Greene County

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2024 COMMUNITY HEALTH NEEDS ASSESSMENT

Greene County Department of Public Health
Public Health
Prevent. Promote. Protect.

ECU HEALTH
Medical Center

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)

Greene County CHNA Leadership

In addition to the Steering Committee, the Greene County 2024 CHNA was developed in partnership with representatives from Greene County Department of Public Health and ECU Health.

Name	Title	Organization
Joy Brock, MPH	Health Director	Greene County DPH
Emmanuelle Quenum, MPH, MCHES®, NBC-HWC	Health Education Director	Greene County DPH
Rose Ann Simmons, MPH	Senior Administrator, Community Health Improvement	ECU Health
Jennifer Bennett Lane, BS, CHES®	Health Educator II	Greene County DPH

Greene County CHNA Stakeholders

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

Name	Organization
Joy Brock, MPH	Greene County DPH
Emmanuelle Quenum, MPH, MCHES®, NBC-HWC	Greene County DPH
Jennifer B. Lane, BSPH, CHES®	Greene County DPH
Jordan Walker	Greene County DPH East Carolina University Intern
Michael Rhodes	Greene County Board of Health
Melissa Torres	Contentnea Health
Mike Andrews	Contentnea Health
Sharon Harrison	Greene County Senior Center
Renate Harper	Greene County Senior Center
Kateisha Jones	Trillium Health Resources
Barbara Williams	Community Member

In addition, the Health ENC Steering Committee and Greene 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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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 developed as part of the Health ENC coalition's collaborative, regional 2024 CHNA process. Health ENC – a group of stakeholders who help find ways to collaborate and share resources to improve the health of the population in eastern North Carolina – served an integral role in making this comprehensive assessment possible. The report adheres to North Carolina Local Health Department Accreditation standards, as well as Internal Revenue Service requirements for not-for-profit hospitals.

Vision Statement

Through collaboration between the Health ENC Steering Committee, Greene County Department of Public Health and ECU Health, the 2024 CHNA process aspires to create a healthier eastern North Carolina where collaborative action, shared resources, and community engagement converge to eliminate health disparities and build resilient, connected communities that support wellbeing for generations to come.

Greene County CHNA Leadership

Greene County opted for a bi-sectoral approach to the leadership of the 2024 CHNA process, which included representatives from Greene County Department of Public Health (DPH) and ECU Health.

Name	Title	Organization
Joy Brock, MPH	Health Director	Greene County DPH
Emmanuelle Quenum, MPH, MCHES®, NBC-HWC	Health Education Director	Greene County DPH
Rose Ann Simmons, MPH	Senior Administrator, Community Health Improvement	ECU Health
Jennifer Bennett Lane, BS, CHES®	Health Educator II	Greene County DPH

Greene County CHNA Partnerships

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

Type of Partner Organization	Number of Partners
Public Health Agency	1
Hospital/Health Care System(s)	1
Healthcare Provider(s)	1
Behavioral Healthcare Provider(s)	1
Community Organization(s)	2
Government/Public Agencies	1
Public Member	1

The Health ENC Steering Committee and Greene 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.

Greene County CHNA Timeline and Process

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

Secondary (existing) data came from various public sources related to demographics, social determinants of health, environmental health, disease trends, behavioral health trends, and individual health behaviors. Data was evaluated using the Robert Wood Johnson Foundation's population health framework and compared to state or national benchmarks to identify areas of concern. Top needs identified through the secondary data included health issues related to physical health and tobacco use, and social or environmental concerns such as education, housing and homelessness, and family, community, and social support.
Primary (new) data were collected through a focus group, key informant interviews, and a web-based survey for community members, gathering feedback from 152 people who live, work or receive healthcare in Greene County. Primary data identified chronic health conditions, mental health, and substance use as top needs in the community. Additional concerns included lack of job opportunities, barriers to healthcare access including cost and transportation, and limited access to healthy foods and exercise opportunities.

Representatives from Greene 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. The three priority health needs selected (in alphabetical order) are: Chronic Health Conditions, Mental Health, and Substance Use.

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

Following completion of this report, health leaders throughout Greene County will use its findings to collaborate with community organizations and local residents to develop effective health strategies, new implementation plans and interventions, and action plans to improve the communities they serve.

INTRODUCTION

Background

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

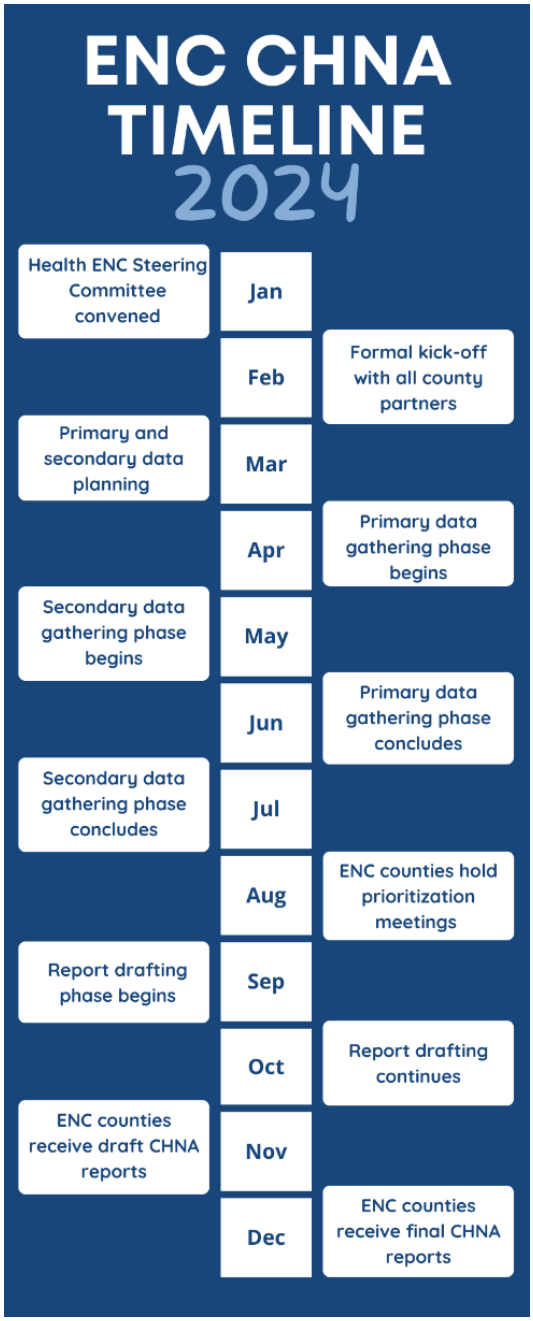
- Define the community it serves;
- Assess the health needs of that community;
- Through the assessment process, take into account input received from people who represent the community's broad interests, including those with special knowledge of or expertise in public health;
- Document the CHNA in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

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

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

Figure 3: The Community Health Assessment Process[3]

Report Structure

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

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

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

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

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

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

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

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

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

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

3) *Detailed Summary of Primary Findings* – Summaries of new data findings from community member surveys, key informant interviews, and 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, Greene County completed its previous assessment. Associated implementation strategies focused on two priority areas, as listed below:

Figure 4: Greene 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.

Greene County Department of Public Health

The Greene County Department of Public Health is located in Snow Hill and employs full-time, part-time, and contract staff. The mission of the Greene County Department of Public Health is to protect, preserve,

and enhance the public health of Greene County through a commitment to the principles of public health practice in the community. Greene County Department of Public Health provides the following programs and clinical services to its community members: Breast and Cervical Cancer Control Program (BCCCP); Care Management for At-Risk Children (CMARC) program; Child Health Clinic; Communicable Disease Program; General Clinic; Care Management for High-Risk Pregnancies (CMHRP) program; STD Clinic; Women, Infants, and Children (WIC) program; and a Women's Health Clinic. The Greene County Department of Public Health also houses Environmental Health.

ECU Health

The ECU Health system includes 1,708 beds across an academic medical center with two campuses, a teaching hospital at East Carolina University; eight community hospitals; and numerous outpatient facilities, home health, hospice, and wellness centers. The system serves more than 1.4 million people in 29 counties and has more than 1,100 academic and community providers practicing in over 185 primary and specialty clinics located in more than 110 locations.

Previous CHNA Priority: Healthy Behaviors

- **The Family Accountability and Recovery Court (FARC):** FARC is a program for parents, guardians, or caretakers who are involved with the Department of Social Services and/or struggle with substance use. Many FARC participants have lost or are at risk of losing their children because of abuse and/or neglect. FARC provides treatment, intensive case management, and judicial supervision to increase the likelihood of reunification of families or positive outcomes for the parents and children. Participants have access to substance and mental health assessments and comprehensive treatment. From FY 2023 to FY 2024, the 9th Judicial District Family Accountability and Recovery Court graduated four participants.
- **Narcan Distribution:** Five locations in Greene County have been distributing Narcan since FY 2022.
- **Media Campaigns:** Greene County Department of Public Health implemented mass media campaigns related to tobacco cessation and awareness.
- **QuitlineNC:** In FY 2023, 13 Greene County residents enrolled in QuitlineNC, a free tobacco cessation service.

Previous CHNA Priority: Physical Environment

- **Minority Diabetes Prevention Program**: From FY 2022 to FY 2023, 32 participants completed the twelve-month Minority Diabetes Prevention program.
- **Weight-Wise:** In FY 2023, 30% of participants lost weight while participating in Weight-Wise, a sixteen-week weight management program.

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

Throughout Greene 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 Greene 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 Greene County CHNA Leadership identified Greene 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 Greene County CHNA Leadership, the focus areas identified as countywide priorities for the 2024 CHNA are Chronic Health Conditions, Mental Health, and Substance Use, as seen in **Figure 5**.

Figure 5: Green 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.

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

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 Greene County CHNA Leadership's goal is to work with other community organizations to address underlying factors that could drive long-term improvements to the county population's health.

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

CHAPTER 1 | METHODOLOGY

Study Design

The process used to assess Greene 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 Greene County's health needs. While the Greene County CHNA Leadership 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 a community focus group, interviews with key informants, and significant input and direction from the Greene County CHNA Leadership. 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 Greene County, including access to care, healthy lifestyle, food security, physical health, substance use disorders, and tobacco use.

Interviews were conducted with four community champions for Greene County. These community champions consisted of long-term residents of Greene County, including a County Commissioner, who had significant local knowledge of health and well-being in the community. In addition, one focus group was conducted among members of the community. Participants were asked a standard set of questions about health and social needs, in order to identify trends across various groups and to highlight areas of concern for specific populations. Through this process, input was gathered from numerous Greene County residents and other stakeholders. This included survey responses (web and printed form in English and Spanish languages) from over 150 community members and one focus group that included three community members and other people who live, work or receive healthcare in Greene County, in addition to the four community champions interviewed. Fliers that contained a QR code to access the survey were distributed to local businesses throughout the county. Paper surveys were distributed to community partners to share, faith-based organizations, Greene County Department of Public Health, Greene County Senior Center, and community events such as the Juneteenth Festival.

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

- *County Health Rankings*, developed in partnership by Robert Wood Johnson Foundation (RWJF) and University of Wisconsin Population Health Institute
- *The Opportunity Atlas*, developed in partnership by the U.S. Census Bureau, Harvard University, and Brown University
- *Food Access Research Atlas*, published by the U.S. Food and Drug Administration
- *Social Vulnerability Index*, developed by the CDC and the Agency for Toxic Substances and Disease Registry (ATSDR)
- *Environmental Justice Index*, developed by the CDC and the ATSDR
- *American Community Survey*, as collected and published by the U.S. Census Bureau
- Data provided by CHNA Steering Committee members and other affiliated organizations, including previous Community Health Assessments from Greene County in 2019 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 Greene County to an outside measure, it would be impossible to determine how the county is performing. For this process, each data measure was compared to outside data as available, including the following:

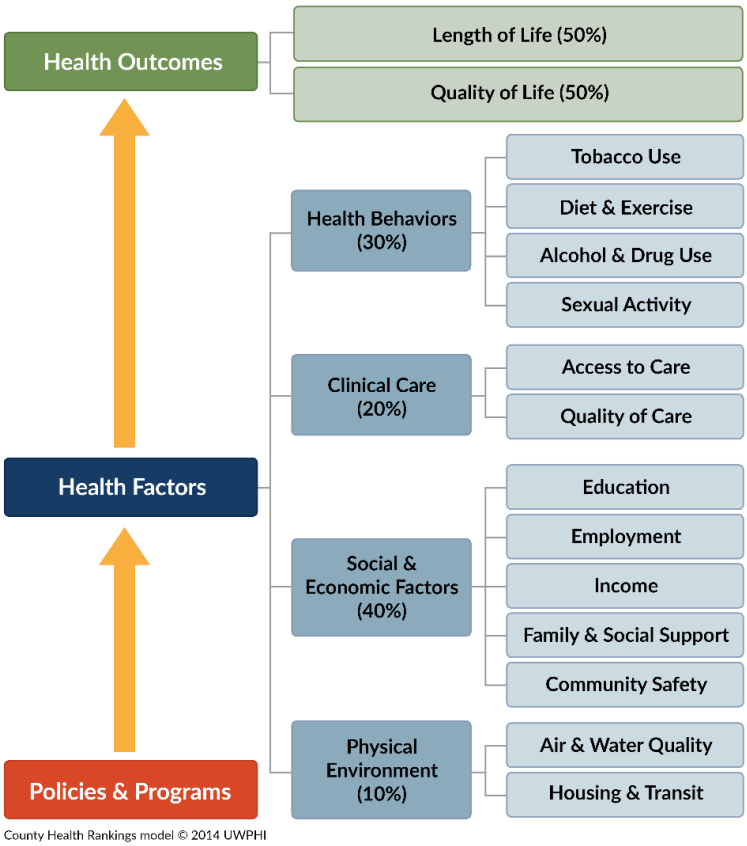
- *County Health Rankings* Top Performers: This is a collaboration between the RWJF and the University of Wisconsin Population Health Institute that ranks counties across the nation by various health factors.
- State of North Carolina: The Steering Committee determined that comparisons with the state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

Population Health Framework

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

Using the population health framework as a guide for the CHNA process helps categorize many individual pieces of data in a way that connects the dots between health status and social drivers of health, in a way that helps local leaders better understand and address the health and well-being of the communities they serve. This understanding is critical in identifying potential interventions to address priority needs in the community, and to helping develop partnerships across sectors that can help drive these interventions forward. **Figure 6** below illustrates the broad categories and sub-categories within the population health framework.

Figure 6: Population Health Framework[5]



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

Figure 7: Social Determinants of Health[6]

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

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

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

Figure 8: SDoH and Health Disparities[7]

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 Greene County CHNA Leadership considered which focus areas had data measures of high need or worsening performance, priorities from the primary data, and how possible it is for health departments or hospitals to impact the given need to help determine which health needs should be prioritized.

The leadership in Greene County utilized the multi-voting technique to determine Greene County's priority need areas, while considering the following factors:

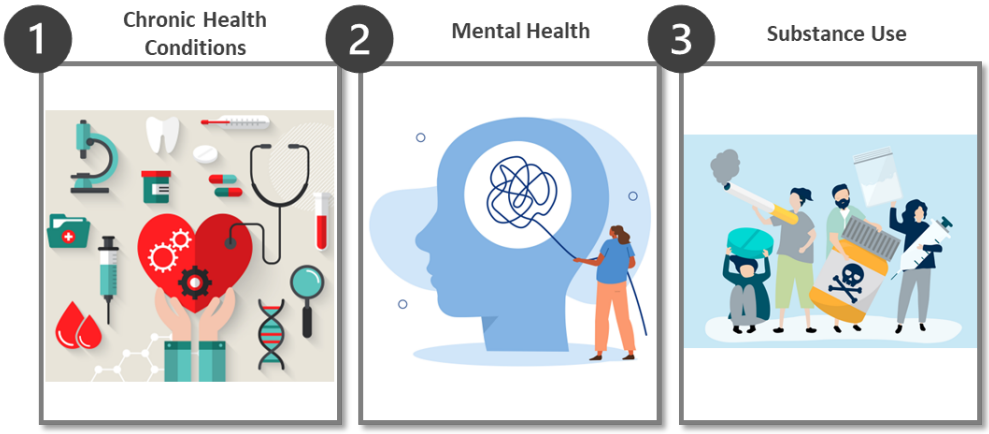
- Size and scope of the health need;

[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/

- 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 Greene County CHNA Leadership. The following three focus areas (Chronic Health Conditions, Mental Health, and Substance Use) were identified as Greene County's top priority health needs to be addressed over the next three years, as seen in **Figure 9** below:

Figure 9: Greene County 2024 Priority Health Needs



The following organizations participated in the prioritization voting process.

- Community Member
- Contentnea Health
- Greene County Board of Health
- Greene County Department of Public Health
- Greene County Senior Center
- Trillium Health Resources

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 Greene County CHNA Leadership tried to account for these limitations by collecting new data, including focus group 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 Greene County in both population and geography, this study was limited in its ability to fully capture health disparities and health needs across racial and ethnic groups. Resource limitations meant that county leaders relied on convenience sampling to engage with the community via the web-based survey. This method of survey sampling may fail to capture a truly representative cross-section of the community, resulting in overrepresentation of some demographic groups and underrepresentation of others. This can lead to findings that don't accurately reflect the health needs and perspectives of the entire community, particularly those from underrepresented or marginalized groups. Efforts were made to include diverse community members in survey efforts. Roughly 50% of all respondents were White compared to 46% of the Greene County population reported as being White. Another 40% of respondents were Black or African American, exceeding the county population reported as being 35%. Roughly 9% of respondents identified as Hispanic, which is less than the reported county population level of 15%. Although survey respondents could choose from multiple race or ethnicity categories, limited responses were received from these groups. This made it difficult for the Greene County CHNA Leadership to assess health needs and disparities for other racial/ethnic minority groups in the community. Furthermore, while the percentage of respondents identifying from certain racial/ethnic minority groups were similar or exceeded the community composition, a lower overall survey response rate also may have impacted the ability to assess health needs and disparities for all community groups.

In addition, there are existing gaps in information for some population groups. Many available datasets are not able to isolate historically underserved populations, including the uninsured, low-income persons, and/or certain minority groups. Despite the lack of available data, attempts were made to include underserved sub-segments of the greater population through the new data gathered throughout the CHNA process. For example, the Steering Committee chose to focus on Spanish-speaking members of the community by providing a Spanish language version of the web-based community 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 a focus group. 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 Greene County CHNA Leadership has assumed that participating community members accurately and completely represented their fellow residents.

Geography

Greene County is located in the Inner Coastal Plain region of North Carolina, characterized by the presence of low-lying areas, winding rivers, and rolling hills. It covers a total of 267 square miles. The county seat, Snow Hill, is the largest town and major commercial center in the county. The town draws its name from the historic white sandy banks of nearby Contentnea Creek. Among the towns and communities in the county are Hookerton, Maury, and Walstonburg. All of Greene 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.

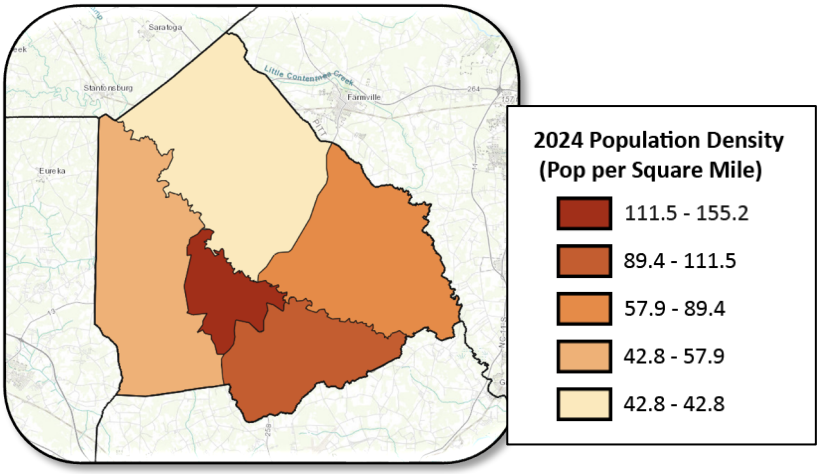
Greene County makes up less than 0.2% of the state's population.

Table 1: Total Population, 2023[8]

	Greene County	North Carolina	United States
Population	20,112	10,765,678	337,470,185

Greene County has a population density of 74.7 persons per square mile – lower than the population density for North Carolina (214.7 persons per square mile). Snow Hill is the most densely populated area in the county.

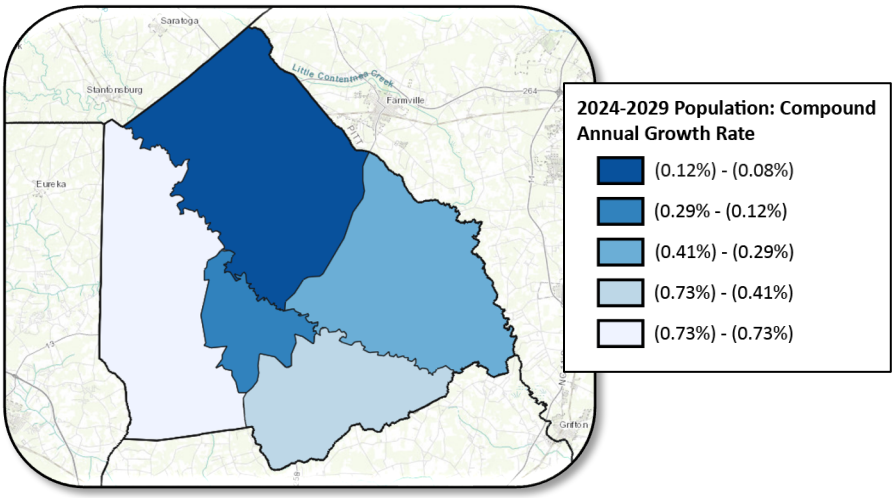
Figure 10: Greene County Map: Population Density[8]



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

In total, the population of Greene County is projected to decline 0.34% annually between 2024 and 2029. Areas in the western part of the county are experiencing greater declines.

Figure 11: Greene 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 Greene County differs from state averages. The county has a lower percentage of residents below 15 (16.4%) compared to North Carolina (17.9%). However, the percentage of residents between 15 and 44 (42.4%) is notably higher than the state average (39.3%). The proportion ages 45 to 64 (24.8%) is similar to North Carolina's (25.1%), while those 65 and older (16.4%) are slightly lower than the state average (17.7%). This suggests a younger working-age population in Greene County compared to state demographics.

Table 2: Age Distribution, 2023[8]

	Greene County	North Carolina	United States
Percentage below 15	16.4%	17.9%	18.1%
Percentage between 15 and 44	42.4%	39.3%	39.5%
Percentage between 45 and 64	24.8%	25.1%	24.6%
Percentage 65 and older	16.4%	17.7%	17.8%

The sex distribution in Greene County differs from state averages, with males making up 52.2% and females 47.8% of the population. This is the inverse of North Carolina's distribution (51.0% female, 49.0% male), making Greene County one of the few counties with a higher male population.

Table 3: Sex Distribution, 2023[8]

	Greene County		North Carolina		United States	
	Count	Pct. of Total	Count	Pct. of Total	Count	Pct. of Total
Female	9,611	47.8%	5,489,419	51.0%	170,118,720	50.4%
Male	10,501	52.2%	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. Greene County's racial composition differs from state averages. Non-Hispanic Black residents comprise 35.4% of the population, significantly higher than North Carolina's 20.4%. Non-Hispanic White residents make up 48.0% of the population, lower than the state's 61.2%. The county has notably small percentages of Asian, American Indian Alaskan Native (AIAN), and Native Hawaiian Pacific Islander (NHPI) populations, with each group making up less than 1% of the population.

Table 4: Racial Distribution, 2023[8]

	Greene County		North Carolina		United States	
	Count	Pct. of Total	Count	Pct. of Total	Count	Pct. of Total
Black (Non-Hispanic)	7,120	35.4%	2,199,488	20.4%	42,132,758	12.5%
White (Non-Hispanic)	9,652	48.0%	6,590,161	61.2%	204,562,590	60.6%
Asian	41	0.2%	379,374	3.5%	21,088,177	6.2%
AIAN	187	0.9%	133,820	1.2%	3,831,126	1.1%
NHPI	12	0.1%	9,214	0.1%	712,229	0.2%
Some Other Race Alone	2,189	10.9%	677, 338	6.3%	29,432,586	8.7%
Two or More Races	911	4.5%	776,283	7.2%	35,710,719	10.6%

By ethnicity, approximately 15% of Greene County residents are Hispanic. This is significantly higher than the proportion in the state overall (11.2%).

Table 5: Ethnic Distribution, 2023[8]

	Greene County		North Carolina		United States	
	Count	Pct. of Total	Count	Pct. of Total	Count	Pct. of Total
Non-Hispanic	17,049	84.8%	9,465,874	88.6%	271,934,049	80.6%
Hispanic	3,063	15.2%	1,299,804	11.4%	65,536,136	19.4%

The proportion of foreign-born individuals residing in Greene County is nearly 7%. This is slightly lower than the state level of 9%.

Table 6: Foreign Born Population, 2022[9]

	Greene County	North Carolina	United States
Foreign Born	6.9%	9%	13.9%

The diversity of Greene County is reflected in the languages that residents speak at home. According to the most recent American Community Survey (ACS), approximately 17% of Greene County residents speak a language other than English at home, compared to around 13% of North Carolina and 22% U.S. residents. Nearly 16% of county residents speak Spanish at home.

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

	Greene County	North Carolina	United States
English Only	83%	87.3%	78%
Spanish	15.7%	7.9%	13.3%
Indo-European Languages	0.5%	2.1%	3.8%
Asian and Pacific Islander Languages	0.3%	1.9%	3.6%
Other Languages	0.6%	0.8%	1.2%

Disability Status[10]

Data on disabilities helps us understand how to create fair and equal opportunities for everyone in the county. In addition, individuals with disabilities may require targeted services and outreach by health and other service providers. The percentage of Greene County's population with a disability (21%) is significantly higher than both the state average (13.3%) and national average (12.9%).

Table 8: Disability Status, 2022[9]

	Greene County	North Carolina	United States
Population with a Disability	21%	13.3%	12.9%

[9] Source: U.S. Census Bureau. "Selected Social Characteristics in the United States." American Community Survey, ACS 5-Year and 1-Year Estimates Data Profiles, Table DP02, 2022, https://data.census.gov. Accessed on April 1, 2024.
[10] Disability status is classified in the ACS according to yes/no responses to questions about six types of disability concepts. For children under 5 years old, hearing and vision difficulty are used to determine disability status. For children between the ages of 5 and 14, disability status is determined from hearing, vision, cognitive, ambulatory, and self-care difficulties. For people aged 15 years and older, they are considered to have a disability if they have difficulty with any one of the six difficulty types.

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. There is a smaller veteran population in Greene County (5.7%) compared to the state rate (7.8%).

Table 9: Veteran Status 2022[9]

	Greene County	North Carolina	United States
Veterans	5.7%	7.8%	6.2%

Economic Indicators

In addition to demographic data, socioeconomic factors in the community such as income, poverty, and food scarcity play a significant role in identifying health-related needs. The median household income in Greene County is $48,707, lower than state and national figures.

Table 10: Median Household Income, 2022[8]

	Greene County	North Carolina	United States
Median Household Income	$48,707	$64,316	$72,603

In 2023, approximately 15.2% of Greene County households were below the federal poverty level (FPL), higher than the state or nation. Poverty has a significant impact on health. Across the lifespan, people who live in impoverished communities have a higher risk of poor health outcomes, including mental illness, chronic diseases, higher mortality and lower life expectancy. Poverty is a concern across the lifespan; children who live in poverty are at risk for developmental delays, toxic stress and poor nutrition, and are likely to live in poverty as adults as well. Unmet social needs, including having low or no income, can also limit people's ability to access healthcare when they need it, or to provide for basic necessities needed to live healthy lives, such as safe housing or healthy food.

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

	Greene County	North Carolina	United States
Percent Below FPL	15.2%	10.1%	9.5%

One-quarter of Greene County households received Food Stamps/SNAP (Supplemental Nutrition Assistance Program) in 2022. This is roughly double the rate of state and national figures.

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

	Greene County	North Carolina	United States
Number of Households Receiving Food Stamps/SNAP	1,790	575,860	16,072,733
Total Number of Households	6,916	4,299,266	129,870,928
Percentage of Households receiving Food Stamps/SNAP	25.8%	13.4%	12.4%

In Greene County, 22.7% of the population has completed high school alone, slightly higher than the state average (21.2%). Greene County also has higher percentages of residents with less than a 9th grade education (9.4%) and some high school but no diploma (14.2%) compared to state figures (6.0% and 5.5% respectively). The county has comparable rates for residents with some college education (21.5% vs. 21.1% state) and higher rates for associate's degrees (12.5% vs. 9.9% state). However, the county shows significantly lower rates of advanced education, with bachelor's degrees (7.7%) at about one-third of the state average (20.4%) and graduate/professional degrees (4.4%) less than half of North Carolina's rate (11.6%).

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

	Greene County	North Carolina	United States
Less than 9th Grade	9.4%	6.0%	3.5%
Some High School/No Diploma	14.2%	5.5%	5.3%
High School Diploma	22.7%	21.2%	28.5%
GED/Alternative Credential	9.2%	4.3%	*
Some College/No Diploma	21.5%	21.1%	14.6%
Associate's Degree	12.5%	9.9%	10.5%
Bachelor's Degree	7.7%	20.4%	23.4%
Graduate/ Professional Degree	2.7%	11.6%	14.2%

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

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

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

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

The total unemployment rate in Greene County (5.3%) is similar to the state average (5.1%). However, there are variations across age groups. Young people between ages 16 to 24 face slightly higher unemployment (13.8%) than the state average (12.4%). The unemployment rate for ages 25 to 54 (5.8%) is also higher than the state figure (4.7%). Notably, the county shows lower unemployment rates for older workers ages 55 to 64, but higher rates for those 65 or more.

Table 14: Unemployment, 2022[15,16]

	Greene County	North Carolina	United States
Percentage unemployed ages 16 to 24	13.8%	12.4%	11.0%
Percentage unemployed ages 25 to 54	5.8%	4.7%	3.4%
Percentage unemployed ages 55 to 64	0.7%	3.3%	2.7%
Percentage unemployed ages 65 or more	4.1%	3.0%	2.9%
Total unemployment	5.5%	5.1%	3.9%

Greene County's overall uninsured rate (16.9%) is higher than the state average (15.0%), which is consistent across all age groups. For ages 18 and below, Greene County's rate (10.6%) is double the state average (5.2%). The uninsured rate for ages 19 to 34 (28.1%) is significantly higher than North Carolina's 15.5%. For ages 35 to 64, the county's rate (21.2%) is also notably higher than the state's 12.5%. This data indicates that Greene County residents face greater challenges in accessing health insurance compared to state averages across all age groups.

Table 15: Health Insurance Status, 2022[17]

	Greene County	North Carolina	United States
Percentage uninsured ages 18 or below	10.6%	5.2%	5.4%
Percentage uninsured ages 19 to 34	28.1%	15.5%	13.6%
Percentage uninsured ages 35 to 64	21.2%	12.5%	9.9%
Total % Uninsured	16.9%	15.0%	12.0%

[15] 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.

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

[17] 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 Greene County CHNA Leadership also collected new data via a focus group, community champion interviews, and surveys to ensure that residents and key community health leaders could provide input regarding the needs of their specific communities. This information will be presented in detail later in this report.

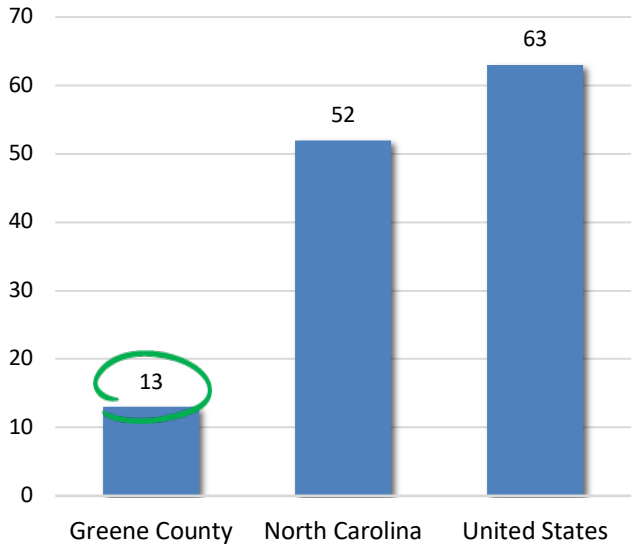
<u>Disparities</u>

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

Residential segregation is measured by the index of dissimilarity, a demographic measure ranging from 0 to 100 that represents how evenly two demographic groups are distributed across a county's census

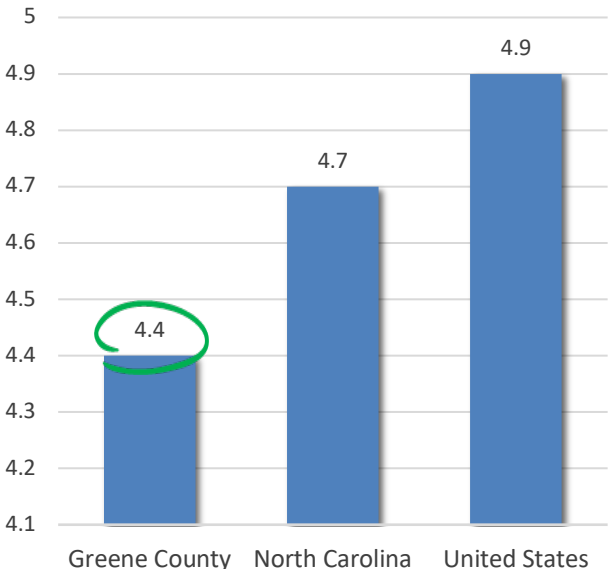
tracts. Lower scores represent a higher level of integration. The residential segregation in Greene County is significantly lower than state and national averages, as seen in **Figure 13**.

Figure 13: Residential Segregation[5]



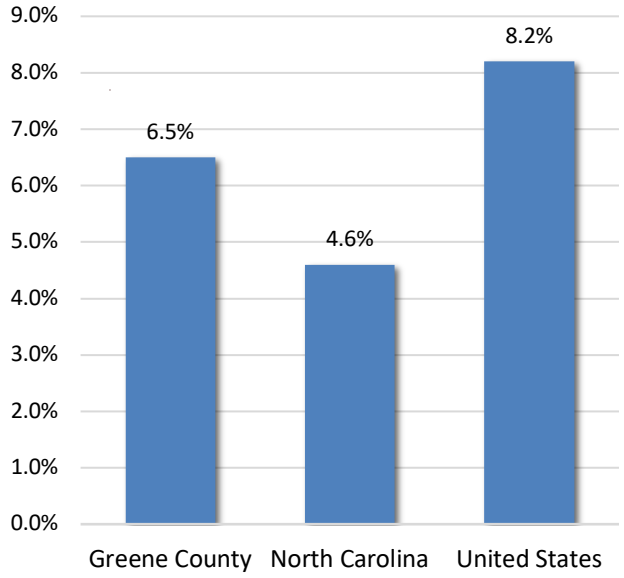
Income inequality is measured as the ratio of household income at the 80th percentile to household income at the 20th percentile. Communities with greater income inequality may have worse outcomes on a variety of metrics, including mortality, poor health, sense of community, and social support. As seen in **Figure 14**, the income inequality ratio is lower in Greene County compared to 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. More people in Greene County are not fluent in English compared to North Carolina overall, as seen in **Figure 15**.

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

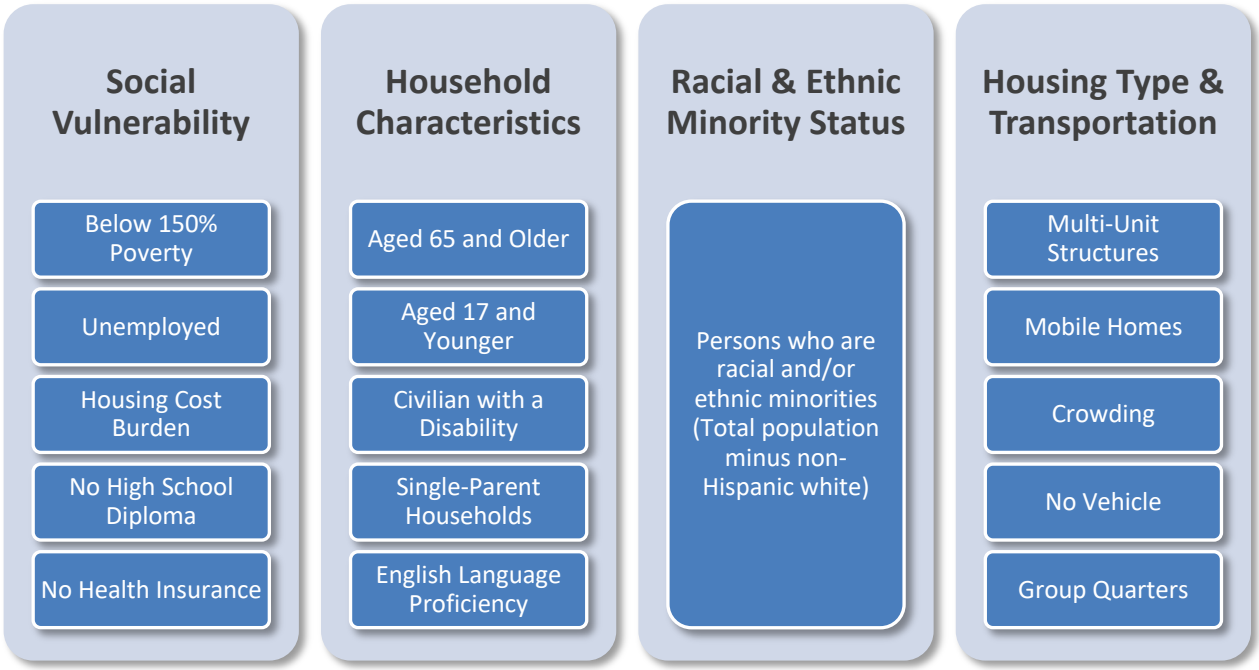


Social Vulnerability Index

One resource that can help show variation and disparities between geographic areas is the Social Vulnerability Index (SVI), which was developed by the CDC and the Agency for Toxic Substances and Disease Registry (ATSDR).[18] 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. 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.

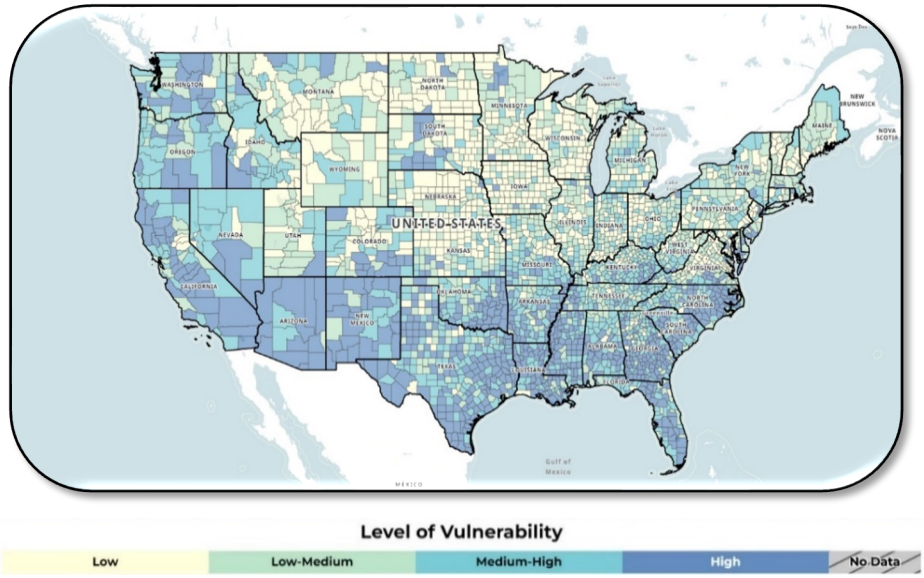
Figure 16: SVI Variables



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

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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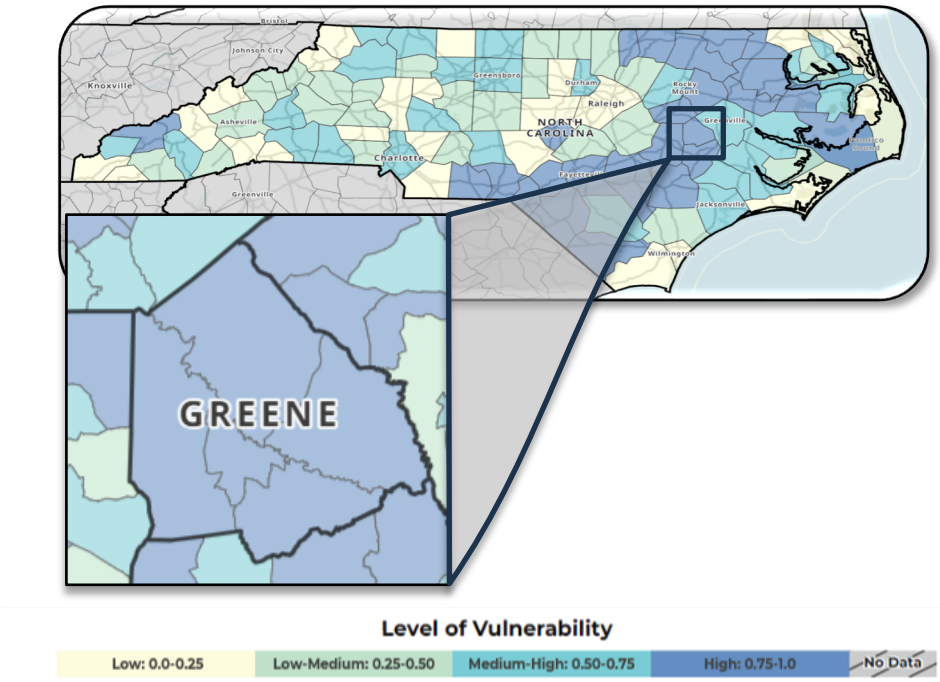
The 2022 SVI scores for Greene County are shown in **Figure 18** below. Possible scores range from 0 (lowest vulnerability) to 1 (highest vulnerability), and these scores show a relative comparison with other counties and census tracts in North Carolina. The vulnerability of Greene County overall is much higher than average compared to the state. Levels of vulnerability are consistent across the county with the average being 0.97.

Figure 18: Green County SVI by Census Tract, 2022



Environmental Justice Index

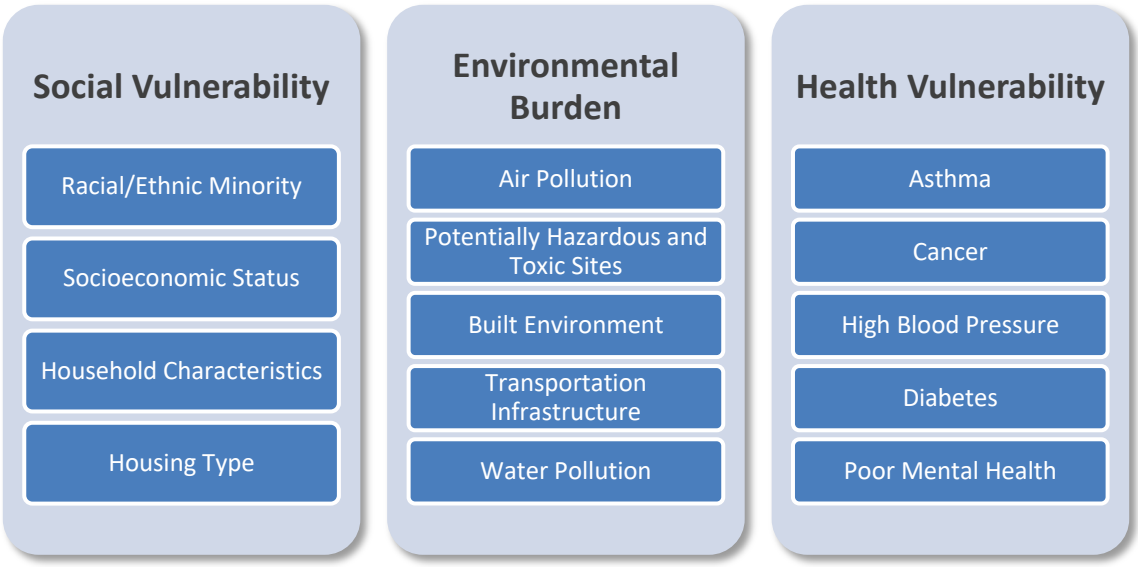
Environmental justice means the just treatment and meaningful involvement of all people, regardless of income, race, color, national origin, Tribal affiliation, or disability, in agency decision-making and other Federal activities that affect human health and the environment. It aims to protect everyone 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.[19]

The CDC/ATSDR Environmental Justice Index (EJI) is a database that ranks the impact of environmental injustice on health. It uses data from the U.S. Census Bureau, the U.S. Environmental Protection Agency, the U.S. Mine Safety and Health Administration, and the U.S. Centers for Disease Control and Prevention. The Index scores environmental burden and injustice at the census tract level in the U.S. based on multiple social, environmental, and health factors.

Over time, communities with a higher EJI score are generally shown to experience more severe impacts from environmental burden than communities in other census tracts. **Figure 19** outlines the variables used to calculate EJI scores.

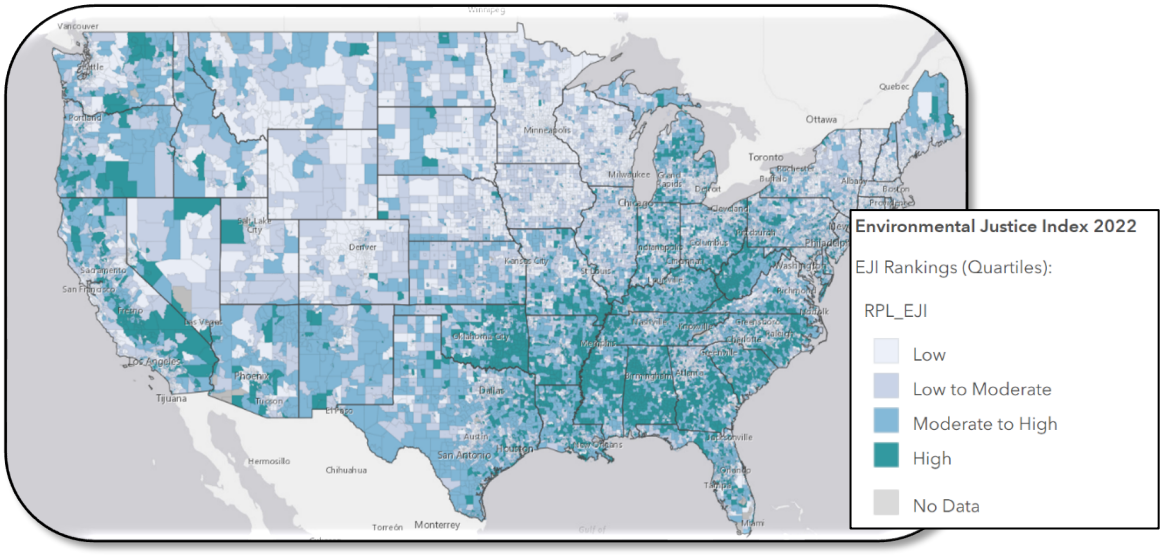
[19] Source: Centers for Disease Control and Prevention (2024). Environmental Justice Index. https://www.atsdr.cdc.gov/place-health/php/eji/index.html#cdc_generic_section_3-eji-tools-and-resources

Figure 19: EJI Variables



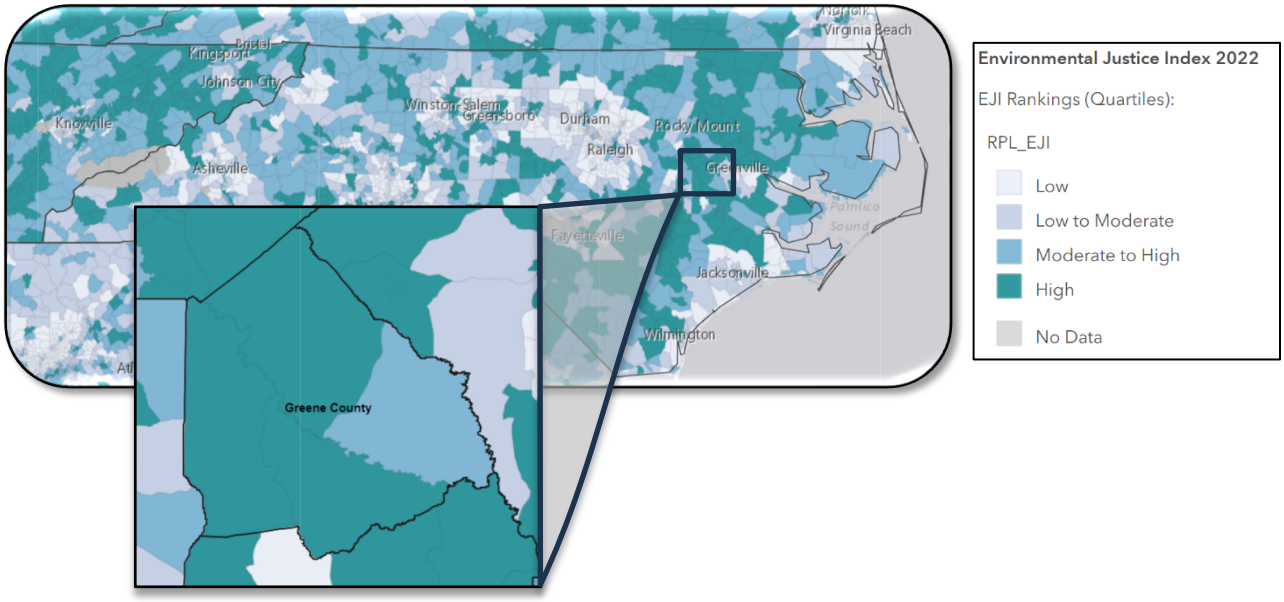
The United States EJI by county is shown in **Figure 20** below. As shown, a lot of variation exists across the country, and even within individual states.

Figure 20: United States EJI by Census Tract, 2022



The 2022 EJI scores for Greene County are shown in **Figure 2.12** below. EJI scores use percentile ranking which represents the proportion of census tracts that experience environmental burden relative to other census tracts in North Carolina. The index ranges from 0-1 with higher scores indicating more environmental burden compared to other census tracts. Levels of environmental burden are variable across the county with the average being 0.75.

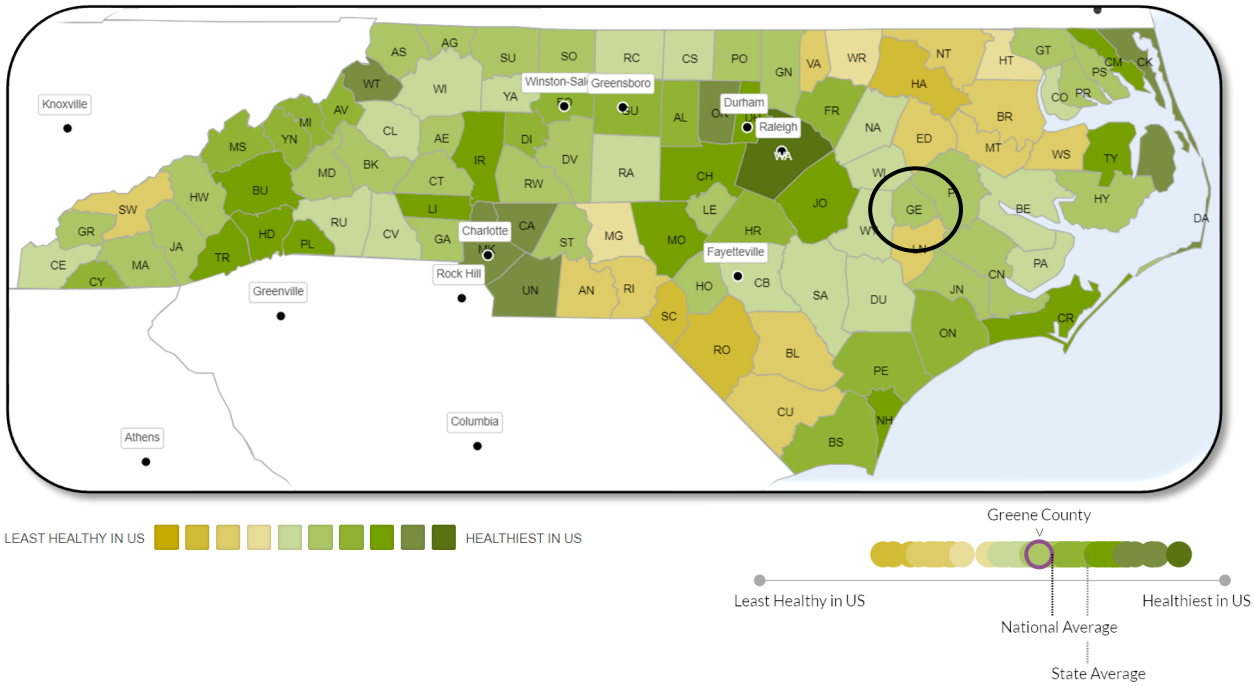
Figure 21: Greene County EJI by Census Tract, 2022



Health Outcome and Health Factor Rankings

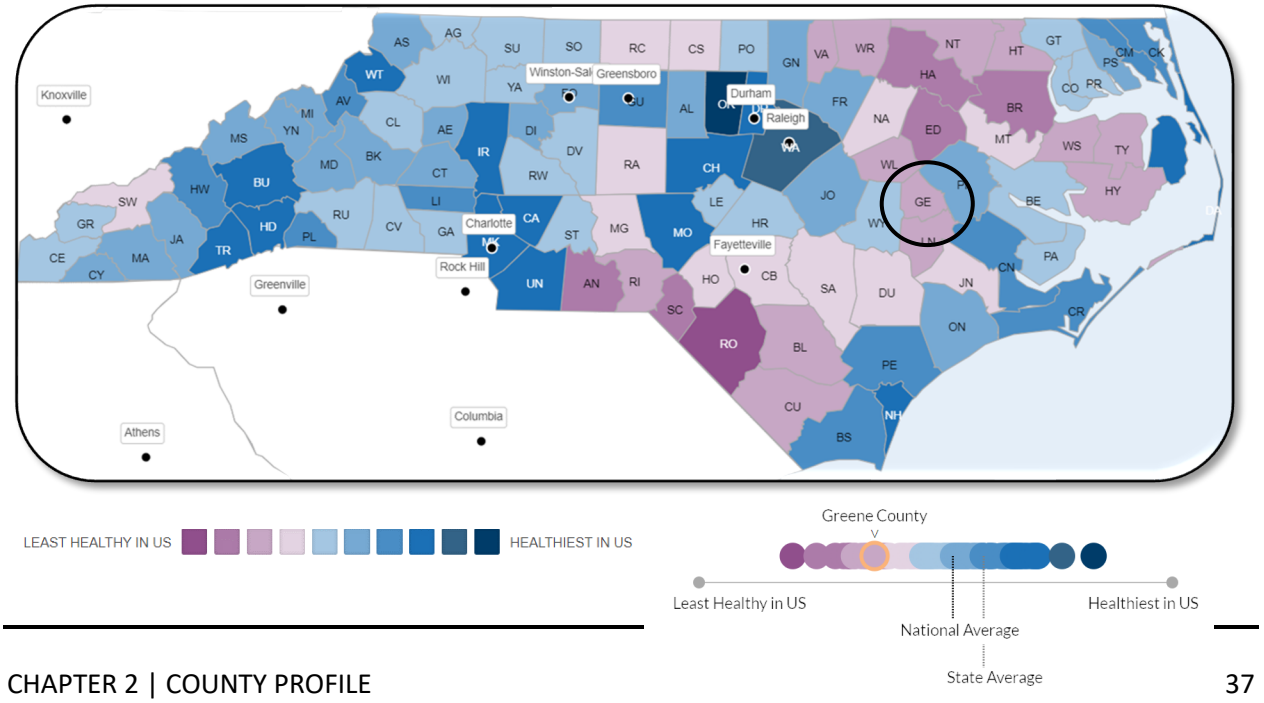
County leaders also reviewed and analyzed data from the Robert Wood Johnson Foundation and the University of Wisconsin County Health Rankings for the year 2024. The Health Outcomes measure looks at how long people in a community live and how physically and mentally healthy they are. These categories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

Figure 22: State Health Outcomes Rating Map[5]



The Health Factors measure looks at variables that affect people's health including health behaviors, clinical care, social & economic factors, and the physical environment they live in. More details about these indicators can be found in Appendices 2 through 4. Similarly to the Health Outcome measure, Greene County falls below 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 a focus group). As previously described in

CHAPTER 1 | METHODOLOGY, secondary data was primarily sourced using the North Carolina Data Portal. For additional descriptive information on data sources and methodology, please see **APPENDIX 2** | SECONDARY DATA METHODOLOGY AND SOURCES.

Greene County conducted a focus group and community champion interviews as part of its Community Health Needs Assessment process. Conversations from focus groups allow the gathering of richer data from in-depth discussions. The Greene County CHNA Leadership looked at the survey demographic data to determine where gaps existed in survey representation and used focus groups to fill the gaps. The team reached out to African American and Hispanic community partners to help recruit focus group participants. Greene County CHNA Leadership was able to conduct one focus group. The focus group was held on June 26th, 2024, where community members shared their perspectives on living, working, and receiving healthcare in Greene County. Additionally, four community champion interviews were conducted with long-term residents, including a County Commissioner, to gain deeper insight into the health and well-being of the community. During a separate prioritization meeting, stakeholders reviewed county health data via a PowerPoint presentation and applied a multi-voting process to identify the key health priorities for the county: Chronic Health Conditions, Mental Health, and Substance Use.

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

Context and National Perspective

As society has changed and people live longer, chronic health conditions have become more common than communicable diseases like typhoid and cholera. As defined by the World Health Organization (WHO), chronic diseases are those with a long duration, that are influenced by a combination of genetic, environmental, psychological, or behavioral factors.[20] Chronic health conditions are extremely common

in the United States, with 6 in 10 Americans living with at least one chronic disease, such as diabetes, obesity, cancer, hypertension, or heart disease.[21]

Chronic diseases are the leading cause of death and disability in the United States.[20] According to the WHO, chronic health conditions kill 41 million people globally each year and are responsible for 7 in 10 deaths in the U.S. annually.[20] The number of individuals living with a chronic health condition is expected to increase as the U.S. population continues to age. The population over the age of 50 is expected to increase by 61% to 221.1 million people by 2050.[22] Among those 221 million, nearly two-thirds (142.7 million people) are expected to have at least one chronic health condition, with approximately 15 million people living with multiple chronic health conditions.[22]

Cancer is a group of diseases characterized by the uncontrolled growth and spread of abnormal cells that can result in death if not treated. While the risk of dying from cancer has declined significantly over the past 30 years, it remains the second most common cause of death in the U.S. Incidence of new cancer cases has continued to rise, with 2 million new cases expected to be identified in 2024.[23] This trend is largely affected by the aging and growth of the population and by a rise in diagnoses of 6 of the 10 most common cancers—breast, prostate, endometrial, pancreatic, kidney, and melanoma. Some research has attributed this rise to the impact of the obesity epidemic. [23] Cigarette smoking is another significant risk factor for cancer and is responsible for about 20% of all cancers and 30% of cancer deaths in the U.S. each year.[24]

The CDC recommends four ways to prevent chronic conditions and maintain good physical health. Recommended healthy behaviors include stopping or refraining from smoking, eating low-fat whole food diets, exercising moderately for at least 150 minutes a week, and limiting or refraining from consuming alcohol.[25] Annual physicals with a primary care provider are also necessary to help prevent or treat chronic health conditions. Yearly screenings can allow providers to identify any warning signs for developing conditions and enable patients to correct or develop healthy behaviors to avoid developing a physical health condition. A CDC study noted that one-third of visits to health centers in 2020 were for preventive care.[26] For those living with chronic conditions, the CDC recommends some general steps people can take to manage their diseases. These include taking medications as prescribed by a provider, self-monitoring

[20] Source: World Health Organization (WHO) (2023). *Noncommunicable diseases*. Retrieved September 10th, 2024, from: https://www.who.int/news-room/fact-sheets/detail/noncommunicable-diseases.
[21] Source: CDC (2024). *National Center for Chronic Disease Prevention and Health Promotion*. Retrieved September 10th, 2024, from: https://www.cdc.gov/chronic-disease/about/index.html .
[22] Source: Ansah, J.P. & Chiu, T.C., (2022). Projecting the chronic disease burden among the adult population in the United States using a multi-state population model. *Frontiers in Public Health*. Retrieved September 10th, 2024, from: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC9881650/.
[23] Source: American Cancer Society (ACS) (2024). *ACS Fast & Figures 2024*. Retrieved September 10th, 2024, from https://www.cancer.org/research/acs-research-news/facts-and-figures-2024.html.
[24] ACS (2020). *Health Risks of Smoking Tobacco.* Retrieved September 10th , 2024 from https://www.cancer.org/cancer/risk-prevention/tobacco/health-risks-of-tobacco/health-risks-of-smoking-tobacco.html
[25] Source: CDC (2024). *Preventing chronic diseases: What you can do now.* Retrieved September 10th, 2024 from https://www.cdc.gov/chronic-disease/prevention/index.html
[26] Source: CDC (2022). *Characteristics of visits to health centers: United States, 2020*. Retrieved September 10th, 2024, from https://www.cdc.gov/nchs/products/databriefs/db438.htm.

symptoms as needed (such as conducting home blood sugar checks), and regularly seeing a provider for check-ups.

As the population in North Carolina and the individual counties continues to collectively age, the prevalence of chronic disease grows. In fact, eight out of the top 10 deaths in North Carolina are related to a chronic health condition[27], accounting for at least two-thirds (50,000) of all annual deaths.[28] Additionally, the population of North Carolina is largely rural, which hinders access to clinical care for these conditions. Finding ways to utilize existing resources for helping community members learn about and manage their chronic health conditions is key for improving health outcomes in these areas.

Secondary Data Findings

Secondary data collected through the CHNA process identified chronic health conditions as an area of concern for residents of Greene County. The county performed worse than state averages on several chronic disease indicators. A higher percentage of Greene County adults (21.6%) report poor or fair health compared to the state average (14.4%). Adults in Greene County also demonstrate higher rates of various chronic conditions compared to state averages, including hypertension (37.3% versus 32.1%), coronary heart disease (6.8% versus 5.5%), and stroke (4.1% versus 3.1%). Asthma prevalence is also elevated at 10.4% compared to 9.8% for North Carolina.

Table 16: Chronic Disease Prevalence

Indicator	Greene County	North Carolina	United States
Adults (Age 18+) with Asthma	10.4%	9.8%	9.7%
Adults (Age 20+) with Diagnosed Diabetes	8.7%	9.0%	8.9%
Adults (Age 18+) Ever Diagnosed with Coronary Heart Disease	6.8%	5.5%	5.2%
Adults (Age 18+) with Hypertension	37.3%	32.1%	29.6%
Adults (Age 18+) with High Cholesterol	32.6%	31.4%	31.0%
Adults (Age 18+) with Kidney Disease	3.5%	2.9%	2.7%
Adults (Age 18+) Ever Having a Stroke	4.1%	3.1%	2.8%

[27] Source: CDC (2022). *North Carolina.* Retrieved October 3, 2024, from https://www.cdc.gov/nchs/pressroom/states/northcarolina/nc.htm
[28] Source: NCDHHS. (2023). *Chronic disease and injury.* Retrieved October 3, 2024, from https://www.dph.ncdhhs.gov/programs/chronic-disease-and-injury#:~:text=Chronic%20diseases%20and%20injuries%20are,of%20death%20in%20North%20Carolina.

Adults with BMI > 30.0 (Obese)	20.8%	29.7%	30.1%
Adults (Age 18+) with Poor Dental Health	18.4%	12.0%	13.9%
Percent Reporting Poor or Fair Health	21.6%	14.4%	-

Healthcare utilization data further highlights concerns around chronic disease management in Greene County. While the county has a lower rate of emergency department visits compared to the state average, both cardiovascular disease and ischemic stroke hospitalization rates exceed state and national figures, as displayed in the table below. The cardiovascular disease hospitalization rate of 14.5 per 1,000 population is notably higher than both the state (11.7) and national (10.4) rates.

Table 17: Healthcare Utilization Rates

Indicator	Greene County	North Carolina	United States
Cancer Incidence (Rate per 100,000 Population)	426.5	464.4	442.3
Emergency Room Visits (Rate per 100,000 Medicare Beneficiaries)	559	563	535
Cardiovascular Disease Hospitalizations (Rate per 1,000 Medicare Beneficiaries)	14.5	11.7	10.4
Ischemic Stroke Hospitalizations (Rate per 1,000 Medicare Beneficiaries)	11.5	9.5	8.0

Physical activity and access to exercise opportunities appear to be significant challenges in Greene County. The percentage of physically inactive adults in the county is 30.0%, substantially higher than the state average of 21.6%. Just 42% of the county population has access to exercise opportunities, compared to 73% statewide and 84% nationally. The county's walkability index score of 4 falls below both state (7) and national (10) averages, suggesting limited infrastructure for physical activity.

Table 18: Physical Activity and Built Environment Indicators

Indicator	Greene County	North Carolina	United States
Recreation and Fitness Facility Establishments, (Rate per 100,000 Population)	N/A	13.1	14.7
Walkability Index Score	4	7	10

% Physically Inactive	30.0	21.6	-
Percentage of Population with Access to Exercise Opportunities	42%	73%	84%

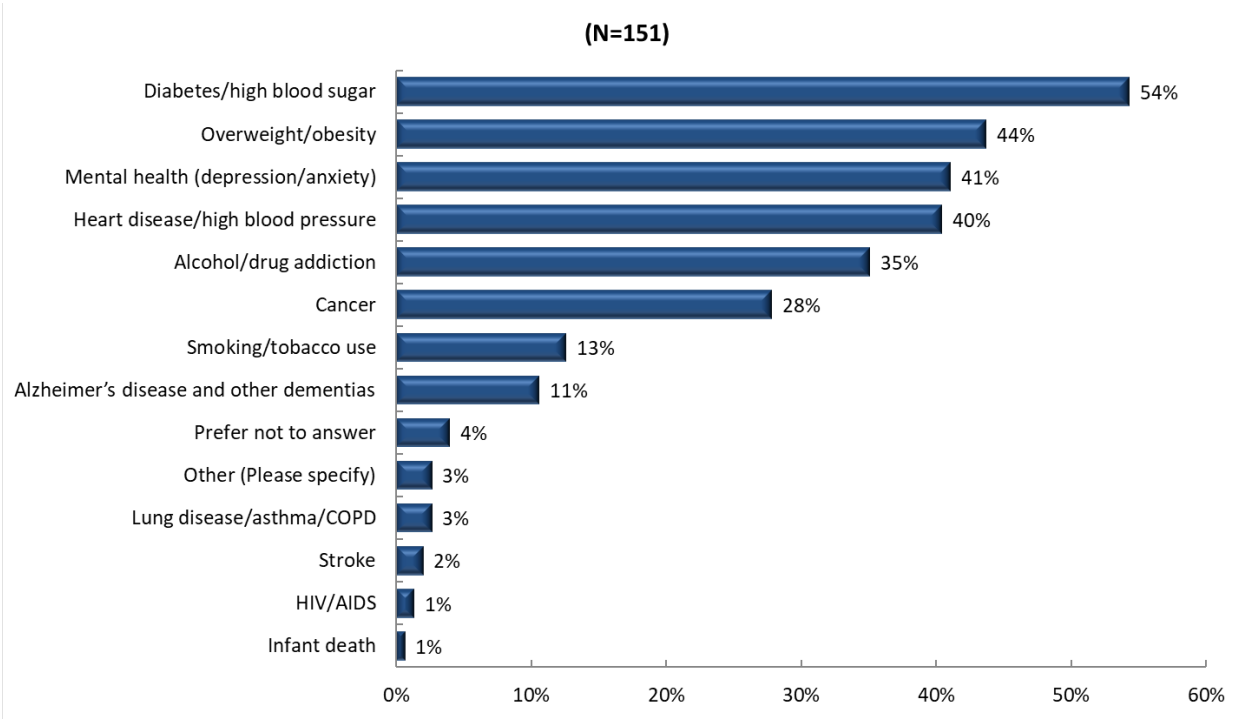
Physical inactivity may be contributing to other health challenges in the community. While obesity rates in Greene County (20.8%) are lower than state (29.7%) and national (30.1%) averages, other indicators suggest ongoing challenges with maintaining healthy lifestyles. The data indicates particular challenges around access to physical activity opportunities, which may create barriers to addressing chronic disease prevention and management in the community.

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

Primary Data Findings – Community Member Web Survey

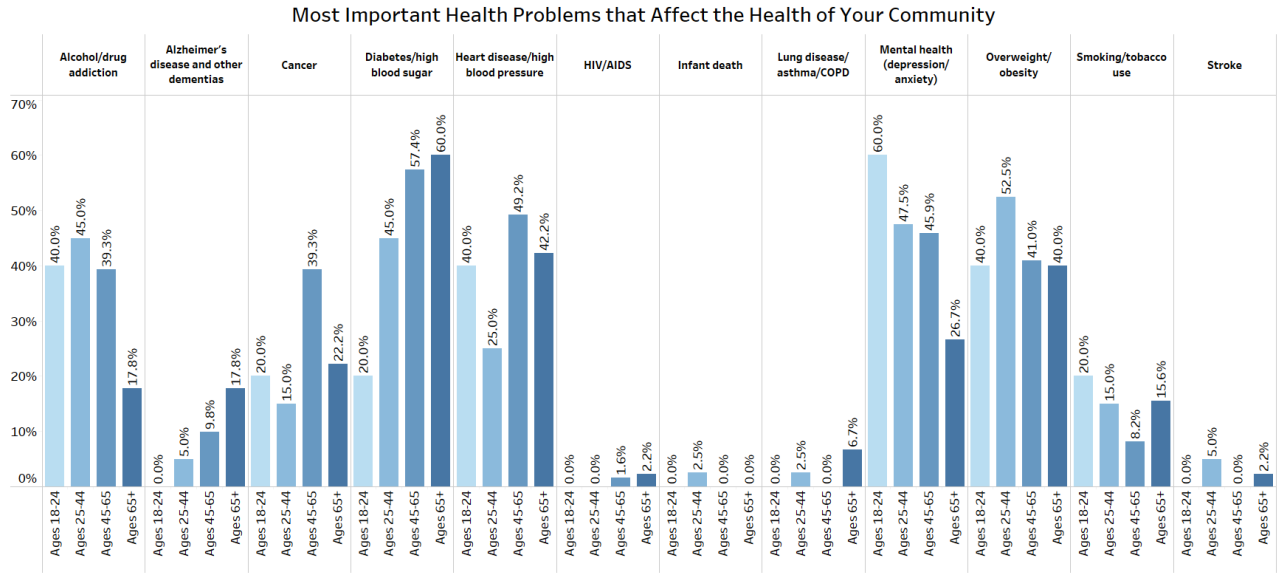
Greene County residents identified several chronic health conditions of concern in the community in the web survey. In fact, two out of the top three most frequently identified community health needs were chronic health conditions, with the most frequently identified being diabetes/high blood sugar (54% of respondents), followed by overweight/obesity (44%). Another 40% of respondents also identified heart disease/high blood pressure as an important community health problem.

Figure 24: What are the three most important health problems that affect the health of your community? Please select up to three.



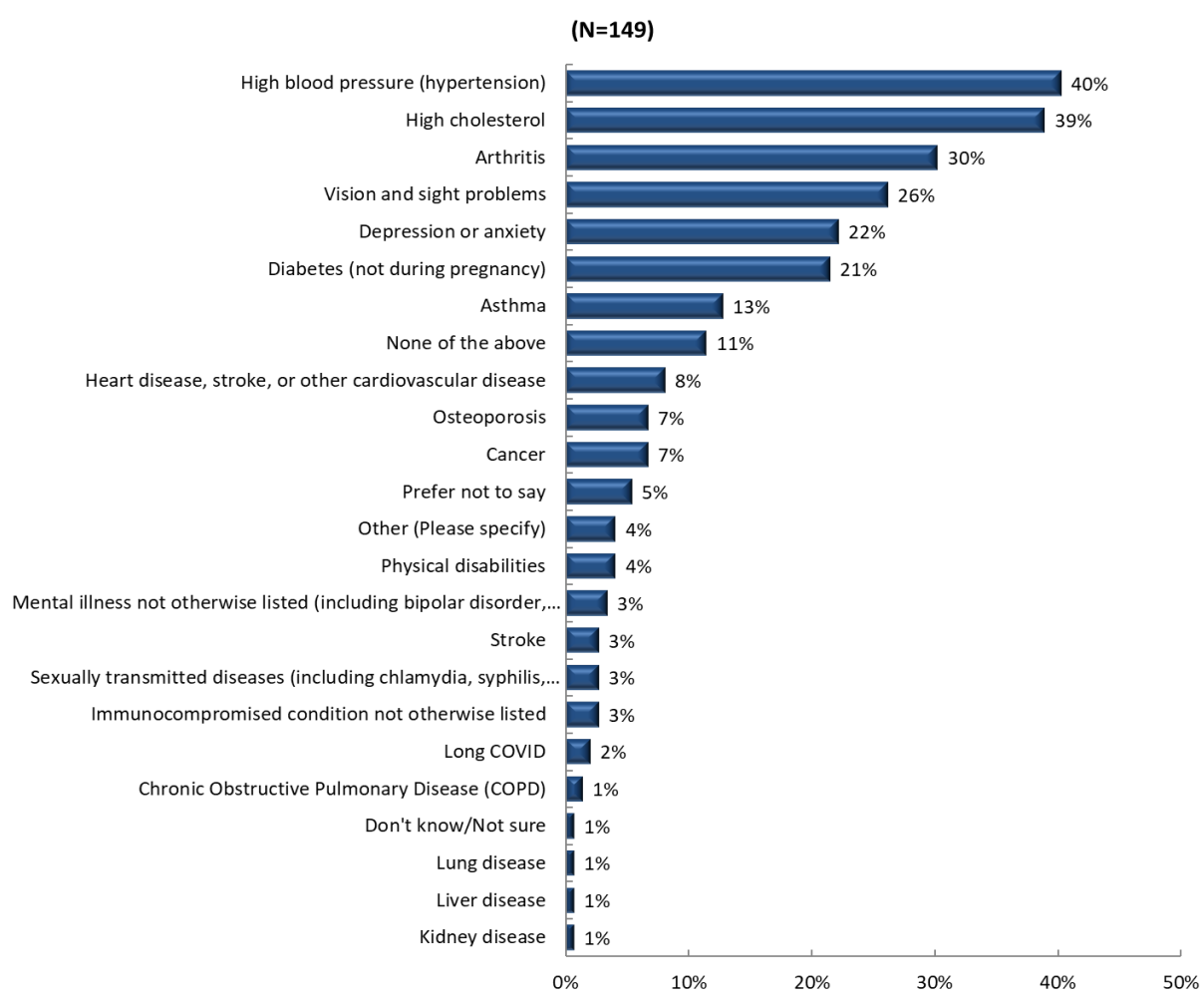
When these results were examined by various respondent characteristics, responses varied. Older adults viewed diabetes and heart disease as more significant problems than younger respondents, as displayed in **Figure 25** below. Respondents identifying as Black or African American identified diabetes/high blood sugar pressure more frequently than respondents identifying as White; however, respondents identifying as White were most likely to identify heart disease/high blood pressure as a concern. By gender, women were significantly more likely to identify these as important community health problems than men. Considering these differences in targeted efforts to address specific community health indicators may be important.

Figure 25: What are the three most important health problems that affect the health of your community? Please select up to three. (by age group)



Community member respondents were also asked questions regarding their personal physical health, with one-third of respondents describing their overall physical health as "fair." Additionally, 40% of respondents reported having been informed by a health professional that they have high blood pressure, and 39% of respondents reported that they have high cholesterol.

Figure 26: Have you ever been told by a doctor, nurse, or other health professional that you have any of the following health conditions? Select all that apply



In terms of community perspectives on health behaviors and food security, one in five Greene County respondents viewed limited access to healthy foods as an important social or environmental problem in the community and one in ten the limited places to exercise. Men were more likely to view limited places to exercise as a top concern (15% compared to 12% for women), while women were more likely to view limited access to healthy foods as a significant factor (20% compared to 12% for men). Greene County respondents were also asked questions regarding their own experience with food security. Nearly 35% of respondents indicated they were worried about whether their food would run out before their household had money to buy more, highlighting food access issues exist for some residents in Greene County.

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

Primary Data Findings – Focus Groups

Similar to the secondary data discussed above, chronic health conditions emerged as a major concern in in the focus group. Focus group participants identified diabetes, heart disease, and high blood pressure as among the most serious health problems in the community. Participants specifically identified African American and Hispanic or Latino community members as those most affected by these problems. When asked what could be done to address these health issues, focus group participants emphasized education, particularly regarding food and nutrition. They also noted the high cost of healthy foods as a barrier to managing chronic conditions. The lack of free or affordable locations for safe walking and exercise were also highlighted as issues keeping residents in Greene County from living healthy lives.

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

Primary Data Findings – Key Informant Interviews

Key health concerns identified by community champions focused heavily on chronic conditions such as stroke, obesity, diabetes, hypertension, and heart disease, as well as conditions associated with aging. Interviewees specifically noted that Black/African American and Hispanic/Latino communities were disproportionately impacted by these issues.

When asked about barriers to addressing these conditions, champions highlighted several social and environmental factors. Champion 4 emphasized that "local health leaders should prioritize expanding access to affordable healthcare, addressing social determinants of health, and increasing community engagement in health initiatives." Other identified barriers included limited access to healthy food, lack of transportation to medical appointments, and financial constraints that forced residents to choose between basic needs and healthcare.

For a more detailed description of key informant interviews, see **Appendix 5**.

PRIORITY NEED: MENTAL HEALTH

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 mental health to be an area of urgent need within Greene County.

[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

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

Mental illness can occur due to multiple different factors, such as genetics, drug and/or alcohol usage, isolation, adverse childhood experiences, and chronic health conditions. Additionally, mental illness can act like other chronic health conditions, in that it can worsen or improve depending on the environment. Mental health services have evolved in the past five years, especially during the COVID-19 pandemic. However, accessing mental health care services can be challenging. According to the National Institute of Mental Health, less than half (47.2%) of adults with a common mental illness received any mental health services in 2021. Those who had an SMI were more likely (65.4%) to have received mental health services that same year.[33] While access to telehealth mental health services has increased, those living in rural areas may still find it difficult to access care. This is a particular concern among those who are low-income or experiencing homelessness, two groups at high risk for developing an acute or chronic mental health 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 in live in North Carolina are seven times more likely to be pushed out of network of their behavioral health providers, than a primary care provider, furthering cost as a cause for stopping treatment. [35]

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.

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

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

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

[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

Secondary Data Findings

Secondary data analysis identified several mental health concerns in Greene County. Regarding access to mental health providers, Greene County has a significantly lower rate of mental health providers (24.5 per 100,000 population) compared to both state (155.7) and national (178.7) averages. The county reports an average of 5.1 poor mental health days per month, higher than both the state (4.6) and national (4.9) averages. This suggests residents may be experiencing greater psychological distress compared to other areas.

The crude death rate for deaths of despair (which includes deaths by suicide, alcohol-related conditions, and drug poisoning) in Greene County is 49.2 per 100,000 population, lower than both state (58.7) and national (55.9) rates.

Table 19: Mental Health Indicators

Indicator	Greene County, NC	North Carolina	United States
Deaths of Despair (Crude Rate per 100,000 Population)	49.2	58.7	55.9
Average Number of Poor Mental Health Days (per Month)	5.1	4.6	4.9
Mental Health Providers (Rate per 100,000 Population)	24.5	155.7	178.7

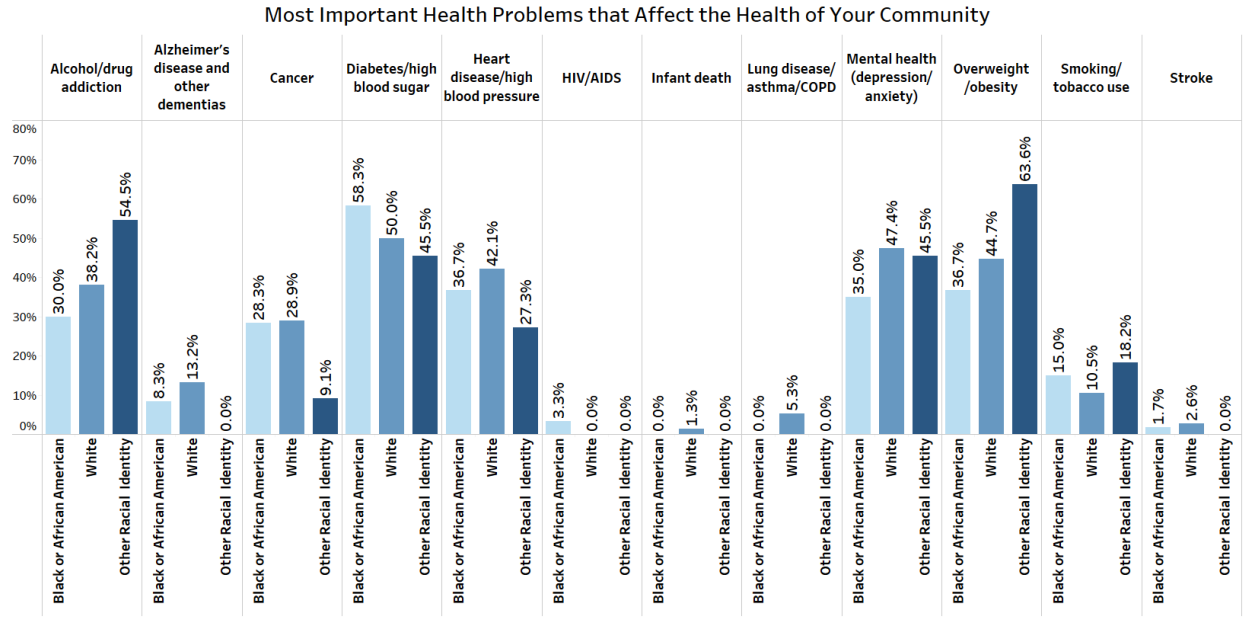
For additional detail on secondary data findings, see **Appendix 3**.

Primary Data Findings – Community Member Web Survey

Greene County residents highlighted different aspects of mental health as areas of community concern on the web-based survey. When asked to identify the most important community health needs, 41% of these respondents identified mental health (depression/anxiety), the third most frequent of all community health needs identified, as shown in **Figure 24** in the Chronic Health Conditions section.

However, when these data were examined by the race of community member respondents, differences emerged. Those who identified as White (47%) or with the other racial identities category (46%) selected mental health as an important community health need more frequently than those who identified as Black/African American (35%), as displayed in the figure below.

Figure 27: 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. The youngest respondents, those ages 18 to 24 (60%) identified mental health as more significant than older respondents, particularly those ages 65 and older. In fact, this youngest group of respondents was separated from the oldest group of respondents by a difference of over 33 percentage points, as previously seen in **Figure 25** in the Chronic Health Conditions section. By ethnicity, there were less significant differences, with non-Hispanic/Latino respondents (42%) being slightly more likely to identify mental health as an important health problem than Hispanic/Latino respondents (39%). These perceived differences by different demographic groups may be important in planning efforts to address behavioral health in the community.

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

<u>Primary Data Findings – Focus Groups</u>

Mental health emerged as a critical concern through focus groups and key informant interviews in Greene County. Both sources highlighted increased mental health challenges in the community, with particular emphasis on access barriers and stigma around seeking mental healthcare.

Mental health emerged as a major concern during the focus group. Participants highlighted concerning increases in suicide and noted significant challenges with mental health stigma in the community. The lack of mental health resources in the county was emphasized as a particular challenge, with participants expressing concern about both availability and accessibility of mental health services. Focus group participants specifically highlighted the need for better mental health education to address stigma. When

discussing potential solutions, participants suggested collaborating with community activists and facilitating discussions with like-minded individuals to address mental health challenges. They emphasized the importance of having an unbiased facilitator for community meetings addressing mental health concerns.

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

Primary Data Findings – Key Informant Interviews

Community champions identified several barriers to accessing mental healthcare services in Greene County. These included lack of insurance coverage, financial constraints and high out-of-pocket costs, transportation issues, and a notable shortage of local mental healthcare providers.
To overcome these barriers, champions offered several suggestions. These included expanding insurance coverage for mental health services, providing financial assistance programs, improving public transportation options, and creating incentives for mental healthcare providers to practice in underserved areas. Champion 4 specifically noted the importance of "understanding the unique challenges faced by different segments of the population and tailoring solutions accordingly" when addressing mental health needs in the community.

For a more detailed description of key informant interviews, see **Appendix 5.**

PRIORITY NEED: SUBSTANCE USE

Context and National Perspective

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

[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/.

the same time, such as co-occurring use of alcohol and cannabis.[39] Treatment SUDs generally cannot follow a cookie-cutter approach, as each person receiving treatment will have different withdrawal and coping needs. Treatment is typically provided through various therapies, inpatient admissions, and forms of medication-assisted treatment such as methadone. Opioid overdoses are one of the most common types of deaths related to SUDs, and can be preventable and treatable if caught in time. Multiple efforts have been coordinated within the past two years to incorporate the storage of overdose reversing medications such as Naloxone in public facilities such as federal facilities, and over the counter, as was approved in 2023 by the FDA. This is critical, as in 2022, the number of opioid overdoses nationwide surpassed 81,051 – a 63% increase in overdoses since 2019.[40]

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.[41]

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.[42] 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.

Secondary Data Findings

Secondary data analysis revealed mixed findings regarding substance use in Greene County. The percentage of adults reporting excessive drinking (16%) is lower than both state and national averages (18%). Similarly, emergency department utilization for opioid use disorder is lower in Greene County at 22 visits per 100,000 Medicare beneficiaries compared to 43 for North Carolina and 41 nationally.

However, alcohol-involved crash deaths present a significant concern. The county's rate of 5.9 deaths per 100,000 population is more than twice the state average of 2.9 and significantly higher than the national

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

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

[41] 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.

[42] 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.

rate of 2.3. This suggests that while overall substance use rates may be lower, the community faces particular challenges around impaired driving.

Table 20: Substance Use Indicators

Indicator	Greene County	North Carolina	United States
Percentage of Adults Reporting Excessive Drinking	16%	18%	18%
Opioid Use Disorder Emergency Department Utilization (Rate per 100,000 Beneficiaries)	22	43	41
Alcohol-Involved Crash Deaths, Annual (Rate per 100,000 Population)	5.9	2.9	2.3

Access to treatment resources appears to be a challenge in Greene County as well. The rate of substance abuse providers (4.9 per 100,000 population) is significantly lower than both state (25.0) and national (27.9) averages. Similarly, the rate of buprenorphine providers (9.5 per 100,000 population) falls below state (15.2) and national (15.5) averages.

Table 21: Substance Use Providers

Indicator	Greene County	North Carolina	United States
Substance Abuse Providers (Rate per 100,000 Population)	4.9	25.0	27.9
Buprenorphine Providers (Rate per 100,000 Population)	9.5	15.2	15.5

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

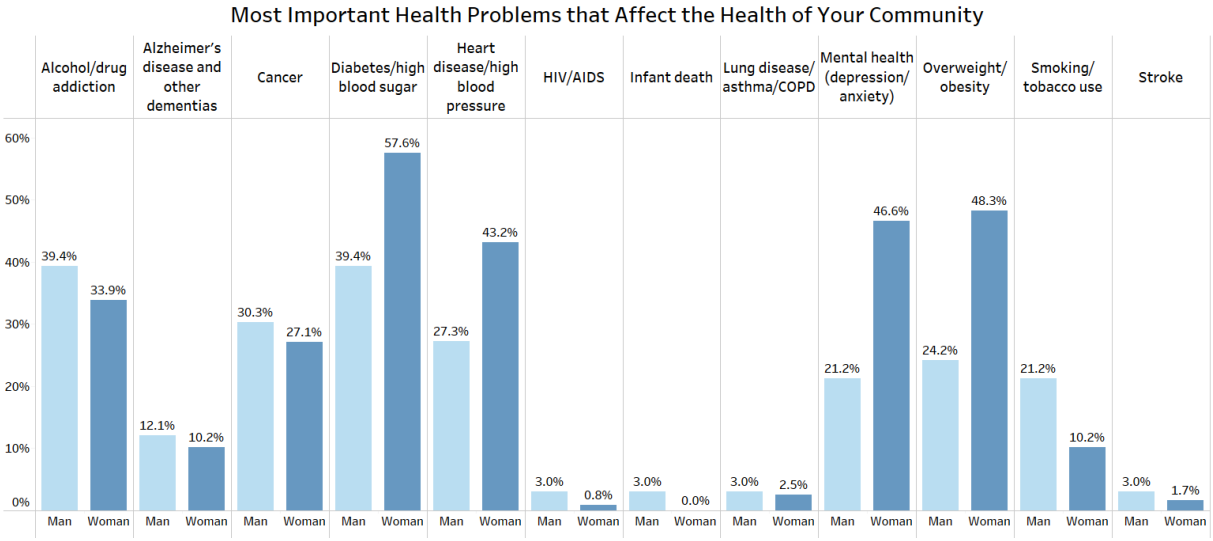
Primary Data Findings – Community Member Web Survey

Greene County residents also highlighted substance use as an area of community concern on the web-based survey. As previously shown in **Figure 24**, when asked to identify the most important community health needs, 35% of respondents identified alcohol/drug addiction, the fifth most frequent of all the community health needs identified.

When these data were examined by the demographics of the community respondents, key differences emerged, especially by age. The second youngest cohort of respondents, ages 25 to 44, was more likely than all other age groups to identify alcohol/drug addiction as the most important health problem in the community, as displayed in the figure below. In fact, 45% of respondents in this age group identified alcohol/drug addiction as a top concern, as previously shown in **Figure 25** in the Chronic Health Conditions section.

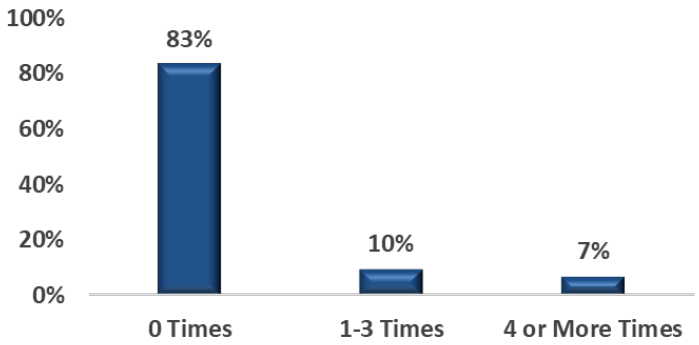
Alcohol/drug addiction was much more frequently identified by respondents who identified with the other racial identity category (55%) than by respondents who identified as White (38%) or as Black/African American (30%), as shown in **Figure 27** in the Mental Health section. By gender, more men (39%) selected alcohol/drug addiction as a problem than women (34%), as seen in **Figure 31** below. These perceived differences by demographic characteristics may be important in planning efforts to address substance use in the community.

Figure 28: What are the three most important health problems that affect the health of your community? Please select up to three. (by gender)



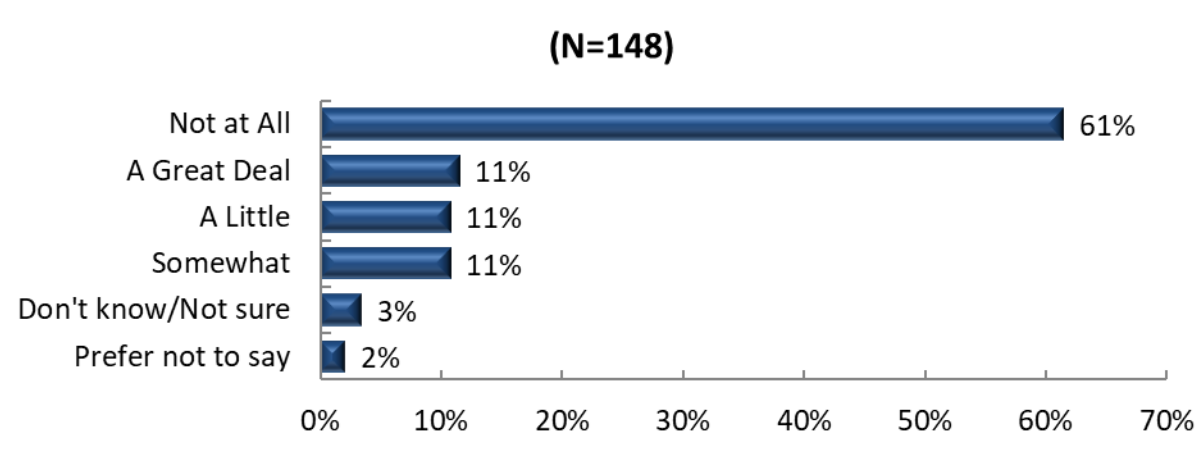
When respondents were asked about their own substance use, 17% of respondents reported drinking enough to meet the definition of "binge drinking" at least once in the past 30 days, with an average of one occasion of binge drinking in the past month among all respondents.

Figure 29: 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?



One-quarter of respondents reported that they consume alcohol, with the majority of those indicating the frequency of their consumption as "some days". Over 90% of community member respondents reported no personal or household misuse of prescription drugs. However, when asked the degree to which personal or someone else's substance abuse negatively impacted their life, one in ten selected "a great deal", the second most frequent response, highlighting the presence of substance use issues in the community.

Figure 30: To what degree has your life been negatively affected by your own or someone else's substance abuse issues, including alcohol, prescription, and other drugs?



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

Primary Data Findings – Focus Groups

Focus group and key informant interviews identified substance use as a significant concern in Greene County, with particular emphasis on drug overdoses. While key informants addressed broader systemic issues related to substance use, focus group participants specifically highlighted concerns about fentanyl in the community.

Focus group participants identified substance use issues as among the most serious health problems facing the community. Participants specifically emphasized concerns about fentanyl overdoses. The group discussed how the cost of healthcare and need to prioritize basic needs over health services created barriers to accessing healthcare, including substance use treatment. When discussing potential solutions, participants emphasized the importance of bringing different voices to the table, particularly engaging young people in discussions about substance use prevention and treatment. The group suggested capitalizing on existing resources and involving community activists to address substance use challenges in the community.

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

Primary Data Findings – Key Informant Interviews

Community champions discussed substance use in the context of broader community challenges, including poverty, lack of job opportunities, and limited access to healthcare services. These champions identified several barriers to accessing substance use treatment, including lack of insurance, financial constraints, transportation issues, and a shortage of local treatment providers.

When asked about potential improvements, the champions provided general recommendations rather than recommendations specific to substance use treatment and support. Champion 3 emphasized the need to focus on "anything for minorities," while Champion 4 stressed the importance of "expanding access to affordable healthcare, addressing social determinants of health, and increasing community engagement in health initiatives." Overall, the champions suggested that expanding insurance coverage, providing financial assistance programs, improving public transportation options, and incentivizing healthcare providers to practice in underserved areas could help address a variety of challenges in the community.

For a more detailed description of key informant interviews, see **Appendix 5**.

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 Greene County that provide resources to address general community health needs, as well as the county's 2024 priority need areas: Chronic Health Conditions, Mental Health, and Substance Use.

Category	Organization Name
County Resource Directories	• Greene County Department of Public Health
Healthcare Facilities	**Hospitals & Clinics** • ECU Health Medical Center • UNC Health Lenoir Health Care • Wayne UNC Health Care • Wilson Medical Center • Contentnea Health • Contentnea Greene • Kate B. Reynolds Medical Center • Student Health services at Greene Central High School • Hookerton Family Practice • Heritage Family Health & Wellness **Dental Care** • Lane & Associates Family Dentistry • Dr. Whit Bartholomew, Family Practice Dentistry • Greene Dental Services **Visions Care** • Eastern Eye Care **Mental Health** • Trillium Health Resources: Trillium Health Resources is a specialty care manager (LME/MCO) for individuals with serious behavioral health, intellectual / developmental disabilities, and traumatic brain injury in North Carolina **Pharmacies** • Realo Discount Drugs

	• Walgreens • Contentnea Health Pharmacy
Other Healthcare Services	• Greene County Wellness Center
Community Services	• Greene County Parks and Recreation • Lenoir/Greene United Way • Partnership for Children of Lenoir and Greene Counties • 201 Dobbs Street • Greene County Senior Services • Greene County Department of Social Services • Greene County Transportation • North Carolina Cooperative Extension – Greene County Center • QuitlineNC • Lenoir Community College – Greene County Center • Greene County Public Library • Greene County Schools

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 Greene 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. Greene 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.

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.[43]

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

[43] 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: Greene County (2021-2023)

The Greene County Department of Public Health is excited to share the **Healthy NC 2030 Scorecard for Greene County**. This Community Health Improvement Scorecard is an easy way to learn about some of the efforts currently underway in Greene County to address two health priorities identified in the 2019 Greene County Community Health Needs Assessment (CHNA):

- **Healthy Behaviors** (includes addressing Chronic Disease and Physical Activity & Nutrition)
- **Substance Use Disorders** (includes addressing tobacco and opioids)

While the COVID-19 pandemic has adversely impacted our community since March 2020, Greene County and our community partners are united in our efforts to support community health improvements to address these priorities. This Scorecard also serves as **Greene *County's Community Health Improvement Plans (CHIPs)***, fulfilling the NC Local Health Department Accreditation requirement that local health departments submit two CHIPs following the CHNA submission.

For each priority, this Scorecard spotlights:

- A ***Result Statement***, a picture of where we would like to be,
- Important ***local Indicators*** or measures of how we are doing linked to ***Healthy NC 2030 indicators*** and
- Select ***Programs*** or activities and
- Key ***Performance Measures*** that show how those programs are making an impact.

The Scorecard also contains the annual **Greene County State of the County Health** reports (SOTCH).

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

Results	R
Indicators	I
Programs	P
Performance Measures	PM

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

Community Health Needs Assessment

Greene County CHNA 2021

Time Period	Current Actual Value	Current Trend	Baseline % Change

Healthy Behaviors (Chronic Disease and Physical Activity & Nutrition)

All people in Greene County have affordable equitable access to culturally appropriate nutrient dense foods, exercise opportunities, community support, and supporting education.	Time Period	Current Actual Value	Current Trend	Baseline % Change
FHU-NC HNC2030 Life Expectancy (Total) in North Carolina: Average number of years of life remaining for people who have attained a given age.	2022	76.2	↗ 1	-2% ↘
FHU-NC HNC2030 Limited Access to Healthy Foods: Percent of People in North Carolina (Total) with Limited Access to Healthy Foods	2022	7%	→ 2	0% →
FHU-NC HNC2030 Access to Exercise Opportunities: Percent of People in North Carolina (Total) with Access to Exercise Opportunities	2022	68%	↘ 1	0% →
FHU-NC HNC2030 Sugar-Sweetened Beverage (SSB) Consumption Among Adults in NC: % of Adults (Total) reporting consumption of one or more sugar-sweetened beverages (SSBs) per day.	2022	36.8%	↗ 1	12% ↗

Minority Diabetes Prevention Program	Time Period	Current Actual Value	Current Trend	Baseline % Change
How much Number of eligible participants completing program	2023	13	↗ 2	30% ↗
Better off Number of people completing program with a decrease of A1C over baseline	2022	3	→ 0	0% →
Better off Percentage of people completing program with a decrease of A1C over baseline	2023	46.0	↘ 1	-8% ↘
How much Number of people completing program with a decrease in body weight of at least 5%	2022	1	↘ 1	0% →
Better off Percentage of people completing program with a decrease in body weight of at least 5%	2022	0.1	↘ 1	-93% ↘

Weight-Wise	Time Period	Current Actual Value	Current Trend	Baseline % Change
Better off Percentage of people losing weight at the end of the program	2023	30	↘ 1	20% ↗

Substance Use Disorder

All people in Greene County have affordable, equitable, and stigma-free access to mental health, behavioral health, and substance misuse treatment, community support, and education.	Time Period	Current Actual Value	Current Trend	Baseline % Change
FHU-NC HNC2030 Drug Overdose Death Rate in North Carolina: Drug Poisoning Deaths (Total) per 100,000 population	2022	42.1	↗ 4	205% ↗
Drug Overdose Death Rate in Greene County: Drug Poisoning Deaths (Total) per 100,000 population	2021	26.0	↗ 2	33% ↗
FHU-NC HNC2030 Percent of Adults Using Tobacco in North Carolina (Total)	2022	21.6%	↗ 1	-10% ↘
FHU-NC HNC2030 Percent of High School Youth Using Tobacco in North Carolina (Total)	2019	27.3%	↘ 1	-1% ↘
FHU-NC HNC2030 Percent of Middle School Youth Using Tobacco in North Carolina (Total)	2019	10.4%	↘ 2	-10% ↘

8th Judicial District Family Accountability & Recovery Court (Greene County)

		Time Period	Current Actual Value	Current Trend	Baseline % Change
How much	Number of participants enrolled	2023	2	→ 2	0% →
Better off	Percentage of participants that graduate from the program	2023	2	↗ 1	100% ↗

QuitlineNC

		Time Period	Current Actual Value	Current Trend	Baseline % Change
How much	Number of participants enrolled	2023	13	↗ 1	18% ↗
Better off	Percentage of participants that complete the program	–	–	–	–

Narcan Distribution

		Time Period	Current Actual Value	Current Trend	Baseline % Change
How much	Number of locations that distribute narcan	2023	5	↗ 1	25% ↗

Mass Media Campaign for Tobacco

		Time Period	Current Actual Value	Current Trend	Baseline % Change
How much	Number of tobacco cessation and awareness campaigns that were implemented	2022	24	→ 0	0% →

SOTCH Report

Greene County's 2022 SOTCH Report

Time Period	Current Actual Value	Current Trend	Baseline % Change

Greene County's 2023 SOTCH Report

Time Period	Current Actual Value	Current Trend	Baseline % Change

APPENDIX 2 | SECONDARY DATA METHODOLOGY AND SOURCES

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

Methodology

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

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

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

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

These measures are noted with an asterisk.

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

Data Sources

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

Table 31: 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	Centers for Medicare and Medicaid Services (CMS) – National Plan and Provider Enumeration System (NPPES). Data accessed via the North	2024

Measure	Description	Data Source	Most Recent Data Year(s)
	practice medicine, family medicine, internal medicine, and pediatrics.	Carolina Data Portal, June 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
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	U.S. Census Bureau, American Community Survey (ACS). Data accessed via the North Carolina Data Portal, June 2024.	2018-2022

Measure	Description	Data Source	Most Recent Data Year(s)
	relevant because a shortage of health professionals contributes to access and health status issues.		
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 32: 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	Federal Communications Commission (FCC) FABRIC Data. Additional data analysis by CARES. Data accessed via the North Carolina Data Portal, June 2024.	2023

Measure	Description	Data Source	Most Recent Data Year(s)
	fixed/terrestrial wireless internet providers. Cellular internet providers are not included.		
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
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		2022

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

Table 33: Diet and Exercise

Measure	Description	Data Source	Most Recent Data Year(s)
Physical inactivity (percent of adults that report no leisure time physical activity)	Percentage of adults ages 20 and over reporting no leisure-time physical activity in the past month. Examples of physical activities include running, calisthenics, golf, gardening, or walking for exercise. The method for calculating Physical Inactivity changed. Data for Physical Inactivity are provided by the CDC Interactive Diabetes Atlas which combines 3 years of survey data to provide county-level estimates. In 2011, BRFSS changed their methodology to include cell phone and landline participants. Previously	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)
	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 encourages physical activity and other healthy behaviors.	U.S. Census Bureau, County Business Patterns. Additional data analysis by CARES. Data accessed via the North Carolina Data Portal, June 2024.	2022

Measure	Description	Data Source	Most Recent Data Year(s)
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 34: 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 35: 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 36: Environmental Quality

Measure	Description	Data Source	Most Recent Data Year(s)
Climate and Health – Flood Vulnerability	Estimated number of housing units within the special flood hazard area (SFHA) per county. The SFHAs have 1% annual chance of coastal or riverine flooding.	Federal Emergency Management Agency (FEMA), National Flood Hazard Layer. Data accessed via the North Carolina Data Portal, June 2024.	2011
Air and Water Quality – Drinking Water Safety	Number of drinking water violations recorded in a two-year period. Health-based violations include incidents where either the amount of contaminant exceeded the maximum contaminant level (MCL) safety standard, or where water was not treated properly. In cases where a water system serves multiple counties and has a violation, each county served by the system is given a violation.	EPA. Data accessed via the North Carolina Data Portal, June 2024.	2023

Table 37: 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 38: 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

Measure	Description	Data Source	Most Recent Data Year(s)
Food Insecure Children	Estimated percentage of the population under age 18 that experienced food insecurity at some point during the report year. Food insecurity is the household-level economic and social condition of limited or uncertain access to adequate food.	Feeding America. Data accessed via the North Carolina Data Portal, June 2024.	2021
Low-Income and Low Food Access	Percentage of the low-income population with low food access. Low food access is defined as living more than 1 mile (urban) or 10 miles (rural) from the nearest supermarket, supercenter, or large grocery store. Data are from the April 2021 Food Access Research Atlas dataset. This indicator is relevant because it highlights populations and geographies facing food insecurity.	U.S. Department of Agriculture (USDA), Economic Research Service, USDA – Food Access Research Atlas. 2019. Data accessed via the North Carolina Data Portal, June 2024.	2019
Limited access to healthy foods	Percentage of population who are low-income and do not live close to a grocery store.	USDA Food Environment Atlas. Data accessed via RWJF & UWPHI County Health Rankings & Roadmaps, June 2024.	2019
Food Environment - Fast Food Restaurants (per 100,000 population)	Number of fast food restaurants per 100,000 population. The prevalence of fast food restaurants provides a measure of both access to healthy food and environmental influences on dietary behaviors. Fast food restaurants are defined as limited-service establishments primarily engaged in providing food services (except snack and nonalcoholic beverage bars) where patrons generally order or select items and pay before eating.	US Census Bureau, County Business Patterns. Additional data analysis by CARES. 2022. Data accessed via the North Carolina Data Portal, June 2024.	2022
Food Environment - Grocery Stores (per 100,000 population)	Number of grocery establishments per 100,000 population. Grocery stores are defined as supermarkets and smaller grocery stores primarily engaged in retailing a general line of food, such as canned and frozen foods; fresh fruits and vegetables; and fresh and prepared meats, fish, and poultry. Delicatessen-type	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)
	establishments are also included. Convenience stores and large general merchandise stores that also retail food, such as supercenters and warehouse club stores, are excluded. Healthy dietary behaviors are supported by access to healthy foods, and grocery stores are a major provider of these foods.		

Table 39: 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

Measure	Description	Data Source	Most Recent Data Year(s)
Housing & Urban Development (HUD)-Assisted Housing Units (per 10,000 households)	Number of HUD-funded assisted housing units available to eligible renters as well as the unit rate (per 10,000 total households).	U.S. Department of HUD. Data accessed via the North Carolina Data Portal, June 2024.	2017-2021
Substandard Housing, Severe	Percentage of owner- and renter-occupied housing units having at least one of the following conditions: 1) lacking complete plumbing facilities, 2) lacking complete kitchen facilities, 3) with 1.51 or more occupants per room, 4) selected monthly owner costs as a percentage of household income greater than 50%, and 5) gross rent as a percentage of household income greater than 50%. Selected conditions provide information in assessing the quality of the housing inventory and its occupants. This data is used to easily identify homes where the quality of living and housing can be considered substandard.	U.S. Census Bureau, ACS. Data accessed via the North Carolina Data Portal, June 2024.	2011-2015
Homeless Children and Youth	Number of homeless children and youth enrolled in the public school system during the school year 2019-2020. According to the data source definitions, homelessness is defined as lacking a fixed, regular, and 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 40: 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	U.S. Census Bureau, ACS. Data accessed via the	2018-2022

Measure	Description	Data Source	Most Recent Data Year(s)
	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.	North Carolina Data Portal, June 2024.	
Gender Pay Gap	Ratio of women's median earnings to men's median earnings for all full-time, year-round workers, presented as "cents on the dollar." Data are acquired from the 2018-2022 ACS and are used in the 2024 County Health Rankings.	U.S. Census Bureau, ACS. Data accessed via the North Carolina Data Portal, June 2024.	2018-2022
Population Below 100% Federal Poverty Level (FPL)	Percentage of population living in households with income below the FPL. This indicator is relevant because poverty creates barriers to access including health services, healthy food, and other necessities that contribute to poor health status.	U.S. Census Bureau, ACS. Data accessed via the North Carolina Data Portal, June 2024.	2022
Population Below 200% FPL	Percentage of population living in households with income below 200% of the FPL. This indicator is relevant because poverty creates barriers to access including health services, healthy food, and other necessities that contribute to poor health status.	U.S. Census Bureau, ACS. Data accessed via the North Carolina Data Portal, June 2024.	2018-2022
Children Below 200% FPL	Percentage of children living in households with income below 200% of the FPL. This indicator is relevant 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

Measure	Description	Data Source	Most Recent Data Year(s)
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 41: 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	National Center for Health Statistics – Natality and Mortality Files; Census Population	2019-2021

Measure	Description	Data Source	Most Recent Data Year(s)
	(2019-2021) and are used for the 2024 County Health Rankings.	Estimates Program. Data accessed via RWJF & UWPHI County Health Rankings & Roadmaps, June 2024.	

Table 42: Maternal and Infant Health

Measure	Description	Data Source	Most Recent Data Year(s)
Births with no or late prenatal care	Percentage of women who did not obtain prenatal care until the 7th month (or later) of pregnancy or who didn't have any prenatal care, as of all who gave birth during the three-year period from 2017 to 2019. This indicator is relevant because engaging in prenatal care decreases the likelihood of maternal and infant health risks. This indicator can also highlight a lack of access to preventive care, a lack of health knowledge, insufficient provider outreach, and/or social barriers preventing utilization of services.	CDC – National Vital Statistics System (NVSS). CDC WONDER. CDC, Wide-Ranging Online Data for Epidemiologic Research. Data accessed via the North Carolina Data Portal, June 2024.	2017-2019
Low birthweight (percent of live births with birthweight < 2500 grams)	Percentage of live births where the infant weighed less than 2,500 grams (approximately 5 lbs., 8 oz.). The numerator is the number of low birthweight infants born over a 7-year time span, while the denominator is the total number of births in a county during the same time.	National Center for Health Statistics – Natality Files. Data accessed via RWJF & UWPHI County Health Rankings & Roadmaps, June 2024.	2016-2022
Infant Mortality	Number of all infant deaths (within 1 year) per 1,000 live births. Data were 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 43: Mental Health

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

Table 44: 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	Behavioral Risk Factor Surveillance System. Data accessed via RWJF & UWPHI County Health Rankings & Roadmaps, June 2024.	2021

Measure	Description	Data Source	Most Recent Data Year(s)
	rated their health “fair” or “poor.” Poor or Fair Health is age-adjusted. Poor or Fair Health estimates are created using statistical modeling.		
Asthma Prevalence (Adult)	Percentage of adults ages 18 and older who answer “yes” to both of the following questions: “Have you ever been told by a doctor, nurse, or other health professional that you have asthma?” and the question “Do you still have asthma?”	CDC, BRFSS. Data accessed via the North Carolina Data Portal, June 2024.	2022
Heart Disease (Adult)	Percentage of adults ages 18 and older who report ever having been told by a doctor, nurse, or other health professional that they had angina or coronary heart disease.	CDC, BRFSS. Data accessed via the North Carolina Data Portal, June 2024.	2022
High Blood Pressure (Adult)	Percentage of adults ages 18 and older who report ever having been told by a doctor, nurse, or other health professional that they have high blood pressure (HTN). Women who were told high blood pressure only during pregnancy and those who were told they had borderline hypertension were not included.	CDC, BRFSS. Data accessed via the North Carolina Data Portal, June 2024.	2021
High Cholesterol (Adult)	Percentage of adults ages 18 and older who report having been told by a doctor, nurse, or other health professional that they had high cholesterol.	CDC, BRFSS. Data accessed via the North Carolina Data Portal, June 2024.	2021
Diabetes Prevalence (Adult)	Percentage of adults ages 20 and older who have ever been told by a doctor that they have diabetes. This indicator is relevant because diabetes is a prevalent problem in the U.S.; it may indicate an unhealthy lifestyle and puts individuals at risk for further health issues.	CDC, National Center for Chronic Disease Prevention and Health Promotion. Data accessed via the North Carolina Data Portal, June 2024.	2021
Kidney Disease (Adult)	Percentage of adults ages 18 and older who report ever having been told by a doctor, nurse, or other health professional that they have kidney disease.	CDC, BRFSS. Data accessed via the North Carolina Data Portal, June 2024.	2021
Stroke (Adult)	Percentage of adults ages 18 and older who report ever having been told by a doctor, nurse, or other	CDC, BRFSS. Data accessed via the North	2022

Measure	Description	Data Source	Most Recent Data Year(s)
	health professional that they have had a stroke.	Carolina Data Portal, June 2024.	
Obesity	Percentage of adults ages 20 and older self-report having a Body Mass Index (BMI) greater than 30.0 (obese). Respondents were considered obese if their BMI was 30 or greater. BMI (weight [kg]/height [m]2) was derived from self-report of height and weight. Excess weight may indicate an unhealthy lifestyle and puts individuals at risk for further health issues.	CDC, National Center for Chronic Disease Prevention and Health Promotion. Data accessed via the North Carolina Data Portal, June 2024.	2021
Poor Dental Health – Teeth Loss	Percentage of adults ages 18 and older who report having lost all of their natural teeth because of tooth decay or gum disease.	CDC, BRFSS. Data accessed via the North Carolina Data Portal, June 2024.	2022
Cancer Incidence – All Sites (per 100,000 population)	Age-adjusted incidence rate (cases per 100,000 population per year) of cancer (all sites) adjusted to 2000 U.S. standard population age groups (Under age 1, 1-4, 5-9, ..., 80-84, 85 and older).	State Cancer Profiles. Data accessed via the North Carolina Data Portal, June 2024.	2016-2020
Emergency Room (ER) Visits (per 100,000 Medicare beneficiaries)	Rate of ER visits among Medicare beneficiaries age 65 and older (per 100,000 beneficiaries). This indicator is relevant because ER visits are "high intensity" services that can burden on both health care systems and patients. High rates of ER visits "may indicate poor care management, inadequate access to care or poor patient choices, resulting in ER visits that could be prevented".	CMS – Geographic Variation Public Use File. Data accessed via the North Carolina Data Portal, June 2024.	2022
Hospitalizations – Heart Disease (per 1,000 Medicare beneficiaries)	Hospitalization rate for coronary heart disease among Medicare beneficiaries ages 65 and older for hospital stays occurring between 2018 and 2020.	CDC – Atlas of Heart Disease and Stroke. Data accessed via the North Carolina Data Portal, June 2024.	2018-2020
Hospitalizations – Stroke (per 1,000 Medicare beneficiaries)	Hospitalization rate for Ischemic stroke among Medicare beneficiaries ages 65 and older for hospital stays occurring between 2018 and 2020.	CDC – Atlas of Heart Disease and Stroke. Data accessed via the North Carolina Data Portal, June 2024.	2018-2020

Table 45: Quality of Care

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

Table 46: Safety

Measure	Description	Data Source	Most Recent Data Year(s)
Incarceration Rate	Percentage of individuals born in each census tract who were incarcerated at the time of the 2010 Census as estimated by Opportunity Atlas data.	Opportunity Insights. Data accessed via the North Carolina Data Portal, June 2024.	2018

Measure	Description	Data Source	Most Recent Data Year(s)
Juvenile Arrest Rate (per 1,000 juveniles)	Rate of delinquency cases per 1,000 juveniles. Data are acquired from the 2021 Easy Access to State and County Juvenile Court Case Counts (EZACO) and are used in the 2024 County Health Rankings.	Office of Juvenile Justice and Delinquency Department, Easy Access to State and County Juvenile Court Case Counts (EZACO). Data accessed via the North Carolina Data Portal, June 2024.	2021
Violent Crime (per 100,000 people)	Annual rate of reported violent crimes per 100,000 people during the three-year period of 2015-2017. Violent crime includes homicide, rape, robbery, and aggravated assault.	Federal Bureau of Investigation (FBI), FBI Uniform Crime Reports. Additional analysis by the National Archive of Criminal Justice Data. Data accessed via the North Carolina Data Portal, June 2024.	2015-2017
Mortality – Firearm (per 100,000 population)	Five-year average rate of death due to firearm wounds per 100,000 population, which includes gunshot wounds from powder-charged handguns, shotguns, and rifles. Figures are reported as crude rates for the time period of 2018 to 2022. This indicator is relevant because firearm deaths are preventable, and are a cause of premature death.	CDC – National Vital Statistics System. Data accessed via the North Carolina Data Portal, June 2024.	2018-2022
Mortality – Poisoning (per 100,000 population)	Five-year average rate of death due to poisoning (including drug overdose) per 100,000 population. Figures are reported as crude rates for the time period of 2018 to 2022. Rates are re-summarized for report areas from county level data, only where data is available. This indicator is relevant because poisoning deaths, especially from drug overdose, are a national public health emergency.	CDC – National Vital Statistics System. Data accessed via the North Carolina Data Portal, June 2024.	2018-2022

Table 47: Sexual Health

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

Table 48: Substance Use Disorders

Measure	Description	Data Source	Most Recent Data Year(s)
Excessive Drinking – Heavy Alcohol Consumption	Percentage of adults that self-report excessive drinking in the last 30 days. Data for this indicator were based on survey responses to the 2021 Behavioral Risk Factor Surveillance System (BRFSS) annual survey and are used for the 2024 County Health Rankings. Excessive drinking is defined as the percentage of the population who report at least one binge drinking episode involving five or more drinks for men and four or more for women over the past 30 days, or heavy drinking involving more than two drinks per day for men and more than one per day for women, over the same time period. Alcohol use is a behavioral health issue that is also a risk factor for a number of negative health outcomes, including: physical	CDC, BRFSS. Data accessed via the North Carolina Data Portal, June 2024.	2021

Measure	Description	Data Source	Most Recent Data Year(s)
	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-summarized for report areas from county level data, only where data is available. This indicator is relevant because opioid drug overdose is the leading cause of injury deaths in the United States, and they have increased dramatically in recent years.	CDC – NVSS. Data accessed via the North Carolina Data Portal, June 2024.	2018-2022

Table 49: 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 50: 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 Greene 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	Greene County Description
	Low	Represents measures in which Greene 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 Greene 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 Greene 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 Greene County value was compared to the benchmark by calculating the percentage difference between the values, relative to the benchmark value:

(Greene Co Value – Benchmark Value)/(Benchmark) x 100 = % Difference Used to Identify Priority Level

For example, for the % Limited Access to Healthy Foods metric, the following calculation was completed:

(0.1-7.5)/(7.5) x 100% = -98.7% = Displayed as **Low Priority Level**, Shaded in Green

This metric indicates that the percentage of the population with limited access to healthy foods in Greene County is 98.7 percent better (or, in this case, lower) than the percentage of the population with limited access to healthy foods in the state of North Carolina.

Detailed Focus Area Benchmarks

Table 51: Access to Care

Measure	National Benchmark	North Carolina Benchmark	Greene County Data	Most Recent Data Year	Greene County Need
Primary Care Providers Rate	112.4	101.1	44.0	2024	High
Mental Health Providers Rate	178.7	155.7	24.5	2024	High
Addiction/Substance Abuse Providers Rate	27.9	25.0	4.9	2024	High
Buprenorphine Providers Rate	15.5	15.2	9.5	2023	High
Dental Health Providers Rate	39.1	31.5	39.1	2024	Low
% Living in Health Professional Shortage Areas (HPSAs) – Dental Care	17.8%	34.0%	44.2%	2018-2022	High
Federally Qualified Health Centers (FQHCs)	3.5	4.1	24.5	2023	Low
% Receiving Medicaid	22.3%	20.2%	32.6%	2018-2022	High
% Uninsured	10.2%	12.5%	20.5%	2022	High

Table 52: Built Environment

Measure	National Benchmark	North Carolina Benchmark	Greene County Data	Most Recent Data Year	Greene County Need
Broadband Access (Access to DL Speeds >= 25MBPS and UL Speeds >= 3 MBPS)	93.8%	93.6%	68.7%	2023	High
Broadband Access (Access to DL Speeds >= 100MBPS and UL Speeds >= 20 MBPS)	91.2%	90.4%	48.9%	2023	High

Measure	National Benchmark	North Carolina Benchmark	Greene County Data	Most Recent Data Year	Greene County Need
Households with No Computer	6.1%	6.9%	10.9%	2018-2022	High
Households with No or Slow Internet	11.7%	13.0%	21.4%	2018-2022	High
Liquor Stores	13.3	6.2	Suppressed	2022	N/A
Adverse Childhood Experiences (ACEs)	N/A	N/A	N/A	2022	N/A

Table 53: Diet and Exercise

Measure	National Benchmark	North Carolina Benchmark	Greene County Data	Most Recent Data Year	Greene County Need
% Physically Inactive	N/A	21.6%	30.0%	2021	High
Walkability Index Score	10	7	4	2021	High
% with Access to Exercise Opportunities	84.1%	73.0%	42.0%	2023	High
Recreation and Fitness Facility Access	14.8	13.1	Suppressed	2022	N/A
Sugar-Sweetened Beverage (SSB) Consumption	N/A	N/A	36.8%	2022	N/A

Table 54: Education

Measure	National Benchmark	North Carolina Benchmark	Greene County Data	Most Recent Data Year	Greene County Need
% Limited English Proficiency	8.2%	4.6%	6.5%	2018-2022	High
High School Graduation Rate	81.1%	87.6%	94.9%	2020-2021	Low
% with No High School Diploma	10.9%	10.6%	23.9%	2018-2022	High
Student Math Proficiency	63.9%	65.8%	80.3%	2020-2021	High
Student Reading Proficiency	60.1%	59.5%	72.8%	2020-2021	High

Measure	National Benchmark	North Carolina Benchmark	Greene County Data	Most Recent Data Year	Greene County Need
School Funding Adequacy	N/A	-$4,742	-$9,047	2021	High
School Funding Adequacy – Spending per pupil	N/A	$10,655	$13,474	2021	Low

Table 55: Employment

Measure	National Benchmark	North Carolina Benchmark	Greene County Data	Most Recent Data Year	Greene County Need
Unemployment Rate	3.9%	3.7%	2.6%	2024	Low
Average Annual Unemployment Rate, 2013-2023	3.6%	3.5%	2.9%	2024	Low

Table 56: Environmental Quality

Measure	National Benchmark	North Carolina Benchmark	Greene County Data	Most Recent Data Year	Greene County Need
Flood Vulnerability	6.5%	4.9%	3.6%	2011	Low
Drinking Water Safety	16,107	194	0	2023	Low

Table 57: Family, Community and Social Support

Measure	National Benchmark	North Carolina Benchmark	Greene County Data	Most Recent Data Year	Greene County Need
Children Cost Burden	28.8%	27.0%	29.0%	2023	High
% Young People Not in School or Working	6.9%	7.5%	9.6%	2018-2022	High

Table 58: Food Security

Measure	National Benchmark	North Carolina Benchmark	Greene County Data	Most Recent Data Year	Greene County Need
% Food Insecure	10.3%	11.4%	13.6%	2021	High
% Food Insecure Children	13.3%	15.3%	23.3%	2021	High
% Low-Income and with Low Food Access	19.4%	21.3%	0.2%	2019	Low

Measure	National Benchmark	North Carolina Benchmark	Greene County Data	Most Recent Data Year	Greene County Need
% Limited Access to Healthy Foods	N/A	7.5%	0.1%	2019	Low
Fast Food Restaurants	96.2	77.4	24.5	2022	Low
Grocery Stores	23.4	18.7	19.6	2022	Medium

Table 59: Housing and Homelessness

Measure	National Benchmark	North Carolina Benchmark	Greene County Data	Most Recent Data Year	Greene County Need
Renter Costs – Average Gross Rent	$1,366	$1,090	$733	2018-2022	Low
% Severe Housing Cost Burden	14.1%	12.2%	12.9%	2018-2022	High
Assisted Housing Units	413.9	319.2	418.4	2017-2021	High
% Severe Substandard Housing	18.5%	16.1%	18.2%	2011-2015	High
% Homeless Children	2.8%	1.9%	2.5%	2019-2020	High

Table 60: Income

Measure	National Benchmark	North Carolina Benchmark	Greene County Data	Most Recent Data Year	Greene County Need
Median Family Income	$92,646	$82,890	$61,301	2018-2022	High
Gender Pay Gap	81.0%	83.0%	85.0%	2018-2022	Medium
% Living Below 100% FPL	12.5%	13.3%	22.6%	2022	High
% Living Below 200% FPL	28.8%	31.6%	47.0%	2018-2022	High
% Children Living Below 200% FPL	37.2%	41.1%	65.2%	2018-2022	High
% Receiving SNAP	12.4%	15.7%	21.8%	2021	High
Children Eligible for Free/Reduced Price Lunch	51.7%	50.8%	99.2%	2022-2023	High

Table 61: Length of Life

Measure	National Benchmark	North Carolina Benchmark	Greene County Data	Most Recent Data Year	Greene County Need
Years of Potential Life Lost Rate	N/A	8,853	8,476	2019-2021	Medium
Premature Age-Adjusted Mortality	N/A	420	446	2019-2021	High
Life Expectancy	77.6	76.6	75.6	2019-2021	Medium

Table 62: Maternal and Infant Health

Measure	National Benchmark	North Carolina Benchmark	Greene County Data	Most Recent Data Year	Greene County Need
Births with Late or No Prenatal Care	6.1%	6.9%	Suppressed	2019	N/A
Low Birthweight	N/A	9.4%	11.1%	2016-2022	High
Infant Mortality Rate	5.7	7.0	Suppressed	2015-2021	N/A

Table 63: Mental Health

Measure	National Benchmark	North Carolina Benchmark	Greene County Data	Most Recent Data Year	Greene County Need
Poor Mental Health Days	4.9	4.6	5.1	2021	High
Deaths of Despair Rate	55.9	58.7	49.2	2018-2022	Low
Suicide Death Rate	14.5	14.0	N/A	2018-2022	N/A

Table 64: Physical Health

Measure	National Benchmark	North Carolina Benchmark	Greene County Data	Most Recent Data Year	Greene County Need
% Poor or Fair Health	N/A	14.4%	21.6%	2021	High
% Adults with Asthma	9.7%	9.8%	10.4%	2022	High
% Adults with Heart Disease	5.2%	5.5%	6.8%	2022	High
% Adults with High Blood Pressure	29.6%	32.1%	37.3%	2021	High

Measure	National Benchmark	North Carolina Benchmark	Greene County Data	Most Recent Data Year	Greene County Need
% Adults with High Cholesterol	31.0%	31.4%	32.6%	2021	Medium
Diabetes Prevalence	8.9%	9.0%	8.7%	2021	Medium
% Adults with Kidney Disease	2.7%	2.9%	3.5%	2021	High
% Stroke	2.8%	3.1%	4.1%	2022	High
Obesity	30.1%	29.7%	20.8%	2021	Low
% Teeth Loss	13.9%	12.0%	18.4%	2022	High
Cancer Incidence Rate	442.3	464.4	426.5	2016-2020	Low
Emergency Room Visits	535	563	559	2022	Medium
Heart Disease Hospitalization Rate	10.4	11.7	14.5	2018-2020	High
Stroke Hospitalization Rate	8.0	9.5	11.5	2018-2020	High

Table 65: Quality of Care

Measure	National Benchmark	North Carolina Benchmark	Greene County Data	Most Recent Data Year	Greene County Need
Children/adults vaccinated annually against seasonal influenza	44.5%	45.6%	36.8%	2021	High
Preventable Hospital Rate	2,752	2,957	3,561	2021	High
Readmissions Rate	18.1%	17.6%	21.8%	2022	High

Table 66: Safety

Measure	National Benchmark	North Carolina Benchmark	Greene County Data	Most Recent Data Year	Greene County Need
Incarceration Rate	1.3%	1.5%	2.0%	2018	High
Juvenile Arrest Rate	13.8	16.0	22.0	2021	High
Violent Crime	416.0	365.7	279.1	2015-2017	Low
Firearm Death Rate	13.4	15.5	N/A	2018-2022	N/A

Measure	National Benchmark	North Carolina Benchmark	Greene County Data	Most Recent Data Year	Greene County Need
Poisoning Death Rate	28.5	31.5	21.2	2018-2022	Low

Table 67: Sexual Health

Measure	National Benchmark	North Carolina Benchmark	Greene County Data	Most Recent Data Year	Greene County Need
Chlamydia Rate	495.0	603.3	602.4	2021	Medium
HIV Incidence Rate	12.7	15.5	Suppressed	2022	N/A
Teen Births	16.6	18.2	N/A	2016-2022	N/A

Table 68: Substance Use Disorders

Measure	National Benchmark	North Carolina Benchmark	Greene County Data	Most Recent Data Year	Greene County Need
% Excessive Drinking	18.1%	18.2%	16.4%	2021	Low
% Driving Deaths with Alcohol	2.3	2.9	5.9	2018-2022	High
Opioid Use Disorder Rate	41.0	43.0	22.0	2021	Low
Opioid Drug Overdose Deaths	N/A	25.1	N/A	2018-2022	N/A

Table 69: Tobacco Use

Measure	National Benchmark	North Carolina Benchmark	Greene County Data	Most Recent Data Year	Greene County Need
% Smokers	14.5%	15.0%	21.7%	2021	High

Table 70: Transportation Options and Transit

Measure	National Benchmark	North Carolina Benchmark	Greene County Data	Most Recent Data Year	Greene County Need
% Households with No Motor Vehicle	8.3%	5.4%	5.5%	2018-2022	Medium
% Public Transit	3.8%	0.8%	0.0%	2018-2022	High

Measure	National Benchmark	North Carolina Benchmark	Greene County Data	Most Recent Data Year	Greene County Need
% Living Near Public Transit	34.8%	10.9%	0.0%	2021	High

APPENDIX 4 | PRIMARY DATA METHODOLOGY AND SOURCES

Primary data were collected through an in-person focus group, interviews with community champions, 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 Group

One focus group was conducted in person on June 26th, 2024. These groups included representation from members, with participants providing responses on living, working, or receiving healthcare in Greene County.

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 Greene County

The focus group discussion guide questions are below:

FACILITATOR INTRODUCTION:

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

PARTICIPANT INTRODUCTIONS

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

HEALTH AND WELLNESS

2. What are some of the issues that keep residents in [COUNTY NAME] from living healthy lives?

3. What are the most serious health problems facing people who live in [COUNTY NAME]?

    a. Are there particular groups of people (i.e. race, ethnicity, age, LGBTQ+, etc.) who are more affected by these problems than others?

    b. Are there particular areas in the county that are more affected by these problems than others?

4. Thinking about the health problems you described, what do you think could be done to address these issues?

SOCIAL DETERMINANTS OF HEALTH

5. What are some of the environmental and/or social conditions that affect quality of life for people living in [COUNTY NAME]?

    a. Examples of social and environmental issues that negatively impact health: availability or access to health insurance, domestic violence, housing problems, homelessness, lack of job opportunities, lack of affordable childcare, limited access to healthy food, neighborhood safety/ street violence, poverty, racial/ethnic discrimination, limited/poor educational opportunities.

6. Thinking about the social and environmental issues you described; how do you think these issues could be addressed?

ACCESS TO CARE

7. What are some reasons people in [COUNTY NAME] do not get health care when they need it? How can these issues be addressed?

8. What do you think about the health-related services that are available in your community, including medical care, dental care and behavioral health care?

    a. Are there enough locations providing these types of care for people who need it?

    b. Can you find medical, dental or behavioral health care within a reasonable timeframe when you need it?

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

SUGGESTIONS

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

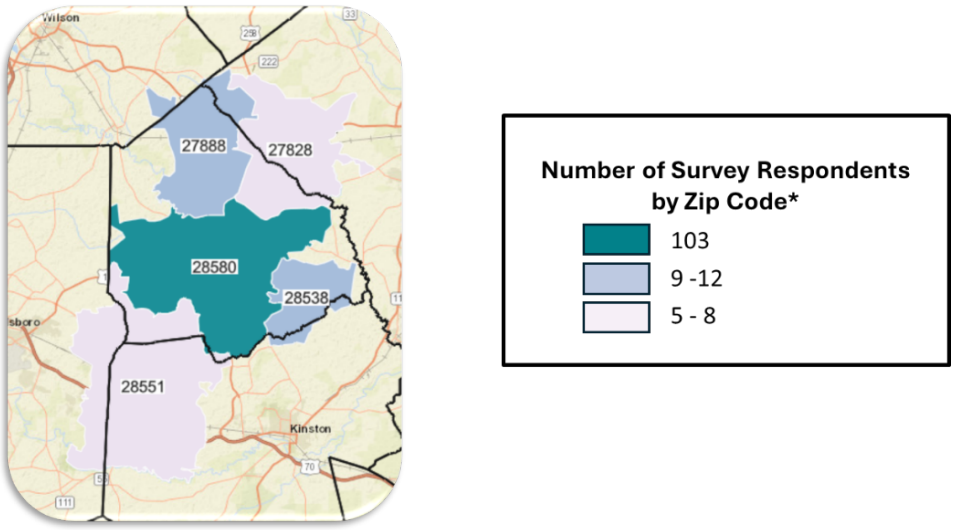
Community Champion (Key Informant) Interviews

Four community champion interviews were conducted in summer 2024 with long-term residents of Greene County to gain perspective on the health and well-being of the community. All participants resided in ZIP code 28580. The group consisted of three Black/African American individuals (two males and one female) and one White male. Their ages ranged from 40 to over 75 years old, with the oldest being 75+ and the youngest in the 40-49 age bracket. These champions had significant ties to the community, with residency durations spanning from 43 to 89 years, providing a wealth of local knowledge and perspective.

Community Member Web Survey

A total of 152 surveys were completed by individuals living, working or receiving healthcare in the Greene County community. The survey was available in both English and Spanish, and approximately 3% were completed in Spanish. Consistent with one of the survey process goals, survey community member respondents were representative of a broad geographic area encompassing areas throughout the county. The map below provides additional information on survey respondents' ZIP code of residence.

Figure 34: Respondent Zip Code of Residence[44]



In general, survey questions focused on:

- Community health problems and concerns
- Community social/environmental problems and concerns
- Other topics of interest to Greene County:
    - Access to care
    - Healthy lifestyle
    - Food security
    - Physical health
    - Substance use disorders
    - Tobacco use

The key findings from the Community Survey are detailed below:

- Diabetes/high blood sugar, overweight/obesity, and mental health (depression/anxiety) were identified as the top three health problems that affect the community. Additionally, over a third of respondents have identified heart disease/high blood pressure and alcohol/drug addiction as important health problems in Greene County.
- Cost, not having insurance, and lack of transportation were the top three barriers to receiving health care identified by the community.
- Lack of job opportunities, availability/access to doctor's office, and poverty were identified as the top three most important social or environmental problems that affect the health of the community. Roughly one in five residents identified availability/access to insurance and limited access to health food as additional problems.

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

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

Figure 35: Respondents by Age Group

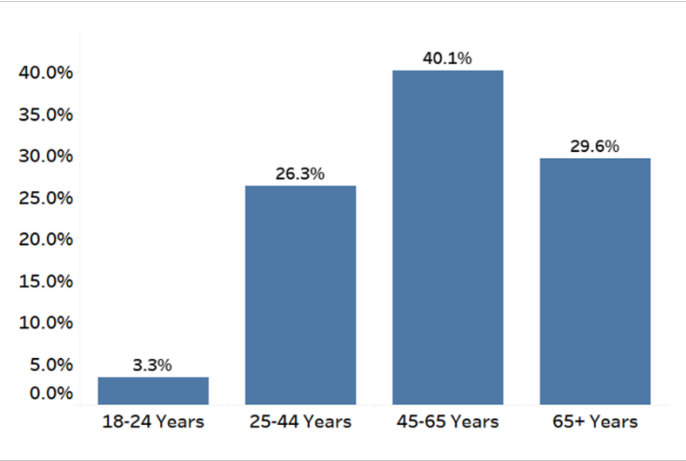


Figure 36: Respondents by Gender

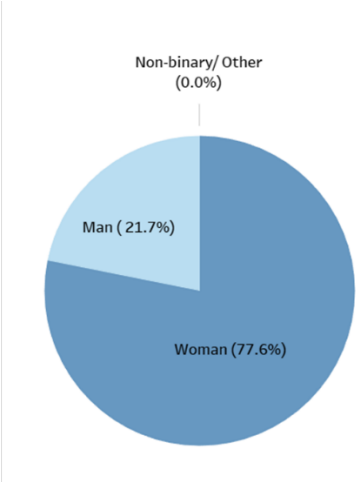


Figure 37: Respondents by Race

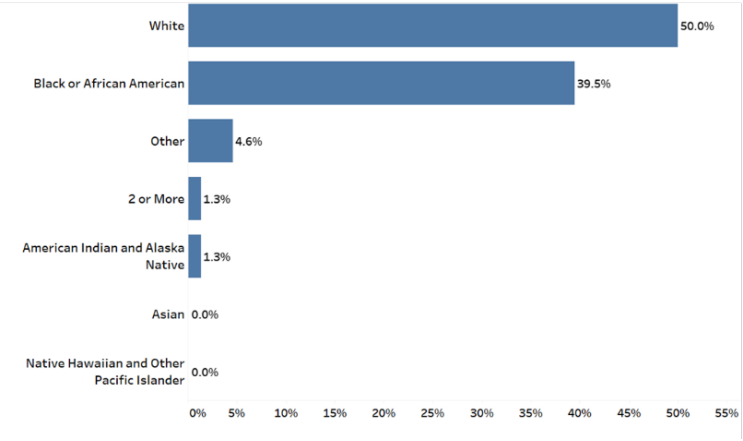
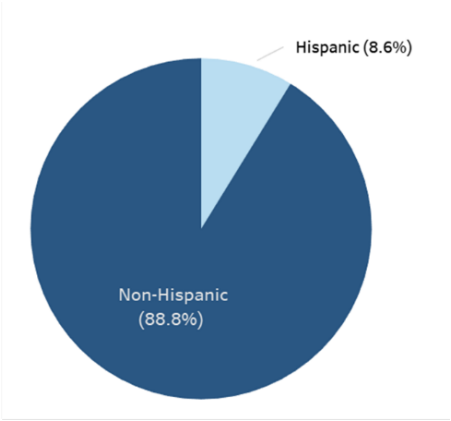


Figure 38: Respondents by Ethnicity



The questions administered via the Community Member Survey instrument are below. The survey instrument was also available in Spanish, and a copy of the Spanish language survey instrument is available on request.

Dear Community Member,

We invite you to participate in your county's Community Health Needs Survey.

Your responses to this optional survey are anonymous and will inform how hospitals and agencies work to improve health in your county. This is not a research survey. It will take less than 10 minutes to complete.

Instructions: You must be 18 years or older to complete this survey. Please answer all questions and return the survey as indicated.

For questions about this survey, contact Ascendient Healthcare Advisors: emilymccallum@ascendient.com

Thank you for your time and participation!

Topic: Demographics

1. What is the zip code where you currently live? _____

2. What is your age group?

   □ 18-24
   □ 25-44
   □ 45-65
   □ 65+
   □ Don't know/ Not sure
   □ Prefer not to say

3. Which of the following best describes your gender? *Select all that apply:*

   □ Man
   □ Woman
   □ Non-binary, genderqueer, or gender nonconforming
   □ Additional gender category: _____
   □ Prefer not to say

4. How would you describe your race? *Select all that apply:*

   □ American Indian and Alaska Native
   □ Asian
   □ Black or African American

□ Native Hawaiian and Other Pacific Islander
□ White
□ Other race: _____
□ Don't know/Not sure
□ Prefer not to say

5. Are you of Hispanic or Latino origin, or is your family originally from a Spanish speaking country?[45]

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

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

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

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

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

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)
□ Homemaker
□ Temporarily unable to work due to illness or injury

[45] 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."

□ Retired
□ Student
□ Armed forces/military
□ Self-employed
□ Unemployed for less than one year
□ Unemployed for more than one year
□ Permanently unable to work
□ Prefer not to answer

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

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

Topic: Community Health Opinion Questions

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

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

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

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

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

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

Topic: Access to Care

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

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

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

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

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

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

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

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

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

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

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

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

Topic: Diet & Exercise

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

    □ Number of servings: _____

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

    □ Number of servings: _____

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

    □ Number of drinks: _____

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

    □ Number of hours: _____

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

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

Topic: Food Security

24. Please tell me whether the following statement(s) was "Often True," "Sometimes True," or "Never True" for you in the past 12 months:
1 = Often true; 2 = Sometimes true; 3 = Never true

	1	2	3	Don't Know	Prefer not to say
a. I worried about whether our food would run out before my household got money to buy more.	□	□	□	□	□
b. The food that my household bought just did not last, and there was not money to get more.	□	□	□	□	□

25. In the last 12 months, did you or someone in your household cut the size of your meals or skip meals because there wasn't enough money for food?

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

26. In the past 12 months, have you gotten fresh fruits and vegetables from any of the following sources? Select all that apply.

□ Corner Store, Convenience Store or Gas Station
□ Farmer's Market or Permanent Farm Stand
□ Food Bank, Pantry
□ Homegrown or home garden
□ Church, or Community Organization
□ Grocery Store or a Superstore Such as Wal-Mart
□ Don't know/Not sure
□ Prefer not to say

Topic: Physical Health

27. Considering your physical health overall, would you describe your health as…

□ Excellent
□ Very Good
□ Good
□ Fair
□ Poor
□ Don't know/Not sure
□ Prefer not to say

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

	Yes	No	Don't Know	Prefer not to say
a. Had a routine/annual physical or check-up?	□	□	□	□
b. Been to the dentist/dental hygienist?	□	□	□	□

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

□ Arthritis
□ Asthma
□ Cancer
□ Chronic Obstructive Pulmonary Disease (COPD)
□ Dementia/Short-term memory loss
□ Depression or anxiety
□ Diabetes (not during pregnancy)
□ Heart disease, stroke, or other cardiovascular disease
□ High blood pressure (hypertension)
□ High cholesterol
□ Immunocompromised condition not otherwise listed
□ Kidney disease
□ Liver disease
□ Long COVID
□ Lung disease

□ Osteoporosis
□ Physical disabilities
□ Mental illness not otherwise listed (including bipolar disorder, schizophrenia, borderline personality disorder, dissociative identity disorder)
□ Sexually transmitted diseases (including chlamydia, syphilis, gonorrhea and HIV)
□ Stroke
□ Vision and sight problems
□ Other *(please specify)*: _____
None of the above
□ Don't know/Not sure
□ Prefer not to say

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

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

Topic: Substance Use Disorders

31. 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: _____

32. 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

33. 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

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

Topic: Tobacco Use

35. Do you currently use any of the following tobacco or nicotine products? *Select all that apply:*

□ Cigarettes
□ Vape/Electronic cigarettes (e-cigarettes) (JUUL, Stig, Puff Bars, Blue, etc.)
□ Smokeless tobacco (chew, dip, snuff, snus)
□ Cigars
□ Pipes
□ Hookah
□ I don't use any tobacco products
□ Prefer not to say

36. If you indicated that you use any of the products listed in Question 1, how often do you use any kind of tobacco or nicotine product, including smokeless products, chewing tobacco, dip, snuff, snus, electronic cigarettes, or vapes?

□ Every Day
□ Some Days
□ Not at All
□ Don't know/Not sure

□ Prefer not to say

37. Are you regularly exposed to secondhand smoke in any of these locations in your county? *Select all that apply:*

□ Home or car
□ Workplace
□ Parks
□ Restaurants or bars
□ School
□ Sidewalks
□ Hospital
□ Other, please specify: _____
□ I am not regularly exposed to secondhand smoke in my county
□ Prefer not to say

APPENDIX 5 | DETAILED PRIMARY DATA FINDINGS

Focus Groups

Key findings from the focus groups are summarized below.

Focus Group Findings:

A focus group was conducted in Greene County as part of the Community Health Needs Assessment (CHNA) process. The group identified several key health and social concerns. These included health equity issues, particularly systemic racism and discrimination affecting minority populations. Housing and homelessness were highlighted, with unsafe housing conditions noted as a significant problem. Mental health emerged as a major concern, with increases in suicide, overdoses, and dementia, as well as a lack of resources and stigma around mental health education. Physical health, particularly chronic conditions like diabetes and high blood pressure, were also emphasized.

Three community members participated in the focus group. Two participants identified as female, and all were Black or African American and non-Hispanic/Latino. All participants were over the age of 39.

This group identified several key health concerns and barriers to care. They noted issues with the built environment, specifically a lack of access to public spaces such as ball fields or fishing areas. Community safety was raised as a concern, with domestic violence highlighted. Employment and income were significant issues, with participants citing a lack of job opportunities, low minimum wage, and limited access to economic development in the county. The group also expressed concerns about family, community, and social support, noting a perceived lack of unity and siloes between community groups.

Healthcare access and quality were major topics of discussion. Participants mentioned the overall cost of care, forcing people to prioritize basic needs over health, insurance issues, and a need for better medical and dental care.

Participants had several suggestions for how local leaders can improve community health. They emphasized the importance of uplifting minority voices and resources, allowing them to decide what their community needs. The group suggested capitalizing on existing resources and engaging young people more by bringing them to the table to have their voices heard. Involving community activists was also recommended. Lastly, they proposed facilitating collaborative talks with like-minded individuals to move the community forward, such as holding community meetings with an unbiased facilitator.

Community Champion (Key Informant) Interviews

The interviews identified several common concerns and challenges in Greene County. Major issues centered around poverty, lack of job opportunities, racial/ethnic discrimination, and limited access to various resources including health insurance, transportation, affordable housing, healthy food, and quality education.

Key health concerns focused on chronic conditions such as stroke, obesity, diabetes, hypertension, and heart disease, as well as cancer and conditions associated with aging. Interviewees noted that

Black/African American and Hispanic/Latino communities were disproportionately impacted by these issues.

Barriers to Healthcare and Potential Solutions

Barriers to accessing healthcare services in Greene County were also revealed. These included lack of insurance, financial constraints and high out-of-pocket costs, transportation issues, and a shortage of local healthcare providers. To overcome these barriers, suggestions included expanding insurance coverage, providing financial assistance programs, improving public transportation options, and incentivizing healthcare providers to practice in underserved areas.

Suggestions for Improvement

When asked about potential improvements, community champions offered varied responses. These ranged from broad suggestions like "Anything" and "Improve things for people to do" to more specific recommendations focused on minorities. One champion provided a detailed response, emphasizing the need for local health leaders to prioritize expanding access to affordable healthcare, addressing social determinants of health, and increasing community engagement in health initiatives.

Community Member Web Survey

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

Additional Demographic Information

Figure 39: What is the highest grade or year of school you completed?

(N=152)

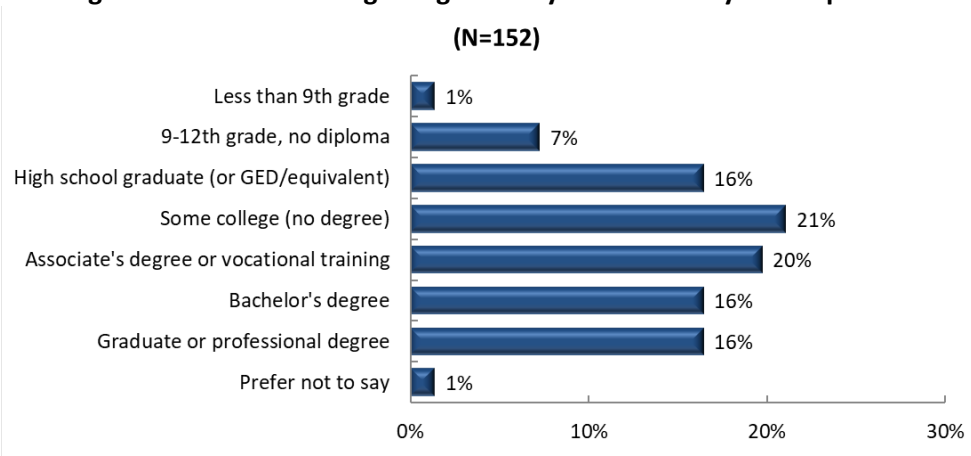


Figure 40: Which language is most often spoken in your home? (Choose one)

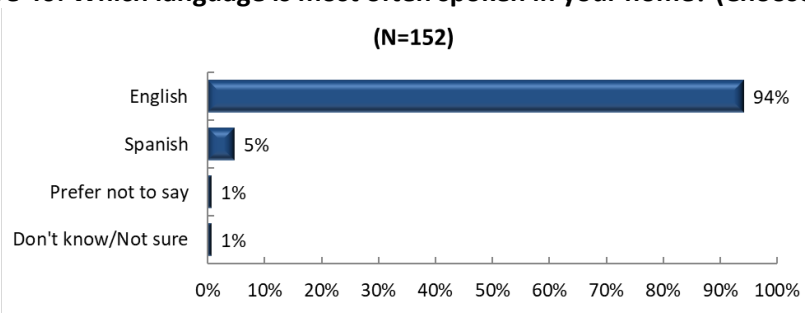


Figure 41: For employment, are you currently... (Select all that apply.)

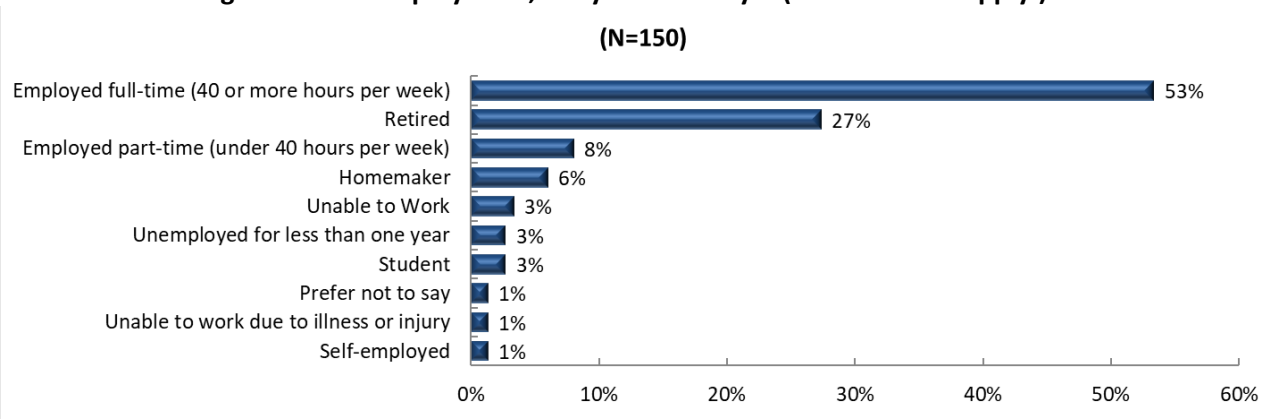
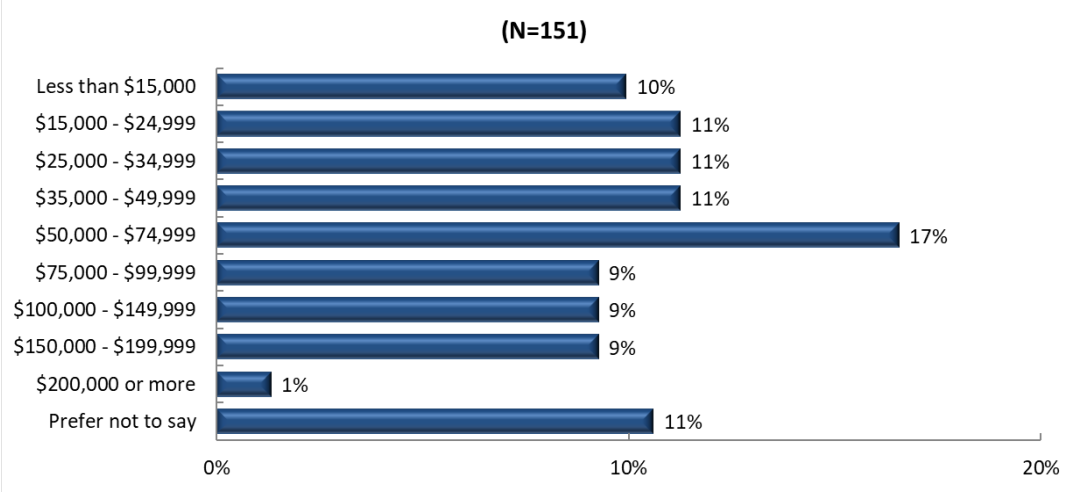


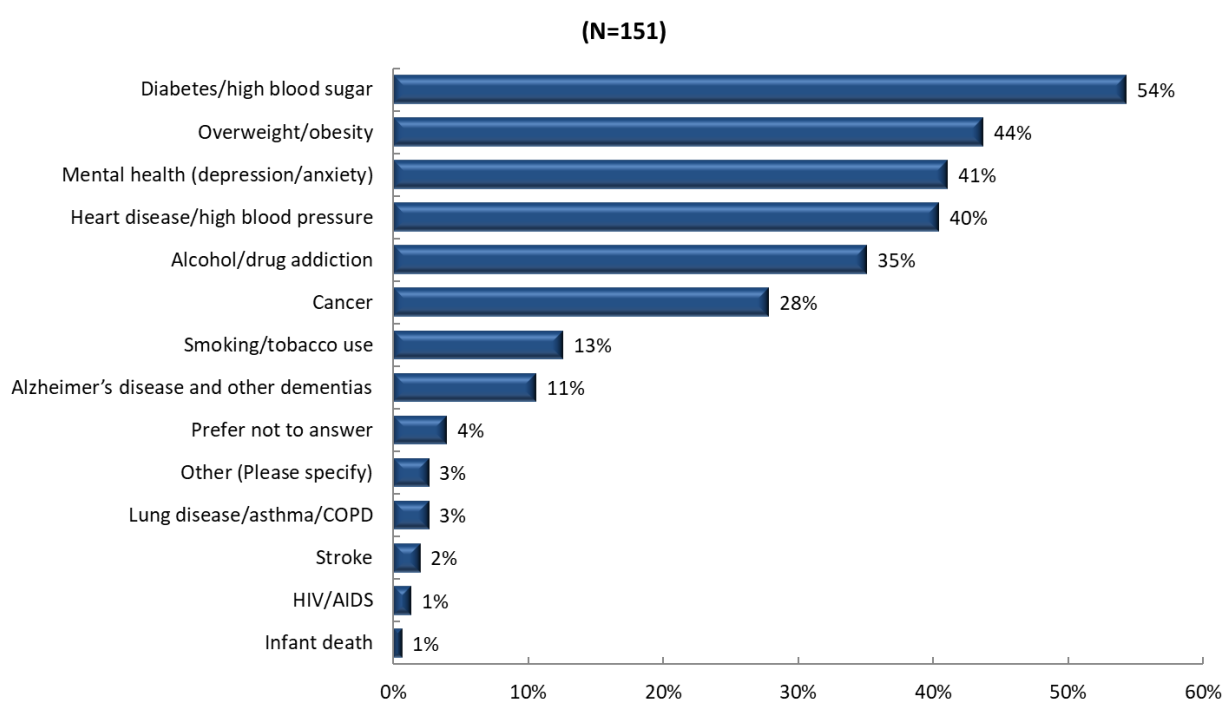
Figure 42: Which category best describes your yearly household income before taxes?[46]



[46] Participants 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, Social Determinants of Health, and Barriers to Care

Figure 43: What are the three most important health problems that affect the health of your community? Please select up to three.



Other (please specify):

- "All of the above"

Figure 44: What are the three most important health problems that affect the health of your community? Please select up to three. (by age)

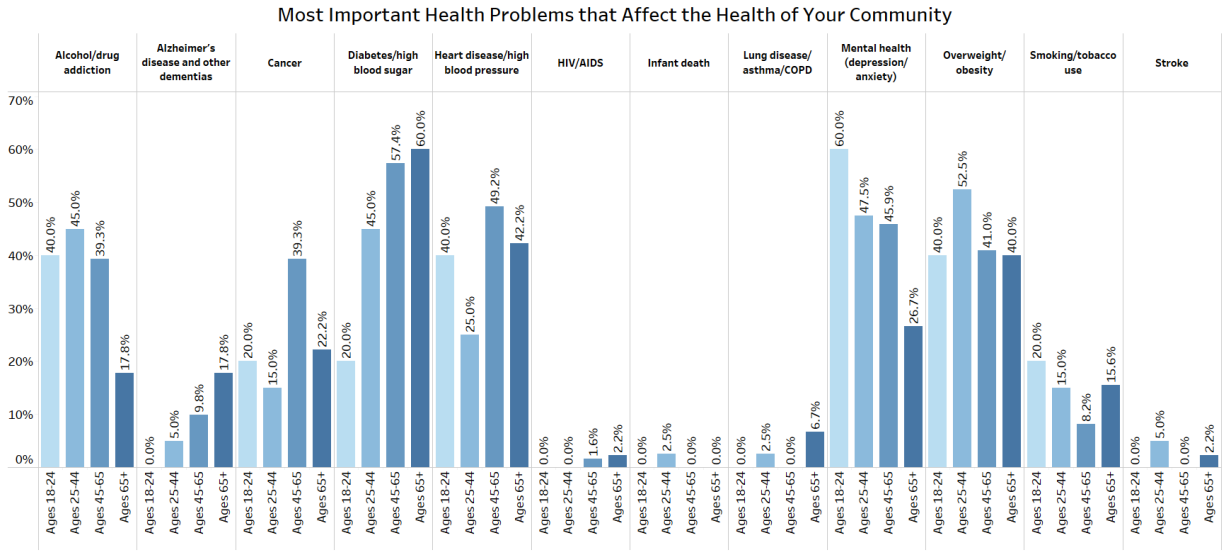


Figure 45: What are the three most important health problems that affect the health of your community? Please select up to three. (by gender)

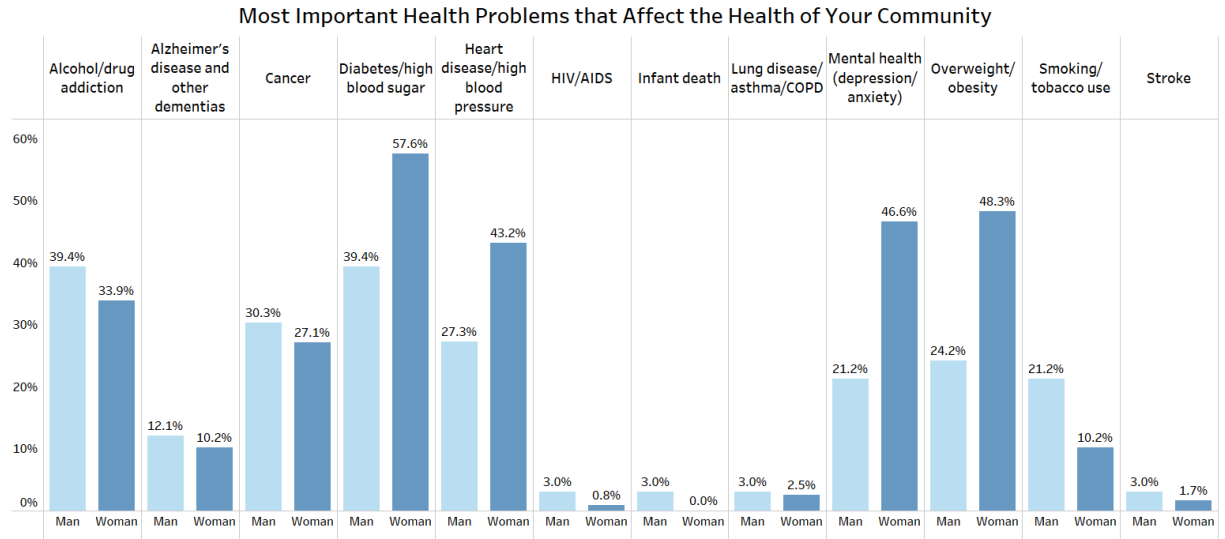


Figure 46: What are the three most important health problems that affect the health of your community? Please select up to three. (by race)

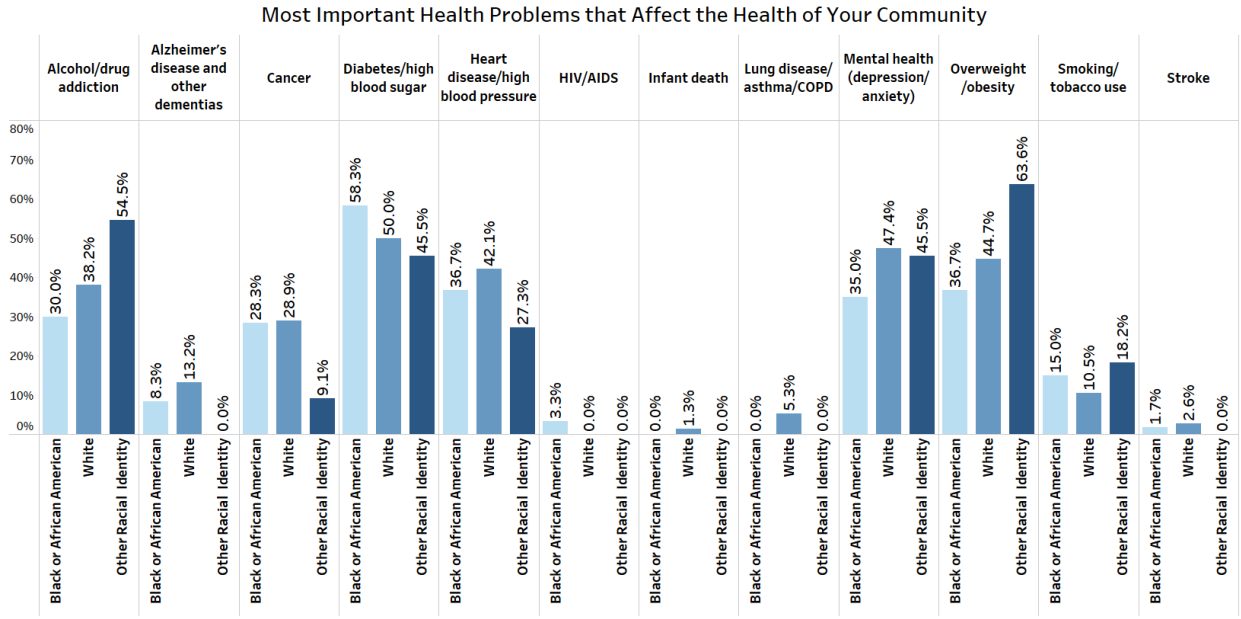


Figure 47: What are the three most important health problems that affect the health of your community? Please select up to three. (by ethnicity)

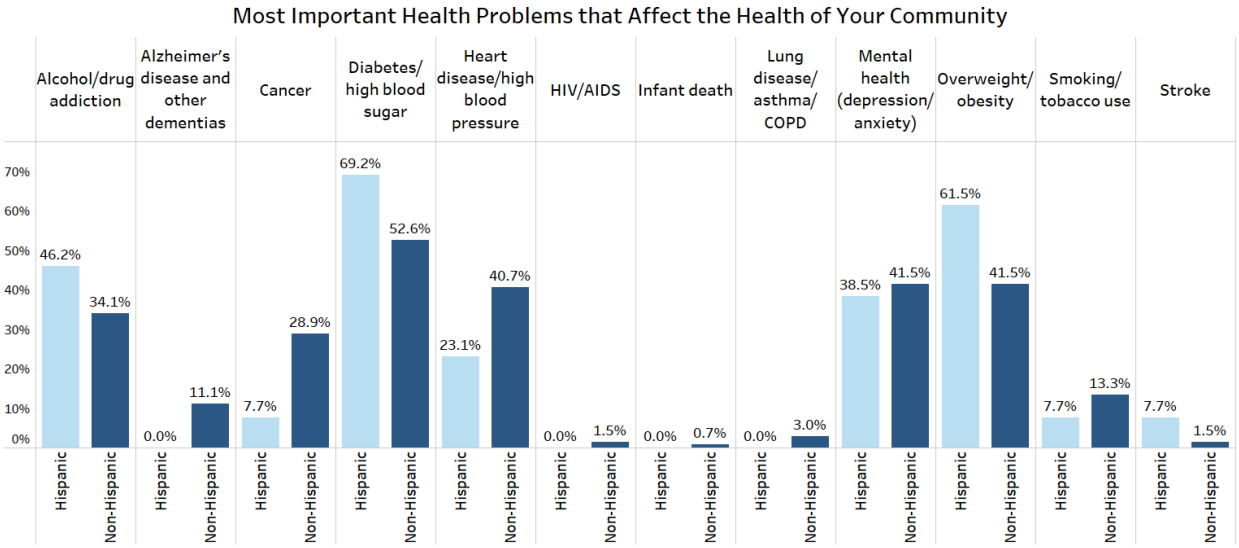
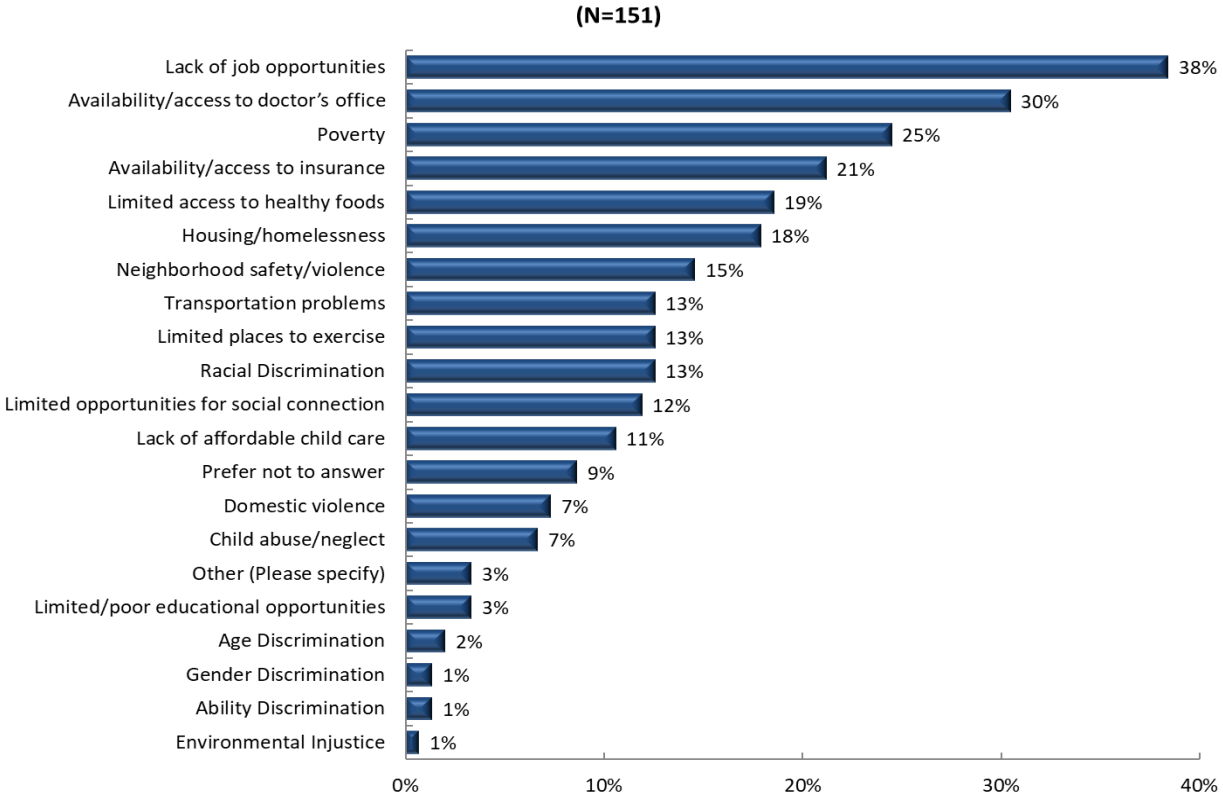


Figure 48: What are the three most important social or environmental problems that affect the health of your community? Please select up to three.



Other (please specify):

- "All of the above"
- "Limited after school childcare and summer camps"
- "Rural area internet for telemed"
- "Warm water pool for exercising senior citizens

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

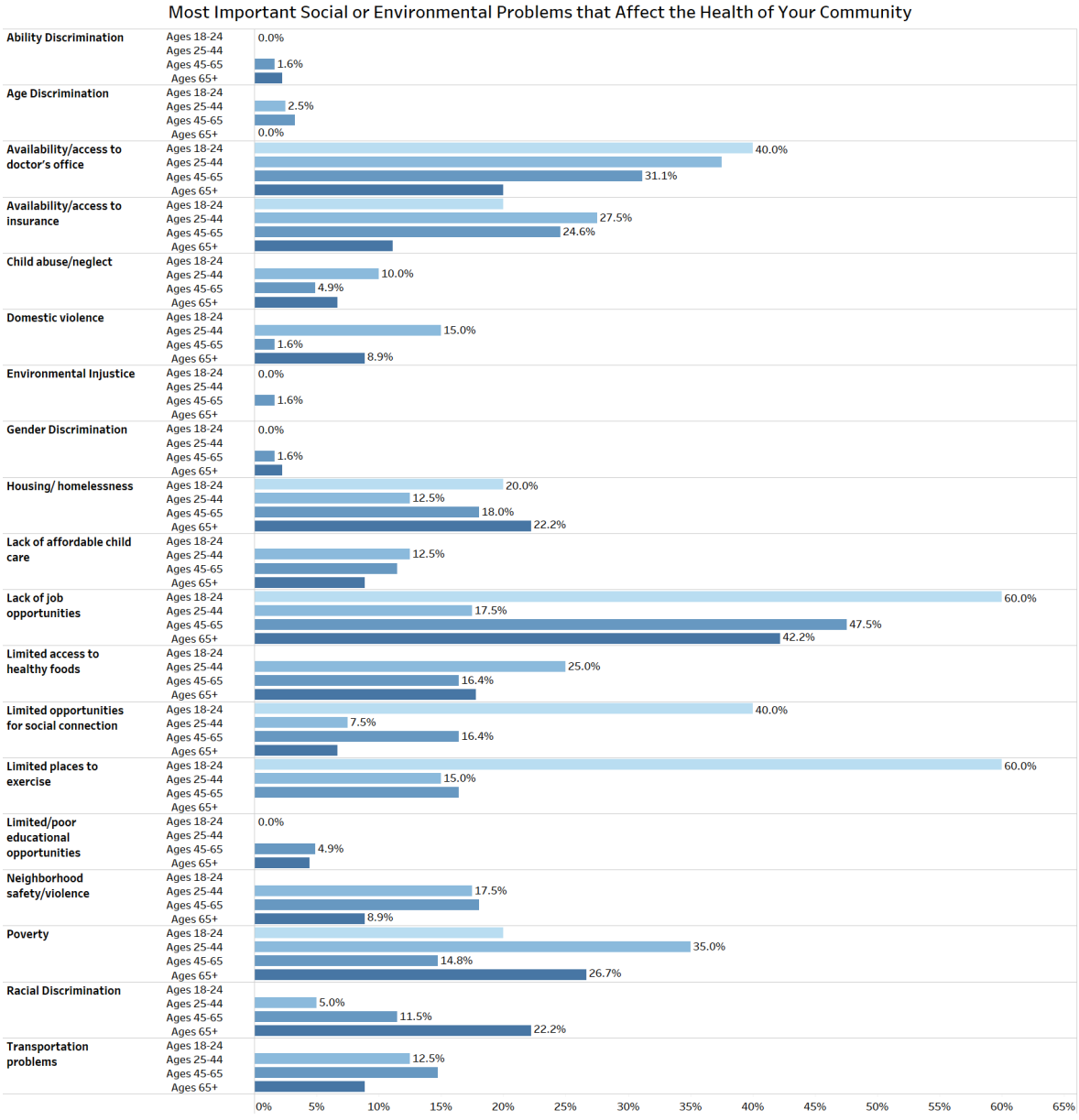


Figure 50: What are the three most important social or environmental problems that affect the health of your community? Please select up to three. (by gender)

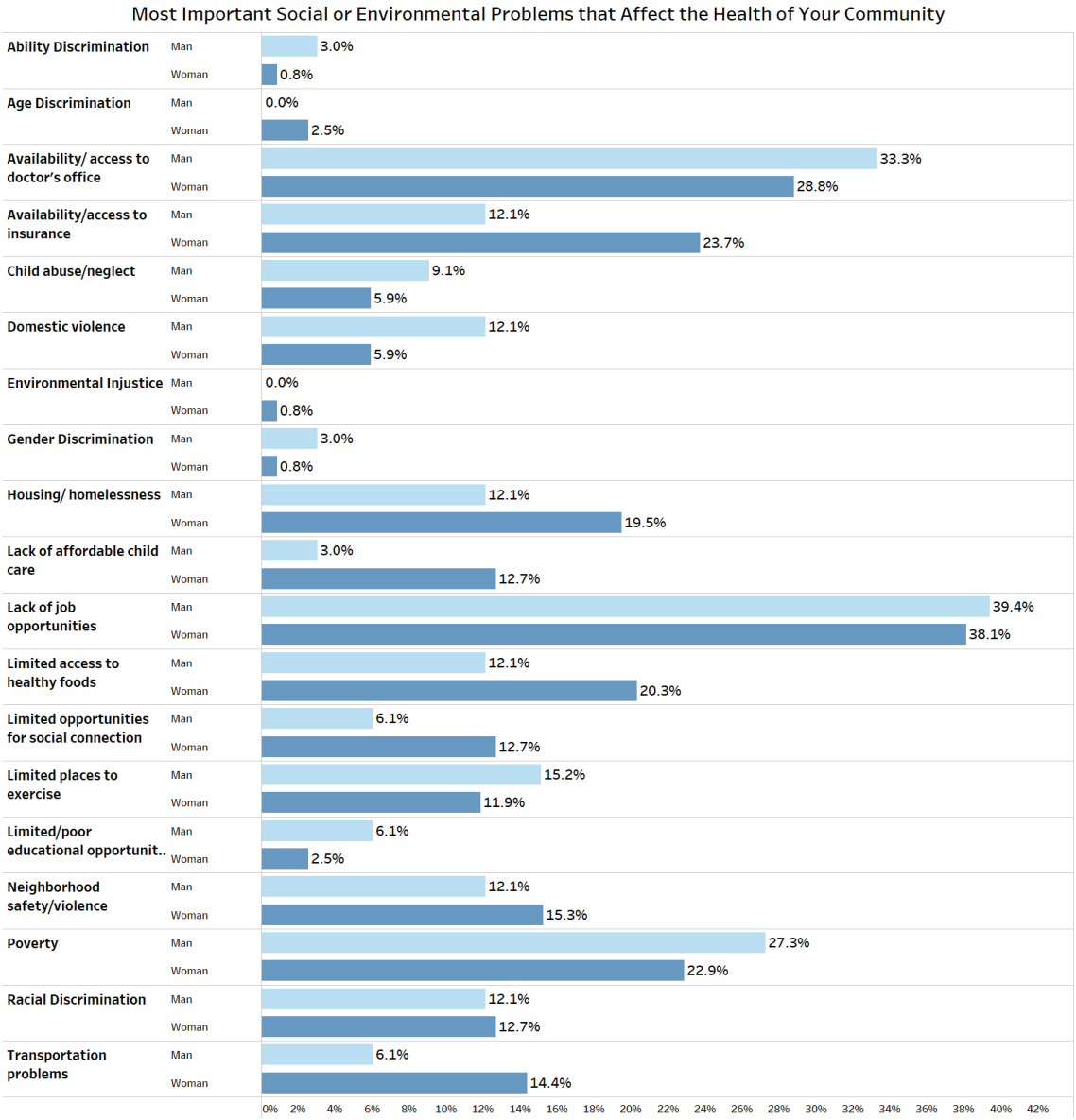


Figure 51: What are the three most important social or environmental problems that affect the health of your community? Please select up to three. (by race)

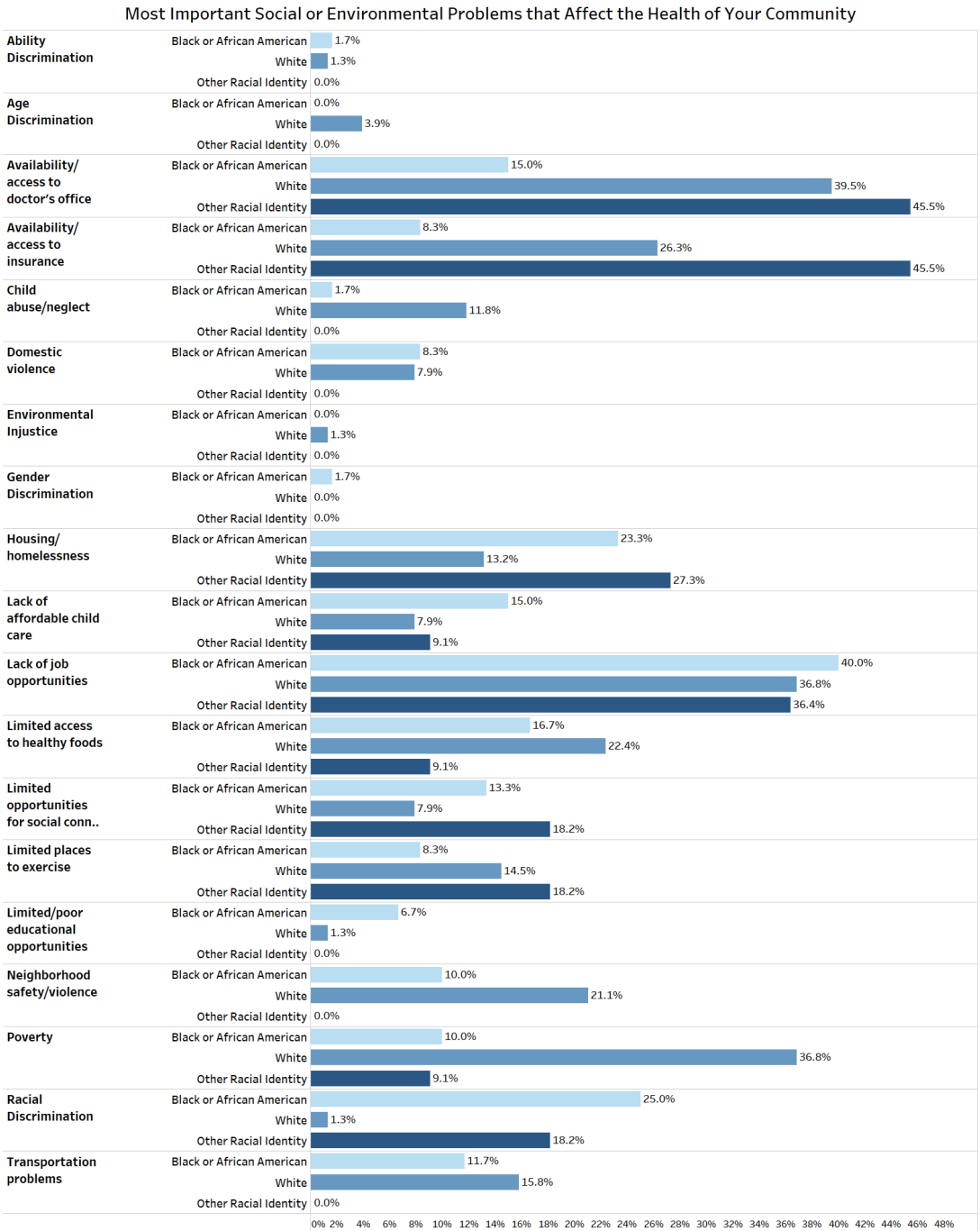


Figure 52: What are the three most important social or environmental problems that affect the health of your community? Please select up to three. (by ethnicity)

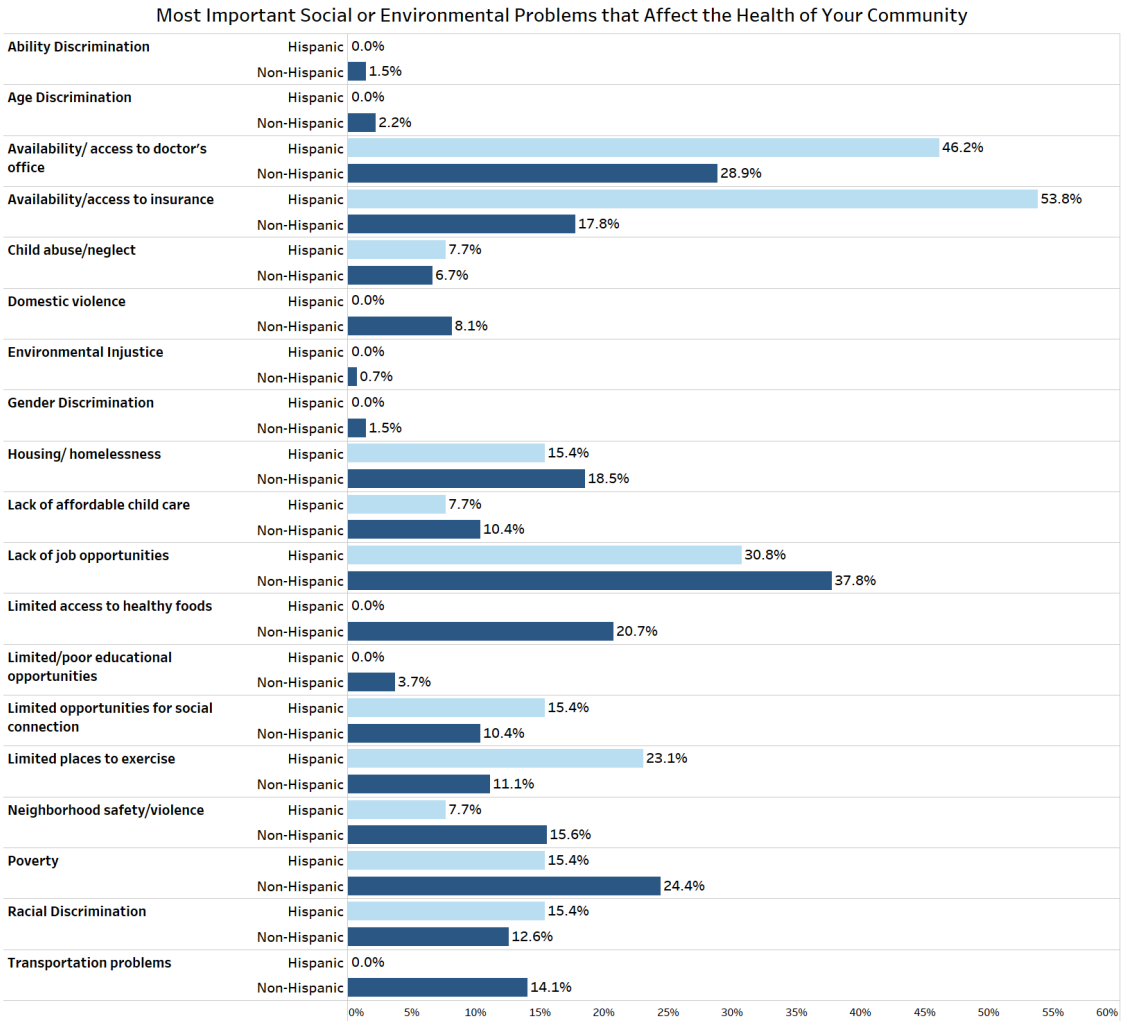
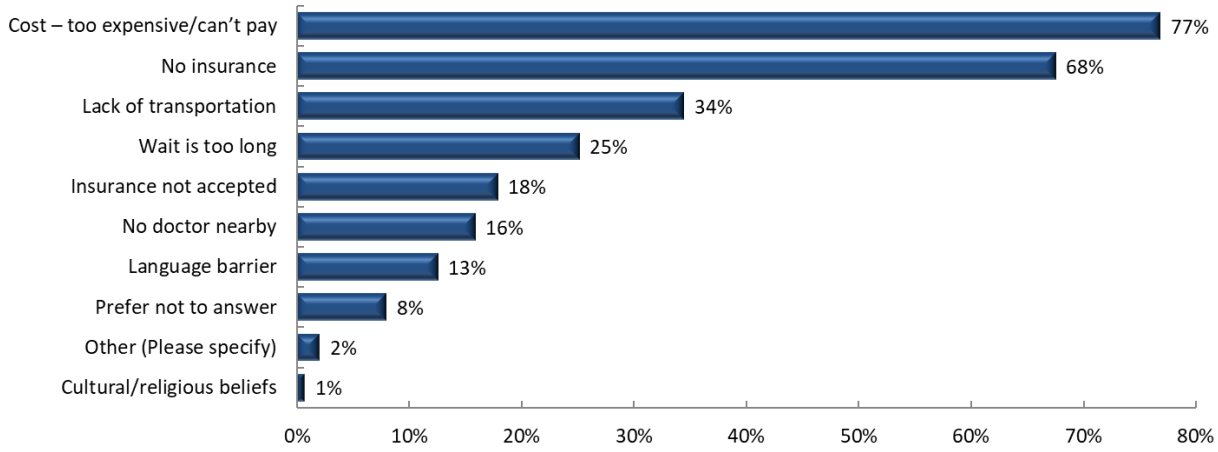


Figure 53: What are the three most important reasons people in your community do not get health care when they need it? Please select up to three.

(N=151)



Other (please specify):

- "Education"
- "Lazy"
- "Unsure"

Figure 54: 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)

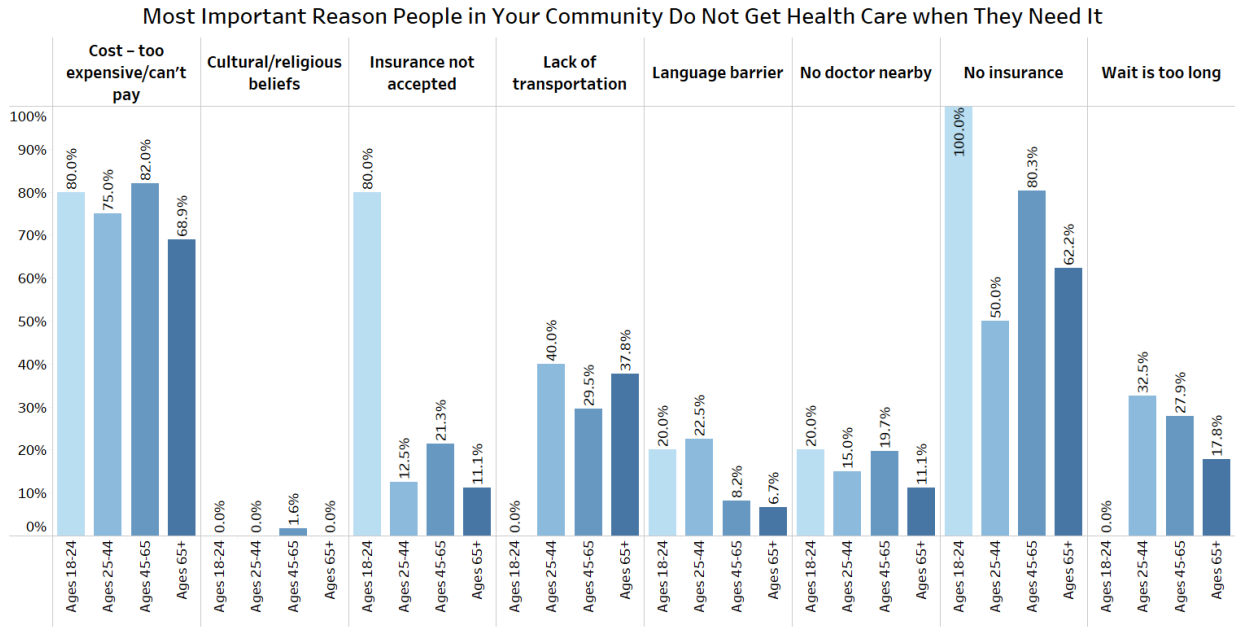


Figure 55: What are the three most important reasons people in your community do not get health care when they need it? Please select up to three. (by gender)

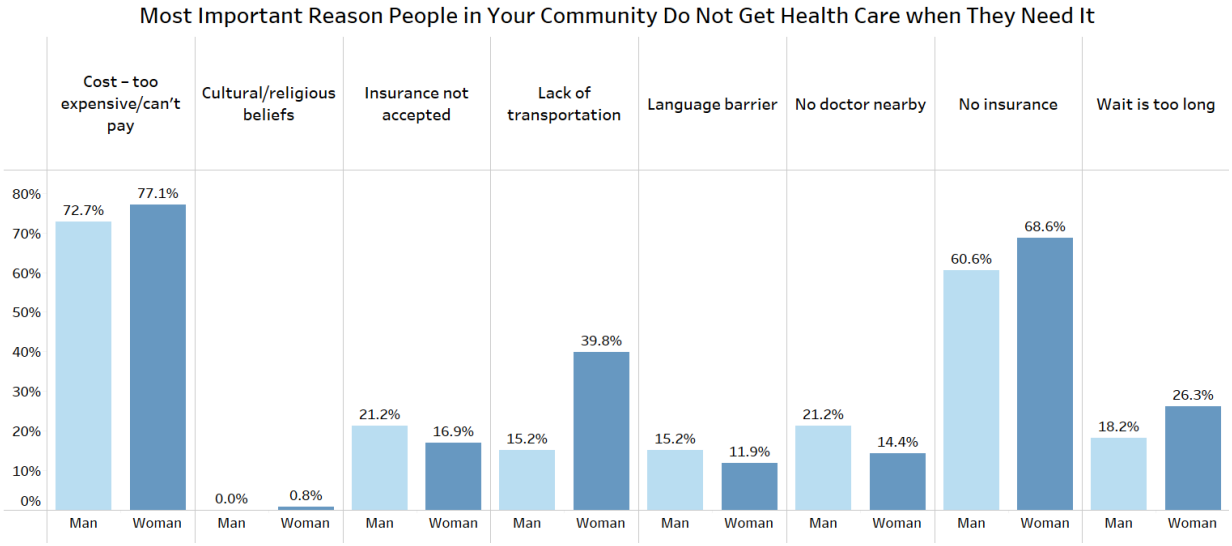


Figure 56: What are the three most important reasons people in your community do not get health care when they need it? Please select up to three. (by race)

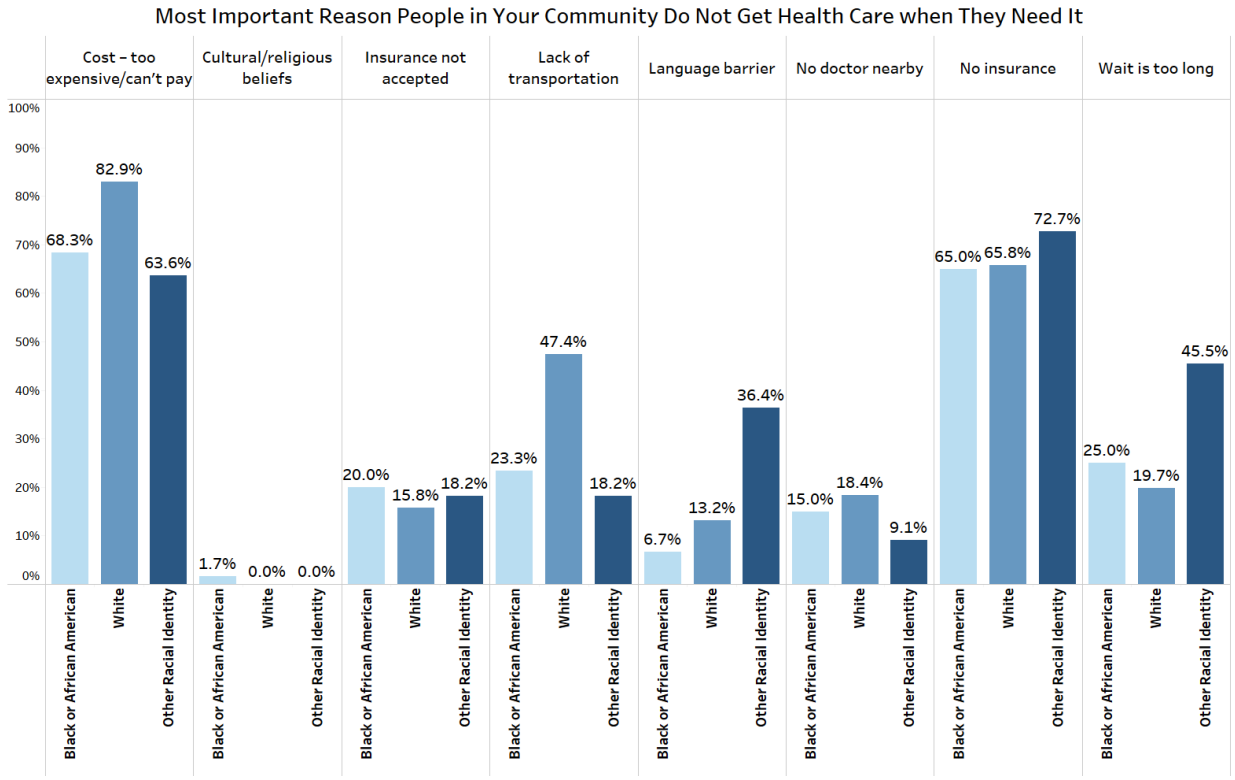
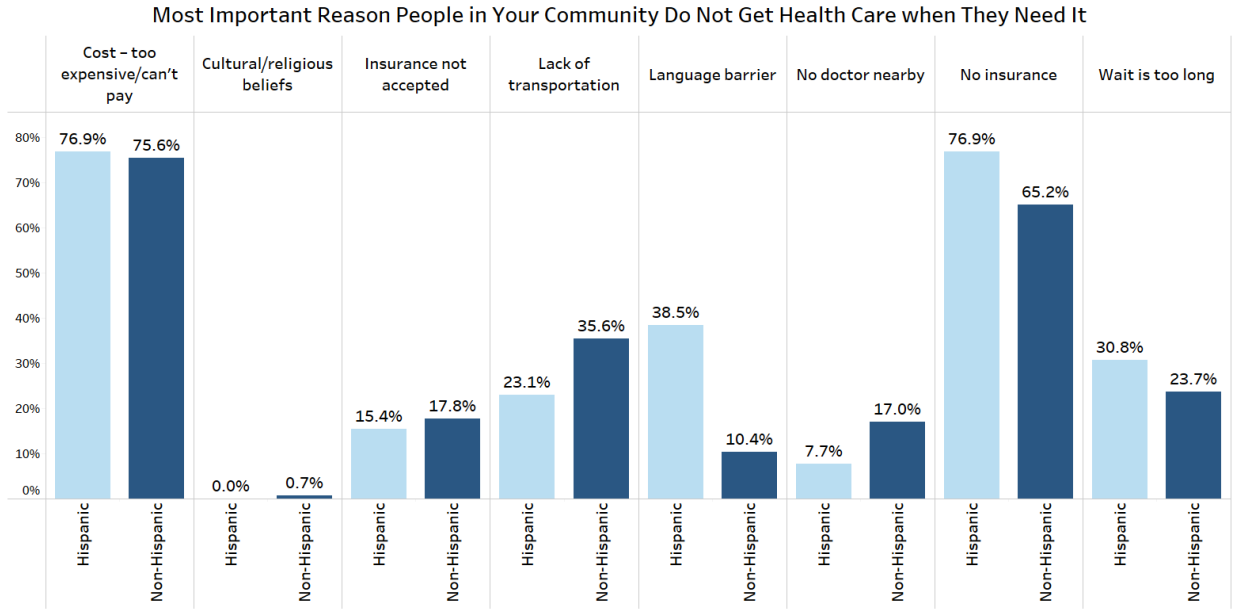


Figure 57: What are the three most important reasons people in your community do not get health care when they need it? Please select up to three. (by ethnicity)



Topic: Access To Care

Figure 58: DURING THE PAST 12 MONTHS, were you told by a health care provider or doctor's office that they did not accept your health care coverage?

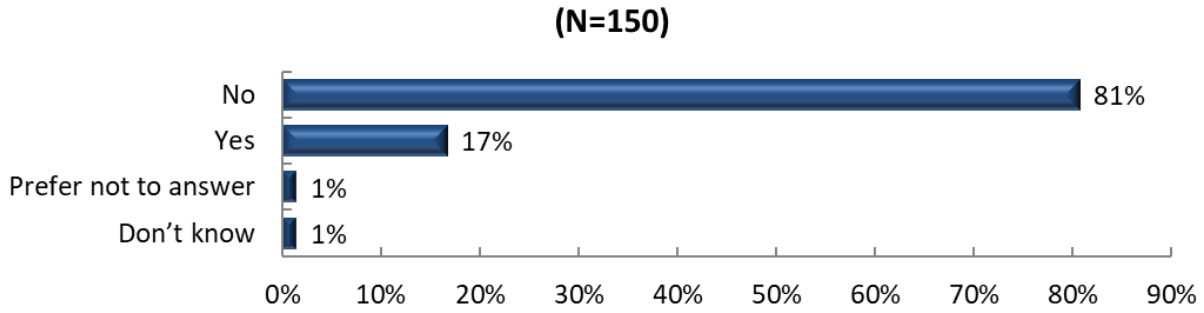


Figure 59: Where do you USUALLY go when you are sick or need advice about your health?

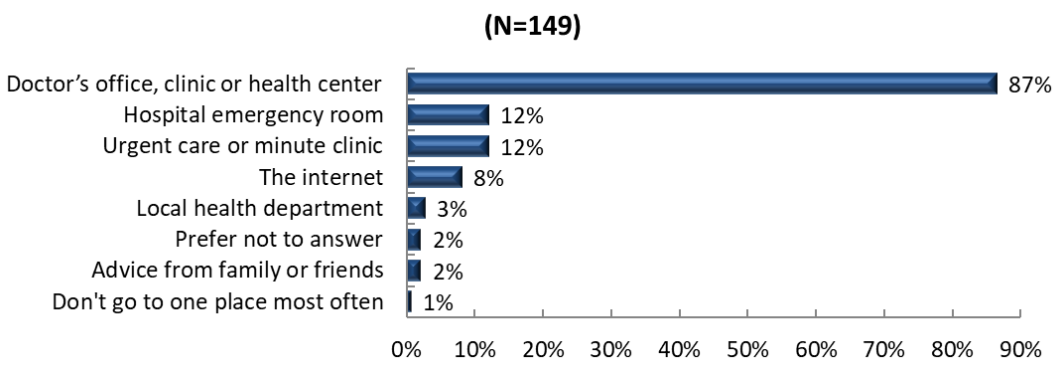
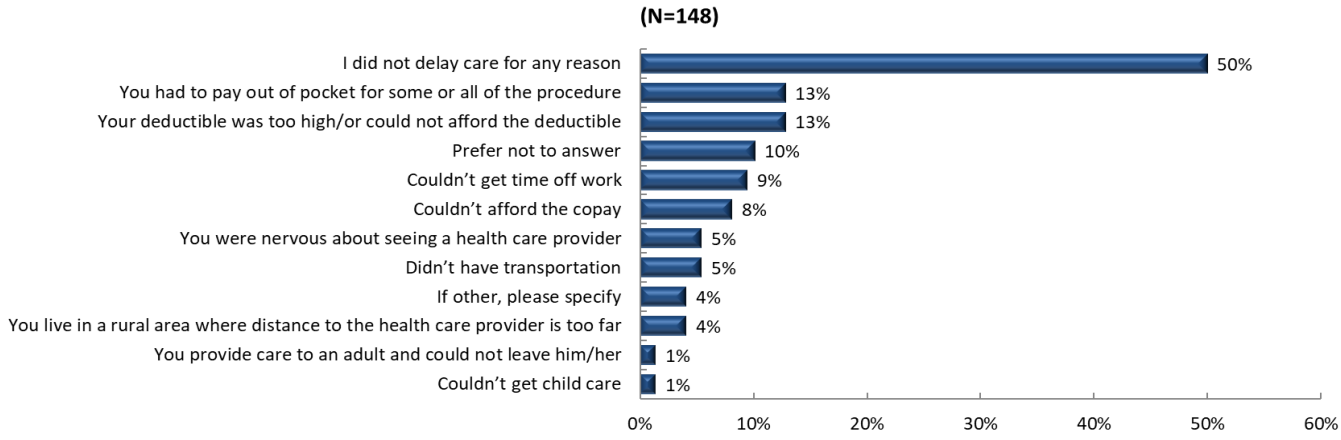


Figure 60: There are many reasons people delay getting medical care. Have you delayed getting care for any of the following reasons in the PAST 12 MONTHS?



Other (please specify):

- "Did not have time to spend multiple visits to get procedure."
- "Dr delayed appoint x 6 months"
- "I do not put off going to the doctor"
- "Long wait times for appointments"
- "Not able to get appointments for months"
- "Wait list to see doctor was very long. Appt was going to be more than 4 weeks"

Figure 61: DURING THE PAST 12 MONTHS, was there any time when you needed any of the following, but didn't get it because you couldn't afford it?

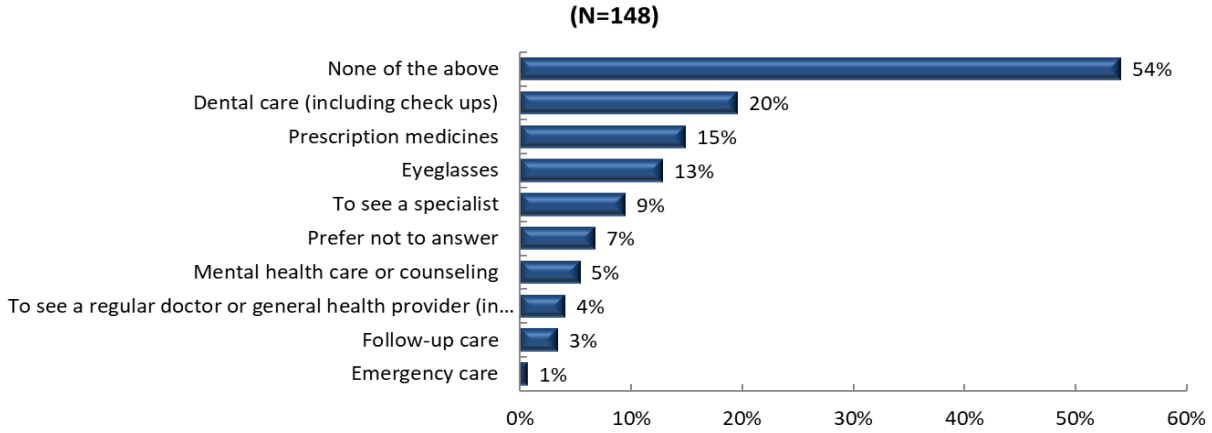


Figure 62: If you get sick or have an accident, how worried are you that you will be able to pay your medical bills?

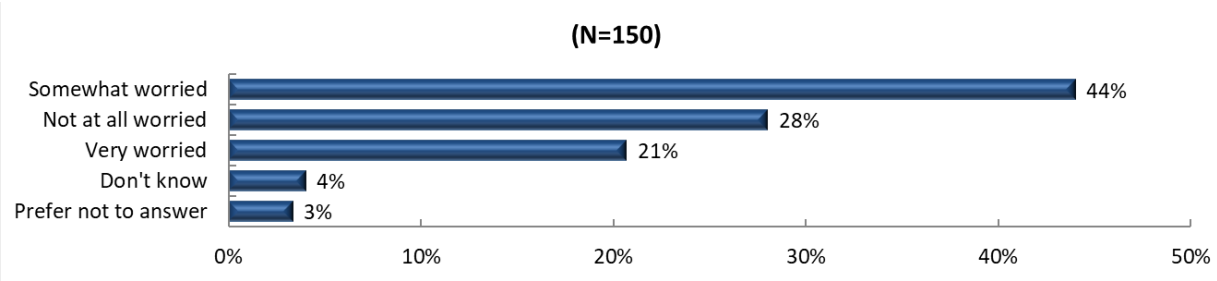
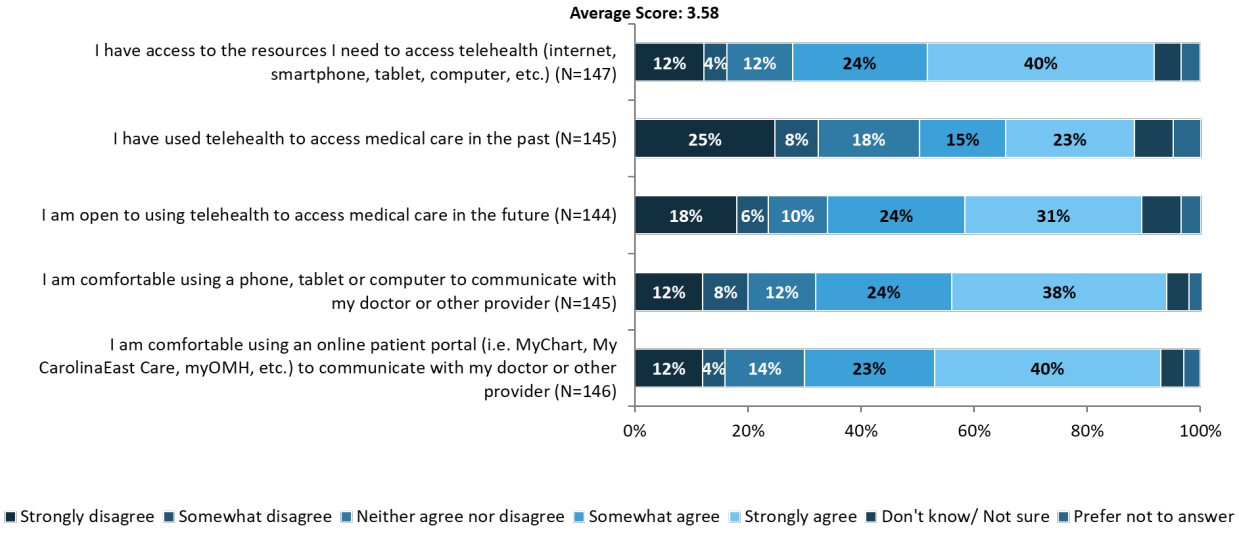


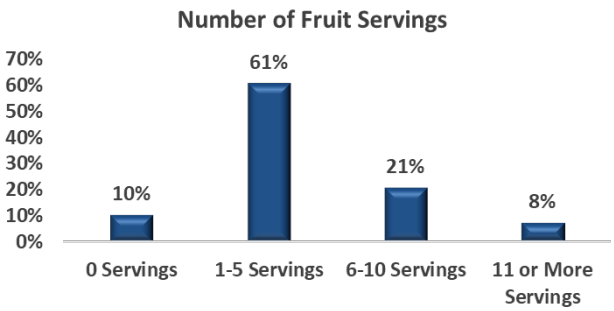
Figure 63: How much do you agree or disagree with the following statements about telehealth? Telehealth means connecting virtually with a medical provider using a smartphone, tablet or computer.

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



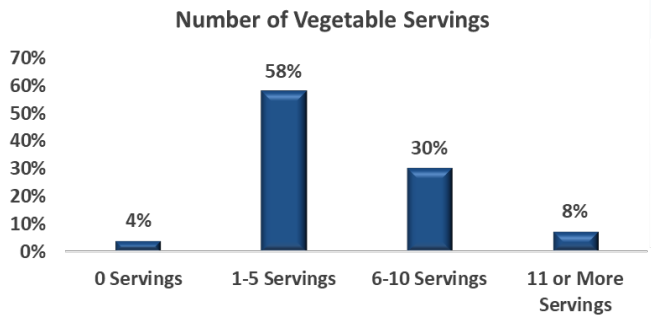
Topic: Healthy Lifestyle (Diet and Exercise)

Figure 64: Think about the food you ate during the past week. On average, how many servings of fruit did you eat, not including juices? (For example, one serving equals a medium apple, a small banana, or 7 strawberries)
(N=144)



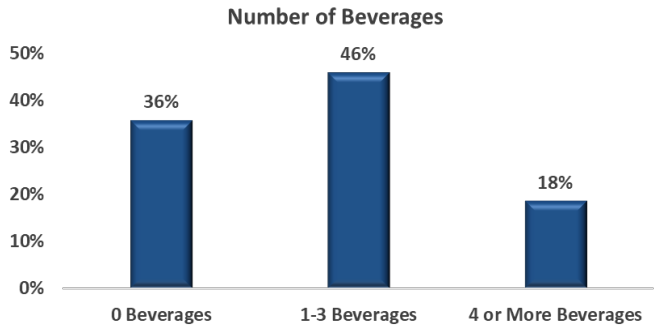
Measure	Value
Mean (Standard Deviation)	5 (5)
Median	4
Mode	3
Minimum-Maximum	0-48

Figure 65: Think about the food you ate during the past week. On average, how many servings of vegetables did you eat, not including potatoes? (For example, one serving equals 6 baby carrots, small bell pepper, or half of a large squash or zucchini)
(N=145)



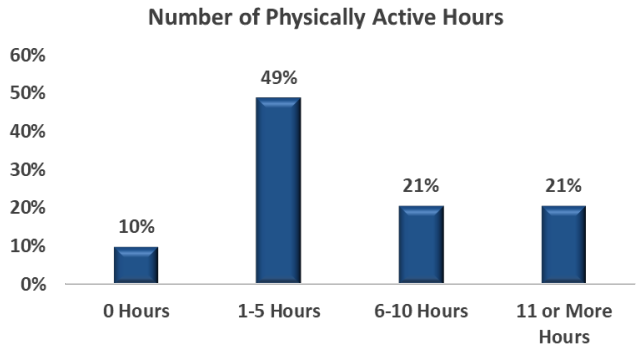
Measure	Value
Mean (Standard Deviation)	6 (6)
Median	5
Mode	5
Minimum-Maximum	0-60

Figure 66: About how many cans, bottles, or glasses of sugar-sweetened beverages, such as regular sodas, sugar sweetened tea, or energy drinks, do you drink each day?
(N=146)



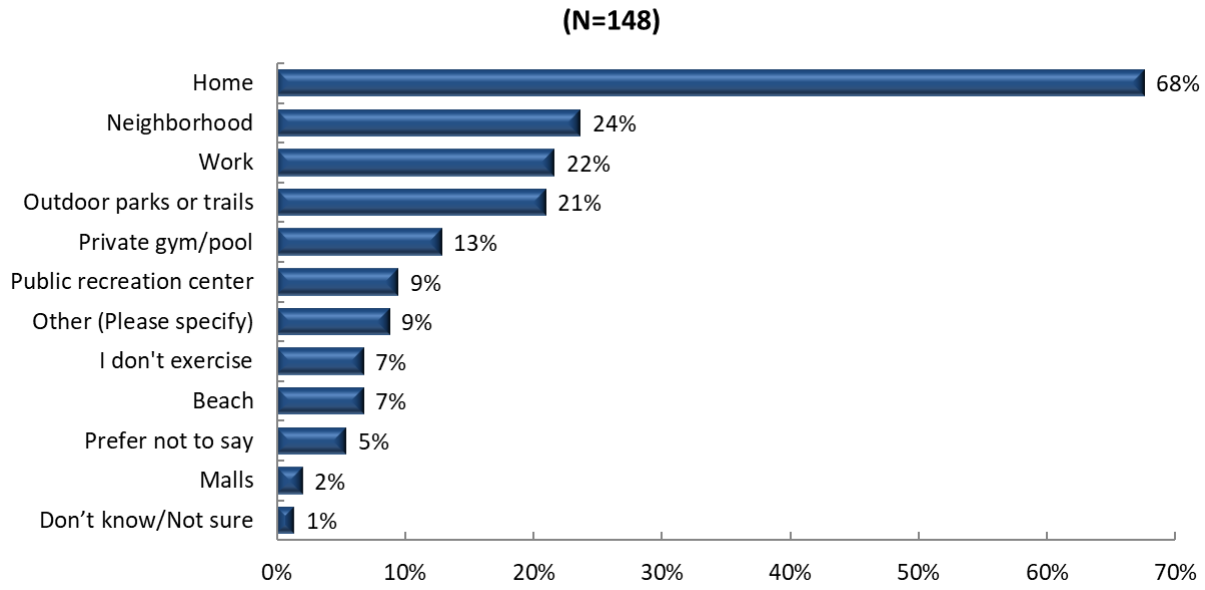
Measure	Value
Mean (Standard Deviation)	2 (4)
Median	1
Mode	0
Minimum-Maximum	0-35

Figure 67: During the past month, approximately how much time (in hours) per week were you physically active outside of your regular job?
(N=141)



Measure	Value
Mean (Standard Deviation)	8 (10)
Median	5
Mode	5
Minimum-Maximum	0-60

Figure 68: When you are active, where do you engage in exercise or physical activities? (Select all that apply.)



Other (Please specify):

- "Gardening walking in woods"
- "Public pool"
- "Pulmonary Rehab/camping"
- "Senior center" (6 responses)
- "Senior center and physical therapy"
- "Yard"

Topic: Food Security

Figure 69: Please tell us how frequently the following statements were for you true in the past 12 months:

Rated on a scale from 1 to 3 with 1 being "often true" and 3 being "never true"

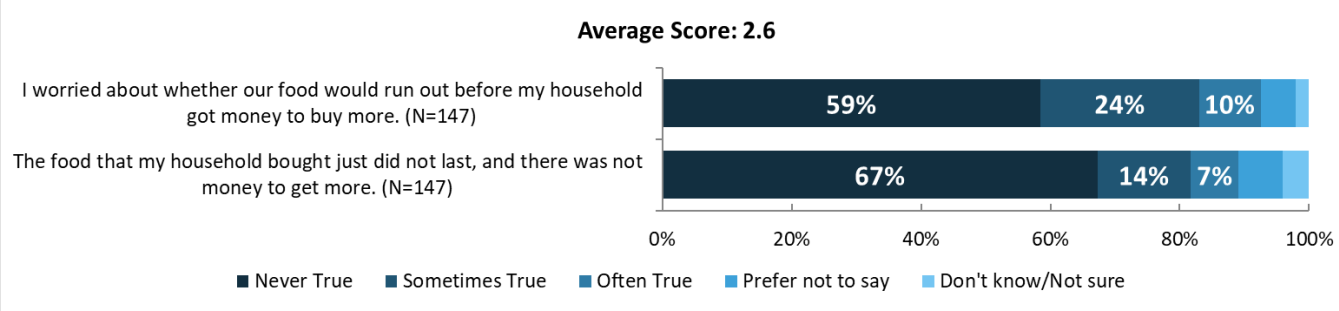


Figure 70: In the last 12 months, did you or someone in your household cut the size of your meals or skip meals because there wasn't enough money for food?

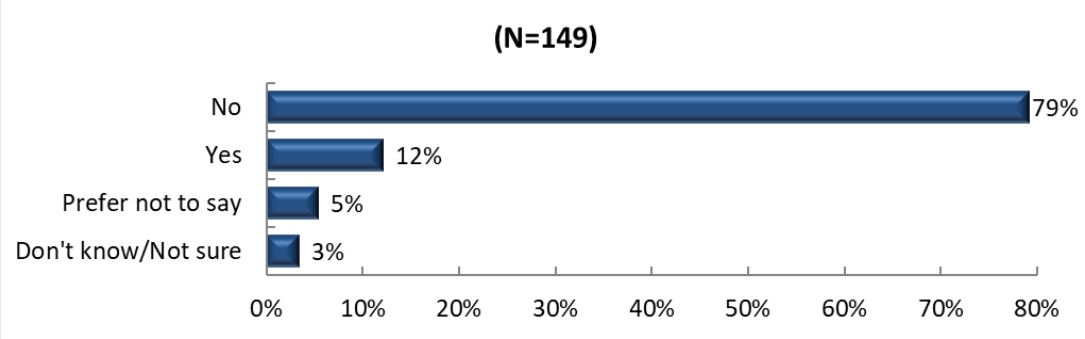
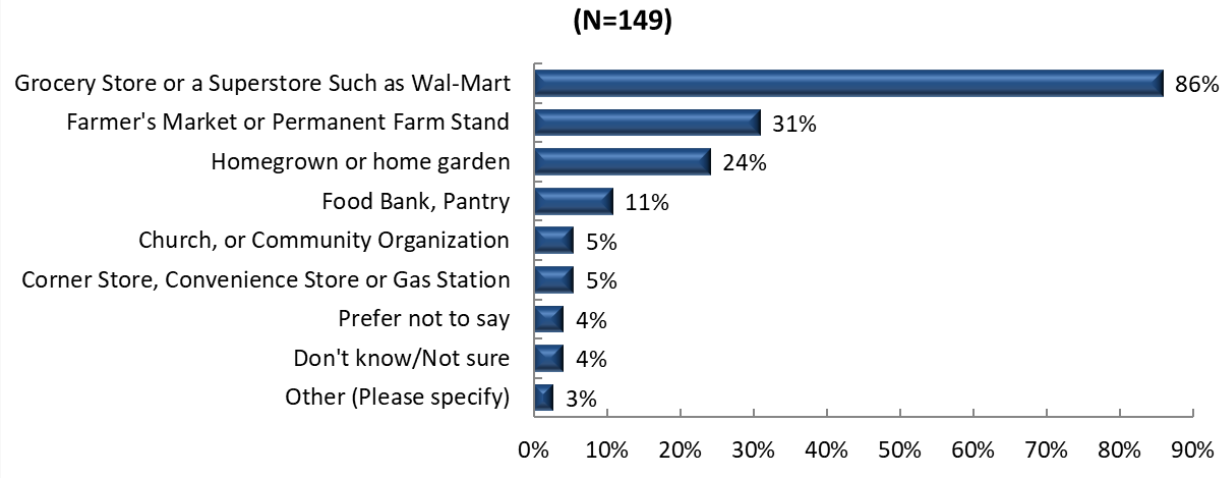


Figure 71: In the past 12 months, have you gotten fresh fruits and vegetables from any of the following sources? (Select all that apply.)



Topic: Physical Health

Figure 72: Considering your physical health overall, would you describe your health as… (N=148)

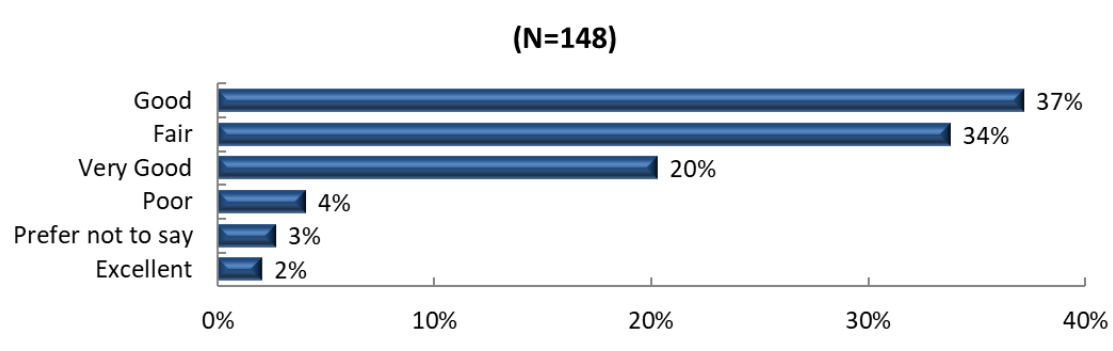


Figure 73: Within the past year (anytime less than one year ago), have you:

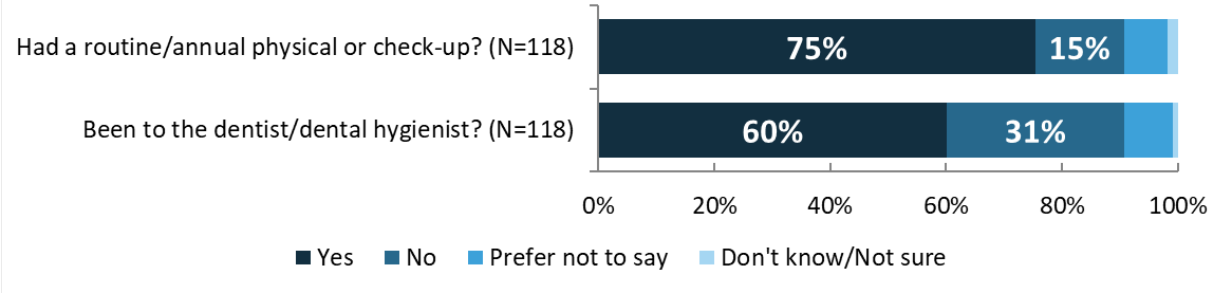
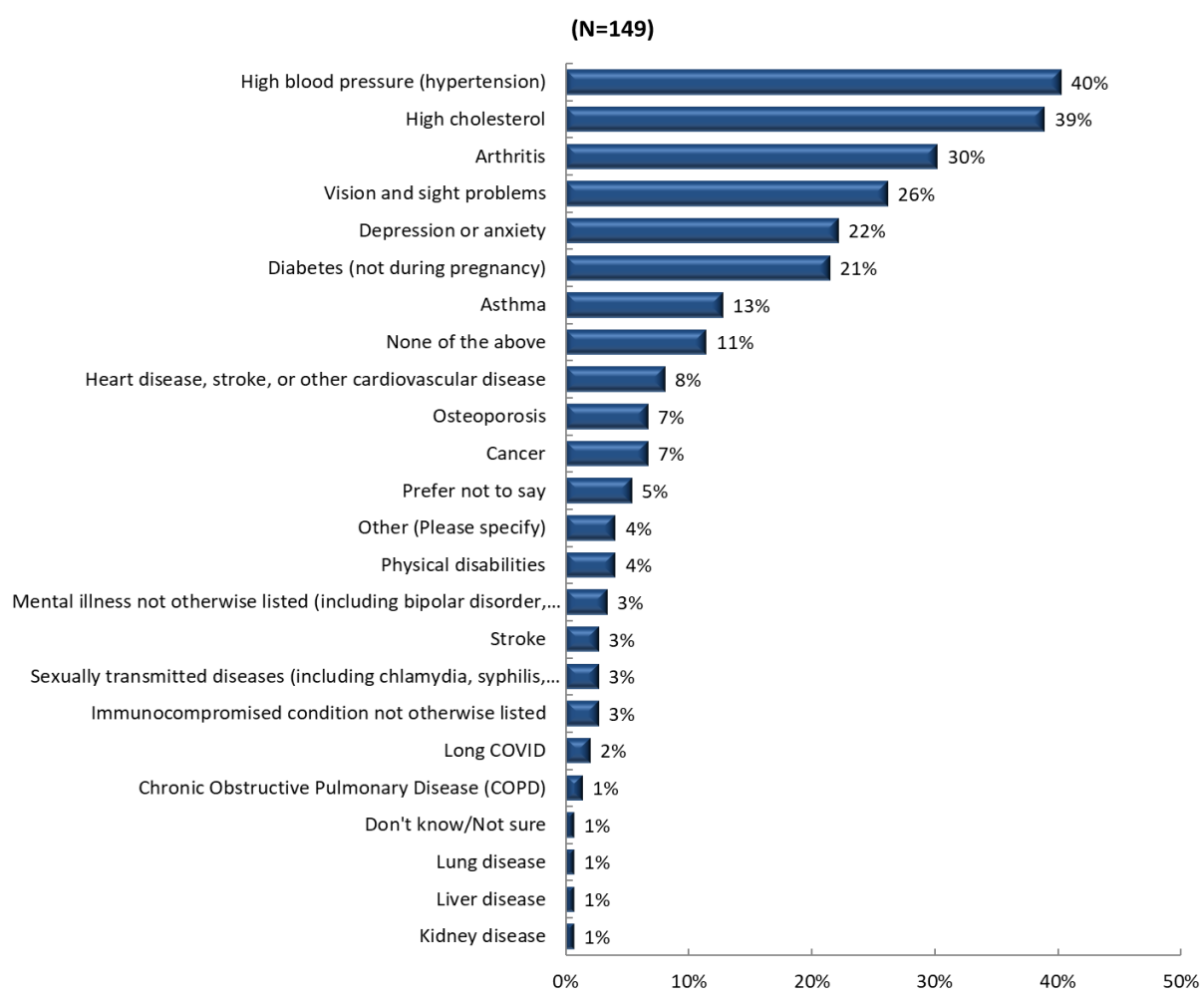


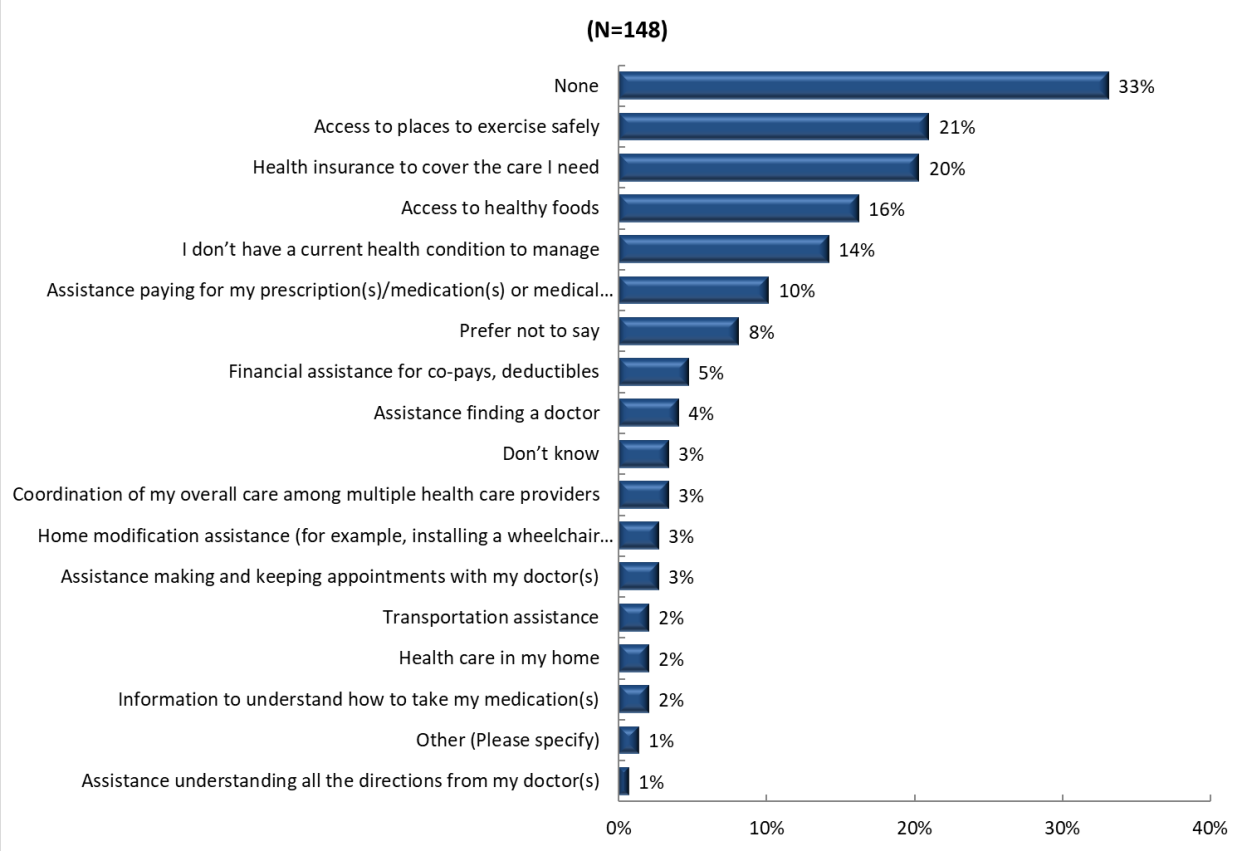
Figure 74: Have you ever been told by a doctor, nurse, or other health professional that you have any of the following health conditions? Select all that apply



Other (please specify):

- "Brain tumor"
- "Hearing. Can't afford hearing aid"
- "Incontinence, sleep apnea, fibromyalgia"
- "Joint pain"
- "Lupus"
- "PCOS"

Figure 75: What do you need to be able to manage your current health conditions (for example, heart conditions, high blood pressure, stroke, diabetes, asthma, cancer, COPD, congestive heart failure, arthritis, HIV, depression, anxiety, other mental health condition, etc.) to stay healthy? (Select all that apply.)



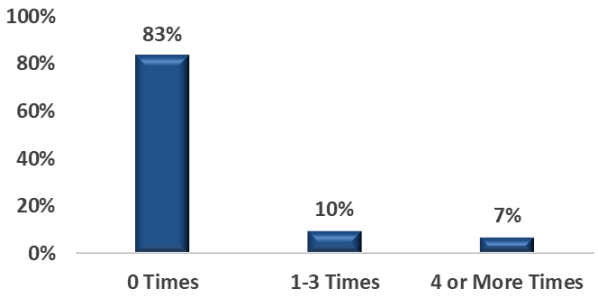
Other (please specify):

- "Need hearing aids"

Topic: Substance Use Disorders

Figure 76: 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=144)



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

Figure 77: How often do you consume any kind of alcohol product, including beer, wine or hard liquor?

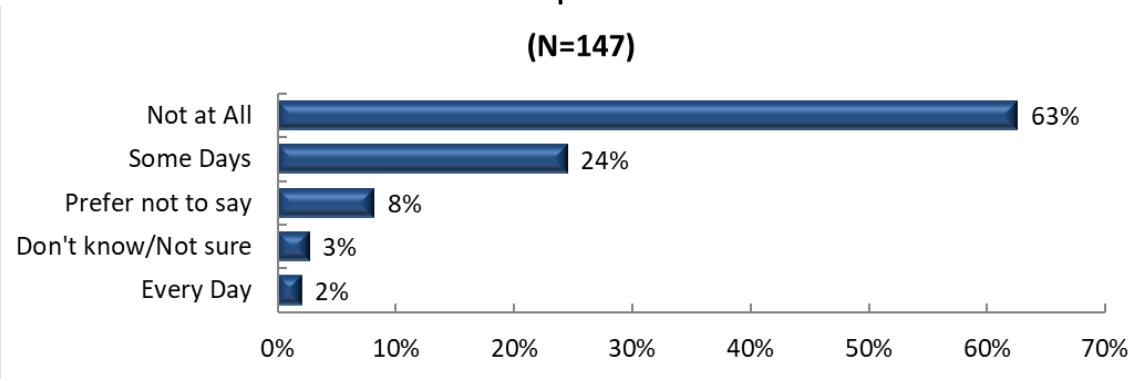


Figure 78: In the past year, have you or a member of your household misused any form of prescription drugs (e.g. used without a prescription, used more than prescribed, used more often than prescribed, or used for any reason other than a doctor's instructions)?

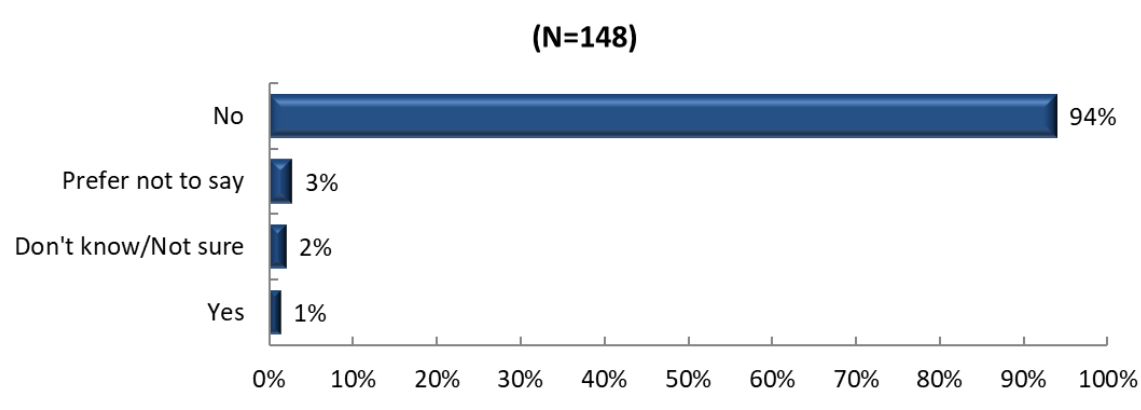
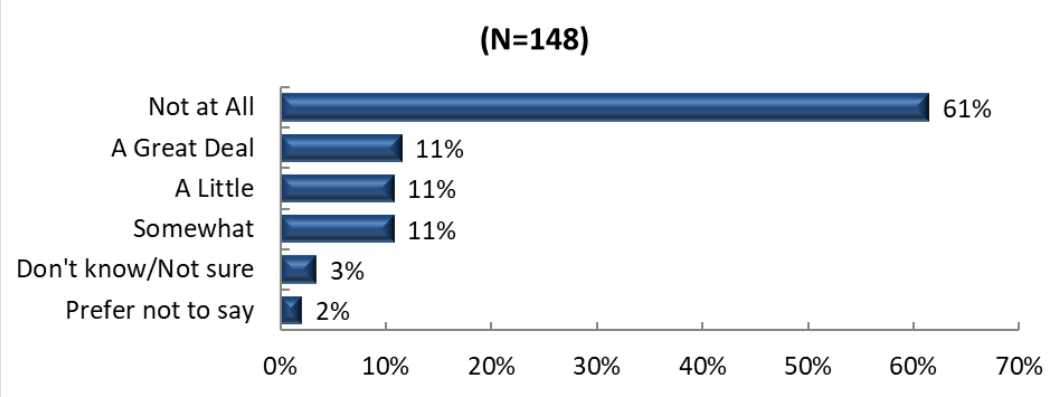


Figure 79: To what degree has your life been negatively affected by YOUR OWN or SOMEONE ELSE's substance abuse issues, including alcohol, prescription, and other drugs?



Topic: Tobacco Use

Figure 80: Do you currently use any of the following tobacco or nicotine products? (Select all that apply.)

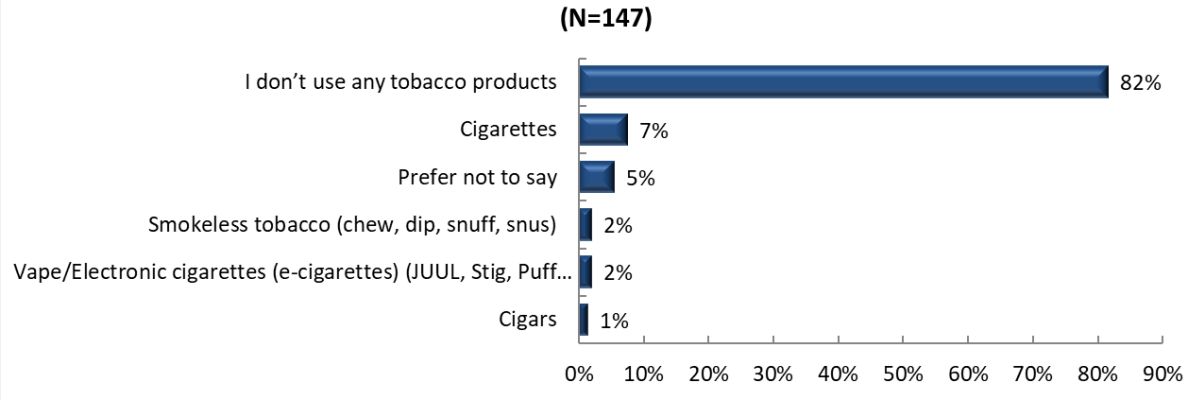


Figure 81: How often do you use any kind of tobacco or nicotine product, including smokeless products, chewing tobacco, dip, snuff, snus, electronic cigarettes, or vapes?

Note: this question was only asked to participants who indicated use of tobacco or nicotine products in previous question

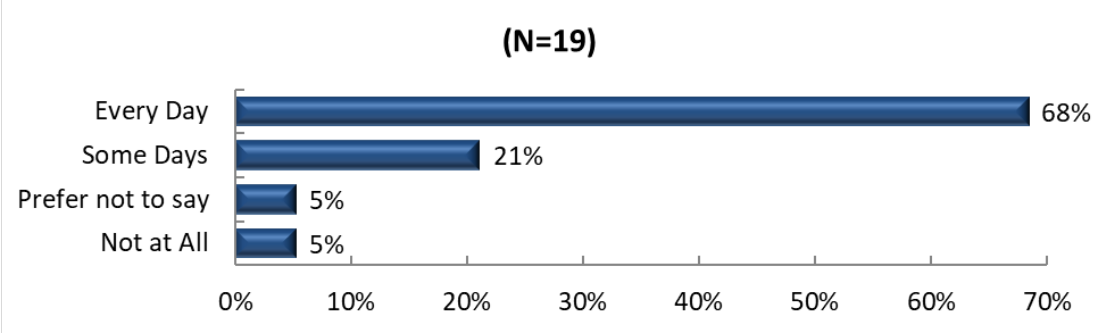
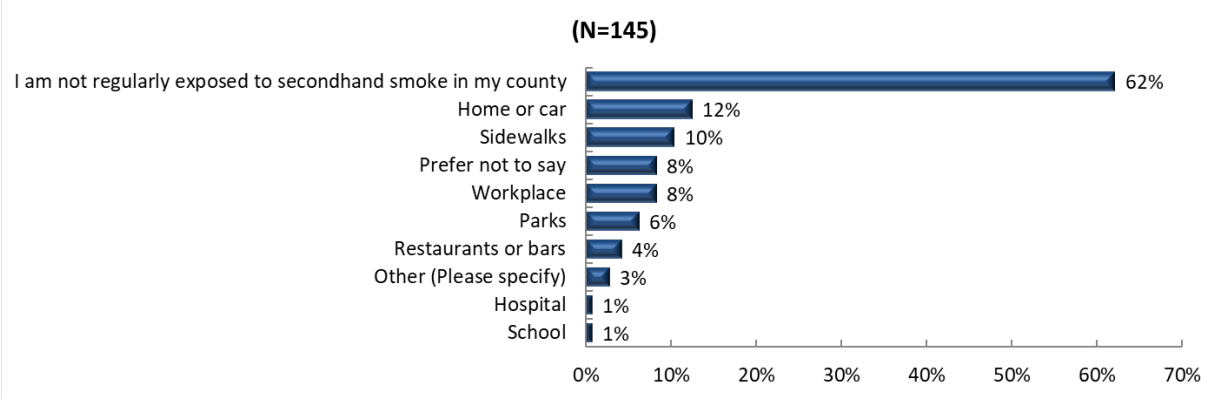


Figure 82: Are you regularly exposed to secondhand smoke in any of these locations in Greene County? (Select all that apply.)



Other (please specify):

- "Grocery stores"
- "Tiendas" (English: "stores")

APPENDIX 6 | SUMMARY OF DATA FINDINGS ACROSS SOURCES

Primary and Secondary data findings are summarized in full by the table below.[47]

Priority Area	Secondary Data	Community Survey	Focus Group	Interviews
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	✓			✓

[47] 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.