# NORTH CAROLINA HEALTH DISPARITIES

## ANALYSIS REPORT • 2024

NC DEPARTMENT OF
HEALTH AND
HUMAN SERVICES
Office of Health Equity

# DEDICATION

**For those who find pieces of themselves reflected within these pages: may we walk arm in arm on this journey together, with courage, joy, resilience, and love.**

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# MESSAGE FROM GOVERNOR

September 5, 2024

In recent years, North Carolina has made remarkable efforts to expand the opportunities for North Carolinians to live healthier, more abundant, and purposeful lives. Our ongoing commitment to reducing health disparities and ensuring positive health outcomes for all North Carolinians is evident in these efforts.

Thanks to the collaborative efforts of the North Carolina Department of Health and Human Services, elected leaders, and tireless community advocates, we enacted Medicaid Expansion in December 2023. In the nine months since, more than 500,000 North Carolinians gained coverage to access health care providers, prescriptions, and other services. Communities across the state continue to experience the life-changing impacts of Medicaid expansion as more than a million prescriptions and counting have been covered for things like heart health, diabetes, seizures, and other illnesses. This significant progress underscores our state's dedication to equitable health care access and improving health outcomes for everyone.

Additionally, I am glad to announce the successful enactment of my administration's Roadmap for $1 Billion in Behavioral Health and Resilience Investments. This is a significant achievement, with our state securing an investment of $835 million for behavioral health thanks to Medicaid expansion. This investment is a testament to our commitment to mental health and resilience, and it is a step toward building a stronger North Carolina where everyone has an opportunity to live in safe, vibrant and healthy communities.

This report provides information about where we need to continue to focus our efforts. We have a real opportunity to continue capitalizing on our historic investments in health. We must close health gaps among population groups that have existed for far too long. In partnership with NCDHHS and partners statewide, we are honored to serve and promote the health of all North Carolinians.

Sincerely,

Governor Roy Cooper

# MESSAGE FROM SECRETARY KINSLEY

September 5, 2024

Imagine for a moment that you are at the airport about to board a plane. You recall reading somewhere that planes flying from Raleigh to Orlando often crash. Other routes are great – landing safely, on-time, and with free ginger ale. While the flight you are about to board is not flying from Raleigh to Orlando, you are now worried about boarding any plane. The failure of one route has undermined your confidence in the entire airline system. The airline industry learned this lesson some time ago – that when one single flight has an issue, ridership and trust in the broader industry falls fast. That's why airlines don't compete on issues of safety and instead work collaboratively to improve quality for the whole system.

Our mission is to improve the health and wellbeing of **all** North Carolinians. And a health system that fails some, fails us all.

When rural North Carolinians experience rates of heart disease higher than their urban relatives – we must look at access to healthy food and transportation and whether primary care services are within reach. When African American/Black mothers die one and a half times as often from causes related to pregnancy than white mothers, we must look to solutions like doulas, group pre-natal care, and getting women insured and in care long before they become pregnant. There are longstanding disparities for certain people – African/American/Black, Rural, American Indian, Hispanic/Latinx, People Experiencing Poverty, Women. We must measure and focus on where the systems of care and support too often fall behind for our fellow North Carolinians.

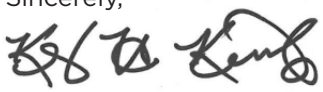
This report aims to track our progress toward the goal of improving the health and wellbeing of all North Carolinians by carefully measuring where gaps exist among different groups or communities. Whether it's a higher rate of cardiovascular disease among rural communities or more cases of unmanaged diabetes among African American/Black North Carolinians – we must act. To reduce disparities, we must address whole person health through both medical and non-medical drivers of health, including physical, behavioral and social health.

This commitment to whole-person health for all begins with the NCDHHS Strategic Plan (2024-2026) and is expanded here in the Health Disparities Report. Decreasing health disparities begins with data; and collecting and utilizing data from populations that have been historically marginalized throughout our state helps to identify, monitor, and address the needs of these communities. We are dedicated to using and sharing this data to decrease disparities in service delivery, engagement efforts, and health outcomes related to physical, behavioral, and social health. We are also committed to creating a statewide support system for public and private sector innovation so that all North Carolinians have the opportunity for good health.

While we have made strides in this important work through Medicaid expansion and historic investments in behavioral health and well-being, there is still work to do. The following report identifies six key categories of health disparities across our state as well as strategies to address and improve them going forward.

Everyone has a role in reducing health disparities and advancing health equity in their own communities and beyond. Together, we can eliminate these disparities and ensure all North Carolinians have the opportunity for health, as we champion whole-person health for all.

Sincerely,



Secretary Kody Kinsley | NC Department of Health and Human Services

# EXECUTIVE SUMMARY: KEY HEALTH DISPARITIES IN NORTH CAROLINA

## NCDHHS' Commitment to Reducing Health Disparities

- **NCDHHS Strategic Plan (2024-2026):** Our goal is a healthy state where the needs of all North Carolinians are met. The North Carolina Department of Health and Human Services (NCDHHS) is committed to removing disparities (differences) and promoting whole-person health.
- **Whole-Person Health:** We aim to reduce disparities by addressing medical factors and non-medical drivers of health like food, housing, transportation, utilities, stress and personal safety through an innovative, coordinated system.
- **Statewide Framework:** We are creating a statewide support system for public and private sector innovation to ensure that all North Carolinians have good health opportunities.
- **Data Use:** We collect, use and share data to identify, analyze and address disparities in service delivery, outreach and health outcomes, particularly for groups that have been historically marginalized (groups that have not been offered the same opportunities as others) in North Carolina.

## Key Successes

### LAUNCHED MEDICAID EXPANSION

- In December 2023, North Carolina started Medicaid Expansion, which aims to provide health care coverage to about 600,000 people.
- In the first nine months, nearly 500,000 people enrolled and more than one million prescriptions were covered. This fast enrollment pace connects many people to health care.
- One of the most powerful tools a state can use to reduce health disparities is Medicaid Expansion. States with Medicaid Expansion have reductions in infant mortality rates and disparities between Black and White babies.[1]

### MAKING HISTORIC INVESTMENTS IN HEALTH AND WELL-BEING

- We have secured $835 million for behavioral health*, including $208.9 million for child and family well-being and $1.56 billion for a strong and inclusive workforce to be implemented in 2024.
- This funding will improve our crisis system, support justice-involved populations, improve the direct care (caregiving) workforce, and increase access to behavioral health care for adults and children.
- Child behavioral health investments will help prevent children from staying in inappropriate settings (such as Social Service offices, emergency departments, or other unsuitable facilities) and provide additional supports for their families.
- These investments include funds for maternal care and increasing Medicaid provider reimbursements.

### LEADING THE NATION IN INNOVATIVE APPROACHES TO WHOLE-PERSON HEALTH

- North Carolina is a leader in whole-person health — the coordination of physical, behavioral and social health services.
- In 2022, NC Medicaid started the Healthy Opportunities Pilot — the first program of its kind in the country — to see how providing non-medical assistance related to food, housing, utilities, transportation, and help with violence and stress affects people's health.
- The latest evaluation of the Healthy Opportunities Pilots showed that the more social and non-medical needs are met, the fewer the hospital visits and lower the health care costs. Independent research found the state saved about $85 per month in medical costs for each program participant.

*The American Medical Association defines behavioral health as "mental health and substance use disorders, life stressors and crises, and stress-related physical symptoms. Behavioral health care refers to the prevention, diagnosis and treatment of those conditions."

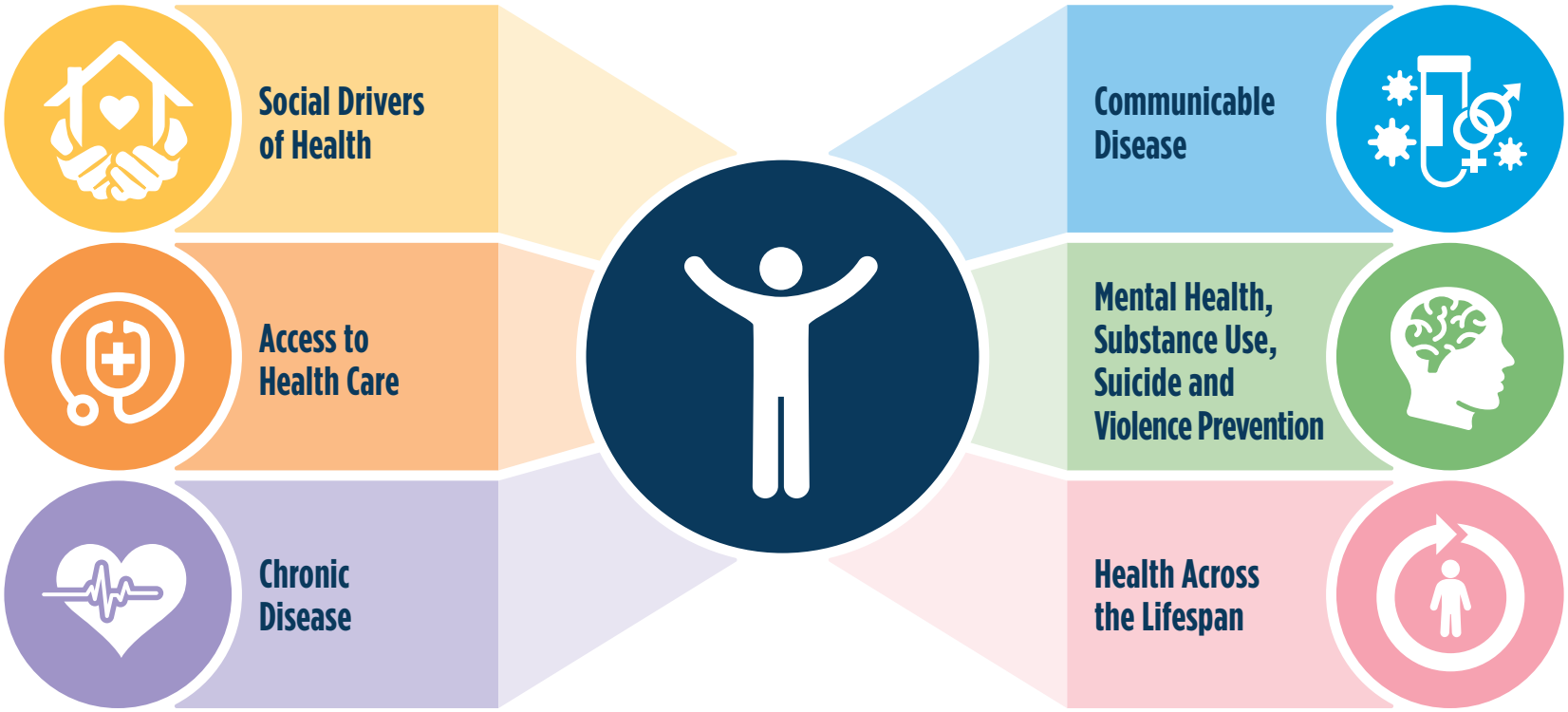
## COMMUNITY AND PARTNER ENGAGEMENT INITIATIVE

- We recently started our Community and Partner Engagement Initiative, which includes a website to highlight the impact of people and organizations that engage with NCDHHS' systems, services, programs and policies.
- This initiative promotes collaboration and engagement across NCDHHS and its partners.
- We focus on individual and community voices through listening sessions, data collection and partnership engagement.
- We also coordinate efforts within NCDHHS and use inclusive strategies to increase the impact of work that addresses health disparities.

## This Report Identifies Six Key Categories in Health Disparities:

1. Social Drivers of Health
2. Access to Health Care
3. Chronic Disease
4. Communicable Disease
5. Mental Health, Substance Use, Suicide and Violence Prevention
6. Health Across the Lifespan

### VISUAL 1: THE SIX KEY CATEGORIES IN HEALTH DISPARITIES



# Health Disparities Overview — Key Category Findings

**1. Social Drivers of Health**

- African American/Black, American Indian and Hispanic/Latinx* populations face higher levels of poverty, unemployment, high housing costs and low home ownership. These economic factors contribute to poor health outcomes.
- Millions of North Carolinians have limited access to opportunities for physical activity, nutritious foods and safe housing, which can negatively impact their health.
- Groups that have been historically marginalized are more likely to face these and other social conditions that can negatively impact health. These groups include people defined by race, ethnicity, location, income, health status, disability status, incarceration and more.

**2. Access to Health Care**

- African American/Black, American Indian, Hispanic/Latinx and people with disabilities have less access to health care and cannot afford quality health care as easily as White people and those without disabilities.
- Immigrants, farmworkers and the LGBTQ+ population also face health care access disparities.
- People who live in rural areas also have less access to health care providers established in their communities.

**3. Chronic disease**

- Chronic (long-term) diseases are a major cause of early death in North Carolina. Lack of health care, unhealthy behaviors, environmental conditions and social drivers of health are some of the factors that contribute to chronic disease disparities.
- African American/Black, American Indian, Hispanic/Latinx and people with disabilities have higher rates of chronic diseases and deaths.
- Despite progress, significant disparities remain in chronic diseases like cancer (prostate, stomach, pancreatic, multiple myeloma, cervical, liver), stroke, diabetes, chronic obstructive pulmonary disease, kidney disease, liver disease and heart disease for the populations described above.

**4. Communicable Disease**

- African American/Black, American Indian, Multiracial and Hispanic/Latinx populations have higher rates of communicable diseases like syphilis and HIV.
- LGBTQ+ populations, young people and people who use substances also experience higher rates of communicable diseases.
- Communicable diseases are still a concern for people at higher risk of more serious diseases, like people with chronic illnesses, people with disabilities, older adults or people who are immunocompromised.

**5. Mental Health, Substance Use, Suicide and Violence Prevention**

The following groups are most affected by mental and behavioral health disparities. Adverse experiences, financial struggles, ongoing hardships, lack of access to care and other factors may contribute to these disparities.

- Youth
- Justice-involved populations
- People experiencing housing insecurity
- African American/Black, American Indian, Hispanic/Latinx and Asian populations
- Rural communities
- Active military and veterans
- People with disabilities
- LGBTQ+ individuals

**6. Health Across the Lifespan**

- Maternal mortality rates are increasing and disparities persist. Differences in health and social conditions, access to health care, and racism and bias in the health care system contribute to disparities.
- Infant mortality rates remain high and disparities persist. African American/Black, American Indian as well as Multiracial infants have higher death rates compared to other populations. Infants within these population groups also have higher rates of low birth weight and being born too early.
- These families need a lot of support because of the rising cost of child care and limited availability of child care. They need help meeting basic needs like food and housing and accessing

*The term “Latinx” is meant to include all people of Latino heritage, no matter their gender. “Latine” can be used interchangeably, too.

services for children with special health care needs, including mental, behavioral or developmental conditions.

- Families in rural areas have less access to supportive resources.
- Adults aged 65 and more are also at risk for several health disparities, including higher rates of injury and falls, chronic diseases, disabilities and limited income.

## Call to Action

- This report focuses on highlighting the significant disparities and proposes collective actions to reduce gaps and eliminate these disparities for identified population groups. NCDHHS has identified several collaborative efforts and policy frameworks to guide our actions. For specific actions, refer to Healthy NC 2030 and other strategic plans and initiatives detailed in the report.
- Everyone can contribute to reducing health disparities. We have outlined recommended actions for all types of partners throughout this report. Connect with NCDHHS to learn more!

## Executive Summary: Priority Disparities and Priority Populations

- The selected key categories and indicators are based on:
    1. Their relevance to complete, whole-person and population health.
    2. The size of the health gaps between different population groups.
    3. The burden of disease or outcome.
    4. The opportunity and right circumstances to reduce disparities.
    5. Community input.
- Disparity ratios compare rates between populations (Rate A divided by Rate B, the reference group) for a specific health indicator. This ratio determines how much more likely an event is to occur in one population compared to another. A ratio of 1.0 indicates no difference (no disparity), while a ratio greater than 1.0 indicates a disparity (e.g., a ratio of 2.0 means the rate for population A is twice that of population B).

## TABLE 1: EXECUTIVE SUMMARY TABLE

| | METRICS/INDICATORS | PRIORITY POPULATIONS | DISPARITY RATIO | SOURCE |
|---|---|---|---|---|
| 1. Social Drivers of Health | **Adults age 25+ with a Bachelors Degree** | American Indian | 2.69 | SCHS North Carolina Resident Population Health Data by Race and Ethnicity 2017-2021 |
| | | Hispanic/Latinx | 2 | SCHS North Carolina Resident Population Health Data by Race and Ethnicity 2017-2021 |
| | **Unemployment** | African American/Black | 2 | SCHS North Carolina Resident Population Health Data by Race and Ethnicity 2017-2021 |
| | **Poverty All Ages** | African American/Black | 2.17 | SCHS North Carolina Resident Population Health Data by Race and Ethnicity 2017-2021 |
| | | American Indian | 2.49 | SCHS North Carolina Resident Population Health Data by Race and Ethnicity 2017-2021 |
| | | Hispanic/Latinx | 2.41 | SCHS North Carolina Resident Population Health Data by Race and Ethnicity 2017-2021 |
| | **Child Poverty (below age 18)** | African American/Black | 3.06 | SCHS North Carolina Resident Population Health Data by Race and Ethnicity 2017-2021 |
| | | American Indian | 3.07 | SCHS North Carolina Resident Population Health Data by Race and Ethnicity 2017-2021 |
| | | Hispanic/Latinx | 2.97 | SCHS North Carolina Resident Population Health Data by Race and Ethnicity 2017-2021 |
| | **Poverty of Elderly (age 65+)** | African American/Black | 2.1 | SCHS North Carolina Resident Population Health Data by Race and Ethnicity 2017-2021 |
| | | American Indian | 2 | SCHS North Carolina Resident Population Health Data by Race and Ethnicity 2017-2021 |
| 2. Access to Health Care | **Uninsured** | American Indian | 2.1 | SCHS North Carolina Resident Population Health Data by Race and Ethnicity 2017-2021 |
| | | Hispanic/Latinx | 3.89 | SCHS North Carolina Resident Population Health Data by Race and Ethnicity 2017-2021 |
| | | Hispanic/Latinx with a disability | 6.82 | CDC Disability and Health Data System 2021 |
| | **Did not see a provider because of cost** | Below 200% of the FPL | ~5.2 | SCHS BRFSS Results 2021 |
| | | Hispanic/Latinx | 2.08 | SCHS BRFSS Results 2021 |
| | | African American/Black with a disability | 3.63 | CDC Disability and Health Data System 2021 |
| | | White with a disability | 3.06 | CDC Disability and Health Data System 2021 |
| | | Multiracial with a disability | 2.51 | CDC Disability and Health Data System 2021 |
| | | Hispanic/Latinx with a disability | 4.24 | CDC Disability and Health Data System 2021 |
| 3. Chronic Disease | **Stomach Cancer Incidence** | African American/Black | 2.02 | SCHS North Carolina Resident Population Health Data by Race and Ethnicity 2017-2021 |
| | **Multiple Myeloma Incidence** | African American/Black | 2.5 | SCHS North Carolina Resident Population Health Data by Race and Ethnicity 2017-2021 |
| | **Prostate Cancer Mortality** | African American/Black | 2.3 | SCHS North Carolina Resident Population Health Data by Race and Ethnicity 2017-2021 |

| | METRICS/INDICATORS | PRIORITY POPULATIONS | DISPARITY RATIO | SOURCE |
|---|---|---|---|---|
| 3. Chronic Disease (Continued) | **Stomach Cancer Mortality** | African American/Black | 2.3 | Data provided by State Center for Health Statistics |
| | | Hispanic/Latinx | 2.25 | Data provided by State Center for Health Statistics |
| | **Multiple Myeloma Mortality** | African American/Black | 2.18 | Data provided by State Center for Health Statistics |
| | **Diabetes Mortality** | African American/Black | 2.2 | SCHS North Carolina Resident Population Health Data by Race and Ethnicity 2017-2021 |
| | **Nephritis, nephrosis, and nephrotic syndrome (kidney disease) mortality** | African American/Black | 2.5 | SCHS North Carolina Resident Population Health Data by Race and Ethnicity 2017-2021 |
| | **Adults who have ever had heart disease** | African American/Black with a disability | 4.17 | CDC Disability and Health Data System 2021 |
| | | White with a disability | 3.93 | CDC Disability and Health Data System 2021 |
| | **Adults who have ever had diabetes** | African American/Black with a disability | 3.38 | CDC Disability and Health Data System 2021 |
| | | Hispanic/Latinx with a disability | 3.33 | CDC Disability and Health Data System 2021 |
| | | Multiracial with a disability | 2.13 | CDC Disability and Health Data System 2021 |
| | | White with a disability | 2.28 | CDC Disability and Health Data System 2021 |
| | **Adults who have ever had a stroke** | White with a disability | 3.56 | CDC Disability and Health Data System 2021 |
| | | African American/Black with a disability | 6.38 | CDC Disability and Health Data System 2021 |
| | **Adults who have ever had COPD** | White with a disability | 3.05 | CDC Disability and Health Data System 2021 |
| | | African American/Black with a disability | 3.68 | CDC Disability and Health Data System 2021 |
| 4. Communicable Disease | **Newly Diagnosed Adult/Adolescent HIV Infection Cases** | African American/Black | 8.21 | SCHS North Carolina Resident Population Health Data by Race and Ethnicity 2017-2021 |
| | | American Indian | 2.7 | SCHS North Carolina Resident Population Health Data by Race and Ethnicity 2017-2021 |
| | | Multiracial | 3.6 | SCHS North Carolina Resident Population Health Data by Race and Ethnicity 2017-2021 |
| | | Hispanic/Latinx | 5.08 | SCHS North Carolina Resident Population Health Data by Race and Ethnicity 2017-2021 |
| | **Newly Diagnosed Adult/Adolescent AIDS Infection Cases** | African American/Black | 8.05 | SCHS North Carolina Resident Population Health Data by Race and Ethnicity 2017-2021 |
| | | American Indian | 3.05 | SCHS North Carolina Resident Population Health Data by Race and Ethnicity 2017-2021 |
| | | Multiracial | 7.2 | SCHS North Carolina Resident Population Health Data by Race and Ethnicity 2017-2021 |
| | | Hispanic/Latinx | 3.85 | SCHS North Carolina Resident Population Health Data by Race and Ethnicity 2017-2021 |
| | **HIV Mortality** | African American/Black | 8.8 | SCHS North Carolina Resident Population Health Data by Race and Ethnicity 2017-2021 |

| | METRICS/INDICATORS | PRIORITY POPULATIONS | DISPARITY RATIO | SOURCE |
|---|---|---|---|---|
| 4.Communicable Disease (Continued) | **Newly Diagnosed Primary and Secondary Syphilis** | African American/Black | 6.98 | SCHS North Carolina Resident Population Health Data by Race and Ethnicity 2017-2021 |
| | | American Indian | 2.33 | SCHS North Carolina Resident Population Health Data by Race and Ethnicity 2017-2021 |
| | | Multiracial | 5.63 | SCHS North Carolina Resident Population Health Data by Race and Ethnicity 2017-2021 |
| | | Hispanic/Latinx | 3.06 | SCHS North Carolina Resident Population Health Data by Race and Ethnicity 2017-2021 |
| | **Newly Diagnosed Chlamydia** | African American/Black | 5.89 | SCHS North Carolina Resident Population Health Data by Race and Ethnicity 2017-2021 |
| | | American Indian | 2.89 | SCHS North Carolina Resident Population Health Data by Race and Ethnicity 2017-2021 |
| | | Multiracial | 2.29 | SCHS North Carolina Resident Population Health Data by Race and Ethnicity 2017-2021 |
| | | Hispanic/Latinx | 2.78 | SCHS North Carolina Resident Population Health Data by Race and Ethnicity 2017-2021 |
| | **Newly Diagnosed Gonorrhea** | African American/Black | 10.01 | SCHS North Carolina Resident Population Health Data by Race and Ethnicity 2017-2021 |
| | | American Indian | 4.28 | SCHS North Carolina Resident Population Health Data by Race and Ethnicity 2017-2021 |
| | | Multiracial | 2.41 | SCHS North Carolina Resident Population Health Data by Race and Ethnicity 2017-2021 |
| | **Newly Diagnosed Acute Hepatitis B** | Rural | 2.29 | Data Provided by Communicable Disease Branch |
| | **Newly Diagnosed Acute Hepatitis C** | American Indian | 2.13 | Data Provided by Communicable Disease Branch |
| | **Newly Reported Chronic Hepatitis B** | African American/Black | 2.82 | Data Provided by Communicable Disease Branch |
| | | American Indian | 2.11 | Data Provided by Communicable Disease Branch |
| | | Asian/Pacific Islanders | 16.44 | Data Provided by Communicable Disease Branch |
| 5. Mental Health, Substance Use, Suicide and Violence Prevention | **Total Drug Overdose Deaths** | American Indian | 2.24 | Opioid and Substance Use Action Plan Data Dashboard |
| | **Overdose Emergency Department Visits** | American Indian | 2 | Data provided by Injury and Violence Prevention Branch |
| | **Acute Alcohol Related Mortality** | American Indian | 2.29 | Data provided by Injury and Violence Prevention Branch |
| | **Homicide** | African American/Black | 7 | Data provided by Injury and Violence Prevention Branch |
| | | American Indian | 5.9 | Data provided by Injury and Violence Prevention Branch |
| | | Hispanic/Latinx | 2 | Data provided by Injury and Violence Prevention Branch |
| | **Assault Hospitalizations** | African American/Black | 3.6 | Data provided by Injury and Violence Prevention Branch |
| | | American Indian | 3.5 | Data provided by Injury and Violence Prevention Branch |
| | **Assault Emergency Department Visits** | African American/Black | 2.2 | Data provided by Injury and Violence Prevention Branch |

| | METRICS/INDICATORS | PRIORITY POPULATIONS | DISPARITY RATIO | SOURCE |
|---|---|---|---|---|
| 5. Mental Health, Substance Use, Suicide and Violence Prevention (Continued) | **Firearm-Related Deaths** | African American/Black | 2.1 | Data provided by Injury and Violence Prevention Branch |
| | | American Indian | 2.3 | Data provided by Injury and Violence Prevention Branch |
| | **Firearm-Related Hospitalizations** | African American/Black | 7.3 | Data provided by Injury and Violence Prevention Branch |
| | | American Indian | 3.7 | Data provided by Injury and Violence Prevention Branch |
| | **Firearm-Related Emergency Department Visits** | African American/Black | 5.8 | Data provided by Injury and Violence Prevention Branch |
| | | American Indian | 4.8 | Data provided by Injury and Violence Prevention Branch |
| 6. Health Across the Lifespan | **Maternal Mortality** | African American/Black | 1.6 | Maternal Mortality Report |
| | **Infant death Rate (per 1,000 births)** | African American/Black | 2.6 | SCHS North Carolina Resident Population Health Data by Race and Ethnicity 2017-2021 |
| | | American Indian | 2 | SCHS North Carolina Resident Population Health Data by Race and Ethnicity 2017-2021 |
| | **Low birthweight (<=2500 grams) Births (%)** | African American/Black | 2.1 | SCHS North Carolina Resident Population Health Data by Race and Ethnicity 2017-2021 |
| | **Infant Not Breastfed at Discharge (%)** | American Indian | 3 | SCHS North Carolina Resident Population Health Data by Race and Ethnicity 2017-2021 |
| | **Maternal Smoking during Pregnancy (%)** | American Indian | 2.1 | SCHS North Carolina Resident Population Health Data by Race and Ethnicity 2017-2021 |
| | **Teen Birth Rate (Ages 15-19)** | African American/Black | 2 | SCHS North Carolina Resident Population Health Data by Race and Ethnicity 2017-2021 |
| | | American Indian | 2.9 | SCHS North Carolina Resident Population Health Data by Race and Ethnicity 2017-2021 |
| | | Multiracial | 2.1 | SCHS North Carolina Resident Population Health Data by Race and Ethnicity 2017-2021 |
| | | Hispanic/Latinx | 2.8 | SCHS North Carolina Resident Population Health Data by Race and Ethnicity 2017-2021 |
| | **Child Mortality** | American Indian | 2.1 | SCHS North Carolina Resident Population Health Data by Race and Ethnicity 2017-2021 |
| | | African American/Black | 1.9 | SCHS North Carolina Resident Population Health Data by Race and Ethnicity 2017-2021 |
| | **Unintentional Fall Deaths** | Adults 65+ | 5.1 | Data provided by Injury and Violence Prevention Branch |
| | **Traumatic Brain Injury (TBI) Deaths** | Adults 65+ | 2.3 | Data provided by Injury and Violence Prevention Branch |
| | **Total Injury Hospitalizations** | Adults 65+ | 2.8 | Data provided by Injury and Violence Prevention Branch |
| | **Unintentional Fall Hospitalizations** | Adults 65+ | 4.5 | Data provided by Injury and Violence Prevention Branch |
| | **TBI Hospitalizations** | Adults 65+ | 2.8 | Data provided by Injury and Violence Prevention Branch |
| | **Unintentional Fall Emergency Department Visits** | Adults 65+ | 2.6 | Data provided by Injury and Violence Prevention Branch; NC Detect Unintentional Falls Dashboard |

*Race/ethnicity minorities are compared to the White population. People with disabilities (of any race/ethnicity, including white) are compared to the white population with no disabilities. Populations below 200% of the Federal Poverty Level are compared to those above 200% of the Federal poverty Level. The rural population is compared to the urban population.

# INTRODUCTION

## Purpose

The North Carolina Health Disparities Analysis Report aims to:

1. Highlight the most significant health disparities recognized by the North Carolina Department of Health and Human Services as opportunities to reduce disparities over the next three to five years.
2. Provide measures and a starting point to track the state's progress in eliminating health gaps experienced by populations that have been historically marginalized.
3. Describe the services, programs and resources dedicated to addressing identified disparities by NCDHHS.
4. Emphasize actionable strategies to reduce health disparities and seek solutions.

## Who This Report Is For

This document offers current data and recommendations based on evidence to assist:

- Community-based organizations
- Faith-based organizations
- State, local and tribal governments
- Local health departments
- Health systems
- Community and rural health centers
- State agencies
- Decision makers
- Local businesses
- Communities

These entities can use the information to develop strategies to address health disparities and to improve the health outcomes of all North Carolinians.

## About the Data

This North Carolina Health Disparities Report includes data from many sources. The **key indicators** were chosen based on:

1. Their relevance to complete, whole-person and population health
2. The size of the health gaps between different population groups
3. The burden of disease or outcome
4. The opportunity and right circumstances to reduce disparities
5. Community input

Most health outcomes are not a direct result of race, ethnicity, geography, income, gender, sexuality, disability status, immigration status, occupation or culture. They are the result of meaningful differences in **access** and **opportunity across these dimensions**, which are shaped by systems, policies and institutions across history and a person's life.

This report uses disparity ratios. **Disparity ratios** compare rates between populations (Rate A divided by Rate B, the reference group) for a specific health indicator. This ratio determines how much more likely an event is to occur in one population compared to another. A ratio of 1.0 indicates no difference (no disparity), while a ratio greater than 1.0 indicates a disparity. For example, a ratio of 2.0 means the rate for population A is twice that of population B. Reference groups in this report are the White, Non-Hispanic population.

Disparity ratios are helpful for comparing health outcomes between two groups. This report uses the 'four-fifths rule' to identify notable disparities. For instance, if the ratio is higher than 1.25, it means there is a noticeable disparity in results that we need to focus on. For more details on specific measurements, please see the original data source.

CATEGORY 1:
# SOCIAL DRIVERS OF HEALTH

Your background, including your education, job and how much money you make, affects your health. Education, career and income influences where you live, what kind of food you can afford, and what kind of resources you can pay for, such as a gym membership or health copays. It can also influence how easily you understand information about your health and how others see you.

Many factors influence how healthy people are. Some communities in North Carolina have a lot of resources that help people stay healthy. Other communities do not have enough money, services and healthy environments to support good health for the people living there.

Our everyday surroundings have a big impact on our health: where we live, learn, grow, play and pray. It makes a big difference whether families can access quality health care, nutritious food and neighborhoods with safe outdoor spaces for activities. All of this impacts our overall health.

## Education Disparities by Race and Ethnicity

### TABLE 2: EDUCATION

| | TOTAL POP. | RACE/ETHNICITY | | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | WHITE NON-HISPANIC | AFRICAN AMERICAN/BLACK, NON-HISPANIC | | | AMERICAN INDIAN, NON-HISPANIC | | | ASIAN/PACIFIC ISLANDER, NON-HISPANIC | | | MULTIRACIAL, NON-HISPANIC | | | HISPANIC/LATINX | | |
| | Rate | Rate | Rate | Disparity Ratio Grade Indicates severity of disparity | Disparity Ratio African American/Blacks X times less likely than white population | Rate | Disparity Ratio Grade Indicates severity of disparity | Disparity Ratio American Indians X times less likely than white population | Rate | Disparity Ratio Grade Indicates severity of disparity | Disparity Ratio Asian/Pacific Islanders X times less likely than white population | Rate | Disparity Ratio Grade Indicates severity of disparity | Disparity Ratio Multiracials X times less likely than white population | Rate | Disparity Ratio Grade Indicates severity of disparity | Disparity Ratio Hispanic/Latinx X times less likely than white population |
| High School Graduation Rate, 2021-2022 (1) | 86.4 | 89.9 | 83.4 | A | 1.08 | 85.3 | A | 1.05 | * | * | * | 83.5 | A | 1.08 | 80.2 | A | 1.08 |
| Adults Ages 25+ with High School Diploma or GED, 2021 (2) | 89.7 | 93.1 | 88.4 | A | 1.05 | 78.4 | A | 1.19 | 87.9 | A | 1.06 | 91.2 | A | 1.02 | 64.5 | B | 1.39 |
| Adults Ages 25+ with Bachelor's Degree, 2021 (2) | 21.7 | 24.5 | 15.3 | B | 1.60 | 9.1 | D | 2.69 | 29.8 | A | 0.82 | 20.7 | A | 1.18 | 12.2 | B | 1.78 |

References: (1) NC Department of Public Instruction. The North Carolina Four-Year Cohort Graduation Rate reflects the percentage of ninth graders (cohort) who graduated from high school four years later. Rates for "other races" include Asians and Multi-race categories. Refer to: http://accrpt.tops.ncsu.edu/app/2022/cgr/ for further information. • (2) 2021 American Community Survey Single-Year Estimates: Table S0201: Selected Population Profile for North Carolina. • Data Provided by State Center for Health Statistics, Minority Health Report 2023

**KEY**
(Disparity ratio grades indicate the severity of the health difference between population groups. It is not indicative of the severity of the health topic or problem as a whole.)

| Disparity Grade (color) | A (dark blue) | B (pale blue) | C (yellow) | D (pink) | F (red) |
|---|---|---|---|---|---|
| Disparity Ratio | 0.0 - 1.24 | 1.25 - 1.9 | 2.0 - 2.4 | 2.5 - 2.9 | ≥ 3.0 |
| Meaning | Little or no disparity. | A disparity exists, should be monitored and may require intervention. | The disparity requires intervention. | Major interventions are needed. | Significant interventions are needed. |

Education is about the opportunities people have to learn and develop important skills like critical thinking, social abilities, emotional skills and physical development. This includes all levels of education from programs for infants and toddlers up through graduate degrees after college. Getting quality education and having good access to it can lead to many positive effects on health.

People with more education typically know more about healthy behaviors, feel empowered to make informed choices and are more likely to develop healthy habits. Achieving higher education levels or specialized job training usually means better access to good job opportunities, health care and other resources. Improving access to quality education in communities gives people the tools they need to make healthier choices and live healthier lives. This helps make the whole community happier and healthier.[2]

Adults with more education also live healthier and longer lives.[3] In North Carolina, high school graduation rates are similar across all racial and ethnic groups. However, Hispanic/Latinx and African American/Black populations are about 1.5 times less likely to have a bachelor's degree (a 4-year college degree) compared to the White, non-Hispanic population. This gap is even wider for American Indians, who are 2.7 times less likely to have a college degree than White, non-Hispanic individuals (see Table 2).

In the United States, nearly 70% of African American/Black children still go to schools where most of the students are from groups of color. They are also more likely than White students to attend high-poverty schools with fewer resources.[4] African American/Black children are also two-to-three times more likely to be suspended from school, starting as early as preschool. Inconsistent discipline actions influenced by bias can make school harder and less welcoming for Black children and cause them to miss more school days and achieve less.

In North Carolina, in 2015 and 2016, 47% of preschool children were suspended once and 73% of those suspended more than once were Black.[5] There are also differences in how North Carolina public schools are funded. This leads to unequal access to well-paid teachers, additional staff, support services and better facilities.[6]

The chance for children to achieve a higher standard of living than their parents is still lowest for African American/Black children.[7]

Immigrant children also face unique barriers to education. About 55,000 students in North Carolina public schools are immigrants.[8] In 2021, it was reported that 270,000 students in North Carolina public schools spoke a primary language other than English at home, with a total of 334 different languages spoken. In 2022, North Carolina public schools had 146,141 English learners, and 20% of children ages 0-17 had a foreign-born parent.[9] Putting more money in bicultural and bilingual workforce education and language access in school, like interpreters, translations, staff that speaks two languages, signs in different languages and digital communication, can help meet the needs of students and families and help them succeed at school.

# Income and Unemployment Disparities by Race and Ethnicity

## TABLE 3: ECONOMIC STATUS

| | TOTAL POP. | RACE/ETHNICITY | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | WHITE NON-HISPANIC | AFRICAN AMERICAN/BLACK, NON-HISPANIC | | | AMERICAN INDIAN, NON-HISPANIC | | | ASIAN/PACIFIC ISLANDER, NON-HISPANIC | | | MULTIRACIAL, NON-HISPANIC | | | HISPANIC/LATINX | | |
| | Rate | Rate | Rate | Disparity Ratio Grade Indicates severity of disparity | Disparity Ratio | Rate | Disparity Ratio Grade Indicates severity of disparity | Disparity Ratio | Rate | Disparity Ratio Grade Indicates severity of disparity | Disparity Ratio | Rate | Disparity Ratio Grade Indicates severity of disparity | Disparity Ratio | Rate | Disparity Ratio Grade Indicates severity of disparity | Disparity Ratio |
| Median Household Income, 2021 | $61,972 | $69,704 | $42,885 | B | 1.63 | $36,977 | B | 1.89 | $103,556 | A | 0.67 | $60,164 | A | 1.16 | $53,880 | B | 1.29 |
| Unemployed, 2021 | 3.5 | 2.8 | 5.6 | C | 2 | 4.2 | B | 1.5 | 3.3 | A | 1.18 | 4.6 | B | 1.64 | 4.0 | B | 1.43 |
| Living in a Home they own, 2021 (2) | 66.9 | 75.2 | 47.0 | B | 1.6 | 65.0 | A | 1.16 | 66.4 | A | 1.13 | 58.8 | B | 1.28 | 51.7 | B | 1.5 |
| Housing Costs >= 30% of Household Income, 2021 (2) | 23.9 | 21.6 | 33.2 | B | 1.54 | 32.7 | B | 1.51 | 18.6 | A | 0.86 | 24.3 | A | 1.13 | 29.7 | B | 1.38 |

References: 2021 American Community Survey Single-Year Estimates: Table S0201: Selected Population Profile for North Carolina. • Data Provided by State Center for Health Statistics, Minority Health Report 2023

African Americans/Blacks are two times more likely to be unemployed than White non-Hispanics. American Indians, Asian/ Pacific Islanders, Multiracial people and Hispanic/Latinx people are also more likely to be unemployed than White non-Hispanics (see Table 3).

The COVID-19 pandemic had a big impact on people in North Carolina. Our state saw a quick drop in jobs but recovered faster than in past recessions. In 2022, the unemployment rate in North Carolina was 3.7%.[10]

Looking into the future, the North Carolina Department of Commerce predicts an increase in 445,000 new jobs from 2021 through 2030, mainly coming from the service-providing sector. The health care and social assistance sector, the largest part of North Carolina's economy, is expected to add the most jobs (76,000).[11]

**KEY**

(Disparity ratio grades indicate the severity of the health difference between population groups. It is not indicative of the severity of the health topic or problem as a whole.)

| Disparity Grade (color) | A (dark blue) | B (pale blue) | C (yellow) | D (pink) | F (red) |
|---|---|---|---|---|---|
| Disparity Ratio | 0.0 - 1.24 | 1.25 - 1.9 | 2.0 - 2.4 | 2.5 - 2.9 | ≥ 3.0 |
| Meaning | Little or no disparity. | A disparity exists, should be monitored and may require intervention. | The disparity requires intervention. | Major interventions are needed. | Significant interventions are needed. |

# Poverty Disparities by Race and Ethnicity

## TABLE 4: POVERTY

| | TOTAL POP. | RACE/ETHNICITY | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | WHITE NON-HISPANIC | AFRICAN AMERICAN/BLACK, NON-HISPANIC | | | AMERICAN INDIAN, NON-HISPANIC | | | ASIAN/PACIFIC ISLANDER, NON-HISPANIC | | | MULTIRACIAL, NON-HISPANIC | | | HISPANIC/LATINX | | |
| | Rate | Rate | Rate | Disparity Ratio Grade Indicates severity of disparity | Disparity Ratio African American/Blacks X times more likely than white population | Rate | Disparity Ratio Grade Indicates severity of disparity | Disparity Ratio American Indians X times more likely than white population | Rate | Disparity Ratio Grade Indicates severity of disparity | Disparity Ratio Asian/Pacific Islanders X times more likely than white population | Rate | Disparity Ratio Grade Indicates severity of disparity | Disparity Ratio Multiracials X times more likely than white population | Rate | Disparity Ratio Grade Indicates severity of disparity | Disparity Ratio Hispanic/Latinx X times more likely than white population |
| Poverty Rate - All Ages, 2021 | 13.4 | 9.5 | 20.6 | C | 2.17 | 23.7 | C | 2.49 | 8.3 | A | 0.87 | 14.4 | B | 1.52 | 22.9 | C | 2.41 |
| Poverty Rate - Children Under 18 Years, 2021 | 18.1 | 9.9 | 30.3 | F | 3.06 | 30.4 | F | 3.07 | 7.3 | A | 0.74 | 16.4 | B | 1.66 | 29.4 | D | 2.97 |
| Poverty Rate - Older Adults Ages 65+ Years, 2021 | 10.2 | 8.3 | 17.4 | C | 2.10 | 16.6 | C | 2.00 | 12.8 | B | 1.54 | 13.3 | B | 1.60 | 14.8 | B | 1.78 |

References: 2021 American Community Survey Single-Year Estimates: Table S0201: Selected Population Profile for North Carolina. • Data Provided by State Center for Health Statistics, Minority Health Report 2023

Economic stability means having enough money and resources to get basic needs like good housing, transportation, health care and healthy food. We can improve this stability by creating more job opportunities for parents, people with disabilities and others, making life better for families. It can also be improved by providing better access to community resources, like housing vouchers and food support. This matters a lot for a community's health because when people can afford or access the resources they need for everyday life, they are healthier.[12]

Poverty indicators show the worst disparities for the economic well-being of North Carolinians (see Table 4):

- American Indian (3.07), African American/Black (3.06) and Hispanic/Latinx (2.97) children are about three times more likely to experience poverty than White children.
- African American/Black (2.1), American Indian (2.0) and Hispanic/Latinx (1.78) adults aged 65 and older are about two times more likely to experience poverty than White older adults.
- African American/Black (2.17), American Indian (2.49) and Hispanic/Latinx (2.41) of all ages are more than two times as likely to experience poverty than Whites.

## SOCIAL AND COMMUNITY CONTEXT

Social and community context refers to our surroundings and how we interact with family, friends, coworkers and community members. These interactions can be protective factors (they are good for health and safety) because they promote healthy behaviors and well-being. But these interactions can also be risk factors (they are bad for health and safety) if they cause physical or emotional harm. Being socially connected can protect us from disease and improve our well-being.[13]

**KEY**

(Disparity ratio grades indicate the severity of the health difference between population groups. It is not indicative of the severity of the health topic or problem as a whole.)

| Disparity Grade (color) | A (dark blue) | B (pale blue) | C (yellow) | D (pink) | F (red) |
|---|---|---|---|---|---|
| Disparity Ratio | 0.0 - 1.24 | 1.25 - 1.9 | 2.0 - 2.4 | 2.5 - 2.9 | ≥ 3.0 |
| Meaning | Little or no disparity. | A disparity exists, should be monitored and may require intervention. | The disparity requires intervention. | Major interventions are needed. | Significant interventions are needed. |

One important part of economic and social development for North Carolina is increased internet access. Internet access helps businesses be more productive and profitable, provides better access to government services, improves education, makes health care easier to access, improves public safety, supports working and getting health care online, helps people with disabilities, revitalizes communities and makes the way we use energy more efficient.[14]

## HOUSING

African American/Black (1.54), American Indian (1.51) and Hispanic/Latinx (1.38) households are more likely to spend over 30% of their household income on housing costs than White non-Hispanic households. African American/Black (1.6), Hispanic/Latinx (1.5) and multiracial (1.28) individuals or families are less likely to own a home (see Table 3).

Many Black households (29.3%) and Latinx households (26.1%) spend more than half of their income on housing.[15] Housing access is also affected by income, limited savings, rising expenses, and lack of legal and financial documents. This impacts both renters and owners. Finding housing is hard for people of color, people with disabilities and people with lower incomes.

Getting affordable and safe housing in neighborhoods with many resources can lead to a healthier life. People living in housing in wealthier areas have better access to fresh food, health care, outdoor places for recreation, gyms, and schools with more resources and funding. Permanent supported housing offers affordable long-term housing and voluntary, tailored support services for people with disabilities. North Carolina's Strategic Housing Plan guides efforts and decisions about resources to create and maximize community-based housing for identified populations in the coming years.

To reduce health disparities, we need to support communities of color financially, invest in all neighborhoods, view housing as a human right and create housing resources for people with disabilities.

## NEIGHBORHOOD CONDITIONS

Neighborhoods are places where people live, work, play and pray. A safe and healthy neighborhood has good access to healthy food, places to exercise like sidewalks and parks, less crime due to lights and maintenance, safe and affordable homes, and accessible transportation like bike lanes, public transportation and upkept roads. This is also called the "*built environment*."[16]

In North Carolina:

- 75% of people have easy access to places for physical activity, like living near a park or recreation center.[17]
- We rank sixth out of ten on the healthy food environment index, which measures access to healthy foods and food security (having reliable access to food).[18]
- 8% of people are low-income and do not live close to a grocery store.[19]
- 12% of people do not have enough access to food.[20]
- Over 1.6 million North Carolinians live in a food desert (area with limited access to affordable and nutritious food) and 47% of them are people of color.[21]
- 14% of households face at least one housing issue like overcrowding, high housing costs, lack of kitchen facilities or lack of plumbing facilities.[22]

In North Carolina, there is a State Action Plan for Nutrition Security that focuses on three key strategies:

1. Expanding nutrition programs
2. Connecting services that support people with health care and nutrition
3. Improving the Special Supplemental Nutrition Program for Women, Infants and Children program (WIC)

North Carolina is also working on a plan to sign up more people for more than one program. This initiative aims to find people and households already enrolled in programs like Supplemental Nutrition Assistance Program (SNAP), WIC or Medicaid who qualify for another program but are not yet enrolled. Many individuals who receive benefits from one program are usually eligible to receive benefits from multiple other programs.[23]

Community-based services are also crucial in addressing food insecurity. For instance, in 2023, the Food Bank of Central and Eastern North Carolina provided $89.6 million worth of food obtained and distributed from a central location, which equaled 677,000 meals for children. It also secured $4.6 million in SNAP benefits for the families they served in 2023.[24]

# Environmental Conditions

Considering environmental conditions is also important. Environmental health examines how human health is affected by factors in our surroundings. This includes pollutants and hazards in soil, air and water, as well as issues like climate change.

Some communities face more environmental hazards than others, which can harm health. Typically, communities with lower incomes or predominantly made up of people of color are more vulnerable to these hazards. This disparity often results from disinvestment in these areas and intentional decisions to place waste and pollutants there, which is reinforced by structural racism.[25]

Some communities in North Carolina are more prone to natural disasters as well. These include hurricanes that impact coastal areas, flooding in western regions, tornadoes and other environmental factors that can affect people's health.[26] The ability of these communities to endure and recover from natural disasters depends, in part, on their access to political, financial and social resources.

For example, farmworkers face unique challenges when recovering from natural disasters. Tornadoes and hurricanes often occur during the growing and harvesting seasons of North Carolina crops. Most farmworkers do not qualify for unemployment benefits or paid time off. Farmworker wages are low and the inability to work because of natural disasters reduces their low wages even more. The assistance that the Federal Emergency Management Agency (FEMA) provides is only available for people with U.S. citizenship, legal permanent residency and qualified immigration status.[27]

In North Carolina, there are several important leaders and initiatives in environmental health:

1. The North Carolina Department of Environmental Quality has an environmental justice program.
2. The Division of Public Health's Environmental Health Branch works across several service areas to ensure a safe and healthy environment for North Carolinians.
3. Many local health departments have branches focused on environmental health.
4. The North Carolina Environmental Health Data Dashboard provides updated indicators related to environmental justice issues.
5. Grassroots-driven networks like the North Carolina Environmental Justice Network focus on climate and environmental justice issues.

These leaders and networks play critical roles in promoting environmental justice, monitoring environmental health and advocating for community well-being across North Carolina.

## HEALTH LITERACY

Health literacy refers to how well individuals can find, understand and use information about health to make decisions for themselves and others. It is crucial for communicating with health care providers, understanding medication instructions, side effects and warnings and giving informed consent.

North Carolina ranks 41st in the United States for lowest health literacy. Older adults, populations that have been historically marginalized and people with paid lower incomes are particularly likely to face challenges with health literacy.[28]

## METRICS FOR FUTURE CONSIDERATION:

Currently, there is a need for readily available, standardized indicators that capture social drivers of health. These indicators would provide demographic data and highlight disparities in different populations. More detailed population-level data on social drivers of health could guide future policies and programs aimed at reducing disparities, especially information about neighborhood conditions as well as social and community contexts.

Examples of metrics could include:

- Density of tobacco and alcohol retailers and related advertising (currently under development)
- Availability of green spaces and parks
- Access to opportunities for recreation
- Access to nutritious foods, such as densities of grocery stores and farmers markets
- Walkability scores
- Presence of substandard housing
- Access to affordable housing

# SUCCESS SPOTLIGHT:
# HEALTHY OPPORTUNITIES PILOTS

The Healthy Opportunities Pilots (HOP) in North Carolina are designed to evaluate the impact of providing non-medical interventions to high-needs Medicaid enrollees. These interventions are based on evidence and include housing support, food assistance, transportation services, interpersonal safety measures and addressing toxic stress. Healthy Opportunities launched services in March 2022 in three predominantly rural regions of North Carolina, covering 33 counties. As of April 2024, over 385,000 Healthy Opportunities services have been delivered to over 22,682 Medicaid enrollees.

This program has been transformative, not only in connecting beneficiaries to whole-person care management, but also providing them with non-medical support. This includes access to housing navigation, nutritious foods and even vehicle repairs to increase access to reliable and safe transportation.

For local community-based organizations in North Carolina, the Healthy Opportunities Pilots have been financially beneficial, with reimbursements totaling over $33 million so far. This predictable funding has enabled these organizations to expand their operations and increase their capacity to serve more people across the state.

Preliminary findings from independent evaluations also indicate promising results. The program has shown a reduction in medical costs of approximately $85 per beneficiary per month. Participants have also experienced fewer emergency department visits and hospitalizations. Moreover, the program has contributed to reducing food insecurity, housing instability and transportation barriers among enrollees. Further, the findings showed that the longer a person was enrolled in the pilots the greater the cost savings and reduction of risk.

The following is just one example of the impact of this program:

Dawn Verret of western North Carolina lost her job at the beginning of the pandemic and then was hospitalized in November 2020 for malnutrition and neuropathy. In June 2022, she was hospitalized again for pneumonia.

Her health plan sent a caseworker to visit her mobile home outside of Asheville. The caseworker saw the conditions that Dawn was living in and recommended her for the Healthy Opportunity Pilot (HOP) in her area.

Dawn, who had not been able to take a full shower since she was in the hospital, was able to have her deteriorating bathroom renovated and covered by HOP. After the project was complete, Dawn said, “I really believe that I’m gonna be able to take care of myself and get stronger because I feel like I’m my best self... You have no idea what being able to take a shower every day does to your self-esteem.”

The Department has requested federal authority to expand the program statewide. For additional information about the program and its impact, please visit Healthy Opportunities Pilots | NCDHHS.

## TABLE 5: HOW YOU CAN PLAY A PART – SOCIAL DRIVERS OF HEALTH

| NCDHHS PARTNER | RECOMMENDED STRATEGIES |
|---|---|
| **Community-Based Organizations and Services** | Join NCDHHS networks and partnerships to amplify the impact of your services and programs that address social drivers of health. |
| **Faith-Based Organizations** | Offer mentoring opportunities to youth, including paying special attention to success in school. |
| **Governmental Agencies** | Develop affordable housing by using subsidies from many sources, including federal, state and local governments; financial institutions; and charitable foundations.<br>Make sure that materials promoting resources and opportunities are appropriate for different cultures and are available in many languages. |
| **Health Care Professionals and Organizations** | Screen patients to identify any social needs they may have and connect them with available resources. NCCARE360, a statewide closed-loop referral system, is one useful tool for referrals for all populations.<br>For patients covered by Medicaid, refer them to the Healthy Opportunities Pilots program through care management. |
| **Advocates, Decision Makers and System Changers** | Increase minimum wage in North Carolina.<br>Offer incentives for companies to expand businesses to North Carolina to create good paying jobs.<br>Require communities to have certain percentages of affordable housing.<br>Increase funding for housing and urban development and offer incentives to landlords who accept it.<br>Expand the Healthy Opportunities Pilots statewide.<br>NC SHIP 2023 proposes these policy initiatives:<br>• Expand access to higher educational opportunities<br>• Expand transit options in rural and low-income communities<br>• Improve access to personal finance credit scores<br>• Increase access to broadband internet<br>• Pass fair chance hiring policies for county and local employees, and work with employers to adopt fair chance hiring policies for themselves<br>• Shift funding from industrial recruitment to support small businesses and social enterprises<br>• Promote employment initiatives like Competitive Integrated Employment and Employment First for people with disabilities, veterans and people in recovery or reentry to encourage their full inclusion in community life.<br>• Develop legislation and advocate with employers to provide paid family medical leave, earned paid sick leave, kin care and safe days for all caregivers<br>• Lengthen phase-out periods to mitigate the negative impact of "benefits cliffs" resulting from reductions in benefits<br>• Eliminate taxation on sanitary products like menstrual supplies, diapers and breastfeeding supplies<br>• Increase the availability and amount of child care subsidies to better align with the actual cost of child care<br>• Raise the minimum wage to $15 per hour<br>• Restore the North Carolina Earned Income Tax Credit<br>• Support "early college while in high school" programs, like REaCH and SEarCH |
| **Business and Industry** | Pay workers a fair wage that aligns with the cost of living in your area. |

CATEGORY 2:

# ACCESS TO HEALTH CARE

Access to health care is an important part of reducing disparities. When thinking about disparities in terms of health care, it is important to consider both access and quality.

**Access:**

1. Do you have health, dental and vision insurance?
2. Do your insurance plans cover everything you need?
3. Do you have high co-pays or deductibles?
4. Can you afford to see primary care and specialist providers?
5. Can you afford prescription medications?
6. Are there enough primary and specialized providers in your community?
7. Do your providers accommodate any disabilities you may have?
8. Are there providers in your community that share your race, ethnicity, language, culture or other valued traits?
9. How far do you have to travel to see a provider?
10. Do you have a quality vehicle or transit system to get you to health care appointments?

**Quality:**

1. Is your provider familiar with your culture or identity?
2. Does your provider use your preferred language?
3. Does your provider offer on-site interpretation services or rely on technological interpretation?
4. Does your provider offer you explanations and materials that you can understand?
5. Is your provider friendly to persons who identify as LGBTQ+, have a disability or come from a population that has been historically marginalized (HMP)?
6. How long does it take to get an appointment?
7. How easy is it to set up an appointment?
8. Do you feel safe, respected and valued when you are in a health care setting?
9. Does your provider consider whole-person health and well-being?

## TABLE 6: ACCESS TO HEALTH CARE

| | TOTAL POP. | RACE/ETHNICITY | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | WHITE NON-HISPANIC | AFRICAN AMERICAN/BLACK, NON-HISPANIC | | | AMERICAN INDIAN, NON-HISPANIC | | | ASIAN/PACIFIC ISLANDER, NON-HISPANIC | | | MULTIRACIAL, NON-HISPANIC | | | HISPANIC/LATINX | | |
| | Rate | Rate/% | Rate/% | Disparity Ratio Grade Indicates severity of disparity | Disparity Ratio African American/Blacks X times more likely than white population | Rate/% | Disparity Ratio Grade Indicates severity of disparity | Disparity Ratio American Indians X times more likely than white population | Rate/% | Disparity Ratio Grade Indicates severity of disparity | Disparity Ratio Asian/Pacific Islanders X times more likely than white population | Rate/% | Disparity Ratio Grade Indicates severity of disparity | Disparity Ratio Multiracials X times more likely than white population | Rate/% | Disparity Ratio Grade Indicates severity of disparity | Disparity Ratio Hispanic/Latinx X times more likely than white population |
| Uninsured, 2021(1) | 10.4 | 7.4 | 10.7 | B | 1.45 | 15.6 | C | 2.1 | 6.8 | A | 0.9 | 9.7 | B | 1.31 | 28.8 | F | 3.89 |
| Percent of adults who could not see a doctor in the previous 12 months due to cost (2021) (2) | 10.60% | 8.50% | 13.50% | B | 1.59 | 6.80% | A | 0.80 | * | * | * | 14.40% | B | 1.69 | 17.70% | C | 2.08 |

| | TOTAL POP. | SOCIOECONOMIC STATUS | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | >200% FPL | LESS THAN 50% OF FPL | | | 50%-100% OF FPL | | | 101-150% OF FPL | | | 151%-200% OF FPL | | | | |
| | Rate | Percentage | Percentage | Disparity Ratio Grade Indicates severity of disparity | Disparity Ratio <50% X times more likely than >200% FPL | Percentage | Disparity Ratio Grade Indicates severity of disparity | Disparity Ratio 50-100% X times more likely than >200% FPL | Percentage | Disparity Ratio Grade Indicates severity of disparity | Disparity Ratio 101-150% X times more likely than >200% FPL | Percentage | Disparity Ratio Grade Indicates severity of disparity | Disparity Ratio 151-200% X times more likely than >200% FPL | | |
| Uninsured, 2021(1) | 10.4 | * | * | * | * | * | * | * | * | * | * | * | * | * | | |
| Percent of adults who could not see a doctor in the previous 12 months due to cost (2021) (2) | 10.60% | 4.20% | 24.10% | F | 5.74 | 26% | F | 6.19 | 18.30% | F | 4.36 | 18.70% | F | 4.45 | | |

References: (1) Data Provided by State Center for Health Statistics, Minority Health Report 2023 • (2) BRFSS 2021 - North Carolina: Was there a time in the past 12 months when you needed to see a doctor but could not because you could not afford it?. N.C. State Center for Health Statistics. (2021). (https://schs.dph.ncdhhs.gov/data/brfss/2021/nc/all/medcost1.html) • Footnotes: Confidence intervals may or may not overlap. Use health disparity ratios cautiously, and refer to original data source for more information. FPL stands for Federal Poverty Level.

### KEY

(Disparity ratio grades indicate the severity of the health difference between population groups. It is not indicative of the severity of the health topic or problem as a whole.)

| Disparity Grade (color) | A (dark blue) | B (pale blue) | C (yellow) | D (pink) | F (red) |
|---|---|---|---|---|---|
| Disparity Ratio | 0.0 - 1.24 | 1.25 - 1.9 | 2.0 - 2.4 | 2.5 - 2.9 | ≥ 3.0 |
| Meaning | Little or no disparity. | A disparity exists, should be monitored and may require intervention. | The disparity requires intervention. | Major interventions are needed. | Significant interventions are needed. |

## Health Care Access Disparities by Race and Ethnicity

Hispanic/Latinx individuals are almost four times more likely to not have health insurance than White non-Hispanic populations. American Indians are twice as likely, African Americans/Blacks are about 1.5 times more likely, and Multiracial people are 1.3 times more likely to not have health insurance (see Table 6). Hispanics, African Americans/Blacks and Multiracial people are also more likely to not see a doctor because the financial cost is too high (see Table 6).

Many factors contribute to these disparities. People of color may be underrepresented in high paying jobs and employment that offers quality health insurance options. Other factors that are likely to contribute to these disparities are historical injustices about building generational wealth through employment and education, the rising costs of higher education, public schools that do not have enough resources, lack of higher paying jobs in certain geographical areas, and bias in job recruitment.

For the Hispanic/Latinx population, particularly immigrants, there are additional barriers to accessing health insurance. Challenges to obtaining health insurance may be not having legal documentation, facing language access barriers, fear and misinformation, cultural barriers and more. North Carolina also has a large farmworker population that is mostly Hispanic/Latinx. In 2017, there were about 80,000 migrant and seasonal* farmworkers in the state. Children as young as 10 may work in agriculture in North Carolina. Most of these workers have no health insurance and live at or below the federal poverty level.[29]

## Health Care Access Disparities by Income

The federal poverty level (FPL) is a measure of income that the U.S. Department of Health and Human Services sets each year. It is based on income and family size, and is used to determine eligibility for services and programs. In North Carolina, people and families who live at or below 200% of the federal poverty level are about five times more likely to avoid seeing a provider because of the cost compared to those who live above 200% of the federal poverty level (see Table 6).

For those with limited or no health insurance, or who cannot afford to see a provider even with insurance, there are community programs available. Examples include federally qualified health centers and free and charitable clinics, which are designed to help these vulnerable populations.

*Migrant farmworkers travel within the state or along the east coast to work in different fields and farms. Seasonal farmworkers live in the state all year and work agriculture on a seasonal basis.

# Health Care Access Disparities by Disability Status

## TABLE 7: ACCESS TO HEALTH CARE FOR PEOPLE WITH DISABILITIES

| | RACE/ETHNICITY FOR INDIVIDUALS WITH ANY DISABILITY | | | | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | WHITE, NON-HISPANIC, NO DISABILITY | WHITE, NON-HISPANIC, ANY DISABILITY | | | AFRICAN AMERICAN/ BLACK, NON-HISPANIC, ANY DISABILITY | | | AMERICAN INDIAN, NON-HISPANIC, ANY DISABILITY | | | ASIAN/PACIFIC ISLANDERS, NON-HISPANIC, ANY DISABILITY | | | MULTIRACIAL, NON-HISPANIC, ANY DISABILITY | | | HISPANIC/LATINX, ANY DISABILITY | | |
| | Rate | Rate | Disparity Ratio Grade Indicates severity of disparity | Disparity Ratio Whites X times more likely than white non disabled population | Rate | Disparity Ratio Grade Indicates severity of disparity | Disparity Ratio African American/Blacks X times more likely than white non disabled population | Rate | Disparity Ratio Grade Indicates severity of disparity | Disparity Ratio American Indians X times more likely than white non disabled population | Rate | Disparity Ratio Grade Indicates severity of disparity | Disparity Ratio Asian/Pacific Islanders X times more likely than white non disabled population | Rate | Disparity Ratio Grade Indicates severity of disparity | Disparity Ratio Multiracial X times more likely than white non disabled population | Rate | Disparity Ratio Grade Indicates severity of disparity | Disparity Ratio Hispanic/Latinx X times more likely than white non disabled population |
| % of adults who do not have health care coverage, 2021 | 6.50% | 9.90% | B | 1.52 | 7.70% | A | 1.18 | * | * | * | * | * | * | *Data Suppressed | * | * | 44.30% | F | 6.82 |
| % of adults who could not see a doctor due to cost in the past 12 months, 2021 | 6.30% | 19.30% | F | 3.06 | 22.90% | F | 3.63 | * | * | * | * | * | * | 15.80% | D | 2.51 | 26.70% | F | 4.24 |

Footnotes: Confidence intervals may or may not overlap. Use health disparity ratios cautiously, and refer to original data source for more information. • Data Source: Disability and Health Data System • References: Centers for Disease Control and Prevention. (n.d.-a). Disability and Health Data System (DHDS): North Carolina Barriers and Costs of Health care. Centers for Disease Control and Prevention. https://dhds.cdc.gov/SP?LocationId=37&CategoryId=BARRIER&ShowFootnotes=true&showMode=&IndicatorIds=CBARRIER%2CPROVIDER%2CINSURE&pnl0=Table%2Cfalse%2CYR6%2CDISSTAT%2C%2CRACE%2C%2CYESNO01%2CAGEADJPREV&pnl1=Chart%2Cfalse%2CYR6%2CDISSTAT%2C%2CRACE%2C%2CPROVIDER01%2CAGEADJPREV&pnl2=Table%2Cfalse%2CYR6%2CDISSTAT%2C%2CRACE%2C%2CYESNO02%2CAGEADJPREV

Disability is a natural part of life. There are many types of disabilities that can affect hearing, vision, thinking, learning, remembering, speaking, mobility, communication, social relationships and mental health. Disability can be present from birth or occur later because of injury, health conditions or aging. A disability can be visible or invisible, and range in severity. People with disabilities have very diverse experiences and backgrounds.

A person's environment affects the experience and extent of disability. People with disabilities may need accommodations, assistive devices, accessible spaces or additional supports to participate in everyday activities. Barriers like inaccessible spaces and lack of communication access can prevent full and equal participation in health care and health promotion activities, leading to health disparities.

The National Institutes of Health (NIH) recently identified people with disabilities as a group with health disparities. Health problems contribute to these disparities, but so do discrimination, unequal access and limited resources.[30]

**KEY**

(Disparity ratio grades indicate the severity of the health difference between population groups. It is not indicative of the severity of the health topic or problem as a whole.)

| Disparity Grade (color) | A (dark blue) | B (pale blue) | C (yellow) | D (pink) | F (red) |
|---|---|---|---|---|---|
| Disparity Ratio | 0.0 - 1.24 | 1.25 - 1.9 | 2.0 - 2.4 | 2.5 - 2.9 | ≥ 3.0 |
| Meaning | Little or no disparity. | A disparity exists, should be monitored and may require intervention. | The disparity requires intervention. | Major interventions are needed. | Significant interventions are needed. |

People with disabilities, no matter their race, are 2.5-4 times more likely to avoid seeing a doctor because of the cost compared to White people without disabilities. Hispanic/Latinx individuals with a disability are nearly seven times (6.82) more likely to not have health insurance when compared to White people without disabilities (see Table 7).

People with disabilities can be healthy and benefit from efforts to promote health and decrease health disparities. The North Carolina Olmstead Plan outlines strategies to ensure accessible and fair services in every community in North Carolina. The 2024-2025 North Carolina Olmstead Plan promotes the use and expansion of Medicaid waivers for those on waitlists. These waivers include:

1. The Innovations waiver for people with intellectual and developmental disabilities (I/DD)
2. The Traumatic Brain Injury (TBI) waiver
3. The Community Alternatives Program for Children (CAP/C) waiver for children who are medically fragile or complex
4. The Community Alternatives Program for Disabled Adults (CAP/DA) waiver for adults 18 and older who are medically fragile and need institutional care

NCDHHS also supports better data systems to track health disparities among people with disabilities and to use for surveillance.

## Health Care Access Disparities for Rural Areas

### TABLE 8: PRIMARY CARE PROVIDERS BY COUNTY

| COUNTY | PCP RATIO | COUNTY | PCP RATIO | COUNTY | PCP RATIO | COUNTY | PCP RATIO | COUNTY | PCP RATIO |
|---|---|---|---|---|---|---|---|---|---|
| Alamance | 2,557 | Chowan | 1,151 | Guilford | 1,257 | Mitchell | 1,653 | Rutherford | 2,236 |
| Alexander | 4,160 | Clay | 1,918 | Halifax | 2,151 | Montgomery | 4,540 | Sampson | 2,347 |
| Alleghany | 861 | Cleveland | 2,153 | Harnett | 3,704 | Moore | 915 | Scotland | 1,823 |
| Anson | 2,410 | Columbus | 3,042 | Haywood | 1,340 | Nash | 2,018 | Stanly | 2,750 |
| Ashe | 1,940 | Craven | 1,426 | Henderson | 1,139 | New Hanover | 1,106 | Stokes | 4,574 |
| Avery | 3,514 | Cumberland | 1,324 | Hertford | 1,444 | Northampton | 19,088 | Surry | 2, 048 |
| Beaufort | 2,354 | Currituck | 3,228 | Hoke | 5,075 | Onslow | 3,090 | Swain | 1,575 |
| Bertie | 6,237 | Dare | 1,976 | Hyde | 4,843 | Orange | 529 | Transylvania | 1,437 |
| Bladen | 4,702 | Davidson | 3,846 | Iredell | 1,376 | Pamlico | 3,179 | Tyrrell | |
| Brunswick | 2,293 | Davie | 2,164 | Jackson | 1,258 | Pasquotank | 1,615 | Union | 1,500 |
| Buncombe | 712 | Duplin | 4,523 | Johnston | 3,728 | Pender | 3,234 | Vance | 2,795 |
| Burke | 1,586 | Durham | 812 | Jones | 1,850 | Perquimans | 6,834 | Wake | 1,159 |
| Cabarrus | 1,197 | Edgecombe | 2,990 | Lee | 1,641 | Person | 2,662 | Warren | 19,522 |
| Caldwell | 2,219 | Forsyth | 863 | Lenoir | 2,064 | Pitt | 879 | Washington | 2,871 |
| Camden | 5,492 | Franklin | 11,977 | Lincoln | 2,098 | Polk | 1,618 | Watauga | 1,227 |
| Carteret | 1,449 | Gaston | 1,784 | Macon | 1,565 | Randolph | 2,158 | Wayne | 2,137 |
| Caswell | 5,611 | Gates | | Madison | 1,812 | Richmond | 4,030 | Wilkes | 2,617 |
| Catawba | 1,541 | Graham | 4,237 | Martin | 2,464 | Robeson | 2,321 | Wilson | 2,484 |
| Chatham | 1,067 | Granville | 2,016 | McDowell | 3,815 | Rockingham | 3,043 | Yadkin | 3,135 |
| Cherokee | 2,077 | Greene | 6,976 | Mecklenburg | 1,111 | Rowan | 2,545 | Yancey | 1,645 |

PCP Placement by County shows 2023 PCP ratios from County Health Rankings and the number of PCP providers placed in those counties. Red counties represent counties with PCP ratios at or higher than 1.500 to 1 ratio.

About 74 counties in North Carolina have a shortage of primary care providers, with a ratio greater than 1500 residents per primary care provider. This means that nearly 75% of counties in North Carolina lack enough primary care access.

## Health Care Access and Quality Disparities by Gender and Sexuality Identity

In North Carolina, about 4% of adults aged 18 and older, as well as 382,000 people aged 13 and older, are LGBTQ+ (Lesbian, Gay, Bisexual, Transgender and Queer/Questioning+).[31] The LGBTQ+ population is diverse in terms of race, ethnicity, gender and other demographics.

This population has unique health needs and requires care and attention that is culturally and socially appropriate. Like all the different population groups in this report, an LGBTQ+ identity itself is not a risk factor. Health disparities come from historical and current treatment of this group.

LGBTQ+ individuals in North Carolina face disparities in health access and quality.

From the largest survey conducted on LGBTQ+ health in the south, which had 927 participants, only 50% of LGBTQ+ individuals in North Carolina felt their health care needs were adequately met. Also, nearly 28% worried about losing their health care coverage.[32]

Loss of health care coverage concerned:

- 36% of Transgender individuals
- 43.3% of African American/Black LGBTQ+ individuals
- 54.5% of African American/Black transgender individuals

In North Carolina:

- 50.2% of non-Black LGBTQ+ respondents believed local doctors can provide adequate care for LGBTQ+ individuals, compared to 32.3% of Black LGBTQ+ respondents
- 41.1% of Black respondents reported that being LGBTQ+ always or often affects how medical professionals treat them, compared to 35.4% of non-Black respondents[33]

Transgender people in North Carolina reported:

- That 48% had to educate their medical providers about their LGBTQ+ identity
- That 41% experienced mistreatment
- That 56.3% waited to seek care because of their LGBTQ+ identity[34]

## Increasing Access to Health Care

With the launch of Medicaid Expansion in North Carolina in 2023, an estimated 600,000 North Carolinians became eligible for improved access to basic health care. Medicaid Expansion went into effect on December 1, 2023. As of early July, North Carolina has enrolled 500,000 eligible individuals and has seen high enrollment rates among rural and African American/Black populations.

NCDHHS also has strong community partners that do important work regionally and locally. NCDHHS works with safety net programs, rural health centers, federally qualified health centers and local health departments to deliver low-cost care to North Carolinians. For example, North Carolina has 91 counties with three areas that lack health professionals: primary care, dental care and mental/behavioral health care.[35]

As urban areas grow and become more diverse, rural areas face challenges in expanding access to resources and retaining health care professionals. This makes it difficult for most North Carolinians to access adequate health care.

The Office of Rural Health's Community Health Program ensures low-income and vulnerable residents, including those who are uninsured, underinsured and covered by Medicare or Medicaid, can access affordable and appropriate high-quality care. This is done in partnership with Area Health Education Centers (AHEC), Federally Qualified Health Centers (FQHC), free and charitable clinics, hospital-owned primary care clinics, non-profit organizations, public health departments, rural health clinics and school-based centers.

## SUCCESS SPOTLIGHT:
# RICHMOND COUNTY HEALTHY CAROLINIANS PARTNERSHIP — MEDICAID REGION 5 (OFFICE OF RURAL HEALTH)

Richmond County Healthy Carolinians Partnership is doing something right in their community after serving more people than expected through their Medical Access Plan (MAP). MAP funds are distributed to State Designated Rural Health Centers to provide primary care services to under and uninsured people. At the end of their first quarter in 2023, MAP usage was at 60%, far higher than their expected 25% usage at that point in time.

Beth Blaise, the Rural Health Operations Specialist who works alongside Richmond, was very excited about their progress. "Richmond has really put the work in within the last year to reach their community and to serve those in need."

Cheryl Speight, director of the Richmond County Health Department, said this about the accomplishment: "Part of our success with getting numbers increased has been our staff looking at each patient we (meet) as someone with underserved needs. We see many patients that have needs and they are not used to getting continuous medical care. Getting them in our clinic helps with continuity and after a while, they feel comfortable with us and start taking better care of themselves and keeping appointments."

### TABLE 9: HOW YOU CAN PLAY A PART – ACCESS TO HEALTH CARE

| NCDHHS PARTNER | RECOMMENDED STRATEGIES |
|---|---|
| **Community-Based Organizations and Services** | Seek funding and other resources to increase language access, like translations and interpretations. |
| **Faith-Based Organizations** | Help community members access health services, through application assistance, transportation, identifying resources and more. |
| **Governmental Agencies** | Expand support for community health workers.<br>Provide information that shows respect and understanding of different cultures (cultural competency), and make sure information is available in the languages spoken by the communities you serve when sharing resources and opportunities.<br>Gather qualitative data about people's experiences.<br>Improve, simplify and continue outreach for the enrollment process for Medicaid and other support services.<br>Like Rural Health Operations, reimburse clinics and providers who treat uninsured patients with incomes at or below 200% of the federal poverty line.<br>When delivering grants, establish a Community-Based Advisory Team to ensure equitable and inclusive grant distribution, supporting promising work. |

| NCDHHS PARTNER | RECOMMENDED STRATEGIES |
|---|---|
| **Health Care Professionals** | Gather qualitative data about people's experiences to better understand their past and present experiences with health care.<br>Address the social drivers of health and use a whole-person wellness approach.<br>Find ways to use computers and phones to give health care from a distance.<br>Give information and resources that show your organization understands and respects people from different cultures in the languages they speak.<br>Put up LGBTQ+ flags, wear pronoun pins and use visual messaging in your office to show that you welcome LGBTQ+ people.<br>Involve all staff in your organization to support and join activities that improve their understanding of different cultures and communities (cultural competency), learn the importance of being humble (humility training) and help them learn more about the health needs of underserved groups.<br>Work together with local and regional health and human service providers to develop and put into action strategies that will make it easier for underserved communities to get better services.<br>Teach staff about the needs of transgender and nonbinary people. |
| **Advocates, Decision Makers and System Changers** | Help get long-term, sustainable funding and investments for communities with fewer resources to make it easier to develop infrastructure to reduce health disparities, like clinic sites, medical equipment and more.<br>Become informed and support efforts that are scientific, effective and based on evidence to make Medicaid and other support systems better for children and adults who need specialty care, like gender affirming care.<br>Participate in yearly training about cultural competency and humility training that is specific to LGBTQ+ populations.<br>Make sure that your policies and practices create a welcoming, equitable and safe place for LGBTQ+ people.<br>NC SHIP 2023 proposes these policy initiatives:<br>• Assess the need for increasing and maintaining financial support for Community Health Workers<br>• Assess the need for maintaining health clinics for people without health insurance<br>• Redirect savings and excess funds from Medicaid transformation and expansion to fund programs for the uninsured, using health system community benefit programs<br>• Improve on-site health care provider training in rural communities<br>• Boost funding for programs that repay loans for health care providers<br>• Use Medicaid, including Medicaid Expansion to ensure the viability of all primary care clinicians in rural areas |
| **Business and Industry** | Use feedback from patient interviews and surveys to improve your work every year.<br>Set up or improve partnering with group of patients or beneficiaries who give advice to help improve how things work.<br>Make a strategic plan to address health disparities in your health care organization.<br>Make sure everyone in your health care organization gets health equity and cultural competency/humility training.<br>Create more chances for people with disabilities to find and keep jobs.<br>Make sure workplaces are accessible to all kinds of workers. |

# CATEGORY 3:
# CHRONIC DISEASE

Chronic (long-term) diseases like heart disease, cancer, injuries and diabetes often develop due to a mix of health behaviors, genetics and environment. These diseases are major causes of death in North Carolina.

Health behaviors, like tobacco use, alcohol use, unhealthy diet and lack of exercise, greatly influence our risk for chronic diseases and health issues. While we make individual choices, our behaviors are shaped by early life experiences, trauma, toxic stress, the way our brain develops as we grow and the environments we live in. Abilities and access to opportunities also play a role. Not everyone has the same chance to engage in healthy behaviors like regular exercise and nutritious eating.

To understand more about how our surroundings and economic circumstances affect our health behaviors, please read the "Social Drivers of Health" section. To learn more about health behaviors related to substance use, like tobacco or alcohol, please read the "Mental Health, Substance Use, Suicide and Violence Prevention" section.

## Cancer Disparities by Race and Ethnicity

### TABLE 10: CANCER INCIDENCE, 2017-2021

| | TOTAL POP. | RACE/ETHNICITY | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | WHITE NON-HISPANIC | AFRICAN AMERICAN/BLACK, NON-HISPANIC | | | AMERICAN INDIAN, NON-HISPANIC | | | ASIAN/PACIFIC ISLANDER, NON-HISPANIC | | | MULTIRACIAL, NON-HISPANIC | | | HISPANIC/LATINX | | |
| | Rate | Rate | Rate | Disparity Ratio Grade Indicates severity of disparity | Disparity Ratio African American/Blacks X times more likely than white population | Rate | Disparity Ratio Grade Indicates severity of disparity | Disparity Ratio American Indians X times more likely than white population | Rate | Disparity Ratio Grade Indicates severity of disparity | Disparity Ratio Asian/Pacific Islanders X times more likely than white population | Rate | Disparity Ratio Grade Indicates severity of disparity | Disparity Ratio Multiracials X times more likely than white population | Rate | Disparity Ratio Grade Indicates severity of disparity | Disparity Ratio Hispanic/Latinx X times more likely than white population |
| Total Cancer | 474.7 | 479.9 | 475.1 | A | 0.99 | 382.3 | A | 0.80 | 270.8 | A | 0.56 | * | * | * | 354.6 | A | 0.74 |
| Lung and Bronchus Cancer | 60.2 | 62.2 | 58.3 | A | 0.94 | 70.9 | A | 1.14 | 28 | A | 0.45 | * | * | * | 28.3 | A | 0.45 |
| Colon and Rectum Cancer | 34.3 | 33.8 | 36.9 | A | 1.09 | 32.1 | A | 0.95 | 22.2 | A | 0.66 | * | * | * | 28.4 | A | 0.84 |
| Female Breast Cancer | 169.3 | 171 | 171.7 | A | 1.00 | 120.6 | A | 0.71 | 113.7 | A | 0.66 | * | * | * | 134.7 | A | 0.79 |
| Cervical Cancer | 6.7 | 6.3 | 6.9 | A | 1.10 | 9 | B | 1.43 | 4.6 | A | 0.73 | * | * | * | 10.8 | B | 1.71 |
| Prostate Cancer | 122.4 | 107.4 | 185.8 | B | 1.73 | 95 | A | 0.88 | 56.6 | A | 0.53 | * | * | * | 81.6 | A | 0.76 |
| Stomach Cancer | 6 | 4.8 | 9.7 | C | 2.02 | 4.7 | A | 0.98 | 7.9 | B | 1.65 | * | * | * | 9.5 | B | 1.98 |
| Pancreatic Cancer | 13.3 | 12.6 | 17 | B | 1.35 | 10 | A | 0.79 | 7.2 | A | 0.57 | * | * | * | 10.5 | A | 0.83 |
| Liver Cancer | 8.6 | 8.1 | 9.1 | A | 1.12 | 11.5 | B | 1.42 | 12 | B | 1.48 | * | * | * | 11.1 | B | 1.37 |
| Kidney Cancer | 18.1 | 17.9 | 20.3 | A | 1.13 | 17.8 | A | 0.99 | 6.4 | A | 0.36 | * | * | * | 15.8 | A | 0.88 |
| Multiple Myeloma | 7.7 | 6 | 15 | C | 2.50 | 5.7 | A | 0.95 | 2.8 | A | 0.47 | * | * | * | 7.5 | A | 1.25 |

Footnotes: 'Incidence' is a term for new disease diagnoses. • Cancer incidence rates are per 100,000 resident population. Denominators are estimates for 2017-2021 based on Vintage 2017-2021 (Postcensal) population estimates • Data Provided by State Center for Health Statistics, Minority Health Report 2023

**KEY**

(Disparity ratio grades indicate the severity of the health difference between population groups. It is not indicative of the severity of the health topic or problem as a whole.)

| Disparity Grade (color) | A (dark blue) | B (pale blue) | C (yellow) | D (pink) | F (red) |
|---|---|---|---|---|---|
| Disparity Ratio | 0.0 - 1.24 | 1.25 - 1.9 | 2.0 - 2.4 | 2.5 - 2.9 | ≥ 3.0 |
| Meaning | Little or no disparity. | A disparity exists, should be monitored and may require intervention. | The disparity requires intervention. | Major interventions are needed. | Significant interventions are needed. |

## TABLE 11: CANCER MORTALITY, 2017-2021

| | TOTAL POP. | RACE/ETHNICITY | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | WHITE NON-HISPANIC | AFRICAN AMERICAN/BLACK, NON-HISPANIC | | | AMERICAN INDIAN, NON-HISPANIC | | | ASIAN/PACIFIC ISLANDER, NON-HISPANIC | | | MULTIRACIAL, NON-HISPANIC | | | HISPANIC/LATINX | | |
| | Rate | Rate | Rate | Disparity Ratio Grade Indicates severity of disparity | Disparity Ratio African American/Blacks X times more likely than white population | Rate | Disparity Ratio Grade Indicates severity of disparity | Disparity Ratio American Indians X times more likely than white population | Rate | Disparity Ratio Grade Indicates severity of disparity | Disparity Ratio Asian/Pacific Islanders X times more likely than white population | Rate | Disparity Ratio Grade Indicates severity of disparity | Disparity Ratio Multiracials X times more likely than white population | Rate | Disparity Ratio Grade Indicates severity of disparity | Disparity Ratio Hispanic/Latinx X times more likely than white population |
| Total Cancer | 154.5 | 154.7 | 176.5 | A | 1.1 | 151.4 | A | 1.0 | 85.7 | A | 0.6 | 34.7 | A | 0.2 | 80.5 | A | 0.5 |
| - Colon, Rectum, and Anus | 12.9 | 12.6 | 16.5 | B | 1.3 | 12.6 | A | 1.0 | 6.2 | A | 0.5 | 5.4 | A | 0.4 | 7.5 | A | 0.6 |
| - Pancreas | 11.1 | 10.8 | 14.0 | B | 1.3 | 10.9 | A | 1.0 | 6.7 | A | 0.6 | * | * | n/a | 6.4 | A | 0.6 |
| - Trachea, Bronchus, and Lung | 38.8 | 40.6 | 38.3 | A | 0.9 | 49.9 | A | 1.2 | 19.4 | A | 0.5 | 10.0 | A | 0.2 | 11.3 | A | 0.3 |
| - Breast | 20.3 | 19.5 | 26.7 | B | 1.4 | 16.2 | A | 0.8 | 8.7 | A | 0.4 | * | * | n/a | 9.6 | A | 0.5 |
| - Prostate | 19.7 | 16.9 | 38.2 | C | 2.3 | 21.5 | B | 1.3 | 9.3 | A | 0.6 | * | * | n/a | 11.2 | A | 0.7 |
| Cervix Uteri Cancer (2018-2022) | 2.00 | 1.80 | 2.80 | B | 1.56 | | | | * | * | * | * | * | * | 2.5 | B | 1.39 |
| Stomach Cancer (2018-2022) | 2.60 | 2.00 | 4.60 | C | 2.30 | 3.10 | B | 1.55 | 3.70 | B | 1.85 | * | * | * | 4.5 | C | 2.25 |
| Liver Cancer (2018-2022) | 6.80 | 6.50 | 7.60 | A | 1.17 | 7.70 | A | 1.18 | 8.00 | A | 1.23 | * | * | * | 7 | A | 1.08 |
| Kidney Cancer (2018-2022) | 3.60 | 3.70 | 3.50 | A | 0.95 | 3.30 | A | 0.89 | 1.80 | A | 0.49 | * | * | * | 2.1 | A | 0.57 |
| Multiple Myeloma (2018-2022) | 3.30 | 2.80 | 6.10 | C | 2.18 | * | * | * | * | * | * | * | * | * | 2.1 | A | 0.75 |

Footnotes: With the exception of infant death rates, mortality rates are age-adjusted per 100,000 resident population. Numerators are derived from 2017-2021 death certificate data. Population denominators for all mortality rates (except for infant deaths) are estimates for 2017-2021 based on Vintage 2017-2021 (Postcensal) population estimates from the U.S. Census Bureau's Population and Housing Unit Estimates Special Tabulation Program. • Data Provided by State Center for Health Statistics, Minority Health Report 2023

In North Carolina, breast and prostate cancers were the most common new cancer diagnoses for all people. Following these, lung, colon and rectal cancers are also frequently diagnosed. Across different groups, there are generally no large disparities in these common cancers, except for prostate cancer among African Americans/Blacks.

- African Americans/Blacks are nearly two times more likely to be diagnosed with prostate cancer, two times more likely to be diagnosed with stomach cancer, 1.4 times more likely to be diagnosed with pancreatic cancer, and 2.5 times more likely to be diagnosed with multiple myeloma than Whites (see Table 10). African Americans/Blacks are also more likely to die from cancer than Whites (see Table 11).
- American Indians are nearly 1.5 times more likely to be diagnosed with cervical cancer and liver cancer (see Table 10),
- Asian-Pacific Islanders are more likely than Whites to be diagnosed with stomach and liver cancer (see Table 11).
- Hispanic/Latinx individuals are 1.7 times more likely to be diagnosed with cervical cancer, nearly two times as likely to be diagnosed with stomach cancer, and nearly 1.4 times more likely to be diagnosed with liver cancer (see Table 10).

**KEY**

(Disparity ratio grades indicate the severity of the health difference between population groups. It is not indicative of the severity of the health topic or problem as a whole.)

| Disparity Grade (color) | A (dark blue) | B (pale blue) | C (yellow) | D (pink) | F (red) |
|---|---|---|---|---|---|
| Disparity Ratio | 0.0 - 1.24 | 1.25 - 1.9 | 2.0 - 2.4 | 2.5 - 2.9 | ≥ 3.0 |
| Meaning | Little or no disparity. | A disparity exists, should be monitored and may require intervention. | The disparity requires intervention. | Major interventions are needed. | Significant interventions are needed. |

These disparities in cancer rates can be influenced by various factors such as genetics, unhealthy diet, lack of physical activity, tobacco and alcohol use, exposure to environmental toxins, and chronic infections. These factors contribute differently across populations, affecting their cancer risks and outcomes.[36]

## Chronic Disease Disparities by Race and Ethnicity

### TABLE 12: CARDIOVASCULAR MORTALITY, 2017-2021

| | TOTAL POP. | RACE/ETHNICITY | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | WHITE NON-HISPANIC | AFRICAN AMERICAN/BLACK, NON-HISPANIC | | | AMERICAN INDIAN, NON-HISPANIC | | | ASIAN/PACIFIC ISLANDER, NON-HISPANIC | | | MULTIRACIAL, NON-HISPANIC | | | HISPANIC/LATINX | | |
| | Rate | Rate | Rate | Disparity Ratio Grade Indicates severity of disparity | Disparity Ratio African American/Blacks X times more likely than white population | Rate | Disparity Ratio Grade Indicates severity of disparity | Disparity Ratio American Indians X times more likely than white population | Rate | Disparity Ratio Grade Indicates severity of disparity | Disparity Ratio Asian/Pacific Islanders X times more likely than white population | Rate | Disparity Ratio Grade Indicates severity of disparity | Disparity Ratio Multiracials X times more likely than white population | Rate | Disparity Ratio Grade Indicates severity of disparity | Disparity Ratio Hispanic/Latinx X times more likely than white population |
| Total Deaths, All Causes | 838.5 | 831.6 | 985.1 | A | 1.2 | 992.5 | A | 1.2 | 414.9 | A | 0.5 | 172.9 | A | 0.2 | 444.9 | A | 0.5 |
| Heart disease | 161.1 | 159.6 | 188.6 | A | 1.2 | 183.0 | A | 1.1 | 76.2 | A | 0.5 | 27.7 | A | 0.2 | 67.2 | A | 0.4 |
| - Acute Myocardial Infarction (heart attack) | 25.9 | 26.0 | 28.9 | A | 1.1 | 41.3 | B | 1.6 | 14.3 | A | 0.6 | * | * | n/a | 12.0 | A | 0.5 |
| - Other Ischemic Heart Disease | 58.3 | 59.3 | 62.8 | A | 1.1 | 74.0 | B | 1.2 | 27.3 | A | 0.5 | 9.8 | A | 0.2 | 21.9 | A | 0.4 |
| Stroke (Cerebrovascular disease) | 44.0 | 41.8 | 57.4 | B | 1.4 | 42.1 | A | 1.0 | 32.1 | A | 0.8 | 5.8 | A | 0.1 | 24.0 | A | 0.6 |

Footnotes: With the exception of infant death rates, mortality rates are age-adjusted per 100,000 resident population. Numerators are derived from 2017-2021 death certificate data. Population denominators for all mortality rates (except for infant deaths) are estimates for 2017-2021 based on Vintage 2017-2021 (Postcensal) population estimates from the U.S. Census Bureau's Population and Housing Unit Estimates Special Tabulation Program. • Data Provided by State Center for Health Statistics, Minority Health Report 2023

**KEY**

(Disparity ratio grades indicate the severity of the health difference between population groups. It is not indicative of the severity of the health topic or problem as a whole.)

| Disparity Grade (color) | A (dark blue) | B (pale blue) | C (yellow) | D (pink) | F (red) |
|---|---|---|---|---|---|
| Disparity Ratio | 0.0 - 1.24 | 1.25 - 1.9 | 2.0 - 2.4 | 2.5 - 2.9 | ≥ 3.0 |
| Meaning | Little or no disparity. | A disparity exists, should be monitored and may require intervention. | The disparity requires intervention. | Major interventions are needed. | Significant interventions are needed. |

## TABLE 13: CHRONIC DISEASE PREVALENCE

| | TOTAL POP. | RACE/ETHNICITY | | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | WHITE NON-HISPANIC | AFRICAN AMERICAN/BLACK, NON-HISPANIC | | | AMERICAN INDIAN, NON-HISPANIC | | | ASIAN/PACIFIC ISLANDER, NON-HISPANIC | | | MULTIRACIAL, NON-HISPANIC | | | HISPANIC/LATINX | | |
| | Percentage | Percentage | Percentage | Disparity Ratio Grade Indicates severity of disparity | Disparity Ratio African American/Blacks X times more likely than white population | Percentage | Disparity Ratio Grade Indicates severity of disparity | Disparity Ratio American Indians X times more likely than white population | Percentage | Disparity Ratio Grade Indicates severity of disparity | Disparity Ratio Asian/Pacific Islanders X times more likely than white population | Percentage | Disparity Ratio Grade Indicates severity of disparity | Disparity Ratio Multiracials X times more likely than white population | Percentage | Disparity Ratio Grade Indicates severity of disparity | Disparity Ratio Hispanic/Latinx X times more likely than white population |
| Diagnosed diabetes (ages 18+), 2021 | 11.20% | 9.30% | 17.40% | B | 1.87 | 14.20% | B | 1.53 | * | * | * | * | * | * | 13.80% | B | 1.5 |
| COPD (Chronic obstructive pulmonary disease) (ages 18+), 2021 | 6.80% | 6.70% | 8.40% | B | 1.25 | * | * | * | * | * | * | * | * | * | * | * | * |

Footnotes: Prevalences are weighted to population characteristics. Uses age-adjusted prevalence, which is the crude prevalence standardized to the age distribution of a specific population, usually the U.S. 2000 standard population. Confidence intervals may or may not overlap. Use health disparity ratios cautiously, and refer to original data source for more information. • Reference: Centers for Disease Control and Prevention. (n.d.-a). Chronic disease indicators: Explore by location. Centers for Disease Control and Prevention. https://nccd.cdc.gov/cdi/rdPage.aspx?rdReport=DPH_CDI.ExploreByLocation&islLocation=37&islTopic=ALC&islYear=9999

## TABLE 14: CHRONIC DISEASE MORTALITY, 2017-2021

| | TOTAL POP. | RACE/ETHNICITY | | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | WHITE NON-HISPANIC | AFRICAN AMERICAN/BLACK, NON-HISPANIC | | | AMERICAN INDIAN, NON-HISPANIC | | | ASIAN/PACIFIC ISLANDER, NON-HISPANIC | | | MULTIRACIAL, NON-HISPANIC | | | HISPANIC/LATINX | | |
| | Rate | Rate | Rate | Disparity Ratio Grade Indicates severity of disparity | Disparity Ratio African American/Blacks X times more likely than white population | Rate | Disparity Ratio Grade Indicates severity of disparity | Disparity Ratio American Indians X times more likely than white population | Rate | Disparity Ratio Grade Indicates severity of disparity | Disparity Ratio Asian/Pacific Islanders X times more likely than white population | Rate | Disparity Ratio Grade Indicates severity of disparity | Disparity Ratio Multiracials X times more likely than white population | Rate | Disparity Ratio Grade Indicates severity of disparity | Disparity Ratio Hispanic/Latinx X times more likely than white population |
| Diabetes | 26.1 | 21.8 | 47.9 | C | 2.2 | 38.6 | B | 1.8 | 13.7 | A | 0.6 | 8.4 | A | 0.4 | 16.6 | A | 0.8 |
| Chronic lower respiratory diseases | 41.4 | 46.0 | 28.9 | A | 0.6 | 48.7 | A | 1.1 | 8.6 | A | 0.2 | 6.3 | A | 0.1 | 9.6 | A | 0.2 |
| Chronic liver disease/cirrhosis | 12.0 | 13.7 | 8.6 | A | 0.6 | 18.2 | B | 1.3 | 4.3 | A | 0.3 | * | * | n/a | 7.9 | A | 0.6 |
| Nephritis, nephrosis, and nephrotic syndrome (kidneys) | 16.8 | 13.3 | 33.8 | D | 2.5 | 21.9 | B | 1.6 | 9.7 | A | 0.7 | * | * | n/a | 11.1 | A | 0.8 |
| Alzheimer's Disease | 38.0 | 38.8 | 37.6 | A | 1.0 | 57.7 | B | 1.5 | 17.7 | A | 0.5 | * | * | n/a | 22.5 | A | 0.6 |

Footnotes: With the exception of infant death rates, mortality rates are age-adjusted per 100,000 resident population. Numerators are derived from 2017-2021 death certificate data. Population denominators for all mortality rates (except for infant deaths) are estimates for 2017-2021 based on Vintage 2017-2021 (Postcensal) population estimates from the U.S. Census Bureau's Population and Housing Unit Estimates Special Tabulation Program. • Data Provided by State Center for Health Statistics, Minority Health Report 2023

### KEY

(Disparity ratio grades indicate the severity of the health difference between population groups. It is not indicative of the severity of the health topic or problem as a whole.)

| Disparity Grade (color) | A (dark blue) | B (pale blue) | C (yellow) | D (pink) | F (red) |
|---|---|---|---|---|---|
| Disparity Ratio | 0.0 - 1.24 | 1.25 - 1.9 | 2.0 - 2.4 | 2.5 - 2.9 | ≥ 3.0 |
| Meaning | Little or no disparity. | A disparity exists, should be monitored and may require intervention. | The disparity requires intervention. | Major interventions are needed. | Significant interventions are needed. |

The overall mortality rates for heart disease, stroke, diabetes and liver disease have slightly risen since the last report from 2014 to 2018.* However, North Carolina has made great strides in reducing the disparity gaps between racial and ethnic population groups for a variety of cancer diagnoses and deaths, heart-related deaths and more.

Despite overall progress, a few chronic disease disparities remain a top concern:

- African American/Black North Carolinians are more likely to die of stroke (see Table 12), more likely to be diagnosed with and die from diabetes (see Table 13 and 14), more likely to be diagnosed with COPD (chronic obstructive pulmonary disease) (see Table 13), and more likely to die from kidney disease than White, non-Hispanics (see Table 14).
- American Indians are more likely to die from diabetes, liver disease, kidney disease and Alzheimer's disease than White, non-Hispanics (see Table 14).

*SCHS NC Resident Population Health Data by Race and Ethnicity 2014-2018 was compared to the SCHS NC Resident Population Health Data by Race and Ethnicity 2017-2021 report. The comments on trends in this report are not statistically significant. These trends are merely used as a tool to indicate what metrics we recommend keeping our eye on.

## Chronic Disease Disparities by Disability Status

### TABLE 15: HEALTH OUTCOMES OF PEOPLE WITH DISABILITIES

| | RACE/ETHNICITY FOR INDIVIDUALS WITH ANY DISABILITY | | | | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | WHITE, NON-HISPANIC, NO DISABILITY | WHITE, NON-HISPANIC, ANY DISABILITY | | | AFRICAN AMERICAN/ BLACK, NON-HISPANIC, ANY DISABILITY | | | AMERICAN INDIAN, NON-HISPANIC, ANY DISABILITY | | | ASIAN/PACIFIC ISLANDERS, NON-HISPANIC, ANY DISABILITY | | | MULTIRACIAL, NON-HISPANIC, ANY DISABILITY | | | HISPANIC/LATINX, ANY DISABILITY | | |
| | Percentage | Percentage | Disparity Ratio Grade Indicates severity of disparity | Disparity Ratio Whites X times more likely than white non disabled population | Percentage | Disparity Ratio Grade Indicates severity of disparity | Disparity Ratio African American/Blacks X times more likely than white non disabled population | Percentage | Disparity Ratio Grade Indicates severity of disparity | Disparity Ratio American Indians X times more likely than white non disabled population | Percentage | Disparity Ratio Grade Indicates severity of disparity | Disparity Ratio Asian/Pacific Islanders X times more likely than white non disabled population | Percentage | Disparity Ratio Grade Indicates severity of disparity | Disparity Ratio Multiracial X times more likely than white non disabled population | Percentage | Disparity Ratio Grade Indicates severity of disparity | Disparity Ratio Hispanic/Latinx X times more likely than white non disabled population |
| % of adults who have ever had heart disease, 2021 (1) | 2.90% | 11.40% | F | 3.93 | 12.10% | F | 4.17 | * | * | * | * | * | * | *Data Suppressed | * | * | *Data Suppressed | * | * |
| % of adults who have ever had high blood pressure (1) | 24.50% | 39.90% | B | 1.63 | 44.80% | B | 1.83 | * | * | * | * | * | * | 39.10% | B | 1.60 | 35.00% | B | 1.43 |
| % of adults who have ever had cancer (excluding skin cancer), 2021 (2) | 5.00% | 9.10% | B | 1.82 | 6.40% | B | 1.28 | * | * | * | * | * | * | *Data Suppressed | * | * | *Data Suppressed | * | * |
| % of adults who have ever had COPD (Chronic Obstructive Pulmonary Disease), 2021 (2) | 4.10% | 12.50% | F | 3.05 | 15.10% | F | 3.68 | * | * | * | * | * | * | *Data Suppressed | * | * | *Data Suppressed | * | * |
| % of adults who have ever had diabetes, 2021 (2) | 6.40% | 14.60% | C | 2.28 | 21.60% | F | 3.38 | * | * | * | * | * | * | 13.60% | C | 2.13 | 21.30% | F | 3.33 |
| % of adults who have ever had a stroke, 2021 (2) | 1.60% | 5.70% | F | 3.56 | 10.20% | F | 6.38 | * | * | * | * | * | * | *Data Suppressed | * | * | *Data Suppressed | * | * |

Footnotes: Confidence intervals may or may not overlap. Use health disparity ratios cautiously, and refer to original data source for more information. • Data Source: Disability and Health Data System • References: (1) Centers for Disease Control and Prevention. (n.d.-b). Disability and Health Data System (DHDS): North Carolina General Health Conditions. Centers for Disease Control and Prevention. https://dhds.cdc.gov/SP?LocationId=37&CategoryId=GENHLTH&ShowFootnotes=true&showMode=&IndicatorIds=FALL12M%2CHEALTH%2CPHDAYS%2CHEART%2CHBP%2CHBPMED%2CHICHOL%2CSLEEPHRS&pnl0=Chart%2Cfalse%2CYR5%2CDISSTAT%2C%2C%2C%2C%2CAGEADJPREV&pnl1=Chart%2Cfalse%2CYR6%2CDISSTAT%2C%2C%2C%2C%2CAGEADJPREV&pnl2=Chart%2Cfalse%2CYR6%2CDISSTAT%2C%2C%2C%2C%2CAGEADJPREV&pnl3=Table%2Cfalse%2CYR6%2CDISSTAT%2C%2CRACE%2C%2CYESNO01%2CAGEADJPREV&pnl4=Table%2Cfalse%2CYR6%2CDISSTAT%2C%2CRACE%2C%2CYESNO01%2CAGEADJPREV&pnl5=Chart%2Cfalse%2CYR6%2CDISSTAT%2C%2C%2C%2C%2CAGEADJPREV&pnl6=Chart%2Cfalse%2CYR6%2CDISSTAT%2C%2C%2C%2C%2CAGEADJPREV&pnl7=Chart%2Cfalse%2CYR5%2CDISSTAT%2C%2C%2C%2C%2CAGEADJPREV • (2) Centers for Disease Control and Prevention. (n.d.-b). Disability and Health Data System (DHDS): North Carolina Chronic Conditions. Centers for Disease Control and Prevention. https://dhds.cdc.gov/SP?LocationId=37&CategoryId=CHRCOND&ShowFootnotes=true&showMode=&IndicatorIds=ARTHRITIS%2CASTHMA%2COTHCAN%2CCOPD%2CDIAB%2CSTROKE&pnl0=Chart%2Cfalse%2CYR6%2CDISSTAT%2C%2C%2C%2C%2CAGEADJPREV&pnl1=Chart%2Cfalse%2CYR6%2CDISSTAT%2C%2C%2C%2C%2CAGEADJPREV&pnl2=Table%2Cfalse%2CYR6%2CDISSTAT%2C%2CRACE%2C%2CYESNO01%2CAGEADJPREV&pnl3=Table%2Cfalse%2CYR6%2CDISSTAT%2C%2CRACE%2C%2CYESNO01%2CAGEADJPREV&pnl4=Table%2Cfalse%2CYR6%2CDISSTAT%2C%2CRACE%2C%2CYESNO01%2CAGEADJPREV&pnl5=Table%2Cfalse%2CYR6%2CDISSTAT%2C%2CRACE%2C%2CYESNO01%2CAGEADJPREV • (3) Centers for Disease Control and Prevention. (n.d.-e). Disability and Health Data System (DHDS): North Carolina Mental and Emotional Health. Centers for Disease Control and Prevention. https://dhds.cdc.gov/SP?LocationId=37&CategoryId=MHLTH&ShowFootnotes=true&showMode=&IndicatorIds=DEPRESS%2CMHDAYS&pnl0=Table%2Cfalse%2CYR6%2CDISSTAT%2C%2CRACE%2C%2CYESNO01%2CAGEADJPREV&pnl1=Chart%2Cfalse%2CYR6%2CDISSTAT%2C%2C%2C%2C%2CAGEADJPREV

**KEY**

(Disparity ratio grades indicate the severity of the health difference between population groups. It is not indicative of the severity of the health topic or problem as a whole.)

| Disparity Grade (color) | A (dark blue) | B (pale blue) | C (yellow) | D (pink) | F (red) |
|---|---|---|---|---|---|
| Disparity Ratio | 0.0 - 1.24 | 1.25 - 1.9 | 2.0 - 2.4 | 2.5 - 2.9 | ≥ 3.0 |
| Meaning | Little or no disparity. | A disparity exists, should be monitored and may require intervention. | The disparity requires intervention. | Major interventions are needed. | Significant interventions are needed. |

People with disabilities often experience more health disparities than people without disabilities. People with disabilities often experience worse overall mental health, less access to adequate health education and care, and, as a result, may show more frequent unhealthy behaviors.[17]

North Carolinians with disabilities, no matter their race, have worse health outcomes in terms of chronic diseases like heart disease, high blood pressure, stroke, diabetes, cancer, COPD and depression than White Non-Hispanics without disabilities (see Table 15):

- White and African American/Black people with disabilities are nearly four times more likely to have heart disease.
- White and African American/Black people with disabilities are nearly three to four times more likely to have COPD.
- White and African American/Black people with disabilities are nearly four to six times more likely to have a stroke.
- White, African American/Black, Multiracial, and Hispanic/Latinx people with disabilities are nearly two to three times more likely to have diabetes.

## Addressing Chronic Disease in North Carolina

Chronic disease is best addressed through multiple approaches, such as:

- Addressing stress in early childhood and supporting family resilience
- Providing health education and promoting healthy habits
- Helping with changes in behavior, like taking medications correctly, maintaining a healthy diet and staying active
- Reducing the use of tobacco, alcohol and other substances
- Increasing access to check-ups and regular treatment and monitoring by a provider
- Making environmental changes like better access to healthy food, walkable neighborhoods and fewer environmental toxins.

The NC Comprehensive Cancer Control Program has a resource hub for people with cancer and their loved ones, providers, community and business partners, and policy makers. They also develop the NC Comprehensive Action Plan, which includes cancer data and strategies to reduce the cancer burden.

The North Carolina Minority Diabetes Prevention Program (NC MDPP) is a program that addresses access to screenings, health education and promotion, and behavior change. It is managed by the Office of Health Equity. The North Carolina Minority Diabetes Prevention Program uses a statewide framework that reduces diabetes prevalence in communities of color. The program performs three main actions:

1. Checks communities of color for prediabetes and runs marketing campaigns to inform people about prediabetes and diabetes in specific regions.
2. Runs a year-long class series about lifestyle changes for people in communities of color.
3. Has community conversations with communities of color across North Carolina. This is the only diabetes program in North Carolina that is run by the state.

The North Carolina Community Health Worker Initiative meets people where they are to go beyond traditional health care. By investing in community health workers, case managers, patient navigators and caregivers, we can make the health care system stronger at dealing with long-term diseases.

## TABLE 16: HOW YOU CAN PLAY A PART – CHRONIC DISEASE

| NCDHHS PARTNER | RECOMMENDED STRATEGIES |
|---|---|
| **Community-Based Organizations and Services** | Take culturally appropriate health education, healthy behavior resources and strategies directly to those who need it the most, especially for people who have a hard time going to classes or programs because of challenges like lack of transportation.<br>Start peer education to help prevent and manage long-term diseases.<br>Create your curriculum and implement it for each population you work with.<br>Partner with DSMES (Diabetes Self-Management Education and Support) providers to host or help with DSMES services.<br>Use NCCARE360 to find resources and organize care better.<br>Make sure printed and electronic materials are easy to access and read (use large fonts, consider color contrast, use plain language and translate them into different languages).<br>Keep learning about people with disabilities and include organizations that help people with disabilities in planning efforts. Ask people with disabilities to share their experiences and knowledge.<br>Make sure people with disabilities can access activities, events and communications.<br>Use plain language, inclusive web access and American Sign Language. Make sure interpreters and captioning is available when needed. |
| **Faith-Based Organizations** | Partner with DSMES providers to host or help with DSMES services. |
| **Governmental Agencies** | Advocate against obstacles that stop patients from taking care of themselves or prevent problems.<br>Provide information that shows cultural competency, and make sure information is available in the languages spoken by the communities you serve when you share resources and opportunities.<br>Ask people with disabilities to share their experiences and knowledge.<br>Use pictures of real people with disabilities to share messages.<br>Always count people with disabilities as a group when looking at data. |
| **Health Care Professionals** | Give information and resources that shows your organization understands and respects people from different cultures in the languages they speak.<br>Use NCCARE360 to find resources and organize care better.<br>Encourage physical and mental health care providers to work together and communicate more.<br>Use social drivers of health screening tools and other related screening tools to find needed services and supports.<br>Find points of contact or patient navigators who can coordinate care better between agencies.<br>Ask people with disabilities to share their experiences and knowledge.<br>Make sure that everyone can access health care facilities easily and that everyone can understand what is being said. |
| **Advocates, Decision Makers and System Changers** | Support policies that help Medicaid pay for preventing and managing long-term diseases, like reimbursing for classes, healthy foods and more.<br>Increase funding to SNAP programs so that people can afford healthier foods or get them at lower costs.<br>Get more resources and better access to programs that help people with disabilities so they do not have to wait for the care and services they need.<br>NC SHIP 2023 proposes these policy initiatives:<br>• Integrate "Rethink Your Drink" toolkit into school curricula to encourage drinking water as a healthier option over sweetened drinks<br>• Set policies for getting healthy food that support public and private investment and make healthy alternatives to sugary drinks more available<br>• Make sure schools have access to safe and clean water at water-filling stations that have been tested for safety<br>• Limit "default beverages" in children's meals to include only milk, 100% fruit juice or water<br>• Include healthier drinks in school and park vending machines |
| **Business and Industry** | Support environments that promote health, including healthy food choices and opportunities for physical activities. |

# CATEGORY 4:
# COMMUNICABLE DISEASE

Communicable diseases are illnesses caused by an infectious agent, like bacteria or viruses. They can spread between people, from people to surfaces, and occasionally between animals and humans. Preventing and controlling these diseases is crucial for managing their impact on the population. The impact of COVID-19 has shown how important it is to control communicable diseases to keep people healthy.

## Communicable Disease Disparities by Race and Ethnicity

### TABLE 17: COMMUNICABLE DISEASE

| | TOTAL POP. | RACE/ETHNICITY | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | WHITE NON-HISPANIC | AFRICAN AMERICAN/BLACK, NON-HISPANIC | | | AMERICAN INDIAN, NON-HISPANIC | | | ASIAN/PACIFIC ISLANDER, NON-HISPANIC | | | MULTIRACIAL, NON-HISPANIC | | | HISPANIC/LATINX | | |
| | Rate | Rate/% | Rate/% | Disparity Ratio Grade Indicates severity of disparity | Disparity Ratio African American/Blacks X times more likely than white population | Rate/% | Disparity Ratio Grade Indicates severity of disparity | Disparity Ratio American Indians X times more likely than white population | Rate/% | Disparity Ratio Grade Indicates severity of disparity | Disparity Ratio Asian/Pacific Islanders X times more likely than white population | Rate/% | Disparity Ratio Grade Indicates severity of disparity | Disparity Ratio Multiracials X times more likely than white population | Rate/% | Disparity Ratio Grade Indicates severity of disparity | Disparity Ratio Hispanic/Latinx X times more likely than white population |
| Newly Diagnosed Adult/Adolescent HIV Infection Cases, 2021 (1) | 15.7 | 5.3 | 43.5 | F | 8.21 | 14.3 | D | 2.70 | 6.5 | A | 1.23 | 19.1 | F | 3.60 | 26.9 | F | 5.08 |
| Newly Diagnosed Adult/Adolescent AIDS Infection Cases, 2021 (1) | 5.7 | 2 | 16.1 | F | 8.05 | 6.1 | F | 3.05 | 1.4 | A | 0.70 | 14.4 | F | 7.20 | 7.7 | F | 3.85 |
| HIV Mortality | 1.6 | 0.6 | 5.3 | F | 8.83 | * | * | * | * | * | * | * | * | * | 1.0 | B | 1.7 |
| Newly Diagnosed Primary and Secondary Syphilis, 2021 (1) | 12.4 | 4.8 | 33.5 | F | 6.98 | 11.2 | C | 2.33 | 1.4 | A | 0.29 | 27.0 | F | 5.63 | 14.7 | F | 3.06 |
| Newly Diagnosed Chlamydia, 2021 (1) | 617.1 | 190.6 | 1122.9 | F | 5.89 | 551.7 | D | 2.89 | 133.4 | A | 0.70 | 436.4 | C | 2.29 | 529.9 | D | 2.78 |
| Newly Diagnosed Gonorrhea, 2021 (1) | 276.5 | 68.8 | 688.4 | F | 10.01 | 294.4 | F | 4.28 | 36.7 | A | 0.53 | 166.1 | C | 2.41 | 134.6 | B | 1.96 |
| Newly Diagnosed Acute Hepatitis B, 2022 (2) | 1.1 | 1.1 | 1.2 | A | 1.09 | 1.7 | B | 1.55 | * | * | * | * | * | * | 0.6 | A | 0.55 |
| Newly Diagnosed Acute Hepatitis C, 2022 (2) | 0.7 | 0.8 | 0.2 | A | 0.25 | 1.7 | C | 2.13 | * | * | * | * | * | * | 0.6 | A | 0.86 |
| Newly Reported Chronic Hepatitis B, 2022 (2) | 10.7 | 4.5 | 12.7 | D | 2.82 | 9.5 | C | 2.11 | 74 | F | 16.44 | 4.9 | A | 1.09 | 3.8 | A | 0.84 |
| Newly Reported Chronic Hepatitis C 2022 (2) | 95.2 | 66.6 | 63.1 | A | 0.95 | 96.7 | B | 1.45 | 17.5 | A | 0.26 | 14.7 | A | 0.22 | 18.2 | A | 0.27 |

**KEY**

(Disparity ratio grades indicate the severity of the health difference between population groups. It is not indicative of the severity of the health topic or problem as a whole.)

| Disparity Grade (color) | A (dark blue) | B (pale blue) | C (yellow) | D (pink) | F (red) |
|---|---|---|---|---|---|
| Disparity Ratio | 0.0 - 1.24 | 1.25 - 1.9 | 2.0 - 2.4 | 2.5 - 2.9 | ≥ 3.0 |
| Meaning | Little or no disparity. | A disparity exists, should be monitored and may require intervention. | The disparity requires intervention. | Major interventions are needed. | Significant interventions are needed. |

| | TOTAL POP. | GEOGRAPHY | | | | | |
|---|---|---|---|---|---|---|---|
| | | URBAN | | | RURAL | | |
| | Rate | Rate/% | Disparity Ratio Grade Indicates severity of disparity | Disparity Ratio Urban X times more likely than total population | Rate/% | Disparity Ratio Grade Indicates severity of disparity | Disparity Ratio Rural X times more likely than urban population |
| Newly Diagnosed Acute Hepatitis B, 2022 (2) | 1.1 | 0.7 | A | 0.64 | 1.6 | C | 2.29 |
| Newly Diagnosed Acute Hepatitis C, 2022 (2) | 0.7 | 0.5 | A | 0.71 | 0.8 | B | 1.60 |
| Newly Reported Chronic Hepatitis B, 2022 (2) | 10.7 | 11.3 | A | 1.06 | 8.4 | A | 0.74 |
| Newly Reported Chronic Hepatitis C 2022 (2) | 95.2 | 76.6 | A | 0.80 | 96.3 | B | 1.26 |

Footnotes: (1) 2021 North Carolina HIV/STD/Hepatitis Surveillance Report, NCDHHS DPH HIV/STD Prevention & Care Branch. HIV infection cases include all newly reported HIV infected individuals by the year of first diagnosis regardless of the stage of infection (HIV or AIDS). All rates are per 100,000 population. Refer to: https://epi.dph.ncdhhs.gov/cd/stds/figures/2021-HIV-AnnualReport.pdf for further information. • (2) Rates are presented by age group, gender, and race/ethnicity for each disease and are expressed as cases per 100,000 population. Cases with a reported race of "other" were included in the unknown race category. Rates are also presented for counties across the state and are expressed as cases per 100,000 population. Rates are not available for unknown/unspecified categories (including age, gender, and race/ethnicity). Beginning with the 2021 Annual Report, rate denominators were estimated using the Census demographic population estimates for 2021 from the Census Bureau's Population Estimates Program (PEP). In this report, 2021 population estimates were used to calculate rates for both 2021 and 2022. More information about Census Population and Housing Estimates is available on the Census website (https://www.census.gov/programs-surveys/popest/data/special-tab/content.html). Use of these population denominators enabled calculation of rates for the multiple race category. • Rates that are based on a small number of cases (fewer than 10) should be viewed with caution and are considered unreliable because these rates have large standard errors and can vary widely with small changes in case numbers. Data are suppressed in this document for table cells with a population denominator less than 500, according to the North Carolina Department of Health and Human Services, Division of Public Health Communicable Disease Branch data release guidelines. • Please note that 2020 data should be treated with caution due to the impact of the COVID-19 pandemic on accessing STD testing, STD treatment, and surveillance activities in North Carolina. • Data Source: North Carolina Electronic Disease Surveillance System (NC EDSS) (data as of August 1, 2023) unless otherwise specified • (1) Data Provided by State Center for Health Statistics, Minority Health Report 2023 • (2) Data Provided by Communicable Disease Branch

African Americans/Blacks, American Indians, Multiracial and Hispanic/Latinx populations all have significant health disparities for HIV and AIDS, syphilis, chlamydia and gonorrhea (see Table 17). These disparities are most severe for African Americans/Blacks, who are six to ten times more likely to contract these sexually transmitted diseases (STDs) compared to White, non-Hispanics (see Table 17). African Americans/Blacks are also nearly nine times more likely to die from HIV disease than Whites (see Table 17).

When hepatitis is caused by a virus, it is called "viral hepatitis." African Americans/Blacks are almost three times more likely to be diagnosed with chronic hepatitis than White, non-Hispanics. American Indians are more likely than Whites to be diagnosed with both acute and chronic Hepatitis B and C, with the most severe disparities seen for chronic Hepatitis B and C. Large disparities exist for Asian Pacific Islanders, who are 16 times more likely to be diagnosed with chronic Hepatitis B than White, non-Hispanics. People in rural communities are also more likely to be diagnosed with acute Hepatitis B and C, as well as chronic Hepatitis C than urban populations (see Table 17).

**KEY**

(Disparity ratio grades indicate the severity of the health difference between population groups. It is not indicative of the severity of the health topic or problem as a whole.)

| Disparity Grade (color) | A (dark blue) | B (pale blue) | C (yellow) | D (pink) | F (red) |
|---|---|---|---|---|---|
| Disparity Ratio | 0.0 - 1.24 | 1.25 - 1.9 | 2.0 - 2.4 | 2.5 - 2.9 | ≥ 3.0 |
| Meaning | Little or no disparity. | A disparity exists, should be monitored and may require intervention. | The disparity requires intervention. | Major interventions are needed. | Significant interventions are needed. |

# Communicable Disease Disparities by Gender and Sexuality

HIV diagnosis rates are much higher for young, gay and bisexual men of color than among other North Carolinians. Viral suppression means that once a person is receiving effective treatment, they usually cannot transmit HIV to others. Black and Hispanic gay, bisexual and other men who have sex with men also have lower viral suppression than others in 2021 in North Carolina.[38]

Accessing care presents challenges for this population[39]:

- 7.9% do not know their HIV status
- 91.8% of those who did not know their status were less likely to get tested regularly or at all compared to those who knew their status
- 24.7% find it easy to access HIV testing
- 30.1% said they know where to access treatment in their community

Addressing communicable disease also requires understanding how disease outbreaks are linked to other factors of health. Communicable diseases remain a large priority for populations historically marginalized, like people of color, LGBTQ+ populations, young people and people who use substances. It is also a significant concern for people who are more vulnerable, like people with chronic illnesses, people with disabilities, older adults or people who have a weakened immune system (immunocompromised). This is a very diverse group of populations who are most at risk for disease transmission and related negative health outcomes. Each population group has unique health risks and needs and will require different strategies to achieve their best health.

However, there are factors that make communicable disease disparities more likely for some people. Some health behaviors, like having unprotected sex (for example, not wearing a condom) or reusing needles can increase the risk of people to get communicable diseases like HIV. These behaviors are increased by the lack of access to, and cultural support for, protective information and services in communities that have been historically marginalized.

To help protect against these diseases, we need more access to screenings, early detection, treatment and public support for risk reduction and protective services. Risk reduction means changing behaviors to lower the chance of getting sick, hurt or dying. For example, it could mean offering free condoms or offering services where people can safely exchange used needles for new ones and get linked to health care.

Reducing stigma (shame) around sexual health for communities that have been historically marginalized can reduce communicable disease too. For example, when society judges LGBTQ+ people and people who use drugs, it makes it harder for them to get the information, help and care they need.

Social drivers of health also have an impact on how fast communicable diseases spread. For example, people who experience homelessness have higher rates of HIV and mental health problems than people with stable homes. When people do not have their basic needs met, like housing, nutrition and safety, they are more likely to get both long-term and communicable diseases. They also struggle to access regular health care, which is vital for finding and treating communicable diseases early.[40]

## SUCCESS SPOTLIGHT:
# HEALTHIER TOGETHER

**Healthier Together is a program of NC Counts Coalition and NCDHHS that works to increase COVID-19 vaccination rates for people of color in North Carolina. Recently, it expanded to focus on improving mental and behavioral health supports for BIPOC (Black, Indigenous, People of Color) and LGBTQ+ youth.**

**Healthier Together used community health workers, nonprofits, grassroots and local partners within communities that have been historically marginalized to build trust and lead local COVID-19 vaccination efforts. They reached and educated the community, coordinated vaccine events, and provided language and physical access. Healthier Together had over 1.5 million interactions with people, distributed 1.5 million N95 masks, distributed 500,000 at-home tests, connected 11,612 individuals to transportation and connected 63,667 individuals to community health workers.**

## Addressing Communicable Disease in North Carolina

Addressing communicable diseases requires a robust approach. We must look at the social drivers of health. We must look at factors of comorbidity (when a patient has two or more medical conditions or diseases at the same time), like chronic disease, disability status, mental health conditions and substance use.[41]

One example is the response to HIV. Reduction of new HIV diagnoses is a goal of the North Carolina State Health Improvement Plan (NC SHIP). HIV cases have been rising in recent years, increasing from 13.9 (2018) to 15.7 (2021) for the total population of North Carolina. The Ryan White HIV/AIDS Part B Program administered by the U.S. Department of Health and Human Services, the Housing Opportunities for Persons with AIDS (HOPWA) program funded by the U.S. Department of Housing and Urban Development and the NC HIV Medication Assistance Program (HMAP) support individuals with HIV care. Local health departments are also a critical partner that offers private and free screenings for HIV.[42]

*SCHS North Carolina Resident Population Health Data by Race and Ethnicity 2014-2018 was compared to the SCHS North Carolina Resident Population Health Data by Race and Ethnicity 2017-2021 report. The comments on trends in this report are not statistically significant. These trends are merely used as a tool to indicate what metrics we recommend keeping our eye on.

## TABLE 18: HOW YOU CAN PLAY A PART – COMMUNICABLE DISEASE

| NCDHHS PARTNER | RECOMMENDED STRATEGIES |
|---|---|
| **Community-Based Organizations and Services** | Develop community partnerships to promote health promotional events and preventative educational opportunities.<br>Promote resources for health screenings, vaccinations, and prevention or risk reduction programming. |
| **Faith-Based Organizations** | Promote and help connect people to community resources.<br>Help to reduce stigma around sexual health. |
| **Governmental Agencies** | Provide information that shows cultural competency, and make sure information is available in the languages spoken by the communities you serve when you share resources and opportunities.<br>Work to reduce stigma around sexual health<br>Incorporate community-based groups that serve people from the beginning of a project to the end.<br>Support syringe service programs and other harm reduction programs. |
| **Health Care Professionals** | Provide information that shows cultural competency, and make sure information is available in the languages spoken by the communities you serve when you share resources and opportunities.<br>Use social drivers of health (SDOH) screening tools and other related screening tools to find needed services and supports.<br>Find points of contact or patient navigators who can coordinate care better between agencies.<br>Put up LGBTQ+ flags, wear pronoun pins and use visual messaging in your office to show that you welcome LGBTQ+ people.<br>Support syringe service programs and other harm reduction programs.<br>Make sure all staff members understand and can communicate how vaccinations will be given. |
| **Advocates, Decision Makers and System Changers** | Provide funding for reproductive health education in schools and related community organizations.<br>Support syringe service programs.<br>NC SHIP 2023 proposes these policy initiatives:<br>• Expand affordable housing for people with HIV.<br>• Grow North Carolina's network of HIV care and prevention providers.<br>• Address health care gaps for former inmates.<br>• Remove barriers for pharmacists to deliver HIV prevention treatment.<br>• Encourage sexual health assessments in routine care.<br>• Increase access to pre-exposure prevention for those at high risk of HIV.<br>• Expand harm reduction programs, including needle exchanges.<br>• Increase the number of people who know their HIV status and link them to prevention or treatment. |
| **Business and Industry** | Through employee health initiatives, promote access to vaccinations through on-site vaccination clinics or paid leave to access off-site vaccinations.<br>Have policies, like paid leave, that support employees not coming to work in-person when they are sick and could spread disease. |

CATEGORY 5:

# MENTAL HEALTH, SUBSTANCE USE, SUICIDE & VIOLENCE PREVENTION

Mental health is becoming more important in North Carolina and the United States. Mental health includes our emotions, thoughts and social connections. There is not just one cause for mental illness. Some factors that can increase risk include bad childhood experiences, like abuse or neglect, long-term illnesses, money problems and drug use. Mental illness can also make it more likely to get other chronic diseases.[43]

## Adult Mental Health

In 2021, nearly one-quarter of people in North Carolina said they had a mental illness: 8% experienced a major depressive episode, 5% had a serious mental illness and 4% had thoughts of suicide (see Figure 1). Eighteen percent received mental health care that year. We do not have specific data on mental illness by race and ethnicity in North Carolina, but in the United States, women, young adults and people of color, especially American Indians and those of mixed race, are more likely to report serious mental illness.[44]

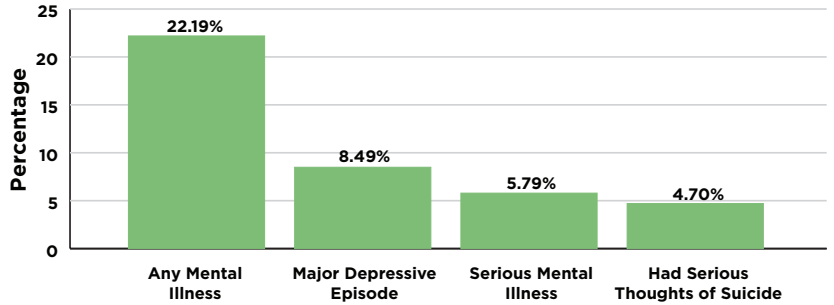
In recent years, mental health concerns have been growing. The stress, trauma and loss many faced during the COVID-19 pandemic may have made this situation worse.

## Youth Mental Health

Nearly 18% of adolescents aged 12 to 17 in North Carolina said they had a major depressive episode in 2021, and 12% experienced a serious emotional problem (see Figure 2). Youth mental health is a growing concern nationwide with many contributing factors. The U.S. Centers for Disease Control and Prevention (CDC) recently released data highlights the distress that our nation's youth is experiencing[45]:

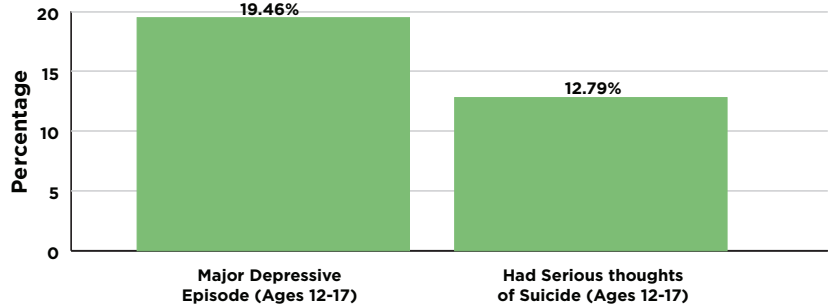
- Young girls are twice as likely as boys to feel persistently sad or hopeless (60%) and nearly twice as likely to attempt suicide (10%)
- 14% of young girls reported experiencing forced sex (rape)
- One in ten LGBTQ+ students skipped school for safety concerns and 25% reported being bullied
- 25% of LGBTQ+ youth have experienced sexual violence
- Two in ten LGBTQ+ youth attempted suicide, which is four times more likely than their heterosexual peers
- Black youth are more likely to attempt suicide than other racial or ethnic groups
- American Indian/Alaskan Native youth were most likely to experience forced sex than other racial or ethnic groups
- American Indian and African American/Black youth are more likely to be homeless

### FIGURE 1: ADULT (18+) MENTAL HEALTH OCCURRENCES IN 2021-2022, NC




Nearly a quarter of North Carolinians reported having a mental illness in 2021-2022. • Source: 2021 NSDUH: State-specific tables | CBHSQ Data. (n.d.). www.samhsa.gov/data/report/2021-nsduh-state-specific-tables

### FIGURE 2: YOUTH MENTAL HEALTH OCCURRENCES IN 2021, NC




~18% of tweens and teens (ages 12 to 17) reported having a major depressive episode. 12% reported a serious emotional disturbance. • Source: 2021 NSDUH: State-specific tables | CBHSQ Data. (n.d.). www.samhsa.gov/data/report/2021-nsduh-state-specific-tables

In North Carolina specifically, data indicates an increase in high school students reporting:

1. Feelings of loneliness
2. Feelings of sadness and hopelessness
3. Suicidal behaviors
4. Feeling unsafe at school
5. Experiencing physical dating violence[46]

Improving mental health outcomes can happen by showing love and support to family and friends, getting involved in the community and talking openly about feelings. Other things that can help include making homes, neighborhoods and schools safer, reducing poverty, improving economic conditions for people and families, educating people about signs of mental health issues through programs like Mental Health First Aid, and improving access to preventive care and treatment for mental health, behavior and substance use issues.

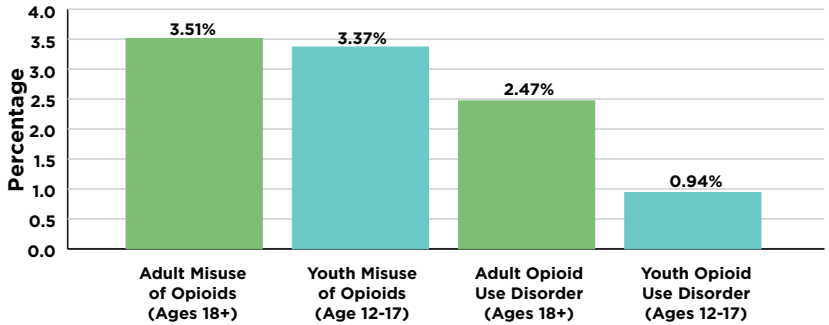
## Substance Use – Alcohol, Drugs and Tobacco

Substance use includes alcohol, tobacco products (when they are not used as part of a ceremony or tradition), and drugs like stimulants and sedatives. Using these substances can lead to both short-term and long-term health issues, mental health problems, injuries and even death. People who use substances may take risks while using them. Regular drug use can change the brain, affecting self-control and behavior. This can lead to tolerance, dependence or substance use disorder, which can interfere with responsibilities at work, school or home, and cause problems in relationships. Substance use disorder is a disease that requires prevention, treatment and management, like other illnesses.[47]

Some people are more likely to develop substance use problems because of their family history, genetics and other factors like mental illness, difficult childhood experiences, early exposure to drugs, and ongoing hardships or trauma.[48] Stigma around substance use as well as misunderstanding addiction as crime-related instead of a medical issue linked to life challenges like trauma and poverty, has led to treating it as a crime rather than a health concern. Changing how we view substance use means tackling the social systems that perpetuate these misunderstandings and fail to address the underlying causes effectively.

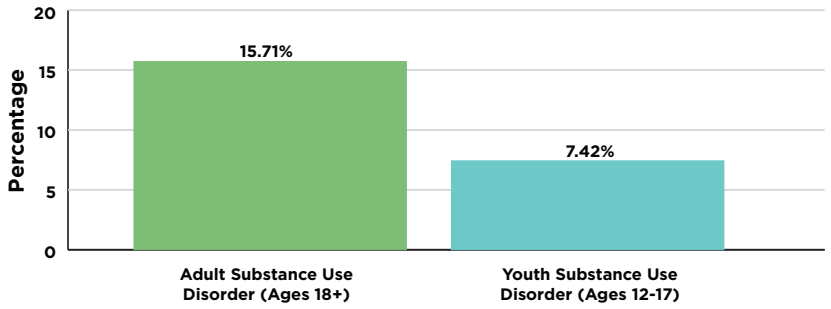
### DRUGS

#### FIGURE 3: ADULT AND YOUTH OPIOIDS MISUSE AND DISORDER IN 2021, NC




Nearly 4% of adults and 3% of youth reported misusing opioids. 2.6% of adults and 1% of youth reported opioid use disorder. • Source: 2021 NSDUH: State-specific tables | CBHSQ Data. (n.d.). www.samhsa.gov/data/report/2021-nsduh-state-specific-tables

#### FIGURE 4: ADULT AND YOUTH SUBSTANCE USE DISORDER IN 2021, NC




16% of adults and nearly 8% of youths reported a substance use disorder. A substance use disorder includes use of alcohol, marijuana, cocaine (including crack), heroin, hallucinogens, inhalants, and methamphetamine, and any past year users of prescription psychotherapeutic drugs. • Source: 2021 NSDUH: State-specific tables | CBHSQ Data. (n.d.). www.samhsa.gov/data/report/2021-nsduh-state-specific-tables

## TABLE 19: DRUGS

| | TOTAL POP. | RACE/ETHNICITY | | | | | | | | | | | | | | | | GEOGRAPHY | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | WHITE, NON-HISPANIC | AFRICAN AMERICAN/BLACK, NON-HISPANIC | | | AMERICAN INDIAN, NON-HISPANIC | | | ASIAN/PACIFIC ISLANDERS, NON-HISPANIC | | | MULTIRACIAL, NON-HISPANIC | | | HISPANIC/LATINX | | | URBAN | | | RURAL | | |
| | Rate/% | Rate/% | Rate/% | Disparity Ratio Grade Indicates severity of disparity | Disparity Ratio African American/Blacks X times more likely than whites | Rate/% | Disparity Ratio Grade Indicates severity of disparity | Disparity Ratio American Indians X times more likely than whites | Rate/% | Disparity Ratio Grade Indicates severity of disparity | Disparity Ratio Asian/Pacific Islanders X times more likely than whites | Rate/% | Disparity Ratio Grade Indicates severity of disparity | Disparity Ratio Multiracial X times more likely than whites | Rate/% | Disparity Ratio Grade Indicates severity of disparity | Disparity Ratio Hispanic/Latinx X times more likely than whites | Rate/% | Disparity Ratio Grade Indicates severity of disparity | Disparity Ratio Urban X times more likely than total population | Rate/% | Disparity Ratio Grade Indicates severity of disparity | Disparity Ratio Rural X times more likely than urban |
| Total Drug Overdose deaths, 2021 | 38.1 | 42.0 | 38.5 | A | 0.92 | 94.1 | C | 2.24 | 2.7 | A | 0.06 | * | * | * | 16.0 | A | 0.38 | 36.1 | A | 0.95 | 43.6 | A | 1.21 |
| Overdose Emergency Department Visits, 2021 | 261.7 | 267.6 | 257.0 | A | 0.96 | 535.6 | C | 2.00 | 41.0 | A | 0.15 | * | * | * | 97.2 | A | 0.36 | 254.0 | A | 0.97 | 281.9 | A | 1.11 |

Data provided by Injury and Violence Prevention Branch • *Demographic variable not available; **Estimate suppressed because it did not meet statistical reliability standards • Death Data Source: Overdose Deaths: North Carolina State Center for Health Statistics, Vital Statistics Death Certificate Data, 2021. • Alcohol-related Deaths: North Carolina State Center for Health Statistics, Vital Statistics Death Certificate Data, 2021, and CDC's Alcohol-Related Disease Impact methodology. For more information on ARDI see https://nccd.cdc.gov/DPH_ARDI/default/default.aspx. • ED Visit Data Source: NC DETECT: NC DETECT is a statewide public health syndromic surveillance system, funded by the NCDHHS Division of Public Health (DPH) Federal Public Health Emergency Preparedness Grant and managed through collaboration between DPH and the UNC-CH Department of Emergency Medicine's Carolina Center for Health Informatics. The NC DETECT Data Oversight Committee is not responsible for the scientific validity or accuracy of methodology, results, statistical analyses, or conclusions presented. • Drug Overdose: Opioid and Substance Use Action Plan Data Dashboard | Centering Equity and Lived Experience. NCDHHS. (2020). https://www.ncdhhs.gov/opioid-and-substance-use-action-plan-data-dashboard

Nearly 4% of adults and 3% of youth in North Carolina report using opioids in a harmful way (see Figure 3). A larger percentage of people report having a substance use disorder: about 16% of adults and 8% of youth in North Carolina (see Figure 4).

Socio-economic conditions and historical trauma have caused ongoing racial and ethnic differences for American Indians. These inequalities and other factors have led to health problems. American Indians are twice as likely to visit the emergency room or die from an overdose compared to White, non-Hispanics (see Table 19). In North Carolina, American Indians have the worst health problems related to substance use, including overdose and alcohol-related deaths and emergency room visits (see Tables 19 and 20).

For more information, please view North Carolina's Opioid and Substance Use Action Plan.

### PRIORITY POPULATIONS REGARDING SUBSTANCE USE

**Justice-Involved Populations:** People are 40 times more likely to die from an overdose in the two weeks after leaving jail or prison than the general population.[49] The 2023-2025 state budget provides $99 million to help people in the justice system by increasing services for reentry, diversion and capacity restoration.

**People Experiencing Housing Insecurity:** People in North Carolina that do not have a home were 13.8 times more likely to die from overdose than the general population.[50]

**Populations Historically Marginalized:** Over the past decade, overdose rates have increased among groups that have been treated unfairly in the past, including American Indian, African American/Black, Hispanic and Asian populations.

## ALCOHOL BY RACE AND ETHNICITY

People in rural communities die from alcohol-related causes more often than people in urban areas. American Indians are 1.6 times more likely to die from alcohol-related causes than Whites and 2.3 times more likely to die from serious alcohol-related events like injuries, overdose and violence. African Americans/Blacks are slightly more likely to die from acute alcohol-related events or visit the emergency room for these issues (see Table 20).

### TABLE 20: ALCOHOL

| | TOTAL POP. | RACE/ETHNICITY | | | | | | | | | | | | | | GEOGRAPHY | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | WHITE, NON-HISPANIC | AFRICAN AMERICAN/BLACK, NON-HISPANIC | | | AMERICAN INDIAN, NON-HISPANIC | | | ASIAN/PACIFIC ISLANDERS, NON-HISPANIC | | | MULTIRACIAL, NON-HISPANIC | | | HISPANIC/LATINX | | | URBAN | | | RURAL | | |
| | Rate/% | Rate/% | Rate/% | Disparity Ratio Grade (Indicates severity of disparity) | Disparity Ratio (African American/Blacks X times more likely than whites) | Rate/% | Disparity Ratio Grade (Indicates severity of disparity) | Disparity Ratio (American Indians X times more likely than whites) | Rate/% | Disparity Ratio Grade (Indicates severity of disparity) | Disparity Ratio (Asian/Pacific Islanders X times more likely than whites) | Rate/% | Disparity Ratio Grade (Indicates severity of disparity) | Disparity Ratio (Multiracial X times more likely than whites) | Rate/% | Disparity Ratio Grade (Indicates severity of disparity) | Disparity Ratio (Hispanic/Latinx X times more likely than whites) | Rate/% | Disparity Ratio Grade (Indicates severity of disparity) | Disparity Ratio (Urban X times more likely than total population) | Rate/% | Disparity Ratio Grade (Indicates severity of disparity) | Disparity Ratio (Rural X times more likely than urban) |
| Total Estimated Alcohol Related Mortality, 2021 | 59.7 | 64.7 | 63.8 | A | 0.99 | 104.7 | B | 1.62 | 12.2 | A | 0.19 | * | * | * | 26.1 | A | 0.40 | 55.4 | A | 0.93 | 71.1 | B | 1.28 |
| Chronic Alcohol Related Mortality, 2021 (Chronic Disease) | 32.7 | 38.9 | 28.5 | A | 0.73 | 45.6 | A | 1.17 | 7.3 | A | 0.19 | * | * | * | 9.2 | A | 0.24 | 30.4 | A | 0.93 | 39.0 | B | 1.28 |
| Acute Alcohol Related Mortality, 2021 (Injuries, Overdose, Violence) | 27.0 | 25.9 | 35.3 | B | 1.37 | 59.2 | C | 2.29 | 4.9 | A | 0.19 | * | * | * | 16.9 | A | 0.65 | 25.0 | A | 0.93 | 32.1 | B | 1.28 |
| Youth Alcohol Consumption, 2021 | 19.4% | 24.3% | 15.1% | A | 0.62 | * | * | * | 0.0% | | 0.00 | * | * | * | 16.0% | A | 0.66 | * | * | * | * | * | * |
| Adult Alcohol Consumption, 2021 | 49.8% | 52.8% | 43.3% | A | 0.82 | * | * | * | * | * | * | * | * | * | 49.2% | A | 0.93 | * | * | * | * | * | * |
| Adult Excessive (binge) Drinking, 2021 | 16.7% | 18.4% | 10.6% | A | 0.58 | * | * | * | * | * | * | * | * | * | 18.5% | A | 1.01 | * | * | * | * | * | * |
| Acute Alcohol Intoxication ED Visits, 2021 | 314.7 | 296.5 | 379.1 | B | 1.28 | 385.2 | B | 1.30 | 43.1 | A | 0.15 | * | * | * | 147.9 | A | 0.50 | 326.8 | A | 1.04 | 282.6 | A | 0.86 |

Data provided by Injury and Violence Prevention Branch • *Demographic variable not available; **Estimate suppressed because it did not meet statistical reliability standards • Death Data Source: Overdose Deaths: North Carolina State Center for Health Statistics, Vital Statistics Death Certificate Data, 2021. • Alcohol-related Deaths: North Carolina State Center for Health Statistics, Vital Statistics Death Certificate Data, 2021, and CDC's Alcohol-Related Disease Impact methodology. For more information on ARDI see https://nccd.cdc.gov/DPH_ARDI/default/default.aspx. • ED Visit Data Source: NC DETECT: NC DETECT is a statewide public health syndromic surveillance system, funded by the NCDHHS Division of Public Health (DPH) Federal Public Health Emergency Preparedness Grant and managed through collaboration between DPH and the UNC-CH Department of Emergency Medicine's Carolina Center for Health Informatics. The NC DETECT Data Oversight Committee is not responsible for the scientific validity or accuracy of methodology, results, statistical analyses, or conclusions presented. • Youth Alcohol Consumption Data Source: North Carolina Department of Public Instruction, Youth Risk Behavior Surveillance System (YRBSS), 2021. • Adult Alcohol Consumption and Excessive Drinking Data Source: North Carolina State Center for Health Statistics, Behavioral Risk Factor Surveillance System (BRFSS), 2021. • ED and Death case definitions: For details of the overdose case definitions see All Intent Medication and Drug Overdose definition: https://injuryfreenc.dph.ncdhhs.gov/DataSurveillance/poisoning/SummaryTableforPoisoningDefinitions.pdf. For details of the acute alcohol intoxication ED visit case definition, see https://ncdetect.org/case-definitions/. For alcohol-related deaths, total causes of alcohol attributable deaths include both chronic and acute causes of death. These causes of death include 40 alcohol-related chronic diseases (ex: liver cirrhosis, alcohol dependence) and 18 alcohol-related injuries (ex: poisonings, falls, homicide, suicide). Chronic causes of alcohol attributable deaths result from long-term, excessive use of alcohol, such as a lifetime of heavy drinking. These causes of death include 40 alcohol-related chronic diseases (ex: liver cirrhosis, alcohol dependence). Acute causes of alcohol attributable deaths, including injuries, take place in the short-term, such as a single event of binge drinking. These causes of death include 18 alcohol-related injuries (ex: poisonings, falls, homicide, suicide). • Youth and Adult alcohol consumption definitions: Youth Alcohol Consumption: At least one alcoholic drink in the past 30 days. • Adult Alcohol Consumption: At least one alcoholic drink in the past 30 days. Adult Excessive Drinking: Among those who drank (at least one alcoholic drink in the past 30 days), had at least one binge drinking episode (5 or more drinks on one occasion for men; 4 or more drinks for women) or were heavy drinkers (2 or more drinks per day for men, more than 1 drink per day for women). • Technical Notes: (1) Due to changes within NC SCHS, the 2021 population file is currently on hold. The 2020 population file will be used as a proxy for 2021. Rates will be subject to change until a new file is created. (2) Rates are per 100,000 NC residents. (3) Alcohol-related death rates by race and ethnicity are calculated using the Alcohol-Related Disease Impact (ARDI) methodology to estimate alcohol-attributable deaths. ARDI does not provide stratification by race/ethnicity, only by age and sex. Alcohol-attributable deaths for race/ethnicity may be high among one race/ethnicity group due to a broader disparity in one of the 58 alcohol-attributable causes of death, and not necessarily attributable to alcohol's involvement. • NCDHHS Division of Public Health. (n.d.-a). Alcohol & the Public's Health in North Carolina. https://dashboards.ncdhhs.gov/t/DPH/views/AlcoholDashboard_2020Update_04042021/Story?%3Aembed=y&%3AisGuestRedirectFromVizportal=y

**KEY**

(Disparity ratio grades indicate the severity of the health difference between population groups. It is not indicative of the severity of the health topic or problem as a whole.)

| Disparity Grade (color) | A (dark blue) | B (pale blue) | C (yellow) | D (pink) | F (red) |
|---|---|---|---|---|---|
| Disparity Ratio | 0.0 - 1.24 | 1.25 - 1.9 | 2.0 - 2.4 | 2.5 - 2.9 | ≥ 3.0 |
| Meaning | Little or no disparity. | A disparity exists, should be monitored and may require intervention. | The disparity requires intervention. | Major interventions are needed. | Significant interventions are needed. |

## PRIORITY POPULATIONS WHEN IT COMES TO TOBACCO USE

**Active Military and Veterans:** The Chronic Disease and Injury Section reports that nearly half (47%) of the people at Fort Liberty (formerly Fort Bragg) use tobacco. Thirty-one percent started using tobacco after arriving at Fort Liberty and 75% of all active-duty soldiers living in the barracks use tobacco. In North Carolina, 20.1% of veterans use tobacco.[51]

**People with Disabilities:** 25.6% of people with disabilities in North Carolina use tobacco.[52]

**LGBTQ+ Individuals:** LGBTQ+ individuals often use tobacco at higher rates than non-LGBTQ+ individuals.

**People with Mental Health or Substance Use Disorders:** Estimates from the North Carolina Treatment Outcomes and Program Performance System (NC TOPPS) show that 47% of adults with mental health conditions use tobacco and 57.4% of adults with substance use disorder use tobacco.[53]

North Carolina's Behavioral Health and Resilience Plan offers strategies to improve mental and behavioral health across North Carolina[54]:

1. Make behavioral health services more available when and where people need them
2. Build strong systems to support people in crisis and with complex needs
3. Enable better health access and results with data and technology

The General Assembly allocated $835 million for behavioral health in the 2023 legislative session. These funds will strengthen the state's behavioral health crisis system. For example, $15 million will go to nine behavioral health urgent care centers across North Carolina,[55] support children with complex needs and their families, address the needs of people involved in the justice system, and strengthen the behavioral health workforce.[56]

# Suicide, Violence and Injury by Race and Ethnicity

## TABLE 21: SUICIDE, VIOLENCE AND INJURY

| | TOTAL POP. | RACE/ETHNICITY | | | | | | | | | | | | GEOGRAPHY | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | WHITE, NON-HISPANIC | AFRICAN AMERICAN/BLACK, NON-HISPANIC | | | AMERICAN INDIAN, NON-HISPANIC | | | ASIAN/PACIFIC ISLANDERS, NON-HISPANIC | | | HISPANIC/LATINX | | | URBAN | | | RURAL | | |
| | Rate | Rate | Rate | Disparity Ratio Grade Indicates severity of disparity | Disparity Ratio African American/Black's X times more likely than whites | Rate | Disparity Ratio Grade Indicates severity of disparity | Disparity Ratio American Indians X times more likely than whites | Rate | Disparity Ratio Grade Indicates severity of disparity | Disparity Ratio Asian/Pacific Islanders X times more likely than whites | Rate | Disparity Ratio Grade Indicates severity of disparity | Disparity Ratio Hispanic/Latinx X times more likely than whites | Rate | Disparity Ratio Grade Indicates severity of disparity | Disparity Ratio Urban X times more likely than total population | Rate | Disparity Ratio Grade Indicates severity of disparity | Disparity Ratio Rural X times more likely than urban |
| Total Violent Death, 2021*(2) | 23.9 | 22.0 | 34.3 | B | 1.6 | 37.8 | B | 1.7 | 7.9 | A | 0.4 | 16.3 | A | 0.7 | 22.9 | A | 1.0 | 26.5 | A | 1.2 |
| Suicide, 2021*(2) | 15.1 | 18.3 | 8.3 | A | 0.5 | 13.7 | A | 0.8 | 7.6 | A | 0.4 | 10.7 | A | 0.6 | 13.8 | A | 0.9 | 18.3 | B | 1.3 |
| Homicide, 2021(2) | 9.0 | 3.7 | 25.5 | F | 7.0 | 21.7 | F | 5.9 | ** | ** | ** | 7.3 | C | 2.0 | 9.0 | A | 1.0 | 8.8 | A | 1.0 |
| Firearm-Related Deaths, 2021(2) | 16.8 | 13.8 | 29.2 | C | 2.1 | 31.4 | C | 2.3 | 4.3 | A | 0.3 | 10.5 | A | 0.8 | 16.0 | A | 1.0 | 18.9 | A | 1.2 |
| Self Inflicted Injury Hospitalizations, 2021*(3) | 33.3 | 35.0 | 28.3 | A | 0.8 | 32.1 | A | 0.9 | 13.0 | A | 0.4 | 26.8 | A | 0.8 | 34.5 | A | 1.04 | 30.1 | A | 0.9 |
| Assault Hospitalizations, 2021(3) | 17.5 | 10.5 | 37.7 | F | 3.6 | 37.0 | F | 3.5 | 4.1 | A | 0.4 | 13.6 | B | 1.3 | 17.9 | A | 1.02 | 16.6 | A | 0.9 |
| Firearm-Related Hospitalizations, 2021(3) | 14.3 | 5.6 | 40.9 | F | 7.3 | 20.9 | F | 3.7 | 2.4 | A | 0.4 | 9.1 | B | 1.6 | 14.3 | A | 1.00 | 14.3 | A | 1.0 |
| Self Inflicted Injury Emergency Department Visits, 2021*(4) | 59.1 | 57.4 | 60.8 | A | 1.1 | 57.7 | A | 1.0 | 15.5 | A | 0.3 | 31.6 | A | 0.6 | 59.1 | A | 1.00 | 59.1 | A | 1.0 |
| Assault Emergency Department Visits, 2021(4) | 221.6 | 166.0 | 361.4 | C | 2.2 | 255.0 | B | 1.5 | 27.9 | A | 0.2 | 134.8 | A | 0.8 | 217.5 | A | 0.98 | 232.6 | A | 1.1 |
| Firearm-Related Emergency Department Visits, 2021(4) | 28.1 | 12.2 | 70.1 | F | 5.8 | 58.7 | F | 4.8 | 2.7 | A | 0.2 | 13.7 | A | 1.1 | 26.3 | A | 0.94 | 32.7 | A | 1.2 |

Data provided by Injury and Violence Prevention Branch • Technical Notes: (1) Due to changes in population estimates, the 2021 population file is currently on hold and 2021 rates were calculated with 2020 population estimates as proxy. Rates are subject to change when population estimates are finalized; (2) Rates per 100,000 NC residents, data limited to residents. (3) Rurality classified at the county-level using US Census definition, see IVPB Technical Notes Table 5a (https://injuryfreenc.dph.ncdhhs.gov/DataSurveillance/Technical-Notes.pdf) • References: (1) NC State Center for Health Statistics (SCHS), Death Certificate Data, 2021; (2) NC SCHS, Hospital Discharge Data, 2021; (3) NC Violent Death Reporting System (NC-VDRS), 2021, data are provisional and subject to change, as of 7/10/2023; (4) NC DETECT, ED Visit Data, 2021 • Analysis by the NCDHHS DPH Injury Epidemiology, Surveillance, and Informatics Unit

**KEY**

(Disparity ratio grades indicate the severity of the health difference between population groups. It is not indicative of the severity of the health topic or problem as a whole.)

| Disparity Grade (color) | A (dark blue) | B (pale blue) | C (yellow) | D (pink) | F (red) |
|---|---|---|---|---|---|
| Disparity Ratio | 0.0 - 1.24 | 1.25 - 1.9 | 2.0 - 2.4 | 2.5 - 2.9 | ≥ 3.0 |
| Meaning | Little or no disparity. | A disparity exists, should be monitored and may require intervention. | The disparity requires intervention. | Major interventions are needed. | Significant interventions are needed. |




## MENTAL HEALTH AND THE IMPACT OF VIOLENCE

People with mental illness are three times more likely to be a victim than a perpetrator of violence. High levels of exposure to violence also reinforce cycles of trauma and fear that can worsen mental health. More than half of U.S. adults worry about a loved one being a victim of violence.

## RISK AND PROTECTIVE FACTORS FOR VIOLENCE

Risk factors are things that make it more likely for someone to experience violence. Protective factors are things that make it less likely for someone to experience violence or help them handle it better. Violence can happen between individuals or affect an entire community. Some community risk factors include low neighborhood unity, social isolation, lack of jobs, unemployment and seeing violence in the community. Community protective factors include having enough food, affordable housing, education and job opportunities, access to mental health and substance use services, and strong social connections at home and in the community.[57]

## FIREARM RELATED DISPARITIES BY RACE & ETHNICITY

American Indians and African Americans/Blacks are more likely to be involved in assaults, firearm deaths and injuries, and homicides (see Table 21). People ages 19 to 24 are also greatly affected by violence. Firearms are the leading cause of violent deaths, making up 63.1% of all violent deaths. The most common way both suicides and homicides happen is by firearms, at 57.3% and 75.8% respectively.[58] Limiting access to deadly means, such as firearms and medications, can reduce homicides and suicides. In 2023, Governor Roy Cooper created the Office of Violence Prevention to help reduce violence and firearm misuse in North Carolina.

## PRIORITY POPULATION FEATURE

**Veterans:** Military veterans' suicide rates were 250% higher than the general population from 2016 to 2020. For younger veterans ages 18 to 34, this number was even higher at 610%.[59]

Like violence, there are also risk and protective factors for suicide. Individual risk factors include mental illness, social isolation, substance use and personal stress or crises. A person's life experiences can also affect their risk. For example, negative childhood experiences like neglect or abuse, being bullied, having a family history of suicide or experiencing violence can increase the risk of suicidal thoughts.

Additionally, not having access to mental health care, social stigma around mental illness and easy access to deadly means can make suicide more common.[60] But we can also strengthen protective factors for ourselves, our loved ones and our communities. We can make a difference by raising children in safe and loving homes, schools and neighborhoods, ensuring firearms are secured safely, having open and honest conversations, building healthy relationships and seeking help when needed. There are many ways communities can support those who are having a tough time.

## SUCCESS SPOTLIGHT:
# FAITH LEADERS FOR LIFE

There is a shortage of mental health care providers in North Carolina, especially in rural areas. For many people in crisis, their first contact for help may be a faith leader. However, most faith leaders have little or no training in suicide prevention. To meet this need, the NC Comprehensive Suicide Prevention (CSP) team created a program called Faith Leaders for Life. In one year, the CSP team held this five-week program six times, training 98 faith leaders and 138 congregants in suicide prevention, ultimately helping 48,900 congregants in North Carolina. Seventy of the 98 leaders represent BIPOC congregations and many of these communities are in rural areas. This program has been life-changing for some; one participant said: "This was an amazing, life changing training. It has provided me the skill set to have tough conversations. This training has enabled me to also speak with my church in ways in which we can strengthen our ministry."

The COVID-19 Health Equity grant supported the Faith Leaders for Life Program and helped train faith communities in suicide prevention and reduce the stigma of suicide in 37 counties across North Carolina.

If you or someone you know is having a mental health or substance use crisis, you can call or text 988, or chat online at www.988lifeline.org, to talk to a trained crisis counselor any time. For Spanish-speaking help, call or text 988 and press option 2, text "AYUDA" to 988 or chat at 988lineadevida.org. Mobile Crisis Teams can also meet you wherever you feel safe. These teams provide a tailored response to mental health and behavioral crises and are not part of the police force.

Another option is the statewide Peer Warmline, staffed by Peer Support Specialists who offer non-clinical support and resources to those in crisis. Peers are people living in recovery with mental illness and/or substance use disorder who provide support to others, which helps reduce stigma and improve overall care engagement. Like 988, North Carolina's Peer Warmline is available 24/7. To speak with a peer, call 1-855-PEERS NC (1-855-733-7762). If you call 988, you can also choose to connect with the Peer Warmline if that is what you prefer.

## TABLE 22: HOW YOU CAN PLAY A PART – MENTAL HEALTH, SUBSTANCE USE, SUICIDE AND VIOLENCE PREVENTION

| NCDHHS PARTNER | RECOMMENDED STRATEGIES |
|---|---|
| **Community-Based Organizations and Services** | Establish peer support programs.<br>Help address barriers to mental health care, like transportation.<br>Increase access to naloxone for people involved with the justice system, through partnerships with jails, local health departments and community organizations.<br>Educate incarcerated individuals about naloxone and provide it upon release or to their visitors.<br>Implement restorative justice programming.[61]<br>Provide suicide prevention and gatekeeper training, especially in places like faith-based groups, veteran services, schools and youth organizations. [62]<br>Implement mentoring and youth development programs. Educate families and community members on safe firearm storage (see NC S.A.F.E. for details).[63]<br>Distribute firearm safety devices. |
| **Faith-Based Organizations** | Provide suicide prevention and gatekeeper training, especially in places like faith-based groups, veteran services, schools and youth organizations.[64]<br>Implement mentoring and youth development programs.<br>Implement restorative justice programming.[65] |
| **Governmental Agencies** | Incorporate people with lived experience into decision-making and policy-making processes.<br>Partner with other community partners, advocates and elected officials.<br>Serve as a resource and education center.<br>Increase training for school counselors to support students with mental and behavioral health challenges. Provide culturally appropriate materials in Spanish and other languages to connect people with mental and behavioral health resources.<br>Invest in increasing the number of bilingual and bicultural mental health providers.<br>Support crisis intervention infrastructure.[66]<br>Establish Community Violence Interruption and Prevention Programs. |
| **Health Care Professionals and Organizations** | Use trauma-informed, person-centered and culturally sensitive approaches in service delivery.<br>Screen for mental health and substance use disorders.<br>Adopt collaborative care model for integrating physician and behavioral health care.<br>Provide cultural competence training for providers to better serve the mental health needs of diverse populations.<br>Offer culturally competent information and resources in the languages spoken by the community.<br>Use resources in NC S.A.F.E.<br>Establish Hospital-Based Violence Interruption Programs and connect survivors of gun violence with resources.[67]<br>Develop or improve community services for injury and violence prevention and response.<br>Partner with NC Trauma System centers around violence intervention prevention. |

| NCDHHS PARTNER | RECOMMENDED STRATEGIES |
|---|---|
| **Advocates, Decision Makers and System Changers** | Maintain limits on price promotions, such as happy hours.<br>Maintain state control over alcohol sales and avoid privatization.<br>Increase the price of alcohol by raising alcohol taxes.<br>Adjust days and hours that alcohol is sold.<br>Increase funding to schools and local mental health and substance abuse programs.<br>Advocate for standardized firearm surrender policies in intimate partner violence cases.[68]<br>Promote safe firearm storage practices.[69]<br>Expand access to mental health and substance use services.[70]<br>NC SHIP 2023 proposes these policy initiatives:<br>• Create a coordinated infrastructure<br>• Reduce access to methods that can cause death<br>• Increase community awareness and prevention<br>• Provide crisis intervention<br>• Provide access to and delivery of suicide care<br>• Measure our impact and revise strategies based on results<br>• Build partnerships to increase awareness of fall risk factors<br>• Advance access to fall prevention interventions<br>• Cultivate strategic partnerships with traditional and nontraditional agencies and organizations addressing falls<br>• Ensure access to behavioral health treatment, adequate medical care and stable housing for people who were incarcerated<br>• Expand or create Medication Assisted Treatment programs for incarcerated people with substance use disorders<br>• Improve access to treatment for substance use disorders, physical illnesses and mental illnesses<br>• Increase access to multisystemic therapy for young offenders<br>• Invest in public health alternatives instead of using police and courts for mental health issues.<br>• Center equity and lived experiences by changing systems that have harmed people that have been treated unfairly in the past, and improving access to more appropriate health services that respect their cultures and language<br>• Support children and families to prevent future addiction and address trauma<br>• Reduce harm by addressing other substances besides opioids<br>• Connect to care by expanding housing options and treatment access for justice-involved people |
| **Business and Industry** | Include people with lived experience on your community advisory boards.<br>Ensure that hiring and retention is fair and diverse.<br>Start or do more checks to make sure stores follow rules about selling alcohol and tobacco to minors.<br>Reduce alcohol advertisements in different places like TV, papers, signs, online ads and sponsoring events.<br>Support programs that repair harm caused by crime and bring people back to society after incarceration[71], which may include giving them jobs or work training. |

## Mothers and Babies

Improving the health of mothers and babies is important for public health in the United States and remains a top priority in North Carolina. Maternal health is not just about being healthy during pregnancy. It is about a person's health throughout their whole life. Many things can affect maternal health, like existing health conditions, genetics, age, the place where they live, having enough food and a safe place to live, violence, how healthy their habits are, getting medical care when they need it, quality of care, their knowledge about health and more. Maternal health also includes the time after pregnancy.

The well-being of mothers and babies affects the health of the next generation. Investing in women and infants is a top priority for NCDHHS.

The NC Perinatal Health Strategic Plan has three goals[72]:

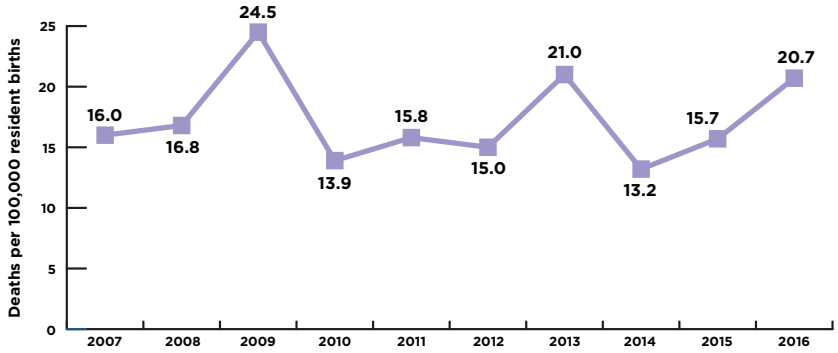
1. Addressing disparities in economic and social needs
2. Strengthening families and communities
3. Making health care better for anyone who can have children

### MATERNAL MORTALITY BY RACE AND ETHNICITY

African Americans/Blacks in North Carolina are more than 1.5 times as likely as Whites to die from causes related to pregnancy. Between 2018 and 2019, 85% of pregnancy-related deaths in North Carolina could have been prevented.[73]

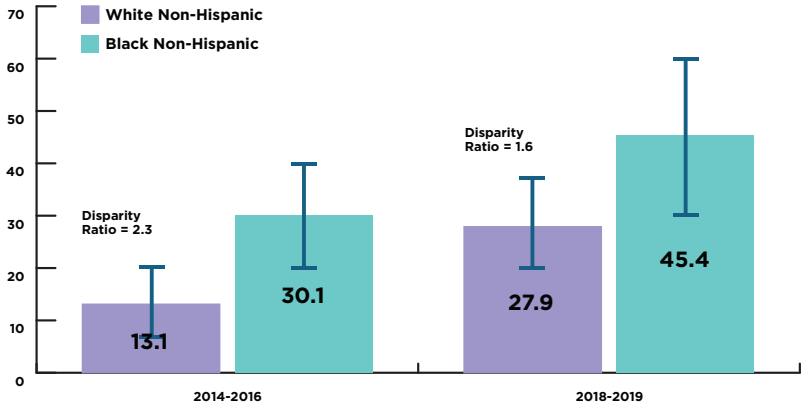
Out of the 76 deaths during this period, about a third (34 people) were linked to mental health issues and injuries; specifically, 20 deaths were due to drug overdose and eight deaths were from homicide. Some factors that contributed to these deaths were bias and discrimination (69.7%), mental health conditions (46.1%), substance use disorder (38.2%) and obesity (27.6%).[74]

**FIGURE 5 : PREGNANCY-RELATED MORTALITY RATIOS BY YEAR OF DEATH, NORTH CAROLINA RESIDENTS 2007-2016**



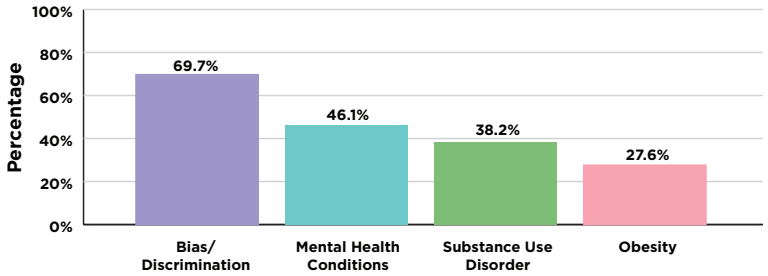

Source: NCDHHS / Division of Public Health / Women, Infant and Community Wellness Section / Maternal Health Branch / NC Maternal Mortality Review Committee

**FIGURE 6: NON-HISPANIC BLACK AND NON-HISPANIC WHITE PREGNANCY-RELATED MORTALITY RATIOS BY YEAR, NORTH CAROLINA RESIDENTS 2001-2016**




Source: NCDHHS / Division of Public Health / Women, Infant and Community Wellness Section / Maternal Health Branch / NC Maternal Mortality Review Committee

## FIGURE 7: PERCENTAGE OF PREGNANCY-RELATED DEATHS WITH KEY CONTRIBUTORY FACTORS DOCUMENTED BY MMRC NC RESIDENTS 2018-2019




Source: NCDHHS / Division of Public Health / Women, Infant and Community Wellness Section / Maternal Health Branch / NC Maternal Mortality Review Committee

## MATERNAL RISK FACTORS BY RACE AND ETHNICITY

### TABLE 23: MATERNAL RISK FACTORS

| | TOTAL POP. | RACE/ETHNICITY | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | WHITE NON-HISPANIC | AFRICAN AMERICAN/BLACK, NON-HISPANIC | | | AMERICAN INDIAN, NON-HISPANIC | | | ASIAN/PACIFIC ISLANDER, NON-HISPANIC | | | MULTIRACIAL, NON-HISPANIC | | | HISPANIC/LATINX | | |
| | Rate/% | Rate/% | Rate/% | Disparity Ratio Grade Indicates severity of disparity | Disparity Ratio African American/Blacks X times more likely than white population | Rate/% | Disparity Ratio Grade Indicates severity of disparity | Disparity Ratio American Indians X times more likely than white population | Rate/% | Disparity Ratio Grade Indicates severity of disparity | Disparity Ratio Asian/Pacific Islanders X times more likely than white population | Rate/% | Disparity Ratio Grade Indicates severity of disparity | Disparity Ratio Multiracials X times more likely than white population | Rate/% | Disparity Ratio Grade Indicates severity of disparity | Disparity Ratio Hispanic/Latinx X times more likely than white population |
| Late or No Prenatal Care (%), 2019-21 | 25.5 | 19.0 | 31.9 | B | 1.7 | 29.7 | B | 1.6 | 26.0 | B | 1.4 | 28.9 | B | 1.5 | 36.1 | B | 1.9 |
| Maternal Smoking during Pregnancy (%), 2019-21 | 6.6 | 8.6 | 6.2 | A | 0.7 | 18.1 | C | 2.1 | 0.6 | A | 0.1 | 9.5 | A | 1.1 | 1.2 | A | 0.1 |
| Maternal Obesity (%), 2019-21 | 30.7 | 26.9 | 42.1 | B | 1.6 | 38.0 | B | 1.4 | 12.4 | A | 0.5 | 32.6 | A | 1.2 | 31.0 | A | 1.2 |
| Maternal Overweight (%), 2019-21 | 25.8 | 24.8 | 24.6 | A | 1.0 | 22.8 | A | 0.9 | 25.3 | A | 1.0 | 24.8 | A | 1.0 | 31.3 | B | 1.3 |
| Teen Birth Rate (Ages 15-19), 2017-21 | 18.1 | 11.7 | 23.6 | C | 2.0 | 34.5 | F | 2.9 | 4.8 | A | 0.4 | 24.6 | C | 2.1 | 33.3 | D | 2.8 |

Footnotes: Based on information reported on North Carolina resident birth certificates from 2019-2021. Obesity is defined as moms having a Pre-pregnancy Body Mass Index >=30.0. Teen birth rates represent the number of live births per 1,000 females ages 15-19. • Data Provided by State Center for Health Statistics, Minority Health Report 2023

**KEY**

(Disparity ratio grades indicate the severity of the health difference between population groups. It is not indicative of the severity of the health topic or problem as a whole.)

| Disparity Grade (color) | A (dark blue) | B (pale blue) | C (yellow) | D (pink) | F (red) |
|---|---|---|---|---|---|
| Disparity Ratio | 0.0 - 1.24 | 1.25 - 1.9 | 2.0 - 2.4 | 2.5 - 2.9 | ≥ 3.0 |
| Meaning | Little or no disparity. | A disparity exists, should be monitored and may require intervention. | The disparity requires intervention. | Major interventions are needed. | Significant interventions are needed. |

Teenagers who get pregnant often face higher risks for negative health outcomes as well as social and economic challenges for themselves and for their infants.[75] American Indian and Hispanic teenagers are nearly three times more likely to have babies compared to White teenagers. African Americans/Blacks and Multiracial teenagers are twice as likely to become mothers than White teenagers (see Table 23).

These groups also tend to have other health risks, such as receiving prenatal care late or not at all (see Table 23). Delayed or no prenatal care, along with inadequate screening, increases the risk of congenital syphilis (when a baby is born with syphilis). From 2012 to 2022, the number of syphilis cases in women increased by 547%, and cases of congenital syphilis 5600% (from one case in 2012 to 57 cases in 2022). In just one year, from 2022 to 2023, congenital syphilis cases grew by 36%. Congenital syphilis can cause serious harm and even death in babies. Due to this troubling trend, syphilis prevention, early detection and treatment for pregnant women and babies has become a top priority for NCDHHS. We have launched campaigns to educate health care providers and the public about the importance of syphilis testing and detection for pregnant women, expanded access to testing and treatment, and collaborated with health leaders and experts from southeastern states as well as the CDC and Centers for Medicare and Medicaid Services (CMS).[76]

## INFANT OUTCOMES BY RACE AND ETHNICITY

### TABLE 24: INFANT OUTCOMES

| | TOTAL POP. | RACE/ETHNICITY | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | WHITE NON-HISPANIC | AFRICAN AMERICAN/BLACK, NON-HISPANIC | | | AMERICAN INDIAN, NON-HISPANIC | | | ASIAN/PACIFIC ISLANDER, NON-HISPANIC | | | MULTIRACIAL, NON-HISPANIC | | | HISPANIC/LATINX | | |
| | Rate | Rate | Rate | Disparity Ratio Grade Indicates severity of disparity | Disparity Ratio African American/Blacks X times more likely than white population | Rate | Disparity Ratio Grade Indicates severity of disparity | Disparity Ratio American Indians X times more likely than white population | Rate | Disparity Ratio Grade Indicates severity of disparity | Disparity Ratio Asian/Pacific Islanders X times more likely than white population | Rate | Disparity Ratio Grade Indicates severity of disparity | Disparity Ratio Multiracials X times more likely than white population | Rate | Disparity Ratio Grade Indicates severity of disparity | Disparity Ratio Hispanic/Latinx X times more likely than white population |
| Infant death Rate (per 1,000 births), 2017-21 (1) | 6.9 | 4.8 | 12.6 | D | 2.6 | 9.7 | C | 2.0 | 4.0 | A | 0.8 | 8.5 | B | 1.8 | 5.4 | A | 1.1 |
| Low birthweight (<=2500 grams) Births (%), 2019-21 (2) | 9.4 | 7.3 | 15.3 | C | 2.1 | 11.6 | B | 1.6 | 9.0 | A | 1.2 | 10.4 | B | 1.4 | 7.7 | A | 1.1 |
| Preterm Births (%), 2019-21 (2) | 10.8 | 9.5 | 14.6 | B | 1.5 | 11.4 | A | 1.2 | 8.4 | A | 0.9 | 11.1 | A | 1.2 | 9.7 | A | 1.0 |
| Infant Not Breastfed at Discharge (%), 2019-21 (2) | 19.0 | 15.9 | 30.2 | B | 1.9 | 47.3 | F | 3.0 | 11.0 | A | 0.7 | 21.5 | B | 1.4 | 12.8 | A | 0.8 |

Footnotes: (1) Infant mortality rates per 1,000 live births (based on birth certificate and death certificate data). Child death rates exclude infants and are presented per 100,000 population ages 1-17 (based on death certificate data). • (2) Based on information reported on North Carolina resident birth certificates from 2019-2021. Preterm births are defined as those occurring at less than 37 weeks clinical/obstetric gestation. • Data Provided by State Center for Health Statistics, Minority Health Report 2023

**KEY**

(Disparity ratio grades indicate the severity of the health difference between population groups. It is not indicative of the severity of the health topic or problem as a whole.)

| Disparity Grade (color) | A (dark blue) | B (pale blue) | C (yellow) | D (pink) | F (red) |
|---|---|---|---|---|---|
| Disparity Ratio | 0.0 - 1.24 | 1.25 - 1.9 | 2.0 - 2.4 | 2.5 - 2.9 | ≥ 3.0 |
| Meaning | Little or no disparity. | A disparity exists, should be monitored and may require intervention. | The disparity requires intervention. | Major interventions are needed. | Significant interventions are needed. |

The infant death rate is highest for African American/Black infants, followed by American Indian and Multiracial infants (see Table 24).

Over the past three decades, North Carolina has seen infant mortality reduced by 38% from 1991 to 2021.[77] But the 2022 infant mortality rate stayed the same as 2021, making North Carolina the state with the 10th highest rate in the nation (2022 rates for all states are not yet available).

Although there has been progress, North Carolina's infant mortality rate is still higher than the national average. In 2022, the state reached its lowest infant death rate in 31 years, but there is still work to do. Significant differences in infant death rates, especially among African Americans/Black, highlight the need for specific interventions.

The African American/Black infant death rate has improved, but it is still more than twice as high as the rate for White infants.[78] For instance, in 2022, African American/Black babies were 2.7 times more likely to die in their first year compared to White babies. They also face higher rates of being born prematurely and having a low birth weight.

Addressing these concerns, the state's Perinatal Health Strategic Plan aims to reduce these differences by 2026 by improving access to and the quality of maternal care. Reducing infant mortality is also a primary goal of the North Carolina Early Childhood Action Plan, Healthy North Carolina 2030 and the State Health Improvement Plan. The state has a comprehensive approach to infant mortality, including initiatives supported by the Child Fatality Task Force (CFTF). The CFTF has recommended funding to improve access to maternal care, support mothers with doula services and encourage group prenatal care. In 2021, 60% of all child deaths in the state were infants.

In 2023, the North Carolina General Assembly provided funds and the NC Medicaid program increased payments for maternal care and group prenatal care. About half of pregnancies in North Carolina are unintended, which can increase the risk of negative health outcomes for mothers and babies. North Carolina has worked to make contraception more available, including allowing pharmacists to provide it, and increasing health care access during childbearing years.

North Carolina has made progress in reducing infant mortality and is committed to continuing these efforts, especially in addressing racial differences. Investing in maternal and infant health will improve birth results and lead to a healthier North Carolina.

African American/Black, American Indian and Multiracial infants have higher rates of low birth weight, being born too early and not being breastfed when they leave the hospital (see Table 24). African American/Black and American Indian women and infants face the greatest overall health challenges. People of color often have worse health outcomes throughout their lives and may start and end pregnancy with worse health conditions than White people. While differences in maternal health education, health literacy and access to health care exist among populations, other factors like racism and discrimination also contribute to worse health outcomes for people of color, especially African Americans/Blacks. Studies show that African American/Black women still have higher death rates compared to White women, even when they have the same education, income and type of insurance.[79]

# Children

Childhood, especially during early childhood and teenage years, are important times for physical, mental, cognitive and emotional growth. Children and teenagers often need special care and attention during these years. What happens to a person in their first five years of life is very important for their health throughout their entire lifetime. For example, young children who go through difficult experiences, such as family problems, poverty, neglect, abuse or environmental dangers, are more likely to develop mental and physical health problems as they grow up.[80]

The NCDHHS Early Childhood Action Plan has ten goals:[81]

1. Healthy Babies
2. Preventive Health Services
3. Food Security
4. Safe and Secure Housing
5. Safe and Nurturing Relationships
6. Permanent Families for Children in Foster Care
7. Social-Emotional Health and Resilience
8. High Quality Early Learning
9. On Track for School Success
10. Reading at Grade Level

The NCDHHS Division of Child and Family Well-being also focuses on the health needs of elementary and teenage kids. This includes food and nutrition, child behavioral health, school health programs, home visits and support for youth with special needs or developmental disabilities.

## CHILD MORTALITY BY RACE AND ETHNICITY

### TABLE 25: CHILD MORTALITY

| | TOTAL POP. | RACE/ETHNICITY | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | WHITE NON-HISPANIC | AFRICAN AMERICAN/BLACK, NON-HISPANIC | | | AMERICAN INDIAN, NON-HISPANIC | | | ASIAN/PACIFIC ISLANDER, NON-HISPANIC | | | MULTIRACIAL, NON-HISPANIC | | | HISPANIC/LATINX | | |
| | Rate/% | Rate/% | Rate/% | **Disparity Ratio Grade** Indicates severity of disparity | **Disparity Ratio** African American/Blacks X times more likely than white population | Rate/% | **Disparity Ratio Grade** Indicates severity of disparity | **Disparity Ratio** American Indians X times more likely than white population | Rate/% | **Disparity Ratio Grade** Indicates severity of disparity | **Disparity Ratio** Asian/Pacific Islanders X times more likely than white population | Rate/% | **Disparity Ratio Grade** Indicates severity of disparity | **Disparity Ratio** Multiracials X times more likely than white population | Rate/% | **Disparity Ratio Grade** Indicates severity of disparity | **Disparity Ratio** Hispanic/Latinx X times more likely than white population |
| Child (ages 1-17) Death Rate (per 100,000 pop), 2017-2021 | 21.8 | 18.2 | 35.1 | B | 1.9 | 37.6 | C | 2.1 | 16.3 | A | 0.9 | 10.6 | A | 0.6 | 17.4 | A | 0.95 |

Data Provided by State Center for Health Statistics, Minority Health Report 2023

**KEY**
(Disparity ratio grades indicate the severity of the health difference between population groups. It is not indicative of the severity of the health topic or problem as a whole.)

| Disparity Grade (color) | A (dark blue) | B (pale blue) | C (yellow) | D (pink) | F (red) |
|---|---|---|---|---|---|
| Disparity Ratio | 0.0 - 1.24 | 1.25 - 1.9 | 2.0 - 2.4 | 2.5 - 2.9 | ≥ 3.0 |
| Meaning | Little or no disparity. | A disparity exists, should be monitored and may require intervention. | The disparity requires intervention. | Major interventions are needed. | Significant interventions are needed. |

African American/Black and American Indian children are twice as likely to die as White children in North Carolina (see Table 25).

In recent years, the highest death rates were among children ages 15 to 17 and children ages one to four. For teens ages 15 to 17, the top causes of death in 2021 were homicide, car accidents, suicide and other injuries. For children ages one to four, the top causes of death in 2021 were accidental injuries, homicide, car accidents and health conditions.[82] In North Carolina, firearms are the leading cause of injury deaths in children, surpassing car accidents since 2019. Many of these deaths can be prevented through simple actions like wearing seatbelts, not speeding and safely storing firearms.

## THE COST OF RAISING CHILDREN

Families need special support to provide for their children. In North Carolina, families spend an average of $9,000 to $9,850 per year on full-time child care.[83] This totals nearly $45,000 for child care in the first five years of a child's life before kindergarten. Child care programs, especially PreK, promote healthy development and can prevent chronic diseases and disabilities. Early childhood education benefits entire families by allowing mothers to work more, increasing family income, as well as reducing crime, welfare dependency, child neglect and abuse.[84] It is important to make affordable, high-quality child care and PreK available to all families in North Carolina, no matter where they live or how much they earn.

Besides child care, families also struggle with basic needs. Over 22,600 students in kindergarten through grade 12 are homeless in North Carolina.[85] Families facing financial difficulties are more likely to have children without enough food or stable housing. These families may also have trouble accessing health services, child care and other support. There are services and programs that help with housing and food insecurity, such as food banks, affordable housing programs and food assistance programs like WIC and SNAP, including SUN Bucks. Schools, churches and other community organizations also provide child care and support services.

To help families be strong, we need to improve access to community resources for everyone. We need more affordable housing and child care, family-friendly workplaces and culturally appropriate services.

## CHILDREN WITH SPECIAL HEALTH CARE NEEDS

About 23% of children in North Carolina have special health care needs. Children with special health care needs, as defined by the Maternal and Child Health Bureau, are children who have or are at increased risk for chronic physical, developmental, behavioral or emotional conditions. 12.9% of children ages 0 to 17 may have one functional difficulty* and 9.1% may have two or more functional difficulties. Nearly 25% of children ages 3-17 have a mental, emotional, developmental or behavioral problem.[86]

## JUSTICE-INVOLVED YOUTH

African American/Black children in North Carolina are much more affected by the criminal justice system than other children. Ninety-nine percent (99%) of youth in youth development centers have a mental health diagnosis and 48% have both a mental health and substance use diagnosis.[87]

There is a need for more mental, behavioral and developmental health services for youth. This includes prevention, early detection,and treatment, as well as creating safe, nurturing environments for children and teenagers to grow. It is important for families, child care specialists and anyone involved in the lives of children to understand the history and current context of mental health and discipline (both in schools and the justice system) for African American/Black children.

NCDHHS keeps investing in mental health for young people, child welfare and programs for young people in the justice system.

*FUNCTIONAL DIFFICULTIES MAY BE: Breathing problems; eating or swallowing issues; digesting food, including stomach problems, constipation, or diarrhea; chronic pain, like headaches or other body pain; using their hands (ages 0 to 5); coordination and moving around (ages 0 to 5); serious difficulty concentrating, remembering, or making decisions (ages 6 to 17); serious difficulty walking or climbing stairs (ages 6 to 17); difficulty dressing or bathing (ages 6 to 17); difficulty doing errands alone, like visiting a doctor or shopping (ages 12 to 17); hearing problems or deafness; vision problems or blindness, even with glasses.

### BUILDING FAMILY-CENTERED RESILIENCY

Children need a positive social and emotional environment to thrive. This includes not only their family, but also their neighborhoods and schools. Children benefit from having positive adults and peers to guide them.

Families are healthier and stronger when they have enough money to afford their needs, can spend quality time together, have a community of trusted adults, live in safe neighborhoods, have high-quality education, access to health and safety education, resources and support services, access to quality health care, and live in communities that honor and celebrate their unique cultures.

## Aging Adults

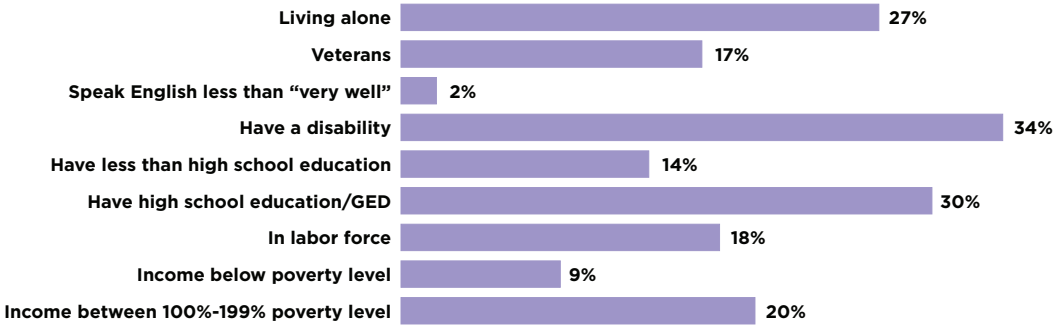
North Carolina has a large aging population. In over half of North Carolina counties, at least one in five people are ages 65 or older. By 2031, there will be more older adults 65 and older than children.[88] As we age, we are more likely to experience diseases and disabilities due to our body's natural processes, and the effects of our environment and health behaviors over time. Older adults are also more vulnerable to health issues because they may have less social interaction, be less involved in work and have lower incomes.

### AGING ADULTS SOCIAL DRIVERS OF HEALTH

About 10% of older adults have an income below poverty level and 20% have an income between 100 and 199% of the poverty level. It is crucial for them to have access to affordable health care and community services. Older adults with less money are more likely to have health problems and to pass away earlier than those with more money.[89]

### FIGURE 8: QUICK FACTS ON AGING ADULTS

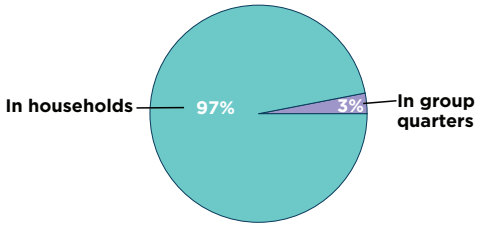
#### CHARACTERISTICS OF ADULTS 65 AND OLDER




*As % of population 65 and older

**Older adults living alone are at risk for social isolation, loneliness and poor health outcomes**

#### HOUSING, 65+




**43% of housing units with people 65+ are single-person**

*As % of population 65 and older

**Aging in place requires livable communities, home modifications, transportation, access to services, health care, and social engagement**

**Aging population increases demand for home and community-based services**

SOURCE: U.S. Census Bureau, American Community Survey 2021, 5-year estimates. Table S0103: Population 65 and over; B09020: Relationship by household type (including living alone) for population 65 and over, https://data.census.gov/cedsci

## AGING ADULTS HEALTH CHARACTERISTICS

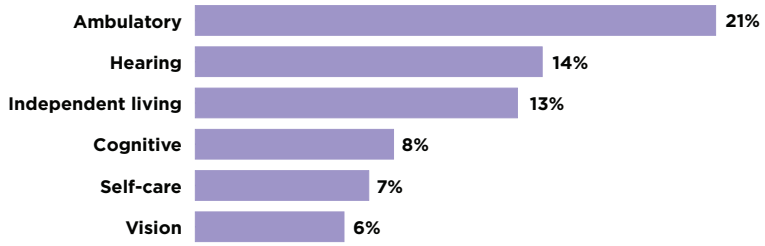
### FIGURE 9: HEALTH CHARACTERISTICS, 65+

*As % of population 65 and older

- 34% have a disability
- 83% have one or more chronic diseases
- 70% had adult flu shot/spray in past 12 months
- 75% ever had pneumonia shot
- 72% exercised in past 30 days
- 7% self-reported poor health

SOURCE: U.S. Census Bureau, American Community Survey 2021, 5-year estimates. Table C18019: Age by number of disabilities, https://data.census.gov/cedsci: NC State Center for Health Statistics. BRFSS 2021 survey results. https://schs.dph.ncdhhs.gov/data/brfss/survey.htm

### FIGURE 10: DISABILITY STATUS, 65+




*As % of population 65 and older. Civilian non-institutionalized population only.

SOURCE: U.S. Census Bureau, American Community Survey 2021, 5-year estimates. Table S1810: Disability Characteristics,

Older adults in North Carolina are at risk for many health disparities:

- Most of them (83%) have one or more chronic diseases
- 34% have a disability
- 7% reported poor health

## AGING ADULTS AND INJURIES BY RACE AND ETHNICITY

### TABLE 26: INJURIES

| | TOTAL POP. | AGE GROUP | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | ≤18* | | | 19-24 | | | 25-44 | | | 45-64 | | | 65+ | | |
| | Rate | Rate | Disparity Ratio Grade Indicates severity of disparity | Disparity Ratio ≤18 X times more likely than total population | Rate | Disparity Ratio Grade Indicates severity of disparity | Disparity Ratio 19-24 X times more likely than total population | Rate | Disparity Ratio Grade Indicates severity of disparity | Disparity Ratio 25-44 X times more likely than total population | Rate | Disparity Ratio Grade Indicates severity of disparity | Disparity Ratio 45-64 X times more likely than total population | Rate | Disparity Ratio Grade Indicates severity of disparity | Disparity Ratio 65+ X times more likely than total population |
| Total Injury Deaths, 2021(1) | 105.8 | 20.6 | A | 0.2 | 104.9 | A | 1.0 | 143.9 | B | 1.4 | 109.2 | A | 1.0 | 158.3 | B | 1.5 |
| Unintentional Fall Deaths, 2021(1) | 15.6 | ** | ** | ** | ** | ** | ** | 1.1 | A | 0.1 | 6.3 | A | 0.4 | 79.5 | F | 5.1 |
| Traumatic Brain Injury (TBI) Deaths, 2021(1) | 23.8 | 6.6 | A | 0.3 | 25.9 | A | 1.1 | 20.6 | A | 0.9 | 20.7 | A | 0.9 | 55.4 | C | 2.3 |
| Total Injury Hospitalizations, 2021(3) | 473.5 | 155.8 | A | 0.3 | 278.7 | A | 0.6 | 322.3 | A | 0.7 | 400.9 | A | 0.8 | 1,332.2 | D | 2.8 |
| Unintentional Fall Hospitalizations, 2021(3) | 238.5 | 24.6 | A | 0.1 | 18.2 | A | 0.1 | 41.9 | A | 0.2 | 146.4 | A | 0.6 | 1,067.8 | F | 4.5 |
| TBI Hospitalizations, 2021(3) | 71.2 | 30.7 | A | 0.4 | 50.9 | A | 0.7 | 47.0 | A | 0.7 | 55.1 | A | 0.8 | 196.6 | D | 2.8 |
| Total Injury Emergency Department Visits, 2021(4) | 7,323.4 | 6,535.2 | A | 0.9 | 8,151.8 | A | 1.1 | 7,436.3 | A | 1.0 | 6,074.6 | A | 0.8 | 9,661.4 | B | 1.3 |
| Unintentional Fall Emergency Department Visits, 2021(4) | 1,621.9 | 1,234.4 | A | 0.8 | 716.8 | A | 0.4 | 813.1 | A | 0.5 | 1,349.9 | A | 0.8 | 4,203.3 | D | 2.6 |
| Traumatic Brain Injury (TBI) Emergency Department Visits, 2021(4) | 238.3 | 222.0 | A | 0.9 | 306.3 | B | 1.3 | 202.7 | A | 0.9 | 168.3 | A | 0.7 | 382.3 | B | 1.6 |

Data provided by Injury and Violence Prevention Branch • Footnotes: Limited to NC Residents; 2021 NC VDRS data are provisional and subject to change, data as of 7/10/2023 • Technical Notes: (1) Due to changes in population estimates, the 2021 population file is currently on hold and 2021 rates were calculated with 2020 population estimates as proxy. Rates are subject to change when population estimates are finalized; (2) Rates per 100,000 NC residents, data limited to residents. • References: (1) NC State Center for Health Statistics (SCHS), Death Certificate Data, 2021; (2) NC SCHS, Hospital Discharge Data, 2021; (3) NC Violent Death Reporting System (NC-VDRS), 2021, data are provisional and subject to change, as of 7/10/2023; (4) NC DETECT, ED Visit Data, 2021 • Analysis by the NCDHHS DPH Injury Epidemiology, Surveillance, and Informatics Unit

Compared to the total population, people above the age of 65 in North Carolina are (see Table 26):

- 2.6 times more likely to visit the emergency department for an accidental fall
- 4.5 times more likely to be hospitalized for an accidental fall
- 5 times more likely to die by an accidental fall
- 2.8 times more likely to be hospitalized for an injury
- 2.8 times more likely to be hospitalized for traumatic brain injury
- 2.3 times more likely to die by traumatic brain injury

As people get older and their health problems increase, it's crucial for communities to help them stay in their homes as long as possible. This means designing neighborhoods and homes that are easy for people with disabilities to use, making homes safer to prevent falls, improving access to services that older adults find hard to use, helping them get and pay for equipment that makes life easier, and keeping them connected to their families and communities.

**KEY**

(Disparity ratio grades indicate the severity of the health difference between population groups. It is not indicative of the severity of the health topic or problem as a whole.)

| Disparity Grade (color) | A (dark blue) | B (pale blue) | C (yellow) | D (pink) | F (red) |
|---|---|---|---|---|---|
| Disparity Ratio | 0.0 - 1.24 | 1.25 - 1.9 | 2.0 - 2.4 | 2.5 - 2.9 | ≥ 3.0 |
| Meaning | Little or no disparity. | A disparity exists, should be monitored and may require intervention. | The disparity requires intervention. | Major interventions are needed. | Significant interventions are needed. |

## ADVANCING OPPORTUNITIES FOR AGING ADULTS WITHIN NORTH CAROLINA

North Carolina's Multisector Plan for Aging is an effort between different agencies to help older adults age in place North Carolina. The plan started in 2023 and will take several years to complete.[90]

The North Carolina State Aging Plan for 2023-2027 focuses on six areas related to older adults:[91]

1. Keeping them safe, protected and advocating for their needs
2. Promoting healthy aging and improving their quality of life
3. Addressing their housing issues and homelessness
4. Supporting caregivers and developing the workforce that cares for them
5. Planning for long-term needs and challenges
6. Advancing fairness and changing how we view aging

### TABLE 27: HOW YOU CAN PLAY A PART – HEALTH ACROSS THE LIFESPAN

| NCDHHS PARTNER | RECOMMENDED STRATEGIES |
|---|---|
| **Community-Based Organizations and Services** | Connect women and young families to supports like job opportunities.<br>Provide information about health needs for aging adults, people with disabilities and caregivers. |
| **Faith-Based Organizations** | Offer services like food pantries, affordable child care, senior programs and youth activities. |
| **Governmental Agencies** | Ensure access to a variety of contraception options.<br>Recruit more providers to offer maternal and infant care to Medicaid recipients, especially in rural counties.<br>Provide information that shows cultural competency and make sure information is available in the languages spoken by the communities you serve when you share resources and opportunities.<br>Collaborate with agencies and divisions to improve partnerships.<br>Research and share a comprehensive list of resources for child care workers, teachers and families.<br>Use data to identify and address disparities in outreach, partnerships and funding. |
| **Health Care Professionals and Organizations** | Use different providers in the field of women's health.<br>Partner with NCCARE360 and NC211 for referrals to support young families and aging adults.[92]<br>Train support personnel working with older adults on mental health and substance use.[93] |

| NCDHHS PARTNER | RECOMMENDED STRATEGIES |
|---|---|
| **Advocates, Decision Makers and System Changers** | Support policies that address social factors affecting health, like income, education, nutrition and safety.<br><br>Increase and protect access to high quality reproductive health services.<br><br>Support policies that improve the economic well-being of children and families.<br><br>Support summer food programs.<br><br>Invest in early childhood education.<br><br>NC SHIP 2023 proposed policy initiatives for maternal health:<br>• Increase same-day access to all methods of contraception<br>• Train perinatal staff in health equity, implicit bias and cultural competency<br>• Expand Prepaid Health Plans (PHPs) to cover doula services<br>• Strengthen the role of community health workers to address social health drivers<br>• Expand Medicaid to cover affordable health, mental health and dental care, including mobile and online options<br>• Launch the NC Area Health Education Centers (AHEC) Scholars Program to train students of color and rural students as providers in underserved areas<br>• Use proven methods highlighted in the Maternal Health Innovation Program, like doula services, group prenatal care, group child visits and community health workers<br><br>Increase funding for Adult Protective Services.[94]<br><br>Boost funding for Senior Center General Purpose initiatives.[95]<br><br>Provide ongoing funding increases for the Home and Community Care Block Grant.[96]<br><br>Secure recurring funds to support long-term care ombudsmen.[97]<br><br>Strengthen long-term care staffing standards.<br><br>NC SHIP 2023 proposed policy initiatives for aging adults:<br>• Teach people, caregivers and health care providers about risks for cognitive decline, including checking for hearing loss and ways to support brain health<br>• Use more screenings and tests to find early signs of cognitive decline and dementia, to lower risk, slow decline and handle symptoms better<br>• Improve access to medical and community services for those with Alzheimer's disease and related dementias (ADRD) |
| **Business and Industry** | Extend health care hours for people with irregular work schedules or seniors who need family assistance for transportation.<br><br>Offer paid maternity and parental leave to employees.<br><br>Promote family-friendly workplace policies like flexible hours, paid sick and vacation days, competitive wages and more.<br><br>Support the recommendations of the Child Fatality Prevention System and Taskforce.<br><br>Support workplace recruitment and retention efforts in workplaces for people with disabilities, non-English speakers and other groups facing job challenges. |

# CALL TO ACTION: WE CAN ALL HELP REDUCE HEALTH DISPARITIES

Everyone can contribute to reducing health disparities, even you! Whether you are a community-based organization, a faith-based organization, a governmental agency, a health care professional or system, an advocate or decision maker, business or even an individual, we all have a role to play.

Here are some recommendations to make a difference:

1. Focus on understanding and respecting different cultures when promoting resources and opportunities
2. Improve the capacity of organizations to provide inclusive language access
3. Address all aspects of a person's health, including health care access, health care quality and social factors
4. Create a coordinated system of programs and services by forming more local partnerships, using tools like NCCARE360, and changing policies and systems
5. Join key NCDHHS meetings, events and webinars to get involved (learn more on our Community and Partner Engagement webpage).

Reducing health disparities requires teamwork from individuals, communities, businesses, health care providers, policymakers, government agencies and more. The North Carolina Department of Health and Human Services is committed to improving the health of all North Carolinians and we invite you to join us in this effort.

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[2] Education encompasses the opportunities that people have to learn and develop critical thinking skills, as well as social, emotional, and physical development. This includes education for infants and toddlers through post graduate education. Education access and quality can have several positive effects on health. People with higher levels of education typically have more knowledge about healthy behaviors, are empowered to make informed decisions, and more often engage in healthy habits. Achieving higher levels of education or specialized trade skills typically increase access to better job opportunities, health care access, and more. By improving education access and quality in communities, individuals are equipped with the tools needed to make healthier choices and live healthier lives. This helps make the community itself happier and healthier.clxxv

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# FOR MORE INFORMATION

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