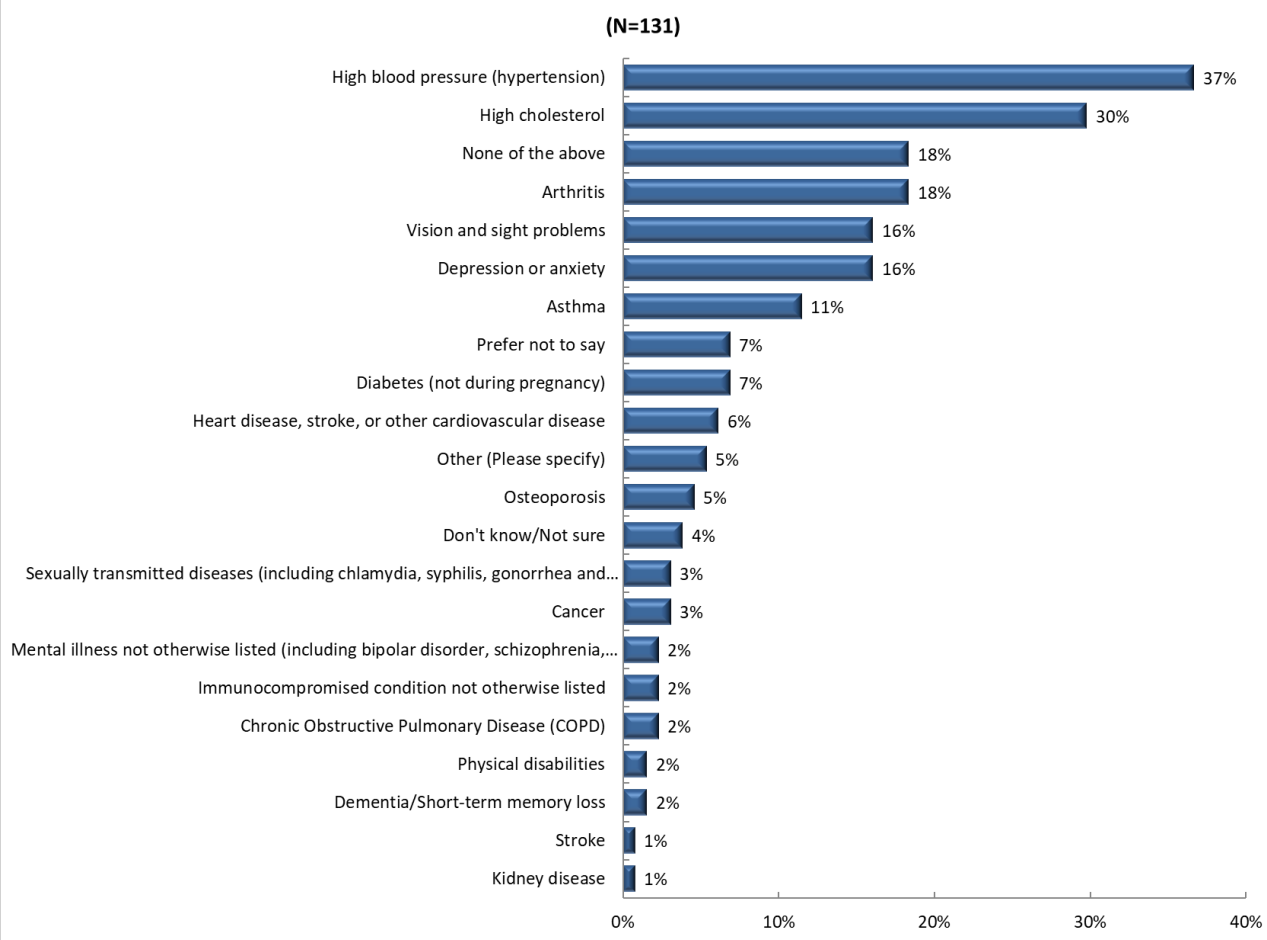


Figure A5.40: Have you ever been told by a doctor, nurse, or other health professional that you have any of the following health conditions? Select all that apply

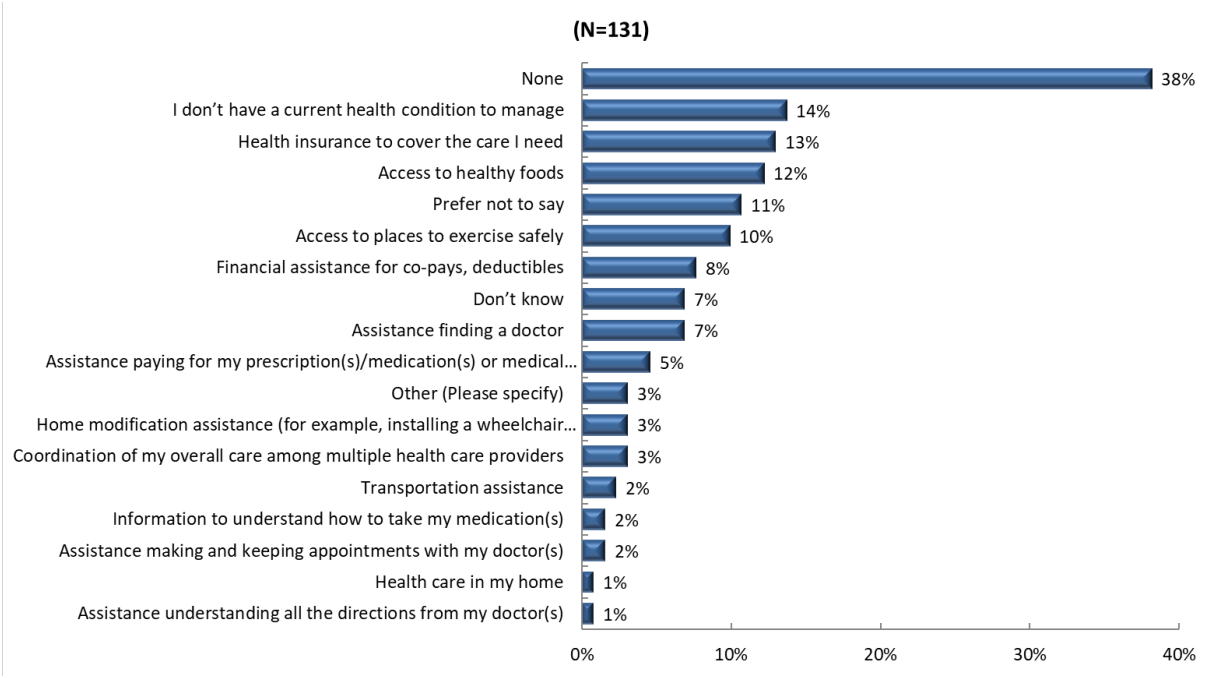


Other (please specify):

- "Autism"
- "H. pylori, beginning of Catara"
- "Heart arrhythmia"

- "Internal bleeding"
- "Syncopal episodes, POTS, migraines"
- "Tension headaches"
- "Thyroid disease, psoriasis, insomnia"

Figure A5.41: 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.)



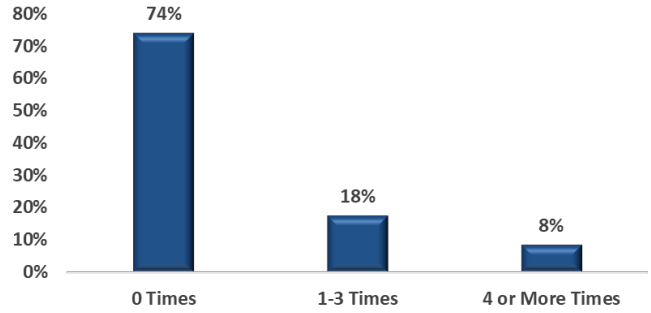
Other (please specify):

- "I'm worried that my doctor always focuses on treating the symptoms and never trying to get to the source of the symptoms."
- "Neuro and cardio specialists"
- "Visual support"
- "We need local specialists"

Topic: Substance Use

Figure A5.42: 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=131)



Measure	Value
Mean (Standard Deviation)	1 (3)
Median	0
Mode	0
Minimum-Maximum	0-24

Figure A5.43: How often do you consume any kind of alcohol product, including beer, wine or hard liquor?

(N=131)

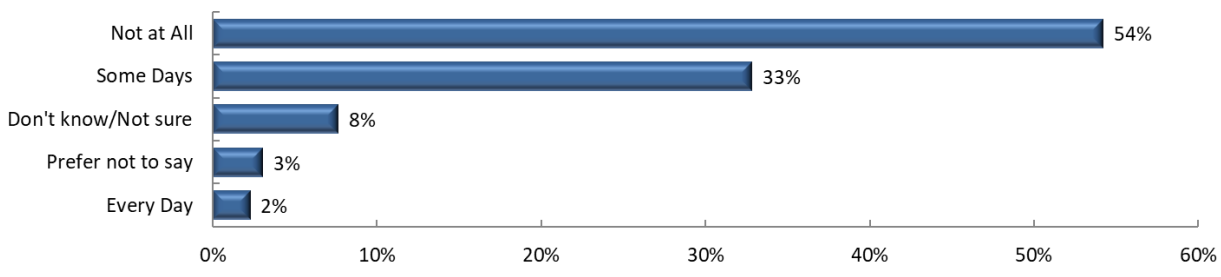


Figure A5.44: In the past year, have you or a member of your household misused any form of prescription drugs (e.g. used without a prescription, used more than prescribed, used more often than prescribed, or used for any reason other than a doctor's instructions)?

(N=131)

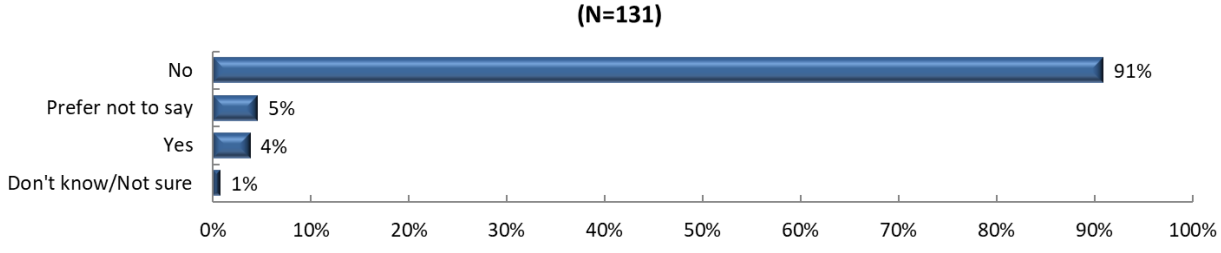
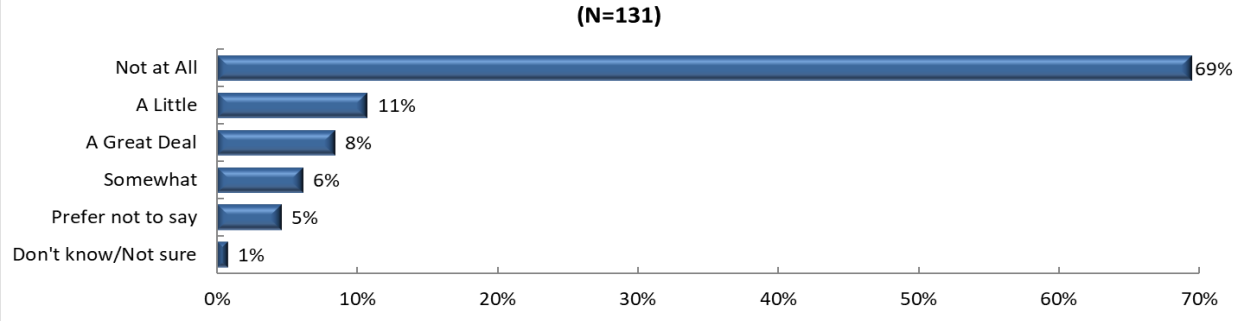


Figure A5.45: To what degree has your life been negatively affected by YOUR OWN or SOMEONE ELSE's substance abuse issues, including alcohol, prescription, and other drugs?



Topic: Transportation and Transit

Figure A5.46: In a typical week, what kinds of transportation do you use the most? (Select all that apply.)

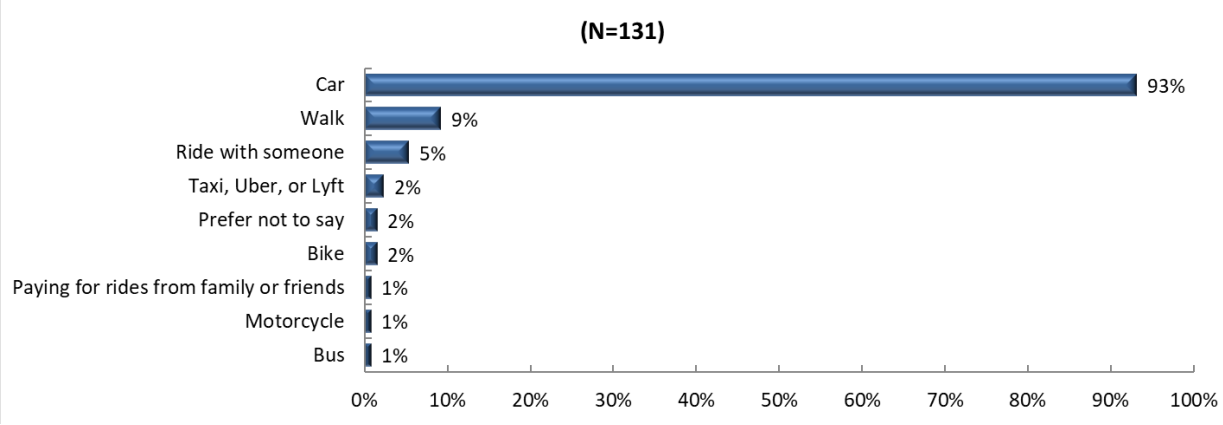


Figure A5.47: In the past 12 months has lack of transportation kept you from medical appointments, meetings, work, or getting things for daily living? Select all that apply:

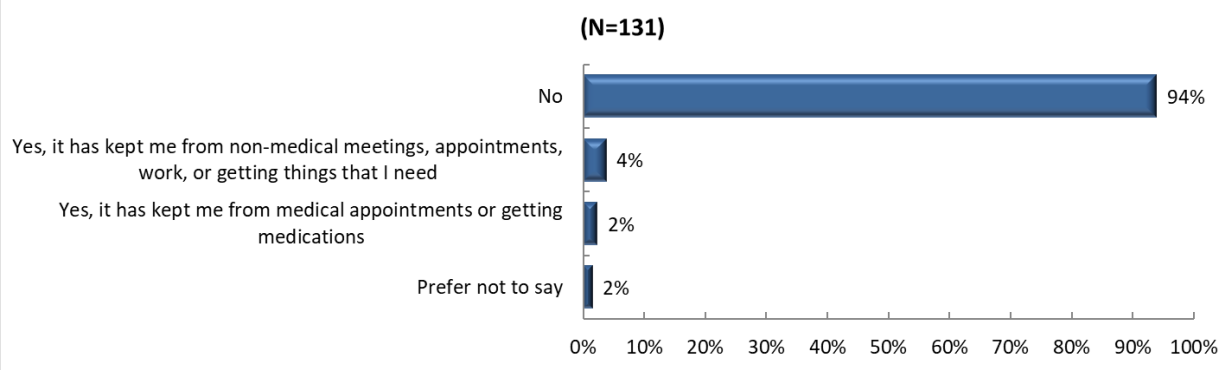
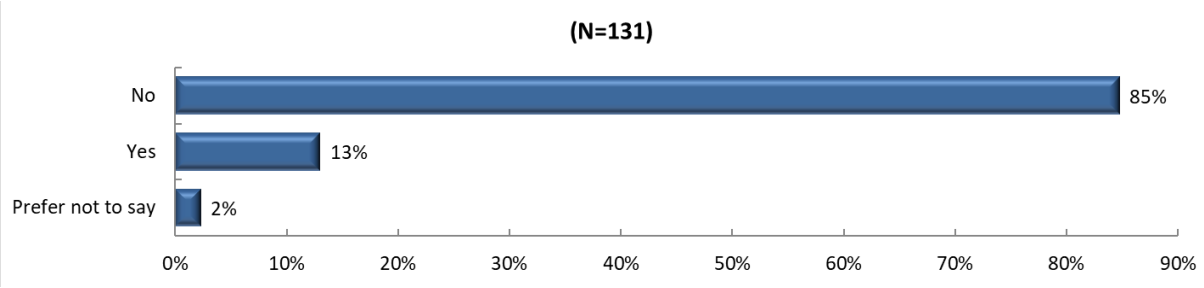


Figure A5.48: Do you put off or neglect going to the doctor because of distance or transportation?



APPENDIX 6 | SUMMARY OF DATA FINDINGS ACROSS SOURCES

Primary and Secondary data findings are summarized in full by the table below.[45]

Priority Area	Secondary Data	Community Survey	Focus Group
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	✓		✓

[45] 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.