Community Health Needs Assessment

Hyde County

2025

ECU HEALTH
Beaufort Hospital
A CAMPUS OF 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 Health ENC Steering Committee throughout this CHNA. The Health ENC 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.

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Hyde County CHNA Leadership

In addition to the Health ENC Steering Committee, the Hyde County CHNA was developed in partnership with representatives from Hyde County Health Department (HCHD) and ECU Health Beaufort Hospital.

Name	Title	Organization
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Luana Gibbs	Hyde County Health Director	HCHD
Mike Wheeler	Substance Abuse Worker	HCHD
Tony Garcia	Information Technology Specialist	HCHD
Sherry Harris	Administrative Assistant I	HCHD
Savannah Equils	Public Health Educator I	HCHD
Melissa Sadler	Nursing Supervisor II	HCHD
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In addition, the Health ENC Steering Committee and Hyde 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

ECU Health Beaufort Hospital

ECU Health Beaufort Hospital (formerly Vidant Beaufort Hospital) is a not-for-profit, community hospital located in Washington, NC. The hospital offers a broad range of inpatient and outpatient services including medical, surgical, intensive care, emergency, pediatrics, and women's services. In addition, there is a lab, diagnostic imaging services, and physical and respiratory therapy. ECU Health Beaufort Hospital – A Campus of ECU Health Medical Center also features the Marion L. Shepard Cancer Center, offering leading-edge chemotherapy and radiation therapy, among other cancer services.

ECU Health Beaufort is one of nine hospitals that comprise ECU Health. ECU Health is a regional health system serving more than 1.4 million people in 29 counties throughout rural eastern North Carolina. Most of the counties served by ECU Health are ranked in the top 40 most economically distressed areas in the state with Hyde County being ranked a Tier 1 (67% of ECU Health's counties are classified as Tier 1 counties; 33% of the counties are classified as Tier 2 counties[1]). The system consists of ECU Health Medical Center (an academic medical center), eight community hospitals, an ambulatory surgery center, wellness and rehabilitation facilities, home health agencies, and other independently operated health services. ECU Health is also affiliated with the Brody School of Medicine at East Carolina University. The mission of ECU Health is to improve the health and well-being of Eastern North Carolina. The system's vision is to become a national model for rural health and wellness by creating a premier, trusted health care delivery and education system. Integral to the mission is the commitment to be responsive to the community's needs and to provide high quality, cost-effective health care services.

CHNA Overview

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 2024-2025 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, Hyde County Health Department and ECU Health Beaufort Hospital, the 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.

[1] Source: North Carolina Department of Commerce (2024). County Distress Rankings (Tiers), retrieved from https://www.commerce.nc.gov/grants-incentives/county-distress-rankings-tiers

Hyde County CHNA Leadership

The local health organizations who came together to help develop this CHNA included Hyde County Health Department (HCHD) and ECU Health Beaufort Hospital.

Name	Title	Organization
Anna Schafer	Director of Health Education & Substance Awareness Services, Human Services Planner/Evaluator II	HCHD
Luana Gibbs	Hyde County Health Director	HCHD
Mike Wheeler	Substance Abuse Worker	HCHD
Tony Garcia	Information Technology Specialist	HCHD
Sherry Harris	Administrative Assistant I	HCHD
Savannah Equils	Public Health Educator I	HCHD
Melissa Sadler	Nursing Supervisor II	HCHD
Carmen O'Sullivan	Accounting Tech IV	HCHD
Hugh Watson	Environmental Health Program Coordinator	HCHD
Kelly Ange	Community Health Improvement Coordinator	ECU Health Beaufort Hospital
Pam Shadle	Director of Marketing and Development	ECU Health Beaufort Hospital

Hyde County CHNA Partnerships

The CHNA process for Hyde 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)	3
Behavioral Healthcare Provider(s)	1
EMS Provider(s)	1
Community Organization(s)	5
Public/Private/Charter School System(s)	1
Government/Public Agencies	2

The Health ENC Steering Committee and Hyde 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.

Hyde County CHNA Process

The process formally began with a collaborative meeting of all participating counties in February 2024. This included discussions on secondary data and primary data collection methods, such as surveys and focus groups. Subsequent priority-setting meetings were held to determine upcoming priorities, culminating in the delivery of a final report.

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 community needs identified through secondary data analysis included health concerns related to physical and behavioral health, and social or environmental concerns such as employment and income, food access and security, and family, community, and social support, among others.

Primary (new) data were collected through focus groups and a web-based survey for community members, and included feedback from 373 people who live, work or receive healthcare in Hyde County. A total of two in-person focus groups were conducted, with a variety of community members from different backgrounds, age groups and life experiences. Primary data identified behavioral health (specifically substance use), employment and income, food access and security, healthcare access and quality, housing and homelessness, and physical health (chronic diseases, cancer, obesity) as top needs that impact the health and well-being of people living in Hyde County.

Representatives from Hyde County worked together to identify the priorities the county should focus on over the following three-year period. Leaders evaluated the primary and secondary data collected throughout the process to identify needs based on the size and scope, severity, the ability for hospitals or health departments to make an impact, associated health disparities, and importance to the community. Although it was not possible for every single area of potential need to be identified as a priority, three top priority health needs were selected by ECU Health Beaufort Hospital for Hyde County (in alphabetical order): Access to Healthcare, Behavioral Health (to include substance abuse), and heart disease & Hypertension. Similarly, Hyde County Health Department selected the following four top priority health needs (in alphabetical order): Access to Healthcare, Alcohol and Drug Addiction, Heart Disease and Hypertension, and Mental Health.

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

Following completion of this report, health leaders throughout Hyde 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

ECU Health Beaufort Hospital and the Hyde County Health Department with guidance from the Health ENC Steering Committee, local leaders, and community residents completed the assessment to document the greatest health needs. 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 community partners to proactively identify and respond to the needs of Hyde County residents.

This report was created in compliance 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.

Process Overview

A significant amount of information has been reviewed during this planning process. 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 Hyde 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 Hyde County residents. Key objectives of this CHNA include:

- Identify the health needs of Hyde 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;

[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.

- 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 1** 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 1: 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.

[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

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

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

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

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

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

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

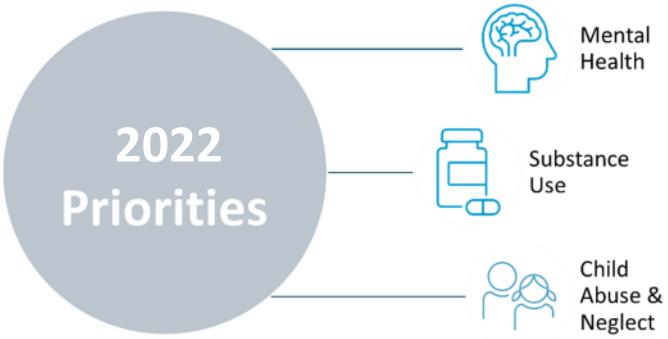
2) *Detailed Summary of Secondary Data Measures and Findings* – Existing data measures and findings used in the prioritization process are presented in **Appendices 2-3.**

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

Evaluation of Prior CHNA Implementation Strategies

A CHNA is an ongoing process that begins with an evaluation of the previous CHNA. In 2022, Hyde County completed its previous assessment. Associated implementation strategies focused on three priority areas, as listed below:

Figure 2: Hyde County 2022 Priority Need Areas



Previous CHNA Priorities: Mental Health and Substance Abuse

- **Community Benefit Grants Program**: ECU Health Beaufort Hospital, with the support of the ECU Health Foundation, provides funding through the Community Benefit Grant program to community partners that focus on mental health and/or substance use disorder.
    - In 2023, ECU Health Beaufort Hospital awarded $3,000.00 to Beaufort County 360 Behavioral Health Task Force to assist with producing the podcast, Riverfront Talks: Substance Matters. Podcast audience reach spans far past Beaufort County.
    - In 2024, ECU Health Beaufort Hospital awarded $11,500.00 to 4 community partners that focus on mental health and/or substance use disorder.

Previous CHNA Priority: Child Abuse & Neglect

- **Community Benefit Grants Program**: ECU Health Beaufort Hospital, with the support of the ECU Health Foundation, provides funding through the Community Benefit Grant program to community partners that focus on child abuse and neglect.
    - In 2023, ECU Health Beaufort Hospital awarded $4,500.00 to Hyde County Department of Social Services for their program DSS On Hand to Make a Difference. The intent of this program was to raise awareness about child abuse and to remind the community that abuse and neglect are preventable. The goal was to provide the community with the proper resources to help prevent and respond to child abuse and neglect. This program served 855 people with 550 being financially needy.

Information about previous county-level Community Health Improvement efforts, as referenced in the NCLHDA State of the County Health (SOTCH) report, can be found in **Appendix 1**.

Summary Findings: Hyde County 2025 Priority Health Need Areas

To achieve the study objectives in the 2025 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 Hyde 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 February 2024 and continued through July 2024.

Throughout Hyde 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 Hyde County, as well as how the severity of those needs might vary across subpopulations based on the information obtained and analyzed during this process.

Through the prioritization process, the CHNA Stakeholders identified Hyde 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 priority need areas. After looking at all relevant data and feedback, ECU Health Beaufort Hospital will focus the following priorities from the 2025 CHNA: Access to Healthcare, Behavioral Health (to include substance abuse), and heart disease & Hypertension, as seen in **Figure 3**. Similarly, Hyde County Health Department selected the following four top priority health needs (in alphabetical order): Access to Healthcare, Alcohol and Drug Addiction, Heart Disease and Hypertension, and Mental Health.

Figure 3: 2025 Priority Health Needs[4]

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

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

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

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

CHAPTER 1 | METHODOLOGY

Study Design

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

Specifically, the following data types were collected and analyzed:

New (Primary) Data

Public engagement and feedback were received through a web-based community member survey along with community focus groups and significant input and direction from the CHNA Stakeholders. The Health ENC 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 Hyde County, including mental health, quality of care, safety, substance use disorders, and transportation and transit. Focus group participants were asked a standard set of questions about health and social needs, in order to identify trends across various groups and to highlight areas of concern for specific populations. In total, the input was gathered from over 365 Hyde County residents and other stakeholders. This included web survey responses from over 350 community members and three focus groups that included 15 community members and other people who live, work or receive healthcare in Hyde County.

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

Existing (Secondary) Data

The primary source for existing data on Hyde 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
- Previous Community Health Assessment from Hyde County

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 Hyde 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 Health ENC Steering Committee determined that comparisons with the state of North Carolina were appropriate.

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

When viewing the secondary data summary tables in this report, please note that the following color shadings have been included to identify how Hyde 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	Hyde County Description
	Low	Represents measures in which Hyde 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 Hyde 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 Hyde County scores are **more than five percent worse** than the most applicable target/benchmark and for which a high priority level was assigned.

Please note that to categorize each metric in this manner and identify the priority level, the Hyde County value was compared to the benchmark by calculating the percentage difference between the values, relative to the benchmark value:

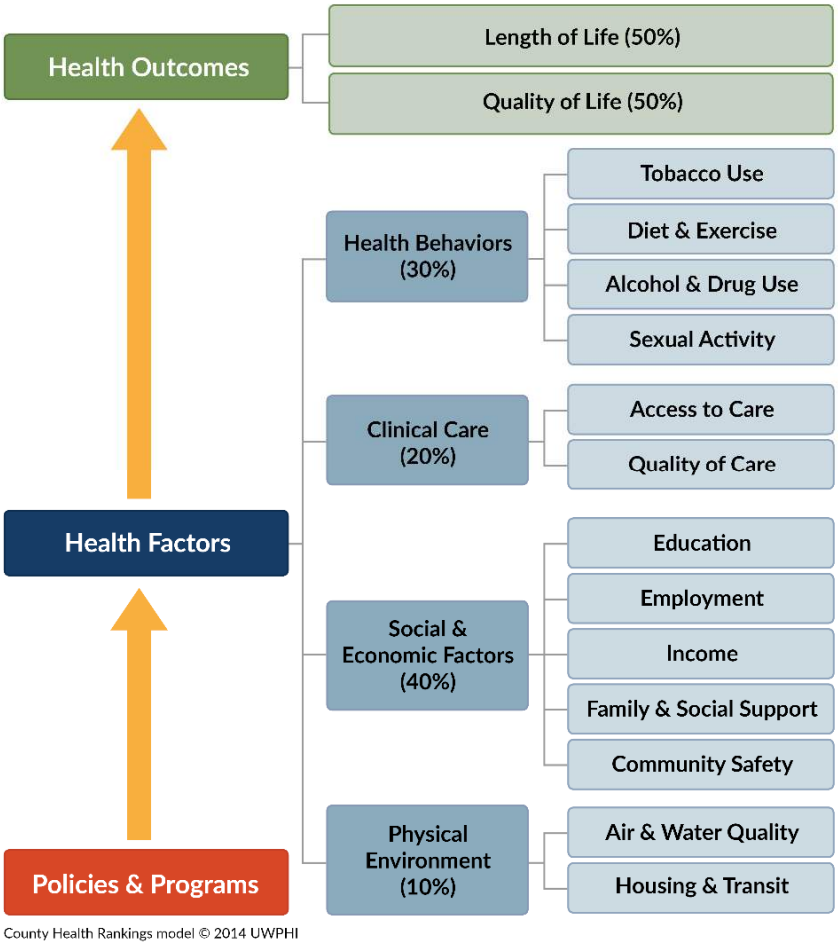
(Hyde Co Value – Benchmark Value)/(Benchmark) x 100 = % Difference Used to Identify Priority Level.

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.

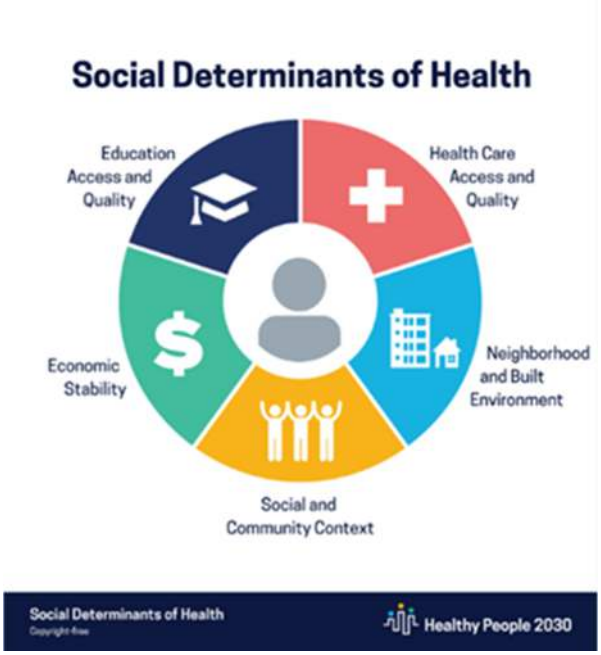
Using the population health framework as a guide for the CHNA process helps categorize many individual pieces of data in a way that connects the dots between health status and social drivers of health, in a way that helps local leaders better understand and address the health and well-being of the communities 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 4** below illustrates the broad categories and sub-categories within the population health framework.

Figure 4: Population Health Framework[5]



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

Figure 5: Social Determinants of Health[6]



Throughout the process, the Health ENC 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 5**.

Recognizing that SDoH have an impact on health disparities and inequities in the community was a key point Hyde County leaders considered throughout the CHNA process. **Figure 6** describes the way various social and economic conditions may affect health and well-being.

Figure 6: SDoH and Health Disparities[7]

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

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

Prioritization Process Overview and Results

The process of identifying the priority health needs for the 2025 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 4**. 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 Hyde 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.

Once the primary and secondary data had been grouped into the focus areas detailed in **Appendix 2**, the leaders in Hyde County evaluated and prioritized the health needs of Hyde County while considering the following factors:

- Size and scope of the health need;
- Severity and intensity of the health need;
- Whether possible interventions would be possible and effective;
- Health disparities associated with the need; and
- Importance the community places on addressing the need.

Specifically, the primary and secondary data were presented to the CHNA community stakeholders, and a multi-voting technique was used to facilitate the prioritization process. Based on the results in the primary and secondary data findings, a list of 15 priority areas was compiled and presented to the CHNA community stakeholders to vote on. Virtual and in-person votes were tallied, from which eight top health outcome-related need priorities and seven top social need priorities emerged. Following this exercise, the group selected four overall priority need areas for Hyde County in round two of voting.

The final priority need areas were not ranked in any particular order of importance. Access to Healthcare, Behavioral Health (to include substance abuse) and Heart Disease & Hypertension were identified as ECU Health Beaufort Hospital's top priority health needs for Hyde County to be addressed over the next three years, as seen in **Figure 7** below:

Figure 7: 2025 Priority Health Needs

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

- Agape Health Services
- Beaufort-Hyde Partnership for Children
- County of Hyde
- ECU Health Beaufort Hospital
- Engelhard Medical Center
- Hyde Correctional Institution
- Hyde County Cooperative Extension
- Hyde County EMS
- Hyde County Health Department
- Hyde County Schools
- Hyde Hotline
- Hyde Transit
- Ocracoke Health Center
- Project DIRECT Legacy
- 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 becomes 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. To account for these limitations, new data was collected, including focus groups and web-based 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 Hyde 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, and overall, the composition of survey respondents in terms of race and ethnicity were similar to that of the county as a whole. Roughly 28% of all respondents identified as Black or African American compared to 25% of Hyde County as a whole. Roughly 9% of respondents identified as Hispanic, which slightly exceeded the percentage of the overall county population (8%). Additionally, 5% of survey respondents identified as an "Other" race, which also exceeded the percentage of the overall county population reported as other (3%).

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 Health ENC 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, local leaders 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 substance use disorder (SUD) services would also be helpful in future assessments.

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

CHAPTER 2 | COUNTY PROFILE

Geography

Hyde County is located in the Outer Coastal Plain region of North Carolina, characterized by the presence of large sounds, bays, and river mouths. It covers a total of 1,459 square miles, including 612 square miles of land and 847 square miles of water. Hyde County is comprised of five townships: Currituck, Fairfield, Lake Landing, Ocracoke, and Swan Quarter (County Seat). All of Hyde 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.

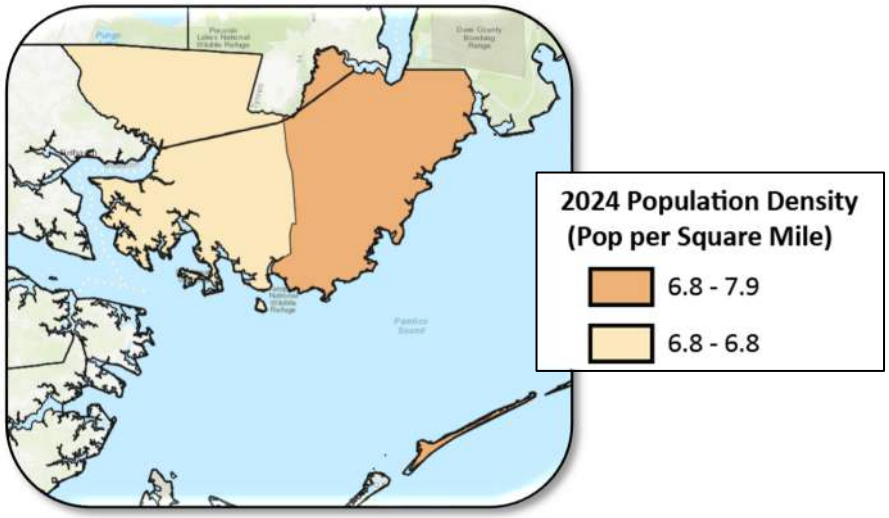
Hyde County has a very small population of 4,404, making up less than 0.1% of North Carolina's total population.

Table 1: Total Population, 2023[8]

	Hyde County	North Carolina	United States
Population	4,404	10,765,678	337,470,185

Hyde County has a population density of 7.3 persons per square mile – lower than the population density for North Carolina (214.7 persons per square mile). Lake Landing is the most densely populated area in the county.

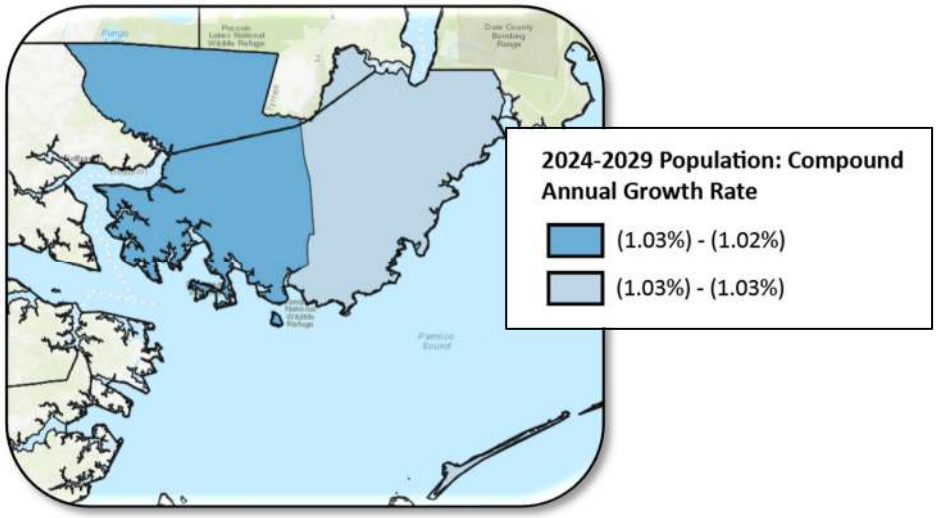
Figure 8: Hyde County Map: Population Density[8]



[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 Hyde County is projected to decline 1.02% annually between 2024 and 2029. Areas in the eastern parts of the county are experiencing the greatest population decline.

Figure 9: Hyde 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 Hyde County skews older than the state. Hyde County's age distribution differs notably from state averages. The county has a lower percentage of residents below 15 (14.2%) compared to North Carolina (17.9%). The percentage of residents between 15 and 44 (37.4%) is also lower than the state average (39.3%), while there is a slightly higher percentage of residents aged 45-64 (25.9% vs. 25.1% state) and a significantly higher percentage aged 65 and older (22.5% vs. 17.7% state). This suggests an older population overall, with a particularly high proportion of seniors, which may have implications for healthcare needs and services in the county.

Table 2: Age Distribution, 2023[8]

	Hyde County	North Carolina	United States
Percentage below 15	14.2 %	17.9 %	18.1%
Percentage between 15 and 44	37.4 %	39.3 %	39.5 %
Percentage between 45 and 64	25.9 %	25.1 %	24.6 %
Percentage 65 and older	22.5 %	17.7 %	17.8%

Like North Carolina overall, Hyde County has a notably higher proportion of females than males in its population. Females make up 55.1% of the county's residents while males comprise 44.9%, a distribution that is significantly more pronounced than the state's ratio.

Table 3: Sex Distribution, 2023[8]

	Hyde County		North Carolina		United States	
	Count	Pct. of Total	Count	Pct. of Total	Count	Pct. of Total
Female	2,426	55.1%	5,489,419	51.0%	170,118,720	50.4%
Male	1,978	44.9%	5,276,259	49.0%	167,351,465	49.6%

Race and Ethnicity

Data on race and ethnicity helps inform the need for healthcare services and cultural factors that can impact how services are delivered. Hyde County's racial composition differs somewhat from state averages. Non-Hispanic White residents make up 63.6% of the population, slightly higher than the state (61.2%). Just over a quarter of the population are Non-Hispanic Black residents, higher than the state average (20.4%). Hyde County has lower percentages of Asian (0.2% vs. 3.5% state) and American Indian Alaska Native (AIAN) (0.2% vs. 1.2% state) populations, and very few Native Hawaiian and Pacific Islander (NHPI) residents. This suggests that Hyde County is less diverse compared to the state and nation.

Table 4: Racial Distribution, 2023[8]

	Hyde County		North Carolina		United States	
	Count	Pct. of Total	Count	Pct. of Total	Count	Pct. of Total
Black (Non-Hispanic)	1,129	25.6 %	2,199,488	20.4 %	42,132,758	12.5 %
White (Non-Hispanic)	2,802	63.6 %	6,590,161	61.2 %	204,562,590	60.6 %
Asian	7	0.2 %	379,374	3.5 %	21,088,177	6.2 %
AIAN	10	0.2 %	133,820	1.2 %	3,831,126	1.1 %
NHPI	2	0.0 %	9,214	0.1 %	712,229	0.2 %
Some Other Race Alone	221	5.0 %	677, 338	6.3 %	29,432,586	8.7 %
Two or More Races	233	5.3 %	776,283	7.2 %	35,710,719	10.6 %

Hyde County's Hispanic population is just over 8%, which is lower than the North Carolina average (11.4%)

Table 5: Ethnic Distribution, 2023[8]

	Hyde County		North Carolina		United States	
	Count	Pct. of Total	Count	Pct. of Total	Count	Pct. of Total
Non-Hispanic	4,048	91.9 %	9,465,874	88.6 %	271,934,049	80.6 %
Hispanic	356	8.1 %	1,299,804	11.4 %	65,536,136	19.4 %

The proportion of foreign-born individuals residing in Hyde County is 5%, lower than state and national averages.

Table 6: Foreign Born Population, 2022[9]

	Hyde County	North Carolina	United States
Foreign Born	5%	9%	13.9%

According to the most recent American Community Survey (ACS), approximately 10% of Hyde County residents speak a language other than English at home, compared to around 13% of North Carolina and 22% U.S. residents. Spanish is the most common language other than English spoken at home in Hyde County. This data suggests a similar level of linguistic diversity between the county and the state.

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

	Hyde County	North Carolina	United States
English Only	90.2%	87.3%	78%
Spanish	9.8%	7.9%	13.3%
Indo-European Languages	-	2.1%	3.8%
Asian and Pacific Islander Languages	-	1.9%	3.6%
Other Languages	-	0.8%	1.2%

Disability Status[10]

Data on disability status helps us understand how to create fair and equal opportunities for everyone in the county. Individuals with disabilities may require services that look different or are delivered in different ways and may require unique outreach by health and other service providers. Nearly one in five Hyde County residents have a disability, which is higher than the North Carolina average. This higher prevalence of disability in the county suggests a greater need for accessible healthcare services and support programs compared to North Carolina overall.

Table 8: Disability Status, 2022[9]

	Hyde County	North Carolina	United States
Population with a Disability	19%	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 health needs. Of the Hyde County population, nearly 7% are veterans, a rate comparable to that of North Carolina.

Table 9: Veteran Status, 2022[9]

	Hyde County	North Carolina	United States
Veterans	6.9%	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 Hyde County ($47,495) is notably lower than the average in North Carolina ($64,316).

Table 10: Median Household Income, 2023[8]

	Hyde County	North Carolina	United States
Median Household Income	$47,495	$64,316	$72,603

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. In 2023, approximately 11% of Hyde County households were below the federal poverty level (FPL) which is similar to that reported for North Carolina and the United States.

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

	Hyde County	North Carolina	United States
Percent Below FPL	10.9 %	10.1 %	9.5 %

Approximately one-quarter of Hyde County households received Food Stamps/SNAP (Supplemental Nutrition Assistance Program) benefits in 2022. This is almost double the state rate of 13.4%, suggesting a significantly higher level of food insecurity among county households.

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

	Hyde County	North Carolina	United States
Number of Households Receiving Food Stamps/SNAP	435	575,860	16,072,733
Total Number of Households	1,767	4,299,266	129,870,928
Percentage of Households receiving Food Stamps/SNAP	24.6 %	13.4 %	12.4 %

In Hyde County, 31.3% of the population has an educational attainment of high school only, which is significantly higher than the state average (21.2%). There are other sizable disparities in educational achievement between Hyde County and North Carolina. The county has a much higher percentage of residents with some high school education but no diploma (20.6%) compared to the state average (5.5%). While the county shows slightly higher rates for associate's degrees (10.2% vs. 9.9% state), it has significantly lower rates of advanced education, with bachelor's degrees (7.9%) at less than half the state average (20.4%) and graduate/professional degrees (2.6%) at less than a quarter of North Carolina's rate (11.6%). This data indicates that students in Hyde County may face potential challenges in accessing or completing higher education.

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

	Hyde County	North Carolina	United States
Less than 9th Grade	0.9%	6.0%	3.5%
Some High School/No Diploma	20.6%	5.5%	5.3%
High School Diploma	31.3%	21.2%	28.5%
GED/Alternative Credential	5.7%	4.3%	*[15]
Some College/No Diploma	20.8%	21.1%	14.6%
Associate's Degree	10.2%	9.9%	10.5%
Bachelor's Degree	7.9%	20.4%	23.4%
Graduate/ Professional Degree	2.6%	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.

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

The overall unemployment rate in Hyde County (6.4%) is higher than the state average (5.1%). Young people between ages 16 to 24 face similar unemployment rates (12.7%) when compared to North Carolina's rate (12.4%). However, the unemployment rate for ages 25 to 54 (6.3%) is higher than the state figure (4.7%). Hyde County has lower rates of unemployment for workers ages 55 to 64 (2.8% vs. 3.3% state) but significantly higher rates for those 65 or more (4.9% vs. 3.0% state). This data indicates employment challenges particularly among working-age adults and seniors.

Table 14: Unemployment, 2022[16,17]

	Hyde County	North Carolina	United States
Percentage unemployed ages 16 to 24	12.7 %	12.4 %	11.0%
Percentage unemployed ages 25 to 54	6.3 %	4.7 %	3.4%
Percentage unemployed ages 55 to 64	2.8 %	3.3 %	2.7%
Percentage unemployed ages 65 or more	4.9 %	3.0 %	2.9%
Total unemployment	6.4 %	5.1 %	3.9%

Hyde County's overall uninsured rate (13.8%) is lower than the state average (15.0%). The county has better insurance coverage for those 18 and younger (2.3%) compared to the state average (5.2%). However, the uninsured rate for ages 19 to 34 (51.2%) is more than triple North Carolina's rate (15.5%). The county's uninsured rate for ages 35 to 64 (26.3%) is also substantially higher than the state's 12.5%. This data suggests particularly severe challenges in healthcare access for both young and middle-aged adults in Hyde County.

Table 15: Health Insurance Status, 2022[18]

	Hyde County	North Carolina	United States
Percentage uninsured ages 18 or below	2.3 %	5.2 %	5.4 %
Percentage uninsured ages 19 to 34	51.2 %	15.5 %	13.6 %
Percentage uninsured ages 35 to 64	26.3 %	12.5%	9.9%
Total % Uninsured	13.8 %	15.0%	12.0%

[16] 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.

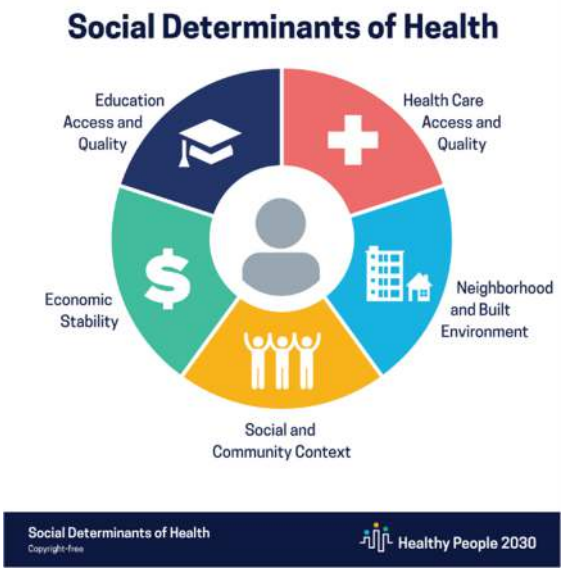
[17] Source (for United States): Federal Reserve Bank of Saint Louis. Federal Reserve Economic Data - FRED (March 2024). https://fred.stlouisfed.org/

[18] 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 CHNA Leadership Team 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 10: Social Determinants of Health



As seen in **Figure 10**, 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. Further, people in communities with fewer resources may also experience high levels of stress, which also contributes to worse health outcomes, particularly related to mental or behavioral health.

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

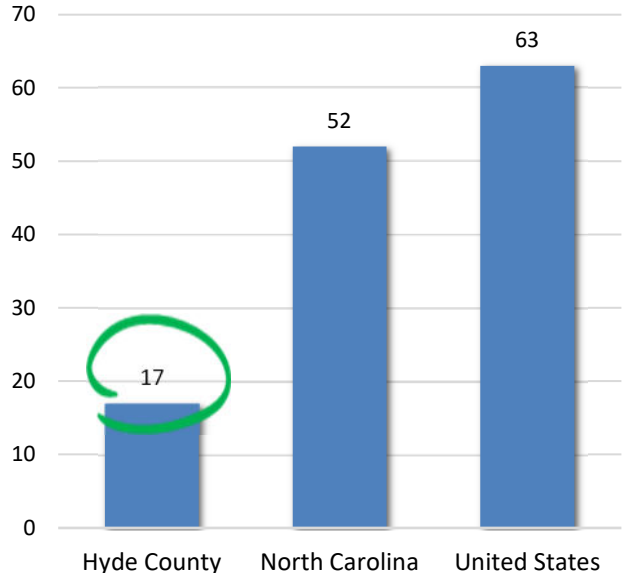
Disparities

Recognizing the diversity of Hyde County, as discussed above, the CHNA Stakeholders 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

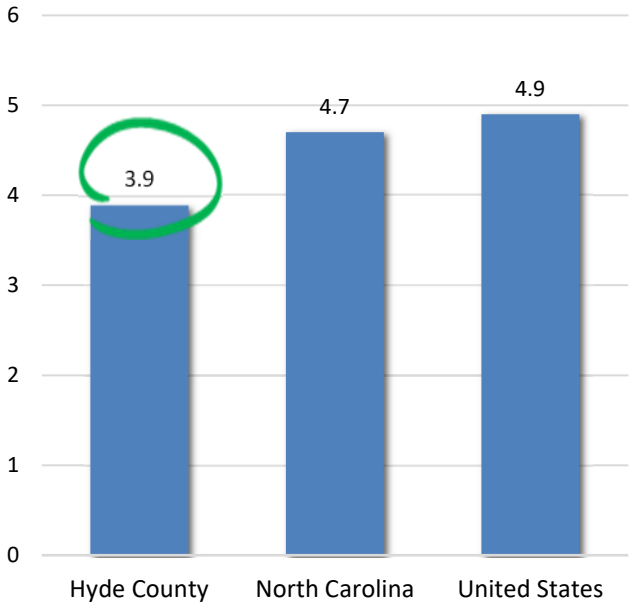
tracts. Lower scores represent a higher level of integration. The rate of residential segregation in Hyde County is lower than North Carolina and the U.S, as seen in **Figure 11**.

Figure 11: Residential Segregation[5]



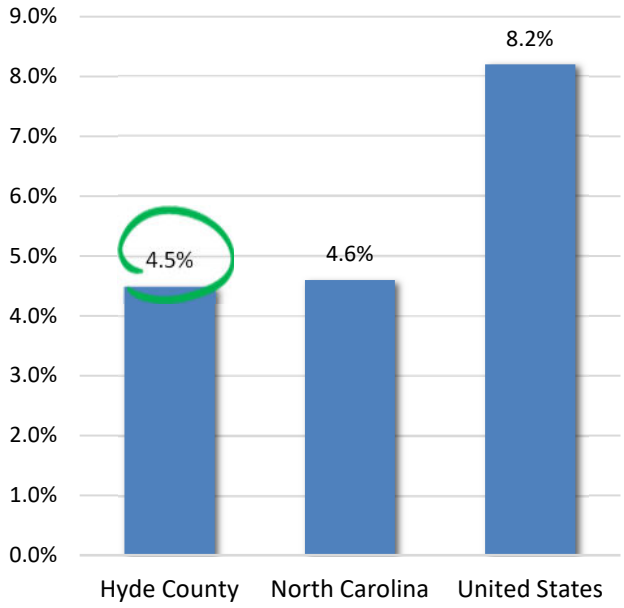
Income inequality is measured as the ratio of household income at the 80th percentile to household income at the 20th percentile. Communities with greater income inequality may have worse outcomes on a variety of metrics, including mortality, poor health, sense of community, and social support. As seen in **Figure 12**, the income inequality ratio in Hyde County is lower than the state and the country.

Figure 12: 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 provided during the COVID-19 pandemic. Slightly fewer people have limited English proficiency in Hyde County compared to North Carolina and the United States, as seen in **Figure 13**.

Figure 13: Percent of Population with Limited English Proficiency[9]



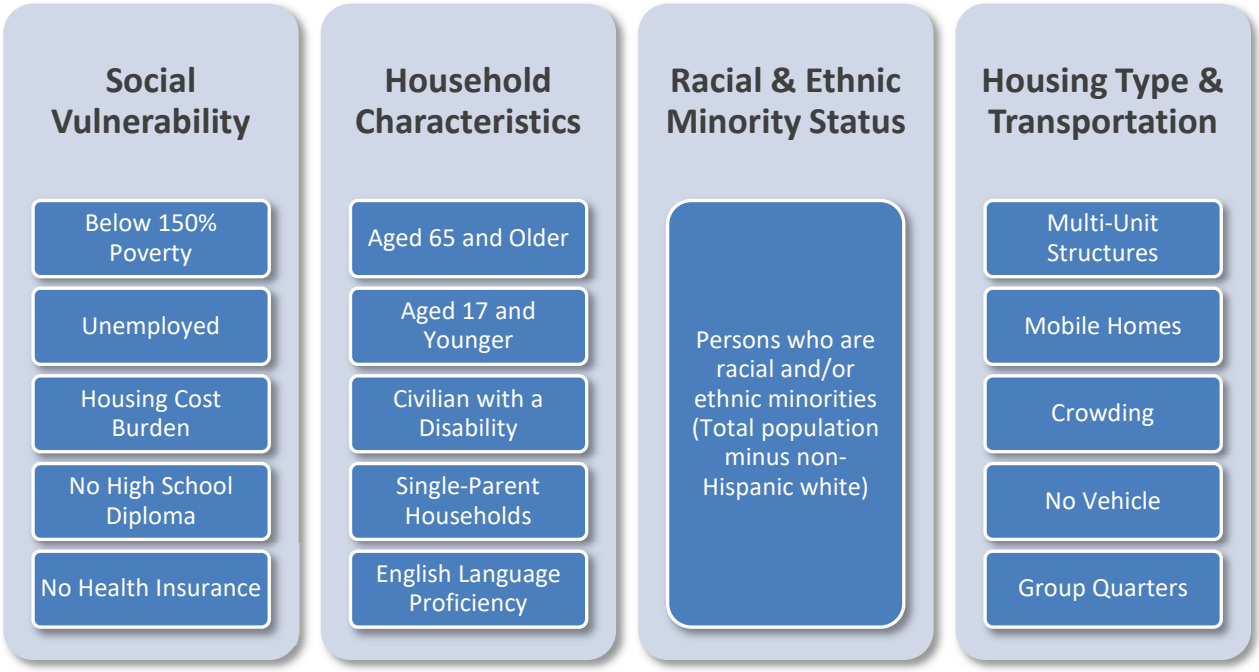
Social Vulnerability Index

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

The SVI uses 16 U.S. Census variables to help local officials identify communities that may need support before, during, or after a public health emergency.[19] 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 14** outlines the variables used to calculate SVI scores.

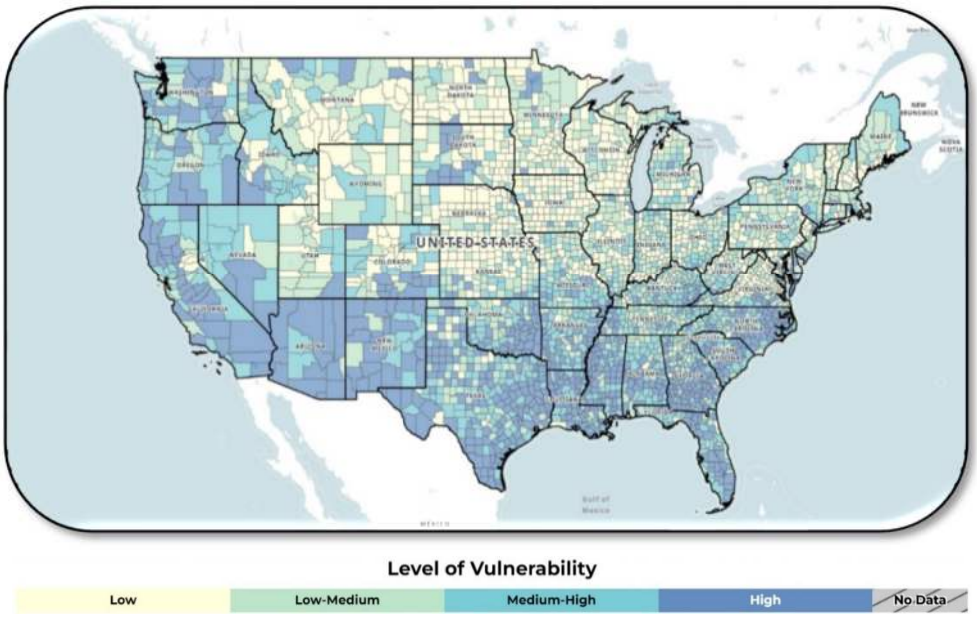
[19] Source: Centers for Disease Control and Prevention (2024). Social Vulnerability Index. https://www.atsdr.cdc.gov/place-health/php/svi/index.html

Figure 14: SVI Variables



The United States SVI by county is shown in **Figure 15** below. As shown, a lot of variation exists across the country, and even within individual states.

Figure 15: United States SVI by County, 2022



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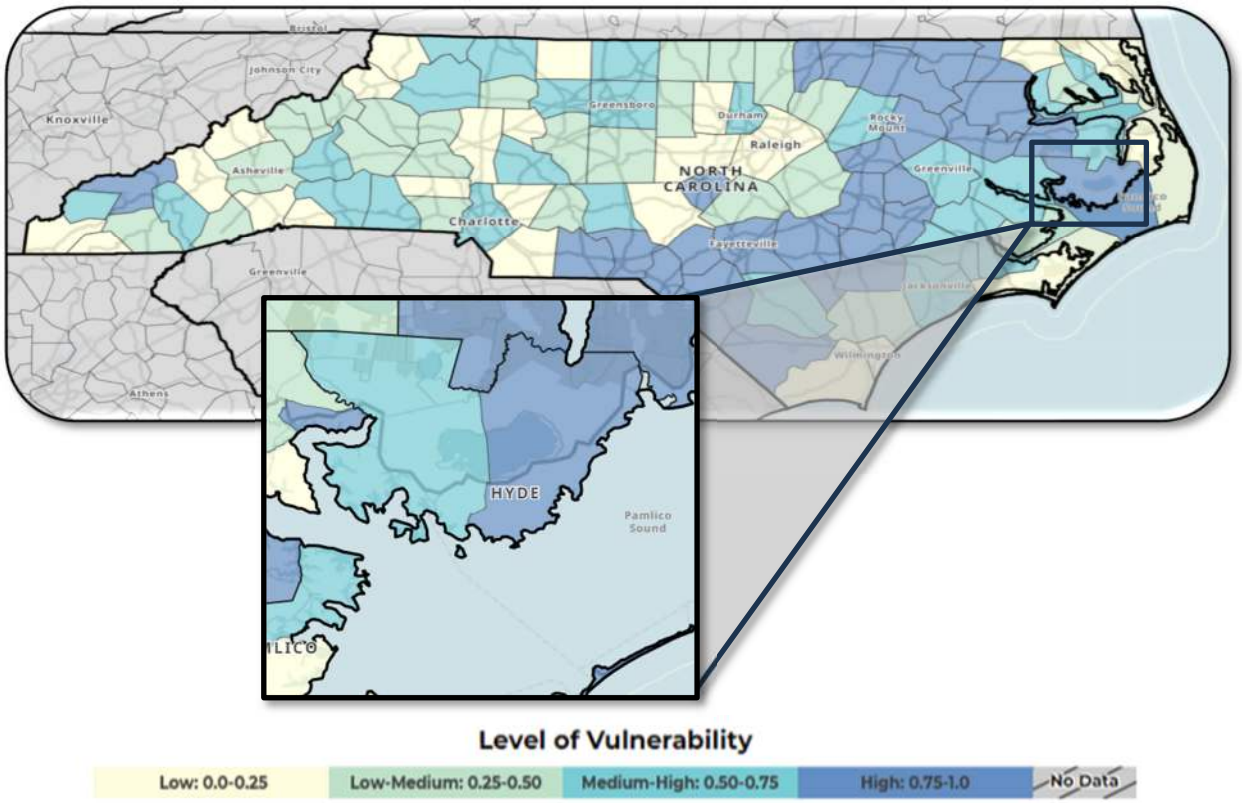
The 2022 SVI scores for Hyde County are shown in **Figure 16** below. Possible scores range from 0 (lowest vulnerability) to 1 (highest vulnerability), and these scores show a relative comparison with other counties and census tracts in North Carolina. The vulnerability of Hyde County overall is higher than average compared to the state. Levels of vulnerability are variable across the county with the average being 0.81.

Figure 16: Hyde County SVI by Census Tract, 2022



Environmental Justice Index

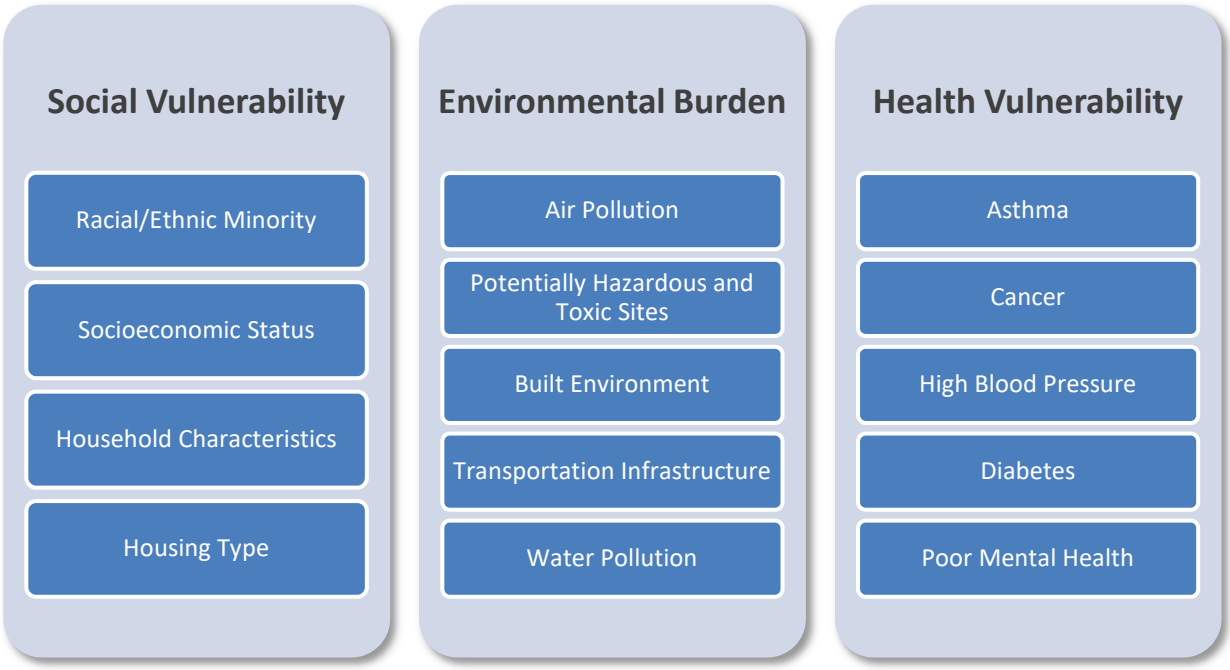
Environmental justice means the just treatment and meaningful involvement of all people, regardless of income, race, color, national origin, Tribal affiliation, or disability, in agency decision-making and other Federal activities that affect human health and the environment. It aims to protect everyone 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.[20]

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.

[20] 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

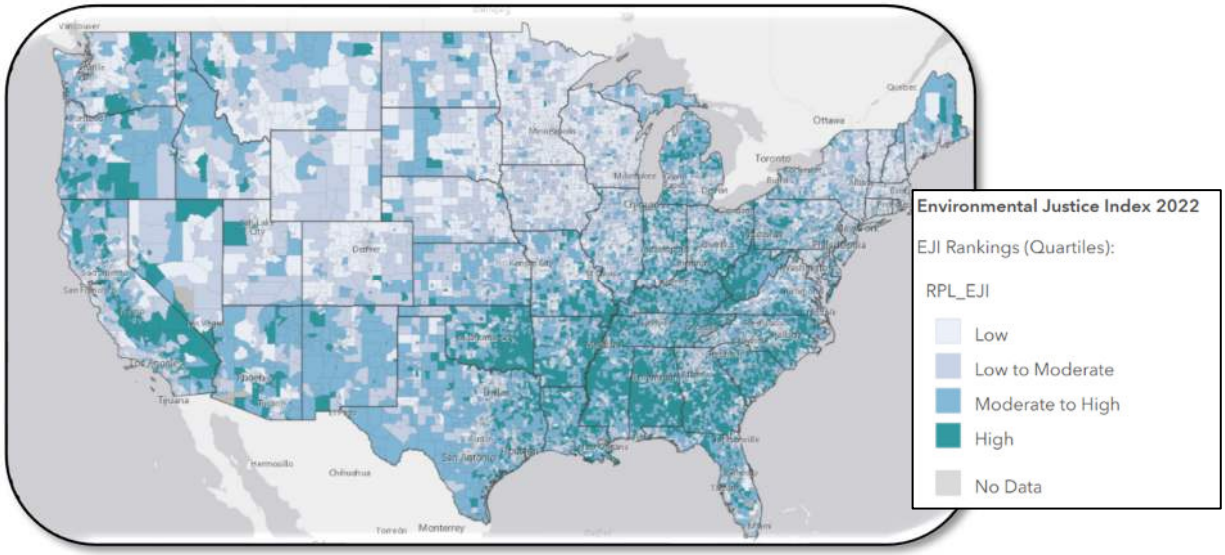
Over time, communities with a higher EJI score are generally shown to experience more severe impacts from environmental burden than communities in other census tracts. **Figure 17** outlines the variables used to calculate EJI scores.

Figure 17: EJI Variables



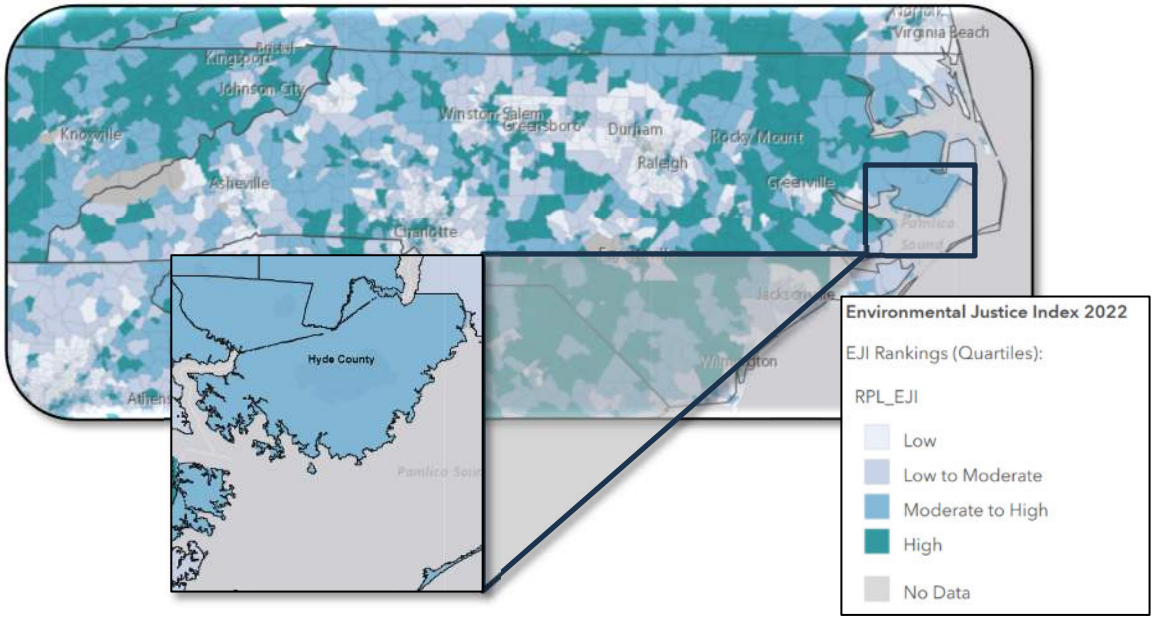
The United States EJI by census tract is shown in **Figure 18** below. As shown, a lot of variation exists across the country, and even within individual states.

Figure 18: United States EJI by Census Tract, 2022



The 2022 EJI scores for census tracts within Hyde County are shown in **Figure 19** below. EJI scores use a 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 0.60.

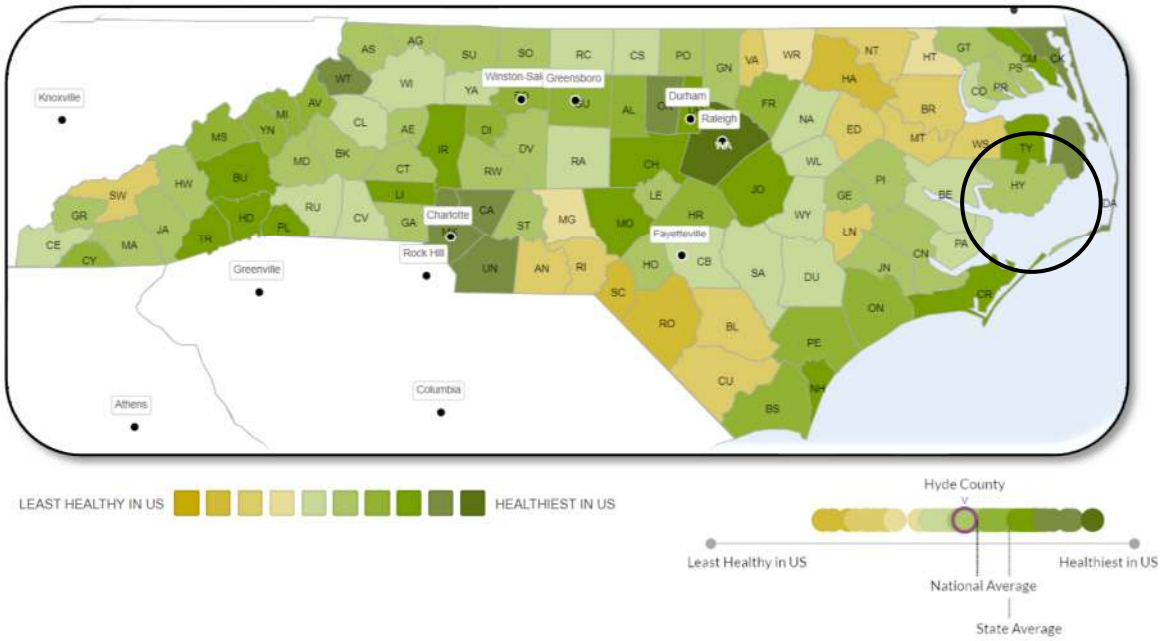
Figure 19: Hyde County EJI by Census Tract, 2022



Health Outcome and Health Factor Rankings

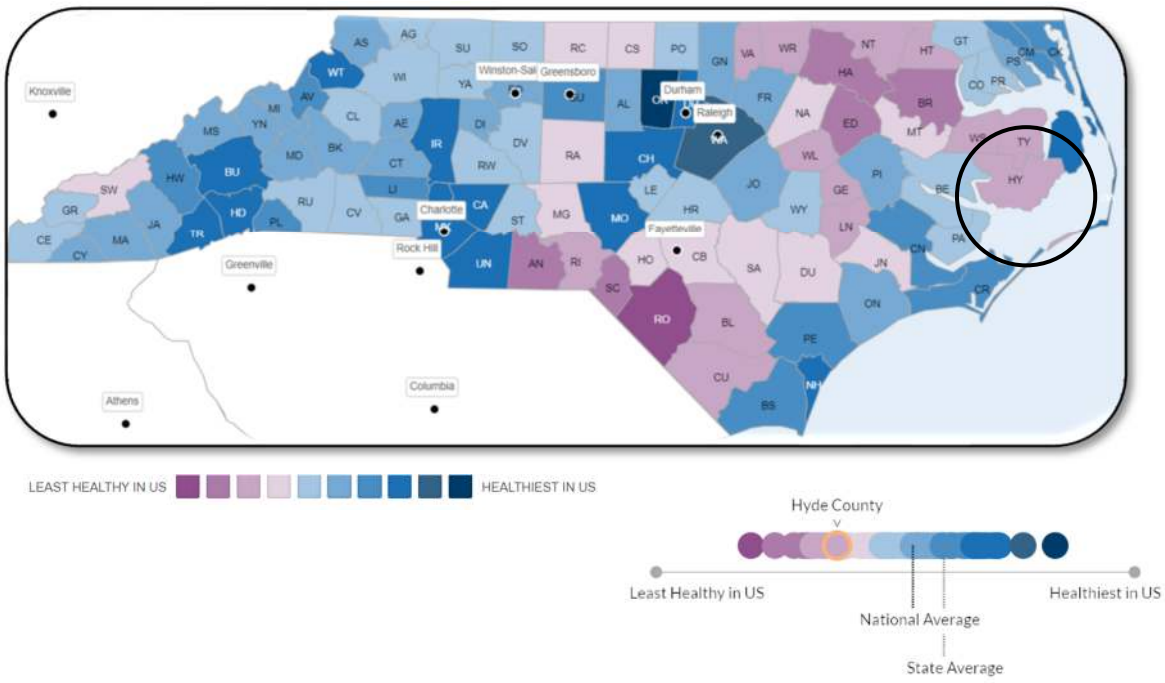
CHNA Stakeholders also reviewed and analyzed data from the Robert Wood Johnson Foundation and the University of Wisconsin County Health Rankings for the year 2024. The Health Outcomes measure looks at how long people in a community live and how physically and mentally healthy they are. These categories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

Figure 20: State Health Outcomes Rating Map[5]



The Health Factors measure considers variables that affect people's health including health behaviors, clinical care, social & economic factors, and the physical environment in which they live. More details about these indicators can be found in **APPENDIX 2 | SECONDARY** DATA METHODOLOGY AND SOURCES. Like the Health Outcome measure, Hyde County falls behind the average for the country and the state.

Figure 21: State Health Factors Rating Map[5]



CHAPTER 3 | PRIORITY NEED AREAS

This chapter explores all community health priority areas in detail. While the health department has identified four priorities, the hospital has adopted three—Access to Care, Behavioral Health, and Heart Disease/Hypertension. The information in this section includes context and national perspective, secondary data findings, and primary data findings (including the community member survey and focus groups). As previously described in **CHAPTER 1 |** METHODOLOGY, secondary data was primarily sourced using the North Carolina Data Portal. For additional descriptive information on data sources and methodology, please see **APPENDIX 2** | SECONDARY DATA METHODOLOGY AND SOURCES.

On August 29, 2024, key stakeholders from Hyde County gathered at the Hyde County Government Center in Swan Quarter to participate in a prioritization meeting for the 2025 CHNA. The prioritization meeting brought together representatives from diverse organizations including healthcare providers, county departments, schools, social services, and community organizations.

Using a multi-voting technique, these stakeholders evaluated fifteen priority areas based on primary and secondary data. After thorough discussion, each participant voted on their top choices, engaging in further discussion to ensure the selected priorities were feasible for the community to address. From this process, four priority needs emerged: Access to Healthcare, Alcohol/Drug Addition, Heart Disease/Hypertension, and Mental Health.

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

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

PRIORITY NEED: ACCESS TO HEALTHCARE

Context and National Perspective

Access to care means patients are able to get high quality, affordable healthcare in a timely fashion to achieve the best possible health outcomes. It includes several components, including coverage (i.e. insurance), a physical location where care is provided, the ability to receive timely care, and enough providers in the workforce. The CHNA Stakeholders identified access to care as a high priority need for residents of Hyde County

From a national perspective, according to Healthy People 2030, approximately one in ten people in the U.S. do not have health insurance, which means they are less likely to have a primary care provider or to be able to afford the services or medications they need.[21] Access is a challenge even for those who are insured.[22]

The availability and distribution of health providers in the U.S. contributes to healthcare access challenges. According to the Association of American Medical Colleges (AAMC), there is estimated to be a shortage of 13,500 to 86,000 physicians in the U.S. by 2036, which will impact both primary and specialty care.[23] Access issues are anticipated to increase in coming years. Growing shortages of both nurses and doctors are being driven by several factors, including population growth, the aging U.S. population requiring higher levels of care, provider burnout (physical, mental and emotional exhaustion) made worse by the COVID-19 pandemic, and a lack of clinical training programs and faculty – particularly for nurses.[24] The aging of the current physician workforce is also driving anticipated personnel shortages. In North Carolina, 30.6% of actively practicing physicians were over the age of 60 in 2020.[25] Access is also impacted by the number of actively practicing physicians overall. In 2020, there were just 9,211 primary care physicians in North Carolina, with 27,650 physicians actively practicing overall.[26]

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

[21] Source: U.S. Department of Health and Human Services Office of Disease Prevention and Health Promotion (2023). *Healthy People 2030: Health Care Access and Quality*. Retrieved September 9th, 2024 from https://health.gov/healthypeople/objectives-and-data/browse-objectives/health-care-access-and-quality.

[22] Source: Phillips, K.A., Marshall, D.A., Adler, L., Figueroa, J., Haeder, S.F., Hamad, R., Hernandez, I., Moucheraud, C., Nikpay, S. (2023). Ten health policy challenges for the next ten years. *Health Affairs Scholar*. Retrieved from: https://academic.oup.com/healthaffairsscholar/article/1/1/qxad010/7203673.

[23] Source: Association of American Medical Colleges (AAMC) (2024). *The complexities of physician supply and demand: Projections from 2021 to 2036*. Retrieved from: https://www.aamc.org/media/75236/download?attachment .

[24] Source: Association of American Medical Colleges (AAMC) (2024). *State of US Nursing Report 2024*. Retrieved, from https://www.incrediblehealth.com/wp-content/uploads/2024/03/2024-Incredible-Health-State-of-US-Nursing-Report.pdf .

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

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

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

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

Secondary Data Findings

Secondary data collected through the CHNA process identified significant healthcare access challenges for residents of Hyde County. The county faces severe provider shortages across multiple specialties, with provider rates substantially below state and national averages. The primary care provider rate (65.4 per 100,000 population) is notably lower than both the state (101.1) and national (112.4) averages.

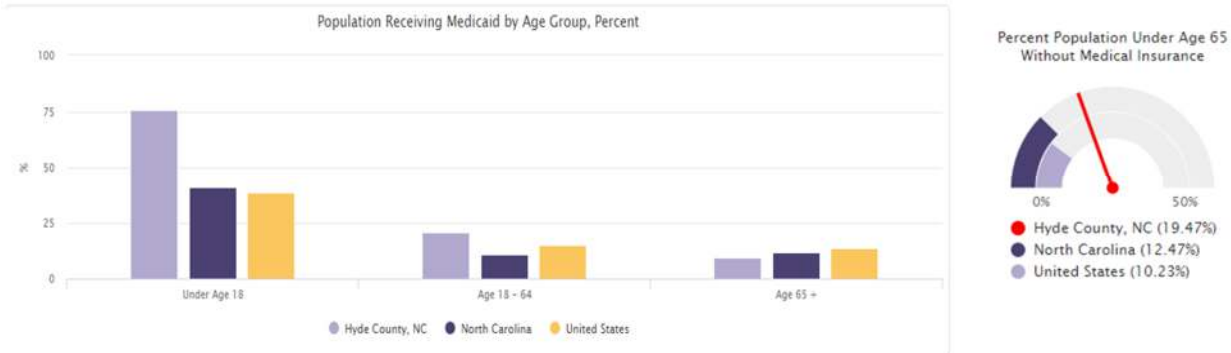
Table 16: Access to Care Indicators

Indicator	Hyde County	North Carolina	United States
Dental Providers, (Rate per 100,000 Population)	0.0	31.5	39.1
Primary Care Providers (Rate per 100,000 Population)	65.4	101.1	112.4
Percentage of Population Living in an Area Affected by a Dental Care HPSA	100%	34%	18%
Percent of Insured Population Receiving Medicaid	35%	20%	22%
Rate of Federally Qualified Health Centers (Rate per 100,000 Population)	43.6	4.0	3.5

Even more concerning, residents in Hyde County have no local access to dental providers. The entire population of Hyde County (100%) lives in an area designated as a Dental Health Professional Shortage Area (HPSA), compared to just 34% of North Carolina's population and 18% of the U.S. population. While the county faces significant provider shortages, it does have a higher rate of Federally Qualified Health Centers (43.6 per 100,000 population) compared to both state (4.0) and national (3.5) averages.

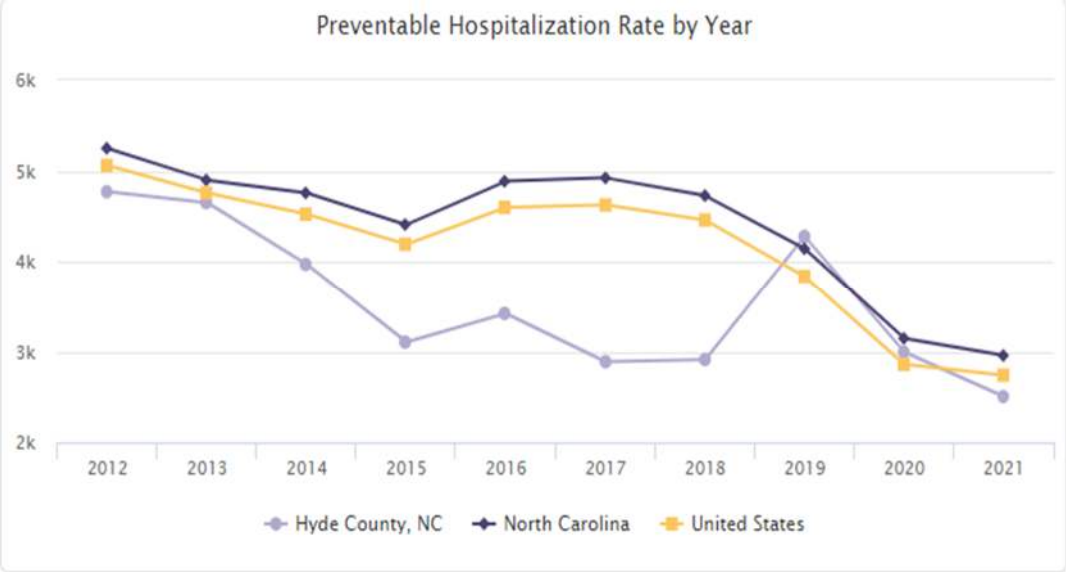
Hyde County has a higher percentage of the insured population receiving Medicaid (35%) compared to state (20%) and national (22%) averages. This is particularly pronounced among residents under age 18, with nearly 75% of this population enrolled in Medicaid. While Medicaid coverage can support access to care, the severe provider shortages may create additional barriers for these residents.

Figure 22: Population Receiving Medicaid by Age Group and Under Age 65 Uninsured



Another access-related indicator, Hyde County has fewer preventable hospital stays for ambulatory care-sensitive conditions per 100,000 Medicare enrollees compared to both state and national averages.

Figure 23: Preventable Hospital Stays



However, significant racial disparities exist in preventable hospitalizations, with Black Medicare beneficiaries in the county experiencing a rate more than three times higher (8,853) than White Medicare beneficiaries (2,763).

Figure 24: Preventable Hospital Stays by Race/Ethnicity

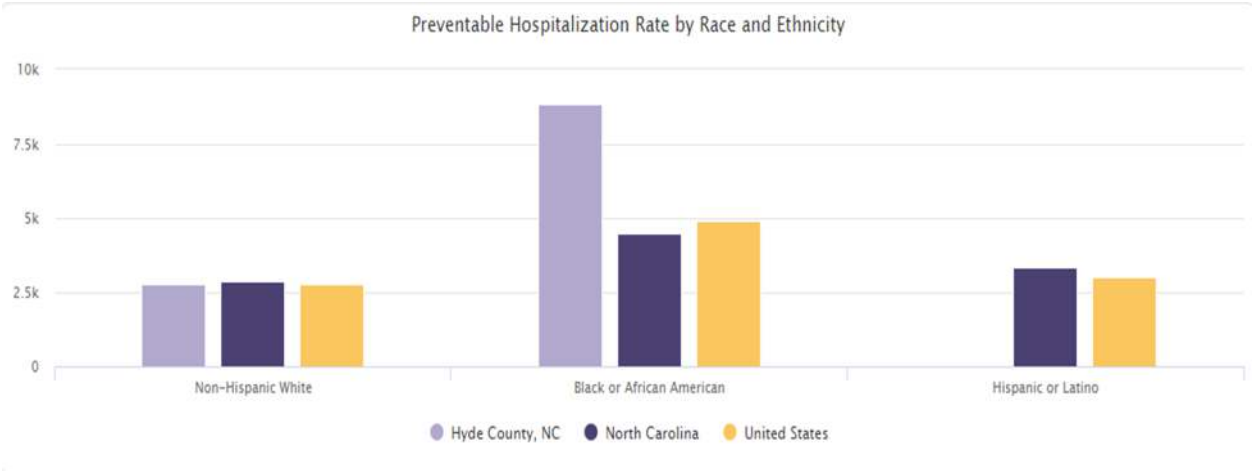


Table 17: Preventable Hospital Stays by Race/Ethnicity

Preventable Hospital Stays (per 100,000 Medicare Beneficiaries)	Hyde County Rate
Preventable Hospital Stays	2,505
Black or African American Medicare Beneficiaries	8,853
White Medicare Beneficiaries	2,763

Access to care may not be equitable across all county populations, particularly those with socioeconomic or transportation-related challenges. A lack of access to reliable transportation or transit is a key barrier that can prevent someone from being able to see their provider and can influence their ability to thrive in other areas of their life as well (such as getting to school or work). Households in Hyde County had a lower proportion with no motor vehicle present compared to the state value; however, many residents may face transportation challenges.

Table 18: Transportation Indicators

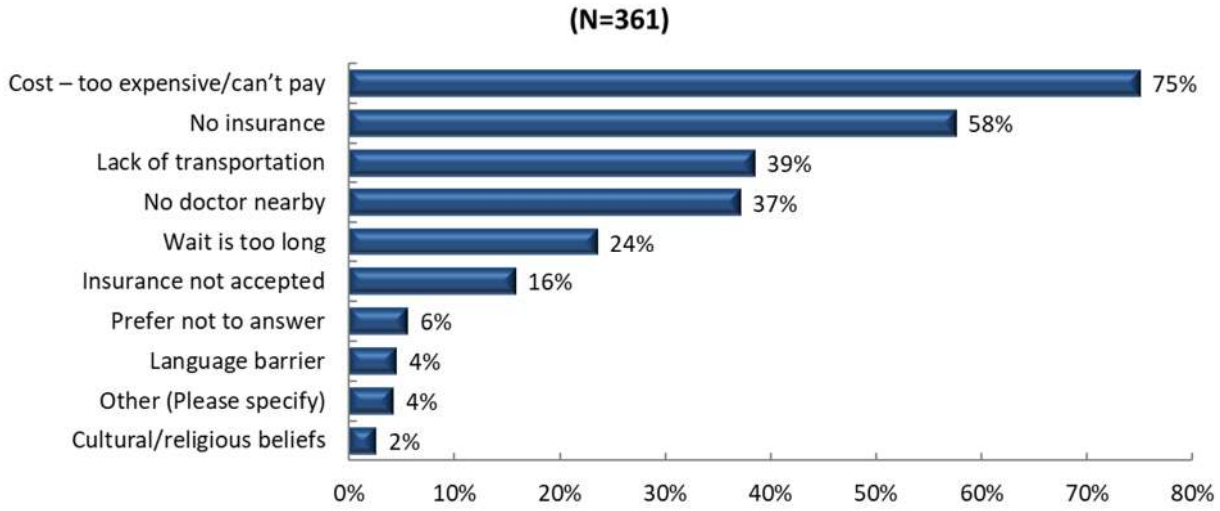
Indicator	Hyde County	North Carolina	United States
Households with No Motor Vehicle, Percent	2.0%	5.4%	8.3%
Percent Population Using Public Transit for Commute to Work	0.7%	0.8%	3.8%

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

Primary Data Findings – Community Member Web Survey

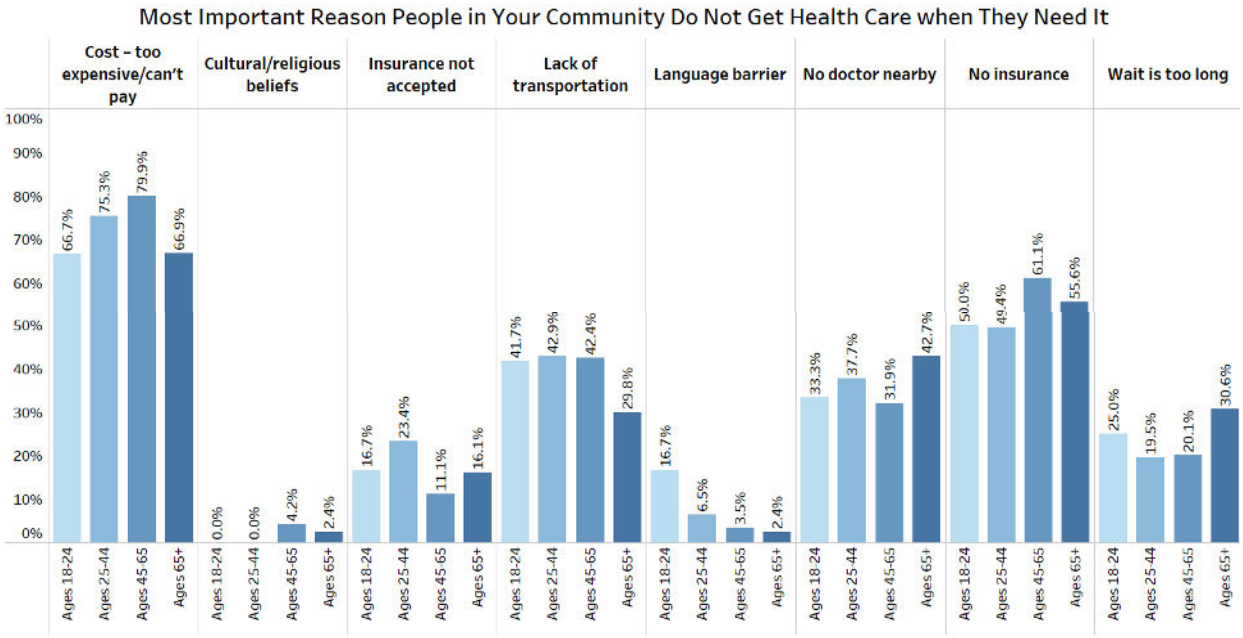
Nearly 375 Hyde County residents responded to the web-based survey. Respondents identified several access to care needs that impact residents in Hyde County. In the survey, community members were asked to identify the top barriers to receiving healthcare. Cost (75%), no insurance (58%), and lack of transportation (39%) were the top three identified reasons why people in the community are not getting care when they need it. Another third of responses identified a lack of nearby doctors and a quarter of responses indicated long wait times as the top barriers to care.

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



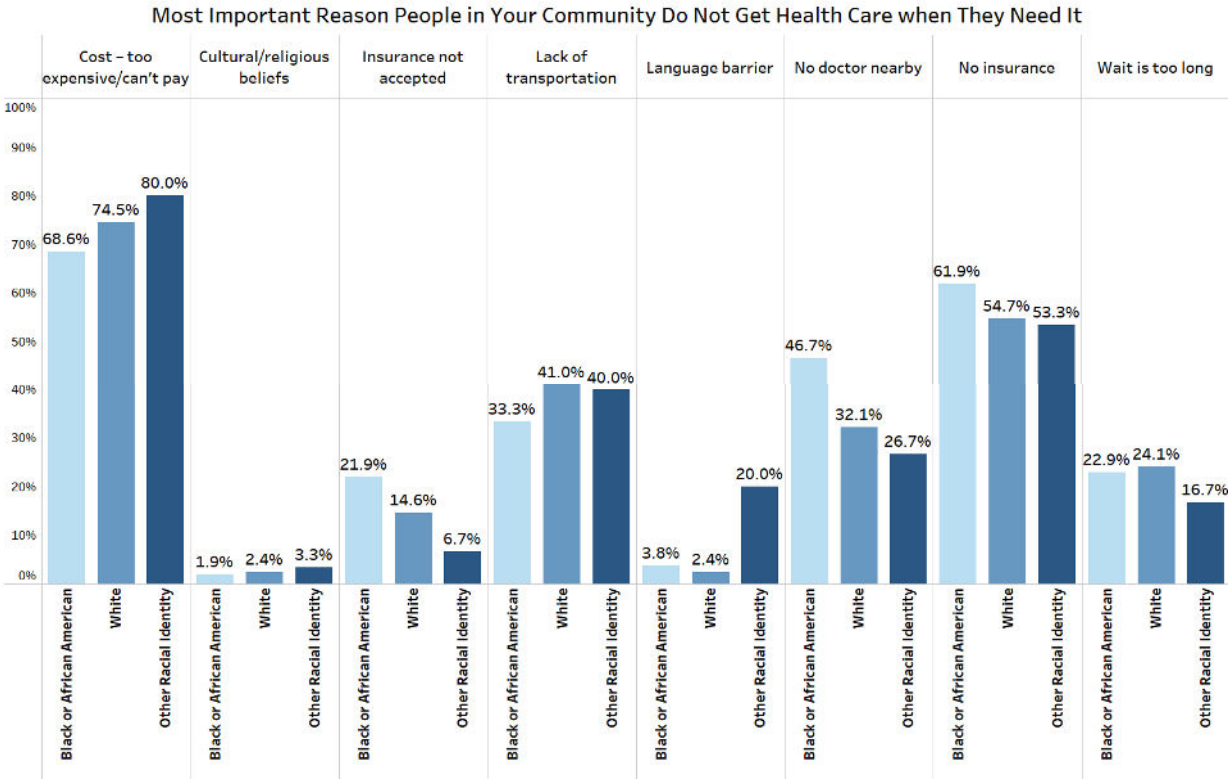
When these data were examined by age group, the age group that most frequently identified cost (80%) and lack of insurance (61%) as top barriers was those ages 45 to 65. The oldest group, ages 65 and older, was least likely to identify lack of transportation (30%) as a barrier to care compared to all other age groups.

Figure 26: 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)



Responses also differed by race. More than three-quarters of respondents identifying with the "Other" racial category[29] noted cost as a top barrier to healthcare compared to 69% of respondents identifying as Black/African American and 75% of respondents identifying as White. By contrast, respondents identifying as Black/African American, were most likely to select no doctor nearby and no insurance as barriers to care (Black/African American: 47%, 62%; White: 32%, 55%; Other: 27%, 53%).

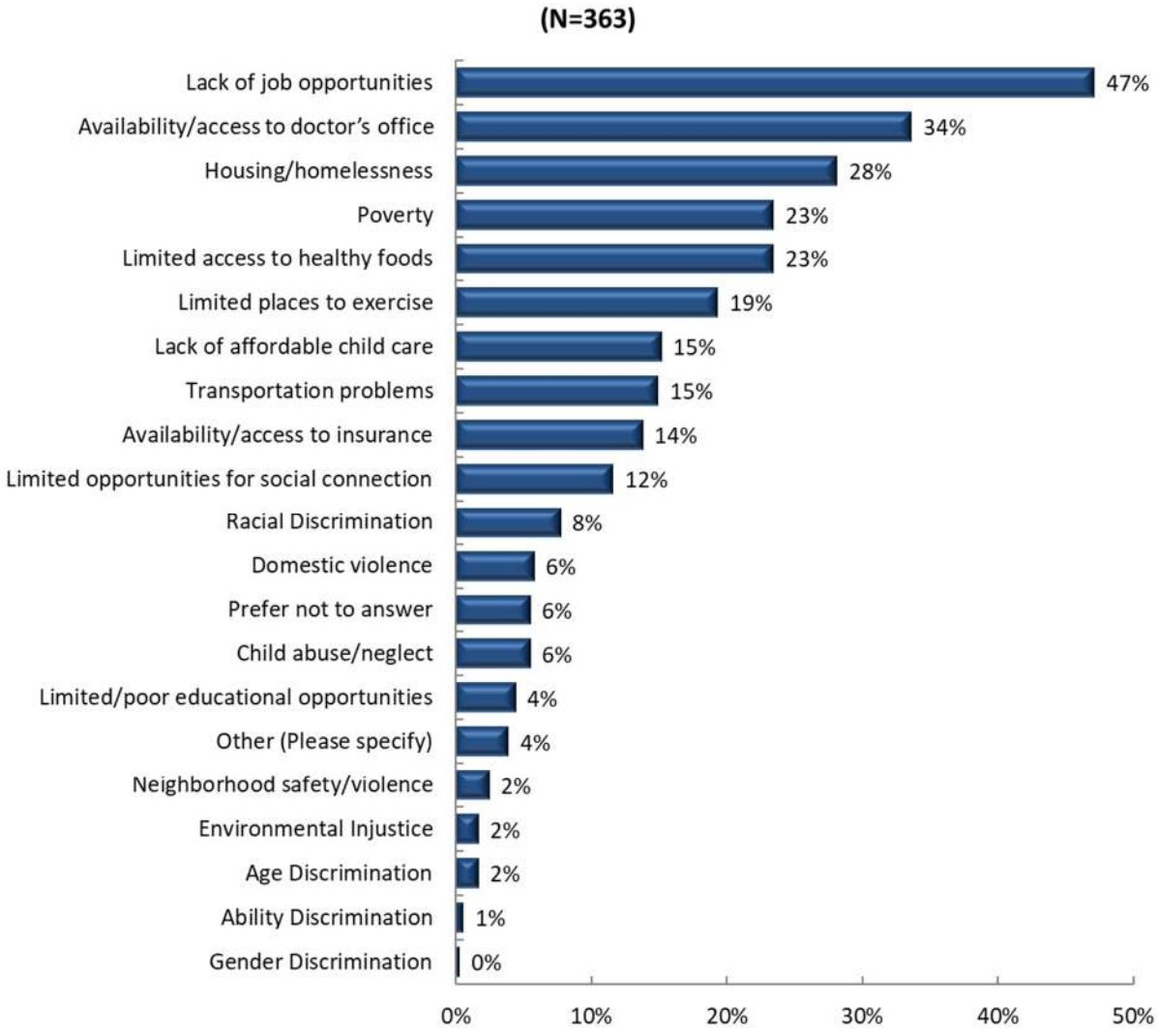
Figure 27: What are the three most important reasons people in your community do not get health care when they need it? Please select up to three. (by race)



Community members were also asked to identify the most important social or environmental problems that affect the health of the community. As displayed in the figure below, the second most frequent problem identified was the availability or access to doctor's offices (34%), again highlighting access to care challenges within the community. Transportation (15%) was identified as the eighth most frequent social or environmental problem that affects the health of the community.

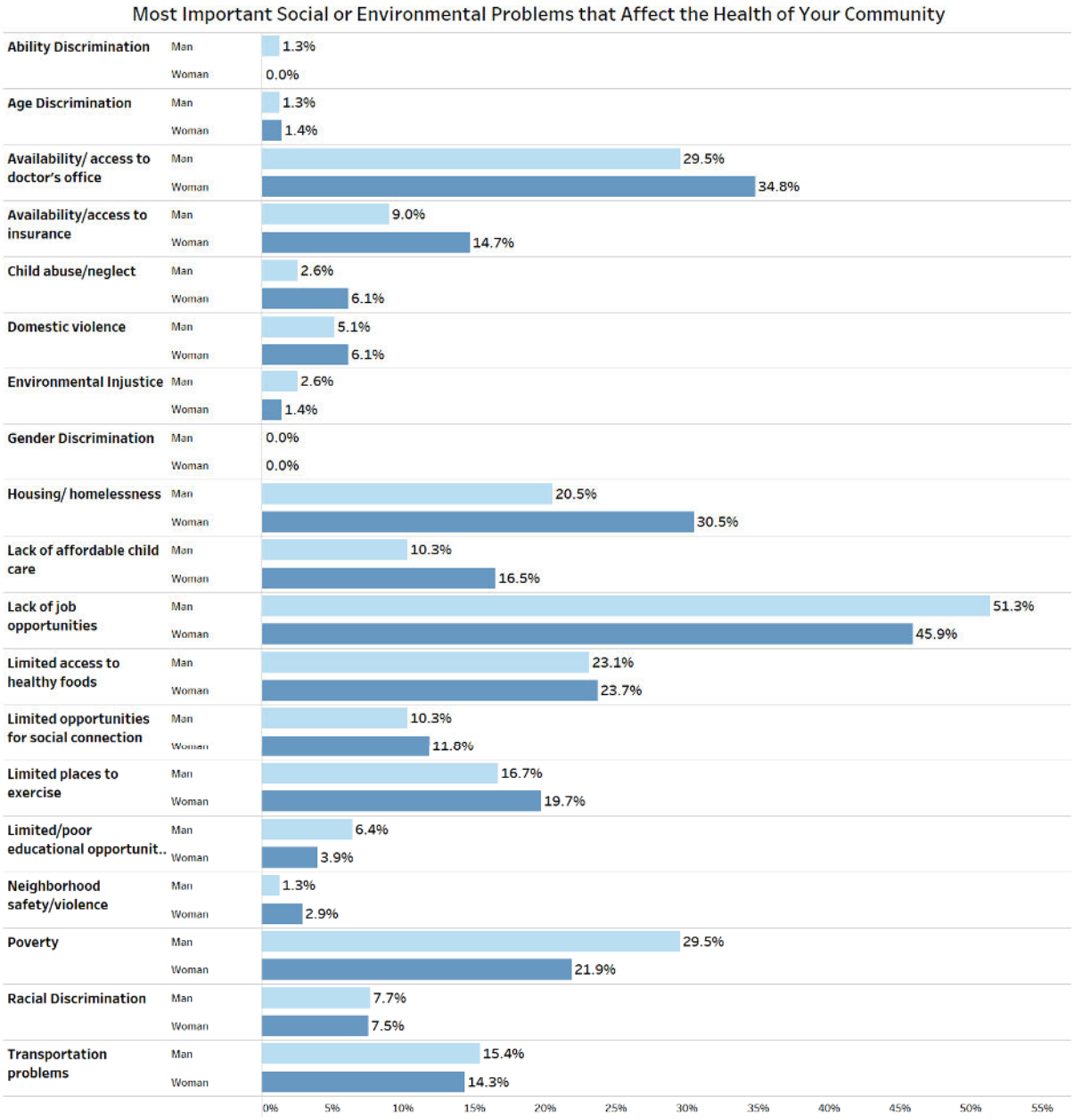
[29] Includes those who identified as American Indian and Alaska Native, Asian, Native Hawaiian and other Pacific Islander, and/or those who selected more than one race or "other."

Figure 28: What are the three most important social or environmental problems that affect the health of your community? Please select up to three.



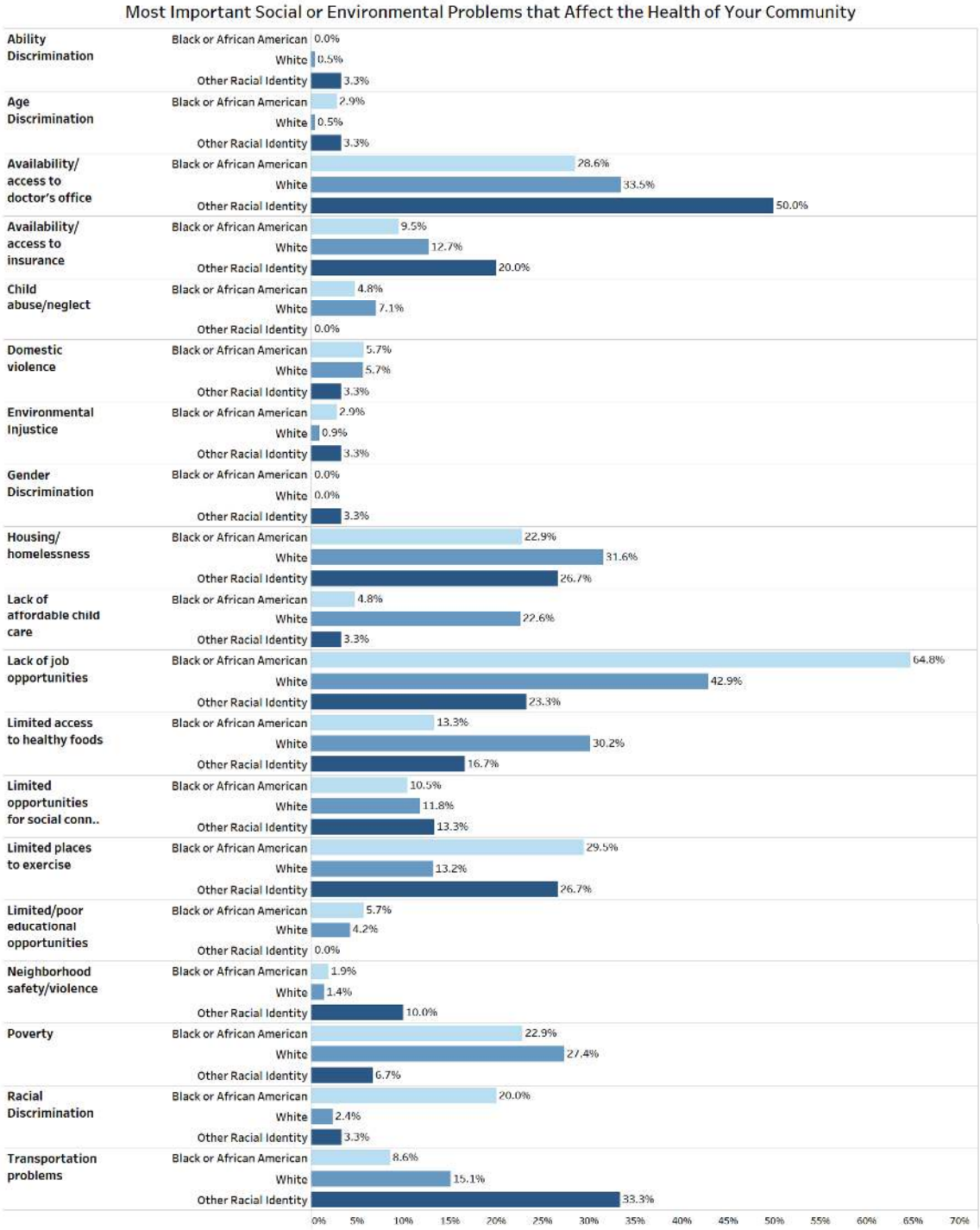
Notably, men and women differed in their responses. More women identified availability and access to doctor's offices as a top social and environmental problem (35% for women vs. 30% for men). Women were also more likely than men to identify availability and access to insurance as an important social and environmental problem (15% compared to 9%).

Figure 29: What are the three most important social or environmental problems that affect the health of your community? Please select up to three. (by gender)



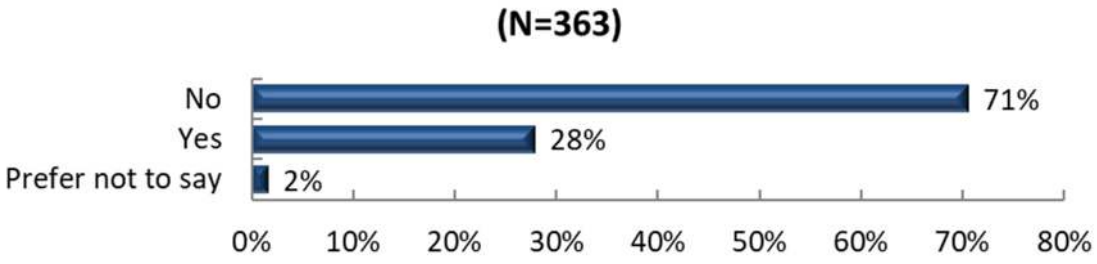
Responses also varied by race. Those identifying with other racial identities were more likely to cite availability of doctor's offices, availability or access to insurance, and transportation than all other races (Other: 50%, 20%, 33%; Black or African American: 29%, 10%, 9%; White: 34%, 13%, 15%).

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



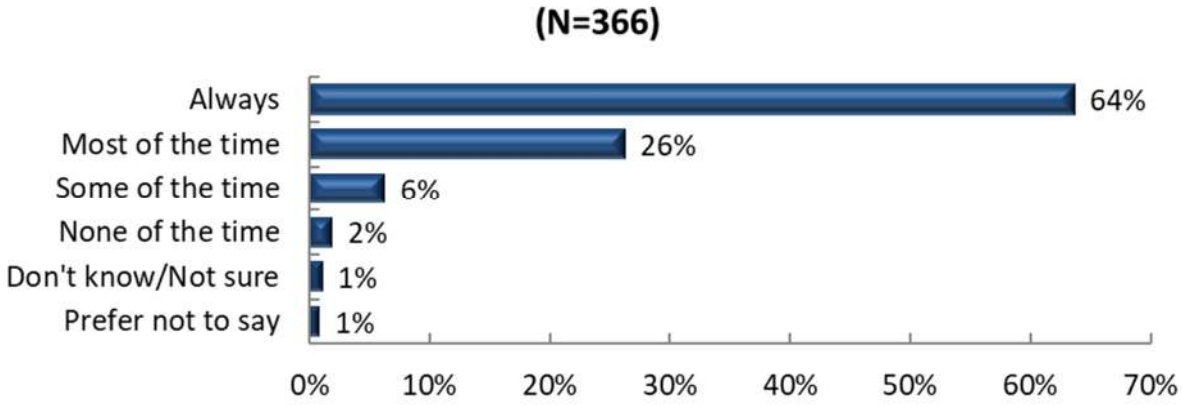
Respondents were also asked if they have put off or neglected going to the doctor due to distance or transportation, to which 28% of respondents answered yes, further emphasizing that transportation can be a barrier for at least a portion of the community.

Figure 31: Do you put off or neglect going to the doctor because of distance or transportation?



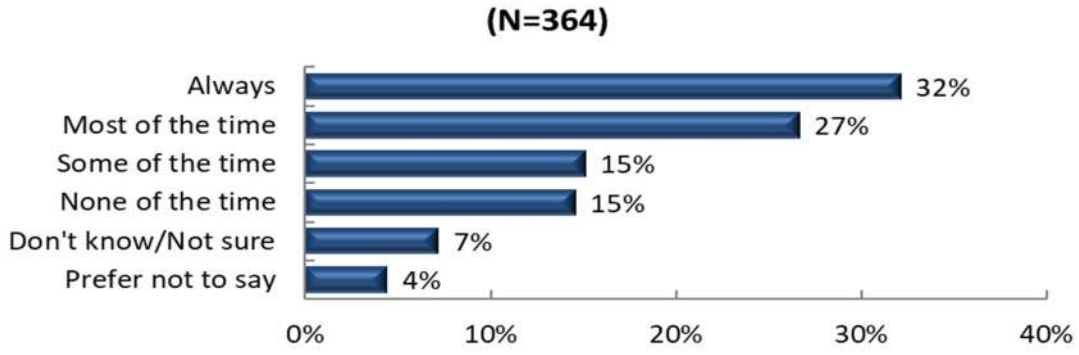
When community members were asked about the quality of their experiences getting medical care in the past year, 26% of respondents reported being treated with respect by doctors and health providers "most of the time," the second most frequent response.

Figure 32: Thinking about your experiences getting medical care in the past year, how often were you treated with respect by your doctors or health providers?



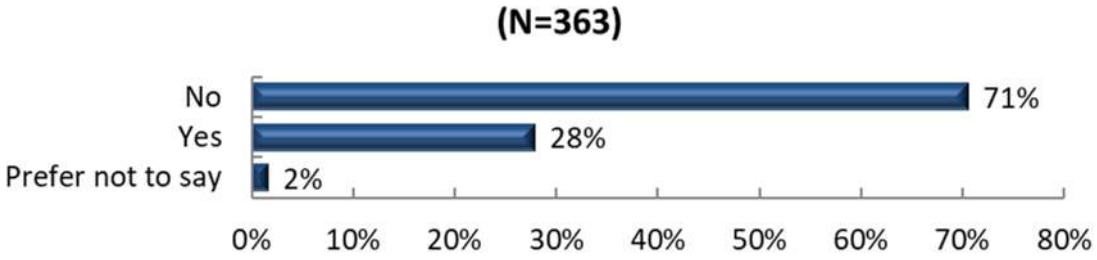
When community members were asked how often they were able to see doctors or healthcare providers with similar backgrounds, 15% answered "some of the time," and another 15% answered "none of the time," further emphasizing a need to address quality of care in the community.

Figure 33: Some people think it is helpful if their providers are from the same background that they are – like in terms of race or religion or native language –because they think their doctors will better understand what they're experiencing or going through. In the past year, how often were you able to see doctors or healthcare providers who were similar to you in these ways?



Respondents were asked if they have put off or neglected going to the doctor due to distance or transportation, to which nearly 30% of respondents answered yes, further emphasizing that transportation can be a barrier for at least a portion of the community.

Figure 34: Do you put off or neglect going to the doctor because of distance or transportation?



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

Primary Data Findings – Focus Groups

Access to healthcare emerged as a significant concern across all focus groups in Hyde County. Focus group participants consistently highlighted the lack of services available within the county, particularly noting deficiencies in specialty care, maternity care, and home health services. The unavailability of specialty healthcare services means residents often must travel significant distances for care, with participants noting that accessing medical appointments outside the county can require an entire day of travel.

Location-specific concerns and recommendations varied. In Ocracoke, participants emphasized unique challenges related to ferry schedules impacting access to mainland healthcare services, with particular concern about interpreter availability for Spanish-speaking residents seeking care. They suggested utilizing an unused public camper for mobile health services to improve access. The Swanquarter/Scranton group emphasized the need for bolstered EMS services with mental health training

and supplemental care options for older adults. In Fairfield/Engelhard, participants noted that relying on public transportation for medical appointments is especially challenging, often requiring an entire day just for basic healthcare needs.

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

PRIORITY NEED: ALCOHOL/DRUG ADDICTION

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.[30] SUDs often occur in conjunction with other mental illness. In 2023, 16 million (46.9%) young adults aged 18-25 reported having either a SUD or Acute Mental Illness (AMI) in the past year. In that same year, 17.1% (48.5 million) of all U.S. adults were reported as having an SUD.[31] These trends have been increasing in recent years. According to the National Center for Drug Abuse Statistics, in 2018 (3.7%) of all adults aged 18 and older (9.2 million) had both an AMI and at least one SUD.[32] By 2021, this had increased to 13.5% of U.S. adults, with the highest incidence among Multiracial adults.

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

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

[30] Source: American Psychiatric Association (2024). *Addiction and Substance Use Disorders*. Retrieved January 16, 2024, from https://www.psychiatry.org/patients-families/addiction-substance-use-disorders.
[31] Source: SAMHSA (2024). *Highlights from the 2023 National Survey on Drug Use and Health*. Retrieved October 10th, 2024 from https://www.samhsa.gov/data/sites/default/files/reports/rpt42731/2022-nsduh-main-highlights.pdf.
[32] Source: National Center for Drug Abuse Statistics (2023). *Drug Abuse Statistics*. Retrieved January 8th, 2024, from https://drugabusestatistics.org/.
[33] Source: Cleveland Clinic. (2024). Substance Use Disorder (SUD). Retrieved October 1, 2024, from https://my.clevelandclinic.org/health/diseases/16652-drug-addiction-substance-use-disorder-sud
[34] Source: KFF. (2023). Saunders, H., Rudowitz, R. (2023). Will the availability of Over-The-Counter Narcan increase access? Retrieved October 1, 2024 from https://www.kff.org/policy-watch/will-availability-of-over-the-counter-narcan-increase-access/

addition, both drug overdose and suicide deaths have sharply increased over the past several years – often disproportionately impacting younger people and communities of color.[35]

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

Secondary Data Findings

Secondary data analysis revealed a mixed picture of substance use challenges in Hyde County. The percentage of adults reporting excessive drinking (15%) was lower than both state and national averages (18%). Similarly, the county had lower rates of emergency department utilization for opioid use disorder (22 per 100,000 beneficiaries) compared to state (43) and national (41) averages.

The rate of alcohol-involved crash deaths in Hyde County (0.0 per 100,000 population) was lower than both state (2.9) and national (2.3) averages. However, it's important to note that rates for small populations can be unstable and may not fully reflect the scope of the issue. The opioid overdose death rate data was not available for Hyde County due to small numbers that could compromise privacy. Moreover, the county reports having no substance abuse providers or buprenorphine providers, which represents a significant barrier to accessing addiction or substance use services.

Table 19: Substance Use Indicators

Indicator	Hyde County	North Carolina	United States
Percentage of Adults Reporting Excessive Drinking	15%	18%	18%
Opioid Use Disorder Emergency Department Utilization (Rate per 100,000 Beneficiaries)	22	43	41
Alcohol-Involved Crash Deaths, Annual (Rate per 100,000 Population)	0.0	2.9	2.3
Opioid Overdose Death Rate (Crude Rate per 100,000 Population)	N/A	25.1	N/A
Substance Abuse Providers	0.0	25.0	27.9

[35] 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.

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

(Rate per 100,000 Population)			
Buprenorphine Providers (Rate per 100,000 Population)	0.0	15.2	15.5

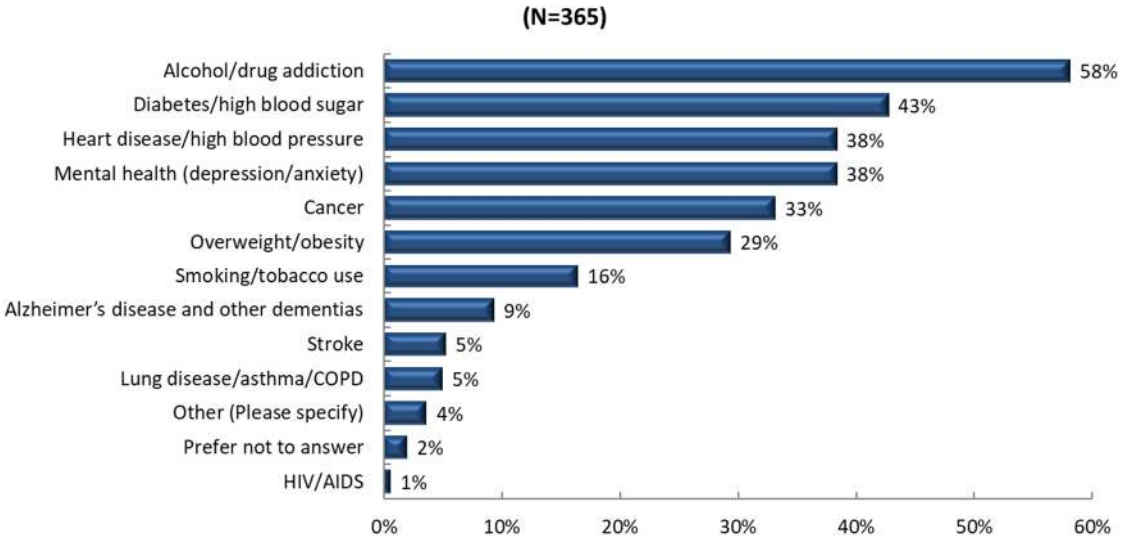
The county's crude death rate for deaths of despair, which includes deaths from drug and alcohol poisoning as well as suicide, was significantly higher (83.0 per 100,000 population) than both state (58.7) and national (55.9) averages, suggesting that substance use may have severe consequences for county residents despite lower reported rates of use and emergency department visits.

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

Primary Data Findings – Community Member Web Survey

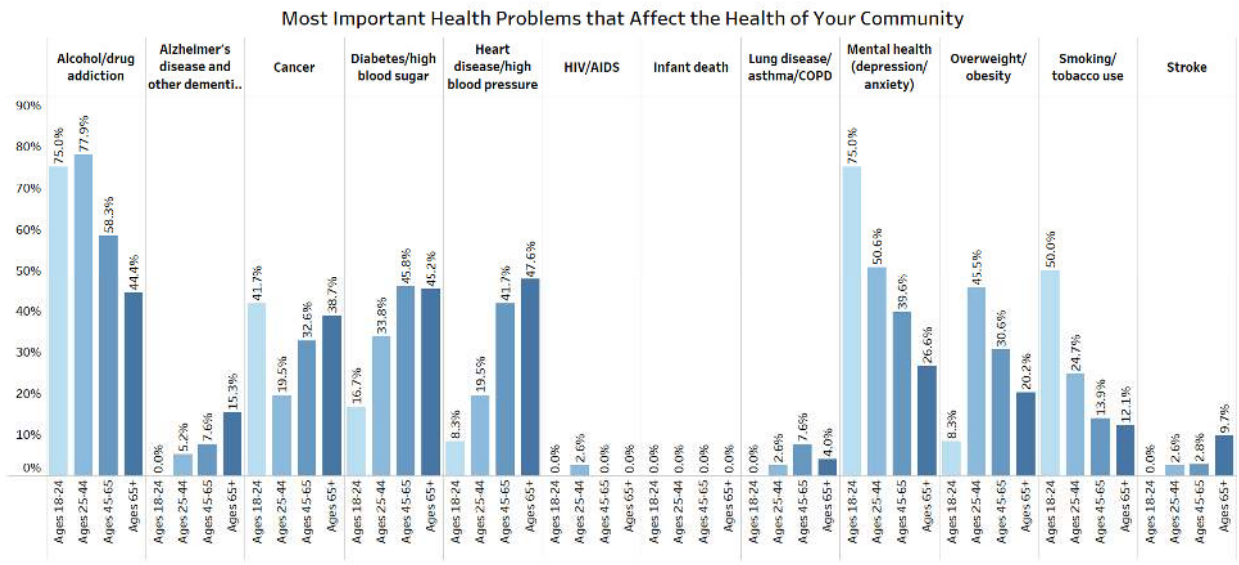
Hyde County residents also highlighted substance use as an area of community concern on the web-based survey. When asked to identify the most important community health needs, 58% of respondents identified alcohol/drug addiction, the most frequent of all the community health needs identified.

Figure 35: What are the three most important health problems that affect the health of your community? Please select up to three.



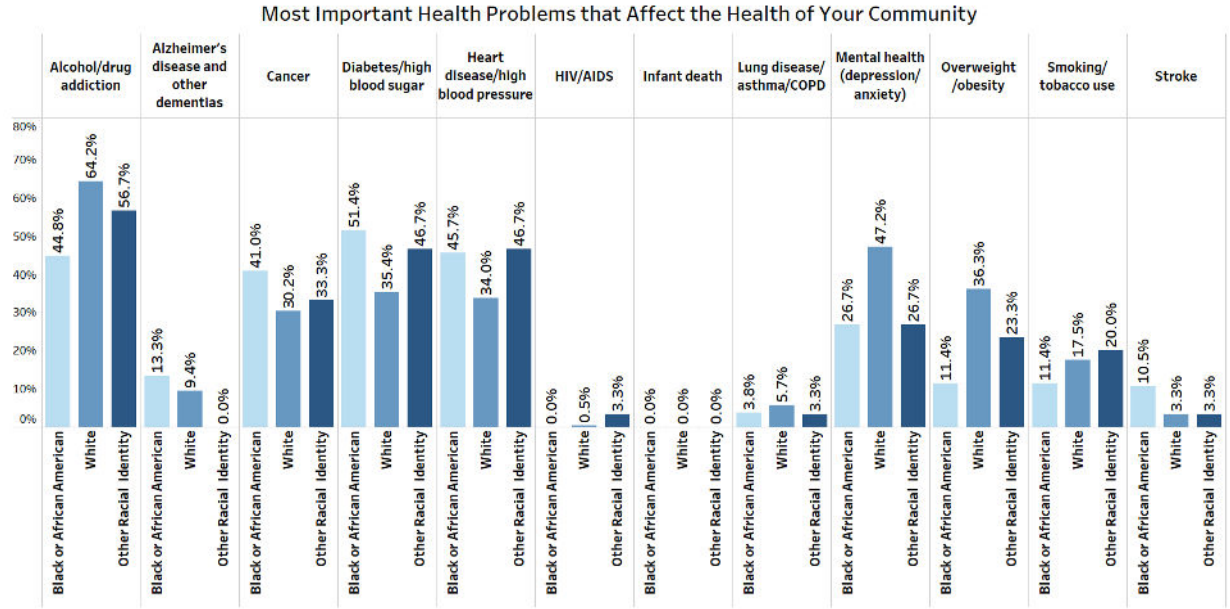
When these data were examined by the demographics of the community respondents, key differences emerged, especially by age. The youngest and second youngest cohorts of respondents, ages 18 to 24 and 25 to 44, were more likely than all other age groups to identify alcohol/drug addiction as an important health problem in the community, as displayed in the figure below. In fact, 75% and 78% of respondents in these age groups identified alcohol/drug addiction as a top concern, respectively.

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



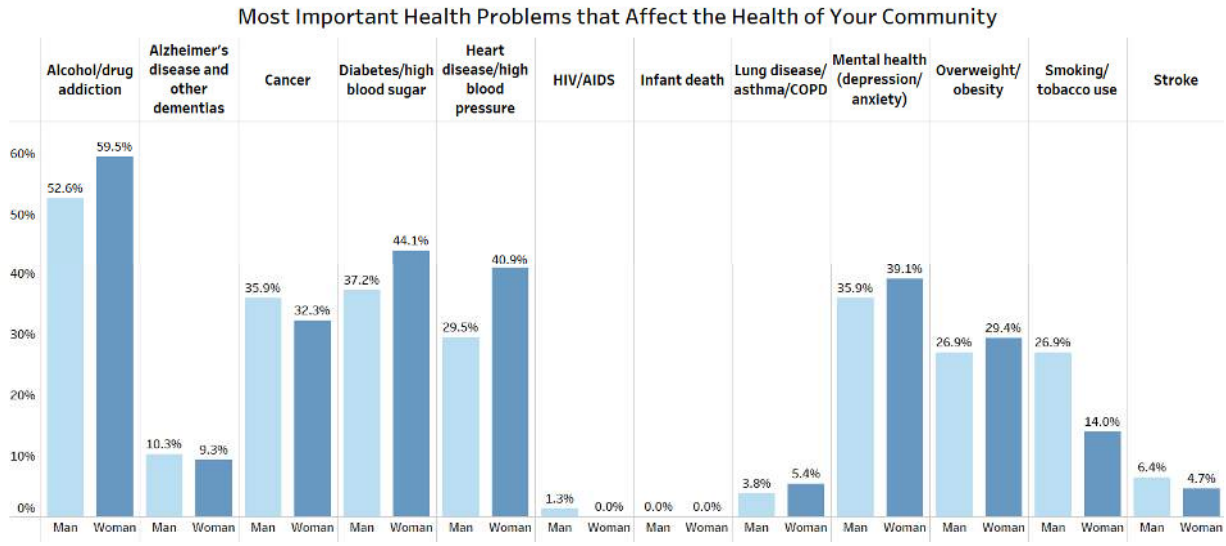
Alcohol/drug addiction was more frequently identified by respondents who identified as White (64%) than by respondents who identified as Black/African American (45%) or as all other racial identities (57%).

Figure 37: What are the three most important health problems that affect the health of your community? Please select up to three. (by race)



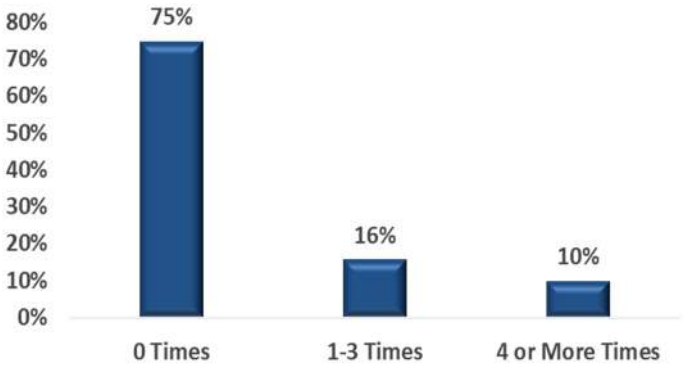
By gender, more women (60%) selected alcohol/drug addiction as a problem than men (53%). These perceived differences by demographic characteristics may be important in planning efforts to address substance use in the community.

Figure 38: What are the three most important health problems that affect the health of your community? Please select up to three. (by gender)



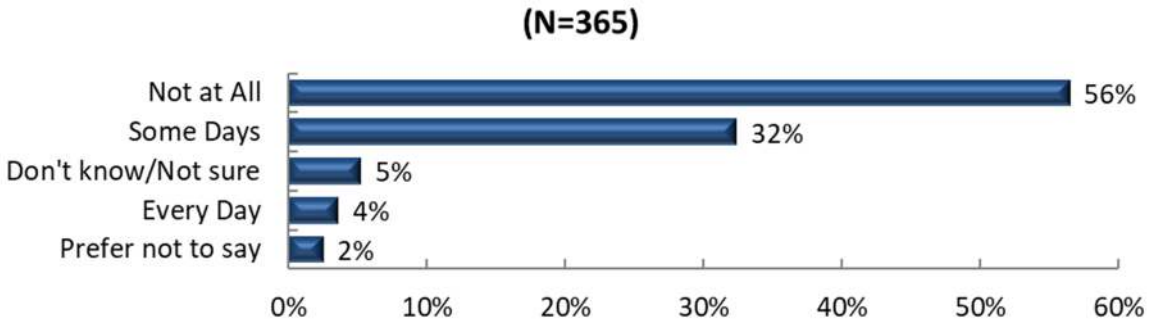
When respondents were asked about their own substance use, one-quarter of respondents reported drinking enough to meet the definition of "binge drinking" at least once in the past 30 days, with an average of one occasion of binge drinking in the past month among all respondents.

Figure 39: Considering all types of alcoholic beverages, how many times during the past 30 days did you have 4 (females)/ 5 (males) or more drinks on an occasion?



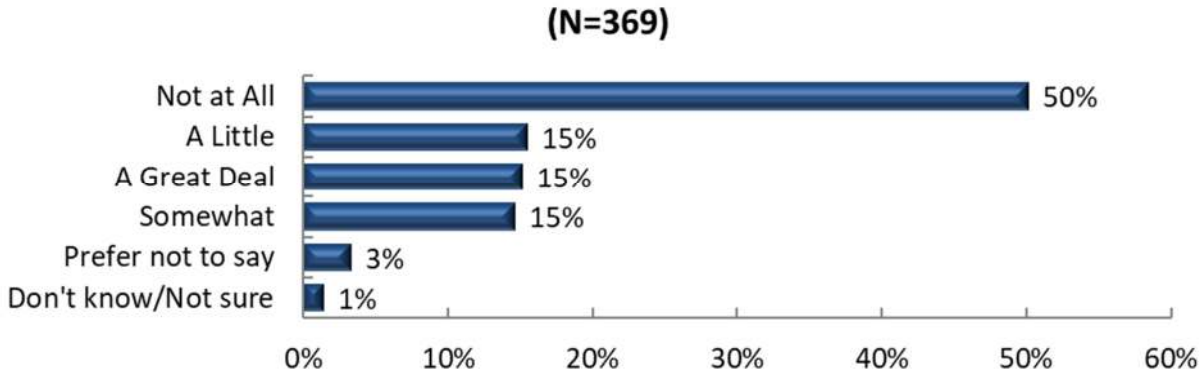
Of those respondents that they do drink alcohol, 32% reported a frequency of "some days," and 4% noted that they drink alcohol every day.

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



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, 15% answered "a little", followed by 15% selecting "a great deal," the third most frequent response, highlighting the impact of substance use in the community.

Figure 41: To what degree has your life been negatively affected by your own or someone else's substance abuse issues, including alcohol, prescription, and other drugs?



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

Primary Data Findings – Focus Groups

Substance use disorders, particularly alcoholism, were identified as a significant concern across focus group locations. Participants noted poor community education about addiction and a general lack of knowledge about available resources for treatment and support.

Each location identified distinct challenges and potential solutions. In Ocracoke, participants described alcoholism as "accepted and expected" in the community, noting concerns about confidentiality when seeking services, alcohol-related golf cart accidents, and underage drinking. The Fairfield/Engelhard group emphasized the need for more Narcan education in schools and highlighted the pervasive nature of alcoholism in their community. They recommended expanding community health education classes and making counseling services more accessible. The Swanquarter/Scranton group connected substance use

issues to broader community safety concerns, noting that confidentiality issues with the only local shelter create additional barriers for those seeking help.

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

PRIORITY NEED: HEART DISEASE/HYPERTENSION

Context and National Perspective

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

Chronic diseases, including heart disease and hypertension, are the leading cause of death and disability in the United States.[37] 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.[37] The number of individuals living with a chronic health condition is expected to increase as the U.S. population continues to age. The population over the age of 50 is expected to increase by 61% to 221.1 million people by 2050.[39] Among those 221 million, nearly two-thirds (142.7 million people) are expected to have at least one chronic health condition, with approximately 15 million people living with multiple chronic health conditions.[39]

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.[40] 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.[41] For those living with chronic conditions, the CDC recommends some general steps people can take to manage their diseases. These include taking medications as prescribed by a provider, self-monitoring symptoms as needed (such as conducting home blood sugar checks), and regularly seeing a provider for check-ups.

[37] Source: World Health Organization (WHO) (2023). *Noncommunicable diseases*. Retrieved September 10th, 2024, from: https://www.who.int/news-room/fact-sheets/detail/noncommunicable-diseases.
[38] Source: CDC (2024). *National Center for Chronic Disease Prevention and Health Promotion*. Retrieved September 10th, 2024, from: https://www.cdc.gov/chronic-disease/about/index.html .
[39] Source: Ansah, J.P. & Chiu, T.C., (2022). Projecting the chronic disease burden among the adult population in the United States using a multi-state population model. *Frontiers in Public Health*. Retrieved September 10th, 2024, from: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC9881650/.
[40] Source: CDC (2024). *Preventing chronic diseases: What you can do now*. Retrieved September 10th, 2024 from https://www.cdc.gov/chronic-disease/prevention/index.html
[41] 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.

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[42], accounting for at least two-thirds (50,000) of all annual deaths.[43] Additionally, the population of North Carolina is largely rural, which hinders access to clinical care for these conditions. Finding ways to utilize existing resources to help community members learn about and manage their chronic health conditions is key for improving health outcomes in these areas.

Secondary Data Findings

Secondary data indicated that Hyde County residents face significant challenges related to heart disease and hypertension. The percentage of adults ever diagnosed with coronary heart disease (6.8%) was higher than both state (5.5%) and national (5.2%) averages. Even more concerning, the proportion of adults with hypertension in Hyde County (36.7%) substantially exceeded state (32.1%) and national (29.6%) averages.

Table 20: Chronic Disease-Related Indicators

Indicator	Hyde County	North Carolina	United States
Adults (Age 18+) Ever Diagnosed with Coronary Heart Disease	6.8%	5.5%	5.2%
Adults (Age 18+) with Hypertension	36.7%	32.1%	29.6%
Adults (Age 18+) with High Cholesterol	32.2%	31.4%	31.0%
Adults (Age 18+) Ever Having a Stroke	3.8%	3.1%	2.8%
Adults with BMI > 30.0 (Obese)	18.2%	29.7%	30.1%
Adults (Age 18+) with Poor Dental Health	17.6%	12.0%	13.9%
Percent Reporting Poor or Fair Health	20.3%	14.4%	-

The cardiovascular disease hospitalization rate in Hyde County (11.9 per 1,000 population) was slightly higher than the state average (11.7) and notably higher than the national rate (10.4). However, the county's ischemic stroke hospitalization rate (8.0 per 1,000 population) was lower than the state average (9.5) and equal to the national rate (8.0).

[42] Source: CDC (2022). *North Carolina.* Retrieved October 3, 2024, from https://www.cdc.gov/nchs/pressroom/states/northcarolina/nc.htm

[43] 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.

Table 21: Cancer Incidence and Cardiovascular Disease and Stroke Hospitalizations

Indicator	Hyde County	North Carolina	United States
Cancer Incidence (Rate per 100,000 Population)	404.9	464.4	442.3
Emergency Room Visits (Rate per 1,000 Population)	393	563	535
Cardiovascular Disease Hospitalizations (Rate per 1,000 Population)	11.9	11.7	10.4
Ischemic Stroke Hospitalizations (Rate per 1,000 Population)	8.0	9.5	8.0

Several health behaviors that can impact cardiovascular health were also identified as areas of concern. The county had a higher percentage of physically inactive adults (28.3%) compared to the state average (21.6%). Additionally, Hyde County residents have limited access to exercise opportunities, with only 53% of the population having access compared to 73% statewide and 84% nationally. The county also had a lower walkability index score (5) compared to state (7) and national (10) averages. Food insecurity was also a concern for Hyde County residents. The county performed worse on food environment measures, too, including a higher rate of fast-food restaurants per population compared to the state value.

Table 22: Health Behavior Indicators

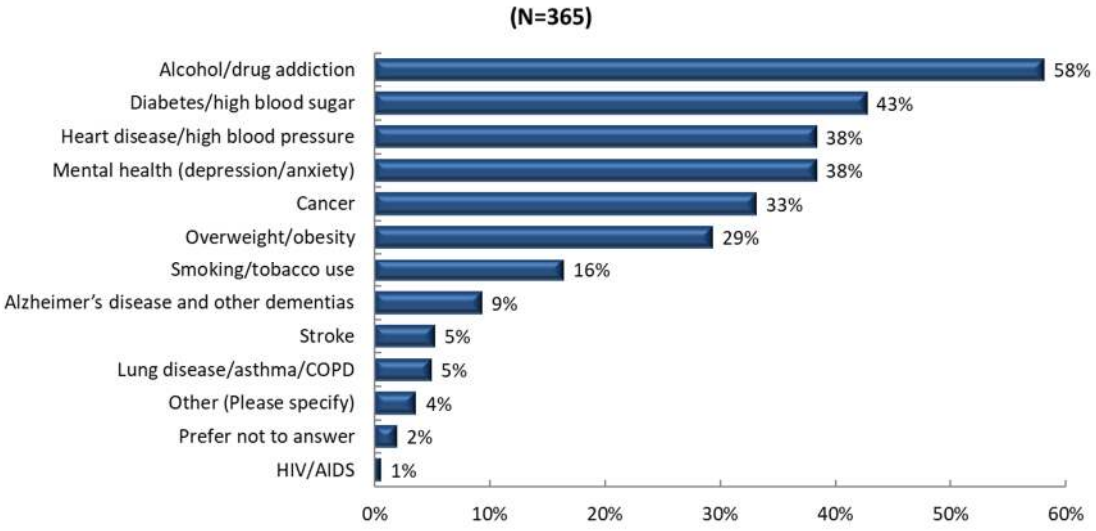
Indicator	Hyde County	North Carolina	United States
% Adults Reporting Currently Smoking	21.6%	15.0	-
% Physically Inactive	28.3	21.6	-
Recreation and Fitness Facility Establishments, (Rate per 100,000 Population)	N/A	13.1	14.7
Walkability Index Score	5	7	10
Percentage of Population with Access to Exercise Opportunities	53%	73%	84%
Food Insecurity Rate	14.9%	11%	10%
Child Food Insecurity Rate	22.3%	15%	13%
Percent Low Income Population with Low Food Access	66.2%	21%	19%
Food Environment - Fast Food Restaurants Establishments (Rate per 100,000 Population)	65.4	77.4	96.2
Food Environment - Grocery Stores Establishments (Rate per 100,000 Population)	N/A	18.7	23.4

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

Primary Data Findings – Community Member Web Survey

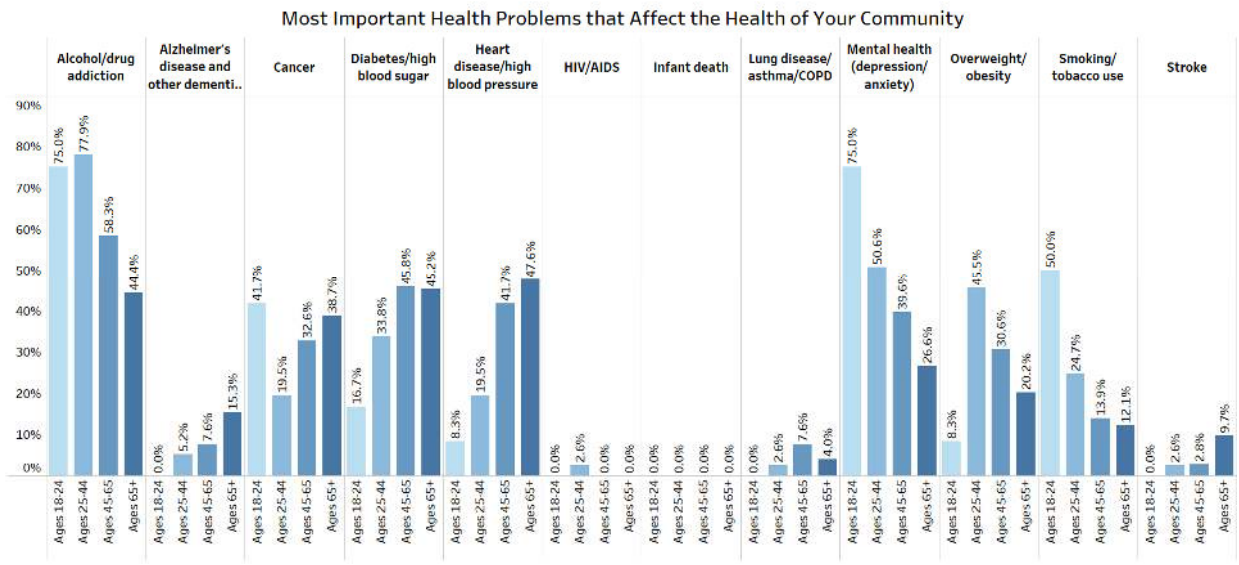
Cardiovascular health concerns identified through various secondary data were also reflected in the responses provided by Hyde County residents, with nearly 40% of respondents indicating heart disease/high blood pressure was a significant problem affecting the community. Among the chronic health conditions identified on the community survey, heart disease/high blood pressure ranked as the third most frequently chosen response.

Figure 42: What are the three most important health problems that affect the health of your community? Please select up to three.



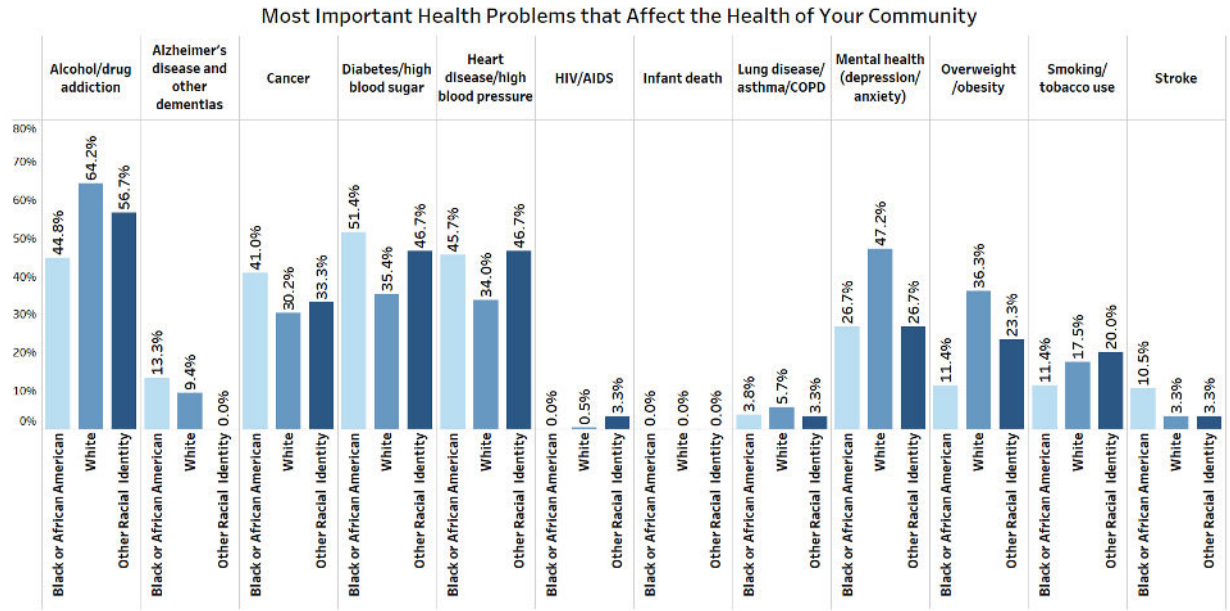
When these results were examined by various demographics of the respondents, responses varied. Older adults viewed heart disease as a more significant problem than younger respondents.

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



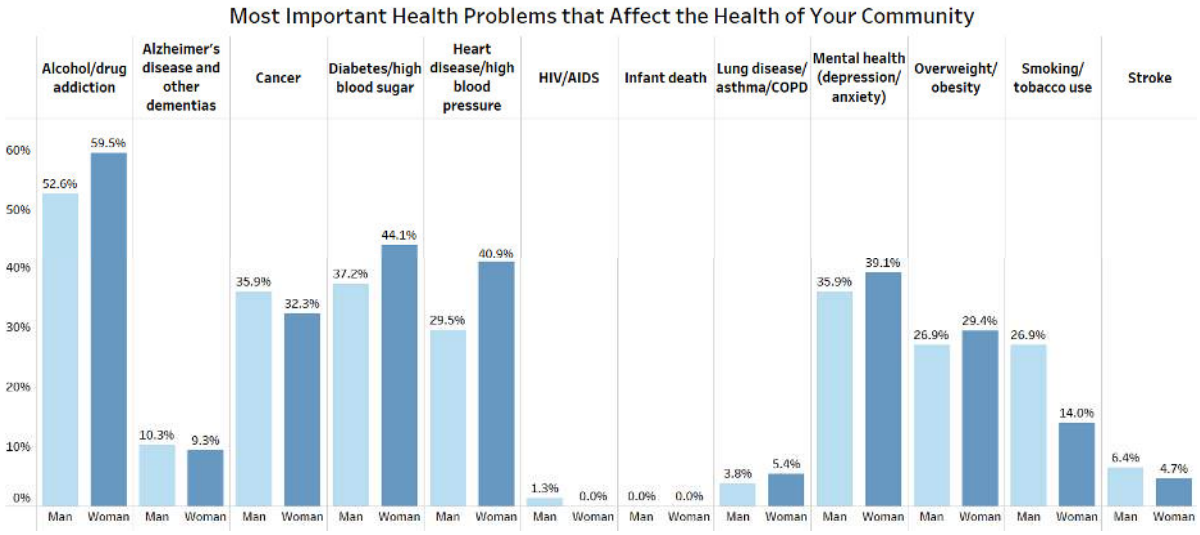
Respondents identifying as all other races and Black or African American identified heart disease/high blood pressure more frequently than respondents identifying as White.

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



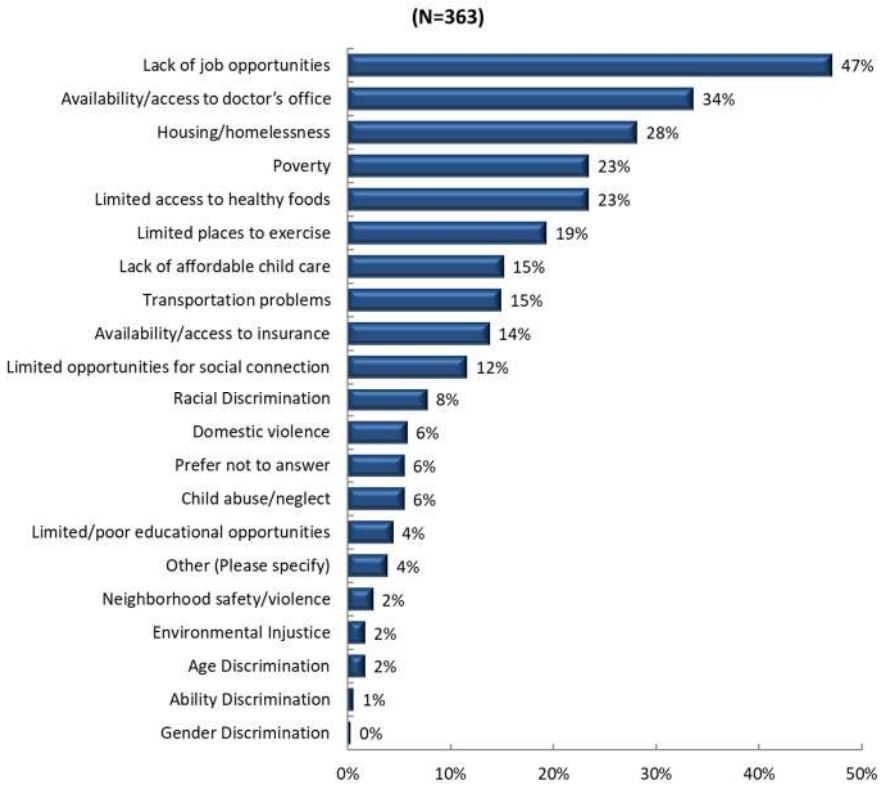
Women were also more likely to identify heart disease as an important community health problem than men. Considering these differences in targeted efforts to address specific community health indicators may be important.

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



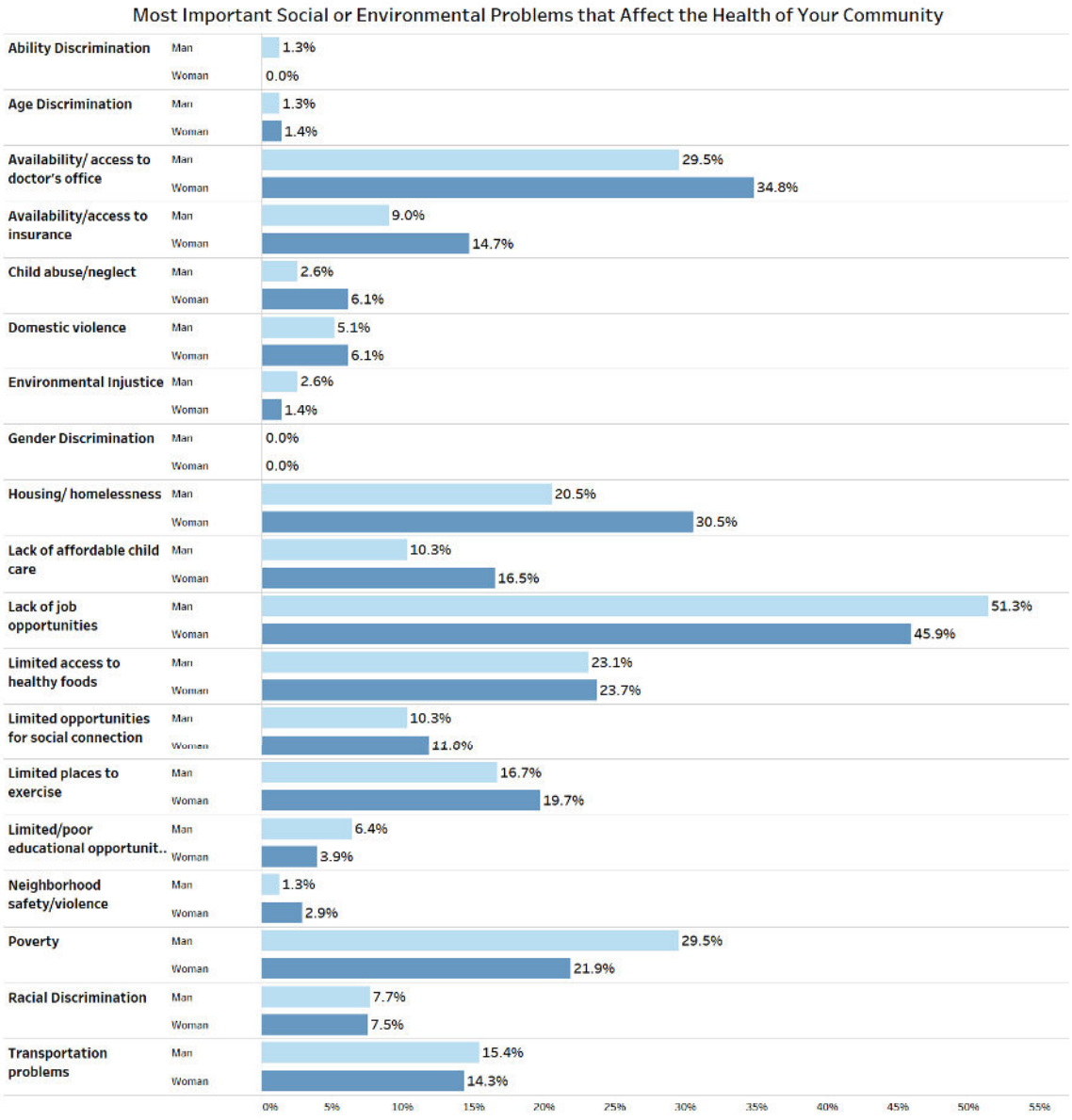
In terms of community perspectives on health behaviors and food security, 23% of Hyde County respondents viewed limited access to healthy foods as an important social or environmental problem in the community and nearly 20% selected limited places to exercise.

Figure 46: What are the three most important social or environmental problems that affect the health of your community? Please select up to three.



Women were slightly more likely to view limited places to exercise as a top concern (20% compared to 17% for men), while both genders were similar in their responses regarding limited access to healthy foods.

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



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

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

Heart disease and high blood pressure were consistently identified as serious health problems across all focus group locations. Participants linked these conditions to broader community challenges, including limited access to healthy foods following the loss of a local grocery store and restricted opportunities for physical activity.

Location-specific discussions revealed varying concerns and suggestions. The Ocracoke group noted that flooding and natural disasters impact opportunities for physical activity, potentially contributing to heart disease risk factors. The Swanquarter/Scranton participants recommended investing in a local YMCA with a pool to provide more exercise opportunities for residents. The Fairfield/Engelhard group emphasized that limited exercise opportunities particularly affect seniors in their community and suggested implementing community health education classes to address chronic health conditions like heart disease.

For a more detailed description of focus group findings, 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.[44] 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.[45] After evaluating data from a variety of sources including surveys and focus groups conducted throughout the assessment process, CHNA stakeholders identified mental health and substance use to be an area of urgent need within Hyde County.

Mental illnesses are common in the United States: in 2021, an estimated 57.8 million U.S. adults – nearly one in five – were living with a mental illness.[46] 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. [47]

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.[48] 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

[44] 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.
[45]Source: CDC. (2024). About mental health. Retrieved October 1, 2024, from: https://www.cdc.gov/mentalhealth/learn/index.htm
[46] Source: National Institute of Mental Health (2023). *Mental Illness*. Retrieved September 13th, 2023, from https://www.nimh.nih.gov/health/statistics/mental-illness.
[47] Source: CDC. (2024). Mental health. Retrieved October 1, 2024, from https://www.cdc.gov/mentalhealth/learn/index.htm
[48] Source: National Institute of Mental Health. (2023). Mental Illness. Retrieved October 1, 2024, from https://www.nimh.nih.gov/health/statistics/mental-illness

condition. As of 2023, over seven million people in the U.S. who reported having a mental illness lived in a rural area.[49]

Mental illness is a prevalent concern in North Carolina, with nearly 1.5 million adults reported to have a mental health condition in 2023. Additionally, that same year, 1 in 7 individuals who were identified as homeless also were living with an SMI. Access to mental health care in North Carolina is changing; however, it is still unavailable to many. Specifically, over 452,000 individuals did not seek care in 2023, with 44.8% citing cost as the main reason. Additionally, those living in North Carolina are seven times more likely to be pushed out of network of their behavioral health providers, than a primary care provider, furthering cost as a cause for stopping treatment. [50]

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

Secondary Data Findings

Secondary data analysis revealed significant mental health challenges in Hyde County. Access to mental healthcare is severely limited in the county, with a mental health provider rate of 0.0 per 100,000 population, compared to state (155.7) and national (178.7) averages. This provider shortage may create significant barriers for residents seeking mental health treatment and support services. County residents reported experiencing an average of 5.0 poor mental health days per month, higher than both the state (4.6) and national (4.9) averages. This suggests that mental health issues may have a significant impact on quality of life for Hyde County residents.

Table 23: Mental Health Indicators

Indicator	Hyde County	North Carolina	United States
Deaths of Despair (Crude Rate per 100,000 Population)	83.0	58.7	55.9
Suicide (Crude Rate per 100,000 Population)	N/A	14.0	14.5
Average Number of Poor Mental Health Days (per Month)	5.0	4.6	4.9

[49] RHI Hub. (2023). Rural mental health. Retrieved October 1, 2024 from: https://www.ruralhealthinfo.org/topics/mental-health
[50] Source: NAMI (2023). *Mental Health in North Carolina.* Retrieved October 10, 2024, from https://www.nami.org/wp-content/uploads/2023/07/NorthCarolinaStateFactSheet.pdf

Mental Health Providers, (Rate per 100,000 Population)	0.0	155.7	178.7

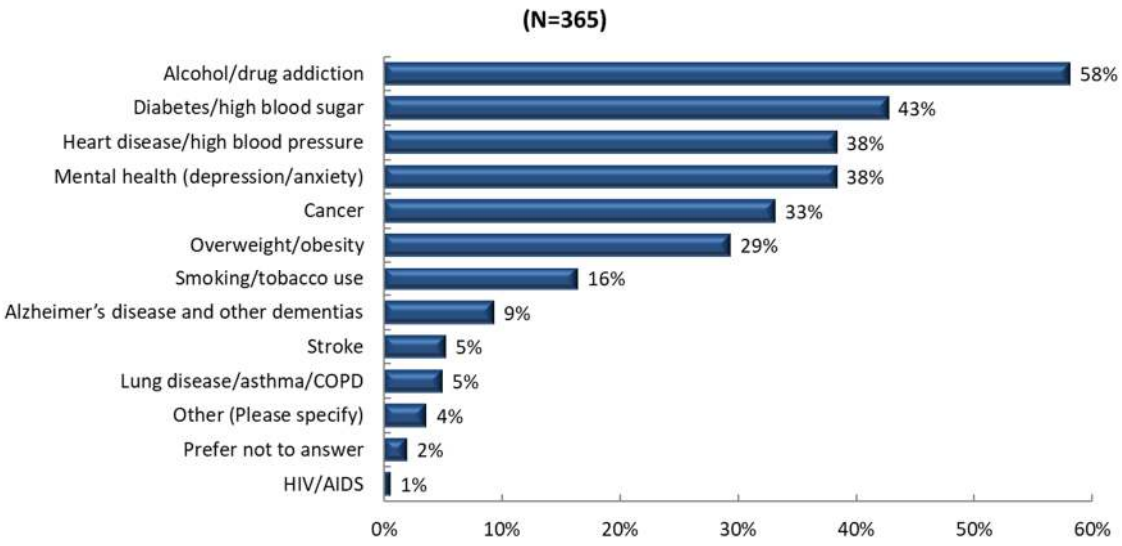
The crude death rate for deaths of despair, which includes deaths from suicide and drug/alcohol poisoning, was substantially higher in Hyde County (83.0 per 100,000 population) compared to both state (58.7) and national (55.9) averages. The suicide mortality rate for Hyde County was suppressed due to small numbers that could compromise privacy.

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

Primary Data Findings – Community Member Web Survey

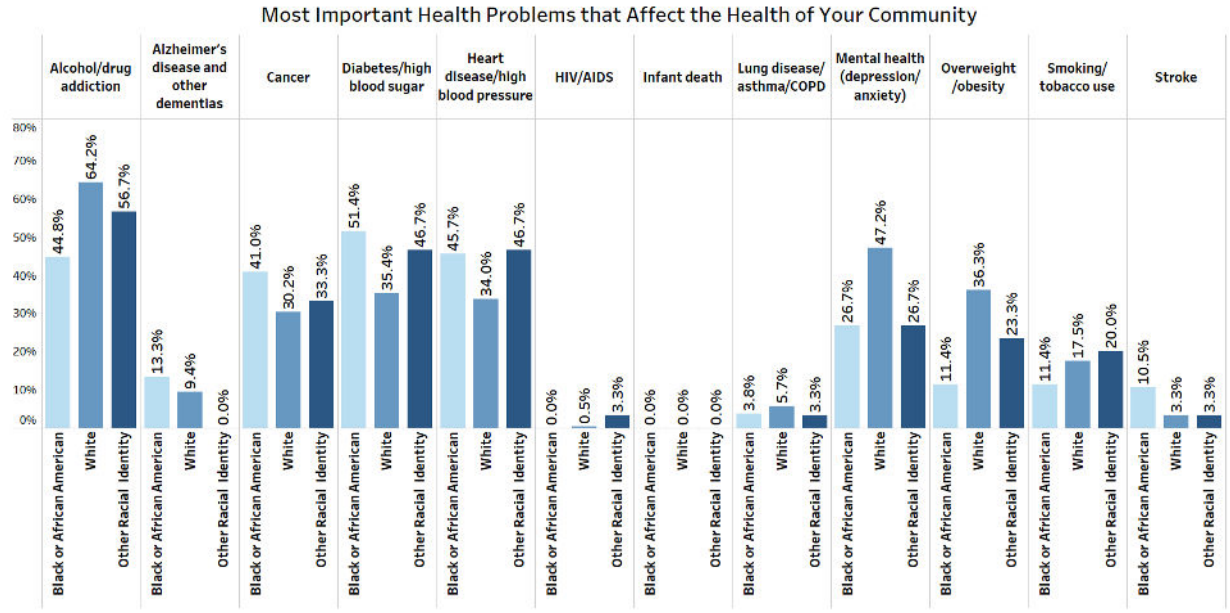
Hyde County residents highlighted different aspects of mental health as areas of community concern on the web-based survey. When asked to identify the most important community health needs, 38% of these respondents identified mental health (depression/anxiety), the fourth most frequent of all community health needs identified.

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



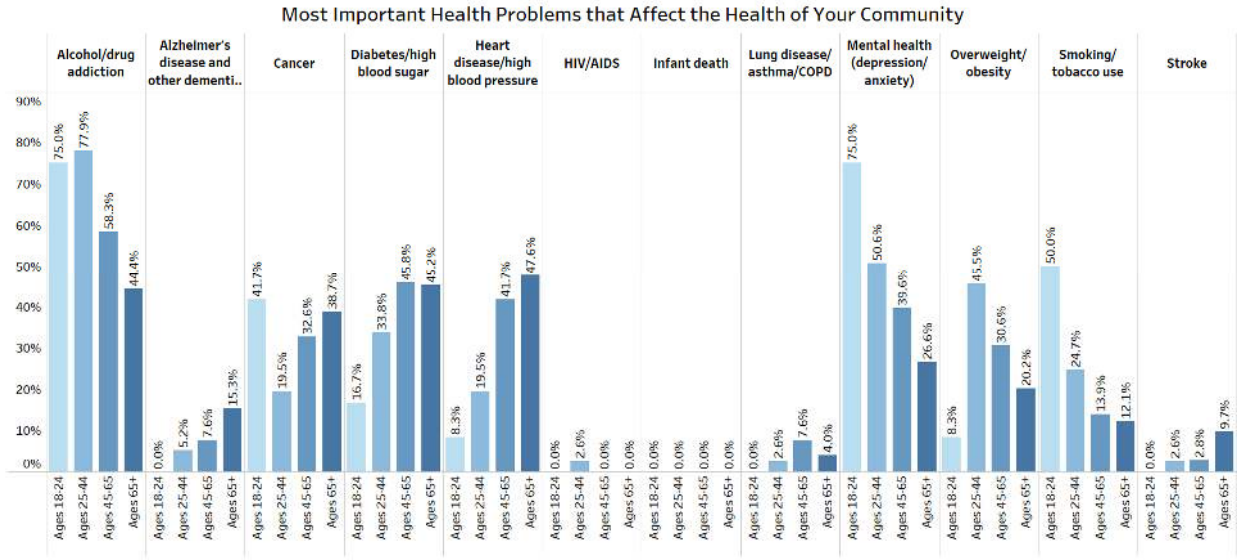
However, when these data were examined by the race of community member respondents, differences emerged. Those who identified as White (47%) selected mental health as an important community health need more frequently than those who identified as Black/African American (27%) or with the other racial category (27%).

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



Similarly, there were differences in responses across age groups. Younger respondents, those ages 18 to 24 (75%) and 25 to 44 (78%), identified mental health as more significant than older respondents.

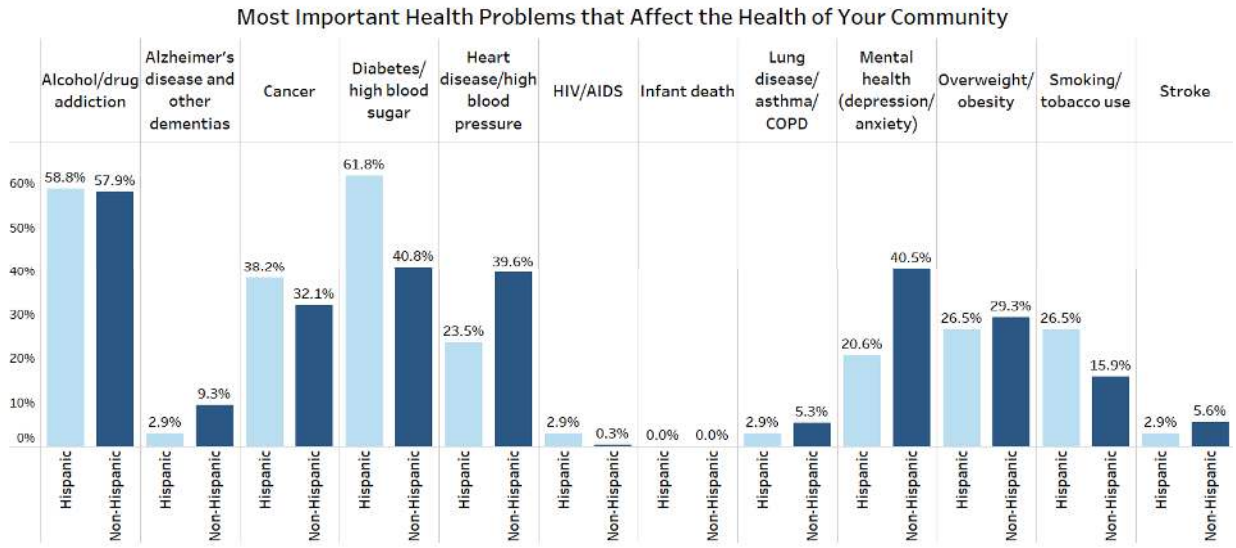
Figure 50: What are the three most important health problems that affect the health of your community? Please select up to three. (by age)



By ethnicity, there were significant differences, with non-Hispanic/Latino respondents (41%) being almost twice as likely to identify mental health as an important health problem than Hispanic/Latino respondents

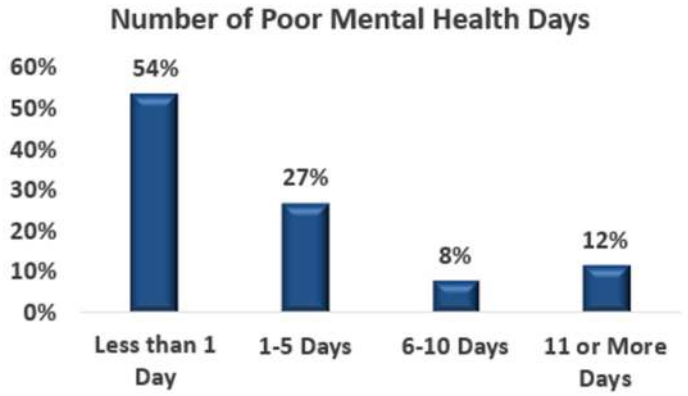
(21%). These perceived differences by demographic characteristics may be important in planning efforts to address behavioral health in the community.

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



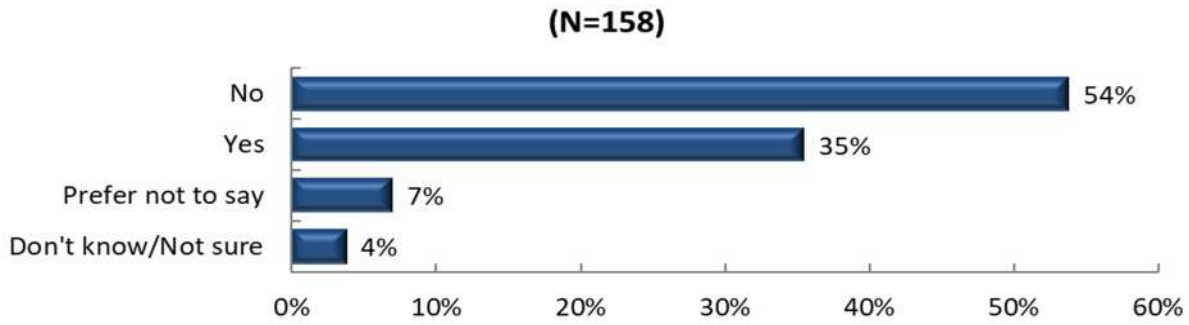
When respondents were asked about their own mental health, nearly half of respondents indicated they had one or more poor mental health days in the past 30 days, with an average of 4 poor mental health days among these respondents.

Figure 52: Now thinking about your mental health, which includes stress, depression, and problems with emotions, for how many days during the past 30 days was your mental health NOT good?



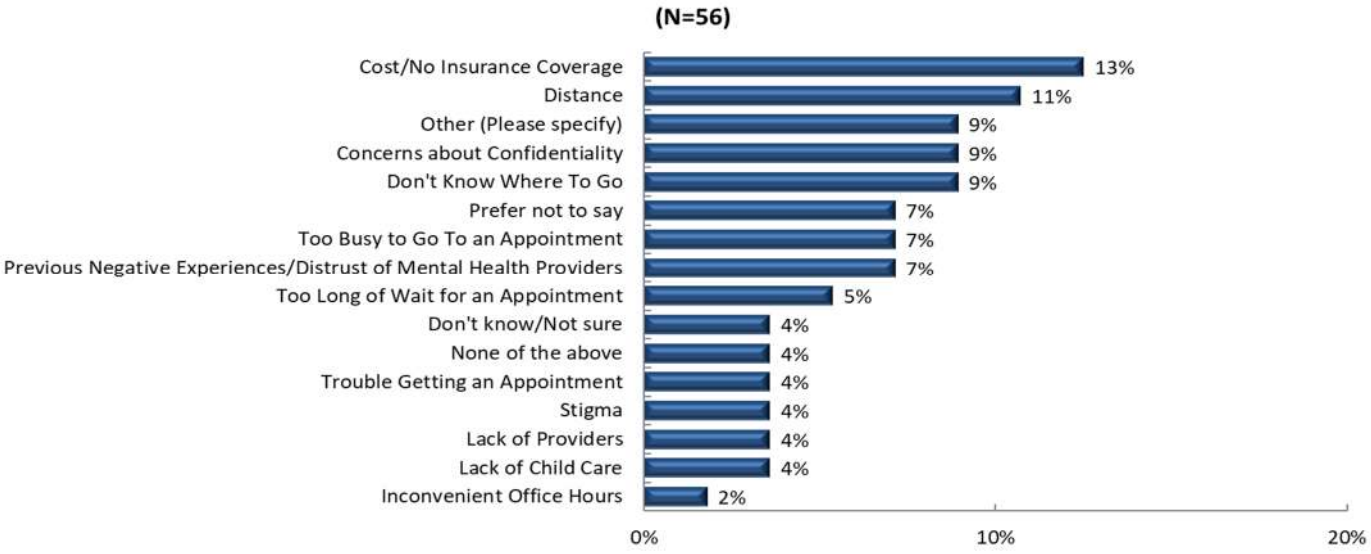
Community member respondents who indicated they experienced at least 1 poor mental health day a month were asked if there was a time in the past 12 months when they needed mental healthcare or counseling but did not get it at that time. More than one-third of these respondents answered yes.

Figure 53: Was there a time in the past 12 months when you needed mental healthcare or counseling, but did not get it at that time?



The top responses for why care was not received for this group included cost/no insurance (13%), distance (11%), and concerns about confidentiality (9%), suggesting accessibility and privacy concerns exist in the community impacting access to needed mental healthcare.

Figure 54: What was the main reason you did not get mental health care or counseling?



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

Primary Data Findings – Focus Groups

Mental health emerged as a significant concern across all focus group locations, with participants consistently noting limited awareness about available services and challenges accessing mental healthcare within the county. Focus group participants emphasized that the lack of local mental health providers creates substantial barriers to care.

Each location identified unique challenges and recommendations. The Ocracoke group suggested utilizing an unused public camper for mobile mental health support services and emphasized the need for better outreach to the Latino community regarding mental health services. The Swanquarter/Scranton participants recommended providing mental health training for EMS services to better respond to crisis situations. The Fairfield/Engelhard group emphasized the need to make counseling services more available and accessible to working families, suggesting expanded hours and locations for mental health services.

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

CHAPTER 4 | HEALTH RESOURCE INVENTORY

NCLHDA requirements for local health departments and IRS requirements for nonprofit hospitals require the CHNA report to include a description of the resources available in a county to address the significant health needs identified in the assessment. This section includes information about local organizations in Hyde County that provide resources to address general community health needs, as well as the county's 2025 priority need areas.

Category	Organization Name
County Resource Directories	• NC 211 • 988 • NCCARE360
Healthcare Facilities	• ECU Health Beaufort Hospital • Hyde County Health Department • Engelhard Medical Center • Ocracoke Health Center
Home-based Health Services	• Meals on Wheels • CenterWell Home Health • Amedysis Home Health & Hospice
Other healthcare services	• Hyde County Behavioral Health • ECU Dental Clinic • Agape Health Services
Community services	• Hyde County Senior Center • BRACE Community Outreach • Food Bank of the Albemarle • Hyde County Transit • Davis Ventures
Priority Need: Access to Healthcare	• Hyde County Health Department • ECU Health Beaufort Hospital • Engelhard Medical Center • Ocracoke Health Center • Outer Banks Hospital
Priority Need: Heart Disease & Hypertension	• Hyde County Health Department • ECU Health Beaufort Hospital • Engelhard Medical Center • Ocracoke Health Center

Priority Need: Behavioral Health (to include Substance Abuse)	• Trillium Health Resources • ECU Health Behavioral Health • Hyde County Behavioral Health • Agape Health Services

CHAPTER 5 | NEXT STEPS

The findings from the Community Health Needs Assessment (CHNA) are instrumental in developing effective strategies to address the identified priority needs. The final steps in the CHNA process involve creating community-based health improvement strategies and making both the CHNA and Implementation Strategies publicly available.

Hospital leaders at ECU Health Beaufort will utilize the CHNA insights to formulate implementation strategies. They will collaborate with community partners to ensure that priority needs are addressed efficiently and effectively. These strategies will include measurable objectives to track progress.

The final CHNA report and Implementation Strategies are available on our public website at https://www.ecuhealth.org/about-us/community/health-needs-assessment/. For further questions or more information, please contact Kelly Ange, Coordinator, Community Health Improvement at ECU Health Beaufort, at kelly.ange@ecuhealth.org.

APPENDIX 1 | STATE OF THE COUNTY HEALTH REPORT

Results-Based Accountability Framework

To meet North Carolina accreditation requirements, LHDs are required to track progress on their implementation plans by publishing an annual State of the County Health Report (SOTCH). The SOTCH is guided by the Clear Impact Results-Based Accountability (RBA) Framework™ and demonstrates that the LHD is tracking priority issues identified in the community health (needs) assessment process, identifying emerging issues, and implementing any relevant new initiatives to address community concerns.[51]

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. ECU Health Hospitals also adopted the RBA framework, leveraging the Clear Impact Scorecard to document and track their improvement efforts. The scorecard mirrors RBA and links results with indicators and programs with performance measures. Hyde County's most recent SOTCH is presented on the following pages.

[51] 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: Hyde County (2021-2023)

ABOUT THE REPORT

The 2021-2023 Hyde County Community Health Improvement Plan (CHIP) provides a detailed description of specific community health goals, as well as the means by which these goals are intended to be achieved. Each goal was designed to address the health needs of the Hyde County community, as identified in the 2021 Community Health Assessment (CHA). These priority health issues include: 1) Mental Health, 2) Substance Use, and 3) Child Abuse/Neglect.

COMMUNITY PARTNERS

The CHA process, from data collection to action planning, brings together a vast array of community partners with the ultimate goal of improving the health and quality of life of Hyde County. These community partners work together to identify priority issues, develop and implement strategies for action, and establish accountability to ensure measurable health improvement, which is outlined in the form of a CHIP. We would like to thank each and every one of our community partners for aligning their efforts and supporting one another for the greater collective impact on the health of Hyde County.

For reference, the 2021 CHA can be found on our website at https://hydehealth.com/services/health-promotion

Community Health Assessment

2021-2024 Community Health Assessment	Time Period	Current Actual Value	Current Trend	Baseline % Change

Mental Health

All Hyde County residents live in communities that foster and support positive mental health.	Time Period	Current Actual Value	Current Trend	Baseline % Change
FHU-NC HNC2030 Suicide Rate (TOTAL) in North Carolina (per 100, 000)	2022	14.4	↗ 1	11% ↗
Percentage of Adults in Hyde County Reporting 14 or More Days of Poor Mental Health per Month (Age-Adjusted)	2023	16%	↘ 1	45% ↗
Average Number of Mentally Unhealthy Days Reported by Hyde County Residents in Past 30 days (Age-Adjusted)	2023	4.5	↘ 1	22% ↗

Telepsychiatry	Time Period	Current Actual Value	Current Trend	Baseline % Change
How much # of Telepsychiatry Visits at Hyde County Behavioral Health	Q4 2023	8	↗ 1	33% ↗

Counseling Services	Time Period	Current Actual Value	Current Trend	Baseline % Change
How much # of Licensed Clinical Counseling Visits at Hyde County Behavioral Health	Q4 2023	12	↗ 1	-74% ↘

Grief Support	Time Period	Current Actual Value	Current Trend	Baseline % Change
# of Grief Support Groups	Q4 2023	5	↗ 1	400% ↗

Substance Use

All Hyde County residents live in communities with equitable access to substance use disorder services.	Time Period	Current Actual Value	Current Trend	Baseline % Change
Drug Overdose Death Rate in North Carolina: Drug Poisoning Deaths (Total) per 100,000 population	2022	42.1	↗ 4	205% ↗
Number of Drug Poisoning Related ED Visits Among Hyde County Residents (2016-2021)	2021	17#	↗ 1	-35% ↘
Number of Cases of Acute Hepatitis C in Hyde County (2016-2021)	2021	0	→ 2	0% →
Rate of Overdose Deaths Among Hyde County Residents, 2010-2021 (rate per 100,000 residents)	2022	20.3	↘ 1	1930% ↗

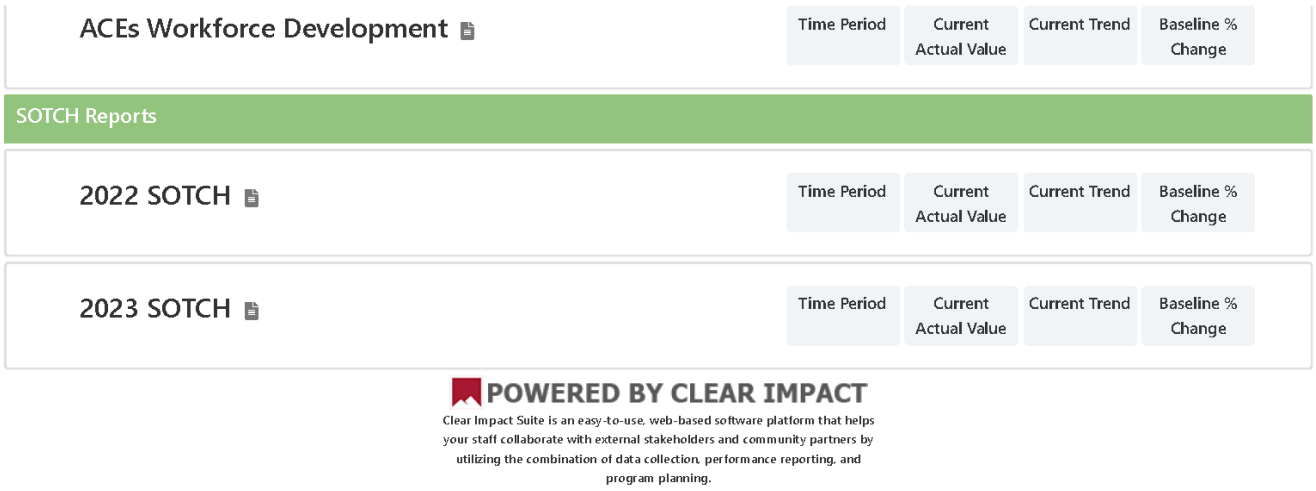
Naloxone Distribution	Time Period	Current Actual Value	Current Trend	Baseline % Change
# of Double-Dose Naloxone Kits Distributed	Q4 2023	53	↗ 1	13% ↗

Peer Support Programming	Time Period	Current Actual Value	Current Trend	Baseline % Change
# of Peer Support Group Participants	Q4 2023	11	↘ 1	-74% ↘
# of Peer Support Groups	Q4 2023	4	↘ 1	300% ↗
# of Narcotics Anonymous Meetings	Q4 2023	15	↘ 1	15% ↗
# of Narcotics Anonymous Participants	Q4 2023	243	↘ 2	465% ↗

Syringe Service Programming	Time Period	Current Actual Value	Current Trend	Baseline % Change
Total Syringe Services Participants	Q4 2023	41#	↗ 1	4000% ↗
# of Fentanyl Test Strips Distributed	Q4 2023	150	↗ 1	3650% ↗
# of Syringes Distributed	Q4 2023	600	↗ 1	-59% ↘
# of Used Syringes Received	Q4 2023	868	↗ 1	-22% ↘

Child Abuse & Neglect

All children in North Carolina thrive in safe, stable, and nurturing environments.	Time Period	Current Actual Value	Current Trend	Baseline % Change
Adverse Childhood Experiences (ACEs): Percent of children in NC (Total) with 2 or more ACEs	2022	18.5%	↗ 3	-22% ↘
Rate of Substantiated Child Abuse & Neglect Reports in Hyde County (per 1,000 population)	2022	8.7	↗ 2	412% ↗
Rate of Investigated Child Abuse & Neglect Reports in Hyde County (per 1,000 population)	2022	62.3	↗ 4	210% ↗
# of Children in Foster Care in Hyde County	2021	12	↗ 1	140% ↗


ACEs Workforce Development
Time Period
Current Actual Value
Current Trend
Baseline % Change
SOTCH Reports
2022 SOTCH
Time Period
Current Actual Value
Current Trend
Baseline % Change
2023 SOTCH
Time Period
Current Actual Value
Current Trend
Baseline % Change
POWERED BY CLEAR IMPACT
Clear Impact Suite is an easy-to-use, web-based software platform that helps your staff collaborate with external stakeholders and community partners by utilizing the combination of data collection, performance reporting, and program planning.

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 Hyde County, its performance on each data measure was compared to targets/benchmarks. If Hyde 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 24: Access to Care

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

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

Table 25: Built Environment

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

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

Table 26: Diet and Exercise

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

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

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

Table 27: 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 28: 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 29: Environmental Quality

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

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

Table 30: 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 31: Food Security

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

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

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

Table 32: Housing and Homelessness

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

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

Table 33: Income

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

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

Table 34: Length of Life

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

Table 35: Maternal and Infant Health

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

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

Table 36: Mental Health

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

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

Table 37: Physical Health

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

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

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

Table 38: Quality of Care

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

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

Table 39: Safety

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

Measure	Description	Data Source	Most Recent Data Year(s)
	Figures are reported as crude rates for the time period of 2018 to 2022. Rates are re-summarized for report areas from county level data, only where data is available. This indicator is relevant because poisoning deaths, especially from drug overdose, are a national public health emergency.	Carolina Data Portal, June 2024.	

Table 40: 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 41: Substance Use Disorders

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

Measure	Description	Data Source	Most Recent Data Year(s)
	report at least one binge drinking episode involving five or more drinks for men and four or more for women over the past 30 days, or heavy drinking involving more than two drinks per day for men and more than one per day for women, over the same time period. Alcohol use is a behavioral health issue that is also a risk factor for a number of negative health outcomes, including: physical injuries related to motor vehicle accidents, stroke, chronic diseases such as heart disease and cancer, and mental health conditions such as depression and suicide. There are a number of evidence-based interventions that may reduce excessive/binge drinking; examples include raising taxes on alcoholic beverages, restricting access to alcohol by limiting days and hours of retail sales, and screening and counseling for alcohol abuse.		
Mortality - Motor Vehicle Crash – Alcohol-Involved (annual rate per 100,000 population)	Crude rate of persons killed in motor vehicle crashes involving alcohol as an annual rate per 100,000 population. Fatality counts are based on the location of the crash and not the decedent's residence. Motor vehicle crash deaths are preventable and are a leading cause of death among young persons.	U.S. Department of Transportation, National Highway Traffic Safety Administration, Fatality Analysis Reporting System. Data accessed via the North Carolina Data Portal, June 2024.	2018-2022
Opioid Use Disorder (per 100,000 Medicare beneficiaries)	Rate of emergency department utilization for opioid use and opioid use disorder among the Medicare population. Figures are reported as age-adjusted to year 2000 standard. Rates are re-summarized for report areas from county level data, only where data is available. This indicator is relevant because mental health and substance use is an indicator of poor health.	CMS, Mapping Medicare Disparities Tool. Data accessed via the North Carolina Data Portal, June 2024.	2021
Mortality – Opioid Overdose (per 100,000 population)	Five-year average rate of death due to opioid drug overdose per 100,000 population. Figures are reported as crude rates for the time period of 2018 to 2022. Rates are re-	CDC – NVSS. Data accessed via the North Carolina Data Portal, June 2024.	2018-2022

Measure	Description	Data Source	Most Recent Data Year(s)
	summarized for report areas from county level data, only where data is available. This indicator is relevant because opioid drug overdose is the leading cause of injury deaths in the United States, and they have increased dramatically in recent years.		

Table 42: 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 43: 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

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 Hyde County compares to North Carolina and the national benchmark. If both statewide North Carolina and national data were available, North Carolina data was preferentially used as the target/benchmark value.

Secondary Data Summary Table Color Comparisons

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

(Hyde 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:

(30.1-7.5)/(7.5) x 100% = 301.3% = Displayed as **High Priority Level**, Shaded in Red

This metric indicates that the percentage of the population with limited access to healthy foods in Hyde County is 301.3 percent worse (or, in this case, higher) than the percentage of the population with limited access to healthy foods in the state of North Carolina.

Detailed Focus Area Benchmarks

Table 44: Access to Care

Measure	National Benchmark	North Carolina Benchmark	Hyde County Data	Most Recent Data Year	Hyde County Need
Primary Care Providers Ratio	112.4	101.1	65.4	2024	High
Mental Health Providers Ratio	178.7	155.7	0.0	2024	High
Addiction/Substance Abuse Providers Ratio	27.9	25.0	0.0	2024	High
Buprenorphine Providers Ratio	15.5	15.2	0.0	2023	High
Dental Health Providers Ratio	39.1	31.5	0.0	2024	High
% Living in Health Professional Shortage Areas (HPSAs) – Dental Care	17.8%	34.0%	100.0%	2018-2022	High
Federally Qualified Health Centers (FQHCs)	3.5	4.1	43.6	2023	Low
% Receiving Medicaid	22.3%	20.2%	34.9%	2018-2022	High
% Uninsured	10.2%	12.5%	19.5%	2022	High

Table 45: Built Environment

Measure	National Benchmark	North Carolina Benchmark	Hyde County Data	Most Recent Data Year	Hyde County Need
Broadband Access (Access to DL Speeds >= 25MBPS and UL Speeds >= 3 MBPS)	93.8%	93.6%	18.3%	2023	High
Broadband Access (Access to DL Speeds >= 100MBPS and UL Speeds >= 20 MBPS)	91.2%	90.4%	0.1%	2023	High
Households with No Computer	6.1%	6.9%	17.3%	2018-2022	High

Measure	National Benchmark	North Carolina Benchmark	Hyde County Data	Most Recent Data Year	Hyde County Need
Households with No or Slow Internet	11.7%	13.0%	29.5%	2018-2022	High
Liquor Stores	13.3	6.2	Suppressed	2022	N/A
Adverse Childhood Experiences (ACEs)	N/A	N/A	18.5%	2022	N/A

Table 46: Diet and Exercise

Measure	National Benchmark	North Carolina Benchmark	Hyde County Data	Most Recent Data Year	Hyde County Need
% Physically Inactive	N/A	21.6%	28.3%	2021	High
Walkability Index Score	10	7	5	2021	High
% with Access to Exercise Opportunities	84.1%	73.0%	53.0%	2023	High
Recreation and Fitness Facility Access	14.8	13.1	Suppressed	2022	N/A
Sugar-Sweetened Beverage (SSB) Consumption	N/A	N/A	Suppressed	2022	N/A

Table 47: Education

Measure	National Benchmark	North Carolina Benchmark	Hyde County Data	Most Recent Data Year	Hyde County Need
% Limited English Proficiency	8.2%	4.6%	4.5%	2018-2022	Medium
High School Graduation Rate	81.1%	87.6%	95.2%	2020-2021	Low
% with No High School Diploma	10.9%	10.6%	19.0%	2018-2022	High
Student Math Proficiency	63.9%	65.8%	72.3%	2020-2021	High
Student Reading Proficiency	60.1%	59.5%	53.5%	2020-2021	Low
School Funding Adequacy	N/A	-$4,742	-$3,929	2021	Low
School Funding Adequacy –	N/A	$10,655	$21,562	2021	Low

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

Table 48: Employment

Measure	National Benchmark	North Carolina Benchmark	Hyde County Data	Most Recent Data Year	Hyde County Need
Unemployment Rate	3.9%	3.7%	4.3%	2024	High
Average Annual Unemployment Rate, 2013-2023	3.6%	3.5%	5.8%	2024	High

Table 49: Environmental Quality

Measure	National Benchmark	North Carolina Benchmark	Hyde County Data	Most Recent Data Year	Hyde County Need
Flood Vulnerability	6.5%	4.9%	96.1%	2011	High
Drinking Water Safety	16,107	194	0	2023	Low

Table 50: Family, Community and Social Support

Measure	National Benchmark	North Carolina Benchmark	Hyde County Data	Most Recent Data Year	Hyde County Need
Children Cost Burden	28.8%	27.0%	34.0%	2023	High
% Young People Not in School or Working	6.9%	7.5%	35.8%	2018-2022	High

Table 51: Food Security

Measure	National Benchmark	North Carolina Benchmark	Hyde County Data	Most Recent Data Year	Hyde County Need
% Food Insecure	10.3%	11.4%	14.9%	2021	High
% Food Insecure Children	13.3%	15.3%	22.3%	2021	High
% Low-Income and with Low Food Access	19.4%	21.3%	66.2%	2019	High
% Limited Access to Healthy Foods	N/A	7.5%	30.1%	2019	High
Fast Food Restaurants	96.2	77.4	65.4	2022	Low
Grocery Stores	23.4	18.7	Suppressed	2022	N/A

Table 52: Housing and Homelessness

Measure	National Benchmark	North Carolina Benchmark	Hyde County Data	Most Recent Data Year	Hyde County Need
Renter Costs – Average Gross Rent	$1,366	$1,090	$756	2018-2022	Low
% Severe Housing Cost Burden	14.1%	12.2%	21.7%	2018-2022	High
Assisted Housing Units	413.9	319.2	209.1	2017-2021	Low
% Severe Substandard Housing	18.5%	16.1%	10.7%	2011-2015	Low
% Homeless Children	2.8%	1.9%	11.2%	2019-2020	High

Table 53: Income

Measure	National Benchmark	North Carolina Benchmark	Hyde County Data	Most Recent Data Year	Hyde County Need
Median Family Income	$92,646	$82,890	$51,263	2018-2022	High
Gender Pay Gap	81.0%	83.0%	37.0%	2018-2022	High
% Living Below 100% FPL	12.5%	13.3%	29.9%	2022	High
% Living Below 200% FPL	28.8%	31.6%	51.5%	2018-2022	High
% Children Living Below 200% FPL	37.2%	41.1%	80.8%	2018-2022	High
% Receiving SNAP	12.4%	15.7%	20.4%	2021	High
Children Eligible for Free/Reduced Price Lunch	51.7%	50.8%	70.1%	2022-2023	High

Table 54: Length of Life

Measure	National Benchmark	North Carolina Benchmark	Hyde County Data	Most Recent Data Year	Hyde County Need
Years of Potential Life Lost Rate	N/A	8,853	10,397	2019-2021	High
Premature Age-Adjusted Mortality	N/A	420	471	2019-2021	High
Life Expectancy	77.6	76.6	75.2	2019-2021	Medium

Table 55: Maternal and Infant Health

Measure	National Benchmark	North Carolina Benchmark	Hyde County Data	Most Recent Data Year	Hyde County Need
Births with Late or No Prenatal Care	6.1%	6.9%	Suppressed	2019	N/A
Low Birthweight	N/A	9.4%	8.8%	2016-2022	Low
Infant Mortality Rate	5.7	7.0	Suppressed	2015-2021	N/A

Table 56: Mental Health

Measure	National Benchmark	North Carolina Benchmark	Hyde County Data	Most Recent Data Year	Hyde County Need
Poor Mental Health Days	4.9	4.6	5.0	2021	High
Deaths of Despair Rate	55.9	58.7	83.0	2018-2022	High
Suicide Death Rate	14.5	14.0	N/A	2018-2022	N/A

Table 57: Physical Health

Measure	National Benchmark	North Carolina Benchmark	Hyde County Data	Most Recent Data Year	Hyde County Need
% Poor or Fair Health	N/A	14.4%	20.3%	2021	High
% Adults with Asthma	9.7%	9.8%	10.2%	2022	Medium
% Adults with Heart Disease	5.2%	5.5%	6.8%	2022	High
% Adults with High Blood Pressure	29.6%	32.1%	36.7%	2021	High
% Adults with High Cholesterol	31.0%	31.4%	32.2%	2021	Medium
Diabetes Prevalence	8.9%	9.0%	7.9%	2021	Low
% Adults with Kidney Disease	2.7%	2.9%	3.4%	2021	High
% Stroke	2.8%	3.1%	3.8%	2022	High
Obesity	30.1%	29.7%	18.2%	2021	Low
% Teeth Loss	13.9%	12.0%	17.6%	2022	High
Cancer Incidence Rate	442.3	464.4	404.9	2016-2020	Low
Emergency Room Visits	535	563	393	2022	Low

Measure	National Benchmark	North Carolina Benchmark	Hyde County Data	Most Recent Data Year	Hyde County Need
Heart Disease Hospitalization Rate	10.4	11.7	11.9	2018-2020	Medium
Stroke Hospitalization Rate	8.0	9.5	8.0	2018-2020	Low

Table 58: Quality of Care

Measure	National Benchmark	North Carolina Benchmark	Hyde County Data	Most Recent Data Year	Hyde County Need
Children/adults vaccinated annually against seasonal influenza	44.5%	45.6%	41.2%	2021	High
Preventable Hospital Rate	2,752	2,957	2,505	2021	Low
Readmissions Rate	18.1%	17.6%	17.2%	2022	Medium

Table 59: Safety

Measure	National Benchmark	North Carolina Benchmark	Hyde County Data	Most Recent Data Year	Hyde County Need
Incarceration Rate	1.3%	1.5%	2.0%	2018	High
Juvenile Arrest Rate	13.8	16.0	N/A	2021	N/A
Violent Crime	416.0	365.7	915.9	2015-2017	High
Firearm Death Rate	13.4	15.5	N/A	2018-2022	N/A
Poisoning Death Rate	28.5	31.5	N/A	2018-2022	N/A

Table 60: Sexual Health

Measure	National Benchmark	North Carolina Benchmark	Hyde County Data	Most Recent Data Year	Hyde County Need
Chlamydia Rate	495.0	603.3	244.0	2021	Low
HIV Incidence Rate	12.7	15.5	Suppressed	2022	N/A
Teen Births	16.6	18.2	24.0	2016-2022	High

Table 61: Substance Use Disorders

Measure	National Benchmark	North Carolina Benchmark	Hyde County Data	Most Recent Data Year	Hyde County Need
% Excessive Drinking	18.1%	18.2%	15.3%	2021	Low
% Driving Deaths with Alcohol	2.3	2.9	0.0	2018-2022	Low
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 62: Tobacco Use

Measure	National Benchmark	North Carolina Benchmark	Hyde County Data	Most Recent Data Year	Hyde County Need
% Smokers	14.5%	15.0%	21.6%	2021	High

Table 63: Transportation Options and Transit

Measure	National Benchmark	North Carolina Benchmark	Hyde County Data	Most Recent Data Year	Hyde County Need
% Households with No Motor Vehicle	8.3%	5.4%	2.2%	2018-2022	Low
% Public Transit	3.8%	0.8%	0.7%	2018-2022	High

APPENDIX 4 | PRIMARY DATA METHODOLOGY AND SOURCES

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

Methodologies

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

Focus Groups

The following two focus groups were conducted in person in summer 2024. These groups included representation from key community leaders, non-profit partners, patients, and community members, with over 15 participants providing responses. Focus groups represented the following communities:

- Ocracoke
- Swanquarter/Scranton
- Engelhard/Fairfield

Input was gathered on the following topics:

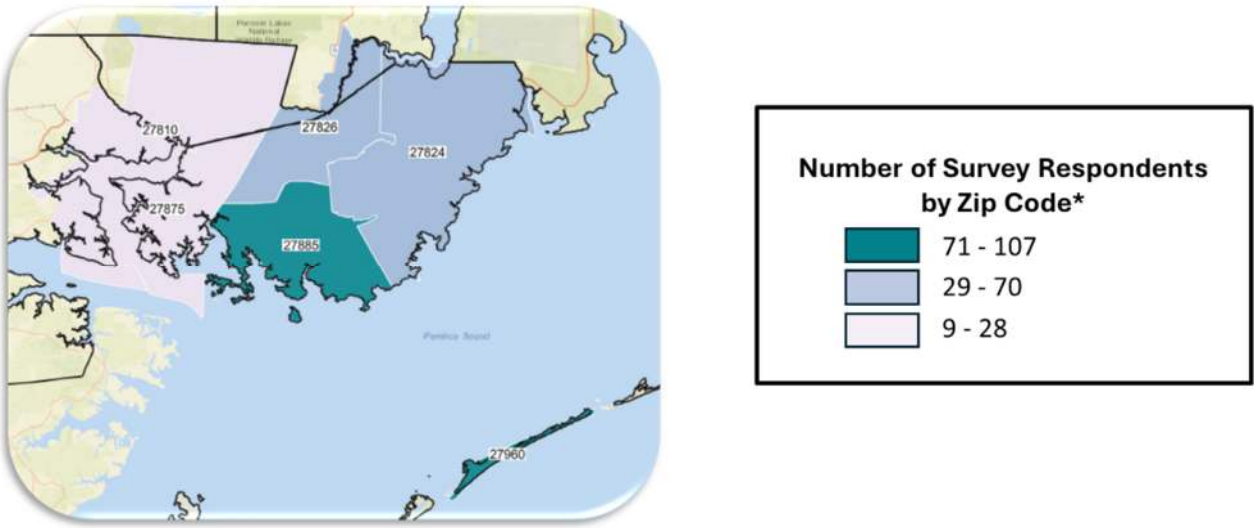
- Community health concerns
- Social and environmental concerns that may impact health
- Access to care
- Other topics of concern for Hyde County

Over half (53.3%) of participants identified as female, and the group was predominantly White (66.7%) and non-Hispanic/Latino (100%). Participants represented a wide range of age groups.

Community Member Web Survey

A total of 373 surveys were completed by individuals living, working or receiving healthcare in the Hyde County community. The survey was available in both English and Spanish, and approximately 7% 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 55: Respondent Zip Code of Residence[52]



In general, survey questions focused on:

- Community health problems and concerns
- Community social/environmental problems and concerns
- Specific topics of interest to Hyde County:
    - Mental health
    - Quality of care
    - Safety
    - Substance use disorders
    - Transportation and transit

The key findings from the Community Survey are detailed below:

- Alcohol/drug addiction, diabetes/high blood sugar, and heart disease/high blood pressure were identified as the top three health problems affecting the community. Over one third of respondents also identified mental health (e.g., depression and anxiety) as important health problems.
- 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 and access to doctor's offices, and housing/homelessness were identified as the top three most important social or environmental problems that affect the health of the community. Limited access to healthy foods and poverty were also identified by almost one in four respondents.

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

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

Figure 56: Respondents by Age Group

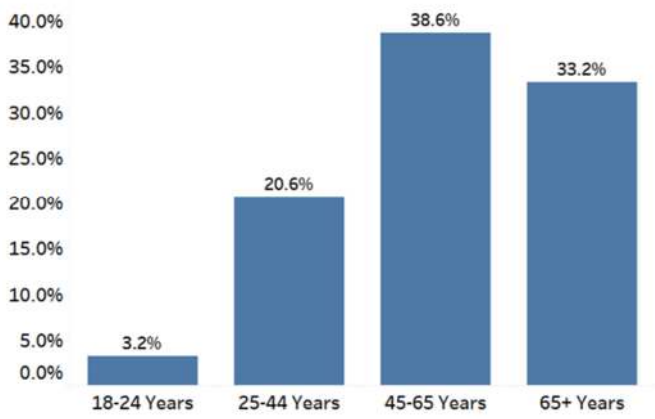


Figure 57: Respondents by Gender

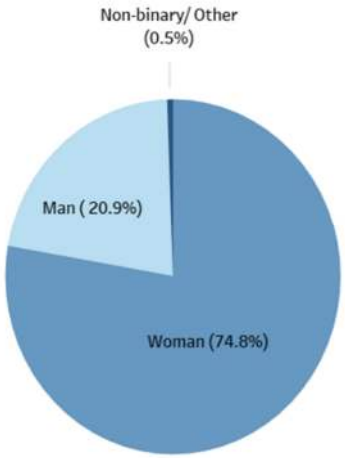


Figure 58: Respondents by Ethnicity

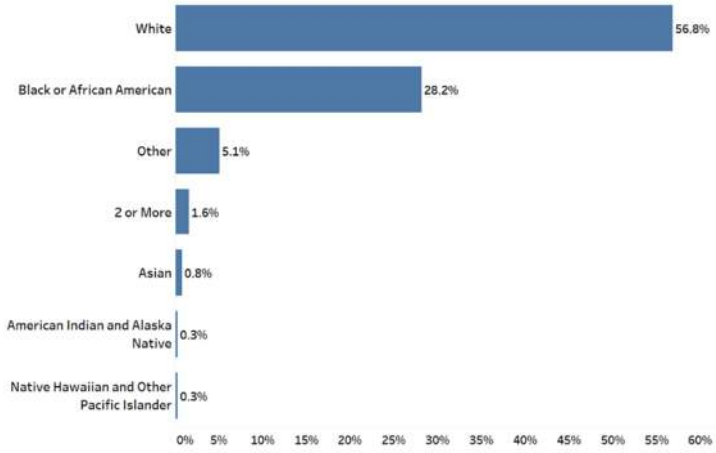
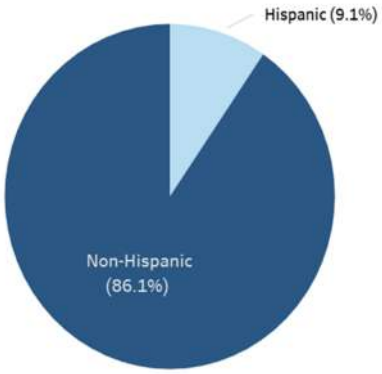


Figure 59: Respondents by Race



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

County name: _____

Date: _____

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?[53]

   □ 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

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

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

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

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

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

Topic: Community Health Opinion Questions

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

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

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

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

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

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

Topic: Mental Health

13. Now thinking about your MENTAL health, which includes stress, depression, and problems with emotions, for how many days during the past 30 days was your mental health NOT good?

□ Number of days: _____

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

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

15. If you answered 'Yes' to the previous question, what was the MAIN reason you did not get mental health care or counseling?

□ Cost/No insurance coverage
□ Distance
□ Don't know where to go
□ Concerns about confidentiality
□ Inconvenient office hours
□ Lack of childcare
□ Lack of providers
□ Lack of transportation
□ Previous negative experiences/Distrust of mental health providers
□ Stigma
□ Too busy to go to an appointment
□ Too long of wait for an appointment
□ Trouble getting an appointment
□ Other *(please specify)*: _____
□ None of the above
□ Don't know/Not sure
□ Prefer not to say

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

□ Yes
□ No
□ Prefer not to say

Topic: Quality of Care

17. 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?	□	□	□	□

18. Thinking about your experiences getting medical care in the past year, how often were you treated with respect by your doctors or health providers?

    □ Always
    □ Most of the time
    □ Some of the time
    □ None of the time
    □ Don't know
    □ Prefer not to say

19. Some people think it is helpful if their providers are from the same background that they are (in terms of things like race or religion or native language) because they think their doctors will better understand what they're experiencing or going through.

    In the past year, how often were you able to see doctors or healthcare providers who were similar to you in any of these ways?

    □ Always
    □ Most of the time
    □ Some of the time
    □ None of the time
    □ Don't know
    □ Prefer not to say

Topic: Safety

20. The following statements describe what your neighborhood might be like. Tell us how much you agree or disagree. 1 = Strongly disagree; 2 = somewhat disagree; 3 = neither agree nor disagree; 4 = somewhat agree; 5 = strongly agree

	1	2	3	4	5	Don't know	Prefer not to say
a. There is a lot of graffiti in my neighborhood.	☐	☐	☐	☐	☐	☐	☐
b. Vandalism is common in my neighborhood.	☐	☐	☐	☐	☐	☐	☐
c. There are lot of abandoned buildings in my neighborhood.	☐	☐	☐	☐	☐	☐	☐
d. There are too many people hanging around on the streets near my home.	☐	☐	☐	☐	☐	☐	☐
e. There is a lot of crime in my neighborhood.	☐	☐	☐	☐	☐	☐	☐
f. There is too much drug use in my neighborhood.	☐	☐	☐	☐	☐	☐	☐
g. There is too much alcohol use in my neighborhood.	☐	☐	☐	☐	☐	☐	☐
h. I'm always having trouble with my neighbors.	☐	☐	☐	☐	☐	☐	☐

21. The following questions ask about safety. Tell us how much you agree or disagree. 1 = Not at all; 2 = A little; 3 = Somewhat; 4 = A lot; 5 = To a great extent

	1	2	3	4	5	Prefer not to say
a. To what extent do you feel safe in your community when you are outside alone during the day?	☐	☐	☐	☐	☐	☐
b. To what extent do you feel safe in your community when you are outside alone at night?	☐	☐	☐	☐	☐	☐

22. How much do you trust your local law enforcement agency?

□ Not at all
□ A little
□ Somewhat
□ A lot
□ To a great extent
□ Prefer not to say

Topic: Substance Use Disorders

23. 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: _____

24. 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

25. 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

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

Topic: Transportation and Transit

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

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

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

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

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

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

APPENDIX 5 | DETAILED PRIMARY DATA FINDINGS

Focus Groups

Key findings from the focus groups are summarized below.

Hyde County Focus Group General Findings

Three focus groups were conducted in Hyde County in June 2024, with a total of 15 community members participating. The focus groups were held in Ocracoke, Swanquarter/Scranton, and Engelhard/Fairfield. Common themes across all groups included concerns related to the built environment, employment/income, healthcare access and quality, housing/homelessness, mental health, and physical health.

All three focus groups identified several common health concerns and barriers to care. First, they identified food access and security as a major issue, noting the loss of a grocery store several years ago has created a food desert, and food pantries lack fresh produce. The second common theme described healthcare access and quality as barriers to receiving care, including a need for home health services, lack of services available in the county, and limited access to specialists and maternity care. Housing and homelessness were also identified as significant challenges, with limited rental options, multiple families living in one dwelling, and affordability issues for both renters and buyers. Lastly, the focus groups identified mental health and physical health as areas of concern, with limited awareness of mental health services and prevalence of chronic health conditions like diabetes, asthma, heart disease, and high blood pressure.

Focus Group 1 Unique Insights: Ocracoke

Six group members participated in a focus group in Ocracoke. Four of the participants identified as female, two identified as male. All participants identified as non-Hispanic and white and were over the age of 28.

Participants in the Ocracoke focus group identified several key health concerns and barriers to care unique to their community. Environmental quality was a major concern, with flooding and natural disasters impacting opportunities for physical activity. Health equity issues were highlighted, particularly regarding the growing divide between white and Latino populations, including language barriers and mistrust in healthcare settings. Substance use, especially alcoholism, was identified as a significant problem that is often "accepted and expected" in the community. Transportation and transit challenges, particularly related to ferry schedules, were also noted as barriers to accessing care and other needed services.

Participants suggested several ways to address these health concerns and barriers to care. They recommended expanding after-school programs offering healthy snacks, improving outreach and engagement with the Latino community, utilizing unused public campers for mobile health or mental health support, and expanding services targeted to older adults.

Focus Group 2 Unique Insights: Scranton/Swan Quarter

Six community members participated in the Scranton/Swan Quarter focus group. Half (3) of the participants identified as female, while the other half identified as male. Four of the participants identified as African American, and two identified as white. All participants were over the age of 29.

The Scranton/Swan Quarter focus group identified unique concerns related to community safety, environmental quality, and employment/income. Community safety issues included domestic violence, confidentiality concerns with the local shelter, mistrust of law enforcement, and child abuse. Environmental quality concerns were centered on water contamination, flooding, and infrastructure issues. Employment and income challenges were highlighted, including a lack of available jobs and childcare options forcing some parents to stay home.

Suggestions for local health leaders included investing in a local YMCA with a pool, bolstering EMS services with mental health training, providing supplemental care for older adults, offering more after-school activities for young people, and providing ESL classes for the Spanish-speaking population.

Focus Group 3 Unique Insights: Fairfield/Engelhard

At the Fairfield/Engelhard focus group, three participants emphasized employment and income issues, noting high poverty rates across the county and childcare challenges for working families. Substance use was another key concern, with participants highlighting poor community education about addiction, the need for more Narcan education in schools, and pervasive alcoholism. Transportation and transit issues were also discussed, with participants noting that relying on public transportation can take an entire day just to get groceries.

To address these concerns, the participants suggested increasing staff engagement in the community, offering childcare and other resources to working families, providing community health education classes, and making counseling services more available.

Community Member Web Survey

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

Topic: Additional Demographic Information

Figure 60: What is the highest grade or year of school you completed?

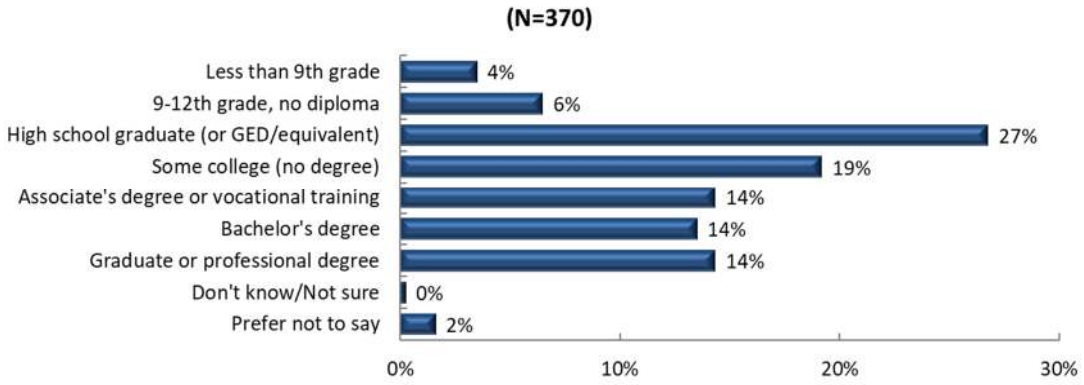
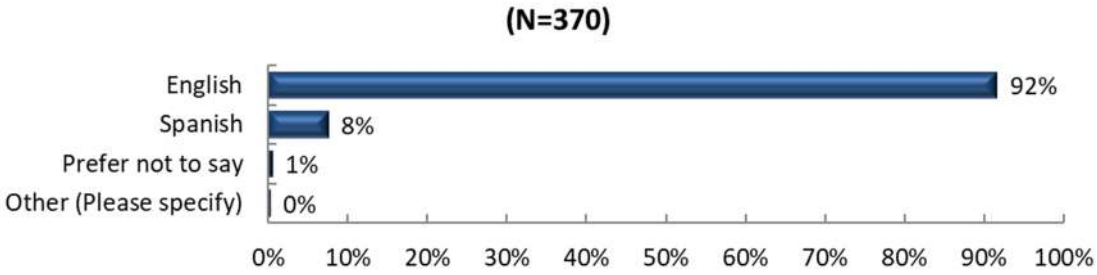


Figure 61: Which language is most often spoken in your home? (Choose one)



Other (please specify):

- "Spanish & English"

Figure 62: For employment, are you currently... (Select all that apply.)

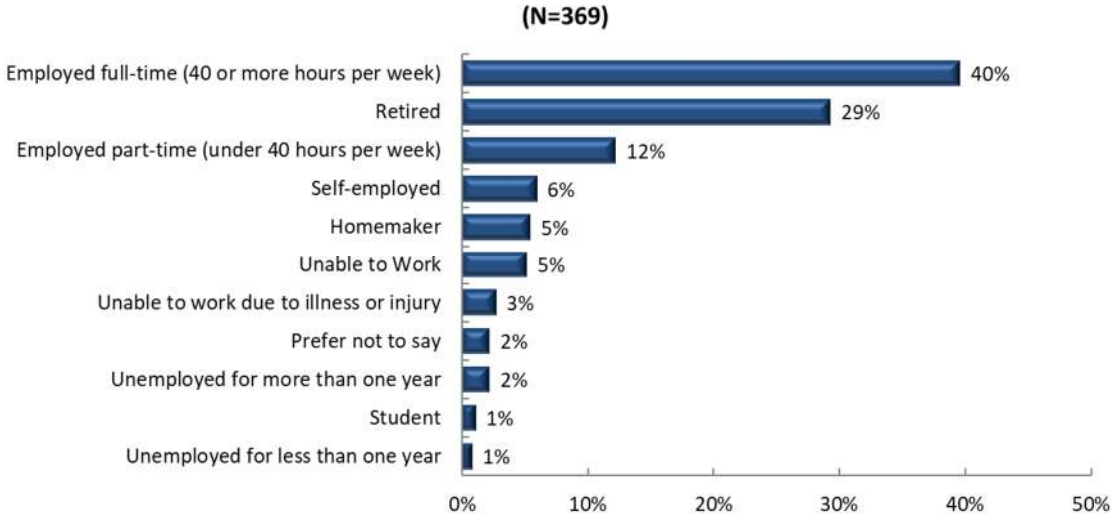
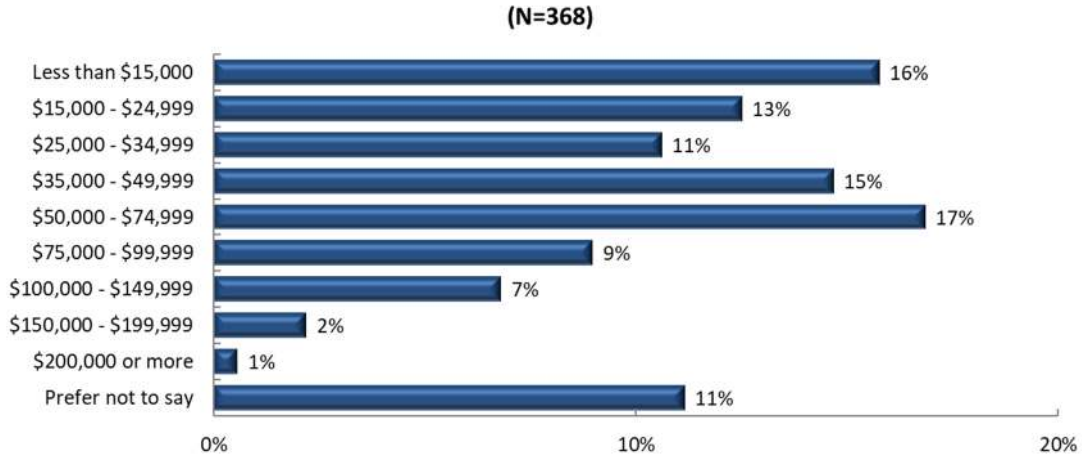


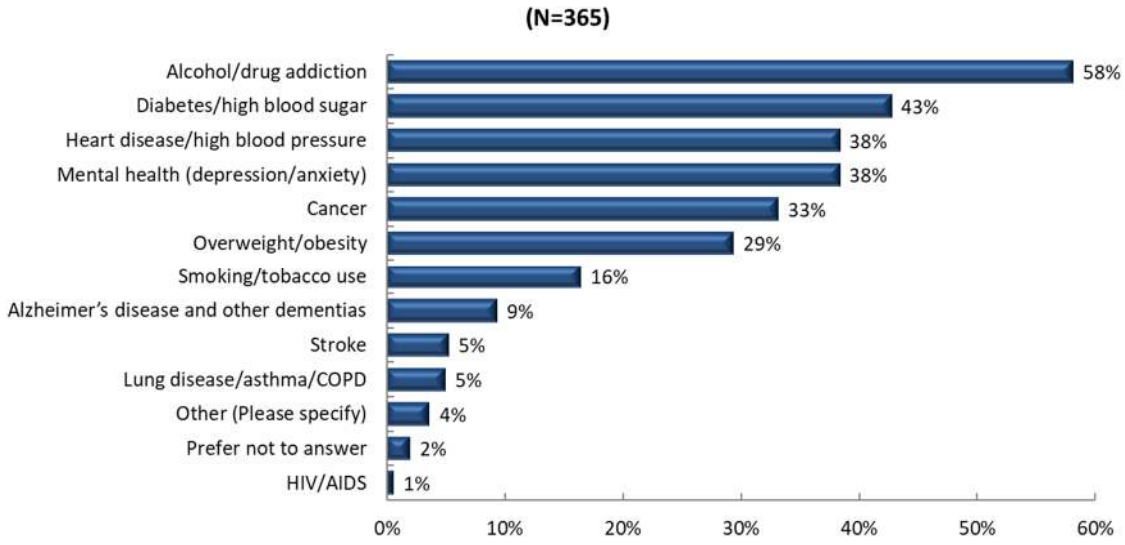
Figure 63: Which category best describes your yearly household income before taxes?

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



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

Figure 64: What are the three most important health problems that affect the health of your community? Please select up to three.



Other (please specify):

- "Cholesterol"
- "COPD"
- "don't know"
- "Hepatitis"
- "Home health care"
- "lupus"
- "Multiple sclerosis"
- "sleep"
- "Taxes cause stress"
- "Teens needing positive things to do - place to hang out safely especially weekend nights"

Figure 65: What are the three most important health problems that affect the health of your community? Please select up to three. (by age)

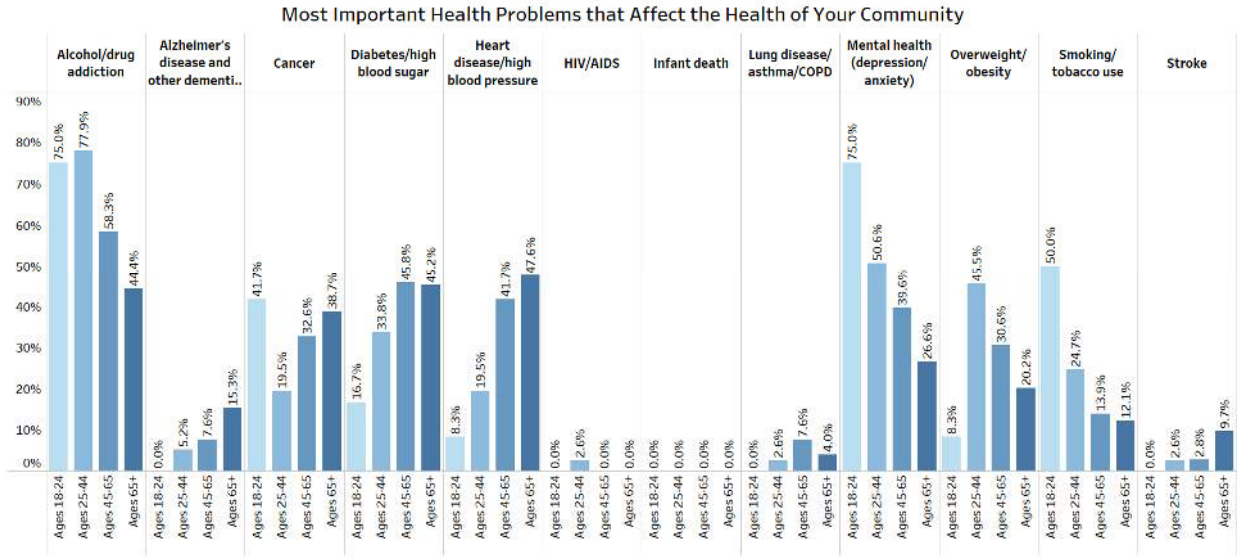


Figure 66: What are the three most important health problems that affect the health of your community? Please select up to three. (by gender)

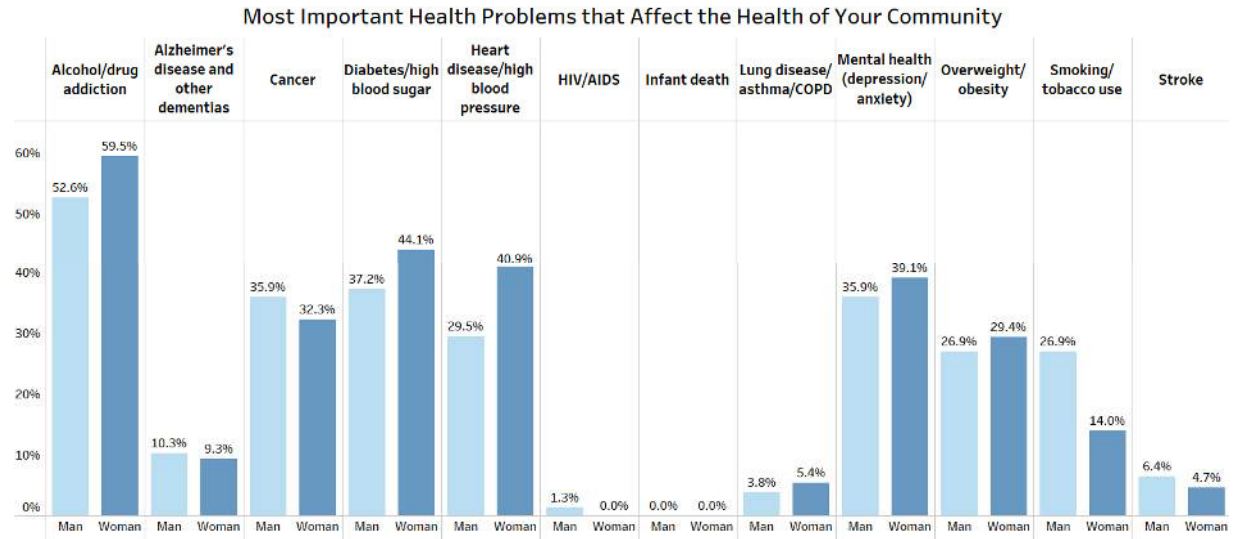


Figure 67: What are the three most important health problems that affect the health of your community? Please select up to three. (by race)

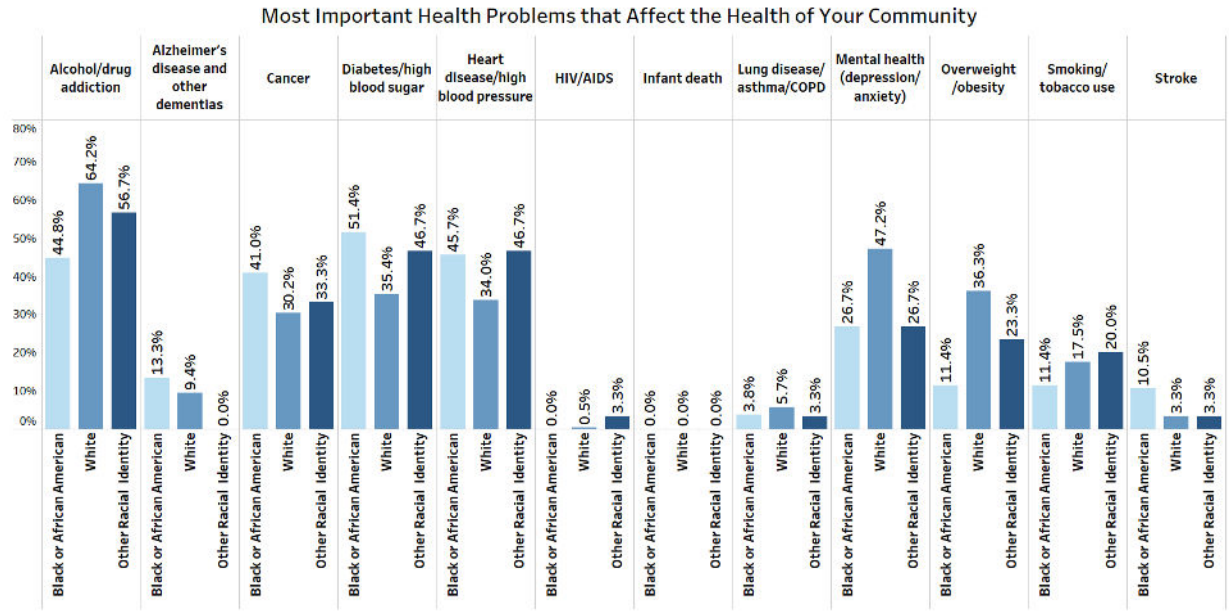


Figure 68: What are the three most important health problems that affect the health of your community? Please select up to three. (by ethnicity)

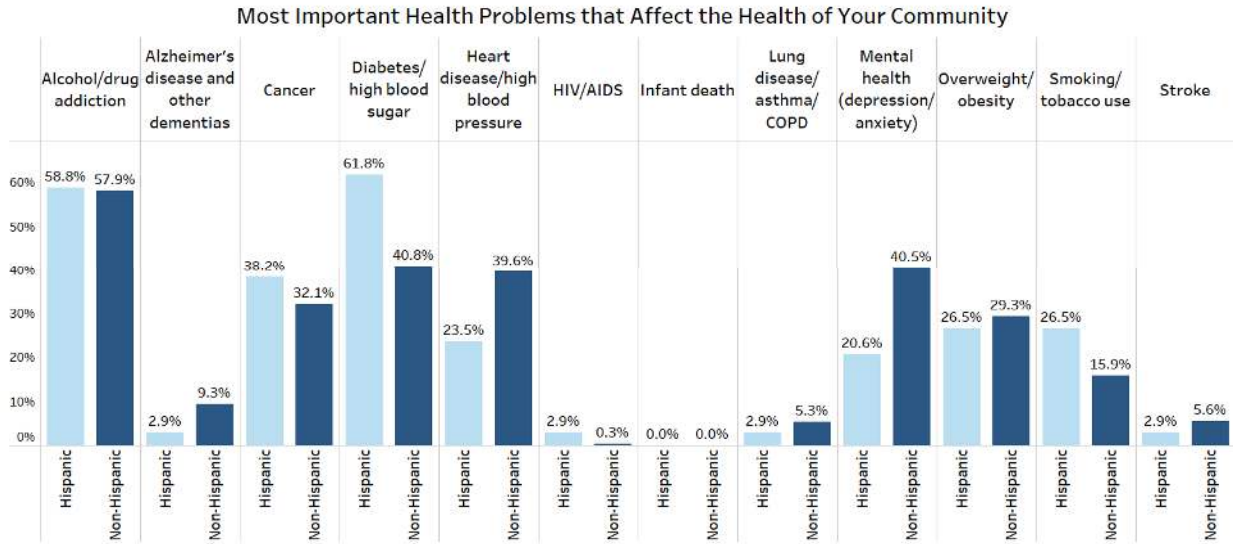
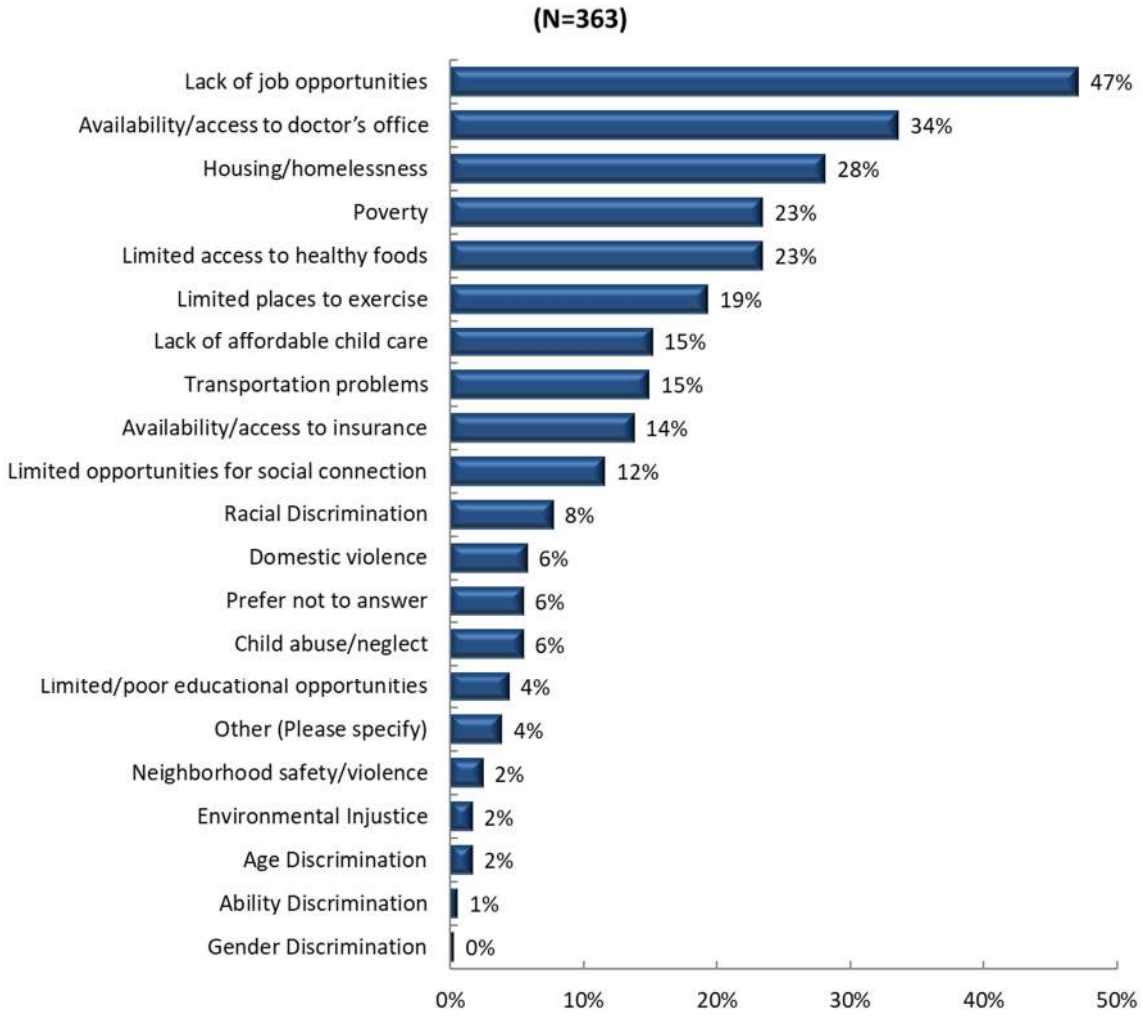


Figure 69: What are the three most important social or environmental problems that affect the health of your community? Please select up to three.



Other (please specify):

- "Affordable housing" (2 responses)
- "Drugs"
- "Home health care"
- "I can't really think of any social problems that affect the health of our Mennonite community."
- "Jobs are posted after it has been filled."
- "Lack of emergency services"
- "Lazy"
- "Medical specialties, dental, medical diagnostics"
- "PEOPLE NOT WANTING TO WORK LAZYNESS"
- "Poor decisions"
- "Taxes cause stress"
- "Undocumented immigrants don't want to speak up"

Figure 70: What are the three most important social or environmental problems that affect the health of your community? Please select up to three. (by age)

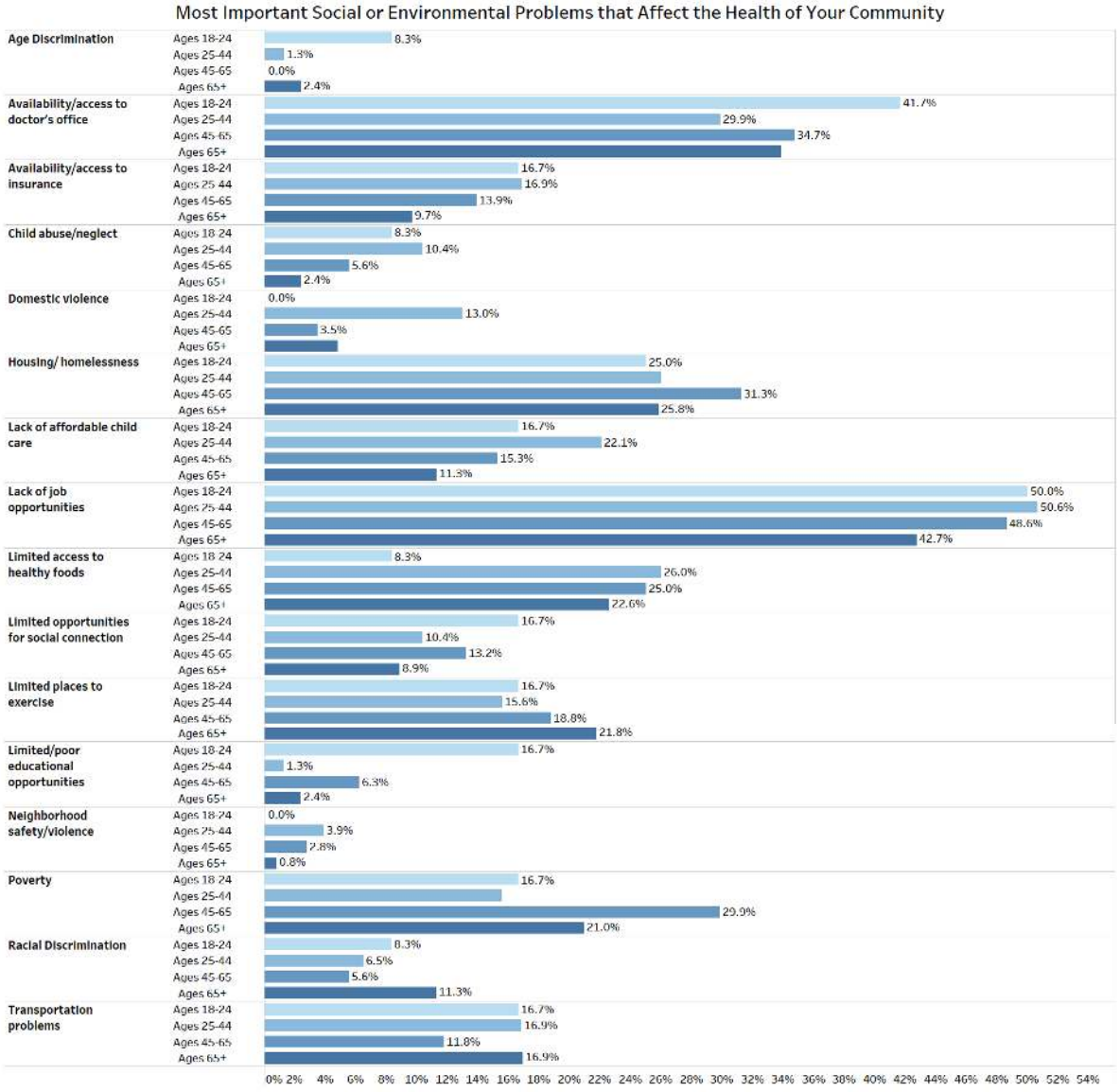


Figure 71: What are the three most important social or environmental problems that affect the health of your community? Please select up to three. (by gender)

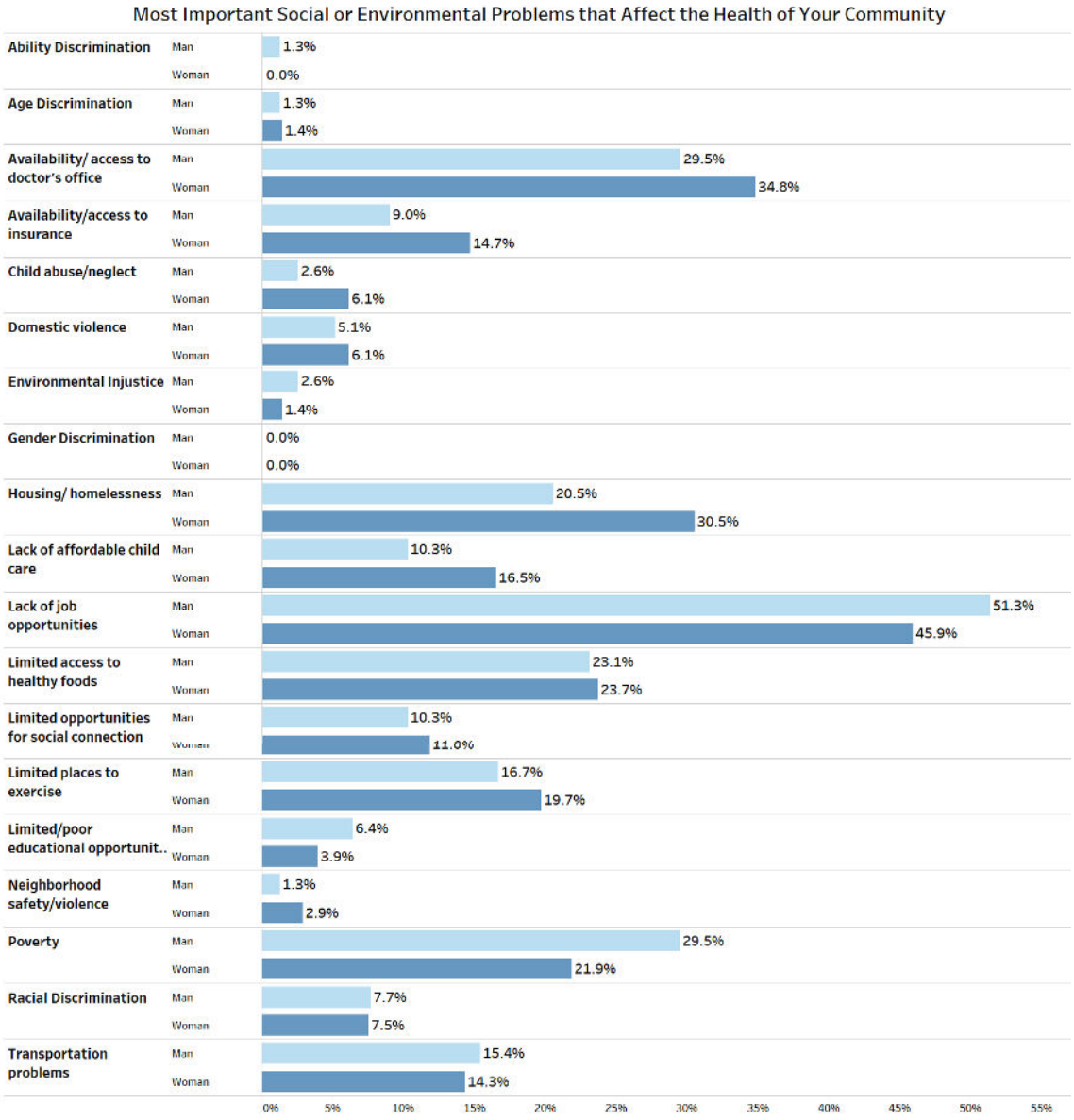


Figure 72: What are the three most important social or environmental problems that affect the health of your community? Please select up to three. (by race)

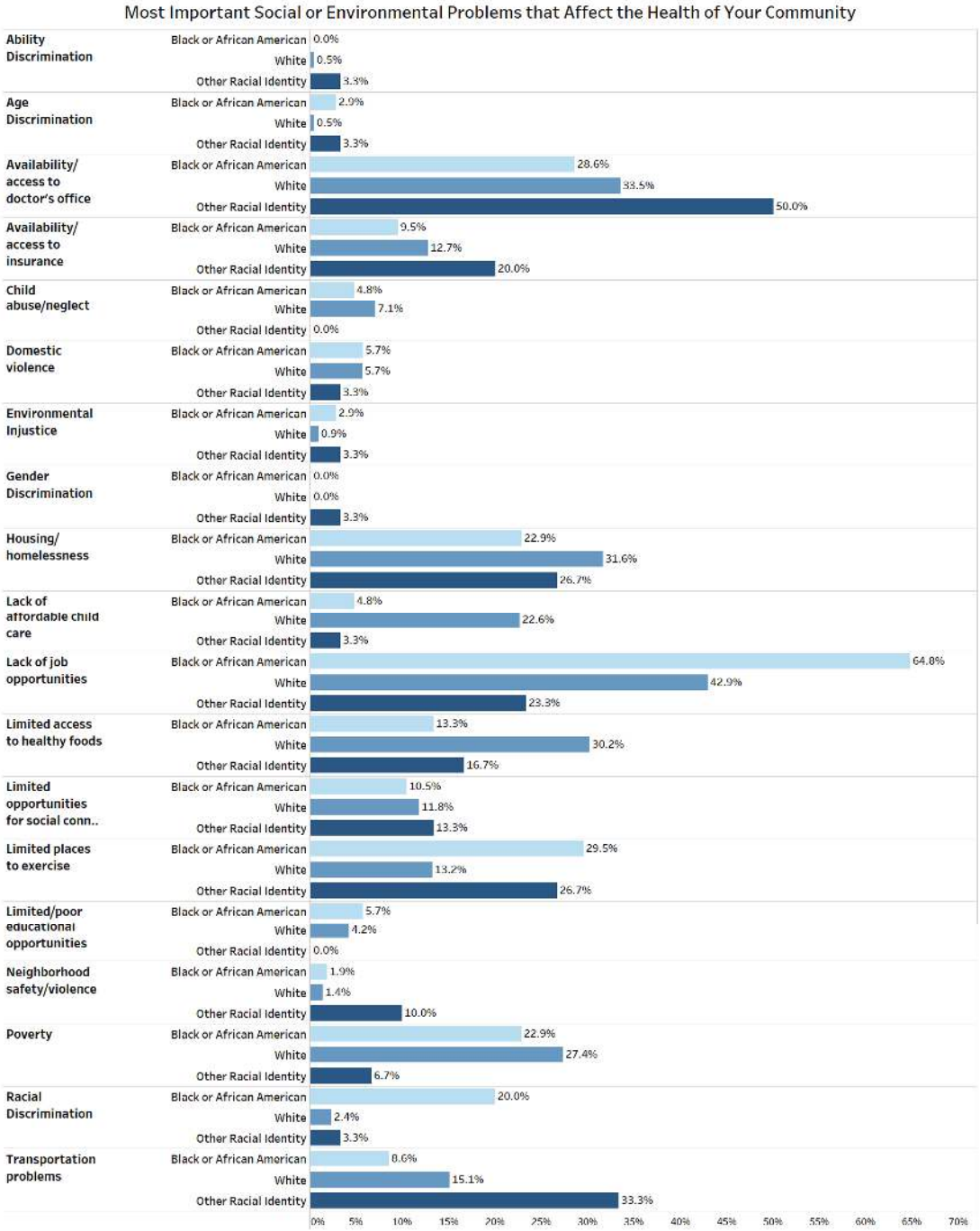


Figure 73: What are the three most important social or environmental problems that affect the health of your community? Please select up to three. (by ethnicity)

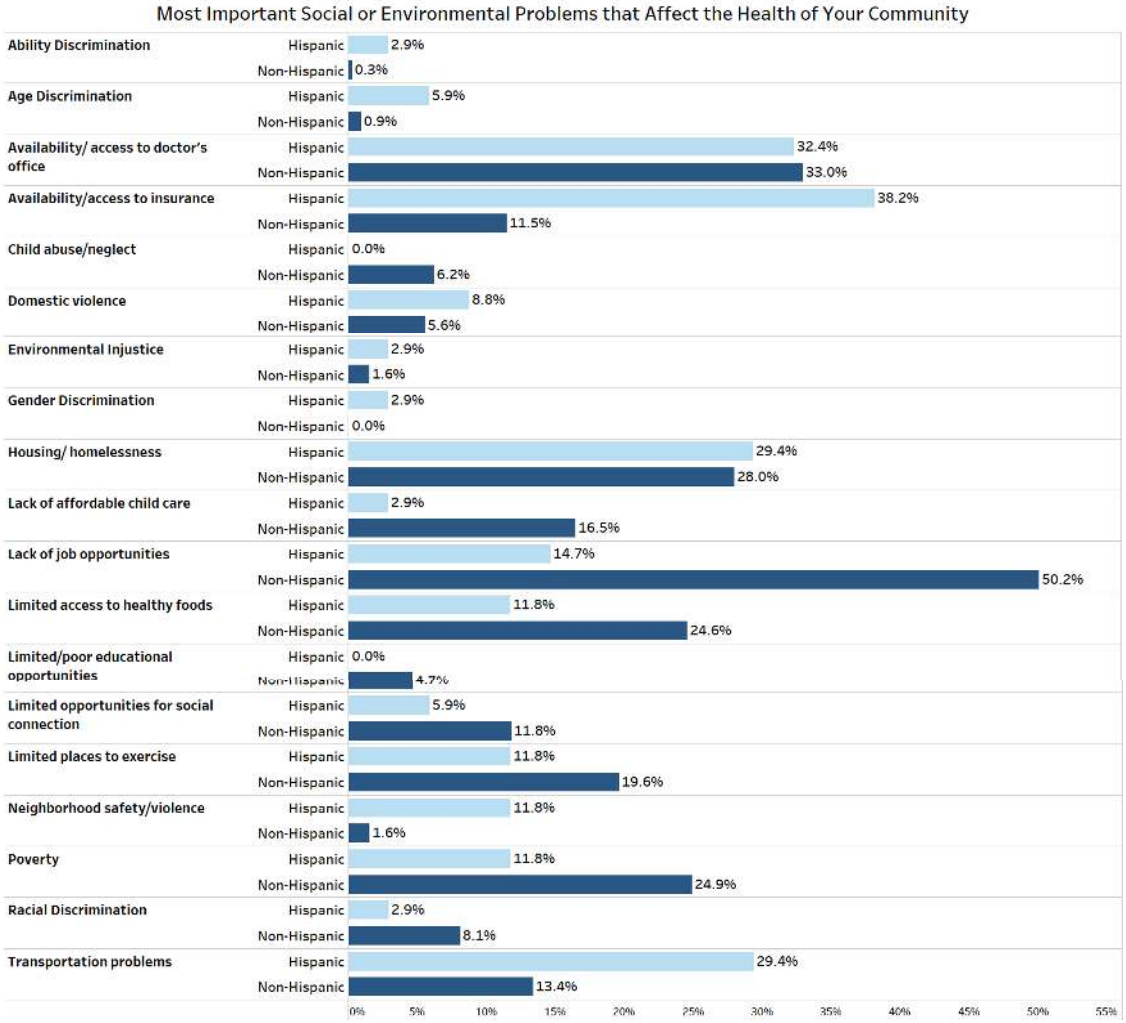
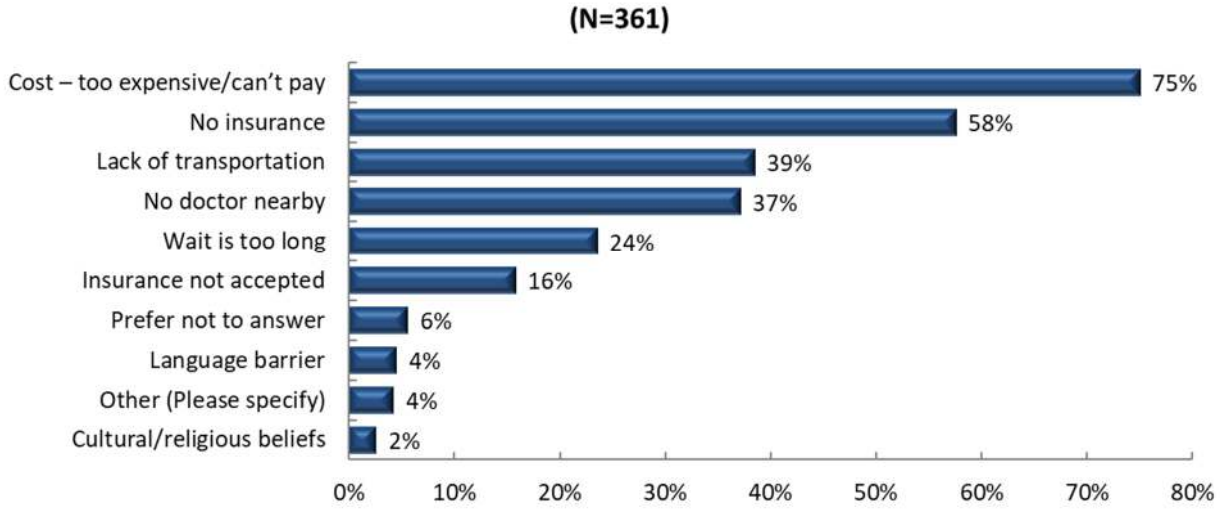


Figure 74: What are the three most important reasons people in your community do not get health care when they need it? Please select up to three.



Other (please specify):

- "Anything above basic is off island. Have a clinic for advanced troubles on rotation? Heart Doctor etc."
- "Cost of insurance deductible and coinsurance"
- "Emergency care"
- "Folks work so many jobs, finding time is an issue."
- "I think there are alot of sick people. The doctors are overwhelmed with patients. So the care is rushed. Spread appointments out 3-6 months and if you need them before then, it's hard to get an appointment in a timely manner."
- "Individuals may choose to put off going to the doctor for various reasons"
- "Limited services are offered, have to travel 60-90 miles to the nearest hospital and the wait could be as long as 8-10 hours before you a seen no matter how sick you are."
- "Long travel time for special medical needs."
- "Not sure if people are not able to get healthcare"
- "Small local place where everyone knows everyone or is related. Despite HIPDAA, pts may not trust privacy"
- "Specialty health care such as occupational therapy is not available locally and leaving Ocracoke Island takes all day to get to the doctor's offices"
- "The medical center has some terrible doctors, and everyone knows everyone's business, so I rather not even go to anyone in the county."
- "They believe that others should pay for it."
- "They don't think they need a doctor. Prefer to go natural routes."

Figure 75: 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)

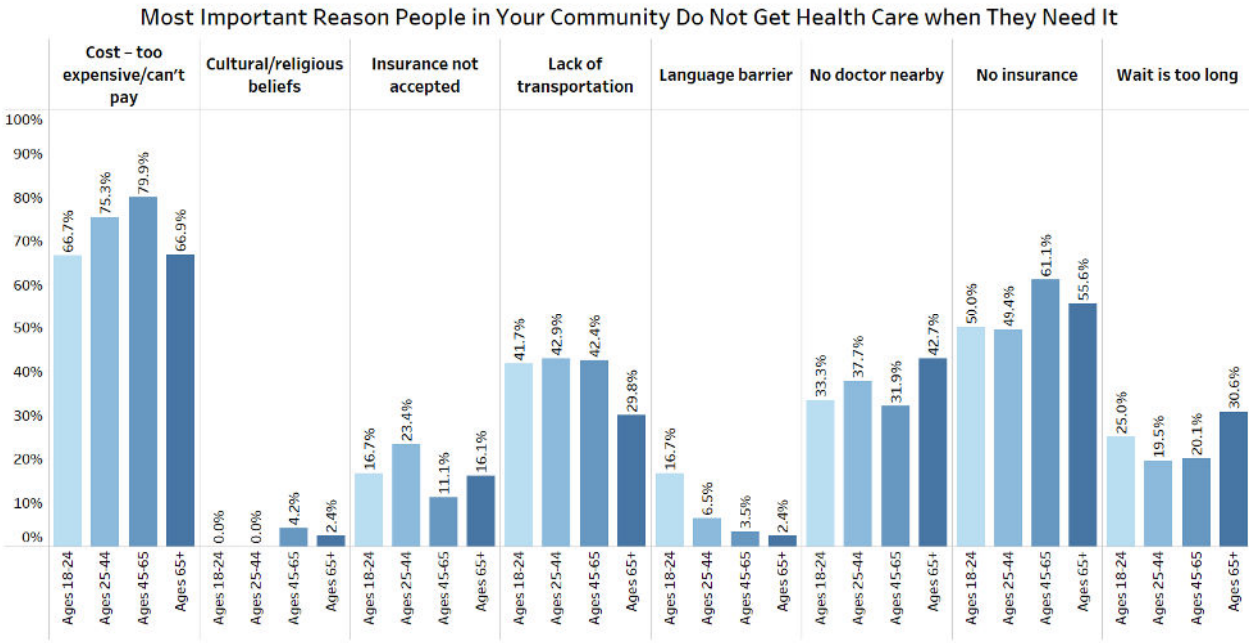


Figure 76: What are the three most important reasons people in your community do not get health care when they need it? Please select up to three. (by gender)

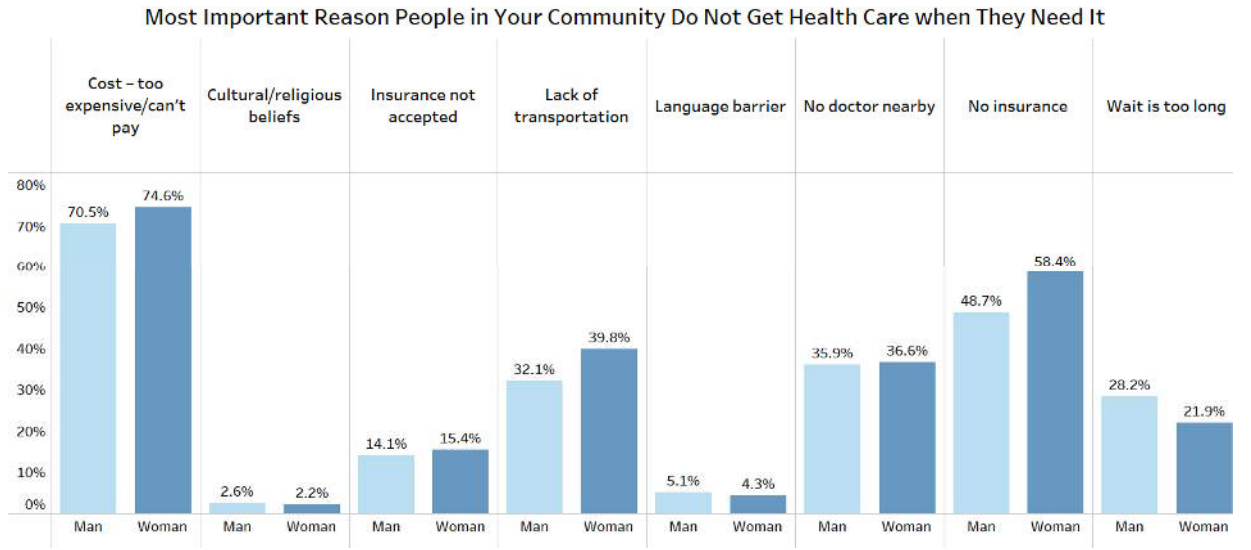


Figure 77: What are the three most important reasons people in your community do not get health care when they need it? Please select up to three. (by race)

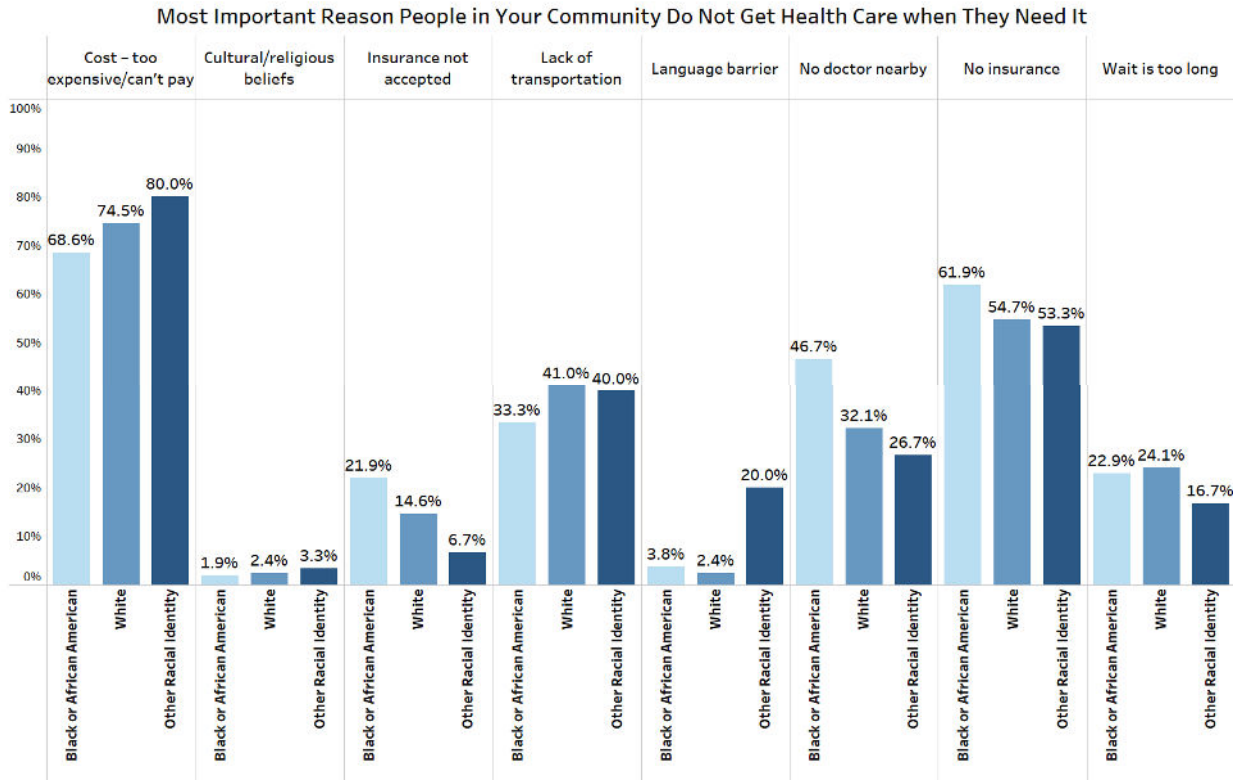
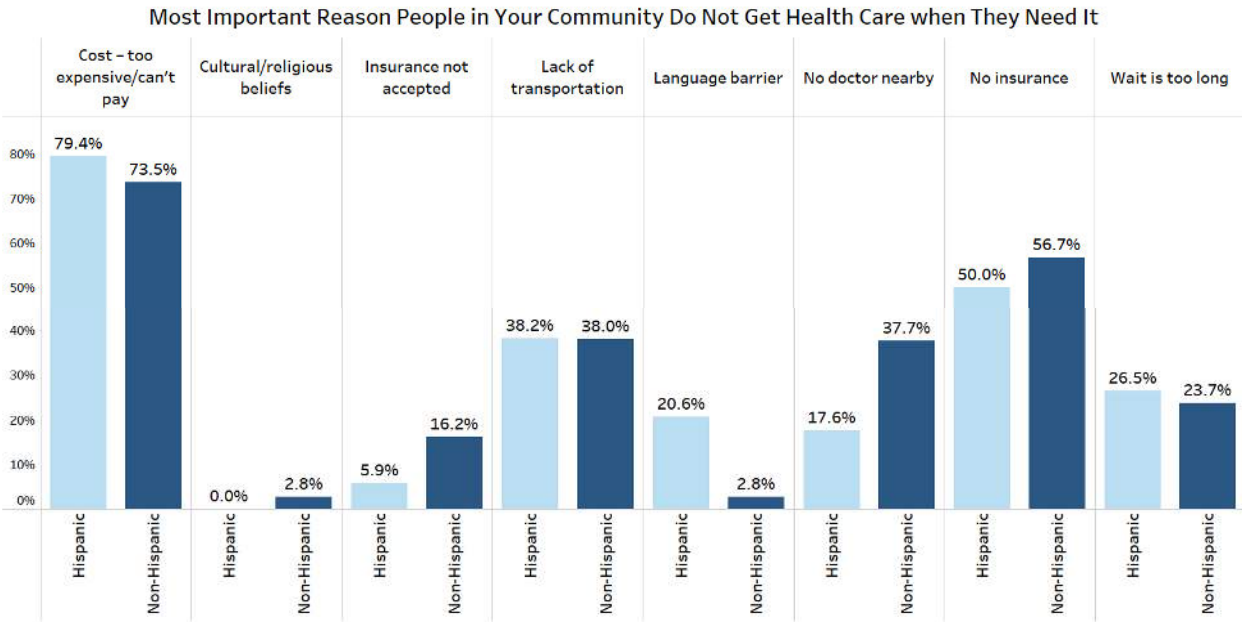


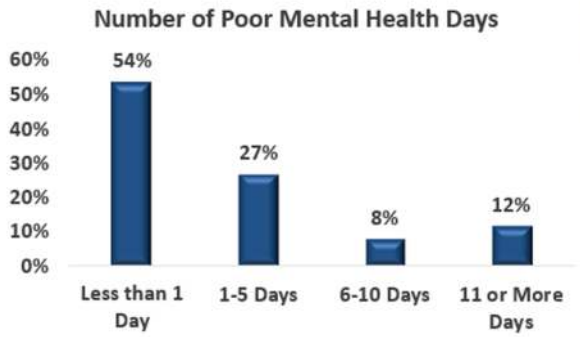
Figure 78: What are the three most important reasons people in your community do not get health care when they need it? Please select up to three. (by ethnicity)



Topic: Mental health

Figure 79: Now thinking about your MENTAL health, which includes stress, depression, and problems with emotions, for how many days during the past 30 days was your mental health NOT good?

(N=343)



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

Figure 80: Was there a time in the past 12 months when you needed mental health care or counseling, but did not get it at that time?

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

(N=158)

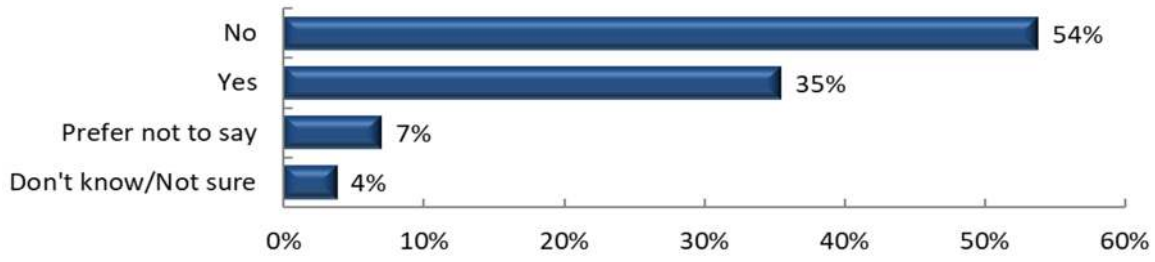


Figure 81: What was the MAIN reason you did not get mental health care or counseling?
Note: only participants who responded "yes" to previous question were asked the current question

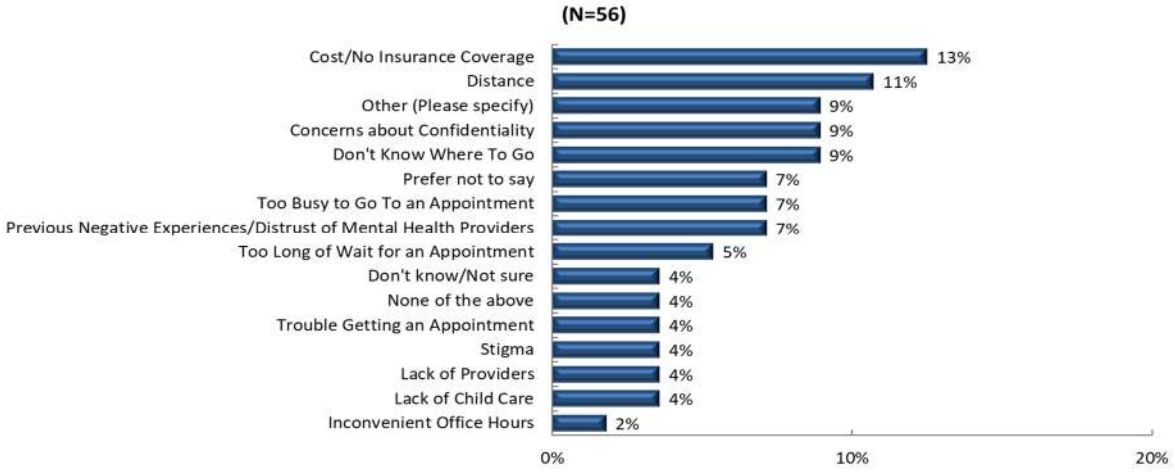
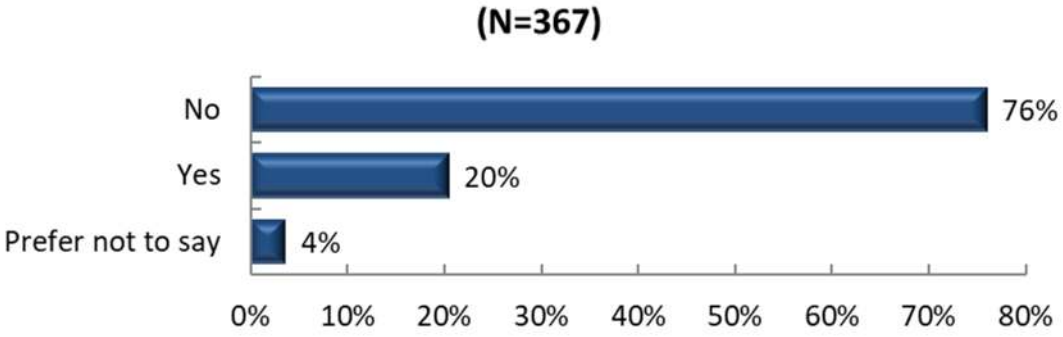


Figure 82: Are you currently taking medication or receiving treatment, therapy, or counseling from a health professional for any type of MENTAL or EMOTIONAL HEALTH NEED?



Topic: Quality of care

Figure 83: Within the past year (anytime less than one year ago), have you:

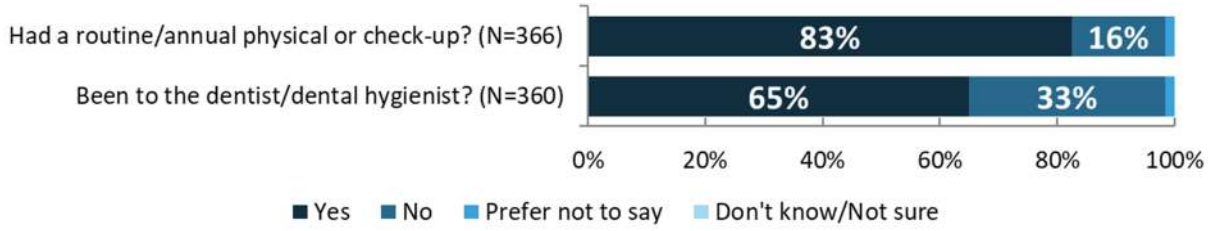


Figure 84: Thinking about your experiences getting medical care in the past year, how often were you treated with respect by your doctors or health providers?

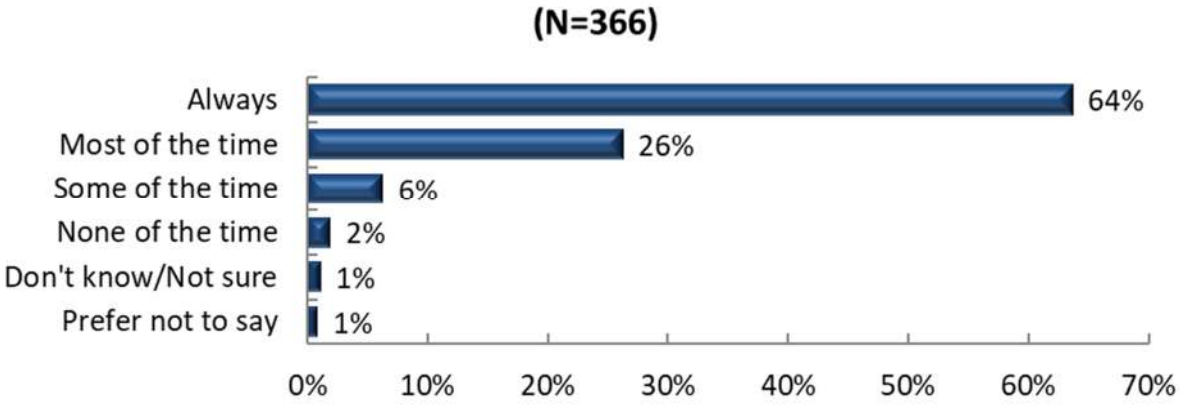


Figure 85: Some people think it is helpful if their providers are from the same background that they are – like in terms of race or religion or native language –because they think their doctors will better understand what they're experiencing or going through.
In the past year, how often were you able to see doctors or healthcare providers who were similar to you in any of these ways?

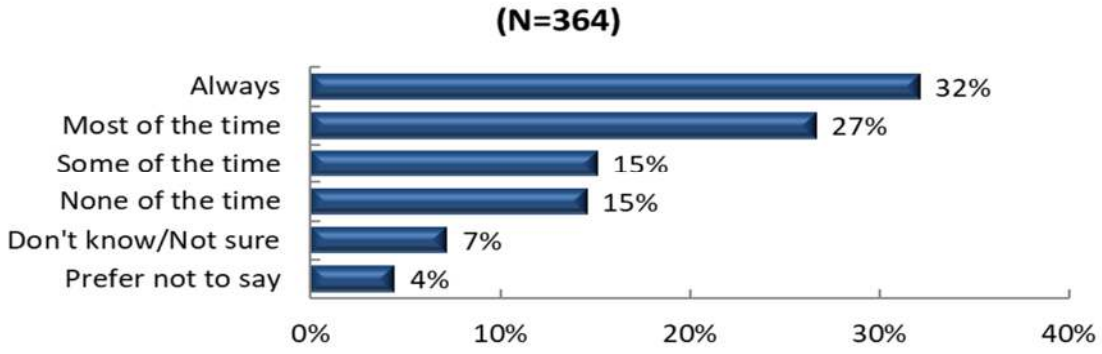
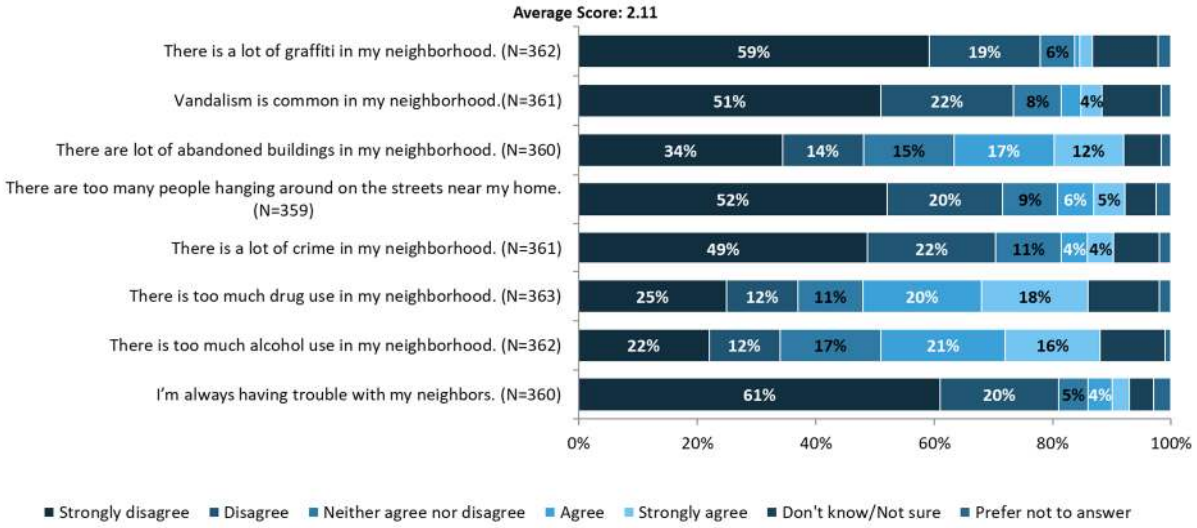


Figure 86: The following statements describe what your neighborhood might be like. Tell us how much you agree or disagree.

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



Topic: Safety

Figure 87: The following statements ask about safety. Tell us how much you agree or disagree.

Rated on a scale from 1 to 5 with 1 being "Not at all" and 5 being "To a great extent"

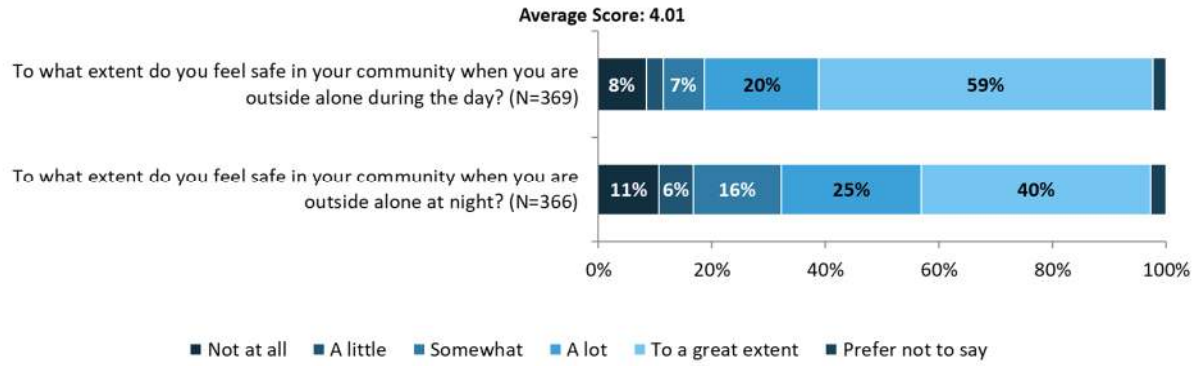
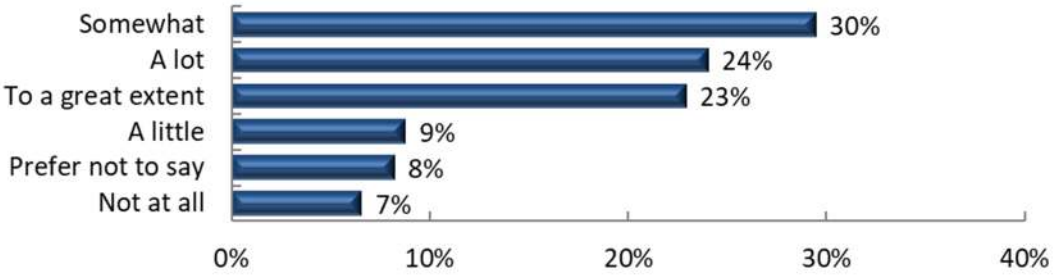


Figure 88: How much do you trust your local law enforcement agency?

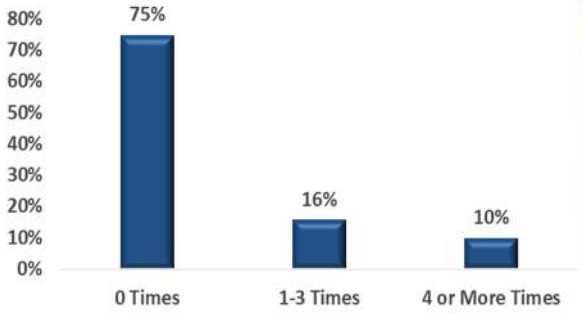
(N=366)



Topic: Substance Use Disorders

Figure 89: 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=339)



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

Figure 90: How often do you consume any kind of alcohol product, including beer, wine or hard liquor?

(N=365)

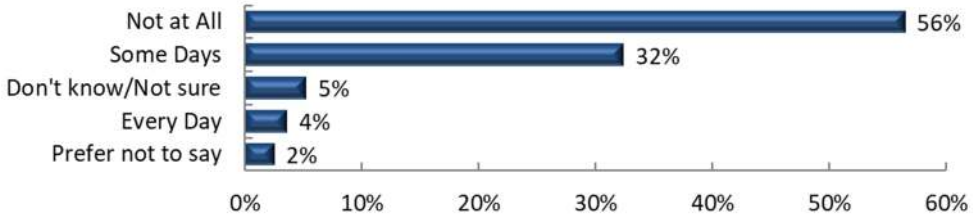


Figure 91: In the past year, have you or a member of your household misused any form of prescription drugs (e.g. used without a prescription, used more than prescribed, used more often than prescribed, or used for any reason other than a doctor's instructions)?

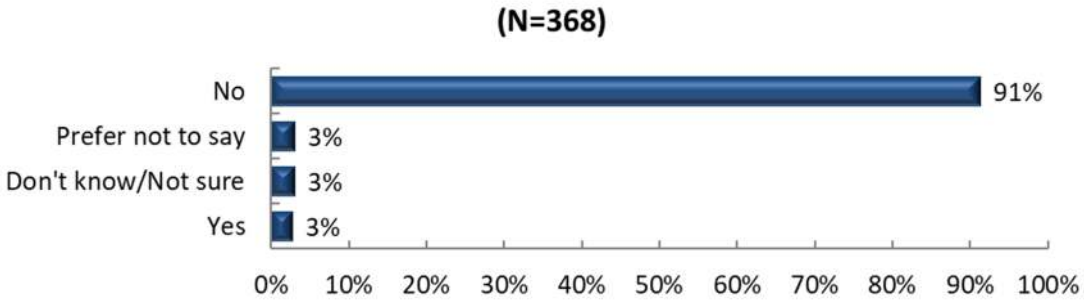
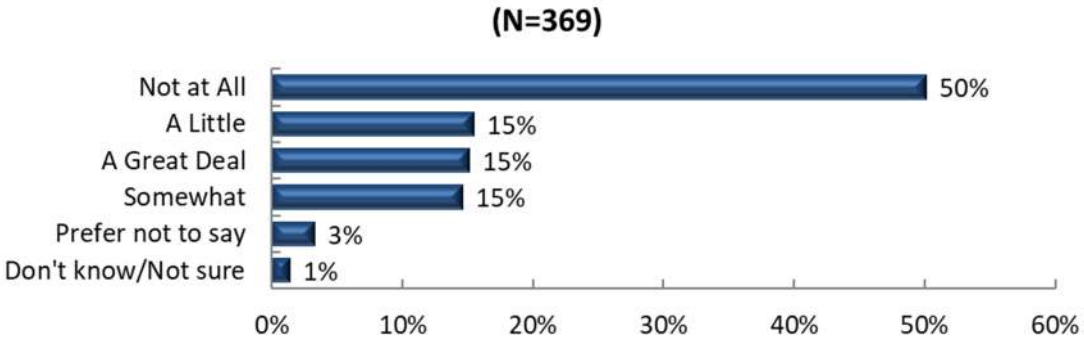
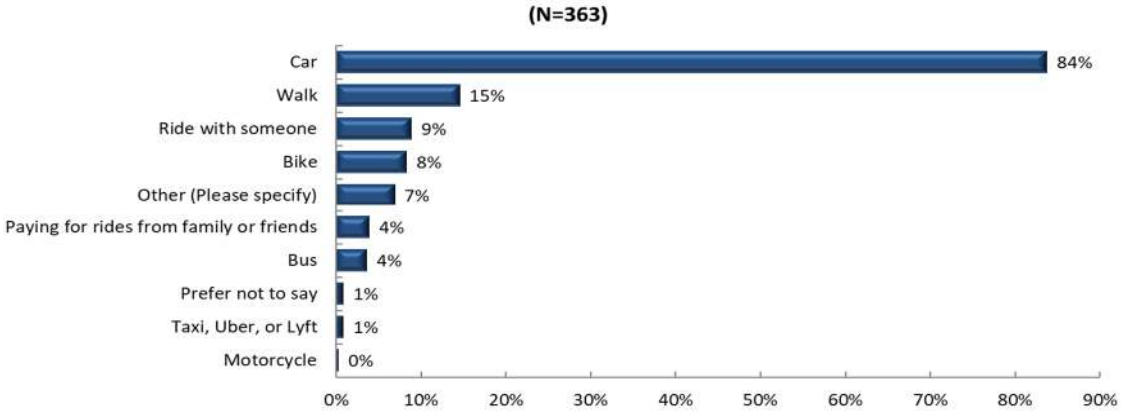


Figure 92: To what degree has your life been negatively affected by YOUR OWN or SOMEONE ELSE's substance abuse issues, including alcohol, prescription, and other drugs?



Topic: Transportation And Transit

Figure 93: In a typical week, what kinds of transportation do you use the most? (Select all that apply.)



Other (Please specify):

- "Gator" (2 responses)
- "Golf cart" (17 responses)
- "Hyde Transit" (2 responses)
- "Most days I don't. On days I do, I bike ok walk."
- "Social services"
- "Transit"
- "Truck"

Figure 94: In the past 12 months has lack of transportation kept you from medical appointments, meetings, work, or getting things for daily living? Select all that apply:

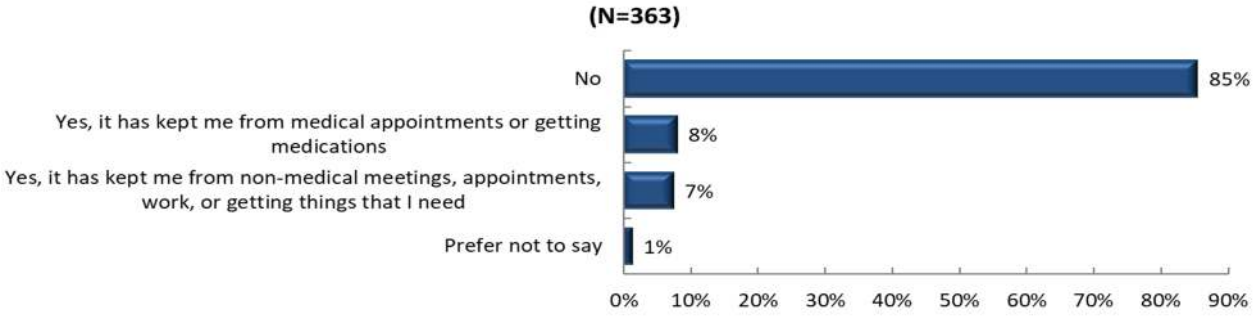
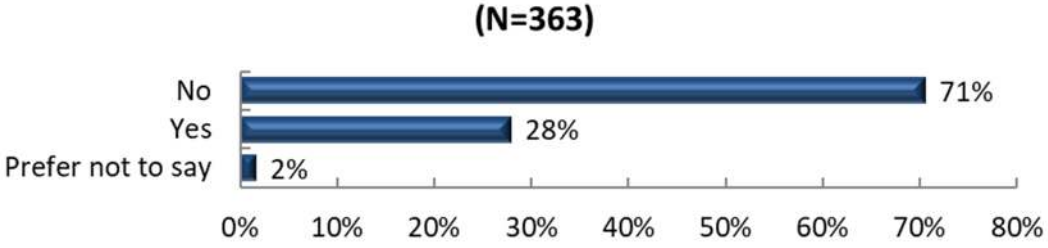


Figure 95: Do you put off or neglect going to the doctor because of distance or transportation?



APPENDIX 6 | SUMMARY OF DATA FINDINGS ACROSS SOURCES

Primary and Secondary data findings are summarized in full by the table below.[54]

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

[54] 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.

APPENDIX 7 | LEADING CAUSES OF DEATH AND HOSPITAL DATA

Leading Causes of Death (Crude death rate per 100,000.)

From 2020 to 2022, the leading causes of death in Hyde County included diseases of the heart (215.4 per 100,000) and malignant neoplasms (208.2 per 100,000). COVID-19 and accidents also ranked among the top causes of death, though their exact death rates were not provided due to statistical unreliability, as the number of events was too low. These figures were sourced from the CDC Wonder database.

Source: CDC Wonder
https://wonder.cdc.gov/ucd-icd10-expanded.html

Leading Causes of Causes of Emergency Department Visits

From FY 2022 to FY 2024, the top cause of emergency department visits for Hyde County residents was consistently abdominal and pelvic pain, with 67 visits in FY 2022, 78 in FY 2023, and 77 in FY 2024. Other common diagnoses included pain in the throat and chest, which ranked second each year, and conditions such as back pain, soft tissue disorders, other joint disorders, sepsis, and nausea and vomiting. COVID-19 appeared as a leading cause in FY 2022 but was not among the top causes in subsequent years.

Top 5 Diagnoses for ED Visits for Hyde County Residents FY 2022			Top 5 Diagnoses for ED Visits for Hyde County Residents FY 2023			Top 5 Diagnoses for ED Visits for Hyde County Residents FY 2024		
Rank	Cause	#	Rank	Cause	#	Rank	Cause	#
1	Abdominal and Pelvic Pain	67	1	Abdominal and Pelvic Pain	78	1	Abdominal and Pelvic Pain	77
2	Pain in Throat and Chest	56	2	Pain in Throat and Chest	69	2	Pain in Throat and Chest	71
3	COVID-19	46	3	Back Pain	33	3	Soft Tissue Disorders	30
4	Other Joint Disorders	28	4	Other Joint Disorders	29	4	Sepsis	30
5	Cellulitis and Acute Lymphangitis	24	5	Nausea and Vomiting	26	5	Nausea and Vomiting	27

Note: Data reflects emergency department visits from ECU Health hospitals only and may not represent visits to other healthcare facilities in the region.

Leading Causes of Avoidable Emergency Department Visits

From FY 2022 to FY 2024, the top causes of avoidable emergency department visits for Hyde County residents were mainly musculoskeletal and digestive issues. The leading diagnosis was "Other Joint Disorders," with 28 visits in both FY 2022 and FY 2023, and 22 visits in FY 2024. Nausea and vomiting

became the top cause in FY 2024. Other frequent diagnoses included soft tissue disorders, acute upper respiratory infections, disorders of the urinary system, and cystitis (bladder inflammation).

Top 5 Diagnoses for Avoidable ED Visits for Hyde County Residents FY 2022			Top 5 Diagnoses for Avoidable ED Visits for Hyde County Residents FY 2023			Top 5 Diagnoses for Avoidable ED Visits for Hyde County Residents FY 2024		
Rank	Cause	#	Rank	Cause	#	Rank	Cause	#
1	Other Joint Disorders	28	1	Other Joint Disorders	28	1	Nausea and Vomiting	27
2	Soft Tissue Disorders	18	2	Nausea and Vomiting	25	2	Soft Tissue Disorders	23
3	Acute Upper Respiratory Infection	15	3	Acute Upper Respiratory Infection	24	3	Other Joint Disorders	22
4	Disorders of Urinary System	14	4	Cystitis or Inflammation of the Bladder	21	4	Cystitis or Inflammation of the Bladder	20
5	Cystitis or Inflammation of the Bladder	12	5	Malaise and Fatigue	18	5	Disorders of Urinary System	18

Note: Data reflects emergency department visits from ECU Health hospitals only and may not represent visits to other healthcare facilities in the region.

Leading Causes of Emergency Department Visits Leading to Admission

From FY 2022 to FY 2024, the leading cause of emergency department visits resulting in admission for Hyde County residents was sepsis, with 22 visits in FY 2022, 20 in FY 2023, and 27 in FY 2024. Other common diagnoses included atrial fibrillation, hypertensive heart disease, acute myocardial infarction (heart attack), ischemic stroke, and type 2 diabetes mellitus. Hypertensive heart disease and ischemic stroke appeared frequently across all years, while COVID-19 and acute pancreatitis were more prominent in FY 2022.

Top 5 Diagnoses for ED Visits Resulting in Admission for Hyde County Residents FY 2022			Top 5 Diagnoses for ED Visits Resulting in Admission for Hyde County Residents FY 2023			Top 5 Diagnoses for ED Visits Resulting in Admission for Hyde County Residents FY 2024		
Rank	Cause	#	Rank	Cause	#	Rank	Cause	#
1	Sepsis	22	1	Sepsis	20	1	Sepsis	27
2	Atrial Fibrillation and Flutter	9	2	Hypertensive Heart Disease	12	2	Acute Myocardial infarction / Heart Attack	15
3	Hypertensive Heart Disease	8	3	Acute Myocardial infarction / Heart Attack	12	3	Hypertensive Heart and Chronic Kidney Disease	12
4	COVID-19	7	4	Ischemic Stroke	9	4	Hypertensive Heart Disease	10
5	Acute Pancreatitis	7	5	Type 2 Diabetes Mellitus	9	5	Ischemic Stroke	10
6	Ischemic Stroke	7	6	Chronic Obstructive Pulmonary Disease	9			

Note: Data reflects emergency department visits from ECU Health hospitals only and may not represent visits to other healthcare facilities in the region.

Leading Causes of Admission

Over the past three fiscal years, the top diagnoses for admission among Hyde County residents have shifted slightly. In FY 2022, the leading cause was liveborn infants, followed by sepsis, atrial fibrillation and flutter, hypertensive heart disease, and type 2 diabetes mellitus. In FY 2023, liveborn infants remained the top cause, with sepsis, hypertensive heart disease, acute myocardial infarction, and chronic obstructive pulmonary disease following. By FY 2024, sepsis became the most common diagnosis, with liveborn infants, acute myocardial infarction, hypertensive heart and chronic kidney disease, and hypertensive heart disease rounding out the top five.

Top 5 Diagnoses for Admission for Hyde County Residents FY 2022			Top 5 Diagnoses for Admission for Hyde County Residents FY 2023			Top 5 Diagnoses for Admission for Hyde County Residents FY 2024		
Rank	Cause	#	Rank	Cause	#	Rank	Cause	#
1	Liveborn Infant	25	1	Liveborn Infant	33	1	Sepsis2	37
2	Sepsis2	24	2	Sepsis2	26	2	Liveborn Infant	19
3	Atrial Fibrillation and Flutter	12	3	Hypertensive Heart Disease	14	3	Acute Myocardial Infarction / Heart Attack	17
4	Hypertensive Heart Disease	8	4	Acute Myocardial Infarction / Heart Attack	14	4	Hypertensive Heart and Chronic Kidney Disease	13
5	Type 2 Diabetes Mellitus	8	5	Chronic Obstructive Pulmonary Disease	10	5	Hypertensive Heart Disease	10

Note: Data reflects emergency department visits from ECU Health hospitals only and may not represent visits to other healthcare facilities in the region.

Top 5 Leading Causes of Injury Death, Hospitalization, and Emergency Department Visits

From 2017 to 2021, the leading causes of injury-related deaths in Hyde County included unintentional poisoning (11 deaths) and falls (4 deaths). Falls were also the top cause of injury hospitalizations (48) and emergency department visits (276). Motor vehicle traffic incidents were significant for hospitalizations (13) and ED visits (116). Other notable causes included being struck by/against objects and unspecified injuries. These figures were sourced from the N.C. Injury & Violence Prevention Branch.

Source: N.C. Injury & Violence Prevention Branch
https://injuryfreenc.dph.ncdhhs.gov/DataSurveillance/pdf/Top5TablesByCounty2017-2021_Final.pdf