CRAVEN COUNTY

COMMUNITY HEALTH NEEDS ASSESSMENT

2024

CRAVEN COUNTY HEALTH DEPARTMENT
Working Together For Your Health
CRAVEN COUNTY COMMUNITY HEALTH CENTER

CAROLINAEAST HEALTH SYSTEM

Craven County
1712

Health ENC
Working Together for a Healthier Eastern North Carolina

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

Craven County CHNA Leadership

In addition to the Steering Committee, the Craven County 2024 CHNA was developed in partnership with representatives from Craven County Health Department (CCHD) and CarolinaEast Health System.

Name	Title	Organization
Scott Harrelson	Health Director	Craven County Health Department
Amber Tabarrini	CHNA Lead/Public Information Officer	Craven County Health Department
Janzen Brendle	Public Health Educator	Craven County Health Department
Dawn Peele	Vice President of Quality and Compliance	CarolinaEast Medical Center

Craven County CHNA Stakeholders

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

Name	Title	Organization
Geoff Marrett	Director	Craven County Department of Social Services
Jim Davis	Vice President of Nursing	CarolinaEast Medical Center
Mark Seymour	Assistant Director	Craven County Recreation & Parks
Luanne Mack	Director of Health Services	Craven County Schools
Garett Biss	Executive Director	Realize U252
Alissa Andrews Brown	Director	Craven County Senior Services

Craven County Health Department and CarolinaEast Health System would like to acknowledge the community members that participated in the 2024 Community Health Needs Assessment. In addition, thank you to the community members and organizations that helped to promote the health assessment and collect survey data. Thank you to the partners at Health ENC and North Carolina Department of Health and Human Services for assisting in data collection, data analysis, reporting, and guidance throughout this process. The Craven County Health Department (CCHD) and CarolinaEast Health System would also like to acknowledge the support from the Craven County Board of Commissioners, CarolinaEast Board of Directors, and leadership for their dedication to public health and improving health outcomes for the residents of Craven County. A special thanks to the partners, stakeholders and organization leaders who helped prioritize the data to determine and set Craven County's priority areas for the next three years.

In addition, the Health ENC Steering Committee and Craven County CHNA Leadership would like to thank Kathryn Dail, Director of Community Health Assessment at the NCDHHS Division of Public Health, for her valuable guidance throughout the development of this assessment, as well as Ascendient Healthcare Advisors for directing the CHNA process and producing this report.

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Copies of the 2024 CHNA report can be found online at www.cravencountync.gov/153/Health and www.carolinaeasthealth.com/education-and-resources/community-health-needs-assessment-dashboard/.

For additional information regarding the Community Health Needs Assessment, please contact Amber Tabarrini at atabarrini@cravencountync.gov .

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.

Vision Statement

It is the vision of Craven County CHNA Leadership and Stakeholders, "To create a thriving, equitable community where all residents have access to quality healthcare and enjoy optimal health, by identifying and addressing critical health needs through comprehensive assessment and collaborative action".

CHA Leadership

Craven County opted for a bi-sectoral approach to the leadership of the 2024 CHNA process, which included representatives from Craven County Health Department and CarolinaEast Health System.

Name	Title	Organization
Scott Harrelson	Health Director	Craven County Health Department
Amber Tabarrini	CHNA Lead/Public Information Officer	Craven County Health Department
Janzen Brendle	Public Health Educator	Craven County Health Department
Dawn Peele	Vice President of Quality and Compliance	Carolina East Medical Center

Partnerships/Collaborations

The 2024 CHNA process for Craven County included a variety of different stakeholders who assisted with community engagement activities, provided feedback, and participated in the prioritization process.

Type of Partner Organization	Number of Partners
Public Health Agency	1
Hospital/Health Care System(s)	1
Community Organizations	2
Business(es)	0
Public/Private/Charter School System(s)	1
Government/Public Agencies	3
Other: Recreation & Parks	1

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

Craven County CHNA Timeline and Process

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

Secondary (existing) data came from various public sources related to demographics, social determinants of health, environmental health, disease trends, behavioral health trends, and individual health behaviors. Data was evaluated using the Robert Wood Johnson Foundation's population health framework and compared to state or national benchmarks to identify areas of concern. Secondary data analysis revealed several health challenges in Craven County, including higher rates of chronic diseases, a significant behavioral health burden, and social determinants impacting health outcomes. The county experiences higher rates of deaths of despair (91.6 per 100,000) compared to state (58.7) and national (55.9) averages, and the opioid overdose death rate (48.0 per 100,000) significantly exceeds the state average (25.1).

Primary data from nearly 600 community survey responses and three focus groups identified mental health (depression/anxiety) and substance use as the most pressing health concerns, with 55% and 49% of survey respondents identifying these issues respectively. Cost (84%), lack of insurance (60%), and long wait times (44%) were identified as the top barriers to healthcare access. Transportation challenges and the availability of healthcare providers were also highlighted as significant concerns.

Representatives from Craven 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, Craven County selected three top priority health needs (**Access to Care**, **Behavioral Health**, and **Community Wellness and Education**), which are shown here in alphabetical order.

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

Following completion of this report, health leaders throughout Craven County will use the 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 facing local residents. Guidance was also provided by local representatives from Craven County Health Department and CarolinaEast Health System. 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 Craven County residents.

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

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

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

Figure 1: The 10 Essential Public Health Services

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

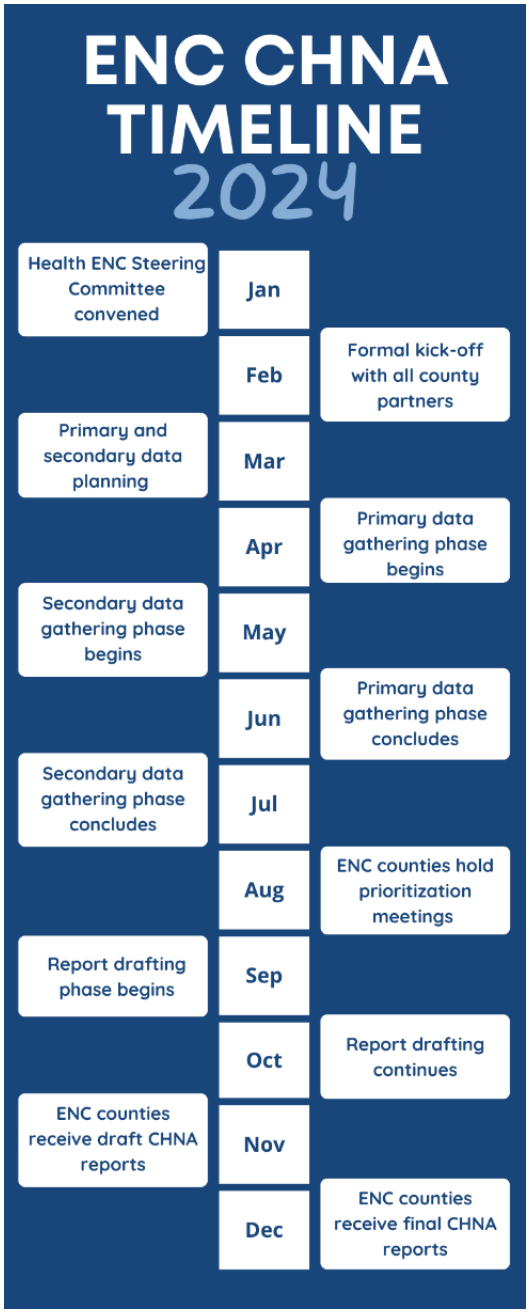
- Define the community it serves;
- Assess the health needs of that community;
- Through the assessment process, take into account input received from people who represent the community's broad interests, including those with special knowledge of or expertise in public health;
- Document the CHNA in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

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

Timeline

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

Figure 2: Health ENC 2024 CHNA Milestones



Process Overview

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

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

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

Figure 3: The CHNA Process[3]

Report Structure

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

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

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

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

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

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

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

Figure 4: Craven County 2021 Priority Need Areas

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

Craven County Health Department

The Craven County Health Department began in 1921 and has been evolving to serve the needs of its community for over 100 years. It is the mission of the Craven County Health Department to build upon the history of public health while responding to the dynamics of the growth of our county and the changing priorities of the health system. The health department provides a full range of services including maternity care, adult and child services, dental, family planning, WIC, environmental health, animal services, and hospice. The Craven County Health Department was the first public entity federally qualified

health center (FQHC) in North Carolina, which affords the ability to provide primary care services for adults and children, along with behavioral health and pharmacy. The Craven County Health Department also operates one of the few remaining health department hospice agencies in the state. In addition, Craven County is a hub for refugees coming from all over the world, and Craven County Health Department is one of only a handful of health departments in the state that see refugees upon entering the country, providing physicals and health care to all refugees in our area. The Craven County Health Department has filled a niche within its community by offering care to those that would otherwise have no place to go. The Craven County Health Department has many valuable partners, including CarolinaEast Medical Center.

CarolinaEast Medical Center

CarolinaEast Medical Center is a nationally recognized, 350-bed acute care hospital that provides both inpatient and outpatient care to residents in Craven, Jones, Pamlico and surrounding counties in eastern and coastal North Carolina. CarolinaEast Health System has been serving the growing needs of the coastal North Carolina community since 1963. In addition to the hospital, CarolinaEast includes a rehabilitation center, surgery center, the SECU Comprehensive Cancer Center, and numerous CarolinaEast Physician practices providing primary and specialty care for all phases of life from offices in four counties. It is the mission of CarolinaEast to deliver compassionate, quality care that serves to promote the region's health.

Previous CHNA Priority: Community Wellness

- **COVID-19 Response:** The Craven County Health Department held numerous community events to promote the prevention of the spread of COVID-19. Over 5,000 N95 mask kits were provided to the public. Kits included: N95 masks, Slow the Spread information, a COVID-19 vaccine information card, testing site information, and isolation and quarantine guidelines. At-home COVID-19 tests kits were also provided to the public at no cost. Over 3,500 kits were provided to the public through community events and walk-in services at the health department in FY 2022. Over 1,000 COVID-19 test kits were provided to the public during FY 2023.
- **Prevent T2:** A CDC evidence-based diabetes prevention program, Prevent T2, started new cohorts in FY 2022 and FY 2023. The program is taught by a certified Lifestyle Coach.
- **Community Events:** The Craven County Health Department participated in 35 community events in 2022 and 56 community events in 2023 with a combined reach of over 4,000.
- **Recreation and Parks:** Craven County Recreation and Parks continues to offer programs to adults and children. Youth program participation has grown since CY 2021 from 1,695 participants to 2,598 in CY 2023.

Previous CHNA Priority: Workforce Development

- **Career Coaching:** Craven Community College Career Coaches continue to be on-site at different locations within the county throughout the year. The coach is dedicated to helping individuals explore a career path that matches their interests. They offer several resources that can help in making this important decision, including career-planning tools, information about college programs, and career readiness classes and seminars.
- **Pilot Training Program:** In the fall of 2023, the Craven Community College Volt Center announced a partnership with the North Carolina Division of Juvenile Justice and Delinquency Prevention to

develop a pilot program for justice-involved individuals in Craven County. The program will offer training and employment opportunities. Programs of study include welding, carpentry, electrical, construction, and diesel mechanics. Classes will be provided for students at no cost. The pilot program will run through the fall of 2026.

Previous CHNA Priority: Behavioral Health

- **Naloxone:** Through a partnership with the North Carolina Department of Health and Human Services, the Craven County Health Department provided nasal naloxone to local law enforcement agencies and the community at large. In CY 2022, the health department distributed over 150 naloxone kits and over 250 kits were distributed in CY 2023.
- **Drug Takeback Events:** The New Bern Police Department continues to collect unused and expired medications at community drug takeback events twice per year. Through this initiative, over 600 pounds of medications were safely disposed of in CY 2022 and over 700 pounds in CY 2023.
- **Mental Health Town Hall:** Craven, Jones, and Pamlico County Health Departments collaborated to bring a Mental Health Town Hall to New Bern in March of 2023. The event was sponsored by the North Carolina Department of Health and Human Services (DHHS) and held at the Riverfront Convention Center. DHHS Secretary Kinsley and other esteemed panelists were available to answer questions and listen to citizens' concerns about the state of mental health services in and around our tri-county area. Over 150 individuals attended.
- **Craven County Opioid Epidemic Response Department:** Craven County Government established the Craven County Opioid Epidemic Response department to reduce opioid-related overdoses and deaths in Craven County through prevention, collaboration, harm reduction, treatment, short-term and long-term recovery, and recovery support services. In the fall of 2023, the newly formed Craven County Opioid Epidemic Response office collaborated with the Craven County Health Department to provide community and organizational trainings. Opioid Epidemic Response staff provided overdose and Narcan training while Health Department staff taught Hands-Only CPR.

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

Summary Findings: Craven 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 Craven County participated. Existing data included information regarding demographics, health and healthcare resources, behavioral health, disease trends, and county rankings. The data collection and analysis process began in January 2024 and continued through July 2024.

Throughout Craven 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 Craven 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 Stakeholders Committee identified Craven 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 Stakeholders Committee, the Craven focus areas identified as countywide priorities for the 2024 CHNA are Access to Healthcare, Behavioral Health, and Community Wellness and Education, as seen in **Figure 5**.

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

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

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

CHAPTER 1 | METHODOLOGY

Study Design

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

Specifically, the following data types were collected and analyzed:

New (Primary) Data

Public engagement and feedback were received through a web-based community member survey along with community focus groups and significant input and direction from the CHNA Steering Committee. The Steering Committee worked together to develop the survey questions for the web-based survey, and county leaders were provided with a set of target numbers based on their county population's race, ethnicity and age distribution to encourage recruitment of a representative sample of the community. Community members were asked to identify the most significant health and social needs in their community, as well as asked questions about topics specific to Craven County, including employment, equity and equality, mental health, and substance use disorders. Focus group participants were asked a standard set of questions about health and social needs, in order to identify trends across various groups and to highlight areas of concern for specific populations. In total, the input was gathered from over 610 Craven County residents and other stakeholders. This included web survey responses from over 590 community members and three focus groups that included 20 community members and other people who live, work or receive healthcare in Craven County.

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

Existing (Secondary) Data

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

- *County Health Rankings*, developed in partnership by Robert Wood Johnson Foundation (RWJF) and University of Wisconsin Population Health Institute
- *The Opportunity Atlas*, developed in partnership by the U.S. Census Bureau, Harvard University, and Brown University

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

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

Comparisons

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

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

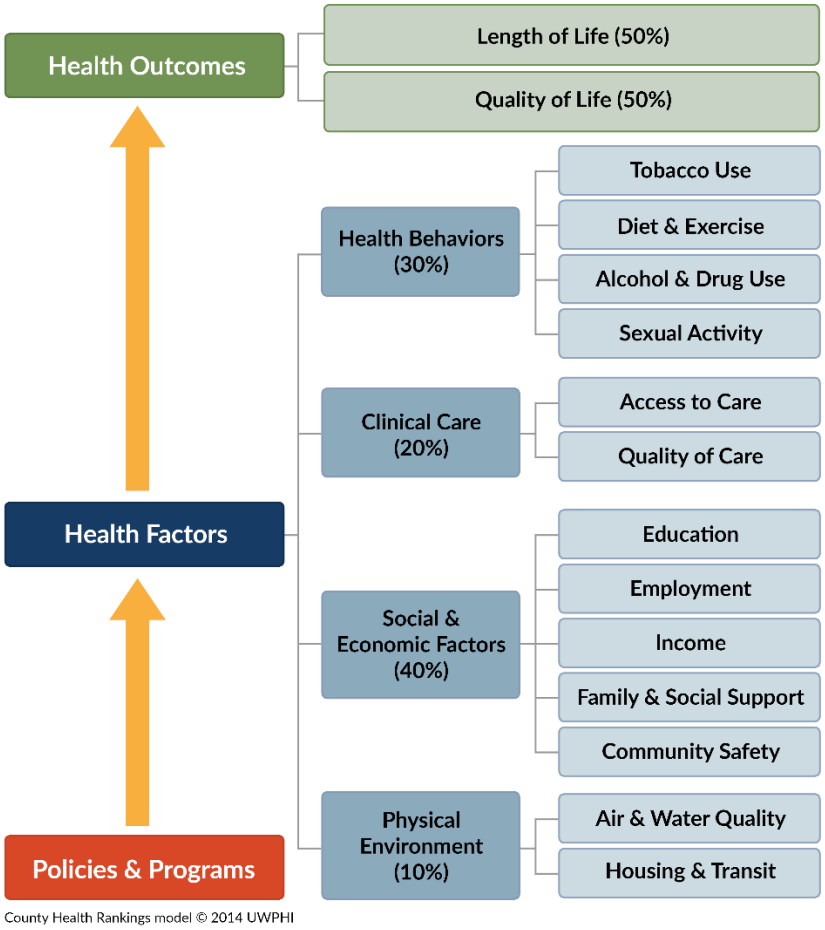
Population Health Framework

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

Using the population health framework as a guide for the CHNA process helps categorize many individual pieces of data in a way that connects the dots between health status and social drivers of health, in a way that helps local leaders better understand and address the health and well-being of the communities they serve. This understanding is critical in identifying potential interventions to address priority needs in the community, and to helping develop partnerships across sectors that can help drive these interventions

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

Figure 6: Population Health Framework[5]



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

Throughout the process, the Steering Committee also considered *Healthy People 2030*'s "Social Determinants of Health and Health Equity." The CDC defines social determinants of health (SDoH) as the conditions in the environments where people are born, live, learn, work, play, worship and age that affect a wide range of health, functioning and quality of life outcomes and risks. These factors can include healthcare access and quality, neighborhood and built environment, social and community context, economic stability, and education access and quality, as outlined in **Figure 7**.[6]

Figure 7: Social Determinants of Health

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

Figure 8: SDoH and Health Disparities[7]

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

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

Prioritization Process Overview and Results

The process of identifying the priority health needs for the 2024 CHNA began with the collection and analysis of hundreds of new and existing data measures. In order to create more easily discussable categories, all individual data measures were then grouped into six categories and 20 corresponding focus areas based on "common themes" that correspond to the Population Health Model, as seen in **Figure 6**. These focus areas are detailed further in **Appendix 2.**

Since a large number of individual data measures were collected and analyzed to develop these 20 focus areas, it was not reasonable to make each of them a priority. The 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.

Once the primary and secondary data had been grouped into the focus areas and was reviewed and discussed, the CHNA Steering Committee utilized the multi-voting technique to evaluate and prioritize the health needs of Craven County 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.

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 and Substance Use, and Community Wellness and Education) were identified as Craven County's top priority health needs to be addressed over the next three years, as seen in **Figure 9** below:

Figure 9: Craven County 2024 Priority Health Needs

The following organizations participated in the prioritization voting process:

- CarolinaEast Medical Center
- Craven County Department of Social Services
- Craven County Health Department
- Craven County Recreation & Parks
- Craven County Schools
- Craven County Senior Services
- Realize U252

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 Craven County in both population and geography, this study was limited in its ability to fully capture health disparities and health needs across racial and ethnic groups. Resource limitations meant that county leaders relied on convenience sampling to engage with the community via the web-based survey. This method of survey sampling may fail to capture a truly representative cross-section of the community, resulting in overrepresentation of some demographic groups and underrepresentation

of others. This can lead to findings that don't accurately reflect the health needs and perspectives of the entire community, particularly those from underrepresented or marginalized groups. While efforts were made to include diverse community members in survey efforts, roughly 80% of all respondents were White compared to the White population of Craven County only comprising 63% of the total county population. Another 11% of respondents were Black or African American, which was less than the 20% of the total county population that is Black or African American. Only 3% of respondents identified as Hispanic, which is less than the reported county population level of 8%. Although survey respondents could choose from multiple races and ethnicities, limited responses were received from these groups. This made it difficult for the Steering Committee to assess health needs and disparities for other racial/ethnic minority groups in the community.

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

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

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

CHAPTER 2 | COUNTY PROFILE

Geography

Craven County is in the Outer Coastal Plain region of North Carolina, characterized by the presence of large sounds, bays, and river mouths. It covers a total of 773 square miles, including 707 square miles of land and 67 square miles of water. Craven County is comprised of eight municipalities: Bridgeton, Cove City, Dover, Havelock, New Bern, River Bend, Trent Woods, and Vanceboro. Craven County is home to Marine Corps Air Station Cherry Point and Fleet Readiness Center (FRC) East. The military base and FRC East employ thousands of people, providing limitless opportunities for both active duty servicemembers, civilian personnel and veterans while also significantly impacting the local economy of Craven County. Over one-third (35%) of Craven County's population resides in rural areas.

Population

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

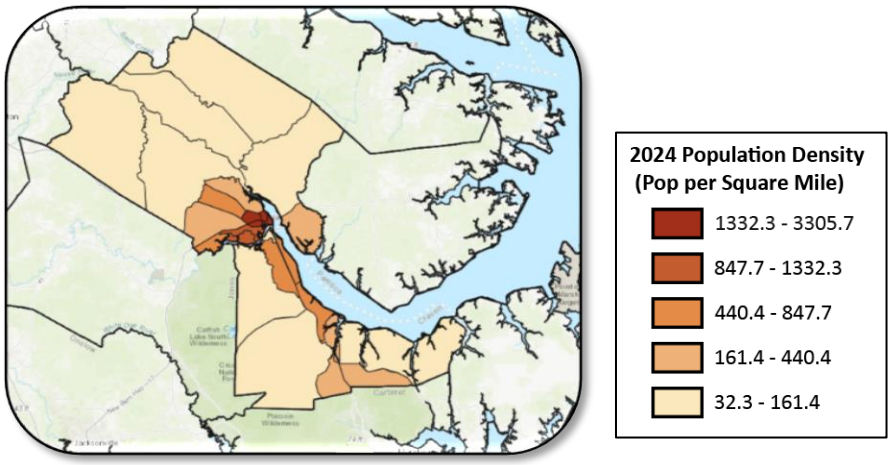
Craven County has a population of 101,230, making up less than 1% of North Carolina's total population.

Table 1: Total Population, 2023[8]

	Craven County	North Carolina	United States
Population	101,230	10,765,678	337,470,185

Craven County has a population density of 142.7 persons per square mile – lower than the population density for North Carolina (214.7 persons per square mile). New Bern is the most densely populated area in the county.

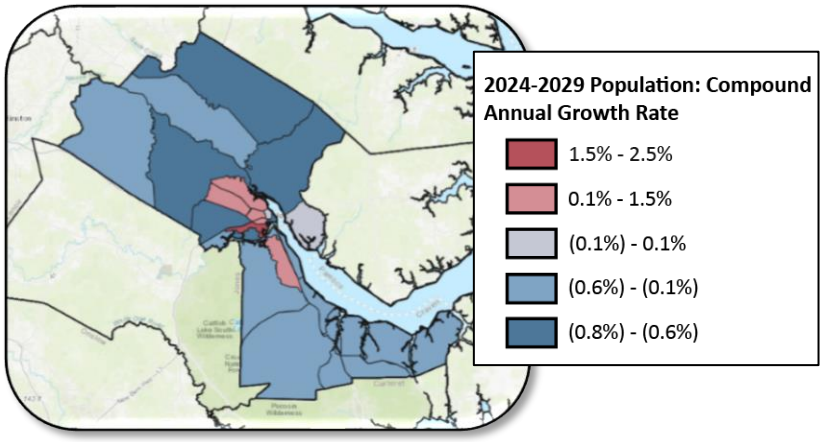
Figure 10: Craven County Map: Population Density[8]



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

In total, the population of Craven County is projected to decline 0.02% annually between 2024 and 2029. Areas in the northeastern parts of the county are experiencing greater declines, while the central part of the county is expected to see annual population growth.

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



Age and Sex Distribution

Data on age and sex helps health providers understand who lives in the community and informs planning for needed health services. The age distribution of Craven County skews slightly older compared to both state and national averages. New Bern has become a popular retirement destination and could explain why our population of 65 and older is higher than state and national averages.

Table 2: Age Distribution, 2023[8]

	Craven County	North Carolina	United States
Percentage below 15	18.2 %	17.9 %	18.1%
Percentage between 15 and 44	37.8 %	39.3 %	39.5 %
Percentage between 45 and 64	23.1 %	25.1 %	24.6 %
Percentage 65 and older	20.9 %	17.7 %	17.8%

Similarly to the sex distribution of North Carolina and the U.S, Craven County skews more female than male.

Table 3: Sex Distribution, 2023[8]

	Craven County		North Carolina		United States	
	Count	Pct. of Total	Count	Pct. of Total	Count	Pct. of Total
Female	53,447	52.8%	5,489,419	51.0%	170,118,720	50.4%
Male	47,783	47.2%	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. Craven County's racial distribution shows that 20.1% of the population is non-Hispanic Black, closely mirroring the state average but significantly higher than the national average of 12.5%. The county's non-Hispanic White population (65.2%) is slightly above both state and national figures. Craven has smaller proportions of Asian, American Indian and Alaska Native (AIAN), and multiracial residents compared to the U.S., indicating less racial diversity in these groups.

Table 4: Racial Distribution, 2023[8]

	Craven County		North Carolina		United States	
	Count	Pct. of Total	Count	Pct. of Total	Count	Pct. of Total
Black (Non-Hispanic)	20,369	20.1 %	2,199,488	20.4 %	42,132,758	12.5 %
White (Non-Hispanic)	66,042	65.2 %	6,590,161	61.2 %	204,562,590	60.6 %
Asian	3,439	3.4 %	379,374	3.5 %	21,088,177	6.2 %
AIAN	427	0.4 %	133,820	1.2 %	3,831,126	1.1 %
NHPI[9]	177	0.2 %	9,214	0.1 %	712,229	0.2 %
Some Other Race Alone	3,192	3.2 %	677, 338	6.3 %	29,432,586	8.7 %
Two or More Races	7,584	7.5 %	776,283	7.2 %	35,710,719	10.6 %

By ethnicity, 7.6% of Craven County's population is Hispanic, lower than the state and national averages.

Table 5: Ethnic Distribution, 2023[8]

	Craven County		North Carolina		United States	
	Count	Pct. of Total	Count	Pct. of Total	Count	Pct. of Total
Non-Hispanic	93,543	92.4 %	9,465,874	88.6 %	271,934,049	80.6 %
Hispanic	7,687	7.6 %	1,299,804	11.4 %	65,536,136	19.4 %

The proportion of foreign-born individuals residing in Craven County is less than 4%, which is significantly lower than state or national figures.

Table 6: Foreign Born Population, 2022[10]

	Craven County	North Carolina	United States
Foreign Born	3.9%	9%	13.9%

[9] Native Hawaiian and Pacific Islander

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

The diversity of Craven County is reflected in the languages that residents speak at home. According to the most recent American Community Survey (ACS), 8% of Craven County residents speak a language other than English at home, compared to around 13% of North Carolina and 22% U.S. residents. Approximately 5% of county residents speak Spanish at home.

Table 7: Language Spoken at Home, 2022[10]

	Craven County	North Carolina	United States
English Only	92%	87.3%	78%
Spanish	5.0%	7.9%	13.3%
Indo-European Languages	0.9%	2.1%	3.8%
Asian and Pacific Islander Languages	1.9%	1.9%	3.6%
Other Languages	0.2%	0.8%	1.2%

Source: ACS 2018-2022 5-Year Estimates

Disability Status[11]

Data on disabilities helps us understand how to create fair and equal opportunities for everyone in the county. In addition, individuals with disabilities may require targeted services and outreach by health and other service providers. Nearly one-fifth of residents in Craven County have a disability, approximately five percentage points higher than state and national figures.

Table 8: Disability Status, 2022[10]

	Craven County	North Carolina	United States
Population with a Disability	18.2%	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. At nearly 16%, the proportion of veterans in Craven is more than double the rates in North Carolina and the U.S.

Table 9: Veteran Status, 2022[10]

	Craven County	North Carolina	United States
Veterans	15.7%	7.8%	6.2%

[11] 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 Craven County is approximately $58,000, notably less than North Carolina and U.S figures.

Table 10: Median Household Income, 2023[8]

	Craven County	North Carolina	United States
Median Household Income	$57,983	$64,316	$72,603

In 2023, one in ten Craven 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 11: Percent of Households Below the Federal Poverty Level, 2023[8]

	Craven County	North Carolina	United States
Percent Below FPL	10.0 %	10.1 %	9.5 %

Higher than the percentage of households below the FPL, approximately 16% of Craven County households received Food Stamps/SNAP (Supplemental Nutrition Assistance Program) in 2022. This is slightly higher than state and national figures.

Table 12: Households Receiving Food Stamps/SNAP, 2022[12,13]

	Craven County	North Carolina	United States
Number of Households Receiving Food Stamps/SNAP	6,732	575,860	16,072,733
Total Number of Households	41,405	4,299,266	129,870,928
Percentage of Households receiving Food Stamps/SNAP	16.3 %	13.4 %	12.4 %

[12] Source (for County): North Carolina Department of Health and Human Services. FNS Cases and Participants (March 2024). https://www.ncdhhs.gov/divisions/social-services/program-statistics-and-reviews/fns-caseload-statistics-reports. Note: county household estimate is from Esri (2023).

[13] Source (for North Carolina and United States): U.S. Census Bureau. "Food Stamps/Supplemental Nutrition Assistance Program (SNAP)." *American Community Survey, ACS 1-Year Estimates Subject Tables, Table S2201,* 2022, https://data.census.gov/table/ACSST1Y2022.S2201?q=s2201&g=010XX00US_040XX00US37&moe=false. Accessed on April 1, 2024.

Craven County has a higher percentage of residents with some college education, but no diploma (25.9%) compared to both state and national averages. The county also has a lower percentage of residents with bachelor's (15.5%) and graduate degrees (9.5%) than the state and national averages. However, the rate of associate's degree attainment (12.2%) is higher than both the state and national averages.

Table 13: Educational Attainment, 2020[14,15]

	Craven County	North Carolina	United States
Less than 9th Grade	4.1%	6.0%	3.5%
Some High School/No Diploma	7.0%	5.5%	5.3%
High School Diploma	21.0%	21.2%	28.5%
GED/Alternative Credential	4.8%	4.3%	*[16]
Some College/No Diploma	25.9%	21.1%	14.6%
Associate's Degree	12.2%	9.9%	10.5%
Bachelor's Degree	15.5%	20.4%	23.4%
Graduate/ Professional Degree	9.5%	11.6%	14.2%

Craven County's overall unemployment rate (5.1%) matches the state average but exceeds the national rate of 3.9%. Unemployment among young adults (16 to 24) is relatively high at 11.4%, slightly below the state average but higher than the national rate. The unemployment rate for those aged 65 and older (4.7%) is notably higher than both state and national figures, indicating economic challenges for older adults in the workforce.

[14] Source (for County and North Carolina): U.S. Census Bureau. "Educational Attainment for the Population 25 Years and Over." *American Community Survey, ACS 5-Year Estimates Detailed Tables, Table B15003,* 2020, https://data.census.gov/table/ACSDT5Y2020.B15003?q=b15003&g=040XX00US37,37$0500000&moe=false. Accessed on April 1, 2024.

[15] Source (for United States): U.S. Census Bureau. "Educational Attainment in the United States: 2022." Table 1, All Races. https://www.census.gov/data/tables/2022/demo/educational-attainment/cps-detailed-tables.html.

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

Table 14: Unemployment, 2022[17,18]

	Craven County	North Carolina	United States
Percentage unemployed ages 16 to 24	11.4 %	12.4 %	11.0%
Percentage unemployed ages 25 to 54	4.9 %	4.7 %	3.4%
Percentage unemployed ages 55 to 64	2.2 %	3.3 %	2.7%
Percentage unemployed ages 65 or more	4.7 %	3.0 %	2.9%
Total unemployment	5.1 %	5.1 %	3.9%

Craven County's overall uninsured rate (10.1%) is lower than both state and national averages. However, 18.8% of residents aged 19 to 34 and 7.1% of residents under the age of 19 are uninsured, which is higher than both state and national rates, highlighting a coverage gap for young people.

Table 15: Health Insurance Status, 2022[19]

	Craven County	North Carolina	United States
Percentage uninsured ages 18 or below	7.1 %	5.2 %	5.4 %
Percentage uninsured ages 19 to 34	18.8 %	15.5 %	13.6 %
Percentage uninsured ages 35 to 64	10.3 %	12.5%	9.9%
Total % Uninsured	10.1 %	15.0%	12.0%

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

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

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

Social Determinants of Health

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

Figure 12: Social Determinants of Health

As seen in **Figure 12**, many of the factors that contribute to health are hard to control or societal in nature. As such, health and healthcare organizations need to consider many underlying factors that may impact an individual's health and not simply their current health conditions.

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

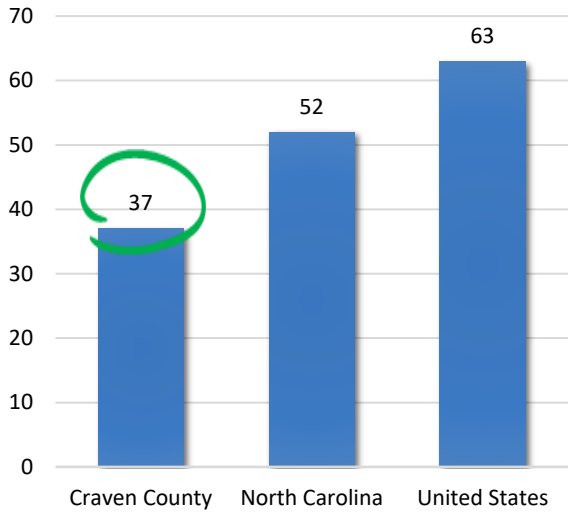
An analysis of the racial and geographic disparities that emerged in the information obtained and analyzed during this process is detailed below. The CHNA Steering Committee also collected new data via focus groups and surveys to ensure that residents and key community health leaders could provide input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

Disparities

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

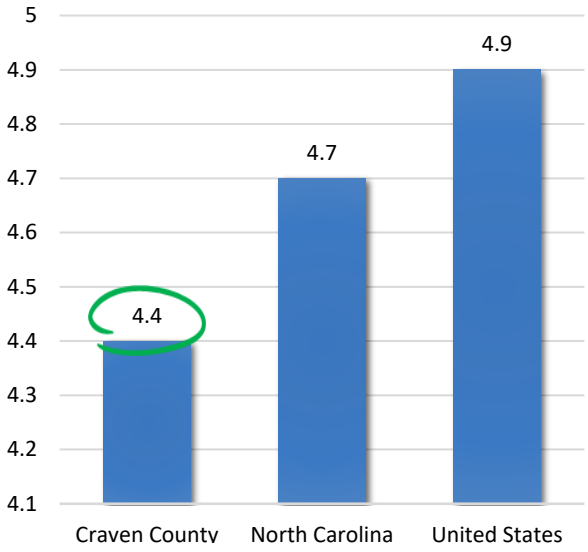
Residential segregation is measured by the index of dissimilarity, a demographic measure ranging from 0 to 100 that represents how evenly two demographic groups are distributed across a county's census tracts. Lower scores represent a higher level of integration. There is less residential segregation in Craven compared to the state and country, as seen in **Figure 13**.

Figure 13: Residential Segregation[5]



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

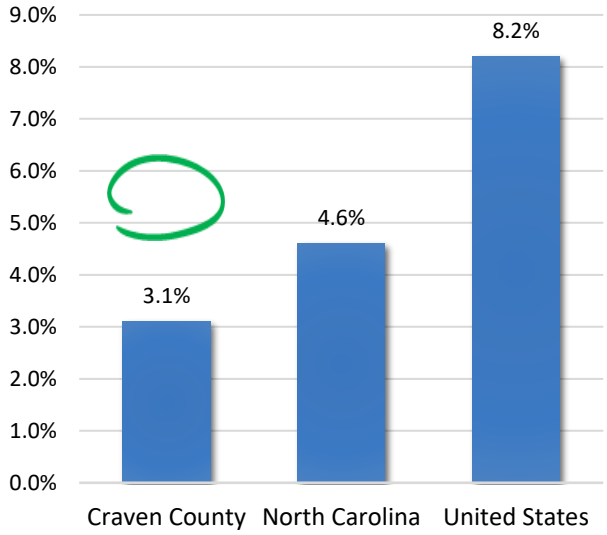
Figure 14: Income Inequality Ratio[5]



People with limited English proficiency (LEP) may face challenges accessing care and resources that fluent English speakers do not. Language barriers may make it hard to access transportation, medical, and social services as well as limit opportunities for education and employment. Importantly, LEP community members may not understand critical public health and safety notifications, such as safety-focused

communications during the COVID-19 pandemic. Fewer people are not fluent in English in Craven compared to the state and country, as seen in **Figure 15**.

Figure 15: Percent of Population with Limited English Proficiency[10]



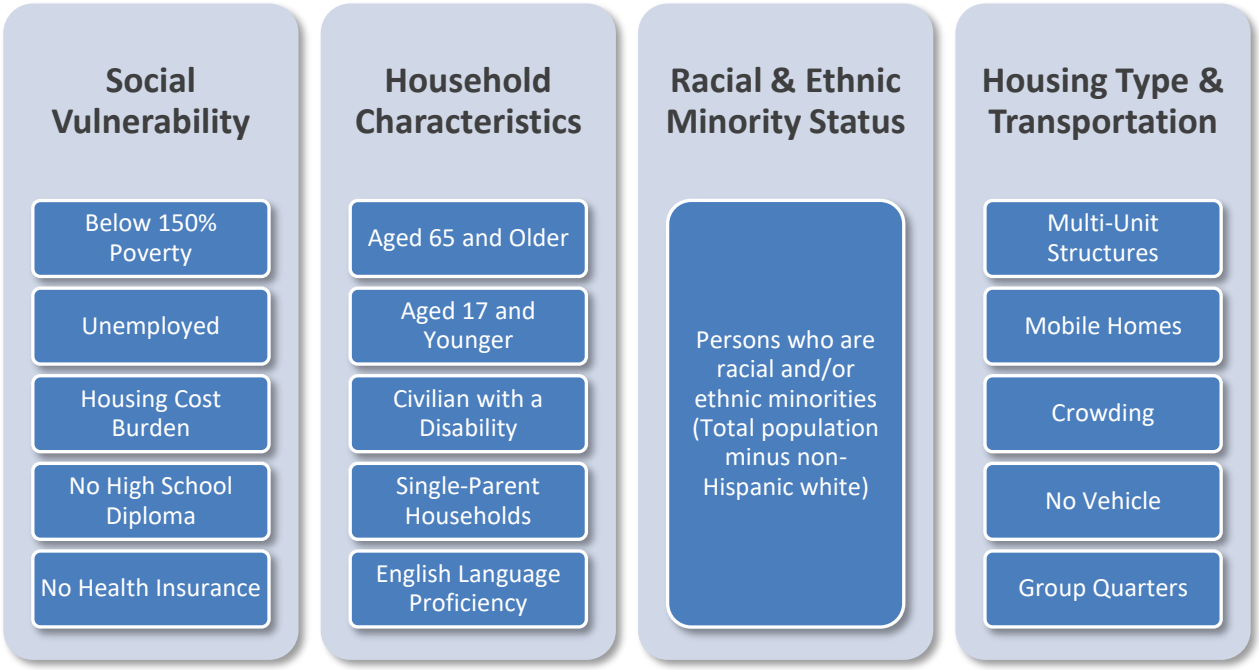
Social Vulnerability Index

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.[20] Communities with a higher SVI score are generally at a higher risk for poor health outcomes. Instead of relying on public health data alone, the SVI accounts for underlying economic and structural conditions that affect overall health, including SDoH. SVI scores are calculated at the census tract level and based on U.S. Census variables across four related themes: socioeconomic status, household characteristics, racial and ethnic minority status, and housing type/transportation. **Figure 16** outlines the variables used to calculate SVI scores.

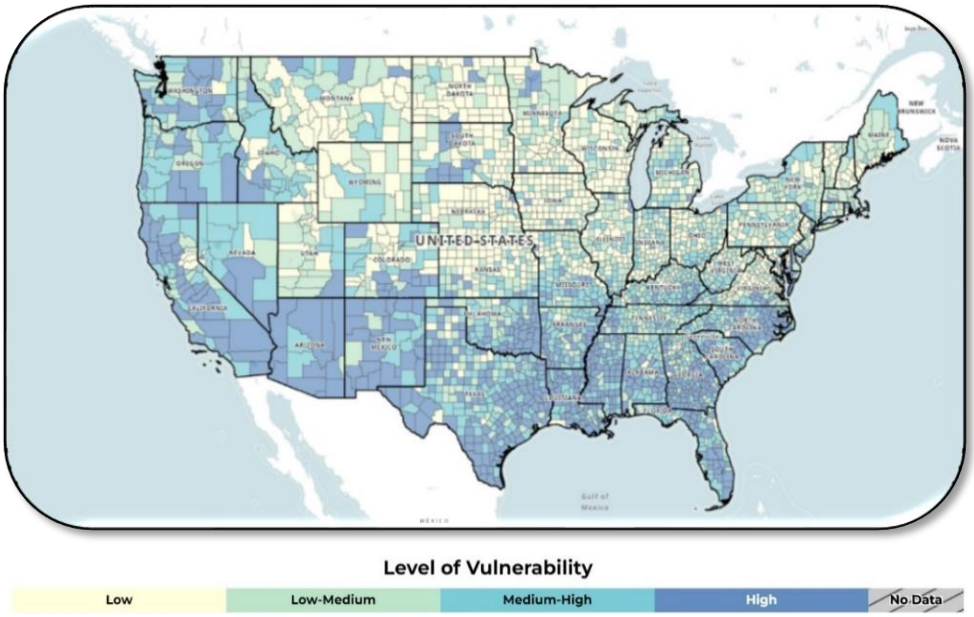
[20] CDC/ATSDR Social Vulnerability Index (SVI). Retrieved from https://www.atsdr.cdc.gov/placeandhealth/svi/index.html.

Figure 16: SVI Variables



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

Figure 17: United States SVI by County, 2022



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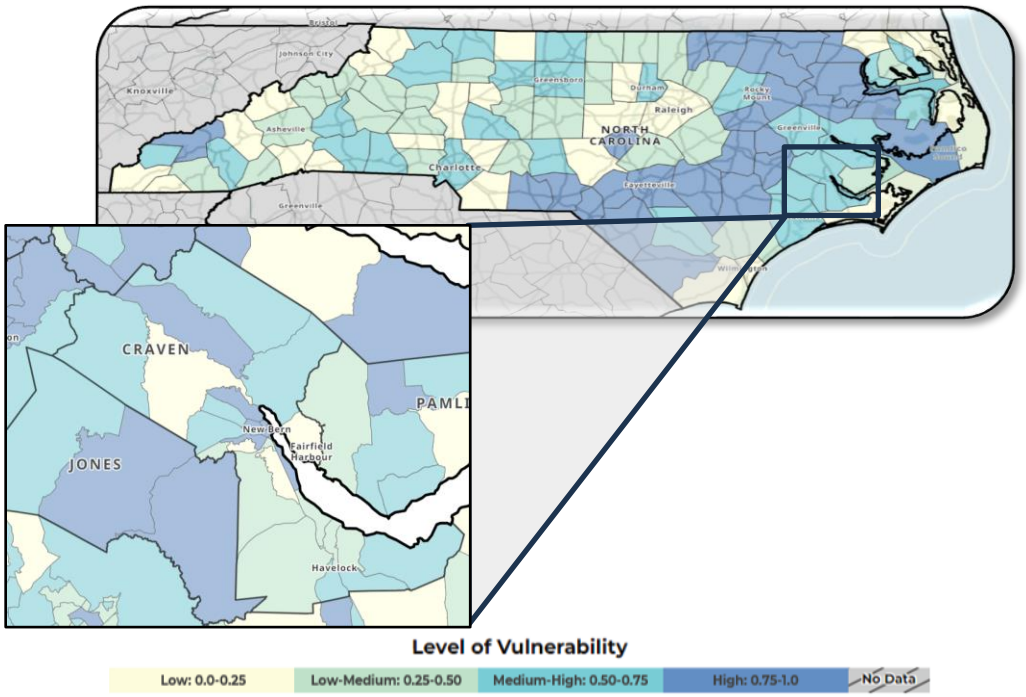
The 2022 SVI scores for Craven County are shown in **Figure 18** below. Possible scores range from 0 (lowest vulnerability) to 1 (highest vulnerability), and these scores show a relative comparison with other counties and census tracts in North Carolina. The vulnerability of Craven County overall is higher than average compared to the state. Levels of vulnerability are variable across the county with the average being 0.53.

Figure 18: Craven County SVI by Census Tract, 2022



Environmental Justice Index

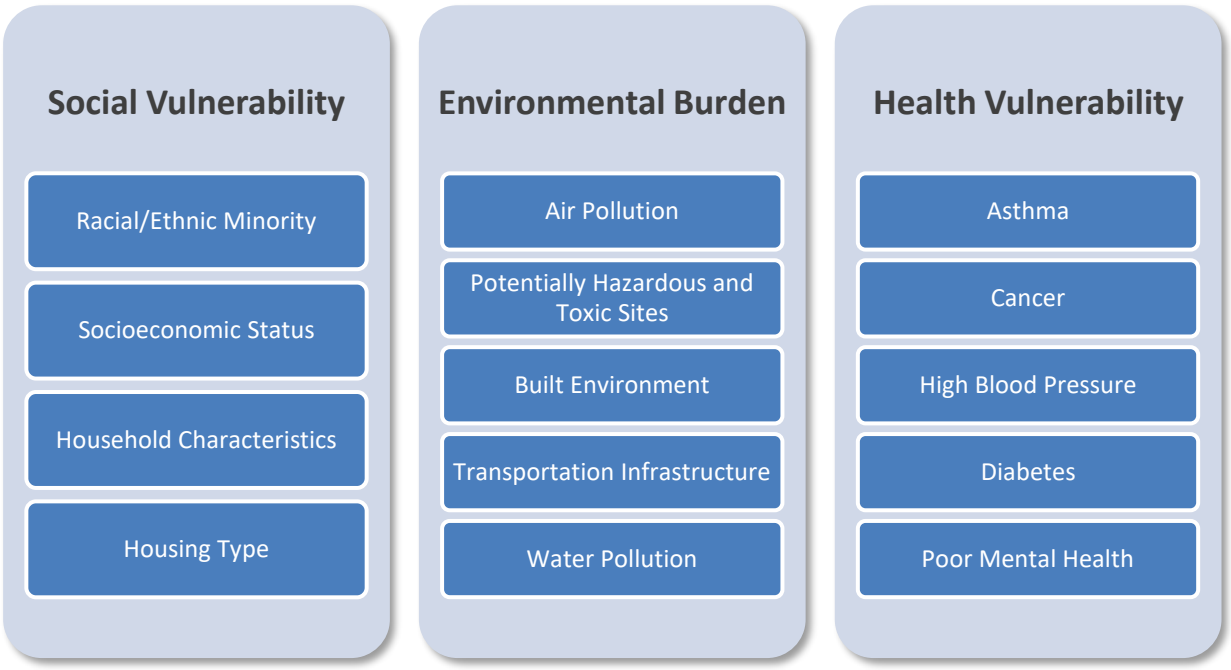
Environmental justice means the just treatment and meaningful involvement of all people, regardless of income, race, color, national origin, Tribal affiliation, or disability, in agency decision-making and other Federal activities that affect human health and the environment. It aims to protect everyone 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.[21]

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 19** outlines the variables used to calculate EJI scores.

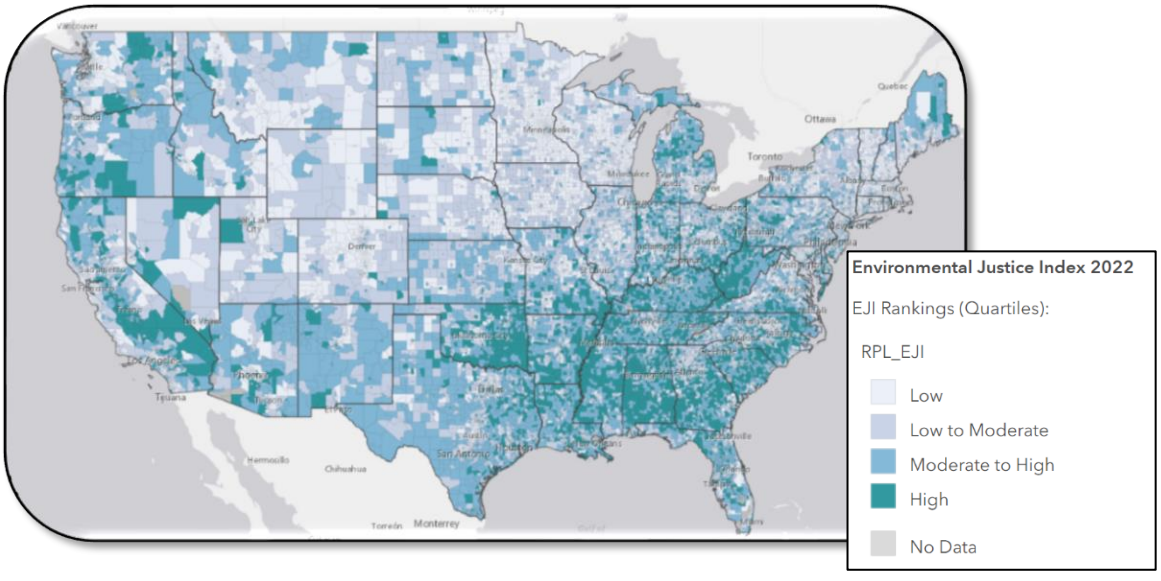
[21] U.S. Environmental Protection Agency (2024). Retrieved from https://www.epa.gov/environmentaljustice

Figure 19: EJI Variables



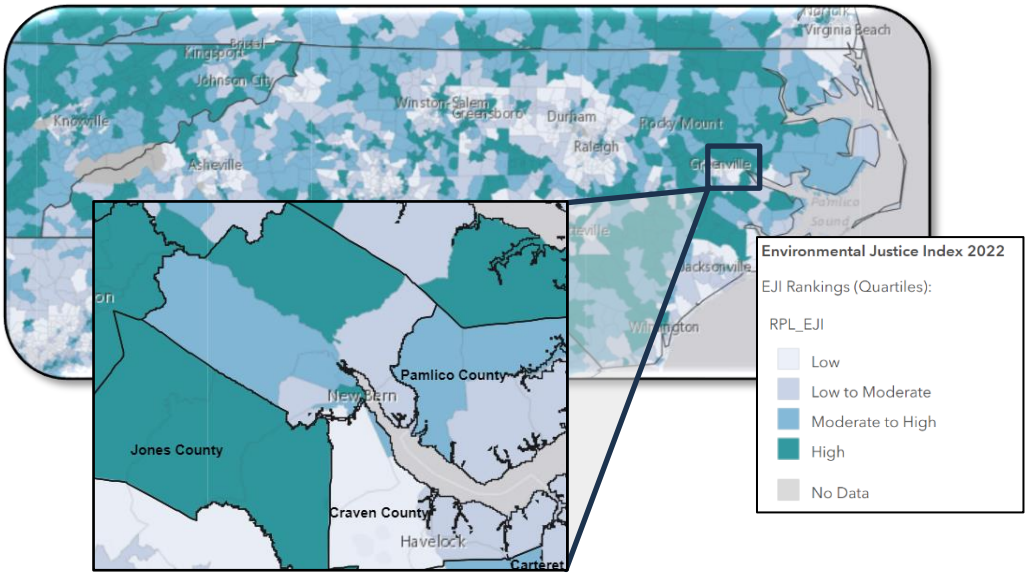
The United States EJI by county is shown in **Figure 20**below. As shown, a lot of variation exists across the country, and even within individual states.

Figure 20: United States EJI by Census Tract, 2022



The 2022 EJI scores for Craven County range from low to moderate as shown in **Figure 21** below. EJI scores use percentile ranking which represents the proportion of census tracts that experience environmental burden relative to other census tracts in North Carolina. The index ranges from 0-1 with higher scores indicating more environmental burden compared to other census tracts. Levels of environmental burden are variable across the county with the average being 0.48

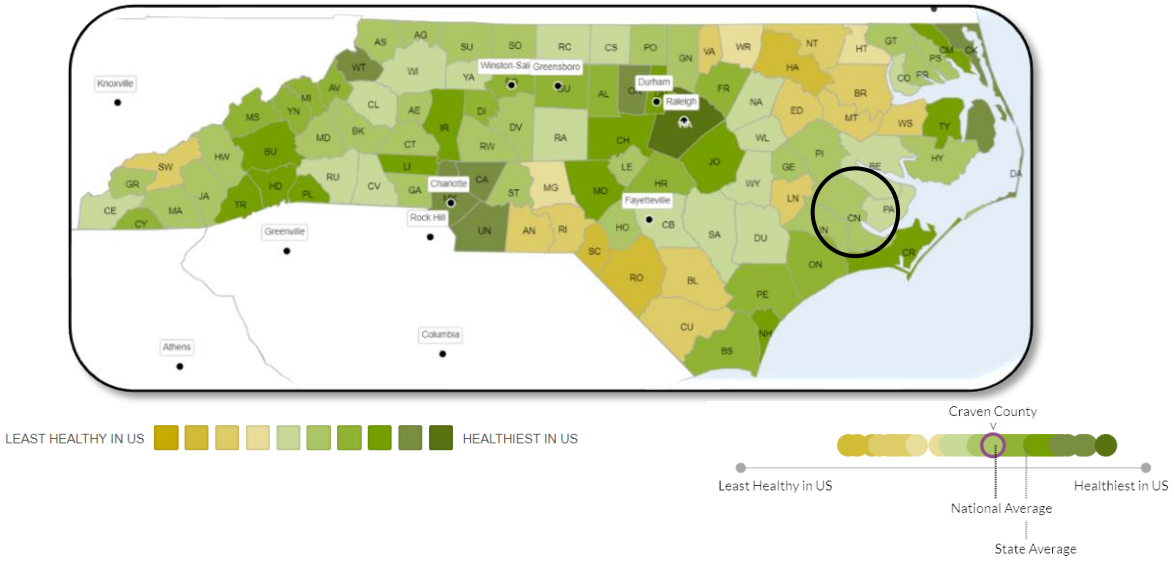
Figure 21: Craven County EJI by Census Tract, 2022



Health Outcome and Health Factor Rankings

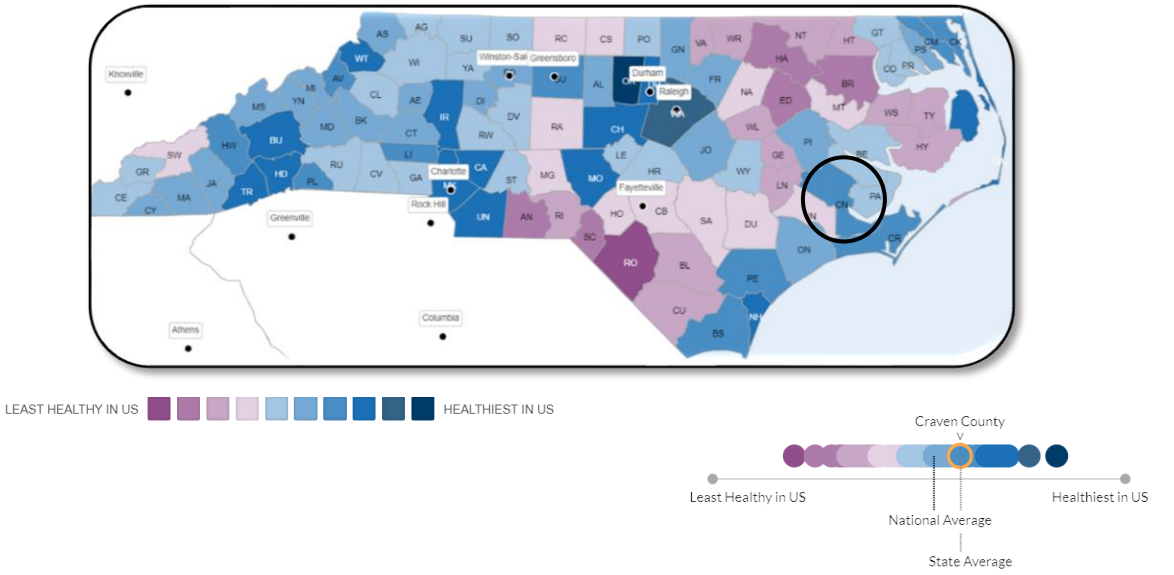
County leaders also reviewed and analyzed data from the Robert Wood Johnson Foundation and the University of Wisconsin County Health Rankings for the year 2024. The Health Outcomes measure looks at how long people in a community live and how physically and mentally healthy they are. These categories are discussed further in Appendices 2 through 4. Craven County falls slightly behind the state average and comparable to the national average for health outcomes

Figure 22: State Health Outcomes Rating Map[5]



The Health Factors measure looks at variables that affect people's health including health behaviors, clinical care, social & economic factors, and the physical environment they live in. More details about these indicators can be found in Appendices 2 through 4. Craven County is comparable to the average in North Carolina for health factors.

Figure 23: State Health Factors Rating Map[5]



CHAPTER 3 | PRIORITY NEED AREAS

This chapter describes each of the three priority areas in more detail and discusses the data that supports each priority. The information in this section includes context and national perspective, secondary data findings, and primary data findings (including the community member survey and focus groups). As previously described in **Chapter 1: Methodology**, secondary data was primarily sourced using the North Carolina Data Portal. For additional descriptive information on data sources and methodology, please see **Appendix 2**.

On August 26, 2024, stakeholders gathered at the Craven County Health Department (CCHD) to identify and prioritize the community's most pressing health needs for the 2024 Community Health Needs Assessment. Participants included leadership from both the health department and the local hospital system, with representatives from CCHD and CarolinaEast Health System. The group also included key community partners from Craven County DSS, Craven County Recreation & Parks, Craven County Schools, Craven County Senior Services, and Realize U 252. After reviewing primary and secondary data and discussing the demographics of Craven County's population, the multi-voting technique was used to determine three priority areas for the county.

As mentioned previously, these priority needs areas are not listed in any hierarchical order of importance and all will be addressed by the Craven 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 Craven 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.[22] Access is a challenge even for those who are insured.[23]

The availability and distribution of health providers in the U.S. contributes to healthcare access challenges. According to the Association of American Medical Colleges (AAMC), there is estimated to be a shortage of 13,500 to 86,000 physicians in the U.S. by 2036, which will impact both primary and specialty care.[24] 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.[25] 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.[26] Access is also impacted by the number of actively practicing physicians overall. In 2020, there were just 9,211 primary care physicians in North Carolina, with 27,650 physicians actively practicing overall.[26]

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

Secondary Data Findings

Secondary data analysis revealed several key access challenges facing Craven County residents. The county faces shortages across multiple provider types, including lower rates of dental providers (28.8 per 100,000 population) compared to both state (31.5) and national averages (39.1). While the county's rate

[22] 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.

[23] 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.

[24] 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 .

[25] 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 .

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

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

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

of primary care providers (104.3 per 100,000) is slightly higher than the state average (101.1), it remains below the national figure (112.4).

Table 16: Provider Rates by Type

Indicator	Craven County	North Carolina	United States
Dental Providers (Rate per 100,000 Population)	28.8	31.5	39.1
Primary Care Providers (Rate per 100,000 Population)	104.3	101.1	112.4

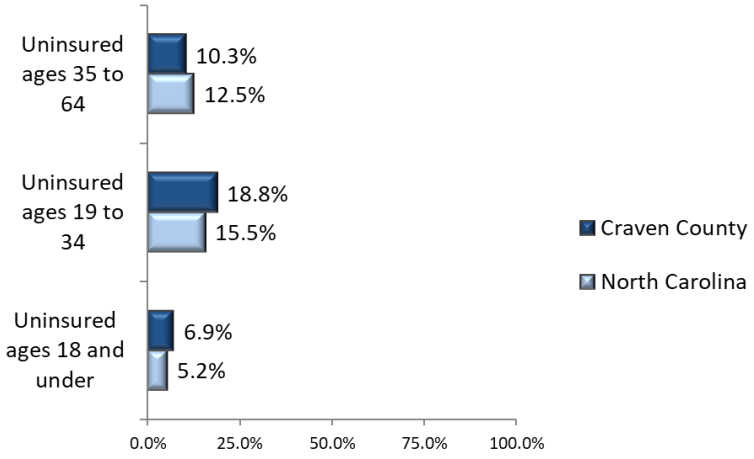
More than one-third (36%) of Craven County's population lives in an area designated as a Dental Health Professional Shortage Area, compared to 34% statewide and 18% nationally. The county also has a lower rate of Federally Qualified Health Centers (0.9 per 100,000 population) compared to both state (4.0) and national (3.5) averages, potentially limiting access points for care.

Table 17: Population Living in a Dental Care HSPA and Rate of FQHCs

Indicator	Craven County	North Carolina	United States
Percentage of Population Living in an Area Affected by a Dental Care HPSA	36%	34%	18%
Rate of Federally Qualified Health Centers (Rate per 100,000 Population)	0.9	4.0	3.5

Insurance coverage presents another barrier to accessing care. While 22% of Craven County's insured population receives Medicaid, similar to national figures, the uninsured rates vary significantly by age group. The county's uninsured rate is particularly high among adults aged 19 to 34 at 18.8%, compared to 15.5% for the state.

Figure 24: Uninsured Rates by Age Group



Transportation challenges may also impact access to care. While 6% of households in Craven County have no motor vehicle (compared to 5.4% statewide), there is no public transit system available for the purpose of seven day a week travel throughout the county. Craven Area Rural Transit System (CARTS) is a limited transit system that operates in Craven County, Monday through Friday, providing transportation for shopping, medical appointments, and work. The data shows 0% of the population lives within a half-mile of public transit, compared to 10.9% statewide and 34.8% nationally.

Table 18: Transportation Options and Transit

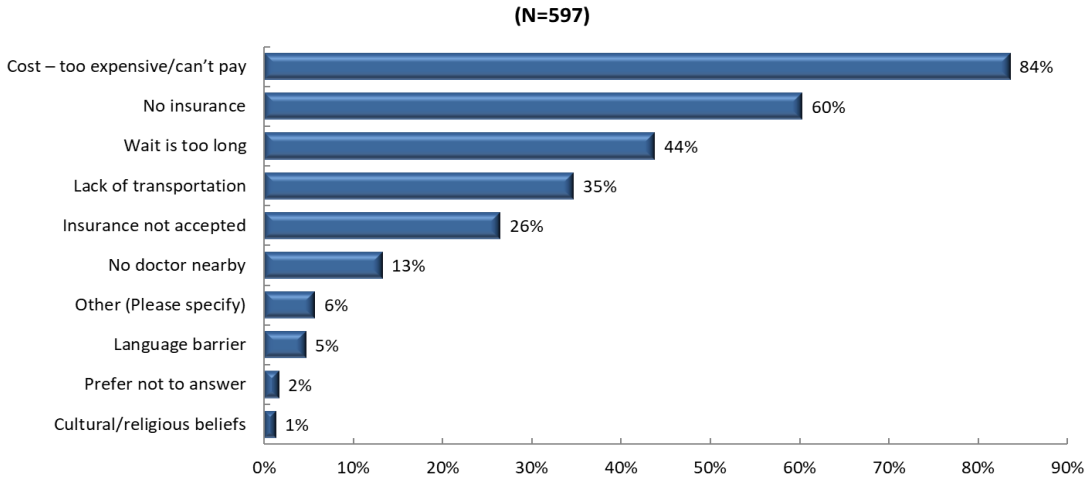
Indicator	*Craven County*	*North Carolina*	*United States*
Households with No Motor Vehicle, Percent	*6.0%*	*5.4%*	*8.3%*
Percent Population Using Public Transit for Commute to Work	*0.0%*	*0.8%*	*3.8%*
Percentage of Population within Half Mile of Public Transit	*0.0%*	*10.9%*	*34.8%*

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

Primary Data Findings – Community Member Web Survey

Nearly 600 Craven County residents responded to the web-based survey. Respondents identified several access to care needs in Craven County. In the survey, community members were asked to identify the top barriers to receiving healthcare. Cost (84%), no insurance (60%), and long wait times (44%) were the top three identified reasons why people in the community are not getting care when they need it. Another third of responses identified lack of transportation and a quarter of responses indicated insurance not being accepted as major barriers to care.

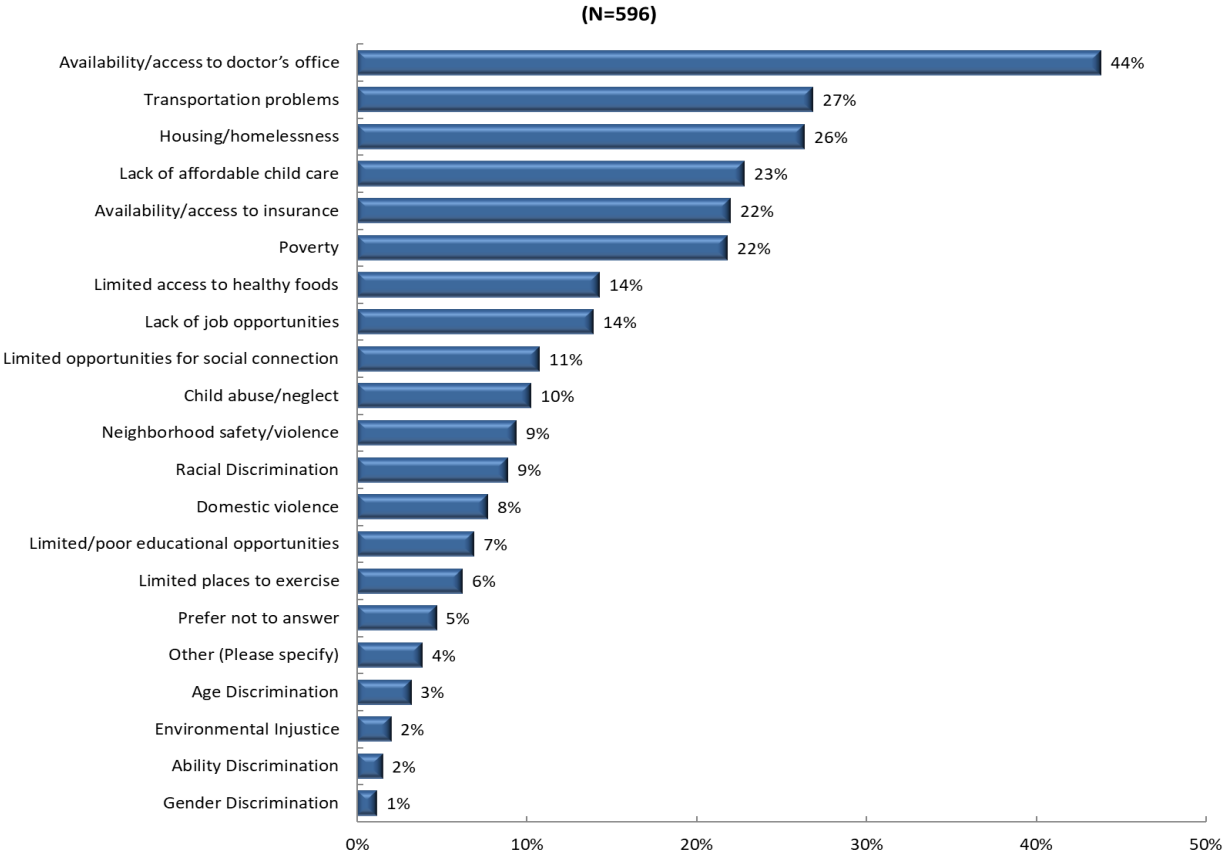
Figure 25: What are the three most important reasons people in your community do not get health care when they need it? Please select up to three.



When these data were examined by age, the age group that most frequently identified cost (88%) and no insurance (67%) as top barriers was those aged 45 to 65. Lack of transportation (43%) and long wait times as barriers (47%) were identified most frequently by respondents aged 25 to 44 compared to all other age groups. Responses also differed by race. Nearly 47% of respondents identifying as Black or African American noted lack of transportation as a top barrier to healthcare compared to 33%% of respondents identifying as White and 30% of respondents identifying with the "Other" race category, including those who identified as American Indian and Alaska Native, Asian, Native Hawaiian and other Pacific Islander, and/or those who selected more than one race or "other." By contrast, respondents identifying as White (48%) named long wait times more frequently compared to respondents identifying as Black or African American (22%) or with other racial identities (33%).

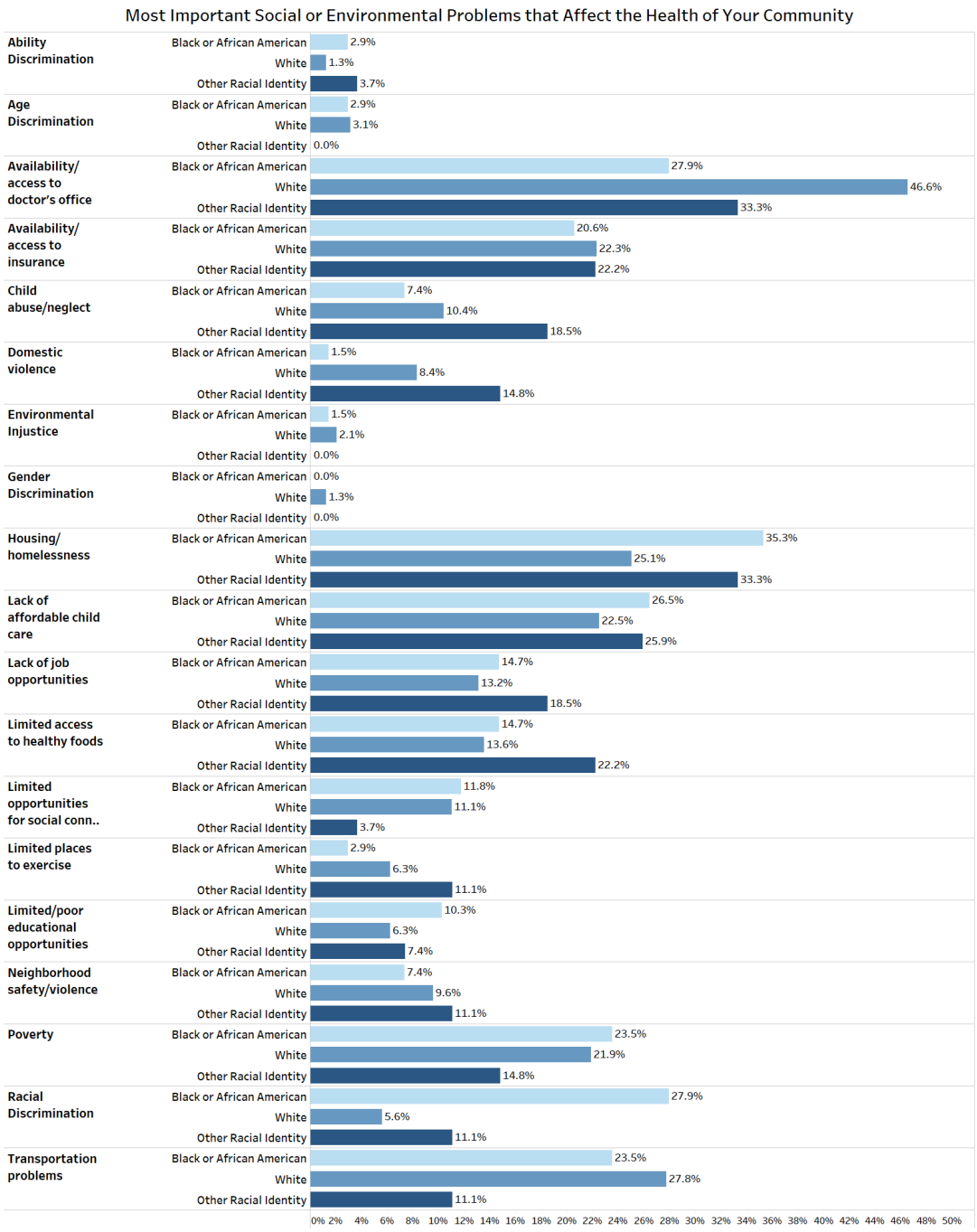
Community members were also asked to identify the most important social or environmental problems that affect the health of the community. As displayed in the figure below, the most frequent problem identified was the availability or access to doctor's offices (44%), again highlighting access to care challenges within the community. Transportation (27%) was identified as the second most frequent social or environmental problem that affects the health of the community.

Figure 26: What are the three most important social or environmental problems that affect the health of your community? Please select up to three.



Notably, men and women differed in their responses. More women identified availability and access to doctor's offices as a top social and environmental problem (46% for women vs. 31% for men). Women were also more likely than men to identify transportation problems as an important social and environmental problem (29% compared to 19%). Responses also varied by race. Those identifying as White were more likely to cite availability of doctor's offices, availability or access to insurance, and transportation than all other races (White: 47%, 22%, 28%; Black or African American: 28%, 21%, 24%; All Other: 33%, 22%, 11%).

Figure 27: What are the three most important social or environmental problems that affect the health of your community? Please select up to three. (by race)



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

Primary Data Findings – Focus Groups

Focus group participants in Craven County identified several key barriers related to accessing healthcare services. These barriers span across various dimensions including transportation, cost, availability of services, and cultural factors. Participants emphasized how these access issues disproportionately affect certain demographic groups, particularly those with lower incomes, rural residents, and historically marginalized communities. Transportation challenges were frequently mentioned, especially for rural residents and those without personal vehicles. The high costs of care and lack of health insurance coverage were also significant concerns. Many participants noted long wait times for appointments and limited availability of healthcare providers in the area. Language barriers and cultural factors were highlighted as impacting access for non-English speaking residents. There was also a general lack of awareness about available healthcare resources and services in the community, with many expressing difficulties in navigating the healthcare system, particularly for complex health needs. The limited availability of specialty care services within the county was another key issue raised.

Focus group participants suggested several potential solutions to address these access issues, including expanding public transportation options, increasing the number of providers who accept Medicaid, and improving community education about available healthcare resources. The groups also highlighted the need for more culturally competent care and translation services to better serve Craven County's diverse population.

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

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

Context and National Perspective

The definition of behavioral health often describes conditions related to both mental health and substance use.[29] Mental health is defined as an emotional, psychological, and social state of well-being. Mental health impacts every stage of life and affects how one is able to handle their relationships, daily stressors, and health behaviors.[30] After evaluating data from a variety of sources including surveys and focus groups conducted throughout the assessment process, the Steering Committee identified behavioral health/mental health, including both mental health and substance use, to be an area of urgent need within Craven County.

Mental illnesses are common in the United States: in 2021, an estimated 57.8 million U.S. adults – nearly one in five – were living with a mental illness.[31] There is risk for developing a mental illness across the lifespan, with over one in five children and adults in the U.S. reported to have a mental illness, and nearly one in twenty-five adults currently coping with a serious mental illness (SMI) such as major depression, schizophrenia or bipolar disorder. [32]

[29] Source: American Medical Association (2022). *What is behavioral health?* Retrieved September 13th, 2023, from https://www.ama-assn.org/delivering-care/public-health/what-behavioral-health.
[30] Source: CDC. (2024). About mental health. Retrieved October 1, 2024, from: https://www.cdc.gov/mentalhealth/learn/index.htm
[31] Source: National Institute of Mental Health (2023). *Mental Illness*. Retrieved September 13th, 2023, from https://www.nimh.nih.gov/health/statistics/mental-illness.
[32] Source: CDC. (2024). Mental health. Retrieved October 1, 2024, from https://www.cdc.gov/mentalhealth/learn/index.htm

Mental illness can occur due to multiple different factors, such as genetics, drug and/or alcohol usage, isolation, adverse childhood experiences, and chronic health conditions. Additionally, mental illness can act like other chronic health conditions, in that it can worsen or improve depending on the environment. Mental health services have evolved in the past five years, especially during the COVID-19 pandemic. However, accessing mental health care services can be challenging. According to the National Institute of Mental Health, less than half (47.2%) of adults with a common mental illness received any mental health services in 2021. Those who had an SMI were more likely (65.4%) to have received mental health services that same year.[33] While access to telehealth mental health services has increased, those living in rural areas may still find it difficult to access care. This is a particular concern among those who are low-income or experiencing homelessness, two groups at high risk for developing an acute or chronic mental health condition. As of 2023, over seven million people in the U.S. who reported having a mental illness lived in a rural area.[34]

Mental illness is a prevalent concern in North Carolina, with nearly 1.5 million adults reported to have a mental health condition in 2023. Additionally, that same year, 1 in 7 individuals who were identified as homeless also were living with an SMI. Access to mental health care in North Carolina is changing, however it is still unavailable to many. Specifically, over 452,000 individuals did not seek care in 2023, with 44.8% citing cost as the main reason. Additionally, those living 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.[35]

Substance use disorders (SUDs) are one of the fastest rising categories of behavioral health disorders. According to the American Psychiatric Association, SUDs are a complex condition in which there is uncontrolled use of a substance (such as alcohol or drugs), despite harmful consequences.[36] SUDs often occur in conjunction with other mental 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.[37] These trends have been increasing in recent years. According to the National Center for Drug Abuse Statistics, in 2018 (3.7%) of all adults aged 18 and older (9.2 million) had both an AMI and at least one SUD.[38] By 2021, this had increased to 13.5% of U.S. adults, with the highest incidence among Multiracial adults.

There are multiple common forms of SUD, such as alcohol use, cocaine use, cannabis use, opioid use, and methamphetamine use disorders. An individual living with one SUD can also be coping with another at the same time, such as co-occurring use of alcohol and cannabis.[39] Treating SUDs generally cannot follow a cookie-cutter approach, as each person receiving treatment will have different withdrawal and coping

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

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

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

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

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

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

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

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.[40]

Substance use disorders have also had an impact in North Carolina. Over 36,000 overdose deaths occurred in the state between 2000 and 2022 – an average of more than 1,600 deaths each year.[41] Multiple programs have been developed in North Carolina to combat substance use disorder, notably surrounding opioid usage, which has led to an increase in access and usage of Medication Assisted Treatment (MAT) and methadone clinics within the state. Additionally, North Carolina launched the Opioid and Substance use action plan, which involved the development of multiple interventions, dashboards, and educational materials to help support counties and organizations with reducing not only overdose deaths, but the incidence of SUDs as well.

The pandemic impacted public mental health and well-being in many ways. Community members continue to grapple with the pandemic-related effects of isolation and loneliness, financial instability, long-term health impacts and grief, all of which are drivers for developing a substance use disorder. In addition, both drug overdose and suicide deaths have sharply increased over the past several years – often disproportionately impacting younger people and communities of color.[42]

Access to services that address mental health and substance use is an ongoing challenge across the U.S. According to the Substance Abuse and Mental Health Services Administration (SAMHSA), in 2021, less than half (47.2%) of U.S. adults who reported having a mental illness utilized any type of mental health services, including inpatient, outpatient or telehealth services or prescription drug therapies. Demand for mental health services, particularly anxiety and depression treatment, remains high across the nation, while the prevalence of stress- and trauma-related disorders, along with substance use disorders, continues to grow. The American Psychological Association reports that the percentage of psychologists in the U.S. seeing more patients than they did before the pandemic increased from 15% in 2020 to 38% in 2021 to 43% in 2022. Further, 60% of psychologists reported having no openings for new patients and 38% maintained a waitlist for their services.

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

[41] Source: NCDHHS. (2022). *Overdose epidemic.* Retrieved October 3, 2024 from: https://www.ncdhhs.gov/about/department-initiatives/overdose-epidemic#:~:text=Combating%20North%20Carolina's%20Opioid%20Crisis,is%20devastating%20families%20and%20communities.

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

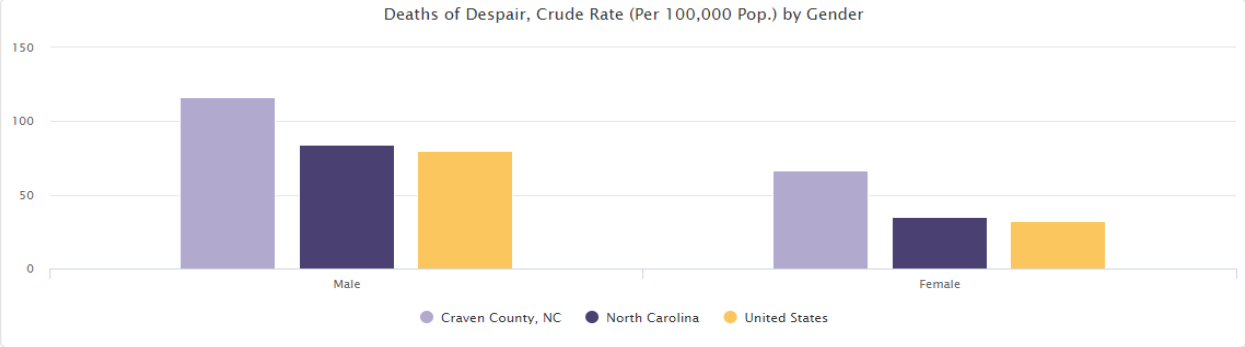
Secondary Data Findings

Secondary data analysis highlighted significant behavioral health challenges in Craven County, encompassing both mental health concerns and substance use disorders. The county's crude death rate for deaths of despair (including suicide, alcohol-related deaths, and drug overdoses) is 91.6 per 100,000 population, substantially higher than both state (58.7) and national (55.9) averages. As seen in **Figure 3.5** below, there are also notable gender disparities in the crude rate of deaths of despair. The suicide rate in Craven County is 18.3 per 100,000 population, also exceeding state (14.0) and national (14.5) figures.

Table 19: Mental Health Indicators

Indicator	Craven County	North Carolina	United States
Deaths of Despair (Crude Rate per 100,000 Population)	91.6	58.7	55.9
Suicide (Rate per 100,000 Population)	18.3	14.0	14.5
Average Number of Poor Mental Health Days (per Month)	4.7	4.6	4.9

Figure 28: Deaths of Despair, Crude Rate (Per 100,000) by Gender



Substance use disorders present particular challenges in Craven County. While the percentage of adults reporting excessive drinking (17%) is slightly lower than state and national averages (18%), the county faces more severe outcomes related to substance use. The opioid overdose death rate in Craven County (48.0 per 100,000 population) is notably higher than the state average (25.1). Emergency department utilization for opioid use disorder is also elevated at 46 visits per 100,000 beneficiaries, compared to 43 statewide and 41 nationally.

Table 20: Substance Use Indicators

Indicator	Craven County	North Carolina	United States
Percentage of Adults Reporting Excessive Drinking	17%	18%	18%
Opioid Use Disorder Emergency Department Utilization (Rate per 100,000 Beneficiaries)	46	43	41
Alcohol-Involved Crash Deaths, Annual (Rate per 100,000 Population)	2.4	2.9	2.3
Opioid Overdose Death Rate (Crude Rate per 100,000 Population)	48.0	25.1	N/A

Mental health provider access remains a concern, though the county's rate of 160.8 providers per 100,000 population is slightly higher than the state average (155.7) but lower than the national figure (178.7). The county's limited number of substance abuse providers (18.9 per 100,000 population) compared to state (25.0) and national (27.9) averages may impact treatment accessibility. Additionally, the rate of buprenorphine providers (3.9 per 100,000) is substantially lower than both state (15.2) and national (15.5) averages, potentially affecting medication-assisted treatment options for opioid use disorder.

Table 21: Substance Abuse and Mental Health Providers

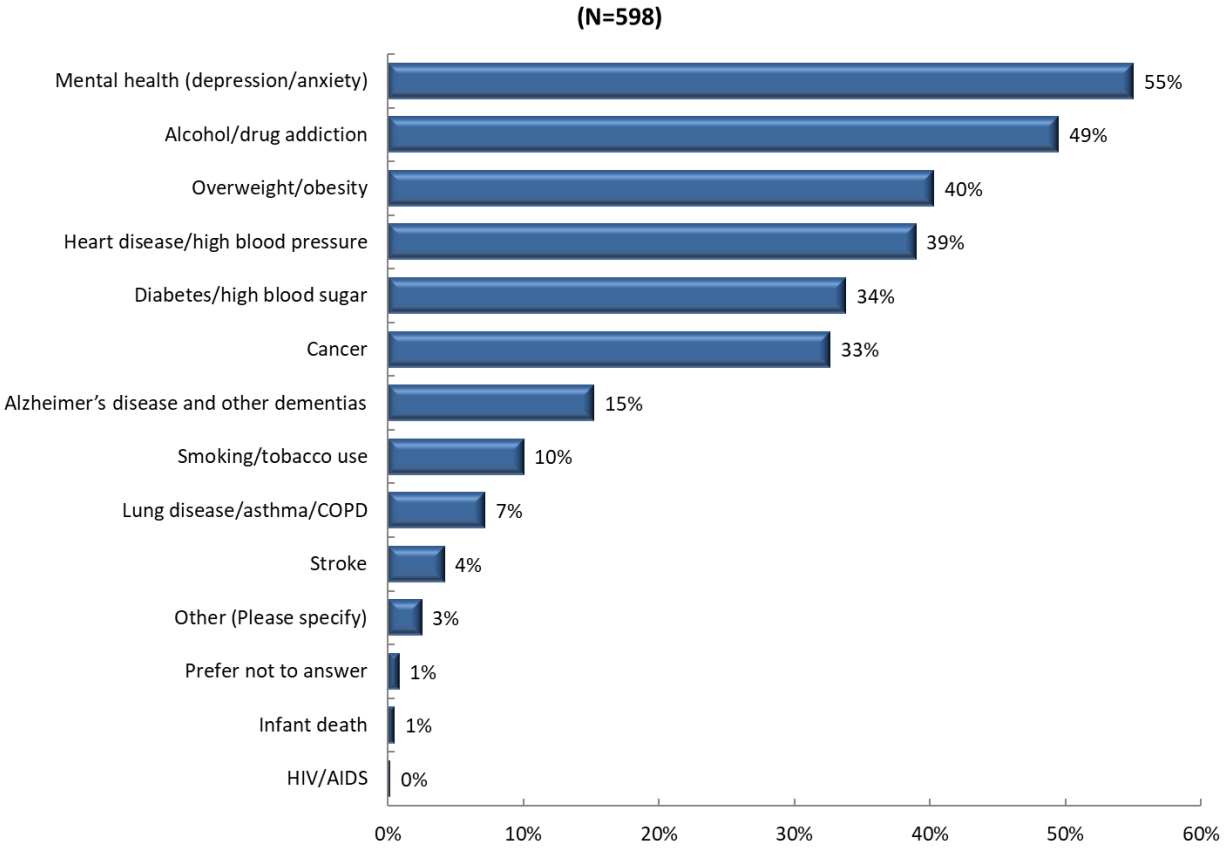
Indicator	Craven County	North Carolina	United States
Substance Abuse Providers (Rate per 100,000 Population)	18.9	25.0	27.9
Buprenorphine Providers (Rate per 100,000 Population)	3.9	15.2	15.5
Mental Health Providers (Rate per 100,000 Population)	160.8	155.7	178.7

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

Primary Data Findings – Community Member Web Survey

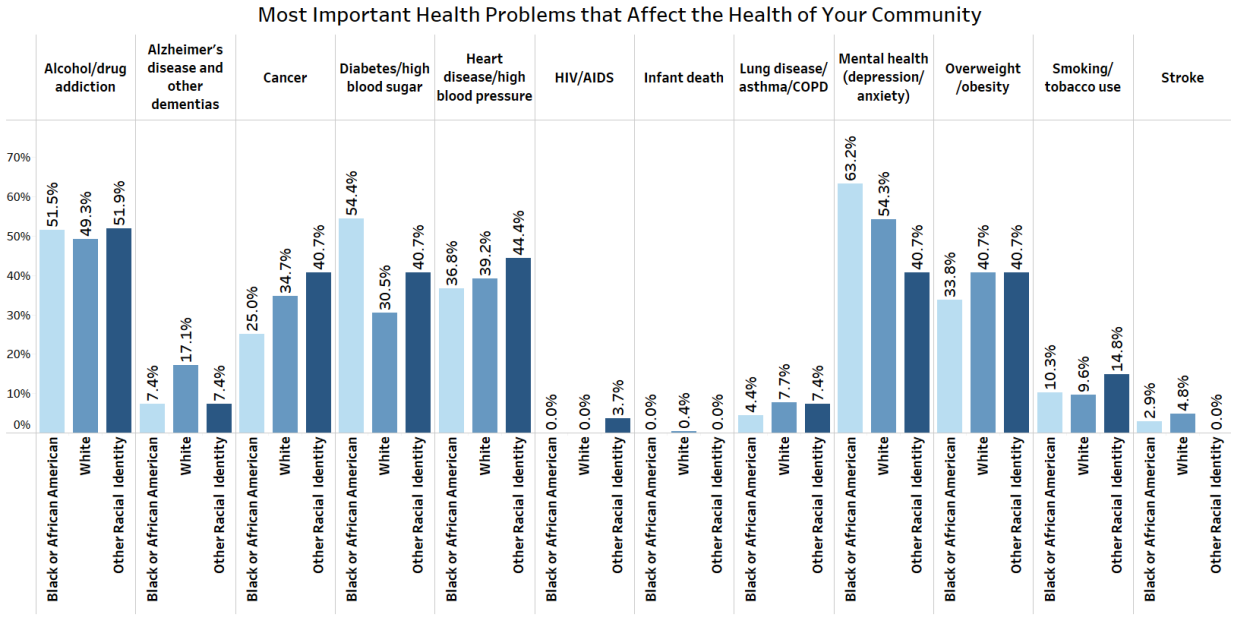
Craven County residents highlighted different aspects of behavioral health as areas of community concern on the web-based survey. When asked to identify the most important community health needs, 55% of these respondents identified mental health (depression/anxiety) and 49% of respondents identified alcohol/drug addiction. These were the most frequent and second most frequent of all community health needs identified, respectively.

Figure 29: What are the three most important health problems that affect the health of your community? Please select up to three.



However, when these data were examined by the race of community member respondents, differences emerged. Mental health (depression/anxiety) had among the most significant differences. Those who identified as Black or African American (63%) selected this as an important community health need more frequently than those who identified as White (54%) and all other races (41%), as displayed in the figure below. The percentages identifying alcohol/drug addiction as a top community health need were nearly equivalent across respondents.

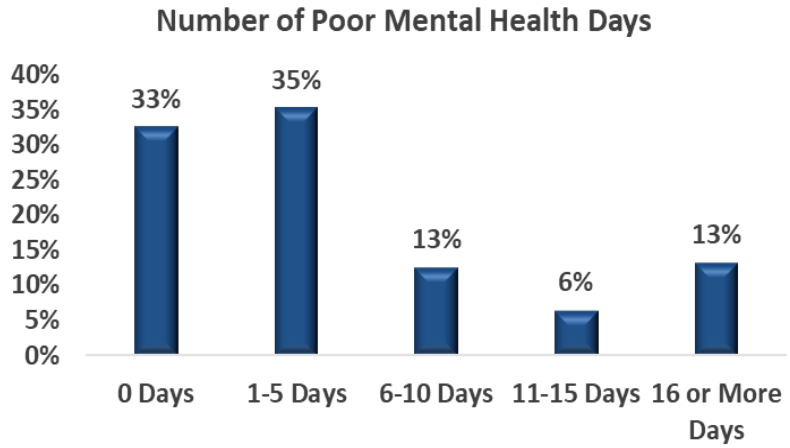
Figure 30: What are the three most important health problems that affect the health of your community? Please select up to three. (by race)



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

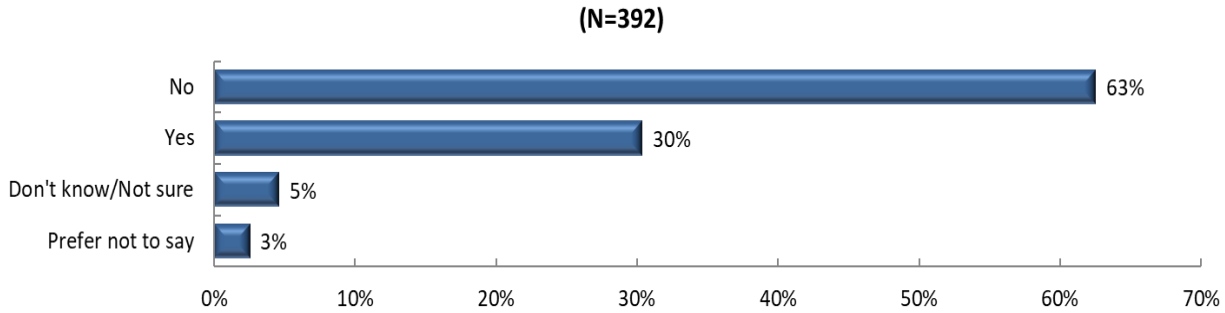
When respondents were asked about their own mental health, two-thirds of respondents indicated having one or more poor mental health days in the past 30 days, with an average of 7 poor mental health days among all respondents.

Figure 31: Mental Health Status



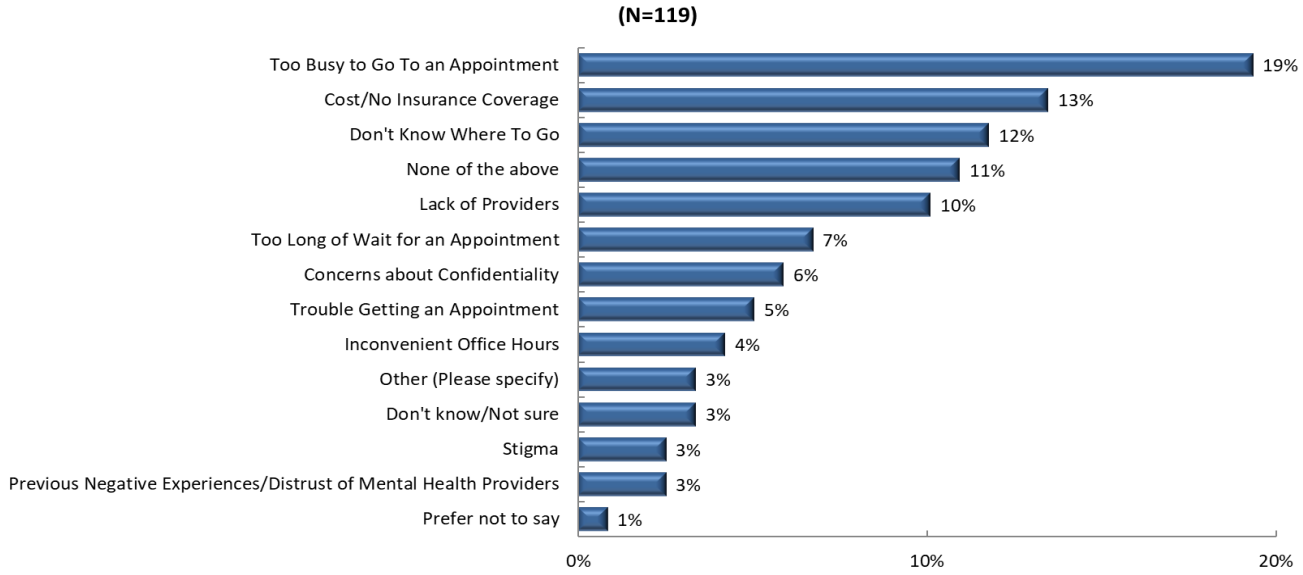
Community member respondents who indicated they experienced at least one poor mental health day a month were asked if there was a time in the past 12 months when they needed mental healthcare or counseling but did not get it at that time. Nearly 30% of these respondents answered yes.

Figure 32: Was there a time in the past 12 months when you needed mental healthcare or counseling, but did not get it at that time?



The top responses for why care was not received for this group, included being too busy to go to an appointment (19%), cost/no insurance coverage (13%), and not knowing where to go (12%), suggesting accessibility and resource awareness issues exist in the community impacting access to needed mental healthcare.

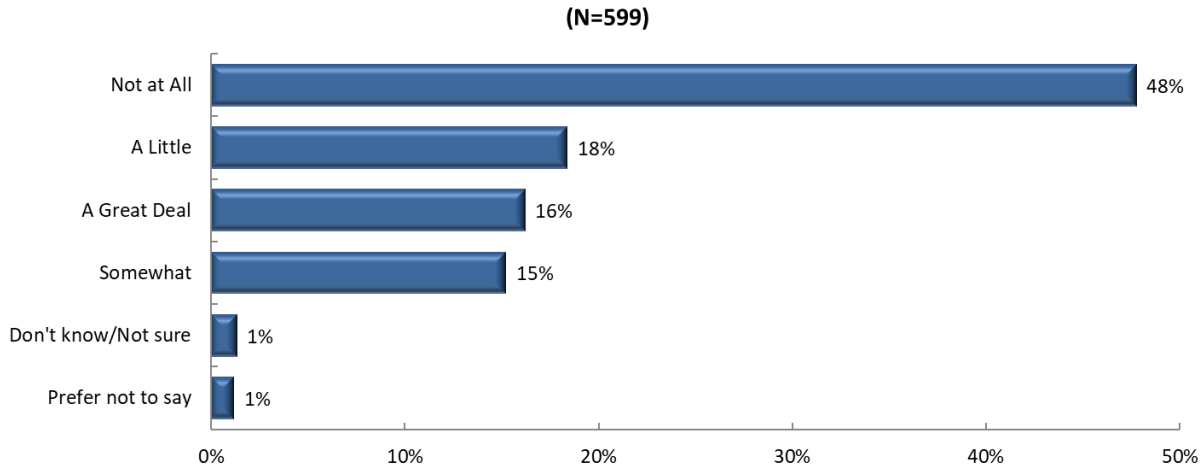
Figure 33: What was the MAIN reason you did not get mental health care or counseling?



When respondents were asked about alcohol consumption, nearly half of respondents reported to having alcohol “some days”, while 41% answered “not at all.” While 95% of community member respondents reported no personal or household misuse of prescription drugs, 18% answered “a little” and 16%

answered “a great deal” when asked the degree to which personal or someone else’s substance abuse negatively impacted their life, the second and third most selected responses.

Figure 34: To what degree has your life been negatively affected by YOUR OWN or SOMEONE ELSE's substance abuse issues, including alcohol, prescription, and other drugs?



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

Primary Data Findings – Focus Groups

Mental health emerged as a prominent concern across all three focus groups conducted in Craven County. Participants specifically discussed the prevalence of depression, suicidality, and stress in the community, with particular concern for young people affected by bullying or trauma. The peer recovery focus group provided detailed insights into substance use challenges, identifying significant needs for additional resources including availability of Narcan, detox centers, peer support groups, and jail diversion programs. This group also highlighted how substance use issues intersect with other health challenges, noting that people with substance use disorders often face complications including hypertension, skin infections, liver issues, dental concerns, and diabetes.

Employment barriers for those with substance use disorders were emphasized by the peer recovery group, who discussed the difficulty of finding high-quality jobs with a criminal record. This employment challenge was noted to impact both access to treatment and overall recovery outcomes. Focus group participants from historically marginalized communities discussed how overall mental well-being contributes to alcohol and drug addiction in their community. They highlighted how stress exacerbates both mental health challenges and substance use issues.

Multiple barriers to accessing mental healthcare were identified across groups, including transportation challenges, lack of health insurance coverage, provider distrust, and stigma. The peer recovery group specifically suggested implementing telehealth mental health services for incarcerated individuals and developing a detox court to keep people out of jail.

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

PRIORITY NEED: COMMUNITY WELLNESS AND EDUCATION

Context and National Perspective

Community wellness includes the different forms of SDoH that form a community's goals and priorities.[43] Community wellness and education is a core component of public health that encompasses other typical health needs and SDoH factors, such as health education sessions for healthy living, diabetes and chronic disease management, physical activity events like walkathons and races, and other holistic community activities. The CDC utilizes a "whole school, whole community, whole child" (WSCC) model, which focuses on 10 different components for addressing health needs in school settings. These components include physical activity, nutrition, health education, social climate, clinical care, and community involvement.[44] Other community wellness programs may focus on health disparities and access and helping those with chronic diseases navigate their insurance or the best ways to manage their health needs. Implementation of community wellness and education programs are a grassroots way of involving a community with improving their health outcomes. While frameworks and models of these programs may be developed nationally, concentrated programs are typically developed at the state or county level through various organizations and health departments.

Community wellness and education in rural areas is often a high priority for health departments, and events are often held in community public spaces, such as churches and community centers. These programs are typically not complex but have a significant impact in promoting positive health outcomes by providing information and opportunities for social connection.

Multiple community health grants have been allocated in North Carolina, with the general assembly awarding $15.2 million in 2023. These grants have focused on promoting access and availability to primary care and prevention services to individuals who are underinsured or uninsured. These grants have had a staggering impact in North Carolina, with a reported 72% of patients across the state receiving tobacco cessation screenings, 58% receiving obesity screenings, and 120 new health professional jobs created. [45]

Secondary Data Findings

Secondary data analysis revealed several challenges related to community wellness in Craven County. The county experiences 11,171 years of potential life lost before age 75 per 100,000 population, higher than the state average of 8,853. Life expectancy in Craven County (74.7 years) lags behind both state (76.6) and national (77.6) averages.

Chronic disease indicators show varying levels of health challenges. The percentage of adults diagnosed with diabetes in Craven County (9.8%) exceeds both state (9.0%) and national (8.9%) averages. The county also has higher rates of adults with hypertension (33.3%) and high cholesterol (32.7%) compared to state (32.1% and 31.4%) and national (29.6% and 31.0%) averages respectively.

[43] Source: Michalski, C. et.al, (2023). *Towards a community-driven definition of community wellbeing: A qualitative study of residents.* Retrieved October 4, 2024, from https://www.ncbi.nlm.nih.gov/pmc/articles/PMC10662708/

[44] Source: CDC. (2023). *Whole School, Whole Community, Whole Child (WSCC).* Retrieved October 4, 2024 from https://www.cdc.gov/healthyschools/wscc/index.htm

[45] Source: NCDHHS (2023). *North Carolina Community Health Grants.* Retrieved October 4, 2024 from: https://www.ncdhhs.gov/nc-dhhs-orh-community-health-grant-one-pager/open

Table 22: Chronic Disease Prevalence

Indicator	Craven County	North Carolina	United States
Adults (Age 18+) with Asthma	9.9%	9.8%	9.7%
Adults (Age 20+) with Diagnosed Diabetes	9.8%	9.0%	8.9%
Adults (Age 18+) Ever Diagnosed with Coronary Heart Disease	5.8%	5.5%	5.2%
Adults (Age 18+) with Hypertension	33.3%	32.1%	29.6%
Adults (Age 18+) with High Cholesterol	32.7%	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)	29.0%	29.7%	30.1%
Adults (Age 18+) with Poor Dental Health	12.7%	12.0%	13.9%
Percent Reporting Poor or Fair Health	15.4%	14.4%	-

While the county's obesity rate (29.0%) is slightly lower than state (29.7%) and national (30.1%) averages, physical inactivity presents a concern, with 23.8% of adults reporting being physically inactive compared to 21.6% statewide.

Environmental and structural factors may impact community wellness. The county has fewer recreation and fitness facilities (10.9 per 100,000 population) compared to state (13.1) and national (14.7) averages. The county's walkability index score of 6 is lower than both state (7) and national (10) averages, potentially limiting opportunities for physical activity.

Table 23: Physical Activity and Community Health Resources and Infrastructure

Indicator	Craven County	North Carolina	United States
Recreation and Fitness Facility Establishments, (Rate per 100,000 Population)	10.9	13.1	14.7
Walkability Index Score	6	7	10
% Physically Inactive	23.8	21.6	-
Percentage of Population with Access to Exercise Opportunities	73%	73%	84%

Maternal and infant health indicators also reflect community wellness challenges. The county's infant mortality rate of 8.0 deaths per 1,000 live births exceeds both state (7.0) and national (5.7) averages. Additionally, 9.0% of births in Craven County are classified as low birthweight, though this is slightly better than the state average of 9.4%.

Table 24: Maternal and Infant Health

Report Area	Number of Infant Deaths	Deaths per 1,000 Live Births	% of Births with Late/No Care	% Low Birthweight
Craven County	78	8.0	6.9%	9.0%
North Carolina	5,820	7.0	6.9%	--
United States	150,841	5.7	6.1%	9.4%

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

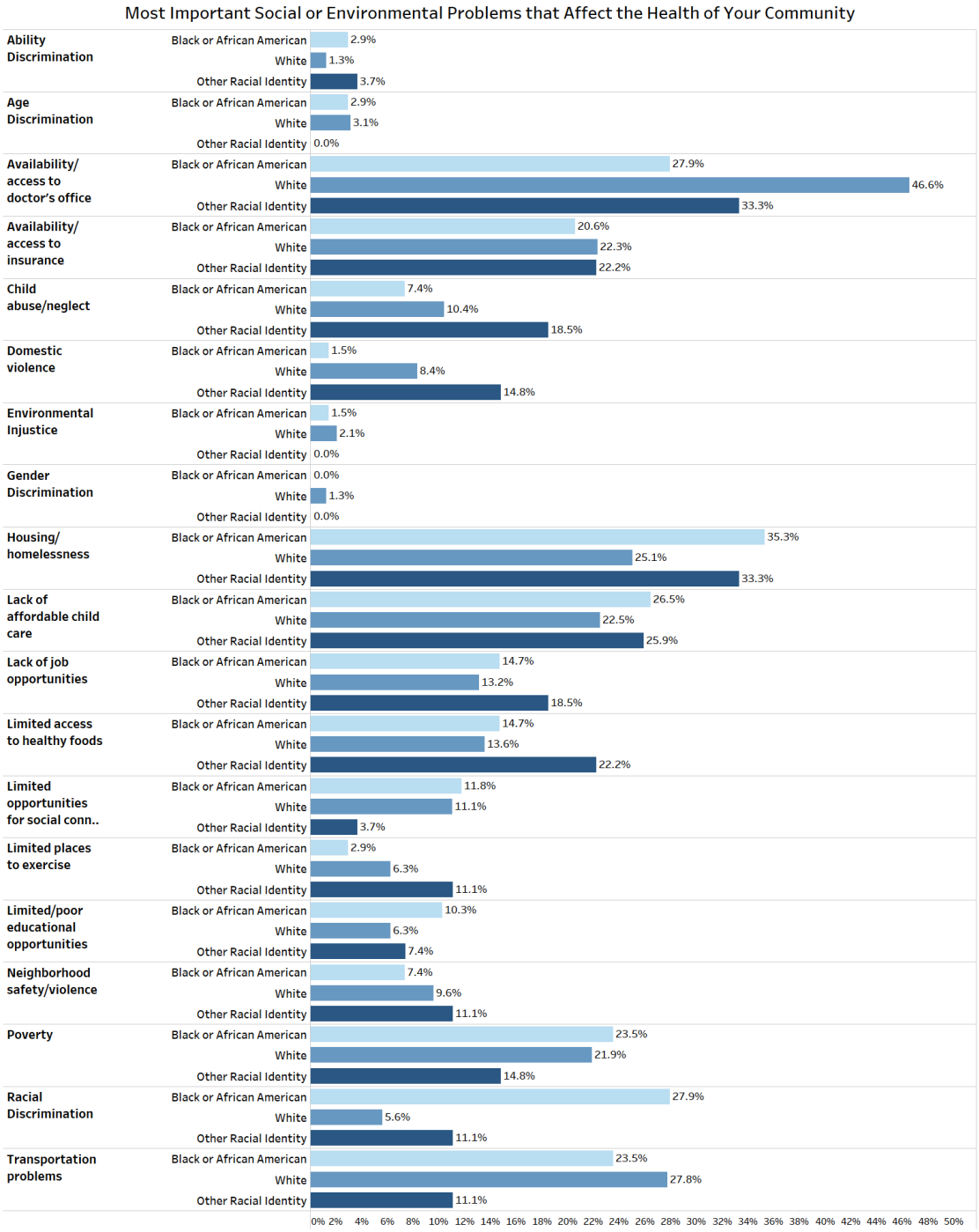
Primary Data Findings – Community Member Web Survey

Craven County residents identified several community wellness and education concerns in the web survey. Across all demographic groups, 14% of respondents indicated limited access to healthy foods, 7% indicated limited/poor educational opportunities, and 6% indicated limited places to exercise were top social or environmental problems affecting the health of the community, as previously displayed in **Figure 3.3** in the Access to Care section.

Responses somewhat differed by demographic characteristics of the respondents. When examined by gender, women (15%%) more frequently identified limited access to healthy foods than men (10%), while men more frequently identified limited places to exercise (11%) and limited/poor educational opportunities (11%) than women (6% each). Respondents who identified with another racial identity were more likely to select access to healthy foods (22%) and limited places to exercise (11%) as problems than

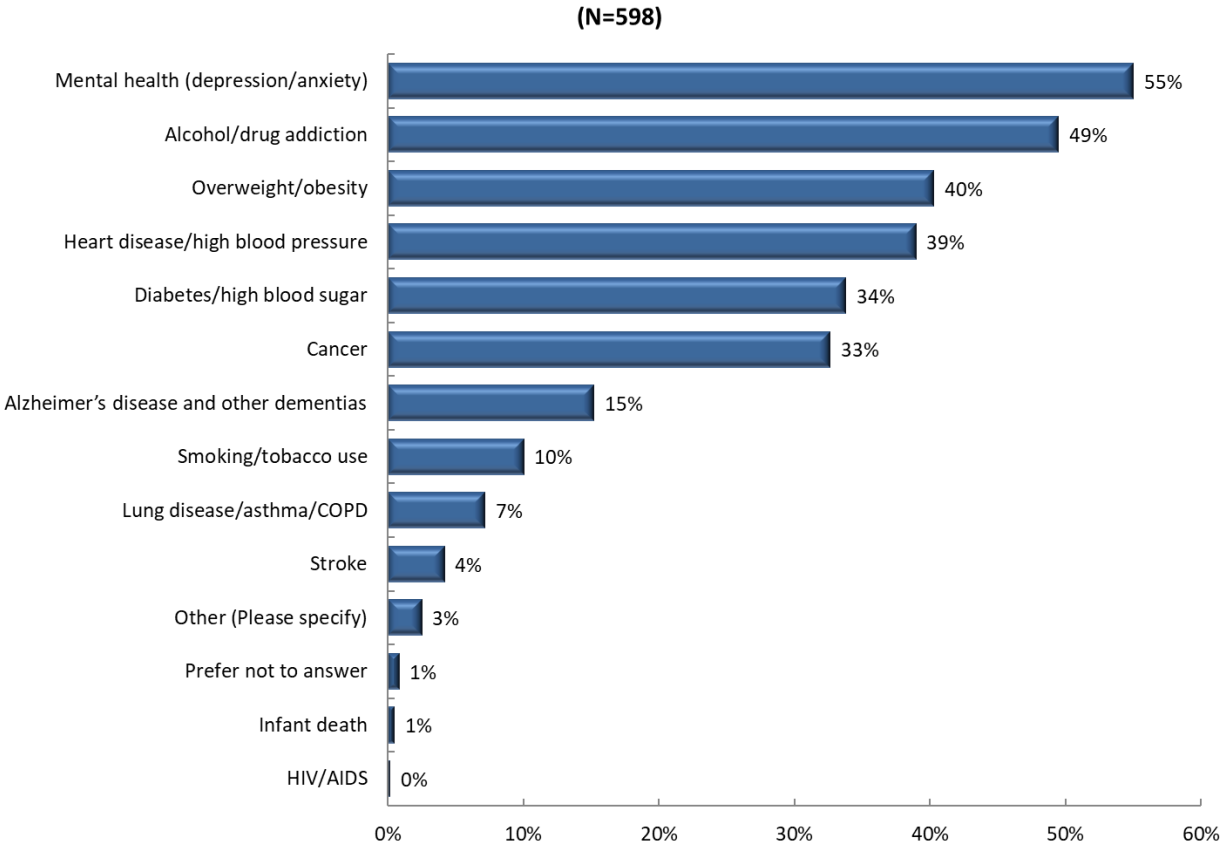
those who identified as White (14% and 6%) or Black or African American (15% and 3%). In contrast, those who identified as Black or African American (10%) were more likely to select limited/poor educational opportunities as a problem than the other races (White: 6%, Other: 7%).

Figure 35: What are the three most important social or environmental problems that affect the health of your community? Please select up to three. (by race)



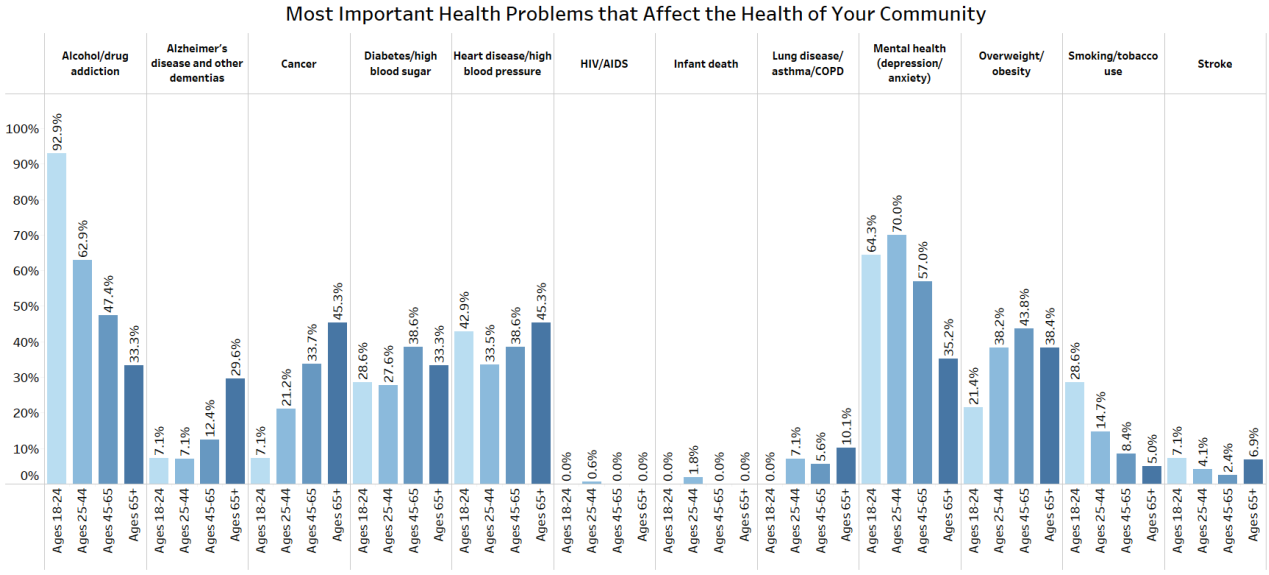
In addition to healthy living and educational concerns, Craven County respondents also highlighted chronic health conditions as top community concerns in the survey. Heart disease/high blood pressure, diabetes/high blood sugar, and overweight/obesity were identified among the top five health problems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

Figure 36: What are the three most important health problems that affect the health of your community? Please select up to three.



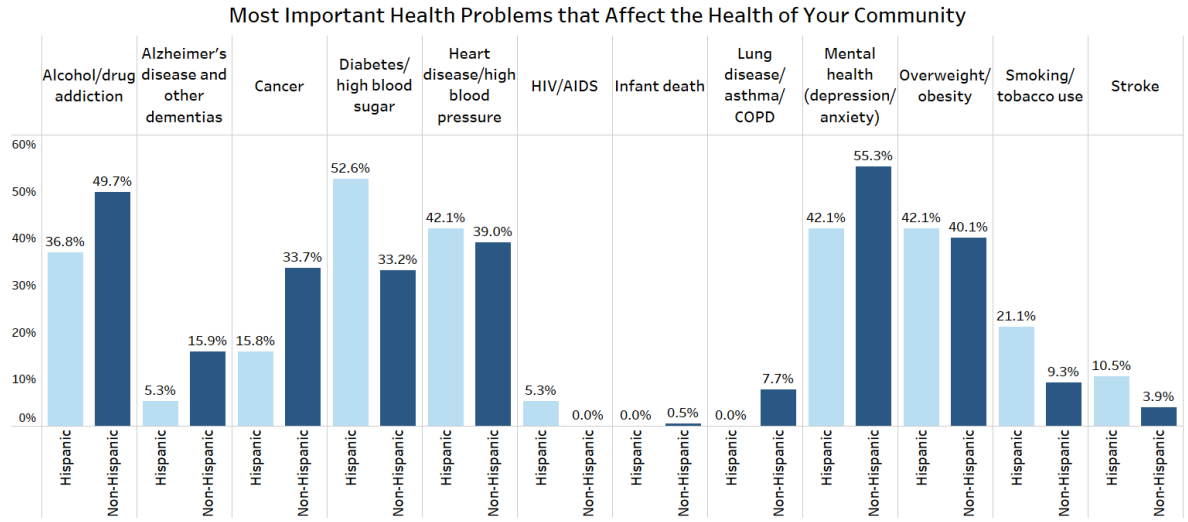
When these results were examined by various demographics of the respondents, responses varied. Older adults viewed overweight/obesity and diabetes/high blood sugar as more significant problems than younger respondents, as displayed in figure below. Compared to those aged 18 to 24 and those aged 25-44, older cohorts viewed cancer as a more significant health problem in the community.

Figure 37: What are the three most important health problems that affect the health of your community? (by age group)



Respondents identifying as Black or African American (54%) identified diabetes/high blood sugar more frequently than respondents identifying as White (31%) or all other races (41%). Those identifying with all other races (44%) were more likely to select heart disease/high blood pressure as an important community health problem than those identifying as Black or African American (37%) or White (39%). Black or African American respondents and those identifying all other races were equally likely to identify overweight/obesity as a top community health problem (41%). More dramatic differences emerged in comparison by respondents' ethnicity. Craven County respondents who identified as Hispanic were much more likely to identify diabetes/high blood sugar and slightly more likely to identify heart disease/high blood pressure, and overweight/obesity as significant health problems affecting the community, as displayed in the figure below. Considering these differences in targeted efforts to address specific community health indicators may be important.

Figure 38: What are the three most important health problems that affect the health of your community? (by ethnicity)



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

Primary Data Findings – Focus Groups

Focus group participants discussed various aspects of community wellness and education that impact Craven County residents' health. The parent focus group highlighted educational challenges, including uninvolved parents, cultural barriers, and health issues that affect students' ability to learn effectively. They also noted concerns about teacher burnout and staff vacancies that impact educational quality.

Participants from historically marginalized communities emphasized the need for low-cost after-school activities for young people. They identified several existing community resources that help address health issues, including parks, the health department, scholarship programs, Craven Community College, and employment opportunities at VOLT Center and NC Works.

Prevention and wellness education needs were highlighted across groups. The parent focus group suggested implementing parent resource liaisons to help connect families with needed programs and services. The historically marginalized communities focus group emphasized the need for better community education about existing resources and health services.

Physical activity and recreation opportunities were discussed as well, with focus group participants noting the availability of parks as a community strength. However, the historically marginalized communities group indicated a need for more affordable locations for safe walking and exercise.

Finally, food access and education emerged as important components of community wellness, with participants from historically marginalized communities specifically highlighting the need for education about food and nutrition, as well as addressing the high cost of healthy foods.

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 Craven 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 Community Wellness and Education.

For a comprehensive list of existing resources, facilities, and programs, please refer to the Craven County Community Resource Guide webpage.

Category	Organization Name
Healthcare Facilities	**Urgent Care/Emergency Room** • CarolinaEast Medical Center • CCHC Urgent Care • Med First Primary & Urgent Care **Primary Care** • CCHC New Bern Family Practice • CarolinaEast Internal Medicine • Craven County Health Department/Community Health Center • Merci Clinic **Pediatricians** • CarolinaEast Pediatrics • Coastal Children's Clinic • Dr. Stephen Engle, MD • Craven County Health Department/Community Health Center **Vision Care** • Coastal Eye Clinic (Ages 6+) • Eye Care Center (Ages 6 months+) • My Eye Doctor (Ages 5+) • New Bern Family Eye Care **Dental Care** • Coastal Pediatric Dentistry • Complete Dental Care • Warren & Miller (Ages 7+) • Smile Mobile Dental Unit (Ages 1-20)

	Internal Medicine • CarolinaEast Internal Medicine • CCHC New Bern Internal Medicine Specialists **Infectious Disease** • East Carolina University – ID Clinic – Ryan White Program **Specialty Care** • CarolinaEast Cardiac, Thoracic and Vascular Surgery • CCHC Heart and Vascular Specialist • Eastern Nephrology • CarolinaEast Ear, Nose, and Throat • CarolinaEast Gastroenterology • CarolinaEast Rehabilitation • CarolinaEast Urology • CarolinaEast Orthopedics & Sports Medicine • CCHC Southern Gastroenterology Associates • CCHC Craven Podiatry • CCHC Subacute Care Specialist • East Carolina Dermatology • Eastern Carolina Women's Center **Rehabilitation** • Bayview Nursing and Rehab Center • CarolinaEast Rehabilitation Hospital/Medical Center • Riverpoint Crest Nursing and Rehabilitation Center • Cherry Point Bay Nursing and Rehabilitation Center **Assisted Living Facilities** • The Indigo at New Bern • Navion of New Bern • The Viridian • Golden Heights • Truewood by Merrill • Homeplace of New Bern • The Gardens of Trent • Riverstone
Hospice & Home-Based Health Services	• Gentiva Hospice • Cardinal Hospice Care • Craven County Hospice • East Carolina Home Care • Our House Home Care • Home Instead

	• 3HC Home Health and Hospice • PruittHealth Hospice – New Bern • Wilson's Home Care Agency
Other Healthcare Services	**Counseling, Mental Health, and Substance Abuse** • Trillium Health Resources • Access Family Services, Inc. • Eastern Carolina Psychiatric Services • LeChris Health Systems • Easterseals PORT Health • Hakuna Wellness **Disability Services and Assistance** • Affordable Hearing • Abound Health • Department of Social Services • Easterseals PORT Health • Disabled American Veterans • Life Inc. • Vocational Rehabilitation

Crisis Services	• RHA Mobile Crisis (Mental Health/Substance Abuse)
	  ○ 252-638-7875; 1-844-709-4097
	• Integrated Family Services (Mental Health/Substance Abuse)
	  ○ 252-577-1906; 1-866-437-1821
	• Coastal Center for Hope & Healing (Domestic and Sexual Violence)
	  ○ 252-638-4509
	  ○ Crisis Line: 252-638-5995

Community Services	**Recreation** • New Bern Parks & Recreation • Stanley White Recreation Center • New Bern Boys & Girls Club • Twin Rivers YMCA • West New Bern Recreation Center • Craven County Recreation and Parks **Healthy Eating** • New Bern Farmer's Market **Food Assistance** • Religious Community Services • Salvation Army-New Bern

	• Food Bank of Central and Eastern North Carolina • WIC Program – Craven County Health Department • SNAP/EBT – Craven County Department of Social Services **Refugee Services** • Interfaith Refugee Ministries **Transportation** • Craven Area Rural Transit System (CARTS) **Employment** • Eastern Carolina Workforce Development Board • Employment Security Commission of North Carolina (ESC) • North Carolina Division of Vocational Rehabilitation • NCWorks Career Center – Craven **Local Support Groups** • Stephens Ministry: Provides emotional and spiritual care when faced with a crisis or difficulty such as illness, divorce, or unemployment • Prostate Cancer Support Group of Craven County • Grief Share: Provides help and encouragement after the death of a loved one • Post-Adoption & Foster Parent Support Group: community support group that provides additional training to foster and adoptive parents to help them better meet the needs of the children (meets monthly at the HOPE Family Resource Center) • STOP: domestic violence intervention group for male and female offenders (men and women meet separately) • Grandparents Raising Grandchildren: support group for grandparents who have full responsibility for raising their grandchildren • CarolinaEast Support Groups (cancer, stroke, and other conditions)
Priority Need: Access to Healthcare	• CARTS • Interfaith Refugee Ministry • Amexcan • NCDHHS Medicaid
Priority Need: Behavioral Health (Mental Health and Substance Use)	• Craven County Opioid Epidemic Response • 988 Suicide & Crisis Lifeline • Easterseals PORT Health • Hope Mission of Coastal Carolina
Priority Need: Community Wellness and Education	• Craven County Health Department • Craven County Recreation and Parks • Craven County Community Resource Guide webpage

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 Craven 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. Craven County leaders recognize that the most effective strategies will be those that have the collaborative support of community organizations and residents. The strategies developed will include measurable objectives through which progress can be measured.

APPENDIX 1 | STATE OF THE COUNTY HEALTH REPORT

Results-Based Accountability Framework

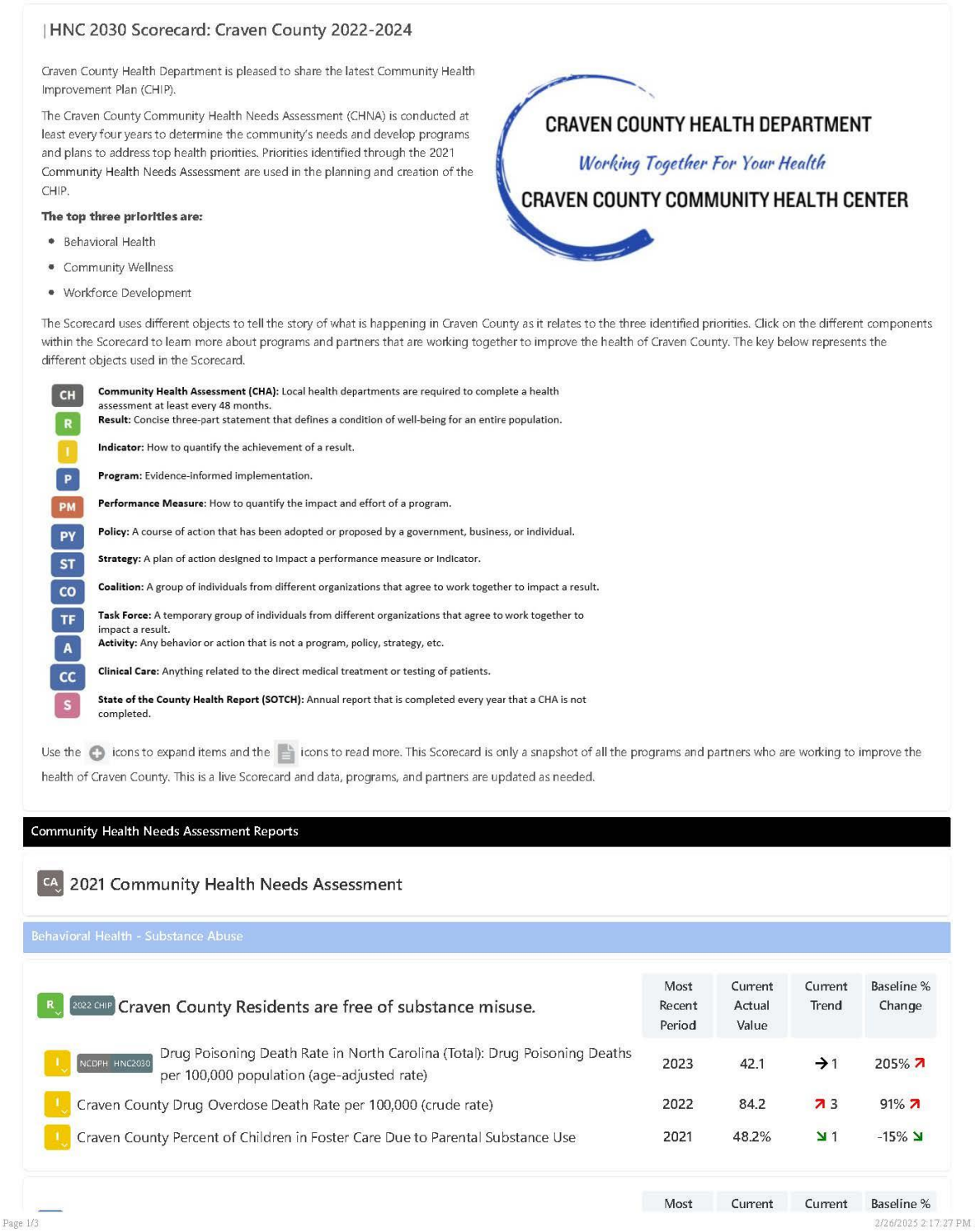
To meet North Carolina accreditation requirements, LHDs are required to track progress on their implementation plans by publishing an annual State of the County Health Report (SOTCH). The SOTCH is guided by the Clear Impact Results-Based Accountability (RBA) ™ Framework, and demonstrates that the LHD is tracking priority issues identified in the community health (needs) assessment process, identifying emerging issues, and implementing any relevant new initiatives to address community concerns.[46]

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

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

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

State of the County Health Report



| HNC 2030 Scorecard: Craven County 2022-2024

Craven County Health Department is pleased to share the latest Community Health Improvement Plan (CHIP).

The Craven County Community Health Needs Assessment (CHNA) is conducted at least every four years to determine the community's needs and develop programs and plans to address top health priorities. Priorities identified through the 2021 Community Health Needs Assessment are used in the planning and creation of the CHIP.

CRAVEN COUNTY HEALTH DEPARTMENT
Working Together For Your Health
CRAVEN COUNTY COMMUNITY HEALTH CENTER

The top three priorities are:

- Behavioral Health
- Community Wellness
- Workforce Development

The Scorecard uses different objects to tell the story of what is happening in Craven County as it relates to the three identified priorities. Click on the different components within the Scorecard to learn more about programs and partners that are working together to improve the health of Craven County. The key below represents the different objects used in the Scorecard.

CH **Community Health Assessment (CHA):** Local health departments are required to complete a health assessment at least every 48 months.
R **Result:** Concise three-part statement that defines a condition of well-being for an entire population.
I **Indicator:** How to quantify the achievement of a result.
P **Program:** Evidence-informed implementation.
PM **Performance Measure:** How to quantify the impact and effort of a program.
PY **Policy:** A course of action that has been adopted or proposed by a government, business, or individual.
ST **Strategy:** A plan of action designed to impact a performance measure or indicator.
CO **Coalition:** A group of individuals from different organizations that agree to work together to impact a result.
TF **Task Force:** A temporary group of individuals from different organizations that agree to work together to impact a result.
A **Activity:** Any behavior or action that is not a program, policy, strategy, etc.
CC **Clinical Care:** Anything related to the direct medical treatment or testing of patients.
S **State of the County Health Report (SOTCH):** Annual report that is completed every year that a CHA is not completed.

Use the ⊕ icons to expand items and the 📄 icons to read more. This Scorecard is only a snapshot of all the programs and partners who are working to improve the health of Craven County. This is a live Scorecard and data, programs, and partners are updated as needed.

Community Health Needs Assessment Reports

CA 2021 Community Health Needs Assessment

Behavioral Health - Substance Abuse

	Most Recent Period	Current Actual Value	Current Trend	Baseline % Change
R 2022 CHIP Craven County Residents are free of substance misuse.				
I NCDPH HNC2030 Drug Poisoning Death Rate in North Carolina (Total): Drug Poisoning Deaths per 100,000 population (age-adjusted rate)	2023	42.1	→ 1	205% ↗
I Craven County Drug Overdose Death Rate per 100,000 (crude rate)	2022	84.2	↗ 3	91% ↗
I Craven County Percent of Children in Foster Care Due to Parental Substance Use	2021	48.2%	↘ 1	-15% ↘

Most Current Current Baseline %

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A Drug Take Back Event	Recent Period	Actual Value	Trend	Change
PM How much Pounds of Medication Collected	HY2 2024	219	↗ 1	67% ↗

P CATCH My Breath	Most Recent Period	Current Actual Value	Current Trend	Baseline % Change
PM Number of Students that Completed CATCH My Breath	2023	300	↗ 1	1900% ↗

Behavioral Health - Mental Health

R 2022 CHIP Craven County residents experience improved mental health and overall well-being.	Most Recent Period	Current Actual Value	Current Trend	Baseline % Change
I NCDPH HNC2030 Suicide Death Rate (TOTAL) in North Carolina (per 100,000) - age-adjusted rates	2023	14.8	↗ 2	14% ↗
I Craven County Suicide Rate per 100,000 (crude rate)	2022	26.9	↗ 1	102% ↗

P Mental Health First Aid	Most Recent Period	Current Actual Value	Current Trend	Baseline % Change
PM How much Mental Health First Aid Trainings Completed by Class in Craven County	2024	1	↘ 1	-90% ↘

ST Question, Persuade, Refer (QPR)	Most Recent Period	Current Actual Value	Current Trend	Baseline % Change
PM How much QPR Trainings Completed by Class in Craven County	2024	3	↘ 1	200% ↗

Community Wellness

R 2022 CHIP Craven County residents are living a healthy and active lifestyle.	Most Recent Period	Current Actual Value	Current Trend	Baseline % Change
I NCDPH HNC2030 Life Expectancy (Total) in NC - ONE YEAR DATA: Average # of years of life remaining for people who have attained a given age	2023	77.0	↗ 2	-1% ↘
I Craven County ED Visits	Q2 2022	12,440	↗ 1	5% ↗

P Minority Diabetes Prevention Program	Most Recent Period	Current Actual Value	Current Trend	Baseline % Change
PM How much MDPP Participant Enrollment	2024	11	↗ 1	-31% ↘

P New Craven County Parks and Recreation Program Participation	Most Recent Period	Current Actual Value	Current Trend	Baseline % Change
PM How much Number of Youth that Participated in Craven County Parks and Recreation Programs	2024	2,782	↗ 4	68% ↗
PM How much Number of Adults that Participated in Craven County Parks and Recreation Programs	2024	1,322	↗ 4	88% ↗

Workforce Development

	Most Recent Period	Current Actual Value	Current Trend	Baseline % Change
R 2022 CHIP **Craven County working age individuals are gainfully employed.**				
I NCDPH HNC2030 Unemployment (Total): Percent of Population in NC Aged 16 and Older Who are Unemployed but Seeking Work	2023	4.8%	↘ 9	-54% ↘
I Craven County High School Completion Percent	2023	90%	↗ 1	6% ↗

	Most Recent Period	Current Actual Value	Current Trend	Baseline % Change
P New **Craven Community College Volt Center**				
PM How much Students Receiving NCCER Trade Certification	2024	358	↗ 1	72% ↗

SOTCH Reports

S 2022 SOTCH Report

S 2023 SOTCH Report

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 Craven County, its performance on each data measure was compared to targets/benchmarks. If Craven 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 recent 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 26: 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 27: 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 28: 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 29: 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 30: 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 31: 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 32: 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 33: 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 non-alcoholic 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 34: 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 35: 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 36: 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 37: 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 38: 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 39: 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 40: 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 41: 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 42: 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 it 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 43: 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 44: 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 45: 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 Craven 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	Craven County Description
	Low	Represents measures in which Craven 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 Craven 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 Craven 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 Craven County value was compared to the benchmark by calculating the percentage difference between the values, relative to the benchmark value:

(Craven 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:

(8.7-7.5)/(7.5) x 100% = 16.0% Displayed as **High Priority Level**, Shaded in Red

This metric indicates that the percentage of the population with limited access to healthy foods in Craven County is 16.0 percent worse (or, in this case, higher) than the percentage of the population with limited access to healthy foods in the state of North Carolina.

Detailed Focus Area Benchmarks

Table 46: Access to Care

Measure	National Benchmark	North Carolina Benchmark	Craven County Data	Most Recent Data Year	Craven County Priority Level
Primary Care Providers Ratio	112.4	101.1	104.3	2024	Medium
Mental Health Providers Ratio	178.7	155.7	160.8	2024	Medium
Addiction/Substance Abuse Providers Ratio	27.9	25.0	18.9	2024	High
Buprenorphine Providers Ratio	15.5	15.2	3.9	2023	High
Dental Health Providers Ratio	39.1	31.5	28.8	2024	High
% Living in Health Professional Shortage Areas (HPSAs) – Dental Care	17.8%	34.0%	35.6%	2018-2022	Medium
Federally Qualified Health Centers (FQHCs)	3.5	4.1	1.0	2023	High
% Receiving Medicaid	22.3%	20.2%	21.8%	2018-2022	High
% Uninsured	10.2%	12.5%	11.3%	2022	Low

Table 47: Built Environment

Measure	National Benchmark	North Carolina Benchmark	Craven County Data	Most Recent Data Year	Craven County Priority Level
Broadband Access (Access to DL Speeds >= 25MBPS and UL Speeds >= 3 MBPS)	93.8%	93.6%	89.0%	2023	Medium
Broadband Access (Access to DL Speeds >= 100MBPS and UL Speeds >= 20 MBPS)	91.2%	90.4%	87.1%	2023	Medium
Households with No Computer	6.1%	6.9%	8.4%	2018-2022	High

Measure	National Benchmark	North Carolina Benchmark	Craven County Data	Most Recent Data Year	Craven County Priority Level
Households with No or Slow Internet	11.7%	13.0%	17.6%	2018-2022	High
Liquor Stores	13.3	6.2	7.9	2022	Low
Adverse Childhood Experiences (ACEs)	N/A	N/A	Suppressed	2022	N/A

Table 48: Diet and Exercise

Measure	National Benchmark	North Carolina Benchmark	Craven County Data	Most Recent Data Year	Craven County Priority Level
% Physically Inactive	N/A	21.6%	23.8%	2021	High
Walkability Index Score	10	7	6	2021	High
% with Access to Exercise Opportunities	84.1%	73.0%	73.0%	2023	Medium
Recreation and Fitness Facility Access	14.8	13.1	10.9	2022	High
Sugar-Sweetened Beverage (SSB) Consumption	N/A	N/A	Suppressed	2022	N/A

Table 49: Education

Measure	National Benchmark	North Carolina Benchmark	Craven County Data	Most Recent Data Year	Craven County Priority Level
% Limited English Proficiency	8.2%	4.6%	3.1%	2018-2022	Low
High School Graduation Rate	81.1%	87.6%	85.0%	2020-2021	Medium
% with No High School Diploma	10.9%	10.6%	9.1%	2018-2022	Low
Student Math Proficiency	63.9%	65.8%	70.0%	2020-2021	High
Student Reading Proficiency	60.1%	59.5%	60.6%	2020-2021	Medium
School Funding Adequacy	N/A	-$4,742	-$3,163	2021	Low

Measure	National Benchmark	North Carolina Benchmark	Craven County Data	Most Recent Data Year	Craven County Priority Level
School Funding Adequacy – Spending per pupil	N/A	$10,655	$10,497	2021	Medium

Table 50: Employment

Measure	National Benchmark	North Carolina Benchmark	Craven County Data	Most Recent Data Year	Craven County Priority Level
Unemployment Rate	3.9%	3.7%	3.2%	2024	Low
Average Annual Unemployment Rate, 2013-2023	3.6%	3.5%	3.5%	2024	Medium

Table 51: Environmental Quality

Measure	National Benchmark	North Carolina Benchmark	Craven County Data	Most Recent Data Year	Craven County Priority Level
Flood Vulnerability	6.5%	4.9%	14.2%	2011	High
Drinking Water Safety	16,107	194	0	2023	Low

Table 52: Family, Community and Social Support

Measure	National Benchmark	North Carolina Benchmark	Craven County Data	Most Recent Data Year	Craven County Priority Level
Childcare Cost Burden	28.8%	27.0%	28.0%	2023	Medium
% Young People Not in School or Working	6.9%	7.5%	12.1%	2018-2022	High

Table 53: Food Security

Measure	National Benchmark	North Carolina Benchmark	Craven County Data	Most Recent Data Year	Craven County Priority Level
% Food Insecure	10.3%	11.4%	12.0%	2021	Medium
% Food Insecure Children	13.3%	15.3%	17.9%	2021	High
% Low-Income and with Low Food Access	19.4%	21.3%	25.3%	2019	High
% Limited Access to Healthy Foods	N/A	7.5%	8.7%	2019	High
Fast Food Restaurants	96.2	77.4	88.4	2022	High

Measure	National Benchmark	North Carolina Benchmark	Craven County Data	Most Recent Data Year	Craven County Priority Level
Grocery Stores	23.4	18.7	21.8	2022	Low

Table 54: Housing and Homelessness

Measure	National Benchmark	North Carolina Benchmark	Craven County Data	Most Recent Data Year	Craven County Priority Level
Renter Costs – Average Gross Rent	$1,366	$1,090	$1,008	2018-2022	Low
% Severe Housing Cost Burden	14.1%	12.2%	13.2%	2018-2022	Medium
Assisted Housing Units	413.9	319.2	481.9	2017-2021	High
% Severe Substandard Housing	18.5%	16.1%	15.2%	2011-2015	Low
% Homeless Children	2.8%	1.9%	1.8%	2019-2020	Medium

Table 55: Income

Measure	National Benchmark	North Carolina Benchmark	Craven County Data	Most Recent Data Year	Craven County Priority Level
Median Family Income	$92,646	$82,890	$77,888	2018-2022	High
Gender Pay Gap	81.0%	83.0%	90.0%	2018-2022	Low
% Living Below 100% FPL	12.5%	13.3%	14.1%	2022	High
% Living Below 200% FPL	28.8%	31.6%	32.9%	2018-2022	Medium
% Children Living Below 200% FPL	37.2%	41.1%	42.6%	2018-2022	Medium
% Receiving SNAP	12.4%	15.7%	14.4%	2021	Low
Children Eligible for Free/Reduced Price Lunch	51.7%	50.8%	58.8%	2022-2023	High

Table 56: Length of Life

Measure	National Benchmark	North Carolina Benchmark	Craven County Data	Most Recent Data Year	Craven County Priority Level
Years of Potential Life Lost Rate	N/A	8,853	11,171	2019-2021	High

Measure	National Benchmark	North Carolina Benchmark	Craven County Data	Most Recent Data Year	Craven County Priority Level
Premature Age-Adjusted Mortality	N/A	420	515	2019-2021	High
Life Expectancy	77.6	76.6	74.7	2019-2021	Medium

Table 57: Maternal and Infant Health

Measure	National Benchmark	North Carolina Benchmark	Craven County Data	Most Recent Data Year	Craven County Priority Level
Births with Late or No Prenatal Care	6.1%	6.9%	6.9%	2019	Medium
Low Birthweight	N/A	9.4%	9.0%	2016-2022	Medium
Infant Mortality Rate	5.7	7.0	8.0	2015-2021	High

Table 58: Mental Health

Measure	National Benchmark	North Carolina Benchmark	Craven County Data	Most Recent Data Year	Craven County Priority Level
Poor Mental Health Days	4.9	4.6	4.7	2021	Medium
Deaths of Despair Rate	55.9	58.7	91.6	2018-2022	High
Suicide Death Rate	14.5	14.0	18.3	2018-2022	High

Table 59: Physical Health

Measure	National Benchmark	North Carolina Benchmark	Craven County Data	Most Recent Data Year	Craven County Priority Level
% Poor or Fair Health	N/A	14.4%	15.4%	2021	High
% Adults with Asthma	9.7%	9.8%	9.9%	2022	Medium
% Adults with Heart Disease	5.2%	5.5%	5.8%	2022	High
% Adults with High Blood Pressure	29.6%	32.1%	33.3%	2021	Medium
% Adults with High Cholesterol	31.0%	31.4%	32.7%	2021	Medium
Diabetes Prevalence	8.9%	9.0%	9.8%	2021	High
% Adults with Kidney Disease	2.7%	2.9%	3.0%	2021	Medium

Measure	National Benchmark	North Carolina Benchmark	Craven County Data	Most Recent Data Year	Craven County Priority Level
% Stroke	2.8%	3.1%	3.2%	2022	Medium
Obesity	30.1%	29.7%	29.0%	2021	Medium
% Teeth Loss	13.9%	12.0%	12.7%	2022	High
Cancer Incidence Rate	442.3	464.4	495.8	2016-2020	High
Emergency Room Visits	535	563	514	2022	Low
Heart Disease Hospitalization Rate	10.4	11.7	9.9	2018-2020	Low
Stroke Hospitalization Rate	8.0	9.5	9.8	2018-2020	Medium

Table 60: Quality of Care

Measure	National Benchmark	North Carolina Benchmark	Craven County Data	Most Recent Data Year	Craven County Priority Level
Children/adults vaccinated annually against seasonal influenza	44.5%	45.6%	49.2%	2021	Low
Preventable Hospital Rate	2,752	2,957	2,802	2021	Low
Readmissions Rate	18.1%	17.6%	16.0%	2022	Low

Table 61: Safety

Measure	National Benchmark	North Carolina Benchmark	Craven County Data	Most Recent Data Year	Craven County Priority Level
Incarceration Rate	1.3%	1.5%	1.3%	2018	Low
Juvenile Arrest Rate	13.8	16.0	17.0	2021	High
Violent Crime	416.0	365.7	250.3	2015-2017	Low
Firearm Death Rate	13.4	15.5	18.1	2018-2022	High
Poisoning Death Rate	28.5	31.5	55.3	2018-2022	High

Table 62: Sexual Health

Measure	National Benchmark	North Carolina Benchmark	Craven County Data	Most Recent Data Year	Craven County Priority Level
Chlamydia Rate	495.0	603.3	501.6	2021	Low

Measure	National Benchmark	North Carolina Benchmark	Craven County Data	Most Recent Data Year	Craven County Priority Level
HIV Incidence Rate	12.7	15.5	15.3	2022	Medium
Teen Births	16.6	18.2	N/A	2016-2022	N/A

Table 63: Substance Use Disorders

Measure	National Benchmark	North Carolina Benchmark	Craven County Data	Most Recent Data Year	Craven County Priority Level
% Excessive Drinking	18.1%	18.2%	17.5%	2021	Medium
% Driving Deaths with Alcohol	2.3	2.9	2.4	2018-2022	Low
Opioid Use Disorder Rate	41.0	43.0	46.0	2021	High
Opioid Drug Overdose Deaths	N/A	25.1	48.0	2018-2022	High

Table 64: Tobacco Use

Measure	National Benchmark	North Carolina Benchmark	Craven County Data	Most Recent Data Year	Craven County Priority Level
% Smokers	14.5%	15.0%	17.5%	2021	High

Table 65: Transportation Options and Transit

Measure	National Benchmark	North Carolina Benchmark	Craven County Data	Most Recent Data Year	Craven County Priority Level
% Households with No Motor Vehicle	8.3%	5.4%	5.9%	2018-2022	High
% 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 three focus groups were conducted in person between May 22nd and May 30th, 2024. These groups included representation from community members, with over 20 participants providing responses on living, working, or receiving healthcare in Craven County.

- Craven County Health Department – Peer Recovery Group
- Craven County Health Department – Parents of School-Aged Children
- Craven Terrace Community Room – Historically Marginalized

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 Craven County

More than half (55%) of participants identified as female, and the group was predominantly white (60%) and non-Hispanic/Latino (100%). Participants represented a wide range of ages, with most of the group (75%) between the ages of 30 and 49.

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?

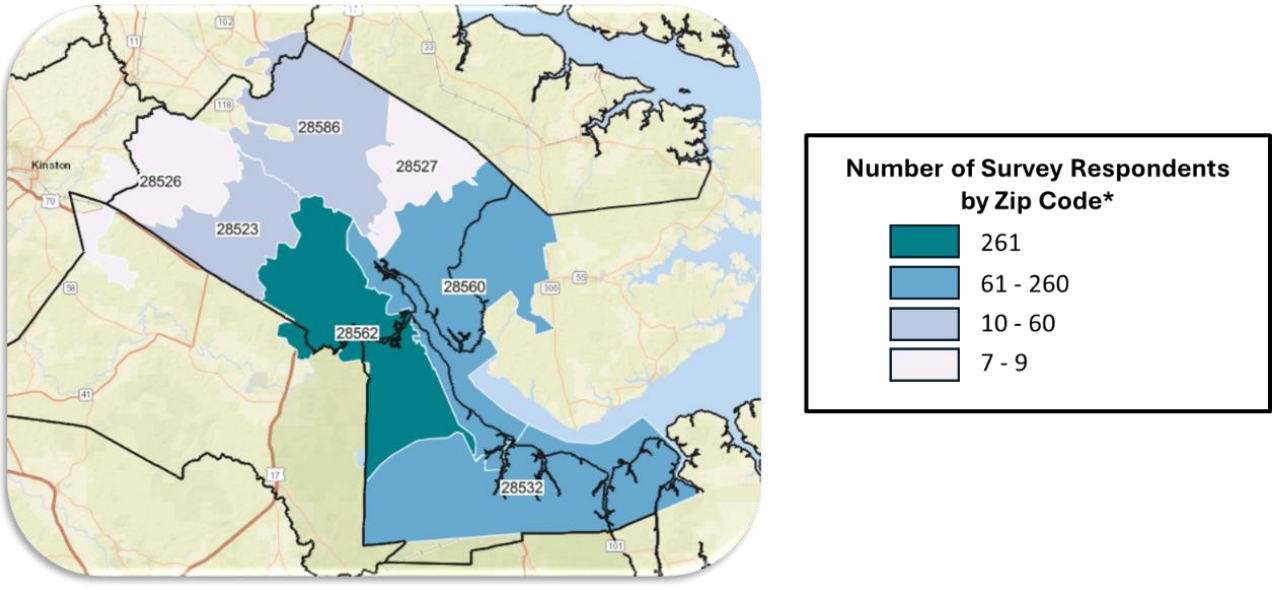
11. What actions can local residents take to help improve the health of the community?

Community Member Web Survey

A total of 600 surveys were completed by individuals living, working or receiving healthcare in the Craven County community. The survey was available in both English and Spanish, and less than 1% 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 39: Respondent Zip Code of Residence[47]



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

In general, survey questions focused on:

- Community health problems and concerns
- Community social/environmental problems and concerns
- Specific topics of interest to Craven County:
    - Employment
    - Equity and equality
    - Mental health
    - Substance use disorders

The key findings from the Community Survey are detailed below:

- Mental health (e.g., depression and anxiety), alcohol/drug addiction, and weight/obesity were identified as the top 3 health problems affecting the community. About one third of respondents also identified heart disease/high blood pressure and diabetes/high blood sugar as important health problems.
- Cost, not having insurance, and long wait times were the top three barriers to receiving health care identified by the community.
- Availability and access to doctor's offices, transportation, and housing were identified as the top three most important social or environmental problems that affect the health of the community. Lack of affordable childcare, insurance, and poverty were also identified by almost one in four respondents.

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

Figure 40: Respondents by Age Group

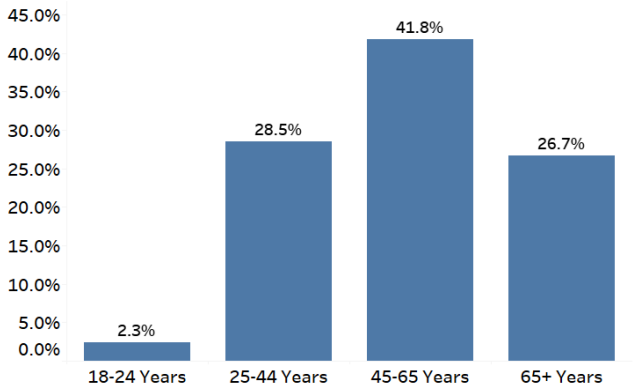


Figure 41: Respondents by Gender

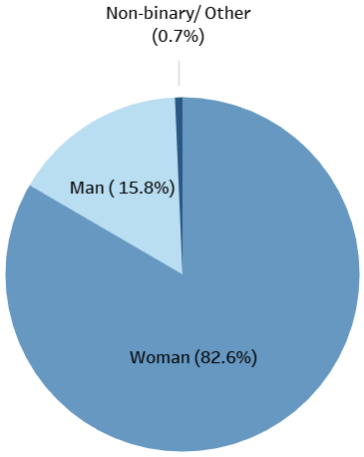


Figure 42: Respondents by Ethnicity

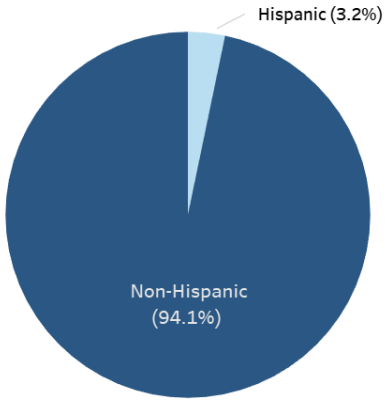
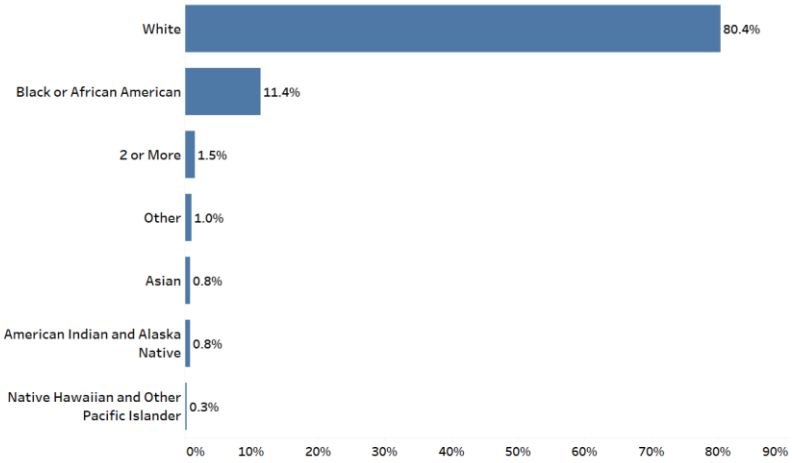


Figure 43: Respondents by Race



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?[48]

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

[48] 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: Employment

13. 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

[NOTE: If employed full- or part-time or self-employed, please answer questions 2-4. If unemployed or temporarily unable to work, please answer questions 5-7. All other responses proceed to the next topic.]

14. Which of the following best describes the industry you work in?

□ Office work (administrative, managerial, professional, desk work, etc.)
□ Manual labor (driving, working with your hands, assembling, moving, etc.)
□ Customer/client/patient service (education, retail, food service, healthcare, entertainment, etc.)
□ Other (please specify): _____
□ Prefer not to answer

15. How concerned are you that an economic slump, downturn, or recession will cause you to be laid off, furloughed, or lose your job in the next 12 months?

□ Not at all concerned
□ Not very concerned
□ Somewhat concerned
□ Very concerned
□ Prefer not to say

16. Do you intend to look for a new job at a different company or organization in the next year?

□ Yes
□ No
□ Prefer not to say

17. Do you currently want a job, either full or part time?

□ Yes
□ No
□ Prefer not to say

18. Have you been doing anything to find work during the last four weeks?

□ Yes
□ No
□ Retired
□ Disabled
□ Unable to work
□ Prefer not to say

19. What are all the things you have done to find work during the last four weeks?

□ Contact employer directly/interview
□ Contacted public employment agency
□ Contacted private employment agency
□ Contacted friends or relatives
□ Contacted school/university employment center
□ Sent out resumes/filled out applications
□ Checked union/professional registers
□ Placed or answered ads
□ Looked at ads
□ Attended job training programs/courses
□ Other (please specify): _____
□ Nothing

Topic: Family, Community and Social Support

20. The following statements describe what your neighborhood might be like. Tell us how much you agree or disagree.
    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. People around here are willing to help their neighbors.	☐	☐	☐	☐	☐	☐	☐
b. People in my neighborhood generally get along with each other.	☐	☐	☐	☐	☐	☐	☐
c. People in my neighborhood can be trusted.	☐	☐	☐	☐	☐	☐	☐
d. People in my neighborhood share the same values.	☐	☐	☐	☐	☐	☐	☐
e. My neighborhood is noisy.	☐	☐	☐	☐	☐	☐	☐
f. My neighborhood is clean.	☐	☐	☐	☐	☐	☐	☐
g. People in my neighborhood take good care of their houses and apartments.	☐	☐	☐	☐	☐	☐	☐
h. I'm always having trouble with my neighbors.	☐	☐	☐	☐	☐	☐	☐
i. In my neighborhood, people watch out for each other.	☐	☐	☐	☐	☐	☐	☐
j. My neighborhood is safe.	☐	☐	☐	☐	☐	☐	☐
k. My neighborhood is a good place to grow old.	☐	☐	☐	☐	☐	☐	☐

21. People sometimes look to others for friendship, help, or other types of support. In the following situations, how often could you find someone to support you? 1 = None of the time; 2 = A little of the time; 3 = Some of the time; 4 = Most of the time; 5 = All of the time

	1	2	3	4	5	Prefer not to say
a. Someone to help you if you were confined to bed	□	□	□	□	□	□
b. Someone to take you to the doctor if you need it	□	□	□	□	□	□
c. Someone to help with daily chores if you were sick	□	□	□	□	□	□
d. Someone to have a good time with	□	□	□	□	□	□
e. Someone to turn to for suggestions about how to deal with a personal problem	□	□	□	□	□	□
f. Someone who understands your problems	□	□	□	□	□	□
g. Someone to love and make you feel wanted	□	□	□	□	□	□

Topic: Mental Health

22. 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: _____

23. 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

24. 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

25. 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: Substance Use Disorders

26. 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: _____

27. 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

28. 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

29. To what degree has your life been negatively affected by YOUR OWN or SOMEONE ELSE's substance abuse issues, including alcohol, prescription, and other drugs? Would you say:
    □ A Great Deal
    □ Somewhat
    □ A Little
    □ Not at All
    □ Don't know/Not sure
    □ Prefer not to say

APPENDIX 5 | DETAILED PRIMARY DATA FINDINGS

Focus Groups

Key findings from the focus groups are summarized below.

Focus Group General Findings

As part of the 2024 CHNA process, Craven County conducted three focus groups in order to learn more about the experiences of Craven County residents. These focus groups were comprised of a peer recovery group, historically marginalized communities, and parents. Several common themes emerged from these three focus groups, most notably mental health. Specifically, the groups were concerned about the prevalence of depression, suicidality, and stress, particularly among young people affected by bullying or trauma. Participants surfaced several barriers to addressing mental health including transportation, lack of health insurance, distrust in providers, and stigma.

Focus Group 1 Unique Insights: Behavioral Health (Peer Recovery Group)

The Peer Recovery focus group consisted of 8 participants. This group was mostly men, were between the ages of 18 and 64, and all identified as white. This group identified five main health and social/environmental barriers that keep residents with substance use disorders in Craven County from living healthier lives. Firstly, the group aligned on the need for additional resources for those with substance use issues including Narcan availability, detox centers, peer support groups, and jail diversion programs. Additionally, this group discussed challenges around employment and income for those with substance use disorders, most notably the difficulty with finding high-quality jobs with a criminal record. The participants also noted challenges with healthcare access and quality, specifically calling out the silos that exist between physical and behavioral health and the difficulties navigating the system. The high cost of care was also discussed with participants discussing the challenge around needing to prioritize basic needs over healthcare. Physical health and sexual health issues among those with substance use disorders were also discussed, specifically the prevalence of hypertension, skin infections, liver issues, dental concerns, diabetes, and sexually transmitted infections.

When asked what local health leaders should do to address issues members of this community face, the group suggested more community education about available resources and programs. Additionally, the group would like to see better support for peer support specialists and develop a detox court to keep folks out of jail. Lastly, the group suggested providing telehealth mental health services to those who are incarcerated.

Focus Group 2 Unique Insights: Marginalized Communities

The second focus group conducted for this CHNA consisted of historically marginalized communities. There were 9 participants, 6 women and 3 men. Most identified as Black and ranged in age from 30 to 64 years old. This group identified several key barriers to health in Craven County including food access and security (e.g., high cost of healthy foods and few available grocery stores), physical health (e.g., chronic health conditions such as stroke, cancer, diabetes, heart disease, and COPD which are all exacerbated by stress), sexual health (e.g., HIV and STI prevalence), substance use as a result of poor mental well-being, and transportation and transit (i.e., lack of services in the county which impact the availability of healthcare

services, education, and employment). This group also specifically noted maternal and infant health as an important concern for their community.

When asked what local health leaders should do to address their concerns, the group called for low-cost after-school activities for young people, better transit options throughout the county, and more awareness and education about existing resources. The participants of this group noted a few existing resources they believe are helping to address community health issues including availability of parks, the health department, scholarship programs, Craven Community College, and employment opportunities at VOLT Center, the community college, and NC Works.

Focus Group 3 Unique Insights: Parents of School-Aged Children

The third and final focus group consisted of three parents who discussed issues facing them and their children. They discussed challenges in schools that impact all students' abilities to learn including uninvolved parents, cultural barriers, and health issues. They surfaced challenges with virtual learning and acknowledged the burnout that teachers are experiencing that lead to staff vacancies. In addition to issues around education, the parents in this group discussed family, community, and social support needs such as parent and teacher involvement, noting the importance of positive student/teacher relationships to the success of students. Shifting from school focused challenges, the parents noted healthcare access and quality (including distrust, stigma, and lack of understanding how to find services) as well as tobacco use issues (i.e., vaping) among young people.

Participants want local health leaders to make more resources for tutoring available and provide opportunities for learning outside of the classroom for young people. Additionally, they would like to see more supplies and funding for schools. Lastly, they suggested implementing parent resource liaisons to help connect families with needed programs and services.

Community Member Web Survey

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

Topic: Additional Demographic Information

Figure 44: What is the highest grade or year of school you completed? (N=599)

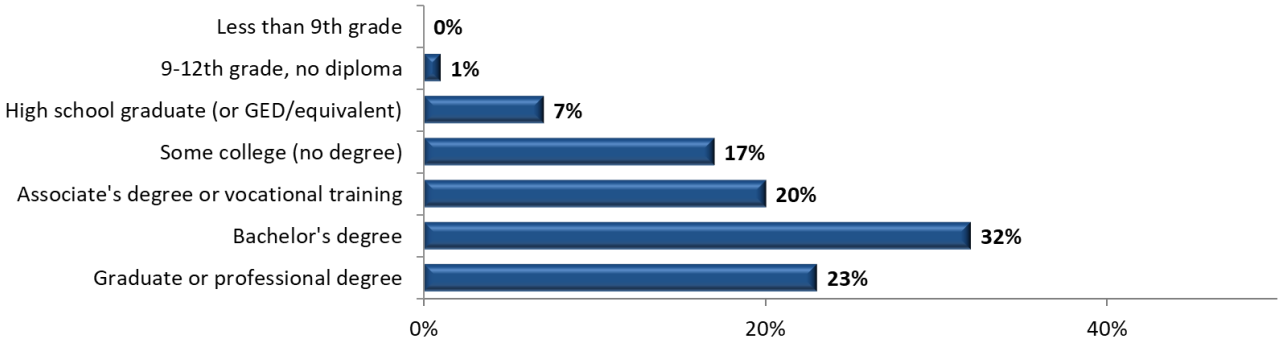


Figure 45: Which language is most often spoken in your home? (Choose one)
(N=598)

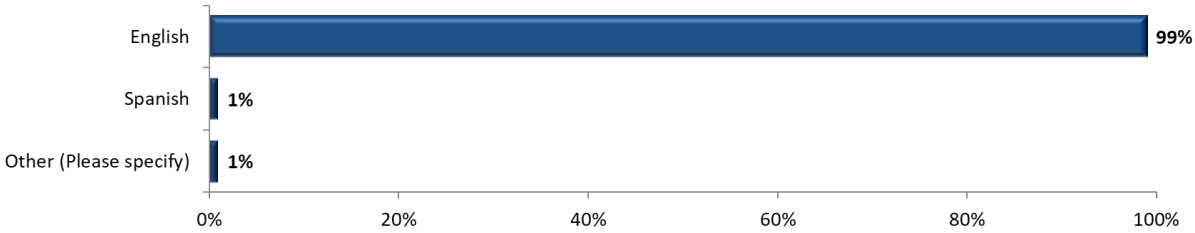


Figure 46: For employment, are you currently... (Select all that apply.)

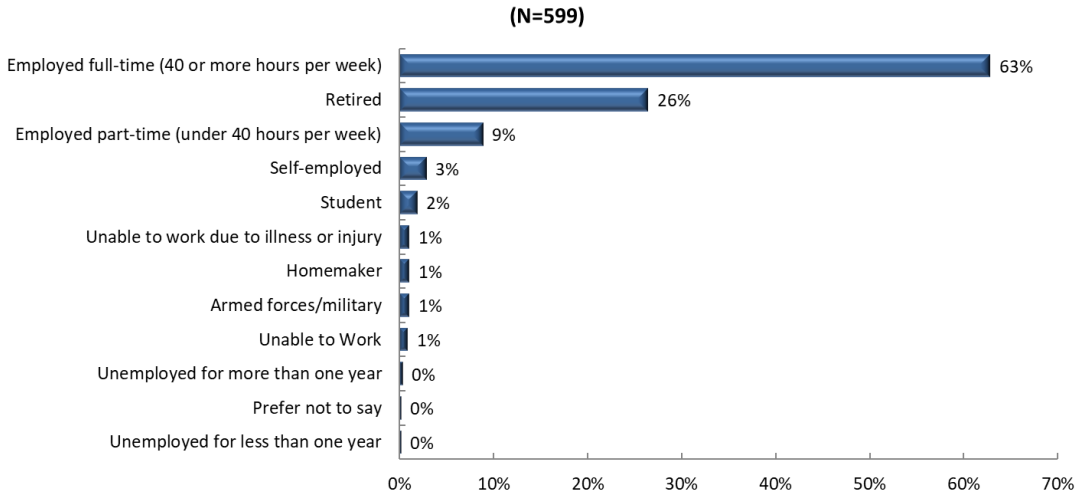
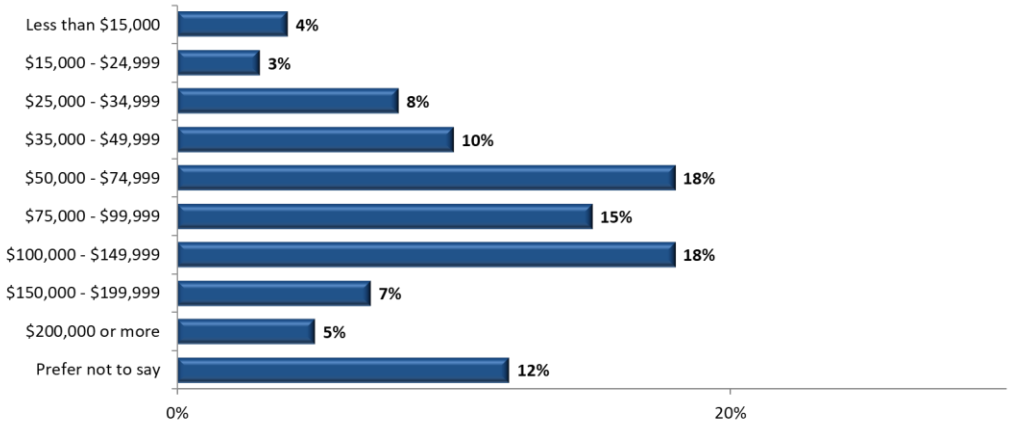


Figure 47: Which category best describes your yearly household income before taxes?[49]
(N=599)

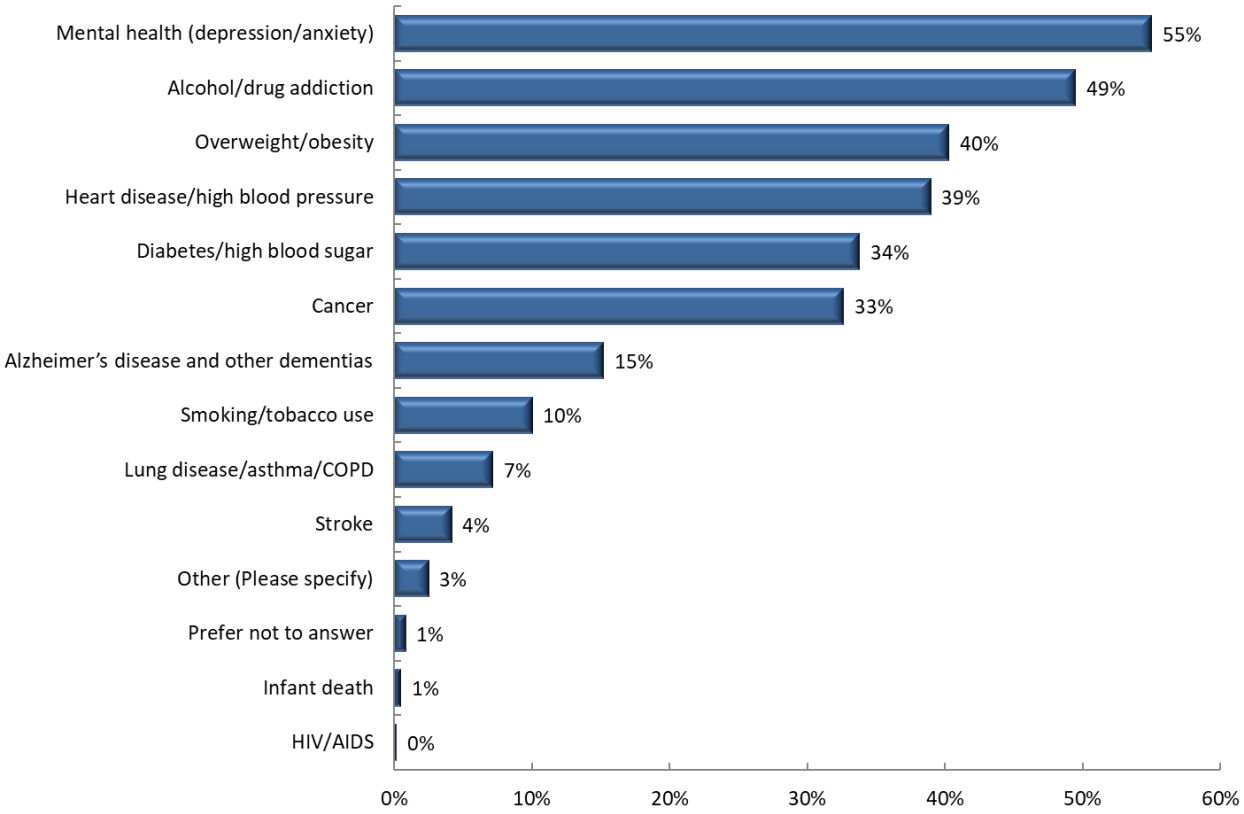


[49] Respondents were asked to include all income received from employment, social security, support from children or other family, welfare, Aid to Families with Dependent Children (AFDC), bank interest, retirement accounts, rental property, investments, etc.

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

Figure 48: What are the three most important health problems that affect the health of your community? Please select up to three.

(N=598)



Other (please specify):

- "Access to care"
- "Arthritis/ joint pain debility"
- "Dehydration"
- "Effective health care is inaccessible"
- "Homelessness"
- "Housing/Shelter Options"
- "Immobility"
- "Infertility and OB/GYN issues"
- "Lack of education"
- "Limited prenatal and postpartum care"
- "Maternal Health"
- "Movement disorders"
- "Vape usage, especially by school aged kids"

Figure 49: What are the three most important health problems that affect the health of your community? Please select up to three. (by age)

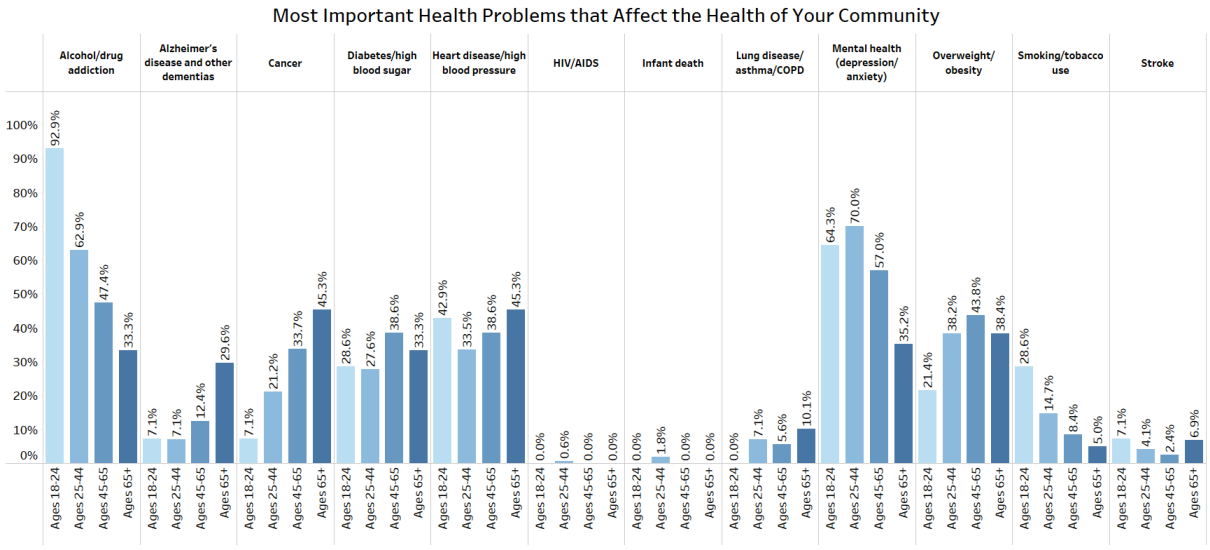


Figure 50: What are the three most important health problems that affect the health of your community? Please select up to three. (by gender)

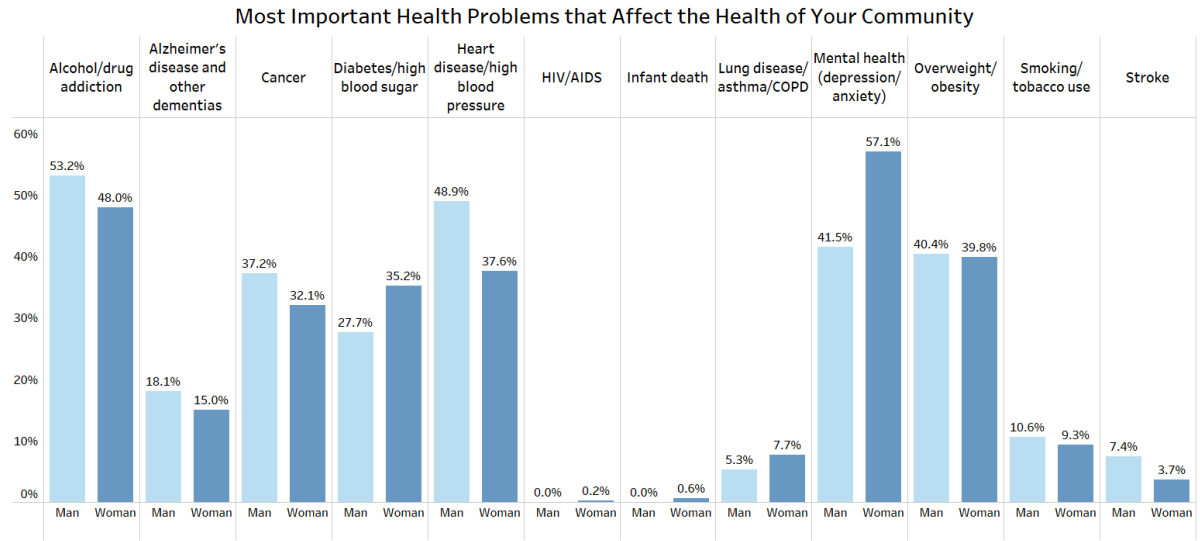


Figure 51: What are the three most important health problems that affect the health of your community? Please select up to three. (by race)

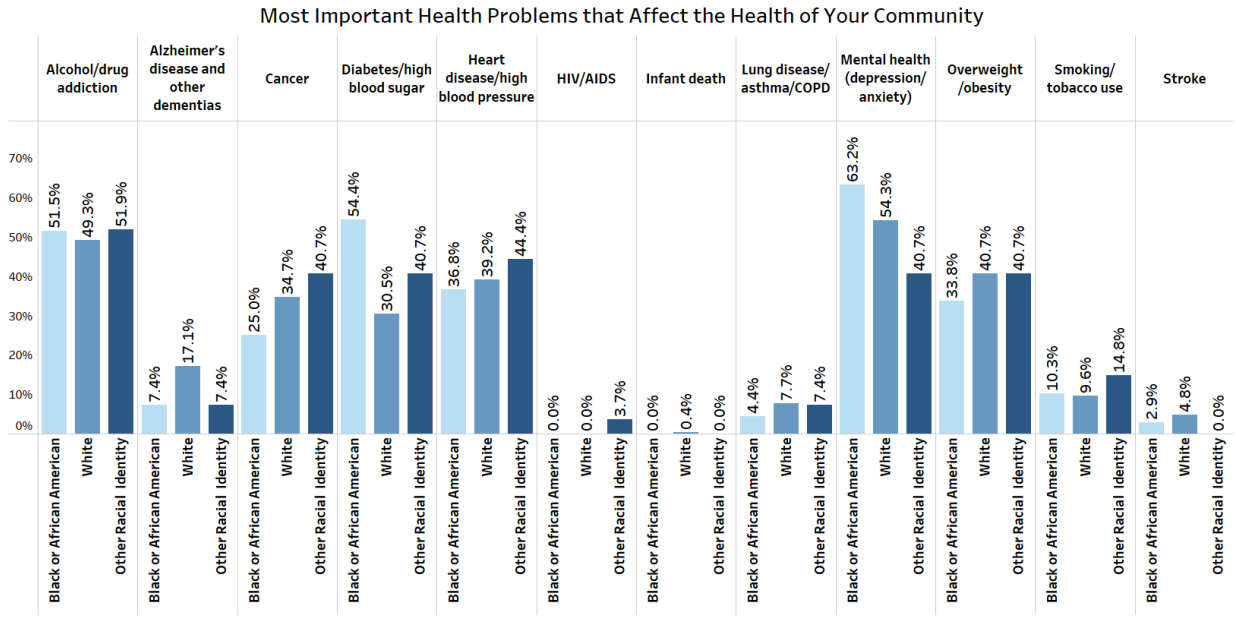


Figure 52: What are the three most important health problems that affect the health of your community? Please select up to three. (by ethnicity)

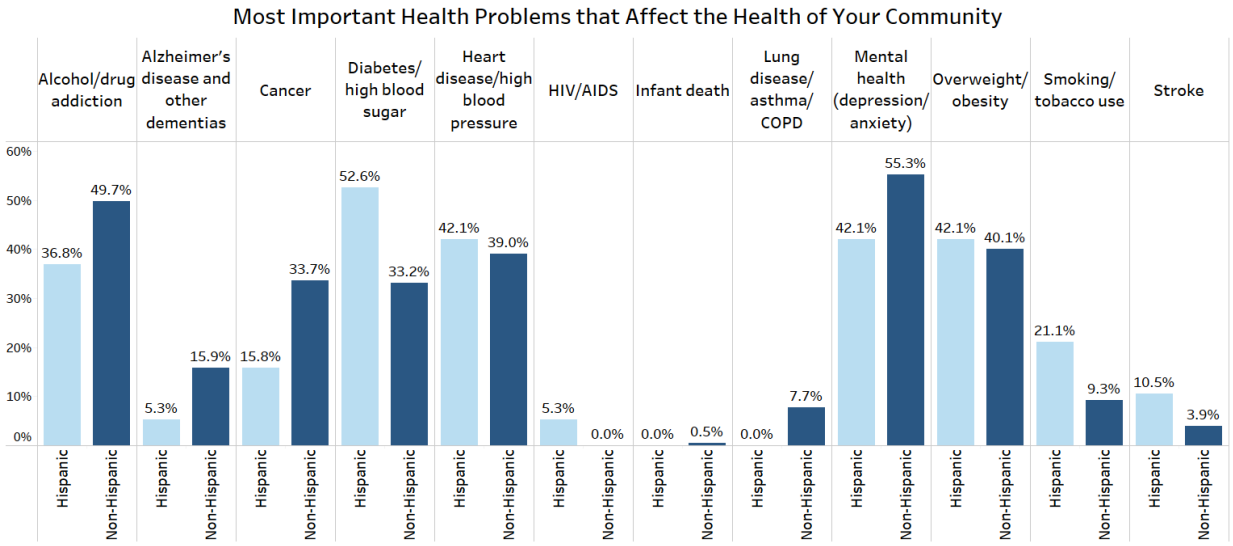
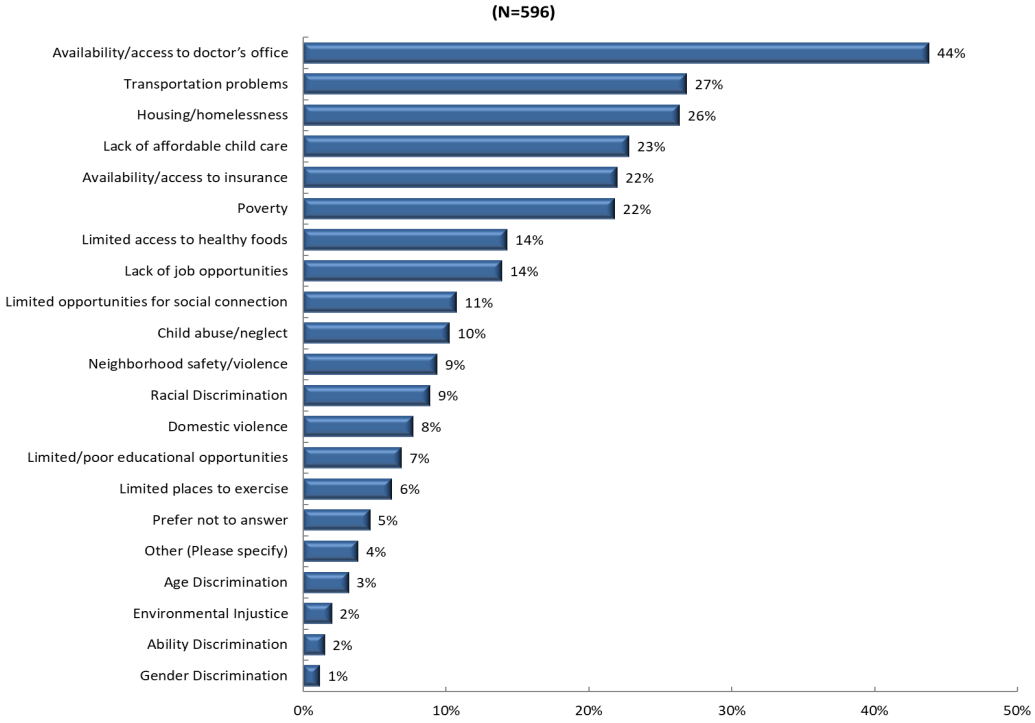


Figure 53: What are the three most important social or environmental problems that affect the health of your community? Please select up to three.



Other (please specify):

- "Affordable medical care"
- "Age discrimination."
- "Availability/Access to mental health & substance use treatment & prevention services"
- "Climate change"
- "Difficulty with obtaining resources. Example not everyone has access to computer and internet to apply for aid"
- "Distance from EMS"
- "Economic oppression"
- "Environment of low performance--I grew up in a trailer, my kids will too. I never went to college, neither will my kids"
- "Fatherless children" / "Too much fatherlessness"
- "Lack of affordable care for people with dementias"
- "Lack of store selection/variety to buy needs within town."
- "Language barriers"
- "Noncompliance"
- "Not enough working class, especially doctors, in our area for the amount of elderly moving here to retire. We can't keep up with them. Patients end up on waiting lists for months"
- "Political differences"
- "Resources currently in place are not effective. Dix Crisis Center will not provide transportation. No available beds when referred. Opiate task coordinator does not reach out to community programs/will not return calls. Craven needs their own detox/crisis center."
- "Respite Care for Elderly for Caregiver"
- "Some of these choices are self inflicted, some are imagined, others are just a cop-out"
- "Substance abuse"
- "Too many with criminal records unable to find jobs"

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

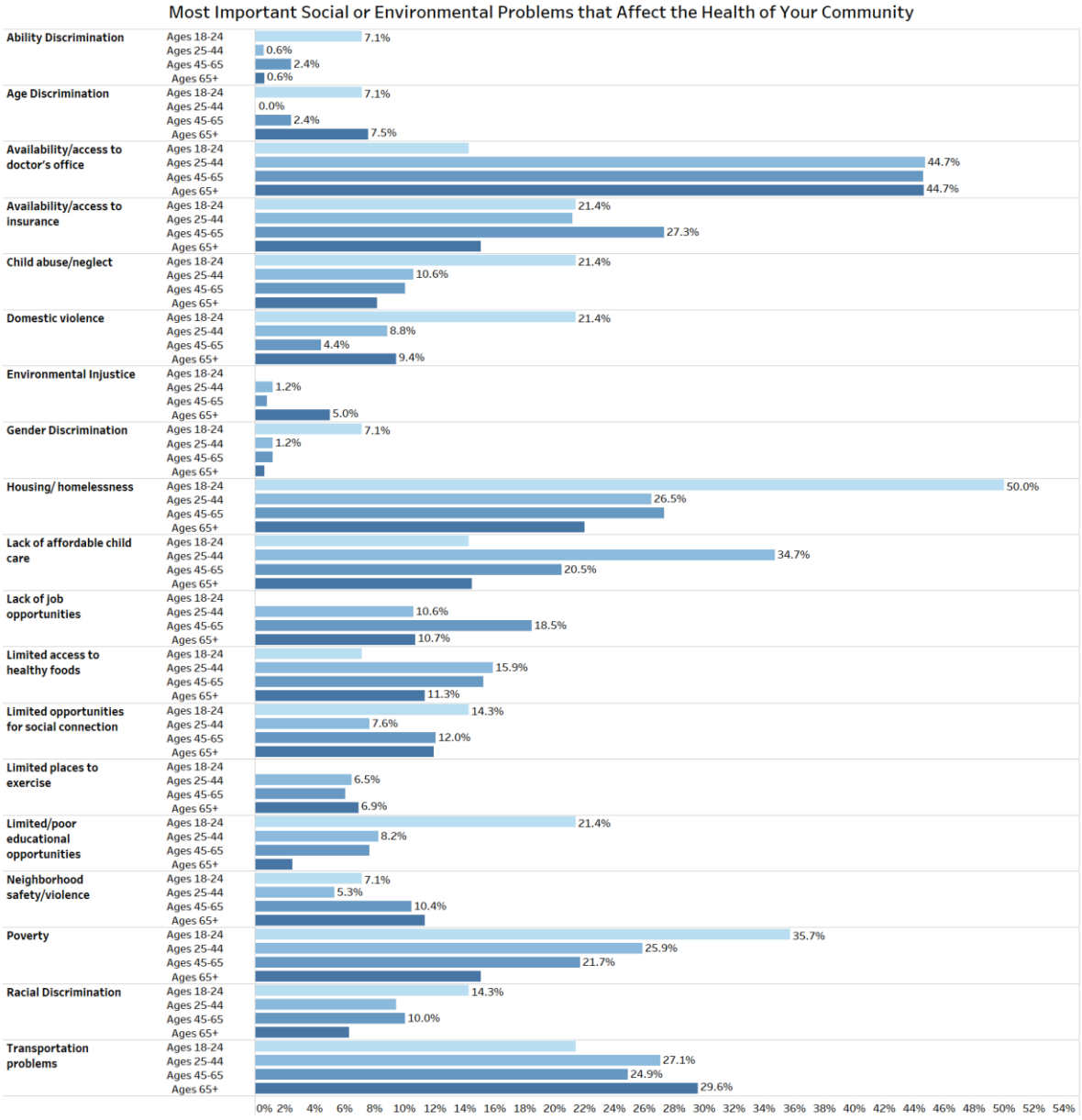


Figure 55: What are the three most important social or environmental problems that affect the health of your community? Please select up to three. (by gender)

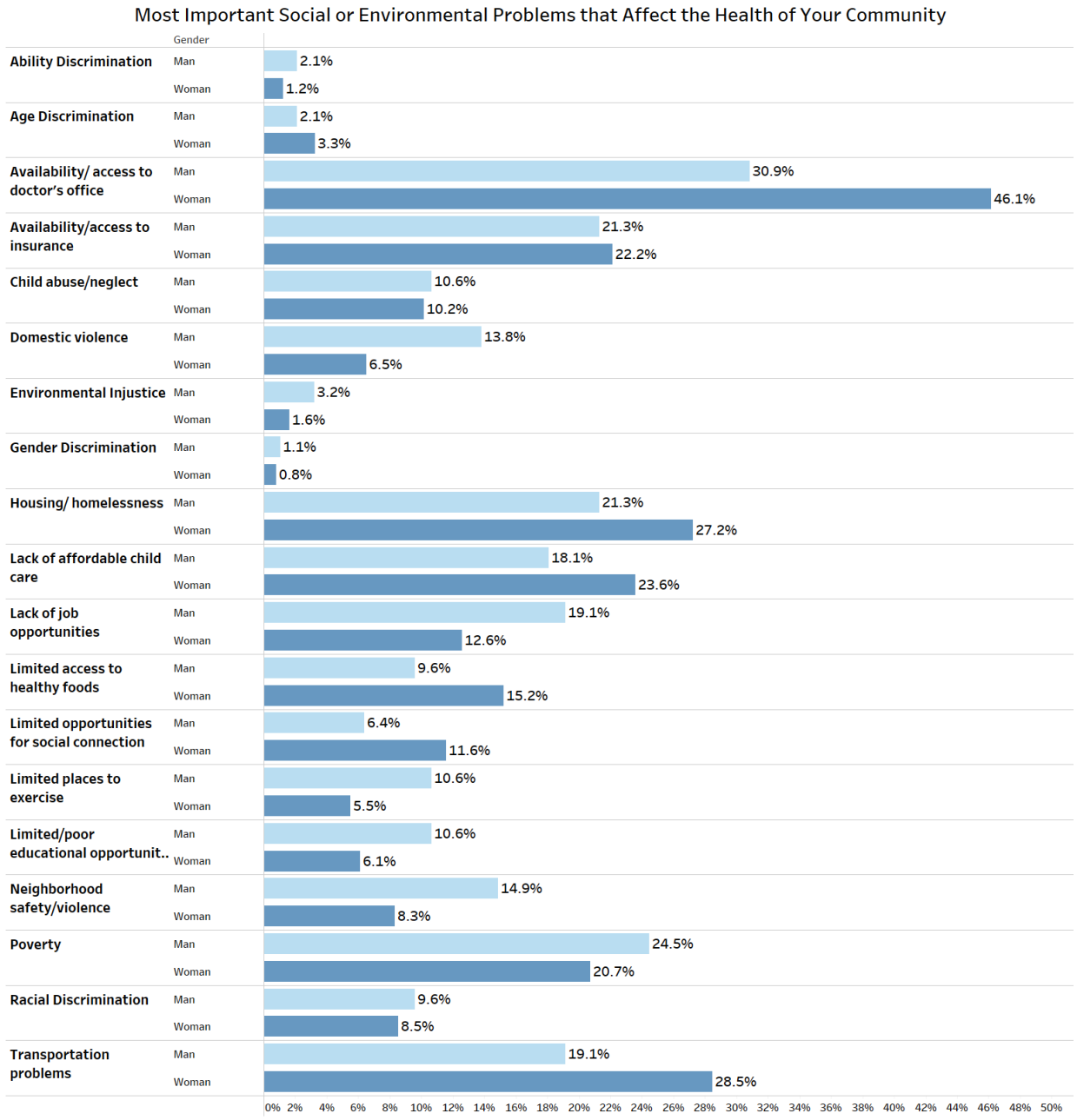


Figure 56: What are the three most important social or environmental problems that affect the health of your community? Please select up to three. (by race)

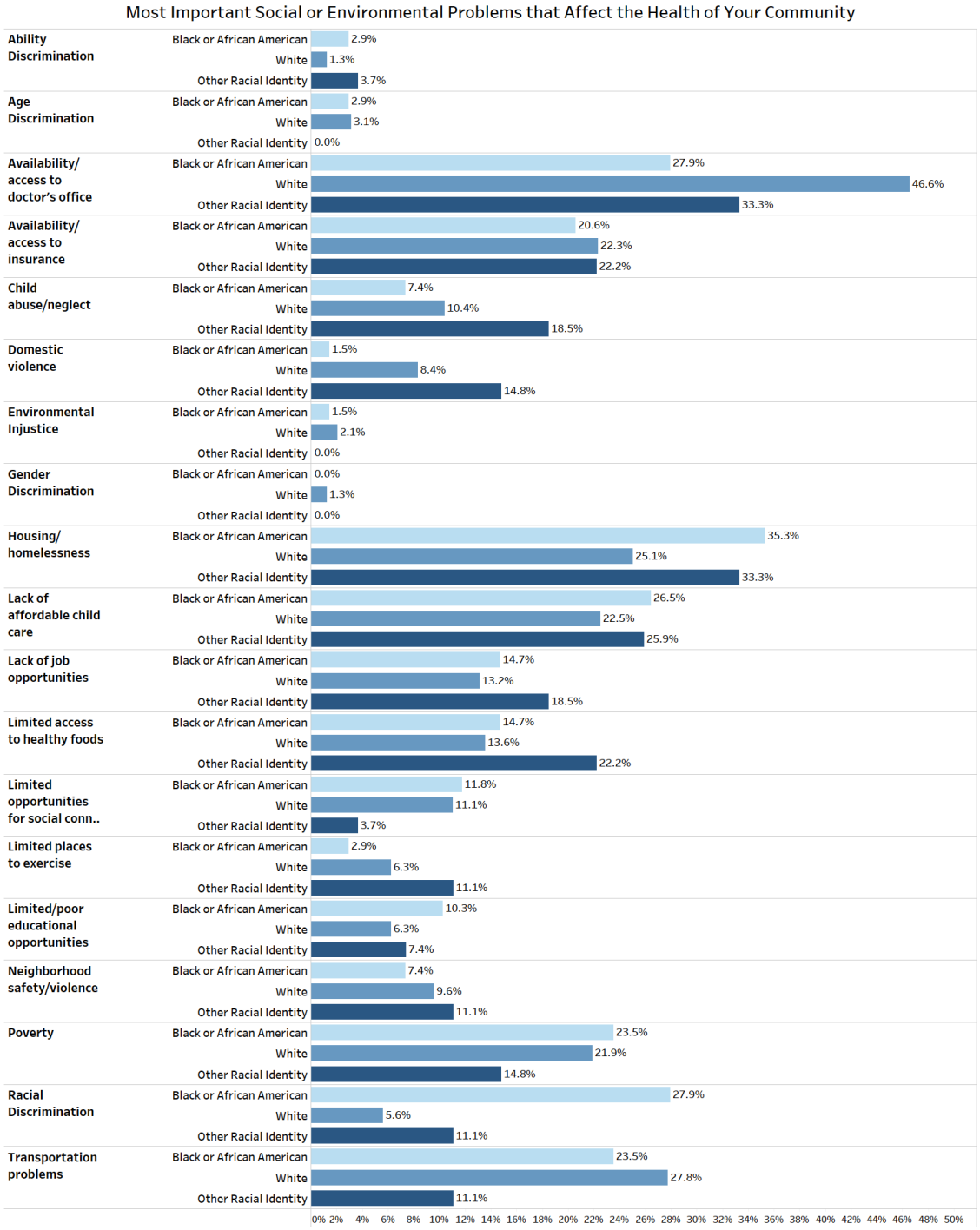


Figure 57: What are the three most important social or environmental problems that affect the health of your community? Please select up to three. (by ethnicity)

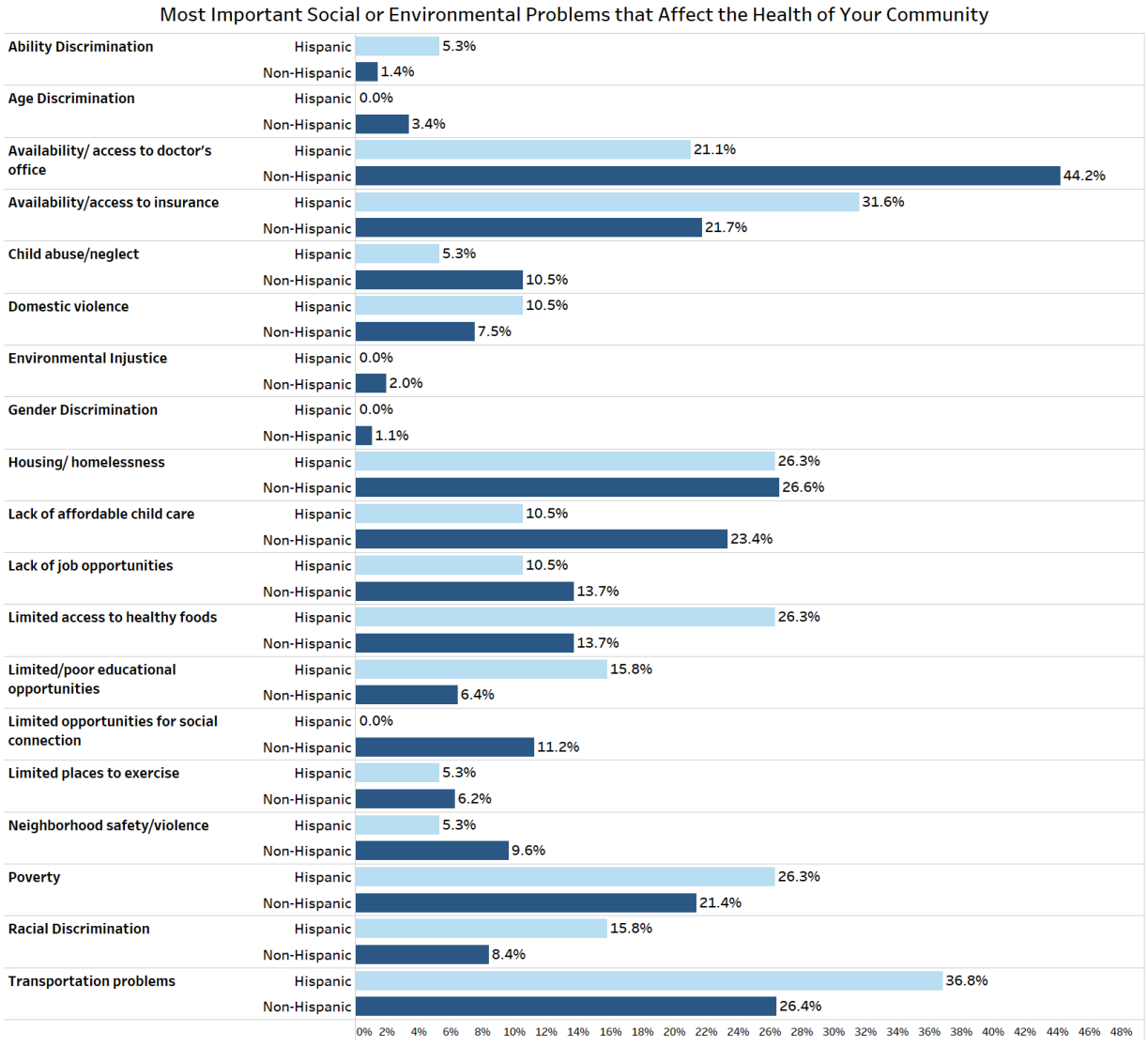
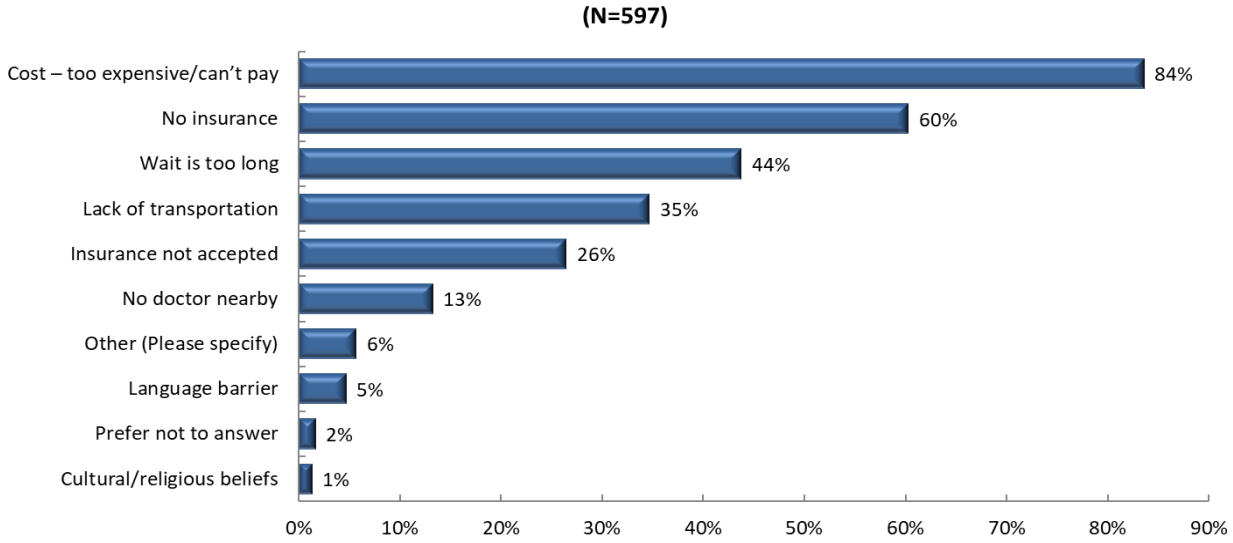


Figure 58: What are the three most important reasons people in your community do not get health care when they need it? Please select up to three.



Other (please specify):

- "Access to acute health care outside of er or urgent care er"
- "Addicts"
- "Afraid"
- "Appointments not readily available, takes several months to be seen"
- "Clinic hours over at 5 and no where for children to go but to the er if office not open"
- "Co-pay and insurance deductible is too high insurance policies . The amount of the insurance doesn't cover is high."
- "Difficulty for newcomers to find dr."
- "Doctors are screening patients and only taking on patients without major health concerns"
- "Doctors aren't accepting new patients"
- "Doctor's offices not accepting new patients."
- "fear"
- "I still hear if you go to a doctor they will find something wrong"
- "Ignorance"
- "Inability to actually get a dr as primary care provider. Wait lists"
- "Insurance not covering tests/meds"
- "Lack of communication from physician offices about appointments"
- "Lack of doctors"
- "Lack of doctors taking on new patients"
- "Long waits to get appts at physician offices"
- "No access to high risk pregnancy or neonatal care close by"
- "No doctors accepting new patients."
- "Not enough doctors to meet population needs"
- "Not enough doctors to take new patients"
- "Not enough doctors. many in this area are not accepting new patients or have extremely long waiting periods"
- "People do get health care"
- "People do not strive to secure employment that will enable to get them insurance"
- "Preference to reply on government programs for low-income."
- "stigma"
- "They don't have a primary care doctor"
- "Unaware of available resources"
- "Unfamiliar with how to navigate the system to get started with receiving routine care."
- "Working too much, no time"

Figure 59: 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)

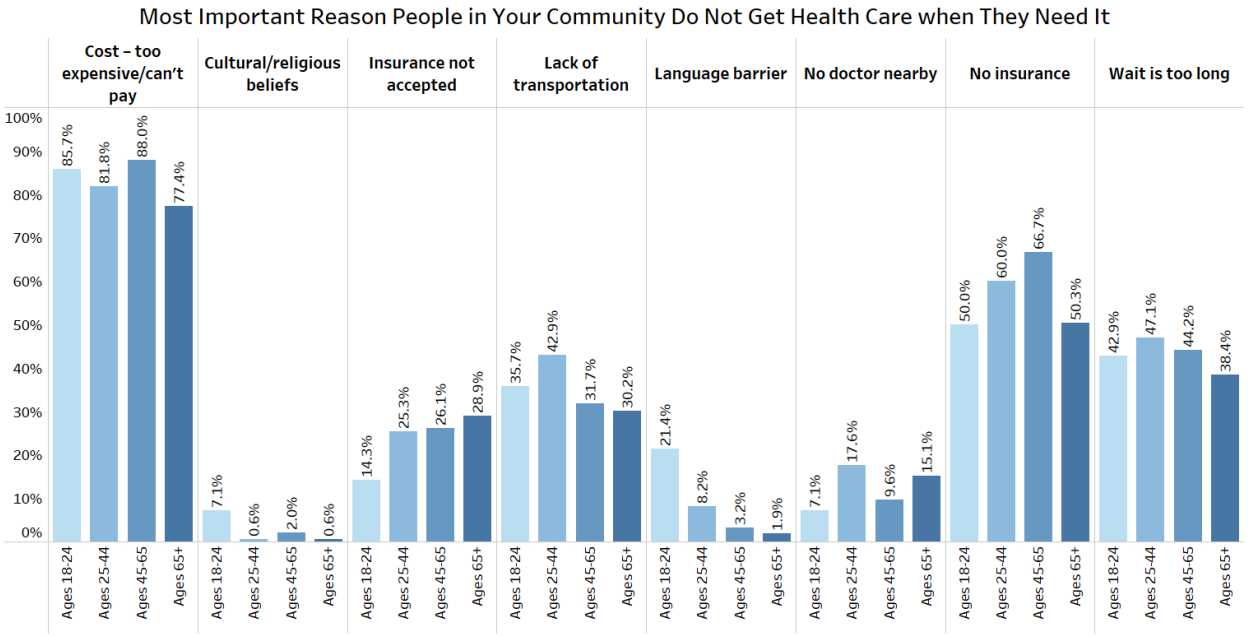


Figure 60: What are the three most important reasons people in your community do not get health care when they need it? Please select up to three. (by gender)

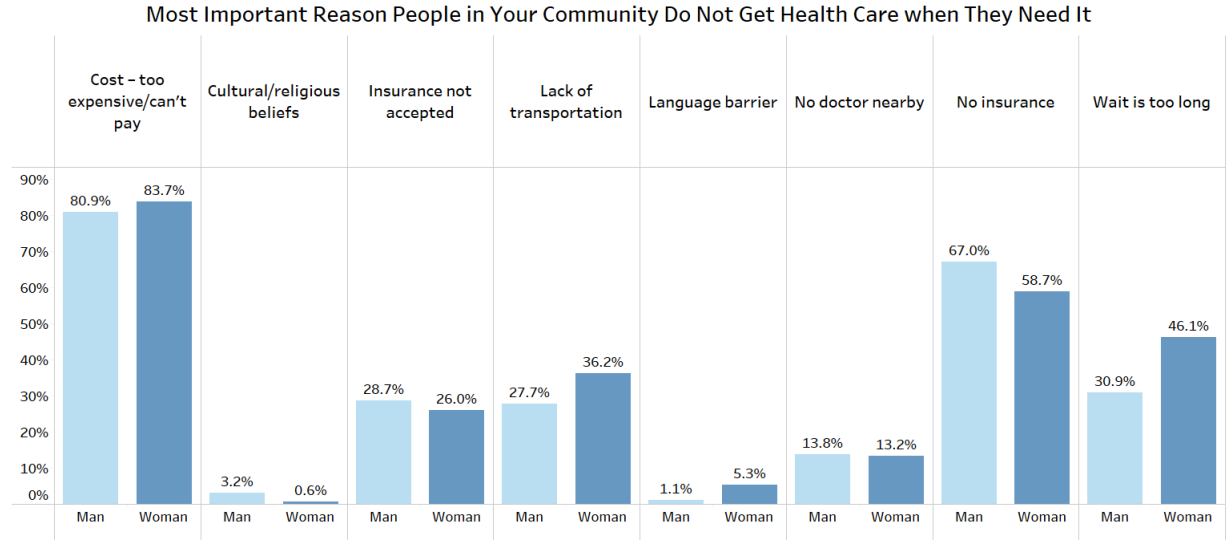


Figure 61: What are the three most important reasons people in your community do not get health care when they need it? Please select up to three. (by race)

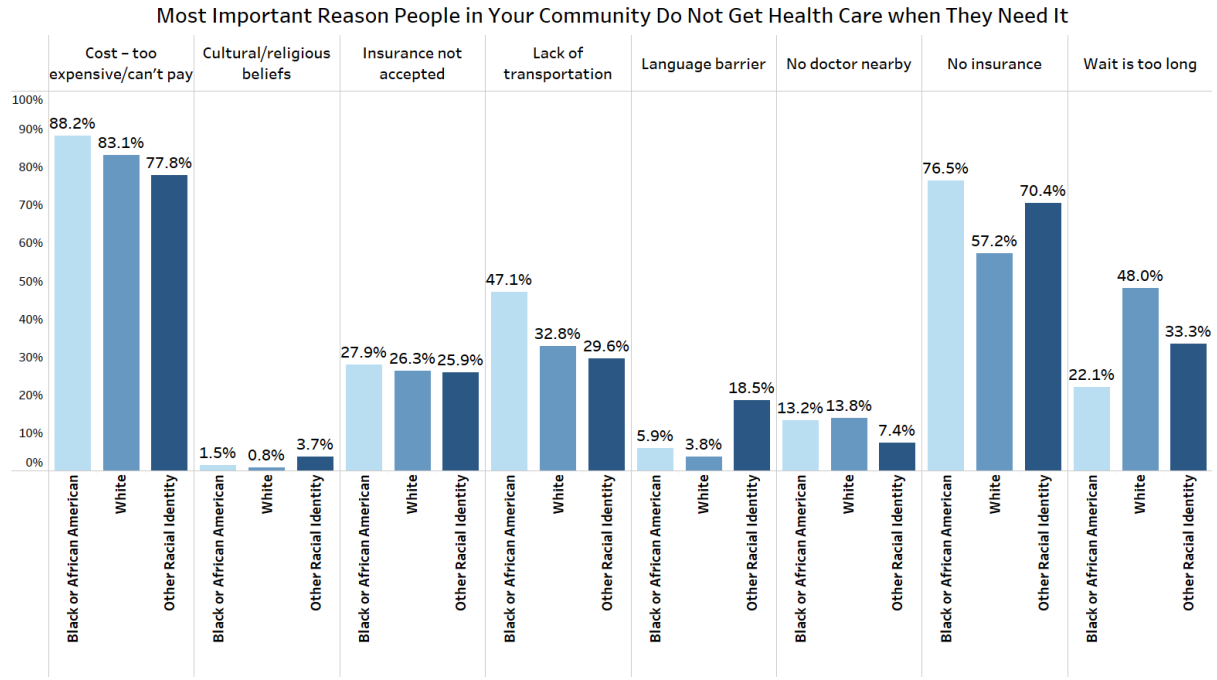
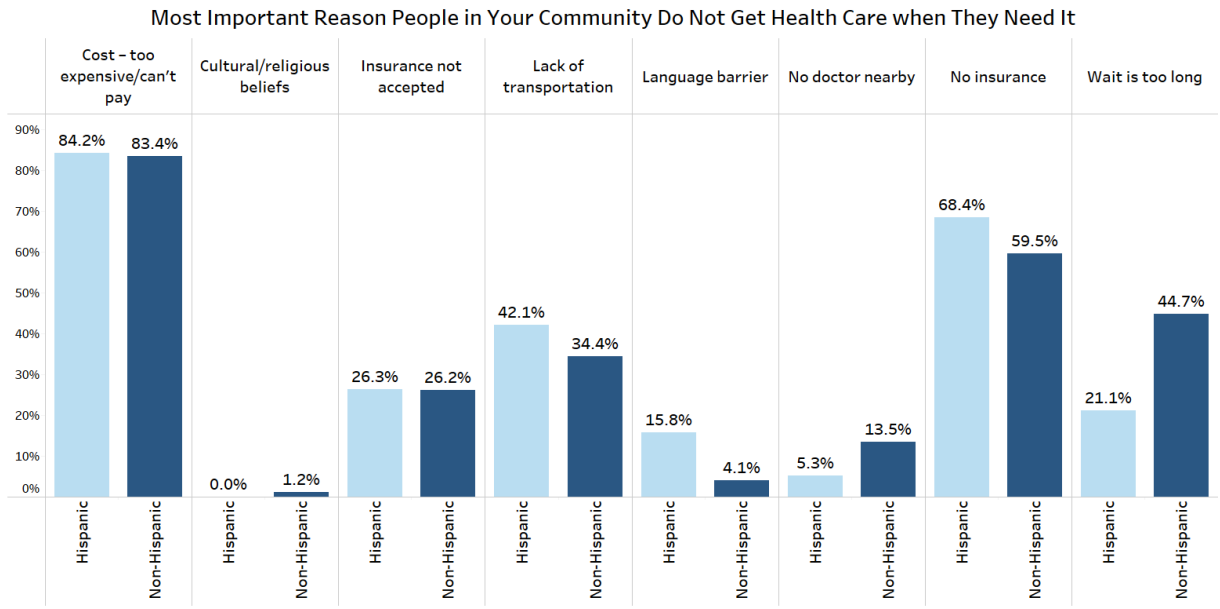


Figure 62: What are the three most important reasons people in your community do not get health care when they need it? Please select up to three. (by ethnicity)



Topic: Employment

Figure 63: For employment, are you currently... (Select all that apply.)

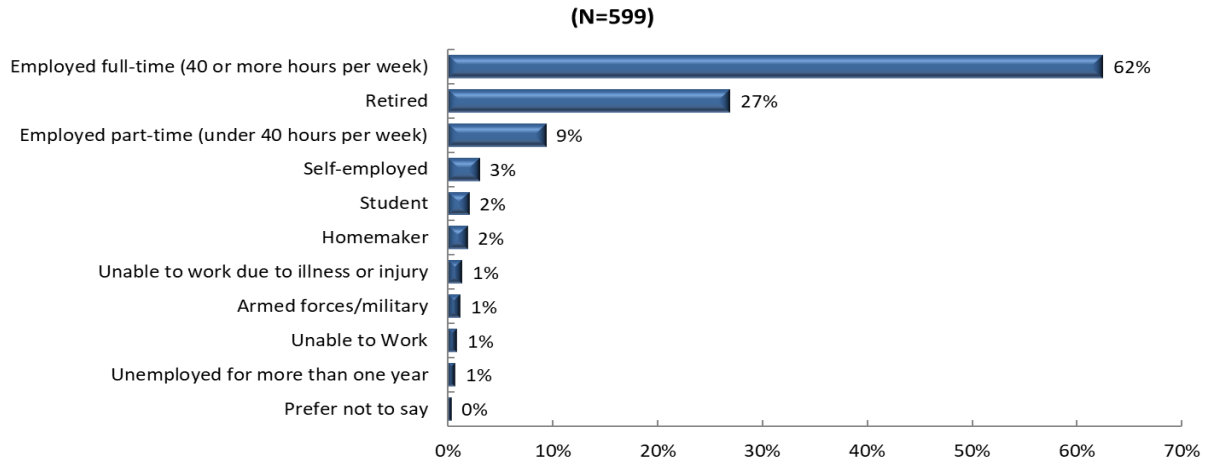


Figure 64: How concerned are you that an economic slump, downturn, or recession will cause you to be laid off, furloughed, or lose your job in the next 12 months?

Note: only participants who indicated they were currently employed were asked the current question

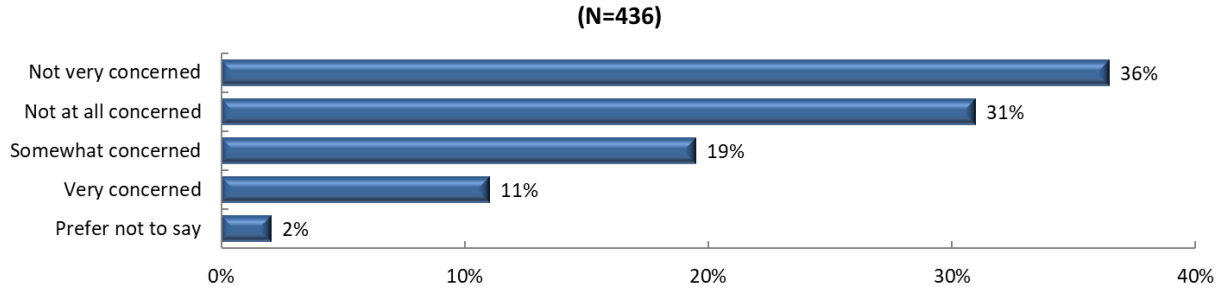


Figure 65: Do you intend to look for a new job at a different company or organization in the next year?

Note: only participants who indicated they were currently employed were asked the current question

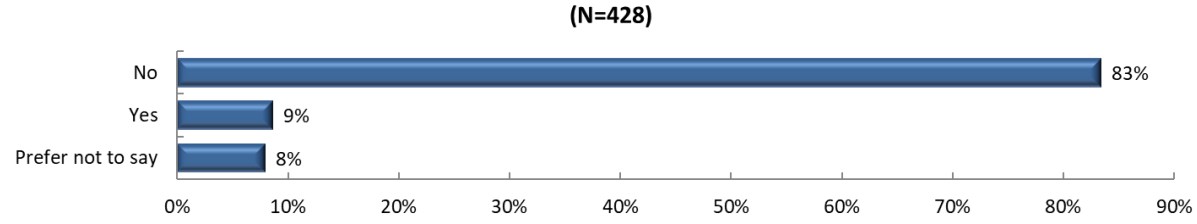


Figure 66: Do you currently want a job, either full or part time?
Note: only respondents who indicated that they were **not** currently employed (except those who indicated they were retired) were asked the current question

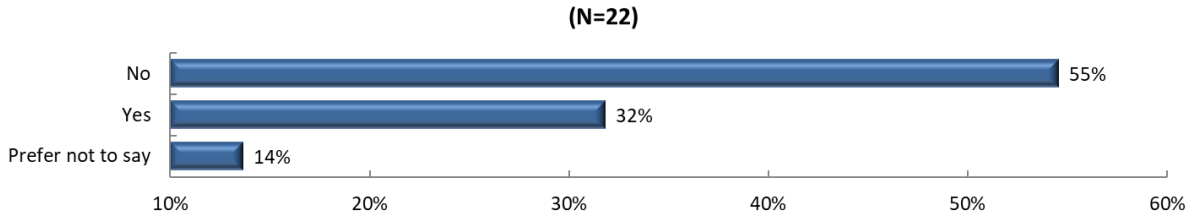


Figure 67: Have you been doing anything to find work during the last four weeks?
Note: only respondents who indicated that they were unemployed or unable to work were asked the current question

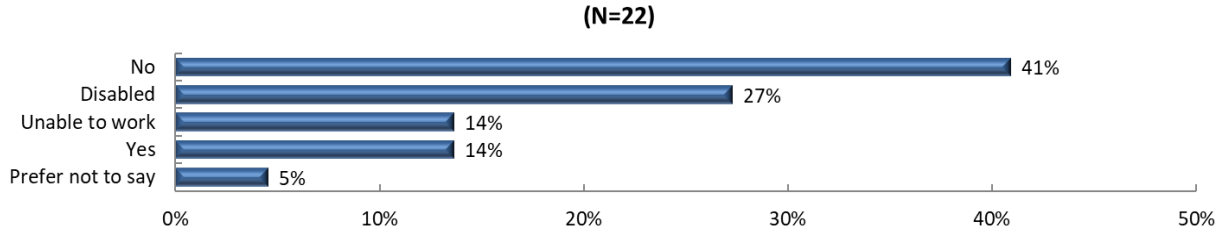
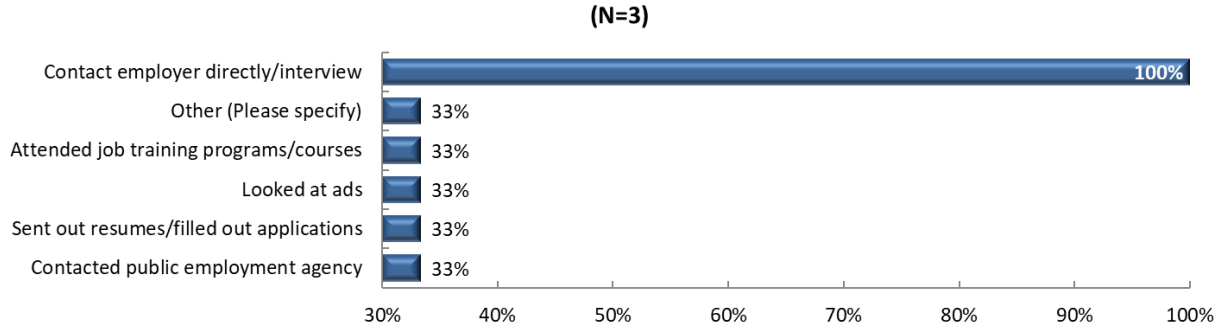


Figure 68: What are all the things you have done to find work during the last four weeks?
Note: that only respondents who indicated "YES" to previous question were asked the current question



Other (please specify):

- "Indeed"

Topic: Family, Community, and Social Support

Figure 69: The following statements describe what your neighborhood might be like. Tell us how much you agree or disagree.

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

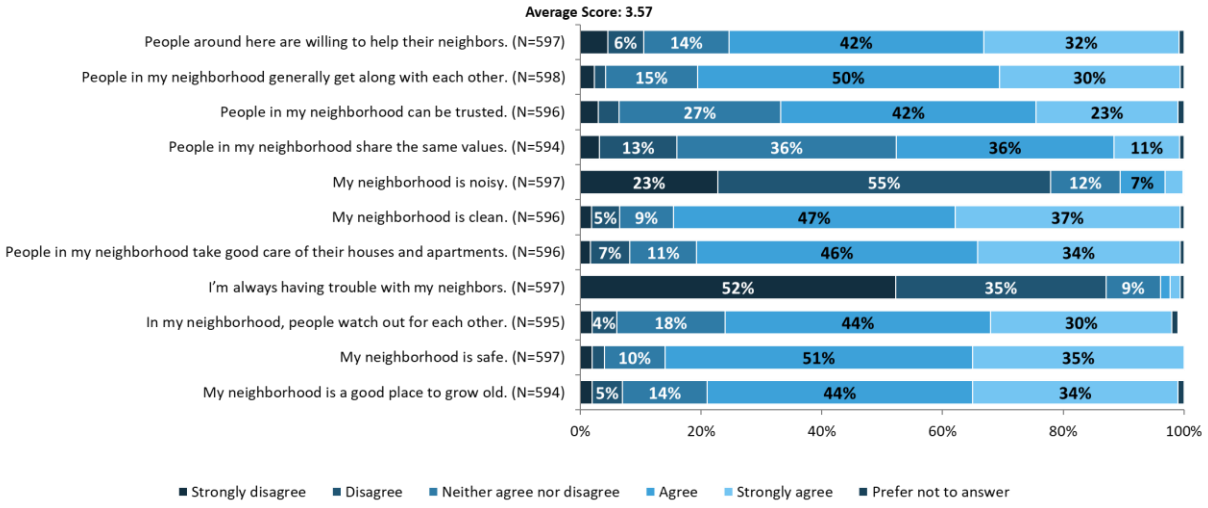
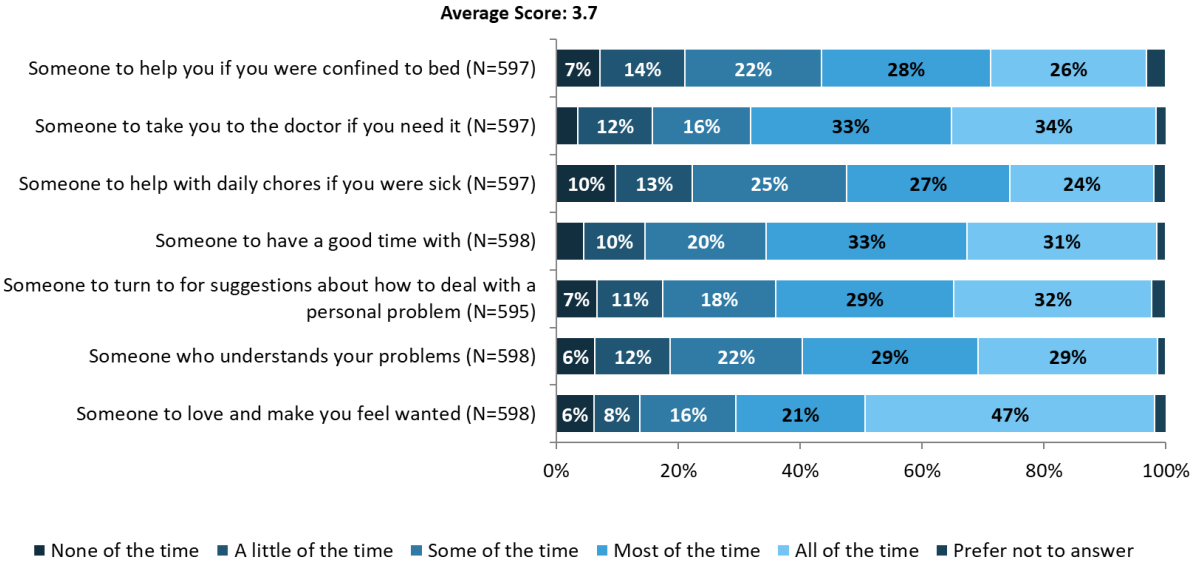


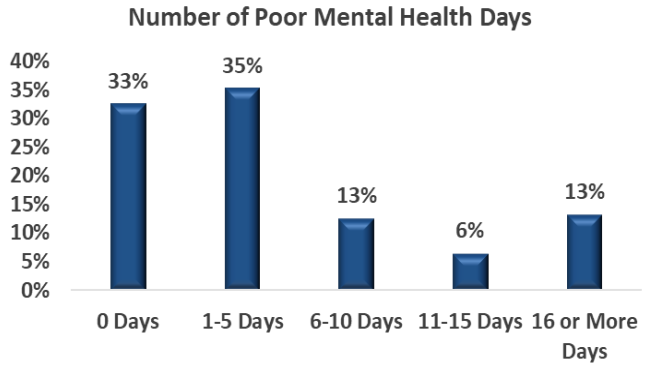
Figure 70: People sometimes look to others for friendship, help, or other types of support. In the following situations, how often could you find someone to support you?

Scale from 1 to 5 with 1 being "none of the time" and 5 being "all of the time"



Topic: Mental Health

Figure 71: 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=590)



Measure	Value
Mean (Standard Deviation)	7 (9)
Median	3
Mode	0
Minimum-Maximum	0-30

Figure 72: 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 responded that they had experienced at least 1 poor mental health day in the previous question were asked the current follow-up question

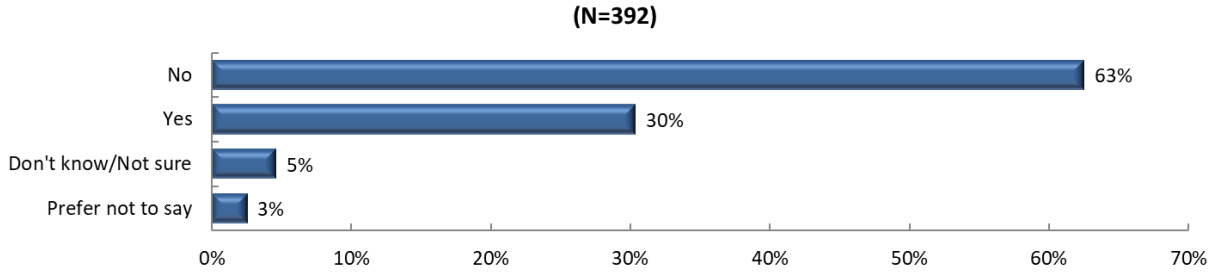
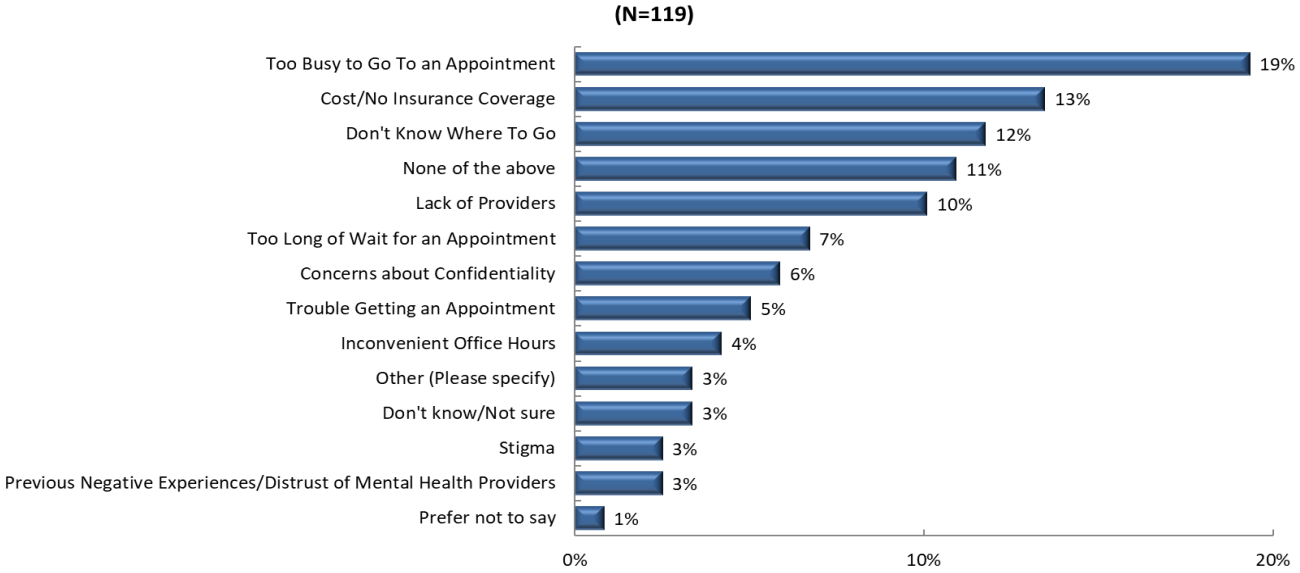


Figure 73: What was the MAIN reason you did not get mental health care or counseling?

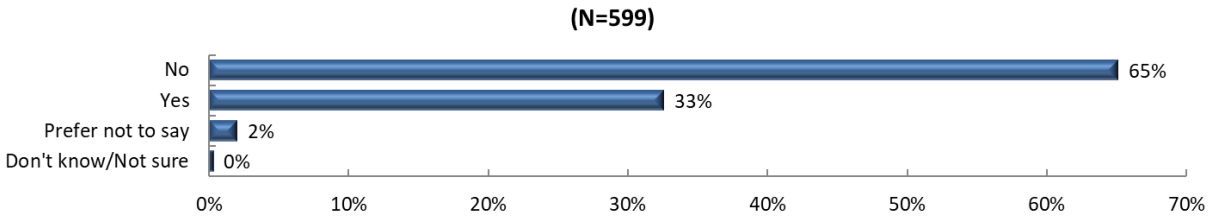
Note: only participants who answered "YES" to previous question were asked the current follow-up question



Other (please specify):

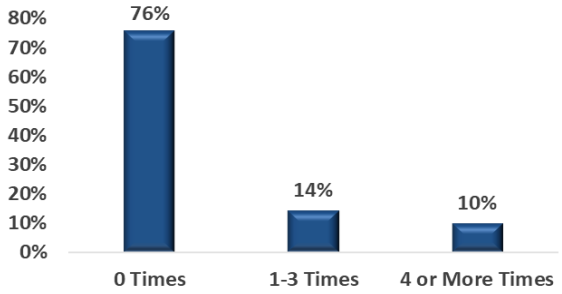
- "Cost WITH insurance coverage"
- "Had an appointment which got rescheduled"
- "I contacted about 5 social workers with experience in cPTSD and support for being a caregiver of spouse with dementia. Left message never called back. Don't know if it's me or them"
- "Not enough resources and providers"

Figure 74: 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: Substance Use Disorders

Figure 75: Considering all types of alcoholic beverages, how many times during the past 30 days did you have 4 (females)/ 5 (males) or more drinks on an occasion?
(N = 593)



Measure	Value
Mean (Standard Deviation)	1 (4)
Median	0
Mode	0
Minimum-Maximum	0-30

Figure 76: How often do you consume any kind of alcohol product, including beer, wine or hard liquor?

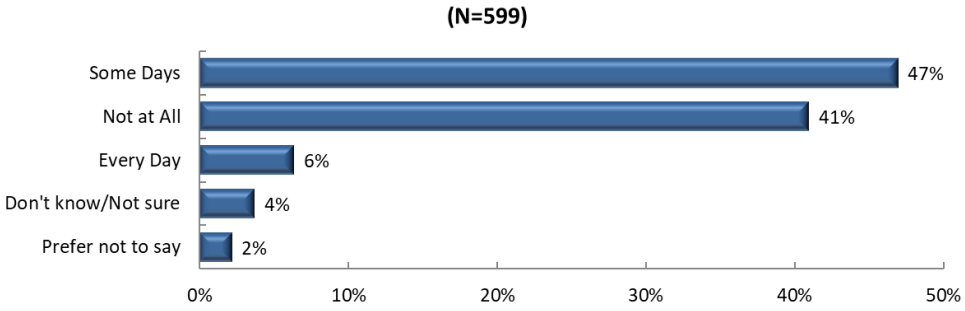


Figure 77: In the past year, have you or a member of your household misused any form of prescription drugs (e.g. used without a prescription, used more than prescribed, used more often than prescribed, or used for any reason other than a doctor's instructions)?

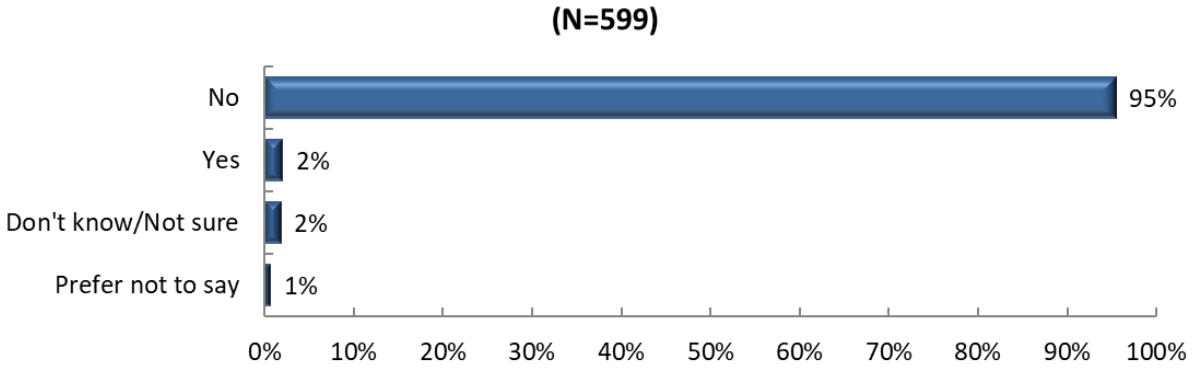
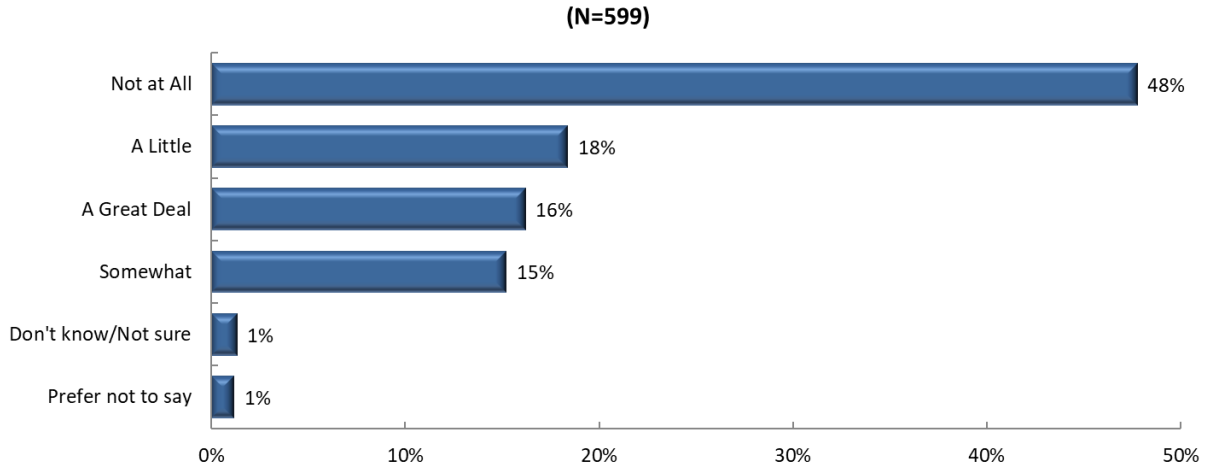


Figure 78: To what degree has your life been negatively affected by YOUR OWN or SOMEONE ELSE's substance abuse issues, including alcohol, prescription, and other drugs?



APPENDIX 6 | SUMMARY OF DATA FINDINGS ACROSS SOURCES

Primary and Secondary data findings are summarized in full by the table below.[50]

Priority Area	Secondary Data	Community Survey	Focus Group 1	Focus Group 2	Focus Group 3
Behavioral Health: Mental Health		✓	✓	✓	✓
Behavioral Health: Substance Use	✓	✓	✓	✓	
Built Environment	✓				
Community Safety					
Diet & Exercise	✓				
Education					✓
Employment & Income	✓		✓		
Environmental Quality	✓				
Family, Community & Social Support	✓				✓
Food Access & Security	✓			✓	
Healthcare: Access & Quality	✓	✓	✓		✓
Health Equity & Literacy					
Housing & Homelessness		✓			
Length of Life	✓				
Maternal & Infant Health				✓	
Physical Health (Chronic Diseases, Cancer, Obesity)		✓	✓	✓	
Sexual Health			✓	✓	
Tobacco Use	✓				✓
Transportation & Transit	✓	✓		✓	

[50] 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.