Albemarle Regional Health Services
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PERQUIMANS COUNTY

COMMUNITY HEALTH NEEDS ASSESSMENT

2024 CHNA REPORT

ACKNOWLEDGEMENTS

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

The Health ENC CHNA Steering Committee

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

In addition to the Steering Committee, the Perquimans County 2024 CHNA was developed in partnership with representatives from Albemarle Regional Health Services and Sentara Healthcare.

Perquimans County CHNA Leadership

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

- ARHS
- Sentara Albemarle Medical Center (SAMC)
- 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

Perquimans County CHNA Leadership

In addition to the organizations listed above, the Perquimans County 2024 CHNA was 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	ARHS
Matt Sabin	ARHS
Amy Underhill	ARHS
Molly Brown	ARHS
Wanda Stallings	ARHS
Gabi Corprew	ARHS
Kellie Lane	ARHS
Teresa Beardsley	ARHS
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 Perquimans County. Top community needs identified through secondary data analysis included health concerns related to physical and behavioral health, and social or environmental concerns such as employment and income, food access and security, and environmental quality, among others.

Primary (new) data were collected through a focus group and a web-based survey for community members, and included feedback from 290 people who live, work or receive healthcare in Perquimans County. The focus group was conducted in person, with a variety of community members from different backgrounds, age groups and life experiences. Primary data identified healthcare access and quality and physical health (chronic diseases, cancer, obesity) as top needs that impact the health and well-being of people living in Perquimans County.

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

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

Following completion of this report, health leaders throughout Perquimans 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

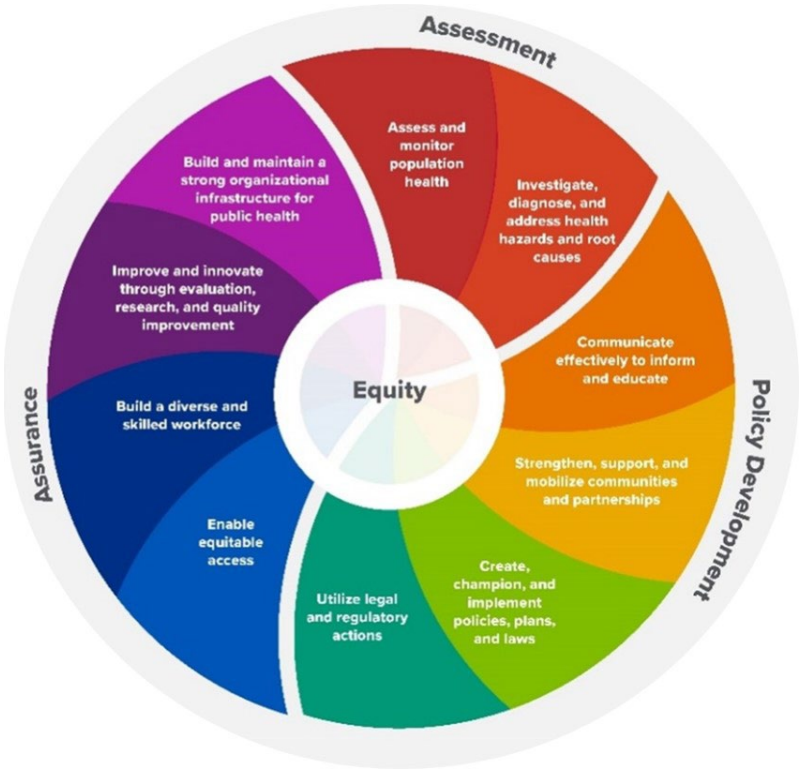
To illustrate its commitment to the health and well-being of the community, the Health ENC CHNA Steering Committee has completed this assessment to understand and document the greatest health needs currently faced by local residents. Guidance was also provided by local representatives from Albemarle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

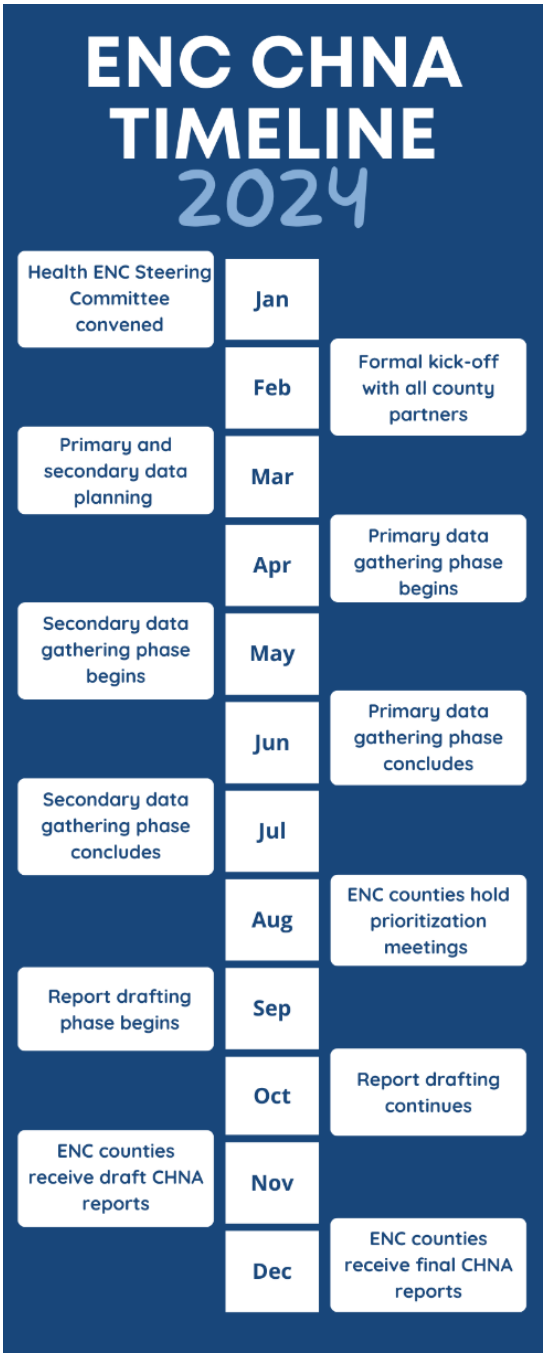
- Define the community it serves;
- Assess the health needs of that community;
- Through the assessment process, take into account input received from people who represent the community's broad interests, including those with special knowledge of or expertise in public health;
- Document the CHNA in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

- Identify the health needs of Perquimans 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 Perquimans County residents.

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

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

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

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

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

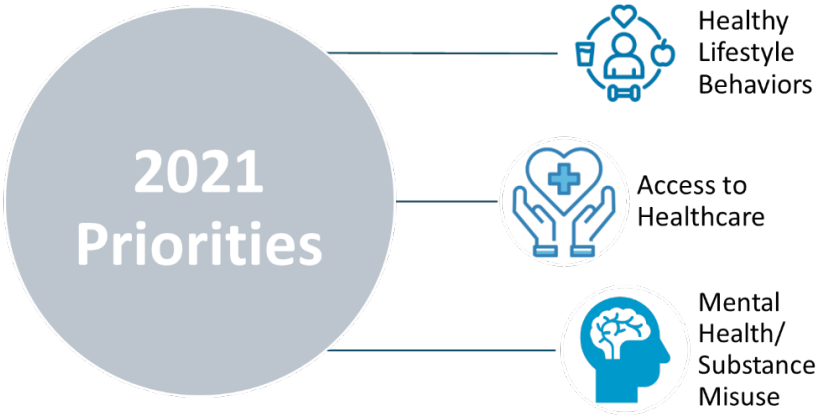
2) *Detailed Summary of Secondary Data Measures and Findings* – Existing data measures and findings used in the prioritization process are presented in **Appendices 2-3.**

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

Evaluation of Prior CHNA Implementation Strategies

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

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



ARHS and other local organizations developed goals and implementation plans to address these priority health needs. Below are brief summaries of each organization's most recent CHNA implementation plans.

Albemarle Regional Health Services

Albemarle Regional Health Services (ARHS) is a district health department serving northern North Carolina. The ARHS district model serves as a shining example of regionalization and what true public

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

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

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

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

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

Sentara Healthcare – Sentara Albemarle Medical Center

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

Previous CHNA Priority: Behavioral Health

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

Previous CHNA Priority: Chronic Disease

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

Previous CHNA Priority: Social Determinants of Health

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

A vital phase of the Community Health Needs Assessment (CHNA) involves reporting out to the communities being served and to those residents who participated in the data gathering process. Community health presentations were held to provide the opportunity for community residents and key stakeholders to learn about the health–related primary and secondary data from the 2021 CHNA process.

The data was presented by ARHS, SAMC, and ECU Health through presentations geographically dispersed throughout the Albemarle Region.

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

Summary Findings: Perquimans 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 Perquimans 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 Perquimans 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 Perquimans 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 Perquimans 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 Perquimans focus areas identified as countywide priorities for the 2024 CHNA are Access to Healthcare, Behavioral Health, and Healthy Living, as seen in **Figure I.6**.

Figure I.6: Perquimans County 2024 Priority Health Needs

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

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

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

CHAPTER 1 | METHODOLOGY

Study Design

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

Specifically, the following data types were collected and analyzed:

New (Primary) Data

Public engagement and feedback were received through a 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 Perquimans 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 to identify trends across various groups and to highlight areas of concern for specific populations. In total, the input was gathered from over 300 Perquimans County residents and other stakeholders. This included web survey responses from nearly 300 community members and one focus group that included 10 community members and other people who live, work or receive healthcare in Perquimans 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 Perquimans 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 previous Community Health Assessments from Perquimans County in 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 Perquimans 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.

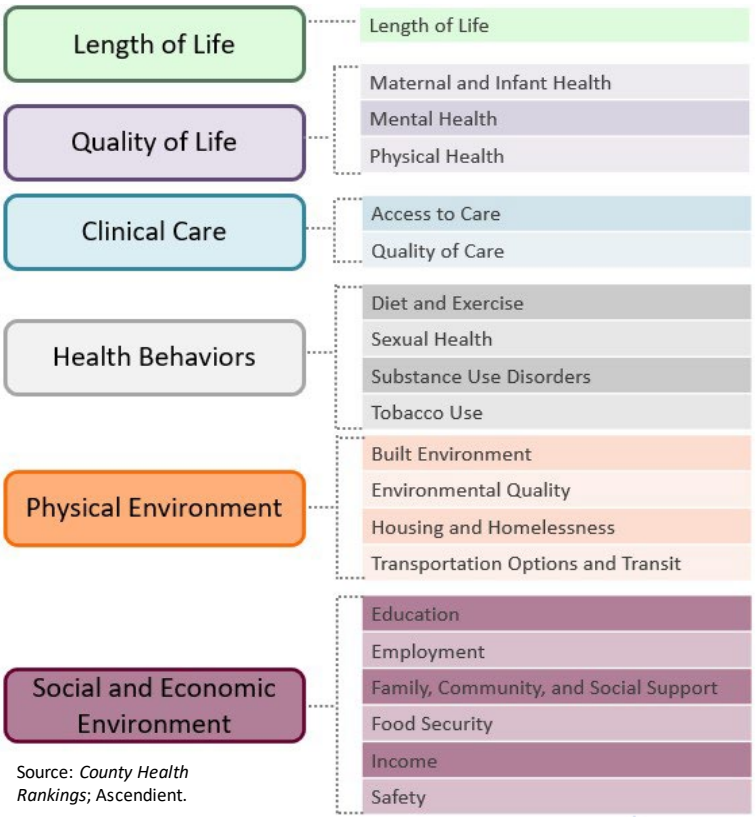
Population Health Framework

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, so that

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

Figure 1.1: Population Health Framework



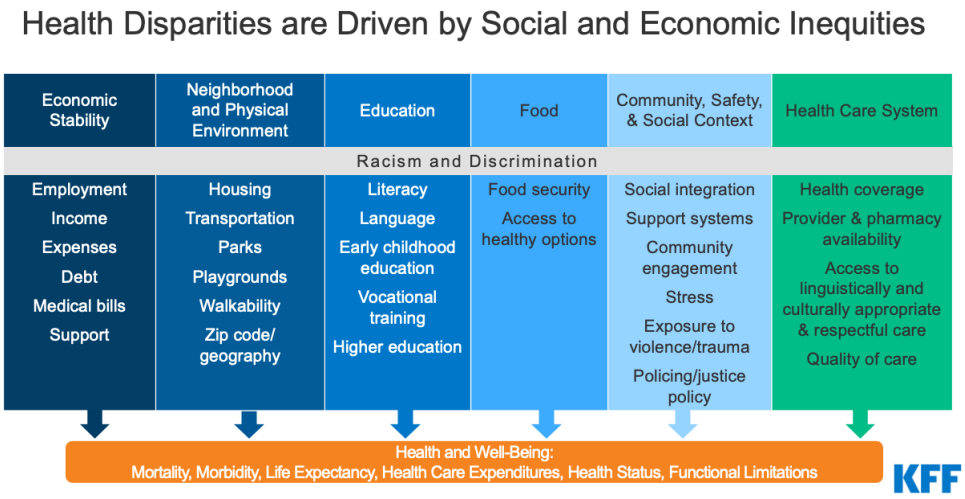
Source: *County Health Rankings*; Ascendient.

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

Figure 1.2: Social Determinants of Health

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. 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 variety 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 Perquimans 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 Perquimans County's top priority health needs to be addressed over the next three years, as seen in **Figure 1.4** below:

Figure 1.4: Perquimans County 2024 Priority Health Needs

The following organizations participated in the prioritization voting process:

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

Study Limitations

Developing a CHNA is a long and time-consuming process. Because of this, more recent data may have been made available after the collection and analysis timeframe. Existing data typically become available between one and three years after the data is collected. This is a limitation, because the "staleness" of certain data may not depict current trends. For example, the U.S. Census Bureau's American Community Survey is a valuable source of demographic information, however data for a particular year is not published until late the following year. This means 2022 data on community characteristics, such as languages spoken at home, did not become available until late fall 2023. The Steering Committee tried to account for these limitations by collecting new data, including focus groups and web-based community member surveys. Another limitation of existing data is that, depending on the source, it may have limited demographic information, such as gender, age, race, and ethnicity.

Given the size of Perquimans County in both population and geography, this study was limited in its ability to fully capture health disparities and health needs across racial and ethnic groups. Efforts were made to include diverse community members in survey efforts. Roughly 80% of all respondents were White compared to 71% of the Perquimans County population reported as being White. Another 17% of respondents were Black or African American, exceeding the county population reported as being 21%. Only 3.1% of respondents identified as Hispanic, exceeding the reported county population level of 2.5%. 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. Furthermore, while the percentage of respondents identifying from certain racial/ethnic minority groups were similar or exceeded the community composition, a lower overall survey response rate also may have impacted the ability to assess health needs and disparities for all community groups.

In addition, there are existing gaps in information for some population groups. Many available datasets are not able to isolate historically underserved populations, including the uninsured, low-income persons, and/or certain minority groups. Despite the lack of available data, attempts were made to include underserved sub-segments of the greater population through the new data gathered throughout the CHNA process. For example, the Steering Committee chose to focus on Spanish-speaking members of the

community by providing a Spanish language version of the web-based community. Paper surveys were also distributed 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

Perquimans County is a narrow, primarily rural county located in the Inner Coastal Plain region of northeastern North Carolina. Perquimans County is adjacent to Pasquotank County on the east, Chowan County on the southwest, and Gates County on the northwest. The county seat is the town of Hertford. Perquimans County encompasses a land area of 329 square miles, including 82 square miles of waterfront. US Highway 17 runs through Hertford northeast (toward the Outer Banks) and southwest (towards Wilmington, North Carolina), joining US 64. NC Highway 37 runs northwest and leads towards the state of VA. The nearest major interstate to the county is I-95, which is 60 miles to the west.

The earliest inhabitants of what is now Perquimans County were the Yeopim Indians, who deeded Perquimans County to George Durant, one of the first settlers in what is present-day Perquimans County, in 1661. Today Perquimans County covers lowland between the Albemarle Sound and the Dismal Swamp. Communities and townships within the region include Hertford, Winfall, Chapanoke, Belvidere, Durant's Neck and Snug Harbor. By the early 1700s farming, livestock and fur trade had become major industries in the region. All residents of Perquimans County live 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.

Perquimans County has a population of 12,992, making up approximately 0.12% of North Carolina's total population.

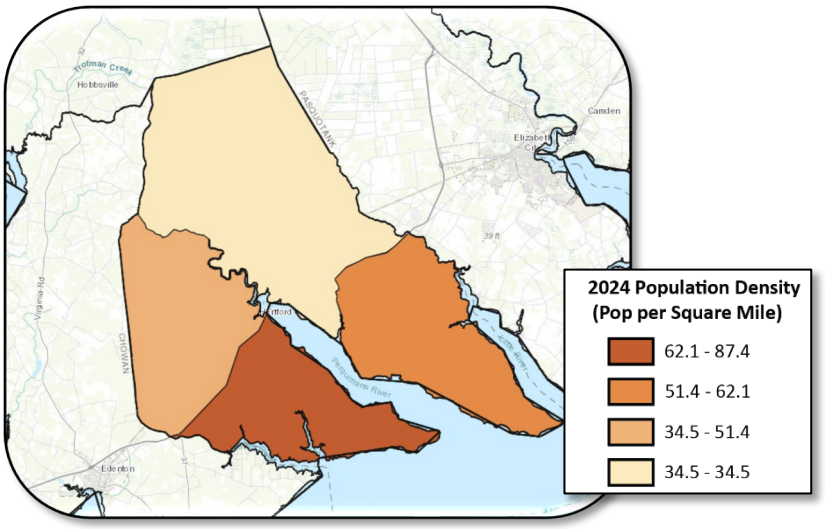
Table 2.1: Total Population, 2023[4]

	Perquimans County	North Carolina	United States
Population	12,992	10,765,678	337,470,185

Perquimans County has a population density of 52.9 persons per square mile – lower than the population density for North Carolina (214.7 persons per square mile). Bethel is the most densely populated area in the county.

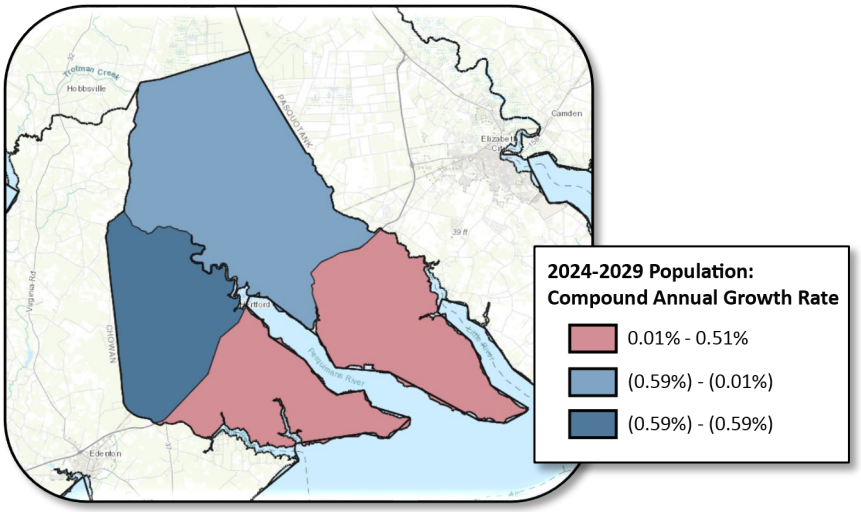
[4] Source: Esri 2023

Figure 2.1: Perquimans County Map: Population Density[4]1 above



In total, the population of Perquimans County is projected to decline 0.08% annually between 2024 and 2029. Areas in the southern part of the county are experiencing greater declines.

Figure 2.2: Perquimans 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. The age distribution of Perquimans County skews older than the state. [The county has a lower percentage of children under 15 (15.0% vs. state's 17.9%) and a significantly lower proportion of residents ages 15 to 44 (29.1% vs. state's 39.3%). The percentage of middle-aged adults 45 to 64 is slightly higher at 26.7% compared to the state's 25.1%. Most notably, seniors 65 and older make up 29.2% of the population, considerably higher than the state average of 17.7%.

Table 2.2: Age Distribution, 2023[4]			
	Perquimans County	North Carolina	United States
Percentage below 15	15.0%	17.9%	18.1%
Percentage between 15 and 44	29.1%	39.3%	39.5%
Percentage between 45 and 64	26.7%	25.1%	24.6%
Percentage 65 and older	29.2%	17.7%	17.8%

Like the state overall, Perquimans County has a higher distribution of the female population. The proportion of females (52.3%) is higher than the state average (51.0%), with males comprising 47.7% of the population compared to the state's 49.0%.

Table 2.3: Sex Distribution, 2023[4]						
	Perquimans County		North Carolina		United States	
	Count	Pct. of Total	Count	Pct. of Total	Count	Pct. of Total
Female	6,794	52.3%	5,489,419	51.0%	170,118,720	50.4%
Male	6,198	47.7%	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. Perquimans County's racial composition shows some notable differences from state patterns. Non-Hispanic White residents make up 71.8% of the population, higher than the state's 61.2%. Non-Hispanic Black residents comprise 21.1%, similar to the state average of 20.4%. The county has smaller percentages of other racial groups compared to state averages: Asian residents (0.3% vs. state's 3.5%), American Indian and Alaska Native residents (0.3% vs. state's 1.2%), and Native Hawaiian and Pacific Islander residents (0.1%, equal to state average). Residents of Some Other Race Alone constitute 1.1% (vs. state's 6.3%), while those of Two or More Races represent 5.3%.

Table 2.4: Racial Distribution, 2023[4]						
	Perquimans County		North Carolina		United States	
	Count	Pct. of Total	Count	Pct. of Total	Count	Pct. of Total
Black (Non-Hispanic)	2,738	21.1%	2,199,488	20.4%	42,132,758	12.5%
White (Non-Hispanic)	9,323	71.8%	6,590,161	61.2%	204,562,590	60.6%
Asian	44	0.3%	379,374	3.5%	21,088,177	6.2%
AIAN	40	0.3%	133,820	1.2%	3,831,126	1.1%
NHPI	10	0.1%	9,214	0.1%	712,229	0.2%
Some Other Race Alone	143	1.1%	677, 338	6.3%	29,432,586	8.7%
Two or More Races	694	5.3%	776,283	7.2%	35,710,719	10.6%

By ethnicity, 2.5% of Perquimans County's population is Hispanic. This rate is notably lower than the state rate of 11.4%.

Table 2.5: Ethnic Distribution, 2023[4]						
	Perquimans County		North Carolina		United States	
	Count	Pct. of Total	Count	Pct. of Total	Count	Pct. of Total
Non-Hispanic	38,556	94.1%	9,465,874	88.6%	271,934,049	80.6%
Hispanic	327	2.5%	1,299,804	11.4%	65,536,136	19.4%

The percentage of the population who is foreign-born in Perquimans County (2.3%) is substantially lower than the state (9.0%).

Table 2.6: Foreign Born Population, 2022[5,6]			
	Perquimans County	North Carolina	United States
Foreign Born	2.3%	9%	13.9%

The diversity of Perquimans County is reflected in the languages that residents speak at home. According to the most recent American Community Survey (ACS), approximately 4% of Perquimans County residents speak a language other than English at home, compared to around 13% of North Carolina and 22% U.S. residents. Less than 3% of county residents speak Spanish at home.

[5] Source: U.S. Census Bureau (2022)
[6] Source: American Community Survey 2018-2022 5-Year Estimates

Table 2.7: Language Spoken at Home, 2022[6]			
	Perquimans County	North Carolina	United States
English Only	96%	87.3%	78%
Spanish	2.5%	7.9%	13.3%
Indo-European Languages	0.5%	2.1%	3.8%
Asian and Pacific Islander Languages	0.4%	1.9%	3.6%
Other Languages	0.6%	0.8%	1.2%

Disability Status[7]

Data on disability status 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. Perquimans County's disability rate (21.0%) is significantly higher than the state average of 13.3%.

Table 2.8: Disability Status, 2022[5,6]			
	Perquimans County	North Carolina	United States
Population with a Disability	21%	13.3%	12.9%

Veteran Status

Military veterans often need special services and support, so it is important to collect data about them to be better able to meet their specific needs. The veteran population in Perquimans County (11.0%) is notably higher than the state average of 7.8%.

Table 2.9: Veteran Status, 2022[5,6]			
	Perquimans County	North Carolina	United States
Veterans	11%	7.8%	6.2%

[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.

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 Perquimans County is $57,560 and falls below the state figure of $64,316.

Table 2.10: Median Household Income, 2023[4]			
	Perquimans County	North Carolina	United States
Median Household Income	$57,560	$64,316	$72,603

In 2023, approximately 13% of Perquimans County households were below the federal poverty level (FPL). 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]			
	Perquimans County	North Carolina	United States
Percent Below FPL	13.1%	10.1%	9.5%

Approximately one in five Perquimans County households received Food Stamps/SNAP (Supplemental Nutrition Assistance Program) in 2022. This rate is significantly higher than the state average of 13.4%.

Table 2.12: Households Receiving Food Stamps/SNAP, 2022[6,8]			
	Perquimans County	North Carolina	United States
Number of Households Receiving Food Stamps/SNAP	1,197	575,860	16,072,733
Total Number of Households	5,594	4,299,266	129,870,928
Percentage of Households receiving Food Stamps/SNAP	21.4%	13.4%	12.4%

Perquimans County has lower rates of residents with less than 9th grade education (4.7%) compared to the state's 6.0%. However, it has higher percentages of residents who started but did not complete high school (8.7% compared to the state's 5.5%). The county exceeds state averages in high school completion

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

alone (24.6% compared to 21.2%) and some college attendance without completion (28.2% compared to 21.1%). Lower proportions of residents hold higher degrees compared to the state: bachelor's degrees (11.5% compared to 20.4%) and graduate/professional degrees (8.1% compared to 11.6%).

Table 2.13: Educational Attainment, 2020[5,9]

	Perquimans County	North Carolina	United States
Less than 9th Grade	4.7%	6.0%	3.5%
Some High School/No Diploma	8.7%	5.5%	5.3%
High School Diploma	24.6%	21.2%	28.5%
GED/Alternative Credential	6.3%	4.3%	*[10]
Some College/No Diploma	28.2%	21.1%	14.6%
Associate's Degree	8.1%	9.9%	10.5%
Bachelor's Degree	11.5%	20.4%	23.4%
Graduate/ Professional Degree	8.1%	11.6%	14.2%

Perquimans County shows distinct unemployment patterns across age groups. Youth unemployment is particularly high at 24.7%, double the state's 12.4%. However, working-age adults (25 to 54) have lower unemployment at 2.4% compared to the state's 4.7%. The rates for ages 55 to 64 (0.6%) and seniors 65 and older (0.5%) are notably lower than state averages (3.3% and 3.0% respectively). The overall unemployment rate of 5.0% is similar to the state average of 5.1%.

Table 2.14: Unemployment, 2022[6,11]

	Perquimans County	North Carolina	United States
Percentage unemployed ages 16 to 24	24.7%	12.4%	11.0%
Percentage unemployed ages 25 to 54	2.4%	4.7%	3.4%
Percentage unemployed ages 55 to 64	0.6%	3.3%	2.7%
Percentage unemployed ages 65 or more	0.5%	3.0%	2.9%
Total unemployment	5.0%	5.1%	3.9%

Perquimans County's overall uninsured rate (10.7%) is lower than the state average (15.0%). However, the county shows concerning disparities across age groups. The uninsured rate for children 18 and below (9.8%) is notably higher than the state average (5.2%). Young adults ages 19 to 34 show a lower uninsured rate (13.4%) than the state average (15.5%), while those ages 35 to 64 have a significantly higher uninsured rate (18.1%) compared to the state's 12.5%.

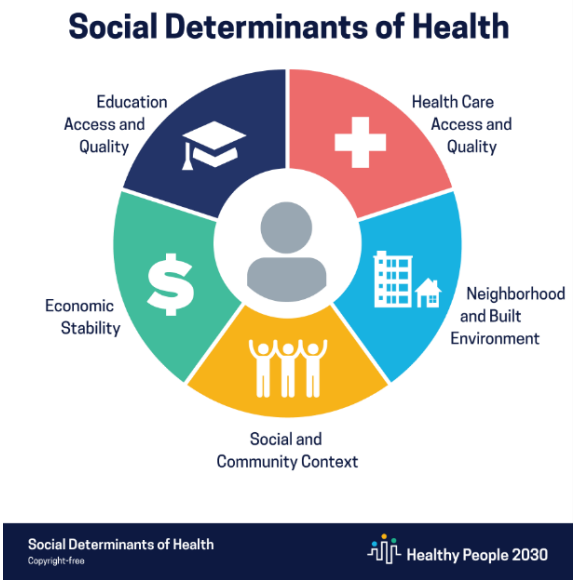
[9] Source: North Carolina Office State of Budget and Management
[10] U.S. totals combine GED with High School Diploma
[11] Source: Federal Reserve Economic Data (FRED)

Table 2.15: Health Insurance Status, 2022[6]			
	Perquimans County	North Carolina	United States
Percentage uninsured ages 18 or below	9.8%	5.2%	5.4%
Percentage uninsured ages 19 to 34	13.4%	15.5%	13.6%
Percentage uninsured ages 35 to 64	18.1%	12.5%	9.9%
Total % Uninsured	10.7%	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, neighborhood and built environment, social and community context, economic stability, and education access and quality.

Figure 2.3: Social Determinants of Health



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

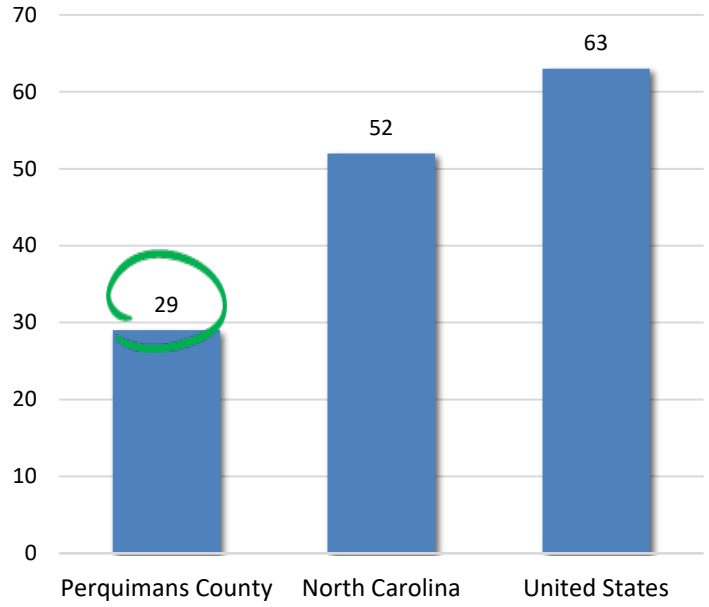
regarding the needs of their specific communities. This information will be presented in detail later in this report.

Disparities

Recognizing the diversity of Perquimans County, as discussed above, the Steering Committee evaluated factors that may contribute to health disparities in its community. These included racial equity; racial segregation; financial barriers; nutrition; social, behavioral, and economic factors that influence health; and English language proficiency.

Residential segregation is measured by the index of dissimilarity, a demographic measure ranging from 0 to 100 that represents how evenly two demographic groups are distributed across a county's census tracts. Lower scores represent a higher level of integration. There is less residential segregation in Perquimans compared to the state and country, as seen in **Figure 2.4**.

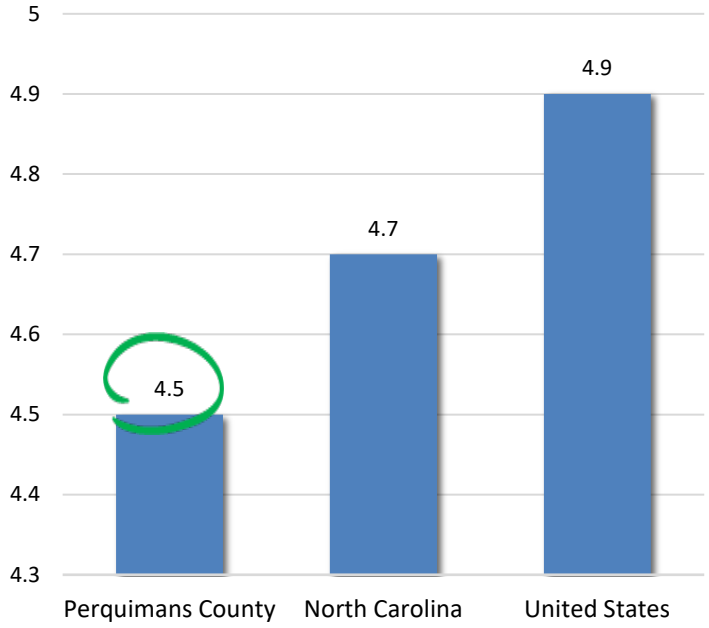
Figure 2.4: Residential Segregation[12]



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 Perquimans is notably lower than state and national figures.

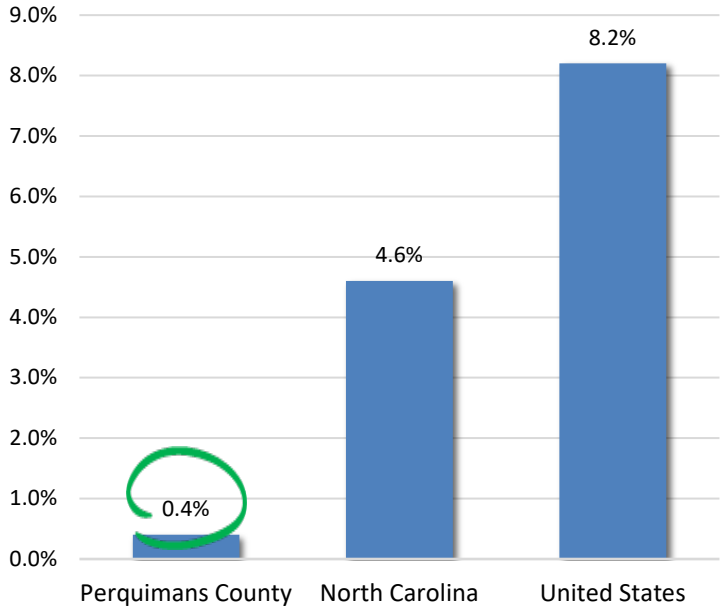
[12] Source: Robert Wood Johnson County Health Rankings 2024

Figure 2.5: Income Inequality Ratio[12]



People with limited English proficiency (LEP) may face challenges accessing care and resources that fluent English speakers do not. Language barriers may make it hard to access transportation, medical, and social services as well as limit opportunities for education and employment. Importantly, LEP community members may not understand critical public health and safety notifications, such as safety-focused communications during the COVID-19 pandemic. Significantly fewer people are not fluent in English in Perquimans compared to the state and country, as seen in **Figure 2.6**.

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

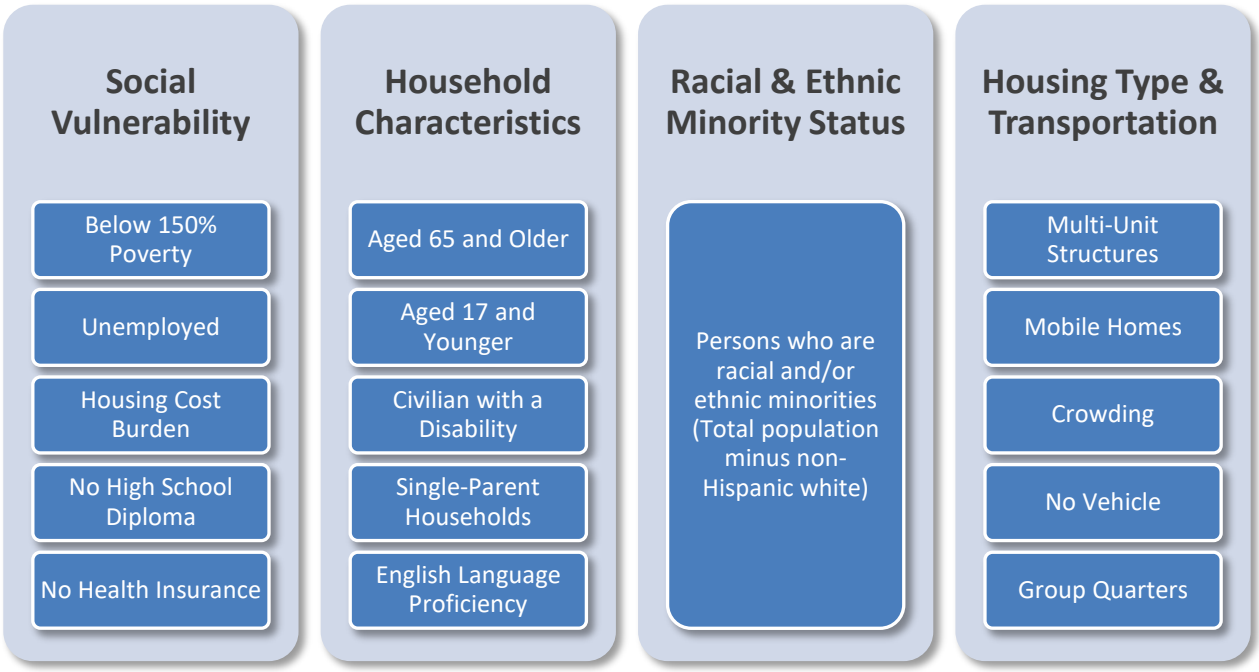


Social Vulnerability Index

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.

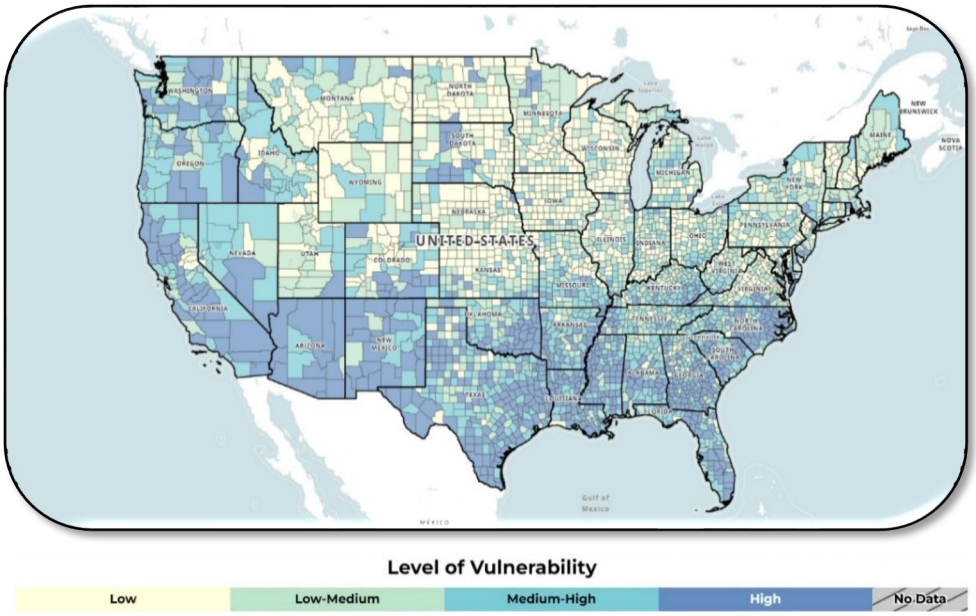
Figure 2.7: Social Vulnerability Index Variables



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.

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

Figure 2.8: United States SVI by County, 2022



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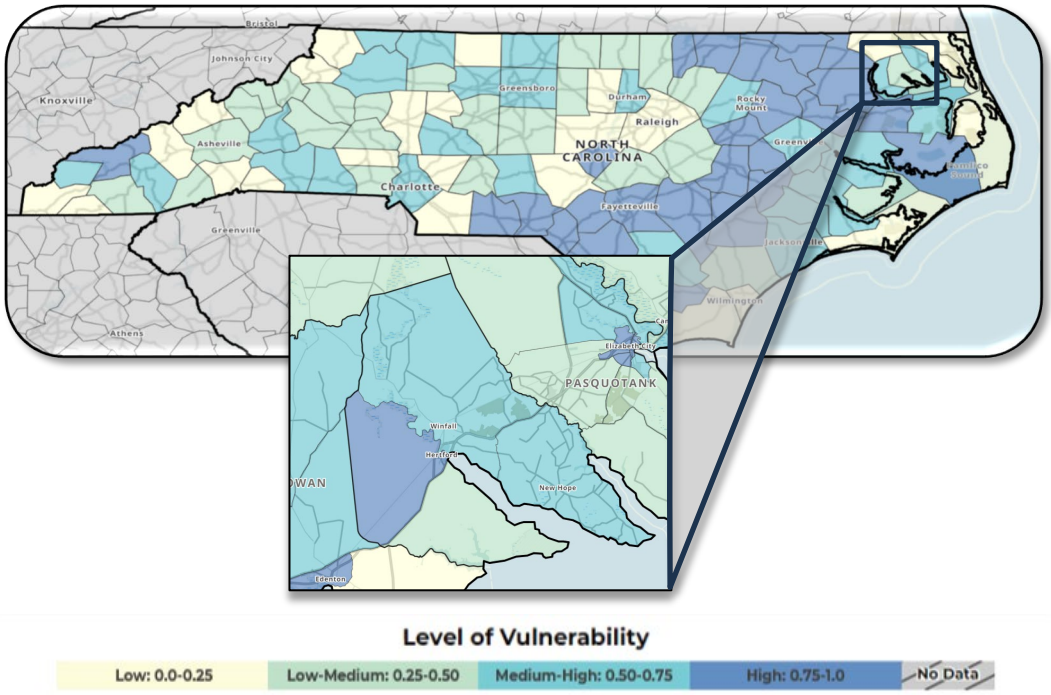
The 2022 SVI scores for Perquimans County are shown in **Figure 2.9** below. Possible scores range from 0 (lowest vulnerability) to 1 (highest vulnerability), and these scores show a relative comparison with other counties and census tracts in North Carolina. The vulnerability of Perquimans County overall is lower than average compared to the state. Levels of vulnerability are variable across the county with the average being 0.37.

Figure 2.9: Perquimans County SVI by Census Tract, 2022



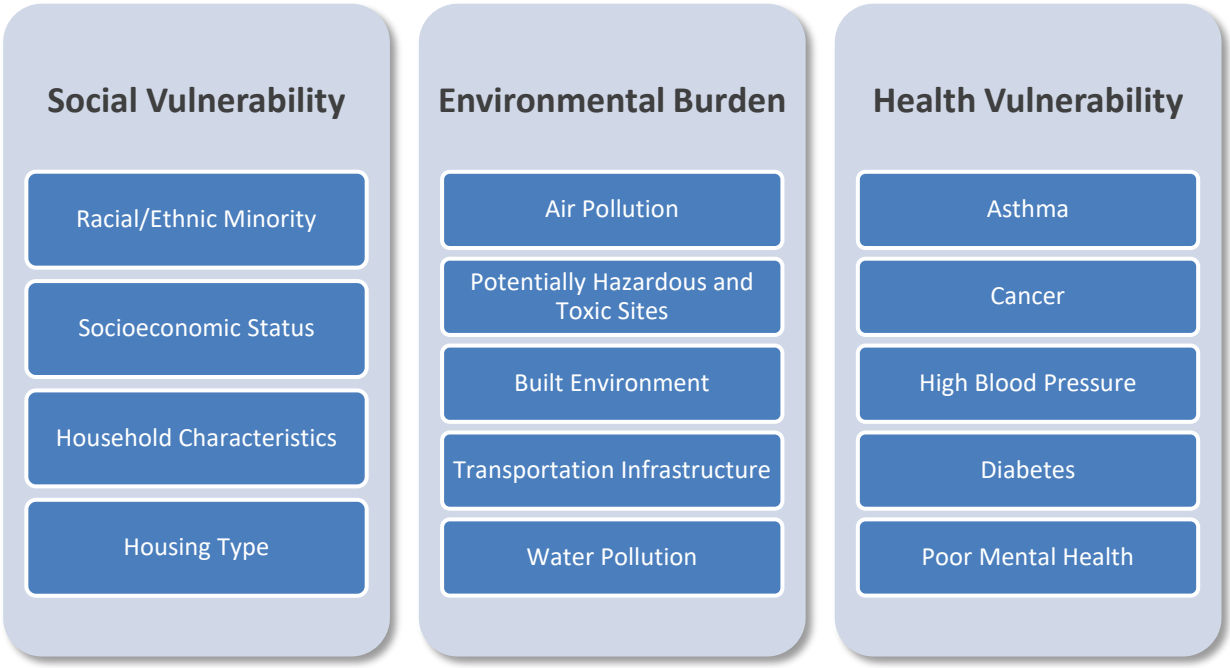
Environmental Justice Index

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.

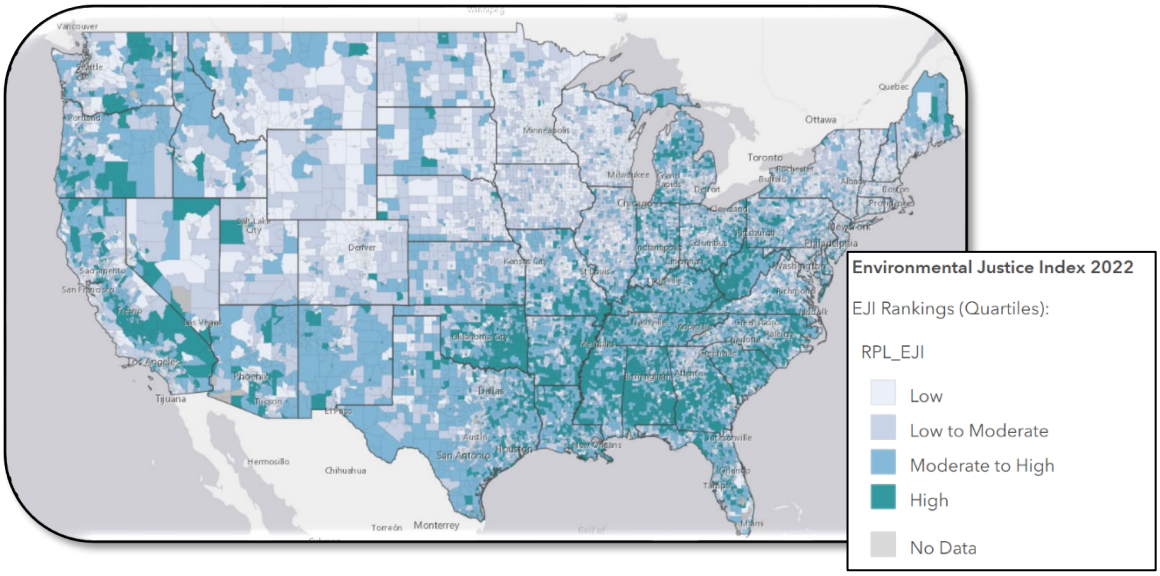
Figure 2.10: Environmental Justice Index Variables



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

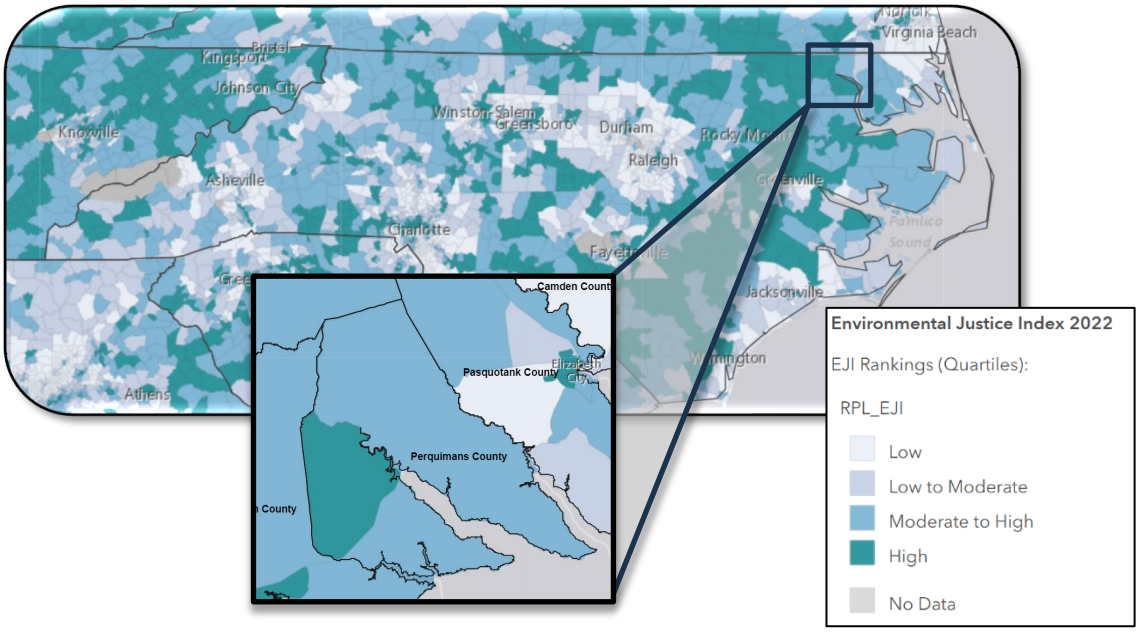
[14] U.S. Environmental Protection Agency (2024). Retrieved from https://www.epa.gov/environmentaljustice

Figure 2.11: United States EJI by Census Tract, 2022



The 2022 EJI scores for Perquimans 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 0.68.

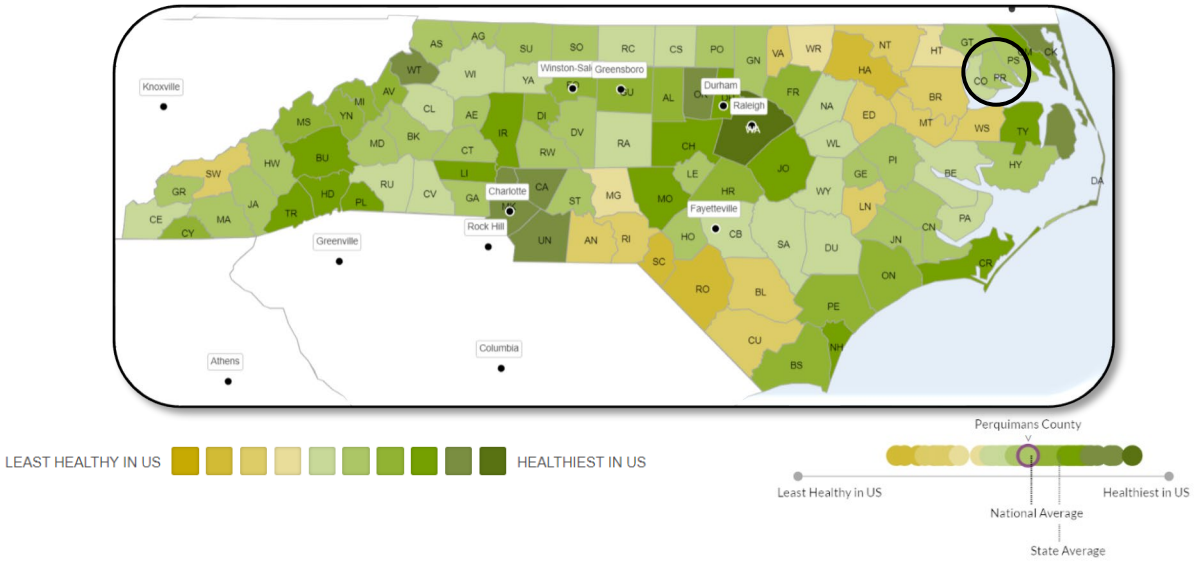
Figure 2.12: Perquimans County EJI by Census Tract, 2022



Health Outcome and Health Factor Rankings

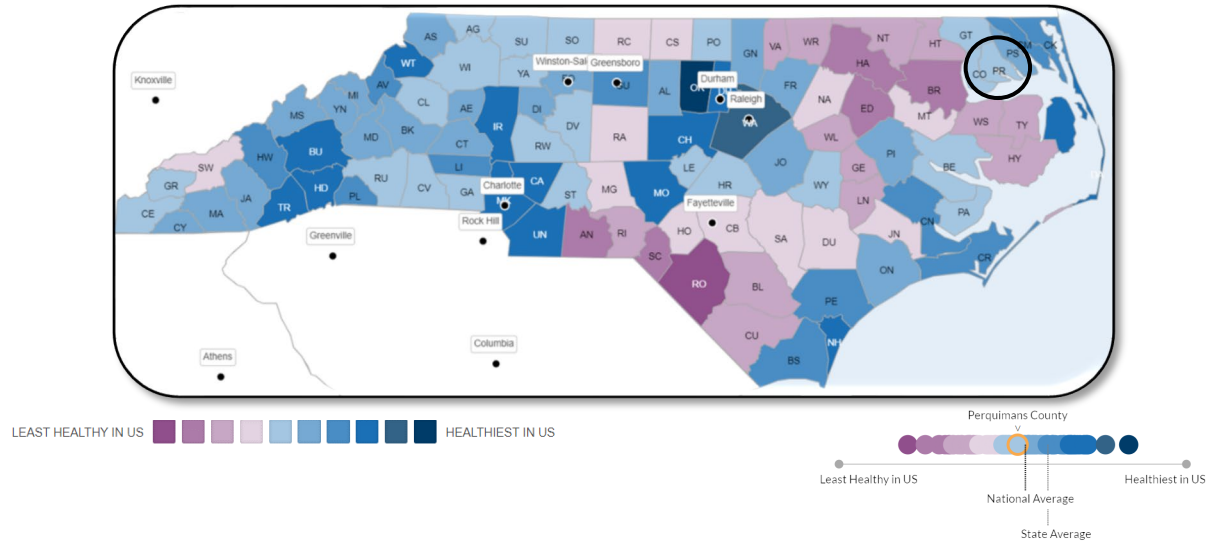
County leaders also reviewed and analyzed data from the Robert Wood Johnson Foundation and the University of Wisconsin County Health Rankings for the year 2024. The Health Outcomes measure looks at how long people in a community live and how physically and mentally healthy they are. These categories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

Figure 2.14: State Health Factors Rating Map



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 key leader survey, community member survey, and focus groups).

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

[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.

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 Perquimans County.

Secondary Data Findings

Access to care emerged as a significant concern for Perquimans County based on several key indicators. The county's performance on multiple healthcare access metrics was worse than state and national averages, indicating a high level of need in this area.

Perquimans County faces significant challenges in terms of healthcare provider availability. The rate of primary care providers per 100,000 population in Perquimans County (23.1) is substantially lower than both the state (101.1) and national (112.4) averages. This shortage of primary care professionals may contribute to difficulties in accessing timely and appropriate care for various health concerns.

[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 Indicators			
Indicator	**Perquimans County**	**North Carolina**	**United States**
Substance Abuse Providers (Rate per 100,000 Population)	0.0	25.0	27.9
Buprenorphine Providers (Rate per 100,000 Population)	7.4	15.2	15.5
Dental Providers (Rate per 100,000 Population)	0.0	31.5	39.1
Mental Health Providers (Rate per 100,000 Population)	53.8	155.7	178.7
Primary Care Providers (Rate per 100,000 Population)	23.1	101.1	112.4

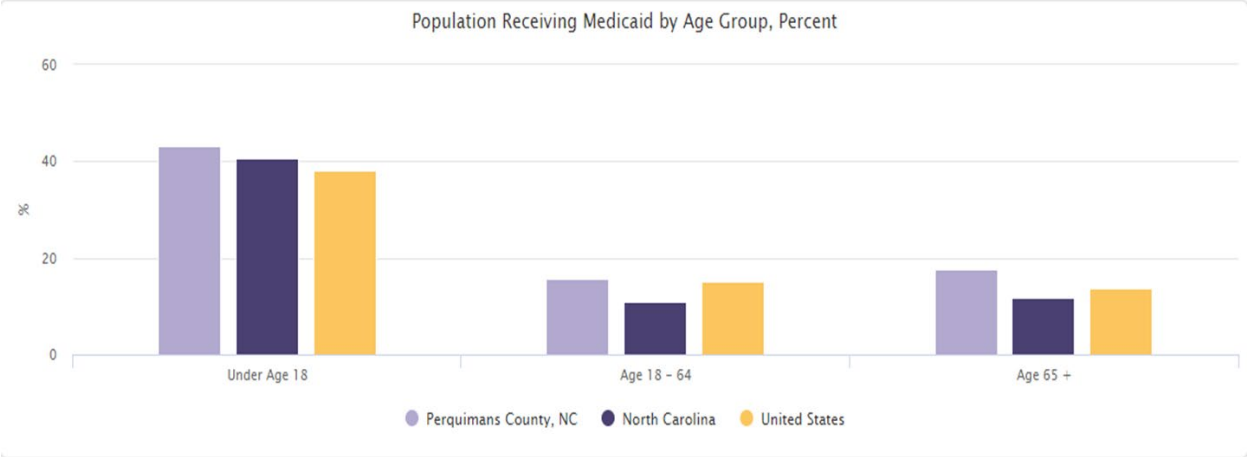
The disparity is even more pronounced for other types of healthcare providers. Perquimans County has no local substance use providers, compared to the state rate of 25.0 per 100,000 population and the national rate of 27.9. The rate of dental providers is also zero, compared to 31.5 in North Carolina and 39.1 nationally. This severe shortage is further highlighted by the fact that 39% of Perquimans County's population lives in an area designated as a Dental Health Professional Shortage Area (HPSA), compared to 34% in North Carolina and 18% nationally.

Perquimans County shows mixed results in terms of healthcare quality indicators. The 30-day hospital readmission rate in Perquimans County (16%) is lower than both the state and national averages (18% each), suggesting potentially better quality of care or support for patients after an inpatient stay. However, the county has a higher rate of emergency room visits (622 per 1,000 population) compared to the state average (563), which could indicate issues with access to primary care or urgent care services.

Table 3.2: Healthcare Quality Indicators			
Indicator	**Perquimans County**	**North Carolina**	**United States**
Percentage of Population Living in an Area Affected by a Dental Care HPSA	39%	34%	18%
Percent of Insured Population Receiving Medicaid	24%	20%	22%
Rate of Federally Qualified Health Centers (Rate per 100,000 Population)	0.0	4.0	3.5
Preventable Hospitalizations, (Rate per 100,000 Beneficiaries)	2,678	2,957	2,752
30-Day Hospital Readmissions, Rate	16%	18%	18%
Emergency Room Visits (Rate per 1,000 Population)	622	563	535

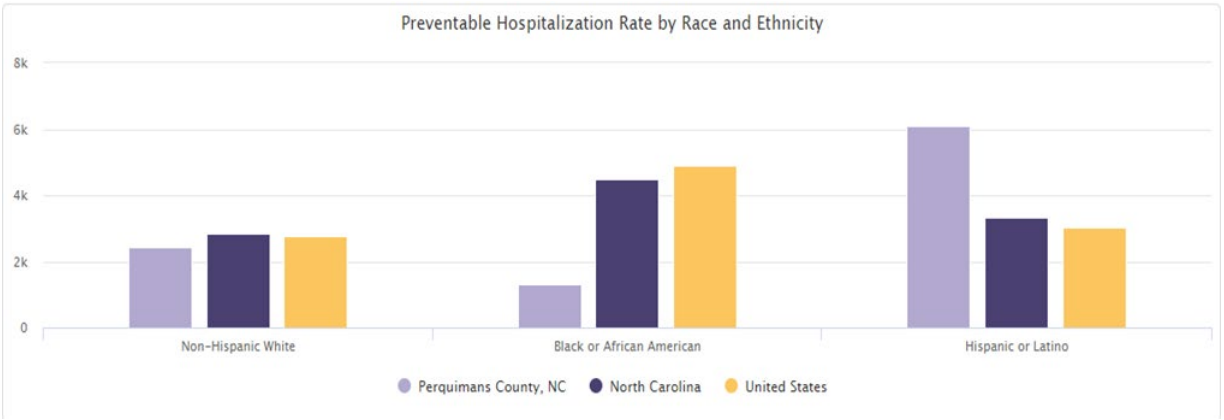
Perquimans County has higher Medicaid enrollment rates across all age groups compared to state and national averages, with particularly high rates among individuals under age 18. This higher Medicaid enrollment rate could indicate a higher level of need for affordable healthcare options in the county.

Figure 3.1: Medicaid Enrollment by Age Group



The county faces challenges in terms of preventable hospital stays, particularly among certain demographic groups. While the overall rate of preventable hospital stays (2,678 per 100,000 Medicare beneficiaries) is lower than the state average (2,957), there are significant disparities. Hispanic or Latino Medicare beneficiaries in Perquimans County have a much higher rate of preventable hospital stays (6,111 per 100,000) compared to White (2,428) and Black (1,306) beneficiaries. This disparity suggests potential issues with equitable access to preventive care or management of chronic conditions among diverse populations.

Figure 3.2: Preventable Hospital Stays by Race/Ethnicity



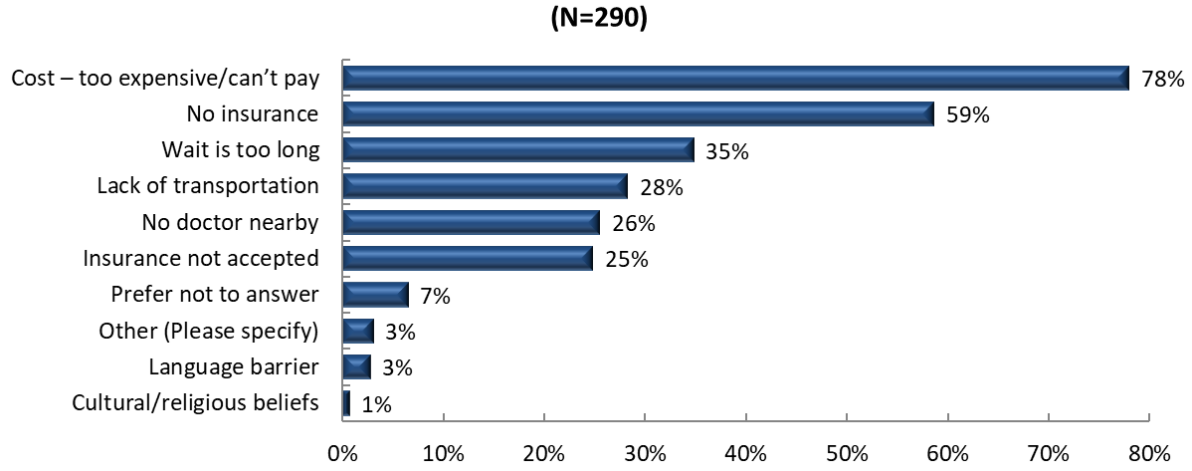
These data suggest that Perquimans County faces significant challenges in healthcare access, particularly in terms of healthcare provider availability. The lower rates of various types of healthcare providers, combined with higher emergency room visit rates and disparities in preventable hospital stays, suggest a need to focus on improving access to care in the county.

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

Primary Data Findings – Community Member Web Survey

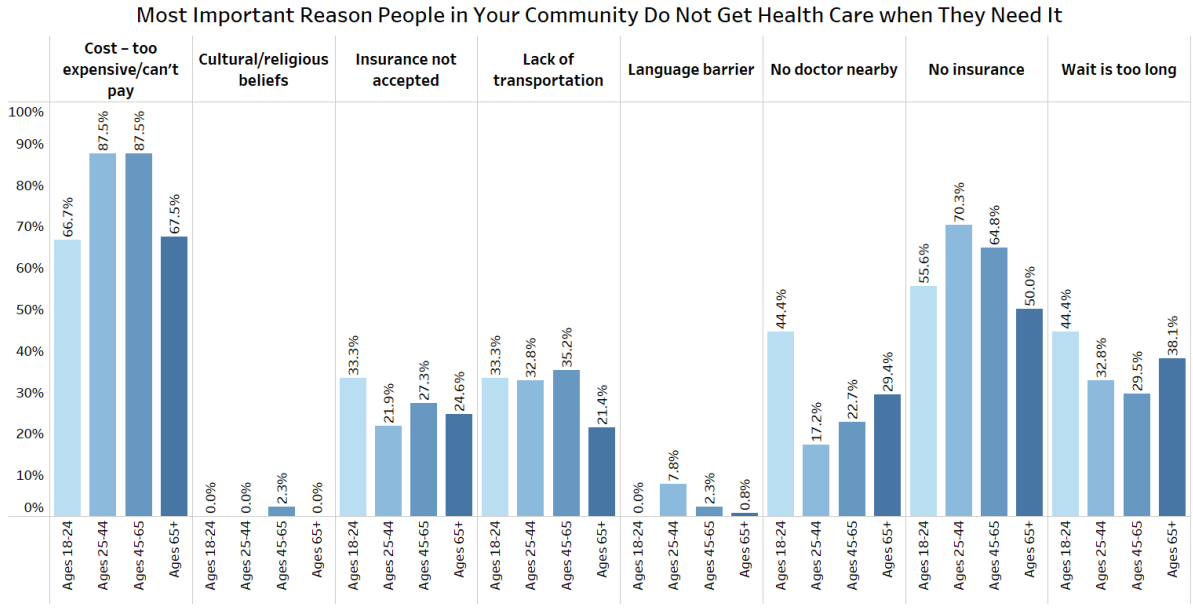
Almost 300 Perquimans residents responded to the web-based survey. Respondents identified several access to care needs in Perquimans County. In the survey, community members were asked to identify the top barriers to receiving healthcare. Cost (78%), no insurance (59%), and long wait times (35%) were the top three identified reasons why people in the community are not getting care when they need it. More than one-quarter of responses (28%) also identified a lack of nearby providers and 25% cited that insurance was not widely accepted.

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



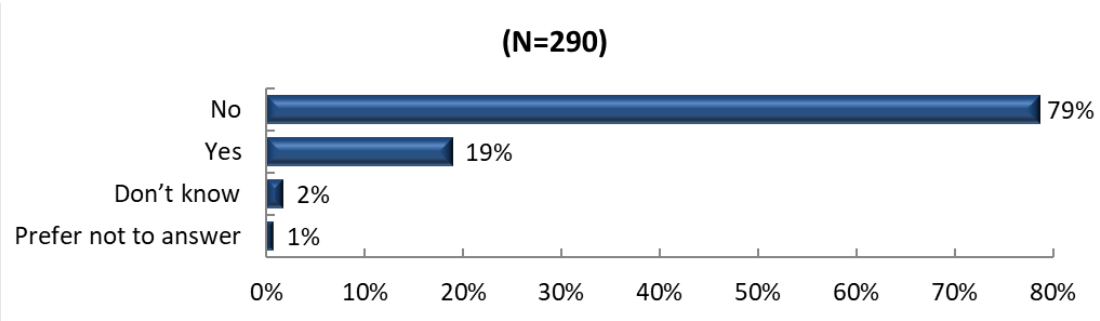
When these data were examined by age group, the age groups that most frequently identified cost (88%) as a top barrier were those 25 to 44 and 45 to 65. The second top barrier, lack of insurance, was also most frequently selected by those 25 to 44 (70%). When the data was viewed by ethnicity, non-Hispanic/Latino community members ranked cost (80%) and a lack of insurance (61%) higher as major barriers to care, compared to those who were Hispanic/Latino (56%, 33%).

Figure 3.4: 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)



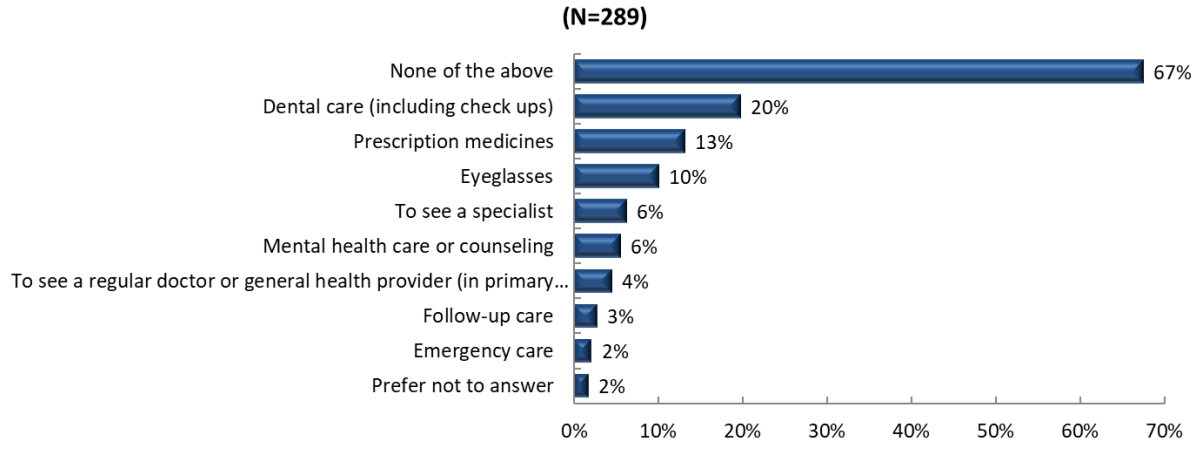
Perquimans County community survey respondents were also asked if there was a time during the past 12 months that they were told by their healthcare provider that their insurance was not accepted. While most respondents (79%) indicated that this was not an issue, nearly one-fifth (19%) were told that their insurance was not accepted by their provider.

Figure 3.5: 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?



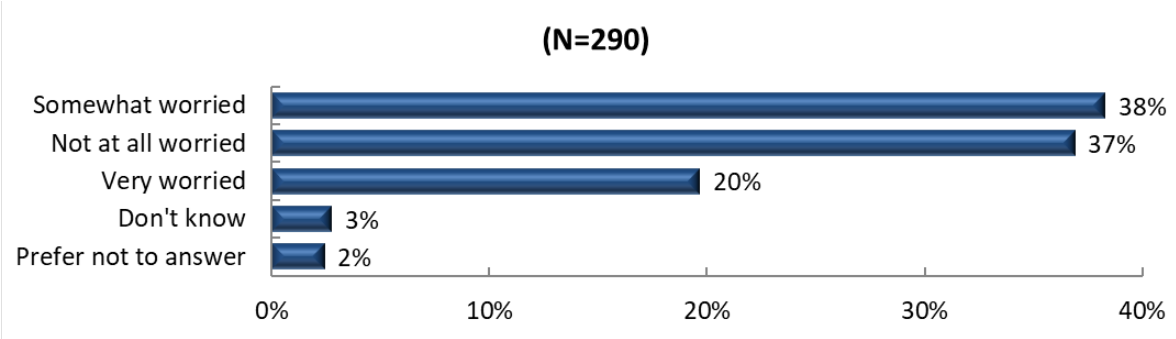
Perquimans County community survey respondents were also asked if there was a time during the past 12 months that they needed specific medical care or other health-related items and were unable to access it due to the cost. While two-thirds (67%) of respondents indicated that they did not have this problem, one-fifth (20%) cited not receiving dental care, and nearly 13% of respondents cited not being able to purchase their prescription medications due to cost.

Figure 3.6: During the past 12 months, was there any time when you needed any of the following, but didn't get it because you couldn't afford it?



Respondents were also asked if they were worried about being able to afford an unexpected medical bill should they fall ill or become injured. As displayed in **Figure 3.7** below, 58% of respondents indicated being at least somewhat worried about a surprise medical bill, further supporting cost as a top ranked barrier to care.

Figure 3.7: If you get sick or have an accident, how worried are you that you will be able to pay your medical bills?



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

Primary Data Findings – Focus Groups

Focus group participants in Perquimans County identified access to healthcare as a significant concern in their community. They highlighted several challenges, including lack of providers and specialists in the area, accessibility and lack of insurance, and long appointment wait times with limited availability. Transportation was noted as a significant barrier impacting residents' ability to access healthcare and other needed services.

To address these challenges, participants suggested implementing more mobile care and home visits, and creating a comprehensive educational catalogue with events, services, and programs available to the community. Participants emphasized that many residents are unable to find needed healthcare services within a reasonable time frame and do not know what services are currently available to them.
For a more detailed description of focus group findings, see **Appendix 5**.

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

Context and National Perspective

The definition of behavioral health often describes conditions related to both mental health and substance use.[23] 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.[24] After evaluating data from a variety of sources including surveys and focus groups conducted throughout the assessment process, the Steering Committee identified behavioral health/mental health, including both mental health and substance use, to be an area of urgent need within Perquimans 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.[25] 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. [26]

Mental illness can occur due to multiple different factors, such as genetics, drug and/or alcohol usage, isolation, adverse childhood experiences, and chronic health conditions. Additionally, mental illness can act like other chronic health conditions, in that it can worsen or improve depending on the environment. Mental health services have evolved in the past five years, especially during the COVID-19 pandemic. However, accessing mental health care services can be challenging. According to the National Institute of Mental Health, less than half (47.2%) of adults with a common mental illness received any mental health services in 2021. Those who had an SMI were more likely (65.4%) to have received mental health services that same year.[27] While access to telehealth mental health services has increased, those living in rural areas may still find it difficult to access care. This is a particular concern among those who are low-income or experiencing homelessness, two groups at high risk for developing an acute or chronic mental health

[23] 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.
[24]Source: CDC. (2024). About mental health. Retrieved October 1, 2024, from: https://www.cdc.gov/mentalhealth/learn/index.htm
[25] Source: National Institute of Mental Health (2023). *Mental Illness*. Retrieved September 13th, 2023, from https://www.nimh.nih.gov/health/statistics/mental-illness.
[26] Source: CDC. (2024). Mental health. Retrieved October 1, 2024, from https://www.cdc.gov/mentalhealth/learn/index.htm
[27] Source: National Institute of Mental Health. (2023). Mental Illness. Retrieved October 1, 2024, from https://www.nimh.nih.gov/health/statistics/mental-illness

condition. As of 2023, over seven million people in the U.S. who reported having a mental illness lived in a rural area.[28]

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. [29]

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.[30] 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.[31] 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.[32] 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.[33] Treatment SUDs generally cannot follow a cookie-cutter approach, as each person receiving treatment will have different withdrawal and coping needs. Treatment is typically provided through various therapies, inpatient admissions, and forms of medication-assisted treatment such as methadone. Opioid overdoses are one of the most common types of deaths related to SUDs and can be preventable and treatable if caught in time. Multiple efforts have been coordinated within the past two years to incorporate the storage of overdose reversing medications such as Naloxone in public facilities such as federal facilities, and over the counter, as was approved in 2023 by the FDA. This is critical, as in 2022, the number of opioid overdoses nationwide surpassed 81,051 – a 63% increase in overdoses since 2019.[34]

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

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

[30] 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.

[31] 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.

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

[33] 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

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

Substance use disorders have also had an impact in North Carolina. Over 36,000 overdose deaths occurred in the state between 2000 and 2022 – an average of more than 1,600 deaths each year.[35] 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.[36]

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

Mental health and substance use emerged as a significant concern for Perquimans County based on several key indicators. The county's performance on various metrics related to mental health and substance use disorder showed mixed results compared to state and national averages, suggesting a need for more attention in this area.

In terms of mental health provider availability, Perquimans County faces significant challenges. The rate of mental health providers per 100,000 population in Perquimans County (53.8) is substantially lower than both the state (155.7) and national (178.7) averages. Additionally, as shown in the table below, there are no substance use providers in Perquimans County, and a rate of 7.4 buprenorphine providers per 100,000 population – much lower than state or national rates. This shortage of mental health professionals may contribute to difficulties in accessing timely and appropriate care for mental health concerns.

[35] 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.

[36] 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.

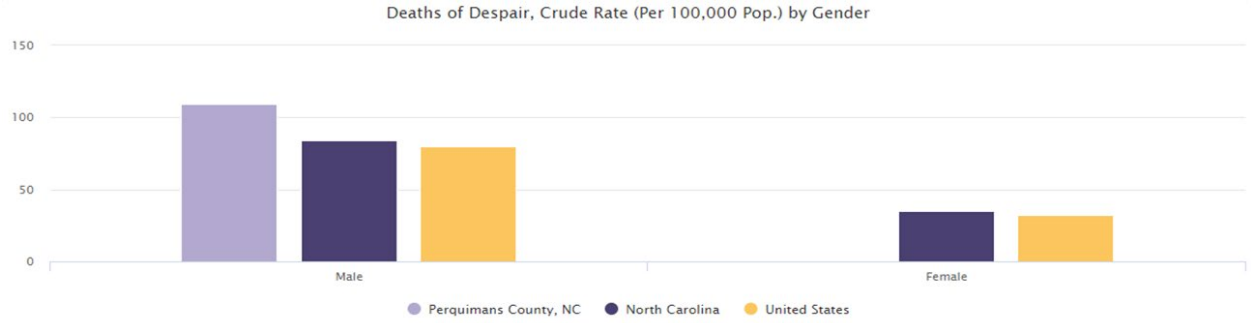
Table 3.3: Mental Health Provider Rates			
Indicator	**Perquimans County**	**North Carolina**	**United States**
Substance Abuse Providers (Rate per 100,000 Population)	0.0	25.0	27.9
Buprenorphine Providers (Rate per 100,000 Population)	7.4	15.2	15.5
Mental Health Providers (Rate per 100,000 Population)	53.8	155.7	178.7

Despite the shortage of providers, Perquimans County residents reported an average number of poor mental health days per month (4.9) that was higher than the North Carolina state average (4.6) and on par with the national average (4.9) as indicated in **Table 3.7** below. This could potentially indicate unmet mental health needs in the community.

Table 3.4: Mental Health Indicators			
Indicator	**Perquimans County**	**North Carolina**	**United States**
Deaths of Despair (Crude Rate per 100,000 Population)	67.3	58.7	55.9
Average Number of Poor Mental Health Days (per Month)	4.9	4.6	4.9

The county faces significant challenges in terms of deaths of despair, which include deaths from suicide, drug overdose, and alcohol-related causes. The crude mortality rate for deaths of despair in Perquimans County (67.3 per 100,000 population) is higher than both the state (58.7) and national (55.9) averages. Notably, there is a substantial gender disparity in deaths of despair in Perquimans County, with men experiencing significantly higher rates of deaths of despair, than both the state and national averages.

Figure 3.8: Deaths of Despair by Gender in Perquimans County



Perquimans County shows some mixed data related to substance use. The percentage of adults reporting excessive drinking in Perquimans County (15%) is lower than both the state and national averages (18% for both). However, the county has a higher rate of alcohol-involved crash deaths in the county (3.1 per 100,000 population) than the state average (2.9).

Perquimans County faces challenges in other areas related to substance use. The opioid overdose death rate in Perquimans County (34.4 per 100,000 population) is significantly higher than the state average (25.1). However, the county has a lower rate of emergency department visits for opioid use disorder (31 per 100,000 beneficiaries) compared to the state average (43).

Table 3.5: Substance Use Indicators

Indicator	Perquimans County	North Carolina	United States
Percentage of Adults Reporting Excessive Drinking	15%	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)	3.1	2.9	2.3
Opioid Overdose Death Rate (Crude Rate per 100,000 Population)	34.4	25.1	N/A

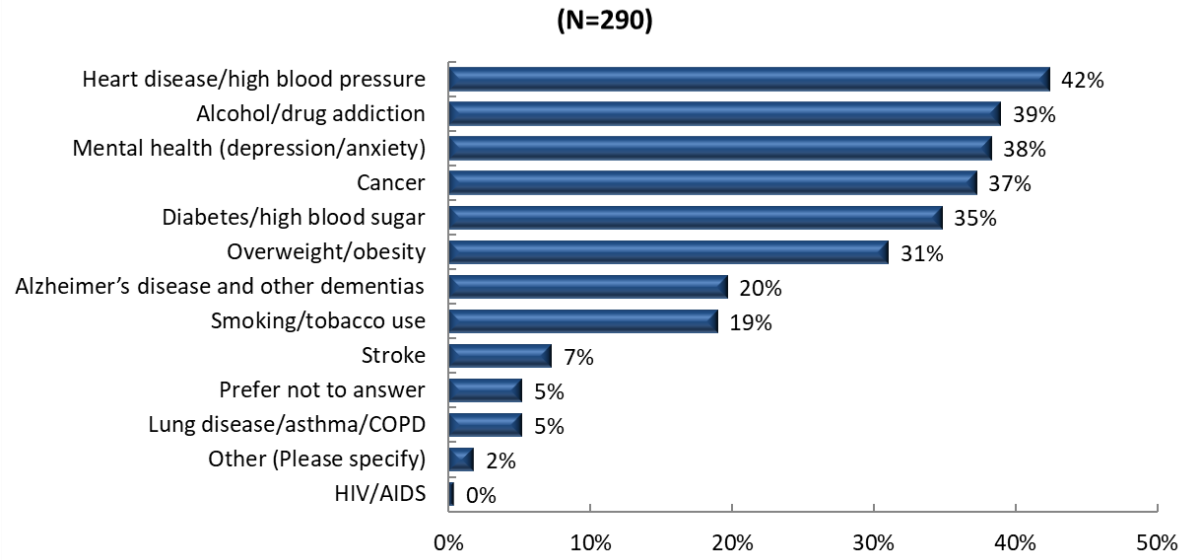
These data suggest that while Perquimans County is performing better in some substance use and mental health measures, there are significant challenges related to behavioral health. The higher rates of deaths of despair, particularly among men, and the higher opioid overdose death rate indicate a need for increased focus on mental health and substance use prevention and treatment services in the county.

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

Primary Data Findings – Community Member Web Survey

Perquimans County residents highlighted different aspects of mental health and substance use as areas of community concern through the web-based survey. When asked to identify the most important community health needs, substance use emerged as the second highest concern, identified by 39% of all respondents. Mental health was ranked third, chosen by 38% of all respondents.

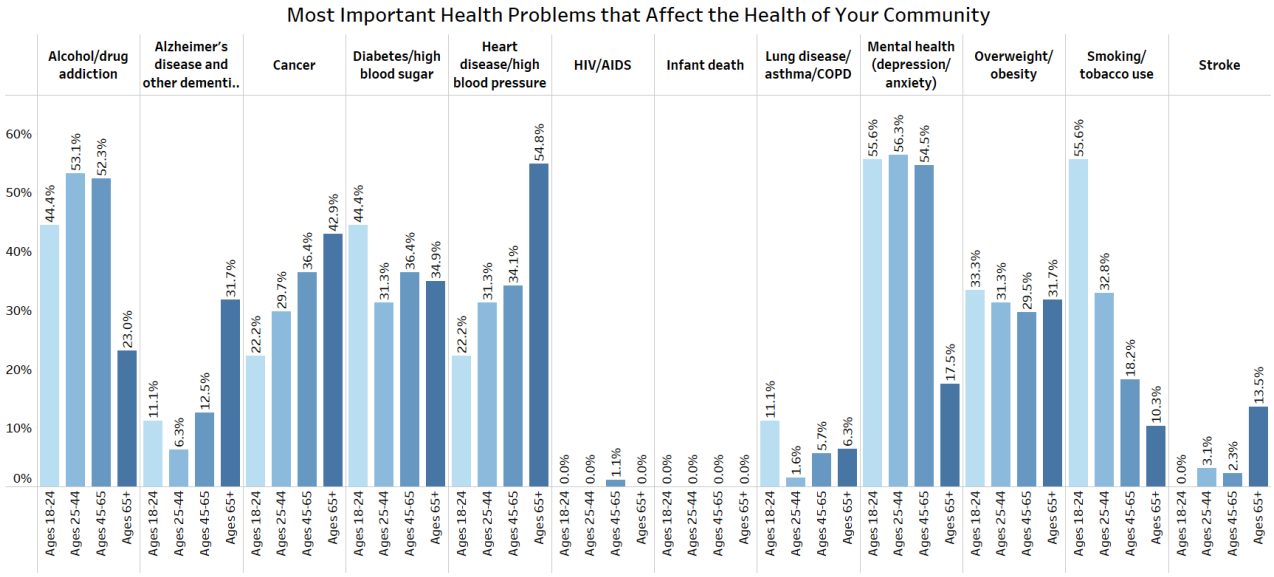
Figure 3.9: What are the three most important health problems that affect the health of your community? Please select up to three.



Those between the ages of 25 to 44 were the age group most likely to select mental health as a top need (56%), compared to only 18% of those over the age of 65. Furthermore, 44% of female respondents cited mental health as a top concern, compared to 21% of male respondents.

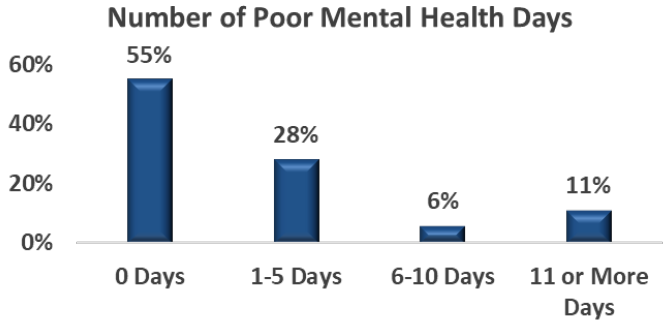
Disparities also emerged when reviewing alcohol and substance use. Respondents ages 25 to 44 were the group most likely (53%) to cite this as a key health concern, compared to just 23% of those over the age of 65. Gender disparities were also present, with nearly half (43%) of female respondents selecting alcohol and substance use as a major concern, compared to 27% of male respondents. "Other" race respondents were also most likely (52%) to cite alcohol and substance use, compared to 26% of White respondents. Finally, nearly half (41%) of non-Hispanic/Latino respondents indicated that alcohol and substance use was a top health problem, versus just 11% of Hispanic/Latino community members.

Figure 3.10: What are the three most important health problems that affect the health of your community? Please select up to three. (by age)



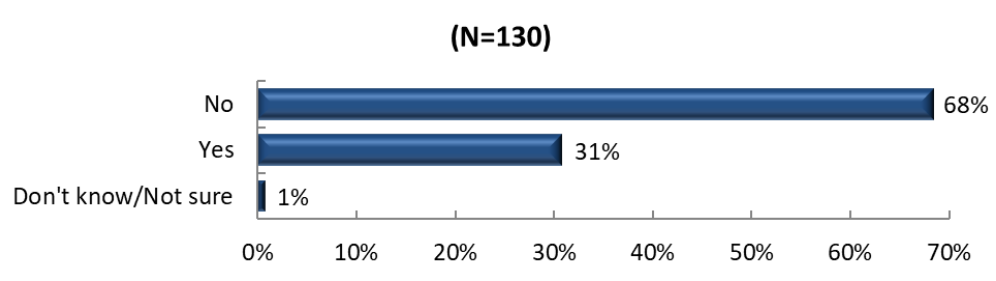
When respondents were asked about their own mental health, 45% of respondents indicated they had one or more poor mental health days in the past 30 days, with an average of four poor mental health days across all respondents. Concerningly, more than one in ten survey respondents indicated that they had 11 or more poor mental health days in the prior month. However, 55% of respondents did not experience any poor mental health days in the past 30 days.

Figure 3.11: 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=288)



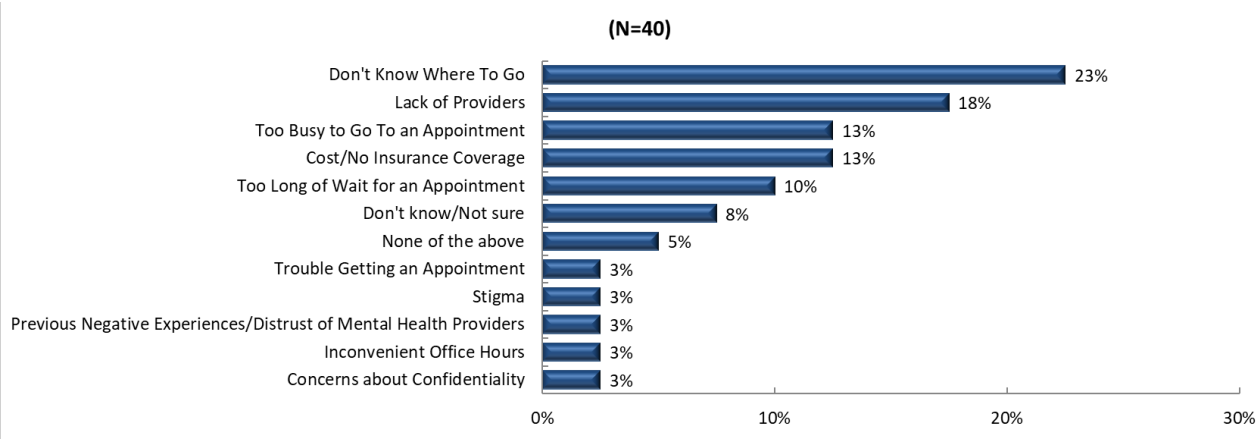
Survey respondents who indicated they experienced at least one poor mental health day in the previous month were also asked if there was a time in the past 12 months when they needed mental healthcare or counseling but did not get it at that time. Nearly one-third (31%) of these respondents answered yes.

Figure 3.12: Was there a time in the past 12 months when you needed mental health care or counseling, but did not get it at that time?



The top responses for why this group did not receive care included a lack of knowledge about where to go for care (23%), a lack of local providers (18%) and being too busy to go to an appointment (13%), which was additionally tied with high cost and lack of insurance, suggesting a need for lower cost services and better awareness of available resources to improve community members' ability to access needed mental healthcare.

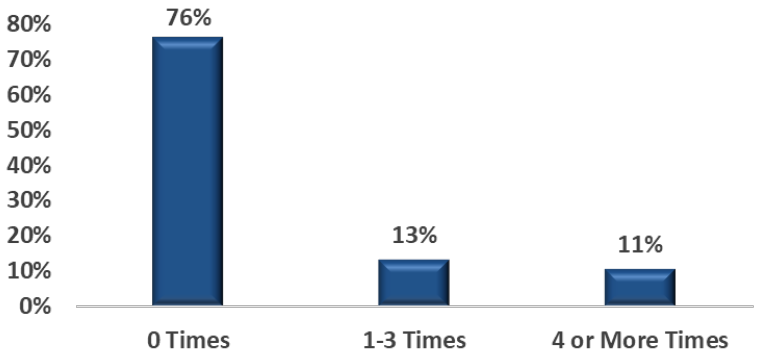
Figure 3.13: What was the main reason you did not get mental health care or counseling?



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

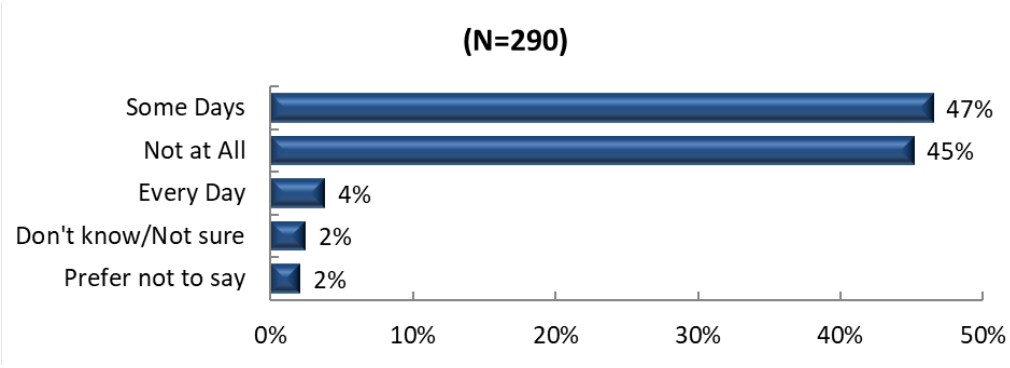
Community members were asked to identify the number of times they consumed enough drinks to meet the definition of "binge drinking" on a single occasion in the prior month. Over three-quarters (76%) reported that they did not consume an excessive amount (4 drinks for females and 5 drinks for males) at all in the past 30 days. However, nearly one-quarter (24%) of respondents identified that they had consumed more than that threshold one or more times in the past month.

Figure 3.14: 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?



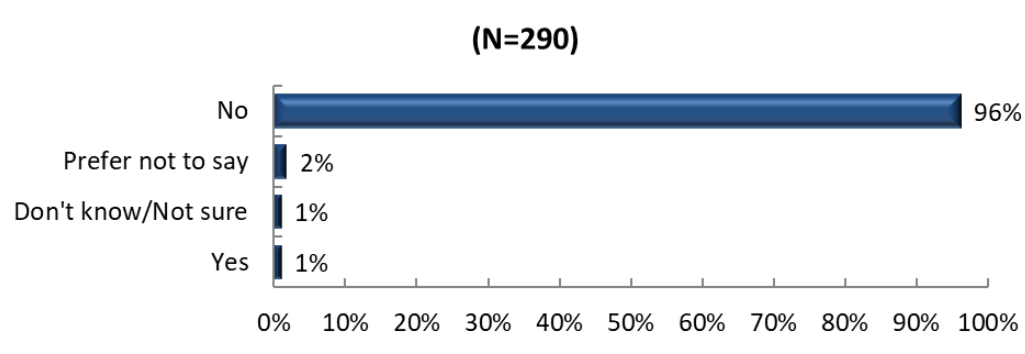
When community members were asked how often they consume any alcohol, over half (51%) stated that they drank at least "some days." However, nearly half (45%) of respondents reported that they do not drink at all.

Figure 3.15: How often do you consume any kind of alcohol product, including beer, wine or hard liquor?



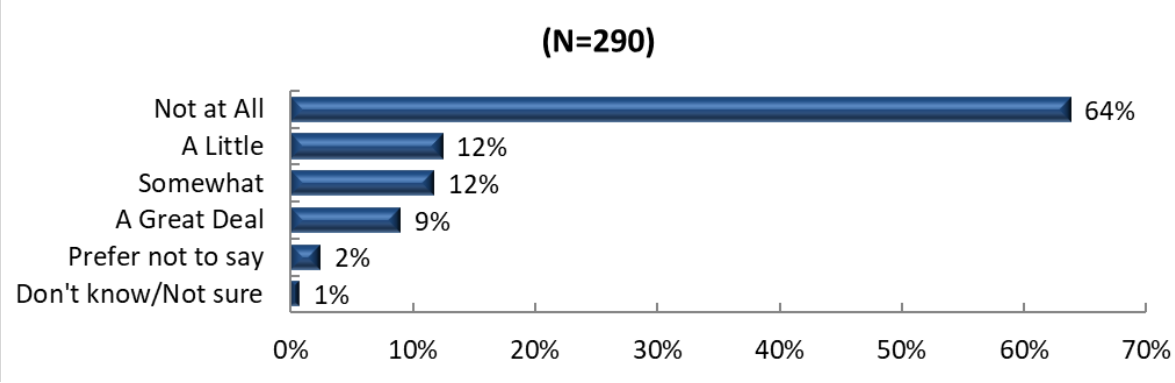
Just one percent of participants reported that they or a member of their household had misused any prescription medications in the prior year.

Figure 3.16: In the past year, have you or a member of your household misused any form of prescription drugs (e.g. used without a prescription, used more than prescribed, used more often than prescribed, or used for any reason other than a doctor's instructions)?



While many substance use-related survey responses were positive, over one-third (33%) of respondents indicated that their life has been negatively impacted by their own or someone else's substance use. Furthermore, nearly one in ten noted that their life has been impacted in this way a great deal.

Figure 3.17: To what degree has your life been negatively affected by your own or someone else's substance abuse issues, including alcohol, prescription, and other drugs?



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

Primary Data Findings – Focus Groups

Mental health and substance use emerged as key concerns during the Perquimans County focus group discussions. Participants acknowledged the limited mental health services available in the county, noting a significant shortage of mental health providers and specialists. This shortage was seen as particularly problematic given the growing prevalence of mental health issues in the community. Substance use, especially alcohol use, was identified as a concern, with participants noting its impact on community health and safety. The group recognized the interconnectedness of mental health and substance use issues, emphasizing the need for comprehensive services that address both areas. Participants also discussed the stigma associated with seeking mental health and substance use treatment, which they saw as a barrier to care. To address these issues, the group suggested implementing more education programs, particularly for youth, to raise awareness about mental health and substance use. They also proposed

developing more community-based programs to support individuals struggling with these issues, emphasizing the importance of accessible, local resources.

Focus group participants in Perquimans County briefly acknowledged substance abuse/addiction among the community's health concerns, but did not provide detailed discussion about mental health or substance use challenges or potential solutions.

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

PRIORITY NEED: HEALTHY LIVING

Context and National Perspective

As society has changed and people live longer, chronic health conditions have become more common than communicable diseases like typhoid and cholera. As defined by the World Health Organization (WHO), chronic diseases are those with a long duration, that are influenced by a combination of genetic, environmental, psychological, or behavioral factors.[37] Chronic health conditions are extremely common in the United States, with 6 in 10 Americans living with at least one chronic disease, such as diabetes, obesity, cancer, hypertension, or heart disease.[38]

Chronic diseases are the leading cause of death and disability in the United States.**Error! Bookmark not defined.** According to the WHO, chronic health conditions kill 41 million people globally each year and are responsible for 7 in 10 deaths in the U.S. annually.**Error! Bookmark not defined.** The number of individuals living with a chronic health condition is expected to increase as the U.S. population continues to age. The population over the age of 50 is expected to increase by 61% to 221.1 million people by 2050.[39] Among those 221 million, nearly two-thirds (142.7 million people) are expected to have at least one chronic health condition, with approximately 15 million people living with multiple chronic health conditions.**Error! Bookmark not defined.**

Cancer is a group of diseases characterized by the uncontrolled growth and spread of abnormal cells that can result in death if not treated. While the risk of dying from cancer has declined significantly over the past 30 years, it remains the second most common cause of death in the U.S. Incidence of new cancer cases has continued to rise, with 2 million new cases expected to be identified in 2024.[40] This trend is largely affected by the aging and growth of the population and by a rise in diagnoses of 6 of the 10 most common cancers—breast, prostate, endometrial, pancreatic, kidney, and melanoma. Some research has attributed this rise to the impact of the obesity epidemic.**Error! Bookmark not defined.** Cigarette smoking is another

[37] Source: World Health Organization (WHO) (2023). *Noncommunicable diseases*. Retrieved September 10th, 2024, from: https://www.who.int/news-room/fact-sheets/detail/noncommunicable-diseases.
[38] Source: CDC (2024). *National Center for Chronic Disease Prevention and Health Promotion*. Retrieved September 10th, 2024, from: https://www.cdc.gov/chronic-disease/about/index.html .
[39] Source: Ansah, J.P. & Chiu, T.C., (2022). Projecting the chronic disease burden among the adult population in the United States using a multi-state population model. *Frontiers in Public Health*. Retrieved September 10th, 2024, from: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC9881650/.
[40] Source: American Cancer Society (ACS) (2024). *ACS Fast & Figures 2024*. Retrieved September 10th, 2024, from https://www.cancer.org/research/acs-research-news/facts-and-figures-2024.html.

significant risk factor for cancer and is responsible for about 20% of all cancers and 30% of cancer deaths in the U.S. each year.[41]

The CDC recommends four ways to prevent chronic conditions and maintain good physical health. Recommended healthy behaviors include stopping or refraining from smoking, eating low-fat whole food diets, exercising moderately for at least 150 minutes a week, and limiting or refraining from consuming alcohol.[42] Annual physicals with a primary care provider are also necessary to help prevent or treat chronic health conditions. Yearly screenings can allow providers to identify any warning signs for developing conditions and enable patients to correct or develop healthy behaviors to avoid developing a physical health condition. A CDC study noted that one-third of visits to health centers in 2020 were for preventive care.[43] For those living with chronic conditions, the CDC recommends some general steps people can take to manage their diseases. These include taking medications as prescribed by a provider, self-monitoring symptoms as needed (such as conducting home blood sugar checks), and regularly seeing a provider for check-ups.

As the population in North Carolina and the individual counties continues to collectively age, the prevalence of chronic disease grows. In fact, eight out of the top 10 leading causes of death in North Carolina are related to a chronic health condition[44], accounting for at least two-thirds (50,000) of all annual deaths.[45] Additionally, the population of North Carolina is largely rural, which hinders access to clinical care for these conditions. Finding ways to utilize existing resources for helping community members learn about and manage their chronic health conditions is key for improving health outcomes in these areas.

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. [46]

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

[41] ACS (2020). *Health Risks of Smoking Tobacco.* Retrieved September 10th , 2024 from https://www.cancer.org/cancer/risk-prevention/tobacco/health-risks-of-tobacco/health-risks-of-smoking-tobacco.html
[42] Source: CDC (2024). *Preventing chronic diseases: What you can do now.* Retrieved September 10th, 2024 from https://www.cdc.gov/chronic-disease/prevention/index.html
[43] Source: CDC (2022). *Characteristics of visits to health centers: United States, 2020.* Retrieved September 10th, 2024, from https://www.cdc.gov/nchs/products/databriefs/db438.htm.
[44] Source: CDC (2022). *North Carolina.* Retrieved October 3, 2024, from https://www.cdc.gov/nchs/pressroom/states/northcarolina/nc.htm
[45] Source: NCDHHS. (2023). *Chronic disease and injury.* Retrieved October 3, 2024, from https://www.dph.ncdhhs.gov/programs/chronic-disease-and-injury#:~:text=Chronic%20diseases%20and%20injuries%20are,of%20death%20in%20North%20Carolina.
[46] 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

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.[47]

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.[48] 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.[49] North Carolina's Department of Health and Human Services has implemented several workshops and classes that individuals can take to learn healthy habits, such as Living Healthy workshops. Additionally, several nonprofits have implemented programs to help individuals learn healthy behaviors, and North Carolina also has an extensive WIC program, as well as the NCCARE360 program, which seeks to connect individuals with all necessary resources for living a healthier life.

Secondary Data Findings

Regarding chronic disease prevention, Perquimans County shows mixed results. The county has a lower percentage of adults who are obese (17.5%) compared to both the state (29.7%) and national (30.1%) averages, which is a positive indicator for chronic disease prevention. However, the county faces challenges with several chronic conditions.

The prevalence of adults with hypertension in Perquimans County (33.2%) is slightly higher than both the state (32.1%) and national (29.6%) averages. Similarly, the county has a higher percentage of adults with high cholesterol at 31.8%, compared to 31.4% in North Carolina and 31.0% nationally. The rate of adults with diagnosed diabetes (7.9%) is lower than both the state (9.0%) and national (8.9%) averages.

[47] 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

[48] 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.

[49] Source: Eat Smart Move More North Carolina. (2017). *The roles of nutrition and physical activity in Chronic Disease in North Carolina.* Retrieved October 23, 2024 from https://www.communityclinicalconnections.com/wp-content/themes/cccph/assets/downloads/2024/07/factsheets/Physical/CCCPHB_FactSheet_HealthyEating-0724.pdf

Table 3.6: Chronic Health Conditions			
Indicator	**Perquimans County**	**North Carolina**	**United States**
Adults (Age 18+) with Asthma	10.2%	9.8%	9.7%
Adults (Age 20+) with Diagnosed Diabetes	7.9%	9.0%	8.9%
Adults (Age 18+) Ever Diagnosed with Coronary Heart Disease	5.8%	5.5%	5.2%
Adults (Age 18+) with Hypertension	33.2%	32.1%	29.6%
Adults (Age 18+) with High Cholesterol	31.8%	31.4%	31.0%
Adults (Age 18+) with Kidney Disease	3.0%	2.9%	2.7%
Adults (Age 18+) Ever Having a Stroke	3.2%	3.1%	2.8%
Adults with BMI > 30.0 (Obese)	17.5%	29.7%	30.1%

Healthy living, with a focus on food security and chronic disease prevention, also emerged as a significant concern for Perquimans County based on several key indicators. The county's performance on multiple related metrics showed mixed results compared to state and national averages, indicating a need for focused attention in this area.

Perquimans County faces some challenges related to food security. The overall food insecurity rate in the county (12%) is slightly higher than the state average (11%) and the national average (10%). The disparity is more pronounced for child food insecurity, with 17% of children in Perquimans County experiencing food insecurity compared to 15% in North Carolina and 13% nationally. However, the county has a lower rate of low food access among low-income residents (7%) compared to both state (21%) and national (19%) averages.

Table 3.7: Food Security Indicators			
Indicator	**Perquimans County**	**North Carolina**	**United States**
Food Insecurity Rate	12%	11%	10%
Child Food Insecurity Rate	17%	15%	13%
Percent Low Income Population with Low Food Access	7%	21%	19%
Food Environment - Fast Food Restaurants Establishments (Rate per 100,000 Population)	30.8	77.4	96.2
Food Environment - Grocery Stores Establishments (Rate per 100,000 Population)	N/A	18.7	23.4
Children Eligible for Free or Reduced Price Lunch by Eligibility	41%	46%	37%
Population Receiving SNAP Benefits, Percent	30%	32%	29%

The food environment in Perquimans County presents some challenges for healthy living. The county has a lower rate of fast-food restaurants (30.8 per 100,000 population) compared to the state average (77.4), which could help residents make healthier food choices. However, data on the rate of grocery stores per 100,000 population was not available for Perquimans County, making it difficult to assess the availability of healthy food options.

When considering health behaviors related to chronic disease prevention and healthy living, Perquimans County performs worse than the state on various metrics. The percentage of physically inactive adults in the county (23.7%) is higher than the state average (21.6%). Additionally, only 20% of the population in Perquimans County has access to exercise opportunities, significantly lower than both the state (73%) and national (84%) averages. This lack of access to exercise opportunities could make it harder for residents to maintain a healthy lifestyle and prevent chronic diseases.

Table 3.8: Physical Activity Indicators			
Indicator	**Perquimans County**	**North Carolina**	**United States**
Recreation and Fitness Facility Establishments, (Rate per 100,000 Population)	N/A	13.1	14.7
Walkability Index Score	5	7	10
% Physically Inactive	23.7	21.6	-
Percentage of Population with Access to Exercise Opportunities	20%	73%	84%

These data suggest that, while Perquimans County is performing well in some areas related to healthy living, such as lower obesity rates, there are significant challenges in food security, particularly for children, and in the prevalence of certain chronic conditions. Limited access to exercise opportunities and higher rates of physical inactivity suggest a need to focus on creating environments and opportunities that support healthy lifestyles and help prevent chronic disease in the county.

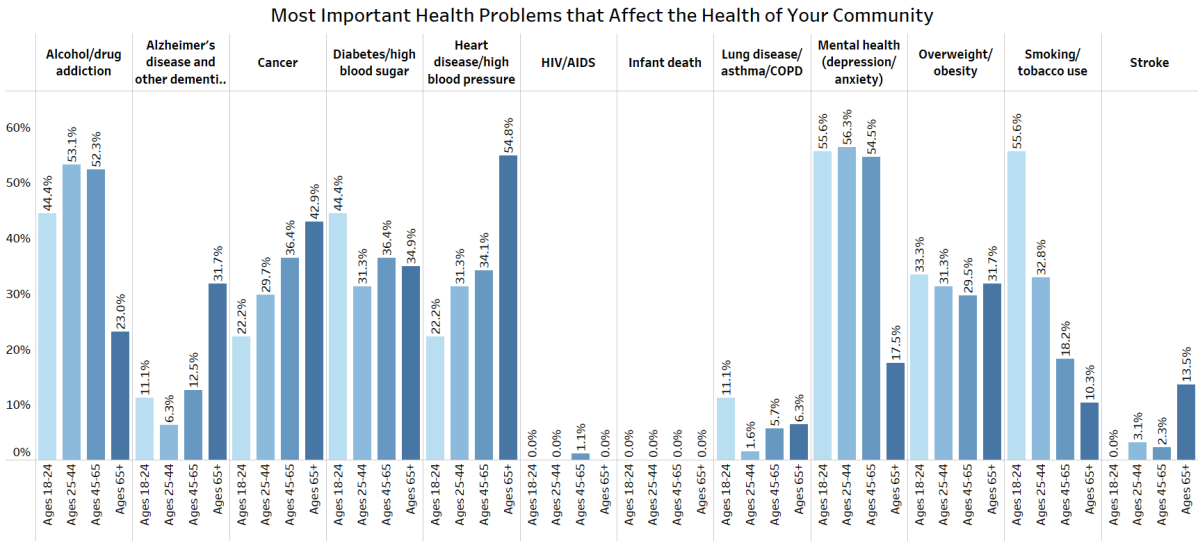
For additional detail on secondary data findings, see **Appendix 3**.

Primary Data Findings – Community Member Web Survey

Perquimans County respondents who responded to the community web member survey highlighted chronic health conditions as a priority health need. As indicated in **Figure 3.9** above in the Behavioral Health section, heart disease and high blood pressure was ranked as the most important health concern impacting the community by nearly half (42%) of all respondents. Additionally, 37% of respondents indicated cancer as a top concern, 35% cited diabetes, and 31% highlighted obesity among the top chronic health problems.

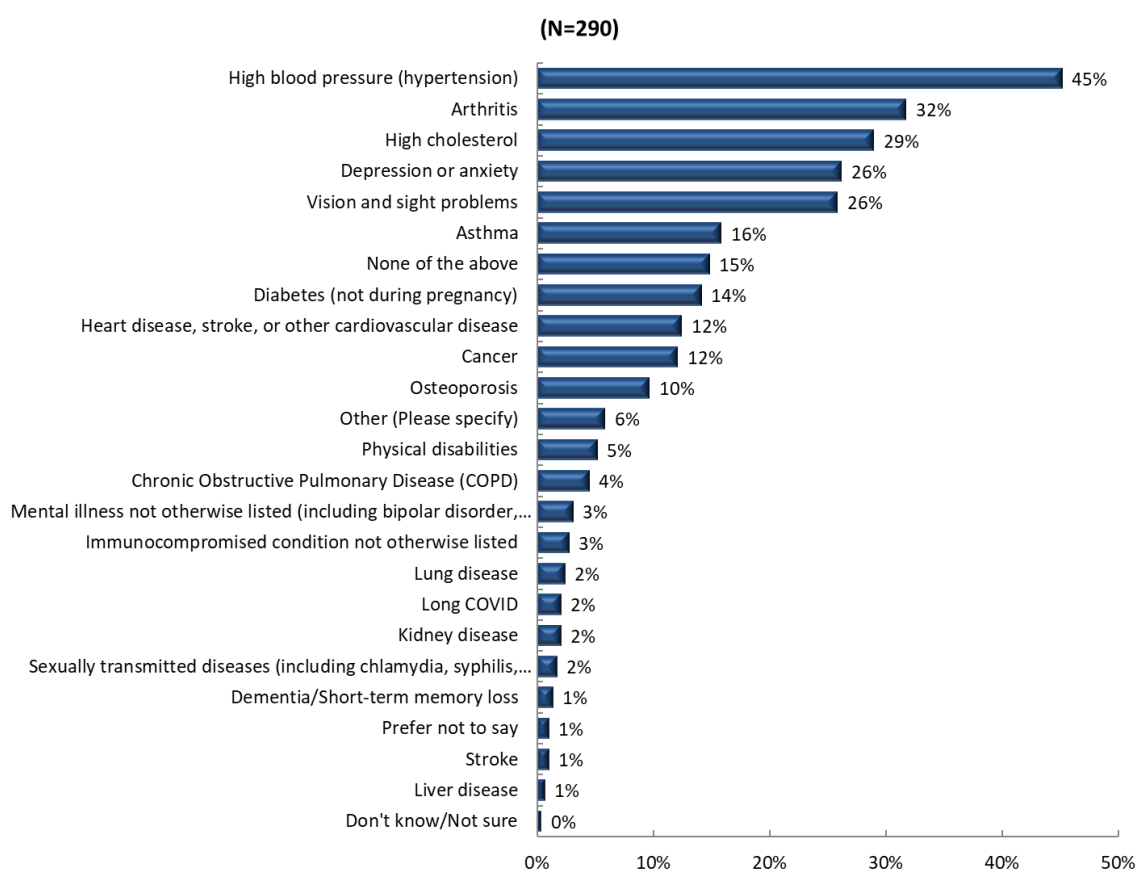
When reviewing this data further by demographics, those over the age of 65 most frequently selected heart disease (55%), and cancer (43%) as top health problems. Conversely, those between the ages of 18 and 24 were least likely to cite heart disease (22%) and cancer (22%) as top health concerns. Additionally, nearly half (49%) of male respondents indicated cancer as an issue, compared to just 33% of female respondents.

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



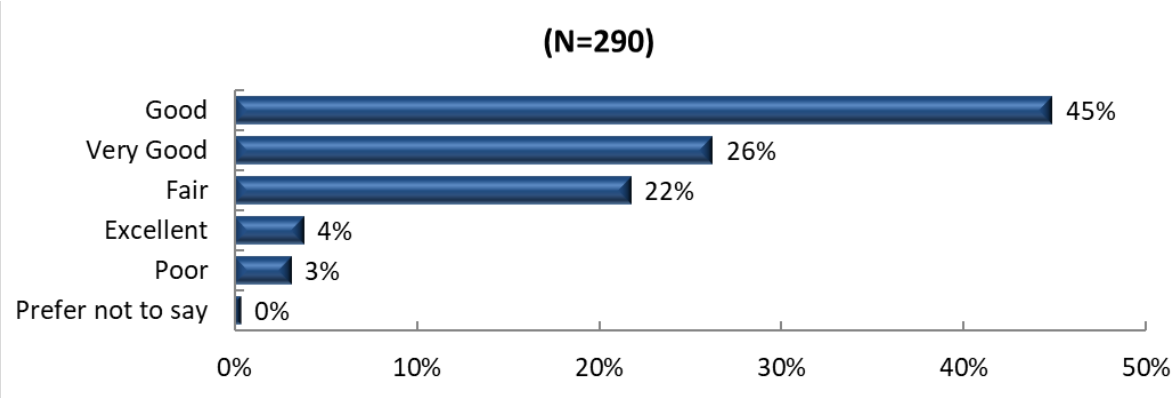
Respondents were also asked to identify any chronic health conditions that they may have been diagnosed with in the past year by a healthcare provider. Nearly half (45%) of all who responded to this question indicated that they had been diagnosed with high blood pressure. Furthermore, one-third (32%) indicated being diagnosed with arthritis, 29% high cholesterol, and 14% cited being diagnosed with diabetes.

Figure 3.18: 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



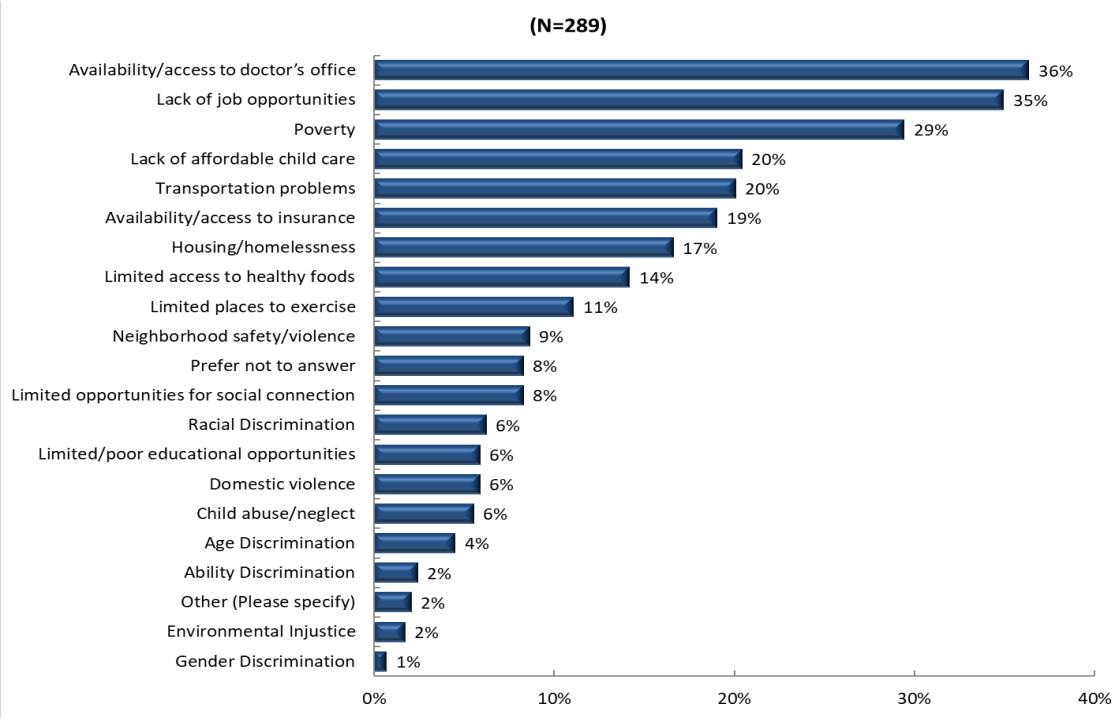
Physical health was also highlighted as a concern by Perquimans County residents who responded to the community member web survey. Community members were asked to rate the condition of their physical health. While two-thirds (75%) of residents indicated that they were in at least good health, nearly one-quarter (25%) of residents ranked their health as “fair” or “poor”.

Figure 3.19: Considering your physical health overall, would you describe your health as…



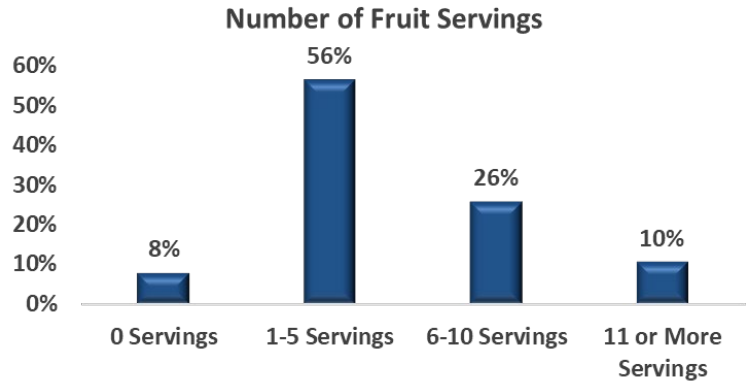
Residents were also asked to indicate the top social and environmental problems in their community. Nearly one-fifth (14%) of respondents cited limited access to healthy foods, and 11% indicated there were limited places to exercise in their community.

Figure 3.20: What are the three most important social or environmental problems that affect the health of your community? Please select up to three.



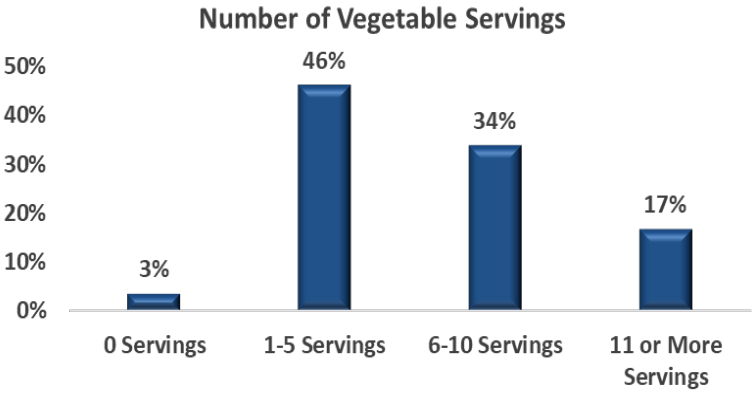
Community members were also asked about their diet, particularly food that they had eaten within the past week. First, residents were asked on average how many servings of fruit they had eaten in the past week. Results were positive, with 92% of respondents citing that they had eaten at least one serving of fruit within the past week, and over one-third (36%) having eaten at least six servings of fruit.

Figure 3.21: 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=288)



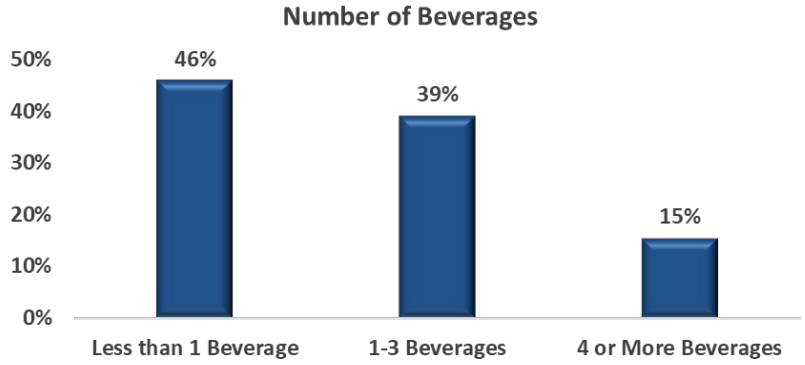
Respondents were asked a similar question about servings of vegetables. Vegetable consumption followed a similar trend as fruit, with nearly all (97%) of respondents stating that they had eaten at least one serving of vegetables in the past week, and half (51%) reporting having at least six or more servings in that same time period.

Figure 3.22: 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=288)



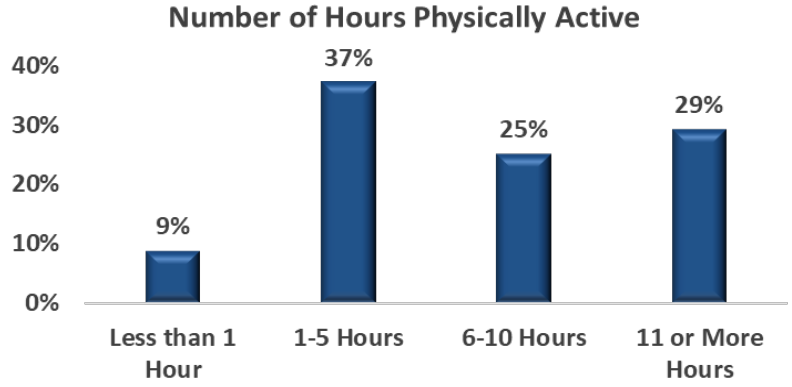
When asked about how many sugar-sweetened beverages residents drank each day, just under half (46%) cited having less than one drink per day. However, 54 % stated having at least one drink per day, with 15% indicating they drink four or more sugary beverages on a daily basis.

Figure 3.23: 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=288)



Community members who responded to the survey were also asked about their physical activity levels during the week. Residents were specifically asked about how many hours per week they had spent being physically active outside of their job in the last 30 days. Results from this question were also positive, with nearly all (91%) respondents stating that they had spent at least one hour being physically active per week, and over half (54%) being active at least six hours per week. However, roughly one-tenth of residents stated that they were active for less than an hour each week.

Figure 3.24: During the past month, approximately how much time (in hours) per week were you physically active outside of your regular job? (N=288)



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

Primary Data Findings – Focus Groups

Focus group participants in Perquimans County identified several significant physical health concerns in their community, specifically highlighting high blood pressure, diabetes, asthma, cancer, and strokes as the most serious health problems affecting residents. Poor diet and eating choices were noted as factors that keep residents from living healthy lives. Accessibility to care and lack of insurance were identified as barriers to managing these chronic conditions.

When discussing potential solutions, participants suggested creating a community pool or swimming area for water exercise. They also proposed organizing an event for seniors and individuals who lack regular care access, where they could receive all needed care in one centralized area, including annual physicals and other health screenings.

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 Perquimans 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
County Resources Directories	• Perquimans Inventory of Resources

Healthcare Facilities	• Albemarle Regional Health Services - Perquimans County
	  ○ Mission: Inspiring people to lead healthy lives
	  ○ Vision: Public Health professionals and programs dedicated to disease prevention and promotion of healthy environment to reduce morbidity, mortality, and disability through quality service, education, and advocacy
	  ○ 103 Arpdc St, Hertford, NC 27944
	  ○ 252-426-2105
	  ○ Website: www.arhs-nc.org
	• ECU Health Chowan Hospital
	  ○ 211 Virginia Rd, Edenton, NC 27932
	  ○ 252-482-8451
	• Sentara Albemarle Medical Center
	  ○ 1144 N Road St, Elizabeth City, NC 27909
	  ○ 252-335-0531
	• ECU Health Immediate Care
	  ○ 701 Luke St, Ste C, Edenton, NC 27932
	  ○ 252-482-6811
	• NextCare Urgent Care
	  ○ 615 S Hughes Blvd, Elizabeth City, NC 27909
	  ○ 252-338-3111
	• Coastal Carolina Family Practice
	  ○ 600 S Church St, Hertford, NC 27944
	  ○ 252-426-5711
	• ECU Health Family Medicine - Hertford
	  ○ 1124 Harvey Point Rd, Hertford, NC 27944
	  ○ 252-426-2946
	• Dr. Yiping Fang, DDS
	  ○ 212 Ainsley Ave, Hertford, NC 27944
	  ○ 252-426-5585
	• The Landings of the Albemarle

	○ 603 S. Church St, Hertford, NC 27944 ○ 252-319-5600 • Hertford Rehabilitation and Healthcare Facility ○ 1300 Don Juan Rd, Hertford, NC 27944 ○ 252-426-5391
Other Healthcare Services	Senior Center **Mental Health and Substance Use Resources** • Homestead Healing, PLLC ○ 118 W Market St, Hertford, NC 27944 ○ 252-216-2635 • Albemarle Hopeline ○ 1802 W Ehringhaus St, Elizabeth City, NC 27909 ○ 252-338-5338 ○ 24-hour crisis line: 252-338-3011 • Trillium Health Resources ○ Regional Office: 144 Community College Rd, Ahoskie, NC 27910 ○ 866-998-2597 • NENC Connect ○ 110 W Market St, Hertford, NC 27944 ○ 252-426-3130 • NC Quitline ○ 1-800-QUIT-NOW ○ Website: www.quitlinenc.com
Community Services	**Childcare Services** • Precious Gifts Child Development Center ○ 1132 Don Juan Rd, Hertford, NC 27944 ○ 252-426-1364 • The Learning Center of Perquimans County ○ 103 Bear Garden Rd, Hertford, NC 27944 ○ 252-426-5014 • Up River Friends Preschool ○ 523 Up River Rd, Belvidere, NC 27919 ○ 252-297-2442 • Starting Point Child Development Center ○ 1891 Ocean Highway S, Edenton, NC 27932 ○ 252-368-1745 • EIC Head Start ○ 712 Virginia Rd, Edenton, NC 27932 ○ 252-482-4458 • Chowan Perquimans Smart Start Partnership ○ 409 Old Hertford Rd, Edenton, NC 27932 ○ 252-482-3035 **Educational Services** • Perquimans Central School

- 181 Winfall Blvd, Winfall, NC 27985
- 252-426-5332

- Hertford Grammar School
  - 603 Dobbs St, Hertford, NC 27944
  - 252-426-7166
- Perquimans County Middle School
  - 312 W Main St, Winfall, NC 27985
  - 252-426-7355
- Perquimans County High School
  - 305 S Edenton Road St
  - 252-426-5778

Emergency Services

- Perquimans County Emergency Medical Services
  - 159 Creek Drive, Hertford, NC 27944
  - 252-426-5646
- Perquimans County Sheriff's Office
  - 110 N Church St, Hertford, NC 27944
  - 252-426-5615
- Volunteer Fire Departments:
  - Belvidere-Chapell Hill
    - 143 Drinking Hole Rd, Belvidere, NC 27919
    - 252-297-2166
  - Bethel
    - 462 Snug Harbor Rd, Hertford, NC 27944
    - 252-426-5110
  - Durants Neck
    - 2087 New Hope Rd, Hertford, NC 27944
    - 252-264-2865
  - Hertford
    - 328 W Grubb St, Hertford, NC 27944
    - 252-426-8389
  - Inter-County
    - 118 Woodville Rd, Hertford, NC 27944
    - 252-264-4600
  - Winfall
    - 341 Wiggins Rd, Winfall, NC 27985
    - 252-426-1745

Healthy Eating

- NC Cooperative Extension - Perquimans County
  - 601A Edenton Road St, Hertford, NC 27944
  - 252-426-5428
- The Open Door Food Pantry of Perquimans County
  - 293 Creek Dr, Hertford, NC 27944

    - 252-421-3700
- Jesse Byrum's Produce
    - Corner of Church and Grubbs St, Hertford, NC 27944
    - 252-312-5938 or 252-221-8634
- Hertford Farmers Market
    - 600 S Church St, Hertford, NC 27944
    - 252-339-3764
- Manley's Produce Hut
    - Corner of U.S. Highway 17 and E Bear Swamp Rd, Hertford, NC 27944
    - 252-333-4123
- The Market at Planters Ridge
    - 1106 Harvey Point Rd, Hertford, NC 27944
    - 252-426-3636

Healthy Living & Fitness

- Albemarle GetFit
    - 709 Roanoke Ave, Elizabeth City, NC 27909
    - 252-338-4400
- Foundation Fitness
    - 220 Ocean Highway S, Ste G, Hertford, NC 27944
    - 252-207-7793
- Missing Mill Park
    - 300 W Grubb St, Hertford, NC 27944
    - 252-426-5311
- Perquimans County Recreation Department
    - 310 Granby St, Hertford, NC 27944
    - 252-426-5695
- Perquimans County Center for Active Living
    - 1072 Harvey Point Rd, Hertford, NC 27944
    - 252-426-5404
- The Albemarle Commission Council on Aging
    - 512 S Church St, Hertford, NC 27944
    - 252-426-5753
- Boys & Girls Club of the Albemarle
    - 824 N Oakum St, Edenton, NC 27932
    - 252-482-7082

Housing

- Chowan-Perquimans Habitat for Humanity
    - 1370 N Broad St, Edenton, NC 27932
    - 252-482-2686
- Hertford Housing Authority
    - 104 White St, Hertford, NC 27944
    - 252-426-5663

	• Economic Improvement Council
	  ○ 712 Virginia Rd, Edenton, NC 27932
	  ○ 252-482-4458
	
	Transportation & Transit
	• Inter County Public Transportation Authority
	  ○ 110 Kitty Hawk Ln, Elizabeth City, NC 27909
	  ○ 252-338-4480
	
	Additional Community Services
	• Albemarle Alliance for Children and Families
	  ○ 1403 Parkview Dr, Elizabeth City, NC 27909
	  ○ 252-333-1233
	• Perquimans County Department of Social Services
	  ○ 103 Charles St, Ste A, Hertford, NC 27944
	  ○ 252-426-7373
	• Perquimans County Library
	  ○ 514 S Church St, Hertford, NC 27944
	  ○ 252-426-5319
	• Perquimans County Veteran Services
	  ○ 104 Dobbs St, Hertford, NC 27944
	  ○ 252-426-1796
	
	Additional Resources (Hotlines)
	• American Association of Poison Control Centers: 1-800-222-1222
	• Children's Home Society of North Carolina: 1-800-632-1400
	• East Carolina Behavioral Health: 1-877-685-2415
	• 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 Alliance on Mental Illness: 1-800-950-6264
	• National Drug Abuse Hotline: 1-800-662-HELP (4357)
	• National Gay Task Force: 202-393-5177
	• National Mental Health Association: 1-800-969-6642
	• National Suicide Prevention Lifeline: 1-800-784-2433
	• Rape Crisis Center: 1-800-656-4673
	• Real Crisis Center: 252-758-HELP (4357)

Priority Need: Access to Healthcare	• See Healthcare Facilities and Services Above
Priority Need: Behavioral Health	• See Mental Health and Substance Use Resources Above

Priority Need Healthy Living	• See Community Services Above

CHAPTER 5 | NEXT STEPS

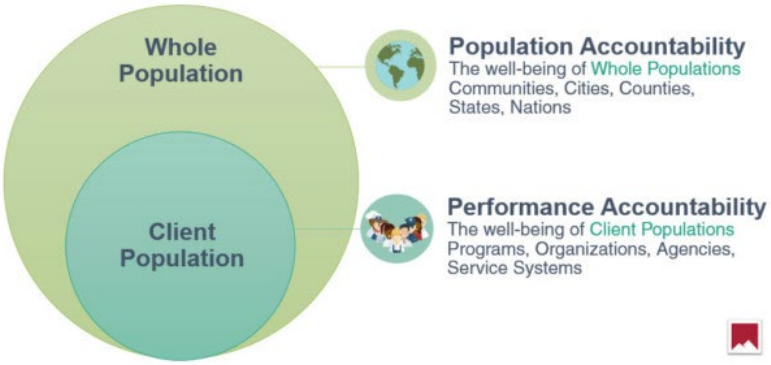
The CHNA findings are used to develop effective community health improvement strategies to address the priority needs identified throughout the process. The next and final step in the CHNA process is to develop community-based health improvement strategies and action plans to address the priorities identified in this assessment. Health leaders in Perquimans 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. Perquimans 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. Perquimans 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 Perquimans County, its performance on each data measure was compared to targets/benchmarks. If Perquimans County's performance was more than five percent worse than the comparative benchmark, it was concluded that improvements could be needed to better the health of the community. Conversely, if an area performed more than five percent better than the benchmark, it was concluded that while a need is still present, the significance of that need relative to others is likely less acute. The most recently available data were compared to these targets/benchmarks in the following order (as applicable):

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

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

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

These measures are noted with an asterisk.

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

Data Sources

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

Table A2.1: Access to Care

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

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

Table A2.2: Built Environment

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

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

Table A2.4: Diet and Exercise

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

Measure	Description	Data Source	Most Recent Data Year(s)
	combines 3 years of survey data to provide county-level estimates. In 2011, BRFSS changed their methodology to include cell phone and landline participants. Previously only landlines were used to collect data. Physical Inactivity is created using statistical modeling.		
Community Design - Walkability Index Score	The National Walkability Index (2021) is a nationwide index score developed by the Environmental Protection Agency (EPA) that ranks block groups according to their relative walkability using selected variables on density, diversity of land uses, and proximity to transit from the Smart Location Database. The block groups are assigned their final National Walkability Index scores on a scale of 1 to 20 where the higher a score, the more walkable the community is.	EPA – Smart Location Database. Data accessed via the North Carolina Data Portal, June 2024.	2021
Access to Exercise Opportunities	Percentage of individuals in the county who live reasonably close to a location for physical activity. Locations for physical activity are defined as parks or recreational facilities. The numerator is the 2020 total population living in census blocks with adequate access to at least one location for physical activity (adequate access is defined as census blocks where the border is a half-mile or less from a park, 1 mile or less from a recreational facility in an urban area, or 3 miles or less from a recreational facility in a rural area) and the denominator is the 2020 resident county population. This indicator is used in the 2024 County Health Rankings.	ArcGIS Business Analyst and Living Atlas of the World, YMCA & U.S. Census Tigerline Files. Data accessed via the North Carolina Data Portal, June 2024.	2023
Recreation and Fitness Facility Access (per 100,000 population)	Number of establishments primarily engaged in operating fitness and recreational sports facilities featuring exercise and other active physical fitness conditioning or recreational sports activities, such as swimming, skating, or racquet sports. Access to recreation and fitness facilities	U.S. Census Bureau, County Business Patterns. Additional data analysis by CARES. Data accessed via the North Carolina Data Portal, June 2024.	2022

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

Table A2.5: Education

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

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

Table A2.6: Employment

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

Table A2.7: Environmental Quality

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

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

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

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

Table A2.9: Food Security

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

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

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

Table A2.10: Housing and Homelessness

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

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

Table A2.11: Income

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

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

Table A2.12: Length of Life

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

Table A2.13: Maternal and Infant Health

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

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

Table A2.14: Mental Health

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

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

Table A2.15: Physical Health

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

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

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

Table A2.16: Quality of Care

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

Measure	Description	Data Source	Most Recent Data Year(s)
	however readmissions within 30 days are often related to the care received in the hospital, whereas readmissions over a longer time period have more to do with other complicating illnesses, patients' own behavior, or care provided to patients after hospital discharge.		

Table A2.17: Safety

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

(Perquimans 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:

(2.3-7.5)/(7.5) x 100% = -69.3% = Displayed as **Low Priority Level**, Shaded in Green

This metric indicates that the percentage of the population with limited access to healthy foods in Perquimans County is 69.3 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	Perquimans County Data	Most Recent Data Year	Perquimans County Need
Primary Care Providers Ratio	112.4	101.1	23.1	2024	High
Mental Health Providers Ratio	178.7	155.7	53.8	2024	High
Addiction/Substance Abuse Providers Ratio	27.9	25.0	0.0	2024	High
Buprenorphine Providers Ratio	15.5	15.2	7.4	2023	High
Dental Health Providers Ratio	39.1	31.5	0.0	2024	High
% Living in Health Professional Shortage Areas (HPSAs) – Dental Care	17.8%	34.0%	39.0%	2018-2022	High
Federally Qualified Health Centers (FQHCs)	3.5	4.1	0.0	2023	High
% Receiving Medicaid	22.3%	20.2%	24.3%	2018-2022	High
% Uninsured	10.2%	12.5%	12.6%	2022	Medium

Table A3.2: Built Environment

Measure	National Benchmark	North Carolina Benchmark	Perquimans County Data	Most Recent Data Year	Perquimans County Need
Broadband Access (Access to DL Speeds >= 25MBPS and UL Speeds >= 3 MBPS)	93.8%	93.6%	65.1%	2023	High
Broadband Access (Access to DL Speeds >= 100MBPS and UL Speeds >= 20 MBPS)	91.2%	90.4%	58.0%	2023	High
Households with No Computer	6.1%	6.9%	11.2%	2018-2022	High

Measure	National Benchmark	North Carolina Benchmark	Perquimans County Data	Most Recent Data Year	Perquimans County Need
Households with No or Slow Internet	11.7%	13.0%	19.1%	2018-2022	High
Liquor Stores	13.3	6.2	Suppressed	2022	N/A
Adverse Childhood Experiences (ACEs)	N/A	N/A	Suppressed	2022	N/A

Table A3.3: Diet and Exercise

Measure	National Benchmark	North Carolina Benchmark	Perquimans County Data	Most Recent Data Year	Perquimans County Need
% Physically Inactive	N/A	21.6%	23.7%	2021	High
Walkability Index Score	10	7	5	2021	High
% with Access to Exercise Opportunities	84.1%	73.0%	20.0%	2023	High
Recreation and Fitness Facility Access	14.8	13.1	Suppressed	2022	N/A
Sugar-Sweetened Beverage (SSB) Consumption	N/A	N/A	36.8%	2022	N/A

Table A3.4: Education

Measure	National Benchmark	North Carolina Benchmark	Perquimans County Data	Most Recent Data Year	Perquimans County Need
% Limited English Proficiency	8.2%	4.6%	0.4%	2018-2022	Low
High School Graduation Rate	81.1%	87.6%	87.1%	2020-2021	Medium
% with No High School Diploma	10.9%	10.6%	13.6%	2018-2022	High
Student Math Proficiency	63.9%	65.8%	54.9%	2020-2021	Low
Student Reading Proficiency	60.1%	59.5%	51.7%	2020-2021	Low
School Funding Adequacy	N/A	-$4,742	-$6,450	2021	High
School Funding Adequacy –	N/A	$10,655	$11,954	2021	Low

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

Table A3.5: Employment

Measure	National Benchmark	North Carolina Benchmark	Perquimans County Data	Most Recent Data Year	Perquimans County Need
Unemployment Rate	3.9%	3.7%	3.8%	2024	Medium
Average Annual Unemployment Rate, 2013-2023	3.6%	3.5%	4.0%	2024	High

Table A3.6: Environmental Quality

Measure	National Benchmark	North Carolina Benchmark	Perquimans County Data	Most Recent Data Year	Perquimans County Need
Flood Vulnerability	6.5%	4.9%	15.9%	2011	High
Drinking Water Safety	16,107	194	0	2023	Low

Table A3.7: Family, Community and Social Support

Measure	National Benchmark	North Carolina Benchmark	Perquimans County Data	Most Recent Data Year	Perquimans County Need
Children Cost Burden	28.8%	27.0%	28.0%	2023	Medium
% Young People Not in School or Working	6.9%	7.5%	1.7%	2018-2022	Low

Table A3.8: Food Security

Measure	National Benchmark	North Carolina Benchmark	Perquimans County Data	Most Recent Data Year	Perquimans County Need
% Food Insecure	10.3%	11.4%	12.3%	2021	High
% Food Insecure Children	13.3%	15.3%	17.4%	2021	High
% Low-Income and with Low Food Access	19.4%	21.3%	7.0%	2019	Low
% Limited Access to Healthy Foods	N/A	7.5%	2.3%	2019	Low
Fast Food Restaurants	96.2	77.4	30.8	2022	Low
Grocery Stores	23.4	18.7	Suppressed	2022	N/A

Table A3.9: Housing and Homelessness

Measure	National Benchmark	North Carolina Benchmark	Perquimans County Data	Most Recent Data Year	Perquimans County Need
Renter Costs – Average Gross Rent	$1,366	$1,090	$895	2018-2022	Low
% Severe Housing Cost Burden	14.1%	12.2%	12.2%	2018-2022	Medium
Assisted Housing Units	413.9	319.2	460.4	2017-2021	High
% Severe Substandard Housing	18.5%	16.1%	18.3%	2011-2015	High
% Homeless Children	2.8%	1.9%	2.9%	2019-2020	High

Table A3.10: Income

Measure	National Benchmark	North Carolina Benchmark	Perquimans County Data	Most Recent Data Year	Perquimans County Need
Median Family Income	$92,646	$82,890	$76,291	2018-2022	High
Gender Pay Gap	81.0%	83.0%	81.0%	2018-2022	Medium
% Living Below 100% FPL	12.5%	13.3%	13.3%	2022	Medium
% Living Below 200% FPL	28.8%	31.6%	30.0%	2018-2022	Medium
% Children Living Below 200% FPL	37.2%	41.1%	29.9%	2018-2022	Low
% Receiving SNAP	12.4%	15.7%	18.3%	2021	High
Children Eligible for Free/Reduced Price Lunch	51.7%	50.8%	43.2%	2022-2023	Low

Table A3.11: Length of Life

Measure	National Benchmark	North Carolina Benchmark	Perquimans County Data	Most Recent Data Year	Perquimans County Need
Years of Potential Life Lost Rate	N/A	8,853	11,138	2019-2021	High
Premature Age-Adjusted Mortality	N/A	420	466	2019-2021	High
Life Expectancy	77.6	76.6	75.8	2019-2021	Medium

Table A3.12: Maternal and Infant Health

Measure	National Benchmark	North Carolina Benchmark	Perquimans County Data	Most Recent Data Year	Perquimans County Need
Births with Late or No Prenatal Care	6.1%	6.9%	Suppressed	2019	N/A
Low Birthweight	N/A	9.4%	8.4%	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	Perquimans County Data	Most Recent Data Year	Perquimans County Need
Poor Mental Health Days	4.9	4.6	4.9	2021	High
Deaths of Despair Rate	55.9	58.7	67.3	2018-2022	High
Suicide Death Rate	14.5	14.0	N/A	2018-2022	N/A

Table A3.14: Physical Health

Measure	National Benchmark	North Carolina Benchmark	Perquimans County Data	Most Recent Data Year	Perquimans County Need
% Poor or Fair Health	N/A	14.4%	16.0%	2021	High
% Adults with Asthma	9.7%	9.8%	10.2%	2022	Medium
% Adults with Heart Disease	5.2%	5.5%	5.8%	2022	High
% Adults with High Blood Pressure	29.6%	32.1%	33.2%	2021	Medium
% Adults with High Cholesterol	31.0%	31.4%	31.8%	2021	Medium
Diabetes Prevalence	8.9%	9.0%	7.9%	2021	Low
% Adults with Kidney Disease	2.7%	2.9%	3.0%	2021	Medium
% Stroke	2.8%	3.1%	3.2%	2022	Medium
Obesity	30.1%	29.7%	17.5%	2021	Low
% Teeth Loss	13.9%	12.0%	13.4%	2022	High
Cancer Incidence Rate	442.3	464.4	399.2	2016-2020	Low
Emergency Room Visits	535	563	622	2022	High

Measure	National Benchmark	North Carolina Benchmark	Perquimans County Data	Most Recent Data Year	Perquimans County Need
Heart Disease Hospitalization Rate	10.4	11.7	14.3	2018-2020	High
Stroke Hospitalization Rate	8.0	9.5	8.8	2018-2020	Low

Table A3.15: Quality of Care

Measure	National Benchmark	North Carolina Benchmark	Perquimans County Data	Most Recent Data Year	Perquimans County Need
Children/adults vaccinated annually against seasonal influenza	44.5%	45.6%	45.9%	2021	Medium
Preventable Hospital Rate	2,752	2,957	2,678	2021	Low
Readmissions Rate	18.1%	17.6%	16.0%	2022	Low

Table A3.16: Safety

Measure	National Benchmark	North Carolina Benchmark	Perquimans County Data	Most Recent Data Year	Perquimans County Need
Incarceration Rate	1.3%	1.5%	1.1%	2018	Low
Juvenile Arrest Rate	13.8	16.0	36.0	2021	High
Violent Crime	416.0	365.7	198.8	2015-2017	Low
Firearm Death Rate	13.4	15.5	N/A	2018-2022	N/A
Poisoning Death Rate	28.5	31.5	43.4	2018-2022	High

Table A3.17: Sexual Health

Measure	National Benchmark	North Carolina Benchmark	Perquimans County Data	Most Recent Data Year	Perquimans County Need
Chlamydia Rate	495.0	603.3	418.9	2021	Low
HIV Incidence Rate	12.7	15.5	0.0	2022	Low
Teen Births	16.6	18.2	24.1	2016-2022	High

Table A3.18: Substance Use Disorders

Measure	National Benchmark	North Carolina Benchmark	Perquimans County Data	Most Recent Data Year	Perquimans County Need
% Excessive Drinking	18.1%	18.2%	15.2%	2021	Low
% Driving Deaths with Alcohol	2.3	2.9	3.1	2018-2022	High
Opioid Use Disorder Rate	41.0	43.0	22.0	2021	Low
Opioid Drug Overdose Deaths	N/A	25.1	34.4	2018-2022	High

Table A3.19: Tobacco Use

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

Table A3.20: Transportation Options and Transit

Measure	National Benchmark	North Carolina Benchmark	Perquimans County Data	Most Recent Data Year	Perquimans County Need
% Households with No Motor Vehicle	8.3%	5.4%	4.0%	2018-2022	Low
% Public Transit	3.8%	0.8%	0.2%	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 focus group was conducted in person on June 10th, 2024. These groups included representation from key leaders, non-profit partners, patients, and community members, with over 10 participants providing responses.

- Perquimans County Center for Active Living

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 Perquimans County

The majority (80%) of participants were female. The group was split between White (60%) and Black or African American (40%) and all participants were over the age of 50.

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?

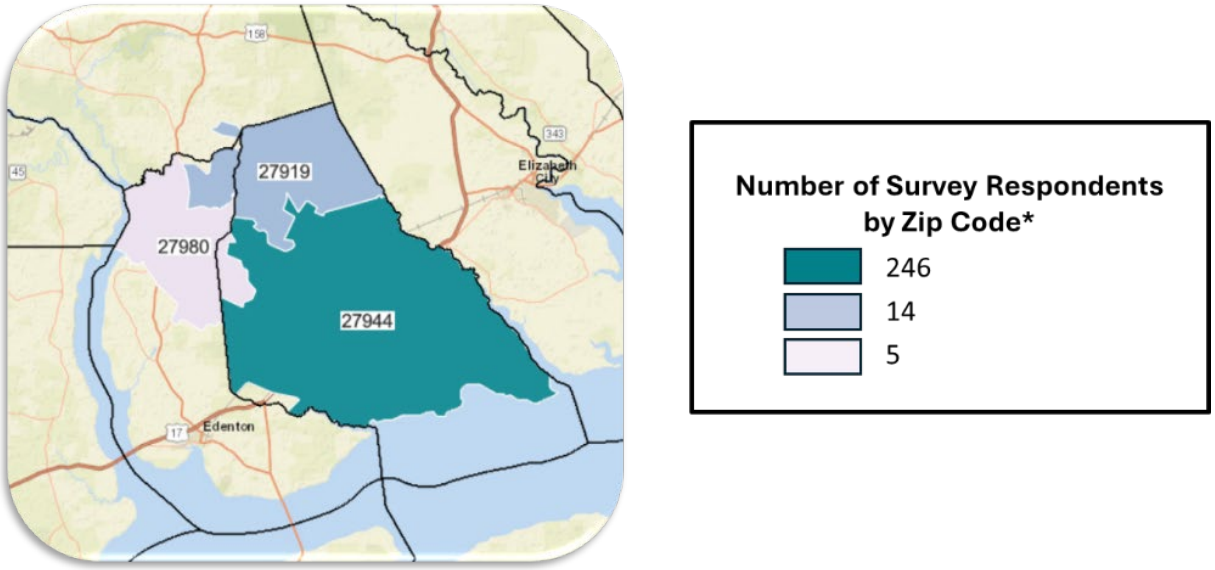
10. What do you think local health leaders should do to improve health and quality of life in [COUNTY NAME]? What do you want local health leaders to know?

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

Community Member Web Survey

A total of [290] surveys were completed by individuals living, working or receiving healthcare in the Perquimans 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[50]



In general, survey questions focused on:

- Community health problems and concerns
- Community social/environmental problems and concerns
- Specific topics of interest to Perquimans County
    - Access to care
    - Healthy lifestyle

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

- Housing and homelessness
- Mental health
- Physical health
- Substance use disorders
- Transportation and transit

The key findings from the Community Survey are detailed below:

- Heart disease/high blood pressure, alcohol/drug addiction, and mental health were identified as the top three health problems affecting the community. Over 30% of respondents also identified cancer, diabetes/high blood pressure, and weight issues as significant health problems.
- Cost, not having insurance, and long wait times were identified as the top 3 barriers to receiving health care.
- Availability/access to doctor's offices, lack of job opportunities, and poverty were identified as the top three social/environmental factors affecting the health of the community.

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

Figure A4.2: Respondents by Age Group

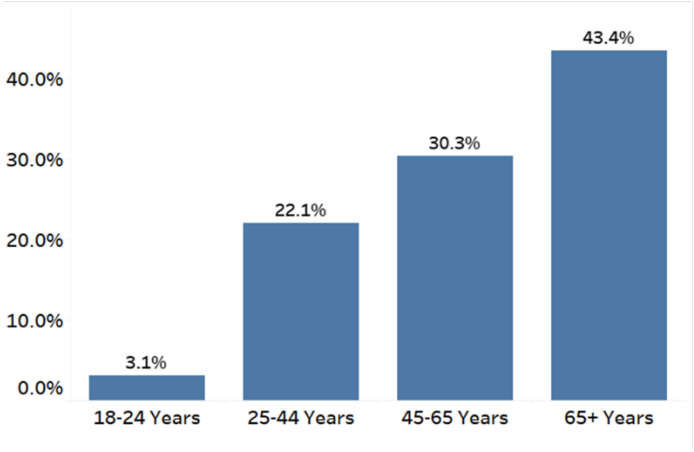


Figure A4.3: Respondents by Gender

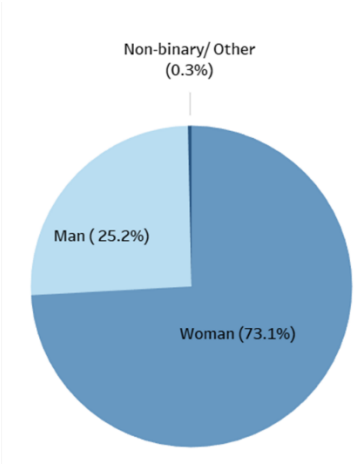


Figure A4.4: Respondents by Race

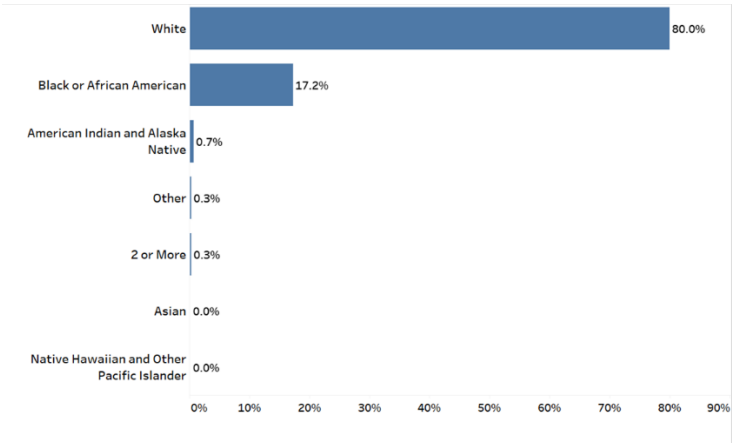
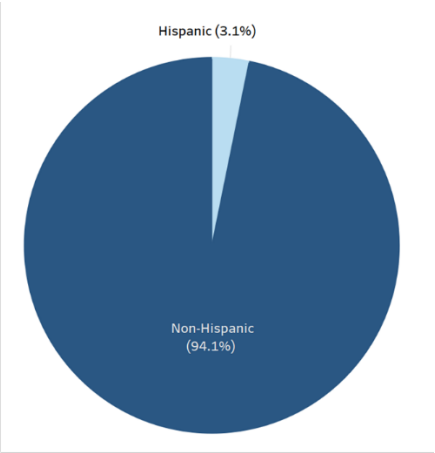


Figure A4.5: Respondents by Ethnicity



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?[51]

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

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

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

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

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

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

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

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

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

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

Topic: Community Health Opinion Questions

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

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

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

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

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

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

Topic: Access to Care

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

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

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

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

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

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

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

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

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

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

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

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

Topic: 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 group are summarized below.

Focus Group General Findings

The focus group conducted in Perquimans County identified several common health concerns and barriers to care. First, they identified food access and security as a significant issue, noting difficulties in affording healthy foods, learned food behaviors, and challenges for those living alone. The second common theme described healthcare access and quality as barriers to receiving care, including lack of insurance, shortage of providers and specialists, and long wait times. Additionally, the focus group identified housing and homelessness, physical health issues, and transportation as major challenges in the community.

Focus Group Unique Insights: Perquimans County Center for Active Living

Ten community members participated in the focus group conducted at the Perquimans County Center for Active Living on June 10th, 2024. The majority (80%) identified as women, and the group was split between white (60%) and Black or African American (40%). All participants were over the age of 50. This group identified several key health concerns and barriers to care.

Food access and security was a primary concern, with participants noting difficulties affording healthy foods, generational food habits, and food waste among those living alone. Healthcare access and quality were also significant issues, particularly the lack of insurance, providers, and specialists in the area, as well as long wait times for appointments. Housing and homelessness were identified as community concerns. Physical health issues such as high blood pressure, diabetes, asthma, cancer, and strokes were top health concerns. Lastly, transportation was seen as a major barrier to accessing healthcare and other needed services.

Participants had several suggestions for how to address these health concerns and barriers to care in their community. First, they suggested implementing more mobile care or home visits to improve healthcare access. They also emphasized the need for better education for youth and more programs to get young people involved in the community. Additionally, the group proposed creating a comprehensive educational catalogue with events, services, and programs available to the community. Lastly, participants suggested building a community pool or swimming area for water exercise to promote physical 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?

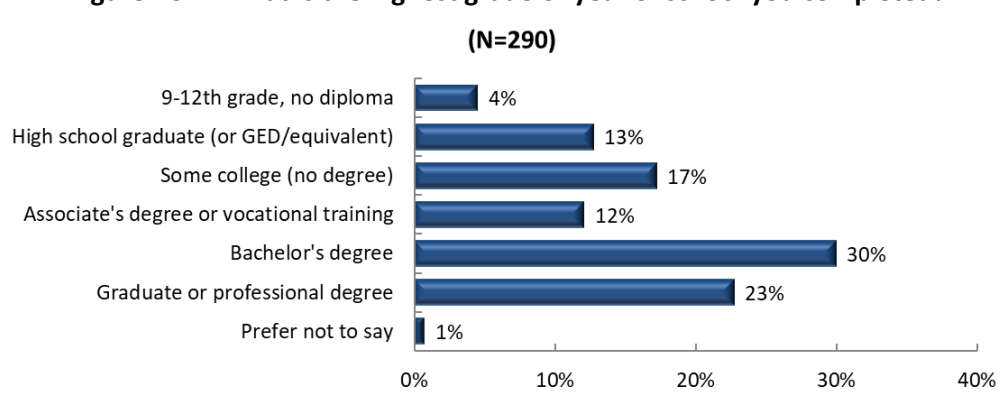


Figure A5.2: Which language is most often spoken in your home? (Choose one)

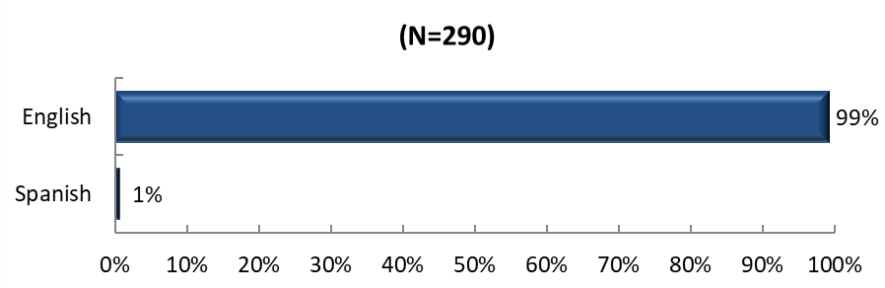


Figure A5.3: For employment, are you currently... (Select all that apply.)

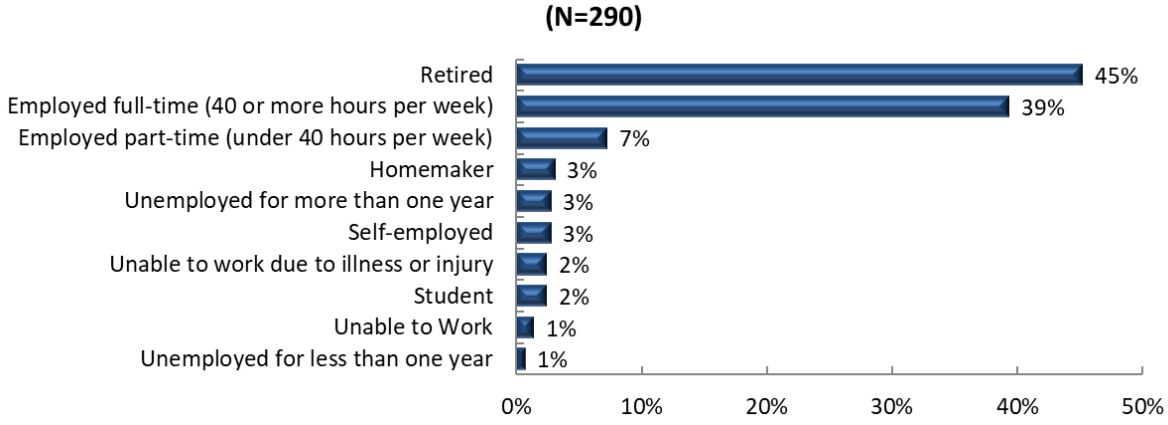
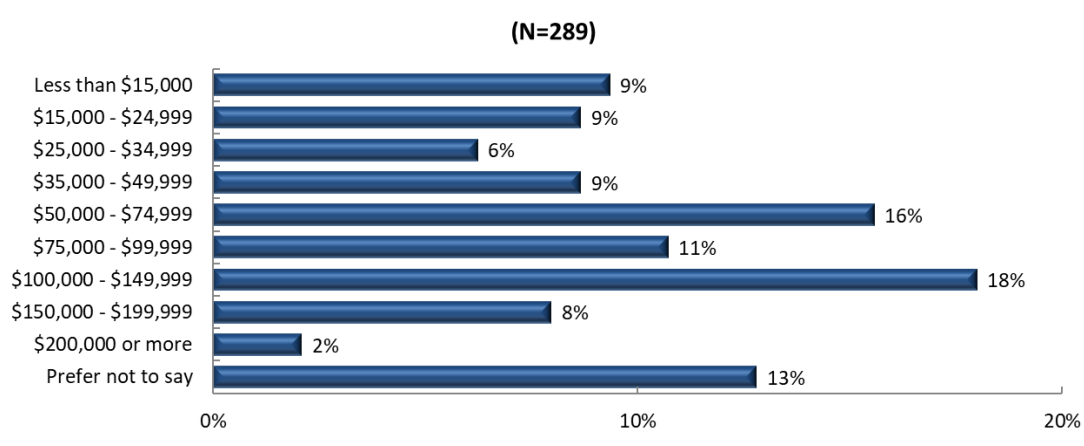


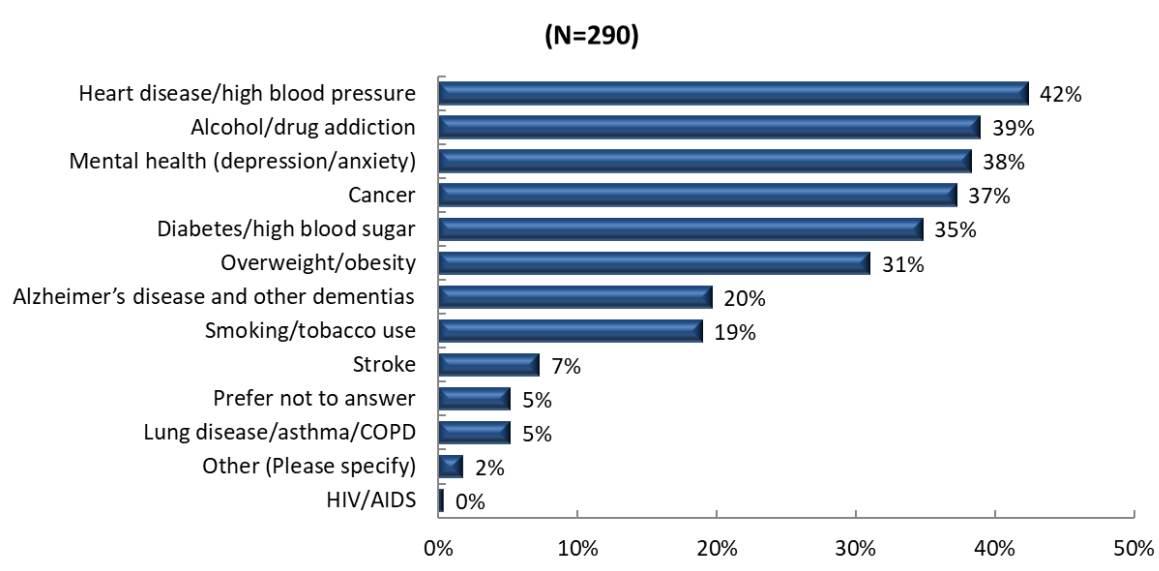
Figure A5.4: Which category best describes your yearly household income before taxes?

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



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

Figure 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):

- "Kidney failure"
- "People living in their own filth and bathing in the sound, and they don't have running water or proper sewage."
- "Trauma (High ACE Score)"
- "Vaping" (2 responses)

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

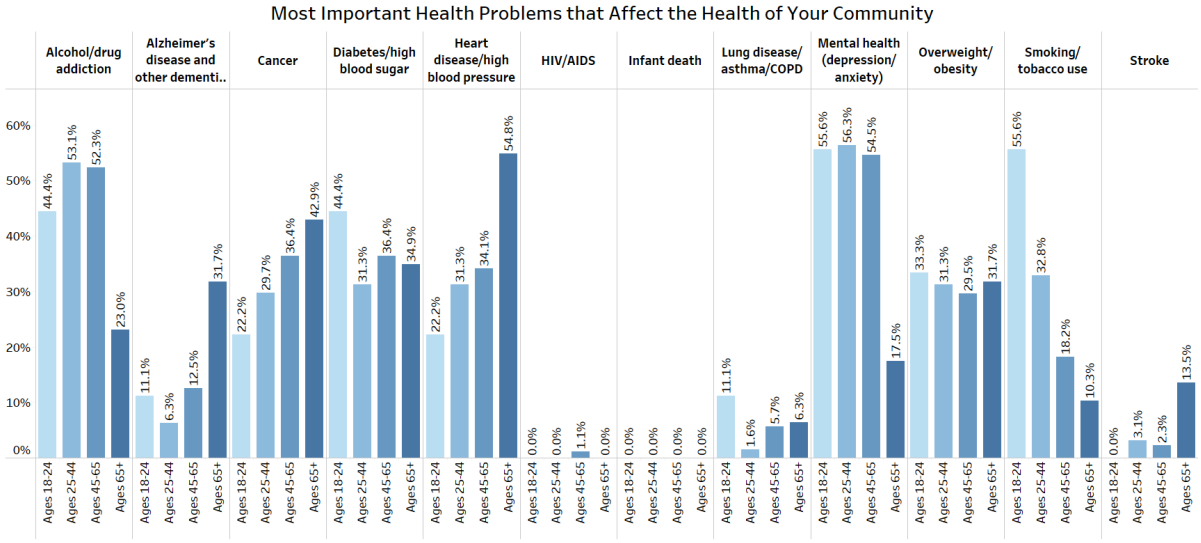


Figure A5.7: What are the three most important health problems that affect the health of your community? Please select up to three. (by gender)

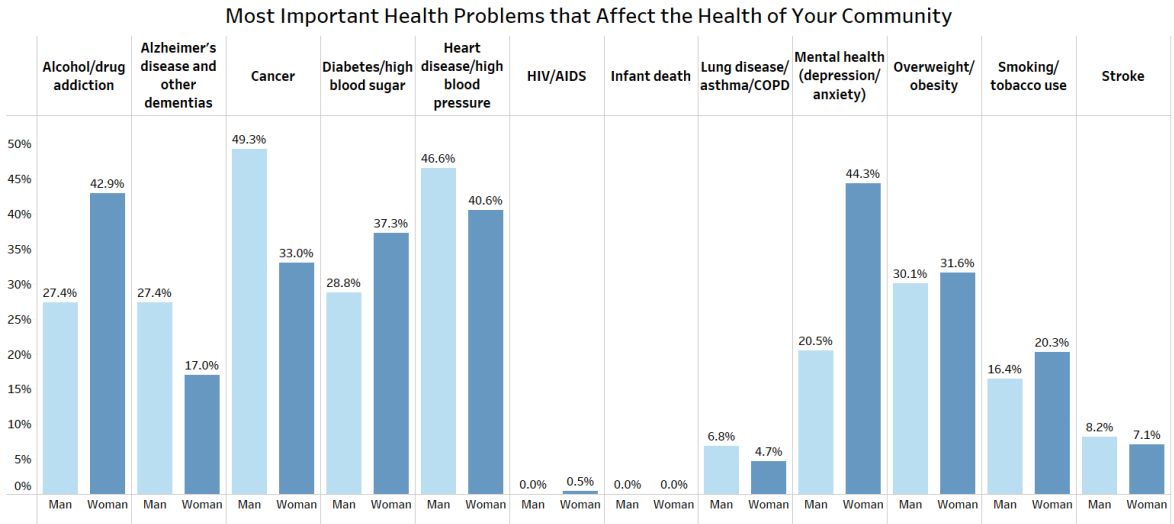


Figure A5.8: What are the three most important health problems that affect the health of your community? Please select up to three. (by race)

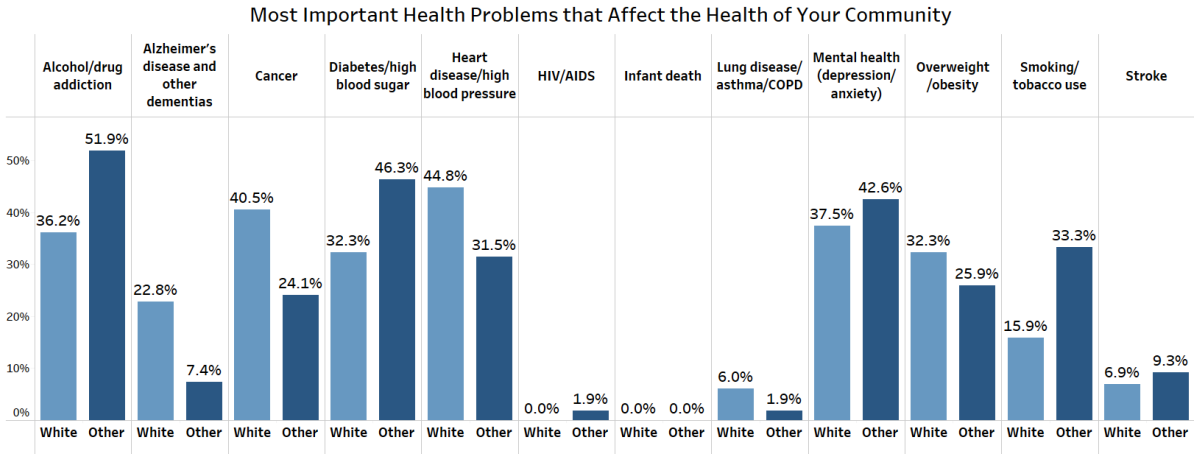


Figure A5.9: What are the three most important health problems that affect the health of your community? Please select up to three. (by ethnicity)

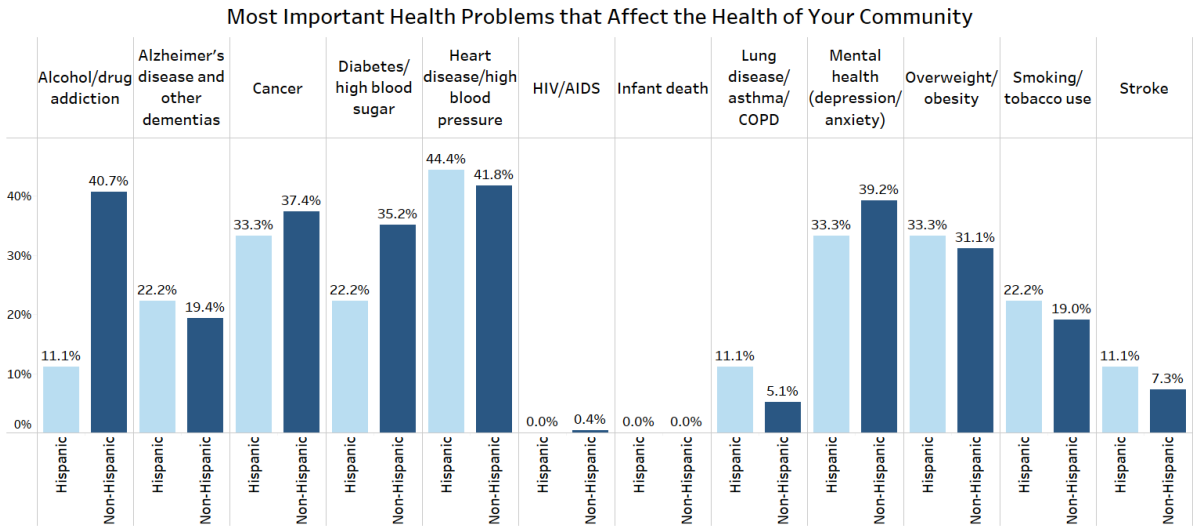
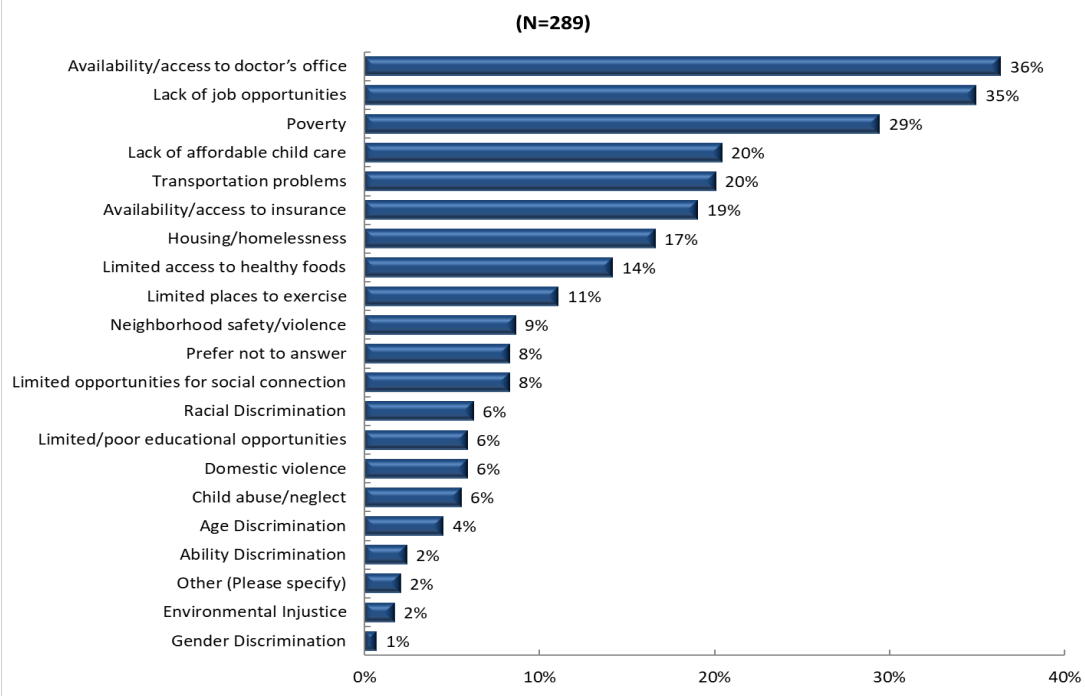


Figure A5.10: What are the three most important social or environmental problems that affect the health of your community? Please select up to three.



Other (specify):

- "Limited, Accessable Substance Abuse Treatment and Recovery Services"
- "People don't have proper sewage and have to use buckets."
- "Pesticide and herbicide usage on large agriculture"
- "Safe drinking water"
- "Senior housing"
- "Water"

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

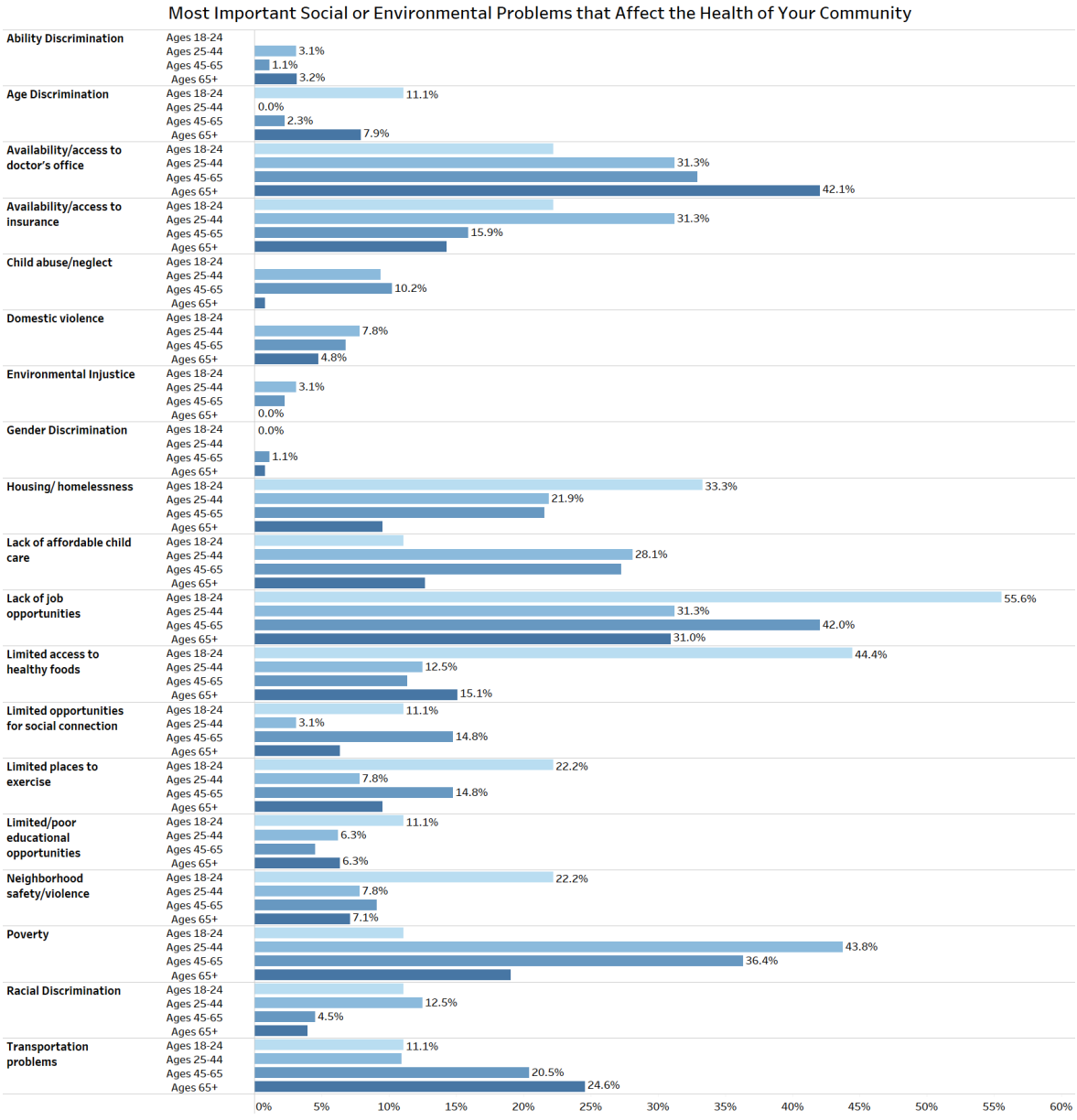


Figure A5.12: What are the three most important social or environmental problems that affect the health of your community? Please select up to three. (by gender)

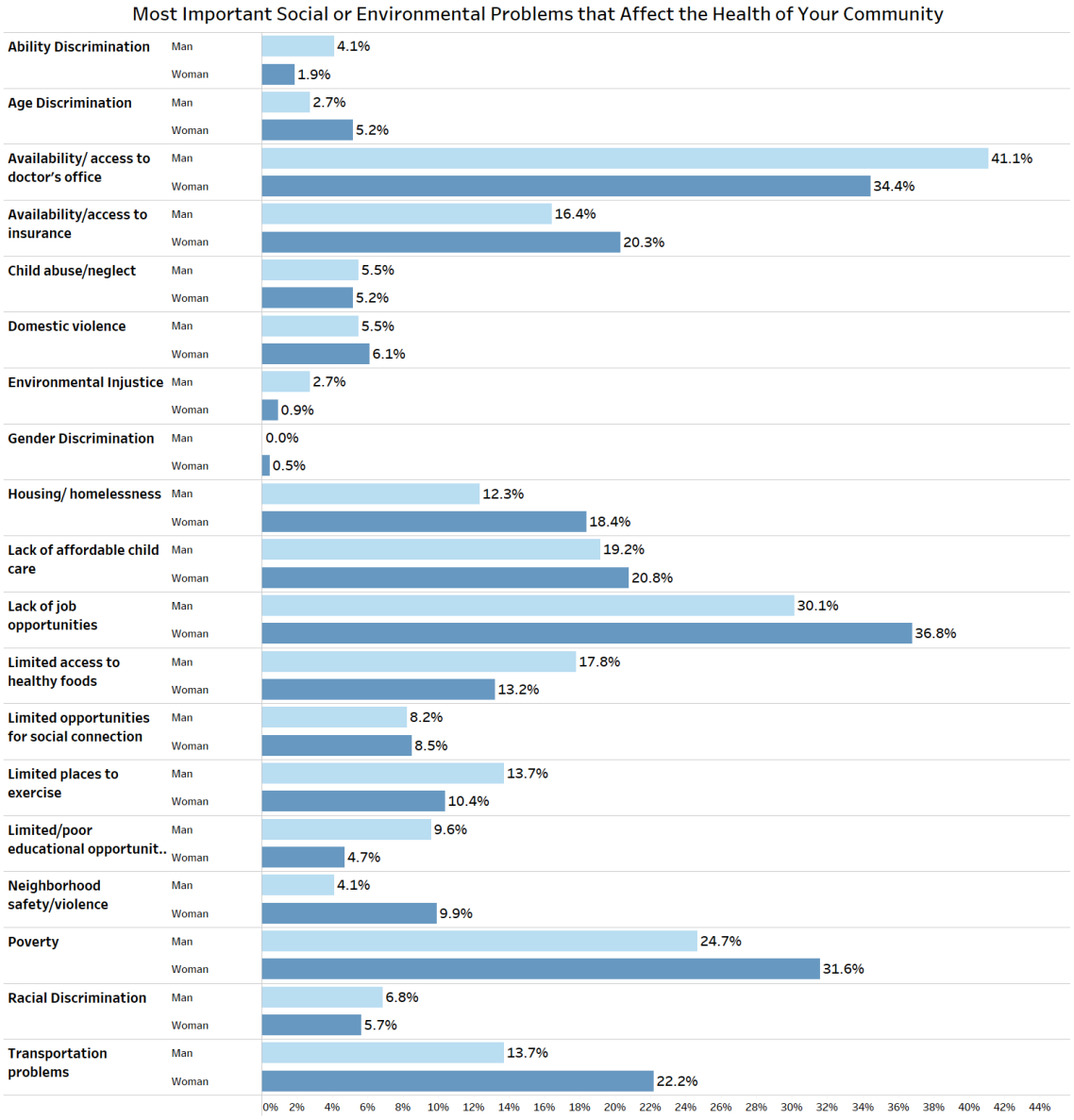


Figure A5.13: What are the three most important social or environmental problems that affect the health of your community? Please select up to three. (by race)

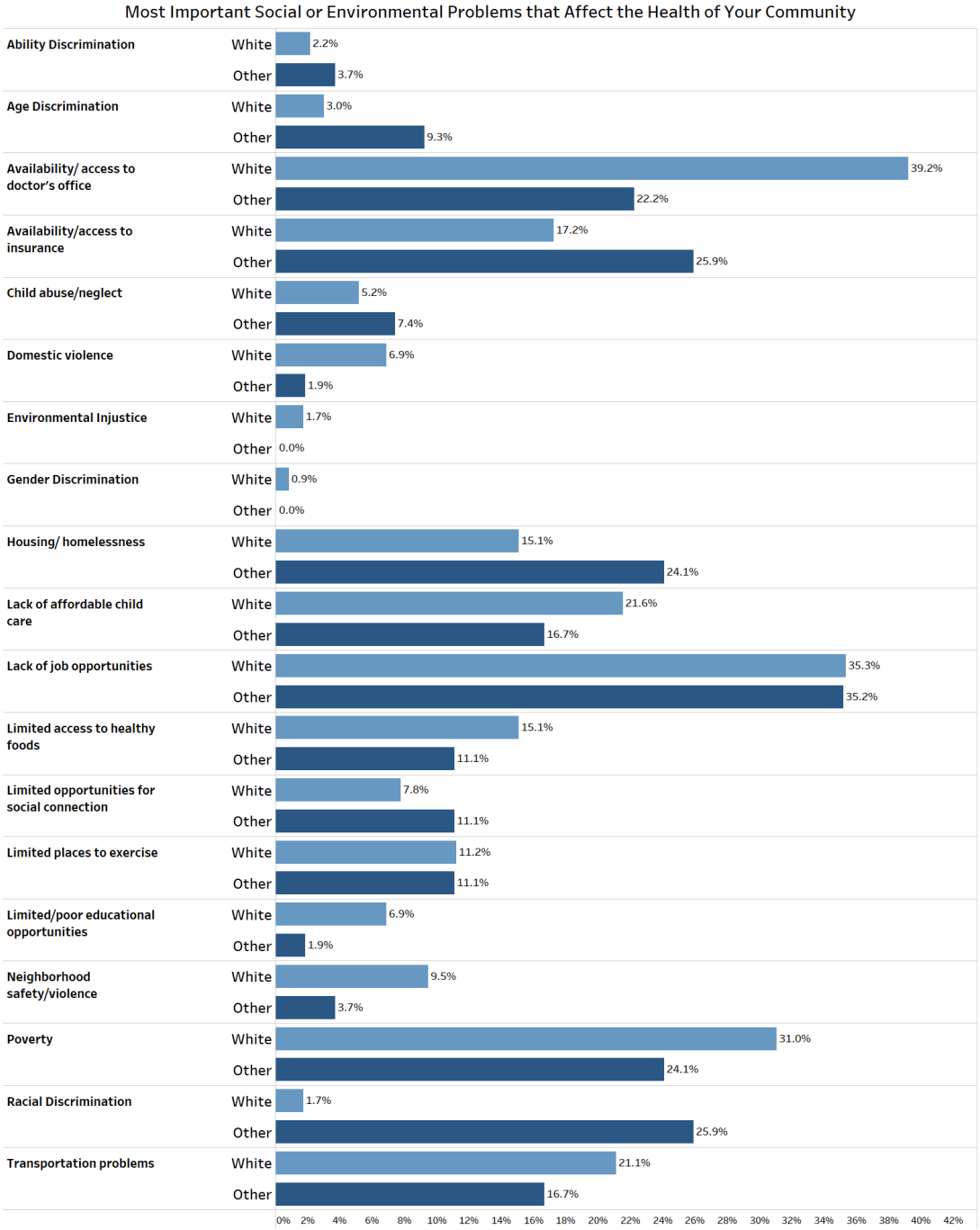


Figure A5.14: What are the three most important social or environmental problems that affect the health of your community? Please select up to three. (by ethnicity)

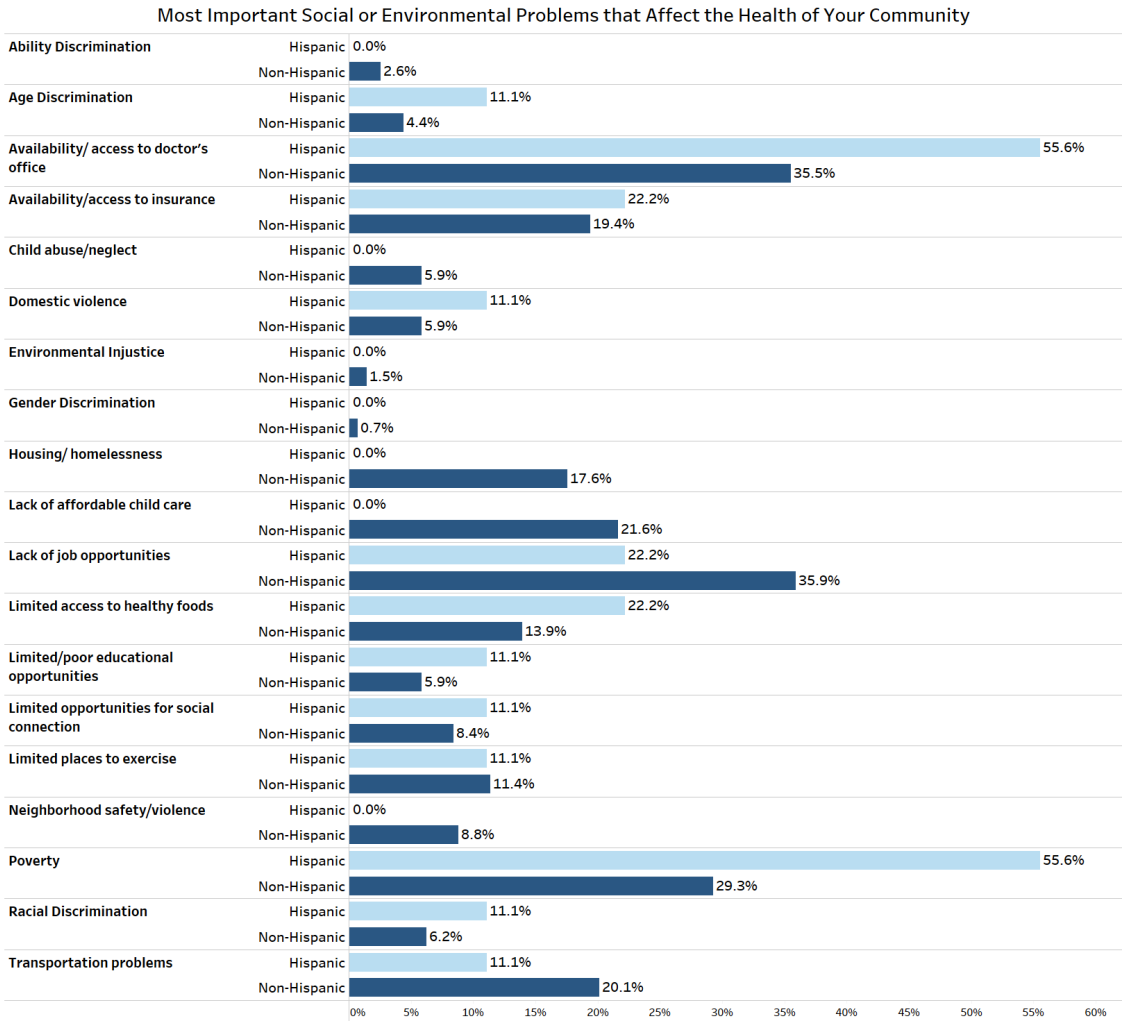
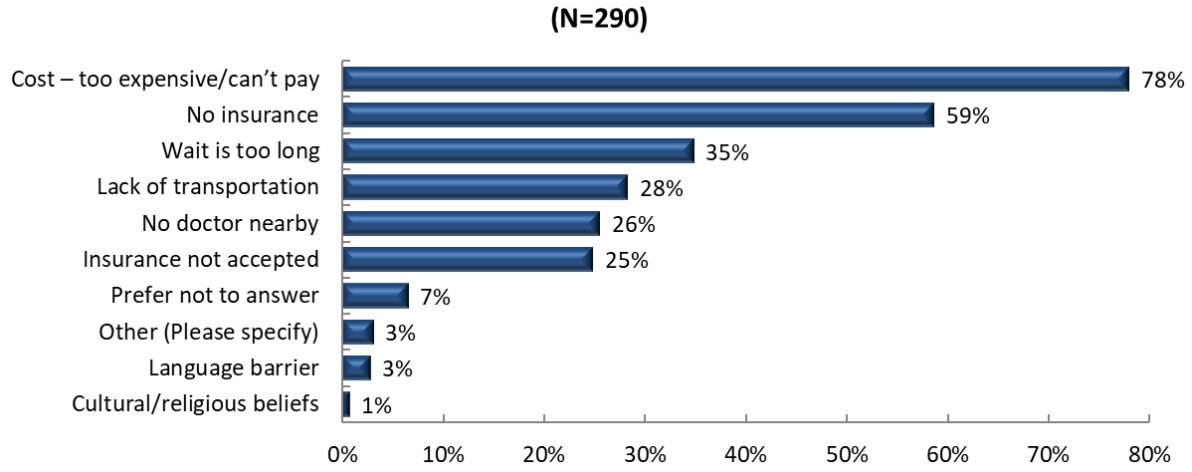


Figure A5.15: What are the three most important reasons people in your community do not get health care when they need it? Please select up to three.



Other (please specify):

- "Don't have a job to have insurance"
- "Everything is too expensive"
- "Inadequate Care by Providers"
- "No knowledge"
- "No Urgent care!!!!!!!!!!!!!!!! Especially a 24hr or reliable location. Have to spend 400 dollars at ER each time or drive 1.25 hours to Virginia"
- "PCPs are overbooked, cant get in"
- "Too few doctors, so limited availability of Healthcare providers"
- "Unwilling"
- "Unwilling to"

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

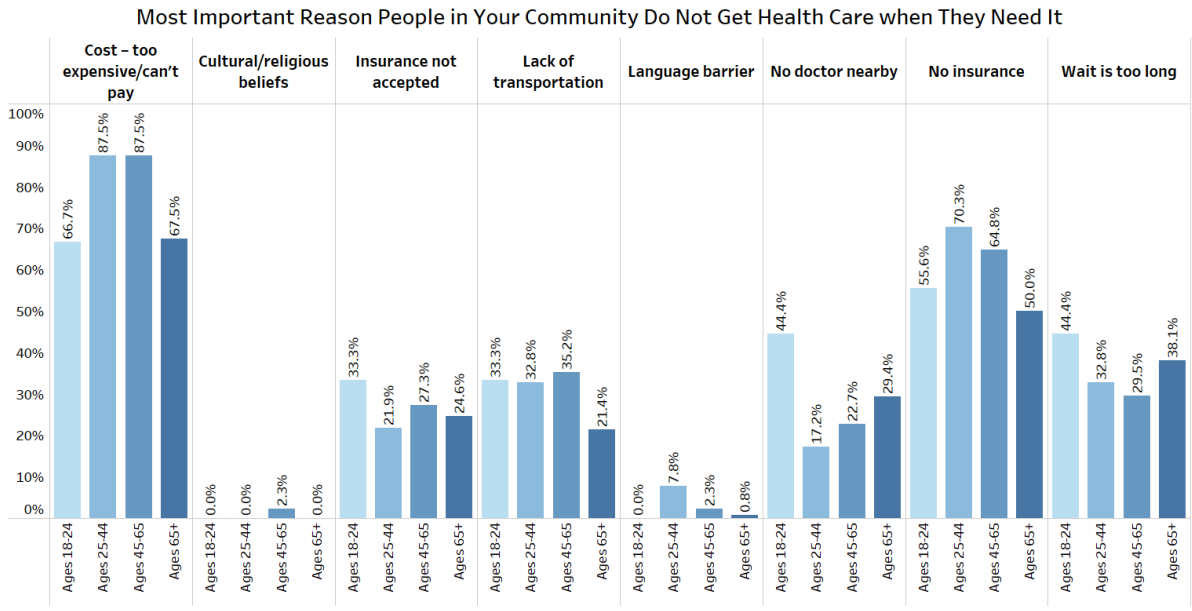


Figure A5.17: What are the three most important reasons people in your community do not get health care when they need it? Please select up to three. (by gender)

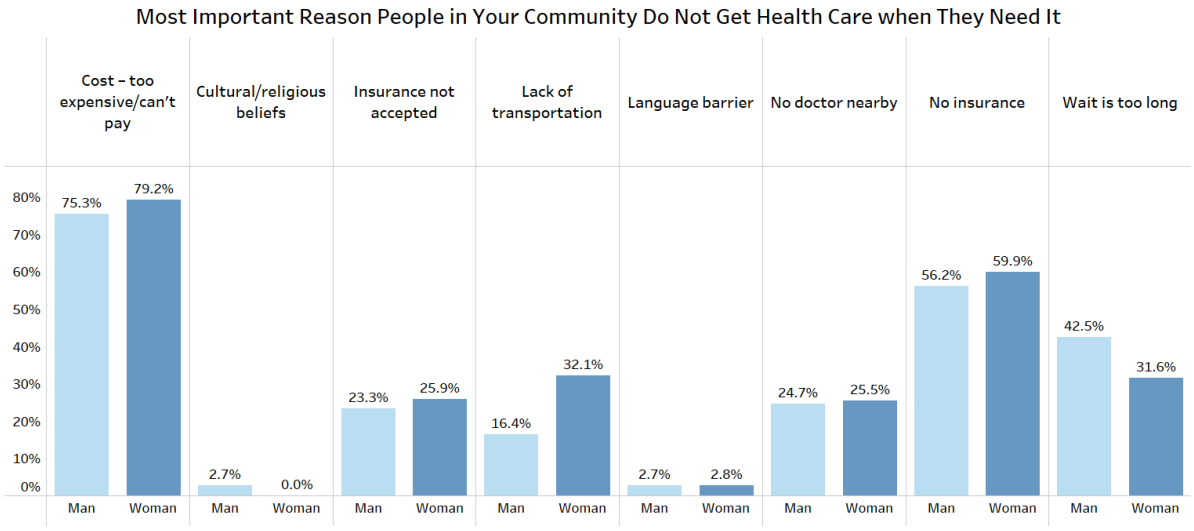


Figure A5.18: What are the three most important reasons people in your community do not get health care when they need it? Please select up to three. (by race)

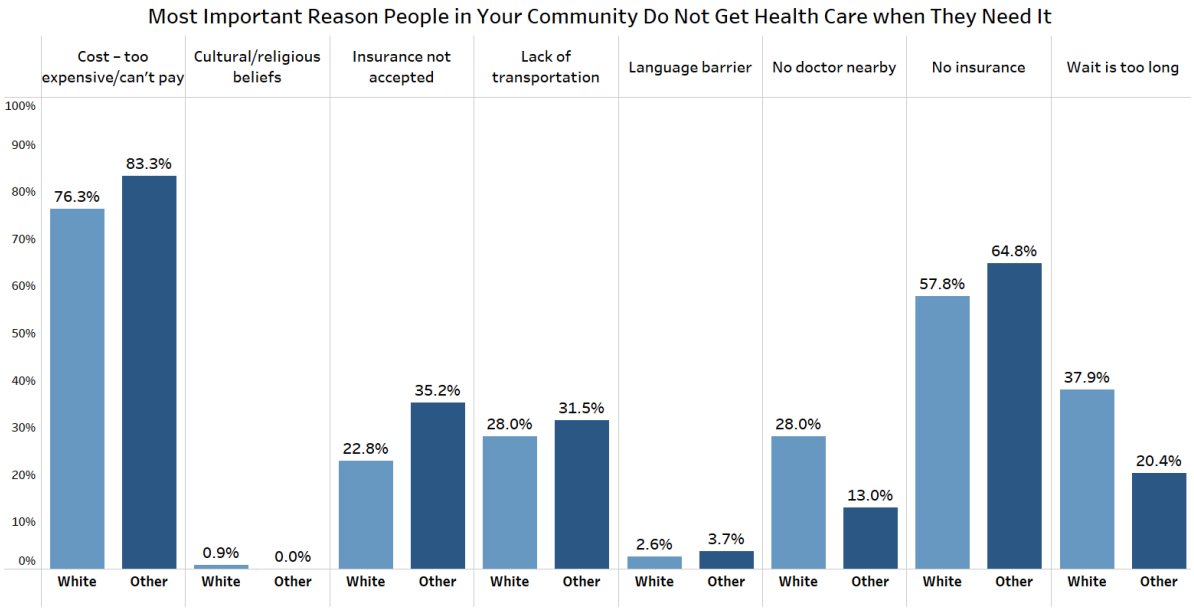
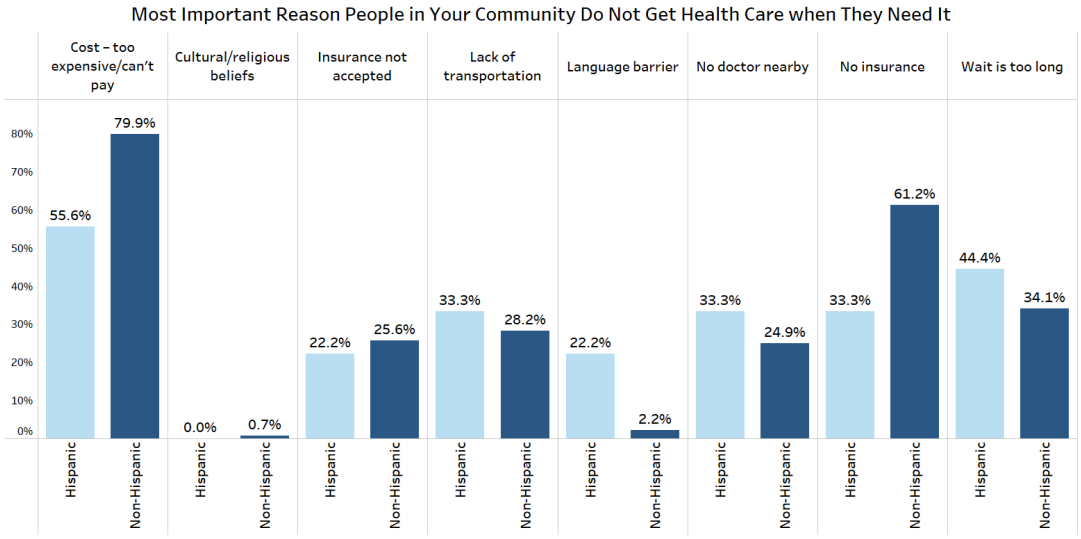


Figure A5.19: What are the three most important reasons people in your community do not get health care when they need it? Please select up to three. (by ethnicity)



Topic: Access to Care

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

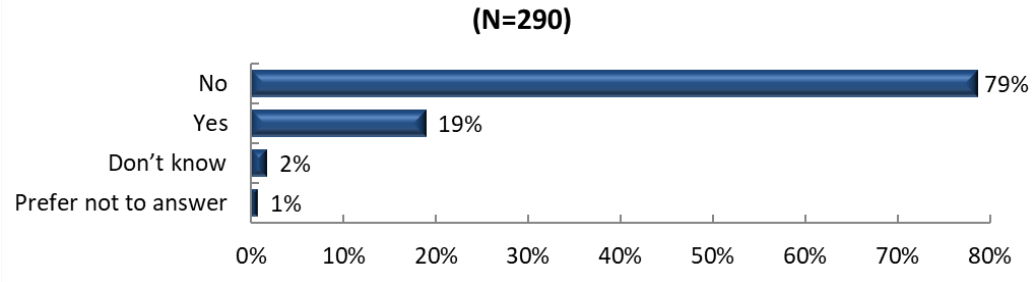
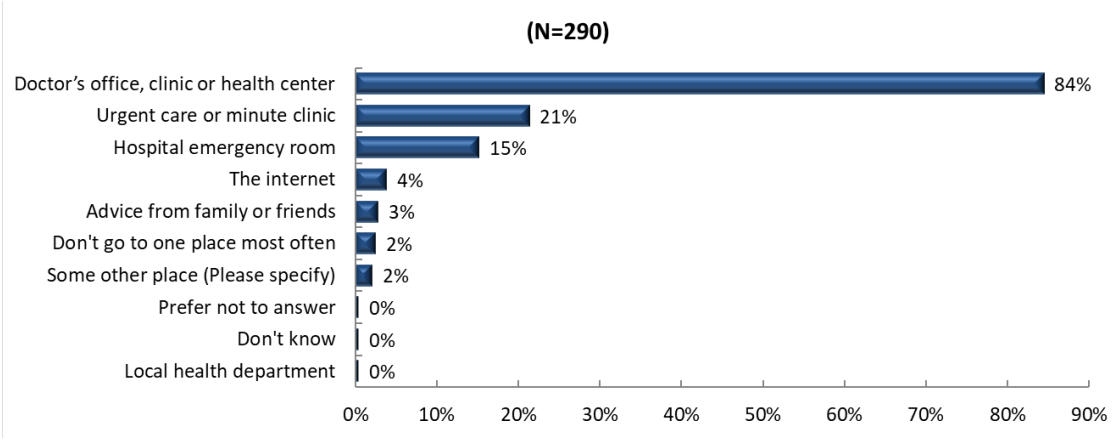


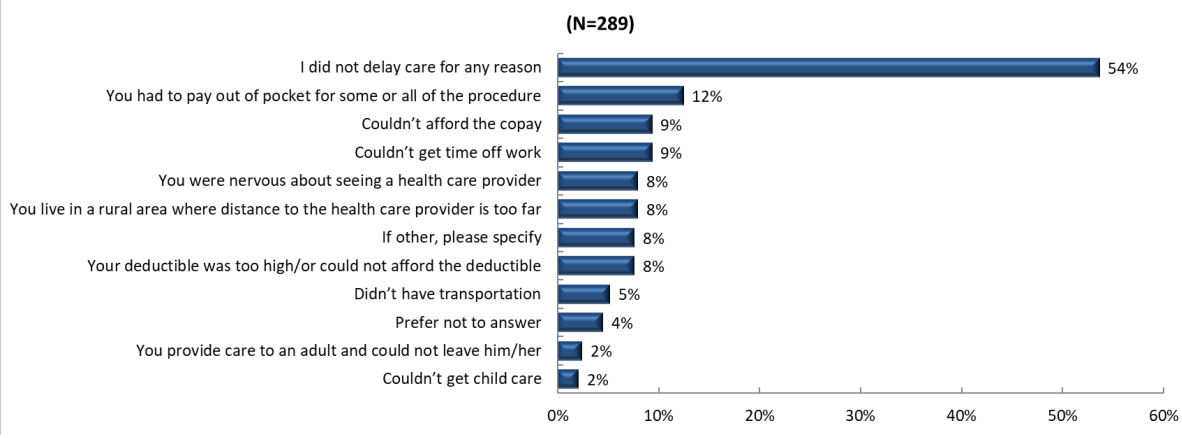
Figure A5.21: Where do you USUALLY go when you are sick or need advice about your health?



Other (please specify):

- "God or sometimes Teledoc"
- "Health Net Albemarle EC"
- "I work with nurses"
- "Nurse (friend)"
- "Telehealth" (2 responses)

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



Other (please specify):

- "Cannot get a doctor's appointment less than 3-4 months out. Cannot get a specialist's appointment without a referral."
- "Can't get in to office in timely manner"
- "Could not get an appointment with a primary care provider. Many in my area not accepting new patients."

- "Could not get appointment"
- "Couldn't see a Dr for months!"
- "Difficult to promptly obtain an appointment."
- "Dr. office overbooked, 4-8 hour wait time, sitting in car in hot/cold climate"
- "Due to the limited number of providers, I had to wait longer than ideal to get an appointment"
- "Everything is too expensive"
- "Hard to get an appointment with my primary physician."
- "Has taken 3 months to get an appointment"
- "Healthcare not available"
- "Medical practices not accepting new patients in Perquimans County"
- "Moved here recently, and had to wait for a doctor to take me as a patient."
- "No available appointments"
- "No money for gas"
- "Out of town"
- "The whole process is too complicated and expensive"
- "Too busy working"
- "Wait at urgent care was too long, or doctors office didn’t have soon appointments"
- "Wait times are 12+ months"
- "Waiting List"

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

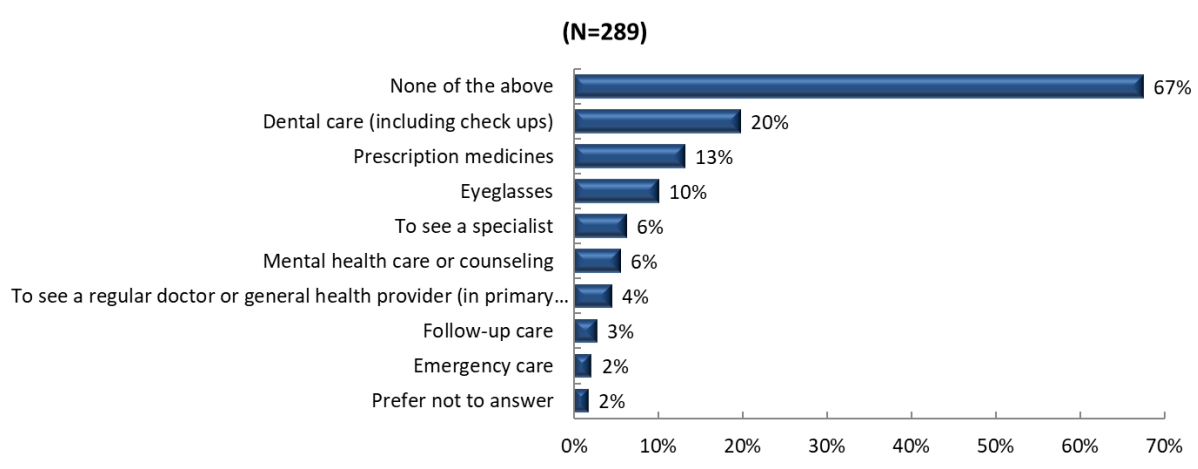


Figure A5.24: If you get sick or have an accident, how worried are you that you will be able to pay your medical bills?

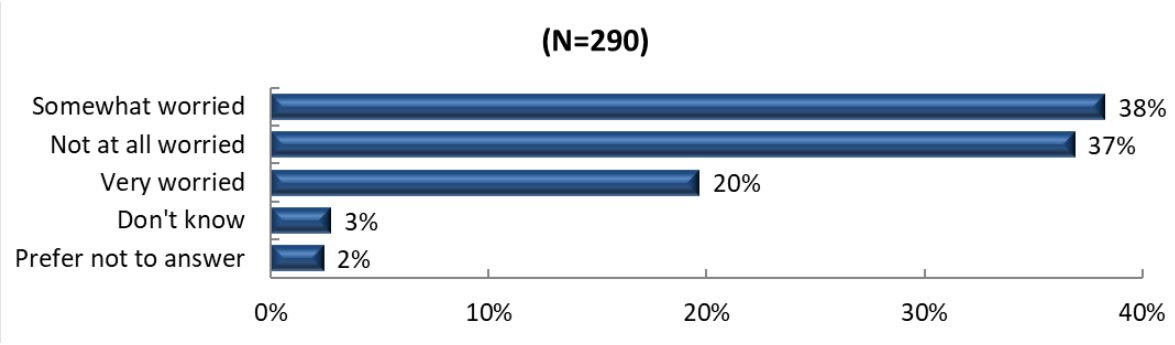
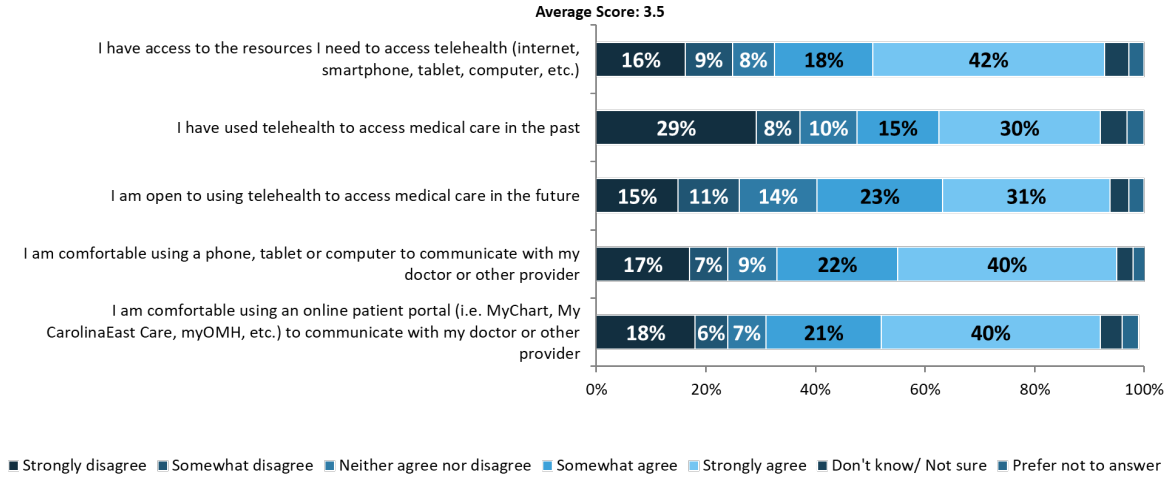


Figure A5.25: How much do you agree or disagree with the following statements about telehealth? Telehealth means connecting virtually with a medical provider using a smartphone, tablet or computer.

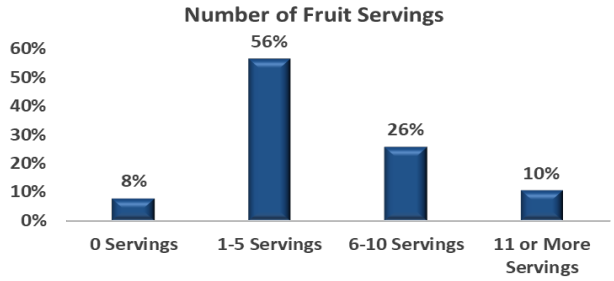
Rated on a scale from 1 to 5 with 1 being "strongly disagree" and 5 being "strongly agree"



Topic: Healthy Lifestyle (Diet and Exercise)

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

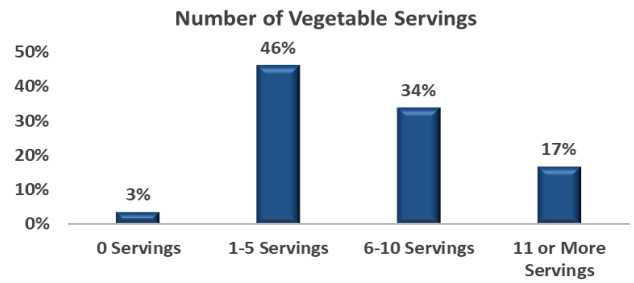
(N=288)



Measure	Value
Mean (Standard Deviation)	6 (8)
Median	4
Mode	3
Minimum-Maximum	0-74

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

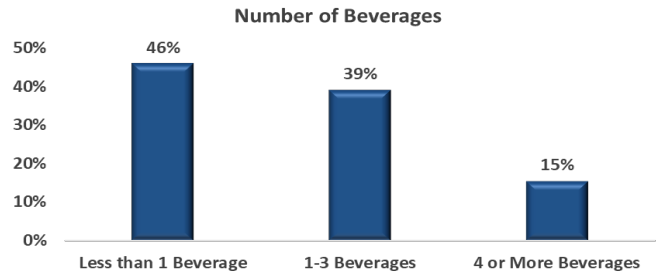
(N=288)



Measure	Value
Mean (Standard Deviation)	8 (10)
Median	6
Mode	7
Minimum-Maximum	0-100

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

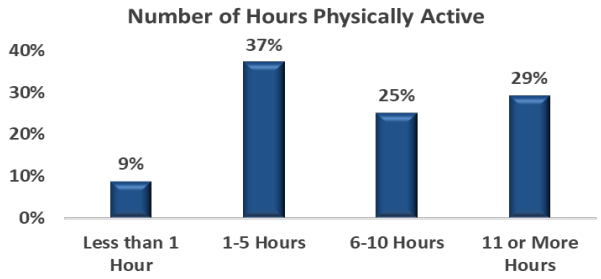
(N=288)



Measure	Value
Mean (Standard Deviation)	2 (4)
Median	1
Mode	0
Minimum-Maximum	0-28

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

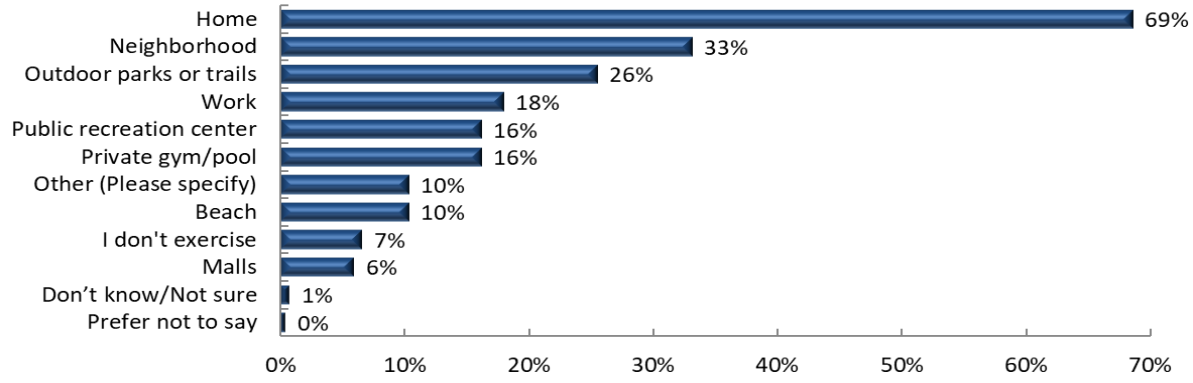
(N=288)



Measure	Value
Mean (Standard Deviation)	12 (16)
Median	6
Mode	2
Minimum-Maximum	0-100

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

(N=290)



Other (please specify):

- "Fishing"
- "Gardening/yard work."
- "Golf" (5 responses)
- "golf, yard work , clean up aroun the house"
- "PT personal training"
- "Senior Center" (17 responses)
- "Stores" (2 responses)
- "Yard work"
- "Yoga"

Topic: Housing and Homelessness

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

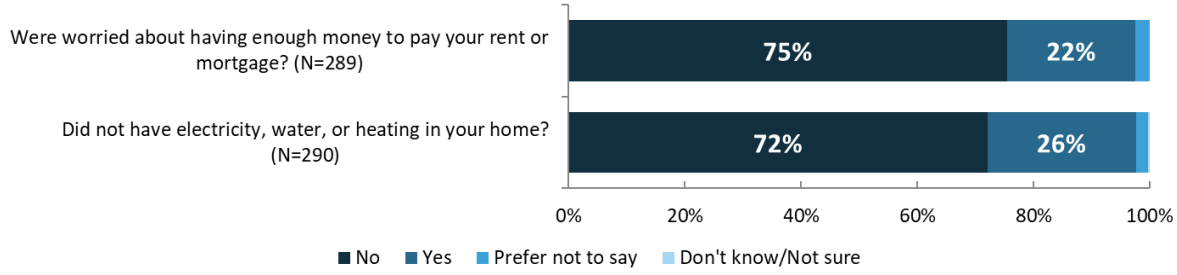


Figure A5.32: In the PAST THREE YEARS, were there times when you:

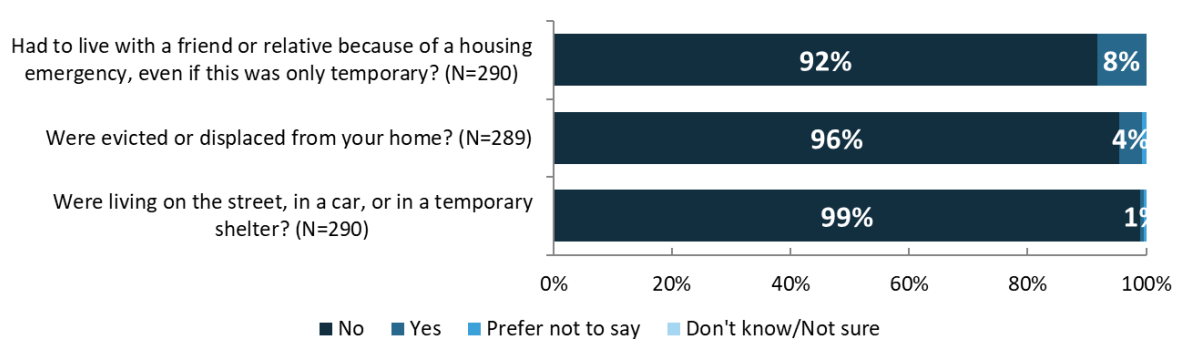
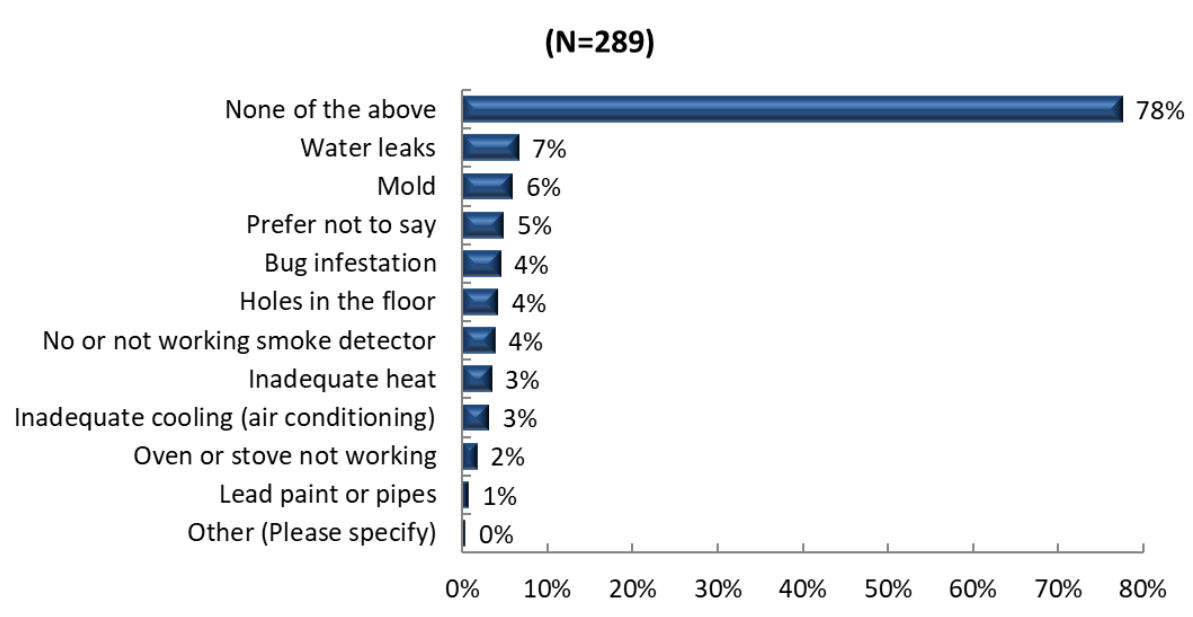


Figure A5.33: Think about the place you live. Do you have problems with any of the following? (Check all that apply.)

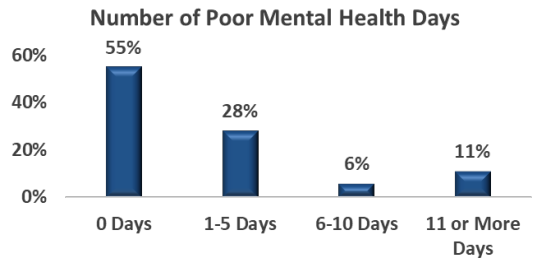


Other (please specify)

- "Mice"

Topic: Mental Health

Figure A5.34: Now thinking about your MENTAL health, which includes stress, depression, and problems with emotions, for how many days during the past 30 days was your mental health NOT good? (N=288)



Measure	Value
Mean (Standard Deviation)	4 (7)
Median	0
Mode	0
Minimum-Maximum	0-30

Figure A5.35: Was there a time in the past 12 months when you needed mental health care or counseling, but did not get it at that time?

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

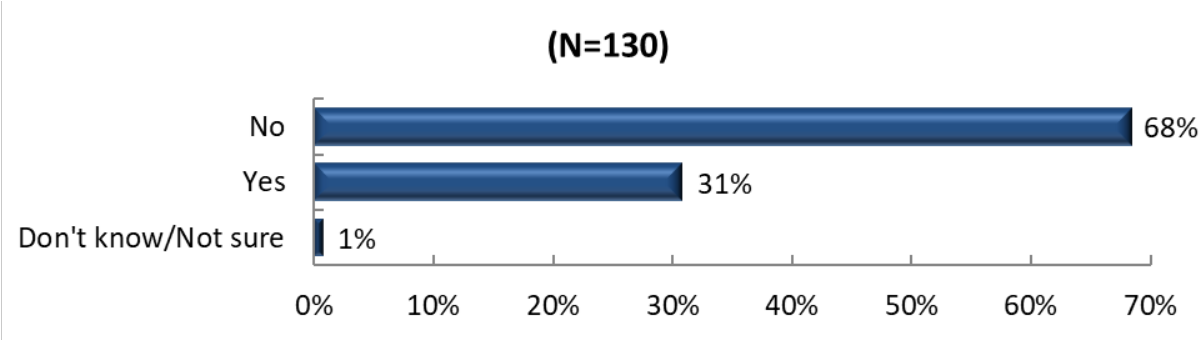


Figure A5.36: What was the MAIN reason you did not get mental health care or counseling?

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

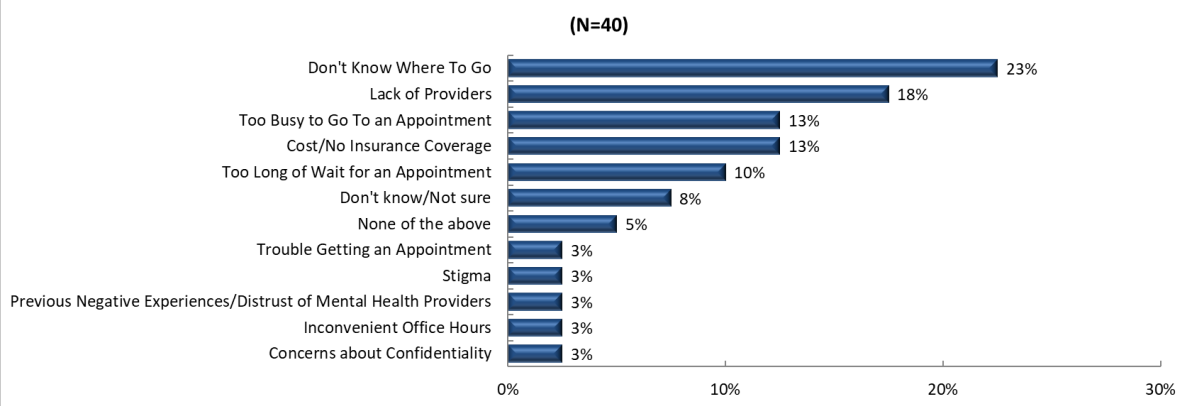
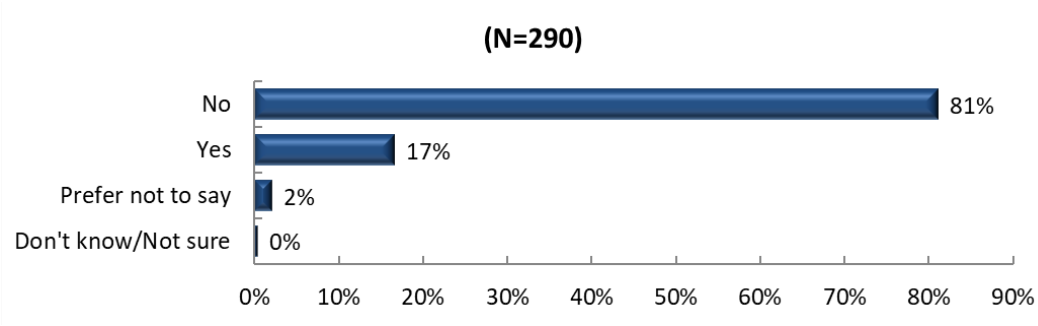


Figure A5.37: Are you currently taking medication or receiving treatment, therapy, or counseling from a health professional for any type of MENTAL or EMOTIONAL HEALTH NEED?



Topic: Physical Health

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

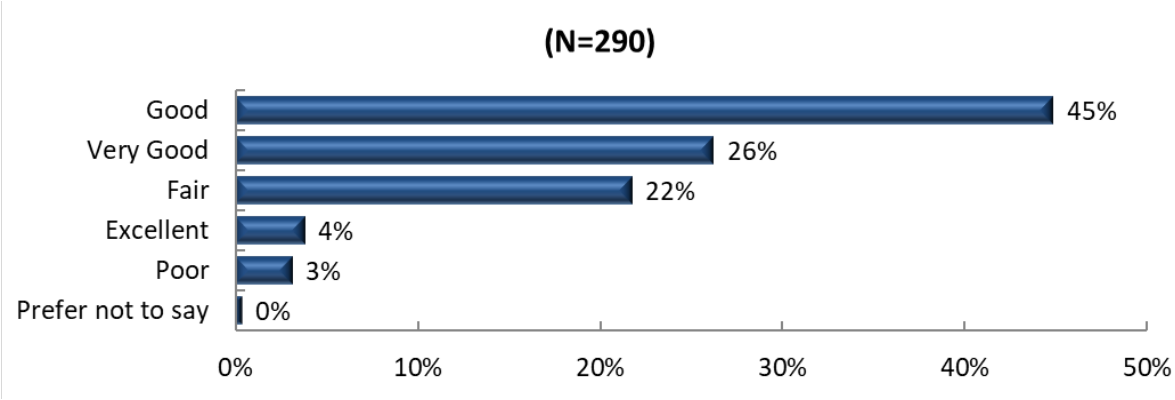


Figure A5.39: Within the past year (anytime less than one year ago), have you:

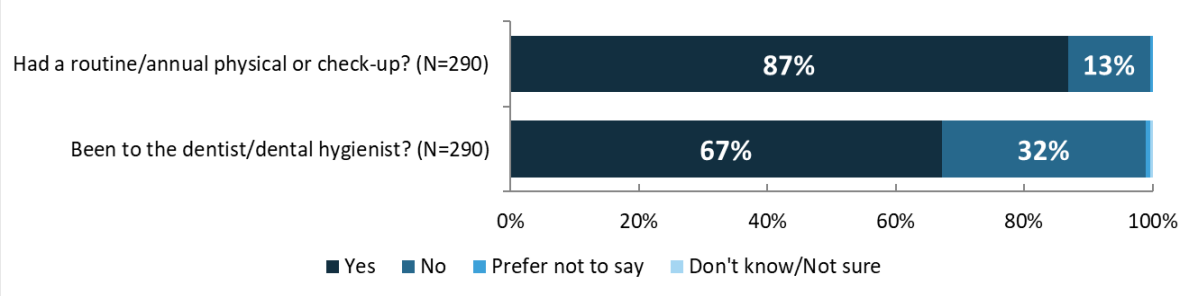
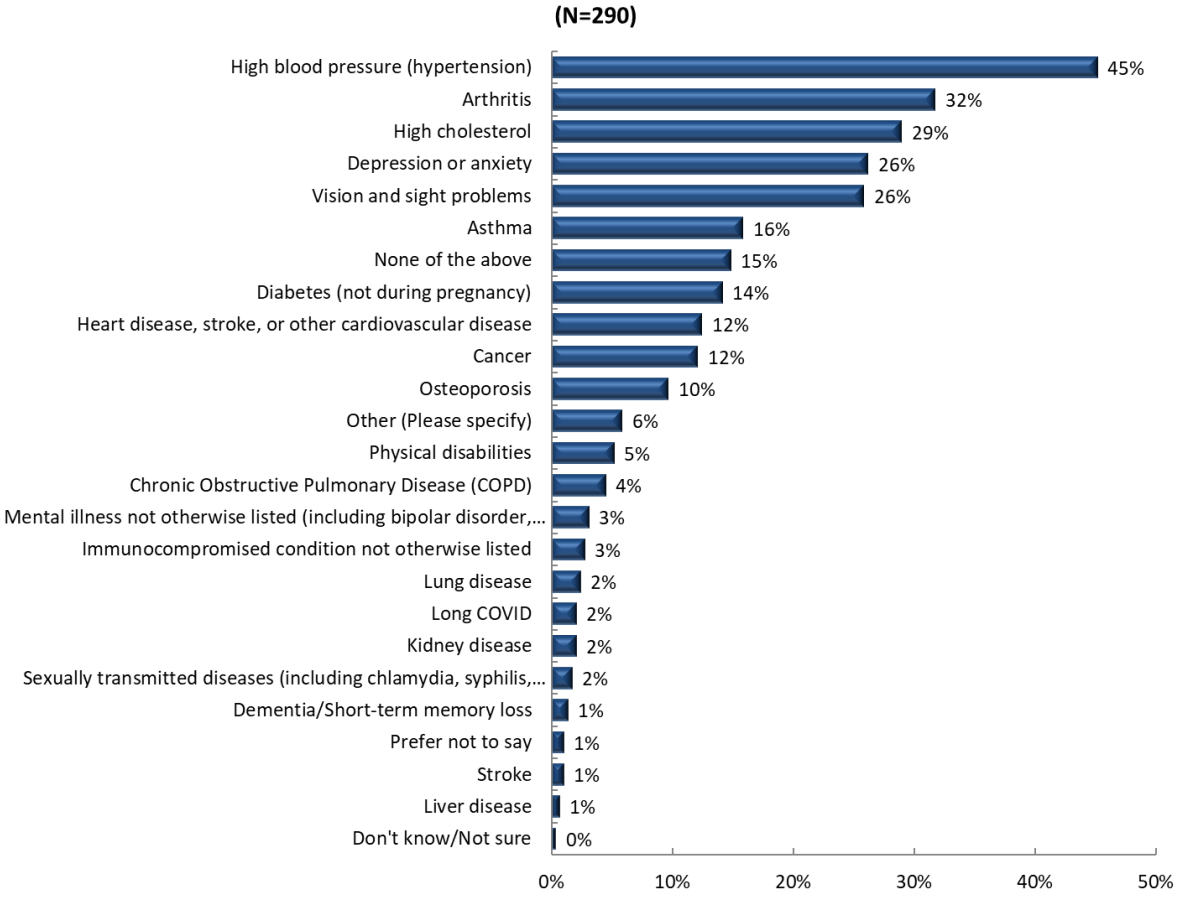


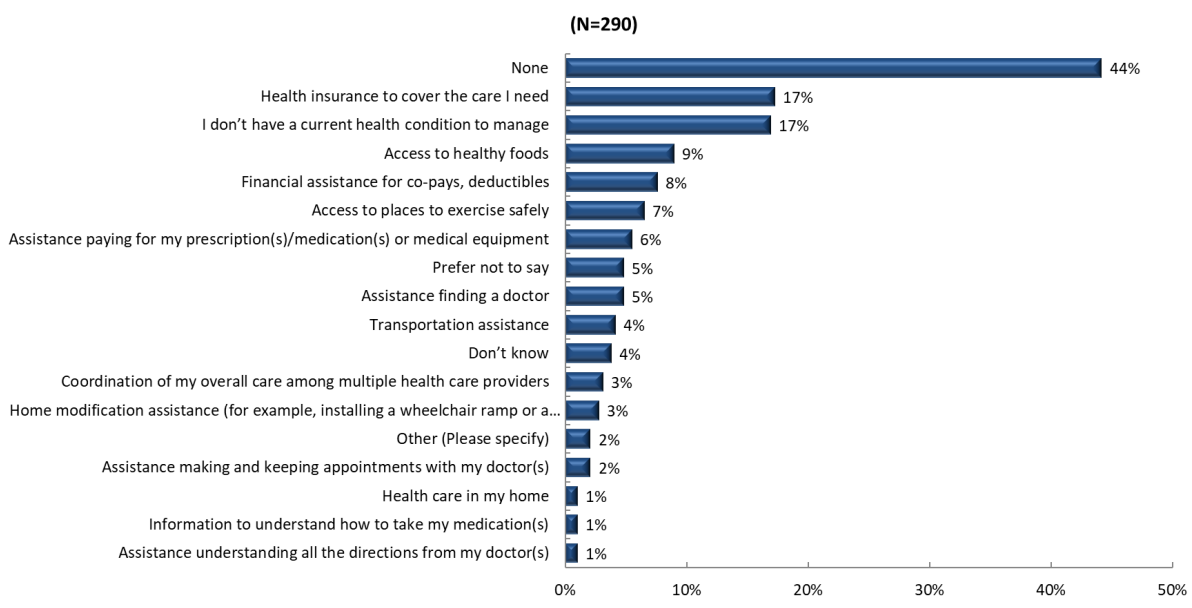
Figure A5.40: Have you ever been told by a doctor, nurse, or other health professional that you have any of the following health conditions? Select all that apply



Other (please specify):

- "Afib"
- "Asthma and Allergies"
- "Autoimmune disease - spondylitis"
- "Crohn's" (2 respones)
- "Ehlers-danlos *rare disease*"
- "Ehlers-Danlos Syndrome"
- "Gallstones"
- "Hearing"
- "Hiatal Hernia"
- "Hypothyroidism and Hashimoto"
- "Multiple Sclerosis" (3 responses)
- "Overweight"
- "PCOS, hypothyroidism, fibromyalgia, 5 back surgeries"
- "TIA"

Figure A5.41: What do you need to be able to manage your current health conditions (for example, heart conditions, high blood pressure, stroke, diabetes, asthma, cancer, COPD, congestive heart failure, arthritis, HIV, depression, anxiety, other mental health condition, etc.) to stay healthy? (Select all that apply.)

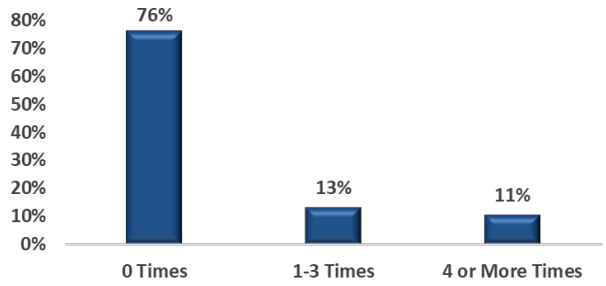


Other (please specify):

- "Access to care within reasonable waits and distance."
- "Better availability with scheduling appointments"
- "More providers in our area"
- "My budget can not afford any extra costs"
- "rails for steps"
- "Synthroid - had thyroid removed 40+years ago"

Topic: Substance Use Disorders

Figure A5.42: Considering all types of alcoholic beverages, how many times during the past 30 days did you have 4 (females)/ 5 (males) or more drinks on an occasion?



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

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

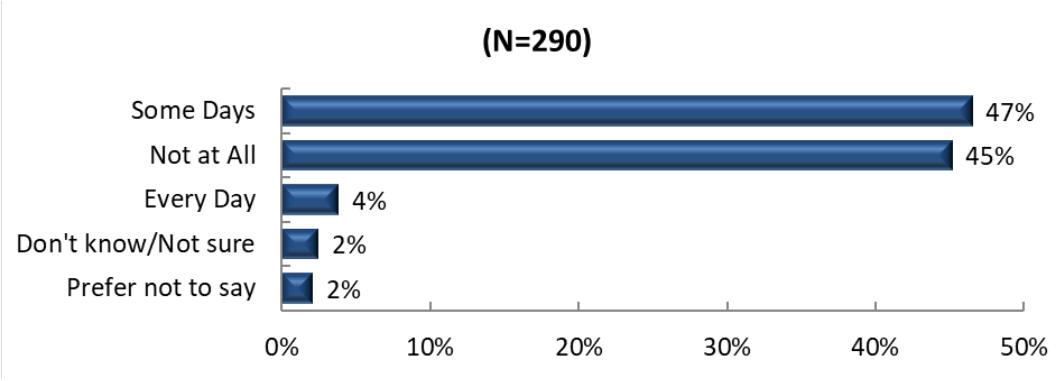


Figure A5.44: In the past year, have you or a member of your household misused any form of prescription drugs (e.g. used without a prescription, used more than prescribed, used more often than prescribed, or used for any reason other than a doctor's instructions)?

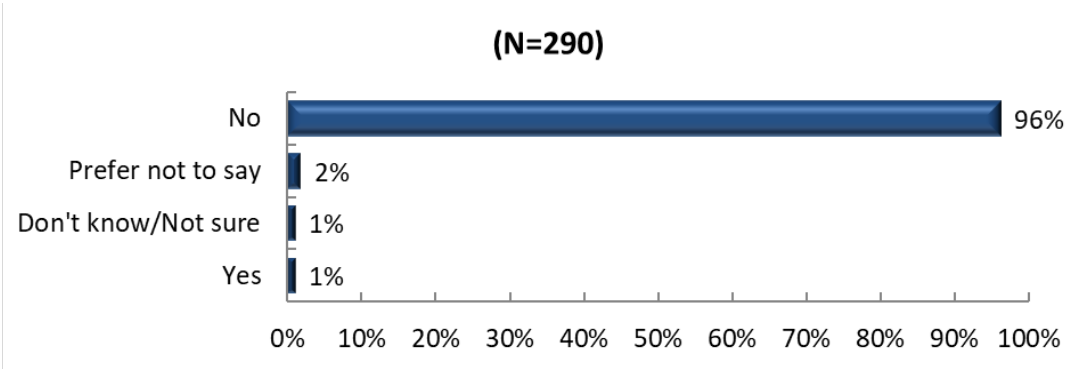
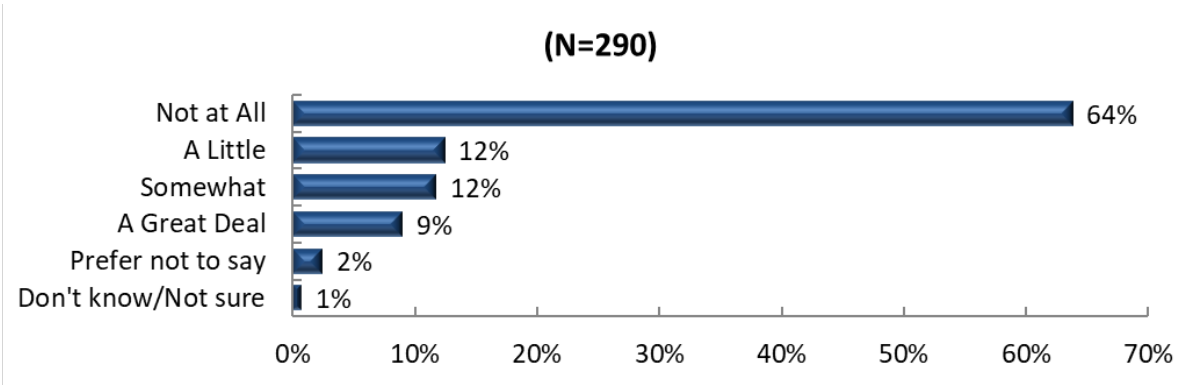


Figure A5.45: To what degree has your life been negatively affected by YOUR OWN or SOMEONE ELSE's substance abuse issues, including alcohol, prescription, and other drugs?



Topic: Transportation and Transit

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

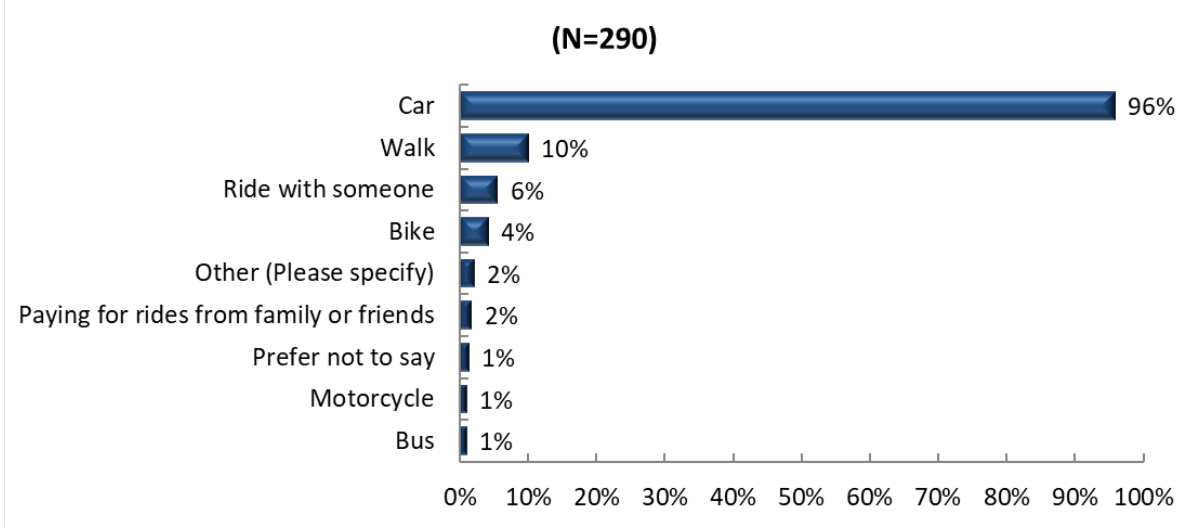


Figure A5.47: In the past 12 months has lack of transportation kept you from medical appointments, meetings, work, or getting things for daily living? Select all that apply:

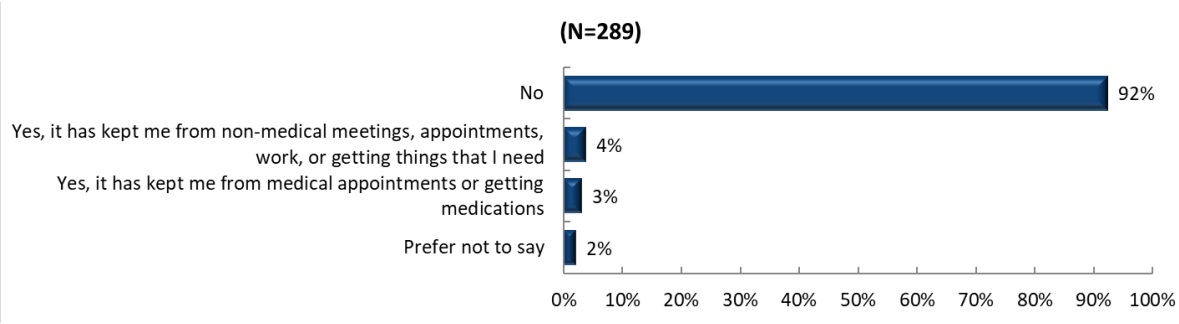
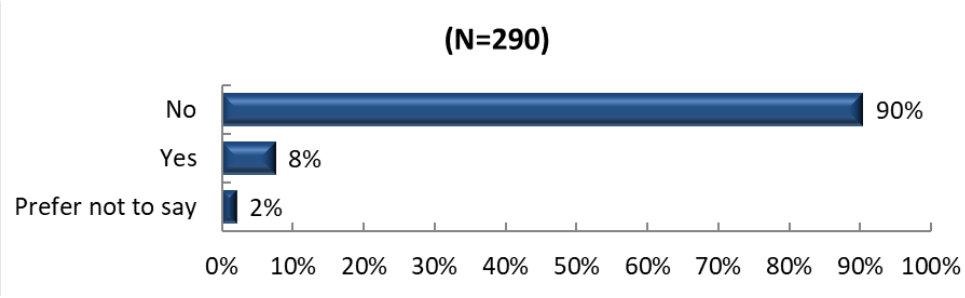


Figure A5.48: Do you put off or neglect going to the doctor because of distance or transportation?



APPENDIX 6 | SUMMARY OF DATA FINDINGS ACROSS SOURCES

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

Priority Area	Secondary Data	Community Survey	Focus Group
Behavioral Health: Mental Health	✓	✓	
Behavioral Health: Substance Use	✓	✓	
Built Environment	✓		
Community Safety			
Diet & Exercise	✓		
Education			
Employment & Income	✓	✓	
Environmental Quality	✓		
Family, Community & Social Support			
Food Access & Security	✓		✓
Healthcare: Access & Quality	✓	✓	✓
Health Equity & Literacy			
Housing & Homelessness	✓		✓
Length of Life			
Maternal & Infant Health			
Physical Health (Chronic Diseases, Cancer, Obesity)		✓	✓
Sexual Health			
Tobacco Use	✓		
Transportation & Transit	✓		✓

[52] Survey results captured here reflect major findings from the Community Health Opinion Survey questions. Red boxes indicate categories identified as high need consistently across data sources.