CAPE FEAR VALLEY HEALTH

HOKE COUNTY

COMMUNITY HEALTH NEEDS ASSESSMENT

2024 CHNA REPORT

ACKNOWLEDGEMENTS

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

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Hoke County CHNA Leadership

In addition to the Steering Committee, the Hoke County 2024 CHNA was developed in partnership with representatives from Hoke County Health Department, Hoke County Community Partners, and Cape Fear Valley Health System.

The Health ENC Steering Committee and Hoke 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.

TABLE OF CONTENTS

ACKNOWLEDGEMENTS i
TABLE OF CONTENTS ii
REPORT TABLES AND FIGURES v
EXECUTIVE SUMMARY 1
INTRODUCTION 4
Background 4
Timeline 6
Process Overview 7
Report Structure 8
Evaluation of Prior CHNA Implementation Strategies 9
Summary Findings: Hoke County 2024 Priority Health Need Areas 14
CHAPTER 1 | METHODOLOGY 16
Study Design 16
New (Primary) Data 16
Existing (Secondary) Data 16
Comparisons 17
Population Health Framework 17
Prioritization Process Overview and Results 20
Study Limitations 21
CHAPTER 2 | COUNTY PROFILE 23
Geography 23
Population 23
Age and Sex Distribution 24
Race and Ethnicity 25
Disability Status 26
Veteran Status 27
Economic Indicators 27
Social Determinants of Health 30
CHAPTER 3 | PRIORITY NEED AREAS 38

PRIORITY NEED: BEHAVIORAL HEALTH – SUBSTANCE MISUSE 38
Context and National Perspective 38
Secondary Data Findings 40
Primary Data Findings – Community Member Web Survey 40
Primary Data Findings – Focus Groups 44
PRIORITY NEED: HEALTHCARE ACCESS & QUALITY 45
Context and National Perspective 45
Secondary Data Findings 46
Primary Data Findings – Community Member Web Survey 48
Primary Data Findings – Focus Groups 51
PRIORITY NEED: PHYSICAL HEALTH – CHRONIC DISEASE MANAGEMENT 52
Context and National Perspective 52
Secondary Data Findings 53
Primary Data Findings – Community Member Web Survey 55
Primary Data Findings – Focus Groups 58
CHAPTER 4 | HEALTH RESOURCE INVENTORY 60
CHAPTER 5 | NEXT STEPS 61
APPENDIX 1 | STATE OF THE COUNTY HEALTH REPORT 62
Results-Based Accountability Framework 62
State of the County Health Report 63
APPENDIX 2 | SECONDARY DATA METHODOLOGY AND SOURCES 66
Methodology 66
Data Sources 66
APPENDIX 3 | SECONDARY DATA COMPARISONS 88
Description of Focus Area Comparisons 88
Detailed Focus Area Benchmarks 89
APPENDIX 4 | PRIMARY DATA METHODOLOGY AND SOURCES 96
Methodologies 96
Focus Groups 96
Community Member Web Survey 96
APPENDIX 5 | DETAILED PRIMARY DATA FINDINGS 109

Focus Groups..... 109
Community Member Web Survey 111
APPENDIX 6 | SUMMARY OF DATA FINDINGS ACROSS SOURCES 130

REPORT TABLES AND FIGURES

Table 1: Total Population, 2023 23
Table 2: Age Distribution, 2023 24
Table 3: Sex Distribution, 2023 25
Table 4: Racial Distribution, 2023 25
Table 5: Ethnic Distribution, 2023 25
Table 6: Foreign Born Population, 2022 26
Table 7: Language Spoken at Home, 2022 26
Table 8: Disability Status, 2022 26
Table 9: Veteran Status, 2022 27
Table 10: Median Household Income, 2023 27
Table 11: Percent of Households Below the Federal Poverty Level, 2023 27
Table 12: Households Receiving Food Stamps/SNAP, 2022 28
Table 13: Educational Attainment, 2020 28
Table 14: Unemployment, 2022 29
Table 15: Health Insurance Status, 2022 29
Table 16: Substance Use Indicators 40
Table 17: Substance Abuse Providers 40
Table 18: Access to Care Indicators 46
Table 19: Transportation and Transit Options 47
Table 20: Chronic Disease Prevalence 53
Table 21: Physical Activity and Food Environment Indicators 54
Table 22: Emergency Department Utilization and Hospitalization Rates 55

Figure 1: The 10 Essential Public Health Services 5
Figure 2: Health ENC 2024 CHNA Milestones 6
Figure 3: The Community Health Assessment Process 8
Figure 4: Hoke County 2021 Priority Need Areas 9
Figure 5: Hoke County 2024 Priority Need Areas 15
Figure 6: Population Health Framework 18
Figure 7: Social Determinants of Health 19
Figure 8: SDoH and Health Disparities 19
Figure 9: Hoke County 2024 Priority Need Areas 21
Figure 10: Hoke County Map: Population Density 23
Figure 11: Hoke County Map: Population Growth 24
Figure 12: Social Determinants of Health 30
Figure 13: Residential Segregation 31
Figure 14: Income Inequality Ratio 31
Figure 15: Percent of Population with Limited English Proficiency 32

Figure 16: SVI Variables 33
Figure 17: United States SVI by County, 2022 33
Figure 18: Hoke County SVI by Census Tract, 2022 34
Figure 19: EJI Variables 35
Figure 20: United States EJI by Census Tract, 2022 35
Figure 21: Hoke County EJI by Census Tract, 2022 36
Figure 22: State Health Outcomes Rating Map 37
Figure 23: State Health Factors Rating Map 37
Figure 24: What are the three most important health problems that affect the health of your community? Please select up to three. 41
Figure 25: What are the three most important health problems that affect the health of your community? Please select up to three. (by race) 42
Figure 26: What are the three most important health problems that affect the health of your community? Please select up to three. (by age group) 42
Figure 27: 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? 43
Figure 28: How often do you consume any kind of alcohol product, including beer, wine or hard liquor? 43
Figure 29: 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)? 44
Figure 30: To what degree has your life been negatively affected by your own or someone else's substance abuse issues, including alcohol, prescription, and other drugs? 44
Figure 31: Distribution of Primary Care Physicians 47
Figure 32: 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. 48
Figure 33: 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) 49
Figure 34: What are the three most important social or environmental problems that affect the health of your community? Please select up to three. 50
Figure 35: What are the three most important social or environmental problems that affect the health of your community? Please select up to three. (by gender) 51
Figure 36: Preventable Hospital Stays by Race/Ethnicity 55
Figure 37: What are the three most important social or environmental problems that affect the health of your community? Please select up to three. (by ethnicity) 57
Figure 38: 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 58

EXECUTIVE SUMMARY

A Community Health Needs Assessment (CHNA) helps health leaders evaluate the health and wellness of the community they serve and identify gaps and challenges that should be addressed through new programs, services and policy changes. This report was developed as part of the Health ENC coalition's collaborative, regional 2024 CHNA process. Health ENC – a group of stakeholders who help find ways to collaborate and share resources to improve the health of the population in eastern North Carolina – served an integral role in making this comprehensive assessment possible. The report adheres to North Carolina Local Health Department Accreditation standards, as well as Internal Revenue Service requirements for not-for-profit hospitals.

Vision Statement

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

Hoke County CHNA Leadership

The Hoke County 2024 CHNA was developed in partnership with representatives from Hoke County Health Department, community partners in Hoke County, and Cape Fear Valley Health System.

The Health ENC Steering Committee and Hoke 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.

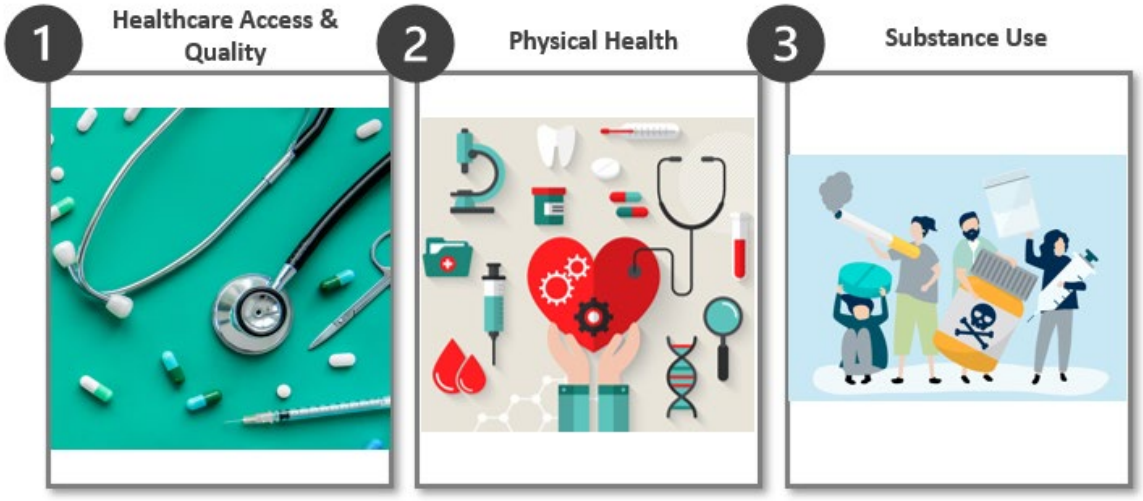
Hoke County CHNA Timeline and Process

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

Secondary (existing) data came from various public sources related to demographics, social determinants of health, environmental health, disease trends, behavioral health trends, and individual health behaviors. Data was evaluated using the Robert Wood Johnson Foundation's population health framework and compared to state or national benchmarks to identify areas of concern. Top community needs identified through secondary data analysis included health concerns related to physical and behavioral health, and social or environmental concerns such as employment and income, food access and security, and family, community, and social support, among others.

Primary (new) data were collected through focus groups and a web-based survey for community members, and included feedback from 302 people who live, work or receive healthcare in Hoke County. A total of two in-person focus groups were conducted, with a variety of community members from different backgrounds, age groups and life experiences. Primary data identified behavioral health (including mental health and substance use), employment and income, housing and homelessness, and physical heath (chronic diseases, cancer, obesity) as top needs that impact the health and well-being of people living in Hoke County.

Representatives from Hoke County worked together to identify the priorities the county should focus on over the following three-year period. Leaders evaluated the primary and secondary data collected throughout the process to identify needs based on the size and scope, severity, the ability for hospitals or health departments to make an impact, associated health disparities, and importance to the community. Although it was not possible for every single area of potential need to be identified as a priority, three top priority health needs were selected by Hoke County (in alphabetical order): Healthcare Access and Quality, Physical Health, and Substance Use.



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

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

INTRODUCTION

Background

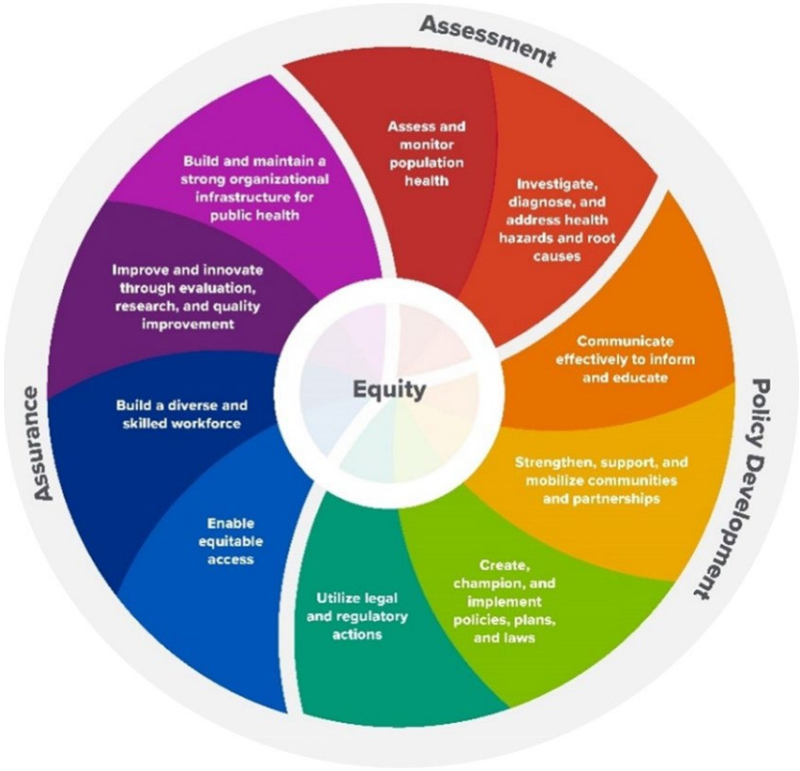
To illustrate its commitment to the health and well-being of the community, the Health ENC CHNA Steering Committee has completed this assessment to understand and document the greatest health needs currently faced by local residents. Guidance was also provided by local representatives from Hoke County Health Department and Cape Fear Valley Health System. These organizations helped gather the focus group and survey data that are detailed in this report. The CHNA process helps local leaders continuously evaluate how best to improve and promote the health of the community. It builds upon formal collaborations between the Steering Committee and other community partners to proactively identify and respond to the needs of Hoke County residents.

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

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

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

Figure 1: The 10 Essential Public Health Services



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

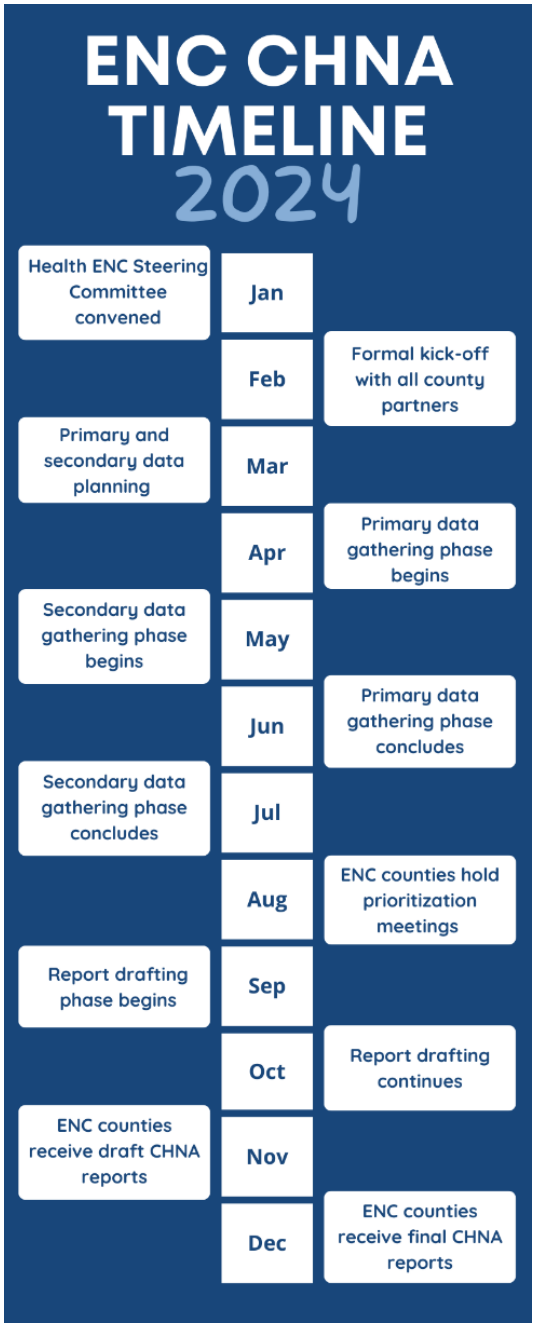
- Define the community it serves;
- Assess the health needs of that community;
- Through the assessment process, take into account input received from people who represent the community's broad interests, including those with special knowledge of or expertise in public health;
- Document the CHNA in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

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

Timeline

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

Figure 2: Health ENC 2024 CHNA Milestones



Process Overview

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

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

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

Figure 3: The Community Health Assessment Process[3]

Report Structure

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

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

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

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

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

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

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

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

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

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

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

Evaluation of Prior CHNA Implementation Strategies

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

Figure 4: Hoke County 2021 Priority Need Areas

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

Cape Fear Valley Health System – Hoke Hospital

At Cape Fear Valley Health System (CFVHS), the goal is to improve the quality of every life touched by providing exceptional healthcare for all patients. To achieve that, CFVHS's doctors, surgeons and staff are committed to excellence in every aspect of the healthcare process. CFVHS' values of patient-centeredness, integrity, innovation, teamwork, diversity, accountability, and education help create a

better experience for every patient, every time. System medical facilities include Cape Fear Valley Medical Center, Highsmith-Rainey Specialty Hospital, Cape Fear Valley Rehabilitation Center, Behavioral Health Care, Bladen County Hospital, Hoke Hospital, Central Harnett Hospital, Betsy Johnson Hospital, as well as several medical offices and clinics spread throughout the Cape Fear region. The doctors at CFVHS proudly serve a seven-county region of southeastern North Carolina, including Fayetteville, Fort Liberty, Hope Mills, Raeford, Lumberton, Elizabethtown, Clinton, Lillington, Dunn, and beyond. CFVHS provides exceptional medical care, serving more than 1 million patients annually – each of whom is treated to knowledgeable, personal care.

Cape Fear Valley opened Hoke County's first full-service hospital in March of 2015. The two-story hospital includes 37 medical-surgical beds, four intensive care beds, 27 emergency department beds, radiology services, operating rooms, an inpatient pharmacy, and therapy services. In addition, a primary care clinic and an OBGYN clinic located in Hoke County offer access to care for the local community. Outpatient imaging services are also offered to provide streamlined care for patients.

Hoke County Health Department

The Hoke County Health Department (HCHD) is dedicated to providing comprehensive public health services to individuals and families of all ages. With a team of over 40 employees, the department collaborates with local, regional, and state healthcare professionals to address the diverse needs of the community. In addition to mandated public health services, the department offers an array of programs and clinics, including an adult primary care and maternity clinic with a sliding fee scale for self-pay patients, ensuring accessible and affordable care. Services also include a robust Communicable Disease Program, Family Planning Services, Behavioral Health Services, and Case Management for at-risk pregnancies. The department supports nutrition and wellness through WIC and other health promotion activities such as First Aid/CPR training, Mental Health First Aid, Childbirth Education, and ADA Diabetes Self-Management classes. As a hub for community engagement, the Health Department hosts meetings to unite local leaders around critical health issues. Guided by a mission to promote, protect, and preserve wellness and a vision to achieve health equity and eliminate disparities, the Hoke County Health Department remains committed to fostering partnerships, embracing cultural diversity, and empowering residents to lead healthier lives.

Previous CHNA Priority: Behavioral Health

- **Opioid Stewardship Program:** CFVHS has established a system-wide Opioid Stewardship Program which exists to reduce opioid use, decrease harm related to opioid use, and identify patients with potential opioid use disorders. These goals are met by educating patients, identifying and monitoring high risk patients, systemic screening, and providing alternative treatment options. Ordering practices of physicians are monitored regularly and alternatives for pain control are offered in the Emergency Departments. Kits are provided through the outpatient pharmacy to dispose of opioids safely. Additionally, safe drug disposals are located at CFVHS pharmacies for prescription take-back during operating hours. Narcan is available for use on EMS Transport Vehicles. CFVHS has established several community partnerships to address substance abuse issues in the area such as Fighting Addiction through Community Empowerment Teams with Southeastern Regional Area Health Education Center (SRAHEC) & Cumberland-Fayetteville Opioid Response Teams.

- **Peer Support Specialists:** In May of 2023, CFVHS Emergency Departments implemented Peer Support Specialists. These specialists interact with Emergency Department patients who have existing drug and/or alcohol issues to help patients identify community assets. Training modules are being developed for healthcare professionals for prescribing opioids for pain based on recent CDC guidelines.
- **Syringe Service Program**: The HCHD is committed to addressing the complex health needs of its community through innovative and collaborative efforts. In partnership with Tia Hart Community Recovery Organization, the department has established a Syringe Service Program. It conducts Stigma and Narcan Demonstration Training to support harm reduction and overdose prevention initiatives.
- **Comprehensive Suicide Prevention Program**: The department has also developed a Comprehensive Suicide Prevention Program, which included creating a Firearm Safety Team, conducting CALM (Counseling on Access to Lethal Means) and ASIST (Applied Suicide Intervention Skills Training), and hosting two successful Suicide Symposiums.
- **Other HCHD Behavioral Health Initiatives**:
    - A Licensed Clinical Social Worker (LCSW) has been added to the staff to enhance behavioral health services further, enabling the department to identify, screen, assess, and provide immediate wraparound services to needy individuals.
    - The department worked with the Hoke County Sheriff's Office to establish a program specifically designed to support justice-involved individuals in accessing care for substance use disorders. This program operates independently from the jail's programming and services, ensuring broader access to necessary resources.
    - HCHD collaborated with the Lumbee Tribe of North Carolina to provide culturally relevant guidance for establishing a suicide prevention program tailored to their community's unique needs and traditions. These initiatives highlight the department's dedication to promoting wellness, advancing health equity and empowering the community to lead healthier lives.

Previous CHNA Priority: Health Equity

- **Community Paramedicine:** CFVHS continues to utilize and expand its community paramedicine program which provides home visits to patients with chronic conditions to prevent readmissions and to maintain stable health outcomes. A grant was received to support the expansion of this program. This program provides patients and families with additional education and routine support in managing their conditions.
- **NC MedAssist Over the Counter Medicine Program:** CFVHS participated in the NC MedAssist Over the Counter Medicine Program. NC MedAssist tries to eliminate the barriers for homebound patients who would like to participate in a scheduled Mobile Free Pharmacy event by providing a process to select over-the-counter medicine items without physically attending the event. Over-the-counter medications available through NC MedAssist include allergy, cough, cold, pain relief, vitamins, and children's medications.
- **Community Health Worker Program**: HCHD has made significant progress in promoting health equity through a broad range of initiatives to address disparities in care. Recognizing the importance of community engagement, HCHD has recruited two Community Health Workers (CHWs) from underserved populations to deliver culturally tailored education and support.

Through listening sessions and focus groups with diverse community members, HCHD has gained a deeper understanding of local health needs, barriers, and priorities.

- **Culturally Competent Services**: To foster culturally sensitive care, HCHD provides cultural competency training for its staff and offers multilingual support services, including interpreters, translated materials for non-English-speaking residents, and access to a language line. Health programs are thoughtfully designed to reflect the unique values, traditions, and preferences of the community, guided by data on social determinants of health such as housing, transportation, and employment.
- **Integrated Clinical Care**: An integrated care model has been introduced within the clinical setting, ensuring coordinated physical, mental, and behavioral health services that address the whole person's needs. Expanded maternal and child health services offer crucial support for prenatal care, breastfeeding, and parenting education, working to reduce disparities in maternal and infant health outcomes.
- **Health Literacy**: HCHD has also launched health literacy campaigns to make complex health information more accessible, aligning with the population's cultural and literacy needs. A user-friendly health app and portal have been developed to improve access to health records, appointment scheduling, and educational resources.
- **Post-Incarceration Services**: Recognizing the needs of justice-involved individuals, HCHD has implemented a specialized program to support care continuity and successful reintegration into the community. The department's commitment to continuous improvement is evident through its practice of adapting programs based on community feedback, affirming its dedication to advancing health equity and improving the well-being of all residents.

Previous CHNA Priority: Chronic Disease

- **Step Up 4 Health & Wellness Expo**: A partnership between Cape Fear Valley Health Foundation and Methodist University, the event was hosted for its second year on April 15, 2023 in Fayetteville, NC. Over 500 participants and 50 vendors were present. A 4k or 1 mile route was available for attendees to participate in which required a registration fee where registrants could choose the beneficiary (Friends of the Cancer Center, Children's Services, etc.). This health-related educational festival featured informational booths for CFVHS services as well as food trucks, music, and sponsor tables. Participants learned about hands-only CPR and received free wellness checks and other health-related goodies.
- **Outreach and Education Events:** CFVHS hosted many Breast Cancer Awareness outreach events throughout the year, educating members of the community about Breast Care Education and Breast Cancer Awareness. CFVHS Friends of the Cancer Center also continued to provide funding for mammograms to catch breast cancer in earlier stages. Hands-only CPR instruction and Blood Pressure checks are offered at most outreach events, reaching over 6,166 community members across four counties (including Hoke County) in 2023. Over 3,100 community members participated in sponsored blood drives that offered education and blood donation to CFVHS hospitals. CFVHS also hosted eighteen educational events, including Making Rounds LIVE which provides education from doctors and leaders to members of the community. Over 21,900 community members participated in the Making Rounds LIVE educational events and learned more about heart health, orthopedics, healthy habits (exercise and diet), the opioid crisis, chronic disease management/prevention, early detection of cancer, strokes and heart attacks, palliative care, and Alzheimer's awareness. Lastly, stroke education events were held to educate over 220

members of the community on identifying and preventing strokes as well as caring for yourself and others after a stroke.

- **Nutrition Education and Diabetes Self-Management**: HCHD has made meaningful progress in combating chronic disease within the community by providing residents with essential resources and support. Through nutrition education and diabetes self-management initiatives, HCHD offers personalized counseling and support groups, empowering individuals to make informed decisions about their health and well-being.
- **Tobacco Cessation**: In tobacco prevention and education, HCHD has implemented targeted tobacco cessation efforts, including an engaging social media campaign promoting the Quitline program. The department has also established a smoke-free campus policy to reinforce its commitment to creating a healthier environment for residents and staff.
- **Employee Wellness Garden**: The Employee Wellness Garden has been an innovative educational platform, teaching employees and community members about healthy nutrition, physical activity, small-space gardening, and understanding where food comes from. Further enhancing local food access, HCHD has partnered with UNC-Chapel Hill to support Mount Elim Church and the surrounding community in a gardening initiative that has cultivated over three acres of fresh produce, providing healthier food options for residents.
- **Men's Health**: HCHD's dedication to community engagement is evident in its successful Men's Health event and its organization of over 25 outreach and education events. These efforts showcase HCHD's unwavering commitment to improving health outcomes and fostering a healthier, more empowered community in Hoke County.

Summary of Other Activities

- **Residency Program:** The provider residency program at CFVHS boasts 13 programs and over 275 residents. Program areas offered by the health system include the traditional rotating internship, internal medicine, family medicine, emergency medicine, surgery, psychiatry, OB/GYN, podiatry, pharmacy, and orthopedics. Fellows in the Cardiology and Adolescent Psychiatry Fellowship program have grown 30% since 2022. More than half of eligible residents have committed to work at CFVHS upon completion of their residency. The residency program at CFVHS fosters outreach amongst residents and raises awareness of the residency program and its expected impact. CFVHS will continue its aggressive outreach efforts to help educate patients about the various risk factors associated with all the identified needs. CFVHS continues to strengthen its relationships with local health departments, area churches and the school systems to better identify areas of future community impact.
- **School of Medicine:** On February 27, 2023, Methodist University and CFVHS announced their intent to establish a state-of-the-art School of Medicine on the campus of Cape Fear Valley Medical Center. The new medical school will combine the expertise and resources of both institutions to provide students with unparalleled educational and clinical experiences. The partnership will have a mission that focuses on providing better medical care for rural and underserved populations and diversifying the physician workforce. This partnership between CFVHS and Methodist University is a significant milestone in the history of medical education in Southeastern North Carolina. The new medical school will be an important contributor to the healthcare industry, addressing the shortage of healthcare professionals and improving the quality of healthcare delivery. Students will be given the opportunity to learn in a collaborative and innovative environment, with access to innovative technologies and new, state-of-the-art

facilities constructed at CFVMC. Students will be given the opportunity to work alongside experienced faculty and healthcare professionals, gaining valuable real-world experience that will prepare them for their future careers. Construction on the medical school building began in early 2024. The building is scheduled for completion in late 2025. The first class (Class of 2030) will matriculate in July 2026. Recruitment of students will begin pending receipt of preliminary accreditation from the Liaison Commission on Medical Education (LCME) in the spring of 2025. The school will start with 80 students per year and grow to 120 students per year.

- **Center for Medical Education & Research and Neuroscience Institute:** In January 2023, CFVHS opened the Center for Medical Education & Research and Neuroscience Institute, a state-of-the-art education and research center for medical residency programs that will benefit medical students for generations to come. The Center for Medical Education & Research and Neuroscience Institute spans five floors and 120,000 square feet and includes lecture halls, classrooms, and simulation labs to provide resident medical students with hands-on, applied learning with sophisticated technology. The facility was under construction for several years and has been a wonderful addition to the community since its opening in January 2023. The new Center for Medical Education allows CFVMC to expand to its full educational capacity; thus, the residency program is poised to bring hundreds of new doctors to the region in the next decade.
- **Clinical Pharmacist Practitioners:** Pharmacy has continued to expand into the outpatient clinics through the integration of Clinical Pharmacist Practitioners, or CPPs, who provide services in four Cape Fear Valley outpatient clinics including Fayetteville Family, Senior Health Services, the Diabetes and Endocrine clinic, and the Medical Oncology clinic at the main campus. These advanced practice providers offer patients in-depth medication counseling to improve outcomes and help ease the burden of heavy caseloads for providers. Since the introduction of the CPP in the Diabetes and Endocrine Center, patient A1C levels were dramatically decreased in patients receiving medication counseling from the pharmacist. In 2023, six clinical pharmacist practitioners joined the health system in outpatient pharmacies and clinics.
- **Vaccines:** CFVHS' outpatient pharmacies continued the mission of vaccinating the public against COVID-19 and influenza with both new vaccinations and boosters. CFVHS has provided over 183,000 vaccines to members of the community since the COVID-19 vaccine was made available. Further, CFVHS administered 17,679 influenza vaccines systemwide in 2023. The ease of online scheduling and walk-in options led to very short wait times and increased availability of these life-saving vaccines. CFVHS hosted regular clinics at its hospitals, community pharmacies, and clinics, and also hosted events at local high schools for adults and students, as well as multiple other community events.

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

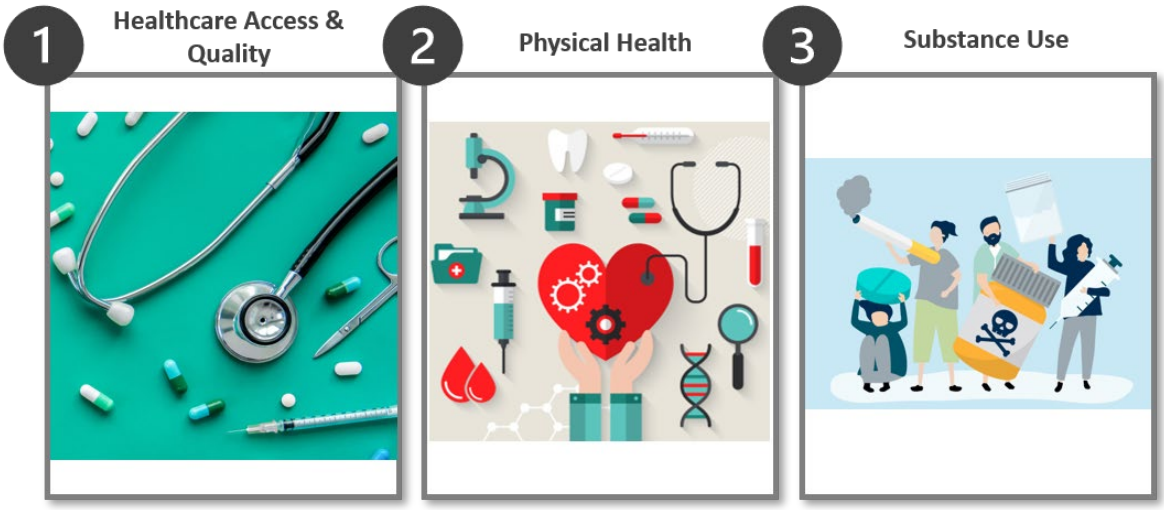
Summary Findings: Hoke County 2024 Priority Health Need Areas

To achieve the study objectives in the 2024 assessment, both new and existing data were collected and reviewed. New data included information from web-based surveys of adults (18+ years) and focus groups; various local organizations, community members, and health service providers within Hoke County participated. Existing data included information regarding the demographics, health and healthcare resources, behavioral health, disease trends, and county rankings. The data collection and analysis process began in January 2024 and continued through July 2024.

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

Through the prioritization process, the CHNA Steering Committee identified Hoke County's priority health need areas from a list of over 100 health indicators. Please note that the final priority needs were not ranked in any order of importance and county health leaders will engage in each of the three priority need areas. After looking at all relevant data and feedback from the CHNA Steering Committee, the Hoke focus areas identified as countywide priorities for the 2024 CHNA are Healthcare Access and Quality, Physical Health, and Substance Use, as seen in **Figure 5**.

Figure 5: Hoke County 2024 Priority Need Areas[4]



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

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

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

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

CHAPTER 1 | METHODOLOGY

Study Design

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

Specifically, the following data types were collected and analyzed:

New (Primary) Data

Public engagement and feedback were received through a web-based community member survey along with community focus groups and significant input and direction from the CHNA Steering Committee. The Steering Committee worked together to develop the survey questions for the web-based survey, and county leaders were provided with a set of target numbers based on their county population's race, ethnicity and age distribution to encourage recruitment of a representative sample of the community. Community members were asked to identify the most significant health and social needs in their community, as well as asked questions about topics specific to Hoke County, including equity and equality, mental health, physical health, and substance use disorders. Focus group participants were asked a standard set of questions about health and social needs, in order to identify trends across various groups and to highlight areas of concern for specific populations. Through this process, input was gathered from numerous Hoke County residents and other stakeholders. This included web survey responses from over 300 community members and five focus groups that included community members and other people who live, work or receive healthcare in Hoke 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 Hoke County was the North Carolina Data Portal. This website is a joint effort by NCDHHS and the University of Missouri Center for Applied Research and Engagement Systems (CARES), which includes over 120 data indicators focused on demographics, health status and social determinants of health. In addition to information from the North Carolina Data Portal, a variety of other sources were leveraged in this assessment process, including:

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

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

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

Comparisons

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

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

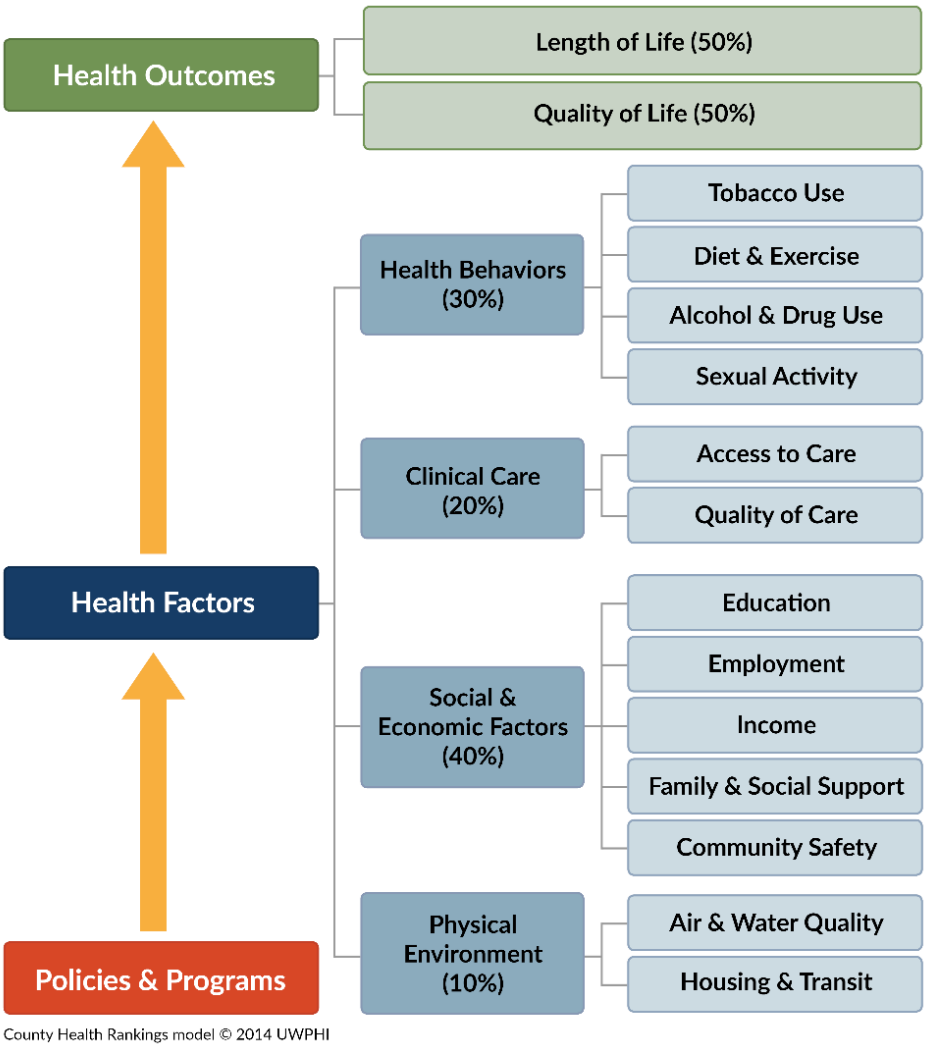
Population Health Framework

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

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

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

Figure 6: Population Health Framework[5]



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

Figure 7: Social Determinants of Health[6]

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

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

Figure 8: SDoH and Health Disparities[7]

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

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

Prioritization Process Overview and Results

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

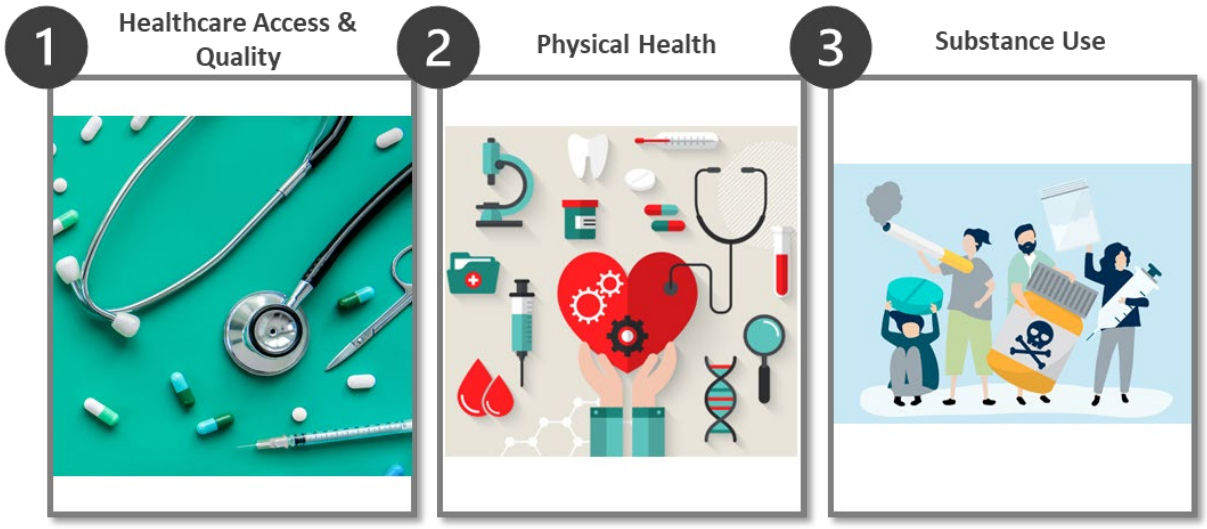
Since a large number of individual data measures were collected and analyzed to develop these 20 focus areas, it was not reasonable to make each of them a priority. The Hoke County CHNA leadership considered which focus areas had data measures of high need or worsening performance, priorities from the primary data, and how possible it is for health departments or hospitals to impact the given need to help determine which health needs should be prioritized.

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

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

The final priority need areas were not ranked in any order of importance, and each will be addressed by the Hoke County CHNA leadership. The following three focus areas (Healthcare Access and Quality, Physical Health, and Substance Use) were identified as Hoke County's top priority health needs to be addressed over the next three years, as seen in **Figure 9** below:

Figure 9: Hoke County 2024 Priority Need Areas



The following particpants were involved in the prioritization process.

- Cape Fear Valley Health System
- Hoke County Health Department
- Community Partners
- Hoke County Public Health Advisory Assessment Team

Study Limitations

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

Given the size of Hoke County in both population and geography, this study was limited in its ability to fully capture health disparities and health needs across racial and ethnic groups. Resource limitations meant that county leaders relied on convenience sampling to engage with the community via the web-based survey. This method of survey sampling may fail to capture a truly representative cross-section of the community, resulting in overrepresentation of some demographic groups and underrepresentation of others. This can lead to findings that don't accurately reflect the health needs and perspectives of the entire community, particularly those from underrepresented or marginalized groups. Efforts were made to include diverse community members in survey efforts, and overall, the composition of survey

respondents in terms of race and ethnicity indicates that diverse community members were adequately sampled, which ensures the Hoke County leadership was able to assess health needs and disparities across racial/ethnic minority groups in the community. Roughly 46% of all respondents identified as Black or African American compared to 31% of Hoke County as a whole, and 35% of all respondents identified as White compared to 37% of the county as a whole. However, 12.3% of respondents identified as Hispanic, which was slightly less than percentage of the population of the county as a whole (15.5%). Additionally, 10% of survey respondents identified as American Indian and Alaska native, which was greater than the overall county population that is Indigenous (7.4%).

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 Steering Committee chose to focus on Spanish-speaking members of the community by providing a Spanish language version of the web-based community survey. Paper surveys were also distributed in an effort to reach as much of the community as possible. To increase future survey responses, members of the Steering Committee should consider working directly with partner organizations in the community who can connect directly with populations who are hard to access through traditional outreach methods, including people with disabilities, the uninsured and people who are disengaged.

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

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

CHAPTER 2 | COUNTY PROFILE

Geography

Hoke County is 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 391 square miles. The county seat of Hoke is Raeford, which also serves as its largest municipality. Over 42% of Hoke County's population resides in rural areas, reflecting the county's strong agricultural heritage while maintaining proximity to urban centers.

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.

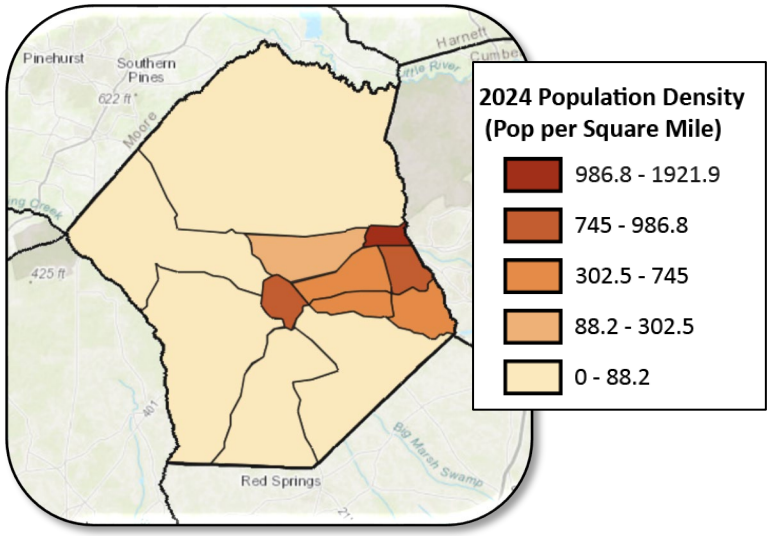
Hoke County has a population of 53,776, making up approximately 0.5% of North Carolina's total population.

Table 1: Total Population, 2023[8]

	Hoke County	North Carolina	United States
Population	53,776	10,765,678	337,470,185

Hoke County has a population density of 140.4 persons per square mile – lower than the population density for North Carolina (214.7 persons per square mile). McLauchlin is the most densely populated area in the county.

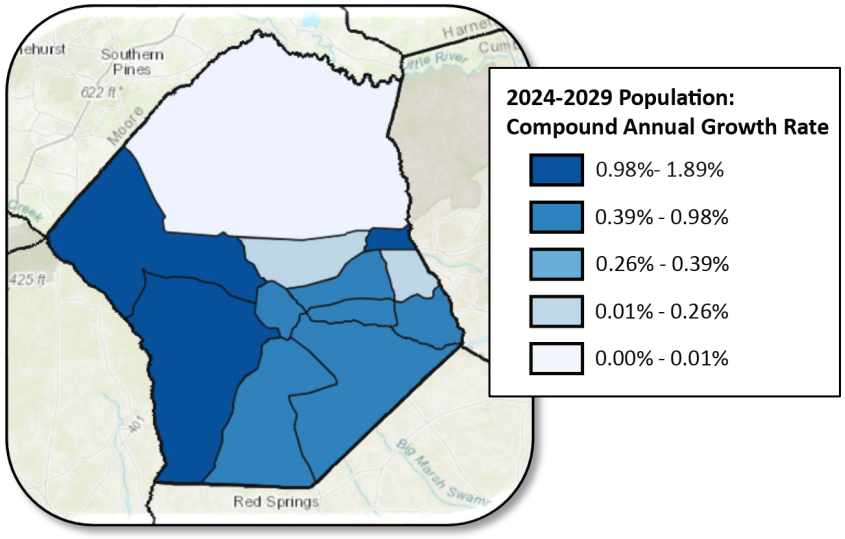
Figure 10: Hoke County Map: Population Density[8]



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

In total, the population of Hoke County is projected to grow 0.82% annually between 2024 and 2029. Areas in the southwestern parts of the county are experiencing greater growth.

Figure 11: Hoke 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. Hoke County's age distribution differs from state averages, showing a younger population. The county has a notably higher percentage of residents below 15 (25.1%) compared to North Carolina (17.9%). The percentage of residents between 15 and 44 (42.7%) is also higher than the state average (39.3%). Conversely, the county has lower proportions of residents aged 45-64 (21.0% vs. 25.1% state) and 65 and older (11.2% vs. 17.7% state).

Table 2: Age Distribution, 2023[8]

	Hoke County	North Carolina	United States
Percentage below 15	25.1%	17.9%	18.1%
Percentage between 15 and 44	42.7%	39.3%	39.5%
Percentage between 45 and 64	21.0%	25.1%	24.6%
Percentage 65 and older	11.2%	17.7%	17.8%

Like North Carolina overall, Hoke County has more females than males in its population. Females make up 52.0% of the county's residents while males comprise 48.0%, a distribution that is slightly more pronounced than the state's ratio.

Table 3: Sex Distribution, 2023[8]

	Hoke County		North Carolina		United States	
	Count	Pct. of Total	Count	Pct. of Total	Count	Pct. of Total
Female	28,658	52.0%	5,489,419	51.0%	170,118,720	50.4%
Male	25,118	48.0%	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 impacting how care is delivered. Hoke County shows significant racial diversity. Non-Hispanic Black residents comprise 32.0% of the population, higher than North Carolina's 20.4%. Non-Hispanic white residents make up 39.5% of the population, notably lower than the state's 61.2%. The county has a significantly higher percentage of American Indian and Alaska Native (AIAN) residents (7.9%) compared to the state average (1.2%). Hoke County also has a higher percentage of residents identifying as Two or More Races (11.1%) compared to the state average (7.2%).

Table 4: Racial Distribution, 2023[8]

	Hoke County		North Carolina		United States	
	Count	Pct. of Total	Count	Pct. of Total	Count	Pct. of Total
Black (Non-Hispanic)	17,194	32.0%	2,199,488	20.4%	42,132,758	12.5%
White (Non-Hispanic)	21,239	39.5%	6,590,161	61.2%	204,562,590	60.6%
Asian	844	1.6%	379,374	3.5%	21,088,177	6.2%
AIAN	4,252	7.9%	133,820	1.2%	3,831,126	1.1%
NHPI	229	0.4%	9,214	0.1%	712,229	0.2%
Some Other Race Alone	4,045	7.5%	677, 338	6.3%	29,432,586	8.7%
Two or More Races	5,973	11.1%	776,283	7.2%	35,710,719	10.6%

By ethnicity, over 15% of Hoke County's population is Hispanic. This is higher than the state average of 11.4%.

Table 5: Ethnic Distribution, 2023[8]

	Hoke County		North Carolina		United States	
	Count	Pct. of Total	Count	Pct. of Total	Count	Pct. of Total
Non-Hispanic	45,425	84.5%	9,465,874	88.6%	271,934,049	80.6%
Hispanic	8,351	15.5%	1,299,804	11.4%	65,536,136	19.4%

The proportion of foreign-born individuals residing in Hoke County is 5.3%, lower than the average for North Carolina.

Table 6: Foreign Born Population, 2022[9]

	Hoke County	North Carolina	United States
Foreign Born	5.3%	9%	13.9%

According to the most recent American Community Survey (ACS), approximately 11% of Hoke County residents speak a language other than English at home. This is lower than the roughly 13% of North Carolina and 22% U.S. residents who speak a language other than English at home. A little over 8% of Hoke County residents speak Spanish at home.

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

	Hoke County	North Carolina	United States
English Only	89.2%	87.3%	78%
Spanish	8.4%	7.9%	13.3%
Indo-European Languages	1.1%	2.1%	3.8%
Asian and Pacific Islander Languages	1.1%	1.9%	3.6%
Other Languages	0.2%	0.8%	1.2%

Disability Status[10]

Disability status helps us understand how to create fair and equal opportunities for everyone in the county. Individuals with disabilities may require services that look different or are delivered in different ways, and may require unique outreach by health and other service providers. Nearly one in five Hoke County residents have a disability. This rate is higher than the North Carolina average (13.3%).

Table 8: Disability Status, 2022[9]

	Hoke County	North Carolina	United States
Population with a Disability	18%	13.3%	12.9%

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

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

Veteran Status

Military veterans often need special services and support, so it is important to collect data about them to be better able to meet their health needs. Nearly one in five Hoke County residents are veterans. This rate is more than double the North Carolina average.

Table 9: Veteran Status, 2022[9]

	Hoke County	North Carolina	United States
Veterans	18%	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 Hoke County ($52,762) is lower than the average in North Carolina ($64,316).

Table 10: Median Household Income, 2023[8]

	Hoke County	North Carolina	United States
Median Household Income	$52,762	$64,316	$72,603

Poverty has a significant impact on health. Across the lifespan, people who live in impoverished communities have a higher risk of poor health outcomes, including mental illness, chronic diseases, higher mortality and lower life expectancy. Poverty is a concern across the lifespan; children who live in poverty are at risk for developmental delays, toxic stress and poor nutrition, and are likely to live in poverty as adults as well. Unmet social needs, including having low or no income, can also limit people's ability to access healthcare when they need it, or to provide for basic necessities needed to live healthy lives, such as safe housing or healthy food. In 2023, over 15% of Hoke County households were below the federal poverty level (FPL), which is higher than the average for both North Carolina and the United States.

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

	Hoke County	North Carolina	United States
Percent Below FPL	15.5%	10.1%	9.5%

Approximately one-quarter of Hoke County households received Food Stamps/SNAP (Supplemental Nutrition Assistance Program) benefits in 2022. This is nearly 10 percentage points higher than the state average.

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

	Hoke County	North Carolina	United States
Number of Households Receiving Food Stamps/SNAP	4,455	575,860	16,072,733
Total Number of Households	19,313	4,299,266	129,870,928
Percentage of Households receiving Food Stamps/SNAP	23.1%	13.4%	12.4%

In Hoke County, 25.6% of the population has an educational attainment of high school only, which is higher than the state average (21.2%). The county shows higher rates of residents with some college education (25.7%) compared to the state (21.1%), and notably higher rates of associate's degrees (14.0% vs. 9.9% state). However, the county has lower rates of advanced education, with bachelor's degrees (12.6%) significantly lower than North Carolina's rate (20.4%) and graduate/professional degrees (5.8%) at half the state average (11.6%).

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

	Hoke County	North Carolina	United States
Less than 9th Grade	4.6%	6.0%	3.5%
Some High School/No Diploma	7.9%	5.5%	5.3%
High School Diploma	25.6%	21.2%	28.5%
GED/Alternative Credential	3.9%	4.3%	*[15]
Some College/No Diploma	25.7%	21.1%	14.6%
Associate's Degree	14.0%	9.9%	10.5%
Bachelor's Degree	12.6%	20.4%	23.4%
Graduate/ Professional Degree	5.8%	11.6%	14.2%

The overall unemployment rate in Hoke County (6.4%) is higher than the state average (5.1%). Young people between ages 16 to 24 face similar unemployment (12.7%) to North Carolina's rate (12.4%). However, the unemployment rate for ages 25 to 54 (6.3%) is notably higher than the state figure (4.7%). The county shows lower rates for workers ages 55 to 64 (2.8% vs. 3.3% state) but higher rates for those

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

65 or more (4.9% vs. 3.0% state). This data indicates employment challenges particularly among working-age adults and seniors.

Table 14: Unemployment, 2022[16,17]

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

Hoke County's overall uninsured rate (11.0%) is lower than the state average (15.0%). The county shows better insurance coverage for those 18 and below (4.6%) compared to the state average (5.2%). However, the uninsured rate for ages 19 to 34 (18.9%) is higher than North Carolina's 15.5%. The county's uninsured rate for ages 35 to 64 (14.5%) is also higher than the state's 12.5%. This data suggests that while Hoke County performs better overall in terms of insurance coverage, both young and middle-aged adults face greater challenges in accessing health insurance compared to statewide averages.

Table 15: Health Insurance Status, 2022[18]

	Hoke County	North Carolina	United States
Percentage uninsured ages 18 or below	4.6%	5.2%	5.4%
Percentage uninsured ages 19 to 34	18.9%	15.5%	13.6%
Percentage uninsured ages 35 to 64	14.5%	12.5%	9.9%
Total % Uninsured	11.0%	15.0%	12.0%

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

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

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

Social Determinants of Health

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

Figure 12: Social Determinants of Health

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

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

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

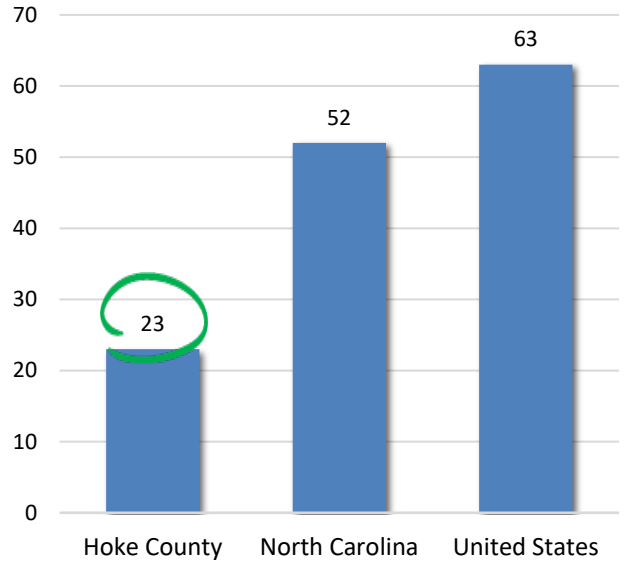
Disparities

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

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

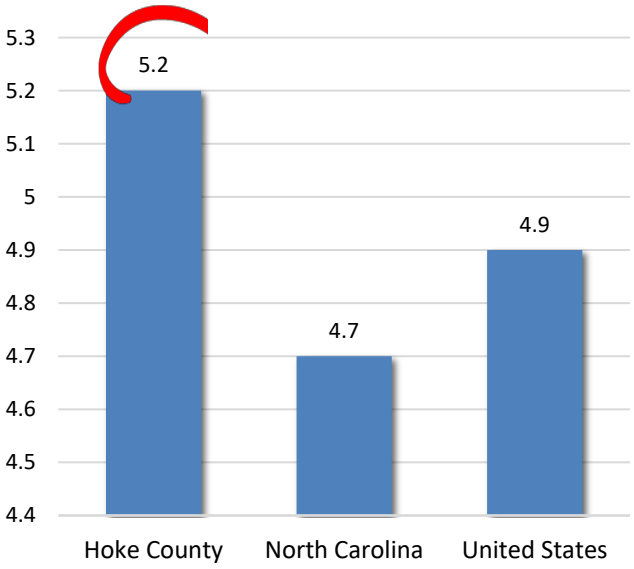
tracts. Lower scores represent a higher level of integration. There is less residential segregation in Hoke County compared to the state and country, as seen in **Figure 13**.

Figure 13: Residential Segregation[5]



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

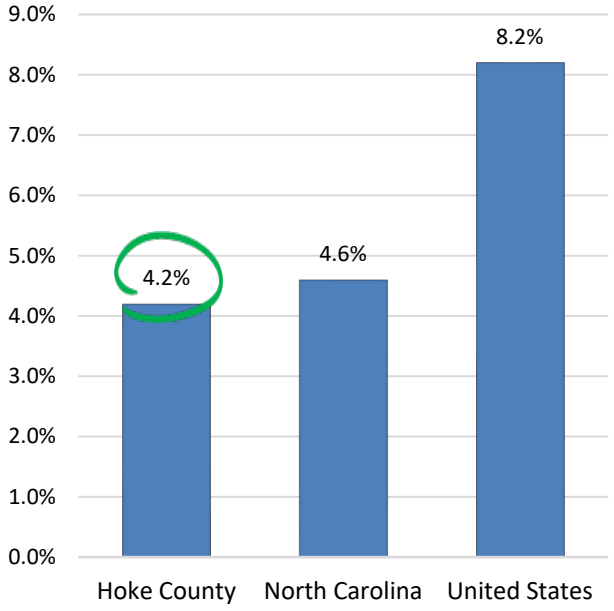
Figure 14: Income Inequality Ratio[5]



People with limited English proficiency (LEP) may face challenges accessing care and resources that fluent English speakers do not. Language barriers may make it hard to access transportation, medical, and social

services as well as limit opportunities for education and employment. Importantly, LEP community members may not understand critical public health and safety notifications, such as safety-focused communications provided during the COVID-19 pandemic. Fewer people have limited English proficiency in Hoke County when compared to the state and country, as seen in **Figure 15**.

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



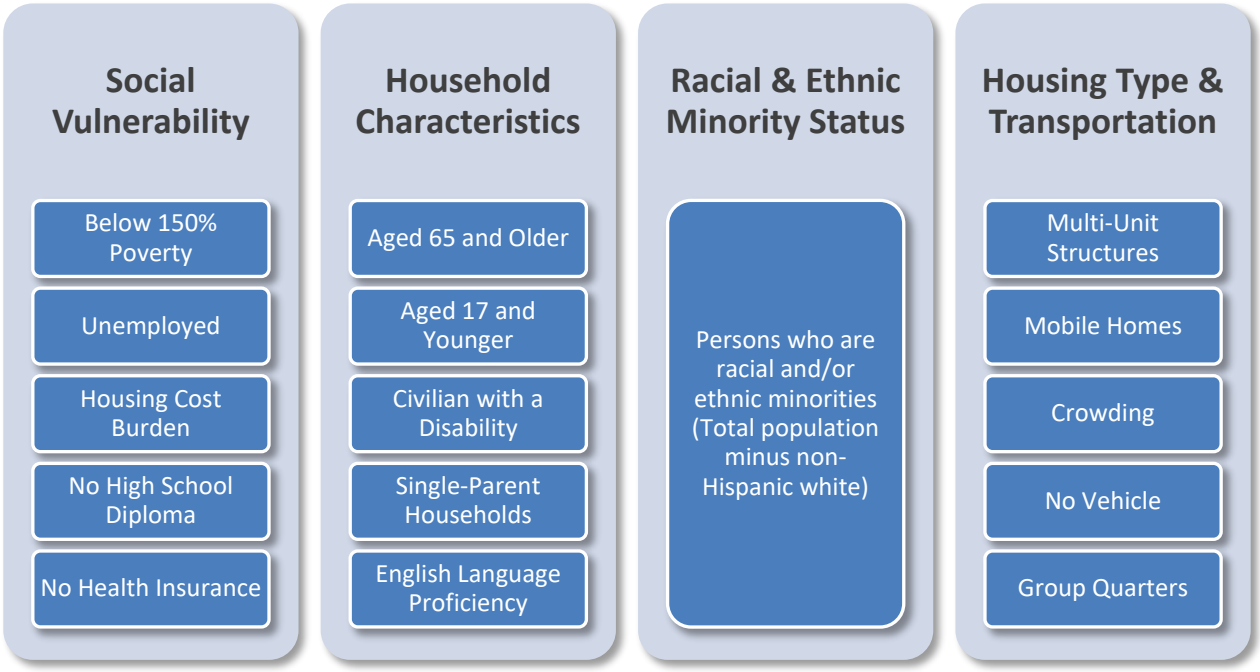
Social Vulnerability Index

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

The SVI uses 16 U.S. Census variables to help local officials identify communities that may need support before, during, or after a public health emergency.[19] Communities with a higher SVI score are generally at a higher risk for poor health outcomes. Instead of relying on public health data alone, the SVI accounts for underlying economic and structural conditions that affect overall health, including SDoH. SVI scores are calculated at the census tract level and based on U.S. Census variables across four related themes: socioeconomic status, household characteristics, racial and ethnic minority status, and housing type/transportation. **Figure 16** outlines the variables used to calculate SVI scores.

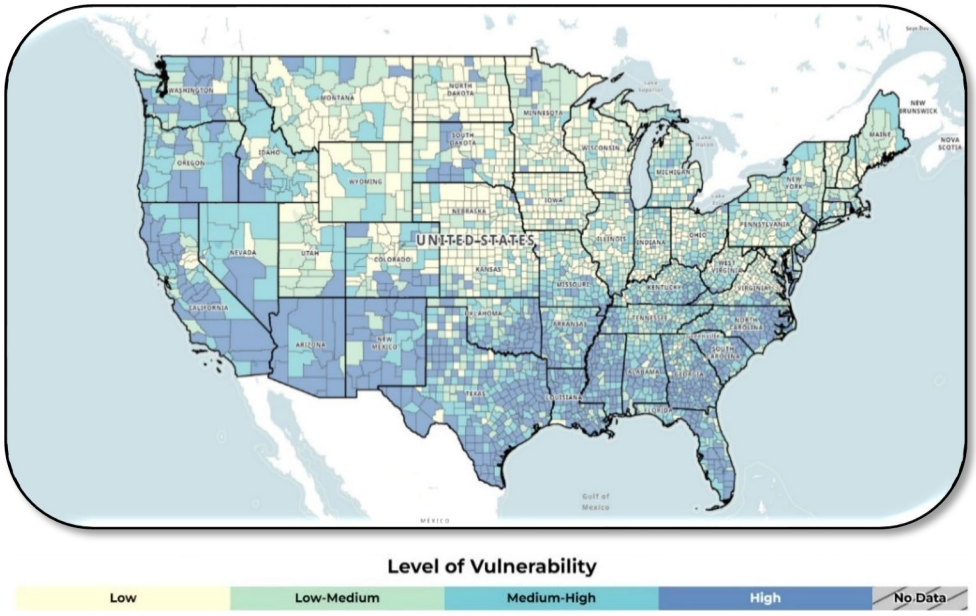
[19] Source: Centers for Disease Control and Prevention (2024). Social Vulnerability Index. https://www.atsdr.cdc.gov/place-health/php/svi/index.html.

Figure 16: SVI Variables



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

Figure 17: United States SVI by County, 2022



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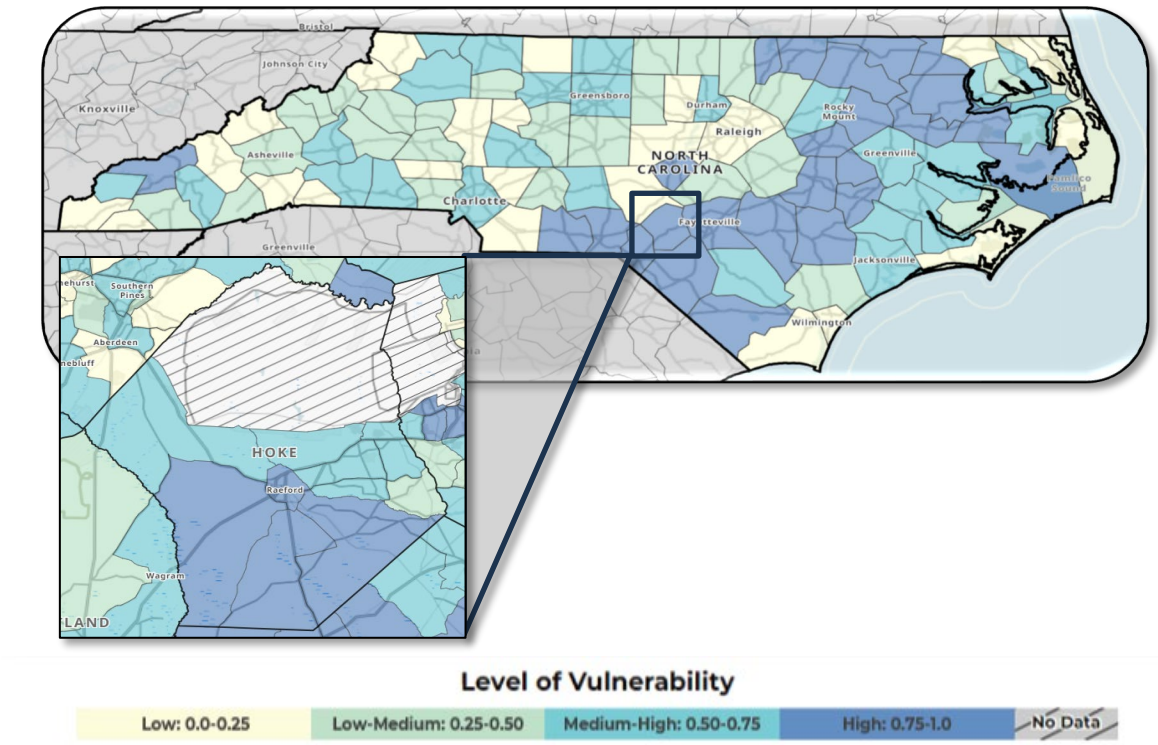
The 2022 SVI scores for Hoke County are shown in **Figure 18** below. Possible scores range from 0 (lowest vulnerability) to 1 (highest vulnerability), and these scores show a relative comparison with other counties and census tracts in North Carolina. The vulnerability of Hoke County overall is higher than average compared to the state. Levels of vulnerability are variable across the county with the average being 0.78.

Figure 18: Hoke County SVI by Census Tract, 2022



Environmental Justice Index

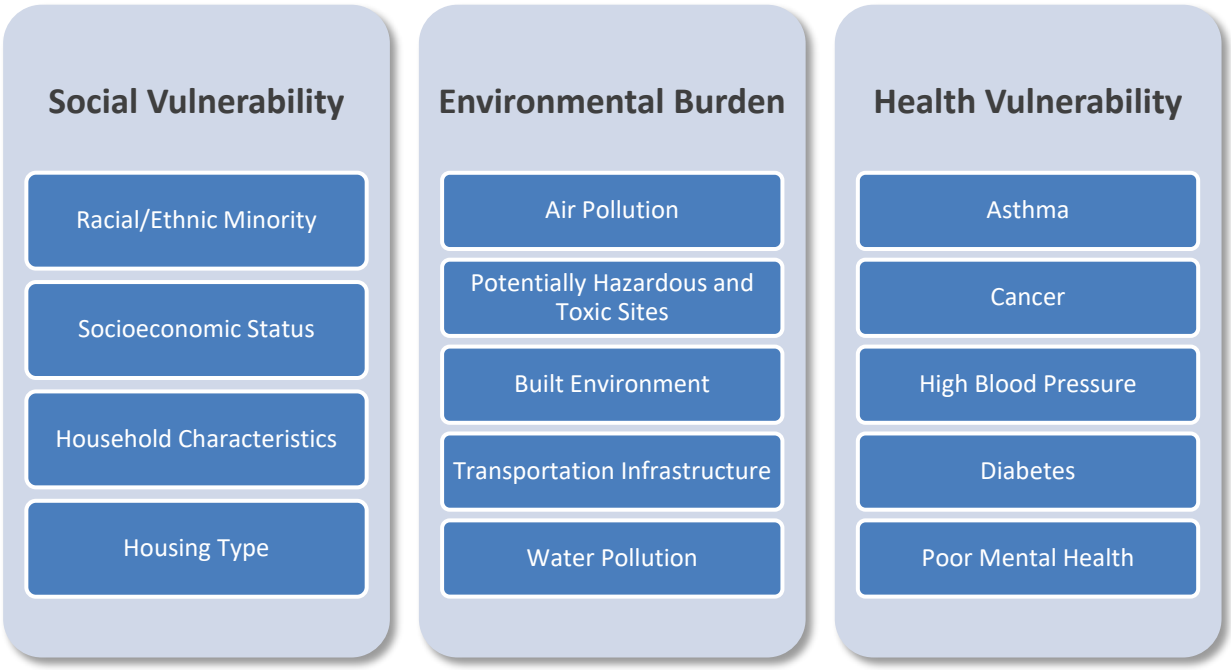
Environmental justice means the just treatment and meaningful involvement of all people, regardless of income, race, color, national origin, Tribal affiliation, or disability, in agency decision-making and other Federal activities that affect human health and the environment. It aims to protect everyone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

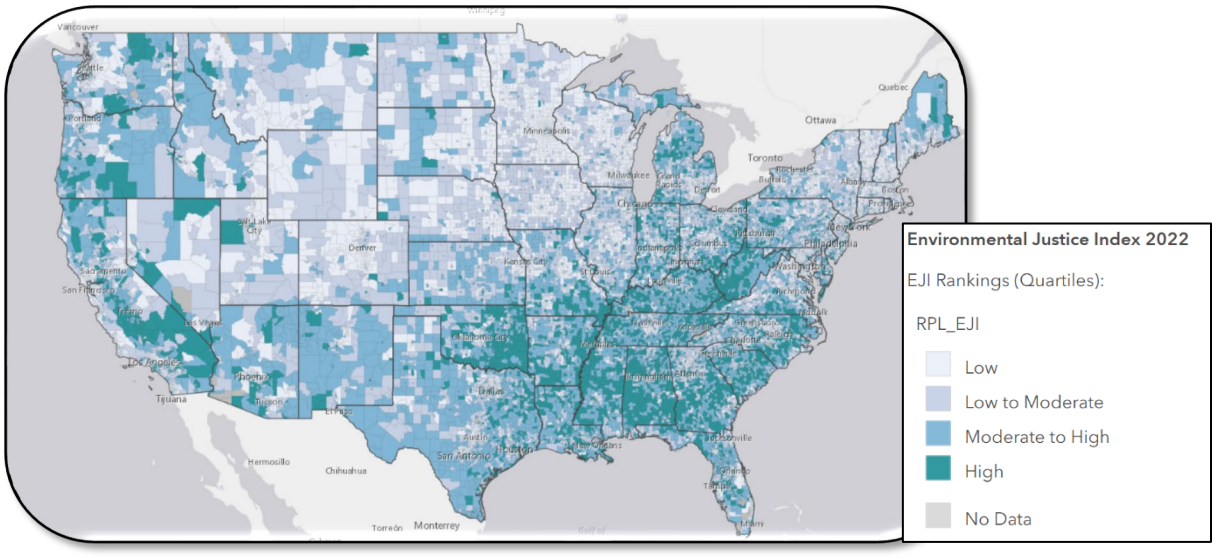
Over time, communities with a higher EJI score are generally shown to experience more severe impacts from environmental burden than communities in other census tracts. **Figure 19** outlines the variables used to calculate EJI scores.

Figure 19: EJI Variables



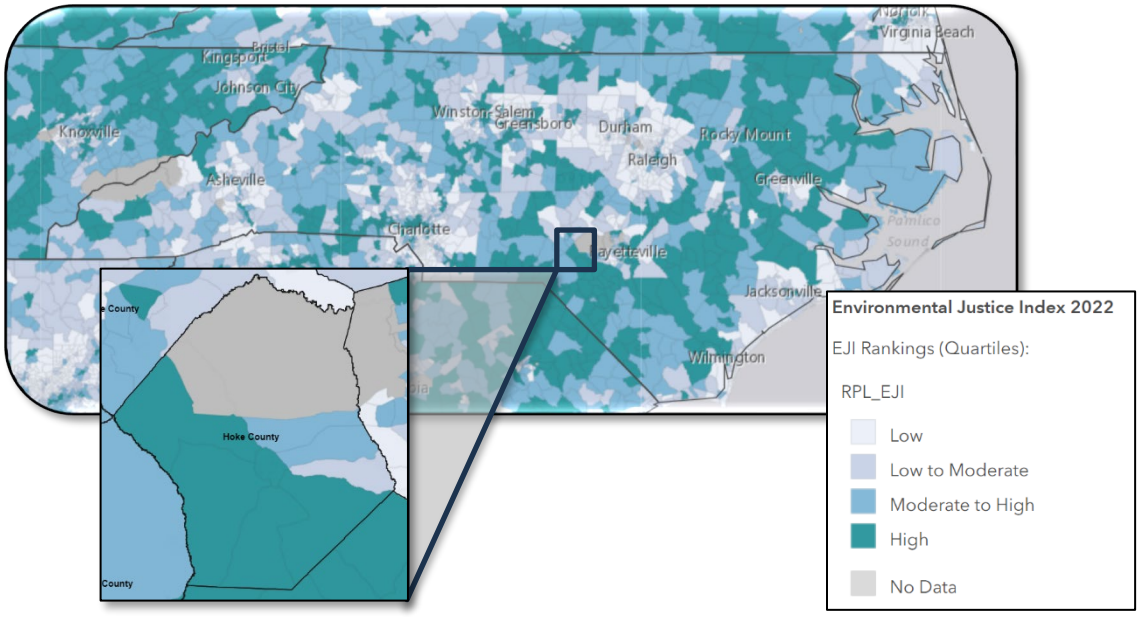
The United States EJI by census tract is shown in **Figure 20** below. As shown, a lot of variation exists across the country, and even within individual states.

Figure 20: United States EJI by Census Tract, 2022



The 2022 EJI scores for census tracts within Hoke County are shown in **Figure 21** below. EJI scores use percentile ranking which represents the proportion of census tracts that experience environmental burden relative to other census tracts in North Carolina. The index ranges from 0-1 with higher scores indicating more environmental burden compared to other census tracts. Levels of environmental burden are variable across the county with the average being 0.71

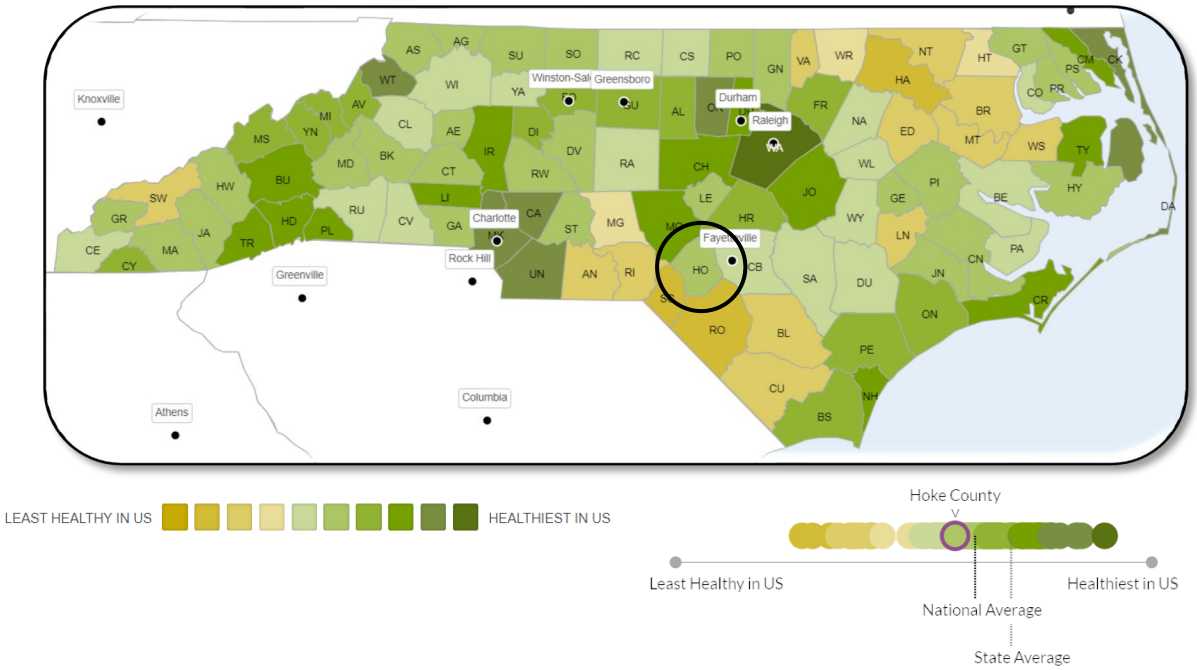
Figure 21: Hoke County EJI by Census Tract, 2022



Health Outcome and Health Factor Rankings

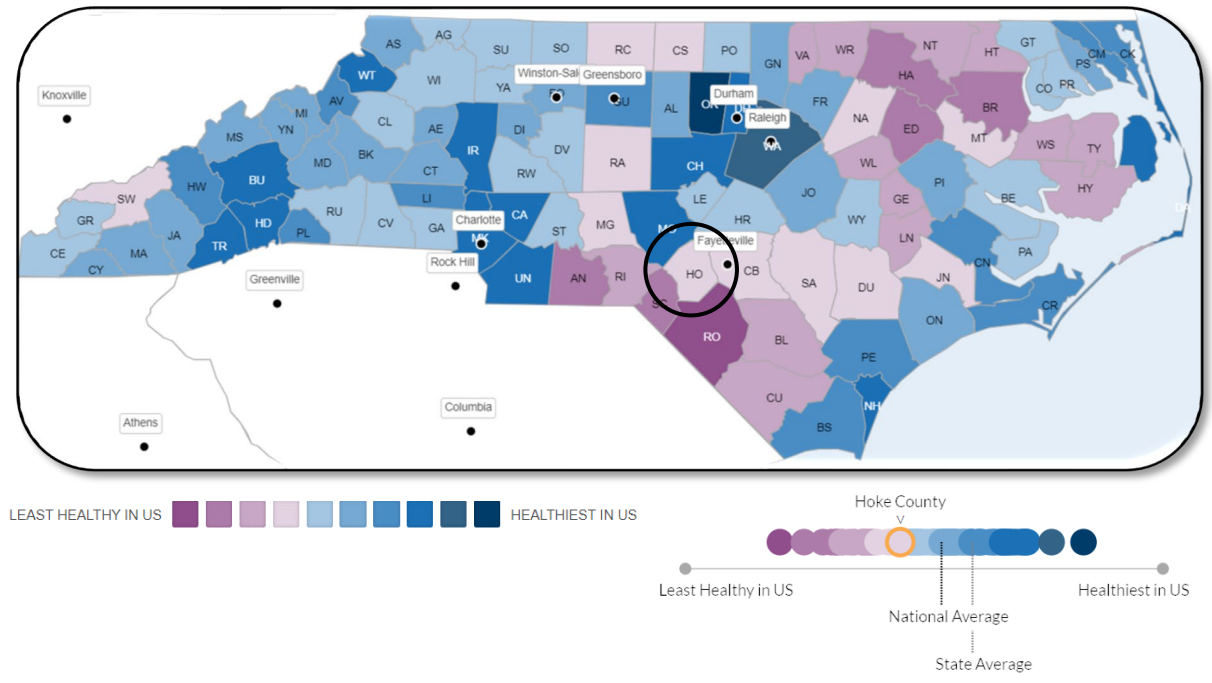
County leaders also reviewed and analyzed data from the Robert Wood Johnson Foundation and the University of Wisconsin County Health Rankings for the year 2024. The Health Outcomes measure looks at how long people in a community live and how physically and mentally healthy they are. These categories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

Figure 22: State Health Outcomes Rating Map[5]



The Health Factors measure considers variables that affect people's health including health behaviors, clinical care, social and economic factors, and the physical environment in which they live. More details about these indicators can be found in **Appendices 2 through 4**. Similarly to the Health Outcome measure, Hoke County falls behind the average for the country and the state.

Figure 23: State Health Factors Rating Map[5]



CHAPTER 3 | PRIORITY NEED AREAS

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

The prioritization process was guided by factors such as the size and severity of the need, the feasibility and effectiveness of potential interventions, associated health disparities, and the importance placed on the issues by the community. Input from diverse stakeholders and community members was crucial in shaping these priorities, ensuring inclusivity and alignment with local concerns. Data trends, comparisons to previous CHNAs, and interconnections between the priority areas were also considered to provide a clear picture of ongoing needs and opportunities. Challenges such as data gaps or limited participation were acknowledged, along with plans for improvement in future assessments. This transparent and community-centered approach ensures that Hoke County's health leaders can develop effective and equitable strategies to address these priorities.

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

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

PRIORITY NEED: BEHAVIORAL HEALTH – SUBSTANCE MISUSE

Context and National Perspective

Substance use disorders (SUDs) are one of the fastest rising categories of behavioral health disorders. According to the American Psychiatric Association, SUDs are a complex condition in which there is uncontrolled use of a substance (such as alcohol or drugs), despite harmful consequences.[21] SUDs often occur in conjunction with other mental illness. In 2023, 16 million (46.9%) young adults aged 18-25 reported having either a SUD or Acute Mental Illness (AMI) in the past year. In that same year, 17.1% (48.5

[21] 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.

million) of all U.S. adults were reported as having an SUD.[22] 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.[23] 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.[24] 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.[25]

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.[26]

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.[27] 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.

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[22] 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.

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

[24] 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

[25] 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/

[26] 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.

[27] 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.

Secondary Data Findings

Secondary data collected through the CHNA process identified substance misuse as an area of concern for residents of Hoke County. Several substance use disorder indicators for Hoke County were higher than state and national averages, as displayed in the table below. The rate of emergency department visits related to opioid use disorder was notably higher in Hoke County (57 per 100,000 beneficiaries) compared to both North Carolina (43) and national (41) rates. Additionally, the county had a higher rate of deaths due to alcohol-involved vehicle crashes at 3.8 per 100,000 population compared to state (2.9) and national (2.3) averages.

Table 16: Substance Use Indicators

Indicator	Hoke County	North Carolina	United States
Percentage of Adults Reporting Excessive Drinking	17%	18%	18%
Opioid Use Disorder Emergency Department Utilization (Rate per 100,000 Beneficiaries)	57	43	41
Alcohol-Involved Crash Deaths, Annual (Rate per 100,000 Population)	3.8	2.9	2.3
Opioid Overdose Crude Death Rate (Rate per 100,000 Population)	23.8	25.1	N/A

While the percentage of adults reporting excessive drinking (17%) was slightly lower than state and national averages (18%), access to treatment remains a concern. The rate of substance abuse providers in Hoke County (28.8 per 100,000 population) is only slightly higher than the state average (25.0), but the county has a significantly lower rate of buprenorphine providers (3.6 per 100,000 population) compared to both state (15.2) and national (15.5) averages, indicating potential gaps in medication-assisted treatment options.

Table 17: Substance Abuse Providers

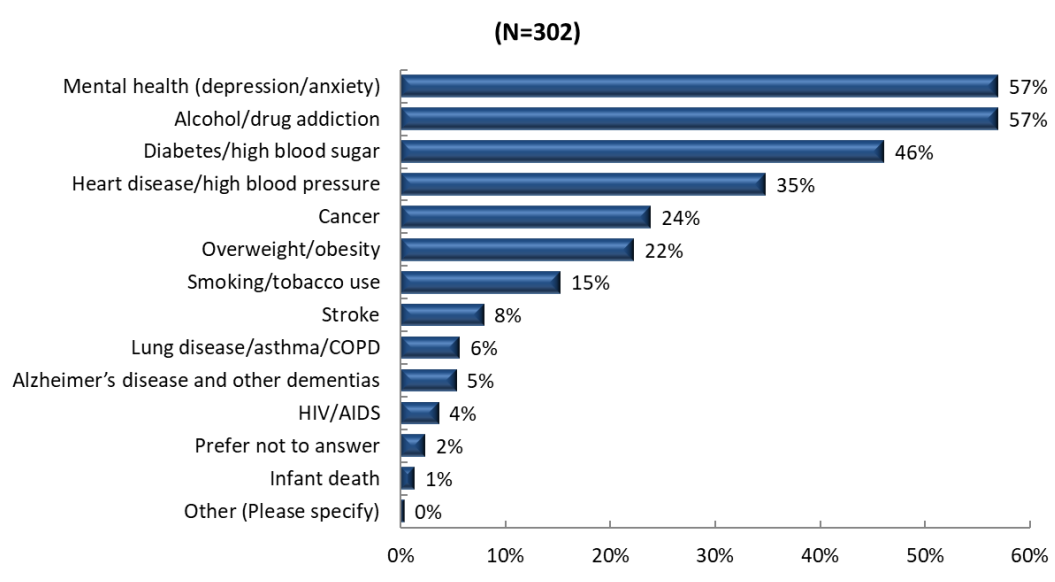
Indicator	Hoke County	North Carolina	United States
Substance Abuse Providers (Rate per 100,000 Population)	28.8	25.0	27.9
Buprenorphine Providers (Rate per 100,000 Population)	3.6	15.2	15.5

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

Primary Data Findings – Community Member Web Survey

Hoke County residents highlighted different aspects of behavioral health and substance use as areas of community concern on the web-based survey. When asked to identify the most important community health needs, 57% of respondents identified mental health (depression/anxiety) and an equal percentage of respondents identified alcohol/drug addiction. These were the two most frequent of all community health needs identified.

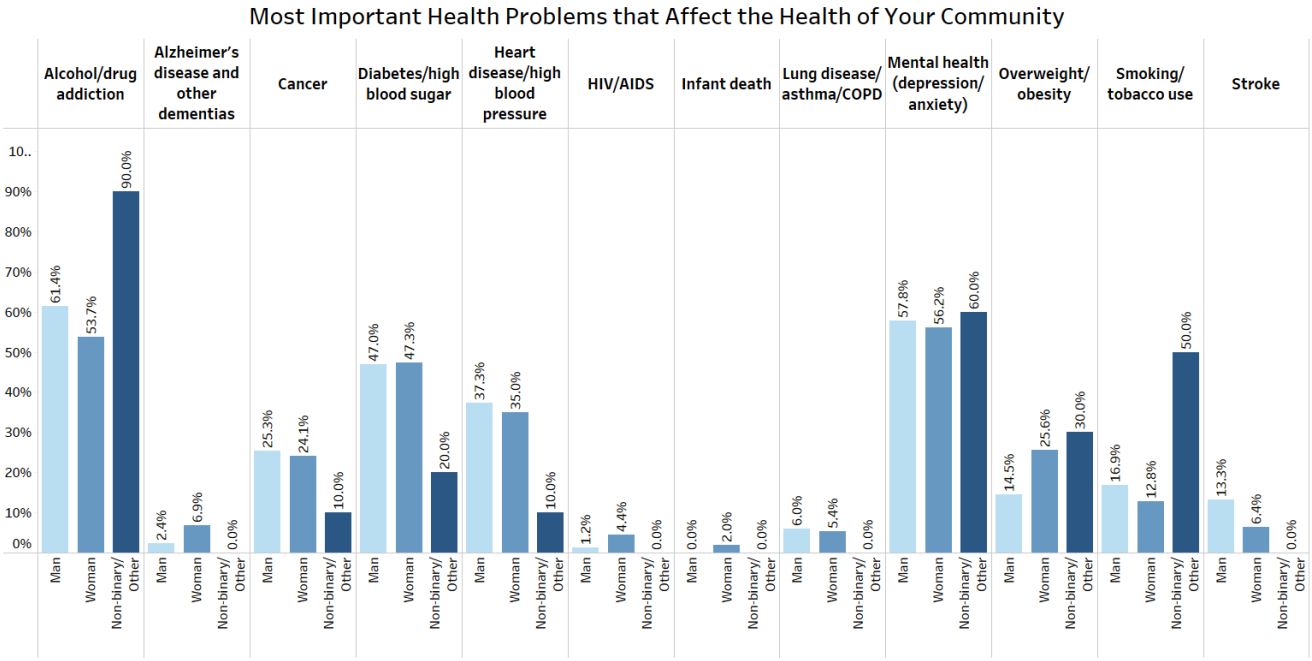
Figure 24: What are the three most important health problems that affect the health of your community? Please select up to three.



However, when these data were examined by the race of community member respondents, differences emerged. Those who identified with other racial identities[28] selected mental health as an important community health need more frequently and alcohol/drug addiction much more frequently than those who identified as Black or African American and White, as displayed in the figure below (Other: 60%, 90%; Black/African American: 58%, 61%; White: 56%, 54%).

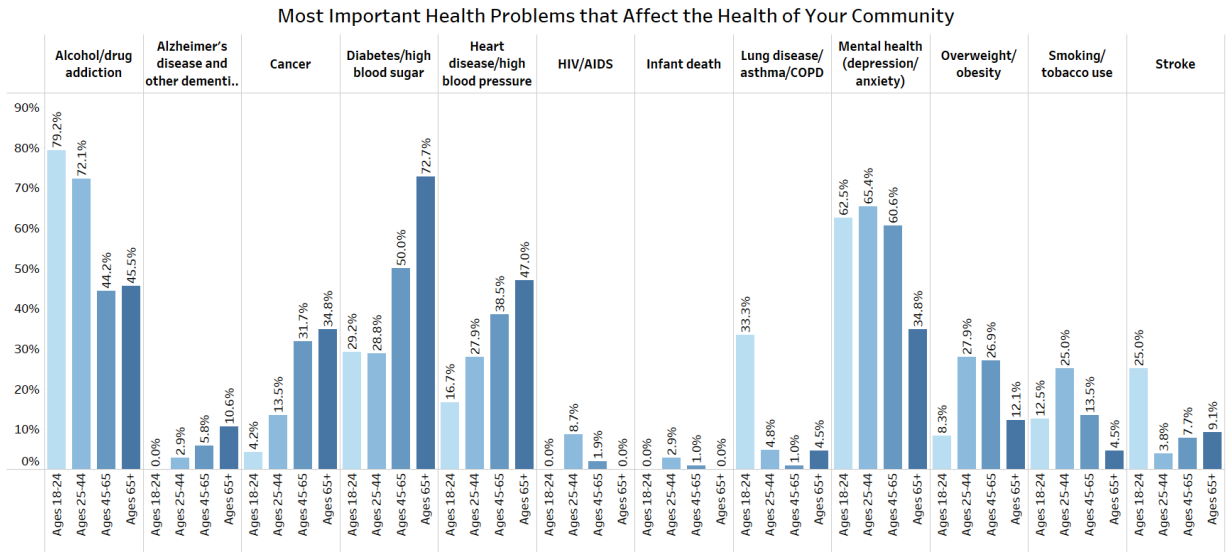
[28] Includes those who identified as American Indian and Alaska Native, Asian, Native Hawaiian and other Pacific Islander, and/or those who selected more than one race or "other."

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



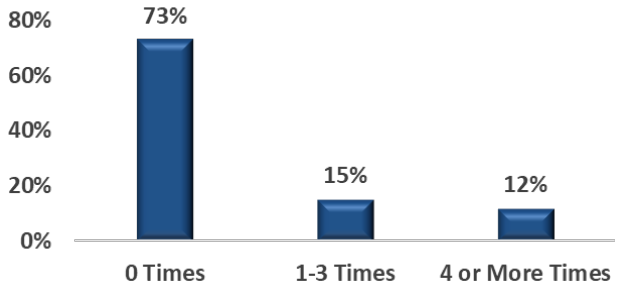
Similarly, there were differences in responses across age groups. Younger people identified alcohol/drug addiction and mental health as more significant than older respondents. These perceived differences by demographic characteristics may be important in planning efforts to address behavioral health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

Figure 26: What are the three most important health problems that affect the health of your community? Please select up to three. (by age group)



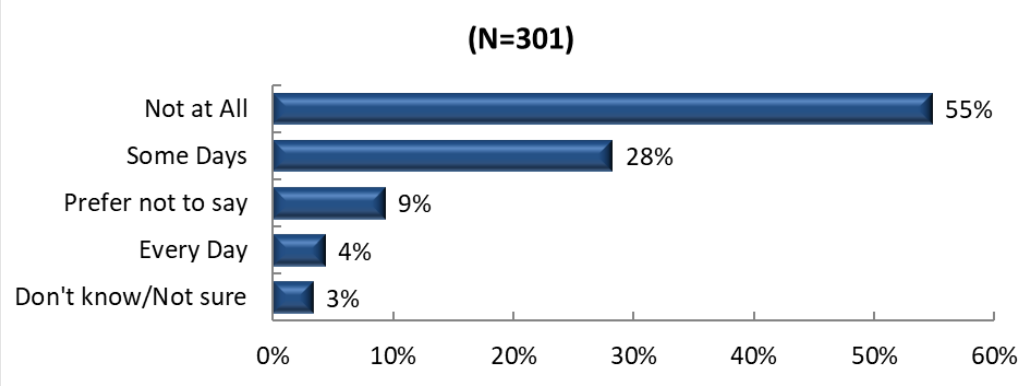
When respondents were asked about their own substance use, one-quarter of respondents reported drinking enough to meet the definition of "binge drinking" at least once in the past 30 days, with an average of one occasion of binge drinking in the past month among all respondents.

Figure 27: Considering all types of alcoholic beverages, how many times during the past 30 days did you have 4 (females)/ 5 (males) or more drinks on an occasion?



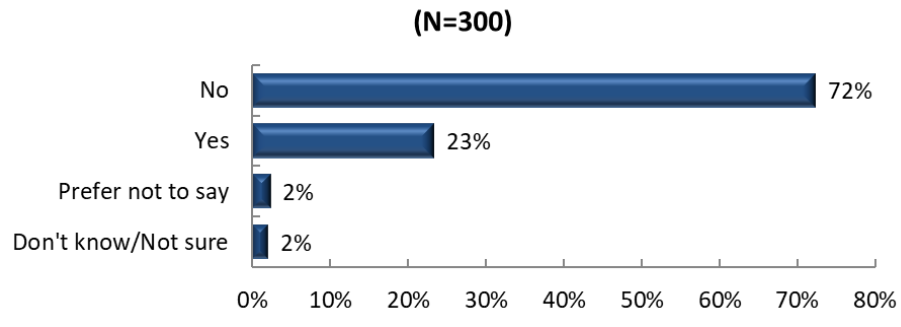
Of those respondents who indicated that they did consume alcohol, 28% reported a frequency of "some days".

Figure 28: How often do you consume any kind of alcohol product, including beer, wine or hard liquor?



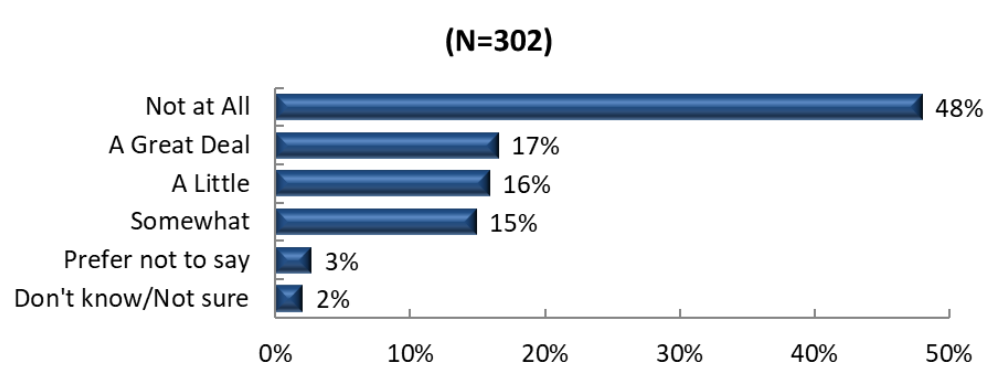
Further, nearly 25% of community member respondents reported personal or household misuse of prescription drugs.

Figure 29: 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)?



When asked the degree to which personal or someone else's substance abuse negatively impacted their life, 17% selected "a great deal", the second most frequent response, highlighting the impact of substance use in the community.

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



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

Primary Data Findings – Focus Groups

Focus group participants identified substance use as a significant concern affecting both youth and adult populations in Hoke County. For youth, participants specifically highlighted concerns about alcohol, tobacco, and CBD vaping behaviors. The lack of addiction recovery programs and harm reduction services was noted as a major gap in addressing substance use disorders in the community. Gang violence was also mentioned as an associated concern that compounds substance use challenges in the area.

Participants emphasized the need for expanded access to counseling services and substance use treatment programs. Specific recommendations included providing more community health education classes focused on substance use prevention, increasing the availability of harm reduction services, and developing youth-focused prevention and intervention initiatives.

Additionally, participants suggested strengthening partnerships between healthcare providers, social services, and community organizations to create more comprehensive support systems for those struggling with substance use disorders.
For a more detailed description of focus group findings, see **Appendix 5**.

PRIORITY NEED: HEALTHCARE ACCESS & QUALITY

Context and National Perspective

Access to care means patients are able to get high quality, affordable healthcare in a timely fashion to achieve the best possible health outcomes. It includes several components, including coverage (i.e. insurance), a physical location where care is provided, the ability to receive timely care, and enough providers in the workforce. The CHNA Steering Committee identified access to care as a high priority need for residents of Hoke 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.[29] Access is a challenge even for those who are insured.[30]

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.[31] Access issues are anticipated to increase in coming years. Growing shortages of both nurses and doctors are being driven by several factors, including population growth, the aging U.S. population requiring higher levels of care, provider burnout (physical, mental and emotional exhaustion) made worse by the COVID-19 pandemic, and a lack of clinical training programs and faculty – particularly for nurses.[32] 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.[33] 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.[33]

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

[29] 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.
[30] 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.
[31] 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 .
[32] 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 .
[33] Source: AAMC (2021). *North Carolina physician workforce profile*. Retrieved September 9, 2024, from: https://www.aamc.org/media/58286/download.

areas (rural areas; tribal communities), members of the LGBTQIA+ community, and certain age groups – particularly the very young or the very old.[34] 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.[35] Both primary and secondary data resources analyzed for this report highlight the need for greater access to health services within Hyde County.

Secondary Data Findings

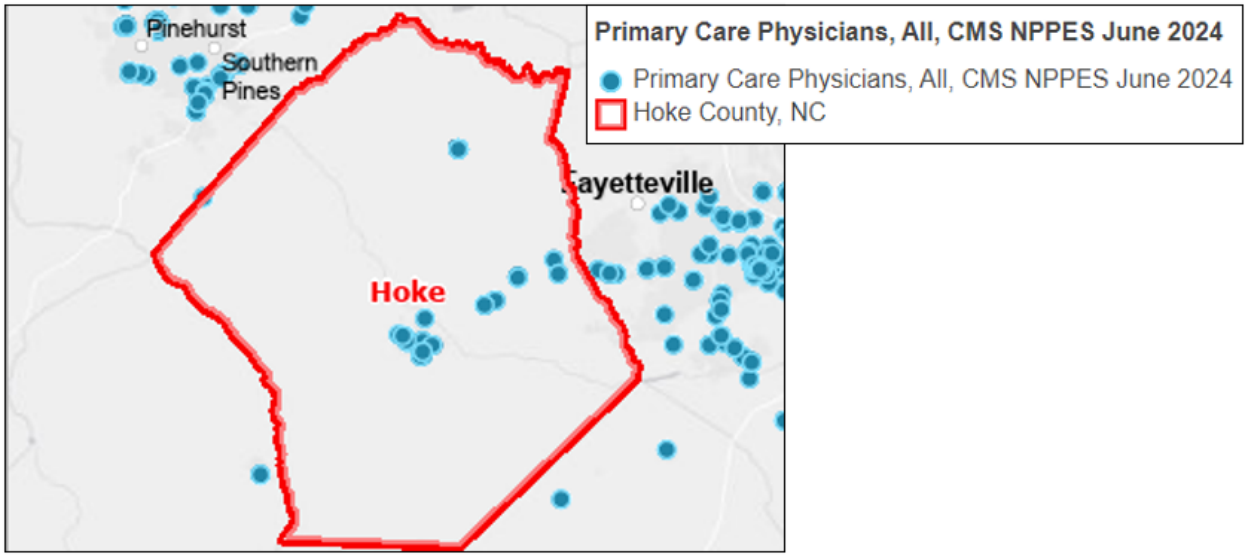
Secondary data analysis revealed significant healthcare access challenges in Hoke County. The county has lower than state average rates across multiple provider types, as shown in the table below. Of particular concern are the rates of dental providers (25.0 per 100,000 population compared to state rate of 31.5), mental health providers (97.9 compared to 155.7), and primary care providers (61.4 compared to 101.1). Access to primary care providers located in Hoke County is further complicated by their geographic distribution, which is largely limited to the central part of the county, as shown in the map below. Additionally, 45% of the county's population lives in an area designated as a Dental Health Professional Shortage Area (HPSA), significantly higher than both state (34%) and national (18%) averages.

Table 18: Access to Care Indicators

Indicator	Hoke County	North Carolina	United States
Dental Providers (Rate per 100,000 Population)	25.0	31.5	39.1
Mental Health Providers (Rate per 100,000 Population)	97.9	155.7	178.7
Primary Care Providers (Rate per 100,000 Population)	61.4	101.1	112.4
Percentage of Population Living in an Area Affected by a Dental Care HPSA	45%	34%	18%
Percent of Insured Population Receiving Medicaid	26%	20%	22%
Rate of Federally Qualified Health Centers (Rate per 100,000 Population)	5.8	4.0	3.5

[34] 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.
[35] 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.

Figure 31: Distribution of Primary Care Physicians



Insurance coverage patterns in Hoke County also indicate potential access challenges. The county has a higher percentage of the population receiving Medicaid (26%) compared to state (20%) and national (22%) averages. While the county has a higher rate of Federally Qualified Health Centers (5.8 per 100,000 population) than the state average (4.0), geographic distribution of these facilities may affect accessibility for some residents.

Transportation poses an additional barrier to healthcare access. While the county has a slightly lower percentage of households with no motor vehicle (5.0%) compared to the state average (5.4%), public transit options are limited. Only 1.0% of the population uses public transit for commuting, and none of the population lives within a half-mile of public transit options, compared to 10.9% statewide.

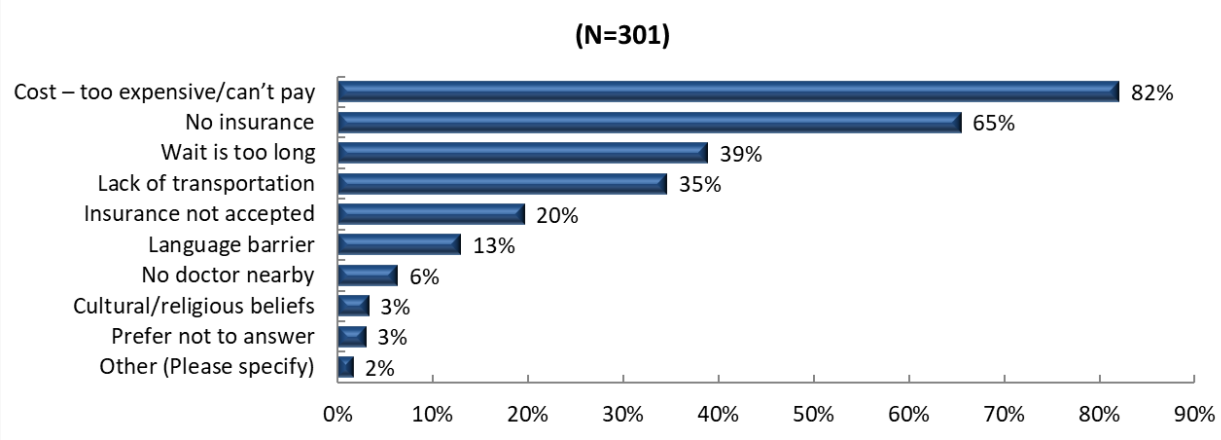
Table 19: Transportation and Transit Options

Indicator	Hoke County	North Carolina	United States
Households with No Motor Vehicle, Percent	5.0%	5.4%	8.3%
Percent Population Using Public Transit for Commute to Work	1.0%	0.8%	3.8%
Percentage of Population within Half Mile of Public Transit	0.0%	10.9%	34.8%

Primary Data Findings – Community Member Web Survey

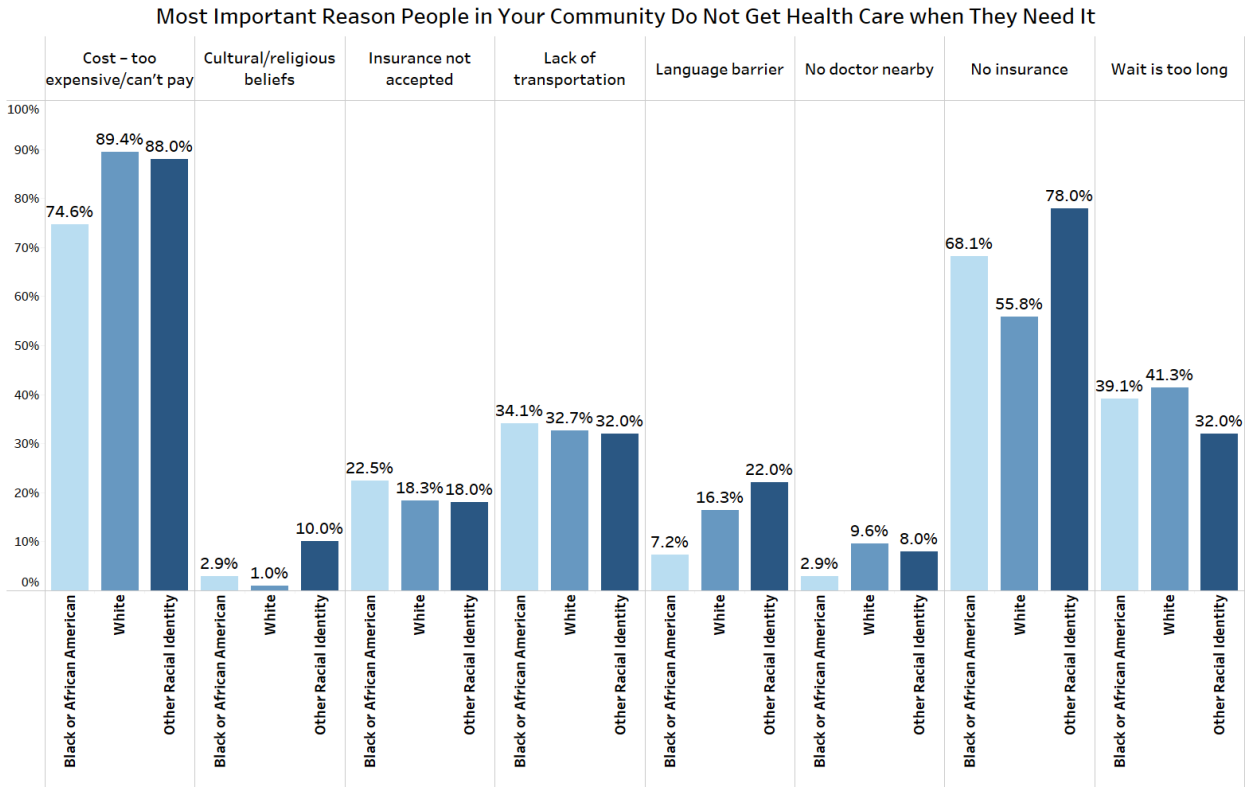
Respondents identified several access to care needs in Hoke County. In the survey, community members were asked to identify the top barriers to receiving healthcare. Cost (82%), no insurance (65%), and long wait times (41%) were the top three identified reasons why people in the community are not getting care when they need it. Another third of responses identified lack of transportation and a quarter of responses indicated insurance not being accepted as the top barriers to care.

Figure 32: What are the three most important reasons people in your community do not get health care when they need it? Please select up to three.



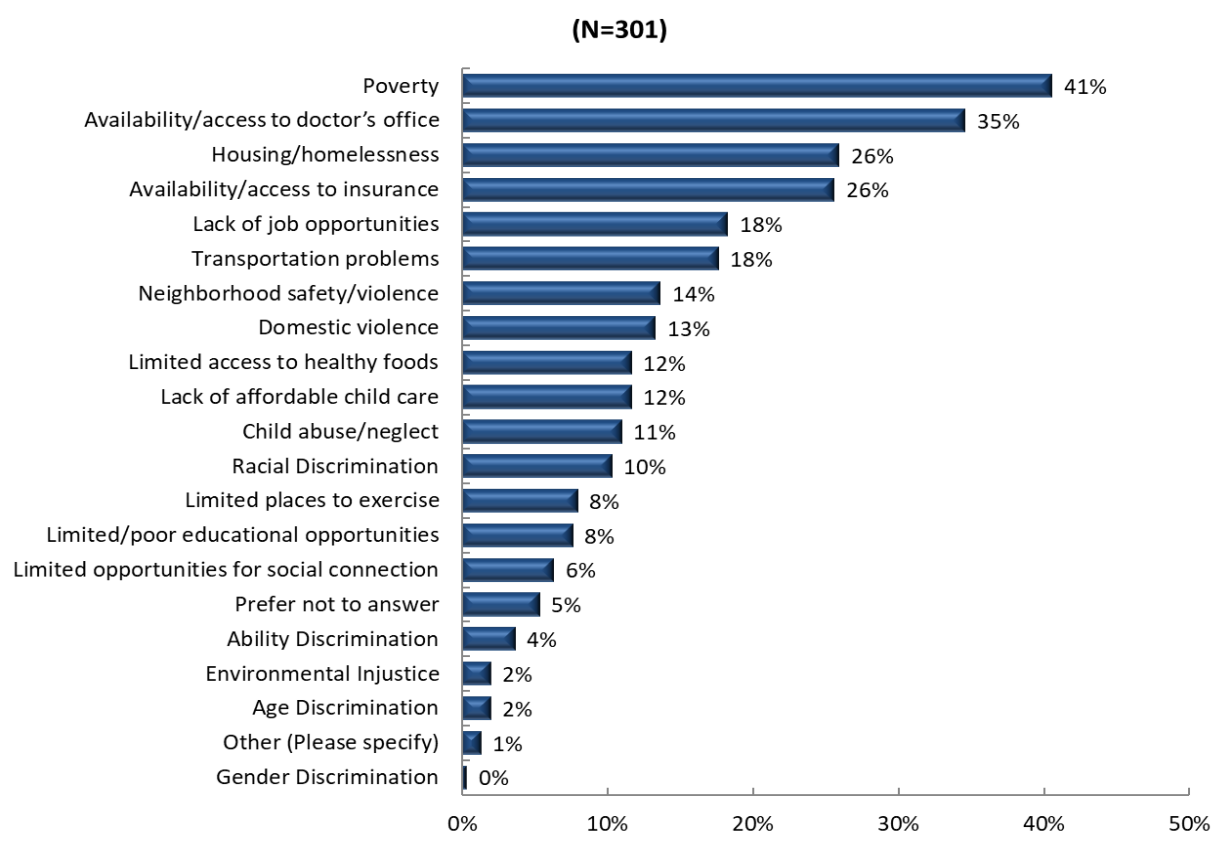
When these data were examined by age group, the youngest respondents, those aged 18 to 24 (88%) were slightly more likely to indicate cost than all other age groups that most frequently identified cost, while those aged 45 to 65 were the most likely age group to cite lack of insurance (71%). Responses also differed by race. Respondents identifying as White (89%) or with other racial categories (88%) noted cost as a top barrier to healthcare compared to 75% of respondents identifying as Black/African American. Similarly, a higher percentage of respondents identifying with other racial categories (78%) indicated lack of insurance than the percentages of respondents identifying as Black/African American (68%) and White (56%).

Figure 33: What are the three most important reasons people in your community do not get health care when they need it? Please select up to three. (by race)



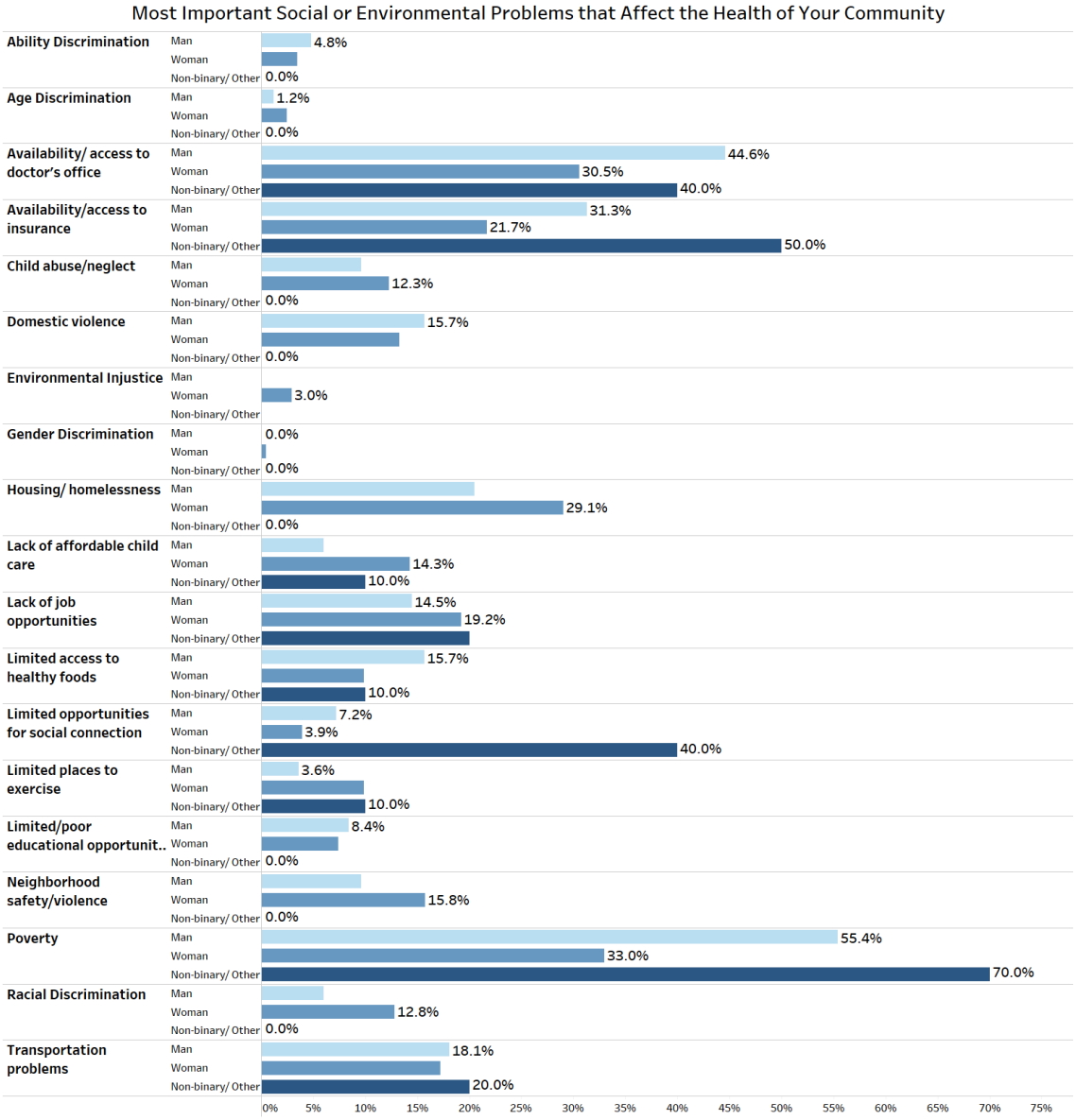
Community members were also asked to identify the most important social or environmental problems that affect the health of the community. As displayed in the figure below, the second most frequent problem identified was the availability or access to doctor's offices (35%), again highlighting access to care challenges within the community. Transportation (18%) was identified as the sixth most frequent social or environmental problem that affects the health of the community.

Figure 34: What are the three most important social or environmental problems that affect the health of your community? Please select up to three.



Notably, men, women, and "other" gender (transgender or non-binary) respondents differed in their selections. More men and non-binary individuals identified availability and access to doctor's offices, availability and access to insurance, and transportation problems as top social and environmental problems (men: 45%, 31%, 18%; non-binary: 40%, 50%, 20%; women: 31%, 22%, 17%). Responses also varied by race. Those identifying with other racial identities were more likely to cite availability of doctor's offices and availability or access to insurance than respondents identifying as Black/African American and White (Other: 50%, 40%; Black or African American: 28%, 23%; White: 37%, 23%).

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



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

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

Participants identified multiple barriers to healthcare access in Hoke County, including high costs associated with insurance premiums, deductibles, and out-of-pocket expenses. Transportation emerged as a critical barrier, with limited public transportation options preventing many residents from accessing needed services. Long wait times, insufficient healthcare providers, and a lack of nearby healthcare

facilities further compound access challenges. Participants noted that marginalized populations feel particularly overlooked in healthcare planning and service delivery.

The Cape Fear Valley Medical Center healthcare workers focus group emphasized the need for low-cost health screenings and affordable transportation for patients. They also highlighted the importance of providing more reliable health information to help link patients with providers. The Hoke Hospital community member focus group identified several access barriers including fear of judgment and lack of urgent and emergency care services. They noted insurance challenges and a need for more specialists in the county. The overall cost of care was highlighted as a significant barrier.

Recommendations for improving healthcare access included providing affordable transportation services for patients, offering low-cost health screenings, and implementing mobile health services. Participants suggested expanding childcare resources to support working families' ability to access healthcare services. Additional recommendations included increasing staff engagement in the community, providing more reliable health information to help link patients with providers, and developing strategies to enhance transportation access. Participants emphasized the importance of making healthcare delivery more proactive rather than reactive, with a greater focus on prevention and wellness.

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

PRIORITY NEED: PHYSICAL HEALTH – CHRONIC DISEASE MANAGEMENT

Context and National Perspective

Physical health is the monitoring and maintenance of the human body. There are many factors involved in an individual's overall physical health status, such as disease prevention, timely access to primary and preventive healthcare, exercise, and maintaining a healthy diet. Living a healthy lifestyle is not a one size fits all approach, and many individuals choose to incorporate different healthy behaviors at different times, slowly building more and more healthy habits. The CDC recommends multiple healthy behaviors that can be integrated for healthier living, such as getting enough sleep, moving more and sitting less, limiting alcohol intake, and eating healthy food. Sleep needs can vary from person to person; however, the CDC recommends that an adult gets at least 7 hours of regular sleep. Another healthy behavior that can be incorporated is movement, starting at least 20 minutes a day with some light activity, such as walking or dancing. [36]

Another form of healthy living and disease prevention is taking a proactive role in preventative health care, which can often start with one's diet. According to experts, losing just 5-10 % of one's current weight can lower the risk for multiple chronic conditions such as diabetes, arthritis, cancer, and high blood pressure. When speaking with a primary doctor, or a nutritionist about creating a healthy diet, it is important to have some information prepared, such as food allergies, health goals, the types of medication taken, and any other health concerns that one may have. When considering a diet for weight loss, ensuring that the diet is both filling and matches a daily activity level is key. When implementing a new diet, there are a few recommendations for success. First, eating when hungry and stopping when full is key, and choosing to eat filling foods that one might enjoy, such as one's favorite vegetables, fruit, or

[36] Source: Centers for Disease Control and Prevention. (2023). *Taking care of your body.* Retrieved October 3, 2024 from: https://www.cdc.gov/howrightnow/taking-care/index.html

lean protein. Secondly, seasoning the food with different herbs and spices, and reducing the amount of salt and sugar in a recipe if possible. Finally, drinking enough water throughout the day helps with digestion and other body functions.[37]

When considering healthy living in rural communities, research has shown that just one in four adults in rural areas are consistently performing at least four healthy behaviors.[38] Rural areas often have fewer or less diverse grocery stores, with many relying on smaller general stores, which may not always have fresh produce and meat. Additionally, these areas may also not have safe places to walk or exercise, such as sidewalks, recreation centers, or parks.

In North Carolina, over half (52%) of adults do not get at least two and a half hours of moderate exercise per week, and over 70% don't meet weekly muscle strengthening recommendations. However, 84% of adults eat at least one vegetable a day, and over 60% eat fruit at least once a day.[39] North Carolina's Department of Health and Human Services has implemented several workshops and classes that individuals can take to learn healthy habits, such as Living Healthy workshops. Additionally, several nonprofits have implemented programs to help individuals learn healthy behaviors, and North Carolina also has an extensive WIC program, as well as the NCCares 360 program, which seeks to connect individuals with all necessary resources for living a healthier life.

Secondary Data Findings

Secondary data identified chronic disease management as a significant health concern in Hoke County, with the county performing worse than state averages on multiple chronic disease indicators. The county has higher rates of adults with various chronic conditions, including asthma (10.6% vs. 9.8% state), diabetes (9.9% vs. 9.0%), hypertension (35.8% vs. 32.1%), and stroke (3.7% vs. 3.1%).

Table 20: Chronic Disease Prevalence

Indicator	Hoke County	North Carolina	United States
Adults (Age 18+) with Asthma	10.6%	9.8%	9.7%
Adults (Age 20+) with Diagnosed Diabetes	9.9%	9.0%	8.9%
Adults (Age 18+) Ever Diagnosed with Coronary Heart Disease	6.0%	5.5%	5.2%

[37] Source: U.S. Department of Veterans Affairs. (2023). *Healthy living overview.* Retrieved October 10th, 2024 from https://www.prevention.va.gov/Healthy_Living/index.asp
[38] Source: CDC (n.d.) *Health behaviors in rural America.* Retrieved October 3, 2024 from https://www.cdc.gov/rural-health/php/public-health-strategy/public-health-considerations-for-health-behaviors-in-rural-america.html#:~:text=People%20living%20in%20rural%20areas,and%20getting%20regular%20health%20screenings.
[39] Source: Eat Smart Move More North Carolina. (2017). *The roles of nutrition and physical activity in Chronic Disease in North Carolina.* Retrieved October 23, 2024 from https://www.communityclinicalconnections.com/wp-content/themes/cccph/assets/downloads/2024/07/factsheets/Physical/CCCPHB_FactSheet_HealthyEating-0724.pdf

Adults (Age 18+) with Hypertension	35.8%	32.1%	29.6%
Adults (Age 18+) with High Cholesterol	31.7%	31.4%	31.0%
Adults (Age 18+) with Kidney Disease	3.4%	2.9%	2.7%
Adults (Age 18+) Ever Having a Stroke	3.7%	3.1%	2.8%
Adults with BMI > 30.0 (Obese)	31.6%	29.7%	30.1%
Adults (Age 18+) with Poor Dental Health	15.1%	12.0%	13.9%
Percent Reporting Poor or Fair Health	18.1%	14.4%	-

Environmental factors that influence chronic disease management show room for improvement. The county has fewer recreation and fitness facilities (7.7 per 100,000 population) compared to state (13.1) and national (14.7) averages. Just 58% of the population has access to exercise opportunities, significantly lower than state (73%) and national (84%) averages. The food environment presents additional challenges, with fewer grocery stores (11.5 per 100,000 population) compared to state (18.7) and national (23.4) averages, though the county has a lower rate of fast-food establishments (34.6) compared to state (77.4) and national (96.2) averages. Physical inactivity is also higher in Hoke County (25.6%) compared to the state average (21.6%).

Table 21: Physical Activity and Food Environment Indicators

Indicator	Hoke County	North Carolina	United States
Recreation and Fitness Facility Establishments, (Rate per 100,000 Population)	7.7	13.1	14.7
Walkability Index Score	5	7	10
% Physically Inactive	25.6	21.6	-
Percentage of Population with Access to Exercise Opportunities	58%	73%	84%
Food Environment - Fast Food Restaurants Establishments (Rate per 100,000 Population)	34.6	77.4	96.2
Food Environment - Grocery Stores Establishments (Rate per 100,000 Population)	11.5	18.7	23.4

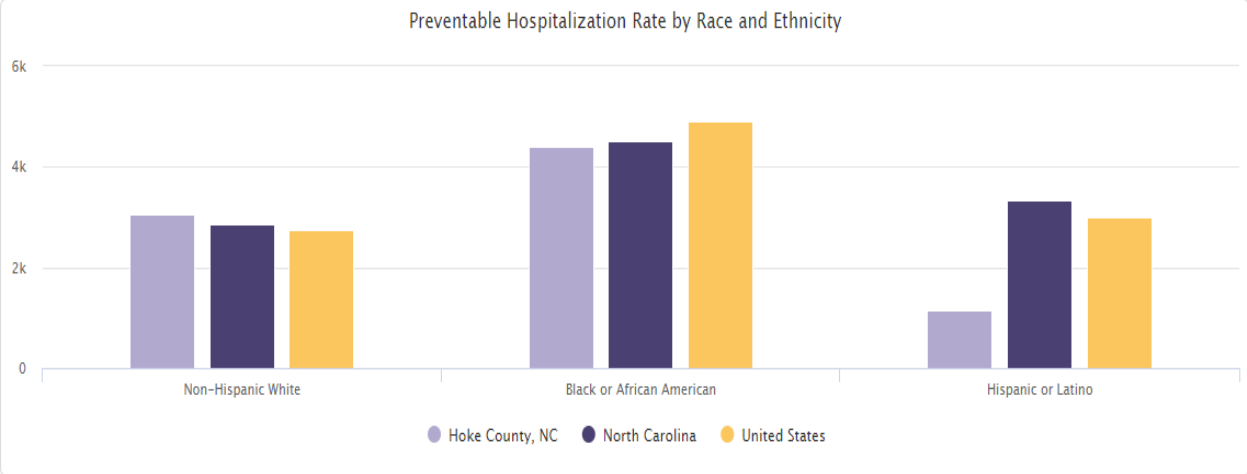
The county's emergency department utilization rate (802 visits per 1,000 population) is substantially higher than both state (563) and national (535) averages, which may indicate challenges in chronic disease management and primary care access.

Table 22: Emergency Department Utilization and Hospitalization Rates

Indicator	Hoke County	North Carolina	United States
Emergency Room Visits (Rate per 1,000 Population)	802	563	535
Cardiovascular Disease Hospitalizations (Rate per 1,000 Population)	11.4	11.7	10.4
Ischemic Stroke Hospitalizations (Rate per 1,000 Population)	10.3	9.5	8.0

Preventable hospital stays, which often indicate challenges in chronic disease management, show significant racial disparities in the county. The rate among Black Medicare beneficiaries (4,398 per 100,000) was substantially higher than among White Medicare beneficiaries (3,045 per 100,000). The county's overall rate of preventable hospitalizations (3,680 per 100,000 beneficiaries) exceeds both state (2,957) and national (2,752) averages.

Figure 36: Preventable Hospital Stays by Race/Ethnicity



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

Primary Data Findings – Community Member Web Survey

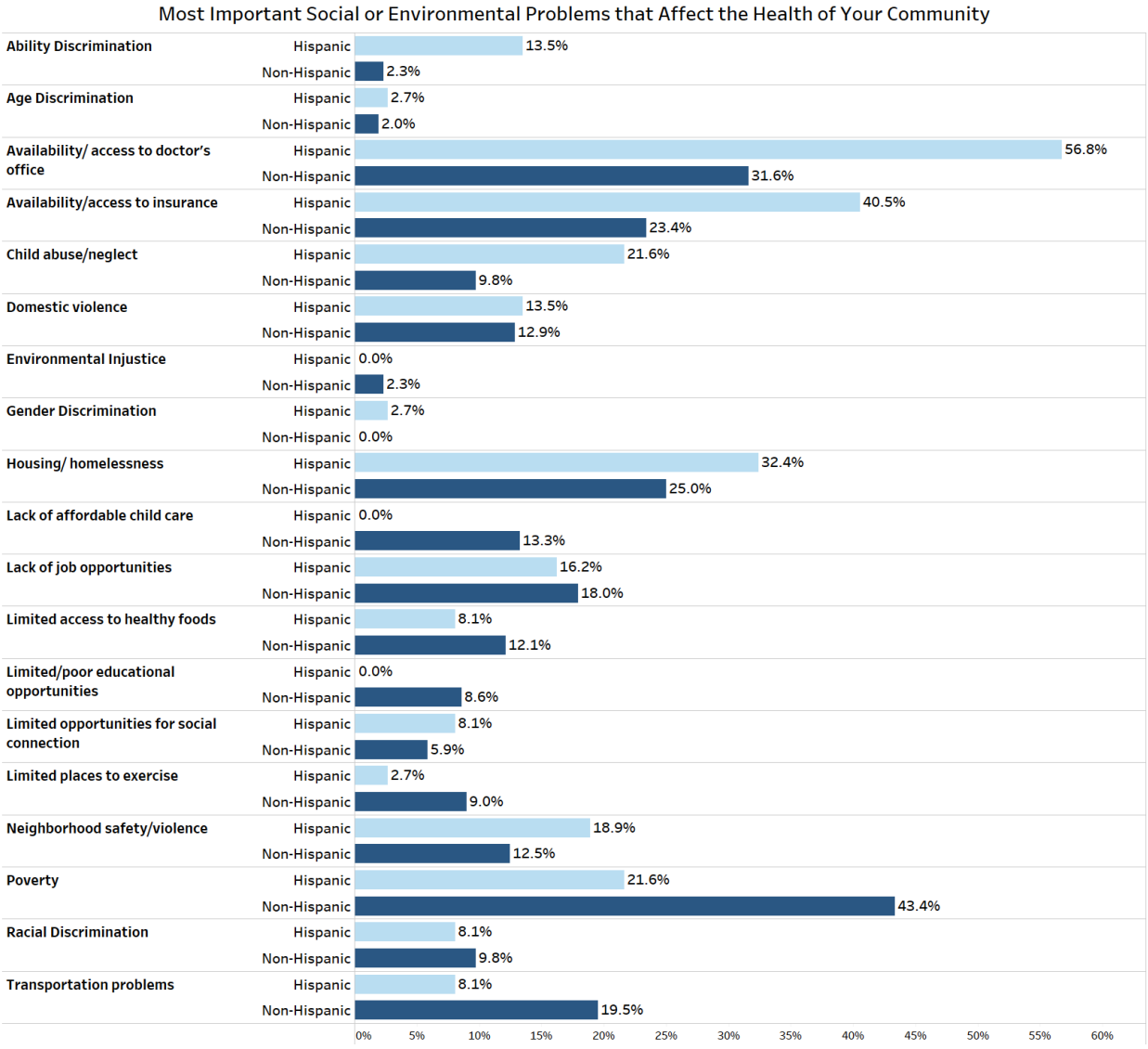
Hoke County residents identified several chronic health conditions of concern in the community in the web survey. In fact, seven out of the top 10 most frequently identified community health needs were chronic health conditions with the top being diabetes/high blood sugar (46% of respondents), followed by heart disease/high blood pressure (35%). A quarter of respondents also identified overweight/obesity

as an important community health problem, as previously shown in **Figure 24** in the Behavioral Health – Substance Misuse section.

When these results were examined by various demographics of the respondents, responses varied. Older adults viewed diabetes and heart disease as more significant problems than younger respondents, as previously displayed in **Figure 26** in the Behavioral Health – Substance Misuse section. Respondents identifying as Black or African American identified diabetes/high blood sugar more frequently than respondents identifying as White and all other races, whereas respondents identifying as White were most likely to indicate obesity as a health concern. Men and women were also much more likely to identify diabetes and heart disease as important community health problems than "other" gender identity respondents. Considering these differences in targeted efforts to address specific community health indicators may be important.

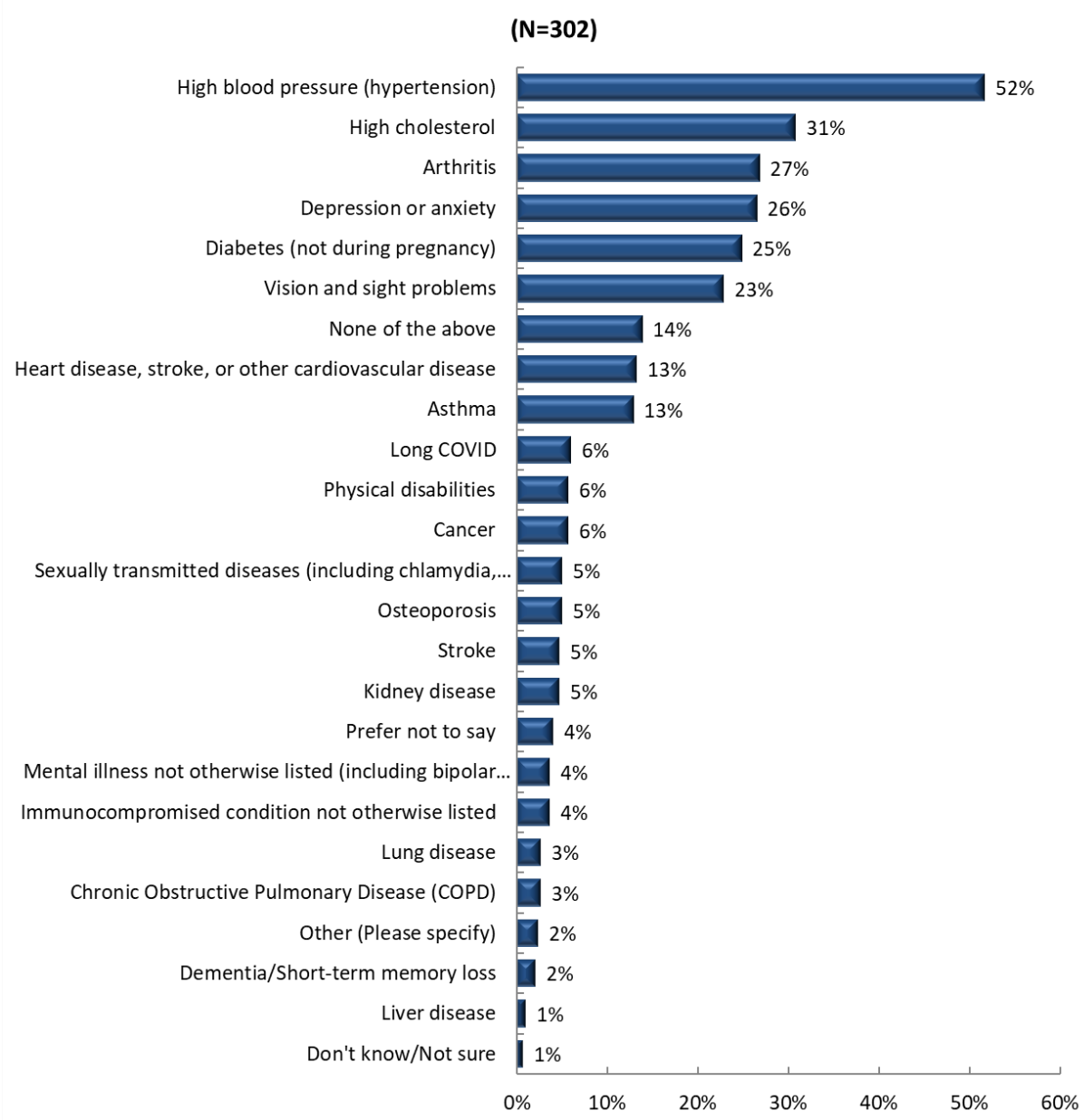
In terms of community perspectives on health behaviors and food security, 12% of Hoke County respondents viewed limited access to healthy foods as an important social or environmental problem in the community and 8% identified limited places to exercise. Men were more likely to view limited access to healthy foods as a top concern (16% compared to 10% for women and "other" gender individuals). Hoke County respondents were asked questions regarding their own experience with food security. Notably, non-Hispanic/Latino respondents more frequently selected limited access to healthy foods (12% vs. 8%) and limited places to exercise (9% vs. 3%) compared to Hispanic/Latino respondents.

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



When asked about their overall physical health, 20% of respondents described it as "fair". Moreover, 52% of respondents reported having been told by a health professional that they have high blood pressure, and 31% of respondents reported having high cholesterol, contributing factors to chronic health conditions. Equally concerning, one-quarter of respondents also indicated having diabetes as a result of factors unrelated to pregnancy.

Figure 38: 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



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

Primary Data Findings – Focus Groups

Focus group participants highlighted the prevalence of chronic conditions including diabetes, hypertension, heart disease, and obesity as pressing health concerns in Hoke County. Managing these conditions is particularly challenging due to financial and logistical constraints. Food access and security were identified as significant barriers to maintaining healthy lifestyles, with many residents unable to

access or afford nutritious food. The built environment, including a lack of sidewalks and playgrounds, was noted as an additional barrier to physical activity and healthy living.

Suggested solutions focused on both prevention and management strategies. Participants recommended organizing more community events to promote health awareness and education, establishing community gardens, and improving the built environment to support physical activity. Additional suggestions included providing chronic disease management education classes, expanding access to affordable healthy food options, and creating more opportunities for physical activity through enhanced recreational facilities. Participants also emphasized the importance of providing support resources to help residents better manage their chronic conditions, including transportation assistance to medical appointments and affordable medication access programs.

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 Hoke County that provide resources to address general community health needs, as well as the county's 2024 priority need areas: Healthcare Access and Quality, Physical Health, and Substance Use.

Category	Organization Name
Healthcare Facilities	• **Hoke County Health Department**: Provides services including WIC, immunizations, and family planning. (683 E. Palmer St., Raeford, NC 28376, (910) 875-3717) • **Hoke Family Medical Center**: Offers primary care services. (405 S. Main St., Raeford, NC 28376, (910) 615-5800) • **Hoke Primary Care**: Comprehensive health services. (300 Medical Pavilion Dr., Suite 102, Raeford, NC 28376, (910) 904-8025) • **FirstHealth of the Carolinas - Hoke**: Provides a variety of medical services. (313 Teal Dr., Raeford, NC 28376, (910) 878-6700) • **Goshen Medical Center**: 102 Southern Avenue, Raeford, NC 28376, (910) 248-4600)
Community Services	• **Hoke County Partnership for Children and Families**: Focuses on early childhood education and family support. (1089 East Central Ave., Raeford, NC 28376, (910) 875-5893) • **Hoke County Domestic Violence and Sexual Assault Center**: Provides support and resources for individuals affected by domestic violence and sexual assault. (225 S Main St., Raeford, NC 28376, (910) 878-0118)
Priority Need: Substance Use	• **Tia Hart Community Recovery Organization:** 116 E. Elwood Avenue., Raeford, NC 28376, (910) 875-8424)

CHAPTER 5 | NEXT STEPS

The CHNA findings are used to develop effective community health improvement strategies to address the priority needs identified throughout the process. The next and final step in the CHNA process is to develop community-based health improvement strategies and action plans to address the priorities identified in this assessment. Health leaders in Hoke County will leverage information from this CHNA to develop implementation and action plans for their local community, while also working together with other community partners to ensure the priority need areas are being addressed in the most efficient and effective way. Hoke County leaders recognize that the most effective strategies will be those that have the collaborative support of community organizations and residents. The strategies developed will include measurable objectives through which progress can be measured.

APPENDIX 1 | STATE OF THE COUNTY HEALTH REPORT

Results-Based Accountability Framework

To meet North Carolina accreditation requirements, LHDs are required to track progress on their implementation plans by publishing an annual State of the County Health Report (SOTCH). The SOTCH is guided by the Clear Impact Results-Based Accountability (RBA) Framework™ and demonstrates that the LHD is tracking priority issues identified in the community health (needs) assessment process, identifying emerging issues, and implementing any relevant new initiatives to address community concerns.[40]

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

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

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

State of the County Health Report

HNC 2030 Scorecard: Hoke County (2021-2024)

We strive to promote Healthy People, a Healthy Environment for Healthy Communities within and surrounding Hoke County, through recognizing, valuing, and pursuing health and overall wellness.

This scorecard tells the story of the work that is happening in Hoke County as it related to the health priorities (listed below) that were identified in the 2021 Hoke County Community Health Assessment.

- Chronic Disease
- Behavioral Health
- Promotion of Health Equity

Below are the table of icons that are used throughout the scorecard.

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

Community Health Needs Assessment

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

Chronic Disease

All people in Hoke County have long and healthy lives.	Time Period	Current Actual Value	Current Trend	Baseline % Change
NCDPH HNC2030 Life Expectancy (Total) in North Carolina: Average number of years of life remaining for people who have attained a given age.	2022	76.2	↗ 1	-2% ↘
Life Expectancy (Total) in Hoke County: Average number of years of life remaining for people who have attained a given age.	2022	72.5	↘ 6	-7% ↘
NCDPH HNC2030 Sugar-Sweetened Beverage (SSB) Consumption Among Adults in NC: % of Adults (Total) reporting consumption of one or more sugar-sweetened beverages (SSBs) per day.	2022	36.8%	↗ 1	12% ↗
NCDPH HNC2030 Percent of Adults Using Tobacco in North Carolina (Total)	2022	21.6%	↗ 1	-10% ↘

Diabetes Self-Management Program	Time Period	Current Actual Value	Current Trend	Baseline % Change
better off % of individuals receiving chronic disease education who self report positive behavior changes	2024	18	↗ 4	125% ↗
how much # of individuals receiving diabetes self-management through support groups	2024	12	↗ 2	50% ↗
how much # of participants receiving nutrition education	–	–	–	–

Tobacco Prevention and Education Program	Time Period	Current Actual Value	Current Trend	Baseline % Change
how much # of individuals using QuitlineNC	2024	6	→ 1	20% ↗
how much # of tobacco cessation media messages provided	2024	36	↗ 2	200% ↗

Behavioral Health

All people living in Hoke County have equitable access to compassionate mental health, addiction and recovery support services.	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% ↗
NCDPH HNC2030 Drug Poisoning Death Rate by in NC by gender (Female)	2022	26.2	↗ 3	134% ↗
NCDPH HNC2030 Drug Poisoning Death Rate by in NC by gender (Male)	2022	58.3	↗ 4	255% ↗
Hoke County Drug Poisoning Deaths Total per 100,000 population	2022	44.9	↗ 7	259% ↗
NCDPH HNC2030 Suicide Rate (TOTAL) in North Carolina (per 100,000)	2022	14.4	↗ 1	11% ↗
Hoke County Self Harm (Suicide Rate) Total per 100,000 population	2022	21.9	↗ 1	86% ↗
Overall Firearm Deaths by Suicide: Rates in Hoke County	2020	26	↗ 1	65% ↗
Overall Firearm Deaths by Homicide: Rates in Hoke County	2020	18	↗ 2	61% ↗

Hoke Syringe Service Program	Time Period	Current Actual Value	Current Trend	Baseline % Change
how much # of syringes distributed	2024	2,650	↘ 1	657% ↗
how much # of outreach events held	2024	34	↗ 5	1600% ↗
how much # of individuals served	2024	68	↗ 5	3300% ↗
how much # of syringes collected	2024	2,230	↘ 1	643% ↗

Applied Suicide Intervention Skills Training (ASIST)	Time Period	Current Actual Value	Current Trend	Baseline % Change
how much # of individuals trained in ASIST	2024	82	↗ 2	583% ↗
how much # of gun locks distributed	2024	290	↗ 2	73% ↗
how much # of outreach events	2024	26	↗ 2	117% ↗

Counseling on Access to Lethal Means (CALM)	Time Period	Current Actual Value	Current Trend	Baseline % Change
how much # of individuals trained in CALM	2024	18	↘ 1	-25% ↘

Firearm Safety Team	Time Period	Current Actual Value	Current Trend	Baseline % Change

how much	# of gun locks distributed	2024	290	↗ 2	73% ↗
how much	# of partners as members of Firearm Safety Team	2024	22	↗ 2	175% ↗
how much	# of Firearm Safety Team meetings held	2024	3	↘ 2	-40% ↘

Promotion of Health Equity

All people in Hoke County have equitable access to healthcare.

	Time Period	Current Actual Value	Current Trend	Baseline % Change
NCDPH HNC2030 Uninsured: % of North Carolina population under age 65 without health insurance (Total) - SAHIE	2022	11.2%	↘ 3	-26% ↘
Uninsured: % of Hoke County population under age 65 without health insurance (Total) - SAHIE	2022	11.2	↘ 3	-31% ↘
NCDPH Number of counties in North Carolina where the primary care clinician to population ratio is less than 1:1500 (certified nurse midwives, nurse practitioners, and primary care physicians)	2022	77	→ 1	20% ↗
Ratio: Population to Primary Care Clinician (goal is less than 1:1500)	2022	1,557	↗ 1	-3% ↘

Behavior Health Referrals for People Receiving Clinical Care

Time Period	Current Actual Value	Current Trend	Baseline % Change

SOTCH Reports

2022 State of the County Health Report (SOTCH)

Time Period	Current Actual Value	Current Trend	Baseline % Change

2023 State of the County Health Report (SOTCH)

Time Period	Current Actual Value	Current Trend	Baseline % Change

APPENDIX 2 | SECONDARY DATA METHODOLOGY AND SOURCES

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

Methodology

All individual secondary data measures were grouped into six categories and 20 corresponding focus areas based on "common themes." In order to draw conclusions about the secondary data for Hoke County, its performance on each data measure was compared to targets/benchmarks. If Hoke 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 23: 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 24: 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 25: 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 26: 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 27: 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 28: 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 29: 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 30: 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 Health Rankings & Roadmaps, June 2024.	2019

Measure	Description	Data Source	Most Recent Data Year(s)
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 31: Housing and Homelessness

Measure	Description	Data Source	Most Recent Data Year(s)
Renter Costs – Average Gross Rent	Average gross rent is the contract rent plus the estimated average monthly cost of utilities (electricity, gas, and water and sewer) and fuels (oil, coal, kerosene, wood, etc.) if these are paid by the renter (or paid for the renter by someone else). Gross rent provides information on the monthly housing cost expenses for renters. When the data is used in conjunction with income data, the information offers an excellent	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)
	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 definitions, homelessness is defined as lacking a fixed, regular, and	US Department of Education, EDFacts. Additional data analysis by CARES. 2019-2020. Data accessed via the	2019-2020

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

Table 32: 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
Children Below 200% FPL	Percentage of children living in households with income below 200% of the FPL. This indicator is relevant	U.S. Census Bureau, ACS. Data accessed via the	2018-2022

Measure	Description	Data Source	Most Recent Data Year(s)
	because poverty creates barriers to access including health services, healthy food, and other necessities that contribute to poor health status.	North Carolina Data Portal, June 2024.	
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 33: Length of Life

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

Measure	Description	Data Source	Most Recent Data Year(s)
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 34: Maternal and Infant Health

Measure	Description	Data Source	Most Recent Data Year(s)
Births with no or late prenatal care	Percentage of women who did not obtain prenatal care until the 7th month (or later) of pregnancy or who didn't have any prenatal care, as of all who gave birth during the three-year period from 2017 to 2019. This indicator is relevant because engaging in prenatal care decreases the likelihood of maternal and infant health risks. This indicator can also highlight a lack of access to preventive care, a lack of health knowledge, insufficient provider outreach, and/or social barriers preventing utilization of services.	CDC – National Vital Statistics System (NVSS). CDC WONDER. CDC, Wide-Ranging Online Data for Epidemiologic Research. Data accessed via the North Carolina Data Portal, June 2024.	2017-2019
Low birthweight (percent of live births with birthweight < 2500 grams)	Percentage of live births where the infant weighed less than 2,500 grams (approximately 5 lbs., 8 oz.). The numerator is the number of low birthweight infants born over a 7-year time span, while the denominator is the total number of births in a county during the same time.	National Center for Health Statistics – Natality Files. Data accessed via RWJF & UWPHI County Health Rankings & Roadmaps, June 2024.	2016-2022
Infant Mortality	Number of all infant deaths (within 1 year) per 1,000 live births. Data were	National Center for Health Statistics –	2015-2021

Measure	Description	Data Source	Most Recent Data Year(s)
	from the National Center for Health Statistics - Mortality Files (2015-2021) and are used for the 2024 County Health Rankings.	Natality and Mortality Files. Data accessed via RWJF & UWPHI County Health Rankings & Roadmaps, June 2024.	

Table 35: 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 36: Physical Health

Measure	Description	Data Source	Most Recent Data Year(s)
Poor or fair health (percent of adults reporting fair or poor health age-adjusted)	Percentage of adults in a county who consider themselves to be in poor or fair health. This measure is based on responses to the BRFSS question: “In general, would you say that your health is excellent, very good, good, fair, or poor?” The value reported in the County Health Rankings is the	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)
	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 told by a doctor, nurse, or other	CDC, BRFSS. Data accessed via the North Carolina Data Portal, June 2024.	2022

Measure	Description	Data Source	Most Recent Data Year(s)
	health professional that they have had a stroke.		
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 37: 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 38: 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 39: 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 40: 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 41: 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 42: Transportation Options and Transit

Measure	Description	Data Source	Most Recent Data Year(s)
Households with No Motor Vehicle	Percentage of households with no motor vehicle based on the latest 5-year American Community Survey estimates.	U.S. Census Bureau, ACS. Data accessed via the North Carolina Data Portal, June 2024.	2018-2022
Commuter Travel Patterns - Public Transportation	Percentage of population using public transportation as their primary means of commuting to work. Public transportation includes buses or trolley buses, streetcars or trolley cars, subway or elevated rails, and ferryboats.	U.S. Census Bureau, ACS. Data accessed via the North Carolina Data Portal, June 2024.	2018-2022
Community Design – Distance to Public Transit	Proportion of the population living within 0.5 miles of a GTFS (General Transit Feed Specification) or fixed-guideway transit stop. Transit data is available from over 200 transit agencies across the United States, as well as all existing fixed-guideway transit service in the U.S. This includes rail, streetcars, ferries, trolleys, and some bus rapid transit systems.	EPA – Smart Location Database. Data accessed via the North Carolina Data Portal, June 2024.	2021

APPENDIX 3 | SECONDARY DATA COMPARISONS

Description of Focus Area Comparisons

When viewing the secondary data summary tables, please note that the following color shadings have been included to identify how Hoke 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	Hoke County Description
	Low	Represents measures in which Hoke 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 Hoke 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 Hoke 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 Hoke County value was compared to the benchmark by calculating the percentage difference between the values, relative to the benchmark value:

(Hoke 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:

(7.9-7.5)/(7.5) x 100% = 5.3% = Displayed as **High Priority Level**, Shaded in Red

This metric indicates that the percentage of the population with limited access to healthy foods in Hoke County is 5.3 percent worse (or, in this case, higher) than the percentage of the population with limited access to healthy foods in the state of North Carolina.

Detailed Focus Area Benchmarks

Table 43: Access to Care

Measure	National Benchmark	North Carolina Benchmark	Hoke County Data	Most Recent Data Year	Hoke County Need
Primary Care Providers Ratio	112.4	101.1	61.4	2024	High
Mental Health Providers Ratio	178.7	155.7	97.9	2024	High
Addiction/Substance Abuse Providers Ratio	27.9	25.0	28.8	2024	Low
Buprenorphine Providers Ratio	15.5	15.2	3.6	2023	High
Dental Health Providers Ratio	39.1	31.5	25.0	2024	High
% Living in Health Professional Shortage Areas (HPSAs) – Dental Care	17.8%	34.0%	44.6%	2018-2022	High
Federally Qualified Health Centers (FQHCs)	3.5	4.1	5.8	2023	Low
% Receiving Medicaid	22.3%	20.2%	25.8%	2018-2022	High
% Uninsured	10.2%	12.5%	13.9%	2022	High

Table 44: Built Environment

Measure	National Benchmark	North Carolina Benchmark	Hoke County Data	Most Recent Data Year	Hoke County Need
Broadband Access (Access to DL Speeds >= 25MBPS and UL Speeds >= 3 MBPS)	93.8%	93.6%	88.3%	2023	High
Broadband Access (Access to DL Speeds >= 100MBPS and UL Speeds >= 20 MBPS)	91.2%	90.4%	84.0%	2023	High
Households with No Computer	6.1%	6.9%	10.4%	2018-2022	High

Measure	National Benchmark	North Carolina Benchmark	Hoke County Data	Most Recent Data Year	Hoke County Need
Households with No or Slow Internet	11.7%	13.0%	13.5%	2018-2022	Medium
Liquor Stores	13.3	6.2	Suppressed	2022	N/A
Adverse Childhood Experiences (ACEs)	N/A	N/A	Suppressed	2022	N/A

Table 45: Diet and Exercise

Measure	National Benchmark	North Carolina Benchmark	Hoke County Data	Most Recent Data Year	Hoke County Need
% Physically Inactive	N/A	21.6%	25.6%	2021	High
Walkability Index Score	10	7	5	2021	High
% with Access to Exercise Opportunities	84.1%	73.0%	58.0%	2023	High
Recreation and Fitness Facility Access	14.8	13.1	7.7	2022	High
Sugar-Sweetened Beverage (SSB) Consumption	N/A	N/A	36.8%	2022	N/A

Table 46: Education

Measure	National Benchmark	North Carolina Benchmark	Hoke County Data	Most Recent Data Year	Hoke County Need
% Limited English Proficiency	8.2%	4.6%	4.2%	2018-2022	Low
High School Graduation Rate	81.1%	87.6%	83.0%	2020-2021	High
% with No High School Diploma	10.9%	10.6%	11.1%	2018-2022	High
Student Math Proficiency	63.9%	65.8%	68.3%	2020-2021	Medium
Student Reading Proficiency	60.1%	59.5%	65.2%	2020-2021	High
School Funding Adequacy	N/A	-$4,742	-$5,937	2021	High
School Funding Adequacy –	N/A	$10,655	$10,406	2021	Medium

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

Table 47: Employment

Measure	National Benchmark	North Carolina Benchmark	Hoke County Data	Most Recent Data Year	Hoke County Need
Unemployment Rate	3.9%	3.7%	4.0%	2024	High
Average Annual Unemployment Rate, 2013-2023	3.6%	3.5%	4.4%	2024	High

Table 48: Environmental Quality

Measure	National Benchmark	North Carolina Benchmark	Hoke County Data	Most Recent Data Year	Hoke County Need
Flood Vulnerability	6.5%	4.9%	1.1%	2011	Low
Drinking Water Safety	16,107	194	0	2023	Low

Table 49: Family, Community and Social Support

Measure	National Benchmark	North Carolina Benchmark	Hoke County Data	Most Recent Data Year	Hoke County Need
Children Cost Burden	28.8%	27.0%	27.0%	2023	Medium
% Young People Not in School or Working	6.9%	7.5%	9.3%	2018-2022	High

Table 50: Food Security

Measure	National Benchmark	North Carolina Benchmark	Hoke County Data	Most Recent Data Year	Hoke County Need
% Food Insecure	10.3%	11.4%	13.3%	2021	High
% Food Insecure Children	13.3%	15.3%	19.8%	2021	High
% Low-Income and with Low Food Access	19.4%	21.3%	18.6%	2019	Low
% Limited Access to Healthy Foods	N/A	7.5%	7.9%	2019	High
Fast Food Restaurants	96.2	77.4	34.6	2022	Low
Grocery Stores	23.4	18.7	11.5	2022	High

Table 51: Housing and Homelessness

Measure	National Benchmark	North Carolina Benchmark	Hoke County Data	Most Recent Data Year	Hoke County Need
Renter Costs – Average Gross Rent	$1,366	$1,090	$983	2018-2022	Low
% Severe Housing Cost Burden	14.1%	12.2%	14.5%	2018-2022	High
Assisted Housing Units	413.9	319.2	136.6	2017-2021	Low
% Severe Substandard Housing	18.5%	16.1%	17.0%	2011-2015	High
% Homeless Children	2.8%	1.9%	1.4%	2019-2020	Low

Table 52: Income

Measure	National Benchmark	North Carolina Benchmark	Hoke County Data	Most Recent Data Year	Hoke County Need
Median Family Income	$92,646	$82,890	$70,671	2018-2022	High
Gender Pay Gap	81.0%	83.0%	81.0%	2018-2022	Medium
% Living Below 100% FPL	12.5%	13.3%	17.3%	2022	High
% Living Below 200% FPL	28.8%	31.6%	36.4%	2018-2022	High
% Children Living Below 200% FPL	37.2%	41.1%	42.0%	2018-2022	Medium
% Receiving SNAP	12.4%	15.7%	20.6%	2021	High
Children Eligible for Free/Reduced Price Lunch	51.7%	50.8%	98.5%	2022-2023	High

Table 53: Length of Life

Measure	National Benchmark	North Carolina Benchmark	Hoke County Data	Most Recent Data Year	Hoke County Need
Years of Potential Life Lost Rate	N/A	8,853	11,136	2019-2021	High
Premature Age-Adjusted Mortality	N/A	420	521	2019-2021	High
Life Expectancy	77.6	76.6	73.8	2019-2021	Medium

Table 54: Maternal and Infant Health

Measure	National Benchmark	North Carolina Benchmark	Hoke County Data	Most Recent Data Year	Hoke County Need
Births with Late or No Prenatal Care	6.1%	6.9%	Suppressed	2019	N/A
Low Birthweight	N/A	9.4%	9.5%	2016-2022	Medium
Infant Mortality Rate	5.7	7.0	8.0	2015-2021	High

Table 55: Mental Health

Measure	National Benchmark	North Carolina Benchmark	Hoke County Data	Most Recent Data Year	Hoke County Need
Poor Mental Health Days	4.9	4.6	4.9	2021	High
Deaths of Despair Rate	55.9	58.7	51.3	2018-2022	Low
Suicide Death Rate	14.5	14.0	13.2	2018-2022	Low

Table 56: Physical Health

Measure	National Benchmark	North Carolina Benchmark	Hoke County Data	Most Recent Data Year	Hoke County Need
% Poor or Fair Health	N/A	14.4%	18.1%	2021	High
% Adults with Asthma	9.7%	9.8%	10.6%	2022	High
% Adults with Heart Disease	5.2%	5.5%	6.0%	2022	High
% Adults with High Blood Pressure	29.6%	32.1%	35.8%	2021	High
% Adults with High Cholesterol	31.0%	31.4%	31.7%	2021	Medium
Diabetes Prevalence	8.9%	9.0%	9.9%	2021	High
% Adults with Kidney Disease	2.7%	2.9%	3.4%	2021	High
% Stroke	2.8%	3.1%	3.7%	2022	High
Obesity	30.1%	29.7%	31.6%	2021	High
% Teeth Loss	13.9%	12.0%	15.1%	2022	High
Cancer Incidence Rate	442.3	464.4	452.3	2016-2020	Medium
Emergency Room Visits	535	563	802	2022	High

Measure	National Benchmark	North Carolina Benchmark	Hoke County Data	Most Recent Data Year	Hoke County Need
Heart Disease Hospitalization Rate	10.4	11.7	11.4	2018-2020	Medium
Stroke Hospitalization Rate	8.0	9.5	10.3	2018-2020	High

Table 57: Quality of Care

Measure	National Benchmark	North Carolina Benchmark	Hoke County Data	Most Recent Data Year	Hoke County Need
Children/adults vaccinated annually against seasonal influenza	44.5%	45.6%	41.9%	2021	High
Preventable Hospital Rate	2,752	2,957	3,680	2021	High
Readmissions Rate	18.1%	17.6%	19.0%	2022	High

Table 58: Safety

Measure	National Benchmark	North Carolina Benchmark	Hoke County Data	Most Recent Data Year	Hoke County Need
Incarceration Rate	1.3%	1.5%	2.5%	2018	High
Juvenile Arrest Rate	13.8	16.0	23.0	2021	High
Violent Crime	416.0	365.7	143.5	2015-2017	Low
Firearm Death Rate	13.4	15.5	24.2	2018-2022	High
Poisoning Death Rate	28.5	31.5	31.5	2018-2022	Medium

Table 59: Sexual Health

Measure	National Benchmark	North Carolina Benchmark	Hoke County Data	Most Recent Data Year	Hoke County Need
Chlamydia Rate	495.0	603.3	894.3	2021	High
HIV Incidence Rate	12.7	15.5	18.8	2022	High
Teen Births	16.6	18.2	25.6	2016-2022	High

Table 60: Substance Use Disorders

Measure	National Benchmark	North Carolina Benchmark	Hoke County Data	Most Recent Data Year	Hoke County Need
% Excessive Drinking	18.1%	18.2%	17.4%	2021	Medium
% Driving Deaths with Alcohol	2.3	2.9	3.8	2018-2022	High
Opioid Use Disorder Rate	41.0	43.0	57.0	2021	High
Opioid Drug Overdose Deaths	N/A	25.1	23.8	2018-2022	Low

Table 61: Tobacco Use

Measure	National Benchmark	North Carolina Benchmark	Hoke County Data	Most Recent Data Year	Hoke County Need
% Smokers	14.5%	15.0%	18.5%	2021	High

Table 62: Transportation Options and Transit

Measure	National Benchmark	North Carolina Benchmark	Hoke County Data	Most Recent Data Year	Hoke County Need
% Households with No Motor Vehicle	8.3%	5.4%	5.2%	2018-2022	Medium
% Public Transit	3.8%	0.8%	0.9%	2018-2022	Low
% Living Near Public Transit	34.8%	10.9%	0.0%	2021	High

APPENDIX 4 | PRIMARY DATA METHODOLOGY AND SOURCES

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

Methodologies

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

Focus Groups

The following two focus groups were conducted in person between May 23rd and June 14th, 2024. These groups included representation from and community members, with participants providing responses, on living, working, or receiving healthcare in Hoke County.

- Cape Valley Fear Medical Center
- Hoke Hospital

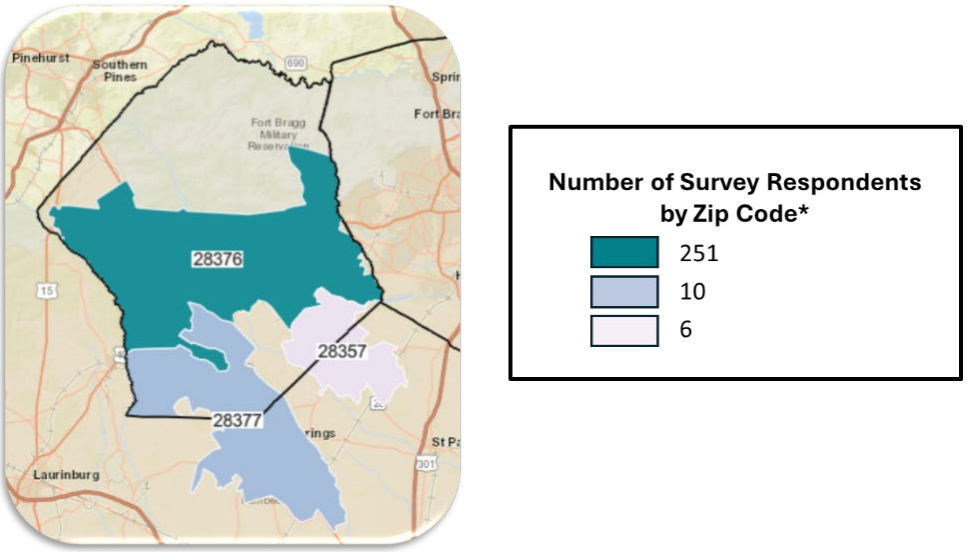
Input was gathered on the following topics:

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

Community Member Web Survey

A total of 302 surveys were completed by individuals living, working or receiving healthcare in the Hoke County community. The survey was available in both English and Spanish, and zero were completed in Spanish. Consistent with one of the survey process goals, survey community member respondents were representative of a broad geographic area encompassing areas throughout the county. The map below provides additional information on survey respondents' ZIP code of residence.

Figure 39: Respondent Zip Code of Residence[41]



In general, survey questions focused on:

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

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. Additionally, over a third of respondents identified heart disease/high blood pressure as a significant health concern.
- Cost, not having insurance, and long wait times were the top three barriers to receiving health care identified by the community.
- Poverty, access to doctors' offices, and housing/homelessness were identified as the top three most important social or environmental barriers to health. Additionally, a quarter of respondents noted access to insurance as a significant barrier.

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

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

Figure 40: Respondents by Age Group

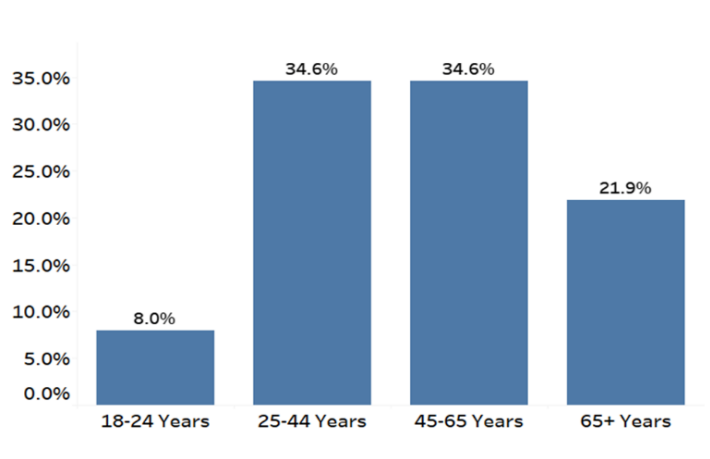


Figure 41: Respondents by Gender

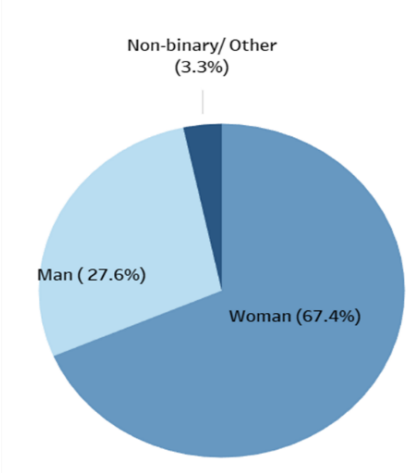


Figure 42: Respondents by Race

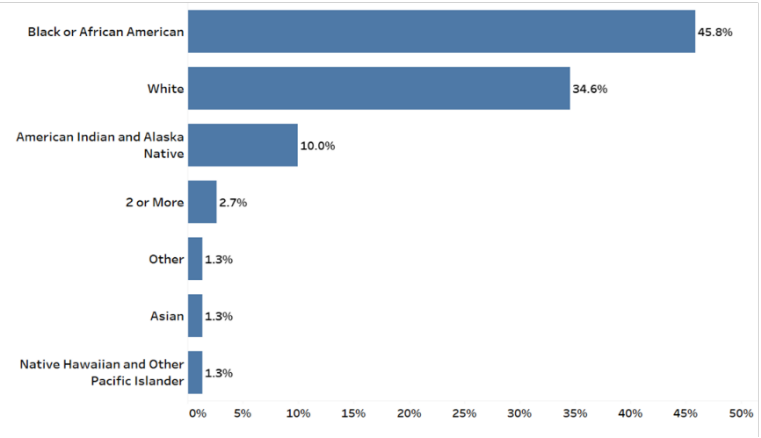
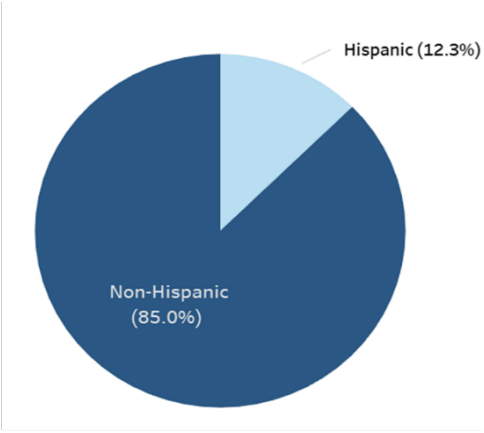


Figure 43: Respondents by Ethnicity



The questions administered via the Community Member Survey instrument are below:

County name: _____

Date: _____

Dear Community Member,

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

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

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

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

Thank you for your time and participation!

Topic: Demographics

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

2. What is your age group?

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

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

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

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

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

5. Are you of Hispanic or Latino origin, or is your family originally from a Spanish speaking country?[42]

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

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

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

7. Which language is most often spoken in your home? *Select one:*
   □ English
   □ Spanish
   □ Other, please specify: _____
   □ Don't know/Not sure
   □ Prefer not to say

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

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

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

9. Which category best describes your yearly household income before taxes?[43]
□ 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

[43] Respondents were asked to 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.

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: Family, Community and Social Support

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

	1	2	3	4	5	Don't know	Prefer not to say
a. People around here are willing to help their neighbors.	☐	☐	☐	☐	☐	☐	☐
b. People in my neighborhood generally get along with each other.	☐	☐	☐	☐	☐	☐	☐
c. People in my neighborhood can be trusted.	☐	☐	☐	☐	☐	☐	☐
d. People in my neighborhood share the same values.	☐	☐	☐	☐	☐	☐	☐
e. My neighborhood is noisy.	☐	☐	☐	☐	☐	☐	☐
f. My neighborhood is clean.	☐	☐	☐	☐	☐	☐	☐
g. People in my neighborhood take good care of their houses and apartments.	☐	☐	☐	☐	☐	☐	☐
h. I'm always having trouble with my neighbors.	☐	☐	☐	☐	☐	☐	☐
i. In my neighborhood, people watch out for each other.	☐	☐	☐	☐	☐	☐	☐
j. My neighborhood is safe.	☐	☐	☐	☐	☐	☐	☐
k. My neighborhood is a good place to grow old.	☐	☐	☐	☐	☐	☐	☐

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

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

Topic: Mental Health

15. 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: _____

16. 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

17. 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

18. 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

19. 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

20. 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?	□	□	□	□

21. 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

22. 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

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

□ Number of drinks: _____

24. How often do you consume any kind of alcohol product, including beer, wine or hard liquor?

□ Every Day
□ Some Days
□ Not at all
□ Don't know/not sure
□ Prefer not to say

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

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

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

APPENDIX 5 | DETAILED PRIMARY DATA FINDINGS

Focus Groups

Key findings from the focus groups are summarized below.

Focus Group General Findings

Five focus groups were conducted in Hoke County to identify health concerns and barriers to care. Common themes emerged across both groups, including issues related to the built environment, employment and income, healthcare access and quality, housing and homelessness, mental health, and physical health. Specifically, participants noted a lack of sidewalks and playgrounds, limited job opportunities, high childcare costs, challenges with healthcare access and quality, concerns about homelessness, a need for more mental health providers, and the prevalence of chronic health conditions.

Focus Group 1 Unique Insights: Cape Fear Valley Medical Center (Healthcare Workers)

The first focus group was conducted at Cape Fear Valley Medical Center on May 23rd, 2024, and consisted of CFVH employees. In addition to the common themes, this group identified education as a significant barrier to healthy living in Hoke County, particularly noting limited educational support for local students, especially after high school.

Participants suggested several ways to improve community health and wellness. They recommended providing low-cost health screenings and affordable transportation for patients. The group also emphasized the importance of organizing more community events to promote health awareness and education. Additionally, they suggested providing more reliable health information to help link patients with providers.

Focus Group 2 Unique Insights: Hoke Hospital (Community Members)

The second focus group was held at Hoke Hospital on June 14th, 2024, and included general community members. This group identified additional health and social/environmental concerns. Community safety was a significant issue, with gang violence being identified as a particular concern. Food access and security were also highlighted, as financial constraints prevent many people from accessing the food they need. Substance use was noted as a concern for the community. Furthermore, the group pointed out the limited public transportation options as a barrier to accessing services.

This group had several suggestions for improving health and well-being in Hoke County. They emphasized the need for more staff engagement in the community. The participants also suggested offering childcare and other resources to working families to support their ability to access healthcare and maintain healthy lifestyles. Providing community health education classes was seen as an important step in improving overall health awareness. Lastly, they stressed the importance of making counseling services more available to address mental health needs in the community.

Focus Group 3 Unique Insights: Health Advisors

The third focus group centered on lay health advisors and included 18 lay leaders who highlighted significant community health concerns. Participants emphasized affordability as a primary barrier, citing high costs associated with insurance premiums, deductibles, and out-of-pocket expenses. They also noted the prevalence of chronic illnesses such as diabetes, hypertension, heart disease, and obesity as pressing issues. Mental health services were identified as critically lacking, particularly for youth and seniors, while limited access to addiction recovery programs and harm reduction services compounded challenges related to substance use. Additionally, participants expressed frustration that healthcare delivery remains reactive mainly, with insufficient focus on prevention and wellness. These insights underscore the need for targeted interventions and community-driven solutions to address these challenges effectively.

Focus Group 4 Unique Insights: Youth Leaders

The fourth focus group engaged youth-serving organizations and leaders, with nine participants identifying critical health concerns affecting young populations. Transportation barriers were a significant challenge, as the lack of reliable public transit limits access to health services for many youth. Marginalized populations, particularly those from underserved communities, were reported to feel overlooked in healthcare planning and service delivery. Additionally, participants highlighted the prevalence of substance use disorders among youth, particularly involving alcohol, tobacco, and CBD vaping. These findings underscore the need for tailored strategies to enhance transportation access, ensure equitable healthcare planning, and implement substance use prevention and intervention initiatives for young people.

Focus Group 5 Unique Insights: Local Community Members

The fifth focus group brought together 15 community members to discuss health-related challenges and opportunities. Participants identified transportation difficulties, a lack of nearby healthcare facilities, long wait times, and insufficient healthcare providers as significant barriers to accessing care. Managing chronic conditions was reported to be especially difficult due to financial and logistical constraints. At the same time, stigma around mental health care, particularly in rural or underserved areas, further discouraged individuals from seeking support. Employment challenges, including unemployment and underemployment, were also noted as significant factors impacting health coverage and access to care. Despite these obstacles, participants emphasized the community's strong support and willingness to collaborate on solutions. They also highlighted the importance of strengthening partnerships between healthcare providers, social services, and community organizations to address these concerns. These insights highlight the critical role of community-driven strategies in overcoming barriers and leveraging collective strengths.

Community Member Web Survey

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

Topic: Additional Demographic Information

Figure 44: What is the highest grade or year of school you completed?

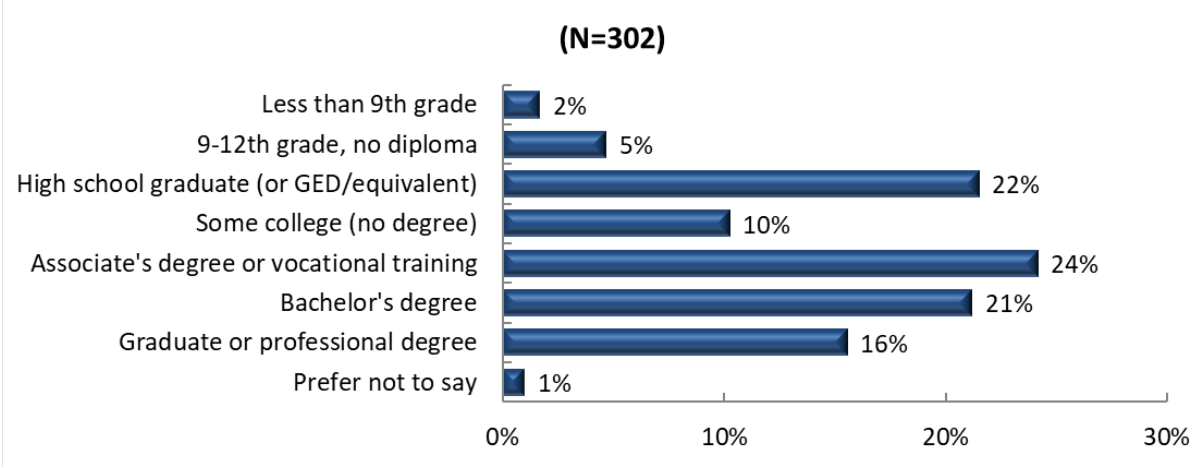
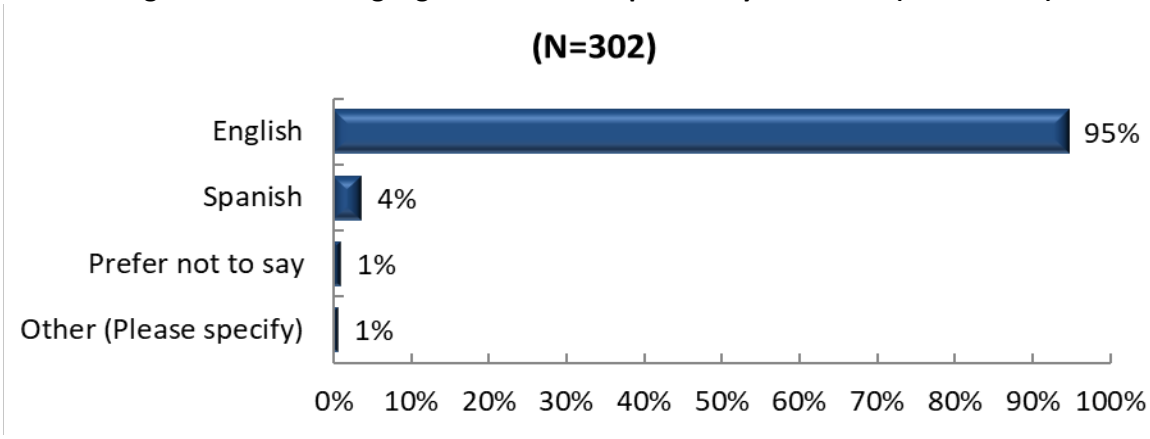


Figure 45: Which language is most often spoken in your home? (Choose one)



Other (please specify):

- "German"
- "Tagalog (Philippines)"

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

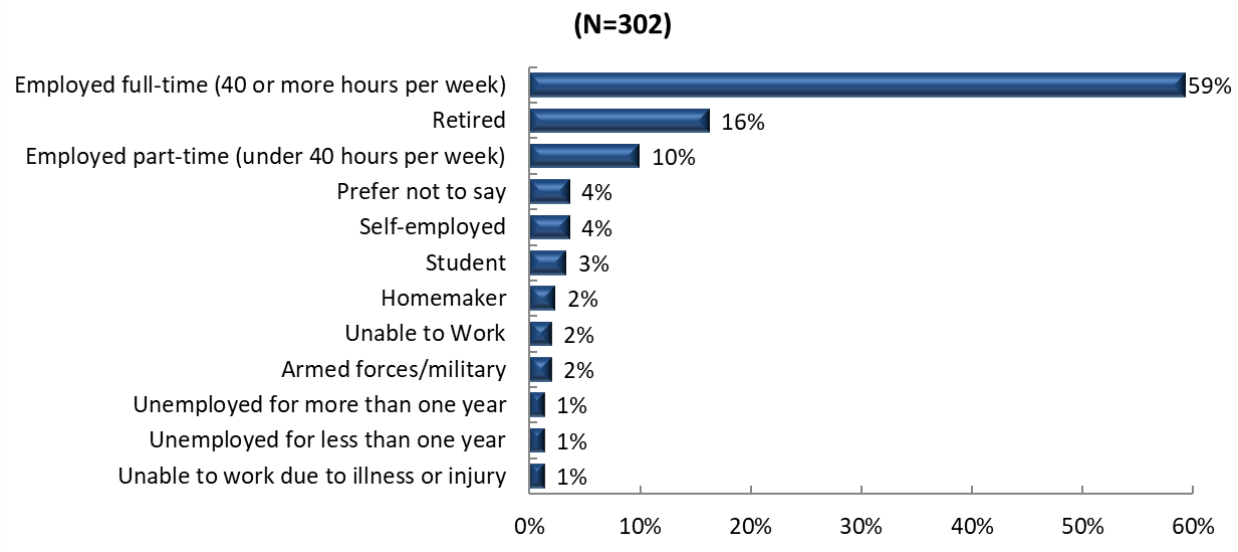
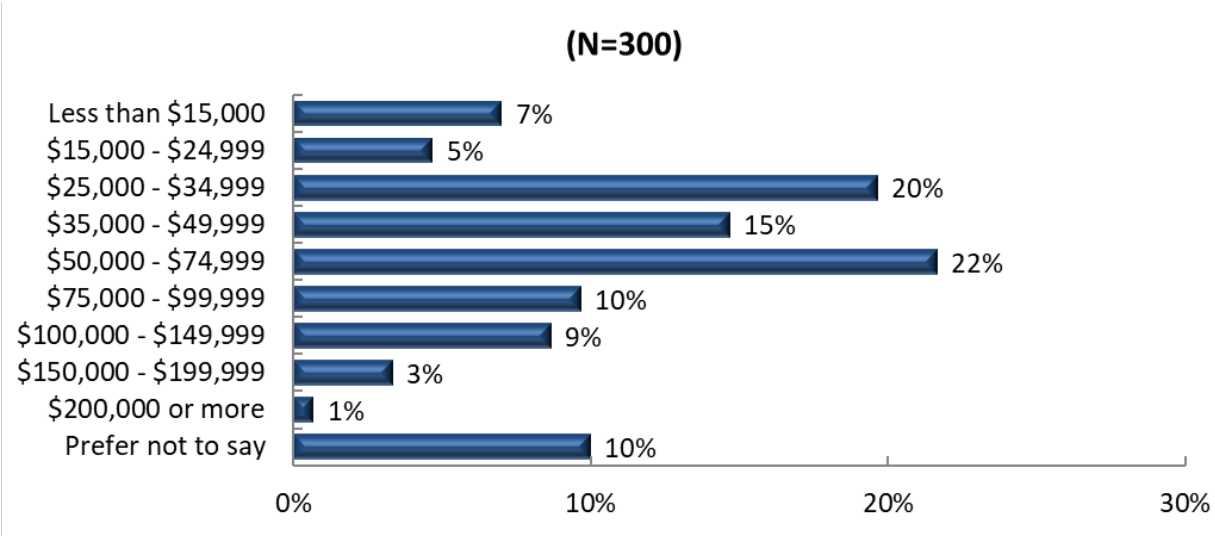


Figure 47: Which category best describes your yearly household income before taxes?[44]



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

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

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

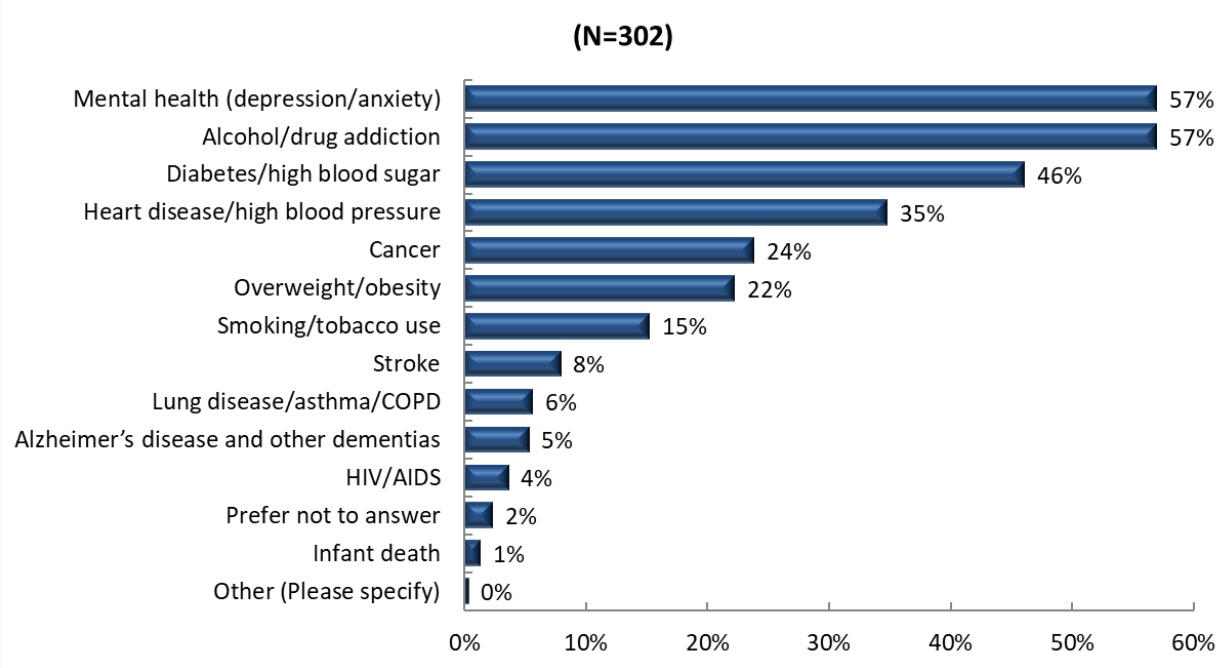


Figure 49: What are the three most important health problems that affect the health of your community? Please select up to three. (by age)

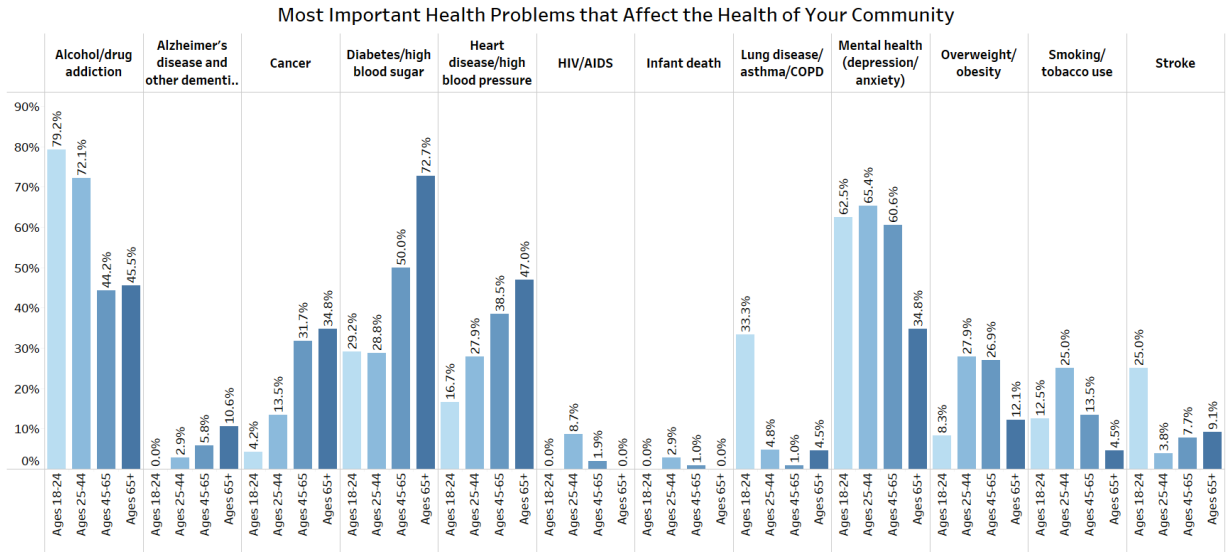


Figure 50: What are the three most important health problems that affect the health of your community? Please select up to three. (by gender)

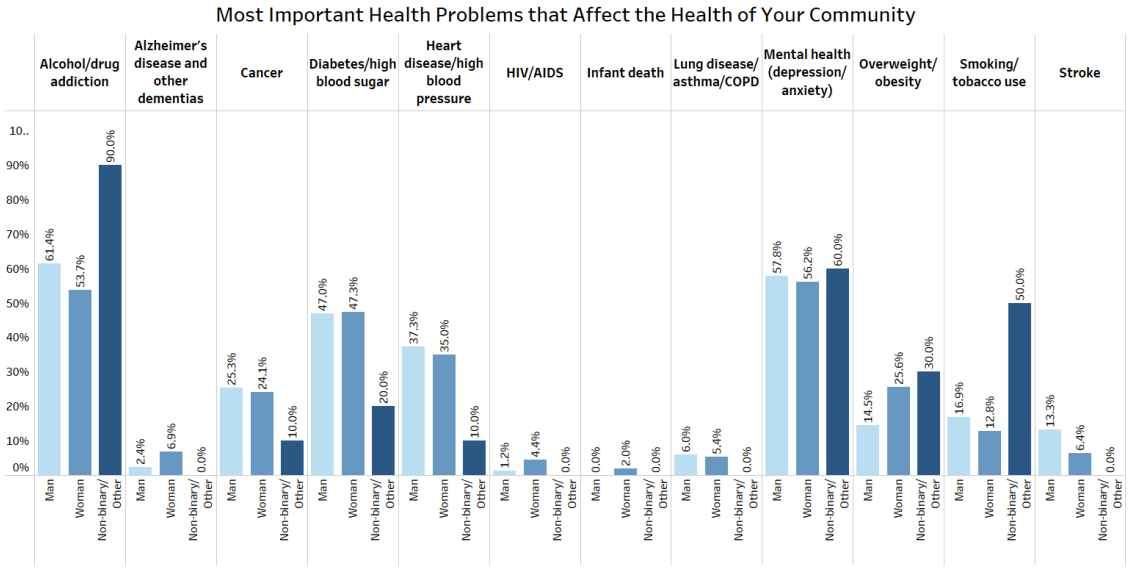


Figure 51: What are the three most important health problems that affect the health of your community? Please select up to three. (by race)

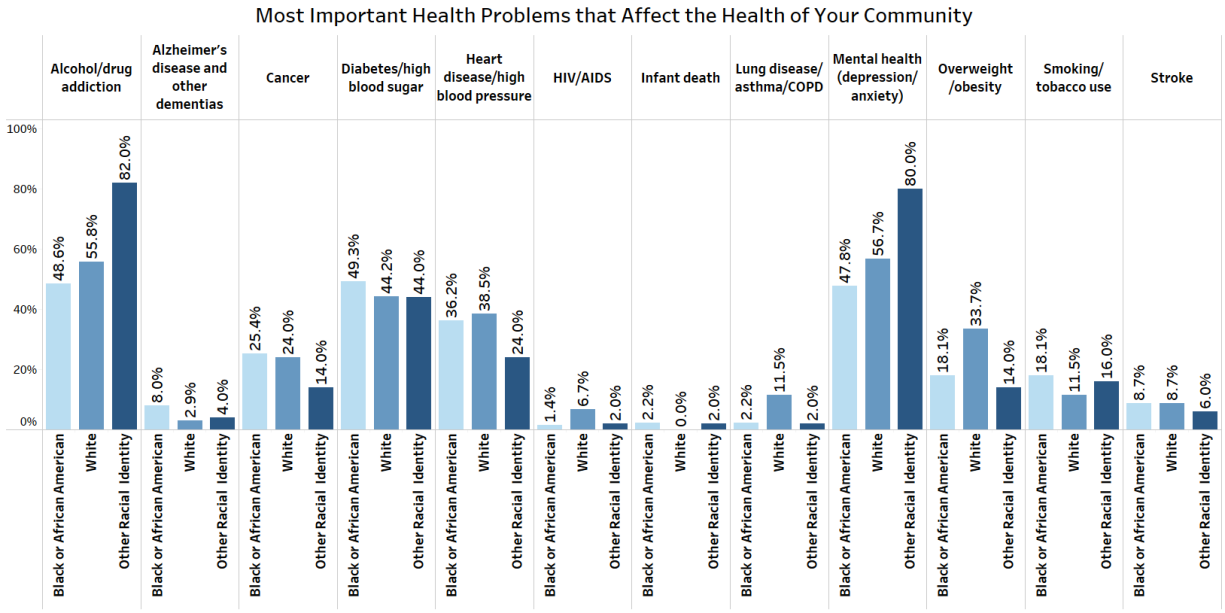


Figure 52: What are the three most important health problems that affect the health of your community? Please select up to three. (by ethnicity)

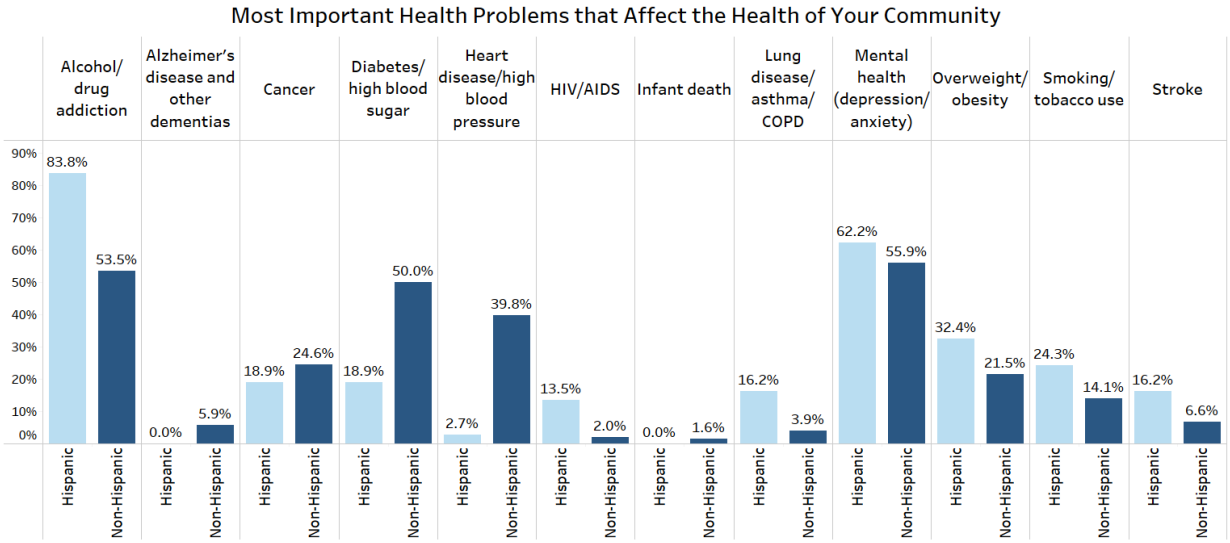
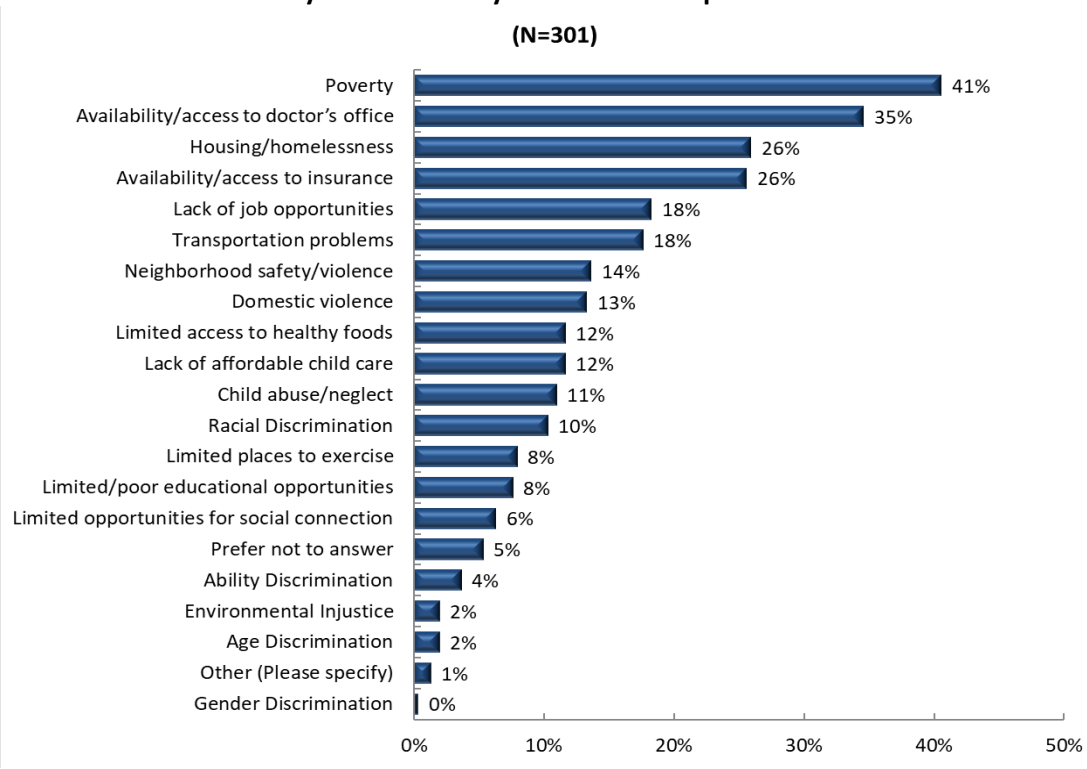


Figure 53: What are the three most important social or environmental problems that affect the health of your community? Please select up to three.



Other (please specify):

- "Affordable food"
- "All of them"
- "Undocumented citizens"

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

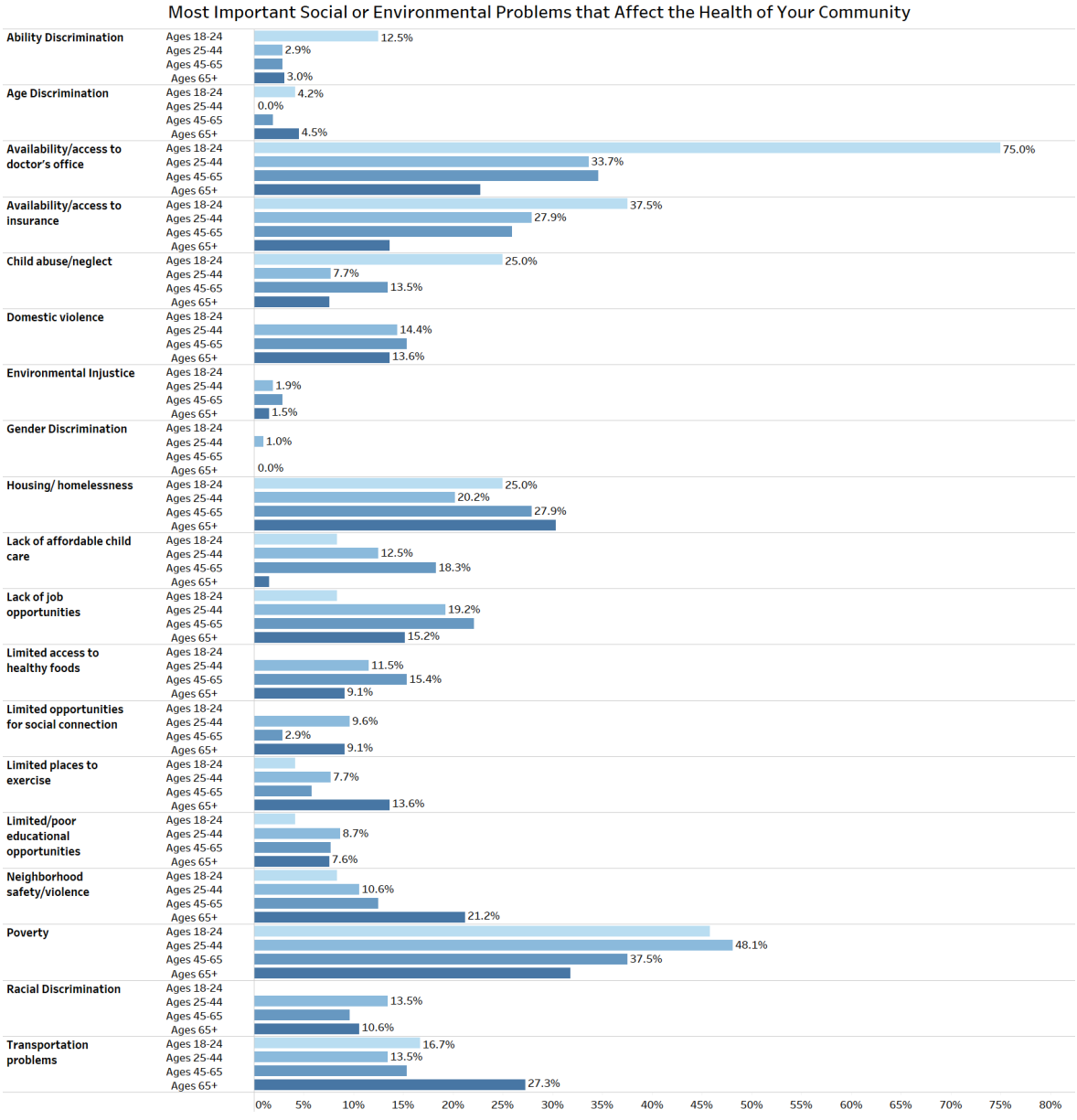


Figure 55: What are the three most important social or environmental problems that affect the health of your community? Please select up to three. (by gender)

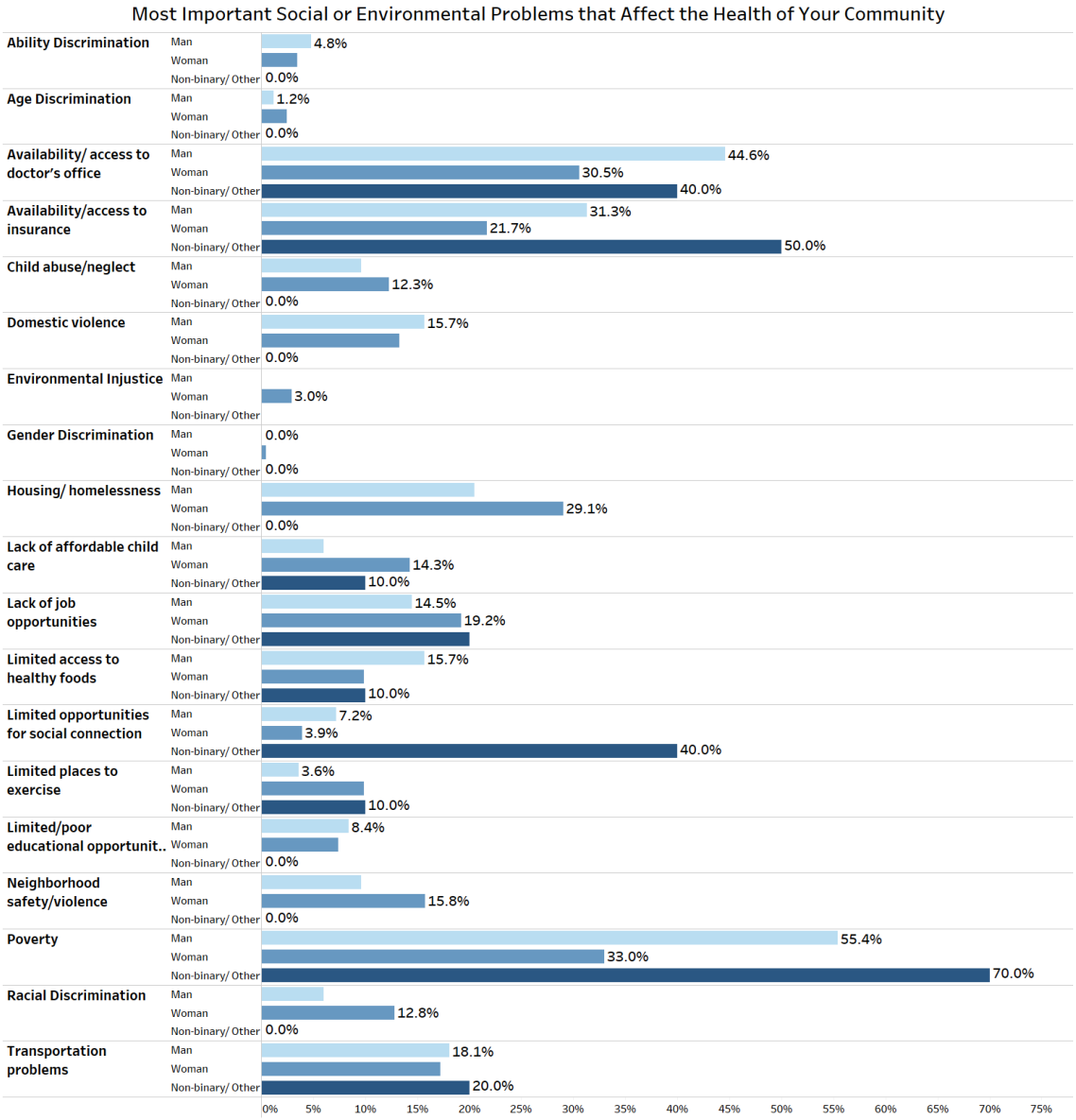


Figure 56: What are the three most important social or environmental problems that affect the health of your community? Please select up to three. (by race)

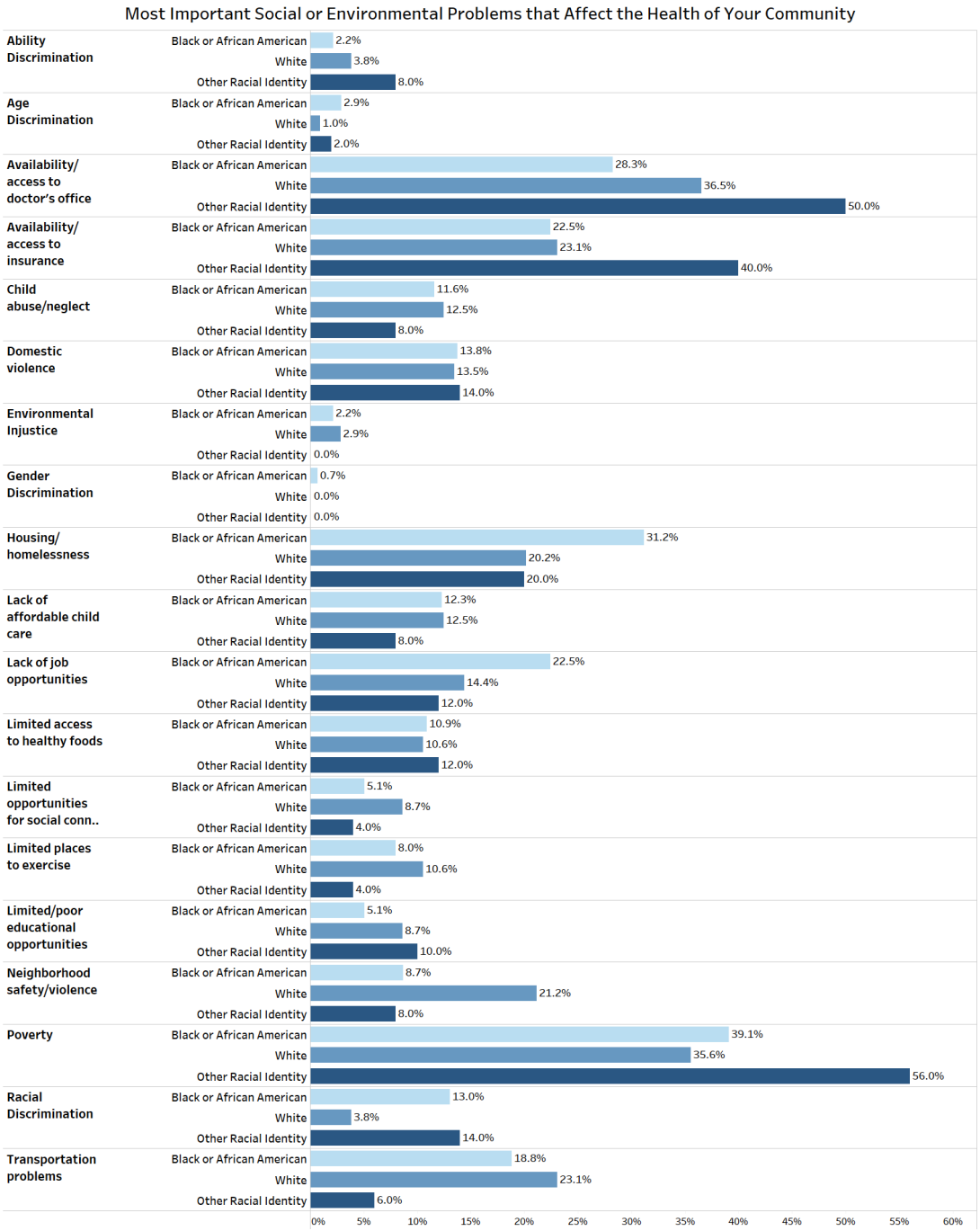


Figure 57: What are the three most important social or environmental problems that affect the health of your community? Please select up to three. (by ethnicity)

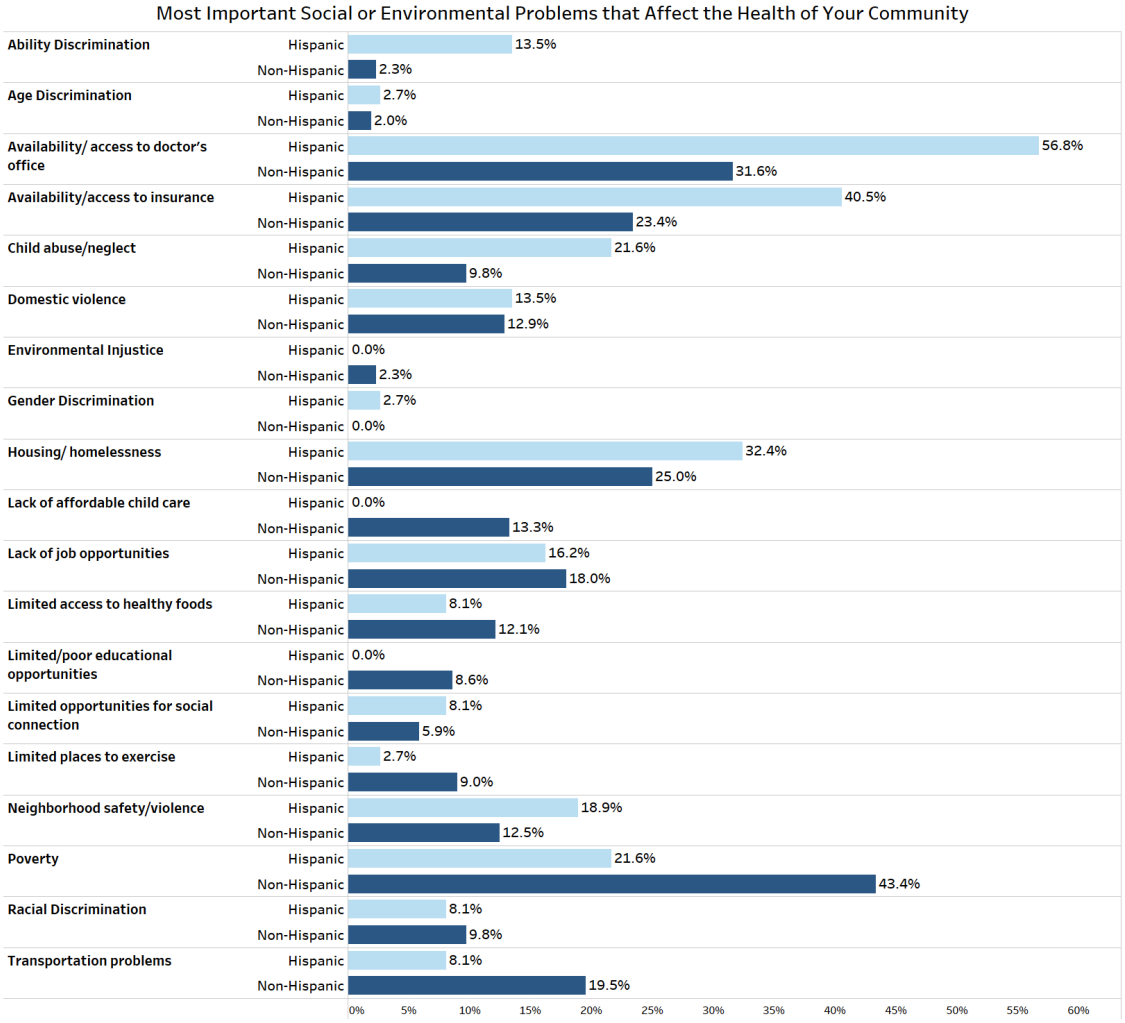
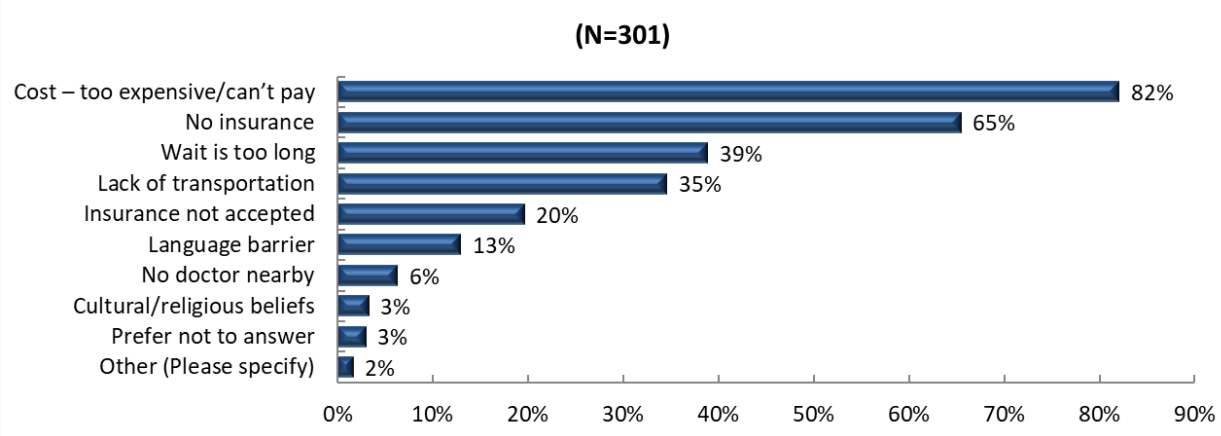


Figure 58: What are the three most important reasons people in your community do not get health care when they need it? Please select up to three.



Other (please specify):

- "All of them"
- "Hours of operation"
- "No Availability, Drs not taking new pts"
- "No history of regular medical visits"

Figure 59: What are the three most important reasons people in your community do not get health care when they need it? Please select up to three. (by age)

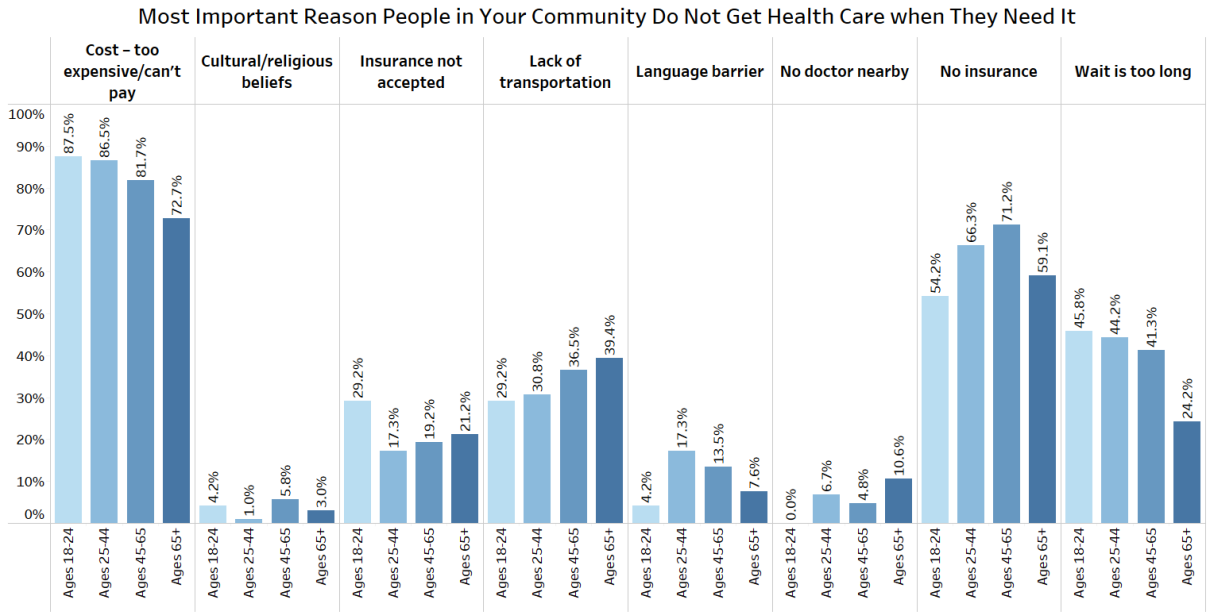


Figure 60: What are the three most important reasons people in your community do not get health care when they need it? Please select up to three. (by gender)

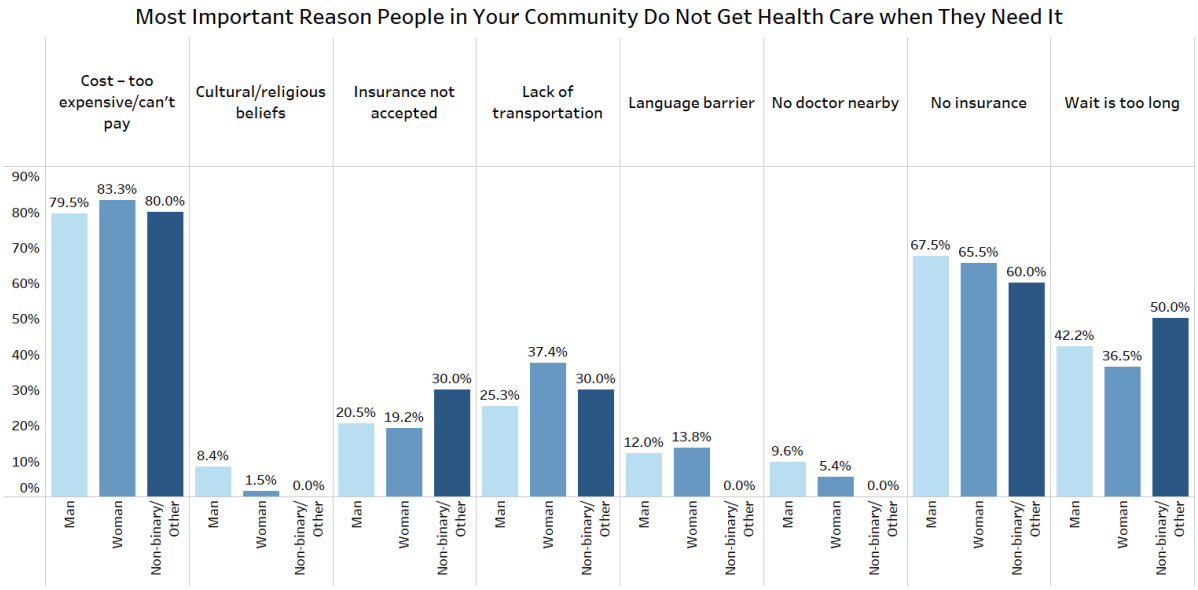


Figure 61: What are the three most important reasons people in your community do not get health care when they need it? Please select up to three. (by race)

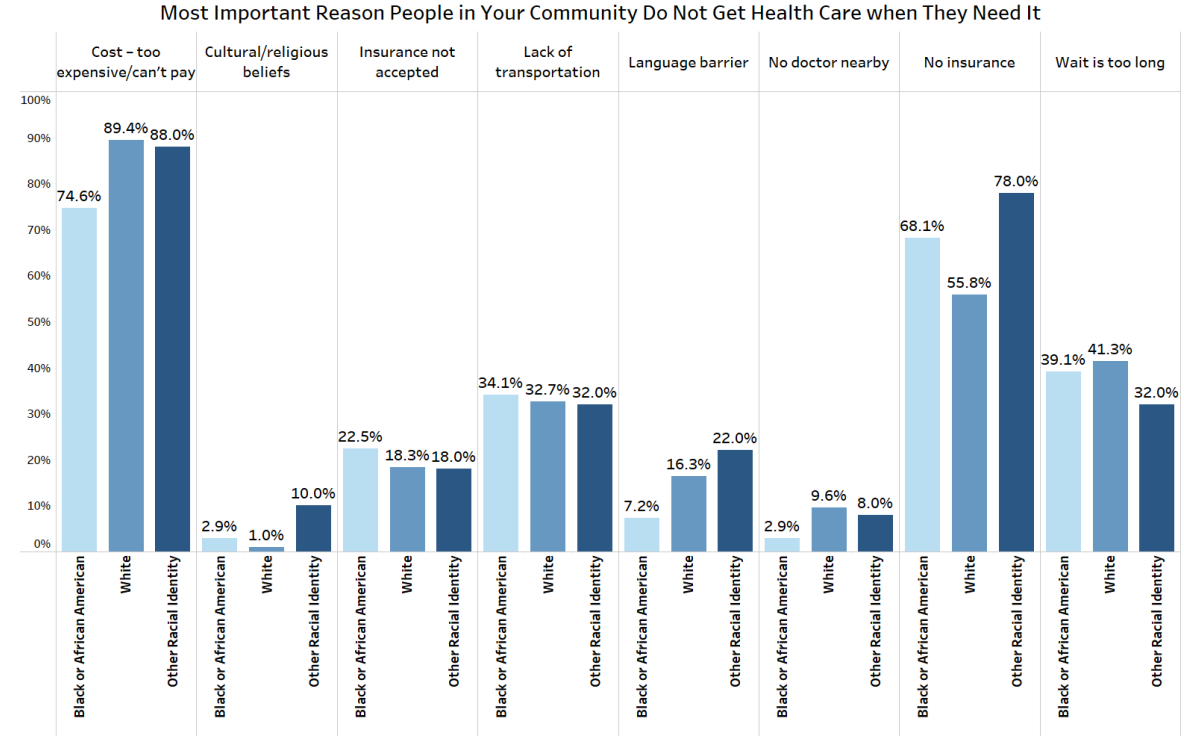
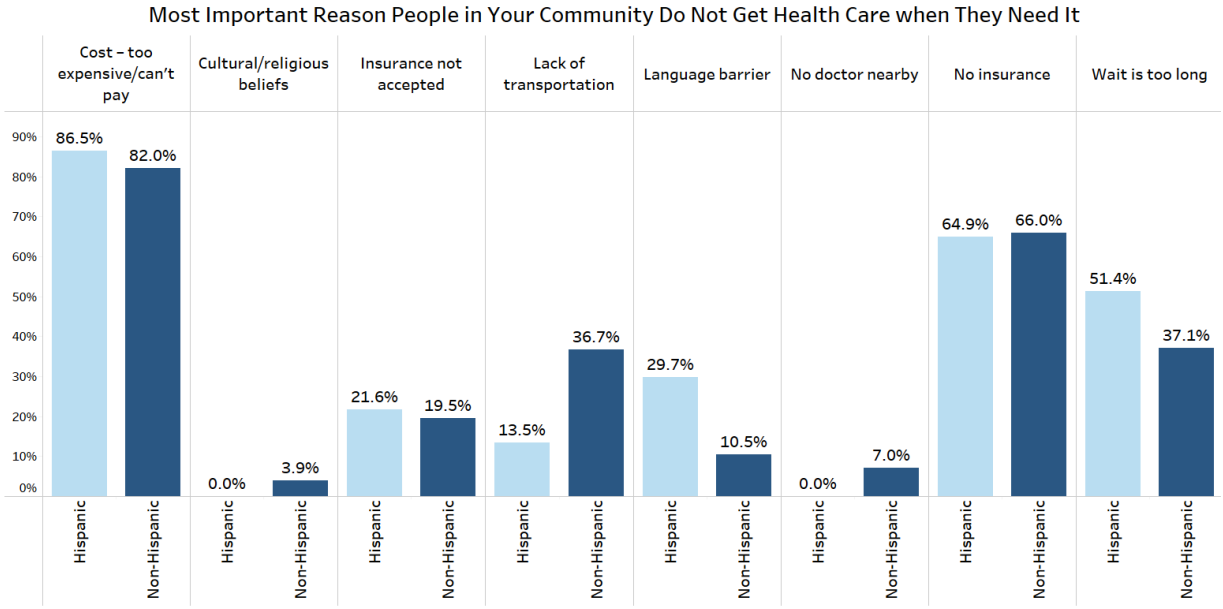


Figure 62: What are the three most important reasons people in your community do not get health care when they need it? Please select up to three. (by ethnicity)



Topic: Equity And Equality (Family, Community and Social Support)

Figure 63: The following statements describe what your neighborhood might be like. Tell us how much you agree or disagree.

Rated on a scale from 1 to 5 with being "Strongly Disagree" and 5 being "Strongly Agree"

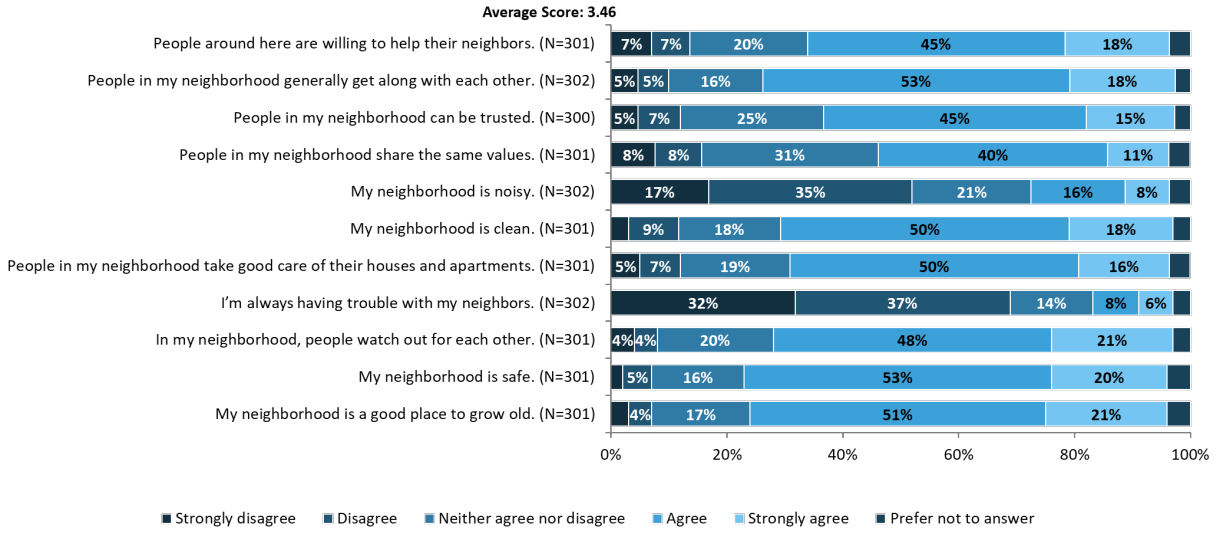
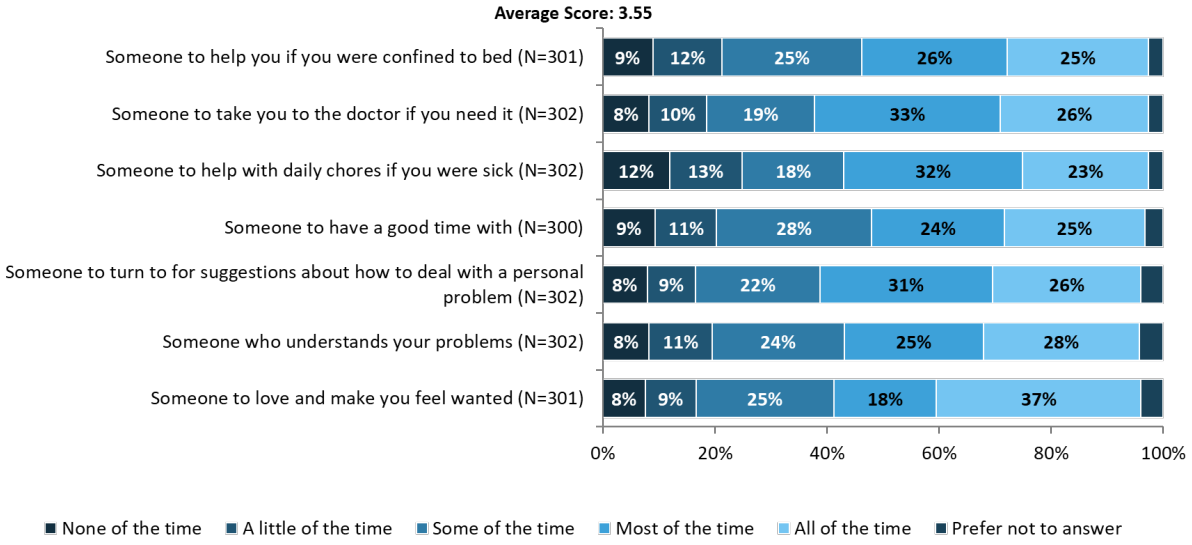


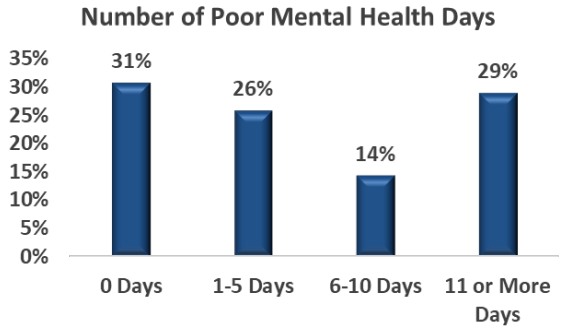
Figure 64: People sometimes look to others for friendship, help, or other types of support. In the following situations, how often could you find someone to support you?
Rated on a scale from 1 to 5 with 1 being "None of the Time" and 5 being "All of the Time"



Topic: Mental Health

Figure 65: 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=286)



Measure	Value
Mean (Standard Deviation)	8 (9)
Median	5
Mode	0
Minimum-Maximum	0-30

Figure 66: Was there a time in the past 12 months when you needed mental health care or counseling, but did not get it at that time?

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

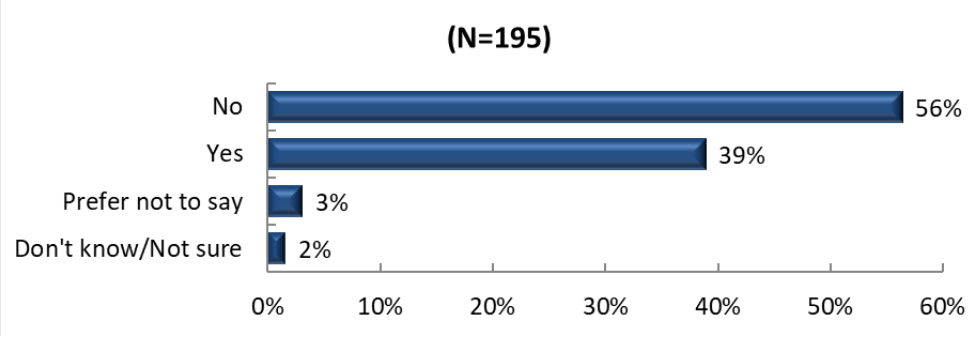


Figure 67: What was the MAIN reason you did not get mental health care or counseling?

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

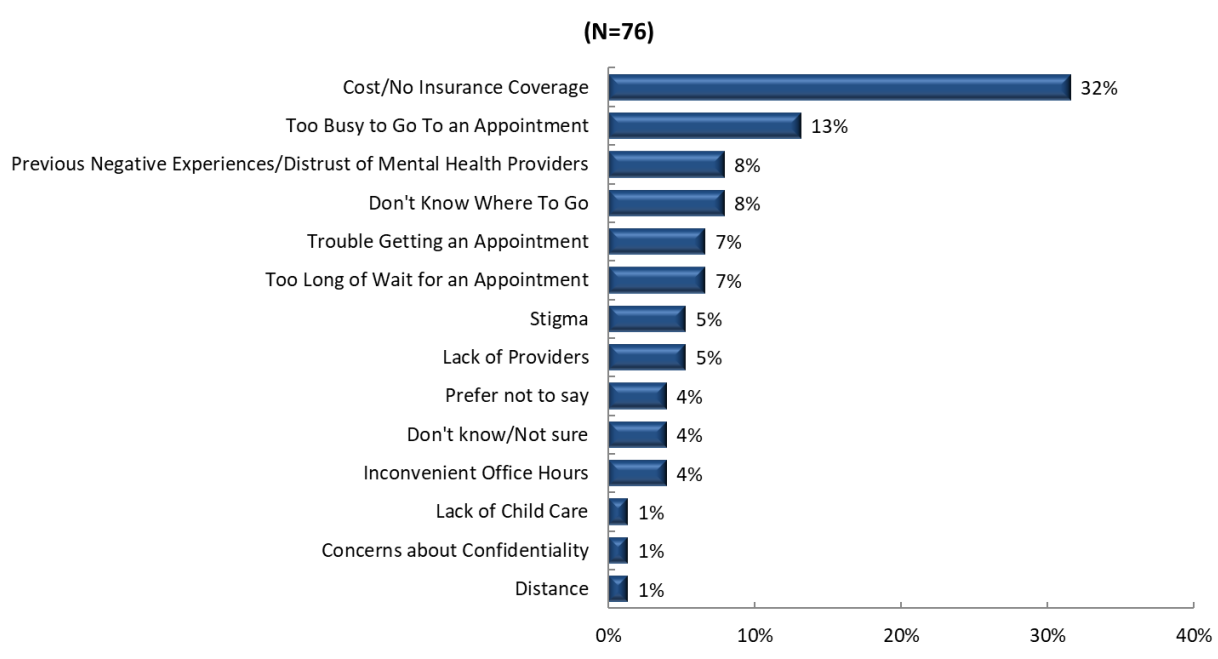
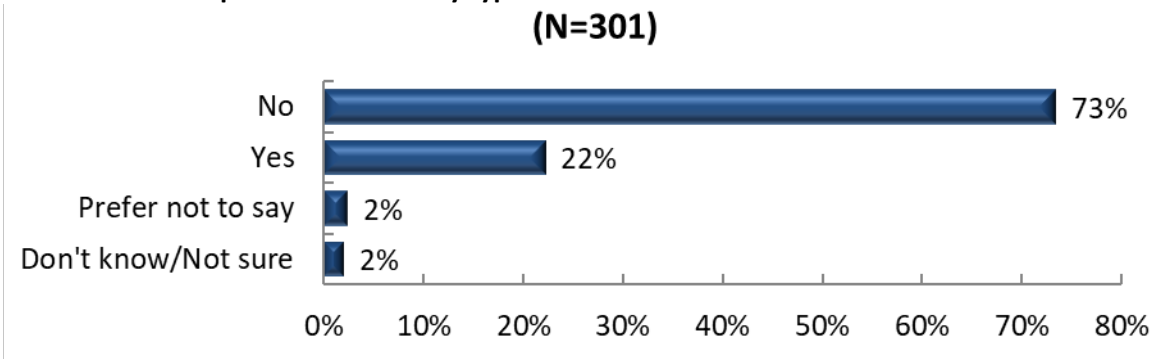


Figure 68: Are you currently taking medication or receiving treatment, therapy, or counseling from a health professional for any type of MENTAL or EMOTIONAL HEALTH NEED?



Topic: Physical Health

Figure 69: Considering your physical health overall, would you describe your health as…

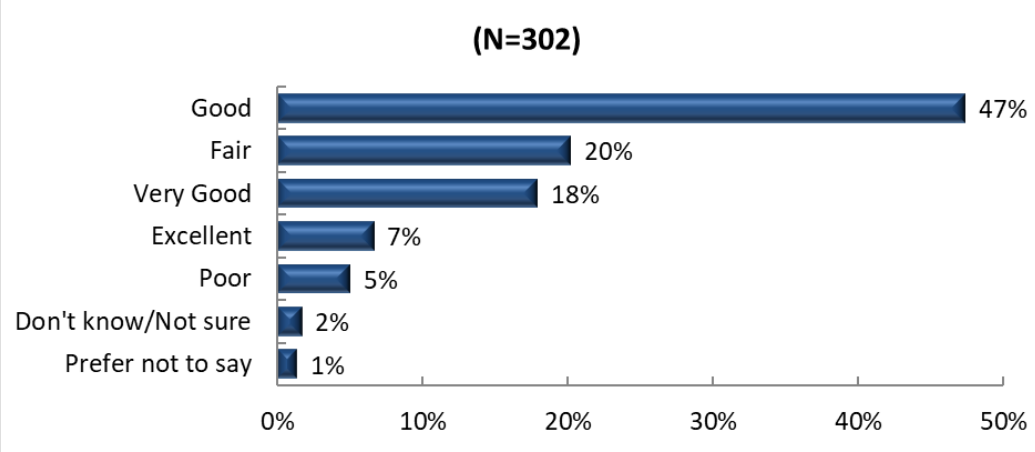


Figure 70: Within the past year (anytime less than one year ago), have you:

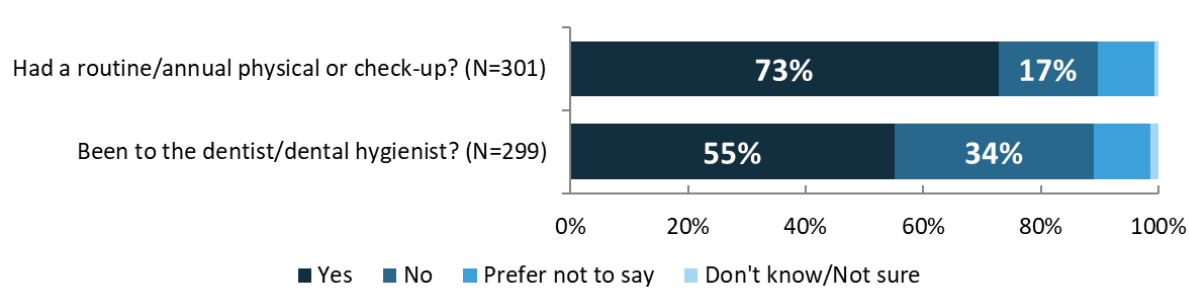
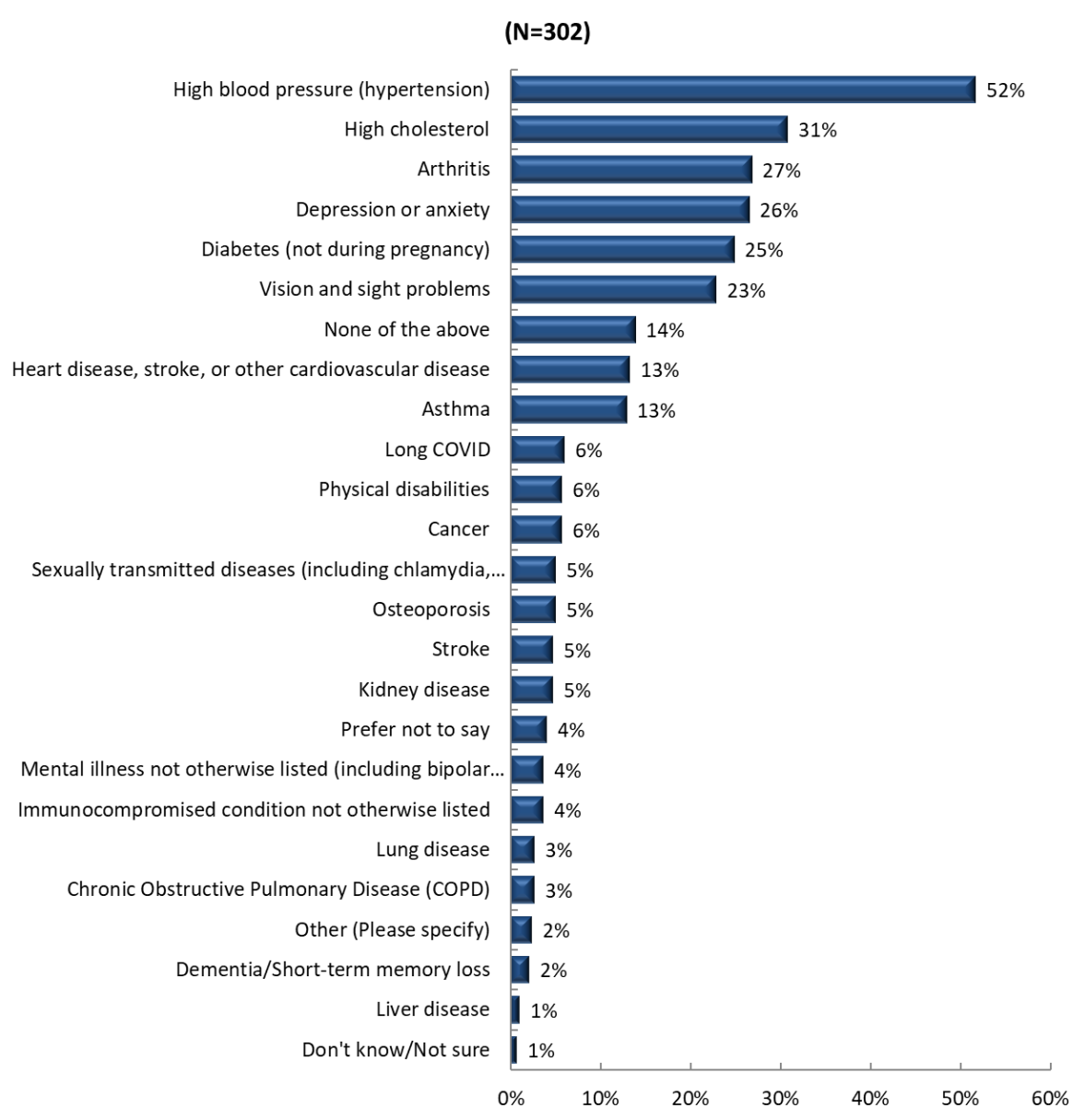


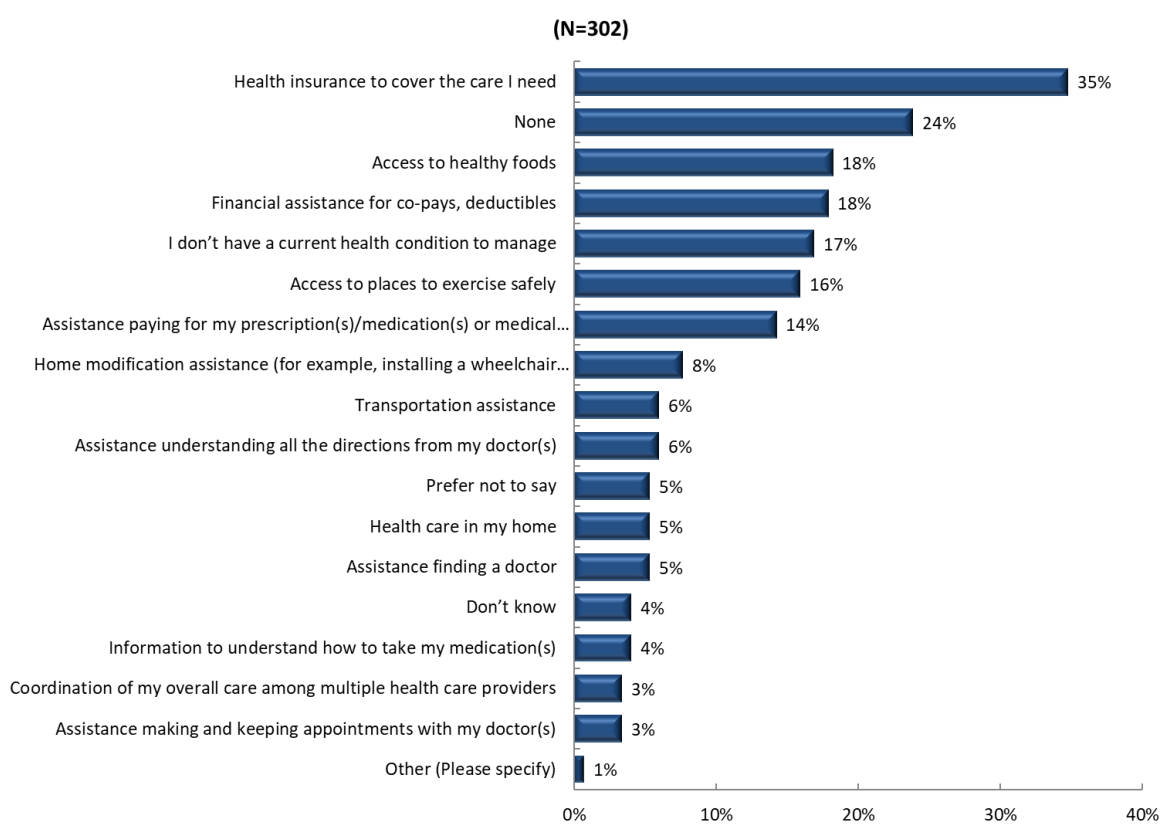
Figure 71: Have you ever been told by a doctor, nurse, or other health professional that you have any of the following health conditions? Select all that apply



Other (please specify):

- "ADHD"
- "Graves Disease"
- "PCOS"
- "Spinal" / "Spinal issues"
- "Thyroid disease"

Figure 72: What do you need to be able to manage your current health conditions (for example, heart conditions, high blood pressure, stroke, diabetes, asthma, cancer, COPD, congestive heart failure, arthritis, HIV, depression, anxiety, other mental health condition, etc.) to stay healthy? (Select all that apply.)



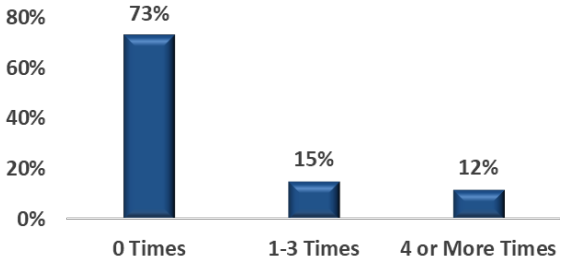
Other (please specify):

- "For the service providers to communicate better with patient resources such as physical therapy. I've been waiting months to get it in concerning my neck. I've called, nothing."
- "Jobs don't provide time off for appointments or look down on you if you have to be out. Most others feel the same way."

Topic: Substance Use Disorders

Figure 73: 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=290)



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

Figure 74: How often do you consume any kind of alcohol product, including beer, wine or hard liquor?

(N=301)

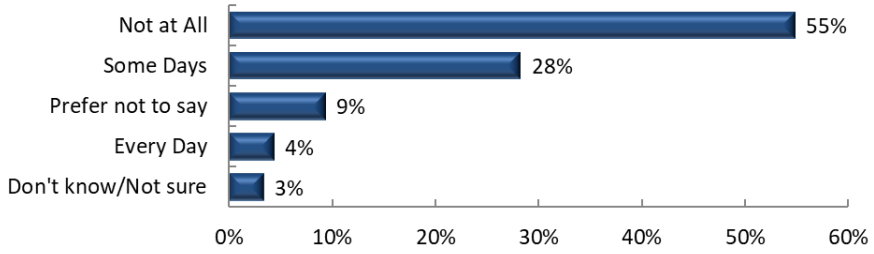


Figure 75: In the past year, have you or a member of your household misused any form of prescription drugs (e.g. used without a prescription, used more than prescribed, used more often than prescribed, or used for any reason other than a doctor's instructions)?

(N=300)

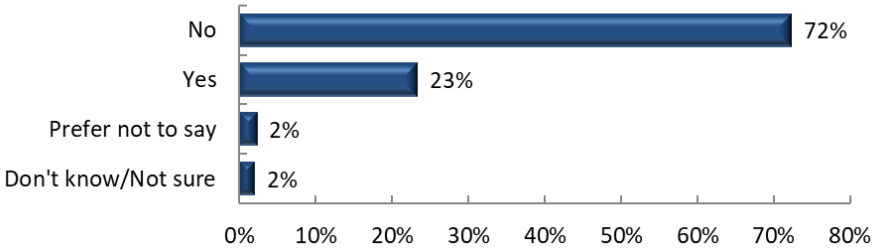
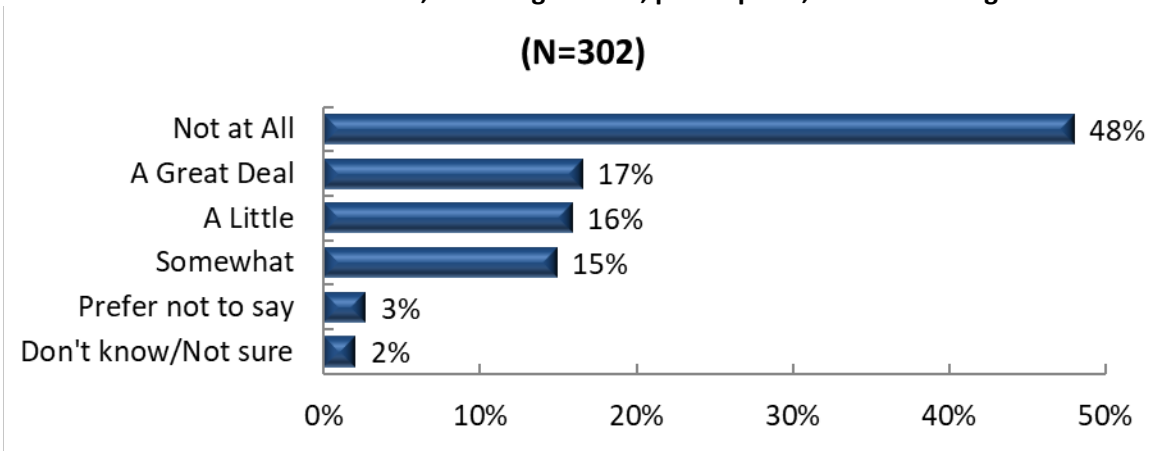


Figure 76: To what degree has your life been negatively affected by YOUR OWN or SOMEONE ELSE's substance abuse issues, including alcohol, prescription, and other drugs?



APPENDIX 6 | SUMMARY OF DATA FINDINGS ACROSS SOURCES

Primary and Secondary data findings are summarized in full by the table below.[45]

Priority Area	Secondary Data	Community Survey	Focus Group 1	Focus Group 2
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				✓

[45] 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.