2025

NORTH CAROLINA STATE HEALTH ASSESSMENT

A Mid-Cycle Review of HNC 2030

HEALTHY NORTH CAROLINA 2030: A PATH TOWARD HEALTH (HNC 2030)

NC DEPARTMENT OF HEALTH AND HUMAN SERVICES
Division of Public Health

Dedication

"Start by doing what's necessary; then do what's possible; and suddenly you are doing the impossible."

— Attributed to St. Francis of Assisi

On September 27, 2024, Hurricane Helene swept into western North Carolina, bringing torrents of rain, furious winds, devastating floods, and unimaginable destruction. What followed was one of the most deadly and destructive natural disasters in our state's history. More than 100 North Carolinians lost their lives. Entire communities were reshaped, and places that had stood for generations were washed away or irreparably damaged.

According to official estimates, Helene impacted more than 126,000 homes; damaged over 5,000 miles of roads; and harmed more than 600 bridges and 700 culverts. Critical utilities — electricity, water, sewer, gas, telecommunications, internet, and waste management systems — suffered widespread disruption. These numbers represent not only structural loss, but also the thousands of families, workers, and communities who now face years of rebuilding.

The storm also tore through the region's natural landscape, leaving hillsides unstable, streams rerouted, forests stripped, and cherished parklands and trails scarred. The environmental impact will likely have long-term effects on soils, vegetation, drainage basins, endangered species, and natural amenities across the mountains.

Recovery from Helene's devastation is expected to exceed $59 billion, underscoring both the magnitude of the destruction and the scale of the work ahead.

Yet even in the storm's darkest hours, the people of western North Carolina showed extraordinary courage. From the valleys of Yancey County and the hollers of Madison to the riverbanks of the French Broad and the ridgelines above Asheville, neighbors reached across broken landscapes to care for one another. First responders pushed through mud and floodwaters. Community groups offered hot meals, dry blankets, and a steadfast light of hope.

Your resilience, compassion, and determination have built an enduring foundation that is the bedrock upon which recovery and renewal are already taking shape.

In gratitude to every resident of North Carolina — for your perseverance, your neighborly care, and your unwavering spirit of rebuilding — this 2025 North Carolina State Health Assessment is dedicated to you. May your strength be honored in these pages, and may our shared work contribute to a healthier, safer, and stronger tomorrow.

NC DEPARTMENT OF HEALTH AND HUMAN SERVICES

JOSH STEIN • Governor
DEVDUTTA SANGVAI • Secretary
KELLY KIMPLE • Director, Public Health

Dear Fellow North Carolinians,

On behalf of the North Carolina Department of Health and Human Services, Division of Public Health, I am pleased to share the 2025 North Carolina State Health Assessment (SHA). This report reflects a year-long effort to better understand health, strengths, and challenges of communities across our state. It offers a detailed, data-driven picture of factors that shape health and well-being for more than 10 million people.

The 2025 SHA brings together statewide and local data, community insights, and evidence-based research to illuminate opportunities for progress. The assessment also reflects the voices of public health professionals, health care providers, community leaders, and individuals who contributed valuable perspectives through key informant interviews, surveys, and engagement efforts. Their expertise and experience were essential in shaping a clearer understanding of issues that matter most.

Healthy NC 2030 is our shared vision for a healthier state. The State Health Assessment shows us where we stand today, and the State Health Improvement Plan outlines the steps we'll take together to reach the goals of Healthy NC 2030. At the midpoint of this decade, this assessment serves as the diagnostic tool for developing the next State Health Improvement Plan (SHIP), which will guide collective action across multiple sectors in 2026 and beyond. Aligned with the Public Health Accreditation Board (PHAB) Standards, the SHA helps ensure that North Carolina continues to strengthen its public health system while promoting opportunities for health for all people.

As our state continues to grow, becoming more diverse, older, and more interconnected, North Carolina faces complex challenges as well as remarkable opportunities. The 2025 SHA highlights areas where progress has been made, areas where gaps persist, and areas where targeted investment, collaboration, and innovation are needed most. It also honors the resilience of communities across North Carolina, including those most affected by recent natural disasters, economic shifts, and gaps in access to care.

I extend my sincere appreciation to the many partners who contributed to this assessment, including local health departments, state agencies, academic institutions, tribal nations, health systems, community organizations, and people across all 100 counties. This shared work underscores the importance of collaboration and the strength of North Carolina's public health network.

I invite you to explore the 2025 State Health Assessment and join us in advancing a healthier future for every community in our state. Together, we can build on the progress we have made and work toward a North Carolina where everyone has the opportunity to thrive.

Sincerely,

Kelly Kimple, MD, MPH
Division Director
North Carolina Division of Public Health
North Carolina Department of Health and Human Services

NC DEPARTMENT OF HEALTH AND HUMAN SERVICES • DIVISION OF PUBLIC HEALTH

LOCATION: 1915 Human Services Way, Building 3, Raleigh, NC 27607
MAILING ADDRESS: 1931 Mail Service Center, Raleigh, NC 27699-1931
www.ncdhhs.gov

AN EQUAL OPPORTUNITY / AFFIRMATIVE ACTION EMPLOYER

Acknowledgments

The North Carolina Department of Health and Human Services, Division of Public Health, acknowledges that the 2025 North Carolina State Health Assessment was made possible through funding from the Centers for Disease Control and Prevention's National Initiative to Address COVID-19 Health Disparities Among Populations at High-Risk and Underserved, Including Racial and Ethnic Minority Populations and Rural Communities (Federal Award Identification Number: NH75OT00002).

We also extend our appreciation to the members of the Steering Committee, Advisory Committee and Project Team. These individuals represent a broad range of organizational partners whose guidance and expertise helped shape the direction and quality of this assessment.

We are deeply grateful to the maternal health staff across state and local public health agencies whose participation in key informant interviews provided critical insights grounded in their resilience, lived experience, and unwavering commitment to the communities they serve. Their voices illuminated the real-world barriers to care and significantly strengthened the findings and recommendations of this assessment.

Finally, we value the essential contributions of our partners, the North Carolina Institute of Medicine (NCIOM) and the North Carolina Area Health Education Centers (NC AHEC). NCIOM's leadership was instrumental in the creation of HNC 2030, setting a statewide vision for improving health and well-being. NC AHEC's collaboration ensured that this vision became a living framework, fully integrated into the community health improvement plans (CHIPs) of all North Carolina local health departments, their partners, and many health care systems across the state.

TABLE OF CONTENTS

PRIMARY DATA

SECONDARY DATA

NEXT STEPS

APPENDICES

LIST OF FIGURES

LIST OF FIGURES

LIST OF TABLES

2025 North Carolina State Health Assessment

Chair, Steering Committee

Stacie Turpin Saunders, MPH
Deputy Director/Section Chief, Local and Community Support
Division of Public Health
NC Department of Health and Human Services

Project Manager

Kathryn G. Dail, PhD, RN
Director, HNC 2030 and Community Health Assessment and Improvement
Division of Public Health
NC Department of Health and Human Services

Editor

Laura D. Webb, MRP, BSN, RN
HNC 2030 Resource Center - Resource & Training Coordinator
Division of Public Health
NC Department of Health and Human Services

Data Analyst

Eric Lai, BSE, MS
NC Data Portal Data Manager
Division of Public Health
NC Department of Health and Human Services

Writers/Contributors/Researchers

Savannah Bolick, MPH Candidate	East Carolina University
Lily Obrecht Buck, BSPH	Independent Contractor
Elizabeth Brownfield, MAT, BA	Eastern Area Health Education Center (EAHEC)
Judy Jones Butler, BSN, RN	Independent Contractor
Sarah Huott Cozens, BSW, BSN, RN	Independent Contractor
Zachary King, MPH	Managing Director, DellaRe Consulting
Ashley Rink, MPH	NCDHHS, Division of Public Health
Chelsea Shannon, MPH	NCDHHS, Division of Public Health
Ellen Wilson, MPH, PhD	President and Principal Researcher, Insight Evaluation, LLC

Design and Layout

Kayleigh Creech
Graphic Designer, Kraft + Design

With contributions from Data Soapbox, LLC, Cary, NC

Kelly Crosbie, MSW, LCSW
Director
Division of Mental Health, Developmental Disabilities, and Substance Use Services
NC Department of Health and Human Services

Kathryn G. Dail, PhD, RN
Division of Public Health
NC Department of Health and Human Services

Candice DuVernois, JD, MPH, BSN, RN
Division of Public Health
Local and Community Support
NC Department of Health and Human Services

Kelly Kimple, MD, MPH
Director, Division of Public Health /State Health Officer
Chief Medical Officer for Public Health
NC Department of Health and Human Services

Suzanne Metcalf
Communication Lead
Division of Public Health
NC Department of Health and Human Services

Gerri L. Mattson, MD, MSPH, FAAP
Early Intervention Medical Director
NC Infant Toddler Program, Early Intervention Part C
Division of Child and Family Well-Being
NC Department of Health and Human Services

Ashley Rink, MPH
North Carolina State Health Improvement Plan (NC SHIP)
Community Partnership Manager
Division of Public Health
NC Department of Health and Human Services

Stacie Turpin Saunders, MPH
Deputy Director/Section Chief,
Local and Community Support
Division of Public Health
NC Department of Health and Human Services

Erin Fry Sosne, MPH
Director of Strategy
Division of Public Health
NC Department of Health and Human Services

Joseph Watkins, MBA, MSA
Section Chief
Division of Public Health, State Center for Health Statistics
NC Department of Health and Human Services

Wanda Boone, PhD
Chief Executive Officer
Together for Resilient Youth (TRY)

Ingrid Bou-Saada, MA, MPH
ACEs and Resilience Program Manager
NC Department of Health and Human Services, Division of Public Health, Injury and Violence Prevention Branch

Heather G. Carter, DCM, MA, CDP, CSGF
Dementia Services Coordinator
NC Department of Health and Human Services, Division of Aging, Service Operations

Fisher Charlton, MPH
Alcohol Epidemiologist
NC Department of Health and Human Services, Division of Public Health, Injury and Violence Prevention Branch

Chris Collins, MSW
Consultant

April Cook, MBA
Chief Executive Officer
North Carolina Association of Free and Charitable Clinics

Mary Beth Cox, MPH
Substance Use Epidemiologist
NC Department of Health and Human Services, Division of Public Health, Injury and Violence Prevention Branch

Cindy Ehlers, MS, LCMHC
Chief Strategy and Innovation Officer
Trillium Health Resources

Kerri Erb, MPA
Chief Program Officer
Autism Society of North Carolina

Anne L. Geissinger, MPH, RDN
NC Comprehensive Suicide Prevention Program Coordinator & Team Lead
NC Department of Health and Human Services, Division of Public Health, Injury and Violence Prevention Branch

Jim Goodman, CMP, CAE
Chief Executive Officer and Executive Director
North Carolina Dental Society

Wes Gray, MPA, MPH
Health Director
Pitt County Health Department

Greg Griggs, MPA, CAE
Executive Vice President & CEO
NC Academy of Family Physicians, Inc.

Chelsea Gulden, MSW
President & CEO
RAIN, Inc.

Sharon Hirsch
President & CEO
Positive Childhood Alliance North Carolina (PCANC)

Elizabeth Hudgins, MPP
Executive Director
North Carolina Pediatric Society (NCPeds)

Amy Joy Lanou, PhD
Director
North Carolina Institute for Public Health (NCIPH)

Jennifer Matthews, PhD, MSPH
Professor, Health Education and Promotion
East Carolina University, College of Health and Human Performance

Gerri Mattson, MD, MSPH, FAAP
Early Intervention Medical Director
NC Department of Health and Human Services, Division of Child and Family Well-Being

Lisa McKeithan, MS, CRC
Placement Services Manager
NC Department of Health and Human Services, Office of Rural Health

Lt. Col. Teresa Pearce, MD, MPH
Former Director
Fort Bragg Department of Public Health

Carolina Siliceo Perez, MLAS
Acting Director
Office of Minority Health and Health Disparities
NC Department of Health and Human Services, Office of Health Equity

Alice Pollard, MSW, MSPH
Vice President of Operations and Strategy
North Carolina Community Health Center Association

Michelle G. Ries, MPH
President and CEO
North Carolina Institute of Medicine

Gretchen Taylor, MPH
Data Analyst
NC Department of Health and Human Services, Office of Rural Health

Hugh H. Tilson, Jr., JD, MPH
Associate Dean and Director
North Carolina Area Health Education Centers (NC AHEC)

Sarah Verbiest, DrPH, MPH, MSW
Director, Jordan Institute for Families
UNC School of Social Work

Sonya Wachacha
Secretary Division of Public Health & Human Services
Eastern Band of Cherokee Indians

2020

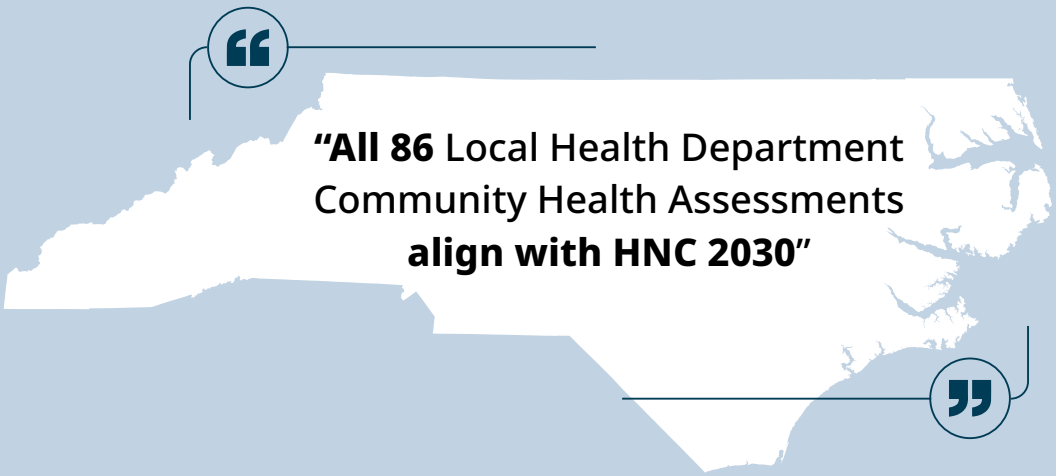
HNC 2030

2025

NC SHA 2025 Mid-Cycle Review

2030

HNC 2040



INTRODUCTION

2025 North Carolina State Health Assessment

Mid-Cycle Review of Healthy North Carolina 2030

The 2025 North Carolina State Health Assessment (SHA) provides a comprehensive look at the health and well-being of the state's 10.8 million people and serves as the official mid-cycle review of Healthy North Carolina 2030 (HNC 2030). Developed through a year-long, collaborative, and data-driven process led by the North Carolina Department of Health and Human Services (NCDHHS), Division of Public Health (DPH), the SHA evaluates progress on statewide health goals, identifies emerging trends, and assesses opportunities to strengthen community conditions that influence health.

Anchored in the HNC 2030 framework, this assessment synthesizes secondary statistical data, primary qualitative insights, and an inventory of statewide assets to provide a balanced view of where North Carolina is making progress and where disparities persist. The SHA precedes and informs the North Carolina State Health Improvement Plan (SHIP), guiding the selection of shared priorities for coordinated action across public health, health care, community organizations, and other sectors. The assessment offers valuable information for stakeholders, including local leaders, community-based organizations, businesses, non-profits, and academic institutions.

Purpose and Approach

Results-Based Accountability (RBA) is a disciplined, data-driven approach to improving population and program outcomes by defining clear results, selecting measurable indicators, and using performance measures to drive continuous improvement and accountability.

The 2025 SHA was conducted using RBA and designed to answer three core questions:

1. **How are we doing on the HNC 2030 indicators?**
2. **Are we focused on the right priorities?**
3. **What new opportunities or emerging issues require attention before identifying the next decadal Healthy North Carolina 2040 (HNC 2040) framework?**

The assessment incorporates:

- **Secondary data:** population health statistics from state and national sources; trend analyses for all HNC 2030 indicators; demographic, environmental, economic, and social determinants of health profiles.
- **Primary data:** key informant interviews with maternal health professionals, offering grounded insights on barriers to care, system navigation challenges, and community needs.
- **Asset inventory:** mapping of statewide resources, partnerships, programs, and infrastructure supporting health improvement at state and local levels.
- **Cross-sector engagement:** contributions from more than 50 partners serving on the Steering and Advisory Committees; collaboration with NC AHEC, NCIOM, and local health departments (LHDs) in all 86 public health jurisdictions.

Key Themes and Findings

/ 01 Progress and Persistent Disparities in HNC 2030 Indicators

Mid-cycle analysis shows improvement in some statewide indicators, while others remain off-trend or indicate widened disparities. Many of the persistent gaps are tied to structural drivers such as income inequality, housing instability, limited access to preventive care, a rapidly aging and changing population, and geographic isolation affecting rural communities.

/ 02 The Impact of Medicaid Expansion

North Carolina's 2023 Medicaid expansion has broadened insurance coverage for hundreds of thousands of people. Early data indicate increased enrollment in preventive and behavioral health services, though challenges remain in provider availability, system navigation, and continuity of care. At time of publication, political uncertainties remain around sustained implementation of Medicaid expansion.

/ 03 Maternal and Child Health Challenges

Primary data collection highlighted significant barriers to maternal health care, including workforce shortages, transportation barriers, fragmentation across service systems, and limited access to culturally responsive care. Maternal health staff emphasized resilience and deep commitment to the families they serve, underscoring the need for integrated, community-centered approaches.

/ 04 Mental Health and Substance Use

Communities across North Carolina continue to report growing behavioral health needs, including increasing rates of anxiety, depression, suicide risk, and overdose. Additionally, local health departments and health systems describe increasing pressures on their workforce, limited service capacity, and the need for stronger prevention and early-intervention strategies.

/ 05 The Social and Economic Context of Health

Economic growth in North Carolina is strong; however, it is not evenly shared. Rural communities, older adults, individuals with low income, and some racial and ethnic minority groups face disproportionate barriers related to broadband access, transportation, workforce participation, affordable housing, and chronic disease prevalence.

/ 06 Environmental and Infrastructure Pressures

Through related workstreams, including the Environmental Health Data Workshop Series, DPH and partners identified growing vulnerabilities in drinking water systems, wastewater infrastructure, food and lodging inspection findings, and other environmental health domains. Recent climate-related disasters, including Hurricane Helene, have heightened awareness of long-term resilience needs.

Community Assets and Strengths

North Carolina possesses robust assets that support health improvement statewide, including:

- A strong network of local health departments serving all 100 counties
- Extensive NC AHEC workforce development infrastructure
- Health systems and academic partners contributing data, research, and innovation
- Cross-sector collaboratives aligned around HNC 2030 and emerging HNC 2040 planning
- Community-based organizations providing culturally grounded, locally responsive services
- Statewide partnerships, including NCIOM, The Duke Endowment (TDE), and other philanthropic networks supporting collaborative impact

These assets create a strong foundation for coordinated measurable improvement.

Looking Ahead to Healthy North Carolina 2040 (HNC 2040)

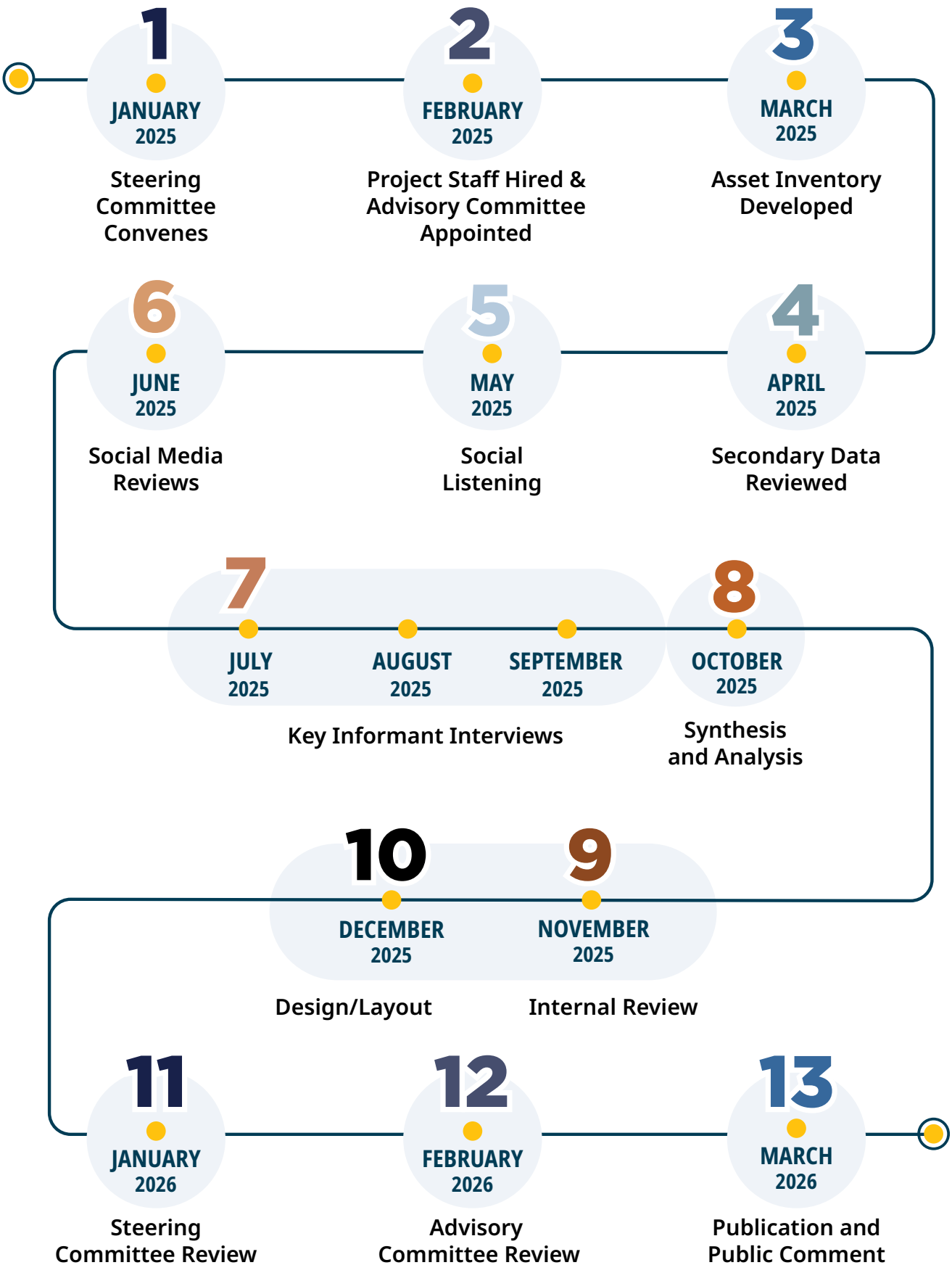
The findings of the 2025 SHA directly inform planning for the North Carolina State Health Improvement Plan (NC SHIP) and the next decadal HNC 2040 framework. The assessment highlights the need for:

- Stronger cross-sector alignment
- Continued investment in data and analytics capacity
- Workforce recruitment and retention strategies
- Scalable models for community engagement
- Resilient infrastructure and environmental health protections
- Sustained attention to the health needs and lived experiences of communities most affected by disparities

Conclusion

The 2025 SHA offers a data-driven, and community-informed picture of health in North Carolina at the midpoint of the HNC 2030 decade. It reflects the dedication of hundreds of partners across public health, health care, education, business, philanthropy, and community organizations. Most importantly, it elevates the voices of those closest to the work, including health professionals, local practitioners, community leaders, and individuals whose lived experiences guide the path toward better health outcomes.

This assessment sets the stage for the next phase of statewide action, ensuring that the NC SHIP, local community health assessments (CHAs) and community health improvement plans (CHIPs) and the forthcoming HNC 2040 plan are aligned, responsive, and grounded in measurable improvement for all North Carolinians.


1
JANUARY 2025
Steering Committee Convenes
2
FEBRUARY 2025
Project Staff Hired & Advisory Committee Appointed
3
MARCH 2025
Asset Inventory Developed
4
APRIL 2025
Secondary Data Reviewed
5
MAY 2025
Social Listening
6
JUNE 2025
Social Media Reviews
7
JULY 2025
AUGUST 2025
SEPTEMBER 2025
Key Informant Interviews
8
OCTOBER 2025
Synthesis and Analysis
9
NOVEMBER 2025
Internal Review
10
DECEMBER 2025
Design/Layout
11
JANUARY 2026
Steering Committee Review
12
FEBRUARY 2026
Advisory Committee Review
13
MARCH 2026
Publication and Public Comment

STATE HEALTH ASSESSMENT

North Carolina DHHS/DPH conducted the 2025 State Health Assessment (SHA) from January 2025 through January 2026. The assessment was led by a project team and guided by a steering committee of internal stakeholders. The 2025 SHA meets all Public Health Accreditation Board (PHAB) requirements for state health agencies and informs the 2026 State Health Improvement Plan (SHIP).

The Public Health Accreditation Board (PHAB) is the national accrediting body for state, local, tribal, and territorial public health departments. The set of standards and measures is organized around the Foundational Public Health Services Framework (FPHS) and defines a minimum package of public health capabilities and programs that no jurisdiction can be without.

PHAB accreditation standards specify that the state health agency must participate in or lead a collaborative process resulting in a comprehensive state health assessment. The guidance states that the assessment must

- Describe demographics of the population (age, sex, race/ethnicity, subpopulations, etc.)
- Include health status (morbidity, mortality, disease burdens, behavioral risk factors, quality of life, chronic diseases, etc.)
- Include social, economic, environmental, structural determinants of health (e.g., socioeconomic status, housing/poverty, access to services, environmental exposures, built environment, inequities)
- Include community assets and resources: services, programs, social supports, protective factors, infrastructure, community strengths — not just deficits.
- Provide analysis and interpretation of data, including identification of health inequities, disparities, root causes, social determinants, subpopulation differences, and priority health issues.
- Document the collaborative development process, highlighting evidence of community involvement and engagement with stakeholders and partners, especially the inclusion of marginalized or underrepresented groups.
- Disseminate results: make findings accessible and available to stakeholders and the public via reports, dashboards, meetings, etc., to support transparency and guide improvement planning (Public Health Accreditation Board [PHAB], 2022)

NCDHHS, Division of Public Health (DPH) used a combination approach: a state-based model, MAPP 2.0, and RBA:

- The state-based model involves 12 steps including establishing an advisory committee, authentic community engagement, primary data, dissemination, and evaluation.
- We incorporated MAPP 2.0 principles for the Asset Inventory.
- We have adopted RBA which is best characterized as a community participatory process. RBA focuses on bringing stakeholders together, reviewing data, prioritizing health problems and crafting clear statements of desired results.

STATE HEALTH IMPROVEMENT PLAN (SHIP)

PHAB requires state health agencies to develop a state health improvement plan (SHIP) through a collaborative, data-driven process that reflects SHAs; identifies priorities, goals, and strategies; involves partners in implementation; monitors and reports progress annually; addresses gaps in health; and makes the plan publicly accessible.

Develop the SHIP based on findings from the SHA

- Use a collaborative, multisector process to develop priorities and strategies
- Identify statewide priority areas supported by data and evidence
- Include measurable goals and objectives for each priority
- Ensure the plan includes strategies/actions that address:
  - Root causes of health issues
  - Social and economic factors
  - Gaps in health
- Describe the roles and commitments of partners in implementing the plan
- Establish a timeline for implementation
- Make the SHIP publicly accessible

Show evidence that partners are actively involved in implementing SHIP strategies.

- Document shared responsibilities, including how partners contribute staff, expertise, or resources
- Maintain a coordinated process (e.g., councils, committees, workgroups) to oversee implementation
- Demonstrate ongoing engagement of community and cross-sector partners

Monitor and Report Progress

- Track progress toward goals, including performance measures and health indicators
- Analyze results to identify improvements, challenges, disparities, and equity impacts.
- Produce regular public reports (at least annually) on SHIP progress
- Provide updates to partners and community stakeholders
- Use progress findings to adjust strategies as needed

Alignment With Other Plans (Crosswalk)

- Align SHIP priorities and objectives with:
  - Agency strategic plan
  - Statewide initiatives (e.g., HNC 2030)
- Ensure metrics and implementation structures support consistent direction across plans (Public Health Accreditation Board [PHAB], 2022)

Population Health Model

Frameworks and models are foundational to facilitating community health assessment (CHA) processes because they provide a structured and intentional approach to identifying needs, guiding data selection and analysis, and framing a shared narrative. By standardizing definitions and prioritizing different data sets, they create opportunities to establish goals and benchmarks and explore disparities across populations (Green & Kreuter, 2005). Leveraging frameworks and models strengthens processes like this state health assessment by promoting intentional and structured approaches to assessing health and well-being and informing collaborative prioritization and planning.

Models and frameworks that are used to guide community health assessments typically include several key practices and elements to structure the organization of the assessment and planning process. Models and frameworks emphasize stakeholder engagement and shape shared visions of the assessment. They establish a common understanding of factors impacting health and quality of life, prioritizing data to be gathered and analyzed to ensure that findings are systematically examined and effectively communicated. Together these core principles of a framework ensure that the assessment can be leveraged to inform collaborative planning and action to improve health (Centers for Disease Control and Prevention [CDC], 2024).

The population health model was developed to provide a multi-sectoral approach to improving community health and quality of life by identifying key factors across health care, public health, economic, structural, and social determinants (Kindig & Isham, 2014). This model has been widely used over the past decade, informing the theoretical foundations for public health assessment and planning efforts including the County Health Rankings and Roadmaps model, Healthy People 2030, and Healthy North Carolina 2030 (HNC 2030), providing shared context and alignment across local, state, and national partners; U.S. Department of Health and Human Services [USDHHS], 2020; North Carolina Institute of Medicine [NCIOM], 2020). The population health model emphasizes that improving multiple determinants can foster healthier environments where individuals live, learn, work, and play.

The population health model acknowledges that health and well-being are shaped by a complex interplay of individual, community, and systemic factors. It integrates traditional data sources regarding morbidity, mortality, and quality of life while also incorporating measures related to structural health drivers such as poverty, education, and environmental conditions. This approach transcends a narrow, individualistic view of health and emphasizes the broader systems that influence population health.

The selection of the population health model for a state health assessment is driven by its comprehensive and inclusive approach. Unlike traditional models focusing primarily on health care, morbidity, and mortality, the population health model incorporates behavioral, social, and environmental determinants. This allows us to identify upstream factors influencing health outcomes and define how all sectors of a community contribute to quality of life while analyzing disparities and potential root causes.

The model also provides a shared context for meaningful conversations and intentional collaboration among multi-sector partners about drivers of health that extend beyond health care alone. Notably, only 20% of health outcomes are attributed to clinical care, while 80% are influenced by the intersection of health behaviors, physical environment, and social and economic factors (Kindig & Isham, 2014). Using this model helps shape priorities that foster opportunities for health and quality of life for all community members while providing specific attention to certain health outcomes or populations.

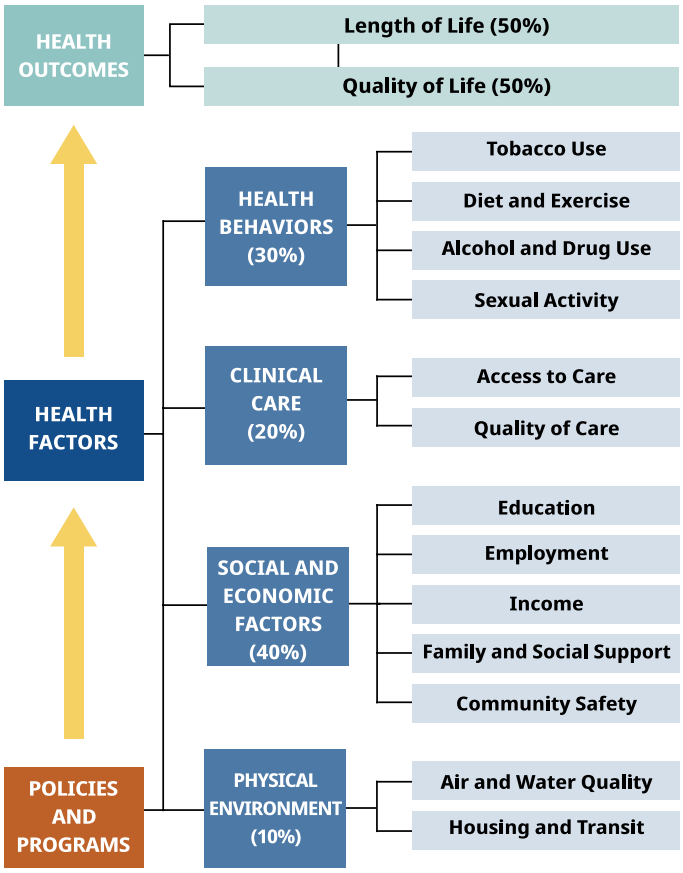
Utilizing the population health model in a state health assessment enables systematic selection of relevant indicators that reflect community needs. The model guides the gathering and analysis of data, ensuring that key determinants are incorporated. This structured process supports the creation of a comprehensive community health profile, essential for evidence-based decision-making and resource allocation.

Additionally, the model supports effective communication of findings through data storytelling. By framing health information within broader context, public health professionals can convey narratives that resonate with policymakers, stakeholders, and the public. This enhances engagement and promotes collaboration in implementing health improvement strategies.

The model is not without limitations, however. Its broad, multifactorial structure can be perceived as difficult to translate from conceptual theory to actionable strategies (Krieger, 2012). The data used in population health models can sometimes overemphasize individual-level factors, potentially underrepresenting systemic determinants and the root causes of disparities (Braveman & Gottlieb, 2014; Marmot, 2005). Further, the model's emphasis on outcomes may fall short in addressing structural power dynamics and inequities that shape health opportunities for different populations (Navarro, 2009).

In conclusion, the population health model provides a robust foundation for conducting a state health assessment. Its emphasis on multifactorial determinants of health, the integration of social determinants, and its capacity for addressing disparities make it a valuable tool for shaping public health strategies and policies.

Figure 1. The County Health Rankings Model



The County Health Rankings Model used with permission of the University of Wisconsin Population Health Institute (2018)


Welcome
To
NORTH CAROLINA
NATION'S MOST MILITARY
FRIENDLY STATE


E. TRADE ST
200


RDU
WELCOME

ASSET INVENTORY

What do we already have in place that can help us improve health?

An **Asset Inventory** is an important element of the state health assessment. The inventory is simply a list of a community's strengths, resources, supports, and capabilities that contribute to people's health and well-being. Instead of focusing on the community's problems, the asset inventory highlights those current assets that can be leveraged to promote community health.

The Mobilizing for Action through Planning and Partnerships (MAPP 2.0) framework, developed by the National Association of County and City Health Officials (NACCHO), defines an asset inventory as a tool for identifying the people, organizations, programs, services, partnerships, and physical resources that contribute to a community's well-being.

Community assets can include:

- Local health departments, clinics, and hospitals
- Community organizations and coalitions
- Schools, universities, and early childhood programs
- Parks, greenways, and recreation centers
- Food assistance programs, transportation supports, or housing services
- Cultural groups, faith-based organizations, and trusted community leaders

Data systems, training programs, and other capacity-building resources. An asset inventory helps the community identify existing strengths that partners can use to address health priorities. The inventory helps ensure that planning is realistic, collaborative, and grounded in local capacity, expanding the focus from merely identifying gaps to also recognizing and leveraging opportunities.

Historical Profile
of North Carolina

North Carolina's historical trajectory provides essential context for understanding the state's contemporary demographic patterns, economic development, and persistent health disparities. From Indigenous stewardship through colonial settlement, industrial expansion, and modern population growth, the state's past has profoundly shaped the conditions experienced by communities today.

Indigenous Peoples and Early Colonial Development

For thousands of years, the region now known as North Carolina has been home to diverse Indigenous nations, including but not limited to the Catawba, Cherokee, Lumbee and Tuscorora. European colonization began in the late 1600s, primarily by English settlers migrating from Virginia. In 1729, North Carolina was established as a separate royal colony.

Agriculture anchored the colonial economy, with tobacco, naval stores, and later cotton driving growth. Enslaved African labor became central to this system. By 1860, about one-third of North Carolina's population was enslaved (University of Maryland).

Civil War and Reconstruction

North Carolina was the final state to secede from the Union, joining the Confederacy in May 1861 and ultimately contributing more troops to the Confederate Army than any other state. Despite having fewer large plantations than parts of the Deep South, the state experienced extensive wartime losses.

Reconstruction (1865 – 1877) created opportunities for political participation and expanded civil rights for Black North Carolinians, particularly in eastern counties. Unfortunately, these gains were later undone through racial suppression and violence.

In 1898, a coup in Wilmington overthrew the city's multiracial government. Tragically, dozens of Black people were killed or displaced, marking the beginning of a sustained period of Jim Crow segregation and disenfranchisement.

Industrialization and Urbanization (1900 – 1950)

During the early 20th century, North Carolina's Piedmont region developed into a major industrial center, with Charlotte, Durham, Greensboro, and Winston-Salem emerging as national leaders in textiles, tobacco, and furniture manufacturing. Urbanization accelerated over the next half century, rising from approximately 10% of the population in 1900 to about 34% in 1950 (NCpedia, U.S. Census Bureau, 1950). Nevertheless, structural inequities remained, as Black workers continued to be excluded from higher-wage positions and many rural communities still faced historical gaps in sanitation, transportation, and public health infrastructure.

Postwar Growth and Civil Rights (1950 – 2000)

The post–World War II era ushered in significant economic transformation for North Carolina. Although the state's traditional industries began to decline, the finance, education, and research industries began a significant expansion. A noteworthy example of this mid-20th-century industrial expansion is Research Triangle Park (RTP) in central North Carolina. Created in 1959, RTP accelerated technological innovation and has attracted significant federal investment.

North Carolina played a visible role in the Civil Rights Movement, including the pivotal 1960 Greensboro sit-ins. Integration and voting rights were advanced by landmark federal legislation, notably the Civil Rights Act of 1964 and the Voting Rights Act of 1965. However, disparities in housing, schooling, income, and health outcomes persisted.

Meanwhile, by the 1980s and 1990s, Charlotte had become one of the nation's leading banking centers in contrast to many rural and former manufacturing communities — particularly in tobacco and textile dependent counties — who simultaneously experienced economic decline and population loss.

Population Growth and Demographic Change (1990 – Present)

Between 1990 and 2020, North Carolina's population grew from about 6.7 million to more than 10.4 million, driven by both domestic migration and international immigration (Carolina Demography; Office of State Budget and Management, 2021). Growth was concentrated in metropolitan regions such as the city of Charlotte, the Research Triangle, and the Triad.

At the same time, the state experienced profound demographic diversification. North Carolina's Hispanic/Latine population grew to about 10.7% by 2020 (NALEO Educational Fund, 2022), and Asian and multiracial populations also expanded. The foreign-born population reached around 9% in recent years, leading to an increase in linguistic and cultural diversity (Axios, 2024).

In addition to these demographic changes, North Carolina' s population is rapidly aging. As of 2023, approximately 17–18% of people were ages 65 or older, a significant increase from the much lower percentages at the turn of the century (America's Health Rankings, 2023; Office of State Budget and Management, 2023). The rise in proportion of older populations is most pronounced in rural counties, with implications for the health care workforce, long-term services, and community infrastructure.

THE DEMOGRAPHIC SHIFTS TO WATCH

Population growth, increased cultural diversity, and a rapidly aging population are reshaping the state's workforce, health care needs, and community infrastructure.

North Carolina Office of State Budget and Management, 2024; North Carolina Healthcare Association, 2024

Geographical and Infrastructural Profile
of North Carolina

North Carolina's physical geography and infrastructure have a direct impact on population health, access to services, and economic opportunity. The state encompasses three distinct geographic regions: mountains, piedmont, and coastal plain. Each region is shaped by unique environmental conditions, distinct development patterns, and diverse transportation systems.

Regional Geography

Mountain Region (Western North Carolina)
Home to the Blue Ridge and Great Smoky Mountains, is the most rural region of the state. It is characterized by low population density, limited public transit, and long travel distances to health care and social services. Topographic barriers further complicate infrastructure development and emergency response (NCpedia; NCDHHS Office of Rural Health, 2023; Arcury et al., 2005).

Piedmont Region (Central North Carolina)
The Piedmont is the most urbanized and economically developed region, encompassing North Carolina's five largest cities — Charlotte, Raleigh, Durham, Winston-Salem, and Greensboro. It contains the highest concentration of interstate highways, rail lines, and public transit systems, supporting both population growth and economic activity (NCpedia, North Carolina Department of Transportation (NCDOT), 2019, NCDOT, 2017).

Coastal Plain (Eastern North Carolina)
The Coastal Plain includes both inland agricultural areas and the Atlantic coastline. Its flat, low-lying terrain makes the region highly vulnerable to hurricanes, flooding, storm surge, and sea-level rise. Many eastern counties continue to face limited access to health care and persistent infrastructure challenges (Geography of North Carolina, 2024; North Carolina Department of Environment and Natural Resources, 2014; U.S. Environmental Protection Agency, 2025).

Transportation Infrastructure

Roads
The North Carolina Department of Transportation (NCDOT) maintains nearly 80,000 miles of public roads, which constitutes the second-largest state-maintained highway network in the U.S. (NCDOT, 2017). The state's population and economic centers are connected by several major interstate corridors (including I-26, I-40, I-73, I-74, I-85, and I-95). However, direct interstate access remains limited in many western and eastern counties, creating barriers to education, employment, and health care services (NCDOT, 2017).

Public Transit
Public transit services operate primarily in metropolitan areas and remain limited in rural regions.

- **Charlotte Area Transit System (CATS):** Offers extensive bus service and operates the state's only light rail line, the LYNX Blue Line (Charlotte Area Transit System; *Lynx Blue Line*, 2025).
- **GoTriangle:** Connects Raleigh, Durham, Chapel Hill, and surrounding communities through regional bus service and vanpool programs (GoTriangle; *GoTriangle*, 2024).
- **Other Cities:** Greensboro, Winston-Salem, Asheville, and Fayetteville maintain municipal bus systems with more limited service.

Overall, only about 1% of North Carolinians commute to work using public transit, far below the national average (Carolina Demography, 2015; King, 2023). According to national data, the national average is 5% (U.S. Census Bureau, 2021).

Airports

North Carolina is served by four international airports and a network of regional airports.

- **Albert J. Ellis Airport (OAJ)**
- **Asheville Regional Airport (AVL)**
- **Charlotte Douglas International Airport (CLT)**
- **Coastal Carolina Regional Airport (EWN)**
- **Fayetteville Regional Airport (FAY)**
- **Piedmont Triad International Airport (GSO)**
- **Pitt-Greenville Airport (PGV)**
- **Raleigh-Durham International Airport (RDU)**
- **Wilmington International Airport (ILM)**

These airports, along with smaller general aviation facilities, make up North Carolina's extensive public airport system (Federal Aviation Administration).

Rail

Amtrak provides intercity rail service through two primary routes:

- **Carolinian** (Charlotte–Raleigh–Rocky Mount–Northeast Corridor)
- **Piedmont** (Charlotte–Raleigh)

Rail service remains limited to select corridors and does not provide full statewide coverage (Amtrak; NCDOT).

Broadband and Digital Infrastructure

Connectivity to high-speed internet is essential for accessing health care, education, employment, and civic participation. As of 2023, at least 1.1 million North Carolina households were on the underserved side of the digital divide and lacking either access, affordability, or the digital skills needed for full participation (Broadband USA, 2023; North Carolina Department of Information Technology, 2023).

The North Carolina Broadband Infrastructure Office leads statewide digital equity efforts. The Growing Rural Economies with Access to Technology (GREAT) Grant Program has been capitalized at approximately $380 million, supporting last-mile broadband infrastructure expansion in underserved communities (North Carolina Department of Information Technology, 2024).

Environmental and Geographic Barriers

Physical geography creates unique challenges for health care access, infrastructure resilience, and emergency response:

- **Mountain Terrain:** Limits hospital locations, increases travel distances for care, and complicates emergency response (Arcury et al., 2005).
- **Flood-Prone Eastern Regions:** Frequently impacted by hurricanes and inland flooding that disrupt transportation, power, and health services (North Carolina Department of Environment and Natural Resources, 2014).
- **Health Workforce Shortages:** Many rural counties in all three regions are federally designated Health Professional Shortage Areas (HPSAs), reflecting geographic isolation and provider scarcity (North Carolina Department of Health and Human Services Office of Rural Health, 2023; Health Resources and Services Administration).

Cultural Profile
of North Carolina

North Carolina's cultural identity reflects the intersection of its geographic diversity, racial and ethnic composition, and longstanding public and private investment in the arts, heritage, and education. The state supports a rich cultural landscape that integrates Indigenous histories, longstanding regional traditions, a vibrant multilingual landscape, and the contributions of increasingly diverse populations.

Multicultural Landscape

North Carolina has long served as a crossroads of cultures. Indigenous communities have lived in the region for thousands of years, and today the state recognizes eight tribes, including the Lumbee, Coharie, Haliwa-Saponi, Sappony, Waccamaw Siouan, Meherrin, Occaneechi Band of the Saponi Nation, and the Eastern Band of Cherokee Indians (North Carolina Commission of Indian Affairs). Two tribes have federal recognition (Eastern Band of Cherokee Indians and Lumbee Tribe of North Carolina).

Over the past several decades, North Carolina has experienced substantial racial and ethnic diversification. The Hispanic/Latine population grew from less than 2% of people in 1990 to more than 10% in 2020, making it one of the fastest-growing demographic groups in the state (U.S. Census Bureau, 1990; NALEO Educational Fund, 2022). Immigration from Latin America, Southeast Asia, Africa, and the Caribbean has contributed to growing linguistic, religious, and culinary diversity across communities (North Carolina Department of Commerce, 2022).

The majority of North Carolinians ages five and older (approximately 8.7 million people, or 88%) primarily speak English at home; however, this percentage varies by county. From 2018 to 2022, Duplin County had the lowest population percentage who spoke English at home, at 77%.

Spanish is the state's second most spoken language at home, used by about 8% of the state's population ages five and older. Duplin County has the highest proportion of Spanish speakers, at 21%.

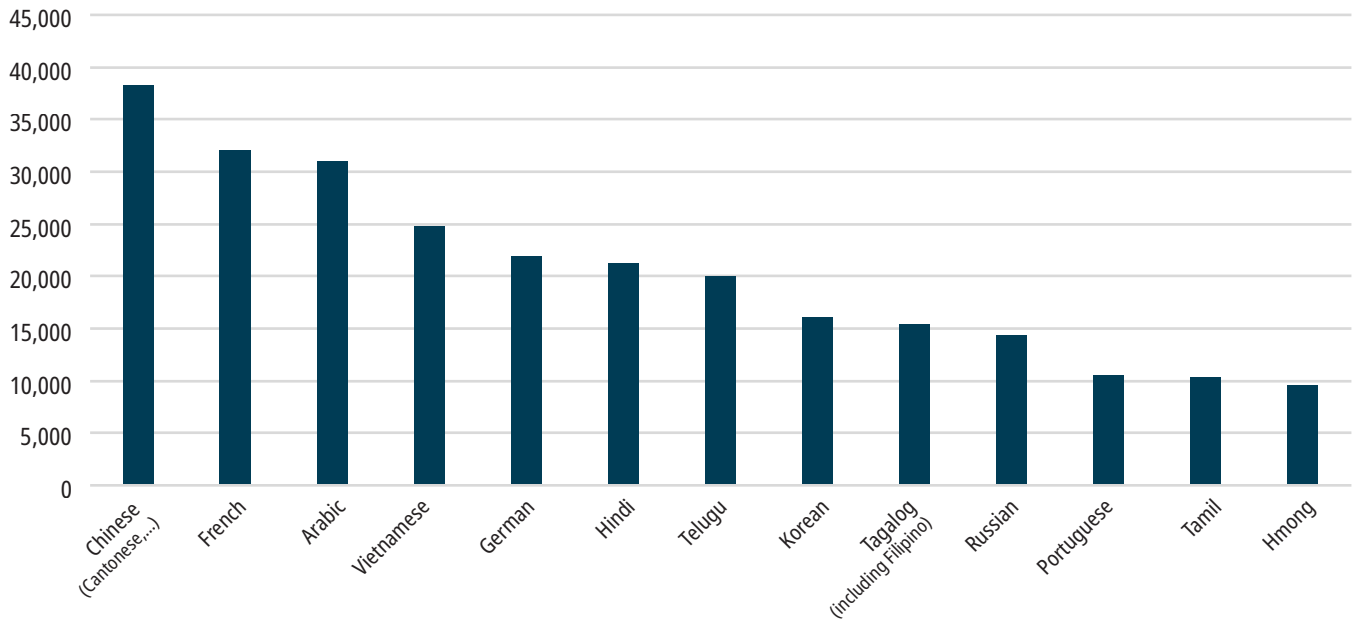
In addition to English and Spanish, 13 other languages are each spoken by at least 10,000 North Carolinians ages five and over (Cline, 2024; OSBM).

Table 1. Language Spoken at Home in North Carolina (Population Ages 5+)

Language	Population
English	8,700,000
Spanish	775,000
Chinese (Cantonese, Mandarin)	38,296
French	32,019
Arabic	30,931
Vietnamese	24,822
German	21,901
Hindi	21,244
Telugu	19,921
Korean	16,130
Tagalog (including Filipino)	15,442
Russian	14,390
Portuguese	10,498
Tamil	10,390
Hmong	9,508

Source: U.S. Census Bureau, American Community Survey, 2018–2022.

Figure 2. Language Spoken at Home in North Carolina Other Than English or Spanish (Population Ages 5+)



Source: US Census Bureau, American Community Survey, 2018-2022

To support cross-cultural engagement and strengthen community cohesion, many public institutions, community organizations and nonprofits have expanded culturally relevant programming including language access services, multicultural festivals and inclusive arts initiatives.

Arts Infrastructure and Public Support

North Carolina has built a robust arts infrastructure with significant public investment. The North Carolina Arts Council, a division of the Department of Natural and Cultural Resources (DNCR), provides grants, training, and technical assistance to artists, schools, and nonprofit organizations in all 100 counties (North Carolina Arts Council). Since its establishment in 1967, the Council has supported traditional, folk, and contemporary arts while promoting access to cultural programming in both rural and urban communities.

DNCR also administers statewide cultural heritage programs and manages state historic sites, archives, and museum divisions that preserve North Carolina's history and elevate diverse narratives (North Carolina Department of Natural and Cultural Resources). Public higher education institutions — including members of the UNC System and the North Carolina Community College System — contribute to the cultural ecosystem through performing arts series, artist residencies, gallery exhibitions, and community events (University of North Carolina System; North Carolina Community College System).

Private foundations, local arts councils, and nonprofit organizations further support festivals, heritage programming, and arts education initiatives across the state.

Museums and Cultural Institutions

North Carolina maintains a strong network of museums that reflects a wide range of disciplines:

- **North Carolina Museum of Art (Raleigh):** A leading regional art museum with a permanent collection and rotating exhibitions (North Carolina Museum of Art).
- **North Carolina Museum of History and North Carolina Museum of Natural Sciences (Raleigh):** Offer interactive exhibits and educational programs for families, students, and visitors (North Carolina Museum of History, North Carolina Museum of Natural Sciences).
- Regional museums such as the Mint Museum (Charlotte), Cameron Art Museum (Wilmington), and Reynolda House Museum of American Art (Winston-Salem) expand access to arts and cultural experiences statewide (Mint Museum, Cameron Art Museum, Reynolda House Museum of American Art).

These institutions are supported through a mix of state appropriations, philanthropy, and competitive grants, and many maintain partnerships with schools and universities to promote cultural literacy and lifelong learning.

Festivals and Community Celebrations

Festivals across North Carolina highlight the state's artistic traditions and multicultural communities:

- **Arts and Music:** MerleFest in Wilkesboro, one of the country's premier Americana and roots music festivals (MerleFest); American Dance Festival in Durham (American Dance Festival); and LEAF Global Arts programming in programming in western North Carolina.
- **Cultural Heritage:** North Carolina Azalea Festival (Wilmington); American Indian Heritage Celebration (Raleigh); and the NC Folk Festival (Greensboro) (North Carolina Folklife Institute).
- **Seasonal and Agricultural:** North Carolina State Fair (Raleigh) and the Hendersonville Apple Festival (North Carolina State Fair).
- **Food and Drink:** Lexington Barbecue Festival; North Carolina Wine Festival (North Carolina Winegrowers Association).

Local governments, arts councils, and grassroots organizations further enrich cultural life by hosting multicultural celebrations, LGBTQ+ pride events, neighborhood parades, and community festivals throughout the year.

Sports and Community Identity

Youth Sports

Youth sports remain a cornerstone of community life. Local parks and recreation departments offer opportunities in soccer, basketball, baseball/softball, and other sports, supporting physical activity, teamwork, and youth development. The North Carolina High School Athletic Association (NCHSAA) provides statewide governance for interscholastic athletics (NCHSAA).

Collegiate Athletics

North Carolina's colleges and universities have a rich tradition of athletic participation across a wide range of intercollegiate conferences, reflecting the state's long-standing commitment to collegiate sports and student-athlete excellence. Institutions across the state compete at the NCAA Division I, II, and III levels, with representation in nationally recognized conferences including the ACC, AAC, CAA, MEAC, Sun Belt, Big South, Conference Carolinas, CIAA, USA South, and ODAC (National Collegiate Athletic Association [NCAA], 2025).

Table 2. National Collegiate Athletic Association (NCAA)

NCAA Division I

Atlantic Coast Conference (ACC)
American Athletic Conference (AAC)
Coastal Athletic Association (CAA)
Mid-Eastern Athletic Conference (MEAC)
Sun Belt Conference
Big South Conference

NCAA Division II

Conference Carolinas
Central Intercollegiate Athletic Association (CIAA)

NCAA Division III

USA South Athletic Conference
Old Dominion Athletic Conference (ODAC)

Professional Sports

North Carolina is home to several professional franchises, including:

- Carolina Panthers (NFL)
- Carolina Hurricanes (NHL)
- Charlotte Hornets (NBA)
- Charlotte FC (MLS)

Minor league baseball also has a strong presence, with teams such as the Durham Bulls, Asheville Tourists, and Winston-Salem Dash anchoring local sports culture (Minor League Baseball).

Economic Profile
of North Carolina

North Carolina's economy is dynamic and multifaceted, evolving from historical roots in agriculture and manufacturing to a modern landscape anchored by technology, health care, finance, clean energy, and advanced manufacturing. As the nation's ninth most populous state, North Carolina plays a significant role in the United States economy, leveraging strong population growth, a competitive business climate and ongoing investments in infrastructure and workforce development (U.S. Census Bureau, 2024).

North Carolina has one of the larger state economies in the country. In current dollars, the state's gross domestic product (GDP) grew from roughly $600 billion in 2020 to about $795 billion in 2023, reflecting substantial post-pandemic expansion (Federal Reserve Bank of St. Louis, 2024; Bureau of Economic Analysis, 2024). The state has repeatedly been recognized for its business climate. For example, CNBC named North Carolina "America's Top State for Business" in both 2022 and 2023, citing strengths in workforce, infrastructure and economic development strategy (CNBC, 2022, 2023; U.S. Bureau of Labor Statistics, 2022).

Labor market conditions remain relatively strong. The statewide unemployment rate has been holding in the mid 3% range — about 3.6% in 2024 — aligning closely with the national average and remaining near historic lows (Bureau of Labor Statistics [BLS], 2024; High Point Office of Budget and Evaluation, 2025). At the same time, the state's households continue to struggle with expenses following the sharp run-up in prices during 2021–2022. Although inflation has recently eased, elevated costs for housing, transportation, and other essential goods and services continue to strain household budgets (Census Bureau data summarized in Timiraos, 2025).

Major Employment Sectors

North Carolina's employment base is broadly diversified, spanning management, health care, education, manufacturing, services and technology sectors. May 2023 Occupational Employment and Wage Statistics reported an approximate state total of 4.8 million jobs across all occupations, including the following:

291,430 (6.1%)
MANAGEMENT OCCUPATIONS

263,540 (5.5%)
BUSINESS AND FINANCIAL OCCUPATIONS

171,450 (3.6%)
COMPUTER AND MATHEMATICAL OCCUPATIONS

79,640 (1.7%)
ARCHITECTURE AND ENGINEERING OCCUPATIONS

268,890 (5.6%)
HEALTH CARE PRACTITIONERS AND TECHNICAL OCCUPATIONS

263,050 (5.5%)
EDUCATION, TRAINING AND LIBRARY OCCUPATIONS

474,970 (9.9%)
SALES AND RELATED OCCUPATIONS

655,540 (13.7%)
OFFICE AND ADMINISTRATIVE SUPPORT OCCUPATIONS

444,760 (9.3%)
PRODUCTION OCCUPATIONS

(BLS, 2024; Economic Policy Institute, 2024).

These data underscore the importance of traditional sectors such as production and office support, as well as the expanding footprint of knowledge-intensive occupations in business, technology and health care sectors.

Regional Disparities and the County Tier System

Economic conditions vary markedly across North Carolina's regions. The state's six most metropolitan counties (Wake, Mecklenburg, Guilford, Durham, Forsyth and Buncombe) all benefit from diversified economies, strong job growth, higher average incomes and robust infrastructure. In contrast, many rural counties, particularly in eastern and far-western North Carolina, face higher poverty rates, slower job growth, and more limited employment opportunities, reflecting and reinforcing persistent disparities in health, education, and access to services (North Carolina Department of Commerce, 2024; International Monetary Fund, 2025).

Each year, the North Carolina Department of Commerce employs a statutory three-tier system to classify all 100 counties and direct economic development investment. Counties are ranked based on four indicators: average unemployment rate, median household income, population growth, and per capita property tax base. Rankings are then used to assign each county to one of three tiers:

TIER 1: 40 most economically distressed counties

TIER 2: The next 40 counties

TIER 3: 20 least distressed (most prosperous) counties

The three-tier system is used to target incentive programs toward Tier 1 and Tier 2 counties seeking to attract and retain employers. Program incentives include Job Development Investment Grants and other supports (North Carolina Department of Commerce, 2024; International Monetary Fund, 2025). Critics note that the system may not fully capture within-county disparities or rapidly changing local conditions, yet the three-tier system remains central to North Carolina's strategy for promoting more balanced regional growth.

Labor Force and Employment Trends

North Carolina's labor market has largely recovered from the COVID-19 downturn. However, disparities persist. Unemployment and underemployment rates remain higher for Black, Latine, and Indigenous workers than among white workers, reflecting long-standing inequities in access to education, transportation, child care and professional networks (North Carolina Justice Center, 2023; myFutureNC, 2025; World Population Review, 2025).

People living in rural areas, especially in counties with limited public transit or broadband access, may face additional barriers to stable employment and career advancement. These include longer commutes, fewer local job openings and limited access to training programs that require reliable internet.

Key Industries and Emerging Sectors

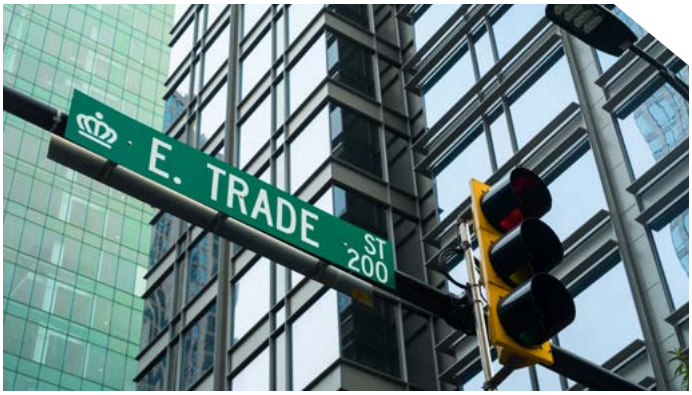
North Carolina has cultivated competitive advantages across several high-growth industries:

Biotechnology and Life Sciences

North Carolina is an established, national leader in life sciences and is anchored by Research Triangle Park (RTP), the largest research park in the United States. Recent estimates indicate more than 800 life sciences companies, employing 70,000–75,000 workers and demonstrating a strong growth trend since 2018 (Economic Development Partnership of North Carolina, 2024, 2025; Edgeton, 2025). New investments in biomanufacturing and pharmaceutical production continue to expand this sector.

Advanced Manufacturing

The state has transitioned from traditional textiles and furniture manufacturing to aerospace, automotive, pharmaceuticals, and precision machinery industries, leveraging logistics assets and a skilled manufacturing workforce (North Carolina Department of Commerce, 2024; International Monetary Fund, 2025).



Finance and Financial Technology (FinTech)

Charlotte is widely recognized as one of the nation's leading banking centers, home to major institutions such as Bank of America and Truist and an emerging hub for digital financial services (Economic Development Partnership of North Carolina, 2024; International Monetary Fund, 2025; TAC Economics, 2025; Tok & Heng, 2022).

Information Technology

Firms specializing in cloud computing, data analytics, cybersecurity, and software development have increasingly located in the Triangle, Charlotte, and other metropolitan areas, drawn by proximity to research universities and a growing technology workforce (Economic Development Partnership of North Carolina, 2024; TAC Economics, 2025).

Clean Energy and Climate Technology

North Carolina is a major solar energy state. In 2023, it ranked fourth nationally in installed solar generating capacity, with about 6,600 megawatts of capacity and roughly 10% of the state's electricity coming from solar energy (U.S. Energy Information Administration [EIA], 2024, 2025; Solar Energy Industries Association [SEIA], 2024). State policy and private investment are also advancing offshore-wind planning, energy storage, and grid modernization.

These industries offer opportunities for high-wage employment but often require postsecondary credentials or specialized skills, making alignment of education and workforce systems critical to ensuring equitable access to these jobs.

Income, Wages, and Cost of Living

In 2023, North Carolina's median household income was $69,904, which is below the national median (Data USA; U.S. Census Bureau, 2024). Income inequality is pronounced across geographic and demographic groups, with higher earnings concentrated in fast-growing metropolitan counties and among individuals with four-year degrees or higher.

Housing affordability is one of the most acute pressures on household budgets. Statewide data indicate that nearly half of renter households are cost-burdened, spending 30% or more of their income on housing, and renter cost burden has remained near 50% for much of the past decade (North Carolina Department of Commerce, 2025; North Carolina Housing Coalition, 2025). Severe cost burden — spending more than 50% of income on housing — is especially common among extremely low-income renters (National Low Income Housing Coalition; Smith, 2025).

The cost of living varies widely. Urban areas such as Raleigh, Charlotte, and Asheville have seen rapid increases in home prices and rents, while many rural communities struggle with stagnant wages, aging housing stock, and limited new construction (ncIMPACT Initiative, 2024). These patterns translate directly into disparities in health, educational opportunity and economic mobility.

$69,904

Median Household Income

Nearly Half of Renters Cost-Burdened

In 2023, the statewide median household income was $69,904, below the national median. Nearly one in two renter households spends 30% or more of income on housing, underscoring widespread affordability challenges.

North Carolina | Data USA

Business Environment and Economic Development

Multiple national rankings place North Carolina among the top states for business climate. CNBC named North Carolina America's Top State for Business in 2022 and 2023, citing strengths in workforce, education, infrastructure, and access to capital (CNBC, 2022, 2023; U.S. Bureau of Labor Statistics, 2022). The state's economic development strategy leverages:

/ 01 Targeted incentive programs to support industry relocation and expansion

/ 02 Rural economic development initiatives, including site-readiness and main-street revitalization

/ 03 Support for small businesses and entrepreneurship, often in partnership with community colleges, regional councils of government, and local chambers of commerce

Despite this strong macro-level environment, stakeholders in tribal communities, historically Black neighborhoods, and rural areas frequently point to underinvestment in broadband, industrial sites, and small business capital, which can limit the reach of statewide growth.

Workforce Development and Education Alignment

North Carolina has set postsecondary attainment and workforce alignment as a central policy priority. The statewide myFutureNC goal is for two million North Carolinians ages 25–44 to hold a high-quality degree or credential by 2030 (myFutureNC).

According to the 2025 myFutureNC Educational Attainment Report, about 1.19 million adults ages 25 to 44, roughly 42% of that age group, have not yet earned a postsecondary degree or credential. This group includes hundreds of thousands of adults with "some college" experience or "no degree" (myFutureNC, 2025). Closing this attainment gap presents challenges for both employers and communities, particularly as many of the fastest-growing jobs require education beyond high school.

To address these gaps, the state is investing in:

- K–12 to college pathways, including dual-enrollment and Career & College Promise
- Community college programs aligned with key industries (e.g., life sciences, advanced manufacturing, information technology and clean energy)
- Adult learner initiatives such as NC Reconnect, which help adults with some college but no credential return to school and complete their education (myFutureNC, 2024, 2025).

Regional and Racial Disparities

Economic health in North Carolina continues to vary by region and race. Urban regions like the Research Triangle, Charlotte, and the Triad, have experienced the greatest benefits from recent job announcements, while many rural counties in eastern and western North Carolina continue to face persistent poverty, an aging population, and ongoing out-migration (Bhatt, 2025; ncIMPACT Initiative, 2024; North Carolina Department of Commerce, 2024; International Monetary Fund, 2025).

Communities of color, particularly Black and Latine people, are more likely to experience lower wages, higher unemployment, lower homeownership rates, and greater exposure to housing cost burden (Childress, 2025; NC Budget & Tax Center, 2025; North Carolina Housing Coalition, 2025). These patterns reflect long-standing structural racism, segregation, and disinvestment, underscoring the need for intentional, place-based strategies that pair economic development investments with efforts to expand affordable housing, quality education, and asset-building opportunities.

Military Profile
of North Carolina

North Carolina's military presence is a defining feature of its economic, social, and workforce landscape. As home to some of the nation's largest and most strategically important installations, the state plays a critical role in national defense while benefiting from substantial economic activity generated by service members, veterans, military families, and defense-related industries (Our NC Military).

North Carolina hosts a wide array of Army, Marine Corps, Air Force, and Coast Guard facilities that support training, aviation, logistics, special operations, and coastal security. These installations anchor local economies, attract defense contractors, and contribute to a robust pipeline of skilled workers transitioning into civilian careers, supporting approximately 11% of statewide employment (Our NC Military, North Carolina Military Affairs Commission, 2022).

Major Military Installations

Fort Bragg (Cumberland County). Formerly known as Fort Liberty, Fort Bragg is the largest U.S. military installation by population, with more than 50,000 active-duty personnel and over 14,000 civilian employees. The installation is home to the 82nd Airborne, XVIII Airborne Corps, and the U.S. Army Special Operations Command, among other elite units (North Carolina Department of Military & Veterans Affairs).

Marine Corps Base Camp Lejeune (Onslow County) is the largest Marine Corps installation on the East Coast, spanning over 150,000 acres, including 14 miles of Atlantic coastline. Camp Lejeune serves as the headquarters for Marine Corps Installations East (MCIEAST) (Marine Corps Installations East; Headquarters and Support Battalion).

Marine Corps Air Station (MCAS) New River (Onslow County) hosts approximately 7,000 active-duty personnel and 1,000 civilian employees, supporting Marine aviation and helicopter operations (North Carolina Department of Military and Veterans Affairs).

Marine Corps Air Station (MCAS) Cherry Point (Craven County) employs roughly 6,000 active-duty personnel and 5,400 civilian workers. Among Cherry Point's major tenants is the Fleet Readiness Center (FRC) East, which performs aircraft maintenance for the Marine Corps and other military services (Military OneSource, 2024; Military OneSource).

Seymour Johnson Air Force Base (Wayne County) supports the 4th Fighter Wing and employs approximately 4,100 active-duty service members and 1,000 civilian staff (MilitaryINSTALLATIONS; Military OneSource, 2024).

U.S. Coast Guard Air Station Elizabeth City (Pasquotank County) is one of the nation's largest Coast Guard aviation facilities, supporting mid-Atlantic and offshore missions (MyBaseGuide, 2025; U.S. Coast Guard, 2024; United States Coast Guard).

Together, these installations form a statewide network of military readiness, training, aviation support, and coastal defense.

Statewide Military and Defense Impact

Defense is North Carolina's second-largest economic sector, generating approximately $66 billion annually (Our NC Military). The defense industry supports about 11% of statewide employment, equal to roughly 653,000 jobs when accounting for active-duty service members, civilian employees, contractors, and indirect economic activity (Our NC Military; North Carolina Military Affairs Commission, 2022).

Military installations also anchor local economies. Camp Lejeune alone generates nearly $3.6 billion in annual economic activity for the Jacksonville region (Marine Corps Installations East, 2023). Defense procurement, construction, logistics, aerospace manufacturing, and information technology services further amplify the economic contributions of these installations, particularly in Cumberland, Onslow, Craven, and Wayne counties (Our NC Military).

Transitioning Service Members and Workforce Development

Each year, approximately 20,000 North Carolina service members transition out of the military, providing a steady influx of experienced workers with skills in logistics, aviation, cybersecurity, health care, and operations management (Our NC Military). Although veterans contribute to a highly capable labor force, they may experience challenges related to credential transferability, housing affordability, and gaps in behavioral health services (National Veterans Homeless Support).

Veterans and Military Families

North Carolina is home to one of the nation's largest veteran populations. In 2024, the state had over 620,000 non-active-duty veterans, comprising a substantial segment of the state's civilian labor force. Veterans ages 35 to 64 account for the highest number of employed veterans (approximately 125,880), but this same group also comprises the largest number of unemployed veterans (Carolina Demography, 2025).

The national Veterans Health Administration (VHA) meets the health care needs of the country's veteran population through 18 regional networks known as Veterans Integrated Service Networks (VISNs). VISN 06, also called the VA Mid-Atlantic Health Care Network, provides services to veterans throughout North Carolina and parts of Virginia. The VISN structure is intended to deliver comprehensive health care to veterans while coordinating care with community providers (U.S. Department of Veterans Affairs, U.S. Department of Veterans Affairs, 2025).

Within VISN 06, there are seven VA medical centers (VAMCs), four of which are located in North Carolina: Asheville, Fayetteville, Salisbury, and Durham. Additional VHA facilities are distributed throughout North Carolina and parts of Virginia, including Community-Based Outpatient Clinics (CBOCs), Health Care Centers (HCCs), specialty clinics such as dialysis and rehabilitation centers, and Vet Centers offering mental health services (North Carolina Department of Military & Veterans Affairs; U.S. Department of Veterans Affairs).

National Guard and Statewide Support Infrastructure

Military readiness is also supported by the North Carolina National Guard, along with additional training, research, and support facilities located across the state. These units provide domestic emergency response, aviation support, engineering services, and cybersecurity capabilities, playing a vital role during hurricanes, wildfires, floods, and other emergencies (National Guard Bureau, 2024; North Carolina National Guard).

Educational Profile
of North Carolina

North Carolina's education system spans a broad continuum from early childhood programs through higher education and adult learning. While the state is home to nationally recognized innovations and strong public institutions, persistent gaps in access, funding, and outcomes continue to shape educational opportunities, particularly for rural, low-wealth, and historically underserved communities.

Early Childhood Education and Child Care

North Carolina has a longstanding commitment to early learning through both public and private programs, including North Carolina Pre-kindergarten Program (NC Pre-K), Smart Start, and Head Start/Early Head Start. Despite this infrastructure, access remains limited. As of 2023, licensed child care providers could accommodate only 18.7% of the state's infants and toddlers, with the most severe shortages occurring in rural counties (Child Care Association, 2022).

The average annual cost of infant care currently exceeds $11,000, often surpassing in-state university tuition (Economic Policy Institute, 2023). Subsidies are available to working families earning up to 200% of the federal poverty level. In 2023 more than 60,000 children benefited from child care subsidies; however, thousands remain on waiting lists due to funding constraints (NCDHHS Division of Child Development and Early Education [DCDEE], 2023).

NC Pre-K provides free preschool for eligible four-year-olds, particularly children at risk of poor academic outcomes. Smart Start promotes early literacy, family engagement and child health through partnerships in all 100 counties. Head Start and Early Head Start extend comprehensive early learning and wraparound services to include low-income and migrant families (U.S. Administration for Children & Families, 2023).

K–12 Education: Changing Models and Expanding Choice

North Carolina's K–12 landscape has undergone significant diversification. Traditional public schools continue to serve the majority of students (approximately 76%); however, charter schools, private schools, home schools and other alternative models are steadily expanding. These alternative models account for a growing share of the state's overall enrollment (North Carolina Department of Public Instruction [NCDPI], 2023). Charter school enrollment has grown sharply since the statewide cap was lifted in 2011 and home school enrollment surged during the COVID-19 pandemic.

In 2023, the Opportunity Scholarship program was expanded to include all families regardless of income, leading to an acceleration in private school enrollment and prompting questions regarding accountability, funding equity and statewide system coherence (NC State Education Assistance Authority, 2023). These structural shifts reflect a broader trend toward pluralism in educational delivery and have intensified discussions about resource allocation and student outcomes.

Accelerated Pathways and High School Innovation

North Carolina is a national leader in early college and dual enrollment models. Through the Career & College Promise (CCP) initiative, high school students earn tuition-free college credit, thereby shortening the time required to complete a degree and reducing overall student debt. Cooperative Innovative High Schools (CIHS) — often located on community college campuses — target first-generation college students and those at risk of not completing high school. As of 2023, 134 CIHS programs were operating across the state (NCDPI, 2023).

134 Cooperative Innovative High Schools

North Carolina leads the nation in early college models, with high schools offering accelerated pathways.

Postsecondary and Adult Education

North Carolina's higher education ecosystem includes:

- **The University of North Carolina System:** 16 public universities and the North Carolina Schools of Science and Mathematics with nearly 250,000 students enrolled systemwide (UNC System, 2023). Five of the 16 UNC institutions are historically black colleges and universities (HBCUs).
- **The North Carolina Community College System (NCCCS):** Fifty-eight colleges serving all 100 counties and providing academic transfer pathways, workforce credentials, basic skills programs and correctional education (NCCCS, 2023).
- **Private nonprofit colleges and universities:** Enrolling roughly 87,000 students, these institutions offer key contributions to research, liberal arts education and state workforce pipelines (NC Independent Colleges and Universities, 2023).

Programs such as NC Promise offer reduced tuition ($500 per semester for in-state students) at select UNC institutions, improving affordability for thousands of students annually.

Adult education opportunities like high school equivalency, English language acquisition, and workforce upskilling are available through community colleges and partnerships with employers, libraries, and correctional facilities.

Supporting Special Populations

The state of North Carolina administers several specialized programs to support equitable access:

- Migrant Education Program and McKinney-Vento Homeless Education Program provide tutoring, transportation and enrollment support for mobile and unhoused students.
- Youth in foster care benefit from school stability requirements, while juveniles in detention receive instruction through North Carolina Department of Public Safety programs (NC DPS, 2023).
- For incarcerated adults, 43 community colleges partner with prisons to deliver high school equivalency and career preparation, supporting reentry and reducing recidivism.

Funding and Access Challenges

Funding inequities persist across North Carolina's public schools and are largely tied to property tax revenue. Wealthier districts supplement state education allocations to provide higher salaries, updated facilities, and expanded instructional supports, while low-wealth districts often struggle to meet basic needs.

The Leandro v. State of North Carolina case and its Comprehensive Remedial Plan highlight systemic inequities and outline reforms, including expanded early childhood education, strengthened instructional leadership, and targeted funding supports (WestEd, 2019; NC DPI, 2024; Leandro v. State, 488 S.E.2d 249 (N.C. 1997). Federal Title I funds and state low-wealth appropriations mitigate some disparities but do not fully close persistent gaps.

Digital Infrastructure and Workforce Challenges

The digital divide remains a barrier for rural and low-income communities. The NC Student Connect initiative, launched during the COVID-19 pandemic, expanded broadband access, devices, and hotspots to underserved students through public–private partnerships (North Carolina Department of Information Technology, 2023).

Staffing shortages, particularly in teaching, special education and school counseling, continue to constrain instructional quality. The TeachNC initiative seeks to strengthen educator pipelines through recruitment campaigns, licensure support, and targeted incentives for hard-to-staff subjects and high-need schools (TeachNC, 2024).

Digital Access

The **NC Student Connect initiative** expanded broadband and device access during the pandemic, improving connectivity for underserved learners.

North Carolina Department of Health and Human Services, 2023

Teacher Workforce

Teacher and counselor shortages continue to challenge school systems; **TeachNC** is helping rebuild educator pipelines statewide

North Carolina Department of Health and Human Services, 2023

Health Care Profile
of North Carolina

North Carolina's health care system is a diverse and evolving network serving more than 10 million people across urban, suburban and rural regions. Anchored by nationally recognized academic medical centers and a blend of public and private health care systems, North Carolina delivers high-quality, specialty care in metropolitan areas while confronting persistent disparities in access, affordability, and workforce capacity, particularly in rural and historically marginalized communities.

Health Insurance Coverage and Medicaid Expansion

A transformative shift in North Carolina's health care landscape occurred on December 1, 2023, when the state expanded Medicaid eligibility to low-income adults for the first time. By early 2025, more than 630,000 people had enrolled through Medicaid expansion, significantly increasing access to primary, behavioral and preventive care (North Carolina Department of Health and Human Services [NCDHHS], 2025).

Before expansion, approximately 9.2% of North Carolinians — nearly one million people — lacked health insurance, a rate above the national average (U.S. Census Bureau, 2024). In 2023, 46.5% of the state's population obtained coverage through employer-sponsored plans, with the remainder enrolled in Medicare, Medicaid, Marketplace plans or military/veterans' benefits (Kaiser Family Foundation, 2024).

Medicaid expansion is expected to reduce uncompensated care costs for hospitals, stabilize rural facilities, and narrow long-standing racial and geographic disparities in access to health care (NCDHHS, 2025; North Carolina Rural Health Research Program, 2024).

Health Care Infrastructure and Provider Availability

North Carolina's health care infrastructure includes large academic and regional systems as well as dozens of independent community hospitals and Critical Access Hospitals (CAHs). Table 3 shows the largest health care system employers in North Carolina. While metropolitan areas support major tertiary and quaternary care centers, many rural hospitals face financial pressures, workforce shortages and limited-service lines (North Carolina Rural Health Research Program, 2024).

The NCDHHS Division of Health Service Regulation (DHSR) oversees licensure for hospitals, nursing and adult care homes, mental health facilities, ambulatory surgical centers and home health agencies, ensuring compliance with state and federal standards (NCDHHS, 2025). Many facilities pursue voluntary accreditation through The Joint Commission, the Accreditation Commission for Health Care (ACHC) or the Commission on Accreditation of Rehabilitation Facilities (CARF) to demonstrate their commitment to continuous quality improvement.

North Carolina also operates a Certificate of Need (CON) program to prevent unnecessary duplication of health services and promote efficient allocation of resources. Although critics contend that CON laws can restrict competition, recent legislative changes have eased requirements for certain outpatient services in high-growth markets (North Carolina General Assembly, 2023).

Table 3. Largest Health Care System Employers in North Carolina

Rank	Health Care System	Approximate Employees	Notes	In-text Citation
1	UNC Health	50,000+	Statewide public academic health system	(UNC Health)
2	Atrium Health (Advocate Health – NC operations)	30,000–35,000	NC operations only	(Atrium Health)
3	Novant Health	~30,000	Operates primarily in NC and Southeast	(Novant Health)
4	Duke University Health System	25,000–27,000	Health system only	(Duke Health)
5	ECU Health	~12,000	Regional system serving eastern NC	(ECU Health)
6	Cone Health	~13,000	Regional system serving the Triad	(Cone Health)
7	Mission Health (HCA Healthcare – Western NC)	10,000–12,000	Systemwide NC workforce	(HCA Healthcare)
8	WakeMed Health & Hospitals	8,000–9,000	Wake County/Raleigh region	(WakeMed)
9	CaroMont Health	5,000+	Gaston County region	(CaroMont Health)
10	FirstHealth of the Carolinas	5,000+	Sandhills region	(FirstHealth of the Carolinas)

Note: Employee counts are reported by each health system on its official fact sheet, annual report, or "About" organizational profile page (or, where noted, a reputable nonprofit profile summarizing the organization's disclosures). Health systems vary in how they define and report their "workforce" (e.g., "employees" vs. "team members/teammates," inclusion of part-time staff, employed clinicians, affiliates, and multi-state operations). To support comparability, figures are presented as reported by the source and should be interpreted as approximations of workforce size. Counts were accessed on January 11, 2026.

Emergency Medical Services (EMS) operate across all 100 counties through county-based, hospital-based, and contracted models. Staffing shortages, especially in rural counties, have prompted the expansion of community paramedicine, enabling EMS personnel to provide in-home preventive and transitional care (North Carolina Office of EMS, 2024).

Workforce and Specialty Care Access

Persistent workforce shortages affect nearly every aspect of North Carolina's health care delivery system. Over half the state's counties are designated Health Professional Shortage Areas (HPSAs) for primary care, dental care, or behavioral health — often due to geographic isolation, aging populations, and limited provider recruitment pipelines (Health Resources and Services Administration, 2024).

Consistent access across North Carolina to quality and affordable dental care is strained and varies significantly by market. At the same time, the dental workforce has grown rapidly; a recent 10-year analysis (2014–2024) found that the number of dentists per 100,000 North Carolina residents increased faster than in any other state (J. Goodman, NC Dental Society, personal communication). While private practitioners provide more than 80% of the North Carolina's dental services, their statewide distribution is uneven: over half of all dentists practice in just six counties, and several rural counties have no practicing dentist (North Carolina Oral Health Collaborative, 2024). With Medicaid expansion including adult dental benefits, demand for safety net dental care is projected to grow substantially.

Stagnant Medicaid reimbursement (unchanged since 2008) is the primary driver of participation decline and access barriers – not dentist supply.

Mental and Behavioral Health

Mental and behavioral health needs rank among the state's most pressing challenges. Nearly one in five adults reports experiencing mental health symptoms, and 97 of North Carolina's 100 counties are classified as mental health HPSAs (Health Resources and Services Administration, 2024). The state ranks 39th nationally in access to mental health care (Mental Health America, 2024).

In response, North Carolina is implementing major system reforms, including:

- $835 million investment in crisis services, facilities, and behavioral health workforce development (NCDHHS, 2024)
- Expansion of the 988 Suicide & Crisis Lifeline
- Mobile crisis teams and telepsychiatry
- Integration of behavioral health into Medicaid tailored plans

These strategies aim to strengthen crisis response systems, expand treatment capacity, and reduce avoidable hospitalizations, particularly in rural communities.

Safety Net and Community-Based Care

North Carolina's safety net infrastructure includes:

- **Federally Qualified Health Centers (FQHCs):** Served around 750,000 patients in 2023, many uninsured or living in poverty (North Carolina Community Health Center Association, 2024).
- **Free and Charitable Clinics:** Provided more than 200,000 patient visits to over 80,000 individuals in 2023 (North Carolina Association of Free & Charitable Clinics, 2024).
- **Local Health Departments:** Deliver services in all 100 counties, including clinical services, maternal and child health programs, immunizations, disease surveillance, and environmental health services.
- **School-Based Health Centers:** Expand access to youth-centered care, especially in rural and low-income communities.

$835 MILLION

North Carolina is investing $835 million in crisis services, treatment capacity and the behavioral health workforce.

North Carolina Department of Health and Human Services, 2023

These organizations provide integrated medical, dental, behavioral health, pharmacy, and enabling services, including case management, interpretation and transportation.

State-Operated Facilities

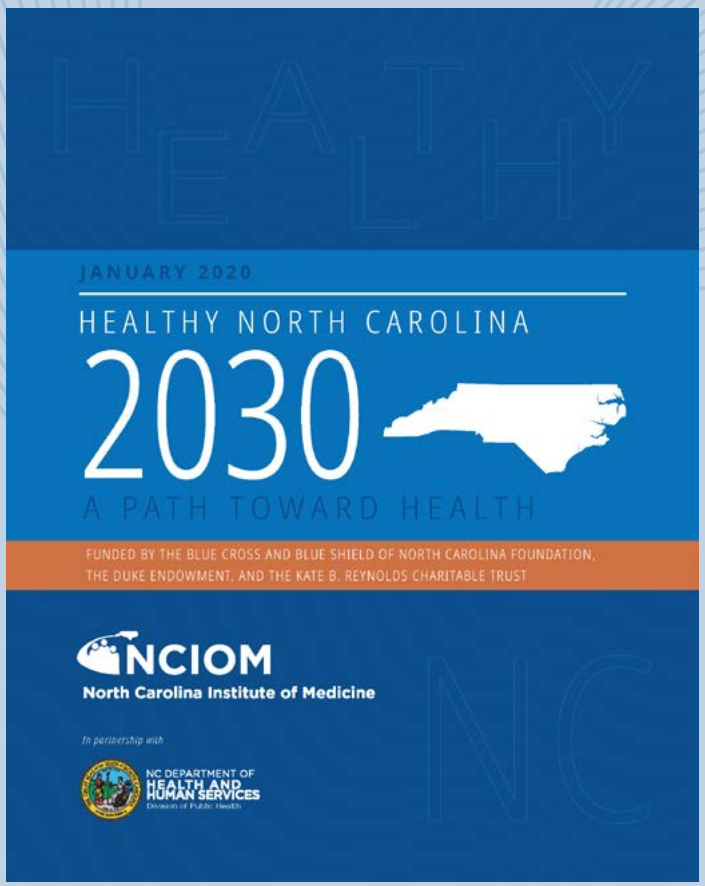
The NCDHHS Division of State Operated Healthcare Facilities (DSOHF) provides specialized inpatient and residential care for individuals with significant behavioral health, developmental or chronic health needs. State-operated facilities include:

- Three psychiatric hospitals
- Three developmental centers
- Two neuro-medical centers
- Additional programs serving children, adults with intellectual/developmental disabilities, and individuals recovering from substance use disorders (NCDHHS, 2025).

These facilities represent the most intensive service settings in the state's continuum of care.

Overall Outlook

North Carolina's health care system is undergoing a period of accelerated transformation. Medicaid expansion, behavioral health investments, digital connectivity improvements and efforts to rebuild the health workforce signal meaningful progress toward a more equitable and resilient system. However, persistent disparities — across geography, race, disability, and income — underscore the importance of sustained investment and policy coordination.


HEALTHY
JANUARY 2020
HEALTHY NORTH CAROLINA
2030
A PATH TOWARD HEALTH
FUNDED BY THE BLUE CROSS AND BLUE SHIELD OF NORTH CAROLINA FOUNDATION, THE DUKE ENDOWMENT, AND THE KATE B. REYNOLDS CHARITABLE TRUST
NCIOM
North Carolina Institute of Medicine
In partnership with
NC DEPARTMENT OF HEALTH AND HUMAN SERVICES
Division of Public Health
NC

HEALTHY NORTH CAROLINA 2030 (HNC 2030) INDICATORS

Poverty

WHAT RESULT DO WE WANT?

All people in North Carolina are financially stable and have lifetime economic prosperity.

WHAT DO WE MEASURE?

- Percent of individuals with incomes below 200% of the Federal Poverty Level (American Community Survey, Five-Year Rolling Estimate, Table 1701)
- Percent of individuals with incomes below 100% of the Federal Poverty Level (American Community Survey, Five-Year Rolling Estimate, Table 1701)*

HOW ARE WE DOING?

The percentage of individuals below 200% of the Federal Poverty Level (FPL) in North Carolina has steadily declined since 2014. However, at 31.0% in 2023, this measure remains four percentage points above the HNC 2030 target goal of 27.0%.

**Healthy North Carolina 2030 uses the percent of individuals 200% below Federal Poverty Level. However, these data are not disaggregated at the 200% level for gender or race/ethnicity. For disaggregated data, use percent of individuals 100% below Federal Poverty Level from the American Community Survey (ACS, Table 1701).*

PRIORITIES OF THE NC SHIP COMMUNITY COUNCIL (2024-2025)

– Poverty and Unemployment Work Group –

Digital Access/Opportunities

- Increase access to affordable broadband internet and digital literacy programs in rural counties.

Educational Access and Support

- Expand early childhood education programs, including Early Head Start, Head Start, and Pre-K.
- Expand access to higher educational opportunities, including early college in high school and pipeline programs.
- Increase health care workforce.
- Support education, awareness, and outreach services for those experiencing poverty, unemployment, or homelessness.

Familial Support

- Track and monitor legislation submitted to NC government to expand paid family medical leave, earned paid sick leave, kin care, and safe days for all caregivers.
- Expand the availability and amount of child care subsidies to reflect the cost of care.
- Increase access to developmental education programs for parents.

Transitional Support

- Implement "activation strategies" to serve populations re-entering the job market: strengthening job-seeking motivation, improving jobseekers' capabilities, and expanding accessible work opportunities (Immervoll & Scarpetta, 2012).
- Invest in CIE (Competitive Integrated Employment) support program initiatives.

Poverty

Figure 3. North Carolina Population Below 200% Federal Poverty Level by Year

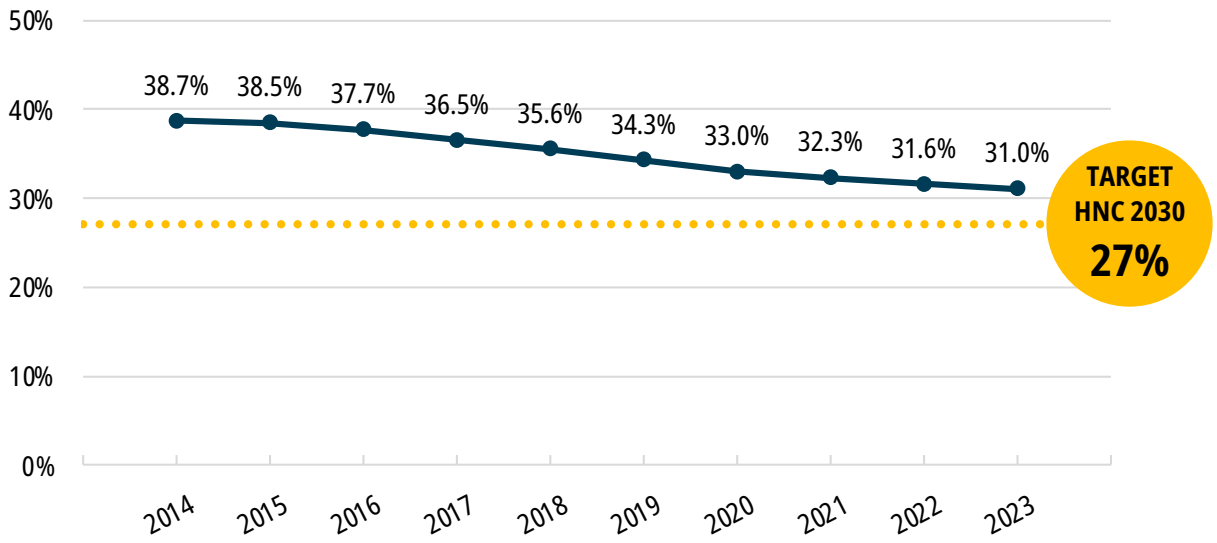
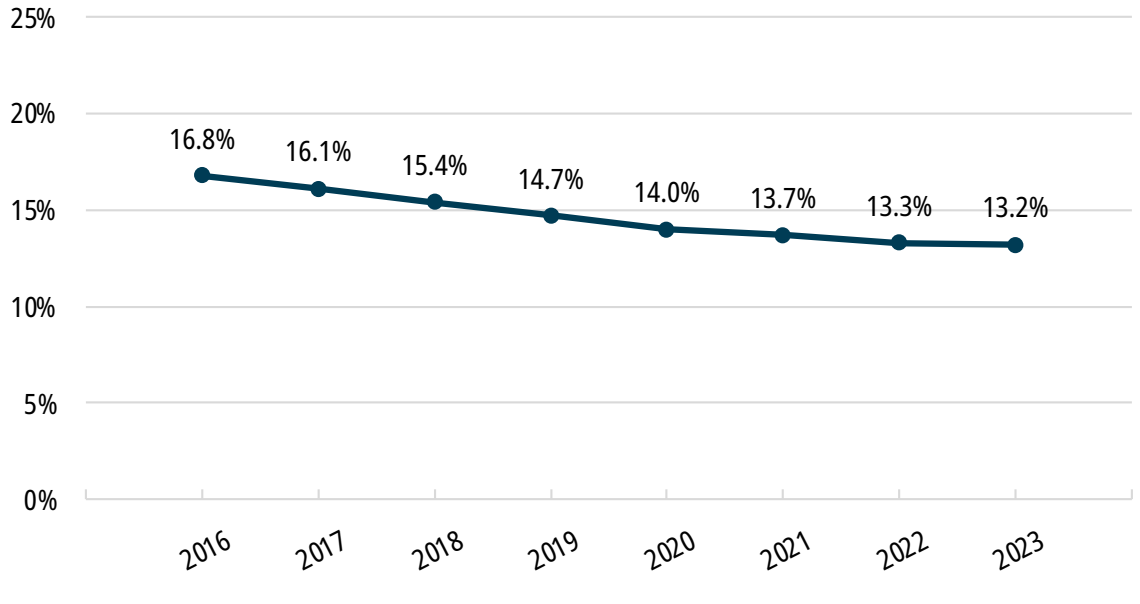


Figure 4. North Carolina Population Below Federal Poverty Level by Year



Data Source: North Carolina State Center for Health Statistics, American Community Survey, 5-year rolling estimates

Poverty

Figure 5. North Carolina Population Below Federal Poverty Level by Race/Ethnicity and Year

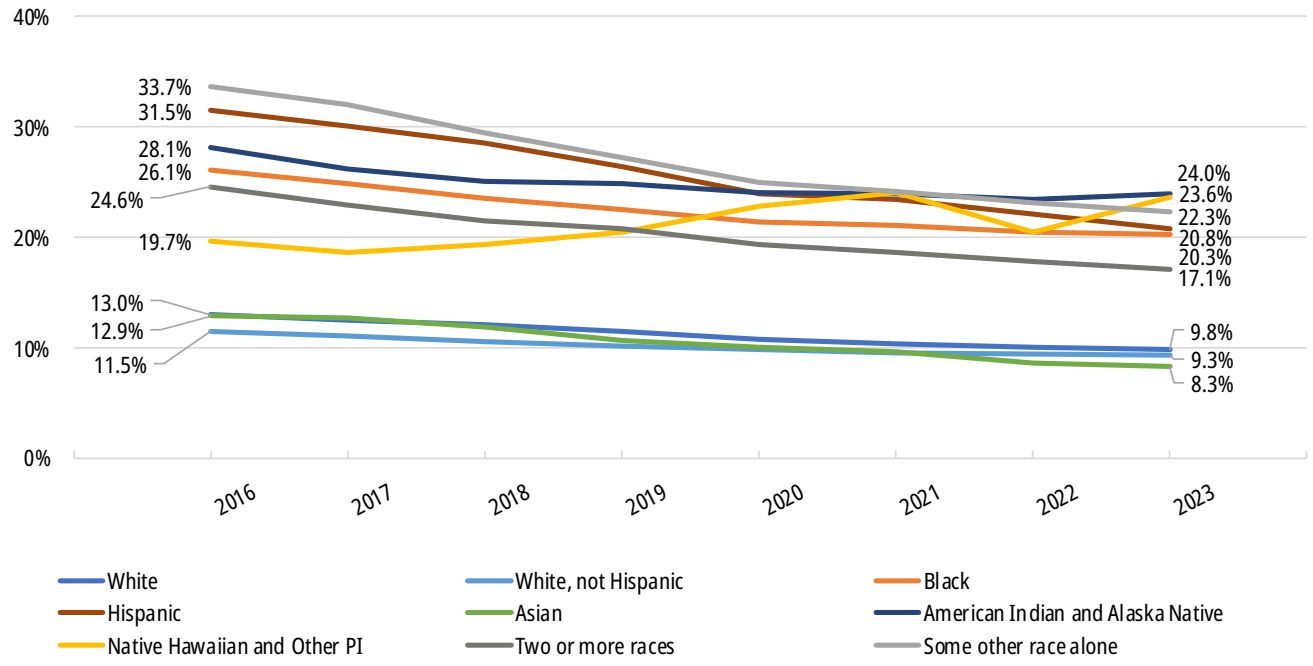
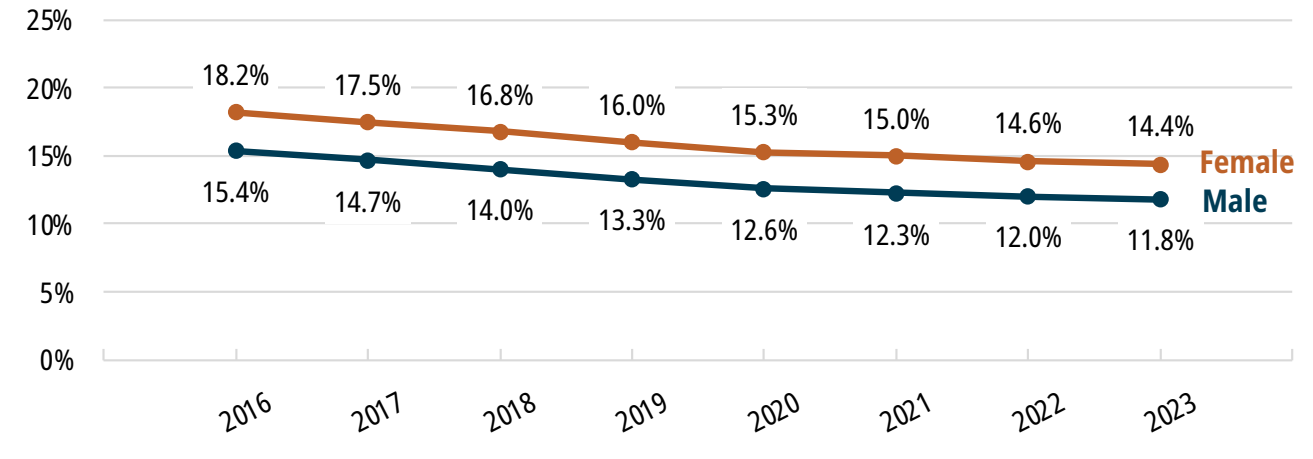


Figure 6. North Carolina Population Below Federal Poverty Level by Gender and Year



Data Source: North Carolina State Center for Health Statistics, American Community Survey, 5-year rolling estimates

Unemployment

WHAT RESULT DO WE WANT?

All people of working age in North Carolina have equitable pathways to fulfilling employment throughout life.

WHAT DO WE MEASURE?

Percent of North Carolina's population ages 16 and older who are unemployed but seeking work (U.S. Census, American Community Survey, Table S2301, Five-Year Rolling Estimate)*

HOW ARE WE DOING?

The percentage of North Carolina's population ages 16 and older who are unemployed but seeking work has steadily decreased from 10.5% in 2014 to 4.8% in 2023. The disparity ratio between percent unemployed white and Black populations has not changed.

Gender data are measured for ages 20 and older.

PRIORITIES OF THE NC SHIP COMMUNITY COUNCIL (2024-2025)

– Poverty and Unemployment Work Group –

Digital Access/Opportunities

- Increase access to affordable broadband internet and digital literacy programs in rural counties.

Educational Access and Support

- Expand early childhood education programs, including Early Head Start, Head Start, and Pre-K.
- Expand access to higher educational opportunities, including early college in high school and pipeline programs.
- Increase health care workforce.
- Support education, awareness, and outreach services for those experiencing poverty, unemployment, or homelessness.

Familial Support

- Track and monitor legislation submitted to NC government to expand paid family medical leave, earned paid sick leave, kin care, and safe days for all caregivers.
- Expand the availability and amount of child care subsidies to reflect the cost of care.
- Increase access to developmental education programs for parents.

Transitional Support

- Implement "activation strategies" to serve populations re-entering the job market: strengthening job-seeking motivation, improving jobseekers' capabilities, and expanding accessible work opportunities (Immervoll & Scarpetta, 2012).
- Invest in CIE (Competitive Integrated Employment) support program initiatives.

Unemployment

Figure 7. North Carolina Disparity Ratio Between White and Other Races/Ethnicities for Percent of Population Ages 16 and Older Who Are Unemployed but Seeking Work by Year

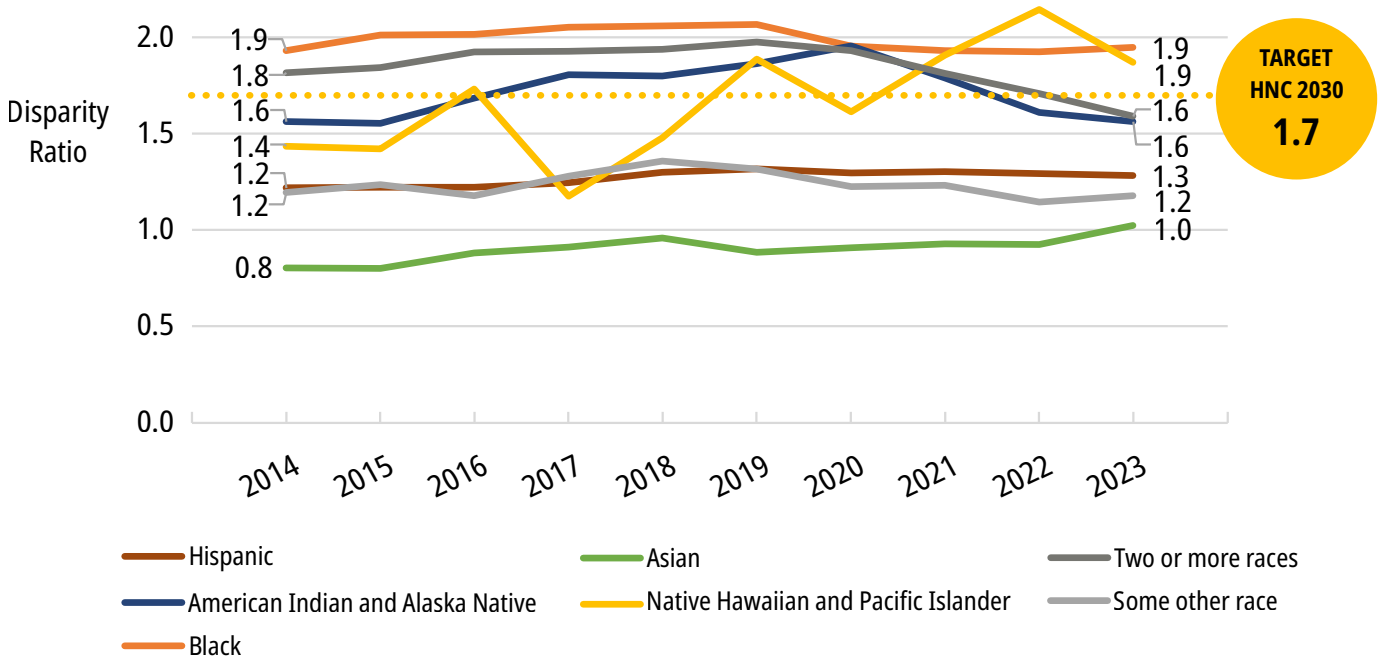
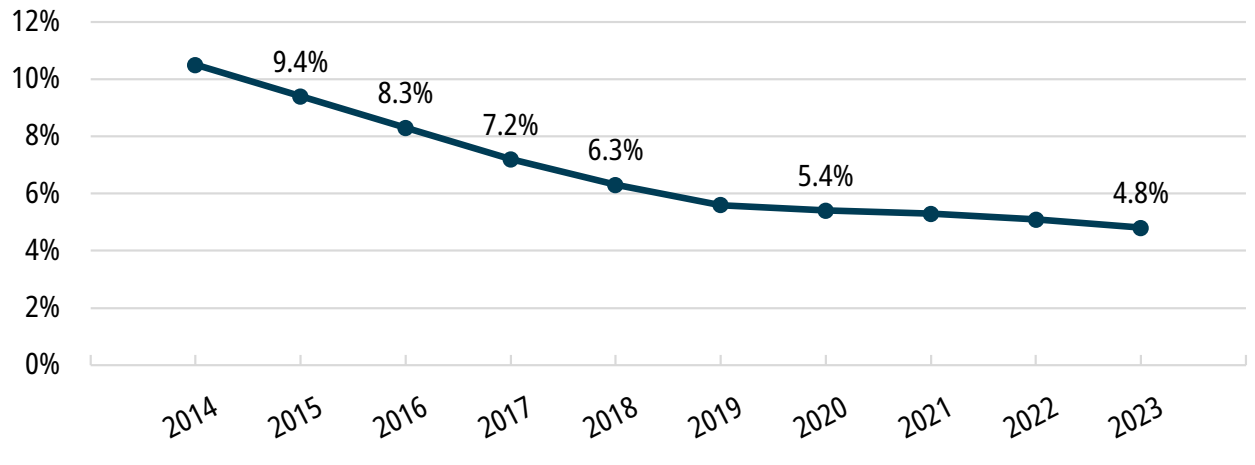


Figure 8. North Carolina Population Ages 16 and Older Who Are Unemployed but Seeking Work by Year



Data Source: North Carolina State Center for Health Statistics, American Community Survey, 5-year rolling estimates

Unemployment

Figure 9. North Carolina Population Ages 16 and Older Who Are Unemployed but Seeking Work by Race/Ethnicity and Year

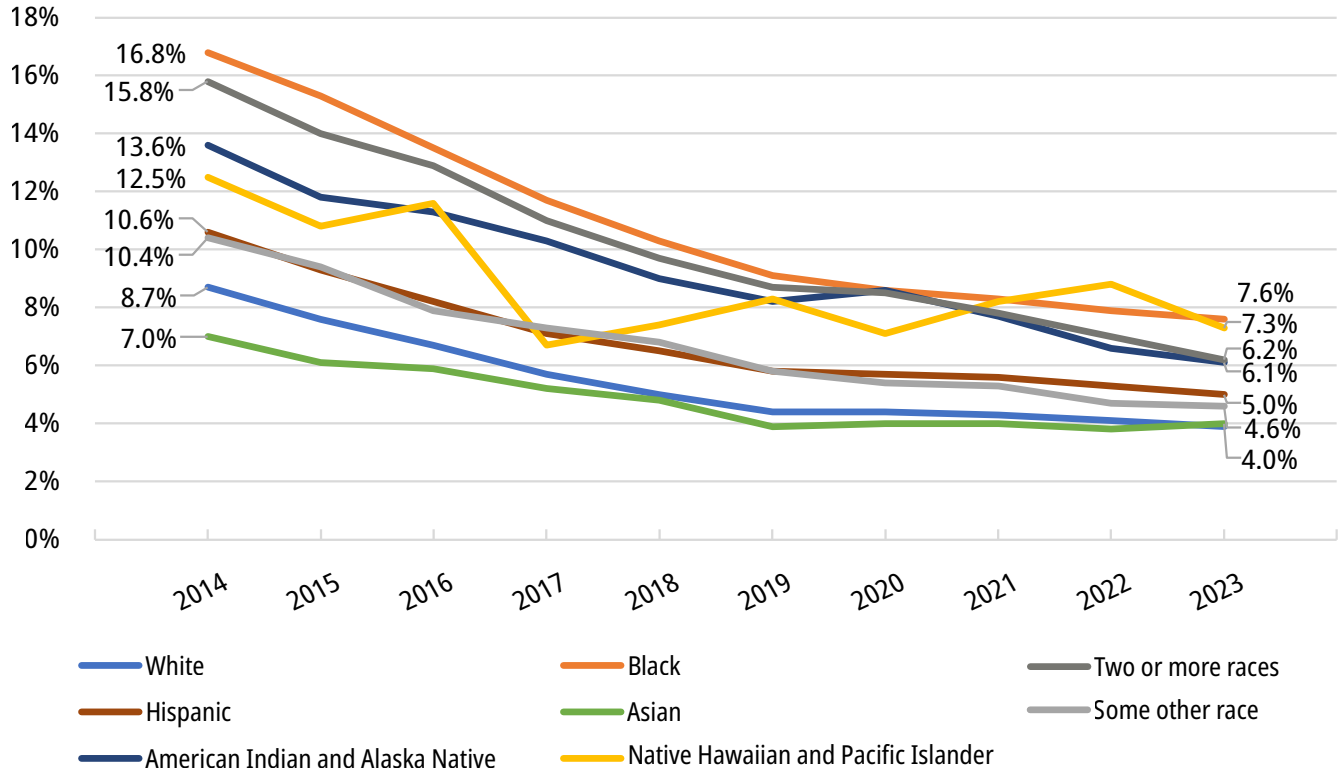
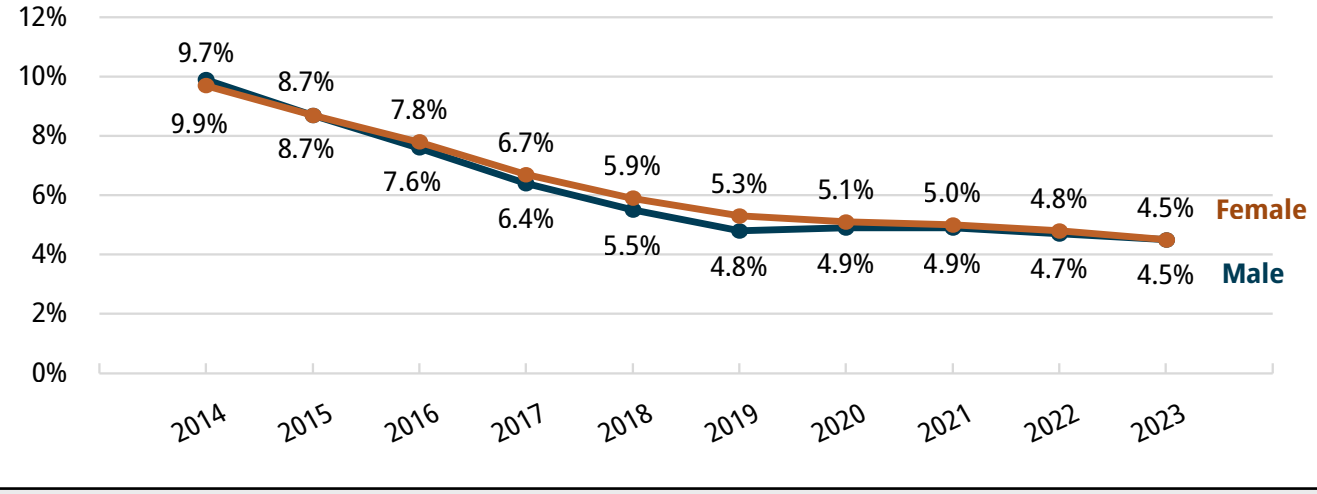


Figure 10. North Carolina Population Ages 20 and Older Who Are Unemployed but Seeking Work by Gender and Year



Data Source: North Carolina State Center for Health Statistics, American Community Survey, 5-year rolling estimates

Short-Term Suspensions

WHAT RESULT DO WE WANT?

All people in North Carolina are supported by a K-12 education system that values divergent perspectives with schools reflecting a diverse community of students, faculty, and staff.

WHAT DO WE MEASURE?

Short-term suspension rate for all acts reported in educational facilities per 1,000 students (North Carolina Department of Public Instruction Consolidated Data Report)

HOW ARE WE DOING?

The state's short-term suspension rate continues to trend twice as high as the *HNC 2030* target (162.3 for academic year 2023-2024 versus target rate of 80).

PRIORITIES OF THE NC SHIP COMMUNITY COUNCIL (2024-2025)

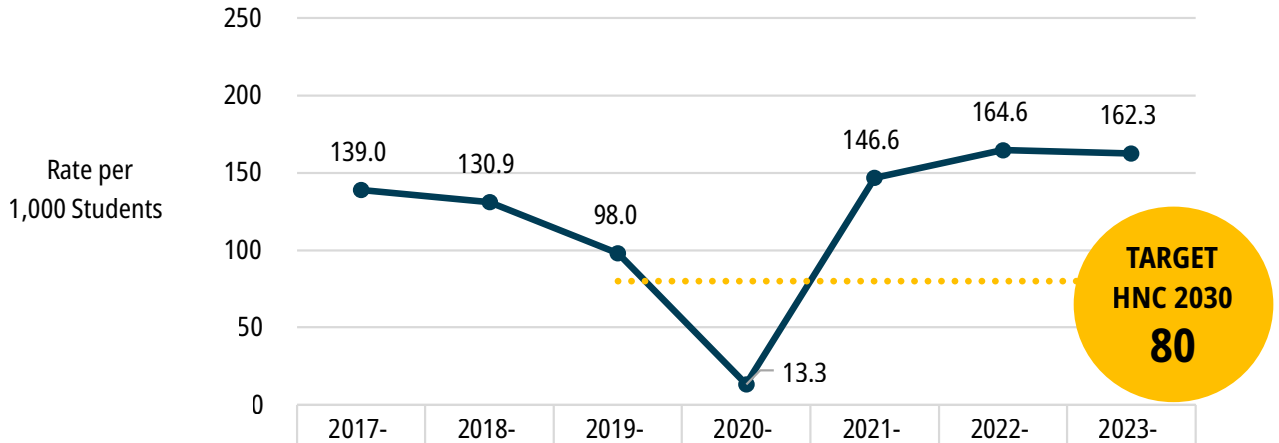
– Short-Term Suspensions Work Group –

- Disrupt the school-to-prison pipeline, beginning with early childhood programs by reducing the use of school suspensions and expulsions and increasing the use of counseling services and community-based programs and initiatives.
- Increase racial, ethnic, gender, and disability status diversity among school and child care leadership and staff and the institutions that train them.

A short-term suspension (STS) is defined as the exclusion of a student from school attendance for disciplinary purposes for up to 10 days [NCGS § 115C-390.1]. Data include suspensions across all grades and may reflect multiple suspensions by one or more students.

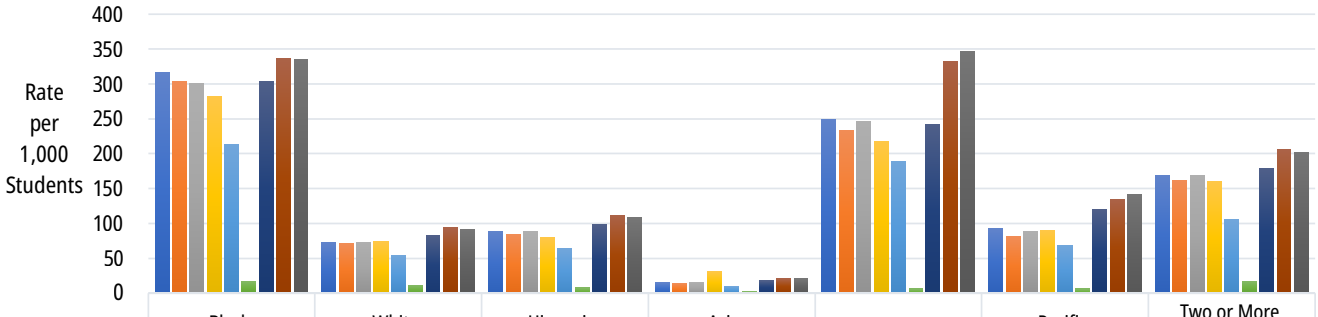
Short-Term Suspensions

Figure 11. Short-Term Suspensions for All Acts Reported in NC Public Schools by Year



	2017-2018	2018-2019	2019-2020	2020-2021	2021-2022	2022-2023	2023-2024
Rate Per 1,000 Students	139.0	130.9	98.0	13.3	146.6	164.6	162.3
Total Short-term Suspensions	211,228	203,298	152,873	19,482	217,928	247,454	244,836
HNC 2030 Target			80	80	80	80	80

Figure 12. Short-Term Suspension Rate in NC Public Schools by Race/Ethnicity and Year



	Black	White	Hispanic	Asian	American Indian	Pacific	Two or More Races
2015-2016	317	72	89	17	249	93	169
2016-2017	303	71	84	16	233	81	162
2017-2018	300	73	88	18	246	88	169
2018-2019	281.6	73.6	79.1	31.2	217.3	89.9	159.7
2019- 2020	214.0	54.1	63.6	11.3	189.2	69.1	105.8
2020-2021	18.7	12.2	7.9	1.6	6.7	6.2	18.8
2021-2022	303.8	82.1	98.4	19.8	242.8	119.5	179.0
2022-2023	335.6	93.1	111.8	23.2	331.5	134.3	205.7
2023-2024	335.0	91.5	107.6	23.0	346.9	141.6	201.6

Data Source: North Carolina State Center for Health Statistics, American Community Survey, 5-year rolling estimates

Short-Term Suspensions

Figure 13. Short-Term Suspension Rate in NC Public Schools by Gender and Year

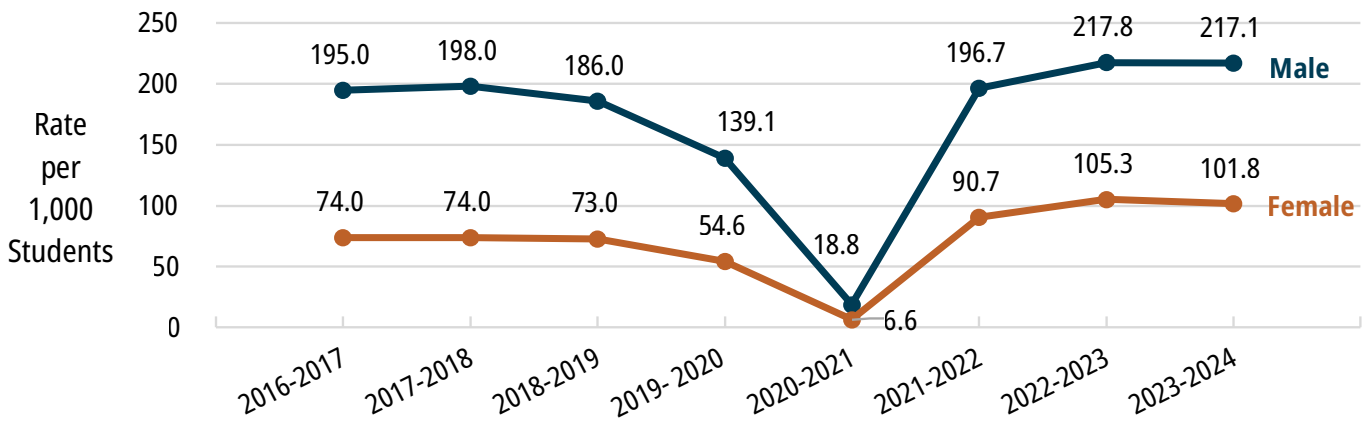
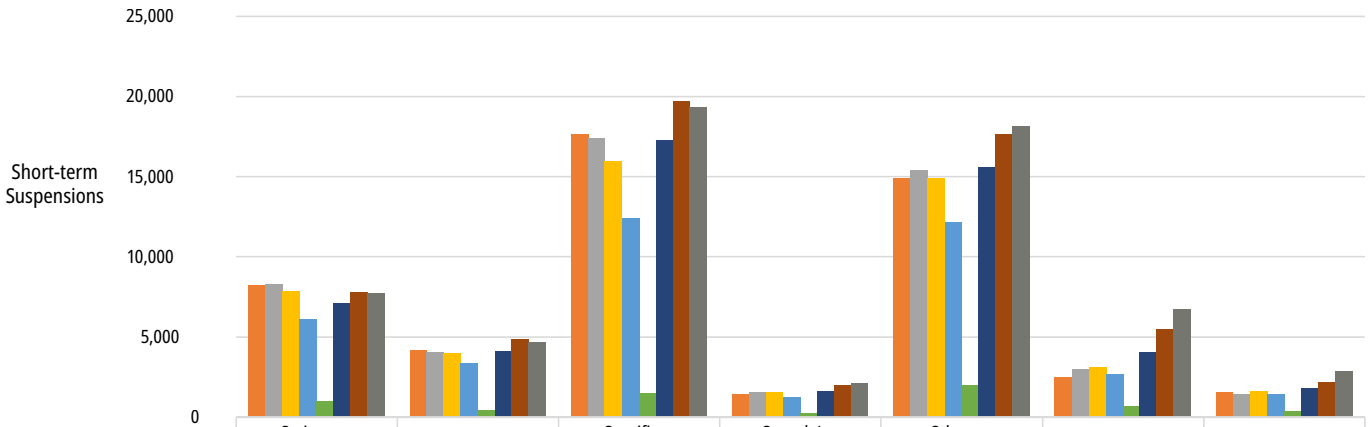


Figure 14. Short-Term Suspensions in NC Public Schools by Exceptional Children (EC) Status and Year



	Serious Emotional Disability	Intellectual Disability	Specific Learning Disability	Speech/ Language Impaired	Other Health Impaired	Autistic	Developmentally Delayed
2016-2017	8,211	4,166	17,612	1,434	14,875	2,469	1,536
2017-2018	8,284	4,057	17,403	1,559	15,396	2,964	1,415
2018-2019	7,816	3,934	15,923	1,561	14,905	3,120	1,620
2019-2020	6,114	3,322	12,401	1,246	12,104	2,692	1,444
2020-2021	1,007	397	1,468	205	1,985	678	352
2021-2022	7,107	4,116	17,242	1,624	15,539	4,024	1,763
2022-2023	7,794	4,862	19,705	1,988	17,600	5,460	2,175
2023-2024	7,707	4,659	19,316	2,082	18,123	6,718	2,836

Data Source: North Carolina State Center for Health Statistics, American Community Survey, 5-year rolling estimates

Incarceration

WHAT RESULT DO WE WANT?

North Carolina embraces a fair and equitable justice system where safety is foundational to all aspects of a free society, and all communities are free from harm and violence.

WHAT DO WE MEASURE?

- Number of people ages 13 and older and entering North Carolina prisons per 100,000 population.
- Values for this measure were calculated based on data from the North Carolina Department of Adult Correction (NCDAC) and U.S. Census Bureau National Vintage Population Estimates, and calculated by the North Carolina State Center for Health Statistics.

HOW ARE WE DOING?

The state's incarceration rate decreased from 233 in 2014 to 192 in 2023, but the overall rate remains higher than the *HNC 2030* target of 150 per 100,000 population ages 13 and older.

PRIORITIES OF THE NC SHIP COMMUNITY COUNCIL (2024-2025)

– Incarceration Work Group –

- Invest in public health alternatives to traditional law enforcement and sentencing, particularly for behavioral health issues.
- Increase access to multi-systemic therapy, including functional family therapy, for juvenile offenders.
- Improve resources and legislation pertaining to jails and prisons to reduce harmful impact of incarceration and foster successful reintegration into the community
- Improve access to treatment for substance use disorders, physical illnesses, and mental illnesses.
- Expand existing or create medications for opioid use disorder treatment programs for people with substance use disorder detained in jails and prisons or transitioning to and from prison.
- Ensure access to behavioral health treatment, adequate medical care, and stable housing for those returning from incarceration.

Incarceration

Figure 15. Incarceration in North Carolina Prisons by Year

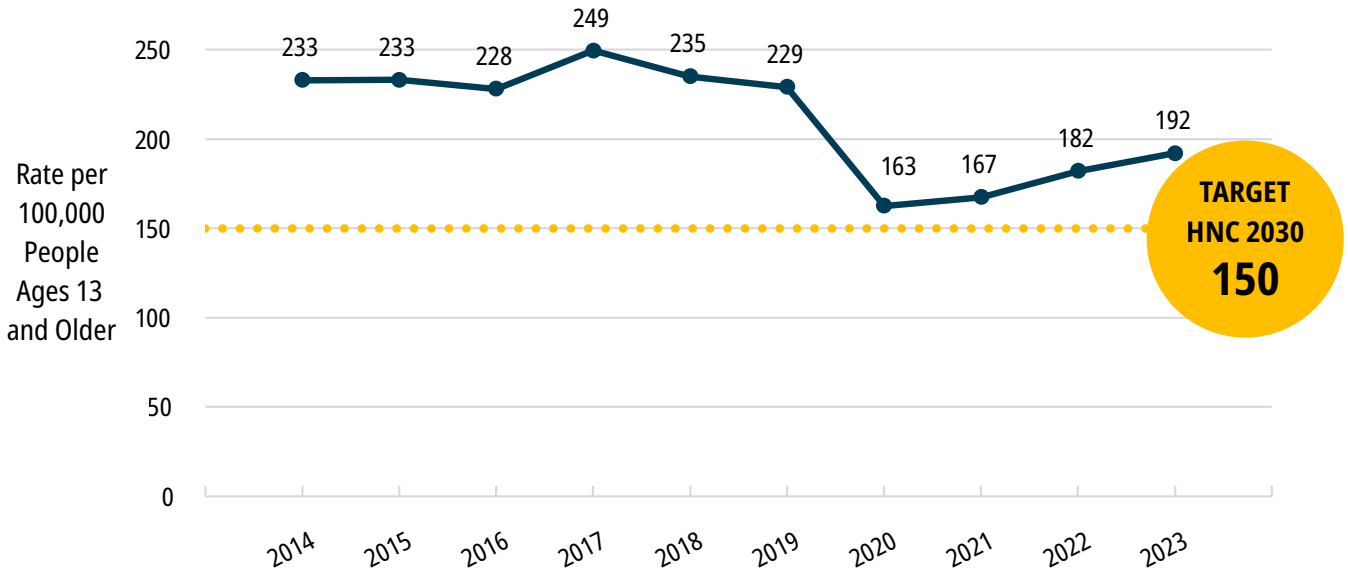
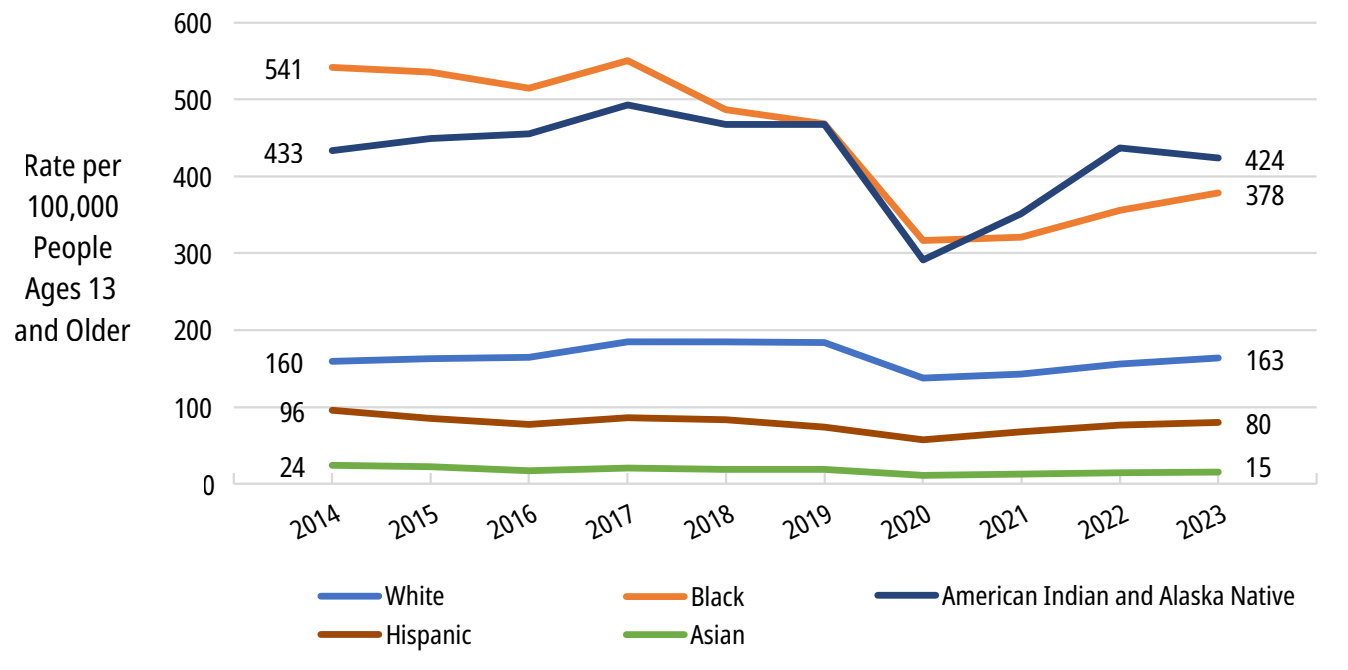


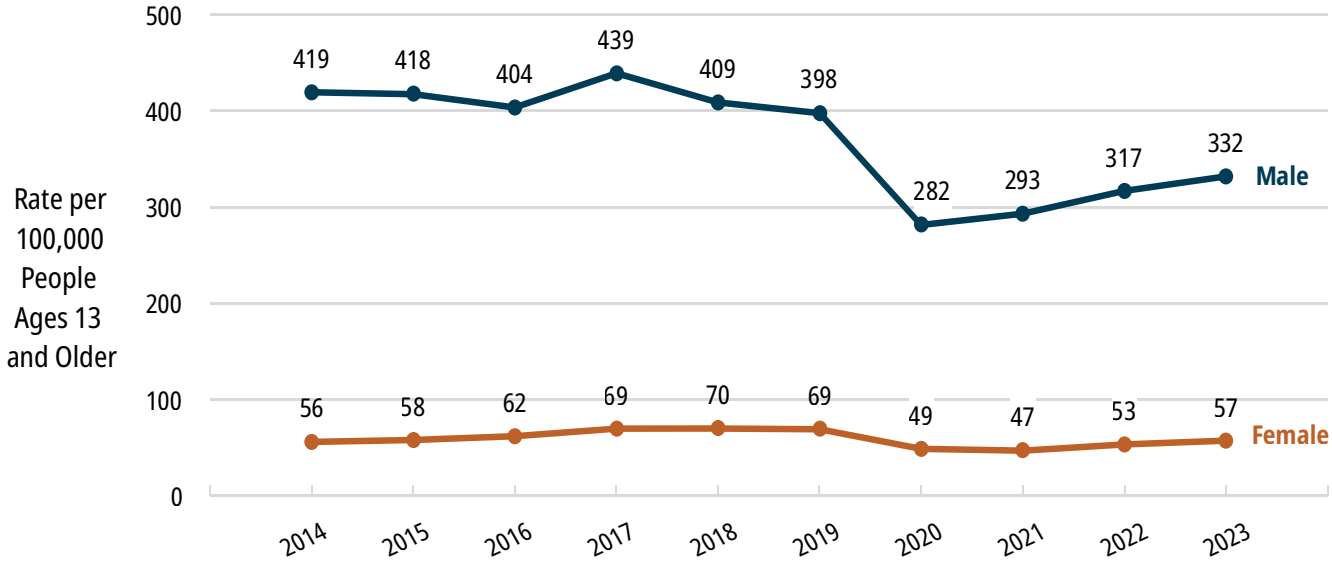
Figure 16. Incarceration in North Carolina Prisons by Race/Ethnicity and Year



Data source: N.C. Department of Public Safety, North Carolina State Center for Health Statistics, Vital Statistics, and National Center for Health Statistics

Incarceration

Figure 17. Incarceration in North Carolina Prisons by Gender and Year



Data Source: North Carolina State Center for Health Statistics, American Community Survey, 5-year rolling estimates

Adverse Childhood Experiences

WHAT RESULT DO WE WANT?

All children in North Carolina thrive in safe, stable, and nurturing environments.

WHAT DO WE MEASURE?

Percent of children with two or more adverse childhood experiences (National Survey of Children's Health, two-year estimate)*

HOW ARE WE DOING?

- Overall, the estimated percentage of North Carolina children experiencing two or more adverse childhood experiences (ACEs) has decreased from 23.6% (2016-2017) to 17.3% (2022-2023).
- Data for race/ethnicity show that the highest percentage of the state's children with adverse childhood experiences is reported for Black/African Americans. This percentage is almost twice as high as the percentage reported for the state's white/Caucasian children.
- The data suggest an association between family household income and the percentage of adverse childhood experiences reported.

PRIORITIES OF THE NC SHIP COMMUNITY COUNCIL (2024-2025)

– Adverse Childhood Experiences Work Group –

- Improve data available on trauma and ACEs at the local level.
- Increase funding for and embed community-rooted, culturally affirming family and community support programs into existing initiatives.

Two-year combined data pulled from interactive site: www.childhealthdata.org/browse

Adverse Childhood Experiences

Figure 18. North Carolina Children with Two or More Adverse Childhood Experiences by Year

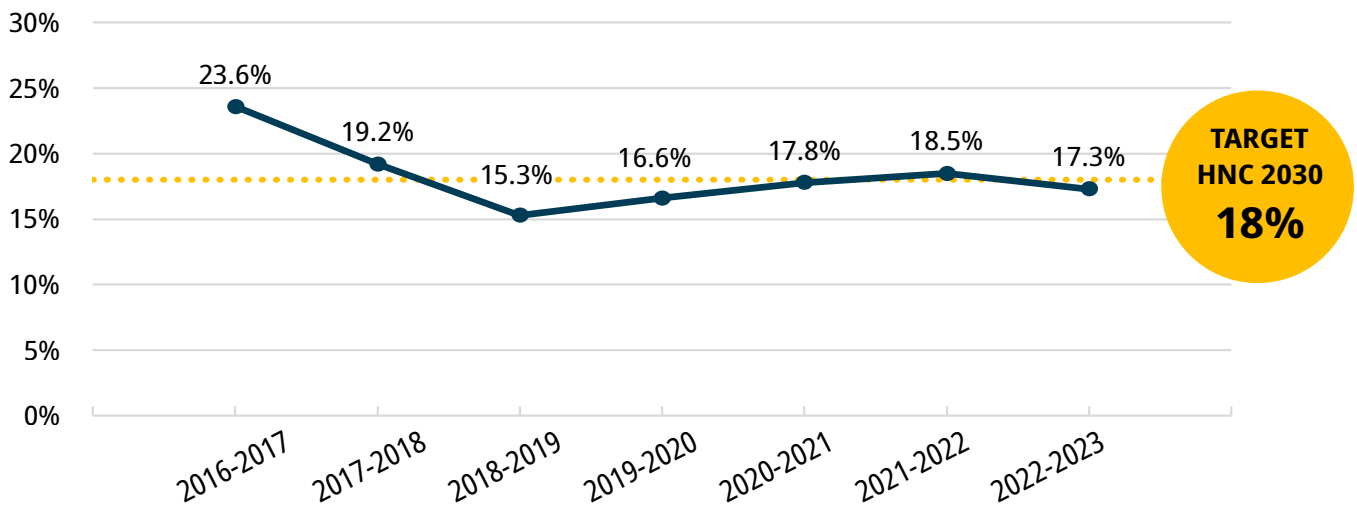
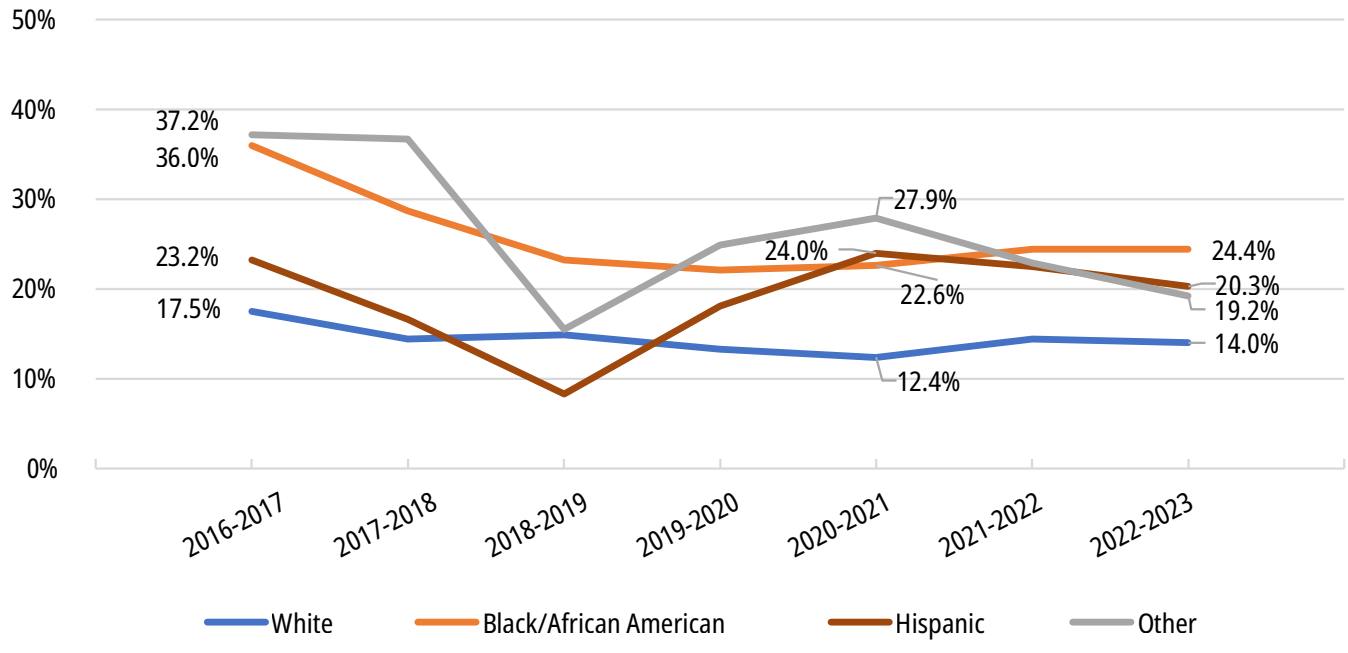


Figure 19. North Carolina Children with Two or More Adverse Childhood Experiences by Race/Ethnicity and Year



Data Source: Child and Adolescent Health Measurement Initiative, NSCH Data Resource Center.

Adverse Childhood Experiences

Figure 20. North Carolina Children with Two or More Adverse Childhood Experiences by Gender and Year

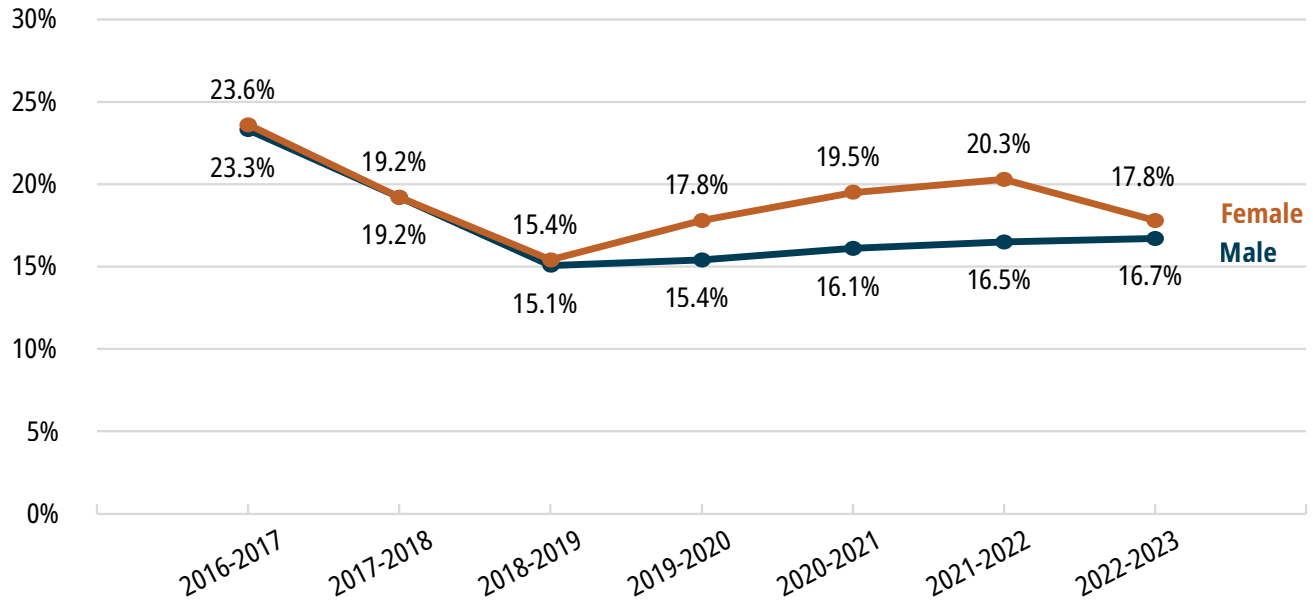
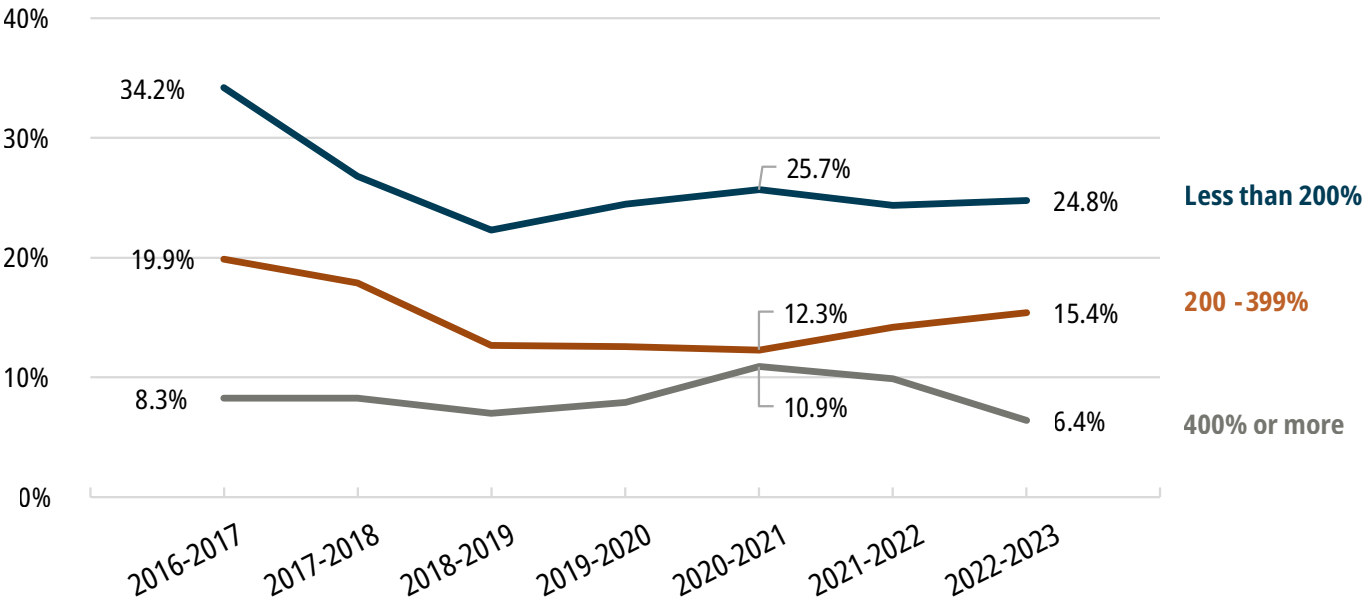


Figure 21. North Carolina Children with Two or More Adverse Childhood Experiences by Poverty Level and Year



Data Source: North Carolina State Center for Health Statistics, American Community Survey, 5-year rolling estimates

Third Grade Reading Proficiency

WHAT RESULT DO WE WANT?

All children in North Carolina discover the joy of reading at an early age and are supported in the home, school, and community to be lifelong readers.

WHAT DO WE MEASURE?

Percent of children in North Carolina who are proficient in reading at the end of third grade (North Carolina Department of Public Instruction)

HOW ARE WE DOING?

- The graph includes data for academic years, 2016–2017 through 2023–2024. (Note that no data are available for academic year 2019–2020 due to the COVID-19 pandemic.)
- The state's third grade reading proficiency percentages declined almost 10% between the 2016–2017 and the 2023–2024 academic years (falling from 57.8% to 48.5%).
- The greatest decline corresponds with the COVID-19 pandemic, when proficiency dropped almost 12 percentage points (from 56.8% in the 2018–2019 academic year to 45.1% in the 2020–2021 academic year).
- Since 2021, the state's third grade reading proficiency percentages have risen annually, reaching 48.5% for the 2023–2024 academic year.

PRIORITIES OF THE NC SHIP COMMUNITY COUNCIL (2024-2025)

– Third Grade Reading Proficiency Work Group –

Expand awareness of training and professional development resources related to early literacy.

Additional Information

North Carolina Department of Public Instruction

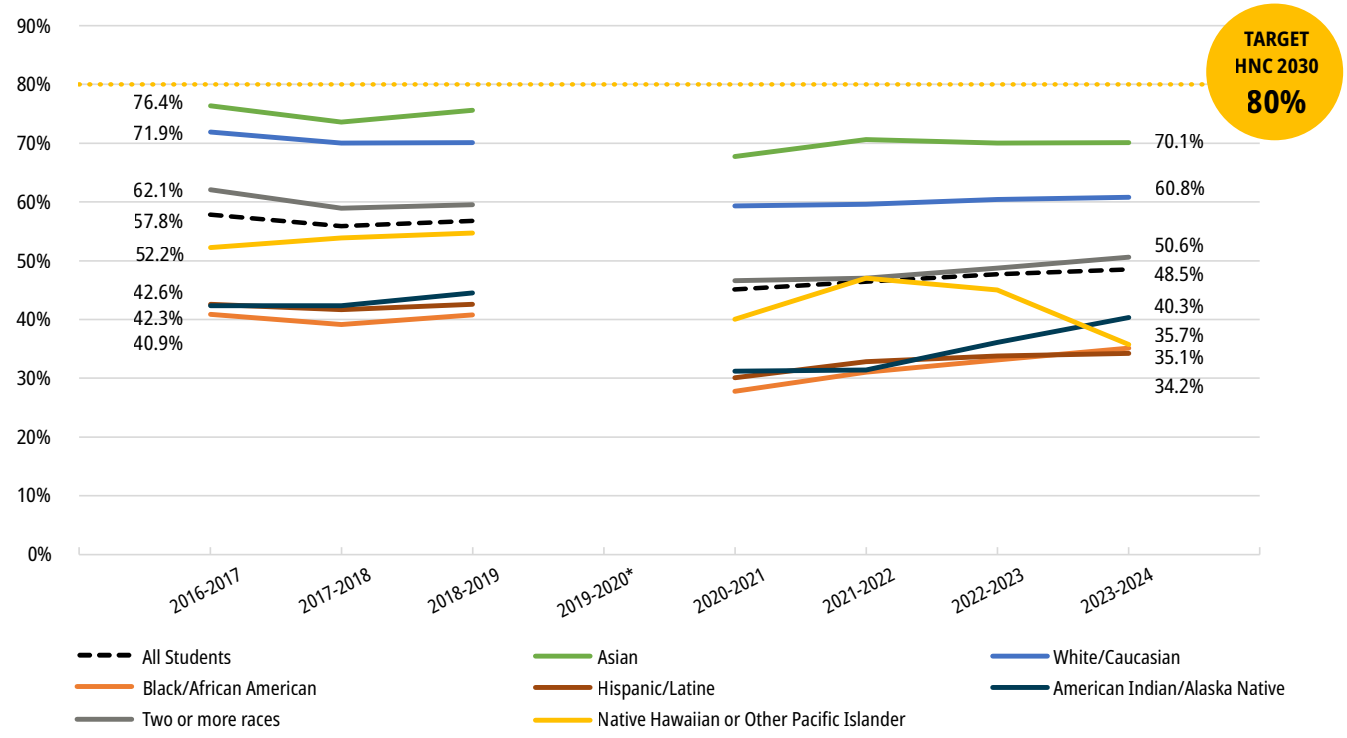
The Department leads statewide literacy policy and implementation efforts, including professional development for educators and alignment with the Science of Reading framework. DPI provides curriculum guidance, literacy coaching models, and educator training aligned with legislative requirements.

North Carolina State Board of Education

The State Board sets literacy standards and oversees implementation of statewide reading initiatives, including accountability measures for school districts.

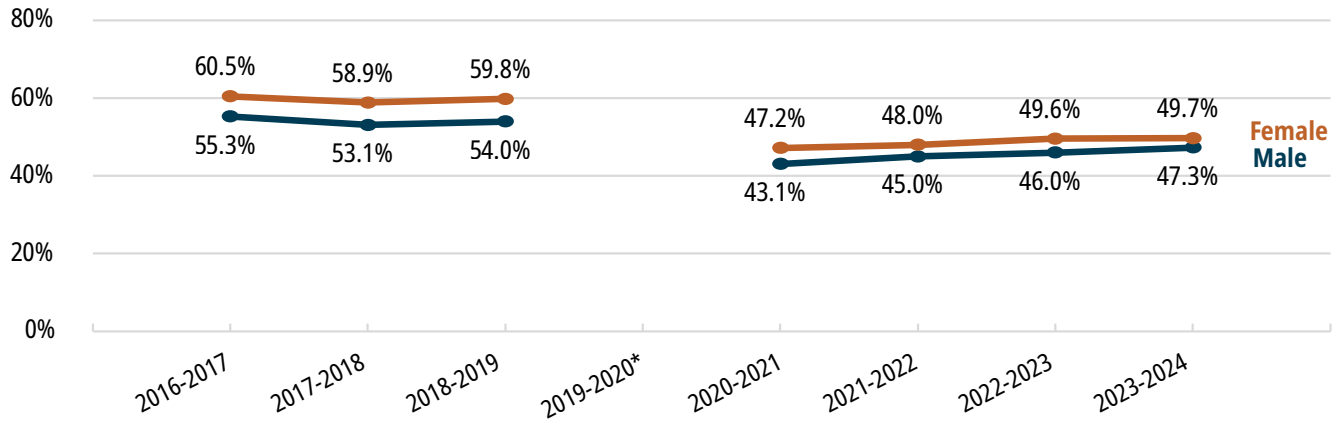
Third Grade Reading Proficiency

Figure 22. North Carolina Children Who Are Proficient in Reading at the End of Third Grade by Race/Ethnicity and Academic Year



** There are no data for 2019-2020 due to COVID-19.*

Figure 23. North Carolina Children Who Are Proficient in Reading at the End of Third Grade by Gender and Academic Year

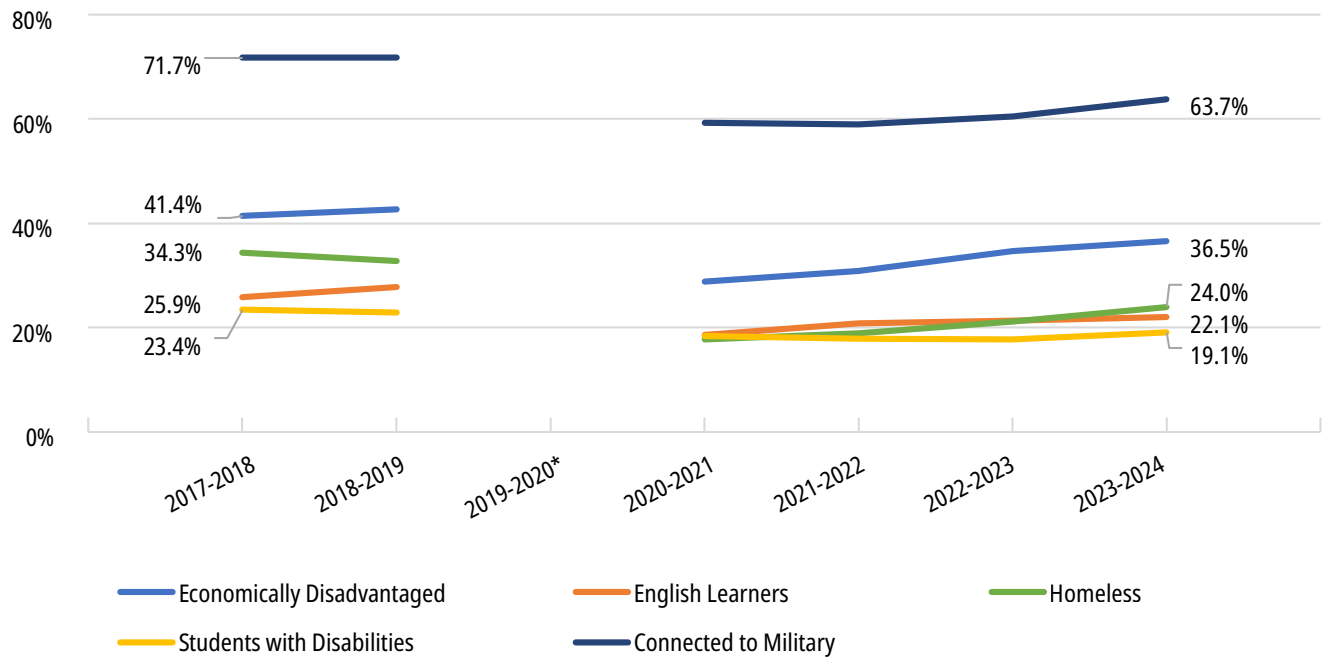


** There are no data for 2019-2020 due to COVID-19.*

Data Source: North Carolina Department of Public Instruction, State testing results: Green book.

Third Grade Reading Proficiency

Figure 24. North Carolina Children Who Are Proficient in Reading at the End of Third Grade by Subgroup and Academic Year



** There are no data for 2019-2020 due to COVID-19.*

Data Source: North Carolina Department of Public Instruction, State testing results: Green book.

Access to Exercise Opportunities

WHAT RESULT DO WE WANT?

All people in North Carolina have equitable and adaptive/adaptable access to physical activity opportunities across the lifespan.

WHAT DO WE MEASURE?

Percent of people in North Carolina with access to exercise opportunities (County Health Rankings & Roadmaps

**The measure is not inclusive of all exercise opportunities within a community. For instance, sidewalks, which serve as locations for running or walking; malls, which may have walking clubs; and schools, which may have gyms open to community members, are not able to be captured in this measure.*

HOW ARE WE DOING?

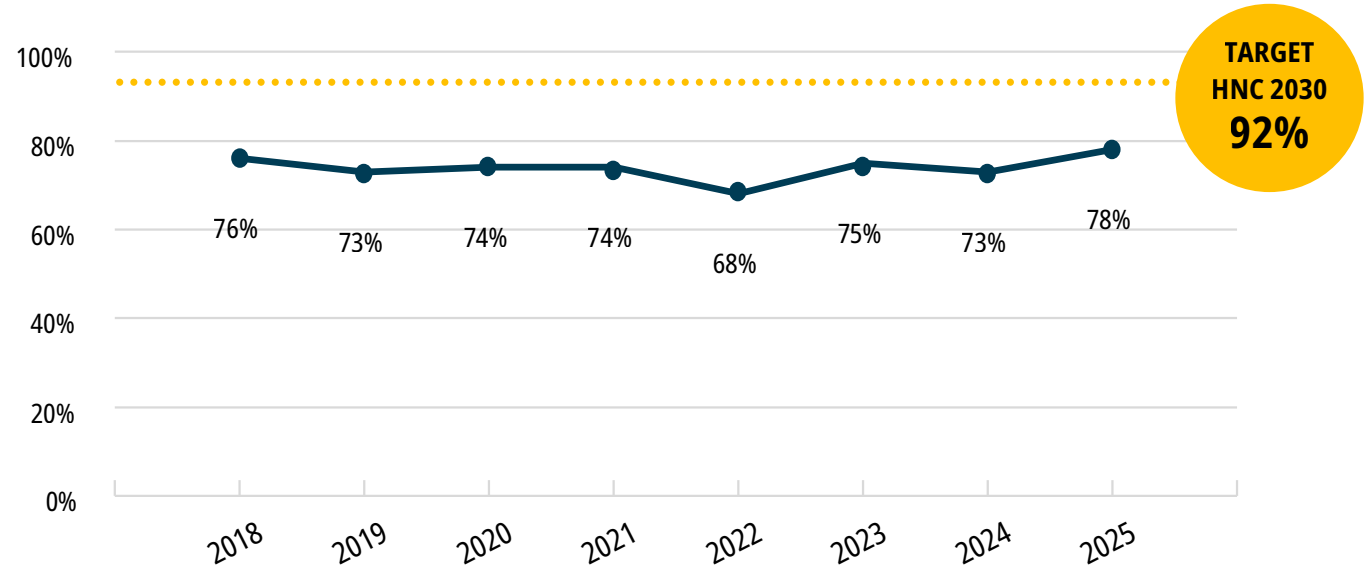
- The HNC 2030 target seeks to increase North Carolinians' access to exercise opportunities (currently at 78%) to 92% by 2030.
- Access to exercise opportunities in North Carolina has remained in the 70th percentile for the past eight years, with the exception of a significant drop to 68% in 2021 (recorded in 2022 data). This post pandemic dip may reflect the closure of many public structures and decreased social interactions arising from the COVID-19 pandemic.

PRIORITIES OF THE NC SHIP COMMUNITY COUNCIL (2024-2025)

– Access to Exercise Opportunities Work Group –

Planning healthier communities with access to key destinations (e.g. schools, medical facilities, food sources, parks, retail, work).

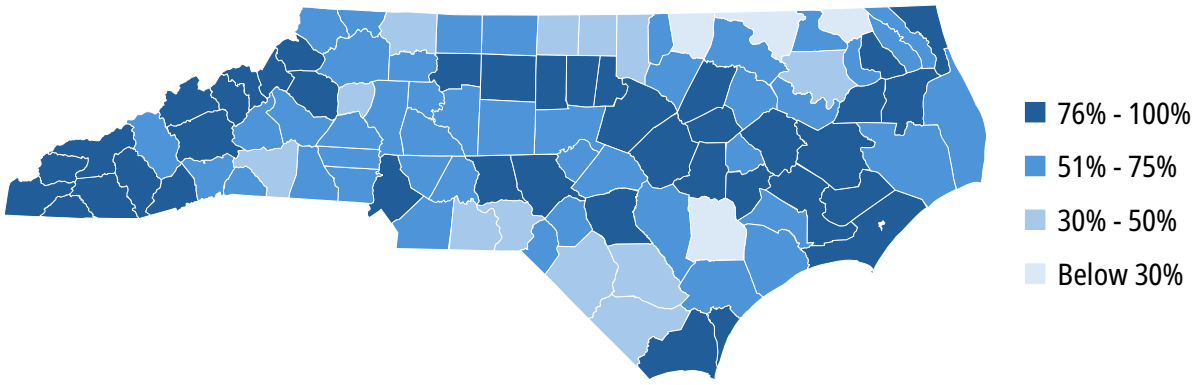
Figure 25. North Carolina Population with Access to Exercise Opportunities by Year



Data Source: County Health Rankings and Roadmaps

Access to Exercise Opportunities

Figure 26. North Carolina Population with Access to Exercise Opportunities by County, 2025



North Carolina	**78%**
Alamance	81%
Alexander	47%
Alleghany	65%
Anson	36%
Ashe	56%
Avery	100%
Beaufort	86%
Bertie	50%
Bladen	47%
Brunswick	77%
Buncombe	76%
Burke	59%
Cabarrus	62%
Caldwell	80%
Camden	62%
Carteret	85%
Caswell	44%
Catawba	61%
Chatham	73%
Cherokee	98%
Chowan	56%
Clay	100%
Cleveland	64%
Columbus	38%
Craven	88%
Cumberland	87%
Currituck	87%
Dare	66%
Davidson	64%
Davie	67%
Duplin	27%
Durham	91%
Edgecombe	67%
Forsyth	81%
Franklin	64%
Gaston	74%
Gates	27%
Graham	100%
Granville	48%
Greene	75%
Guilford	90%
Halifax	52%
Harnett	70%
Haywood	72%
Henderson	72%
Hertford	55%
Hoke	61%
Hyde	54%
Iredell	67%
Jackson	98%
Johnston	97%
Jones	65%
Lee	64%
Lenoir	78%
Lincoln	68%
Macon	100%
Madison	88%
Martin	69%
McDowell	62%
Mecklenburg	89%
Mitchell	100%
Montgomery	89%
Moore	80%
Nash	79%
New Hanover	95%
Northampton	22%
Onslow	56%
Orange	83%
Pamlico	76%
Pasquotank	56%
Pender	62%
Perquimans	86%
Person	45%
Pitt	90%
Polk	61%
Randolph	56%
Richmond	33%
Robeson	40%
Rockingham	71%
Rowan	66%
Rutherford	34%
Sampson	60%
Scotland	64%
Stanly	68%
Stokes	66%
Surry	48%
Swain	97%
Transylvania	84%
Tyrrell	92%
Union	71%
Vance	66%
Wake	99%
Warren	29%
Washington	92%
Watauga	87%
Wayne	86%
Wilkes	67%
Wilson	93%
Yadkin	52%
Yancey	100%

Data Source: County Health Rankings and Roadmaps

Limited Access to Healthy Foods

WHAT RESULT DO WE WANT?

All people in North Carolina have equitable access to affordable, nutritious, culturally appropriate foods.

WHAT DO WE MEASURE?

- Percent of people in North Carolina with limited access to healthy foods (County Health Rankings and Roadmaps www.countyhealthrankings.org/app/north-carolina/2021/measure/factors/133/data)*
- Percent of people in North Carolina without access to a reliable source of food (County Health Rankings www.countyhealthrankings.org)**

HOW ARE WE DOING?

- The HNC 2030 target seeks to decrease the percentage of the state's population who have limited access to healthy foods (currently at 8%) to 5% by 2030.
- The Food Insecurity measure provides an alternative measure for tracking progress on access to healthy foods.
- Both measures have limitations due to changes in definitions and frequency of data updates and reporting.

PRIORITIES OF THE NC SHIP COMMUNITY COUNCIL (2024-2025)

– Limited Access to Healthy Food Work Group –

- Enhance how children and families access programs supporting their well-being, including SNAP, WIC, CACFP, school and summer nutrition programs, Medicaid, Healthy Opportunities Pilots (HOP), and NCCARE360 through better data and analysis, infrastructure, and integration.
- Provide financial incentives such as "Double Up Food Bucks" and Produce Prescriptions for SNAP/ FNS recipients for purchasing fresh fruit and vegetables from grocery stores and farmers markets AND Support farmers markets and enable Electronic Benefit Transfer payment at farmers markets.
- Collaborate with community partners to provide nutritious and culturally responsive options at food banks, pantries and soup kitchens.

**HNC 2030 originally selected Limited Access to Healthy Foods as its measure. County Health Rankings & Roadmaps discontinued this measure in 2020, rendering it inappropriate for measuring progress.*

***The Food Insecurity measure was added to the HNC 2030 indicators in 2021 because the data are updated annually. Note that there is a 3-year interval between data collection and reporting.*

Limited Access to Healthy Foods

Figure 27. North Carolina Population with Limited Access to Healthy Foods by Year

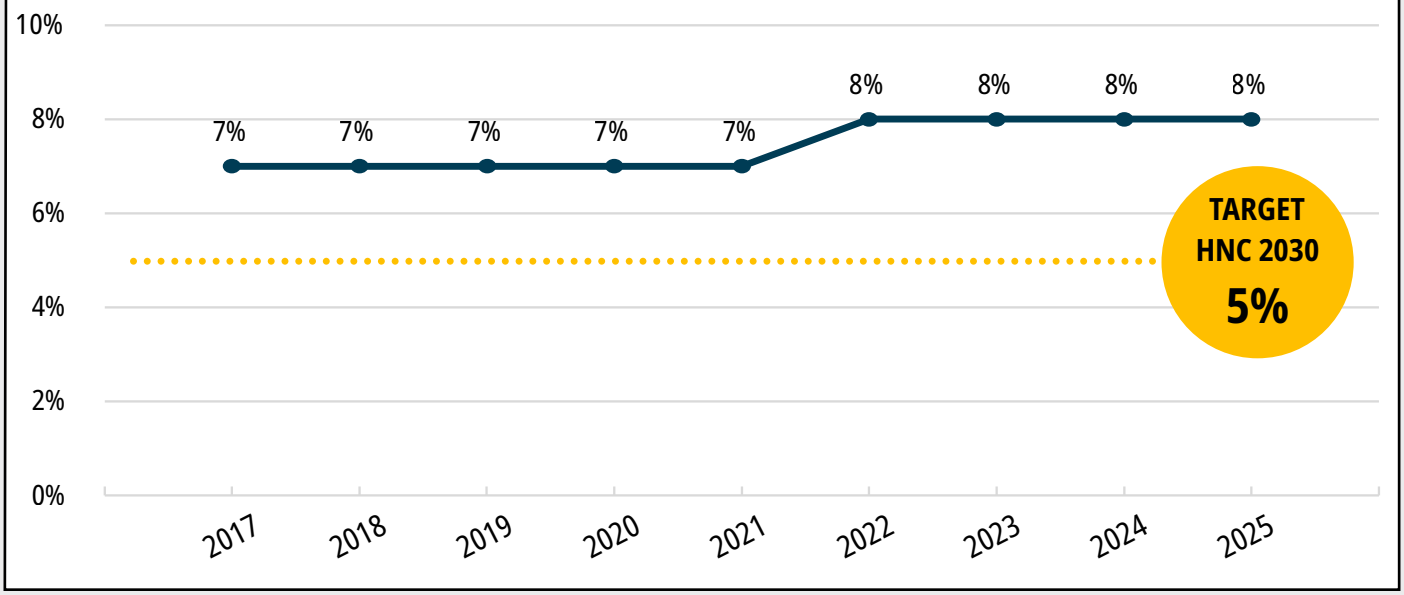
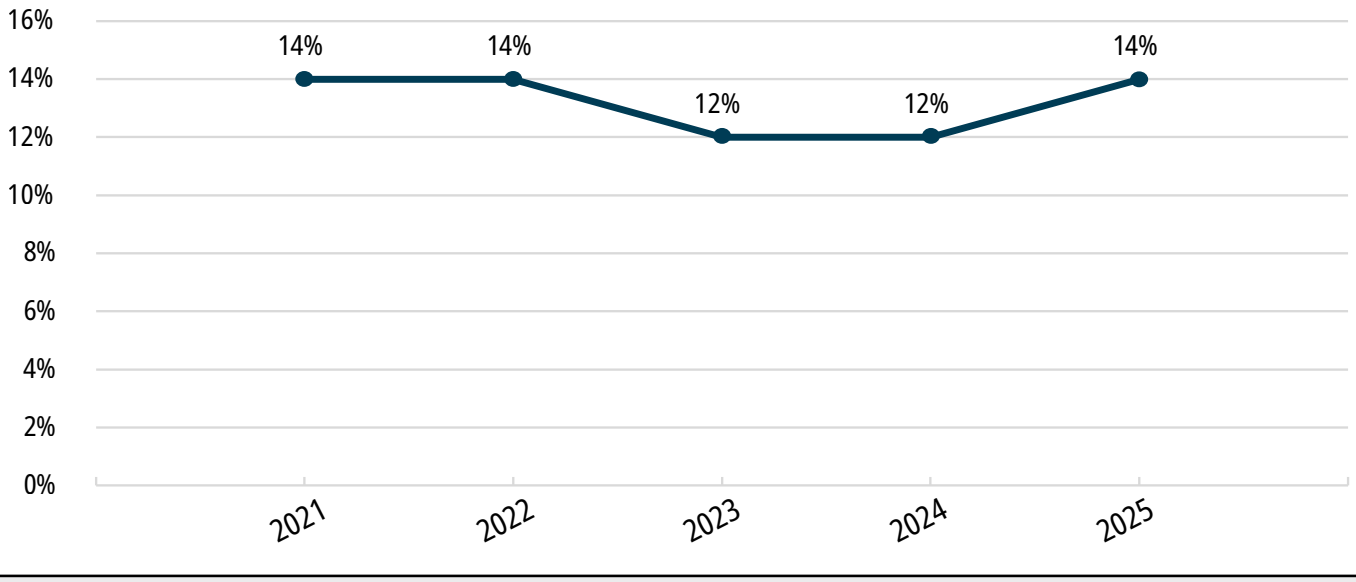


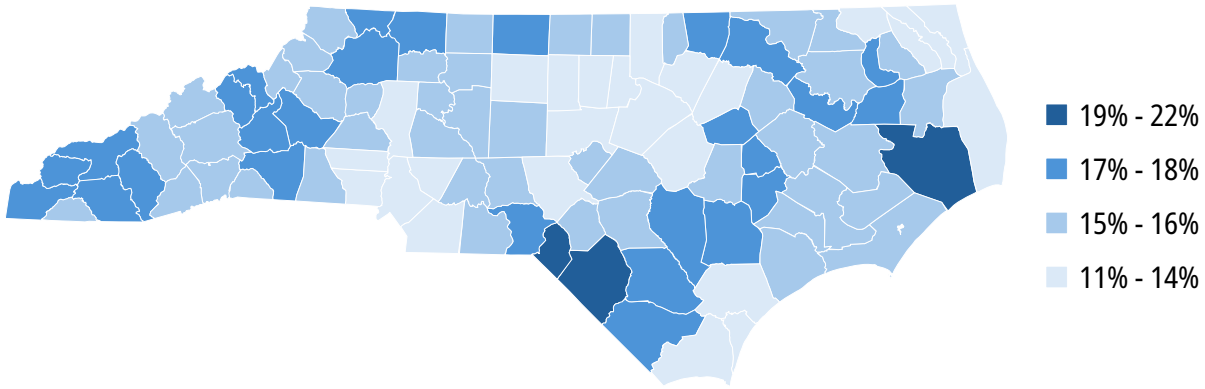
Figure 28. North Carolina Population without Access to a Reliable Source of Food by Year



Data Source: County Health Rankings and Roadmaps

Limited Access to Healthy Foods

Figure 29. North Carolina Population with Food Insecurity by County, 2025



North Carolina	**14%**
Alamance	14%
Alexander	15%
Alleghany	18%
Anson	16%
Ashe	16%
Avery	15%
Beaufort	16%
Bertie	16%
Bladen	18%
Brunswick	14%
Buncombe	15%
Burke	17%
Cabarrus	12%
Caldwell	16%
Camden	12%
Carteret	15%
Caswell	15%
Catawba	15%
Chatham	13%
Cherokee	17%
Chowan	17%
Clay	16%
Cleveland	16%
Columbus	17%
Craven	15%
Cumberland	16%
Currituck	12%
Dare	12%
Davidson	15%
Davie	15%
Duplin	17%
Durham	12%
Edgecombe	16%
Forsyth	15%
Franklin	13%
Gaston	14%
Gates	14%
Graham	17%
Granville	13%
Greene	17%
Guilford	14%
Halifax	18%
Harnett	15%
Haywood	15%
Henderson	15%
Hertford	16%
Hoke	16%
Hyde	22%
Iredell	13%
Jackson	17%
Johnston	13%
Jones	16%
Lee	16%
Lenoir	18%
Lincoln	14%
Macon	17%
Madison	16%
Martin	17%
McDowell	17%
Mecklenburg	12%
Mitchell	17%
Montgomery	16%
Moore	13%
Nash	14%
New Hanover	14%
Northampton	15%
Onslow	16%
Orange	12%
Pamlico	15%
Pasquotank	13%
Pender	14%
Perquimans	16%
Person	16%
Pitt	16%
Polk	15%
Randolph	16%
Richmond	18%
Robeson	20%
Rockingham	17%
Rowan	16%
Rutherford	18%
Sampson	17%
Scotland	19%
Stanly	15%
Stokes	16%
Surry	18%
Swain	18%
Transylvania	15%
Tyrrell	16%
Union	11%
Vance	16%
Wake	11%
Warren	17%
Washington	18%
Watauga	15%
Wayne	16%
Wilkes	18%
Wilson	17%
Yadkin	16%
Yancey	17%

Data Source: County Health Rankings and Roadmaps

Severe Housing Problems

WHAT RESULT DO WE WANT?

All people in North Carolina have safe, affordable, quality housing opportunities.

WHAT DO WE MEASURE?

- Percent of households in North Carolina with at least one of four problems — Housing Cost Burden, Overcrowding, Inadequate Kitchen Facilities, or Lack of Plumbing.* (US Department of Housing & Urban Development; County Health Rankings)
- Percent of households in North Carolina that spend 50% or more of their household income on housing.** (American Community Survey: 5-Year Rolling Estimates)

HOW ARE WE DOING?

Composite measure: Based on data from 2017–2021, 14% of North Carolina households experienced at least one of the following housing problems: High Cost Housing Costs, Overcrowding, Lack of Kitchen Facilities, or Lack of Plumbing. The percentage of Severe Housing Problems ranged from 7% to 23% of households across counties in the state. The 2025 Annual Data Release used data from 2017–2021 for this measure.

PRIORITIES OF THE NC SHIP COMMUNITY COUNCIL (2024-2025)

– Severe Housing Problems Work Group –

Tenant Support: Increase measures and funding to provide tenants with access to mediation, legal representation, and legal education to secure and protect housing.

Assistance Programs: Simplify and expand the Weatherization Assistance Program, Low-Income Energy Assistance Programs, and other healthy homes and utility assistance programs by affirmatively engaging low-income communities through targeted outreach to help families meet their energy needs.

Housing cost burden only measure: Over the past few years, housing costs have increased faster than many household incomes which has increased pressure on individual families to meet basic needs (including health insurance, health care, healthy foods, utilities and transportation). These are five-year rolling estimates. Therefore, only compare non-overlapping years.

**This is the original HNC 2030 measure and includes factors other than housing cost burden.*

*** A second measure was added in 2021 due to the increase in housing cost burden observed in the pandemic.*

Severe Housing Problems

Figure 30. North Carolina Households with at Least One of Four Problems by Year: Housing Cost Burden, Overcrowding, Inadequate Kitchen Facilities, or Lack of Plumbing

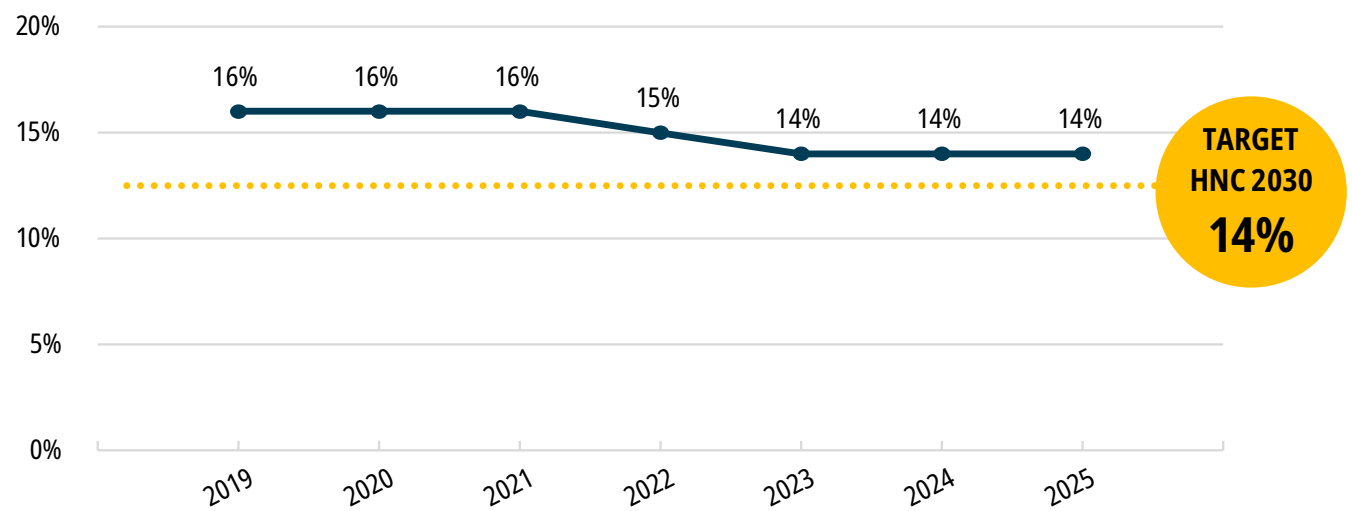
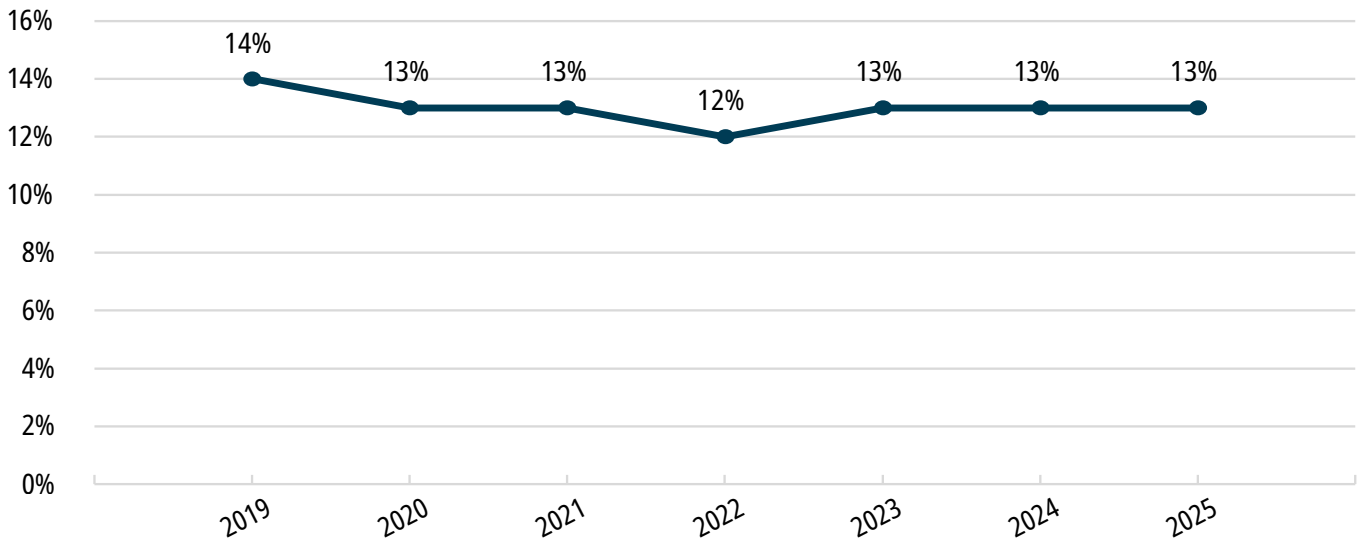


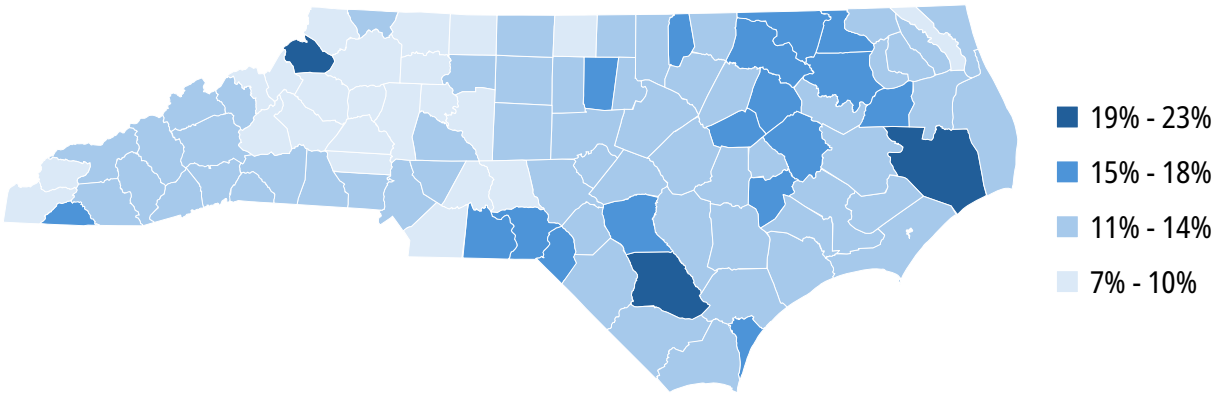
Figure 31. North Carolina Households That Spend 50% or More of Their Household Income on Housing by Year



Data Source: County Health Rankings and Roadmaps

Severe Housing Problems

Figure 32. North Carolina Population with Severe Housing Cost Burden by County, 2025



North Carolina	**13%**
Alamance	11%
Alexander	7%
Alleghany	11%
Anson	17%
Ashe	9%
Avery	8%
Beaufort	11%
Bertie	17%
Bladen	19%
Brunswick	13%
Buncombe	12%
Burke	10%
Cabarrus	11%
Caldwell	7%
Camden	10%
Carteret	12%
Caswell	10%
Catawba	8%
Chatham	11%
Cherokee	9%
Chowan	14%
Clay	16%
Cleveland	11%
Columbus	14%
Craven	12%
Cumberland	17%
Currituck	11%
Dare	14%
Davidson	10%
Davie	10%
Duplin	11%
Durham	13%
Edgecombe	16%
Forsyth	13%
Franklin	11%
Gaston	14%
Gates	12%
Graham	7%
Granville	13%
Greene	14%
Guilford	14%
Halifax	16%
Harnett	13%
Haywood	11%
Henderson	12%
Hertford	15%
Hoke	14%
Hyde	22%
Iredell	10%
Jackson	13%
Johnston	11%
Jones	11%
Lee	13%
Lenoir	15%
Lincoln	10%
Macon	11%
Madison	11%
Martin	12%
McDowell	7%
Mecklenburg	14%
Mitchell	8%
Montgomery	9%
Moore	11%
Nash	11%
New Hanover	17%
Northampton	15%
Onslow	14%
Orange	16%
Pamlico	12%
Pasquotank	13%
Pender	12%
Perquimans	13%
Person	14%
Pitt	16%
Polk	11%
Randolph	11%
Richmond	18%
Robeson	14%
Rockingham	11%
Rowan	13%
Rutherford	11%
Sampson	12%
Scotland	17%
Stanly	10%
Stokes	9%
Surry	10%
Swain	13%
Transylvania	12%
Tyrrell	11%
Union	9%
Vance	15%
Wake	12%
Warren	13%
Washington	16%
Watauga	23%
Wayne	12%
Wilkes	9%
Wilson	15%
Yadkin	8%
Yancey	12%

Data Source: County Health Rankings and Roadmaps

Drug Overdose Deaths

WHAT RESULT DO WE WANT?

North Carolina is a recovery-focused community with affordable and equitable access to substance use disorder services.

WHAT DO WE MEASURE?

Drug overdose deaths in North Carolina per 100,000 population, age-adjusted rates (North Carolina State Center for Health Statistics)

HOW ARE WE DOING?

- Beginning in 2020, North Carolina has experienced a sharp increase in drug overdose deaths, largely due to the opioid epidemic, and a preponderance of those deaths from illegally manufactured fentanyl. The trend flattened from 2022 to 2023; however, at 42.1, the state's overall overdose death rate remains well above the target rate of 18.0.
- The state's drug overdose death rate has more than tripled over the last nine years.
- North Carolina's age-adjusted female drug overdose death rate continues to trend below age-adjusted overdose death rates for the state's male population. Both male and female populations have experienced a significant rise in these death rates since 2014. The rise in male age-adjusted overdose death rates has been at a steeper climb since 2019, broadening the gap between male and female age-adjusted overdose death rates to over thirty points.
- Caution should be used in interpreting rates for American Indian/Alaska Native, Asian/Pacific Islander, and Hispanic populations due to small number effect.

PRIORITIES OF THE NC SHIP COMMUNITY COUNCIL (2024-2025)

_ NC Opioid and Prescription Drug Abuse _ Advisory Committee (OPDAAC)

The following priority areas are from North Carolina's Opioid and Substance Use Action Plan (OSUAP). For additional information refer to the current OSUAP and data dashboard at www.ncdhhs.gov/about/department-initiatives/overdose-epidemic/north-carolinas-opioid-and-substance-use-action-plan/.

- **Focus on Lived Experiences** by acknowledging systems that have disproportionately harmed historically marginalized people (HMP), implementing programs that reorient those systems, and increasing access to comprehensive, culturally competent, and linguistically appropriate drug user health services for HMPs
- **Prevent** future addiction and address trauma by supporting children and families
- **Reduce Harm** by moving beyond just opioids to address polysubstance use
- **Connect to Care** by increasing treatment access for justice-involved people and expanding access to housing and employment supports to recover from the pandemic together

Drug Overdose Deaths

Figure 33. North Carolina Drug Overdose Death Rate by Year

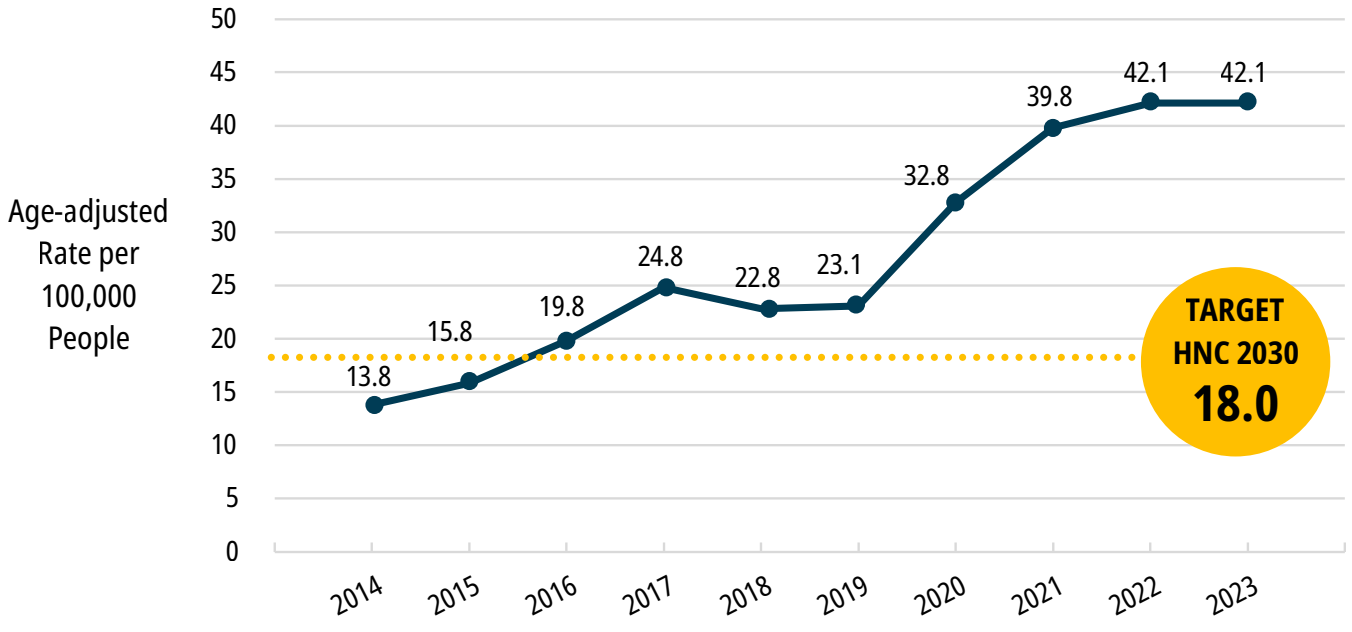
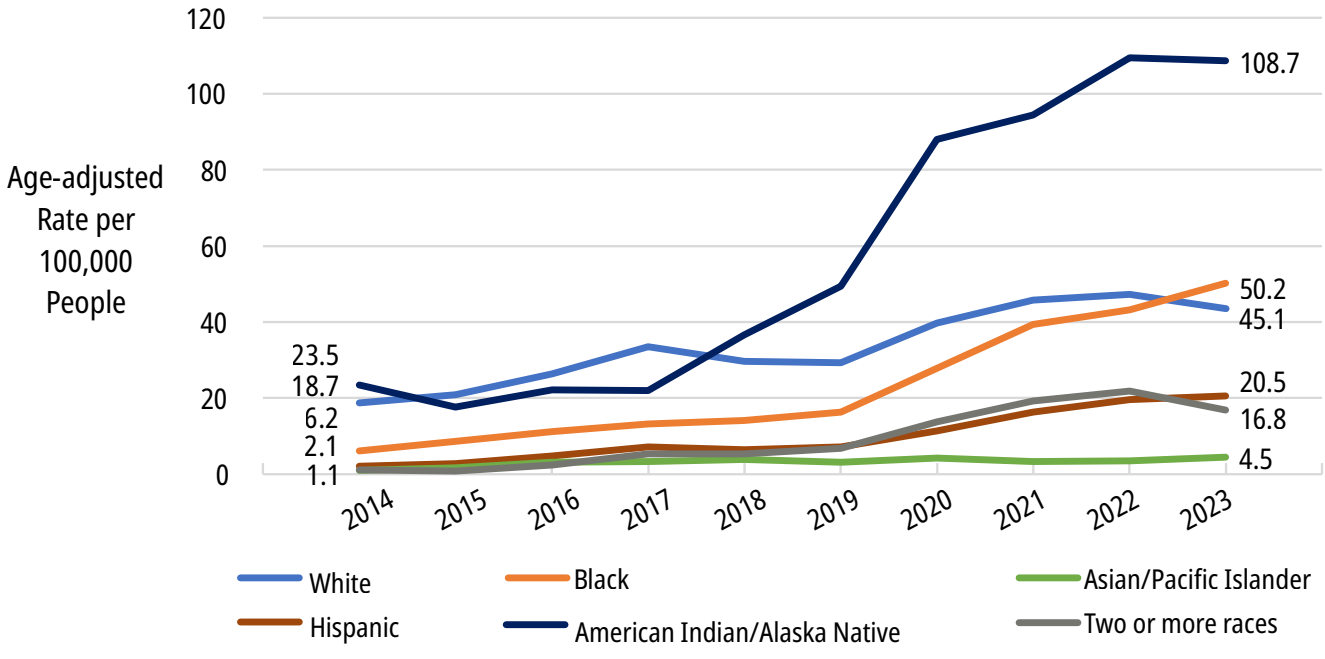


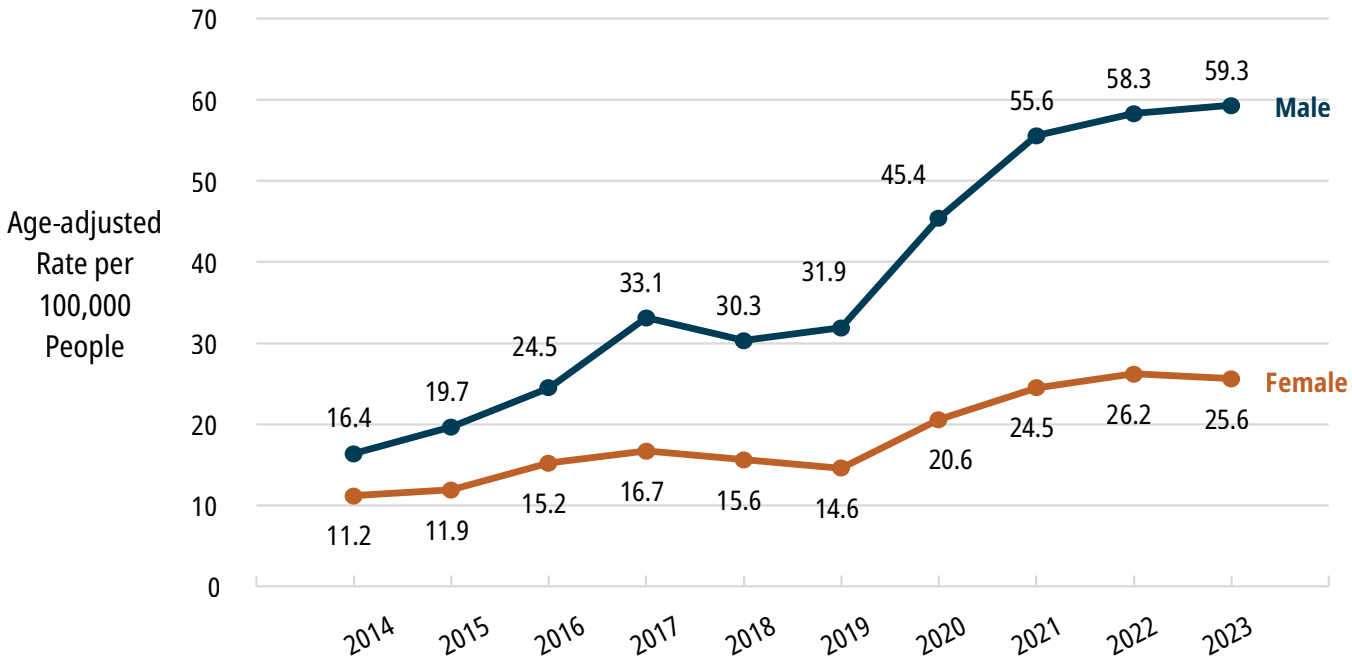
Figure 34. North Carolina Drug Overdose Death Rate by Race/Ethnicity and Year



Data Source: North Carolina State Center for Health Statistics

Drug Overdose Deaths

Figure 35. North Carolina Drug Overdose Death Rate by Gender and Year



Data Source: North Carolina State Center for Health Statistics

Tobacco Use

WHAT RESULT DO WE WANT?

All people in North Carolina live in communities that support tobacco-free/e-cigarette-free lifestyles.

WHAT DO WE MEASURE?

Percent of youth and adults reporting current use of e-cigarettes, cigarettes, cigars, smokeless tobacco, pipes, and/or hookah

Adults: North Carolina State Center for Health Statistics, Behavioral Risk Factor Surveillance System (BRFSS)

Youth: The North Carolina Youth Tobacco Survey (NC YTS)

HOW ARE WE DOING?

Adults: The percentage of North Carolina adults using tobacco has decreased over the past six years, from 23.8% in 2018 to 19.0% in 2024, but remains well over the target rate of 15.0%.

Youth:

- NC YTS is conducted every two years, however the survey's methodology and response rate changed in 2022.
- In 2022, NC YTS was collected electronically for the first time in classrooms. Due to changes in survey methodology and lower response rates, data from 2022 onward may not be comparable to data from 2019 and previous years.

PRIORITIES OF THE NC SHIP COMMUNITY COUNCIL (2024-2025)

– SHIP Tobacco Committee –

- Raise the state minimum sales age of tobacco products from 18 to 21 and establish a tobacco retailer permitting system to protect NC young people.
- Ensure that all Medicaid and Uninsured populations have barrier-free access to evidence-based, standard of care tobacco treatment which includes coaching/ counseling and FDA approved medications.
- Implement state and local tobacco-free and smoke-free air policies; continue to monitor and track progress and promote quality, effective implementation.
- Promote increased and recurring appropriations for robust and evidence-based tobacco prevention and cessation programs and services.

Tobacco Use

Figure 36. North Carolina Adult Tobacco Use by Year

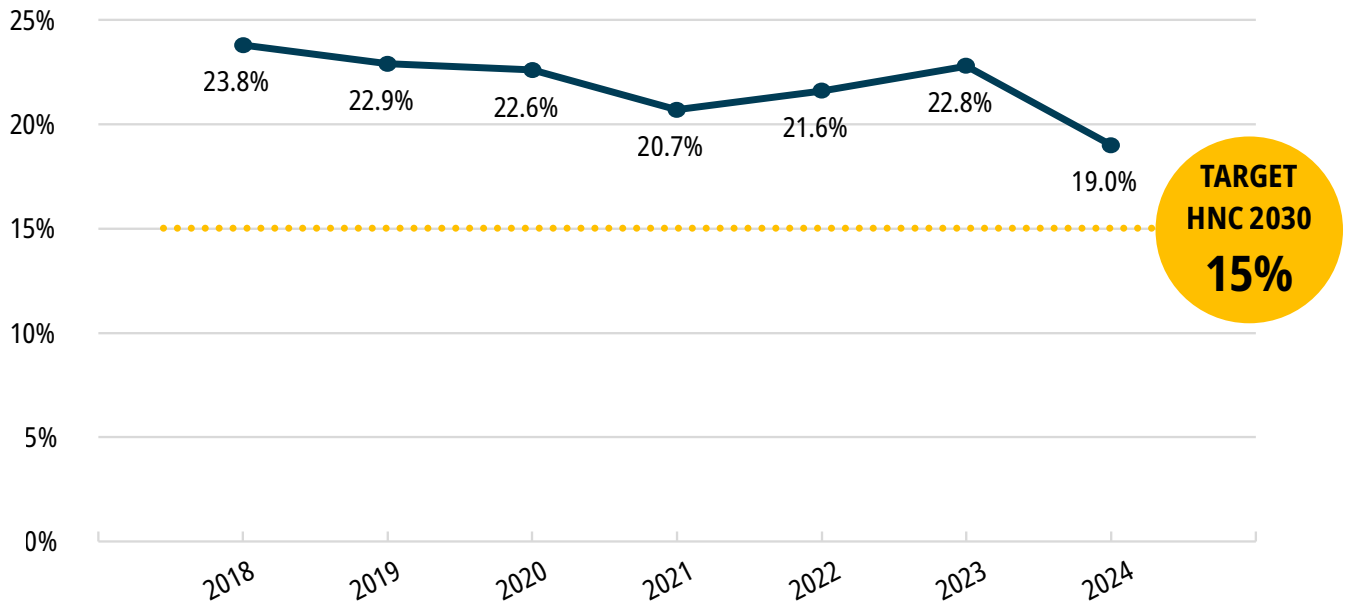
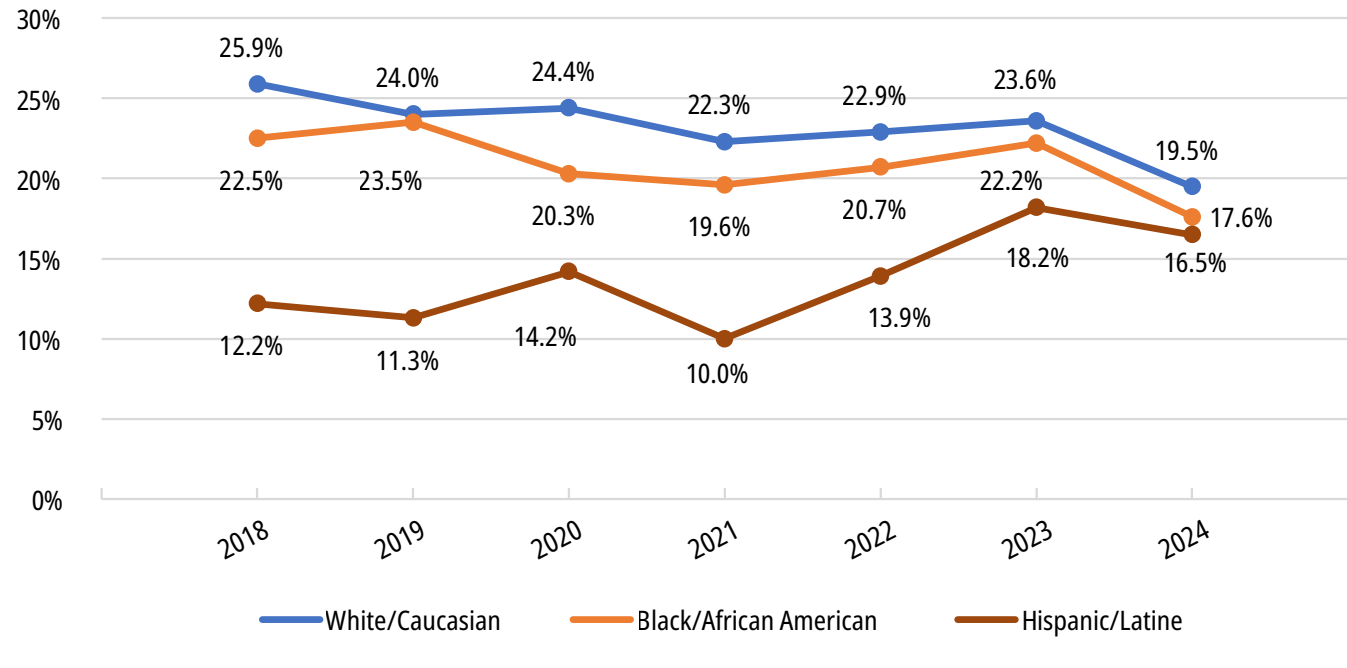


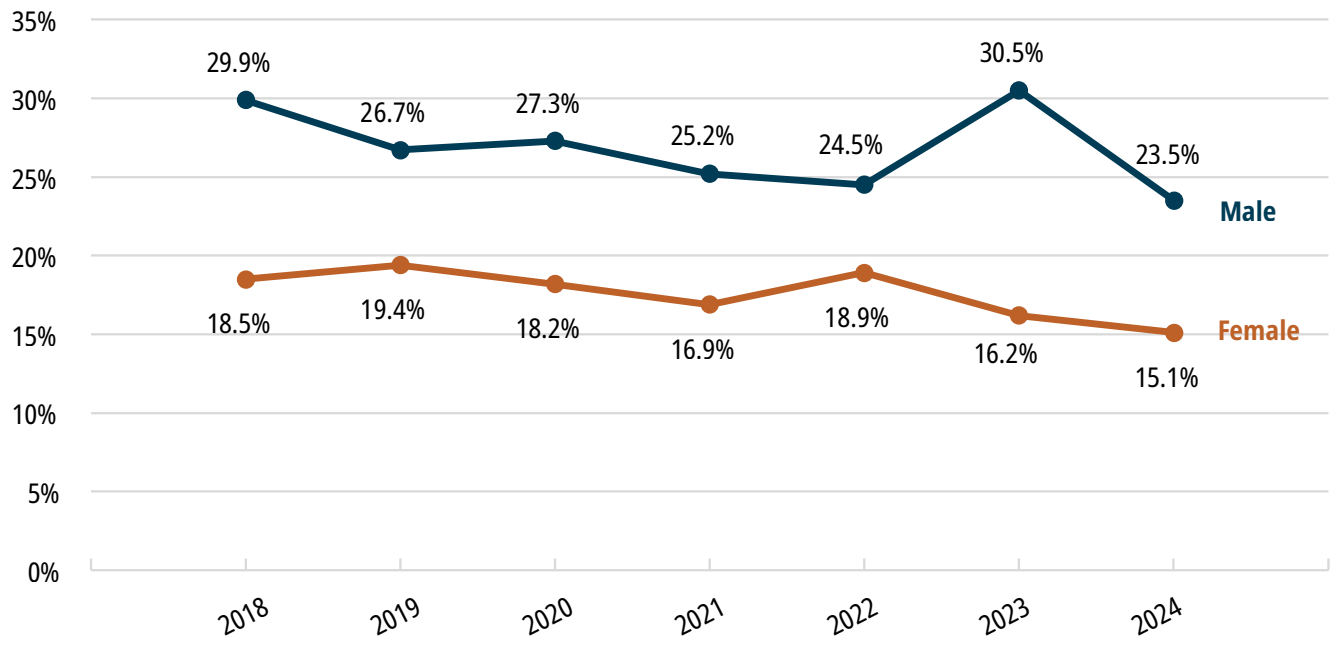
Figure 37. North Carolina Adult Tobacco Use by Race/Ethnicity and Year



Data Source: North Carolina State Center for Health Statistics, Behavioral Risk Factor Surveillance System (BRFSS)

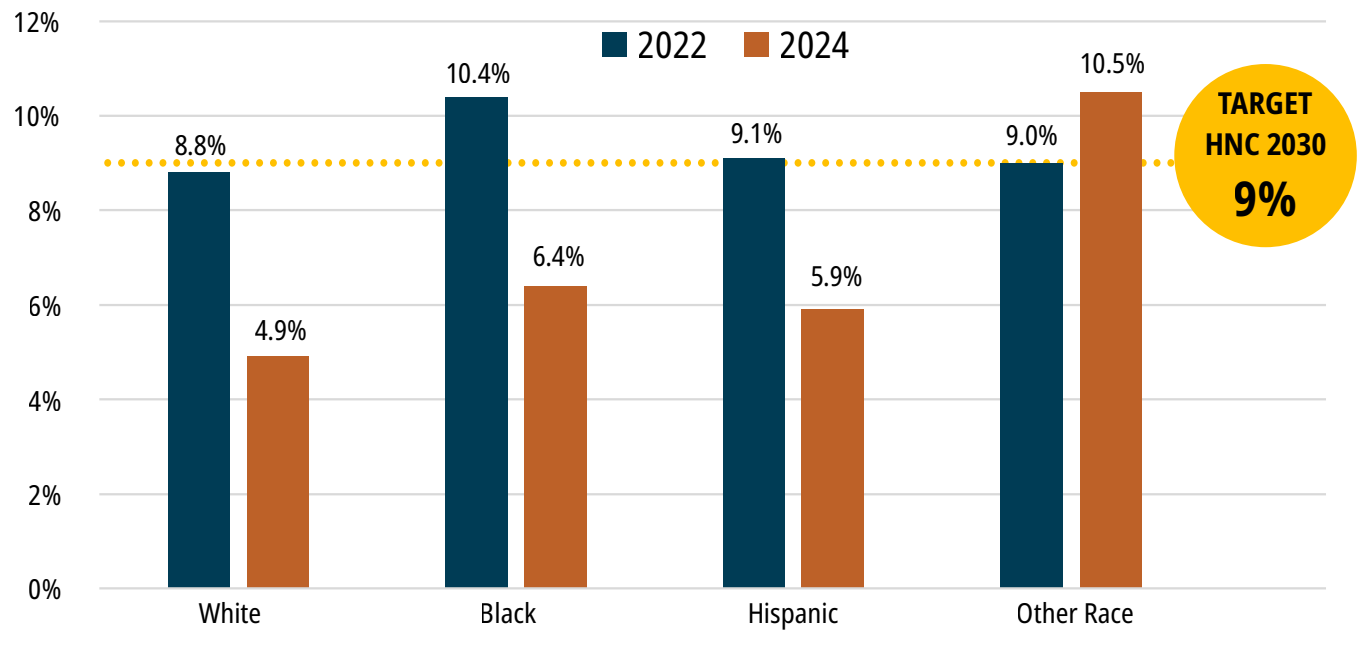
Tobacco Use

Figure 38. North Carolina Adult Tobacco Use by Gender and Year



Data Source: North Carolina State Center for Health Statistics, Behavioral Risk Factor Surveillance System (BRFSS)

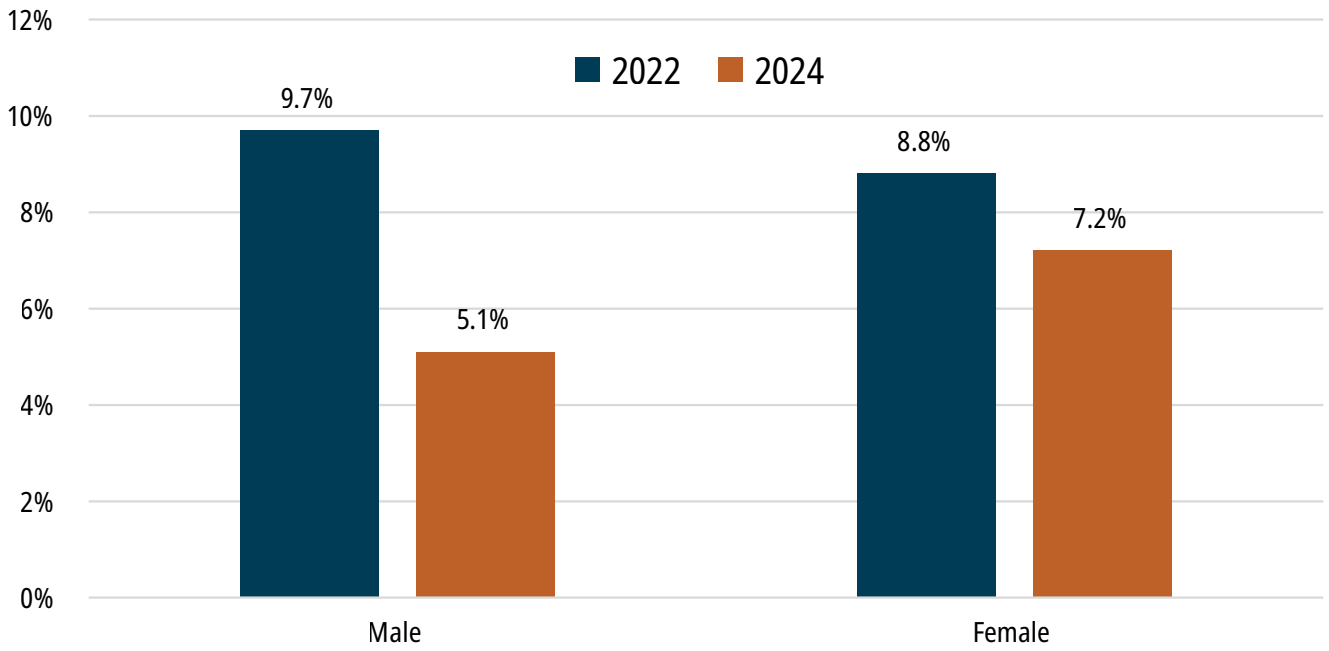
Figure 39. North Carolina Youth Tobacco Use by Race/Ethnicity and Year



Data Source: North Carolina Youth Tobacco Survey (NC YTS)

Tobacco Use

Figure 40. North Carolina Youth Tobacco Use by Gender and Year



Data Source: North Carolina Youth Tobacco Survey (NC YTS)

Excessive Drinking

WHAT RESULT DO WE WANT?

All North Carolina communities support the reduction of excessive use of alcohol.

WHAT DO WE MEASURE?

Percent of adults reporting binge or heavy drinking in North Carolina (North Carolina State Center for Health Statistics, Behavioral Risk Factor Surveillance System*)

HOW ARE WE DOING?

The percentage of all North Carolina adults self-reporting binge or heavy drinking (alcohol consumption) rose from 15.6% in 2019 to 18.1% in 2022. The percentage dropped to pre-pandemic levels (14.9%) in 2023; however, it remains over the target rate of 12.0%. Rates among males have remained significantly higher than rates for females during this time period.

**Behavioral Risk Factor Surveillance System (BRFSS) is a random telephone survey of state residents ages 18 and older. The survey collects information on health behaviors and preventive health practices related to the leading causes of death and disability.*

PRIORITIES OF THE NC SHIP COMMUNITY COUNCIL (2024-2025)

– NC State Excessive Alcohol Advisory Committee - (NCSEAAC)

Evidence-Based Strategies Addressing Excessive Alcohol Use

The following practices were determined to be evidence-based strategies for reducing excessive drinking by the Community Preventive Services Task Force:

- **Maintain Commercial Host Liability:** Maintain laws that permit retail establishments to be held liable for injuries or harms caused by illegal service to intoxicated or underage customers.
- **Increase Alcohol Taxes:** Increase the price of alcohol by raising alcohol taxes.
- **Regulate Alcohol Density:** Limit the number of businesses selling alcohol in neighborhoods.
- **Increase Electronic Screening and Brief Intervention:** Electronically screen every adult for excessive drinking using validated questions and have a brief conversation with those who screen positive.
- **Limit the Days and Hours of Alcohol Sales:** Maintain or decrease days and hours that alcohol is sold.
- **Maintain State-Controlled Alcohol Sales:** State-controlled alcohol sales are recommended as an evidence-based strategy to minimize the number of off-premise alcohol retailers, which has been shown to decrease alcohol consumption.

For additional information refer to the NC Alcohol and Related Harms Data Dashboard, under "Evidence-Based Strategies Addressing Excessive Alcohol Use."

Excessive Drinking

Figure 41. North Carolina Population Drinking Excessively by Year

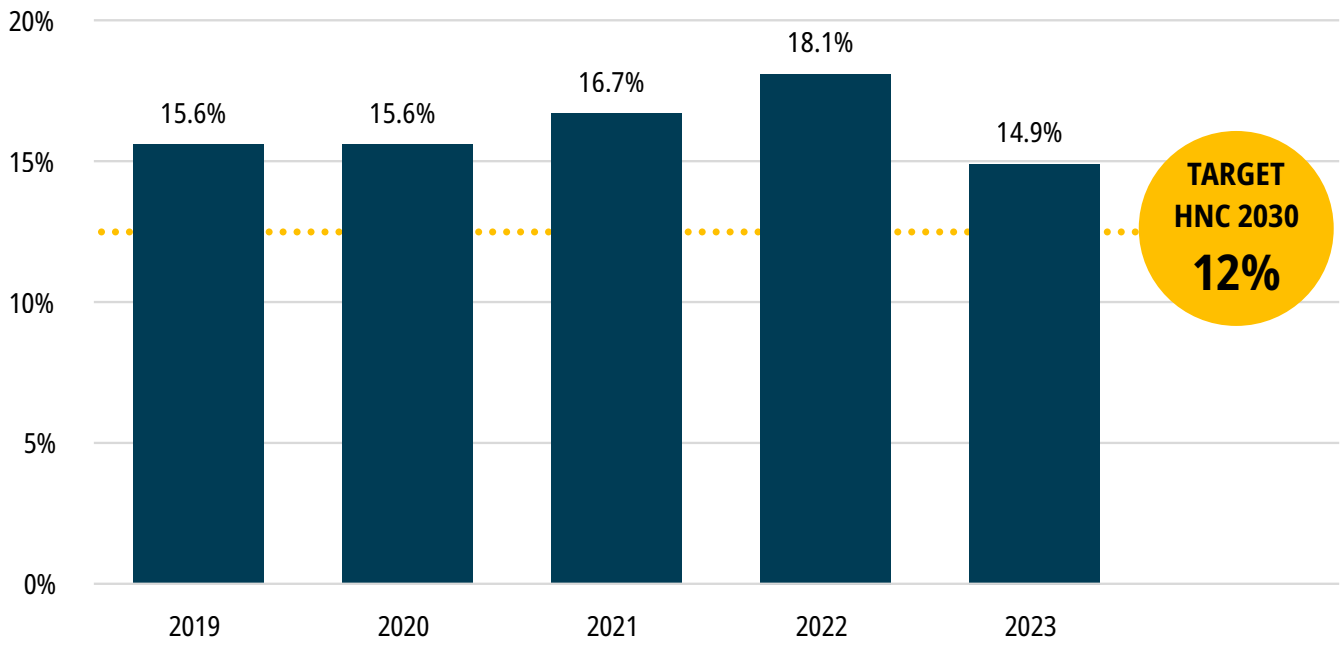
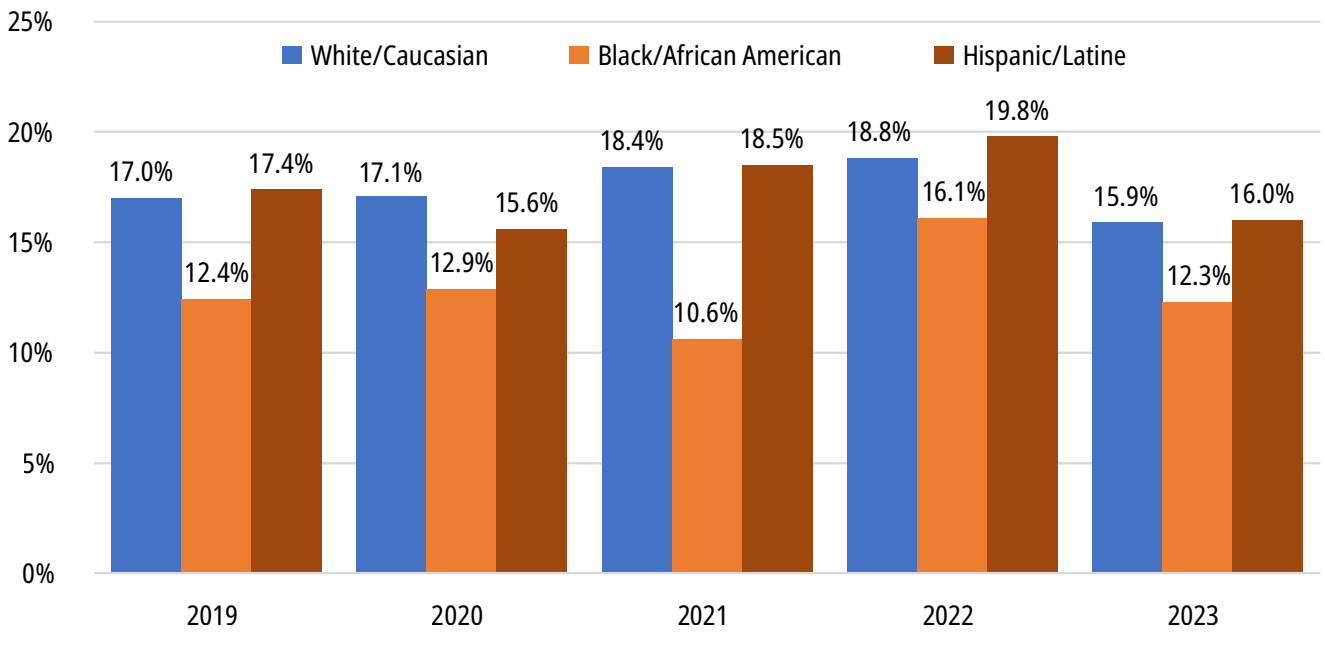


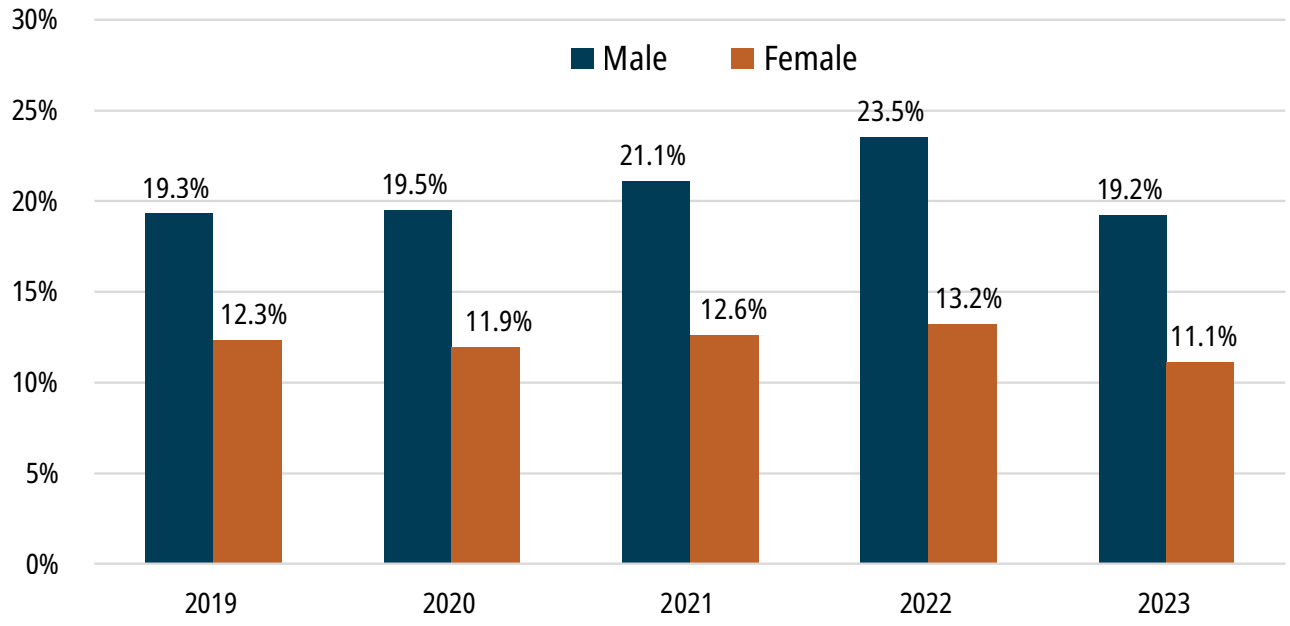
Figure 42. North Carolina Population Drinking Excessively by Race/Ethnicity and Year



Data Source: North Carolina State Center for Health Statistics, Behavioral Risk Factor Surveillance System

Excessive Drinking

Figure 43. North Carolina Population Drinking Excessively by Gender and Year



Data Source: North Carolina State Center for Health Statistics, Behavioral Risk Factor Surveillance System

Sugar-Sweetened Beverage Consumption

WHAT RESULT DO WE WANT?

All people in North Carolina live in communities that support healthy food and beverage choices.

WHAT DO WE MEASURE?

Adults: Percent of adults reporting consumption of one or more sugar-sweetened beverages per day (North Carolina State Center for Health Statistics, Behavioral Risk Factor Surveillance System*)

Youth: Percent of high school youth reporting consumption of one or more sugar-sweetened beverages per day (North Carolina Department of Public Instruction, Youth Risk Behavioral Surveillance System**)

HOW ARE WE DOING?

- Over recent years, the state's overall adult, self-reported, daily consumption of sugar-sweetened beverages hovered between 29.8% (in 2021) and 36.8% (in 2022). The rate was 32.9% in 2015 and 32.2% in 2023.
- Sugar-sweetened beverage (SSB) consumption (percent) among North Carolina students in grades 9–12 declined from 39.2% in 2015 to 29.8% in 2023.

PRIORITIES OF THE NC SHIP COMMUNITY COUNCIL (2024-2025)

- Sugar-Sweetened Beverage Consumption Work Group -

- Integrate "Rethink Your Drink" toolkit into school curricula, promoting water as a healthy alternative to sweetened beverages.
- Promote healthy procurement policies to support public and private investment to increase the availability of healthy alternatives to sugary drinks and limit "default beverage" options for all meals served to people of all ages at food venues to include only milk, 100% fruit juice, or water.
- Ensure access to safe and clean water in schools at water-filling stations that have been tested for safety.
- Implement healthy choice beverages in vending machines at schools, community colleges, universities, and parks.
- Build collaborations/partnerships with nutrition education providers and oral health.

**Behavioral Risk Factor Surveillance System (BRFSS) is a random telephone survey of state residents ages 18 and older. The survey collects information on health behaviors and preventive health practices related to the leading causes of death and disability. Data for 2020 are not shown because Sugar-Sweetened Beverage (SSB) consumption was measured only every two years prior to its inclusion as a Healthy North Carolina 2030 (HNC 2030) indicator. Once SSB consumption became part of HNC 2030, BRFSS began collecting these data annually for the remainder of the decade.*

***The North Carolina Youth Risk Behavior Survey (YRBS) is administered to a representative sample of randomly selected students on odd numbered years. Survey responses are anonymous, and parents may opt their child out of participation.*

Sugar-Sweetened Beverage Consumption

Figure 44. North Carolina Adults Consuming One or More Sugar-Sweetened Beverages per Day by Population and Year

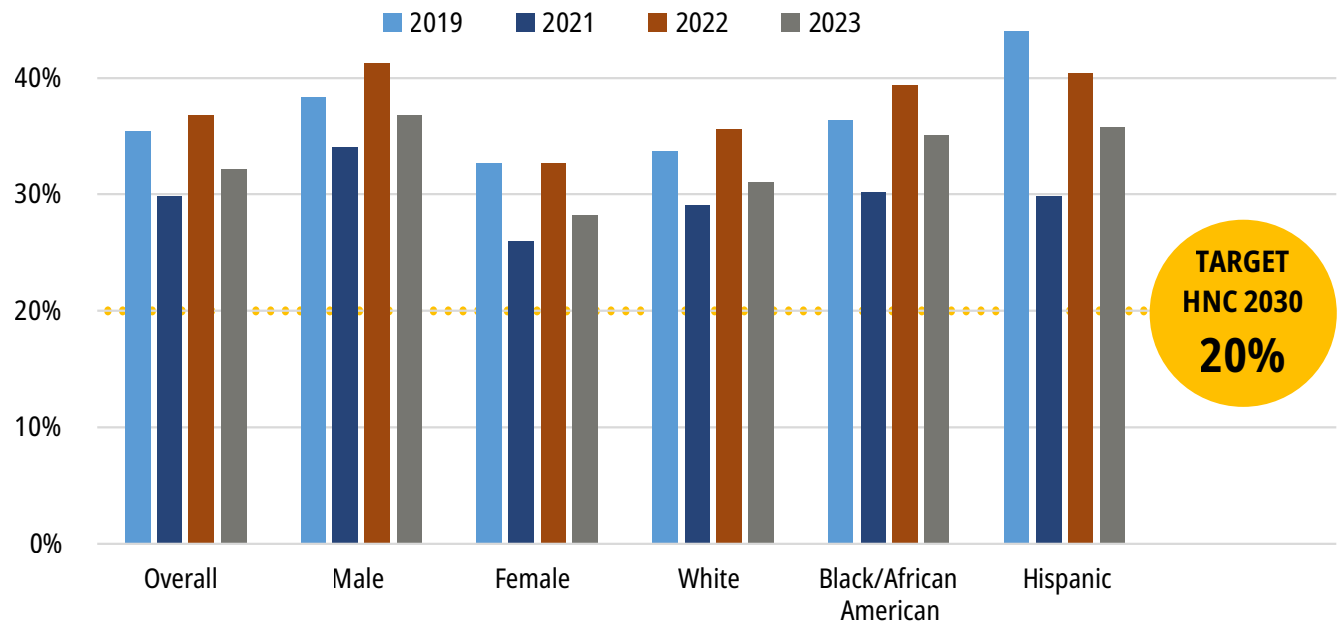
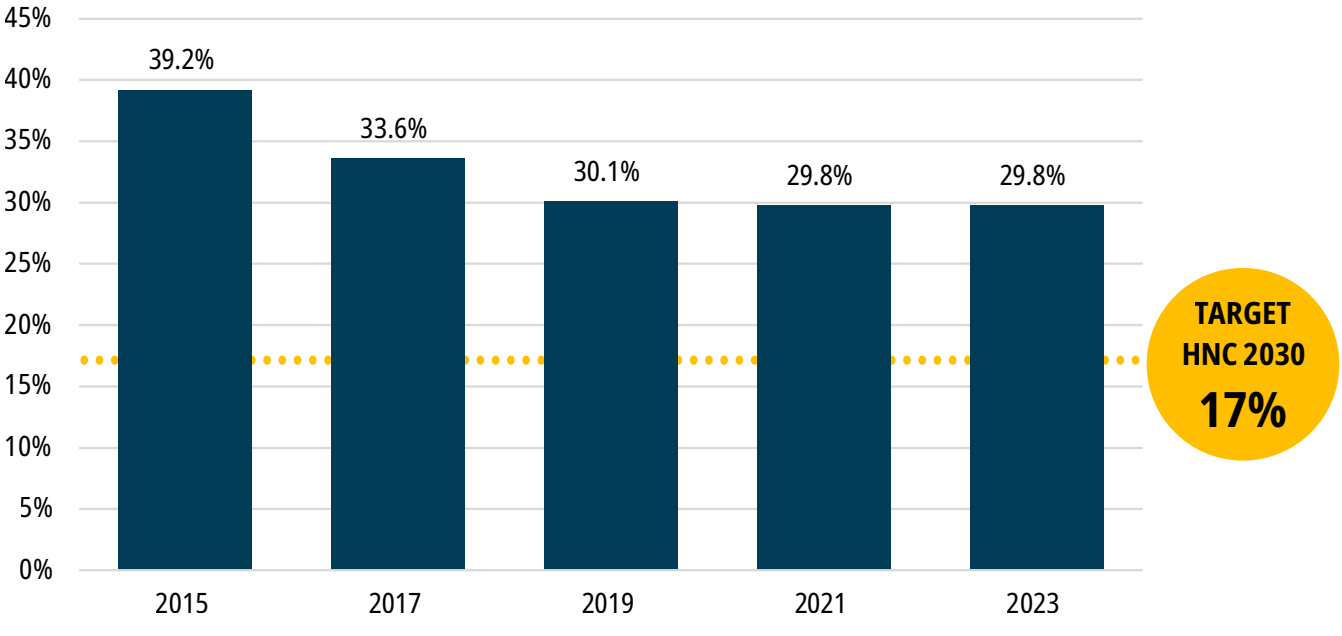


Figure 45. North Carolina High School Youth Consuming One or More Sugar-Sweetened Beverages per Day by Year



Data Source: North Carolina State Center for Health Statistics, Behavioral Risk Factor Surveillance System

Sugar-Sweetened Beverage Consumption

Figure 46. North Carolina High School Youth Consuming One or More Sugar-Sweetened Beverages per Day by Race/Ethnicity and Year

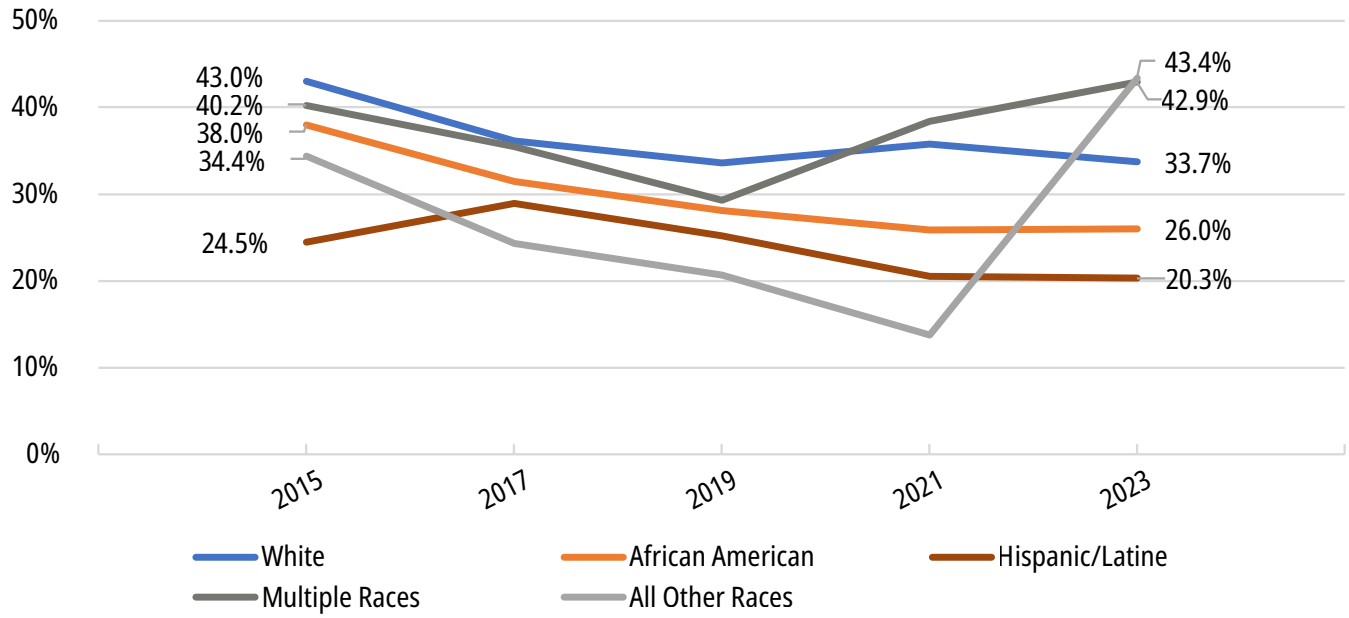
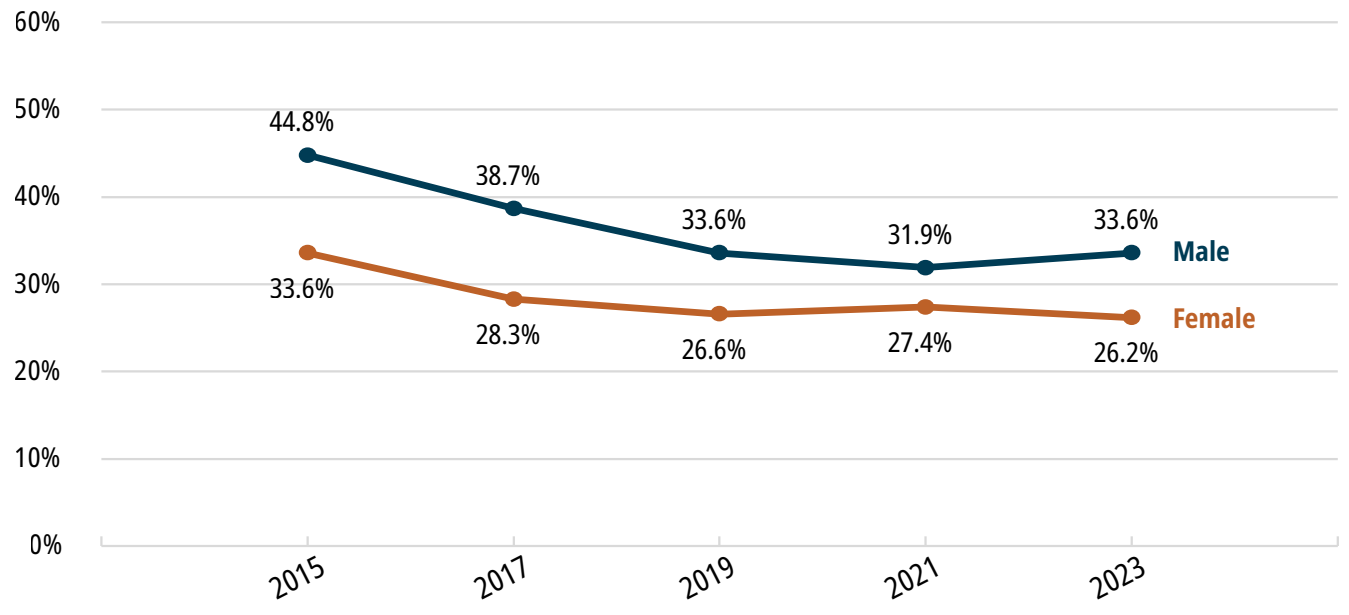


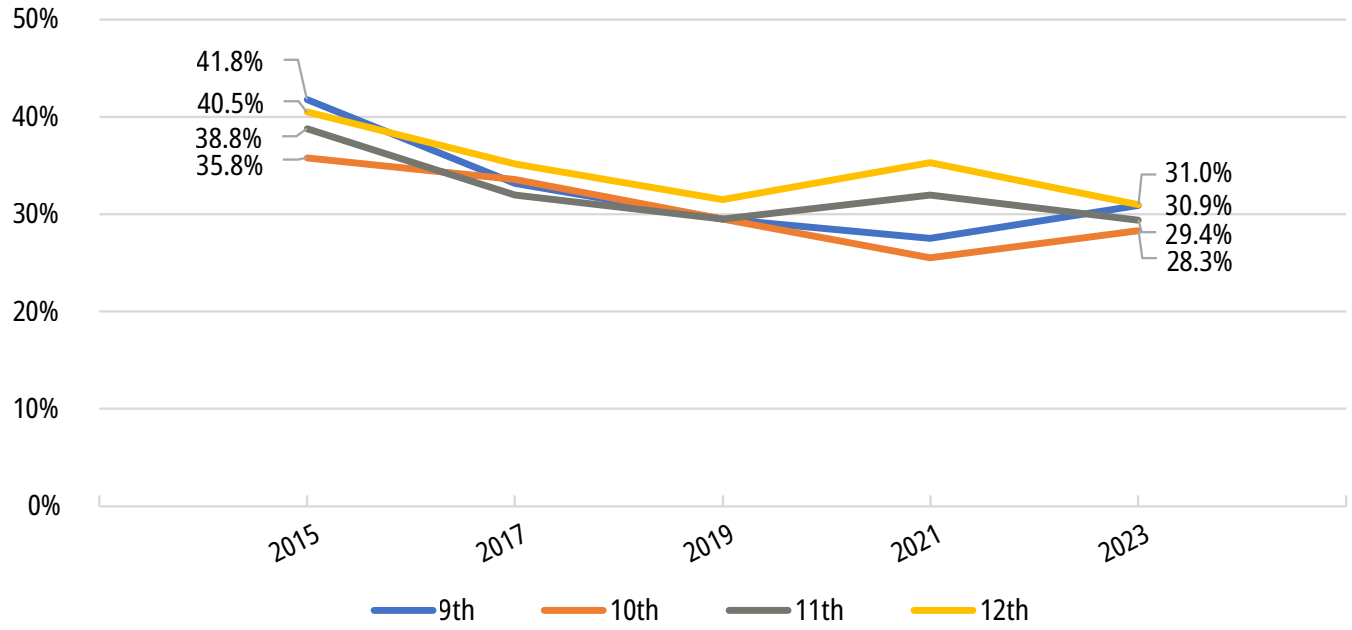
Figure 47. North Carolina High School Youth Consuming One or More Sugar-Sweetened Beverages per Day by Gender and Year



Data Source: North Carolina Department of Public Instruction, Youth Risk Behavioral Surveillance System

Sugar-Sweetened Beverage Consumption

Figure 48. North Carolina High School Youth Consuming One or More Sugar-Sweetened Beverages per Day by Grade and Year



Data Source: North Carolina Department of Public Instruction, Youth Risk Behavioral Surveillance System

HIV Diagnosis

WHAT RESULT DO WE WANT?

All people in North Carolina experience sexual health with equitable access to quality and culturally competent prevention, treatment, and management of sexually transmitted infections.

WHAT DO WE MEASURE?

Number of new HIV diagnoses in North Carolina per 100,000 population (NCDHHS Division of Public Health, Epidemiology Section, Enhanced HIV/AIDS Reporting System)

HOW ARE WE DOING?

The state's HIV new diagnosis rates have remained over 15.0 for the past three years, well above the *HNC 2030* target rate of 6.0.*

**2020 data should be treated with caution due to reduced availability of testing caused by the COVID-19 pandemic.*

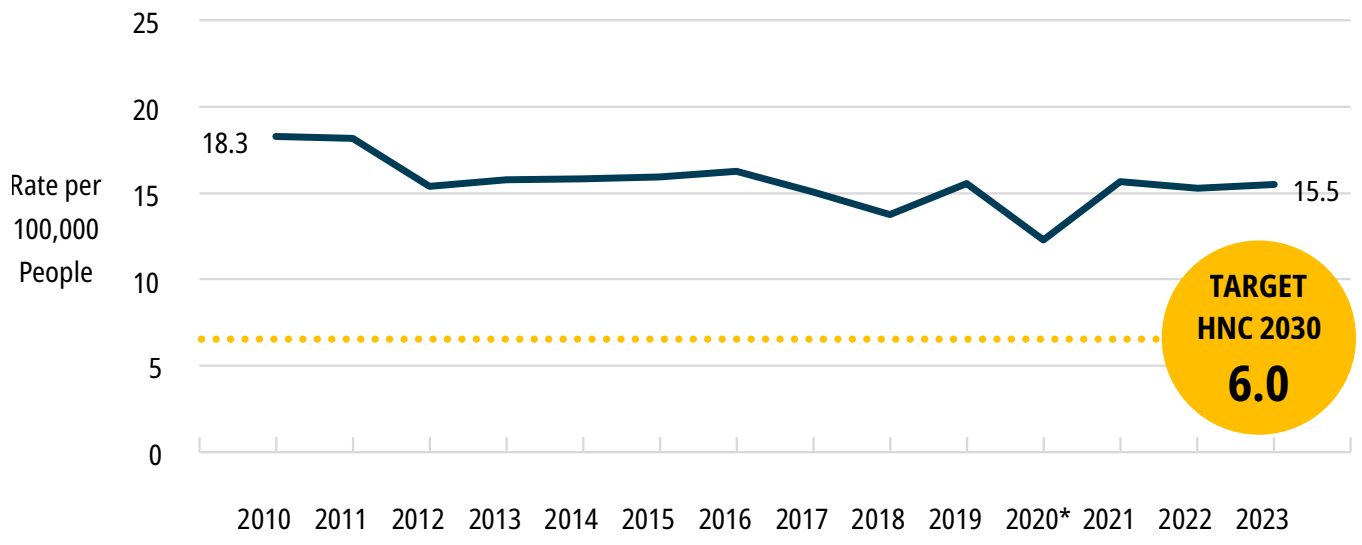
PRIORITIES OF THE NC SHIP COMMUNITY COUNCIL (2024-2025)

– HIV Diagnosis Work Group –

- Expand affordable housing programs for people living with HIV
- Identify and address gaps in HIV health care access for formerly incarcerated populations
- Identify barriers to HIV post exposure prophylaxis being delivered by pharmacists
- Increase the number of harm reduction programs, including needle exchange programs
- Increase the number of people who know their HIV status and are linked to prevention or treatment services
- Understand the impact of NC's Medicaid Managed Care Plans on health outcomes for CMS clients living with HIV

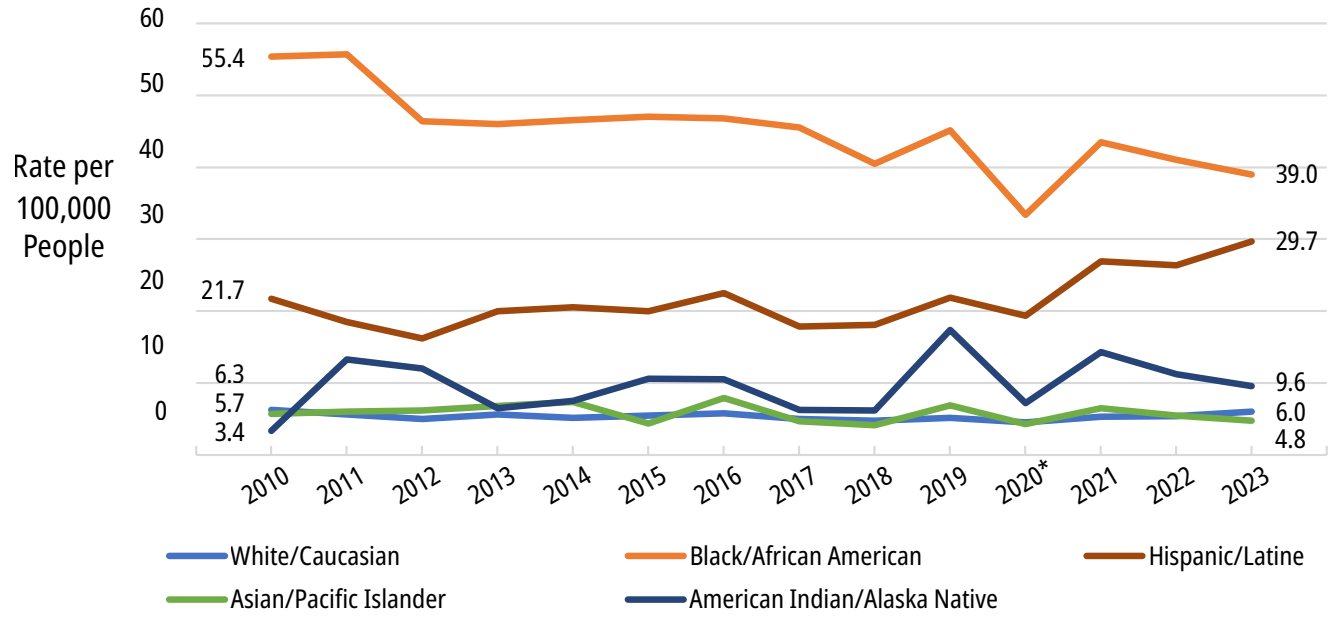
HIV Diagnosis

Figure 49. North Carolina Newly Diagnosed HIV Rates by Year



**2020 data should be treated with caution due to reduced availability of testing caused by the COVID-19 pandemic.*

Figure 50. North Carolina Newly Diagnosed HIV Rates by Race/Ethnicity and Year

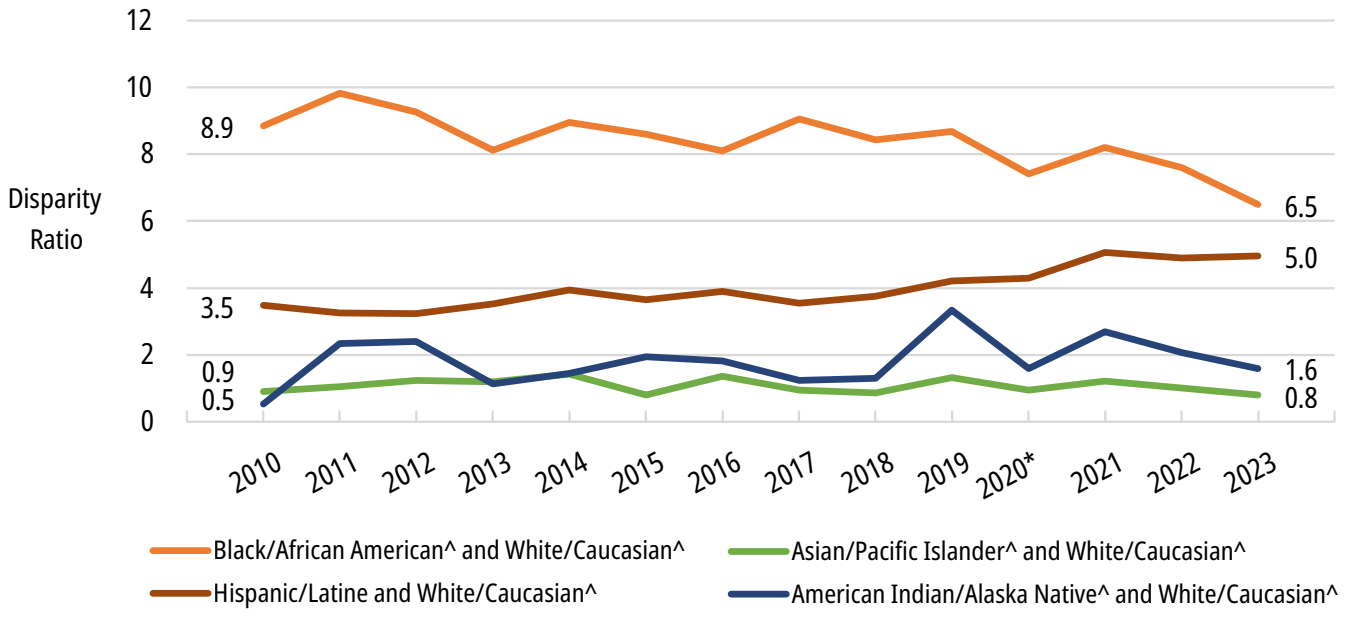


**2020 data should be treated with caution due to reduced availability of testing caused by the COVID-19 pandemic.*

Data Source: DHHS, Division of Public Health, Epidemiology Section, Enhanced HIV/AIDS Reporting System

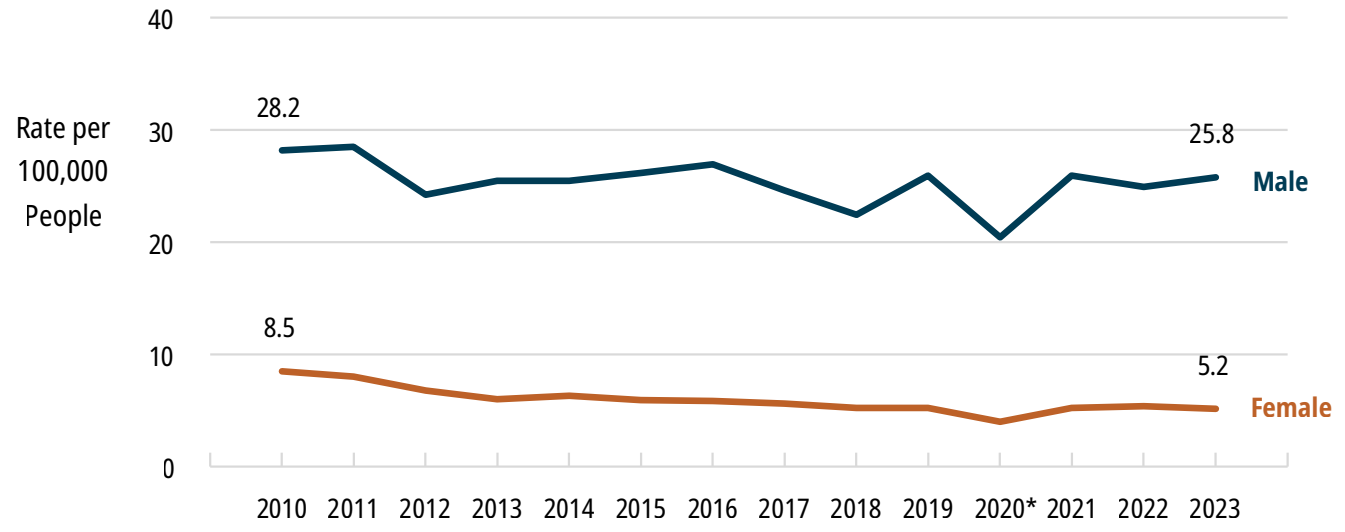
HIV Diagnosis

Figure 51. North Carolina Disparities in New HIV Diagnoses by Race/Ethnicity and Year



**2020 data should be treated with caution due to reduced availability of testing caused by the COVID-19 pandemic. ^Non-Hispanic/Latine.*

Figure 52. North Carolina Newly Diagnosed HIV Rates by Gender and Year



**2020 data should be treated with caution due to reduced availability of testing caused by the COVID-19 pandemic.*

Data Source: DHHS, Division of Public Health, Epidemiology Section, Enhanced HIV/AIDS Reporting System

Teen Births

WHAT RESULT DO WE WANT?

All people in North Carolina live in communities that support healthy choices for family planning and have equitable access to high quality, affordable reproductive health services.

WHAT DO WE MEASURE?

Number of births to females ages 15–19 per 1,000 population (North Carolina State Center for Health Statistics, Vital Statistics)

HOW ARE WE DOING?

Since 2015, total rates of teen births has dropped from 23.6 to 14.3 in 2024.

PRIORITIES OF THE NC SHIP COMMUNITY COUNCIL (2024-2025)

– Perinatal Health Equity Collective (PHEC) – Policy Work Group

Evidence-Based Strategies Addressing Teen Births

The North Carolina Perinatal Health Equity Collective (PHEC) unites more than 200 experts statewide to guide implementation of the NC Perinatal Health Strategic Plan (PHSP) and advance equitable maternal, infant, and reproductive health outcomes.

The following practices were identified as evidence-based strategies for reducing teen births:

- **Comprehensive Reproductive Health Education:** Provide age-appropriate reproductive and preconception health education across school and community settings.
- **Access to Contraception:** Expand availability of same-day insertion of contraceptive implants and intrauterine devices in local health departments.
- **Reproductive Life Planning:** Support Teen Pregnancy Prevention Initiatives (TPPI), Healthy Beginnings, and other programs that promote reproductive justice and informed choice.
- **Adolescent Well Visits:** Increase use of comprehensive adolescent well visits that include confidential reproductive health conversations.

For additional information, refer to the NC Perinatal Health Data Dashboard under “Teen Birth Rate: Ages 15–17.”

Teen Births

Figure 53. North Carolina Teen Birth Rate by Year

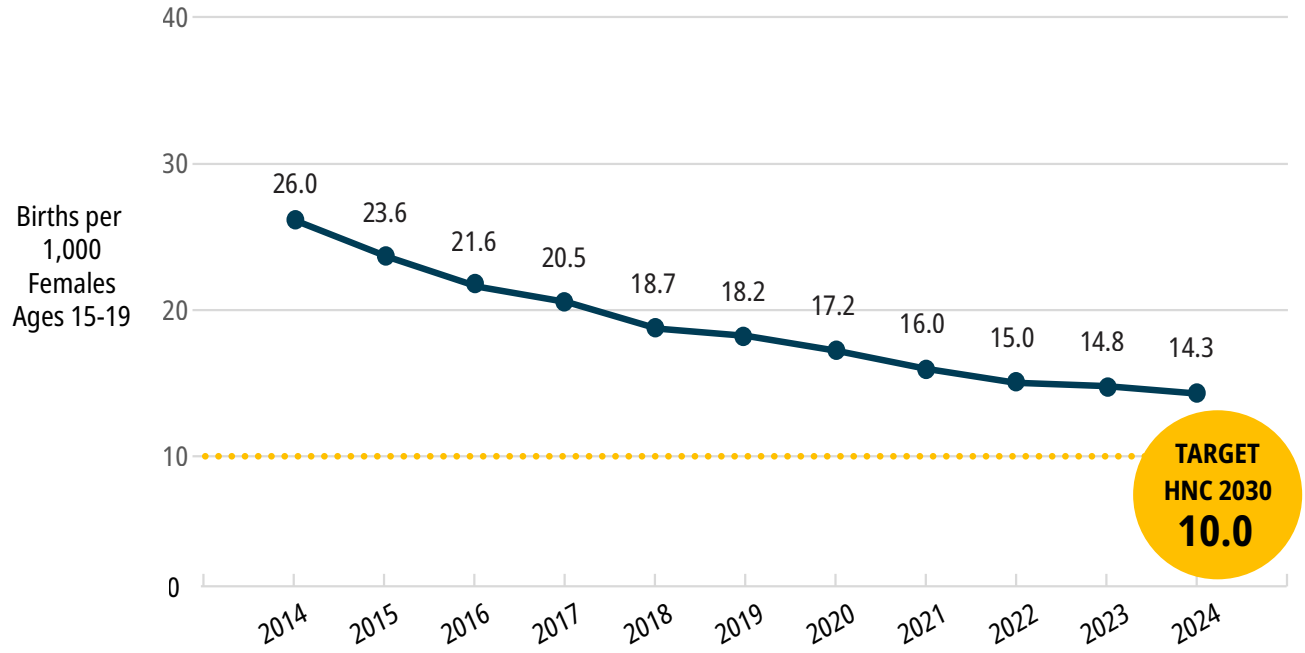
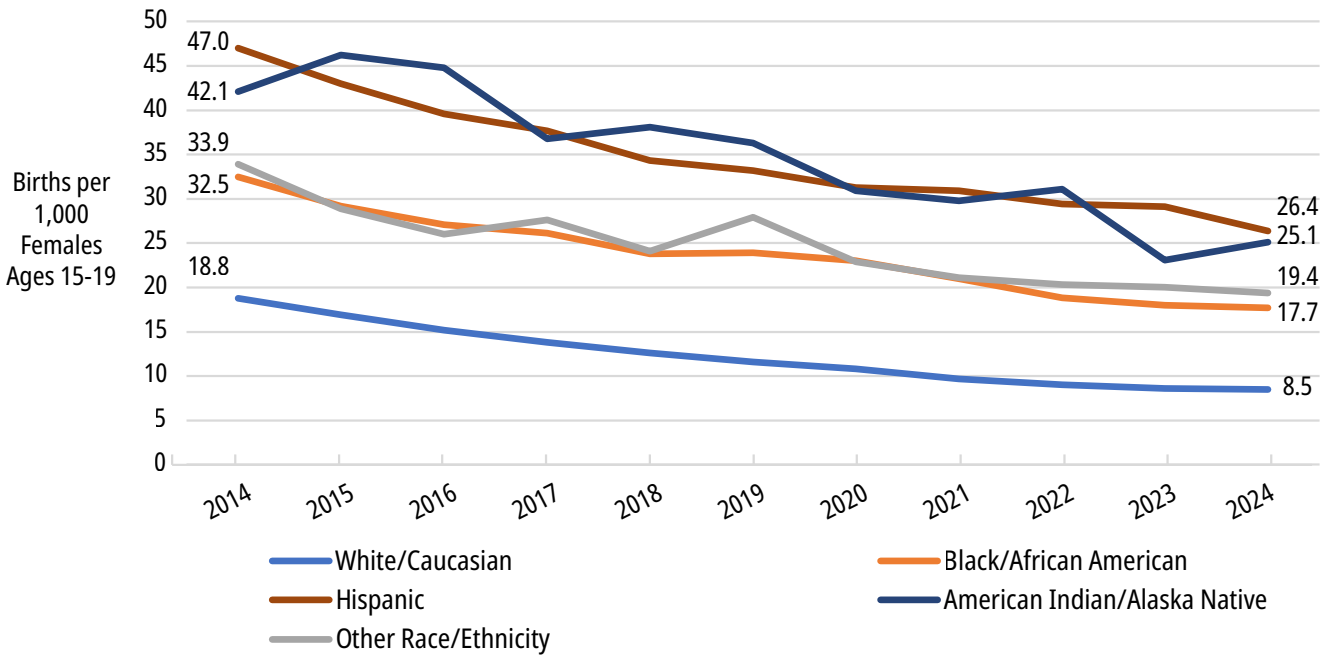


Figure 54. North Carolina Teen Birth Rate by Race/Ethnicity and Year



Data Source: North Carolina State Center for Health Statistics, Vital Statistics

Uninsured

WHAT RESULT DO WE WANT?

All people in North Carolina have access to comprehensive, high quality, affordable health insurance.

WHAT DO WE MEASURE?

Percent of North Carolina population under age 65 without health insurance (U.S. Census SAHIE Program)*

- From 2014–2020, data were only available for uninsured white/ Black/Hispanic populations.
- Uninsured data for "All Other Races" were available only for the years 2021 & 2022.

HOW ARE WE DOING?

- North Carolina expanded Medicaid eligibility on December 1, 2023, extending coverage to adults ages 19–64 with incomes up to 138% of the federal poverty level.
- Medicaid expansion in North Carolina was estimated to benefit around 600,000 people.
- The HNC 2030 target rate for North Carolina's uninsured population is 8%, yet data from 2023 suggest that 11.1% of the state's population was uninsured.

**Small Area Health Insurance Estimates, reported annually by the U.S. Census Bureau.*

PRIORITIES OF THE NC SHIP COMMUNITY COUNCIL (2024-2025)

– Uninsured Work Group –

- Maximize eligible people who enroll in newly expanded Medicaid coverage.
- Determine the need for expanding and sustaining financial support to recruit and retain Community Health Workers.
- Support and increase funding to health clinics for the uninsured.

Uninsured

Figure 55. North Carolina Population Younger Than Age 65 without Health Insurance by Year

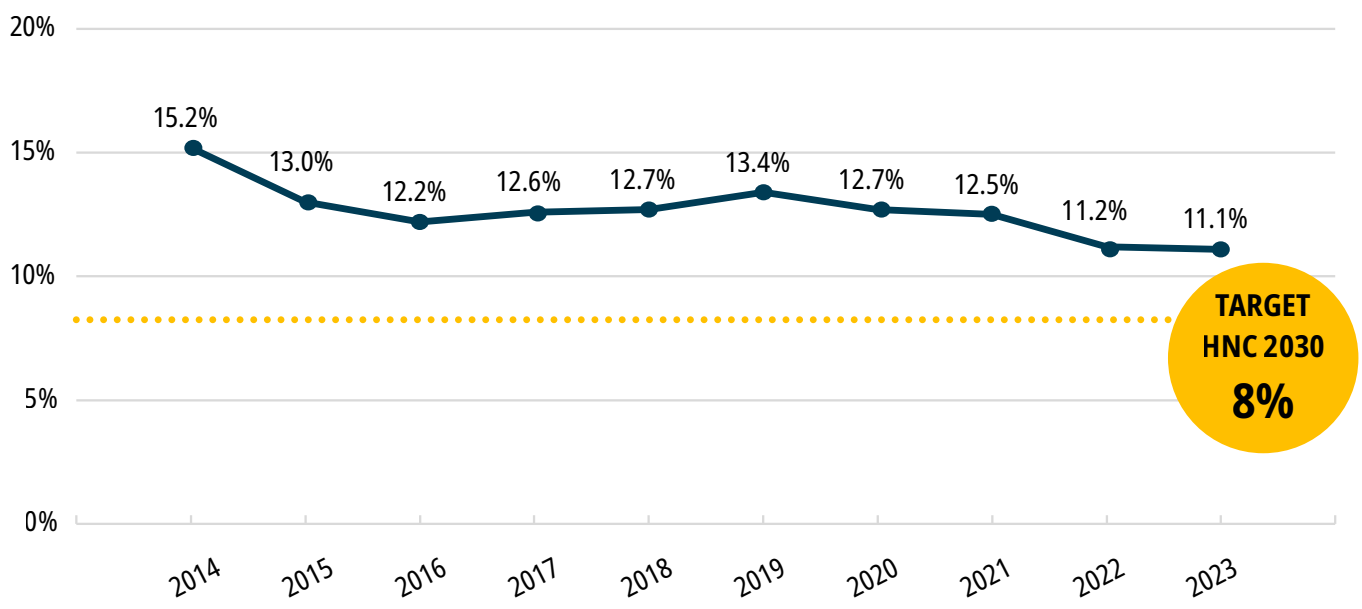
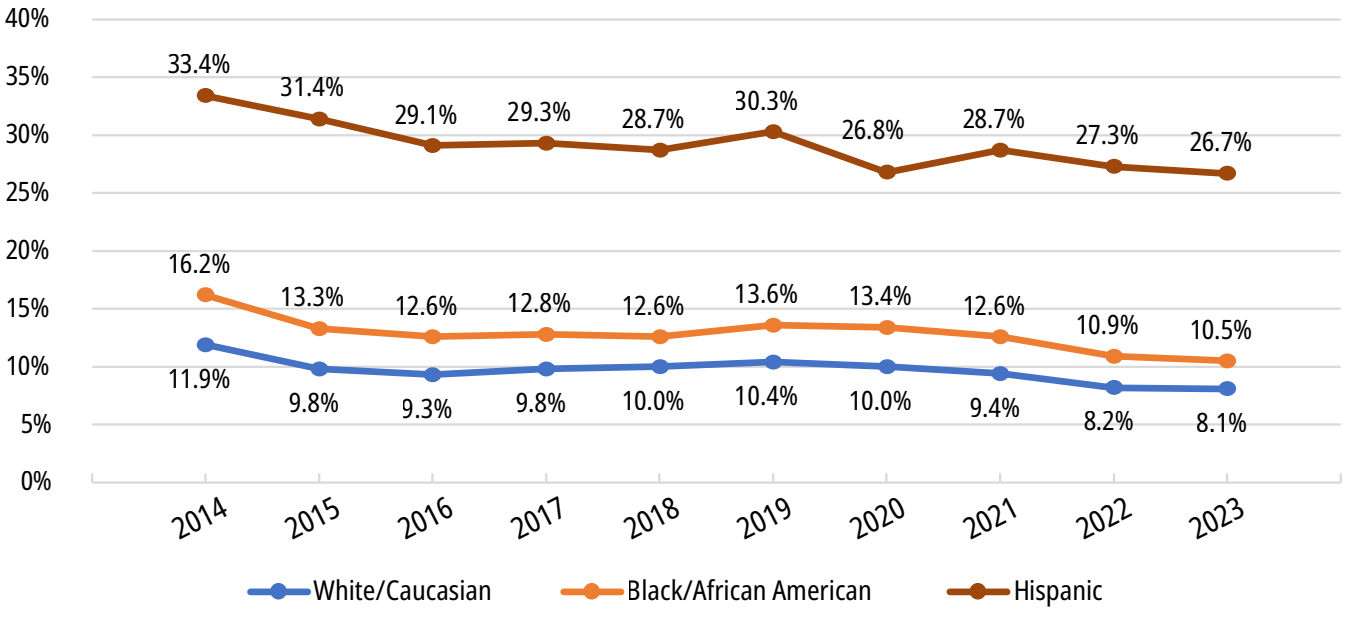


Figure 56. North Carolina Population Younger Than Age 65 without Health Insurance by Race/Ethnicity and Year



Data Source: U.S. Census Small Area Health Insurance Estimates (SAHIE) Program

Uninsured

Figure 57. North Carolina Population Younger Than Age 65 without Health Insurance by Gender and Year

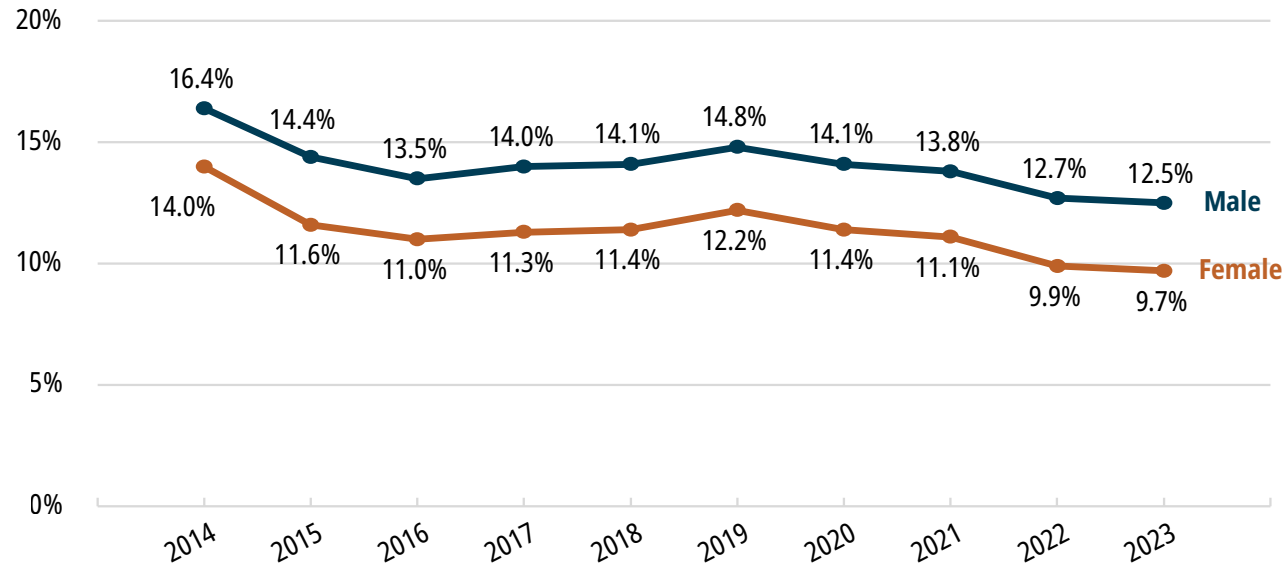
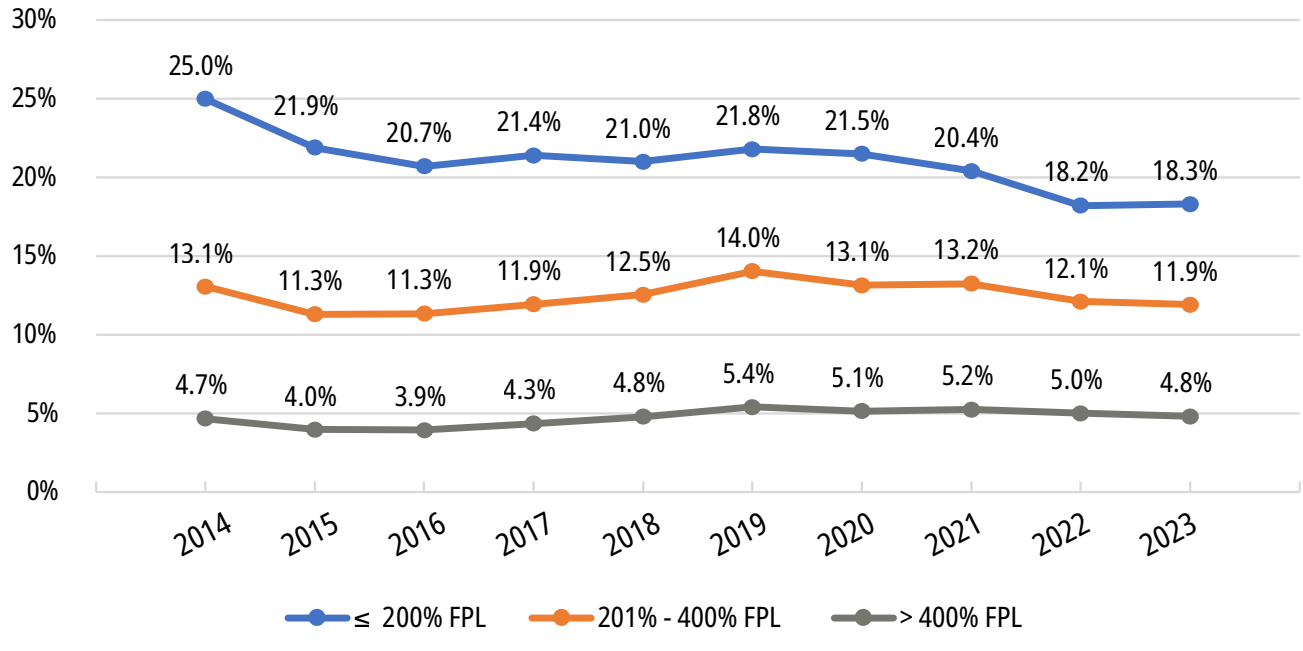


Figure 58. North Carolina Population Younger Than Age 65 without Health Insurance by Poverty Level and Year



Data Source: U.S. Census Small Area Health Insurance Estimates (SAHIE) Program

Primary Care Clinicians

WHAT RESULT DO WE WANT?

All people in North Carolina have access to comprehensive, affordable, high quality health care from clinicians who respect and understand their varied backgrounds and needs.

WHAT DO WE MEASURE?

The number of counties in North Carolina where the ratio of population to primary care clinician* is equal to or less than 1500:1 (University of North Carolina at Chapel Hill - Cecil B. Sheps Center - adjusted for age and gender)

HOW ARE WE DOING?

- Overall, the state is improving (i.e., there is an increasing number of counties with an adequate number of providers).
- The graph shows the percentage of counties meeting the standard ratio of 1,500 or fewer people to 1 primary care clinician (i.e., the county has sufficient primary care clinicians to meet population health needs).
- Overall, the number of counties meeting the goal of less than or equal to 1500:1 ratio has increased from 64 in 2017 to 80 in 2024.
- A significant number of physicians were issued temporary licenses during the COVID-19 pandemic (2021).

**The definition of "clinician" includes certified nurse midwives (CNMs), nurse practitioners (NPs), physician assistants (PAs) and primary care physicians.*

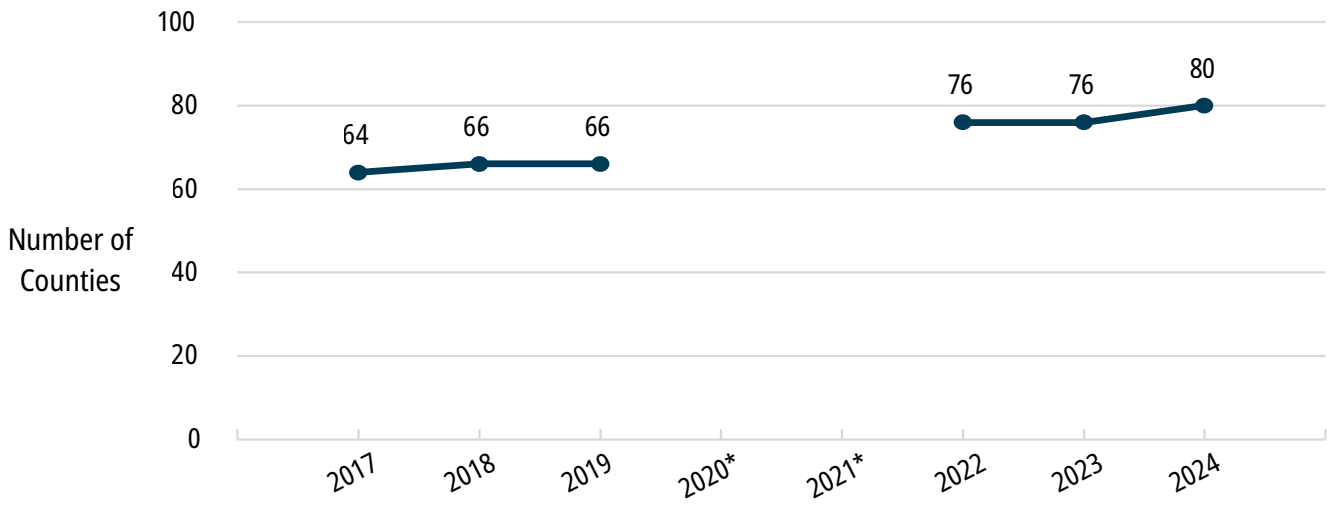
PRIORITIES OF THE NC SHIP COMMUNITY COUNCIL (2024-2025)

– Primary Care Clinicians Work Group –

- Leverage Medicaid, including Medicaid Expansion, to support the viability of all primary care clinicians, especially in rural settings.
- Reduce cost to trainees, including strategic deployment and loan repayment programs.
- Leverage health care provider training onsite in rural communities and other investments.

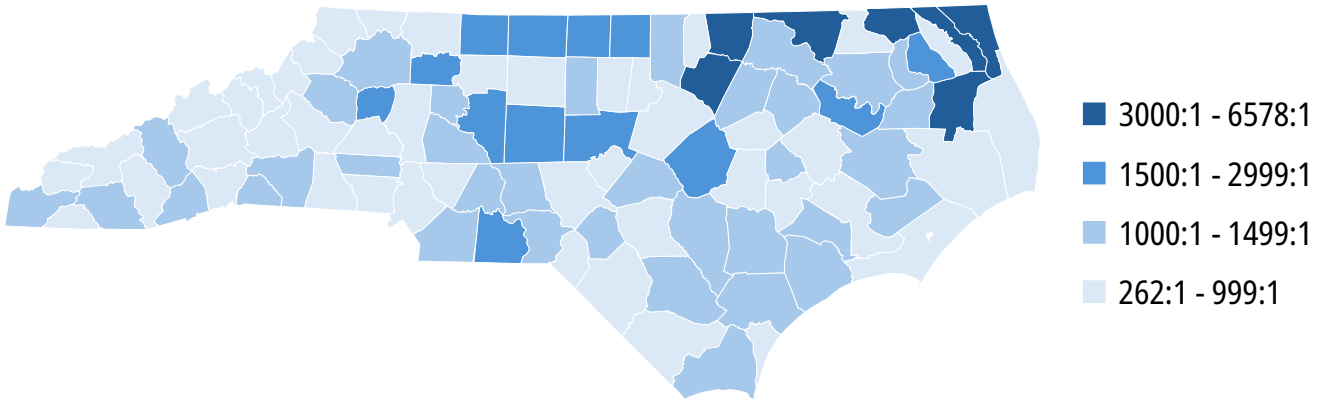
Primary Care Clinicians

Figure 59. North Carolina Counties Where There Was More Than One Primary Care Clinician per 1,500 People by Year



**Data for 2020 and 2021 were omitted due to difficulties in the verification of practice locations (in-state versus out-of-state) during the COVID-19 pandemic*

Figure 60. North Carolina Ratio of Population to Primary Care Clinician by County, 2024



Data Source: Cecil G. Sheps Center for Health Services Research, University of North Carolina at Chapel Hill

Early Prenatal Care

WHAT RESULT DO WE WANT?

All birthing people in North Carolina have healthy pregnancies and maternal birth outcomes.

WHAT DO WE MEASURE?

Percent of birthing women who receive pregnancy-related health care services during the first trimester of a pregnancy (North Carolina State Center for Health Statistics, Vital Statistics)

HOW ARE WE DOING?

The percentage of birthing women in North Carolina who receive prenatal care in the first trimester of pregnancy has trended within the low 70 percentile since 2014 (with 73.2% receiving early prenatal care in 2014, and 71.9% receiving early prenatal care in 2024).

PRIORITIES OF THE NC SHIP COMMUNITY COUNCIL (2024-2025)

– Perinatal Health Equity Collective (PHEC) Policy Work Group –

Evidence-Based Strategies Addressing Early Prenatal Care

The North Carolina Perinatal Health Equity Collective (PHEC) unites more than 200 experts statewide to guide implementation of the NC Perinatal Health Strategic Plan (PHSP) and advance equitable maternal, infant, and reproductive health outcomes. The following practices were identified as evidence-based strategies for increasing early and equitable access to prenatal care:

- **Medicaid Expansion and Coverage Continuity:** Expand Medicaid and extend postpartum coverage to 12 months to ensure consistent, affordable care.
- **Inclusive Access to Care:** Provide prenatal services for all birthing people and expand midwifery practice authority.
- **Community-Based Models:** Increase use of group prenatal care, doula support, and community health workers.
- **Early Referral and Enrollment:** Promote early WIC referrals and coordination through NCCARE360 and Care Management for High-Risk Pregnant Women.
- **Provider Training:** Expand implicit bias and health equity training for perinatal care providers.

For additional information, refer to “Percent of Infants Born to People Receiving First Trimester Prenatal Care” in the NC Perinatal Health Data Dashboard.

Early Prenatal Care

Figure 61. North Carolina Women Receiving Prenatal Care in First Trimester of Pregnancy by Year

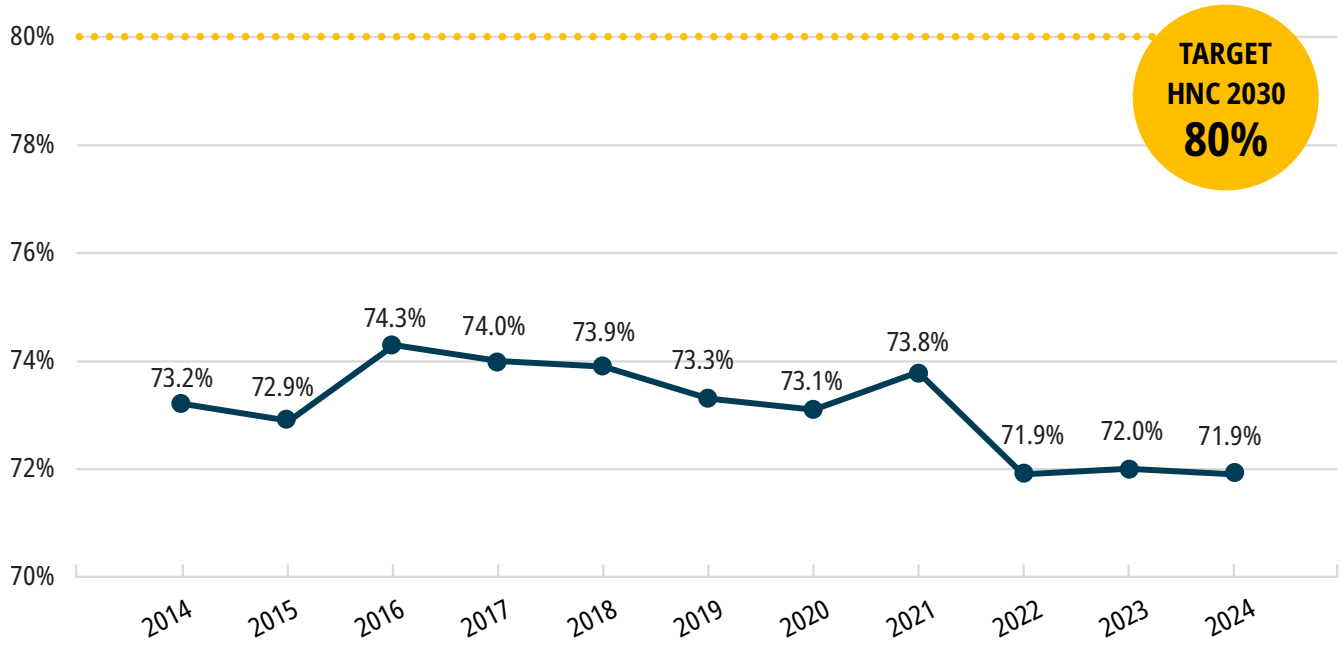
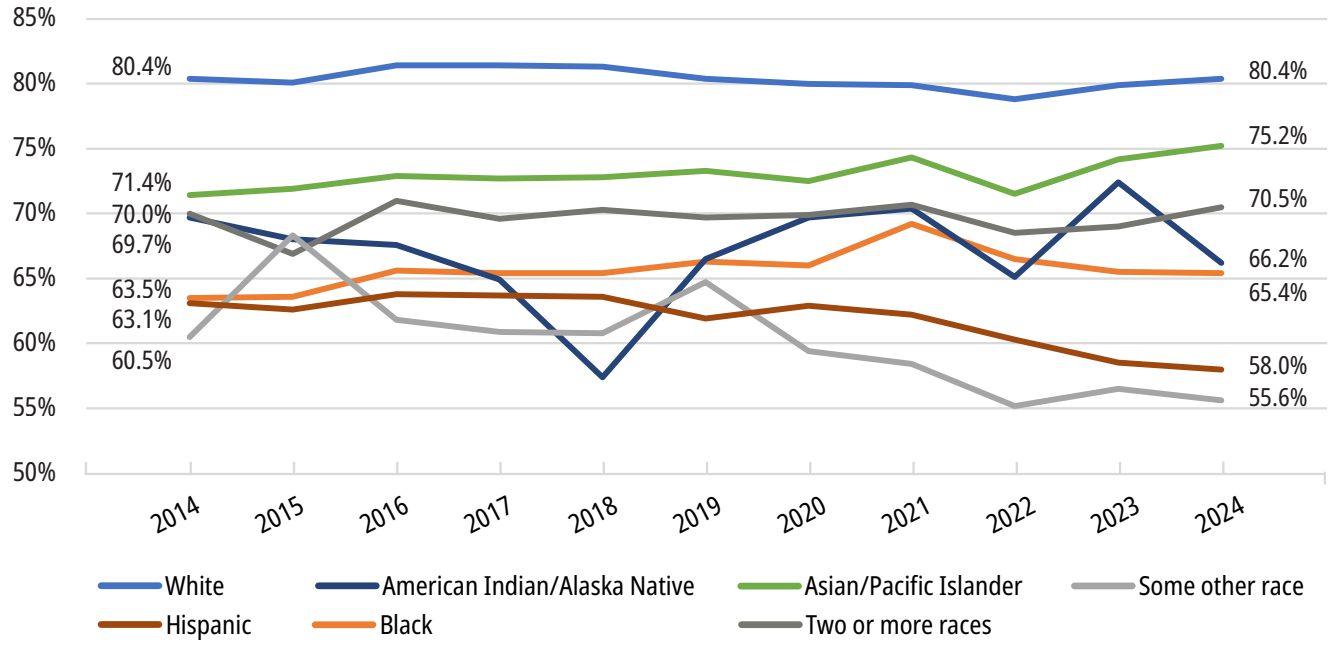


Figure 62. North Carolina Women Receiving Prenatal Care in First Trimester of Pregnancy by Race/Ethnicity and Year



Data Source: North Carolina State Center for Health Statistics, Vital Statistics

Early Prenatal Care

Figure 63. North Carolina Women Receiving Prenatal Care in First Trimester of Pregnancy by Perinatal Health Region, 2024

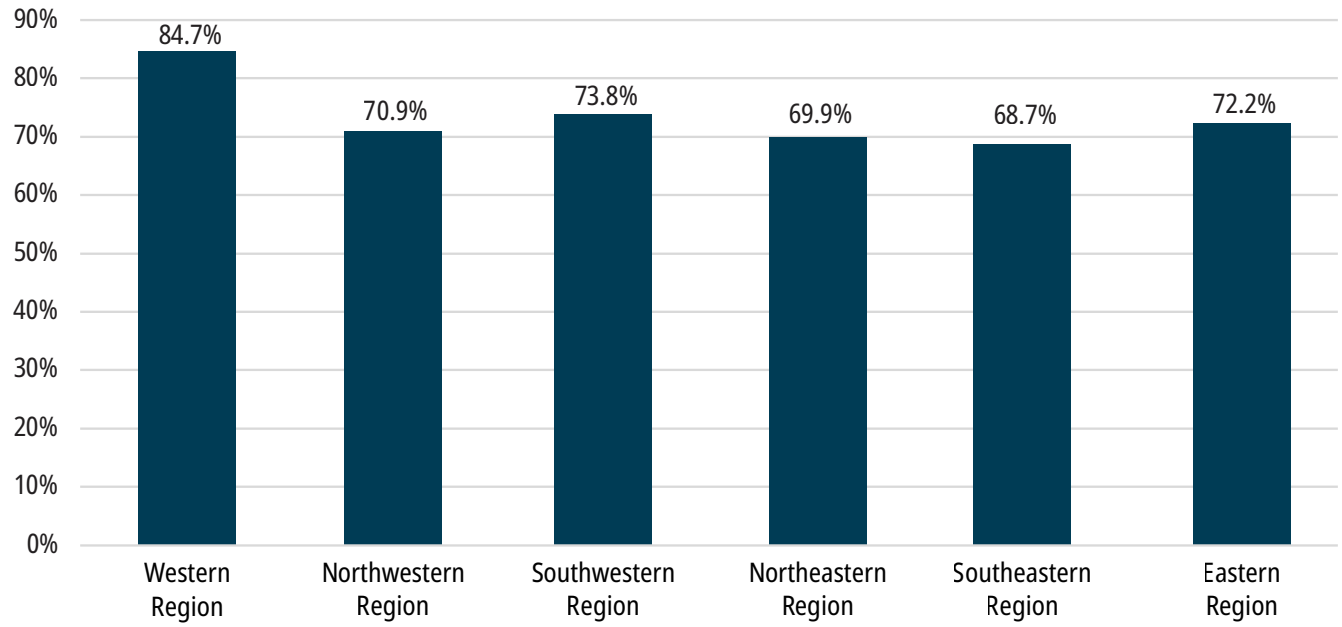
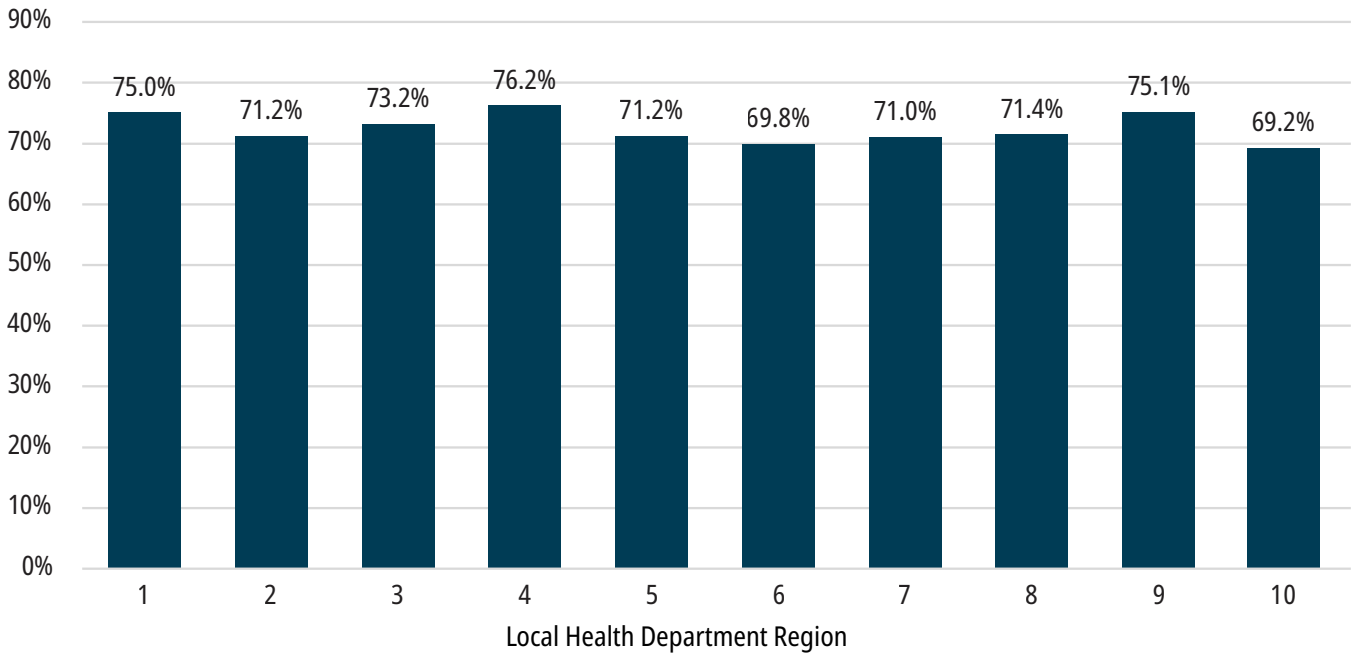


Figure 64. North Carolina Women Receiving Prenatal Care in First Trimester of Pregnancy by Local Health Department Region, 2024



Data Source: North Carolina State Center for Health Statistics, Vital Statistics

Suicide

WHAT RESULT DO WE WANT?

All North Carolinians feel mentally and emotionally well, have access to care without fear or judgment, and are supported regardless of their background and lived experience.

WHAT DO WE MEASURE?

Suicide death rate* per 100,000 people - age-adjusted number of deaths attributable to self-harm per 100,000 population (North Carolina State Center for Health Statistics)

HOW ARE WE DOING?

- Overall, the state's suicide rate has trended upwards from 13.0 in 2014 to 14.2 in 2024.
- In 2024, North Carolina's white/ Caucasian population had the state's highest suicide rate, at 17.8.
- The state's 2023 suicide rate is more than four times higher for males than for females

**Deaths by suicide are defined as having ICD–10 underlying cause-of-death codes X60–X84 or Y870.*

PRIORITIES OF THE NC SHIP COMMUNITY COUNCIL (2024-2025)

– Comprehensive Suicide Prevention Advisory Council – (CSPAC)

The NC SHIP priorities were integrated into the existing Comprehensive Suicide Prevention Advisory Council (CSPAC). The North Carolina Suicide Prevention Action Plan (NC SPAP: 2026-2030) acknowledges that suicide prevention is complex, and the plan is structured to implement comprehensive strategies in the following focus areas to reduce injury and death by suicide. Refer to the NC Suicide Prevention Action Plan for additional information about this plan, data and justification, strategies, and related actions. (NC SPAP: 2026-2030 at www.ncdhhs.gov/media/28662/open)

Given that suicide prevention is complex, the plan is structured to implement comprehensive strategies in the following focus areas to reduce injury and death by suicide.

- / 01 **Coordinated infrastructure**
- / 02 **Reduce access to lethal means**
- / 03 **Increase community awareness and prevention**
- / 04 **Identify and support populations at risk**
- / 05 **Provide crisis intervention with specific focus on priority populations**
- / 06 **Provide access to and delivery of suicide care**
- / 07 **Measure impact**

Suicide

Figure 65. North Carolina Suicide Death Rate by Year

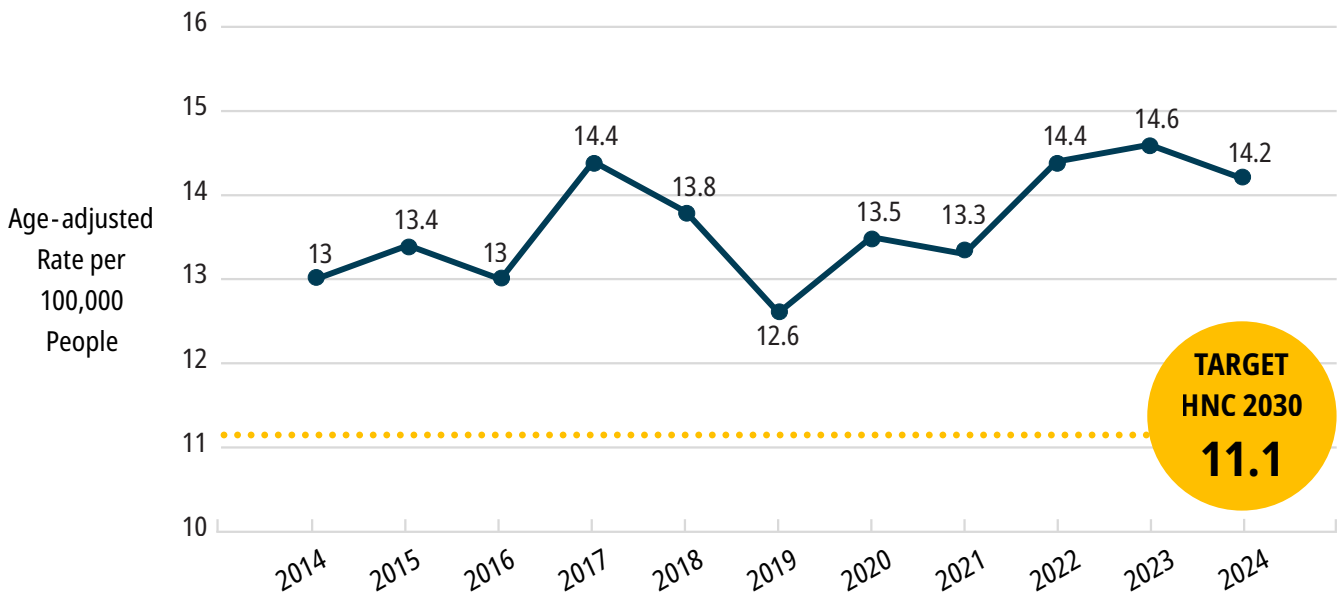
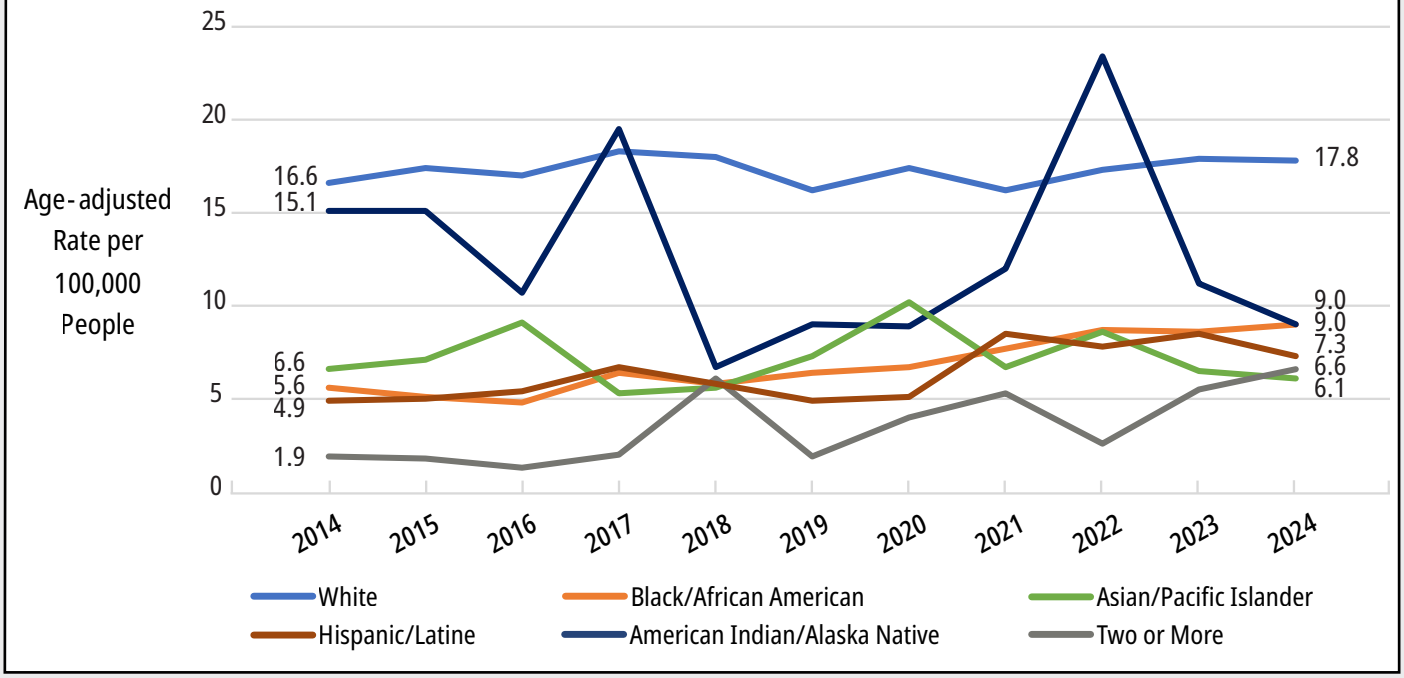


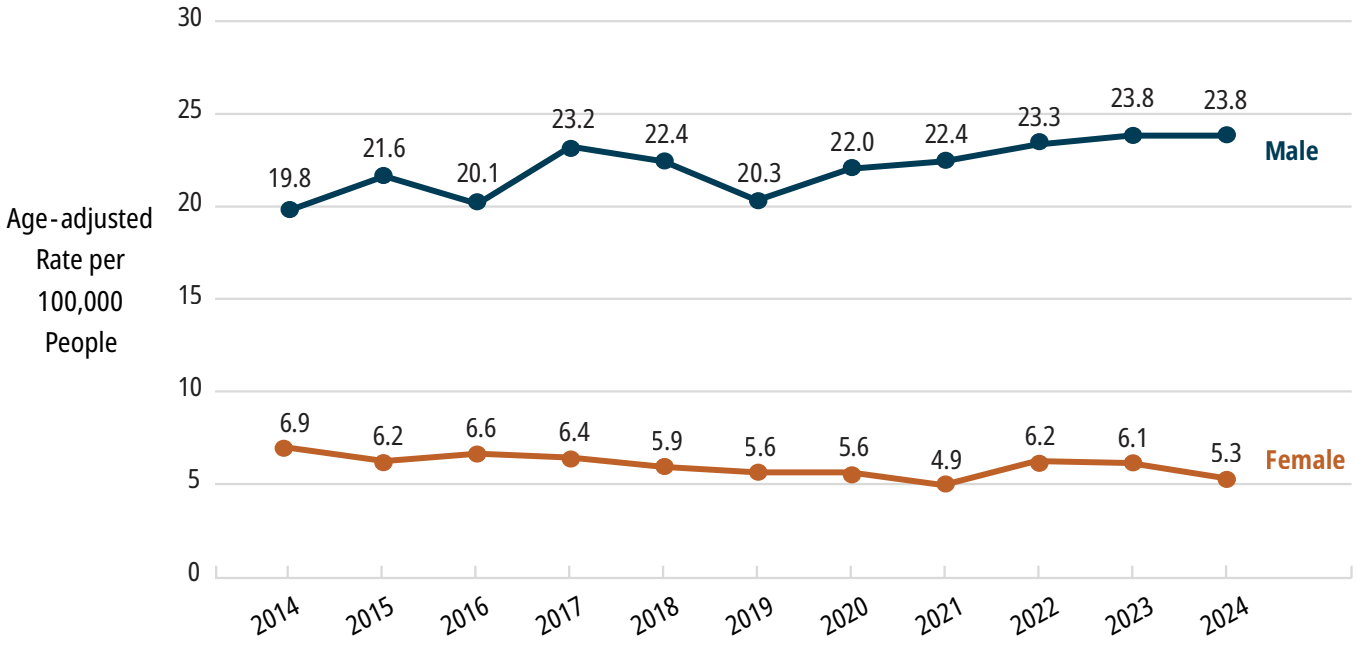
Figure 66. North Carolina Suicide Death Rate by Race/Ethnicity and Year



Data Source: North Carolina State Center for Health Statistics

Suicide

Figure 67. North Carolina Suicide Death Rate by Gender and Year



Data Source: North Carolina State Center for Health Statistics

Infant Mortality

WHAT RESULT DO WE WANT?

All babies in North Carolina are born healthy, thrive in caring and healthy homes, and see their first birthday.

WHAT DO WE MEASURE?

Rate of infant deaths in North Carolina per 1,000 live births (North Carolina State Center for Health Statistics, Vital Statistics)

HOW ARE WE DOING?

North Carolina's overall infant mortality ratio has very slightly declined since 2014; however, the disparity ratio between Black/African Americans and white/Caucasians shows an upward trend.

- In 2014, the overall infant mortality rate was 7.1 and in 2023 it was 6.9, a drop of just 0.2 in nine years.
- In 2014, the disparity ratio was 2.5, and in 2023 it was 3.0.
- A Black/African American baby is three times more likely to die before their first birthday than a white/Caucasian baby.

PRIORITIES OF THE NC SHIP COMMUNITY COUNCIL (2024-2025)

– Perinatal Health Equity Collective (PHEC) Policy Work Group –

Evidence-Based Strategies Addressing Infant Mortality

The North Carolina Perinatal Health Equity Collective (PHEC) unites more than 200 experts statewide to guide implementation of the NC Perinatal Health Strategic Plan (PHSP) and advance equitable maternal, infant, and reproductive health outcomes. The following practices were identified as evidence-based strategies for reducing infant mortality and eliminating racial disparities:

- **Quality Maternal and Neonatal Care:** Adopt and verify nationally recognized levels of care for all birthing facilities.
- **Home Visiting and Safe Sleep Programs:** Expand evidence-based home visiting services and safe sleep education.
- **Comprehensive Maternal Services:** Strengthen access to prenatal, postpartum, and interconception care, including mental health, dental, and lactation support.
- **Equity-Focused Community Investments:** Address social and economic factors such as poverty, housing, and community safety.
- **Public Awareness and Accountability:** Support statewide campaigns and track progress toward eliminating the Black and white disparity in infant mortality.

For additional information, refer to the NC Perinatal Health Strategic Plan 2022–2026, Overarching Indicator 1: Eliminate the Black and White Disparity in Infant Mortality.

Infant Mortality

Figure 68. North Carolina Infant Mortality Rate by Year

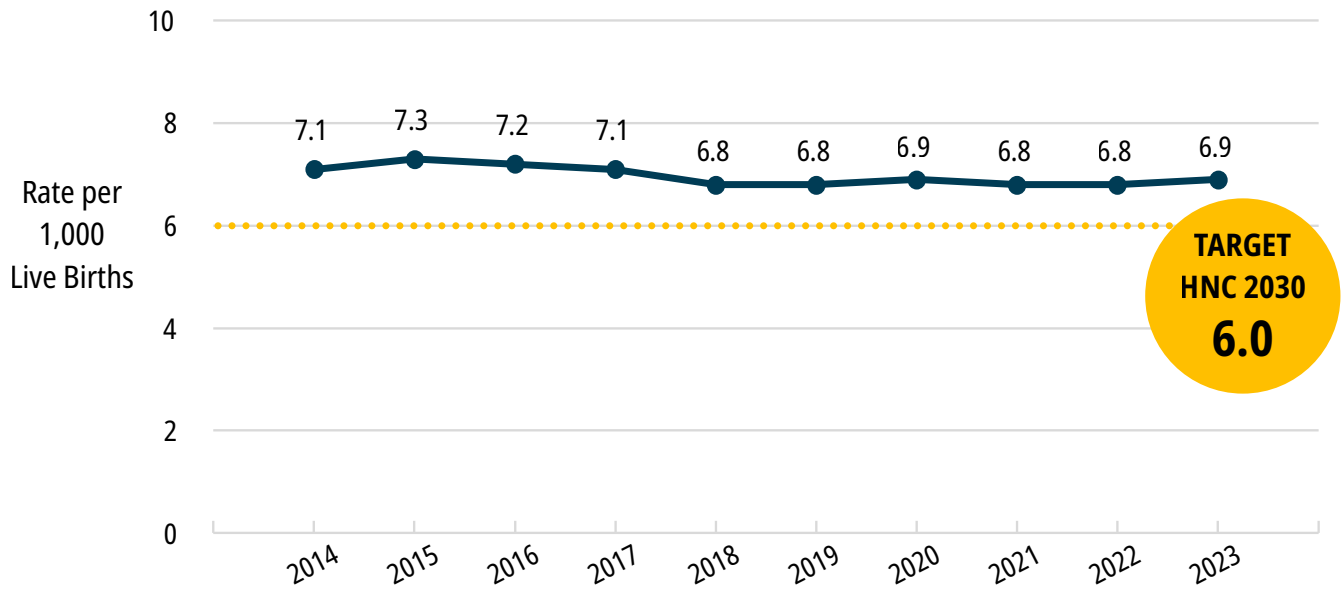
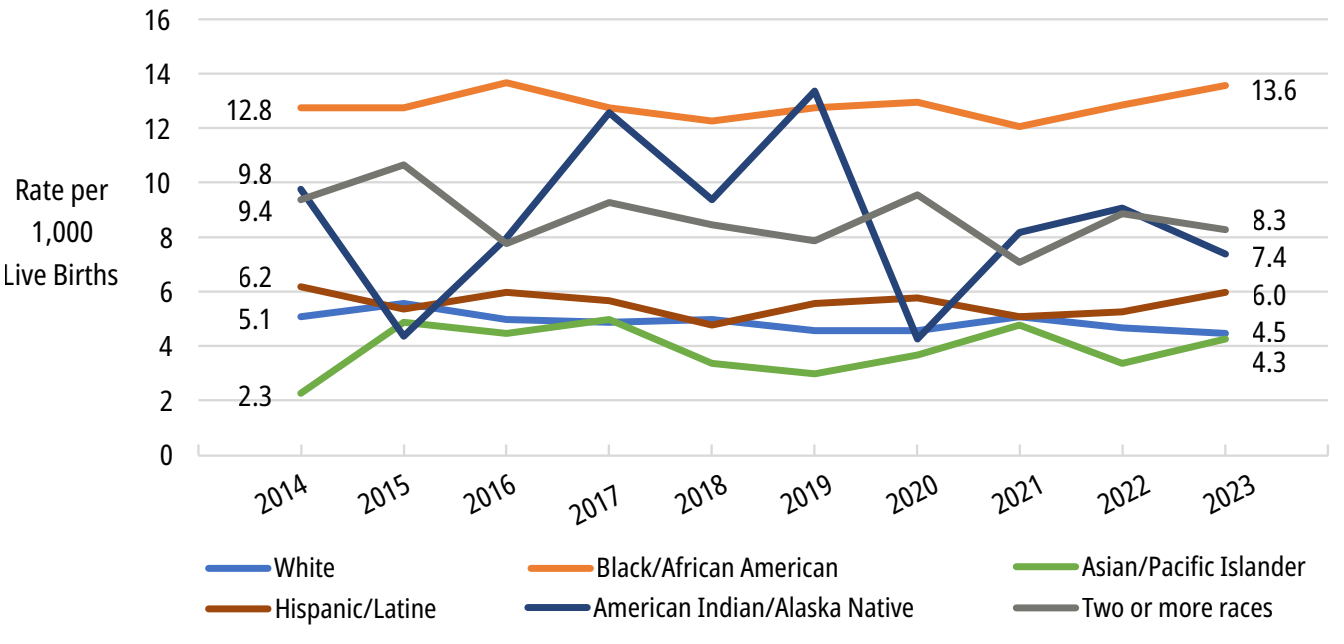


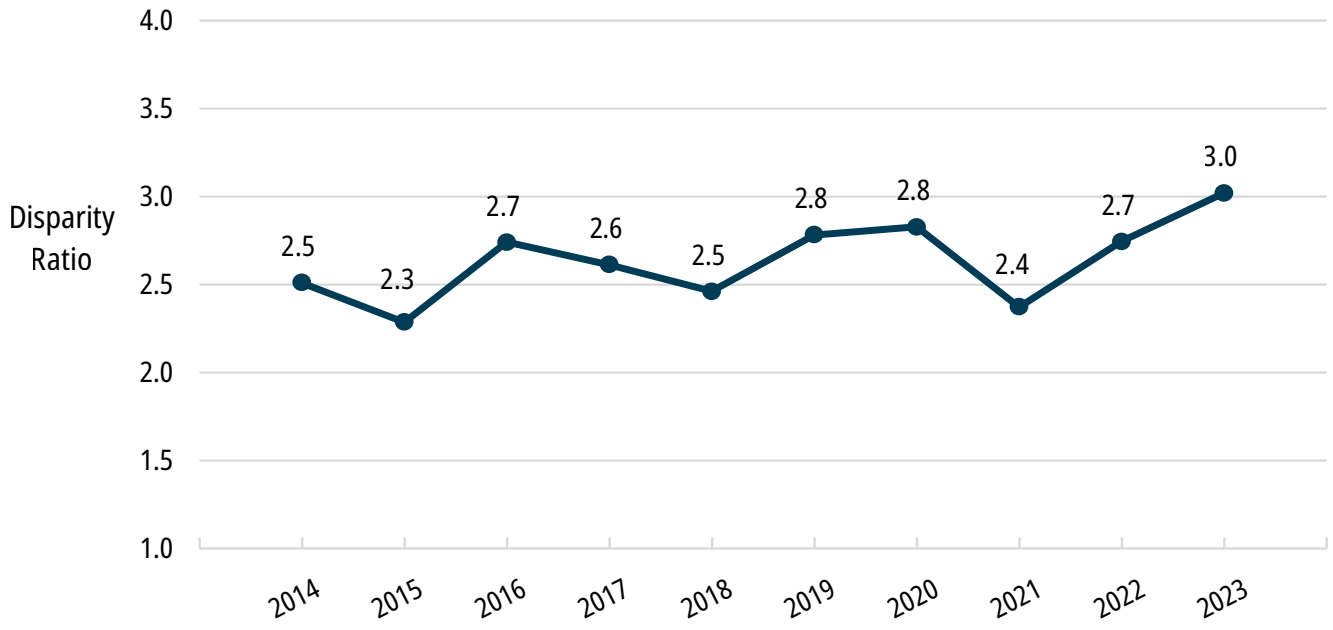
Figure 69. North Carolina Infant Mortality Rate by Race/Ethnicity and Year



Data Source: North Carolina State Center for Health Statistics, Vital Statistics

Infant Mortality

Figure 70. North Carolina Infant Mortality Disparity Ratio Between Black/African Americans and White/Caucasians by Year



Data Source: North Carolina State Center for Health Statistics, Vital Statistics

Life Expectancy

WHAT RESULT DO WE WANT?

All people in North Carolina have long and healthy lives.

WHAT DO WE MEASURE?

Average number of years of life remaining for people who have attained a given age (N.C. State Center for Health Statistics).*

North Carolina life expectancy data (total and gender) are available both annually and based on three-year rolling averages.

North Carolina life expectancy data (disaggregated by race/ethnicity) are available for three-year rolling averages only.

North Carolina county level life expectancy data are available for three-year rolling averages only.

HOW ARE WE DOING?

- The HNC 2030 target life expectancy is 82.0 years. North Carolina's 2023 life expectancy of 76.0 years falls six years below the HNC 2030 target.
- Since 2019, the state's three-year average for life expectancy declined across all races/ethnicities.
- Females continue to have a life expectancy that is about five years longer than males.

** Life Expectancy (LE) is the average number of additional years that someone at a given age would be expected to live if current mortality conditions remained constant throughout their lifetime. Numbers represent life expectancy at birth. Data from overlapping years should not be compared.*

PRIORITIES OF THE NC SHIP COMMUNITY COUNCIL (2024-2025)

– Life Expectancy Work Group –

Brain Health and Dementia Care

- Utilize inclusive formats to educate individuals, caregivers, and health care providers, including direct care and community health workers, about cognitive decline risk factors, including screening for potential hearing loss and evidence-based interventions to support brain health.
- Encourage effective screening and diagnostic assessment to identify early signs of cognitive decline risk factors and dementia to reduce risk, slow decline and manage symptoms.

Falls Prevention

- Foster partnerships with traditional and nontraditional agencies and organizations to advocate and increase awareness of shared risk and protective factors of falls.
- Promote the utilization of fall screenings, assessments, and appropriate interventions.
- Educate individuals, caregivers, and health care providers about falls and associated risk factors by providing consistent and quality falls prevention information and resources for providers across the continuum of care.

Radon

- Reduce exposure to radon including through increasing grant funds to eligible homeowners for mitigation, improving access to free radon test kits and education, and requiring public schools, licensed child and adult day care facilities, and long-term care facilities to test and mitigate for high levels of radon.

Life Expectancy

Figure 71. North Carolina Life Expectancy by Year

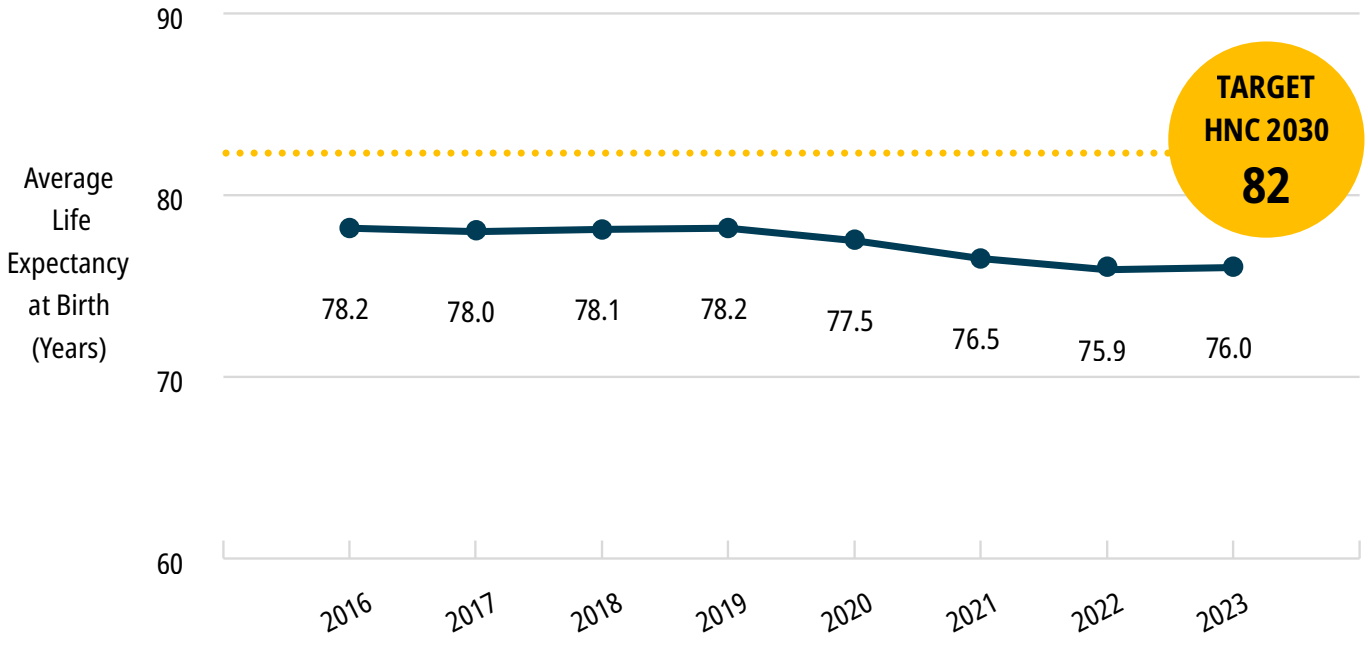
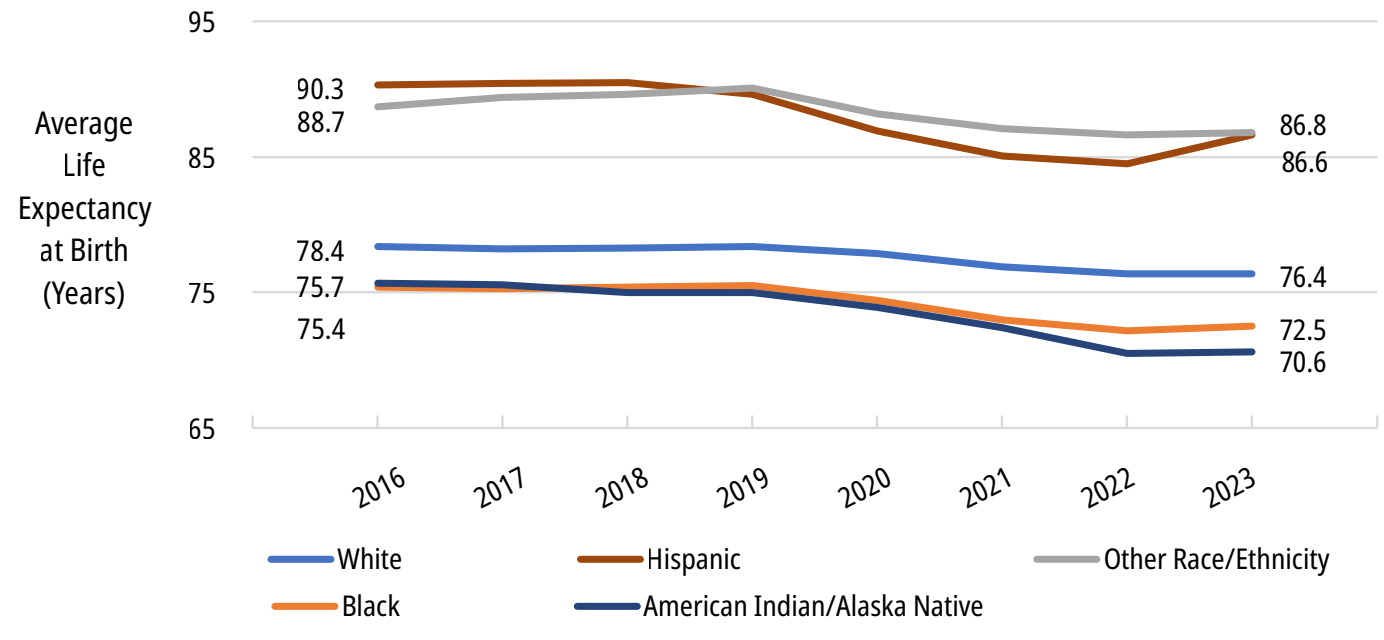


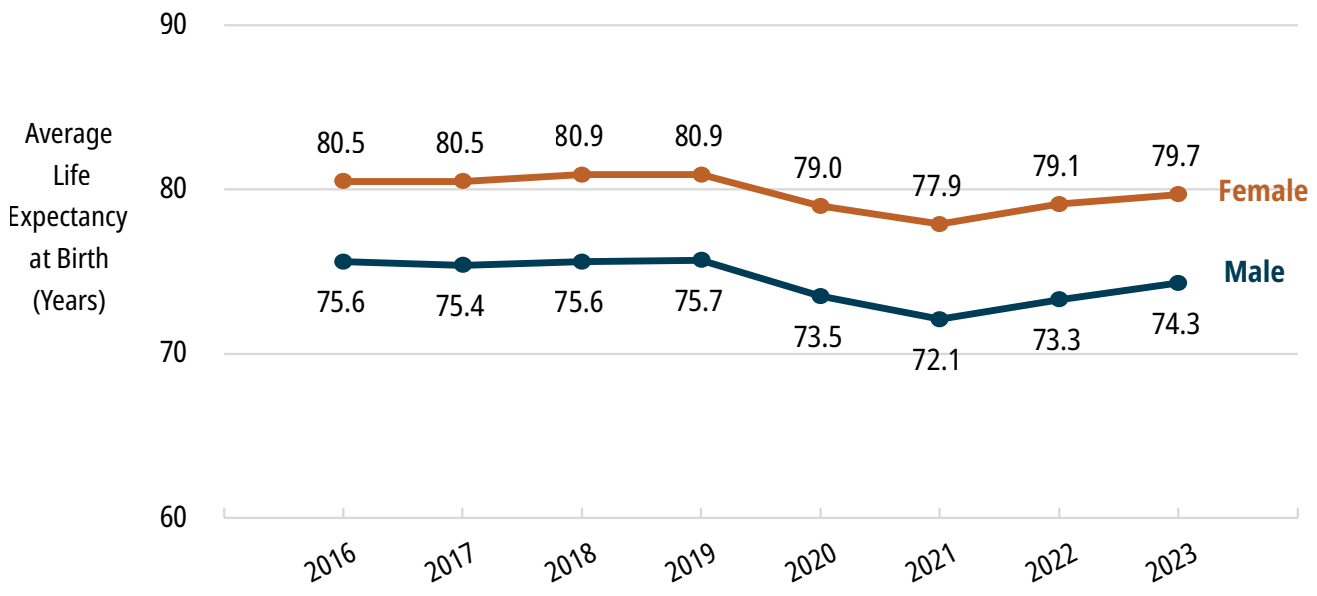
Figure 72. North Carolina Life Expectancy by Race/Ethnicity and Year



Data Source: North Carolina State Center for Health Statistics, Vital Statistics

Life Expectancy

Figure 73. North Carolina Life Expectancy by Gender and Year



Data Source: North Carolina State Center for Health Statistics, Vital Statistics

Durham County:
Bridging the Gap in Maternal Health Through Nurse Navigation

Durham County has taken a proactive step to improve maternal and child health outcomes by creating a **Nurse Navigator** position that bridges critical gaps in care for pregnant and postpartum women. This innovative role goes beyond traditional referrals — it provides **personalized education, compassionate support, and consistent follow-up** to ensure women receive the care they need when they need it most.

The Nurse Navigator connects women to vital community resources, including medical, behavioral health, and social support services. Just as importantly, she helps women understand the **importance of ongoing health maintenance** beyond the postpartum period — empowering them to manage fertility, chronic conditions, and overall wellness. Recognizing that many women lose contact with the health system after delivery, the Navigator also assists in establishing connections with **primary care providers**, ensuring continuity of care long after the baby's first birthday.

Mental health is a cornerstone of this approach. The Nurse Navigator prioritizes early identification and linkage to **culturally responsive mental health services**, particularly for women at higher risk for postpartum depression and anxiety. By meeting women "where they are" — in both readiness and understanding — the Navigator fosters trust, provides education in real time, and promotes self-advocacy in navigating the health care system.

This initiative is already making a measurable difference. Women report feeling **more supported, informed, and connected** to care during one of the most vulnerable times in their lives. Providers have seen improvements in appointment follow-through and early intervention for complications.

Ultimately, the Nurse Navigator program reflects Durham County's commitment to **building healthier futures for mothers, children, and families — one connection at a time.**

PRIMARY DATA

Ancillary Documents in the Appendix:

- LHD Regions 1-10: Resources for Birthing Families
- Key Informant Interview Guide
- Social Listening Military/Veteran Sources
- Social Listening Hispanic/Latine Sources

Social Listening: Military/Veteran Population

Background

Because traditional secondary data sources did not offer sufficient detail on military and veteran issues, we used social listening to conduct a review of media coverage from January 2024 through March 2025 (Appendix E). This review helped identify key themes, trends, and emerging concerns for this population.

Summary

North Carolina is one of the most militarily significant states in the nation — home to large installations like Fort Bragg and Camp Lejeune, a vibrant defense economy, with over 615,000 veterans residing within the state. The military sector generates over $66 billion annually and supports 11% of statewide employment. With approximately 20,000 service members transitioning to civilian life in North Carolina each year, the state benefits from a continuous infusion of skilled workers and veteran leadership. A comprehensive network of Veterans Administration (VA) medical centers and outpatient clinics helps meet the diverse health care needs of this population, underscoring the importance of integrated support systems that serve those who have served.

Syracuse University is home to the National Veterans Resource Center and the D'Aniello Institute for Veterans and Military Families. The institute hosts the Veterans Strategic Analysis & Research Tool (V-SMART), a data visualization platform that brings together veteran demographic, education, socioeconomic, and employment data in a user-friendly interface. It enables users to quickly explore geographic trends and make informed decisions about veteran programs and services.

V-SMART supports transitioning service members, veterans, and military families in making informed post-service choices, and provides corporations, foundations, nonprofits, and government agencies with data to guide initiatives that benefit veterans and their families (D'Aniello Institute for Veterans and Military Families).

FOUR THEMES EMERGED:

- Veteran Homelessness
- Environmental Health Concerns
- Health Care Access
- Workforce Development

Veteran Homelessness

Homelessness and housing insecurity remain significant challenges for North Carolina veterans. According to the 2024 Point-in-Time (PIT) Count, 688 veterans were experiencing homelessness, representing 5.9% of the state's total homeless population. This reflects an 11% decrease from 2023, when 777 veterans (7.9%) were counted (North Carolina Department of Military & Veterans Affairs [NCDMVA], 2024). While encouraging, this downward trend underscores the need for continued statewide efforts to address housing instability among veterans.

The PIT Count may underestimate the full scope of veteran homelessness, as some individuals do not report their living situation or experience housing insecurity without meeting HUD's definition of homelessness. Data from the 2023–2024 NCServes Annual Report highlight the ongoing demand for housing support: *Housing & Shelter* was the most commonly requested service category, accounting for 25,435 cases (30.3%) (Veterans Services of the Carolinas, 2024). Rising housing costs across North Carolina may further intensify future need.

Local initiatives are working to address these challenges. For example, the City of Raleigh launched the Addressing Crises through Outreach, Referrals, Networking, and Service (ACORNS) program in 2024 to connect veterans experiencing homelessness with housing and mental health services (City of Raleigh, 2024).

Environmental Health Concerns

The Honoring Our PACT Act, signed in 2024, expanded health care and benefits for veterans exposed to toxic substances during military service. As of 2024, approximately 74,000 North Carolina veterans had submitted PACT-related claims, and 45,000 had been approved (U.S. Department of Veterans Affairs, 2024).

Veterans in western North Carolina also experienced significant impacts from Hurricane Helene. Medically vulnerable veterans — including those with disabilities and chronic conditions — faced disruptions when local VA clinics closed or modified services due to power outages and building damage. Clinics shifted to emergency-only operations, diverting routine care to neighboring VA facilities (U.S. Department of Veterans Affairs, 2024). While intended to maintain continuity of care, many veterans struggled with accessibility during regional recovery efforts. The VA deployed clinical teams to local emergency shelters to support displaced veterans, while ongoing home-visiting and social support programs have assisted those rebuilding their homes and lives (Governor's Office of North Carolina, 2024).

Health Care Access

There is growing concern about the potential impacts of federal VA staffing reductions on service delivery in North Carolina. Staff losses at VA facilities in Asheville, Fayetteville, and Durham have raised questions about the long-term implications of budget cuts and future staffing constraints for veterans' access to timely and comprehensive care (U.S. Office of Personnel Management, 2024).

Workforce Development

Veteran workforce development is a rising priority for Governor Josh Stein and leaders in the North Carolina Department of Commerce and Department of Military & Veterans Affairs. Recent statewide roundtables emphasized veterans' economic contributions, the importance of translating military skills into civilian employment, and the role of NCWorks in providing veteran-centered career services (NCDMVA, 2024). These discussions highlight North Carolina's commitment to strengthening pathways to employment for transitioning service members and veterans.

Social Listening: Hispanic/Latine Population

Background

Because traditional secondary data sources did not provide enough detail on Hispanic/Latine issues, we used social listening to review media coverage from January 2024 through March 2025. This approach helped identify key themes, trends, and emerging concerns affecting this population.

Summary

Since we were not able to conduct focus groups or community listening sessions with the Hispanic/Latine population, we reviewed media sources from May 2020 through November 2024. We looked for recurring themes, trends, and emerging issues. Appendix F contains a detailed summary of the media sources reviewed.

FOUR THEMES EMERGED:

- Access to Health Care and Services
- COVID-19 Response
- Environmental Health Concerns
- Hurricane Helene and Long-Term Impacts

Access to Health Care and Services

Hispanic/Latine individuals in North Carolina face significant disparities in accessing health care. Adults and children in this population are more likely to be uninsured than their non-Hispanic peers and the national average. Lack of insurance limits choices and discourages the use of preventive services. Local health departments (LHDs) are the only safety net provider in all 100 counties. While Federally Qualified Health Centers (FQHCs) and free clinics provide essential support for uninsured individuals, many health care settings do not deliver culturally, linguistically, or socially responsive care that meets the diverse needs of Hispanic/Latine communities.

Medicaid expansion has improved access to care, and by July 2024 more than 45,000 Hispanic/Latine individuals had enrolled. Local enrollment navigators have been central to this progress by building trust, dispelling misinformation, and assisting with eligibility and enrollment.

Despite increased coverage, Hispanic/Latine individuals remain less likely to engage with the health care system. Many health care providers lack Spanish-speaking staff and do not offer culturally competent care, which can create confusion and discourage engagement — especially when navigating health insurance. Changes in immigration policy and national discourse about immigration and immigrant rights have also created fear and uncertainty. These concerns may deter individuals from seeking care, particularly from government-funded services, unless they are facing an emergency. These challenges contribute to delayed care, increased health risks, and higher costs over time.

Mental health access is also a growing concern. Community members report increasing anxiety, depression, and social stressors related to discrimination, isolation, economic hardship, and immigration-related fears. Barriers such as stigma, cost, lack of insurance, and a shortage of Spanish-speaking mental health providers make it difficult for Hispanic/Latine people to receive timely support. In response,

the North Carolina Farmworker Health Program is working with community partners to expand behavioral health services, particularly in areas with large migrant and seasonal farmworker populations.

COVID-19 Response

The COVID-19 pandemic disproportionately affected Hispanic/Latine communities in North Carolina but also demonstrated the effectiveness of culturally informed public health outreach. As of November 2021, 67% of Hispanic/Latine individuals ages 12 and older had been vaccinated — a rate 10 percentage points higher than the non-Hispanic population.

This success is credited to community-driven engagement, including the use of trusted ambassadors, local leaders, and bilingual community health workers who served as effective messengers. The state also provided direct compensation to grassroots organizations and community networks to support outreach and relationship-building, laying the groundwork for more inclusive partnerships between government agencies and Hispanic/Latine communities.

Environmental Health Concerns

Environmental exposures and occupational health risks continue to disproportionately affect Hispanic/Latine communities. Research from the University of Virginia found that ammonia levels were 35% higher in areas with significant Hispanic/Latine populations in eastern North Carolina, particularly near industrial hog operations. Many people in these communities are also employed by these facilities, compounding exposure risks and related health outcomes.

Agricultural worker — many of whom are Hispanic/Latine — face additional environmental and occupational hazards. In response, organizations such as El Futuro es Nuestro, the NC Environmental Justice Network, and the Farmworker Defense Fund advocate for stronger worker protections, especially given North Carolina's severe weather conditions, including extreme heat. These efforts include the "Not One More Life" campaign, launched after the death of Jose Arturo Gonzalez Mendoza, a farmworker from Nash County.

Hurricane Helene and Long-Term Impacts

The aftermath of Hurricane Helene in western North Carolina highlighted the vulnerability of Hispanic/Latine communities to natural disasters. An estimated 60,000 Hispanic/Latine individuals live in this region, many in high-risk flood zones or in housing especially susceptible to damage, such as mobile homes.

Although the hurricane affected the entire region, some Hispanic/Latine people were hesitant to seek recovery assistance due to concerns about immigration status and federal requirements (e.g., Social Security numbers for FEMA applications). Language barriers also created challenges throughout the response and recovery periods. In the absence of formal assistance, many people relied on faith communities, neighbors, and grassroots organizations for support. Hispanic/Latine construction workers also played a visible and essential role in local recovery efforts, using their skills to repair homes and rebuild community infrastructure.

Summary Statement

Hispanic/Latine people are an integral and growing part of North Carolina's population, yet they continue to face persistent barriers to health care access, mental health services, and environmental safety. While Medicaid expansion has improved coverage for tens of thousands of Hispanic/Latine individuals, challenges such as limited cultural and linguistic responsiveness in health care, fear stemming from immigration policy, and environmental exposures remain significant. Community-led strategies — especially those rooted in trusted relationships — have proven essential in promoting vaccine uptake, expanding Medicaid enrollment, and navigating disaster response. Continued investment in culturally tailored services, environmental justice, and inclusive disaster recovery is vital to advancing health outcomes for Hispanic/Latine communities across the state.

Key Informant Interviews:

Maternal Child Health Nurses and Social Workers

Community and Social Factors Affecting Maternal Health

Poverty, Food Insecurity, and Economic Stress

Respondents across regions described poverty and related economic pressures as fundamental barriers shaping maternal health. These pressures influence maternal nutrition, economic and social stability, and women's ability to prioritize care.

Persistent poverty. Respondents cited poverty as an underlying driver of poor maternal health. Respondents described it as deep and generational in many areas, shaping women's overall circumstances — from limited access to stable housing and healthy food to higher rates of chronic conditions that complicate pregnancy. In rural counties, limited employment opportunities further constrain economic stability, while in urban areas, rising costs of living have outpaced wages, leaving many families strained. Respondents emphasized that persistent poverty is a long-standing barrier that health services alone cannot resolve.

> "If you're lower income, you don't have access to transportation, you don't have paid leave to take time off for your visits, you don't have support to help with child care or other basic needs. You may not have anyone you can call on to help in a pinch. Or even steady access to food. All of those things affect [whether you can get the care you need.]"

Economic trade-offs. Poverty translates into difficult daily choices. Women often have to weigh the costs of housing, food, transportation, or medical care against one another. Respondents described women skipping prenatal appointments or medications because they couldn't afford gas, child care, or time off from hourly jobs. These pressures have become more acute as costs rise faster than wages.

Food insecurity. Families often struggle to afford or access healthy foods. Some counties are designated as food deserts with very few grocery stores, compelling families to rely on small convenience shops which typically lack fresh produce. Respondents said food insecurity directly affects maternal health through poor nutrition during pregnancy and reliance on stopgap supports. Families frequently turn to WIC for supplemental foods, but benefits are limited and do not cover all household needs. Many women also enroll only after the first trimester, missing an opportunity for early nutrition support. Families depend heavily on food pantries, church distributions, and similar programs, which provide critical short-term relief but are limited in frequency and availability, leaving many families without steady access to nutritious food.

Housing Instability and Cost

Housing was one of the most universally cited barriers to maternal health, with respondents across nearly all counties and regions pointing to high costs, poor-quality stock, storm damage, and the loss of supports that once helped families stay housed.

Rising housing costs in high-growth areas. Rapid population growth in coastal, metro, and some mountain communities has driven steep increases in rent and home prices, fueled in part by in-migration and outside investment. Families with low or moderate incomes are being priced out of traditional neighborhoods and pushed farther from services, lengthening trips to prenatal and postpartum care. Respondents emphasized that these pressures have worsened in recent years as rents rise faster

than wages, forcing many families into neighboring counties or temporary, unstable housing.

Homelessness and poor-quality housing in rural regions. In smaller rural counties, poverty combines with limited housing stock to leave families in precarious living situations. Some described rising homelessness, families doubling up in unsafe housing, or waiting lists for subsidized housing programs that stretch indefinitely. Storm damage has also reduced the supply of safe housing in both eastern and western parts of the state, from hurricane-related flooding in coastal counties to the destruction caused by Hurricane Helene in 2024 in the mountains.

Impact of program cuts. Several respondents emphasized the end of the Healthy Opportunities Pilots (HOP) in July 2025 as a major setback. Launched in 2022, HOP operated in selected eastern, southeastern, and western counties, providing Medicaid-funded support for essential needs such as housing deposits, repairs, furnishings, utilities, food, and transportation. Respondents said the program helped families stabilize their living situations and address barriers that directly affect health. When funding ended, needs remained, but the safety net disappeared, leaving health departments and care managers unable to fill the gap.

> "I think [social determinants of health] are buzzwords that people latch onto and say, "Oh, we really need to work on transportation."... But when it comes down to it, nobody is willing to pay. ... A great [example] is HOP, the Healthy Opportunities Pilot. It was going in North Carolina. They were showing, hey, by providing food to those who are experiencing food insecurity, there is a positive impact. And then it was written out of the budget. ... So, I think it's very easy to identify and say these are the issues that are impacting maternal health, but I don't see anybody who really wants to fund it."

Family and Social Stressors

Respondents emphasized that maternal health is shaped not only by poverty and housing but also by family and social conditions that create instability and stress.

Substance use and its ripple effects. Many respondents linked maternal health challenges to high rates of substance use in their communities — especially opioids and, increasingly, methamphetamines. They emphasized that substance use affects far more than individual health: it contributes to family instability, financial strain, and heightened stress during pregnancy and postpartum. Partners' substance use and related domestic conflict can exacerbate these pressures, sometimes leading to involvement with child protective services. Respondents said that fear of custody loss or judgment often discourages women from seeking help, compounding isolation and stress.

Domestic violence and partner conflict. A few respondents noted that women sometimes face violence or conflict in their relationships, which compounds stress during pregnancy and limits their ability to seek help. These risks were said to be especially visible in counties also struggling with poverty and substance use, where services for women in abusive situations are limited.

Fear of child protective services involvement. Respondents said that fear of child protective services looms large for many families, discouraging women from disclosing needs or accepting help. This fear extends to many situations, such as behavioral health struggles or housing instability, where women worry that seeking help could draw scrutiny from the agency.

> "A challenge is people understanding who you are and that you're here for them, that you're not there to judge them. A lot of times care management gets mixed up with Department of Social Services, and [thinking] that we're going to take their children."

Social isolation and lack of support networks. Respondents noted that some women lack strong family or community support, leaving them more vulnerable during pregnancy and postpartum. Without partners, extended family, or reliable community ties, mothers may struggle with child care, transportation, and emotional support, making it harder to engage with health services. These issues of social isolation may be especially pronounced in counties with large military installations, where the transience of the population limits opportunities to build and sustain local support networks.

Community Strengths & Partnerships

Respondents emphasized that health departments are not working in isolation. Families benefit from various community-based organizations and informal networks that supplement public health services. These partnerships provide material support, education, and trusted relationships that help families navigate pregnancy and postpartum challenges.

Faith-based and nonprofit supports. Churches, sororities and fraternities, local businesses, and nonprofits often step in to provide resources that health departments cannot. These supports include diaper banks, food pantries, baby supplies, transportation, and parenting education. Pregnancy resource centers also play a role, offering classes and distributing items such as car seats, formula, and Pack 'N Plays. Most of these programs operate on church or nonprofit funding rather than public dollars and are concentrated in urban areas where larger populations sustain them. In smaller or rural communities, support networks are often more informal — rooted in churches, civic groups, and personal relationships. Respondents described these local networks as vital but less consistent, relying on individual initiative and limited resources rather than formal funding or structure.

> "For a lot of …our communities, because we're so tight knit and we know everybody, our communities come together and they rally and they help. We've got two separate food banks here. We have [a church program]. Every Saturday, it's open. It doesn't matter who you are, you just come and get your groceries. And they have diapers and they have clothes and they have over-the-counter medication. They have so many things. So our local churches and our community "rally' together."

Community coalitions and networks. Formal coalitions and partnerships help align efforts across agencies. Respondents described coalitions that bring together hospitals, DSS, nonprofits, and schools to coordinate referrals, reduce duplication, and ensure families get connected to the right services. These partnerships are especially important in smaller counties, where no single agency has the resources to meet all needs.

Peer and group supports. In some counties, group prenatal care models such as CenteringPregnancy, as well as childbirth classes and support groups, provide education and emotional support. Respondents described these peer-based programs as valuable for reducing isolation and helping women build networks of support during pregnancy.

Factors Affecting Access to Maternal Health Care

Transportation Challenges

Transportation was raised by nearly all counties and consultants as a barrier to maternal health. Distance, geography, and cost make access to care difficult and unreliable, even when women ultimately find ways to reach appointments.

Long travel distances and geographic barriers. Respondents shared that in many rural and mountainous areas, women must drive long distances for prenatal care, childbirth facilities, or specialty services — sometimes traveling up to two hours on winding roads which can be especially hazardous in winter. Even within metropolitan counties, families in outlying areas often face long commutes or lack convenient transit routes connecting them to services.

Referrals far from home. Women with high-risk pregnancies are increasingly referred to tertiary hospitals for specialized services such as maternal-fetal medicine or neonatal intensive care. This occurs even in areas that still have delivery hospitals, as local providers become more cautious about managing complicated cases or lose the capacity to do so. While referrals facilitate access to advanced care, they often involve increased travel times, additional transportation and child care costs, and greater potential for fragmented care across multiple providers.

Medicaid transport. Respondents emphasized that Medicaid transportation is a critical resource for addressing transportation challenges. The program provides rides to medical appointments for eligible enrollees who have no other means of transportation, facilitating access to prenatal, postpartum, and other essential care. This service makes it possible for many women to obtain care they would otherwise have to forgo, particularly in rural areas where travel distances are long and public transit is limited.

Limitations of Medicaid transport. Despite its value, Medicaid transportation has practical limitations. Rides often must be scheduled several days in advance, making the service unsuitable for urgent visits. The service also poses challenges for mothers with young children: under traditional Medicaid, children generally could not accompany their mothers, and car seat requirements further restricted who could be transported. Some managed care plans now allow children to ride along and offer more flexible scheduling. However, differences across plans have also increased administrative complexity. Each plan operates its own transportation system with different vendors, rules, and procedures, requiring care managers to master multiple processes and devote considerable time to helping families arrange rides — time that could otherwise be spent on direct support.

> "It's particularly difficult with last-minute appointments, if they would need to be seen quickly, because a lot of the transportation providers through the Medicaid plans require at least 48 hours advance notice for a ride reservation."

Public transit and navigation barriers. Where public transportation exists, it does not always align well with families' needs. Rural areas often have no fixed-route service at all, while urban systems may not extend into outlying neighborhoods or may require long, multi-transfer trips. Even when routes are available, language barriers, low literacy, or complex scheduling can make them difficult to navigate for some patients. These issues particularly affect low-income and immigrant families who depend on public systems but often lack the time, flexibility, or support — such as child care or time off work — to manage lengthy or complicated trips.

Broader impacts on care. Transportation challenges compound other maternal obstacles such as child care, work schedules, and associated costs. Lengthy or unreliable travel can delay the start of prenatal care, lead to missed appointments, or discourage follow-up after delivery — factors that contribute to worse maternal health outcomes across the state.

Provider & System Capacity

Respondents consistently described provider shortages as a central barrier to maternal health. These shortages shape whether counties continue offering prenatal services themselves or shift to an assurance model in which hospitals or private providers deliver care.

Loss of delivery providers. Many communities have lost local obstetricians or delivery hospitals, forcing increased reliance on external providers. Hospital closures, staff retirements, and persistent challenges recruiting obstetricians to rural areas have accelerated this trend. Nurse consultants noted that younger providers are often reluctant to practice in small counties, and in some areas the number of births is too low to sustain a practice. Midwives remain limited in number and unevenly distributed across the state, particularly in rural areas. Respondents cited state supervision requirements, restrictive practice regulations, and hospital privileging policies as barriers to expanding the role of midwives. Moreover, some remaining providers do not accept Medicaid, thus further limiting access for low-income women.

> "One of the biggest challenges we have right now is the loss of providers and not having enough, so patients are waiting way too long to get appointments. Like, we have one patient right now that's going back to her home county, which is three hours away, for prenatal care, because it was going to take her two months to get an appointment here."

Limited availability of doulas. Several respondents noted that doula services are largely unavailable across much of the state. Even in some urban counties, respondents said there are few or no practicing doulas, and those who are available may not be covered by insurance or accessible to low-income families. Some health plans have begun reimbursing doula services, but respondents described the benefit as difficult to obtain because families must find their own providers and navigate complex plan requirements.

Reliance on assurance arrangements. North Carolina requires every county health department to either provide maternal health services directly or to "assure" that people have access to them. Assurance can include partnering with or contracting through another provider rather than offering services in-house. In many rural counties, assurance is used after repeated struggles to recruit or retain obstetricians or because birth volumes are too low to sustain a practice. In other counties, assurance is viewed as a way to connect families with hospital-based care that can offer a broader range of services than the health department alone. One respondent noted that a factor driving the shift to assurance was that more private practices began accepting Medicaid patients during the 2009–2010 economic downturn, leading to a reduction in the number of women served in health department clinics. Respondents said the model works well in those places where hospitals provide nearby care. However, in places where hospitals are more remote, health departments must often depend on external partners whose capacity and priorities are beyond their control. When those partners reduce services, reach capacity, or are located far from where women live, the health department has limited ability to intervene or fill the gap.

Limited local capacity for high-risk pregnancies. Respondents said the growing number of referrals for complicated pregnancies reflects deeper capacity constraints within local systems. Smaller hospitals are increasingly unable, or unwilling, to manage high-risk cases, leading to reliance on tertiary centers for maternal-fetal medicine and neonatal intensive care. This broader contraction of local capacity stems from maternity-unit closures and provider shortages. While referrals improve access to specialized care, they underscore the shrinking ability of local systems to manage high-risk pregnancies close to home.

> "We lost our high risk clinic here for maternity patients at the health department. And so that meant that a lot of people had to go to private practices. Patients that did not have Medicaid or a source of income were affected by that because they … couldn't afford the prices of going to a private clinic."

Uneven distribution of resources. Provider shortages are a statewide issue. Urban centers have more clinicians than rural areas, but demand still outpaces supply, leading to long wait times even in well-resourced counties. However, rural areas continue to experience the greatest deficits, in some cases with no local providers, and respondents said this disparity is widening as more clinicians cluster in metro areas as rural capacity declines.

Insurance Coverage

Respondents consistently described health insurance as one of the most important determinants of maternal health in North Carolina. Medicaid is the primary coverage source for low-income pregnant and postpartum women, and several recent policy changes have expanded its reach. These expansions have brought important gains, yet gaps and barriers to access and affordability remain.

Coverage and Services Available

Medicaid eligibility during pregnancy. Most low-income pregnant women in North Carolina qualify for Medicaid, which provides eligibility at higher income levels during pregnancy than for non-pregnant adults. A key feature is presumptive eligibility: local health departments (LHDs) and hospitals can grant immediate, temporary coverage so that prenatal care can begin while a full application is being processed. This ensures that women who will ultimately qualify can start care right away rather than waiting weeks. Respondents also emphasized the importance of presumptive eligibility for immigrant women who do not qualify for full Medicaid, because it allows them to receive a limited amount of prenatal care — typically an initial visit and some follow-up services — even if they cannot remain enrolled long term.

Postpartum extension. Effective April 2022, North Carolina extended Medicaid postpartum coverage from 60 days to 12 months. Respondents described this change as a critical improvement, ensuring that women continue to receive medical, behavioral health, and family planning services during a period when many complications and maternal deaths can occur.

Impact of Medicaid expansion. In December 2023, North Carolina expanded Medicaid to all low-income adults. Respondents highlighted its value for women's health not just during pregnancy but before conception. Continuous coverage allows earlier detection and management of conditions such as hypertension or diabetes, improving outcomes once women become pregnant. Expansion also reduces gaps in coverage between pregnancies, creating more stability across the reproductive years. At the same time, respondents emphasized that coverage alone does not guarantee access — some newly eligible adults remain unaware of their eligibility, and provider participation is still uneven, particularly for mental health and specialty services. Several respondents also expressed concern about future policy changes and funding stability. They noted that ongoing debates at the state level could alter how expansion is implemented or maintained, creating uncertainty about whether these recent gains will be sustained.

"There are pending policy changes that we're concerned about... [regarding] Medicaid expansion. We don't yet know how that's going to affect people receiving Medicaid and getting the care that they need."

Care management. Medicaid funds the Care Management for High-Risk Pregnancies (CMHRP) program, a statewide Medicaid care management program delivered by registered nurses and social workers through local health departments. The program is available at no cost to Medicaid-enrolled pregnant women in North Carolina. The program is available at no cost to Medicaid-enrolled pregnant women in North Carolina. Women are eligible if they are enrolled in Medicaid and identified as high-risk through a standardized screening tool used by prenatal care providers. Qualifying factors can include chronic health conditions (such as hypertension or diabetes), behavioral health concerns, history of preterm birth, multifetal pregnancies, substance use, late entry into care, or unsafe living environments. A limited number of uninsured women may also be enrolled when capacity allows.

Care managers provide one-on-one support — coordinating appointments, offering health education, and linking families to resources for food, housing, and behavioral health services. Respondents consistently praised these services as invaluable for helping women navigate a complex health system and address needs that extend beyond medical care. They emphasized that in-person, ongoing relationships are central to the program's effectiveness. For many women without family support, their care manager may be the one consistent person they can rely on, and this trust was described as key to improving outcomes.

"[The care manager] doing those regular in-person visits makes a huge difference in the birth outcomes. A lot of the members that we see, they don't have family support and they just feel like we're the one person they can truly rely on and trust."

Exclusion of undocumented women. Respondents stressed that immigrant women without eligible status remain excluded from full Medicaid coverage. While presumptive eligibility may allow an initial visit and limited follow-up, most prenatal and postpartum care remains out of reach. Undocumented women often depend on charity clinics or other safety-net services. Even for documented immigrant families, language barriers, confusion about eligibility, and fear of sharing personal information can delay enrollment and limit access to needed services.

Financial strain despite coverage. Even insured women face significant out-of-pocket costs to access care. Co-pays for visits, prescription expenses, and uncovered services — such as certain tests, procedures, or postpartum supports — can still pose barriers to receiving recommended care. Too often, families must weigh these expenses against essentials like rent, utilities, and food, and respondents said such trade-offs sometimes lead women to delay or skip appointments, forego medications, or avoid follow-up after delivery.

Provider participation and limitations. Coverage does not always equal access. Some providers only accept certain Medicaid plans, while others decline to serve high-risk pregnancies or limit the number of Medicaid patients they see. Respondents said this can force women to switch providers mid-pregnancy or travel long distances for care, disrupting continuity and eroding trust in the system.

Coverage awareness and administrative complexity. Families often struggle to understand what is included in their coverage or which providers participate in their plan. Respondents said this leads to missed services, unexpected bills, and stress. Some care managers also reported that families remain unaware of recent coverage expansions or how to enroll, particularly those without internet access or English proficiency.

Medicaid Transformation

North Carolina implemented Medicaid Transformation in July 2021, shifting most beneficiaries from fee-for-service to managed care plans administered by private insurance companies. Five commercial plans now operate statewide. In July 2024, the state also launched separate tailored plans to serve individuals with behavioral health or intellectual and developmental disability needs. Local health departments continue providing CMHRP, while health plans employ their own case managers, creating both new opportunities for coordination and added layers of complexity.

Added supports under managed care. Respondents said managed care has expanded some supports for families — such as more flexible transportation policies and plan-based case managers who can help coordinate care and connect families to needed services. When collaboration works well, these additional touchpoints strengthen engagement and reduce missed appointments.

Coordination challenges. In many counties, however, overlapping responsibilities between CMHRP and plan case managers have led to confusion for families and fragmented follow-up. The complexity of multiple care-management systems contributes to duplication and gaps in communication. Several care managers also reported that navigating multiple systems and plan-specific requirements consumes significant time, diverting attention from direct support to families.

Importance of local, in-person relationships. Nearly all respondents emphasized that telephonic case management cannot replace the community-based connections that local care managers provide. In-person engagement allows care managers to build trust, understand local resources, and identify social or behavioral health needs that families might not disclose otherwise.

> "I would like to see care management remain in the communities versus an insurance company taking it over. Telephonic care management when needed is great, but we really need care managers in the community who can see members face-to-face, who understand the resources that are available, the resources that are not available."

Health-plan incentives and value-added benefits. Respondents described a range of incentives and supplemental benefits offered through Medicaid managed care plans. These include gift cards, Pack 'N Plays, and other baby items for completing prenatal or postpartum visits, as well as "value-added" benefits such as gym memberships and doula support. Several respondents said these benefits help families with limited resources and encourage attendance at key appointments. Respondents said availability varies by plan and region but is often viewed as a meaningful way to meet basic needs.

> "'[With Medicaid transformation], I think the patient gets lost in all the bureaucracy of it all. [Before], it was less complicated, because Medicaid paid for services directly. And as care managers, all we had to do was just understand the Medicaid policy.... Now, you've got five different health plans involved. So if you're having a struggle getting something covered or making sure the patient has access to a particular service that should be covered, you've got to try to navigate that health plan. ... So everything is just not as simple because there's more room for misinterpretation and more people involved to say, 'No, that's not covered.'"

Variation in hospital plan acceptance. Respondents said that not all hospitals accept every Medicaid managed care plan, creating barriers for women who rely on specific plans for maternity care. In counties with only one delivery hospital, this can leave women with no local option that aligns with their insurance. When hospitals or health systems choose not to contract with certain plans, women may have to travel long distances or give birth outside their established provider network, disrupting continuity of care and delaying access to services.

Concentration of provider networks. Respondents also expressed concern that provider networks under the Medicaid managed care plans are concentrated in urban areas, leaving rural counties with fewer participating providers and less capacity for coordination.

Uncertain impacts. Respondents said it is too soon to fully assess the long-term effects of Medicaid Transformation. Some respondents expressed optimism that additional resources and flexibility could ultimately strengthen maternal health care. Others worried that Medicaid Transformation's shift in responsibilities to health plans could erode the role of health departments, create inequities between counties, and destabilize programs like CMHRP.

Language, Cultural, and Immigration Factors

Respondents described language access and cultural differences as persistent barriers to care for immigrant and minority populations. These barriers often intersect with health care coverage exclusions, challenges, and mistrust, compounding the difficulty of accessing consistent maternal health services. Language access and interpretation. Spanish is the primary language need beyond English for families served by local health departments, and most departments are well equipped to meet it. Many have bilingual staff or in-house interpreters who provide consistent support for Spanish-speaking clients. For languages other than Spanish, health departments often rely on phone- or tablet-based interpretation systems, which respondents said are useful but can feel impersonal during clinical visits. Language barriers become even more challenging after referral to specialty services, since many outside providers have fewer interpreter resources, leaving families to rely on relatives or health department staff to bridge communication barriers.

Cultural responsiveness and inclusion. Respondents said that while cultural differences can sometimes pose challenges in maternal health services, health departments make strong efforts to address them. Most departments have bilingual or bicultural staff and work to ensure that care is respectful of families' beliefs and practices. Several respondents highlighted examples of culturally responsive practices, such as employing a community outreach worker to help care managers better understand the expectations of Haitian families. Even so, families from immigrant or minority communities at times feel misunderstood or judged, which can lead them to disengage from services. One respondent noted that ongoing attention to cultural humility and representation in staffing remains important for building trust and sustaining engagement.

> "I think that the health departments have really been dedicated to making sure that they serve clients in as culturally appropriate a way as they are capable of doing. So, I applaud our rural health departments for doing what they do."

Availability of written materials. Most health departments provide written materials in both English and Spanish, but materials in other languages are less common. Health departments that serve multiple immigrant or refugee groups said it is difficult to keep information current across the range of languages spoken in their communities. Even when translations are available, respondents noted that some materials are overly technical or not adapted to local context or literacy levels, limiting their usefulness for families with different educational backgrounds or health beliefs.

Immigration enforcement fears. Respondents said concerns about immigration enforcement have made some immigrant families — particularly those who are undocumented — more hesitant to engage with public health services. Some health departments have not yet seen a clear decline in participation, while others reported an increase in missed appointments or greater reluctance to come in for care. Fear of entering government buildings or sharing personal information has led some women to delay or avoid prenatal or home-visiting services. In response, staff are emphasizing education and reassurance — explaining that services are available regardless of immigration status, clarifying what information is collected and why, and stressing confidentiality. One department is also taking services out into the community, using a mobile unit and partnering with trusted organizations — such as local food pantries — to offer classes and screenings in familiar settings where families feel comfortable receiving care.

> "With our Haitian Creole and Spanish-speaking immigrants, it is challenging getting them in the building in this climate that we're in politically. We have seen a decline in those populations coming to receive services, or just a lot more hesitation."

Community Perceptions of Public Health Services

Respondents described how community perceptions and social attitudes can shape whether families seek out or avoid public health programs. These dynamics sometimes limit engagement even when services are available.

Pandemic-related trust shifts. Several respondents reported that the COVID-19 pandemic affected public trust in health departments. In some communities, health departments were closely associated with the implementation of public health mitigation strategies, including mask requirements and vaccination campaigns. Respondents noted that, in certain areas, this association contributed to lingering hesitancy or reduced engagement with public health services. less willing to engage with public health services. One respondent noted, however, that their department had regained considerable trust after Hurricane Helene through its active role in recovery efforts.

Preferences of younger mothers. Respondents noted that younger mothers increasingly rely on online information and social media for health guidance, shaping how they seek and engage with services. This shift toward digital communication and preference for flexible or virtual options may reduce participation in in-person postpartum visits or public health programs. Respondents also highlighted the spread of misinformation on social media as a growing barrier to effective engagement.

> "'Pre-pandemic, I would have 17-,18- and 19-year-old moms that just delivered that would be ringing my phone off the hook, needing visits. And those are some of the ones that really need the education that I provide. And I call them up now and they're like, 'Nope, I don't need that.'"

Perceptions and awareness of public care. Many families have limited awareness of the range of services local health departments provide, especially beyond prenatal care. In one urban county, respondents said families also view health department services as lower quality than those offered in hospitals or private clinics. Both misperceptions and lack of awareness can prevent eligible women from accessing public health services.

Health Department Capacity

Local health departments remain the backbone of maternal health infrastructure across North Carolina, yet respondents said they operate under increasing strain. Counties vary in how they organize and deliver services, but most face similar staffing, funding, and system-level pressures.

Staffing

Staff shortages and turnover. Health departments across the state struggle to recruit and retain qualified staff — particularly nurses, social workers, and pregnancy care managers. Obstetricians are especially difficult to hire in rural areas, where salaries are lower and professional isolation greater. Vacancies that last for months leave remaining staff stretched thin, reducing both the number of families served and the intensity of support provided.

Community-rooted staff and cohesive teams. Many departments benefit from long-serving employees who are locally known and trusted. Their personal relationships help families feel comfortable engaging with care, especially in small counties where informal networks matter as much as formal systems. Several respondents said that close-knit, stable teams also help maintain morale and continuity despite limited resources.

> "You get to know the people, and people know you. Sometimes I'm driving through the streets, I'll hear somebody yell [my name], and they're waving. You know what I mean? You make an impression when you're local."

Qualification changes for care managers. The state's recent decision to lower educational requirements for pregnancy care managers has helped some counties fill vacancies. However, several respondents expressed concern that the change weakens case management skills that are vital for effectively serving high-risk populations.

Funding and Resources

Inadequate and stagnant budgets. Several respondents said that health department budgets cover only the most basic services, leaving little capacity for innovation, staff development, or program expansion, and limiting the ability to offer competitive salaries. Furthermore, funding has not kept pace with rising costs — for example, the per-month rate for care management has remained unchanged since 2011.

Variation in local support. Some county boards of commissioners actively champion maternal and child health, while others provide minimal attention or funding. This variability contributes to unequal capacity and resources across counties.

Instability of grant support. Many departments rely on categorical or short-term grants to sustain maternal health programs and staff positions. This reliance creates cycles of expansion and contraction, as programs grow during grant periods but must scale back or end when funding ends. These shifts disrupt services for families and eliminate positions for experienced staff whose roles depend on temporary funding.

> "This grant is supposed to address X, Y and Z. We might have it for five years and let's say it's up and running. It's doing great. But the grant is only for five years, so once it's over, then what? I think that's where we have kind of done a bad job towards the community because it has built distrust. Because it's like, 'Hey, you keep promising us these things and you keep coming in our community offering these great services. But two years later, that program is completely gone.'"

Trust and Public Perception

Lingering distrust of public health. Distrust not only acts as a barrier to care but also poses a challenge for health departments. The pandemic-related trust shifts left some families viewing health departments as punitive or political actors rather than service providers. This reputation has made outreach and engagement more difficult, particularly in rural and conservative counties, and has contributed to burnout among staff who feel their efforts are undervalued or misunderstood.

Rebuilding trust. Respondents said that trust can be rebuilt through direct relationships and visible engagement in the community. Familiar, long-serving staff who are known locally can overcome skepticism through steady, personal connection. Families' trust in their care managers often extends to other providers, since care managers are located on site and serve as consistent, trusted points of contact. Several respondents said that these long-term relationships — sometimes spanning multiple pregnancies — help families feel understood and supported even when other systems feel impersonal. Respondents from one county said trust improved after Hurricane Helene, when people saw the central role the health department played in recovery efforts.

Care Management and Postpartum Support

Care management. Health departments' CMHRP teams were consistently described as a major strength. Care managers are embedded in the community and work across clinical and social domains. Respondents emphasized that in-person, ongoing relationships with care managers help families feel supported and improve birth outcomes. The program was often described as one of the most effective tools local health departments have for promoting maternal health.

Postpartum support. Postpartum support is another key service provided by health departments to support women after birth. Through check-ins and home visits, staff help identify emerging concerns such as depression, hypertension, or family stressors and connect women with appropriate care. In most counties, this work is carried out through CMHRP care managers, but limited staffing and high caseloads make it difficult to reach all women or provide multiple contacts. Some counties have expanded their postpartum outreach by adding nurse-navigator or care-management roles focused specifically on follow-up for behavioral health and other postpartum concerns. One county reported using grant funding to support dedicated staff for home visits, allowing them to reach more women after delivery than would otherwise be possible.

Partnerships and Collaboration

Cross-sector partnerships. Collaboration with hospitals, local departments of social services (DSS), private practices, and behavioral-health providers helps coordinate referrals, fill service gaps, and maintain continuity of care. Counties often collaborate with nearby universities to expand clinical, mental health, and research capacity.

Variation in partnership strength. Larger health departments often have formal referral networks and shared records, while smaller counties rely on personal relationships and informal communication. Despite these differences, respondents consistently described partnerships as essential for sustaining maternal health services amid limited resources.

Behavioral Health

Respondents emphasized that behavioral health is a critical but under-resourced dimension of maternal health. Needs are diverse, ranging from common postpartum mental health concerns to severe substance use disorders.

Behavioral Health Needs

Perinatal depression and anxiety. Depression and anxiety during pregnancy and postpartum were described as widespread. While many health departments screen for depression, most do not provide ongoing treatment. Women are typically referred to external counseling or therapy, but availability is limited — especially in rural counties where there are few or no local mental health providers. Urban counties also reported challenges: Even where providers are more numerous, wait times are long and many practices do not accept Medicaid or uninsured patients. Long wait times and lack of specialized perinatal services mean many women go without timely care.

Serious mental illness. A smaller but important group of women experience conditions such as bipolar disorder, schizophrenia, or severe anxiety that require psychiatric management. Health departments generally lack in-house capacity to serve these women, and rely on referrals to community mental health centers or tailored Medicaid plans. This leads to gaps in medication management and follow-up.

Substance use. Respondents identified substance use — particularly opioids and methamphetamines — as one of the most pressing behavioral health concerns affecting maternal health. Several noted that while opioid misuse remains widespread, methamphetamine use appears to be increasing, a pattern consistent with broader statewide data. In addition, one respondent observed a growing normalization of marijuana or THC use, particularly among younger populations, with limited awareness of potential risks during pregnancy. Access to medications for opioid use disorder (MOUD) for pregnant and postpartum women is limited, especially in rural counties, and many must travel long distances for care or go without treatment because few programs accept pregnant clients.

Factors Affecting Behavioral Health Care

Stigma and barriers to disclosure. Across all types of behavioral health needs, stigma was described as a major obstacle to behavioral health care. Women feared being judged, losing custody of their children, or being reported to DSS. Respondents said this discourages disclosure, even when screenings indicate a need for further support.

Role of care managers. Pregnancy care managers often serve as the first point of identification for behavioral health needs. Their ongoing relationships allow them to recognize depression, anxiety, or substance use and encourage disclosure. They make referrals to specialty services, but their effectiveness depends on whether those services exist and are accessible. Respondents stressed that in counties with few providers, care managers have limited options to connect women with the help they need.

> "We do a lot of screenings for mental health concerns, particularly depression and anxiety... I think that has helped get a lot of people help who may not have otherwise known that they needed that help or that that help was available."

Availability and adequacy of services. Respondents consistently described behavioral health services for pregnant and postpartum women as limited and difficult to access. Even where community providers or programs exist, many are unable or unwilling to treat pregnant women, and few have expertise in perinatal mental health. Others limit eligibility based on diagnosis, insurance, or pregnancy status, further

constraining access. A few respondents mentioned the state's NC MATTERS program — which provides consultation and referral support to clinicians caring for patients with perinatal mental-health needs — as a valuable resource, but emphasized that it does not substitute for local treatment capacity.

> "Access to mental health care is almost non-existent out in the far west. That's been a big issue... And that's one thing that our care managers can help assist with. If they have to go out of county or out of state, we can help arrange transportation to get them to and from."

Tailored Medicaid plans. Respondents in one health department commented that most of their clients with behavioral health issues who qualify for Medicaid are in a tailored Medicaid plan serving members with serious mental health, substance use, or developmental conditions. These plans have their own care management team, and the respondents felt that they provide relatively robust services in connecting members with mental health or substance abuse services.

Emerging health department responses. While most health departments do not provide behavioral health treatment directly, several offer limited counseling or short-term support services and refer clients elsewhere for ongoing therapy or medication management. One county reported prioritizing behavioral health and hiring staff to address these needs more directly, though this position depends on short-term grant funding. Some larger counties are exploring integrated or co-located behavioral health staff within maternal health programs to improve access and reduce stigma. Respondents said these efforts are still uncommon, and most health departments continue to rely on external providers, leaving significant gaps in availability.

Disparities

Respondents said disparities are evident across multiple dimensions of maternal health in North Carolina. They most often highlighted racial and ethnic inequities, but also pointed to geographic, economic, and immigration-related differences that shape women's access to care and health outcomes.

Racial and ethnic inequities. Black women were most often identified as experiencing the greatest burden of poor outcomes, including higher rates of preterm birth, infant mortality, and pregnancy complications. Respondents emphasized that these gaps persist even when income and education are similar, reflecting the cumulative effects of racism, chronic stress, and differential treatment within health care. Racial disparities are evident in both rural and urban settings and remain a central challenge for improving maternal health statewide.

Geographic and economic inequities. Access to care varies sharply by location and income. Rural areas face shortages of providers and delivery hospitals, while urban areas contend with long wait times and affordability pressures. Notably, even health departments that include urban or suburban centers often have outlying areas that lack providers and transportation. Low-income women across settings encounter persistent obstacles related to cost, transportation, and child care — even when insured through Medicaid. Respondents described these geographic and economic divides as reinforcing one another: Families with fewer financial resources are often those who must travel the farthest or navigate the most fragmented systems to obtain care.

Immigration-related inequities. Immigrant women — particularly those who are undocumented — face overlapping barriers of language, cultural differences, and restricted eligibility for insurance coverage. Limited interpreter availability and fear of immigration enforcement further discourage engagement with care.

Respondents said these challenges affect both rural and urban communities, where growing immigrant populations often outpace available bilingual staff and culturally responsive services.

Intersecting vulnerabilities. Respondents emphasized that these disparities rarely occur in isolation. Women who are simultaneously affected by racial inequities, geographic isolation, and economic hardship face the greatest challenges in accessing care and achieving healthy outcomes. Many noted that health department programs mitigate some barriers but cannot fully overcome the structural inequities that underlie them.

Recommendations from Respondents

Respondents offered ideas for strengthening maternal health in North Carolina, reflecting both immediate operational needs and broader system changes. These suggestions highlight areas that county and state partners may wish to explore further; they do not represent an exhaustive or consensus set of recommendations. Continued analysis and stakeholder input will be needed to develop a comprehensive action plan informed by these findings.

Strengthen System Capacity and Stability

Invest in the workforce. Respondents emphasized improving recruitment and retention of obstetric, nursing, and social work staff through competitive salaries, loan repayment, and incentives for rural service. One consultant also expressed concern that recent reductions in qualification requirements for pregnancy care managers could affect case-management skills and recommended restoring higher standards for that role. Others underscored the need to expand training pipelines for behavioral-health and bilingual staff.

Stabilize funding. Participants recommended establishing longer-term, predictable funding streams to reduce staff turnover and service interruptions caused by short-term grants. They also suggested updating the per-member, per-month rate for care management, which has remained unchanged for more than a decade.

Expand Access and Continuity of Care

Address rural service gaps. Respondents recommended incentives for providers to practice in underserved counties, expansion of telehealth where feasible, and stronger support for overcoming transportation and mobility barriers. Other respondents proposed the development of regional approaches to share provider networks and specialty services.

Enhance insurance coverage. Participants emphasized maintaining recent gains from Medicaid expansion and postpartum extension and exploring ways to improve continuity of care for immigrant women who are currently ineligible for full coverage — such as extending presumptive eligibility or strengthening safety-net supports.

Expand access to doula services. Several respondents expressed interest in expanding access to doula support as a way to improve women's experiences during pregnancy, delivery, and postpartum care. One respondent suggested that state or grant funding could help establish community-based doula programs and raise awareness among both families and hospital systems about the value of doula care.

Advancing Community Engagement

Increase cultural and language support. Respondents urged greater investment in interpreters, translated materials, and culturally responsive care to better serve immigrant and minority populations. In one county, participants also noted that increasing staff diversity and improving the health department's community presence could help strengthen trust among underrepresented groups.

Deepen partnerships and local engagement. Some respondents emphasized expanding coalitions and collaborations with trusted community organizations — such as churches, sororities, and nonprofits — to extend the reach of maternal health programs and build trust with families who may be hesitant to engage with public health systems.

Taken together, these recommendations point to the need for sustained investment in the maternal health workforce, reliable program funding, and equitable access to care across all communities. They also underscore the importance of community-rooted approaches that rebuild trust and extend the reach of maternal health services beyond traditional systems.

Structured Web Search: Resource for Birthing Families

Background

This section describes the process used to collect and analyze primary data on maternal and infant health (MIH) resources in all North Carolina counties. Prior to the initiation of the NC SHA process, stakeholders identified limited public awareness of available (MIH) as an ongoing concern. Given that many individuals rely on social media and online sources for health information, the SHA team worked with maternal health staff in local health departments to confirm the accuracy and availability of identified resources.

The goal of this effort was to create a comprehensive, up-to-date inventory of publicly available services that support birthing families from pregnancy through the postpartum period. A transparent, systematic, and consistent approach was essential to accurately identify resource gaps and guide public health planning.

Findings from many local health department community health assessments show that community members are often unaware of available resources in their own area. Developing a centralized database of MIH services is an important first step toward improving visibility, maintaining accurate information, and promoting web-based resources for birthing families.

Appendix B provides a detailed summary of MIH resources by local health department region.

Search Criteria and Approach

To guide the data collection process, the following criteria and parameters were established:

Geographic Scope

All 100 counties in North Carolina were included.

Focus Areas

Services related to maternity and postpartum care were prioritized, including but not limited to:

- Breastfeeding and lactation support
- WIC programs
- Medicaid enrollment offices
- Doulas and perinatal support providers
- Transportation services for medical care
- Parenting education and family support resources

Sources Consulted

Information was gathered from:

- Official state and county government websites
- Local health departments
- Nonprofit and community-based organizations
- Faith-based service providers
- Verified online community directories

Inclusion Criteria

Services were included if they were:

- Currently active and publicly accessible
- Clearly relevant to maternity, infant, or family health

Exclusion Criteria

Services were excluded if they:

- Were duplicative
- Lacked public contact information
- Appeared inactive or outdated
- Did not directly serve the target population

Data Collection Timeframe

Data were collected from **February through June 2025,** with all final entries completed by **June 30, 2025.**

Limitations

While significant effort was made to ensure the completeness and accuracy of the inventory, several limitations should be noted

- **Availability of Information:** Some counties had outdated websites or limited online presence, which may have affected the comprehensiveness of the findings.
- **Lack of Standardization:** Service descriptions varied widely across counties, requiring interpretation and standardization of terminology.
- **Geographic Variability:** Some services operate regionally or across multiple counties, while others are limited to a single locality.
- **Time-Bound Accuracy:** Information reflects service availability as of mid-2025; some listings may have changed since data collection.
- **Time Constraints:** Given the limited data collection window, some services may have been unintentionally omitted and may require future validation or outreach.

Definitions of Key Terms

The following definitions were used to ensure clarity and consistency during the data collection and classification process

Governmental: Services operated or directly funded by federal, state, or local governments.

NGO (Non-Governmental Organization): Independent nonprofit or community-based organizations.

Faith-Based: Services provided by or affiliated with religious organizations.

Other: Includes hospital systems and private providers offering public-facing maternal or family services.

Maternity Care Deserts: Areas lacking adequate access to maternity care providers and facilities.

WIC (Women, Infants, and Children): A supplemental federal nutrition program for low-income pregnant/postpartum individuals and children under age five.

Doula: A trained professional offering non-medical support during pregnancy, birth, and the postpartum period.

Perinatal Services: Programs supporting pregnant and postpartum individuals from conception through one year after birth.

Postpartum Care: Services addressing health, recovery, and mental well-being following childbirth.

Smart Start: A key initiative with focus on early care and education, family support, literacy, and the health and development of children ages 0–5.

Medicaid (Maternal Care): Public insurance for low-income individuals that covers prenatal, delivery, and postpartum services.

Transportation Services: Government-supported programs that help individuals access medical or WIC appointments.

Lactation Consultant: Certified professionals who provide breastfeeding and infant feeding support.

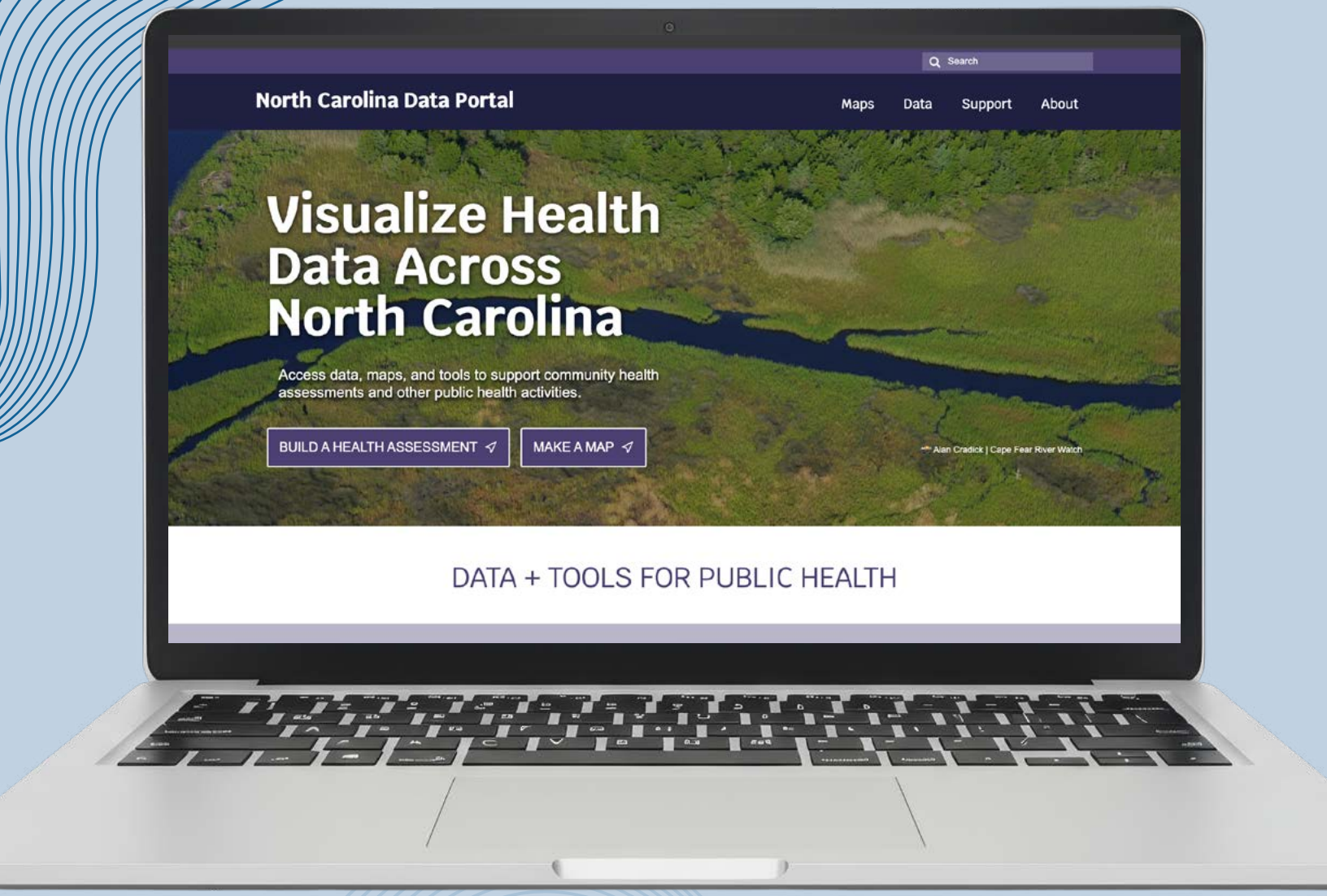
Parenting Classes: Educational programs that promote child development and strengthen caregiver skills.

Early Intervention Programs: A program under the Individuals with Disabilities Education Act (IDEA) that provides services for children with developmental delays or disabilities, including screenings and therapy.

Family Resource Centers: Community hubs offering wraparound services and referrals for families.

Home Visiting Programs: Voluntary in-home education and support for families during pregnancy and postpartum.

Lactation Support Groups: Group-based programs offering breastfeeding education, support, and peer connection.


Search
North Carolina Data Portal
Maps
Data
Support
About
Visualize Health Data Across North Carolina
Access data, maps, and tools to support community health assessments and other public health activities.
BUILD A HEALTH ASSESSMENT
MAKE A MAP
Alan Cradick | Cape Fear River Watch
DATA + TOOLS FOR PUBLIC HEALTH

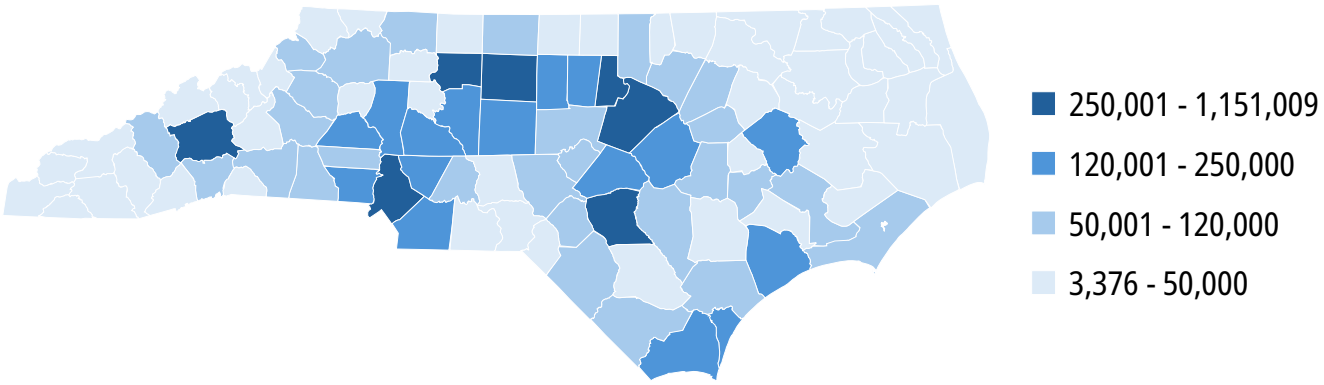
SECONDARY DATA

Total Population Size of North Carolina Counties

About 10,584,340 people live in the 48,624.12 square miles of North Carolina, according to the U.S. Census Bureau American Community Survey (ACS) 2019-2023 five-year estimates. The population density for this area, estimated at 218 people per square mile, is greater than the national average of 94 people per square mile.

The North Carolina Office of State Budget and Management (OSBM) reports county and state population projections using vintage population projections. It is important to note that there are 12 counties in North Carolina with age structures significantly affected by institutions. They are: Avery (prisons and college), Craven (military), Cumberland (military), Durham (university), Jackson (university), Madison (university), New Hanover (university), Onslow (military), Orange (university), Pasquotank (university and prisons), Pitt (university), and Watauga (university) (North Carolina Office of State Budget & Management, 2025).

Figure 74. Total Population Size of North Carolina Counties



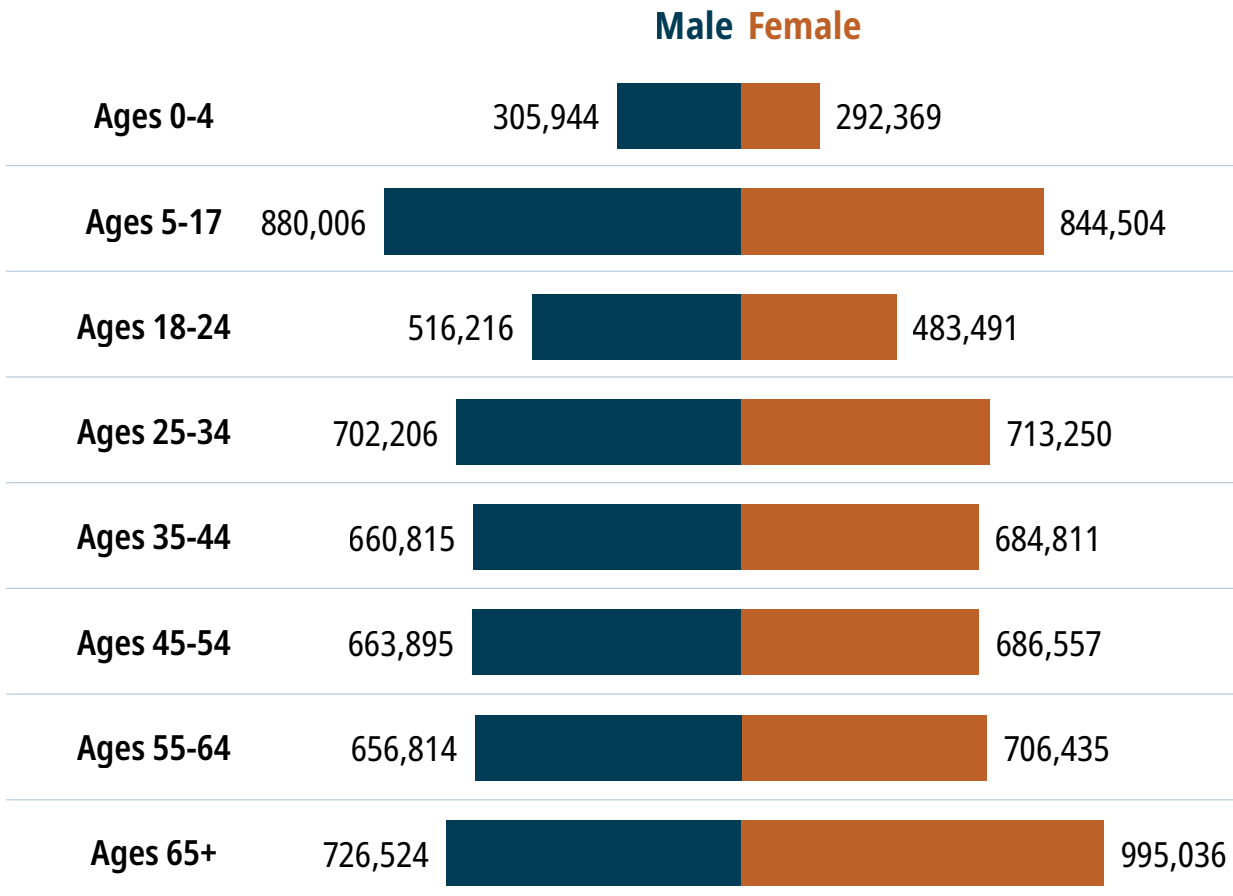
Data Source: US Census Bureau, American Community Survey, 2019-2023; Population based on five-year estimates

North Carolina Population by Age Group and Sex

The median age in North Carolina is 39.1, based on the ACS 2019-2023 five-year estimates. Of the total population, 18% are under age 15, 20% are ages 15 to 29, 45% are ages 30 to 64, 15% are ages 65 to 84 and 2% are ages 85 and older. The largest age group is children ages 5 to 17 (1.725 million), followed closely by adults ages 65 and older (1.722 million).

Females make up 51.08% of the total population in the area, higher than the national average of 50.5%. Males account for 48.92% of the total population in the area, lower than the national average of 49.5%.

Figure 75. North Carolina Population by Age Group and Sex



Data Source: US Census Bureau, American Community Survey, 2019-2023; Population based on five-year estimates

North Carolina Population by Race/Ethnicity

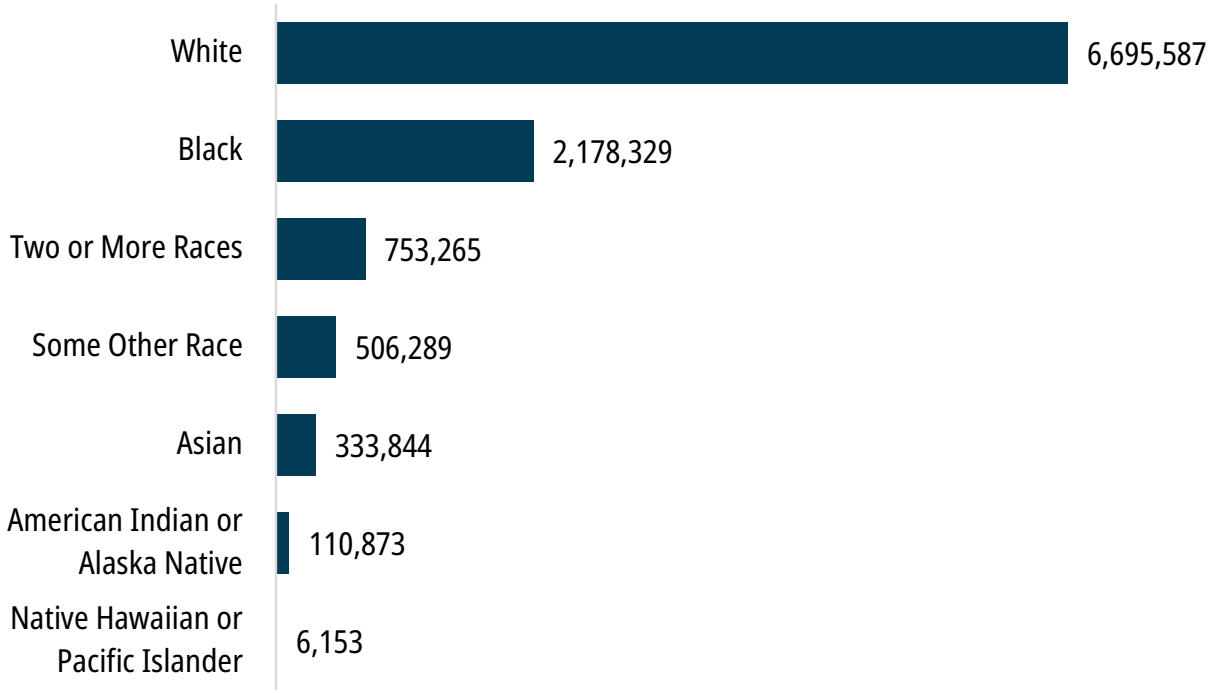
The estimated Black or African American population in North Carolina is 2,178,329, representing 20.58% of the state's total.

When including individuals who identify as Black or African American alone or in combination with another race, the total is 2,422,743, or 22.89% of the population.

The estimated population of Hispanic, Latine, or Spanish origin in North Carolina is 1,158,750 (10.95% of the total), a lower proportion than the national rate. Origin refers to a person's heritage, nationality group, lineage, or country of birth and may be of any race.

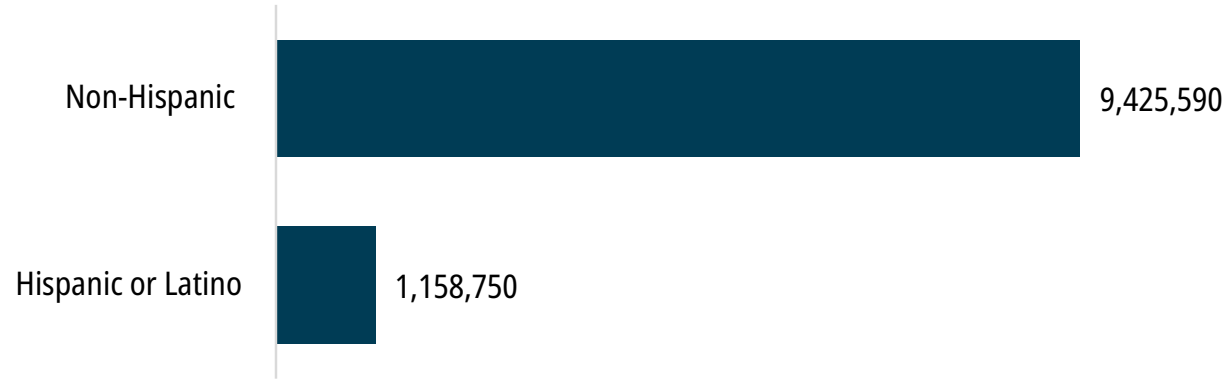
Race and ethnicity are collected separately in the American Community Survey. Race categories include white, Black, American Indian/Alaska Native, Asian, and Other, with respondents able to select one or more. Those who select more than one race are categorized as "Two or More Races." Ethnicity includes only two categories — Hispanic or Latine and Not Hispanic or Latine — and respondents choose one. Social and economic ACS data are reported by race alone, ethnicity alone and for the white non-Hispanic population.

Figure 76. North Carolina Population by Race



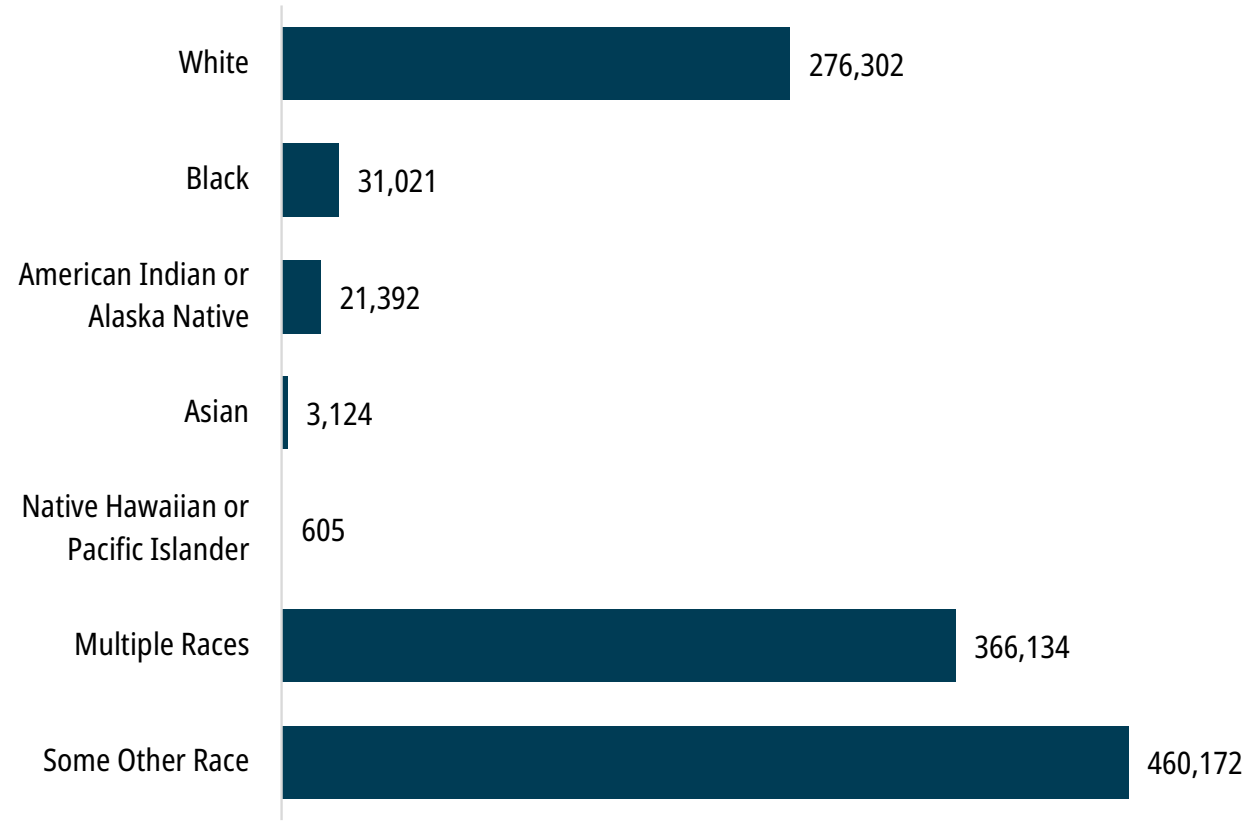
Data Source: US Census Bureau, American Community Survey, 2019-2023; Population based on five-year estimates

Figure 77. North Carolina Population by Ethnicity



Data Source: US Census Bureau, American Community Survey, 2019-2023; Population based on 5-year estimates

Figure 78. North Carolina Hispanic Population by Race

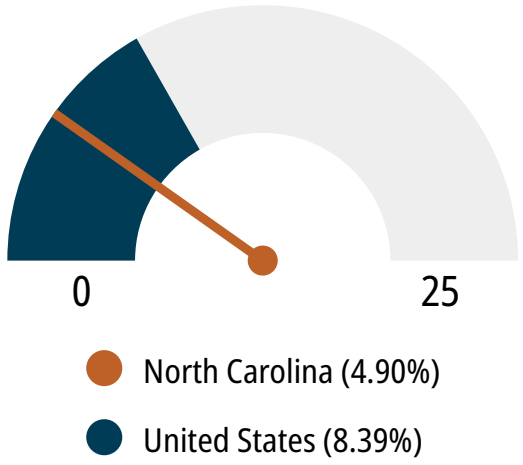


Data Source: US Census Bureau, American Community Survey, 2019-2023; Population based on five-year estimates

North Carolina Population with Limited English Proficiency

This indicator reports the percentage of the population ages 5 and older who speak a language other than English at home and speak English less than "very well." This indicator is relevant because limited English proficiency can create barriers to health care access, provider communication, and health literacy and education. Of North Carolina's 9,986,027 people ages 5 and older, 489,594 — or 4.9% — have limited English proficiency The national percentage is 8.39%.

Figure 79. Population Ages 5+ with Limited English Proficiency, Percent



Data Source: US Census Bureau, American Community Survey. 2019-2023. Downloaded from ncdataportal.org, 12/6/2025.

Note: This indicator is compared to national average.

North Carolina Indigenous People Population

North Carolina is home to more than 130,000 Native American and Alaska Native people and has the second-largest tribal population east of the Mississippi River.

The state's Native American population is culturally and tribally diverse. North Carolina formally recognizes eight Native American tribal nations, including some that are state-recognized and two that are federally recognized.

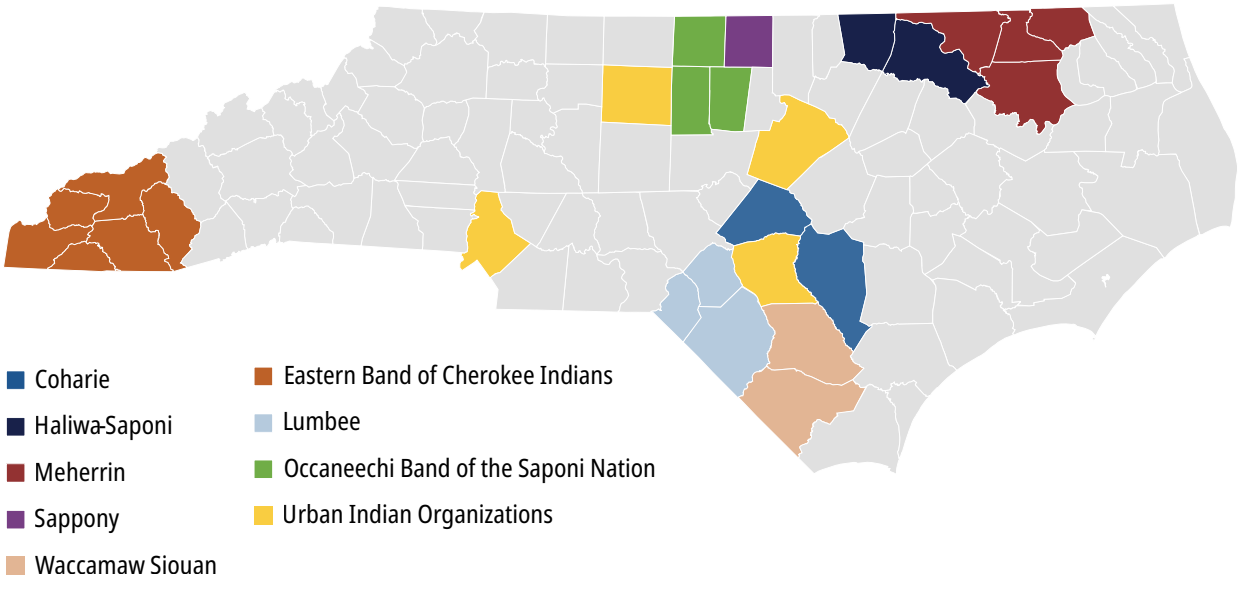
The Eastern Band of Cherokee Indians first received federal recognition in 1868. On December 18, 2025, Congress passed and the president signed the National Defense Authorization Act for Fiscal Year 2026, which included the Lumbee Fairness Act granting federal recognition to the Lumbee Tribe of North Carolina.

Recognized Tribes of North Carolina

- **Coharie**
- **Eastern Band of the Cherokee***
- **Haliwa-Saponi**
- **Lumbee***
- **Meherrin**
- **Occaneechi Band of Saponi**
- **Sappony**
- **Waccamaw Siouan**

**Federal and state recognized tribes*

Figure 80. North Carolina Tribal and Urban Communities



Data Source: Adapted from the North Carolina Commission of Indian Affairs. Map of NC tribal communities. North Carolina Department of Administration. www.doa.nc.gov/divisions/american-indian-affairs/map-nc-tribal-communities

Every county in North Carolina is home to people who identify as American Indian. In more than three-quarters of the counties, the number of American Indian people has grown over the past decade. The state's largest population and concentration of American Indian people is in Robeson County.

Figure 80 shows the distribution of American Indian people in North Carolina as a percentage of each county's total population. As in the past, Robeson County has the highest share in the state, with 38.5% of its the county's total population identifying as American Indian.

Figure 81. American Indian People of North Carolina

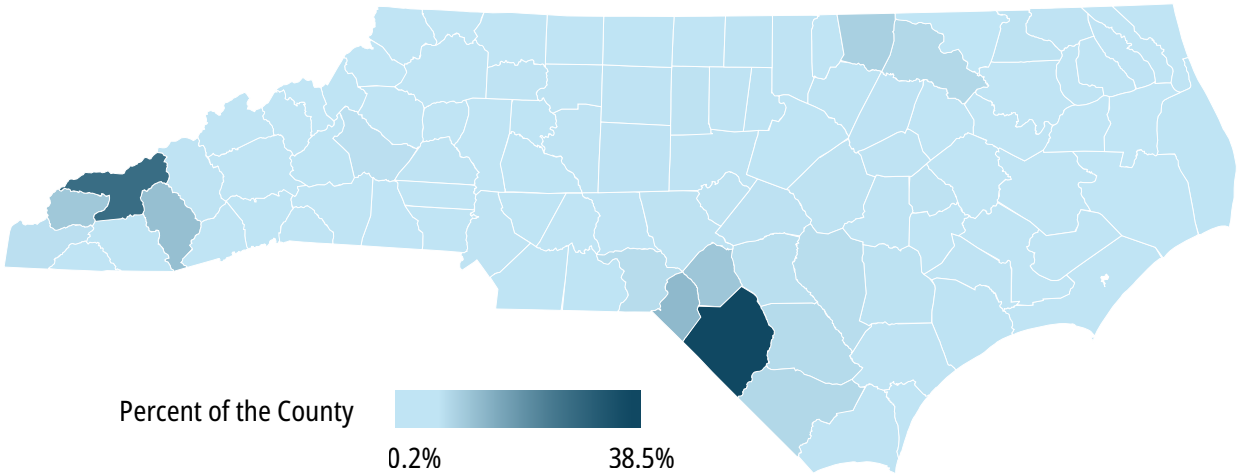


Table1 shows the top 10 counties with the highest percentage of American Indian people with respect to each county's total population.

Table 4. Top 10 North Carolina Counties of American Indian Resident Population

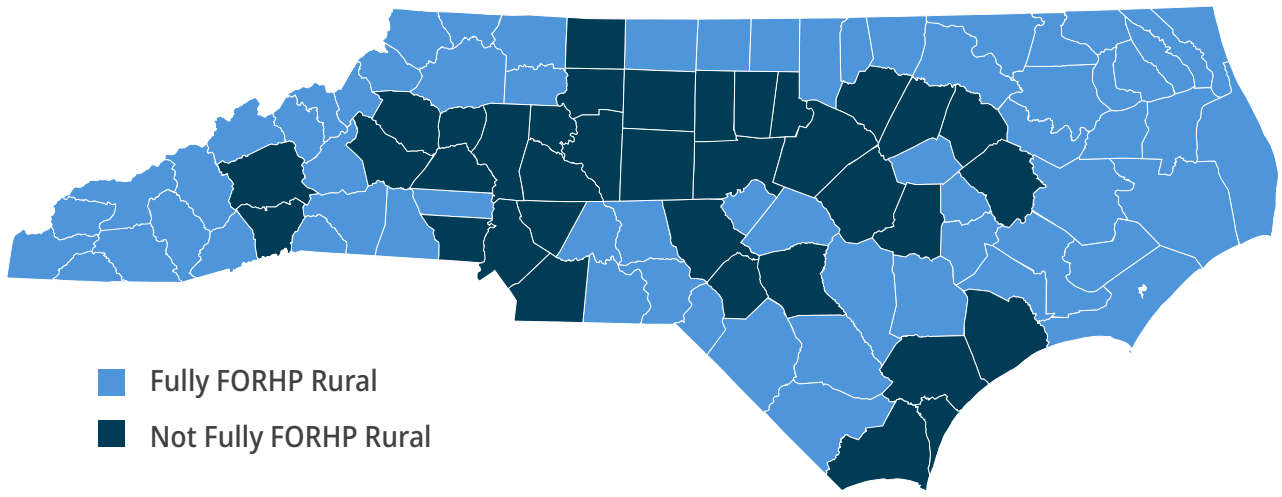
County	American Indian Population	Total Population	Percent of the County
Robeson	44,871	116530	38.5%
Swain	4,171	14117	29.5%
Scotland	3,745	34174	11.0%
Jackson	4,098	43109	9.5%
Hoke	4,063	52082	7.8%
Graham	590	8030	7.3%
Warren	978	18642	5.2%
Halifax	1,667	48622	3.4%
Columbus	1,732	50623	3.4%
Bladen	799	29606	2.7%

Data Source: U.S. Census Bureau. (2020). 2020 Decennial Census, Table P8: Race. www2.census.gov/programs-surveys/decennial/2020/data/

North Carolina Urban versus Rural Areas, By Census Tracts

The North Carolina Urban and Rural Designations are based on 2023 data from the Health Resources and Services Administration (HRSA). A county is designated as rural if all census tracts within the county are defined as rural areas by the Federal Office of Rural Health Policy (FORHP). A county is considered urban if at least one census tract is not defined as a rural area by FORHP.

Figure 82. North Carolina Urban and Rural Designations, 2023



U.S. Department of Health & Human Services, Health Resources & Services Administration, Federal Office of Rural Health Policy. FORHP data files. https://www.hrsa.gov/rural-health/about-us/what-is-rural/data-files

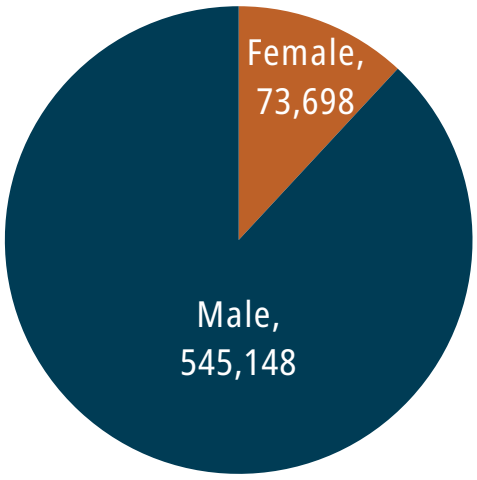
North Carolina Veteran Population

This indicator reports the percentage of the population ages 18 and older that served, even briefly, but are not currently on active duty in the U.S. Army, Navy, Air Force, Marine Corps, or the Coast Guard, or who served in the U.S. Merchant Marine during World War II. Of 8,153,570 North Carolinians, 618,846 (about 8%) are veterans.

Among all males in North Carolina, 545,148 (approximately 14%) are veterans, while 73,698 females (about 2%) are veterans.

Additionally, about one-third (33%) of all veterans in North Carolina are ages 65 and older (282,104 individuals).

Figure 83. North Carolina Veteran Population by Sex



Total: 618,846

Data Source: US Census Bureau, American Community Survey, 2019-23; Population based on five-year estimates

North Carolina Population With Any Disability

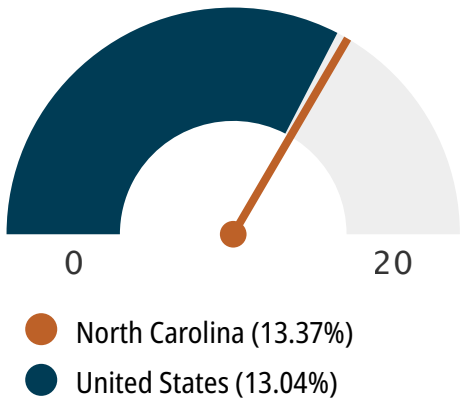
This indicator measures the percentage of the civilian, noninstitutionalized population with any disability. In North Carolina, disability status has been determined for 10,366,704 people. Of that total, 1,386,506 (13.37%) have a disability. This measure is important because individuals with disabilities may require targeted services and outreach.

Among males in North Carolina, 13.24% have a disability; among females, the rate is 13.50%.

The indicator also reports disability by type. The ACS defines disability differently by age group: hearing and vision difficulty for all ages; cognitive, ambulatory, and self-care difficulty for those 5 and older; and independent living difficulty for those 15 and older (reported for ages 18 and older in the ACS vintage year).

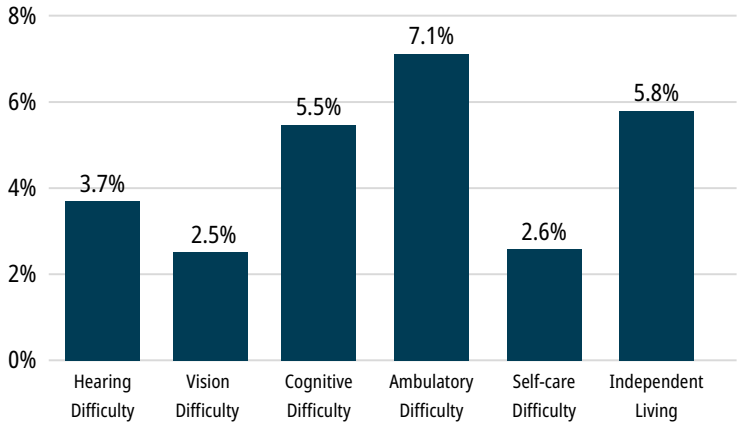
Within North Carolina, 3.7% of the population have hearing difficulty; 2.52% have vision difficulty; 5.48% have cognitive difficulty (ages 5 and older); 7.13% have ambulatory difficulty (ages 5 and older); 2.58% have self-care difficulty (ages 5 and older); and 5.8% have independent living difficulty (ages 18 and older).

Figure 84. Population with Any Disability, Percent



Note: This indicator is compared to national average.
Data Source: US Census Bureau, American Community Survey. 2019-2023. Downloaded from ncdataportal.org, 12/06/2025

Figure 85. North Carolina Population with Any Disability



Data Source: US Census Bureau, American Community Survey, 2019-2023; Population based on five-year estimates

Income - Median Family Income

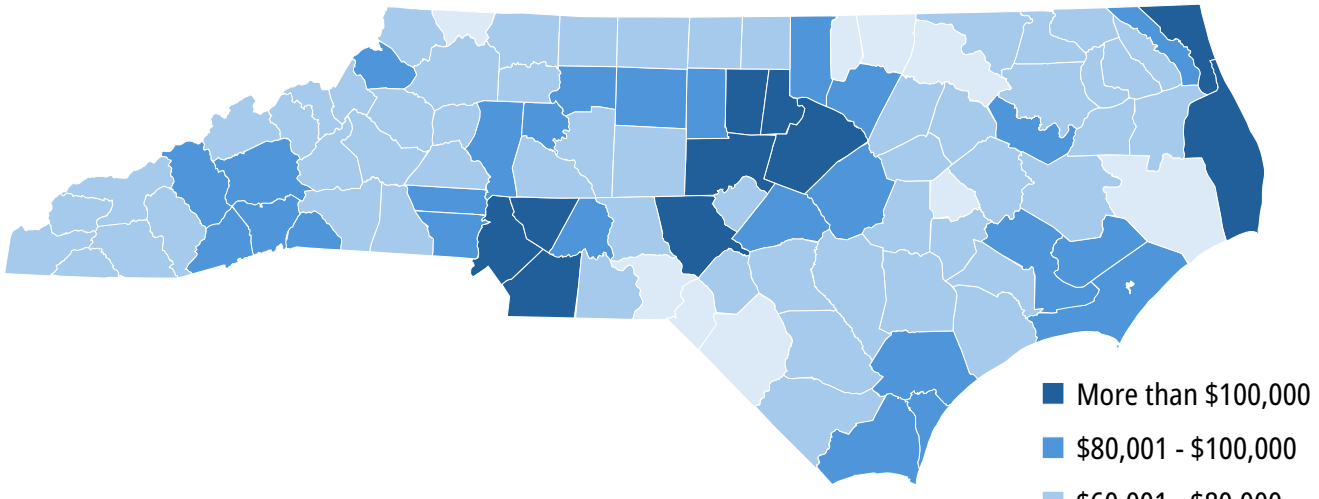
There is a notable difference between household income and family income. A family is typically defined as a group of two or more people related by birth, marriage, or adoption residing together. A household may include unrelated individuals or a single person living alone. Median family income tends to be higher than median household income, as families often have multiple earners (e.g. two spouses). As a result, household income figures tend to be lower than corresponding family income figures.

Figures 86 and 87 report median family income from the most recent five-year American Community Survey (ACS) estimates. A family household is any housing unit in which the householder lives with one or more individuals related to him or her by birth, marriage, or adoption. Family income includes the incomes of all family members aged 15 and older.

Figure 88 reports median household income. Using median household income as a proxy, the data suggest a modest upward trend over the past decade with occasional periods of stagnation or slight decline in real (inflation-adjusted) terms.

Family income data (Figures 86 and 87) are based on survey data. Household income figures (Figure 88) are derived primarily from Federal Reserve Bank of St. Louis that aggregates thousands of economic time series from trusted sources like the U.S. Census Bureau, Bureau of Labor Statistics, Bureau of Economic Analysis, and others.

Figure 86. North Carolina Median Family Income By County

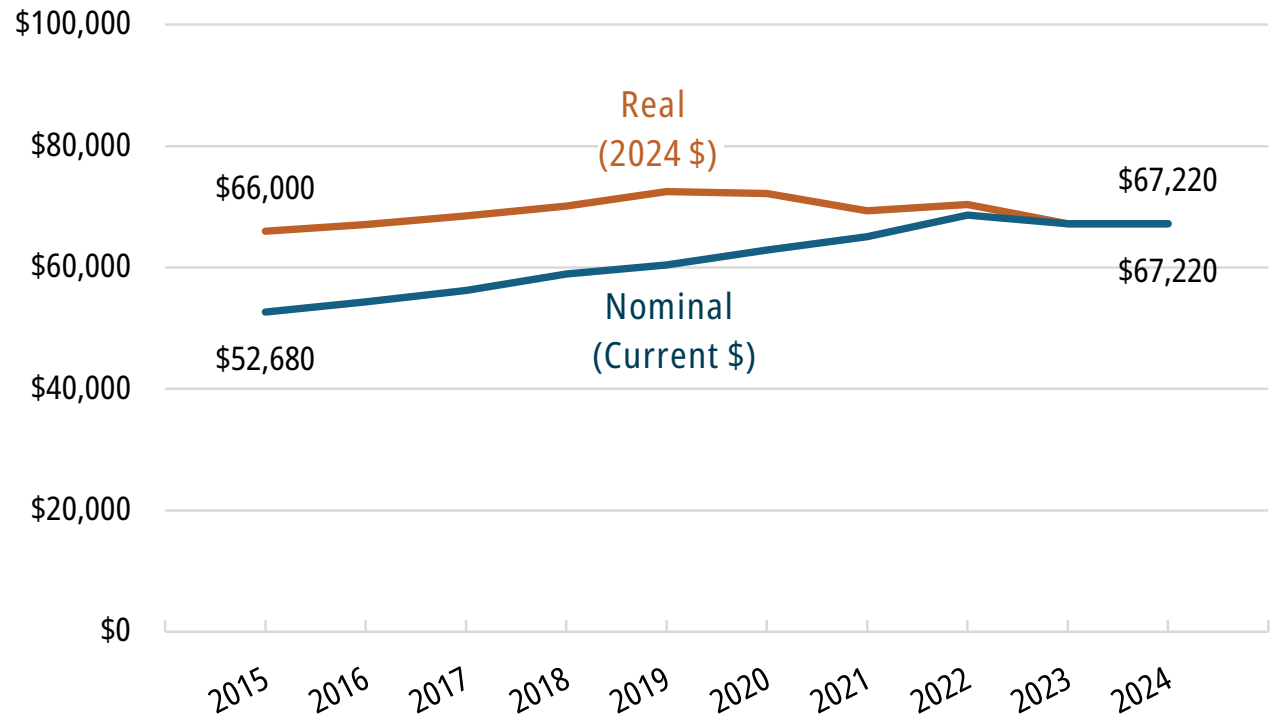


Data Source: US Census Bureau, Small Area Income and Poverty Estimates, 2022

Figure 87. Median Family Income Comparison

Data Source: US Census Bureau, Small Area Income and Poverty Estimates, 2022

Figure 88. North Carolina Median Family Income by Year



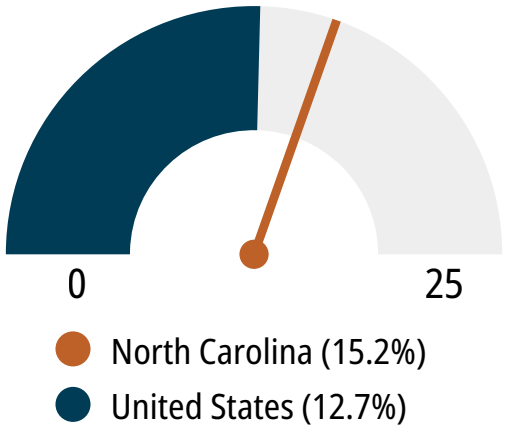
Data Sources: Federal Reserve Bank of St. Louis (FRED). Median Household Income in North Carolina [MEHOINUSNCA646N]. Retrieved from https://fred.stlouisfed.org/series/MEHOINUSNCA646N; Federal Reserve Bank of St. Louis (FRED). Real Median Household Income in North Carolina [MEHOINUSNCA672N]. Retrieved from https://fred.stlouisfed.org/series/MEHOINUSNCA672N; U.S. Census Bureau (2024) American Community Survey, 2023 and 2024 One-Year Estimates

SNAP Benefits

The Supplemental Nutrition Assistance Program (SNAP) is a federal program that provides nutrition benefits to low-income individuals and families to purchase food from authorized stores. The SNAP indicator reports the average percentage of the population receiving SNAP benefits in July of the latest report year.

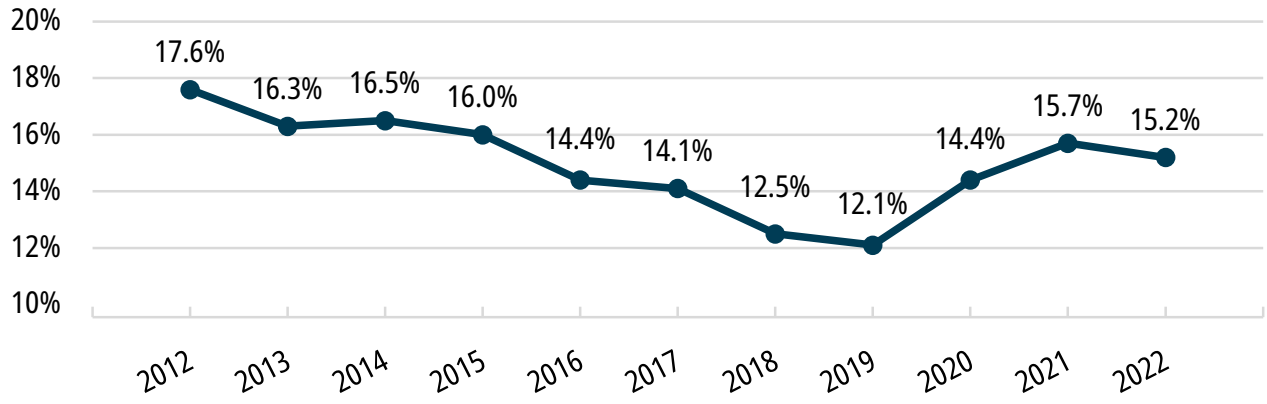
The percentage of North Carolinians receiving SNAP benefits is above the national average, highlighting the continued need for food and economic assistance across the state. In North Carolina, 15.2% of the total population relies on SNAP, compared with 12.7% nationally. This difference suggests that many communities in the state experience greater financial strain and face barriers to consistent access to nutritious food. Higher SNAP participation may also reflect broader socioeconomic challenges — such as lower household incomes, limited employment opportunities in rural areas, and rising costs of living — that place pressure on families' ability to meet basic needs. Understanding this reliance on SNAP is essential for shaping efforts to strengthen food security and support economic stability for North Carolinians.

Figure 90. Percentage of Total Population Receiving SNAP Benefits



Note: This indicator is compared to national average.
Data Source: US Census Bureau, Small Area Income and Poverty Estimates. 2022. Downloaded from ncdataportal.org 12/12/2025

Figure 89. North Carolina Population Receiving SNAP Benefits



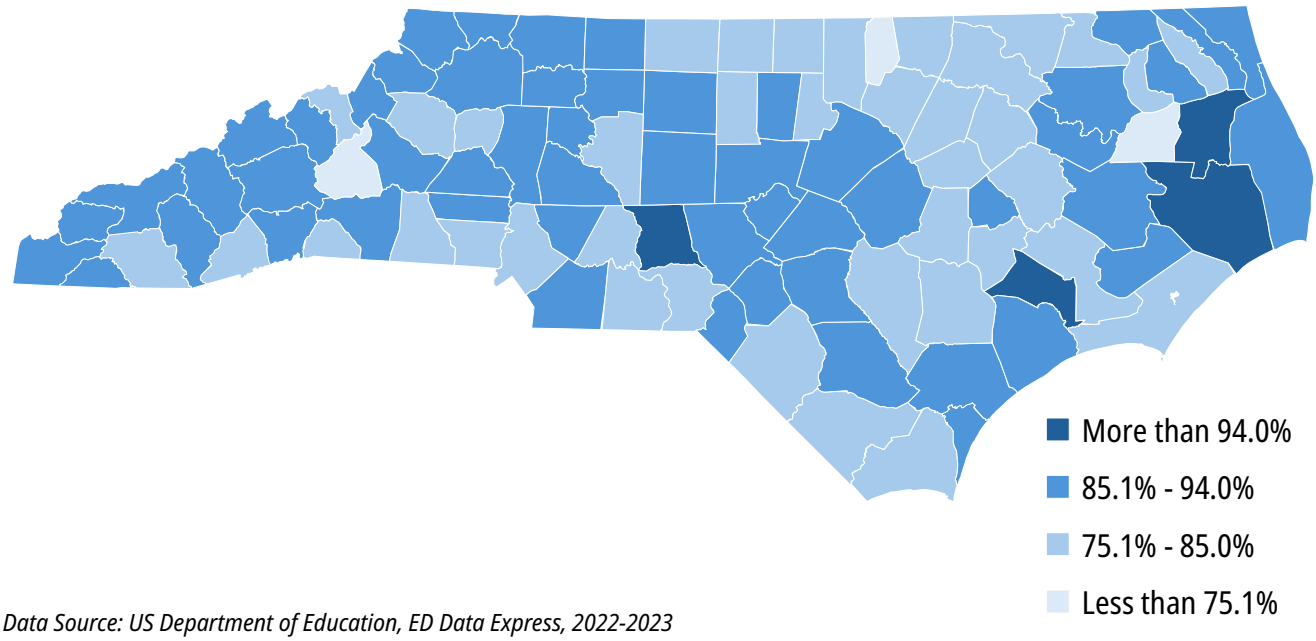
Data Source: US Census Bureau, Small Area Income and Poverty Estimates, 2022

High School Graduation Rate

The adjusted cohort graduation rate (ACGR) is a graduation metric that tracks a "cohort" of first-time 9th graders in a given school year. The metric is adjusted by adding students who transfer into the cohort after 9th grade and subtracting any students who transfer out, emigrate to another country, or pass away.

The ACGR is the percentage of the students in this cohort who graduate within four years. The adjusted cohort graduation rate for the cohort area was 86.9% for the most recently reported school year. Students in North Carolina graduated on time at a slightly lower rate than the national ACGR average of 88.2%.

Figure 91. North Carolina High School Graduation Rate by County



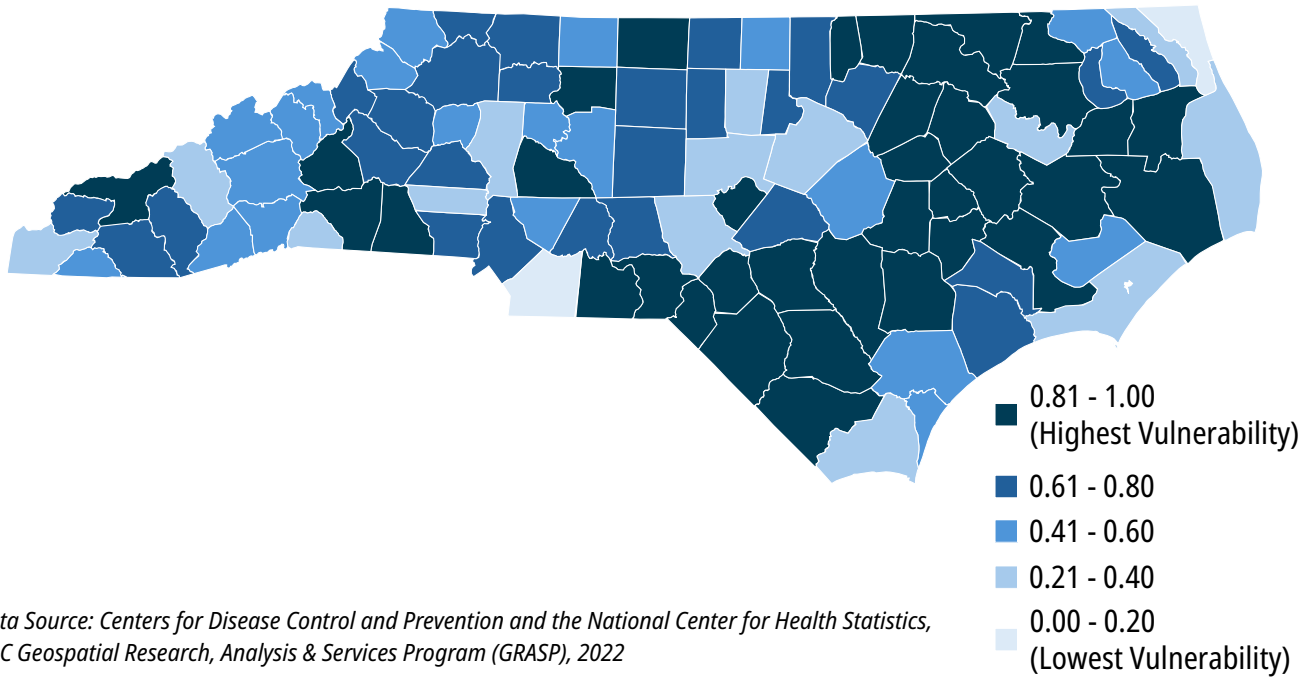
Data Source: US Department of Education, ED Data Express, 2022-2023

Social Vulnerability Index

The degree to which a community exhibits certain social conditions, including high poverty, low percentage of vehicle access, or crowded households, may affect that community's ability to prevent human suffering and financial loss in the event of disaster. These factors describe a community's social vulnerability.

The social vulnerability index is a measure of the degree of social vulnerability in counties and neighborhoods across the United States, where a higher score indicates higher vulnerability. North Carolina has a social vulnerability index score of 0.63, which is above the United States average of 0.53.

Figure 92. North Carolina Social Vulnerability Index by County



Data Source: Centers for Disease Control and Prevention and the National Center for Health Statistics, CDC Geospatial Research, Analysis & Services Program (GRASP), 2022

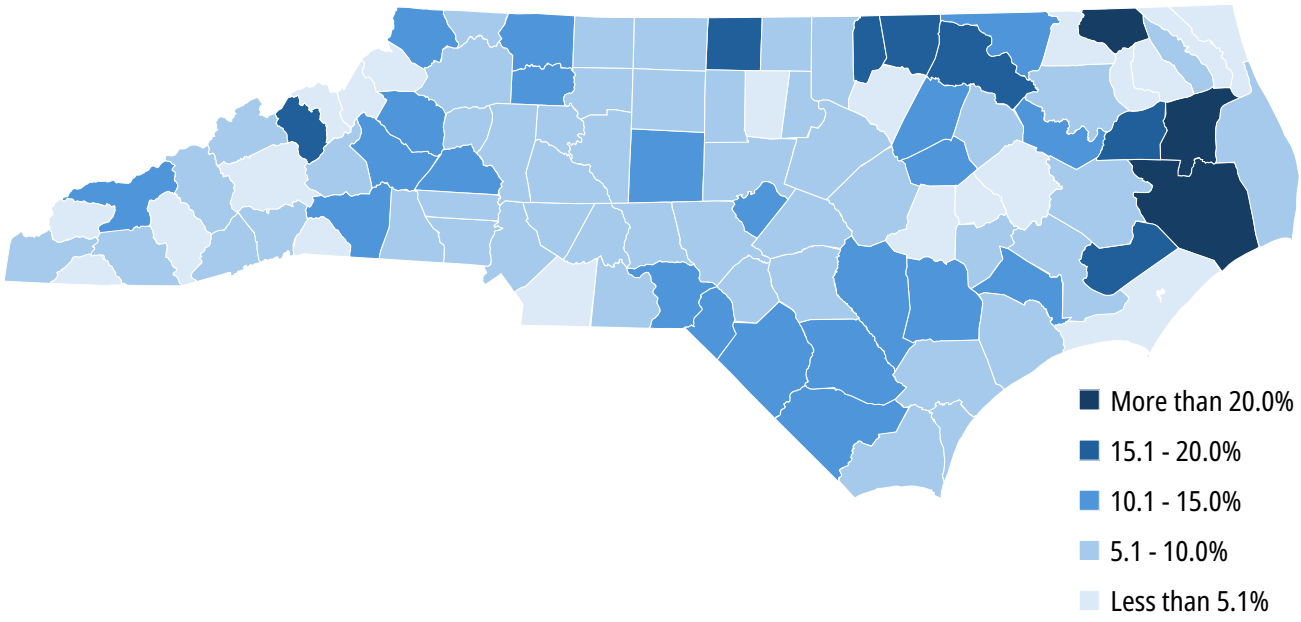
Young People Not in School and Not Working

This indicator reports the percentage of youth ages 16 to 19 who are not currently enrolled in school and who are not employed. Of the 566,736 youth ages 16 to 19, 41,104 not in school and not employed. These youth are often referred to as disconnected youth. Figure 93 displays a map of youth not in school and not working, by county. The 10 most impacted counties are Tyrrell, Gates, Hyde, Washington, Yancey, Halifax, Vance, Pamlico, Caswell, and Warren.

Figure 94 shows that in North Carolina, 7.3% of teens are not in school and not working, compared with 6.8% nationally. While the difference is relatively small, North Carolina's rate is slightly higher than the U.S. average, suggesting that a meaningful share of older adolescents in the state may be facing challenges related to educational engagement, workforce entry, or access to supportive services.

Disconnected youth often experience barriers such as limited job opportunities, transportation challenges, caregiving responsibilities, or academic disengagement. Even modestly elevated rates can signal underlying structural issues that affect long-term economic and health outcomes for young people. This measure highlights the importance of programs that support school completion, workforce development, and pathways to employment for teens across North Carolina.

Figure 93. North Carolina Young People Not in School and Not Working by County



Data Source: US Census Bureau, American Community Survey, 2019-2023; Population based on five-year estimates

Figure 94. Young People Not in School and Not Working Comparison

Data Source: US Census Bureau, American Community Survey, 2019-2023; Population based on five-year estimates

Households with No Computer

This indicator reports the percentage of households who don't own or use any type of computers — including desktop or laptop, smartphone, tablet or other portable devices — based on 2019-2023 American Community Survey (ACS) estimates. Of the state's 4,186,924 households, 246,430 (5.9%) are without a computer (North Carolina Data Portal).

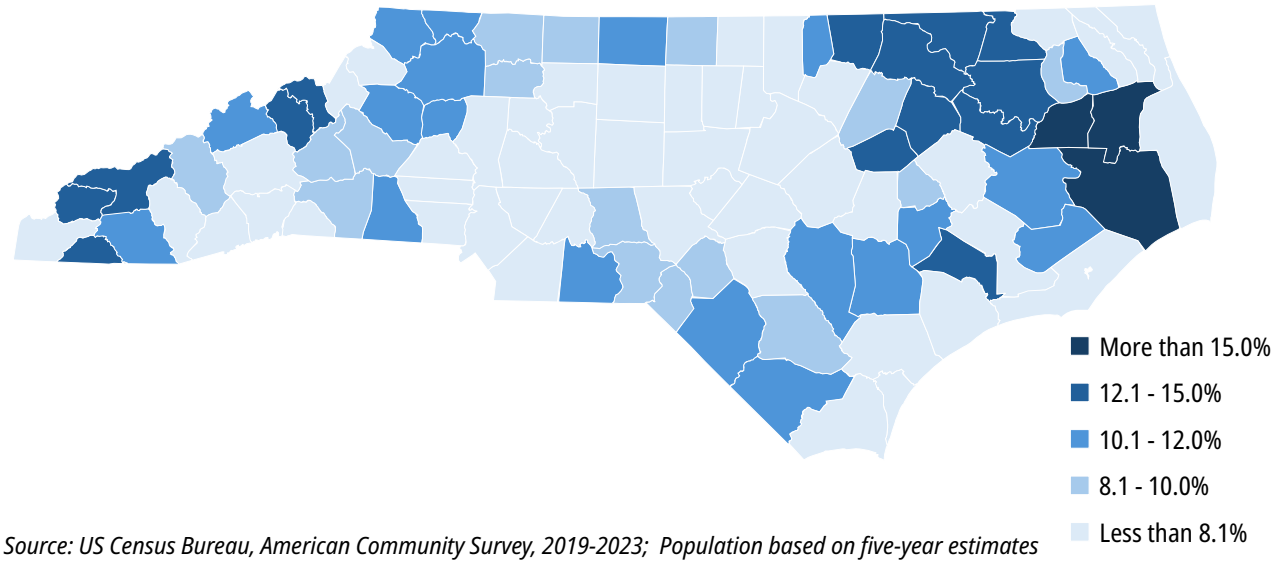
In North Carolina, 5.9% of households lack a computer, which is slightly above the national rate of 5.2%. Although the difference is modest, it highlights a persistent digital access gap that affects families' ability to fully participate in education, employment, telehealth, and other essential online services.

Households without computers often face obstacles including expense, limited digital literacy, and unreliable internet connections.

Even small disparities may compound existing inequities, particularly in rural areas and low-income communities where technology access is already uneven. The computer access measure underscores the importance of continued investments in digital inclusion, including affordable devices, broadband expansion, and support for digital skills, to ensure all North Carolina households can engage in the modern digital economy.

The internet access indicator reports the percentage of population with access to high-speed internet. Data are based on North Carolina providers offering download speeds of 25 Mbps and upload speeds of 3 or more Mbps These data represent both wireline and fixed/terrestrial wireless internet providers. Cellular internet providers are not included.

Figure 95. North Carolina Households with No Computer by County



Data Source: US Census Bureau, American Community Survey, 2019-2023; Population based on five-year estimates

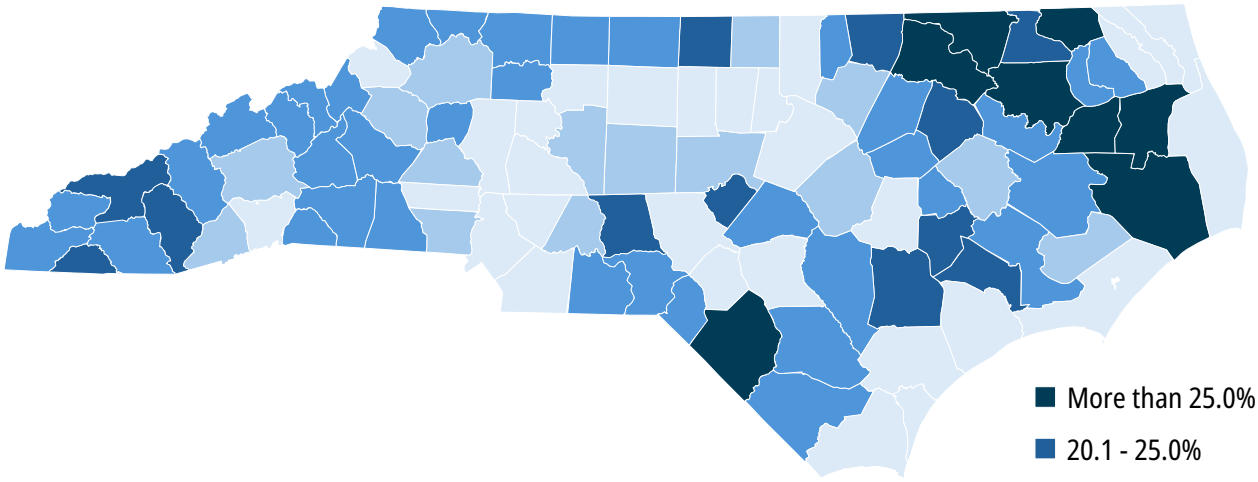
Figure 96. Households with No Computer Comparison

Data Source: US Census Bureau, American Community Survey, 2019-2023; Population based on five-year estimates

Households with No or Slow Internet

Figure 97 shows the percentage of households who rely solely on dial-up internet, have internet access without a paid subscription, or have no internet access at home, based on the 2019-2023 American Community Survey (ACS) estimates. The survey asks respondents about the type of computer used and the availability and means of internet access. Of the 4,186,924 total households in North Carolina, 479,288 or 11.5% have no or slow internet. The 2019-23 ACS questions on internet and computer use are not asked of the group quarters population; therefore, the data do not include people living in group residential settings such as dorms, prisons, nursing homes, and similar housing.

Figure 97. North Carolina Households with No or Slow Internet by County



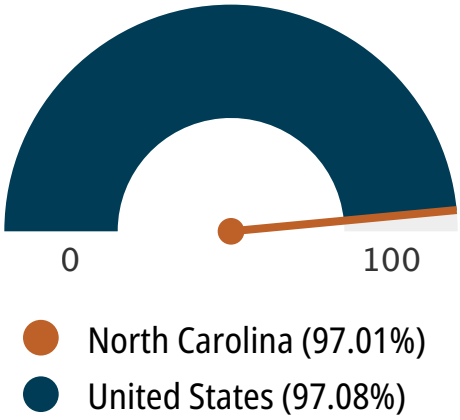
Data Source: US Census Bureau, American Community Survey, 2019-2023; Population based on five-year estimates

Figure 98 shows the percentage of the population with access to broadband internet at download speeds greater than 25 Mbps. Overall, North Carolina's broadband internet access is very high, with 97% of the population covered, essentially identical to the national average. This indicates that, at a statewide level, broadband infrastructure reaches the vast majority of households.

However, high overall coverage does not necessarily reflect actual affordability, connection quality, or consistent availability, especially in rural or mountainous regions where service reliability may vary. While most North Carolinians technically have broadband access, disparities in device ownership, digital literacy, and the cost of internet service can still limit meaningful connectivity for many households.

This measure demonstrates that North Carolina largely meets baseline broadband coverage benchmarks, while also highlighting the need for continued investment in affordable, reliable, and high-quality internet to ensure true digital inclusion.

Figure 98. Percentage of Population with Access to Broadband Internet (DL Speeds > 25Mbps)



Note: This indicator is compared to national average.
Data Source: FCC FABRIC Data. Additional data analysis by CARES. June, 2025. Downloaded from ncdataportal.org 12/12/2025

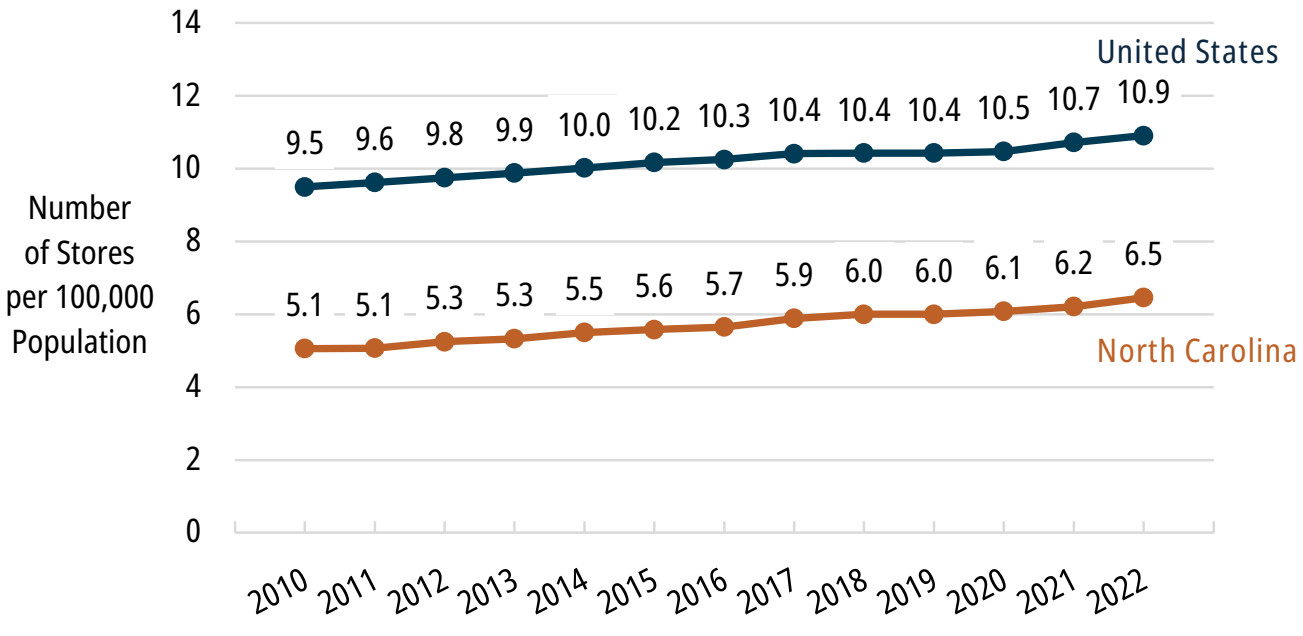
Figure 99. Households with No or Slow Internet Comparison

Data Source: US Census Bureau, American Community Survey, 2019-2023; Population based on five-year estimates

Liquor Stores

There are 671 establishments in North Carolina primarily engaged in retailing packaged alcoholic beverages, such as ale, beer, wine, and liquor. The number of liquor stores per 100,000 population provides a measure of environmental influences on dietary behaviors and the accessibility of healthy foods. Note that these data exclude establishments preparing and serving alcohol for consumption on premises (including bars and restaurants) or which sell alcohol as a secondary retail product (including gas stations and grocery stores). North Carolina has significantly fewer liquor stores per capita than the national average.

Figure 100. Beer, Wine, and Liquor Stores Comparison by Year



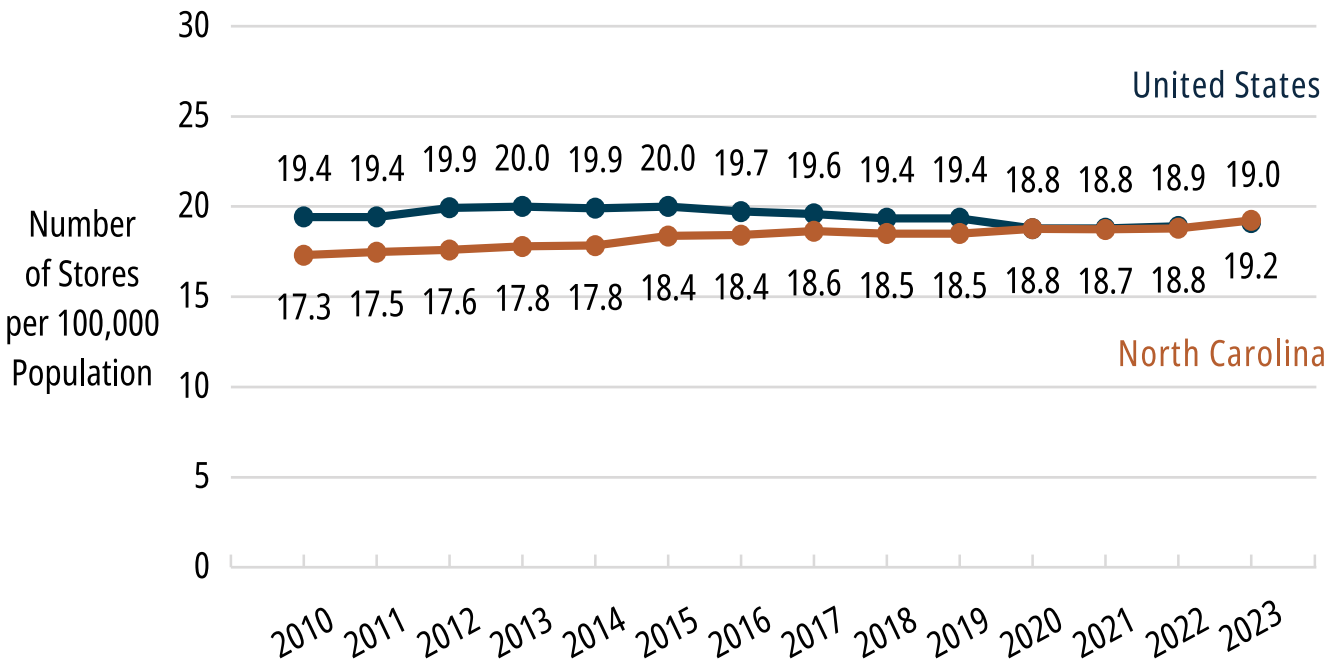
Data Source: US Census Bureau, County Business Patterns; Additional data analysis by Center for Applied Research and Engagement Systems (CARES); 2022

Grocery Stores

Healthy dietary behaviors are supported by access to healthy foods, and grocery stores are a major provider of these foods. There are 2,007 grocery establishments in the report area, at a rate of 19.2 per 100,000 population. Grocery stores are defined as supermarkets and smaller grocery stores primarily engaged in retailing a general line of food, such as canned and frozen foods; fresh fruits and vegetables; and fresh and prepared meats, fish, and poultry. Delicatessen-type establishments are also included. Convenience stores and large general merchandise stores that also retail food, such as supercenters and warehouse club stores, are excluded.

North Carolina has a similar — and slightly higher — density of grocery stores compared to the United States overall, suggesting that retail food access through grocery stores is generally on par with national availability.

Figure 101. Grocery Stores and Supermarkets Comparison by Year

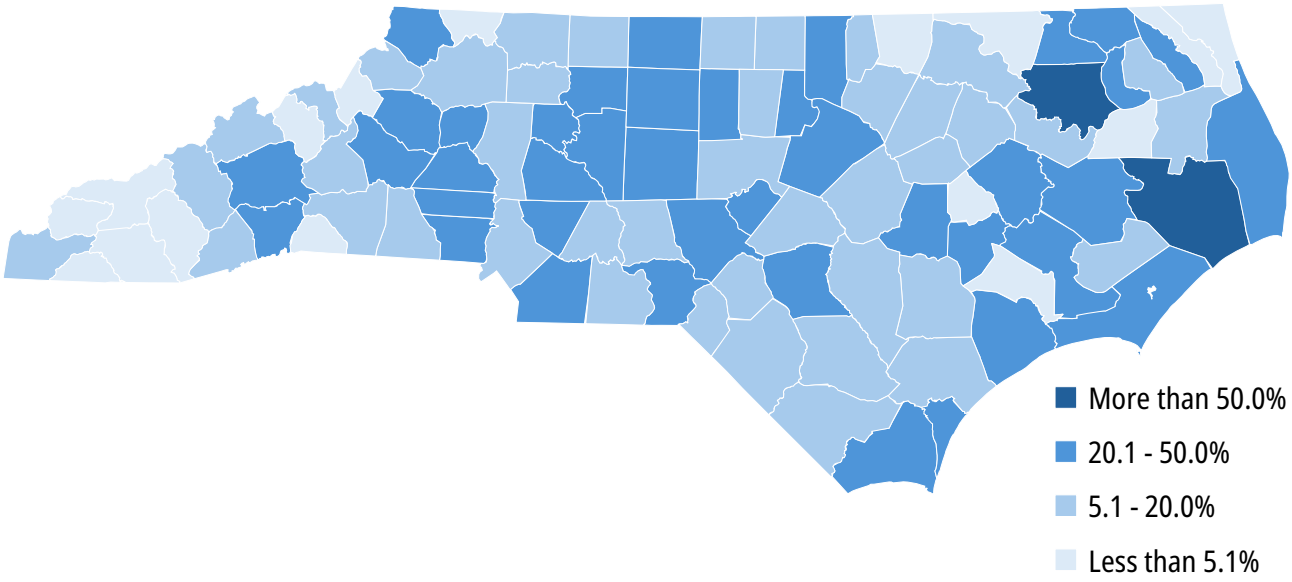


Data Source: US Census Bureau, County Business Patterns; Additional data analysis by Center for Applied Research and Engagement Systems (CARES); 2023

Food Vulnerability

This indicator reports the percentage of the low-income population with low food access. Low food access is defined as living more than one mile (urban) or 10 miles (rural) from the nearest supermarket, supercenter, or large grocery store. This indicator is relevant because it highlights populations and geographies facing food insecurity. North Carolina has a larger proportion of low-income people experiencing limited food access than the nation as a whole, highlighting ongoing challenges in food availability, transportation, and neighborhood retail infrastructure, particularly in rural and underserved communities.

Figure 102. North Carolina Low-Income Population with Low Food Access by County



Data Source: US Department of Agriculture, Economic Research Service, USDA Food Access Research Atlas, 2019

Figure 103. Low-Income Population with Low Food Access Comparison

Data Source: US Department of Agriculture, Economic Research Service, USDA Food Access Research Atlas, 2019

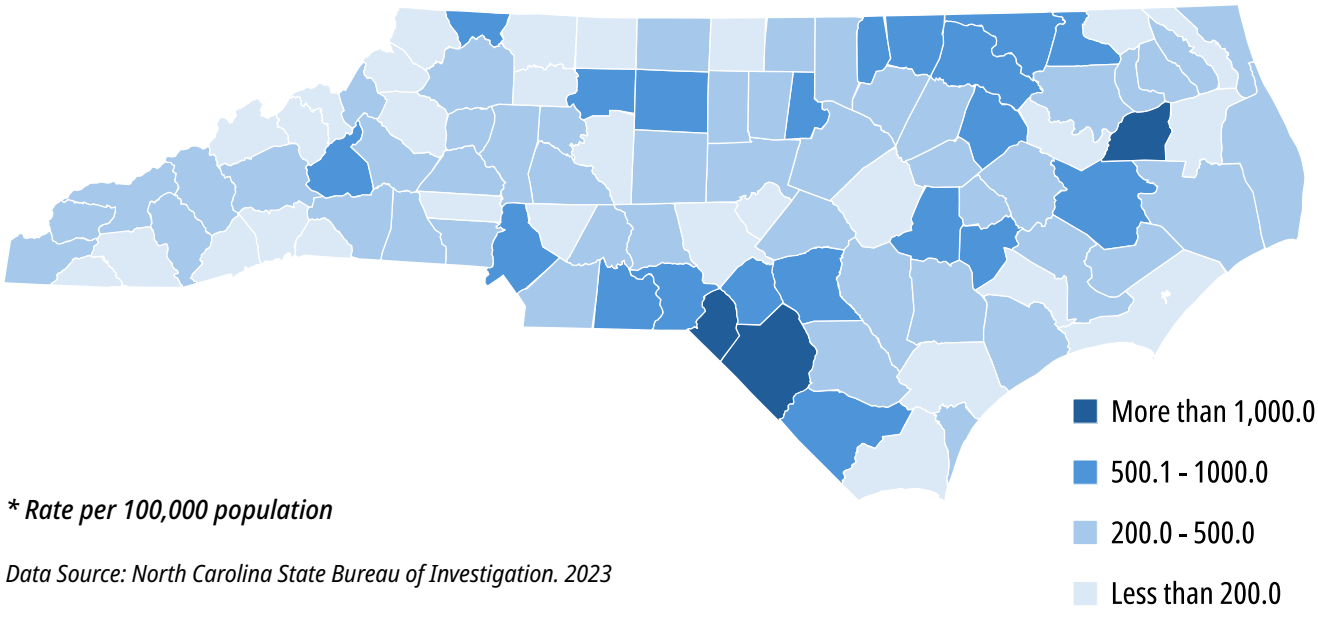
Violent Crime

This indicator reports the rate of violent crimes per 100,000 total population in North Carolina. Data are acquired from the North Carolina Department of Public Safety (NCDPS). Violent crimes include murder, rape, robbery, and aggravated assault.

In 2023, North Carolina reported 41,452 violent crimes, a rate of 380.95 per 100,000 population. Violent crime rose sharply in 2020, mirroring national trends during the COVID-19 pandemic. Since then, the state has seen three consecutive years of decline. By 2023, violent crime rates had fallen well below the 2020 peak, though they remained slightly above pre-pandemic levels.

From 2018 to 2023, North Carolina had a lower violent crime rate than the United States overall, indicating comparatively lower levels of serious crime during that period.

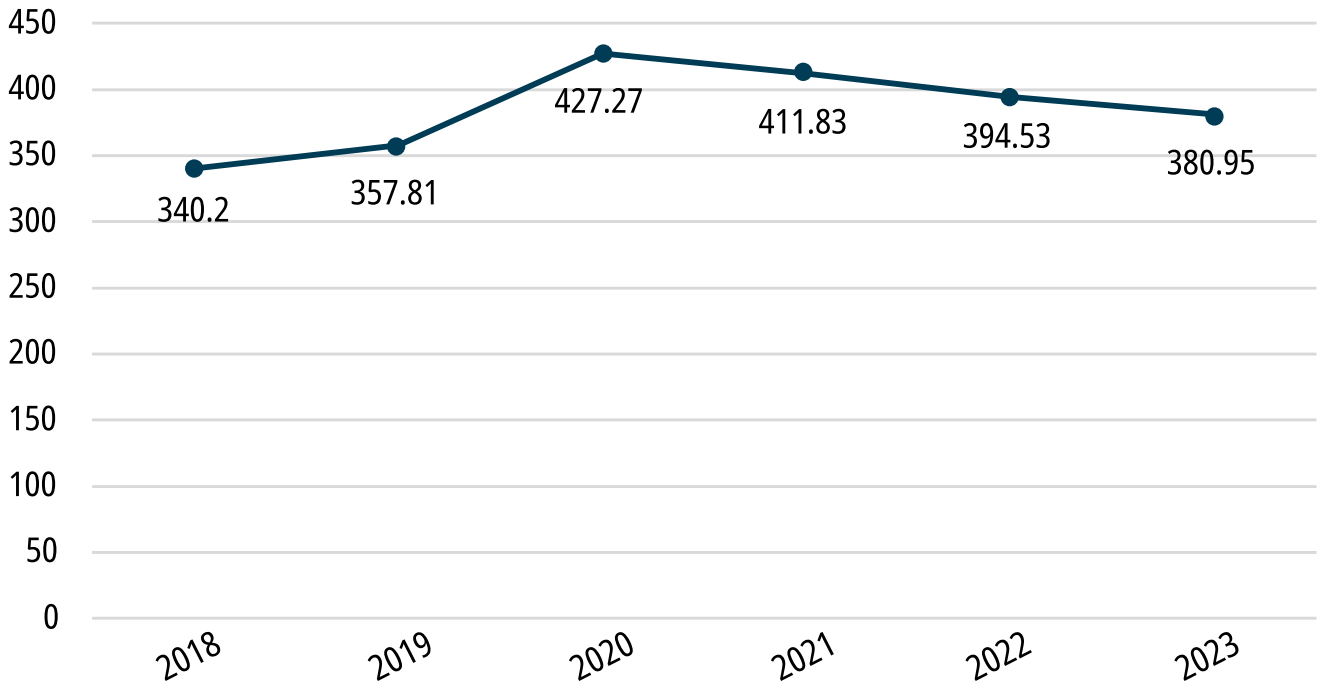
Figure 104. North Carolina Violent Crime Rate by County*



** Rate per 100,000 population*

Data Source: North Carolina State Bureau of Investigation. 2023

Figure 105. North Carolina Violent Crime Rate, 2018 - 2023*



** Rate per 100,000 population*

Data Source: North Carolina State Bureau of Investigation. 2023

Juvenile Arrest Rate

This indicator reports the rate of delinquency cases per 1,000 juveniles ages 8 to 17 in North Carolina. Data are acquired from the North Carolina State Bureau of Investigation (NCSBI).

In 2024, North Carolina reported 38,994 juvenile arrest cases or a rate of 28.33 per 100,000 population. Juvenile arrest cases include three classes:

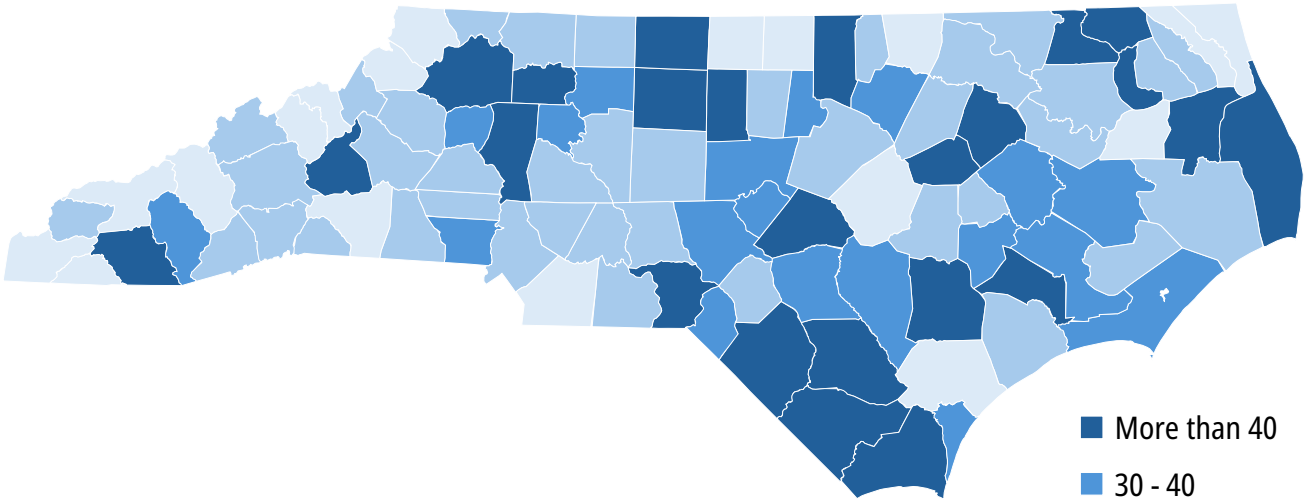
/ 01 **Violent Class A - E:** Person and violent offenses (e.g., robbery, kidnapping, attempted murder, etc.) by youth ages 8 to 17 at offense.

/ 02 **Serious Class F - I, A1:** F-I felony class-serious property or weapons offenses; A1 misdemeanors - assaults by youth ages 8 to 17 at offense.

/ 03 **Minor Class 1 - 3:** Misdemeanor classes (e.g., shoplifting, communicating threats, disorderly conduct at school, etc.) by youth ages 8 to 17 at offense.

The majority of juvenile arrest cases constitute minor offenses (21,010) compared to 2,688 violent offenses, and 15,218 serious offenses.

Figure 106. North Carolina Juvenile Delinquency Case Rate by County*



** Rate per 1,000 juveniles*

Data Source: North Carolina Department of Public Safety, North Carolina Division of Juvenile Justice and Delinquency Prevention; 2024

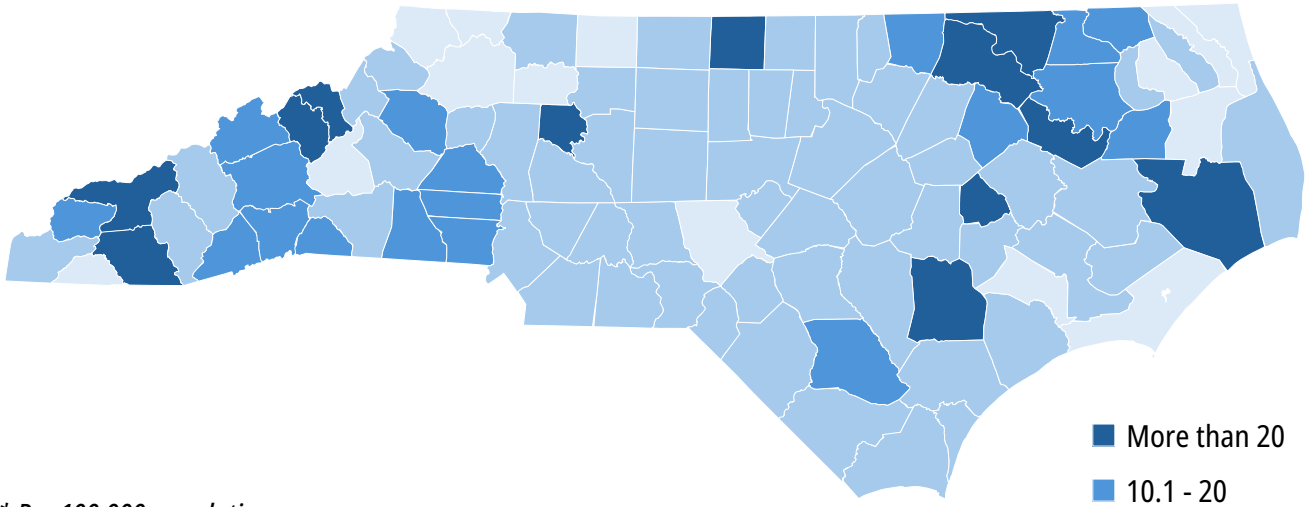
Federally Qualified Health Care Centers

This indicator reports the number of Federally Qualified Health Centers (FQHCs) in the community. This indicator is relevant because FQHCs are community assets that provide health care to vulnerable populations; they receive extra funding from the federal government to promote access to ambulatory care in areas designated as medically underserved.

Within North Carolina there are 465 FQHCs. This means there is a rate of 4.45 FQHCs per 100,000 total population.

North Carolina has more FQHCs per capita than the United States overall, indicating comparatively stronger availability of community-based primary care for low-income and medically underserved individuals.

Figure 107. North Carolina Federally Qualified Health Centers by County*



** Per 100,000 population*

Data Source: US Department of Health & Human Services, Center for Medicare & Medicaid Services, Provider of Services File, 2024

Figure 108. Federally Qualified Health Centers Comparison*

** Per 100,000 population*

Data Source: US Department of Health & Human Services, Center for Medicare & Medicaid Services, Provider of Services File, 2024

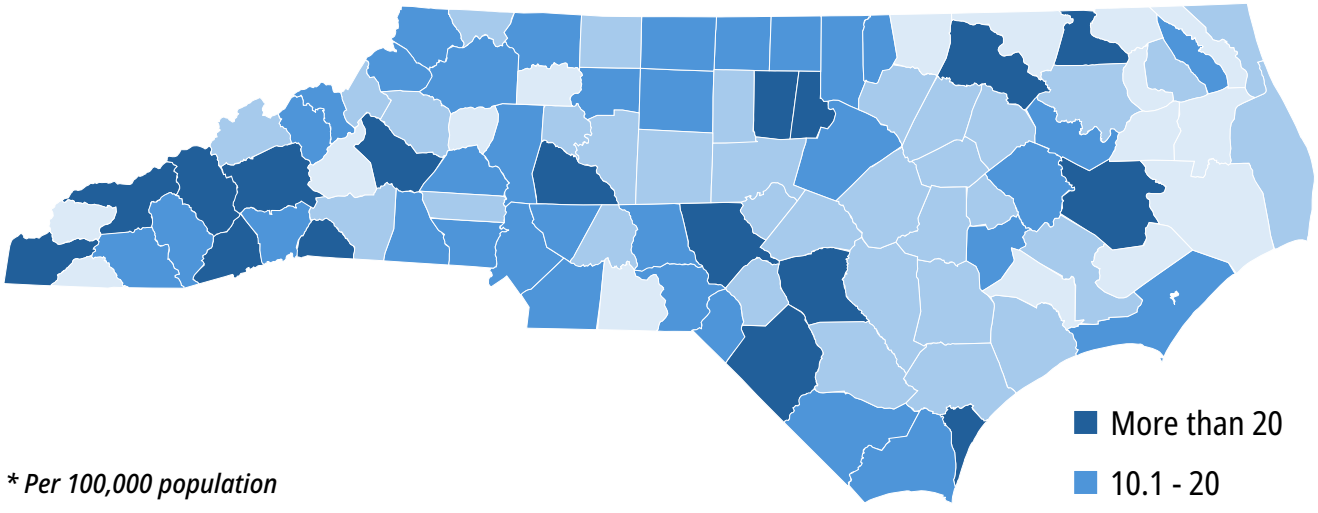
Access to Care – Buprenorphine Providers

Buprenorphine is the first medication to treat opioid dependency that is permitted to be prescribed or dispensed in physician offices, significantly increasing treatment access. Qualified physicians are required to acquire and maintain certifications to legally dispense or prescribe opioid dependency medications. The table below shows the number of providers authorized to treat opioid dependency with buprenorphine based on the latest available data from the Substance Abuse and Mental Health Services Administration (SAMHSA).

Within North Carolina there are 1,561 providers treating opioid dependency with buprenorphine. This represents 14.13 providers per 100,000 total population.

North Carolina has nearly the same number of buprenorphine providers per capita as the United States overall, indicating a generally comparable level of access to medications for opioid use disorder (MOUD), although modest expansion could help close the remaining gap.

Figure 109. North Carolina Buprenorphine Providers by County*



** Per 100,000 population*

Data Source: Substance Abuse and Mental Health Services Administration, SAMHSA - Buprenorphine Practitioner Locator, Oct. 2024

Figure 110. Buprenorphine Providers Comparison*

** Per 100,000 population*

Data Source: Substance Abuse and Mental Health Services Administration, SAMHSA - Buprenorphine Practitioner Locator, Oct. 2024

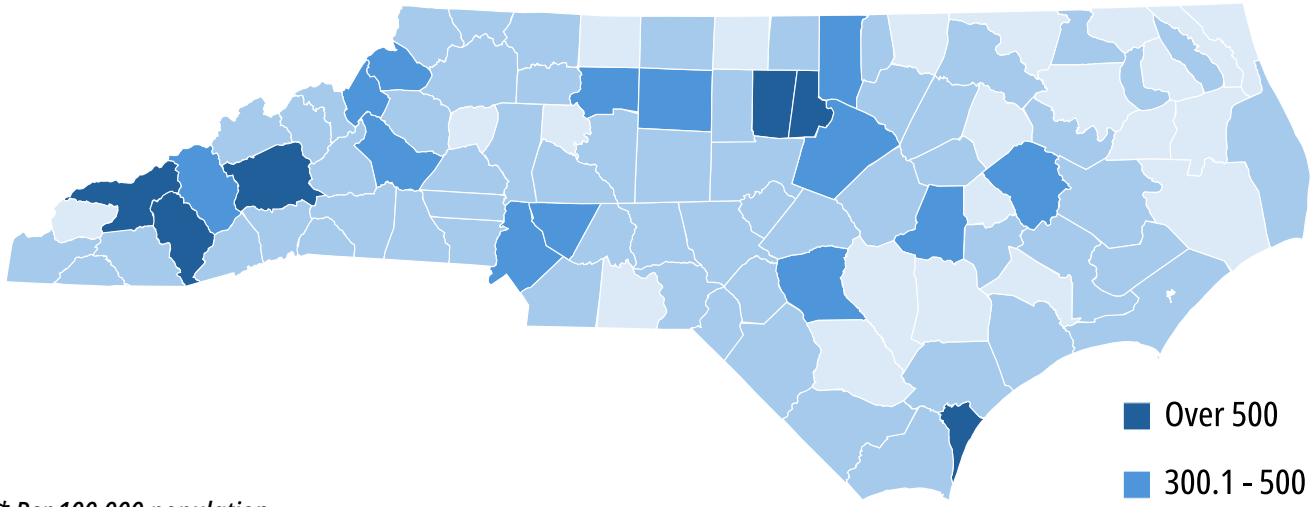
Access to Care - Mental Health Providers

This indicator reports the number of providers with a Centers for Medicare & Medicaid Services (CMS) National Provider Identifier (NPI) that specialize in mental health. Mental health providers include licensed clinical social workers and other licensed or credentialed professionals specializing in psychiatry, psychology, counseling, and behavioral health services for children, adolescents, and adults.

Within North Carolina, there are 34,204 mental health providers with a CMS NPI. This represents 327.64 providers per 100,000 total population.

North Carolina's mental health provider capacity is close to, but still below, the national average — highlighting ongoing workforce shortages that may contribute to challenges in accessing timely mental health services, especially in rural and underserved areas.

Figure 111. North Carolina Mental Health Providers by County*



** Per 100,000 population*

Data Source: Centers for Medicare & Medicaid Services, CMS - National Plan and Provider Enumeration System (NPPES), December 2025

Figure 112. Mental Health Providers Comparison*

** Per 100,000 population*

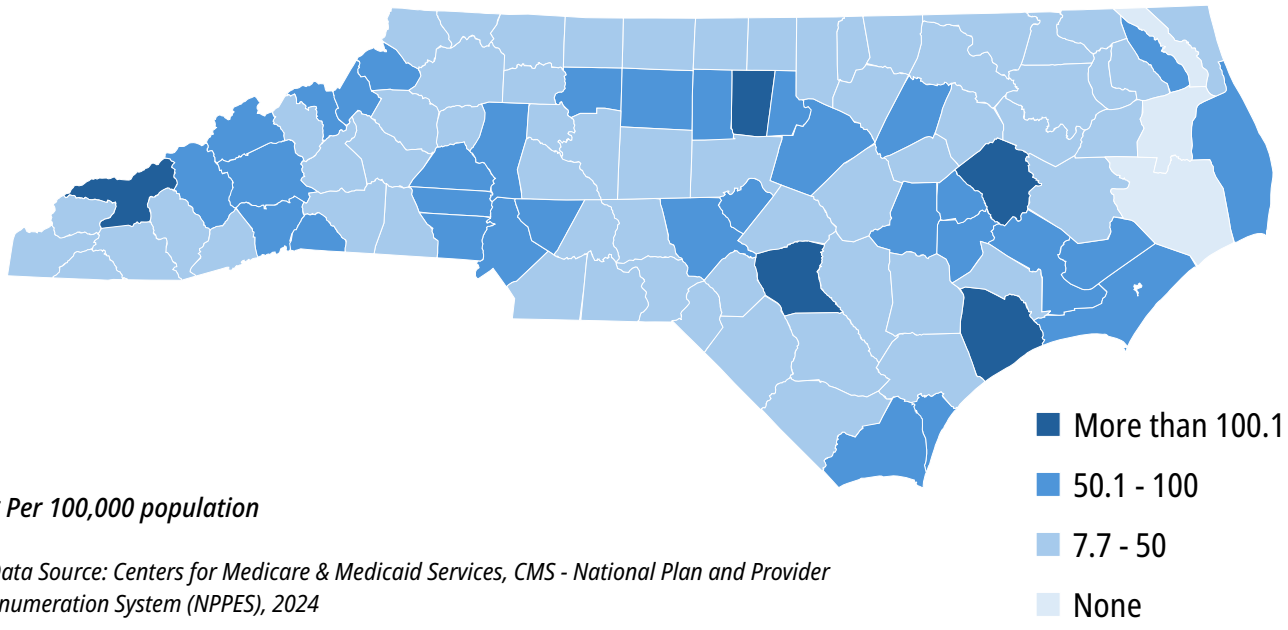
Data Source: Centers for Medicare & Medicaid Services, CMS - National Plan and Provider Enumeration System (NPPES), December 2025

Access to Care - Dental Health Providers

This indicator reports the number of oral health care providers with a CMS National Provider Identifier (NPI). Providers included in this summary are those who list "dentist," "general practice dentist," or "pediatric dentistry" as their primary practice classification, regardless of sub-specialty.

North Carolina's dental provider availability is lower than the U.S. average, highlighting a gap in oral health workforce capacity and the need for continued investment in dental access, recruitment, and retention strategies.

Figure 113. North Carolina Dental Health Providers by County*



** Per 100,000 population*

Data Source: Centers for Medicare & Medicaid Services, CMS - National Plan and Provider Enumeration System (NPPES), 2024

Figure 114. Dental Health Providers Comparison*

** Per 100,000 population*

Data Source: Centers for Medicare & Medicaid Services, CMS - National Plan and Provider Enumeration System (NPPES), 2024

Health Professional Shortage Areas - Dental Care

The Health Professional Shortage Area (HPSA) designation, assigned by the U.S. Health Resources and Services Administration (HRSA), identifies geographic areas, populations, or facilities that lack sufficient health care professionals to meet the health needs of the community. HPSAs are categorized into three main types according to the specific type of health professional shortage:

Types of HPSA

- **Primary Care HPSA:** Areas with a shortage of primary care physicians, including family medicine, internal medicine, pediatrics, obstetrics, and gynecology.
- **Dental Health HPSA:** Areas with a shortage of dental health professionals, such as general and pediatric dentists.
- **Mental Health HPSA:** Areas with a shortage of mental health providers, including psychiatrists, clinical psychologists, clinical social workers, psychiatric nurse specialists, and marriage and family therapists.

This indicator reports the total population in North Carolina that is living in a dental health care Health Professional Shortage Area, regardless of the degree of shortage, or whether the HPSA covers the entire geographic area or a population subgroup.

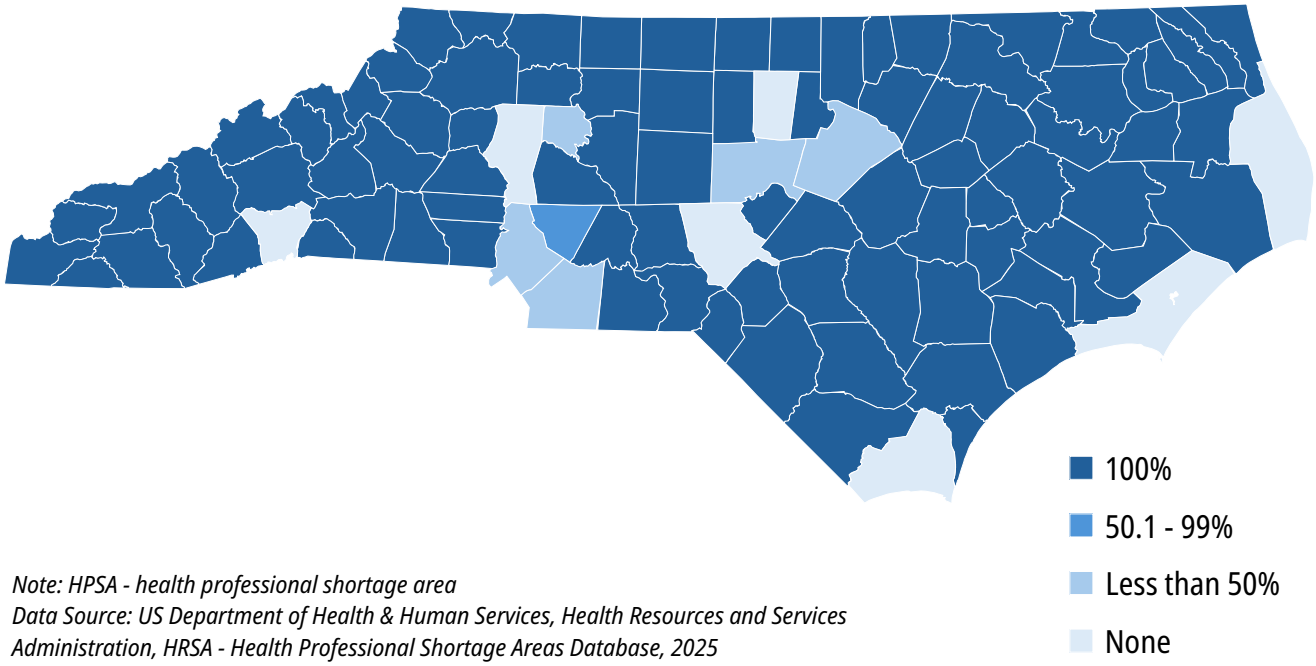
Within North Carolina, there are 7,869,993 people living in a dental health care Health Professional Shortage Area. This means 74.36% of people likely don't have reliable or affordable access to a dentist.

Two primary drivers of access decline: (1) stagnant Medicaid rates since 2008 and (2) insufficient hygienist supply growth. Both require investment and policy intervention.

Access to dental care remains a significant challenge across North Carolina. In 2024, 74.36% of North Carolinians lived in a Dental Health Professional Shortage Area (Dental HPSA) — more than double the national rate of 36.94%. This means that nearly three out of every four North Carolinians reside in communities with an insufficient number of dental providers. These shortages contribute to delayed or unmet dental care, higher rates of preventable oral disease, and increased use of emergency departments for dental conditions. The magnitude of North Carolina's dental workforce gaps underscores the urgent need for expanded provider recruitment, retention, and service delivery models, particularly in rural and underserved communities where shortages are most pronounced.

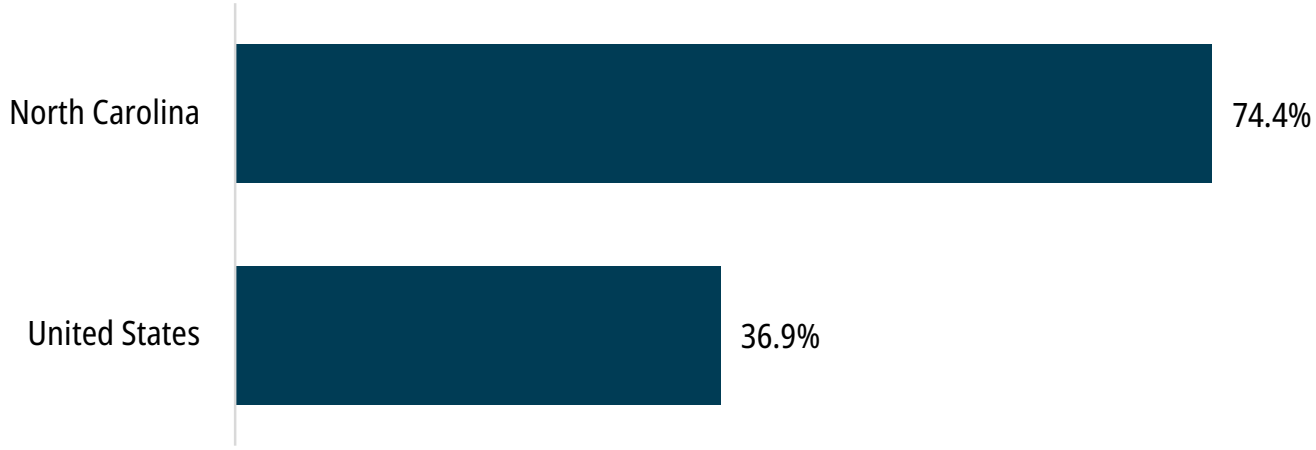
Registered dental hygienist (RDH) shortage is a critical and unaddressed workforce trend. RDH growth is not keeping pace with population growth or dentist supply. Since 2020, the ratio declined from 1.2 to 1.1 (RDH:DDS) since 2020. Without expanded educational pathways and retention efforts, shortages will intensify.

Figure 115. North Carolina Population Living in a Dental Health Care HPSA by County



Note: HPSA - health professional shortage area
Data Source: US Department of Health & Human Services, Health Resources and Services Administration, HRSA - Health Professional Shortage Areas Database, 2025

Figure 116. Population Living in a Dental Health Care HPSA Comparison



Note: HPSA - health professional shortage area
Data Source: US Department of Health & Human Services, Health Resources and Services Administration, HRSA - Health Professional Shortage Areas Database, 2025

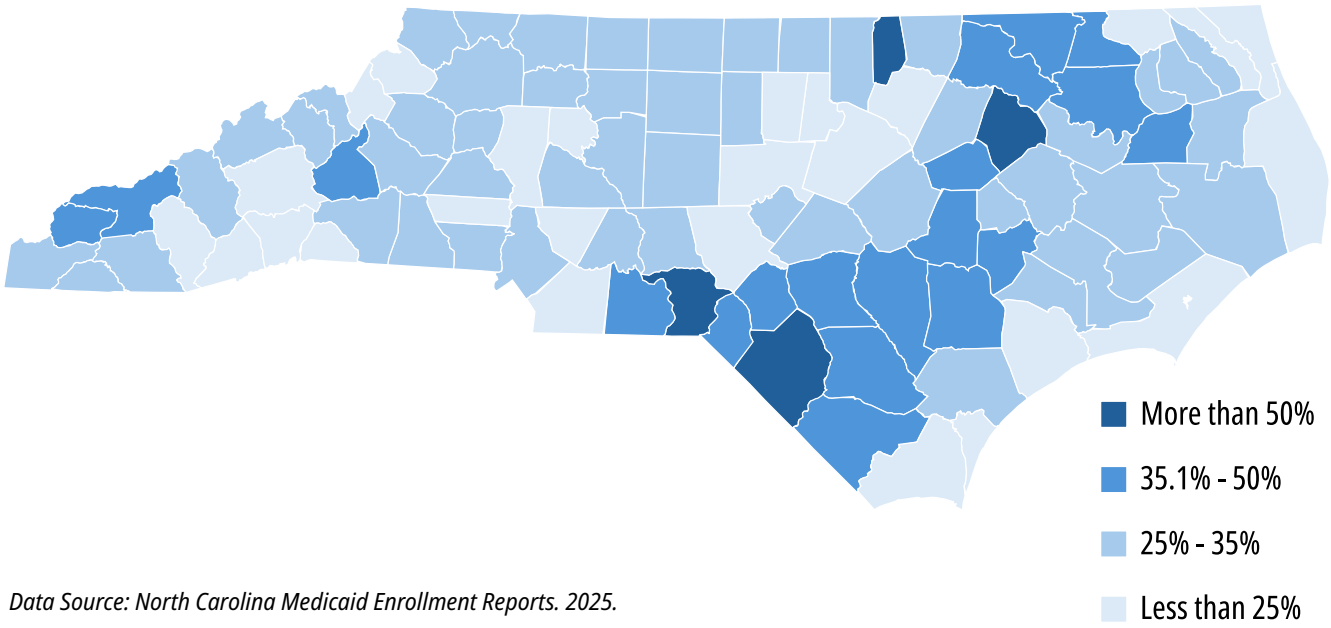
Health Insurance - Population Receiving Medicaid

NC Medicaid provides health coverage to eligible low-income individuals in North Carolina, including children, pregnant women, older adults, people with disabilities, and working families. Jointly funded by the state and federal governments, NC Medicaid offers access to essential health services such as doctor visits, hospital care, and prescription medications. This program plays a vital role in improving public health, lowering the uninsured rate, and promoting financial stability for millions of North Carolinians.

This indicator reports the number and percentage of unique individuals enrolled in the NC Medicaid program.

With a total population of 11,046,024, North Carolina has 2,978,559 individuals enrolled in Medicaid in 2025, representing 27% percentage of the total population.

Figure 117. North Carolina Insured Population Receiving Medicaid by County



Data Source: North Carolina Medicaid Enrollment Reports. 2025.

Prevention - High Blood Pressure Management (Medicare)

This indicator reports the number and percentage of Medicare beneficiaries not adhering to blood pressure medication schedules. Nonadherence is defined as having medication coverage days at less than 80%.

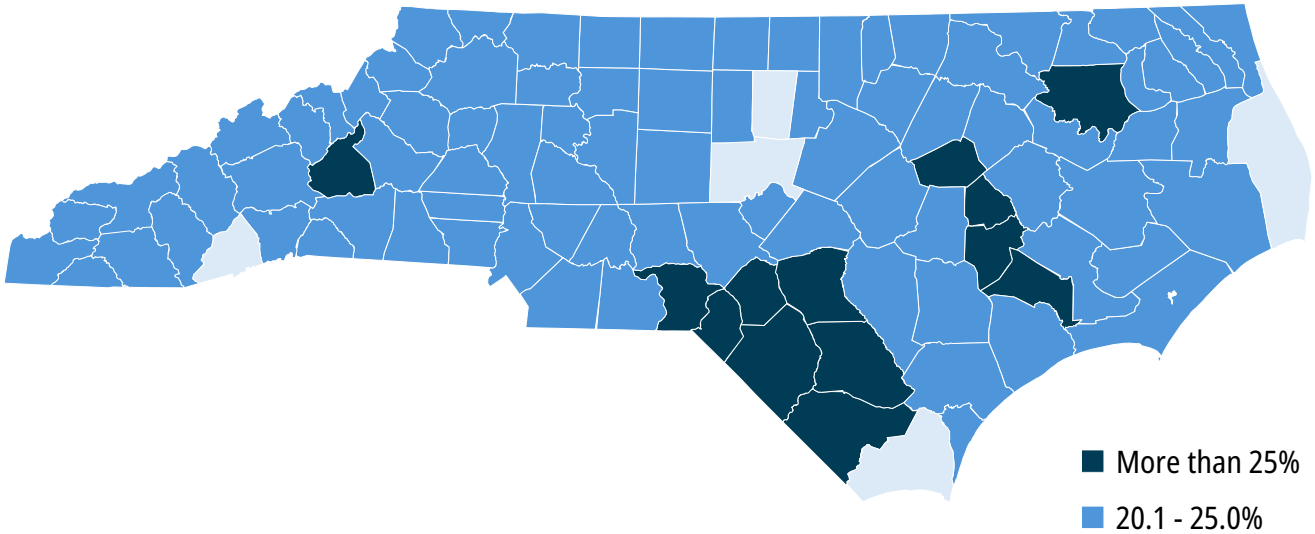
Medication nonadherence among older adults is a major risk factor for:

- Poorly controlled hypertension
- Stroke and heart attack
- Kidney disease
- Avoidable emergency department visits and hospitalizations

Older adults often face barriers such as medication cost, complexity of regimens, side effects, transportation challenges, or difficulty managing multiple prescriptions.

North Carolina has a slightly higher rate of blood pressure medication nonadherence among Medicare beneficiaries than the U.S. overall, indicating a need for continued focus on medication management support, affordability, patient education, and chronic disease management programs for older adults.

Figure 118. North Carolina Medicare Beneficiaries with Blood Pressure Medication Nonadherence by County



Data Source: Centers for Disease Control and Prevention, CDC - Atlas of Heart Disease and Stroke, 2019-2021

Figure 119. Medicare Beneficiaries with Blood Pressure Medication Nonadherence Comparison

Data Source: Centers for Disease Control and Prevention, CDC - Atlas of Heart Disease and Stroke, 2019-2021

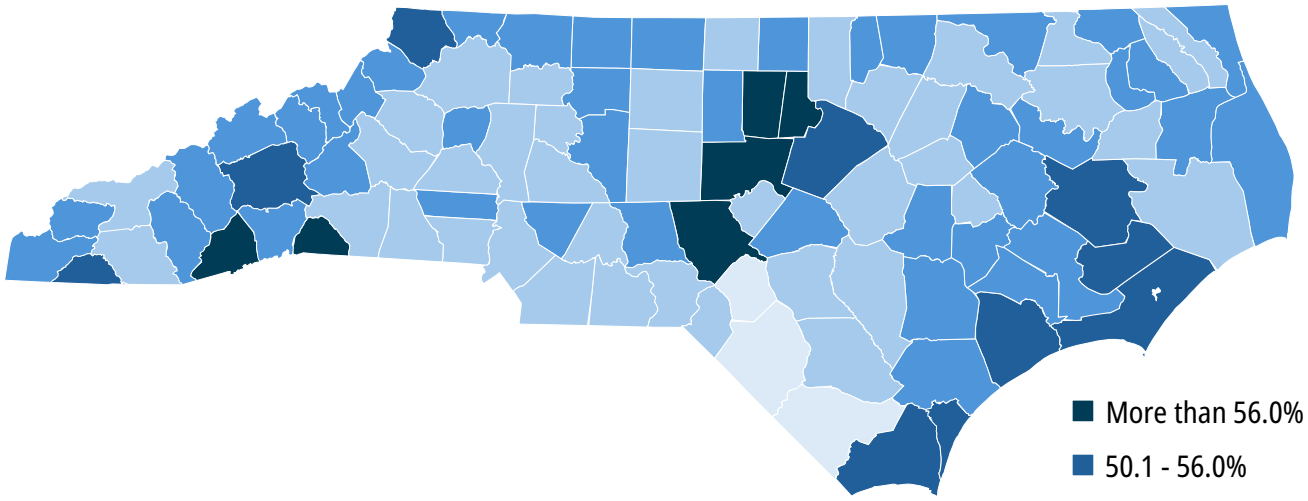
Prevention - Seasonal Influenza Vaccine

The most recent data from North Carolina show that 46.2% of adults ages 18 and older reported receiving an influenza vaccination in the past 12 months.

Influenza vaccination is a key preventive measure that reduces severe illness, hospitalizations, and strain on the health care system, especially important for older adults, medically vulnerable individuals, and during years with high respiratory disease activity.

North Carolina adults receive influenza immunizations at similar — and slightly higher — rates compared to adults nationwide.

Figure 120. Seasonal Influenza Vaccine Among North Carolina Adults by County



Data Source: Centers for Disease Control and Prevention, CDC - FluVaxView, 2022

Figure 121. Seasonal Influenza Vaccine Among Adults Comparison

Data Source: Centers for Disease Control and Prevention, CDC - FluVaxView, 2022

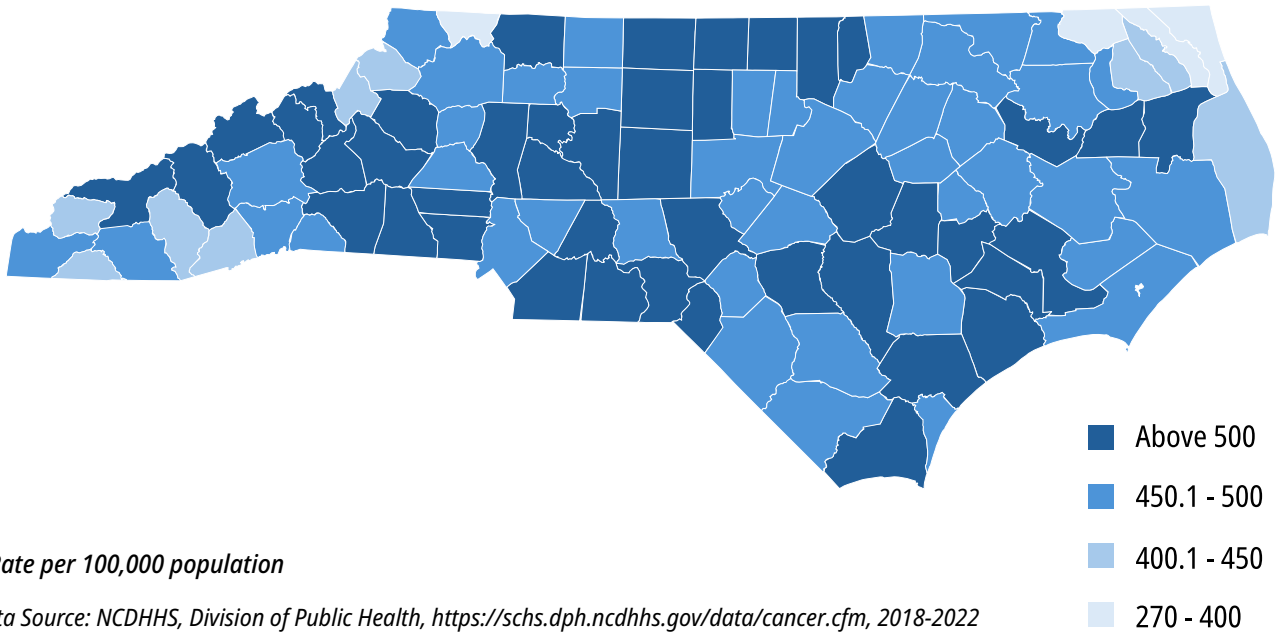
Cancer Incidence - All Sites

This indicator shows the rate of all cancer incidence in North Carolina. Rates are expressed per 100,000 population and are age-adjusted to the 2000 U.S. Standard Population. County cancer statistics are calculated using five-year aggregates ending in the selected year. For example, 2022 rates are based on aggregate data from 2018 to 2022.

In 2022, there were 320,588 total cases, resulting in a cancer incidence rate of 495.3 per 100,000 population for the entire state.

- Cancer remains a leading cause of death in North Carolina and continues to impose a substantial burden across all population groups (North Carolina State Center for Health Statistics [SCHS], 2025; American Cancer Society [ACS], 2024).
- Although overall cancer incidence and mortality have declined over the past several decades due to advances in prevention, early detection, and treatment, North Carolina continues to experience thousands of new cancer diagnoses and deaths each year (U.S. Cancer Statistics Working Group, 2024; National Cancer Institute [NCI]).
- Persistent disparities remain evident, with higher incidence and mortality among individuals living in rural counties, people with lower socioeconomic status, and certain racial and ethnic groups — particularly Black North Carolinians (Centers for Disease Control and Prevention [CDC], 2024; ACS, 2024).
- Continued investment in cancer prevention, expanded access to evidence-based screening, strengthened tobacco control, and improved access to high-quality treatment are essential to further reducing the burden of cancer and improving health outcomes statewide (CDC, 2024; NCI; ACS, 2024).

Figure 122. North Carolina Cancer Incidence (All Sites) by County, 2018 – 2022*



** Rate per 100,000 population*

Data Source: NCDHHS, Division of Public Health, https://schs.dph.ncdhhs.gov/data/cancer.cfm, 2018-2022
https://ncdataportal.org/cares_shortlinks/7pbvk3lz/

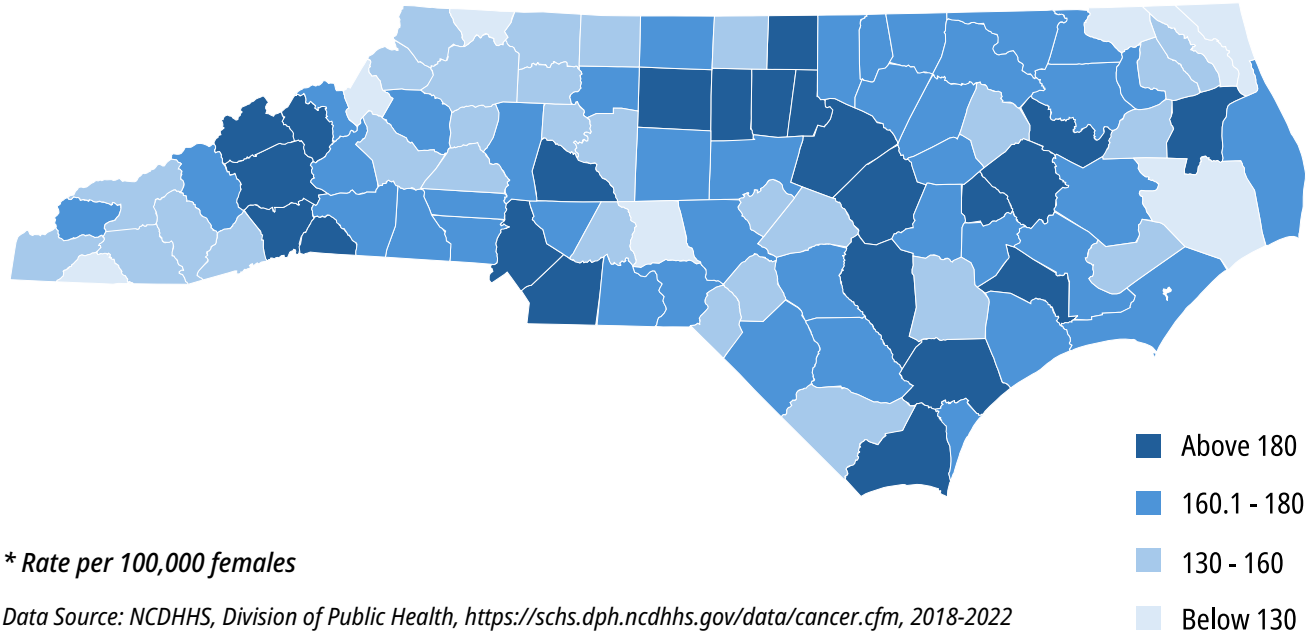
Cancer Incidence - Breast

This indicator shows the rate of breast cancer incidence in North Carolina. Rates are expressed per 100,000 population and are age-adjusted to the 2000 U.S. Standard Population. County cancer statistics are calculated using five-year aggregates ending in the selected year. For example, 2022 rates are based on aggregate data from 2018 to 2022.

In 2022, there were 58,979 total cases, resulting in a breast cancer incidence rate of 176.7 per 100,000 population for the entire state. This rate is notably higher than the U.S. average.

- Breast cancer is the most commonly diagnosed cancer among women in North Carolina, and the state continues to experience a substantial burden of disease (National Cancer Institute [NCI]; North Carolina State Center for Health Statistics [SCHS], 2025).
- North Carolina's age-adjusted incidence rate remains higher than the national average; breast cancer accounts for thousands of new diagnoses each year and a significant number of cancer-related deaths (NCI; U.S. Cancer Statistics Working Group, 2024; American Cancer Society [ACS], 2024).
- Persistent disparities are evident, with Black women in North Carolina experiencing higher mortality despite similar or lower incidence, reflecting longstanding differences in access to early detection, timely follow-up, and treatment (Centers for Disease Control and Prevention [CDC], 2024; ACS, 2024).
- Efforts to improve screening, promote early detection, and strengthen access to high-quality treatment — especially in rural and underserved communities — remain essential to reducing breast cancer mortality statewide (CDC, 2024; ACS, 2024; SCHS, 2025).

Figure 123. North Carolina Breast Cancer Incidence by County, 2018 – 2022*



** Rate per 100,000 females*

Data Source: NCDHHS, Division of Public Health, https://schs.dph.ncdhhs.gov/data/cancer.cfm, 2018-2022
https://ncdataportal.org/cares_shortlinks/cndu5gte/

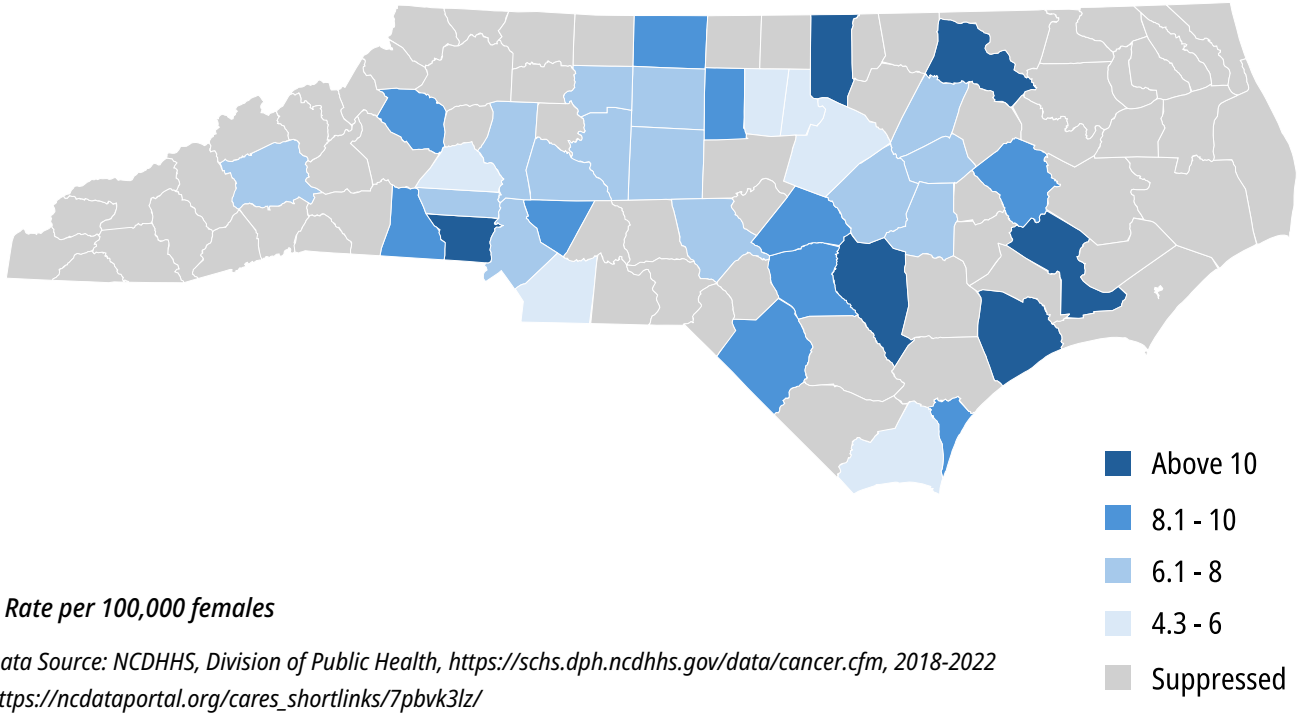
Cancer Incidence - Cervical

This indicator shows the rate of cervical and uterine cancer incidence in North Carolina. Rates are expressed per 100,000 population and are age-adjusted to the 2000 U.S. Standard Population. County cancer statistics are calculated using five-year aggregates ending in the selected year. For example, 2022 rates are based on aggregate data from 2018 to 2022.

In 2022, there were 1,966 total cases, resulting in a cancer incidence rate of 7.0 per 100,000 population for the entire state.

- Cervical cancer in North Carolina is largely preventable, yet the state continues to experience persistent disparities in incidence and mortality (National Cancer Institute [NCI]; North Carolina State Center for Health Statistics [SCHS], 2024; Centers for Disease Control and Prevention [CDC], 2024).
- Although overall rates have declined, Black and Hispanic women and those in rural communities bear a disproportionate burden of disease (NCI, 2023; CDC, 2024; SCHS, 2024).
- Expanded access to preventive services — Pap and HPV testing, HPV vaccination, and timely diagnostic care — remains critical to eliminating cervical cancer as a public health problem (CDC, 2024; CDC, 2024; American Cancer Society [ACS], 2024).

Figure 124. North Carolina Cervical Cancer Incidence by County, 2018 – 2022*



** Rate per 100,000 females*

Data Source: NCDHHS, Division of Public Health, https://schs.dph.ncdhhs.gov/data/cancer.cfm, 2018-2022
https://ncdataportal.org/cares_shortlinks/7pbvk3lz/

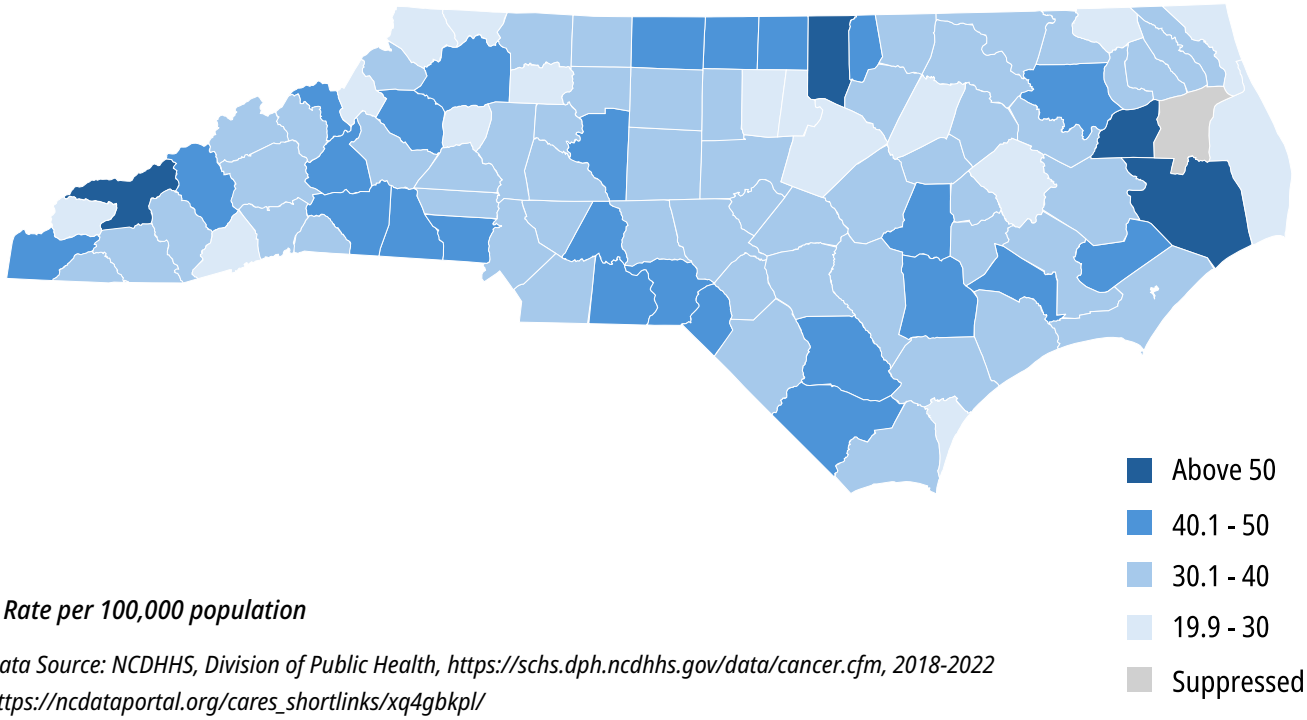
Cancer Incidence - Colon and Rectum

This indicator shows the rate of colorectal cancer incidence in North Carolina. Rates are expressed per 100,000 population and are age-adjusted to the 2000 U.S. Standard Population. County cancer statistics are calculated using five-year aggregates ending in the selected year. For example, 2022 rates are based on aggregate data from 2018 to 2022.

In 2022, there were 22,205 total cases, resulting in a colorectal cancer incidence rate of 35.5 per 100,000 population for the entire state.

- Colorectal cancer remains a significant public health concern in North Carolina, ranking among the leading causes of cancer-related deaths for both men and women (North Carolina State Center for Health Statistics [SCHS], 2025; American Cancer Society [ACS], 2024).
- Although North Carolina's age-adjusted incidence rate is similar to or slightly lower than the national average, colorectal cancer continues to account for a substantial number of diagnoses each year (National Cancer Institute [NCI]; U.S. Cancer Statistics Working Group, 2024).
- Mortality has declined over time, reflecting improvements in screening, early detection, and treatment, yet disparities persist across racial and geographic groups, with Black individuals and individuals living in rural areas experiencing higher mortality rates (Centers for Disease Control and Prevention [CDC], 2024; ACS, 2024).
- Continued efforts to expand access to recommended screening — particularly colonoscopy and stool-based tests — are essential for reducing the burden of colorectal cancer and addressing screening gaps among uninsured and underserved adults statewide (CDC, 2024; NCI; ACS, 2024).

Figure 125. North Carolina Colon and Rectum Cancer Incidence by County, 2018 – 2022*



** Rate per 100,000 population*

Data Source: NCDHHS, Division of Public Health, https://schs.dph.ncdhhs.gov/data/cancer.cfm, 2018-2022
https://ncdataportal.org/cares_shortlinks/xq4gbkpl/

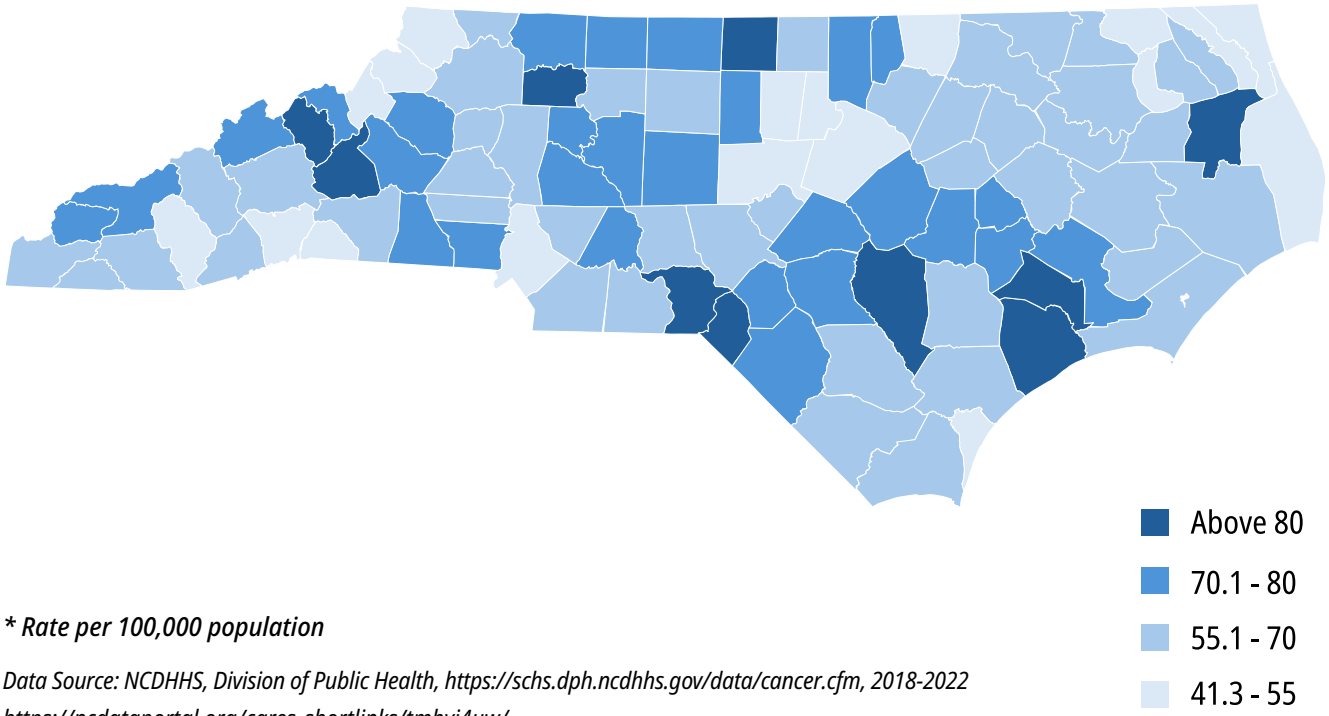
Cancer Incidence - Lung

This indicator shows the rate of lung cancer incidence in North Carolina. Rates are expressed per 100,000 population and are age-adjusted to the 2000 U.S. Standard Population. County cancer statistics are calculated using five-year aggregates ending in the selected year. For example, 2022 rates are based on aggregate data from 2018 to 2022.

In 2022, there were 41,880 total cases, resulting in a lung cancer incidence rate of 61.5 per 100,000 population for the entire state.

- Lung cancer remains the leading cause of cancer death in North Carolina, accounting for more deaths than breast, colorectal, and prostate cancers combined (American Cancer Society [ACS], 2024; North Carolina State Center for Health Statistics [SCHS], 2025).
- Although incidence and mortality have declined over the past decade due to reductions in smoking and improvements in early detection and treatment, North Carolina continues to experience a substantial burden of disease, with thousands of new cases and deaths each year (National Cancer Institute [NCI]; U.S. Cancer Statistics Working Group, 2024).
- Persistent disparities are evident across demographic and geographic groups, with higher incidence and mortality among individuals living in rural counties and among populations with higher rates of tobacco use (Centers for Disease Control and Prevention [CDC], 2024; ACS, 2024).
- Expanding access to smoking cessation resources, increasing uptake of evidence-based lung cancer screening, and ensuring timely access to diagnostic and treatment services remain essential strategies for reducing the burden of lung cancer statewide (CDC, 2024; NCI; ACS, 2024).

Figure 126. North Carolina Lung Cancer Incidence by County, 2018 – 2022*



** Rate per 100,000 population*

Data Source: NCDHHS, Division of Public Health, https://schs.dph.ncdhhs.gov/data/cancer.cfm, 2018-2022
https://ncdataportal.org/cares_shortlinks/tmhyi4uw/

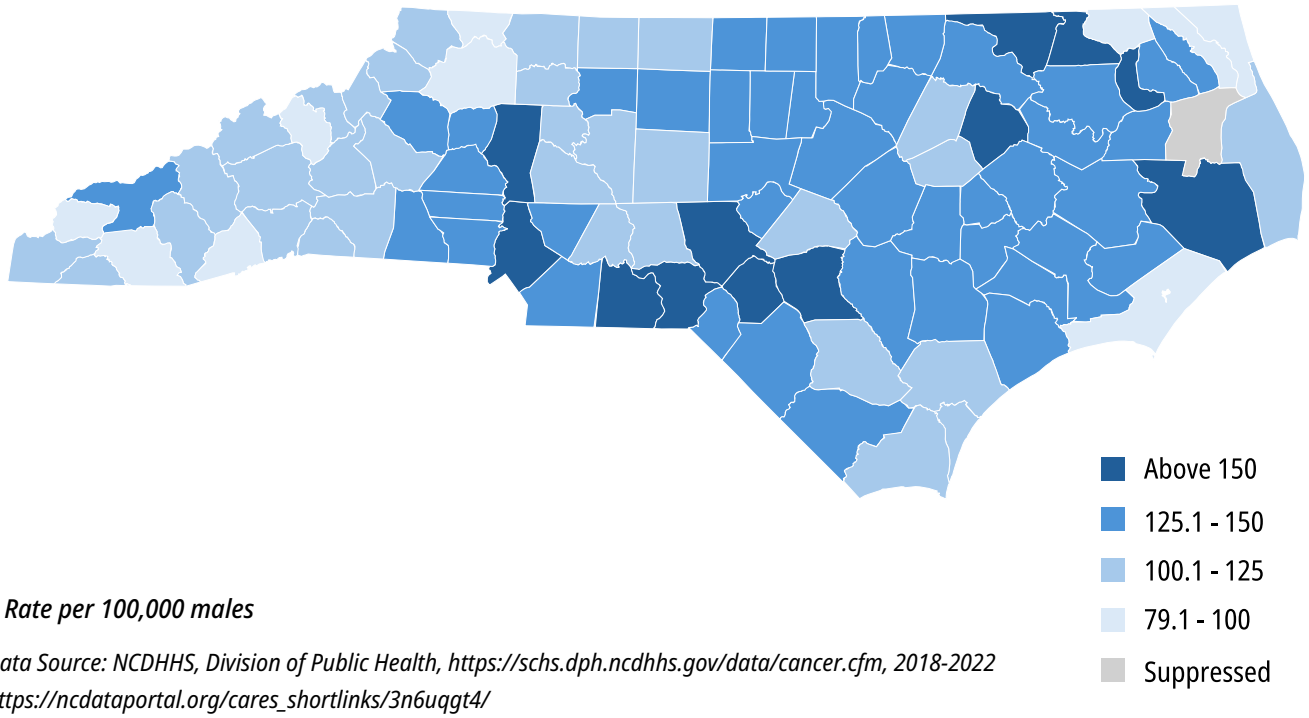
Cancer Incidence - Prostate

This indicator shows the rate of prostate cancer incidence in North Carolina. Rates are expressed per 100,000 population and are age-adjusted to the 2000 U.S. Standard Population. County cancer statistics are calculated using five-year aggregates ending in the selected year. For example, 2022 rates are based on aggregate data from 2018 to 2022.

In 2022, there were 43,072 total cases, resulting in a prostate cancer incidence rate of 132.2 per 100,000 population for the entire state.

- Prostate cancer is one of the most commonly diagnosed cancers among men in North Carolina, accounting for a substantial proportion of annual cancer diagnoses statewide (North Carolina State Center for Health Statistics [SCHS], 2025; American Cancer Society [ACS], 2024).
- Although mortality has declined over the past several decades due to improvements in early detection and treatment, North Carolina continues to experience notable disparities, with Black men facing significantly higher incidence and mortality rates compared to white men (National Cancer Institute [NCI]; Centers for Disease Control and Prevention [CDC], 2024).
- Geographic variation is also evident, with rural counties experiencing higher mortality along with reduced access to screening and specialty care services (U.S. Cancer Statistics Working Group, 2024; ACS, 2024).
- Continued investment in equitable access to preventive care, patient education, and timely treatment — especially for populations at highest risk — remains essential for reducing the burden of prostate cancer across North Carolina (CDC, 2024; ACS, 2024).

Figure 127. North Carolina Prostate Cancer Incidence by County, 2018 – 2022*



** Rate per 100,000 males*

Data Source: NCDHHS, Division of Public Health, https://schs.dph.ncdhhs.gov/data/cancer.cfm, 2018-2022
https://ncdataportal.org/cares_shortlinks/3n6uqgt4/

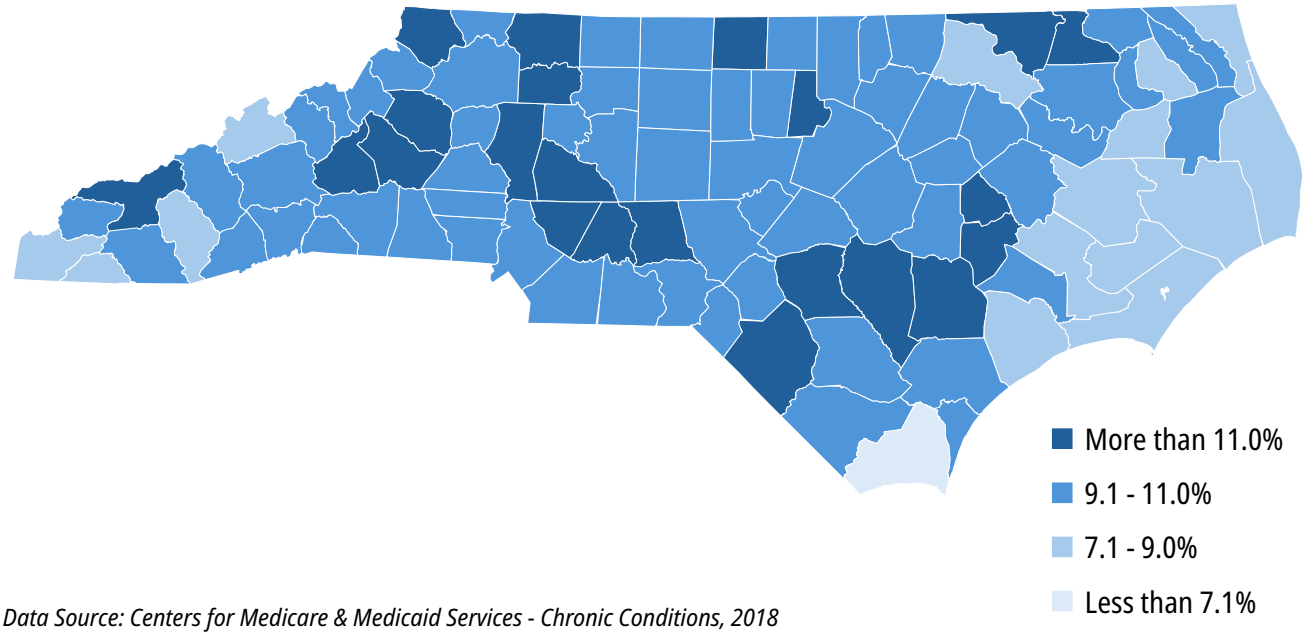
Chronic Conditions - Alzheimer's Disease/Dementia

This indicator reports the percentage of Medicare Fee-for-Service population with Alzheimer's Disease. Data are based upon Medicare administrative enrollment and claims-related data for Medicare beneficiaries enrolled in the Fee-for-Service program.

- Alzheimer's disease and related dementias (ADRD) represent a growing public health challenge in North Carolina, affecting more than **180,000 adults ages 65 and older**, a number projected to exceed **230,000 by 2035** as the state's population continues to age (Alzheimer's Association, 2024; North Carolina Department of Health and Human Services [NCDHHS], 2024).
- Among Medicare beneficiaries, Alzheimer's disease is one of the most common chronic conditions, contributing to higher rates of hospitalization, emergency department use, and long-term care needs compared to beneficiaries without dementia (Centers for Medicare & Medicaid Services [CMS], 2024; Alzheimer's Association, 2024).
- Significant disparities persist, with **Black and Hispanic Medicare beneficiaries** experiencing substantially higher prevalence and poorer outcomes due to barriers in early detection, diagnosis, and access to specialty care (Centers for Disease Control and Prevention [CDC], 2024; CMS, 2024).
- Rural regions of North Carolina face additional challenges, including limited memory care services and increased caregiver burden (NCDHHS, 2024; Alzheimer's Association, 2024).
- Continued investment in early diagnosis, caregiver support, dementia-capable health systems, and community-based services will be essential to addressing the increasing burden of ADRD across the state (CDC, 2024; CMS, 2024).

North Carolina's Alzheimer's disease prevalence among Medicare beneficiaries is nearly identical to the national rate, indicating that the state faces a comparable level of dementia burden and will require continued investment in aging services, caregiver support, and dementia-capable health care as the population grows older.

Figure 128. North Carolina Medicare Beneficiaries with Alzheimer's Disease by County



Data Source: Centers for Medicare & Medicaid Services - Chronic Conditions, 2018

Figure 129. Medicare Beneficiaries with Alzheimer's Disease Comparison

Data Source: Centers for Medicare & Medicaid Services - Chronic Conditions, 2018

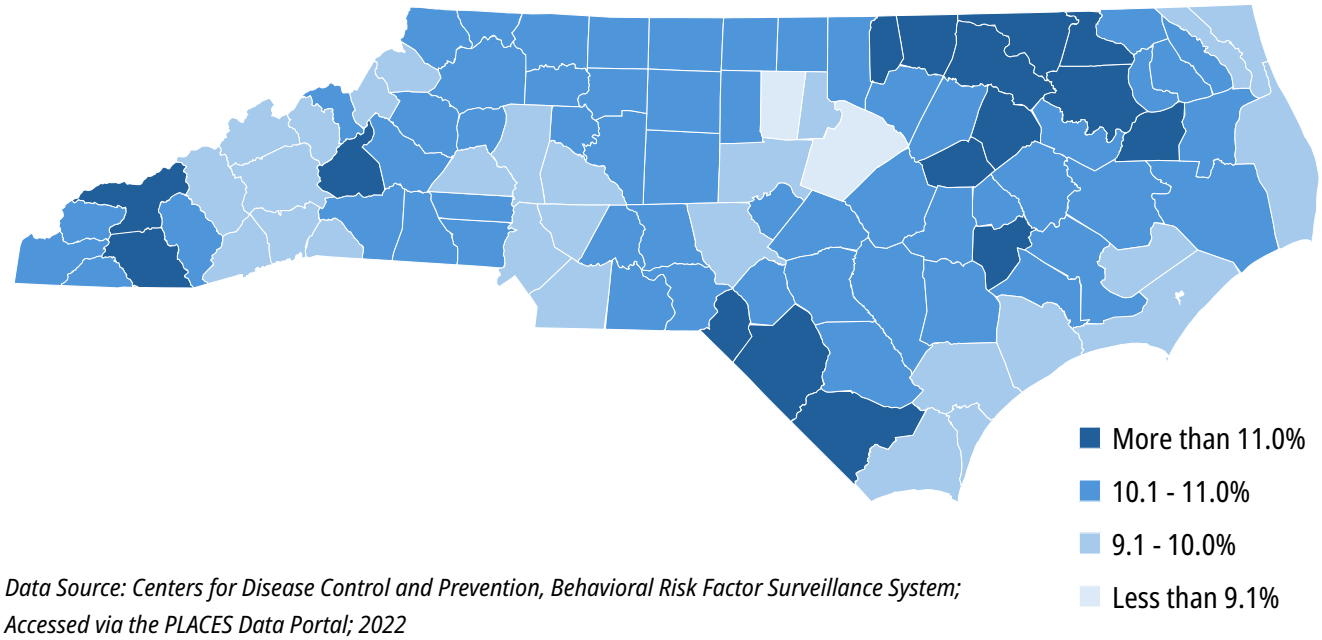
Chronic Conditions - Asthma Prevalence (Adult)

This indicator reports the percentage of adults ages 18 and older who answer "yes" to both of the following questions: "Have you ever been told by a doctor, nurse, or other health professional that you have asthma?" and the question "Do you still have asthma?"

Asthma affects hundreds of thousands of adults across the state and is a major cause of missed workdays, reduced quality of life, and preventable emergency department visits.

- Adult asthma remains a significant chronic health condition in North Carolina, affecting approximately 9 to 10% of adults — slightly above national prevalence — and contributing to substantial morbidity across the state (Centers for Disease Control and Prevention [CDC], 2024; North Carolina Department of Health and Human Services [NCDHHS], 2023).
- Persistent disparities exist, with higher prevalence and more severe outcomes reported among women, Black adults, low-income households, and individuals living in rural counties (CDC, 2024; NCDHHS, 2023).
- Asthma continues to be a major cause of preventable emergency department visits and hospitalizations in North Carolina, particularly in eastern counties where environmental and socioeconomic stressors amplify disease burden (NCDHHS, 2023; CDC, 2024).
- Environmental triggers — including poor air quality, high pollen levels, older housing conditions, and occupational exposures — further contribute to uncontrolled symptoms and increased health care use (CDC, 2024).
- Efforts to improve asthma control, expand access to preventive and specialty care, and address environmental contributors remain essential for reducing asthma-related disparities and improving quality of life among adults statewide (CDC, 2024; NCDHHS, 2023).

Figure 130. North Carolina Adults with Asthma by County



Data Source: Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System; Accessed via the PLACES Data Portal; 2022

Figure 131. Adults with Asthma Comparison

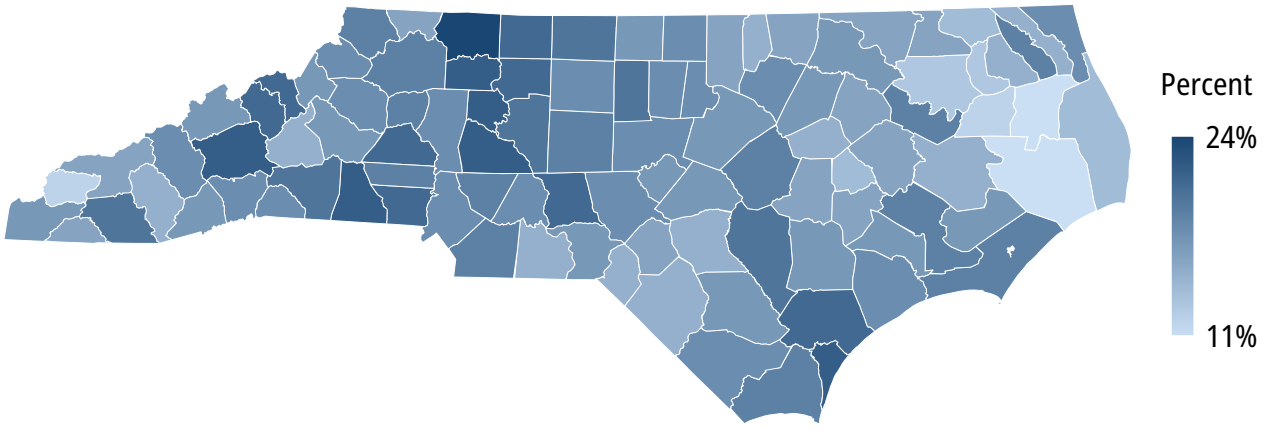
Data Source: Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System; Accessed via the PLACES Data Portal; 2022

Chronic Conditions - Depression (Medicare Population)

This indicator reports the unsmoothed, age-adjusted rate of depressive disorders prevalence for the Medicare Fee-For-Service (FFS) population for the year 2023.

- Depression is one of the most common chronic conditions among Medicare beneficiaries, affecting nearly one in five older adults nationwide, and North Carolina's prevalence is comparable to or slightly higher than national averages depending on the year and dataset (Centers for Medicare & Medicaid Services [CMS], 2024; Centers for Disease Control and Prevention [CDC], 2024).
- In North Carolina, depression is consistently among the top chronic conditions reported within the Medicare population, contributing to higher rates of health care utilization, emergency department visits, and hospitalizations for co-occurring medical conditions (CMS, 2024; North Carolina Department of Health and Human Services [NCDHHS], 2024).
- Marked gender differences persist. Women enrolled in Medicare are diagnosed with depression at nearly twice the rate of men, mirroring national trends and reflecting both biological and social determinants of mental health (CDC, 2024; CMS, 2024).
- North Carolina also experiences disparities across racial, socioeconomic, and geographic groups, with rural beneficiaries and those with limited access to behavioral health services experiencing higher symptom burden and poorer treatment access (NCDHHS, 2024; CDC, 2024).
- Strengthening access to integrated behavioral health services, expanding screening and follow-up care, and addressing social drivers of mental health remain essential to improving outcomes for Medicare beneficiaries statewide (CMS, 2024; CDC, 2024).

Figure 132. North Carolina Medicare Beneficiaries with Depressive Disorder by County

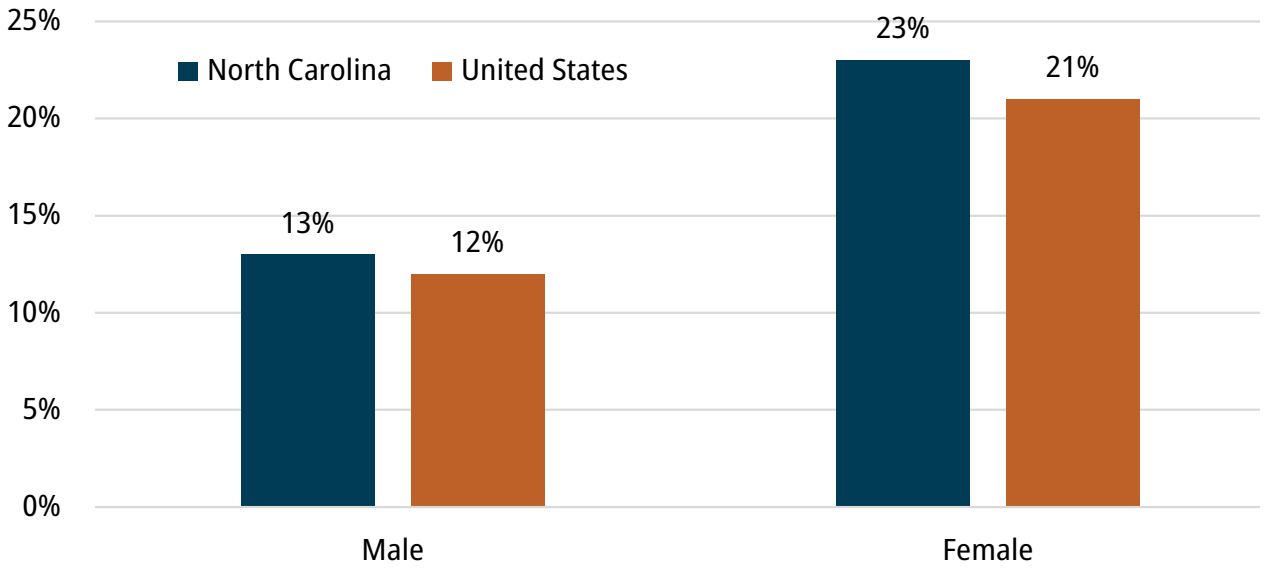


Data Source: Centers for Medicare & Medicaid Services, Mapping Medicare Disparities Tool, 2023

Figure 133. Medicare Beneficiaries with Depressive Disorder Comparison

Data Source: Centers for Medicare & Medicaid Services, Mapping Medicare Disparities Tool, 2023

Figure 134. Medicare Beneficiaries with Depressive Disorder by Gender Comparison



Data Source: Centers for Medicare & Medicaid Services, Mapping Medicare Disparities Tool, 2023

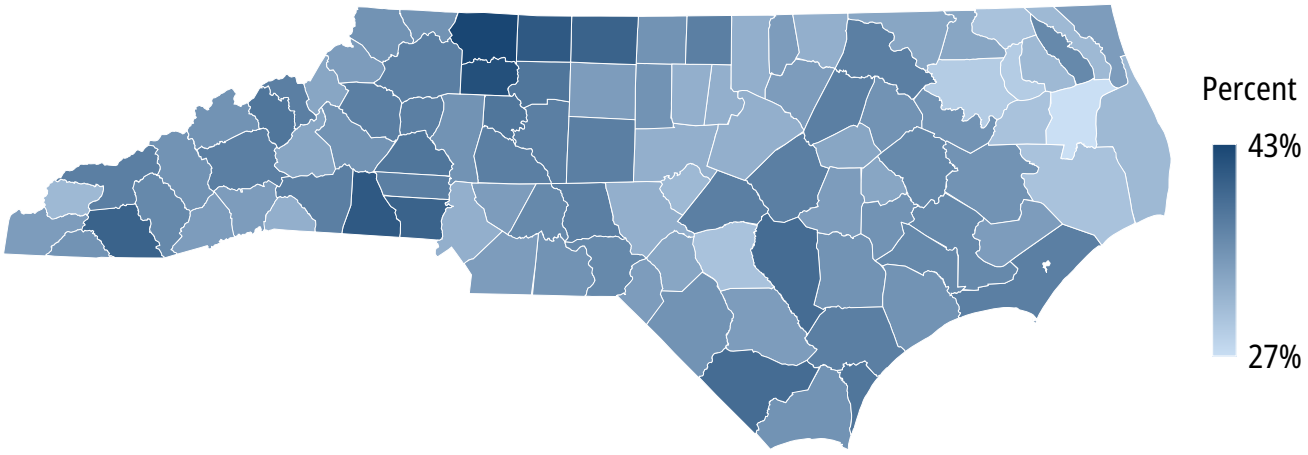
Chronic Conditions - Mental Health and Substance Use Conditions

This indicator reports the unsmoothed, age-adjusted rate of annual wellness visits among the Medicare Fee-For-Service (FFS) population for the year 2023.

- Chronic mental health and substance use conditions remain major contributors to morbidity and mortality in North Carolina, with more than one in three adults reporting a mental health concern or substance use disorder (Centers for Disease Control and Prevention [CDC], 2024; Substance Abuse and Mental Health Services Administration [SAMHSA], 2024).
- Depression and anxiety are the most commonly reported mental health conditions, and both have increased in prevalence since the COVID-19 pandemic, contributing to greater demand for behavioral health services statewide (CDC, 2024; North Carolina Department of Health and Human Services [NCDHHS], 2024).
- Substance use disorders, including alcohol, opioids, and stimulants, continue to drive significant health and social impacts, with North Carolina experiencing persistently high rates of overdose deaths and increased hospitalizations related to polysubstance use (NCDHHS, 2024; SAMHSA, 2024).
- Marked disparities persist, with higher burden observed among rural communities, low-income adults, and Black and American Indian/Alaska Native populations due to structural barriers that limit access to timely diagnosis, treatment, and recovery supports (CDC, 2024; NCDHHS, 2024).
- Continued investment in integrated behavioral health care, crisis response, harm reduction, and long-term recovery services remains essential to improving outcomes for individuals living with mental health and substance use conditions across the state (SAMHSA, 2024; CDC, 2024).

North Carolina has a slightly higher prevalence of mental health and substance use conditions compared to the U.S. overall, underscoring the need for expanded behavioral health services, coordinated care, and continued investment in prevention and early intervention strategies.

Figure 135. North Carolina Mental Health and Substance Use Prevalence by County



Data Source: Centers for Medicare & Medicaid Services, Mapping Medicare Disparities Tool, 2023

Figure 136. Mental Health and Substance Use Prevalence Comparison

Data Source: Centers for Medicare & Medicaid Services, Mapping Medicare Disparities Tool, 2023

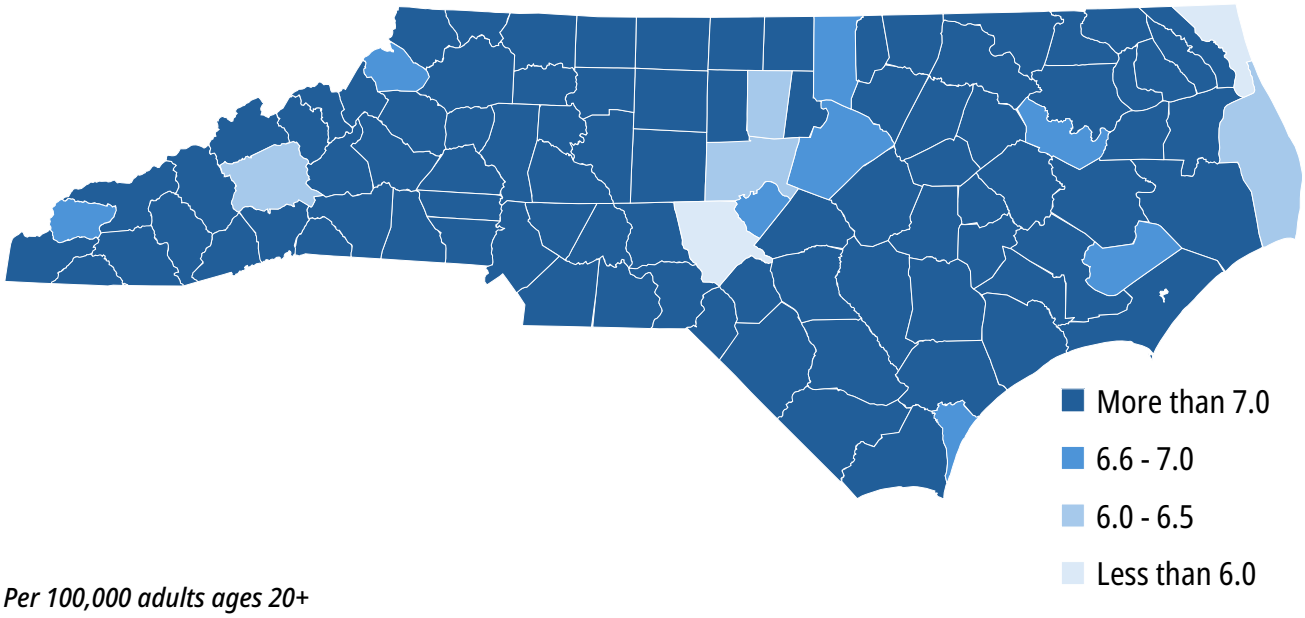
Chronic Conditions - Diabetes Incidence (Adult)

This indicator reports the number and rate (per 1,000 population) of adults ages 20 and older who were diagnosed with diabetes within the past year. Estimates are derived from the CDC's Behavioral Risk Factor Surveillance System (BRFSS). Respondents whose reported age at diagnosis was less than one year prior to the survey are counted as newly diagnosed cases. Respondents whose age at diagnosis was between one and two years prior to the survey are counted as 0.5 cases to account for partial-year incidence.

- Diabetes remains a major chronic disease affecting adults in North Carolina, with incidence and prevalence consistently higher than national averages, reflecting the state's aging population and the continued impact of obesity, physical inactivity, and socioeconomic factors (Centers for Disease Control and Prevention [CDC], 2024; North Carolina Department of Health and Human Services [NCDHHS], 2024).
- Approximately one in ten North Carolina adults has diagnosed diabetes, and thousands of new adult cases are identified each year, placing the state among those with the highest diabetes burden in the nation (CDC, 2024; American Diabetes Association [ADA], 2024).
- Marked disparities persist, with higher incidence and complication rates among Black, American Indian, and low-income adults, as well as among individuals living in rural counties where access to preventive care and diabetes self-management resources is more limited (CDC, 2024; NCDHHS, 2024).
- Diabetes is also a leading contributor to cardiovascular disease, kidney failure, vision loss, and preventable hospitalizations, driving substantial health care costs and reduced quality of life for affected individuals (ADA, 2024; CDC, 2024).
- Strengthening prevention efforts, improving access to evidence-based lifestyle interventions, and expanding chronic disease management and care coordination remain critical to reducing the burden of diabetes among adults in North Carolina (CDC, 2024; NCDHHS, 2024).

North Carolina's adult diabetes incidence rate is higher than the national average.

Figure 137. North Carolina Diabetes Incidence by County*



** Per 100,000 adults ages 20+*

Data Source: Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, 2019

Figure 138. Diabetes Incidence Comparison*

** Per 100,000 adults ages 20+*

Data Source: Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, 2019

Chronic Conditions - Diabetes Prevalence (Adult)

This indicator reports the number and percentage of adults ages 20 and older who have ever been told by a doctor that they have diabetes.

Diabetes remains a highly prevalent chronic condition among adults in North Carolina, with the state consistently reporting higher prevalence than the United States overall (Centers for Disease Control and Prevention [CDC], 2024; North Carolina Department of Health and Human Services [NCDHHS], 2024).

Approximately 10% to 12% of North Carolina adults have a diabetes diagnosis, compared to approximately 9% to 10% nationally, placing North Carolina among those states with the greatest diabetes burden (CDC, 2024; American Diabetes Association [ADA], 2024).

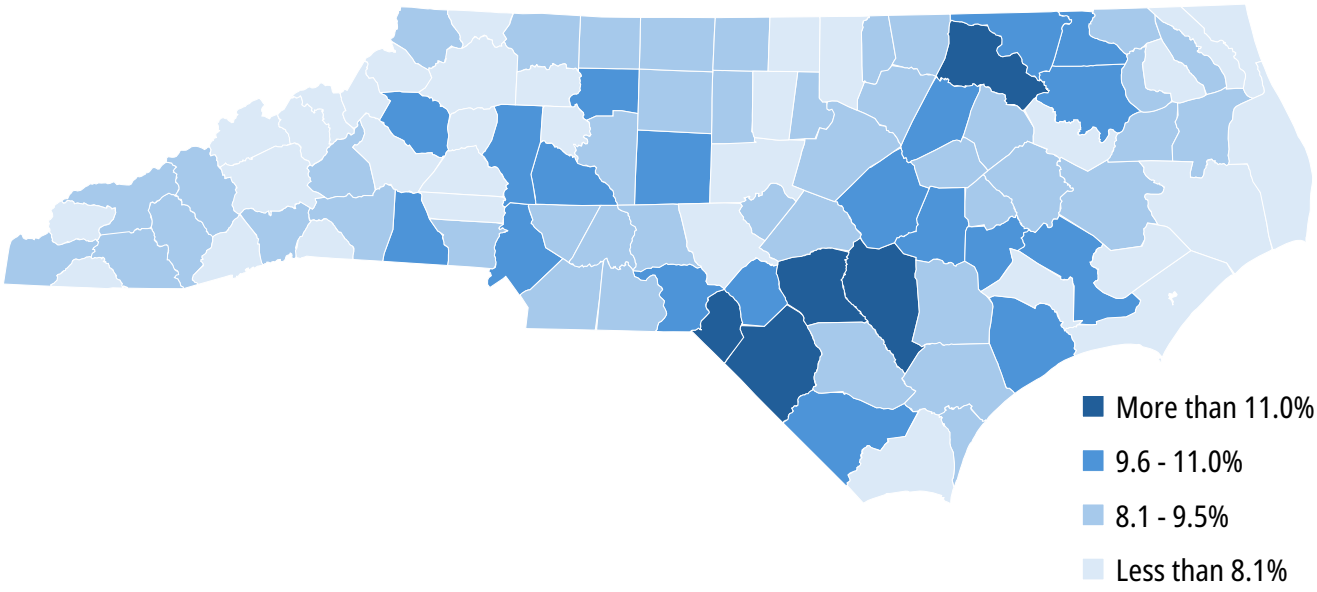
Diabetes prevalence increases sharply with age and is disproportionately higher among Black and American Indian adults, individuals with lower income or educational attainment, and people living in rural counties, reflecting the influence of structural and social determinants of health (CDC, 2024; NCDHHS, 2024).

Diabetes contributes substantially to premature mortality, disability, and health care costs in North Carolina and is a major driver of cardiovascular disease, kidney failure, and preventable hospitalizations (ADA, 2024; CDC, 2024).

Continued emphasis on diabetes prevention, early diagnosis, and long-term self-management support is essential to reducing prevalence and improving outcomes for adults across the state (CDC, 2024; NCDHHS, 2024).

Even small differences in prevalence translate into large numbers of affected individuals statewide. Diabetes is a chronic condition associated with increased risk of heart disease, stroke, kidney failure, vision loss, and preventable hospitalizations, placing substantial demands on health care systems and communities. In 2021, North Carolina's adult diabetes prevalence was virtually the same as the U.S. average, underscoring that diabetes remains a widespread chronic disease affecting a significant share of adults statewide and nationally.

Figure 139. North Carolina Adults Ages 20+ with Diabetes by County



Data Source: Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, 2021

Figure 140. Adults Ages 20+ with Diabetes Comparison

Data Source: Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, 2021

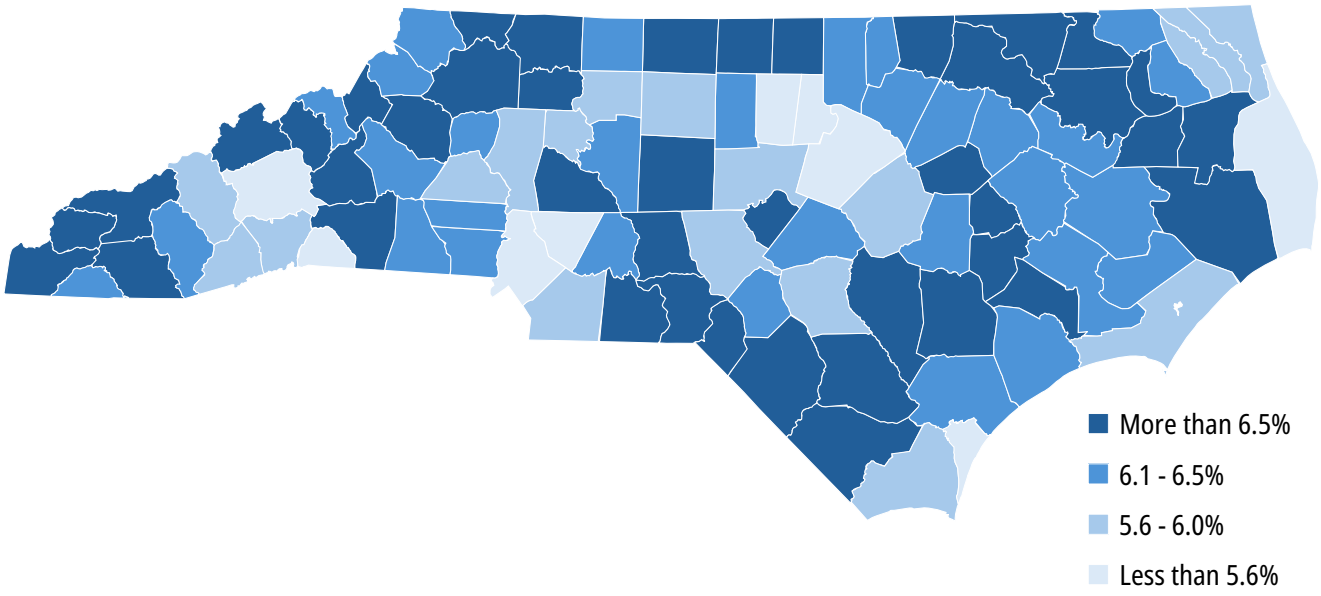
Chronic Conditions - Heart Disease (Adult)

This indicator reports the percentage of adults ages 18 and older who report ever having been told by a doctor, nurse, or other health professional that they had angina or coronary heart disease.

- Coronary heart disease (CHD) remains a leading cause of illness and death among adults in North Carolina, with prevalence that is slightly higher than or comparable to the U.S. overall, reflecting the state's elevated burden of cardiovascular risk factors such as hypertension, diabetes, obesity, and tobacco use (Centers for Disease Control and Prevention [CDC], 2024; North Carolina Department of Health and Human Services [NCDHHS], 2024).
- An estimated 5to 6% of North Carolina adults report having been diagnosed with CHD, a rate that places the state among those with a higher cardiovascular disease burden, particularly in rural and economically distressed counties (CDC, 2024; American Heart Association [AHA], 2024).
- Significant disparities persist, with higher prevalence and mortality observed among older adults, men, Black adults, and individuals with lower income or educational attainment, underscoring the influence of social and structural determinants of health (CDC, 2024; NCDHHS, 2024).
- CHD continues to drive substantial health care utilization, disability, and premature mortality across the state, highlighting the importance of prevention strategies focused on blood pressure control, cholesterol management, smoking cessation, physical activity, and equitable access to primary and specialty cardiovascular care (AHA, 2024; CDC, 2024).

North Carolina's adult coronary heart disease prevalence is essentially the same as the national rate, underscoring that CHD remains a widespread and ongoing public health challenge for adults in the state.

Figure 141. North Carolina Adults with Coronary Heart Disease by County



Data Source: Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System; Accessed via the PLACES Data Portal; 2022

Figure 142. Adults with Coronary Heart Disease Comparison

Data Source: Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System; Accessed via the PLACES Data Portal; 2022

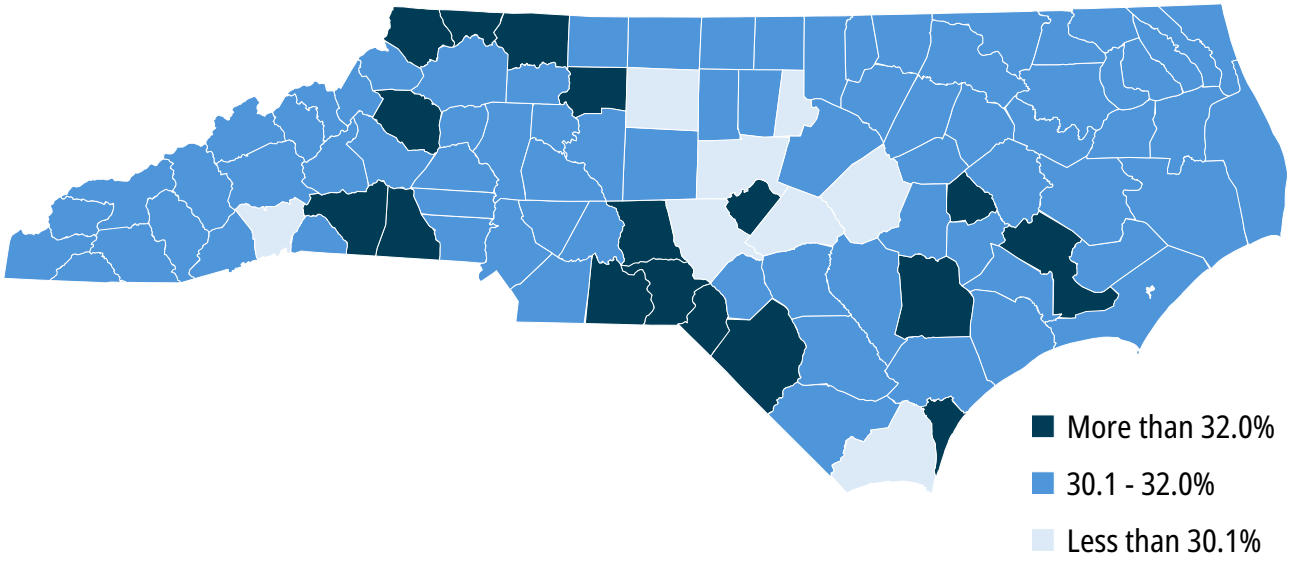
Chronic Conditions - High Cholesterol (Adult)

This indicator reports the percentage of adults ages 18 and older who report having been told by a doctor, nurse, or other health professional that they had high cholesterol.

- High cholesterol remains a common cardiovascular risk factor among adults in North Carolina, with prevalence that is comparable to the United States overall and affects a substantial share of the adult population (Centers for Disease Control and Prevention [CDC], 2024; North Carolina Department of Health and Human Services [NCDHHS], 2024).
- An estimated one-third of adults in North Carolina report having been told by a health professional that they have high cholesterol, a level similar to national estimates and reflective of widespread cardiometabolic risk across the state (CDC, 2024 American Heart Association [AHA], 2024).
- Prevalence increases with age and is higher among men, adults with obesity or diabetes, and individuals with limited access to preventive health care, highlighting the interconnected nature of chronic disease risk factors (CDC, 2024; NCDHHS, 2024).
- Elevated cholesterol is a major contributor to coronary heart disease and stroke and is closely linked to medication adherence, diet, physical activity, and access to ongoing primary care (AHA, 2024; CDC, 2024).
- Continued emphasis on cholesterol screening, lifestyle interventions, and effective lipid-lowering treatment remains essential to reducing cardiovascular disease burden among adults in North Carolina (AHA, 2024; CDC, 2024).

North Carolina's prevalence of high cholesterol among adults is essentially the same as the U.S. average, underscoring that elevated cholesterol is a widespread cardiovascular risk factor requiring continued attention to screening, lifestyle interventions, medication adherence, and access to primary care statewide.

Figure 143. North Carolina Adults with High Cholesterol by County



Data Source: Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System; Accessed via the PLACES Data Portal; 2021

Figure 144. Adults with High Cholesterol Comparison

Data Source: Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System; Accessed via the PLACES Data Portal; 2021

Chronic Conditions - Kidney Disease (Adult)

This indicator reports the number and percentage of adults ages 18 and older who report ever having been told by a doctor, nurse, or other health professional that they have kidney disease.

Chronic kidney disease (CKD) is a significant and growing public health concern among adults in North Carolina, with prevalence that is comparable to or slightly higher than the U.S. average, largely driven by the state's high burden of diabetes, hypertension, and cardiovascular disease (Centers for Disease Control and Prevention [CDC], 2024; North Carolina Department of Health and Human Services [NCDHHS], 2024).

An estimated 15% to 16% of adults in North Carolina have CKD, mirroring national estimates that indicate roughly one in seven adults is affected, many of whom are unaware of their condition (CDC, 2024; National Kidney Foundation [NKF], 2024).

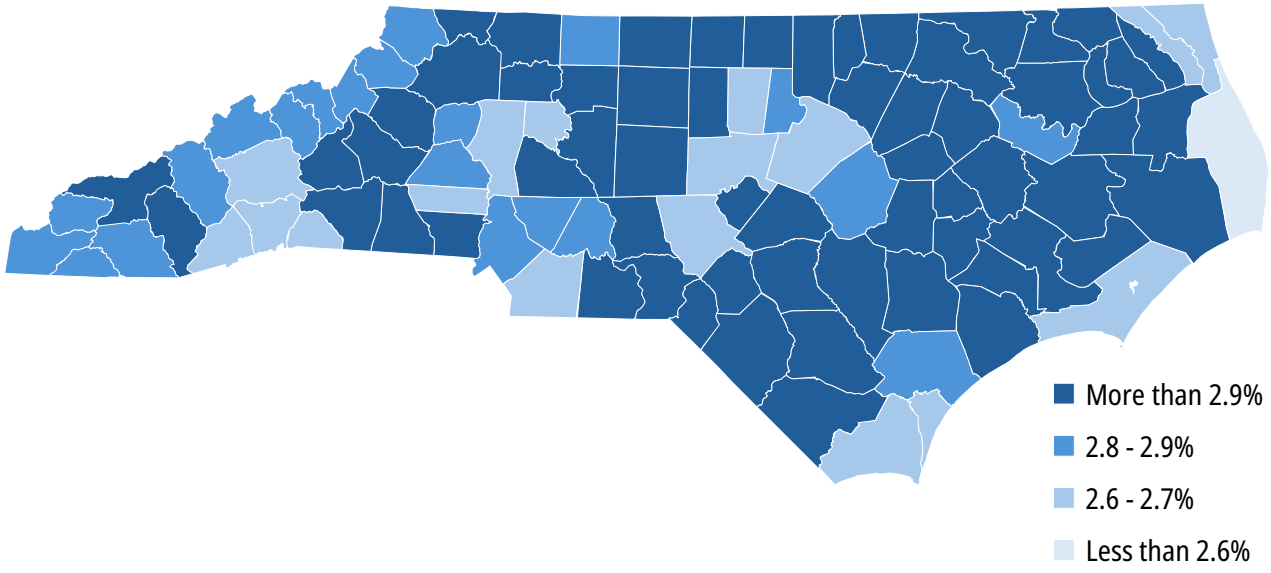
Disparities persist across demographic and geographic groups, with higher prevalence and progression to kidney failure among Black adults, American Indian adults, older adults, and people living in rural counties, reflecting inequities in chronic disease risk factors, access to preventive care, and early detection (CDC, 2024; NCDHHS, 2024).

CKD contributes substantially to premature mortality, reduced quality of life, and health care costs, particularly among individuals who progress to end-stage kidney disease requiring dialysis or transplant (NKF, 2024; United States Renal Data System [USRDS], 2024).

Strengthening prevention strategies, improving management of diabetes and hypertension, and expanding early screening and care coordination are essential to reducing the burden of CKD among adults in North Carolina (CDC, 2024; NCDHHS, 2024).

Adult kidney disease prevalence in North Carolina is comparable to, but slightly higher than, the national average, underscoring the importance of early detection, chronic disease management, and prevention efforts focused on controlling diabetes and high blood pressure across the state.

Figure 145. North Carolina Adults with Chronic Kidney Disease by County



Data Source: Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System; Accessed via the PLACES Data Portal; 2021

Figure 146. Adults with Chronic Kidney Disease Comparison

Data Source: Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System; Accessed via the PLACES Data Portal; 2021

Chronic Conditions - Stroke (Adult)

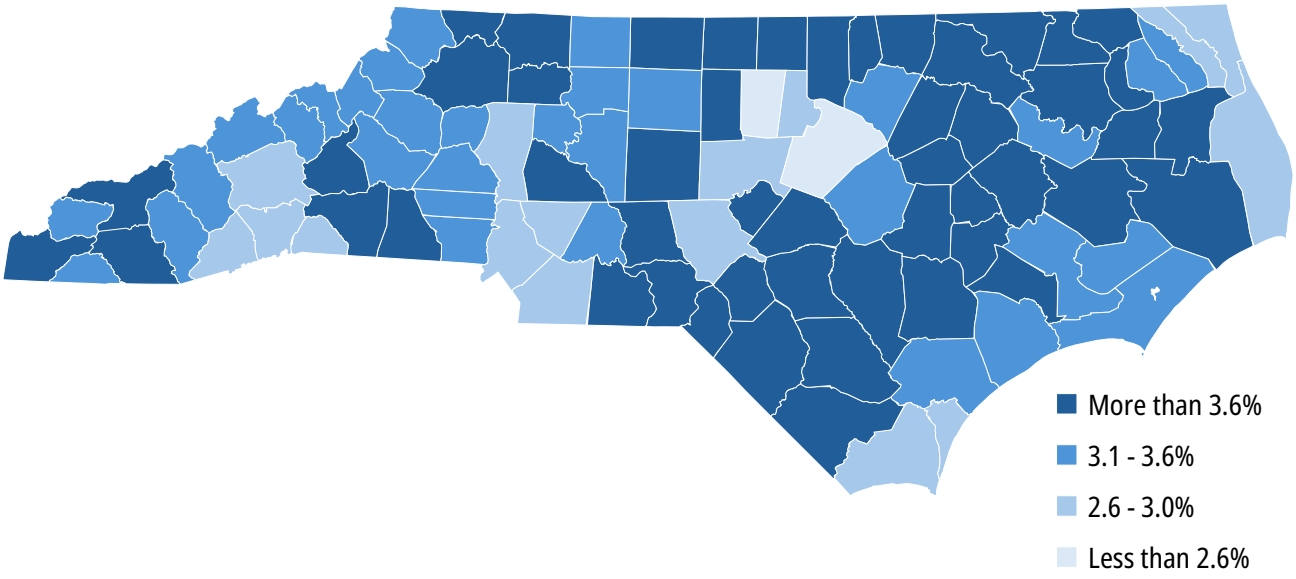
This indicator reports the number and percentage of adults ages 18 and older who report ever having been told by a doctor, nurse, or other health professional that they have had a stroke.

Within North Carolina, 3.8% of adults ages 18 and older reported ever having had a stroke.

- Stroke remains a major cause of death and long-term disability among adults in North Carolina, with the state consistently reporting a higher prevalence and mortality rate than the United States overall, reflecting its location within the "Stroke Belt" of the southeastern U.S. (Centers for Disease Control and Prevention [CDC], 2024; North Carolina Department of Health and Human Services [NCDHHS], 2024).
- Disparities are pronounced, with higher prevalence and mortality among older adults, Black adults, men, and people living in rural counties, driven by elevated rates of hypertension, diabetes, smoking, and barriers to timely emergency and post-acute care (CDC, 2024; NCDHHS, 2024).
- Stroke contributes substantially to disability, caregiver burden, and health care costs in North Carolina, underscoring the importance of prevention strategies focused on blood pressure control, diabetes management, smoking cessation, rapid recognition of stroke symptoms, and equitable access to high-quality acute and rehabilitative care (AHA, 2024; CDC, 2024).

North Carolina's adult stroke prevalence is slightly higher than the U.S. overall, underscoring the state's continued burden of stroke and the importance of prevention, rapid treatment, and access to rehabilitation services — particularly in rural and high-risk communities.

Figure 147. North Carolina Adults Ever Having a Stroke by County



Data Source: Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System; Accessed via the PLACES Data Portal; 2022

Figure 148. Adults Ever Having a Stroke Comparison

Data Source: Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System; Accessed via the PLACES Data Portal; 2022

Hospitalizations – Stroke

This indicator reports the hospitalization rate for Ischemic stroke among Medicare beneficiaries ages 65 and older for hospital stays from 2018 through 2020.

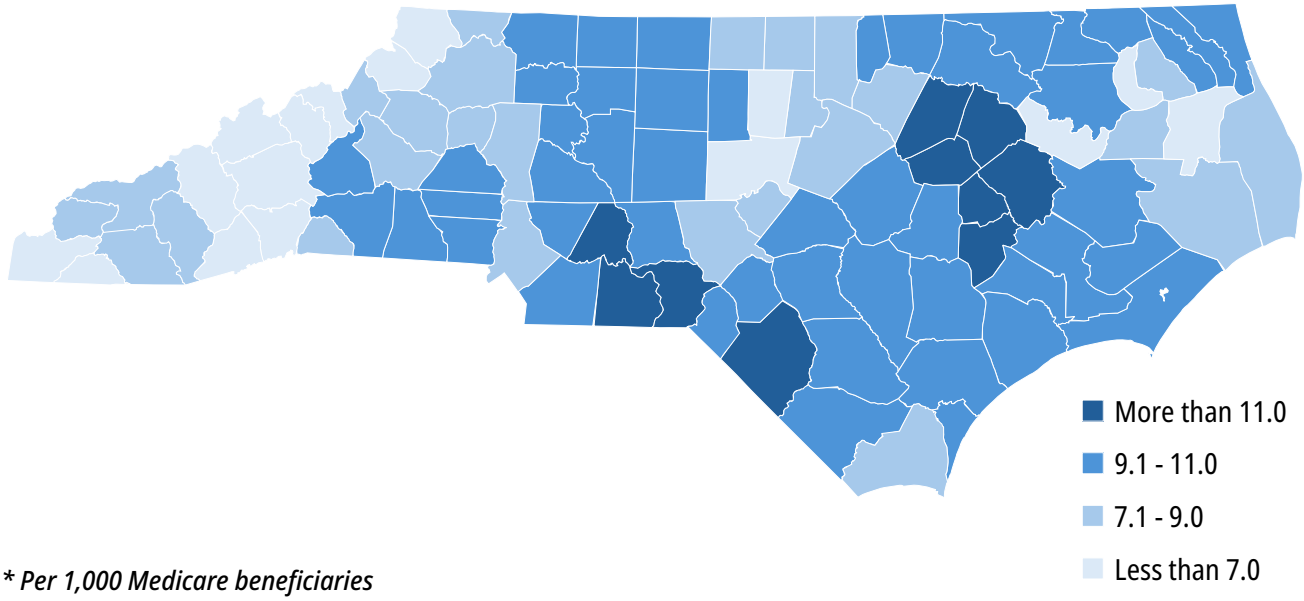
Hospitalizations for stroke remain a significant concern in North Carolina, with rates that are consistently higher than the United States overall, reflecting the state's location within the country's southeastern "Stroke Belt" and its elevated burden of cardiovascular risk factors (Centers for Disease Control and Prevention [CDC], 2024; North Carolina Department of Health and Human Services [NCDHHS], 2024).

Stroke hospitalizations contribute substantially to health care costs, long-term disability, and caregiver burden across the state, underscoring the importance of prevention and secondary prevention strategies, including blood pressure control, cholesterol management, medication adherence, and rapid recognition and treatment of stroke symptoms (AHA, 2024; CDC, 2024).

Continued investment in primary prevention, equitable access to acute stroke care, and coordinated post-acute and rehabilitation services remains essential to reducing stroke-related hospitalizations and improving outcomes for adults in North Carolina (NCDHHS, 2024; CDC, 2024).

Medicare beneficiaries in North Carolina experience higher rates of ischemic stroke hospitalizations than beneficiaries nationwide, highlighting the need for continued focus on cardiovascular risk reduction, timely access to acute stroke care, and effective secondary prevention strategies to reduce recurrent stroke and hospital use.

Figure 149. North Carolina Medicare Ischemic Stroke Hospitalization Rate by County*



** Per 1,000 Medicare beneficiaries*

Data Source: Centers for Disease Control and Prevention, CDC - Atlas of Heart Disease and Stroke, 2019-2021

Figure 150. Ischemic Stroke Hospitalization Rate Comparison*

** Per 1,000 Medicare beneficiaries*

Data Source: Centers for Disease Control and Prevention, CDC - Atlas of Heart Disease and Stroke, 2019-2021

Maternal and Child Health (MCH) - Child Deaths

Child mortality remains a critical public health concern in North Carolina, with recent data indicating an increase in the overall child death rate (ages 0 to 17) in the early 2020s, following a period of gradual decline (North Carolina State Center for Health Statistics [SCHS], 2023).

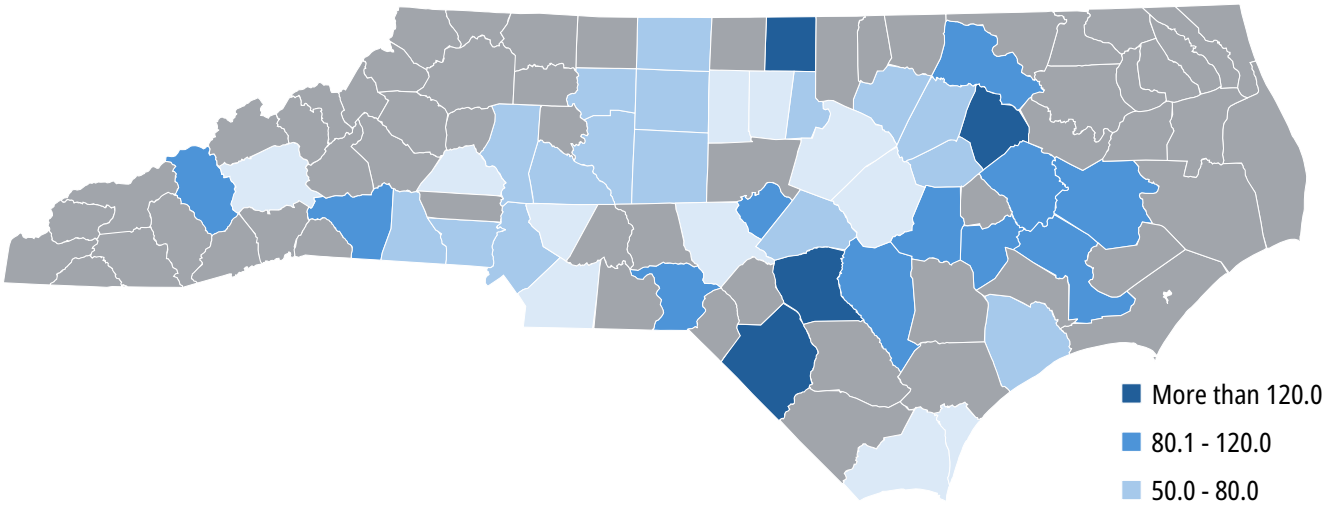
In 2022 and 2023, North Carolina reported child death rates exceeding pre-pandemic levels, driven largely by infant mortality as well as injury-related deaths among older children and adolescents (SCHS, 2023; North Carolina Child Fatality Task Force, 2024).

Infants under one year of age account for a substantial share of child deaths, and North Carolina's infant mortality rate remains higher than the national average, with persistent racial disparities — particularly among Black infants — reflecting broader inequities in maternal and child health outcomes (Centers for Disease Control and Prevention [CDC], 2024; North Carolina Department of Health and Human Services [NCDHHS], 2025).

Among children and adolescents, leading causes of death include unintentional injuries, motor vehicle crashes, firearm-related injuries, suicide, and homicide — patterns that mirror but often exceed national trends (SCHS, 2023; CDC, 2024).

These findings underscore the need for continued investment in injury prevention, maternal and infant health, behavioral health services, and community-based strategies to reduce preventable infant/child deaths and address longstanding disparities across North Carolina (NCDHHS, 2025; North Carolina Child Fatality Task Force, 2024).

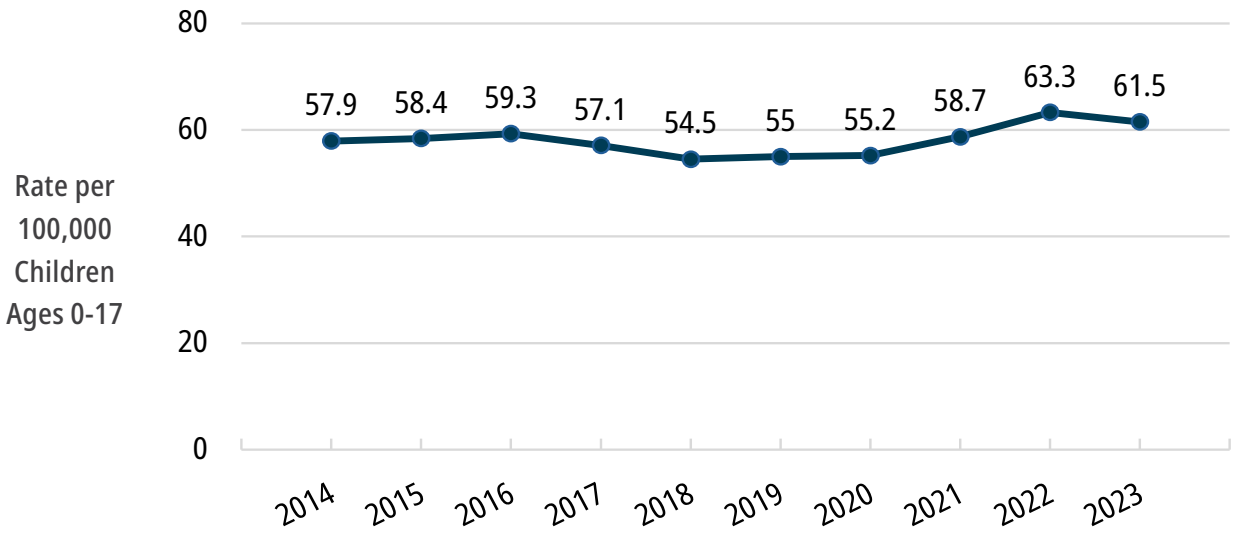
Figure 151. North Carolina Child Death Rate by County*



** Per 100,000 children ages 0-17*

Data Source: NCDHHS, Division of Public Health, Maternal and Infant Health Data Dashboard; Data obtained from NCDHSS; Analysis of Vital Statistics records is provided by the North Carolina State Center for Health Statistics; Title V Office Analysis of 2023 Birth Certificate data. Note: Data are suppressed when the numerator is less than 10.

Figure 152. North Carolina Child Death Rate by Year



Data Source: NCDHHS, Division of Public Health, Maternal and Infant Health Data Dashboard; Data obtained from NCDHSS; Analysis of Vital Statistics records is provided by the North Carolina State Center for Health Statistics; Title V Office Analysis of 2023 Birth Certificate data.

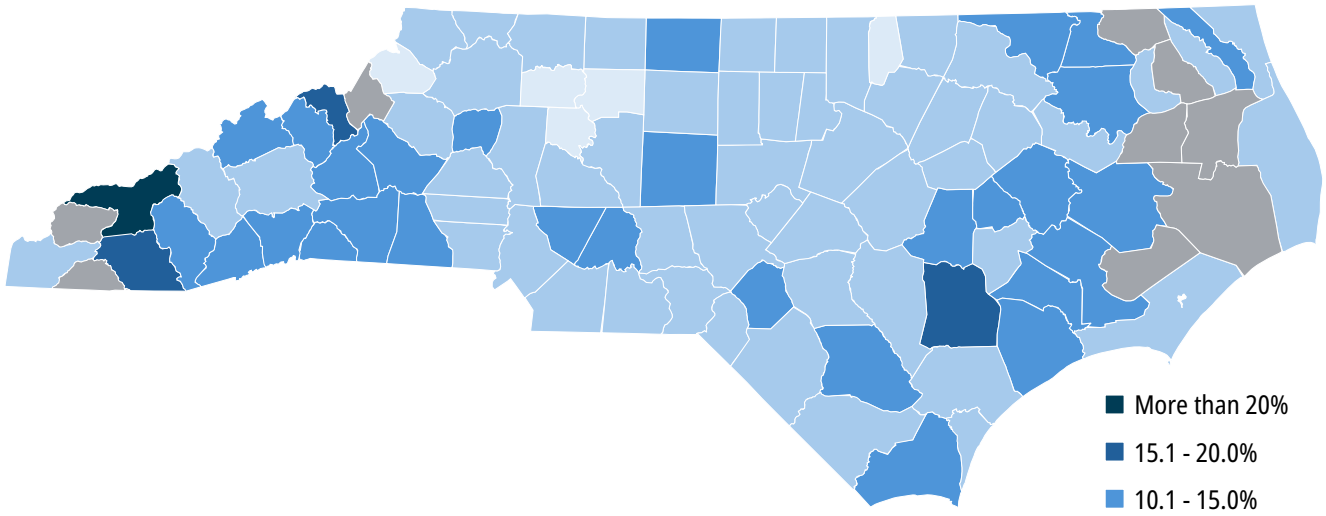
Maternal and Child Health (MCH) - Gestational Diabetes

This indicator shows the percentage of births where the mother developed gestational diabetes during pregnancy, based on live birth certificate data.

This indicator is important because gestational diabetes can lead to serious complications for both mothers and infants. Mothers are at increased risk for preterm delivery, high blood pressure, cesarean birth, and perinatal depression. Infants may face higher risks of low blood sugar, breathing problems, jaundice, and long-term risks including obesity and diabetes.

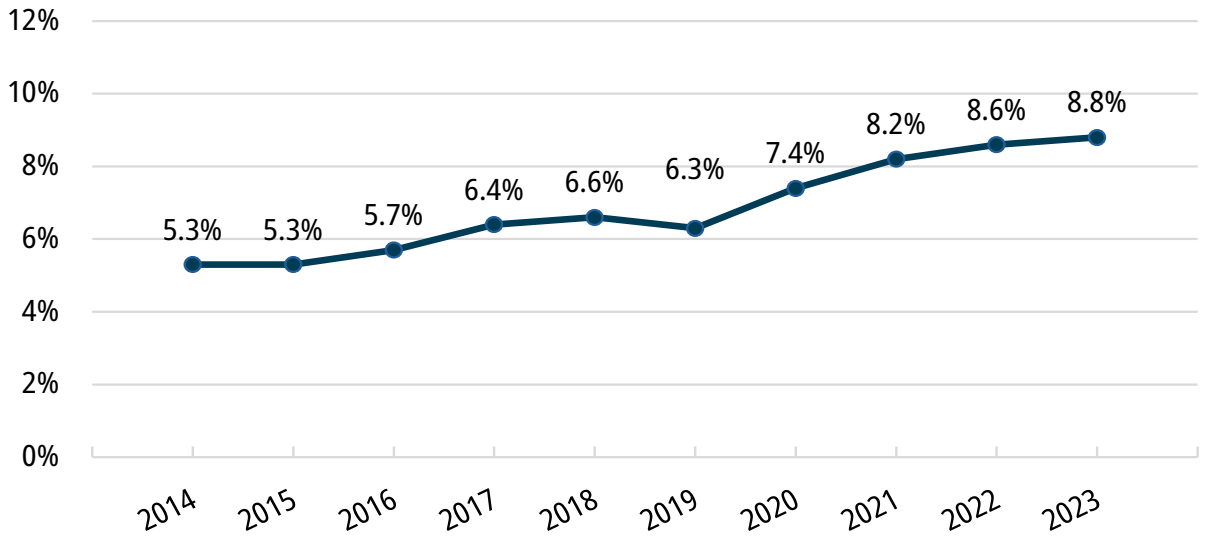
During the latest reporting period in North Carolina, **10,546** of **120,065** live births **(8.8%)** were to mothers diagnosed with gestational diabetes.

Figure 153. North Carolina Gestational Diabetes by County



Data Source: NCDHHS, Division of Public Health, Maternal and Infant Health Data Dashboard; Data obtained from NCDHSS; Analysis of Vital Statistics records is provided by the North Carolina State Center for Health Statistics; Title V Office Analysis of 2023 Birth Certificate data.
Note: Data are suppressed when the numerator is less than 10.

Figure 154. North Carolina Gestational Diabetes by Year



Data Source: NCDHHS, Division of Public Health, Maternal and Infant Health Data Dashboard; Data obtained from NCDHSS; Analysis of Vital Statistics records is provided by the North Carolina State Center for Health Statistics; Title V Office Analysis of 2023 Birth Certificate data.

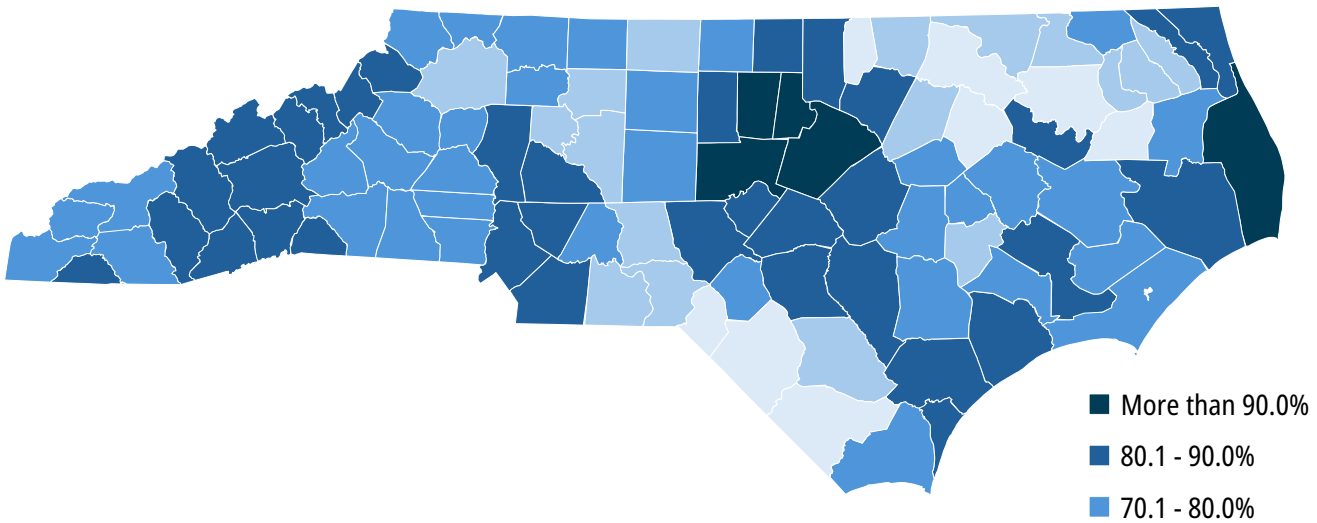
Maternal and Child Health (MCH) - Infants Breastfeeding at Delivery Discharge

This indicator shows the percentage of infants who received any breastmilk or colostrum prior to hospital discharge, based on live birth certificate data. The percentage is calculated as the number of resident births where the infant was reported as breastfed (by nursing or pumped milk) before discharge, divided by the total number of resident live births, and multiplied by 100. This indicator does not reflect exclusive breastfeeding and may include infants who also received formula.

This indicator is important because breastfeeding provides significant health benefits for both infants and mothers. Breastfed infants have reduced risk of asthma, obesity, Type 1 diabetes, ear and respiratory infections, and sudden infant death syndrome (SIDS). Mothers who breastfeed have lower risk of high blood pressure, Type 2 diabetes, and certain cancers.

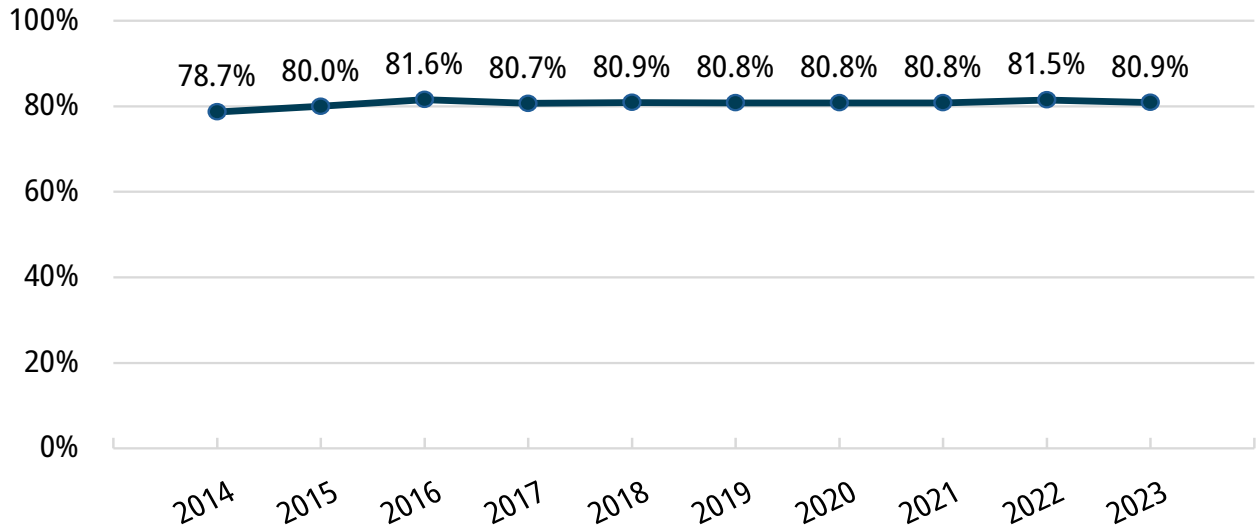
In 2023, **97,154** infants (**80.9%**) were breastfed prior to hospital discharge, out of **120,065** total live births.

Figure 155. North Carolina Breastfeeding at Delivery Discharge by County



Data Source: NCDHHS, Division of Public Health, Maternal and Infant Health Data Dashboard; Data obtained from NCDHSS; Analysis of Vital Statistics records is provided by the North Carolina State Center for Health Statistics; Title V Office Analysis of 2023 Birth Certificate data.
Note: Data are suppressed when the numerator is less than 10.

Figure 156. North Carolina Breastfeeding at Delivery Discharge by Year



Data Source: NCDHHS, Division of Public Health, Maternal and Infant Health Data Dashboard; Data obtained from NCDHSS; Analysis of Vital Statistics records is provided by the North Carolina State Center for Health Statistics; Title V Office Analysis of 2023 Birth Certificate data.

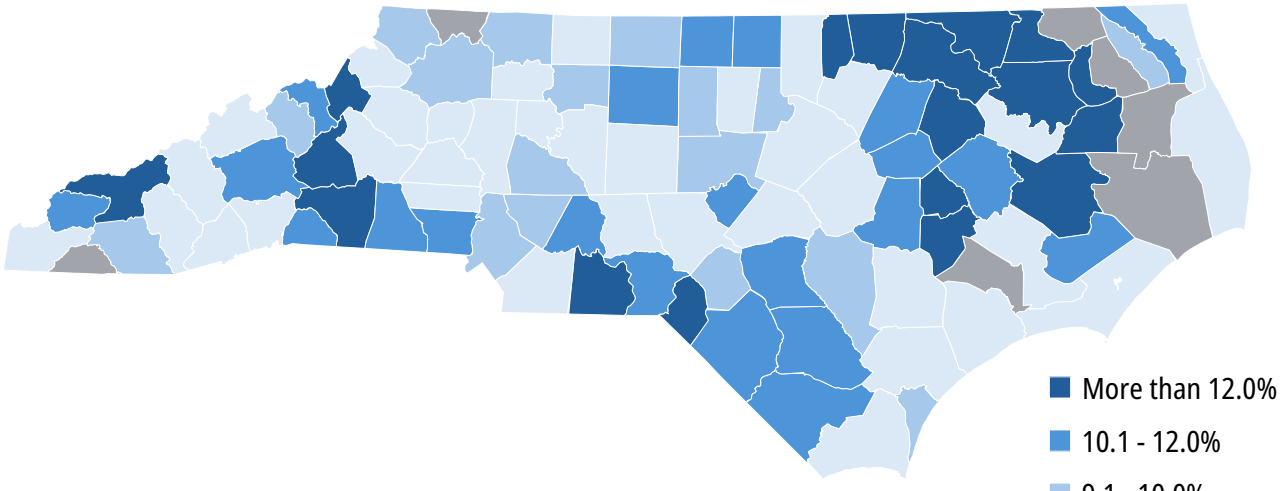
Maternal and Child Health (MCH) - Low Birthweight Births

This indicator shows the percentage of infants born with low birthweight, based on live birth certificate data. The percentage is calculated as the number of live births weighing less than 2,500 grams (5 lbs. 8 oz.) divided by total resident live births, multiplied by 100.

This indicator is important because low birthweight is a leading contributor to infant mortality and long-term health complications. Infants born with low birthweight are at higher risk for immediate concerns such as respiratory distress, jaundice, infections, and brain bleeds, as well as long-term outcomes like developmental delays, heart disease, and chronic conditions.

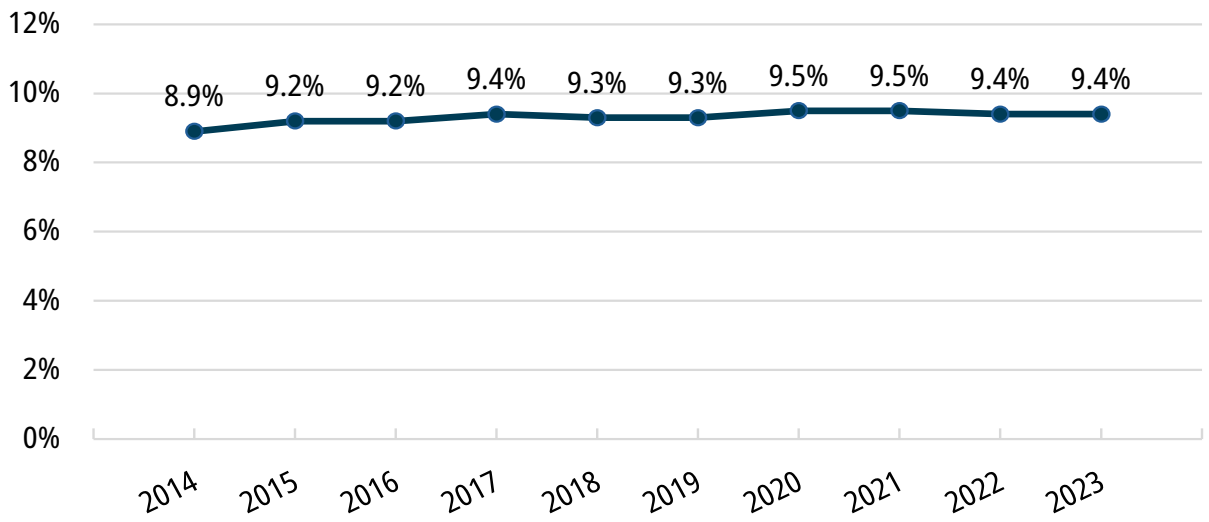
In North Carolina, over the latest reporting period, there were **11,320** or **9.4%** with low birthweight births among **120,065** total live births.

Figure 157. North Carolina Low Birthweight by County



Data Source: NCDHHS, Division of Public Health, Maternal and Infant Health Data Dashboard; Data obtained from NCDHSS; Analysis of Vital Statistics records is provided by the North Carolina State Center for Health Statistics; Title V Office Analysis of 2023 Birth Certificate data
Note: Data are suppressed when the numerator is less than 10; Low birthweight = less than 2,500 grams or 5 lbs 8 oz at birth.

Figure 158. North Carolina Low Birthweight by Year



Data Source: NCDHHS, Division of Public Health, Maternal and Infant Health Data Dashboard; Data obtained from NCDHSS; Analysis of Vital Statistics records is provided by the North Carolina State Center for Health Statistics; Title V Office Analysis of 2023 Birth Certificate data
Note: Low birthweight = less than 2,500 grams or 5 lbs 8 oz at birth.

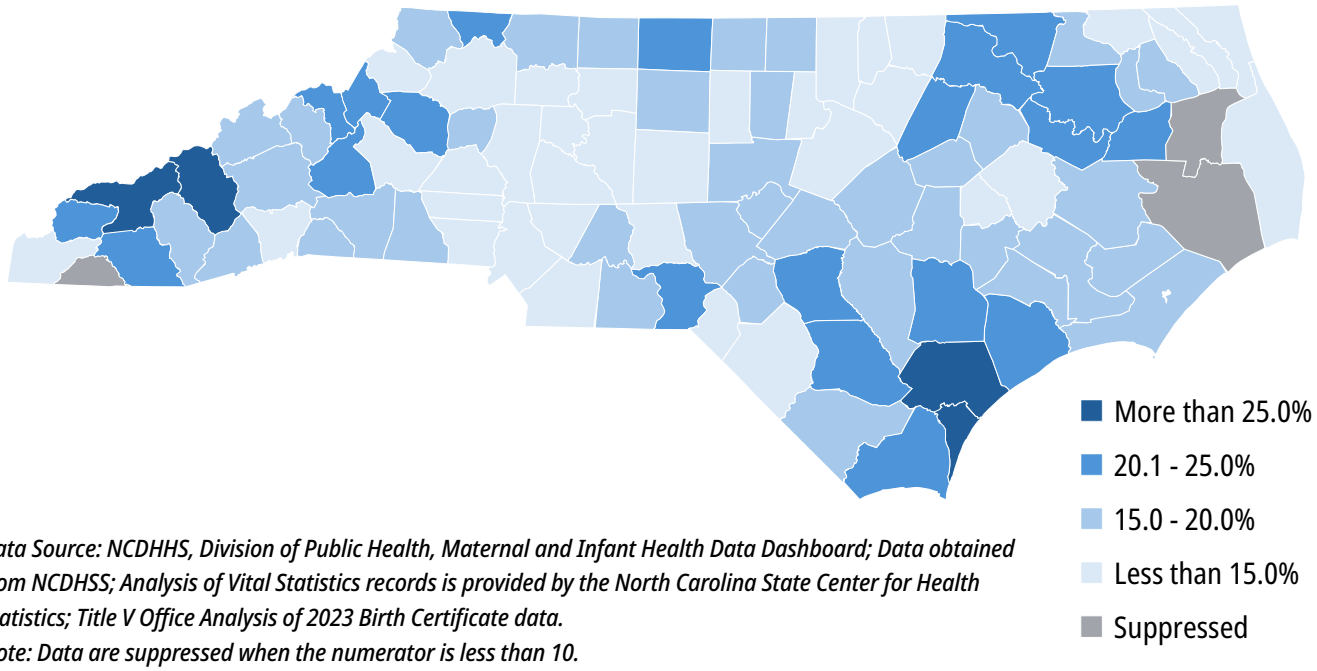
Maternal and Child Health (MCH) - Maternal Hypertension

This indicator shows the percentage of births where the mother had any form of documented hypertension, based on live birth certificate data. The percentage is calculated as the number of live births to mothers with pre-pregnancy hypertension, hypertension during pregnancy, or eclampsia divided by total resident live births, multiplied by 100.

This indicator is important because maternal hypertension poses serious risks to both mother and infant. Mothers with hypertension are at increased risk for gestational diabetes, stroke, heart complications, and pregnancy-related death. Infants born to mothers with hypertension are more likely to experience preterm birth, low birthweight, growth restriction, and stillbirth.

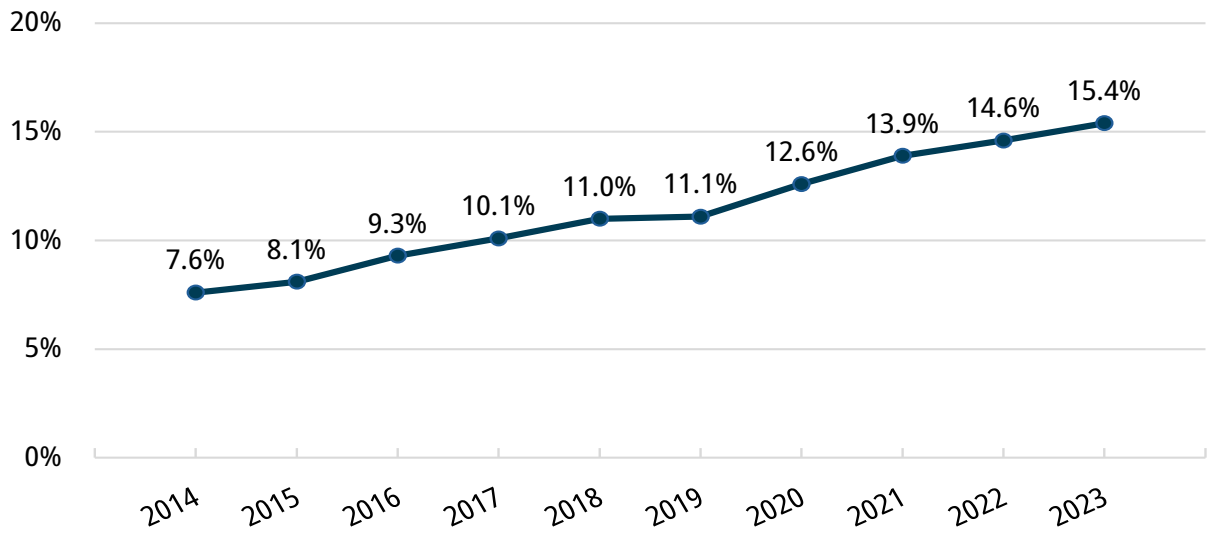
In North Carolina, over the latest reporting period, there were **18,461** or **15.4%** of births to mothers with any form of hypertension among **120,065** total live births.

Figure 159. North Carolina Maternal Hypertension by County



Data Source: NCDHHS, Division of Public Health, Maternal and Infant Health Data Dashboard; Data obtained from NCDHSS; Analysis of Vital Statistics records is provided by the North Carolina State Center for Health Statistics; Title V Office Analysis of 2023 Birth Certificate data.
Note: Data are suppressed when the numerator is less than 10.

Figure 160. North Carolina Maternal Hypertension by Year



Data Source: NCDHHS, Division of Public Health, Maternal and Infant Health Data Dashboard; Data obtained from NCDHSS; Analysis of Vital Statistics records is provided by the North Carolina State Center for Health Statistics; Title V Office Analysis of 2023 Birth Certificate data.

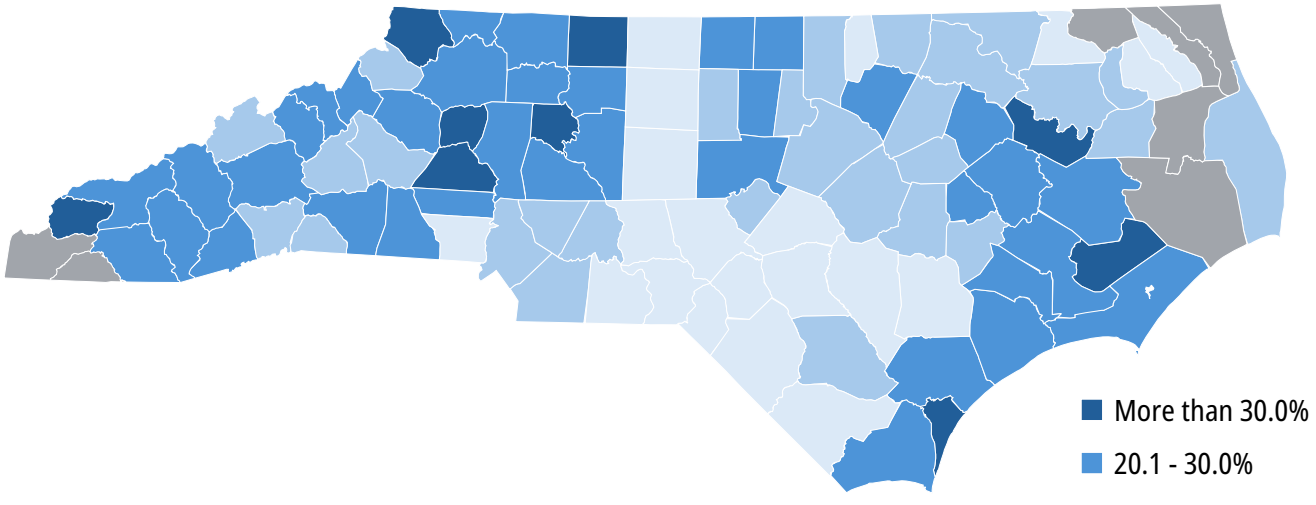
Maternal and Child Health (MCH) - Perinatal Mental Health Conditions

This indicator shows the percentage of deliveries with a documented perinatal mental health condition (PMHC), based on hospital discharge data. The percentage is calculated as the number of deliveries with any diagnosis of a mental health condition — such as depression, anxiety, bipolar disorder, PTSD, OCD, psychosis, or other PMHC — divided by total resident deliveries in non-federal hospitals, multiplied by 100.

This indicator is important because perinatal mental health conditions can affect both maternal, infant, and family health. PMHCs are associated with higher risks for obstetric complications, poor birth outcomes, breastfeeding difficulties, and maternal suicide. Tracking PMHCs helps identify gaps in mental health screening and treatment during pregnancy and postpartum.

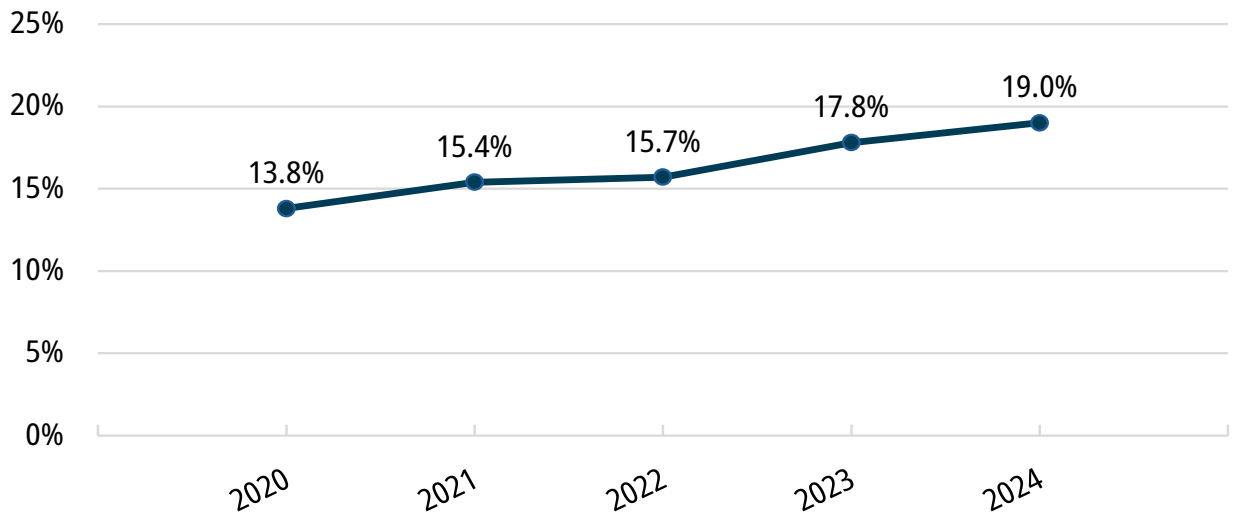
In North Carolina, over the latest reporting period, there were **21,699** or **19.0%** of deliveries with a documented PMHC among **114,082** total resident deliveries.

Figure 161. North Carolina Perinatal Mental Health Conditions by County



Data Source: NCDHHS, Division of Public Health, Maternal and Infant Health Data Dashboard; Data obtained from NCDHSS; Analysis of Vital Statistics records is provided by the North Carolina State Center for Health Statistics; Title V Office Analysis of 2024 Birth Certificate data.
Note: Data are suppressed when the numerator is less than 10.

Figure 162. North Carolina Perinatal Mental Health Conditions by Year



Data Source: NCDHHS, Division of Public Health, Maternal and Infant Health Data Dashboard; Data obtained from NCDHSS; Analysis of Vital Statistics records is provided by the North Carolina State Center for Health Statistics; Title V Office Analysis of 2024 Birth Certificate data.

Maternal and Child Health (MCH) - Prenatal Smoking

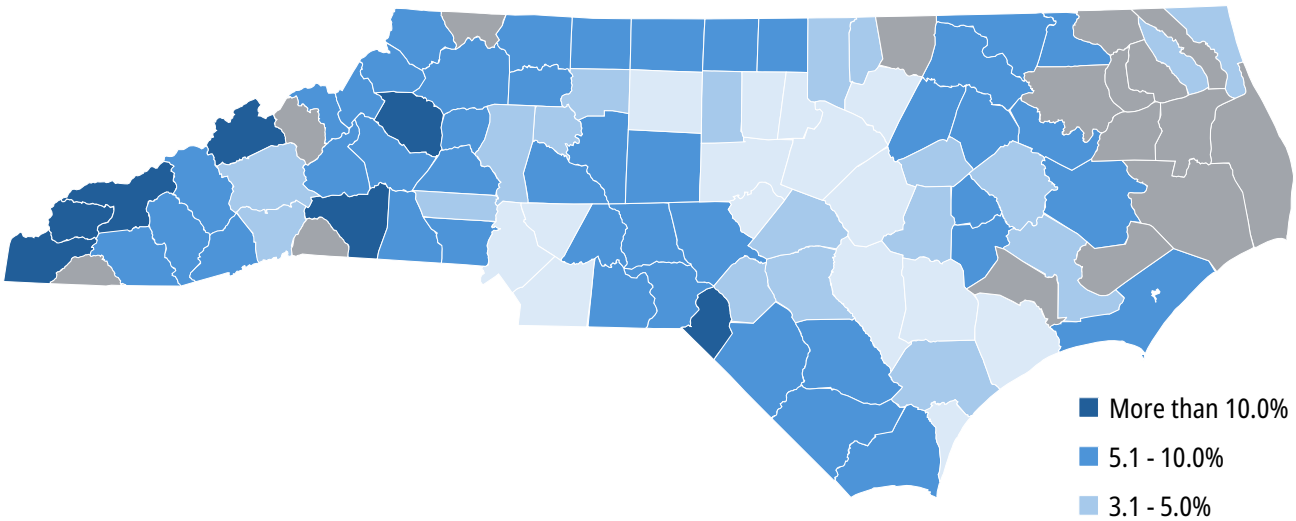
This indicator shows the percentage of births where the mother reported smoking cigarettes during pregnancy, based on live birth certificate data. The percentage is calculated as the number of births to mothers who reported smoking during any trimester divided by total resident live births, multiplied by 100.

This indicator is important because smoking during pregnancy can lead to serious health risks for both the mother and the infant. These risks include preterm birth, low birthweight, birth defects, stillbirth, and long-term complications such as respiratory problems and developmental delays. Smoking also increases the risk of maternal complications such as ectopic pregnancy and placental disorders.

In North Carolina, over the latest reporting period, there were **4,293** or **3.6%** of births where the mother reported smoking during pregnancy among **120,065** total live births.

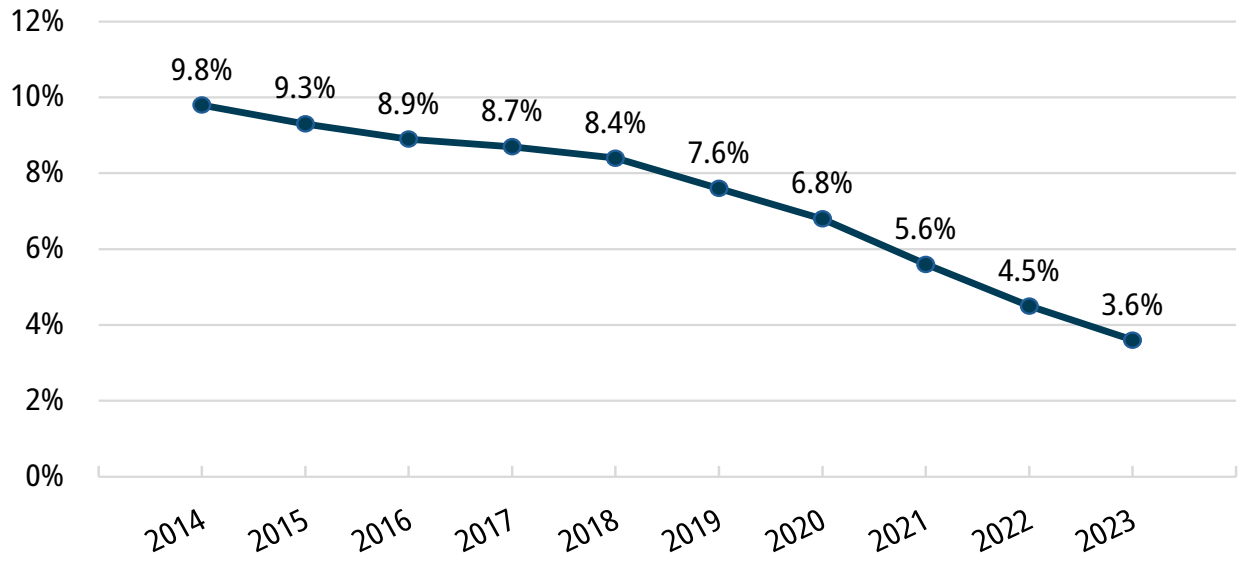
Note: the North Carolina birth certificate does not collect any information about vaping.

Figure 163. North Carolina Prenatal Smoking by County



Data Source: NCDHHS, Division of Public Health, Maternal and Infant Health Data Dashboard; Data obtained from NCDHSS; Analysis of Vital Statistics records is provided by the North Carolina State Center for Health Statistics; Title V Office Analysis of 2023 Birth Certificate data.
Note: Data are suppressed when the numerator is less than 10.

Figure 164. North Carolina Prenatal Smoking by Year



Data Source: NCDHHS, Division of Public Health, Maternal and Infant Health Data Dashboard; Data obtained from NCDHSS; Analysis of Vital Statistics records is provided by the North Carolina State Center for Health Statistics; Title V Office Analysis of 2023 Birth Certificate data.

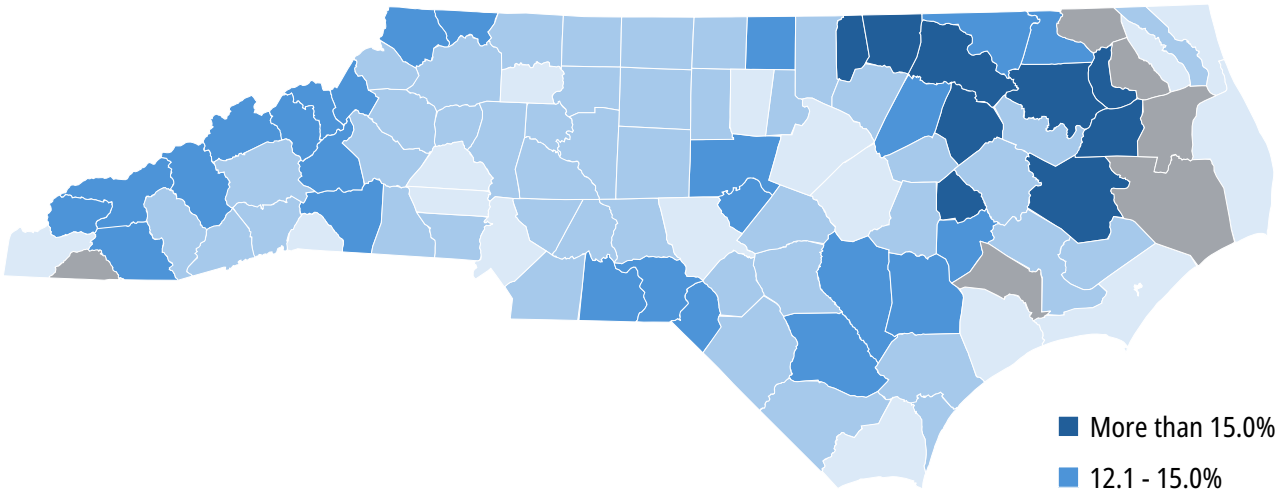
Maternal and Child Health (MCH) - Preterm Birth

This indicator shows the percentage of infants born preterm (before 37 weeks gestation), based on live birth certificate data. The percentage is calculated as the number of live births delivered at less than 37 completed weeks of gestation divided by total resident live births, multiplied by 100. Gestational age is based on the obstetric estimate recorded at delivery.

This indicator is important because preterm birth is a leading contributor to infant illness, disability, and mortality. Babies born too early are at higher risk for complications such as breathing problems, infections, brain hemorrhage, and jaundice. Long-term effects may include developmental delays, learning difficulties, and neurological disorders.

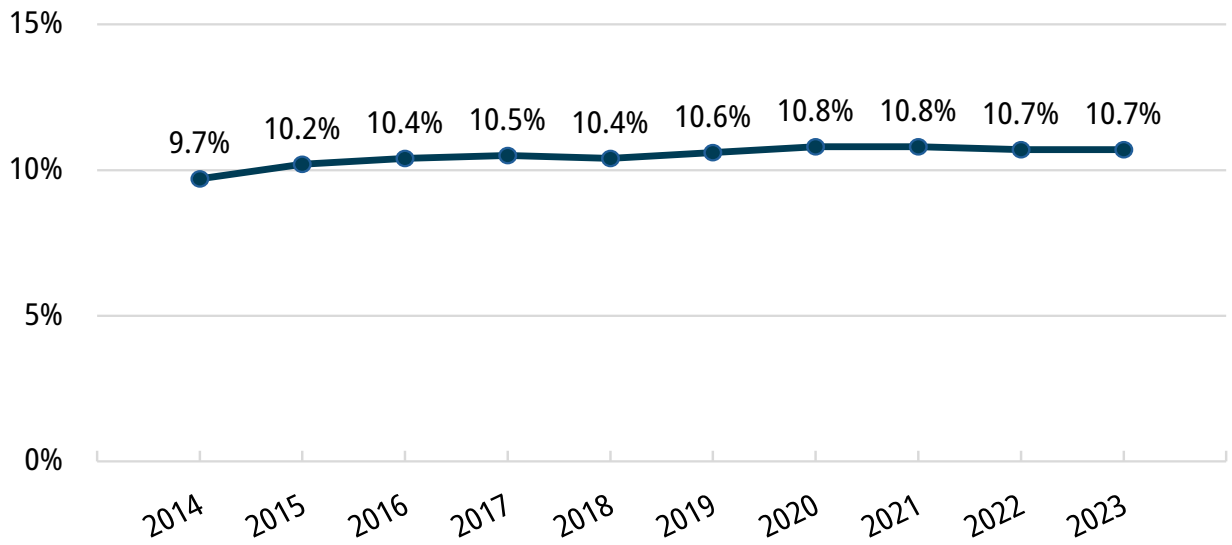
In North Carolina, over the latest reporting period, there were **12,885** or **10.7%** preterm births among **120,065** total live births.

Figure 165. North Carolina Preterm Births by County



Data Source: NCDHHS, Division of Public Health, Maternal and Infant Health Data Dashboard; Data obtained from NCDHSS; Analysis of Vital Statistics records is provided by the North Carolina State Center for Health Statistics; Title V Office Analysis of 2023 Birth Certificate data.
Note: Data are suppressed when the numerator is less than 10.

Figure 166. North Carolina Preterm Births by Year



Data Source: NCDHHS, Division of Public Health, Maternal and Infant Health Data Dashboard; Data obtained from NCDHSS; Analysis of Vital Statistics records is provided by the North Carolina State Center for Health Statistics; Title V Office Analysis of 2023 Birth Certificate data.

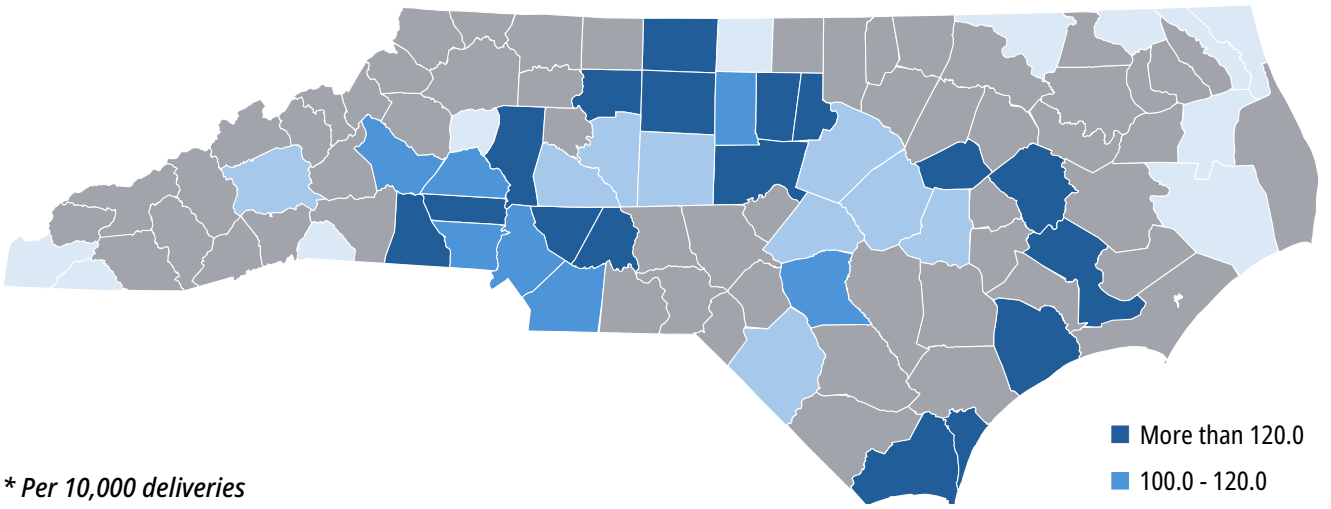
Maternal and Child Health (MCH) - Severe Maternal Morbidity

This indicator shows the rate of severe maternal morbidities (SMMs) per 10,000 deliveries, based on hospital discharge data. The rate is calculated as the number of deliveries involving one or more severe maternal complications (excluding blood transfusions) divided by total resident deliveries in non-federal hospitals, multiplied by 10,000.

This indicator is important because severe maternal morbidities can result in serious health risks for mothers, including prolonged hospitalization, increased medical costs, and long-term physical and emotional complications. Monitoring SMMs helps identify opportunities for improving the quality of obstetric care and reducing preventable maternal harm.

In North Carolina, over the latest reporting period (2024), there were **1,286** severe maternal morbidities recorded among **114,082** total resident deliveries. This equates to a rate of **112.7** documented SMMs per 10,000 deliveries.

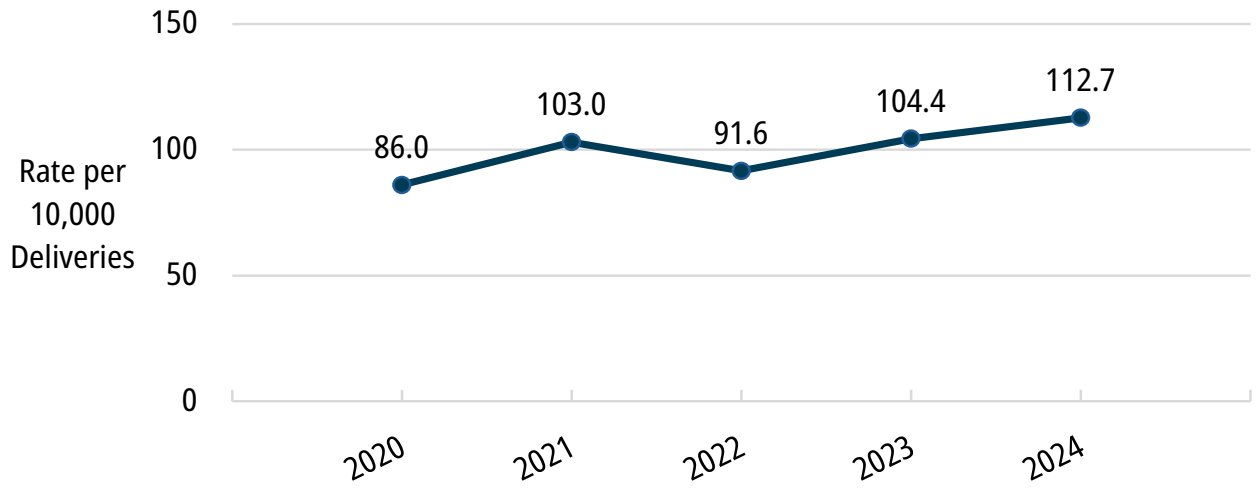
Figure 167. North Carolina Severe Maternal Morbidity (SMM) Rate by County*



** Per 10,000 deliveries*

Data Source: NCDHHS, Division of Public Health, Maternal and Infant Health Data Dashboard; Data obtained from NC DHSS; Analysis of Vital Statistics records is provided by the North Carolina State Center for Health Statistics; Title V Office Analysis of 2024 Hospital Discharge data.
Note: Data are suppressed when the numerator is less than 10.

Figure 168. North Carolina Severe Maternal Morbidity (SMM) Rate by Year



Data Source: NCDHHS, Division of Public Health, Maternal and Infant Health Data Dashboard; Data obtained from NC DHSS; Analysis of Vital Statistics records is provided by the North Carolina State Center for Health Statistics; Title V Office Analysis of 2024 Hospital Discharge data.
Note: Data are suppressed when the numerator is less than 10.

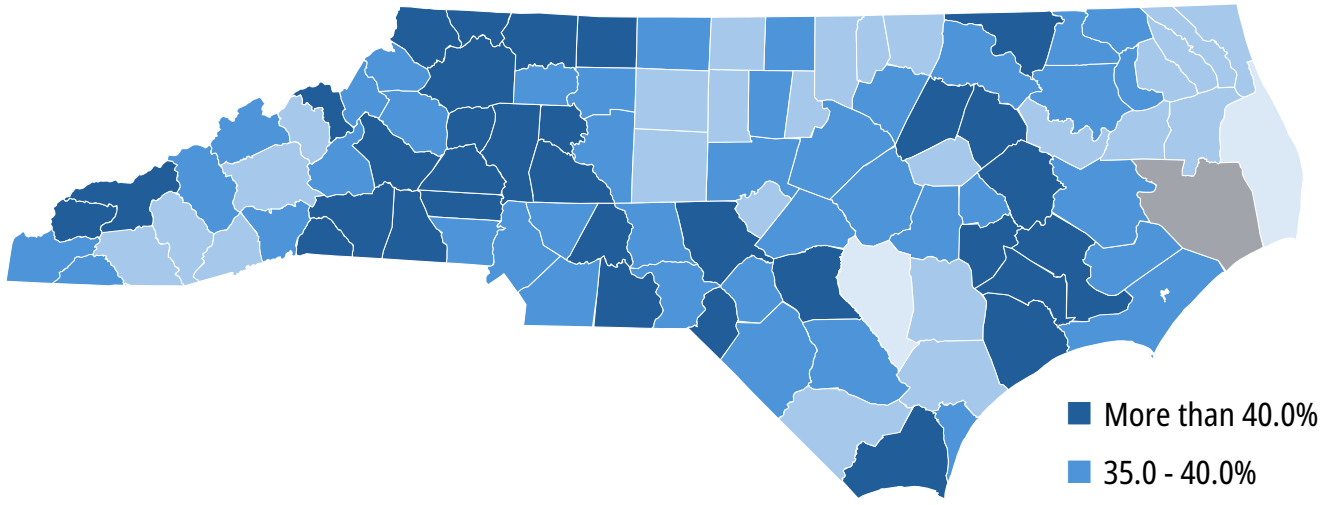
Maternal and Child Health (MCH) - Short Birth Interval

This indicator shows the proportion of births (excluding first pregnancies) where the interval from the last delivery or other pregnancy outcome to conception was less than 18 months, according to dates recorded on live birth certificate data.

This indicator is important because research indicates that birth spacing of greater than 18 months may improve outcomes for both infants and mothers. Pregnancies occurring within short intervals of less than 18 months are associated with increased risk for preterm delivery, low birthweight, and infant death.

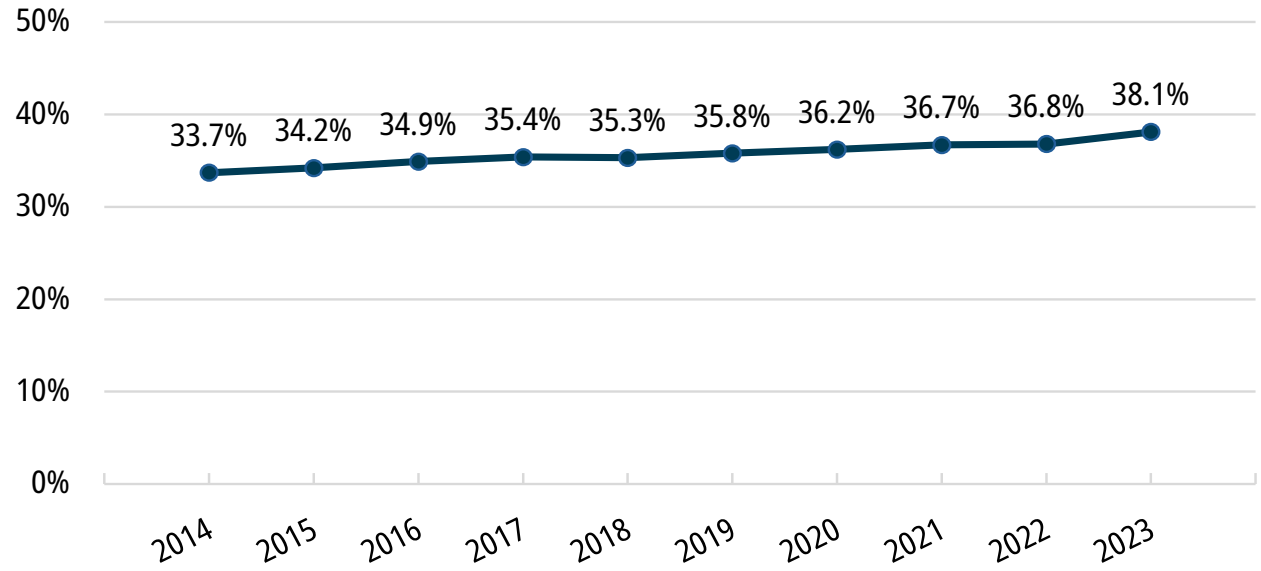
In North Carolina, over the latest reporting period, there were **30,655** or **38.1%** of births with a pregnancy interval of less than 18 months among **80,470** eligible births (excluding first pregnancies).

Figure 169. North Carolina Births with Short Birth Interval (18 Months or Less) by County



Data Source: NCDHHS, Division of Public Health, Maternal and Infant Health Data Dashboard; Data obtained from NCDHSS; Analysis of Vital Statistics records is provided by the North Carolina State Center for Health Statistics; Title V Office Analysis of 2023 Birth Certificate data.
Note: Data are suppressed when the numerator is less than 10.

Figure 170. North Carolina Births with Short Birth Interval (18 Months or Less) by Year



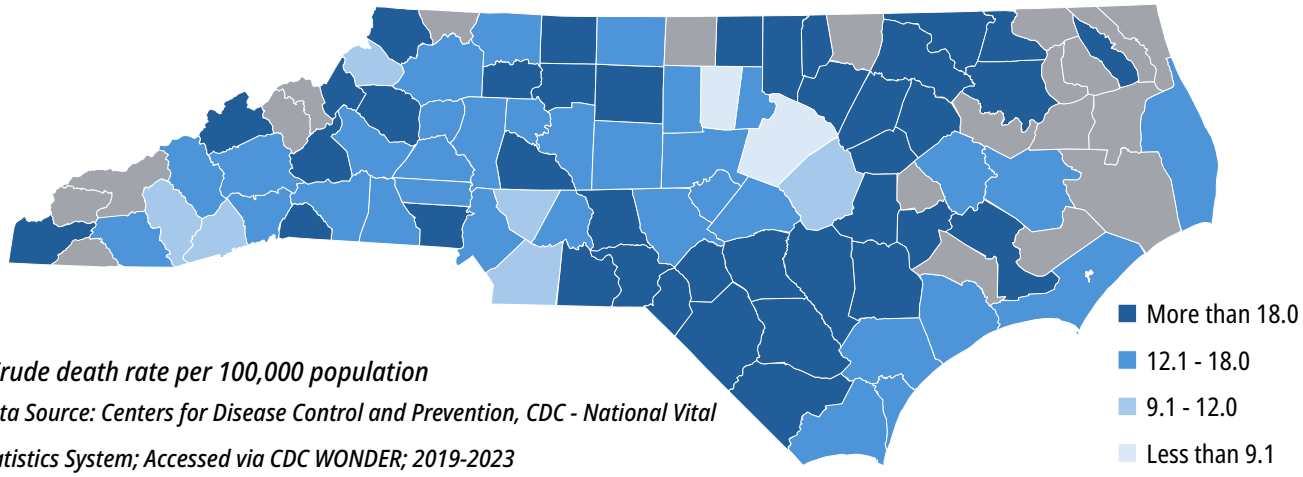
Data Source: NCDHHS, Division of Public Health, Maternal and Infant Health Data Dashboard; Data obtained from NCDHSS; Analysis of Vital Statistics records is provided by the North Carolina State Center for Health Statistics; Title V Office Analysis of 2023 Birth Certificate data.

Mortality – Firearm

This indicator reports the 2019-2023 five-year average rate of death due to firearm wounds per 100,000 population, which includes gunshot wounds from powder-charged handguns, shotguns, and rifles. Figures are reported as crude rates. This indicator is relevant because firearm deaths are preventable and they are a cause of premature death.

In North Carolina, from 2019 to 2023 there were a total of 8,569 deaths due to firearm wounds. This represents a crude death rate of 16.1 per every 100,000 total population.

Figure 171. North Carolina Firearm Mortality Rate by County*



**Crude death rate per 100,000 population*

Data Source: Centers for Disease Control and Prevention, CDC - National Vital Statistics System; Accessed via CDC WONDER; 2019-2023

Note: Data are suppressed for counties with fewer than 20 deaths.

Figure 172. Firearm Mortality Rate Comparison*

**Crude death rate per 100,000 population*

Data Source: Centers for Disease Control and Prevention, CDC - National Vital Statistics System; Accessed via CDC WONDER; 2019-2023

Note: Data are suppressed for counties with fewer than 20 deaths.

Mortality - Motor Vehicle Crash, Alcohol-Involved

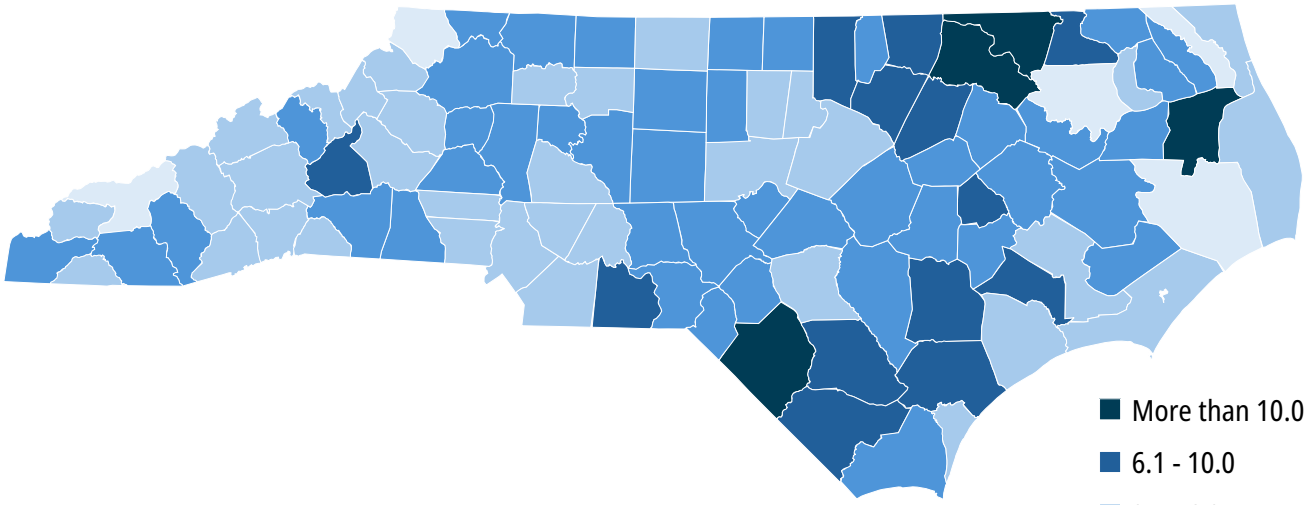
Motor vehicle crash deaths are preventable and are a leading cause of death among young people. This indicator reports the crude rate of people killed in motor vehicle crashes involving alcohol as a rate per 100,000 population. Fatality counts are based on the location of the crash and not the decedent's residence.

Alcohol-involved crashes are a preventable cause of death and are closely associated with impaired driving, substance use, and road safety conditions. Higher mortality rates may reflect a combination of factors, including rural roadway characteristics, longer emergency response times, and higher prevalence of alcohol-impaired driving in certain communities.

Within North Carolina, there are a total of 1,696 deaths due to motor vehicle crashes involving alcohol. The crude rate per 100,000 total population is 3.2.

North Carolina experiences a higher rate of alcohol-involved motor vehicle crash deaths than the U.S. overall, highlighting the need for continued investment in impaired-driving prevention, enforcement, public education, and substance use intervention strategies to reduce preventable traffic fatalities across the state.

Figure 173. North Carolina Alcohol-Involved Motor Vehicle Fatalities by County*



** Crude death rate per 100,000 population*

Data Source: US Department of Transportation, National Highway Traffic Safety Administration, Fatality Analysis Reporting System, 2018-2022

Note: Fatality counts are based on the location of the crash and not the decedent's residence.

Figure 174. Alcohol-Involved Motor Vehicle Fatalities Comparison*

** Crude death rate per 100,000 population*

Data Source: US Department of Transportation, National Highway Traffic Safety Administration, Fatality Analysis Reporting System, 2018-2022
Note: Fatality counts are based on the location of the crash and not the decedent's residence.

Obesity (Adult)

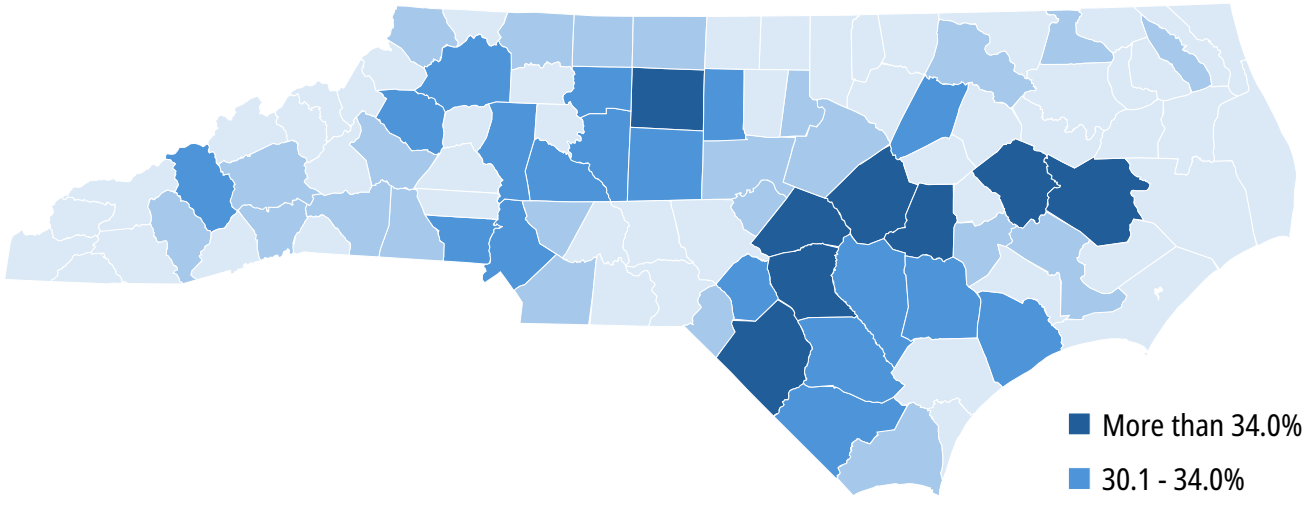
This indicator reports the number and percentage of adults ages 20 and older who self-report having a Body Mass Index (BMI) greater than 30.0 (obese). Respondents were considered obese if their Body Mass Index (BMI) was 30 or greater. Body mass index (weight [kg]/height [m]2) was derived from self-report of height and weight. Excess weight may indicate an unhealthy lifestyle and puts individuals at risk for further health issues.

Obesity is a major risk factor for numerous chronic conditions, including diabetes, heart disease, stroke, certain cancers, and chronic kidney disease. Even when prevalence mirrors national levels, the absolute number of affected adults represents a substantial burden for individuals, health systems, and communities.

Within North Carolina, there are a total of 2,371,515 adults ages 20 and older who self-reported having a BMI greater than 30.0. This represents about 30% of the population survey.

In 2021, North Carolina's adult obesity prevalence was slightly below — but essentially consistent with — the U.S. average, underscoring that obesity remains a widespread and significant public health issue across the state.

Figure 175. Obesity in North Carolina Adults Ages 20+ by County



Data Source: Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, 2021
Note: Obese is defined as BMI ≥ 30.

Figure 176. Obesity in Adults Ages 20+ Comparison

Data Source: Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, 2021
Note: Obese is defined as BMI ≥ 30.

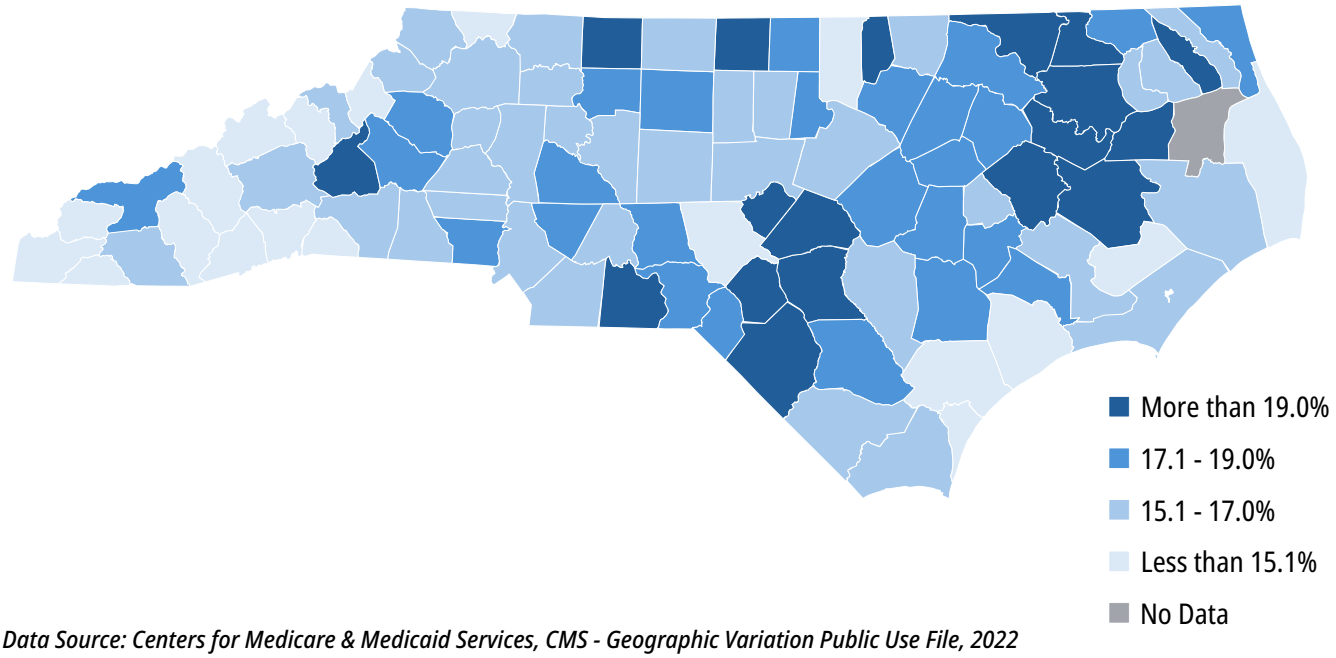
Readmissions - All Causes (Medicare Population)

This indicator reports the number and rate of 30-day hospital readmissions among Fee-for-Service (FFS) Medicare beneficiaries. Hospital readmissions are unplanned visits to an acute care hospital within 30 days after discharge from a hospitalization. Patients may have unplanned readmissions for any reason, however readmissions within 30 days are often related to the care received in the hospital, whereas readmissions over a longer time period have more to do with other complicating illnesses, patients' own behavior, or care provided to patients after hospital discharge.

- Hospital readmissions are widely used as an indicator of health care quality, care coordination, and the effectiveness of discharge planning, particularly for older adults with multiple chronic conditions (Centers for Medicare & Medicaid Services [CMS], 2023; Agency for Healthcare Research and Quality [AHRQ], 2022).
- Lower 30-day readmission rates are associated with more effective transitions from hospital to home or post-acute care, improved chronic disease management, and stronger coordination between hospitals, primary care providers, and community-based services (AHRQ, 2022; CMS, 2023; Jencks et al., 2009).
- Reductions in avoidable readmissions are also linked to improved patient outcomes and reduced health care costs, especially among Medicare beneficiaries (CMS, 2023).

In the latest reporting period there were 2,038,070 FFS Medicare beneficiaries in North Carolina. North Carolina performs better than the U.S. average in reducing 30-day readmissions among FFS Medicare beneficiaries, indicating relatively stronger performance in hospital discharge planning and post-acute care coordination for older adults.

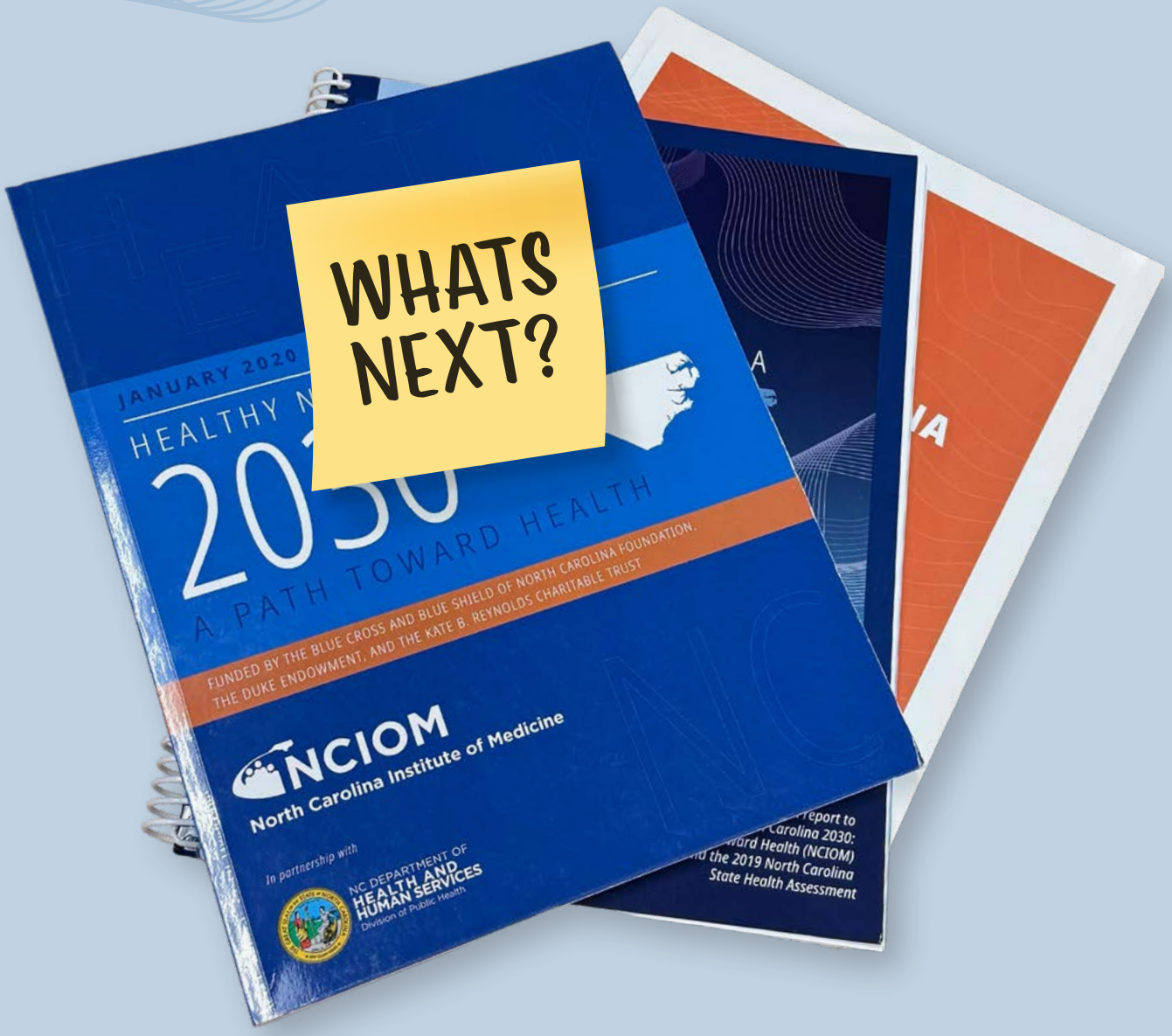
Figure 177. North Carolina Medicare 30-Day Hospital Readmission by County



Data Source: Centers for Medicare & Medicaid Services, CMS - Geographic Variation Public Use File, 2022

Figure 178. Medicare 30-Day Hospital Readmission Comparison

Data Source: Centers for Medicare & Medicaid Services, CMS - Geographic Variation Public Use File, 2022


WHATS NEXT?
JANUARY 2020
HEALTHY N
2030
A PATH TOWARD HEALTH
FUNDED BY THE BLUE CROSS AND BLUE SHIELD OF NORTH CAROLINA FOUNDATION, THE DUKE ENDOWMENT, AND THE KATE B. REYNOLDS CHARITABLE TRUST
NCIOM
North Carolina Institute of Medicine
In partnership with
NC DEPARTMENT OF HEALTH AND HUMAN SERVICES
Division of Public Health

NEXT STEPS

Healthy North Carolina 2030: Mid-Cycle Progress

Midway through the Healthy North Carolina 2030 (HNC 2030) decade, the state has made meaningful progress in several indicators, while indicators that are more deeply rooted in structural, economic, and social conditions remain stagnant or are worsening. This landscape of progress and ongoing challenges highlights both the impact of recent investments and the urgency of course correction as the state moves from assessment to action under the 2026 North Carolina State Health Improvement Plan (SHIP).

Several indicators demonstrate sustained or emerging improvement. Insurance coverage among adults under age 65 has increased following Medicaid expansion, contributing to gains in early prenatal care and access to preventive services. Long-term declines in teen births and tobacco use continue (among teens and adults), reflecting the cumulative impact of public health policy, community-based prevention, and health education efforts. Employment levels have largely rebounded from the pandemic, and high school graduation rates show gradual improvement. Together, these trends suggest that coordinated policy action and sustained prevention strategies can produce measurable population-level gains.

At the same time, a substantial set of indicators shows limited or uneven progress. Poverty rates, access to healthy food and opportunities for physical activity have not improved consistently, particularly in rural and historically marginalized communities. While educational indicators such as third-grade reading proficiency and short-term school suspensions show partial recovery from pandemic disruptions, they continue to reflect persistent racial and geographic disparities. Meanwhile, although life expectancy has risen slightly from its pandemic low point, it has not returned to pre-COVID levels. Although infant and suicide mortality rates show modest gains in some populations these indicators remain unacceptably high in others.

More concerning, several HNC 2030 indicators are moving in the wrong direction. Drug overdose deaths remain elevated, driven largely by synthetic opioids. Excessive drinking has increased and chronic disease indicators — including obesity, diabetes, cardiovascular disease, stroke, chronic kidney disease, and asthma — continue to rise.

Housing affordability has declined, contributing to severe housing problems and compounding health risks. Hospital readmission rates for several Medicare conditions remain stagnant or have worsened, reflecting system strain, care coordination challenges, and unmet social needs. These trends highlight the interconnected nature of behavioral health, chronic disease, housing, and economic stressors, many of which were intensified by the COVID-19 pandemic and subsequent workforce and cost-of-living pressures.

Taken together, the mid-cycle assessment makes clear that North Carolina cannot achieve HNC 2030 goals solely through clinical care and individual behavior change. Progress is strongest where policy, systems, and funding are aligned, and weakest where upstream determinants — such as housing, income, education, transportation, and environmental conditions — remain unaddressed. The 2026 North Carolina State Health Improvement Plan (SHIP) therefore represents a critical opportunity to move from measurement to coordinated action, focusing on a smaller set of high-leverage priorities that address root causes, reduce disparities, and support sustainable improvement.

Mapping HNC 2030 Indicators to Priority Opportunities for the 2026 North Carolina State Health Improvement Plan (NC SHIP)

The following mapping translates indicator performance into strategic opportunity areas for the 2026 NC SHIP. These groupings are designed to support cross-sector ownership, measurable strategies, and alignment with local Community Health Assessments (CHAs) and Community Health Improvement Plans (CHIPs).

/ 01 Strengthen Behavioral Health and Substance Use Systems

Indicators driving this priority

- Drug overdose deaths
- Excessive drinking
- Suicide mortality
- Prevalence of mental health conditions/distress
- Hospital readmissions (behavioral health–related)

Opportunity for the 2026 SHIP

Focus on prevention, treatment access, workforce capacity, and recovery-oriented systems of care. Emphasize integration of behavioral health into primary care, crisis response infrastructure, and community-based supports, with explicit attention to rural access and high-risk populations.

/ 02 Reverse Chronic Disease Trends Through Upstream Action

Indicators driving this priority

- Obesity (adult and youth)
- Diabetes (incidence and prevalence)
- Cardiovascular disease and stroke
- Chronic kidney disease
- Asthma

Opportunity for the 2026 SHIP

Shift from downstream disease management to upstream prevention by aligning food systems, physical activity, housing quality, environmental health, and chronic disease prevention strategies. Prioritize community-level conditions that facilitate affordable healthy choices.

/ 03 Improve Housing Stability and Community Infrastructure

Indicators driving this priority

- Severe housing problems
- Poverty
- Hospital readmissions
- Life expectancy

Opportunity for the 2026 SHIP

Elevate housing as a core health strategy. Strengthen partnerships across housing, transportation, economic development, and health sectors. Build on lessons learned from time-limited pilots to develop sustainable approaches that address affordability, quality, and stability of housing.

/ 04 Advance Maternal, Infant, and Family Health

Indicators driving this priority

- Infant mortality
- Early prenatal care
- Maternal health indicators
- Teen births
- Life expectancy

Opportunity for the 2026 SHIP

Prioritize maternal and infant health as a foundational investment in long-term population health. Expand culturally responsive care, workforce support, care navigation, and community-based services, particularly in regions with persistent disparities.

/ 05 Promote Educational Success and Youth Well-Being

Indicators driving this priority

- Third-grade reading proficiency
- Short-term suspensions
- Adverse childhood experiences (ACEs)
- Youth tobacco use

Opportunity for the 2026 SHIP

North Carolina can strengthen outcomes for infants, children and youth by better aligning early care, education, public health, and family support systems to promote early childhood development and social emotional learning. Emphasizing relational health and resilience across infancy, childhood and adolescence, through trauma-informed, prevention-oriented approaches, shifts the focus from punitive responses to supportive interventions that foster long-term health and well-being.

/ 06 Sustain and Leverage Gains in Health Care Access

Indicators driving this priority

- Uninsured rate
- Population per primary care clinician
- Early prenatal care

Opportunity for the 2026 SHIP

Protect and build upon recent gains by addressing provider shortages, strengthening care coordination, and reducing access barriers such as transportation and language. Ensure that coverage translates into meaningful, timely, and high-quality care across all communities.

Implications for Action

The 2026 NC SHIP should focus on fewer, higher-impact priorities, each supported by:

- Clear population-level outcomes
- Cross-sector strategies that address root causes
- Shared accountability among state, local, and community partners
- Performance measures that track progress and gaps in health

By aligning SHIP priorities with the indicators most in need of course correction, North Carolina is able to move from mid-cycle assessment to coordinated, measurable improvement, ensuring the remainder of the HNC 2030 decade delivers healthier conditions and better outcomes for all North Carolinians.

2026 North Carolina State Health Improvement Plan

Priority Framework Aligned to Healthy North Carolina 2030 (Mid-Cycle Findings)

SHIP Priority Area	HNC 2030 Indicators Driving Priority	Mid-Cycle Status	Strategic Opportunity for 2026 SHIP
Behavioral Health & Substance Use	Drug Overdose Deaths; Excessive Drinking; Suicide Mortality; Mental Health Prevalence; Behavioral Health–Related Hospital Readmissions	**Worsening**	Strengthen prevention, treatment, crisis response, and recovery systems; expand workforce capacity; integrate behavioral health into primary care; prioritize rural and high-risk populations
Chronic Disease Prevention & Management	Obesity (Adult & Youth); Diabetes; Cardiovascular Disease; Stroke; Chronic Kidney Disease; Asthma	**Worsening**	Shift upstream to address food access, physical activity, environmental conditions, and prevention; align public health, health care, and community systems to slow disease progression
Housing Stability & Community Infrastructure	Severe Housing Problems; Poverty; Life Expectancy; Hospital Readmissions	**Worsening/ Stagnant**	Elevate housing as a health strategy; strengthen cross-sector partnerships (housing, transportation, economic development); pursue sustainable models beyond time-limited pilots
Maternal, Infant & Family Health	Infant Mortality; Early Prenatal Care; Teen Births; Maternal Health Indicators; Life Expectancy	**Mixed**	Expand culturally responsive care, workforce supports, and navigation models; focus on regions and populations with persistent disparities
Educational Success & Youth Well-Being	Third Grade Reading Proficiency; Short-Term Suspensions; Adverse Childhood Experiences (ACEs); Youth Tobacco Use	**Mixed**	Promote early childhood development, trauma-informed approaches, and supportive school environments; align education, public health, and family support systems
Health Care Access & System Capacity	Uninsured (Under 65); Primary Care Clinician Availability; Early Prenatal Care	**Improving**	Sustain Medicaid expansion gains; address provider shortages, care coordination, transportation, and language access to ensure coverage translates into care

References

State Health Assessment / State Health Improvement Plan Process

Public Health Accreditation Board. Standards and measures, version 2022. https://phaboard.org/accreditation-recognition/initial-accreditation/

Frameworks and Models

Braveman, Paula, and Laura Gottlieb. The social determinants of health: It's time to consider the causes of the causes. *Public Health Reports*, vol. 129, suppl. 1, 2014, pp. 19–31. https://doi.org/10.1177/00333549141291S206

Centers for Disease Control and Prevention. Community health assessment and health improvement planning. 2024. https://www.cdc.gov/publichealthgateway/cha/index.html

Green, Lawrence W., and Marshall W. Kreuter. Health program planning: An educational and ecological approach. 4th ed., McGraw-Hill, 2005.

Kindig, David A., and Daniel Isham. Population health improvement: A community health business model that engages partners in all sectors. *Frontiers of Health Services Management*, vol. 30, no. 4, 2014, pp. 3–20. https://doi.org/10.1097/01974520-201404000-00002

Krieger, Nancy. Epidemiology and the people's health: Theory and context. Oxford University Press, 2012. https://global.oup.com/academic/product/epidemiology-and-the-peoples-health-9780195383874

Marmot, Michael. Social determinants of health inequalities. *The Lancet*, vol. 365, no. 9464, 2005, pp. 1099–1104.

Navarro, Vicente. What we mean by social determinants of health. *International Journal of Health Services*, vol. 39, no. 3, 2009, pp. 423–441. https://doi.org/10.2190/HS.39.3.a

North Carolina Institute of Medicine. Healthy North Carolina 2030: A path toward health. 2020. https://nciom.org/healthy-north-carolina-2030-report

U.S. Department of Health and Human Services. Healthy People 2030. 2020. https://health.gov/healthypeople

Asset Inventory

National Association of County and City Health Officials. Mobilizing for Action through Planning and Partnerships (MAPP) 2.0 framework. 2022. https://www.naccho.org/programs/public-health-infrastructure/performance-improvement/community-health-assessment/mapp

Historical Profile

America's Health Rankings. Older adults: Percent of population ages 65+ (North Carolina). 2023. https://www.americashealthrankings.org/explore/measures/pct_65plus/NC

Axios. Foreign-born population in North Carolina rises to 9.18%. Oct. 20, 2024. https://www.axios.com/local/charlotte/2024/10/20/foreign-born-population-north-carolina

Carolina Demography. North Carolina population trends. https://carolinademography.cpc.unc.edu/

NALEO Educational Fund. 2020 census profile: North Carolina. 2022. https://naleo.org/wp-content/uploads/2022/01/2020-Census-Profile-NC.pdf

NCpedia. Demography. https://www.ncpedia.org/demography

NCpedia. General demographics, part 1. https://www.ncpedia.org/general-demographics-part-1

Office of State Budget and Management. North Carolina population dynamics report. 2021. https://www.osbm.nc.gov/2021-population-dynamics-report/open

Office of State Budget and Management. North Carolina's older adult population to almost double in next 20 years. Nov. 16, 2023. https://www.osbm.nc.gov/blog/2023/11/16/north-carolinas-older-adult-population-almost-double-next-20-years

University of Maryland. Population statistics, 1860. https://terpconnect.umd.edu/~sfmiller/population%20statistics,%201860.htm

U.S. Census Bureau. Census of population: 1950, vol. II, part 32: North Carolina. 1950. https://www2.census.gov/library/publications/decennial/1950/pc-08/pc-8-32.pdf

Geographical and Infrastructural Profile

Amtrak. Carolinian train. https://www.amtrak.com/carolinian-train

Amtrak. Piedmont train. https://www.amtrak.com/piedmont-train

Arcury, Thomas A., William M. Gesler, John S. Preisser, Jennifer Sherman, Jamie Spencer, and John Perin. The effects of geography and spatial behavior on health care utilization among residents of a rural region. Health Services Research, vol. 40, no. 1, 2005, pp. 135–156. https://pubmed.ncbi.nlm.nih.gov/15667007/

BroadbandUSA. It's time to close the digital divide in North Carolina. National Telecommunications and Information Administration, June 8, 2023. https://broadbandusa.ntia.gov/sites/default/files/2023-06/State_and_NTIA_Update_-_Denny.pdf

Carolina Demography. NC in focus: Mode of transportation to work. Aug. 20, 2015. https://carolinademography.cpc.unc.edu/2015/08/20/nc-in-focus-mode-of-transportation-to-work/

Charlotte Area Transit System. Rail routes and schedules. https://charlottenc.gov/CATS/Ride/Rail/Rail-Routes-and-Schedules

Federal Aviation Administration. Passenger boarding (enplanement) and all-cargo data for U.S. airports – Previous years. U.S. Department of Transportation. Retrieved January 11, 2026, from https://www.faa.gov/airports/planning_capacity/passenger_allcargo_stats/passenger/previous_years

Health Resources and Services Administration. HPSA Find. https://data.hrsa.gov/tools/shortage-area/hpsa-find

King, Patrick. North Carolina needs to live up to its transportation commitments. Natural Resources Defense Council, 2023. https://www.nrdc.org/bio/patrick-king/north-carolina-needs-live-its-transportation-commitments

NCpedia. Our state geography in a snap. https://www.ncpedia.org/our-state-geography-snap-three

North Carolina Department of Environment and Natural Resources. North Carolina sea level rise impact study. 2014. https://media.coastalresilience.org/NC/North%20Carolina%20Sea%20Level%20Rise%20Impact%20Study_FinalReport_20140627.pdf

North Carolina Department of Health and Human Services, Office of Rural Health. Counties designated Health Professional Shortage Areas. 2023. https://www.ncdhhs.gov/allhpsa/open

North Carolina Department of Health and Human Services, Office of Rural Health. Rural and urban counties. 2023. https://www.ncdhhs.gov/ruralurban-2019/open

North Carolina Department of Information Technology. Closing the digital divide in North Carolina. 2023. https://www.ncbroadband.gov/digital-divide

North Carolina Department of Information Technology. Broadband program update. 2024. https://www.franklincountync.gov/DocumentCenter/View/557

North Carolina Department of Transportation. North Carolina's highway system fact sheet. 2017. https://www.ncdot.gov/initiatives-policies/Transportation/nc-2050-plan/Documents/nc-moves-fact-sheet-highways.pdf

North Carolina Department of Transportation. About highways. 2019. https://www.ncdot.gov/divisions/highways/Pages/about.aspx

U.S. Census Bureau. Public transportation commuters report. 2021. https://www.census.gov/newsroom/press-releases/2021/public-transportation-commuters.html

Cultural Profile

American Dance Festival. About the festival. https://americandancefestival.org/

Atlantic Coast Conference. Member institutions. https://theacc.com/

Cameron Art Museum. About CAM. https://cameronartmuseum.org/

Cline, M. (2024, March 4). *Language characteristics of North Carolina's population.* North Carolina Office of State Budget and Management. https://www.osbm.nc.gov/blog/2024/03/04/language-characteristics-north-carolinas-population?utm_source

Lexington Barbecue Festival. History. https://www.thebarbecuefestival.com/

MerleFest. About MerleFest. https://merlefest.org/

Mid-Eastern Athletic Conference. Member schools. https://meacsports.com/

Mint Museum. About. https://mintmuseum.org/

Minor League Baseball. Teams. https://www.milb.com/

NALEO Educational Fund. 2020 census profile: North Carolina. 2022. https://naleo.org/wp-content/uploads/2022/01/2020-Census-Profile-NC.pdf

National Collegiate Athletic Association. (2025). NCAA member schools and conferences. https://www.ncaa.org/sports/2021/2/8/student-athletes-future.aspx

North Carolina Arts Council. About the council. https://www.ncarts.org/

North Carolina Commission of Indian Affairs. Recognized tribes. https://ncadmin.nc.gov/about-doa/divisions/commission-of-indian-affairs

North Carolina Community College System. Arts and culture. https://www.nccommunitycolleges.edu/

North Carolina Department of Commerce. Immigration and demographic change in North Carolina. 2022. https://www.commerce.nc.gov/

North Carolina Department of Natural and Cultural Resources. Historic sites and cultural programs. https://www.dncr.nc.gov/

North Carolina Folklife Institute. NC Folk Festival. https://ncfolk.org/

North Carolina Museum of Art. About NCMA. https://ncartmuseum.org/

North Carolina Museum of History. About the museum. https://ncmuseumofhistory.org/

North Carolina Museum of Natural Sciences. About. https://naturalsciences.org/

North Carolina State Fair. About the fair. https://www.ncstatefair.org/

North Carolina Winegrowers Association. NC wine festivals. https://www.ncwine.org/

Reynolda House Museum of American Art. About Reynolda. https://reynoldahouse.org/

University of North Carolina System. Arts programs across UNC campuses. https://www.northcarolina.edu/

U.S. Census Bureau. (2023). *American Community Survey 5-year estimates, 2018–2022* [Dataset]. U.S. Department of Commerce. https://www.census.gov/data/developers/data-sets/acs-5year.html.

Economic Profile

Bhatt, Saurabh. The shifting geography of start-ups. Finance & Development, 2025. https://www.imf.org/-/media/files/publications/fandd/article/2025/09/bhatt.pdf

Childress, Greg. County "snapshots" show high renter burden. NC Newsline, March 25, 2025. https://ncnewsline.com/2025/03/25/county-snapshots-show-north-carolinians-burdened-by-high-rents/

CNBC. America's top states for business. 2022. https://www.cnbc.com/

CNBC. America's top states for business. 2023. https://www.cnbc.com/

Data USA. North Carolina: Economy and demographics. 2024. https://datausa.io/

Economic Development Partnership of North Carolina. Life sciences bloom in North Carolina. 2025. https://edpnc.com/

Economic Policy Institute. State unemployment by race and ethnicity. 2024. https://www.epi.org/

Edgeton, David. NC's booming biotech sector. Fierce Pharma, 2025.

Federal Reserve Bank of St. Louis. North Carolina GDP by industry. 2024. https://fred.stlouisfed.org/

High Point Office of Budget and Evaluation. Economic indicators. 2025.

International Monetary Fund. World Economic Outlook. 2025. https://www.imf.org/

myFutureNC. About the 2M by 2030 goal. https://www.myfuturenc.org/

myFutureNC. North Carolina state of educational attainment report. 2024. https://www.myfuturenc.org/

myFutureNC. State of educational attainment report. 2025. https://www.myfuturenc.org/

National Low Income Housing Coalition. North Carolina housing needs. https://nlihc.org/

ncIMPACT Initiative. North Carolina housing shortage. University of North Carolina School of Government, 2024.

North Carolina Budget and Tax Center. County economic snapshots. 2025. https://ncbudget.org/

North Carolina Department of Commerce. 2025 county tier designations. 2024. https://www.commerce.nc.gov/

North Carolina Department of Commerce. Industry snapshots. 2024. https://www.commerce.nc.gov/data-tools-reports/labor-market-data-tools

North Carolina Department of Commerce. Understanding housing costs. 2025. https://www.commerce.nc.gov/grants-incentives/community-housing-grants

North Carolina Housing Coalition. North Carolina housing summary. 2025.

Smith, Michael. Homeowner and renter cost burden. North Carolina Department of Commerce, 2025.

Solar Energy Industries Association. Solar in North Carolina. 2024. https://www.seia.org/

Timiraos, Nick. What the jobs report means for the Federal Reserve. Wall Street Journal, 2025. https://www.wsj.com/livecoverage/stock-market-tariffs-trade-war-04-04-2025/card/what-the-jobs-report-means-for-the-federal-reserve-dIlmm4CuyXU2whFHA25X?mod=author_content_page_5_pos_19

TAC Economics. U.S. tariffs and global outlook. 2025. https://taceconomics.com/en/us-tariffs-impact-global-economy-2025/

Tok, Yuen W., and Daniel Heng. Fintech: Financial inclusion or exclusion? IMF Working Paper No. 2022/080, International Monetary Fund, 2022. https://ssrn.com/abstract=4117830

U.S. Bureau of Economic Analysis. GDP by state. 2025. https://www.bea.gov/

U.S. Bureau of Labor Statistics. Consumer prices up 9.1%. July 13, 2022. https://www.bls.gov/news.release/archives/cpi_07132022.htm

U.S. Bureau of Labor Statistics. Local area unemployment statistics: North Carolina. 2024. https://www.bls.gov/web/laus/laumstrk.htm

U.S. Bureau of Labor Statistics. State occupational wage estimates: North Carolina. 2024. https://www.bls.gov/oes/

U.S. Census Bureau. American Community Survey: 2023 North Carolina estimates. 2024. https://www.census.gov/

U.S. Energy Information Administration. North Carolina energy profile. 2024. https://www.eia.gov/state/data.php?sid=NC

U.S. Energy Information Administration. North Carolina energy profile. 2025. https://www.eia.gov/states/NC/overview

World Population Review. U.S. population rankings. 2025. https://worldpopulationreview.com/states

Military Profile

Carolina Demography. NC veterans 2024 snapshot. Nov. 13, 2025. https://carolinademography.cpc.unc.edu/2025/11/13/nc-veterans-2024-snapshot/

Defense Alliance of North Carolina. North Carolina defense asset inventory and target industry cluster analysis. North Carolina Military Affairs Commission, 2020. https://ies.ncsu.edu/wp-content/uploads/sites/15/2020/06/NCDefenseAssetInventor26Web_2020Feb26.pdf

Headquarters and Support Battalion. Headquarters and Support Battalion — Marine Corps Base Camp Lejeune. U.S. Marine Corps. https://www.lejeune.marines.mil/Units/Headquarters-and-Support-Bn/utm/

Marine Corps Installations East. Home — Marine Corps Installations East. U.S. Marine Corps. https://www.mcieast.marines.mil/

Marine Corps Installations East. Economic impact study: Camp Lejeune and Marine Corps Air Station New River. 2021. https://www.mcieast.marines.mil/Portals/33/Documents/G7/2021%20MCIEAST%20Economic%20Impact%20Book.pdf

Marine Corps Installations East. MCIEAST economic impact brochure. 2023. https://www.mcieast.marines.mil/Portals/33/Documents/G7/2023-MCIEAST-Economic-Impact_Brochure%20-%20Trifold%20-%20FINAL%20-%20FINAL%20-%20FINAL%205%20NOV%2024.pdf?ver=0CQ32aF35Br1VjX1zPwsug%3D%3D

Marine Corps Installations East. MCIEAST economic impact: Camp Lejeune (FY 2023) fact sheet. U.S. Marine Corps, 2023.

Military Installations. Seymour Johnson Air Force Base: Base overview and information. U.S. Department of Defense. https://installations.militaryonesource.mil/in-depth-overview/seymour-johnson-afb

Military OneSource. MCAS Cherry Point: Installation overview and information. U.S. Department of Defense. https://installations.militaryonesource.mil/military-installation/mcas-cherry-point

Military OneSource. MCAS Cherry Point: In-depth overview. 2024. https://installations.militaryonesource.mil/in-depth-overview/mcas-cherry-point

Military OneSource. Seymour Johnson Air Force Base: In-depth overview. 2024. https://installations.militaryonesource.mil/in-depth-overview/seymour-johnson-afb

MyBaseGuide. Largest U.S. Coast Guard bases by land area and population. 2025. https://mybaseguide.com/largest-coast-guard-bases

National Guard Bureau, Office of the General Counsel. Domestic operations law and policy handbook. 3rd ed., 2024. https://www.tagtoolkit.org/blog-2-1/domestic-operations-law-and-policy

National Veterans Homeless Support. Military to civilian life. https://nvhs.org/veteran-resources/military-to-civilian-life/

North Carolina Department of Military and Veterans Affairs. USDVA medical facilities: Open facilities list. https://www.milvets.nc.gov/documents/files/medical-facilities/open

North Carolina Department of Military and Veterans Affairs. Military bases in North Carolina: Fort Bragg. https://www.milvets.nc.gov/benefits-services/military-bases-north-carolina

North Carolina Department of Military and Veterans Affairs. Military installations impact. https://www.milvets.nc.gov/

North Carolina Department of Commerce and North Carolina Department of Military and Veterans Affairs. Military economic impact on North Carolina. October 2022. https://www.commerce.nc.gov/report-military-economic-impact-north-carolina

North Carolina Department of Military and Veterans Affairs. Military installations and economic impact in North Carolina. 2025. https://www.ncsl.org/military-and-veterans-affairs/militarys-impact-on-state-economies

North Carolina Department of Military and Veterans Affairs. North Carolina Veterans Insights Report. 2025. https://www.milvets.nc.gov/north-carolina-veterans-insight-report/open

Our NC Military. Defense is the No. 2 economic sector in North Carolina. https://ourncmilitary.nc.gov/defense-2-economic-sector-north-carolina

Our NC Military. Honor veterans by hiring veterans. https://ourncmilitary.nc.gov/honor-veterans-hiring-veterans

Our NC Military. Military economic impact on North Carolina. 2022. https://ourncmilitary.nc.gov/military-economic-impact-nc-2022/open

United States Coast Guard. Base Elizabeth City. 2024. https://www.dcms.uscg.mil/Our-Organization/Director-of-Operational-Logistics-DOL/Bases/Base-Elizabeth-City/

United States Coast Guard. Air Station Elizabeth City, North Carolina. https://www.history.uscg.mil/Browse-by-Topic/Assets/Air/Article/3062021/air-station-elizabeth-city-north-carolina/

United States Department of Veterans Affairs. VISN 06. https://department.va.gov/integrated-service-networks/visn-06/

Educational Profile

Child Care Services Association. North Carolina child care landscape report. 2022. https://ncearlyeducationcoalition.org/wp-content/uploads/2022/05/a_FINAL-WEB_CCSA-2022-Infant-Toddler-Landscape-Statewide-Study.pdf

Division of Child Development and Early Education. Child care subsidies and early childhood programs in North Carolina. 2023. https://ncchildcare.ncdhhs.gov/Portals/0/documents/pdf/2/2023-2024_Statewide.pdf

North Carolina Department of Health and Human Services. Homepage. https://www.ncdhhs.gov

Economic Policy Institute. The cost of child care in North Carolina. 2023. https://www.epi.org/child-care-costs-in-the-united-states/#/NC

North Carolina Department of Public Instruction. Statistical profile of North Carolina public schools. 2023. https://www.dpi.nc.gov/districts-schools/district-operations/financial-and-business-services/statistical-profile

North Carolina Department of Public Safety. Education programs in juvenile and adult correctional facilities. 2023. https://www.ncdps.gov/division/juvenile-justice/2023-jjdp-annual-report/download

North Carolina Independent Colleges and Universities. Enrollment and institutional profiles. 2023. https://ncicu.org/wp-content/uploads/2024/12/ncicu-2023-2024-annual-report.pdf

North Carolina State Education Assistance Authority. Opportunity Scholarship Program annual report. 2023. https://www.ncseaa.edu/wp-content/uploads/sites/1429/2025/01/2023-2024-Annual-Report-FINAL.pdf

North Carolina Community College System. Fast facts and enrollment overview. 2023. https://www.nccommunitycolleges.edu/about-us/data-reporting/data-dashboards-page/

TeachNC. Strengthening North Carolina's educator pipeline. 2024. https://teachnc.org

University of North Carolina System. Enrollment dashboard and system overview. 2023. https://oira.unc.edu/dashboards/student-enrollment-by-level/

WestEd. Sound basic education for all: An action plan for North Carolina. 2019. https://www.wested.org/resource/leandro-north-carolina/

Health Care Profile

Atrium Health. "Atrium Health and Best Buy Health Partner to Improve Experience." Atrium Health Newsroom, July 3, 2023. Accessed Jan. 11, 2026.

Cone Health. "Cone Health Fact Sheet." Cone Health. Accessed Jan. 11, 2026.

ECU Health. "About Us." ECU Health Careers. Accessed Jan. 11, 2026.

FirstHealth of the Carolinas. "About Us." FirstHealth. Accessed Jan. 11, 2026.

GuideStar. "CaroMont Health Services Inc." Candid/GuideStar. Accessed Jan. 11, 2026.

Health Resources and Services Administration. Health Professional Shortage Areas data. 2024. https://data.hrsa.gov/tools/shortage-area/hpsa-find

Kaiser Family Foundation. Health insurance coverage of the total population. 2024. https://www.kff.org/state-health-policy-data/state-indicator/total-population/

Mental Health America. State rankings for mental health access. 2024. https://www.mhanational.org/the-state-of-mental-health-in-america/data-rankings/ranking-the-states/

North Carolina Association of Free and Charitable Clinics. Homepage. 2024. https://www.ncafcc.org

North Carolina Community Health Center Association. Homepage. 2024. https://www.ncchca.org/

North Carolina Department of Health and Human Services. Investment in strengthening North Carolina's behavioral health crisis response system. April 8, 2024. https://www.ncdhhs.gov/news/press-releases/2024/04/08/investment-strengthening-north-carolinas-behavioral-health-crisis-response-system

North Carolina Department of Health and Human Services. Medicaid expansion. 2025. https://medicaid.ncdhhs.gov/north-carolina-expands-medicaid

North Carolina Department of Health and Human Services, Division of Health Service Regulation. Facility licensure and regulation. 2025. https://info.ncdhhs.gov/dhsr/

North Carolina Department of Health and Human Services, Division of State Operated Healthcare Facilities. Overview of state-operated facilities. 2025. https://www.ncdhhs.gov/divisions/state-operated-healthcare-facilities

North Carolina General Assembly. Certificate of need overview. 2023. https://webservices.ncleg.gov/ViewDocSiteFile/20035

North Carolina Office of EMS. EMS programs and services. 2024. https://info.ncdhhs.gov/dhsr/EMS/ems.htm

North Carolina Oral Health Collaborative. Homepage. 2024. https://oralhealthnc.org

North Carolina Rural Health Research Program. Homepage. University of North Carolina at Chapel Hill, Cecil G. Sheps Center for Health Services Research, 2024. https://www.shepscenter.unc.edu/programs-projects/rural-health/

Novant Health. "Our Company." Novant Health. Accessed Jan. 11, 2026.

UNC Health. "UNC Health Named One of the Top Places to Work in Healthcare." UNC Health Newsroom, March 24, 2023. Accessed Jan. 11, 2026.

U.S. Census Bureau. Health insurance coverage by state. 2024. https://www.census.gov/topics/health/health-insurance.html

WakeMed Health & Hospitals. "WakeMed By the Numbers." WakeMed. Accessed Jan. 11, 2026.

Secondary Data

Population Demographics

National Defense Authorization Act for Fiscal Year 2026, Pub. L. No. 119-__ (Dec. 18, 2025)

North Carolina Commission of Indian Affairs. Map of North Carolina tribal communities. North Carolina Department of Administration. https://www.doa.nc.gov/divisions/american-indian-affairs/map-nc-tribal-communities

North Carolina Office of State Budget and Management. Projected population of the state of North Carolina and its counties, July 1, 2024–July 1, 2060 (Vintage 2024): Technical document. Jan. 15, 2025.

NC Data Portal. NC Data Portal. 2025. https://ncdataportal.org/

U.S. Census Bureau. 2020 decennial census, table P8: Race. 2020. https://www2.census.gov/programs-surveys/decennial/2020/data/

U.S. Department of Health and Human Services, Health Resources and Services Administration. How we define rural. Sept. 2025. https://www.hrsa.gov/rural-health/about-us/what-is-rural

U.S. Department of Health and Human Services, Health Resources and Services Administration, Federal Office of Rural Health Policy. FORHP data files. https://www.hrsa.gov/rural-health/about-us/what-is-rural/data-files

Socioeconomic and Education Data and Health Behavior and Health Outcome Data

NC Data Portal. NC Data Portal. https://ncdataportal.org/

Health Outcomes

Cancer — All Sites

American Cancer Society. Cancer facts and figures. 2024. https://www.cancer.org/research/cancer-facts-statistics

Centers for Disease Control and Prevention. Cancer statistics: United States cancer burden. 2024. https://www.cdc.gov/cancer/

Centers for Disease Control and Prevention. Cancer prevention and screening recommendations. 2024. https://www.cdc.gov/cancer/dcpc/prevention/

National Cancer Institute. State cancer profiles: North Carolina — all cancer sites incidence and mortality. https://statecancerprofiles.cancer.gov/

North Carolina State Center for Health Statistics. Cancer incidence and mortality overview. 2025. https://schs.dph.ncdhhs.gov/

U.S. Cancer Statistics Working Group. U.S. cancer statistics: Data visualizations — all cancer sites. Centers for Disease Control and Prevention, 2024. https://www.cdc.gov/united-states-cancer-statistics/dataviz/?CDC_AAref_Val=https://www.cdc.gov/cancer/uscs/dataviz/index.htm

Cancer — Breast Cancer

American Cancer Society. Breast cancer facts and figures. 2024. https://www.cancer.org/research/cancer-facts-statistics

Centers for Disease Control and Prevention. U.S. cancer statistics: Breast cancer statistics. 2024. https://www.cdc.gov/cancer/breast/statistics

Centers for Disease Control and Prevention. Breast cancer screening rates and disparities. 2024. https://www.cdc.gov/cancer/breast/basic_info/screening.htm

National Cancer Institute. State cancer profiles: North Carolina — breast cancer incidence and mortality. https://statecancerprofiles.cancer.gov/

North Carolina State Center for Health Statistics. Breast cancer fact sheet. 2025. https://schs.dph.ncdhhs.gov/

U.S. Cancer Statistics Working Group. U.S. cancer statistics: Data visualizations — breast cancer. Centers for Disease Control and Prevention, 2024. https://www.cdc.gov/united-states-cancer-statistics/dataviz/?CDC_AAref_Val=https://www.cdc.gov/cancer/uscs/dataviz/index.htm

Cancer — Cervical Cancer

Centers for Disease Control and Prevention. HPV-associated cervical cancer statistics. 2024. https://www.cdc.gov/united-states-cancer-statistics/publications/hpv-associated-cancers.html

National Cancer Institute. State cancer profiles: North Carolina — cervical cancer incidence and mortality. https://statecancerprofiles.cancer.gov/

North Carolina Department of Health and Human Services, Breast and Cervical Cancer Control Program. North Carolina BCCCP program overview. 2024. https://www.dph.ncdhhs.gov/programs/chronic-disease-and-injury/cancer-prevention-and-control-branch/nc-cancer-screening-and-support-programs/nc-breast-and-cervical-cancer-control-program

North Carolina State Center for Health Statistics. Cancer incidence and mortality: Cervical cancer fact sheet. 2024. https://schs.dph.ncdhhs.gov/data/

U.S. Cancer Statistics Working Group. U.S. cancer statistics: Data visualizations — cervical cancer. Centers for Disease Control and Prevention, 2024. https://www.cdc.gov/united-states-cancer-statistics/dataviz/?CDC_AAref_Val=https://www.cdc.gov/cancer/uscs/dataviz/index.htm

Centers for Disease Control and Prevention. HPV vaccination coverage among adolescents: United States. 2024. https://www.cdc.gov/mmwr/volumes/74/wr/mm7430a1.htm

National Cancer Institute. Cervical cancer disparities and social determinants of health. 2023. https://www.cancer.gov/about-cancer/understanding/disparities

American Cancer Society. Cervical cancer facts and figures. 2024. https://www.cancer.org/research/cancer-facts-statistics

Cancer — Colorectal Cancer

American Cancer Society. Colorectal cancer facts and figures. 2024. https://www.cancer.org/research/cancer-facts-statistics

Centers for Disease Control and Prevention. Colorectal cancer statistics. 2024. https://www.cdc.gov/cancer/colorectal/

Centers for Disease Control and Prevention. Colorectal cancer screening: Basic information and guidelines. 2024. https://www.cdc.gov/colorectal-cancer/screening/?CDC_AAref_Val=https://www.cdc.gov/cancer/colorectal/basic_info/screening/

National Cancer Institute. State cancer profiles: North Carolina — colorectal cancer incidence and mortality. https://statecancerprofiles.cancer.gov/

North Carolina State Center for Health Statistics. Colorectal cancer fact sheet. 2025. https://schs.dph.ncdhhs.gov/

U.S. Cancer Statistics Working Group. U.S. cancer statistics: Data visualizations — colorectal cancer. Centers for Disease Control and Prevention, 2024. https://www.cdc.gov/united-states-cancer-statistics/dataviz/?CDC_AAref_Val=https://www.cdc.gov/cancer/uscs/dataviz/index.htm

Cancer — Lung Cancer

American Cancer Society. Lung cancer facts and figures. 2024. https://www.cancer.org/research/cancer-facts-statistics

Centers for Disease Control and Prevention. Lung cancer statistics. 2024. https://www.cdc.gov/lung-cancer/statistics/?CDC_AAref_Val=https://www.cdc.gov/cancer/lung/statistics/

Centers for Disease Control and Prevention. Screening for lung cancer: Guidelines and recommendations. 2024. https://www.cdc.gov/lung-cancer/screening/?CDC_AAref_Val=https://www.cdc.gov/cancer/lung/basic_info/screening.htm

National Cancer Institute. State cancer profiles: North Carolina — lung and bronchus cancer incidence and mortality. https://statecancerprofiles.cancer.gov/

North Carolina State Center for Health Statistics. Lung cancer fact sheet. 2025. https://schs.dph.ncdhhs.gov/

U.S. Cancer Statistics Working Group. U.S. cancer statistics: Data visualizations — lung cancer. Centers for Disease Control and Prevention, 2024. https://www.cdc.gov/united-states-cancer-statistics/dataviz/?CDC_AAref_Val=https://www.cdc.gov/cancer/uscs/dataviz/index.htm

Cancer — Prostate Cancer

American Cancer Society. Prostate cancer facts and figures. 2024. https://www.cancer.org/research/cancer-facts-statistics

Centers for Disease Control and Prevention. Prostate cancer statistics. 2024.https://www.cdc.gov/prostate-cancer/statistics/?CDC_AAref_Val=https://www.cdc.gov/cancer/prostate/statistics/

Centers for Disease Control and Prevention. Screening and early detection for prostate cancer. 2024. https://www.cdc.gov/prostate-cancer/screening/?CDC_AAref_Val=https://www.cdc.gov/cancer/prostate/basic_info/screening.htm

National Cancer Institute. State cancer profiles: North Carolina — prostate cancer incidence and mortality. https://statecancerprofiles.cancer.gov/

North Carolina State Center for Health Statistics. Prostate cancer fact sheet. 2025. https://schs.dph.ncdhhs.gov/

U.S. Cancer Statistics Working Group. U.S. cancer statistics: Data visualizations — prostate cancer. Centers for Disease Control and Prevention, 2024. https://www.cdc.gov/prostate-cancer/screening/?CDC_AAref_Val=https://www.cdc.gov/cancer/prostate/basic_info/screening.htm

Chronic Conditions

Diabetes — Incidence

American Diabetes Association. Statistics about diabetes. 2024. https://diabetes.org/about-diabetes/statistics/about-diabetes

Centers for Disease Control and Prevention. National diabetes statistics report. 2024. https://archive.cdc.gov/#/details?url=https://www.cdc.gov/diabetes/php/data-research/methods.html

Centers for Disease Control and Prevention. Diabetes surveillance: Prevalence, incidence, and complications. 2024. https://gis.cdc.gov/grasp/diabetes/DiabetesAtlas.html

North Carolina Department of Health and Human Services. Diabetes and chronic disease surveillance in North Carolina. 2024. https://www.ncdhhs.gov

Diabetes — Prevalence

American Diabetes Association. Statistics about diabetes. 2024. https://diabetes.org/about-diabetes/statistics/about-diabetes

Centers for Disease Control and Prevention. National diabetes statistics report. 2024. https://archive.cdc.gov/#/details?url=https://www.cdc.gov/diabetes/php/data-research/methods.html

Centers for Disease Control and Prevention. U.S. diabetes surveillance system. 2024. https://gis.cdc.gov/grasp/diabetes/DiabetesAtlas.html

North Carolina Department of Health and Human Services. Diabetes and chronic disease surveillance in North Carolina. 2024. https://www.ncdhhs.gov

Heart Disease (Adult)

American Heart Association. Heart disease and stroke statistics — 2024 update. 2024. https://www.ahajournals.org/doi/10.1161/CIR.0000000000001209

Centers for Disease Control and Prevention. Heart disease facts and disparities. 2024. https://www.cdc.gov/heart-disease/data-research/facts-stats/?CDC_AAref_Val=https://www.cdc.gov/heartdisease/facts.htm

Centers for Disease Control and Prevention. Behavioral Risk Factor Surveillance System: Coronary heart disease prevalence. 2024. https://www.cdc.gov/brfss

North Carolina Department of Health and Human Services. Cardiovascular disease surveillance and trends in North Carolina. 2024. https://www.ncdhhs.gov

High Cholesterol (Adult)

American Heart Association. Heart disease and stroke statistics — 2024 update. 2024. https://www.ahajournals.org/doi/10.1161/CIR.0000000000001209

Centers for Disease Control and Prevention. High cholesterol facts and cardiovascular risk. 2024. https://www.cdc.gov/cholesterol

Centers for Disease Control and Prevention. Behavioral Risk Factor Surveillance System: Cholesterol prevalence data. 2024. https://www.cdc.gov/brfss

North Carolina Department of Health and Human Services. Cardiovascular and chronic disease surveillance in North Carolina. 2024. https://www.ncdhhs.gov

Kidney Disease (Adult)

Centers for Disease Control and Prevention. Chronic kidney disease surveillance and disparities. 2024. https://www.cdc.gov/kidneydisease

Centers for Disease Control and Prevention. Chronic kidney disease in the United States. 2024. https://www.cdc.gov/kidney-disease/php/data-research/?CDC_AAref_Val=https://www.cdc.gov/kidneydisease/publications-resources/ckd-national-facts.html

National Kidney Foundation. CKD facts and statistics. 2024. https://www.kidney.org/about/kidney-disease-fact-sheet

North Carolina Department of Health and Human Services. Chronic disease surveillance and kidney health in North Carolina. 2024. https://www.ncdhhs.gov

Adult Asthma

Centers for Disease Control and Prevention. Asthma data: National prevalence and trends. 2024. https://www.cdc.gov/asthma/

Centers for Disease Control and Prevention. Most recent asthma surveillance data: Disparities and high-risk populations. 2024. https://www.cdc.gov/asthma/asthma_stats/

Centers for Disease Control and Prevention. Asthma-related hospitalizations and emergency department visits. 2024. https://www.cdc.gov/asthma/healthcare-use/2020/data.htm#:~:text=Number%20and%20rate%20of%20emergency,patient%20characteristics%3A%20United%20States%2C%202020l

North Carolina Department of Health and Human Services. North Carolina asthma program: State asthma surveillance report. 2023. https://www.ncdhhs.gov

Stroke

Adult Stroke (Prevalence)

American Heart Association. Heart disease and stroke statistics — 2024 update. 2024. https://www.ahajournals.org/doi/10.1161/CIR.0000000000001209

Centers for Disease Control and Prevention. Stroke facts, risk factors, and disparities. 2024. https://www.cdc.gov/stroke

Centers for Disease Control and Prevention. Behavioral Risk Factor Surveillance System: Stroke prevalence data. 2024. https://www.cdc.gov/brfss

North Carolina Department of Health and Human Services. Cardiovascular disease and stroke surveillance in North Carolina. 2024. https://www.ncdhhs.gov

Stroke Hospitalizations

American Heart Association. Heart disease and stroke statistics — 2024 update. 2024.
American Heart Association. Heart disease and stroke statistics — 2024 update. 2024.

Centers for Disease Control and Prevention. Stroke facts, hospitalization trends, and risk factors. 2024. https://www.cdc.gov/stroke

Centers for Disease Control and Prevention. Stroke hospitalization and emergency department visit data. 2024. https://www.cdc.gov/nchs/fastats/emergency-department.htm

North Carolina Department of Health and Human Services. Cardiovascular disease and stroke hospitalization trends in North Carolina. 2024. https://www.ncdhhs.gov

Mental Health and Substance Use

Centers for Disease Control and Prevention. Behavioral health statistics and national mental health indicators. 2024. https://www.cdc.gov/nchs/fastats/mental-health.htm

Centers for Disease Control and Prevention. Anxiety and depression trends among U.S. adults. 2024. https://www.cdc.gov/nchs/data/nhsr/nhsr213.pdf

North Carolina Department of Health and Human Services. Behavioral health in North Carolina: Mental health trends and service utilization. 2024. https://www.ncdhhs.gov

North Carolina Department of Health and Human Services. Opioid and substance use data dashboard. 2024. https://www.ncdhhs.gov/opioid-epidemic

Substance Abuse and Mental Health Services Administration. National Survey on Drug Use and Health: Mental health and substance use findings. 2024. https://www.samhsa.gov/data

Injury and Child Mortality

Injury (All Ages)

Centers for Disease Control and Prevention. WISQARS fatal and nonfatal injury data. 2024. https://www.cdc.gov/injury/wisqars

Centers for Disease Control and Prevention. Injury data and statistics. 2024. https://www.cdc.gov/injury

North Carolina Department of Health and Human Services. Injury and violence prevention data and reports. 2024. https://www.ncdhhs.gov

Child Mortality

Centers for Disease Control and Prevention. WISQARS fatal injury and child mortality data. 2024. https://www.cdc.gov/injury/wisqars

North Carolina Child Fatality Task Force. Annual report to the governor and General Assembly. 2024. https://sites.ncleg.gov/nccftf/wp-content/uploads/sites/13/2024/05/2024-CFTF-Annual-Report-FINAL.pdf

North Carolina Department of Health and Human Services. Infant mortality and child health indicators in North Carolina. 2025. https://www.ncdhhs.gov

North Carolina State Center for Health Statistics. Child deaths in North Carolina: 2023 annual report. 2023. https://schs.dph.ncdhhs.gov

Hospital Readmissions

Centers for Medicare & Medicaid Services. Hospital Readmissions Reduction Program. 2023. https://www.cms.gov/medicare/payment/prospective-payment-systems/acute-inpatient-pps/hospital-readmissions-reduction-program-hrrp

Jencks, Stephen F., Mark V. Williams, and Eric A. Coleman. Rehospitalizations among patients in the Medicare fee-for-service program. New England Journal of Medicine, vol. 360, no. 14, 2009, pp. 1418–1428. https://doi.org/10.1056/NEJMsa0803563

Photography Credits

Inside Front Cover

Graves, D. (2022). *[Photograph of Smokey Mountains in spring rhododendrons showing bright colors, evergreen trees in foreground and layers of mountain peaks, Horizontal photo on Blue Ridge Parkway, Western NC Appalachians USA]*. Adobe Stock_512667005.

https://stock.adobe.com/images/smokey-mountains-in-spring-rhododendrons-showing-bright-colors-evergreen-trees-in-foreground-and-layers-of-mountain-peaks-horizontal-photo-0n-blue-ridge-parkway-western-nc-appalachians-usa-stock/512667005

Asset Inventory: Pages 22-38

Pavone, S. (2015). *North Carolina State Capitol in Raleigh, North Carolina, USA at twilight* [Photograph]. Adobe Stock_161544367.

https://stock.adobe.com/search?k=161544367_&search_type=usertyped&filters%5Bgentech%5D=exclude&asset_id=161544367

Sagdejev, I. (2008). *RDU welcome sign* [Photograph]. Wikimedia Commons. Creative Commons Attribution-ShareAlike License (CC BY-SA) https://commons.wikimedia.org/wiki/File:2008-07-30_RDU_welcome_sign.jpg

Wirestock. *Bank of America Stadium and Charlotte skyline* [Photograph]. Adobe Stock_823275204.

https://stock.adobe.com/images/aerial-view-of-a-baseball-stadium-in-the-cityscape-of-charlotte-north-carolina/823275204

Fotoluminate LLC. *Uptown Charlotte* [Photograph]. Adobe Stock_121472559.

https://stock.adobe.com/images/uptown-charlotte/121472559

Brandis, D. *North Carolina Welcome Sign* [Photograph]. Adobe Stock_215905525.

https://stock.adobe.com/images/north-carolina-welcome-sign/215905525

Louis, P. *[Photograph of education and school concept, little student girl studying at school]*. Adobe Stock_301245840.

https://stock.adobe.com/images/education-and-school-concept-little-student-girl-studying-at-school/301245840

Coetzee/peopleimages.com. *[Photograph of Nurse, doctor and man with blood pressure test in hospital for heart health or wellness. Healthcare, hypertension consultation and medical physician with patient for examination with sphygmomanometer]*. Adobe Stock_574550231.

https://stock.adobe.com/images/nurse-doctor-and-man-with-blood-pressure-test-in-hospital-for-heart-health-or-wellness-healthcare-hypertension-consultation-and-medical-physician-with-patient-for-examination-with-sphygmomanometer/574550231

Primary Data: Page 105

Popov, A. *Pregnant Woman Massage By Doula. Baby Care* [Photograph]. Adobe Stock_618822526.

https://stock.adobe.com/images/pregnant-woman-massage-by-doula-baby-care/618822526

Inside Back Cover

Noel. *Nags Head - North Carolina - Outer Banks* [Photograph]. Adobe Stock_288981641.

https://stock.adobe.com/images/nags-head-north-carolina-outer-banks/288981641

APPENDICES

Appendix A
ACRONYMS

ACEs — Adverse Childhood Experiences

ACGR — Adjusted Cohort Graduation Rate

ACORNS — Addressing Crises through Outreach, Referrals, Networking, and Service

ACS — American Community Survey

ADA — American Diabetes Association

ADRD — Alzheimer's Disease and Related Dementias

AHA — American Heart Association

AHEC — Area Health Education Centers

AHRQ — Agency for Healthcare Research and Quality

BMI — Body Mass Index

BRFSS — Behavioral Risk Factor Surveillance System

CAH — Critical Access Hospitals

CDC — Centers for Disease Control and Prevention

CHA — Community Health Assessment

CHD — Coronary Heart Disease

CHIP — Community Health Improvement Plan

CKD — Chronic Kidney Disease

CMHRP — Care Management for High-Risk Pregnancies

CMS — Centers for Medicare & Medicaid Services

COPD — Chronic Obstructive Pulmonary Disease

COVID-19 — Coronavirus Disease 2019

DPH — North Carolina Division of Public Health

DSS — Department of Social Services

EC — Exceptional Children

EMA — Emergency Management Agency

FEMA — Federal Emergency Management Agency

FFS — Fee-for-Service

FORHP — Federal Office of Rural Health Policy

FPHS — The Foundational Public Health Services Framework

FQHC — Federally Qualified Health Center

HIV — Human Immunodeficiency Virus

HNC 2030 — Healthy North Carolina 2030

HNC 2040 — Healthy North Carolina 2040

HOP — Healthy Opportunities Pilot

HPSA — Health Professional Shortage Area

HPV — Human Papillomavirus

HRRP — Hospital Readmissions Reduction Program

HRSA — Health Resources and Services Administration

HUD — U.S. Department of Housing and Urban Development

LHD — Local Health Department

MAPP 2.0 — Mobilizing for Action through Planning and Partnerships 2.0 framework

Mbps — Megabits per second

MCH — Maternal and Child Health

Medicaid — Joint federal and state public health insurance program for low-income individuals

MIH — Maternal and Infant Health

MOUD — Medications for Opioid Use Disorder

NACCHO — National Association of County and City Health Officials

NC AHEC — North Carolina Area Health Education Centers

NCDHHS — North Carolina Department of Health and Human Services

NC MATTERS — North Carolina Maternal Mental Health MATTERS Program

NC SHIP — North Carolina State Health Improvement Plan

NCDMVA — North Carolina Department of Military and Veterans Affairs

NCDPS — North Carolina Department of Public Safety

NCI — National Cancer Institute

NCIOM — North Carolina Institute of Medicine

NCSBI — North Carolina State Bureau of Investigation

NCServes — Coordinated network platform connecting veterans, service members, and families to resources in North Carolina

NCWorks — North Carolina Workforce Development System

NGO — Non-Governmental Organization

NKF — National Kidney Foundation

NPI — National Provider Identifier

OCD — Obsessive-Compulsive Disorder

OSBM — Office of State Budget and Management

PACT Act — Honoring Our Promise to Address Comprehensive Toxics Act

PHAB — Public Health Accreditation Board

PIT — Point-in-Time (Count)

PMHC — Perinatal Mental Health Condition

PTSD — Post-Traumatic Stress Disorder

RBA — Results-Based Accountability

SAMHSA — Substance Abuse and Mental Health Services Administration

SCHS — North Carolina State Center for Health Statistics

SHA — State Health Assessment

SIDS — Sudden Infant Death Syndrome

SMM — Severe Maternal Morbidity

SNAP — Supplemental Nutrition Assistance Program

THC — Tetrahydrocannabinol

USDHHS — U.S. Department of Health and Human Services

USRDS — United States Renal Data System

VA — U.S. Department of Veterans Affairs

V-START — Veterans Strategic Analysis & Research Tool

WIC — Women, Infants, and Children Nutrition Program

WISQARS — Web-based Injury Statistics Query and Reporting System

Appendix B

Maternal/Infant Health Resources by Local Health Department Region

Note: The resources listed in this appendix were confirmed as functional as of October 2025. Many of the organizations represented are community-based and mission-driven, and their programs and online presence may evolve over time in response to funding cycles, community needs, and changing priorities. As a result, some links or services may change or become unavailable. Readers are encouraged to verify details directly with each organization.

Table 5. Region 1 Maternal/Infant Health Resources

Organization	URL	Agency Type
Jackson County Department of Public Health – WIC	https://health.jacksonnc.org/breastfeeding	Governmental
Jackson County Department of Social Services	https://jcdss.org/services/medicaid/	Governmental
Mountain AHEC (MAHEC) – Project CARA	https://mahec.net/obgyn/project-cara	NGO
Lifespring Lactation & Doula Services	https://brandisaxon.wixsite.com/lifespringlactation	Other
Smart Start Region A – PFC	https://www.smartstart.org/smart-start-in-your-community/	NGO
Jackson County Transit	https://www.jacksonnc.org/transit	Governmental

Table 6. Region 2 Maternal/Infant Health Resources

Organization	URL	Agency Type
Yancey County WIC	https://sites.google.com/view/yanceycountyhealthdepartment/departments/women-infants-children	Governmental
Yancey County Health Department – Maternal Health & Pregnancy Support	https://sites.google.com/view/yanceycountyhealthdepartment/departments/family-support-services	Governmental
Yancey County Department of Social Services	https://www.yanceycountydss.us/	Governmental
Yancey County Cooperative Extension – Parent Education	https://yancey.ces.ncsu.edu/parent-education-opportunities/	NGO
Circle of Parents – Yancey County	https://yancey.ces.ncsu.edu/parent-education-opportunities/circle-of-parents/	NGO
Blue Ridge Partnership for Children	https://blueridgechildren.org/	NGO
Yancey County Transportation Authority (YCTA)	https://yanceycountync.gov/181/Transportation-Authority	Governmental

Table 7. Region 3 Maternal/Infant Health Resources

Organization	URL	Agency Type
Forsyth County WIC	https://forsythcountync.gov/HHS/wic.aspx	Governmental
Forsyth County DSS	https://www.ncdhhs.gov/assistance/medicaid	Governmental
Forsyth County Health Department	https://forsyth.cc/HHS/pregnancy_care.aspx	Governmental
Smart Start of Forsyth County	https://smartstart-fc.org/	NGO
Bridges to Hope Family Justice Center	https://forsythcountync.gov/bridgestohope/supporting-b2h.aspx	Governmental
Birthright of Winston-Salem	https://birthrightws.com/	NGO
Planned Parenthood – Winston-Salem Health Center	https://www.plannedparenthood.org/health-center/north-carolina/winston-salem/27103/winston-salem-health-center-2845-90860	NGO
Novant Health Today's Woman OB/GYN	https://www.novanthealth.org/locations/clinics/todays-woman-obgyn/	Other
Novant Health Forsyth Medical Center – Birth and Beginnings & Infant Classes	https://www.novanthealth.org/locations/medical-centers/forsyth-medical-center/services/maternity-services/	Other
Forsyth Connects – In-Home Postnatal Support	https://supportnovanthealth.org/forsyth-connects-help-mothers-across-county/	NGO
Imprints Cares – Parenting Programs	https://www.imprintscares.org/programs	NGO
Parenting PATH – Welcome Baby Home Visiting	https://parentingpath.org/what-we-do/welcome-baby.html	NGO
Parenting PATH – Fathers Are Parents Too	https://parentingpath.org/what-we-do/fathers.html	NGO
Catholic Charities – Hand to Hand Program	https://ccdoc.org/children-youth	NGO
Family Services of Forsyth County – Counseling & Child Development Services	https://familyservicesforsyth.org/	Governmental
Florence Crittenton Services – Maternity & Teen Mom Programs	https://crittentonofnc.org/	NGO
Room at the Inn	https://www.roominn.org/	Faith-based
La Leche League NC	https://www.lllofnc.org/localgroups/	NGO
Child Care Resource Center (formerly Work Family Resource Center)	https://childcareresourcecenter.org/	NGO
Winston-Salem Transit Authority (WSTA) – Paratransit (Trans-AID)	https://www.cityofws.org/765/Transportation	Governmental

Table 8. Region 4 Maternal/Infant Health Resources

Organization	URL	Agency Type
Union County WIC Program	https://www.unioncountync.gov/government/departments-a-e/community-support-outreach/women-infants-children-wic	Governmental
Union County Parenting Support Program	https://www.unioncountync.gov/government/departments-a-e/community-support-outreach/parenting-support	Governmental
Union County Health Department	https://www.unioncountync.gov/government/departments-f-p/public-health/community-service-programs/early-childhood-care-management	Governmental
Union County Department of Social Services	https://www.ncdhhs.gov/divisions/social-services/union-county-department-social-services	Governmental
The Arc of Union/Cabarrus	https://thearcisthere.org/	NGO
Alliance for Children	https://theallianceforchildren.org/	NGO
Union County Transportation Services	https://www.unioncountync.gov/government/departments-r-z/transportation	Governmental

Table 9. Region 5 Maternal/Infant Health Resources

Organization	URL	Agency Type
Caswell County WIC	https://www.caswellnc.us/wic/	Governmental
Caswell County Department of Social Services	https://www.socialservicesdepartment.com/office/caswell_county_dss_27379	Governmental
Caswell County Smart Start	https://www.caswellchildren.org/	Governmental
Caswell County Health Department	https://www.caswellnc.us/	Governmental
Caswell County Partnership for Children	https://www.caswellchildren.org/	NGO
Caswell County Area Transportation System (CATS)	https://www.caswellcountync.gov/cats-transportation	Governmental

Table 10. Region 6 Maternal/Infant Health Resources

Organization	URL	Agency Type
Scotland County WIC Office	https://www.scotlandcounty.org/167/Women-Infants-Children-WIC-Program	Governmental
Scotland County Health Dept – Maternal Health & Pregnancy Case Management	https://www.scotlandcounty.org/162/Maternal-Health	Governmental
Scotland County DSS – Medicaid for Pregnant Women	https://www.scotlandcounty.org/269/Pregnant-Women	Governmental
Vita Choices Pregnancy Center	https://vitachoicesprc.com/free-services	Faith-Based
Baby Shower Events – Carolina Complete Health	https://www.carolinacompletehealth.com/members/medicaid/resources/benefits-services/start-smart-for-your-baby/baby-showers.html	NGO
Scotland County Partnership for Children and Families	https://www.facebook.com/scotlandss/ (website under construction)	NGO
Scotland County Area Transit System (SCATS)	https://www.scotlandcounty.org/470/Trip-Scheduling	Governmental

Table 11. Region 7 Maternal/Infant Health Resources

Organization	URL	Agency Type
Wake County WIC Office	https://www.wake.gov/departments-government/health-human-services/programs-assistance/wic-program	Governmental
Wake County Maternal and Child Health Services	https://www.wake.gov/departments-government/health-human-services/public-health-and-medical-services/maternal-and-child-health	Governmental
Wake County Health & Human Services – Medicaid & Public Health Programs	https://www.wake.gov/departments-government/health-human-services	Governmental
Wake County Family Support Services	https://www.wake.gov/departments-government/health-human-services/children-and-family-services/child-welfare-prevention-and-support-services/family-support-services	Governmental
North Regional Center Breastfeeding Support Group	https://www.wake.gov/departments-government/health-human-services/health-human-services-locations/northern-regional-center/nrc-breastfeeding-support-group	Governmental
WakeMed Lactation Support Groups	https://www.wakemed.org/care-and-services/womens/pregnancy-and-childbirth/support-for-new-parents/breastfeeding-support-group	Governmental
Triangle Area Parenting Support (TAPS) – Breastfeeding	https://www.tapsnc.org/breastfeeding	NGO
East Raleigh Doula Collective	https://www.eastraleighdoula.com/	NGO
Doulas of Raleigh	https://www.doulasofraleigh.com/	NGO
Triangle Doulas of Color	https://www.triangledoulasofcolor.com/	NGO
New Creation Birth and Family Services	https://newcreationbirthservices.com/	NGO
WakeMed Supportive Birth Services	https://www.wakemed.org/care-and-services/womens/pregnancy-and-childbirth/pregnancy-and-childbirth-resources/supportive-birth-services	Governmental
Catholic Parish Outreach Food Pantry	https://www.catholiccharitiesraleigh.org/programs/catholic-parish-outreach-food-pantry/	Faith-Based
Western Wake Pediatrics	https://www.westernwakepediatrics.com/	Other
Jeffers, Mann and Artman Pediatrics	https://www.jeffersandmann.com/	Other
Triangle Lactation Consultants – Ann Conlon-Smith	https://trianglelactation.com/	Other
Carolina Lactation Consultants	https://carolinalactationconsultants.com/	Other

Organization	URL	Agency Type
Four Sisters' Hands	https://www.foursistershands.com/	Other
Milestones Pediatric & Maternal Nutrition	https://www.milestonesnutrition.com/	Other
Jordan Smith Lactation	https://jordansmithlactation.com/	Other
Relatable Lactation LLC – Sophia Taylor	https://www.relatable-lactation.com/	Other
Wake County Public Libraries – Parenting Resources	https://www.wake.gov/departments-government/libraries	Governmental
Best Baby Wake	https://www.wake.gov/departments-government/health-human-services/public-health-and-medical-services/maternal-and-child-health/best-baby-wake	Governmental
Wake County Smart Start – Supporting Families	https://www.wakesmartstart.org/families/supporting-families/	NGO
Hand of Hope Pregnancy Centers – Raleigh & Fuquay-Varina	https://www.handofhope.net/	NGO
iChoose Pregnancy Support Services – Knightdale	https://www.ichoose.me/appointments/schedule-now	NGO
Salvation Army Women & Children Shelter	https://www.salvationarmycarolinas.org/wakecounty/	Faith-Based
Triangle Family Services – Housing & Shelter	https://www.tfsnc.org/housing/	NGO
OAK City Cares – Homeless Outreach	https://raleighnc.gov/housing/services/resources-housing-crises-and-homelessness	Governmental
Wake County Continuum of Care	https://www.wake.gov/departments-government/wake-county-continuum-care	Governmental
Catholic Charities – Raleigh	https://www.catholiccharitiesraleigh.org/get-help/	Faith-Based
SAFEchild (Stop Abuse for Every Child)	https://safechildnc.org/	NGO
GoWake Access Transportation	https://www.wake.gov/departments-government/health-human-services/programs-assistance/gowake-access-transportation	Governmental
GoRaleigh Public Transit	https://raleighnc.gov/transportation/service-unit/public-transportation	Governmental
GoTriangle Regional Transit	https://gotriangle.org/waketransit	Governmental
GoCary Transit	https://gocary.org/	Governmental

Table 12. Region 8 Maternal/Infant Health Resources

Organization	URL	Agency Type
Onslow County WIC Program	https://www.onslowcountync.gov/216/WIC	Governmental
Onslow County Health Dept - New & Expecting Patients	https://www.onslowcountync.gov/2257/New-Expecting-Moms	Governmental
Onslow County Health Dept – Newborn & Maternal Postpartum Home Visit	https://www.onslowcountync.gov/284/Newborn-and-Maternal-Post-partum-Home-Vis	Governmental
Onslow County DSS – Medicaid & Economic Services	https://www.onslowcountync.gov/353/Medicaid-Programs	Governmental
PEERS Family Development Center	https://www.peersfamilydevelopmentcenter.com/	NGO
Bosom Babies Lactation (Carolina Coast Location)	https://carolinacoastlactation.com/	Private
La Leche League of Jacksonville & Camp Lejeune	https://lalecheofjaxnc.weebly.com	NGO
Onslow Pregnancy Resource Center (Hope First)	https://hopefirst.org/	Faith-Based
One Place – Early Head Start	https://www.oneplaceonslow.org/blog/early-head-start-pregnant-women-and-expectant-family-services/	NGO
Onslow Memorial Hospital – Maternity Services	https://www.onslow.org/services/maternity	NGO
Bella Donna Midwifery--Birth & Women's Health	https://www.belladonnamidwifery.com/services-9	Private
Military Birth Resource Network	https://www.mbrnpc.org/	NGO
Navy-Marine Corps Relief Society	https://www.nmcrs.org/our-services/visiting-nurses	NGO
Naval Medical Center Camp Lejeune	https://camp-lejeune.tricare.mil/Health-Services/Womens-Health-Pregnancy	NGO
Onslow United Transit System (OUTS)	https://www.onslowunitedtransit.org/	NGO
Windows Womb	https://www.wombswindow.com	Private

Table 13. Region 9 Maternal/Infant Health Resources

Organization	URL	Agency Type
Halifax County Health Dept. WIC	https://www.halifaxnc.com/335/Women-Infants-Children-WIC	Governmental
Halifax County Health Dept. Clinic Services	https://www.halifaxnc.com/186/Clinic-Services	Governmental
Halifax County DSS – Medicaid & Social Services	https://www.halifaxnc.com/170/Department-of-Social-Services	Governmental
Triple P – Positive Parenting Program	https://www.halifaxnc.com/338/Triple-P	NGO/Governmental
Pregnancy Support Center of Roanoke Rapids	https://www.pregnancysupportcenterofrr.com/about-us.html	NGO
Nurse-Family Partnership (Halifax Community College)	https://halifaxcc.edu/community/nurse-family-partnership/	NGO
Rural Health Group (FQHC)	https://connector.hrsa.gov/connector/site-profile/C90FCA53-A554-42F5-A1ED-427A7F36FEB7	NGO
Catholic Charities Tar River Region	https://www.catholiccharitiesraleigh.org/?s=halifax+county	Faith-based/NGO
Choanoke Public Transportation Authority (CPTA)	https://choanokepta.org/	Governmental

Table 14. Region 10 Maternal/Infant Health Resources

Organization	URL	Agency Type
Wayne County Health Dept - WIC	https://www.waynegov.com/282/Women-Infants-Children-Program-WIC	Governmental
Wayne County - Medicaid Office	https://www.waynegov.com/964/Family-Childrens-Medicaid	Governmental
Wayne County Public Health	https://www.waynegov.com/2192/Maternal-And-Infant-Health	Governmental
Wayne Pregnancy Center	https://waynepregnancycenter.com/	NGO (faith-affiliated)
Partnership for Children of Wayne County (Smart Start/NC Pre-K)	https://pfcw.org/	NGO
Goldsboro-Wayne Transportation Authority (GWTA)	https://ridegwta.com/van-services/	Governmental

Appendix C

Key Informant Interview Instructions

Before the Interview

/ 01 Send the Email Invitation

- Use the draft email provided at the end of this appendix (modify as needed).
- Update the tracking spreadsheet:
  - In the Status column, select **"email sent."**

/ 02 Schedule the Interview

- Plan for a 30-minute interview.
- If multiple participants will attend, schedule 45 minutes.
- Interviews may be conducted via Zoom or Microsoft Teams.
- Update the tracking spreadsheet:
  1. Enter the scheduled interview date and select **"interview scheduled"** in the Status column.
  2. Enter the name and email of the person who will validate the resource guide (if different from the interviewee).

/ 03 Select the Appropriate Interview Guide

There are three versions of the interview guide:

- **Social Worker Guide** – focuses on non-clinical, social factors.
- **Clinical Staff Guide** – focuses on clinical care.
- **Assuring Counties Guide** – includes questions about assurance arrangements.

Note: The guides are similar; choose the one that best fits the interviewee's role.

During the Interview

/ 01 Begin with the Introduction Script

- Thank the participant for their time.
- Explain the purpose of the study and note that findings will inform the State Health Assessment.
- Indicate the interview duration (typically 30 minutes).
- Request permission to record, emphasizing that recordings are used only for analysis and that neither individuals nor counties will be identified.

/ 02 Recording Procedures

- Start recording **only after** the participant provides consent.
- Stop the recording immediately after the interview ends.
- If the participant declines recording, take detailed notes.

/ 03 Follow the Interview Guide

- You do not need to ask questions in order.
- If the participant covers a topic early, acknowledge it and ask if they wish to add anything.
- Questions labeled **"if time"** should be asked last and may be skipped if time is limited.

/ 04 Use Follow-Up Questions

Use prompts to clarify, deepen, or expand responses:

<u>To check for completeness</u>

- "Are there any other challenges you've noticed?"
- "Besides what you mentioned, are there other factors that stand out?"

<u>To clarify or deepen</u>

- "Can you say more about what you mean by that?"
- "Could you give an example of how that plays out?"

To explore causes

- "Why do you think that happened?"
- "What do you think contributed to that?"

To explore consequences

- "What do you think the impact has been on maternal health?"
- "How has this affected the way services are delivered?"

/ 05 Monitor Time

- Keep track of remaining time throughout the interview.
- Prioritize essential questions if time runs short.
- At approximately 25 minutes, you may say:
- "We have about 5 minutes left—are you able to stay on a little longer, or should we begin wrapping up?"

After the Interview

/ 01 Conclude the Conversation

- Thank the participant for their time and insights.

/ 02 Save the Recording

- Save the audio file and notes to the shared drive the same day.
- Use the following naming format: County_Interviewer_Date

/ 03 Update the Tracking Spreadsheet

- In the Status column, select "interview completed."

/ 04 Send a Thank-You Email

- Email the respondent to thank them for participating.

Draft Email Invitation

New Message

To :

cc : bcc :

Subject : Request for Interview – Maternal Health Study

Dear [Name],

I am a consultant working with the North Carolina Department of Health and Human Services on a study to better understand the factors affecting maternal health in North Carolina. Findings from this project will help inform the State Health Improvement Plan and the upcoming State Health Assessment.

We would like to invite you to participate in a 30-minute interview about maternal and infant health in your county. We hope to complete all interviews by September 10, and we can meet via Zoom or Teams. Could you please reply with 2–3 times that work for you within that timeframe? [Name of referrer] recommended you as someone with valuable insights to share.

During the interview, we will ask about community and environmental factors, barriers to care, departmental capacity and strengths, behavioral health and social needs, and any changes or disparities you have observed over time.

We recognize this is a busy time and sincerely appreciate your assistance. Thank you for considering this request, and I look forward to your reply.

Best regards,
[Your Name]

Appendix D

Key Informant Interview Guide

The following guides were used to conduct interviews with local health department (LHD) personnel as part of the 2025 North Carolina State Health Assessment. Each guide is tailored to the interviewee's role and includes a standard introductory script, core questions, optional "if time" questions, and probes to support deeper discussion.

Care Manager / Social Work Supervisor

Introductory Script

Thank you for meeting with me today. The purpose of this conversation is to better understand what is helping and challenging maternal health in your county. We are interested in hearing your perspectives on what is working well, where the biggest needs are, and how things may be changing over time.

This conversation should take about 30 minutes. I will be taking notes and, if it is okay with you, I would like to record our discussion so I do not miss any details. The recording will be used only for data analysis, and neither you nor your county will be identified in any report.

Would you be comfortable with me recording this conversation?

Introduction

Q **Please tell me a little about your role and how long you have been in this position.**

Probe: From your viewpoint, what does your role as a care manager involve when supporting pregnant or postpartum individuals?

Q **Can you tell me a little about your county and the factors that most shape public health work there?**

Community and Environmental Factors

Q **What community or environmental factors most affect maternal and infant health in your region?**

Q **On the positive side, what factors in your community help support healthy pregnancies and healthy babies?**

Q **Have any of these factors — either challenges or strengths — changed in recent years? If so, how?**

Local Health Department Capacity

Q **What are your health department's main challenges in meeting the needs of pregnant and postpartum women?**

Probe: Can you share examples of strategies or approaches that have worked well to address these challenges?

Q **What strengths does your health department bring to supporting maternal and infant health?**

Q **Have any of these factors — either challenges or strengths — changed in recent years? If so, how?**

Access to Maternal Health Care (if time)

- **Q** **What barriers do your clients face in accessing prenatal or postpartum care?**
- **Q** **Have there been any policy changes in the past few years that have influenced maternal health services or access to care?**

  Probe: Have you noticed any changes since Medicaid expansion?

Behavioral Health and Social Needs (if time)

- **Q** **What kinds of behavioral health or social needs do you most often see?**
- **Q** **How do you help connect clients with appropriate support? How adequate is the support that is available?**

Disparities (if time)

- **Q** **Are there some sub-groups in your community that confront more challenges related to maternal health than others?**
- **Q** **What factors seem to drive those differences?**

Wrap-Up

- **Q** **If you could make one or two recommendations — whether related to programs, policies, or resources — what would make the biggest difference in improving maternal health in your county?**
- **Q** **Is there anything we have not discussed that you think is important for us to know about maternal health in your county?**

Clinical Staff

Introductory Script

(Use the same script as page 239)

Introduction

- **Q** **Please tell me a little about your role and how long you have been in this position.**

  Probe: From your viewpoint, what does your role as a maternity care coordinator involve when supporting pregnant or postpartum individuals?
- **Q** **Can you tell me a little about your county and the factors that most shape public health work there?**

Access to Maternal Health Care

- **Q** **What barriers do your clients face in accessing prenatal or postpartum care?**
- **Q** **Have there been any changes in the past few years that have influenced maternal health services or access to care?**

  Probe: Have you noticed any changes since Medicaid expansion? Have other policy changes affected access?

Local Health Department Capacity

- **Q** **What are the main challenges your health department faces in meeting the needs of pregnant and postpartum women?**

  Probe: Can you share examples of strategies or approaches that have worked well?
- **Q** **What strengths does your health department bring to supporting maternal and infant health?**
- **Q** **Have any of these factors — either challenges or strengths — changed in recent years? If so, how?**

Community and Environmental Factors (if time)

- **Q What community or environmental factors most affect maternal and infant health?**
- **Q On the positive side, what factors in your communities help support healthy pregnancies and healthy babies?**
- **Q Have any of these factors — either challenges or strengths — changed in recent years? If so, how?**

Behavioral Health and Social Needs (if time)

- **Q What kinds of behavioral health or social needs do you most often see?**
- **Q How do you help connect clients with appropriate support? How adequate is the support that is available?**

Disparities (if time)

- **Q Are there sub-groups in your community that confront more challenges related to maternal health than others?**
- **Q What factors seem to drive those differences?**

Wrap-Up

- **Q If you could make one or two recommendations — programs, policies, or resources — what would make the biggest difference in improving maternal health in your region?**
- **Q Is there anything we have not discussed that you think is important for us to know about maternal health in your county?**

Assuring Counties

Introductory Script

(Use the same script as page 239)

Introduction

- **Q Please tell me a little about your role and how long you have been in this position.**

  Probe: From your viewpoint, what does your role as a maternity care coordinator involve?

- **Q Can you tell me a little about your county and the factors that most shape public health work there?**
- **Q I understand that your county provides access to maternal health care through an assuring arrangement. Could you explain how that process works in your county?**

  Probe: What impact do you think assuring has on maternal health outcomes?

Access to Maternal Health Care

- **Q What barriers do your clients face in accessing prenatal or postpartum care?**
- **Q Have there been any changes in the past few years that have influenced maternal health services or access to care?**

  Probe: Have you noticed any changes since Medicaid expansion? Have other policy changes affected access?

Local Health Department Capacity

- **Q What challenges affect your ability to provide or assure maternal health services?**

  Probe: How do staffing, funding, and partnerships influence your ability to address maternal health needs?

- **Q How has your department's ability to serve pregnant and postpartum people changed over time?**
- **Q What strengths does your health department have in addressing maternal health?**

System and Policy Factors

- **Q Have there been any policy changes that have influenced maternal health services or access to care?**

  Probe: Have you noticed any changes since Medicaid expansion?

- **Q Are there system-level or policy-level factors that have significantly shaped maternal health in your area?**

Community and Environmental Factors (if time)

- **Q What community or environmental factors most affect maternal and infant health?**
- **Q On the positive side, what factors in your community help support healthy pregnancies and healthy babies?**
- **Q Have any of these factors — either challenges or strengths — changed in recent years? If so, how?**

Behavioral Health and Social Needs (if time)

- **Q What kinds of behavioral health or social needs do you most often see?**
- **Q How do you help connect clients with appropriate support? How adequate is the support that is available?**

Disparities (if time)

- **Q Are there sub-populations that face more challenges related to maternal health than others?**
- **Q What factors seem to drive those differences?**

Wrap-Up

- **Q If you could make one or two recommendations — programs, policies, or resources — what would make the biggest difference in improving maternal health in your region?**
- **Q Is there anything we have not discussed that you think is important for us to know about maternal health in your county?**

Appendix E

Social Listening: Military/Veteran Sources

Table 15. Veteran Homelessness

Date	Article	Source	Link
2/18/25	As US, NC homelessness numbers rise, officials and nonprofits make headway in helping veterans	NC Newsline	https://ncnewsline.com/2025/02/18/as-us-nc-homelessness-numbers-rise-officials-and-nonprofits-make-headway-in-helping-veterans/
11/13/24	New community for homeless veterans under construction in High Point	WXII	https://www.wxii12.com/article/community-homeless-veterans-construction-high-point/62898907
12/7/24	Police officer, ACORNS program help homeless veterans across Raleigh	ABC11	https://abc11.com/post/police-officer-wr-jackson-acorns-program-help-homeless-veterans-raleigh-north-carolina/15626639/
9/25/25	Beyond the battlefield: Nonprofit Off-Road Outreach makes a difference in the lives of homeless Veterans through support, service and compassion	Greater Fayetteville Business Journal	https://bizfayetteville.com/military-business/2024/8/29/beyond-the-battlefield-nonprofit-off-road-outreach-makes-a-difference-in-the-lives-of-homeless-veterans-through-support-service-and-compassion/3385
3/14/25	Charlotte's innovative plan to house every homeless veteran	PBS	https://www.pbs.org/video/charlottes-innovative-plan-to-house-every-homeless-veteran-50gl8k/
2/28/24	More than 700 veterans estimated to be homeless in NC	The Daily News	https://www.jdnews.com/news/local/more-than-700-veterans-estimated-homeless-in-north-carolina/article_747f0075-51a3-574c-96ad-18574314b44f.html

Table 16. Health Care Access

Date	Article	Source	Link
2/26/25	Federal employee terminations hit Durham, Fayetteville VA health care systems	ABC11	https://abc11.com/post/va-cuts-nc-durham-fayetteville-veterans-affairs-employees-terminated-trump-elon-musk-us-reps-respond/15957557/
3/19/25	Concerns rise among Asheville veterans over potential job cuts at VA hospital	WLOS13	
3/19/25	VA Secretary Doug Collins in Asheville addresses federal job cuts, protestors	Asheville Citizen Times	https://www.usatoday.com/story/news/local/2025/03/19/va-secretary-in-asheville-job-cuts-wont-affect-benefits-and-care/82487879007/
3/3/25	Triad veteran devastated after he was cut in latest round at the VA; 'A lot of shock'	Fox 8	https://myfox8.com/news/north-carolina/piedmont-triad/triad-veteran-devastated-after-he-was-cut-in-latest-round-at-the-va-a-lot-of-shock/
3/14/25	How many Fayetteville Veterans Affairs jobs have been cut?	The Fayetteville Observer	https://www.fayobserver.com/story/news/military/2025/03/14/will-va-job-cuts-impact-fayetteville-nc/81766149007/

Table 17. Environmental Health Concerns

Date	Article	Source	Link
10/3/24	Damage from Helene devastating for some veterans	NC Health News	https://www.northcarolinahealthnews.org/2024/10/03/helene-devastating-for-some-veterans/
12/2/24	DEMPS volunteers answer the call to help in hurricane-ravaged North Carolina	VA News	https://www.va.gov/milwaukee-health-care/stories/demps-volunteers-answer-the-call-to-help-in-hurricane-ravaged-north-carolina/
10/8/24	Veterans Affairs, nonprofit get outreach services going for Asheville veterans	Citizen Times	https://www.citizen-times.com/story/news/local/2024/10/08/va-nonprofit-continue-outreach-efforts-to-asheville-veterans/75553619007/
5/28/24	Pact Act expansion of approved claims to impact NC veterans	WITN7	https://www.witn.com/2024/05/28/pact-act-expansion-approved-claims-impact-north-carolina-veterans/
3/5/24	Veterans exposed to burn pits, toxins no longer have to wait to apply for health benefits	ABC11	https://abc11.com/nc-veterans-burn-pits-toxics-military-pact-act-health-benefits/14493969/
8/9/24	More than 1 million veterans receiving benefits via PACT Act ahead of anniversary	NC Newsline	https://ncnewsline.com/2024/08/09/more-than-1-million-veterans-receiving-benefits-via-pact-act-ahead-of-anniversary/
3/6/24	VA expands access to health care under PACT Act to millions of veterans	News 17	https://www.cbs17.com/news/north-carolina-news/va-expands-access-to-health-care-under-pact-act-to-millions-of-veterans/

Table 18. Workforce Development

Date	Article	Source	Link
2/5/25	Governor Josh Stein Holds Workforce Development Roundtable Focusing on North Carolina Veterans	Office of the Governor	https://governor.nc.gov/news/press-releases/2025/02/05/governor-josh-stein-holds-workforce-development-roundtable-focusing-north-carolina-veterans
2/5/25	Gov. Josh Stein visits Wilmington, talks improving veteran workforce at NCWorks	WECT	https://www.wect.com/2025/02/05/gov-josh-stein-visits-wilmington-talks-improving-veteran-workforce-ncworks/
3/7/25	Trump's federal workforce cuts jeopardize the careers of nearly 900,000 veterans and veteran or military spouses	Economic Policy Institute	https://www.epi.org/blog/trumps-federal-workforce-cuts-jeopardize-the-careers-of-nearly-900000-veterans-and-veteran-or-military-spouses/

Table 19. Active Duty Housing

Date	Article	Source	Link
4/27/22	Health risks for families in military private housing probed by U.S. Senate panel	NC Newsline	https://ncnewsline.com/2022/04/27/health-risks-for-families-in-military-private-housing-probed-by-u-s-senate-panel/
2/27/25	Senators call for military housing price-gouging investigation in cities including Wilmington	Port City Daily	https://portcitydaily.com/latest-news/2025/02/27/senators-call-for-military-housing-price-gouging-investigation-in-cities-including-wilmington/
12/19/24	Homes at Fort Liberty to get renovations after years of families complaints about living conditions	ABC11	https://abc11.com/post/fort-liberty-housing-issues-addressed-after-years-complaints-settlement-corvias/15678033/

Appendix F

Social Listening: Hispanic/Latine Sources

Table 20. Access to Health Care and Services

Date	Article	Source	Link
7/14/24	More than 45 thousand Latinos enrolled in Medicaid in North Carolina	Enlace Latino	https://enlacelatinonc.org/en/more-than-45-thousand-Latinos-enrolled-in-Medicaid-in-North-Carolina/
4/5/24	Five North Carolina counties account for 37% of Latinos enrolled in Medicaid	Enlace Latino	https://enlacelatinonc.org/en/Latinos-enrolled-in-Medicare-North-Carolina/
12/1/23	Medicaid expansion in North Carolina: impact on the Latino community and rural areas	Enlace Latino	https://enlacelatinonc.org/en/Medicaid-expansion-in-North-Carolina-impact-on-the-Latino-community-and-rural-areas/
12/14/23	Navigators make it easier for the Latino community to enroll in Medicaid	Enlace Latino	https://enlacelatinonc.org/en/Navigators-make-it-easier-for-the-Latino-community-to-register-for-Medicaid/
12/21/23	Young Latinos: those who benefit most from Medicaid expansion in North Carolina	Enlace Latino	https://enlacelatinonc.org/en/expansion-of-medicaid-young-latinos/
8/14/24	Undocumented and Undiagnosed: The Fight to Ease A Health Crisis Among North Carolina's Farmworkers	Enlace Latino	https://enlacelatinonc.org/en/the-fight-to-ease-a-health-crisis-among-north-carolinas-farmworkers/
6/10/24	Even when insured, NC's Latino residents are less likely to receive health care	NC Newsline	https://ncnewsline.com/briefs/even-when-insured-ncs-latino-residents-are-less-likely-to-receive-healthcare/
8/5/24	Report: NC's growing Latino population needs better access to health care	WHQR	https://www.whqr.org/local/2024-08-05/report-ncs-growing-latino-population-needs-better-access-to-health-care
4/18/24	Health care works better for North Carolina's white residents than for everyone else	NC Newsline	https://ncnewsline.com/2024/04/18/health-care-works-better-for-north-carolinas-white-residents-than-for-everyone-else/
9/19/24	ICE cooperation bill could have impact on immigrant health	WUNC	https://www.wunc.org/2024-09-19/ice-sheriff-cooperation-bill-immigrant-health
12/3/24	Coastal Horizons expanding mental health program for Hispanic and Latinx community	WECT	https://www.wect.com/2024/12/03/coastal-horizons-expanding-mental-health-program-hispanic-latinx-community/
4/22/24	Recently published study looks at health care and race, including in North Carolina	WHQR	https://www.whqr.org/local/2024-04-22/recently-published-study-looks-at-healthcare-and-race-including-in-north-carolina
7/25/22	A new clinic to meet WNC Latinos' medical, mental and social health needs	NC Health News	https://www.northcarolinahealthnews.org/2022/07/25/new-vecinos-clinic-to-meet-wnc-latinos-needs/
9/19/24	El Futuro provides culturally informed mental health care to the Hispanic community	Healthcare Brew	https://www.healthcare-brew.com/stories/2024/09/19/el-futuro-culturally-informed-mental-health-care-hispanic-community
9/18/24	Hispanic and Latin American Heritage Month: Triangle organizations help to support the community	ABC11	https://abc11.com/post/hispanic-latin-american-heritage-month-triangle-organizations-el-centro-hispano-futuro-support-community/15321135/
2/23/22	Increase in Cumberland County's Latino population creates public health care challenges	The Fayetteville Observer	

Table 21. Covid-19

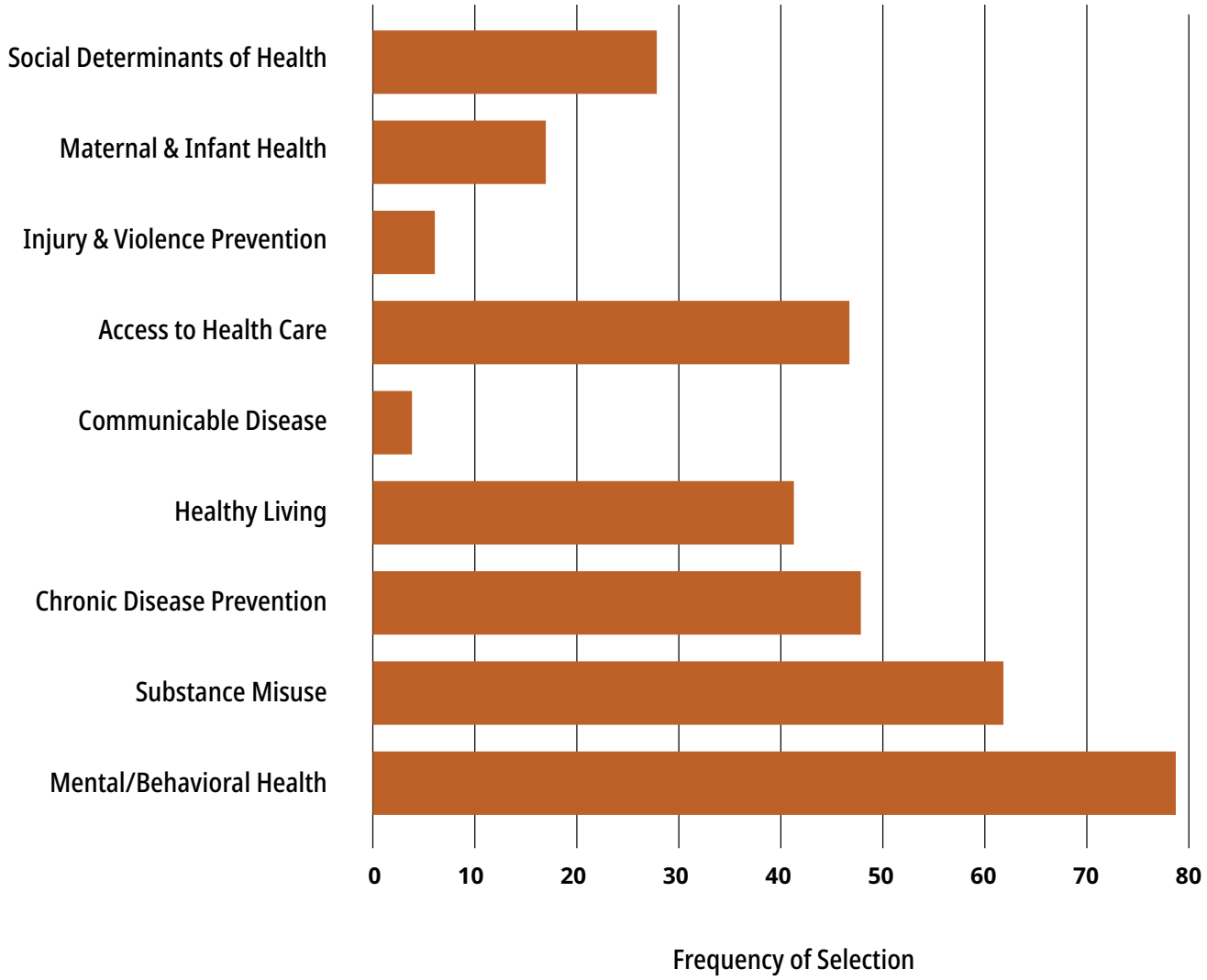
Date	Article	Source	Link
11/1/21	North Carolina's Latino residents are more vaccinated than the non-Hispanic population	NC Health News	https://www.northcarolinahealthnews.org/2021/11/01/north-carolinas-latino-residents-are-more-vaccinated-than-the-non-hispanic-population/
9/8/20	North Carolina Department of Agriculture says asymptomatic Farmworkers exposed to COVID-19 must continue working	Enlace Latino	https://enlacelatinonc.org/en/north-carolina-department-of-agriculture-says-asymptomatic-farmworkers-exposed-to-covid-19-must-continue-working/
8/3/20	How Latinos In North Carolina Are Disproportionately Affected By COVID-19	WFAE	https://www.wfae.org/local-news/2020-08-03/how-latinos-in-north-carolina-are-disproportionately-affected-by-covid-19
5/14/20	Durham city leaders respond to uptick in COVID-19 cases in Hispanic community	WRAL	https://www.wral.com/durham-city-leaders-reapond-to-uptick-in-covid-19-cases-in-hispanic-community/19097533/
5/29/20	Latinos, the coronavirus and a single ZIP code	NC Health News	https://www.northcarolinahealthnews.org/2020/05/29/latinos-coronavirus-and-a-single-zip-code/
6/19/20	The first child to die of COVID-19 in NC illustrates spread through Latino communities	The News and Observer	https://www.newsobserver.com/news/local/article243591547.html
8/4/22	Trusted community messengers, data key in North Carolina's journey to vaccine equity	NC Health News	https://www.northcarolinahealthnews.org/2022/08/04/trusted-community-messengers-data-key-in-north-carolinas-journey-to-vaccine-equity/
5/3/20	North Carolina Poultry Plant Workers Say Butterball Isn't Protecting Them from COVID-19	Civil Eats	https://civileats.com/2020/05/03/north-carolina-poultry-plant-workers-say-butterball-isnt-protecting-them-from-covid-19/
5/21/20	After worker's death, employees at Pilgrim's Pride plant in NC to get coronavirus test	The News and Observer	https://www.newsobserver.com/news/coronavirus/article242898471.html

Table 22. Environmental Health Concerns

Date	Article	Source	Link
7/23/24	Farmworker's death sparks investigation from the North Carolina Department of Labor	Enlace Latino	https://enlacelatinonc.org/en/farmworkers-death-sparks-investigation-from-the-north-carolina-department-of-labor/
7/24/24	Flor Herrera-Picasso: How North Carolina fails its farmworkers	Enlace Latino	https://enlacelatinonc.org/en/flor-herrera-picasso-how-north-carolina-fails-its-farmworkers/
11/17/22	Study finds Latino workers die of occupational injuries at higher rates than other groups	NC Health News	https://www.northcarolinahealthnews.org/2022/11/17/study-finds-latino-workers-die-of-occupational-injuries-at-higher-rates-than-other-groups/
2/9/25	We can see factory farm pollution all the way from space	Vox	https://www.vox.com/future-perfect/398131/factory-farm-air-pollution-space-north-carolina
8/30/21	Mountaire Farms workers in Lumber Bridge allege chemicals are making them sick	NC Health News	https://www.northcarolinahealthnews.org/2021/08/30/mountaire-farms-workers-in-lumber-bridge-allege-chemicals-are-making-them-sick/
10/3/24	Aid Is Slow to Reach Some Latino Areas in Storm-Hit North Carolina	NY Times	https://www.nytimes.com/2024/10/03/us/helene-north-carolina-latino-swannanoa.html
12/10/24	'Community helping community': Latino groups in Western NC fill gaps in Helene recovery	The News and Observer	https://www.newsobserver.com/news/state/north-carolina/article296310934.html
3/14/25	"Photos from Helene": the project that seeks to return photos lost in the hurricane to their owners	Enlace Latino	https://enlacelatinonc.org/en/Photos-from-Helene%3A-The-project-that-seeks-to-return-photos-lost-in-the-hurricane-to-their-owners./
12/3/24	Western NC Latino community forms makeshift delivery service after Helene	The Charlotte Observer	https://www.charlotteobserver.com/news/state/north-carolina/article293573319.html
10/11/24	Language can be a barrier in seeking disaster aid. These volunteers are helping Latinos in NC get help	WUNC	https://www.wunc.org/race-class-communities/2024-10-11/fema-federal-aid-language-spanish-immigrant-helene
10/17/24	Latino workers on the front lines of Hurricane Helene cleanup and reconstruction	Enlace Latino	https://enlacelatinonc.org/en/Latino-workers-on-the-front-lines-of-cleanup-and-reconstruction-after-Hurricane-Helene/
11/7/24	Asheville reporter covers Helene's impact in Spanish for Latino communities	NPR	https://www.npr.org/2024/11/07/nx-s1-5171072/asheville-reporter-covers-helenes-impact-in-spanish-for-latino-communities
9/29/24	"We are devastated," Latinos describe the devastation in western North Carolina	Enlace Latino	https://enlacelatinonc.org/en/Latinos-devastation-western-North-Carolina-hurricane-Helene/
11/27/24	Latino businesses struggle to stay afloat after Helene	Enlace Latino	https://enlacelatinonc.org/en/helene-latin-businesses-struggle-to-stay-afloat/
10/4/24	Latino organizations mobilize to bring aid to the affected community in Asheville	Enlace Latino	https://enlacelatinonc.org/en/asheville-hurricane-helene-aid-centers-latino-organizations/
11/7/24	How do migrants who lost everything in the storm rebuild their lives?	Enlace Latino	https://enlacelatinonc.org/en/How-migrants-who-lost-everything-in-the-storm-are-rebuilding-their-lives/
10/31/24	Latino organizations seek solutions at environmental justice symposium	Enlace Latino	https://enlacelatinonc.org/en/Latino-organizations-seek-solutions-at-environmental-justice-symposium/

Appendix G

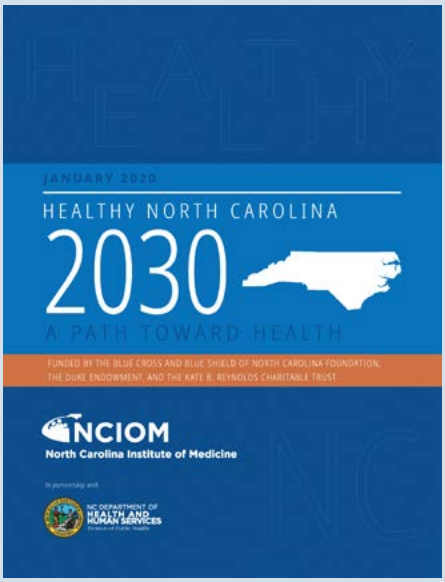
Local Health Department Priorities Community Health Assessments (2021-2024)

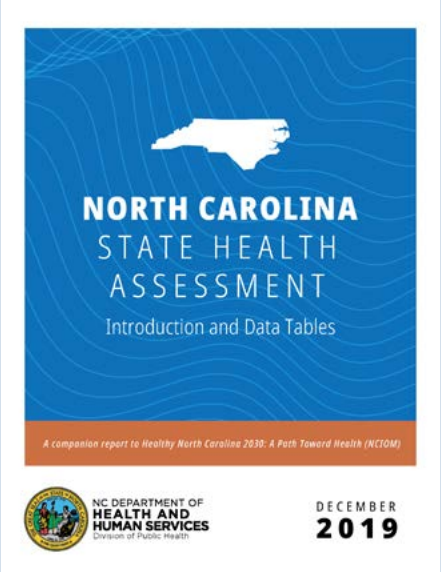


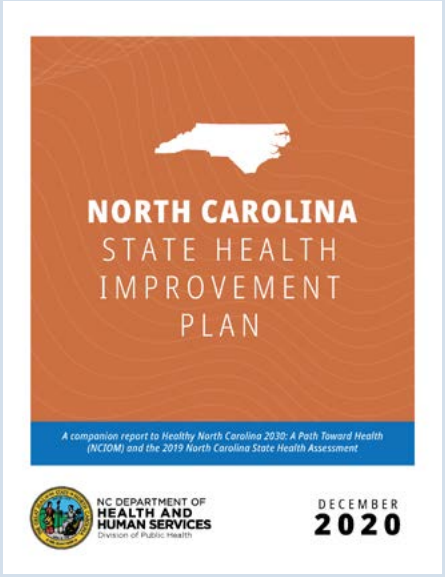
North Carolina local health departments (LHDs) select priorities for community improvement as part of the community health assessment/community health improvement plan (CHA-CHIP) cycle occurring every three to four years. Most LHDs select two to six priorities per cycle.

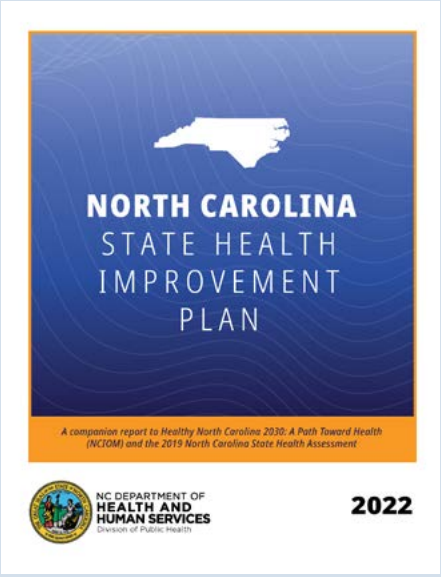
This graph characterizes the 332 priorities identified between 2021-2024 by grouping similar priorities into nine categories (NC DPH, 2025).

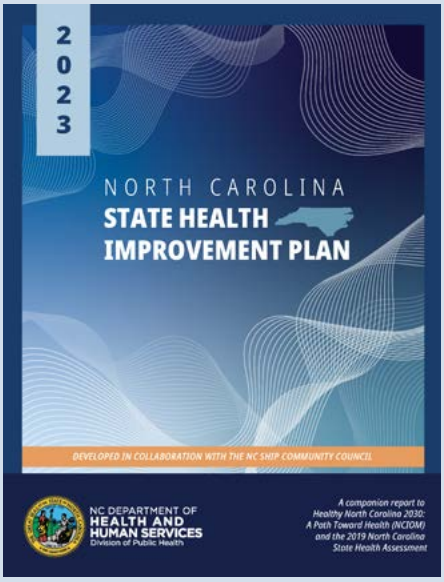
PREVIOUS PUBLICATIONS











NC DEPARTMENT OF
HEALTH AND
HUMAN SERVICES
Division of Public Health

1915 HUMAN SERVICES WAY
BUILDING 3
RALEIGH, NC 27607
NCDHHS.GOV
@NCDHHS