Community Health Needs Assessment

Dare County
2025

Outer Banks Health™

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Report Tables and Figures

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Executive Summary

Dare County is pleased to present its 2025 Community Health Needs Assessment (CHNA). This report provides an overview of the methods and processes used to identify and prioritize significant health needs in Dare County. This document serves as the 2025 CHNA for Outer Banks Health and 2024 CHNA Dare County Department of Health & Human Services.

Outer Banks Health

Outer Banks Health (OBH) is a growing health system, providing a range of health and wellness services for our community. Designed especially to meet the health needs of our coastal community, whose year-round population of 35,000 swells to about 250,000 in the summer season, OBH has approval as a provider of Medicare and Medicaid programs, licensure by the Division of Facility Services, and accreditation by the Joint Commission on the Accreditation of Health Care Organizations, College of American Pathologists, and the American College of Radiology.

OBH is first in the state for patient satisfaction, first in the nation to pilot groundbreaking rural health cancer programs, and the very first to be designated a Dementia Friendly Hospital. OBH works with our partners, ECU Health and Chesapeake Regional Healthcare, along with other health organizations throughout North Carolina and Virginia to help residents and visitors access the best possible care for their diagnosis.

Outer Banks Health Ownership Partners

Outer Banks Health is one of nine hospitals that comprise ECU Health (ECUH), a regional health system serving more than 1.4 million people in 29 counties throughout rural eastern NC. The system consists of ECU Health Medical Center, eight community hospitals, an ambulatory surgery center, wellness and rehabilitation facilities, home health agencies, and other independently operated health services. ECUH is affiliated with the Brody School of Medicine at East Carolina University. The mission of ECUH is to improve the health and well-being of eastern NC, with a vision to become a national model for rural health and wellness. Integral to the mission is the commitment to be responsive to the community's needs and to provide high quality, cost-effective health care services.

Because of proximity of the Outer Banks, NC to Chesapeake, VA, Outer Banks Health is also partially owned by Chesapeake Regional Healthcare, a health system laser-focused on innovation, known for making medical history in the region and providing patients with truly personal care. Its hospital, Chesapeake Regional Medical Center, is the only independent, community-based hospital in Hampton Roads.

Dare County Department of Health & Human Services

The Dare County Department of Health & Human Services (DCDHHS) is the primary department responsible for protecting the health of all Dare County residents and protecting, strengthening, and helping families and individuals achieve self-sufficiency. DCDHHS partners with individuals, families and the community to strengthen their efforts towards healthy living, independence, permanence and safety. The department is comprised of a public health division, social services division, and

CHNA Overview

A Community Health Needs Assessment (CHNA) helps health leaders evaluate the health and wellness of the community they serve and identify gaps and challenges that should be addressed through new programs, services and policy changes. This report was developed as part of the Health ENC coalition's collaborative, regional 2024-2025 CHNA process. Health ENC – a group of stakeholders who help find ways to collaborate and share resources to improve the health of the population in eastern North Carolina – served an integral role in making this comprehensive assessment possible. The report adheres to North Carolina Local Health Department Accreditation standards, as well as Internal Revenue Service requirements for not-for-profit hospitals.

Mission Statement

The Dare County CHNA serves as a document and process to describe the current health status of Dare County with the following overarching goals:

- Evaluate the impact of Community Health Improvement Plans from the 2022 CHNA
- Collect and analyze primary and secondary data to identify areas of need within the county
- Report findings to the residents of Dare County and key stakeholders
- Engage the community to determine priorities that need to be addressed
- Develop a Community Health Improvement Plan to address identified health priorities

Vision Statement

The 2025 CHNA provides a structured process for Dare County to prioritize health needs, and to plan and act upon unmet community needs. The process provides a strong foundation that will support and promote optimal health and wellbeing for all individuals who live in Dare County.

Leadership

Local public health agencies in North Carolina (NC) are required to conduct a CHNA at least once every four years. The CHNA is required of public health departments in the consolidated agreement between the NC Division of Public Health (NCDPH) and the local public health agency. Furthermore, a CHA is required for local public health department accreditation through the NC Local Health Department Accreditation Board (G.S. § 130A-34.1).

As part of the US Affordable Care Act of 2011, non-profit hospitals are also required to conduct a community health (needs) assessment at least every three years. Recognizing that duplicate assessment efforts are a poor use of community resources, LHDs and non-profit hospitals across the state have models for collaboratively conducting the community health assessment process.

Since 2013, Dare County Department of Health & Human Services and Outer Banks Health serve as the local leadership for the CHNA process. This long-term collaboration has been a successful partnership for more than 12 years.

Acknowledgements

This Community Health Needs Assessment (CHNA) represents the culmination of work completed by multiple individuals and groups. Dare County Department of Health & Human Services, Outer Banks Health, and Healthy Carolinians of the Outer Banks 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. In addition, the Health ENC Steering Committee and Dare 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.

Collaborative Process Summary

This assessment is a product of a local and regional collaborative process. On the local level, Healthy Carolinians of the Outer Banks, Outer Banks Health, and Dare County Department of Health & Human Services took a leadership role to facilitate the CHNA process. Health ENC, the regional assessment collaborative, selected and hired the vendor. Ascendient, the chosen vendor, collaborated with a Health ENC Steering Committee to create and implement the CHNA timeline. The process began in February of 2024. Ascendient gathered secondary data, provided technical support through the local primary data collection for each county, analyzed data collected, and provided a draft report for each participating county.

Healthy Carolinians of the Outer Banks (HCOB) had a variety of community partners contributing to the CHNA process on the local level. The table below illustrates the types and numbers of partners involved in the local collaboration process.

Type of Partner	Number of Partners
Healthcare	5
Health & Human Services Agencies	7
Non-Profit Community Aid	3
Older Adult/Dementia-Related Services	2
Criminal Justice & Law Enforcement	1
Community Members	1

The pages that follow outline the members of Healthy Carolinians of the Outer Banks and Health ENC. Details on the roles and responsibilities of these partners and assessment vendor are also provided.

Healthy Carolinians of the Outer Banks Partnership

Healthy Carolinians of the Outer Banks (HCOB) is a Partnership working towards a healthier Dare County. The Partnership has been established in Dare County since the first Community Health Needs Assessment was conducted in Dare County in the early 2000's. Coordinated by the Dare County Department of Health & Human Services and Outer Banks Health, the partnership has input and representation from more than 25 local organizations and agencies. The Healthy Carolinians process supports our community in mobilizing people and resources to evaluate the current state of the community's health and address identified health challenges.

One of the essential functions of the HCOB Partnership is to oversee the Community Health Needs Assessment process every three years. The partnership participates in the gathering and analysis of primary and secondary data. Once the data is reviewed, HCOB prioritizes the identified health opportunities and forms task forces to address concerns as needed.

HCOB includes a partnership board and executive committee. The executive committee includes the HCOB Coordinator, Chair, Vice-Chair, previous Chair (if available), and Community Health Needs Assessment Coordinators and leadership from both Outer Banks Health and Dare County Department of Health & Human Services.

The tables below provide names, titles and organizational information for all HCOB members that participated in the 2025 CHNA process.

HCOB Executive Committee Members

Name	Title	Organization
Gail Hutchison	Victim's Advocate, HCOB Chair	Dare County Sheriff's Office
Dianne Denny	Chair, HCOB Vice Chair	Outer Banks Dementia Task Force
Sheila Davies	Director, Public Health Director	DCDHHS
Ronnie Sloan	President	Outer Banks Health
Amy Montgomery	Executive Director, Operations	Outer Banks Health

Community Health Assessment Coordinators

Name	Title	Organization
Kelly Nettnin Fleming	Health Education & Outreach Supervisor	DCDHHS
Jennifer Schwartzenberg	Director, Community Outreach and Development	Outer Banks Health
Michelle Wagner	Public Health Educator	DCDHHS
Lyndsey Hornock	Program Assistant, Community Outreach and Development	Outer Banks Health
Lea Anne Campbell	Program Coordinator, Community Outreach and Development	Outer Banks Health
Laura Willingham	Human Services Planner	DCDHHS

HCOB Members

Name	Title	Organization
Jennie Collins	Director	Dare County Emergency Medical Services
Lyn Jenkins	Executive Director	Community Care Clinic of Dare
Tess Judge	Member	Dare County Community
Roxana Ballinger	Health Education & Outreach Manager	DCDHHS
Chris Sawin	Executive Director	Outer Banks Community Foundation
Gail Sonnesso	Director	GEM Day Services
Jenniffer Albanese	Executive Director	Interfaith Community Outreach
Patty McKenna	Executive Director	Outer Banks Relief Foundation

Regional & Contracted Services

Health ENC

Health ENC is a collaborative project created in 2018 to establish a regional health assessment process for health departments and hospitals in Eastern North Carolina. The collaborative serves 34 counties with 24 participating health departments and 20 participating hospitals. The collaborative uses a shared approach for primary and secondary data collection to produce a comprehensive Regional Community Health Needs Assessment every three years that can be used to partially satisfy requirements for North Carolina Local Health Department Accreditation and the Internal Revenue Service requirement under the Patient Protection and Affordable Care Act for charitable hospitals.

Health ENC, a group of stakeholders who seek 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.

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

Health Needs Assessment every three years that can be used to partially satisfy requirements for North Carolina Local Health Department Accreditation and the Internal Revenue Service requirement under the Patient Protection and Affordable Care Act for charitable hospitals.

Ascendient

Ascendient is a top-50 healthcare strategy, planning, and feasibility consulting firm. They provide future-focused research and analysis to help facilities positively transform the way they deliver care. Their specialized team combines academic insights with decades of experience to help healthcare organizations adapt and thrive.

Ascendient collected secondary data for this CHNA and provided procedural support for primary data collection through administering the community survey as well as providing resources to

complete focus groups and key informant interviews. They compiled the data, provided analysis, and a draft of the CHNA report.

Theoretical Framework

This assessment was developed in alignment with the RWJF population health framework, originally developed by the University of Wisconsin's Population Health Institute. Using the population health framework as a guide for the CHNA process helps categorize the individual pieces of data to connect the dots between health status and social drivers of health so that local leaders can better understand and address the health and well-being of the communities they serve. Throughout the process, *Healthy People 2030*'s "Social Determinants of Health and Health Equity" was also considered.

Secondary (existing) data is an important piece of the CHNA process. Key sources for secondary data included information provided by the Health ENC CHNA Steering Committee and a variety of public data sources related to demographics, social and economic determinants of health, environmental health, health status and disease trends, mental/behavioral health trends, and individual health behaviors. Each data measure was also compared to state or national benchmarks to identify areas of specific concern for Dare County. Top community needs identified through secondary data analysis included employment and income, environmental quality, healthcare access and quality, and transportation and transit.

Primary (new) data were collected through focus groups, key informant interviews, and a web-based survey for community members that included feedback from 1,211 people who live, work or receive healthcare in Dare County. A total of three in-person focus groups were conducted, with a variety of community members from different backgrounds, age groups and life experiences. Additionally, fifteen key informant interviews were conducted with individuals and organizations in Dare County to gain perspective on the health and well-being of residents. Primary data identified behavioral health (including mental health and substance use), employment and income, healthcare access and quality, and housing and homelessness as top needs that impact the health and well-being of people living in Dare County.

Key Findings

Representatives from Dare 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 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. Dare County also compiled a Health Resources Inventory, which includes resources available to help Dare County residents meet their health and social needs.

Selected Health Priorities

Although it was not possible for every single area of potential need to be identified as a priority, Dare County selected three top priority health needs, which are shown here in alphabetical order:

- Access to Healthcare
- Mental Health
- Substance Use

CHNA leadership will work to develop Community Health Improvement Plans around these three public health concerns.

Next Steps

Following completion of this report, health leaders throughout Dare 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.

Distribution

An electronic copy of this report is available on the following websites:
www.DareNC.gov/HCOB
https://www.ecuhealth.org/about-us/community/health-needs-assessment/
https://www.outerbankshealth.org/about-us/community-health-needs-assessments/

Paper copies of this report are available in all three Dare County libraries.

A high-level summary booklet of this report is available for download at: www.DareNC.gov/HCOB

HCOB Partnership members are available to present this CHNA Report to businesses, government entities, and/or community groups. Please contact HCOB Coordinator: Laura Willingham at Laura.Willingham@DareNC.gov or 252.475.5079 to schedule a presentation today.

Community Health Improvement Plans & Implementation Strategy Plans

The prioritization of the identified significant health needs will guide the community health improvement and implementation strategy efforts of Dare County. Following this process, Dare County Department of Health & Human Services will outline how it plans to address the prioritized health needs in its Community Health Improvement Plans. Outer Banks Health will provide details on how it plans to address priorities through its Implementation Strategy Plan.

When available, finalized plans can be found at:
Dare County Department of Health & Human Services – Community Health Improvement Plans
https://scorecard.clearimpact.com/Scorecard/Embed/91409

Outer Banks Health – Implementation Strategy
https://www.outerbankshealth.org/about-us/community-health-needs-assessments/

Members of the Dare County community are invited and encouraged to become a part of the journey toward optimal health by joining one of the HCOB task forces. Community progress on these priorities will be tracked and documented in the State of the County Health Report as well as the Outer Banks Health Implementation Strategy Scorecard during the years between the CHNA.

Introduction

Background

In addition to HCOB, the Dare County 2025 CHNA was developed in partnership with representatives from Dare County Department of Health & Human Services (DCDHHS), Outer Banks Health (OBH), and Health ENC Steering Committee.

HCOB is a partnership working toward a healthier Dare County. Coordinated by the DCDHHS and Outer Banks Health, the partnership has input and representation from more than 25 local organizations and agencies. The Healthy Carolinians process supports our community in mobilizing people and resources to address community health challenges. One of the essential functions of the HCOB Partnership is to oversee the CHNA process every three years. The partnership participates in the gathering and analysis of primary and secondary data. Once the data is reviewed, HCOB prioritizes the identified health opportunities and forms task forces to address concerns as needed.

HCOB includes a partnership board and executive committee. The executive committee consists of the HCOB Coordinator, Chair, Vice-Chair, previous Chair (if available) as well as CHNA Coordinators and leadership from both OBH and DCDHHS.

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.[1] 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.

Progress Overview

A significant amount of information has been reviewed during this planning process, and 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 Dare 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.

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

The purpose of this study is to better understand, quantify, and articulate the health needs of Dare County residents. Key objectives of this CHNA include:

- Identify the health needs of Dare 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 1** below, beginning with pre-planning and assessing organizational capacity and ending with an evaluation of the process. Once the CHNA process is complete, county leaders must develop community health action plans to describe the specific activities they will implement to address the health and social needs identified in the CHNA.

Figure 1: The Community Health Needs Assessment Process[2]

[2] 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

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 Dare County residents.
3) *Priority Health Need Areas* – This chapter describes each identified priority health need area for Dare 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 Dare County.
4) *Health Resource Inventory* – This chapter documents existing health resources currently available to the Dare County community.
5) *Next Steps* – This chapter briefly summarizes the next steps that will occur to address the priority health need areas discussed throughout this document.

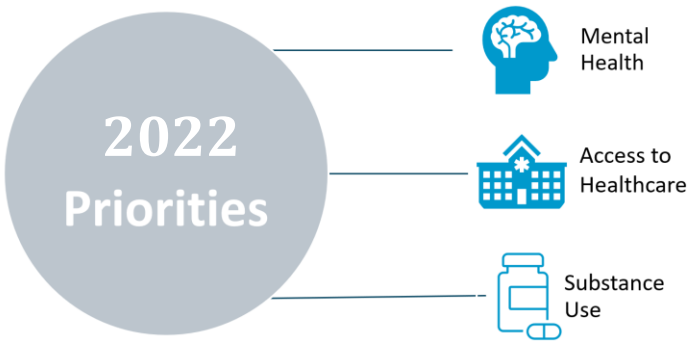
In addition, the appendices discuss all of the data used during the development of this report in detail, including:

1) *State of the County Health Report* – Detailed information about actions taken to address the priority health needs identified in previous CHNAs are presented in **Appendix 1**.
2) *Detailed Summary of Secondary Data Measures and Findings* – Existing data measures and findings used in the prioritization process are presented in **Appendices 2-3.**
3) *Detailed Summary of Primary Findings* – Summaries of new data findings from community member surveys, key informant interviews, and focus groups are presented in **Appendices 4-5.**
4) *Emergency Room and Inpatient Hospitalization Data*- Summaries of data on emergency room visits and inpatient hospitalization data for the Outer Banks Hospital are presented in **Appendix 7.**
5) *Supplemental & Additional Data Collected* – Additional data collected by the CHNA team are presented in **Appendix 8.**
6) *Suicide Study Results* – Data, information, and tools used by members of the CHNA team that partnered with UNC Chapel Hill to conduct a study in 2024 on suicide in Dare County are located in **Appendix 9.**

Evaluation of Prior CHNA Implementation Strategies

A CHNA is an ongoing process that begins with an evaluation of the previous CHNA. In 2021-2022, Dare County completed its previous assessment. Associated implementation strategies focused on three priority areas, as listed below:

Figure 2: Dare County 2022 Priority Health Needs



The community health improvement process should be viewed as an iterative cycle. An important piece of that cycle is revisiting the progress made on priority health topics set forth in the preceding community health needs assessment. By reviewing the actions taken to address priority health issues and evaluating the impact those actions have made in the community, it is possible to better target resources and efforts during the next CHNA cycle.

As part of the 2022 Community Health Needs Assessment, substance use, mental health, and access to care were selected as prioritized health needs.

Previous CHNA Priority: Substance Abuse

- Grey Area Drinking Program: The Outer Banks Health Development Council provided funding in 2023 for a Nurse Practitioner to train in Gray-Area Drinking. The program has since been incorporated into Lifestyle Medicine visits with providers at the Center for Healthy Living.
- Tobacco Cessation Program: The Outer Banks Health Development Council provided funding several providers to become tobacco-cessation certified. The program has since been incorporated into a regular program at the Center for Healthy Living.
- Community Benefit Grants Program – Cross Roads OBX: Cross Roads OBX provides assistance to those in recovery from substance abuse. This includes mental health care, physical health care, housing, clothing, food, transportation, and more.
    - FY 23 (Oct. 2022 – Sept. 2023): Hired a peer support specialist to coordinate needs for each individual
    - FY 24 (Oct. 2023 – Sept. 2024): 684 encounters
    - FY 25 (Oct. 2024 – Apr. 2025): 266 encounters
- Outer Banks Health Community Outreach and Dare County Sheriff's Department: Medication Collection Events
    - FY 23 (Oct. 2022 – Sept. 2023): 3 medication collection events collected medications from 22 people.

    - FY 24 (Oct. 2023 – Sept. 2024): 4 medication collection events collected medications from 16 people.
    - FY 25 (Oct. 2024 – Apr. 2025): 3 medication collection events collected medications from 7 people.
- Saving Lives Task Force
    - FY 23 (Oct. 2022 – Sept. 2023):
        - Created a Faith Leader Sub-committee
        - Walk Against Addiction
        - Suicide Awareness Walk
        - Fentanyl Kills campaign began
        - Mobile vehicle service planning began
    - FY 24 (Oct. 2023 – Sept. 2024)
        - Mobile vehicle acquired for mental health crisis response
        - National Alliance on Mental Illness Walk held on April 18
        - A lunch and a dinner event were held to share information: 92 attended
        - Resource event held in Avon: 42 attended
        - Recovery as a Whole Person event: 170 attended
    - FY 25 (Oct 2024 – Apr. 2025)
        - Mobile response vehicle: 78 individuals served
        - The Road Concert Fundraiser was held on May 8
        - Adult Mental Health First Aid training was held on April 22

Previous CHNA Priority: Mental Health

- An Outer Banks Hospital representative participates on the Healthy Carolinians Breaking Through Task Force.
- Through a community benefit grant, Outer Banks Health has continued to fund the Breaking Through Task Force for a public awareness campaign that focuses on reducing the stigma attached to seeking help for behavioral health issues and creating awareness about local issues.
    - FY 23 (Oct. 2022 – Sept. 2023)
        - Creation of Shattering the Silence: Suicide Documentary (views: 1,032)
        - 700 Children's Mental Health workbooks and 200 Adult Mental Health workbooks provided
        - One Mental Health First Aid training was held and five individuals were trained
        - 764 website sessions
        - Creation of Mental Health Roundtable, made up of local mental health and addictions counselors
    - FY 24 (Oct. 2023 – Sept. 2024)
        - 700 Children's Mental Health workbooks and 800 Adult Mental Health workbooks provided
        - One Mental Health First Aid training was held and five individuals were trained
        - 1,313 website sessions
        - Four Mental Health Roundtable meetings were held
    - FY 25 (Oct. 2024 – Apr. 2025)
        - 200 Children's Mental Health workbooks and 600 Adult Mental Health workbooks provided
        - 536 website sessions
- Community Benefit Grants Program – CYP Mindfulness-Based School Programs: Through a community benefit grant, Outer Banks Health has continued to fund Children and Youth

Partnership to expand mindfulness-based well-being programs that provide students, teachers and community members with skills to manage stress proactively and enhance emotional self-regulation and resiliency. Additionally, the program will further incorporate our Hispanic community by teaching these skills in Spanish.

- FY 23 (Oct. 2022 – Sept. 2023)
  - 30 teachers attended one Calm Places, Kind Spaces workshop.
  - 6 consultations, 4 formal sessions, and 2 informal team planning meetings were held with Nags Head Elementary School.
- FY 24 (Oct. 2023 – Sept. 2024)
  - Nine teachers participated in the 101: Mindfulness Foundations course
  - Three teachers participated in the 201: Mindfulness in the Classroom course
  - Teachers at Cape Hatteras Secondary School participated in the Well-Being Development Committee four hour workshop and the Setting Sail with SEL two hour workshop
  - Education Well-Being Workshop with Nags Head Elementary School, Cape Hatteras Secondary School, First Flight Elementary School, and First Flight Middle School
  - Zones of Regulation and Adult Well-Being workshop with First Flight Elementary School
- FY 25 (Oct. 2024 – Apr. 2025)
  - 6 workshops focused on the Community Resilience Model were presented to various community groups.

- The Outer Banks Hospital will continue to focus on wellness programs offered by the Center for Healthy Living and Community Outreach, such as free yoga classes and in-person connections with Center for Health Living team members.
  - FY 23 (Oct. 2022 – Sept. 2023)
    - 22 free yoga classes were attended by a total of 579 community members.
    - 4 Lunch & Learns were attended by 50 community members.
    - Free samples of healthy recipes and nutrition tips were provided throughout the summer at the Dowdy Park Farmer's Market (10 events, 200 community members).
  - FY 24 (Oct. 2023 – Sept. 2024)
    - 21 free yoga classes were attended by a total of 366 community members.
    - 6 Lunch & Learn events were attended by 123 community members.
    - Free samples of healthy recipes and nutrition tips were provided throughout the summer at the Dowdy Park Farmer's Market (9 events, 925 community members).
  - FY 25 (Oct. 2024 – Apr. 2025)
    - 7 free yoga classes were attended by a total of 366 community members.
    - 3 Lunch & Learn events were attended by 59 people.

Previous CHNA Priority: Access to Care

- Community-Based Health Screenings
  - Cancer screenings: breast cancer screenings, skin cancer screening, lung cancer screenings, prostate cancer screenings
    - FY 23 (Oct. 2022 – Sept. 2023): 262 Total Screenings
    - FY 24 (Oct.2023 – Sept. 2024): 108 Total Screenings
    - FY 25 (Oct. 2024 – Apr. 2025): 48 Total Screenings

    - Biometric Screenings: height, weight, blood pressure, glucose, A1C, and cholesterol
        - FY 23 (Oct. 2022 – Sept. 2023): 531 Total Screenings
        - FY 24 (Oct.2023 – Sept. 2024): 646 Total Screenings
        - FY 25 (Oct. 2024 – Apr. 2025): 118 Total Screenings
- Community Benefit Grants Program – Dare County Transportation: Dare County Transportation provides non-emergency medical transportation services for residents of Dare County.
    - FY 23 (Oct. 2022 – Sept. 2023): 117 rides to out-of-county medical appointments
    - FY 24 (Oct.2023 – Sept. 2024): 89 rides to out-of-county medical appointments
    - FY 25 (Oct. 2024 – Apr. 2025): 125 rides to out-of-county medical appointments
- Community Benefit Grants Program – Interfaith Community Outreach: Provides access to healthcare, mental healthcare, and transportation for medical needs.
    - FY 23 (Oct. 2022 – Sept. 2023): 1100 medical transportation trips
    - FY 24 (Oct.2023 – Sept. 2024): 860 cancer-related medical transportation trips
    - FY 25 (Oct. 2024 – Apr. 2025): 382 cancer-related medical transportation trips
- The Cowell Cancer Center opened on January 29, 2024.
- Community Wellness Education Programs
    - Lunch & Learns
        - FY 23 (Oct. 2022 – Sept. 2023): 4 Lunch & Learns were attended by 50 community members.
        - FY 24 (Oct. 2023 – Sept. 2024): 6 Lunch & Learn events were attended by 123 community members.
        - FY 25 (Oct. 2024 – Apr. 2025): 3 Lunch & Learn events were attended by 59 people.

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

Summary Findings: Dare County 2025 Priority Health Need Areas

To achieve the study objectives in the 2025 assessment, both new and existing data were collected and reviewed. New data included information from web-based surveys of adults (18+ years) and focus groups various local organizations, community members, and health service providers within Dare County participated. Existing data included information regarding the demographics, health and healthcare resources, behavioral health, disease trends, and county rankings. The data collection and analysis process began in February 2024 and continued through July 2024.

Significant variations in demographics and health needs exist within Dare 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 Dare 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, Dare County's priority health need areas were identified from a list of more than 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 Dare

focus areas identified as countywide priorities for the 2025 CHNA are Access to Healthcare, Mental Health, and Substance Use, as seen in **Figure 3**.

Figure 3: Dare County 2025 Priority Health Needs

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 factors such as demographic and socioeconomic that 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**.

Chapter 1 | METHODOLOGY

Study Design

The process used to assess Dare 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 Dare 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, key informant interviews, 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 Dare County, including access to care, healthy lifestyle, equity and equality, food security, housing and homelessness, income, mental health, physical health, substance use disorders, tobacco use, and transportation and transit.

Interviews were conducted with 15 "key informants" for Dare County. These key informants consisted of various community leaders across healthcare, education, and other community resources and services. Focus group participants were asked a standard set of questions about health and social needs, in order to identify trends across various groups and to highlight areas of concern for specific populations. In total, the input was gathered from over 1,240 Dare County residents and other stakeholders. This included web survey responses from over 1,200 community members and three focus groups that included over 25 community members and other people who live, work or receive healthcare in Dare County, in addition to the 15 key informants interviewed.

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

- *County Health Rankings*, developed in partnership by Robert Wood Johnson Foundation (RWJF) and University of Wisconsin Population Health Institute

- *The Opportunity Atlas*, developed in partnership by the U.S. Census Bureau, Harvard University, and Brown University
- *Food Access Research Atlas*, published by the U.S. Food and Drug Administration
- *Social Vulnerability Index*, developed by the CDC and the Agency for Toxic Substances and Disease Registry (ATSDR)
- *Environmental Justice Index*, developed by the CDC and the ATSDR
- *American Community Survey*, as collected and published by the U.S. Census Bureau
- Data provided by CHNA Steering Committee members and other affiliated organizations, including Community Health Assessment reports for Dare County from 2018-2019 and 2021-2022.

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 Dare 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.

For all available data sources, state and national averages were compared. The following methodology was used to assign a priority level to each individual secondary data measure:

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

When viewing the secondary data summary tables in this report, please note that the following color shadings have been included to identify how Dare 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	Dare County Description
	Low	Represents measures in which Dare 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 Dare 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.

Color Shading	Priority Level	Dare County Description
	High	Represents measures in which Dare County scores are **more than five percent worse** than the most applicable target/benchmark and for which a high priority level was assigned.

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

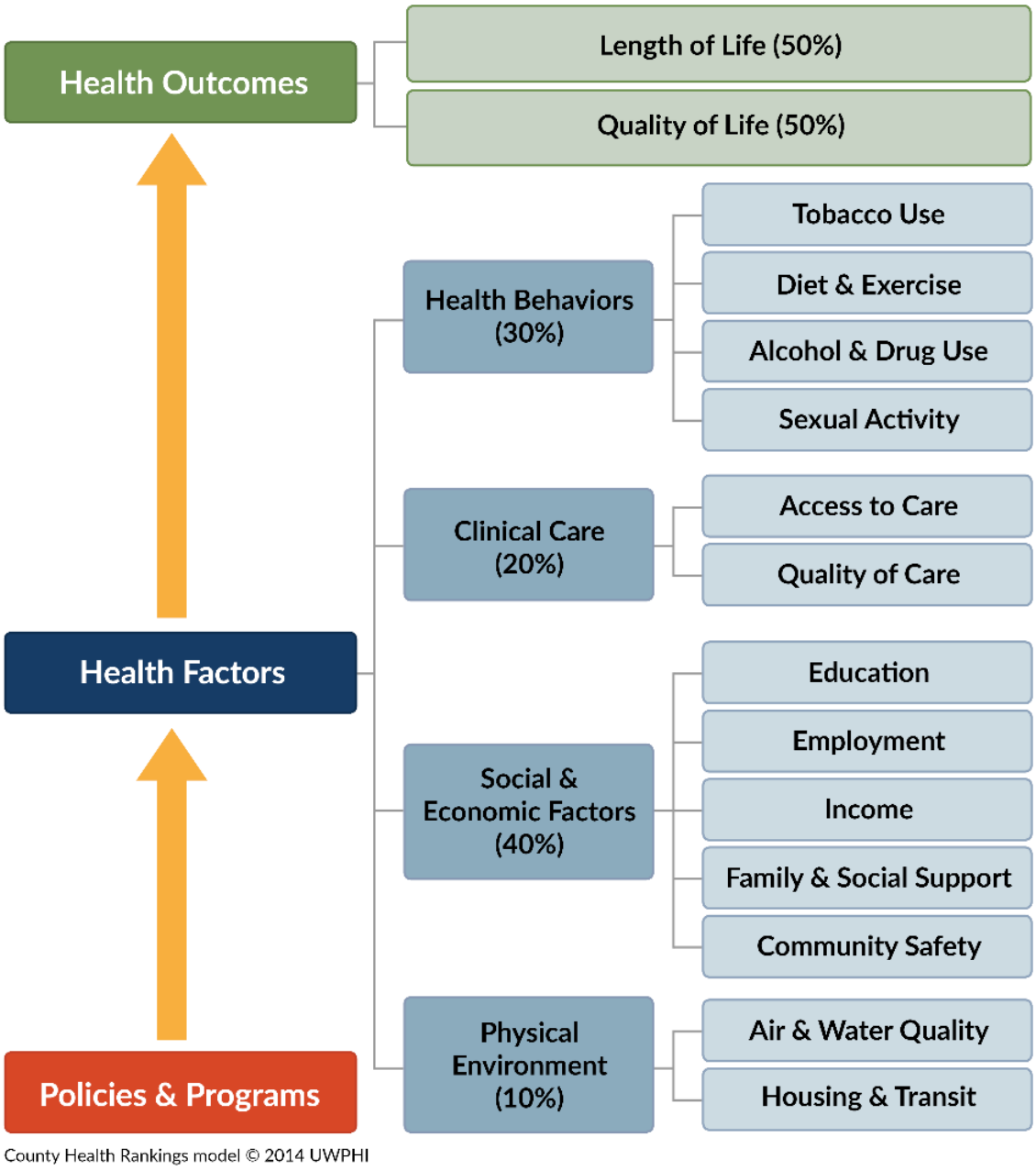
(Dare Co Value – Benchmark Value)/(Benchmark) x 100 = % Difference Used to Identify Priority Level.

Population Health Framework

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

Using the population health framework as a guide for the CHNA process helps categorize many individual pieces of data in a way that connects the dots between health status and social drivers of health, in a way that helps local leaders better understand and address the health and well-being of the communities they serve. This understanding is critical in identifying potential interventions to address priority needs in the community, and to helping develop partnerships across sectors that can help drive these interventions forward. **Figure 4** below illustrates the broad categories and sub-categories within the population health framework.

Figure 4: Population Health Framework[3]



Healthy People 2030's "Social Determinants of Health and Health Equity" was also considered throughout the process. The CDC defines social determinants of health (SDoH) as the conditions in the environments where people are born, live, learn, work, play, worship and age that affect a wide range of health, functioning and quality of life outcomes and risks. These factors can include healthcare access and quality, neighborhood and built environment, social and community context, economic stability, and education access and quality, as outlined in **Figure 5**.

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

Figure 5: Social Determinants of Health[4]

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

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

Figure 6: SDoH and Health Disparities[5]

Prioritization Process Overview and Results

The process of identifying the priority health needs for the 2025 CHNA began with the collection and analysis of hundreds of new and existing data measures. In order to create more easily discussable categories, all individual data measures were then grouped into six categories and 20 corresponding focus areas based on "common themes" that correspond to the Population Health Model, as seen in **Figure 4**: Population Health Framework**.** 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. When determining which health needs should be prioritized, Ascendient 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.

Healthy Carolinians of the Outer Banks met to review the primary and secondary CHNA findings on August 19, 2024. The local CHNA team used the collected secondary and primary data to determine

[5] 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/

a watch-list of eight health concerns. As necessary and recommended by the HCOB partnership, additional data on these topic areas were collected and reviewed.

The 2025 Watch List included the following eight categories: mental health, substance use, cancer, unintentional injuries, access to care, older adults, health behaviors and the economy.

In an effort to include the community again in our CHNA process, input was sought through a press release, website posting, various email blasts, and social media posts. Individuals who live, work, or worship in Dare County were invited to participate in the prioritization process and asked to rank the watch list items based on their individual degree of:

- Concern, and
- Awareness.

A total of 195 individuals completed the community prioritization process.

Healthy Carolinians of the Outer Banks members ranked watch list items based on the following areas:

- Magnitude of the Problem: size and scope of the health need;
- Severity of the Problem: intensity of the health need; and
- Feasibility of Correcting: whether possible interventions would be possible and effective.

The list of organizations had members participate in the prioritization voting process included:

- Community Care Clinic of Dare County
- Dare County Department of Health & Human Services
- Dare County Emergency Medical Services
- Dare County Sheriff's Office
- GEM Day Services
- Interfaith Community Outreach
- Outer Banks Community Foundation
- Outer Banks Dementia Task Force
- Outer Banks Health
- Outer Banks Relief Foundation

After prioritization for both HCOB and the community was completed, the HCOB Executive Committee met on September 4, 2024 to further discuss the findings. **Table 1** shows the prioritization results from the HCOB Partnership and Community along with an overall average of all metrics prioritized.

Table 1: HCOB Partnership & Community Prioritization Results

	HCOB Partnership Prioritization			Community Prioritization		
	Magnitude	**Correcting**	**Severity**	**Concern**	**Awareness**	**Average**
Mental Health	1.44	2.00	1.56	3.76	3.55	**2.46**
Substance Abuse	2.78	3.22	2.67	4.68	4.09	**3.49**
Access to Healthcare	4.22	4.22	4.78	2.1	2.85	**3.63**
Cancer	5.11	4.00	4.78	4.42	4.16	**4.49**
Older Adults	5.22	4.56	5.33	4.07	4.47	**4.73**

Unintentional Injuries	5.89	4.89	5.56	5.91	5.91	**5.63**
Economy	5.00	7.44	5.33	5.41	5.23	**5.68**
Health Behaviors	6.33	5.67	6.00	5.65	5.74	**5.88**

This group evaluated and prioritized the health needs of Dare County while considering the following factors:

- Results from HCOB Prioritization Survey:
  - Magnitude of the Problem: size and scope of the health need;
  - Severity of the Problem: intensity of the health need;
  - Feasibility of Correcting: whether possible interventions would be possible and effective;
- Results from the Community Prioritization Survey:
  - Degree of Concern;
  - Degree of Awareness;
- Current services available for related health need and identified gaps in those services; and
- Health disparities associated with the need;

The final priority need areas were not ranked in any particular order of importance, and each will be addressed by the Steering Committee. The following three focus areas (Access to Healthcare, Mental Health, and Substance Use) were identified as Dare County's top priority health needs to be addressed over the next three years, as seen in **Figure 7**:

Figure 7: Dare County 2025 Priority Health Needs

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 Dare County in both population and geography, this study was limited in its ability to fully capture health disparities and health needs across racial and ethnic groups. Resource limitations meant that county leaders relied on convenience sampling to engage with the community via the web-based survey. This method of survey sampling may fail to capture a truly representative cross-section of the community, resulting in overrepresentation of some demographic groups and underrepresentation of others. This can lead to findings that don't accurately reflect the health needs and perspectives of the entire community, particularly those from underrepresented or marginalized groups. While efforts were made to include diverse community members in survey efforts, roughly 95% of all respondents were White compared to the White population of Dare County only comprising 86% of the total county population. Roughly 1% of respondents were Black or African American, which was less than the 2% of the total county population that is Black or African American. Only 2% of respondents identified as Hispanic, which is less than the reported county population level of 7%. Although survey respondents could choose from multiple race or ethnicity categories, limited responses were received from these groups. This made it difficult to assess health needs and disparities for other racial/ethnic minority groups in the community.

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

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

Understanding Health Statistics

Age-Adjustment

Mortality rates, or death rates, are often used as measures of the health status of a community. Many factors can affect the risk of death, including race, sex, occupation, education and income. The most significant factor is age, because the risk of death inevitably increases with age; that is, as a population ages, its collective risk of death increases. Therefore, an older population will automatically have a higher overall death rate just because of its age distribution. At any one time some communities have higher proportions of "young" people, and others have a higher proportion of "old" people. In order to compare mortality data from one community with the same kind of data from another, it is necessary first to control for differences in the age composition of the communities being compared. This is accomplished by *age-adjusting* the data. Age-adjustment is a statistical manipulation usually performed by the professionals responsible for collecting and cataloging health data, such as the staff of the NC State Center for Health Statistics (NC SCHS). It is not necessary to understand the nuances of age-adjustment to use this report. Suffice it to know that age-adjusted data are preferred for comparing health data from one population or community to another and have been used in this report whenever available.

Aggregate Data

Another convention typically used in the presentation of health statistics is *aggregate data,* which combines annual data gathered over a multi-year period, usually three or five years. The practice of presenting data that are aggregated avoids the instability typically associated with using highly variable year-by-year data consisting of relatively few cases or deaths. It is particularly important to aggregate data for smaller jurisdictions like Dare County. The calculation is performed by dividing the number of cases or deaths due to a particular disease over a period of years by the sum of the population size for each of the years in the same period.

Incidence

Incidence is the population-based rate at which new cases of a disease occur and are diagnosed. It is calculated by dividing the number of newly diagnosed cases of a disease or condition during a given period by the population size during that period. Typically, the resultant value is multiplied by 100,000 and is expressed as cases per 100,000; sometimes the multiplier is a smaller number, such as 10,000. Incidence rate is calculated according to the following formula:

(number of new cases/population) x 100,000 = new cases per 100,000 people

The incidence rates for certain diseases, are simple to obtain when data on newly discovered cases is routinely collected (cancer registry). However, locating accurate incidence data on diagnoses of conditions which are not normally reported to central data-collecting agencies is rare.

Mortality

Mortality is calculated by dividing the number of deaths due to a specific disease in a given period by the population size in the same period. Like incidence, mortality is a rate, usually presented as number of deaths per 100,000 residents. Mortality rates are easier to obtain than incidence rates since the underlying (or primary) cause of death is routinely reported on death certificates. However, some error can be associated with cause-of-death classification, since it is sometimes difficult to choose a single underlying cause of death from potentially many co-occurring conditions.

Mortality rate by cause is calculated according to the following formula:

(number of deaths due to a cause/population) X 100,000 = deaths per 100,000 people)

Morbidity

Morbidity as used in this report refers generally to the presence of injury, sickness or disease (and sometimes the symptoms and/or disability resulting from those conditions) in the population. Morbidity data usually is presented as a prevalence percentage, or a count, but not a rate.

Prevalence

Prevalence, which describes the extent of a problem, refers to the number of existing cases of a disease or health condition in a population at a defined point in time or during a period. Prevalence expresses a proportion, not a rate. Prevalence is often estimated by consulting hospital records; for instance, hospital discharge records available from NC SCHS show the number of residents within a county who use hospital in-patient services for given diseases during a specific period. Typically, these data underestimate the true prevalence of the given disease in the population, since individuals who do not seek medical care or who are diagnosed outside of the hospital in-patient setting are not captured by the measure. Note also that decreasing hospital discharge rates do not necessarily indicate decreasing prevalence; rather they may be a result of a lack of access to hospital care.

Trends

Data for multiple years is included in this report wherever possible. Since comparing data on a year-by-year basis can yield very unstable trends due to the often small number of cases, events or deaths per year (see below), the preferred method for reporting incidence and mortality data is long-term trends using the age-adjusted, multi-year aggregate format. Most trend data used in this report is of that type.

Small Numbers

Year-to-year variance in small numbers of events can make dramatic differences in rates that can be misleading. For instance, an increase from two events one year to four the next could be statistically insignificant but result in a calculated rate increase of 100%. Aggregating annual counts over a five year period before calculating a rate is one method used to ameliorate the effect of small numbers. Sometimes even aggregating data is not sufficient, so the NC State Center for Health Statistics recommends that all rates based on fewer than 20 events—whether covering an aggregate period or not—be considered “unstable”, and interpreted only with caution. In recent years, the NC SCHS has suppressed mortality rates based on fewer than 20 events in a five-year aggregate period. Other state entities that report health statistics may use their own minimum reporting thresholds. To be sure that unstable health data do not become the basis for local decision-making, this report will highlight and discuss primarily rates based on 20 or more events in a five-year aggregate period and on 10 or more events in a single year. Where exceptions occur, the narrative will highlight the potential instability of the rate being discussed.

Describing Difference and Change

In describing differences in data of the same type from two populations or locations, or changes over time in the same kind of data from one population or location—both of which appear frequently in this report—it is useful to apply the concept of percent difference or change. While it is always possible to describe difference or change by the simple subtraction of a smaller number from a larger

number, the result often is inadequate for describing and understanding the scope or significance of the difference or change. Converting the amount of difference or change to a *percent* takes into account the relative size of the numbers that are changing in a way that simple subtraction does not, and makes it easier to grasp the meaning of the change. This document uses percentage almost exclusively to describe and highlight degrees of difference and change, both positive (e.g., increase, larger than, etc.) and negative (e.g., decrease, smaller than, etc.).

Final Health Data Caveat

Some data that is used in this report may have inherent limitations, due to sample size, or its age, for example, but is used nevertheless because there is no better alternative. Whenever this kind of data is used, it will be accompanied by a warning about its limitations.

Several limitations of the data should be considered when reviewing the findings presented in this report. Although the topics by which data are organized cover a wide range of health and health-related areas, within each topic there is a varying scope and depth of data availability. In some topics there is a robust set of secondary data indicators, but in others there may be a limited number of indicators for which data is collected, or limited subpopulations covered by the indicators.

Chapter 2 | County Profile

Geography

Dare County is located in the Outer Coastal Plain region of North Carolina, characterized by the presence of large sounds, bays, and river mouths. It covers a total of 1,542 square miles, including 383 square miles of land and 1,159 square miles of water. Dare County is comprised of six municipalities: Duck, Southern Shores, Kill Devil Hills, Kitty Hawk, Manteo and Nags Head. Nearly one quarter of Dare County's population resides in rural areas.

Population

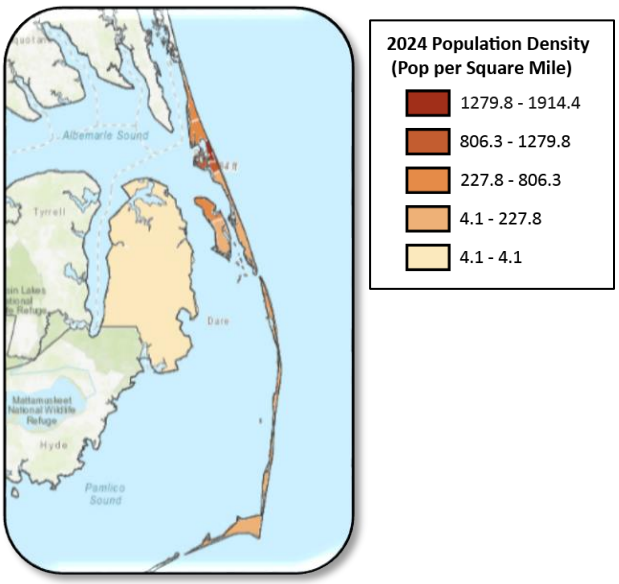
Population figures discussed throughout this chapter were obtained from Esri, a leading GIS provider that utilizes U.S. Census data projected forward using proprietary methodologies. At nearly 38,500, less than 1% of North Carolina's population resides in Dare County.

Table 2: Total Population, 2023[6]

	Dare County	North Carolina	United States
Population	38,482	10,765,678	337,470,185

Dare County has a population density of 100.7 persons per square mile – lower than the population density for North Carolina (214.7 persons per square mile). Kill Devil Hills is the most densely populated area in the county.

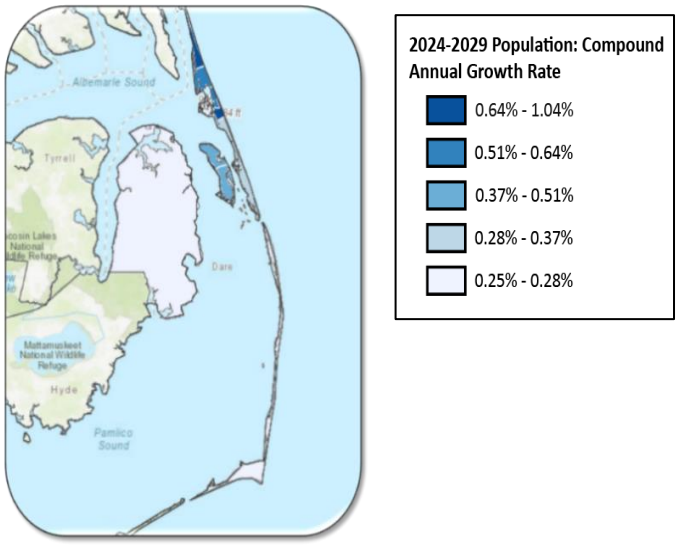
Figure 8: Dare County Map: Population Density[6]



[6] 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 Dare County is projected to grow 0.56% annually between 2024 and 2029. Areas in the northern parts of the county are experiencing greater growth.

Figure 9: Dare County Map: Population Growth[6]



Age and Sex Distribution

Data on age and sex helps health providers understand who lives in the community and informs planning for needed health services. The age distribution of Dare County skews older compared to state and national averages. Dare has a lower percentage of residents below age 15 (14.9%) compared to North Carolina (17.9%) and the United States (18.1%). The percentage of residents between 15 and 44 (33.0%) is also lower than state (39.3%) and national (39.5%) figures. However, Dare County has higher percentages of residents aged 45-64 (29.6%) and 65 and older (22.5%) compared to both state and national averages. This suggests an older population overall, with a particularly high proportion of seniors, which may have implications for healthcare needs and services in the county.

Table 3: Age Distribution, 2023[6]

	Dare County	North Carolina	United States
Percentage below 15	14.9%	17.9%	18.1%
Percentage between 15 and 44	33.0%	39.3%	39.5%
Percentage between 45 and 64	29.6%	25.1%	24.6%
Percentage 65 and older	22.5%	17.7%	17.8%

The sex distribution in Dare County is nearly balanced, with females making up 49.9% and males 50.1% of the population. This distribution closely mirrors the national average and is similar to North Carolina's distribution, which has a slightly higher percentage of females (51.0%) compared to males (49.0%).

Table 4: Sex Distribution, 2023[6]

	Dare County		North Carolina		United States	
	Count	Pct. of Total	Count	Pct. of Total	Count	Pct. of Total
Female	19,392	49.9%	5,489,419	51.0%	170,118,720	50.4%
Male	19,090	50.1%	5,276,259	49.0%	167,351,465	49.6%

Race and Ethnicity

Data on race and ethnicity help us understand the need for healthcare services as well as cultural factors that can impact how care is delivered. Dare County's racial composition differs significantly from state and national averages. Non-Hispanic White residents make up the largest racial group at 84.4%, which is notably higher than both North Carolina (61.2%) and United States (60.6%) figures. Non-Hispanic Black residents comprise just 1.9% of the population, considerably lower than state (20.4%) and national (12.5%) averages. The county has lower percentages of Asian (0.8%), American Indian Alaska Native (AIAN) (0.5%), and Native Hawaiian Pacific Islander (NHPI) (0.0%) populations compared to state and national figures. The percentage of residents identifying as Two or More Races (6.2%) is similar to the state average (7.2%) but lower than the national average (10.6%). This data indicates less racial diversity in Dare County compared to broader state and national demographics.

Table 5: Racial Distribution, 2023[6]

	Dare County		North Carolina		United States	
	Count	Pct. of Total	Count	Pct. of Total	Count	Pct. of Total
Black (Non-Hispanic)	741	1.9%	2,199,488	20.4%	42,132,758	12.5%
White (Non-Hispanic)	33,524	84.4%	6,590,161	61.2%	204,562,590	60.6%
Asian	309	0.8%	379,374	3.5%	21,088,177	6.2%
AIAN	198	0.5%	133,820	1.2%	3,831,126	1.1%
NHPI	11	0.0%	9,214	0.1%	712,229	0.2%
Some Other Race Alone	1,298	3.4%	677, 338	6.3%	29,432,586	8.7%
Two or More Races	2,401	6.2%	776,283	7.2%	35,710,719	10.6%

By ethnicity, 7.4% of Dare County's population is Hispanic. This is lower than the North Carolina average (11.4%) and significantly lower than the United States average (19.4%). The non-Hispanic population in Dare County (92.6%) is higher than both state (88.6%) and national (80.6%) figures.

Table 6: Ethnic Distribution, 2023[6]

	Dare County		North Carolina		United States	
	Count	Pct. of Total	Count	Pct. of Total	Count	Pct. of Total
Non-Hispanic	35,629	92.6%	9,465,874	88.6%	271,934,049	80.6%
Hispanic	2,853	7.4%	1,299,804	11.4%	65,536,136	19.4%

The proportion of foreign-born individuals residing in Dare County is 4.5%, which is lower than both North Carolina (9%) and the United States (13.9%) averages.

Table 7: Foreign Born Population, 2022[7]

	Dare County	North Carolina	United States
Foreign Born	4.5%	9%	13.9%

The diversity of Dare County is reflected in the languages that residents speak at home. The most recent American Community Survey (ACS) shows approximately 8.1% of residents speak a language other than English at home, compared to around 12.7% of North Carolina and 22% of U.S. residents, and 7.0% of county residents speak Spanish at home. This data indicates that Dare County has less linguistic diversity compared to state and national levels, with a strong predominance of English speakers.

Table 8: Languages Spoken at Home, 2022[7]

	Dare County	North Carolina	United States
English Only	91.9%	87.3%	78%
Spanish	7.0%	7.9%	13.3%
Indo-European Languages	1.4%	2.1%	3.8%
Asian and Pacific Islander Languages	0.5%	1.9%	3.6%
Other Languages	-	0.8%	1.2%

Disability Status

Data on disabilities helps us understand how to create fair and equal opportunities for everyone in the county. In addition, individuals with disabilities may require targeted services and outreach by health and other service providers. Just over one in ten (11%) Dare County residents have a disability, lower than both state and national figures.[8]

Table 9: Disability Status, 2022[7]

	Dare County	North Carolina	United States
Population with a Disability	11%	13.3%	12.9%

Veteran Status

Military veterans often need special services and support, so it is important to collect data about them to be better able to meet their specific needs. Veterans make up nearly 9% of Dare County's population, a slightly higher proportion compared to North Carolina and the U.S.

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[7] 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.

[8] 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.

Table 10: Veteran Status, 2022[7]

	Dare County	North Carolina	United States
Veterans	8.7%	7.8%	6.2%

Economic Indicators

In addition to demographic data, socioeconomic factors in the community such as income, poverty, and food scarcity play a significant role in identifying health-related needs. The median household income in Dare County is approximately $73,500. This is higher than both state and national figures.

Table 11: Median Household Income, 2023[6]

	Dare County	North Carolina	United States
Median Household Income	$73,526	$64,316	$72,603

In 2023, 5.4% of Dare County households were below the federal poverty level (FPL) – roughly half the proportion in the state and nation. Poverty has a significant impact on health. Across the lifespan, people who live in impoverished communities have a higher risk of poor health outcomes, including mental illness, chronic diseases, higher mortality and lower life expectancy. Poverty is a concern across the lifespan; children who live in poverty are at risk for developmental delays, toxic stress and poor nutrition, and are likely to live in poverty as adults as well. Unmet social needs, including having low or no income, can also limit people's ability to access healthcare when they need it, or to provide for basic necessities needed to live healthy lives, such as safe housing or healthy food.

Table 12: Percent of Households Below the Federal Poverty Level, 2023[6]

	Dare County	North Carolina	United States
Percent Below FPL	5.4%	10.1%	9.5%

Slightly higher than the percentage of households below the FPL, approximately 8% of Dare County households received Food Stamps/SNAP (Supplemental Nutrition Assistance Program) in 2022. There is a smaller proportion of residents receiving Food Stamps/SNAP in Dare County compared to North Carolina and the U.S, indicating a lower level of food insecurity among county households.

Table 13: Households Receiving Food Stamps/SNAP, 2022[9,10]

	Dare County	North Carolina	United States
Number of Households Receiving Food Stamps/SNAP	1,385	575,860	16,072,733
Total Number of Households	16,715	4,299,266	129,870,928
Percentage of Households receiving Food Stamps/SNAP	8.3%	13.4%	12.4%

[9] 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).

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

In Dare County, 18.6% of the population has completed high school alone, which is lower than both the state (21.2%) and national (28.5%) averages. The county shows higher rates of educational attainment beyond high school compared to state and national figures. Dare County has a higher percentage of residents with some college education (24.7%) compared to both the state (21.1%) and national (14.6%) averages. The county also exceeds state and national figures for residents with bachelor's degrees (25.6% compared to 20.4% for NC and 23.4% for US). The proportion of residents with graduate or professional degrees (7.7%) is lower than state (11.6%) and national (14.2%) averages, but still indicates a well-educated population overall.

Table 14: Educational Attainment, 2020[11,12]

	Dare County	North Carolina	United States
Less than 9th Grade	1.9%	6.0%	3.5%
Some High School/No Diploma	3.7%	5.5%	5.3%
High School Diploma	18.6%	21.2%	28.5%
GED/Alternative Credential	3.3%	4.3%	*[13]
Some College/No Diploma	24.7%	21.1%	14.6%
Associate's Degree	9.4%	9.9%	10.5%
Bachelor's Degree	25.6%	20.4%	23.4%
Graduate/ Professional Degree	2.7%	11.6%	14.2%

Dare County's overall uninsured rate of 11.6% is lower than the state average (15.0%) but slightly higher than the national average (12.0%). The county shows variations across age groups. The uninsured rate for ages 18 and below (11.0%) is more than double the state (5.2%) and national (5.4%) figures. For ages 19 to 34, Dare County's rate (29.0%) is also roughly double state (15.5%) and national (13.6%) averages. The county's uninsured rate for ages 35 to 64 (13.3%) is higher than both the state's 12.5% and the national 9.9% as well, although less significant than the younger age groups. This data indicates that while Dare County performs better than the state overall in terms of insurance coverage, there are still significant challenges across all age groups, particularly for young adults and children.

Table 15: Health Insurance Status, 2022[14]

	Dare County	North Carolina	United States
Percentage uninsured ages 18 or below	11.0%	5.2%	5.4%
Percentage uninsured ages 19 to 34	29.0%	15.5%	13.6%

[11] 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.

[12] 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.

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

[14] 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.

Percentage uninsured ages 35 to 64	13.3%	12.5%	9.9%
Total % Uninsured	11.6%	15.0%	12.0%

The overall unemployment rate in Dare County (5.1%) matches the state average and is higher than the national average (3.9%). Similar to state and national trends, the age group with the highest unemployment rate is young people between the ages of 16 and 24, at 13.4%. This is higher than both North Carolina (12.4%) and United States (11.0%) figures for the same age group. Additionally, the unemployment rate for Dare County residents aged 25 to 54 (6.8%) is higher than state (4.7%) and national (3.4%) figures. Other age groups have either similar or lower rates of unemployment in comparison to broader North Carolina and the U.S. The data suggests that Dare County faces some challenges with unemployment, particularly among younger workers.

Table 16: Unemployment, 2022[15,16]

	Dare County	North Carolina	United States
Percentage unemployed ages 16 to 24	13.4%	12.4%	11.0%
Percentage unemployed ages 25 to 54	6.8%	4.7%	3.4%
Percentage unemployed ages 55 to 64	3.2%	3.3%	2.7%
Percentage unemployed ages 65 or more	1.6%	3.0%	2.9%
Total unemployment	5.1%	5.1%	3.9%

Dare County top five employers were: Dare County Schools, County of Dare, Outer Banks Health, Professional Enterprises of Hatteras, and Caroling Designs Realty Inc. Eight of the twenty-five top employers are identified as the public sector class. Dare County and Dare County Schools employ more than 500 but less than 999 individuals each.[17]

Over 25% of Dare County's workforce works in the retail, accommodation, & food services industries. Retail trade employs more than 13% of the workforce with a median income of $59,958. Accommodation & food service industry employs over 12% of the workforce in Dare County with a median income of $54,894. Over 11% of workers in Dare County work in the construction industry with a median income of $94,265. [11]

More information on Dare County resident employment can be found in **Appendix 8.**

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

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

[17] Source: Data USA

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 10: Social Determinants of Health

As seen in **Figure 10**, many of the factors that contribute to health are hard to control or societal in nature. As such, health and healthcare organizations need to consider many underlying factors that may impact an individual's health and not simply their current health conditions.

It is widely acknowledged that people with lower income, social status and levels of education find it harder to access healthcare services compared to people in the community with more resources. This lack of access is a factor that contributes to poor health 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

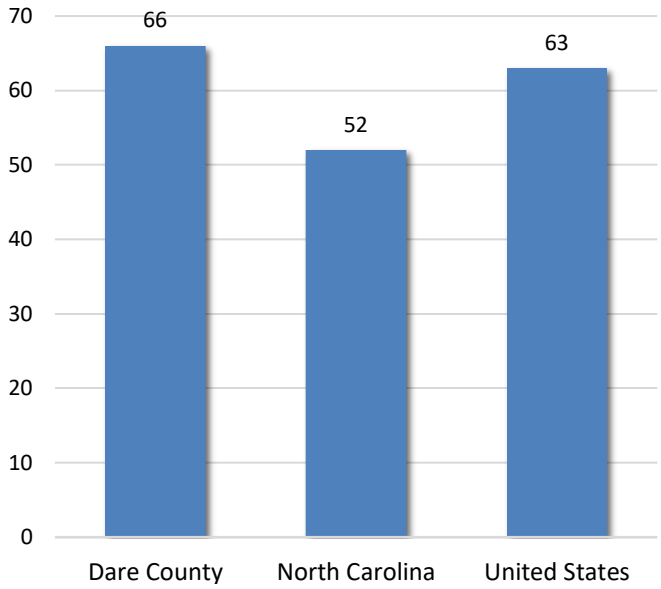
provide input regarding the needs of their specific communities. This information will be presented in detail later in this report.

Disparities

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

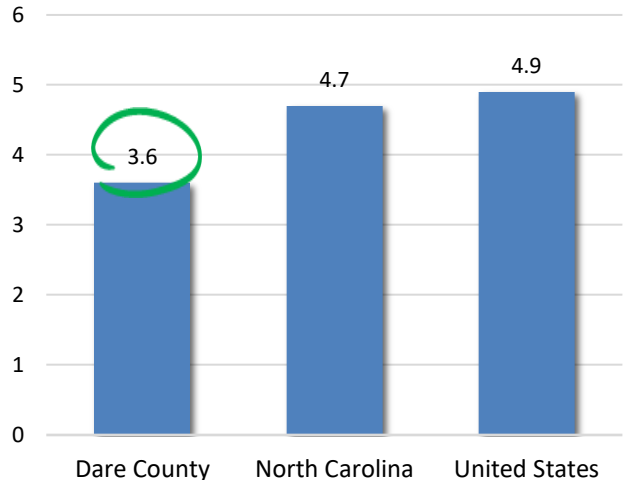
Residential segregation is measured by the index of dissimilarity, a demographic measure ranging from 0 to 100 that represents how evenly two demographic groups are distributed across a county's census tracts. Lower scores represent a higher level of integration. The residential segregation in Dare County is more prominent compared to North Carolina and the U.S, as seen in **Figure 11**.

Figure 11: Residential Segregation[3]



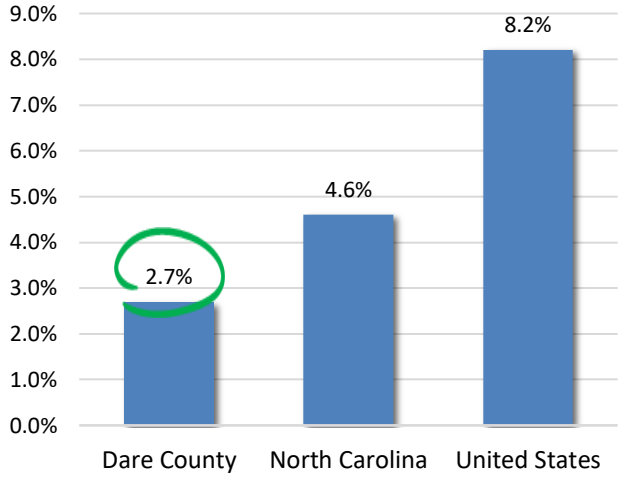
Income inequality is measured as the ratio of household income at the 80th percentile to household income at the 20th percentile. Communities with greater income inequality may have worse outcomes on a variety of metrics, including mortality, poor health, sense of community, and social support. As seen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

Figure 12: Income Inequality Ratio[3]



People with limited English proficiency (LEP) may face challenges accessing care and resources that fluent English speakers do not. Language barriers may make it hard to access transportation, medical, and social services as well as limit opportunities for education and employment. Importantly, LEP community members may not understand critical public health and safety notifications, such as safety-focused communications during the COVID-19 pandemic. Fewer people in Dare County are not fluent in English compared to North Carolina and the U.S, as seen in **Figure 13**.

Figure 13: Percent of Population with Limited English Proficiency[7]

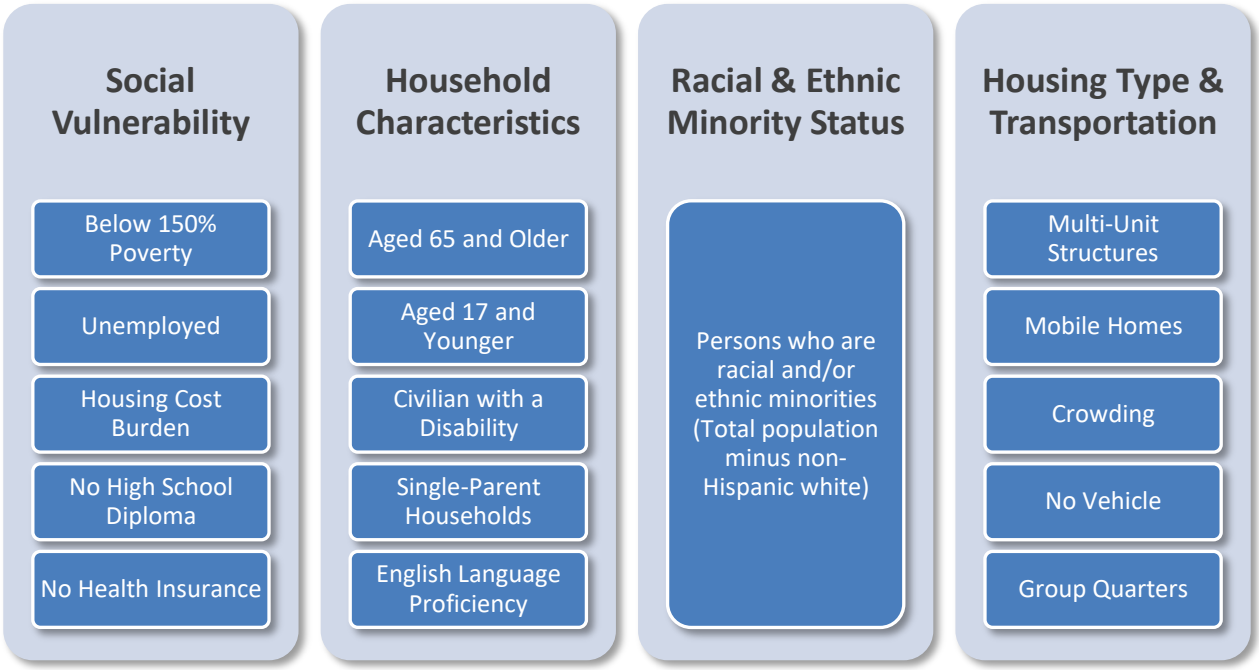


Social Vulnerability Index

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

The SVI uses 16 U.S. Census variables to help local officials identify communities that may need support before, during, or after a public health emergency.[18] Communities with a higher SVI score are generally at a higher risk for poor health outcomes. Instead of relying on public health data alone, the SVI accounts for underlying economic and structural conditions that affect overall health, including SDoH. SVI scores are calculated at the census tract level and based on U.S. Census variables across four related themes: socioeconomic status, household characteristics, racial and ethnic minority status, and housing type/transportation. **Figure 14** outlines the variables used to calculate SVI scores.

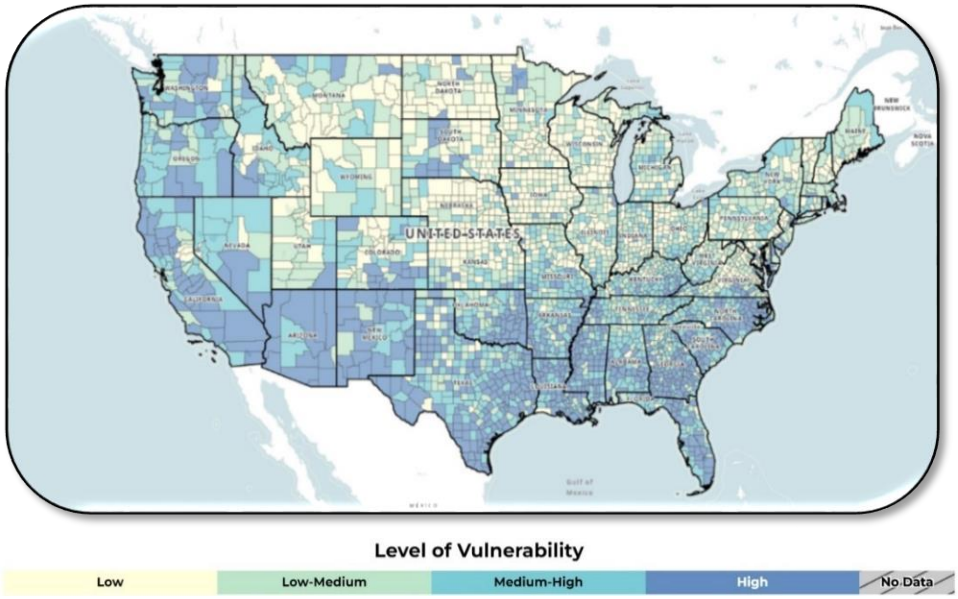
Figure 14: SVI Variables



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

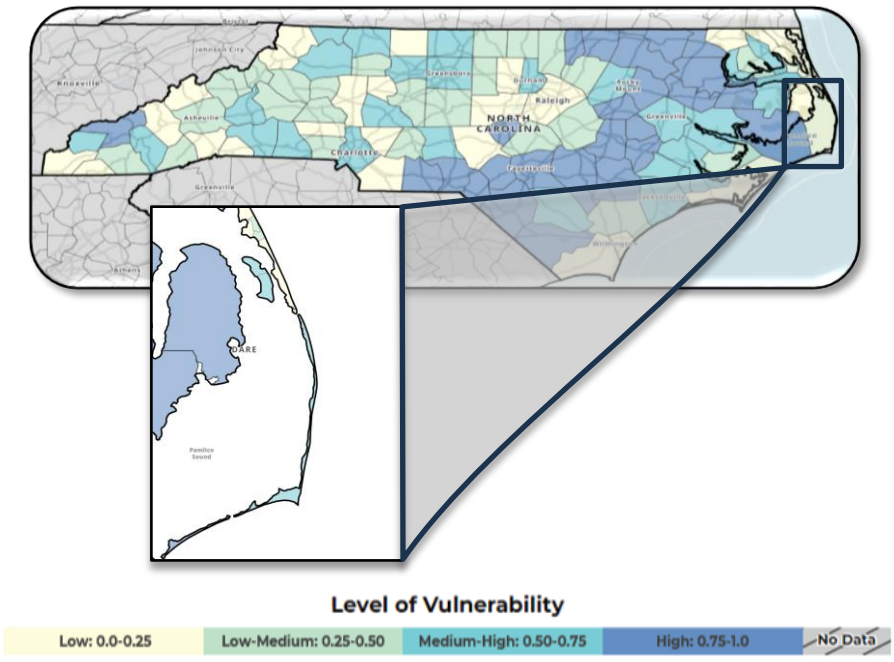
[18]Source: Centers for Disease Control and Prevention (2024). Social Vulnerability Index. https://www.atsdr.cdc.gov/place-health/php/svi/index.html

Figure 15: United States SVI by County, 2022



The 2022 SVI scores for Dare County are shown in **Figure 16** below. Possible scores range from 0 (lowest vulnerability) to 1 (highest vulnerability), and these scores show a relative comparison with other counties and census tracts in North Carolina. The vulnerability of Dare County overall is significantly lower than average compared to the state. Levels of vulnerability are variable across the county with the average being 0.09.

Figure 16: Dare County SVI by Census Tract, 2022



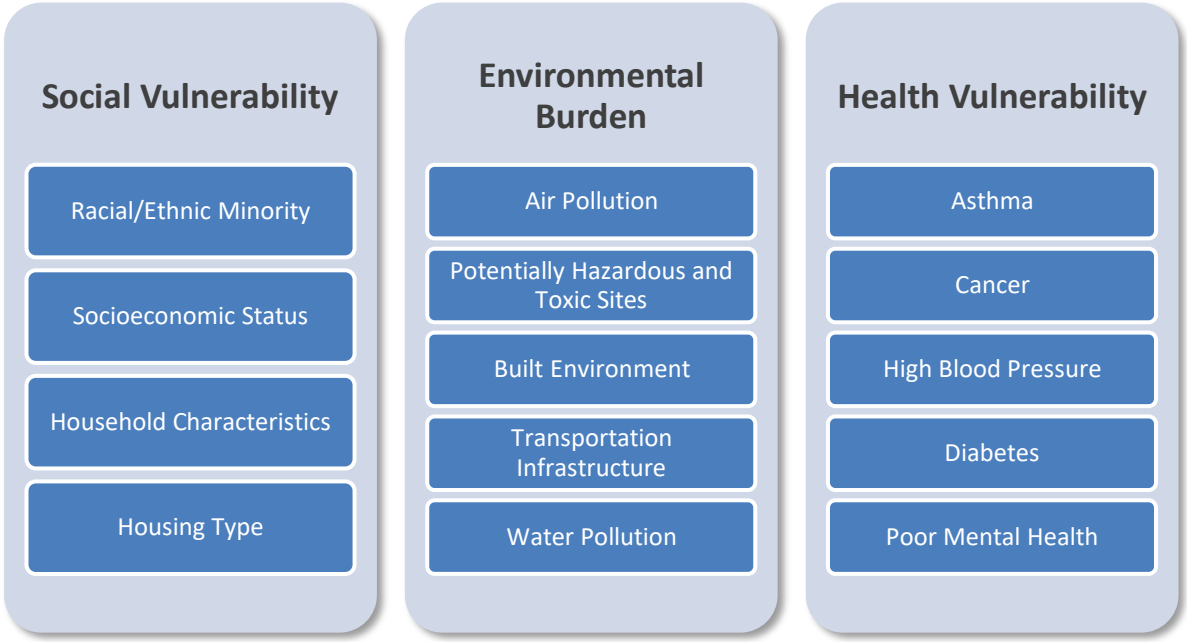
Environmental Justice Index

Environmental justice means the just treatment and meaningful involvement of all people, regardless of income, race, color, national origin, Tribal affiliation, or disability, in agency decision-making and other Federal activities that affect human health and the environment. It aims to protect everyone from disproportionate health and environmental risks, address cumulative impacts and systemic barriers, and provide equitable access to a healthy and sustainable environment for all activities and practices.[19]

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

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

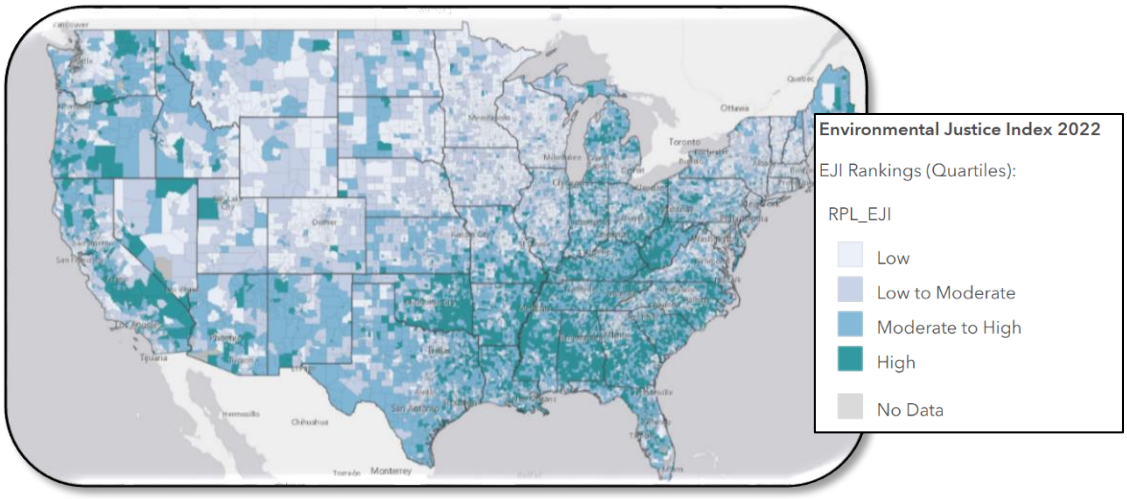
Figure 17: EJI Variables



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

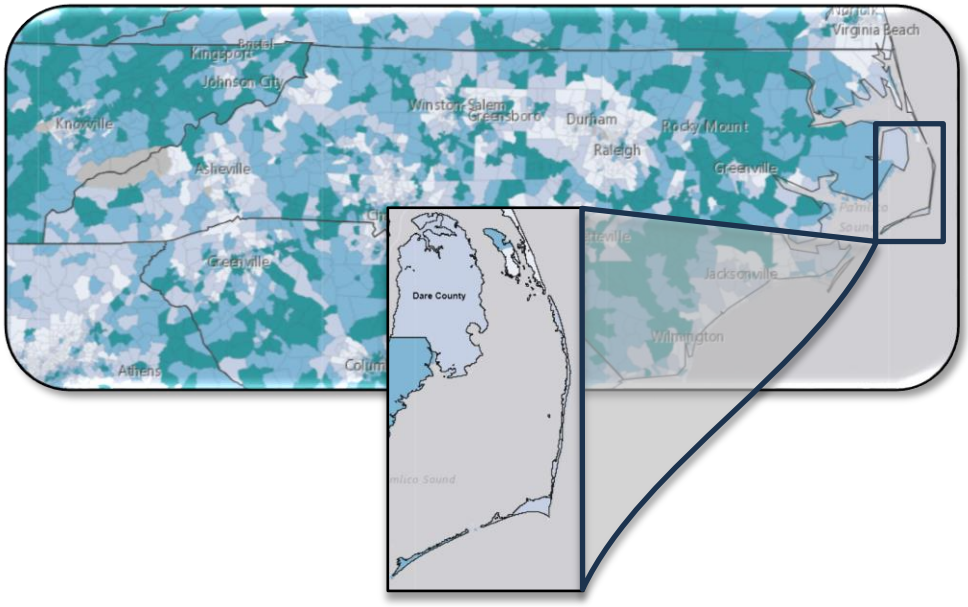
The United States EJI by county is shown in **Figure 18**. As shown, a lot of variation exists across the country, and even within individual states.

Figure 18: United States EJI by Census Tract, 2022



The 2022 EJI scores for Dare County are shown in **Figure 19** below. EJI scores use percentile ranking which represents the proportion of census tracts that experience environmental burden relative to other census tracts in North Carolina. The index ranges from 0-1 with higher scores indicating more environmental burden compared to other census tracts. Levels of environmental burden are variable across the county with the average being 0.24.

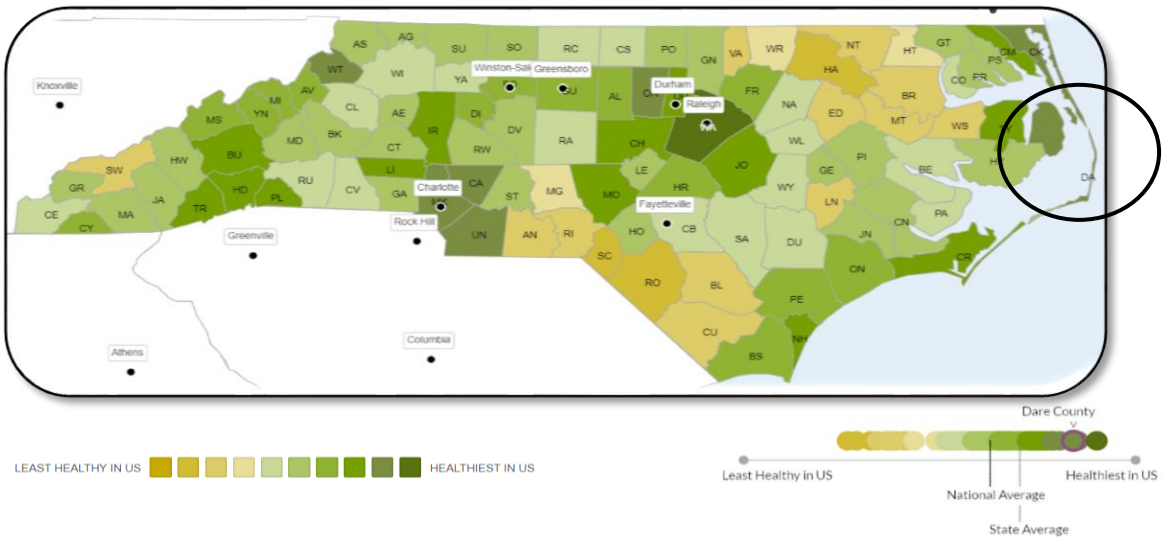
Figure 19: Dare County EJI by Census Tract, 2022



Health Outcomes and Health Factor Rankings

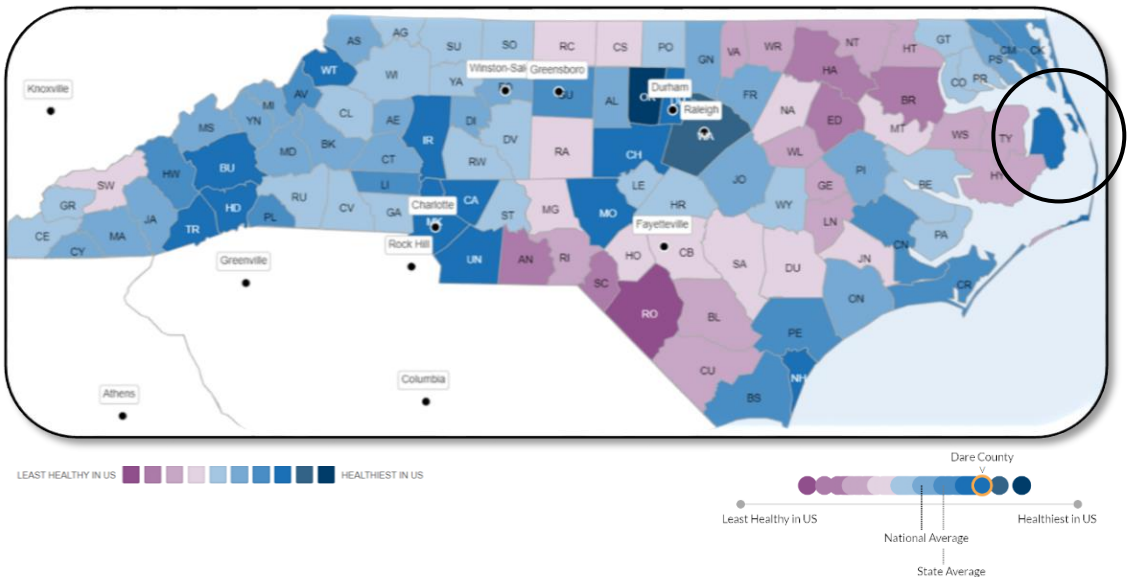
County leaders also reviewed and analyzed data from the Robert Wood Johnson Foundation and the University of Wisconsin County Health Rankings for the year 2024. The Health Outcomes measure looks at how long people in a community live and how physically and mentally healthy they are. These categories are discussed further in **Appendices 2** and **3**. Dare significantly surpasses the average for the country and the state, which means people there may be healthier on average.

Figure 20: State Health Outcomes Rating Map[3]21



The Health Factors measure looks at variables that affect people's health including health behaviors, clinical care, social & economic factors, and the physical environment they live in. More details about these indicators can be found in **Appendices 2** and **3**. Similarly to the Health Outcome measure, Dare

Figure 2222: State Health Factors Rating Map[3]



surpasses the average for the country and the state.

Leading Causes of Death

Comparing rates over years also allows us to better understand trends in Dare County. When examining leading causes of death from 2012-2022, a few observations are noted:

As pictured in **Table 17**, cancer remains the leading cause of death in Dare County. Since 2013 death rates from suicide and pneumonia & influenza have been trending down while rates of unintentional non-motor vehicle injury deaths have increased. Since 2014, rates of cancer deaths have been declining. Chronic lower respiratory disease rates have declined steadily since 2016. Death rates for heart disease and chronic liver diseases & cirrhosis have been trending up since 2017.

Table 17: Leading Causes of Death in Dare County 2012-2022[20]

	Dare County							NC
	2012-2016	2013-2017	2014-2018	2015-2019	2016-2020	2017-2021	2018-2022	2018-2022
1) Cancer	161.9	168.1	164.5	163.1	159.0	154.3	146.8	152.1
2) Heart Diseases	157.3	153.2	151.1	145.1	139.0	143.6	146.1	161.2
3) Unintentional Non-Motor Vehicle Injury	35.1	39.0	48.0	52.5	66.7	77.8	78.6	52.5
4) Cerebrovascular Disease	30.0	35.0	42.1	42.4	43.6	43.3	42.3	44.4
5) Chronic Lower Respiratory Disease	35.4	38.3	36.3	36.9	36.2	33.7	30.1	39.8
6) Alzheimer's Disease	20.8	24.5	27.3	26.9	27.2	28.1	24.8	36.6
7) Chronic Liver Diseases & Cirrhosis	15.0	17.7	17.8	18.7	16.6	17.5	17.9	12.7
8) Pneumonia & Influenza	44.0	34.1	28.8	23.2	21.2	18.4	17.8	13.8
9) Suicide	20.2	19.6	19.9	19.3	17.9	15.9	15.8	13.5
10) COVID-19	n/a	n/a	n/a	n/a	n/a	12.2	15.6	43.5
Total Mortality	**700.2**	**722.0**	**737.1**	**733.1**	**746.0**	**772.7**	**758.0**	**849.4**

Vulnerable & At-Risk Populations

Identifying vulnerable populations during the Community Health Needs Assessment process is essential for ensuring equitable health outcomes, effective resource use, and the development of targeted interventions that improve the health and well-being of our community.

Older Adults

Older adults have an increased prevalence of chronic health conditions and age-related decline in physical and cognitive abilities, which can lead to greater health risks. Futhermore, social isolation, limited mobility, and barriers to accessing healthcare can exacerbate their vulnerabilities, making it essential to address their unique healthcare needs.

- 5.1% of individuals 65 year of age and older are living in poverty.
- Cancer and heart disease are the top two causes of death among individuals 65 years of age and older.
- We have a rapidly aging population with more than half (52.1%) of our residents 45 years of age or older:
    - 29.6% of our population is 45-64 years of age

[20] Source: NC State Center for Health Statistics, County Health Data Book (2018, 2019, 2020, 2021, 2022), Mortality, Race-Specific and Sex-Specific Age-Adjusted Death Rates by County, Retrieved from: https://schs.dph.ncdhhs.gov/data/databook2021/

- 22.5% of our population is 64 years of age or older

Children

Children have developing bodies and immune systems, which make them more susceptible to disease and environmental hazards. Additionally, their reliance on caregivers for access to healthcare, nutrition, and education further exacerbates their vulnerability, as they may lack the agency to advocate for their own health needs.

- Dare County parents spend approximately 27% of household income on childcare costs.
- 11% of children in Dare County are food insecure, which is lower when compared to NC (15%) and the US (13%).
- 30% of Dare County's population under the age of 18 is 200% or more below the federal poverty level.
- Dare had a higher percentage (4%) of homeless children enrolled in school for the 2019-2020 school year when compared to NC (1.9%) and the US (2.8%).

The uninsured rate for individuals in Dare County ages 18 and below (11.0%) is more than double NC (5.2%) and the US (5.4%) figures.

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 Outer Banks community of Dare County engaged in a comprehensive needs assessment process to identify its most pressing health priorities. Primary data collection included a web survey, three focus groups with 27 total community participants and fifteen key informant interviews. Focus group participants included community residents, individuals in recovery, and housing task force members. Key informants represented diverse sectors including health and human services, community outreach organizations, healthcare providers, and local government agencies. Healthy Carolinians of the Outer Banks met on August 19th to review the CHNA data findings, followed by an executive committee meeting on September 4th to review those findings alongside community input. Through this process, the executive committee identified priorities that reflect both ongoing challenges and emerging needs in the coastal community.

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

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

Priority Need: Access to Care

Context and National Perspective

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

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

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

The difficulty in rural areas to support certain specialists is a well-documented issue, and it stems from several factors related to population size, healthcare infrastructure, and the nature of specialized medical practices. Rural areas often have smaller populations, sometimes fewer than 100,000 people. Specialists typically rely on a larger number of patients to sustain their practice and maintain their skill sets. Additionally, with fewer people needing specialized care, there may not be enough patients to justify a full-time position for specialists. In many cases, rural patients are referred to urban centers, making it hard to retain specialists locally.

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

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

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

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

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

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

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

Secondary Data Findings

Secondary data collected through the CHNA process identified access to care as an area of concern for residents of Dare County. Multiple access to care indicators were worse than state and national averages, including the percentage of the population living in a dental health professional shortage area (HPSA). As displayed in the table below, the rate of primary care providers demonstrated high need in Dare County, with a rate much lower than state and national figures. Primary care provider rates showed similar disparities, with Dare County having 75.9 providers per 100,000 population compared to 101.1 for North Carolina and 112.4 nationally. More specifically, as indicated in the table below, there are large deficits in internal medicine providers in Dare County. The county also had a lower rate of Federally Qualified Health Centers (2.7 per 100,000 population) compared to state (4.0) and national (3.5) averages.

Table 18: Access to Care Indicators

Indicator	Dare County	North Carolina	United States
Dental Providers (Rate per 100,000 Population)	35.2	31.5	39.1
Primary Care Providers (Rate per 100,000 Population)	75.9	101.1	112.4
Percentage of Population Living in an Area Affected by a Dental Care HPSA	96%	34%	18%
Percent of Insured Population Receiving Medicaid	9.9%	20%	22%
Rate of Federally Qualified Health Centers (Rate per 100,000 Population)	2.7	4.0	3.5

A recent provider needs assessment focused on Dare County found deficits in the county within primary care specialties – particularly internal medicine. While the local concentration of family medicine providers appears high, as shown in **Table 19** below, this is due to the presence of many urgent care centers throughout the county. While county residents may be able to access urgent care

[27] Source: Joszt, L. (2018). 5 Vulnerable Populations in Healthcare. *American Journal of Managed Care*. Retrieved September 9, 2024 from https://www.ajmc.com/view/5-vulnerable-populations-in-healthcare.
[28] Source: Espinoza, J. and Derrington, S. (2021). How Should Clinicians Respond to Language Barriers That Exacerbate Health Inequity? *AMA Journal of Ethics*. Retrieved from: https://journalofethics.ama-assn.org/article/how-should-clinicians-respond-language-barriers-exacerbate-health-inequity/2021-02.

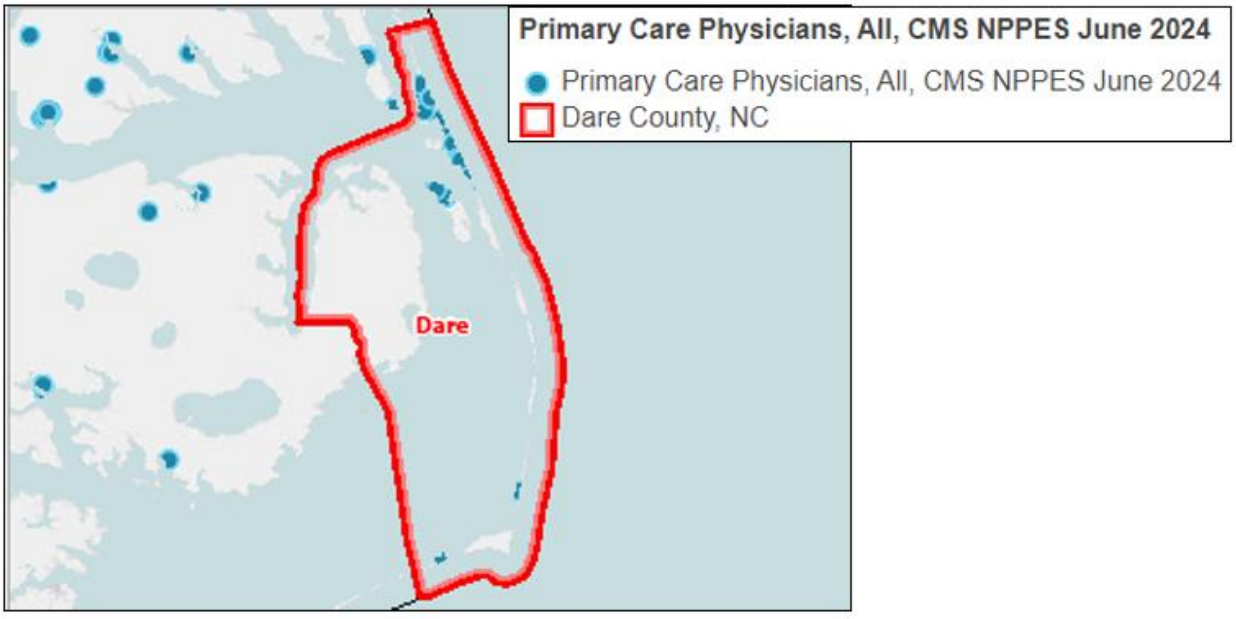
for minor needs, these deficits suggest combined with the rate of PCPs shown in **Table 18** suggest that access to reliable primary care may be a challenge for community members.

Table 19: Providers by Specialty

		Physician Only			Physician plus APP		
Specialty Group	Main Specialty	Supply FTE	Demand FTE	Surplus/Deficit	Supply FTE	Demand FTE	Surplus/Deficit
Primary Care	Family Medicine	10.70	10.67	0.03	35.89	14.15	21.74
	Internal Medicine	1.00	7.92	(6.92)	1.00	8.91	(7.91)
	Pediatrics	4.00	3.91	0.09	7.22	4.46	2.76

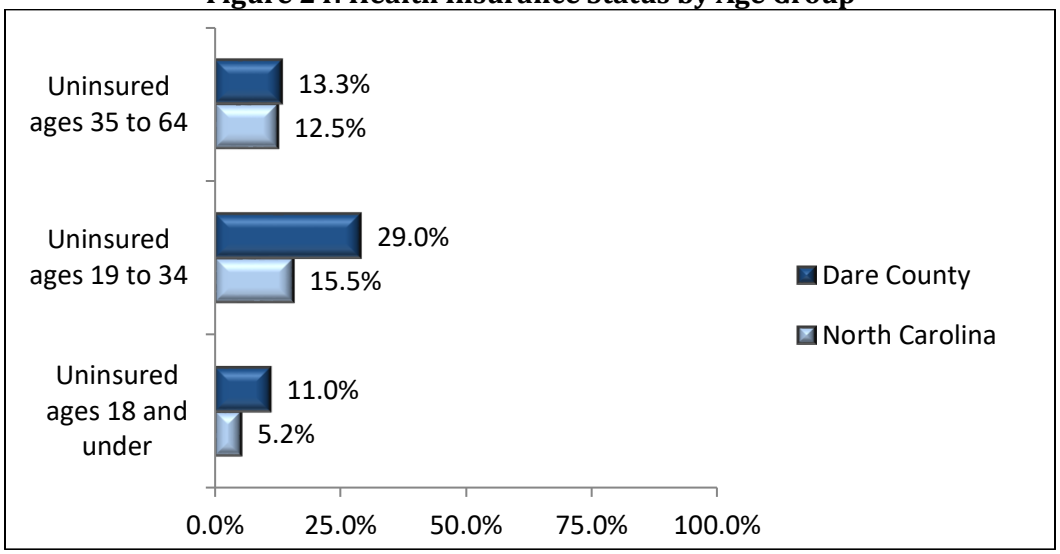
The PCPs practicing in the county are concentrated near the north, suggesting access challenges for residents in the central and southern areas of the county. This geographic distribution of providers creates additional barriers for residents seeking care.

Figure 23: Primary Care Access Map



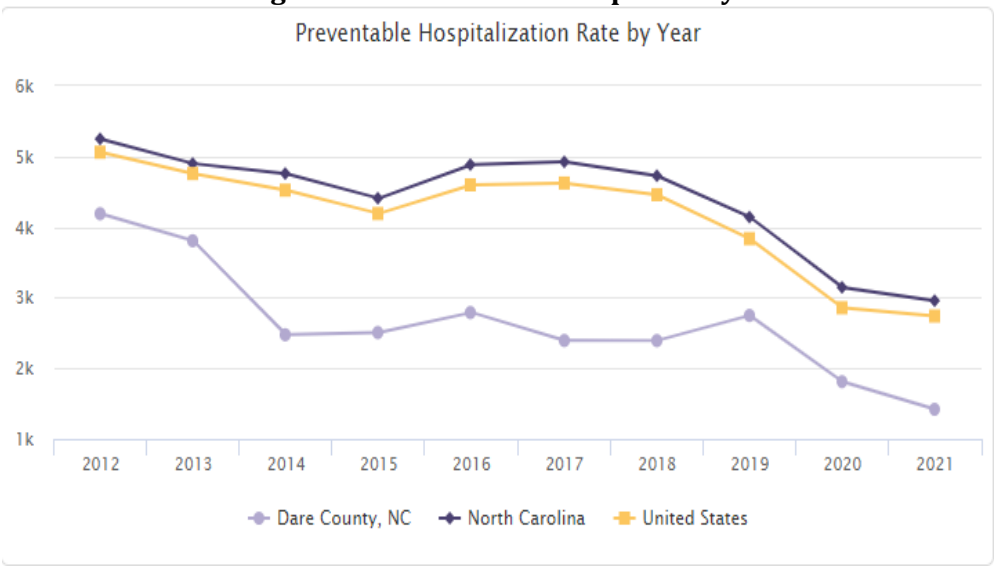
Insurance coverage also presents challenges for certain populations. The uninsured rate varies significantly by age group, with 29.0% of those aged 19-34 lacking insurance coverage, nearly double the rate in the state. The county has a lower percentage of the insured population receiving Medicaid (10%) compared to both state (20%) and national (22%) averages, suggesting potential gaps in coverage for low-income residents.

Figure 24: Health Insurance Status by Age Group



In Dare County, preventable hospital stays for ambulatory care-sensitive conditions per 100,000 have been trending downward, with the county outperforming both state and national rates.

Figure 25: Preventable Hospital Stays



There were also significant disparities in preventable hospital stays among different racial and ethnic groups in Dare County. Hispanic or Latino Medicare beneficiaries experienced the highest rates at 8,266 per 100,000 beneficiaries, followed by Black or African American beneficiaries (6,731). By contrast, the rate for White beneficiaries was 1,703 per 100,000. These disparities suggest inequitable access to preventive and primary care services across different populations in the county.

Figure 26: Preventable Stays by Race/Ethnicity

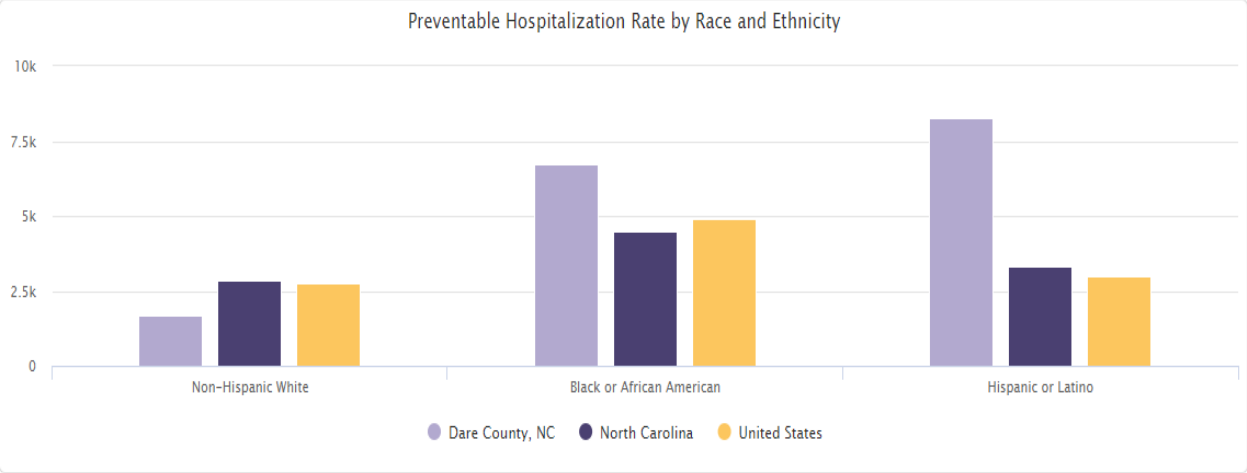


Table 20: Preventable Hospital Stays by Race/Ethnicity

Preventable Hospital Stays (per 100,000 Medicare Beneficiaries)	Dare County Rate
Preventable Hospital Stays	1,422
Black or African American Medicare Beneficiaries	6,731
White Medicare Beneficiaries	1,703
Hispanic or Latino Medicare Beneficiaries	8,266

Transportation access poses significant challenges in Dare County, and has an impact on community members' ability to access healthcare. While the county has a lower percentage of households with no motor vehicle (1.8%) compared to state (5.4%) and national (8.3%) averages, there is no public transit infrastructure in place. None of the population uses public transit for commuting, compared to 0.8% statewide and 3.8% nationally.

Table 21: Transportation Indicators

Indicator	Dare County	North Carolina	United States
Households with No Motor Vehicle, Percent	1.8%	5.4%	8.3%
Percent Population Using Public Transit for Commute to Work	0.0%	0.8%	3.8%

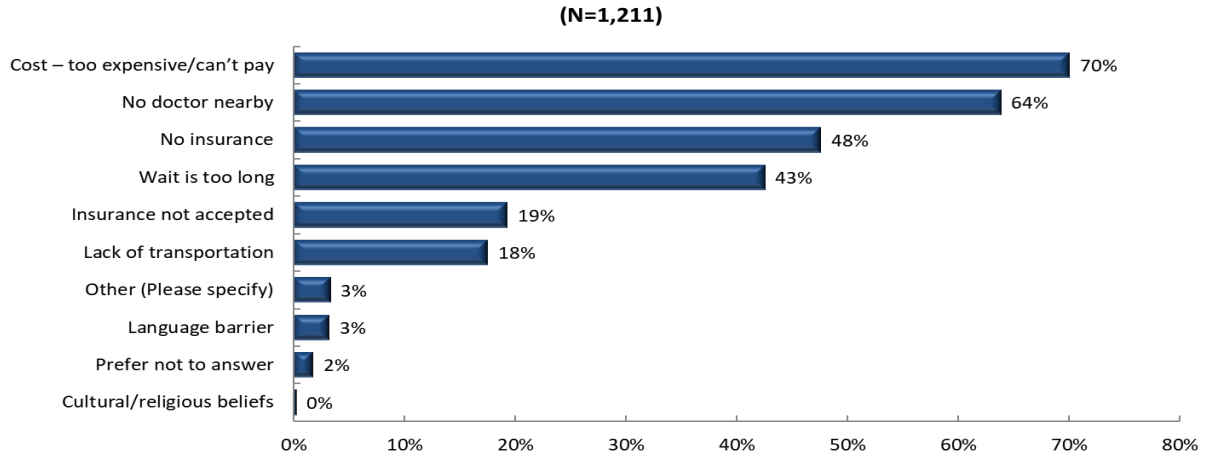
For additional detail on secondary data findings, see **Appendix 3**.

Primary Data Findings – Community Member Web Survey

Nearly 1,200 Dare County residents responded to the web-based survey. Respondents identified several access to care needs in Dare County. In the survey, community members were asked to

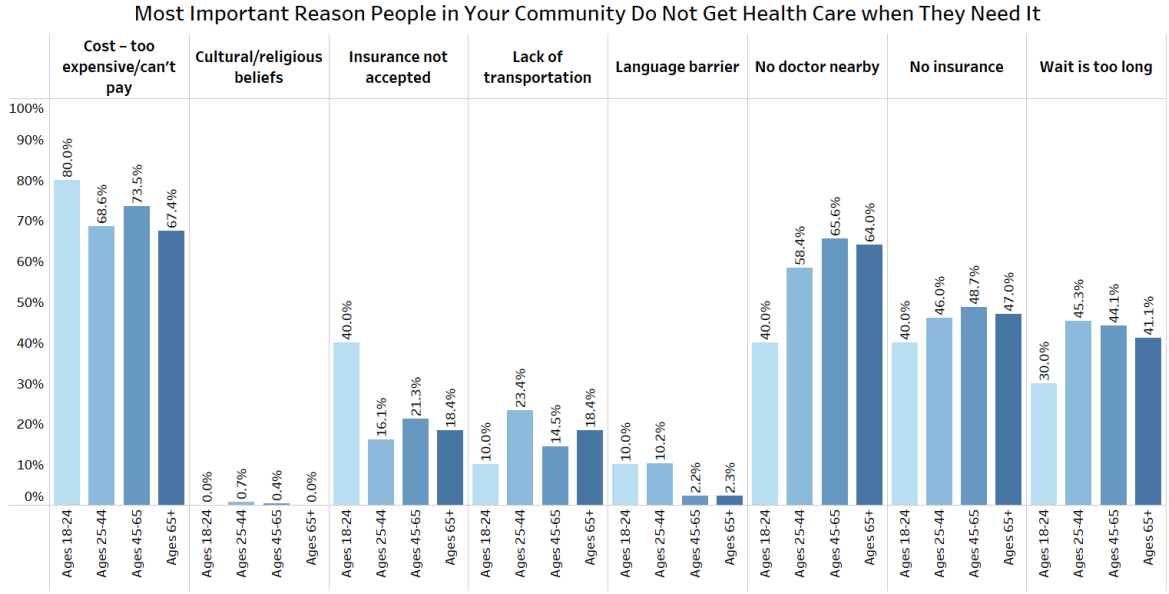
identify the top barriers to receiving healthcare. Cost (70%), no doctor nearby (64%), and lack of insurance (48%) were the top three identified reasons why people in the community are not getting care when they need it. Another 43% of responses identified long wait times and one-fifth of responses indicated insurance not being accepted as the top barriers to care.

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



When these data were examined by age group, the age group that most frequently identified cost (80%) and insurance not being accepted (48%) as top barriers was those ages 18 to 24. The absence of doctors nearby was identified most frequently as a barrier to care by older respondents ages 45 to 65 and 65+ compared to the other age groups. Recognition of lack of insurance was more equal across all age groups.

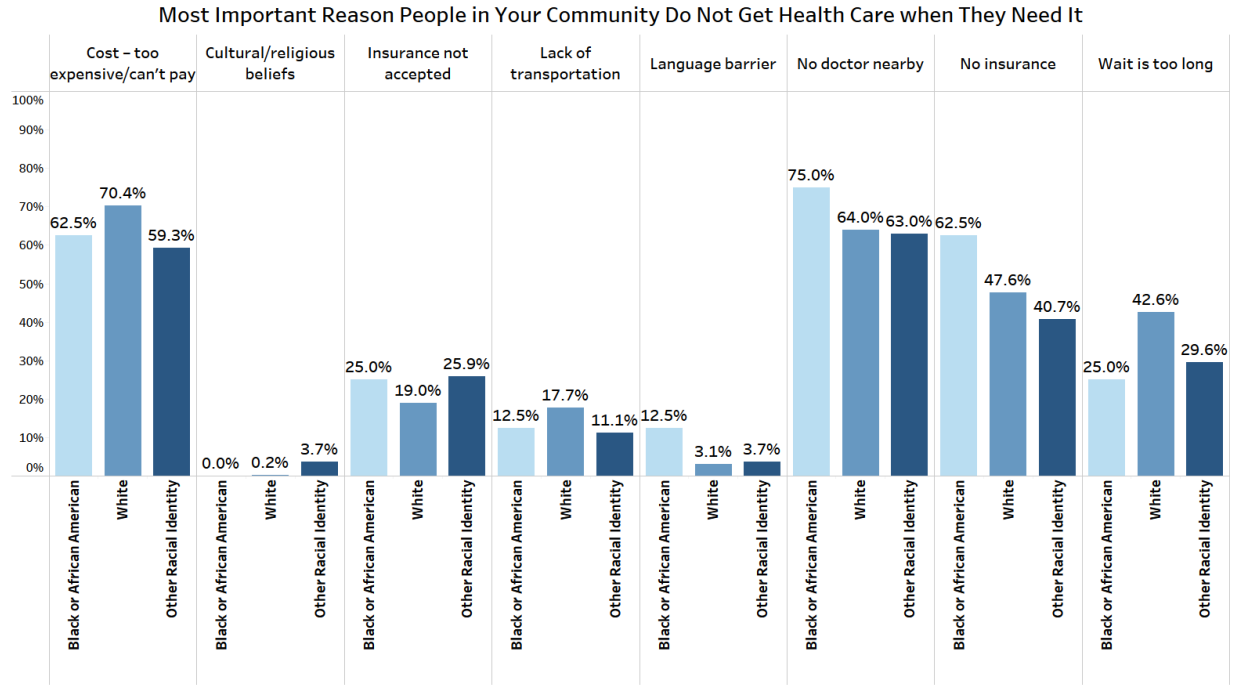
Figure 28: What are the three most important reasons people in your community do not get health care when they need it? Please select up to three. (by age)



Responses also differed by race. Three-quarters of respondents identifying as Black or African American noted having no nearby doctor as a top barrier to healthcare compared to 64% of respondents identifying as White and 63% of respondents identifying with the "Other" race category,

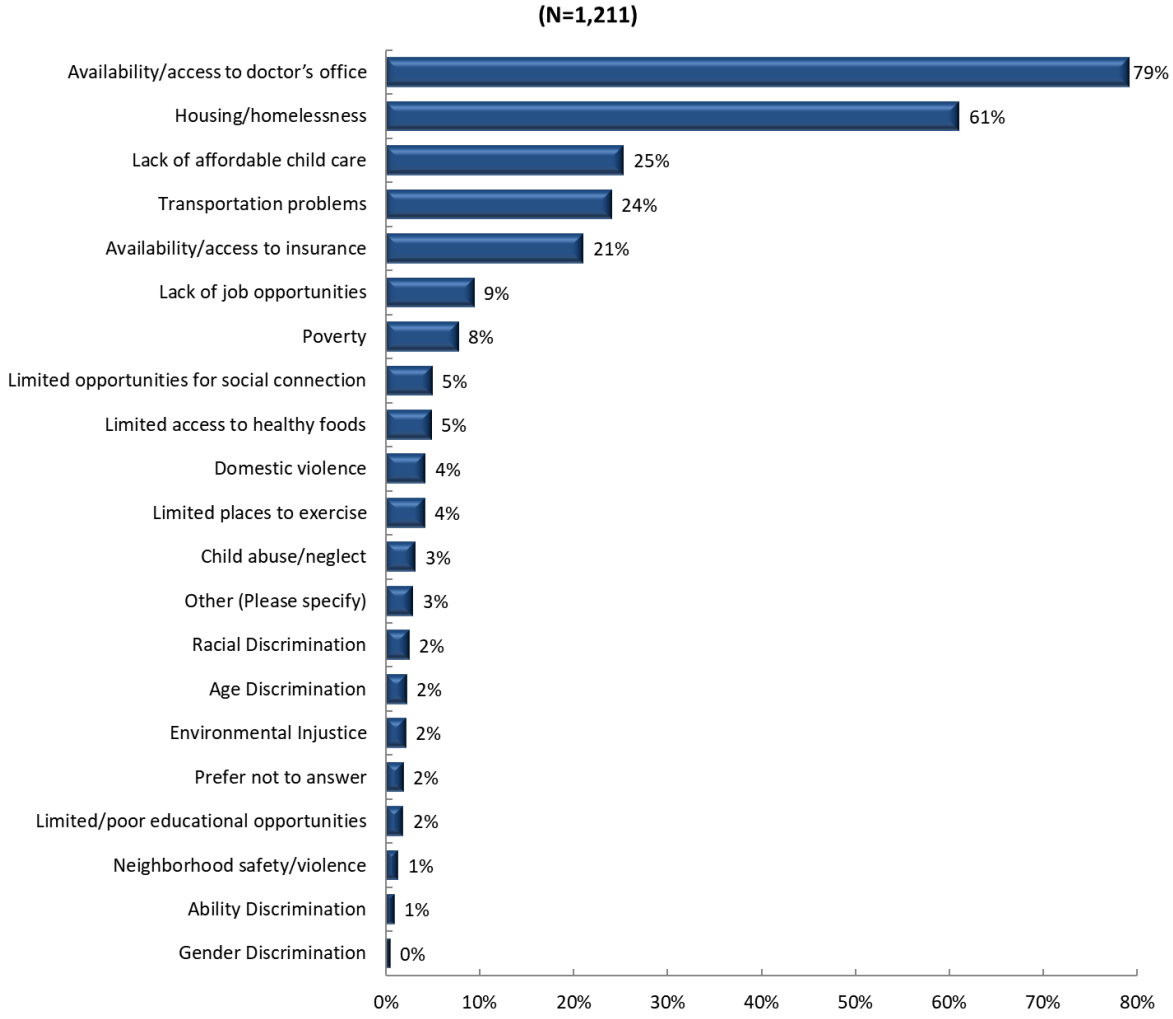
including those who identified as American Indian and Alaska Native, Asian, Native Hawaiian and other Pacific Islander, and/or those who selected more than one race or "other." Similarly, 63% of respondents identifying as Black of African American indicated not having insurance as a barrier, significantly higher than the percentages of respondents identifying as White (48%) and those identifying with all other racial categories (41%).

Figure 29: 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)



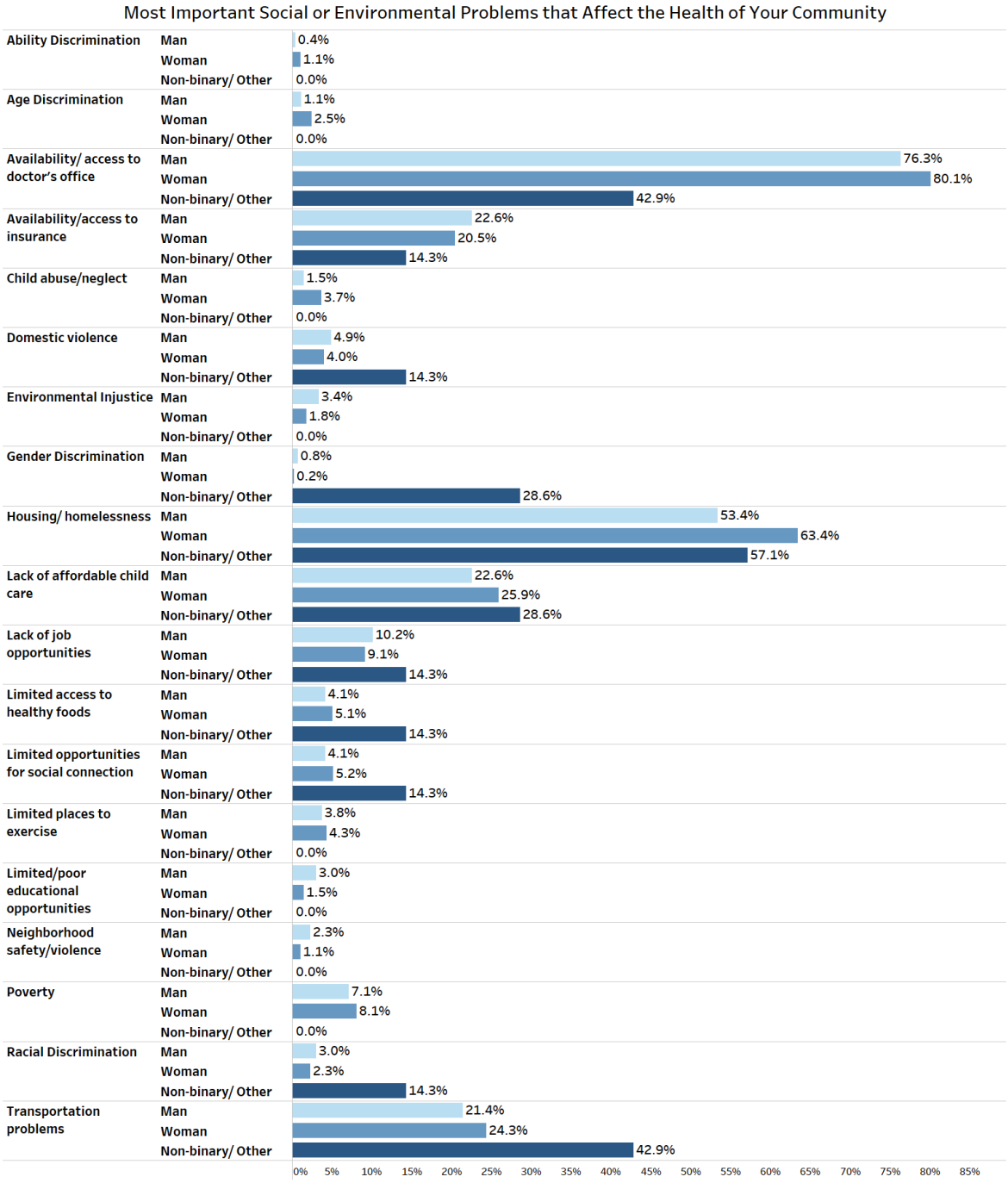
Community members were also asked to identify the most important social or environmental problems that affect the health of the community. As displayed in the figure below, the most frequent problem identified was the availability or access to doctor's offices (79%), again highlighting access to care challenges within the community. Transportation (24%) was identified as the fourth most frequent social or environmental problem that affects the health of the community, followed by availability or access to insurance (21%).

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



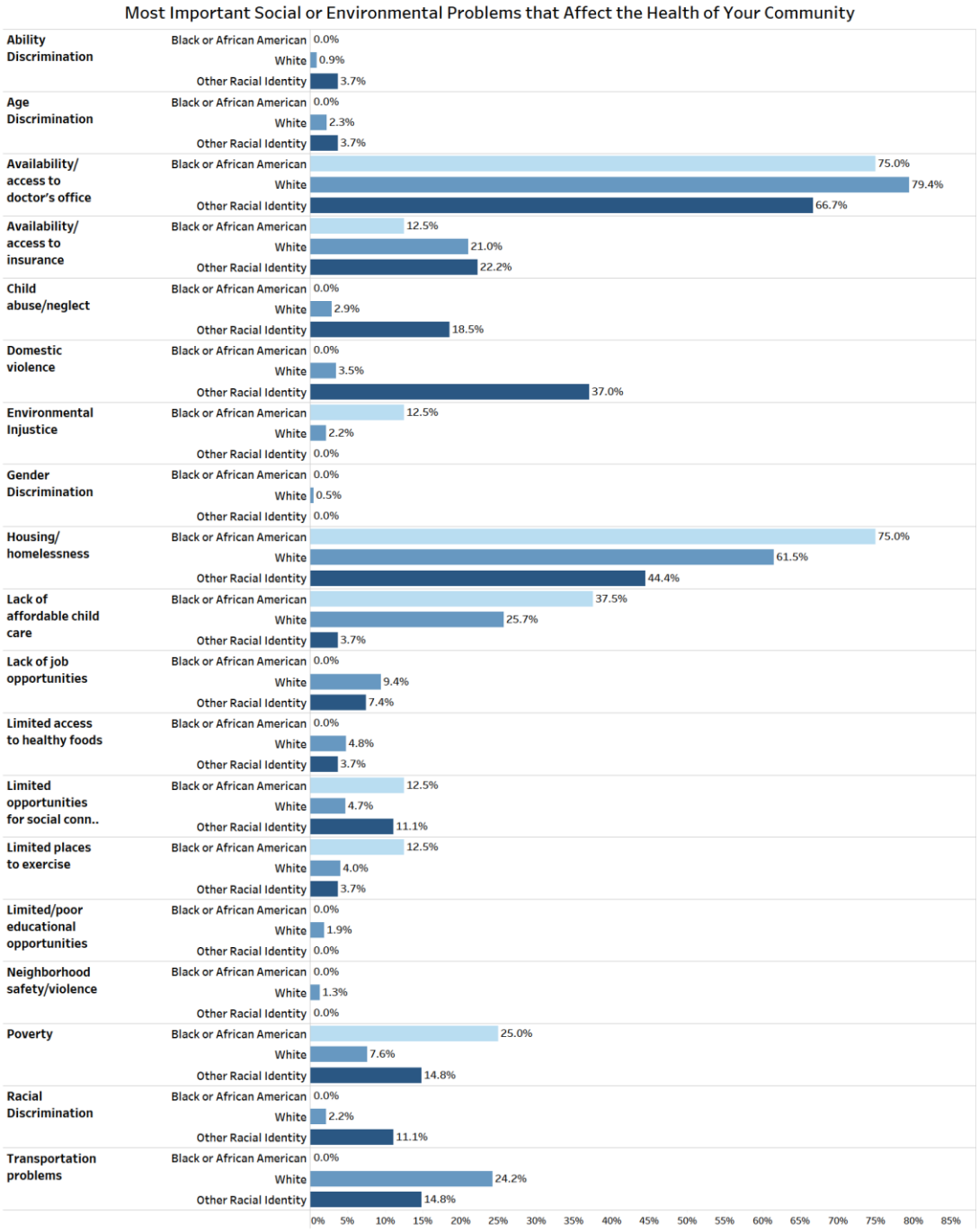
Notably, men, women, and "other" gender identity (transgender and non-binary) respondents differed in their responses. More women identified availability and access to doctor's offices as a top social and environmental problem (80% for women vs. 76% for men and 43% for other). Respondents identifying their gender identity as "other" were more much likely than both men and women to identify transportation problems as an important social and environmental problem (43% compared to 24% for women and 21% for men).

Figure 31: What are the three most important social or environmental problems that affect the health of your community? Please select up to three. (by gender)



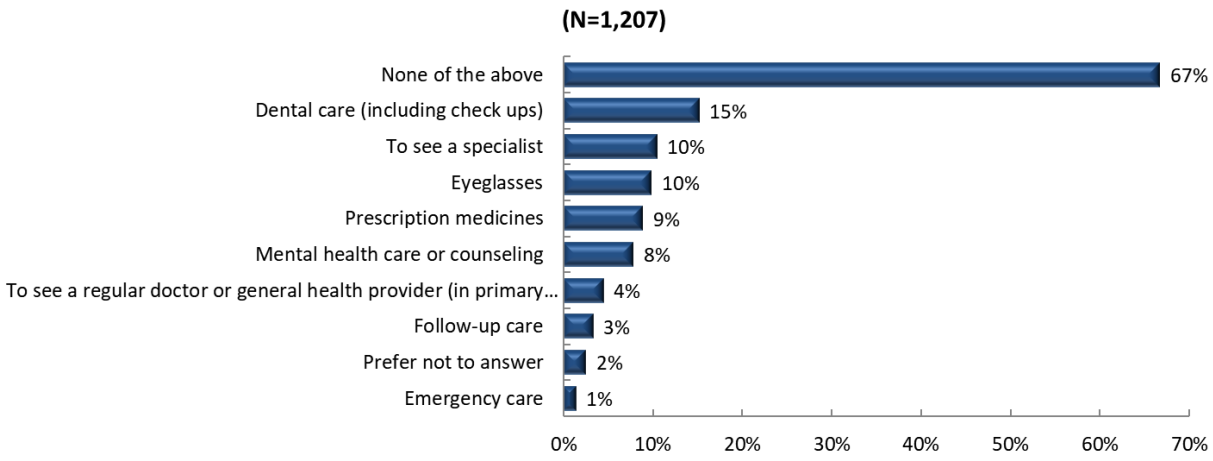
Responses also varied by race. Those identifying as White were more likely to cite availability of doctor's offices and transportation than respondents identifying as Black or African American or with all other races (White: 79%, 24%; Black or African American: 75%, 0%; All Other: 67%, 15%).

Figure 32: What are the three most important social or environmental problems that affect the health of your community? Please select up to three. (by race)



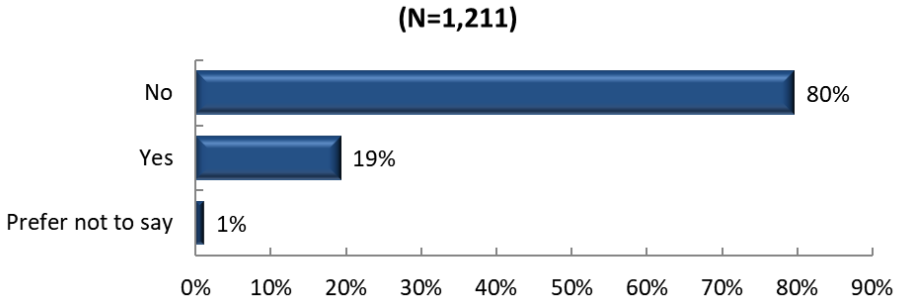
Dare County community member respondents were also asked if there was a time during the past 12 months that they needed specific care and were unable to receive it due to affordability. As displayed in the figure below, 15% of respondents indicated affordability barriers prevented them from accessing dental care. The second highest response identified seeing a specialist (10%) was impacted due to lack of affordability, followed by eyeglasses (10%).

Figure 33: During the past 12 months, was there any time when you needed any of the following, but didn't get it because you couldn't afford it?



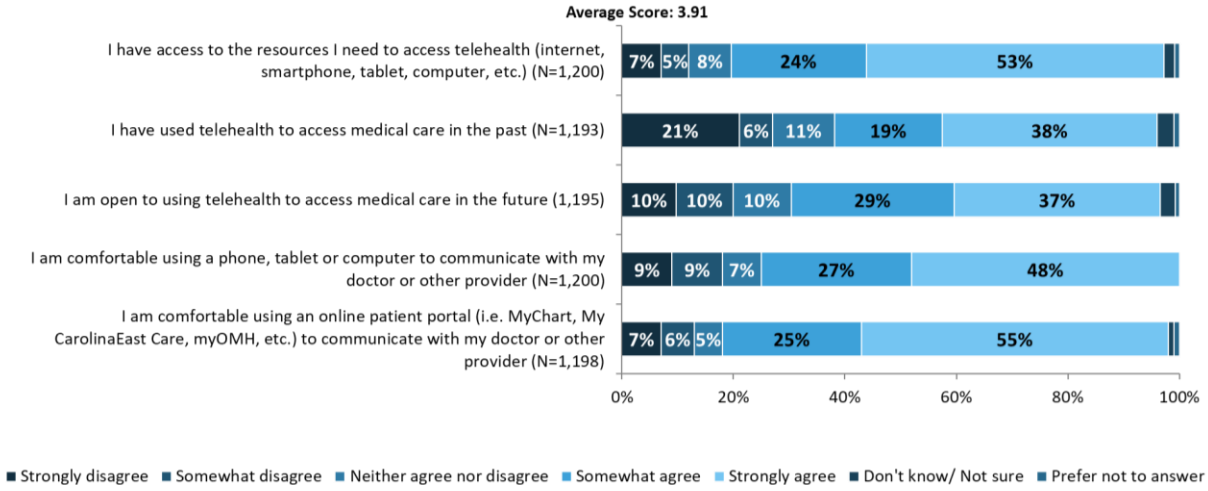
Respondents were asked if they have put off or neglected going to the doctor due to distance or transportation, to which 19% of respondents answered yes, further emphasizing that transportation can be a barrier for at least a portion of the community.

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



Respondents were also asked to agree or disagree with statements related to telehealth, including statements about having access to the necessary resources to use telehealth, past experience using telehealth, and comfort level in using technology or patient portals to communicate with health professionals. Less than 10% of respondents strongly agreed to having access to the necessary resources, with the same percentage of respondents strongly agreeing to being comfortable using an online patient portal and a slightly higher percentage strongly agreeing to being open to using telehealth to access medical care in the future.

Figure 35: How much do you agree or disagree with the following statements about telehealth? Telehealth means connecting virtually with a medical provider using a smartphone, tablet or computer.



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

Primary Data Findings – Focus Groups

Focus group participants identified several critical access to care challenges in Dare County. A primary concern was the significant lack of local healthcare providers, including primary care physicians, specialists, pediatricians, and eye care providers. The Hispanic/Latino community was noted as being particularly impacted by barriers to accessing culturally competent services and lacking insurance coverage. Transportation emerged as a major barrier to accessing healthcare, with participants noting there is no dependable transportation system in the county. This issue particularly affects residents in more remote areas who need to travel significant distances to reach medical facilities. Focus group participants also highlighted poor coordination between healthcare providers as an obstacle to receiving comprehensive care. Discussion emphasized the need for improved coordination of services, particularly for those requiring multiple types of care.

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

Primary Data Findings – Key Informant Interviews

Key informants emphasized several significant barriers preventing residents from accessing healthcare services in Dare County. The lack of primary care providers and specialists was consistently identified as a major challenge. Key informants noted that Medicaid expansion has increased the number of clients seeking services, but there remains a shortage of providers who accept Medicaid, particularly for dental care.

Transportation was highlighted as a significant barrier, with key informants suggesting the need for "a more robust transportation system." Key informants also expressed concerns over the difficulties that some residents face in navigating the healthcare system. Language barriers were noted as particularly impacting the Latino community's ability to access care.

Key informants also identified stigma as a significant obstacle to seeking healthcare services. Insurance coverage gaps and lack of awareness about available services were cited as additional barriers. To address these challenges, informants suggested improving communication and outreach

efforts, developing better systems for helping residents navigate available services, and expanding transportation options beyond current programs.

Potential solutions proposed by key informants included investing in transportation infrastructure, improving assistance for navigating healthcare systems, and increasing the number of providers, particularly those accepting Medicaid. They emphasized the need for better coordination between agencies and improved communication about available resources.

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

Priority Need: Mental Health

Context and National Perspective

The definition of behavioral health often describes conditions related to both mental health and substance use.[29] Mental health is defined as an emotional, psychological, and social state of well-being. Mental health impacts every stage of life and affects how one navigates their relationships, daily stressors, and health behaviors.[30] After evaluating data from a variety of sources, it was determined that mental health was an area of urgent need within Dare County.

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

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

Mental illness is a prevalent concern in North Carolina, with nearly 1.5 million adults reported to have a mental health condition in 2023. Additionally, that same year, 1 in 7 individuals who were identified as homeless also were living with an SMI. Access to mental health care in North Carolina is changing, however it is still unavailable to many. Specifically, over 452,000 individuals did not seek care in 2023, with 44.8% citing cost as the main reason. Additionally, those in live in North Carolina are seven times more likely to be pushed out of network of their behavioral health providers, than a primary care provider, furthering cost as a cause for stopping treatment. [35]

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[29] Source: American Medical Association (2022). *What is behavioral health?* Retrieved September 13th, 2023, from https://www.ama-assn.org/delivering-care/public-health/what-behavioral-health.

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

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

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

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

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

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

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

Secondary Data Findings

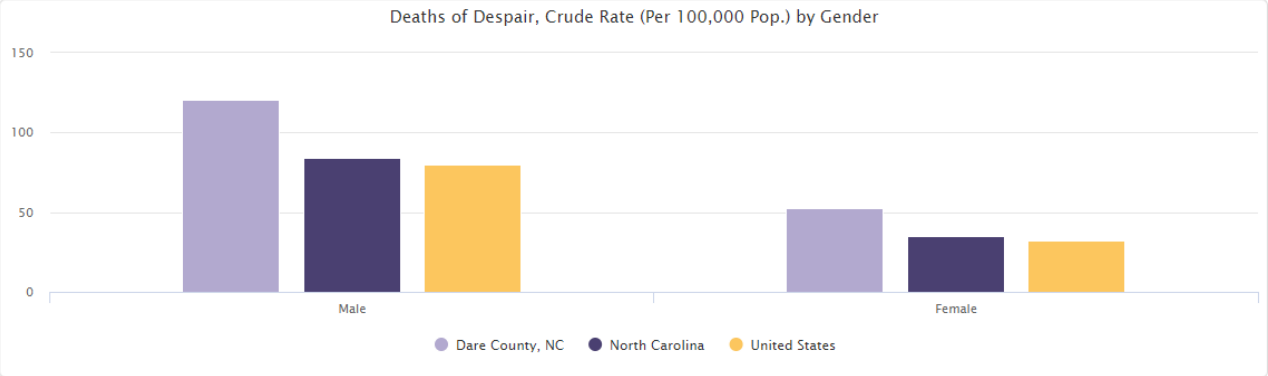
Secondary data collected through the CHNA process identified mental health as a significant concern for Dare County residents, with several indicators showing higher rates than state and national averages. Deaths of despair, which include deaths from suicide, alcohol-related conditions, and drug poisoning, were particularly concerning. As displayed in the table below, the suicide rate in Dare County (19.3 per 100,000 population) was notably higher than both state (14.0) and national (14.5) averages. However, residents reported slightly fewer poor mental health days per month on average (4.3) compared to state (4.6) and national (4.9) averages.

Table 22: Mental Health Indicators

Indicator	Dare County	North Carolina	United States
Deaths of Despair (Crude Rate per 100,000 Population)	86.2	58.7	55.9
Suicide (Crude Rate per 100,000 Population)	19.3	14.0	14.5
Average Number of Poor Mental Health Days (per Month)	4.3	4.6	4.9
Mental Health Providers (Rate per 100,000 Population)	78.6	155.7	178.7

Dare County's crude death rate for deaths of despair (86.2 per 100,000 population) was significantly higher than both North Carolina (58.7) and national (55.9) averages. When examined by gender, the rates for deaths of despair for both men and women in Dare County surpassed statewide and national rates. Additionally, as shown in **Figure 36**, there are also notable gender disparities in the county's crude rates for deaths of despair.

Figure 36: Deaths of Despair by Gender



Access to mental health care providers remains a significant challenge in the county. The rate of mental health providers (78.6 per 100,000 population) was substantially lower than both state (155.7) and national (178.7) averages, indicating a significant shortage of mental health professionals. This provider shortage may contribute to challenges in accessing timely mental health care.

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

Study on Suicide in Dare County

The Breaking Through Task Force and Dare County Department of Health & Human Services joined in a partnership with UNC Chapel Hill to study suicide in Dare County. This study explored the Impact of Cultural Nuances and Contextual Factors on Mental Health/Well-being Perceptions among Residents Aged 18-34 years in Dare County. The study examined suicide in Dare County through three methods:

1) Survey questionnaire for residents 18-34 years of age;
2) Focus groups with community members; and
3) Interviews with key stakeholders.

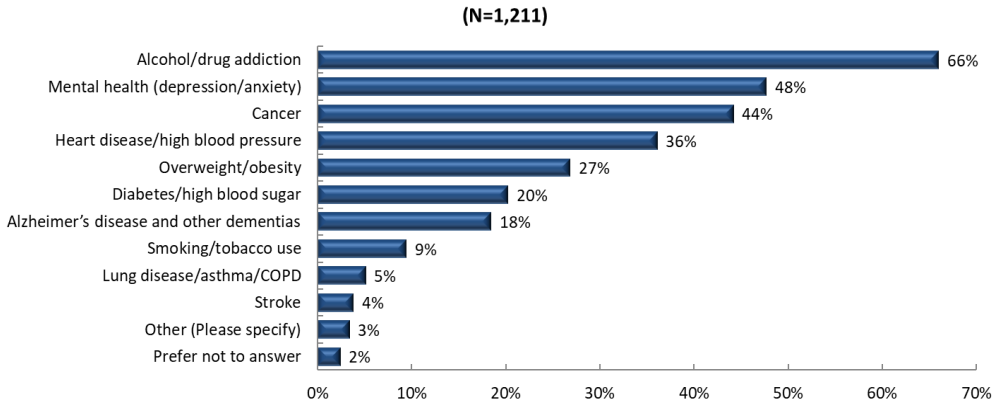
The key findings reveal notable racial and gender disparities in mental health perceptions and service access. White and Black respondents report higher stress levels and face more difficulties accessing mental health support compared to other racial groups. Males generally report better mental health and greater confidence in managing stress than females. Despite available resources, significant gaps in mental health support persist, with stigma around mental health being widespread in the community. Participants emphasized the need for greater awareness and enhanced support for mental health concerns. Qualitative findings underscored barriers to accessing services, including financial constraints, transportation difficulties, cultural perceptions, and a shortage of local therapists. Additionally, the study identifies systemic obstacles, including financial constraints, transportation issues, and cultural beliefs, that limit access to mental health services. Future efforts should focus on expanding mental health resources and support within the community, increasing awareness about mental health issues, and continuing to engage with Dare community members to address their unmet needs more efficiently.

For additional details on the UNC Study on Suicide, see **Appendix 9**.

Primary Data Findings – Community Member Web Survey

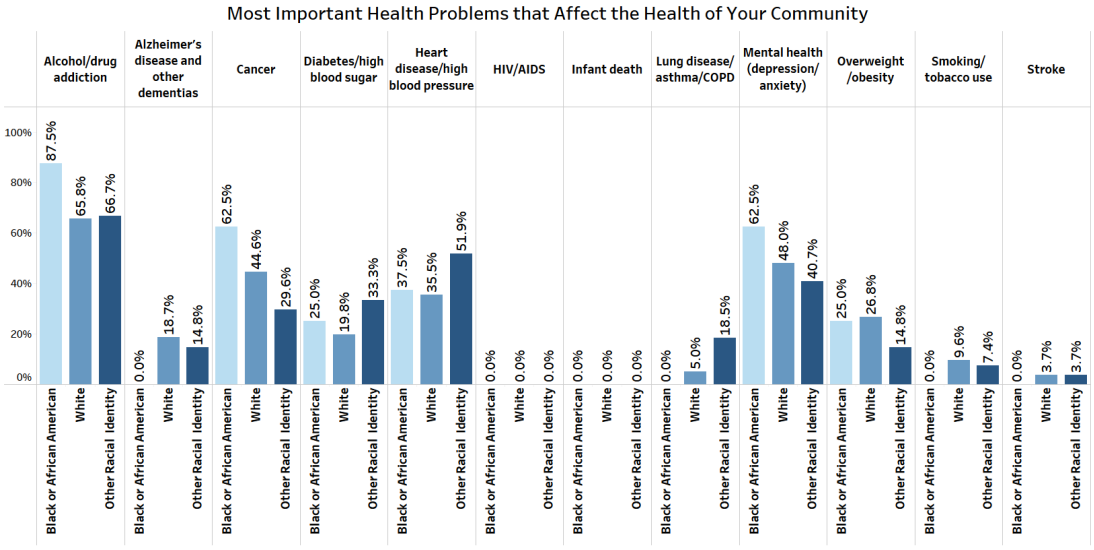
Dare County residents highlighted different aspects of mental health as areas of community concern on the web-based survey. When asked to identify the most important community health needs, 48% of these respondents identified mental health (depression/anxiety), the second most frequent of all community health needs identified.

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



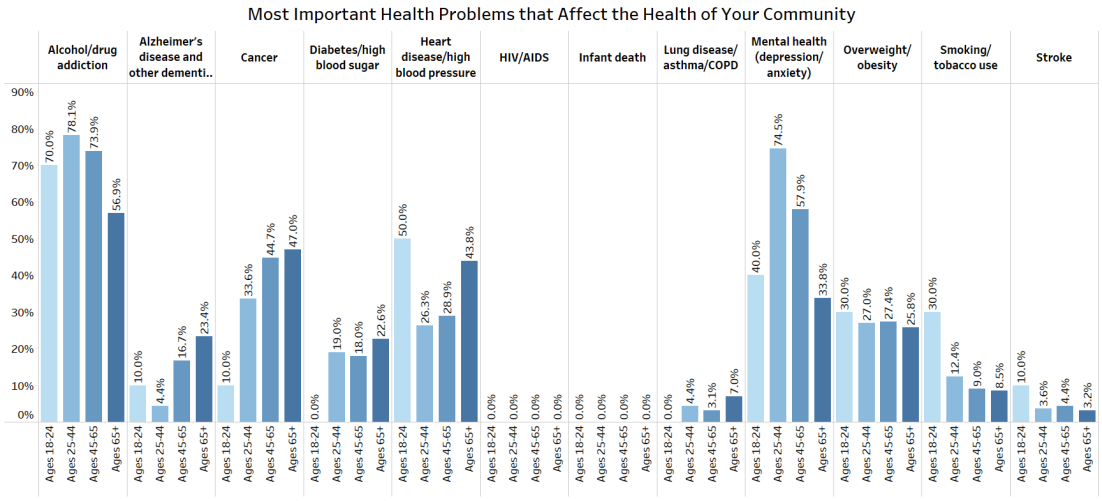
However, when these data were examined by the race of community member respondents, differences emerged. Those who identified as Black or African American (63%) selected mental health as an important community health need more frequently than those who identified as White (48%) and all other races (41%), as displayed in the figure below.

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



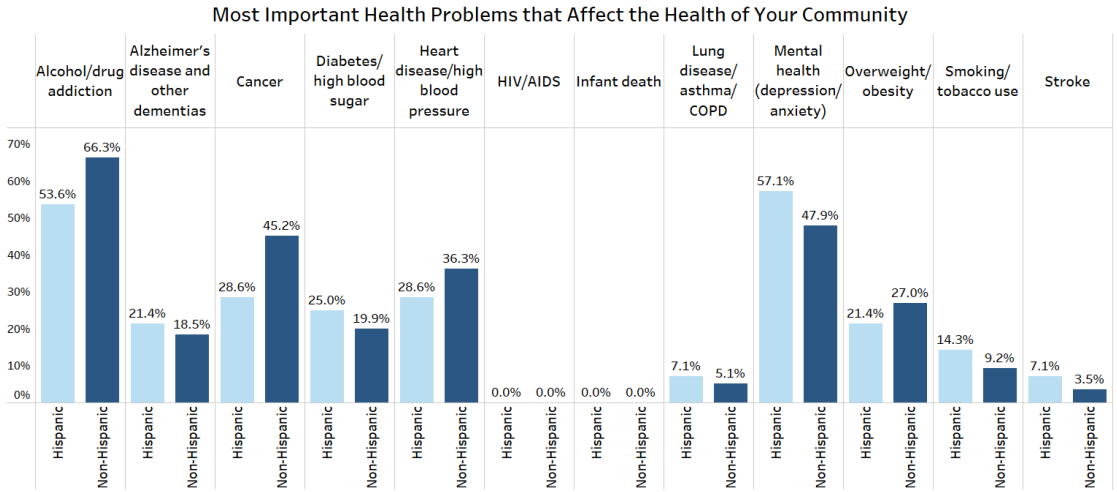
Similarly, there were differences in responses across age groups. Those ages 25 to 44 (75%) and 45 to 64 (58%) identified mental health as more significant than both the youngest (40%) and oldest (34%) groups of respondents.

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



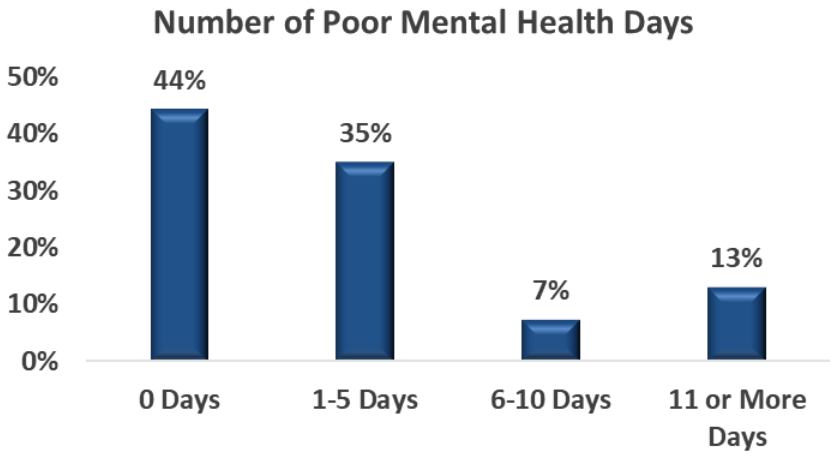
Responses also varied by ethnicity, with a higher percentage of Hispanic/Latino respondents (57%) selecting mental health as an important issue than non-Hispanic/Latino respondents (48%). These perceived differences by demographic characteristics may be important in planning efforts to address behavioral health in the community.

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



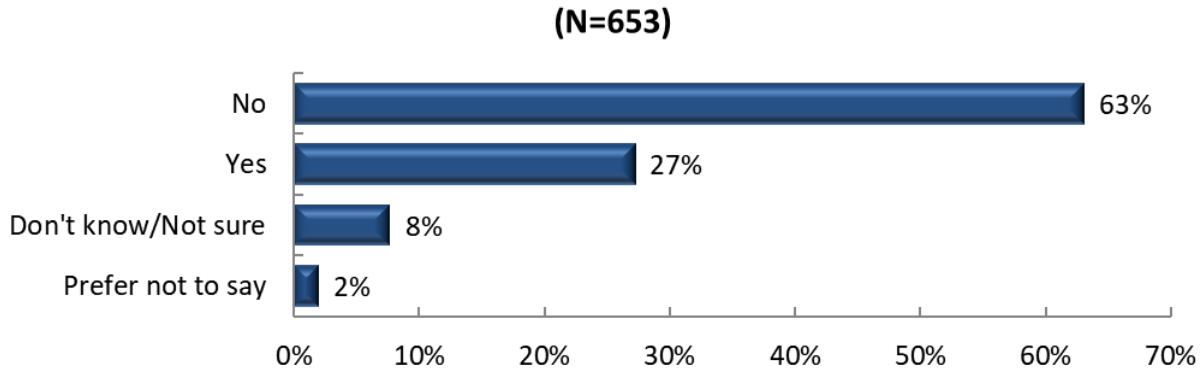
When respondents were asked about their own mental health, more than half of respondents indicated they had one or more poor mental health days in the past 30 days, with an average of 5 poor mental health days among all respondents.

Figure 41: Now thinking about your mental health, which includes stress, depression, and problems with emotions, for how many days during the past 30 days was your mental health not good?



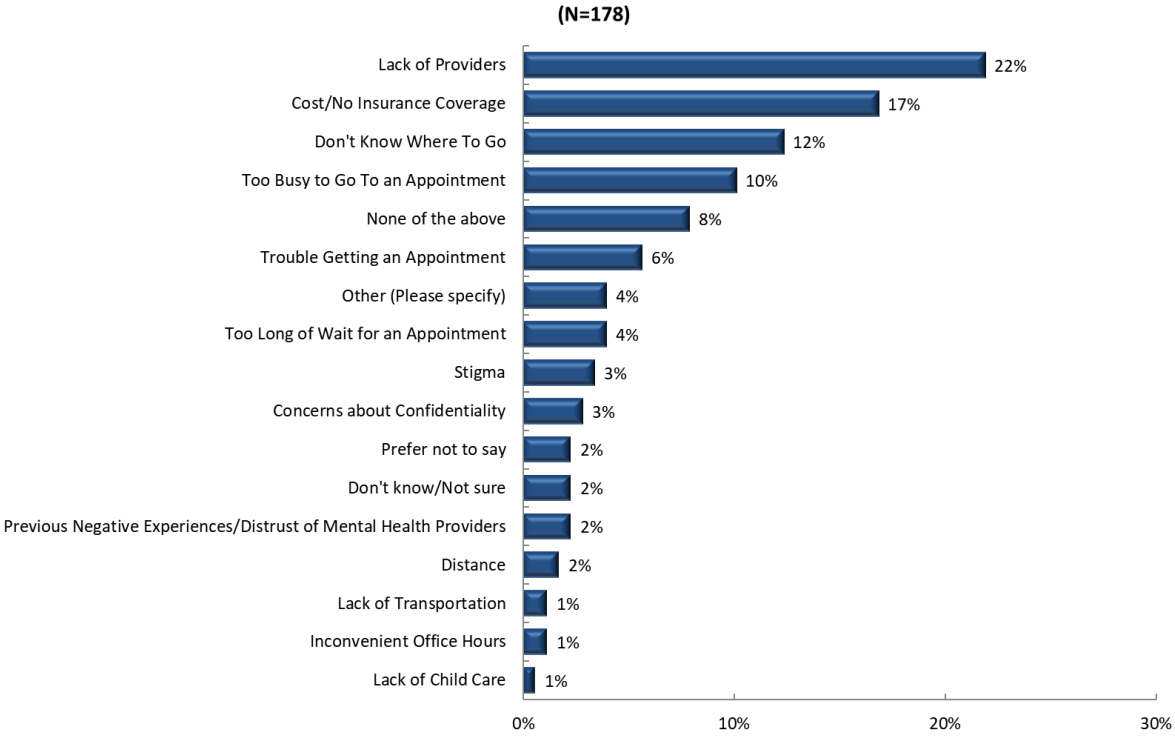
Community member respondents who indicated they experienced at least one poor mental health day a month were asked if there was a time in the past 12 months when they needed mental healthcare or counseling but did not get it at that time. Nearly 30% of these respondents answered yes.

Figure 42: Was there a time in the past 12 months when you needed mental healthcare or counseling, but did not get it at that time?



The top responses for why this group did not receive care included a lack of providers (22%), cost/no insurance (17%), and not knowing where to go (12%), suggesting accessibility and resource awareness issues exist in the community that impact access to needed mental healthcare.

Figure 43: What was the main reason you did not get mental health care or counseling?



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

Primary Data Findings – Focus Groups

Focus group participants identified mental health as a pressing concern in Dare County, highlighting a "dire lack of providers" in the community. The LGBTQIA+ community was specifically noted as facing challenges related to mental health access and appropriate care. Participants expressed concern about the overdependence on telehealth for mental health services, suggesting this may not be an adequate substitute for in-person care. They also noted high levels of stress in the community following COVID-19, and the prevalence of seasonal depression during winter months when there are fewer activities available.

Multiple participants emphasized the need for improved crisis response services, particularly noting that the Mobile Crisis Unit needs to be more consistently present rather than relying on law enforcement intervention. The need for better awareness of available mental health resources was also emphasized by participants.

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

Primary Data Findings – Key Informant Interviews

Key informants consistently identified mental health as one of the most significant health challenges facing Dare County residents. They cited limited resources and workforce shortages as key factors contributing to the inadequate mental health services in the area. Several informants noted a pressing need for mental health counselors in schools.

Stigma was identified as a significant barrier to accessing mental health services. Key informants suggested that investing more in mental health programs could help break down this stigma and encourage more people to seek needed care. They also noted that unaddressed childhood trauma and isolation due to COVID-19 have contributed to increasing mental health concerns in the community.

Several informants emphasized the interconnection between mental health challenges and other community issues, particularly the housing crisis and lack of transportation options. They noted that the lack of funding and inpatient facilities for behavioral health treatment creates additional barriers for those seeking mental health care.

To address these challenges, key informants recommended expanding mental health provider capacity, developing more comprehensive mental health programs, and improving coordination between mental health services and other community resources. They emphasized the need for better systems to help residents navigate available mental health services.

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

Priority Need: Substance Use

Context and National Perspective

Substance use disorders (SUDs) are one of the fastest rising categories of behavioral health disorders. According to the American Psychiatric Association, SUDs are a complex condition in which there is uncontrolled use of a substance (such as alcohol or drugs), despite harmful consequences.[36] SUDs often occur in conjunction with other mental illness. In 2023, 16 million (46.9%) young adults aged 18-25 reported having either a SUD or Acute Mental Illness (AMI) in the past year. In that same year, 17.1% (48.5 million) of all U.S. adults were reported as having an SUD.[37] These trends have been increasing in recent years. According to the National Center for Drug Abuse Statistics, in 2018 (3.7%) of all adults aged 18 and older (9.2 million) had both an AMI and at least one SUD.[38] By 2021, this had increased to 13.5% of U.S. adults, with the highest incidence among Multiracial adults.

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

The pandemic impacted public mental health and well-being in many ways. Community members continue to grapple with the pandemic-related effects of isolation and loneliness, financial instability, long-term health impacts and grief, all of which are drivers for developing a substance use disorder. In addition, both drug overdose and suicide deaths have sharply increased over the past several years – often disproportionately impacting younger people and communities of color.[41]

Substance use disorders have also had an impact in North Carolina. Over 36,000 overdose deaths occurred in the state between 2000 and 2022 – an average of more than 1,600 deaths each year.[42]

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

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

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

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

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

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

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

Multiple programs have been developed in North Carolina to combat substance use disorder, notably surrounding opioid usage, which has led to an increase in access and usage of Medication Assisted Treatment (MAT) and methadone clinics within the state. Additionally, North Carolina launched the Opioid and Substance use action plan, which involved the development of multiple interventions, dashboards, and educational materials to help support counties and organizations with reducing not only overdose deaths, but the incidence of SUDs as well.

Secondary Data Findings

Secondary data analyzed through the CHNA process identified substance use as an area of significant concern for Dare County residents, particularly regarding opioid overdoses. As displayed in the table below, while some substance use indicators showed better performance than state averages, others revealed critical areas of concern.

Table 23: Substance Use Indicators

Indicator	Dare County	North Carolina	United States
Percentage of Adults Reporting Excessive Drinking	19%	18%	18%
Opioid Use Disorder Emergency Department Utilization (Rate per 100,000 Beneficiaries)	39	43	41
Alcohol-Involved Crash Deaths, Annual (Rate per 100,000 Population)	1.6	2.9	2.3
Opioid Overdose Death Rate (Crude Rate per 100,000 Population)	41.2	25.1	N/A
Substance Abuse Providers (Rate per 100,000 Population)	32.5	25.0	27.9
Buprenorphine Providers (Rate per 100,000 Population)	8.1	15.2	15.5

The opioid overdose death rate in Dare County (41.2 per 100,000 population) was significantly higher than the state average (25.1), though national comparison data was not available. However, the county had lower rates of opioid use disorder emergency department utilization (39 per 100,000 beneficiaries) compared to both state (43) and national (41) averages. The county also performed better on alcohol-involved crash deaths, with an annual rate of 1.6 per 100,000 population compared to state (2.9) and national (2.3) averages. The percentage of adults reporting excessive drinking in Dare County (19%) was slightly higher than both state and national averages (18%).

While the county had a higher rate of substance abuse providers (32.5 per 100,000 population) compared to state (25.0) and national (27.9) averages, it had a notably lower rate of buprenorphine providers (8.1 per 100,000 population) compared to state (15.2) and national (15.5) averages. This disparity in medication-assisted treatment providers may present challenges for residents seeking treatment for opioid use disorder.

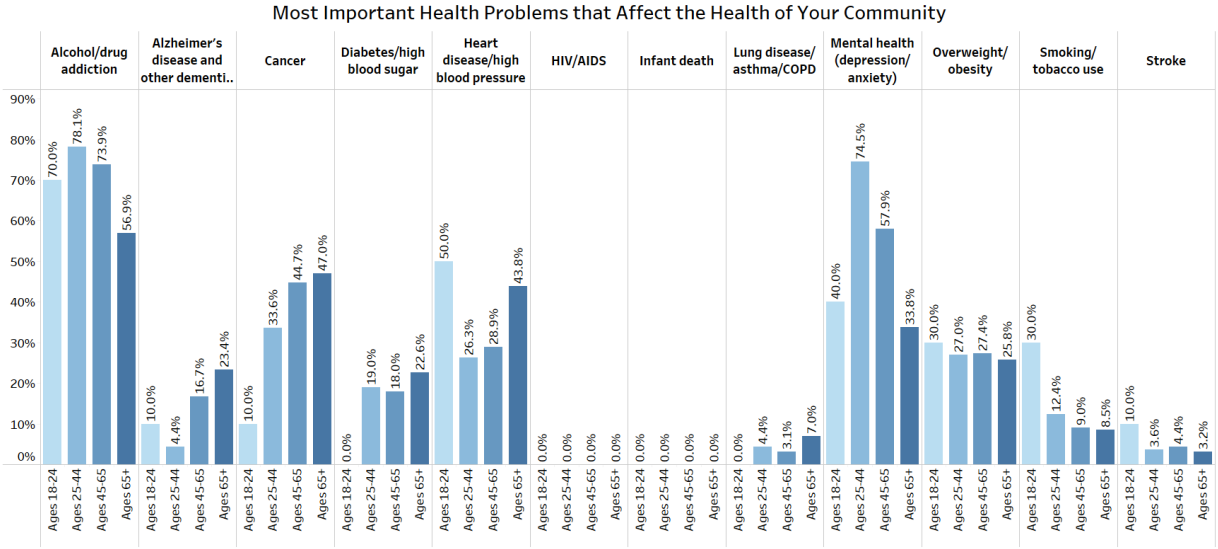
For additional detail on secondary data findings, see **Appendix 3** and **Appendix 8**.

Primary Data Findings – Community Member Web Survey

Dare County residents also highlighted substance misuse as an area of community concern on the web-based survey. When asked to identify the most important community health needs, 66% of respondents identified alcohol/drug addiction, the most frequent of all the community health needs identified, as displayed in **Figure 37** above.

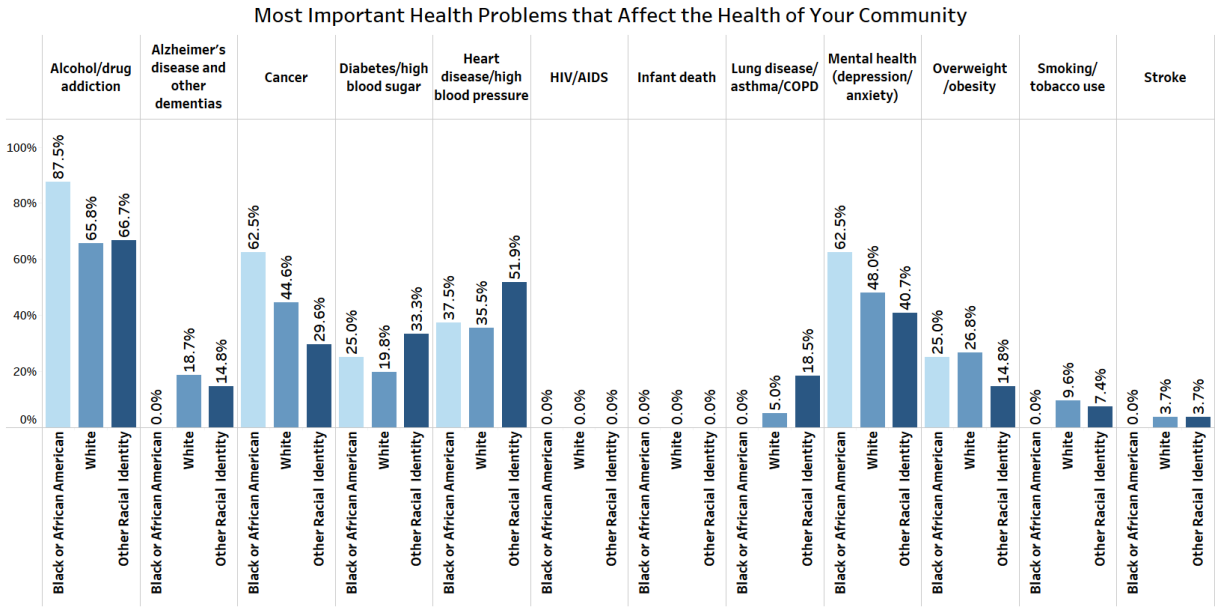
When these data were examined by the demographics of the community respondents, key differences emerged, especially by age. The second youngest cohort of respondents, ages 25 to 44, was more likely than all other age groups to identify alcohol/drug addiction as the most important health problem in the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

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



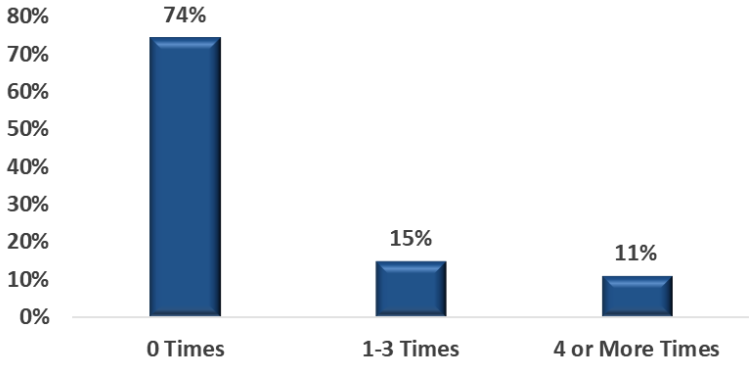
Alcohol/drug addiction was much more frequently identified by respondents who identified as Black or African American (88%) than by respondents who identified as White (56%) or with another racial identity (67%). By gender, non-binary respondents were significantly more likely to select alcohol/drug addiction than both men (59%) and women (68%). These perceived differences by demographic characteristics may be important in planning efforts to address substance use in the community.

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



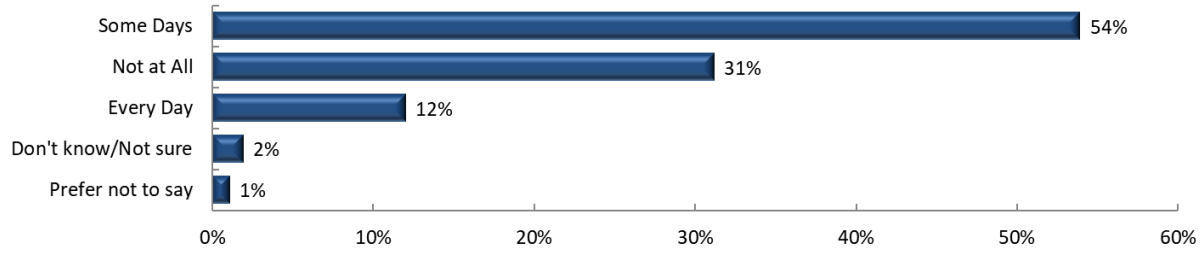
When respondents were asked about their own substance use, one-quarter of respondents reported drinking enough to meet the definition of "binge drinking" at least once in the past 30 days, with an average of one occasion of binge drinking in the past month among all respondents.

Figure 46: 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?



More than half of respondents reported some consumption of alcoholic products, with 54% of those indicating that they consumed alcohol "some days".

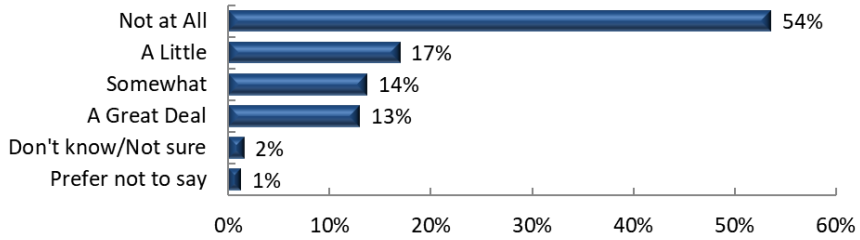
Figure 47: How often do you consume any kind of alcohol product, including beer, wine or hard liquor?



Over 90% of community member respondents reported no personal or household misuse of prescription drugs. However, when asked the degree to which personal or someone else's substance abuse negatively impacted their life, 17% selected "a little", 14% selected "somewhat," and 13% selected "a great deal," highlighting the impact of substance use issues in the community.

Figure 48: 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?

(N=1,210)



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

Primary Data Findings – Focus Groups

Focus group participants identified substance use as a significant concern in Dare County, with particular emphasis on its prevalence during winter months when fewer activities are available. Participants described a strong "party culture" associated with the beach community that contributes to substance use issues. Participants emphasized the need for more substance-free community spaces and activities. They specifically suggested creating an alcohol/substance-free community center to provide alternative gathering spaces. The need for better advertising and education about available substance use resources was also highlighted by participants. The connection between substance use and other community challenges was emphasized, particularly noting how housing instability and lack of transportation options can impact access to treatment and recovery services. Participants also discussed how the seasonal nature of employment in the area can affect substance use patterns in the community.

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

Primary Data Findings – Key Informant Interviews

Key informants consistently identified substance abuse as one of the most pressing health concerns in Dare County. They noted that while the county has a dedicated substance abuse budget, there

remain significant gaps in services and treatment options. Limited resources and workforce shortages were cited as key factors affecting the availability of substance use treatment services.

Informants emphasized how stigma serves as a significant barrier to seeking help for substance use disorders. They noted the need for more investment in substance abuse programs to help break down this stigma. The lack of inpatient facilities for treatment was highlighted as a particular challenge in addressing substance use issues in the community.

Key informants stressed the importance of continued collaboration between county leaders, hospitals, nonprofits, and substance use providers to address these challenges. They emphasized the need for better coordination of services and improved systems for helping residents navigate available substance use treatment options. Several informants also noted the importance of addressing underlying community challenges, such as the housing crisis and transportation limitations, as part of a comprehensive approach to addressing substance use issues.

For a more detailed description of key informant interviews, 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 Dare **C**ounty that provide resources to address general community health needs, as well as the county's 2025 priority need areas: Access to Healthcare, Mental Health, and Substance Use.

Category	Organization Name
County Resource Directories	• NC 211 • Breaking Through Task Force (Mental Health) • Saving Lives Task Force (Substance Use)
Healthcare Facilities	• Outer Banks Health • Outer Banks Health – Carol S. and Edward D. Cowell Jr., Cancer Center • Outer Banks Health – Cardiopulmonary Rehabilitation • Outer Banks Health Family Medicine – Kitty Hawk • Outer Banks Health Family Medicine – Nags Head East • Outer Banks Health Family Medicine – Manteo • Outer Banks Health Family Medicine – Avon • Outer Banks Health Urgent Care – Kitty Hawk • Outer Banks Health Urgent Care – Nags Head • Outer Banks Health Internal Medicine • Outer Banks Health Urology • Outer Banks Health Ear Nose and Throat • Outer Banks Health Orthopedics and Sports Medicine • Outer Banks Health Center for Healthy Living • Outer Banks Health Cardiology • Dare County Department of Health & Human Services • Community Care Clinic of Dare • Manteo Community Health Center • Surf Pediatrics and Medicine • My Md Personal Family Care • Dare Direct Primary Care • Beach Medical • Surf Urgent Care
Physical Therapy	• Outer Banks Health – Physical Therapy • Outer Banks Physical Therapy • Fyzical Therapy & Balance Centers • Coastal Rehabilitation Inc

	• Sentara Therapy Center • Grace Physical Therapy & Pelvic Health • Seaside Physical Therapy • Comprehensive Rehabilitation & Pain Specialists
Home-Based Health Services	• In Home Aide Program (Social Services Division) • Adoration • NC Med Assist (Home Delivery of Prescriptions)
Food Security Services	• Roanoke Island Food Pantry • Beach Food Pantry • Source Food Pantry • Food For Thought • Hatteras Island Food Pantry • Meals On Wheels • Hatteras Island Meals • Albemarle Food Bank
Senior Centers & Services	• Baum Center • Fessenden Center • Virginia Tillet Center • Dementia Task Force • Gem Adult Services • Adult Services (Social Services Division) • Dare County Transportation
Family, Abuse, and Neglect Resources	• The Outer Banks Hotline • Dare County Sheriff's Office Victims Advocate • Children's Services (Social Services Division) • Guardian Ad Litem • Family Services (Social Services Division)
Child Care & Educational Resources	• Children & Youth Partnership for Dare County • Dare County Head Start • Monday Night Alive • More at Four Pre-Kindergarten • Dare County Schools After School Enrichment Program • Dare County Libraries • Childcare Subsidy Program (Social Services Division) • Licensed Childcare Homes and Centers
Recreation	• Dare County Department of Parks & Recreation • Dare County's Manteo Youth Center on Roanoke Island • Outer Banks Family YMCA • Dare County Baum Center • Virginia Tillet Center • Fessenden Center • Dare Arts • Outer Banks Tennis Association • Variety of private gyms
Long Term Care Facilities	• Spring Arbor • Peak Resources Outer Banks

School-Based Services	• Peer Power Program • School Health & Nursing • School Counseling Services • Universal Free Lunch for All Students K-12 • School Health Advisory Council • Dedicated Educator for Exceptional Children Services • NC Pre-K Program

Priority Need: Access to Healthcare	• Community Care Clinic of Dare
	• Dare County Transportation Services
	• Dare County Emergency Services
	  ○ Ambulance
	  ○ Dare Med Flight
	• Dialysis
	• Outer Banks Community Foundation
	• Sound Minds Grant
	• Outer Banks Health
	  ○ Health Coaching
	  ○ Emergency Department
	  ○ Critical Access Hospital
	  ○ Dedicated Task Force of Healthcare Agencies to Raise Awareness About Access to Healthcare On The Outer Banks
	  ○ Dedicated Team Member Who Answers the Primary Care Provider Access Number At 252-449-4540 And Schedules Appointments for These Patients.

Priority Need: Mental Health & Substance Use	• Saving Lives Task Force
	  ○ Prescription Drug Abuse Prevention
	  ▪ Drop Boxes
	  ▪ Pill Disposal Bags
	  ▪ Lock Boxes
	  ▪ Lock You Meds Campaign
	  ▪ One Pill Can Kill
	• Dare County Department of Health & Human Services
	  ○ Fentanyl Kills Education Campaign
	  ○ Recovery & Overdose Services
	  ▪ Overdose Response
	  ▪ Harm Reduction Services
	  • Fentanyl Test Strips
	  • Naloxone
	  ▪ Mobile Recovery Support Unit
	  ▪ Connection To Care & Treatment
	  ○ Peer Power
	  ○ Women Of Worth
	  ▪ Evidence Based Curriculums
	  • Beyond Trauma
	  • Beyond Anger & Violence
	  • Helping Women Recover
	  ○ Keeping Current
	  ○ School Health Program

	• Dare County Sheriff's Office
	  ○ Great Program
	• Prescription Drug Drop Off Events
	• Dare Challenge
	• Cross Roads OBX
	• Be Resilient OBX
	• Healthy Carolinians of The Outer Banks
	• Room In the Inn
	• Outer Banks Community Foundation
	• Interfaith Community Outreach (Sound Minds)
	• Justice Involved Population Resources
	  ○ Dare County Detention Center
	• Recovery Court
	• Outpatient Mental Health & Substance Use Services
	  ○ Individual Counseling
	  ○ Group Therapy
	  ○ Family Counseling
	• Breaking Through Task Force
	  ○ Mental Health Workbooks
	  ▪ Adult Mental Health Workbook
	  ▪ Adult Coloring Book
	  ▪ Children's Mental Health Workbook Series
	  ○ Comprehensive Website & Resources
	  ○ Mental Health Video Series
	  ○ Suicide Awareness & Education
	  ▪ Suicide Documentary
	• Rack Cards for Post Suicide Care
	• Trillium Health Services
	• Thrivewell Counseling Services
	• Easter Seals Port Health
	• Holland & Associates
	• Private Counselors & Providers

Chronic Disease Resources	• Smoke Free Ordinances
	• Older Adult Services
	  ○ Baum Center
	  ○ Virginia Tillet Center
	  ○ Fessenden Center
	• Outer Banks Health
	  ○ Diabetes Education
	  ○ Chronic Disease Nurse Navigator
	  ○ Nutrition Counseling
	  ○ Cardiac Rehabilitation
	  ○ Outer Banks Cowell Cancer Center
	  ○ Primary Care Providers
	  ○ Emergency Department
	  ○ Lab Services
	  ○ Vaccines
	  ○ Center For Healthy Living

	○ Health Coaching ○ Tobacco Cessation • Community Care Clinic of Dare ○ Clinical Services ○ Diabetes Education Program • Dare County Transportation Services • Dialysis • Smoke-Free Ordinances and Organizations • Wellness Centers & Gyms • Walking Trails, Parks, Side Walks • Dare County Department of Health & Human Services ○ Hep C Treatment & Case Management ○ Peer Power- Chronic Disease Prevention ○ Breast Cancer Cervical Cancer Control Program ○ Lab Services ○ School Health Services ○ Vaccines: Flu, COVID, Hep A, Hep B, Shingles, Tdap, HPV, Lynneos, Meningococcal, MMR
Other Adult Services	• Assisted Living • Skilled Nursing Facility • Housing Assistance for Older Adults • Project Lifesaver • Care Giver Support • Care Giver Education • Memory Screenings • Memory Cafes • Educational Classes & Community Outreach • Respite Services • In-Home Aide Services • Outer Banks Community Foundation • Sound Minds Grant • Dementia Friendly Establishments • Adoration Home Health & Hospice • Senior Health Insurance Information Program • Tobacco Cessation Program Through the Outer Banks Health Center for Healthy Living • Dare County Department of Health & Human Services ○ Adult Services ▪ Adult Protective Services ▪ Guardianship ▪ In-Home Aide Program ○ Economic Services ▪ Food & Nutrition Services

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 Dare 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. Dare 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.

The final CHNA report and Implementation Strategies are available on our public website at https://www.outerbankshealth.org/about-us/community-health-needs-assessments. For further questions or more information, please contact Jennifer Schwartzenberg, Director, Community Outreach and Development at Outer Banks Health, at Jennifer.Schwartzenberg@outerbankshealth.org.

Appendix 1 | State of the County Health Report

Results-Based Accountability Framework

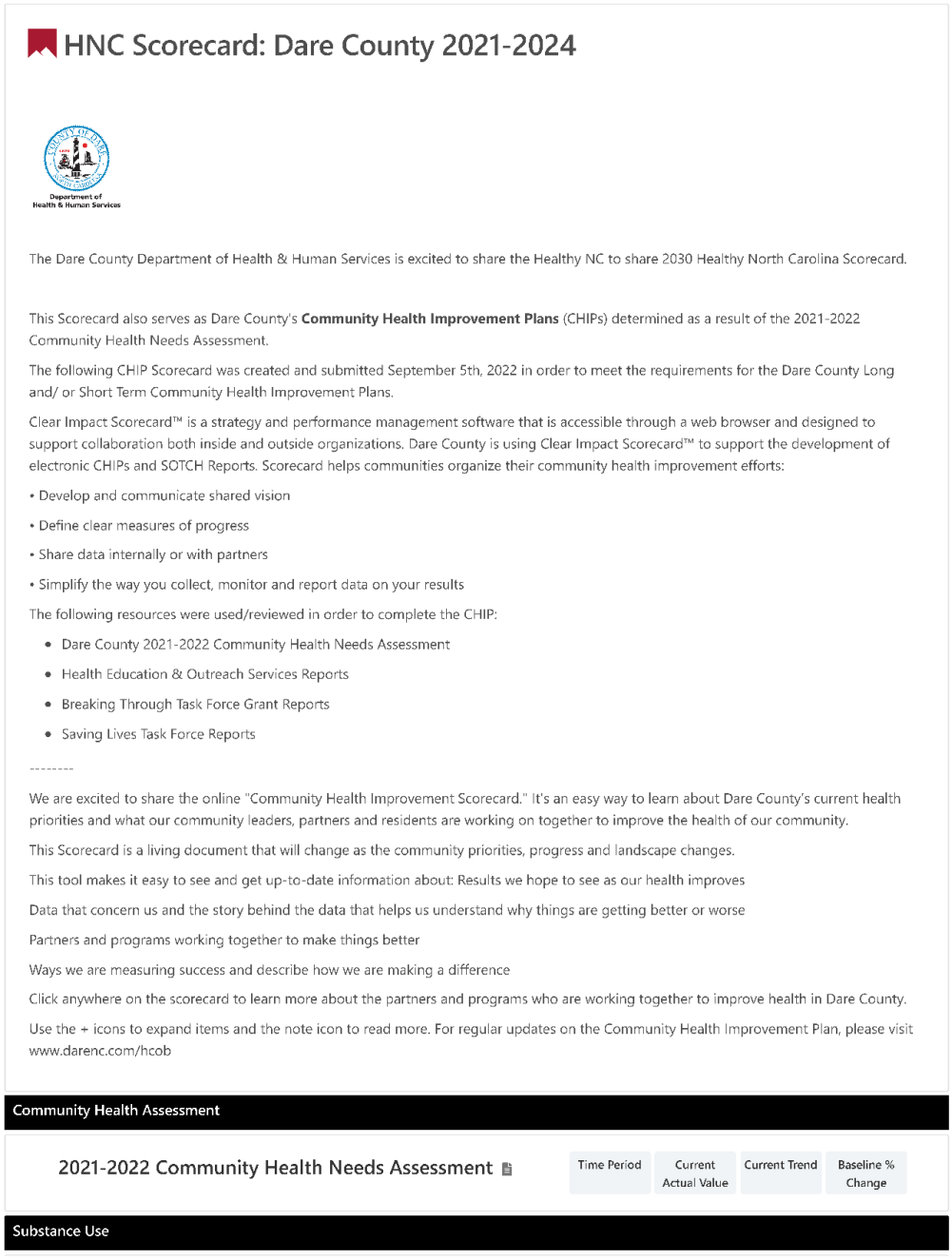
To meet North Carolina accreditation requirements, LHDs are required to track progress on their implementation plans by publishing an annual State of the County Health Report (SOTCH). The SOTCH is guided by the Clear Impact Results-Based Accountability (RBA) Framework™, and demonstrates that the LHD is tracking priority issues identified in the community health (needs) assessment process, identifying emerging issues, and implementing any relevant new initiatives to address community concerns.[43]

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

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

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

State of the County Health Report



HNC Scorecard: Dare County 2021-2024

Department of Health & Human Services

The Dare County Department of Health & Human Services is excited to share the Healthy NC to share 2030 Healthy North Carolina Scorecard.

This Scorecard also serves as Dare County's **Community Health Improvement Plans** (CHIPs) determined as a result of the 2021-2022 Community Health Needs Assessment.

The following CHIP Scorecard was created and submitted September 5th, 2022 in order to meet the requirements for the Dare County Long and/ or Short Term Community Health Improvement Plans.

Clear Impact Scorecard™ is a strategy and performance management software that is accessible through a web browser and designed to support collaboration both inside and outside organizations. Dare County is using Clear Impact Scorecard™ to support the development of electronic CHIPs and SOTCH Reports. Scorecard helps communities organize their community health improvement efforts:

• Develop and communicate shared vision

• Define clear measures of progress

• Share data internally or with partners

• Simplify the way you collect, monitor and report data on your results

The following resources were used/reviewed in order to complete the CHIP:

- Dare County 2021-2022 Community Health Needs Assessment
- Health Education & Outreach Services Reports
- Breaking Through Task Force Grant Reports
- Saving Lives Task Force Reports

We are excited to share the online "Community Health Improvement Scorecard." It's an easy way to learn about Dare County's current health priorities and what our community leaders, partners and residents are working on together to improve the health of our community.

This Scorecard is a living document that will change as the community priorities, progress and landscape changes.

This tool makes it easy to see and get up-to-date information about: Results we hope to see as our health improves

Data that concern us and the story behind the data that helps us understand why things are getting better or worse

Partners and programs working together to make things better

Ways we are measuring success and describe how we are making a difference

Click anywhere on the scorecard to learn more about the partners and programs who are working together to improve health in Dare County.

Use the + icons to expand items and the note icon to read more. For regular updates on the Community Health Improvement Plan, please visit www.darenc.com/hcob

Community Health Assessment

2021-2022 Community Health Needs Assessment

Time Period | Current Actual Value | Current Trend | Baseline % Change

Substance Use

All people in Dare County live in communities with equitable access to substance use prevention and disorder services.	Time Period	Current Actual Value	Current Trend	Baseline % Change
FHU-NC HNC2030 Drug Overdose Death Rate in North Carolina: Drug Poisoning Deaths (Total) per 100,000 population	2022	42.1	↗ 4	205% ↗
Drug Overdose Death Rate for Dare County	2019	45	→ 0	0% →
Poisoning Death Rate	2021	56	↗ 6	100% ↗

Dare County Harm Reduction	Time Period	Current Actual Value	Current Trend	Baseline % Change
Dare County Number of pills collected through Safe & Convenient Pill Disposal	2023	129,624	↗ 1	165% ↗
Dare County Number of Naloxone Kits Distributed	2023	2,556	↗ 3	2591% ↗
How much Number of Syringes Given Out	2023	1,456	↘ 1	183% ↗
How much Number of Fentanyl Test Kits Distributed	2023	2,338	↗ 1	86% ↗

Justice Involved Populations	Time Period	Current Actual Value	Current Trend	Baseline % Change
How much Recovery Court: Number of Individuals Enrolled Yearly	2023	48#	↗ 1	200% ↗
Better off Recovery Court: Percentage of Enrolled that Complete the Program	2023	63%	↘ 1	152% ↗

Women of Worth	Time Period	Current Actual Value	Current Trend	Baseline % Change
How much Number of Lessons Provided	2023	262	↗ 2	97% ↗

Mental Health

All people in Dare County live in communities that foster and support positive mental health.	Time Period	Current Actual Value	Current Trend	Baseline % Change
FHU-NC HNC2030 Suicide Rate (TOTAL) in North Carolina (per 100, 000)	2022	14.4	↗ 1	11% ↗
Suicide Death (Self-Harm) Total for Dare County	2023	3	↘ 1	-50% ↘
Number of EMS Calls for Self-Harm	2023	27	↘ 1	-63% ↘
Deaths Due to Mental, Behavioral and Neurodevelopmental Disorders	2021	25	↘ 1	56% ↗

Breaking Through Task Force: Public Awareness	Time Period	Current Actual Value	Current Trend	Baseline % Change
How much Number of Childrens Mental Health Workbooks Given Out	2023	700	↘ 1	367% ↗
How much Number of Adult Mental Health Workbooks Given Out	2023	300	→ 2	0% →
How much Number of Website Views	2023	956	↗ 1	11% ↗

Mental Health First Aid	Time Period	Current Actual Value	Current Trend	Baseline % Change
How much Number of Individuals Trained in Youth Component	2023	5	→ 1	-62% ↘
How much Number of Individuals Trained in Adult Component	2023	0	↘ 1	-94% ↘

SOTCH REPORTS

2022 SOTCH Report	Time Period	Current Actual Value	Current Trend	Baseline % Change

2023 SOTCH Report	Time Period	Current Actual Value	Current Trend	Baseline % Change

Appendix 2 | Secondary Data Methodology & 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 Dare County, its performance on each data measure was compared to targets/benchmarks. If Dare County's performance was more than five percent worse than the comparative benchmark, it was concluded that improvements could be needed to better the health of the community. Conversely, if an area performed more than five percent better than the benchmark, it was concluded that while a need is still present, the significance of that need relative to others is likely less acute. The most recently available data were compared to these targets/benchmarks in the following order (as applicable):

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

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

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

These measures are noted with an asterisk.

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

Data Sources

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

Table 24: Access to Care

Measure	Description	Data Source	Most Recent Data Year(s)
Primary Care Providers (per 100,000 population)	Number of providers with a CMS National Provider Identifier (NPI) that specialize in primary care. Primary health providers include practicing physicians specializing in general practice medicine, family medicine, internal medicine, and pediatrics.	Centers for Medicare and Medicaid Services (CMS) – National Plan and Provider Enumeration System (NPPES). Data accessed via the North Carolina Data Portal, June 2024.	2024
Mental Health Providers (per 100,000 population)	Number of providers with a CMS National Provider Identifier (NPI) that specialize in mental health. Mental health providers include licensed clinical social workers and other credentialed professionals specializing in psychiatry, psychology, counseling, or child, adolescent, or adult mental health.	CMS –NPPES. Data accessed via the North Carolina Data Portal, June 2024.	2024
Addiction/Substance Abuse Providers (per 100,000 population)	Number of providers who specialize in addiction or substance abuse treatment, rehabilitation, addiction medicine, or providing methadone. The providers include Doctors of Medicine (MDs), Doctors of Osteopathic Medicine (DOs), and other credentialed professionals with a Center for Medicare and Medicaid Services and a valid National Provider Identifier (NPI).	CMS –NPPES. Data accessed via the North Carolina Data Portal, June 2024.	2024
Buprenorphine Providers (per 100,000 population)	Number of providers authorized to treat opioid dependency with buprenorphine. Buprenorphine is the first medication to treat opioid dependency that is permitted to be prescribed or dispensed in physician offices, significantly increasing treatment access. Qualified physicians are required to acquire and maintain certifications to legally dispense or prescribe opioid dependency medications.	US Department of Health and Human Services (DHHS), Substance Abuse and Mental Health Services Administration. Data accessed via the North Carolina Data Portal, June 2024.	2023
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	U.S. Census Bureau, American Community Survey (ACS). Data	2018-2022

Measure	Description	Data Source	Most Recent Data Year(s)
	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.	accessed via the North Carolina Data Portal, June 2024.	
Federally Qualified Health Centers (FQHCs)	Number of Federally Qualified Health Centers (FQHCs) in the community. This indicator is relevant because FQHCs are community assets that provide health care to vulnerable populations; they receive extra funding from the federal government to promote access to ambulatory care in areas designated as medically underserved.	U.S. DHHS, CMS, Provider of Services File. Data accessed via the North Carolina Data Portal, June 2024.	2023
Population Receiving Medicaid	Percentage of the population with insurance enrolled in Medicaid (or other means-tested public health insurance). This indicator is relevant because it assesses vulnerable populations which are more likely to have multiple health access, health status, and social support needs; when combined with poverty data, providers can use this measure to identify gaps in eligibility and enrollment.	U.S. Census Bureau, ACS. Data accessed via the North Carolina Data Portal, June 2024.	2018-2022
Uninsured Population (SAHIE)	Percentage of adults under age 65 without health insurance coverage. This indicator is relevant because lack of health insurance is a primary barrier to healthcare access including regular primary care, specialty care, and other health services that contribute to poor health status. The lack of health insurance is considered a *key driver* of health status.	U.S. Census Bureau, Small Area Health Insurance Estimates (SAHIE). Data accessed via the North Carolina Data Portal, June 2024.	2022

Table 25: Built Environment

Measure	Description	Data Source	Most Recent Data Year(s)
Broadband Access (Access to DL Speeds >= 25MBPS and UL Speeds >= 3 MBPS)	Percentage of population with access to high-speed internet. Data are based on the reported service area of providers offering download speeds of 25 MBPS or more and upload speeds of 3 MBPS	Federal Communications Commission (FCC) FABRIC Data. Additional data analysis by CARES. Data accessed via the	2023

Measure	Description	Data Source	Most Recent Data Year(s)
	or more. These data represent both wireline and fixed/terrestrial wireless internet providers. Cellular internet providers are not included.	North Carolina Data Portal, June 2024.	
Broadband Access (Access to DL Speeds >= 100MBPS and UL Speeds >= 20 MBPS)	Percentage of population with access to high-speed internet. Data are based on the reported service area of providers offering download speeds of 100 MBPS or more and upload speeds of 20 MBPS or more. These data represent both wireline and fixed/terrestrial wireless internet providers. Cellular internet providers are not included.	FCC FABRIC Data. Additional data analysis by CARES. Data accessed via the North Carolina Data Portal, June 2024.	2023
Households with No Computer	Percentage of households who don't own or use any types of computers, including desktop or laptop, smartphone, tablet, or other portable wireless computer, and some other type of computer, based on the 2018-2022 American Community Survey estimates.	U.S. Census Bureau, ACS. Data accessed via the North Carolina Data Portal, June 2024.	2018-2022
Households with No or Slow Internet	Percentage of households who either use dial-up as their only way of internet connection or have internet access but don't pay for the service, or have no internet access in their home, based on the 2018-2022 American Community Survey estimates.	U.S. Census Bureau, ACS. Data accessed via the North Carolina Data Portal, June 2024.	2018-2022
Liquor Stores	Number of liquor stores per 100,000 population provides a measure of environmental influences on dietary behaviors and the accessibility of healthy foods. Note this data excludes establishments preparing and serving alcohol for consumption on premises (including bars and restaurants) or which sell alcohol as a secondary retail product (including gas stations and grocery stores).	U.S. Census Bureau, County Business Patterns. Additional data analysis by CARES. Data accessed via the North Carolina Data Portal, June 2024.	2022
Adverse Childhood Experiences (ACEs)	Percentage of children in North Carolina (total) with two or more ACEs. ACEs are potentially traumatic events that occur in childhood (0-17 years), including experiencing violence, abuse, or neglect; witnessing violence in the		2022

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

Table 26: Diet and Exercise

Measure	Description	Data Source	Most Recent Data Year(s)
Physical inactivity (percent of adults that report no leisure time physical activity)	Percentage of adults ages 20 and over reporting no leisure-time physical activity in the past month. Examples of physical activities include running, calisthenics, golf, gardening, or walking for exercise. The method for calculating Physical Inactivity changed. Data for Physical Inactivity are provided by the CDC Interactive Diabetes Atlas which 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

Measure	Description	Data Source	Most Recent Data Year(s)
Community Design - Walkability Index Score	The National Walkability Index (2021) is a nationwide index score developed by the Environmental Protection Agency (EPA) that ranks block groups according to their relative walkability using selected variables on density, diversity of land uses, and proximity to transit from the Smart Location Database. The block groups are assigned their final National Walkability Index scores on a scale of 1 to 20 where the higher a score, the more walkable the community is.	EPA – Smart Location Database. Data accessed via the North Carolina Data Portal, June 2024.	2021
Access to Exercise Opportunities	Percentage of individuals in the county who live reasonably close to a location for physical activity. Locations for physical activity are defined as parks or recreational facilities. The numerator is the 2020 total population living in census blocks with adequate access to at least one location for physical activity (adequate access is defined as census blocks where the border is a half-mile or less from a park, 1 mile or less from a recreational facility in an urban area, or 3 miles or less from a recreational facility in a rural area) and the denominator is the 2020 resident county population. This indicator is used in the 2024 County Health Rankings.	ArcGIS Business Analyst and Living Atlas of the World, YMCA & U.S. Census Tigerline Files. Data accessed via the North Carolina Data Portal, June 2024.	2023
Recreation and Fitness Facility Access (per 100,000 population)	Number of establishments primarily engaged in operating fitness and recreational sports facilities featuring exercise and other active physical fitness conditioning or recreational sports activities, such as swimming, skating, or racquet sports. Access to recreation and fitness facilities encourages physical activity and other healthy behaviors.	U.S. Census Bureau, County Business Patterns. Additional data analysis by CARES. Data accessed via the North Carolina Data Portal, June 2024.	2022
Sugar-Sweetened Beverage (SSB) Consumption Among Adults	Percentage of total adults reporting consumption of one or more SSBs per day.	Clear Impact. HNC2030 Scorecard, 2021-2024. Data accessed June 2024.	2022

Table 27: Education

Measure	Description	Data Source	Most Recent Data Year(s)
Population with Limited English Proficiency	Percentage of the population aged 5 and older who speak a language other than English at home and speak English less than "very well". This indicator is relevant because an inability to speak English well creates barriers to healthcare access, provider communications, and health literacy/education.	U.S. Census Bureau, ACS. Data accessed via the North Carolina Data Portal, June 2024.	2018-2022
High School Graduation Rate	Percentage of high school students who graduate within four years. The adjusted cohort graduation rate (ACGR) is a graduation metric that follows a "cohort" of first-time 9th graders in a particular school year, and adjusts this number by adding any students who transfer into the cohort after 9th grade and subtracting any students who transfer out, emigrate to another county, or pass away.	U.S. Department of Education, EDFacts. Additional data analysis by CARES. Data accessed via the North Carolina Data Portal, June 2024.	2020-2021
No High School Diploma	Percentage of the population aged 25 and older without a high school diploma (or equivalency) or higher. This indicator is relevant because educational attainment is linked to positive health outcomes.	U.S. Census Bureau, ACS. Data accessed via the North Carolina Data Portal, June 2024.	2018-2022
Student Math Proficiency (4th Grade)	Percentage of 4th grade students testing below the "proficient" level on the Math portion of state-specific standardized tests.	U.S. Department of Education, EDFacts. Additional data analysis by CARES. Data accessed via the North Carolina Data Portal, June 2024.	2020-2021
Student Reading Proficiency (4th Grade)	Percentage of 4th grade students testing below the "proficient" level on the English Language Arts portion of state-specific standardized tests.	US Department of Education, EDFacts. Additional data analysis by CARES. Data accessed 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	2021

Measure	Description	Data Source	Most Recent Data Year(s)
		Rankings & Roadmaps, June 2024.	

Table 28: Employment

Measure	Description	Data Source	Most Recent Data Year(s)
Unemployment Rate (percent of population age 16+ but unemployed)	Percentage of the civilian non-institutionalized population age 16 and older (non-seasonally adjusted) that is unemployed but seeking work. This indicator is relevant because unemployment creates financial instability and barriers to access including insurance coverage, health services, healthy food, and other necessities that contribute to poor health status.	U.S. Department of Labor, Bureau of Labor Statistics. Data accessed via the North Carolina Data Portal, June 2024.	2024
Average Annual Unemployment Rate, 2013-2023	Average yearly percentage across the given time period of the civilian non-institutionalized population age 16 and older (non-seasonally adjusted) that is unemployed but seeking work. This indicator is relevant because unemployment creates financial instability and barriers to access including insurance coverage, health services, healthy food, and other necessities that contribute to poor health status.	U.S. Census Bureau, ACS. Data accessed via the North Carolina Data Portal, June 2024.	2024

Table 29: Environmental Quality

Measure	Description	Data Source	Most Recent Data Year(s)
Climate and Health – Flood Vulnerability	Estimated number of housing units within the special flood hazard area (SFHA) per county. The SFHAs have 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	EPA. Data accessed via the North Carolina Data Portal, June 2024.	2023

Measure	Description	Data Source	Most Recent Data Year(s)
	multiple counties and has a violation, each county served by the system is given a violation.		

Table 30: Family, Community, and Social Support

Measure	Description	Data Source	Most Recent Data Year(s)
Childcare Cost Burden	Childcare costs for a median-income household with two children as a percentage of household income. Data are included as part of the 2024 County Health Rankings.	The Living Wage Calculator, Small Area Income and Poverty Estimates. Data accessed via the North Carolina Data Portal, June 2024.	2023
Young People Not in School and Not Working	Percentage of youth ages 16-19 who are not currently enrolled in school and who are not employed.	U.S. Census Bureau, ACS. Data accessed via the North Carolina Data Portal, June 2024.	2018-2022

Table 31: Food Security

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

Measure	Description	Data Source	Most Recent Data Year(s)
Limited access to healthy foods	Percentage of population who are low-income and do not live close to a grocery store.	USDA Food Environment Atlas. Data accessed via RWJF & UWPHI County Health Rankings & Roadmaps, June 2024.	2019
Food Environment - Fast Food Restaurants (per 100,000 population)	Number of fast food restaurants per 100,000 population. The prevalence of fast food restaurants provides a measure of both access to healthy food and environmental influences on dietary behaviors. Fast food restaurants are defined as limited-service establishments primarily engaged in providing food services (except snack and nonalcoholic beverage bars) where patrons generally order or select items and pay before eating.	US Census Bureau, County Business Patterns. Additional data analysis by CARES. 2022. Data accessed via the North Carolina Data Portal, June 2024.	2022
Food Environment - Grocery Stores (per 100,000 population)	Number of grocery establishments per 100,000 population. Grocery stores are defined as supermarkets and smaller grocery stores primarily engaged in retailing a general line of food, such as canned and frozen foods; fresh fruits and vegetables; and fresh and prepared meats, fish, and poultry. Delicatessen-type establishments are also included. Convenience stores and large general merchandise stores that also retail food, such as supercenters and warehouse club stores, are excluded. Healthy dietary behaviors are supported by access to healthy 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 32: Housing and Homelessness

Measure	Description	Data Source	Most Recent Data Year(s)
Renter Costs – Average Gross Rent	Average gross rent is the contract rent plus the estimated average monthly cost of utilities (electricity, gas, and water and sewer) and fuels (oil, coal, kerosene, wood, etc.) if these are paid by the renter (or paid for the renter by someone else). Gross rent provides information on the monthly housing cost expenses for renters.	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)
	When the data is used in conjunction with income data, the information offers an excellent measure of housing affordability and excessive shelter costs. The data also serve to aid in the development of housing programs to meet the needs of people at different economic levels, and to provide assistance to agencies in determining policies on fair rent.		
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	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)
	defined as lacking a fixed, regular, and adequate nighttime residence. Those who are homeless may be sharing the housing of other persons, living in motels, hotels, or camping grounds, in emergency transitional shelters, or unsheltered. Data are aggregated to the report-area level based on school-district summaries where three or more homeless children are counted.	North Carolina Data Portal, June 2024.	

Table 33: Income

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

Measure	Description	Data Source	Most Recent Data Year(s)
	relevant 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 34: Length of Life

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

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 35: Maternal and Infant Health

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

Measure	Description	Data Source	Most Recent Data Year(s)
	(2015-2021) and are used for the 2024 County Health Rankings.	RWJF & UWPHI County Health Rankings & Roadmaps, June 2024.	

Table 36: Mental Health

Measure	Description	Data Source	Most Recent Data Year(s)
Poor Mental Health Days	Average number of self-reported mentally unhealthy days in past 30 days among adults (age-adjusted to the 2000 standard). Data are included as part of the 2024 County Health Rankings.	CDC, Behavioral Risk Factor Surveillance System (BRFSS). Data accessed via the North Carolina Data Portal, June 2024.	2021
Deaths of Despair (Suicide and Drug/Alcohol Poisoning) (per 100,000 population)	Average rate of death due to intentional self-harm (suicide), alcohol-related disease, and drug overdose, also known as "deaths of despair", per 100,000 population. Figures are reported as crude rates. Rates are re-summarized for report areas from county level data, only where data is available. This indicator is relevant because death of despair is an indicator of poor mental health.	CDC – NVSS. Data accessed via the North Carolina Data Portal, June 2024.	2018-2022
Suicide (per 100,000 population)	Five-year average rate of death due to intentional self-harm (suicide) per 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 37: Physical Health

Measure	Description	Data Source	Most Recent Data Year(s)
Poor or fair health (percent of adults reporting fair or poor health age-adjusted)	Percentage of adults in a county who consider themselves to be in poor or fair health. This measure is based on responses to the BRFSS question: "In general, would you say that your health is excellent, very good, good, fair, or poor?" The value reported in the County Health Rankings is the percentage of respondents who rated their health "fair" or "poor." Poor or Fair Health is age-adjusted. Poor or Fair Health	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)
	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 health professional that they have had a stroke.	CDC, BRFSS. Data accessed via the North Carolina Data Portal, June 2024.	2022
Obesity	Percentage of adults ages 20 and older self-report having a Body Mass Index (BMI) greater than 30.0 (obese). Respondents were	CDC, National Center for Chronic Disease Prevention and Health Promotion. Data	2021

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

Measure	Description	Data Source	Most Recent Data Year(s)
Seasonal Influenza Vaccine	Percentage of adults ages 18 and older who reported receiving an influenza vaccination in the past 12 months. These data are derived from responses to the 2019 BRFSS.	CDC – FluVaxView. Data accessed via the North Carolina Data Portal, June 2024.	2019

Measure	Description	Data Source	Most Recent Data Year(s)
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 39: Safety

Measure	Description	Data Source	Most Recent Data Year(s)
Incarceration Rate	Percentage of individuals born in each census tract who were incarcerated at the time of the 2010 Census as estimated by Opportunity Atlas data.	Opportunity Insights. Data accessed via the North Carolina Data Portal, June 2024.	2018
Juvenile Arrest Rate (per 1,000 juveniles)	Rate of delinquency cases per 1,000 juveniles. Data are acquired from the 2021 Easy Access to State and County Juvenile Court Case Counts (EZACO) and are used in the 2024 County Health Rankings.	Office of Juvenile Justice and Delinquency Department, Easy Access to State and County Juvenile Court Case Counts (EZACO). Data accessed via the North Carolina Data Portal, June 2024.	2021

Measure	Description	Data Source	Most Recent Data Year(s)
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 40: Sexual Health

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

Measure	Description	Data Source	Most Recent Data Year(s)
Teen Births (per 1,000 female population age 15-19)	Seven-year average number of births per 1,000 female population age 15-19. Data were from the National Center for Health Statistics - Natality files (2016-2022) and are used for the 2024 County Health Rankings.	CDC – National Vital Statistics System. Data accessed via the North Carolina Data Portal, June 2024.	2016-2022

Table 41: Substance Use Disorders

Measure	Description	Data Source	Most Recent Data Year(s)
Excessive Drinking – Heavy Alcohol Consumption	Percentage of adults that self-report excessive drinking in the last 30 days. Data for this indicator were based on survey responses to the 2021 Behavioral Risk Factor Surveillance System (BRFSS) annual survey and are used for the 2024 County Health Rankings. Excessive drinking is defined as the percentage of the population who report at least one binge drinking episode involving five or more drinks for men and four or more for women over the past 30 days, or heavy drinking involving more than two drinks per day for men and more than one per day for women, over the same time period. Alcohol use is a behavioral health issue that is also a risk factor for a number of negative health outcomes, including: physical injuries related to motor vehicle accidents, stroke, chronic diseases such as heart disease and cancer, and mental health conditions such as depression and suicide. There are a number of evidence-based interventions that may reduce excessive/binge drinking; examples include raising taxes on alcoholic beverages, restricting access to alcohol by limiting days and hours of retail sales, and screening and counseling for alcohol abuse.	CDC, BRFSS. Data accessed via the North Carolina Data Portal, June 2024.	2021
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	U.S. Department of Transportation, National Highway Traffic Safety Administration, Fatality Analysis Reporting	2018-2022

Measure	Description	Data Source	Most Recent Data Year(s)
	crash and not the decedent's residence. Motor vehicle crash deaths are preventable and are a leading cause of death among young persons.	System. Data accessed via the North Carolina Data Portal, June 2024.	
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 42: Tobacco Use

Measure	Description	Data Source	Most Recent Data Year(s)
Adult smoking	Percentage of the adult population that currently smokes every day or most days and has smoked at least 100 cigarettes in their lifetime. Adult Smoking estimates are created using statistical modeling.	Behavioral Risk Factor Surveillance System. Data accessed via RWJF & UWPHI County Health Rankings & Roadmaps, June 2024.	2021

Table 43: Transportation Options and Transit

Measure	Description	Data Source	Most Recent Data Year(s)
Households with No Motor Vehicle	Percentage of households with no motor vehicle based on the latest 5-year American Community Survey estimates.	U.S. Census Bureau, ACS. Data accessed via the North Carolina Data Portal, June 2024.	2018-2022
Commuter Travel Patterns - Public Transportation	Percentage of population using public transportation as their primary means of commuting to	U.S. Census Bureau, ACS. Data accessed via the	2018-2022

Measure	Description	Data Source	Most Recent Data Year(s)
	work. Public transportation includes buses or trolley buses, streetcars or trolley cars, subway or elevated rails, and ferryboats.	North Carolina Data Portal, June 2024.	

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 Dare 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	Dare County Description
	Low	Represents measures in which Dare 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 Dare 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 Dare 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 Dare County value was compared to the benchmark by calculating the percentage difference between the values, relative to the benchmark value:
(Dare Co Value – Benchmark Value)/(Benchmark) x 100 = % Difference Used to Identify Priority Level

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

(8.5-7.5)/(7.5) x 100% = 13.3% = Displayed as **High Priority Level**, Shaded in Red

This metric indicates that the percentage of the population with limited access to healthy foods in Dare County is 13.3 percent worse (or, in this case, higher) than the percentage of the population with limited access to healthy foods in the state of North Carolina.

Detailed Focus Area Benchmarks

Table 44: Access to Care

Measure	National Benchmark	North Carolina Benchmark	Dare County Data	Most Recent Data Year	Dare County Need
Primary Care Providers Ratio	112.4	101.1	75.9	2024	High
Mental Health Providers Ratio	178.7	155.7	78.6	2024	High
Addiction/Substance Abuse Providers Ratio	27.9	25.0	32.5	2024	Low
Buprenorphine Providers Ratio	15.5	15.2	8.11	2023	High
Dental Health Providers Ratio	39.1	31.5	35.2	2024	Low
% Living in Health Professional Shortage Areas (HPSAs) – Dental Care	17.8%	34.0%	95.6%	2018-2022	High
Federally Qualified Health Centers (FQHCs)	3.5	4.1	2.7	2023	High
% Receiving Medicaid	22.3%	20.2%	9.9%	2018-2022	Low
% Uninsured	10.2%	12.5%	12.3%	2022	Medium

Table 45: Built Environment

Measure	National Benchmark	North Carolina Benchmark	Dare County Data	Most Recent Data Year	Dare County Need
Broadband Access (Access to DL Speeds >= 25MBPS and UL Speeds >= 3 MBPS)	93.8%	93.6%	99.4%	2023	Low
Broadband Access (Access to DL Speeds >= 100MBPS and UL Speeds >= 20 MBPS)	91.2%	90.4%	99.4%	2023	Low
Households with No Computer	6.1%	6.9%	3.3%	2018-2022	Low
Households with No or Slow Internet	11.7%	13.0%	7.2%	2018-2022	Low
Liquor Stores	13.3	6.2	32.5	2022	High
Adverse Childhood	N/A	N/A	Suppressed	2022	N/A

Measure	National Benchmark	North Carolina Benchmark	Dare County Data	Most Recent Data Year	Dare County Need
Experiences (ACEs)					

Table 46: Diet and Exercise

Measure	National Benchmark	North Carolina Benchmark	Dare County Data	Most Recent Data Year	Dare County Need
% Physically Inactive	N/A	21.6%	17.7%	2021	Low
Walkability Index Score	10	7	8	2021	Low
% with Access to Exercise Opportunities	84.1%	73.0%	71.0%	2023	Medium
Recreation and Fitness Facility Access	14.8	13.1	8.1	2022	High
Sugar-Sweetened Beverage (SSB) Consumption	N/A	N/A	Suppressed	2022	N/A

Table 47: Education

Measure	National Benchmark	North Carolina Benchmark	Dare County Data	Most Recent Data Year	Dare County Need
% Limited English Proficiency	8.2%	4.6%	2.7%	2018-2022	Low
High School Graduation Rate	81.1%	87.6%	92.9%	2020-2021	Low
% with No High School Diploma	10.9%	10.6%	5.1%	2018-2022	Low
Student Math Proficiency	63.9%	65.8%	59.0%	2020-2021	Low
Student Reading Proficiency	60.1%	59.5%	58.1%	2020-2021	Medium
School Funding Adequacy	N/A	-$4,742	$1,722	2021	Low
School Funding Adequacy – Spending per pupil	N/A	$10,655	$11,742	2021	Low

Table 48: Employment

Measure	National Benchmark	North Carolina Benchmark	Dare County Data	Most Recent Data Year	Dare County Need
Unemployment Rate	3.9%	3.7%	3.8%	2024	Medium
Average Annual Unemployment Rate, 2013-2023	3.6%	3.5%	4.0%	2024	High

Table 49: Environmental Quality

Measure	National Benchmark	North Carolina Benchmark	Dare County Data	Most Recent Data Year	Dare County Need
Flood Vulnerability	6.5%	4.9%	66.2%	2011	High
Drinking Water Safety	16,107	194	0	2023	Low

Table 50: Family, Community and Social Support

Measure	National Benchmark	North Carolina Benchmark	Dare County Data	Most Recent Data Year	Dare County Need
Children Cost Burden	28.8%	27.0%	27.0%	2023	Medium
% Young People Not in School or Working	6.9%	7.5%	6.5%	2018-2022	Low

Table 51: Food Security

Measure	National Benchmark	North Carolina Benchmark	Dare County Data	Most Recent Data Year	Dare County Need
% Food Insecure	10.3%	11.4%	10.0%	2021	Low
% Food Insecure Children	13.3%	15.3%	10.7%	2021	Low
% Low-Income and with Low Food Access	19.4%	21.3%	30.3%	2019	High
% Limited Access to Healthy Foods	N/A	7.5%	8.5%	2019	High
Fast Food Restaurants	96.2	77.4	184.2	2022	High
Grocery Stores	23.4	18.7	46.1	2022	Low

Table 52: Housing and Homelessness

Measure	National Benchmark	North Carolina Benchmark	Dare County Data	Most Recent Data Year	Dare County Need
Renter Costs – Average Gross Rent	$1,366	$1,090	$1,308	2018-2022	High
% Severe Housing Cost Burden	14.1%	12.2%	11.7%	2018-2022	Medium
Assisted Housing Units	413.9	319.2	37.3	2017-2021	Low
% Severe Substandard Housing	18.5%	16.1%	16.7%	2011-2015	Medium
% Homeless Children	2.8%	1.9%	4.0%	2019-2020	High

Table 53: Income

Measure	National Benchmark	North Carolina Benchmark	Dare County Data	Most Recent Data Year	Dare County Need
Median Family Income	$92,646	$82,890	$101,908	2018-2022	Low
Gender Pay Gap	81.0%	83.0%	81.0%	2018-2022	Medium
% Living Below 100% FPL	12.5%	13.3%	6.5%	2022	Low
% Living Below 200% FPL	28.8%	31.6%	20.0%	2018-2022	Low
% Children Living Below 200% FPL	37.2%	41.1%	29.7%	2018-2022	Low
% Receiving SNAP	12.4%	15.7%	8.3%	2021	Low
Children Eligible for Free/Reduced Price Lunch	51.7%	50.8%	20.6%	2022-2023	Low

Table 54: Length of Life

Measure	National Benchmark	North Carolina Benchmark	Dare County Data	Most Recent Data Year	Dare County Need
Years of Potential Life Lost Rate	N/A	8,853	7,602	2019-2021	Low
Premature Age-Adjusted Mortality	N/A	420	344	2019-2021	Low
Life Expectancy	77.6	76.6	78.5	2019-2021	Medium

Table 55: Maternal and Infant Health

Measure	National Benchmark	North Carolina Benchmark	Dare County Data	Most Recent Data Year	Dare County Need
Births with Late or No Prenatal Care	6.1%	6.9%	Suppressed	2019	N/A
Low Birthweight	N/A	9.4%	6.2%	2016-2022	Low
Infant Mortality Rate	5.7	7.0	Suppressed	2015-2021	N/A

Table 56: Mental Health

Measure	National Benchmark	North Carolina Benchmark	Dare County Data	Most Recent Data Year	Dare County Need
Poor Mental Health Days	4.9	4.6	4.3	2021	Low
Deaths of Despair Rate	55.9	58.7	86.2	2018-2022	High
Suicide Death Rate	14.5	14.0	19.3	2018-2022	High

Table 57: Physical Health

Measure	National Benchmark	North Carolina Benchmark	Dare County Data	Most Recent Data Year	Dare County Need
% Poor or Fair Health	N/A	14.4%	11.1%	2021	Low
% Adults with Asthma	9.7%	9.8%	9.0%	2022	Low
% Adults with Heart Disease	5.2%	5.5%	4.9%	2022	Low
% Adults with High Blood Pressure	29.6%	32.1%	28.3%	2021	Low
% Adults with High Cholesterol	31.0%	31.4%	30.6%	2021	Medium
Diabetes Prevalence	8.9%	9.0%	6.8%	2021	Low
% Adults with Kidney Disease	2.7%	2.9%	2.5%	2021	Low
% Stroke	2.8%	3.1%	2.4%	2022	Low
Obesity	30.1%	29.7%	25.1%	2021	Low
% Teeth Loss	13.9%	12.0%	9.0%	2022	Low
Cancer Incidence Rate	442.3	464.4	416.6	2016-2020	Low
Emergency Room Visits	535	563	482	2022	Low

Measure	National Benchmark	North Carolina Benchmark	Dare County Data	Most Recent Data Year	Dare County Need
Heart Disease Hospitalization Rate	10.4	11.7	12.2	2018-2020	Medium
Stroke Hospitalization Rate	8.0	9.5	7.8	2018-2020	Low

Table 58: Quality of Care

Measure	National Benchmark	North Carolina Benchmark	Dare County Data	Most Recent Data Year	Dare County Need
Children/adults vaccinated annually against seasonal influenza	44.5%	45.6%	51.2%	2021	Low
Preventable Hospital Rate	2,752	2,957	1,422	2021	Low
Readmissions Rate	18.1%	17.6%	14.4%	2022	Low

Table 59: Safety

Measure	National Benchmark	North Carolina Benchmark	Dare County Data	Most Recent Data Year	Dare County Need
Incarceration Rate	1.3%	1.5%	0.9%	2018	Low
Juvenile Arrest Rate	13.8	16.0	24.0	2021	High
Violent Crime	416.0	365.7	234.7	2015-2017	Low
Firearm Death Rate	13.4	15.5	13.4	2018-2022	Low
Poisoning Death Rate	28.5	31.5	47.1	2018-2022	High

Table 60: Sexual Health

Measure	National Benchmark	North Carolina Benchmark	Dare County Data	Most Recent Data Year	Dare County Need
Chlamydia Rate	495.0	603.3	169.2	2021	Low
HIV Incidence Rate	12.7	15.5	0.0	2022	Low
Teen Births	16.6	18.2	N/A	2016-2022	N/A

Table 61: Substance Use Disorders

Measure	National Benchmark	North Carolina Benchmark	Dare County Data	Most Recent Data Year	Dare County Need
% Excessive Drinking	18.1%	18.2%	18.7%	2021	Medium
% Driving Deaths with Alcohol	2.3	2.9	1.6	2018-2022	Low
Opioid Use Disorder Rate	41.0	43.0	39.0	2021	Low
Opioid Drug Overdose Deaths	N/A	25.1	41.2	2018-2022	High

Table 62: Tobacco Use

Measure	National Benchmark	North Carolina Benchmark	Dare County Data	Most Recent Data Year	Dare County Need
% Smokers	14.5%	15.0%	12.9%	2021	Low

Table 63: Transportation Options and Transit

Measure	National Benchmark	North Carolina Benchmark	Dare County Data	Most Recent Data Year	Dare County Need
% Households with No Motor Vehicle	8.3%	5.4%	1.8%	2018-2022	Low
% Public Transit	3.8%	0.8%	0.0%	2018-2022	High

Appendix 4 | Primary Data Methodology & Sources

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

Methodologies

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

Focus Groups

The following three focus groups were conducted in-person between May 21, 2024 and June 26, 2024. These groups included representation from key leaders, non-profit partners, patients, and community members, with over 27 participants providing responses.

- Fessenden Center Annex
- The Studio, Nags Head (SMART group recovery)
- Outer Banks Health (Housing task force leadership)

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 Dare County

The majority (51.9%) of participants identified as male, and the group was predominantly white (63%) and non-Hispanic/Latino (100%). Participants represented a wide range of ages, between 18-75 and older.

The focus group discussion guide questions are below:

FACILITATOR INTRODUCTION:

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

PARTICIPANT INTRODUCTIONS

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

HEALTH AND WELLNESS

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

SOCIAL DETERMINANTS OF HEALTH

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

ACCESS TO CARE

7. What are some reasons people in [COUNTY NAME] do not get health care when they need it? How can these issues be addressed?
8. What do you think about the health-related services that are available in your community, including medical care, dental care and behavioral health care?
    a. Are there enough locations providing these types of care for people who need it?
    b. Can you find medical, dental or behavioral health care within a reasonable timeframe when you need it?
    c. Are your experiences with providers (doctors, dentists, nurses, therapists, emergency personnel, etc.) more positive or negative, and why?

SUGGESTIONS

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

Key Informant Interviews

Fifteen key informant interviews were conducted throughout summer 2024 with individuals and organizations in Dare County to gain perspective on the health and well-being of residents. Participants included representatives from various sectors such as health and human services, community outreach organizations, and local government agencies.

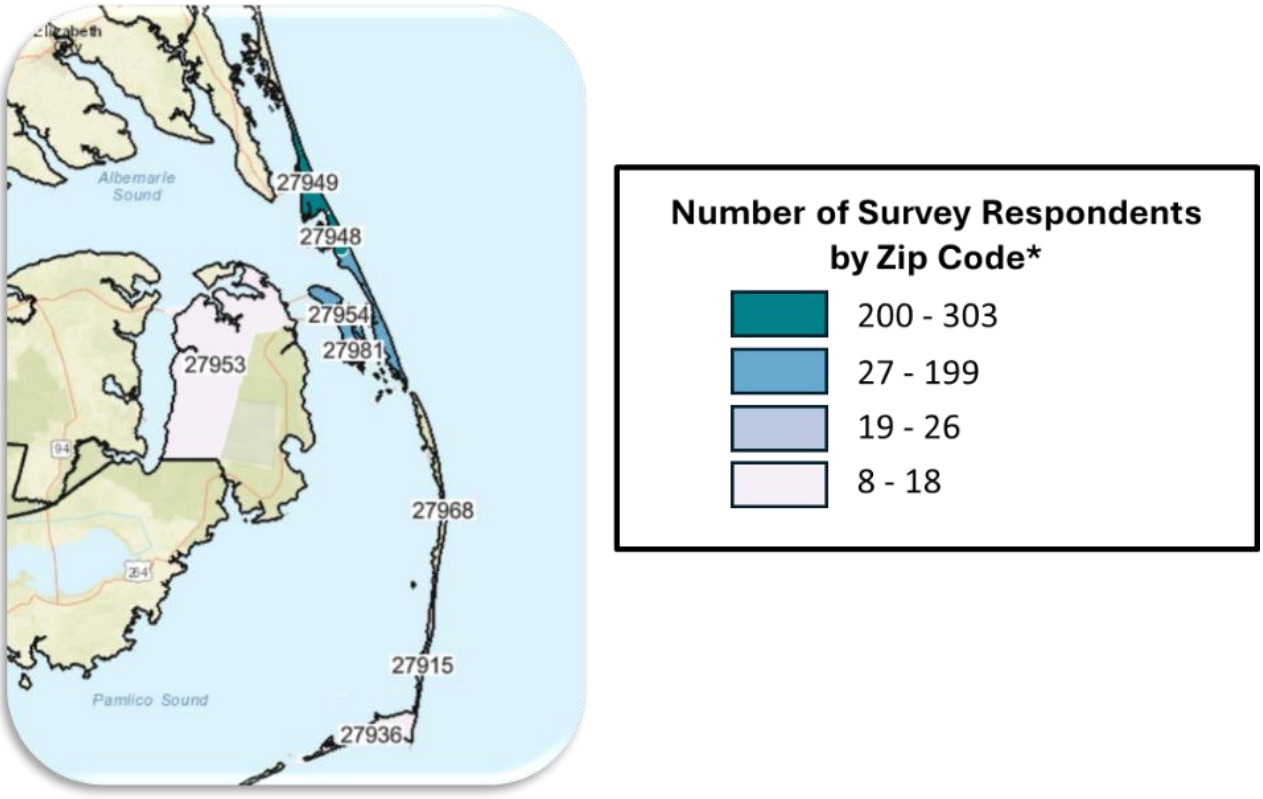
- Beach Food Pantry, Executive Director
- Coastal Studies Institute, Executive Director
- Dare County Health & Human Services (DCDHHS), Director
- DCDHHS, Environmental Health Services Supervisor
- DCDHHS, Health Education and Outreach Director

- DCDHHS, Social Services Director
- DCDHHS, WIC (Women, Infants and Children) Director
- Cape Hatteras National Seashore & Outer Banks Group of the National Park Service, Superintendent
- Interfaith Community Outreach, Executive Director
- Manteo Community Health Center
- Manteo Healthcare Task Force, Vice-chair
- OBX Room at the Inn, Executive Director
- Outer Banks Relief Foundation, Executive Director
- Outer Banks Family YMCA, Executive Director
- Peace Garden Project, Executive Director/Roanoke Island Presbyterian Church, Pastor

Community Member Web Survey

A total of 1,212 surveys were completed by individuals living, working or receiving healthcare in the Dare County community. The survey was available in both English and Spanish; however, no surveys 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 49: Respondent Zip Code of Residence[44]



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

In general, survey questions focused on:

- Community health problems and concerns
- Community social/environmental problems and concerns
- Specific topics of interest to Dare County:
    - Access to care
    - Healthy lifestyle
    - Equity and equality
    - Housing and homelessness
    - Mental health
    - Physical heath
    - Substance use disorders
    - Tobacco use
    - Transportation and transit

The key findings from the Community Survey are detailed below:

- Alcohol/drug addiction, mental health (e.g., depression and anxiety), and cancer were identified as the top 3 health problems affecting the community. About one-third of respondents also identified heart disease/high blood pressure and weight/obesity as important health problems.
- Cost, physician proximity, and not having insurance were the top three barriers to receiving health care identified by the community.
- Availability and access to doctor's offices, housing, and lack of affordable childcare were identified as the top three most important social or environmental problems that affect the health of the community. Transportation and insurance were also identified by almost one in four respondents.

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

Figure 50: Respondents by Age Group

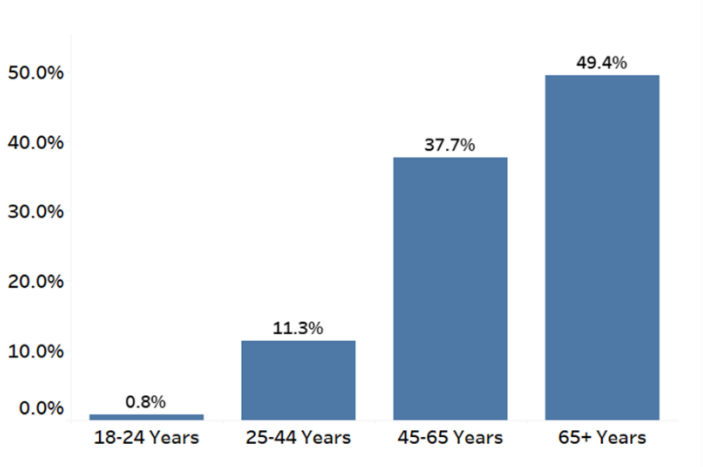


Figure 51: Respondents by Gender

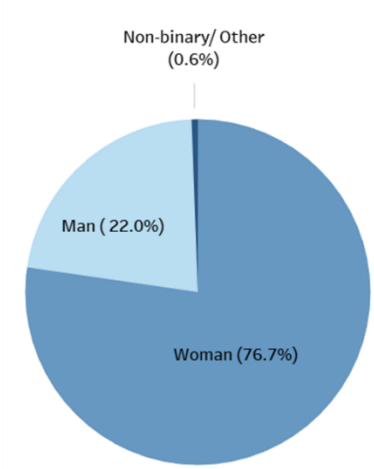


Figure 52: Respondents by Race

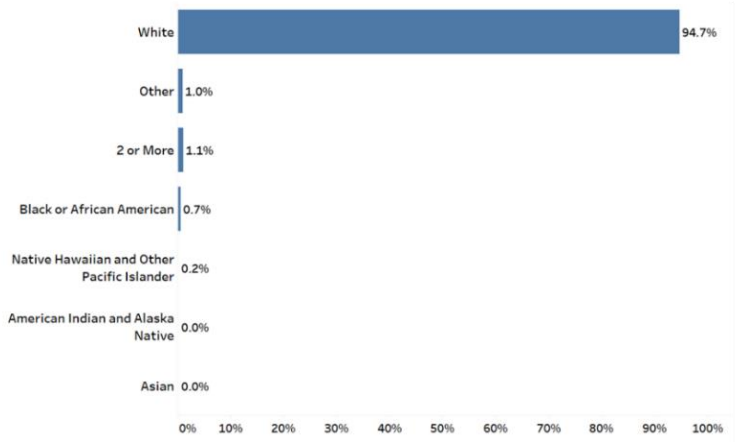
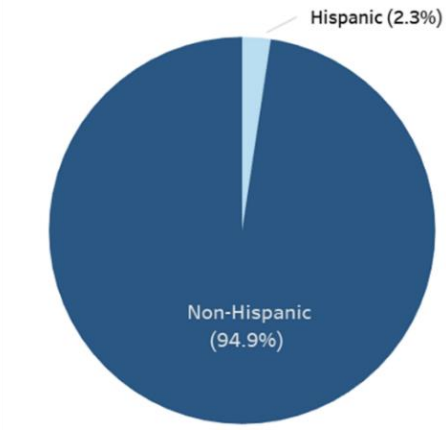


Figure 53: Respondents by



<u>Community Member Survey</u>

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

Dear Community Member,

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

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

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

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

Thank you for your time and participation!

Topic: Demographics

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

2. What is your age group?

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

□ Prefer not to say

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

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

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

4. Are you of Hispanic or Latino origin, or is your family originally from a Spanish speaking country?[45]
□ Yes
□ No
□ Don't know/Not sure
□ Prefer not to say

5. 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

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

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

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

7. 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

8. Which category best describes your yearly household income before taxes?[46]

□ 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

9. 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

[46] Participants 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.

10. 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

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

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

Topic: Access to Care

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

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

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

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

□ Prefer not to answer

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

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

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

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

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

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

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

disagree; 4 = somewhat agree; 5 = strongly agree

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

Topic: Diet & Exercise

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

    □ Number of servings: _____

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

    □ Number of servings: _____

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

    □ Number of drinks: _____

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

    □ Number of hours: _____

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

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

Topic: Family, Community and Social Support

23. 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.	☐	☐	☐	☐	☐	☐	☐

24. 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: Housing and Homelessness

25. In the past 12 months, were there times when you:

	Yes	No	Don't Know	Prefer not to say
a. Were worried about having enough money to pay your rent or mortgage?	☐	☐	☐	☐
b. Did not have electricity, water, or heating in your home?	☐	☐	☐	☐

26. In the PAST THREE YEARS, were there times when you:

	Yes	No	Don't Know	Prefer not to say
a. Had to live with a friend or relative because of a housing emergency, even if this was only temporary?	☐	☐	☐	☐
b. Were evicted or displaced from your home?	☐	☐	☐	☐
c. Were living on the street, in a car, or in a temporary shelter?	☐	☐	☐	☐

27. Think about the place where you live. Do you have problems with any of the following? *Select all that apply:*
□ Bug infestation
□ Mold
□ Lead paint or pipes
□ Inadequate heat
□ Inadequate cooling (air conditioning)
□ Holes in the floor
□ Oven or stove not working
□ No or not working smoke detector
□ Water leaks
□ None of the above
□ Prefer not to say

Topic: Mental Health

28. 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: _____

29. 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

30. 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

31. 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

32. 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

33. 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?	□	□	□	□

34. 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

35. 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

36. 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: _____

37. 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

38. 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

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

Topic: Tobacco Use

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

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

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

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

42. Are you regularly exposed to secondhand smoke in any of these locations in your county? *Select all that apply:*
□ Home or car
□ Workplace
□ Parks
□ Restaurants or bars
□ School
□ Sidewalks
□ Hospital
□ Other, please specify: _____
□ I am not regularly exposed to secondhand smoke in my county
□ Prefer not to say

Topic: Transportation and Transit

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

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

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

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

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

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

Dare County: Additional Questions

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

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

47. In the past year, did you have any of the following assistance needs NOT met? *Select all that apply.*

□ Access and safety modifications to your home (ex. ramp, handrail)
□ Clothing for yourself and your family
□ Critical house repairs
□ Food for yourself and your family
□ Household goods (furniture, a stove or refrigerator)
□ Medical or adaptive equipment not covered by Medicaid or private insurance
□ None of the above
□ 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.

General Findings

Three focus groups were conducted in Dare County with a total of 27 community members providing feedback. All focus groups identified several common health concerns and barriers to care. First, they identified employment and income as a major concern, noting difficulties filling job vacancies due to housing issues, high childcare costs, and the need to work multiple jobs to afford basic needs. The second common theme described healthcare access and quality as barriers, specifically the lack of local providers, lack of health insurance, and poor coordination between providers. Housing and homelessness were also identified as significant challenges, with the proliferation of short-term rentals diverting housing from full-time residents and a lack of affordable housing for the working class. Mental health was another key theme, with a dire lack of behavioral health providers in the county, overdependence on telehealth, and high levels of stress post-COVID. Lastly, substance use was identified as a particular concern, especially during winter months when fewer activities are available.

Focus Group 1 Unique Insights: Community Members (Buxton Residents)

A total of nine Buxton residents participated in focus group one. Nearly all (9) of the group members identified as female, and nearly all (9) identified as white. All participants were over the age of 30. Participants in this focus group identified several key health concerns and barriers to care. They highlighted health equity as a major issue, specifically regarding the large Hispanic/Latino community lacking access to insurance and culturally competent services, as well as specific challenges related to mental health access for the LGBTQIA+ community. Transportation and transit were also identified as significant barriers, making it difficult for community members to access healthcare, employment, or needed resources.

Participants had several suggestions for how to address these health concerns and barriers to care in their community. They proposed increasing the number of doctors and adding an urgent care facility on Hatteras, as well as ensuring a more consistent presence of the Mobile Crisis Unit on Hatteras instead of relying on law enforcement intervention. Additionally, they suggested improving awareness of available community resources.

Focus Group 2 Unique Insights: Behavioral Health (SMART Group Recovery)

Eight community members participated in the SMART Group Recovery focus group. Attendees were evenly split between men and women. Additionally, all participants identified as white, and all were over the age of 18. This focus group identified several unique health and social/environmental issues. Community safety was noted as a concern, with domestic violence being specifically highlighted. Food access and security were also discussed, particularly regarding the cost and availability of

healthy foods. Physical health issues such as skin cancer and obesity were mentioned as prevalent concerns. Transportation and transit were again emphasized, with participants noting there is no dependable transportation in the county.

When asked to provide suggestions for local health leaders, participants proposed creating an alcohol/substance-free community center, improving advertising and education about available community resources, and finding ways to address local housing issues.

Focus Group 3 Unique Insights: Housing Task Force

The Housing Task Force focus group identified environmental quality as a unique concern, specifically mentioning natural disasters such as hurricanes and noting that new residents are often ill-equipped to handle them. They also discussed worsening seasonal flooding and soil erosion impacting the local economy. Food access and security were again highlighted, with participants mentioning affordability and access to healthy food, the proliferation of cheap, unhealthy options, and the need for more community nutrition education.

Suggestions to local health leaders included finding ways to incentivize high-density housing, improving awareness of resources available to help community members with housing costs or home ownership, and continuing collaboration between county leaders, hospitals, nonprofits, substance use providers, and other resources.

Key Informant Interviews

General Findings

The key informant interviews identified several common strengths and challenges in Dare County. Strengths included a strong sense of community, natural beauty and resources, and supportive elected officials. Major challenges centered around lack of affordable housing, inadequate transportation, shortage of childcare facilities, and limited access to mental health and behavioral health services. Additionally, interviewees noted a lack of primary care and specialty care providers as a significant concern.

Service Gaps and Changes Over Time

Interviewees highlighted several service gaps in Dare County, including the need for better transportation, more childcare services, affordable housing, and increased specialty medical care. They also noted changes in the composition of service users over the past five years, with a significant increase in the number of people using services, including more Hispanic or Latino clients and individuals considered "working poor" impacted by inflation and the rising cost of living.

Barriers to Healthcare and Key Health Concerns

The interviews revealed several barriers to accessing healthcare services in Dare County. Stigma was identified as a significant obstacle, along with transportation issues and lack of insurance coverage. To overcome these barriers, suggestions included developing a more robust transportation system and improving assistance for navigating available services.

Key health concerns in Dare County centered around substance abuse, mental health issues, and limited access to primary care providers and specialists. Potential causes for these issues included limited resources, workforce shortages, and the ongoing housing crisis. Interviewees suggested investing more in mental health and substance abuse programs to break stigma, addressing the housing crisis, and expanding transportation services as potential solutions.

Overall, the key informant interviews provided valuable insights into the health and social challenges facing Dare County, as well as potential strategies for improving the well-being of its residents. The findings align with many of the concerns identified in the focus groups conducted in Dare County, highlighting common themes across different communities in the region.

Community Member Web Survey

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

Topic: Additional Demographic Information

Figure 54: What is the highest grade or year of school you completed? (N = 1,212)

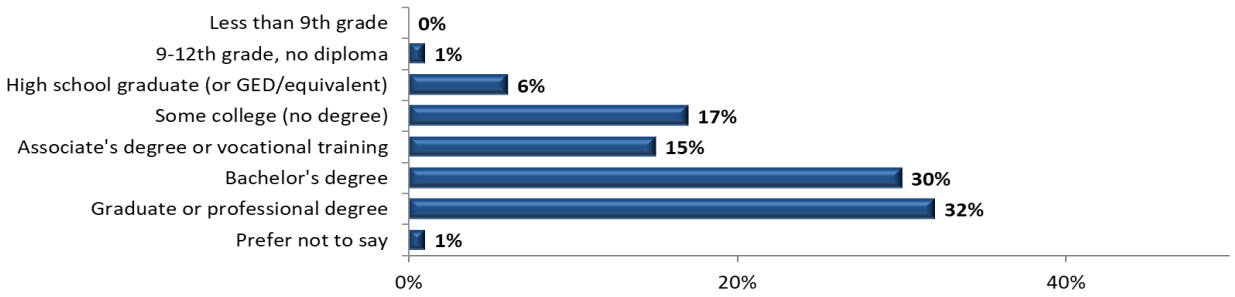


Figure 55: Which language is most often spoken in your home? (Choose one) (N = 1,210)

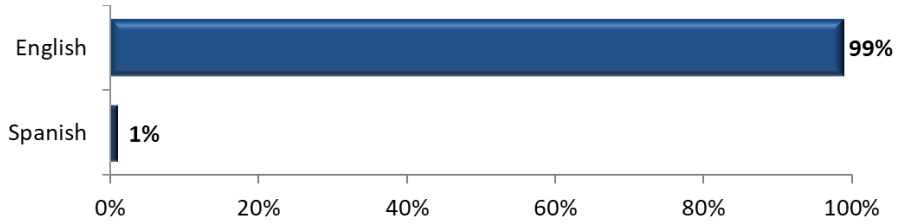


Figure 56: For employment, are you currently... (Select all that apply.)

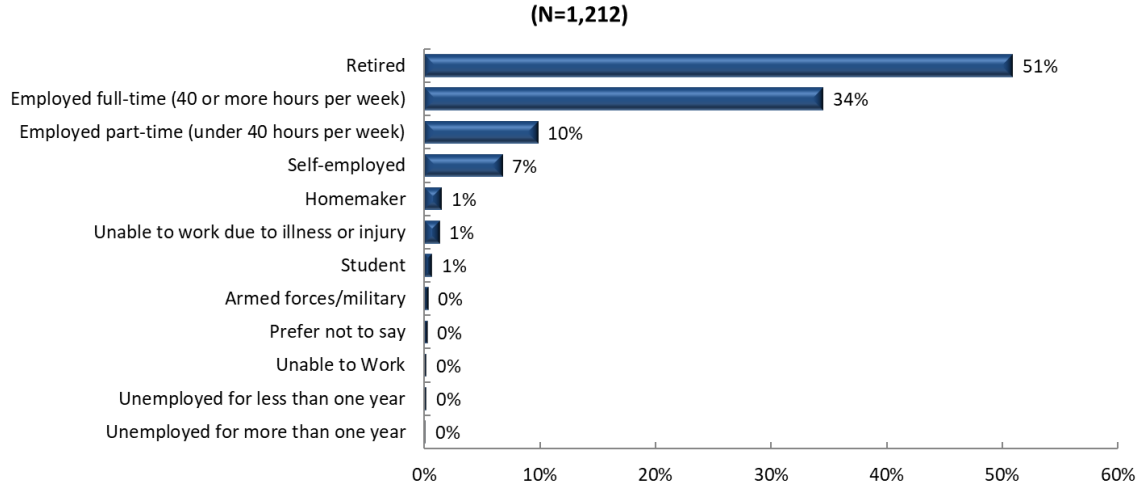
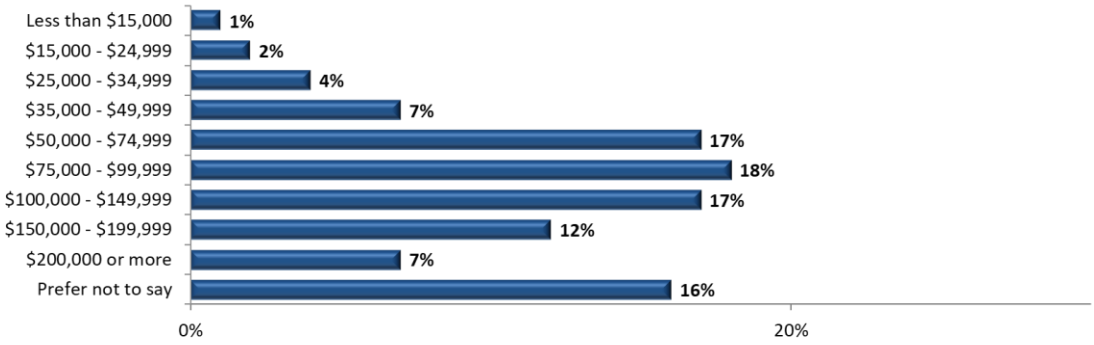
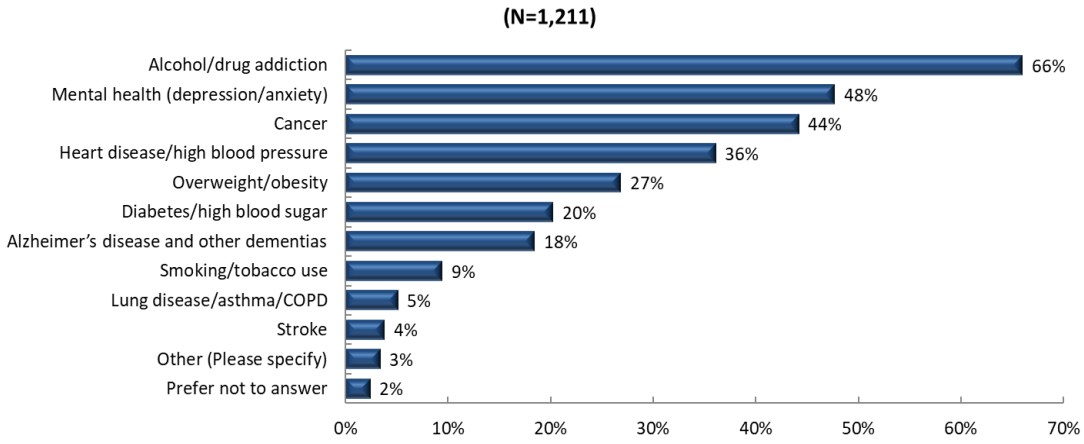


Figure 57: Which category best describes your yearly household income before taxes?[47] (N = 1,211)



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

Figure 58: What are the three most important health problems that affect the health of your community? Please select up to three.



Other (please specify):

- "1 Elder care. 2 Lack of physicians 3 visitors go first residences must wait"
- "Access to high quality healthcare"
- "Aging health"
- "Autoimmune diseases"
- "Benefits for older Population"
- "Bone /? joint injuries"
- "Chronic kidney disease; urinary problems;"
- "COVID"
- "Dental Health"
- "Drugs" (2 Respondents)
- "Environmental Health!!!! Toxins PFAS"
- "Environmental injuries, water sports and sun exposure and fishing or service-related job injuries"
- "Excess traffic and no escape routes if hurricane evacuation is required"
- "General old age"
- "General practitioner"
- "Geriatric care and adult social service needs"
- "Geriatric needs"
- "Home health care providers"

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

- "Homeless people"
- "Immune diseases"
- "Just old age and no specialist."
- "Kidney disease"
- "Lack of (and instability of employment) physicians who are primarily concerned about community care"
- "Lack of care"
- "Lack of housing/food/medical care"
- "Lack of physicians"
- "Lack of primary care providers"
- "Lack of well-qualified doctors and specialists"
- "Neurological disorders"
- "Old age"
- "Overall health care for older residents"
- "Overall number of PCPs and Medical/Psychological Specialists."
- "Parkinson's"
- "Poor food choices leading to the big three."
- "Primary Care Availability and a Real Hospital that does not function as a Giant Urgent Care"
- Vision issues

Figure 59: What are the three most important health problems that affect the health of your community? Please select up to three. (by age)

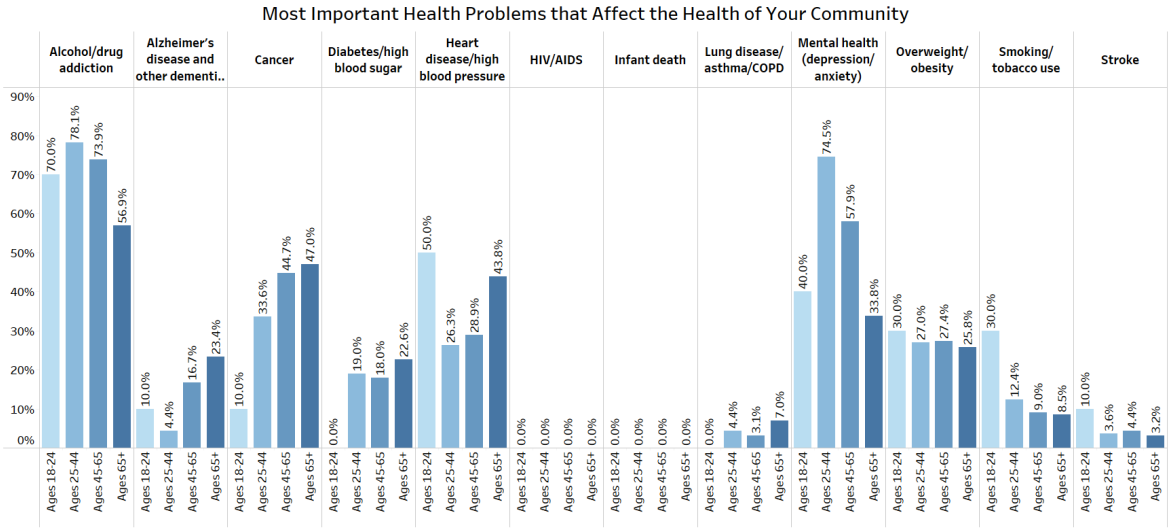


Figure 60: What are the three most important health problems that affect the health of your community? Please select up to three. (by gender)

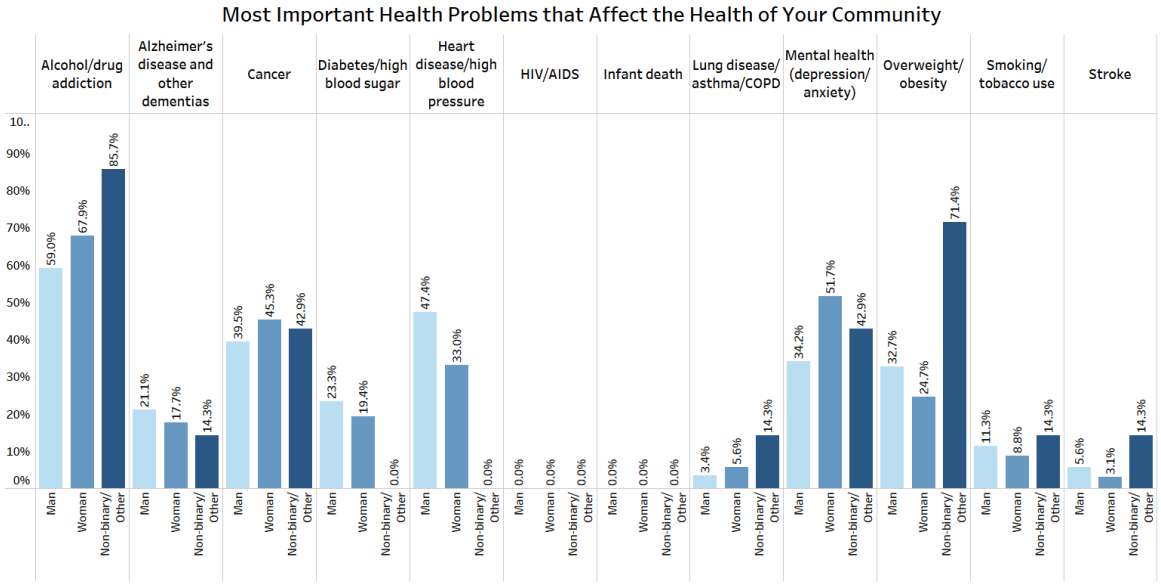


Figure 61: What are the three most important health problems that affect the health of your community? Please select up to three. (by race)

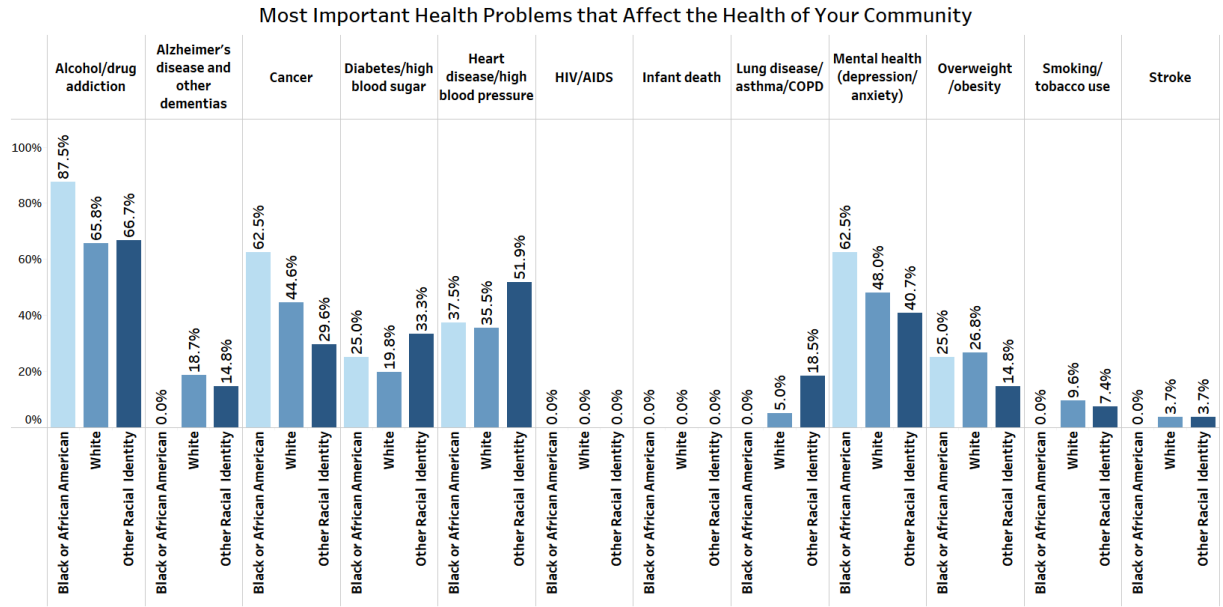


Figure 62: What are the three most important health problems that affect the health of your community? Please select up to three. (by ethnicity)

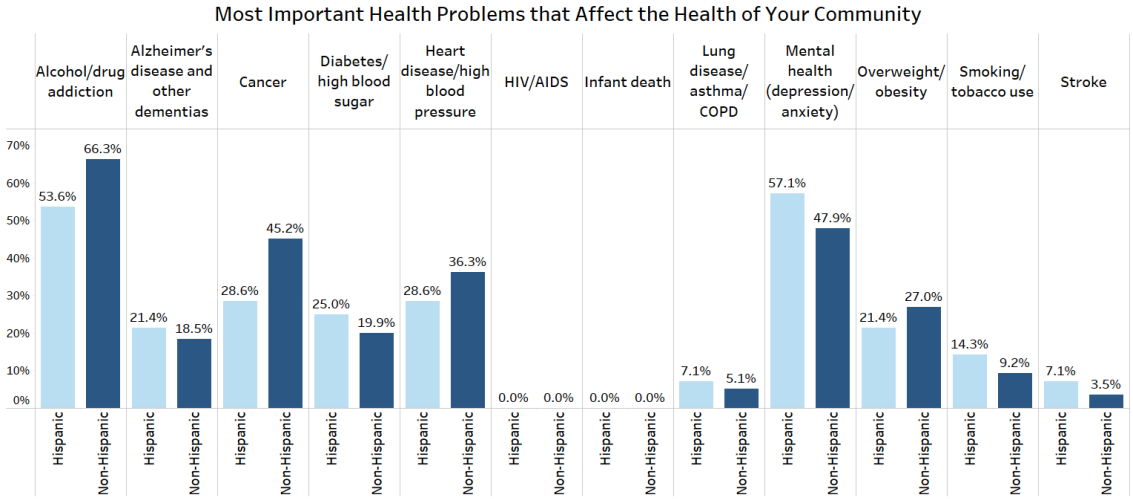
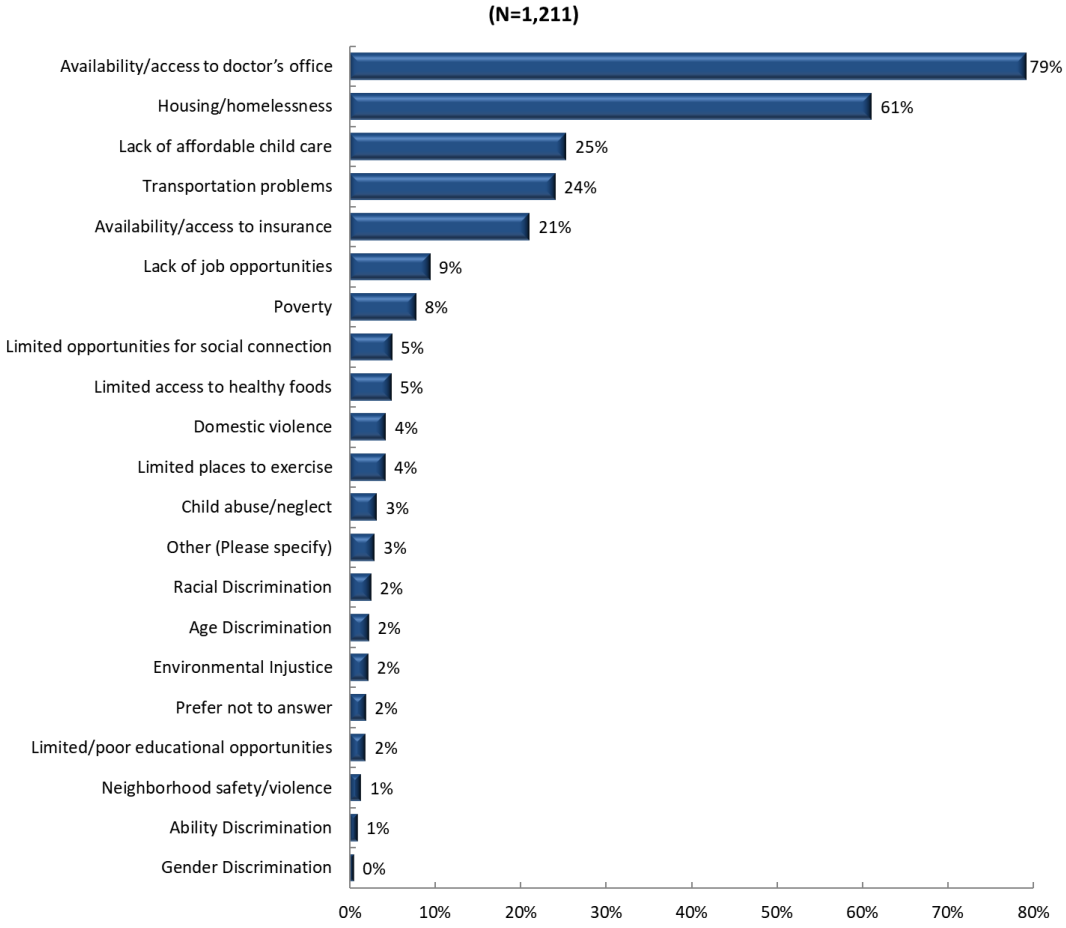


Figure 63: What are the three most important social or environmental problems that affect the health of your community? Please select up to three.



Other (please specify):

- "Access to affordable housing"
- "Access to good doctors"
- "Access to timely appointments, our medical community is slammed due to our population growth!"
- "Affordable healthcare"
- "Affordable housing" (2 respondents)
- "Availability for Mental health services"
- "Cost of living"
- "Cost of living artificially inflated by tourism."
- "Drug crimes"
- "Drugs"
- "Food insecurity - affordability"
- "Government wasting money"
- "Having insurance and it not really helping to cover"
- "Lack of access to specialists and distance to healthcare facilities"
- "Lack of adult day care"
- "Lack of diversity among population"
- "Lack of home health care for the elderly"
- "Lack of medical resources/doctors"
- "Lack of Medical Specialists in Dare Co (GI, Pulmonary, Cardiologist, etc)"
- "Lack of resources for soical/emotional/physical/mental well being."
- "Limited affordable dentist"
- "Limited income advancement"
- "Limited number of physicians and dentists"
- "Motivation"
- "Need an “in facility” hospice facility for when patients are very near death. (1–2-week period)"
- "No decent care, especially for elderly patients"
- "None"
- "Over building on obx Filling swamp and wetlands that will cause a problem in the future as the water table is rising (you can only fill so much!"
- "Pay doesn’t cover cost of living"
- "Refusal of providers to accept Medicare patients."
- "TOXINS, PFAS, PFOS, Buxton FUDS"
- "We have to travel to Virginia for primary Dr. unable to find one here. I had one 6 years ago but he never examined me. Only chatted."

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

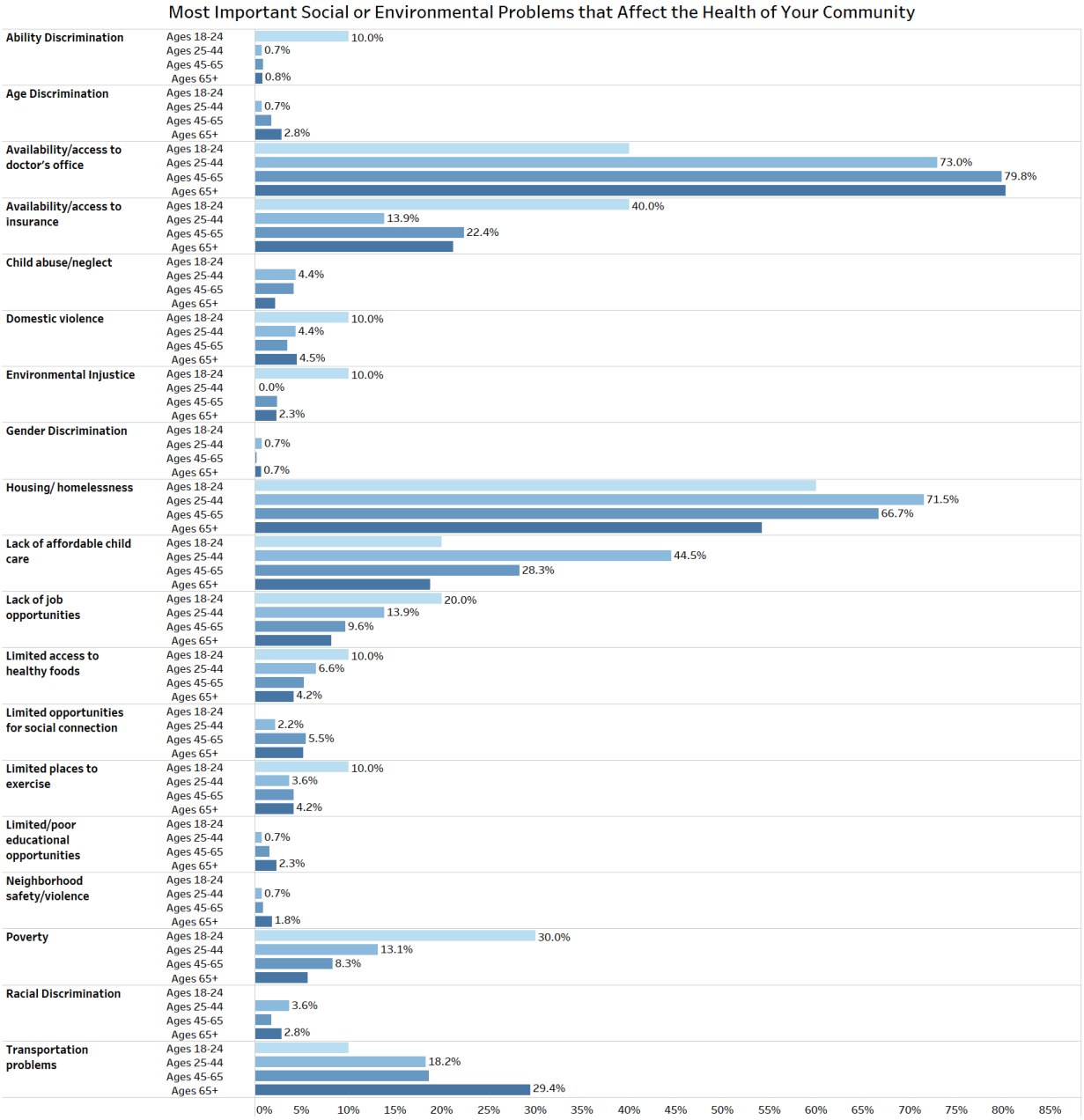


Figure 65: What are the three most important social or environmental problems that affect the health of your community? Please select up to three. (by gender)

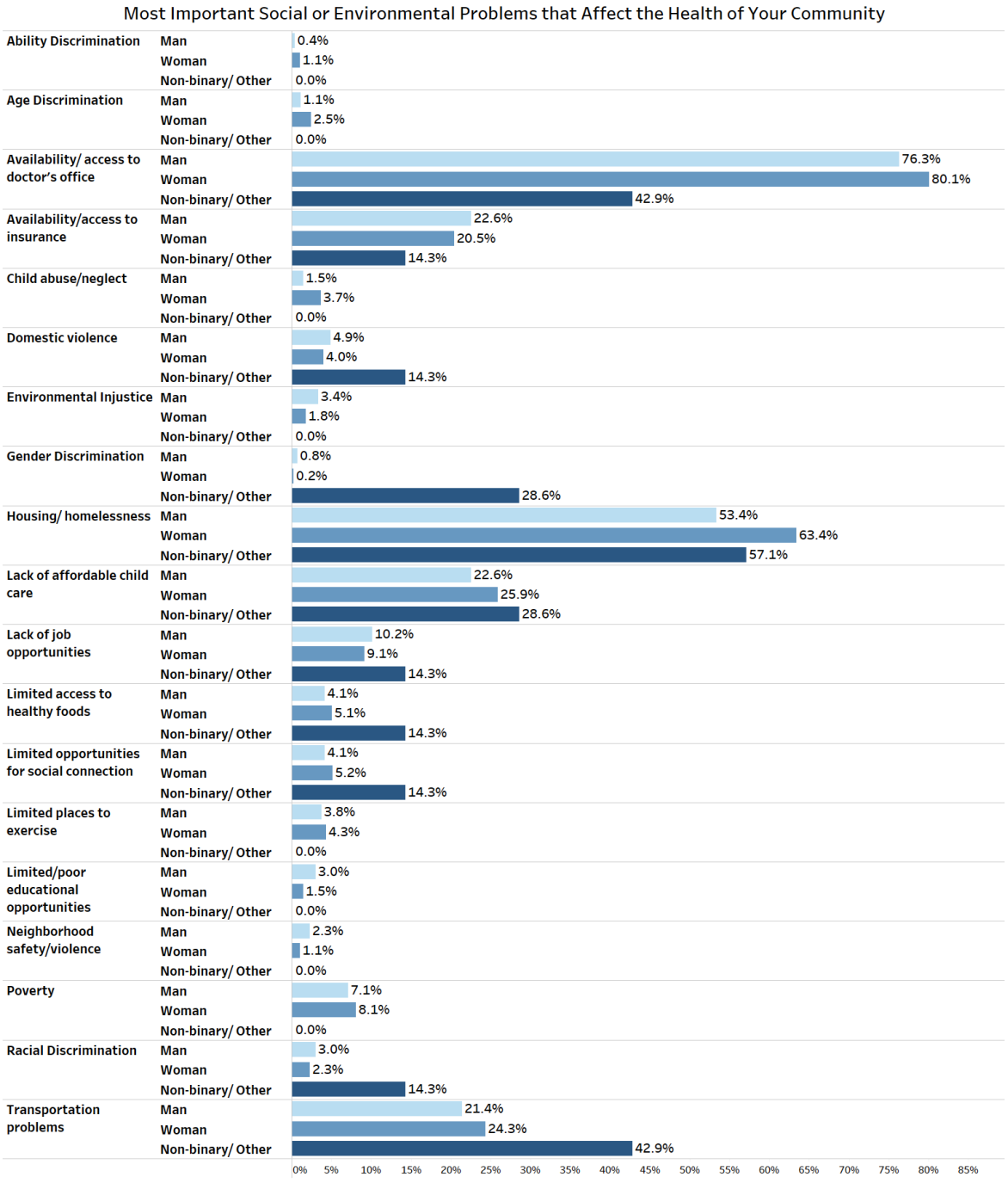


Figure 66: What are the three most important social or environmental problems that affect the health of your community? Please select up to three. (by race)

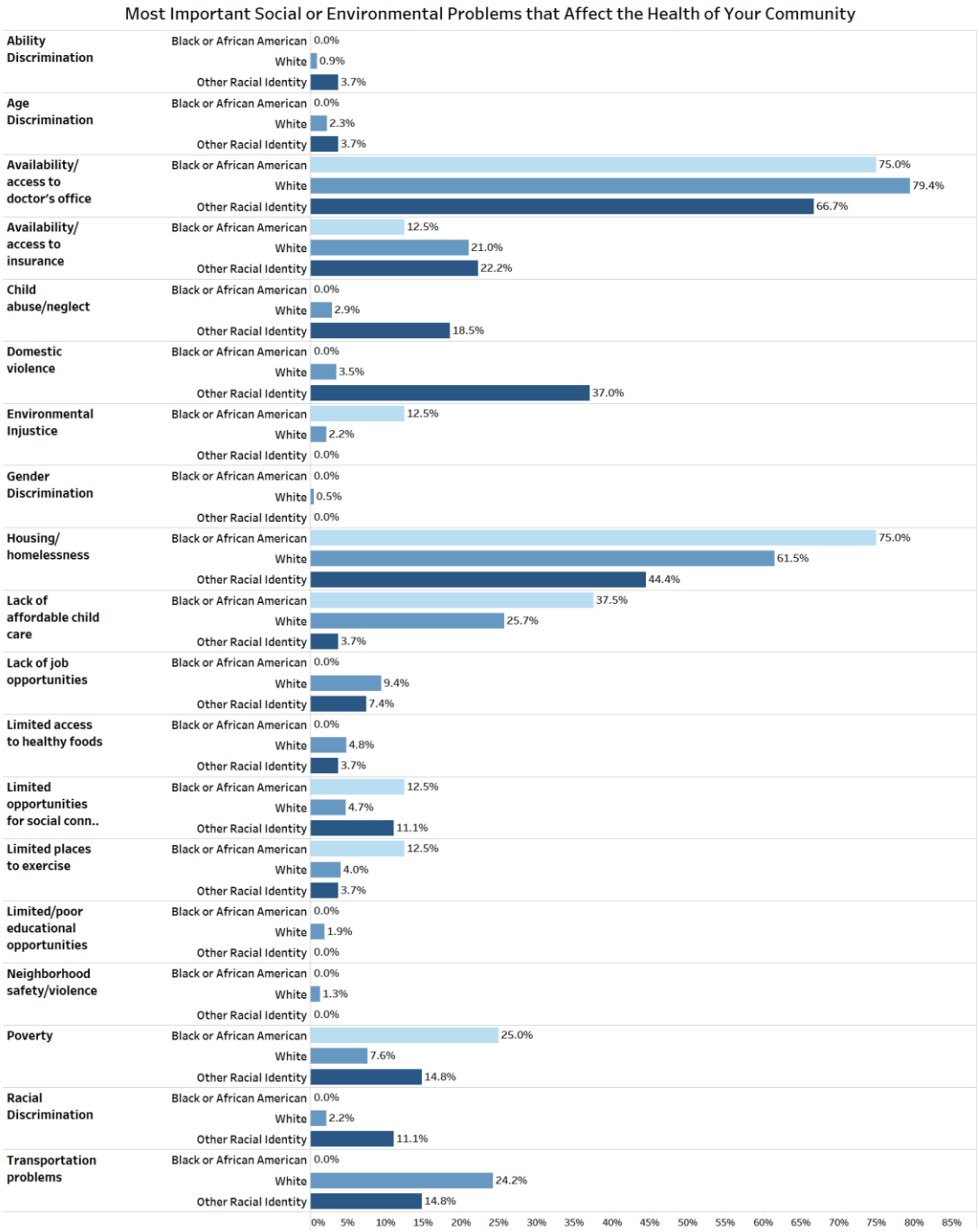


Figure 67: What are the three most important social or environmental problems that affect the health of your community? Please select up to three. (by ethnicity)

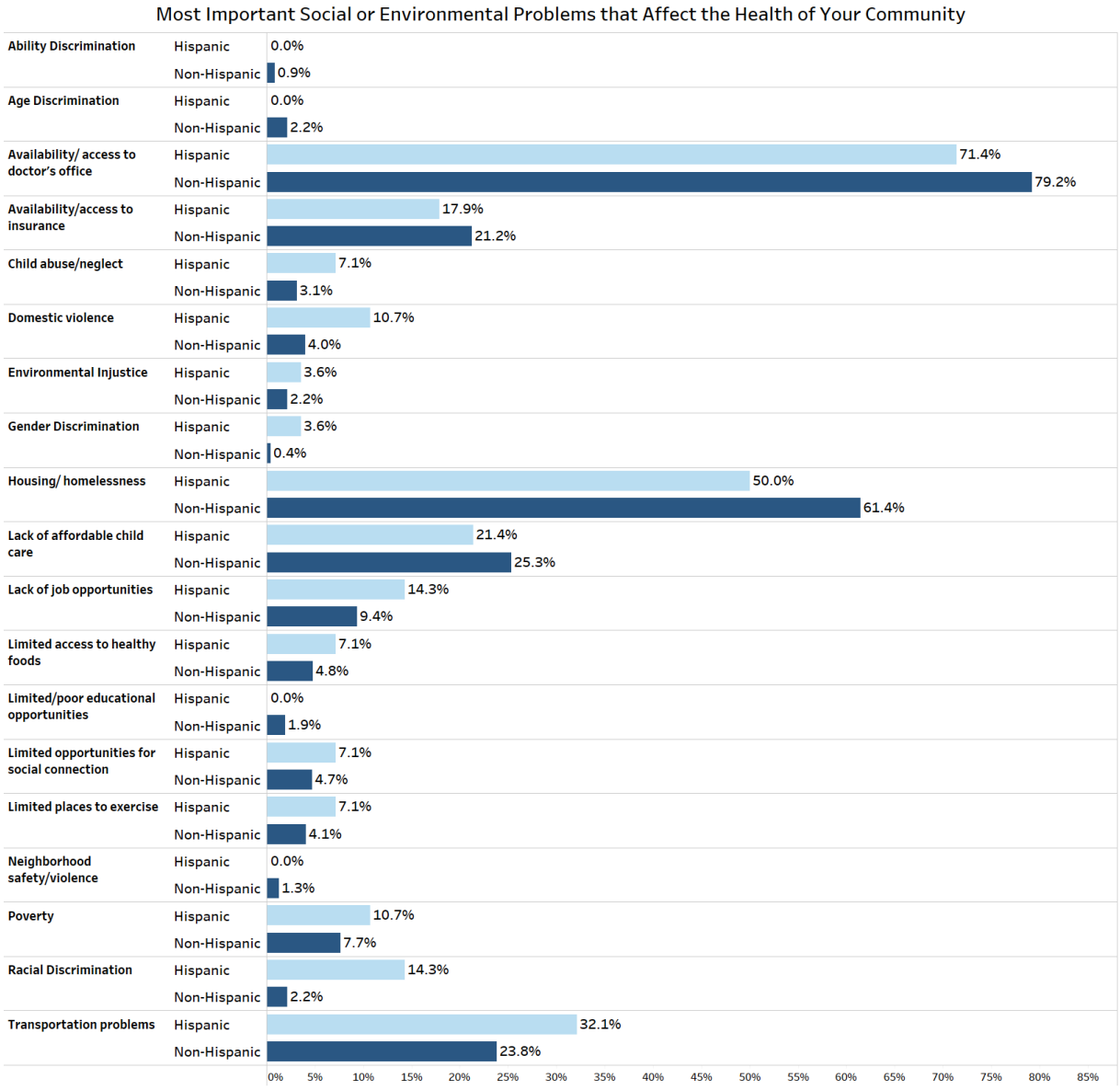
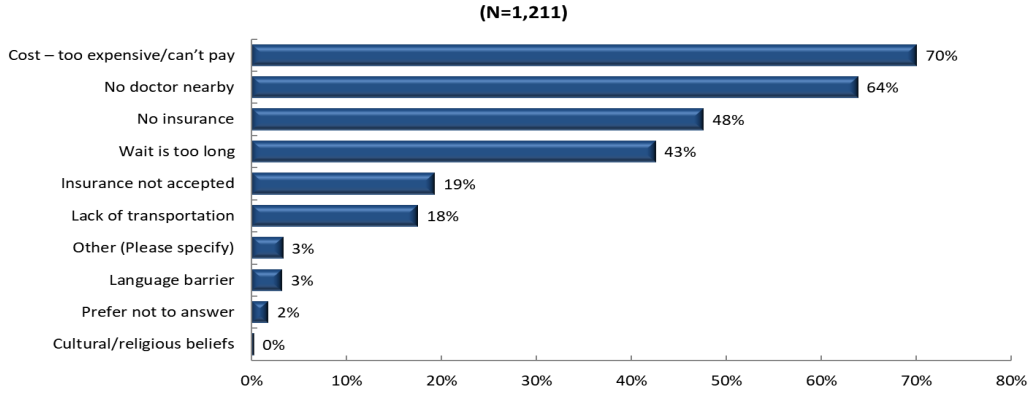


Figure 68: What are the three most important reasons people in your community do not get health care when they need it? Please select up to three.



Other (please specify):

- "Allopathic medicine is a sham, outside of emergent & trauma care."
- "Doctors not accepting new patients" (2 respondents)
- "Gatekeepers—med staff"
- "Have to see someone who is not a doctor"
- "Lack of available health care"
- "Lack of physician options"
- "Lack of primary care physicians accepting new patients"
- "Lack of providers"
- "Lack of specialists"
- "Lack of specialists on the island"
- "Lack of specialty doctors and lack of primary care"
- "Laziness"
- "Limited availability for healthcare providers"
- "Limited local choices - monopoly by Outer Banks Health system"
- "Limited local services. Transportation to specialists that are usually 50+ miles away."
- "Locally For myself no Ophthalmologist"
- "Loss of primary care physicians"
- "Mobility issues /unable to get downstairs can't afford a lift"
- "Never got jobs that included benefits and insurance/chose to party"
- "No available doctors appointments nearby"
- "No clinic after business hours. Emergency Room is only place to be seen."
- "No facilities close by"
- "No guidance to get people enrolled and help them understand the system plus not enough community events such as free skin checks or lead exposure tests etc."
- "No primary care doctors accepting new patients. Lack of well qualified doctors and referrals to well qualified specialists."
- "No specialist care"
- "Not enough primary care doctors."
- "Not enough doctors, especially specialists. Have to go to other cities/states."
- "Not enough MD's or FNP's to take care of specialty illnesses. Also, the war on drugs prevents all patients from taking controlled substances. There are some (not majority) that need this type of help."
- "Not enough physicians"
- "Not enough providers"
- "patience are told to go to urgent care not your primary doctor which is wrong why have a primary doctor?t"
- "Poor doctor quality"
- "Poor quality"
- "Quality Medical Care"
- "RESOURCE BREAKDOWN"
- "Travel distance for care"

- "Urgent Care excellent but waiting list for a primary care physician."

Figure 69: 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)

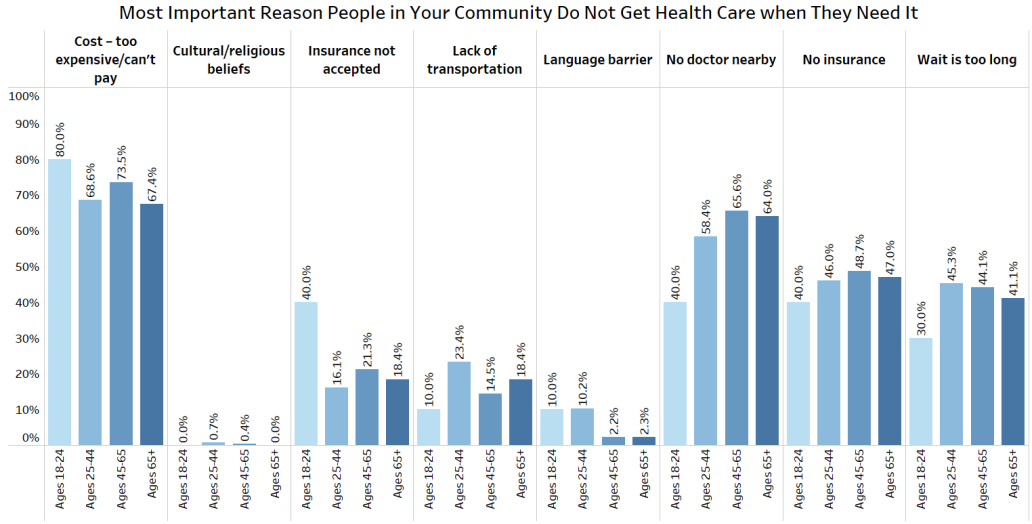


Figure 70: What are the three most important reasons people in your community do not get health care when they need it? Please select up to three. (by gender)

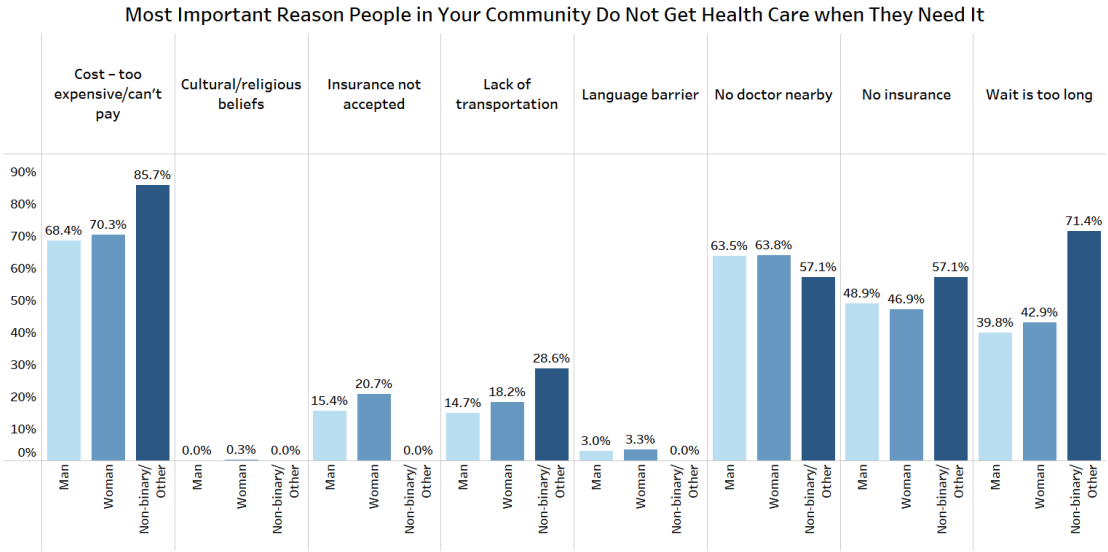


Figure 71: What are the three most important reasons people in your community do not get health care when they need it? Please select up to three. (by race)

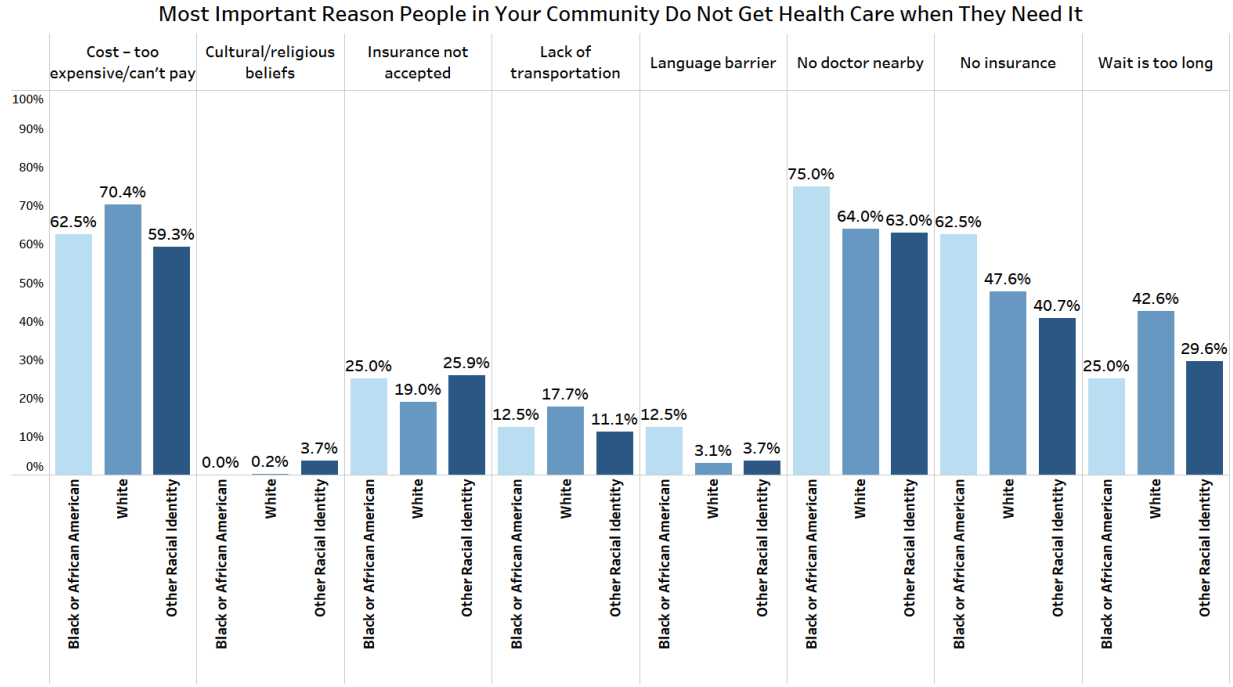
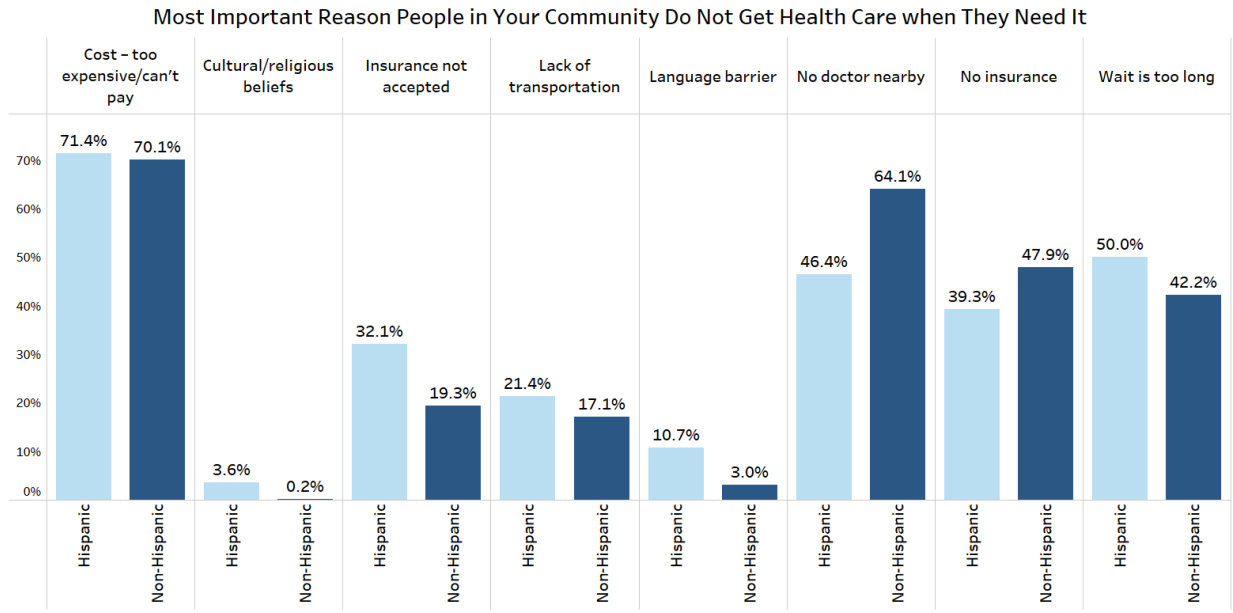
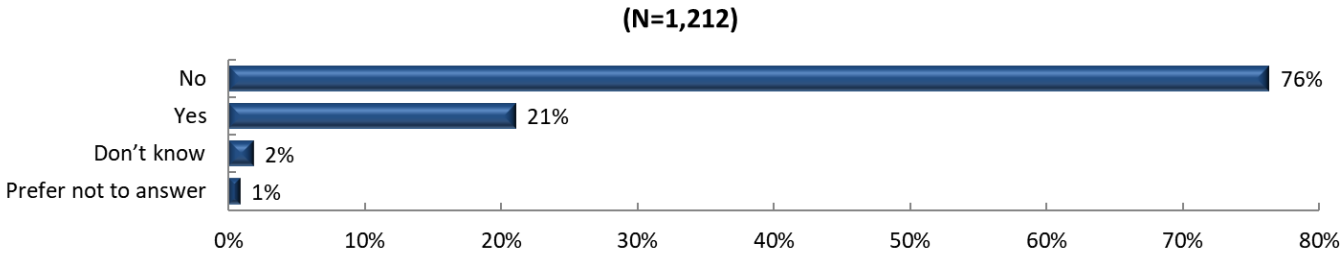


Figure 72: What are the three most important reasons people in your community do not get health care when they need it? Please select up to three. (by ethnicity)



Topic: Access to care

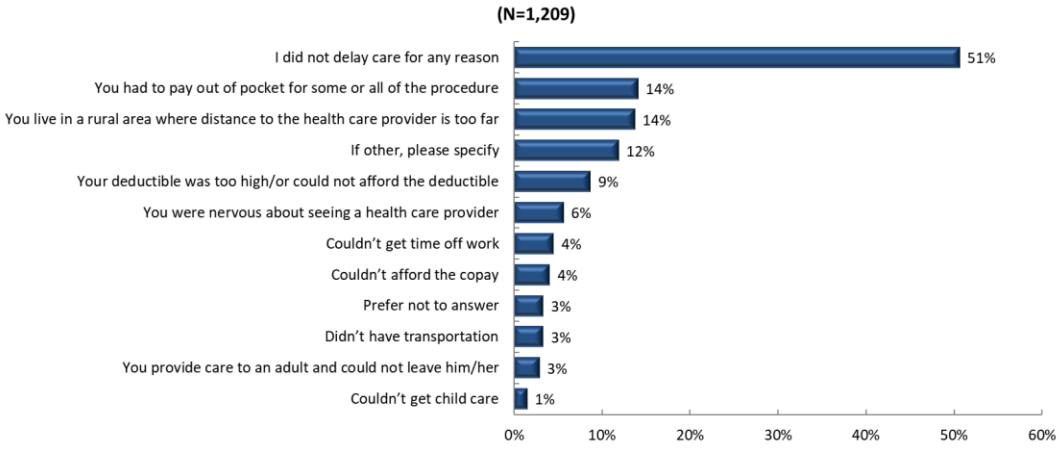
Figure 73: DURING THE PAST 12 MONTHS, were you told by a health care provider or doctor's office that they did not accept your health care coverage?



Other (please specify):

- "Acupuncturist"
- "Another state/county"
- "Clinic for Dare County employees" (2 respondents)
- "Doctor treating specific issues"
- "Doctors are in Virginia"
- "Don't go to the doctor because there are none. If sick enough would go to ED because that is all that's available for actual sick patients. 'not really sick but think they're sick' patients go to uc"
- "Duke Medical Center" (2 Respondents)
- "Family doctor - monthly subscription $65 a month gives me unlimited access to my doctor and up to 6 visits per year."
- "I go to. VA since there is incompetence on this beach"
- "I have a small hose in Carteret Co. I have transferred all my medical needs to Carteret, because Dare co. Has TERRIBLE health care. I feel lucky to have this option."
- "MD and oncology defer to Urgent care for illness that does not require the ER. The ER is he only way to be seen by a doctor"
- "Medical Professionals outside of Dare County because Quality Health Care is not available"
- "Online doctor"
- "Out of Dare County"
- "Out of town"
- "PA on call"
- "Teledoc"
- "Telehealth with out of town specialist"
- "Up to VA Beach area for all doctors"
- "VA"
- "Vidant nurse"
- "We pay a monthly fee to access a doctor"

Figure 74: There are many reasons people delay getting medical care. Have you delayed getting care for any of the following reasons in the PAST 12 MONTHS?



Other (please specify):

Of the 143 respondents who selected "Other" for this question, over half indicated that **long wait times, lack of available primary care doctors and specialists, and inability to get an appointment** were the main reason they delayed getting care. Additional responses are listed below:

- "All my health problems have gone away on their own."
- "Appointment not available so I just had to wait."
- "Availability of physicians"
- "Because most doctors who are here don't really seem to listen or care."
- "Busy, time constraints"
- "Caught in insurance limbo and was denied coverage from company too late to seek other options."
- "Could not find good doctor"
- "Could not find right doctor"
- "Dental insurance stated my dental heath wasn't bad enough to cover, even though 2 dentists said I needed a periodontal procedure."
- "Did not bother to call MD office or Oncology as previous experience ie "no appointments for 1-2 weeks"; "that is a primary care problem even whe being treated for cancer; urgent care is the only option if ER is not appropriate; no access to primary care MD for minor illness or infections."
- "Didn't have the time"
- "Didn't want to pay that much"
- "Distance to get specialist care"
- "Do not have a primary care doctor"
- "Doctors in Virginia felt too bad to drive"
- "ER would not treat me"
- "Finding a doctor that took my insurance"
- "Finding an office that accepted my insurance"
- "General practitioners are not taking new patients and need a referral for some issues."
- "Have delayed a cavity filling for my daughter, because it's an out of pocket expense, and the only one who will fill cavity is in Elizabeth City"
- "Have to take time off for colonoscopy"
- "Health care provider/specialist is in another state/out of area."
- "Hospital would not provide me an estimate of typical, no unusual problem, out of pocket cost for my Medicare plus BCBS procedure."
- "I delayed dental care due to cost"
- "I don't trust the current healthcare system."
- "I felt I would have been healed by the time I was seem"
- "I have to leave the County for care."
- "I know they are busy & my concern can wait."
- "I no longer trust allopathic providers. They are bought & paid for."
- "I wait to go to Carteret Co. unless I need emergency care. Dare is terrible."
- "Inability for medical doctors to provide sincere and quality care"
- "Inadequate providers"
- "Insurance (Aetna) not accepted by dental & vision providers"
- "Mentally not ready to have the procedure"

- "My primary care doctor is supposed to set up a colonoscopy with the OBX Hospital for me. That has been pending since January. I have called to remind them. It still hasn't happened. I don't understand why."
- "Neglected my own health."
- "Never finding time to get around to addressing the concern because iI still am able to live my life without concern. One day I will address the issue"
- "No health insurance coverage"
- "No specialist nearby. Hard to get appointment if have to travel a distance"
- "Pending cataract in VA"
- "Procedure was too costly and didn't accept my insurance."
- "Procrastination"
- "Providers in my area weren't taking new patients or did not accept my insurance"
- "Put off what I thought was a minor problem until I could see a specialist locally."
- "Too many responsibilities"
- "Try to get better on my own."
- "Unable to find a doctor or dentist that takes medicaid"
- "Unable to find doctor who took insurance/had to establish care with primary"
- "Urgent care PA is inadequate"

Figure 75: DURING THE PAST 12 MONTHS, was there any time when you needed any of the following, but didn't get it because you couldn't afford it?

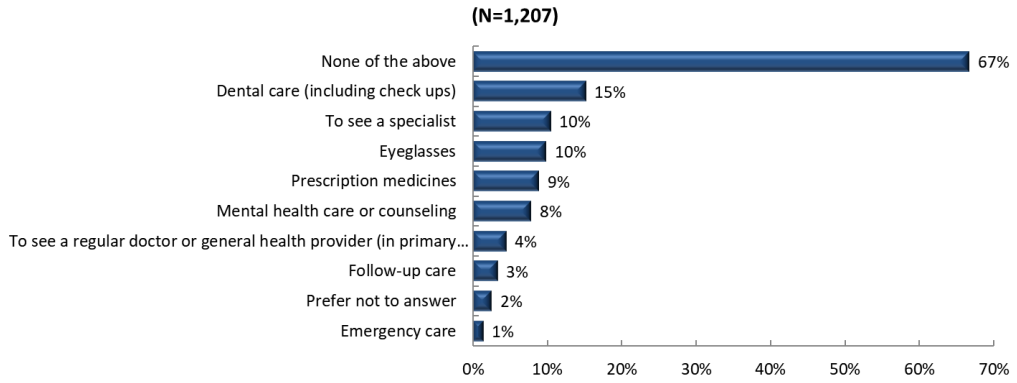


Figure 76: If you get sick or have an accident, how worried are you that you will be able to pay your medical bills?

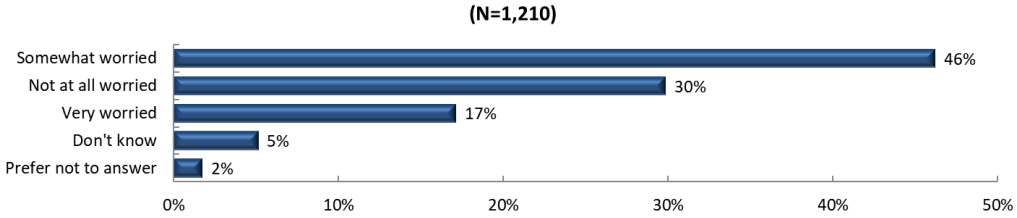
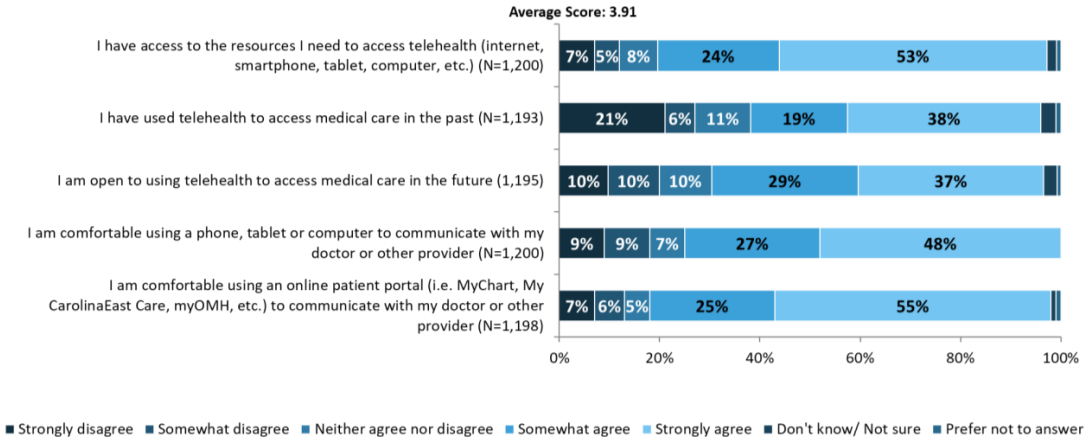


Figure 77: How much do you agree or disagree with the following statements about telehealth? Telehealth means connecting virtually with a medical provider using a smartphone, tablet or computer.

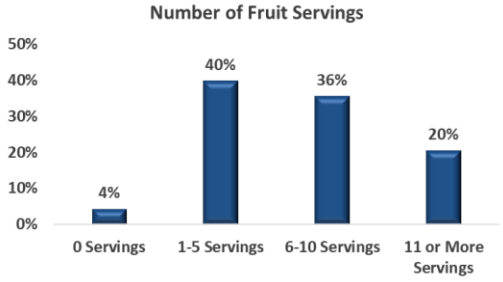
Scale from 1 to 5 with 1 being "strongly disagree" and 5 being "strongly agree"



Topic: Healthy Lifestyle (Diet and Exercise)

Figure 78: Think about the food you ate during the past week. On average, how many servings of fruit did you eat, not including juices? (For example, one serving equals a medium apple, a small banana, or 7 strawberries)

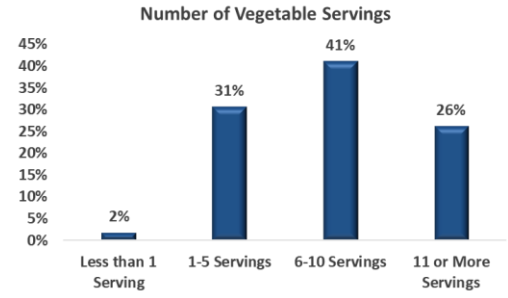
(N=1203)



Measure	Value
Mean (Standard Deviation)	8 (7)
Median	7
Mode	7
Minimum-Maximum	0-97

Figure 79: Think about the food you ate during the past week. On average, how many servings of vegetables did you eat, not including potatoes? (For example, one serving equals 6 baby carrots, small bell pepper, or half of a large squash or zucchini)

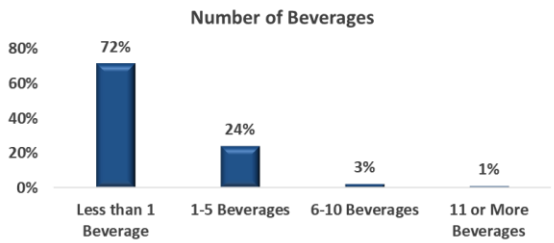
(N=1203)



Measure	Value
Mean (Standard Deviation)	10 (9)
Median	7
Mode	7
Minimum-Maximum	0-100

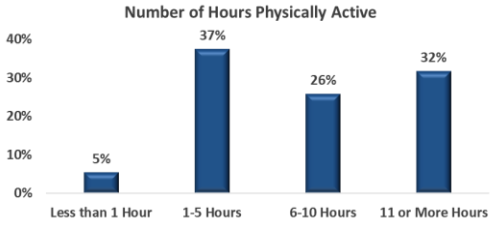
Figure 80: About how many cans, bottles, or glasses of sugar-sweetened beverages, such as regular sodas, sugar-sweetened tea, or energy drinks, do you drink each day?

(N=1205)



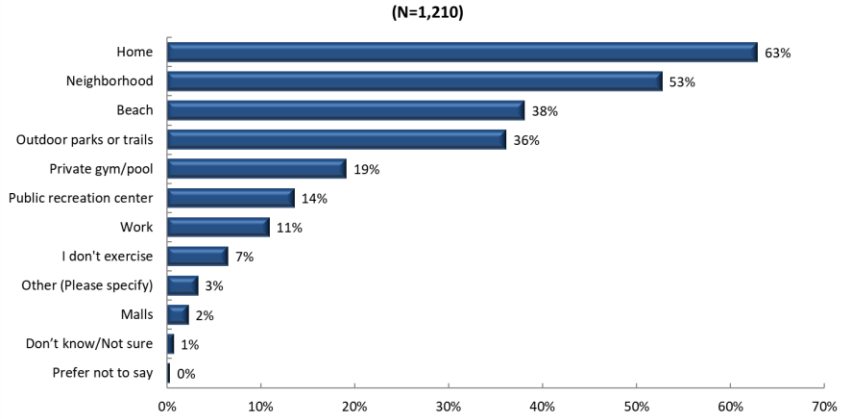
Measure	Value
Mean (Standard Deviation)	1 (4)
Median	0
Mode	0
Minimum-Maximum	0-77

Figure 81: During the past month, approximately how much time (in hours) per week were you physically active outside of your regular job?
(N=1203)



Measure	Value
Mean (Standard Deviation)	12 (14)
Median	7
Mode	5
Minimum-Maximum	0-100

Figure 82: When you are active, where do you engage in exercise or physical activities? (Select all that apply.)



Other (please specify):

- "Arthritis prevents, have disability"
- "Bicycle & garden"
- "Cardiac rehab" (2 respondents)
- "Errands"
- "GEM program" (2 respondents)
- "Golf" (7 respondents)
- "Pickleball court"
- "I garden daily"
- "I have a peloton- the OBX YMCA has become too crowded"
- "I walk around the store while shopping."
- "My exercise when I am doing other things, not specifically scheduled"
- "My farm"
- "My house/my neighborhood"
- "OBX Hospital"
- "Physical Therapist's office" (3 respondents)
- "Private studio"
- "Senior Center" (3 Respondents)

- "Senior center and YMCA"
- "Sound"
- "Tennis and pickleball courts, golf course"
- "Use a Tonal at the house"
- "Walk dogs"
- "yard" / "Outside yard work"
- "YMCA"
- "Yoga studio" (2 respondents)

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

Figure 83: The following statements describe what your neighborhood might be like. Tell us how much you agree or disagree. (N=1204) (Average score=3.61)

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

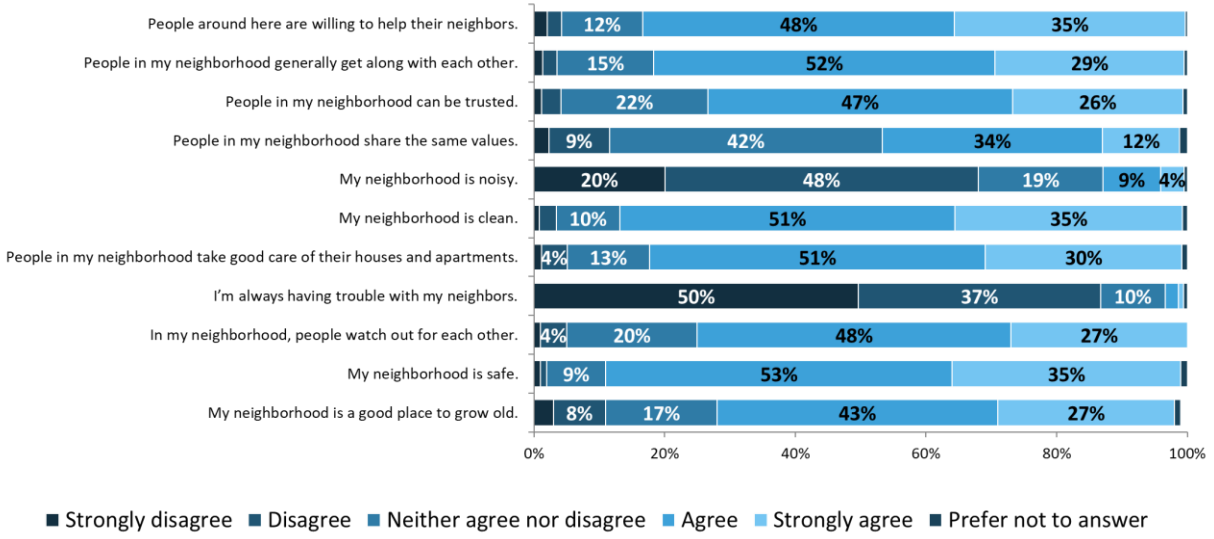
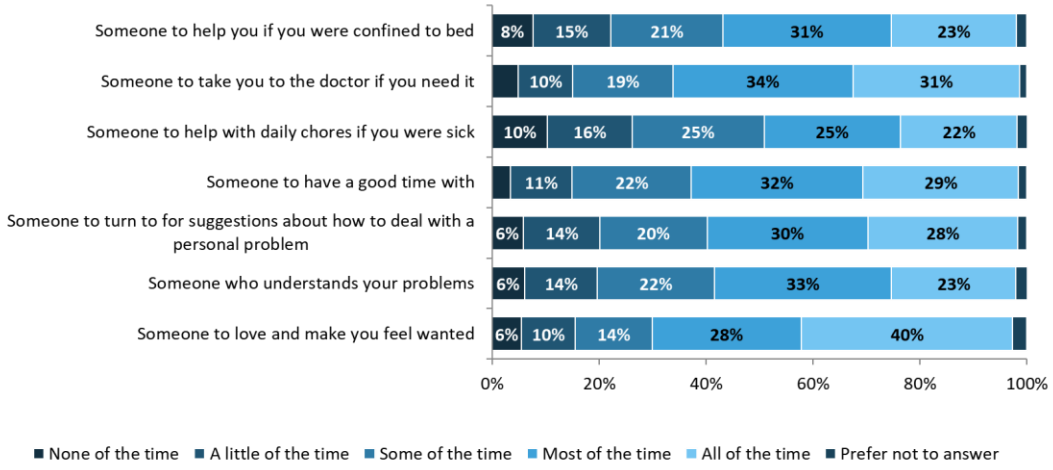


Figure 84: People sometimes look to others for friendship, help, or other types of support. In the following situations, how often could you find someone to support you? (N=1204) Average score=3.63)

Rated on a scale from 1 to 5 with 1 being "None of the time" and 5 being "All of the time"



Topic: Housing and Homelessness

Figure 85: In the past 12 months, were there times when you:

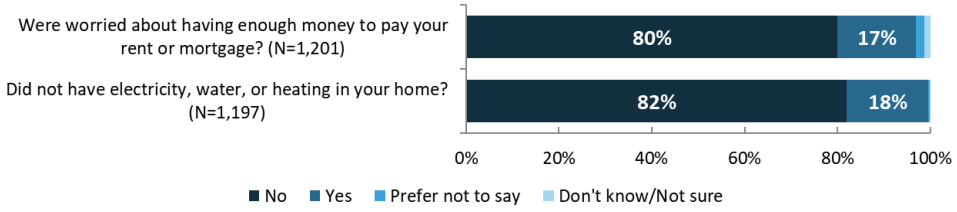


Figure 87: In the PAST THREE YEARS, were there times when you:

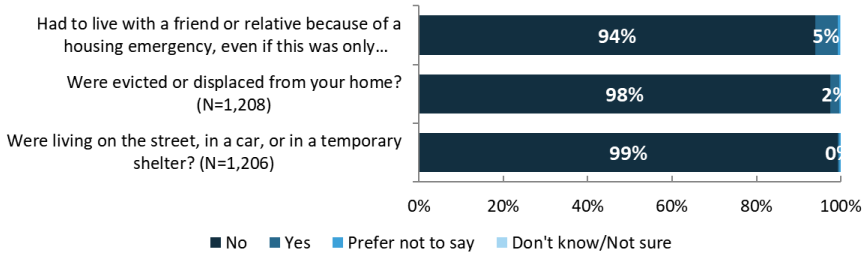
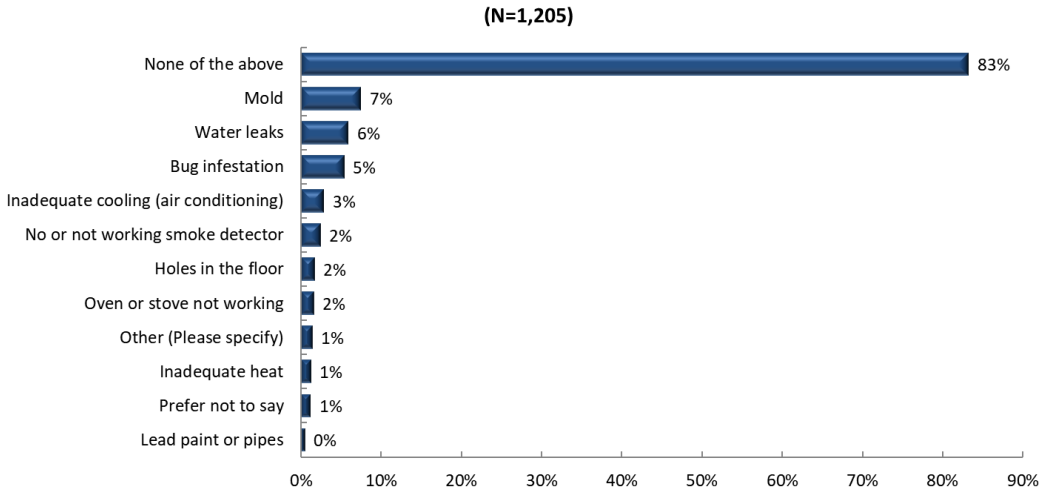


Figure 87: Think about the place you live. Do you have problems with any of the following? (Check all that apply.)



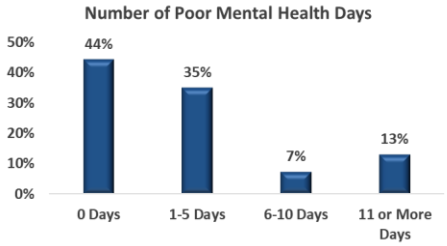
Other (please specify):

- "Cable issues"
- "Cost"
- "EROSION ISSUE"
- "Had a little problem with rats this fall - apparently it's an island wide problem"
- "Holes in wood siding"
- "Home=responsibility & maintenance"
- "many home repairs done, many more needed"
- "No dryer"
- "Old and splintered ramp to enter the house."
- "Poor insulation in the house. High electric bills only have small radiators for heat"

- "Rats"
- "Rats due to neighbors feeding dog/animals outside drawing rats."
- "Roof needs replacing per insurance company over 15 years old"
- "Septic issues the HOA/POA aren't addressing. There is raw sewage in our yard."
- "Speeding on my neighborhood street that is not addressed."
- "Squirrels!"

Topic: Mental health

Figure 88: Now thinking about your MENTAL health, which includes stress, depression, and problems with emotions, for how many days during the past 30 days was your mental health NOT good?
(N=1189)



Measure	Value
Mean (Standard Deviation)	5 (8)
Median	2
Mode	0
Minimum-Maximum	0-30

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

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

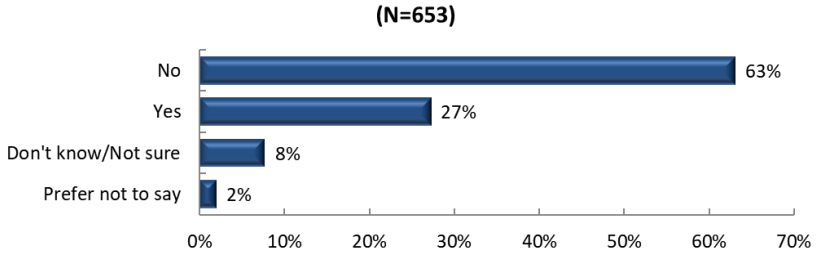
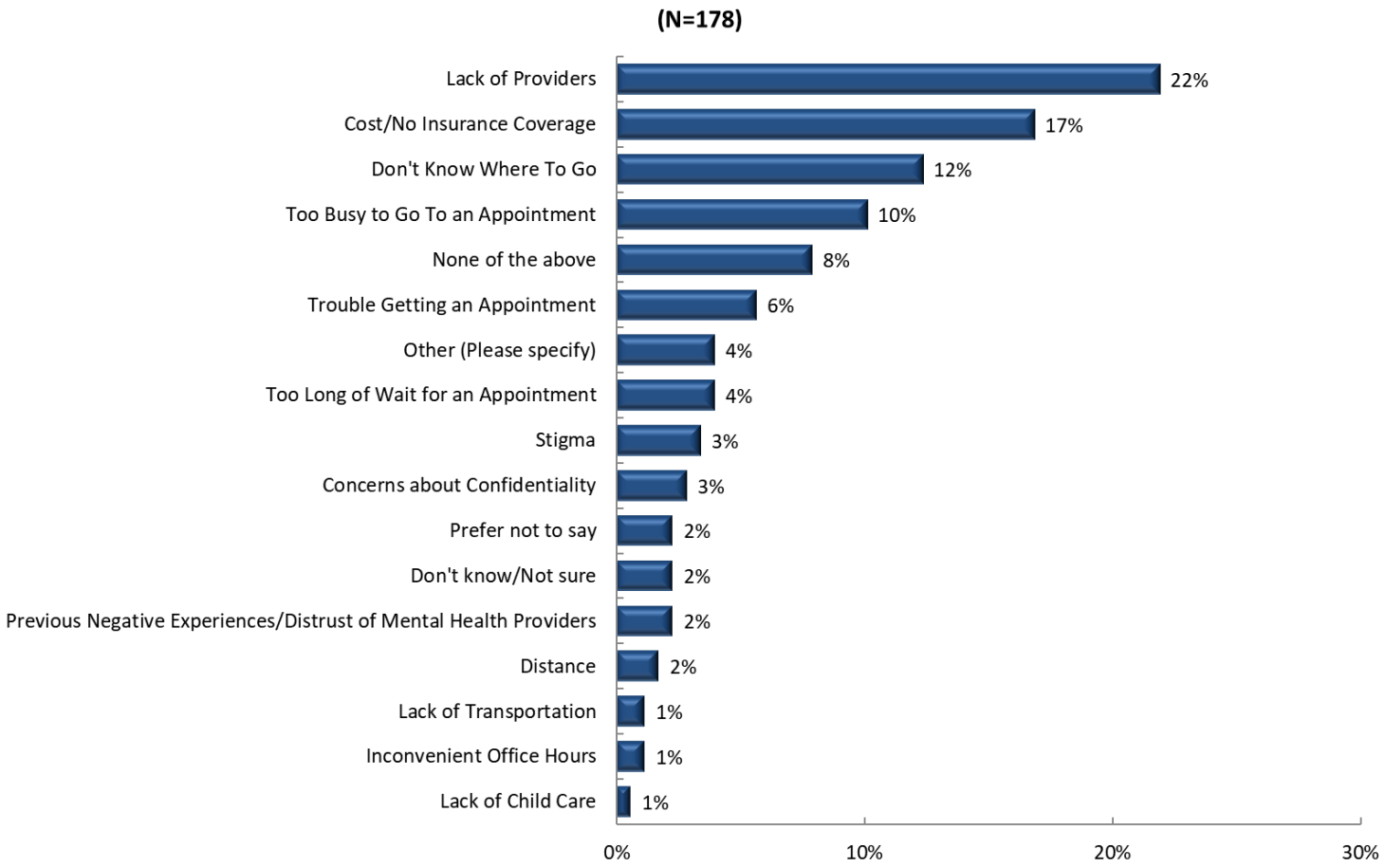


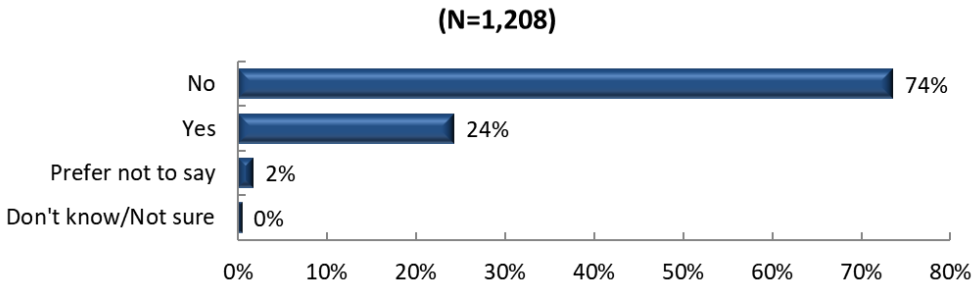
Figure 90: What was the MAIN reason you did not get mental health care or counseling?
Note: only participants who responded "yes" to previous question were asked current question



Other (please specify):

- "Difficulty finding a provider I want to talk to about private things."
- "Fear, Anxiety, high stress levels about seeing/speaking with doctors"
- "I do not like going to doctor"
- "Must care for sick husband and cannot leave him for long periods of time"
- "Scared to open the wounds"
- "Telehealth mental health provider cancelled appointments twice"
- "Too few providers and too long of a wait for ones we could find."

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



Topic: Physical Health

Figure 92: Considering your physical health overall, would you describe your health as…

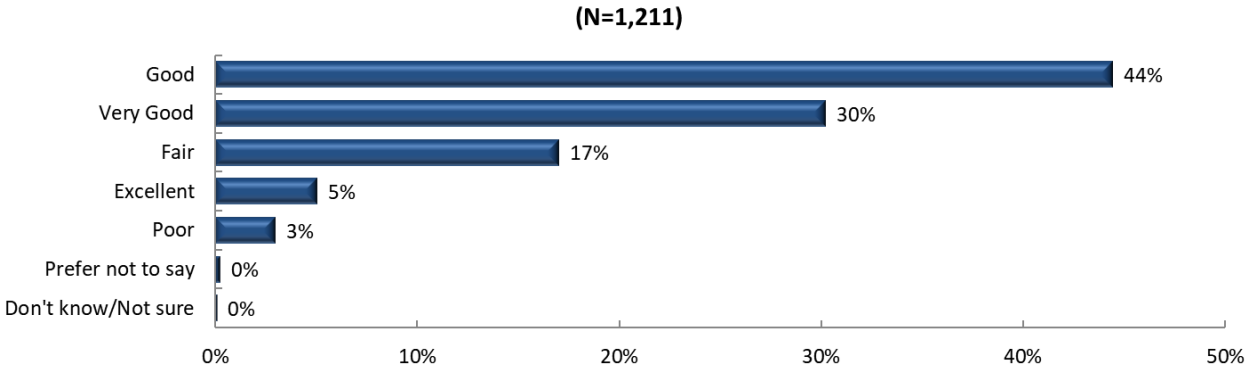


Figure 93: Within the past year (anytime less than one year ago), have you:

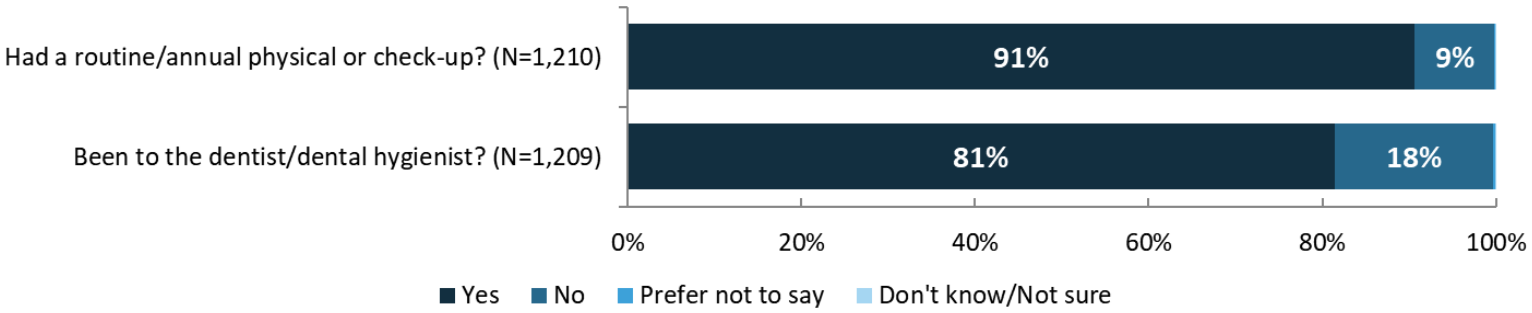
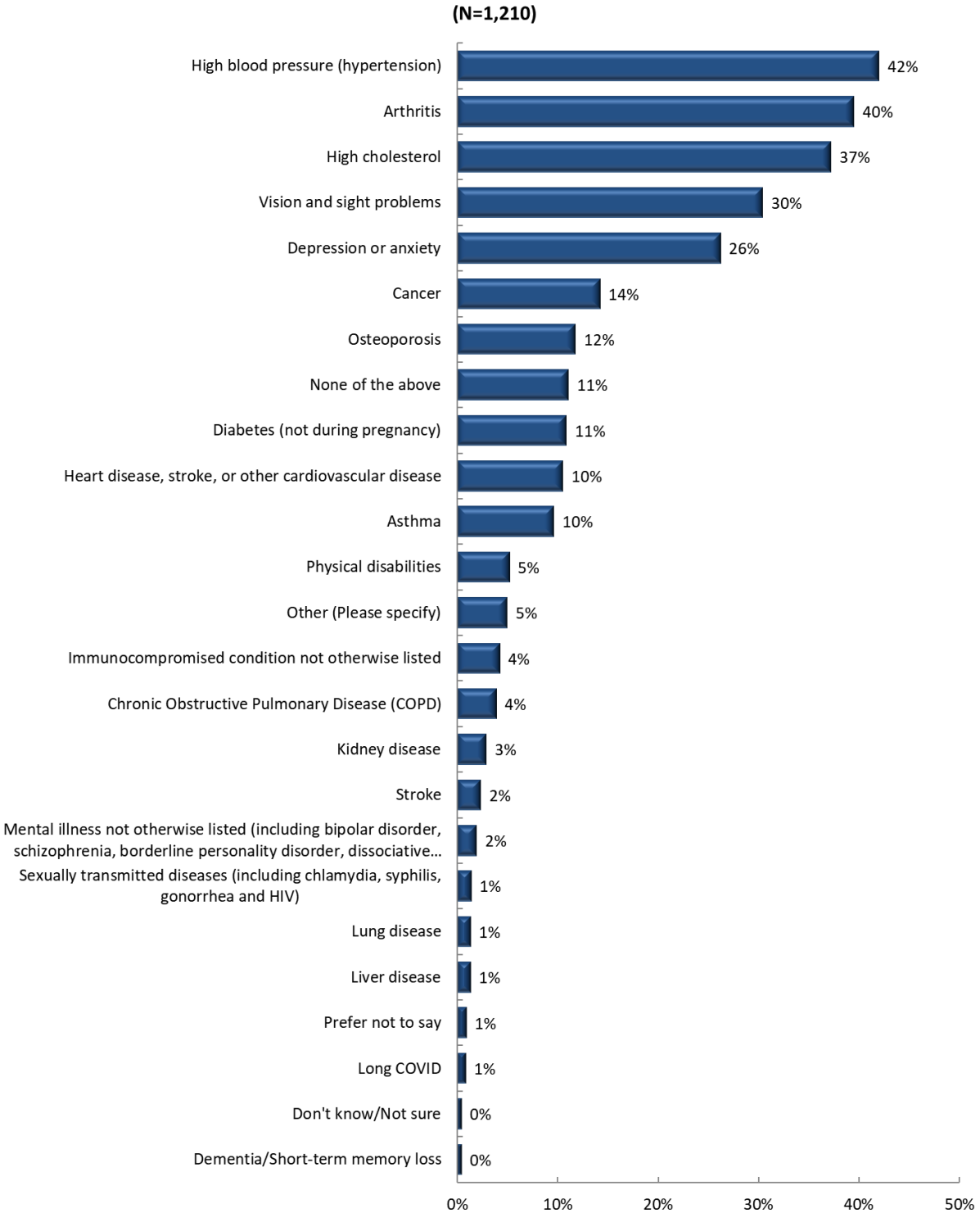


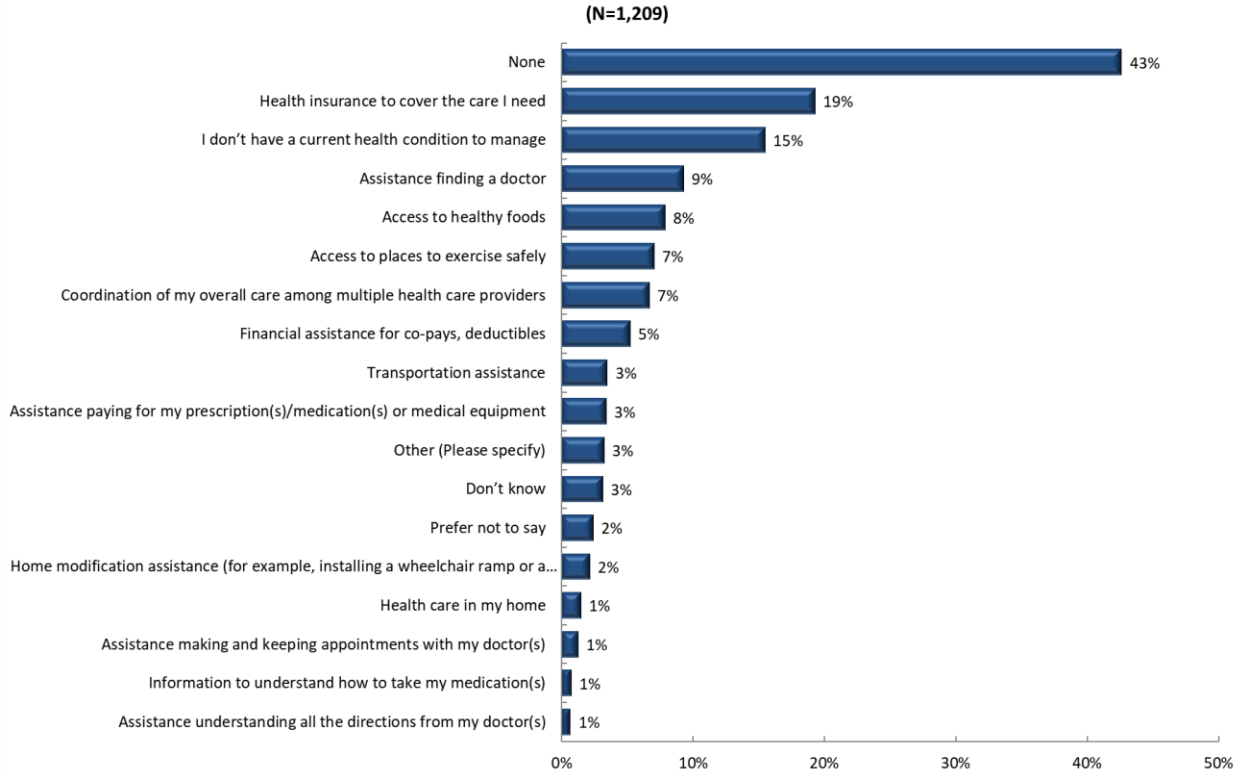
Figure 94: Have you ever been told by a doctor, nurse, or other health professional that you have any of the following health conditions? Select all that apply



Other (please specify):

- "ADHD"
- "Afib"
- "alpha gal"
- "Blood clot in leg, sciatica"
- "Chronic illness"
- "Crohn's Disease"
- "cystocele, uterine fibroids, GI problems"
- "Dental deep cleaning (x3)"
- "Epilepsy, ADHD"
- "Fibromyalgia"
- "Fibromyalgia"
- "Fibromyalgia, ongoing issues due to post covid, anemia (three types) nutrition deficiency and skeleton issues"
- "Gillian Barre syndrome"
- "glaucona"
- "Hearing issues" (4 respondents)
- "Heart palpitations" (2 respondents)
- "Heart palpitations and pass out feeling"
- "hemocromatosis"
- "hip bursitis"
- "Hypothyroidism" (8 respondents)
- "IPF"
- "KIDNEY STONES"
- "Lichen Planus (skin condition)"
- "Low blood pressure, bronchitis, broken hip"
- "Mast cell activation syndrome, alpha gal syndrome"
- "Migraine, Multiple Sclerosis"
- "migraines"
- "Mold toxicity/exposure from home"
- "Multiple Sclerosis"
- "osteopena; over weight"
- "Osteopenia/ Thyroid disease"
- "Ovarian Cyst and Fibroids"
- "PCOS"
- "PCOS, insomnia"
- "Peri menopause. It's hell and not taken seriously"
- "Pernicious anemia"
- "polymyalgia rheumatica"
- "Psoriatic Arthritis"
- "PTSD" (2 respondents)
- "Seizure disorder"
- "skin cancer removal with leg wound healing compromised"
- "Spinal issues, RA,Peripheral Neuropathy,Edema"
- "Spinal stenosis, hearing loss"
- "Thyroid disease"
- "Thyroid, Dermatological"

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



Other (please specify):

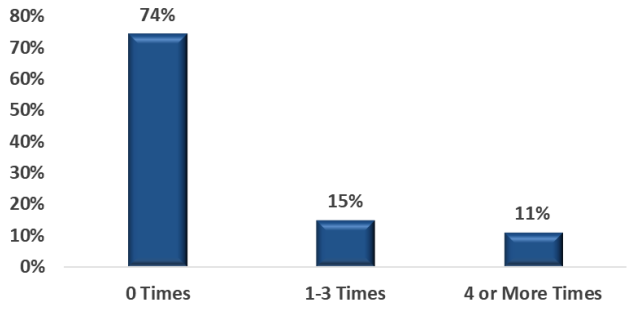
- "Access to a local provider. I travel out of state for health care. I most likely will not retire in Dare county due to the lack of quality health care."
- "Access to doctors"
- "Access to medical cannabis"
- "Access to specialist providers in appropriate time frame"
- "Access to specialists when needed instead of long waiting periods for appointments."
- "Affordable healthier foods"
- "Assistance in finding doctors for the new neighbors/family in town"
- "Availability of appropriate physicians"
- "Clinics on the island and emergent care on the island should absolutely be available as they once were. We NEED an urgent care down here and we need community events."
- "Closer proximity to the doctors needed"
- "Competent care within a reasonable distance"
- "Faster turnaround time with appointments and procedures"
- "Help caring for mother with dementia"
- "I am perfectly capable of managing without any of the above."
- "I have everything I need"
- "I was on a waiting lists to be a new patient for many months finally a new doctor to the area was accepting new patients and I was able to be seen."
- "In person support like Weight Watchers"
- "LACK OF AVAILABILITY OF MENTAL HEALTH PROVIDERS"

- "Local oncoclogist and specialists"
- "Medication to keep kidney stones at bay"
- "meds"
- "More availability to providers locally vs more PTO to make trips to MD appointments"
- "More doctors opening practices in OBX."
- "More health care providers and options"
- "More local doctors"
- "More providers on the beach willing to prescribe controlled substance medications"
- "Need more specialists in this area, have to travel to Virginia for most specialists"
- "Office/tele hours after work or weekends"
- "Podiatrist nearby would by helpful"
- "Remembering to take medications - Forgetting to take or that I already took it."
- "shorter response time from medical professionals"
- "Sunscreen"
- "Time off from work and childcare"
- "Time to do the right things"

Topic: Substance Use Disorders

Figure 96: Considering all types of alcoholic beverages, how many times during the past 30 days did you have 4 (females)/ 5 (males) or more drinks on an occasion?

(N=1,196)



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

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

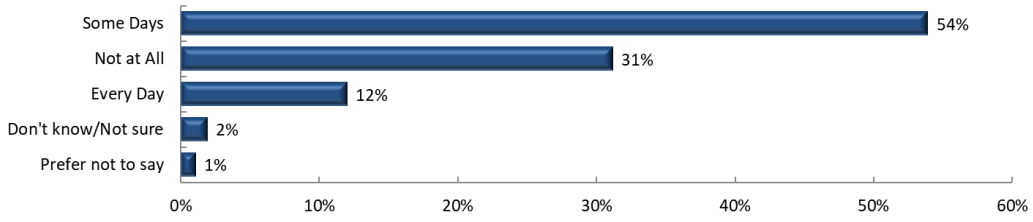


Figure 98: In the past year, have you or a member of your household misused any form of prescription drugs (e.g. used without a prescription, used more than prescribed, used more often than prescribed, or used for any reason other than a doctor's instructions)?

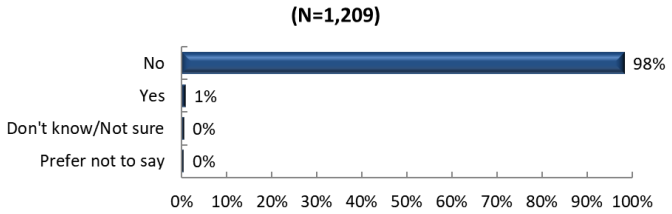
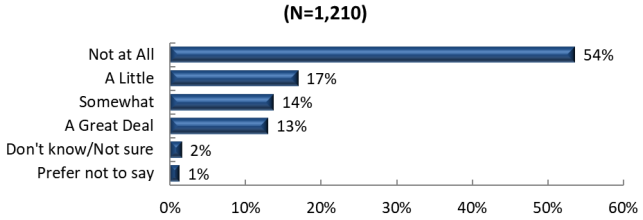


Figure 99: To what degree has your life been negatively affected by YOUR OWN or SOMEONE ELSE's substance abuse issues, including alcohol, prescription, and other drugs?



Topic: Tobacco Use

Figure 100: Do you currently use any of the following tobacco or nicotine products? (Select all that apply.)

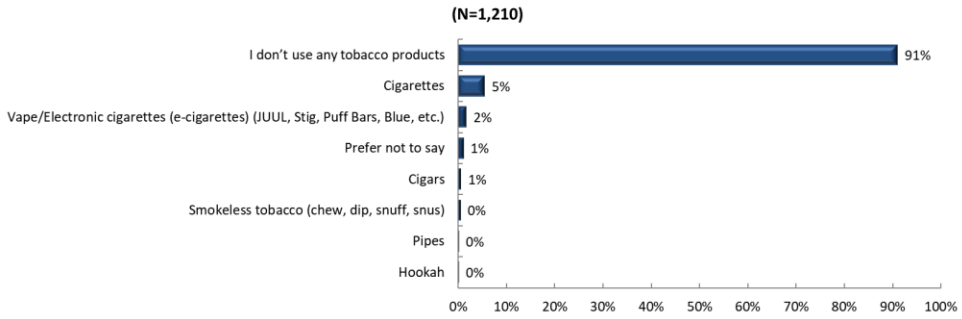


Figure 101: How often do you use any kind of tobacco or nicotine product, including smokeless products, chewing tobacco, dip, snuff, snus, electronic cigarettes, or vapes?
Note: only participants who indicated use of tobacco or nicotine products in previous question were asked current question

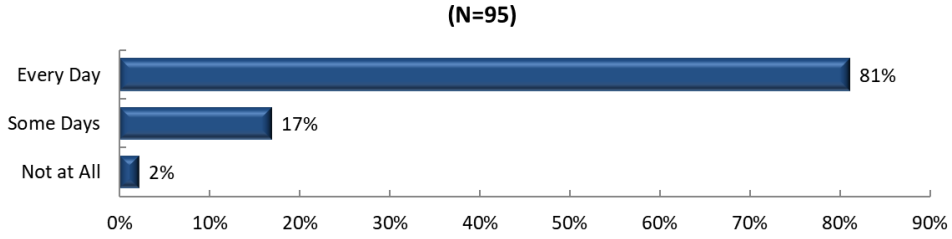
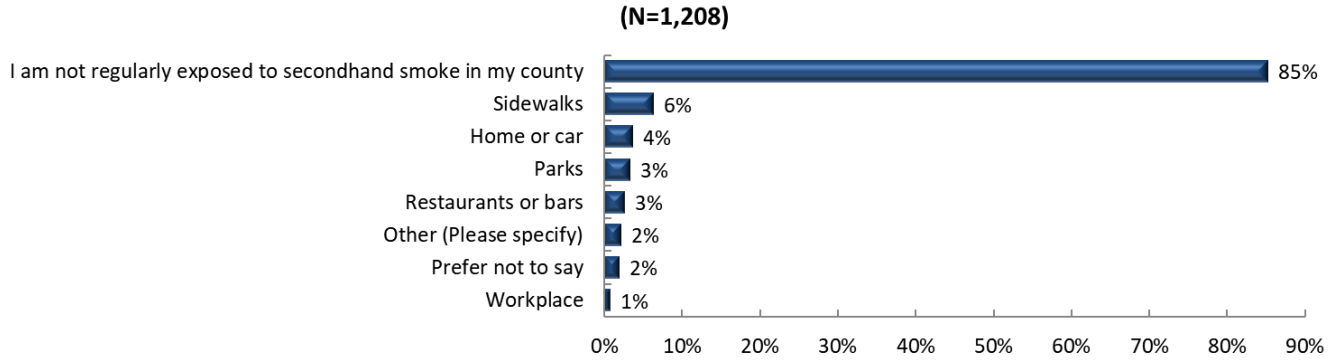


Figure 102: Are you regularly exposed to secondhand smoke in any of these locations in Dare County? (Select all that apply.)



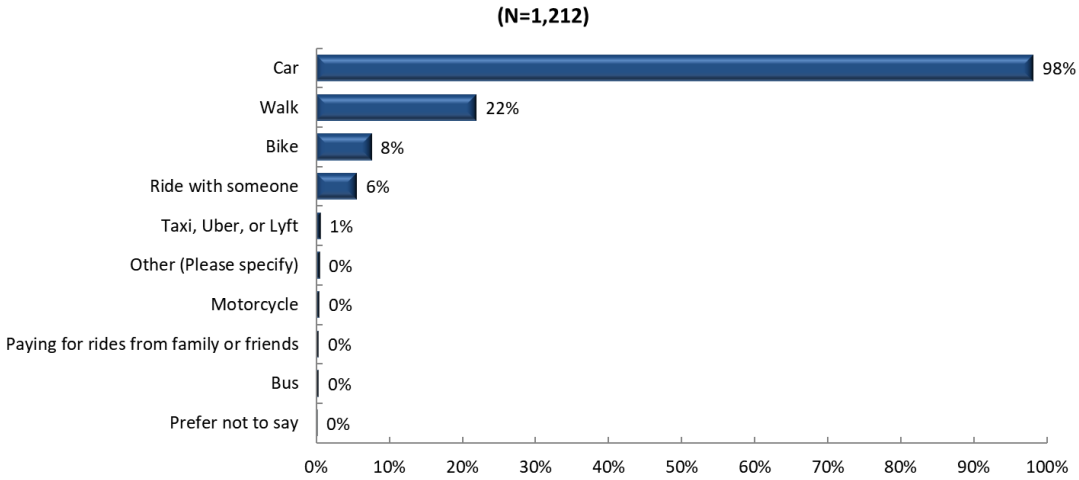
Other (please specify):

- "At the beach" (8 Respondents)
- "Family members homes inside and out."
- "My yard. Next door Neighbor smokes pot outside regularly."
- "Other family members home"
- "Otside the kitty hawk Harris Teeter near the South entrance. Also, Aquarium parking lot."
- "Outside grocery stores"
- "Outside hospital, businesses, stores, parking lots"
- "Outside of retail stores"
- "Parents' home"
- "Shopping areas-outside the stores"
- "Significant other's house"
- "Smokers taking break at shopping centers"
- "Some smokers go outside to smoke, but you have to go by them to get into the facility."
- "Wife smokes on porch. and her car. but rarely around me indoors or car"

Topic: Transportation and Transit

Figure 1013: In a typical week, what kinds of transportation do you use the most? (Select all that apply.)

Other (please specify):



- "Dare County transport" (3 respondents)
- "eBike"
- "Golf cart"

Figure 104: In the past 12 months has lack of transportation kept you from medical appointments, meetings, work, or getting things for daily living? Select all that apply:

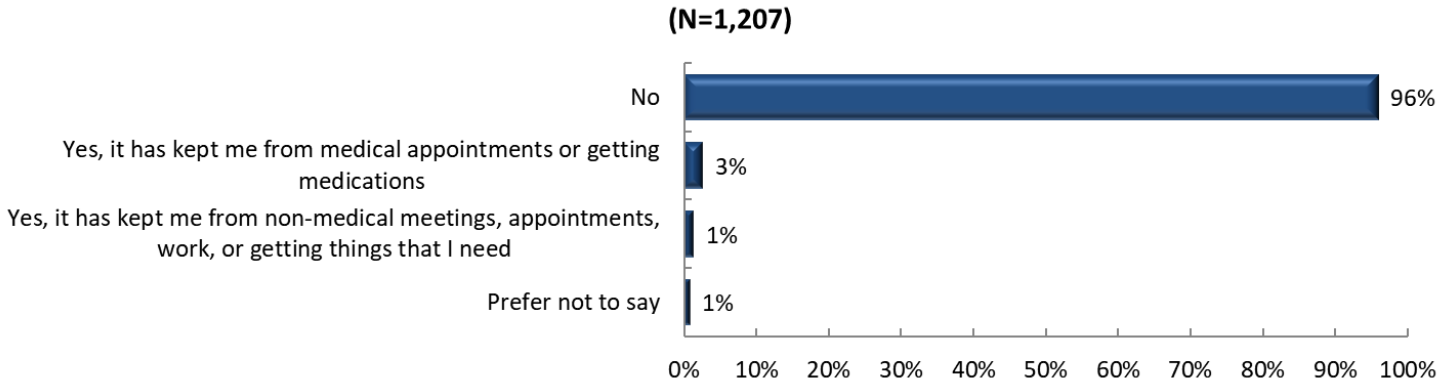
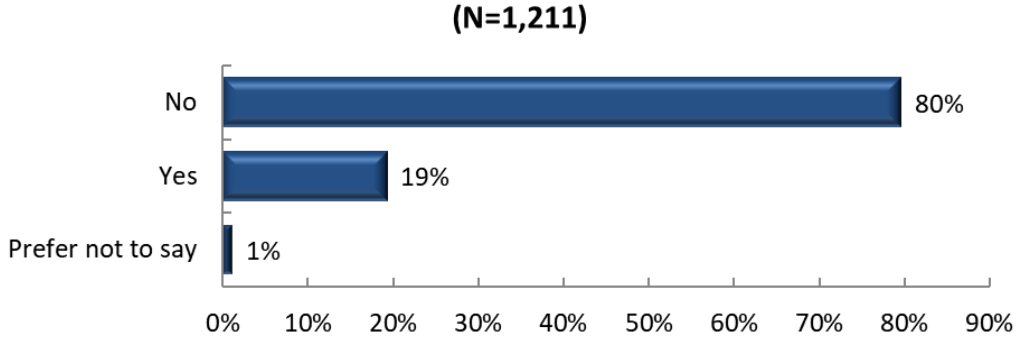


Figure 105: Do you put off or neglect going to the doctor because of distance or transportation?



Topic: Additional Questions

Figure 106: In the past year, did you have any of the following assistance needs NOT met? (Select all that apply.)

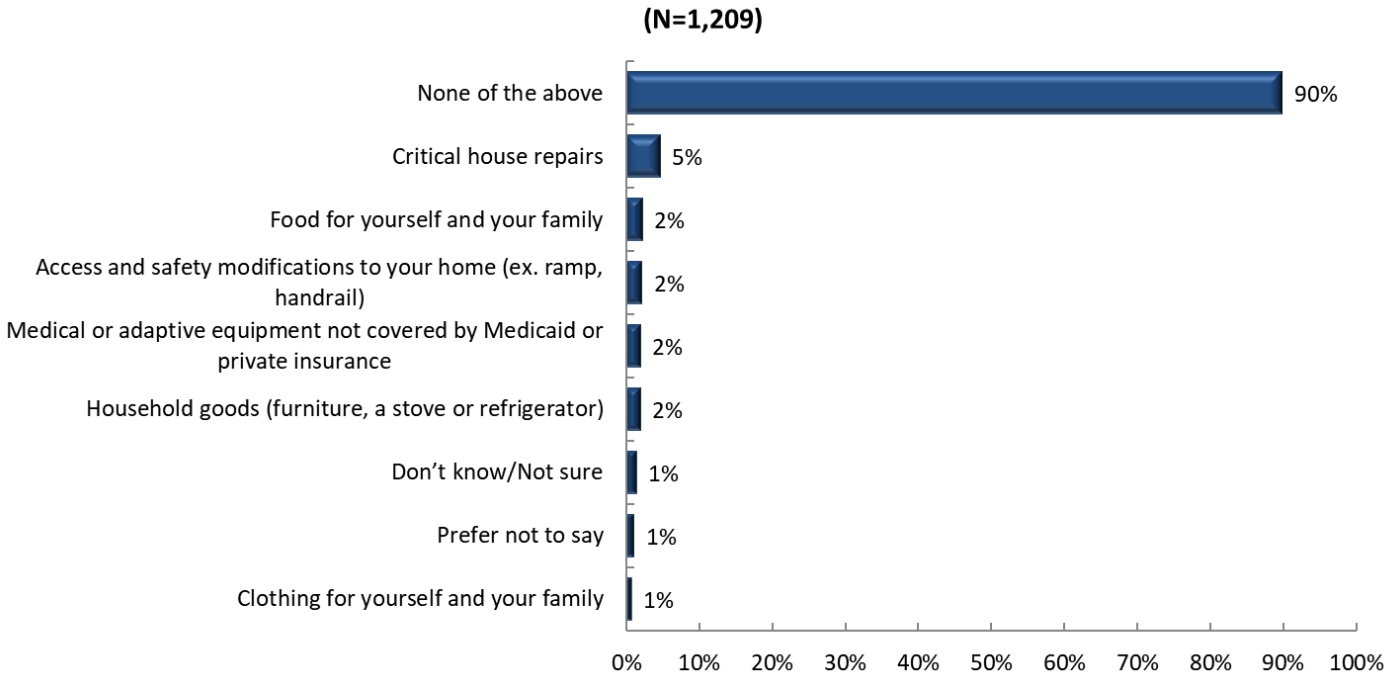
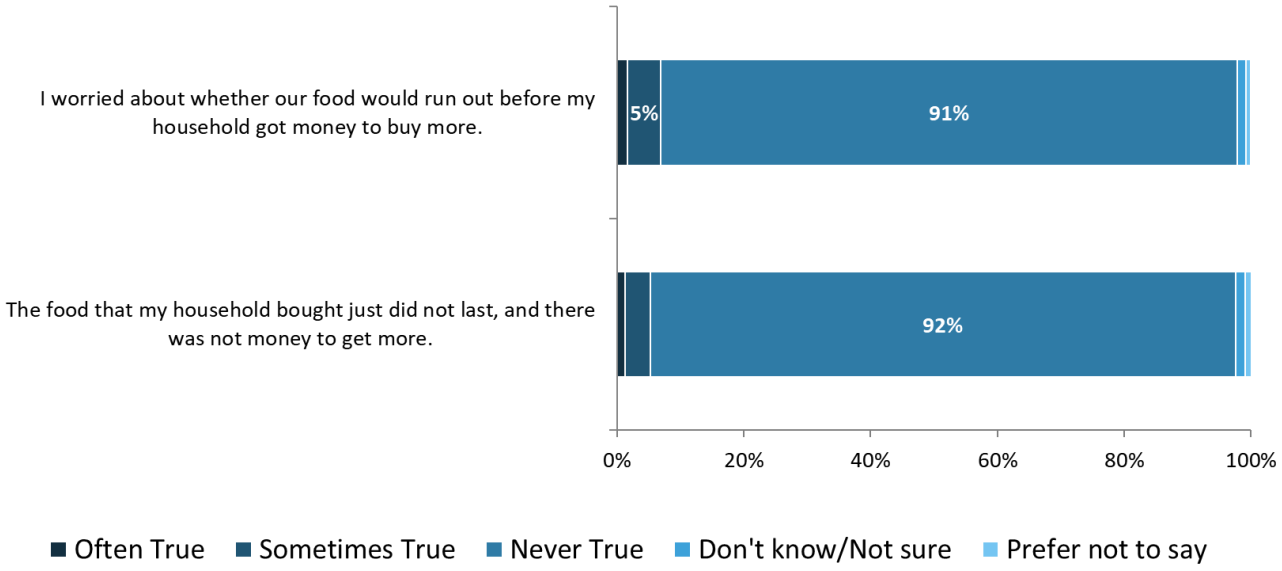


Figure 107: Please tell us how frequently the following statements were for you true in the past 12 months: (N=1204) Average score=2.92

Rated on a scale from 1 to 3 with 1 being "Often True" and 3 being "Never True"



Appendix 6 | Summary of Data Findings Across Sources

Primary and Secondary data findings are summarized in full by the table below.[48]

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

[48] Survey results captured here reflect major findings from the Community Health Opinion Survey questions. Red boxes indicate categories identified as high need consistently across data sources.

Appendix 7 | Emergency Room & Inpatient Data

Leading Causes of Death

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

Table 64: Top Causes of Death in Dare County, 2020, Crude Death Rate per 100,000[49]		
Rank	Cause	Rate
1	Malignant Neoplasms	247.7
2	Diseases of the Heart	165.1
3	Accidents	98.5
4	Cerebrovascular Diseases	-
5	Chronic Lower Respiratory Diseases	-
6	Alzheimer Disease	-
7	Diabetes Mellitus	-
8	-	-
9	-	-
10	-	-

Table 65: Top Causes of Death in Dare County, 2021, Crude Death Rate per 100,000[49]		
Rank	Cause	Rate
1	Malignant Neoplasms	245.9
2	Diseases of the Heart	214.1
3	Accidents	82.0
4	COVID-19	68.7
5	Alzheimer Disease	-
6	Chronic Lower Respiratory Disease	-
7	Cerebrovascular Disease	-
8	Diabetes Mellitus	-
9	-	-
10	-	-

Table 66: Top Causes of Death in Dare County, 2022, Crude Death Rate per 100,000[49]		
Rank	Cause	Rate
1	Diseases of the Heart	234.5
2	Malignant Neoplasms	218.7

[49] Source: CDC Wonder

3	Accidents	89.6
4	Cerebrovascular Disease	68.5
5	Chronic Lower Respiratory Disease	-
6	Chronic Liver Disease and Cirrhosis	-
7	Intention Self-harm (suicide)	-
8	Alzheimer Diseases	-
9	-COVID-19	-

Leading Causes of ED Visits

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

Table 67: Top Diagnoses for ED Visits for Dare County Residents, FY2022

Rank	Cause	Number
1	COVID-19	564
2	Abdominal and Pelvic Pain	521
3	Pain in Throat and Chest	494
4	Back Pain	340
5	Other Joint Disorders	235
6	Open Wound of the Head	188
7	Soft Tissue Disorders	186
8	Cellulitis and Acute Lymphangitis	182
9	Open Wound of Wrist, Hand, or Fingers	164
10	Syncope and Collapse	163

Table 68: Top Diagnoses for ED Visits for Dare County Residents, FY2023

Rank	Cause	Number
1	Abdominal and Pelvic Pain	692
2	Pain in Throat and Chest	565
3	Back Pain	337
4	Other Joint Disorders	216
5	Nausea and Vomiting	212
6	Cellulitis and Acute Lymphangitis	202
7	COVID-19	202
8	Breathing Abnormalities	193
9	Soft Tissue Disorders	181
10	Open Wound of Wrist, Hand, or Fingers	179

Table 69: Top Diagnoses for ED Visits for Dare County Residents, FY2024

Rank	Cause	Number
1	Abdominal and Pelvic Pain	651
2	Pain in Throat and Chest	518
3	Back Pain	333

4	Nausea and Vomiting	234
5	Syncope and Collapse	210
6	Other Joint Disorders	208
7	COVID-19	196
8	Open Wound of the Head	188
9	Cellulitis and Cute Lymphangitis	184
10	Soft Tissue Disorders	177

Table 70: Top Diagnoses for ED Visits for Outer Banks Health Hospital, FY2022

Rank	Cause	Number
1	COVID-19	927
2	Abdominal and Pelvic Pain	902
3	Pain in Throat and Chest	871
4	Back Pain	536
5	Open Wound of the Head	434
6	Other Joint Disorders	413
7	Syncope and Collapse	364
8	Open Wound of Wrist, Hand, or Fingers	363
9	Nausea and Vomiting	340
10	Soft Tissue Disorders	339

Table 71 Top Diagnoses for ED Visits for Outer Banks Health Hospital, FY2023

Rank	Cause	Number
1	Abdominal and Pelvic Pain	1,187
2	Pain in Throat and Chest	932
3	Back Pain	539
4	Open Wound of the Head	431
5	Nausea and Vomiting	426
6	Other Joint Disorders	383
7	Open Wound of Wrist, Hand, or Fingers	370
8	Syncope and Collapse	344
9	COVID-19	336
10	Cellulitis and Acute Lymphangitis	335

Table 72: Top Diagnoses for ED Visits for Outer Banks Health Hospital, FY2024

Rank	Cause	Number
1	Abdominal and Pelvic Pain	1,078
2	Pain in Throat and Chest	925
3	Back Pain	500
4	Nausea and Vomiting	459
5	Open Wound of the Head	436
6	Syncope and Collapse	383
7	Other Joint Disorders	357
8	Soft Tissue Disorders	323
9	Open Wound of Wrist, Hand, or Fingers	323

10	COVID-19	312

Leading Causes of Avoidable ED Visits

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

Table 73: Top Diagnoses for Avoidable ED Visits for Dare County Residents, FY 2022

Rank	Cause	Number
1	Other Joint Disorders	232
2	Soft Tissue Disorders	164
3	Dizziness	161
4	Nausea and Vomiting	158
5	Disorders of Urinary System	128
6	Acute Upper Respiratory Infection	128
7	Cystitis or Inflammation of the Bladder	120
8	Malaise and Fatigue	119
9	Back Pain	101
10	*Patient Left Before Receiving Care	74

Table 74: Top Diagnoses for Avoidable ED Visits for Dare County Residents, FY 2023

Rank	Cause	Number
1	Other Joint Disorders	214
2	Nausea and Vomiting	211
3	Dizziness	178
4	Soft Tissue Disorders	169
5	Malaise and Fatigue	150
6	Disorders of the Urinary System	136
7	Acute Upper Respiratory Infection	130
8	*Patient Left Before Receiving Care	129
9	Cystitis or Inflammation of the Bladder	114
10	Back Pain	101

Table 75: Top Diagnoses for Avoidable ED Visits for Dare County Residents, FY 2024

Rank	Cause	Number
1	Nausea and Vomiting	231
2	Other Joint Disorders	203
3	Dizziness	174
4	Soft Tissue Disorders	162
5	Cystitis or Inflammation of the Bladder	134
6	Disorders of the Urinary System	126
7	Malaise and Fatigue	114
8	Back Pain	109
9	*Patient Left Before Receiving Care	99
10	Acute Upper Respiratory Infection	98

Table 76: Top Diagnoses for Avoidable ED Visits for Outer Banks Health Hospital, FY 2022		
Rank	Cause	Number
1	Other Joint Disorders	408
2	Nausea and Vomiting	333
3	Soft Tissue Disorders	310
4	Dizziness	268
5	Acute Upper Respiratory Infection	260
6	Disorders of the Urinary System	224
7	Cystitis or Inflammation of the Bladder	186
8	Back Pain	178
9	Malaise and Fatigue	156
10	*Patient Left Before Receiving Care	145

Table 77: Top Diagnoses for Avoidable ED Visits for Outer Banks Health Hospital, FY 2023		
Rank	Cause	Number
1	Nausea and Vomiting	421
2	Other Joint Disorders	379
3	Soft Tissue Disorders	294
4	Dizziness	276
5	*Patient Left Before Receiving Care	246
6	Malaise and Fatigue	215
7	Disorders of Urinary System	208
8	Acute Upper Respiratory Infection	205
9	Acute Pharyngitis	184
10	Back Pain	180

Table 78: Top Diagnoses for Avoidable ED Visits for Outer Banks Health Hospital, FY 2024		
Rank	Cause	Number
1	Nausea and Vomiting	453
2	Other Joint Disorders	350
3	Soft Tissue Disorders	302
4	Dizziness	273
5	Cystitis or Inflammation of the Bladder	196
6	Disorders of Urinary System	195
7	*Patient Left Before Receiving Care	183
8	Acute Pharyngitis	176
9	Acute Upper Respiratory Infection	175
10	Back Pain	162

Top Causes of ED Visits Leading to Admission

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

Table 79: Top Diagnoses for ED Visits Resulting in Admission for Dare County Residents, FY 2022		
Rank	Cause	Number
1	Sepsis	68
2	COVID-19	49
3	Pneumonia	25
4	Fracture of Femur	23
5	Hypertensive Heart and Chronic Kidney Disease	22
6	Hypertensive Heart Disease	20
7	Cystitis or Inflammation of the Bladder	20
8	Acute Pancreatitis	19
9	Chronic Obstructive Pulmonary Disease	16
10	Paralytic Ileus and Intestinal Obstruction w/o Hernia	16

Table 80: Top Diagnoses for ED Visits Resulting in Admission for Dare County Residents, FY 2023		
Rank	Cause	Number
1	Sepsis	67
2	Chronic Obstructive Pulmonary Disease	29
3	Cellulitis and Acute Lymphangitis	28
4	Pneumonia	26
5	Hypertensive Heart Disease	23
6	Cystitis or Inflammation of the Bladder	23
7	Hypertensive Heart and Chronic Kidney Disease	22
8	Fracture of Femur	20
9	Complication of Genitourinary Prosthetic Devices, Implants, or Grafts	18
10	COVID-19	17

Table 81: Top Diagnoses for ED Visits Resulting in Admission for Dare County Residents, FY 2024		
Rank	Cause	Number
1	Sepsis	126
2	Chronic Obstructive Pulmonary Disease	53
3	Hypertensive Heart and Chronic Kidney Disease	36
4	Fracture of Femur	36
5	Cellulitis and Acute Lymphangitis	28
6	Hypertensive Heart Disease	28
7	Acute Kidney Failure	25
8	Paralytic Ileus and Intestinal Obstruction w/o Hernia	22
9	Cystitis or Inflammation of the Bladder	18
10	Ischemic Stroke	18

Table 82: Top Diagnoses for ED Visits Resulting in Admission for Outer Banks Health, FY 2022		
Rank	Cause	Number
1	Sepsis	88
2	COVID-19	67
3	Fracture of Femur	43
4	Pneumonia	34
5	Paralytic Ileus and Intestinal Obstruction w/o Hernia	27
6	Hypertensive Heart Disease	27
7	Acute Pancreatitis	26
8	Chronic Obstructive Pulmonary Disease	25
9	Cystitis or Inflammation of the Bladder	23
10	Hypertensive Heart and Chronic Kidney Disease	22

Table 83: Top Diagnoses for ED Visits Resulting in Admission for Outer Banks Health, FY 2023		
Rank	Cause	Number
1	Sepsis	98
2	Cellulitis and Acute Lymphangitis	44
3	Fracture of Femur	41
4	Chronic Obstructive Pulmonary Disease	38
5	Pneumonia	34
6	Cystitis or Inflammation of the Bladder	27
7	Hypertensive Heart and Chronic Kidney Disease	25
8	COVID-19	24
9	Paralytic Ileus and Intestinal Obstruction w/o Hernia	23
10	Hypertensive Heart Disease	21

Table 84: Top Diagnoses for ED Visits Resulting in Admission for Outer Banks Health, FY 2024		
Rank	Cause	Number
1	Sepsis	178
2	Fracture of Femur	59
3	Chronic Obstructive Pulmonary Disease	58
4	Hypertensive Heart and Chronic Kidney Disease	40
5	Cellulitis and Acute Lymphangitis	40
6	Paralytic Ileus and Intestinal Obstruction w/o Hernia	38
7	Hypertensive Heart Disease	35
8	Ischemic Stroke	35
9	Acute Kidney Failure	33
10	Cystitis or Inflammation of the Bladder	26

Appendix 8 | Supplemental & Additional Data

Overview

This Appendix contains additional information and data that was provided to or obtained by the CHNA team. This section consists of both secondary and primary data.

Substance Abuse Data

The Overdose Death rate in Dare was 10.5 (**Figure 109)** out of 100,000 residents in 2023, representing 4.000 (**Figure 108**) people who died of an overdose. This rate is among the lowest rates seen in NC. This rate is a -80% change over the prior year.

Figure 108: Dare Overdose Death Count[50]

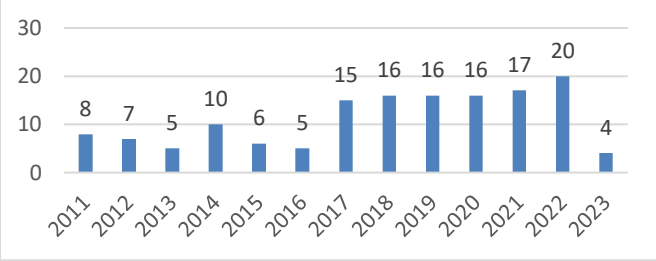
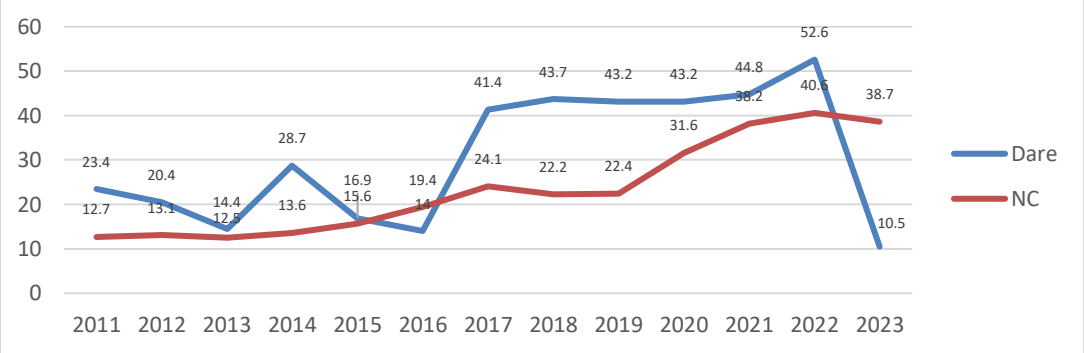


Figure 109: Overdose Death Rates- Dare & North Carolina[49]



The Patients Receiving Opioids rate in Dare was 12.6 percent (**Figure 111**) of residents in 2023, representing 4,773 people (**Figure 110**) with a dispensed opioid prescription. This rate is among the lowest rates seen in NC. This rate is a -4% change over the prior Year.

[50] North Carolina Overdose Epidemic Data, NCDHHS, Division of Public Health, DashLink

Figure 110: Dare Patients Receiving Opioids[49]

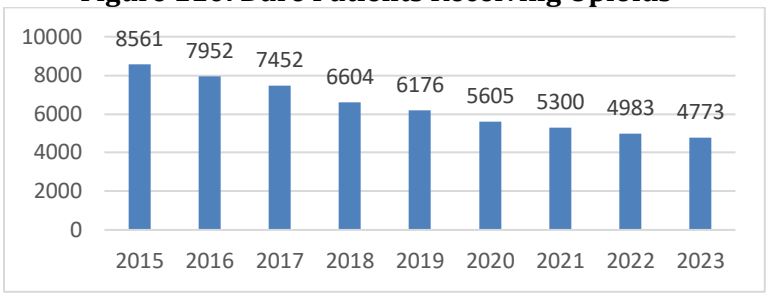
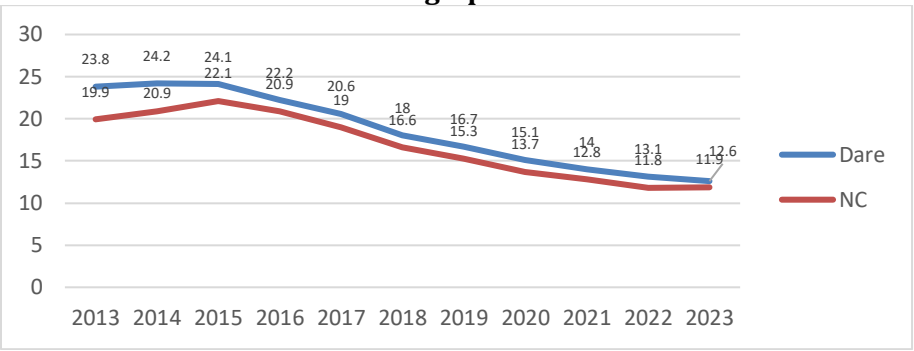


Figure 111: Dare Patients Receiving Opioids Rate- Dare & North Carolina[49]



The estimated Illicit Opioid Overdose rate in Dare is 33.3 percent (**Figure 113**) of overdose deaths in 2023, representing (projected) 1.000 overdose death (**Figure 112**) involving illicit opioids. This rate is among the lowest rates seen in NC. This rate is a -61% change over the prior year.

Figure 112: Illicit Opioid Overdose[49]

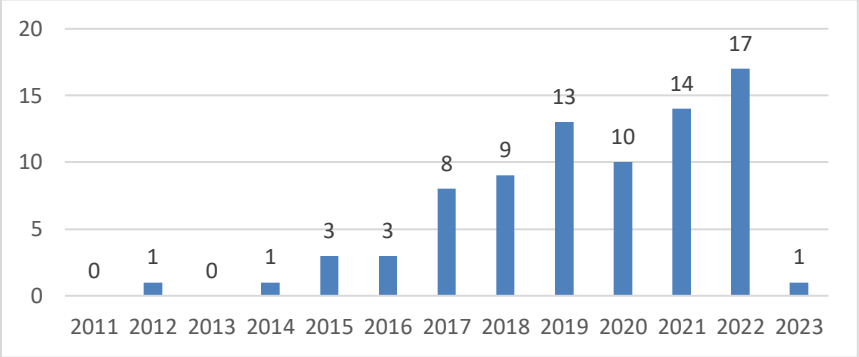
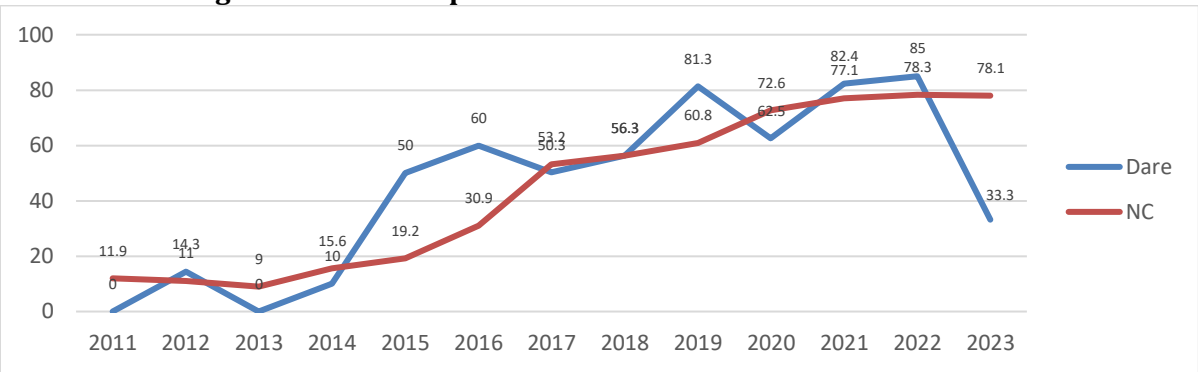


Figure 113: Illicit Opioid Overdose Rate- Dare & North Carolina[49]



The Patients Receiving Buprenorphine rate in Dare was 0.8 percent of residents (**Figure 115**) in 2023, representing 284.0 people (**Figure 114**) with a dispensed buprenorphine prescription. This rate is among the highest rates seen in NC. This rate is a -7% change over the prior year.

Figure 114: Patients Receiving Buprenorphine[49]

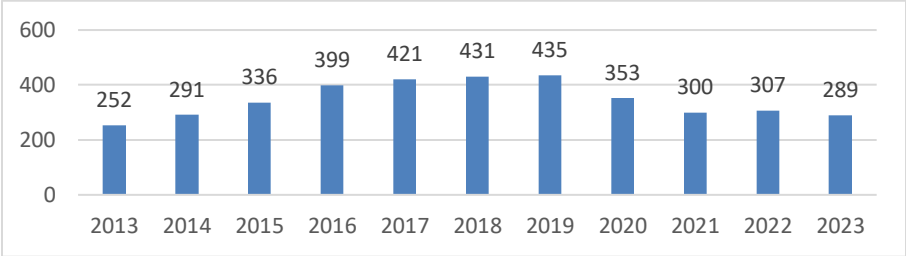
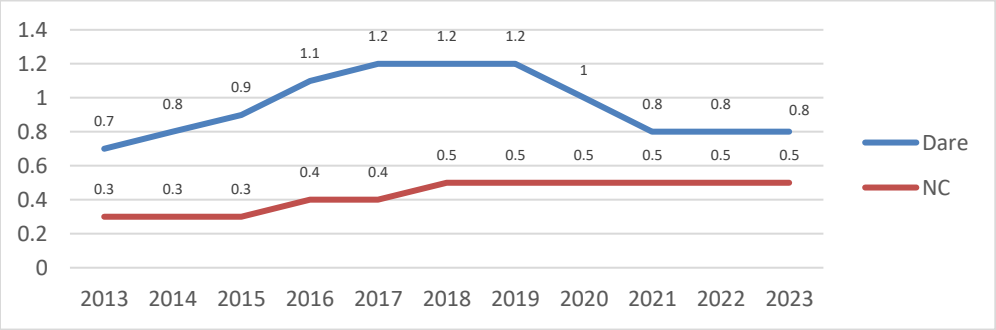


Figure 115: Patients Receiving Buprenorphine Rate- Dare & North Carolina[49]



The Treatment Services rate in Dare was 412.0 out of 100,000 residents (Figure 118) in 2023, representing 157.0 uninsured people (Figure 117) and Medicaid beneficiaries who received treatment for their Opioid Use Disorder (OUD). This rate is among the highest rates seen in NC. This rate is a -19% change over the prior year.

Figure 116: Treatment Services Rate[49]

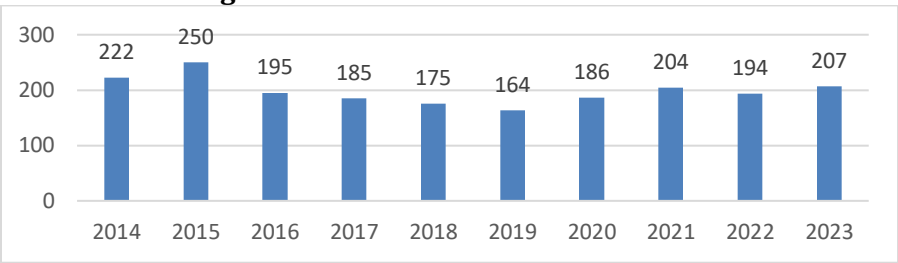
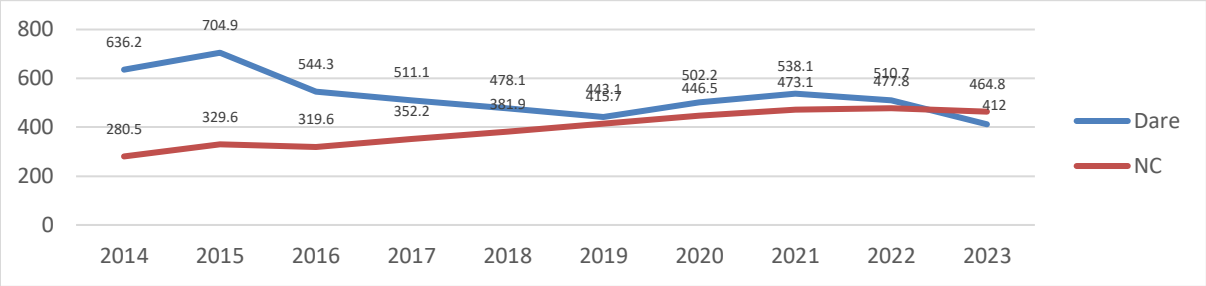


Figure 117: Treatment Services Rates Dare & North Carolina[49]



The Overdose ED Visit rate in Dare was 89.2 per 100,000 residents (Figure A8.13) in 2024, representing 34.00 ED visits (Figure A8.11) for an overdose. This rate is among the lowest rates seen in NC. This rate is a +13% change over the prior year.

Figure 118: Emergency Department Visits for Overdose[49]

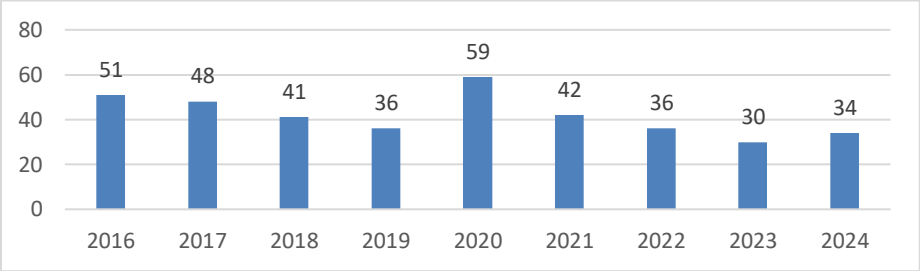
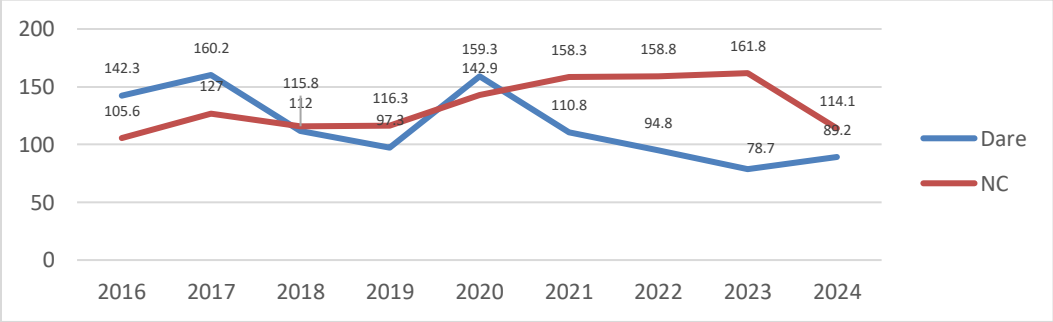


Figure 119: Emergency Department Visits for Overdose Rate- Dare County & North Carolina[49]



Cancer Incidence Rates

Cancer incidence rates in Dare County remain stable, with the exception of colon & rectum cancer rates. Colon & rectum cancer incidence rates are falling. Table 85 illustrates Dare County's colon & rectum cancer rate has gone from 31.8 to 24.6 in 2021.

Table 85: Cancer Incidence Rates (Age Adjusted) in Dare County & North Carolina[51]

Type	Dare County 2014-2018	Dare County 2017-2021	Average Annual Count	Recent Trend	North Carolina 2017-2021
All Cancer Sites	457.3	426.6	245	stable	475.5
Bladder	13.0	23.2	13	stable	19.3
Brain & ONS	*	*	3 or fewer	*	6.4
Breast (Female)	133.6	148.4	23	stable	143.2
Cervix	*	*	3 or fewer	*	6.9
Colon & Rectum	31.8	24.6	14	falling	35.4
Esophagus	*	*	3 or fewer	*	4.3
Kidney & Renal Pelvis	N/A	10.7	6	stable	18.8
Liver & Bile Duct	14.9	7.6	5	stable	9.0
Lung & Bronchus		51.9	32	stable	62.6
Oral Cavity & Pharynx		13.0	9	stable	12.8
Ovary	*	*	*	*	9.3
Pancreas		11.9	7	stable	13.9
Prostate		118.0	36	stable	128.9
Stomach	*	*	*	*	6.2
Thyroid	*	*	*	*	11.0

*Data has been suppressed to ensure confidentiality and stability of rate estimates.

[51] National Cancer Institute. State Cancer Profile. North Carolina. Dare County. Link

Employment in Dare County

Dare County employment industries range from retail to arts and entertainment industries. The top five employment industries (Table 86) in Dare County are 1) Retail Trade 2) Accommodation & Food Service 3) Construction 4) Professional, Scientific & Technical Services and 5) Health Care & Social Assistance.

Dare County occupations with the most employees are: 1) Management 2) Sales & Related Occupations 3) Office & Administrative Support 4) Food Preparation & Serving and 5) Construction & Extraction. Additional information on employment occupations in Dare County can be found in **Table 86.**

Table 86: Dare County Employment by Industries, 2022[52]

Industry	Employee Count	Employee Percentage	Median Income
1) Retail Trade	2507	13.17%	$59,058
2) Accommodation & Food Services	2397	12.59%	$54,894
3) Construction	2101	11.03%	$94,265
4) Professional, Scientific, & Technical Services	1736	9.12%	$133,724
5) Health Care & Social Assistance	1576	8.28%	$125,099
6) Educational Services	1484	7.79%	$109,512
7) Real Estate & Rental & Leasing	1205	6.33%	$97,725
8) Manufacturing	969	5.09%	$103,769
9) Other Services, Except Public Administration	908	4.77%	n/a
10) Public Administration	866	4.55%	$122,364
11) Administrative & Support & Waste Management Services	706	3.71%	$67,700
12) Agriculture, Forestry, Fishing & Hunting	571	3.00%	$ 44,368
13) Arts, Entertainment, & Recreation	549	2.88%	$ 50,779
14) Transportation & Warehousing	485	2.55%	$ 91,363
15) Finance & Insurance	448	2.35%	$ 208,625
16) Wholesale Trade	314	1.65%	$ 211,576
17) Information	137	0.72%	$ 163,708
18) Utilities	74	0.39%	$ 75,417
19) Management of Companies & Enterprises	8	0.04%	n/a

Table 87: Dare County Employment by Occupation, 2022 [45]

Occupation	Count	Percent	Median Earnings
1) Management Occupations	2481	13.25%	$ 138,038
2) Sales & Related Occupations	2219	11.85%	$ 80,720
3) Office & Administrative Support Occupations	2035	10.87%	$ 66,812
4) Food Preparation & Serving Related Occupations	1521	8.13%	$ 50,048
5) Construction & Extraction Occupations	1263	6.75%	$ 59,841

[52] Data USA. Link.

6) Education Instruction, & Library Occupations	1123	6.00%	$ 108,633
7) Health Diagnosing & Treating Practitioners & Other Technical Occupations	1060	5.66%	$ 310,840
8) Building & Grounds Cleaning & Maintenance Occupations	977	5.22%	$ 46,757
9) Business & Financial Operations Occupations	840	4.49%	$ 131,024
10) Installation, Maintenance, & Repair Occupations	786	4.20%	$ 39,470
11) Production Occupations	690	3.69%	$ 60,596
12) Transportation Occupations	513	2.74%	$ 60,865
13) Farming, Fishing, & Forestry Occupations	473	2.53%	$ 67,725
14) Arts, Design, Entertainment, Sports, & Media Occupations	405	2.16%	$ 67,440
15) Health Technologists & Technicians	371	1.98%	$ 90,682
16) Computer & Mathematical Occupations	354	1.89%	$ 207,145
17) Community & Social Service Occupations	353	1.89%	$ 101,019
18) Architecture & Engineering Occupations	304	1.62%	$ 83,661
19) Personal Care & Service Occupations	219	1.17%	$ 38,889
20) Life, Physical, & Social Science Occupations	206	1.10%	$ 173,542
21) Legal Occupations	157	0.84%	$ 132,259
22) Healthcare Support Occupations	155	0.83%	$ 3,929
23) Fire Fighting & Prevention, & Other Protective Service Workers Including Supervisors	149	0.80%	$ 125,013
24) Law Enforcement Workers Including Supervisors	64	0.34%	$ 60,147

Parks in Dare County

Dare County is home to a variety of parks. The following Table 88 breaks down parks by municipal location.

Table 88: Dare County Parks		
Manns Harbor	**Stumpy Point**	**Wanchese**
• Manns Harbor Park	• Pointers Field Park	• Pigum Walker Park
Manteo/Roanoke Island	**Nags Head**	**Kill Devil Hills**
• Collins Playground • Cartwright Park • Roanoke Island Skatepark • George Washington Creef Park • Jules Park • Westcott Park and Lion's Club Center • Old Swimming Hole • North End Park	• Whalebone Park • Jockey's Ridge State Park • Dowdy Park • Nags Head Skate Park • Nags Head Town Park • Nags Head Soccer Complex	• Copley Park • Nags Head Woods Preserve • Parks and Recreation Playground • Casey R. Logan Disc Golf Course • Aviation Park • Outer Banks Arboretum and Teaching Garden • Meekins Field • Hayman Park
Hatteras Island	**Kitty Hawk**	**Duck**
• Rodanthe Community Center Playground • Avon Playground • Burrus Field (Buxton) • Buxton Woods Picnic Area	• Windgrass Circle Park • Kitty Hawk Park • Sandy Run Park • David Paul Pruitt Park	• Duck Town Park and Boardwalk

Interfaith Community Outreach Cancer Transport

Interfaith Community Outreach (ICO) provides a cancer patient medical transport program. In 2024, ICO paid for 167 Veteran rides on Dare County Transportation and 783 cancer patient rides. Additional details can be found in **Table 89**.

Table 89: Interfaith Community Outreach (ICO) – Cancer Patient Medical Transport

2024 ROUND TRIPS													
PLACE	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	TOTAL
OBX	77	19	57	38	0	5	14	16	6	70	54	20	376
E-CITY	8	4	3	8	3	25	12	6	4	21	4	13	111
VA	20	9	17	2	14	4	14	8	15	23	21	34	181
GREENVILLE	0	18	0	0	0	0	0	1	0	1	1	0	21
UNC	3	1	1	0	4	4	3	2	1	2	1	3	25
DUKE	0	0	1	0	1	0	1	0	0	0	0	6	9
MOYOCK	2	0	0	1	0	0	0	2	0	0	0	3	8
WIN/SAL	3	4	0	0	0	0	0	0	0	0	0	0	7
UVA	11	12	10	8	0	0	0	0	0	0	0	0	41
RICHMOND	0	0	0	0	4	0	0	0	0	0	0	0	4
TOTALS	124	67	89	57	26	38	44	35	26	117	81	79	783

Appendix 9 | Suicide Study Results

The Breaking Through Task Force and Dare County Department of Health & Human Services joined in a partnership with UNC Chapel Hill to study suicide in Dare County. This study explored the Impact of Cultural Nuances and Contextual Factors on Mental Health/Well-being Perceptions among Residents Aged 18-34 years in Dare County. The study examined suicide in Dare County through three methods:

- Survey questionnaire for residents 18-34 years of age.
- Focus groups with community members.
- Interviews with key stakeholders.

Title: Analyzing the Influence of Cultural Nuances and Contextual Factors on Mental Health and Well-being Perceptions Among Residents Aged 18-34 in Dare County, NC Study

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Dare County Department of Health & Human Services
Breaking Through Task Force
University of North Carolina at Chapel Hill, USA | Nursing School
University of North Carolina at Chapel Hill, USA | School of Medicine

Background

The 2021-2022 Dare County Community Health Needs Assessment (CHNA) identified mental health as a key factor contributing to mortality rates in the community. The report highlighted suicide as the second leading cause of death among individuals aged 20-34, while Alzheimer's disease was noted for those aged 85 and older. Dare County's suicide rate (19.3) surpasses the North Carolina state average (13.4). In response to this pressing issue, we have dedicated to exploring ways to enhance mental health awareness, improve literacy, and reduce stigma. In collaboration with Dare County Department of Health & Human Services & Breaking Through Task Force, this project aims to investigate how cultural and contextual factors influence perceptions of mental health and well-being among residents aged 18-34 in Dare County, NC by May 2025. Understanding these influences will provide valuable insights to inform targeted interventions and support systems for better mental health outcomes within the community. Our community-academic research initiative, funded by the

2024 Tar Heel Bus Tour Grant through Carolina Across 100, seeks to establish a lasting partnership with Dare County DHHS and the Breaking Through Task Force Team.

Methods

The study comprises three key components: surveys, interviews, and focus groups. Data from 4,363 survey participants analyzed through Stata captures demographic details, mental health status, stress levels, and access to mental health services. Additionally, interviews with seven individuals and two focus group sessions offer qualitative insights into the primary challenges and barriers faced by Dare County residents. A code book was developed. Thematic analysis of interviews and focus groups transcripts using NVivo software revealed multifaceted aspects of the challenges.

Results

The key findings reveal notable racial and gender disparities in mental health perceptions and service access. White and Black respondents report higher stress levels and face more difficulties accessing mental health support compared to other racial groups. Males generally report better mental health and greater confidence in managing stress than females. Despite available resources, significant gaps in mental health support persist, with stigma around mental health being widespread in the community. Participants emphasized the need for greater awareness and enhanced support for mental health concerns. Qualitative findings underscored barriers to accessing services, including financial constraints, transportation difficulties, cultural perceptions, and a shortage of local therapists. Additionally, the study identifies systemic obstacles, including financial constraints, transportation issues, and cultural beliefs, that limit access to mental health services. Future efforts should focus on expanding mental health resources and support within the community, increasing awareness about mental health issues, and continuing to engage with Dare community members to address their unmet needs more efficiently.

Conclusions & Next Steps

Our community-academic study provides a comprehensive analysis of mental health perceptions and challenges faced by young adults in Dare County. The findings underscore the importance of addressing mental health and well-being among residents aged 18-34 years in Dare County. The project highlights the need for increased mental health resources, support, and awareness to combat stigma and improve community well-being. The data also emphasizes the significance of cultural and contextual factors in shaping mental health perceptions and access to care. Further research and in-depth interviews could provide additional insights into the specific challenges and opportunities for improving mental health among residents. Additionally, implementing targeted interventions to address financial, transportation, and cultural barriers will be crucial for enhancing access to mental health services.

The information on the pages that follow are the tools used to collect data and the data collected.

INTERVIEW QUESTIONS

Interview key stakeholders such as local healthcare professionals, community leaders, and mental health advocates to understand their perspectives on the mental health landscape in Dare County and identify potential areas for intervention.

Informed Consent Form

July 15, 2024

University of North Carolina at Chapel Hill

Research Information Sheet

IRB Study #: 24-1780

Principal Investigator: Dr. Marie Lina Excellent

Greetings:

Community-Academic Engaged Project: **Exploring the Impact of Cultural Nuances and Contextual Factors on Mental Health/Well-being Perceptions among Residents Aged 18-34 years in Dare County, NC**

The purpose of this research study has four Aims:

Aim 1: Explore how communities in Dare County of NC understand well-being and mental health;

Aim 2: Identify potential gaps and cultural nuances between needs and available resources to support well-being and mental health;

Aim 3: Assess the level of stigma/discrimination and other related factors associated with well-being and mental health to promote stigma-free conversations.

Aim 4: Identify recommendations for improving the well-being of Dare County community.

You are being asked to take part in a study because you are identified as a resident of Dare County, North Carolina who is at least 18 years and less than 35 years old or

works with individuals in this population. Being in a study is completely voluntary. You can choose not to be in this study. You can also say yes now and change your mind later. Deciding not to be in the study, now or later, will not affect your relationship to UNC or Dare County Department of Health and Human Services (DHHS) or The Breaking Through Task Force. If you agree to take part in this study, you will be asked to participate in an one-on-one interview.

By participating in this semi-structured interview, you are indicating your willingness to be recorded for the scheduled 45-minute virtual conversation over Zoom. We hope to discuss more about your perspectives on the matter and recommendations for ways to improve mental health/well-being awareness and understanding in Dare County, NC community. We expect that 150 people will take part in this study including 25 who will be invited to participate in an interview and another 25 in focus groups.

The greatest risks of this study include the loss of confidentiality of data. To protect your identity as a research subject, the research data will not be stored with your name. We will use for each participant a unique ID so that their responses are not associated with their personal information. And the researcher(s) will not share your information with anyone. The data will be stored on a virtual storage medium such as the UNC server that is backed up nightly. In any publication about this research, your name or other private information will not be used. The results of this assessment will help us design interventions that aim at improving mental health and well-being for Dare County, NC residents.

If you have any questions about this study, please contact the Principal Investigator of the study Dr. Marie Lina Excellent by calling (919) 843-5313 or emailing marilina@ad.unc.edu. If you have questions or concerns about your rights as a study participant, you may contact the UNC Institutional Review Board at 919-966-3113 or by email to IRB_subjects@unc.edu.

Does the respondent agree to participate in the study?

Yes ☐ PROCEED WITH THE INTERVIEW QUESTIONS

No ☐ → END

Does the respondent agree to be recorded during the interview?

Yes ☐ → PROCEED WITH THE INTERVIEW QUESTIONS

No ☐ → END

Demographic data: Please what is your current :

Q1. Age in years

Q2. Gender

Q3. Race/Ethnicity

Q4. Occupation or Line of work

INTERVIEW Questions

Q5 - Please describe how you personally understand the concept of well-being and mental health within your community?

Q6 - From your perspective, what are the key factors that contribute to well-being and mental health in your community?

Q7 - Have you or anyone you know encountered difficulties in accessing mental health services or support within the community?

No => Skip to next question

Yes => What were these challenges?

Q8 - From your perspective, what are some of the most significant challenges individuals face in maintaining good mental health in your community?

Q9 - How aware do you think the community is of the mental health resources available in Dare County?

Q10 - Have you or anyone you know experienced stigma (feeling of disgrace or shame) or discrimination related to mental health within the community? If yes, could you share some examples?

Q11 - How do you perceive the overall attitude towards mental health within the community? Is it generally supportive or stigmatizing (causing disgrace or shame)?

Q12 - Are there specific groups or demographics within the community that you believe face greater challenges or barriers in accessing mental health support? If so, what are these groups and what are the main obstacles they encounter?

Q13 - Do you believe there is adequate education and awareness regarding mental health issues within the community? If not, what improvements do you suggest?

Q14 - Based on your observations, what do you believe are the most pressing needs or priorities for improving mental health and well-being support in Dare County?

Q15 - How might we improve the situation of mental health/well-being in Dare County? Please share any potential solutions that come to your mind. We welcome your ideas.

Closing: We have reached the end of the interview, thank you very much! But please feel free to share any final thoughts, recommendations or anything else that you would like to bring to the attention of the research team?

Thank you very much for your time!

To receive the electronic $10 gift card for completing this Interview, please type in the chat your first name and email address. Allow 24 hours post completion to receive via email your $10 gift card during weekdays or 72 hours if weekends. Please feel free to contact the Principal Investigator (PI), Dr Marie Lina Excellent at marilina@ad.unc.edu should you have difficulty accessing your gift card. Thank you once again for your time!

Focus Groups Questions

Demographics data: Please what is your current :

Age in years

Sex

Gender

Race/Ethnicity

Occupation or Line of work

Use the same questions for all the focus groups

Q1- What do you think are the most important mental health and/or substance use issues and/or needs of our residents?

Q2 - What are the barriers for community members to get mental health and/or substance use services?

Q3 - What are some possible solutions to overcome these barriers?

Q4 – If you were to design mental health services here in Dare County, specifically geared toward our residents, what would that look like?

Q5 - If you, or someone you know, has used mental health services in Dare County what was your/their experience like?

Q6 - What efforts, if any, do you think could be made to reduce stigma (feeling of disgrace or shame) and improve access to mental health resources in Dare County?

Q7 - What might be some Are there any cultural or societal factors within Dare County that you think influence attitudes towards mental health and well-being? If so, could you describe them?

Q8 - How might we improve the situation of mental health/well-being in Dare County? Please share any potential solutions that come to your mind. We welcome your ideas.

Closing: We have reached the end of the focus group, thank you very much! But please feel free to share any final thoughts, recommendations or anything else that you would like to bring to the attention of the research team?

Thank you very much for your time!

To receive the electronic $10 gift card for completing this Focus group, please provide your first name and email address. Allow 24 hours post completion to receive via email your $10 gift card during weekdays or 72 hours if weekends. Please feel free to contact the Principal Investigator, Dr Marie Lina Excellent at marilina@ad.unc.edu should you have difficulty accessing your gift card. Thank you once again for your time!

THE UNIVERSITY of NORTH CAROLINA at CHAPEL HILL

Default Question Block

Informed Consent Form

University of North Carolina at Chapel Hill
Research Information Sheet
IRB Study #: 24-1780
Principal Investigator: Dr. Marie Lina Excellent

Community-Academic Engaged Project: Exploring the Impact of Cultural Nuances and Contextual Factors on Mental Health/Well-being Perceptions among Residents Aged 18-34 years in Dare County, NC
The purpose of this study has four Aims:
Aim 1: Explore how communities in Dare County of NC understand well-being and mental health;
Aim 2: Identify potential gaps and cultural nuances between needs and available resources to support well-being and mental health;

Aim 3: Assess the level of stigma/discrimination and other related factors associated with well-being and mental health to promote stigma-free conversations;
Aim 4: Identify recommendations for improving the well-being of Dare County community.
You are being asked to take part in a study because you are identified as a resident of Dare County, North Carolina who is at least 18 years old and less than 35 years old. Being in a study is completely voluntary. You can choose not to be in this study. You can also say yes now and change your mind later. Deciding not to be in the research study, now or later, will not affect your relationship to UNC or Dare County Department of Health and Human Services (DHHS) or The Breaking Through Task Force. If you agree to take part in this study, you will be asked to complete a 10-15-minute survey to help provide information about yourself as well as your own views on mental health/well-being in the community. Participants will receive $10 electronic gift card via email as incentives for their time. Participating in this Survey is completely voluntary and you can decline to participate at any time. We expect that 150 people will take part in this study, including 25 people who will be invited to participate in an interview along with another 25 people to be in focus groups. The greatest risks of this study include the loss of confidentiality of data. To protect your identity as a research subject, the research data will not be stored with your name. We will use for each participant a unique

ID so that their responses are not associated with their personal information. And the researcher(s) will not share your information with anyone. The data will be stored on a virtual storage medium such as the UNC server that is backed up nightly. In any publication about this research, your name or other private information will not be used. The results of this assessment will help us design interventions that aim at improving mental health and well-being for Dare County, NC residents. If you have any questions about this study, please contact the Principal Investigator, Dr. Marie Lina Excellent, by calling (919) 843-5313 or emailing marilina@ad.unc.edu. If you have questions or concerns about your rights as a study participant, you may contact the UNC Institutional Review Board at 919-966-3113 or by email to IRB_subjects@unc.edu.

Q1- Do you agree to participate in the study?

- ○ Yes, Proceed with the Survey Questions
- ○ No, END

Eligibility Questions

Which of the age ranges below applies to you?

- ○ 18 years - 21 years

- ○ 22 years – 25 years
- ○ 26 years – 29 years
- ○ 30 years – 34 years
- ○ None of the above

Please select the Dare County Zip code in which you live?

- ○ I do not live in any of the zip codes listed below
- ○ 27948
- ○ 27949
- ○ 27954
- ○ 27959
- ○ 27920
- ○ 27936
- ○ 27981
- ○ 27953
- ○ 27968
- ○ 27978
- ○ 27943
- ○ 27915
- ○ 27982
- ○ 27972

Thank you for your interest, but you are not eligible to continue.

Please exit this survey

Demographic Data Questions

Please indicate your Gender or leave it blank if you prefer not to answer:

What is your race/ethnicity? Select all that apply.

- ☐ American Indian or Alaska Native
- ☐ Asian
- ☐ Black or African American
- ☐ Latino or Hispanic
- ☐ Middle Eastern or North African
- ☐ Native Hawaiian or Pacific Islander
- ☐ White or Caucasian
- ☐ Prefer not to answer

Survey Questions

How would you say your mental health is overall, including things like stress, feeling sad, and your emotions?

- ○ Excellent
- ○ Good
- ○ Average
- ○ Poor
- ○ Terrible
- ○ Prefer not to answer

How would you rate your current stress level?

- ○ No stress level
- ○ Minimum stress level
- ○ Moderate stress level
- ○ Extreme/High stress level
- ○ Prefer not to answer

Please share your level of agreement or disagreement with the following statement: I am confident in my ability to manage stress and work through life's difficulties.

- ○ Strongly agree
- ○ Agree
- ○ Neither agree nor disagree

- ○ Disagree
- ○ Strongly disagree
- ○ Prefer not to answer

How often would you say that you get the social and emotional support you need?

- ○ Always
- ○ Most of the time
- ○ About half the time
- ○ Sometimes
- ○ Seldom
- ○ Never
- ○ Prefer not to answer

Was there a time when you needed mental health care or counseling, but did not get it at that time?

- ○ Yes
- ○ No
- ○ Prefer not to answer

What are some of the significant challenges you face in accessing mental health services/support in your community? (Select all that apply)

- [ ] Childcare
- [ ] Transportation
- [ ] Health insurance
- [ ] Lack of available appointments
- [ ] Scheduling conflicts
- [ ] Lack of trust in providers
- [ ] Concerns about confidentiality
- [ ] Concerns about employment/career
- [ ] Lack of awareness about resources
- [ ] Language barriers
- [ ] Restricted mobility
- [ ] Cultural beliefs
- [ ] Lack of providers who might understand me
- [ ] _____ Other, please explain
- [ ] Does not apply
- [ ] Prefer not to answer

How often would you say that you have someone you can rely on to help with things like food, transportation, childcare, or other support if needed?

- ○ Always
- ○ Most of the time
- ○ About half the time
- ○ Sometimes
- ○ Seldom
- ○ Never
- ○ Prefer not to answer

How often would you say that you are worried or stressed about the mental or emotional health of a child in your home/household?

- ○ Always
- ○ Most of the time
- ○ About half the time
- ○ Sometimes
- ○ Seldom
- ○ Never
- ○ Prefer not to answer

Do you think there is enough awareness about mental health resources and support available in your community?

- ○ Yes
- ○ No

- ○ I do not know
- ○ Prefer not to answer

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 answer

Do you know someone in the Dare County community who is currently taking medication or receiving treatment, therapy, or counseling from health professionals for any type of mental or emotional health need?

- ○ Yes
- ○ No
- ○ Prefer not to answer

Who do you feel the most comfortable talking to about your mental health/well-being? Please select the three

most frequent people from the options below:

- [ ] Spouse/ Partner
- [ ] Children
- [ ] Parents
- [ ] Grandparents
- [ ] In-laws
- [ ] Siblings
- [ ] Cousins
- [ ] Other family members
- [ ] Friends
- [ ] Colleagues/ Co-workers
- [ ] Employers
- [ ] Mental Health providers
- [ ] Primary care providers
- [ ] Other healthcare providers
- [ ] Nurses
- [ ] Teachers/Other school staff
- [ ] Faith-based leaders/peers
- [ ] Neighbors
- [ ] Crisis line/chat
- [ ] Nobody
- [ ] _____ Other, please explain
- [ ] Prefer not to answer

What is your level of agreement or disagreement with the following statement: There is stigma (feeling of disgrace or shame) surrounding mental health within the community of Dare County.

- ○ Strongly agree
- ○ Agree
- ○ Neither agree nor disagree
- ○ Disagree
- ○ Strongly disagree
- ○ Prefer not to answer

Would you say that stigma (feeling of disgrace or shame) about mental health impacts your ability to: (Select all that apply)

- ☐ Talk to others about my mental health
- ☐ Talk to others about their mental health
- ☐ Seek treatment for mental health
- ☐ None of the above
- ☐ Prefer not to answer

Have you experienced any instances of negative attitudes or judgments related to mental health within your

community?

- ○ Yes
- ○ No
- ○ Prefer not to answer

From whom have you experienced negative attitudes or judgments related to mental health the most? Please select the three most frequent people from the options below:

- ☐ Spouse/ Partner
- ☐ Children
- ☐ Parents
- ☐ Grandparents
- ☐ In-laws
- ☐ Siblings
- ☐ Cousins
- ☐ Other family members
- ☐ Friends
- ☐ Colleagues/ Co-workers
- ☐ Employers
- ☐ Mental Health providers
- ☐ Primary care providers
- ☐ Other healthcare providers
- ☐ Nurses
- ☐ Teachers/Other school staff

- [ ] Faith-based leaders/peers
- [ ] Neighbors
- [ ] Crisis line/chat
- [ ] Nobody
- [ ] Other, please explain
- [ ] Prefer not to answer

Have you ever treated someone unfairly or unjustly or unkindly because you were aware of their mental health challenges ?

- ○ Yes
- ○ No
- ○ Prefer not to answer

Which of the following scenarios would most accurately reflect your current stress level?

- ○ Feeling relaxed and at ease, with minimal worries or pressures
- ○ Experiencing occasional moments of stress, but overall managing well
- ○ Consistently feeling overwhelmed and tense due to various responsibilities
- ○ Feeling completely unable to cope with the demands of daily life
- ○ Prefer not to answer

Which of the following statements best describes your current mental health?

- ○ I feel generally content and able to cope with life's challenges.
- ○ I experience occasional fluctuations in mood but overall manage well.
- ○ I frequently feel overwhelmed or distressed and struggle to cope with daily life.
- ○ I am experiencing severe mental health challenges and require immediate assistance.
- ○ Prefer not to answer
- ○ If you need immediate assistance, please dial 988 that is freely available or access resources at https://www.breakthestigmaobx.com/

Would you say that you fall asleep easily and get a good night's rest?

- ○ Yes, most of the time (nearly every day)
- ○ Sometimes
- ○ Rarely
- ○ Not at all
- ○ Prefer not to answer

How often do you feel nervous or anxious ?

- ○ Most of the time (nearly every day)
- ○ Sometimes
- ○ Rarely
- ○ Not at all
- ○ Prefer not to answer

Would you say that your level of anxiety hinders your ability to live your best life/do the basic things that you want to do?

- ○ Yes
- ○ No
- ○ Prefer not to answer

How often do you feel annoyed or irritable ?

- ○ Most of the time (nearly every day)
- ○ Sometimes
- ○ Rarely
- ○ Not at all
- ○ Prefer not to answer

Based on your answer to the previous question, does that influence the way you get along with other people?

- ○ Yes
- ○ No
- ○ Prefer not to answer

How would you rate the overall importance of mental health/well-being within your community?

- ○ Very important
- ○ Somewhat important
- ○ Not important
- ○ Prefer not to answer

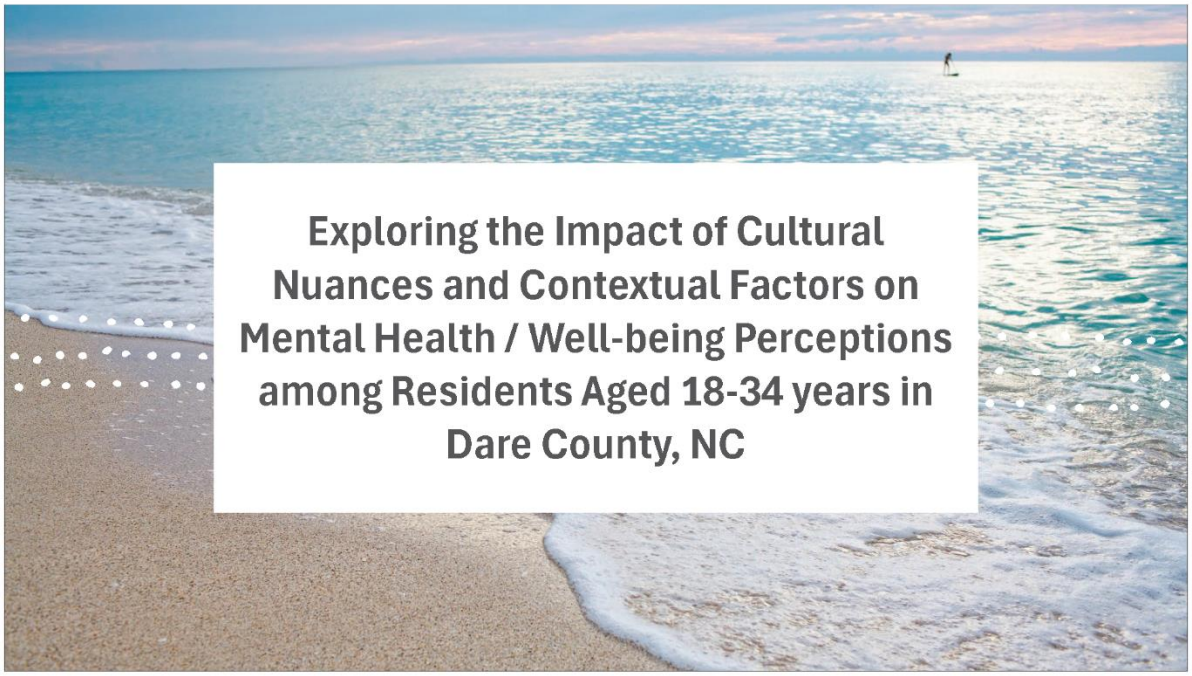
Are you aware of the Suicide and Crisis Lifeline 988 phone number that provides immediate free mental health support?

- ○ Yes
- ○ No
- ○ Prefer not to answer

What do you do to take care of your mental health or well-being?

How might we improve the situation of mental health/well-being in Dare County? Please share any potential solutions that come to your mind. We welcome your ideas.

Any additional information or last comment that you wish to share with us?



Study Results Page 1 of 46

Agenda

- Introduction
- Survey Data
  - Frequency Tables
  - Associations
- Qualitative Data
  - Interview Data
  - Focus Group Data
  - Open-ended Survey Questions

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Introduction

Samira Zahedrozegar, DDS, MPH (Candidate)

- International Dentist | MPH Student in Leadership in Practice
- Gillings School of Global Public Health
- Experienced in Clinical Practice and Published Research
- Graduate Research Assistant

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Participant Introductions

Preliminary Data Analysis

- Total Number of Participants
  - **Surveys**

    34 Questions Online Data Gathering with the number of 4363 Participants
  - **Interviews**

    7 Interviewees
  - **Focus Groups**

    two sessions(2+6)

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Study Results Page 3 of 46

Surveys

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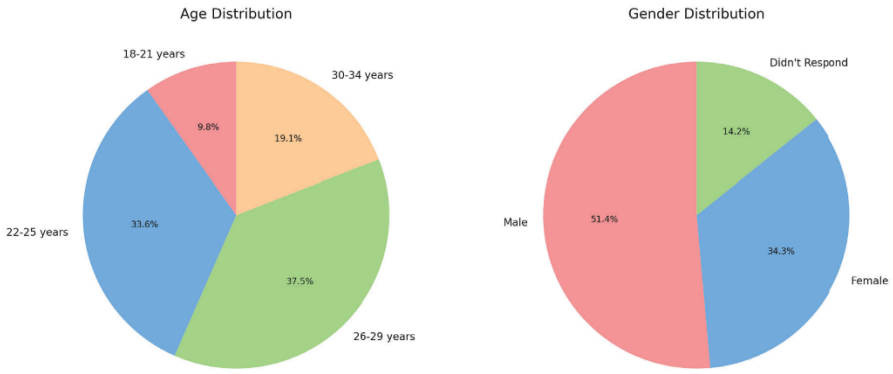
Participants Demographics(visuals)



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Participants Demographics (Data)

Age Range	Freq.	Percent
18-21 years	429	9.84%
22-25 years	1464	33.58%
26-29 years	1636	37.52%
30-34 years	831	19.06%

Gender	Freq.	Percent
Male	2241	51.42%
Female	1,496	34.33%
Didn't Respond	621	14.25%

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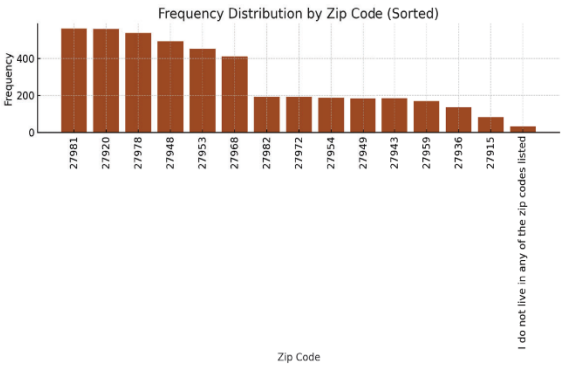
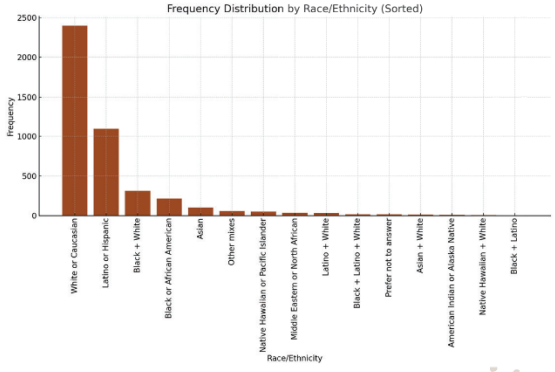
Zip Code & Race Distribution





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Zip Code	Freq.	Percent
I do not live in any of the zip codes listed	32	0.73%
27948	493	11.31%
27949	184	4.22%
27954	187	4.29%
27959	169	3.88%
27920	559	12.82%
27936	135	3.1%
27853	561	12.86%
27968	452	10.36%
27978	412	9.44%
27943	538	12.33%
27915	184	4.22%
27982	83	1.9%
27972	192	4.4%
20XX 27972	192	4.4%

Race/Ethnicity	Freq.	Percent
White or Caucasian	2398	55.06%
Asian	101	2.32%
Black or African American	215	4.94%
Latino or Hispanic	1094	25.12%
Middle Eastern or North African	36	0.83%
Native Hawaiian or Pacific Islander	51	1.17%
Black and White	311	7.14%
Asian and White	12	0.28%
Black and Latino	4	0.09%
Native Hawaiian and White	5	0.11%
Black, Latino, and White	16	0.37%
Latino and White	32	0.73%
American Indian or Alaska Native	9	0.21%
Multiple Races (Other)	57	1.31%

Frequency Tables

Overall Mental Health	Freq.	Percent
Excellent	718	16.49%
Good	1698	38.99%
Average	1259	28.91%
Poor	489	11.23%
Terrible	149	3.42%
Prefer not to answer	42	0.96%

Current Stress Level	Freq.	Percent
No stress	467	10.72%
Minimum Stress Level	1275	29.28%
Moderate Stress Level	1807	41.49%
Extreme/High Stress Level	762	17.5%
Prefer not to answer	44	1.01%

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Confidence in Stress Management	Freq.	Percent
Strongly Agree	831	19.08%
Agree	2071	47.55%
Neither agree or disagree	720	16.53%
Disagree	498	11.44%
Strongly Disagree	184	4.23%
Prefer not to answer	51	1.17%

Social & Emotional Support	Freq.	Percent
Always	650	14.93%
Most of the time	1324	30.4%
About half the time	880	20.21%
Sometimes	979	22.48%
Seldom	363	8.34%
Never	135	3.1%
Prefer not to answer	24	0.55%

Frequency Tables

Needed Mental Support but didn't Get	Freq.	Percent
No	1364	31.32%
Yes	2869	65.88%
Prefer not to answer	122	2.8%

Someone You Can Rely on	Freq.	Percent
Always	633	14.54%
Most of the time	1303	29.92%
About half the time	849	19.49%
Sometimes	1044	23.97%
Seldom	341	7.83%
Never	151	3.47%
Prefer not to answer	34	0.78%

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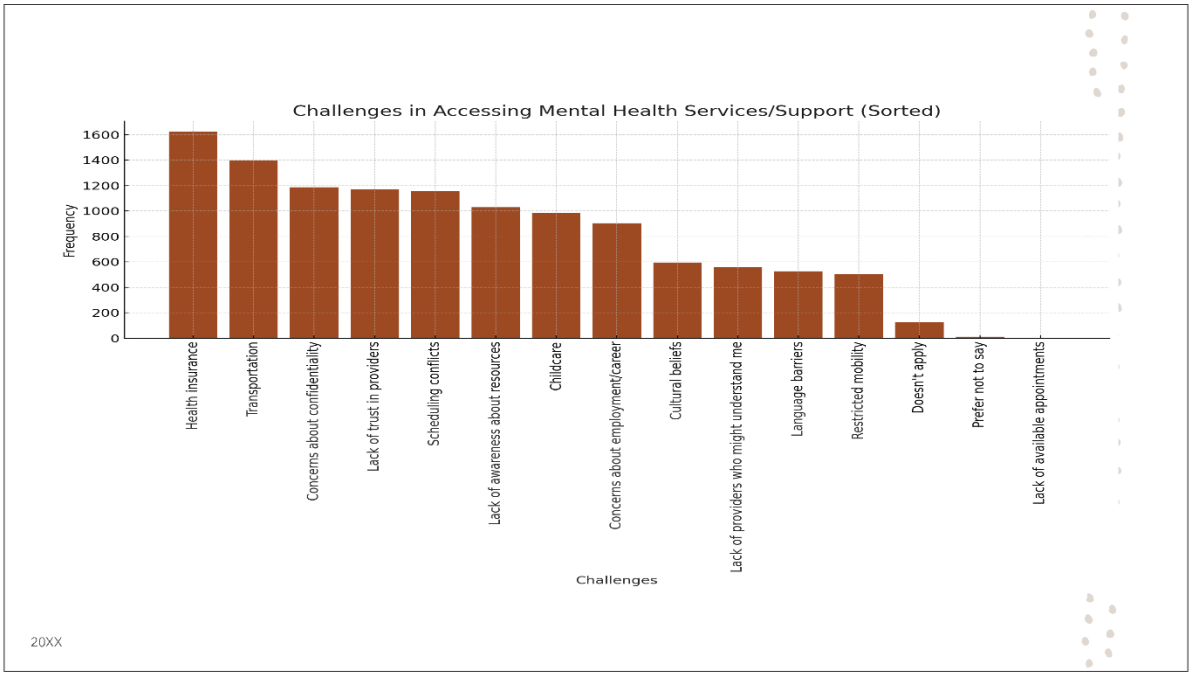

The significant challenges you face in accessing mental health services/support in your community

Childcare	Transportation	Health insurance	Lack of available appointments	Scheduling conflicts	Lack of trust in providers	Concerns about confidentiality	Concerns about employment/ career
985(%22.57)	1,398(%32.03)	1,627 (%37.28)	0	1,156 (%26.49)	1,170 (%26.81)	1,187 (%27.20)	904 (%20.71)

Lack of awareness about resources	Language barriers	Restricted mobility	Cultural beliefs	Lack of providers who might understand me	Doesn't apply	Prefer not to say
1,030 (%23.60)	528 (%12.10)	505 (%11.57)	596 (%13.66)	559 (%12.81	125(%2.86)	13(%0.30)

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Stress Related to Child- Enough Awareness

Worried about Child	Freq.	Percent
Always	706	16.21%
Most of the time	1167	26.8%
About half the time	831	19.08%
Sometimes	952	21.86%
Seldom	443	10.17%
Never	212	4.87%
Prefer not to answer	44	1.01%

Enough Awareness of Resources	Freq.	Percent
No	1661	38.14%
Yes	2315	53.16%
I do not know	305	7%
Prefer not to answer	74	1.7%

20XX

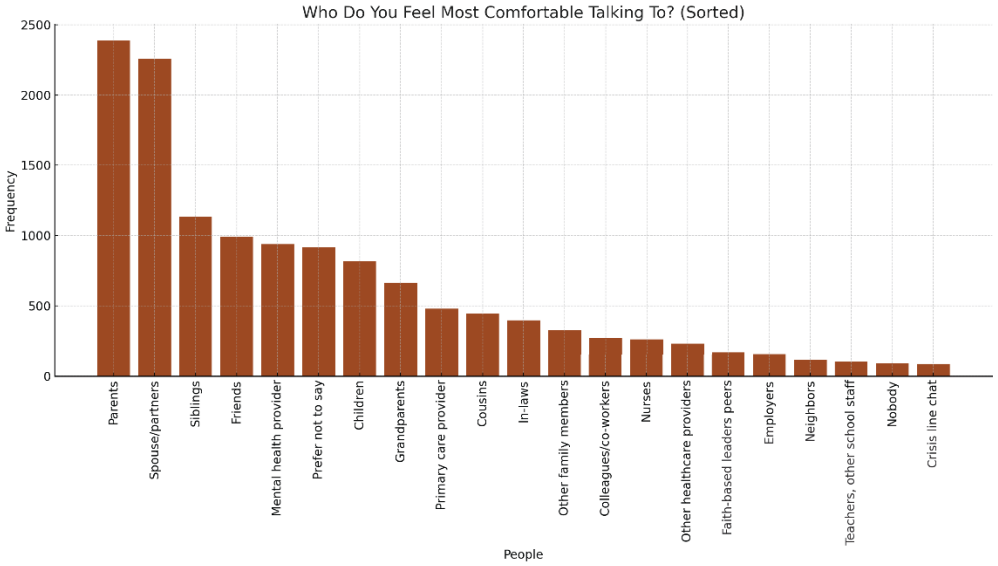
Counseling	Freq.	Percent
No	1726	39.63 %
Yes	2530	58.09 %
Prefer not to answer	99	2.27 %

currently taking medication, receiving treatment, therapy, or counseling from a health professional

Know anyone in the Dare County community who is currently taking medication or receiving treatment

Know Counseling	Freq.	Percent
No	1197	27.49 %
Yes	3041	69.83 %
Prefer not to answer	117	2.69 %

20XX



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Who you feel the most comfortable talking to about your mental health/well-being

Spouse/partners	children	parents	Grandparents	In-laws	Siblings	cousins	Other family members	friends	Colleagues/coworkers	employers
2,258(%51.74)	819(%18.77)	2,386(%54.67	665(%15.24)	397(%9.10)	1,133(%25.96	442(%10.13)	324(%7.42)	992(%22.73)	272(%6.23)	157(%3.60)

Mental health provider	Primary care provider	Other healthcare providers	nurses	Teachers, other school staff	Faith-based leaders peers	neighbors	Crisis line chat	nobody	Prefer not to say
938(%21.49)	478(%10.95)	229(%5.25)	262(%6)	105(%2.41)	168(%3.85)	115(%2,64)	87(%1.99)	91(%2.09)	919%2.09)

20XX

Stigma in Dare County	Freq.	Percent
Strongly agree	975	22.39%
Agree	1924	44.18%
Neither agree nor disagree	700	16.07%
Disagree	457	10.49%
Strongly disagree	243	5.58%
Prefer not to answer	56	1.29%

Negative Attitudes	Freq.	Percent
No	1234	28.34%
Yes	3017	69.28%
Prefer not to answer	104	2.39%

20XX

Impact & Stigma	Freq.	Percent
Talk to others about mental health	2,099	48.1%
Seek treatment for mental health	1,991	45.62 %
Non of the above	365	8.36 %
Prefer not to answer	39	0.89 %

20XX

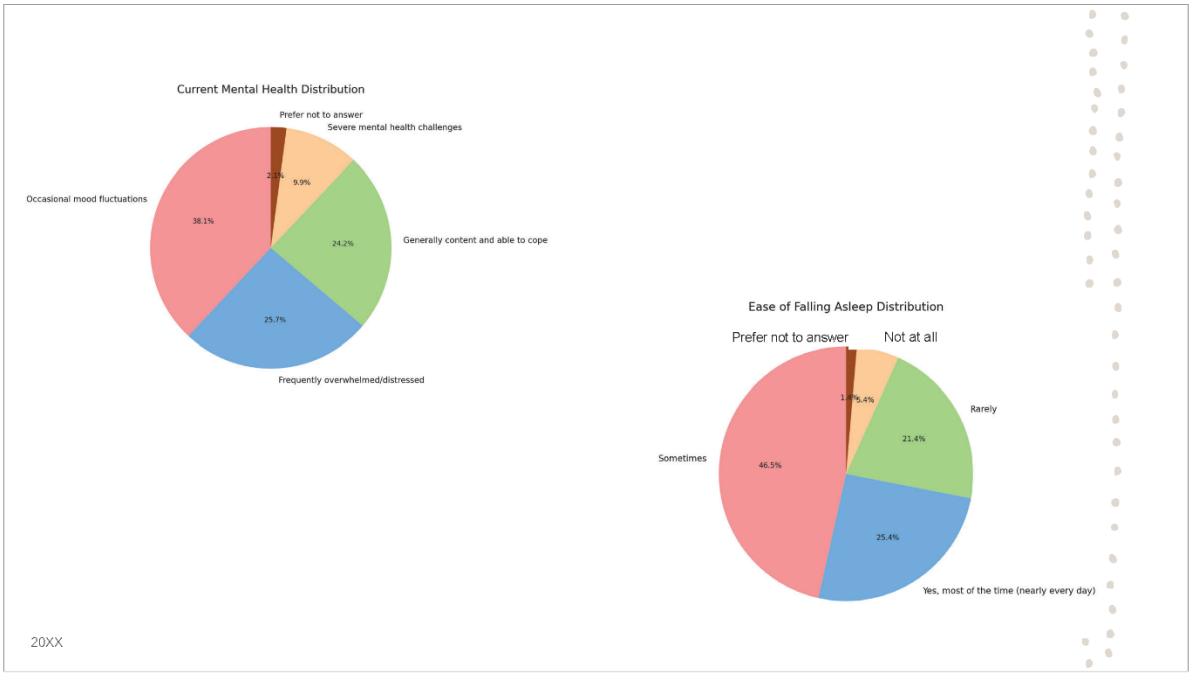
Negative Attitudes from Whom	Percent
Parents	28.67%
Friends	23.03%
Colleagues/Coworkers	22.89%
Spouse/Partner	19.57 %
Neighbors	17.55%
Employers	15.79%
Children	14.55%
Other Family Members	12.53%
In-laws	12.51 %
Siblings	11.55 %
Cousins	11.02%
Grandparents	9.85 %
Primary Care Providers	7.63 %
mental Health Providers	7.47%

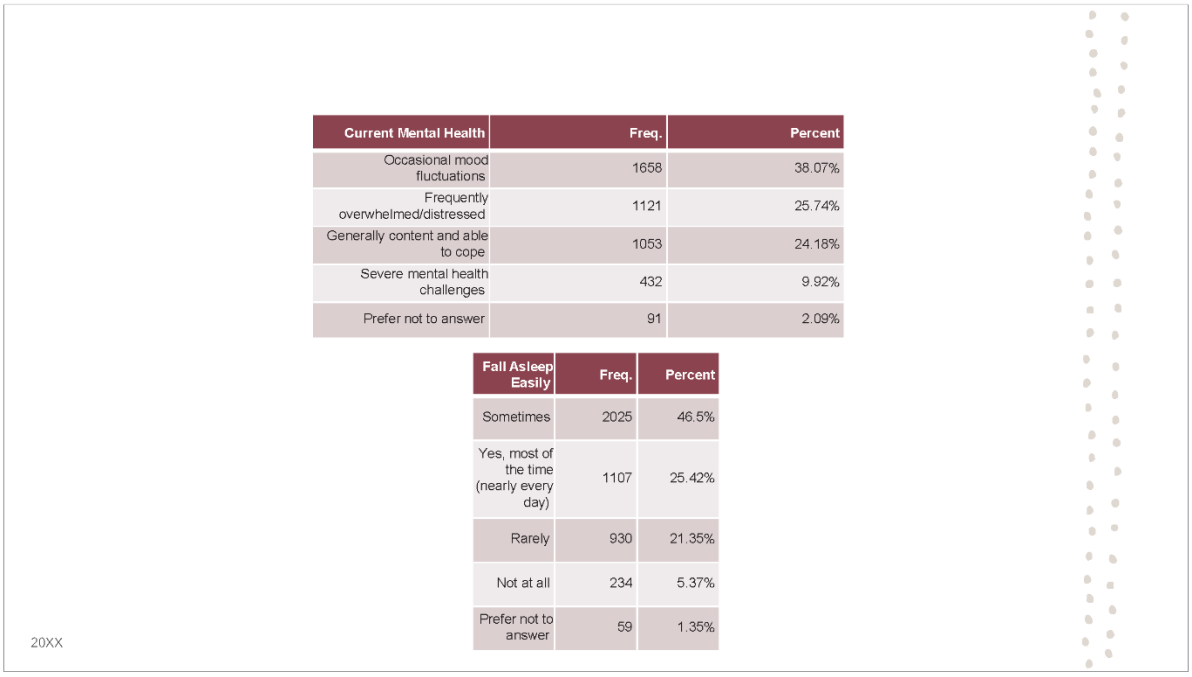
20XX

Treat Bad	Freq.	Percent
No	2626	60.3%
Yes	1648	37.84%
Prefer not to answer	81	1.86%

Current Stress	Freq.	Percent
Experiencing occasional stress	1912	43.9%
Consistently feeling overwhelmed	1081	24.82%
Feeling relaxed and at ease	956	21.95%
Unable to cope with daily demands	338	7.76%
Prefer not to answer	68	1.56%

20XX





Current Mental Health	Freq.	Percent
Occasional mood fluctuations	1658	38.07%
Frequently overwhelmed/distressed	1121	25.74%
Generally content and able to cope	1053	24.18%
Severe mental health challenges	432	9.92%
Prefer not to answer	91	2.09%

Fall Asleep Easily	Freq.	Percent
Sometimes	2025	46.5%
Yes, most of the time (nearly every day)	1107	25.42%
Rarely	930	21.35%
Not at all	234	5.37%
Prefer not to answer	59	1.35%

20XX

Study Results 13 of 46

How often do you feel Nervous	Freq.	Percent
Sometimes	2120	48.68%
Rarely	1034	23.74%
Most of the time (nearly every day)	912	20.94%
Not at all	234	5.37%
Prefer not to answer	55	1.26%

Level of Anxiety Hinder Your Best	Freq.	Percent
No	1581	36.3%
Yes	2655	60.96%
Prefer not to answer	119	2.73%

20XX

How often Annoyed or Irritable	Freq.	Percent
Sometimes	2193	50.36%
Rarely	1125	25.83%
Most of the time (nearly every day)	736	16.9%
Not at all	260	5.97%
Prefer not to answer	41	0.94%

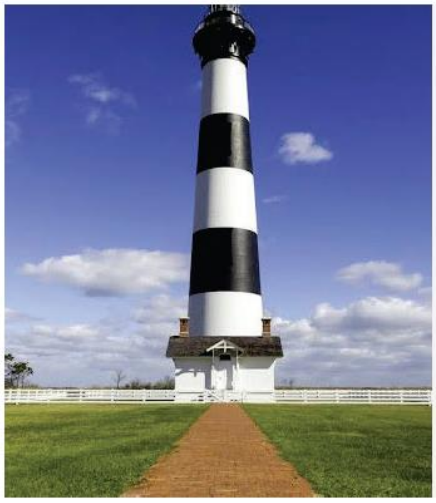
Frequency of Annoyance Influence	Freq.	Percent
No	1672	38.39 %
Yes	2590	59.47 %
Prefer not to answer	93	2.14 %

20XX

Overall Importance of Community Wellness	Freq.	Percent
Very important	2537	58.39
Somewhat important	1428	32.87
Not important	299	6.88
Prefer not to answer	81	1.86

Phone Number Awareness	Freq.	Percent
No	1021	23.44
Yes	3225	74.05
Prefer not to answer	109	2.5

20XX



Associations

You can find the highlights of the associations in the following slides.

Data with tables are in appendix.

20XX

Stress Level

Association with Race:

- There is a statistically significant association between race and stress level.
- White and Black respondents tend to experience higher levels of stress.
- Asians and Latinos report lower levels of stress comparatively.

Association with Gender:

- The p-value of 0.000 indicates that there is a statistically significant relationship between mental health and gender).
- Males seem to have a higher count in categories like "Excellent" and "Good."

20XX

Overall Mental Health

Association with Race:

- There is a statistically significant association between race and overall mental health.
- White respondents have the largest group, with higher reports of Good and Average mental health.
- Black respondents show significant counts in Good and Average categories but fewer in the Excellent category.
- Asians and Latinos also report higher counts in the Good and Average categories.

Association With Gender:

- There is a statistically significant association between gender and overall mental health.
- Males report higher instances of Good and Excellent mental health compared to females.
- Females have fewer reports of Excellent mental health and show a slightly higher tendency to report poorer mental health compared to males.

20XX

Stress Management

Association with Race:

- Statistically significant relationship between race and stress management responses (p = 0.002).
- White and Black respondents have the largest sample sizes and show consistent patterns in Strongly agree and Agree categories.
- Latino, Asian, and smaller racial groups generally fall into Agree and Neither agree nor disagree categories.

Association with Gender:

- There is a statistically significant relationship between gender and stress management responses.
- While both males and females mostly agree with stress management statements, males show a higher tendency to disagree or strongly disagree compared to females.

20XX

Emotional Support

Association with Race:

- Racial disparities in receiving consistent emotional support are evident. Mixed racial groups and White or Caucasian individuals report the highest levels of emotional support availability.
- White and Black respondents typically have higher counts in consistent emotional support categories.

Association with Gender:

- The association between gender and emotional support is **not statistically significant** at the 5% level.
- However, Males report receiving emotional support "Always" and "Most of the time" more frequently than females.

20XX

Needed but didn’t get the support

Association with Race:

- The p-value indicates a statistically significant relationship between race and whether someone needed support but didn’t get it.
- The majority across all racial groups reported "Yes" , indicating they needed support but didn’t receive it. Notably high counts in the White and Black or African American groups.

Association with Gender:

- The chi-square test indicates that gender influences the likelihood of needing support but not receiving it.
- Across all genders, a majority reported needing support but not getting.
- Males show a slightly higher proportion compared to females.

20XX

Rely on Someone for Help

Association with Race:

- This indicates a statistically significant relationship between race and relying on emotional support or help.
- White individuals were the Largest group reporting getting emotional support “Sometimes” and “Most of the time” .

Association with Gender:

- Males report higher levels of relying on help compared to females.

20XX

Child Stress

Association with Race:

- Indicates a statistically significant relationship between race and stress related to a child's physical or emotional health.
- White and Black respondents report higher levels of stress related to the physical or emotional health of a child.

Association with Gender:

- Males report slightly higher child-related stress compared to females.

20XX

Awareness

Association with Race:

- White and Black respondents show a significant split between believing there is and isn't enough awareness of mental health resources.

Association with Gender:

- Males are slightly more likely than females to believe there is enough awareness of mental health resources.

20XX

Currently taking medication, receiving treatment, therapy, or counseling

Association with Race:

- White and Black respondents are the largest groups receiving emotional health treatment or medication.

Association with Gender:

- Males are more likely to be receiving emotional health treatment compared to females. The difference is statistically significant

20XX

Awareness of Mental Health Services

Association with Race:

- Asian & White and American Indian or Alaska Native groups have high awareness of counseling services.
- Black or African American and smaller racial groups show lower levels of awareness.

Association with Gender:

- Males and females show significant awareness of counseling resources, with a higher percentage in the "Yes" category.

20XX

Current Stress Level

Association with Race:

- There is a statistically significant relationship between race and current stress levels .
- White and Black respondents experience the highest levels of stress. Asian and Latino respondents report lower but notable levels of stress.

Association with Gender:

- There is a statistically significant relationship between current stress levels and gender.
- Males are more likely to report being consistently overwhelmed and unable to cope compared to females.

20XX

Ability to Cope with Stress

Association with Race:

- There is a statistically significant relationship between race and the ability to cope with stress.
- White and Black respondents report a mix of coping levels, with significant numbers experiencing occasional mood fluctuations and severe challenges.

Association with Gender:

- There is a statistically significant relationship between gender and the ability to cope.
- Males report higher levels of severe mental health challenges and feeling frequently overwhelmed compared to females

20XX

Other Associations

- Individuals under higher stress tend to have more awareness but also more uncertainty.
- There is a statistically significant relationship between perceived stigma (Q18) and experiencing negative attitudes or judgments related to mental health (Q20).
- There is a statistically significant relationship between current stress level (Q23) and the ability to cope (Q24). Higher stress levels are significantly associated with greater difficulty coping, mood fluctuations, and severe challenges.
- There is a strong association between sleep quality and how often individuals feel nervous or anxious.

20XX

Other Associations

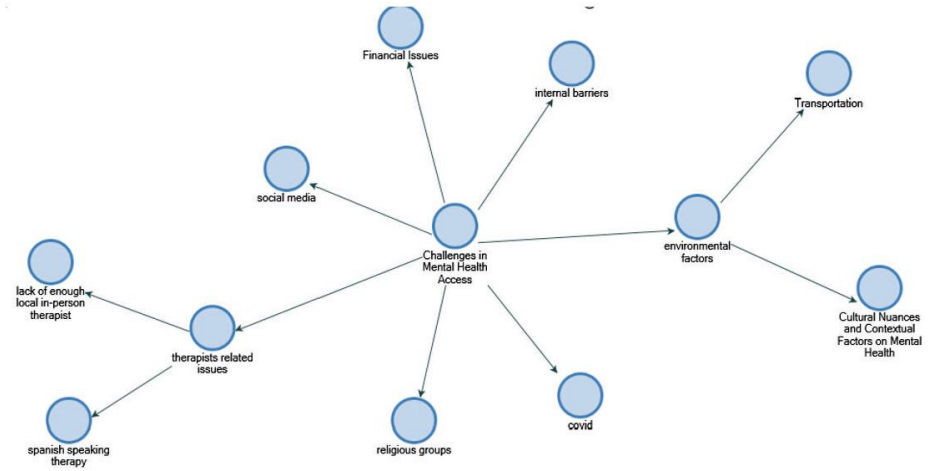
- The frequency of feeling nervous/anxious is strongly associated with how much anxiety impacts daily functioning. Those who feel anxious “most of the time” or “sometimes” report the highest levels of anxiety hindering their ability to live their best life.
- There is a statistically significant relationship between sleep quality (Q25) and whether anxiety hinders the ability to live one’s best life (Q27). Poor sleep quality is strongly associated with anxiety hindering daily life.
- The more anxiety hinders daily functioning, the greater the reported impact on emotional health.
- As emotional health impact increases, the ability to manage daily life significantly decreases.

20XX

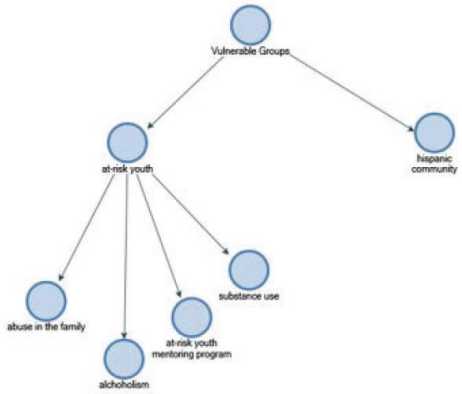
Interviews & Focus Groups

COMMON THEMES

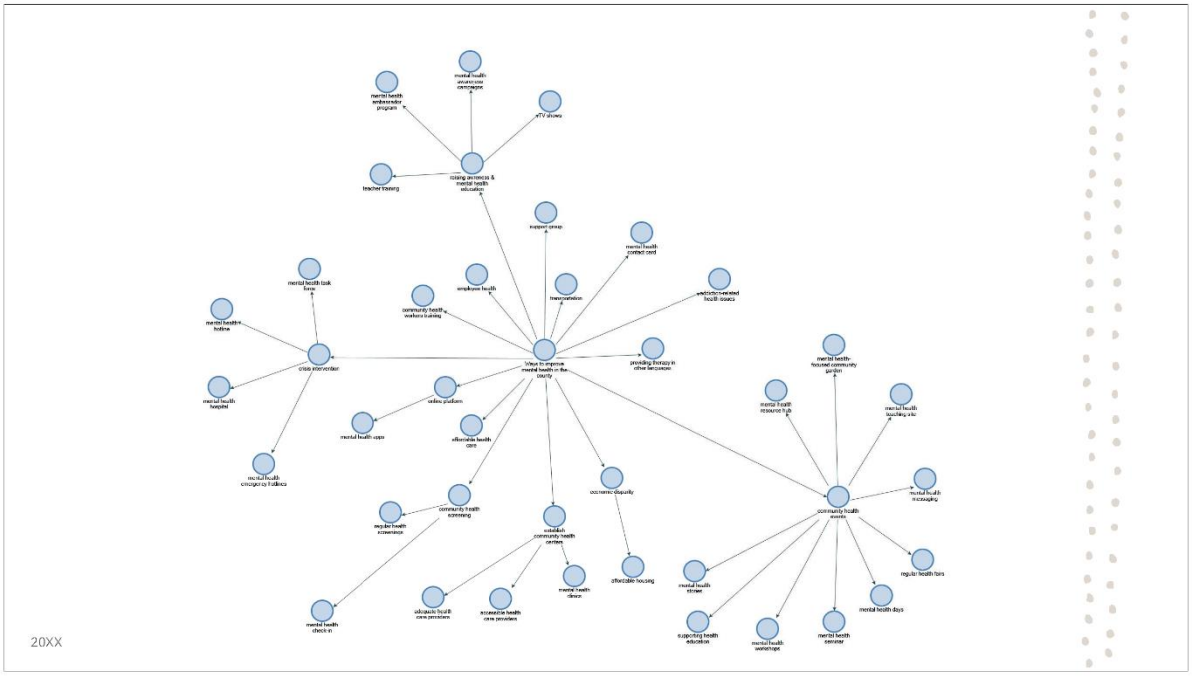
Challenges in Accessing Mental Health



Vulnerable Groups



Survey & Open Ended Questions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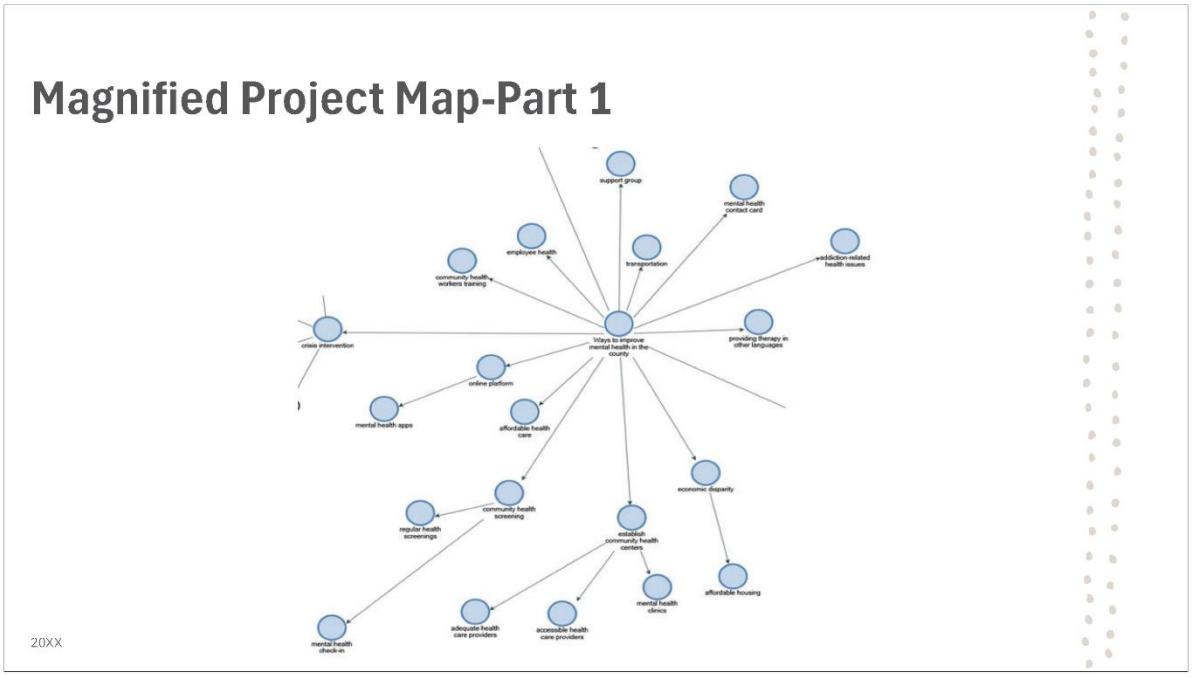
Magnified Project Map-Part 1
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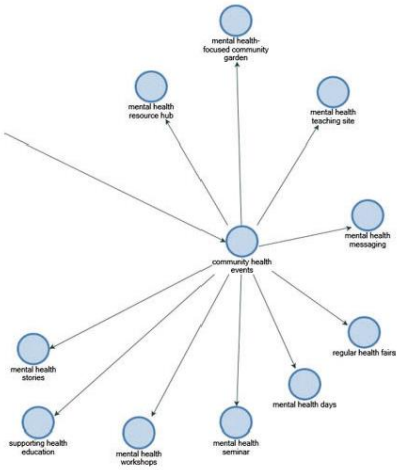
Magnified Project Map-Part 2



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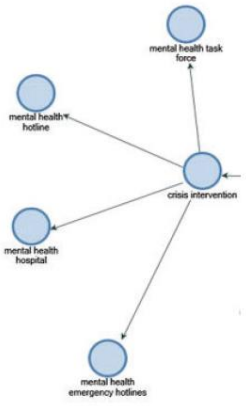
Magnified Project Map-Part 3



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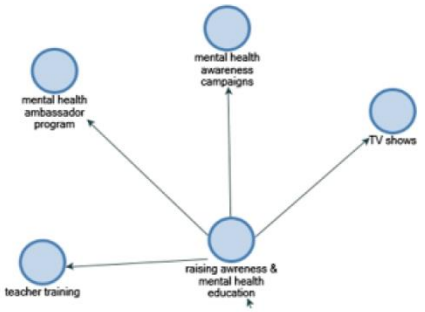
Magnified Project Map-Part 4



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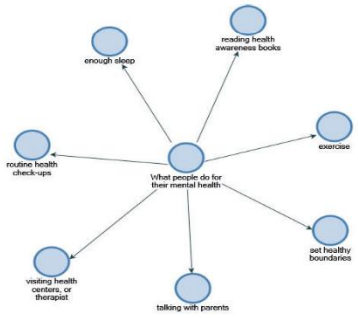
What Do People Do for Their Mental Health?



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Theme Wrap-up

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Therapist Related Issues

- Access to therapists
- Transportation
- Affordable treatment

- *"Mental health is not a luxury; access to a therapist should be as normal as access to a physician."*
- *"Access to care shouldn't be determined by one's ability to travel. The distance to healing should not be a barrier."*
- *"Mental health care shouldn't cost more than the pain of not receiving it."*

20XX

Therapist Related Issues

- Not Enough number of local therapists
- Not Enough number of in-person therapists
- Crisis Line, Emergency Access

- *"The demand for mental health services far exceeds the supply of local therapists; communities deserve better."*
- *"A face-to-face connection with a therapist is a lifeline many can't reach due to shortages."*
- *"A crisis line is a bridge between despair and hope; timely access can save lives."*

20XX

Therapist Related Issues

- Drug Abuse, Alcoholism
- Seasonal Depression
- Affordability

- *"Addiction isn't a choice, but recovery requires access to the right support system."*
- *"Winter's darkness shouldn't dim the light of mental wellness. Support for seasonal depression is vital."*
- *"Mental health support should be within everyone's financial reach, not a privilege of the few."*

20XX

Therapist Related Issues

- Waitlist, overwhelmed therapists
- Therapy in other languages(Spanish)

- *"When therapists are overwhelmed, patients are left waiting. Mental health care shouldn't have a backlog."*
- *"Language should not be a barrier to mental wellness. Everyone deserves therapy in their own voice."*

20XX

Stigma

- Shame and Embarrassment During Crisis Calls
- Law Enforcement and Fear of Job Loss
- Impact of Workplace Culture on Seeking Help

- *"Sometimes, when we respond and people are going through crisis, they're embarrassed that it came to that–that they had to call us. The neighbors are looking around, so a lot of people get a little embarrassed, kind of shameful."*
- *"Nobody wants to talk about their mental health at all. Because if you say the wrong thing, then they'll take your gun, and you can't work. Then you're not making any money, and you get into that cycle."*
- *"My administration started asking what was going on. I told them everything, and then they were like, 'Well, you don't want to hurt yourself or anything, right?' I was like, 'No, I just need help.' But then I became a liability."*

20XX

Stigma

- Community Perceptions
- Mental Health in the Medical Field

- *"We have our 'frequent flyers,' people who are dealing with mental health issues daily. Neighbors will call and say, 'Justin's acting crazy again.' It's very stigmatizing, not realizing the underlying causes of what's actually occurring."*
- *"I've had multiple patients who say, 'I don't want you looking at me the wrong way because I'm on Methadone.' They feel ashamed for taking steps to recover, even though it's the right thing to do."*

20XX

Stigma

- Religious and Cultural Barriers
- Systemic Barriers for Law Enforcement

- *"In some religious groups, people are hesitant to seek help because they follow a pastor who tells them to rely on faith. But I tell them, 'You need to believe in yourself first before you believe in something bigger.'"*
- *"If you disclose that you need help or support, the culture identifies you as weak, and your potential for promotion goes away."*

20XX

List of Potential Solutions

- Bringing in Therapists
- Affordable Therapy sessions
- Free Screening
- Addressing Insurance-related factors
- Social awareness events
- Transportation
- Establishing mental health centers
- Online Platform
- Housing issues
- Events or activities during winter
- Post-Purdum education, High School Education
- Crisis/emergency accessible services

20XX

Potential Solutions

Affordable and Accessible Care

- *"Mental health services need to be affordable, so people don't have to worry about paying out of pocket when they need help."*
- *"We need more therapists to move in, and we have to keep them in town; you know, because of the expenses and housing issues, most of them are moving out."*

Holistic Approach to Well-being

- *"We need something that addresses the environmental, financial, and seasonal factors that impact mental health."*
- *"Mental and physical health should be integrated."*

20XX

Potential Solutions

Middle-Ground Mental Health Support

- *"If there was just somewhere that they can go that was like, 'Hey, I'm just kind of really feeling down right now. I don't wanna harm myself, but I'm in a low point.' If there was something like that available to them... Also to law enforcement that we can call them."*

24/7 Community Mental Health Services

- *"We need somebody who can be available to talk to people and kind of walk them through the process... Some kind of community mental health service that's on call 24/7."*

20XX

Potential Solutions

Reducing the Stigma and Visibility

- *"In Norfolk, what we had is the community mental health team showed up in a regular car, not a police car, so there wasn't that stigmatism of 'the cops are at this house again.' I think that was very beneficial."*

Immediate Access to Mental Health Support

- *"Having someone that we could call who would be there in a timely manner would be beneficial... Especially at 2 or 3 o'clock in the morning when there's no one else to call."*

20XX

Potential Solutions

Improving Access to Resources

- *"If there was something that could help people bridge that gap, where they don't have to wait 4 weeks to get into an appointment or treatment center."*

Community-Based Education and Awareness

- *"The county health system could do workshops, they could do Zoom calls, they could make flyers, but until people actively make the choice, and the stigmas are wiped, it's difficult."*

20XX

Potential Solutions

Financial Stability for Well-being

- *"Supporting year-round employment opportunities could help maintain people's well-being, so they don't face the stress of unemployment during the off-season."*

Language Access for Hispanic Community

- *"We need better language support for the Hispanic community... The language barrier is a huge obstacle for them in accessing mental health services."*

20XX

Thank you!
Q&A

Thank you!

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Appendix

Stress Level

	Male	Female	NA	Total
No stress level	228	167	72	467
Minimum stress level	630	433	211	1274
Moderate stress level	962	624	219	1805
Extreme/High stress level	410	256	95	761
Prefer not to answer	11	16	17	44

	Asian	Black or African American	Latino or Hispanic	Middle Eastern or North African	Native Hawaiian or Pacific Islander	White or Caucasian	Black + White	Other mixes	Latino + White	Prefer not to answer	Total
No stress level	12	80	17	6	6	248	86	1	1	3	467
Minimum stress level	51	310	58	10	11	674	107	5	16	5	1275
Moderate stress level	32	500	113	17	25	984	83	4	28	3	1807
Extreme/High stress level	6	198	24	2	9	463	31	6	12	3	762
Prefer not to answer	0	6	3	1	0	29	4	0	0	0	44

20XX

Overall mental health

	Male	Female	NA	Total
Excellent	381	241	96	718
Good	905	562	229	1696
Average	625	459	174	1258
Poor	253	165	70	488
Terrible	68	51	30	149
Prefer not to answer	9	18	15	42

	Asian	Black or African American	Latino or Hispanic	Middle Eastern or North African	Native Hawaiian or Pacific Islander	White or Caucasian	Black + White	Other mixes	Latino + White	Prefer not to answer
Excellent	13	155	38	1	11	399	63	1	18	4
Good	43	410	79	7	18	947	136	8	20	1
Average	36	360	64	10	12	675	65	2	9	8
Poor	8	120	31	6	8	258	38	4	9	1
Terrible	1	43	2	1	2	92	4	1	1	0
Prefer not to answer	0	6	1	0	0	27	5	0	0	0

20XX

Stress Management

Q4_Gender	Strongly agree	Agree	Neither agree nor disagree	Disagree	Strongly disagree	Prefer not to answer	Total
Male	412	1117	352	267	78	15	2241
Female	288	676	275	164	72	21	1496
NA	130	277	93	65	34	15	614

Q5_Race	Strongly agree	Agree	Neither agree nor disagree	Disagree	Strongly disagree	Prefer not to answer	Total
Asian	2	57	16	8	0	0	101
Black or African American	1	7	2	0	0	0	12
Latino or Hispanic	0	2	0	0	0	0	4
Middle Eastern or North African	0	0	0	0	0	0	9
Native Hawaiian or Pacific Islander	0	0	0	0	0	0	5
White or Caucasian	3	2	0	0	0	1	32
American Indian or Alaska Native	175	310	119	40	40	6	1094
Black & White	568	97	31	10	10	2	215
Latino & White	186	58	113	17	17	5	36
Black & Latino	4	2	0	0	0	0	51
Asian & White	399	947	284	110	110	27	2398
American Indian & White	63	136	32	10	10	5	311
American Indian & Black	1	5	2	1	1	0	16
Other mixes	1	5	2	1	1	0	57
Prefer not to answer	1	4	2	5	0	0	14

20XX

Emotional Support

Q4_Gender	Always	Most of the time	About half the time	Sometimes	Seldom	Never	Prefer not to answer	Total
Male	340	705	441	485	203	61	6	2241
Female	209	449	310	346	114	56	12	1496
NA	101	168	128	148	46	17	6	614
Total	650	1322	879	979	363	134	24	4351

Race	Always	Most of the time	About half the time	Sometimes	Seldom	Never	Total
Asian	0	19	9	0	4	0	101
Black or African American	2	39	4	1	9	2	12
Latino or Hispanic	3	23	1	8	9	1	880
Middle Eastern or North African	2	15	1	8	4	0	979
Native Hawaiian or Pacific Islander	3	10	10	3	0	0	363
White or Caucasian	0	369	28	4	0	0	135
American Indian or Alaska Native	15	473	7	3	9	0	4
Black & White	5	525	3	1	8	0	135
Latino & White	0	204	1	0	7	0	979
Black & Latino	0	86	2	0	4	0	363
Asian & White	1	722	473	525	135	0	979
American Indian & White	1	525	28	4	9	0	135
American Indian & Black	0	204	7	3	8	0	135
Other mixes	1	86	3	1	7	0	979
Prefer not to answer	0	2	4	2	4	2	24

20XX

Needed but didn't get the support

Q4_Gender	No	Yes	Prefer not to answer	Total
Male	706	1499	36	2241
Female	478	960	58	1496
NA	179	407	28	614
Total	1363	2866	122	4351

Q5_Race	No	Yes	Prefer not to answer	Total
Asian	39	61	1	101
Black or African American	2	10	0	12
Latino or Hispanic	2	3	0	4
Middle Eastern or North African	2	7	1	9
Native Hawaiian or Pacific Islander	1	3	0	5
White or Caucasian	9	20	3	32
American Indian or Alaska Native	297	776	21	1094
Black & White	58	148	9	215
Latino & White	0	0	0	0
Black & Latino	1	0	0	1
Asian & White	779	1542	77	2398
American Indian & White	118	185	8	311
American Indian & Black	5	11	0	16
Other mixes	16	41	0	57
Prefer not to answer	4	9	1	14
Total	1364	2869	122	4355

20XX

Rely for Help

Q4_Gender	Always	Most of the time	About half the time	Sometimes	Seldom	Never	Prefer not to answer	Total
Male	306	697	421	552	178	75	12	2241
Female	221	428	308	356	123	50	10	1496
NA	105	177	120	134	40	26	12	614
Total	632	1302	849	1042	341	151	34	4351

Q5_Race	Always	Most of the time	About half the time	Sometimes	Seldom	Never	Prefer not to answer	Total
Asian	29	39	18	8	6	1	0	101
Black or African American	1	6	2	2	1	0	0	12
Latino or Hispanic	2	2	0	0	0	0	0	4
Middle Eastern or North African	1	5	2	2	0	0	0	9
Native Hawaiian or Pacific Islander	0	1	3	3	0	0	0	5
White or Caucasian	0	1	0	1	0	0	0	32
American Indian or Alaska Native	147	310	288	298	94	32	5	1094
Black & White	29	59	49	51	17	8	2	215
Latino & White	0	1	3	4	1	0	0	9
Black & Latino	2	6	3	5	1	0	1	18
Asian & White	335	707	490	570	179	93	24	2398
American Indian & White	68	103	54	54	21	9	2	311
American Indian & Black	2	6	3	4	1	0	0	16
Other mixes	9	31	8	7	2	0	0	57
Prefer not to answer	1	2	4	5	1	1	0	14
Total	633	1303	849	1044	341	151	34	4355

20XX

Child Stress

Q4_Gender	Always	Most of the time	About half the time	Sometimes	Seldom	Never	Prefer not to answer	Total
Male	331	619	426	491	250	103	21	2241
Female	247	401	273	328	153	80	14	1496
NA	127	147	132	130	40	29	9	614
Total	705	1167	831	949	443	212	44	4351

Q5_Race	Always	Most of the time	About half the time	Sometimes	Seldom	Never	Prefer not to answer	Total
Asian	0	26	20	21	8	3	0	101
Black or African American	0	4	2	6	0	0	0	12
Latino or Hispanic	0	1	3	1	0	0	0	4
Middle Eastern or North African	0	4	3	1	0	0	0	9
Native Hawaiian or Pacific Islander	0	1	3	1	0	0	0	5
White or Caucasian	2	9	7	11	3	0	0	32
American Indian or Alaska Native	180	322	204	252	78	40	18	1094
Black & White	33	52	48	46	25	8	3	215
Latino & White	0	4	3	12	2	0	0	36
Black & Latino	0	4	3	10	9	0	0	51
Asian & White	361	639	431	520	292	134	21	2398
American Indian & White	68	68	74	62	21	16	2	311
American Indian & Black	5	4	3	2	1	1	0	16
Other mixes	13	22	11	7	2	1	0	57
Prefer not to answer	0	2	3	7	2	0	0	14
Total	706	1167	831	952	443	212	44	4355

20XX

Awareness

Q4_Gender	No	Yes	I do not know	Prefer not to answer	Total
Male	885	1202	132	22	2241
Female	559	795	113	29	1496
NA	215	316	60	23	614
Total	1659	2313	305	74	4351

Q5_Race	No	Yes	I do not know	Prefer not to answer	Total
Asian	30	65	6	0	101
Black + Latino/ Hispanic	4	4	0	0	12
Asian + White	0	0	0	0	4
American Indian + Black	3	5	1	0	9
American Indian + Black + White	3	2	0	0	5
Other mixes	9	17	5	0	32
Black or African American	476	507	100	11	1094
Latino or Hispanic	77	120	15	3	215
Middle Eastern or North African	0	2	3	0	36
Native Hawaiian or Pacific Islander	14	22	6	0	51
White or Caucasian	918	1301	130	49	2398
American Indian or Alaska Native	81	183	40	7	311
Latino/ Hispanic + White	4	11	0	1	16
Black + White	9	48	0	0	57
Prefer not to answer	8	3	3	0	14
Total	1661	2315	305	74	4355

20XX

Awareness & Stress Level

Q7_Stress Level	No	Yes	I do not know	Prefer not to answer	Total
No stress level	10	12	8	14	44
Minimum stress level	96	334	23	14	467
Moderate stress level	407	754	98	16	1275
Extreme/High stress level	763	911	114	19	1807
Prefer not to answer	385	304	62	11	762
Total	1661	2315	305	74	4355

20XX

Currently taking medication, receiving treatment, therapy, or counseling

Q4_Gender	No	Yes	Prefer not to answer	Total
Male	876	1330	35	2241
Female	614	846	36	1496
NA	234	352	28	614
Total	1724	2528	99	4351

Q5_Race	No	Yes	Prefer not to answer	Total
Asian	33	66	2	101
Black + Latino /Hispanic	3	9	0	12
Asian + White	2	2	0	4
American Indian + Black	1	8	0	9
American Indian + Black + White	4	1	0	5
Other mixes	14	17	1	32
Black or African American	464	608	22	1094
Latino or Hispanic	76	133	6	215
Middle Eastern or North African	16	20	0	36
Native Hawaiian or Pacific Islander	28	21	2	51
White or Caucasian	938	1400	60	2398
American Indian or Alaska Native	117	189	5	311
Latino/ Hispanic + White	7	9	0	16
Black + White	12	45	0	57
Prefer not to answer	11	2	1	14
Total	1726	2530	99	4355

20XX

Know Counseling

Q4_Gender	No	Yes	Prefer not to answer	Total
Male	584	1610	47	2241
Female	415	1040	41	1496
NA	198	387	29	614
Total	1197	3037	117	4351

Q5_Race	No	Yes	Prefer not to answer	Total
Asian	29	69	3	101
Black or African American	2	10	0	12
Latino or Hispanic	1	2	1	4
Middle Eastern or North African	0	9	0	9
Native Hawaiian or Pacific Islander	0	5	0	5
White or Caucasian	14	16	2	32
American Indian or Alaska Native	336	727	31	1094
Black & White	62	142	11	215
Latino & White	16	20	0	36
Black & Latino	18	30	3	51
Asian & White	596	1742	60	2398
American Indian & White	108	198	5	311
American Indian & Black	4	12	0	16
Other mixes	6	51	0	57
Prefer not to answer	5	8	1	14
Total	1197	3041	117	4355

20XX

Perceived Stigma	No	Yes	Prefer not to answer	Total
Strongly agree	133 (3.05%)	831 (19.08%)	11 (0.25%)	**975 (22.39%)**
Agree	454 (10.42%)	1,450 (33.29%)	20 (0.46%)	**1,924 (44.18%)**
Neither agree nor disagree	254 (5.83%)	423 (9.71%)	23 (0.53%)	**700 (16.07%)**
Disagree	227 (5.21%)	205 (4.71%)	25 (0.57%)	**457 (10.49%)**
Strongly disagree	147 (3.37%)	82 (1.88%)	14 (0.32%)	**243 (5.58%)**
Prefer not to answer	19 (0.44%)	26 (0.60%)	11 (0.25%)	**56 (1.29%)**
Total	**1,234 (28.34%)**	**3,017 (69.28%)**	**104 (2.39%)**	**4,355 (100%)**

20XX

Q23: Current Stress Level	Content and able to cope	Occasional mood fluctuations	Frequently overwhelmed	Severe challenges	Prefer not to answer	Total
Feeling relaxed and at ease	8	14	10	24	12	68
Occasional stress, managing well	581	238	75	48	14	956
Consistently overwhelmed and tense	344	1073	347	128	20	1912
Unable to cope with daily life	91	282	565	123	20	1081
Prefer not to answer	29	51	124	109	25	338

20XX

Q23 (Current Stress)	Male	Female	NA	Total
Feeling relaxed	26	20	22	68
Occasional stress	504	318	133	955
Consistently overwhelmed	973	683	255	1911
Unable to cope	577	344	159	1080
Prefer not to answer	161	131	45	337

Race	Feeling relaxed	Occasional stress	Consistently overwhelmed	Unable to cope	Prefer not to answer	Total
Asian	29	41	29	2	0	101
Black or African American	193	493	303	81	24	1094
Latino or Hispanic	58	83	59	11	4	215
Middle Eastern or North African	0	4	1	0	0	5
Native Hawaiian or Pacific Islander	10	19	14	6	2	51
White or Caucasian	505	1065	592	205	31	2398
Black + White	113	126	49	17	6	311
Latino + White	3	8	2	2	1	16
Black + Latino	24	23	7	3	0	57
Asian + White	3	8	2	2	1	12
American Indian + White	1	4	0	0	0	9
American Indian + Black	0	4	6	1	0	32
Other mixes	10	4	1	1	0	32
Prefer not to answer	2	3	5	4	0	14

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Q24	Male	Female	NA	Total
I feel generally content and able to cope with life's challenges.	552	361	139	1052
I experience occasional fluctuations in mood but overall manage well.	873	571	213	1657
I frequently feel overwhelmed or distressed and struggle to cope with daily life.	563	396	160	1119
I am experiencing severe mental health challenges and require immediate assistance.	214	136	82	432
Prefer not to answer	39	32	20	91

Race	I feel generally content and able to cope with life's challenges.	I experience occasional fluctuations in mood but overall manage well	I frequently feel overwhelmed or distressed and struggle to cope with daily life.	I am experiencing severe mental health challenges and require immediate assistance.	Prefer not to answer	Total
Asian	23	35	32	9	2	101
Black or African American	3	5	4	4	2	12
Black + White	1	2	0	1	0	4
30-34 years	0	0	1	0	0	9
Other mixes	0	0	0	0	0	5
Latino or Hispanic	230	434	297	114	19	1094
White or Caucasian	54	76	65	18	2	215
Native Hawaiian or Pacific Islander	2	11	5	5	0	36
American Indian or Alaska Native	0	1	2	1	0	51
Asian + White	558	933	611	238	58	2398
Prefer not to answer	4	4	5	1	0	14

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Sleep quality & Nervousness	Rarely	Yes, most of the time	Not at all	Sometimes	Prefer not to answer	Total
Rarely	198	340	41	437	18	1034
Yes, most of the time (nearly every day)	243	278	94	287	10	912
Not at all	36	95	35	57	11	234
Sometimes	442	379	54	1232	13	2120
Prefer not to answer	11	15	10	12	7	55

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Association between feeling nervous/anxious & how much anxiety impacts daily functioning

	No	Yes	Prefer not to answer	Total
Rarely	600	399	35	1034
Most of the time (nearly every day)	126	769	17	912
Not at all	162	50	22	234
Sometimes	672	1419	29	2120
Prefer not to answer	21	18	16	55
Total	1581	2655	119	4355

20XX

Sleep Quality & Anxiety Impact

Q25	No	Yes	Prefer not to answer	Total
Rarely	254	649	27	930
Yes, most of the time (nearly every day)	517	568	22	1107
Not at all	66	146	22	234
Sometimes	725	1265	35	2025
Prefer not to answer	19	27	13	59

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Anxiety & Emotional Health

Anxiety level based on impacts emotional health	Rarely	Most of the time (nearly every day)	Not at all	Sometimes	Prefer not to answer	Total
No	644	107	162	649	19	1581
Yes	451	611	71	1511	11	2655
Prefer not to answer	30	18	27	33	11	119

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Emotional Impact & Ability to Manage Daily Life

	No	Yes	Prefer not to answer	Total
Rarely	682	416	27	1125
Most of the time	118	608	10	736
Not at all	167	73	20	260
Sometimes	691	1476	26	2193
Prefer not to answer	14	17	10	41

20XX

ALL ABOARD A Healthy COMMUNITY!

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Do you have feedback to share on the Community Health Needs Assessment or process?

Scan the QR code or visit: darenc.gov/HCOB

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County of Dare Department of Health & Human Services

Outer Banks Health™

02.25.2025