Albemarle Regional Health Services
Partners in Public Health

Sentara

CURRITUCK 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 Johnston Health
Caroline Doherty	Community Health Consultant	Roanoke Chowan Community Health Center (RCCHC)
Laura Ellis	Health Education	Halifax County Health Department
Sandra McMasters	Community Benefit Project Manager	Sentara Health
Claire Mills	Director	Eastern AHEC
Emmanuelle Quenum	Health Education Director	Greene County Department of Public Health (DPH)
Rose Ann Simmons	Administrator, Community Health Improvement	ECU Health
Michelle Wagner	Public Health Educator	Dare County Department of Health & Human Services (DHHS)

Currituck County CHNA Leadership

In addition to the Steering Committee, the Currituck 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

Currituck County CHNA Stakeholders

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

Name	Organization
Bill Blake	Albemarle Area United Way
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
Gabi Corprew	Albemarle Regional Health Services
Kellie Lane	Albemarle Regional Health Services
Teresa Beardsley	Albemarle Regional Health Services
Erin Burke	Camden County
Lisa Higgins	Catholic Charities
Yvonne Mullen	Citizen
Robin Harris	College of the Albemarle
Deborah Malenfant	Elizabeth City Downtown
Bryan Spence	Elizabeth City State University
Lenore Jarvis- Mackey	River City Community Development Corp
Mandy Hall	Roanoke Chowan Community Health Center
Bobie Lowe	Trillium Health Resources
Tracey Webster	Trillium Health Resources

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 Currituck County. Top community needs identified through secondary data analysis included behavioral health (including mental health and substance use), environmental quality, healthcare access and quality, and transportation and transit.

Primary (new) data were collected through focus groups and a web-based survey for community members, and included feedback from 134 people who live, work or receive healthcare in Currituck County. A total of three focus groups were conducted, either virtually or in person, with a variety of community members from different backgrounds, age groups and life experiences. Primary data identified behavioral health (including mental health and substance use), healthcare access and quality, housing and homelessness, physical health (chronic diseases, cancer, obesity), and family, community and social support as top needs that impact the health and well-being of people living in Currituck County.

Representatives from Currituck 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, Currituck County selected three top priority health needs (Access to Care, Healthy Living, and Mental Health/Substance Misuse), which are shown here in alphabetical order:

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

Following completion of this report, health leaders throughout Currituck 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

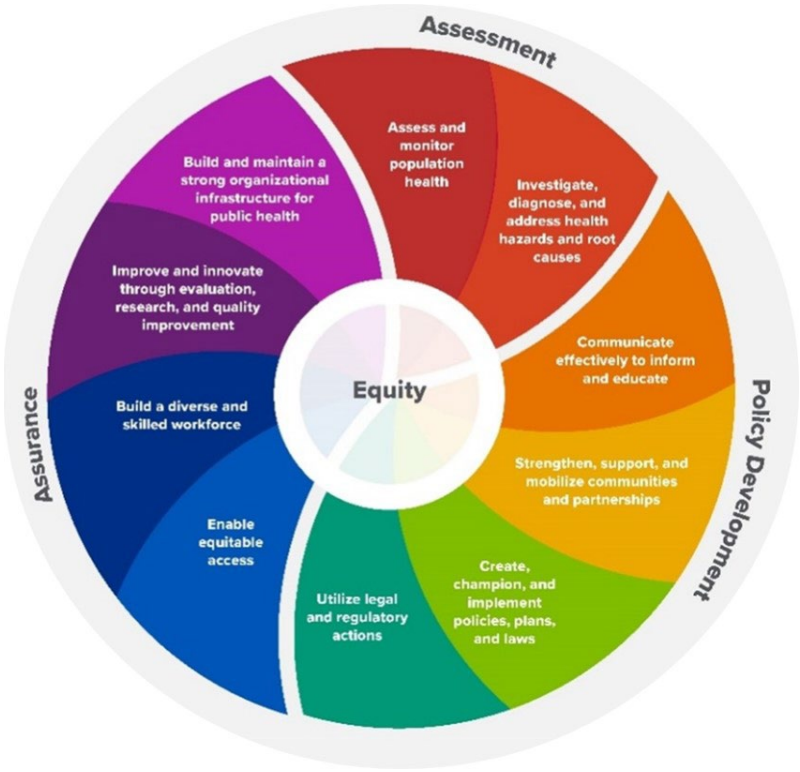
To illustrate its commitment to the health and well-being of the community, the Health ENC CHNA Steering Committee has completed this assessment to understand and document the greatest health needs currently faced by local residents. Guidance was also provided by local representatives from Albemarle 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 Currituck 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 Currituck 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:

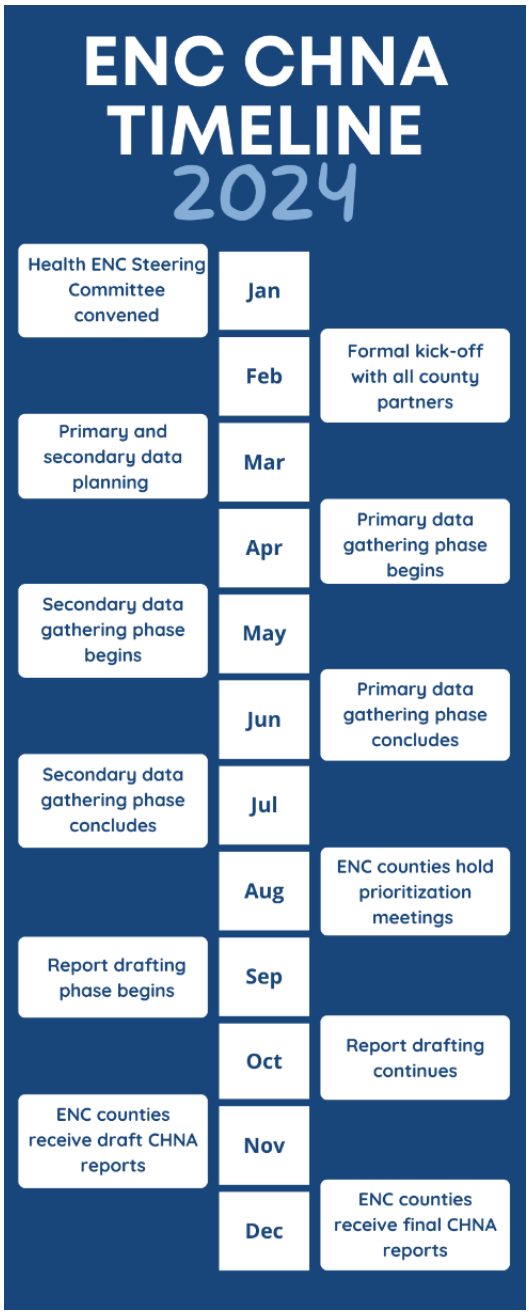
- Define the community it serves;
- Assess the health needs of that community;
- Through the assessment process, take into account input received from people who represent the community's broad interests, including those with special knowledge of or expertise in public health;
- Document the CHNA in 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 Currituck 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 Currituck 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 Currituck County residents. Key objectives of this CHNA include:

- Identify the health needs of Currituck 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 Currituck County residents.

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

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

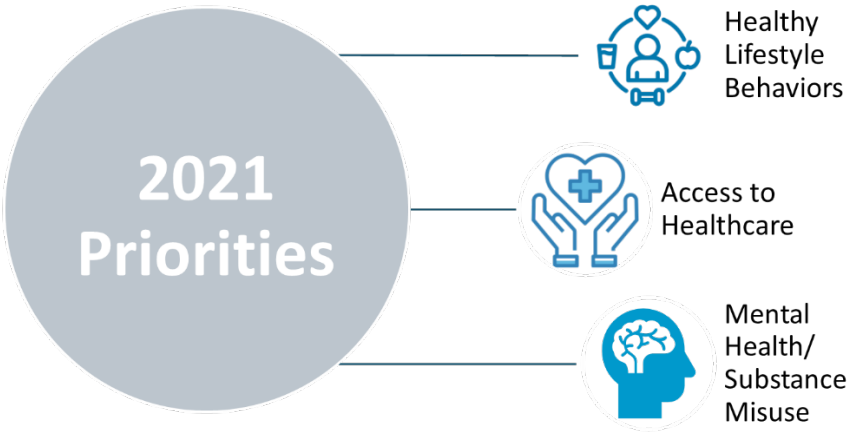
2) *Detailed Summary of Secondary Data Measures and Findings* – Existing data measures and findings used in the prioritization process are presented in **Appendices 2-3.**

3) *Detailed Summary of Primary Findings* – Summaries of new data findings from community member surveys as well as focus groups are presented in **Appendices 4-6.**

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 previous assessment for Currituck County. Associated implementation strategies focused on three priority areas, as listed below:

Figure I.4: Currituck County 2021 Priorities



ARHS and 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 completed its most recent CHNA in 2022, covering Camden, Currituck, Pasquotank, and Perquimans counties. This assessment was focused on the following three priority areas:

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

Sentara Albemarle Medical Center (SAMC), located in Elizabeth City, North Carolina, 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 healthcare 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: Currituck 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 Currituck 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 Currituck 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 Currituck 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 Currituck 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 Currituck focus areas identified as countywide priorities for the 2024 CHNA are Access to Healthcare, Behavioral Health, and Healthy Living, as seen in **Figure I.5**.

Figure I.5: Priority Health Needs, 2024

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 Currituck 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 Currituck 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 Currituck 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. Through this process, input was gathered from Currituck County residents and other stakeholders. This included web survey responses from over 130 community members and three focus groups that included community members and other people who live, work or receive healthcare in Currituck 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 Currituck County included information provided by the Steering Committee and a variety of public data sources related to demographics, social and economic determinants of health, environmental health, health status and disease trends, mental/behavioral health trends, and individual health behaviors. Key information sources leveraged during this process included:

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

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

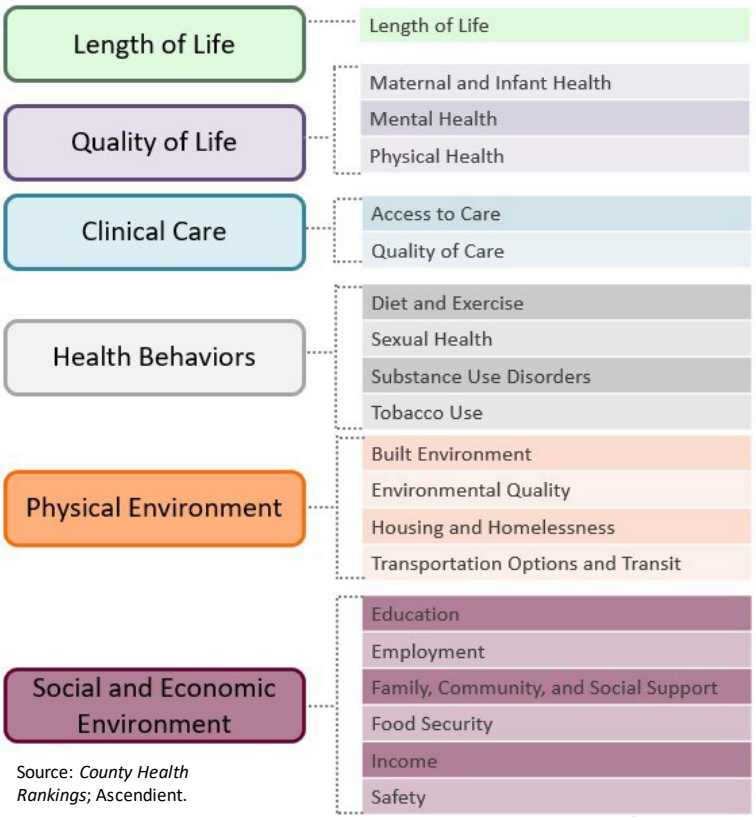
Population Health Framework

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



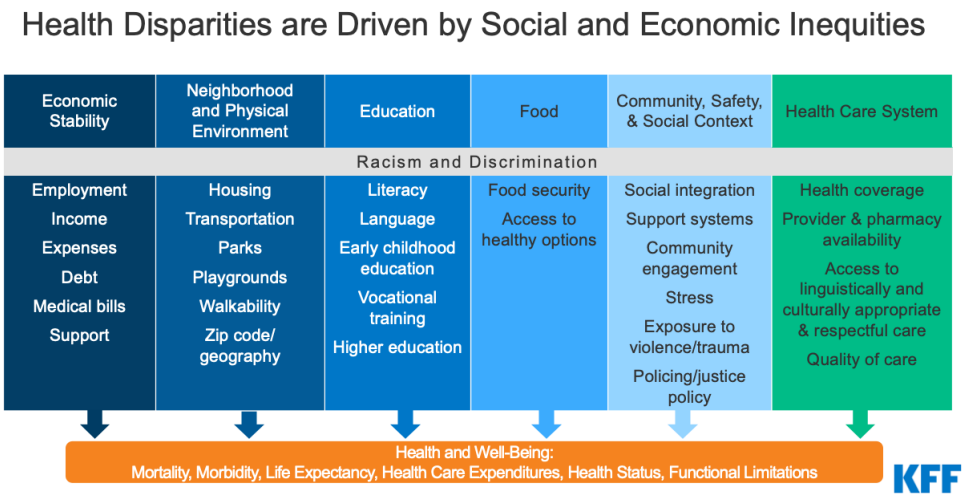
Source: *County Health Rankings*; Ascendient.

Figure 1.2: Social Determinants of Health

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 1.3: SDoH and Health Disparities



Prioritization Process Overview and Results

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

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

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

The Steering Committee utilized the multi-voting technique to determine Currituck 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 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 Currituck County's top priority health needs to be addressed over the next three years, as seen in **Figure 1.4** below:

Figure 1.4: Priority Health Needs, 2024

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
- Elizabeth City Downtown
- River City Community Development Corp
- Roanoke Chowan Community Health Center
- 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 Currituck 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. While efforts were made to include diverse community members in survey efforts, roughly 90% of all respondents were White compared to the White population of Currituck County comprising 83% of the total county population. Only 3% of respondents were Black or African American, which was less than the 5% of the total county population that is Black or African American. Roughly 4% of respondents identified as Hispanic, which is less than the reported county population level of 5%. Although survey respondents could choose from multiple race or ethnicity categories, limited responses were received from these groups. This made it difficult for the Steering Committee to assess health needs and disparities for other racial/ethnic minority groups in the community.

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

responses, members of the Steering Committee should consider working directly with partner organizations in the community who can connect directly with populations who are hard to access through traditional outreach methods, including people with disabilities, the uninsured and people who are disengaged.

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

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

CHAPTER 2 | COUNTY PROFILE

Geography

Currituck County is located in the Outer Coastal Plain region of North Carolina, characterized by the presence of large sounds, bays, and river mouths. It covers a total of 526 square miles, including 262 square miles of land and 264 square miles of water. Currituck is comprised of four townships: Moyock, Crawford, Poplar Branch, and Fruitville. Nearly all (96%) Currituck 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.

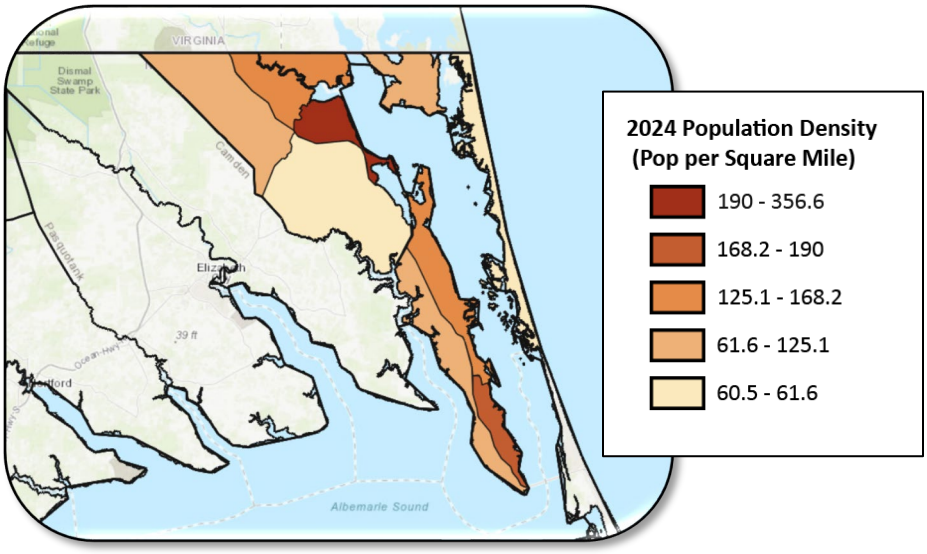
At just over 30,000 residents, the population of Currituck makes up less than one percent of the state's population.

Table 2.1: Total Population, 2023[4]

	Currituck County	North Carolina	United States
Population	30,089	10,765,678	337,470,185

Currituck County has a population density of 121.6 persons per square mile – lower than the population density for North Carolina (214.7 persons per square mile). The City of Currituck is the most densely populated area in the county.

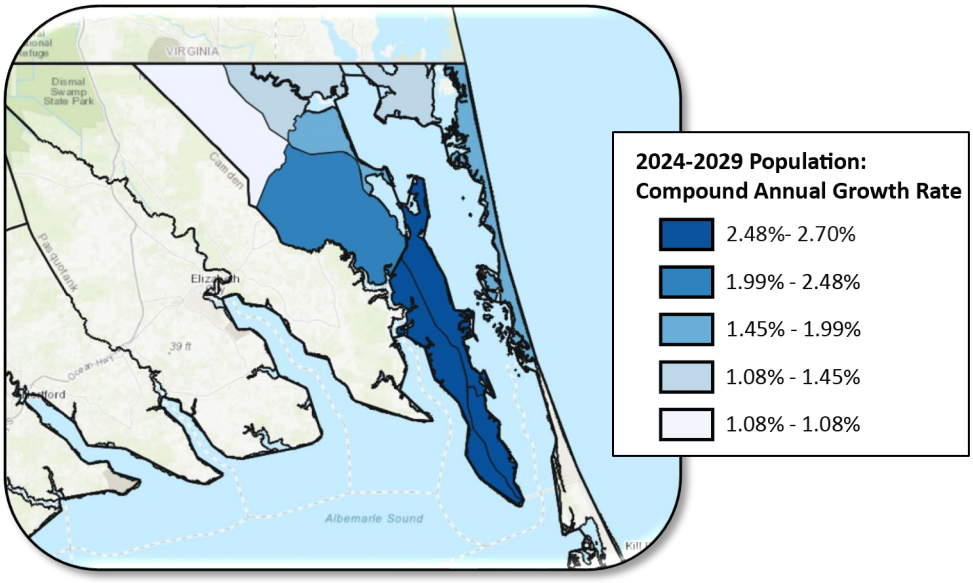
Figure 2.1: Currituck County Map: Population Density[4]



[4] Source: Esri 2023

In total, the population of Currituck County is projected to grow 1.97% annually between 2024 and 2029. Areas in the southern part of the county are experiencing greater growth.

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



Age and Sex Distribution

Data on age and sex helps health providers understand who lives in the community and informs planning for needed health services. Currituck County has a lower percentage of residents below 15 (16.7%) and between 15 and 44 (34.8%) compared to North Carolina and the United States. However, it has a higher percentage of residents aged 45-64 (29.6%) and 65 and older (18.9%) than both state (25.1% and 17.7%, respectively) and national (24.6% and 17.8%, respectively) averages. The largest age group in Currituck County is between 15 and 44 years old (34.8%), suggesting a significant working-age population.

Table 2.2: Age Distribution, 2023[4]

	Currituck County	North Carolina	United States
Percentage below 15	16.7%	17.9%	18.1%
Percentage between 15 and 44	34.8%	39.3%	39.5%
Percentage between 45 and 64	29.6%	25.1%	24.6%
Percentage 65 and older	18.9%	17.7%	17.8%

The sex distribution in Currituck County is nearly balanced, with females making up 49.9% and males 50.1% of the population. This distribution is close to the national average but differs slightly from North Carolina's distribution, which has a slightly higher percentage of females (51.0%) compared to males (49.0%).

Table 2.3: Sex Distribution, 2023[4]						
	Currituck County		North Carolina		United States	
	Count	Pct. of Total	Count	Pct. of Total	Count	Pct. of Total
Female	15,023	49.9%	5,489,419	51.0%	170,118,720	50.4%
Male	15,066	50.1%	5,276,259	49.0%	167,351,465	49.6%

Race and Ethnicity

Data on race and ethnicity help us understand the need for healthcare services as well as cultural factors that can impact how care is delivered. Non-Hispanic White residents make up the largest group at 84.4%, which is higher than both North Carolina (61.2%) and United States (60.6%) figures. Non-Hispanic Black residents comprise 5.0% of the population, notably lower than state (20.4%) and national (12.5%) averages. The county has lower percentages of Asian (1.0%) and American Indian Alaskan Native (AIAN) (0.4%) populations compared to state and national figures. The percentage of residents identifying as Native Hawaiian Pacific Islander (NHPI) and Multiracial (7.6%) is similar to state (7.2%) and lower than national (10.6%) averages.

Table 2.4: Racial Distribution, 2023[4]						
	Currituck County		North Carolina		United States	
	Count	Pct. of Total	Count	Pct. of Total	Count	Pct. of Total
Black (Non-Hispanic)	1,507	5.0%	2,199,488	20.4%	42,132,758	12.5%
White (Non-Hispanic)	25,383	84.4%	6,590,161	61.2%	204,562,590	60.6%
Asian	288	1.0%	379,374	3.5%	21,088,177	6.2%
AIAN	131	0.4%	133,820	1.2%	3,831,126	1.1%
NHPI	31	0.1%	9,214	0.1%	712,229	0.2%
Some Other Race Alone	462	1.5%	677, 338	6.3%	29,432,586	8.7%
Two or More Races	2,287	7.6%	776,283	7.2%	35,710,719	10.6%

By ethnicity, less than 5% of Currituck County's population is Hispanic. This is significantly less than state and national averages.

Table 2.5: Ethnic Distribution, 2023[4]						
	Currituck County		North Carolina		United States	
	Count	Pct. of Total	Count	Pct. of Total	Count	Pct. of Total
Non-Hispanic	28,691	95.4%	9,465,874	88.6%	271,934,049	80.6%
Hispanic	1,398	4.6%	1,299,804	11.4%	65,536,136	19.4%

The proportion of foreign-born individuals residing in Currituck County is 2.6%, significantly lower than both North Carolina and the United States.

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

Source: U.S. Census Bureau (2022), American Community Survey (ACS) 2018-2022 5-Year Estimates

The diversity of Currituck County is reflected in the languages that residents speak at home. According to the most recent American Community Survey (ACS), approximately 5% of Currituck County residents speak a language other than English at home, compared to around 13% of North Carolina and 22% U.S. residents. Less than 4% of county residents speak Spanish at home.

Table 2.7: Language Spoken at Home, 2022[6]			
	Currituck County	North Carolina	United States
English Only	95.3%	87.3%	78%
Spanish	3.6%	7.9%	13.3%
Indo-European Languages	0.5%	2.1%	3.8%
Asian and Pacific Islander Languages	0.5%	1.9%	3.6%
Other Languages	0.1%	0.8%	1.2%

Source: ACS 2018-2022 5-Year Estimates

Disability Status[7]

Data on disabilities helps us understand how to create fair and equal opportunities for everyone in the county. In addition, individuals with disabilities may require targeted services and outreach by health and other service providers. At 12%, the percentage of residents with disabilities in Currituck is comparable to rates in the state and the country.

Table 2.8: Disability Status, 2022[5,6]			
	Currituck County	North Carolina	United States
Population with a Disability	12%	13.3%	12.9%

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

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

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

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. Veterans make up 16% of Currituck's population, more than double the averages of the state and the country.

Table 2.9: Veteran Status, 2022[5,6]			
	Currituck County	North Carolina	United States
Veterans	16%	7.8%	6.2%

Economic Indicators

In addition to demographic data, socioeconomic factors in the community such as income, poverty, and food scarcity play a significant role in identifying health-related needs. The median household income in Currituck County is $81,000, notably higher than both North Carolina and U.S figures.

Table 2.10: Median Household Income, 2023[4]			
	Currituck County	North Carolina	United States
Median Household Income	$81,337	$64,316	$72,603

In 2023, approximately 4.8% of Currituck County households were below the federal poverty level (FPL) – lower than state and national figures. 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[4]			
	Currituck County	North Carolina	United States
Percent Below FPL	4.8%	10.1%	9.5%

Nearly 8% of Currituck County households received Food Stamps/SNAP (Supplemental Nutrition Assistance Program) in 2022. This percentage is lower than both the state average for North Carolina and the national average for the U.S.

Table 2.12: Households Receiving Food Stamps/SNAP, 2022[6,8]			
	Currituck County	North Carolina	United States
Number of Households Receiving Food Stamps/SNAP	893	575,860	16,072,733
Total Number of Households	11,534	4,299,266	129,870,928
Percentage of Households receiving Food Stamps/SNAP	7.7%	13.4%	12.4%

In Currituck County, 26.0% of the population has completed high school alone, which is higher than both the state (21.2%) and national (28.5%) averages. The county also has a higher percentage of residents with some college education (24.8%) compared to the state (21.1%) and national (14.6%) figures. However, Currituck County lags slightly in the percentage of residents with bachelor's degrees (18.2%) compared to North Carolina (20.4%) and the United States (23.4%). The proportion of residents with graduate or professional degrees (7.1%) is also lower than both state (11.6%) and national (14.2%) averages.

Table 2.13: Educational Attainment, 2020[5,9]			
	Currituck County	North Carolina	United States
Less than 9th Grade	2.5%	6.0%	3.5%
Some High School/No Diploma	6.6%	5.5%	5.3%
High School Diploma	26.0%	21.2%	28.5%
GED/Alternative Credential	5.3%	4.3%	*[10]
Some College/No Diploma	24.8%	21.1%	14.6%
Associate's Degree	9.5%	9.9%	10.5%
Bachelor's Degree	18.2%	20.4%	23.4%
Graduate/ Professional Degree	7.1%	11.6%	14.2%

The overall unemployment rate in Currituck County (3.2%) is lower than both state (5.1%) and national (3.9%) averages. Similar to state and national trends, the age group with the highest unemployment rate is young people between the ages of 16 and 24, at 10.8%. However, this is lower than both North Carolina (12.4%) and United States (11.0%) figures for the same age group. Unemployment rates for all other age groups in Currituck County are lower than corresponding state and national rates.

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

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

[10] *US Totals combine GED with High School Diploma

Table 2.14: Unemployment, 2022[6,11]			
	Currituck County	North Carolina	United States
Percentage unemployed ages 16 to 24	10.8%	12.4%	11.0%
Percentage unemployed ages 25 to 54	3.1%	4.7%	3.4%
Percentage unemployed ages 55 to 64	2.5%	3.3%	2.7%
Percentage unemployed ages 65 or more	1.8%	3.0%	2.9%
Total unemployment	3.2%	5.1%	3.9%

Currituck County's overall uninsured rate of 11.2% is lower than the state average (15.0%) but slightly higher than the national average (12.0%). The county shows variations across age groups. The uninsured rate for ages 18 and below (12.0%) is higher than both state (5.2%) and national (5.4%) figures. For ages 19 to 34, Currituck's rate (14.1%) is lower than the state (15.5%) but higher than the national (13.6%) average. The county's uninsured rate for ages 35 to 64 (14.5%) is higher than both the state's 12.5% and the national 9.9%, indicating particular challenges in healthcare access for middle-aged adults.

Table 2.15: Health Insurance Status, 2022[6]			
	Currituck County	North Carolina	United States
Percentage uninsured ages 18 or below	12.0%	5.2%	5.4%
Percentage uninsured ages 19 to 34	14.1%	15.5%	13.6%
Percentage uninsured ages 35 to 64	14.5%	12.5%	9.9%
Total % Uninsured	11.2%	15.0%	12.0%

Social Determinants of Health

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

Figure 2.3: Social Determinants of Health

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

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.

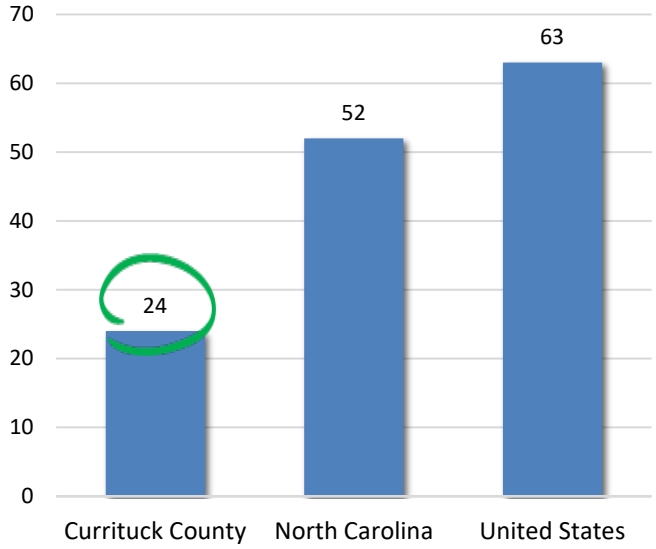
An analysis of the racial and geographic disparities that emerged in the information obtained and analyzed during this process is detailed below. The CHNA Steering Committee also collected new data via focus groups and surveys to ensure that residents and key community health leaders could provide input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

Disparities

Recognizing the diversity of Currituck 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.

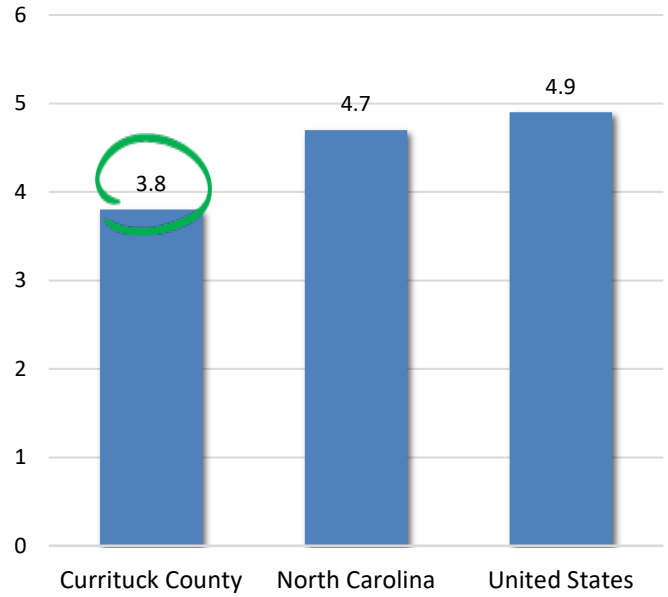
Residential segregation is measured by the index of dissimilarity, a demographic measure ranging from 0 to 100 that represents how evenly two demographic groups are distributed across a county's census tracts. Lower scores represent a higher level of integration. Currituck has a significantly lower rating of residential segregation compared to North Carolina and the U.S, as seen in **Figure 2.4**.

Figure 2.4: Residential Segregation[12]



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

Figure 2.5: Income Inequality Ratio[12]



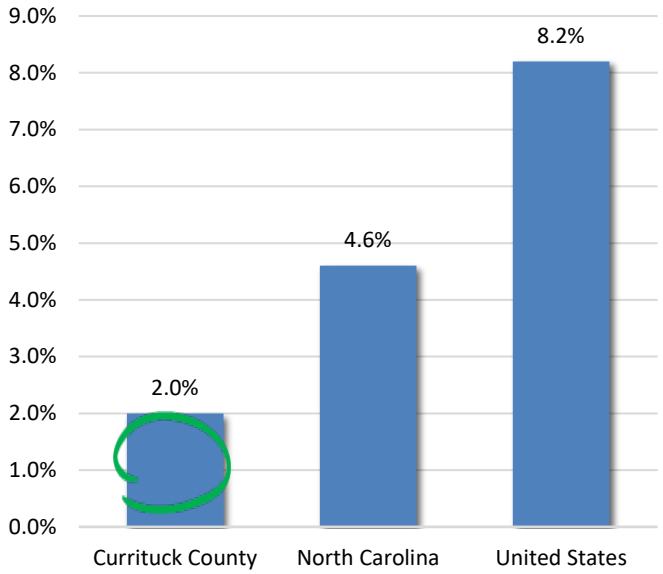
Source: Robert Wood Johnson County Health Rankings 2024

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

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

members may not understand critical public health and safety notifications, such as safety-focused communications during the COVID-19 pandemic. Fewer people are not fluent in English in Currituck compared to the state and country, as seen in **Figure 2.6**.

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



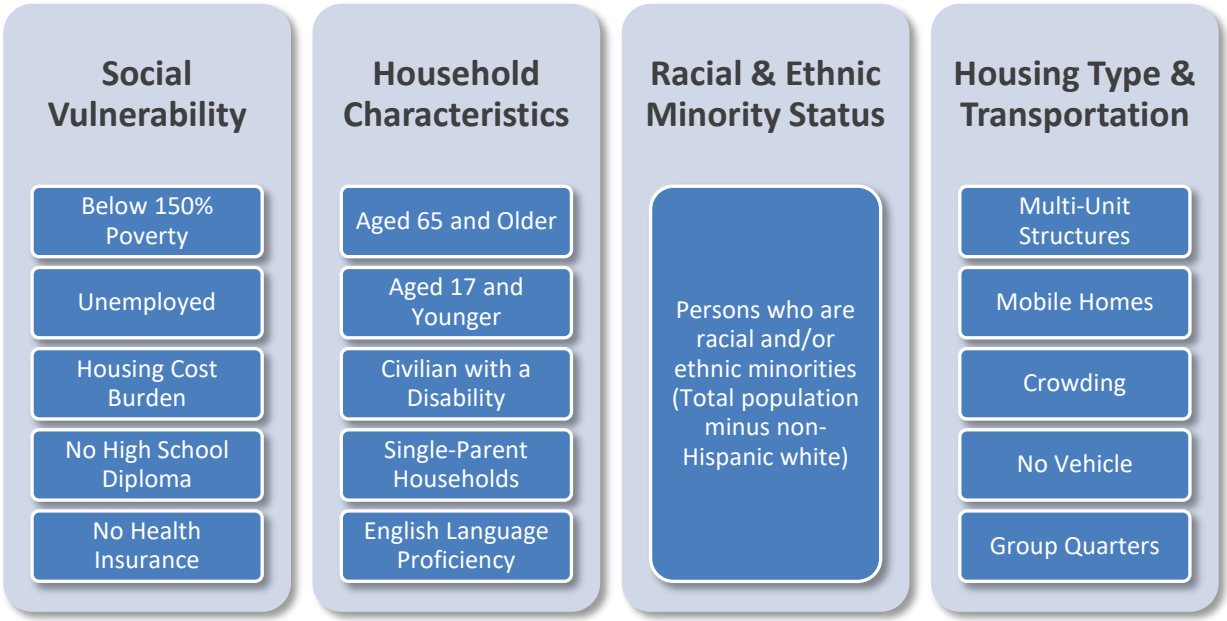
Social Vulnerability Index

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

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

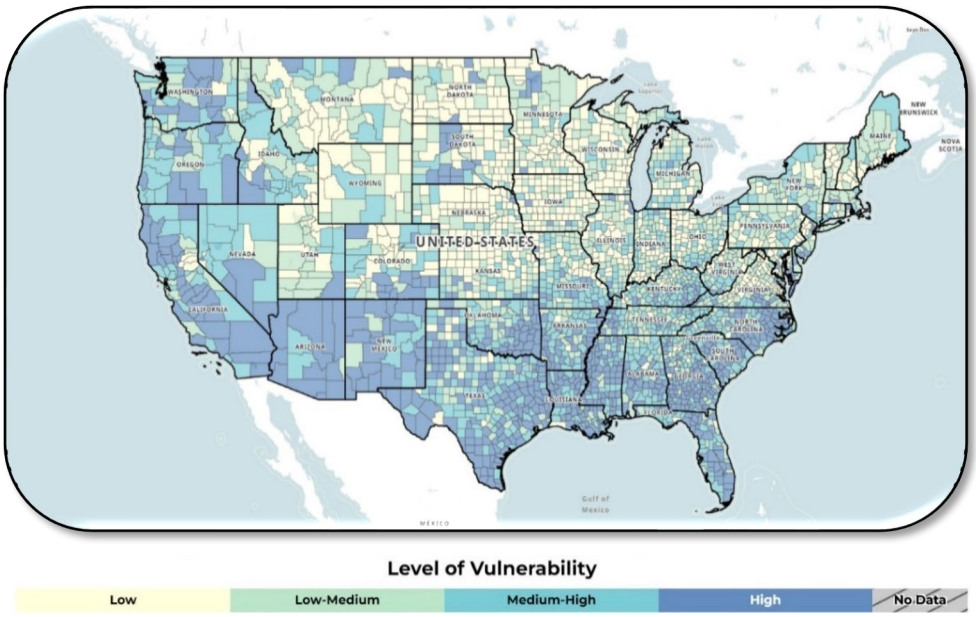
[13] CDC/ATSDR Social Vulnerability Index (SVI). Retrieved from https://www.atsdr.cdc.gov/placeandhealth/svi/index.html.

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



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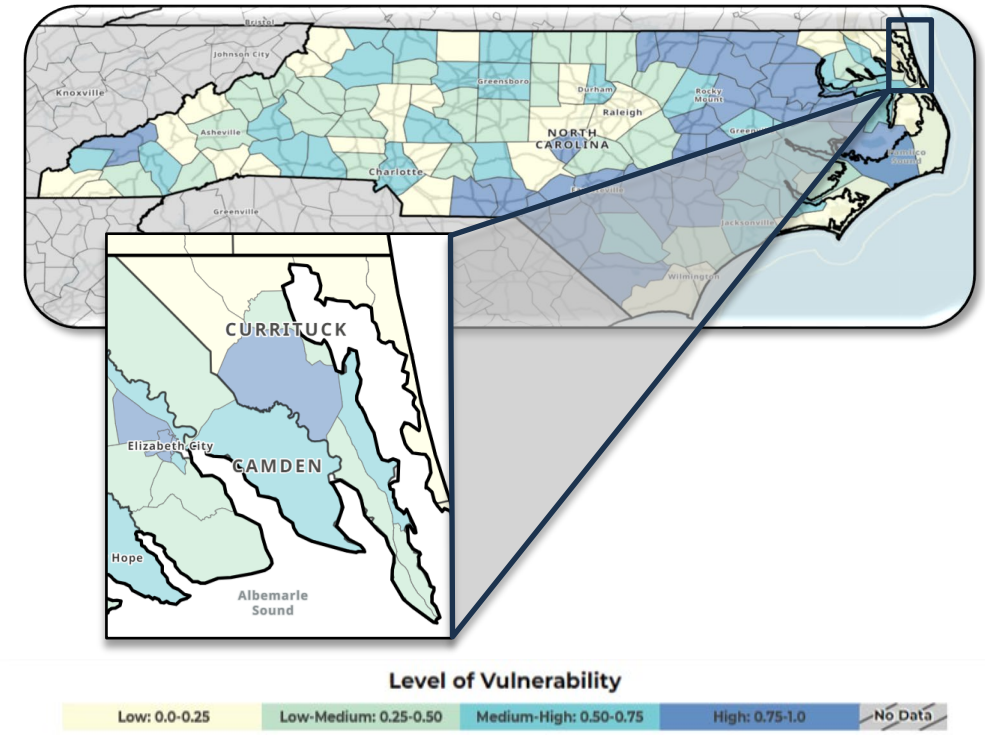
The 2022 SVI scores for Currituck County are shown in **Figure 2.9** below. Possible scores range from 0 (lowest vulnerability) to 1 (highest vulnerability), and these scores show a relative comparison with other counties and census tracts in North Carolina. The vulnerability of Currituck County overall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

average compared to the state. Levels of vulnerability are variable across the county with the average being 0.25.

Figure 2.9: Currituck County SVI by Census Tract, 2022



Environmental Justice Index

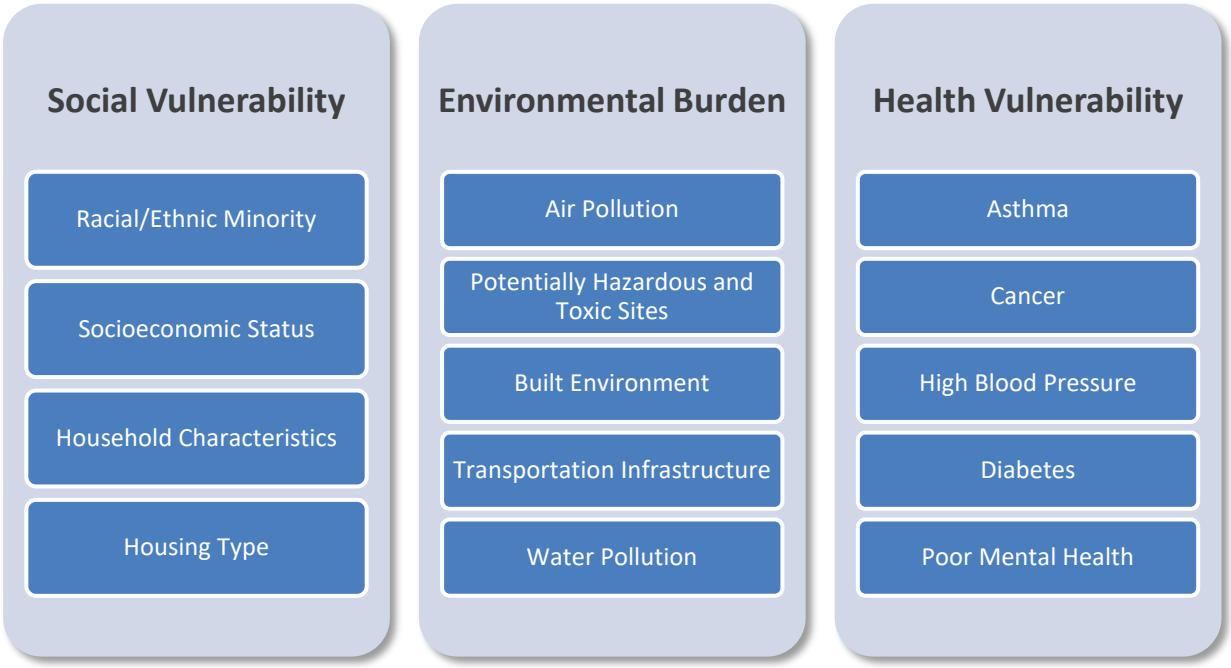
Environmental justice means the just treatment and meaningful involvement of all people, regardless of income, race, color, national origin, Tribal affiliation, or disability, in agency decision-making and other Federal activities that affect human health and the environment. It aims to protect everyone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

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

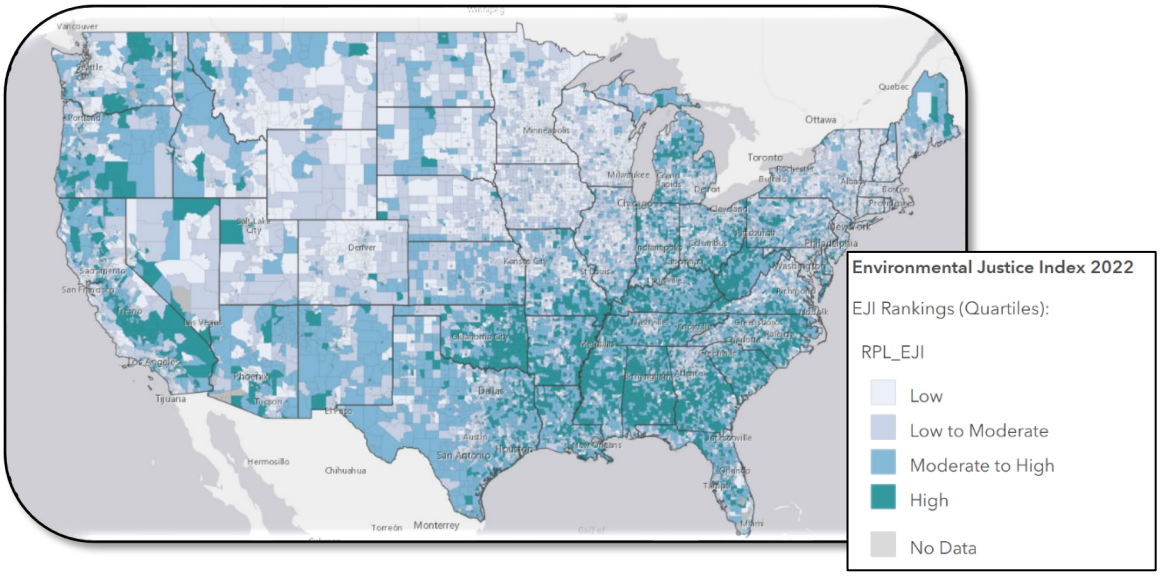
[14] U.S. Environmental Protection Agency (2024). Retrieved from https://www.epa.gov/environmentaljustice

Figure 2.10: EJI Variables



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

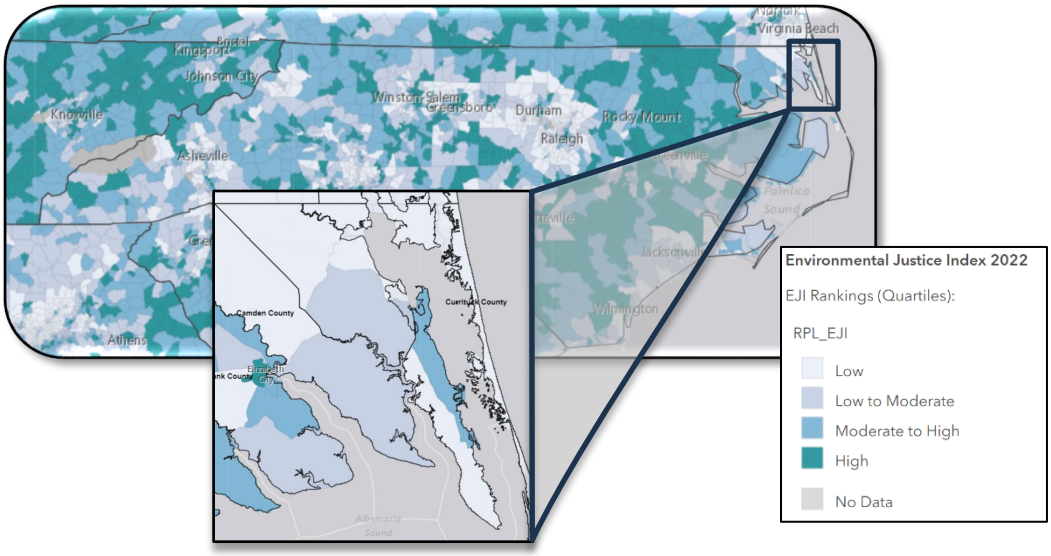
Figure 2.11: United States EJI by Census Tract, 2022



The 2022 EJI scores for Currituck 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.

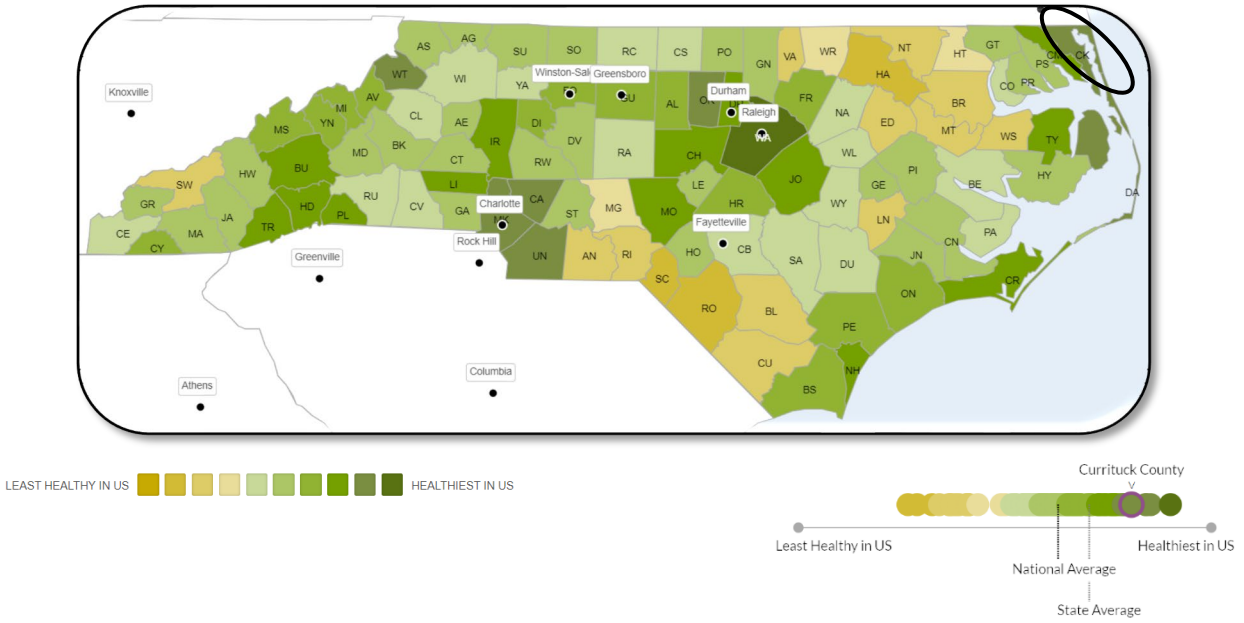
Figure 2.12: Currituck County EJI by Census Tract, 2022



Health Outcome and Health Factor Rankings

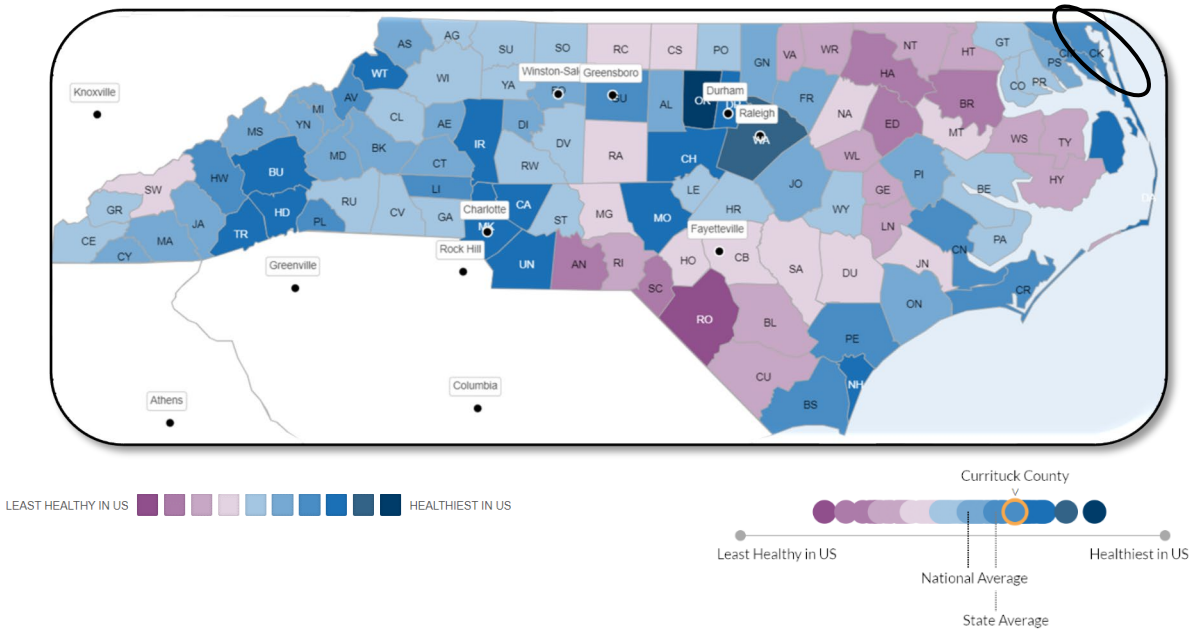
County leaders also reviewed and analyzed data from the Robert Wood Johnson Foundation and the University of Wisconsin County Health Rankings for the year 2024. The Health Outcomes measure looks at how long people in a community live and how physically and mentally healthy they are. These categories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

Figure 2.13: State Health Outcomes Rating Map[12]



The Health Factors measure looks at variables that affect people's health including health behaviors, clinical care, social & economic factors, and the physical environment they live in. More details about these indicators can be found in Appendices 2 through 4. Similarly to the Health Outcome measure, Currituck surpasses the average for the country and the state.

Figure 2.14: State Health Factors Rating Map[12]



CHAPTER 3 | PRIORITY NEED AREAS

This chapter describes each of the 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).

The 2024 Community Health Needs Assessment prioritization process for Currituck County was conducted on August 16, 2024, at the Elizabeth City/Pasquotank Senior Center in Elizabeth City, North Carolina. Stakeholders from diverse sectors of the community participated in the prioritization meeting, including representatives from local health departments, healthcare organizations, educational institutions, social service agencies, and community development organizations. The prioritization process utilized the multi-voting technique, where participants engaged in group discussion to assemble a list of priority areas, followed by individual voting on their top three choices. After votes were tallied, the group held further discussion to ensure the selected priorities were feasible for implementation.

As mentioned previously, these priority needs areas are not listed in any hierarchical order of importance and all will be addressed by the Currituck 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 CARE

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 Currituck 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.[15] Access is a challenge even for those who are insured.[16]

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.[17] 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.[18] 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.[19] 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.[20]

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.[21] 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.[22] Both primary and secondary data resources analyzed for this report highlight the need for greater access to health services within Currituck County.

Secondary Data Findings

Secondary data analysis revealed significant challenges in healthcare access for Currituck County residents, particularly regarding provider availability across multiple specialties. The county demonstrated concerning provider-to-population ratios compared to state and national benchmarks.

[15] 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.

[16] 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.

[17] 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 .

[18] 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 .

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

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

[21] 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.

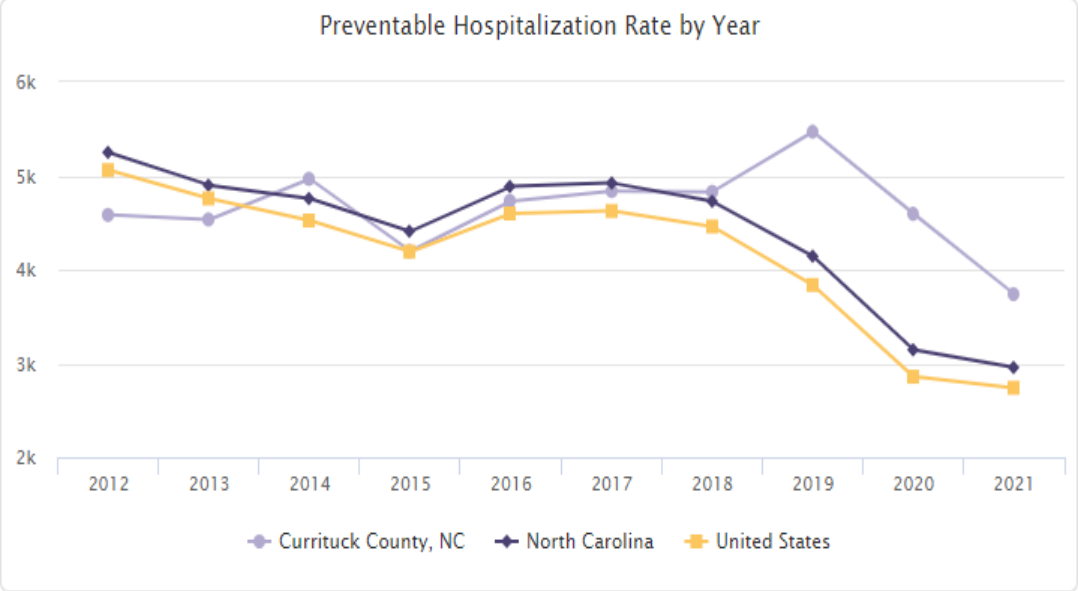
[22] Source: Espinoza, J. and Derrington, S. (2021). How Should Clinicians Respond to Language Barriers That Exacerbate Health Inequity? *AMA Journal of Ethics*. Retrieved from: https://journalofethics.ama-assn.org/article/how-should-clinicians-respond-language-barriers-exacerbate-health-inequity/2021-02.

Table 3.1: Healthcare Provider Availability			
Indicator	**Currituck County**	**North Carolina**	**United States**
Dental Providers (Rate per 100,000 Population)	10.7	31.5	39.1
Primary Care Providers (Rate per 100,000 Population)	39.2	101.1	112.4

The rate of dental providers per 100,000 population (10.7) was notably lower than both the state (31.5) and national (39.1) averages. Similarly, primary care provider rates showed significant gaps, with only 39.2 providers per 100,000 population compared to 101.1 for North Carolina and 112.4 nationally. The shortage of dental providers is particularly acute, with 90% of the county's population living in an area designated as a Dental Health Professional Shortage Area (HPSA), significantly higher than both state (34%) and national (18%) percentages. This suggests many residents may face substantial challenges accessing oral healthcare services.

The county's preventable hospitalization rate provides additional evidence of access challenges. At 3,379 preventable hospitalizations per 100,000 Medicare beneficiaries, the rate exceeds both state (2,957) and national (2,752) averages.

Figure 3.1: Preventable Hospital Stays Trend



Even more concerning are the racial disparities in these hospitalizations. White Medicare beneficiaries had a notably higher rate of preventable hospitalizations (4,166) compared to Black or African American beneficiaries (2,089), suggesting potential differences in primary care utilization or access patterns among different demographic groups.

Table 3.2: Preventable Hospital Stays by Race/Ethnicity	
Preventable Hospital Stays (per 100,000 Medicare Beneficiaries)	**Currituck County Rate**
Preventable Hospital Stays	3,379
Black or African American Medicare Beneficiaries	2,089
White Medicare Beneficiaries	4,166

Transportation access may compound these healthcare accessibility challenges. While Currituck County has a lower percentage of households with no motor vehicle (1.7%) compared to state (5.4%) and national (8.3%) averages, the county has no population living within a half-mile of public transit, compared to 10.9% statewide and 34.8% nationally. Additionally, none of the population uses public transit for commuting, compared to 0.8% statewide, suggesting limited public transportation options for accessing healthcare services.

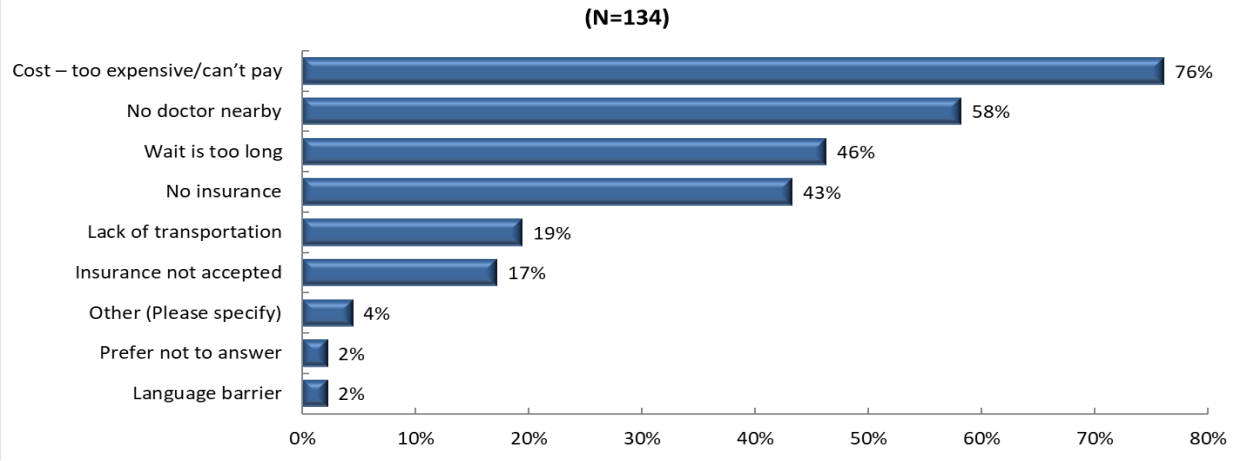
Table 3.3: Transportation Access Indicators			
Indicator	**Currituck County**	**North Carolina**	**United States**
Households with No Motor Vehicle, Percent	1.7%	5.4%	8.3%
Percent Population Using Public Transit for Commute to Work	0.0%	0.8%	3.8%
Percentage of Population within Half Mile of Public Transit	0.0%	10.9%	34.8%

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

Primary Data Findings – Community Member Web Survey

Nearly 135 Currituck County residents responded to the web-based survey. Respondents identified several access to care-related needs in Currituck County. In the survey, community members were asked to identify the top barriers to receiving healthcare. Cost (76%), no doctor nearby (58%), and long wait times (46%) were the top three identified reasons why people in the community are not getting care when they need it. Another 43% of responses identified lack of insurance and a quarter of responses indicated a lack of transportation as a top barrier to care.

Figure 3.2: What are the three most important reasons people in your community do not get health care when they need it? Please select up to three.

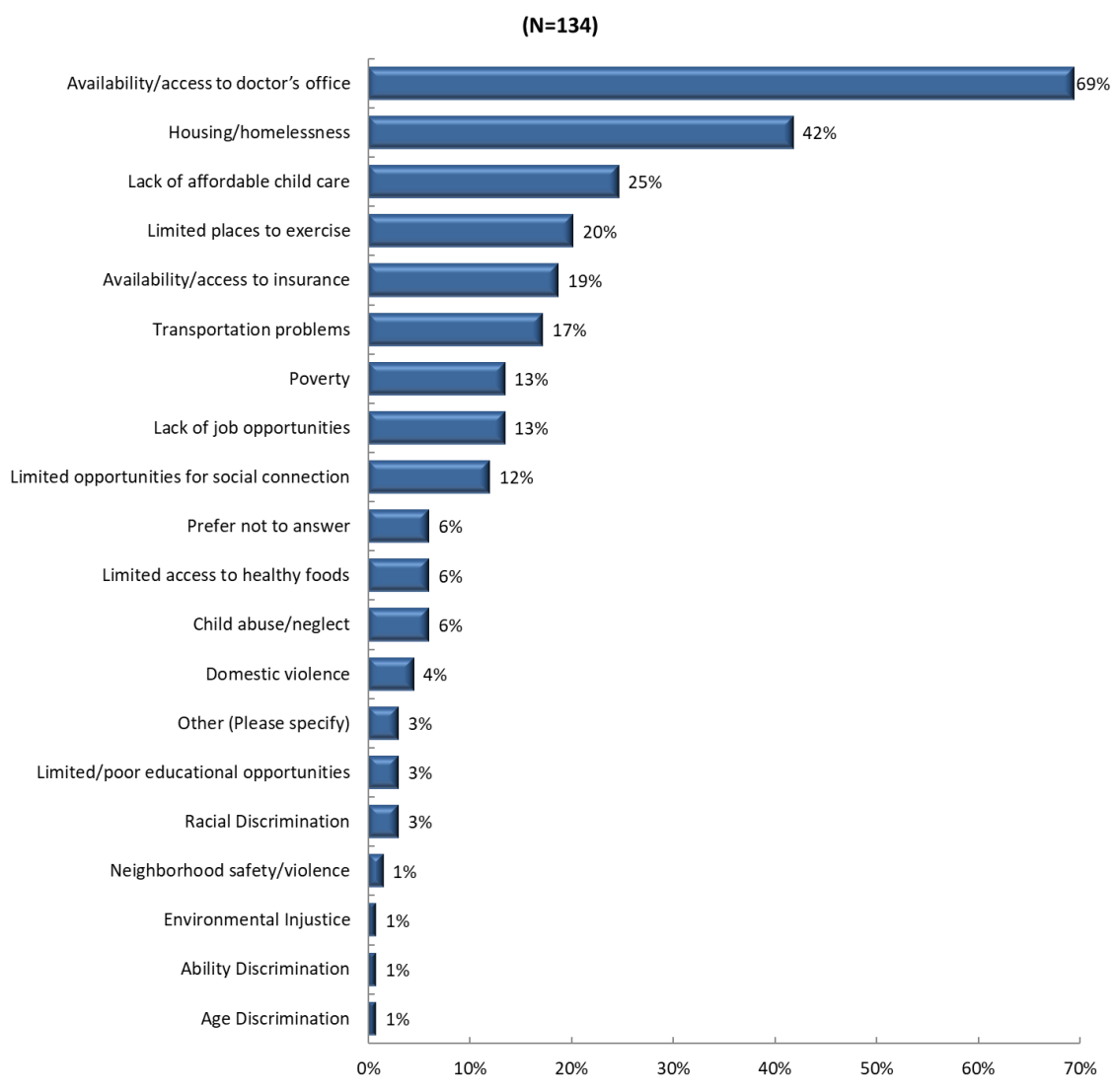


When these data were examined by age group, the age group that most frequently identified cost (85%) and lack of insurance (55%) as top barriers was those ages 45 to 65. Additionally, this cohort most frequently identified the absence of nearby providers (62%) as a barrier compared to all other age groups. Responses also differed by race. Nearly 63% of respondents identifying with the "Other" [23] race category noted lack of insurance as a top barrier to healthcare compared to 41% of respondents identifying as White. Conversely, respondents identified as White were more likely to view cost, the absence of nearby doctors, long wait times, and insurance not being accepted as barriers to healthcare.

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 the availability or access to doctor's offices (69%), again highlighting access to care challenges within the community. Access to insurance (19%) was identified as the fifth most frequent social or environmental problem that affects the health of the community.

[23] Includes those who identified as Black or African American, American Indian and Alaska Native, Asian, Native Hawaiian and other Pacific Islander, and/or those who selected more than one race or "other"

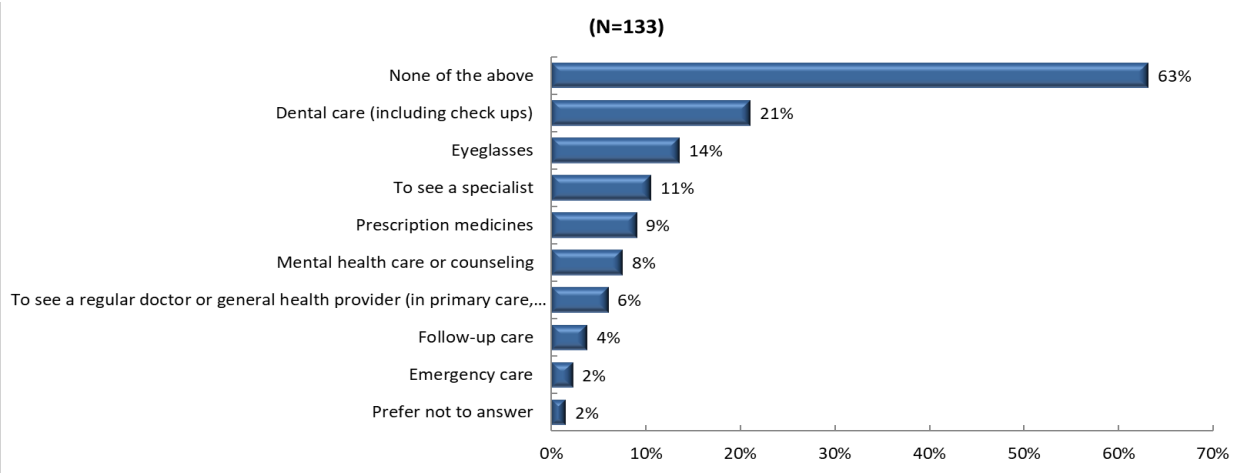
Figure 3.3: What are the three most important social or environmental problems that affect the health of your community? Please select up to three.



Notably, men and women differed in their responses. More women identified availability and access to doctor's offices as a top social and environmental problem (70% for women vs. 67% for men). Women were also more likely than men to identify transportation problems as an important social and environmental problem (18% compared to 11%). Responses also varied by race. Those identifying as White were more likely to cite availability of doctor's offices, availability or access to insurance, and transportation than all other races (White: 74%, 18%, 18%; All Other: 13%, 13%, 13%).

Currituck County community member respondents were also asked if there was a time during the past 12 months that they needed specific medical care or health-related items and were unable to receive it due to the cost. As displayed in the figure below, one-fifth of respondents indicated affordability barriers prevented them from accessing dental care. The second highest response identified obtaining eyeglasses (14%) was impacted due to cost, followed by seeing a specialist (11%).

Figure 3.4: During the past 12 months, was there any time when you needed any of the following, but didn't get it because you couldn't afford it?



Respondents were asked if they have put off or neglected going to the doctor due to distance or transportation, to which 21% of respondents answered yes, further emphasizing that transportation can be a barrier for at least a portion of the community.

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

Primary Data Findings – Focus Groups

Focus group participants across all sessions identified significant barriers to accessing healthcare in Currituck County. A primary concern was the lack of local providers, particularly specialists, resulting in residents having to travel significant distances for care. Participants noted long wait times and limited appointment availability as major obstacles, with many reporting feeling rushed during appointments or not being properly listened to by providers. This was described as particularly challenging for older adults who faced additional transportation barriers. Participants in the Currituck Family YMCA focus groups specifically highlighted the absence of maternal healthcare services in the county, noting limited local pre- and post-natal care options and the need to travel for OBGYN services. The lack of mental health providers was also emphasized as a critical gap in local healthcare services.

Focus group members suggested several potential solutions, including enhancing traveling health provider programs and implementing mobile clinics to provide better care coverage across the county. They also emphasized the need for more effective communication strategies to inform residents about available healthcare programs and services.

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

PRIORITY NEED: HEALTHY LIVING

Context and National Perspective

Physical health is 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. [24]

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.[25]

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.[26] 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.[27] North Carolina's

[24] 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

[25] 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

[26] 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.

[27] 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 NCCares 360 program, which seeks to connect individuals with all necessary resources for living a healthier life.

Secondary Data Findings

Secondary data analysis of healthy living indicators in Currituck County revealed both strengths and areas for improvement in physical health outcomes and related behaviors. In general, the county showed lower rates of various chronic conditions compared to state and national benchmarks.

The percentage of adults with asthma (9.3%) was lower than both state (9.8%) and national (9.7%) averages. Similarly, diagnosed diabetes rates among adults aged 20 and older were lower in Currituck County (7.7%) compared to North Carolina (9.0%) and national (8.9%) figures. The county also demonstrated better performance in obesity rates, with 22.8% of adults having a BMI over 30.0, compared to 29.7% statewide and 30.1% nationally. Additionally, the percentage of physically inactive adults in Currituck County (18.9%) was lower than the state average (21.6%).

Table 3.4: Chronic Disease Prevalence

Indicator	Currituck County	North Carolina	United States
Adults (Age 18+) with Asthma	9.3%	9.8%	9.7%
Adults (Age 20+) with Diagnosed Diabetes	7.7%	9.0%	8.9%
Adults (Age 18+) Ever Diagnosed with Coronary Heart Disease	5.2%	5.5%	5.2%
Adults (Age 18+) with Hypertension	29.6%	32.1%	29.6%
Adults (Age 18+) with High Cholesterol	31.2%	31.4%	31.0%
Adults (Age 18+) with Kidney Disease	2.6%	2.9%	2.7%
Adults (Age 18+) Ever Having a Stroke	2.6%	3.1%	2.8%
Adults with BMI > 30.0 (Obese)	22.8%	29.7%	30.1%
Adults (Age 18+) with Poor Dental Health	10.5%	12.0%	13.9%
Percent Reporting Poor or Fair Health	12.3%	14.4%	-

However, environmental factors that influence healthy living showed some concerning patterns. The county's walkability index score of 6 was lower than both state (7) and national (10) averages. While 79% of the population has access to exercise opportunities, exceeding the state average of 73%, this remains below the national average of 84%.

Table 3.5: Physical Activity and Built Environment Indicators			
Indicator	**Currituck County**	**North Carolina**	**United States**
Recreation and Fitness Facility Establishments, (Rate per 100,000 Population)	N/A	13.1	14.7
Walkability Index Score	6	7	10
% Physically Inactive	18.9	21.6	-
Percentage of Population with Access to Exercise Opportunities	79%	73%	84%

Positively, food security and access to healthy food options pose less significant challenges within the community. The rate of fast-food restaurants (74.7 per 100,000 population) was slightly lower than the state average (77.4) and significantly lower than the national average (96.2). The county had a higher rate of grocery stores (32.0 per 100,000 population) compared to both state (18.7) and national (23.4) averages, suggesting better access to healthy food retailers than many other areas.

Table 3.6: Food Environment Indicators			
Indicator	**Currituck County**	**North Carolina**	**United States**
Food Insecurity Rate	9%	11%	10%
Child Food Insecurity Rate	9%	15%	13%
Percent Low Income Population with Low Food Access	2%	21%	19%
Food Environment - Fast Food Restaurants Establishments (Rate per 100,000 Population)	74.7	77.4	96.2
Food Environment - Grocery Stores Establishments (Rate per 100,000 Population)	32.0	18.7	23.4

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

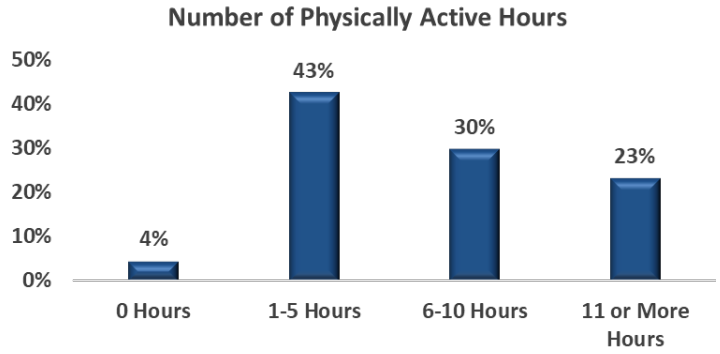
Primary Data Findings – Community Member Web Survey

Currituck County residents identified several healthy living concerns in the community in the web survey. Across all demographic groups, 20% of community respondents indicated limited places to exercise and 6% indicated limited access to healthy foods were top social or environmental problems affecting the health of the community. Responses somewhat differed by demographic characteristics of the respondents. When examined by gender, men (17%) more frequently identified limited access to healthy foods than women (4%), while more women identified limited places to exercise (22% vs. 11% for men). Respondents who identified as White were more likely to select access to healthy foods (7% vs. 0%) and limited places to exercise (21% vs. 0%) than those who identified as any other race.

When respondents were asked how many servings of fruit they ate in the past week, 5% indicated none, while 45% indicated they ate between one and five servings. On average, 31% of community member respondents in Currituck County reported eating six servings of fruit over the past week. Responses for vegetables were similar, suggesting opportunities for increasing healthy food consumption in the community.

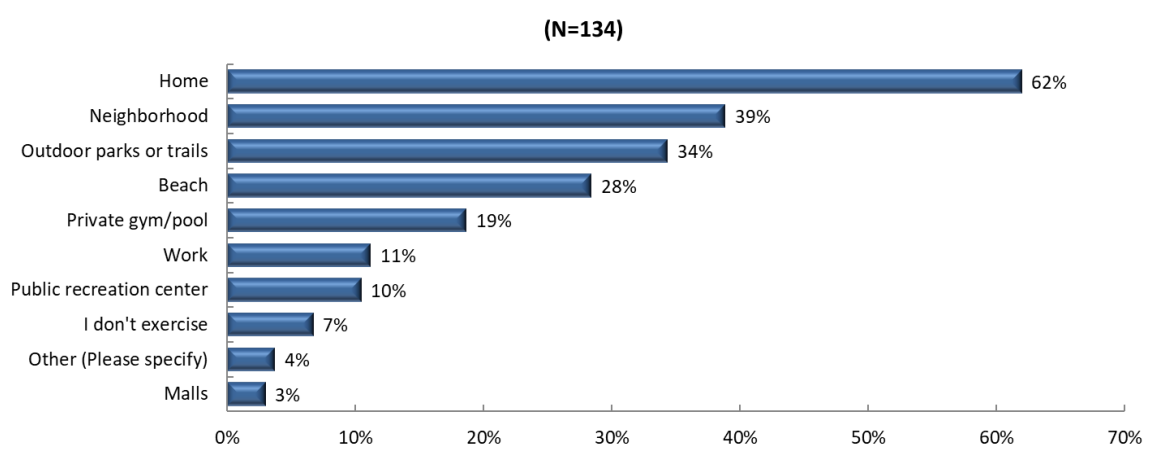
When respondents were asked how often they were physically active outside of their jobs in the last month, just 4% indicated they were not active at all, while 43% indicated they were active between one and 5 hours. On average, community member respondents in Currituck County were active 9 hours per week, suggesting opportunities for increasing physical activity in the community.

Figure 3.5: During the past month, approximately how much time (in hours) per week were you physically active outside of your regular job?



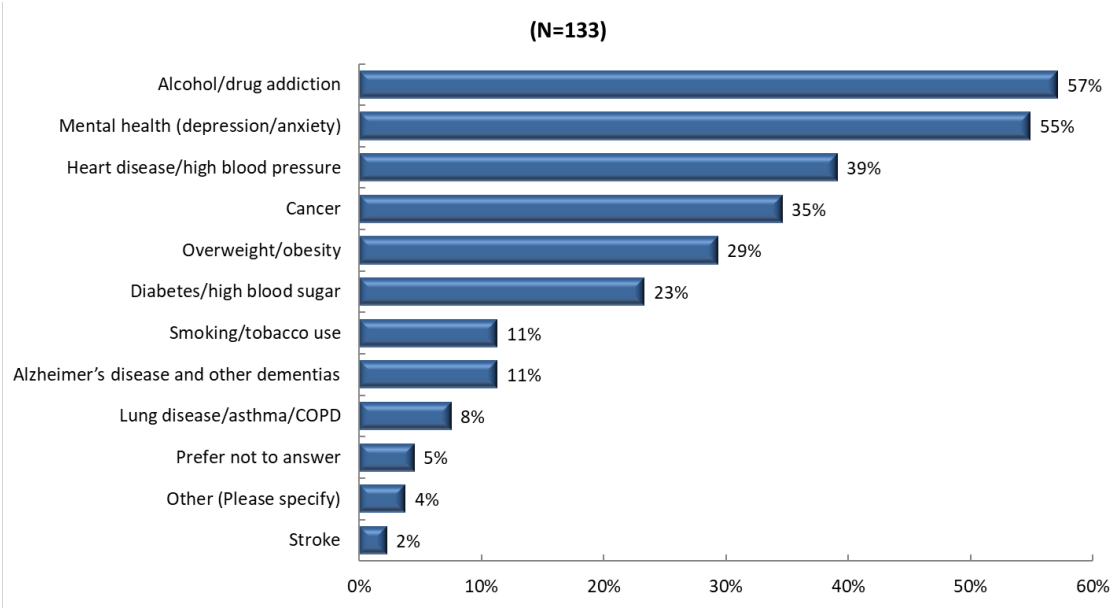
When survey participants were asked where they engage in exercise or physical activities in the community, the majority indicated at home (62%) with nearly 40% selecting their neighborhood and 11% selecting their job.

Figure 3.6: When you are active, where do you engage in exercise or physical activities? (Select all that apply.)



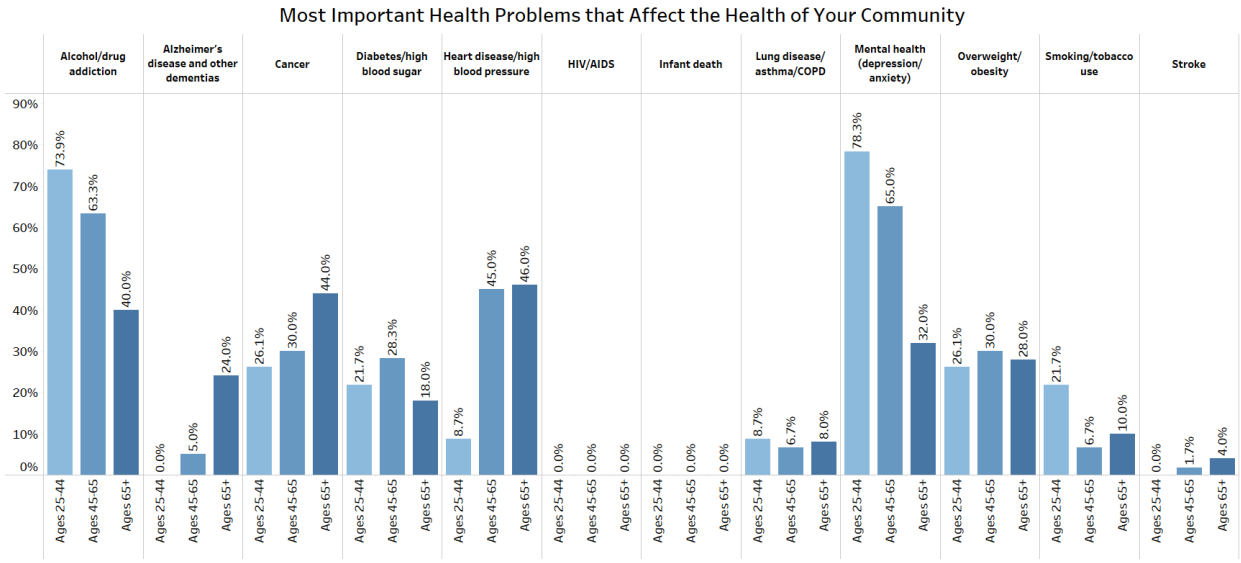
In addition to healthy living concerns, Currituck County respondents also highlighted chronic health conditions as top community concerns in the survey. Heart disease/high blood pressure and overweight/obesity were identified among the top five health problems affecting the community. Nearly one quarter of respondents also identified diabetes/high blood sugar as a top problem. These health conditions are frequently linked to healthy lifestyle habits, underscoring the importance of healthy living in the community.

Figure 3.7: What are the three most important health problems that affect the health of your community? Please select up to three.



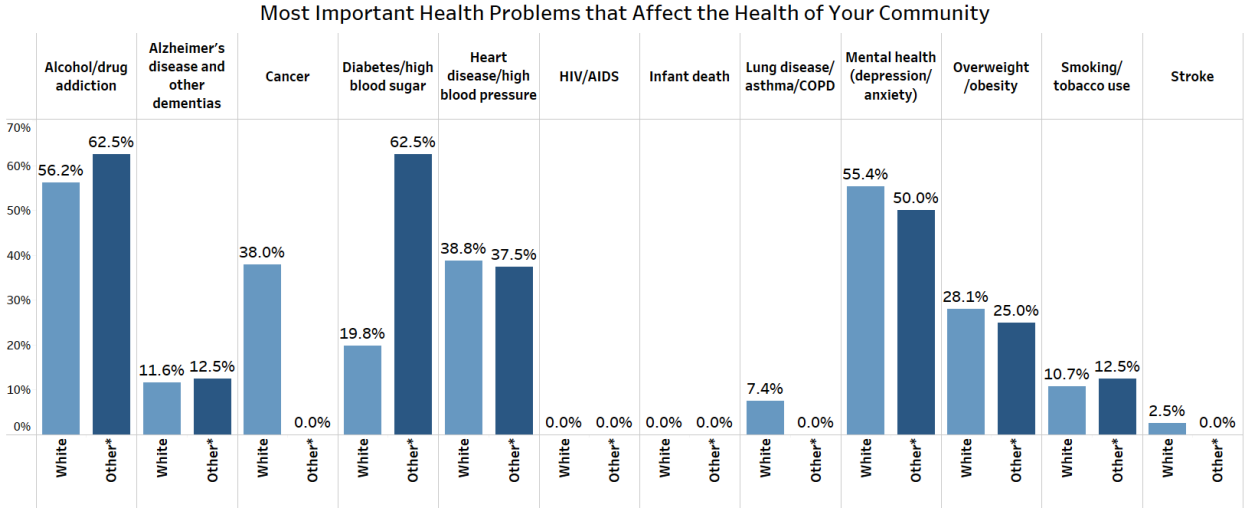
When these results were examined by various demographics of the respondents, responses varied. Older adults viewed heart disease/high blood pressure and diabetes/high blood sugar as more significant problems than younger respondents, as displayed in figure below.

Figure 3.8: What are the three most important health problems that affect the health of your community? (by age group)



Respondents identifying as Other (63%) identified diabetes/high blood sugar more frequently than respondents identifying as White (20%). Those identifying as White (38%) were more likely to select cancer as an important community health problem than those identifying as another race (0%). In contrast, responses were similar for heart disease/high blood sugar and overweight/obesity. Considering these differences in targeted efforts to address specific community health indicators may be important.

Figure 3.9: What are the three most important health problems that affect the health of your community? Please select up to three. (by race)



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

Primary Data Findings – Focus Groups

Focus group participants identified several barriers to maintaining healthy lifestyles in Currituck County. Food access and security emerged as significant concerns, with participants noting that groceries are too expensive to consistently eat a healthy diet and there is limited local access to grocery stores and healthy food options. The lack of nutrition education in the community was also cited as a barrier to healthy eating habits. Participants in the Currituck Family YMCA sessions specifically discussed environmental quality concerns, noting poor quality swamp land and increased traffic due to tourism as factors affecting their ability to maintain healthy and active lifestyles. Physical health conditions such as cancer, high blood pressure, diabetes, and autoimmune diseases were highlighted as serious health concerns in the community.

Focus group members recommended improving walkability by adding sidewalks and crosswalks to encourage physical activity. They also suggested implementing community nutrition education programs and developing solutions for making fruits and vegetables more affordable.

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

PRIORITY NEED: MENTAL HEALTH/SUBSTANCE MISUSE

Context and National Perspective

The definition of behavioral health often describes conditions related to both mental health and substance use.[28] Mental health is defined as an emotional, psychological, and social state of well-being. Mental health impacts every stage of life and affects how one is able to handle their relationships, daily stressors, and health behaviors.[29] After evaluating data from a variety of sources including surveys and focus groups conducted throughout the assessment process, the Steering Committee identified mental health, including substance use, to be an area of urgent need within Currituck 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.[30] There is risk for developing a mental illness across the lifespan, with over one in five children and adults in the U.S. reported to have a mental illness, and nearly one in twenty-five adults currently coping with a serious mental illness (SMI) such as major depression, schizophrenia or bipolar disorder.[29]

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

[28] 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.
[29] Source: CDC. (2024). About mental health. Retrieved October 1, 2024, from: https://www.cdc.gov/mentalhealth/learn/index.htm
[30] Source: National Institute of Mental Health (2023). *Mental Illness*. Retrieved September 13th, 2023, from https://www.nimh.nih.gov/health/statistics/mental-illness.

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

Mental illness is a prevalent concern in North Carolina, with nearly 1.5 million adults reported to have a mental health condition in 2023. Additionally, that same year, 1 in 7 individuals who were identified as homeless also were living with an SMI. Access to mental health care in North Carolina is changing, however it is still unavailable to many. Specifically, over 452,000 individuals did not seek care in 2023, with 44.8% citing cost as the main reason. Additionally, those 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. [32]

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

There are multiple common forms of SUD, such as alcohol use, cocaine use, cannabis use, opioid use, and methamphetamine use disorders. An individual living with one SUD can also be coping with another at the same time, such as co-occurring use of alcohol and cannabis.[36] Treatment 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

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

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

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

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

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

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

approved in 2023 by the FDA. This is critical, as in 2022, the number of opioid overdoses nationwide surpassed 81,051 – a 63% increase in overdoses since 2019.[37]

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.[38] 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.[39]

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 analysis revealed concerning trends in mental health outcomes for Currituck County residents. The crude death rate for deaths of despair (71.3 per 100,000 population) significantly exceeded both state (58.7) and national (55.9) averages. The suicide death rate was also elevated at 18.0 per 100,000 population, compared to 14.0 statewide and 14.5 nationally. Residents reported an average of 4.6 poor mental health days per month, equal to the state average but slightly better than the national average of 4.9 days.

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

[38] Source: 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.

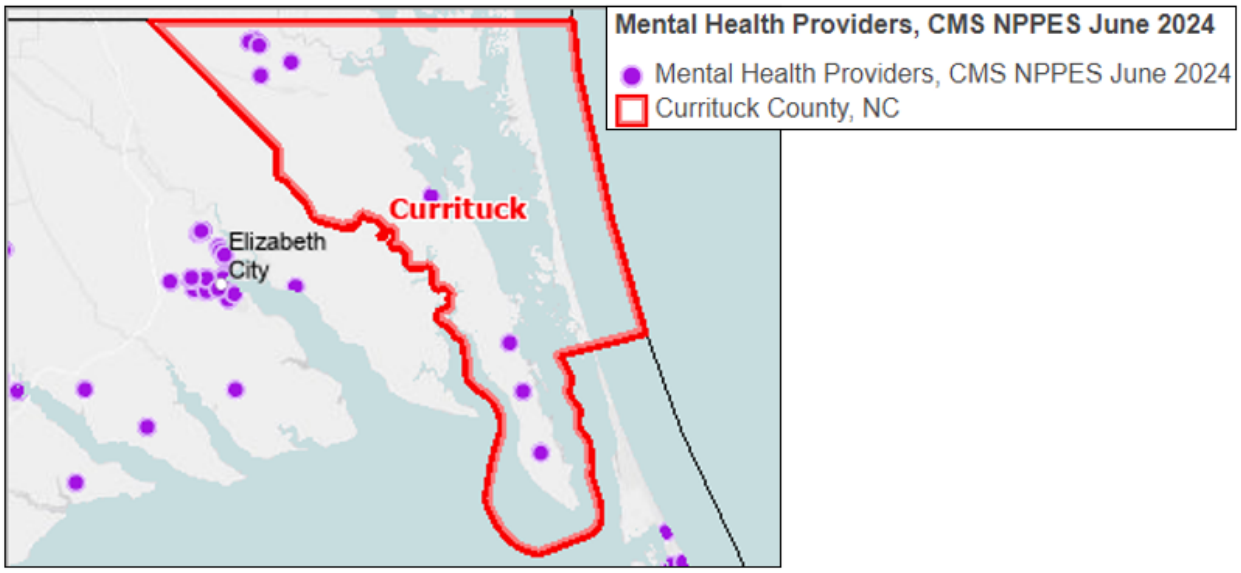
[39] Source: Panchal, N., Saunders H., Rudowitz, R. and Cox, C. (2023). The Implications of COVID-19 for Mental Health and Substance Use. *Kaiser Family Foundation*. Retrieved from https://www.kff.org/mental-health/issue-brief/the-implications-of-covid-19-for-mental-health-and-substance-use.

Table 3.7: Mental Health Indicators			
Indicator	**Currituck County**	**North Carolina**	**United States**
Deaths of Despair (Crude Rate per 100,000 Population)	71.3	58.7	55.9
Suicide Death Rate (Crude Rate per 100,000 Population)	18.0	14.0	14.5
Average Number of Poor Mental Health Days (per Month)	4.6	4.6	4.9

Access to mental health care presents a significant challenge in the county. The county has only 3.6 substance abuse providers per 100,000 population, substantially lower than both state (25.0) and national (27.9) averages. Similarly, the rate of buprenorphine providers (3.6 per 100,000 population) falls well below state (15.2) and national (15.5) averages, potentially limiting access to medication-assisted treatment for opioid use disorder. The rate of mental health providers (42.7 per 100,000 population) was also substantially lower than both state (155.7) and national (178.7) averages, also suggesting potential barriers to accessing mental health services. Providers' geographic distribution throughout the county, displayed in **Figure 3.10** below, further compounds the difficulty of accessing mental health resources and care.

Table 3.8: Mental Health and Substance Abuse Providers			
Indicator	**Currituck County**	**North Carolina**	**United States**
Substance Abuse Providers (Rate per 100,000 Population)	3.6	25.0	27.9
Buprenorphine Providers (Rate per 100,000 Population)	3.6	15.2	15.5
Mental Health Providers (Rate per 100,000 Population)	42.7	155.7	178.7

Figure 3.10: Mental Health Provider Access Map



Analysis of substance use indicators revealed mixed outcomes in Currituck County. The percentage of adults reporting excessive drinking (20%) was higher than both state and national averages (18%). However, the county showed lower rates of emergency department utilization for opioid use disorder at 31 visits per 100,000 beneficiaries, compared to 43 statewide and 41 nationally. Currituck also demonstrated better performance as it relates to alcohol-involved crash deaths with a rate of 2.1 per 100,000 population, lower than both state (2.9) and national (2.3) averages. However, the opioid overdose death rate (24.9 per 100,000 population) was only slightly lower than the state average of 25.1.

Table 3.9: Substance Use Indicators

Indicator	Currituck County	North Carolina	United States
Percentage of Adults Reporting Excessive Drinking	20%	18%	18%
Opioid Use Disorder Emergency Department Utilization (Rate per 100,000 Beneficiaries)	31	43	41
Alcohol-Involved Crash Deaths, Annual (Rate per 100,000 Population)	2.1	2.9	2.3
Opioid Overdose Death Rate	24.9	25.1	N/A

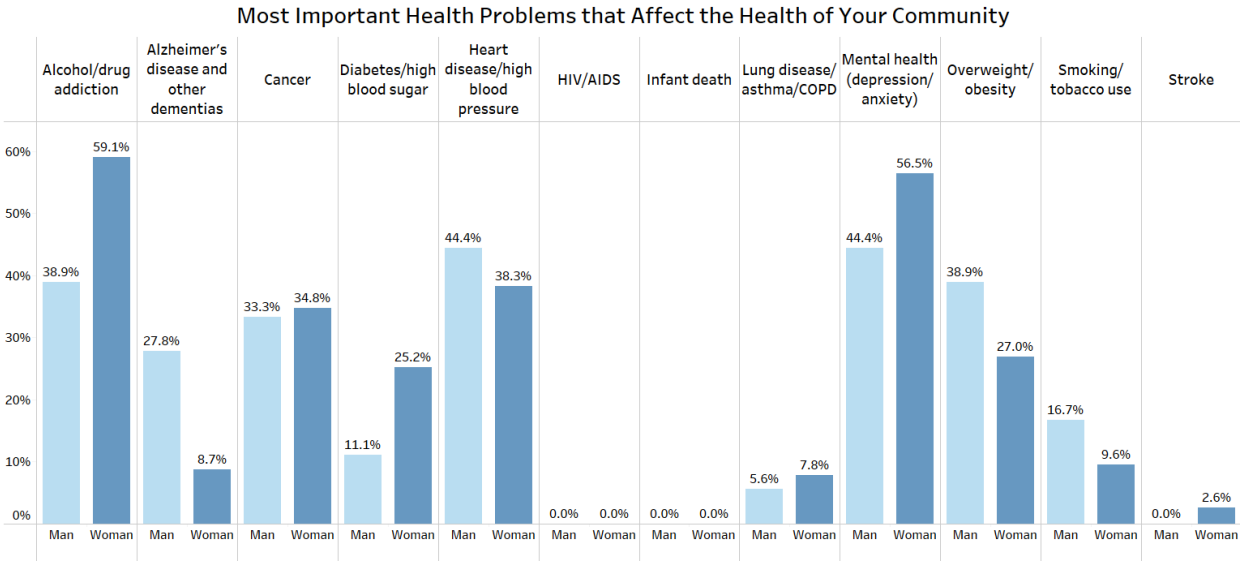
For additional detail on secondary data findings, see **Appendix 3**.

Primary Data Findings – Community Member Web Survey

Currituck County residents highlighted different aspects of mental health and substance misuse as areas of community concern on the web-based survey. When asked to identify the most important community health needs, 57% of these respondents identified alcohol/drug addiction and 55% of respondents identified mental health (depression/anxiety). These were the first and second highest ranked community health needs identified in the survey, respectively.

However, when these data were examined by the race of community member respondents, differences emerged. Those who identified as White (55%) selected mental health (depression/anxiety) as an important community health need more frequently than those who identified as all other races (50%), while those who identified as other racial categories (63%) more frequently selected alcohol/drug addiction as a concern compared to White respondents (56%). Variations also emerged by gender, with significantly higher percentages of women identifying alcohol/drug addiction (59%) and mental health (57%) as significant community needs than men (39% and 44%, respectively).

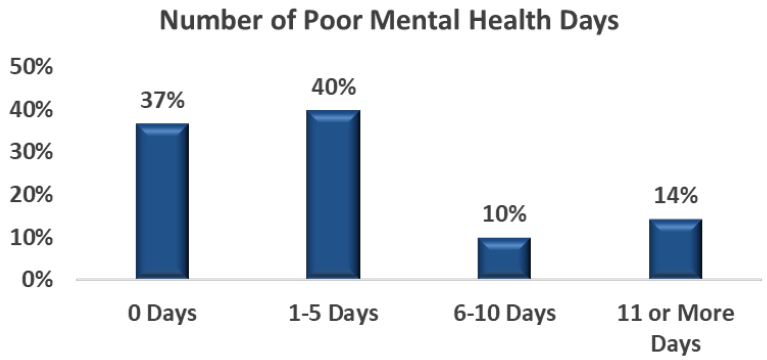
Figure 3.11



Similarly, there were differences in responses across age groups. Younger people identified alcohol/drug addiction and mental health as more significant than older respondents. These perceived differences by demographic characteristics may be important in planning efforts to address behavioral health in the community.

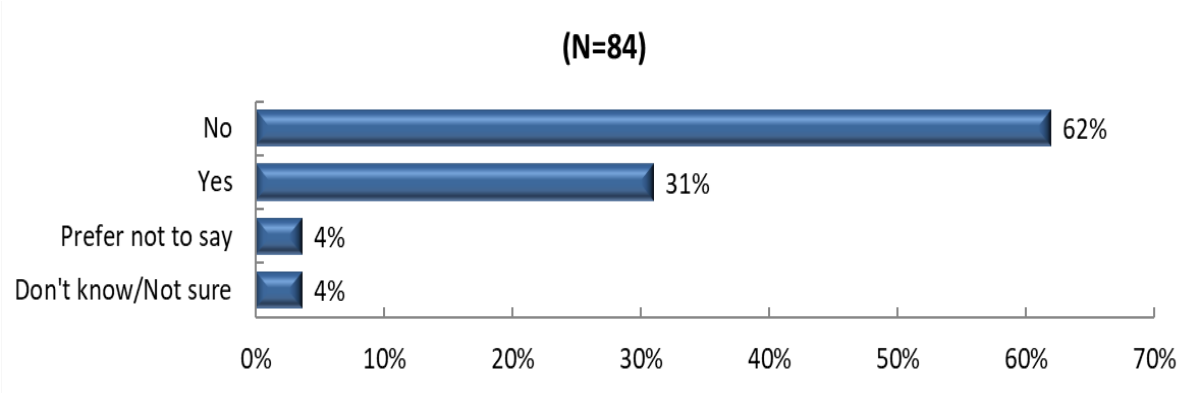
When respondents were asked about their own mental health, nearly two-thirds of respondents indicated they had one or more poor mental health days in the past 30 days, with an average of 5 poor mental health days among all respondents.

Figure 3.12



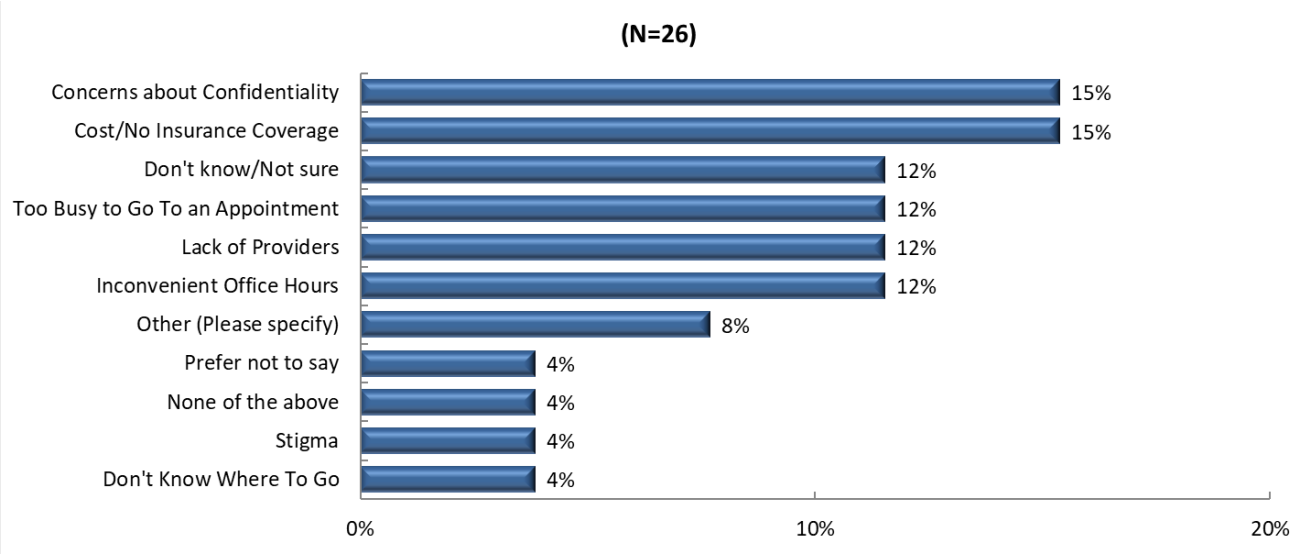
Community member respondents who indicated they experienced at least one poor mental health day in the past month were asked if there was a time in the past 12 months when they needed mental healthcare or counseling but did not get it at that time. Over 30% of these respondents answered yes.

Figure 3.13: Was there a time in the past 12 months when you needed mental healthcare or counseling, but did not get it at that time?



The top responses for why care was not received for this group, included concerns about confidentiality (15%), cost/no insurance coverage (15%), and being too busy to go to an appointment (12%), suggesting accessibility and privacy concerns exist in the community impacting access to needed mental healthcare.

Figure 3.14: What was the MAIN reason you did not get mental health care or counseling?



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

Primary Data Findings – Focus Groups

Mental health and substance use emerged as significant concerns across all focus group sessions. Participants emphasized that overall mental health is a major concern in the community, exacerbated by the complete absence of local mental health services. Social isolation was identified as a particular challenge, especially for vulnerable populations such as older adults. Participants in the Currituck Family YMCA focus groups specifically highlighted concerns about alcohol use and smoking in the community. They noted that the lack of local mental health and substance use treatment services forces residents to travel significant distances to receive care, creating additional barriers for those seeking treatment.

Focus group participants emphasized the need for local mental health services and substance use treatment options. The Currituck Cooperative Extension group added that the lack of resources for young people in the community, including mental health support, often leads to them leaving for college and not returning to the area, further impacting the community's overall well-being.

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 Currituck 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.

Category	Organization Name
Healthcare Facilities	• *See Access to Healthcare Priority below*

Community Services	**Emergency, Fire, and Law Enforcement**
	• Non-Emergency
	  ○ 252-453-3633
	• Currituck County Sherriff's Office
	  ○ 125 College Way Barco, Barco, NC
	  ○ 252-453-82.0
	• Detention Center
	  ○ 252-453-2194
	• Highway Patrol
	  ○ 2824 Caratoke Hwy, Currituck, NC 27928
	  ○ 252- 302-2188
	• Crawford Township Volunteer Fire Department, Inc.
	  ○ 121 Shawboro Rd, Moyock, NC 27958
	  ○ 252-232-3313
	  ○ Barco Station: 252-453-2213
	  ○ Sligo Station: 252-232-3313
	  ○ Sligo Station Fax: 252-232-3489
	• Lower Currituck Volunteer Fire Department, Inc.
	  ○ P.O. Box 207 Grandy, NC 27939
	  ○ 6323 Caratoke Hwy Grandy, NC 27939
	  ○ Grandy Station: 252-453-2761
	  ○ Grandy Station Fax: 252-453-4579
	  ○ Harbinger Station: 252-491-8101
	  ○ Waterlily Station: 252-453-4675
	• Moyock Volunteer Fire Department, Inc.
	  ○ 108 Fire Station Ct., Moyock, NC. 27958
	  ○ 252-435-2281
	  ○ Fax: 252-435-6450
	• Currituck County Fire-EMS (CCFEMS)
	  ○ 2795 Caratoke Highway, Currituck, NC 27929
	  ○ 252-232-7746
	  ○ Fax: 252-232-2930

Housing and Homelessness

- Work First Family Assistance
  - 2793 Caratoke Highway, Currituck, NC 27929
  - 252-232-3083
- Currituck House Assisted Living
  - 141 Moyock Landing Dr., Currituck, NC
  - 252-435-1024

Transportation & Transit

- Inter-County Public Transportation Authority
  - 110 Kitty Hawk Ln, Elizabeth City, NC 27909
  - 252- 338-4480

Family/Social Services

- Department of Social Services
  - 153 Courthouse Road, Suite 400, Currituck, NC 27929
  - 252-232-3083
  - Fax: 252-232-2167
- Albemarle Alliance for Children and Families
  - Mission: To improve children's lives in Bertie, Camden, Currituck, Gates, and Pasquotank Counties.
  - Goals: To make sure children enter school healthy and ready to learn. To provide programs for young children and caregivers to improve quality of child care and funds child care scholarships and programs designed to support families.
  - 1403 Parkview Drive, Elizabeth City, NC 27909
  - 252-333-1233
  - Fax: 252-333-1201
  - Email: contact@albemarleacf.org

Education and Childcare

- Central Elementary School
  - 504 Shortcut Rd., Barco, NC 27917
  - 252-453-0010
- Currituck County High School
  - 4203 Caratoke Hwy., Barco, NC 27917
  - 252-453-0014
- Currituck County Learning Center
  - Located at Currituck County High School
  - 252-453-0017 EXT 3003
- Currituck County Middle School
  - 4263 Caratoke Hwy., Barco, NC 27917
  - 252-453-2171
- Griggs Elementary School

- 261 Poplar Branch Rd., Poplar Branch, NC 27965
- 252-453-2700

- J.P. Knapp Early College
  - 2966 Caratoke Hwy., Currituck, NC 27929
  - 252-232-3107
- Jarvisburg Elementary School
  - 110 Jarvisburg Rd., Jarvisburg, NC 27947
  - 252-491-2050
- Moyock Elementary School
  - 255 Tulls Creek Rd., Moyock, NC 2758
  - 252-435-6521
- Moyock Middle School
  - 216 Survey Rd., Moyock, NC 27958
  - 252-435-2566
- Shawboro Elementary School
  - 370 Shawboro Rd., Moyock, NC 27958
  - 252-232-2237
- Jarvisburg Christian Academy
  - 121 Forbes Rd., Jarvisburg, NC 27947
  - 252-491-8283
- Regional Aviation & Technical Training Center
  - 107 College Way Barco, NC 27917
  - Phone: 252-453-3035
  - Fax: 252-453-3215
- Central Elementary Preschool
  - 504 Shortcut Road, Barco, NC 27917
  - 252-453-0010
- Currituck County Head Start
  - 494 Short Cut Road, Barco, NC 27917
  - 252-453-4992
- Humble Beginnings Child Care Center
  - 268 Caratoke Hwy, Moyock, NC 27958
  - 252-232-1398
- Jarvisburg Elementary School: More at Four
  - 110 Jarvisburg Road
  - Jarvisburg, NC 27947
- A Brighter Start Academy, Inc.
  - 113 Gallop Road
  - Point Harbor, NC 27964
  - 252-491-2040
- Farmer in the Dell Preschool
  - 7467 Caratoke Highway
  - Jarvisburg, NC 27947
  - 252-491-8196
- New Beginnings

	○ Moyock, NC 27958 ○ 252-232-2051 • Tiny Tots Learning Center ○ Highway 3 Aydlett Road, Poplar Branch, NC 27965 ○ 252-453-8218 • Griggs Elementary Preschool ○ Poplar Branch, NC 27965 ○ (252) 453-2700 **Library Services** • Currituck Public Library [Main] ○ 4261 Caratoke Hwy, Barco, NC 27917 ○ 252-453-8345 • East Albemarle Regional Library • Moyock Library ○ 126 Campus Drive (off of Tulls Creek Rd), Moyock, NC 27958 ○ 252-435-6419 **Career Center** • Currituck County Joblink Career Center ○ 2793 Caratoke Highway, Currituck, NC 27929 ○ 252-232-3083
Priority Need: Access to Healthcare	• Albemarle Regional Health Services – Currituck County ○ Mission Statement: Inspiring people to lead healthy lives. ○ Vision Statement: The Public Health professionals and programs of Albemarle Regional Health Services are dedicated to disease prevention and the promotion of a healthy environment to reduce morbidity, mortality, and disability through quality service, education, and advocacy. ○ 2795 Caratoke Hwy, Currituck, NC 27929 ○ (252) 232-2271 • Chesapeake Regional Primary Care - Currituck ○ 534 Caratoke Hwy, Moyock, NC 27958 ○ 252-435-6621 • The Outer Banks Hospital, Inc. ○ 4800 S. Croatan Highway, Nags Head, NC 27959 ○ 877-359-9179 • EMS Chief, Fire & Emergency Medical Services ○ 2795 Caratoke Highway, Currituck, North Carolina 27929 ○ 252-232-7746 ○ Fax: 252-232-0015 • Hometown Med of Moyock and OBX ○ 109 Currituck Commercial Dr, Suite A, Moyock, NC 27958 ○ 252-772-1110 • Sentara Family & Internal Medicine Physicians

	○ 446 Caratoke Hwy, Moyock, NC 27958 ○ 252-435-1275 • Currituck Internal Medicine & Family Practice ○ 534 Caratoke Hwy, Moyock, NC ○ 252-435-6621 • Currituck Health & Rehab Center ○ 3907 Caratoke Highway, Barco, NC 27917 ○ Tel (252) 457-0500 • Mane and Tail Therapeutic Horsemanship Academy ○ 6066 Caratoke Highway, Poplar Branch, NC 27965 ○ 252-448-1774 • Morgan & Morgan: Morgan Jr. Patrick H DDS ○ 153 Worth Guard Rd., Coinjock, NC 27923 ○ 252-453-2181 • Currituck Dental ○ 112 Currituck Commercial Drive, Moyock, NC 27958 ○ 252-232-0800 • Affordable Dentures Implants ○ 107 Lazy Corner Road, Moyock, NC 27958 ○ 252-260-5287 • Dr. Dennis Gaskin, DDS ○ 107 Lazy Corner Rd, Moyock, NC 27958 ○ (252) 435-6335 • Dental Transformations ○ 153 Worth Guard Rd, Coinjock, NC 27923 ○ 252-453-2181 • Outer Banks Family & Cosmetic Dentistry ○ 1 S Dogwood Trail, Southern Shores, NC 27949 ○ 252-255-1001 • Sentara Nursing Center ○ 3907 Caratoke Highway, Barco, NC 27917 ○ 252-457-0500
Priority Need: Behavioral Health	• Albemarle Regional Health Services – Currituck County ○ 2795 Caratoke Hwy, Currituck, NC 27929 ○ (252) 232-2271 • Albemarle Hopeline, Inc. ○ 24-Hour Crisis Line: (252) 338-3011 ○ P.O. Box 2064 ○ Elizabeth City, NC 27906-2064 ○ 252-338-5338 • Trillium ○ Manages mental health, substance use, and intellectual/development disability services in a 24-county area. Trillium partners with agencies and licensed therapists

	to offer services and support to people in need within their community. ○ Crisis Care & Service Enrollment: 1-877-685-2415 ○ Email: info@trilliumnc.org • 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. ○ Available in English and Spanish, provides local referral information, and includes learning and resource section. • Quitline NC ○ Free, confidential, one-on-one support, nicotine replacement therapy - patch, gum and lozenge - is now available for every person who enrolls. ○ Telephone Service is available 24/7 toll-free at ○ 1-800-QUIT-NOW (1-800-784-8669) • East Carolina Behavioral Health: 1-877-685-2415 • National Alliance on Mental Illness: 1-800-950-6264 • National Drug Abuse Hotline: 1-800-662-HELP (4357) • National Mental Health Association: 1-800-969-6642 • National Suicide Prevention Lifeline: 1-800-784-2433
Priority Need: Healthy Living	**Healthy Living and Fitness** • Albemarle Get Fit ○ 711 Roanoke Ave, Elizabeth City, NC 2799 ○ 252-338-4400 • Currituck Family YMCA ○ 130 Community Way, Barco, NC 27917 ○ 252-453-9632 • Currituck County Parks & Recreation ○ 30 Community Way, Barco, NC 27917 ○ 252-232-3007 • Currituck County Senior Center ○ 130 Community Way, Barco, NC 27917 ○ 252- 232-3505 • Currituck County Senior Center ○ 2793 Caratoke Hwy, Currituck, NC 27929 ○ 252-232-3505 **Diet and Healthy Eating** • NC Cooperative Extension ○ 120 Community Way Barco, NC 27917

	○ 252-232-2261 • Coinjock Creek Mobile Market ○ 194 Maple Rd., Maple, NC 27956 ○ 252-267-3332 Accepts: SNAP, EBT • Currituck Farmers Market ○ 6032 Caratoke Highway, Poplar Branch, NC 27965 ○ 252-564-5066 • Grandy Greenhouse and Market ○ 6264 Caratoke Hwy., Grandy, NC 27939 • Home Grown Market ○ 7026 Caratoke Hwy., Jarvisburg, NC 27947 ○ 252-491-2181 • Morris Farm Market ○ 3784 Caratoke Hwy., Barco, NC 27917 ○ 252-453-2837 • Powells Roadside Market ○ 2138 Caratoke Hwy., Moyock, NC 27958 ○ 252-232-2745 • Moyock Farm Market ○ 193 Camellia Rd, Moyock, NC 27958 ○ 252- 435-6449 • Roberts Ridge Farm ○ 501 N. Indiantown Rd. ○ Shawboro, NC 27973 ○ 252-202-9665 • JC Rose Farm Dr. ○ 140 Wildwood Dr., Moyock NC, 27958 ○ 252-435-3918 • Tarheel Produce ○ 6954 Caratoke Hwy., Grandy, NC 27939 ○ 252-491-8600 • Whichard's Farm Market ○ 7464 Caratoke Hwy., Jarvisburg, NC 27947 ○ 252-326-1850 ○ whichardsfarmmarket@gmail.com ○ Accepts: SNAP, EBT
Additional Organizations: Hotlines	• American Association of Poison Control Centers: 1-800-222-1222 • Children's Home Society of North Carolina: 1-800-632-1400 • Emergency Contraception: 1-800-584-9911 • Healthy Start Foundation: 1-800-FOR-BABY (367-2229) • National Domestic Violence Hotline: 1-800-799-SAFE (7233) • National Sexual Assault Hotline: 1-800-656-HOPE • Planned Parenthood: 1-800-230-7526 • National Gay Task Force: (202) 393-5177

	• Rape Crisis Center: 1-800-656-4673 • Real Crisis Center: (252) 758-HELP (4357)

CHAPTER 5 | NEXT STEPS

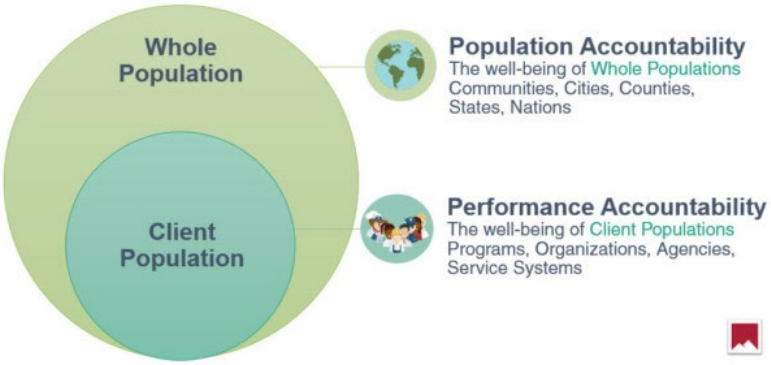
The CHNA findings are used to develop effective community health improvement strategies to address the priority needs identified throughout the process. The next and final step in the CHNA process is to develop community-based health improvement strategies and action plans to address the priorities identified in this assessment. Health leaders in Currituck 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. Currituck 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. Currituck 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 Currituck County, its performance on each data measure was compared to targets/benchmarks. If Currituck 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 facilities, 3) with 1.51 or more	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)
	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 acquired from the 2018-2022 ACS	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)
	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 overdose) per 100,000 population.	CDC – National Vital Statistics System. Data accessed via the North	2018-2022

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

Table A2.18 Sexual Health

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

Table A2.19: Substance Use Disorders

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

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

Measure	Description	Data Source	Most Recent Data Year(s)
	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 Currituck 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	Currituck County Description
	Low	Represents measures in which Currituck 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 Currituck 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 Currituck 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 Currituck County value was compared to the benchmark by calculating the percentage difference between the values, relative to the benchmark value:

(Currituck 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:

(0.5-7.5)/(7.5) x 100% = -93.3% = Displayed as **Low Priority Level**, Shaded in Green

This metric indicates that the percentage of the population with limited access to healthy foods in Currituck County is 93.3 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	Currituck County Data	Most Recent Data Year	Currituck County Need
Primary Care Providers Ratio	112.4	101.1	39.2	2024	High
Mental Health Providers Ratio	178.7	155.7	42.7	2024	High
Addiction/Substance Abuse Providers Ratio	27.9	25.0	3.6	2024	High
Buprenorphine Providers Ratio	15.5	15.2	3.6	2023	High
Dental Health Providers Ratio	39.1	31.5	10.7	2024	High
% Living in Health Professional Shortage Areas (HPSAs) – Dental Care	17.8%	34.0%	89.5%	2018-2022	High
Federally Qualified Health Centers (FQHCs)	3.5	4.1	0.0	2023	High
% Receiving Medicaid	22.3%	20.2%	14.7%	2018-2022	Low
% Uninsured	10.2%	12.5%	12.4%	2022	Medium

Table A3.2: Built Environment

Measure	National Benchmark	North Carolina Benchmark	Currituck County Data	Most Recent Data Year	Currituck County Need
Broadband Access (Access to DL Speeds >= 25MBPS and UL Speeds >= 3 MBPS)	93.8%	93.6%	92.1%	2023	Medium
Broadband Access (Access to DL Speeds >= 100MBPS and UL Speeds >= 20 MBPS)	91.2%	90.4%	89.5%	2023	Medium
Households with No Computer	6.1%	6.9%	3.7%	2018-2022	Low
Households with No or Slow Internet	11.7%	13.0%	10.6%	2018-2022	Low

Measure	National Benchmark	North Carolina Benchmark	Currituck County Data	Most Recent Data Year	Currituck County Need
Liquor Stores	13.3	6.2	28.5	2022	High
Adverse Childhood Experiences (ACEs)	N/A	N/A	Suppressed	2022	N/A

Table A3.3: Diet and Exercise

Measure	National Benchmark	North Carolina Benchmark	Currituck County Data	Most Recent Data Year	Currituck County Need
% Physically Inactive	N/A	21.6%	18.9%	2021	Low
Walkability Index Score	10	7	6	2021	High
% with Access to Exercise Opportunities	84.1%	73.0%	78.0%	2023	Low
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	Currituck County Data	Most Recent Data Year	Currituck County Need
% Limited English Proficiency	8.2%	4.6%	2.0%	2018-2022	Low
High School Graduation Rate	81.1%	87.6%	83.9%	2020-2021	Medium
% with No High School Diploma	10.9%	10.6%	7.2%	2018-2022	Low
Student Math Proficiency	63.9%	65.8%	62.2%	2020-2021	Low
Student Reading Proficiency	60.1%	59.5%	49.0%	2020-2021	Low
School Funding Adequacy	N/A	-$4,742	$1,468	2021	Low
School Funding Adequacy – Spending per pupil	N/A	$10,655	$10,704	2021	Medium

Table A3.5: Employment

Measure	National Benchmark	North Carolina Benchmark	Currituck County Data	Most Recent Data Year	Currituck County Need
Unemployment Rate	3.9%	3.7%	2.7%	2024	Low
Average Annual Unemployment Rate, 2013-2023	3.6%	3.5%	3.1%	2024	Low

Table A3.6: Environmental Quality

Measure	National Benchmark	North Carolina Benchmark	Currituck County Data	Most Recent Data Year	Currituck County Need
Flood Vulnerability	6.5%	4.9%	38.2%	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	Currituck County Data	Most Recent Data Year	Currituck County Need
Childcare Cost Burden	28.8%	27.0%	21.0%	2023	Low
% Young People Not in School or Working	6.9%	7.5%	4.5%	2018-2022	Low

Table A3.8: Food Security

Measure	National Benchmark	North Carolina Benchmark	Currituck County Data	Most Recent Data Year	Currituck County Need
% Food Insecure	10.3%	11.4%	8.9%	2021	Low
% Food Insecure Children	13.3%	15.3%	9.0%	2021	Low
% Low-Income and with Low Food Access	19.4%	21.3%	1.7%	2019	Low
% Limited Access to Healthy Foods	N/A	7.5%	0.5%	2019	Low
Fast Food Restaurants	96.2	77.4	74.7	2022	Medium
Grocery Stores	23.4	18.7	32.0	2022	Low

Table A3.9: Housing and Homelessness

Measure	National Benchmark	North Carolina Benchmark	Currituck County Data	Most Recent Data Year	Currituck County Need
Renter Costs – Average Gross Rent	$1,366	$1,090	$1,001	2018-2022	Low
% Severe Housing Cost Burden	14.1%	12.2%	11.7%	2018-2022	Medium
Assisted Housing Units	413.9	319.2	152.7	2017-2021	Low
% Severe Substandard Housing	18.5%	16.1%	15.9%	2011-2015	Medium
% Homeless Children	2.8%	1.9%	1.3%	2019-2020	Low

Table A3.10: Income

Measure	National Benchmark	North Carolina Benchmark	Currituck County Data	Most Recent Data Year	Currituck County Need
Median Family Income	$92,646	$82,890	$100,195	2018-2022	Low
Gender Pay Gap	81.0%	83.0%	71.0%	2018-2022	High
% Living Below 100% FPL	12.5%	13.3%	8.5%	2022	Low
% Living Below 200% FPL	28.8%	31.6%	21.3%	2018-2022	Low
% Children Living Below 200% FPL	37.2%	41.1%	28.9%	2018-2022	Low
% Receiving SNAP	12.4%	15.7%	7.7%	2021	Low
Children Eligible for Free/Reduced Price Lunch	51.7%	50.8%	21.5%	2022-2023	Low

Table A3.11: Length of Life

Measure	National Benchmark	North Carolina Benchmark	Currituck County Data	Most Recent Data Year	Currituck County Need
Years of Potential Life Lost Rate	N/A	8,853	7,186	2019-2021	Low
Premature Age-Adjusted Mortality	N/A	420	383	2019-2021	Low
Life Expectancy	77.6	76.6	77.2	2019-2021	Medium

Table A3.12: Maternal and Infant Health

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

Table A3.13: Mental Health

Measure	National Benchmark	North Carolina Benchmark	Currituck County Data	Most Recent Data Year	Currituck County Need
Poor Mental Health Days	4.9	4.6	4.6	2021	Medium
Deaths of Despair Rate	55.9	58.7	71.3	2018-2022	High
Suicide Death Rate	14.5	14.0	18.0	2018-2022	High

Table A3.14: Physical Health

Measure	National Benchmark	North Carolina Benchmark	Currituck County Data	Most Recent Data Year	Currituck County Need
% Poor or Fair Health	N/A	14.4%	12.3%	2021	Low
% Adults with Asthma	9.7%	9.8%	9.3%	2022	Low
% Adults with Heart Disease	5.2%	5.5%	5.2%	2022	Low
% Adults with High Blood Pressure	29.6%	32.1%	29.6%	2021	Low
% Adults with High Cholesterol	31.0%	31.4%	31.2%	2021	Medium
Diabetes Prevalence	8.9%	9.0%	7.7%	2021	Low
% Adults with Kidney Disease	2.7%	2.9%	2.6%	2021	Low
% Stroke	2.8%	3.1%	2.6%	2022	Low
Obesity	30.1%	29.7%	22.8%	2021	Low
% Teeth Loss	13.9%	12.0%	10.5%	2022	Low
Cancer Incidence Rate	442.3	464.4	311.3	2016-2020	Low
Emergency Room Visits	535	563	560	2022	Medium

Measure	National Benchmark	North Carolina Benchmark	Currituck County Data	Most Recent Data Year	Currituck County Need
Heart Disease Hospitalization Rate	10.4	11.7	14.1	2018-2020	High
Stroke Hospitalization Rate	8.0	9.5	9.1	2018-2020	Medium

Table A3.15: Quality of Care

Measure	National Benchmark	North Carolina Benchmark	Currituck County Data	Most Recent Data Year	Currituck County Need
Children/adults vaccinated annually against seasonal influenza	44.5%	45.6%	48.4%	2021	Low
Preventable Hospital Rate	2,752	2,957	3,379	2021	High
Readmissions Rate	18.1%	17.6%	17.5%	2022	Medium

Table A3.16: Safety

Measure	National Benchmark	North Carolina Benchmark	Currituck County Data	Most Recent Data Year	Currituck County Need
Incarceration Rate	1.3%	1.5%	1.3%	2018	Low
Juvenile Arrest Rate	13.8	16.0	16.0	2021	Medium
Violent Crime	416.0	365.7	150.3	2015-2017	Low
Firearm Death Rate	13.4	15.5	N/A	2018-2022	N/A
Poisoning Death Rate	28.5	31.5	31.1	2018-2022	Medium

Table A3.17: Sexual Health

Measure	National Benchmark	North Carolina Benchmark	Currituck County Data	Most Recent Data Year	Currituck County Need
Chlamydia Rate	495.0	603.3	185.5	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	Currituck County Data	Most Recent Data Year	Currituck County Need
% Excessive Drinking	18.1%	18.2%	20.1%	2021	High
% Driving Deaths with Alcohol	2.3	2.9	2.1	2018-2022	Low
Opioid Use Disorder Rate	41.0	43.0	31.0	2021	Low
Opioid Drug Overdose Deaths	N/A	25.1	24.9	2018-2022	Medium

Table A3.19: Tobacco Use

Measure	National Benchmark	North Carolina Benchmark	Currituck County Data	Most Recent Data Year	Currituck County Need
% Smokers	14.5%	15.0%	14.8%	2021	Medium

Table A3.20: Transportation Options and Transit

Measure	National Benchmark	North Carolina Benchmark	Currituck County Data	Most Recent Data Year	Currituck County Need
% Households with No Motor Vehicle	8.3%	5.4%	1.7%	2018-2022	Low
% Public Transit	3.8%	0.8%	0.1%	2018-2022	High
% Living Near Public Transit	34.8%	10.9%	0.0%	2021	High

APPENDIX 4 | PRIMARY DATA METHODOLOGY AND SOURCES

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

Methodologies

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

Focus Groups

The following three focus groups were conducted in person between June 3rd, 2024, and June 12th, 2024. These groups included representation from community members, with participants providing responses on their experiences living, working, or receiving healthcare in Currituck County.

- Currituck Family YMCA
- Currituck Cooperative Extension

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 Currituck County

The majority (77.8%) of participants identified as female, and the group was predominantly white (100%), and non-Hispanic/Latino (100%). Participants represented a wide range of ages between 17-65 and older.

The focus group discussion guide questions are below:

FACILITATOR INTRODUCTION:

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

PARTICIPANT INTRODUCTIONS

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

HEALTH AND WELLNESS

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

SOCIAL DETERMINANTS OF HEALTH

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

ACCESS TO CARE

7. What are some reasons people in [COUNTY NAME] do not get health care when they need it? How can these issues be addressed?
8. What do you think about the health-related services that are available in your community, including medical care, dental care and behavioral health care?
    a. Are there enough locations providing these types of care for people who need it?
    b. Can you find medical, dental or behavioral health care within a reasonable timeframe when you need it?

c. Are your experiences with providers (doctors, dentists, nurses, therapists, emergency personnel, etc.) more positive or negative, and why?

SUGGESTIONS

9. What are some of the strengths or community assets in [COUNTY NAME] that can help residents live healthier lives?

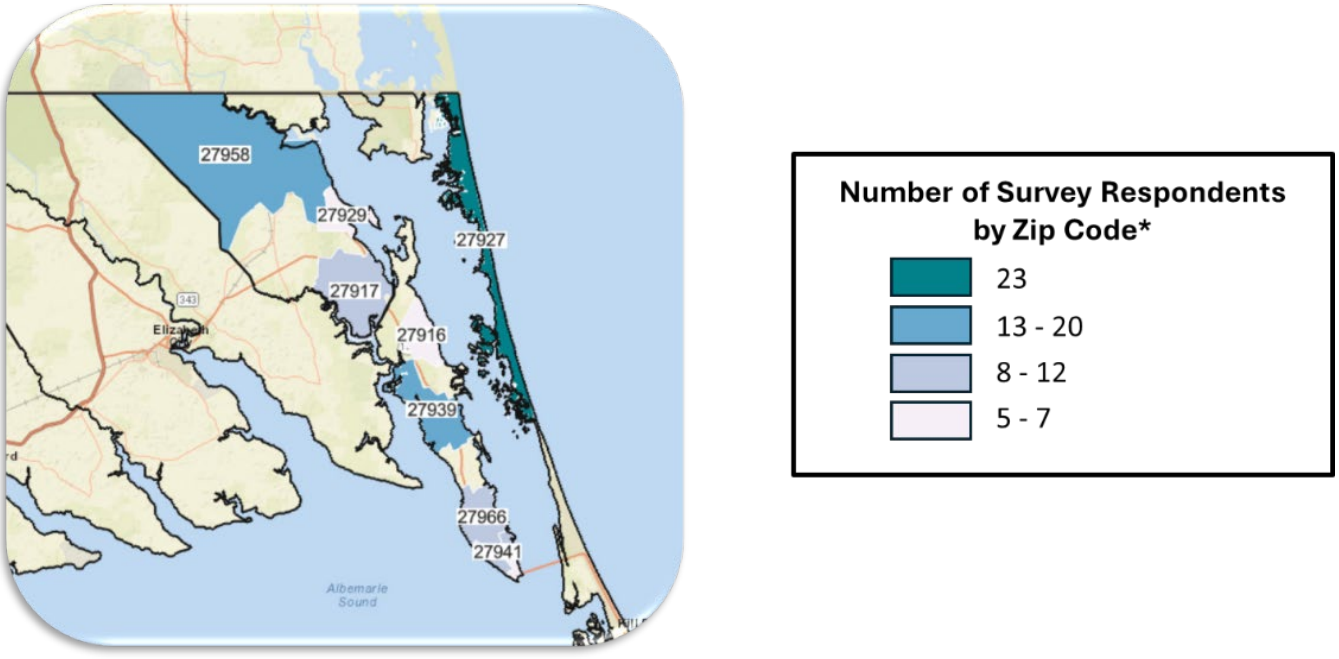
10. What do you think local health leaders should do to improve health and quality of life in [COUNTY NAME]? What do you want local health leaders to know?

11. What actions can local residents take to help improve the health of the community?

Community Member Web Survey

A total of 134 surveys were completed by individuals living, working or receiving healthcare in the Currituck County community. The survey was available in both English and Spanish; however, none were completed in Spanish. Consistent with one of the survey process goals, survey community member respondents were representative of a broad geographic area encompassing areas throughout the county. The map below provides additional information on survey respondents' ZIP code of residence.

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



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

In general, survey questions focused on:

- Community health problems and concerns
- Community social/environmental problems and concerns
- Other topics of interest to Currituck County:
    - Access to care
    - Healthy lifestyle
    - Housing and homelessness
    - Mental health
    - Physical health
    - Substance use disorders
    - Transportation and transit

The key findings from the Community Survey are detailed below:

- Alcohol/drug addiction, mental health (e.g., depression and anxiety), and heart disease/high blood pressure were identified as the top 3 health problems affecting the community. About one third of respondents also identified cancer and weight/obesity as important health problems.
- Cost, physician proximity, and wait times were the top three barriers to receiving health care identified by the community.
- Availability and access to doctor's offices, housing, and lack of affordable child care were identified as the top three most important social or environmental problems that affect the health of the community. Limited places to exercise, insurance, and transportation problems were also identified by almost one in four respondents.

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

Figure A4.2: Respondents by Age Group

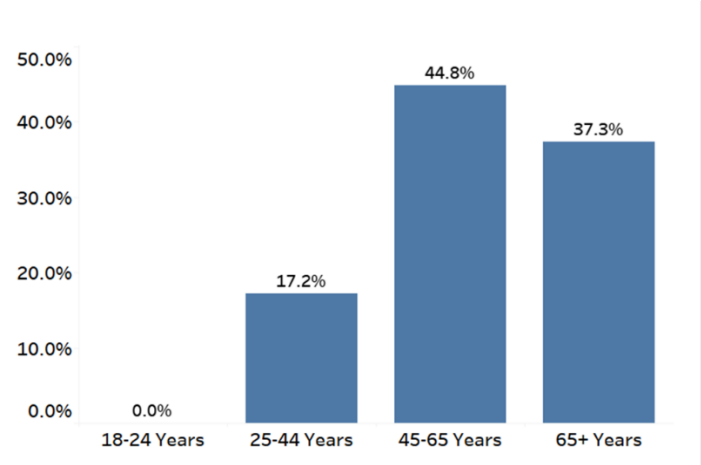


Figure A4.3: Respondents by Gender

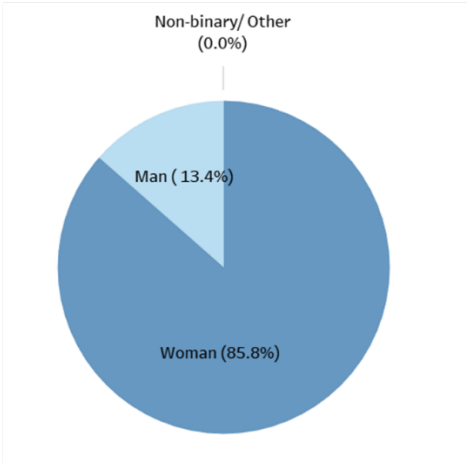


Figure A4.4: Respondents by Race

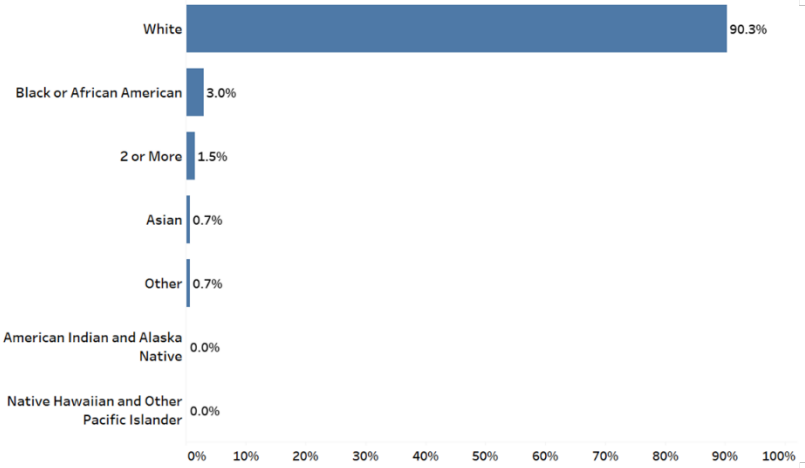
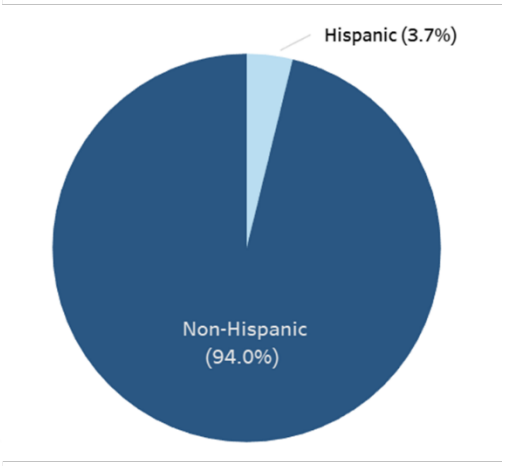


Figure A4.5: Respondents by Ethnicity



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?[41]

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

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

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

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

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

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

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

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

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

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

Topic: Community Health Opinion Questions

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

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

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

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

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

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

Topic: Access to Care

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

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

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

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

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

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

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

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

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

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

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

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

Topic: 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 physical 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 General Findings

As part of the CHNA process, three focus groups were conducted in Currituck County to gain insights into residents' experiences. Two focus groups were held at Currituck Family YMCA, with a third held at Currituck Cooperative Extension. These focus groups identified several common health concerns and barriers to care across the county.

The primary concerns included employment and income issues, particularly the overall cost of living, including food and healthcare costs, as well as extremely high childcare costs. Food access and security were also significant issues, with participants noting that groceries are too expensive to eat healthily, there is limited access to grocery stores and healthy food options, and a lack of nutrition education. Healthcare access and quality emerged as another major barrier, with residents citing a lack of local providers, especially specialists, long wait times, limited appointment availability, and feeling rushed or not listened to by providers. Housing and homelessness were also identified as critical issues, with very high housing costs, residents unable to compete with the military and tourists for housing, and a lack of infrastructure for affordable housing.

Community members provided several suggestions for how local leaders can improve community health. These included enhancing traveling health provider programs and mobile clinics to provide better care across the county, providing community nutrition education and offering solutions for affordable fruits and vegetables, improving walkability by adding sidewalks and crosswalks, and developing more effective strategies to communicate with community members about available programs and services.

Focus Group 1 & 2 Unique Insights: Currituck Family YMCA

Four community members participated in focus group one, with nearly all (3) participants identifying as female. All four participants were identified as white and were over the age of 26. Five community members participated in focus group two, with the same demographics as focus group one, with the exception that all participants were over the age of 17. Participants in the Currituck Family YMCA focus groups identified several additional health and social/environmental barriers specific to their experiences. Environmental quality was a concern, with participants noting poor quality swamp land and increased traffic due to tourism. Maternal and infant health issues were highlighted, particularly the limited local pre- and post-natal care and the need to travel for OBGYN services. Mental health emerged as a significant concern, with participants noting a lack of local mental health services and issues of social isolation. Physical health problems such as cancer, high blood pressure, diabetes, and autoimmune diseases were also top concerns. Substance use, particularly alcohol, and tobacco use were noted as particular health concerns. Transportation and transit issues were identified as barriers, especially impacting people without vehicles and older adults.

Focus Group 3 Unique Insights: Currituck Cooperative Extension

The focus group held at Currituck Cooperative Extension highlighted an additional concern related to family, community, and social support. Participants noted a lack of resources for young people, resulting

in many leaving for college and not returning to the area. This issue impacts the community's ability to retain its younger population and maintain a diverse workforce.

In conclusion, the focus groups in Currituck County revealed a range of interconnected health and social issues affecting residents' well-being. Addressing these concerns will require a multifaceted approach, involving improvements in healthcare access, economic opportunities, housing affordability, and community resources. The suggestions provided by community members offer a starting point for local leaders to develop targeted interventions and improve overall community health.

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=134)

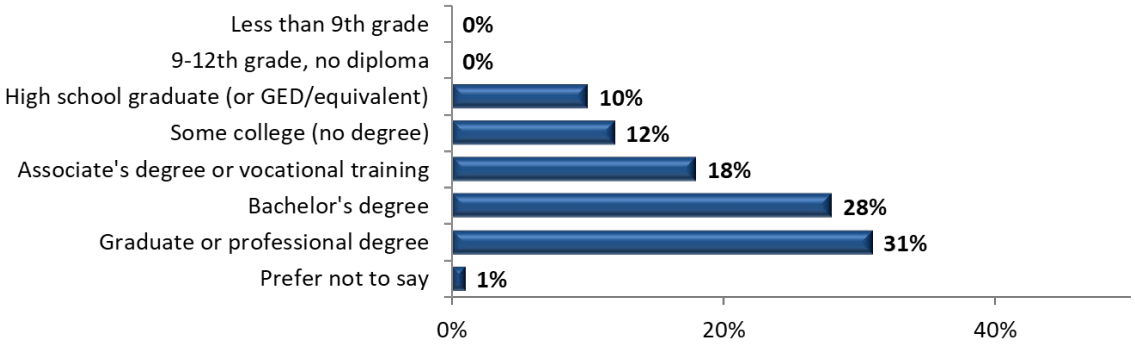


Figure A5.2: Which language is most often spoken in your home? (Choose one)

(N=134)

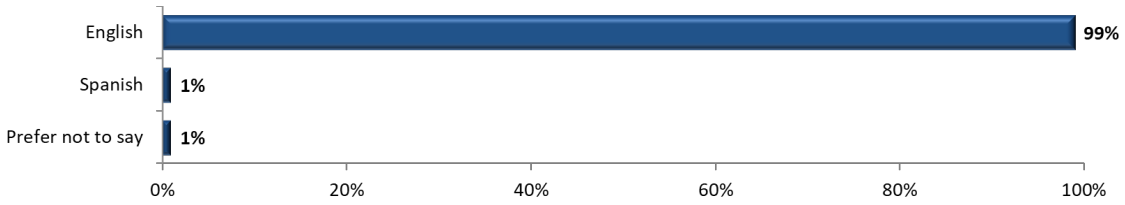


Figure A5.3: Which category best describes your yearly household income before taxes? [42] (N=134)

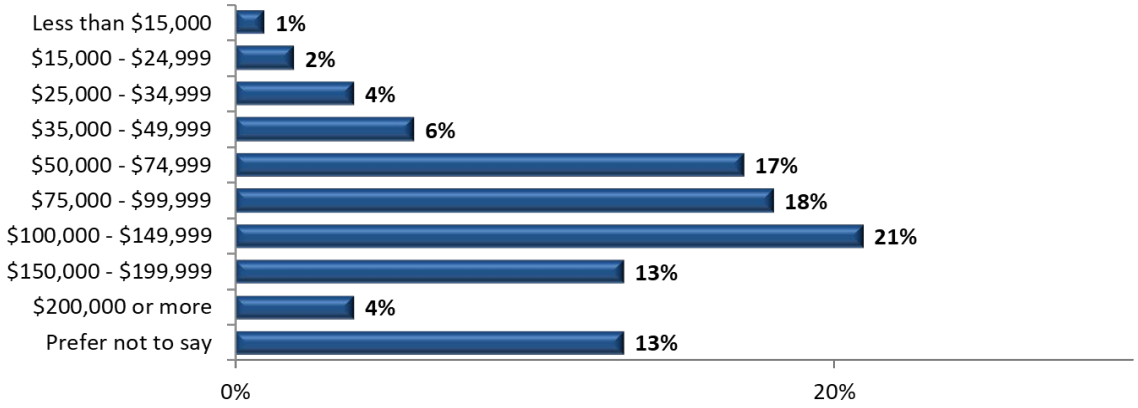
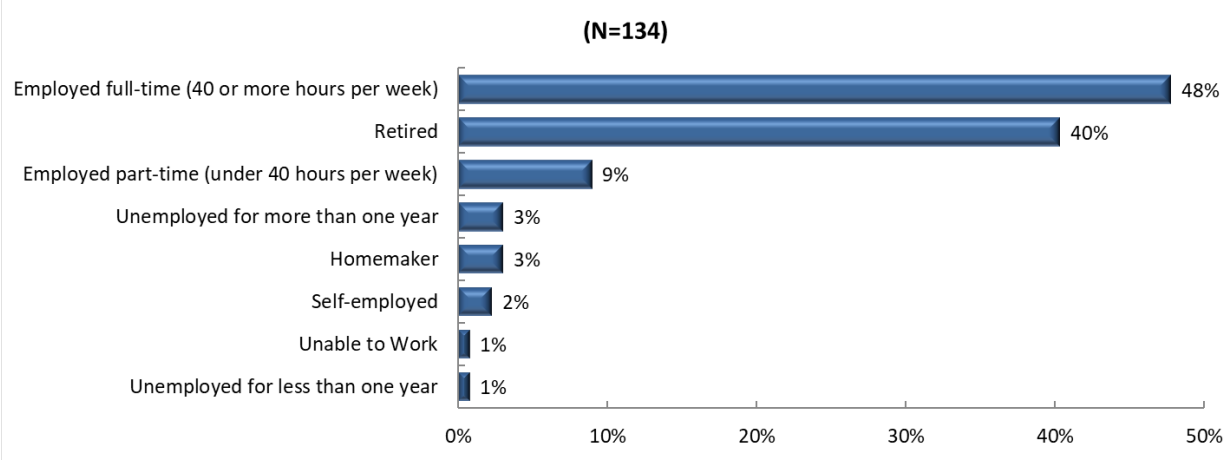


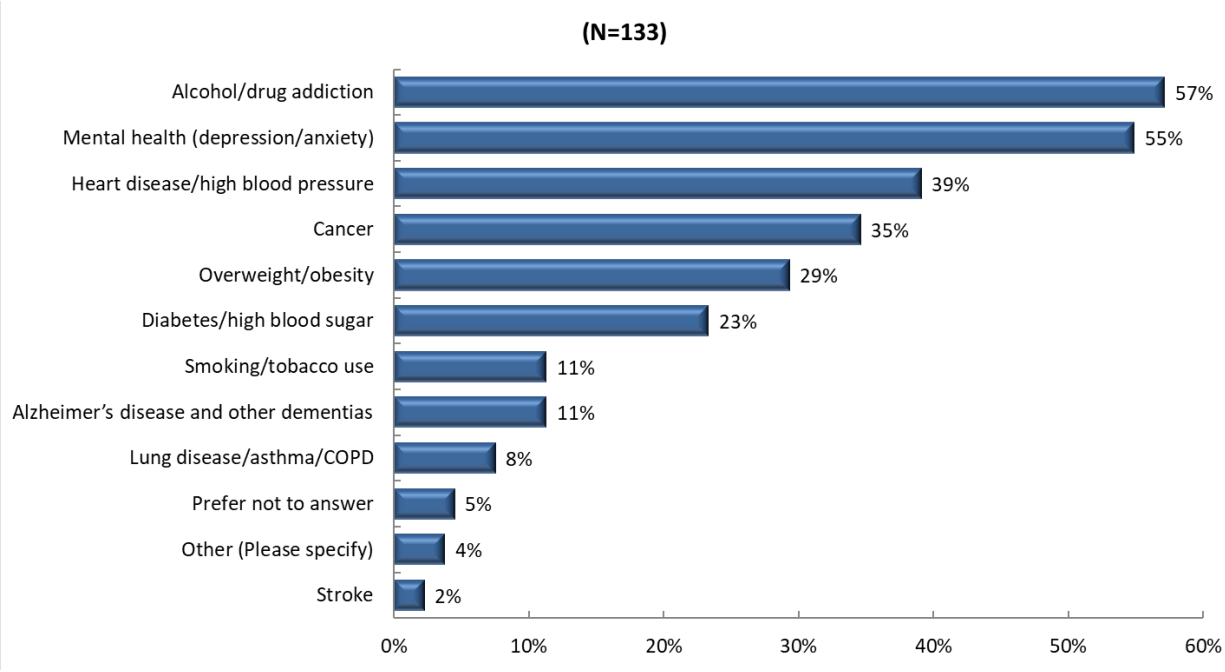
Figure A5.4: For employment, are you currently... (Select all that apply.)



[42] Respondents were asked to include all income received from employment, social security, support from children or other family, welfare, Aid to Families with Dependent Children (AFDC), bank interest, retirement accounts, rental property, investments, etc.

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

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



Other (please specify):

- "Aging issues in general"
- "Eating Disorders"
- "Lack of close care"
- "Local access to health care"
- "Rheumatoid Arthritis, NASH"

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)

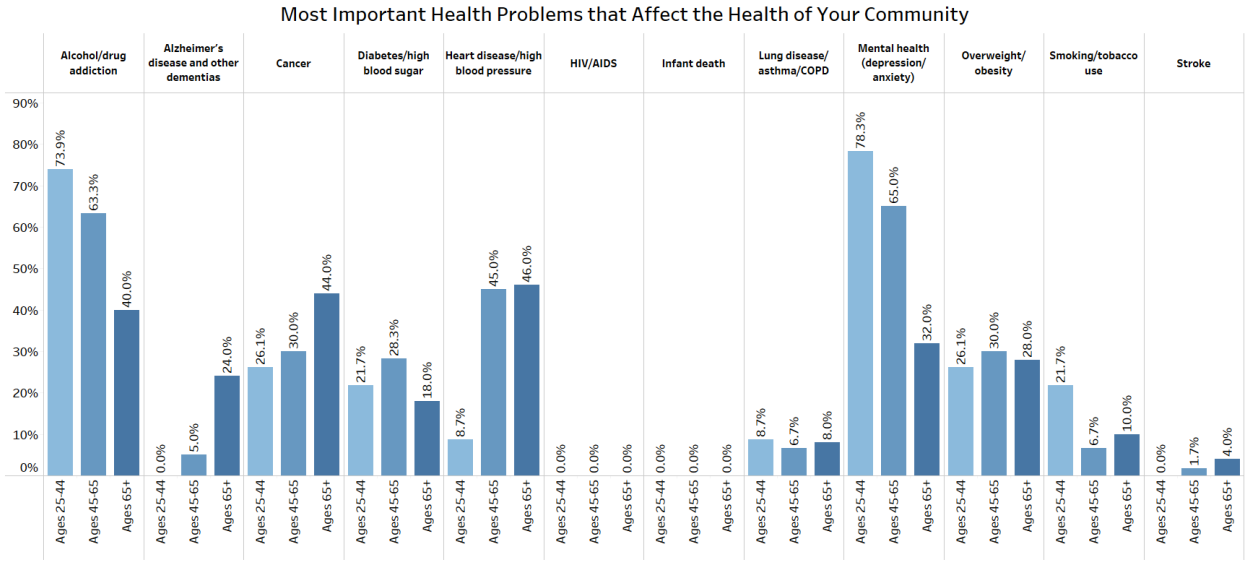


Figure A5.7: What are the three most important health problems that affect the health of your community? Please select up to three. (by gender)

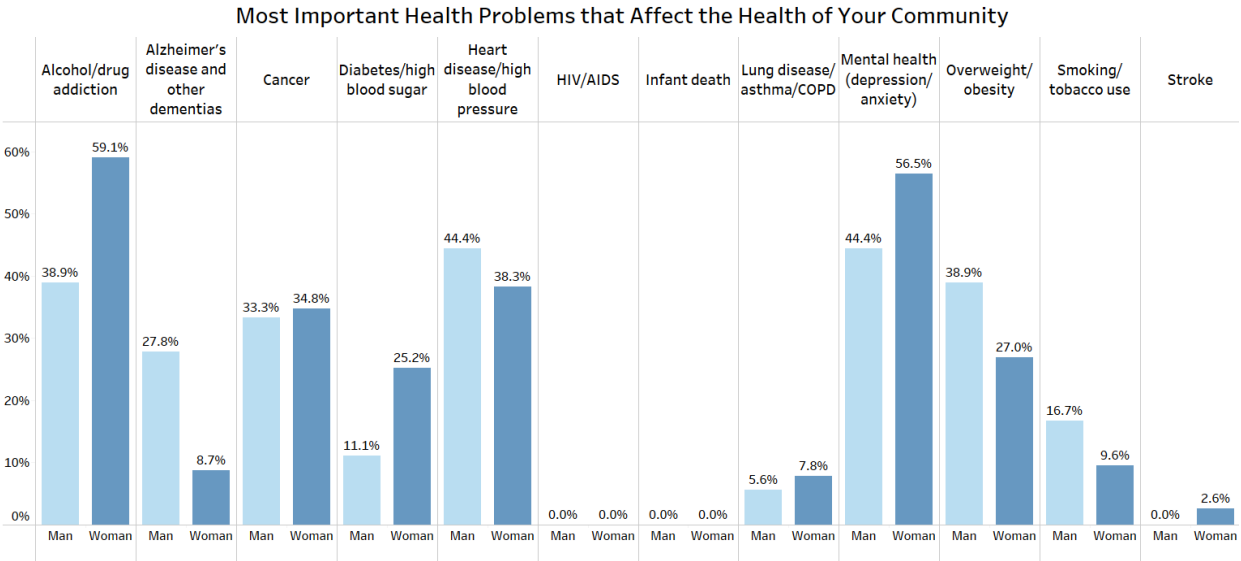
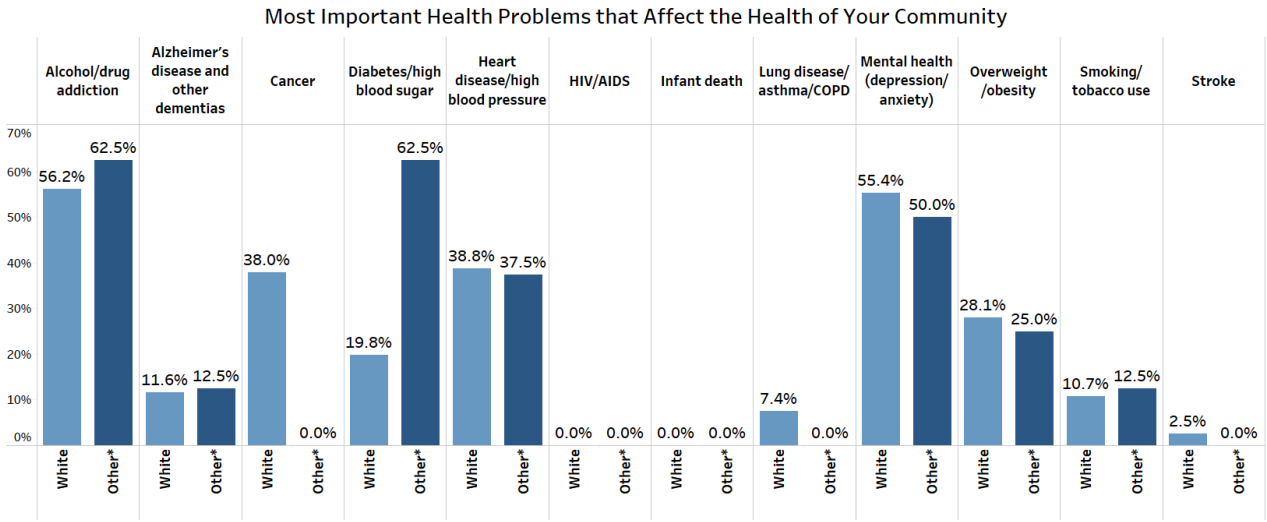
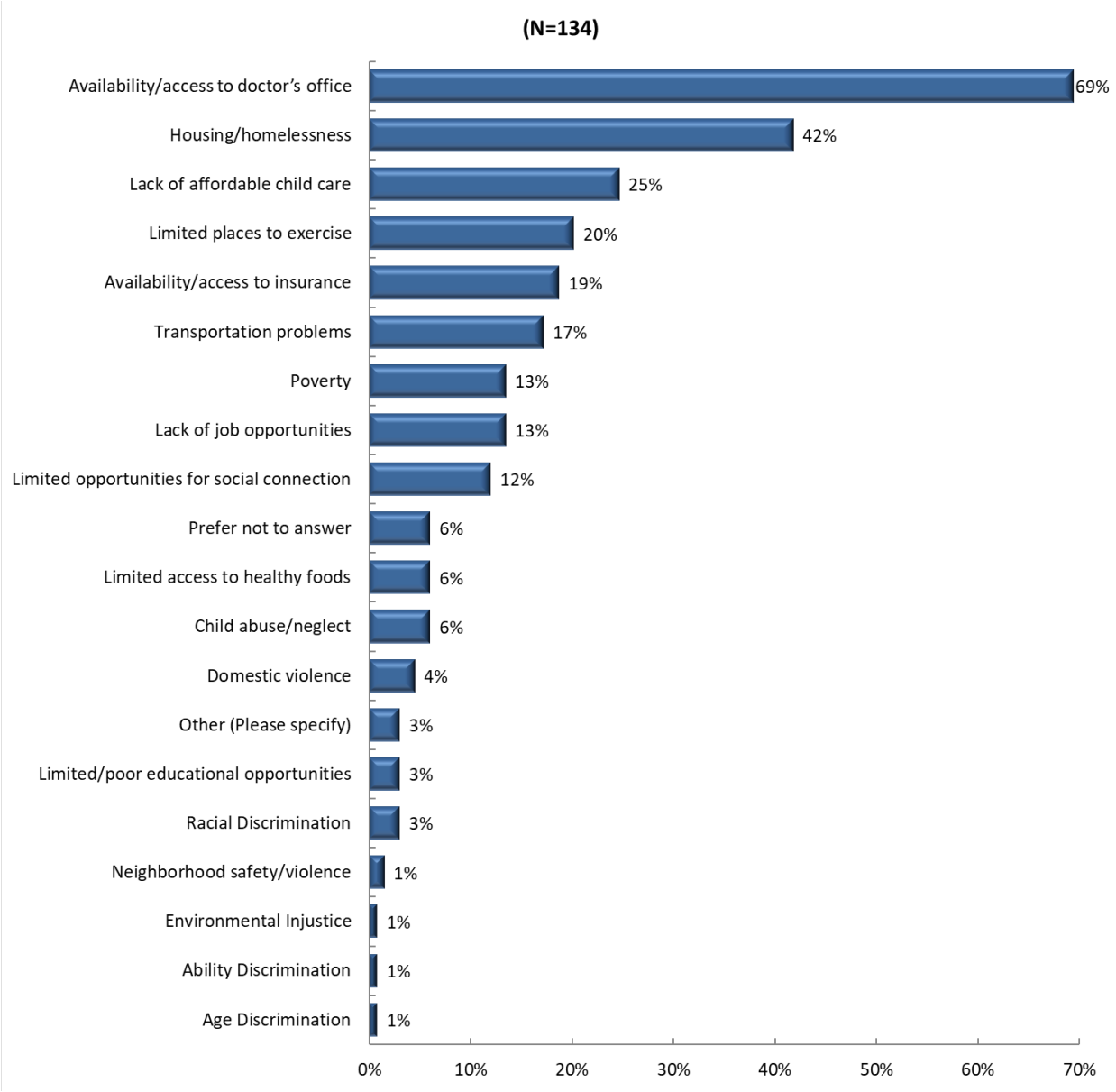


Figure A5.8: What are the three most important health problems that affect the health of your community? Please select up to three. (by race)[43]



[43] "Other" category includes Black or African American, American Indian and Alaska Native, Asian, Native Hawaiian and other Pacific Islander, and/or those who selected more than one race or "other". Racial groups collapsed into single "other" category due to small number of respondents from each racial group

Figure A5.9: 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):

- "County growing faster than the services it can provide for residents"
- "Home health"
- "Local pharmacy"
- "Unemployment my choice"

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. (by age)

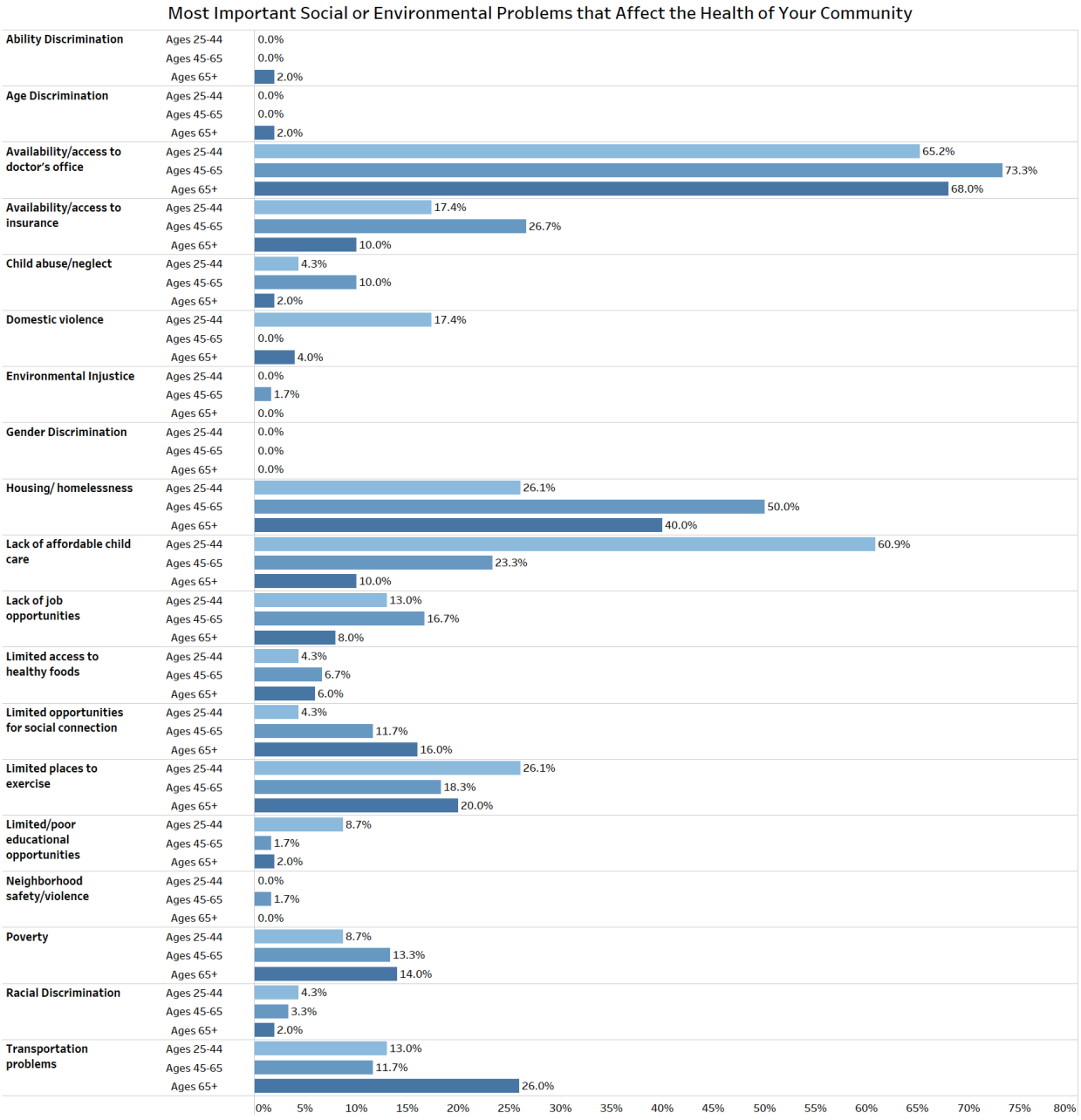


Figure A5.11: What are the three most important social or environmental problems that affect the health of your community? Please select up to three. (by gender)

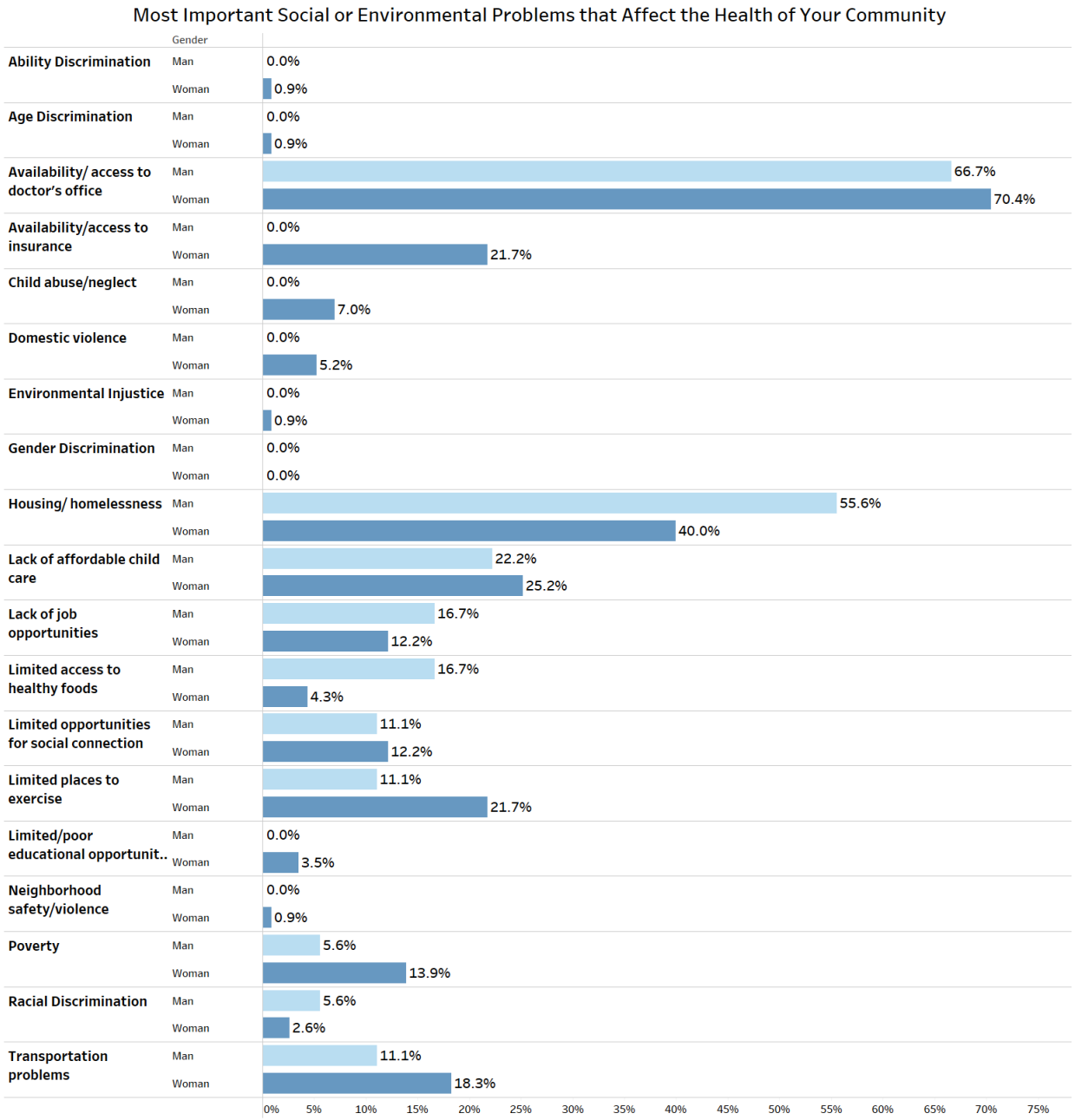


Figure A5.12: What are the three most important social or environmental problems that affect the health of your community? Please select up to three. (by race)

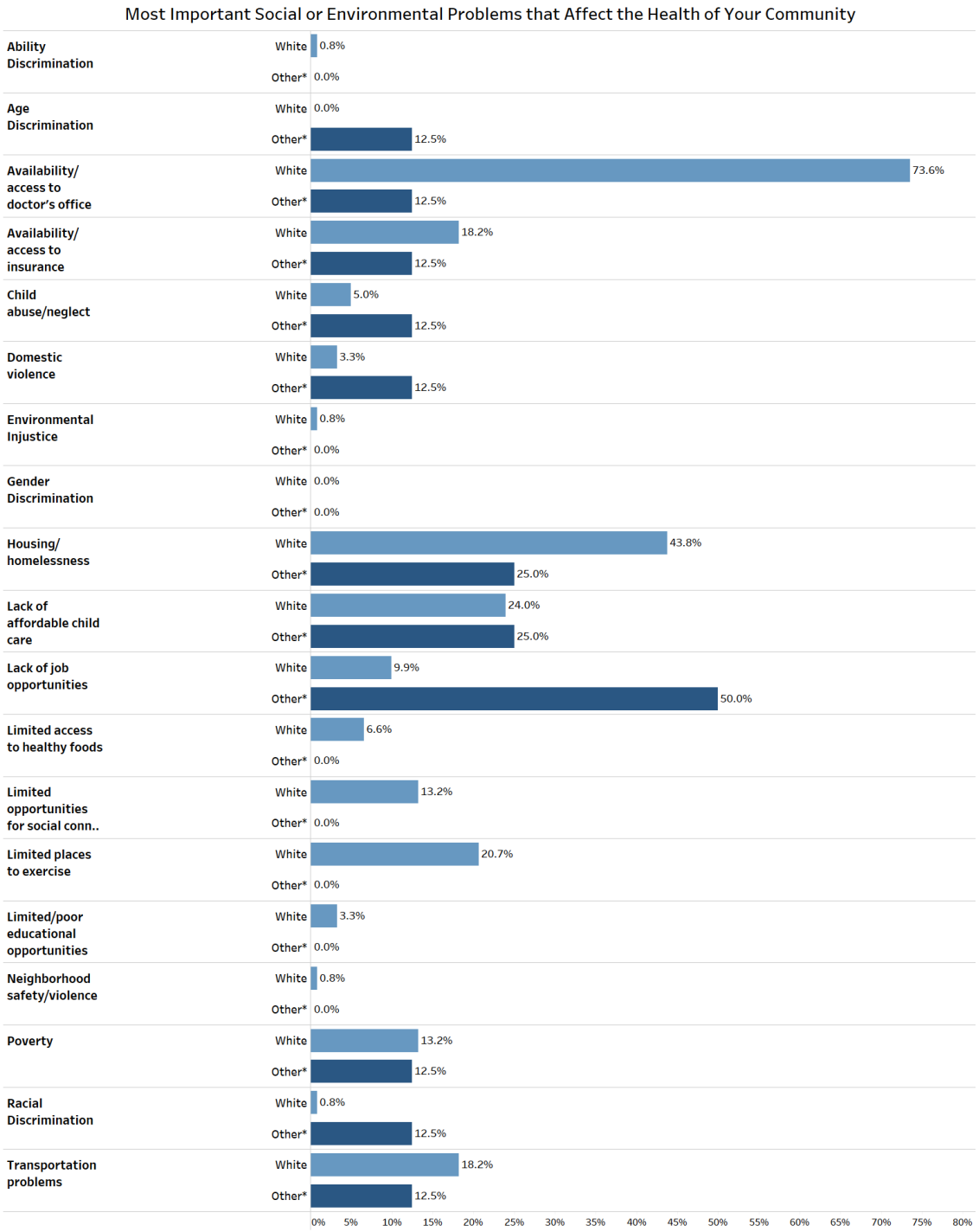
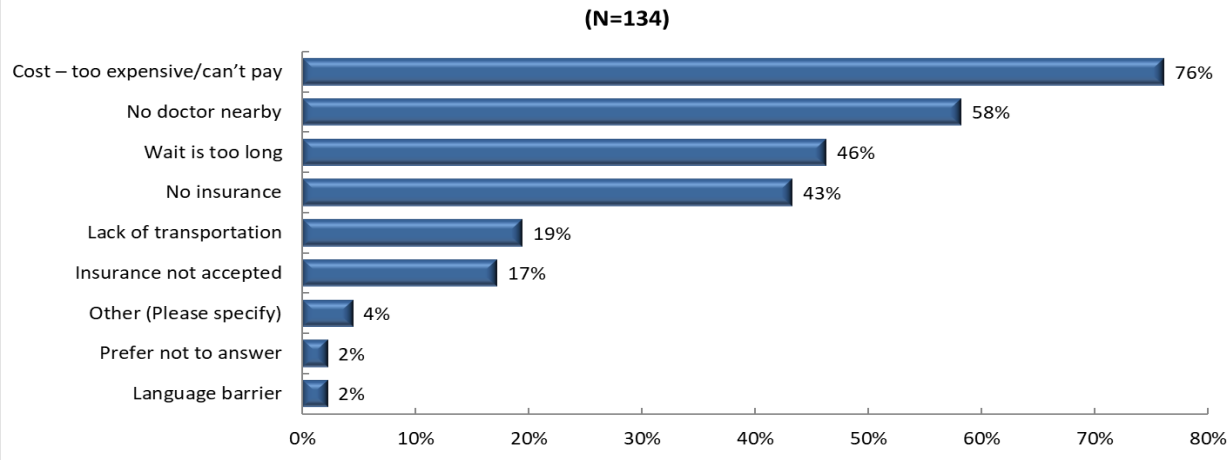


Figure A5.13: What are the three most important reasons people in your community do not get health care when they need it? Please select up to three.



Other (please specify):

- "Complacency"
- "Have to book months in advance for basic checkups and preventative care"
- "Lack of knowledge"
- "Poor personal life choices"
- "Subpar local health care options."
- "Unable to take time off work"

Figure A5.14: 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)

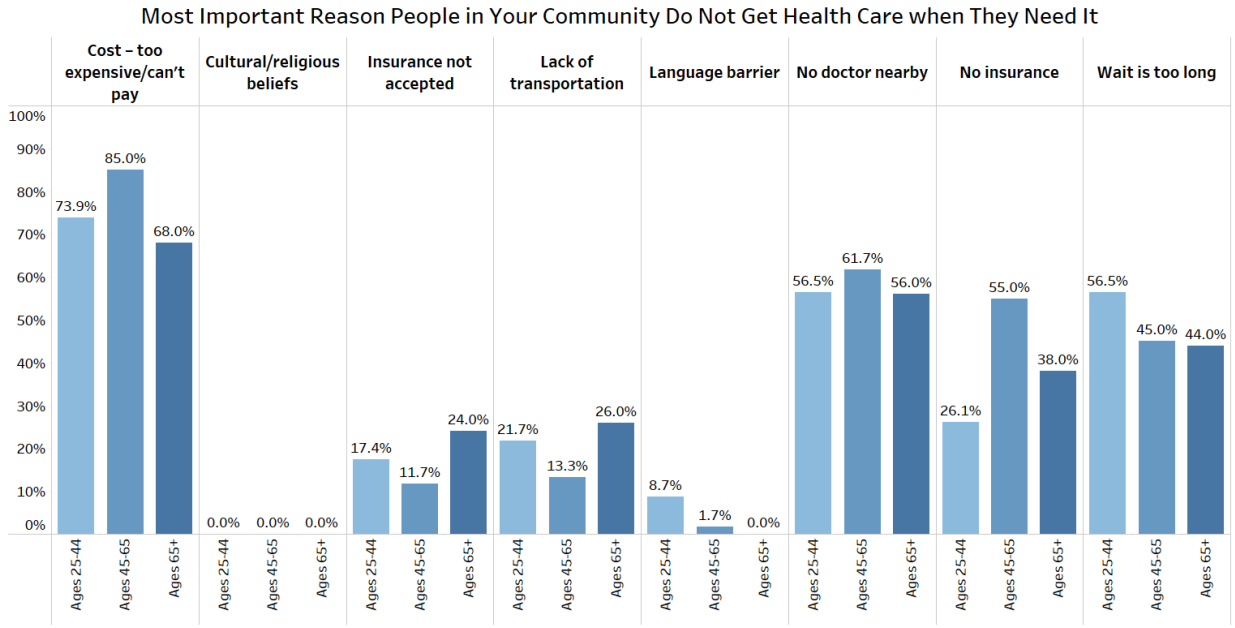


Figure A5.15: What are the three most important reasons people in your community do not get health care when they need it? Please select up to three. (by gender)

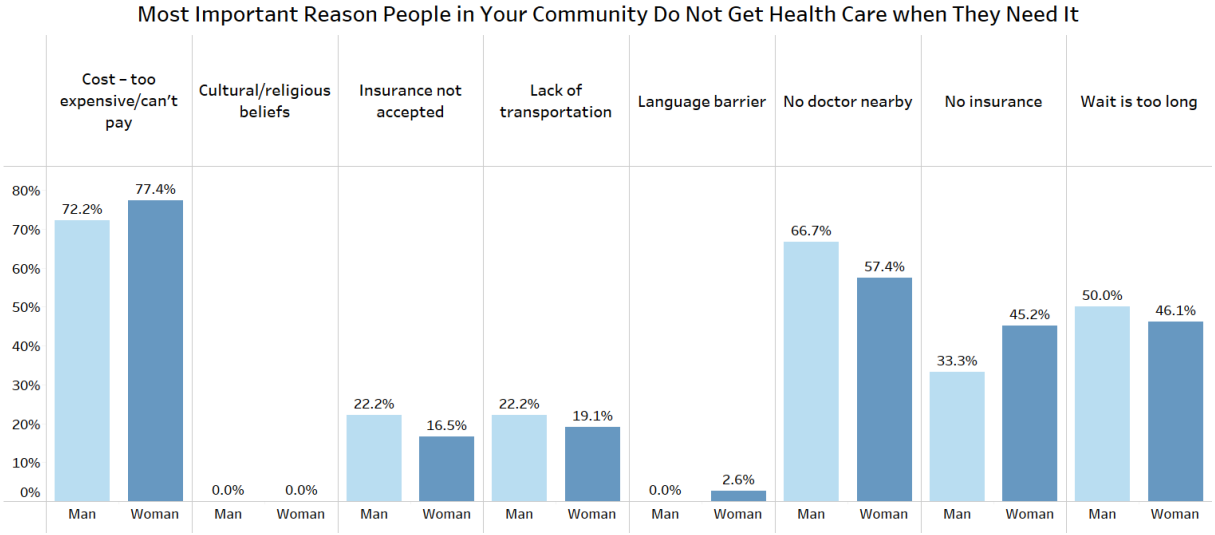
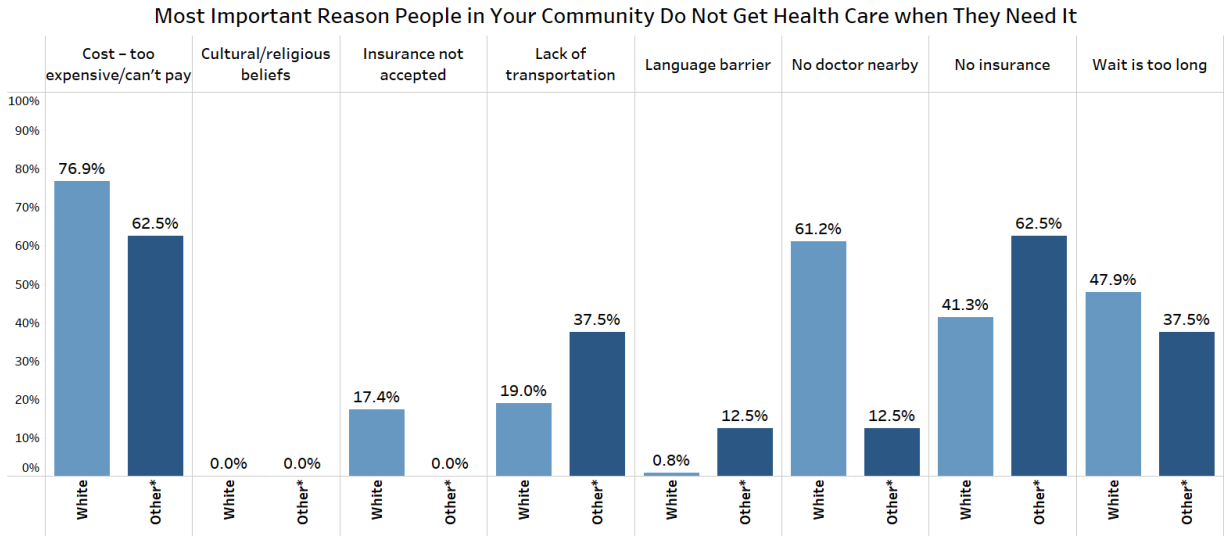


Figure A5.16: What are the three most important reasons people in your community do not get health care when they need it? Please select up to three. (by race)



Topic: Access to care

Figure A5.17: 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?

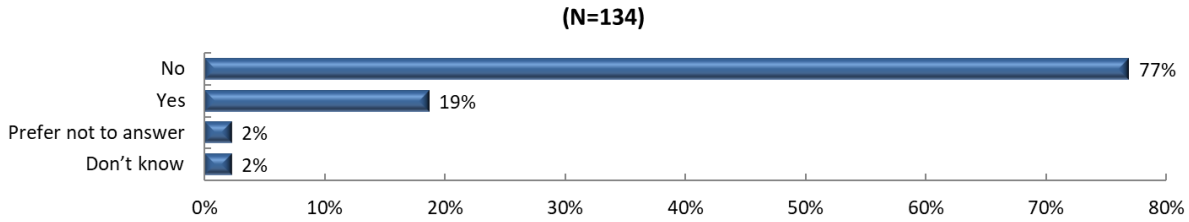
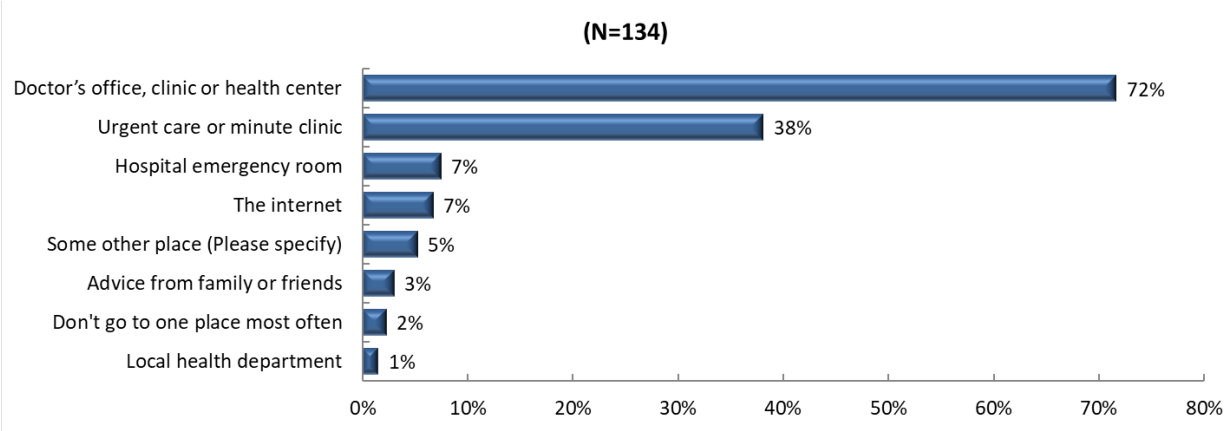


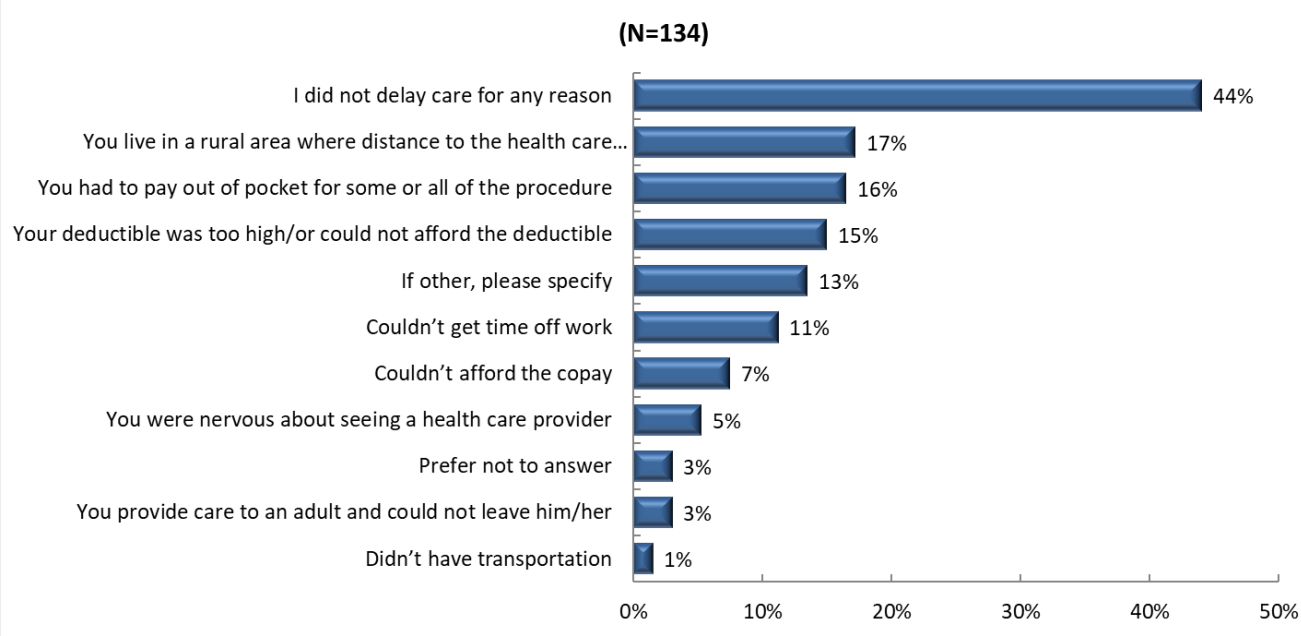
Figure A5.18: Where do you USUALLY go when you are sick or need advice about your health?



Other (please specify):

- "Annapolis, MD"
- "DARE COUNTY"
- "email my doc in Raleigh"
- "Teladoc" / "Telemedicine" / "Virtual Doctor"
- "VA Doctors"

Figure A5.19: 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):

- "1) too frustrating to find a specialist in this area that accepts my insurance and will get the necessary preauthorization (the doctor's are too busy to do this apparently) 2) too depressed to deal with trying to make appt to see appropriate doctor"
- "Able to get help ASAP"
- "Appointments not available for very long time esp for some drs like orthopedic drs"
- "Couldn't get an appointment"
- "Doctor offices not accepting new patients, or excessive wait"
- "Doctors are scheduling more than 1 year out"
- "EXTREMELY LONG WAITS FOR DOCTORS"
- "Had to wait three months for care"
- "Mental health reasons, depression to entrenched to make the calls"
- "No Doctor replaced my former Dr. [redacted name]"
- "No medical appointments were available"
- "No providers available and excessively long waits to be seen (months)"
- "Our local hospital has far too many bad experiences and missed diagnosis."
- "Poor quality of care close to home"
- "Stubborn"
- "Trying to find a Dr that is accepting new patients"
- "Wait is so long issues gets worse"

Figure A5.20: 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?

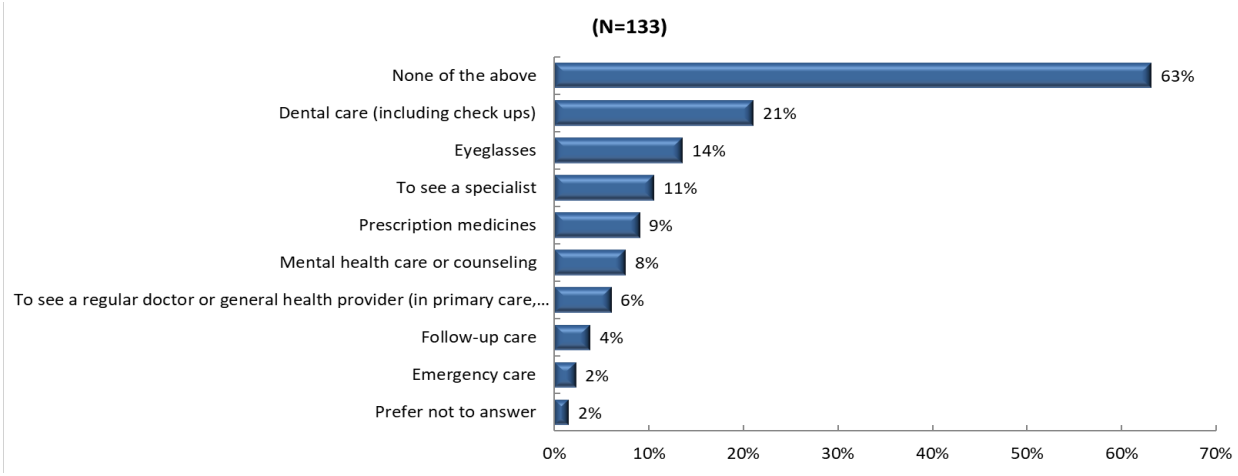


Figure A5.21: If you get sick or have an accident, how worried are you that you will be able to pay your medical bills?

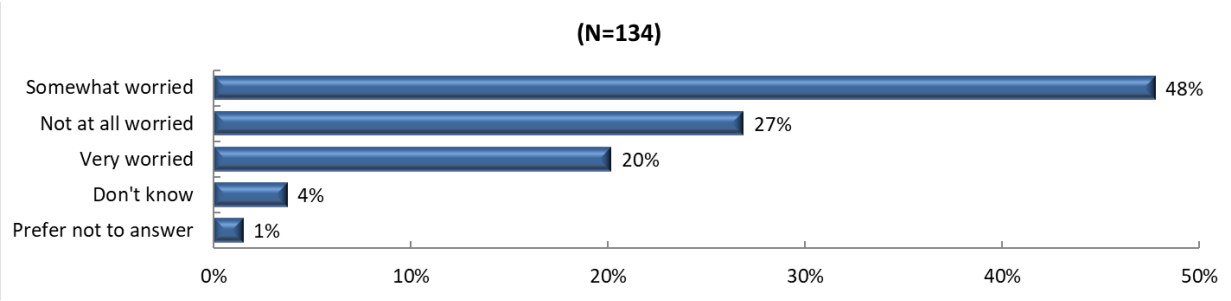
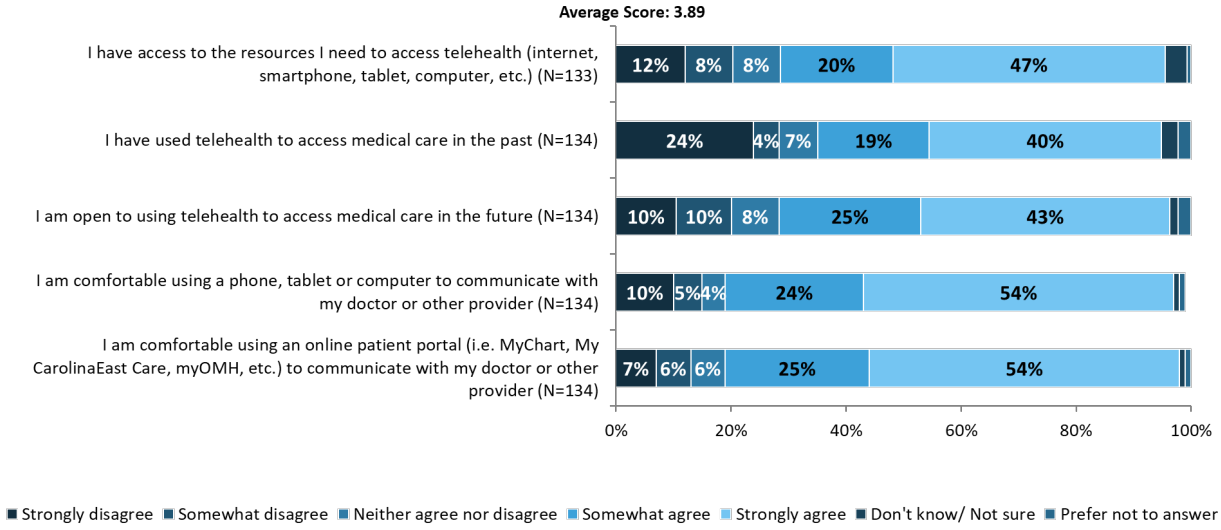


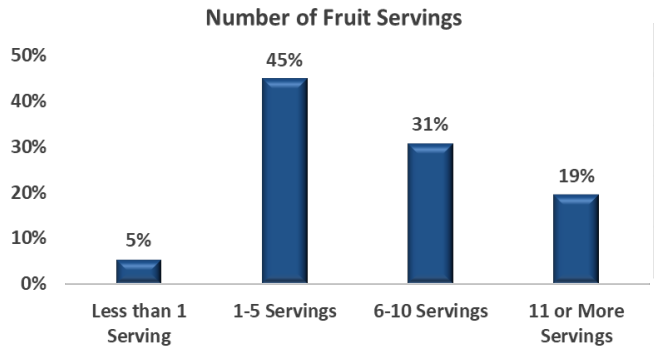
Figure A5.22: How much do you agree or disagree with the following statements about telehealth? Telehealth means connecting virtually with a medical provider using a smartphone, tablet or computer.



Topic: Healthy Lifestyle (Diet and Exercise)

Figure A5.23: 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.)

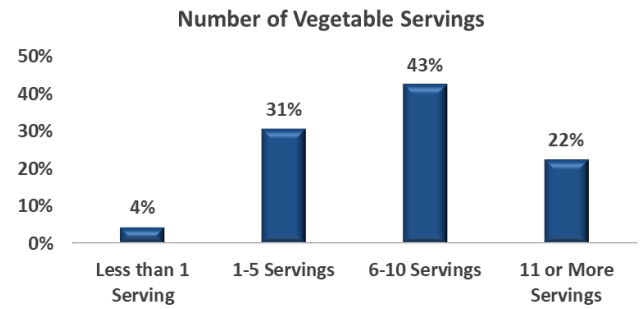
(N=134)



Measure	Value
Mean (Standard Deviation)	7 (6)
Median	6
Mode	7
Minimum-Maximum	0-35

Figure A5.24: 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.)

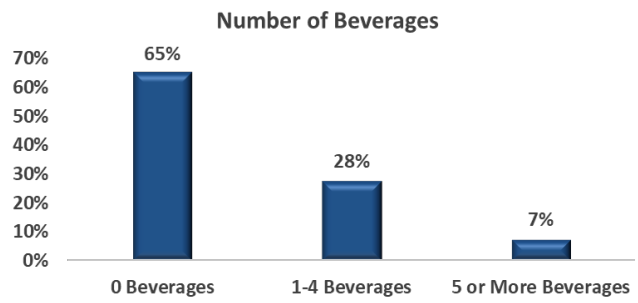
(N=134)



Measure	Value
Mean (Standard Deviation)	9 (7)
Median	7
Mode	10
Minimum-Maximum	0-50

Figure A5.25: 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?

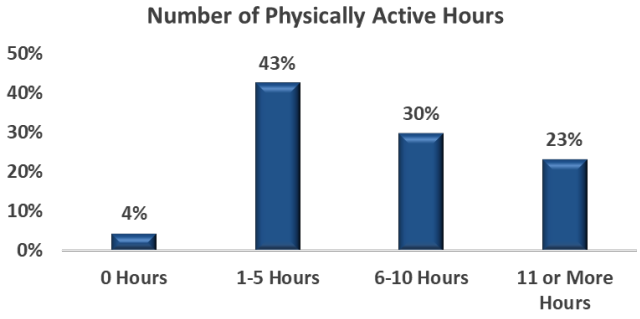
(N=134)



Measure	Value
Mean (Standard Deviation)	1 (3)
Median	0
Mode	0
Minimum-Maximum	0-21

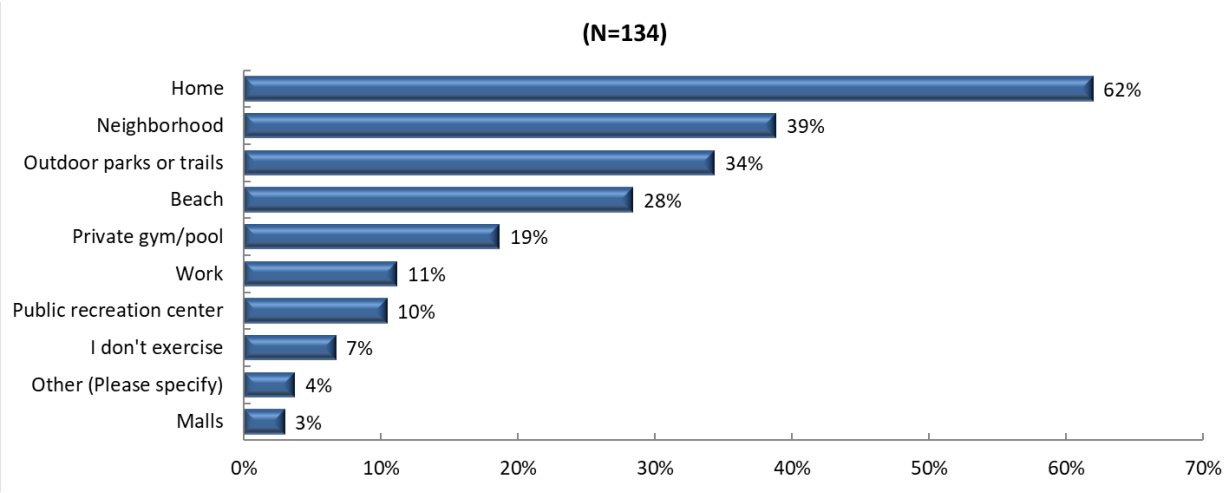
Figure A5.26: During the past month, approximately how much time (in hours) per week were you physically active outside of your regular job?

(N=134)



Measure	Value
Mean (Standard Deviation)	9 (10)
Median	6
Mode	5
Minimum-Maximum	0-48

Figure A5.27: When you are active, where do you engage in exercise or physical activities? (Select all that apply.)



Other (please specify):

- "Garden"
- "Golf Course"
- "YMCA" (3 Respondents)

Topic: Housing and Homelessness

Figure A5.28: In the past 12 months, were there times when you:

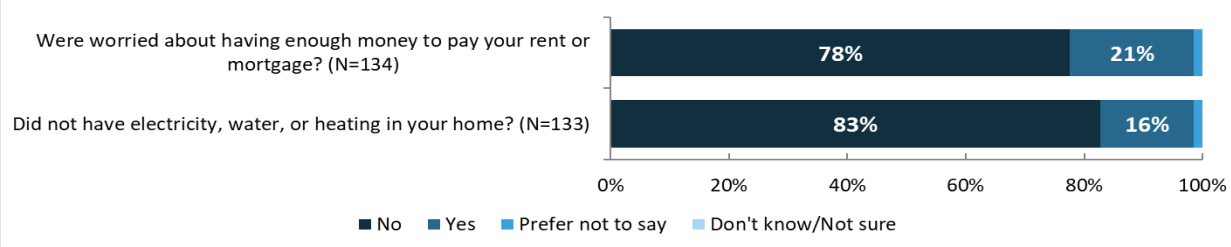


Figure A5.29: In the PAST THREE YEARS, were there times when you:

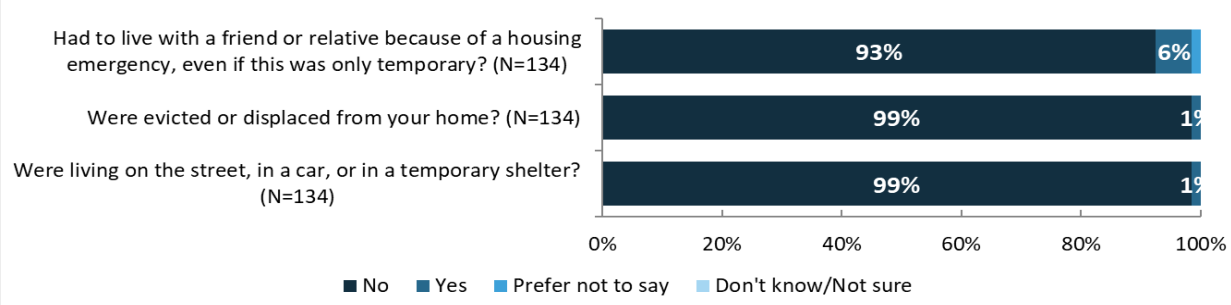
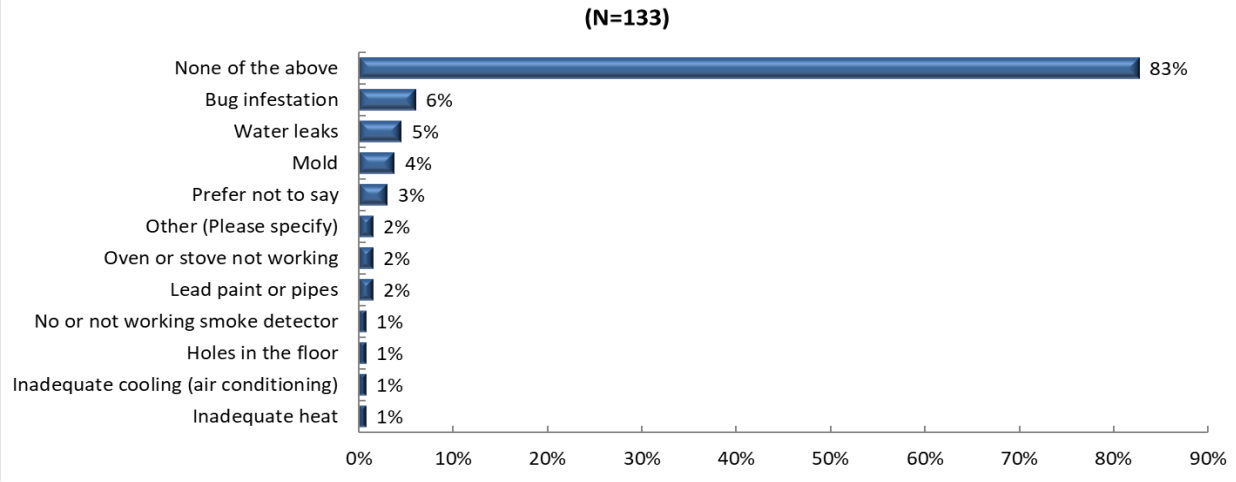


Figure A5.30: Think about the place you live. Do you have problems with any of the following? (Check all that apply.)

(N=133)



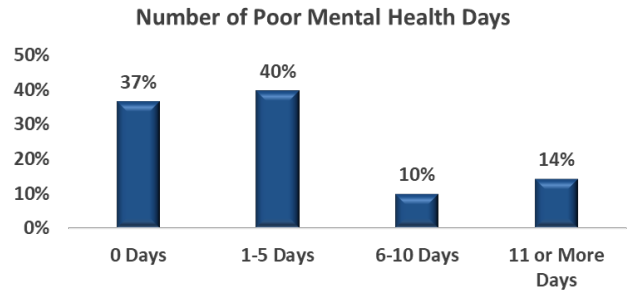
Other (please specify):

- "Water damage" / "Water quality"

Topic: Mental Health

Figure A5.31: 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=134)



Measure	Value
Mean (Standard Deviation)	5 (7)
Median	2
Mode	0
Minimum-Maximum	0-30

Figure A5.32: 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 experiencing one or more poor mental health day in previous question were asked current question

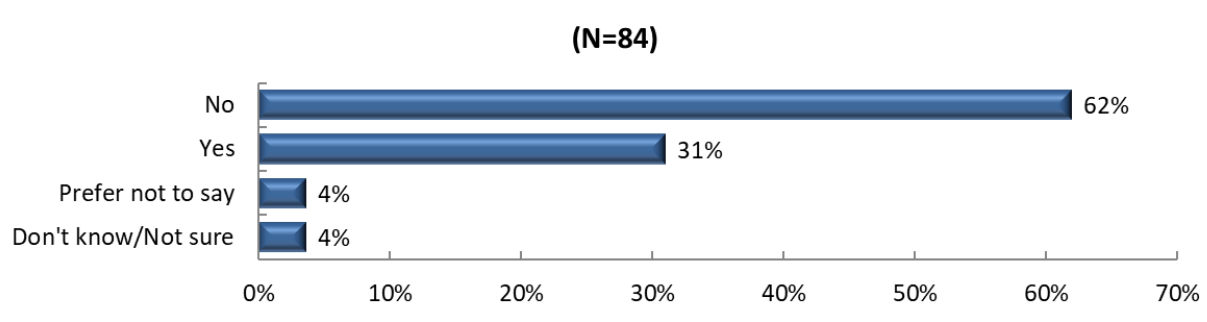
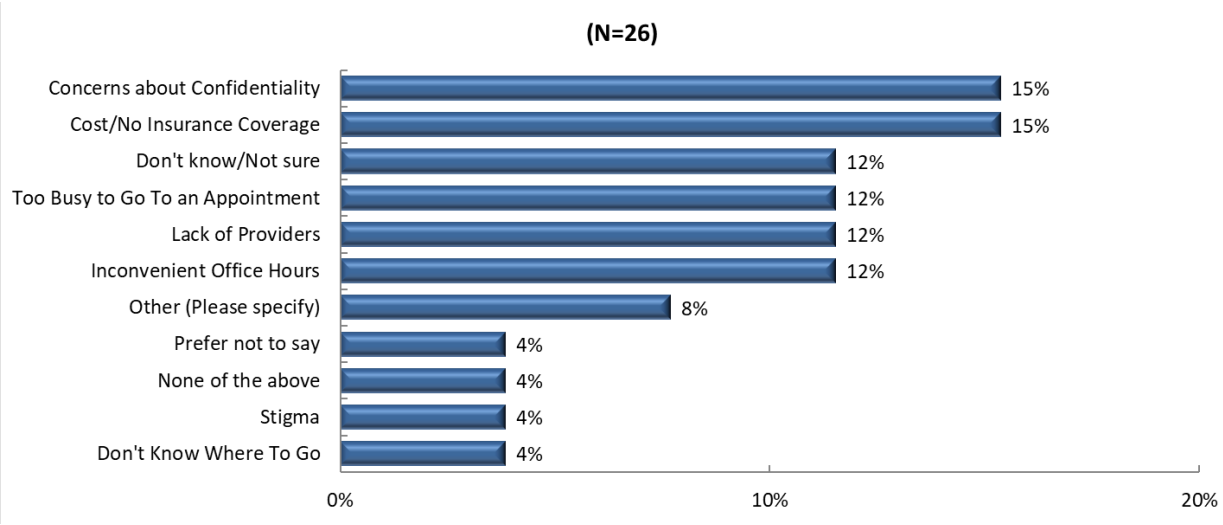


Figure A5.33: What was the MAIN reason you did not get mental health care or counseling?

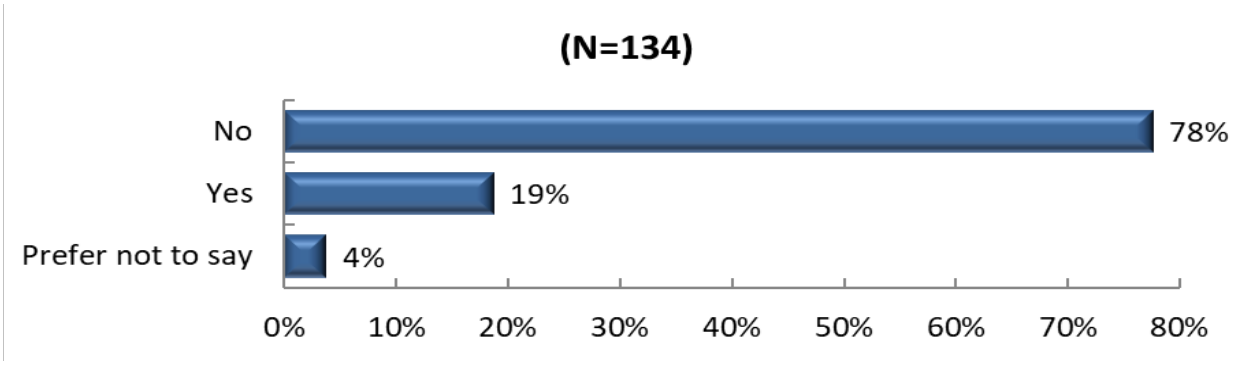
Please note, only participants who answered "YES" to previous question were asked the current follow-up question



Other (please specify):

- "Too depressed"
- "Too depressed to deal with it"

Figure A5.34: 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 A5.35: Considering your physical health overall, would you describe your health as…

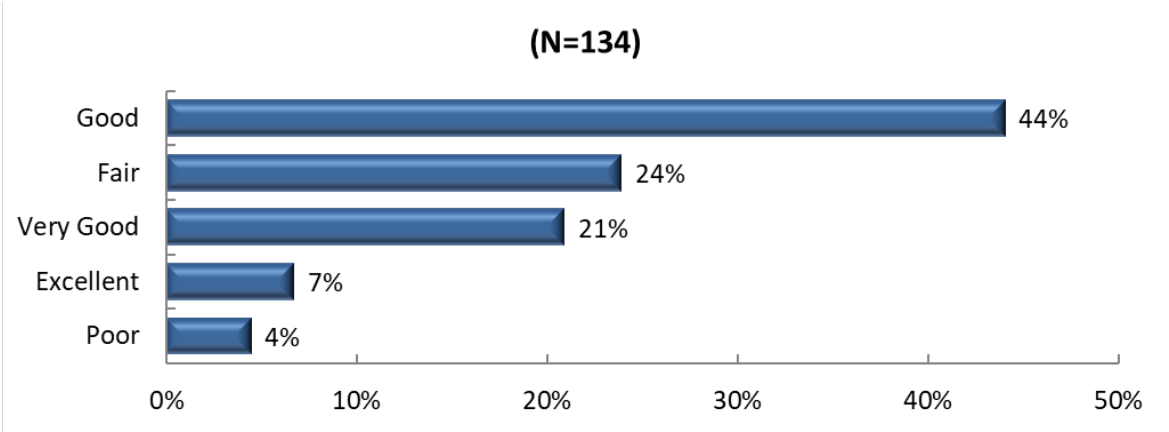


Figure A5.36: Within the past year (anytime less than one year ago), have you:

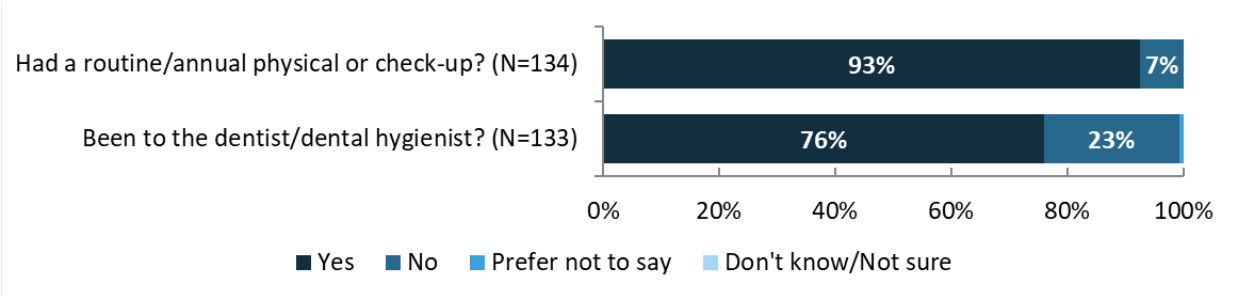
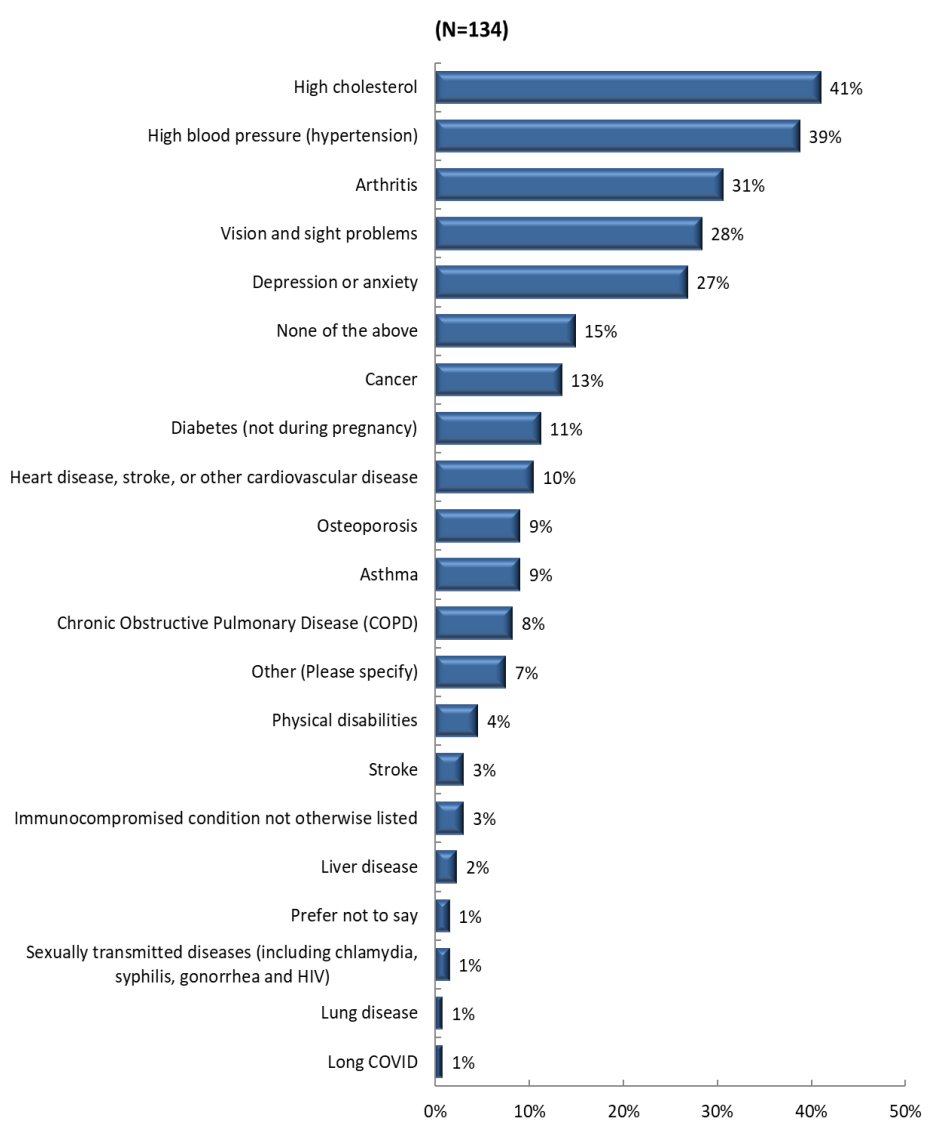


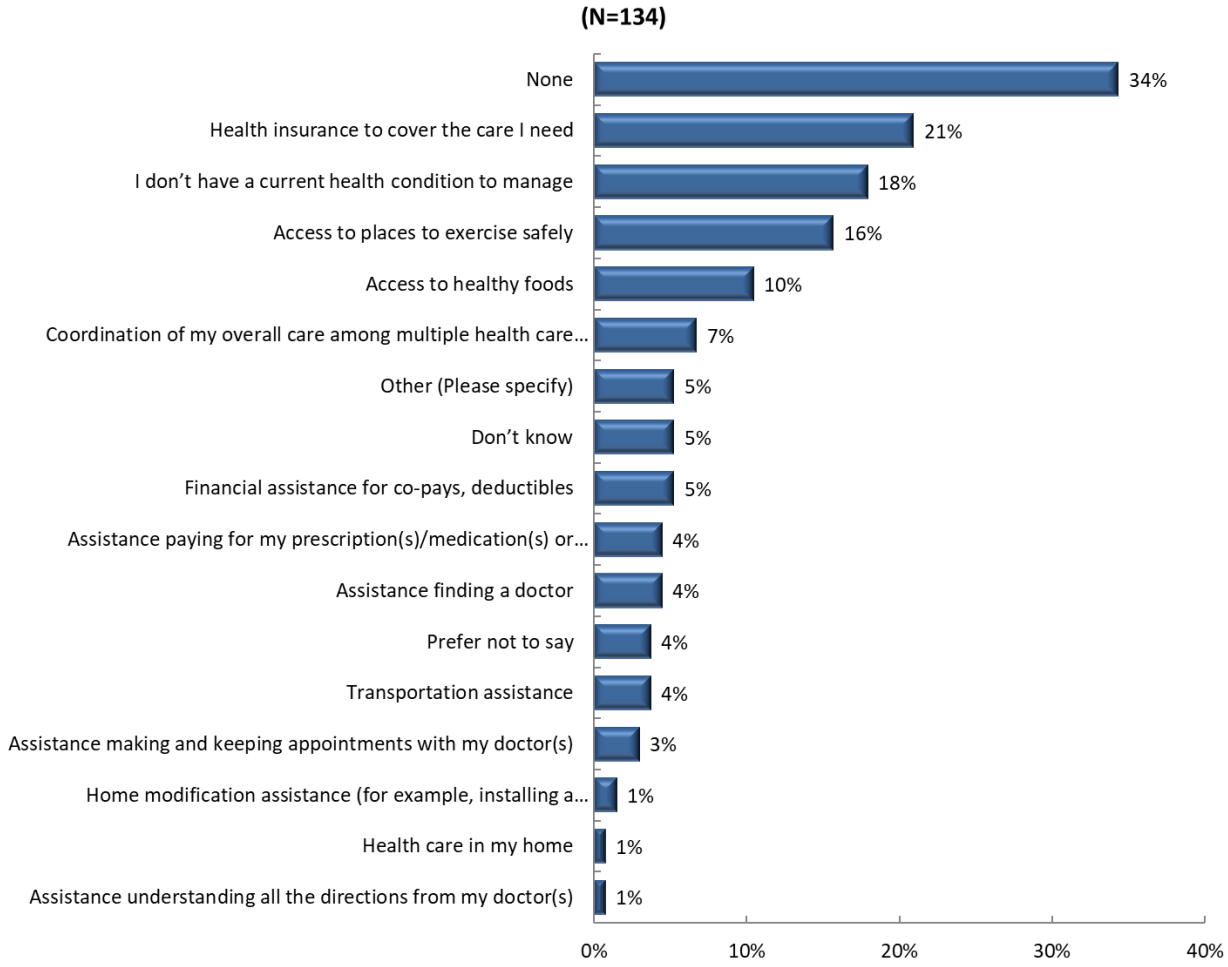
Figure A5.37: Have you ever been told by a doctor, nurse, or other health professional that you have any of the following health conditions? Select all that apply



Other (please specify):

- "Afib"
- "Blood clot disorder"
- "Hashimoto's Thyroiditis and Hypothyroidism"
- "Heart Condition that was "fixed""
- "Hypothyroidism"
- "ILD, mild"
- "Kidney Stones"
- "Kidney Stones"
- "Lupus SLE, Fibromyalgia"
- "Lupus/fibromyalgia"

Figure A5.38: What do you need to be able to manage your current health conditions (for example, heart conditions, high blood pressure, stroke, diabetes, asthma, cancer, COPD, congestive heart failure, arthritis, HIV, depression, anxiety, other mental health condition, etc.) to stay healthy? (Select all that apply.)



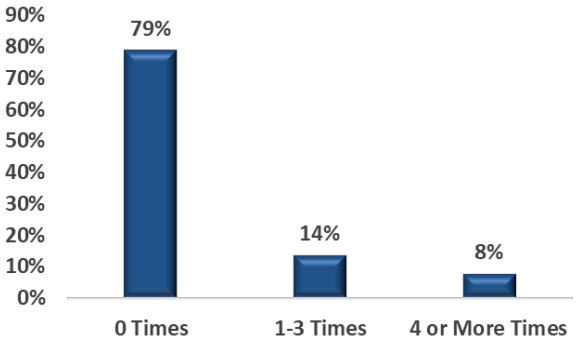
Other (please specify):

- "A better PBM than Express Scripts"
- "Cheaper medications"
- "Getting a doctor to refill my prescription"
- "More specialists local rheumatologists"
- "Need discipline"
- "Quality health care providers"
- "Rheumatologists in the Dare/Currituck area"

Topic: Substance Use Disorders

Figure A5.39: 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=132)



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

Figure A5.40: How often do you consume any kind of alcohol product, including beer, wine or hard liquor?

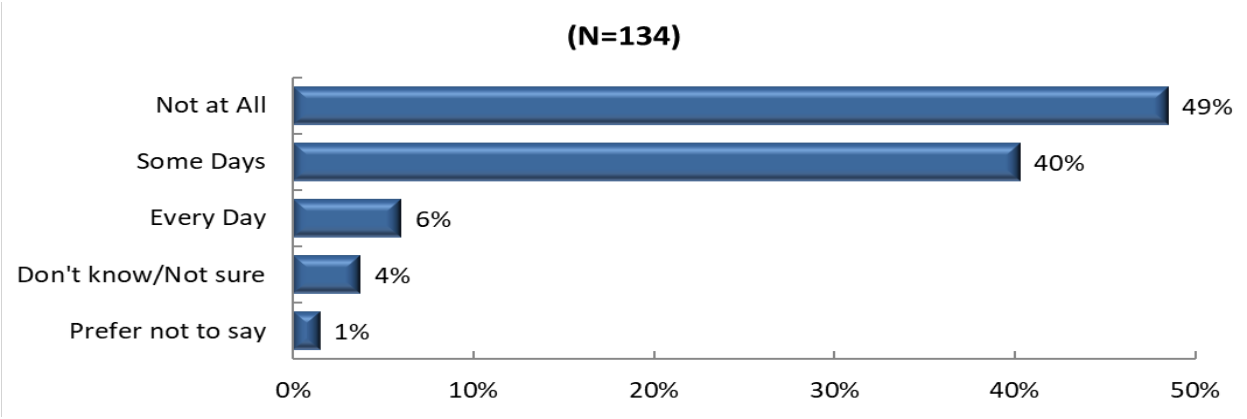
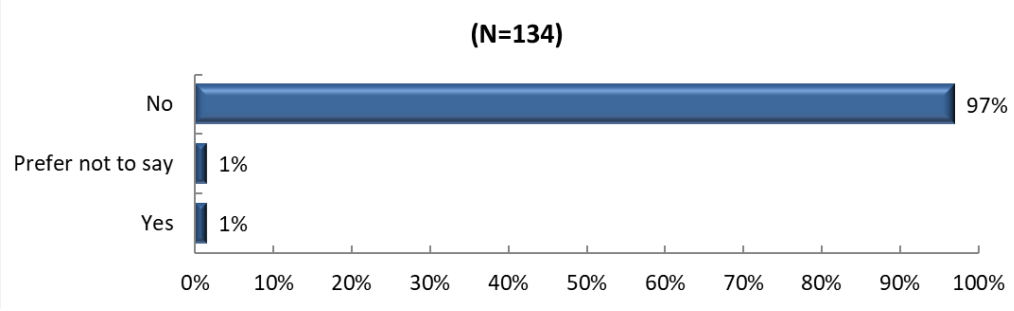


Figure A5.41: In the past year, have you or a member of your household misused any form of prescription drugs (e.g. used without a prescription, used more than prescribed, used more often than prescribed, or used for any reason other than a doctor's instructions)?



Topic: Transportation and Transit

Figure A5.42: In a typical week, what kinds of transportation do you use the most? (Select all that apply.)

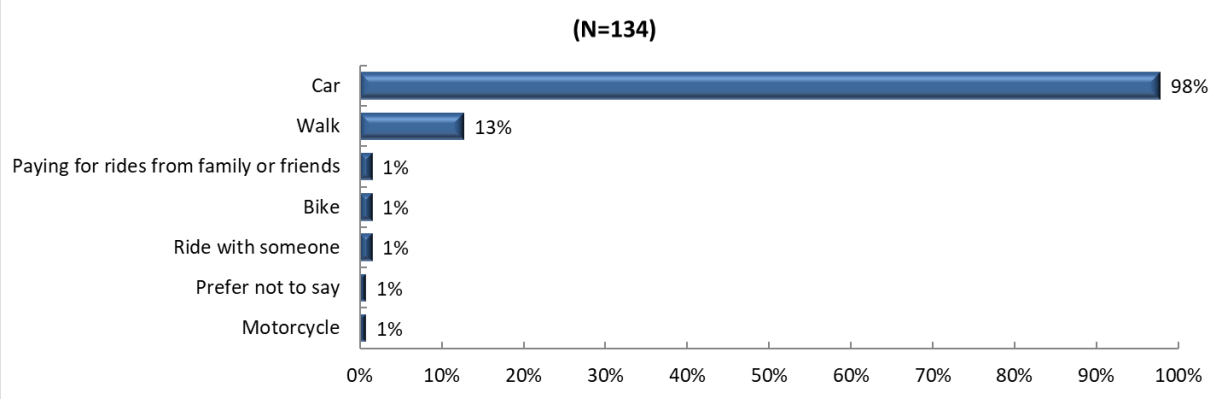


Figure A5.43: In the past 12 months has lack of transportation kept you from medical appointments, meetings, work, or getting things for daily living? Select all that apply:

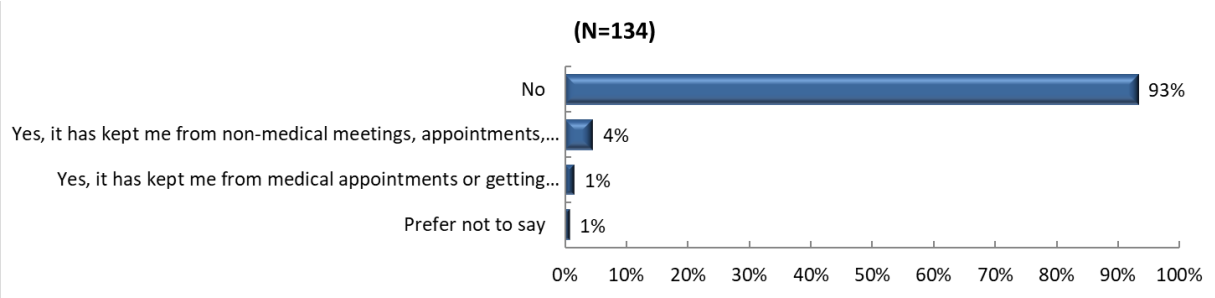
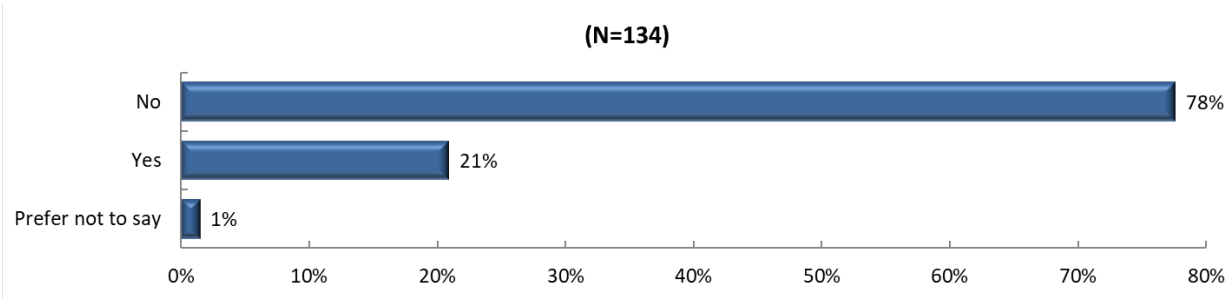


Figure A5.44: Do you put off or neglect going to the doctor because of distance or transportation?



APPENDIX 6 | SUMMARY OF DATA FINDINGS ACROSS SOURCES

Primary and Secondary data findings are summarized in full by the table below.[44]

Priority Area	Secondary Data	Community Survey	Focus Groups 1 & 2	Focus Group 3
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	✓		✓	

[44] 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.