Community Health Needs Assessment

Halifax County

2025

ECU HEALTH
North Hospital

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.

The Health ENC Steering Committee

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

Halifax County CHNA Leadership

In addition to the Health ENC Steering Committee, the Halifax County 2025 CHNA was developed in partnership with representatives from Halifax County Health Department and ECU Health North. Many local organizations assisted ECU Health North Hospital, the Halifax County Health Department, and Healthy Halifax Partners, with the creation of the assessment.

Name	Title	Organization
Cheyenna James	Health Director	HCHD
Laura Ellis	Health Education Supervisor,	HCHD
Betty Macon	Health Educator	HCHD
Jason Harrell	President (Dennis Campbell - Interim beginning August 9, 2024)	ECU Health North
Darlene Wolgemuth	Quality Nurse Specialist II	ECU Health North
Elizabeth Dunlow	Community Health Improvement Coordinator (Beginning in mid-August)	ECU Health North

Betsy Morris	Marketing & Development	ECU Health North
Sawyer Brown	Support Services and Operations	ECU Health North

Halifax County CHNA Stakeholders

The Halifax 2025 CHNA was developed with input from additional representatives from local health providers, government officials, non-profit organizations, social service providers and community members. Specifically, the county CHNA Leadership team would like to recognize individuals from the following organizations who participated in the prioritization process:

Organization	Title
ECU Health North Hospital	Administration, Community Health Improvement Administration, Operations Assistant Manager, Nursing Community Health Improvement Coordinator Contracted Manager Director, Accounting-Controller Director of Education Director, Patient Care Services Director, Support Services and Operation Implementation Education Nurse Specialist Human Resources Business Partner Manager, Marketing and Development Manager, Patient Access Services Manager, Patient Care Services Manager, Pharmacy Supervisor, Facilities Services Supervisor, Regional End User Support
Halifax County Health Department	Board of Health
Halifax County Health Department	Health Director Assistant Health Director Administrative Assistant Administrative Officer Animal Control Supervisor Community Outreach Worker Computer Systems Administrator Director of Nursing Environmental Health Supervisor Environmental Health Program Specialist Family Nurse Practitioner Health Education Social Work Supervisor Wellness Coordinator
Halifax-Warren Smart Start	Director
Roanoke Rapids Parks and Recreation	Director
John 3:16	Coordinator

Turning Point Workforce Development Board	Special Projects and Outreach Coordinator
Halifax County Cooperative Extension	Family and Consumer Services Agent
Community Member	Retired (Dental Hygiene/Nursing)
Faith Based Organization	Members

In addition, the Health ENC Steering Committee and Halifax 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 North Hospital

ECU Health North Hospital is a 204-bed hospital located in Roanoke Rapids, North Carolina, and it offers an array of medical and surgical services, including 24-hour emergency care. Integrating the latest technology, care is provided by a staff made up of approximately 800 employees and 60 physicians representing various medical specialties. ECU Health North Hospital 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 Halifax 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, Halifax County Health Department and ECU Health North 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

Halifax County CHNA Leadership

Halifax County opted for a bi-sectoral approach to the leadership of the CHNA process, which included representatives from Halifax County Health Department (HCHD) and ECU Health North Hospital.

Name	Title	Organization
Cheyenna James	Halifax County Heath Director	HCHD
Laura Ellis	Halifax County Health Education Supervisor	HCHD
Betty Macon	Halifax County Health Educator	HCHD
Dennis Campbell	Interim President	ECU Health
Elizabeth Dunlow	Community Health Improvement Coordinator	ECU Health
Darlene Wolgemuth	Quality Nurse Specialist II	ECU Health
Betsy Morris	Marketing & Development	ECU Health
Sawyer Brown	Support Services and Operations	ECU Health

Halifax County CHNA Partnerships

The 2024 CHNA process for Halifax 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	2
Hospital/Health Care System(s)	1
Healthcare Provider(s)	1
Behavioral Healthcare Provider(s)	1
EMS Provider(s)	1
Community Organization(s)	5
Public/Private/Charter School System(s)	1
Government/Public Agencies	1
Public Member	1

The Health ENC Steering Committee and Halifax 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.

Halifax 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 community safety, education, food access and security, and housing and homelessness, among others.

Primary (new) data were collected through focus groups and a web-based survey for community members, and included feedback from 562 people who live, work or receive healthcare in Halifax County. A total of three 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 (including mental health and substance use), employment and income, food access and security, healthcare access and quality, housing and homelessness, physical health (chronic diseases, cancer, obesity), and transportation and transit as top needs that impact the health and well-being of people living in Halifax County.

Halifax County representatives collaborated to identify four priority areas to focus on over the next three years, evaluating data based on scope, severity, ability to impact, health disparities, and community importance. ECU Health North Hospital will focus on three priority health needs, listed alphabetically: Access to Healthcare, Behavioral Health (including Mental Health and Substance Abuse), and Chronic Disease Prevention, with a focus on Obesity. In addition to these, the Halifax County Health Department has designated Maternal, Fetal, and Infant Health as a fourth priority area.

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

Following completion of this report, health leaders throughout Halifax 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 North and Halifax County Health Department, with guidance from the Health ENC CHNA Steering Committee, local leaders, and community residents completed this assessment to understand and 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 the community partners to proactively identify and respond to the needs of Halifax County residents.

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

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

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 Halifax 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 Halifax County residents. Key objectives of this CHNA include:

- Identify the health needs of Halifax County residents;
- Identify disparities in health status and health behaviors, as well as inequities in the factors that contribute to health challenges;

[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 the challenges residents face when trying to maintain and/or improve their health;
- Understand where underserved populations turn for services needed to maintain and/or improve their health;
- Understand what is needed to help residents maintain and/or improve their health; and
- Prioritize the needs of the community and clarify/focus on the highest priorities.

There are twelve phases in the CHNA process, as shown in **Figure 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.

[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

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

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

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

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

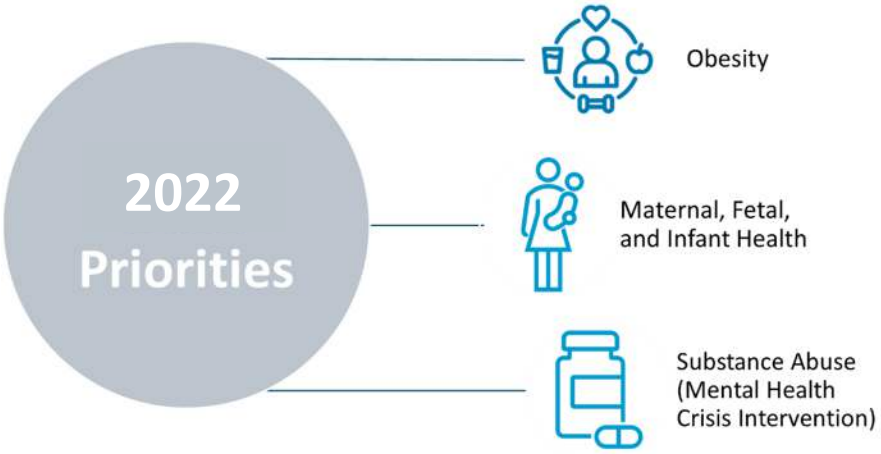
2) *Detailed Summary of Secondary Data Measures and Findings* – Existing data measures and findings used in the prioritization process are presented in **Appendices 2-3.**

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

Figure 2: Halifax County 2022 Priority Need Areas



Below is a summary of the most recent CHNA implementation plan.

Previous CHNA Priority: Obesity

- **Roanoke Valley Community Health Initiative (RVCHI):** Through a KBR grant, RVCHI focused on improving community health through various initiatives, including operating and funding community gardens, hosting summer fit parties, and coordinating food distributions. There were 45 physical activity and healthy eating opportunities offered by Community Partner organizations. ECU Health North Hospital sponsored 3 health education/ outreach events.
- **Community-Based Wellness Screening:** ECU Health North Hospital's community health improvement coordinator organizes health screenings and educational opportunities within the community.
    - Number of screening events
        - FY 23: 1
        - FY 24: 6
        - FY 25 (first 9 months): 6
    - Number of individuals receiving glucose and/or A1c only screening
        - FY 24: 67
        - FY 25 (first 6 months): 93
    - Number of individuals receiving a full biometric screening
        - FY 23: 3
        - FY 24: 56
        - FY 25 (first 9 months): 104
- **Faithful Families:** Faithful Families Thriving Communities (Faithful Families), launched in FY 25, works directly in communities of faith across the country to promote health for individuals, families, and local communities. 23 individuals attended sessions with 15 individuals completing the program.
- **Community Benefits Grant Program (Healthy Lifestyles)** – The Community Benefit Grants program supports community partners to educate people about disease prevention and

management, provide people with the knowledge and tools to be successful in their own health care and establish programs within communities, making them available and more accessible to community members who need these programs/services. In FY 23, the hospital awarded $49,500 in grant funds to 6 organizations and served a total of 3,870 individuals. In FY 24, 12 organizations received $95,000 in funding. Client data for FY24 (July 2024-June 2025) is pending.

- **South Eastern Halifax Coalition & A Better Chance A Better Community:** ECU Health North serves and supports community organizations such as the South Eastern Halifax Coalition and A Better Chance A Better Community, which hold regular meetings aimed at reducing the incidence of unhealthy weight among children, adolescents, and adults across the county.

- **Community Outreach Coordinator:** ECU Health North Hospital provided a community outreach coordinator until February 19, 2024. A new community outreach coordinator was hired and began in mid-August of 2024. The community outreach coordinator will be responsible for working closely with faith communities, community members, leaders, health departments, administrators, hospitals, physicians, academic institutions, community-based organizations, and related businesses to promote wellness and active living.

Previous CHNA Priority: Maternal, Fetal, and Infant Health

- **Community Benefits Grants Program (Maternal, Fetal, and Infant Health) –** The Community Benefit Grants program supports community partners to educate people about disease prevention and management, provide people with the knowledge and tools to be successful in their own health care and establish programs within communities, making them available and more accessible to community members who need these programs/services. In FY 23, the hospital awarded $39,500 in grant funds to 4 organizations. In FY 24, 12 organizations received $95,000 in funding. Client data for FY24 (July 2024-June 2025) is pending.
- **Community Benefits Grants Program – Maternal Child Health**
    - Total amount of funds awarded – Maternal Child Health
        - SY 24-25: $5,000
    - Number of grants rewarded – Maternal Child Health
        - SY 24-25: 1
    - Number of people impacted
        - SY 24-25: 80
- **Community Benefits Grant Program – Access to Care**
    - Total amount of funds awarded – Access to Care
        - SY 24-25: $34,500
    - Number of grants rewarded – Access to Care
        - SY 24-25: 3
    - Number of people impacted
        - SY 24-25: 2,278

- **Connecting High-Risk Patients to Social Needs Resources:** ECU Health North Hospital's contracts with Unite Us to use the NCCARE360 platform, which connects high-risk patients to social needs resources.

Previous CHNA Priority: Substance Abuse (Mental Health Crisis Intervention)

- **Community Benefits Grants Program (Mental Health Crisis Intervention)** – The Community Benefit Grants program supports community partners to educate people about disease prevention and management, provide people with the knowledge and tools to be successful in their own health care and establish programs within communities, making them available and more accessible to community members who need these programs/services. In FY 23, the hospital awarded $6,000 in grant funds to 2 organizations. In FY 24, 12 organizations received $95,000 in funding. Client data for FY24 (July 2024-June 2025) is pending.

    - Number of grants rewarded – Behavioral Health
        - SY 24-25: 2
    - Total amount of funds awarded – Behavioral Health
        - SY 24-25: $6,000
    - Number of people impacted
        - SY 24-25: 1,225

- **Referrals to Crisis Intervention:** ECU Health North Hospital partnered with substance abuse and mental health/crisis intervention organizations to market their program outreach. At the hospital, at-risk patients received referrals to crisis intervention through the Emergency and Behavioral Health departments.
    - **Morse Clinic partnership:** Morse Clinic substance abuse/addiction treatment information was provided to patients upon discharge from the Emergency Department.
    - **Trillium Health partnership:** In addition to monthly community partner meetings to identify patient needs, the Emergency Department provides daily updates on patients currently receiving resources or assistance from Trillium.
    - **Monthly/bi-monthly meetings held with Halifax County Stepping Up**: Members from Northampton County, Halifax County, Trillium, Social Services, Community Paramedics, Crisis Prevention, and Rural Health Group meet regularly to discuss topics including pathways for screening, treatment, and recovery support services for mental health. Other focus areas include funding, financial and social/environmental barriers for patients that need treatment, and programs and treatment access for incarcerated patients.

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

Summary Findings: Halifax 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 Halifax 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 Halifax 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 Halifax 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 Halifax 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 four priority need areas. After looking at all relevant data and feedback, ECU Health North Hospital has identified three priority health needs, listed alphabetically: Access to Healthcare, Behavioral Health (including Mental Health and Substance Abuse), and Chronic Disease Prevention, with a focus on Obesity as seen in **Figure 3**. In addition to these, the Halifax County Health Department has designated Maternal, Fetal, and Infant Health as a fourth priority area. ECU Health North will incorporate strategies for Maternal, Fetal & Infant Health under Access to Healthcare.

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 Halifax 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 Halifax 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 Halifax County, including healthy lifestyle, maternal and infant health, mental health, physical health, substance use disorders, transportation and transit, and tobacco. 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 580 Halifax County residents and other stakeholders. This included web survey responses from over 550 community members and three focus groups that included 31 community members and other people who live, work or receive healthcare in Halifax 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 Halifax 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 Assessments from Halifax 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 Halifax 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 Halifax 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	Halifax County Description
	Low	Represents measures in which Halifax 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 Halifax 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 Halifax 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 Halifax County value was compared to the benchmark by calculating the percentage difference between the values, relative to the benchmark value:

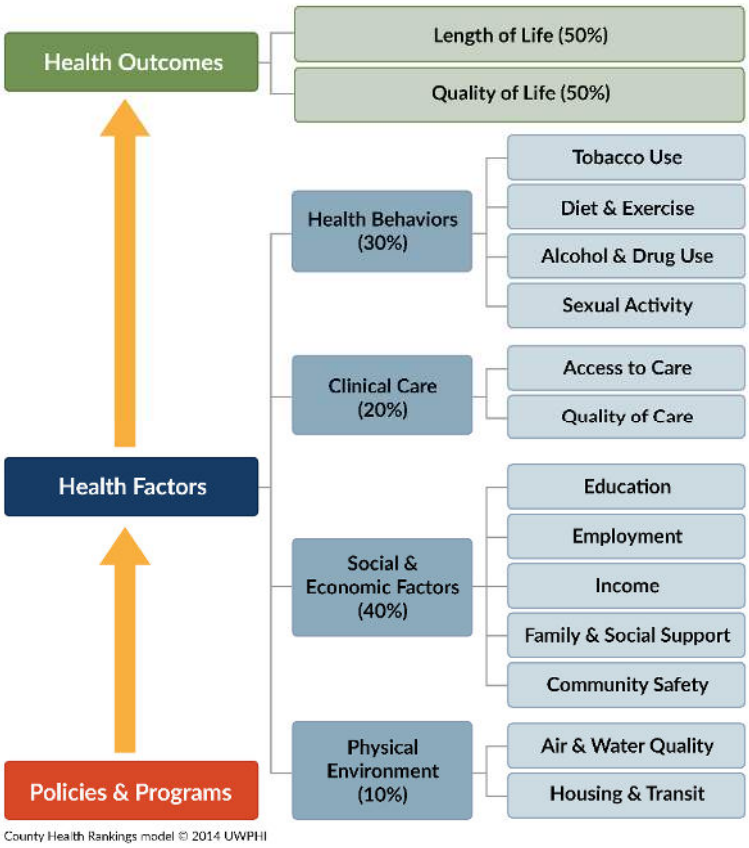
(Halifax Co Value – Benchmark Value)/(Benchmark) x 100 = % Difference Used to Identify Priority Level.

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.

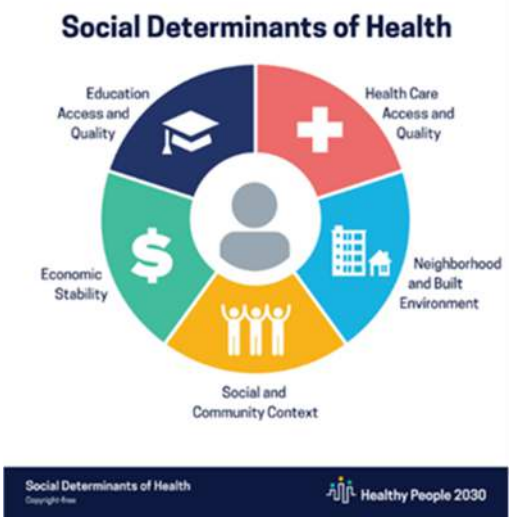
Using the population health framework as a guide for the CHNA process helps categorize many individual pieces of data in a way that connects the dots between health status and social drivers of health, in a way that helps local leaders better understand and address the health and well-being of the communities 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 Halifax 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 Halifax 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, the leaders in Halifax County considered the following factors to identify priority need areas of Halifax County:

- 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 Halifax County CHNA leadership ranked priority health needs based on three criteria: magnitude of the problem, seriousness of the consequences, and feasibility of correcting the problem. The top ranked priority need areas were selected.

The final priority need areas were not ranked in any particular order of importance, and each will be addressed by the Halifax County CHNA leadership. ECU Health North will focus on Access to Healthcare, Behavioral Health (Mental Health/Substance Abuse), and Chronic Disease Prevention (Obesity) 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.

- ECU Health North Hospital
- Halifax County Cooperative Extension
- Halifax County Health Department
- Halifax-Warren Smart Start
- John 3:16
- Roanoke Rapids Parks and Recreation
- Turning Point Workforce Development Board
- Community Members

Study Limitations

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

Given the size of Halifax 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, these were successful. The composition of survey respondents in terms of race and ethnicity were similar to that of the county as a whole. Roughly 50% of all respondents identified as Black or African American compared to 51% of Halifax County as a whole. Roughly 38% of all respondents identified as White compared to 39% of the county as a whole. Hispanic representation in the survey was adequate with 2.5% of respondents identifying as Hispanic compared to 3.2% of the total county population being Hispanic. Additionally, 5.7% of survey respondents identified as American Indian and Alaska native, which was greater than the overall county population that is Indigenous (3.4%).

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. Paper surveys were also distributed in an effort to reach as much of the community as possible. To increase future survey responses, the 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 CHNA Leadership team has assumed that participating community members accurately and completely represented their fellow residents.

CHAPTER 2 | COUNTY PROFILE

Geography

Halifax is located in the Inner Coastal Plain region of North Carolina, characterized by the presence of low-lying areas, winding rivers, and rolling hills. It covers a total of 730 square miles, including 724 square miles of land and 6 square miles of water. Halifax is comprised of seven municipalities: City of Roanoke Rapids, Town of Enfield, Town of Halifax, Town of Hobgood, Town of Littleton, Town of Scotland Neck, and Town of Weldon. More than half (56%) of Halifax 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.

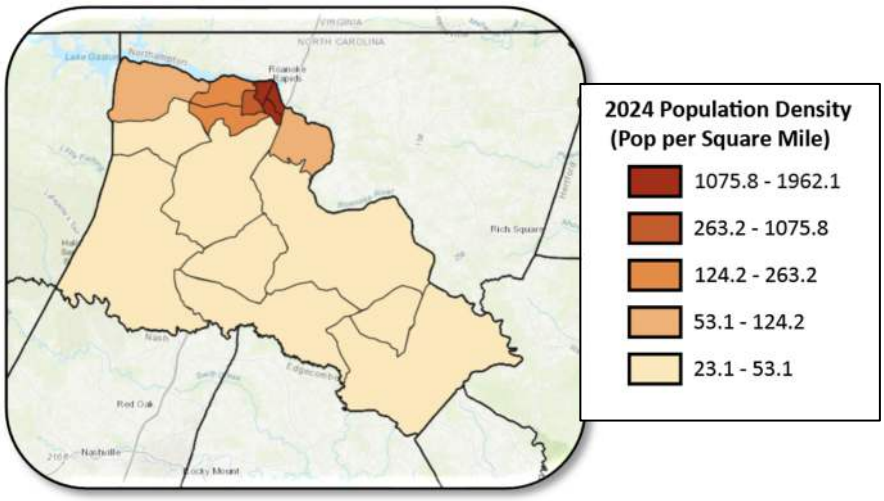
With a population of 47,468, Halifax County makes up approximately 0.2% of the population of North Carolina

Table 1: Total Population, 2023[8]

	Halifax County	North Carolina	United States
Population	47,468	10,765,678	337,470,185

Halifax County has a population density of 65.1 persons per square mile – lower than the population density for North Carolina (214.7 persons per square mile). Roanoke Rapids is the most densely populated area in the county.

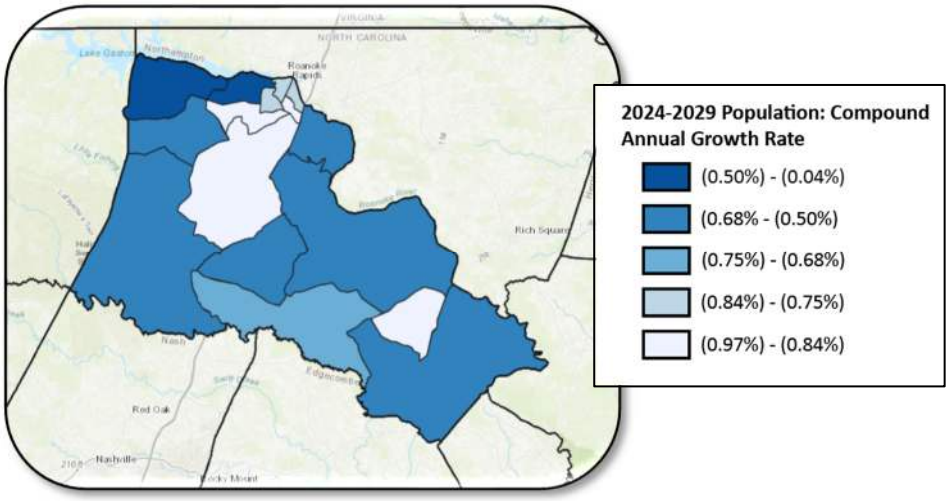
Figure 8: Halifax County Map: Population Density[8]



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

In total, the population of Halifax County is projected to decline 0.64% annually between 2024 and 2029. Areas in the central and southeastern part of the county are experiencing greater declines.

Figure 9: Halifax 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 Halifax County shows some notable differences from state averages. The county has a higher percentage of residents below 15 (18.7%) compared to North Carolina (17.9%). The percentage of residents between 15 and 44 (34.6%) is lower than the state average (39.3%), while the proportion aged 45 to 64 (26.7%) is slightly higher than North Carolina's (25.1%). The percentage of residents 65 and older (22.0%) is notably higher than the state average (17.7%), suggesting an older population that may require more senior-focused healthcare services.

Table 2: Age Distribution[8]

	Halifax County	North Carolina	United States
Percentage below 15	16.7%	17.9%	18.1%
Percentage between 15 and 44	34.6%	39.3%	39.5%
Percentage between 45 and 64	26.7%	25.1%	24.6%
Percentage 65 and older	22.0%	17.7%	17.8%

The sex distribution in Halifax County shows a higher proportion of females (52.1%) compared to males (47.9%). This disparity is slightly more pronounced than North Carolina's distribution (51.0% female, 49.0% male).

Table 3: Sex Distribution, 2023[8]

	Halifax County		North Carolina		United States	
	Count	Pct. of Total	Count	Pct. of Total	Count	Pct. of Total
Female	24,734	52.1%	5,489,419	51.0%	170,118,720	50.4%
Male	22,734	47.9%	5,276,259	49.0%	167,351,465	49.6%

Race and Ethnicity

Data on race and ethnicity help us understand the need for healthcare services as well as cultural factors that can impact how care is delivered. Non-Hispanic Black residents comprise 51.3% of the population, significantly higher than North Carolina's 20.4%. Non-Hispanic White residents make up 39.1% of the population, considerably lower than the state's 61.2%. The county has a higher percentage of American Indian and Alaska Native (AIAN) residents (3.5%) compared to the state average (1.2%), while Asian and Native Hawaiian and Pacific Islander (NHPI) residents make up smaller proportions of the population. This data indicates that Halifax County has a distinctly different racial composition compared to North Carolina overall, with a predominantly Black population.

Table 4: Racial Distribution, 2023[8]

	Halifax County		North Carolina		United States	
	Count	Pct. of Total	Count	Pct. of Total	Count	Pct. of Total
Black (Non-Hispanic)	24,330	51.3%	2,199,488	20.4%	42,132,758	12.5%
White (Non-Hispanic)	18,562	39.1%	6,590,161	61.2%	204,562,590	60.6%
Asian	307	0.6%	379,374	3.5%	21,088,177	6.2%
AIAN	1,667	3.5%	133,820	1.2%	3,831,126	1.1%
NHPI	11	0.0%	9,214	0.1%	712,229	0.2%
Some Other Race Alone	887	1.9%	677, 338	6.3%	29,432,586	8.7%
Two or More Races	1,704	3.6%	776,283	7.2%	35,710,719	10.6%

By ethnicity, 3.2% of Halifax County's population is Hispanic. This is significantly lower than the North Carolina average of 11.4%.

Table 5: Ethnic Distribution[8]

	Halifax County		North Carolina		United States	
	Count	Pct. of Total	Count	Pct. of Total	Count	Pct. of Total
Non-Hispanic	45,959	96.8%	9,465,874	88.6%	271,934,049	80.6%
Hispanic	1,509	3.2%	1,299,804	11.4%	65,536,136	19.4%

The proportion of foreign-born individuals residing in Halifax County (2.4%) is lower than the state rate (9%).

Table 6: Foreign Born Population, 2022[9]

	Halifax County	North Carolina	United States
Foreign Born	2.4%	9%	13.9%

The diversity of Halifax County is reflected in the languages that residents speak at home. According to the most recent American Community Survey (ACS), approximately 4% of Halifax County residents speak a language other than English at home, compared to around 13% of North Carolina and U.S. residents. A little over 2% of county residents speak Spanish at home, suggesting a lower level of linguistic diversity and a strong predominance of English speakers.

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

	Halifax County	North Carolina	United States
English Only	96.1%	87.3%	78%
Spanish	2.4%	7.9%	13.3%
Indo-European Languages	0.5%	2.1%	3.8%
Asian and Pacific Islander Languages	0.5%	1.9%	3.6%
Other Languages	0.5%	0.8%	1.2%

Disability Status[10]

Data on disabilities helps us understand how to create fair and equal opportunities for everyone in the county. In addition, individuals with disabilities may require targeted services and outreach by health and other service providers. One in five residents in Halifax have a disability. 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]

	Halifax County	North Carolina	United States
Population with a Disability	20%	13.3%	12.9%

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

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

Veteran Status

Military veterans often need special services and support, so it is important to collect data about them to be better able to meet their specific needs. The percentage of veterans in Halifax County (5.7%) is lower than the North Carolina average (7.8%).

Table 9: Veteran Status, 2022[9]

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

Economic Indicators

In addition to demographic data, socioeconomic factors in the community such as income, poverty, and food scarcity play a significant role in identifying health-related needs. The median household income in Halifax County is $38,316, significantly lower than state and national figures.

Table 10: Median Household Income, 2023[8]

	Halifax County	North Carolina	United States
Median Household Income	$38,316	$64,316	$72,603

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

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

	Halifax County	North Carolina	United States
Percent Below FPL	24.8%	10.1%	9.5%

Similar to the percentage of households below the FPL, approximately 38% of Halifax County households received Food Stamps/SNAP (Supplemental Nutrition Assistance Program) in 2022. This is roughly three times the rate of the state and national proportions, indicating a significantly higher level of food insecurity among county households.

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

	Halifax County	North Carolina	United States
Number of Households Receiving Food Stamps/SNAP	7,795	575,860	16,072,733
Total Number of Households	20,394	4,299,266	129,870,928
Percentage of Households receiving Food Stamps/SNAP	38.2%	13.4%	12.4%

In Halifax County, nearly a third (31.1%) of the population has completed high school alone, significantly higher than the state average (21.2%). The county also has higher percentages of residents with less than 9th grade education (6.2%) and some high school but no diploma (10.7%) compared to state figures (6.0% and 5.5% respectively). Conversely, the county shows lower rates of higher education attainment compared to the state. The percentage of residents with some college education (18.3%) is lower than the state average (21.1%), and the population with a bachelor's degree (9.9%) is less than half of North Carolina's rate (20.4%). The proportion of residents with graduate or professional degrees (5.8%) is also notably lower than the state average (11.6%. This data indicates that students in Halifax County may face potential barriers in accessing or completing higher education.

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

	Halifax County	North Carolina	United States
Less than 9th Grade	6.2%	6.0%	3.5%
Some High School/No Diploma	14.7%	5.5%	5.3%
High School Diploma	31.1%	21.2%	28.5%
GED/Alternative Credential	6.3%	4.3%	*[15]
Some College/No Diploma	18.9%	21.1%	14.6%
Associate's Degree	8.1%	9.9%	10.5%
Bachelor's Degree	9.9%	20.4%	23.4%
Graduate/ Professional Degree	4.8%	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 Halifax County (9.3%) is significantly higher than the state average (5.1%). Similar to state trends, the age group with the highest unemployment rate is young people between the ages of 16 and 24, at 28.4%, which is more than double North Carolina's 12.4%. The unemployment rate for ages 25 to 54 (8.5%) is also notably higher than the state figure (4.7%). Older workers in the county have lower unemployment rates than state averages: 2.2% for ages 55-64 (vs. state's 3.3%) and 0.7% for those 65 and older (vs. state's 3.0%). This data indicates substantial employment challenges in Halifax County, particularly among younger workers.

Table 14: Unemployment, 2022[16,17]

	Halifax County	North Carolina	United States
Percentage unemployed ages 16 to 24	28.4%	12.4%	11.0%
Percentage unemployed ages 25 to 54	8.5%	4.7%	3.4%
Percentage unemployed ages 55 to 64	2.1%	3.3%	2.7%
Percentage unemployed ages 65 or more	0.7%	3.0%	2.9%
Total unemployment	9.3%	5.1%	3.9%

Halifax County's overall uninsured rate (10.3%) is lower than both the state (15.0%) and national (12.0%) averages. However, there are variations across age groups. The uninsured rate for ages 18 and below (6.1%) is slightly higher than both state (5.2%) and national (5.4%) figures. For ages 19 to 34, Halifax County's rate (18.1%) is higher than both North Carolina (15.5%) and national (13.6%) averages. The county's uninsured rate for ages 35 to 64 (15.0%) is also higher than both the state's 12.5% and the national 9.9%. This data suggests that while Halifax County performs better overall in terms of insurance coverage, both young and middle-aged adults face challenges in accessing health insurance.

Table 15: Health Insurance Status, 2022[18]

	Halifax County	North Carolina	United States
Percentage uninsured ages 18 or below	6.1%	5.2%	5.4%
Percentage uninsured ages 19 to 34	18.1%	15.5%	13.6%
Percentage uninsured ages 35 to 64	15.0%	12.5%	9.9%
Total % Uninsured	10.3%	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

Figure 10: 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.

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

An analysis of the racial and geographic disparities that emerged in the information obtained and analyzed during this process is detailed below. The CHNA 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.

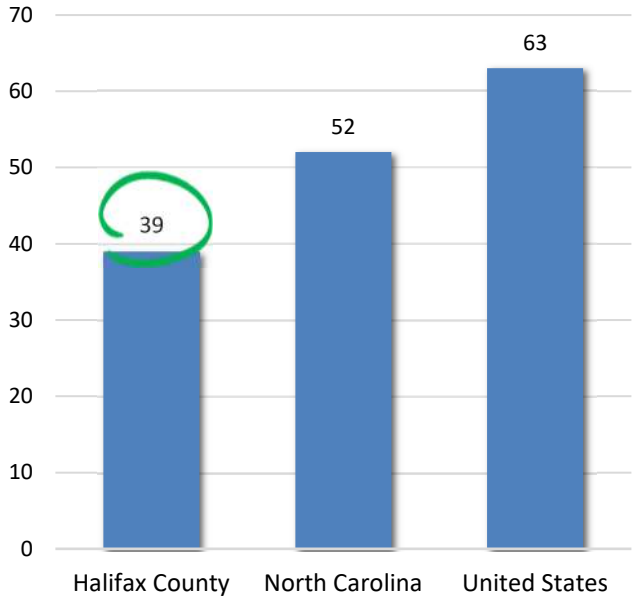
<u>Disparities</u>

Recognizing the diversity of Halifax 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

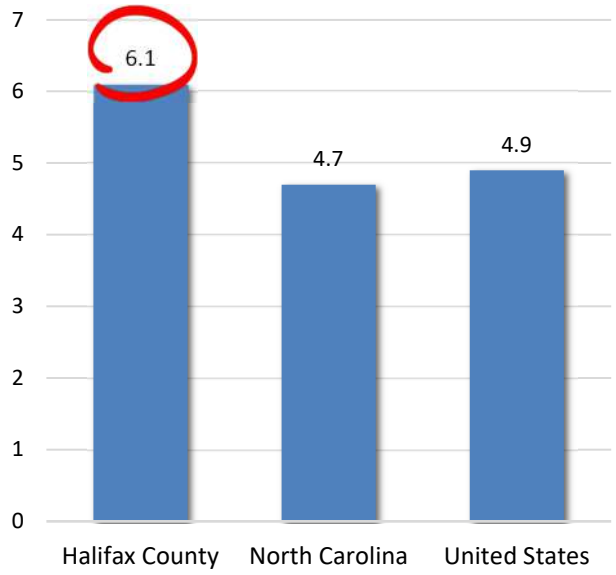
tracts. Lower scores represent a higher level of integration. The rate of residential segregation in Halifax is less than state and national figures, as seen in **Figure 11**.

Figure 11: Residential Segregation[5]



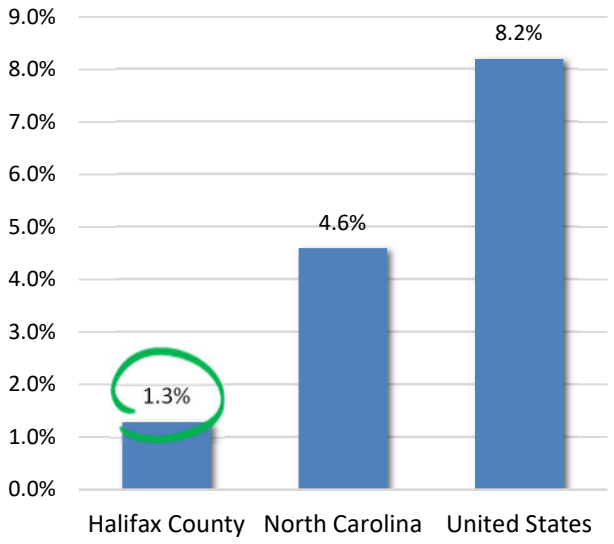
Income inequality is measured as the ratio of household income at the 80th percentile to household income at the 20th percentile. Communities with greater income inequality may have worse outcomes on a variety of metrics, including mortality, poor health, sense of community, and social support. As seen in **Figure 12**, there is a higher rate of income inequality in Halifax compared to North Carolina and the U.S.

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 during the COVID-19 pandemic. There are fewer people in Halifax who are not fluent in English compared to the state and country, as seen in **Figure 13**.

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



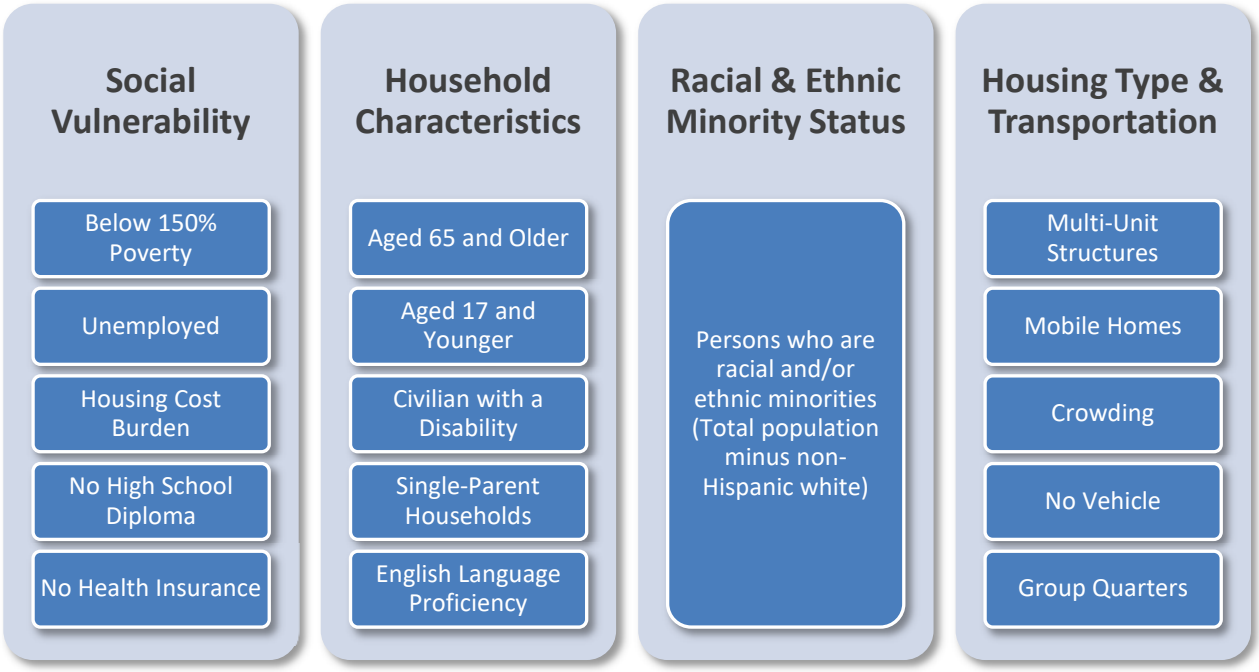
Social Vulnerability Index

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

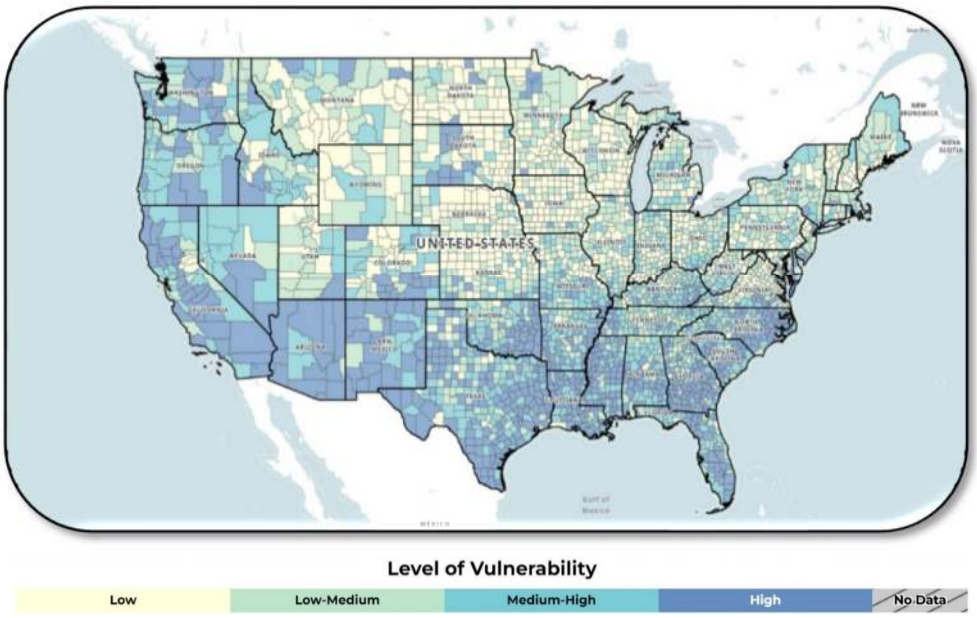
[19] Source: Centers for Disease Control and Prevention (2024). Social Vulnerability Index. https://www.atsdr.cdc.gov/place-health/php/svi/index.html

Figure 14: SVI Variables



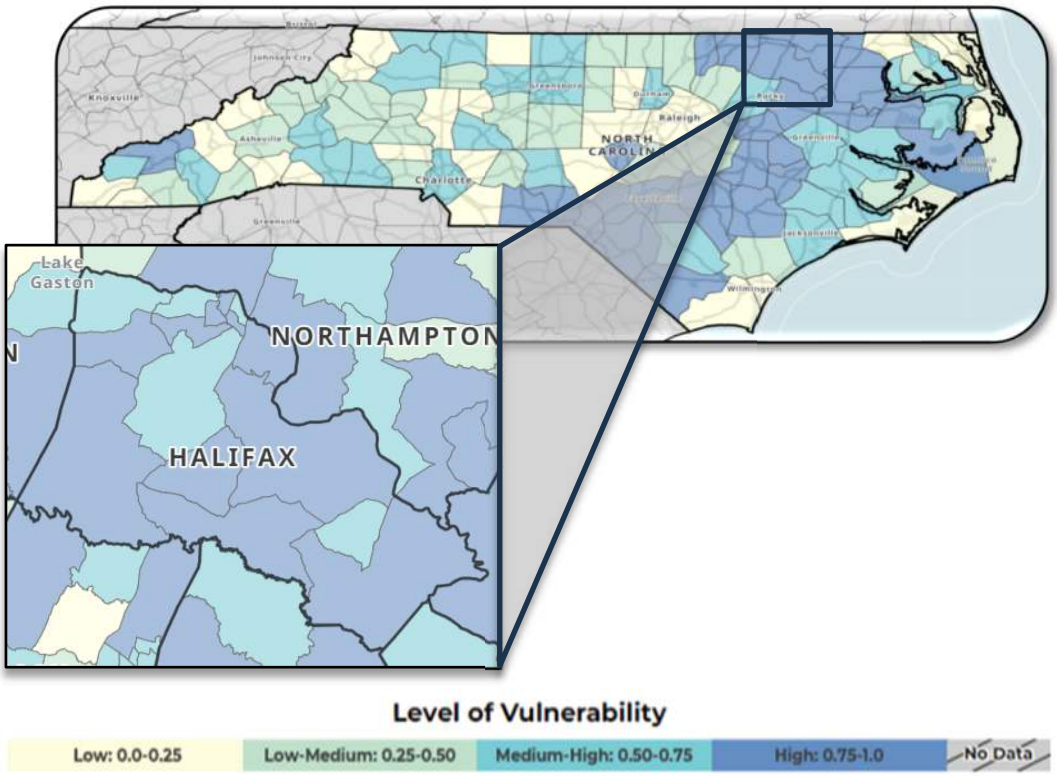
The United States SVI by county is shown in **Figure 15** below. As shown, a lot of variation exists across the country, and even within individual states.

Figure 15: United States SVI by County, 2022



The 2022 SVI scores for Halifax 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 Halifax County overall is significantly higher than average compared to the state. Levels of vulnerability are variable across the county with the average being 0.96.

Figure 16: Halifax County SVI by Census Tract, 2022



Environmental Justice Index

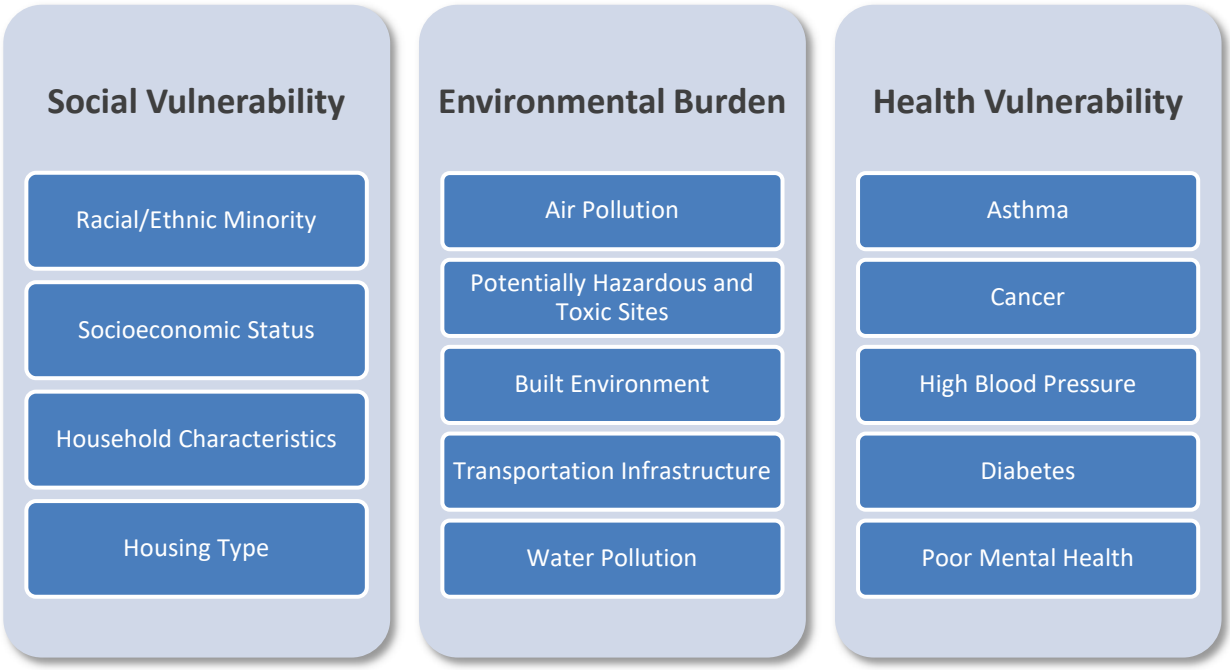
Environmental justice means the just treatment and meaningful involvement of all people, regardless of income, race, color, national origin, Tribal affiliation, or disability, in agency decision-making and other Federal activities that affect human health and the environment. It aims to protect everyone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

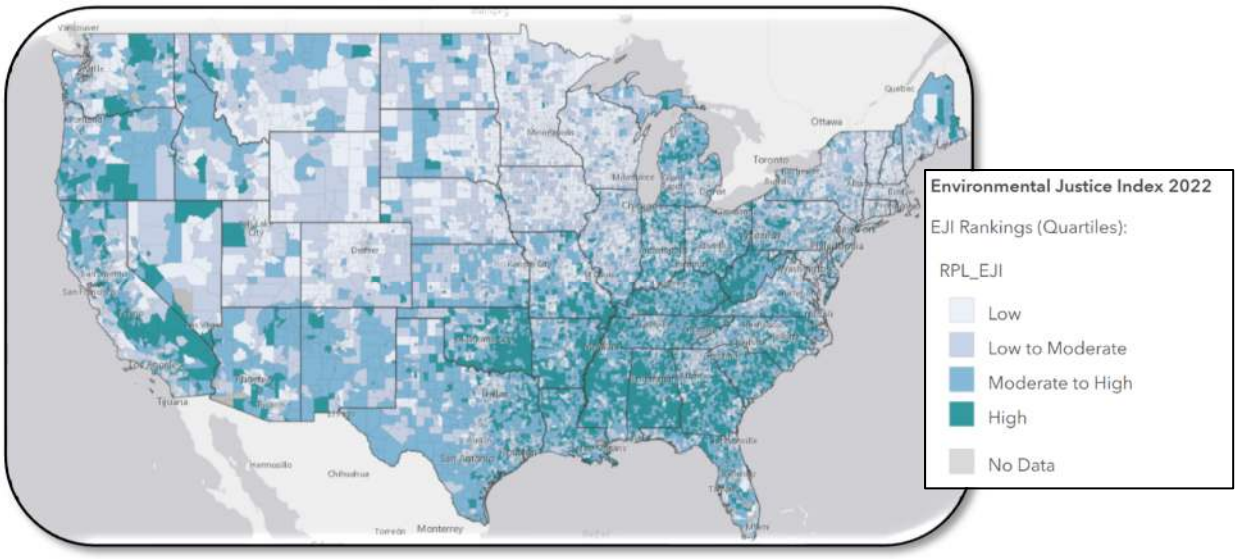
Over time, communities with a higher EJI score are generally shown to experience more severe impacts from environmental burden than communities in other census tracts. **Figure 17** outlines the variables used to calculate EJI scores.

Figure 17: EJI Variables



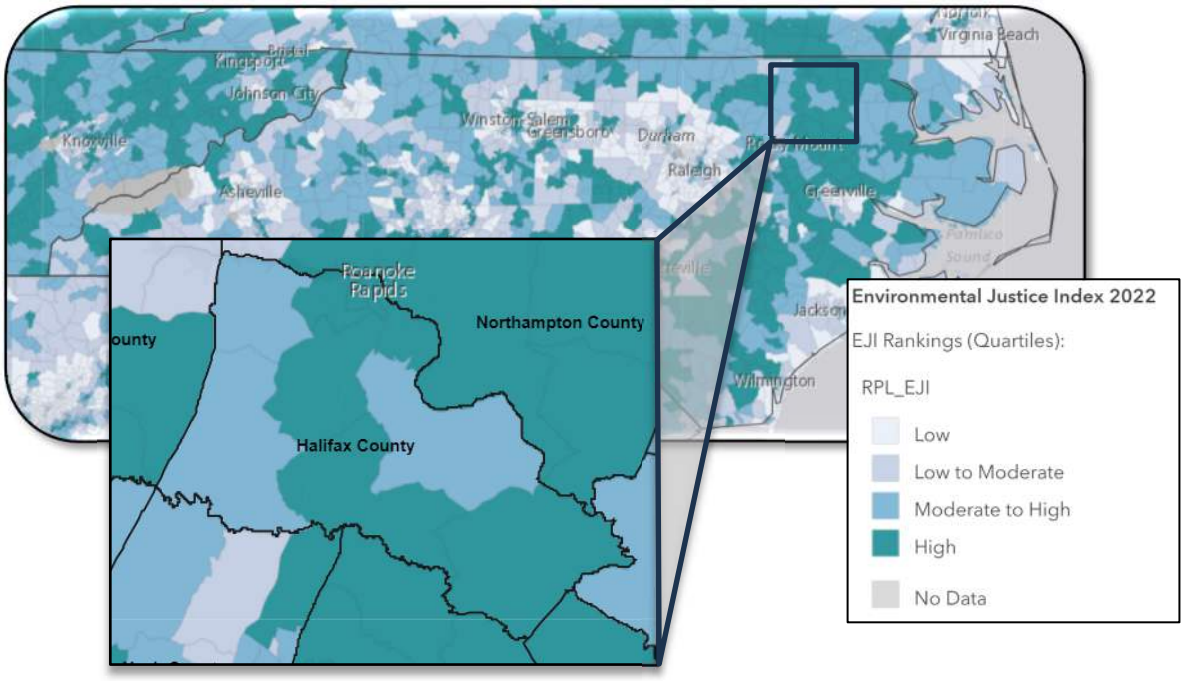
The United States EJI by county is shown in **Figure 18** below. As shown, a lot of variation exists across the country, and even within individual states.

Figure 18: United States EJI by Census Tract, 2022



The 2022 EJI scores for Halifax County are shown in **Figure 19** below. EJI scores use percentile ranking which represents the proportion of census tracts that experience environmental burden relative to other census tracts in North Carolina. The index ranges from 0-1 with higher scores indicating more environmental burden compared to other census tracts. Levels of environmental burden are variable across the county with the average being 0.80.

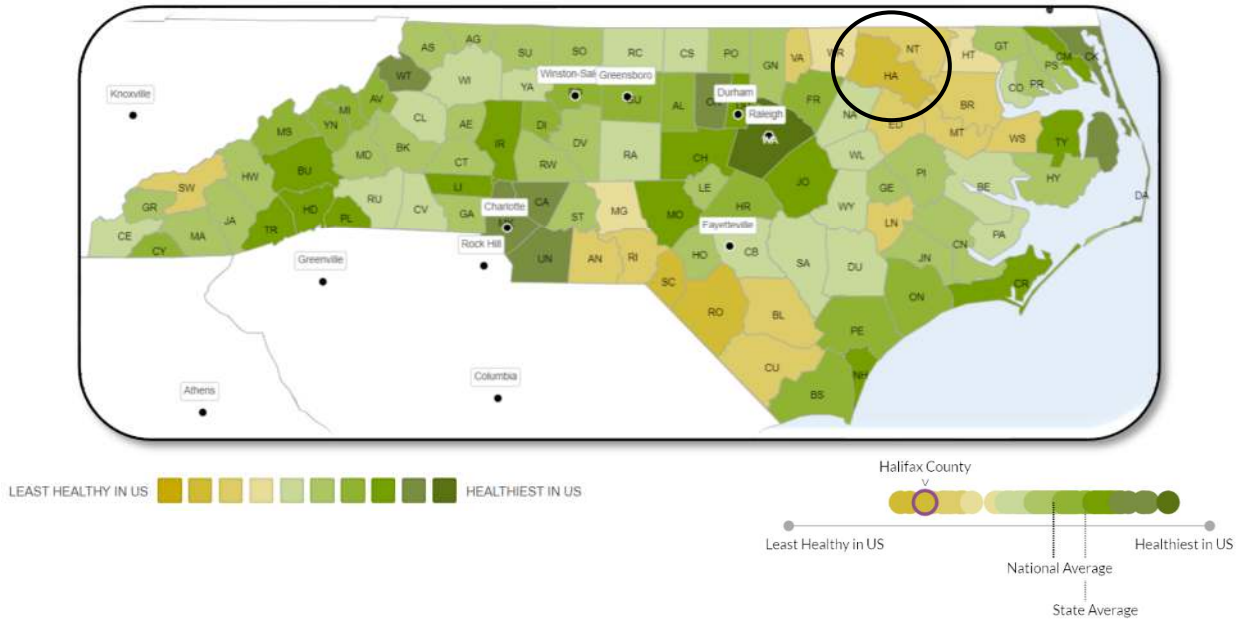
Figure 19: Halifax County EJI by Census Tract, 2022



Health Outcome and Health Factor Rankings

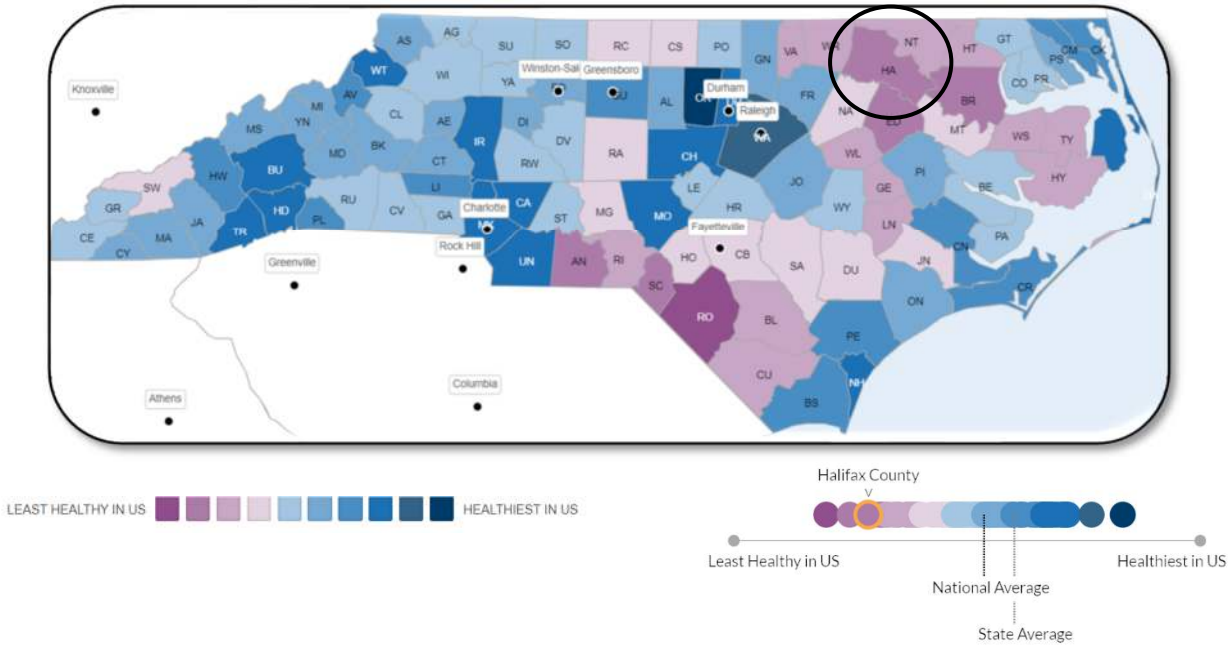
CHNA Stakeholders also reviewed and analyzed data from the Robert Wood Johnson Foundation and the University of Wisconsin County Health Rankings for the year 2024. The Health Outcomes measure looks at how long people in a community live and how physically and mentally healthy they are. These categories are discussed further in Appendices 2 through 4. Halifax is significantly 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 looks at variables that affect people's health including health behaviors, clinical care, social & economic factors, and the physical environment they live in. More details about these indicators can be found in Appendices 2 through 4. Similarly to the Health Outcome measure, Halifax County falls significantly behind for the country and the state.

Figure 21: State Health Factors Rating Map[5]



CHAPTER 3 | PRIORITY NEED AREAS

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

APPENDIX 2 | SECONDARY DATA METHODOLOGY AND SOURCES.

In August 2024, Halifax County conducted a prioritization meeting as part of its 2024 Community Health Needs Assessment. Stakeholders who participated in the process included representatives from ECU Health North Hospital, Halifax County Health Department, Halifax-Warren Smart Start, Roanoke Rapids Parks and Recreation, John 3:16, Turning Point Workforce Development Board, Halifax County Cooperative Extension.

Using a structured method, participants ranked potential priority health needs based on three criteria: magnitude of the problem, seriousness of the consequences, and feasibility of correcting the problem. Focus group findings, combined with other primary and secondary data, informed the selection of the three priority health needs identified: Access to Healthcare, Behavioral Health, & Chronic Disease Prevention.

As mentioned previously, these priority needs areas are not listed in any hierarchical order of importance and all will be addressed by the Halifax County leaders in health improvement plans guided by this CHNA.

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 Halifax 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

[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 .

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 Halifax County.

Secondary Data Findings

Halifax County faces significant challenges in healthcare access across multiple dimensions, particularly regarding the availability of healthcare providers. Various factors contribute to healthcare access barriers, with several key metrics performing much worse than state and national benchmarks. The county has markedly lower rates of healthcare providers compared to North Carolina, especially for dental and primary care providers, as shown in the table below. The county's rate of dental providers (24.7 per 100,000 population) is well below the state rate (31.5), and the rate of primary care providers (61.7 per 100,000) falls substantially short of the state rate of 101.1.

Table 16: Access to Care Indicators

Indicator	Halifax County	North Carolina	United States
Dental Providers (Rate per 100,000 Population)	24.7	31.5	39.1
Primary Care Providers (Rate per 100,000 Population)	61.7	101.1	112.4

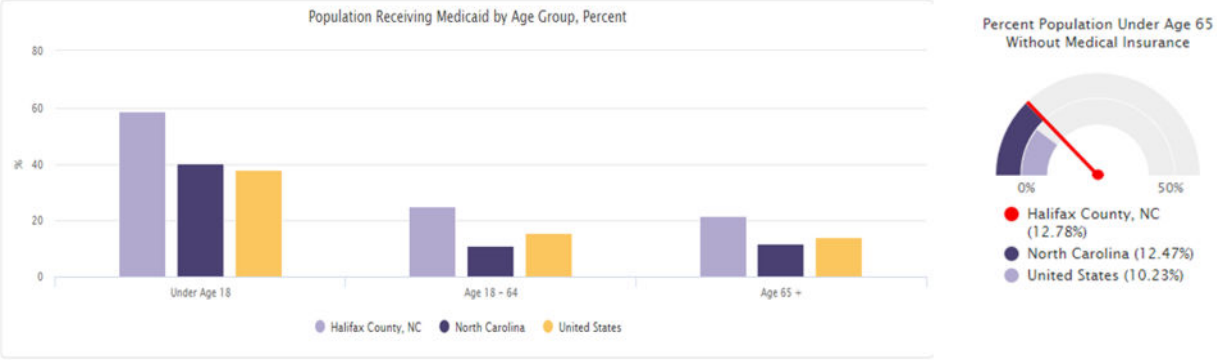
[24] Source: Association of American Medical Colleges (AAMC) (2024). *State of US Nursing Report 2024*. Retrieved, from https://www.incrediblehealth.com/wp-content/uploads/2024/03/2024-Incredible-Health-State-of-US-Nursing-Report.pdf .
[25] Source: AAMC (2021). *North Carolina physician workforce profile*. 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.

Percentage of Population Living in an Area Affected by a Dental Care HPSA	53%	34%	18%
Percent of Insured Population Receiving Medicaid	35%	20%	22%
Rate of Federally Qualified Health Centers (Rate per 100,000 Population)	24.7	4.0	3.5

The shortage of dental providers is particularly concerning as 53% of Halifax County's population lives in an area designated as a Dental Health Professional Shortage Area (HPSA), significantly higher than the state average of 34%. This suggests many residents may have difficulty accessing routine dental care, potentially leading to poorer oral health outcomes. However, the county does show some strengths in certain areas of healthcare access, with a higher rate of Federally Qualified Health Centers (24.7 per 100,000 population) compared to the state average of 4.0, indicating some level of safety net care is available to residents.

Insurance coverage patterns in Halifax County reveal additional healthcare access challenges. Across all age groups, the county has a notably higher percentage of the population receiving Medicaid (35%) compared to both state (20%) and national (22%) averages. This trend is particularly pronounced among Halifax County residents under the age of 18, as illustrated in the figure below.

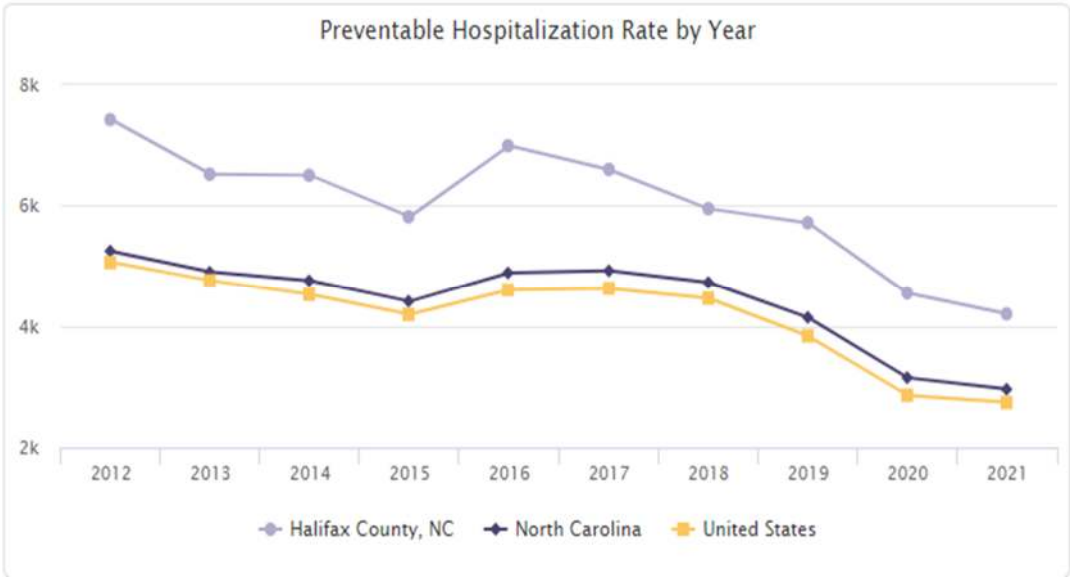
Figure 22: Population Receiving Medicaid by Age Group and Under Age 65 Uninsured



While Medicaid coverage can facilitate healthcare access, the high enrollment rates suggest significant economic challenges in the community that may impact overall healthcare access. Additionally, these residents may face greater difficulty finding providers who accept Medicaid compared to those with private insurance.

Of particular concern are the county's rates of preventable hospital stays, which indicate challenges in accessing appropriate outpatient care. While preventable hospitalization rates have generally declined over time, Halifax County's rate remains substantially higher than state and national averages.

Figure 23: Preventable Hospital Stays



Even more concerning are the significant racial and ethnic disparities in preventable hospitalizations. Black or African American Medicare beneficiaries in Halifax County experience a preventable hospitalization rate of 5,433 per 100,000 beneficiaries, nearly double the rate for White beneficiaries (2,913). Similarly, Hispanic or Latino Medicare beneficiaries face a higher rate of 5,545 per 100,000. These disparities suggest that certain populations in the county face greater barriers to accessing preventive and primary care services.

Figure 24: Preventable Hospitalization Rate by Race/ Ethnicity

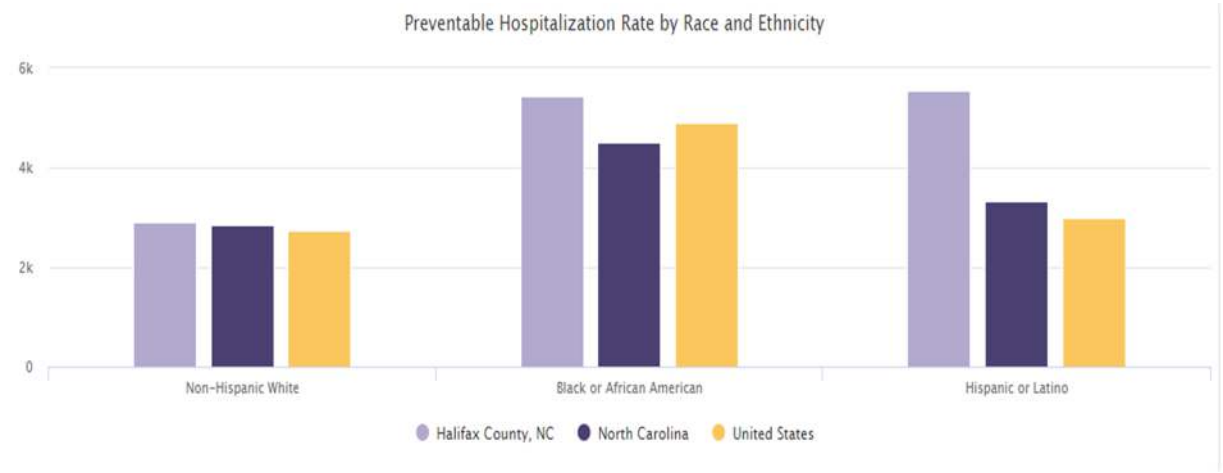


Table 17: Preventable Hospital Stays by Race/Ethnicity

Preventable Hospital Stays (per 100,000 Medicare Beneficiaries)	Halifax County Rate

Preventable Hospital Stays	4,061
Hispanic or Latino Medicare Beneficiaries	5,545
Black or African American Medicare Beneficiaries	5,433
White Medicare Beneficiaries	2,913

Transportation barriers further compound healthcare access challenges in Halifax County. The county has a higher percentage of households with no motor vehicle (9.0%) compared to the state average (5.4%). Additionally, none of the population uses public transit to commute to work. The lack of transportation options, combined with limited healthcare providers, suggests that many residents may face significant logistical barriers to accessing healthcare services.

Table 18: Transportation Indicators

Indicator	Halifax County	North Carolina	United States
Households with No Motor Vehicle, Percent	9.0%	5.4%	8.3%
Percent Population Using Public Transit for Commute to Work	0.0%	0.8%	3.8%

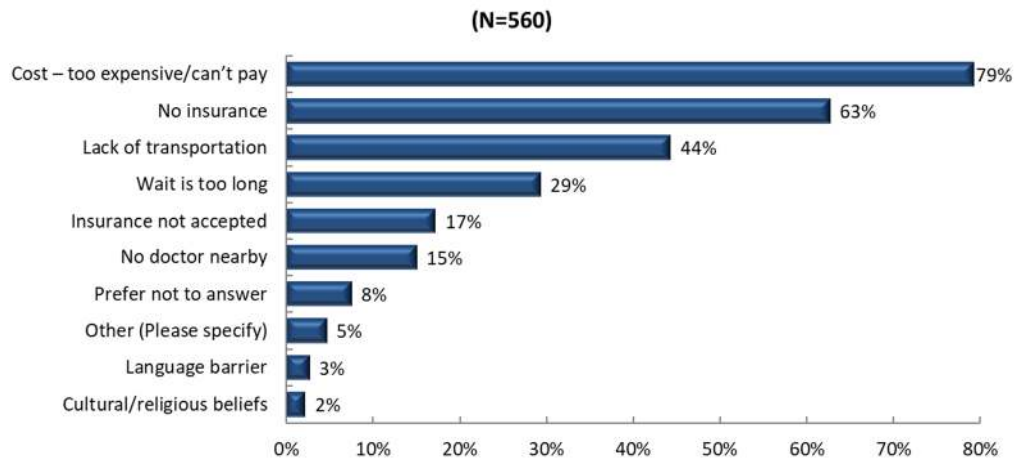
These findings suggest that while Halifax County has some healthcare access strengths, such as a robust FQHC presence, many residents face multiple, overlapping barriers to accessing healthcare services. The combination of provider shortages, high Medicaid enrollment, significant racial/ethnic disparities in preventable hospitalizations, and limited transportation options indicates a need for comprehensive strategies to improve healthcare access across the county.

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

Primary Data Findings – Community Member Web Survey

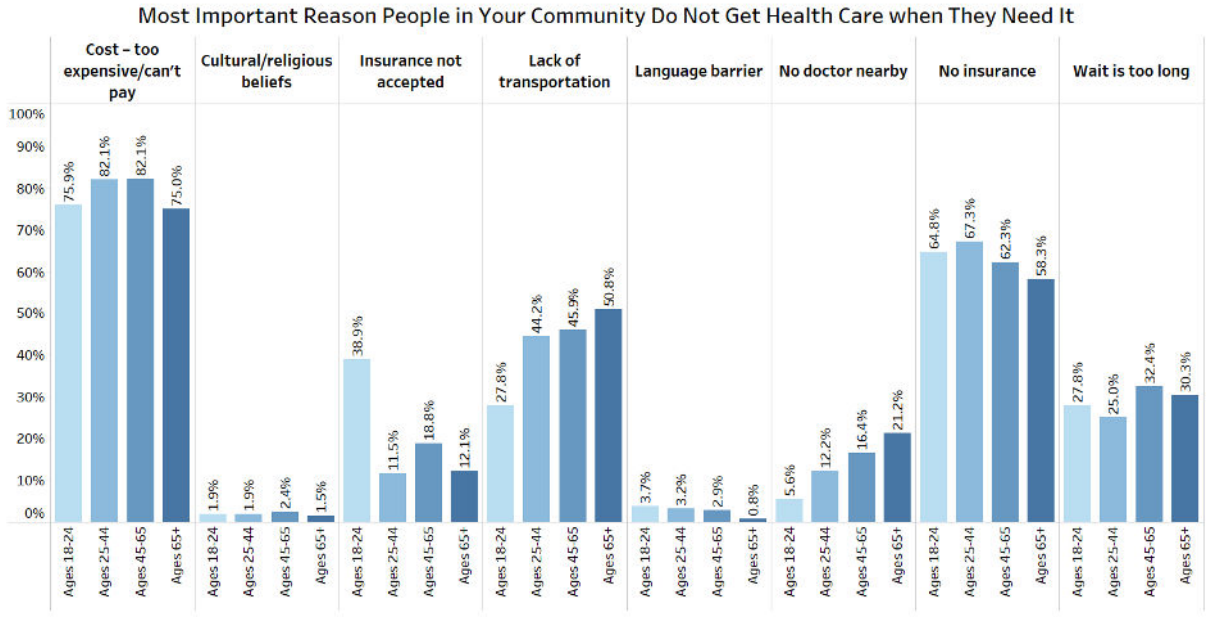
Nearly 560 Halifax County residents responded to the web-based survey. Respondents identified several access to care needs in Halifax County. In the survey, community members were asked to identify the top barriers to receiving healthcare. Cost (79%), no insurance (63%), and lack of transportation (44%) were the top three identified reasons why people in the community are not getting care when they need it. Another third of responses identified long wait times and 17% of responses indicated insurance not being accepted as 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.



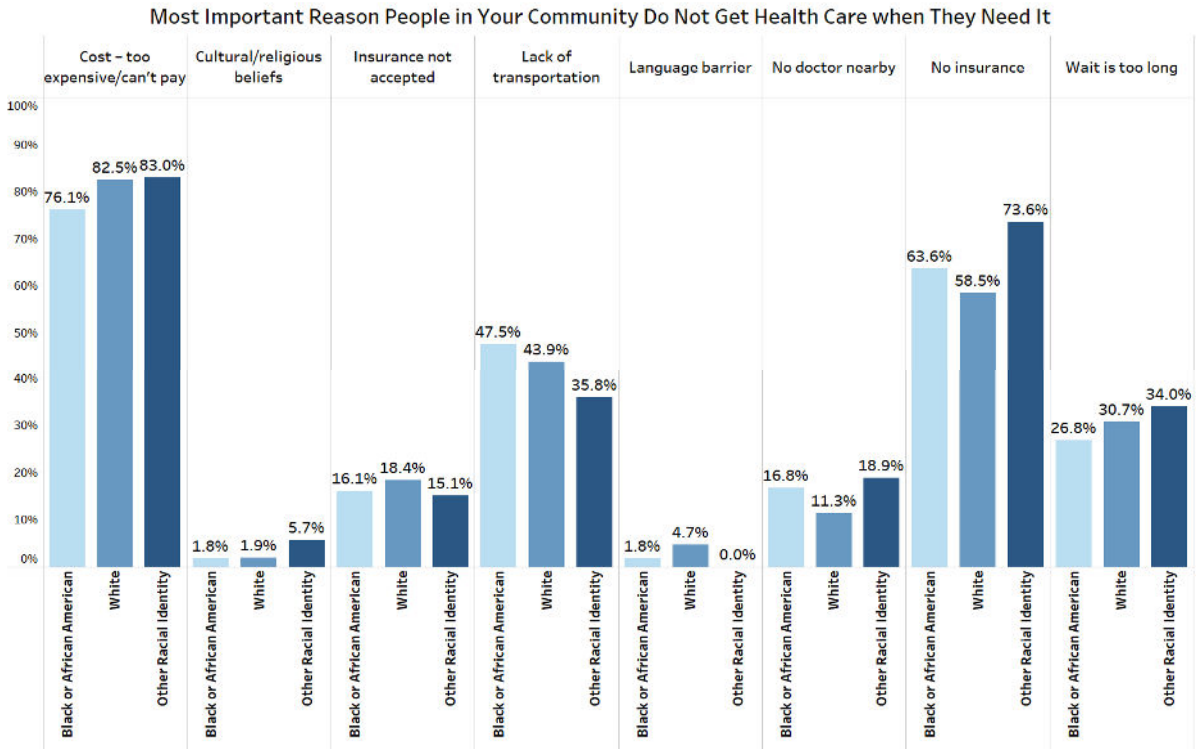
When these data were examined by age group, all age groups similarly identified cost and lack of insurance as the top barriers to care. Older respondents more frequently viewed lack of transportation as an obstacle to healthcare, while the youngest respondents (ages 18 to 24) were far more likely than all other respondents to cite insurance not being accepted (39%) as a barrier.

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.



Responses also differed by race. Nearly 74% of respondents identifying with the "Other" race category[29] noted lack of insurance as a top barrier to healthcare compared to 64% of respondents identifying as Black/African American and 59% of respondents identifying as White.

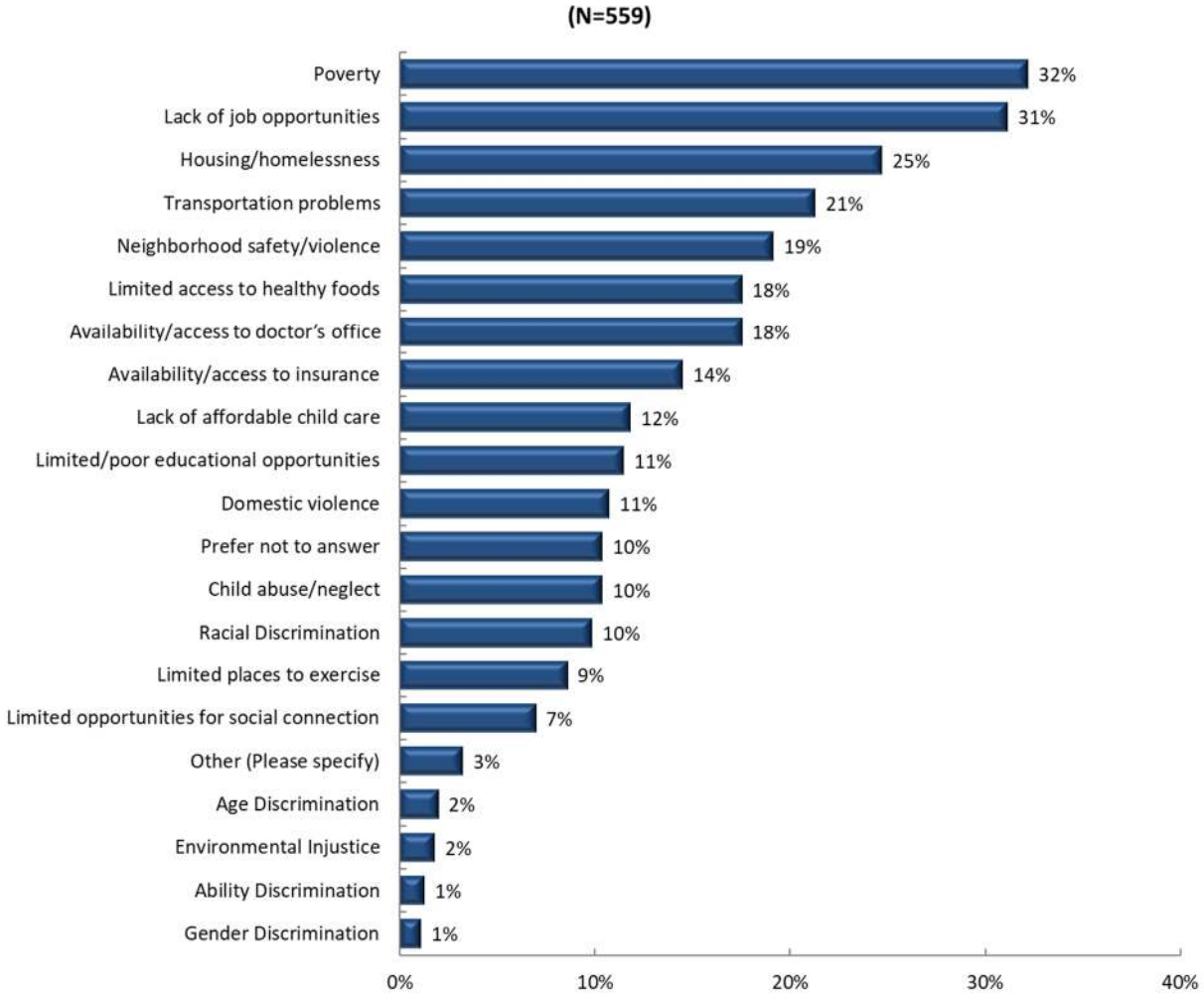
Figure 27: What are the three most important reasons people in your community do not get health care when they need it? Please select up to three.



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, nearly one in five respondents identified availability or access to doctor's offices (18%) as an important problem, again highlighting access to care challenges within the community. Additionally, transportation (21%) was the fourth most frequently identified social or environmental problem that affects the health of the community.

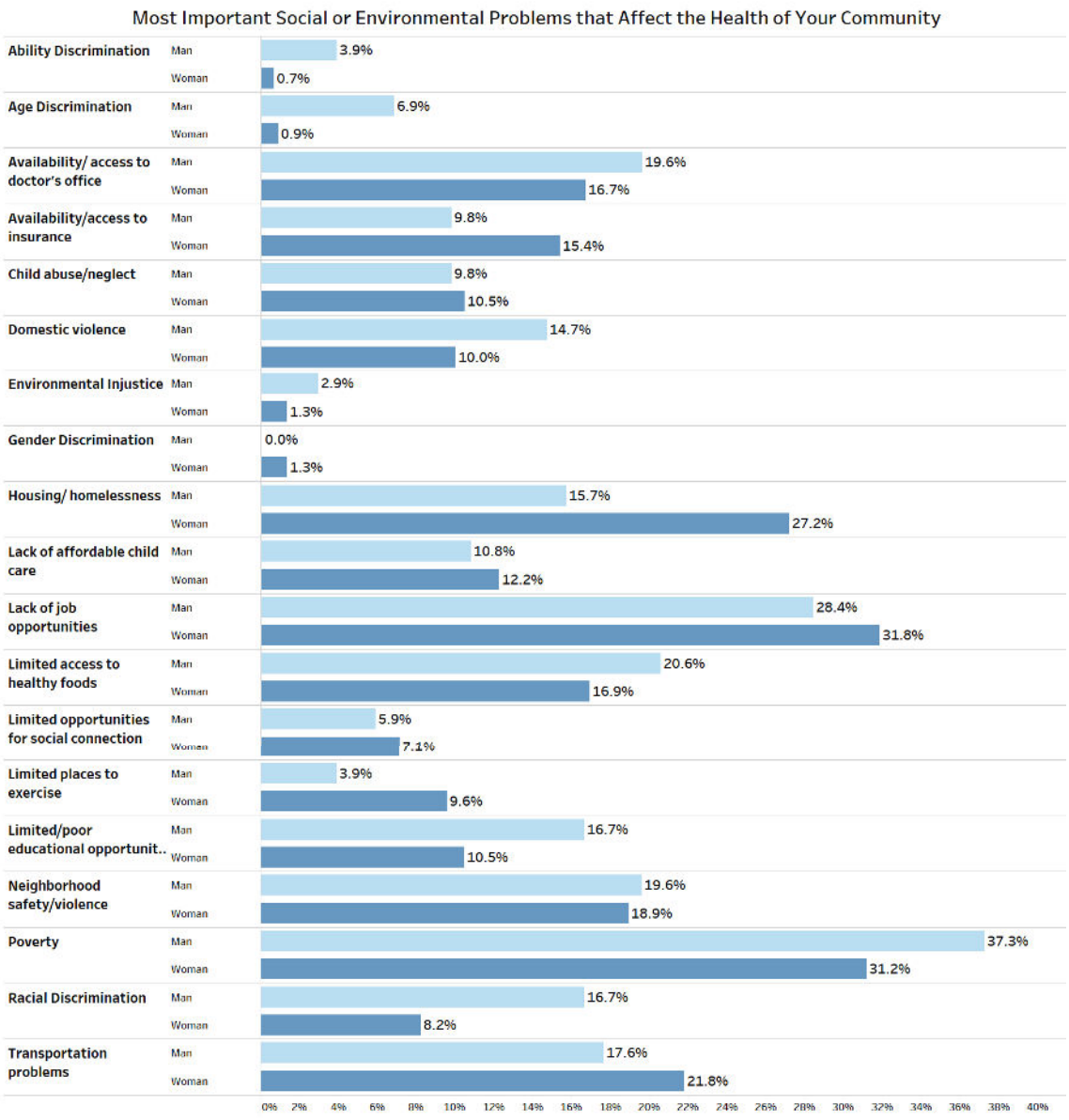
[29] Includes those who identified as American Indian and Alaska Native, Asian, Native Hawaiian and other Pacific Islander, and/or those who selected more than one race or "other."

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



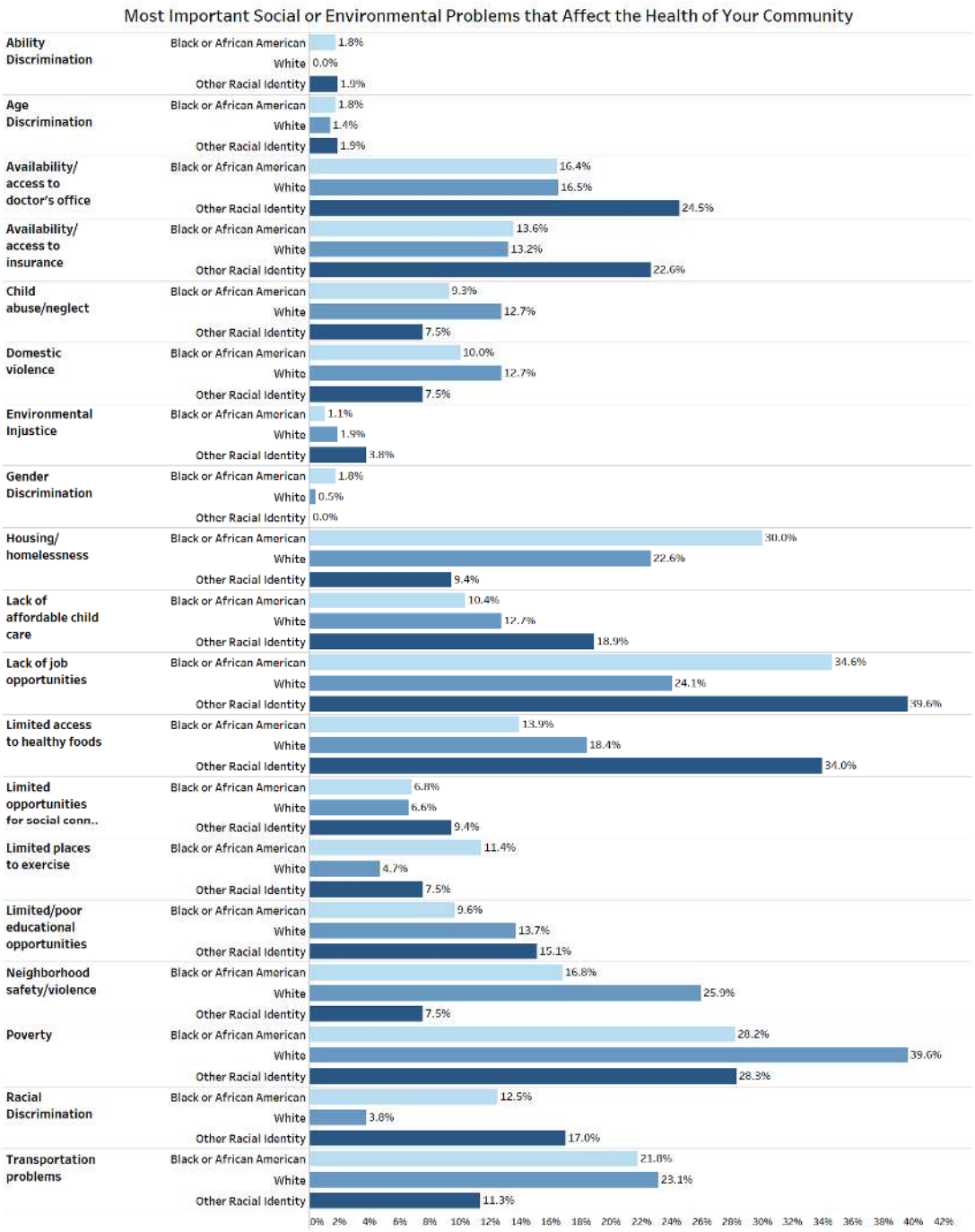
Notably, men and women differed in their responses. More women identified availability and access to insurance as a top social and environmental problem (15% for women vs. 10% for men), while more men identified availability and access to doctor's offices (20% for men vs. 17% for women). Women were also more likely than men to identify transportation problems as an important social and environmental problem (22% compared to 18%).

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)



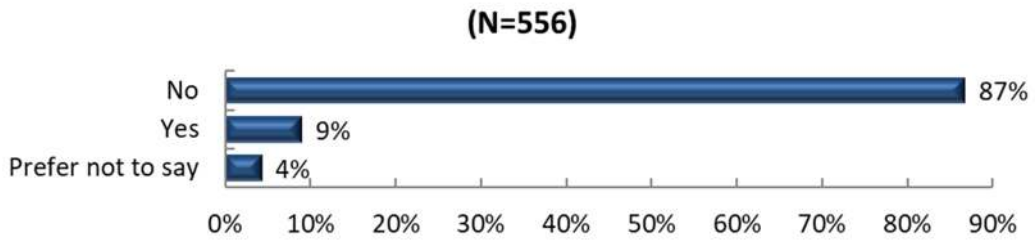
Responses also varied by race. Those identifying as "other" were more likely to cite availability of doctor's offices and availability or access to insurance than all other races (Other: 25%, 23%; Black or African American: 16%, 14%; White: 17% 13%).

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 nearly one in ten 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?



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

Primary Data Findings – Focus Groups

Access to healthcare concerns emerged as a significant theme across all three focus groups conducted in Halifax County. Provider availability was a key concern raised by many focus group participants. The groups noted there are not enough resources or providers for the large number of individuals in the county. Wait times for appointments were cited as a particular challenge, with participants noting that emergency rooms often become the only option due to the inability to get timely appointments. Rural areas of the county were identified as being particularly affected by limited provider access. Transportation was also consistently identified as a major barrier to accessing healthcare services. Focus group participants noted that transportation doesn't exist for many residents, particularly affecting those in rural areas of the county. Cost emerged as another significant barrier to healthcare access. Participants discussed that many residents cannot afford to pay for insurance, and those who have insurance may still struggle with costs. The discussions highlighted that being in the middle class can make it especially difficult to access care due to high prices.

Focus group participants suggested several potential solutions to address these access issues. The health department's work on telemedicine innovation was discussed as one approach to addressing transportation barriers, though participants noted this solution faces challenges related to broadband access and finding places where residents can access WiFi. Participants also emphasized the need for leveraging more state and federal funding to support healthcare access in the county.

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

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

Context and National Perspective

The definition of behavioral health often describes conditions related to both mental health and substance use.[30] 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

[30] 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.

stressors, and health behaviors.[31] After evaluating data from a variety of sources including surveys and focus groups conducted throughout the assessment process, the CHNA Stakeholders identified mental health, including substance use, to be an area of urgent need within Halifax 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.[32] 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. [33]

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.[34] While access to telehealth mental health services has increased, those living in rural areas may still find it difficult to access care. This is a particular concern among those who are low-income or experiencing homelessness, two groups at high risk for developing an acute or chronic mental health condition. As of 2023, over seven million people in the U.S. who reported having a mental illness lived in a rural area.[35]

Mental illness is a prevalent concern in North Carolina, with nearly 1.5 million adults reported to have a mental health condition in 2023. Additionally, that same year, 1 in 7 individuals who were identified as homeless also were living with an SMI. Access to mental health care in North Carolina is changing, however it is still unavailable to many. Specifically, over 452,000 individuals did not seek care in 2023, with 44.8% citing cost as the main reason. Additionally, those in live in North Carolina are seven times more likely to be pushed out of network of their behavioral health providers, than a primary care provider, furthering cost as a cause for stopping treatment. [36]

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.[37] SUDs often occur in conjunction with other mental illness. In 2023, 16 million (46.9%) young adults aged 18-25

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

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

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

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

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

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

[37] 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.

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.[38] 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.[39] 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.[40] 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.[41]

Substance use disorders have also had an impact in North Carolina. Over 36,000 overdose deaths occurred in the state between 2000 and 2022 – an average of more than 1,600 deaths each year.[42] Multiple programs have been developed in North Carolina to combat substance use disorder, notably surrounding opioid usage, which has led to an increase in access and usage of Medication Assisted Treatment (MAT) and methadone clinics within the state. Additionally, North Carolina launched the Opioid and Substance use action plan, which involved the development of multiple interventions, dashboards, and educational materials to help support counties and organizations with reducing not only overdose deaths, but the incidence of SUDs as well.

The pandemic impacted public mental health and well-being in many ways. Community members continue to grapple with the pandemic-related effects of isolation and loneliness, financial instability, long-term health impacts and grief, all of which are drivers for developing a substance use disorder. In addition, both drug overdose and suicide deaths have sharply increased over the past several years – often disproportionately impacting younger people and communities of color.[43]

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[38] 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.

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

[40] 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

[41] 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/

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

[43] 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.

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

Secondary Data Findings

Mental Health

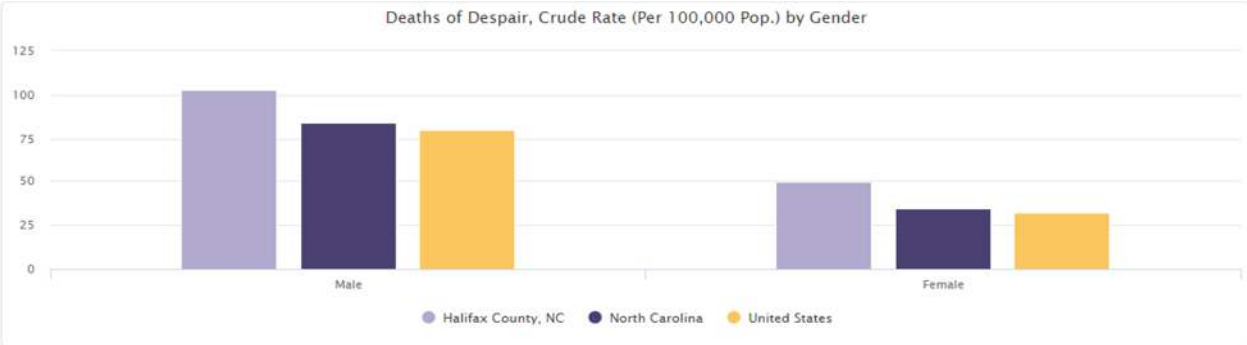
Halifax County residents experience significant mental health challenges compared to state and national averages. The county has a higher crude death rate for deaths of despair at 75.2 per 100,000 population, considerably exceeding both North Carolina (58.7) and United States (55.9) rates. The burden of mental health issues is further evidenced by residents reporting an average of 5.5 poor mental health days per month, higher than both state (4.6) and national (4.9) averages. Access to mental health care is another significant concern, with only 92.6 mental health providers per 100,000 population in the county, substantially lower than both North Carolina (155.7) and national (178.7) rates.

Table 19: Mental Health Indicators

Indicator	Halifax County	North Carolina	United States
Deaths of Despair (Crude Rate per 100,000 Population)	75.2	58.7	55.9
Suicide (Crude Rate per 100,000 Population)	15.8	14.0	14.5
Average Number of Poor Mental Health Days (per Month)	5.5	4.6	4.9
Mental Health Providers (Rate per 100,000 Population)	92.6	155.7	178.7

There was also a gender disparity for deaths of despair, in which the mortality rate was significantly higher among men compared to women. The figure below highlights this gender disparity.

Figure 32: Crude Rate of Deaths of Despair by Gender



Substance Use Disorders

In terms of substance use, Halifax County presents a mixed picture but with several concerning trends. While the county shows a lower percentage of adults reporting excessive drinking (13%) compared to state and national averages (18%), it faces significant challenges with substance-related mortality. The county has a markedly higher death rate due to alcohol-involved crashes at 12.3 per 100,000 population, more than four times the state average of 2.9. The opioid overdose death rate is also elevated at 28.8 per 100,000 population, higher than the state rate of 25.1. The county has fewer substance abuse providers (16.5 per 100,000 population) compared to state (25.0) and national (27.9) averages, though it maintains a higher rate of buprenorphine providers (20.0) compared to state (15.2) and national (15.5) averages.

Table 20: Substance Use Indicators

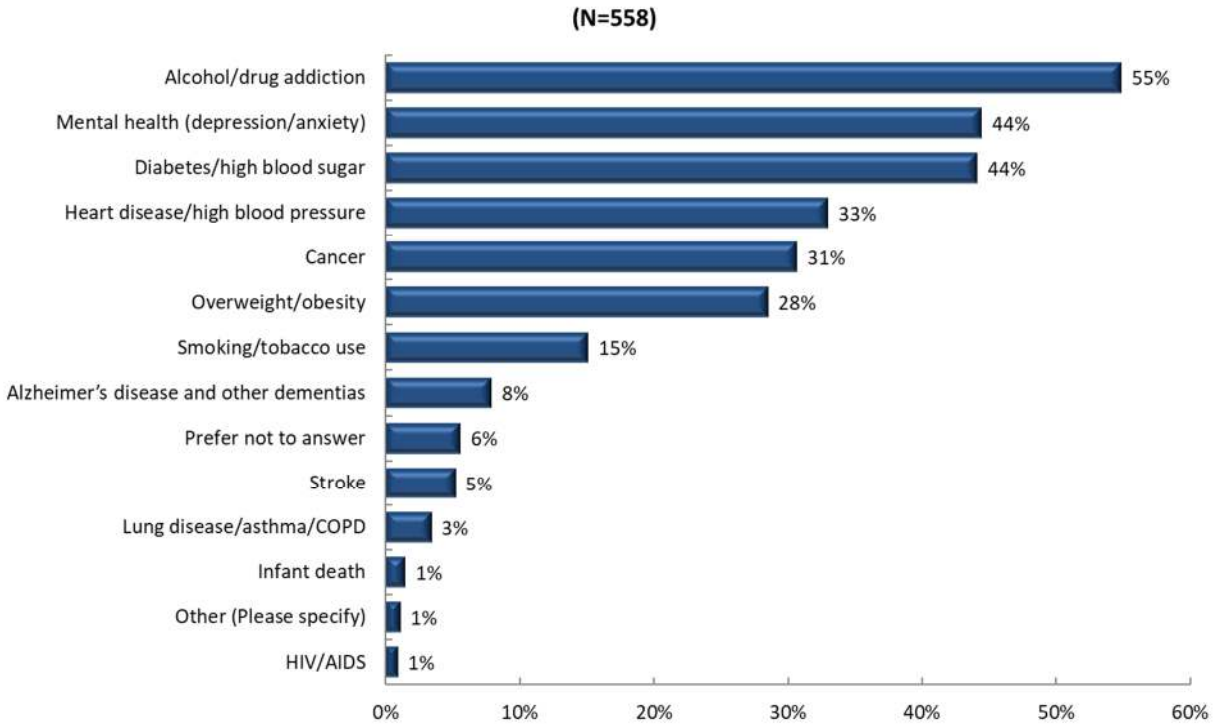
Indicator	Halifax County	North Carolina	United States
Percentage of Adults Reporting Excessive Drinking	13%	18%	18%
Opioid Use Disorder Emergency Department Utilization (Rate per 100,000 Beneficiaries)	29	43	41
Alcohol-Involved Crash Deaths, Annual (Rate per 100,000 Population)	12.3	2.9	2.3
Opioid Overdose Death Rate (Crude Rate per 100,000 Population)	28.8	25.1	N/A
Substance Abuse Providers (Rate per 100,000 Population)	16.5	25.0	27.9
Buprenorphine Providers (Rate per 100,000 Population)	20.0	15.2	15.5

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

Primary Data Findings – Community Member Web Survey

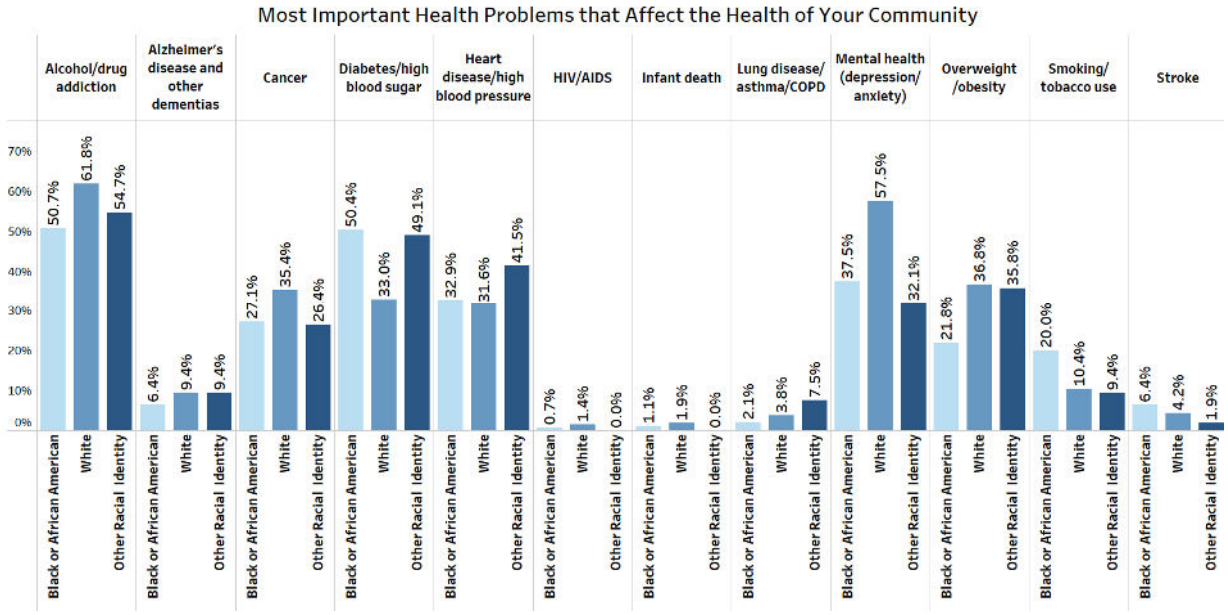
Halifax County residents highlighted different aspects of mental health and substance use as areas of community concern on the web-based survey. When asked to identify the most important community health needs, 55% of these respondents identified alcohol/drug addiction and 44% of respondents identified mental health (depression/anxiety). These were the most frequent and second most frequent of all community health needs identified, respectively.

Figure 33: What are the three most important health problems that affect the health of your community? Please select up to three.



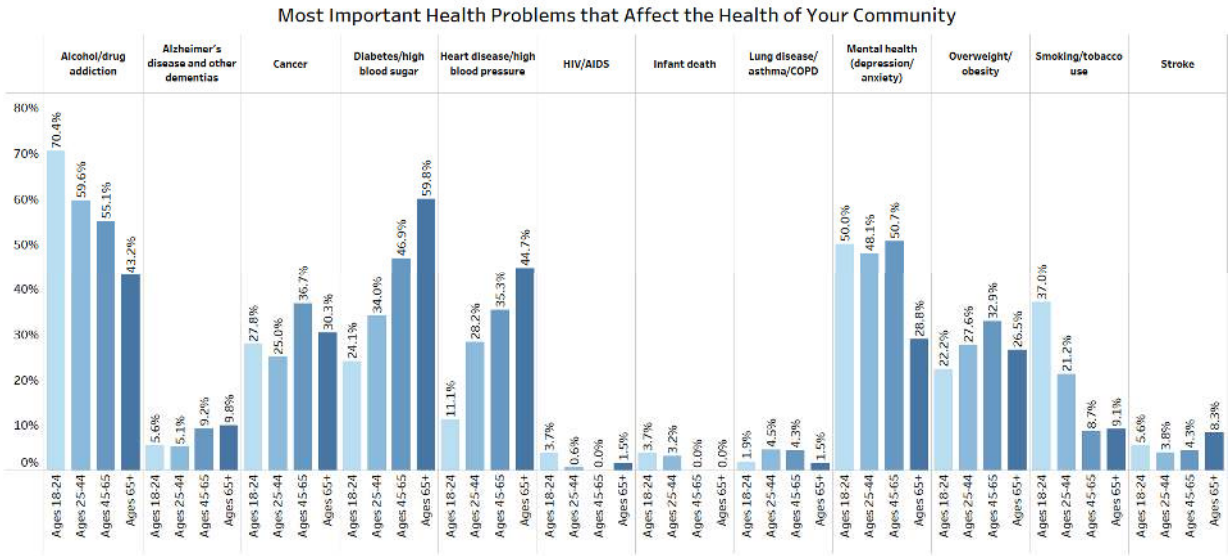
However, when these data were examined by the race of community member respondents, differences emerged. Those who identified as White (62%) selected alcohol/drug addiction as an important community health need more frequently than those who identified as Black or African American (51%) and all other races (55%), as displayed in the figure below. Similarly, a higher percentage of respondents identifying as White selected mental health as a top community health need (58%), while a lower percentage of those identifying as Black or African Americans (38%) and as all other races (32%) selected this as a top need.

Figure 34: What are the three most important health problems that affect the health of your community? Please select up to three. (by race)



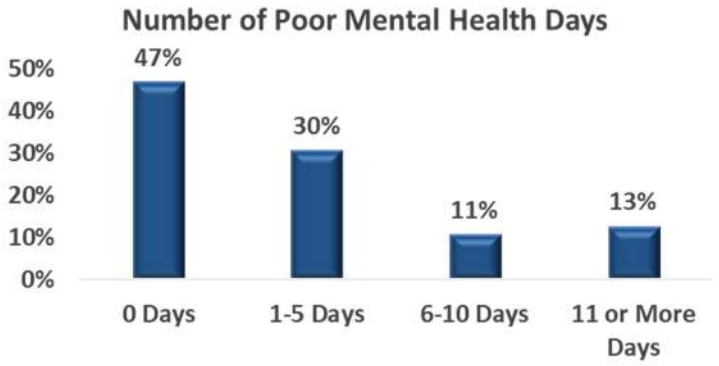
Similarly, there were differences in responses across age groups. Younger people identified alcohol/drug addiction and mental health as more significant issues than older respondents. These perceived differences by demographic characteristics may be important in planning efforts to address behavioral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

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



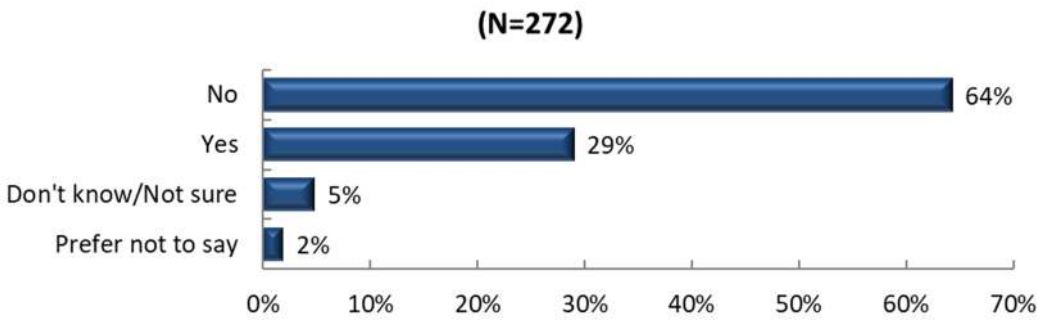
When respondents were asked about their own mental health, half of respondents indicated they had one or more poor mental health days in the past 30 days, with an average of 4 poor mental health days among these respondents.

Figure 36: 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?



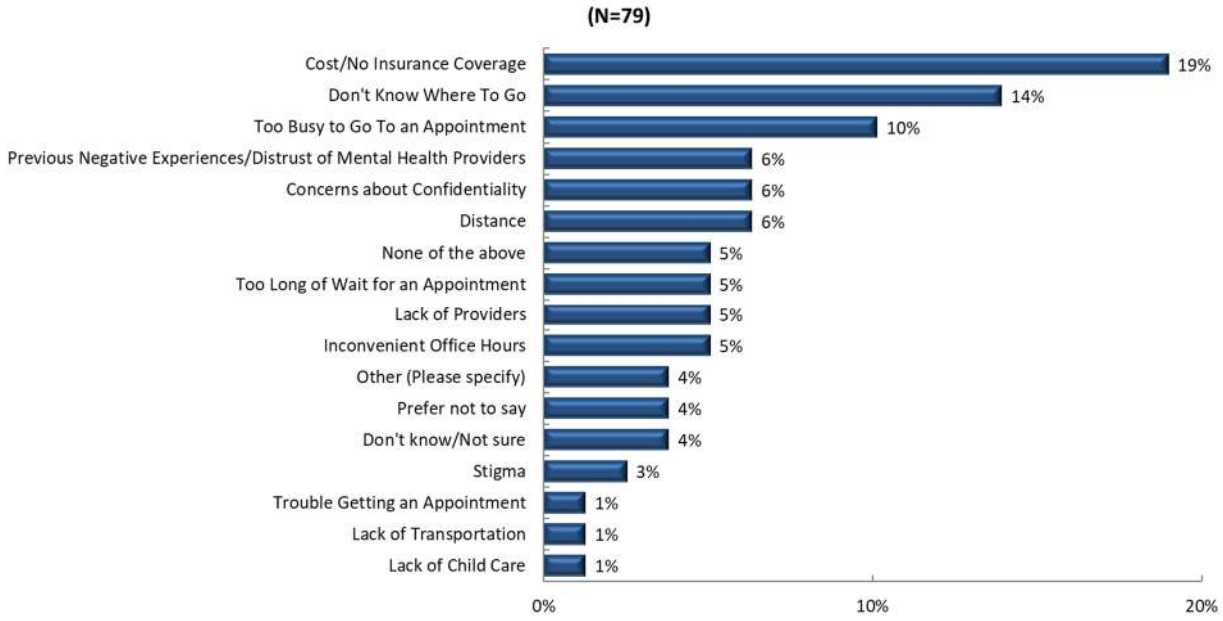
Community member respondents who indicated they experienced at least one poor mental health day a month were asked if there was a time in the past 12 months when they needed mental healthcare or counseling but did not get it at that time. Nearly 30% of these respondents answered yes.

Figure 37: 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 this group did not receive care included cost/no insurance (19%), not knowing where to go (14%), and being too busy to go to an appointment (10%), suggesting accessibility and resource awareness concerns exist in the community impacting access to needed mental healthcare.

Figure 38: What was the MAIN reason you did not get mental health care or counseling?



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

Primary Data Findings – Focus Groups

Mental health and substance use concerns were prominent topics across all three Halifax County focus groups. Participants consistently highlighted the severe shortage of mental health providers throughout the county and emphasized that the high cost of mental health treatment creates significant barriers to care. Focus group members expressed particular concern about mental health challenges affecting both young people and the elderly population. The lack of state funding for mental health services was cited as a key contributing factor to limited provider availability.

Regarding substance use, focus group participants at the Halifax County Health Department specifically noted increasing drug and alcohol use in the community, with particular concern about substance use among young people. This group also raised alarm about the proliferation of vape shops in the community and vaping among youth, including elementary school-aged children. Focus group members at ECU Health North suggested strengthening partnerships with law enforcement to better address substance use challenges in the community. They also advocated for more effective use of available state and federal funding to expand mental health and substance use treatment services in the county. These participants highlighted how transportation barriers compound access issues, making it even more difficult for residents to receive needed mental health and substance use treatment services.

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

PRIORITY NEED: CHRONIC DISEASE PREVENTION (OBESITY)

Context and National Perspective

The WHO defines overweight and obesity as abnormal or excessive fat accumulation that presents risks to a person's health.[44] Obesity is one of the fastest rising chronic conditions in the United States. According to the CDC, the U.S. obesity prevalence rate between 2017-2020 was 41.9%, which represents a significant increase from 30.5% in 2000.[45] Obesity is often a factor in other chronic health conditions, such as stroke, diabetes, heart disease, and in some types of cancer.

Obesity can be expensive to treat, averaging roughly $3,097 per individual each year in 2019 – or $173 billion nationally. [46] Obesity is a common condition, affecting at least 20% of each state's population. Across the South, more than one-third of the population (34.7%) was considered obese in 2023. Obesity rates vary by race and ethnicity, with Hispanic adults (34%) and Non-Hispanic African American adults (38%) having the highest prevalence rates for obesity. [47]

There are multiple factors that can contribute to obesity, such as age, genetics, hormonal changes, lack of physical activity, the type and amount of food consumed, and medications. Various SDoH factors can impact obesity, such as education and the surrounding environment. There are multiple ways to treat obesity, including diet changes, gastric bypass surgery (in extreme cases), GLP-1 medications, and exercise programs. Obesity can be stigmatized due to the lack of knowledge surrounding non-diet and exercise-related causes and can often be a barrier to a patient seeking care.

Obesity rates are estimated to be higher in rural communities than in urban areas. When looking at the impact of physical activity on obesity, studies have indicated that rates may be lower among children due to playing outside or playing on sports teams, but rural children also experience more barriers with access to sidewalks, gyms and parks compared to urban children. Rural adults are more likely to be overweight due to those same barriers, as well as a more limited access to healthy foods than those who live in cities.[48]

In North Carolina, over one-third (34%) of adults were reported as having obesity in 2022 (the most recent data available).[49] Obesity is a medical condition, meaning programs and support are often tailored to a specific patient by their provider or hospital-based support programs. Additionally, many programs are focused on general nutrition and physical activity, such as WIC, NCCARE360, and other NCDHHS initiatives. However, these programs can still be a useful tool for laying the groundwork for building healthy behaviors and habits which can lower obesity rates.

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[44] Source: WHO (2024). *Obesity and Overweight.* Retrieved September 10th, 2024, from https://www.who.int/news-room/fact-sheets/detail/obesity-and-overweight

[45] Source: CDC (2022). *Adult Obesity Facts*. Retrieved September 10th , 2024, from https://www.cdc.gov/obesity/php/data-research/adult-obesity-facts.html?CDC_AAref_Val=https://www.cdc.gov/obesity/data/adult.html

[46] Source: CDC (2022). *Adult Obesity Facts*. Retrieved September 10th , 2024, from https://www.cdc.gov/obesity/php/data-research/adult-obesity-facts.html?CDC_AAref_Val=https://www.cdc.gov/obesity/data/adult.html

[47] Source: CDC (2023). *Adult Obesity prevalence maps.* Retrieved October 3, 2024 from: https://www.cdc.gov/obesity/php/data-research/adult-obesity-prevalence-maps.html

[48] Source: Crouch, E., et.al, (2023). *Rural-Urban Differences in Overweight and Obesity, Physical Activity, and Food Security among Children and Adolescents.* Retrieved October 3, 2024 from: https://www.cdc.gov/pcd/issues/2023/23_0136.htm

[49]Source: America's Health Rankings (2022). *Obesity in North Carolina.* Retrieved October 3, 2024, from https://www.americashealthrankings.org/explore/measures/obesity/NC

Secondary Data Findings

While the county's adult obesity rate of 28.8% is slightly lower than state (29.7%) and national (30.1%) averages, its impact is reflected in related chronic health conditions which present considerable concerns. Halifax County residents show higher rates of various chronic conditions compared to state averages, including hypertension (42.2% vs 32.1%), high cholesterol (32.2% vs 31.4%), and diabetes (11.3% vs 9.0%). These conditions often correlate with and are exacerbated by obesity, suggesting a complex relationship between obesity and overall health outcomes in the county.

Table 21: Chronic Disease-Related Indicators

Indicator	Halifax County	North Carolina	United States
Adults (Age 18+) with Asthma	11.6%	9.8%	9.7%
Adults (Age 20+) with Diagnosed Diabetes	11.3%	9.0%	8.9%
Adults (Age 18+) Ever Diagnosed with Coronary Heart Disease	7.1%	5.5%	5.2%
Adults (Age 18+) with Hypertension	42.2%	32.1%	29.6%
Adults (Age 18+) with High Cholesterol	32.2%	31.4%	31.0%
Adults (Age 18+) with Kidney Disease	3.8%	2.9%	2.7%
Adults (Age 18+) Ever Having a Stroke	4.6%	3.1%	2.8%
Adults (Age 18+) with Poor Dental Health	20.8%	12.0%	13.9%
Percent Reporting Poor or Fair Health	23.8%	14.4%	-

Similarly, Halifax County sees higher rates for cancer incidence and hospitalizations due to cardiovascular disease and stroke, outcomes in which obesity may play a role as a contributing factor.

Table 22: Cancer Incidence and Cardiovascular Disease and Stroke Hospitalizations

Indicator	Halifax County	North Carolina	United States
Cancer Incidence (Rate per 100,000 Population)	497.5	464.4	442.3
Emergency Room Visits (Rate per 1,000 Population)	755	563	535
Cardiovascular Disease Hospitalizations (Rate per 1,000 Medicare Beneficiaries)	12.4	11.7	10.4
Ischemic Stroke Hospitalizations (Rate per 1,000 Medicare Beneficiaries)	10.9	9.5	8.0

Regarding health behaviors related to obesity, the county has a notably higher physical inactivity rate at 31.9% compared to the state average of 21.6%. Access to exercise opportunities is limited as well, with only 52% of the population having access to exercise opportunities, significantly lower than both state (73%) and national (84%) averages.

Table 23: Health Behavior and Food Security Indicators

Indicator	Halifax County	North Carolina	United States
Adults with BMI > 30.0 (Obese)	28.8%	29.7%	30.1%
Walkability Index Score	6	7	10
% Physically Inactive	31.9	21.6	-
Percentage of Population with Access to Exercise Opportunities	52%	73%	84%
Food Insecurity Rate	16%	11%	10%
Child Food Insecurity Rate	30%	15%	13%
Percent Low Income Population with Low Food Access	12%	21%	19%
Food Environment - Fast Food Restaurants Establishments (Rate per 100,000 Population)	90.5	77.4	96.2
Food Environment - Grocery Stores Establishments (Rate per 100,000 Population)	37.0	18.7	23.4

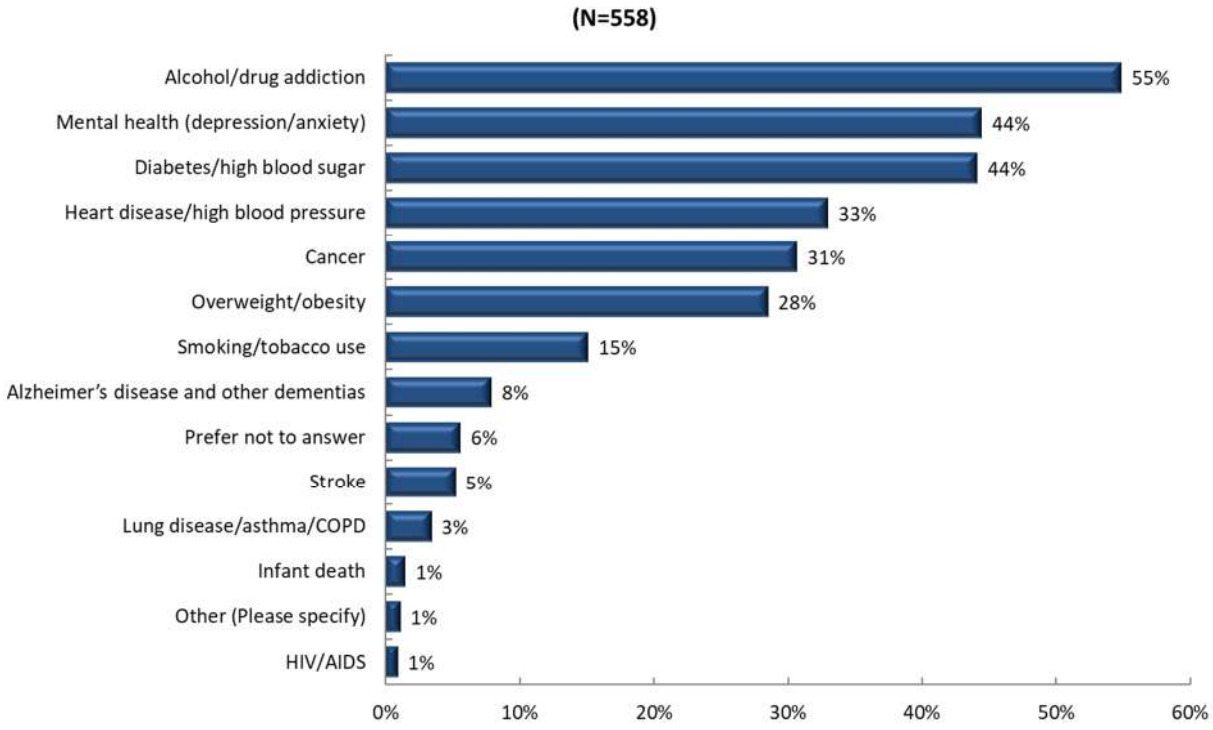
The food environment in Halifax County presents additional challenges that may contribute to obesity rates. The county has a higher concentration of fast-food restaurants (90.5 per 100,000 population) compared to the state average (77.4), though it also maintains a higher rate of grocery stores (37.0 per 100,000) than state (18.7) and national (23.4) averages. Food insecurity affects 16% of the overall population and 30% of children, both significantly higher than state (11% and 15% respectively) and national (10% and 13% respectively) averages.

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

Primary Data Findings – Community Member Web Survey

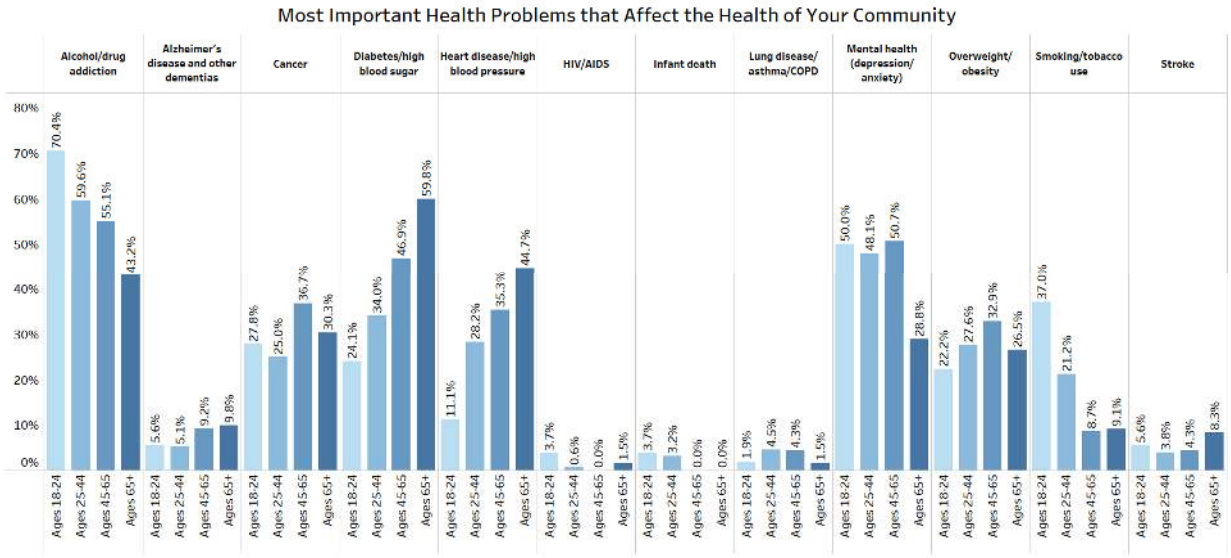
Obesity was identified as an important health problem in Halifax County by 28% of respondents. Other related chronic health conditions were also identified as key health concerns, including diabetes/high blood pressure (44%), heart disease/high blood pressure (33%), and cancer (31%).

Figure 39: What are the three most important health problems that affect the health of your community? Please select up to three.



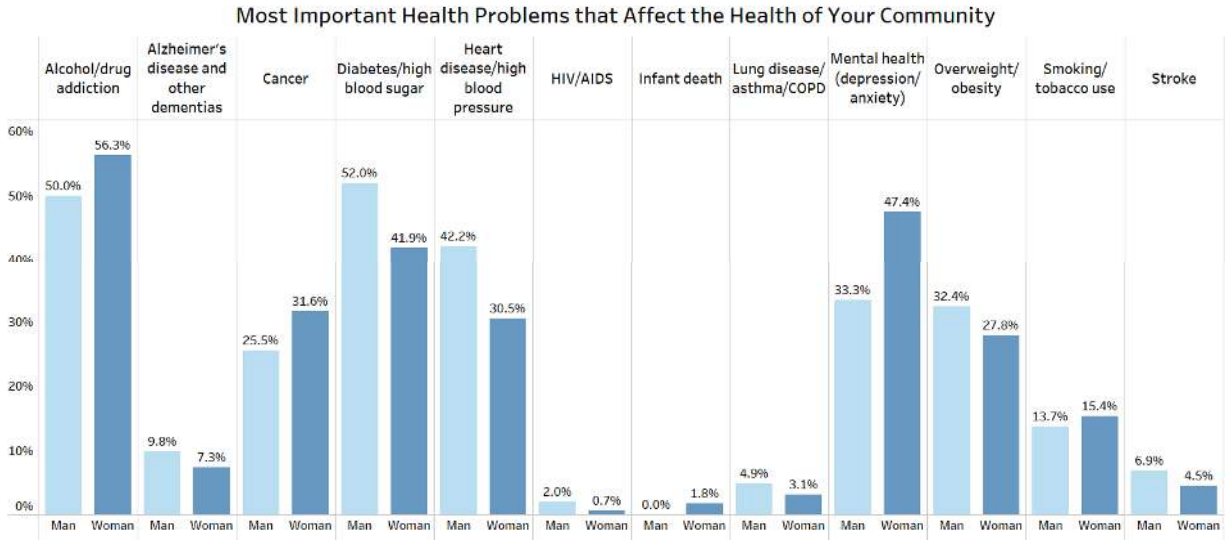
Responses differed with each age group. Those belonging to the age group 45 to 64 (33%) were more likely to identify obesity as a top health concern than all other age groups; however, the oldest respondents, age 65 and older, were the most likely to select diabetes/high blood sugar (60%) and heart disease/high blood pressure (45%) in the survey. Furthermore, those in the youngest age group (18 to 24) were the least likely to indicate diabetes, heart disease, or obesity as concerns (21%, 11%, 22%).

Figure 40: What are the three most important health problems that affect the health of your community? Please select up to three. (by age)



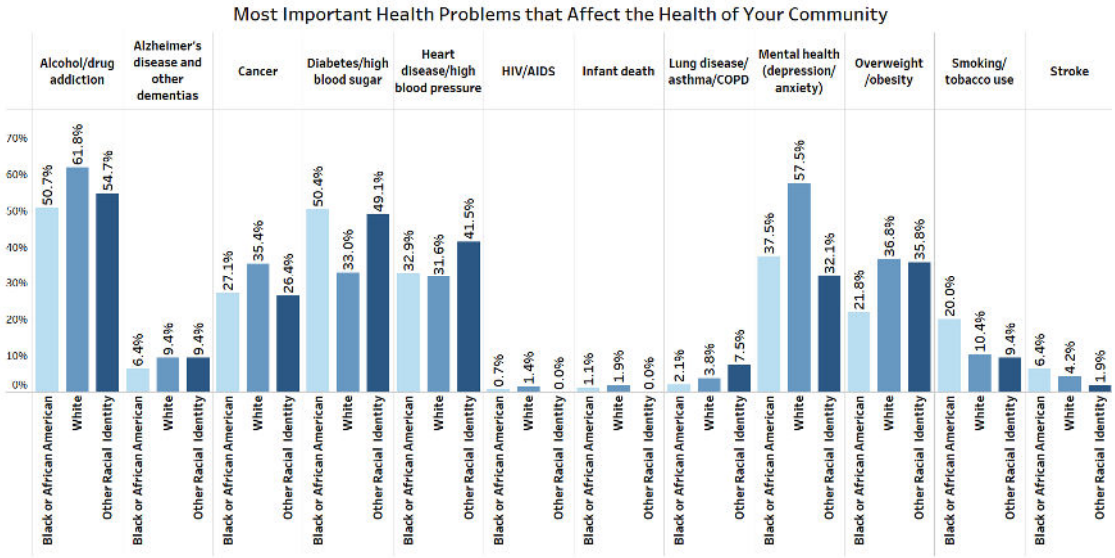
Regarding diabetes, heart disease, and obesity, gender disparities were also significant. Male respondents were far more likely to indicate these conditions as top health concerns versus female respondents (diabetes: 52%, 42%; heart disease: 42%, 31%; obesity; 32%, 28%).

Figure 41: What are the three most important health problems that affect the health of your community? Please select up to three. (by gender)



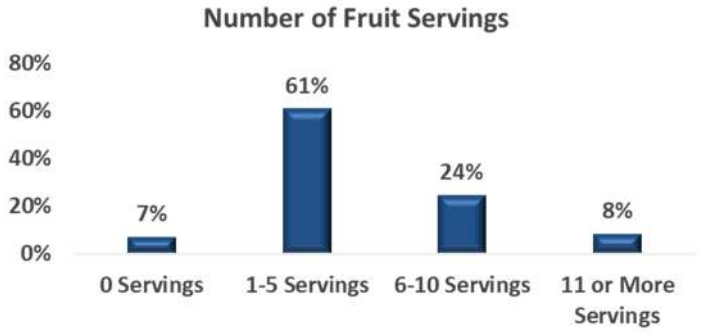
Variations also emerged by race, with respondents identifying as White (37%) or with the "other" racial identity category[50] (36%) more frequently selecting obesity as a problem than respondents identifying as Black/African American (22%).

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



When respondents were asked how many servings of fruit they had eaten in the past week, 7% indicated none, while 61% indicated they ate between one and five servings. On average, community member respondents in Halifax County reported eating six servings of fruit over the prior week. Responses for vegetables were similar, suggesting opportunities for increasing healthy food consumption in the community.

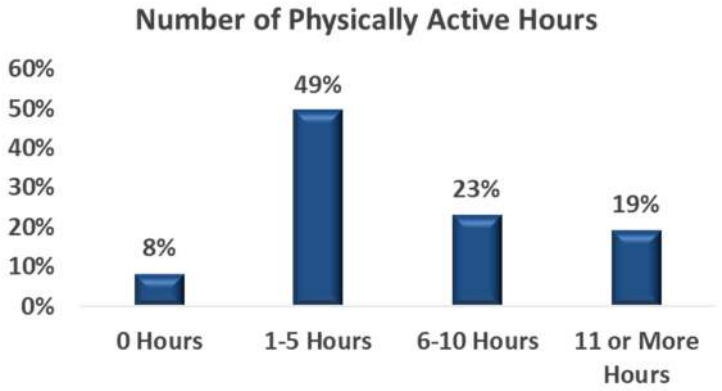
Figure 43: Think about the food you ate during the past week. On average, how many servings of fruit did you eat, not including juices? (For example, one serving equals a medium apple, a small banana, or 7 strawberries)



[50] 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."

When respondents were asked how often they were physically active outside of their jobs on a weekly basis over the prior month, 8% indicated they were not active at all, while 49% indicated they were active between one and five hours. On average, community member respondents in Halifax County were active 8 hours each week in the last month, suggesting opportunities for increasing physical activity in the community.

Figure 44: During the past month, approximately how much time (in hours) per week were you physically active outside of your regular job?



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

Primary Data Findings – Focus Groups

Focus group participants across all three sessions identified obesity as a critical health concern in Halifax County, with the Scotland Neck Library group specifically noting that obesity rates are higher in low-income and rural areas of the county. Participants discussed several interconnected factors contributing to obesity in the community.

Food access and security emerged as major themes related to obesity. Focus group members consistently cited the need for more healthy food options in the community, noting that food prices are very high and many residents lack adequate transportation to reach grocery stores. Participants emphasized that the community needs more education about nutrition, as traditional diets and eating habits tend to be unhealthy. The Halifax County Health Department focus group expressed particular concern about obesity among younger populations. These participants advocated for increasing wellness resources for young people through the school system and ensuring that existing nutrition and physical activity programs are being used appropriately and sustainably.

Focus group participants at ECU Health North discussed how limited health literacy in the community contributes to obesity, noting that many residents have a limited understanding of what constitutes "healthy" eating and physical activity. This group emphasized the need for more basic education around nutrition and healthy lifestyles. The Scotland Neck Library focus group highlighted environmental barriers to physical activity, including limited safe spaces for walking and exercise in many parts of the county. These participants recommended expanding transportation options to help residents access existing recreational facilities and developing creative approaches like health education podcasts to reach community members with wellness information.

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

PRIORITY NEED: ACCESS TO HEALTHCARE (MATERNAL, FETAL, INFANT HEALTH)

Context and National Perspective

Maternal health refers to the overall health of pregnant and postpartum women and can be affected by health prior to a pregnancy. [51] Efforts surrounding maternal health are often concentrated towards reducing maternal mortality, premature births, and other pregnancy-related conditions such as gestational diabetes and post-birth infections. Additionally, access to prenatal care among minority groups and increasing equity in maternal health has become a larger focus post-pandemic, with attempts to increase access to providers and mental health services. Most pregnant women (76.7%) do receive enough prenatal care, however those who do not are at least three times more likely to die from a pregnancy-related complication. Maternal mortality is largely preventable, with estimates suggesting that at least 60% of deaths could be avoided.[52] These concerns become compounded in rural areas, due to a potential lack of access to a physical OB/GYN in the community, and patients may have to drive several miles to see a healthcare provider. While telehealth services are becoming more common, prenatal care requires physically seeing a provider to identify any complications. Health outcomes can be improved with mobile ultrasound services, over-the-counter methods like portable vital sign devices like oximeters, and education, such as learning to monitor blood pressure at home.

Maternal mortality has increased in North Carolina, to 76 deaths in 2019, 26% higher than the prior reporting period of 2016. Over one-quarter (26%) of those deaths were due to a drug overdose, and 85% of deaths were considered to be preventable. Additionally, the North Carolina Division of Public Health found that discrimination was a probable factor in nearly 70% of all the deaths, and was the most common factor recorded.[53] This statistic highlights the need for culturally-competent prenatal and postpartum care for all mothers across the state. Improving maternal health can have a positive impact on fetal health by preventing pre-term births, and complications to the fetus related to maternal health conditions such as gestational diabetes and high blood pressure.

Infant health encompasses the health of a child prior to their first birthday. Mortality among infants can be the result of multiple complications, such as congenital defects, low birthweight, maternal health complications, short gestation, and sudden infant death syndrome. In 2022, the rate of infant mortality in the U.S. was 5.6 deaths per 1,000 live births, roughly equal to 20,927 infants. Health disparities also exist within infant health, with Non-Hispanic African American and indigenous infants twice as likely to die before their first birthday than non-Hispanic white infants. [54] While infant health has improved significantly in recent decades, it is still a vital sign highlighting the overall health of a community and

[51] Source: National Institutes of Health office of Research on Women's Health. (2021). *Maternal Morbidity and Mortality: What do we know? How are we addressing it?* Retrieved October 4, 2024 from https://orwh.od.nih.gov/sites/orwh/files/docs/ORWH22_MMM_Info_Factsheet_508.pdf

[52] Id. 79

[53] Source: North Carolina Medical Society. (2024). *NC Maternal Mortality Report.* Retrieved October 3, 2024 from https://ncmedsoc.org/just-released-nc-maternal-mortality-report/

[54] Source: HRSA. (2022). *Infant health.* Retrieved October 4, 2024 from https://mchb.hrsa.gov/programs-impact/focus-areas/infant-health

state, and is also an indicator for the availability of maternal health care. Low maternal and infant mortality rates generally suggest a community is healthy, and are also often a sign of high access to healthcare, especially in diverse communities.

Secondary Data Findings

Halifax County faces significant challenges in maternal and infant health outcomes compared to state and national benchmarks. The county has a notably high infant mortality rate of 11.0 deaths per 1,000 live births, which is substantially higher than both North Carolina (7.0) and the United States (5.7). Additionally, the percentage of low birthweight births in Halifax County (13.3%) exceeds the state average of 9.4%, indicating a critical area of concern for infant health outcomes.

Table 24: Maternal and Infant Health Indicators

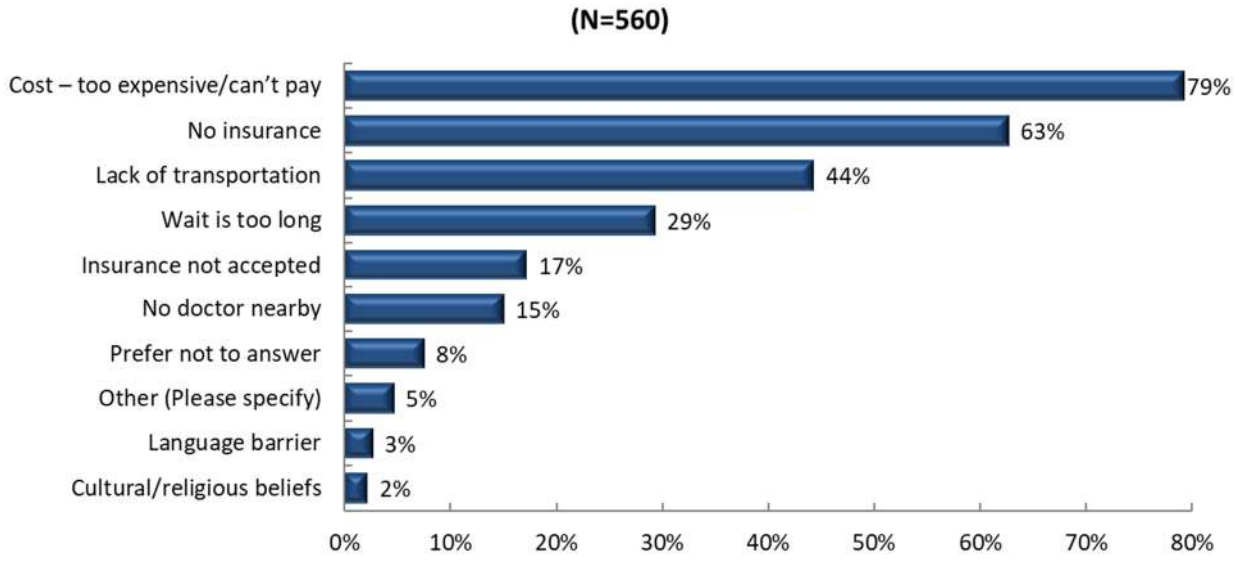
Report Area	Number of Infant Deaths	Deaths per 1,000 Live Births	% Low Birthweight
Halifax County, NC	43	11.0	13.3%
North Carolina	5,820	7.0	9.4%
United States	150,841	5.7	--

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

Primary Data Findings – Community Member Web Survey

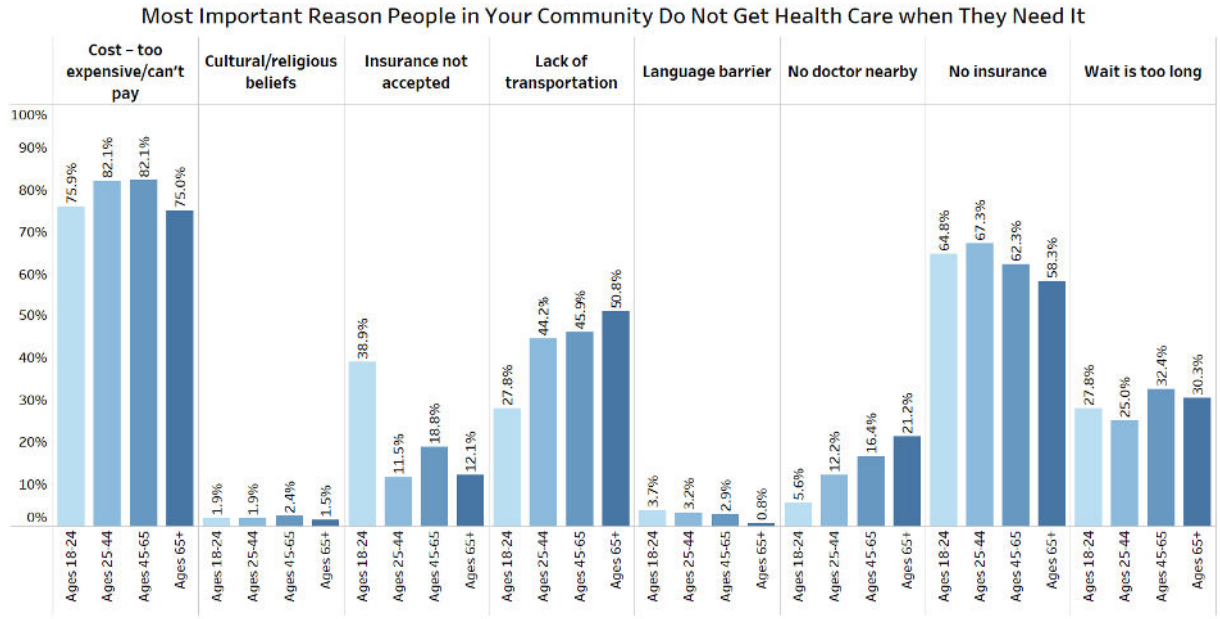
Nearly 560 Halifax County residents responded to the web-based survey. Through a combination of general and specific questions, respondents identified several care needs related to maternal, fetal, and infant health in Halifax County. As contributing factors to positive maternal health outcomes, community members provided general information regarding access to care, cost of care, and access to providers. In the survey, community members were asked to identify the top barriers to receiving healthcare. Cost (79%), no insurance (63%), and lack of transportation (44%) were the top three identified reasons why people in the community are not getting care when they need it. Another one-third of responses (29%) identified insurance non-acceptance, and over one in ten (15%) responses indicated a lack of nearby doctors as the top barriers to care.

Figure 45: 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.



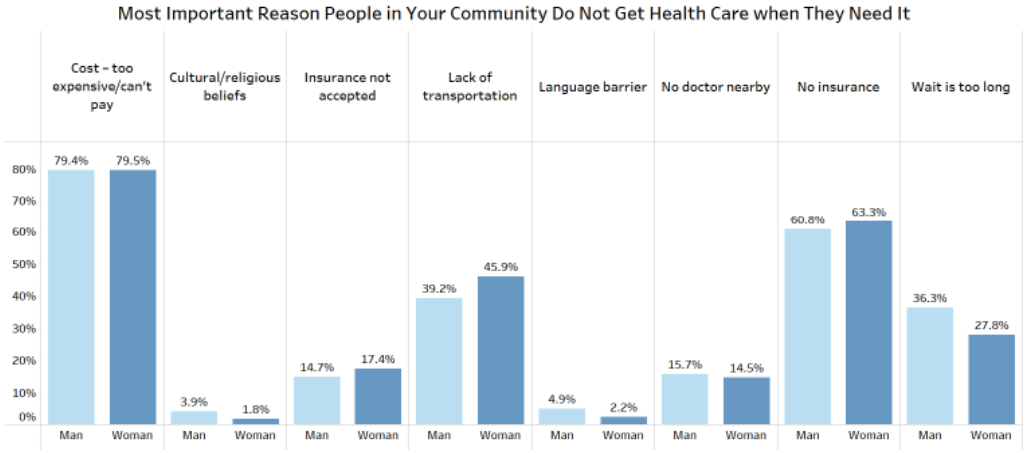
When these data were examined by age group, it was identified that there was not a wide range of disparity in responses indicating cost and lack of insurance, and that all groups indicated the top two barriers to care nearly equally. It is important to note that regarding insurance not being accepted, those ages to 24 were far more likely to identify it as a top barrier to care (39%).

Figure 46: 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)



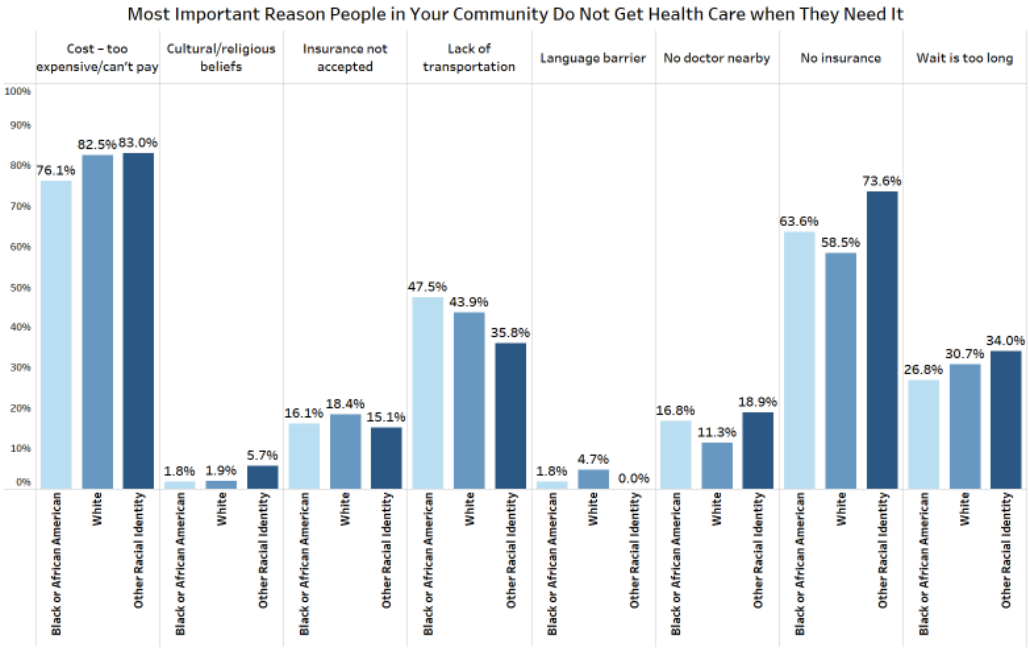
Responses followed a similar trend by gender. However, a higher percentage of women (46%) viewed lack of transportation as a barrier to care than the percentage of men (39%).

Figure 47: 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)



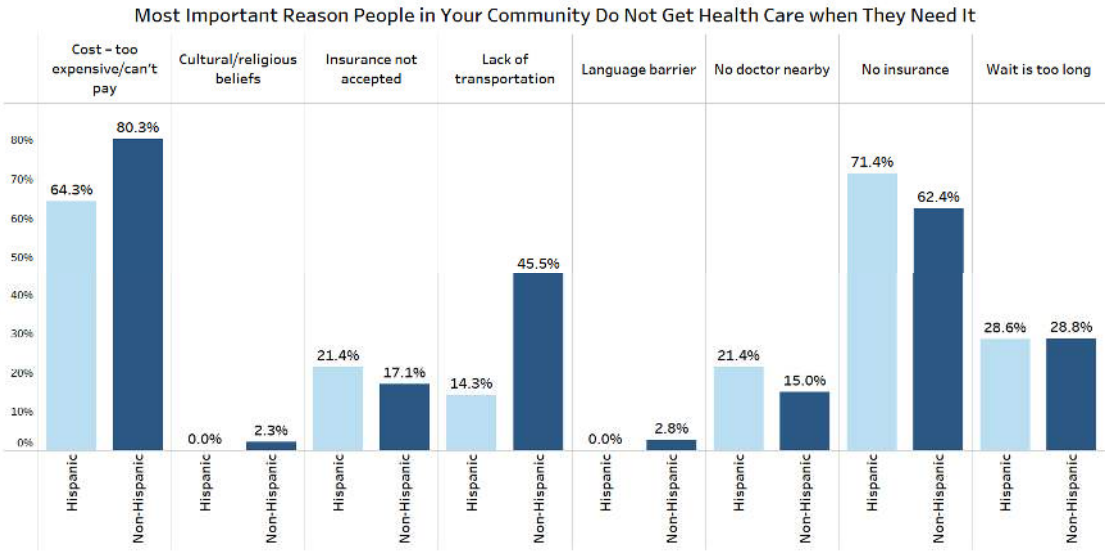
Similar patterns followed with reviewing race and ethnicity. Respondents identifying with the other racial identity category were slightly more likely to view cost and wait times as barriers to care and more likely to cite lack of insurance than respondents identifying as Black/African American or as White (Other: 83%, 34%, 74%; Black/African American: 76%, 27%, 64%; White: 83%, 31%, 59%).

Figure 48: 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)



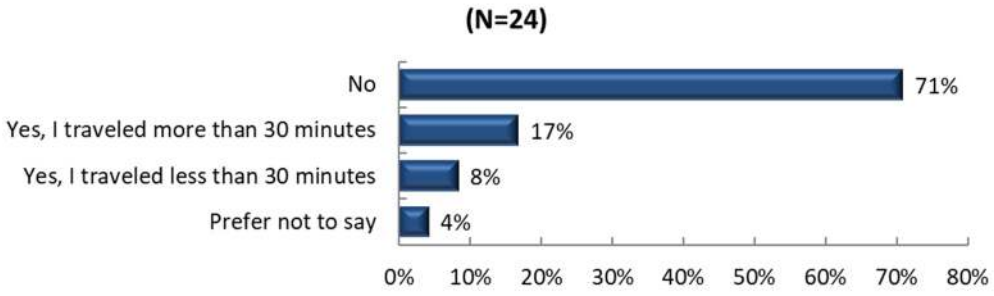
Those who identified as Hispanic/Latino were less likely to identify cost as a barrier to care (64% versus 80% for non-Hispanic/Latino), and those who were non-Hispanic/Latino were less likely to indicate no insurance as a barrier to care (62% versus 71%).

Figure 49: 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)



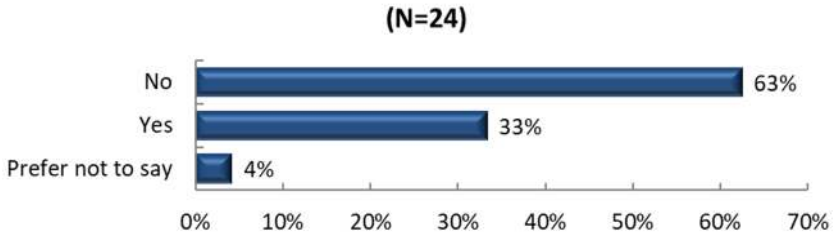
To learn more about maternal and infant health, Halifax County community survey respondents were also asked if they had given birth in the past year, to which 4% responded "yes." Of those who had given birth in the last year, 17% reported traveling more than 30 minutes outside of the county to find prenatal care or to give birth, as shown in **Figure 52** below.

Figure 50: Thinking back to your most recent pregnancy, did you need to travel outside of Halifax County to find prenatal care or to give birth?



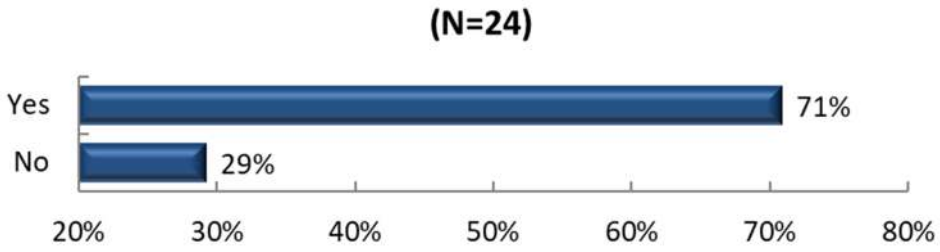
Respondents were further asked, concerning their most recent birth, if the infant was born more than three weeks before the due date, to which one-third of women answered "yes."

Figure 51: Thinking about your most recent birth, was this infant born more than three weeks before your due date?



Finally, community members were asked if their infant born in the past year had ever been breastfed, with nearly a third of respondents indicating "no," highlighting a need to address maternal and infant health concerns in the community.

Figure 52: Thinking about your most recent birth, was this infant ever breastfed?



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

Primary Data Findings – Focus Groups

Focus groups conducted in Halifax County identified multiple factors that could impact maternal, fetal and infant health outcomes. Participants at the Halifax County Health Department noted that healthcare services in the community are often siloed, requiring patients to see multiple providers with limited communication between them. This fragmentation of care was described as making healthcare navigation more complex for patients. The inability to maintain continuity of care was also highlighted, with participants noting that patients may not see the same provider twice.

Transportation emerged as a significant barrier across all focus groups. At both ECU Health North and Scotland Neck Library locations, participants emphasized that transportation limitations impact residents' ability to access healthcare services. The lack of transportation was particularly noted as affecting rural areas of the county.

The cost of healthcare was consistently identified as a barrier across all focus groups. At the Scotland Neck Library location, participants noted that insurance requirements drive healthcare delivery and providers have limited time with patients. Long wait times for appointments were also cited as a concern, with participants noting that this often results in the emergency room becoming the primary option for care.

When discussing solutions, focus group participants at the Halifax County Health Department emphasized the need for improved communication and strategy development among local healthcare leaders. They suggested creating a resource directory that would be available to every household in the county. The health department participants noted that telemedicine initiatives are being developed to address transportation barriers, though they acknowledged that limited broadband access could impact the effectiveness of this solution. Participants across locations emphasized that existing community partnerships and service agencies are community assets that could be leveraged to address these challenges.

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 Halifax County that provide resources to address general community health needs, as well as the county's 2025 priority need areas.

Category	Organization Name

Priority Need: Access to Care (Healthcare Facilities)	**Rural Health Group**
	• Rural Health Group at Enfield
	  ○ 252-445-2332
	• Rural Health Group at Hollister
	  ○ 252-586-5151
	• Rural Health Group at Jackson
	  ○ 252-534-1661
	• Rural Health Group at Lake Gaston
	  ○ 252-586-5411
	• Rural Health Group at Rich Square
	  ○ 252-539-2082
	• Rural Health Group at Roanoke Rapids
	  ○ 252-536-5000
	• Rural Health Group at Scotland Neck
	  ○ 252-826-3143
	
	ECU Health Physicians
	• ECU Health Family Medicine
	  ○ 252-537-9176
	• ECU Health General Surgery
	  ○ 252-537-1933
	• ECU Health Orthopedics, Roanoke Rapids
	  ○ 252-537-5631
	• ECU Health Pulmonology and Sleep Medicine
	  ○ 252-535-1082
	• ECU Health Heart & Vascular Care
	  ○ 252-537-9268
	• ECU Health Urgent Care
	  ○ 252-535-8463
	
	Dentistry
	• Arthur and Nicholson, DDS, PA
	  ○ 252-537-1054
	• Bhagwant's, A. R. "Raj" BDS, DMD

    - 252-537-4141
- Brown, Doris B. DDS
    - 252-537-1412
- Crenshaw, James E. Jr., DDS
    - 252-586-4059
- Drew, Thomas C., DDS, PA
    - 252-445-5998
- Fleming, Thomas E. DDS
    - 252-537-8151
- Howard, Yee DMD, PA
    - 252-537-8822
- Rural Health Group Dental Center
    - 252-536-5880
- Creekside Dental-Brian Maynor, DDS
    - 252-533-9300

Dermatology

- Polly Clinic of Dermatology
    - 800-243-0566

Emergency Medicine

- ECU Health North Hospital
    - 252-535-8425

Gastroenterology

- Halifax Gastroenterology
    - 252-535-6478

General Surgery

- Rao, Shiva MD
    - 252-537-2254
- ECU Health North General Surgery (Ketoff, Weir, Muller)
    - 252-537-1933

Hospitals

- ECU Health North Hospital
    - 252-535-8011
- Duke Medical Center
    - 919-684-8111
    - OBGYN: 919-681-5741
    - Financial Assistance: 919-620-4555
- UNC Hospital
    - 984-974-1000
- ECU Health North Medical Center
    - 252-847-4100

Internal Medicine

- Rural Health Group at Halifax Medical Specialists
  - 252-535-3001
- Halifax-Northampton Internal Medicine, PA
  - 252-537-0077
- Valley Hypertension-Nephrology Associates, PA
  - 252-535-2111

Mental Health

- Trillium Health Resources
  - 866-998-2597
- Edwards Assessments & Counseling
  - 252-535-1070
- Statewide Mental Health & Disability Services, PLLC
  - 252-308-1247

Obstetrics/Gynecology

- Dr. Lawrence Singer and Associates
  - 252-535-4343
- Rural Health Group at Women's Health
  - 252-535-1414

Ophthalmology

- Mid-Atlantic Eye Physicians
  - 252-537-8193
- Rocky Mount Eye
  - 252-443-1006

Optometry

- Mebane, Thomas A. Dr.
  - 252-537-3401
- Pro-Vision Optometric Center, PA
  - 252-519-9401
- Optometric Eye Care Center
  - 252-537-6101

Orthodontics

- Aman, Courtney, DDS, MS
  - 252-365-4234
- My Orthodontist
  - 252-544-5630

Orthopedics

- Nash Orthopedics
  - 252-443-8830
- ECU Health Orthopedics, Roanoke Rapids

- 252-537-5631

Pain Management

- Roanoke Valley Pain Center
  - 252-410-0001

Pediatrics

- Park Avenue Pediatrics
  - 252-537-6465
- Rural Health Group at Roanoke Rapids
  - 252-536-5000

Pharmacies

- CVS Pharmacy
  - 252-537-7011
- Drugco Pharmacy
  - 252-537-7010
- Drugco -- Littleton
  - 252-586-3836
- Drug Care Pharmacy (Drums)
  - 252-445-3414
- Spears Pharmacy
  - 252-537-1146
- Futrell Pharmacy of Littleton
  - 252-586-3414
- McDowell's Pharmacy Scotland Neck
  - 252-826-4137
- Walgreens Pharmacy
  - 252-535-4037
- Walmart Pharmacy
  - 252-535-1170

Primary Care

- Fast Med
  - 252-537-5600
- Med First
  - 252-308-0686
- ECU Health Urgent Care
  - 252-535-8463

Physical Therapy

- ECU Health North Outpatient Rehabilitation
  - 252-535-3028
- dFender Physical Therapy
  - 252-541-1941

	Podiatry
	• ECU Orthopedics, Dr. Luke Batts
	  o 252-537-5631
	
	Psychiatry
	• Roanoke Valley Psychiatric Associates
	  o 252-537-8400
	
	Urology
	• Sai Urology
	  o 252-308-6889

Community services	**<u>Physical Activity and Nutrition Resources</u>**
	
	Enfield
	• Town Hall
	  o 252-445-3146
	• Parks/Recreation/Fitness/Gyms/Walking Trails
	  o Meyer Oakview Park
	  ▪ Bell Street, Enfield, NC 27823
	  ▪ Amenities: playground equipment, basketball court
	  o Enfield Park and Recreation
	  ▪ 6030 South McDaniel Street, Enfield, NC 27823
	  ▪ 252-904-6176
	  ▪ Amenities: playground and exercise equipment, summer camps, ball fields, Senior walking group, walking trail
	  ▪ Activities:
	  ▪ Soccer
	  ▪ Volleyball
	  ▪ Basketball
	  ▪ Baseball
	  ▪ Softball
	  o Senior Center (located at the Parks and Recreation Department)
	
	Tillery
	• Fire Department
	  o 252-826-2434
	• Senior Center
	  o Tillery Community Center
	  ▪ 321 Community Center Road, Halifax, NC 27839
	  ▪ 252-826-2234
	  ▪ Activities: Mild exercises and stretching
	
	Halifax

- Town Hall
    - 252-583-6571
- Parks/Recreation/Fitness/Gyms/Walking Trails
    - Halifax Jr. Women's Club Park
        - Prussia Street, Halifax, NC 27839
        - 252-583-6571
        - Amenities: shelter and playground equipment
    - Walking Trail
        - Mapped course through the town of Halifax
        - 252-583-6571
    - 4-H Rural Life Center
        - 13763 NC Highway 903, Halifax, NC 27839
        - Halifax County Cooperative Extension: 252-583-5161
- Farmers Market/Vegetable/Fruit Stands
    - Oak Grove Orchard
        - Hwy 301 North between Halifax and Weldon
        - 252-583-7661
        - Offers: Seasonal fruit and vegetables
- Senior Center
    - Council on Aging
        - Contact: Audrey Williams
        - 252-538-6755
- Nutrition Services
    - Halifax County Health Department
        - 19 North Dobbs Street, Halifax, NC 27823
        - 252-583-5021
        - Services: High risk, child health, and maternity patients
    - Halifax County WIC
        - 116-A W. 3rd Street Roanoke Rapids, NC 27870
        - 252-535-4845
        - Services: Nutrition education, food supplemental program, healthcare referrals, breastfeeding support
    - Halifax County Cooperative Extension
        - 359 Ferrell Lane Halifax, NC 27839
        - 252-583-5161

Hobgood

- Town Hall
    - 252-826-4573
- Parks/Recreation/Fitness/Gyms/Walking Trails
    - Friendship Park
        - West Commerce Street, Hobgood, NC 27843
        - 252-826-4573
    - Hobgood Community Park
        - West Commerce Street, Hobgood, NC 27843
        - 252-826-4573

- Thomas Shields Community Center
  - 401 North Beech Street, Hobgood, NC 27843
  - Contact: Vanessa Fields
  - 252-907-3785
  - Amenities: basketball court, exercise equipment, weights, men's weight program, Healthy Lifestyle Classes
- Senior Center
  - Thomas Shields Community Center
    - Contact: Vanessa Fields
    - 252-907-3785
    - Activities: classes, meetings, and exercise
- Nutrition Services
  - Thomas Shields Community Center
    - Food bank services (first Friday morning of each month)
    - Healthy Lifestyle Classes
    - Contact: Vanessa Fields
    - 252-907-3785

Hollister

- Haliwa-Saponi Indian Tribe
  - 252-586-4017
- Parks/Recreation/Fitness/Gyms/Walking Trails
  - Medoc Mountain State Park
    - 1541 Medoc State Park, Hollister, NC 27844
    - 252-586-6588
    - Amenities: Camping, Hiking/Walking Trails, Shelter
  - Haliwa-Saponi Multipurpose Center
    - 228 Capps Farm Road, Hollister, NC 27844
    - Amenities: Exercise Equipment, Weights
  - Pleasant Grove Baptist Church
    - Prayer Walk Trail (Cement Walkway Around the Church)
    - Hours: sunrise to sunset

Scotland Neck

- Town Hall
  - 252-826-3152
- Parks/Recreation/Fitness/Gyms/Walking Trails
  - Scotland Neck Education & Recreation Foundation
    - 617 East 11th Street, Scotland Neck, NC 27870
    - Contact: Mildred Moore
    - 252-826-2080
    - Activities: softball, basketball court, exercise, jump rope, various healthy lifestyle classes
  - Bryan Health and Rehabilitation

        - 921 Junior High School Road, Scotland Neck, NC 27874
        - 252-826-4144
- Senior Center
    - Hattie Palmer Staton Senior Center
        - 1403 Church Street, Scotland Neck, NC 27874
        - 252-826-3891
        - Activities: Exercise classes, health screenings, community supplemental food program

Littleton

- Town Hall
    - 252-586-2709
- Parks/Recreation/Fitness/Gyms/Walking Trails
    - Sabina Gould Walkway
        - North Main Street, Littleton, NC 27850
        - 252-586-2709
        - Part of Rails to Trails system
    - Littleton Community Center
        - 225 Oak Street, Littleton, NC 27850
        - 252-586-6773
        - Amenities: playground equipment and weights
    - John 3:16 Center
        - 407 East End Avenue, Littleton, NC 27850
        - 252-586-1800
        - Amenities: playground equipment and basketball court
    - Pocket Park
        - 107 Church Street, Littleton, NC
        - Amenities: playground equipment, picnic tables and shelter (in progress)
- Senior Center
    - Littleton Community Center
        - 225 Oak Street, Littleton, NC 27850
        - 252-586-6773
        - Activities: classes, meetings, and exercise
- Farmer's Market/Vegetable/Fruit Stands
    - Hawkins Farm
        - 11842 Hwy 48, South Littleton, NC 27850
        - 252-586-3223
    - Isles Farm
        - 12246 Hwy 48, South Littleton, NC 27850
        - 252-586-5257
- Nutrition Services
    - Emergency Food Bank at John 3:16 Center
        - 407 East End Avenue, Littleton, NC 27850
        - 252-586-1800
- Weight Loss Programs

- Weight Watchers Lake Gaston
  - Gaston Pointe Conference Center
  - 147 Gaston Pointe Road, Littleton, NC 27850

Roanoke Rapids

- Town Hall
  - 252-533-2800
- Parks/Recreation/Fitness/Gyms/Walking Trails
  - Roanoke Rapids Lake Park
    - 100 Oakwood Avenue
    - 252-410-6318
    - Amenities: Walking Trails, Playground
  - Sonic Playground
    - 1045 E 10th St
    - 252-535-9983
  - Emory Park
    - Corner of 9th and Cleveland Street
    - 252-533-2847
    - Amenities: Walking Trail
  - Chockoyotte Park
    - Chockoyotte Street
    - 252-533-2847
    - Amenities: Walking Trail
  - Additional Parks:
    - C.W. Davis Park (Cedar Street)
    - Edward George Park (Virginia Avenue)
    - Ledgerwood Park (11th and Vance Street)
    - Long Park (400 Block of 4th and 5th Street)
    - Martin Luther King Park (Wyche Street and Virginia Avenue)
    - Melody Park (Cedar Street)
    - Rochelle Park (5th and Vance Street - Walking Trail)
    - Smith Park (600 Block of 4th and 5th Street)
    - Southgate Park (Charles Circle)
    - Tinsley Park (corner of Arbutus and 6th Street)
    - Wheeler Park (Shell and Oak Street)
    - All parks contact: 252-533-2847
  - Manning School Track
    - Contact: Mike Ferguson
    - 252-519-7400
  - Roanoke Canal Trail
    - 51 Jackson Street, Roanoke Rapids, NC 27870
    - 252-537-2769
    - 7.5-mile nature trail
    - Activities: Running, Walking, Hiking, and Biking
  - TJ Davis Recreation Center

- 400 East 6th Street, Roanoke Rapids, NC 27870
- 252-533-2847
- Website: http://www.roanokerapidsnc.com/parkrec
- Activities/Amenities:
  - Fridays in the park (May to September @ Centennial Park)
  - Summer Camps
  - Sports Leagues
  - Wellness room
  - Indoor basketball courts (2)
  - Skate park
  - Indoor walking track
  - Outdoor pool
  - Aquatic Center
  - Tennis courts
  - Free summer lunch site (children 0-18)

- JA Chaloner Recreation Center
  - 200 Dixie Street, Roanoke Rapids, NC 27870
  - 252-533-2855
  - Amenities:
    - Multipurpose court
    - Playground equipment
    - Wii with physical activity games
    - Adult exercise equipment
    - Splash Pad
    - Walking trail
    - Free lunch site (children 0-18)
- Fitness Centers:
  - New Day Fitness
    - 1388 Gregory Drive
    - 252-537-1402
  - The Gym (24-hour)
    - 1054 East 10th Street
    - 252-532-6594
  - Iron Works II (24-hour)
    - 1001 Roanoke Avenue
    - 252-538-2145
  - Spartan Elite 365
    - 43 W 11th St
    - 252-533-9348
  - Anchor'D Fitness
    - 1016 Roanoke Avenue
    - 252-532-5419
- Church Programs:
  - Upwards Basketball
    - Calvary Baptist Church

        - 1405 Bolling Rd
        - 252-537-9828
      - Looking Up Sports
        - Good News Baptist Church
        - 714 NC 125 Hwy
        - 252-537-7389
- Senior Center
  - Jo Story Senior Center (ages 55 and older)
    - 701 Jackson Street
    - 252-533-2849
    - Activities: Bingo, Weight loss support group, quilting, Wii bowling, mall walking, knitting, Tai-Chi Meditation, Exercise, Meals on Wheels/Congregate Meals
- Farmer's Market/Vegetable/Fruit Stands
  - Roanoke Valley Farmer's Market
    - 378 Hwy 158
    - 252-583-5161
  - Windy Acres Farm
    - Corner of Zoo Rd and Hwy 158
    - 252-673-6931
  - Dunlow Farms Produce Stand
    - 250 Premier Blvd
- Nutrition Services
  - WIC Roanoke Rapids Office
    - 116A West 3rd Street
    - 252-535-4845
- Other Physical Activities
  - Dance Studios:
    - Ms. Bonnie's School of Dance
      - 1041 Roanoke Avenue
      - 252-532-6613
      - Website: www.msbonniesschoolofdance.com
    - Studio 10 Dance Center
      - 710 E 10th Street
      - 252-678-0384
    - Tiffany's Dance Studio
      - 1033 Roanoke Avenue
      - 252-676-3606
    - THE ROCK
      - 539 Becker Drive
      - 252-537-3071
      - Website: www.rvdanceandcheer.com
    - Concrete Rose Dance Academy
      - 936 Roanoke Ave
      - 252-260-0028
  - Hangtime

        - 1203 E 19th St
        - 252-541-4232

Weldon

- Town Hall
    - 252-536-4836
- Parks/Recreation/Fitness/Gyms/Walking Trails
    - River Falls Park
        - 100 Rockfish Drive, Weldon, NC 27890
        - 252-536-4836
        - Amenities: Playground equipment, shelters, walking trail
    - Roanoke Canal Trail
        - 7.5-mile nature trail
        - 252-537-2769
    - Jasard's Boxing Club
        - 207 Washington Avenue
        - Contact: Roy Edmonds
        - 718-744-8614
        - Services: Boxing Instructions and Weight Loss Boxing
    - Halifax Community College Fitness Trail
        - 252-536-2551
- Nutrition Services
    - Rural Health Group Clinic
        - Located at Halifax Community College
        - 252-578-8685
        - Open to anyone

<u>Other Community Resources</u>

- Roanoke Valley Community Health Initiative (RVCHI)
    - Mission: Promote healthy living through education, empowerment, and health access for families and individuals of the Roanoke Valley
    - Contact: Elizabeth Dunlow, Community Outreach Coordinator
        - 252-535-8771
- Nurse Family Partnership (NFP)
    - Mission: Evidence-based community health program partnering first-time mothers with registered nurses
    - Focus Areas:
        - Better pregnancy outcomes
        - Healthy child development
        - Economic self-sufficiency
    - Service Area: Halifax, Northampton, Edgecombe, and Bertie counties
    - Contact: Blair Creekmore, NFP Program Nurse Supervisor

	▪ Email: blair.creekmore@nhcnc.net ▪ 252-534-5841 • NC Foundation for Health Leadership and Innovation ○ Mission: Building leadership, shaping practices, affecting policy, and driving innovation ○ Contact: Will Broughton, Program Director Health ENC ▪ Email: will.broughton@foundationhli.org ▪ 919-821-0485 • MDC, Inc. ○ Mission: Creating a thriving South through racial equity ○ Contact: Phillip Sheldon, Partnership Manager ▪ Email: phillip.sheldon@mdcinc.org ▪ 336-269-5386 • Halifax County NC Cooperative Extension ○ Services: ▪ Agricultural programming ▪ Youth development ▪ Family and consumer issues ▪ EFNEP Expanded Food & Nutrition Education Program for Adults ○ Contact: Sara Pike ▪ Email: sara_villwock@ncsu.edu ▪ 252-583-5161 • Halifax Warren Smart Start ○ Mission: Enhance child care services for children birth to age five ○ Goal: Prepare children to enter school healthy and ready to learn ○ Contact: Magda Baligh, Executive Director ▪ Email: mbaligh@hwss.org ▪ 252-537-5621 • Progressive Resources and Opportunities ○ Contact: Mike Scott ▪ Email: mike.scott.pro@gmail.com ▪ 252-537-9050
Priority Need: Behavioral Health	• Trillium ○ Trilliumhealthresources.org ○ 24 hour crisis line – 888-302-0738 • Morse Clinic ○ 608 Jackson St, Roanoke Rapids, NC 27870 ○ (252) 541-4175 • RHA Health Services ○ 60 NC Highway 125, Roanoke Rapids, NC 27870 ○ (252) 537-6619 • Insight Innovations

- (336) 725-8389
- Community Impact North Carolina
  - Coudeng@halifaxnc.com
  - 252-583-5021 ext. 6278
- Halifax County Adult Recovery Court (HARC)
- Stepping Up Initiative
  - Susan Auger - auger@augercommunications.com - 919-361-1857
- Spring Life Behavioral Care
  - 200 Becker Drive, Roanoke Rapids, NC 27870
  - (252) 535-6400
- Northeast Partnership for Public Health (NC Connect)
  - Jtunney@arhs-nc.org
- ECU Health North
  - 250 Smith Church Road, Roanoke Rapids, NC 27870
  - (252) 535-8011
- NC Harm Reduction Coalition
  - (336) 543-8050
- Roanoke Valley Rescue Squad
  - 201 Washington St, Roanoke Rapids, NC 27870
  - (252) 537-7181
- Halifax County Emergency Management System
  - **Emergency Services Director:** James Ellen III – 252-583-2088
  - **Emergency Management Coordinator:** Buddy Wrenn – 252-583-2031
  - **EMS Manager:** Warner Ferguson – 252-536-4494
- Edwards Assessments and Counseling
  - (252) 535-1070
  - 321 NC-125, Roanoke Rapids, NC 27870
- Law Enforcement
  - Halifax County Sheriff's Department
    - 355 Ferrell Ln, Halifax, NC 27839
    - (252) 853-8201
- Rural Health Group (MAT Services)
  - Judy Belch Beasley - (252) 537-0134
  - 270 Smith Church Rd, Roanoke Rapids, NC 27870
- Let's Start Over
  - Marion Frazier
  - 1072 East 10th Street, Roanoke Rapids, NC 27870
- Integrated Family Services
  - 24/7 Crisis Line: 1-866-437-1821
  - 252-209-0388
- Roanoke Valley Psychiatrist Association
  - 252-537-8400
  - 321 Highway 125, Roanoke Rapids, NC 27870

- Holt Assessments
  - 252-541-3833
  - 622 Roanoke Avenue, Suite C, Roanoke Rapids, NC 27870
- Celebrate Recovery (Family Community Church)
  - https://familycommunity.church/contact/
- Alcoholic Anonymous
  - 252-977-7744
- Narcotics Anonymous
  - 1-855-613-2762
- Haliwa-Saponi Tribe
  - 39021 NC Highway 561, Hollister, NC 27844
  - (252) 586-4017
- Halifax County Re-Entry Council
  - 252-535-7943
  - Frince.williams@ncworks.gov
- Monarch (Traveling Medical Facility)
  - 1-866-272-7826
- Hannah's Place
  - 252-541-1127 /hannahsplacenc.org
- Union Mission
  - 252-537-3372 / unionmission.org
- The John 3:16 Center
  - 252-586-1800 / www.john316center.org
- Parks and Recreation Summer Camps
  - 252-583-5161
  - 359 Ferrell Lane, Halifax, NC 27839
- Halifax County Safe Kids Coalition
  - Tmay@roanokerapidsnc.com
- Juvenile Crime Prevention Council
  - 252-593-3067
  - Iris.f.williams@nccourts.org
- Oxford House in Roanoke Rapids
  - (252) 604-1943
- HOPE (Helping Other People Emotionally)
  - 1-855-587-3463
- Grief Share
  - https://www.griefshare.org/findagroup
- CATCH My Breath
  - Teresa Beardsley - teresa.Beardsley@arhs-nc.org
- Roanoke Rapids Graded School District
  - 536 Hamilton St, Roanoke Rapids, NC 27870
  - (252) 519-7100
- Weldon City Schools
  - 301 Mulberry Street, Weldon, NC 27890
  - (252) 536-4821

	• Halifax County Schools
	  ○ 9525 US-301, Halifax, NC 27839
	  ○ (252) 583-2151
	• Halifax Community College
	  ○ 100 College Dr, Weldon, NC 27890
	  ○ (252) 536-4221

Priority Need: Access to Care (Maternal, Fetal and Infant Health)	• Halifax County Health Department
	  ○ 252-583-5021
	• ECU Health North
	  ○ 250 Smith Church Road, Roanoke Rapids, NC 27870
	  ○ (252) 535-8011
	• Rural Health Group
	  ○ Littleton – 252-586-5411
	• Lawrence Singer MD & Associates OB/GYN
	  ○ 63 Office Park Drive, Roanoke Rapids, NC 27870
	  ○ (252) 535-4343
	• Pregnancy Support Center
	  ○ 252-519-4357 / pregnancysupportcenterofrr.com
	• The John 3:16 Center
	  ○ 252-586-1800 / www.john316center.org
	• Halifax County Safe Kids Coalition
	  ○ Tmay@roanokerapidsnc.com
	• Child Development Services Association
	  ○ 252-316-4800
	  ○ Cheryl.yarrell@dhhs.nc.gov
	• Halifax-Warren Smart Start
	  ○ 252-537-4715
	  ○ 1139 Roanoke Avenue, Roanoke Rapids, NC 27870
	• CADA (Choanoke Area Development Association)
	  ○ Dbbie Hardy – 252-537-1111
	  ○ 116 B West Third Street, Roanoke Rapids, NC 27870
	• Halifax Country Environmental Health Inspections
	  ○ 252-583-6651
	  ○ 19 N Dobbs Street, Halifax, NC 27870
	• Child Fatality Task Force
	  ○ 919-733-9390
	• Park Avenue Pediatrics
	  ○ 529 Becker Drive, Roanoke Rapids, NC 27870
	  ○ (252) 537-6465
	• WIC State Agency
	  ○ 116 W 3rd Street, Roanoke Rapids, NC 27870
	  ○ (252) 535-4845
	• Nurse Family Partnership
	  ○ 252-583-5021

Priority Need: Obesity	• ECU Health North
	  ○ 250 Smith Church Road, Roanoke Rapids, NC 27870
	  ○ (252) 535-8011
	• Community Health Improvement Coordinator
	  ○ Elizabeth Galloway - elizabeth.dunlow@ecuhealth.org
	• Halifax County Health Department
	  ○ 252-583-5021
	• Department of Social Services
	  ○ 805 Washington Ave, Weldon, NC 27890
	  ○ (252) 536-2511
	• Rural Health Group
	  ○ Littleton – 252-586-5411
	• CATCH Program
	  ○ 252-583-5021
	• CPTA Transportation
	  ○ 505 North Main Street, Rich Square, NC 27869
	  ○ (252) 539-2022
	• Hannah's Place
	  ○ 252-541-1127 /hannahsplacenc.org
	• Access East
	  ○ info-accesseast@accesseast.org
	• Ripe for Revival
	  ○ Riperevivalmarket.com

Other Resources	• 988- Suicide and Crisis Lifeline
	  ○ 988
	• NC 211- United Way Health & Human Services Information & Referral System
	  ○ 1-888-892-1162
	• NCCARE360 – Social Determinants of Health Information System
	  ○ (888) 892-1162

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 North will utilize the CHNA insights to formulate implementation strategies. They will collaborate with community partners to ensure that the 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 Elizabeth Dunlow Galloway, Community Health Improvement Coordinator at ECU Health North, at Elizabeth.galloway@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.[55]

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

[55] 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 Scorecard Halifax County 2021-2024

HalifaxCounty
PUBLIC HEALTH SYSTEM
— CARING HEARTS, HELPING HANDS —

The Halifax County Health Department is excited to share the Healthy NC 2030 Scorecard for Halifax County. This Community Health Improvement Scorecard is an easy way to learn about some of the efforts currently underway in Halifax County to address three health priorities identified in the 2021-2022 Halifax County Community Health Assessment (CHA):

- Obesity
- Maternal, Fetal and Infant Health
- Substance Abuse (Mental Health Crisis Intervention)

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

For each priority, this Scorecard spotlights:

- A Result Statement, a picture of where we would like to be,
- Important local Indicators or measures of how we are doing linked to Healthy NC2030 indicators and
- Select Programs or activities and
- Key Performance Measures that show how those programs are making an impact.

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

Halifax County Community Health Needs Assessment

Community Health Needs Assessment 2021-2022

Substance Abuse

All people in Halifax County live in a community that fosters and supports positive mental health and prevention of substance abuse.

	Time Period	Current Actual Value	Current Trend	Baseline % Change
NCDPH HNC2030 Drug Overdose Death Rate in North Carolina: Drug Poisoning Deaths (Total) per 100,000 population	2022	42.1	↗ 4	205% ↗
Drug Poisoning Deaths - Halifax County Rate and Count (Age Adjusted)	2022	48.80	↗ 1	526% ↗
NCDPH HNC2030 Suicide Rate (TOTAL) in North Carolina (per 100,000)	2022	14.4	↗ 1	11% ↗
Suicide Rate (TOTAL) in Halifax (per 100,000) (Age Adjusted)	2022	15.7	↗ 1	124% ↗
NCDPH HNC2030 Percent of High School Youth Using Tobacco in North Carolina (Total)	2019	27.3%	↘ 1	-1% ↘
NCDPH HNC2030 Percent of Middle School Youth Using Tobacco in North Carolina (Total)	2019	10.4%	↘ 2	-10% ↘

CATCH My Breath

Time Period	Current Actual Value	Current Trend	Baseline % Change

		Time Period	Current Actual Value	Current Trend	Baseline % Change
How Much	# of student participants in CATCH my Breath program	2023	150	↘ 1	No Data →
How Well	% of students completing the CATCH My Breath Program	Q1 2023	100%	→ 2	0% →
Better Off	% of students completing CATCH My Breath Program that intend to stop vaping/not start vaping	–	–	–	–

Medicine Drop Take Back Initiative

Time Period	Current Actual Value	Current Trend	Baseline % Change

Lock Box Initiative

Time Period	Current Actual Value	Current Trend	Baseline % Change

Opioid Awareness Campaign

Time Period	Current Actual Value	Current Trend	Baseline % Change

Maternal, Fetal and Infant Health

Babies in Halifax County are born healthy, thrive in caring and healthy homes and see their first birthday.

		Time Period	Current Actual Value	Current Trend	Baseline % Change
NCDPH HNC2030	Early Prenatal Care: % of Women in NC (Total) who receive prenatal care in the First Trimester of Pregnancy	2023	72.0%	↗ 1	-1% ↘
NCDPH HNC2030	Teen Birth Rate: Number of births in NC per 1,000 population (Total) to females aged 15-19	2023	14.8	↘ 8	-37% ↘
NCDPH HNC2030	Infant mortality rate in North Carolina: Rate of Infant Deaths (Total) per 1,000 Live Births	2022	6.8	→ 1	-3% ↘

Baby's Easy Safe Sleep Training Program

		Time Period	Current Actual Value	Current Trend	Baseline % Change
How Much	Number of participants	2023	284	→ 0	0% →

Ready Set Baby Breastfeeding Education Program

		Time Period	Current Actual Value	Current Trend	Baseline % Change
How Much	Number of participants	2023	100	→ 0	0% →

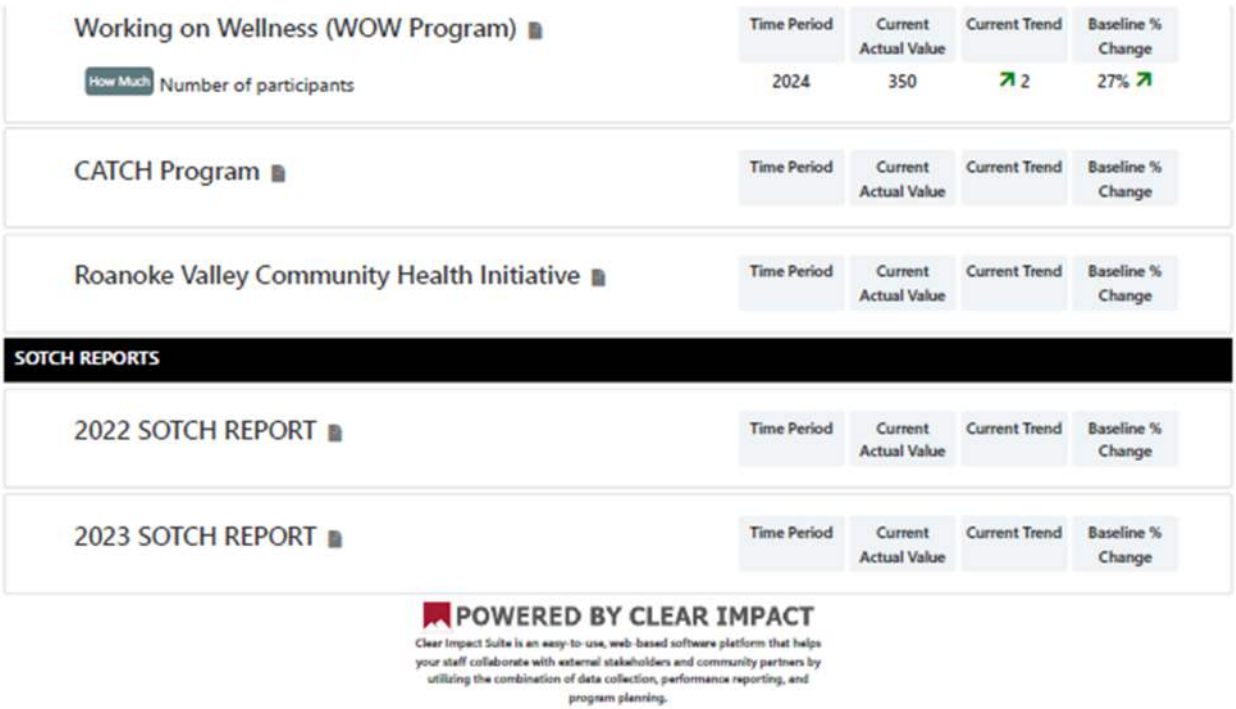
Car Seat Safety Education Program

		Time Period	Current Actual Value	Current Trend	Baseline % Change
How Much	Number of participants	2023	326	→ 0	0% →

Obesity

All people of Halifax County live in communities that support healthy weight initiatives.

		Time Period	Current Actual Value	Current Trend	Baseline % Change
NCDPH HNC2030	Youth SSB Consumption Among NC Students in Grades 9 through 12: % of Youth (Total) reporting consumption of one or more sugar-sweetened beverages (SSBs) per day.	2023	29.8%	→ 1	-24% ↘
NCDPH HNC2030	Sugar-Sweetened Beverage (SSB) Consumption Among Adults in NC: % of Adults (Total) reporting consumption of one or more sugar-sweetened beverages (SSBs) per day.	2022	36.8%	↗ 1	12% ↗


Working on Wellness (WOW Program)
Time Period
Current Actual Value
Current Trend
Baseline % Change
How Much
Number of participants
2024
350
2
27%
CATCH Program
Time Period
Current Actual Value
Current Trend
Baseline % Change
Roanoke Valley Community Health Initiative
Time Period
Current Actual Value
Current Trend
Baseline % Change
SOTCH REPORTS
2022 SOTCH REPORT
Time Period
Current Actual Value
Current Trend
Baseline % Change
2023 SOTCH REPORT
Time Period
Current Actual Value
Current Trend
Baseline % Change
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 Halifax County, its performance on each data measure was compared to targets/benchmarks. If Halifax 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 25: 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

Measure	Description	Data Source	Most Recent Data Year(s)
Mental Health Providers (per 100,000 population)	Number of providers with a CMS National Provider Identifier (NPI) that specialize in mental health. Mental health providers include licensed clinical social workers and other credentialed professionals specializing in psychiatry, psychology, counseling, or child, adolescent, or adult mental health.	CMS –NPPES. Data accessed via the North Carolina Data Portal, June 2024.	2024
Addiction/Substance Abuse Providers (per 100,000 population)	Number of providers who specialize in addiction or substance abuse treatment, rehabilitation, addiction medicine, or providing methadone. The providers include Doctors of Medicine (MDs), Doctors of Osteopathic Medicine (DOs), and other credentialed professionals with a Center for Medicare and Medicaid Services and a valid National Provider Identifier (NPI).	CMS –NPPES. Data accessed via the North Carolina Data Portal, June 2024.	2024
Buprenorphine Providers (per 100,000 population)	Number of providers authorized to treat opioid dependency with buprenorphine. Buprenorphine is the first medication to treat opioid dependency that is permitted to be prescribed or dispensed in physician offices, significantly increasing treatment access. Qualified physicians are required to acquire and maintain certifications to legally dispense or prescribe opioid dependency medications.	US Department of Health and Human Services (DHHS), Substance Abuse and Mental Health Services Administration. Data accessed via the North Carolina Data Portal, June 2024.	2023
Dental Health Providers (per 100,000)	Number of oral health providers with a CMS National Provider Identifier (NPI). Providers included are those who list “dentist”, “general practice dentist”, or “pediatric dentistry” as their primary practice classification, regardless of sub-specialty.	CMS – NPPES. Data accessed via the North Carolina Data Portal, June 2024.	2024
Health Professional Shortage Areas - Dental Care	Percentage of the population that is living in a geographic area designated as a “Health Professional Shortage Area” (HSPA), defined as having a shortage of dental health professionals. This indicator is 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

Measure	Description	Data Source	Most Recent Data Year(s)
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 26: 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 >=	Percentage of population with access to high-speed internet. Data are	FCC FABRIC Data. Additional data analysis	2023

Measure	Description	Data Source	Most Recent Data Year(s)
100MBPS and UL Speeds >= 20 MBPS)	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.	by CARES. Data accessed via the North Carolina Data Portal, June 2024.	
Households with No Computer	Percentage of households who don't own or use any types of computers, including desktop or laptop, smartphone, tablet, or other portable wireless computer, and some other type of computer, based on the 2018-2022 American Community Survey estimates.	U.S. Census Bureau, ACS. Data accessed via the North Carolina Data Portal, June 2024.	2018-2022
Households with No or Slow Internet	Percentage of households who either use dial-up as their only way of internet connection or have internet access but don't pay for the service, or have no internet access in their home, based on the 2018-2022 American Community Survey estimates.	U.S. Census Bureau, ACS. Data accessed via the North Carolina Data Portal, June 2024.	2018-2022
Liquor Stores	Number of liquor stores per 100,000 population provides a measure of environmental influences on dietary behaviors and the accessibility of healthy foods. Note this data excludes establishments preparing and serving alcohol for consumption on premises (including bars and restaurants) or which sell alcohol as a secondary retail product (including gas stations and grocery stores).	U.S. Census Bureau, County Business Patterns. Additional data analysis by CARES. Data accessed via the North Carolina Data Portal, June 2024.	2022
Adverse Childhood Experiences (ACEs)	Percentage of children in North Carolina (total) with two or more ACEs. ACEs are potentially traumatic events that occur in childhood (0-17 years), including experiencing violence, abuse, or neglect; witnessing violence in the home or 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		2022

Measure	Description	Data Source	Most Recent Data Year(s)
	health problems, instability due to parental separation, and instability due to household members being in jail or prison. Other traumatic experiences that impact health and well-being may include not having enough food to eat, experiencing homelessness or unstable housing, or experiencing discrimination. ACEs can have lasting effects on health and well-being in childhood and life opportunities well into adulthood, for example, education and job potential. These experiences can increase the risks of injury, sexually transmitted infections, teen pregnancy, suicide, and a range of chronic diseases including cancer, diabetes, and heart disease.	Clear Impact Healthy North Carolina (HNC) 2030 Scorecard, 2021-2024. Data accessed June 2024.	

Table 27: Diet and Exercise

Measure	Description	Data Source	Most Recent Data Year(s)
Physical inactivity (percent of adults that report no leisure time physical activity)	Percentage of adults ages 20 and over reporting no leisure-time physical activity in the past month. Examples of physical activities include running, calisthenics, golf, gardening, or walking for exercise. The method for calculating Physical Inactivity changed. Data for Physical Inactivity are provided by the CDC Interactive Diabetes Atlas which combines 3 years of survey data to provide county-level estimates. In 2011, BRFSS changed their methodology to include cell phone and landline participants. Previously only landlines were used to collect data. Physical Inactivity is created using statistical modeling.	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
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	EPA – Smart Location Database. Data accessed via the North Carolina Data Portal, June 2024.	2021

Measure	Description	Data Source	Most Recent Data Year(s)
	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.		
Access to Exercise Opportunities	Percentage of individuals in the county who live reasonably close to a location for physical activity. Locations for physical activity are defined as parks or recreational facilities. The numerator is the 2020 total population living in census blocks with adequate access to at least one location for physical activity (adequate access is defined as census blocks where the border is a half-mile or less from a park, 1 mile or less from a recreational facility in an urban area, or 3 miles or less from a recreational facility in a rural area) and the denominator is the 2020 resident county population. This indicator is used in the 2024 County Health Rankings.	ArcGIS Business Analyst and Living Atlas of the World, YMCA & U.S. Census Tigerline Files. Data accessed via the North Carolina Data Portal, June 2024.	2023
Recreation and Fitness Facility Access (per 100,000 population)	Number of establishments primarily engaged in operating fitness and recreational sports facilities featuring exercise and other active physical fitness conditioning or recreational sports activities, such as swimming, skating, or racquet sports. Access to recreation and fitness facilities encourages physical activity and other healthy behaviors.	U.S. Census Bureau, County Business Patterns. Additional data analysis by CARES. Data accessed via the North Carolina Data Portal, June 2024.	2022
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 28: 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	U.S. Census Bureau, ACS. Data accessed via the	2018-2022

Measure	Description	Data Source	Most Recent Data Year(s)
	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.	North Carolina Data Portal, June 2024.	
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 via the North Carolina Data Portal, June 2024.	2020-2021
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 29: 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 30: Environmental Quality

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

Table 31: 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 32: 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 limited or uncertain access to adequate food.	Feeding America. Data accessed via the North Carolina Data Portal, June 2024.	2021
Low-Income and Low Food Access	Percentage of the low-income population with low food access. Low food access is defined as living more than 1 mile (urban) or 10 miles (rural) from the nearest supermarket, supercenter, or large grocery store. Data are from the April 2021 Food Access Research Atlas dataset. This indicator is relevant because it highlights populations and geographies facing food insecurity.	U.S. Department of Agriculture (USDA), Economic Research Service, USDA – Food Access Research Atlas. 2019. Data accessed via the North Carolina Data Portal, June 2024.	2019
Limited access to healthy foods	Percentage of population who are low-income and do not live close to a grocery store.	USDA Food Environment Atlas. Data accessed via RWJF & UWPHI County	2019

Measure	Description	Data Source	Most Recent Data Year(s)
		Health Rankings & Roadmaps, June 2024.	
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 foods, and grocery stores are a major provider of these foods.	US Census Bureau, County Business Patterns. Additional data analysis by CARES. 2022. Data accessed via the North Carolina Data Portal, June 2024.	2022

Table 33: 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	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)
	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.		
Housing Cost Burden, Severe (50%)	Percentage of the households where housing costs are 50% or more total household income. This indicator provides information on the cost of monthly housing expenses for owners and renters. The information offers a measure of housing affordability and excessive shelter costs. The data also serve to aid in the development of housing programs to meet the needs of people at different economic levels.	U.S. Census Bureau, ACS. Data accessed via the North Carolina Data Portal, June 2024.	2018-2022
Housing & Urban Development (HUD)-Assisted Housing Units (per 10,000 households)	Number of HUD-funded assisted housing units available to eligible renters as well as the unit rate (per 10,000 total households).	U.S. Department of HUD. Data accessed via the North Carolina Data Portal, June 2024.	2017-2021
Substandard Housing, Severe	Percentage of owner- and renter-occupied housing units having at least one of the following conditions: 1) lacking complete plumbing facilities, 2) lacking complete kitchen facilities, 3) with 1.51 or more occupants per room, 4) selected monthly owner costs as a percentage of household income greater than 50%, and 5) gross rent as a percentage of household income greater than 50%. Selected conditions provide information in assessing the quality of the housing inventory and its occupants. This data is used to easily identify homes where the quality of living and housing can be considered substandard.	U.S. Census Bureau, ACS. Data accessed via the North Carolina Data Portal, June 2024.	2011-2015
Homeless Children and Youth	Number of homeless children and youth enrolled in the public school system during the school year 2019-2020. According to the data source	US Department of Education, EDFacts. Additional data analysis by CARES. 2019-2020.	2019-2020

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

Table 34: Income

Measure	Description	Data Source	Most Recent Data Year(s)
Median Family Income	Median family income based on the latest 5-year American Community Survey estimates. A family household is any housing unit in which the householder is living with one or more individuals related to him or her by birth, marriage, or adoption. Family income includes the incomes of all family members ages 15 and older.	U.S. Census Bureau, ACS. Data accessed via the North Carolina Data Portal, June 2024.	2018-2022
Gender Pay Gap	Ratio of women's median earnings to men's median earnings for all full-time, year-round workers, presented as "cents on the dollar." Data are acquired from the 2018-2022 ACS and are used in the 2024 County Health Rankings.	U.S. Census Bureau, ACS. Data accessed via the North Carolina Data Portal, June 2024.	2018-2022
Population Below 100% Federal Poverty Level (FPL)	Percentage of population living in households with income below the FPL. This indicator is relevant because poverty creates barriers to access including health services, healthy food, and other necessities that contribute to poor health status.	U.S. Census Bureau, ACS. Data accessed via the North Carolina Data Portal, June 2024.	2022
Population Below 200% FPL	Percentage of population living in households with income below 200% of the FPL. This indicator is relevant because poverty creates barriers to access including health services, healthy food, and other necessities that contribute to poor health status.	U.S. Census Bureau, ACS. Data accessed via the North Carolina Data Portal, June 2024.	2018-2022

Measure	Description	Data Source	Most Recent Data Year(s)
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 35: 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	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

Measure	Description	Data Source	Most Recent Data Year(s)
	lost under age 75 per 100,000 people. These are age-adjusted.		
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 36: Maternal and Infant Health

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

Measure	Description	Data Source	Most Recent Data Year(s)
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 37: Mental Health

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

Table 38: 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,	Behavioral Risk Factor Surveillance System. Data accessed via RWJF & UWPHI County Health Rankings & Roadmaps, June 2024.	2021

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

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

Table 39: Quality of Care

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

Table 40: Safety

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

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

Table 41: 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	2021

Measure	Description	Data Source	Most Recent Data Year(s)
		Rankings & Roadmaps, June 2024.	
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 42: Substance Use Disorders

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

Measure	Description	Data Source	Most Recent Data Year(s)
	excessive/binge drinking; examples include raising taxes on alcoholic beverages, restricting access to alcohol by limiting days and hours of retail sales, and screening and counseling for alcohol abuse.		
Mortality - Motor Vehicle Crash – Alcohol-Involved (annual rate per 100,000 population)	Crude rate of persons killed in motor vehicle crashes involving alcohol as an annual rate per 100,000 population. Fatality counts are based on the location of the crash and not the decedent's residence. Motor vehicle crash deaths are preventable and are a leading cause of death among young persons.	U.S. Department of Transportation, National Highway Traffic Safety Administration, Fatality Analysis Reporting System. Data accessed via the North Carolina Data Portal, June 2024.	2018-2022
Opioid Use Disorder (per 100,000 Medicare beneficiaries)	Rate of emergency department utilization for opioid use and opioid use disorder among the Medicare population. Figures are reported as age-adjusted to year 2000 standard. Rates are re-summarized for report areas from county level data, only where data is available. This indicator is relevant because mental health and substance use is an indicator of poor health.	CMS, Mapping Medicare Disparities Tool. Data accessed via the North Carolina Data Portal, June 2024.	2021
Mortality – Opioid Overdose (per 100,000 population)	Five-year average rate of death due to opioid drug overdose per 100,000 population. Figures are reported as crude rates for the time period of 2018 to 2022. Rates are re-summarized for report areas from county level data, only where data is available. This indicator is relevant because opioid drug overdose is the leading cause of injury deaths in the United States, and they have increased dramatically in recent years.	CDC – NVSS. Data accessed via the North Carolina Data Portal, June 2024.	2018-2022

Table 43: 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	Behavioral Risk Factor Surveillance System. Data accessed via RWJF & UWPHI County Health	2021

Measure	Description	Data Source	Most Recent Data Year(s)
	Smoking estimates are created using statistical modeling.	Rankings & Roadmaps, June 2024.	

Table 44: 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 Halifax 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	Halifax County Description
	Low	Represents measures in which Halifax 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 Halifax 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 Halifax 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 Halifax County value was compared to the benchmark by calculating the percentage difference between the values, relative to the benchmark value:

(Halifax 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:

(6.4-7.5)/(7.5) x 100% = -14.7% = Displayed as **Low Priority Level**, Shaded in Green

This metric indicates that the percentage of the population with limited access to healthy foods in Halifax County is 14.7 percent better (or, in this case, lower) than the percentage of the population with limited access to healthy foods in the state of North Carolina.

Detailed Focus Area Benchmarks

Table 45: Access to Care

Measure	National Benchmark	North Carolina Benchmark	Halifax County Data	Most Recent Data Year	Halifax County Need
Primary Care Providers Ratio	112.4	101.1	61.7	2024	High
Mental Health Providers Ratio	178.7	155.7	92.6	2024	High
Addiction/Substance Abuse Providers Ratio	27.9	25.0	16.5	2024	High
Buprenorphine Providers Ratio	15.5	15.2	20.0	2023	Low
Dental Health Providers Ratio	39.1	31.5	24.7	2024	High
% Living in Health Professional Shortage Areas (HPSAs) – Dental Care	17.8%	34.0%	53.4%	2018-2022	High
Federally Qualified Health Centers (FQHCs)	3.5	4.1	24.7	2023	Low
% Receiving Medicaid	22.3%	20.2%	35.4%	2018-2022	High
% Uninsured	10.2%	12.5%	12.8%	2022	Medium

Table 46: Built Environment

Measure	National Benchmark	North Carolina Benchmark	Halifax County Data	Most Recent Data Year	Halifax County Need
Broadband Access (Access to DL Speeds >= 25MBPS and UL Speeds >= 3 MBPS)	93.8%	93.6%	79.2%	2023	High
Broadband Access (Access to DL Speeds >= 100MBPS and UL Speeds >= 20 MBPS)	91.2%	90.4%	69.9%	2023	High
Households with No Computer	6.1%	6.9%	15.2%	2018-2022	High

Measure	National Benchmark	North Carolina Benchmark	Halifax County Data	Most Recent Data Year	Halifax County Need
Households with No or Slow Internet	11.7%	13.0%	33.3%	2018-2022	High
Liquor Stores	13.3	6.2	12.3	2022	High
Adverse Childhood Experiences (ACEs)	N/A	N/A	Suppressed	2022	N/A

Table 47: Diet and Exercise

Measure	National Benchmark	North Carolina Benchmark	Halifax County Data	Most Recent Data Year	Halifax County Need
% Physically Inactive	N/A	21.6%	31.9%	2021	High
Walkability Index Score	10	7	6	2021	High
% with Access to Exercise Opportunities	84.1%	73.0%	52.0%	2023	High
Recreation and Fitness Facility Access	14.8	13.1	Suppressed	2022	N/A
Sugar-Sweetened Beverage (SSB) Consumption	N/A	N/A	36.8%	2022	N/A

Table 48: Education

Measure	National Benchmark	North Carolina Benchmark	Halifax County Data	Most Recent Data Year	Halifax County Need
% Limited English Proficiency	8.2%	4.6%	1.3%	2018-2022	Low
High School Graduation Rate	81.1%	87.6%	81.3%	2020-2021	High
% with No High School Diploma	10.9%	10.6%	18.9%	2018-2022	High
Student Math Proficiency	63.9%	65.8%	89.3%	2020-2021	High
Student Reading Proficiency	60.1%	59.5%	75.7%	2020-2021	High
School Funding Adequacy	N/A	-$4,742	-$19,740	2021	High
School Funding Adequacy –	N/A	$10,655	$14,348	2021	Low

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

Table 49: Employment

Measure	National Benchmark	North Carolina Benchmark	Halifax County Data	Most Recent Data Year	Halifax County Need
Unemployment Rate	3.9%	3.7%	4.7%	2024	High
Average Annual Unemployment Rate, 2013-2023	3.6%	3.5%	5.2%	2024	High

Table 50: Environmental Quality

Measure	National Benchmark	North Carolina Benchmark	Halifax County Data	Most Recent Data Year	Halifax County Need
Flood Vulnerability	6.5%	4.9%	1.8%	2011	Low
Drinking Water Safety	16,107	194	1	2023	Low

Table 51: Family, Community and Social Support

Measure	National Benchmark	North Carolina Benchmark	Halifax County Data	Most Recent Data Year	Halifax County Need
Children Cost Burden	28.8%	27.0%	31.0%	2023	High
% Young People Not in School or Working	6.9%	7.5%	19.5%	2018-2022	High

Table 52: Food Security

Measure	National Benchmark	North Carolina Benchmark	Halifax County Data	Most Recent Data Year	Halifax County Need
% Food Insecure	10.3%	11.4%	16.0%	2021	High
% Food Insecure Children	13.3%	15.3%	30.0%	2021	High
% Low-Income and with Low Food Access	19.4%	21.3%	12.3%	2019	Low
% Limited Access to Healthy Foods	N/A	7.5%	6.4%	2019	Low
Fast Food Restaurants	96.2	77.4	90.5	2022	High
Grocery Stores	23.4	18.7	37.0	2022	Low

Table 53: Housing and Homelessness

Measure	National Benchmark	North Carolina Benchmark	Halifax County Data	Most Recent Data Year	Halifax County Need
Renter Costs – Average Gross Rent	$1,366	$1,090	$669	2018-2022	Low
% Severe Housing Cost Burden	14.1%	12.2%	16.1%	2018-2022	High
Assisted Housing Units	413.9	319.2	786.8	2017-2021	High
% Severe Substandard Housing	18.5%	16.1%	19.8%	2011-2015	High
% Homeless Children	2.8%	1.9%	3.2%	2019-2020	High

Table 54: Income

Measure	National Benchmark	North Carolina Benchmark	Halifax County Data	Most Recent Data Year	Halifax County Need
Median Family Income	$92,646	$82,890	$54,419	2018-2022	High
Gender Pay Gap	81.0%	83.0%	83.0%	2018-2022	Medium
% Living Below 100% FPL	12.5%	13.3%	23.9%	2022	High
% Living Below 200% FPL	28.8%	31.6%	49.2%	2018-2022	High
% Children Living Below 200% FPL	37.2%	41.1%	65.1%	2018-2022	High
% Receiving SNAP	12.4%	15.7%	31.7%	2021	High
Children Eligible for Free/Reduced Price Lunch	51.7%	50.8%	77.6%	2022-2023	High

Table 55: Length of Life

Measure	National Benchmark	North Carolina Benchmark	Halifax County Data	Most Recent Data Year	Halifax County Need
Years of Potential Life Lost Rate	N/A	8,853	14,930	2019-2021	High
Premature Age-Adjusted Mortality	N/A	420	651	2019-2021	High
Life Expectancy	77.6	76.6	71.2	2019-2021	High

Table 56: Maternal and Infant Health

Measure	National Benchmark	North Carolina Benchmark	Halifax County Data	Most Recent Data Year	Halifax County Need
Births with Late or No Prenatal Care	6.1%	6.9%	Suppressed	2019	N/A
Low Birthweight	N/A	9.4%	13.3%	2016-2022	High
Infant Mortality Rate	5.7	7.0	11.0	2015-2021	High

Table 57: Mental Health

Measure	National Benchmark	North Carolina Benchmark	Halifax County Data	Most Recent Data Year	Halifax County Need
Poor Mental Health Days	4.9	4.6	5.5	2021	High
Deaths of Despair Rate	55.9	58.7	75.2	2018-2022	High
Suicide Death Rate	14.5	14.0	15.8	2018-2022	High

Table 58: Physical Health

Measure	National Benchmark	North Carolina Benchmark	Halifax County Data	Most Recent Data Year	Halifax County Need
% Poor or Fair Health	N/A	14.4%	23.8%	2021	High
% Adults with Asthma	9.7%	9.8%	11.6%	2022	High
% Adults with Heart Disease	5.2%	5.5%	7.1%	2022	High
% Adults with High Blood Pressure	29.6%	32.1%	42.2%	2021	High
% Adults with High Cholesterol	31.0%	31.4%	32.2%	2021	Medium
Diabetes Prevalence	8.9%	9.0%	11.3%	2021	High
% Adults with Kidney Disease	2.7%	2.9%	3.8%	2021	High
% Stroke	2.8%	3.1%	4.6%	2022	High
Obesity	30.1%	29.7%	28.8%	2021	Medium
% Teeth Loss	13.9%	12.0%	20.8%	2022	High
Cancer Incidence Rate	442.3	464.4	497.5	2016-2020	High
Emergency Room Visits	535	563	755	2022	High

Measure	National Benchmark	North Carolina Benchmark	Halifax County Data	Most Recent Data Year	Halifax County Need
Heart Disease Hospitalization Rate	10.4	11.7	12.4	2018-2020	High
Stroke Hospitalization Rate	8.0	9.5	10.9	2018-2020	High

Table 59: Quality of Care

Measure	National Benchmark	North Carolina Benchmark	Halifax County Data	Most Recent Data Year	Halifax County Need
Children/adults vaccinated annually against seasonal influenza	44.5%	45.6%	39.7%	2021	High
Preventable Hospital Rate	2,752	2,957	4,061	2021	High
Readmissions Rate	18.1%	17.6%	18.6%	2022	High

Table 60: Safety

Measure	National Benchmark	North Carolina Benchmark	Halifax County Data	Most Recent Data Year	Halifax County Need
Incarceration Rate	1.3%	1.5%	1.7%	2018	High
Juvenile Arrest Rate	13.8	16.0	34.0	2021	High
Violent Crime	416.0	365.7	513.5	2015-2017	High
Firearm Death Rate	13.4	15.5	29.3	2018-2022	High
Poisoning Death Rate	28.5	31.5	34.9	2018-2022	High

Table 61: Sexual Health

Measure	National Benchmark	North Carolina Benchmark	Halifax County Data	Most Recent Data Year	Halifax County Need
Chlamydia Rate	495.0	603.3	928.1	2021	High
HIV Incidence Rate	12.7	15.5	Suppressed	2022	N/A
Teen Births	16.6	18.2	N/A	2016-2022	N/A

Table 62: Substance Use Disorders

Measure	National Benchmark	North Carolina Benchmark	Halifax County Data	Most Recent Data Year	Halifax County Need
% Excessive Drinking	18.1%	18.2%	12.8%	2021	Low
% Driving Deaths with Alcohol	2.3	2.9	12.3	2018-2022	High
Opioid Use Disorder Rate	41.0	43.0	29.0	2021	Low
Opioid Drug Overdose Deaths	N/A	25.1	28.8	2018-2022	High

Table 63: Tobacco Use

Measure	National Benchmark	North Carolina Benchmark	Halifax County Data	Most Recent Data Year	Halifax County Need
% Smokers	14.5%	15.0%	23.9%	2021	High

Table 64: Transportation Options and Transit

Measure	National Benchmark	North Carolina Benchmark	Halifax County Data	Most Recent Data Year	Halifax County Need
% Households with No Motor Vehicle	8.3%	5.4%	9.2%	2018-2022	High
% Public Transit	3.8%	0.8%	0.0%	2018-2022	High

APPENDIX 4 | PRIMARY DATA METHODOLOGY AND SOURCES

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

Methodologies

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

Focus Groups

The three focus groups were conducted in person between May 22nd and June 13th, 2024. These groups included representation from community members, with 26 participants providing responses.

- ECU Health North
- Halifax County Health Department
- Scotland Neck Library

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 Halifax County

The majority (80.7%) of participants identified as female, and were a mix of White, American Indian and Alaska Native, and Black or African American. Participants represented a wide range of age groups.

The focus group discussion guide questions are below:

FACILITATOR INTRODUCTION:

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

PARTICIPANT INTRODUCTIONS

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

HEALTH AND WELLNESS

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

SOCIAL DETERMINANTS OF HEALTH

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

ACCESS TO CARE

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

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

SUGGESTIONS

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

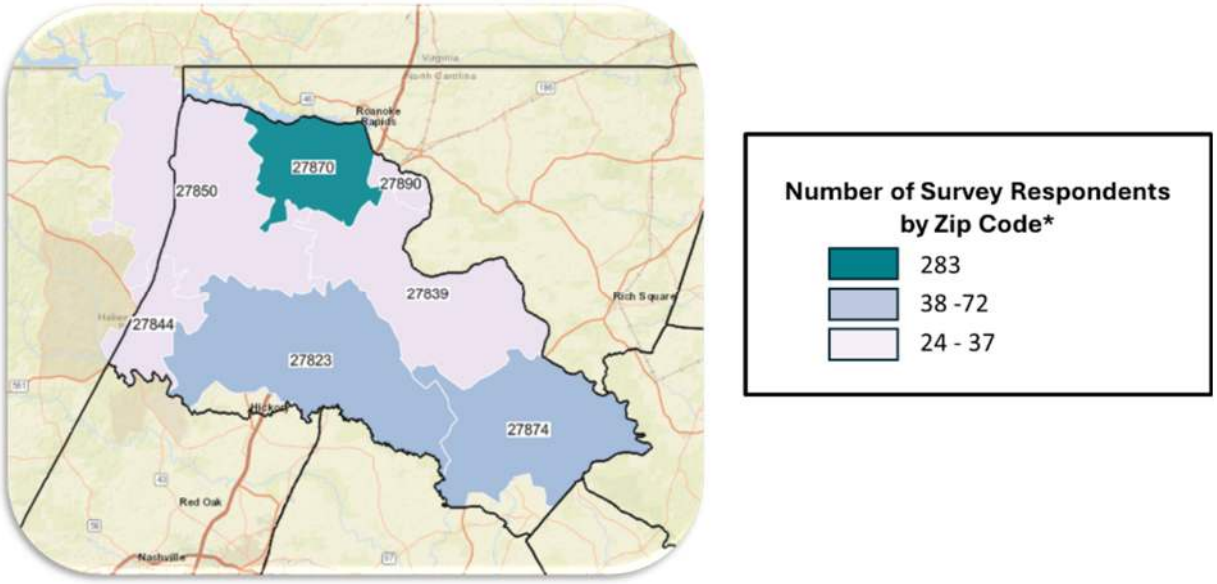
10. What do you think local health leaders should do to improve health and quality of life in [COUNTY NAME]? What do you want local health leaders to know?

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

Community Member Web Survey

A total of 562 surveys were completed by individuals living, working or receiving healthcare in the Halifax County community. The survey was available in both English and Spanish, and approximately 1% were completed in Spanish. Consistent with one of the survey process goals, survey community member respondents were representative of a broad geographic area encompassing areas throughout the county. The map below provides additional information on survey respondents' ZIP code of residence.

Figure 53: Respondent Zip Code of Residence[56]



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

In general, survey questions focused on:

- Community health problems and concerns
- Community social/environmental problems and concerns
- Specific topics of interest to Halifax County:
    - Healthy lifestyle
    - Maternal and infant health
    - Mental health
    - Physical health
    - Substance use disorders
    - Transportation and transit
    - Tobacco

The key findings from the Community Survey are detailed below:

- Alcohol/drug addiction, mental health (e.g., depression and anxiety), and diabetes/high blood sugar were identified as the top 3 health problems affecting the community. About one third of respondents also identified heart disease/high blood pressure and cancer 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.
- Poverty, lack of job opportunities, and housing/homelessness were identified as the top three most important social or environmental problems that affect the health of the community.

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

Figure 54: Respondents by Age Group

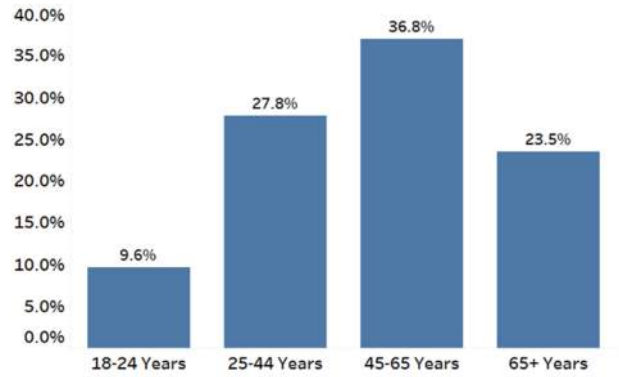


Figure 55: Respondents by Gender

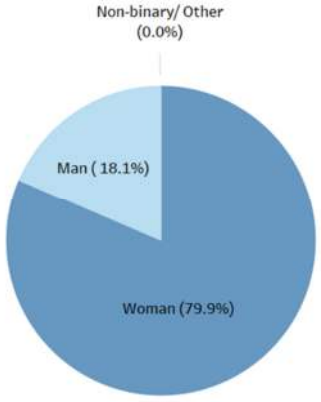


Figure 56: Respondents by Race

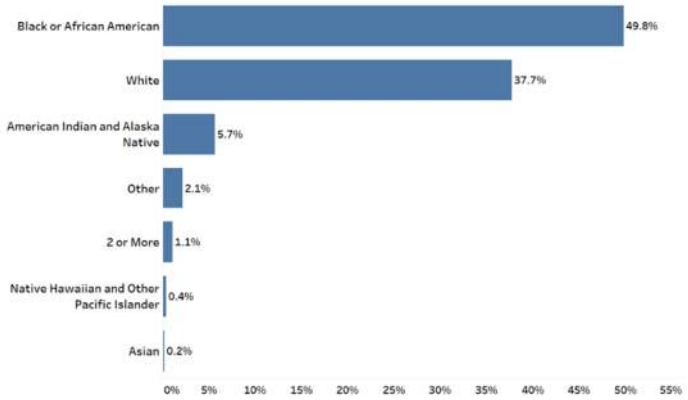
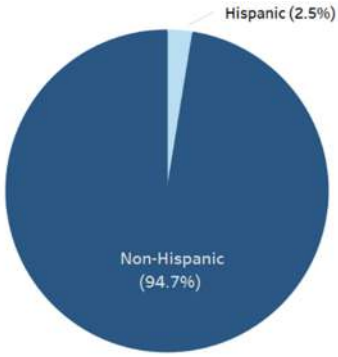


Figure 57: Respondents by Ethnicity



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

Dear Community Member,

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

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

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

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

Thank you for your time and participation!

Topic: Demographics

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

2. What is your age group?

   □ 18-24
   □ 25-44
   □ 45-65

□ 65+
□ Don't know/ Not sure
□ Prefer not to say

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

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

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

□ American Indian and Alaska Native
□ Asian
□ Black or African American
□ Native Hawaiian and Other Pacific Islander
□ White
□ Other race: _____
□ Don't know/Not sure
□ Prefer not to say

5. Are you of Hispanic or Latino origin, or is your family originally from a Spanish speaking country?[57]

□ 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

[57] 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."

□ Graduate or professional degree
□ Don't know/Not sure
□ Prefer not to say

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

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

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

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

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

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

Topic: Community Health Opinion Questions

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

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

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

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

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

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

Topic: Diet & Exercise

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

    □ Number of servings: _____

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

    □ Number of servings: _____

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

    □ Number of drinks: _____

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

    □ Number of hours: _____

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

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

Topic: Maternal and Infant Health

The following section asks questions about maternal and infant health in your county.

18. Have you given birth in the past year?

    □ Yes
    □ No
    □ Not applicable
    □ Prefer not to say

[If you answered 'Yes' to Question 1, please proceed to Question 2. All other responses, please proceed to the next topic.]

19. Thinking back to your most recent pregnancy, did you need to travel outside the county you live in to find prenatal care or to give birth?

    □ Yes, I traveled less than 30 minutes
    □ Yes, I traveled more than 30 minutes
    □ No
    □ Don't know
    □ Prefer not to say

20. Thinking back to your most recent pregnancy, did you receive any prenatal care?

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

[If you answered 'Yes' to Question 3, please proceed to Question 4. All other responses, please proceed to Question 5.]

21. During any of your prenatal care visits, did a healthcare provider do any of the following things:

	Yes	No	Don't Know	Prefer not to say
a. Talk to me about how much weight I should gain during pregnancy.	□	□	□	□
b. Talk to me about doing tests to screen for birth defects or diseases that run in my family.	□	□	□	□
c. Talk to me about what to do if I feel depressed or anxious during my pregnancy or after the baby is born.	□	□	□	□
d. Ask me if I planned to breastfeed my new baby.	□	□	□	□
e. Ask me if I planned to use birth control after my baby was born.	□	□	□	□
f. Ask me if I was taking any prescription medication.	□	□	□	□
g. Ask me if I smoked cigarettes or used any other tobacco products (vapes, smokeless tobacco).	□	□	□	□
h. Ask me if I was drinking alcohol.	□	□	□	□
i. Ask me if someone was hurting me emotionally or physically.	□	□	□	□
j. Ask me if I was using illegal drugs.	□	□	□	□
k. Ask me if I was using marijuana.	□	□	□	□
l. Ask me if I wanted to be tested for HIV.	□	□	□	□

22. Thinking about your most recent birth, was this infant born more than three weeks before your due date?

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

23. Thinking about your most recent birth, was this infant ever breastfed?

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

Topic: Mental Health

24. 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: _____

25. 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

26. 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

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

    □ Yes
    □ No
    □ Prefer not to say

Topic: Physical Health

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

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

29. 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?	□	□	□	□

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

□ Arthritis
□ Asthma
□ Cancer
□ Chronic Obstructive Pulmonary Disease (COPD)
□ Dementia/Short-term memory loss
□ Depression or anxiety
□ Diabetes (not during pregnancy)
□ Heart disease, stroke, or other cardiovascular disease
□ High blood pressure (hypertension)
□ High cholesterol
□ Immunocompromised condition not otherwise listed
□ Kidney disease
□ Liver disease
□ Long COVID
□ Lung disease
□ Osteoporosis
□ Physical disabilities
□ Mental illness not otherwise listed (including bipolar disorder, schizophrenia, borderline personality disorder, dissociative identity disorder)
□ Sexually transmitted diseases (including chlamydia, syphilis, gonorrhea and HIV)
□ Stroke
□ Vision and sight problems
□ Other *(please specify)*:
□ None of the above
□ Don't know/Not sure
□ Prefer not to say

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

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

Topic: Substance Use Disorders

32. 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: _____

33. 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

34. 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

35. 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

36. 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

37. 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

38. 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

Topic: Tobacco Use

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

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

APPENDIX 5 | DETAILED PRIMARY DATA FINDINGS

Focus Groups

Key findings from the focus groups are summarized below.

Focus Group General Findings

Three focus groups conducted in Halifax County identified several common health concerns and barriers to care. First, they identified employment and income as a major issue, noting a divide between "haves and have nots," lack of local job opportunities, and prevalence of poverty. The second common theme was food access and security, with participants highlighting high food prices, limited healthy food options, and a need for nutrition education. Healthcare access and quality was another significant concern, with issues such as unaffordable health insurance, long wait times, and perceived inadequate patient-provider interactions. Mental health emerged as a crucial issue, with participants citing a lack of providers, high treatment costs, and specific concerns for youth and elderly populations. Lastly, the focus groups identified transportation and transit as a challenge, impacting access to healthcare, healthy food, and job opportunities.

Focus Group 1 Unique Insights: ECU Health North

Seven community members participated in focus group one. Four of the participants identified as male, and three identified as female. Half of the participants identified as white, two identified as African American, and one group member identified as American Indian and Alaska Native. All participants were over the age of 18, with half of the group over the age of 40. Participants in the focus group at ECU Health North identified additional concerns beyond the common themes. They highlighted issues with the built environment, specifically inconsistent broadband internet access across the county. Education was another key topic, with participants emphasizing the need for basic education on topics like taxes, mortgages, credit scores, and nutrition. The group also noted limited health literacy among community members, particularly regarding what constitutes a "healthy" lifestyle. Housing and homelessness were identified as significant issues, with participants citing a lack of affordable housing, high prices, and high interest rates.

To address these concerns, participants suggested expanding telemedicine services and improving broadband access. They also recommended more effective use of available state and federal funding to expand services in the county. Lastly, they proposed developing or strengthening partnerships with law enforcement.

Focus Group 2 Unique Insights: Halifax County Health Department

Twelve community members participated in focus group two. Nearly all (11) of the participants identified as female, and two-thirds (8) of the participants identified as American Indian and Alaska Native. Four of the participants identified as white. All participants were over the age of 18. The focus group at Halifax County Health Department raised several unique health and social concerns. Community safety was a notable issue, with gang violence mentioned as a specific concern. Education was again highlighted, with participants noting a decline in student enrollment at Halifax Community College and a need for education on maintaining healthy lifestyles. Housing and homelessness were reiterated as significant challenges, with demand for housing outpacing supply and long waitlists for affordable housing. Physical health

issues, particularly obesity in younger populations and chronic conditions in older adults, were emphasized. Substance use, especially among young people, was identified as a prevalent problem. The group also expressed concern about tobacco use, specifically the proliferation of vape shops and vaping among young people, including elementary-age children.

Suggestions for improvement included better access to phones and internet to help people find health information, more wellness resources for young people in the school system, and ensuring existing resources are being used appropriately and sustainably.

Focus Group 3 Unique Insights: Scotland Neck Library

Seven community members participated in focus group three. All participants identified as female. Half (3) of the participants identified as white, and three identified as American Indian and Alaska Native. One participant identified as African American. All participants were over the age of 30. Participants in the Scotland Neck Library focus group raised unique concerns about environmental quality and physical health. Environmental issues included worries about the dismantling of the EPA and federal policies, as well as the impact of land fields, hog farms, and chicken houses. Regarding physical health, the group noted that obesity, heart disease, and diabetes are more prevalent in low-income and rural areas of the county.

To address these concerns, participants suggested providing more transportation options, developing an informational podcast for health education, and encouraging local health leaders to recognize that the county extends beyond the I-95 area and to better understand the local population.

Community Member Web Survey

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

Topic: Additional Demographic Information

Figure 58: What is the highest grade or year of school you completed?

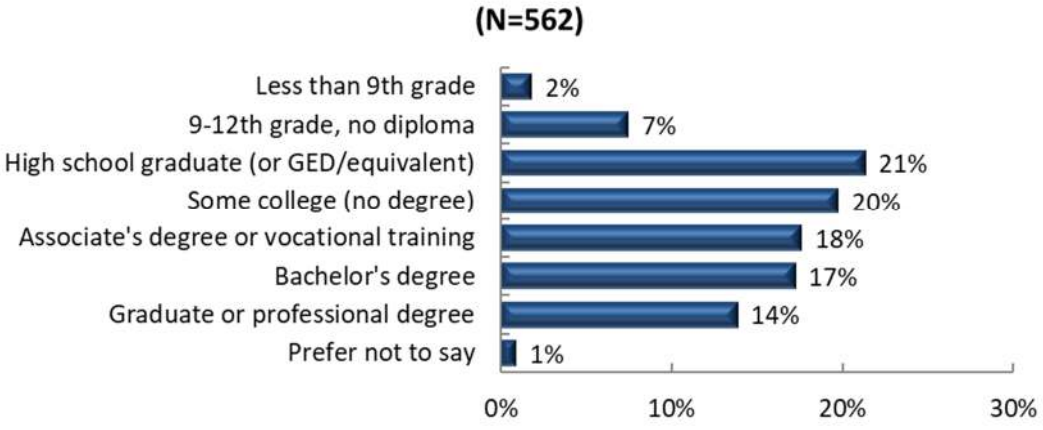


Figure 59: Which language is most often spoken in your home? (Choose one)

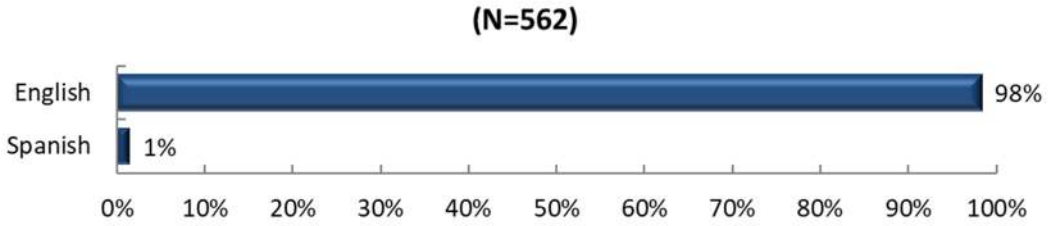


Figure 60: For employment, are you currently... (Select all that apply.)

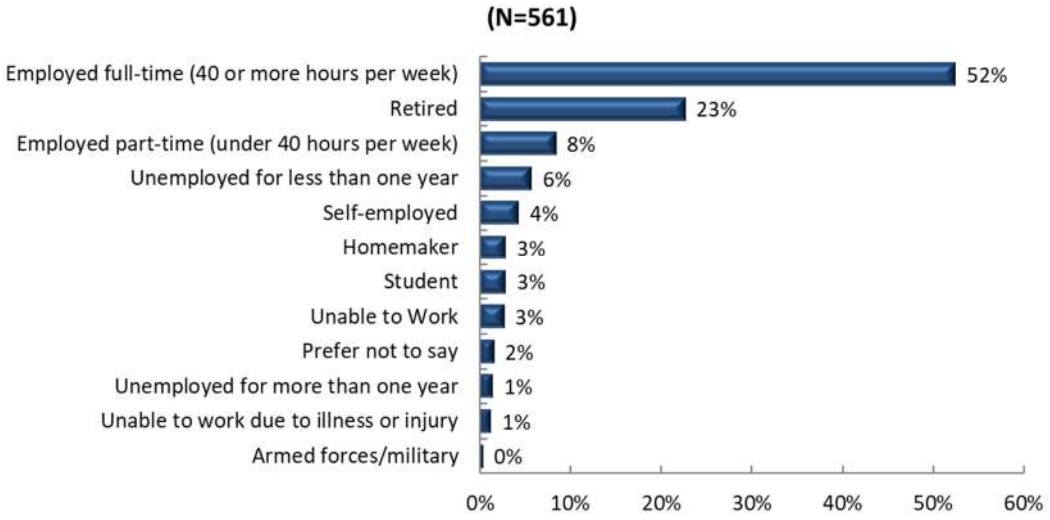
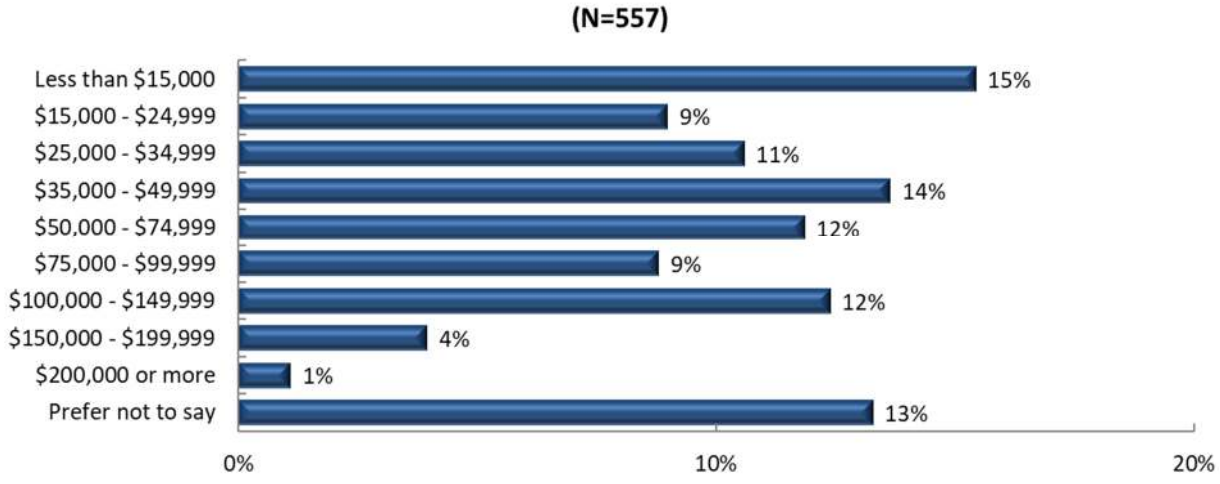


Figure 61: Which category best describes your yearly household income before taxes?[58]



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

Topic: Health Conditions, Social Determinants of Health, and Barriers to Care[59]

Figure 62: What are the three most important health problems that affect the health of your community? Please select up to three.

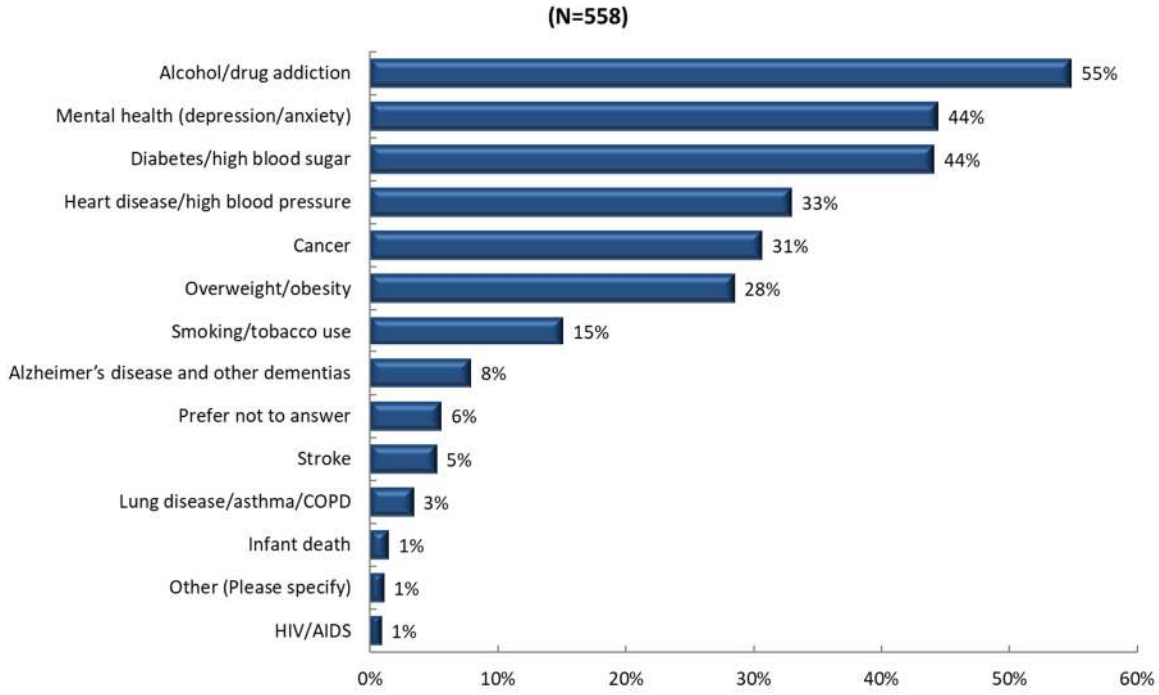
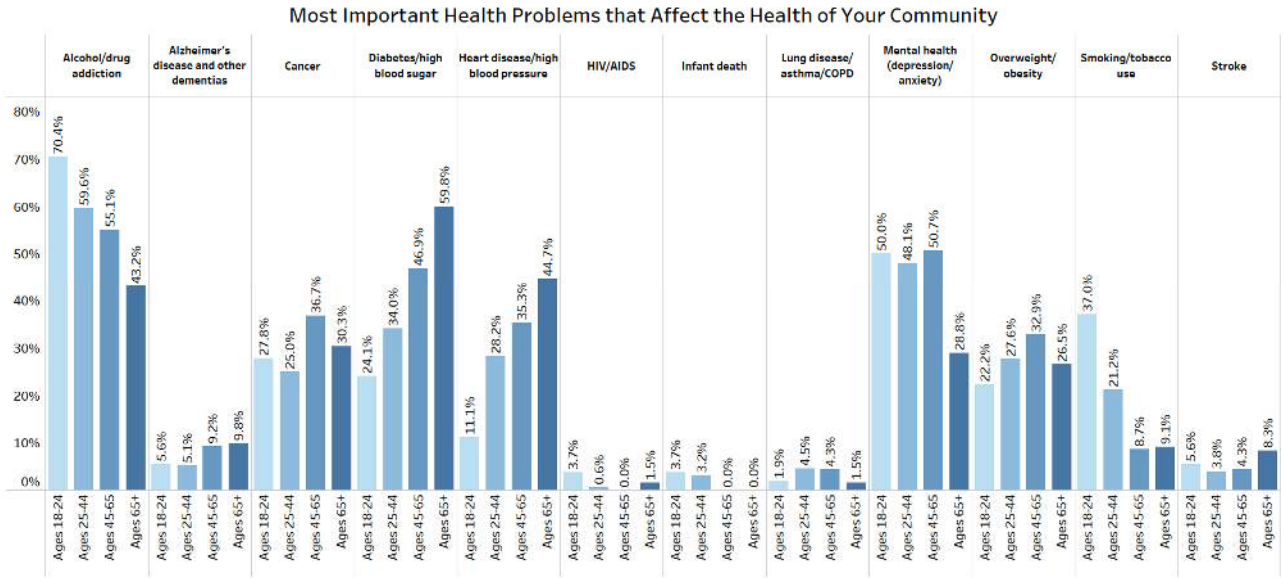


Figure 63: What are the three most important health problems that affect the health of your community? Please select up to three. (by age)



[59] Free-text responses to questions with an "Other (Please Specify) answer selection are available upon request.

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

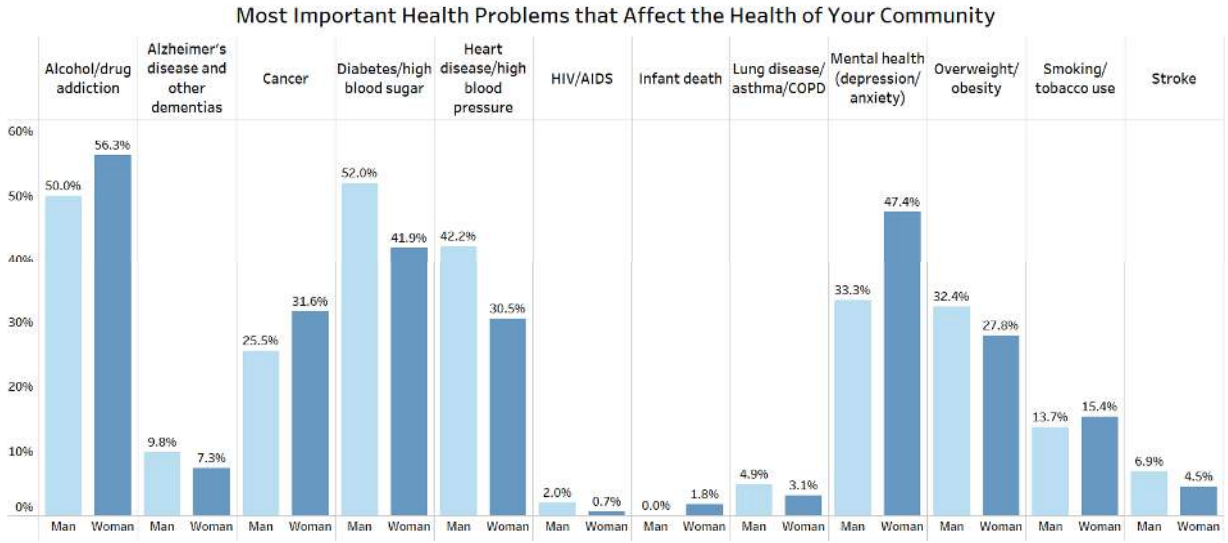


Figure 65: What are the three most important health problems that affect the health of your community? Please select up to three. (by race)

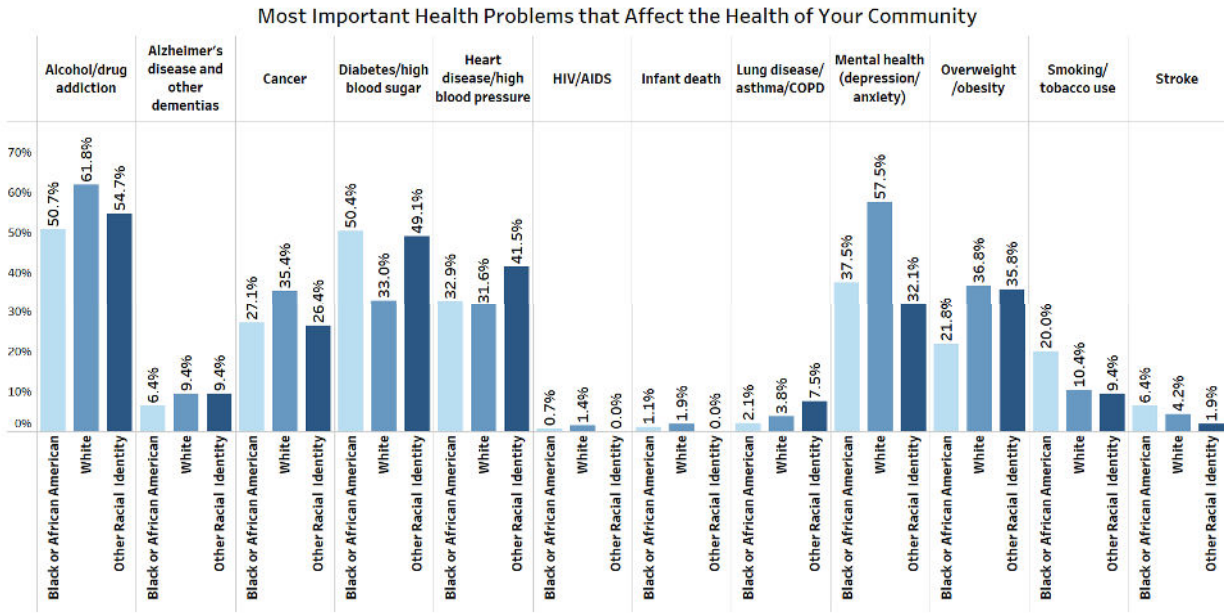


Figure 66: What are the three most important health problems that affect the health of your community? Please select up to three. (by ethnicity)

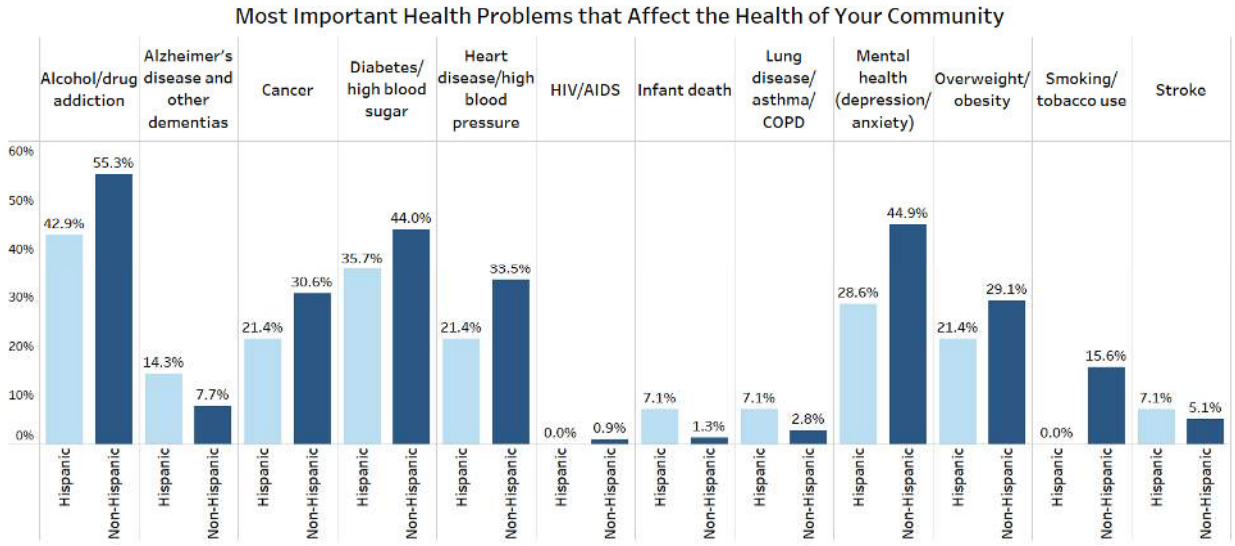


Figure 67: What are the three most important social or environmental problems that affect the health of your community? Please select up to three.

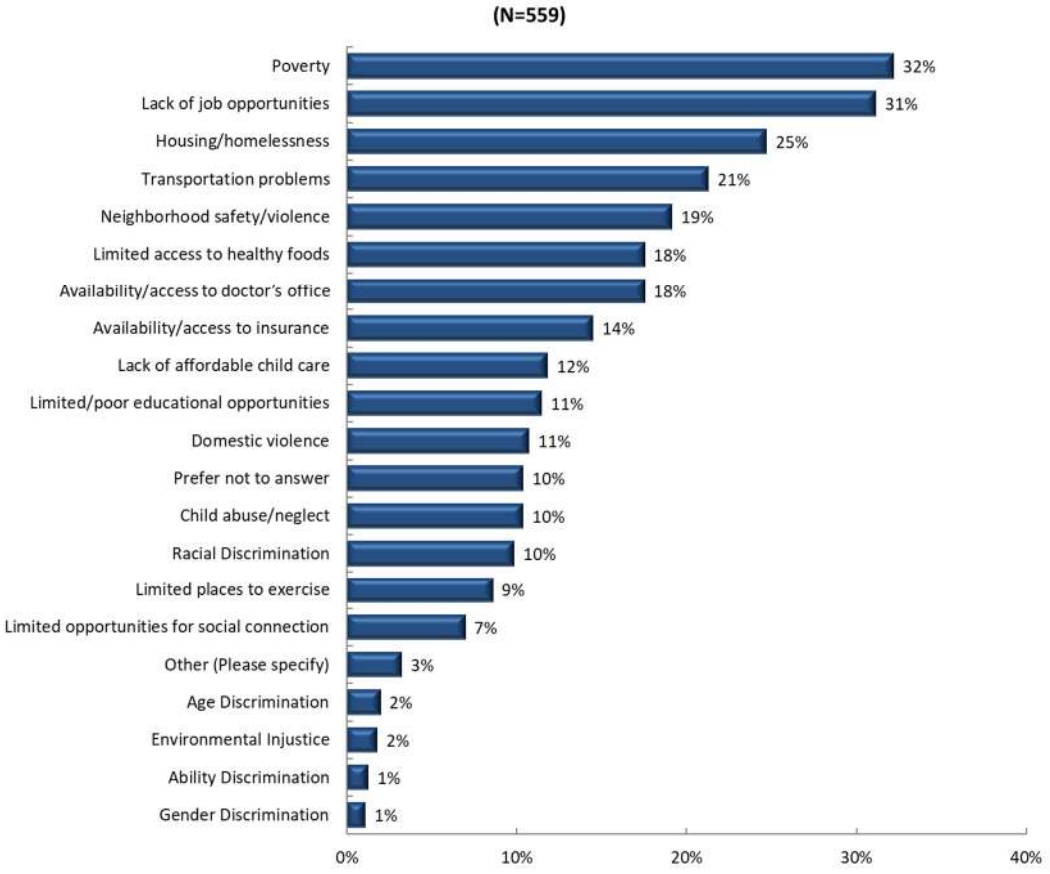


Figure 68: What are the three most important social or environmental problems that affect the health of your community? Please select up to three. (by age)

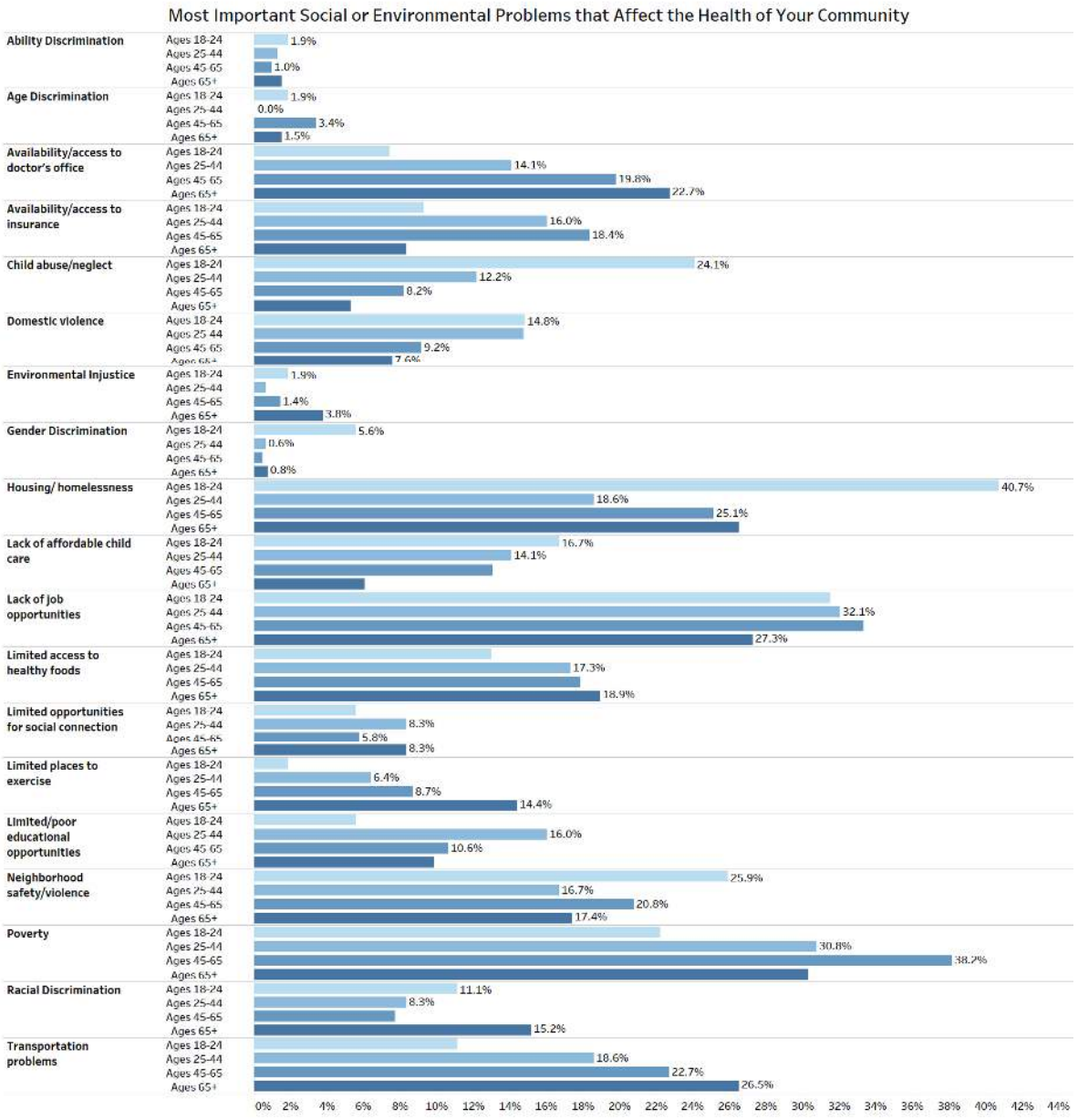


Figure 69: What are the three most important social or environmental problems that affect the health of your community? Please select up to three. (by gender)

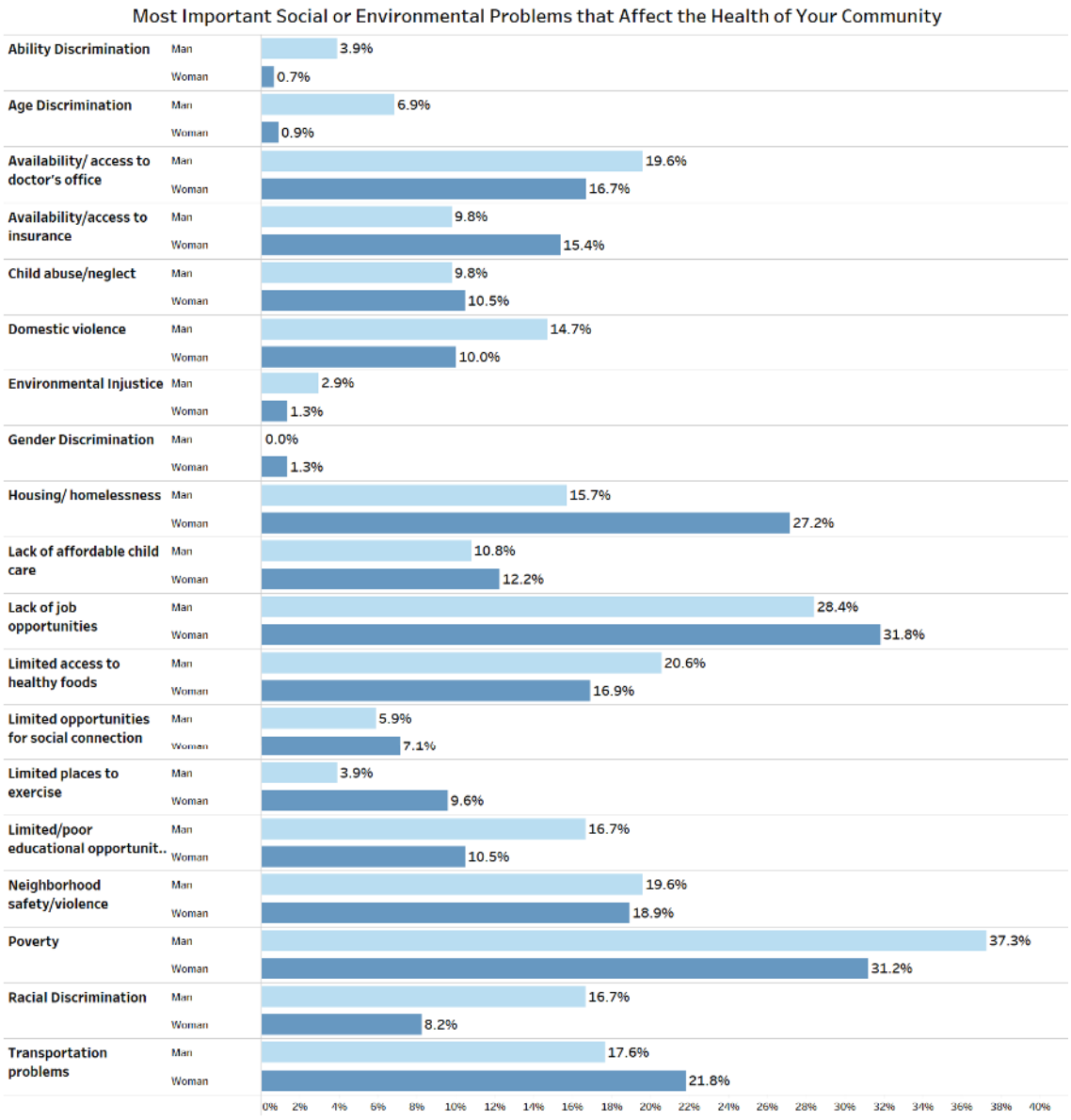


Figure 70: What are the three most important social or environmental problems that affect the health of your community? Please select up to three. (by race)

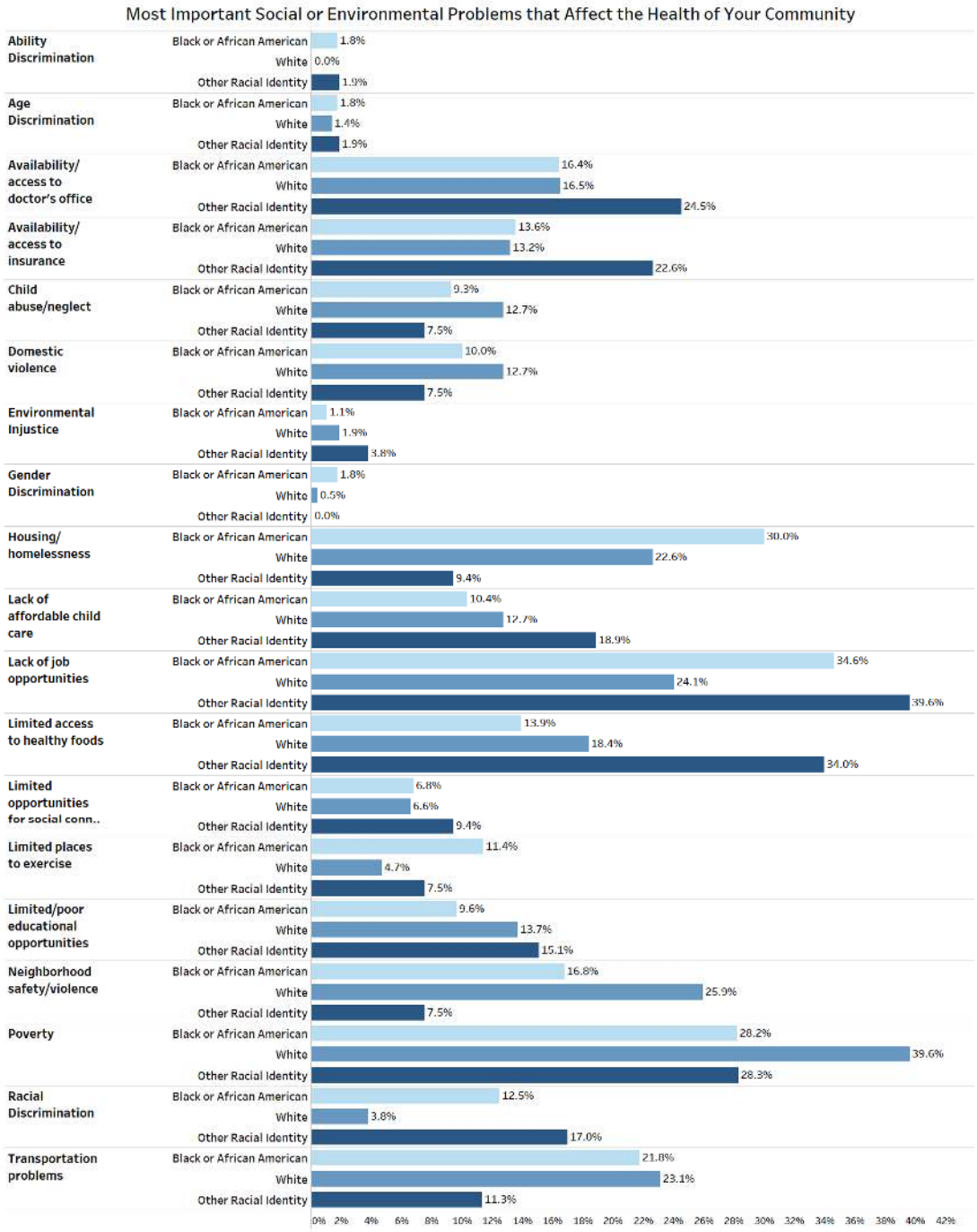


Figure 71: What are the three most important social or environmental problems that affect the health of your community? Please select up to three. (by ethnicity)

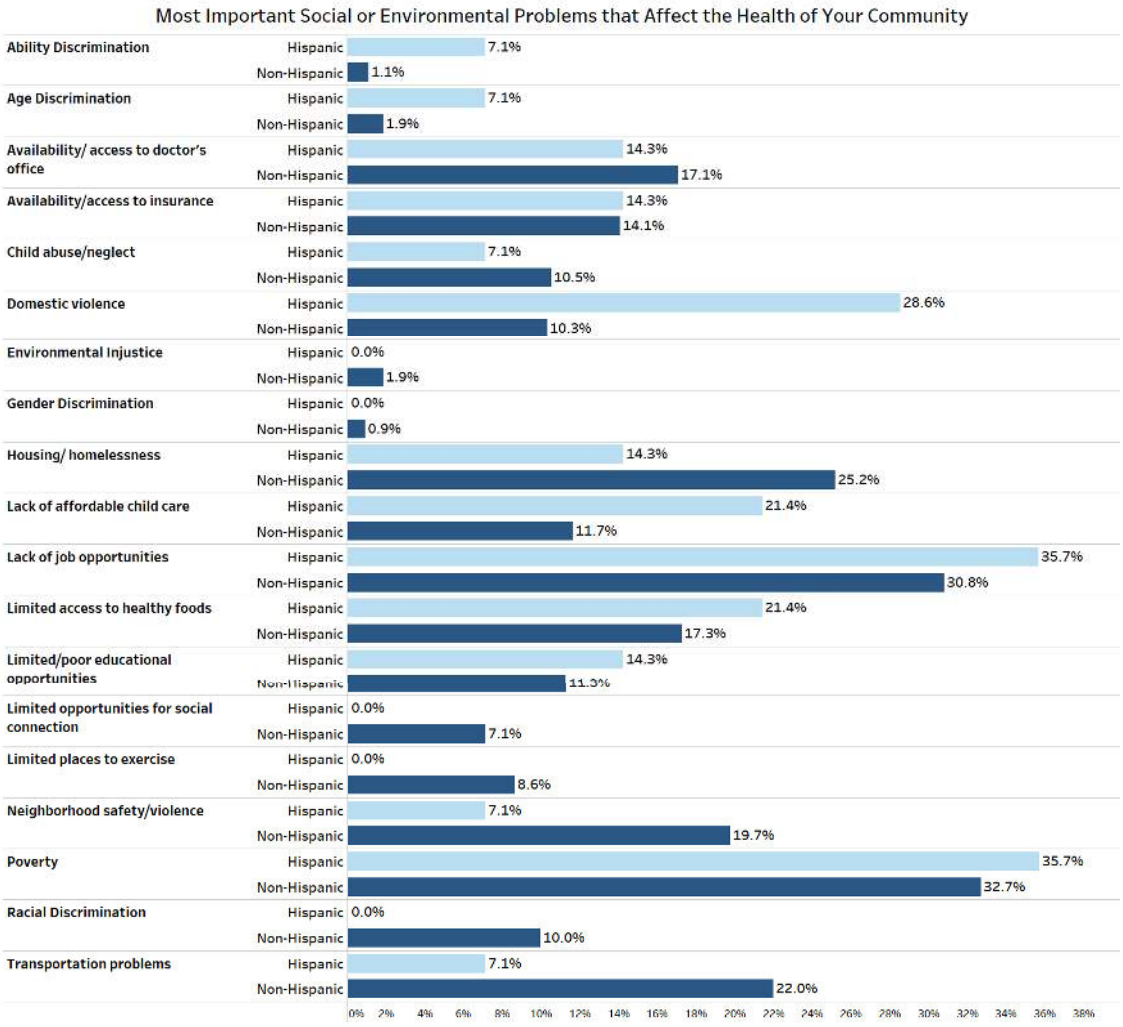


Figure 72: What are the three most important reasons people in your community do not get health care when they need it? Please select up to three.

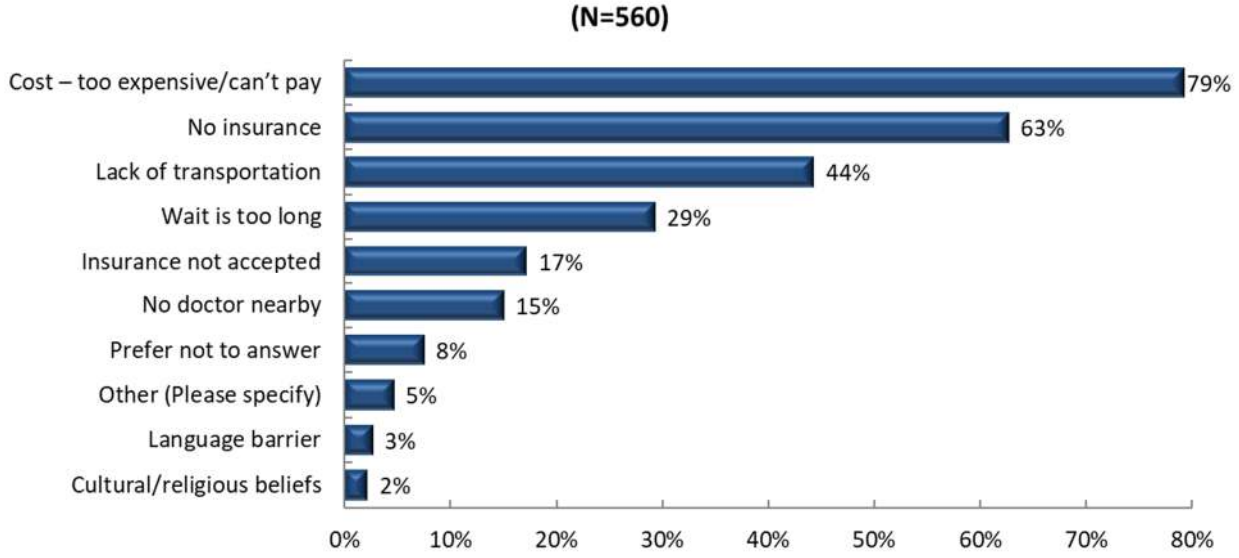


Figure 73: What are the three most important reasons people in your community do not get health care when they need it? Please select up to three.

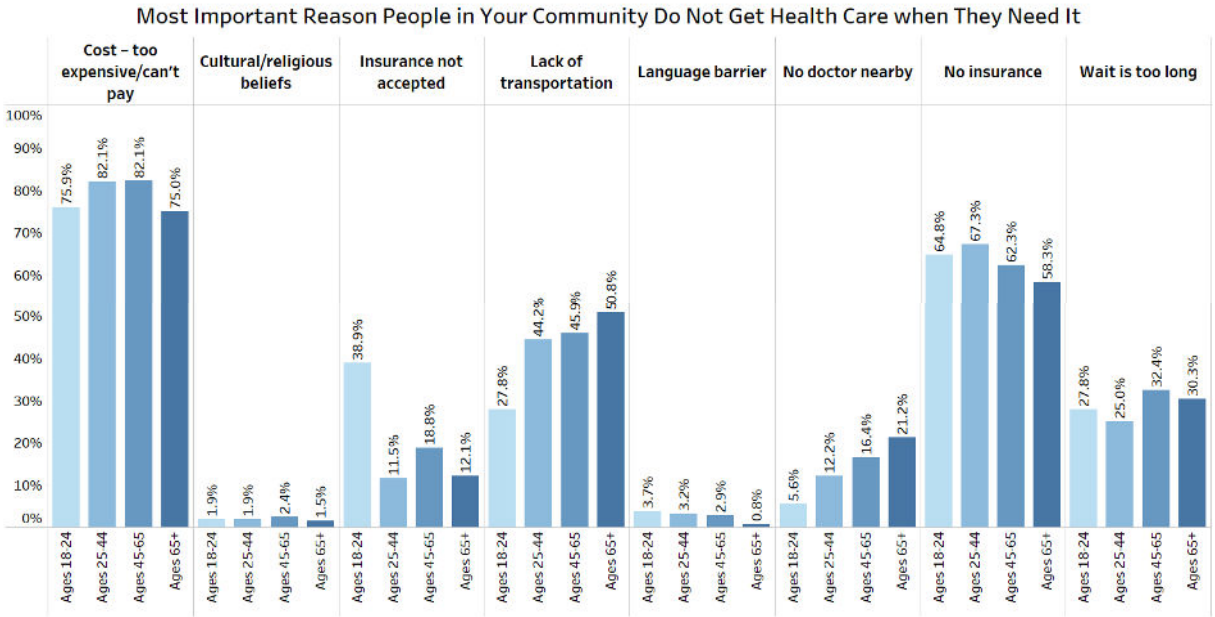


Figure 74: What are the three most important reasons people in your community do not get health care when they need it? Please select up to three.

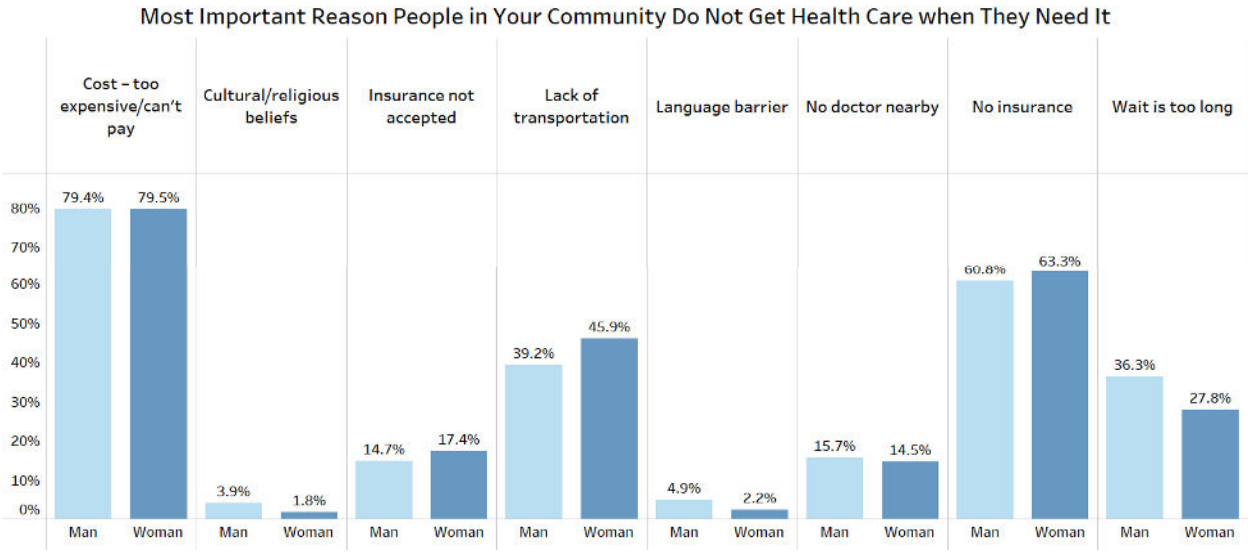


Figure 75: What are the three most important reasons people in your community do not get health care when they need it? Please select up to three.

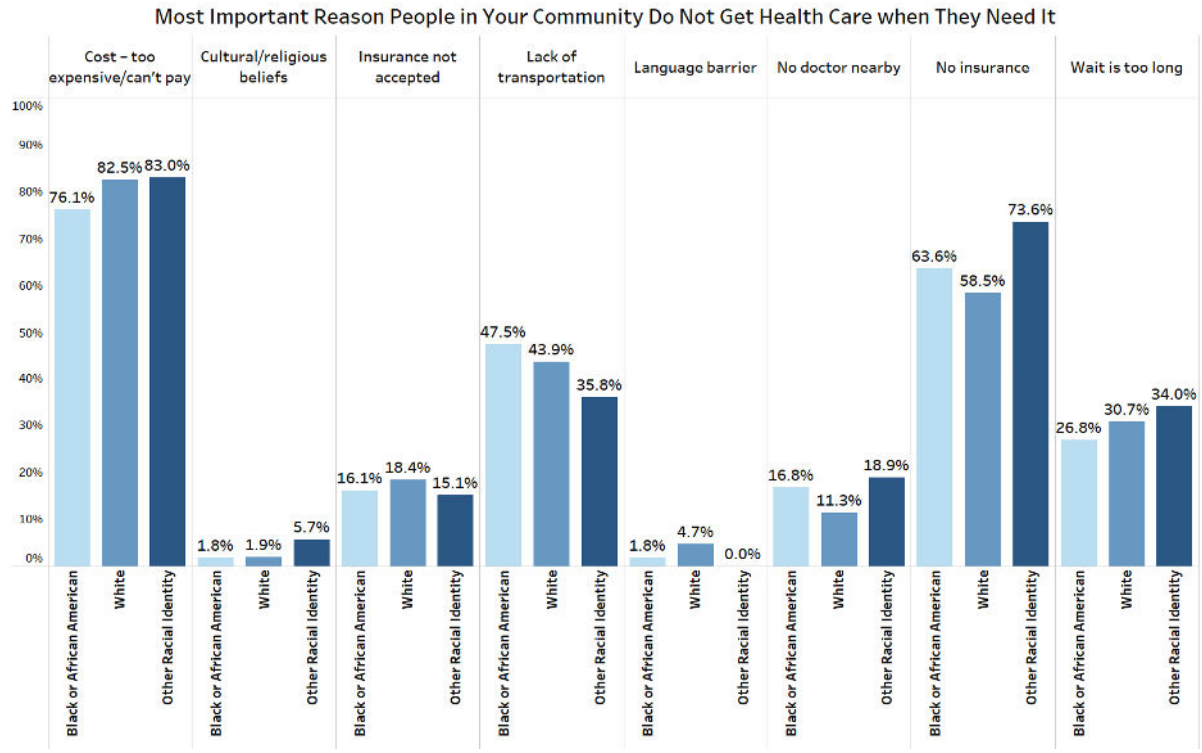
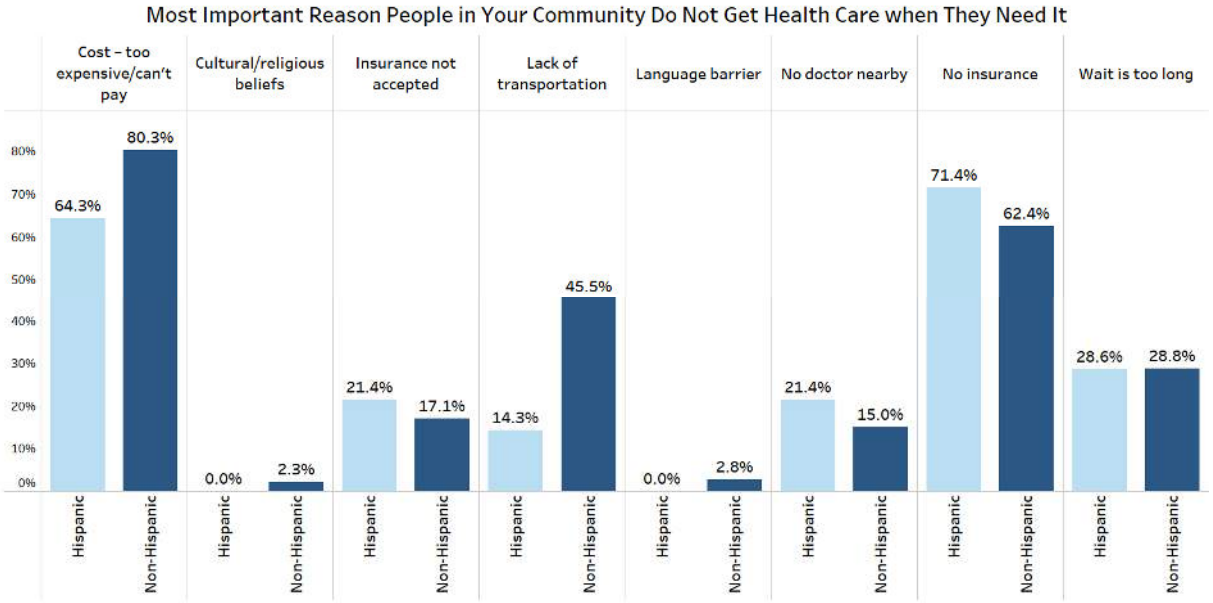


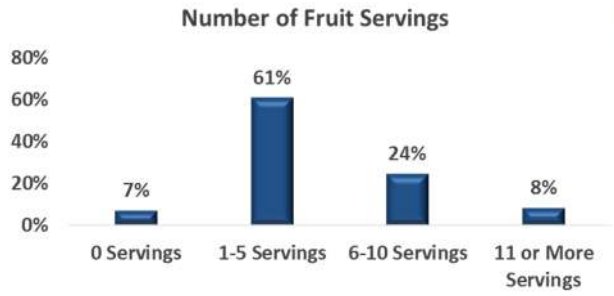
Figure 76: What are the three most important reasons people in your community do not get health care when they need it? Please select up to three.



Topic: Healthy Lifestyle (Diet and Exercise)

Figure 77: Think about the food you ate during the past week. On average, how many servings of fruit did you eat, not including juices? (For example, one serving equals a medium apple, a small banana, or 7 strawberries.).

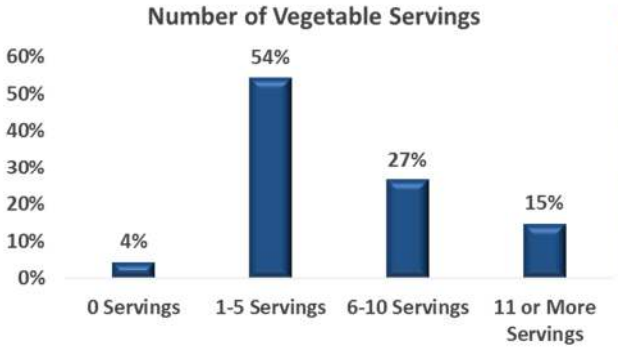
(N=538)



Measure	Value
Mean (Standard Deviation)	6 (8)
Median	4
Mode	3
Minimum-Maximum	0-100

Figure 78: Think about the food you ate during the past week. On average, how many servings of vegetables did you eat, not including potatoes? (For example, one serving equals 6 baby carrots, small bell pepper, or half of a large squash or zucchini.)

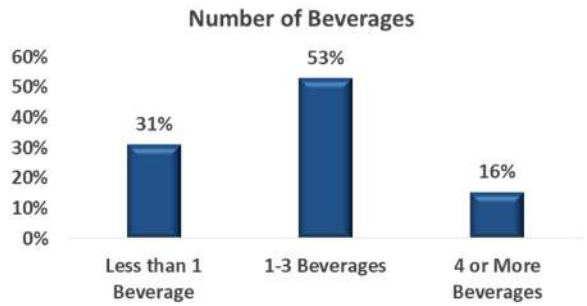
(N=537)



Measure	Value
Mean (Standard Deviation)	7 (8)
Median	5
Mode	5
Minimum-Maximum	0-96

Figure 79: About how many cans, bottles, or glasses of sugar-sweetened beverages, such as regular sodas, sugar sweetened tea, or energy drinks, do you drink each day?

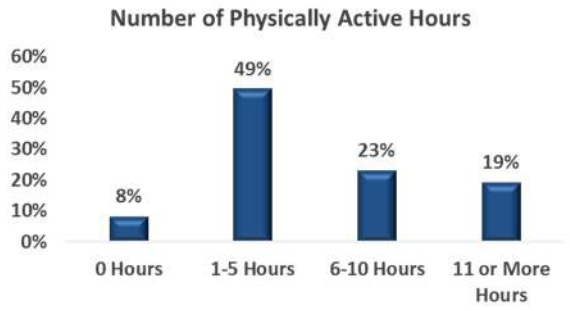
(N=533)



Measure	Value
Mean (Standard Deviation)	2 (3)
Median	1
Mode	0
Minimum-Maximum	0-25

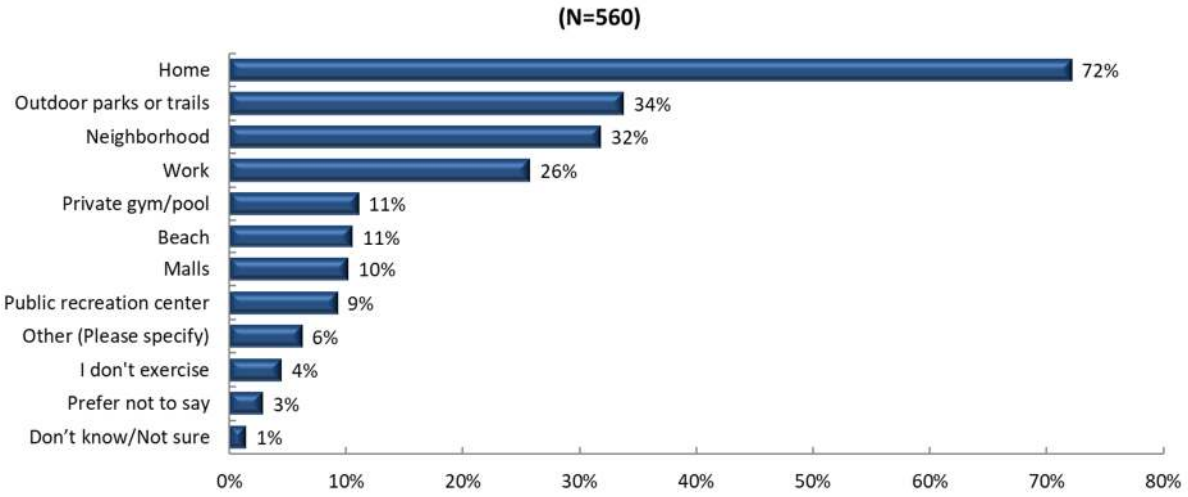
Figure 80: During the past month, approximately how much time (in hours) per week were you physically active outside of your regular job?

(N=532)



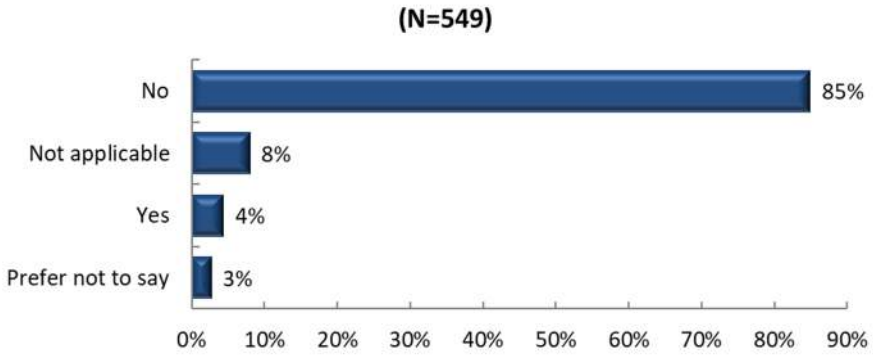
Measure	Value
Mean (Standard Deviation)	8 (11)
Median	5
Mode	2
Minimum-Maximum	0-100

Figure 81: When you are active, where do you engage in exercise or physical activities? (Select all that apply.)



Topic: Maternal And Infant Health

Figure 82: Have you given birth in the past year?



The remaining questions in this section were only asked to those who indicated they gave birth in the past year

Figure 83: Thinking back to your most recent pregnancy, did you need to travel outside of Halifax County to find prenatal care or to give birth?

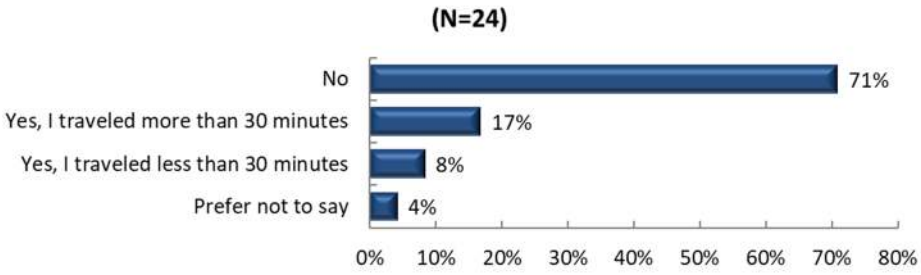


Figure 84: Thinking back to your most recent pregnancy, did you receive any prenatal care?

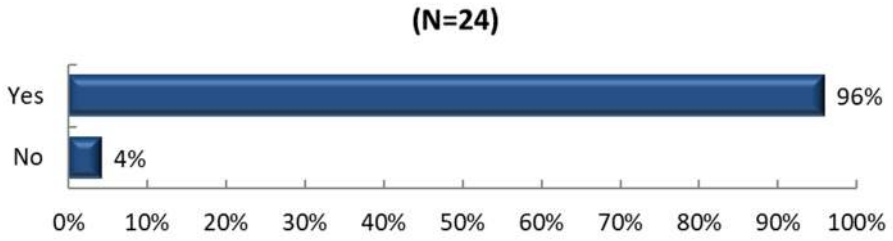


Figure 85: During any of your prenatal care visits, did a healthcare provider do any of the following things?

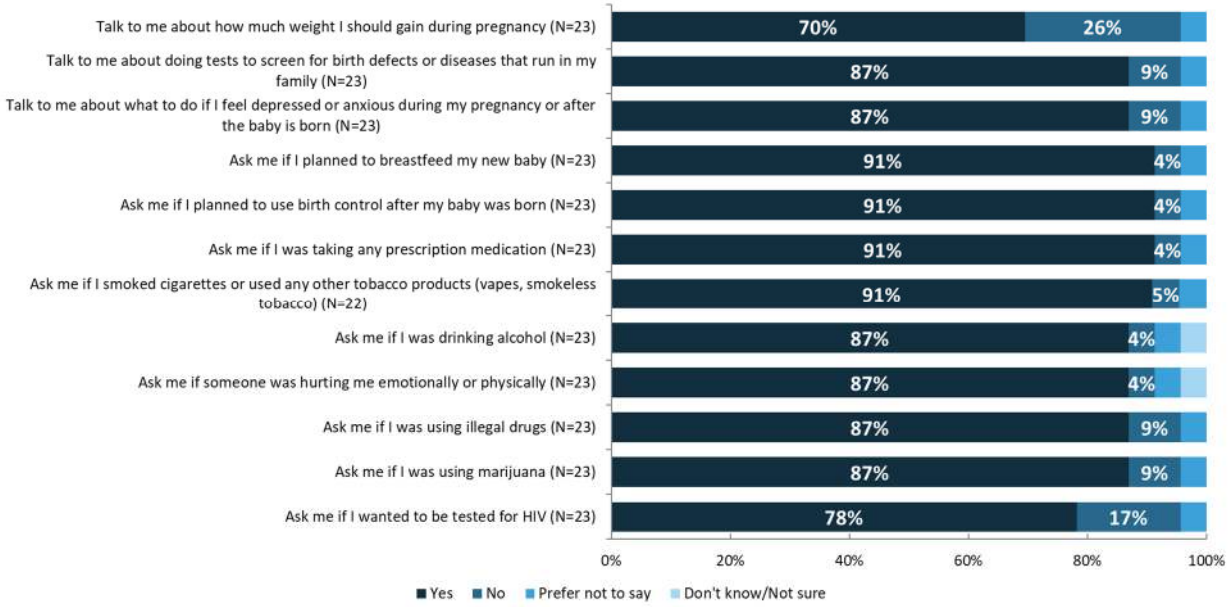


Figure 86: Thinking about your most recent birth, was this infant born more than three weeks before your due date?

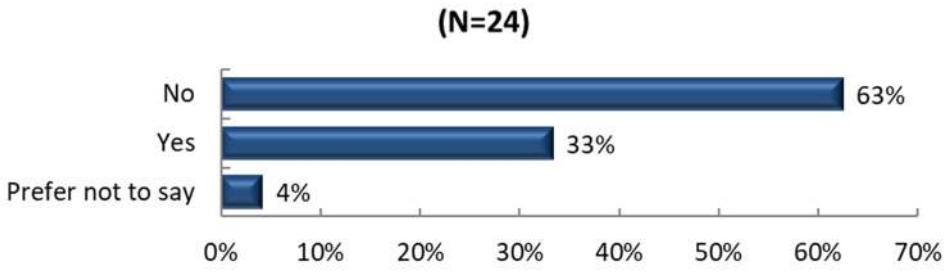
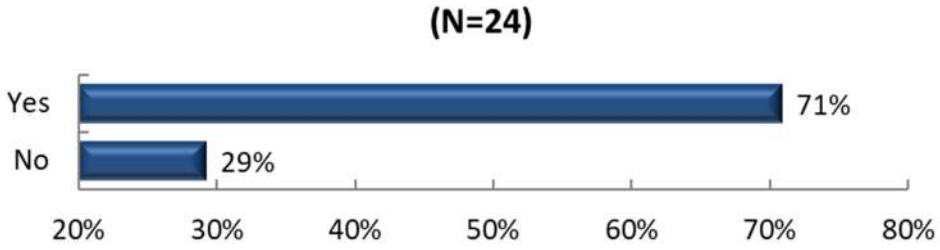


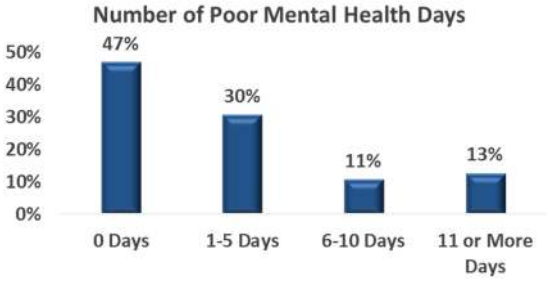
Figure 87: Thinking about your most recent birth, was this infant ever breastfed?



Topic: Mental Health

Figure 88: 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=504)



Measure	Value
Mean (Standard Deviation)	4 (7)
Median	1
Mode	0
Minimum-Maximum	0-30

Figure 89: Was there a time in the past 12 months when you needed mental health care or counseling, but did not get it at that time?

Note: only participants who responded that they had experienced at least one poor mental health day in the previous question were asked the current question

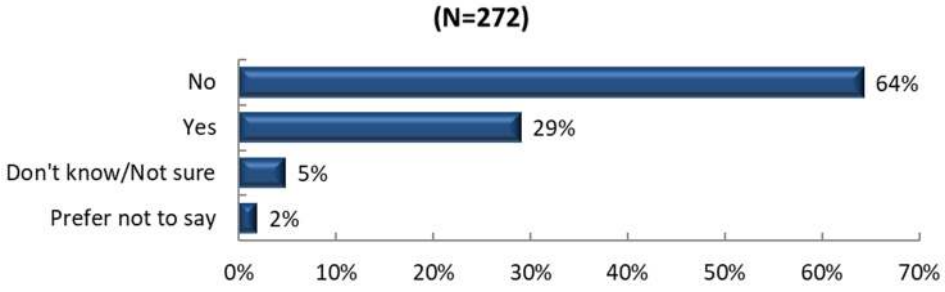


Figure 90: What was the MAIN reason you did not get mental health care or counseling?
Note: only participants who responded "yes" to previous question were asked current question

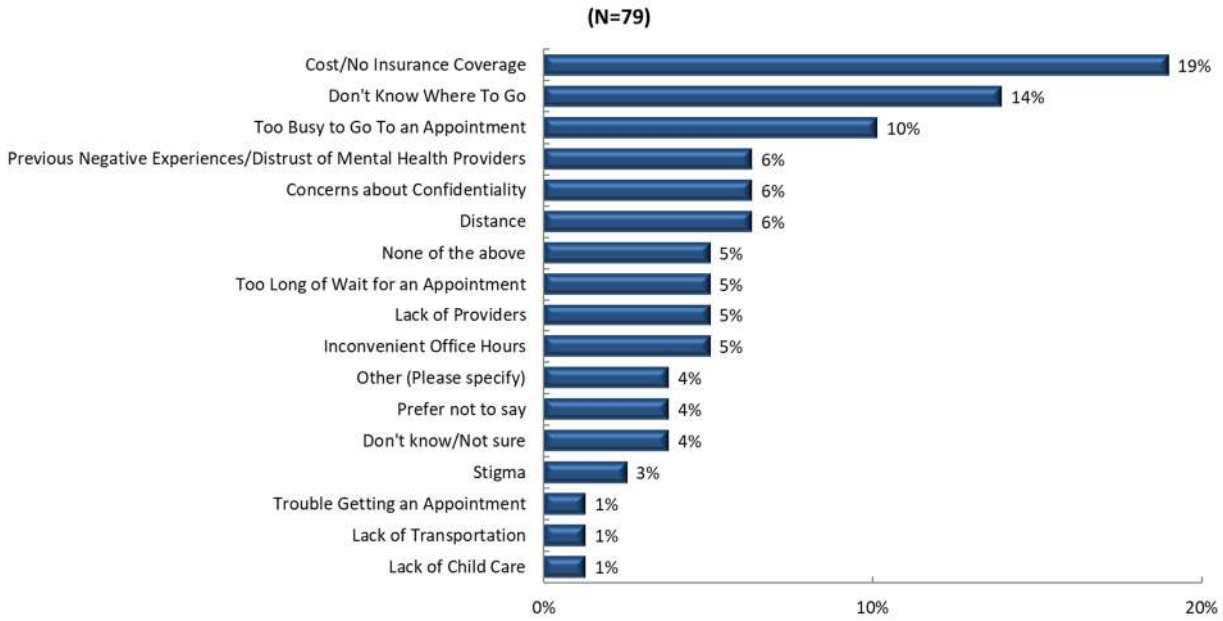
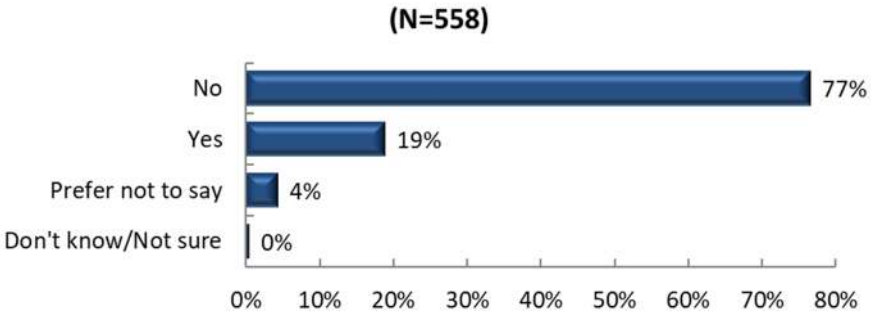


Figure 91: Are you currently taking medication or receiving treatment, therapy, or counseling from a health professional for any type of MENTAL or EMOTIONAL HEALTH NEED?



Topic: Physical Health

Figure 92: Considering your physical health overall, would you describe your health as… (N=559)

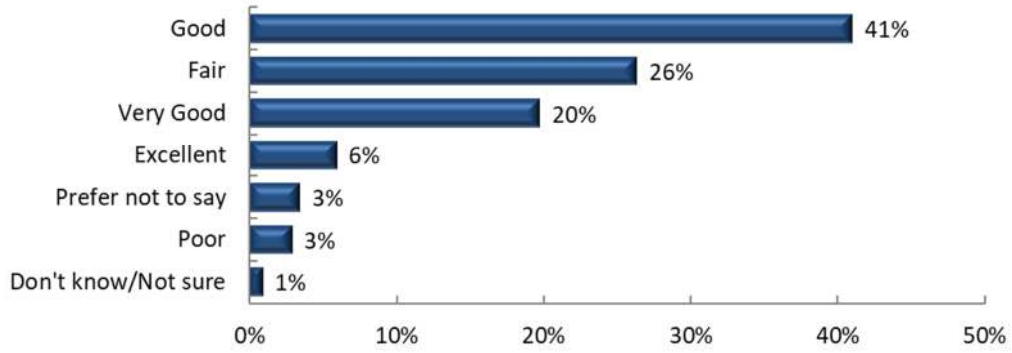


Figure 93: Within the past year (anytime less than one year ago), have you:

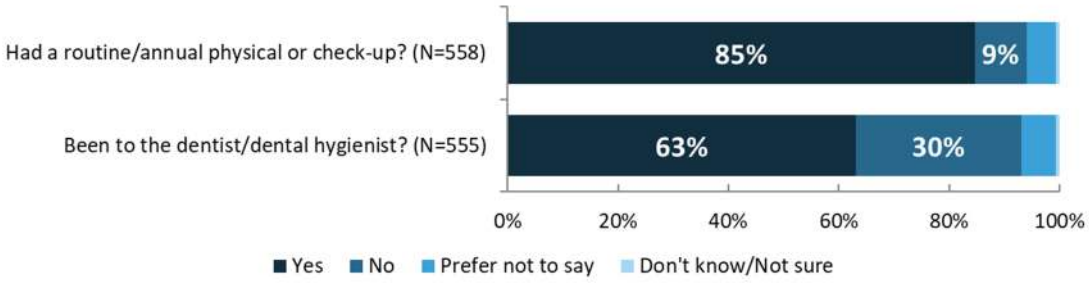


Figure 94: Have you ever been told by a doctor, nurse, or other health professional that you have any of the following health conditions? Select all that apply

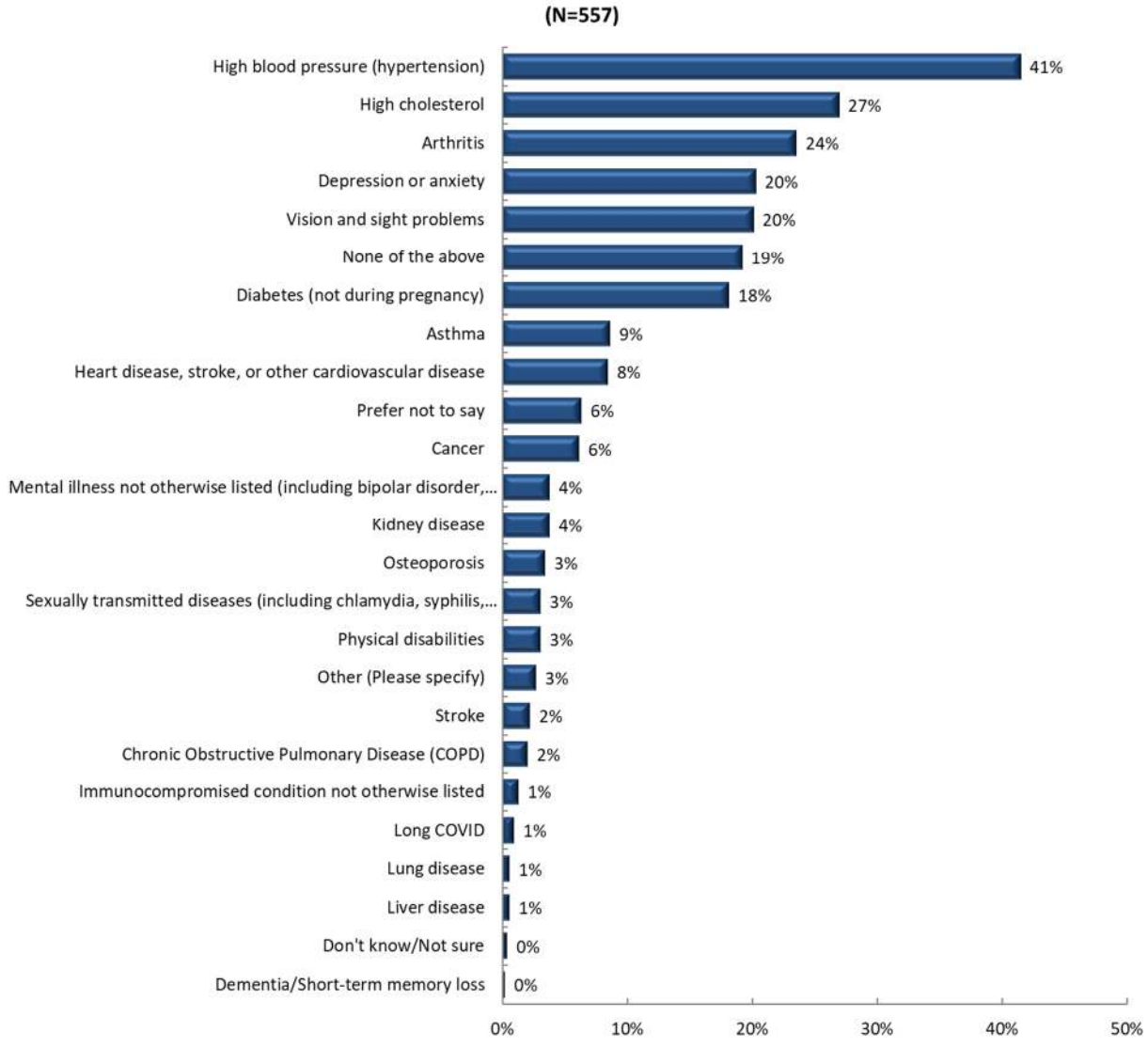
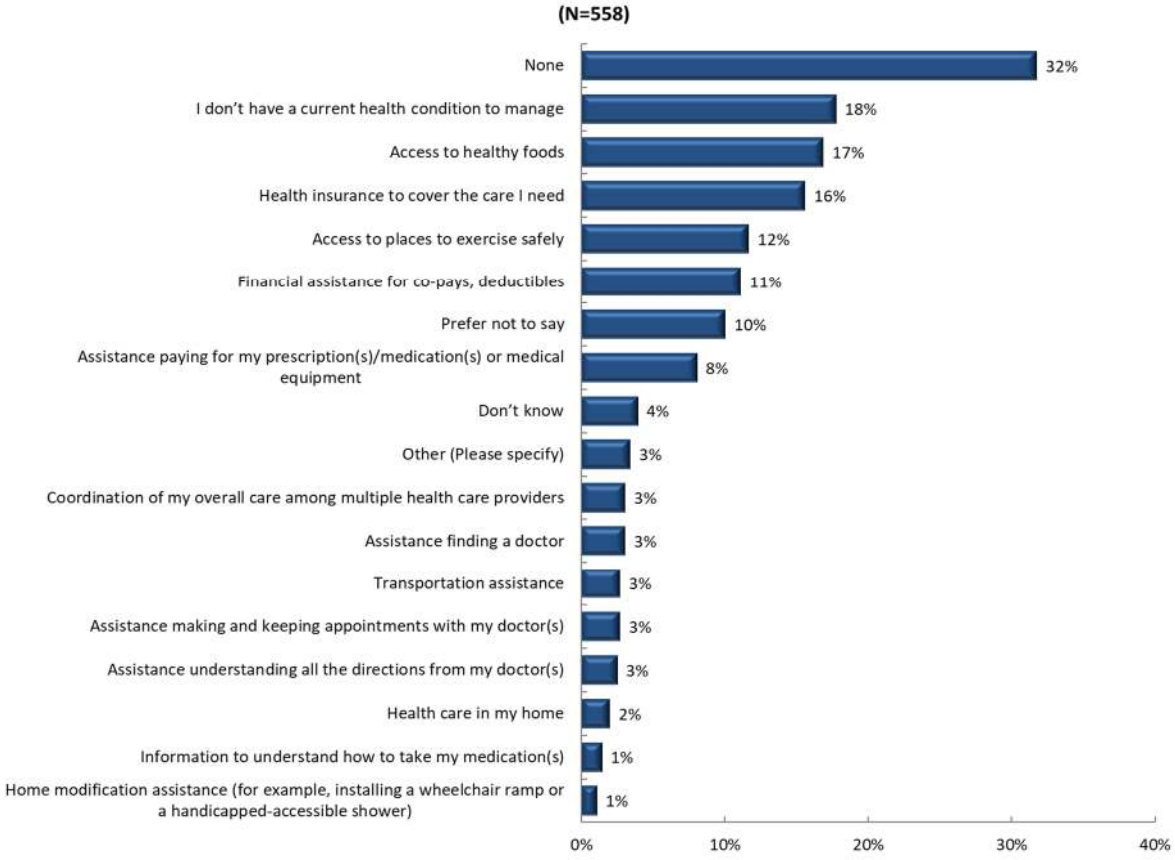


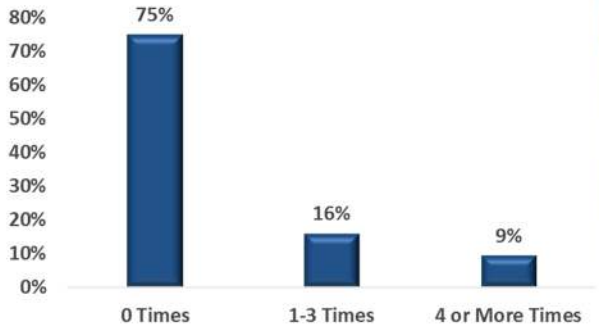
Figure 95: What do you need to be able to manage your current health conditions (for example, heart conditions, high blood pressure, stroke, diabetes, asthma, cancer, COPD, congestive heart failure, arthritis, HIV, depression, anxiety, other mental health condition, etc.) to stay healthy? (Select all that apply.)



Topic: Substance Use Disorders

Figure 96: 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=517)



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

Figure 97: How often do you consume any kind of alcohol product, including beer, wine or hard liquor?

(N=555)

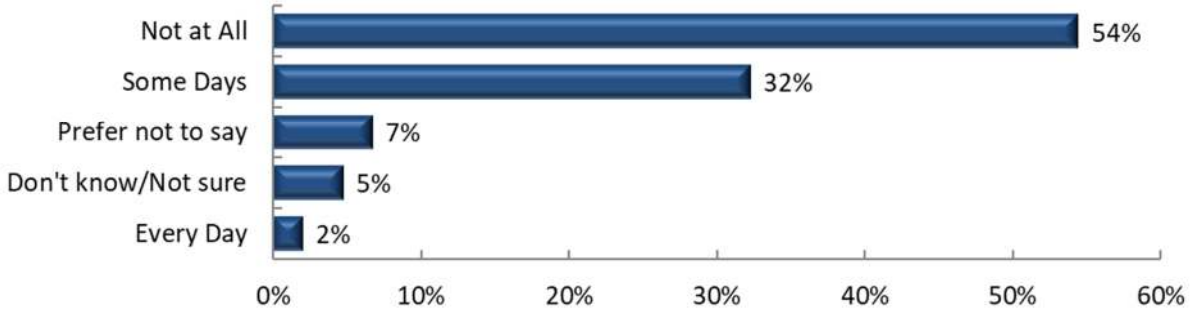


Figure 98: In the past year, have you or a member of your household misused any form of prescription drugs (e.g. used without a prescription, used more than prescribed, used more often than prescribed, or used for any reason other than a doctor's instructions)?

(N=556)

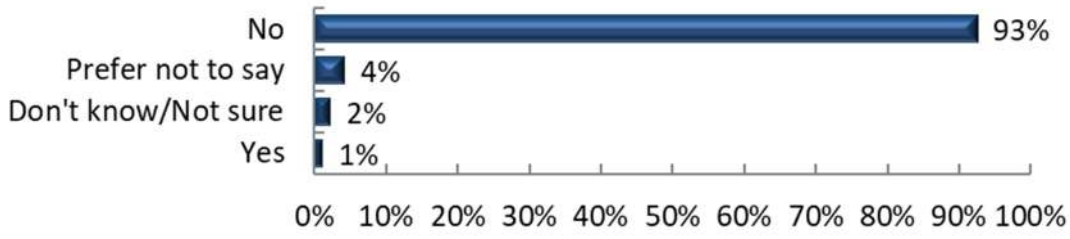
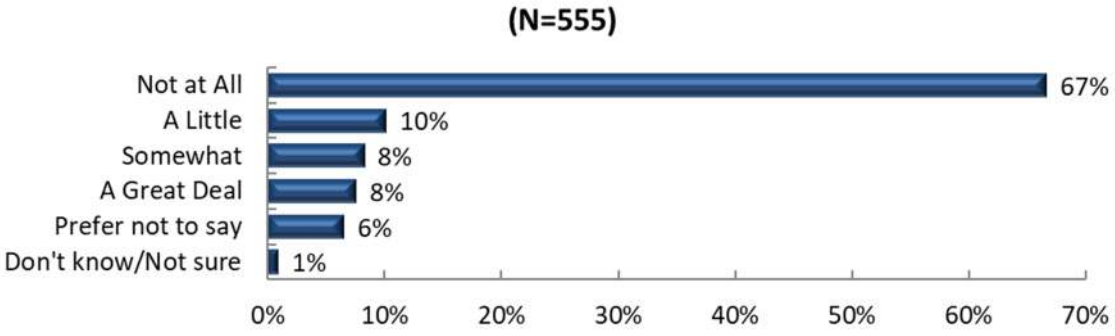


Figure 99: To what degree has your life been negatively affected by YOUR OWN or SOMEONE ELSE's substance abuse issues, including alcohol, prescription, and other drugs?



Topic: Transportation And Transit

Figure 100: In a typical week, what kinds of transportation do you use the most? (Select all that apply.)

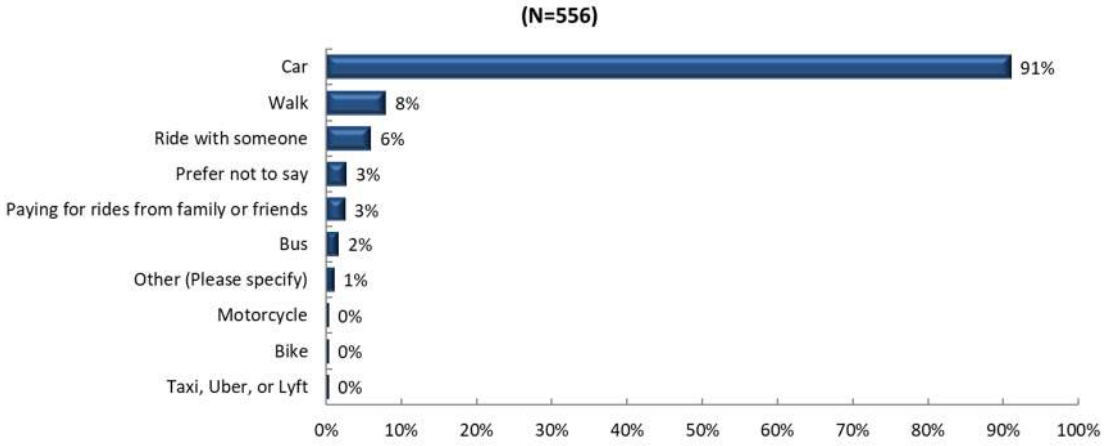


Figure 101: In the past 12 months has lack of transportation kept you from medical appointments, meetings, work, or getting things for daily living? Select all that apply:

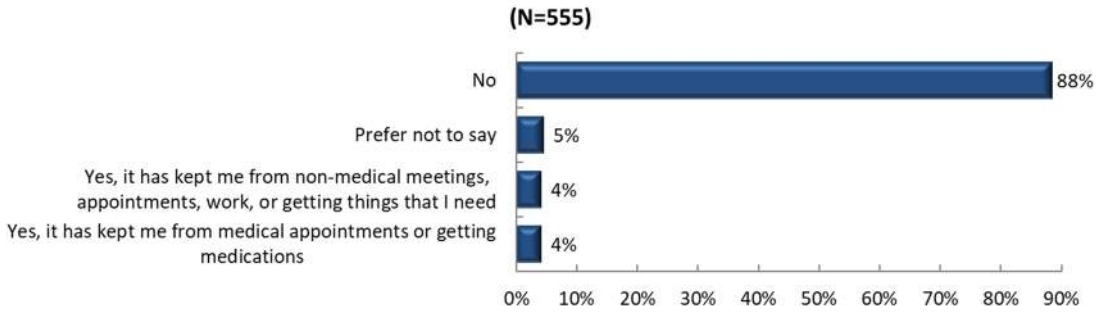
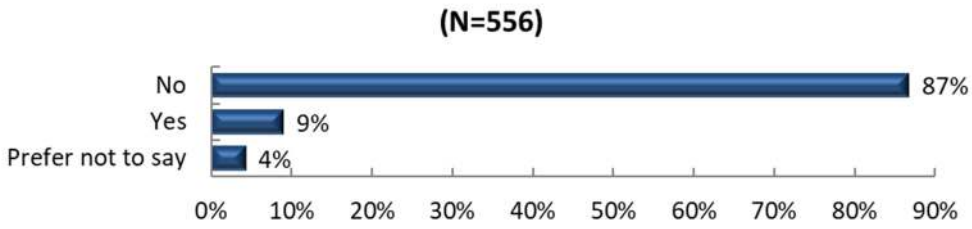
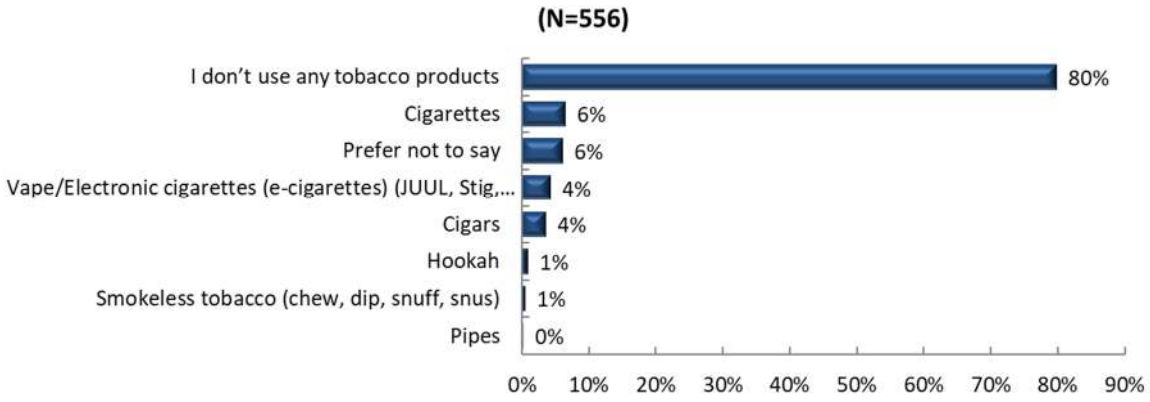


Figure 102: Do you put off or neglect going to the doctor because of distance or transportation?



Topic: Tobacco

Figure 103: Do you currently use any of the following tobacco or nicotine products? (Select all that apply.)



APPENDIX 6| SUMMARY OF DATA FINDINGS ACROSS SOURCES

Primary and Secondary data findings are summarized in full by the table below.[60]

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	✓		✓	✓	✓

[60] 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. Free-text survey responses are available to be shared upon request.

APPENDIX 7 | LEADING CAUSES OF DEATH AND HOSPITAL DATA

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

Note: Deaths based on fewer than 10 events and death rates based on fewer than 20 events are suppressed due to statistical unreliability.

Top Causes of Death in Halifax County 2020			Top Causes of Death in Halifax County 2021			Top Causes of Death in Halifax County 2022		
Rank	Cause	Rate	Rank	Cause	Rate	Rank	Cause	Rate
1	Diseases of the Heart	311.2	1	Diseases of the Heart	341.8	1	Diseases of the Heart	313.5
2	Malignant Neoplasms	305.2	2	Malignant Neoplasms	304.5	2	Malignant Neoplasms	296.8
3	COVID-19	107.1	3	COVID-19	192.7	3	COVID-19	104.5
4	Accidents	97.0	4	Accidents	99.4	4	Accidents	102.4
5	Diabetes Mellitus	95.0	5	Diabetes Mellitus	99.4	5	Cerebrovascular Diseases	92.0
6	Chronic Lower Respiratory Diseases	93.0	6	Cerebrovascular Diseases	99.4	6	Diabetes Mellitus	83.6
7	Essential Hypertension and Hypertensive renal Diseases	74.8	7	Chronic Lower Respiratory Diseases	76.6	7	Chronic Lower Respiratory Diseases	73.1
8	Alzheimer Disease	48.5	8	Alzheimer Disease	47.6	8	Essential Hypertension and Hypertensive renal Diseases	46.0
9	Nephritis, Nephrotic Syndrome, and Nephrosis	46.5	9	Nephritis, Nephrotic Syndrome, and Nephrosis	47.6	9	Alzheimer Disease	43.9
10	Septicemia	-	10	Essential Hypertension and Hypertensive renal Diseases	45.6	10	Septicemia	-

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

Leading Causes of Causes of Emergency Department Visits

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 Diagnoses for ED Visits for Halifax County Residents FY 2022			Top 5 Diagnoses for ED Visits for Halifax County Residents FY 2023			Top 5 Diagnoses for ED Visits for Halifax County Residents FY 2024		
Rank	Cause	#	Rank	Cause	#	Rank	Cause	#
1	COVID-19	1,197	1	Pain in Throat and Chest	1,121	1	Pain in Throat and Chest	1,152
2	Pain in Throat and Chest	932	2	Abdominal and Pelvic Pain	909	2	Abdominal and Pelvic Pain	1,115
3	Abdominal and Pelvic Pain	860	3	Back Pain	465	3	Back Pain	562
4	Back Pain	538	4	COVID-19	451	4	Other Joint Disorders	524
5	Patient Left Before Receiving Care	460	5	Other Joint Disorders	448	5	Nausea and Vomiting	516

Top 5 Diagnoses for ED Visits for ECU Health North Hospital FY 2022			Top 5 Diagnoses for ED Visits for ECU Health North Hospital FY 2023			Top 5 Diagnoses for ED Visits for ECU Health North Hospital FY 2024		
Rank	Cause	#	Rank	Cause	#	Rank	Cause	#
1	COVID-19	1,443	1	Pain in Throat and Chest	1,240	1	Pain in Throat and Chest	1,343
2	Pain in Throat and Chest	1,059	2	Abdominal and Pelvic Pain	1,017	2	Abdominal and Pelvic Pain	1,243
3	Abdominal and Pelvic Pain	918	3	Back Pain	509	3	Back Pain	609
4	Back Pain	614	4	COVID-19	475	4	Nausea and Vomiting	586
5	Patient Left Before Receiving Care	536	5	Other Joint Disorders	466	5	Soft Tissue Disorders	577

Leading Causes of Avoidable Emergency Department Visits

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 Diagnoses for Avoidable ED Visits for Halifax County Residents FY 2022			Top 5 Diagnoses for Avoidable ED Visits for Halifax County Residents FY 2023			Top 5 Diagnoses for Avoidable ED Visits for Halifax County Residents FY 2024		
Rank	Cause	#	Rank	Cause	#	Rank	Cause	#
1	Patient Left Before Receiving Care	441	1	Other Joint Disorders	439	1	Other Joint Disorders	515
2	Other Joint Disorders	387	2	Acute Upper Respiratory Infection	389	2	Nausea and Vomiting	514
3	Soft Tissue Disorders	313	3	Nausea and Vomiting	384	3	Soft Tissue Disorders	463
4	Nausea and Vomiting	290	4	Patient Left Before Receiving Care	358	4	Acute Upper Respiratory Infection	439
5	Acute Upper Respiratory Infection	254	5	Soft Tissue Disorders	342	5	Influenza	338

Top 5 Diagnoses for Avoidable ED Visits for ECU Health North Hospital FY 2022			Top 5 Diagnoses for Avoidable ED Visits for ECU Health North Hospital FY 2023			Top 5 Diagnoses for Avoidable ED Visits for ECU Health North Hospital FY 2024		
Rank	Cause	#	Rank	Cause	#	Rank	Cause	#
1	Patient Left Before Receiving Care	510	1	Other Joint Disorders	455	1	Nausea and Vomiting	582
2	Other Joint Disorders	416	2	Nausea and Vomiting	431	2	Other Joint Disorders	566
3	Soft Tissue Disorders	347	3	Patient Left Before Receiving Care	409	3	Soft Tissue Disorders	531
4	Nausea and Vomiting	341	4	Acute Upper Respiratory Infection	402	4	Acute Upper Respiratory Infection	435
5	Cystitis or Inflammation of the Bladder	242	5	Soft Tissue Disorders	363	5	Cystitis or Inflammation of the Bladder	403

Leading Causes of Emergency Department Visits Leading to Admission

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 Diagnoses for ED Visits Resulting in Admission for Halifax County Residents FY 2022			Top 5 Diagnoses for ED Visits Resulting in Admission for Halifax County Residents FY 2023			Top 5 Diagnoses for ED Visits Resulting in Admission for Halifax County Residents FY 2024		
Rank	Cause	#	Rank	Cause	#	Rank	Cause	#
1	Sepsis	393	1	Sepsis	335	1	Sepsis	435
2	COVID-19	164	2	Hypertensive Heart and Chronic Kidney Disease	134	2	Hypertensive Heart and Chronic Kidney Disease	156
3	Hypertensive Heart and Chronic Kidney Disease	142	3	Ischemic Stroke	87	3	Chronic Obstructive Pulmonary Disease	151
4	Ischemic Stroke	113	4	Chronic Obstructive Pulmonary Disease	86	4	Ischemic Stroke	120
5	Hypertensive Heart Disease	82	5	Hypertensive Heart Disease	84	5	Acute Kidney Failure	114

Top 5 Diagnoses for ED Visits Resulting in Admission for ECU Health North Hospital FY 2022			Top 5 Diagnoses for ED Visits Resulting in Admission for ECU Health North Hospital FY 2023			Top 5 Diagnoses for ED Visits Resulting in Admission for ECU Health North Hospital FY 2024		
Rank	Cause	#	Rank	Cause	#	Rank	Cause	#
1	Sepsis	463	1	Sepsis	421	1	Sepsis	517
2	COVID-19	198	2	Hypertensive Heart and Chronic Kidney Disease	169	2	Hypertensive Heart and Chronic Kidney Disease	212
3	Hypertensive Heart and Chronic Kidney Disease	173	3	Hypertensive Heart Disease	119	3	Chronic Obstructive Pulmonary Disease	179
4	Ischemic Stroke	110	4	Chronic Obstructive Pulmonary Disease	105	4	Acute Kidney Failure	145
5	Hypertensive Heart Disease	97	5	Ischemic Stroke	95	5	Hypertensive Heart Disease	124

Leading Causes of Admission

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 Diagnoses for Admission for Halifax County Residents FY 2022			Top 5 Diagnoses for Admission for Halifax County Residents FY 2023			Top 5 Diagnoses for Admission for Halifax County Residents FY 2024		
Rank	Cause	#	Rank	Cause	#	Rank	Cause	#
1	Sepsis	445	1	Sepsis	384	1	Sepsis	493
2	Liveborn Infant	428	2	Liveborn Infant	369	2	Liveborn Infant	375
3	COVID-19	164	3	Hypertensive Heart and Chronic Kidney Disease	145	3	Hypertensive Heart and Chronic Kidney Disease	163
4	Hypertensive Heart and Chronic Kidney Disease	158	4	Ischemic Stroke	102	4	Chronic Obstructive Pulmonary Disease	143
5	Ischemic Stroke	133	5	Hypertensive Heart Disease	90	5	Acute Myocardial Infarction / Heart Attack	132

Top 5 Diagnoses for Admission for ECU Health North Hospital FY 2022			Top 5 Diagnoses for Admission for ECU Health North Hospital FY 2023			Top 5 Diagnoses for Admission for ECU Health North Hospital FY 2024		
Rank	Cause	#	Rank	Cause	#	Rank	Cause	#
1	Liveborn Infant	509	1	Liveborn Infant	454	1	Sepsis	528
2	Sepsis	460	2	Sepsis	420	2	Liveborn Infant	430
3	COVID-19	190	3	Hypertensive Heart and Chronic Kidney Disease	171	3	Hypertensive Heart and Chronic Kidney Disease	212
4	Hypertensive Heart and Chronic Kidney Disease	174	4	Hypertensive Heart Disease	117	4	Chronic Obstructive Pulmonary Disease	169
5	Ischemic Stroke	110	5	Chronic Obstructive Pulmonary Disease	97	5	Acute Kidney Failure	147

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

Leading Causes of Injury Death 2017-2021 Halifax County			Leading Causes of Injury Hospitalization 2017-2021 Halifax County			Leading Causes of Injury ED Visits 2017-2021 Halifax County		
Rank	Cause	#	Rank	Cause	#	Rank	Cause	#
1	MVT – Unintentional	80	1	Fall – Unintentional	642	1	Fall – Unintentional	8,496
2	Poisoning – Unintentional	70	2	MVT – Unintentional	254	2	Unspecified – Unintentional	6,481
3	Firearm – Assault	45	3	Poisoning – Unintentional	177	3	MVT – Unintentional	4,934
4	Fall – Unintentional	28	4	Unspecified – Unintentional	148	4	No Mechanism or Intent Recorded	3,152
5	Firearm – Self-inflicted	24	5	Firearm - Assault	61	5	Struct By/Against - Unintentional	2,349

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