ALAMANCE COUNTY HEALTH DEPARTMENT

2024 COMMUNITY HEALTH ASSESSMENT

ALAMANCE COUNTY
Health Department
319 North Graham-Hopedale Road Suite B
Burlington, NC 27217-2995
www.alamancecountync.gov

Tony Lo Giudice
Health Director

Dear Alamance County Residents:

We are pleased to share the 2024 Alamance County Community Health Assessment with you. Conducted every three years, this assessment helps us understand the strengths and needs of our community.

This report provides valuable insights into the health and well-being of Alamance County. Building on previous assessments, it explores key factors that impact our residents' health, wellness, and stability. It also highlights priority health concerns identified by the community, along with emerging issues that shape our shared future. Most importantly, it reflects the lived experiences of Alamance County residents, serving as a foundation for meaningful action.

Since our last assessment in 2021, our community has navigated significant changes—emerging from the COVID-19 pandemic, adapting to economic shifts, and addressing challenges related to mental health and substance use, to name a few. Through it all, the work of building a healthier, stronger community continues.

Creating a thriving Alamance County requires all of us to work together. Thank you for your dedication and contributions to improving the human condition—we look forward to continuing this journey with you!

Move Often | Eat Clean | Pursue Happiness

Tony Lo Giudice

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Executive Summary

CHA Vision Statement

On May 23, 2024, a community health visioning meeting was held virtually to bring together community stakeholders and the members of the CHA Advisory Group. The visioning session began with a clear objective: to gather actionable insights from the community that would inform a guiding vision statement for a healthier, more vibrant Alamance County by 2030. Pre-registered participants responded to a pre-session questionnaire that asked them to identify the county's top strengths in health and community well-being, articulate their vision for a healthier future in a single sentence, and name groups that might be left behind if they were not prioritized.

In breakout discussions focused on community strengths, participants examined a visual summary of the top assets identified in the pre-session responses, sharing additional examples and discussing how these strengths could be leveraged for future health improvements. The group then transitioned to envisioning a healthier Alamance County, with each breakout room identifying key themes and phrases that captured their collective aspirations. These discussions centered on concrete ideas for a community that supports safe, high-quality health care, mental health services, and comprehensive support, while also addressing existing disparities and ensuring no one is left behind.

The final segment of the session emphasized the synthesis of all gathered ideas into a draft vision statement. Through further breakout sessions and interactive polling, participants refined their keywords and themes, ensuring that the final vision reflected both the county's strengths and the critical need to support every resident. The session concluded with a creation of a finalized CHA vision statement, which states:

Alamance County will be a place where every individual feels welcomed, connected, and supported. We will promote healthy living by providing safe supportive spaces that offer access to high-quality health care, mental health services, and comprehensive support for those experiencing challenges. Our Commitment is to create an environment where all residents thrive and contribute to a vibrant, healthy community.

CHA Leadership

The CHA was conducted using the traditional leadership model, with Alamance County Health Department taking the primary role in convening critical stakeholders and collaborating partners. Designees of the local health director led the process, ensuring that community health assessments were grounded in established public health practices. This approach provided a clear and unified direction for the assessment, leveraging the expertise and experience of public health staff while engaging key partners across the community.

Key Leaders for the CHA Advisory Group:

- Tony Lo Giudice, Public Health Director, ACHD
- Arlinda Ellison, Public Health Education Supervisor, ACHD
- Ariana Lawrence, Human Services Planner/Evaluator, ACHD
- Jewel Tillman, Community Engagement Manager, Impact Alamance
- Marcy Green, Vice President of Programs, Impact Alamance
- Rose Watlington, Women, Infant & Children, ACHD
- Brandon Enoch, Parks and Recreation Director, Town of Green Level
- Olivia Harper, Health Educator, ACHD
- Tara France, Health Educator, ACHD
- Emanuel Barrera, Regional Coordinator, Minority Diabetes Prevention, ACHD
- Kelly Mendenhall, Public Health Nursing Supervisor, ACHD
- Michelle Dorminy, Public Health Nurse, ACHD
- Cindy Brady, Cone Health
- Janetta Matthews, Cone Health
- Omega Wilson, Co-Founder, West End Revitalization Association (WERA)
- Brenda Wilson, Co-Founder, West End Revitalization Association (WERA)

Partnerships/Collaborations

TYPES OF PARTNERSHIP REPRESENTED ON THE ADVISORY COMMITTEE	NUMBER OF PARTNERS
Public Health Agency	1
Hospital/Health Care System	2
Healthcare Providers (Not BH)	1
Behavioral Healthcare Providers	1
Community Orgs	10
Businesses	2
Educational Institutions – colleges/universities	1
Public/Private/Charter School Systems	1
Media/Communication	1
Public Members	13

Regional/Contracted Services

Alamance County Health Department contracted with Evident Analytics to facilitate the Community Health Assessment process—including leading advisory group meetings, providing data summaries to stakeholders, and drafting sections of the final document.

Theoretical Framework/Model

The theoretical framework for the Alamance County Community Health Assessment (CHA) was based on an adapted version of the MAPP 2.0 process, a model developed by NACCHO to guide community health improvement. This framework was chosen for its emphasis on community engagement and data-driven assessments, and it was carefully tailored to reflect the unique needs and context of our county while preserving its core components.

In our adaptation, Phase 1 was centered on a visioning meeting that set the stage for our entire assessment process. During this phase, we gathered local stakeholders and partners to build a shared vision for a healthier Alamance County. Participants engaged in an interactive process that included guided discussions, enabling participants to articulate a collective vision and identify the county's most significant strengths and assets. This visioning meeting served as a foundational element, aligning our efforts with the principles of MAPP 2.0 while ensuring that the process was deeply rooted in our community's values and aspirations.

Phase 2, "Tell the Community Story," involved implementing adapted versions of three key assessments: the community partners assessment, the community status assessment, and the community context assessment. These tools provided a comprehensive picture of our community’s resources, health issues, and the lived experiences of residents. In the

final phase, we synthesized these insights and conducted a participatory prioritization process. This systematic approach, from visioning to prioritization, adapted the core components of MAPP 2.0 to identify community health priorities that were data-based and community-validated.

Collaborative Processes

The collaborative process for the Alamance County Health Department's Community Health Assessment was structured to ensure broad stakeholder engagement and data-driven decision-making. Beginning in April 2024, the advisory group convened monthly, laying the groundwork for shared vision and strategic planning. In May 2024, a visioning meeting was held to align community values and priorities, setting the stage for the subsequent data reviews. A comprehensive primary data review took place in October 2024, followed by a secondary data review in November 2024, both critical for informing the assessment. Participatory Prioritization occurred in December 2024, actively engaging community members in identifying key health issues. Finally, in January 2025, additional meetings with the board of health and a community partner provided final insights, culminating in the completion of the assessment.

Key Findings

The data review identified six central health priorities for Alamance County—housing affordability, food access, access to primary care, mental health, substance use and overdose prevention, and sexual health—each representing critical points of intervention for improving overall community well-being. These concerns are rooted in both economic and social challenges; for instance, high housing costs exacerbate stress and impede stability, while limited healthy food access correlates with rising rates of diet-related diseases. Access to primary care remains insufficient, constraining preventive services and early intervention for chronic conditions, and mental health challenges—especially among youth—reflect a pervasive unmet need for support and treatment. The prevalence of fentanyl-driven overdoses has rapidly heightened the priority of substance use prevention, underscoring gaps in treatment and harm reduction resources. Finally, persistently high rates of sexually transmitted infections point to unaddressed barriers in testing, stigma, and public education. The CHA advisory group considered each of these areas carefully before the prioritization process. The following sections describe the related findings in primary and secondary data analysis and corresponding data charts and tables can be found in the Appendices.

Housing Affordability

Housing affordability has emerged as a critical public health concern in Alamance County, with survey respondents identifying it as one of the top three barriers to quality of life alongside economic conditions and substance use. Data show that the county's median gross rent is tied for the highest among four comparison counties, which may place a significant financial burden on residents. While rent as a percentage of income has slightly decreased, many households still report struggling to cover housing costs, which are linked to overall health and stability.

Owner-occupied home values in Alamance County are relatively high compared to peer counties, further complicating affordability for families seeking long-term stability. Survey data connect the lack of affordable housing with heightened stress levels, reduced access to healthy food, and barriers to preventive healthcare. These challenges disproportionately affect low-income and underserved communities.

Improvement in housing affordability could include efforts to stabilize housing costs and expand access to affordable options. These changes, supported by community partnerships, could alleviate financial stress, enhance access to essential services, and ultimately improve health outcomes across the county.

Food Access and Food Security

Food insecurity remains a pressing issue in Alamance County, where many residents face challenges obtaining nutritious meals due to cost, limited availability, or convenience barriers. Survey responses consistently highlight food insecurity as a primary obstacle to healthy living, with low ratings for the ability to purchase healthy foods locally. Data show that food insecurity in the county slightly exceeds the state average, and child food insecurity rates are higher than those of neighboring counties.

The rising cost of meals has further strained household budgets, with local food pantries reporting a surge in demand of 25% over the past year. This trend is particularly concerning for children, who require proper nutrition for healthy development. Without adequate access to nutritious food, residents are at greater risk of chronic diseases such as diabetes and hypertension, as well as reduced overall well-being.

Expanding food assistance programs, increasing the availability of healthy food outlets, and fostering community-driven solutions could help reduce hunger and improve nutrition. Collaboration with local agricultural organizations and schools could ensure that all residents have access to affordable, fresh, and nutritious food options.

Access to Primary Care

Access to primary care is a growing concern in Alamance County, where the provider-to-population ratio falls below state and national benchmarks. The gap has widened significantly over the last decade, with a 46.9% increase in unmet need since 2012, despite only a 13.4% population increase in the county over that same period. Longer wait times and limited appointment availability hinder residents' ability to receive preventive and routine healthcare, exacerbating chronic disease management challenges and increasing emergency department usage. The adjacency of the county to larger metropolitan counties with more robust provider networks depresses local demand structures for health care providers, resulting in increased vulnerability for residents who cannot access the availability of providers in surrounding counties (due to issues like limited personal transportation).

Survey data emphasizes the critical role of primary care in improving health outcomes, yet many residents report difficulties accessing these services. This shortage not only impacts individual health but also places additional strain on the broader healthcare system. The limited availability of primary care providers disproportionately affects the more rural areas of the county, where geographic barriers further restrict access.

Recruiting and retaining healthcare professionals, implementing telehealth services, and exploring innovative care delivery models are potential strategies to close the gap in access. Strengthening the primary care infrastructure would enhance preventive care, early intervention, and chronic disease management, leading to better health outcomes across the county.

Mental Health

Mental health consistently ranks as the top health concern among Alamance County residents. Survey results indicate a persistent mismatch between the demand for mental health resources and their availability, with gaps in coverage and access reported by multiple subgroups across the county.

Stress and mental health conditions contribute to hospital admissions, workforce challenges, and diminished daily functioning for many residents. Youth are particularly vulnerable, with rising rates of hopelessness reported among high school students in national surveillance systems. (Local data for this is unavailable, but the latest data from the Youth Risk Behavioral Surveillance Survey indicates that 46% of female high school students in NC report that their mental health is “most of the time or always not good.”) These findings highlight the urgent need for early intervention and accessible support systems in both community and school settings.

Increasing service capacity, enhancing provider networks, and addressing stigma are critical steps toward improving mental health outcomes. Expanding mental health resources and fostering community awareness could ensure that individuals and families receive the care they need to thrive.

Substance Use/Overdose Prevention

Substance use and overdose prevention are urgent priorities for Alamance County, where overdose deaths have become the third leading cause of death, up from sixth, largely due to fentanyl and other synthetic opioids.

Data also reveal significant gaps in treatment and recovery resources, with shortages of treatment providers, long waitlists, and limited access to harm reduction services. These barriers leave many residents unable to receive timely care, increasing the likelihood of repeated overdoses. Furthermore, stigma around substance use continues to hinder public health efforts, complicating outreach and naloxone distribution.

Addressing this crisis requires a multi-faceted approach, including expanded treatment options, strengthened harm reduction initiatives, and targeted education campaigns. These efforts could help reduce overdose deaths and support recovery, fostering healthier and more resilient communities.

Sexual Health

Alamance County faces persistently high rates of sexually transmitted infections (STIs), including chlamydia, gonorrhea, and HIV. Recent data show that local chlamydia rates surpass those in Davidson, Johnston, and Randolph Counties, with historic trends revealing consistently elevated rates over more than a decade. North Carolina's ranking as seventh nationally for STIs underscores the broader context of this public health challenge.

Limited access to testing, awareness, and prevention services contributes to the spread of STIs and delayed diagnoses. Many residents remain unaware of available resources, such as free or low-cost testing, while stigma around sexual health prevents individuals from seeking care. These barriers exacerbate the public health burden and increase the risk of complications associated with untreated infections.

Enhanced public education campaigns, increased access to screening and prevention services, and the promotion of safer sexual practices are critical strategies to address this issue. Strengthening community-based initiatives could reduce STI transmission rates and improve sexual health outcomes countywide.

CHA Health Priorities

The Community Health Assessment (CHA) process identified three key priorities—Access to Healthy Foods, Mental and Behavioral Health, and Substance Use and Overdose Prevention—that will guide Alamance County's Community Health Improvement Plan (CHIP). Collectively, these issues shape the county's health landscape, contributing to disparities in chronic disease, emotional well-being, and the ability to thrive in daily life. By focusing on these three priority areas, the county aims to reduce the burden of preventable illnesses, and enhance access to essential services.

These priority areas also fit well within the Healthy NC 2030 priorities. Spearheaded by the NC Institute of Medicine, Healthy NC 2030 identifies 21 key health indicators for the state. These key health indicators reflect strategic priorities for population health. Our CHA focus on access to healthy foods corresponds to key health indicator #8 limited access to healthy food. Similarly, the CHA priority of mental health corresponds to key health indicator #19 suicide rate. Finally, the CHA Priority of substance use and overdose prevention corresponds to the key health indicator #10 drug overdose deaths. The full report of the NCIOM Healthy NC 2030—including sections on these correlated health priorities and the statewide strategies can be found at https://nciom.org/wp-content/uploads/2020/01/HNC-REPORT-FINAL-Spread2.pdf. In the community health improvement planning process for Alamance County, strategies should be designed to leverage synergy with statewide strategies.

The following sections examine each priority in detail, outlining the scope of the challenges and proposing actionable strategies for improvement.

Access to Healthy Foods

Food insecurity significantly impacts the health and quality of life in Alamance County. Social determinants such as income disparities, geographic location, transportation barriers, and the availability of grocery stores shape residents' access to healthy food. Many areas within the county qualify as "food deserts," where limited access to fresh produce and nutritious options exacerbates health disparities. Low-income families, rural residents, and those without reliable transportation often depend on convenience stores and fast food, resulting in diets high in processed and calorie-dense foods. Such diets contribute to higher rates of chronic diseases, including obesity, diabetes, and cardiovascular conditions.

A systems-thinking approach highlights how food insecurity is interconnected with broader challenges, including economic stability, education, and transportation. For example, families facing housing instability often prioritize rent over groceries, and low wages limit access to fresh food. Education levels also play a role, as families with less health literacy may lack awareness of nutritious food options or resources available to address food insecurity. The cycle of food insecurity and poor health can further strain healthcare systems, increase absenteeism in schools and workplaces, and reduce overall community productivity.

Improving food access and security in Alamance County would result in transformative health and quality-of-life improvements. Addressing food insecurity can reduce the prevalence of diet-related chronic diseases and associated healthcare costs, while also enhancing children's educational outcomes by ensuring they have the nutrition needed for learning and growth. Reducing food insecurity also enhances mental health, as families no longer have to face the stress and stigma of not having enough to eat.

To make impactful changes, the smallest but most effective interventions should focus on leveraging existing resources and expanding access to healthy food. The community could prioritize expanding healthy corner store initiatives, where small local retailers are incentivized to stock fresh produce and staple items. This intervention is cost-effective, scalable, and directly benefits neighborhoods lacking grocery stores. Another critical strategy is expanding participation in programs like the Women, Infants, and Children (WIC) program and Supplemental Nutrition Assistance Program (SNAP) through targeted outreach and education campaigns. By reducing stigma and facilitating enrollment processes, more families could access these essential supports.

Collaborative efforts with community partners, such as schools and local farmers, can amplify the impact of health department interventions. For example, supporting farm-to-school programs can provide students with healthy meals while educating them about nutrition and local agriculture. Additionally, the health department and community partners could explore innovations such as mobile food markets to serve rural and underserved communities, improving equitable access to fresh, nutritious food.

Mental and Behavioral Health

Mental and behavioral health consistently emerge as top public health concerns in Alamance County. Social determinants such as poverty, unemployment, housing instability, and healthcare access significantly contribute to the high prevalence of anxiety,

depression, and other mental health conditions. Data show that nearly one-third of residents experience frequent mental distress, with youth and marginalized populations disproportionately affected.

From a systems perspective, mental health is deeply interconnected with other health and social outcomes. Poor mental health can exacerbate chronic conditions, reduce workplace productivity, and strain emergency and acute care services. It also intersects with substance use, housing insecurity, and food insecurity, creating complex challenges that require coordinated solutions. Addressing mental health involves not just improving access to care but also fostering resilience and supportive environments across schools, workplaces, and communities.

Improving mental health in Alamance County would lead to wide-ranging benefits, from reducing suicide rates and hospital admissions to enhancing economic productivity and community cohesion. Ensuring that residents have access to timely and affordable mental health services can alleviate the burden on emergency departments while improving individual and family well-being. Schools with robust mental health programs can enhance academic performance and reduce behavioral issues, setting students on a path to healthier, more successful lives.

The health department can drive change by focusing on interventions that address both access and stigma. Expanding telehealth services may be an impactful and feasible step, as it addresses barriers related to transportation and provider shortages. The community could also work to better leverage primary care providers to screen for mental health conditions and offer brief interventions, ensuring early detection and treatment. Community-based initiatives, such as peer support networks and crisis hotlines, can provide immediate, low-cost resources for residents in distress.

Reducing stigma around mental health is another critical area of focus. Public education campaigns that normalize seeking help and highlight available resources can encourage residents to prioritize their mental well-being. Additionally, the health department and community partners can collaborate with schools to implement evidence-based mental health programs, such as youth resilience workshops and teacher training on trauma-informed practices. These targeted interventions, when coordinated effectively, can significantly improve mental health outcomes for the county.

Substance Use and Overdose Prevention

Substance use and overdose prevention are urgent priorities in Alamance County, where overdose deaths have risen sharply due to the proliferation of synthetic opioids such as fentanyl. Social determinants including poverty, unemployment, and limited access to treatment services create an environment where substance use disorders (SUDs) flourish. Compounding these issues are stigma and systemic barriers that prevent individuals from seeking help, such as a lack of transportation to treatment centers or limited insurance coverage for recovery services.

A systems-thinking approach reveals the multifaceted nature of the substance use crisis. Substance misuse is often linked to untreated mental health conditions, housing instability, and adverse childhood experiences. For example, individuals who experience trauma or grow up in unstable environments are at higher risk of developing SUDs. The ripple effects extend beyond individuals, impacting families, law enforcement, healthcare systems, and local economies.

Improvement in this area would transform not only individual lives but also community well-being. Effective overdose prevention measures can save lives, reduce hospitalizations, and alleviate the strain on first responders and emergency departments. Expanding access to treatment and harm reduction services would support individuals in recovery while fostering safer, healthier neighborhoods. Addressing substance use also improves workforce readiness, as individuals regain stability and reintegrate into society.

The health department and community partners can lead impactful interventions by focusing on harm reduction and expanding access to care. Increasing the availability of naloxone and ensuring it is distributed widely among first responders, community organizations, and families affected by substance use can save lives immediately. Expanding syringe service programs would reduce the spread of infectious diseases such as HIV and hepatitis C while creating a critical point of contact for individuals to access treatment and counseling.

Expanding medically assisted treatment medication assisted treatment / medication for opioid use disorder (MAT/MOUD) programs in the community can provide evidence-based care to individuals struggling with opioid addiction. Additionally, the health department and community partners can offer training for primary care providers to prescribe MAT/MOUD and recognize signs of substance use disorders early. Recent changes to the policies limiting primary care providers in this area (lifting “X Waiver” requirements) could

significantly increase access to care, if providers are supported in enhancing their care provision in this area.

Public education campaigns focusing on the dangers of fentanyl and the importance of safe storage and disposal of medications can further reduce the prevalence of substance misuse and the incidence of fatal overdoses. Due to the high percentage of illicit drugs that have been adulterated with fentanyl and other drugs, many people who overdose on opioids would not fit the diagnostic criteria for opioid use disorder. Public health interventions that focus on naloxone distribution and education regarding responding to an overdose should become a vital part of public safety efforts for our communities.

Collaboration with community partners is also essential. The health department could coordinate with law enforcement to implement diversion programs that connect individuals with treatment rather than incarceration. Partnering with schools to provide early prevention education and with employers to support workplace recovery programs can amplify the impact of health department efforts. By prioritizing these strategic, targeted interventions, Alamance County can make significant strides in addressing substance use and overdose prevention.

The Importance of Social Determinants of Health for Selected CHA Priorities

The following section describes how the three selected priorities—food access, mental health, and substance use/overdose prevention—are shaped by underlying social determinants of health in Alamance County. It highlights the ways in which socioeconomic disadvantage, housing instability, food insecurity, and limited healthcare access intersect to exacerbate chronic stress and reduce opportunities for prevention and treatment. By examining these contributing factors, this section provides a foundation for more integrated strategies to address the root causes of poor health outcomes.

- Limited access to healthy, affordable food in Alamance County—whether due to low income, unstable housing, or gaps in healthcare access—exacerbates a range of health disparities. Families facing unemployment or high debt levels must frequently choose between buying groceries and covering rent or medical bills, which can result in poor-quality diets and chronic stress. Various housing practices and socio-demographic tendencies, in turn, can confine underserved communities to "food deserts," compounding the mental and physical burdens of poverty. Housing instability itself limits the ability to store and prepare nutritious meals, while also increasing reliance on convenience stores and fast-food outlets. Added to these challenges, inadequate healthcare access hinders nutrition education and early intervention for diet-related conditions, contributing to higher rates of obesity, diabetes, and depression. Tackling these root causes in tandem—by improving wage opportunities, dismantling systemic biases, expanding stable housing

options, and bolstering healthcare resources—can therefore create a more resilient and equitable landscape for food access in Alamance County.

- Mental and behavioral health are profoundly intertwined with economic and social conditions, making it clear that improving the social determinants of health could alleviate many underlying causes of distress. Socioeconomic disadvantage—marked by low incomes, unemployment, and debt—fuels chronic stress and can force people to choose between managing daily costs or seeking mental health care. This problem gets even worse because of social biases, which can raise stress levels and makes depression and anxiety more likely. Housing instability, evidenced by the county's comparatively high rental costs, undermines residents' sense of security and adds yet another layer of hardship. Food insecurity remains a pressing local concern, with insufficient access to affordable, nutritious food exacerbating stress and diminishing emotional resilience. Finally, limited access to healthcare—reflected in provider shortages and long wait times—often prevents early intervention for mental health disorders, leading to more severe and prolonged conditions.

- Substance use and overdose rates in Alamance County reflect how socioeconomic disadvantage, discrimination, housing instability, food insecurity, and limited healthcare access combine to amplify vulnerabilities and undercut prevention efforts. Individuals grappling with low incomes, high debt, or unemployment often experience chronic stress and fewer options for healthy coping, which can increase the appeal of illicit substances. At the same time, discriminatory practices—from stigma or mistrust of clinical settings and law enforcement—discourage many from seeking early help, undermining harm reduction and overdose prevention measures. Housing instability not only disrupts supportive social networks but can also inhibit sustained treatment engagement, while the daily anxiety over finding enough food is yet another stressor that pushes some into self-medication. Compounding these risks is the ongoing shortage of healthcare resources—particularly for mental and behavioral health—leaving many residents without timely intervention or reliable access to life-saving tools like naloxone. In this way, efforts to address substance use and prevent overdoses must go beyond clinical interventions, prioritizing the broader social factors that shape an individual's propensity for and response to substance misuse.

Next Steps

Completion of the community health assessment (CHA) and the selection of three priority areas—Food Access and Food Security, Mental and Behavioral Health, and Substance Use and Overdose Prevention—mark the transition into the community health improvement plan (CHIP) phase. In this next stage, local stakeholders, community members, and organizational partners will collaborate to design and implement strategies that address prevention at every level. This includes primary prevention, such as public education and policy initiatives; secondary prevention, such as screening and early intervention; and tertiary prevention, such as treatment and long-term support services. Building on the findings of the CHA, the CHIP will also focus on social determinants of health that contribute to these challenges, recognizing that economic stability, housing security, and access to healthcare play critical roles in achieving sustainable progress. Through planning and shared decision-making, Alamance County will work to ensure that interventions not only mitigate immediate health risks, but also strengthen long-term community resilience.

Dissemination Plan

The community health assessment (CHA) findings for Alamance County will be shared through targeted distribution efforts with key community partners. The goal is to ensure that relevant stakeholders, service providers, and residents have access to important health data and community resources.

Distribution Channels

- Online Access: The CHA report will be available on the Alamance County Health Department's website, the Division of Public Health website with NCDHHS and promoted through partner organizations such as Cone Health, Impact Alamance, and United Way of Alamance County.
- Community Partners: Organizations such as Cone Health, Impact Alamance, Alamance Regional Medical Center, and the Alamance-Burlington School System will assist in distributing the CHA to key audiences.
- Targeted Outreach: The CHA will be shared with local healthcare providers, non-profits, social service agencies and in meetings throughout the county to support program development and policy initiatives.
- Annual Updates: Updates on the CHA's alignment with the Community Health Improvement Plan (CHIP) will be provided annually on the Alamance County Health Department's website.

County Overview

Alamance County is located in central North Carolina, bordered by Guilford County to the northwest, Orange County to the northeast, Chatham County to the southeast, Randolph County to the southwest, and Caswell County to the north. The county encompasses a land area of approximately 435 square miles and a water area of about 10 square miles. Alamance County is divided geopolitically into 12 townships: Albright, Altamahaw, Boone, Burlington, Coble, Faucette, Graham, Haw River, Melville, Morton, Pleasant Grove, and Thompsonville.

The City of Graham (located in Graham Township) serves as the county seat. Other municipalities recognized as "cities" or "towns" by the US Census Bureau include Burlington (Burlington Township), Elon (Boone Township), Gibsonville (partially in Guilford County), Green Level (Boone Township), Haw River (Haw River Township), and Mebane (partially in Orange County). The county also includes several unincorporated communities, such as Alamance, Ossipee, and Saxapahaw.

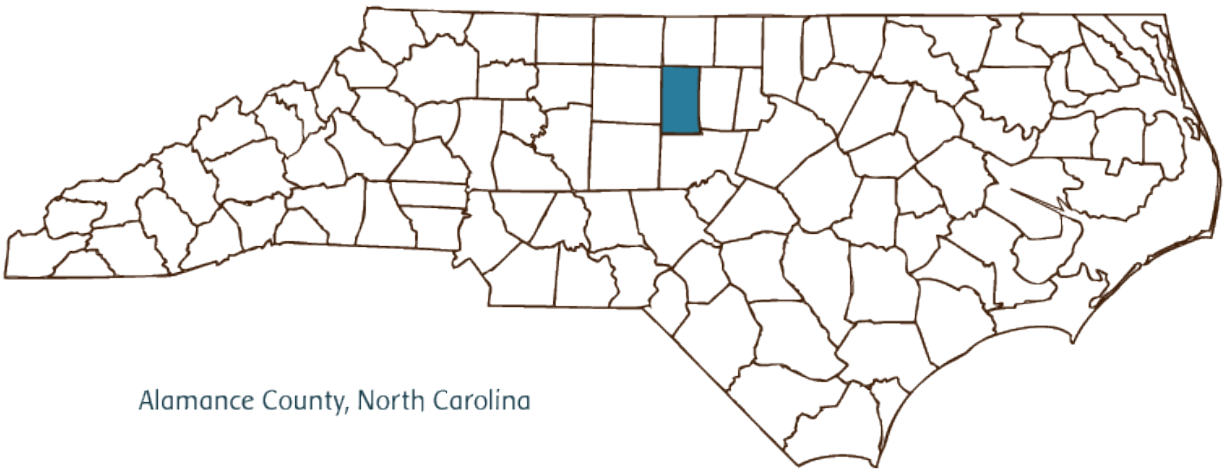
Alamance County is a blend of suburban and rural areas, offering residents a balance of accessibility to urban amenities and a quieter, small-town lifestyle. The county is located between the major metropolitan areas of the Piedmont Triad (Greensboro, Winston-Salem, and High Point) to the west and the Research Triangle (Raleigh, Durham, and Chapel Hill) to the east. This proximity provides residents with access to employment opportunities, healthcare, education, and cultural activities while maintaining a lower cost of living compared to its larger neighbors.

Home to a mix of industries, Alamance County, includes manufacturing, healthcare, and education, with institutions like Elon University contributing to the local economy and culture.

Alamance County is served by several major transportation routes. Interstate 85/40 runs east-west through the county, connecting it to Greensboro and Durham. US Route 70 also traverses the county, providing additional east-west connectivity. North Carolina Highway 49 runs north-south, linking the county to Burlington and Chapel Hill. Other significant state routes include NC 62, NC 87, and NC 100, which serve various parts of the county.

To provide meaningful context and actionable insights in this community health assessment (CHA), Johnston, Davidson, and Randolph counties were selected as peer counties for Alamance County. These counties were chosen due to their demographic, socioeconomic, geographic, and health-related similarities, allowing for relevant comparisons and the identification of shared challenges and opportunities for

improvement. A more detailed justification for these selected peer counties is covered in the section on secondary analysis.



Population Growth and Age Distribution

In 2013, Alamance County had an approximate population of 154,378 persons. In 2023, Alamance County was estimated to have a population of 179,165 persons, according to the U.S. Census Bureau. The population of Alamance County increased by roughly 16% between 2013 and 2023, with 25.2% of individuals under the age of 19 and 17.3% of persons aged 65 and over.

Age Distribution, Alamance County (2013 & 2023)

Age Range	2013		2023	
	Number	Percent	Number	Percent
0-19 years	41,065	26.6	45122	25.2
20-24 years	9,880	6.4	13411	7.5
25-34 years	17,599	11.4	21075	11.8
35-44 years	19,915	12.9	22554	12.6
45-54 years	22,230	14.4	22536	12.6
55-64 years	19,143	12.4	23448	13.1
65 years and over	24,546	15.9	31019	17.3

***Source**: U.S. Census Bureau, U.S. Department of Commerce. (2023). Age and Sex. American Community Survey, ACS 1-Year Estimates Subject Tables, Table S0101. Retrieved December 3, 2024, from https://data.census.gov/table/ACSST1Y2023.S0101?q=050XX00US37001,37057,37101,37151&moe=false.*

As indicated by these data, population growth in Alamance County increased at an annual rate of about 1.6% from 2013 to 2023.

Race and Ethnicity

According to the U.S. Census Bureau, the racial composition of Alamance County residents is primarily White (59.8%) and Black or African American (19.6%), with 40.2% representing racial or ethnic minority groups. As shown in the table below, the overall racial/ethnic distribution in Alamance County closely resembles that of North Carolina.

Race and Ethnicity, Alamance County and North Carolina (2020)

Race	Alamance County		North Carolina	
	Number	Percent	Number	Percent
White alone	102,487	59.8	6,312,148	60.5
Black or African American alone	33,555	19.6	2,107,526	20.2
American Indian and Alaska Native alone	584	0.3	100,886	1.0
Asian alone	2,811	1.6	340,059	3.3
Native Hawaiian and Other Pacific Islander alone	86	0.1	6,980	0.1
Some Other Race alone	762	0.4	46,340	0.4
Population of two or more races:	6,427	3.7	406,853	3.9
Hispanic or Latino	24,703	14.4	1,118,596	10.7
Total:	171,415	100.0	10,439,388	100.0

***Source**: U.S. Census Bureau. (2020). Hispanic or Latino, and Not Hispanic or Latino by Race. Decennial Census, DEC Demographic and Housing Characteristics, Table P9. Retrieved December 3, 2024, from https://data.census.gov/table/DECENNIALDHC2020.P9?q=Race%20and%20Ethnicity&g=040XX00US37_050XX00US37001,37057,37101,37151.*

Education

According to the Alamance-Burlington School System (ABSS) Strategic Plan (2023–2029), the district's mission is to "engage and empower every student to learn and become knowledgeable, responsible community members." In line with this vision, Alamance County shows both areas of strength and opportunities for growth when compared to its peer counties and the state as a whole.

As shown in the table below, 90.2% of Alamance County residents age 25 and older have earned a high school diploma or higher, outperforming the state average of 86.7% and surpassing Davidson (89.0%), Johnston (89.1%), and Randolph (82.9%) counties. Alamance County also has a smaller share of adults who have not completed high school (less than 9th grade plus those with some high school but no diploma) than the state average, suggesting relatively strong performance in basic educational attainment.

Alamance County likewise compares favorably in the share of adults holding an associate's degree (12.7%), which is higher than the state level (10.1%) and peer counties such as Davidson (10.3%) and Randolph (10.9%). Of note, 19.6% of adults hold a bachelor's degree, which is slightly lower than North Carolina's average of 21.7%, and 9.7% have a graduate or professional degree, below the statewide rate of 13.2%.

Education Breakdown for ages 25 and over for Alamance County, Peer Counties, & North Carolina (2023 1-Year Estimate)

Education Level	Alamance County	Davidson County	Johnston County	Randolph County	North Carolina
High school graduate or higher	90.2%	89.0%	89.1%	82.9%	86.7%
Less than 9th grade	3.8%	4.7%	4.9%	6.8%	4.0%
9th to 12th grade, no diploma	5.9%	6.3%	5.9%	10.3%	6.3%
High school graduate (includes equivalency)	29.9%	31.2%	26.6%	34.4%	24.9%
Some college, no degree	18.3%	24.6%	19.8%	17.3%	19.8%
Associate's degree	12.7%	10.3%	11.4%	10.9%	10.1%
Bachelor's degree	19.6%	16.3%	22.3%	14.3%	21.7%
Graduate or professional degree	9.7%	6.6%	9.1%	6.0%	13.2%

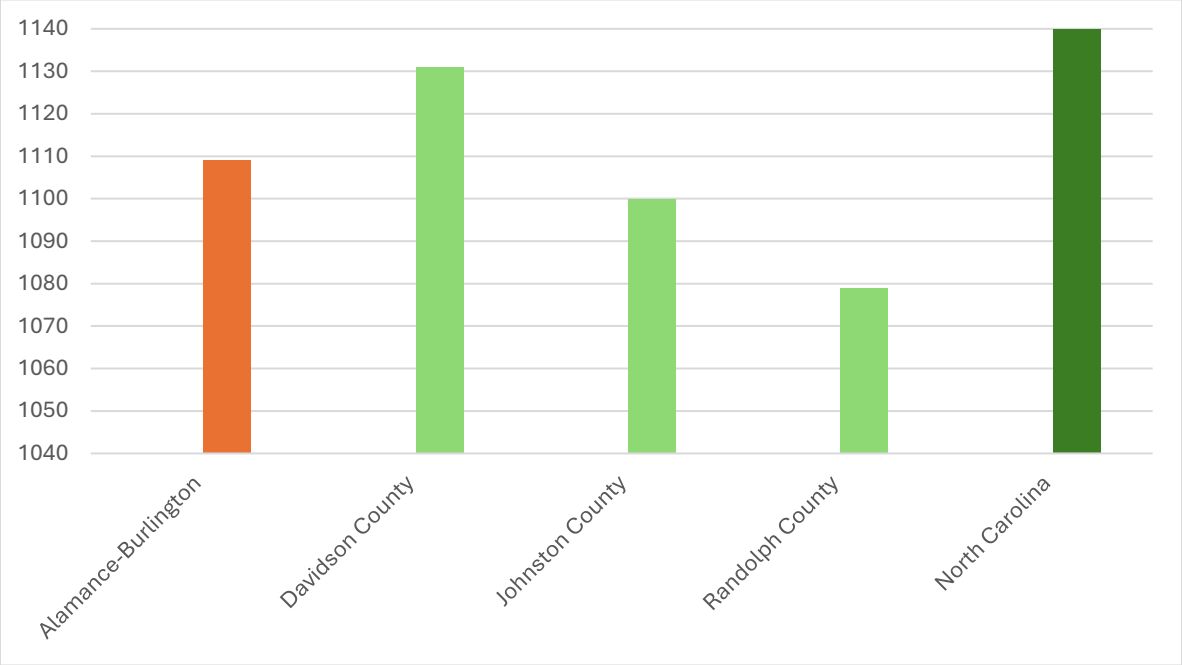
Source: *U.S. Census Bureau, U.S. Department of Commerce. (2023). Educational Attainment. American Community Survey, ACS 1-Year Estimates Subject Tables, Table S1501. Retrieved December 3, 2024, from https://data.census.gov/table/ACSST1Y2023.S1501?q=050XX00US37001,37057,37101,37151&moe=false.*

2024 SAT Scores for Alamance-Burlington Schools and Peer Counties

School System	SAT Scores				
	# Tested	% Tested	Average Total Score	Average ERW Subtest Score	Average Math Subtest Score
Alamance-Burlington	180	12.8	1109	568	541
Davidson County	130	11.2	1131	574	557
Johnston County	224	8.1	1100	562	538
Randolph County	55	5.4	1079	558	521
North Carolina	18,269	18.1	1166	591	576

Source: *North Carolina Department of Public Instruction. https://www.dpi.nc.gov/2024-sat-performance-district-and-school-0/open*

2024 SAT Scores for Alamance-Burlington Schools and Peer Counties (Average Total Score)



Source: *North Carolina Department of Public Instruction.* *https://www.dpi.nc.gov/2024-sat-performance-district-and-school-0/open*

Employment, Household Income, and Poverty

Alamance County, historically known for agriculture and textile production, shifted toward manufacturing and diversified industries in the mid-20th century. Today, major private employers include LabCorp, Glen Raven, Inc., and Cone Health, while the Alamance-Burlington School System and Alamance County Government are leading public employers.

According to the U.S. Census Bureau, Alamance County's median household income is $65,633 (in 2023 inflation-adjusted dollars), which is somewhat lower than North Carolina's median ($70,804). The county's mean household income ($82,394) is also below the statewide mean ($98,139), suggesting incomes in Alamance are less skewed toward higher earnings than in North Carolina overall. However, 13.8% of Alamance County children live below the poverty level—significantly lower than the state's 17.6%—as well as peer counties.

Household Income and Benefits, Alamance County and North Carolina (2023)

Income Level	Alamance County	North Carolina
Less than $10,000	5.4%	5.2%
$10,000 to $14,999	4.2%	3.6%
$15,000 to $24,999	7.7%	7.0%
$25,000 to $34,999	6.9%	7.5%
$35,000 to $49,999	12.1%	11.9%
$50,000 to $74,999	21.1%	17.5%
$75,000 to $99,999	14.5%	13.0%
$100,000 to $149,999	17.6%	16.5%
$150,000 to $199,999	5.8%	7.9%
$200,000 or more	4.7%	9.7%
Median income (dollars)	65,633	70,804
Mean income (dollars)	82,394	98,139

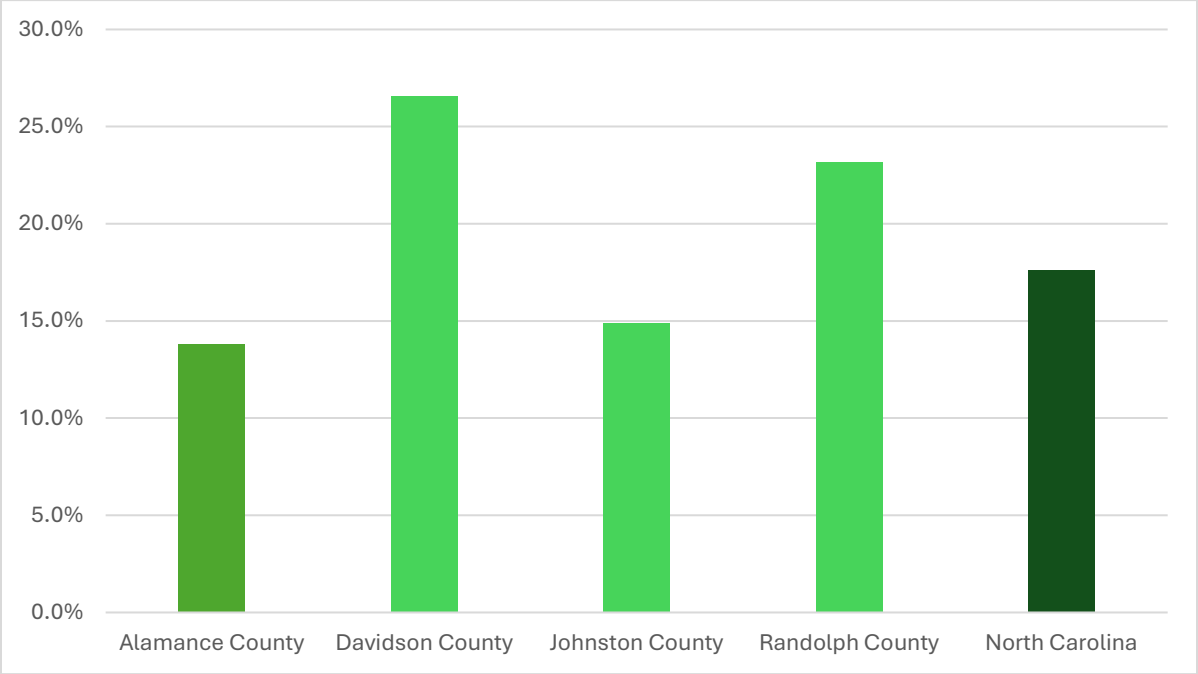
Source: *U.S. Census Bureau, U.S. Department of Commerce. (2023). Income in the Past 12 Months (in 2023 Inflation-Adjusted Dollars). American Community Survey, ACS 1-Year Estimates Subject Tables, Table S1901. Retrieved December 3, 2024, from https://data.census.gov/table/ACSST1Y2023.S1901?q=Household%20Income%20and%20Benefits&g=040XX00US37_050XX00US37001,37057,37101,37151&moe=false.*

Language Spoken at Home, Alamance County (2023)

	Alamance County	
Language Spoken at Home	**Estimate**	**Percent**
Population 5 years and over	169,261.00	
English only	140,162.00	82.8%
Language other than English	29,099.00	17.2%
Speak English less than "very well"	9,752.00	5.8%

Source: *U.S. Census Bureau, U.S. Department of Commerce. (2023). Nativity by Language Spoken at Home by Ability to Speak English for the Population 5 Years and Over. American Community Survey, ACS 5-Year Estimates Detailed Tables, Table B16005. Retrieved February 23, 2025, from https://data.census.gov/table/ACSDT5Y2023.B16005?q=language+spoke+at+home&g=050XX00US37001.*

Percentage of Children Living in Poverty
(Alamance, Peer Counties, and North Carolina)



***Source**: U.S. Census Bureau, U.S. Department of Commerce. (2023). Poverty Status in the Past 12 Months. American Community Survey, ACS 1-Year Estimates Subject Tables, Table S1701. Retrieved December 3, 2024, from https://data.census.gov/table/ACSST1Y2023.S1701?q=Percent%20of%20Children%20Living%20in%20Poverty&g=040XX00US37_050XX00US37001,37057,37101,37151&moe=false.*

Housing and Cost of Living

Housing plays a central role in the overall health and well-being of Alamance County residents by influencing access to jobs, schools, healthy foods, and healthcare services. Safe, stable, and affordable housing helps reduce stress levels, lowers the risk of chronic illness, and supports better educational outcomes.

While Alamance County's median home value ($299,400) is lower than the state median ($343,400), it is still significantly higher than in counties like Davidson ($266,700) and Randolph ($230,400), making homeownership more difficult for lower-income residents.

Additionally, only 7.6% of homes in Alamance County are valued below $100,000, suggesting a scarcity of affordable housing options for lower-income households. At the same time, nearly 50% of homes in Alamance are priced at $300,000 or more, making it harder for first-time buyers and moderate-income families to enter the housing market.

The increasing cost of housing—especially with a smaller share of homes in lower price ranges—indicate that housing affordability is a growing issue. Renters and potential

homebuyers may struggle with high costs, and rising property values may contribute to concerns about displacement or increased financial strain.

Values of Owner-Occupied Homes, Alamance County and North Carolina (2023)

Home Value	Alamance County	Davidson County	Johnston County	Randolph County	North Carolina
Less than $50,000	5.0%	2.0%	1.5%	1.5%	2.6%
$50,000 to $99,999	2.6%	1.9%	0.7%	7.1%	3.5%
$100,000 to $299,999	42.6%	53.8%	32.8%	63.4%	35.2%
$300,000 to $499,999	37.2%	33.6%	47.7%	22.3%	34.1%
$500,000 to $749,999	9.5%	5.6%	13.2%	4.1%	15.5%
$750,000 to $999,999	2.8%	2.2%	2.3%	1.0%	5.2%
$1,000,000 or more	0.5%	0.9%	1.7%	0.6%	3.9%
Median (dollars)	299,400	266,700	344,700	230,400	343,400

***Source**: U.S. Census Bureau, U.S. Department of Commerce. (2023). Financial Characteristics for Housing Units With a Mortgage. American Community Survey, ACS 1-Year Estimates Subject Tables, Table S2506. Retrieved December 3, 2024, from https://data.census.gov/table/ACSST1Y2023.S2506?q=home%20value&g=040XX00US37_050XX00US37001,37057,37101,37151&moe=false.*

Primary Data Analysis

Alamance County Community Health Assessment (CHA) Survey

The 2024 Alamance County Community Health Assessment (CHA) Survey was developed through a collaborative effort involving the CHA advisory aroup, Alamance County Health Department, clinical and community partners. The survey aimed to gather data on community health perceptions, healthcare access, quality of life issues, and behavioral health.

Survey Development and Planning

The CHA survey was strategically designed to ensure accessibility and comprehensiveness. Key elements of development included:

- **Partnerships:** The survey was developed with input from local public health professionals, healthcare organizations, local government agencies, community members and community organizations.

- **Language Accessibility:** To reach a broader audience, the survey was offered in both English and Spanish.
- **Comprehensive Question Structure:** The survey was divided into eight sections, covering various aspects of community health, including healthcare quality, health behaviors, quality of life, substance use and mental health, access to care, and preparedness.

Survey Structure and Topics Covered

The survey was designed with multiple sections, each focusing on critical community health issues:

1. **Community Perceptions**
    - Healthcare quality in Alamance County
    - Suitability for raising children and aging
    - Safety, economic opportunities, and housing
    - Access to parks, recreation, and healthy foods

2. **Quality of Life Issues**
    - Impact of income, employment, and crime on quality of life
    - Perceptions of healthcare access, affordability, and utilization
    - Health education needs related to nutrition, exercise, and mental health

3. **Health Behaviors and Preventative Care**
    - Sources of health information (social media, healthcare providers, schools, etc.)
    - Use of preventative services (mammograms, flu shots, physical exams)
    - Exercise habits and barriers to physical activity

4. **Specific Health Topics**
    - Tobacco and substance use
    - Vaccination uptake (flu, COVID-19, and barriers)
    - Barriers to healthcare access (cost, insurance, transportation, provider availability)

5. **Mental and Behavioral Health**
    - Access to mental health services and most pressing issues (anxiety, depression, stress)
    - Barriers such as stigma, cost, and lack of providers

6. **Substance Use Disorder Services**
    - Availability of services and barriers to access
    - Identification of most needed services (e.g., inpatient/outpatient programs, counseling, naloxone access)

7. **Healthcare Access & Disaster Preparedness**
    - Identifying barriers to healthcare (language, transportation, cost)
    - Steps to improve access (more providers, affordable services)
    - Emergency preparedness awareness

Survey Deployment Strategy

To promote participation, the survey was deployed electronically and in targeted events, with a focus on accessibility and community engagement.

Deployment Timeline & Collection Window

- The survey was officially launched in June 2024 and remained open for responses until October 2024, providing a four-month window for community participation.
- A total of 569 responses were collected throughout the survey period, with 530 usable observations.

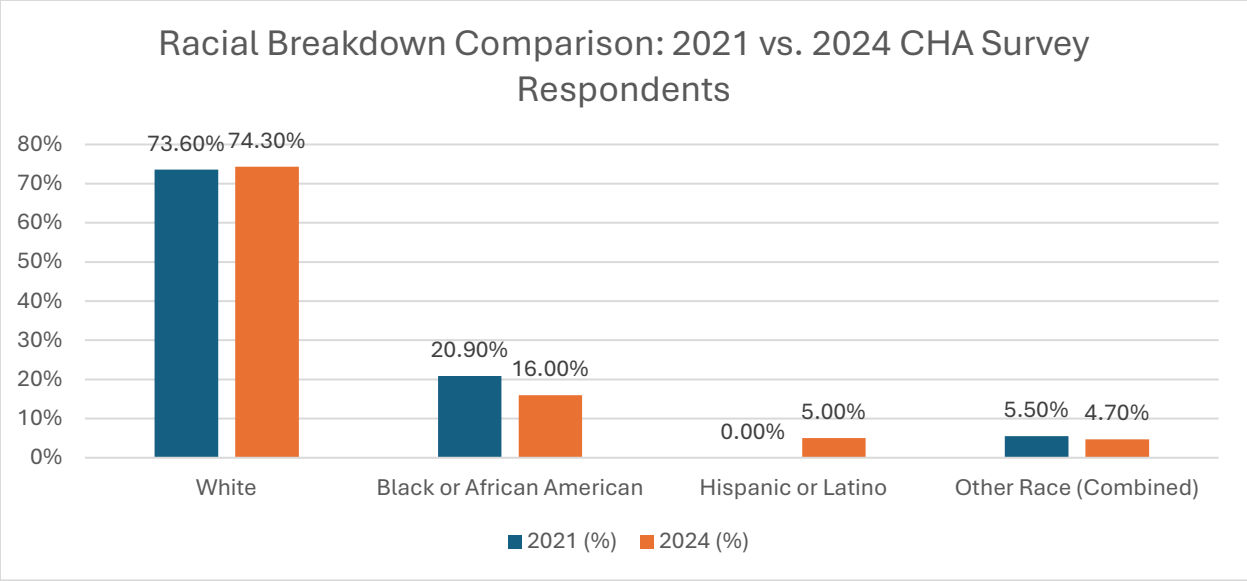
Deployment Methods

1. **Electronic Distribution**
    - Online survey links were shared through public health department websites, social media, and community partner networks.
    - The survey was mobile-compatible and accessible via QR code to increase convenience.

2. **In-Person Distribution**
    - Paper surveys and tablets were available at select community events.
    - Local community health workers assisted in survey distribution.

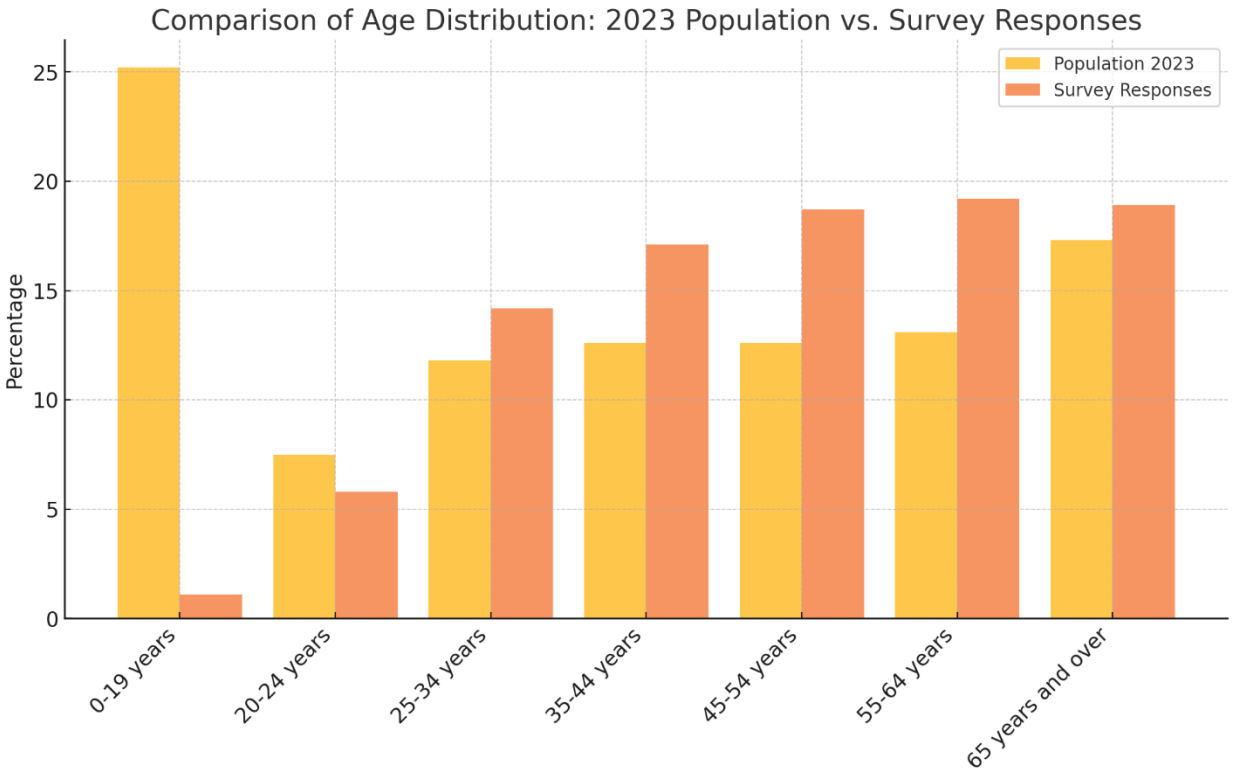
3. **Outreach and Engagement**
    - The CHA team promoted the survey through:
        - Social media campaigns
        - Community health fairs and events
        - Partnerships with churches, schools, and local businesses

- Printed flyers with QR codes were distributed across the county to encourage participation.
    - *Due to the use of online convenience sampling, a predictable oversampling of women, higher-income, white, and educated respondents occurred. However, it should be noted that the oversampling of white respondents is nearly identical to the previous CHA cycle (74.3% in 2024 vs. 73.6% in 2021). Of particular note, in the 2021 CHA, Hispanic or Latino respondents were grouped within the "Other Race" category, which totaled 5.5% of responses. In the 2024 CHA, Hispanic or Latino respondents were reported as a standalone category, representing 5.0% of the respondents, while the percentage of those identifying as "Other Race" (not including Hispanic or Latino Respondents) totaled 4.7%.*



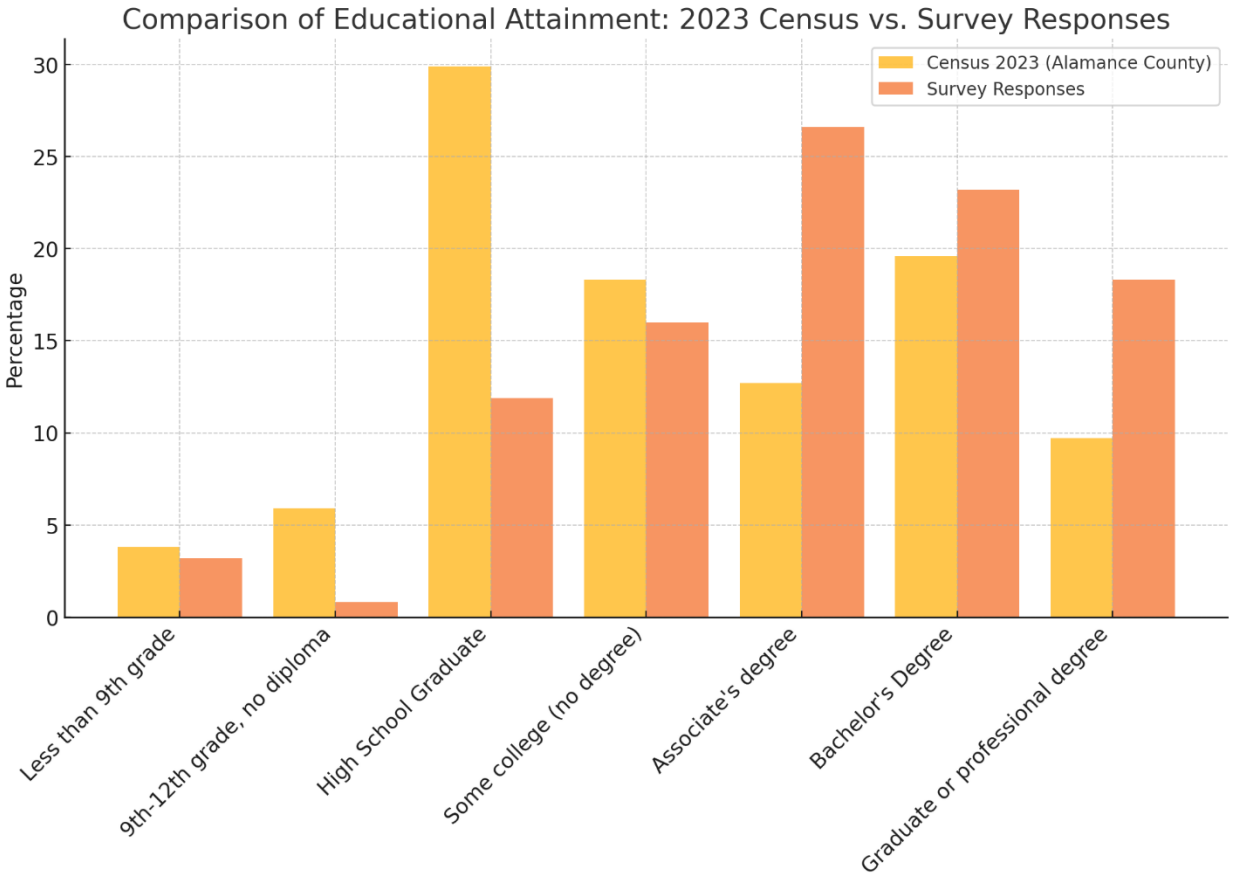
Demographics

Age Range	Frequency	Percent
Age 15-19	6	1.1
Age 20-24	31	5.8
Age 25-29	39	7.4
Age 30-34	36	6.8
Age 35-39	51	9.6
Age 40-44	40	7.5
Age 45-49	51	9.6
Age 50-54	48	9.1
Age 55-59	61	11.5
Age 60-64	41	7.7
Age 65-69	37	7
Age 70-74	27	5.1
Age 75-79	17	3.2
Age 80-84	17	3.2
Age 85+	2	0.4
Did Not Respond	26	4.9
Total	530	



Sex	**Frequency**	**Percent**
Woman	379	71.5
Man	143	27.0
Prefer not to answer	8	1.5
Total	530	
Race/Ethnicity	**Frequency**	**Percent**
Asian	6	1.1
Black / African American	81	15.3
Hispanic / Latino	25	4.7
Native American	8	1.5
Pacific Islander	4	0.8
White / Caucasian	375	70.8
More than 1 race	6	1.1
Prefer not to answer	25	4.7
Total	530	

Education Level	Frequency	Percent
Less than 9th grade	17	3.2
9th-12th grade, no diploma	4	0.8
High School Graduate (or GED/equivalent)	63	11.9
Associate Degree or Vocational Training	141	26.6
Some college (no degree)	85	16
Bachelor's Degree	123	23.2
Graduate or professional degree	97	18.3
Total	530	



Annual Income	Frequency	Percent
Less than $10,000	9	1.7
$10,000 to $14,999	8	1.5
$15,000 to $24,999	21	4.0
$25,000 to $34,999	26	4.9
$35,000 to $49,999	61	11.5
$50,000 to $74,999	247	46.6
$75,000 to $99,999	62	11.7
$100,000 or more	96	18.1
Total	530	

Community Perceptions

Survey respondents expressed general agreement (using "strongly agree," "agree," or "neutral") with the following statements:

- There is good healthcare in Alamance County (**82%**)
- Alamance County is a good place to raise children (**87%**)
- Alamance County is a good place to grow old (**80%**)
- Alamance County is a safe place to live (**83%**)
- There is plenty of help for people during times of need in Alamance County (**75%**)
- There are good parks and recreation facilities in Alamance County (**83%**)
- It is easy to buy healthy foods in Alamance County (**75%**)

However, many respondents (**45%**) disagreed or strongly disagreed with the statement that "There is plenty of economic opportunity in Alamance County," indicating concerns about job availability and economic growth. Additionally, **41%** of respondents disagreed or strongly disagreed that "There is affordable housing that meets the needs in Alamance County." These concerns about economic opportunity and housing affordability reflect broader challenges in the county, despite the positive perceptions of safety, healthcare, and community support.

Community Priorities in Alamance County

To better understand the community's most pressing concerns, survey respondents were asked to identify their top priorities. This approach highlights the issues that residents see as most critical rather than providing a broad ranking of all concerns.

The most frequently identified priority was low income and poverty (248 responses), reflecting widespread economic challenges. Substance use, including drugs and alcohol (231 responses), was also a major concern, pointing to the ongoing impact of addiction in the community. Other top concerns included a lack of community resources (184 responses), affordable housing shortages (180 responses), and transportation issues (156 responses), all of which can significantly impact quality of life and access to essential services.

Beyond these core economic and infrastructure concerns, respondents also highlighted issues related to health insurance access (130 responses), food insecurity (98 responses), and education (93 responses), particularly related to school dropouts and barriers to academic success.

Health Care Access in Alamance County

While most survey respondents (69%) reported no issues accessing health care in the past year, about 31% indicated they had difficulty getting care for themselves or a family member. The most common provider types where residents faced challenges included:

- Primary care doctors
- Dentists
- Specialists
- Hospitals
- Urgent care centers

Beyond individual experiences, many respondents expressed concerns about whether health care is equally available to everyone in the community. Nearly half (49%) felt that not all residents have the same access to quality health care, while only 36% believed that access is the same for everyone. Additionally, 39% of respondents felt that certain groups face greater health challenges, particularly:

- Low-income individuals
- Racial/ethnic minorities
- Children
- Immigrants
- The elderly

The most frequently cited barriers to health care included:

- Cost of services and lack of insurance
- Language barriers and transportation challenges
- Limited awareness of available services
- Shortage of health care providers

To address these challenges, respondents identified several ways to improve access to care:

- Increasing support for low-income families
- Expanding culturally appropriate health care practices
- Raising awareness of available health services
- Offering more multilingual services
- Improving affordability and increasing the number of providers
- Enhancing transportation options to health care facilities

Food Access

Food insecurity remains a challenge for many residents in Alamance County, with one in four respondents (25%) reporting concerns that their family's food would run out before they had money to buy more. While 60% of respondents did not experience food insecurity, 9% were unsure whether they would have enough food. These findings suggest that, despite a majority feeling secure in their access to food, a significant portion of the community continues to face uncertainty about meeting basic nutritional needs.

Mental Health

Mental health remains a significant concern in Alamance County, with many residents expressing dissatisfaction with available services. Only 16% of respondents rated mental health services as excellent, while 33% rated them as fair and nearly 24% rated them as poor. The most commonly identified mental health challenges in the community included substance abuse (341 responses), depression (270 responses), stress (254 responses), anxiety (239 responses), and suicide (230 responses).

Access to mental health care is further complicated by barriers such as cost (244 responses), lack of awareness about available services (226 responses), long wait times (177 responses), and a limited number of providers (168 responses). Stigma surrounding

mental health was also cited as a challenge, highlighting the need for increased community support and education. To improve awareness and reduce stigma, respondents suggested strategies such as public discussions and forums (282 responses), employer-sponsored mental health initiatives (270 responses), community education programs (268 responses), and support groups (254 responses).

Substance Use

Substance use remains a pressing concern in Alamance County, with many residents citing both high rates of substance misuse and challenges in accessing treatment. When asked to rate the availability of substance use disorder services, only 16% of respondents rated them as excellent, while 29% rated them as poor. The most frequently reported substance use issues included marijuana use (241 responses), prescription drug misuse (236 responses), opioid addiction (235 responses), methamphetamine use (232 responses), and alcohol abuse (229 responses).

Several barriers make it difficult for individuals to seek treatment, including transportation challenges, a shortage of providers, lack of insurance, high costs, and long wait times. Stigma surrounding substance use was also identified as a significant hurdle, potentially discouraging people from accessing the care they need. To improve services, respondents highlighted the need for expanded counseling and therapy (239 responses), detoxification programs (206 responses), prevention education (205 responses), and increased telehealth options (200 responses).

When asked about access to naloxone (Narcan), which can reverse opioid overdoses, only 18% felt it was very accessible, while 26% believed it was not accessible at all.

Health Behaviors and Health Literacy in Alamance County

Access to reliable health information plays a crucial role in shaping health behaviors, and survey respondents identified healthcare providers, the internet, and personal networks as their primary sources of information. Doctors and nurses (252 responses) were the most frequently cited source, followed closely by online resources (237 responses), friends and family (166 responses), and social media (134 responses). Other common sources included pharmacists, employers, the health department, and traditional media such as television, newspapers, and radio.

When asked what health topics the community needs more education on, respondents prioritized mental and behavioral health (203 responses), substance misuse prevention (117 responses), and nutrition (98 responses). Other topics of interest included weight management, exercise, elder care, preventive screenings, and parenting resources.

Engagement in preventive health behaviors varied among respondents. The most common screenings reported were blood pressure checks (258 responses), physical exams (241 responses), dental cleanings (220 responses), and flu shots (209 responses). Despite the availability of preventive care, 30% of respondents reported that they do not engage in regular physical activity, with time constraints, fatigue, and work-related factors being the most common barriers to exercise.

The lingering effects of COVID-19 were also evident in the survey results. Many respondents reported that the pandemic had impacted their mental health, increased stress and anxiety (217 responses), and contributed to social isolation (158 responses). Other areas affected included job loss, financial strain, and difficulty accessing medical care.

Disaster Preparedness in Alamance County

The majority of survey respondents (72%) reported feeling confident in their ability to access information during a natural disaster, while 24% stated they do not know how to find the information they need to stay safe. An additional 12% were unsure, indicating that while most residents feel prepared, there is still a notable portion of the community that may struggle to access critical emergency information.

When it comes to sources of disaster information, residents rely most heavily on television (186 responses), the internet (186 responses), and emergency alert text messages (180 responses). Other commonly used sources include cell phones, social media, and radio. Some residents also depend on family members and neighbors for updates, while traditional print media such as newspapers and landline telephones were among the least-used sources.

These findings suggest that while many residents feel prepared for natural disasters, efforts to expand public awareness campaigns, improve emergency communication strategies, and ensure access to timely information for all residents—especially those without digital access—could strengthen disaster preparedness across the county.

Community Conversations in the Community Health Assessment (CHA) Process

Impact Alamance and representatives from The Harwood Institute facilitated community conversations to gather primary qualitative data directly from residents. These structured discussions captured public knowledge—insights and experiences shared by community

members—that complemented the quantitative survey data, ensuring that the CHA process reflected real, lived experiences rather than assumptions made by experts alone.

The Breadth and Depth of Community Engagement

To capture a broad and diverse range of perspectives, Impact Alamance and Harwood Institute facilitators conducted conversations with various community groups across the county, ensuring representation from historically underserved populations. These groups included:

- **Faith-Based Communities** – Conversations were held at Northside, Ebenezer, and St. Mark's churches, as well as The Dream Center. Faith leaders and congregants expressed concerns about safety, education, economic opportunity, and community connectedness.
- **Rural and Farming Communities** – Residents in Southern Alamance (SAFE Community Conversation) and Green Level highlighted transportation barriers, healthcare access, and digital connectivity as major concerns.
- **Latino/Hispanic Communities** – Events such as the *Empodera Te Latina Community Conversation* and Dream Center ESL Class provided insight into the challenges faced by Spanish-speaking residents, including language barriers, employment conditions, and limited culturally relevant healthcare resources.
- **Senior Citizens and Retirement Communities** – Discussions with older adults emphasized concerns related to transportation, healthcare access, and social isolation.

Beyond these discussions, the West End Revitalization Association (WERA) also played a role in ensuring that underserved voices were heard in public health efforts. WERA, a nonprofit dedicated to environmental and public health issues, has long advocated for the basic public health amenities in Alamance County. Their *Community Owned and Managed Research (COMR) model* has been instrumental in addressing disparities through structural and policy-level changes. The Alamance County Health Department has worked with WERA to integrate public health infrastructure needs into CHA discussions, reinforcing the importance of access to clean water, safe transportation, and environmental protections.

How the Conversations Were Conducted

1. **Data Collection Led by Experts in Community Engagement**
    - Conversations were facilitated by Impact Alamance and The Harwood Institute, organizations with expertise in public engagement and community-driven research.
    - Facilitators used a structured approach to ensure that participants felt comfortable sharing honest and open reflections about their communities.
2. **Recruitment & Outreach**
    - Participants were intentionally recruited through trusted community organizations, ensuring representation from historically underrepresented groups.
    - Faith-based groups, Latino organizations, rural networks, and senior advocates played key roles in outreach efforts.
3. **Facilitation & Structure**
    - Each conversation lasted 90 minutes to two hours and followed a guided format developed by The Harwood Institute to ensure meaningful dialogue.
    - Trained facilitators asked open-ended questions that encouraged residents to share personal experiences and community observations.

How These Conversations Strengthened the CHA Process

- **Public Knowledge Over Expert Assumptions** – Unlike traditional survey data, these conversations provided deeper insights into why community members viewed certain issues as critical.
- **Ensuring Representation from Underheard Voices** – Facilitators prioritized engagement with populations historically underrepresented in these processes, ensuring that all residents, including rural communities, seniors, and low-income families, had a voice in shaping public health priorities.
- **Guiding Local Health Priorities** – The themes that emerged from these conversations directly shaped the CHA's priority areas and strategic recommendations, ensuring that future health initiatives align with the needs identified by the community itself.

Through Impact Alamance's leadership and The Harwood Institute's facilitation, these community conversations provided a rich and nuanced understanding of the challenges and strengths within Alamance County. WERA's work in public health infrastructure advocacy complemented these efforts by ensuring that environmental concerns and access to basic amenities were considered in public health planning. More than just a data collection method, this process empowered residents to share their experiences, express their concerns, and play an active role in shaping the future of their community's health and well-being.

Secondary Data Analysis

Peer County Selection: Johnston, Davidson, and Randolph Counties

To provide meaningful context and actionable insights in this community health assessment (CHA), Johnston, Davidson, and Randolph counties were selected as peer counties for Alamance County. These counties were chosen due to their demographic, socioeconomic, geographic, and health-related similarities, allowing for relevant comparisons and the identification of shared challenges and opportunities for improvement.

Demographic Similarities

Alamance, Johnston, Davidson, and Randolph counties share comparable population sizes and densities, with a blend of urban centers and expansive rural areas. This rural-urban mix presents common challenges, such as disparities in access to care, transportation barriers, and differing needs between urban and rural populations. Johnston and Alamance counties also have rapidly growing Hispanic/Latino populations, offering opportunities to explore health disparities and culturally responsive interventions that may benefit both communities.

Socioeconomic Comparability

The socioeconomic profiles of these counties align closely with median household incomes and poverty rates that are slightly below the state average. All four counties have economies rooted in similar industries, such as manufacturing, agriculture, and small businesses, which shape the health challenges faced by their populations. Educational attainment levels are also comparable, influencing health literacy and access to economic opportunities. These shared socioeconomic factors allow for a deeper understanding of the impact of social determinants of health on community well-being.

Shared Health Challenges

All four counties experience high rates of chronic diseases, including diabetes, heart disease, and obesity, reflecting common health behaviors and risk factors. Access to care is another shared concern, as rural areas in these counties face shortages of primary care providers and barriers to specialty care. Behavioral health needs, particularly those related to substance use disorders and mental health, are increasing in Alamance, Davidson, and Randolph counties, highlighting the regional impact of the opioid crisis and associated social stressors.

Geographic and Regional Context

Located in central North Carolina, these counties share similar proximity to major urban centers, such as the Research Triangle and Piedmont Triad. This geographic placement influences access to tertiary care, employment opportunities, and public health resources, creating a shared regional context. Additionally, these counties experience similar environmental health factors, including challenges related to water quality, transportation infrastructure, and housing availability.

Leading Causes of Death

The leading causes of death provide an in-depth view of the conditions that most strongly affect a community's health and longevity. Within a community health assessment, examining these causes of death offers a clear indication of where resources and attention are most needed. High mortality rates point to areas where early detection, preventive measures, and better access to healthcare could significantly reduce avoidable deaths. By looking not just at raw numbers but also at trends over time, decision-makers can see whether certain causes of death are rising or falling, leading to more focused interventions.

In addition, comparing local mortality data with peer counties and statewide averages reveals how issues facing one community align—or differ—from those elsewhere. This broader perspective helps to highlight which problems might benefit from regional collaboration or targeted advocacy. Ultimately, understanding the leading causes of death allows communities to set priorities and develop initiatives that match their most urgent public health needs. By zeroing in on these areas, a well-informed Community Health Assessment paves the way for meaningful improvements in overall health outcomes.

Top Ten Leading Causes of Death in Alamance County, 2014-2018 to 2018-2022

	2014-2018	2015-2019	2016-2020	2017-2021	2018-2022
#1	Cancer - All Sites	Cancer - All Sites	Cancer - All Sites	Cancer - All Sites	Diseases of the heart
#2	Diseases of the heart	Diseases of the heart	Diseases of the heart	Diseases of the heart	Cancer - All Sites
#3	Chronic lower respiratory	Chronic lower respiratory	Chronic lower respiratory	Chronic lower respiratory	Other Unintentional
#4	Cerebrovascular disease	Cerebrovascular disease	Other Unintentional	Other Unintentional	Chronic lower respiratory
#5	Alzheimer's disease	Other Unintentional	Cerebrovascular disease	Cerebrovascular disease	Cerebrovascular disease
#6	Other Unintentional	Alzheimer's disease	Alzheimer's disease	Alzheimer's disease	COVID-19
#7	Diabetes mellitus	Diabetes mellitus	Diabetes mellitus	COVID-19	Alzheimer's disease

#8	Nephritis, nephrotic	Nephritis, nephrotic	Nephritis, nephrotic	Diabetes mellitus	Diabetes mellitus
#9	Pneumonia & influenza	Pneumonia & influenza	Pneumonia & influenza	Nephritis, nephrotic	Nephritis, nephrotic
#10	Septicemia	Septicemia	Septicemia	Pneumonia & influenza	Pneumonia & influenza

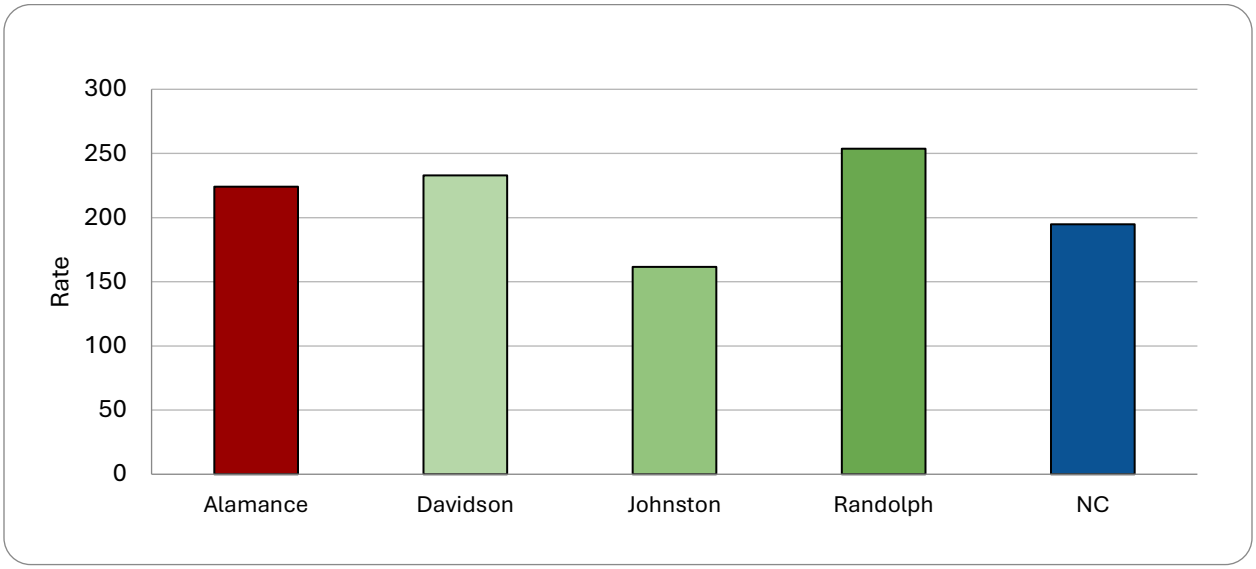
Source: North Carolina Department of Health and Human Services, State Center for Health Statistics. (2024). North Carolina health statistics data book. Retrieved January 14, 2025, from https://schs.dph.ncdhhs.gov/data/databook/

From 2014-2018 through 2017-2021, cancer remained the leading cause of death in Alamance County, with heart disease consistently following in second place. In the most recent period (2018-2022), heart disease moved into the top spot, and cancer shifted to second. Chronic lower respiratory diseases held the third position from 2014-2018 through 2017-2021, but then moved to fourth in 2018-2022 as "Other Unintentional Injuries" rose steadily from sixth (2014-2018) to third (2018-2022). Cerebrovascular disease stayed near the middle, ranking fourth in the earlier periods and fifth from 2016-2020 onward.

Alzheimer's disease started at fifth place in 2014-2018 and gradually shifted to seventh by 2018-2022. Diabetes mellitus remained near seventh or eighth, while nephritis (including nephrotic syndrome and nephrosis) and pneumonia/influenza consistently appeared in the lower ranks, with minor changes in order. Septicemia held a place in the top ten through 2016-2020 but did not appear in the top ten in the last two time spans. COVID-19 first emerged in the 2017-2021 data at seventh place and rose to sixth in 2018-2022. Overall, most rankings changed only slightly across the five overlapping periods, reflecting a relatively stable pattern of leading causes of death in the county.

Diseases of the Heart

2018- 2022 DISEASES OF THE HEART: UNADJUSTED DEATH RATES PER 100,000 POPULATION

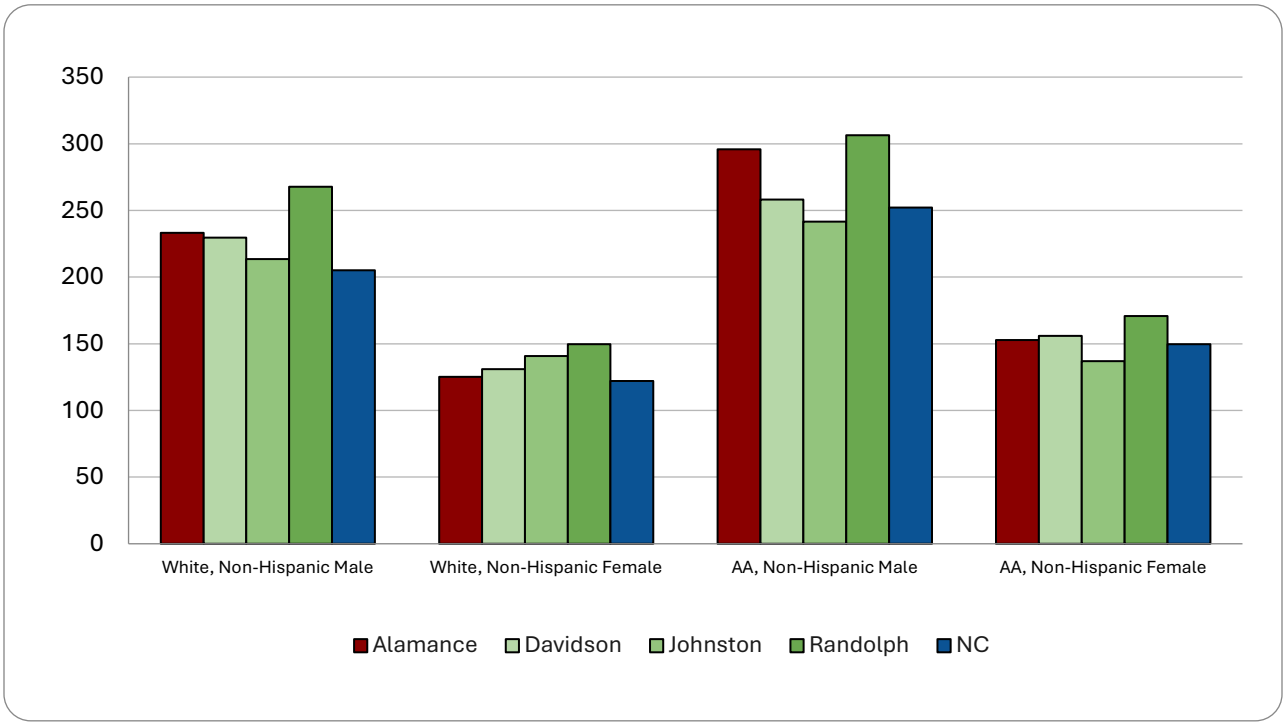


Source: North Carolina Department of Health and Human Services, State Center for Health Statistics. (2024). North Carolina health statistics data book. Retrieved January 14, 2025, from https://schs.dph.ncdhhs.gov/data/databook/

Heart disease is the leading cause of death in Alamance County, encompassing conditions such as coronary artery disease, heart failure, and arrhythmias. The figures presented here reflect the total number of deaths from heart-related illnesses and the corresponding death rate per 100,000 population, offering a snapshot of how significantly heart disease impacts various communities.

In Alamance County, heart disease resulted in 1,923 deaths, translating to a death rate of 224.1 per 100,000 population—about 15 percent higher than the North Carolina rate of 194.8. When compared to peer counties, Alamance's rate is roughly 4 percent below Davidson's 232.9 and about 13 percent below Randolph's 253.7, yet it stands approximately 28 percent above Johnston's 161.6. These variations highlight the differences in heart disease mortality across the region and demonstrate that Alamance's rate remains notably above the statewide average.

2018-2022 DISEASES OF THE HEART: RACE/ETHNICITY AND SEX-SPECIFIC AGE-ADJUSTED DEATH RATES

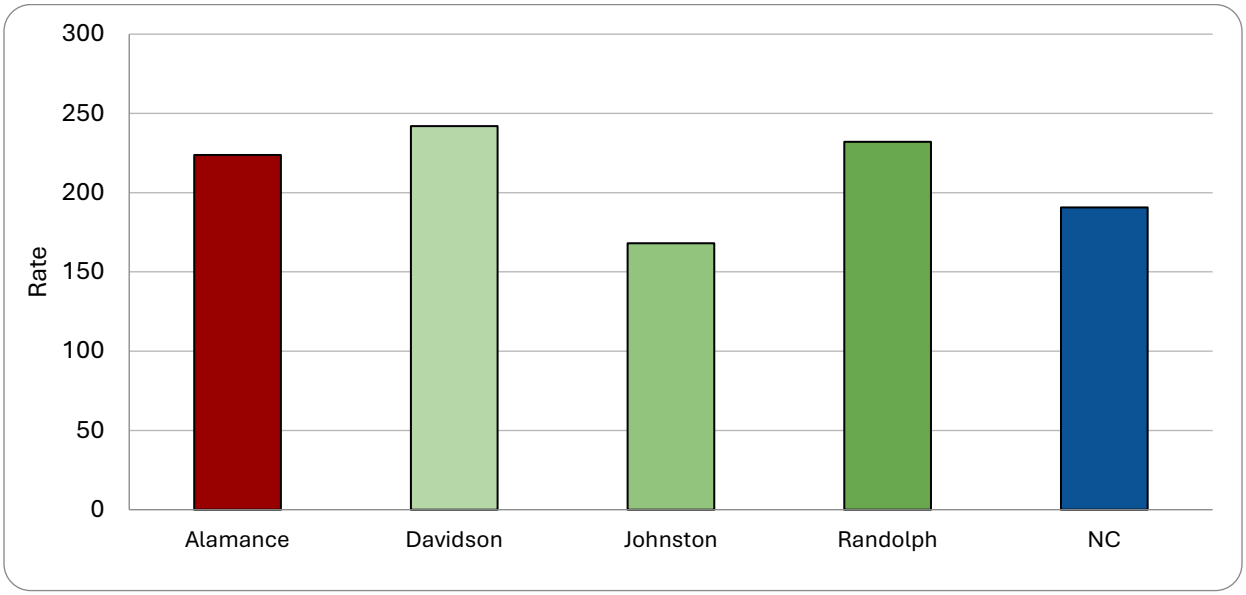


Source: North Carolina Department of Health and Human Services, State Center for Health Statistics. (2024). North Carolina health statistics data book. Retrieved January 14, 2025, from https://schs.dph.ncdhhs.gov/data/databook/

Among the reported figures for Alamance County, African American (AA), Non-Hispanic males have the highest heart disease death rate at 295.8 per 100,000—exceeding the statewide rate of 252.1 for that demographic. White, Non-Hispanic males follow at 233.3 per 100,000, which is also above the North Carolina figure of 205.2. In comparison, White, Non-Hispanic females in Alamance (125.1) and AA, Non-Hispanic females (152.7) remain above the statewide benchmarks of 122.0 and 149.7, respectively, but by a smaller margin. Rates for Hispanic males, as well as other racial/ethnic categories, are not shown for Alamance specifically (or are suppressed) due to small numbers; however, where available, these groups generally have lower rates than the most affected populations noted above.

Cancer

2018- 2022 CANCER- ALL SITES: UNADJUSTED DEATH RATES PER 100,000 POPULATION

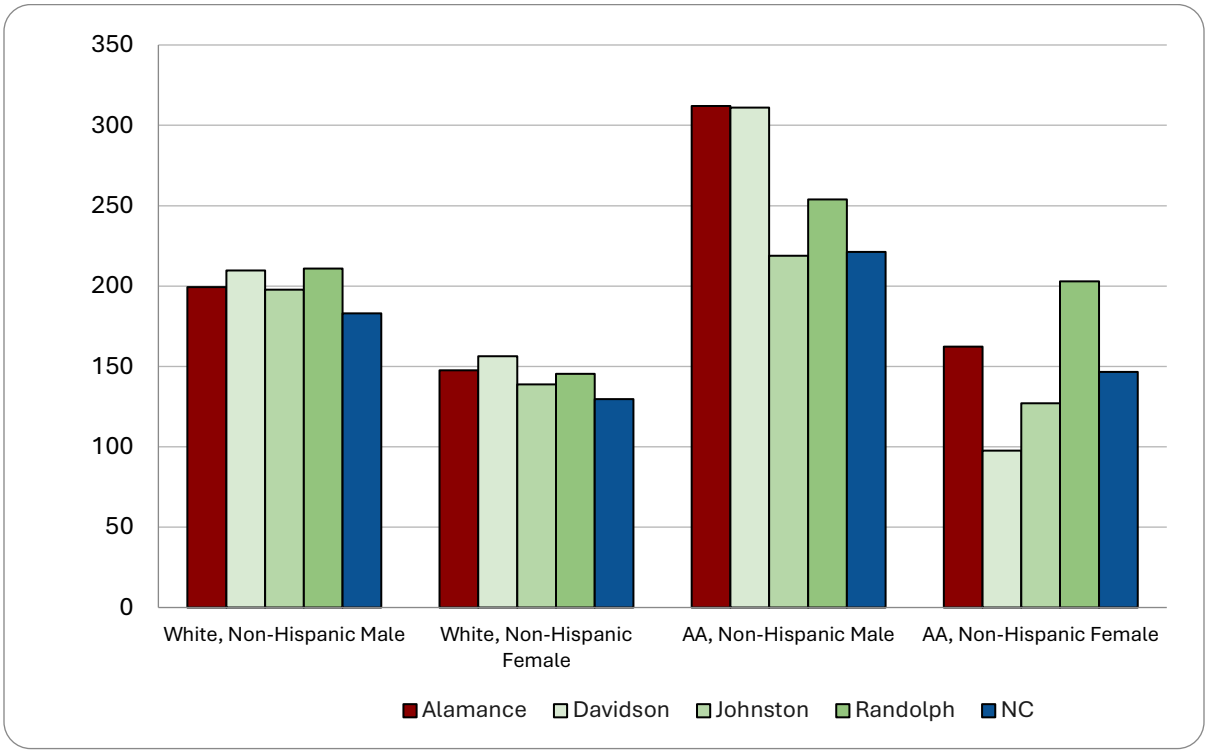


Source: North Carolina Department of Health and Human Services, State Center for Health Statistics. (2024). North Carolina health statistics data book. Retrieved January 14, 2025, from https://schs.dph.ncdhhs.gov/data/databook/

Cancer is the second leading cause of death in Alamance County, encompassing a range of malignant tumors that can affect organs such as the lungs, colon, breast, and prostate. The figures shown here combine all cancer-related fatalities to give an overall view of how significant this group of diseases is across communities.

In Alamance County, cancer accounted for 1,921 deaths and a death rate of 223.8 per 100,000 people—approximately 17 percent higher than the statewide rate of 190.7. Compared to peer counties, Alamance's rate is about 8 percent lower than Davidson's 242.0 and roughly 4 percent lower than Randolph's 232.1, while it remains about 33 percent above Johnston's 168.1. These differences reveal notable variations in cancer mortality across the region, even though each county shows a substantial impact from this disease.

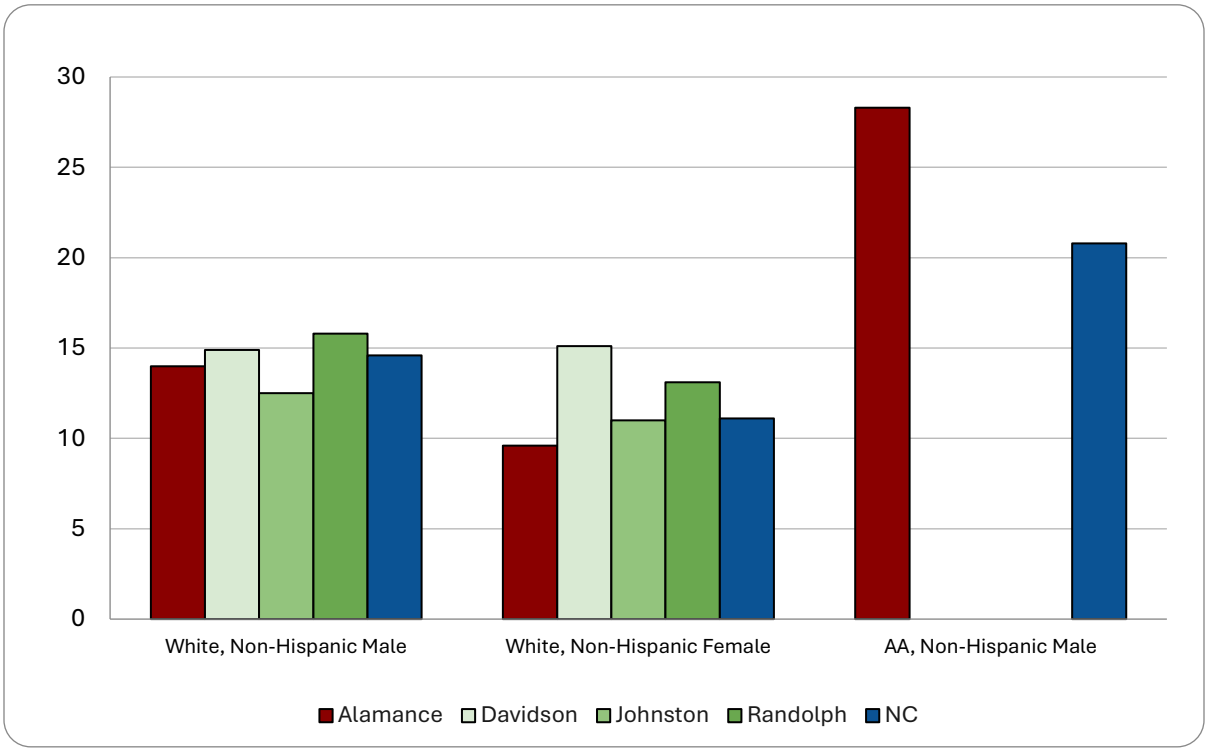
2018-2022 CANCER (ALL): RACE/ETHNICITY AND SEX-SPECIFIC AGE-ADJUSTED DEATH RATES



Source: North Carolina Department of Health and Human Services, State Center for Health Statistics. (2024). North Carolina health statistics data book. Retrieved January 14, 2025, from https://schs.dph.ncdhhs.gov/data/databook/

For Alamance County, African American (AA), Non-Hispanic males show the highest cancer mortality rate at 312 per 100,000—significantly above the statewide rate of 221.2 and comparable to Davidson's 311. Meanwhile, White, Non-Hispanic males in Alamance stand at 199.3, exceeding the North Carolina average of 183 but falling below Davidson's 209.7 and Randolph's 210.9. White, Non-Hispanic females record 147.5 in Alamance, again above the state's 129.7 but slightly lower than Davidson's 156.4. Among AA, Non-Hispanic females, the county's rate (162.3) surpasses the state figure of 146.5, as well as Davidson's 97.6 and Johnston's 127.1, yet remains below Randolph's 203.

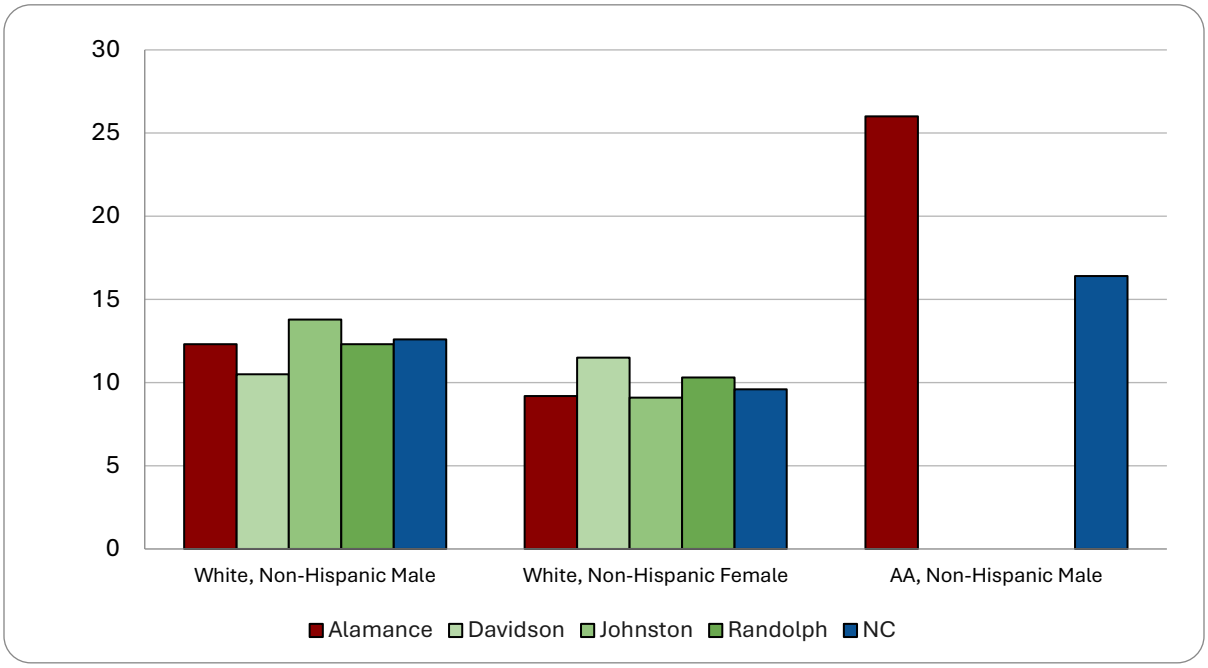
2018-2022 CANCER (COLON, RECTUM, ANUS): RACE/ETHNICITY AND SEX-SPECIFIC AGE-ADJUSTED DEATH RATES



Source: North Carolina Department of Health and Human Services, State Center for Health Statistics. (2024). North Carolina health statistics data book. Retrieved January 14, 2025, from https://schs.dph.ncdhhs.gov/data/databook/

In Alamance County, White, Non-Hispanic males have an age-adjusted colorectal cancer mortality rate of 14.0 per 100,000, which is slightly below the peer-county average (14.4) and close to the statewide figure (14.6). White, Non-Hispanic females in Alamance (9.6) also fall below both the peer-county average (about 13.1) and the statewide rate (11.1). In contrast, African American, Non-Hispanic males register 28.3, nearly double the rate for White, Non-Hispanic males in Alamance and substantially above the statewide rate of 20.8.

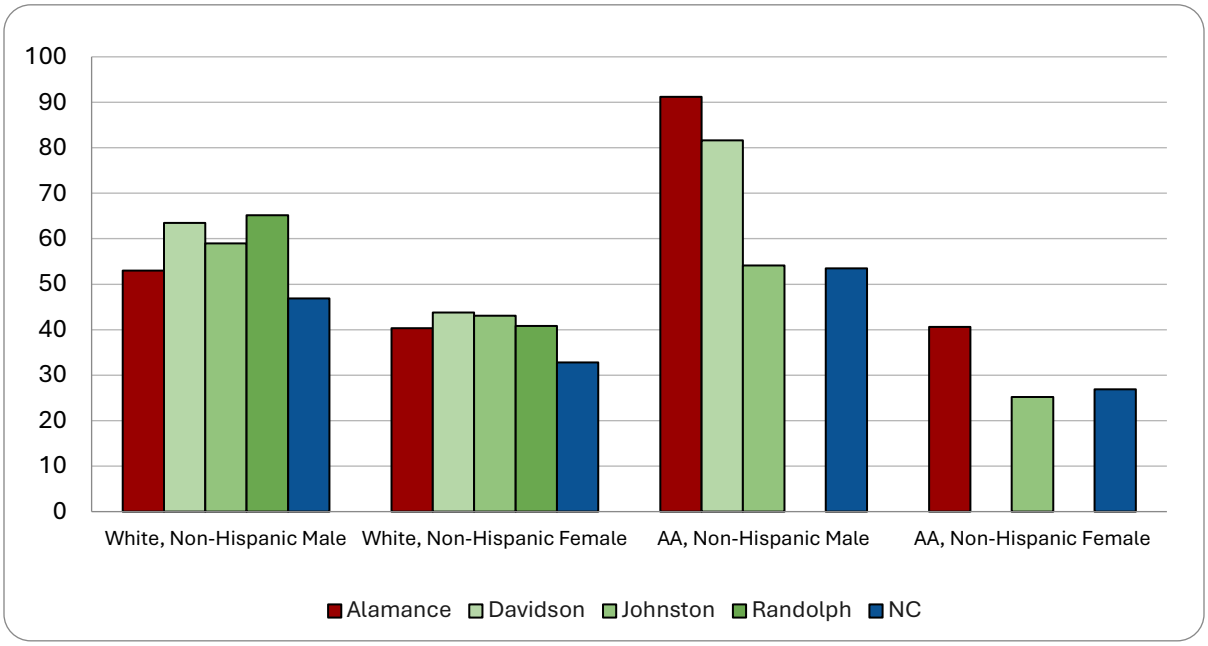
2018-2022 CANCER (PANCREAS): RACE/ETHNICITY AND SEX-SPECIFIC AGE-ADJUSTED DEATH RATES



Source: North Carolina Department of Health and Human Services, State Center for Health Statistics. (2024). North Carolina health statistics data book. Retrieved January 14, 2025, from https://schs.dph.ncdhhs.gov/data/databook/

For White, Non-Hispanic males in Alamance (12.3 per 100,000), the rate closely matches the peer-county average (about 12.2) and sits just below the statewide figure of 12.6. White, Non-Hispanic females register 9.2 in Alamance—about 12% lower than the peer-county average of 10.3 and slightly below the North Carolina rate of 9.6. Notably, African American (AA), Non-Hispanic males in Alamance have a reported rate of 26.0, which is nearly double the White, Non-Hispanic male rate and about 58% higher than the statewide figure of 16.4 for AA males.

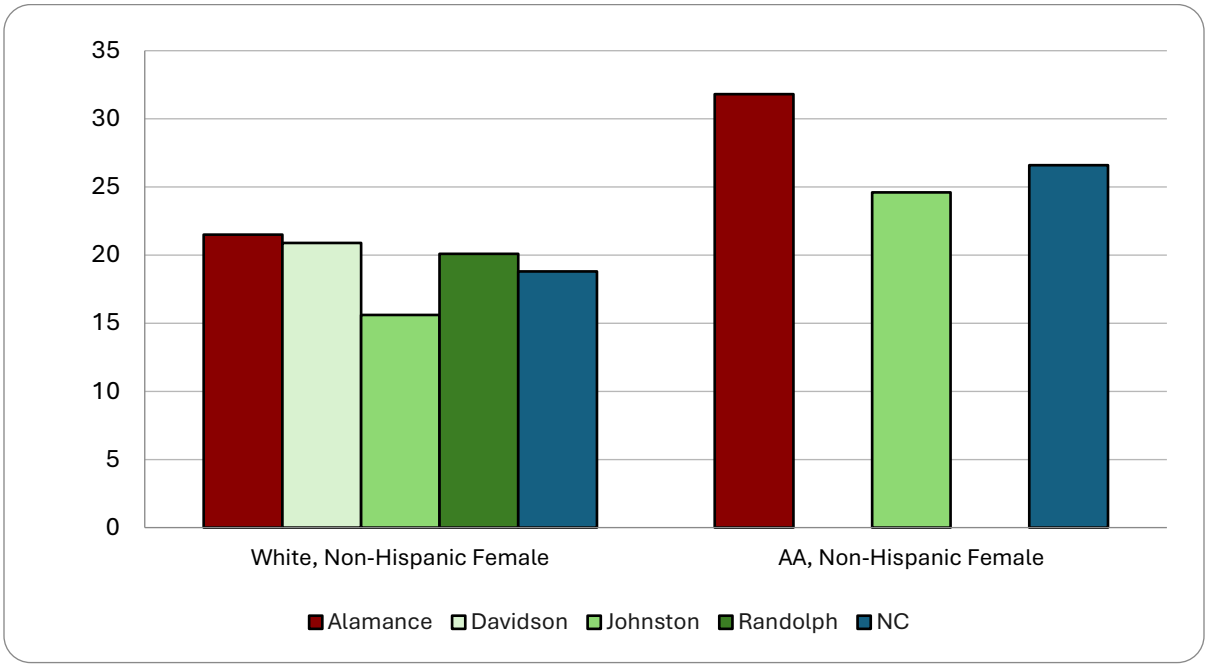
2018-2022 CANCER (TRACHEAS, BRONCHUS, LUNG): RACE/ETHNICITY AND SEX-SPECIFIC AGE-ADJUSTED DEATH RATES



Source: North Carolina Department of Health and Human Services, State Center for Health Statistics. (2024). North Carolina health statistics data book. Retrieved January 14, 2025, from https://schs.dph.ncdhhs.gov/data/databook/

In Alamance County, White, Non-Hispanic males have a rate of 53.0 per 100,000, which is about 13% higher than the North Carolina figure of 46.9 but roughly 15% below the average of nearby counties (about 62.6). White, Non-Hispanic females (40.3) exceed the statewide rate (32.8) by around 23% but sit slightly below the peer-county average (around 42.6). African American, Non-Hispanic males in Alamance (91.2) stand out with a rate approximately 70% above the statewide figure of 53.5 and about one-third higher than the combined average (roughly 67.9) from Davidson and Johnston. Meanwhile, African American, Non-Hispanic females record 40.6—about 51% higher than the statewide rate of 26.9.

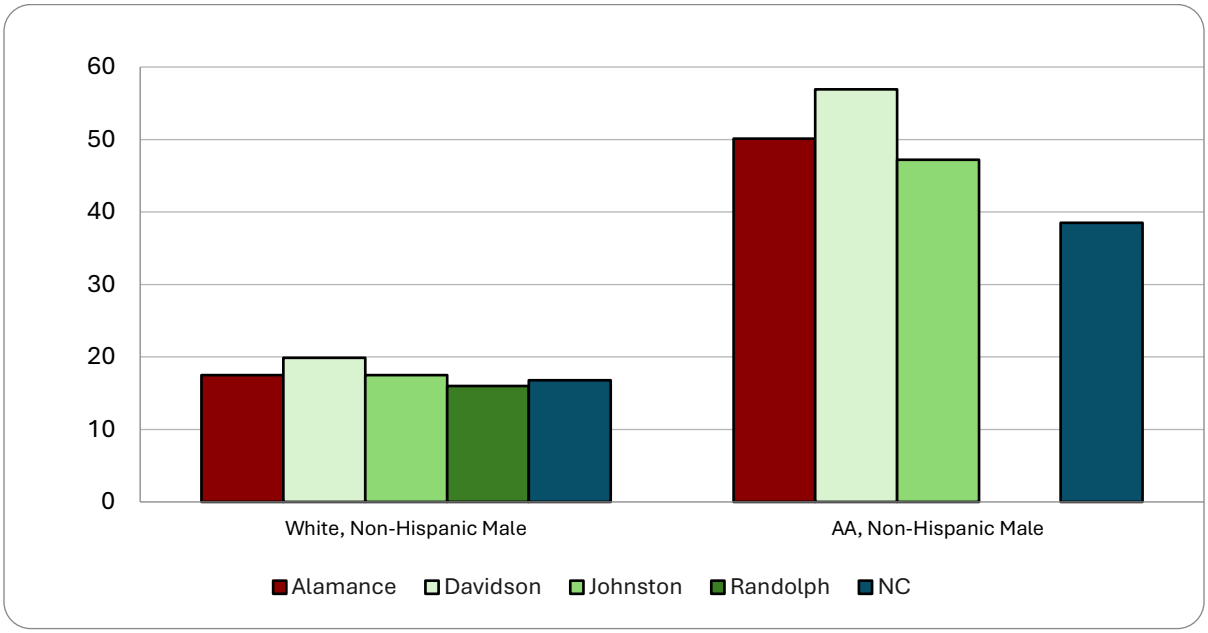
2018-2022 CANCER (BREAST): RACE/ETHNICITY SPECIFIC AGE-ADJUSTED DEATH RATES



Source: North Carolina Department of Health and Human Services, State Center for Health Statistics. (2024). North Carolina health statistics data book. Retrieved January 14, 2025, from https://schs.dph.ncdhhs.gov/data/databook/

Among White, Non-Hispanic females in Alamance County, the age-adjusted breast cancer mortality rate stands at 21.5 per 100,000—about 14% higher than both the statewide figure (18.8) and the average of peer counties (roughly 18.9). In contrast, African American (AA), Non-Hispanic females in Alamance have a rate of 31.8, exceeding the statewide rate of 26.6 by roughly 20% and Johnston County's 24.6 by nearly 30%. While data are suppressed or unavailable for most other race-gender groups in Alamance, these comparisons highlight that AA, Non-Hispanic females face the highest burden among the reported populations.

2018-2022 CANCER (PROSTATE): RACE/ETHNICITY SPECIFIC AGE-ADJUSTED DEATH RATES

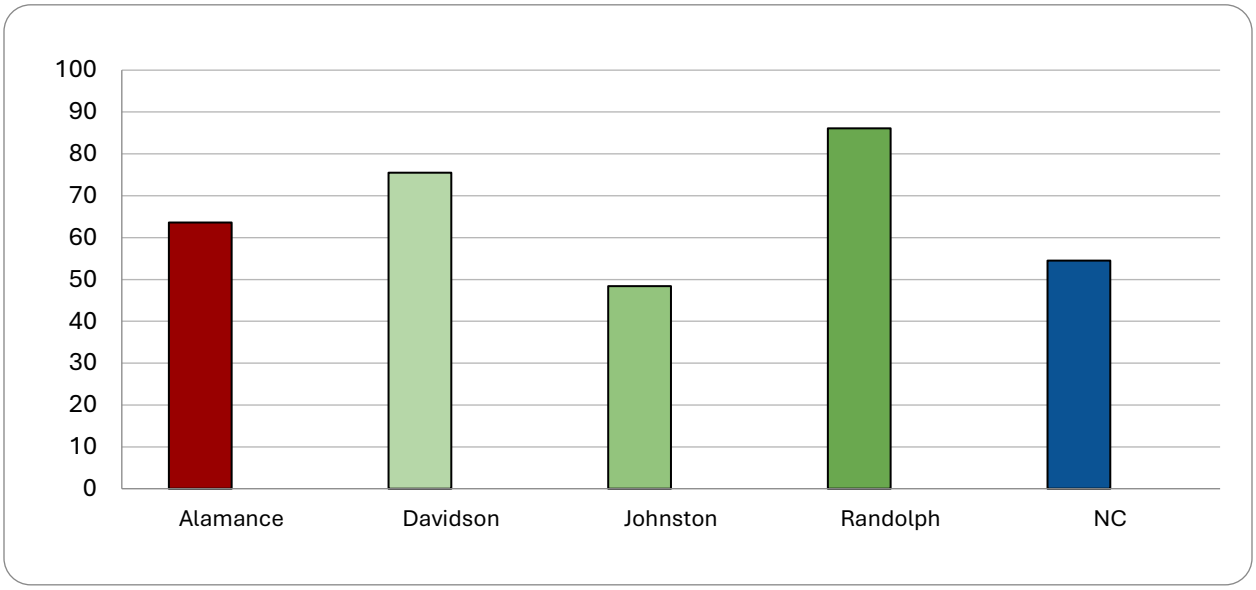


Source: North Carolina Department of Health and Human Services, State Center for Health Statistics. (2024). North Carolina health statistics data book. Retrieved January 14, 2025, from https://schs.dph.ncdhhs.gov/data/databook/

Among White, Non-Hispanic males in Alamance County, the age-adjusted prostate cancer mortality rate is 17.5 per 100,000—slightly above North Carolina's figure of 16.8, on par with Johnston County (17.5), and somewhat lower than Davidson (19.9). By contrast, African American, Non-Hispanic males in Alamance stand at 50.1, a rate nearly triple that of White, Non-Hispanic males—underscoring a stark disparity in prostate cancer outcomes. This gap of more than 30 points in the mortality rate also places Alamance's African American men about 30% above the statewide average for that demographic (38.5).

Other Unintentional Injuries

2018- 2022 OTHER UNINTENTIONAL INJURIES: UNADJUSTED DEATH RATES PER 100,000 POPULATION

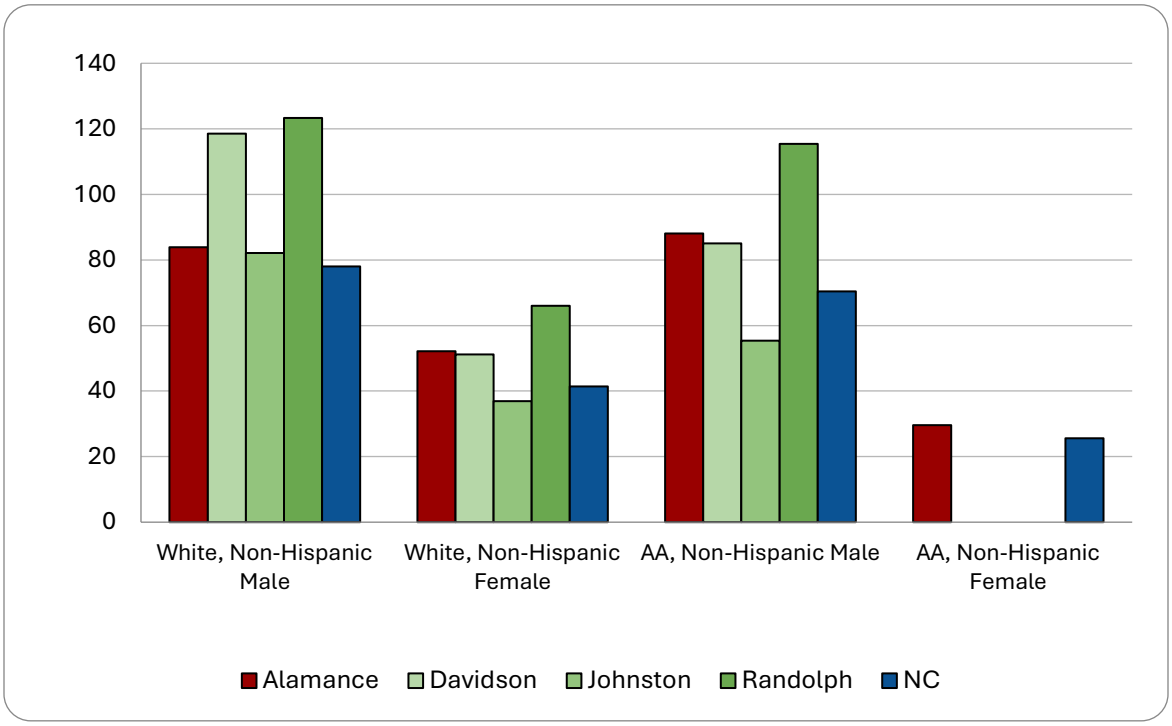


Source: North Carolina Department of Health and Human Services, State Center for Health Statistics. (2024). North Carolina health statistics data book. Retrieved January 14, 2025, from https://schs.dph.ncdhhs.gov/data/databook/

Other unintentional injuries—which include overdose fatalities—have risen in ranking over the past five reporting cycles in Alamance County, moving from sixth to third. This increase is largely driven by an uptick in overdose deaths, highlighting the growing impact of substance misuse on overall mortality rates.

In the most recent data, Alamance County recorded 546 deaths from other unintentional injuries, yielding a death rate of 63.6 per 100,000 residents—about 17 percent higher than the statewide rate of 54.5. Compared to peer counties, Alamance's rate is below Davidson's 75.5 and Randolph's 86.1 but surpasses Johnston's 48.4 by roughly 31 percent. These figures illustrate how unintentional injury mortality, particularly from overdoses, varies across the region and underscores the significance of this cause of death in Alamance.

2018-2022 OTHER UNINTENTIONAL INJURIES: RACE/ETHNICITY AND SEX-SPECIFIC AGE-ADJUSTED DEATH RATES

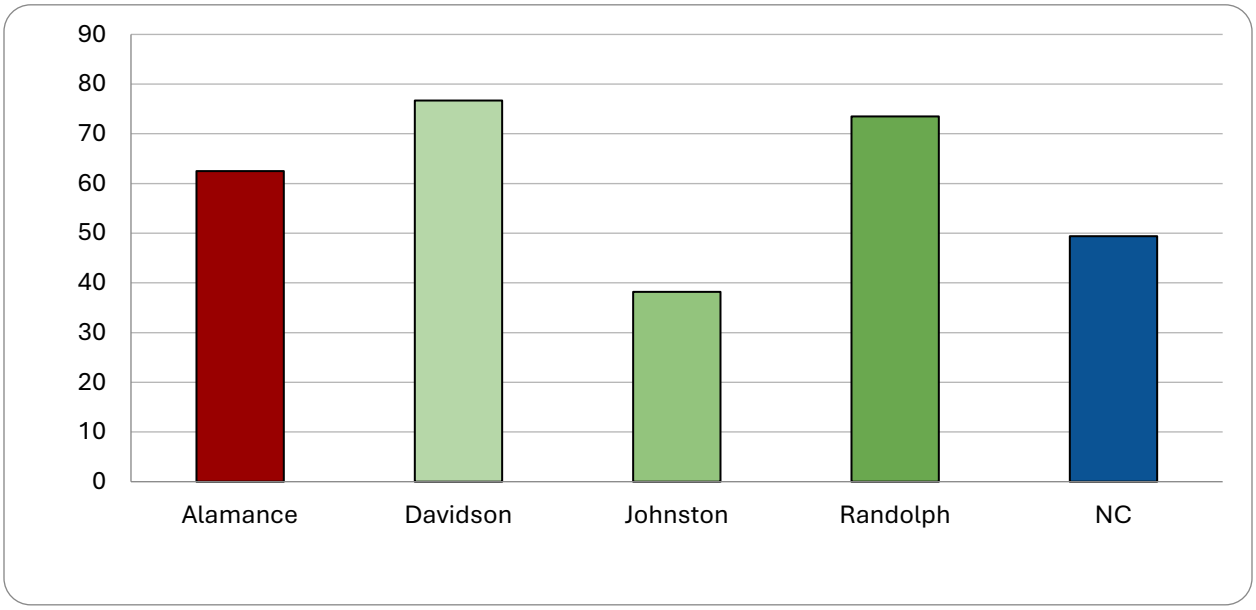


Source: North Carolina Department of Health and Human Services, State Center for Health Statistics. (2024). North Carolina health statistics data book. Retrieved January 14, 2025, from https://schs.dph.ncdhhs.gov/data/databook/

Among the reported figures for Alamance County, African American (AA), Non-Hispanic males show a rate of 88.1 per 100,000, which exceeds the North Carolina figure of 70.4 and is comparable to Davidson's 85.1. White, Non-Hispanic males in Alamance have a rate of 83.9, above the statewide 78.0 but below Davidson's 118.5 and Randolph's 123.3. In contrast, White, Non-Hispanic females in Alamance register 52.2, which is higher than the state rate of 41.4 and Johnston's 36.9 but close to Davidson's 51.2. AA, Non-Hispanic females in Alamance come in at 29.6, slightly above the statewide 25.6. Although other race and gender groups do not appear for Alamance specifically, statewide data show that American Indian, Non-Hispanic males and females, as well as certain Hispanic and Asian subgroups, have varying rates that can be lower or higher than the averages for more populous demographics. Together, these variations underscore the importance of looking beyond overall county rates to understand how unintentional injury risks differ by race and gender.

Chronic Lower Respiratory Diseases

2018- 2022 CHRONIC LOWER RESPIRATORY DISEASES: UNADJUSTED DEATH RATES PER 100,000 POPULATION

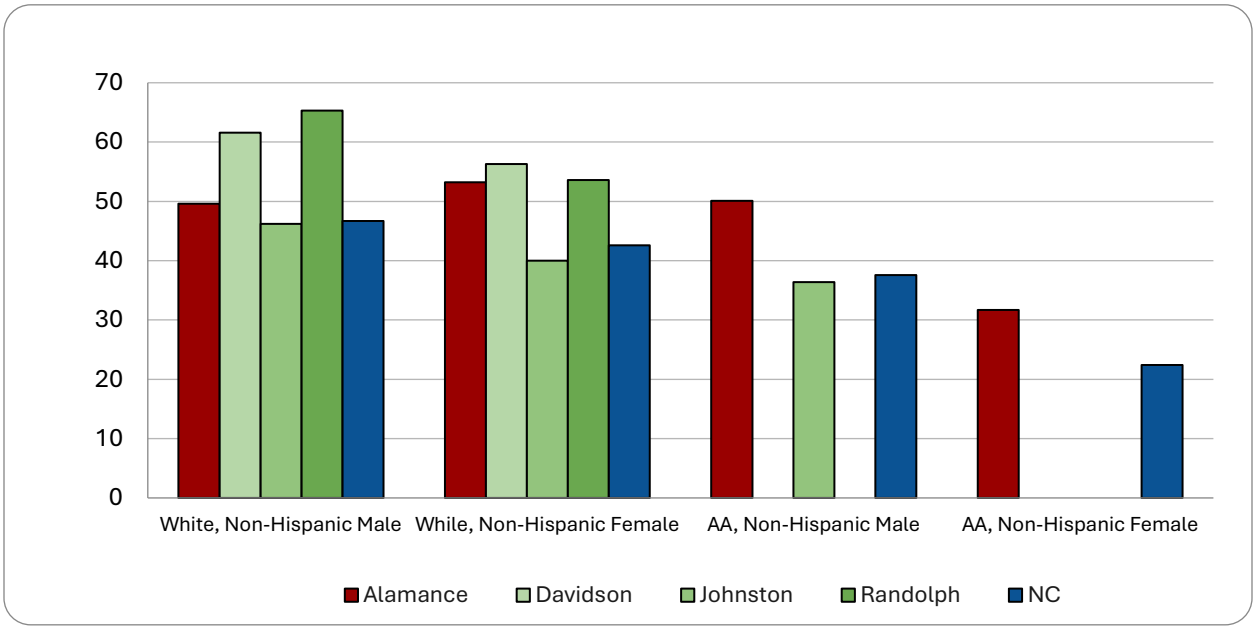


Source: North Carolina Department of Health and Human Services, State Center for Health Statistics. (2024). North Carolina health statistics data book. Retrieved January 14, 2025, from https://schs.dph.ncdhhs.gov/data/databook/

Chronic lower respiratory diseases (CLRD) are the fourth leading cause of death in Alamance County. CLRD include conditions that affect the lungs and airways, such as chronic obstructive pulmonary disease (COPD), emphysema, chronic bronchitis, and, in some cases, severe asthma. These illnesses can make it difficult for individuals to breathe and perform daily activities, often requiring ongoing medical management and, in advanced stages, specialized care.

In Alamance County, CLRD led to 536 deaths, with a death rate of 62.5 per 100,000 residents—approximately 26 percent higher than North Carolina's statewide rate of 49.4. Compared to peer counties, Alamance's rate falls below Davidson's 76.7 and Randolph's 73.5 but is around 64 percent higher than Johnston's 38.2. These figures suggest variation in CLRD mortality across the region, reflecting differing health outcomes and potential risk factors among neighboring communities.

2018-2022 CHRONIC LOWER RESPIRATORY DISEASES: RACE/ETHNICITY AND SEX-SPECIFIC AGE-ADJUSTED DEATH RATES

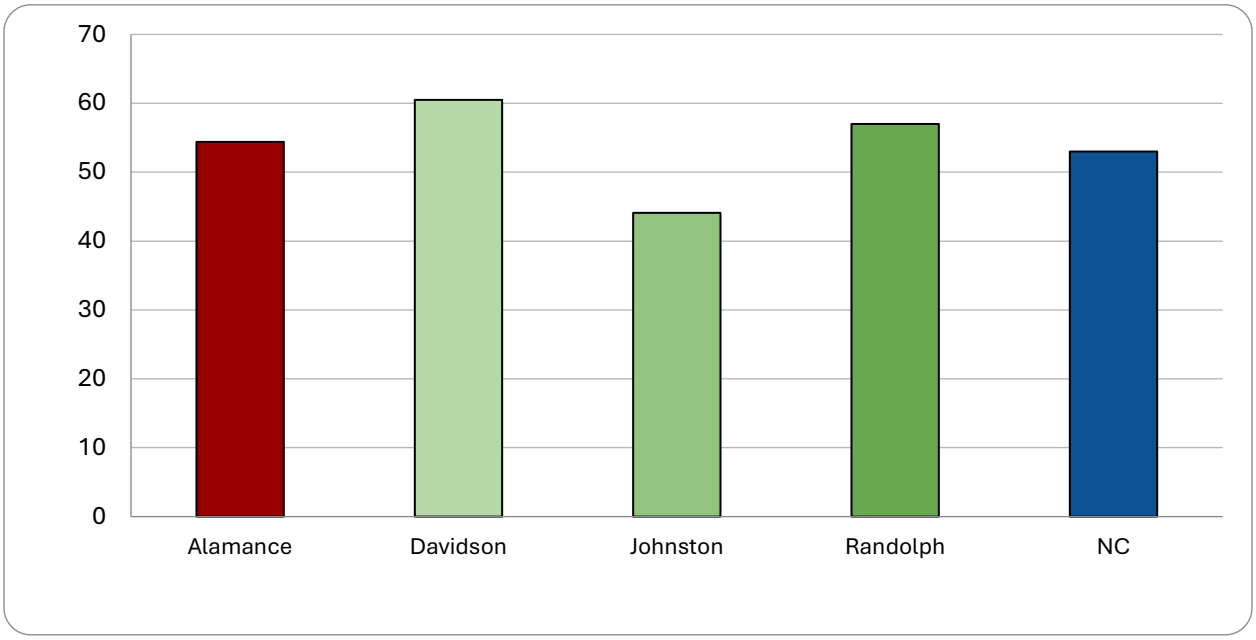


Source: North Carolina Department of Health and Human Services, State Center for Health Statistics. (2024). North Carolina health statistics data book. Retrieved January 14, 2025, from https://schs.dph.ncdhhs.gov/data/databook/

In Alamance County, White, Non-Hispanic females have the highest reported CLRD mortality rate (53.2 per 100,000), followed by African American (AA), Non-Hispanic males (50.1) and White, Non-Hispanic males (49.6). Both of these rates surpass the statewide figures for the same demographics, indicating a higher burden in Alamance for these groups. Although data on other racial/ethnic populations are not shown (or are incomplete) for Alamance specifically, overall state numbers suggest lower rates among Hispanic and Asian Non-Hispanic groups. These distinctions underscore the importance of examining trends at the intersection of race, gender, and disease category to better understand and address CLRD within the community.

Cerebrovascular Diseases

2018- 2022 CEREBROVASCULAR DISEASES: UNADJUSTED DEATH RATES PER 100,000 POPULATION

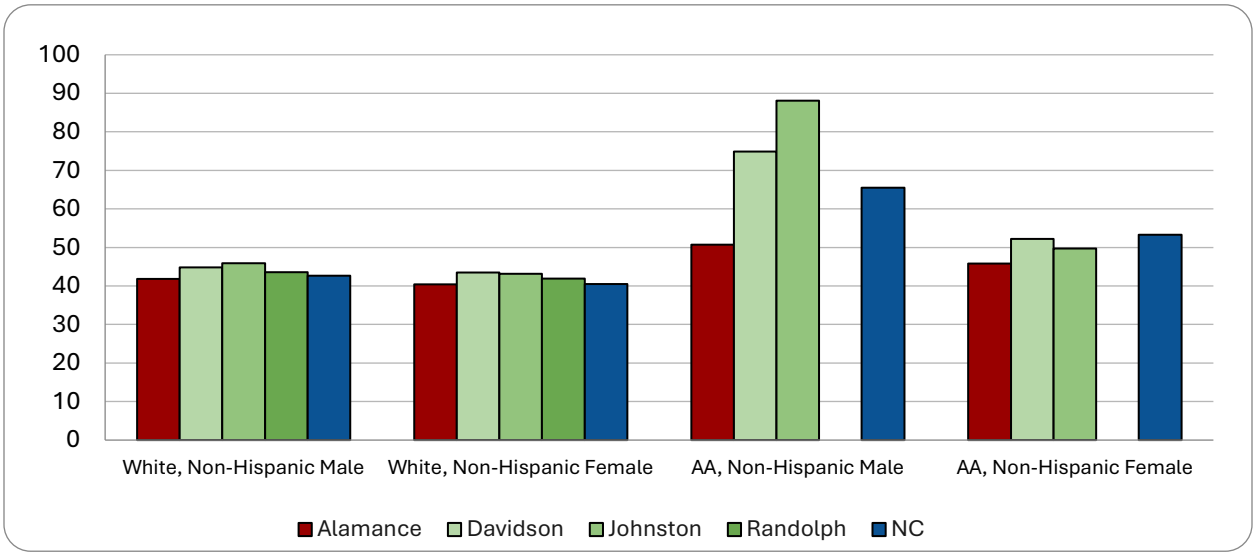


Source: North Carolina Department of Health and Human Services, State Center for Health Statistics. (2024). North Carolina health statistics data book. Retrieved January 14, 2025, from https://schs.dph.ncdhhs.gov/data/databook/

Cerebrovascular diseases are the 5th leading cause of death in Alamance County. These conditions affect blood flow and vessels in the brain, including strokes, transient ischemic attacks (often called "mini-strokes"), and aneurysms. When blood supply to the brain is interrupted or a blood vessel ruptures, serious complications can occur, such as long-term disability or life-threatening events.

Alamance County had 467 deaths from cerebrovascular diseases, with a death rate of 54.4 per 100,000 residents—slightly above North Carolina's rate of 53.0. Compared to nearby counties, this rate is lower than Davidson's 60.5 and Randolph's 57.0 but higher than Johnston's 44.1. These figures show that while Alamance's death rate is close to the statewide average, there is some variation in cerebrovascular disease mortality across the region.

2018-2022 CEREBROVASCULAR DISEASE: RACE/ETHNICITY AND SEX-SPECIFIC AGE-ADJUSTED DEATH RATES

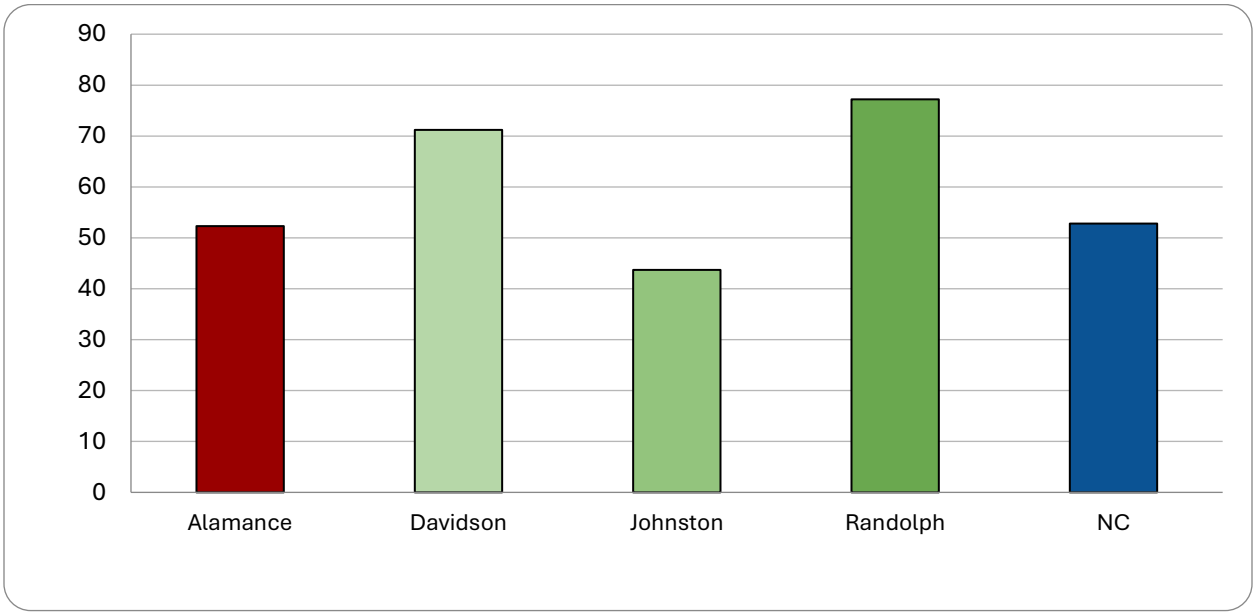


Source: North Carolina Department of Health and Human Services, State Center for Health Statistics. (2024). North Carolina health statistics data book. Retrieved January 14, 2025, from https://schs.dph.ncdhhs.gov/data/databook/

In Alamance County, White, Non-Hispanic males show a rate of 41.8 per 100,000—nearly matching the statewide figure of 42.7—while White, Non-Hispanic females record 40.4, which closely aligns with North Carolina's 40.5. For African American, Non-Hispanic residents, the county's rate is 50.7 among males and 45.8 among females. Although these rates are below statewide comparisons for African American, Non-Hispanic males (65.5) and females (53.3), they remain higher than those of White, Non-Hispanic males and females in Alamance. Neighboring counties vary in how they compare to the state average; for instance, Johnston shows higher rates for both White and African American, Non-Hispanic males (45.9 and 88.1, respectively), while Randolph's data for African American residents are not reported.

COVID-19

2018- 2022 COVID-19: UNADJUSTED DEATH RATES PER 100,000 POPULATION

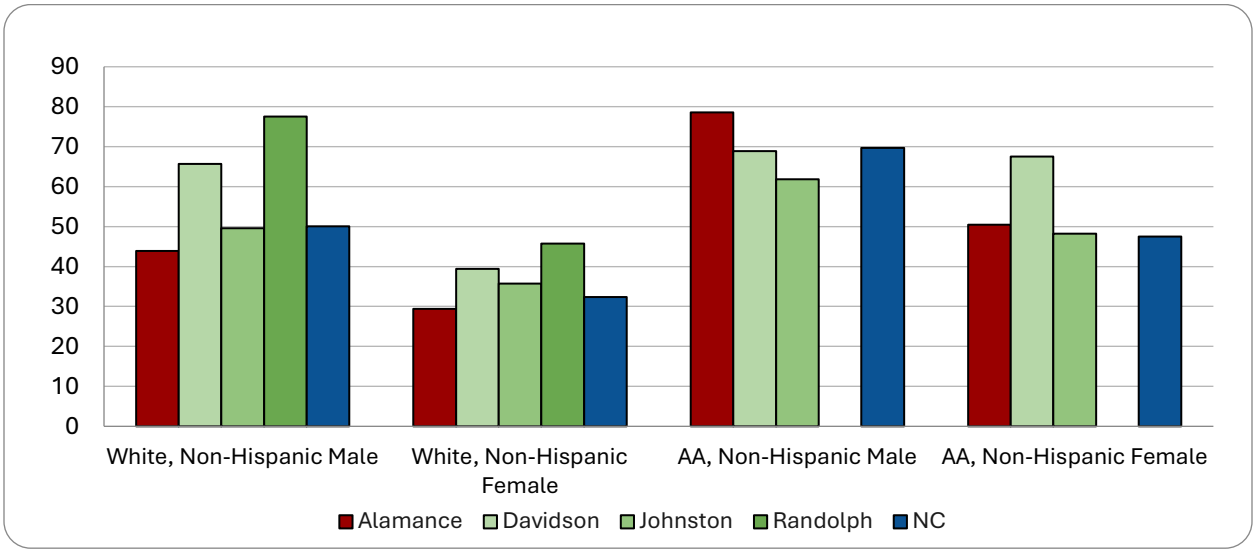


Source: North Carolina Department of Health and Human Services, State Center for Health Statistics. (2024). North Carolina health statistics data book. Retrieved January 14, 2025, from https://schs.dph.ncdhhs.gov/data/databook/

COVID-19 is the 6th leading cause of death in Alamance County. This infectious disease emerged as a global pandemic in 2020, leading to significant illness and, for some people, severe respiratory complications or multi-organ failure. Vaccines and public health measures have helped reduce transmission and severe outcomes, but COVID-19 still contributes notably to mortality rates across communities.

In Alamance County, COVID-19 claimed 449 lives, for a death rate of 52.3 per 100,000 residents—close to North Carolina's rate of 52.8. When compared with its peer counties, Alamance's rate is higher than Johnston's 43.7 but lower than Davidson's 71.2 and Randolph's 77.2. These figures reveal that COVID-19 mortality varies within the region, although Alamance remains near the statewide average.

2018-2022 COVID-19: RACE/ETHNICITY AND SEX-SPECIFIC AGE-ADJUSTED DEATH RATES

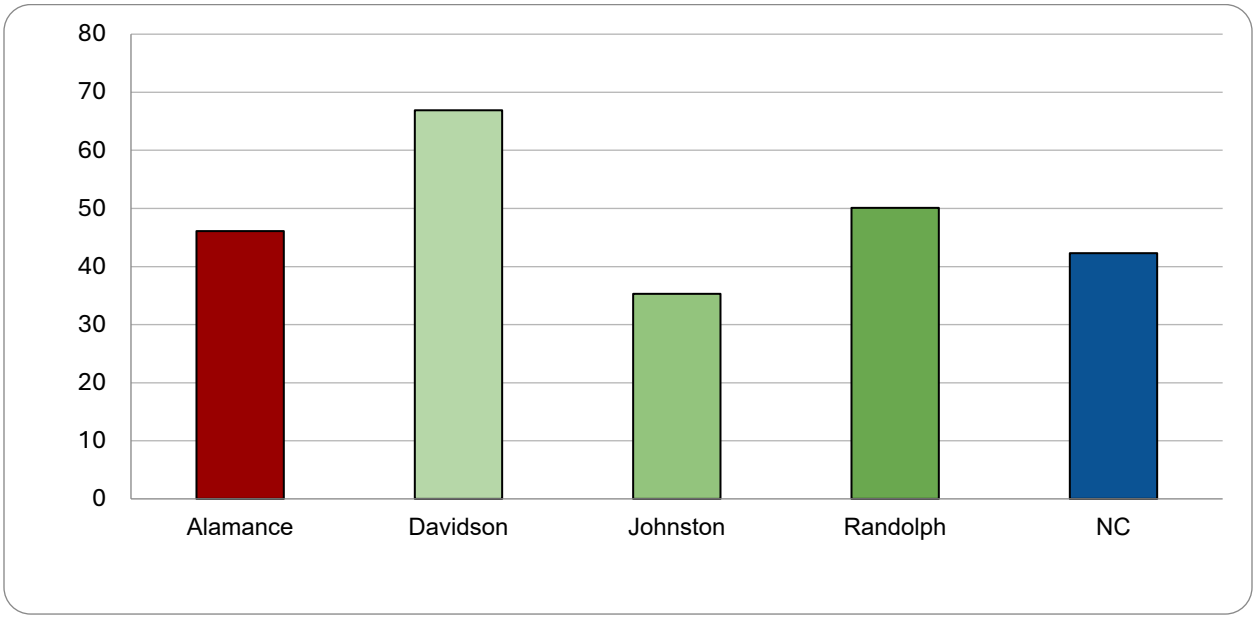


Source: North Carolina Department of Health and Human Services, State Center for Health Statistics. (2024). North Carolina health statistics data book. Retrieved January 14, 2025, from https://schs.dph.ncdhhs.gov/data/databook/

In Alamance County, White, Non-Hispanic males have a COVID-19 mortality rate of 43.9 per 100,000, which is below the North Carolina average of 50.1 and lower than rates in Davidson (65.7) and Randolph (77.5). White, Non-Hispanic females in Alamance register 29.4, also under the statewide 32.4 but still above Johnston's 35.7. African American, Non-Hispanic males in Alamance show 78.6, exceeding both the state figure of 69.7 and the values reported in Davidson (68.9) and Johnston (61.8). For African American, Non-Hispanic females, Alamance's rate is 50.5, slightly above North Carolina's 47.5 but below Davidson's 67.5. Although no data are listed for American Indian, Hispanic, or other race/ethnicity categories in Alamance, the statewide figures (e.g., 72.7 for American Indian, Non-Hispanic males and 87.5 for Hispanic males in Johnston) highlight that COVID-19 mortality rates can vary widely across different populations.

Alzheimer's Disease

2018- 2022 ALZHEIMER'S DISEASE: UNADJUSTED DEATH RATES PER 100,000 POPULATION

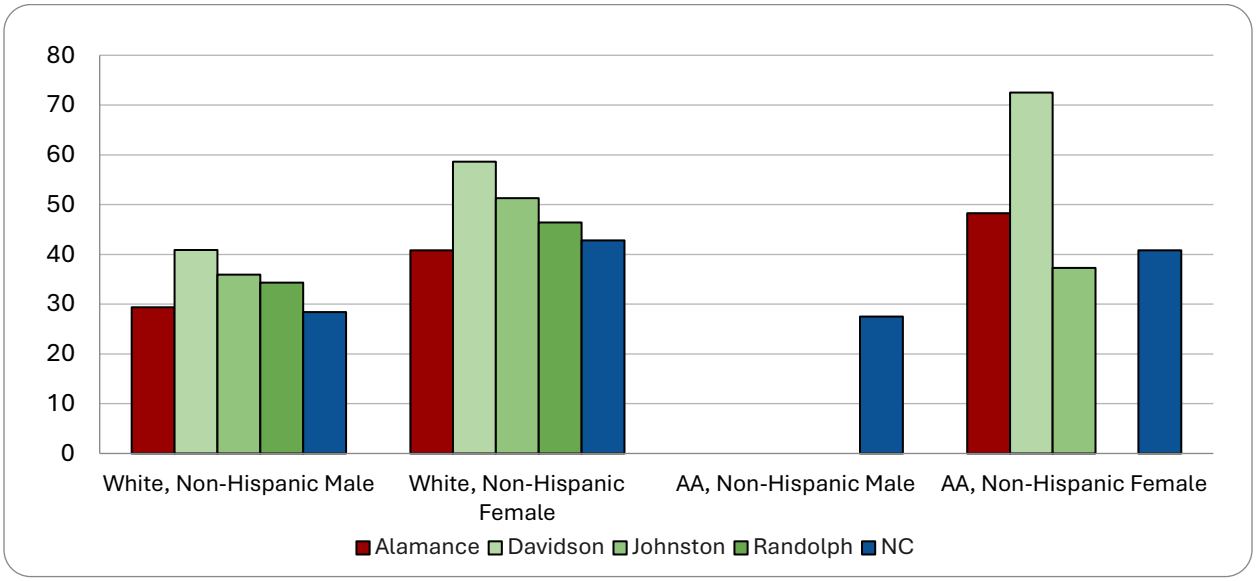


Source: North Carolina Department of Health and Human Services, State Center for Health Statistics. (2024). North Carolina health statistics data book. Retrieved January 14, 2025, from https://schs.dph.ncdhhs.gov/data/databook/

Alzheimer's disease is the 7th leading cause of death in Alamance County. This condition is a progressive brain disorder that gradually impairs memory and thinking skills, often leading to severe cognitive decline and difficulties performing everyday tasks. It is the most common form of dementia among older adults, and its impact typically increases with age.

In Alamance County, Alzheimer's disease accounted for 396 deaths, corresponding to a death rate of 46.1 per 100,000 residents—slightly above the statewide rate of 42.3. When compared with peer counties, Alamance's rate is below Davidson's 66.9 and Randolph's 50.1, but higher than Johnston's 35.3. These data suggest variation in Alzheimer's disease mortality across the region, with Alamance falling in the middle of the range among its neighboring counties.

2018-2022 ALZHEIMER'S: RACE/ETHNICITY AND SEX-SPECIFIC AGE-ADJUSTED DEATH RATES

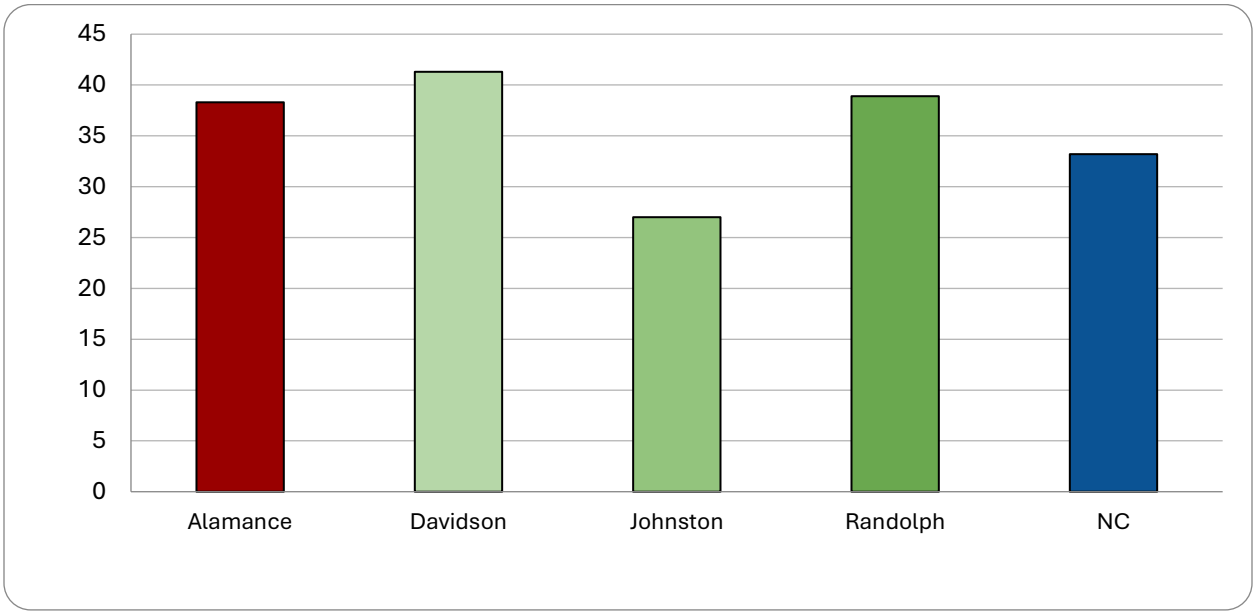


Source: North Carolina Department of Health and Human Services, State Center for Health Statistics. (2024). North Carolina health statistics data book. Retrieved January 14, 2025, from https://schs.dph.ncdhhs.gov/data/databook/

In Alamance County, White, Non-Hispanic males have a rate of 29.4 deaths per 100,000—slightly higher than the statewide figure of 28.4 but below Davidson's 40.9, Johnston's 35.9, and Randolph's 34.3. Among White, Non-Hispanic females, Alamance's rate (40.8) is just under the North Carolina average of 42.8 and notably lower than Davidson's 58.6 and Johnston's 51.3. Data for African American, Non-Hispanic males in Alamance are suppressed; however, African American, Non-Hispanic females in Alamance register 48.3—above both the statewide rate of 40.8 and Johnston's 37.3, yet below Davidson's 72.5. No figures appear for other racial or ethnic groups in Alamance specifically, but the state-level rates for American Indian, Asian, and Hispanic populations reveal wide variations that underscore the importance of examining Alzheimer's Disease mortality at the intersection of race, gender, and geography.

Diabetes Mellitis

2018- 2022 DIABETES MELLITIS: UNADJUSTED DEATH RATES PER 100,000 POPULATION

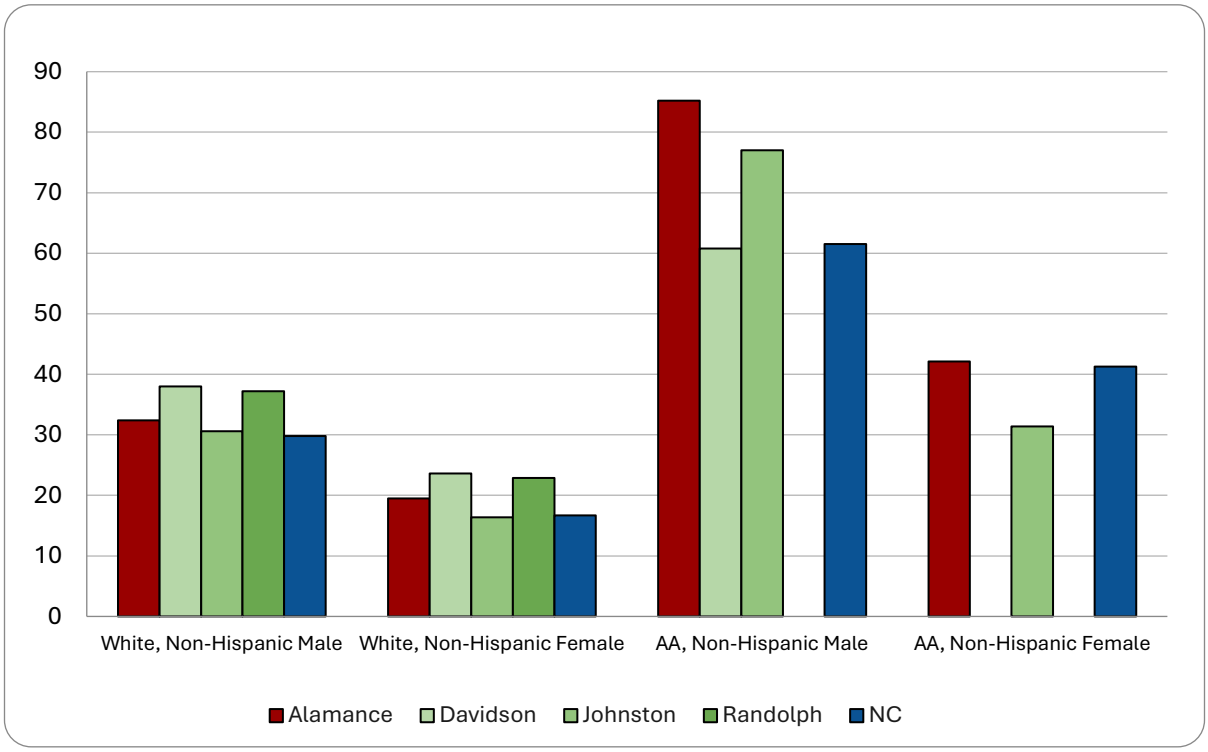


Source: North Carolina Department of Health and Human Services, State Center for Health Statistics. (2024). North Carolina health statistics data book. Retrieved January 14, 2025, from https://schs.dph.ncdhhs.gov/data/databook/

Diabetes mellitus is the 8th leading cause of death in Alamance County. This condition results from the body's inability to produce or use insulin effectively, leading to high blood sugar levels that can damage organs, blood vessels, and nerves over time. It includes both Type 1 (often diagnosed in childhood) and Type 2 (commonly linked to lifestyle factors), though the causes and risk factors vary between individuals.

In Alamance County, 329 residents died from diabetes mellitus, yielding a rate of 38.3 per 100,000 population, which is about 15 percent higher than the statewide rate of 33.2. Compared to peer counties, Alamance's rate is slightly below Davidson's 41.3 and Randolph's 38.9, while notably exceeding Johnston's 27.0. These figures underscore that diabetes mortality rates vary within the region, reflecting both differences in population health and disease management practices.

2018-2022 DIABETES MELLITIS: RACE/ETHNICITY AND SEX-SPECIFIC AGE-ADJUSTED DEATH RATES



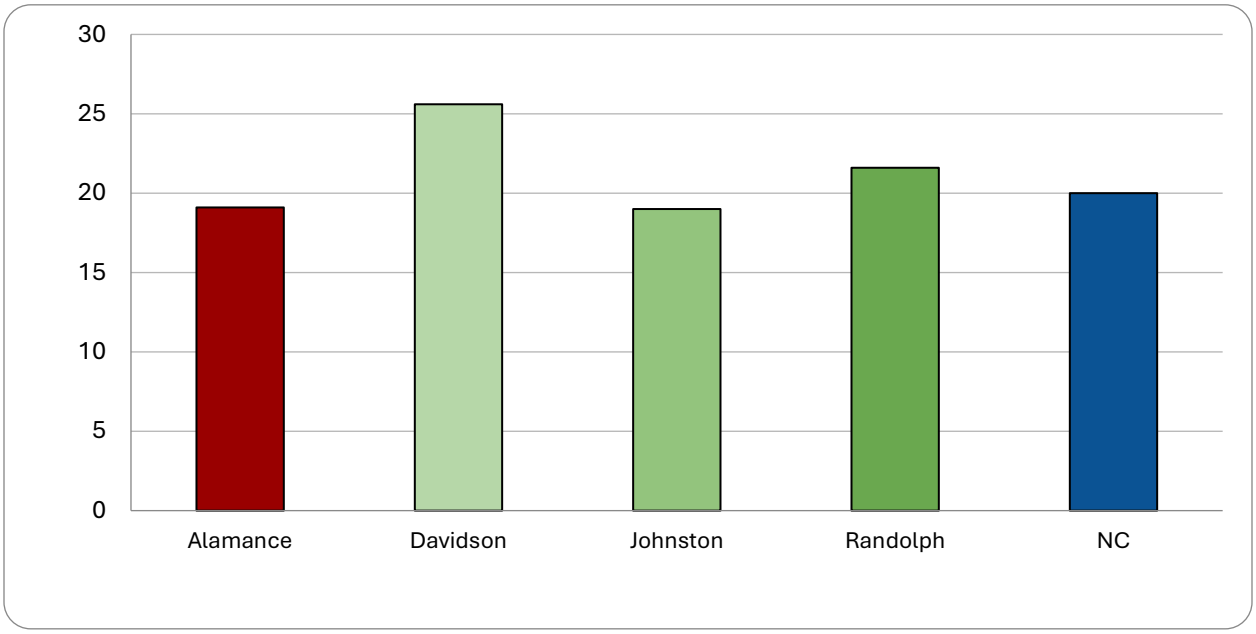
Source: North Carolina Department of Health and Human Services, State Center for Health Statistics. (2024). North Carolina health statistics data book. Retrieved January 14, 2025, from https://schs.dph.ncdhhs.gov/data/databook/

Diabetes death rates in Alamance County reveal major differences between racial groups, especially between African American (AA), Non-Hispanic males and White, Non-Hispanic males. The rate for AA males is 85.2 per 100,000—more than 2.5 times higher than the rate for White males, which is 32.4. This gap is much larger than the statewide difference, where the rate for AA males is 61.5 compared to 29.8 for White males. The rate for AA males in Alamance is also much higher than the rates in nearby counties like Davidson (60.8) and Johnston (77.0).

For females, the racial gap is still large but less extreme. AA, Non-Hispanic females in Alamance have a diabetes death rate of 42.1, which is more than double the rate for White, Non-Hispanic females (19.5). This difference is similar to the statewide figures, where AA females have a rate of 41.3 compared to 16.7 for White females. Data from peer counties show similar patterns. For example, in Johnston County, the rate for AA females (31.4) is still much higher than for White females (16.4).

Nephritis, Nephrotic Syndrome, & Nephrosis

2018- 2022 NEPHRITIS, NEPHROTIC SYNDROME, & NEPHROSIS: UNADJUSTED DEATH RATES PER 100,000 POPULATION

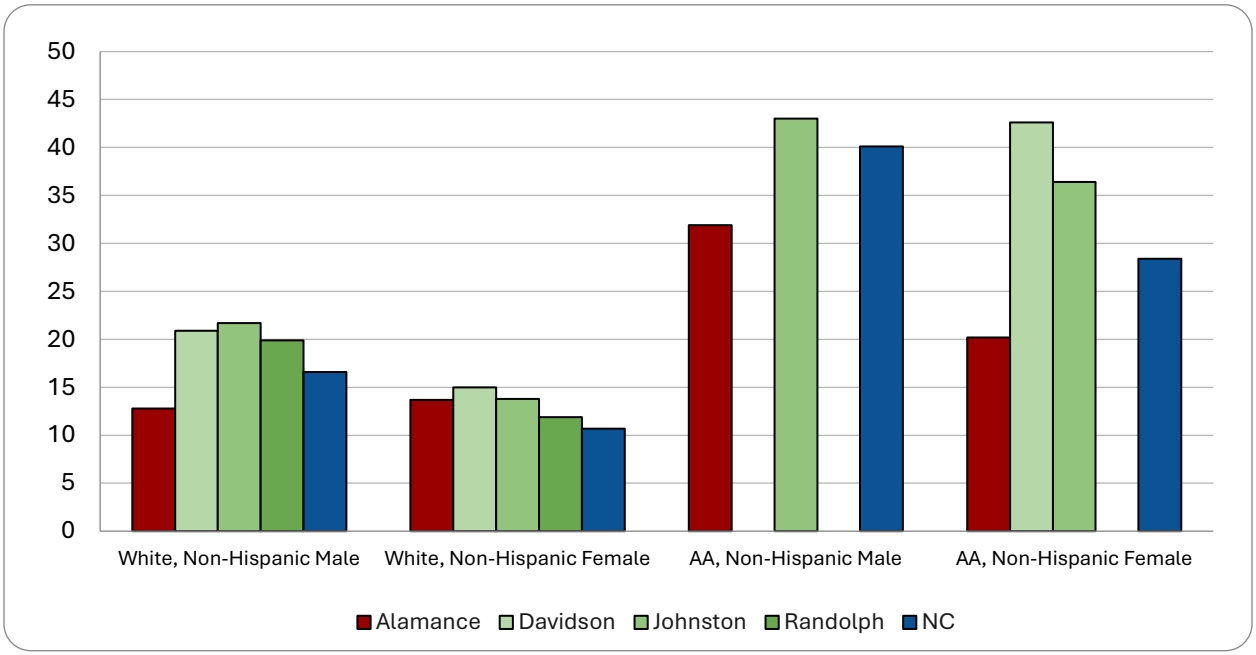


Source: North Carolina Department of Health and Human Services, State Center for Health Statistics. (2024). North Carolina health statistics data book. Retrieved January 14, 2025, from https://schs.dph.ncdhhs.gov/data/databook/

Nephritis, nephrotic syndrome, and nephrosis is the 9th leading cause of death in Alamance County. These conditions involve kidney inflammation or damage to the tiny filtering units within the kidneys, which can lead to chronic kidney disease and potentially progress to kidney failure over time.

In Alamance County, these kidney-related disorders claimed 164 lives, giving a death rate of 19.1 per 100,000 residents—slightly lower than the North Carolina rate of 20.0. When compared to peer counties, Alamance's rate is close to Johnston's 19.0 but lower than Randolph's 21.6 and Davidson's 25.6. This highlights that, while Alamance remains near the statewide average, neighboring counties see variations in mortality from these kidney conditions.

2018-2022 NEPHRITIS, NEPHROTIC SYNDROME, & NEPHROSIS: RACE/ETHNICITY AND SEX-SPECIFIC AGE-ADJUSTED DEATH RATES



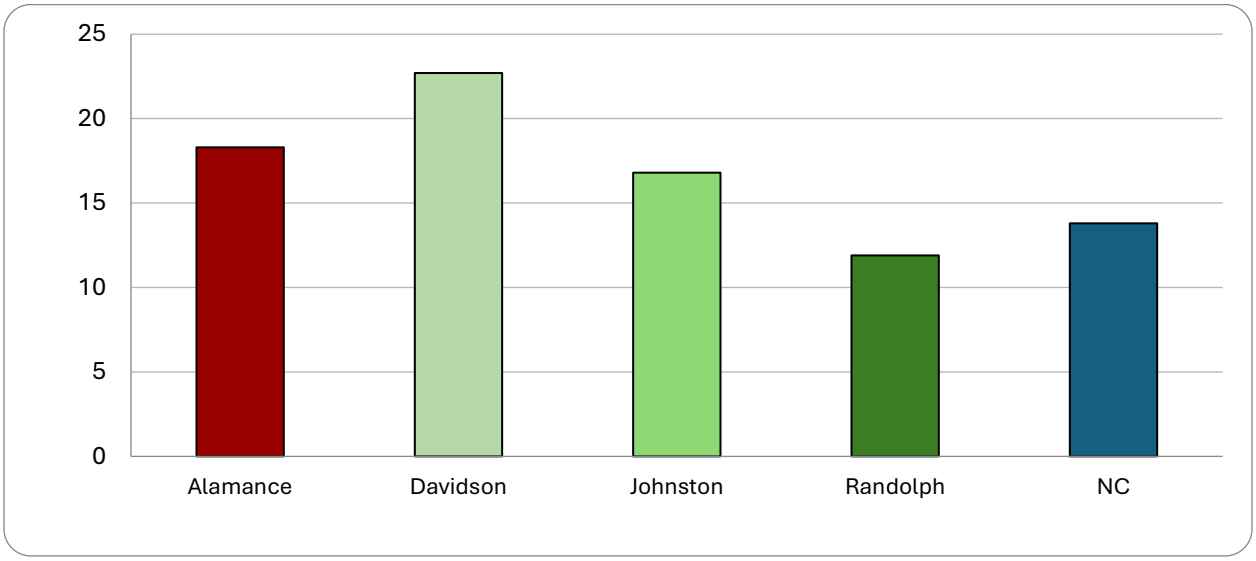
Source: North Carolina Department of Health and Human Services, State Center for Health Statistics. (2024). North Carolina health statistics data book. Retrieved January 14, 2025, from https://schs.dph.ncdhhs.gov/data/databook/

In Alamance County, the mortality rates for kidney diseases, which include nephritis, nephrotic syndrome, and nephrosis, vary significantly across different racial and gender groups. African American (AA), Non-Hispanic males have a rate of 31.9 deaths per 100,000—about 2.5 times higher than the rate for White, Non-Hispanic males (12.8). This disparity is consistent with statewide data, where AA males face a rate of 40.1, compared to 16.6 for White males. The gap is also seen in nearby counties like Johnston, where AA males have a much higher rate of 43.0 compared to 21.7 for White males.

Among females, AA, Non-Hispanic females in Alamance have a rate of 20.2 per 100,000, nearly 50% higher than the rate for White, Non-Hispanic females (13.7). This trend mirrors state figures, where AA females have a rate of 28.4 compared to 10.7 for White females. The differences are even more pronounced in counties like Davidson, where AA females experience a rate of 42.6, far surpassing the rate for White females (15.0).

Pneumonia & Influenza

2018- 2022 PNEUMONIA & INFLUENZA: UNADJUSTED DEATH RATES PER 100,000 POPULATION

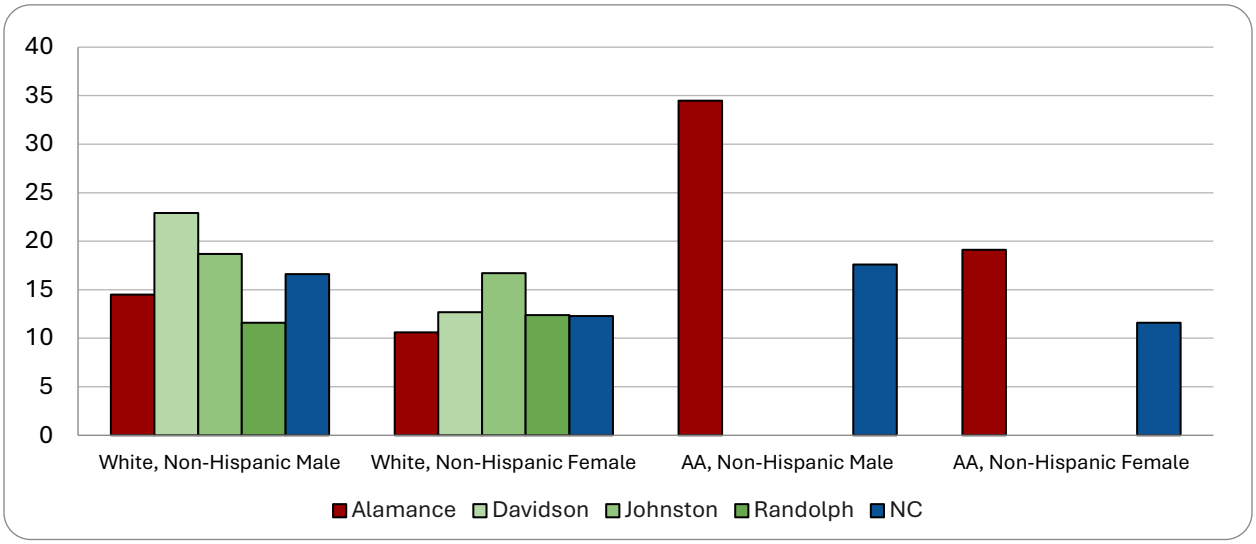


Source: North Carolina Department of Health and Human Services, State Center for Health Statistics. (2024). North Carolina health statistics data book. Retrieved January 14, 2025, from https://schs.dph.ncdhhs.gov/data/databook/

Pneumonia and influenza is the 10th leading cause of death in Alamance County. This category encompasses infectious respiratory illnesses that can be especially serious for older adults, individuals with underlying health conditions, or those with compromised immune systems.

In Alamance County, pneumonia and influenza led to 157 deaths, giving a death rate of 18.3 per 100,000 residents—about 33 percent higher than the North Carolina rate of 13.8. When compared to neighboring counties, Alamance's rate is lower than Davidson's 22.7 but exceeds Johnston's 16.8 and Randolph's 11.9. These data illustrate how pneumonia and influenza mortality rates differ across the region, with Alamance falling in the mid-range among its peers.

2018-2022 PNEUMONIA & INFLUENZA: RACE/ETHNICITY AND SEX-SPECIFIC AGE-ADJUSTED DEATH RATES



Source: North Carolina Department of Health and Human Services, State Center for Health Statistics. (2024). North Carolina health statistics data book. Retrieved January 14, 2025, from https://schs.dph.ncdhhs.gov/data/databook/

The mortality rates for pneumonia and influenza in Alamance County highlight significant disparities, particularly between African American (AA), Non-Hispanic males and White, Non-Hispanic males. AA males have a mortality rate of 34.5 per 100,000—more than double the rate for White males (14.5). This gap is far greater than the statewide difference, where the rates for AA and White males are much closer at 17.6 and 16.6, respectively. Nearby counties do not provide data for AA males, but White male rates vary, such as 22.9 in Davidson and 11.6 in Randolph.

Among females, similar patterns appear. AA, Non-Hispanic females in Alamance experience a mortality rate of 19.1, nearly double the rate for White, Non-Hispanic females (10.6). This difference is also more pronounced than the statewide rates, where AA females have a rate of 11.6 and White females 12.3. Peer counties show varying rates for White females, with 12.7 in Davidson and 16.7 in Johnston, though AA female rates are not reported for these counties.

County Health Rankings

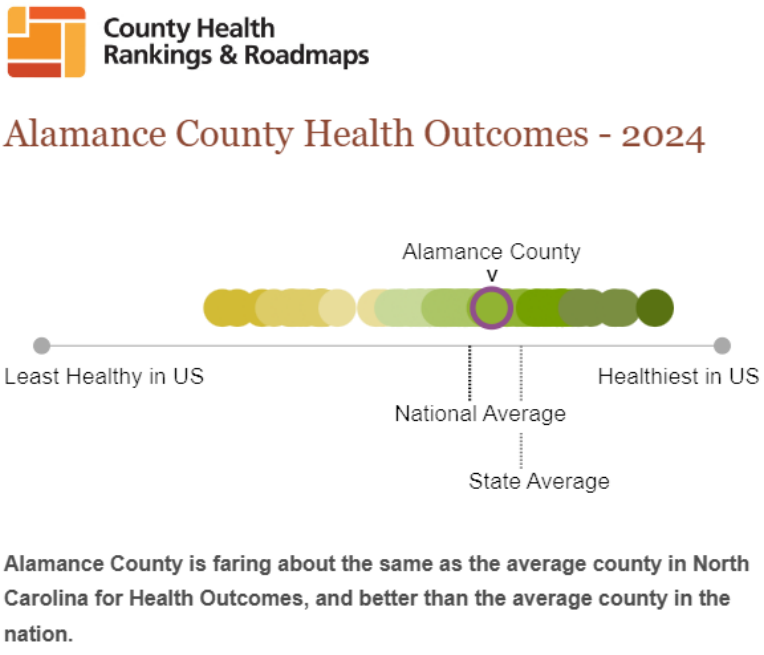
Introduction to County Health Rankings

The county health rankings, produced annually by the Robert Wood Johnson Foundation and the University of Wisconsin Population Health Institute, provide a comprehensive overview of health outcomes and health factors for counties across the United States. These rankings serve as a tool for understanding the multifaceted influences on community health, from clinical care to socioeconomic conditions and physical environments. By comparing counties within states and across the nation, the rankings aim to identify strengths and challenges, guiding local initiatives to improve health outcomes and promote health equality.

Health Outcomes: Alamance County's Performance

Health outcomes, a key component of the county health rankings, reflect how long people live (length of life) and how healthy people feel while alive (quality of life). This category includes metrics such as premature death rates, self-reported health status, and rates of low birthweight.

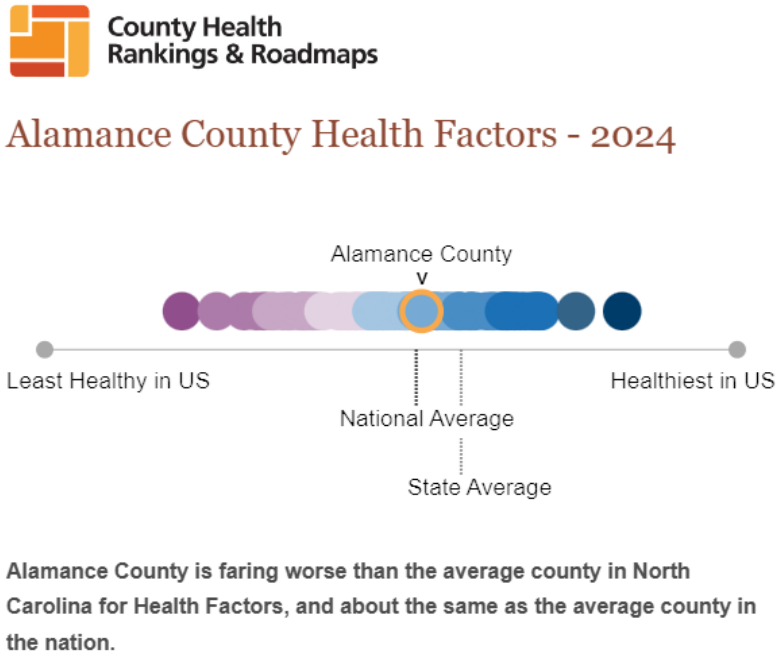
Alamance County performs roughly average in this category. It scores slightly worse than the average North Carolina county, reflecting challenges shared by other areas in the state. However, it performs slightly better than the average county nationwide, indicating some relative strengths in addressing community health issues.



Health Factors

Health factors assess the conditions that influence health outcomes, including health behaviors, clinical care, social and economic factors, and physical environment. This category captures metrics such as access to care, educational attainment, employment, and housing stability.

Alamance County performs worse than the average county in North Carolina across many of these factors. However, its performance aligns closely with the average county in the United States. This suggests that while the county faces challenges, these align with broader national trends and reflect areas for targeted improvement.

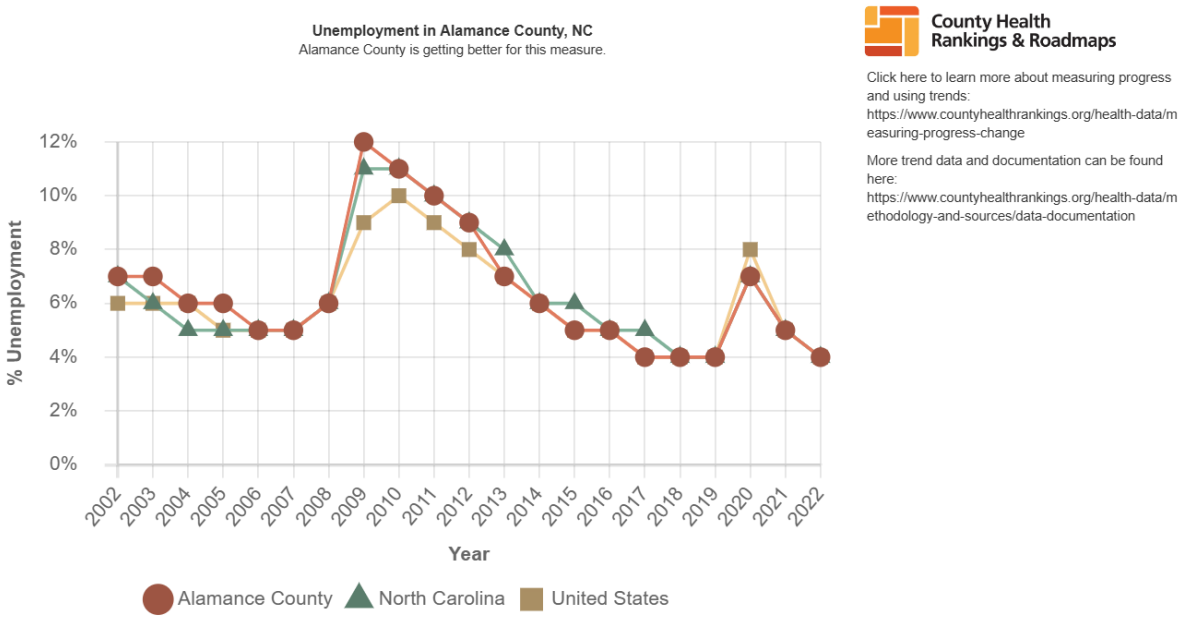


Exploring Trends

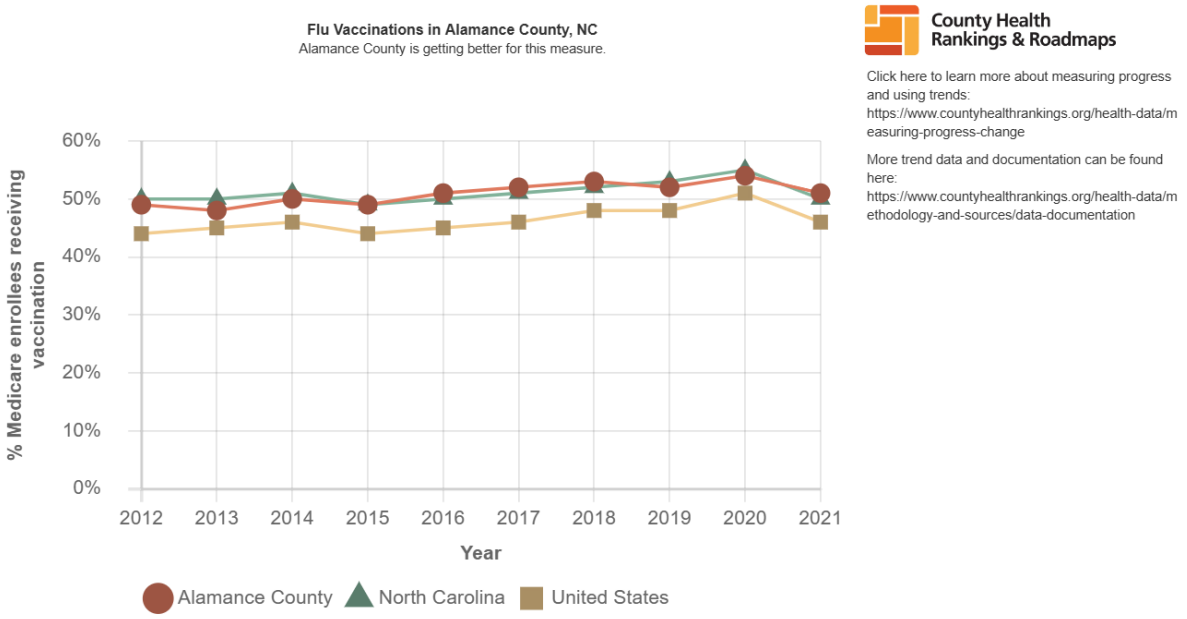
A deeper look at the data reveals trends in which Alamance County has shown improvement over time and areas where the county is facing new or worsening challenges.

Improving Trends

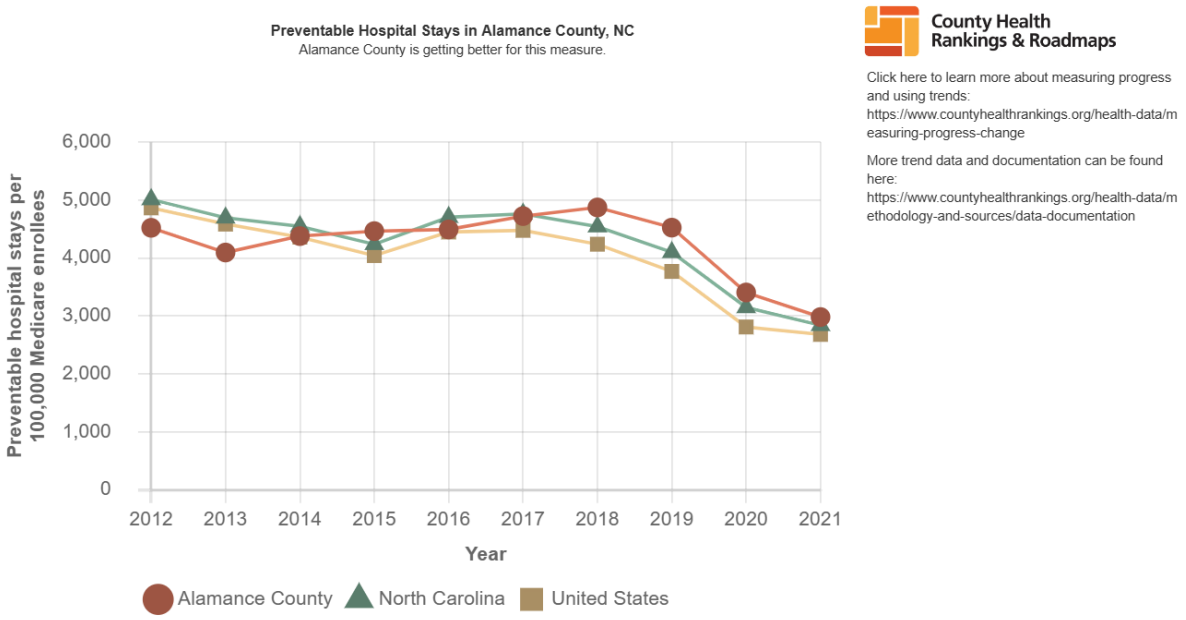
1. **Unemployment**: Unemployment rates have returned to pre-COVID levels, consistent with state and national trends, reaching some of the lowest levels in the past two decades. This indicates economic recovery and stabilization.



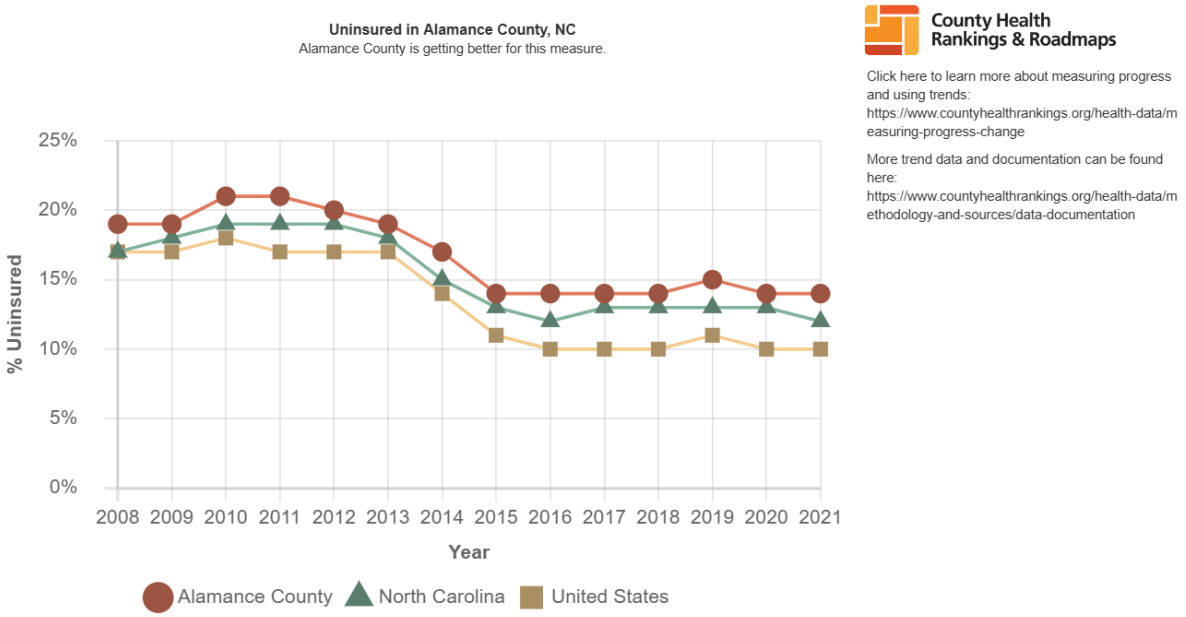
2. **Flu Vaccinations**: The percentage of residents receiving flu vaccinations has gradually increased over time, reflecting efforts to improve preventive care and public health outreach.

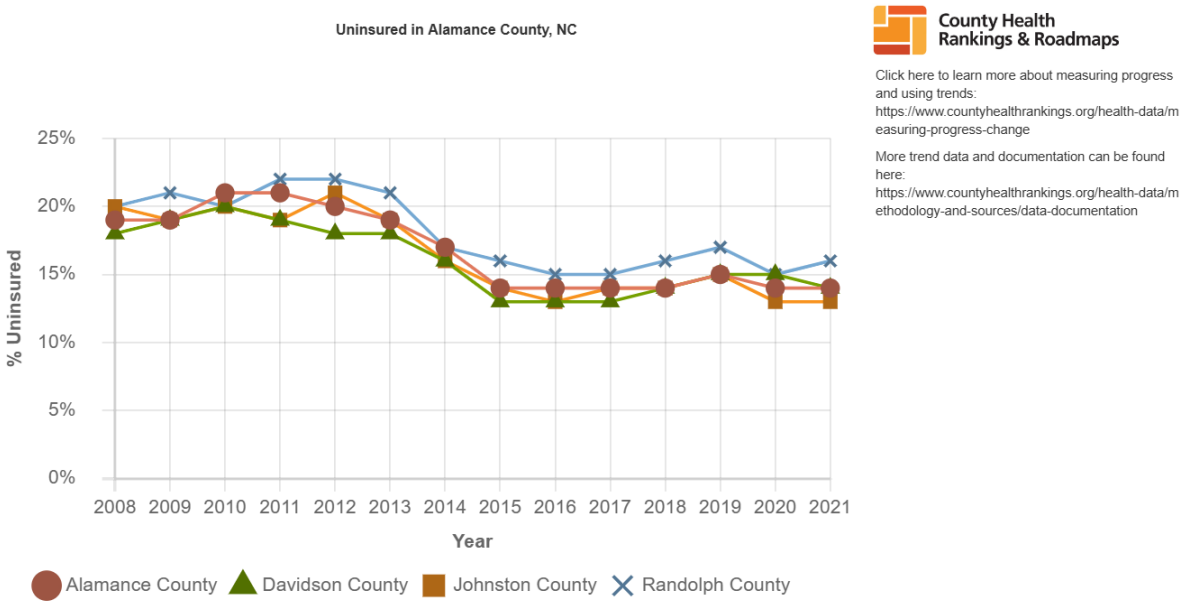


3. **Preventable Hospital Stays**: Preventable hospital stays have decreased by approximately 39% since 2018, suggesting improvements in outpatient care management and preventive services.

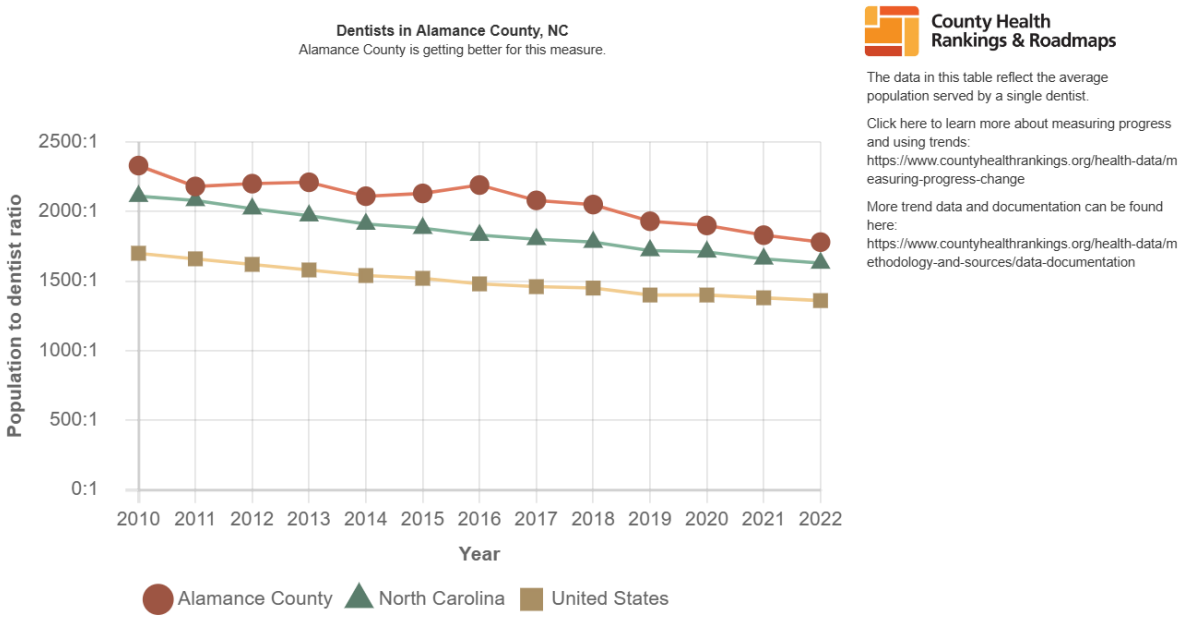


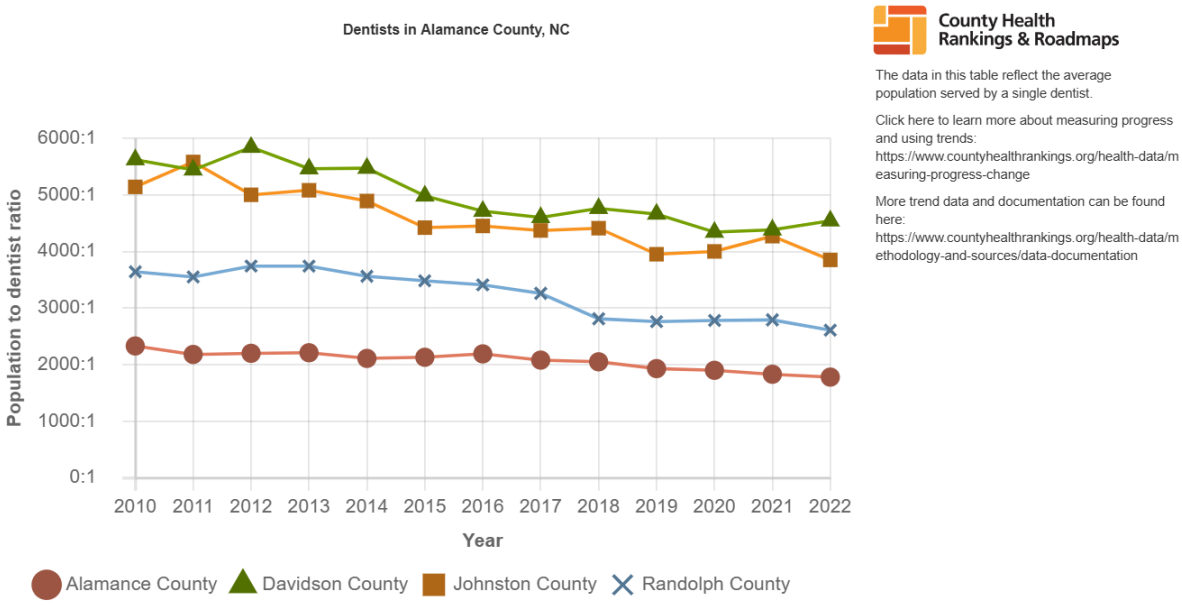
4. **Uninsured Population**: The percentage of uninsured residents dropped significantly following the implementation of the Affordable Care Act (ACA) and has remained stable at around 14% since 2015. Similar trends are seen in the peer counties, the state, and the nation.





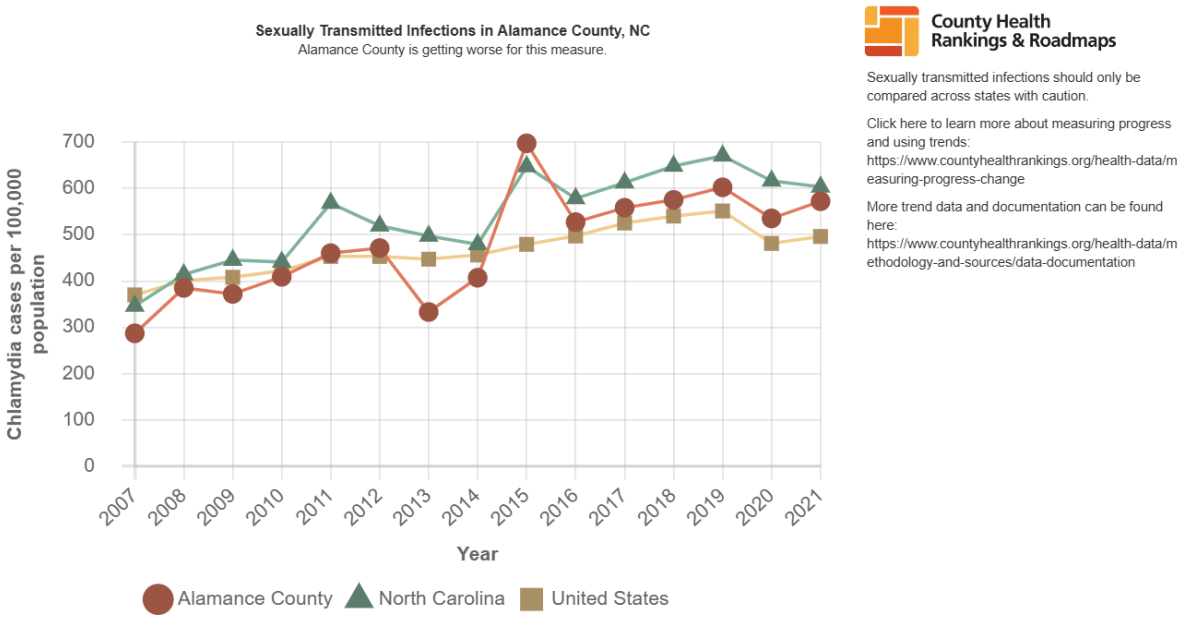
5. **Access to Dental Providers**: Access to dental care has shown incremental improvement over the past 12 years, indicating better resource availability in this area. Alamance has a much lower ratio of population to dentists than its peer counties, though still higher than the state and national averages.

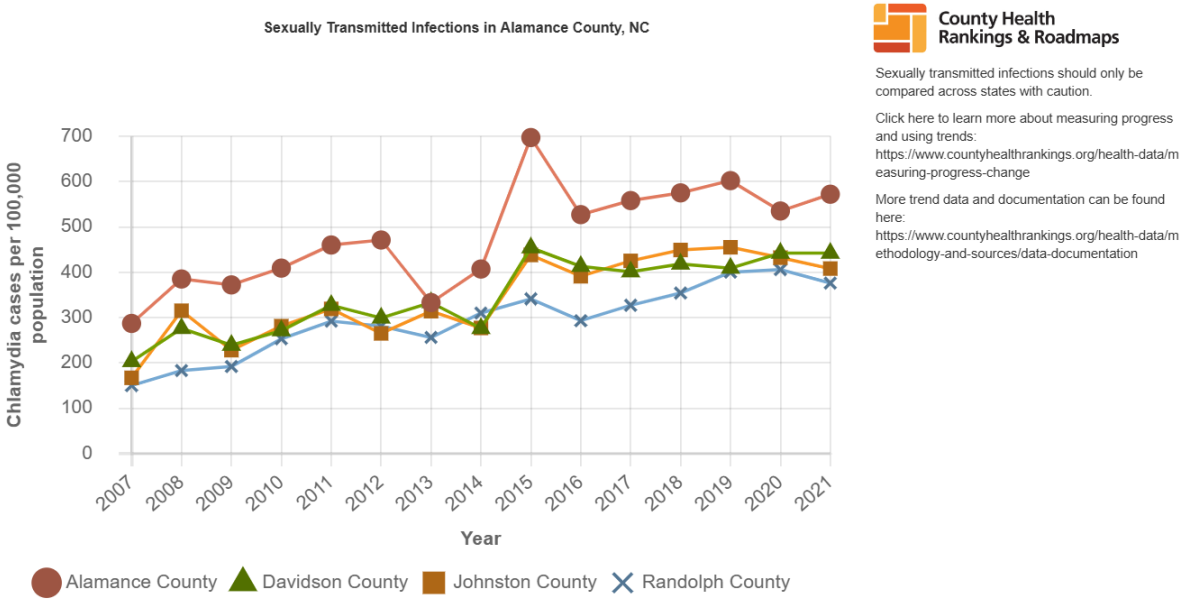




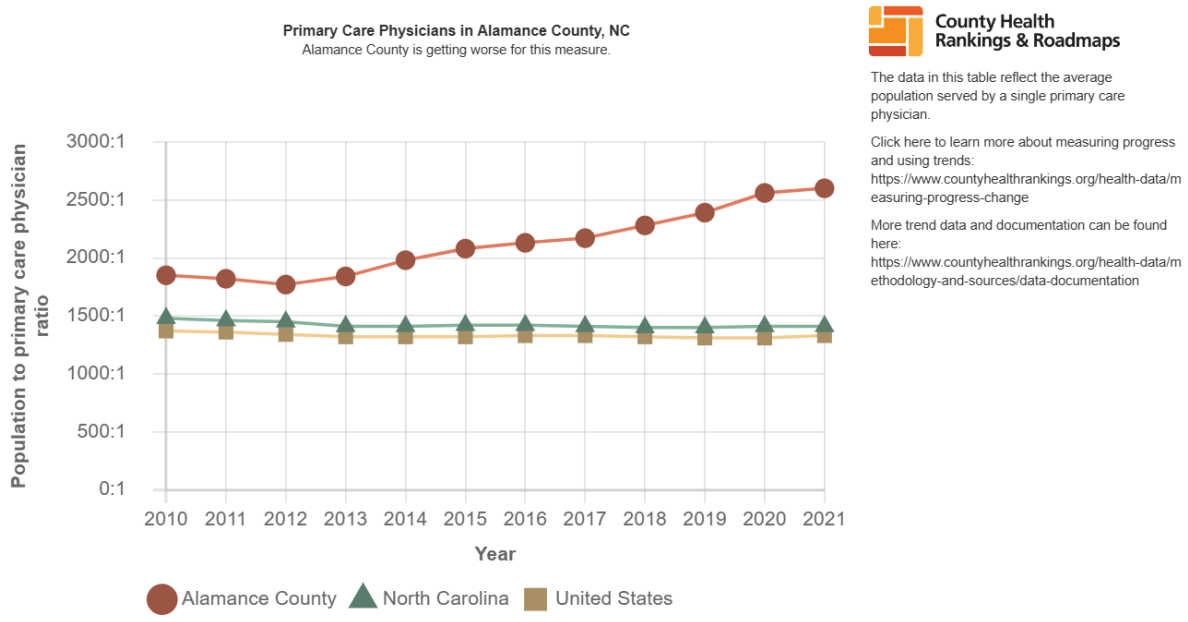
Worsening Trends

1. **Sexually Transmitted Infections (STIs)**: Rates of chlamydia (cases per 100,000) have nearly doubled since 2013, reflecting a significant rise in STI prevalence and potential gaps in sexual health education and services. Compared to peer counties, chlamydia rates in Alamance County are approximately 40% higher in recent years.





2. **Access to Primary Care Physicians**: The ratio of population to primary care providers has steadily worsened over the past decade, increasing from 1,770:1 in 2012 to 2,600:1 in 2021—an increase of nearly 47%. This trend indicates growing challenges in healthcare access and workforce shortages affecting much of NC and certainly affecting peer counties similarly to Alamance.



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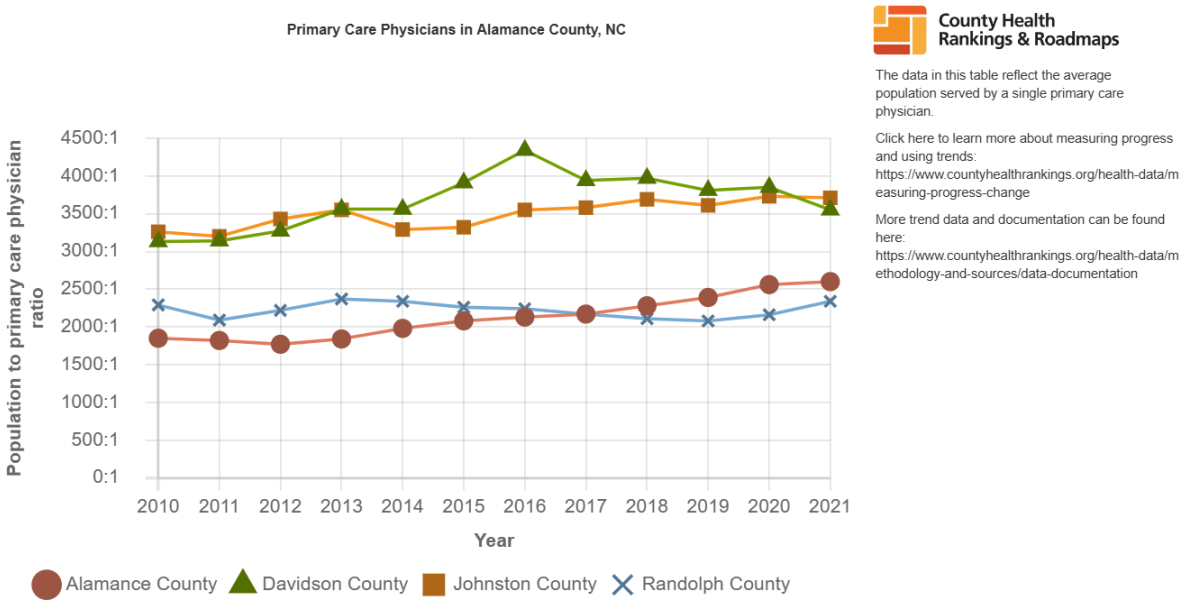


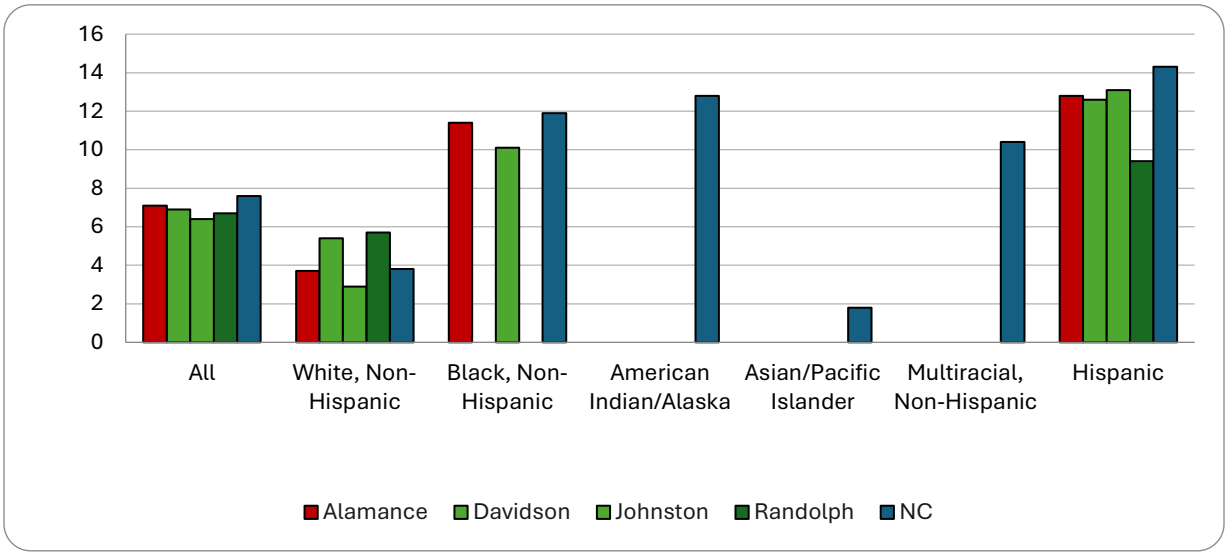
The county health rankings provide a valuable aggregation of secondary data, offering one lens through which to frame community health priorities and opportunities for improvement. While

not exhaustive, the data suggest potential areas of focus for Alamance County, including improving access to primary care physicians, addressing rising rates of sexually transmitted infections, and continuing progress in reducing preventable hospital stays and enhancing access to dental providers. These insights, while helpful, should be complemented by a broader assessment of other secondary data sources and health indicators to ensure a comprehensive understanding of community needs.

Appendix

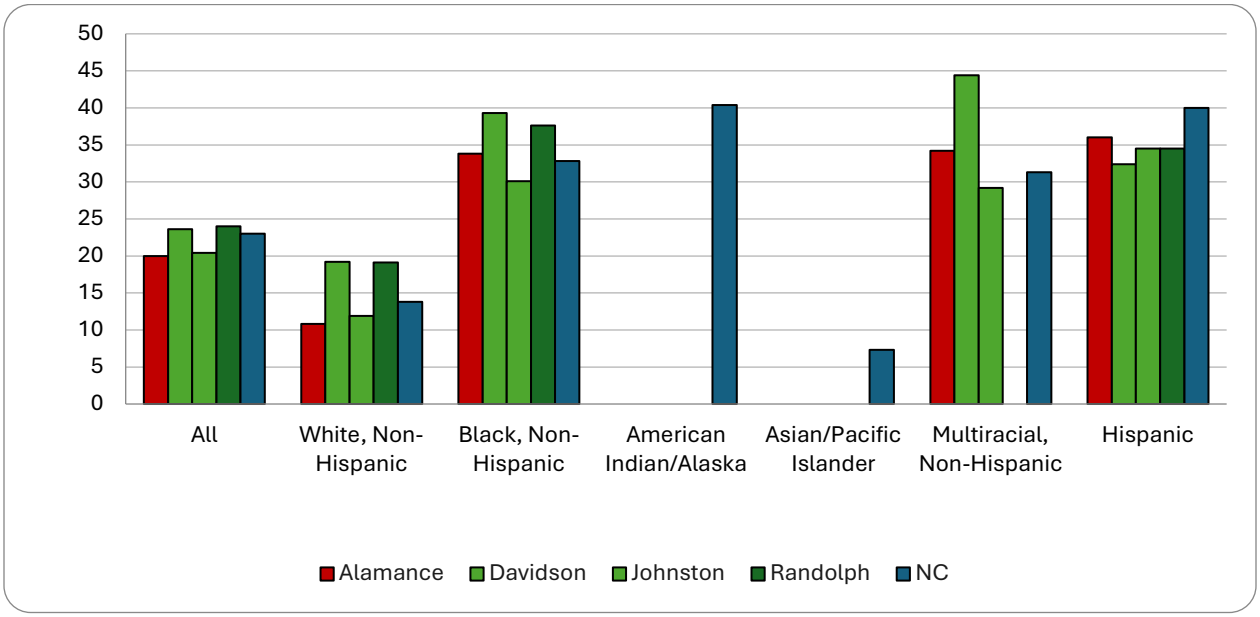
Live Births / Death Rates

2018-2022 NC RESIDENT PREGNANCY RATES PER 1,000 POPULATION: FEMALES 15-17 BY RACE/ETHNICITY, PERINATAL CARE REGIONS, AND COUNTY OF RESIDENCE



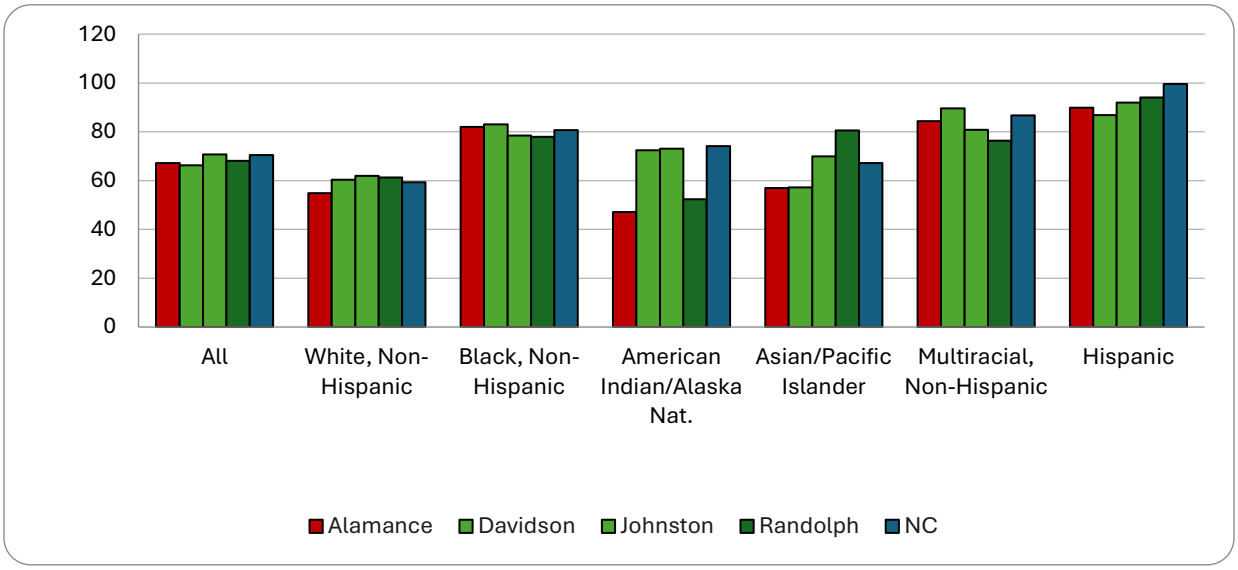
Source: North Carolina Department of Health and Human Services, State Center for Health Statistics. (2024). North Carolina health statistics data book. Retrieved January 14, 2025, from https://schs.dph.ncdhhs.gov/data/databook/

2018-2022 NC RESIDENT PREGNANCY RATES PER 1,000 POPULATION: FEMALES 15-44 BY RACE/ETHNICITY, PERINATAL CARE REGIONS, AND COUNTY OF RESIDENCE



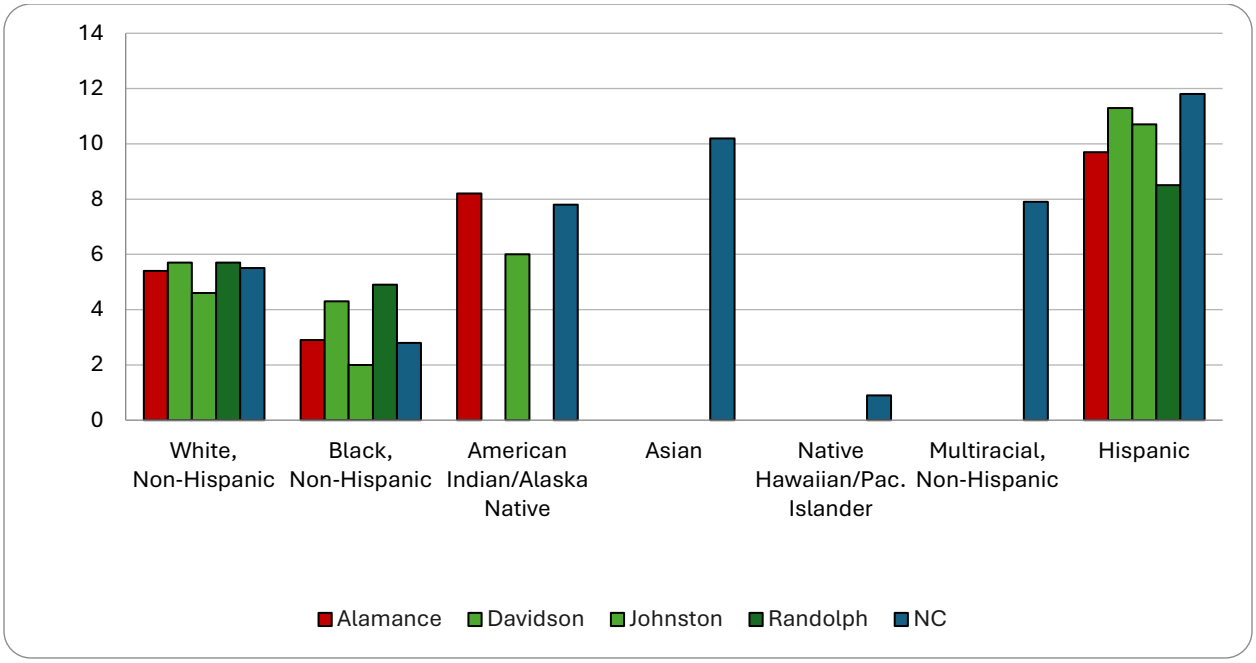
Source: North Carolina Department of Health and Human Services, State Center for Health Statistics. (2024). North Carolina health statistics data book. Retrieved January 14, 2025, from https://schs.dph.ncdhhs.gov/data/databook/

2018-2022 NC RESIDENT PREGNANCY RATES PER 1,000 POPULATION: FEMALES 15-44 BY RACE/ETHNICITY, PERINATAL CARE REGIONS, AND COUNTY OF RESIDENCE



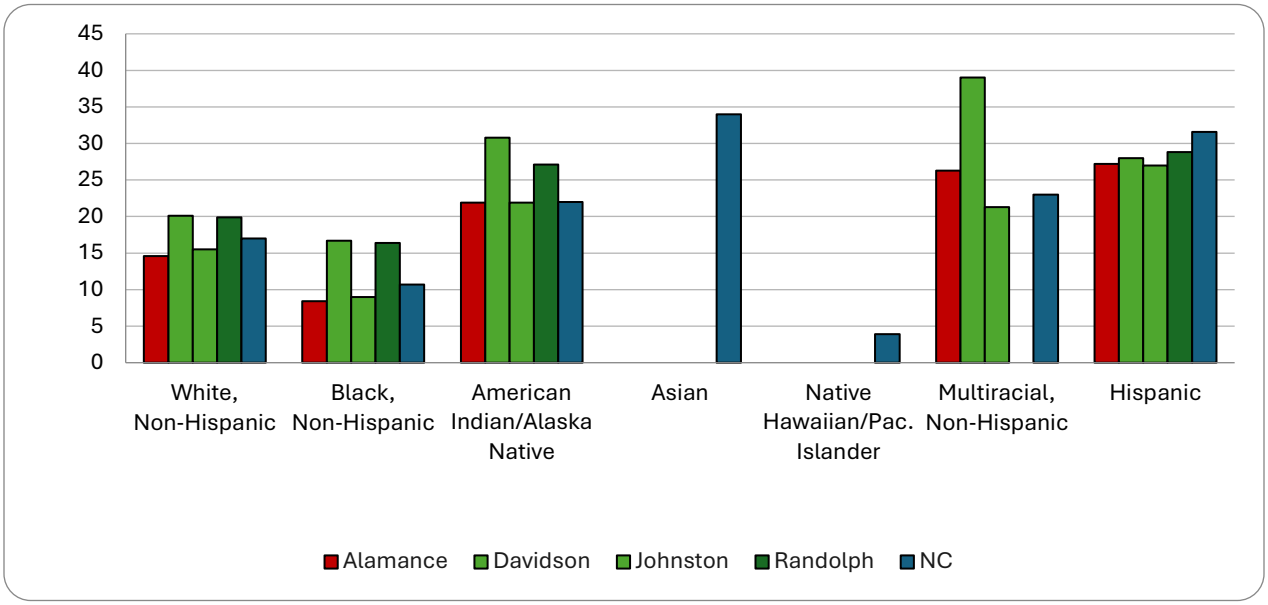
Source: North Carolina Department of Health and Human Services, State Center for Health Statistics. (2024). North Carolina health statistics data book. Retrieved January 14, 2025, from https://schs.dph.ncdhhs.gov/data/databook/

2018-2022 NC RESIDENT FERTILITY RATES PER 1,000 POPULATION: FEMALES 15-17 BY RACE/ETHNICITY, PERINATAL CARE REGIONS, AND COUNTY OF RESIDENCE



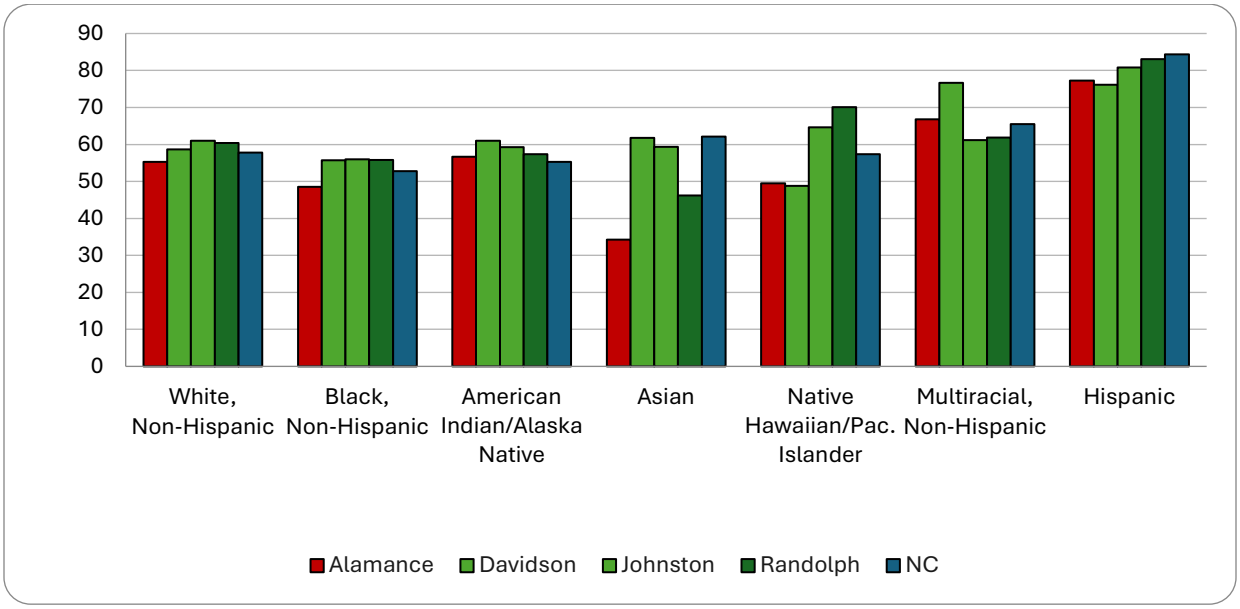
Source: North Carolina Department of Health and Human Services, State Center for Health Statistics. (2024). North Carolina health statistics data book. Retrieved January 14, 2025, from https://schs.dph.ncdhhs.gov/data/databook/

2018-2022 NC RESIDENT FERTILITY RATES PER 1,000 POPULATION: FEMALES 15-19 BY RACE/ETHNICITY, PERINATAL CARE REGIONS, AND COUNTY OF RESIDENCE



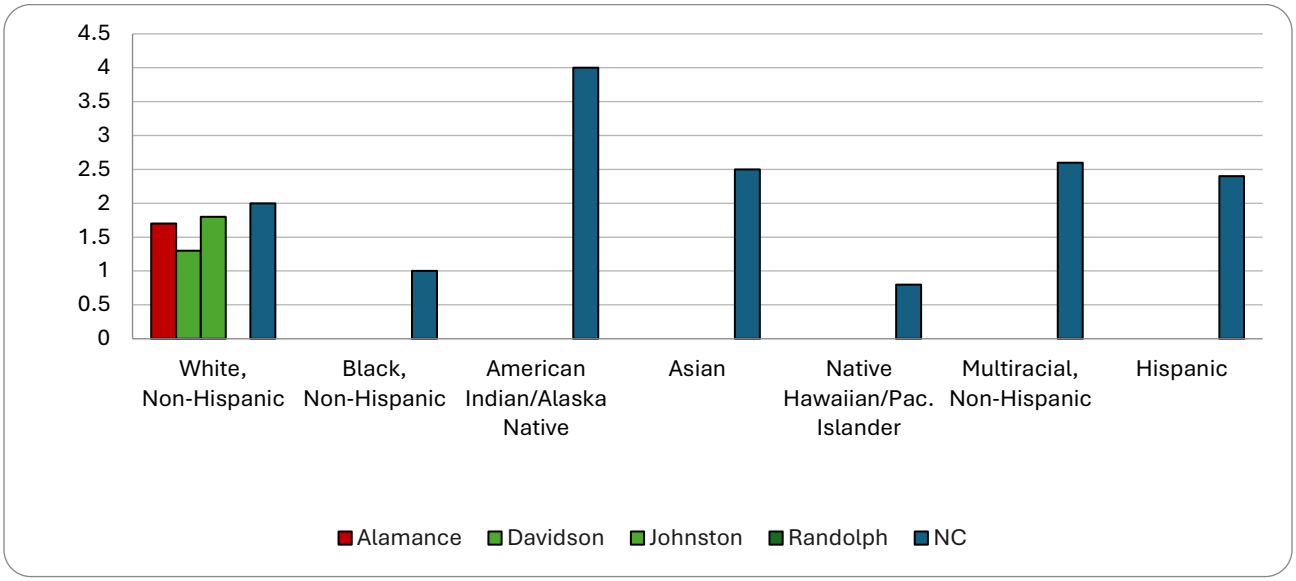
Source: North Carolina Department of Health and Human Services, State Center for Health Statistics. (2024). North Carolina health statistics data book. Retrieved January 14, 2025, from https://schs.dph.ncdhhs.gov/data/databook/

2018-2022 NC RESIDENT FERTILITY RATES PER 1,000 POPULATION: FEMALES 15-44 BY RACE/ETHNICITY, PERINATAL CARE REGIONS, AND COUNTY OF RESIDENCE



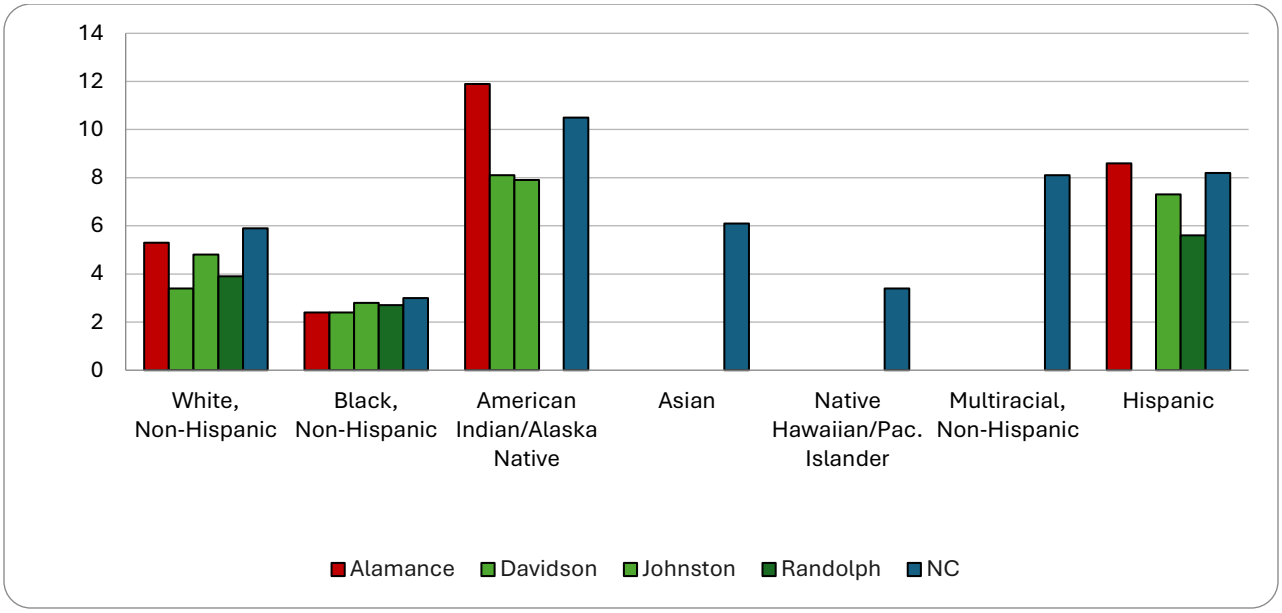
Source: North Carolina Department of Health and Human Services, State Center for Health Statistics. (2024). North Carolina health statistics data book. Retrieved January 14, 2025, from https://schs.dph.ncdhhs.gov/data/databook/

2018-2022 NC RESIDENT ABORTION RATES PER 1,000 POPULATION: FEMALES 15-17 BY RACE/ETHNICITY, PERINATAL CARE REGIONS, AND COUNTY OF RESIDENCE



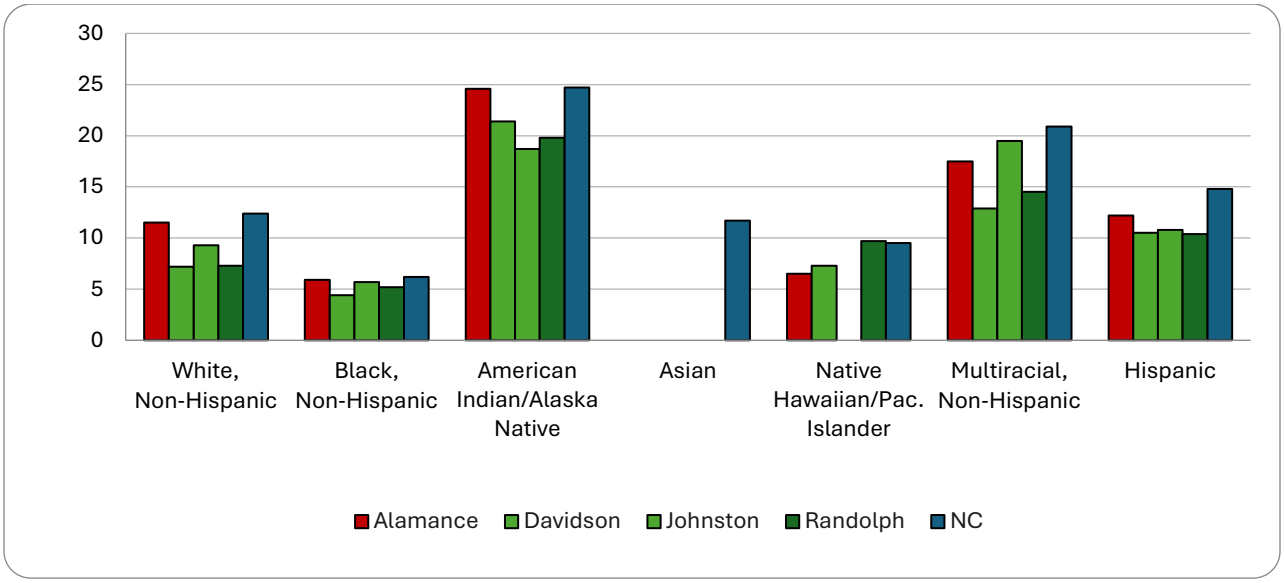
Source: North Carolina Department of Health and Human Services, State Center for Health Statistics. (2024). North Carolina health statistics data book. Retrieved January 14, 2025, from https://schs.dph.ncdhhs.gov/data/databook/

2018-2022 NC RESIDENT ABORTION RATES PER 1,000 POPULATION: FEMALES 15-19 BY RACE/ETHNICITY, PERINATAL CARE REGIONS, AND COUNTY OF RESIDENCE



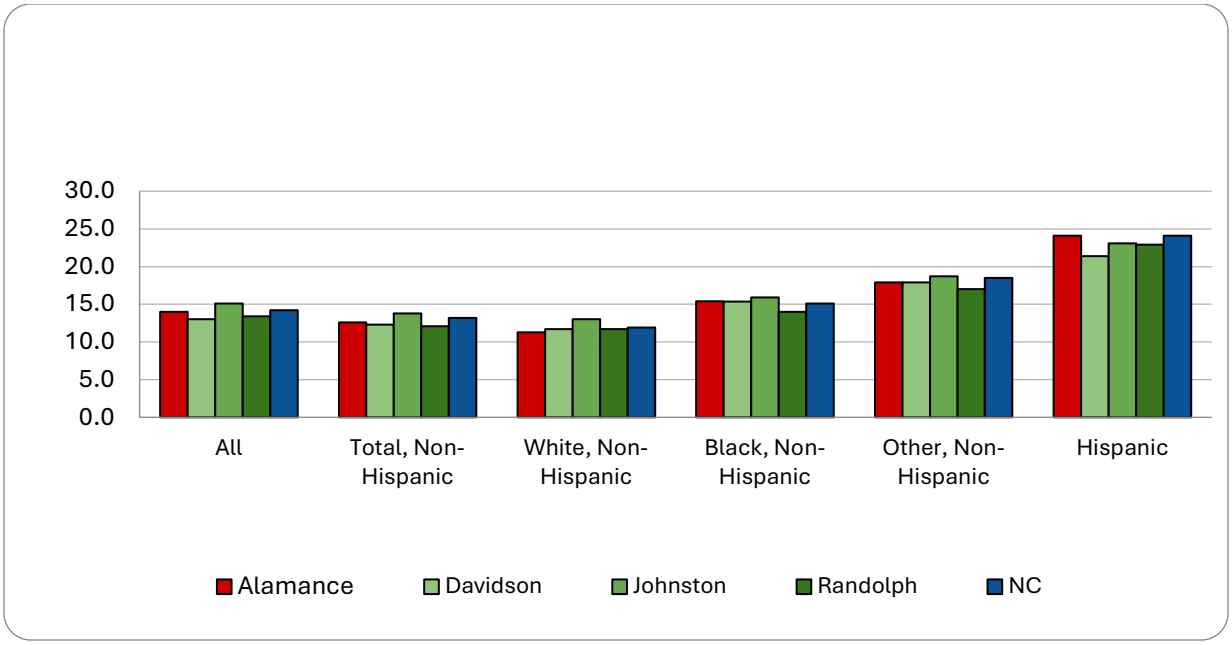
Source: North Carolina Department of Health and Human Services, State Center for Health Statistics. (2024). North Carolina health statistics data book. Retrieved January 14, 2025, from https://schs.dph.ncdhhs.gov/data/databook/

2018-2022 NC RESIDENT ABORTION RATES PER 1,000 POPULATION: FEMALES 15-19 BY RACE/ETHNICITY, PERINATAL CARE REGIONS, AND COUNTY OF RESIDENCE



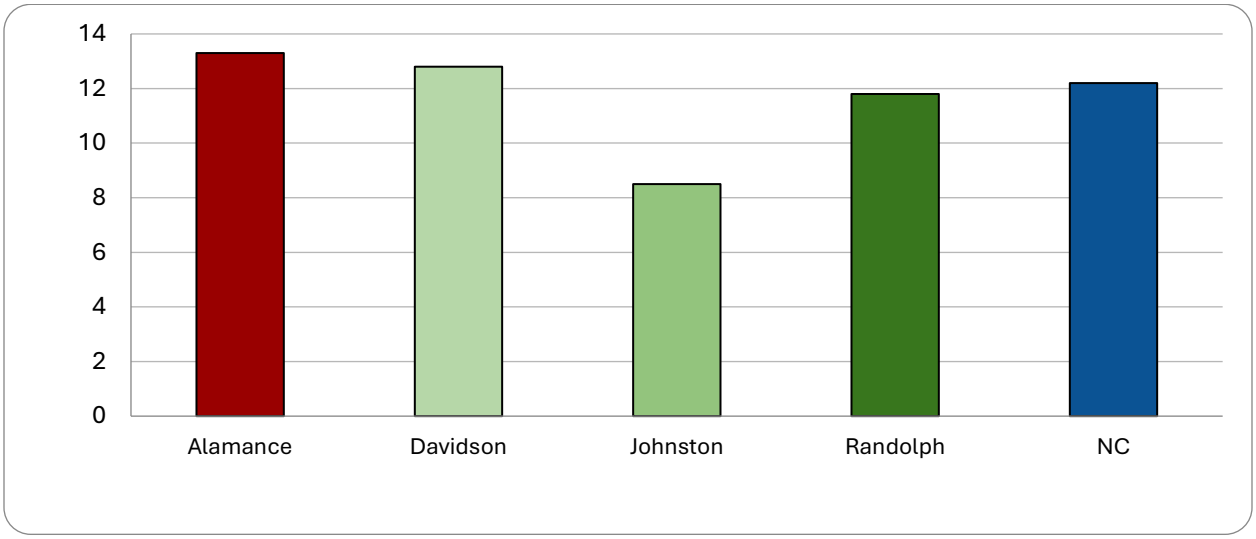
Source: North Carolina Department of Health and Human Services, State Center for Health Statistics. (2024). North Carolina health statistics data book. Retrieved January 14, 2025, from https://schs.dph.ncdhhs.gov/data/databook/

NORTH CAROLINA RESIDENT LIVE BIRTH RATES PER 1,000 POPULATION, 2018-2022



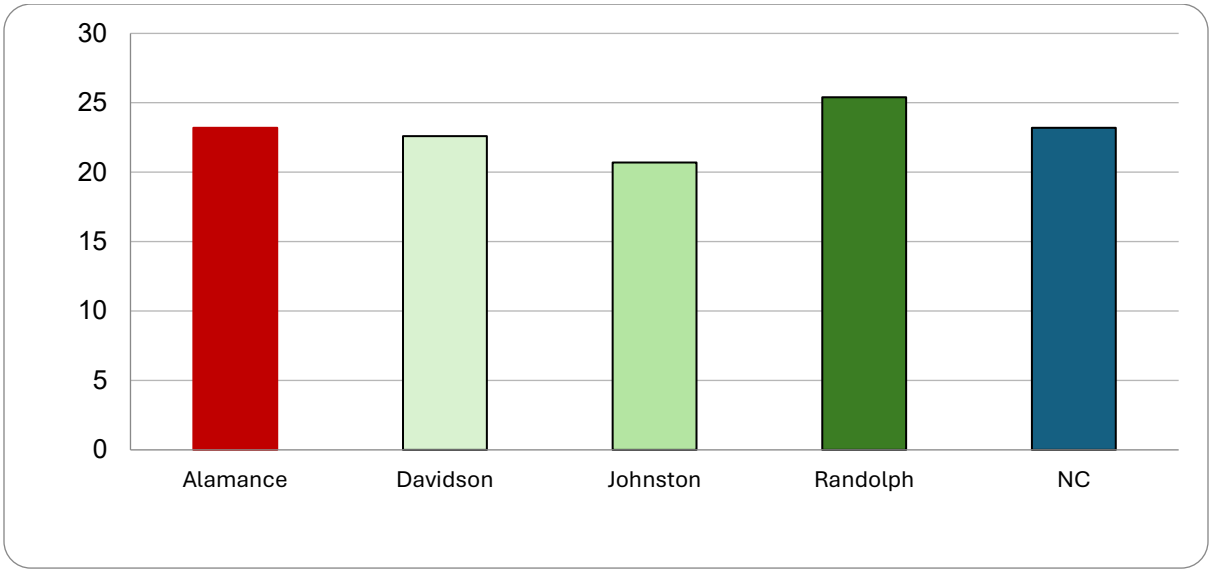
Source: North Carolina Department of Health and Human Services, State Center for Health Statistics. (2024). North Carolina health statistics data book. Retrieved January 14, 2025, from https://schs.dph.ncdhhs.gov/data/databook/

2018- 2022 N.C. RESIDENT LIVE BIRTHS WITH AGE OF MOTHER UNDER 30 BY COUNTY OF RESIDENCE: NUMBER AT RISK DUE TO HIGH PARITY AND PERCENT OF ALL BIRTHS WITH AGE OF MOTHER LESS THAN 30



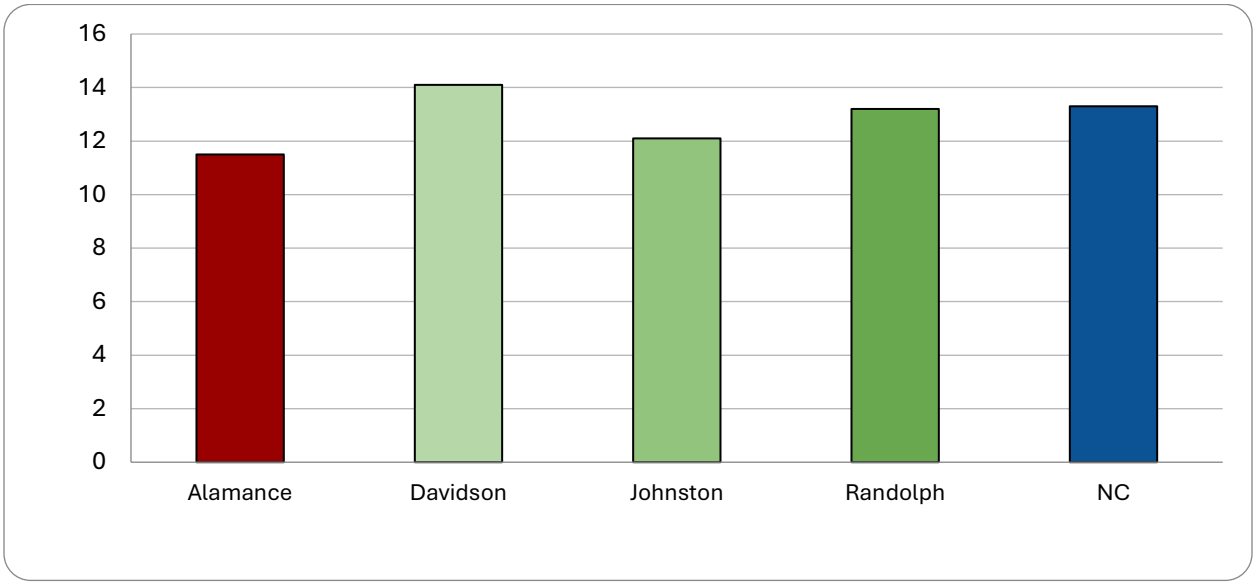
Source: North Carolina Department of Health and Human Services, State Center for Health Statistics. (2024). North Carolina health statistics data book. Retrieved January 14, 2025, from https://schs.dph.ncdhhs.gov/data/databook/

2018- 2022 N.C. RESIDENT LIVE BIRTHS WITH AGE OF MOTHER 30 or MORE BY COUNTY OF RESIDENCE: NUMBER AT RISK DUE TO HIG PARITY AND PERCENT OF ALL BIRTHS WITH AGE OF MOTHER 30 OR MORE



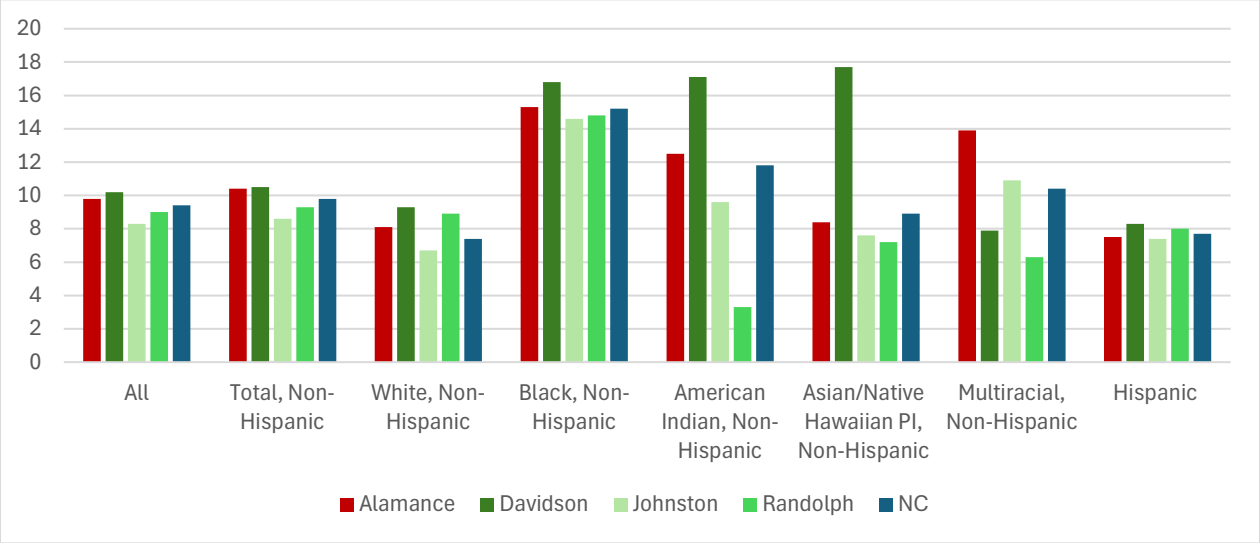
Source: North Carolina Department of Health and Human Services, State Center for Health Statistics. (2024). North Carolina health statistics data book. Retrieved January 14, 2025, from https://schs.dph.ncdhhs.gov/data/databook/

2018-2022 N.C. LIVE BIRTHS BY COUNTY OF RESIDENCE NUMBER WITH INTERVAL FROM LAST DELIVERY TO CONCEPTION OF SIX MONTHS OR LESS AND PERCENT OF ALL BIRTHS 1ST PREGANCIES



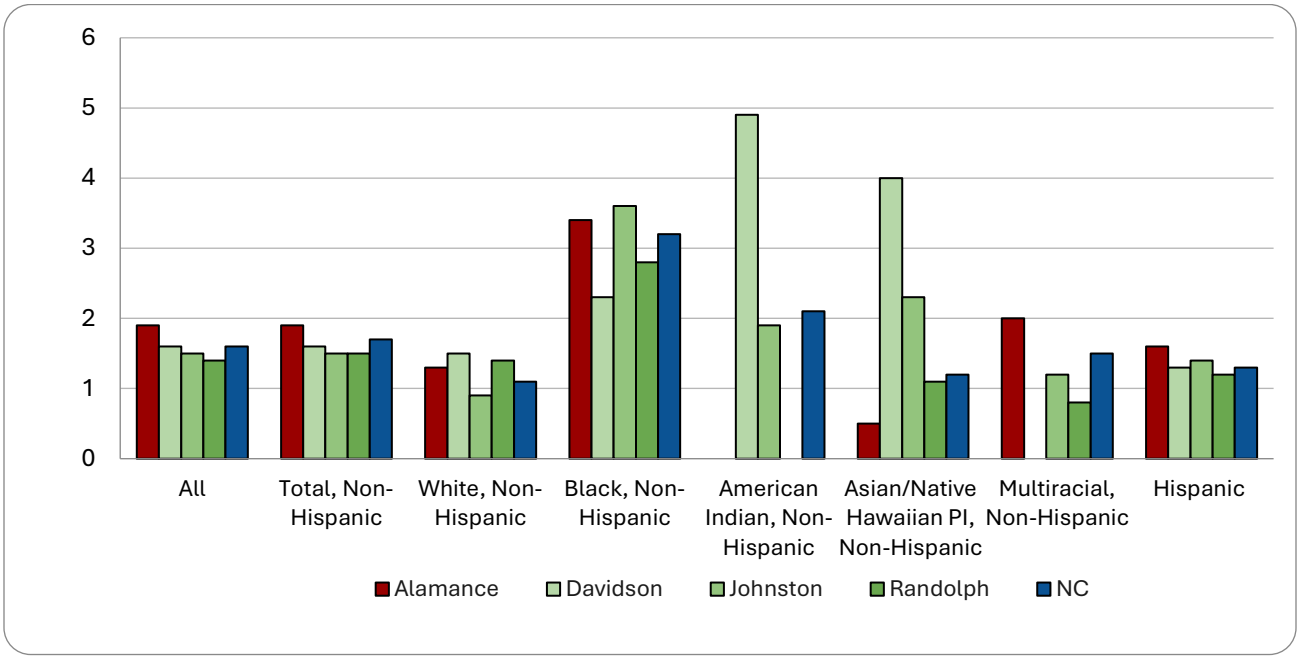
Source: North Carolina Department of Health and Human Services, State Center for Health Statistics. (2024). North Carolina health statistics data book. Retrieved January 14, 2025, from https://schs.dph.ncdhhs.gov/data/databook/

2018-2022 NORTH CAROLINA LIVE BIRTHS BY COUNTY OF RESIDENCE: NUMBER AND PERCENT LOW (<2500 GRAMS) WEIGHT BIRTHS BY RACE AND ETHNICITY



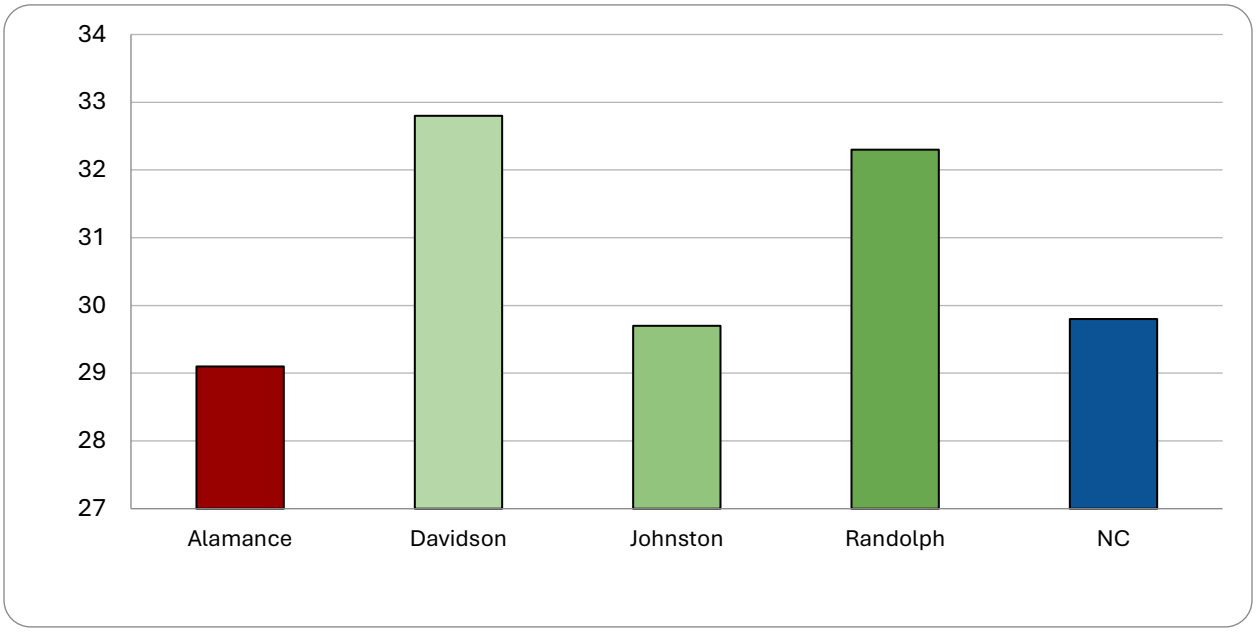
Source: North Carolina Department of Health and Human Services, State Center for Health Statistics. (2024). North Carolina health statistics data book. Retrieved January 14, 2025, from https://schs.dph.ncdhhs.gov/data/databook/

2018-2022 NORTH CAROLINA LIVE BIRTHS BY COUNTY OF RESIDENCE: NUMBER AND PERCENT VERY LOW (<1500 GRAMS) WEIGHT BIRTHS BY RACE AND ETHNICITY



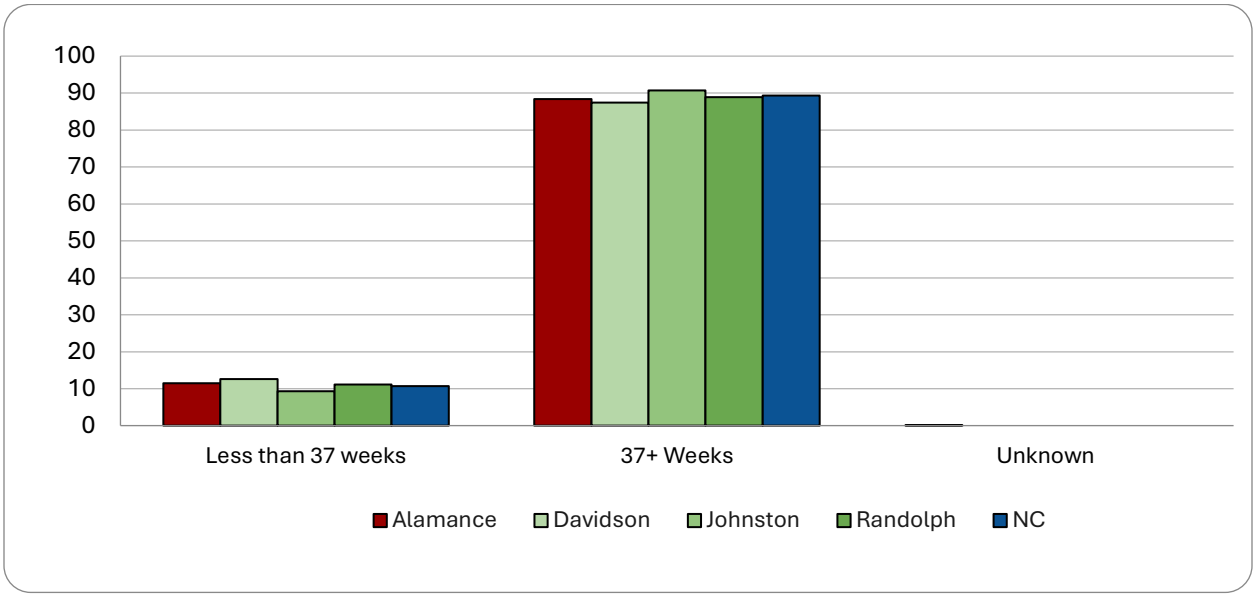
Source: North Carolina Department of Health and Human Services, State Center for Health Statistics. (2024). North Carolina health statistics data book. Retrieved January 14, 2025, from https://schs.dph.ncdhhs.gov/data/databook/

PERCENT OF NC RESIDENT BIRTHS DELIVERED BY CESAREAN SECTION 2018-2022



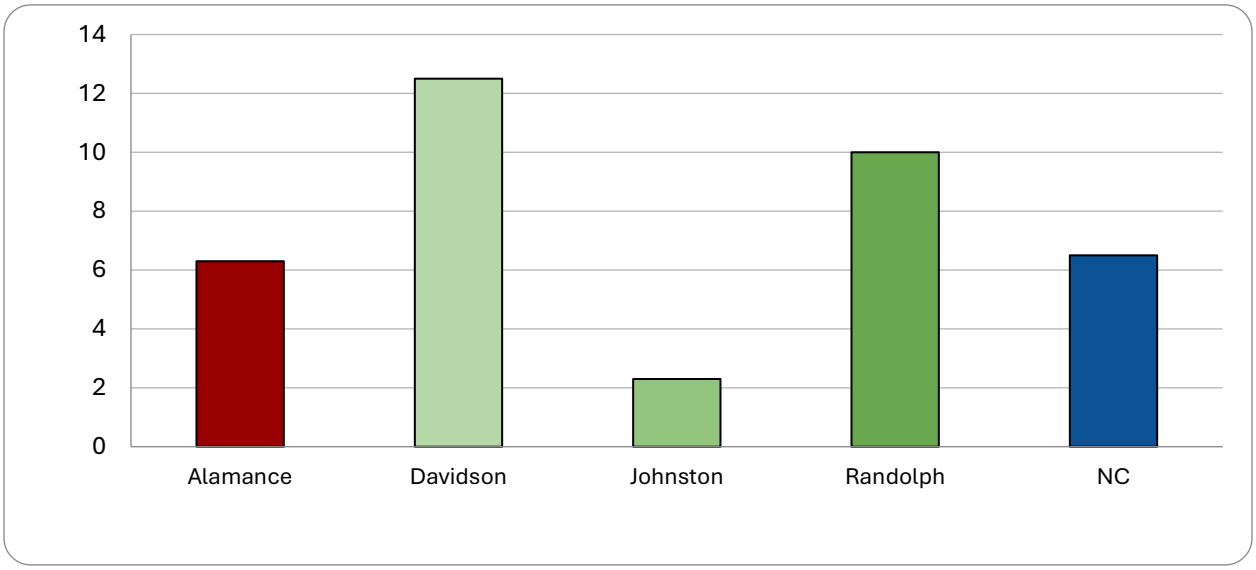
Source: North Carolina Department of Health and Human Services, State Center for Health Statistics. (2024). North Carolina health statistics data book. Retrieved January 14, 2025, from https://schs.dph.ncdhhs.gov/data/databook/

PERCENT OF NC RESIDENT BIRTHS DELIVERED BY GESTATION 2018-2022



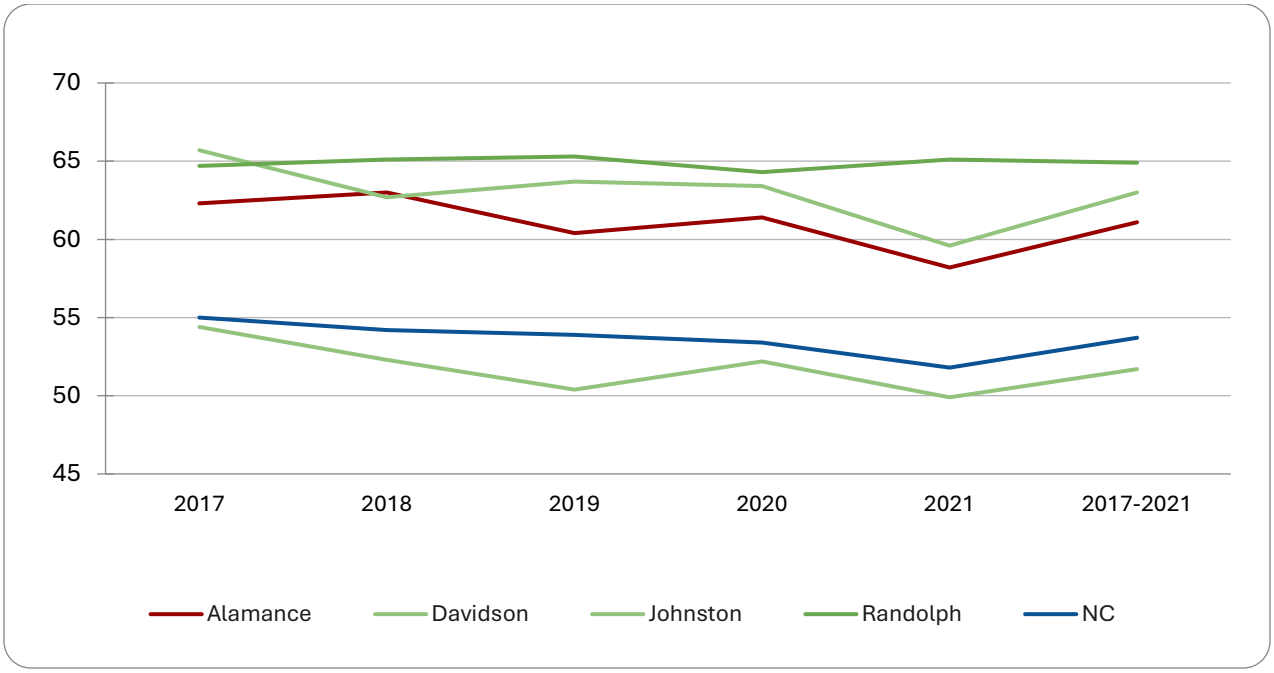
Source: North Carolina Department of Health and Human Services, State Center for Health Statistics. (2024). North Carolina health statistics data book. Retrieved January 14, 2025, from https://schs.dph.ncdhhs.gov/data/databook/

PERCENT OF NC RESIDENT BIRTHS WHERE MOTHER SMOKED DURING PREGNANCY 2018-2022



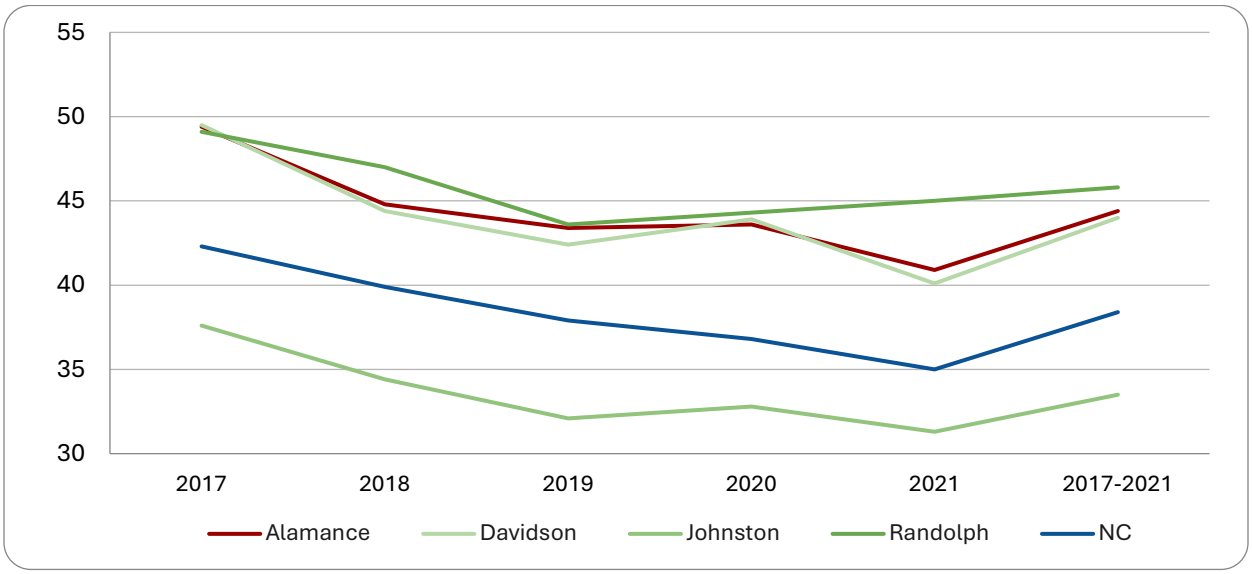
Source: North Carolina Department of Health and Human Services, State Center for Health Statistics. (2024). North Carolina health statistics data book. Retrieved January 14, 2025, from https://schs.dph.ncdhhs.gov/data/databook/

PERCENT OF BIRTHS TO MEDICAID MOTHERS 2017-2021



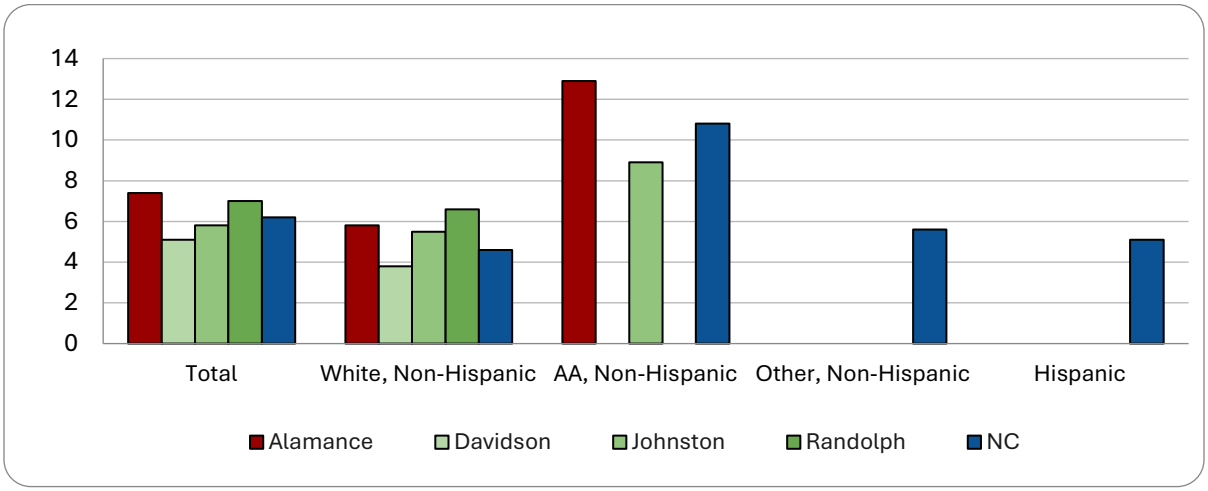
Source: North Carolina Department of Health and Human Services, State Center for Health Statistics. (2024). North Carolina health statistics data book. Retrieved January 14, 2025, from https://schs.dph.ncdhhs.gov/data/databook/

PERCENT OF BIRTHS TO WIC MOTHERS 2017-2021



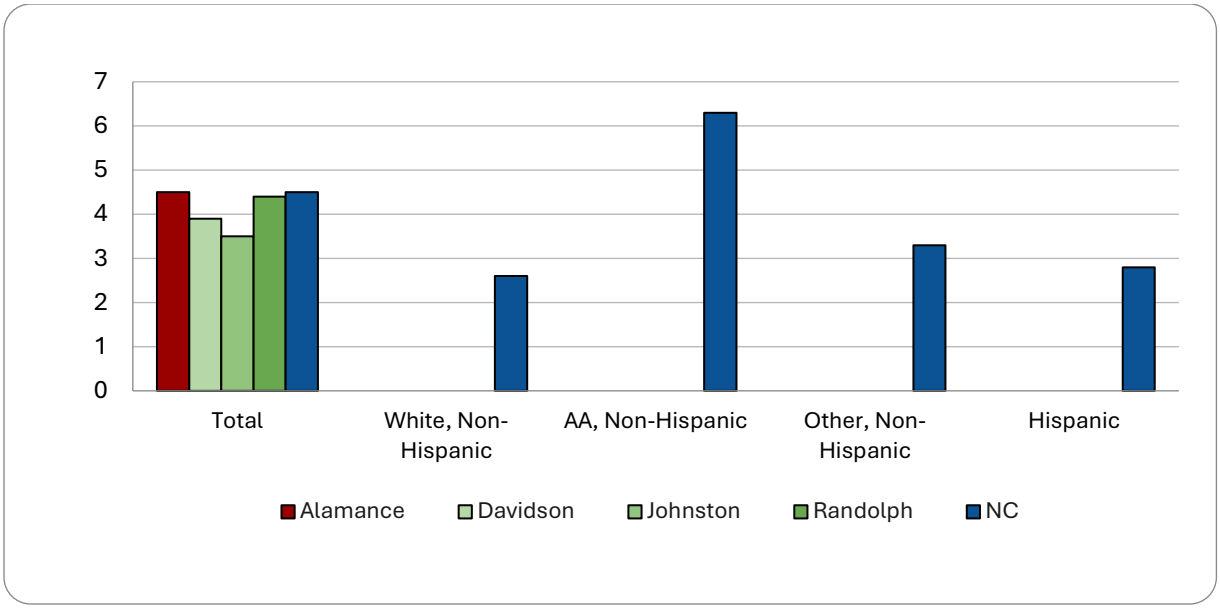
Source: North Carolina Department of Health and Human Services, State Center for Health Statistics. (2024). North Carolina health statistics data book. Retrieved January 14, 2025, from https://schs.dph.ncdhhs.gov/data/databook/

NC RESIDENT FETAL DEATH RATES PER 1,000 DELIVERIES, 2018-2022



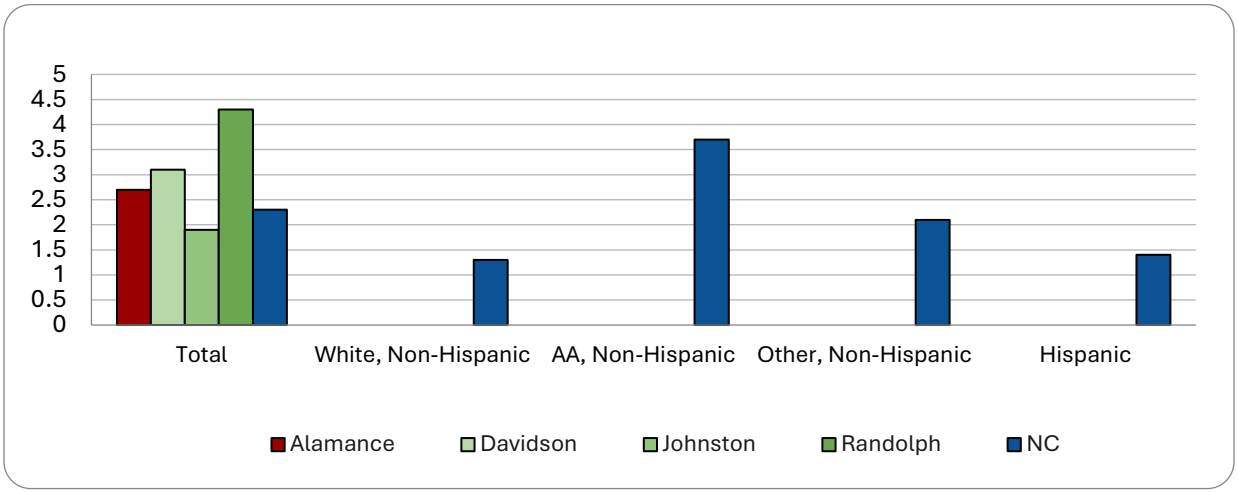
Source: North Carolina Department of Health and Human Services, State Center for Health Statistics. (2024). North Carolina health statistics data book. Retrieved January 14, 2025, from https://schs.dph.ncdhhs.gov/data/databook/

NC RESIDENT NEONATAL (<28 DAYS) DEATH RATES PER 1,000 LIVE BIRTHS, 2018-2022



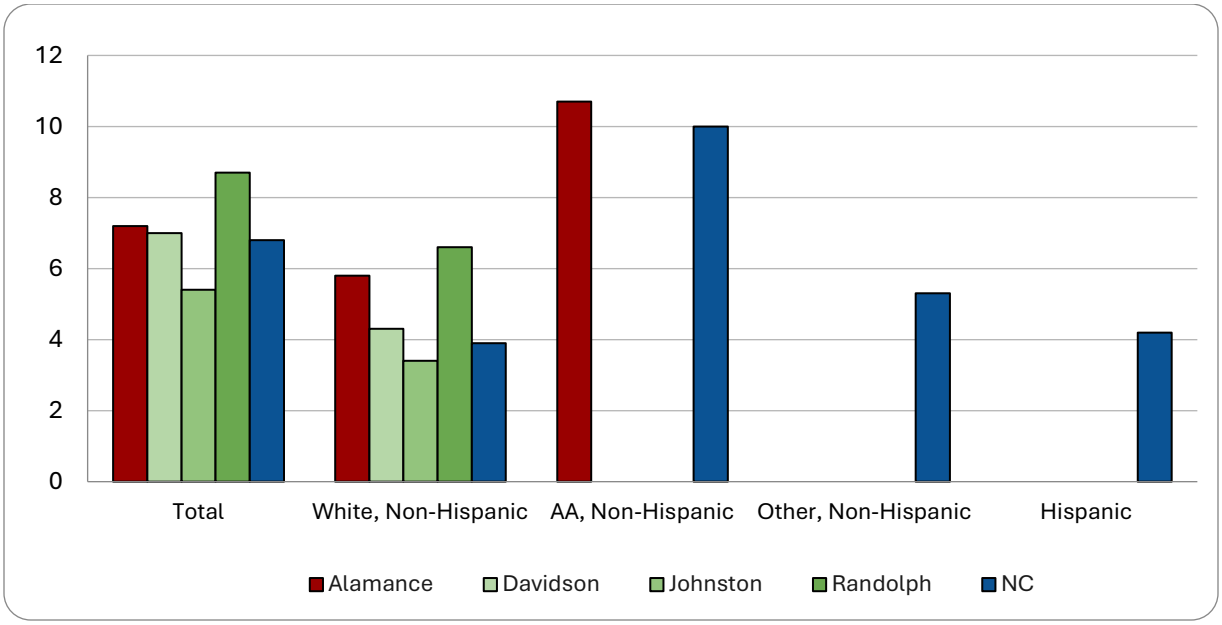
Source: North Carolina Department of Health and Human Services, State Center for Health Statistics. (2024). North Carolina health statistics data book. Retrieved January 14, 2025, from https://schs.dph.ncdhhs.gov/data/databook/

NC RESIDENT POSTNEONATAL (28 DAYS- 1 YEAR) DEATH RATES, 2018-2022



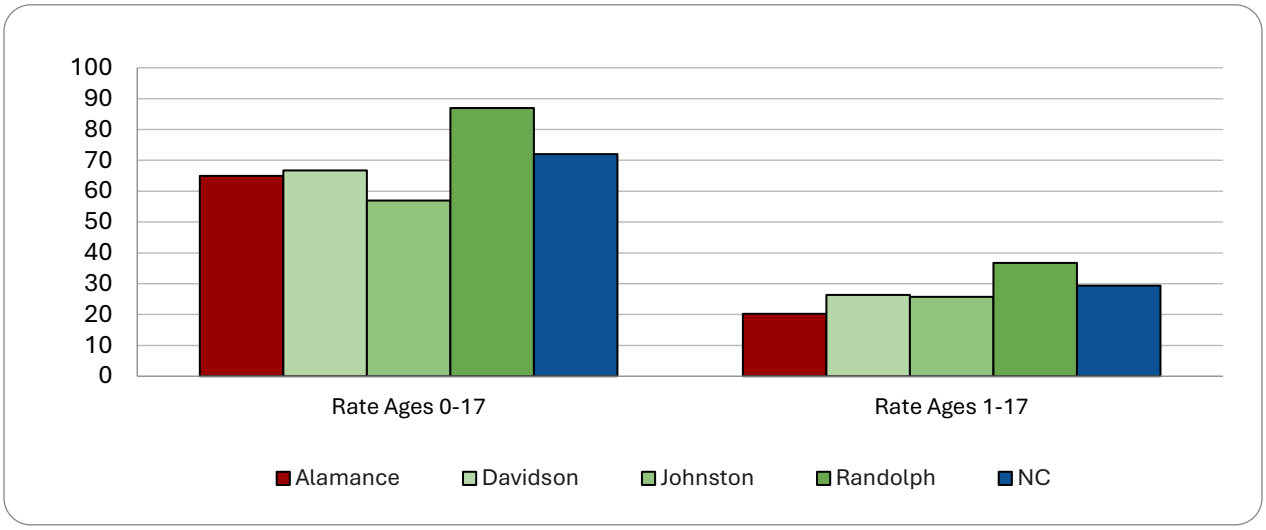
Source: North Carolina Department of Health and Human Services, State Center for Health Statistics. (2024). North Carolina health statistics data book. Retrieved January 14, 2025, from https://schs.dph.ncdhhs.gov/data/databook/

INFANT DEATH RATES PER 1,000 LIVE BIRTHS BY RACE/ETHNICITY, 2018-2022



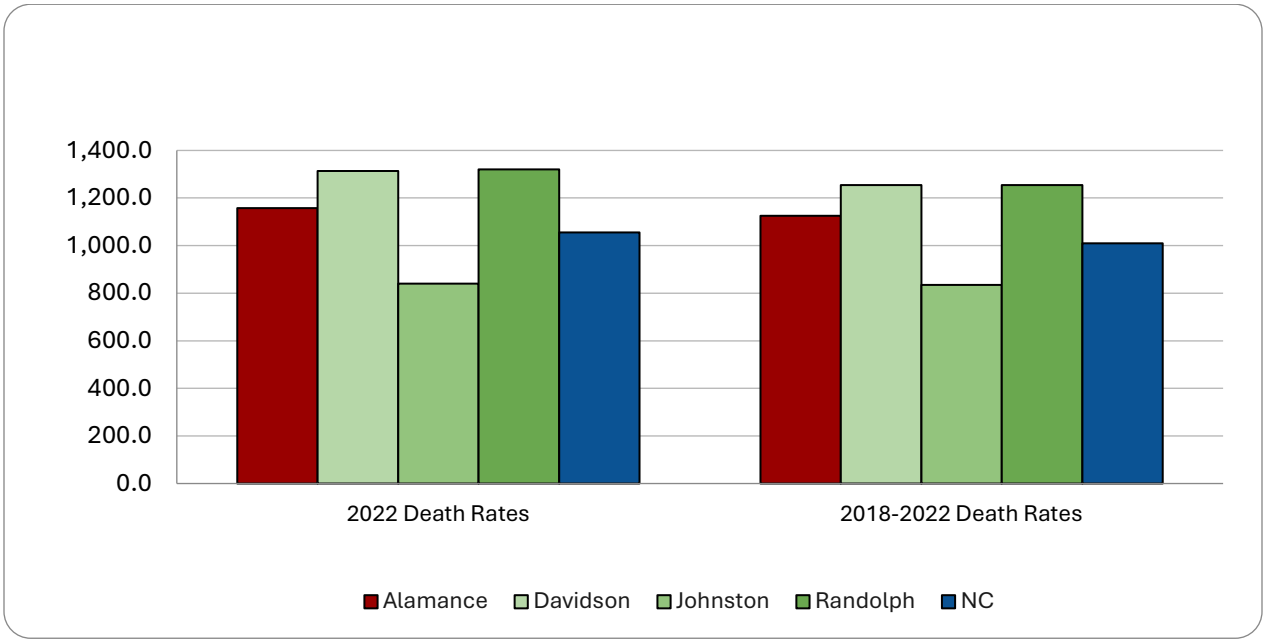
Source: North Carolina Department of Health and Human Services, State Center for Health Statistics. (2024). North Carolina health statistics data book. Retrieved January 14, 2025, from https://schs.dph.ncdhhs.gov/data/databook/

UNADJUSTED CHILD DEATH RATES PER 100,000 POPULATION, 2018-2022 AGES 0-17 AND AGES 1-17



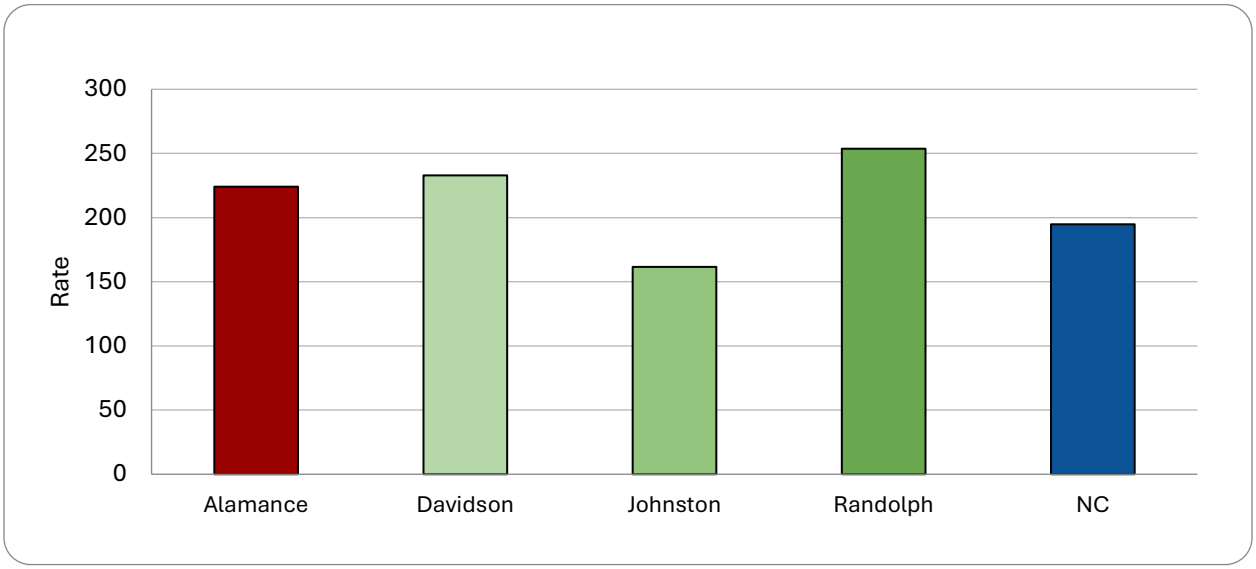
Source: North Carolina Department of Health and Human Services, State Center for Health Statistics. (2024). North Carolina health statistics data book. Retrieved January 14, 2025, from https://schs.dph.ncdhhs.gov/data/databook/

UNADJUSTED DEATH RATES PER 100,000 POPULATION 2022 AND 2018-2022



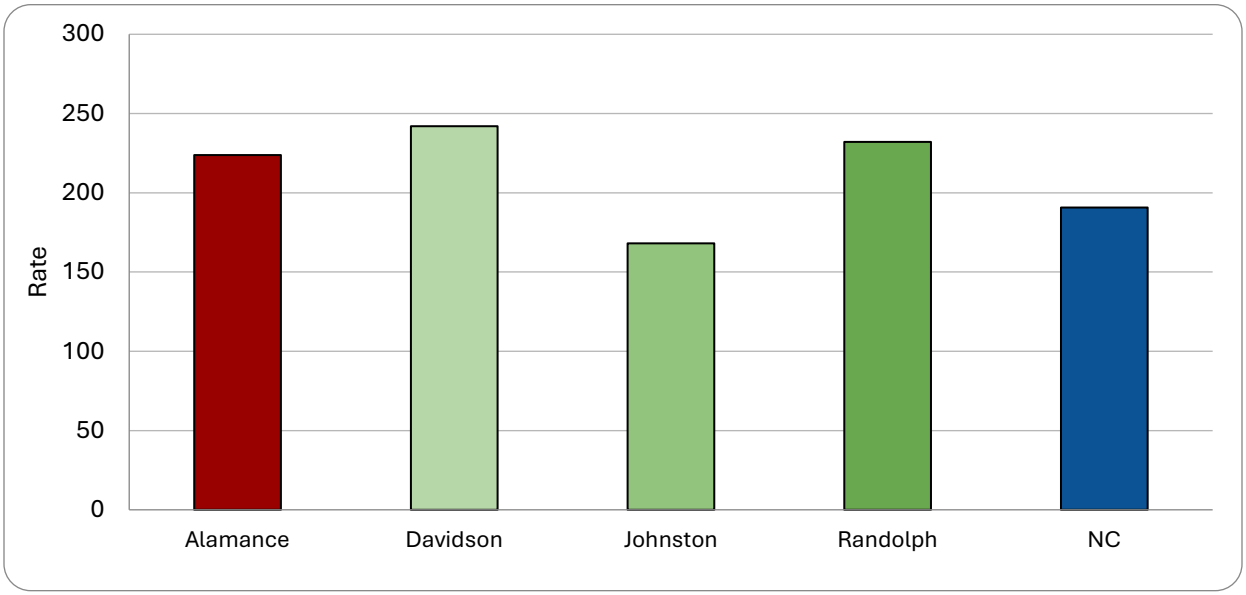
Source: North Carolina Department of Health and Human Services, State Center for Health Statistics. (2024). North Carolina health statistics data book. Retrieved January 14, 2025, from https://schs.dph.ncdhhs.gov/data/databook/

2018- 2022 DISEASE OF THE HEART: UNADJUSTED DEATH RATES PER 100,000 POPULATION



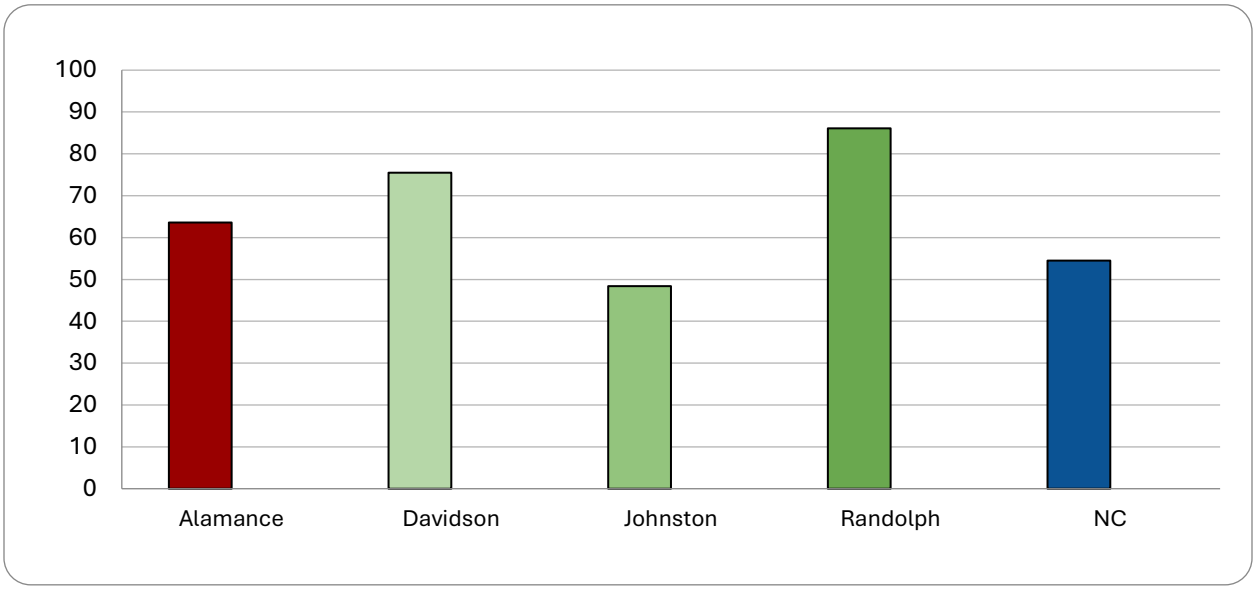
Source: North Carolina Department of Health and Human Services, State Center for Health Statistics. (2024). North Carolina health statistics data book. Retrieved January 14, 2025, from https://schs.dph.ncdhhs.gov/data/databook/

2018- 2022 CANCER- ALL SITES: UNADJUSTED DEATH RATES PER 100,000 POPULATION



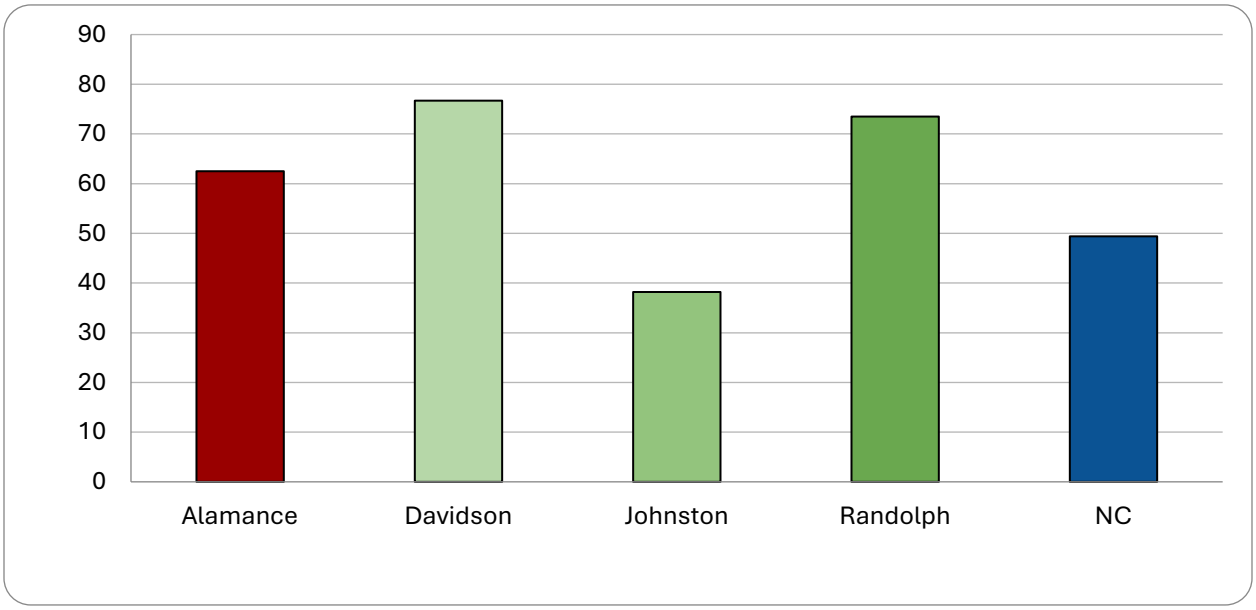
Source: North Carolina Department of Health and Human Services, State Center for Health Statistics. (2024). North Carolina health statistics data book. Retrieved January 14, 2025, from https://schs.dph.ncdhhs.gov/data/databook/

2018- 2022 OTHER UNINTENTIONAL INJURIES: UNADJUSTED DEATH RATES PER 100,000 POPULATION



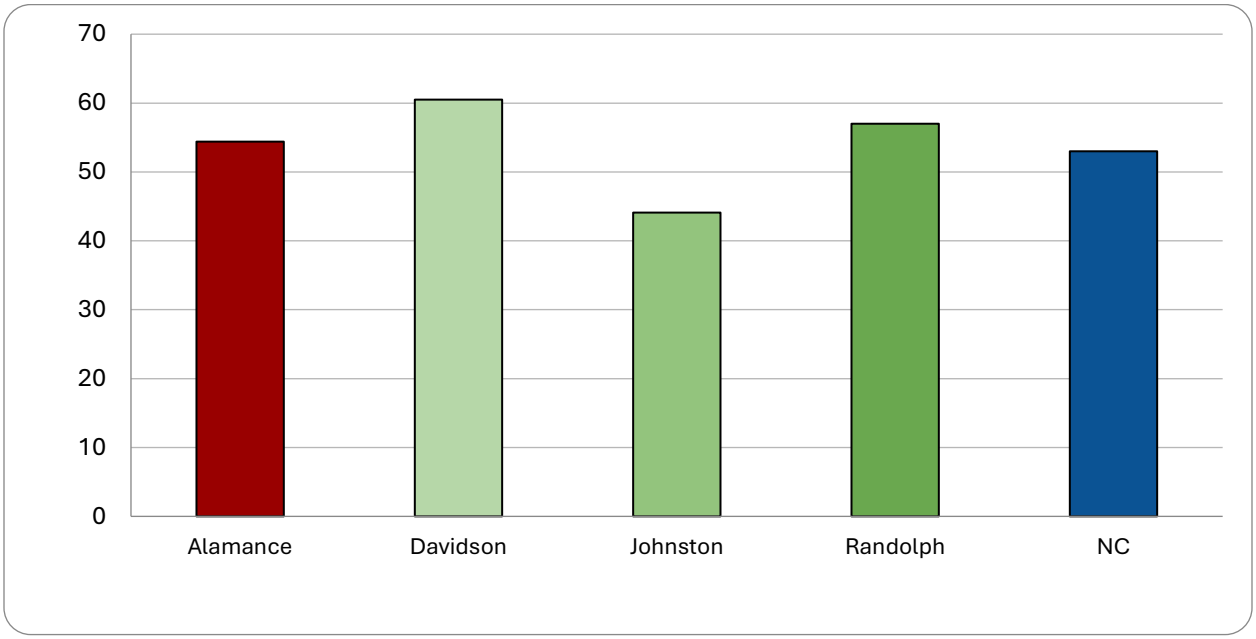
Source: North Carolina Department of Health and Human Services, State Center for Health Statistics. (2024). North Carolina health statistics data book. Retrieved January 14, 2025, from https://schs.dph.ncdhhs.gov/data/databook/

2018- 2022 CHRONIC LOWER RESPIRATORY DISEASES: UNADJUSTED DEATH RATES PER 100,000 POPULATION



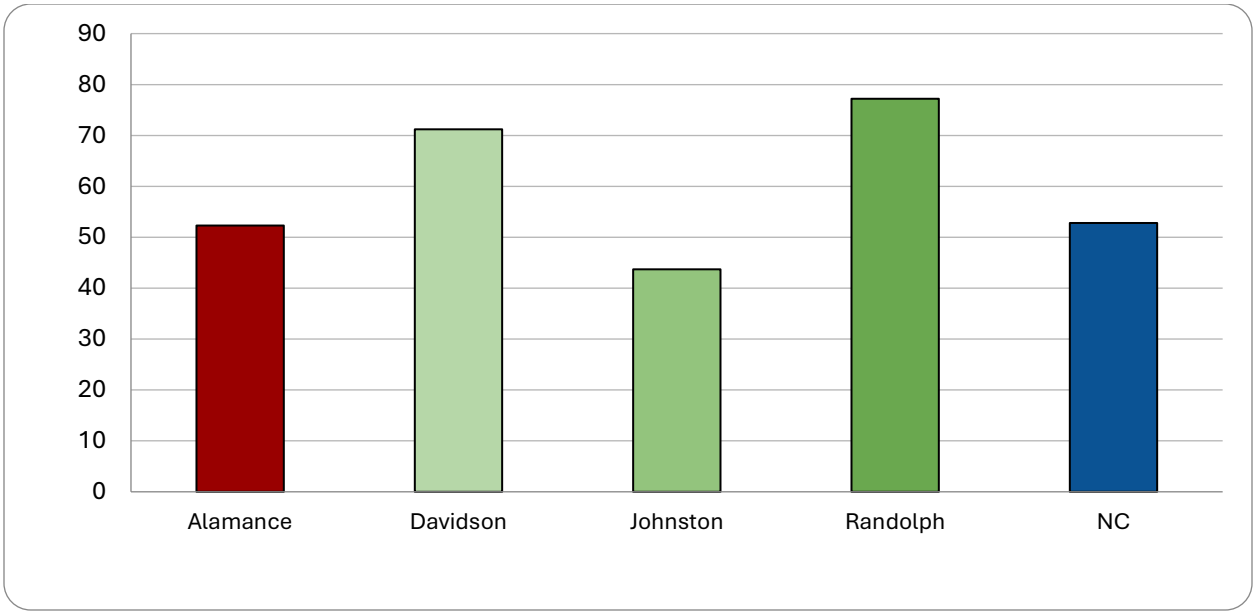
Source: North Carolina Department of Health and Human Services, State Center for Health Statistics. (2024). North Carolina health statistics data book. Retrieved January 14, 2025, from https://schs.dph.ncdhhs.gov/data/databook/

2018- 2022 CEREBROVASCULAR DISEASES: UNADJUSTED DEATH RATES PER 100,000 POPULATION



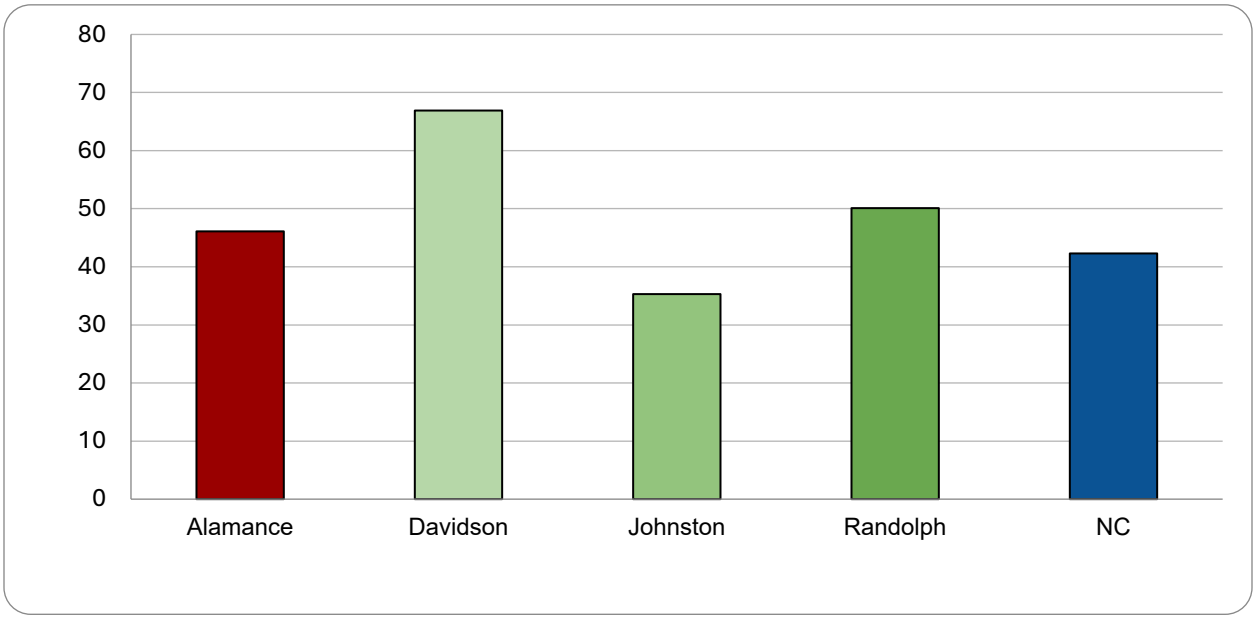
Source: North Carolina Department of Health and Human Services, State Center for Health Statistics. (2024). North Carolina health statistics data book. Retrieved January 14, 2025, from https://schs.dph.ncdhhs.gov/data/databook/

2018- 2022 COVID-19: UNADJUSTED DEATH RATES PER 100,000 POPULATION



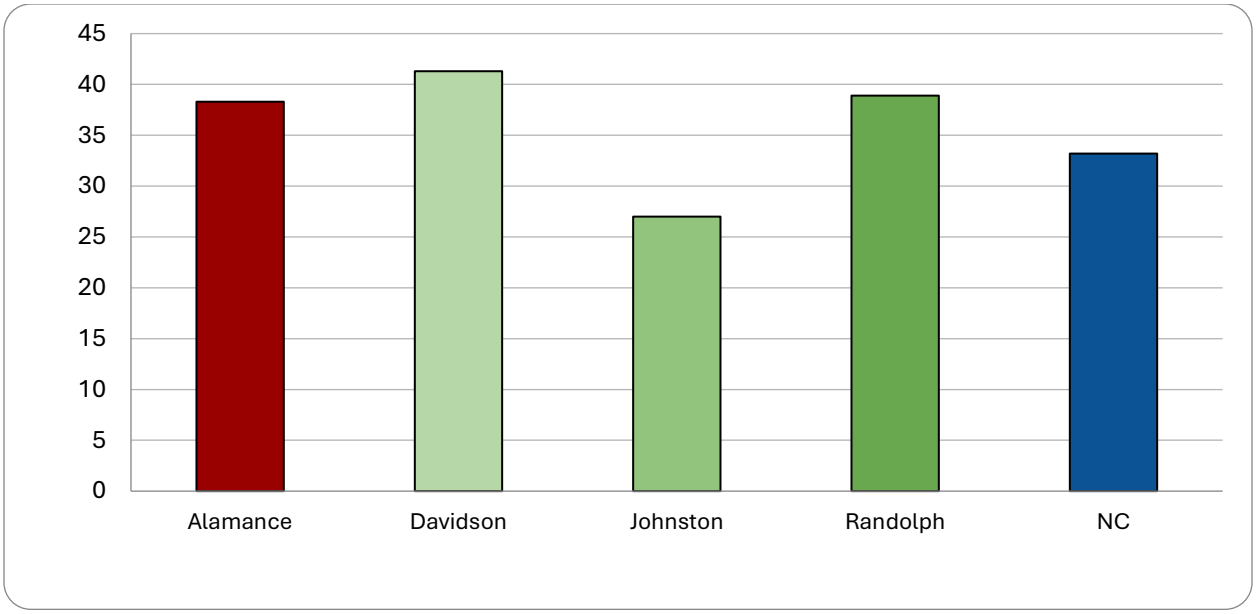
Source: North Carolina Department of Health and Human Services, State Center for Health Statistics. (2024). North Carolina health statistics data book. Retrieved January 14, 2025, from https://schs.dph.ncdhhs.gov/data/databook/

2018- 2022 ALZEIMER'S DISEASE: UNADJUSTED DEATH RATES PER 100,000 POPULATION



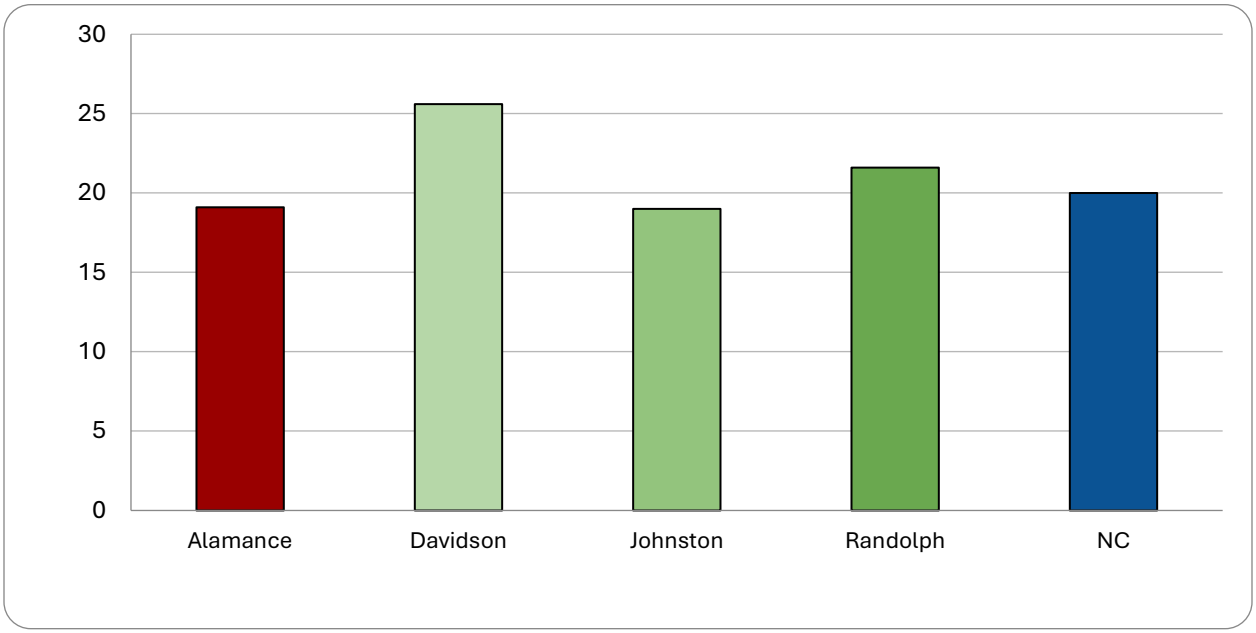
Source: North Carolina Department of Health and Human Services, State Center for Health Statistics. (2024). North Carolina health statistics data book. Retrieved January 14, 2025, from https://schs.dph.ncdhhs.gov/data/databook/

2018- 2022 DIABETES MELLITIS: UNADJUSTED DEATH RATES PER 100,000 POPULATION



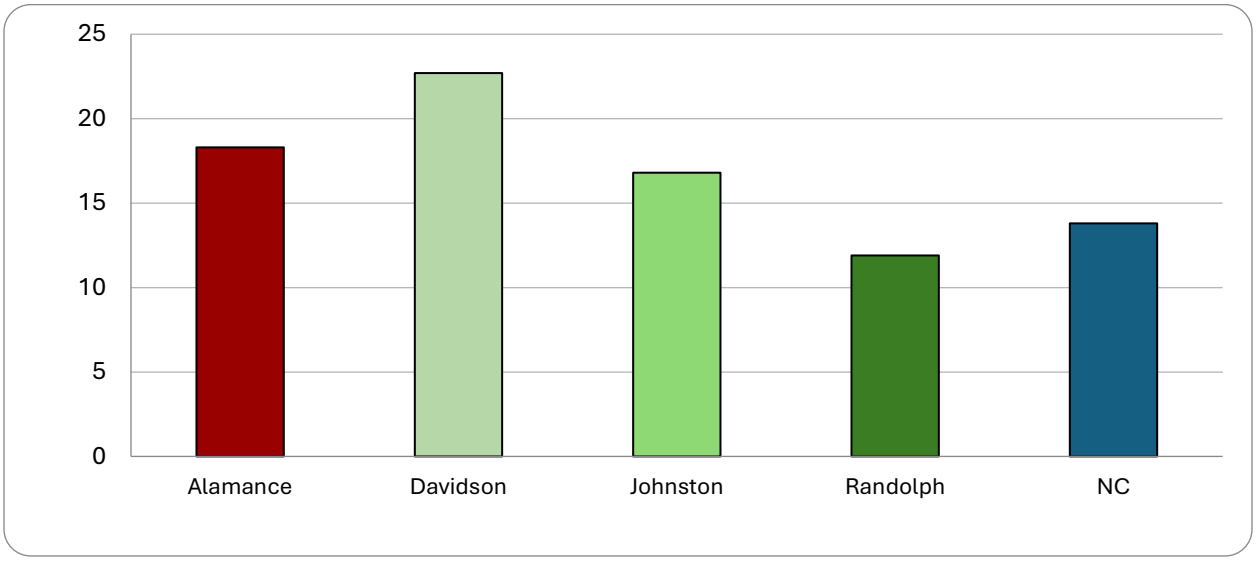
Source: North Carolina Department of Health and Human Services, State Center for Health Statistics. (2024). North Carolina health statistics data book. Retrieved January 14, 2025, from https://schs.dph.ncdhhs.gov/data/databook/

2018- 2022 NEPHRITIS, NEPHROTIC SYNDROME, & NEPHROSIS: UNADJUSTED DEATH RATES PER 100,000 POPULATION



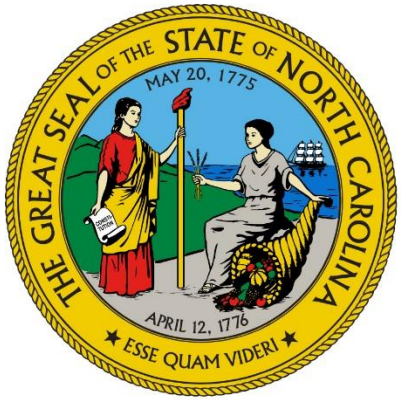
Source: North Carolina Department of Health and Human Services, State Center for Health Statistics. (2024). North Carolina health statistics data book. Retrieved January 14, 2025, from https://schs.dph.ncdhhs.gov/data/databook/

2018- 2022 PNEUMONIA & INFLUENZA: UNADJUSTED DEATH RATES PER 100,000 POPULATION



Source: North Carolina Department of Health and Human Services, State Center for Health Statistics. (2024). North Carolina health statistics data book. Retrieved January 14, 2025, from https://schs.dph.ncdhhs.gov/data/databook/

Opioid Overdoses



Medication and Drug Overdose in Alamance County

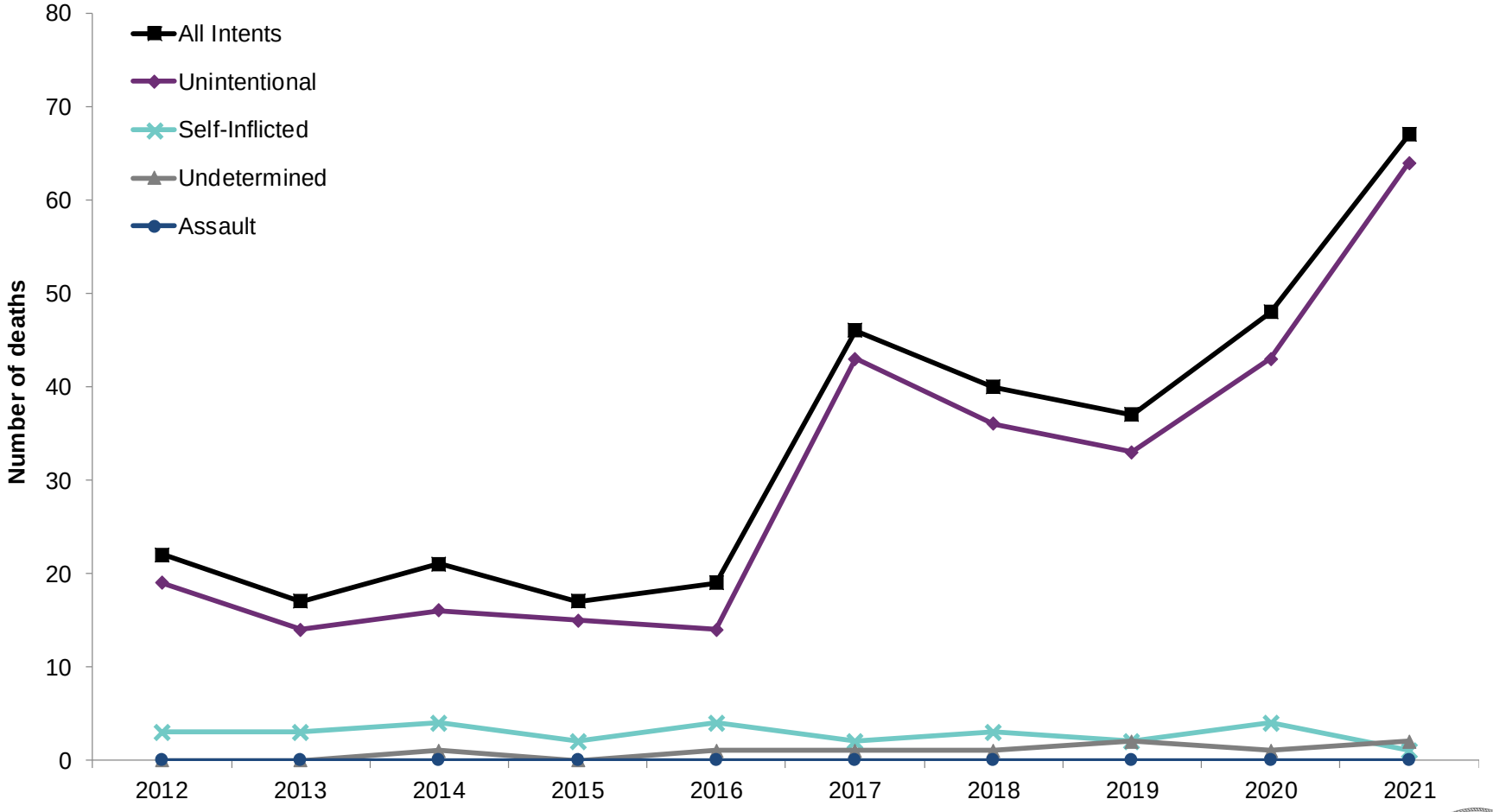
Technical Notes

- **The fatality data provided here are part of the Vital Registry System of the State Center for Health Statistics (SCHS) and have been used to track and monitor the drug overdose burden in NC using ICD-10 codes. Surveillance using ICD-10 codes relies on the immense efforts of the NC Office of the Chief Medical Examiner (OCME) to investigate overdose deaths in NC.**
- **Individual ICD-10 codes do not exist for each specific substance involved in overdose. Other Synthetic Narcotics (T40.4) includes several substances but the majority of deaths with this code involved fentanyl. Similarly, psychostimulants with abuse potential (T43.6) is used for methamphetamine surveillance.**
- **Counts and rates are limited to NC residents. When calculating rates, higher counts provide greater reliability, therefore years are often grouped. Use caution when interpreting rates for counts from 5 - 9. Counts from 1 - 4 are considered unstable and therefore have a low reliability; rates are not calculated for these counts.**
- **Population estimates for 2021 are subject to change.**
- **Speaking and technical notes should be read prior to using.**

If you have questions or concerns about these data, please contact us at SubstanceUseData@dhhs.nc.gov.

County Medication & Drug Overdose Deaths by Intent

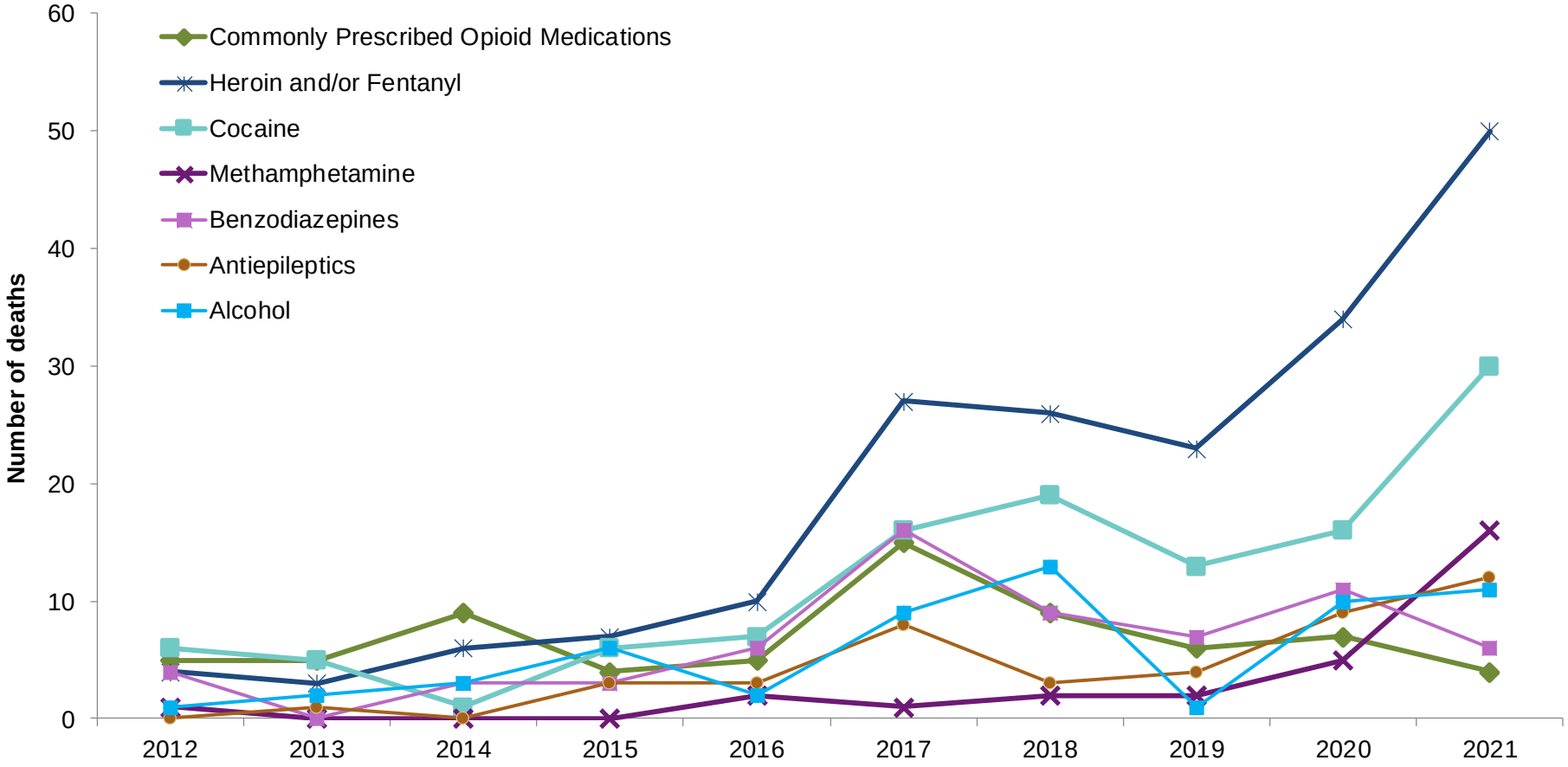
Alamance County Residents, 2012-2021



Technical Notes: Medication and drug overdoses: X40-X44, X60-X64, Y10-Y14, X85
Source: Deaths-NC State Center for Health Statistics, Vital Statistics
Analysis by Injury Epidemiology and Surveillance Unit

Substances* Contributing to Overdose Deaths

Alamance County Residents, 2012-2021

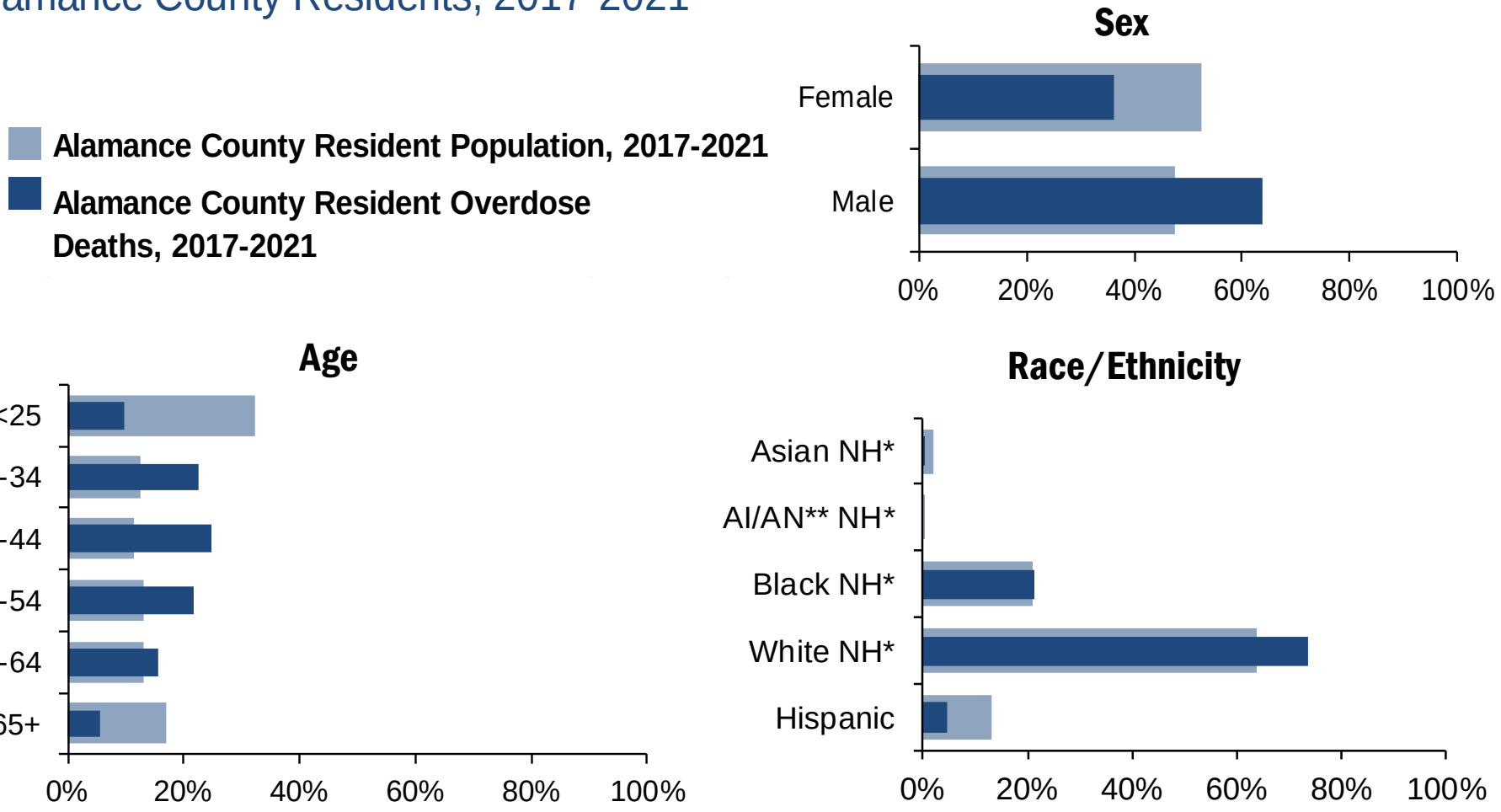


*These counts are not mutually exclusive. If the death involved multiple substances, it can be counted on multiple lines.

Source: NC State Center for Health Statistics, Vital Statistics-Deaths,
All intent medication, drug, alcohol poisoning: X40-X45, Y10-Y15, X85, or X60-X64 with any mention of specific T-codes by drug type (Commonly Prescribed Opioids, Heroin, Other Synthetics, Benzodiazepines, Cocaine, Psychostimulants, Antiepileptics and Alcohol).
Analysis by Injury Epidemiology and Surveillance Unit

Demographics of Medication & Drug Overdose Deaths Compared to County Population

Alamance County Residents, 2017-2021

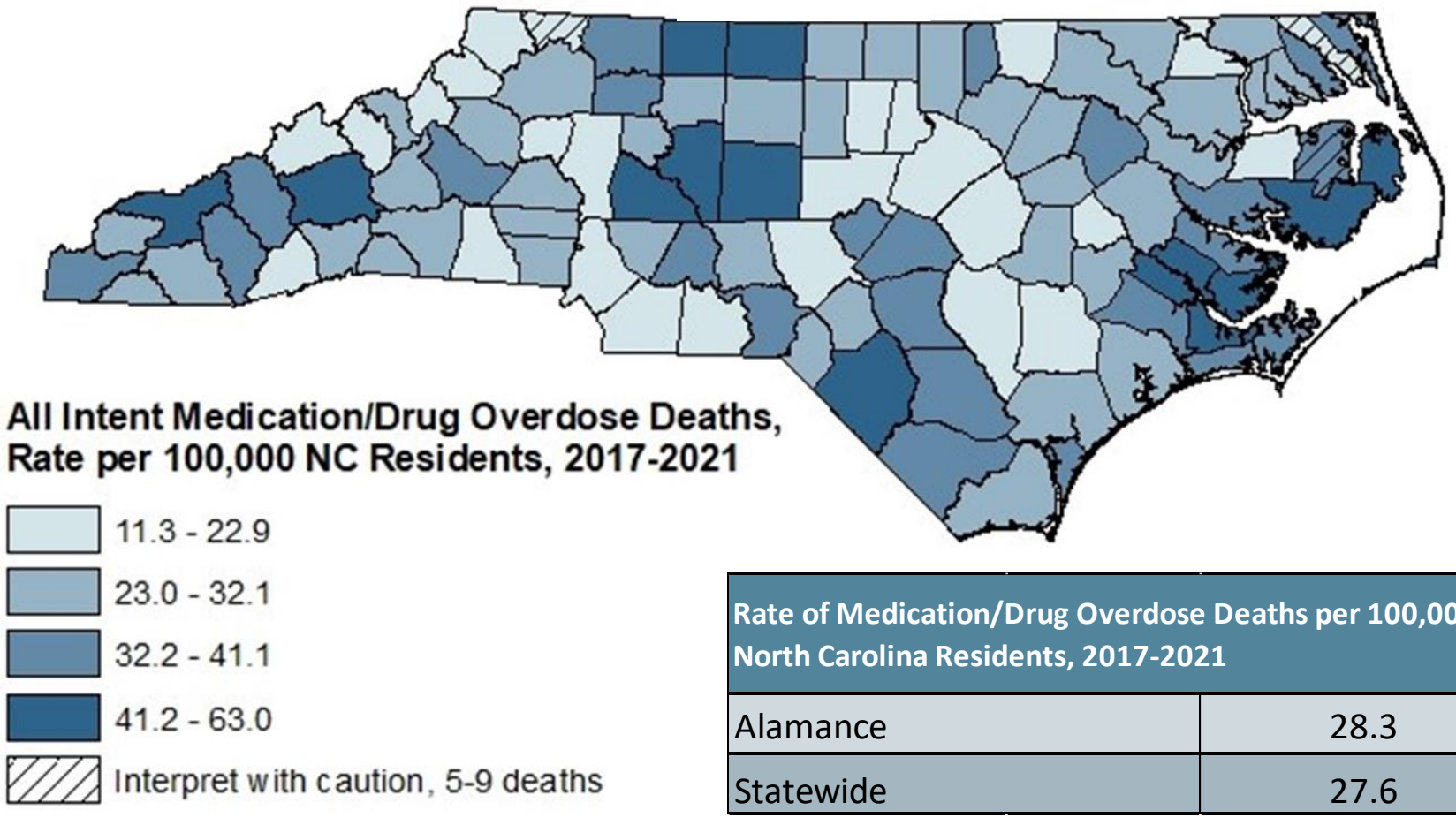


Technical Notes: All intent medication and drug poisoning: X40-X44, X60-X64, Y10-Y14, X85
Source: Deaths-NC State Center for Health Statistics, Vital Statistics; Population-NCHS
Analysis by Injury Epidemiology and Surveillance Unit

* Non-Hispanic
**American Indian/Alaskan Native

Rate of Medication & Drug Overdose Deaths, All Intents

Per 100,000 North Carolina Residents, 2017-2021

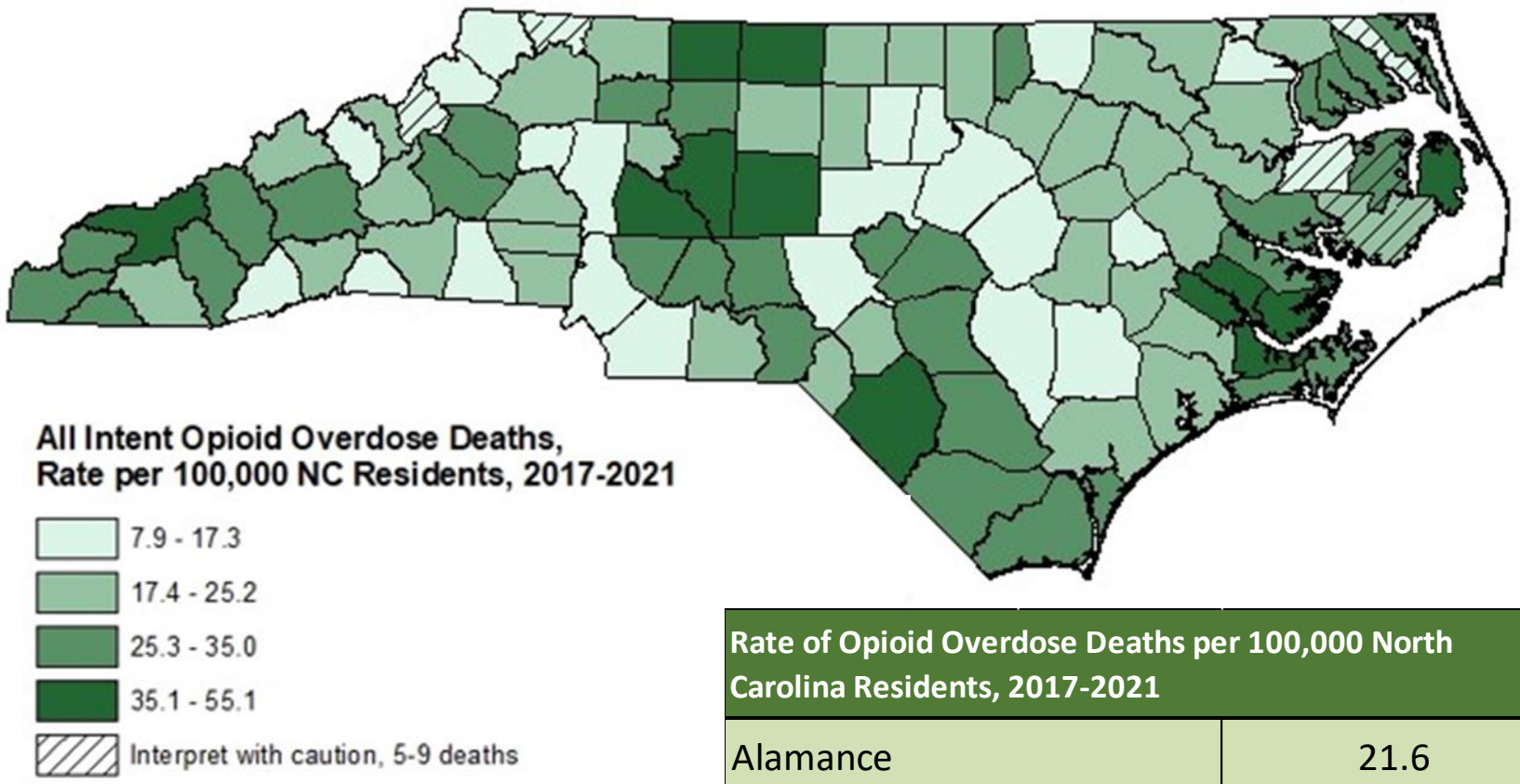


Rate of Medication/Drug Overdose Deaths per 100,000 North Carolina Residents, 2017-2021	
Alamance	28.3
Statewide	27.6

Technical Notes: Rates are per 100,000 NC residents; All intent medication and drug poisoning: X40-X44, X60-X64, Y10-Y14, X85
Source: Deaths-NC State Center for Health Statistics, Vital Statistics; Population-National Center for Health Statistics
Analysis by Injury Epidemiology and Surveillance Unit

Rate of Opioid Overdose Deaths, All Intents

Per 100,000 North Carolina Residents, 2017-2021

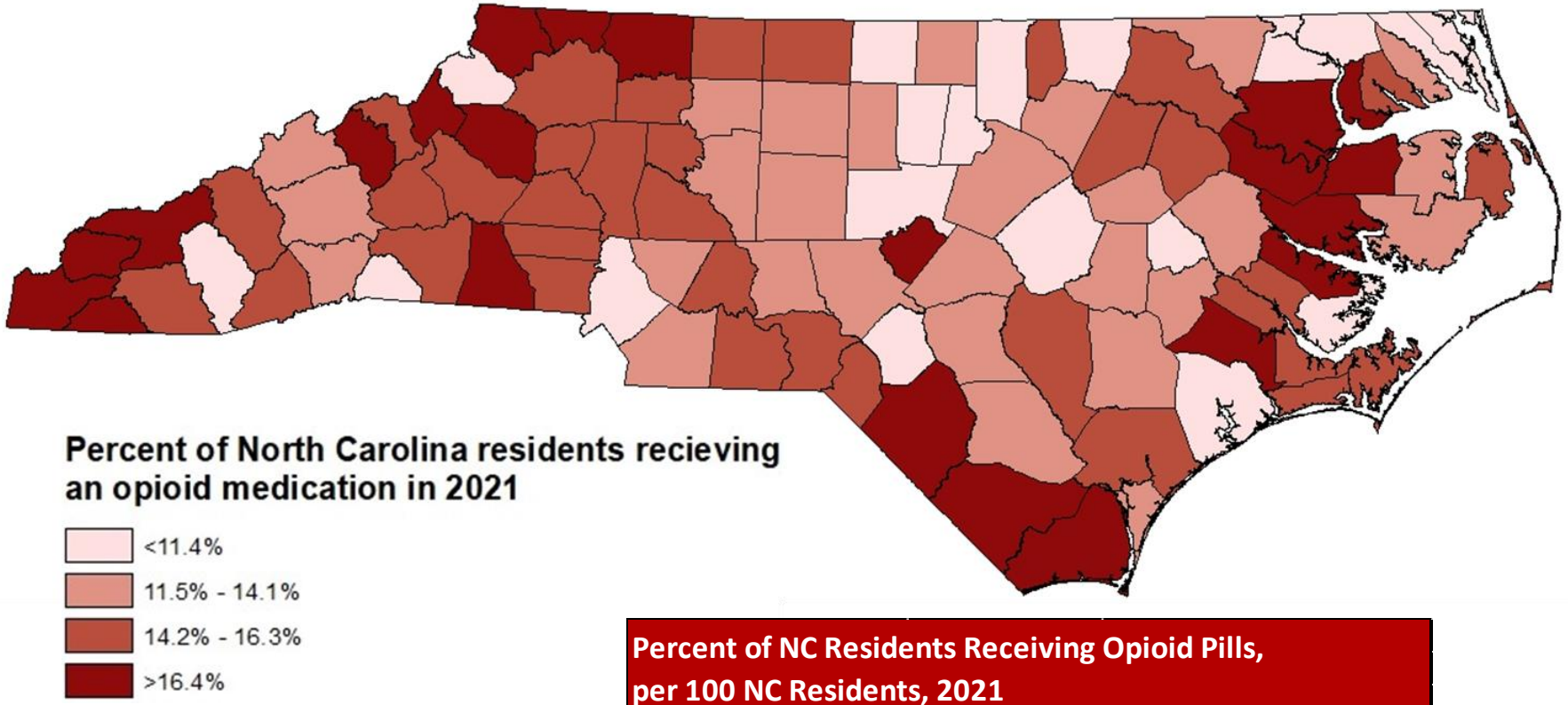


Rate of Opioid Overdose Deaths per 100,000 North Carolina Residents, 2017-2021	
Alamance	21.6
Statewide	22.7

Technical Notes: Rates are per 100,000 N.C. residents, Unintentional medication and drug poisoning: X40-X44 and any mention of T40.0 (opium), T40.2 (Other Opioids), T40.3 (Methadone),T40.4 (Other synthetic opioid) and/or T40.6 (Other/unspecified narcotics)
Source: Deaths-N.C. State Center for Health Statistics, Vital Statistics; Population-National Center for Health Statistics
Analysis by Injury Epidemiology and Surveillance Unit

Percent of North Carolina Residents Receiving Opioid Pills

Per 100 North Carolina Residents, 2021

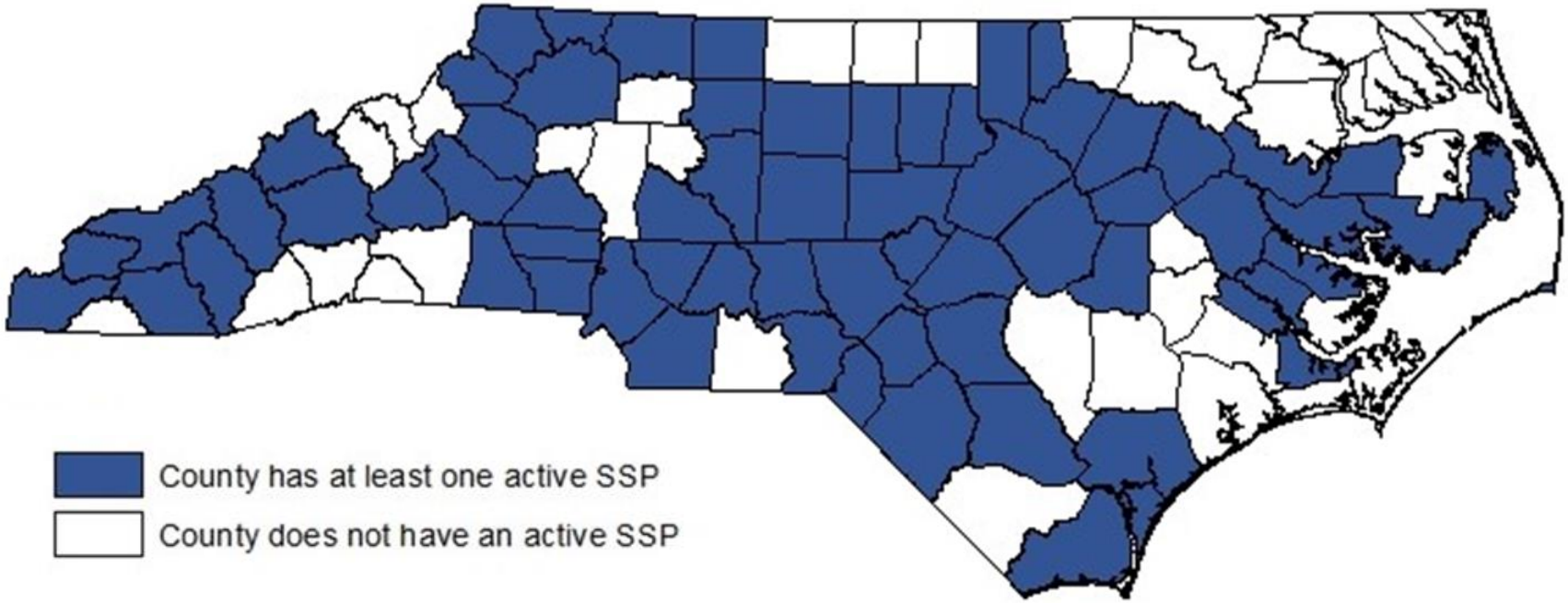


Percent of NC Residents Receiving Opioid Pills, per 100 NC Residents, 2021	
Alamance	13.9
Statewide	13.0

Technical Note: All CSRS data are subject to change
Source: Opioid Dispensing –NC Division of Mental Health, Controlled Substance Reporting System, 2021
Analysis by Injury Epidemiology and Surveillance Unit

Counties covered by Syringe Service Programs (SSPs)

Most Recent Year's Annual Reporting Period, as of 2022 Annual Report



SSP Coverage in Alamance County?	Yes

Technical Notes: There may be SSPs operating that are not represented on this map; in order to be counted as an active SSP, paperwork must be submitted to the NC Division of Public Health
Source: NC Division of Public Health, Safer Syringe Initiative Annual Reporting, as of 2022 Reporting
Analysis by Injury Epidemiology and Surveillance Unit

One Year's Estimated Total Lifetime Costs

Medical* and Statistical Life** Loss from Medication & Drug Overdose Deaths, 2021

	Alamance County	Statewide
Total Medical Costs*	$519,516	$24,535,913
Total Statistical Life** Loss	$752,988,733	$35,304,800,000
Combined Costs	**$753,508,250**	**$35,325,130,000**
Cost per capita	**$4,398**	**$3,332**

Technical Note: These estimates only include fatalities and do not include additional costs associated with non-fatal overdoses, treatment, recovery, and other costs associated with this epidemic.
*Medical costs refer to medical care associated with the fatal event, including health care and lost productivity.
**Value of statistical life refers to the estimated monetized quality of life lost and assesses underlying impacts on life lost.

Source: Deaths-NC State Center for Health Statistics, Vital Statistics, All intents, medication/drug overdose. Population-National Center for Health Statistics. 2020 Economic Impact-CDC WISQARS, Cost of Injury Reports, National Center for Injury Prevention and Control, CDC. Analysis by Injury Epidemiology and Surveillance Unit

Questions?

SubstanceUseData@dhhs.nc.gov

Injury and Violence Prevention Branch
NC Division of Public Health

www.injuryfreenc.ncdhhs.gov

Survey Summary Results

QUALITY OF LIFE

Quality of Life in Alamance County	(% Strongly Agree, Agree, or Neutral)
There is good healthcare in Alamance County	82
Alamance County is a good place to raise children	87
Alamance County is a good place to grow old	80
There is plenty of economic opportunity in Alamance County	55
Alamance County is a safe place to live	83
There is plenty of help for people during times of need in Alamance County	75
There is affordable housing that meets the needs in Alamance County	59
There are good parks and recreation facilities in Alamance County	83
It is easy to buy healthy foods in Alamance County	75

Issue	Frequency (Responses)
Low Income/Poverty	248
Drugs/Alcohol (Substance Use)	231
Lack of Community Resources	184
Lack of Affordable Housing	180
Transportation Issues	156
Health Insurance	130
COVID-19 Pandemic	104
Poor Housing Conditions	103
Dropping Out of School	101
Lack of Access to Enough Food	98

Neglect and Abuse	95
Education	93
Rape/Sexual Assault	87
Child Abuse	85
Crime/Violence	56

What are the top 3 services that need the most improvement in your community?	**Frequency (Responses)**
Higher paying employment	139
More affordable / better housing	128
Counseling / mental and behavioral health / support groups	128
Elder care options	87
Substance Misuse Services/ Recovery Support	85
Better/More healthy food choices	75
Positive teen activities	75
More affordable health services	67
Transportation options	56
Child care options	53
Road maintenance	50
Number of healthcare providers	49
Services for disabled people	46
Education	45
Healthy family activities	40
Availability of employment	34
Pedestrian and cyclist road safety	30
Animal control	24
None	23
Culturally appropriate health services	18
Other (please specify)	9
Better / more recreational facilities (parks, trails, community centers)	4

HEALTH LITERACY/INFORMATION

Source of Health Information	**Frequency (Responses)**
Doctor/Nurse	252
Internet	237
Friends and Family	166
Social Media	134
Pharmacist	123

Employer	122
Health Department	119
Hospital	102
Television	99
Books/Magazines	90
School (My Child's School)	82
Newspaper	80
Help Lines	80
Church	78
Community Health Worker	78
Radio	77
Other	56

What health behaviors do you feel people in your community need more information about?	**Frequency (Responses)**
Mental/Behavioral Health	203
Substance misuse prevention	117
Eating well/nutrition	98
Managing weight	68
Exercising/fitness	64
Elder care	61
Going to the doctor for yearly check-ups and screenings	61
Child care/parenting	58
Crime prevention	57
Caring for family members with special needs / disabilities	56
Driving safely	48
Suicide prevention	47
Preparing for an emergency/disaster	44
Domestic violence awareness/resources	36
Getting flu shots and other vaccines	34
Using child safety car seats	33
Harm reduction	33
Quitting smoking/tobacco use prevention	29
COVID-19	27
Going to a dentist for check-ups/preventive care	25
Getting prenatal care during pregnancy	20
Preventing pregnancy and sexually transmitted infections/disease (safe sex)	19

None	18
Breastfeeding	17
Using seat belts	14
Rape/sexual abuse awareness/resources	10
Other (please specify)	7

COVID-19

How has COVID-19 impacted you most severely/significantly?	**Frequency (Responses)**
Stress and anxiety	217
Social isolation	158
Mental/Behavioral Health	147
Physical Health	97
Employment/Loss of Job	91
Economic Resources	73
Access to food	66
Education	65
Spiritual Health/Well-being	61
Substance Misuse	50
Transportation	49
Lack of comfort in seeking medical care	48
Child care	46
Ability to seek medical care	45
Grief from loss of loved one	44
Access to safe housing	29
Other	27
Access to medication	22

HEALTH BEHAVIORS

Screening/Preventative Service	**Frequency (Responses)**
Blood Pressure Check	258
Physical Exam	241
Dental Cleaning/X-Rays	220
Flu Shot	209
Cholesterol Test	207
Vision Screening	195

Blood Sugar Check	194
Mammogram	167
Pap Smear	159
Skin Cancer Screening	120
Cardiovascular Screening	108
Colon/Rectal Exam	102
Hearing Screening	99
Bone Density Test	94
Prostate Cancer Screening	91

During a normal week, other than in your regular job, do you engage in any physical activity or exercise that lasts at least a half an hour?	**Frequency (Responses)**	**Percentage**
Yes	263	58.8%
No	136	30.30%
Don't know or not sure	48	10.70%
Did not respond to the question	81	

If yes, how many times per week do you engage in physical activity?	**Frequency (Responses)**	**Percentage**
4 times or more per week	95	37.10%
3 times per week	73	28.50%
2 times per week	59	23.00%
1 time per week	28	10.90%
Did not respond to the question	274	

Reason for Not Exercising	**Frequency (Responses)**
I'm too tired to exercise	63
I don't have enough time to exercise	53
My job is physical or hard labor	50
I don't like to exercise	21
It costs too much to exercise	14
There is no safe place to exercise	15
Exercise is not important to me	13

I'm physically disabled	15
I don't know how to find exercise partners	13
I don't know how to safely exercise	13
I would need child care and don't have it	14
I would need transportation and don't have it	15
I don't have access to a facility with what I need (e.g., pool, track)	15
Facilities closed due to COVID-19	15
Low self-image	14
Other (please specify)	15

TOBACCO USE

Do you currently use any tobacco products?	**Frequency (Responses)**	**Percentage**
Yes	87	19.4%
No	315	70.5%
Prefer not to respond	45	10.1%
Did not respond to the question	82	

Tobacco Product	**Frequency (Responses)**
Cigarettes	42
E-cigs/Electronic Cigarettes	19
Snuff/Dip	19
Vaping	16
Pipe	14
Cigars	12
Chewing Tobacco	10
None	4

Where Would You Go for Help if You Wanted to Quit?	**Frequency (Responses)**
Doctor	28
I don't know	24
Health Department	18

Pharmacy	15
Private Counselor/Therapist	15
Quitline NC	9
Other	6
N/A, I don't want to quit	2

FLU/COVID VACCINATION

During the past 12 months, have you received a seasonal flu vaccine?	**Frequency (Responses)**	**Percentage**
Yes (Flu Shot)	246	54.20%
Yes (Flu Mist)	42	9.30%
No	125	27.60%
Don't Know/Not Sure	33	7.30%
Did Not Respond	83	

Reason for Not Getting Flu Vaccine	**Frequency (Responses)**
Concerned about side effects	45
Don't believe it is effective	40
Don't think I need it	38
Too busy or no time	33
Doctor did not recommend it	20
Fear of needles	18
Cost	15
Transportation issues	13
Access issues	12
Personal preference	10
Other reasons	8

Did you receive a COVID vaccine?	**Frequency (Responses)**	**Percentage**
Yes	289	63.80%
No	112	24.70%
Don't Know/Not Sure	43	9.50%
Did Not Respond	85	

Reason for Not Getting COVID Vaccine	**Frequency (Responses)**
Concerned about side effects	33

Need more information / Have questions	24
Fear	24
Too busy / No time	20
Transportation issues	19
Access issues	18
Cost concerns	18
Personal preference	14

ACCESS TO CARE

In the past 12 months, did you have a problem getting the health care you needed for you personally or for a family member from any type of health care provider, dentist, pharmacy, or other facility?	**Frequency (Responses)**	**Percentage**
Yes	122	31.30%
No	268	68.70%
Don't Know/Not Sure	50	11.40%
Did Not Respond	89	—

If Yes - Type of Provider or Facility	**Frequency (Responses)**
Primary Care Doctor	48
Dentist	44
Specialist	40
Hospital	30
Urgent Care Center	29
OB/GYN	27
Pharmacy	25
Eye Care / Optometrist / Ophthalmologist	24
Pediatrician	24
Health Department	24
Medical Clinic	23
Mental/Behavioral Health Providers	17
Other	17

Problem Preventing Health Care Access	**Frequency (Responses)**
Cost too high (deductible/copay)	42
Insurance didn't cover what was needed	34
Could not get an appointment	33

The wait was too long	33
Couldn't miss work	33
COVID-19-related issues	31
Provider would not accept insurance or Medicaid	29
No health insurance	29
Hours did not work with availability	27
Didn't know where to go	24
No way to get there (transportation)	21
Language barriers	20
Other	17

DISASTER PREPAREDNESS

In a natural disaster (hurricane, flooding, tornado, etc.), do you feel like you know how to access or find the information you need to stay safe?	**Frequency (Responses)**	**Percentage**
Yes	295	72.10%
No	96	23.50%
Don't Know/Not Sure	51	12.50%
Did Not Respond	88	—

Source of Information	**Frequency (Responses)**
Television	186
Internet	186
Text Messages (Emergency Alert Systems)	180
Social Media	120
Cell Phone	142
Radio	115
Family	112
Neighbors	70
Don't Know/Not Sure	32
Print Media (Newspaper)	31
Telephone (Landline)	27
Other	13

FOOD INSECURITY

In the past 12 months, were you ever worried about whether your family's food would run out before you got money to buy more?	Frequency (Responses)	Percentage
Yes	115	25.00%
No	276	60.00%
Don't Know/Not Sure	43	9.30%
Did Not Respond	94	—

ACCESS

Do you feel that everyone in our community has equal access to quality healthcare services?	Frequency (Responses)	Percentage
Yes	159	36.40%
No	212	48.50%
Unsure	129	29.50%
Did Not Respond	30	—

Do you believe that certain groups in our community face more significant health challenges than others?	Frequency (Responses)	Percentage
Yes	182	38.70%
No	223	47.40%
Unsure	177	37.60%
Did Not Respond	48	—

Group Facing Significant Health Challenges	Frequency (Responses)
Low-income individuals	53
Racial/Ethnic Minorities	48
Children	45
Immigrants	44
Elderly	39

ACCESS TO CARE

Barrier to Accessing Healthcare	Frequency (Responses)
Cost of services	214
Lack of insurance	211

Language barriers	198
Transportation issues	189
Knowledge about available services	186
Availability of healthcare providers	167
Other (please specify)	10

Step to Improve Access to Healthcare	**Frequency (Responses)**
Enhancing support for low-income families	302
Ensuring culturally sensitive healthcare practices	241
Increasing community awareness about available health services	227
Offering services in multiple languages	186
Providing more affordable healthcare services	180
Increasing the number of healthcare providers	169
Improving transportation options to healthcare facilities	166
Other (please specify)	37

MENTAL HEALTH

How would you rate the overall mental health services available in our community?	**Frequency (Responses)**	**Percentage**
Excellent	76	16.20%
Good	114	24.30%
Fair	158	33.60%
Poor	112	23.80%
No Opinion	41	8.70%
Did Not Respond	29	—

What do you believe are the top mental health issues facing our community?	**Frequency (Responses)**
Substance abuse	341
Depression	270
Stress	254
Anxiety	239
Suicide	230
Trauma/PTSD	146
Other (please specify)	6

Barrier to Accessing Mental Health Services	Frequency (Responses)
Cost of Services	244
Lack of Awareness About Available Services	226
Long Wait Times for Appointments	177
Limited Availability of Providers	168
Stigma Associated with Seeking Help	167
Transportation Issues	140
Lack of Insurance	129
Other (please specify)	45

Best Ways to Improve Mental Health Awareness and Reduce Stigma	Frequency (Responses)
Public Discussions and Forums on Mental Health	282
Employer-Sponsored Mental Health Initiatives	270
Community Education Programs	268
Support Groups and Peer Support Networks	254
Mental Health Awareness Campaigns	253
School-Based Mental Health Education	191
Other (please specify)	39

SUBSTANCE USE

How would you rate the overall availability of substance use disorder services in our community?	Frequency (Responses)	Percentage
Excellent	74	15.70%
Good	104	22.00%
Fair	110	23.30%
Poor	137	29.00%
No opinion	76	16.10%
Did Not Respond to Question	29	—

Substance Use Issue	Frequency (Responses)
Marijuana Use	241
Prescription Drug Misuse	236
Opioid Addiction	235
Methamphetamine Use	232
Alcohol Abuse	229
Cocaine Use	206
Heroin Use	128
Other (please specify)	42

Barrier to Accessing Substance Use Disorder Services	Frequency (Responses)
Transportation Issues	212
Limited Availability of Providers	188
Lack of Insurance	185
Cost of Services	184
Lack of Awareness About Available Services	181
Long Wait Times for Appointments	163
Stigma Associated with Seeking Help	147
Other (please specify)	42

Type of Substance Use Disorder Service Needed in Community	Frequency (Responses)
Counseling/Therapy	239
Detoxification Services	206
Prevention Education Programs	205
Telehealth/Online Services	200
Community Outreach and Education	189
Medication-Assisted Treatment	174
Outpatient Treatment Programs	168
Naloxone (Narcan) Distribution and Access	128
Inpatient Treatment Programs	123
Support Groups (e.g., AA, NA)	39
Other (please specify)	40

How accessible do you believe naloxone (Narcan) is in our community?	Frequency (Responses)	Percentage
Very Accessible	89	18.20%
Somewhat Accessible	188	38.50%

Not Accessible	126	25.80%
Unsure	97	19.90%
Did Not Respond	30	—

DEMOGRAPHICS

Age Range	Frequency	Percent
Age 15-19	6	1.1
Age 20-24	31	5.8
Age 25-29	39	7.4
Age 30-34	36	6.8
Age 35-39	51	9.6
Age 40-44	40	7.5
Age 45-49	51	9.6
Age 50-54	48	9.1
Age 55-59	61	11.5
Age 60-64	41	7.7
Age 65-69	37	7
Age 70-74	27	5.1
Age 75-79	17	3.2
Age 80-84	17	3.2
Age 85+	2	0.4
Did Not Respond	26	4.9
Total	530	

Sex	Frequency	Percent
Woman	379	71.5
Man	143	27.0
Prefer not to answer	8	1.5
Total	530	

Race/Ethnicity	Frequency	Percent
Asian	6	1.1
Black / African American	81	15.3
Hispanic / Latino	25	4.7
Native American	8	1.5
Pacific Islander	4	0.8
White / Caucasian	375	70.8
More than 1 race	6	1.1
Prefer not to answer	25	4.7
Total	530	

Are you a person living with a disability?	Frequency	Percent
Yes	60	16
No	310	80
Prefer not to respond	14	4
Did not respond to question	146	
Total	530	

English Primary Language	Frequency	Percent
Yes	357	93.2
No	26	7.7
Did not respond to question	147	
Total	530	

Marital Status	Frequency	Percent
Never Married/Single	65	17

Married	241	62.9
Unmarried Partner	10	2.6
Divorced	41	10.7
Widowed	15	3.9
Separated	11	2.9
Did not respond to question	147	

Education Level	**Frequency**	**Percent**
Less than 9th grade	17	3.2
9th-12th grade, no diploma	4	0.8
High School Graduate (or GED/equivalent)	63	11.9
Associate Degree or Vocational Training	141	26.6
Some college (no degree)	85	16
Bachelor's Degree	123	23.2
Graduate or professional degree	97	18.3
Total	530	

Category	**Frequency**	**Percent**
Employed full-time	260	51.2
Employed part-time	30	5.9
Employed in multiple jobs	21	4.1
Seasonal Worker/Temporary	10	2
Retired	62	12.2
Armed forces	12	2.4
Disabled	33	6.5
Student	16	3.1
Homemaker	16	3.1
Self-employed	27	5.3
Unemployed for 1 year or less	9	1.8
Unemployed for more than 1 year	12	2.4
Did not respond to question	22	
Total	530	

Employment Field	**Frequency**	**Percent**
Agriculture	19	4.6

Business / Industry	34	8.3
Retail	19	4.6
Homemaker	6	1.5
Government	105	25.7
Healthcare	134	32.8
Student	13	3.2
Education	28	6.8
Food Service	14	3.4
Other	37	9.0
Did not respond to question	121	
Total	530	

Annual Income	**Frequency**	**Percent**
Less than $10,000	9	1.7
$10,000 to $14,999	8	1.5
$15,000 to $24,999	21	4.0
$25,000 to $34,999	26	4.9
$35,000 to $49,999	61	11.5
$50,000 to $74,999	247	46.6
$75,000 to $99,999	62	11.7
$100,000 or more	96	18.1
Total	530	

Number in Household	**Frequency**	**Percent**
I live alone	76	51.4
2-3	19	12.8
4-5	13	8.8
6-7	2	1.4
8-10	19	12.8
More than 10	19	12.8
Did not respond to question	382	
Total	530	
Type of Internet	**Frequency**	**Percent**
Dial up	3	0.6
Broadband / High-Speed	152	30
Wi-Fi	269	53.2
Cellular or Hotspot	47	9.3
None	35	6.9

Did not respond to question	24	
Total	530	

Final CHA Team Presentation Slides to Board of Health

Alamance County Board of Health

CHA Review

January 21, 2025

*Begins at **6:30pm***

Agenda

1. Introductions
2. The Theoretical Framing: Adapted MAPP 2.0
3. Initial Visioning Meeting
4. Community Health Survey
5. Overview of Potential CHA Priorities
6. Final Priorities & Next Steps

Agenda

1. **Introductions**
2. The Theoretical Framing: Adapted MAPP 2.0
3. Initial Visioning Meeting
4. Community Health Survey
5. Overview of Potential CHA Priorities
6. Final Priorities & Next Steps

Agenda

1. Introductions
2. **The Theoretical Framing: Adapted MAPP 2.0**
3. Initial Visioning Meeting
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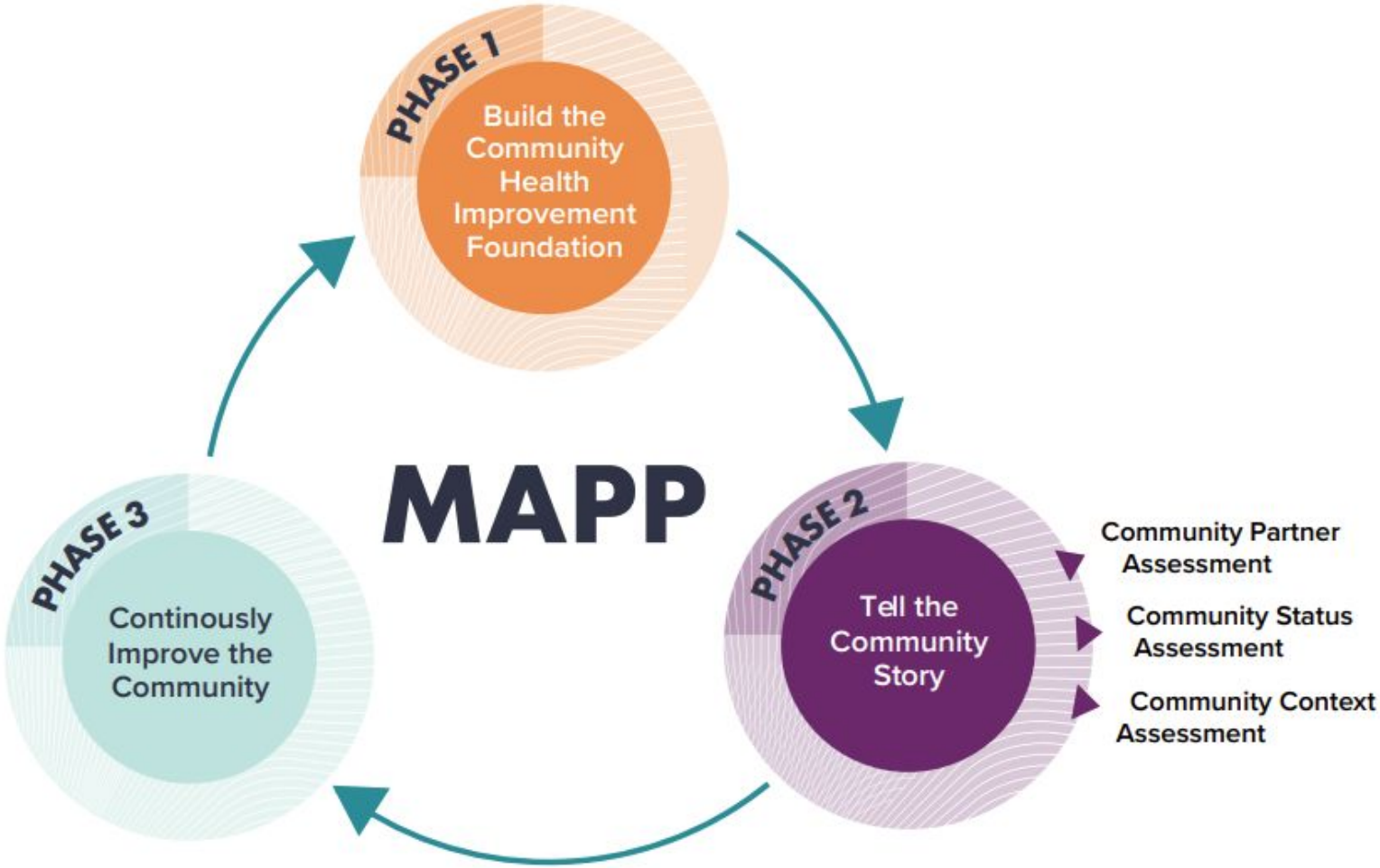

PHASE 1
Build the Community Health Improvement Foundation
MAPP
PHASE 2
Tell the Community Story
Community Partner Assessment
Community Status Assessment
Community Context Assessment
PHASE 3
Continously Improve the Community

MAPP Components

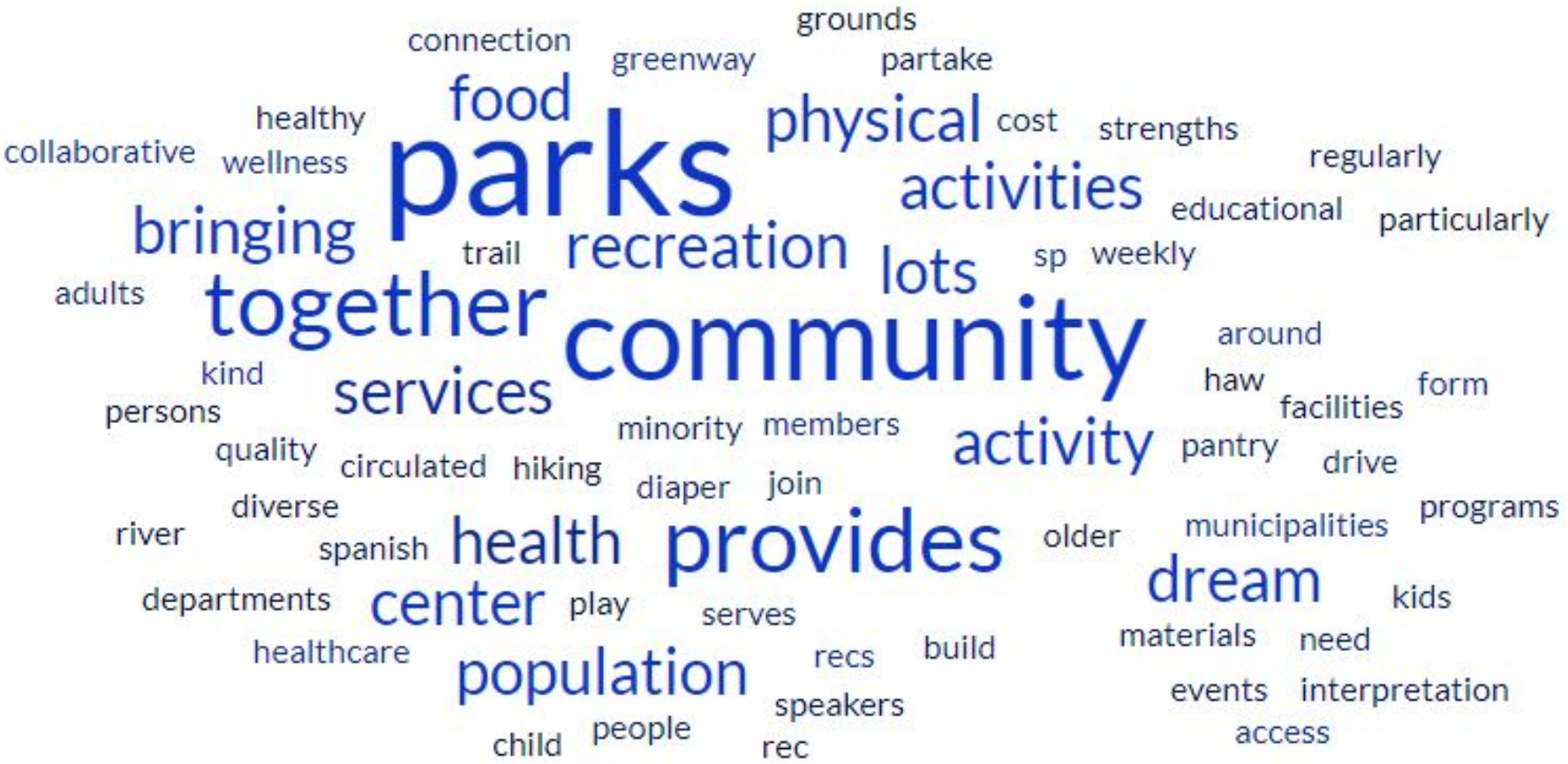
Agenda

1. Introductions
2. The Theoretical Framing: Adapted MAPP 2.0
3. **Initial Visioning Meeting**

   May 23, 2024 @ 6pm (Zoom)

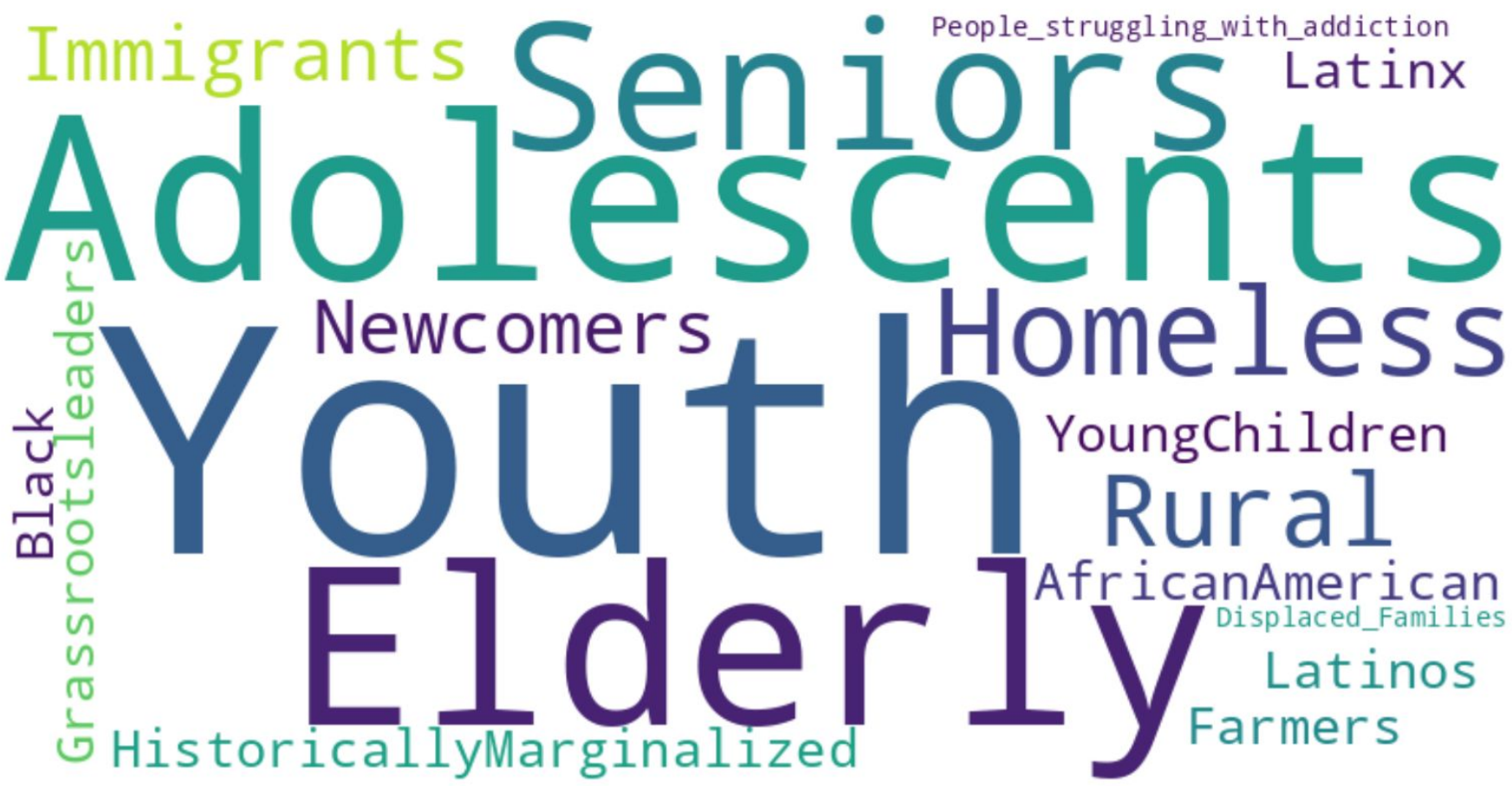
4. Community Health Survey
5. Overview of Potential CHA Priorities
6. Final Priorities & Next Steps

I hope that our Community Health Assessment really highlights and builds from our strength in _____.



A Healthier Alamance will mean that we _____.

In order to include all our people in a vision for a Healthier Alamance, we must _____.



THE VISION FOR THE CHA/CHIP PROCESS…

Alamance County will be a place where every individual feels welcomed, connected, and supported. We will promote healthy living by providing safe supportive spaces that offer access to high-quality health care, mental health services, and comprehensive support for those experiencing challenges. Our Commitment is to create an environment where all residents thrive and contribute to a vibrant, healthy community.

Agenda

1. Introductions
2. The Theoretical Framing: Adapted MAPP 2.0
3. Initial Visioning Meeting
4. **Community Health Survey**
5. Overview of Potential CHA Priorities
6. Final Priorities & Next Steps

Survey Structure & Deployment

- Developed in Collaboration with the CHA Advisory Group
- Deployed in English and Spanish
- Electronic Deployment through multiple channels
- In Person Deployment at select events
- Mobile Device compatible / Accessible by QR code
- Deployed June 2024 - October 2024
- 569 Responses

Survey Structure & Deployment

Section I: Community Perceptions (9 Questions)

Topics: *Healthcare quality, economic opportunities, housing, safety, and access to parks and healthy foods.*

Section II: Quality of Life Issues (21 Questions)

Issues: *Income, housing, employment, and crime.*

Health education needs: *Nutrition, mental health, exercise, and disaster preparedness.*

Section III: Health Behaviors and Preventative Care (22 Questions)

Focus: *Health information sources, screenings (e.g., flu shots, mammograms), and barriers to exercise.*

Section IV: Specific Health Topics (13 Questions)

Topics: *Tobacco and substance use, vaccination uptake, and barriers to healthcare access.*

Section V: Mental and Behavioral Health (7 Questions)

Topics: *Evaluation of services, top issues (e.g., anxiety, depression), and access barriers.*

Section VI: Substance Use Disorder Services (8 Questions)

Focus: *Availability, barriers, and needed services (e.g., counseling, naloxone).*

Section VII: Healthcare Access and Disaster Preparedness (6 Questions)

Topics: *Barriers to healthcare and emergency preparedness.*

Agenda

1. Introductions
2. The Theoretical Framing: Adapted MAPP 2.0
3. Initial Visioning Meeting
4. Community Health Survey
5. **Overview of Potential CHA Priorities**
6. Final Priorities & Next Steps

Potential CHA Priorities

- **Community Impact** (why?)
  *"How much of a positive **C**ommunity impact could addressing this issue have?"*
- **Achievability** (how?)
  *"How **A**chievable is it to make progress on this issue with our current resources and partnerships?"*
- **Positioning/Poise** (when?)
  "How well are we positioned (or poised) to address this issue, considering its urgency and potential consequences of inaction?"

- Housing
- Access to Primary Care
- Sexual Health
- **Food Access**
- **Mental/Behavioral Health**
- **Substance Use/Overdose Prevention**

Housing

Quality of Life

Question	Woman Mean	Man Mean
Alamance County is a good place to raise children	3.47	3.44
Alamance County is a good place to grow old	3.46	3.38
Alamance County is a safe place to live	3.44	3.33
There are good parks and recreation facilities in Alamance County	3.44	3.19
There is good healthcare in Alamance County	3.07	3.24
There is plenty of help for people during times of need in Alamance County	3.04	3.01
It is easy to buy healthy foods in Alamance County	3.01	3.15
There is plenty of economic opportunity in Alamance County	2.87	2.94
There is affordable housing that meets the needs in Alamance County	2.64	2.83

Quality of Life

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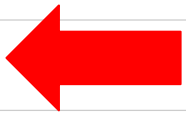
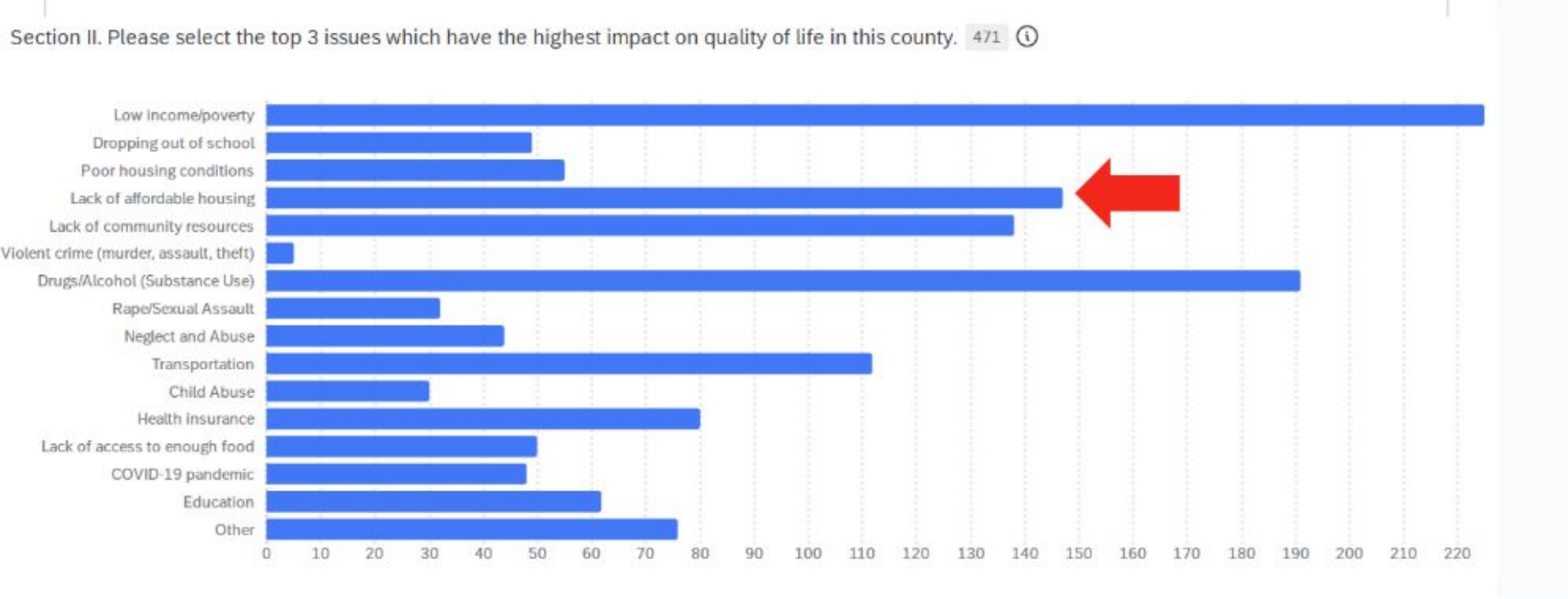
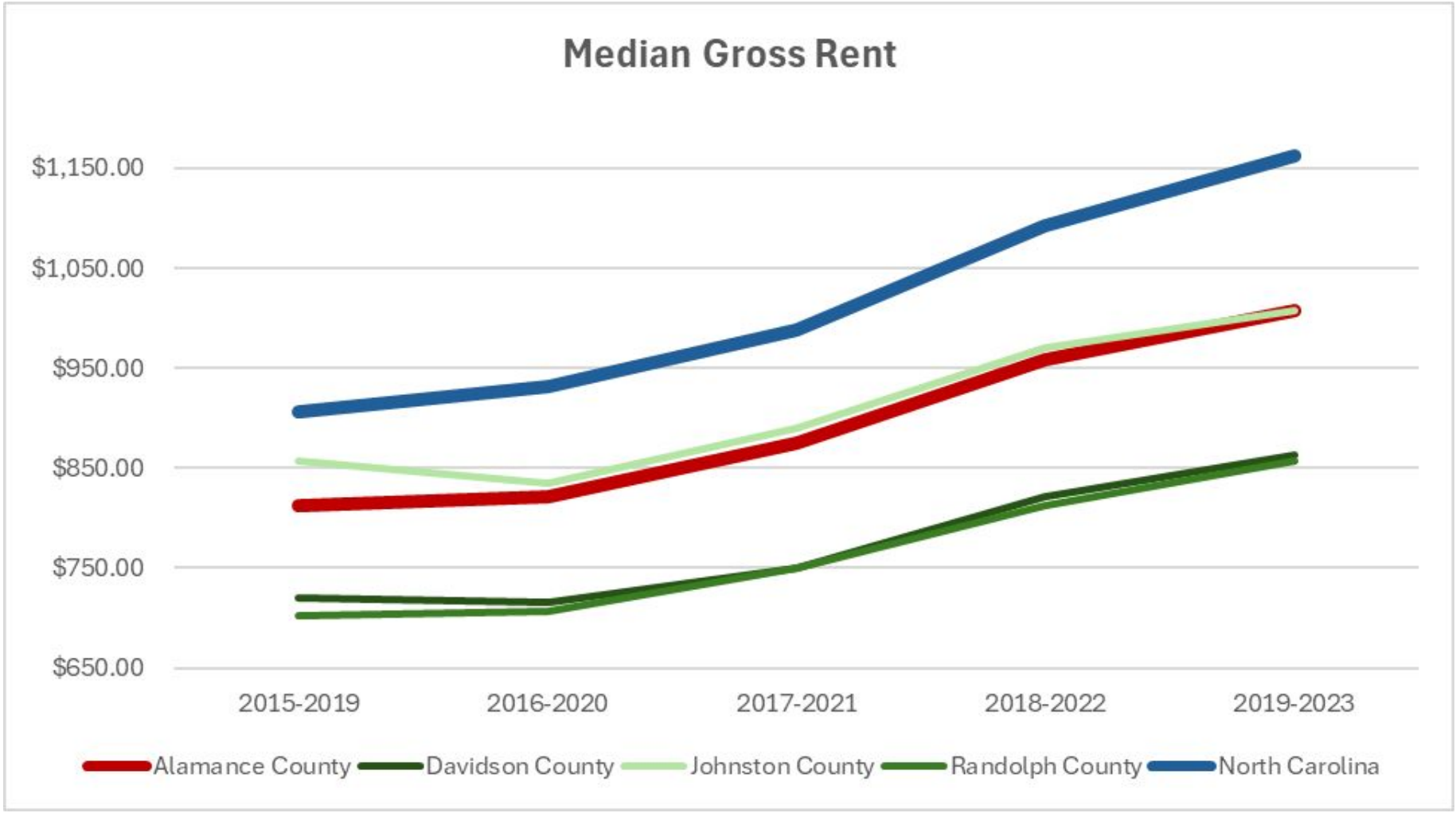
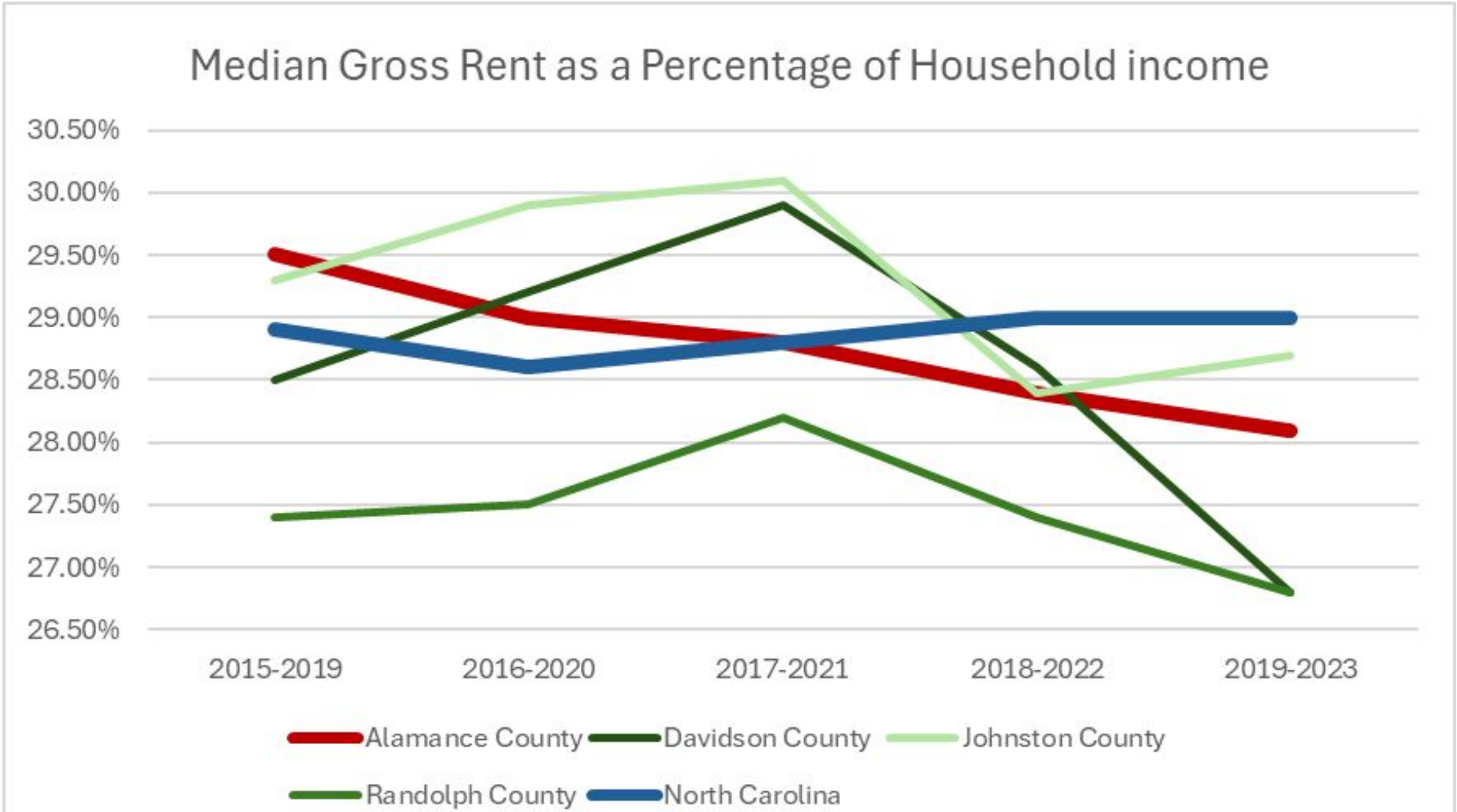
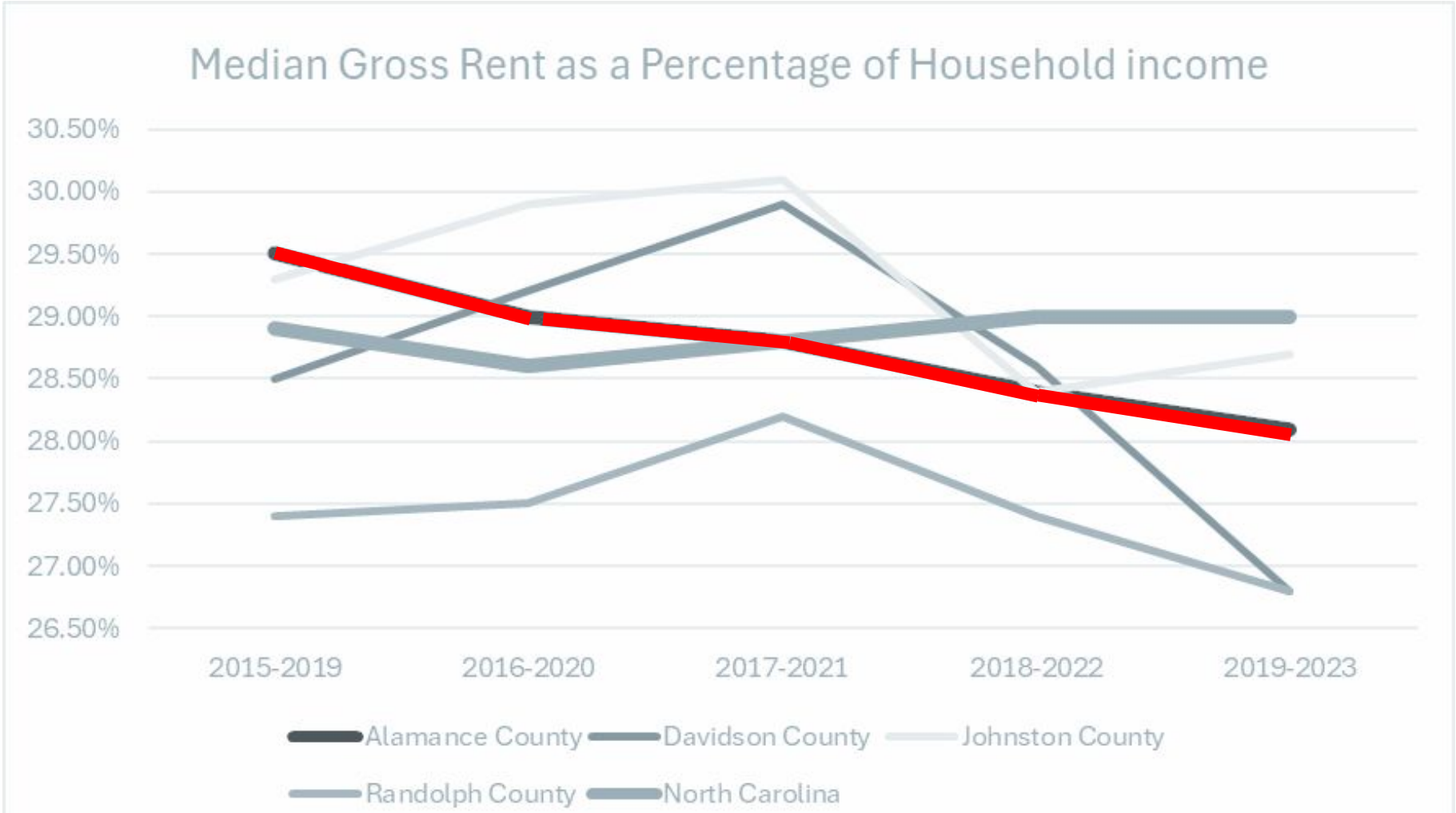


Highest Impact on Quality of Life

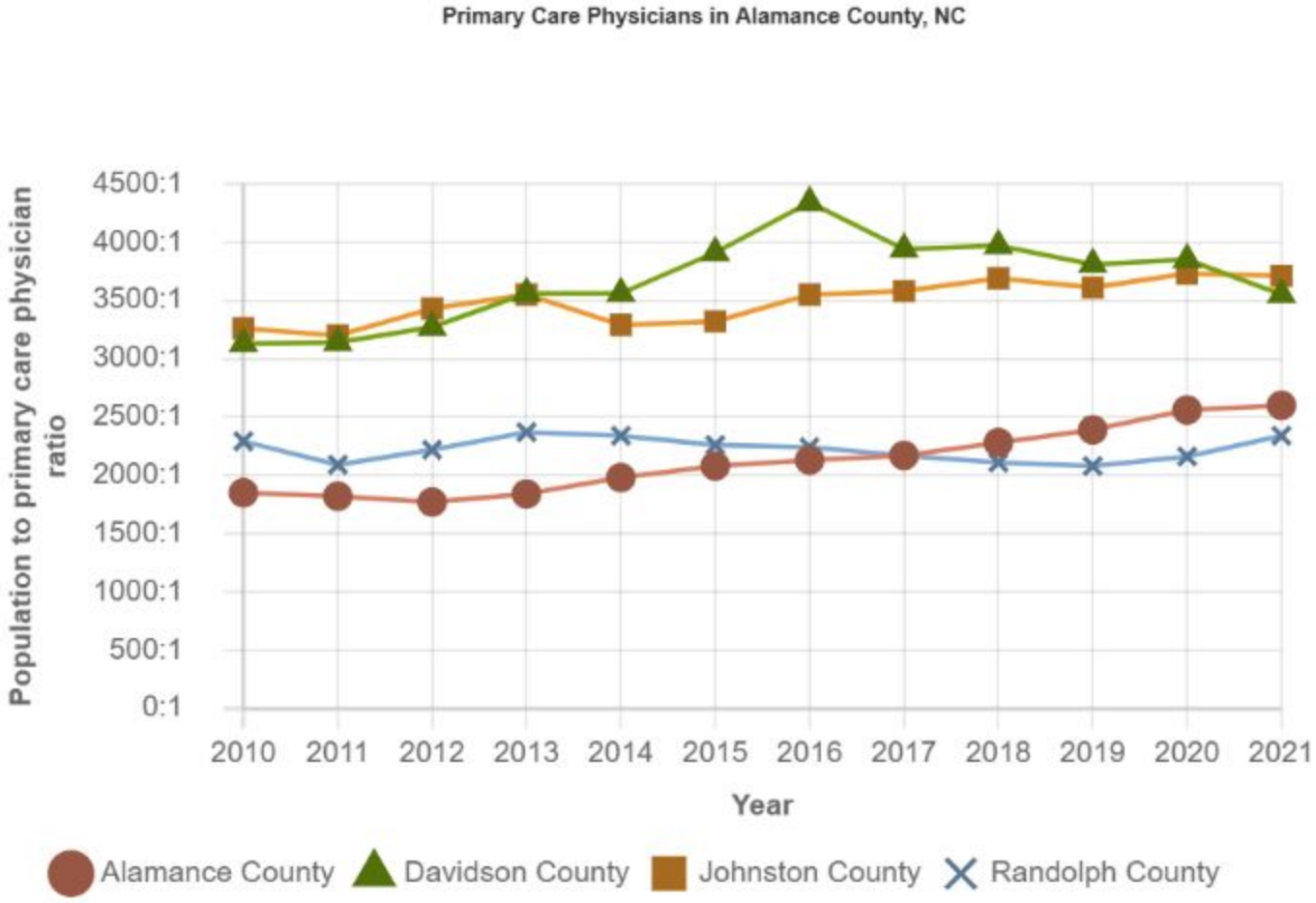



Median Gross Rent
$1,150.00
$1,050.00
$950.00
$850.00
$750.00
$650.00
2015-2019
2016-2020
2017-2021
2018-2022
2019-2023
Alamance County
Davidson County
Johnston County
Randolph County
North Carolina


Median Gross Rent as a Percentage of Household income
30.50%
30.00%
29.50%
29.00%
28.50%
28.00%
27.50%
27.00%
26.50%
2015-2019
2016-2020
2017-2021
2018-2022
2019-2023
Alamance County
Davidson County
Johnston County
Randolph County
North Carolina

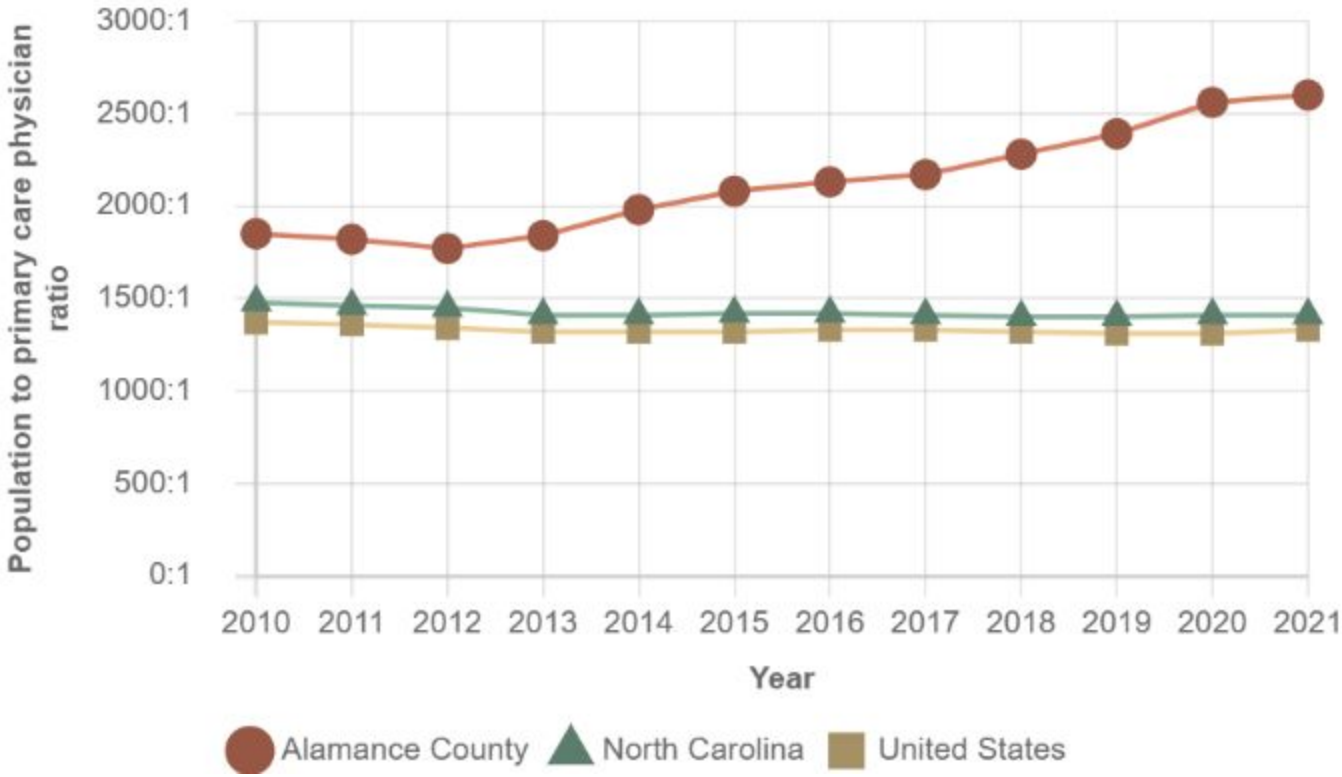

Median Gross Rent as a Percentage of Household income
30.50%
30.00%
29.50%
29.00%
28.50%
28.00%
27.50%
27.00%
26.50%
2015-2019
2016-2020
2017-2021
2018-2022
2019-2023
Alamance County
Davidson County
Johnston County
Randolph County
North Carolina

Access to Primary Care


Primary Care Physicians in Alamance County, NC
Population to primary care physician ratio
4500:1
4000:1
3500:1
3000:1
2500:1
2000:1
1500:1
1000:1
500:1
0:1
2010
2011
2012
2013
2014
2015
2016
2017
2018
2019
2020
2021
Year
Alamance County
Davidson County
Johnston County
Randolph County

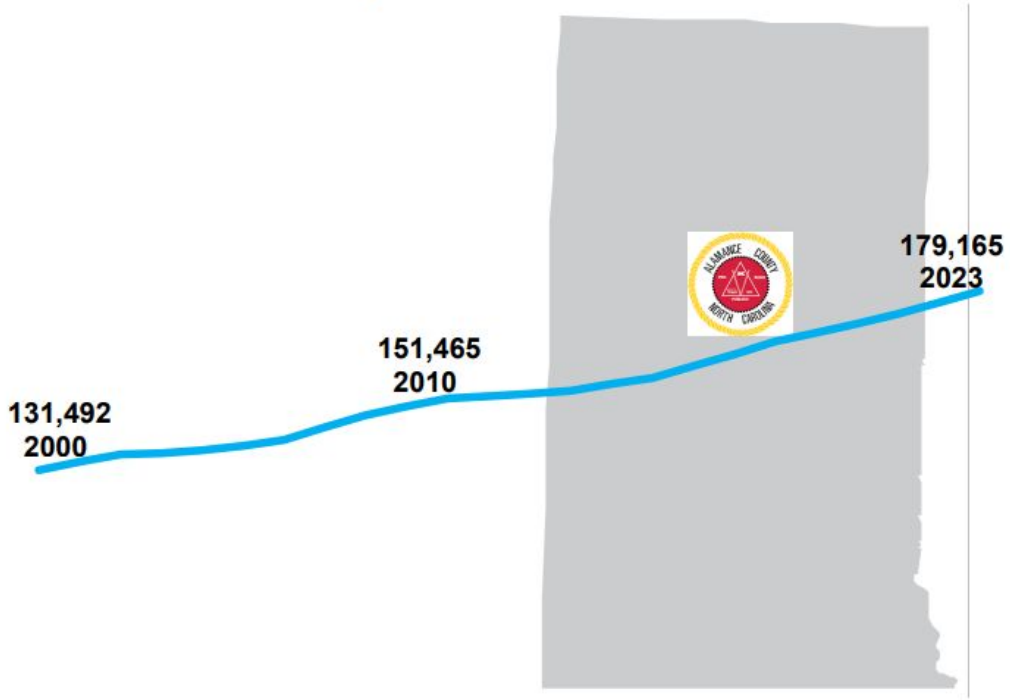
Primary Care Physicians in Alamance County, NC

Alamance County is getting worse for this measure.



Current Population

+ 48K new Alamance County residents since 2000



UNC CAROLINA POPULATION CENTER

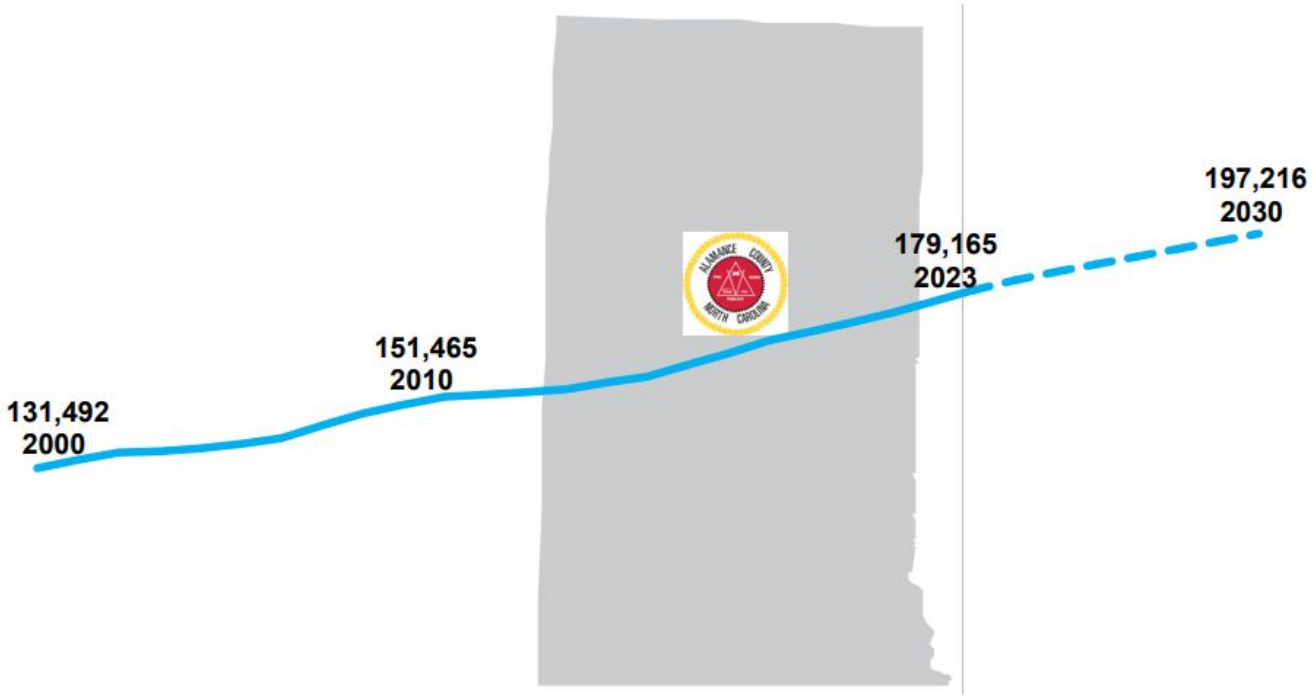
carolinademography.cpc.unc.edu

CAROLINA DEMOGRAPHY

Source: NC OSBM, Population Estimates and Projection, Vintage 2022

By 2030, 197K residents

Projected Population Growth

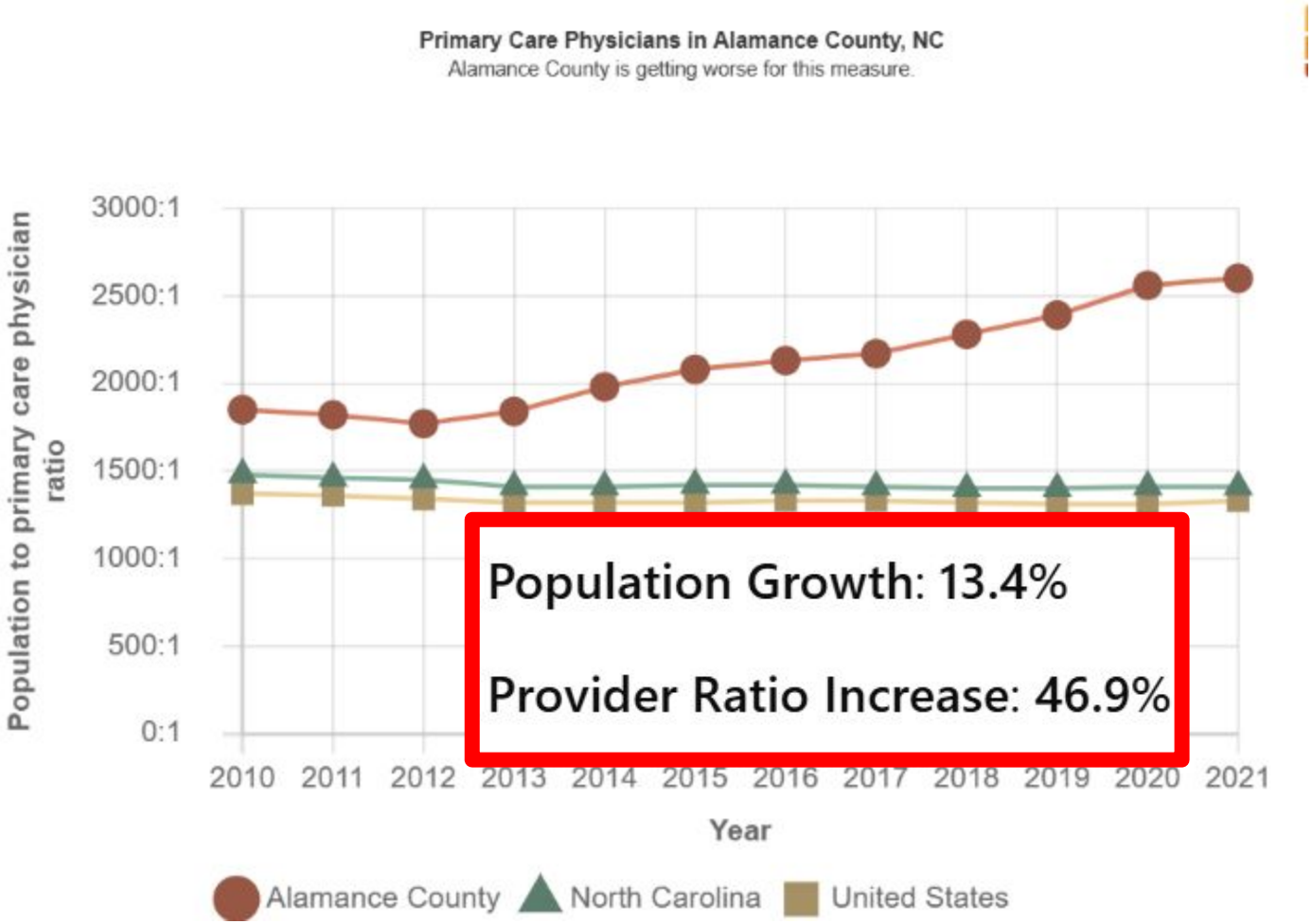


UNC CAROLINA POPULATION CENTER

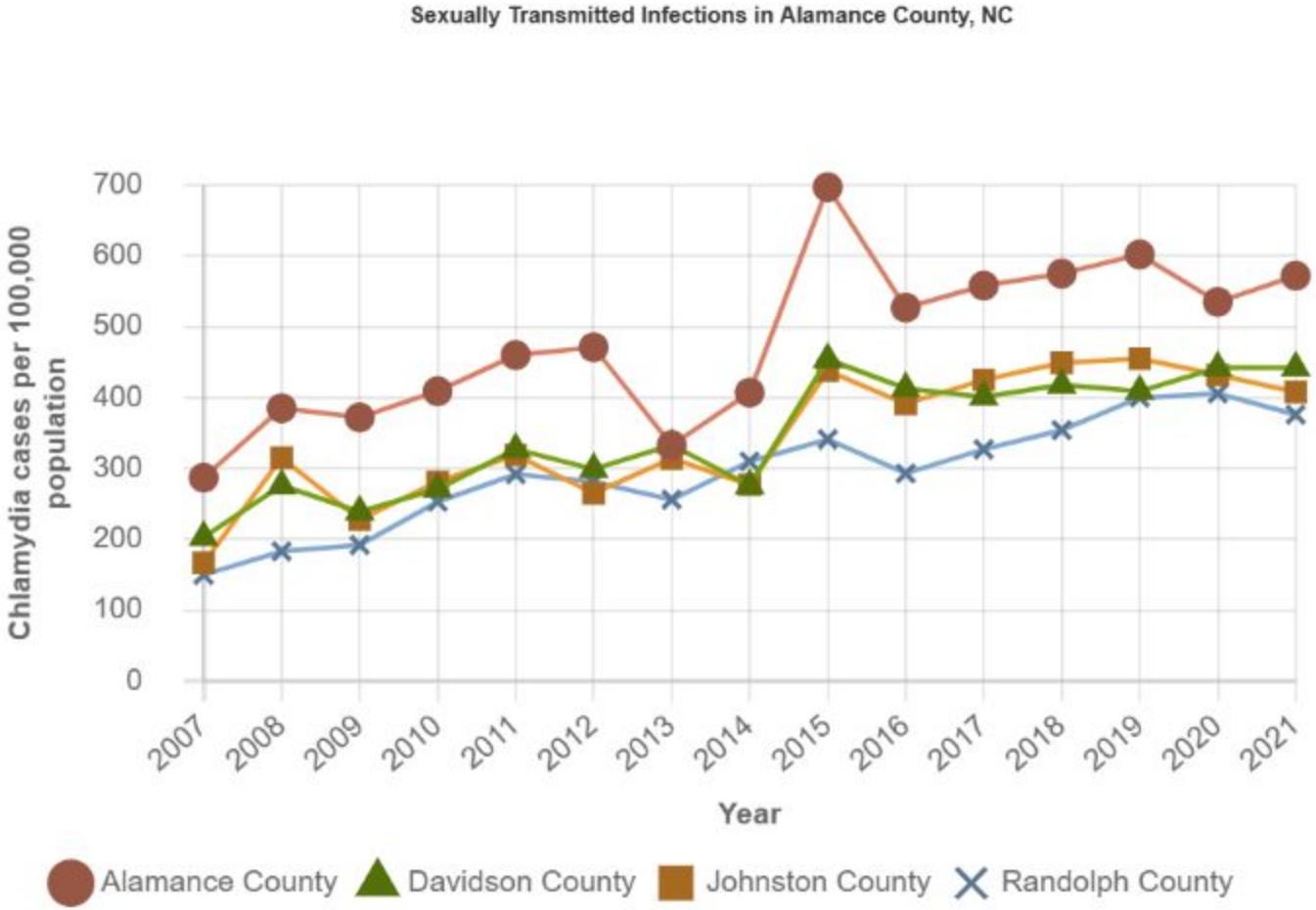
carolinademography.cpc.unc.edu

CAROLINA DEMOGRAPHY

Source: NC OSBM, Population Estimates and Projection, Vintage 2022

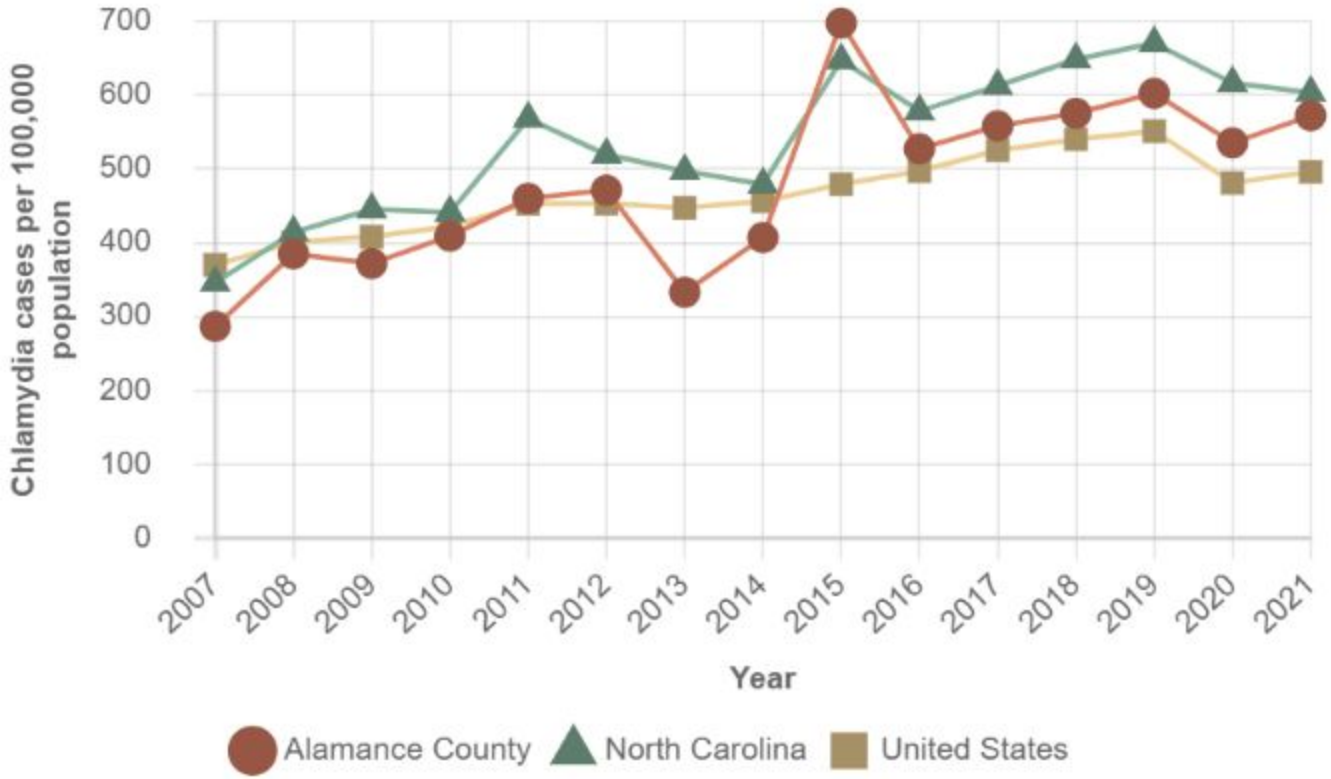

Primary Care Physicians in Alamance County, NC
Alamance County is getting worse for this measure.
Population to primary care physician ratio
3000:1
2500:1
2000:1
1500:1
1000:1
500:1
0:1
2010
2011
2012
2013
2014
2015
2016
2017
2018
2019
2020
2021
Year
Population Growth: 13.4%
Provider Ratio Increase: 46.9%
Alamance County
North Carolina
United States

Sexual Health


Sexually Transmitted Infections in Alamance County, NC
Chlamydia cases per 100,000 population
700
600
500
400
300
200
100
0
2007
2008
2009
2010
2011
2012
2013
2014
2015
2016
2017
2018
2019
2020
2021
Year
Alamance County
Davidson County
Johnston County
Randolph County

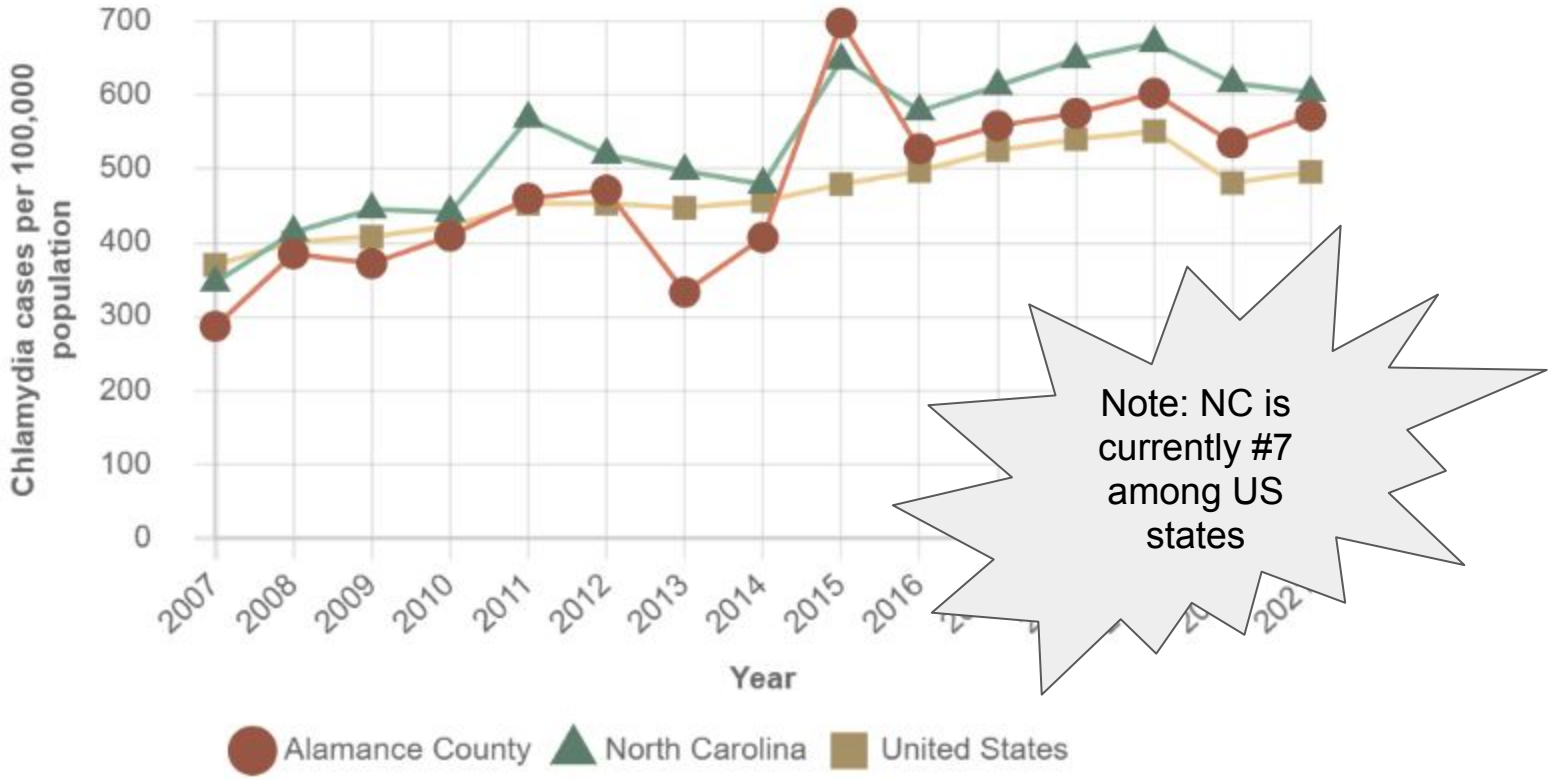
Sexually Transmitted Infections in Alamance County, NC

Alamance County is getting worse for this measure.

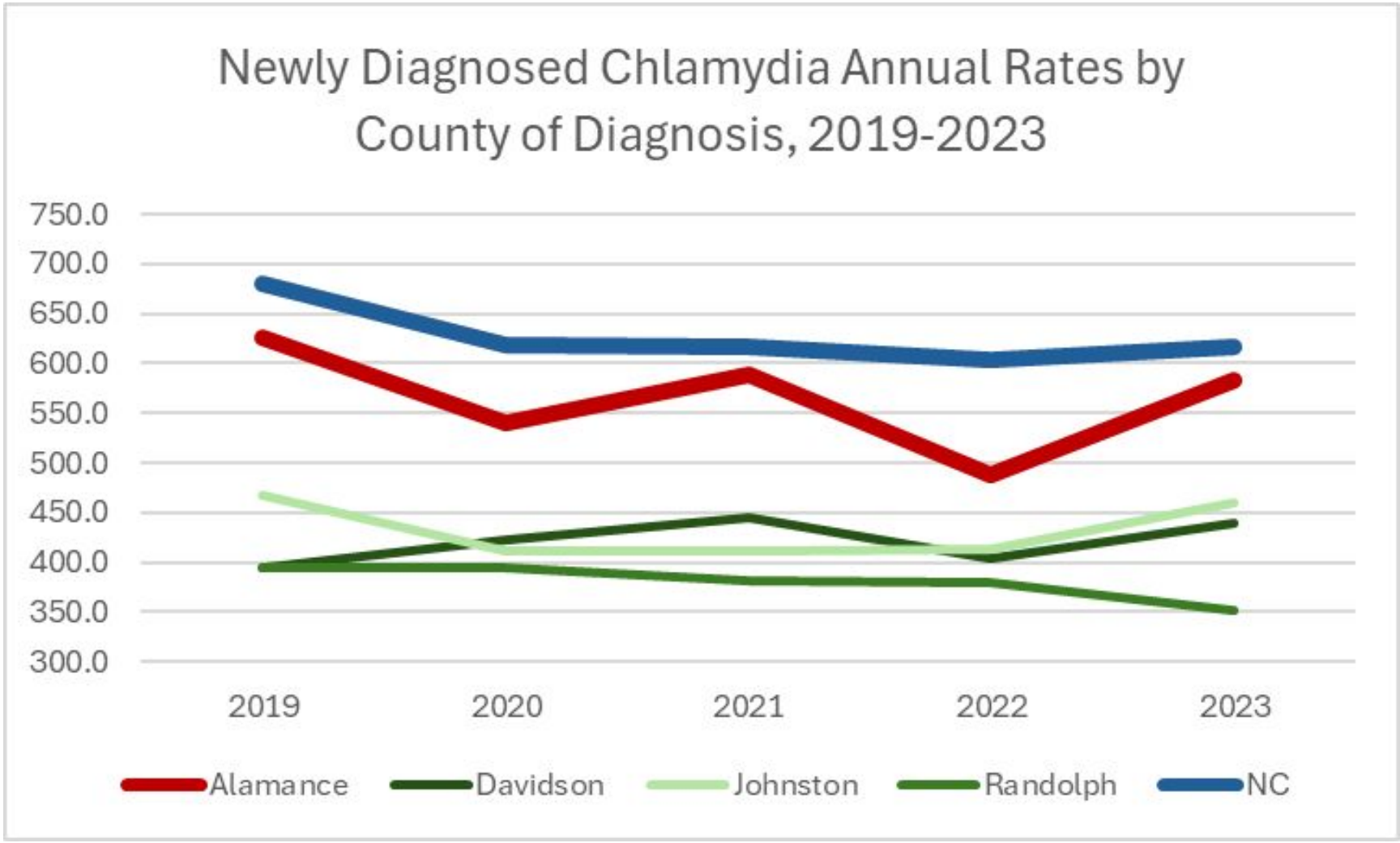


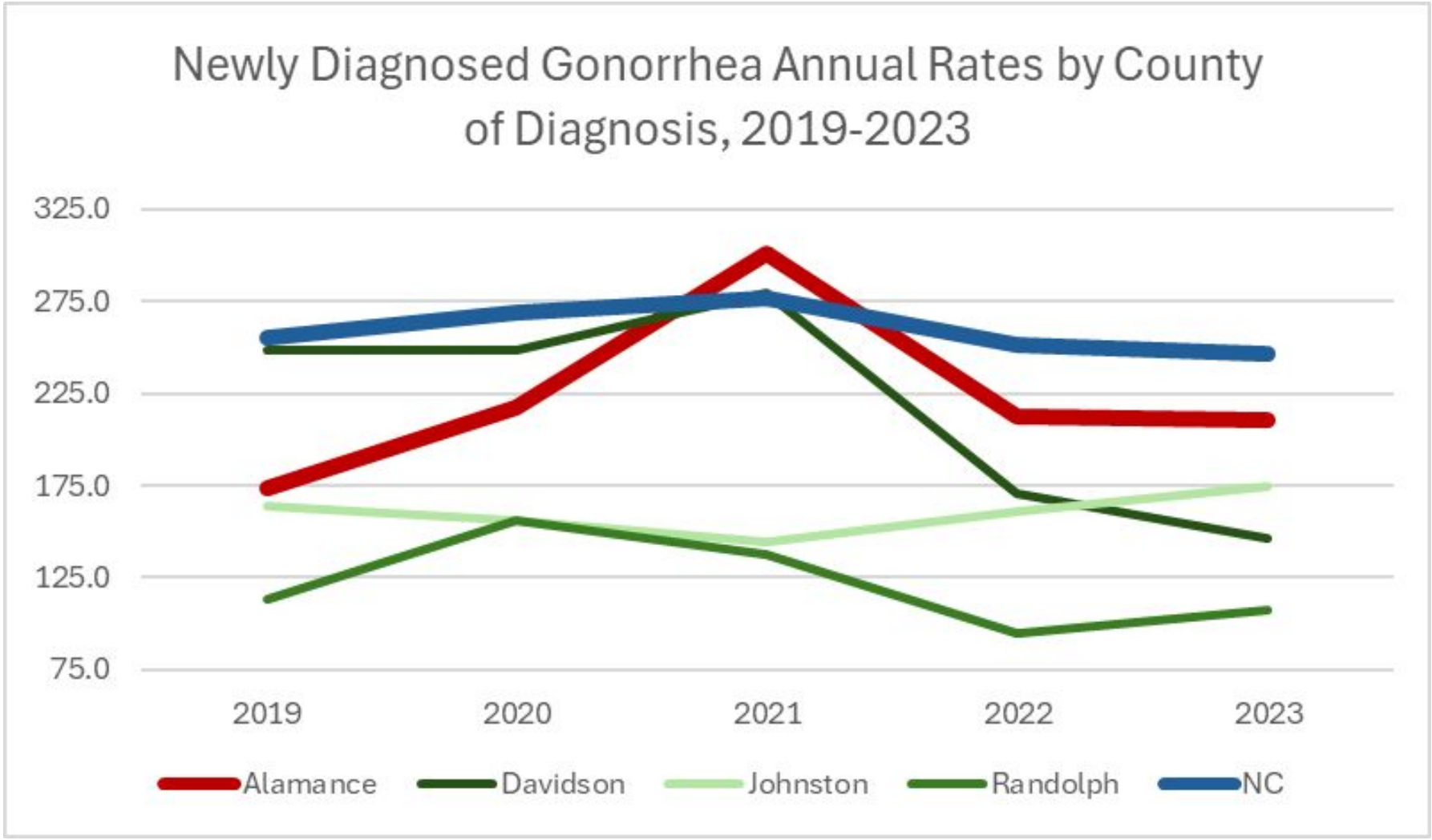
Sexually Transmitted Infections in Alamance County, NC

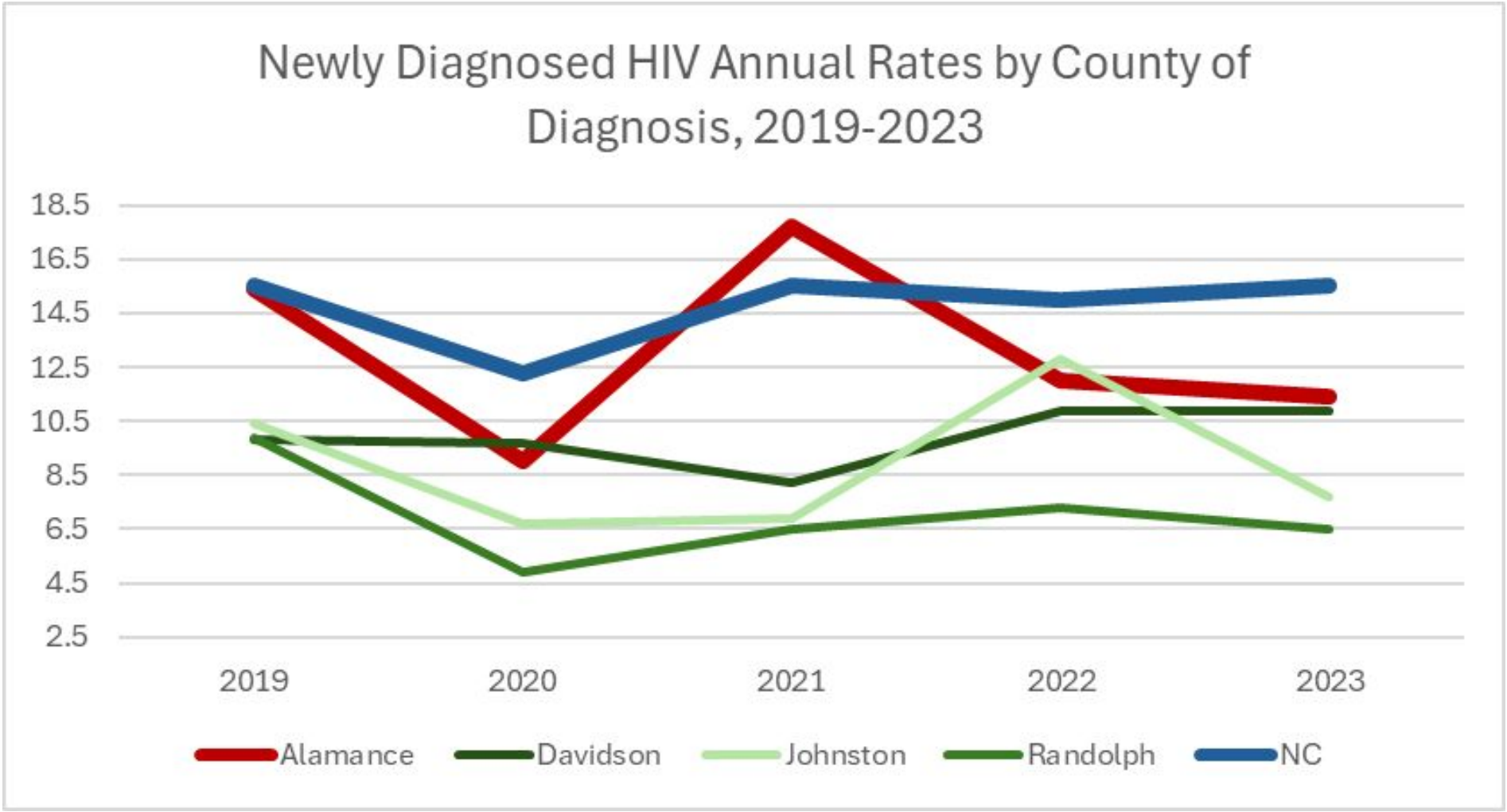
Alamance County is getting worse for this measure.



Note: NC is currently #7 among US states


Newly Diagnosed Chlamydia Annual Rates by County of Diagnosis, 2019-2023
750.0
700.0
650.0
600.0
550.0
500.0
450.0
400.0
350.0
300.0
2019
2020
2021
2022
2023
Alamance
Davidson
Johnston
Randolph
NC


Newly Diagnosed Gonorrhea Annual Rates by County of Diagnosis, 2019-2023
325.0
275.0
225.0
175.0
125.0
75.0
2019
2020
2021
2022
2023
Alamance
Davidson
Johnston
Randolph
NC


Newly Diagnosed HIV Annual Rates by County of Diagnosis, 2019-2023
18.5
16.5
14.5
12.5
10.5
8.5
6.5
4.5
2.5
2019
2020
2021
2022
2023
Alamance
Davidson
Johnston
Randolph
NC

Food Access

Quality of Life

Question	Woman Mean	Man Mean
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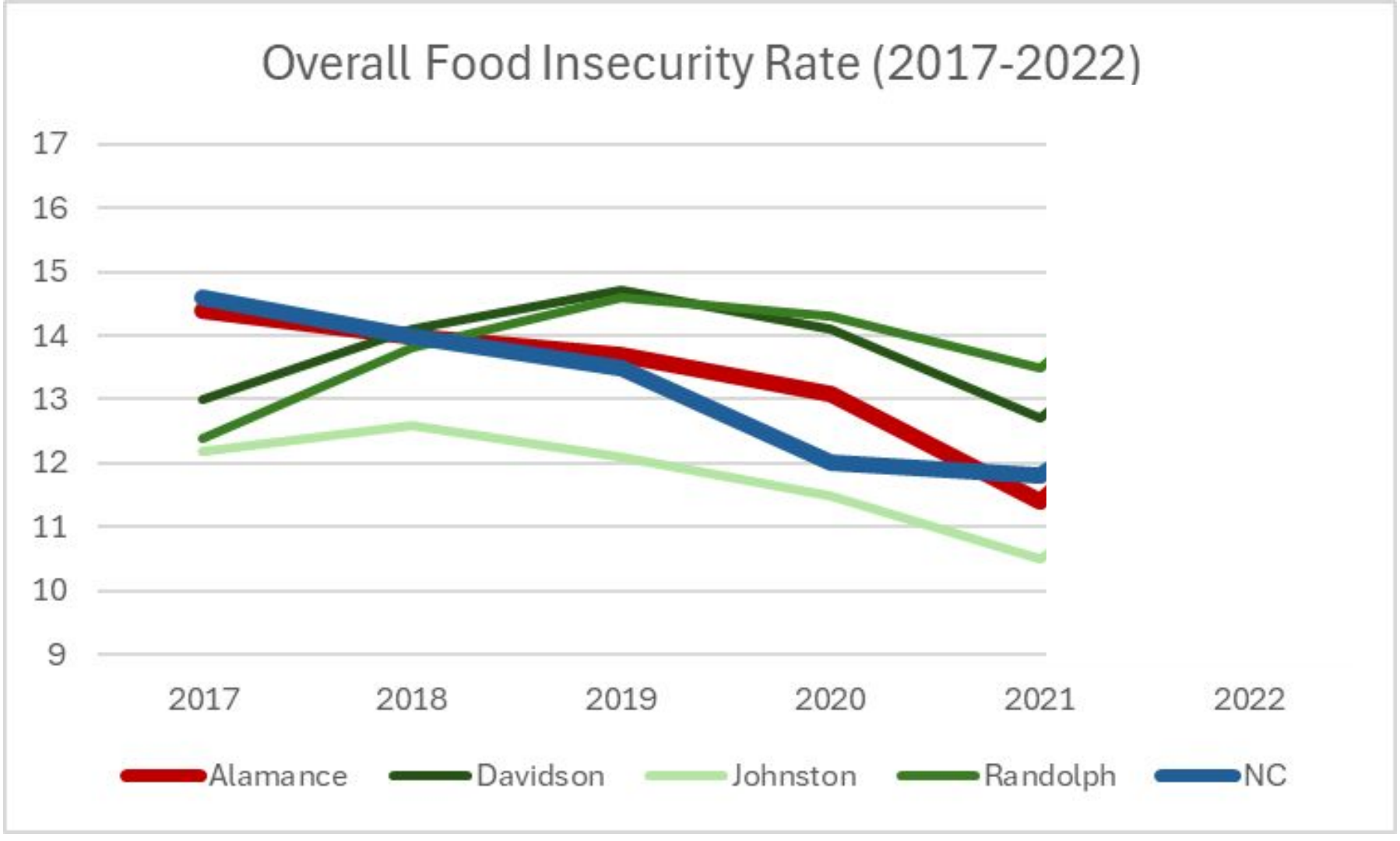
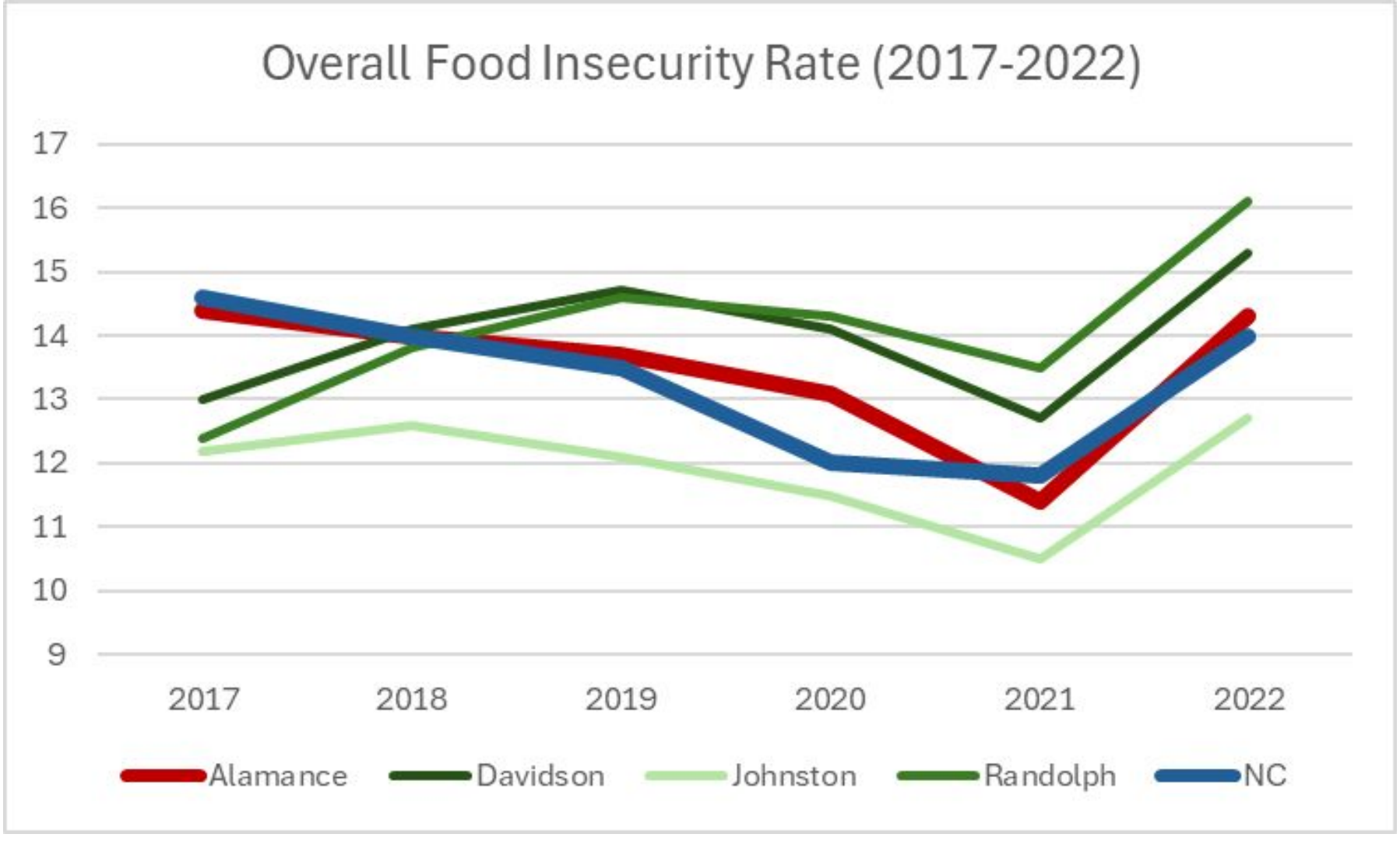
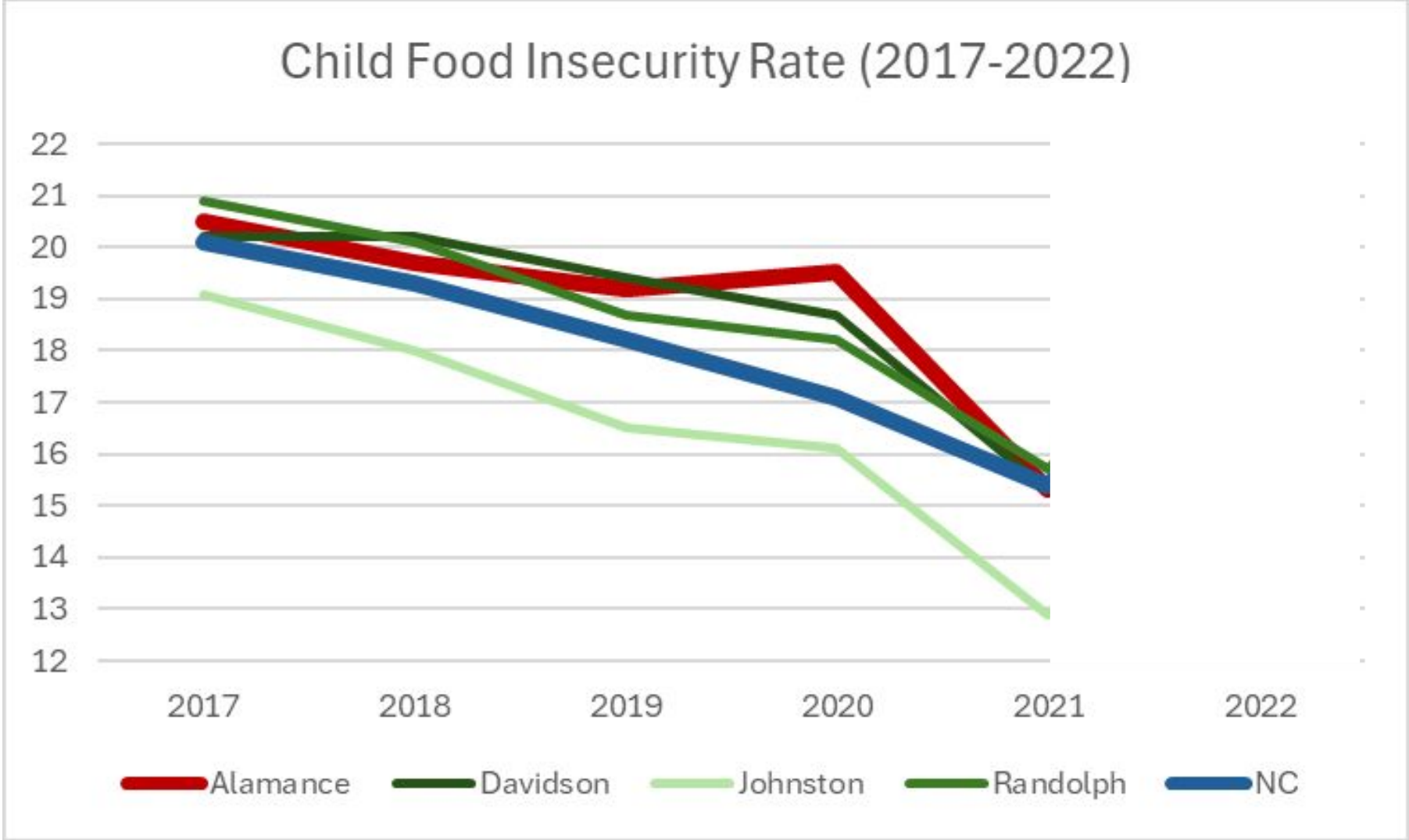
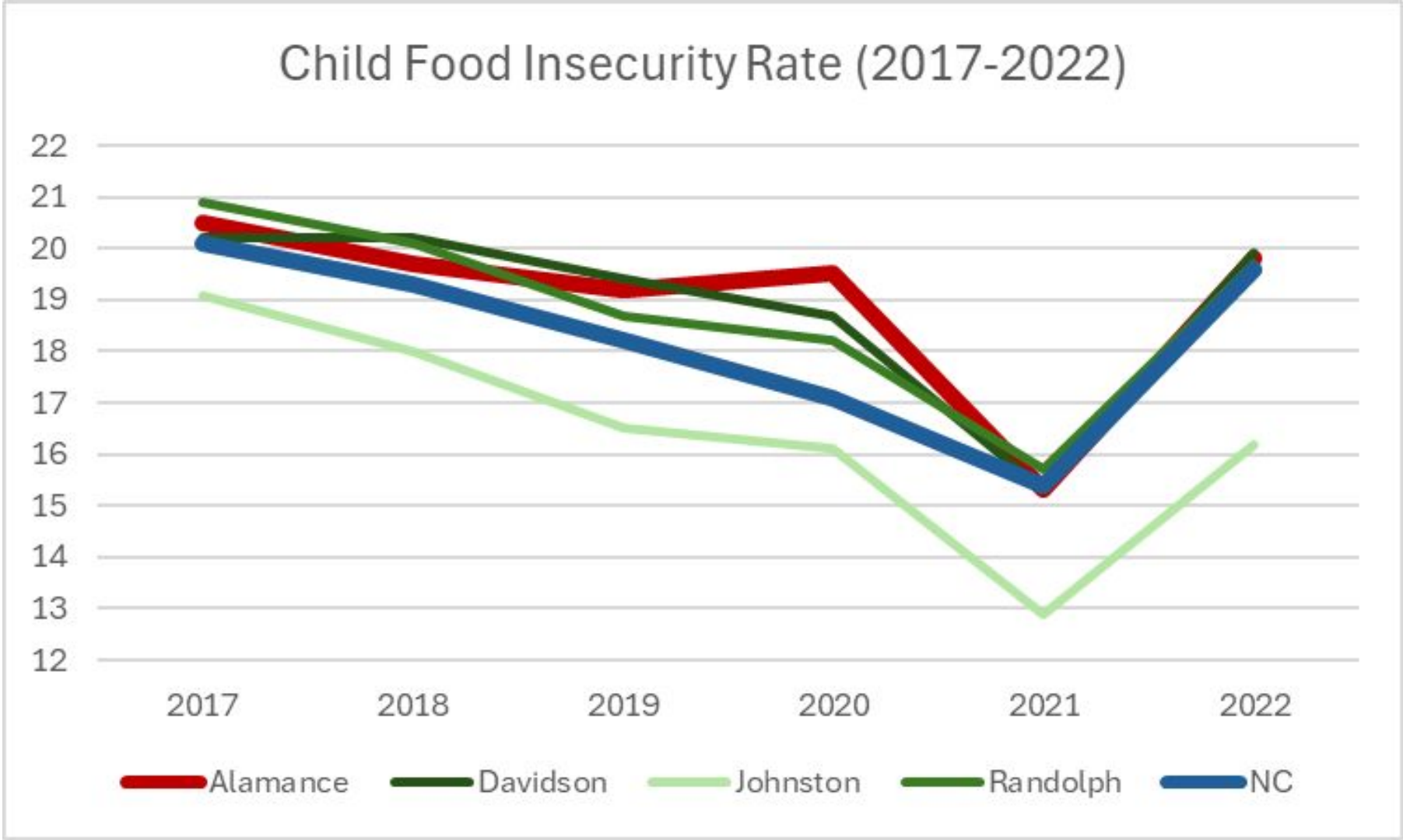
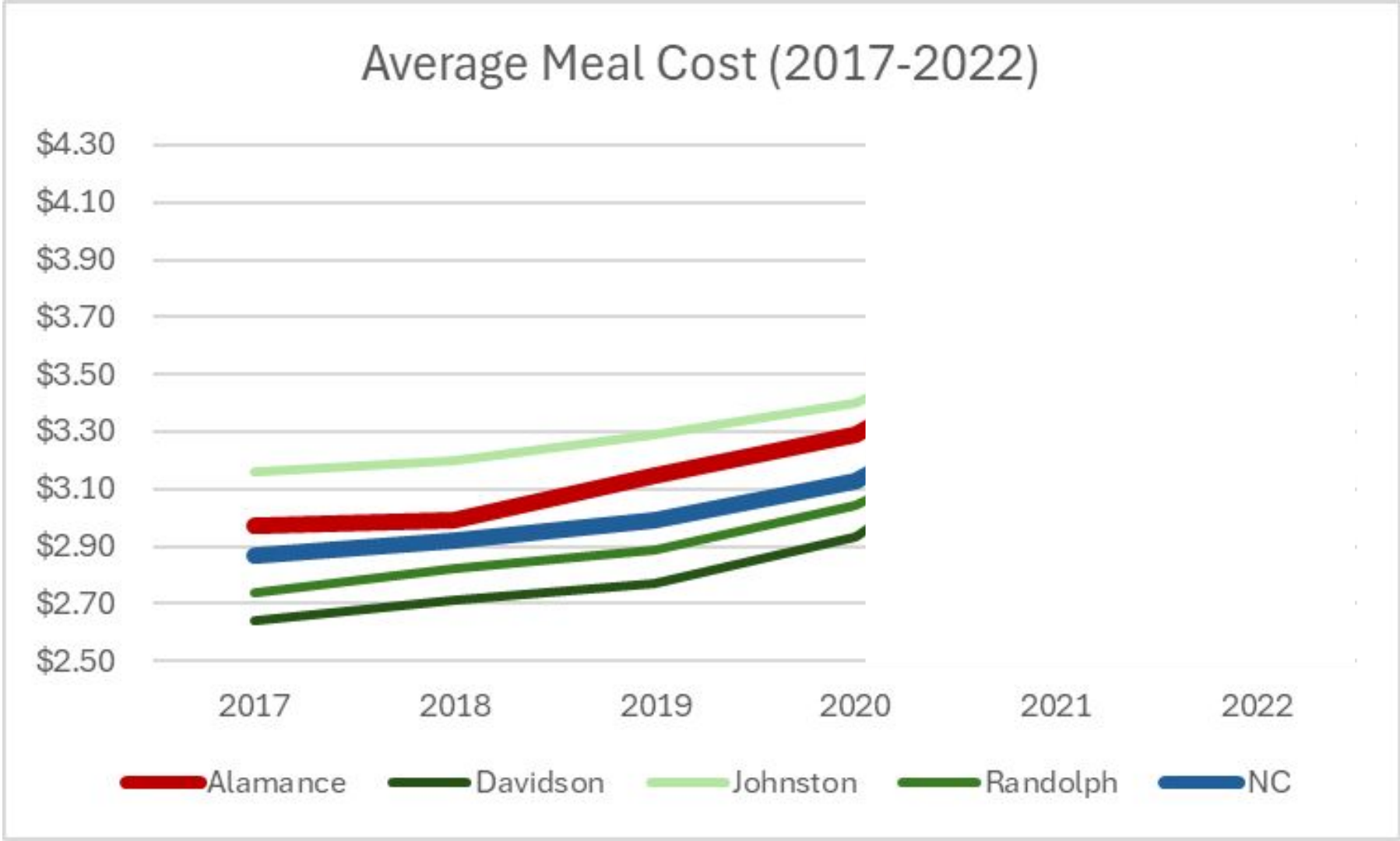
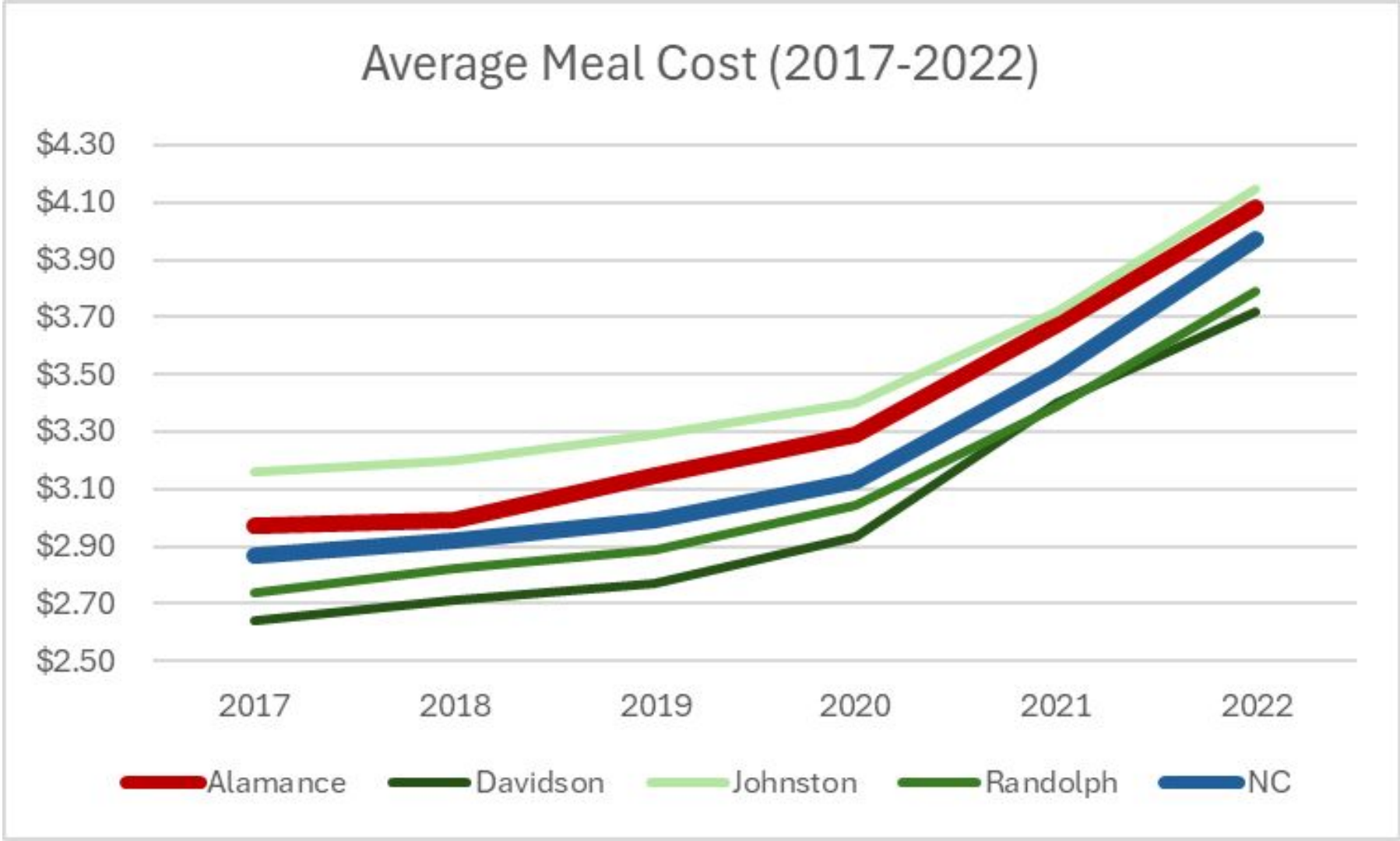

Overall Food Insecurity Rate (2017-2022)
17
16
15
14
13
12
11
10
9
2017
2018
2019
2020
2021
2022
Alamance
Davidson
Johnston
Randolph
NC


Overall Food Insecurity Rate (2017-2022)
17
16
15
14
13
12
11
10
9
2017
2018
2019
2020
2021
2022
Alamance
Davidson
Johnston
Randolph
NC

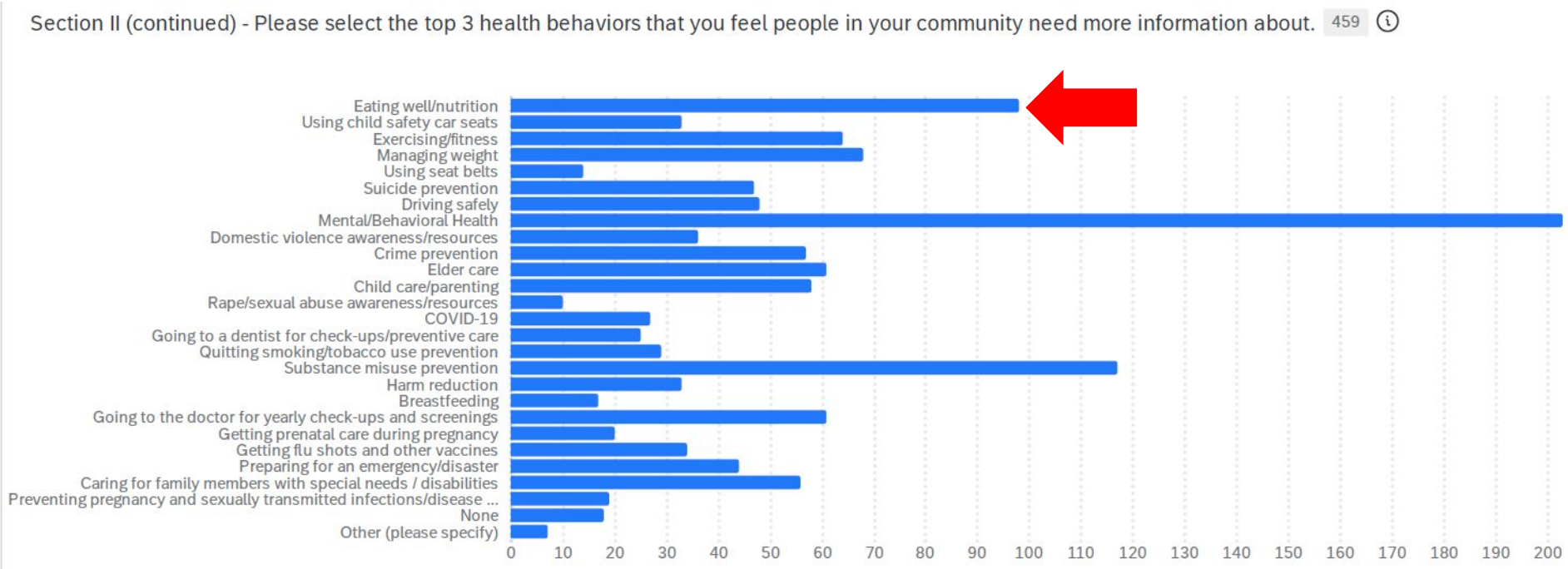

Child Food Insecurity Rate (2017-2022)
22
21
20
19
18
17
16
15
14
13
12
2017
2018
2019
2020
2021
2022
Alamance
Davidson
Johnston
Randolph
NC


Child Food Insecurity Rate (2017-2022)
22
21
20
19
18
17
16
15
14
13
12
2017
2018
2019
2020
2021
2022
Alamance
Davidson
Johnston
Randolph
NC


Average Meal Cost (2017-2022)
$4.30
$4.10
$3.90
$3.70
$3.50
$3.30
$3.10
$2.90
$2.70
$2.50
2017
2018
2019
2020
2021
2022
Alamance
Davidson
Johnston
Randolph
NC


Average Meal Cost (2017-2022)
$4.30
$4.10
$3.90
$3.70
$3.50
$3.30
$3.10
$2.90
$2.70
$2.50
2017
2018
2019
2020
2021
2022
Alamance
Davidson
Johnston
Randolph
NC

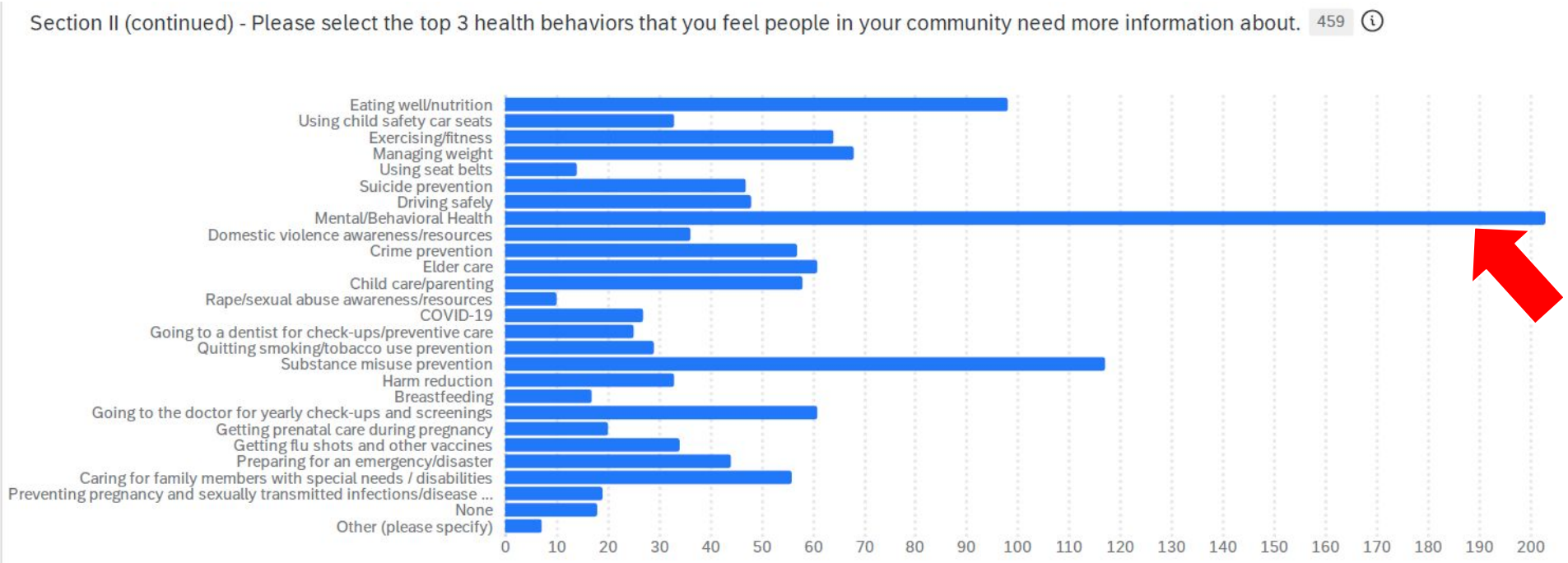
Eating Well


Section II (continued) - Please select the top 3 health behaviors that you feel people in your community need more information about.
459
Eating well/nutrition
Using child safety car seats
Exercising/fitness
Managing weight
Using seat belts
Suicide prevention
Driving safely
Mental/Behavioral Health
Domestic violence awareness/resources
Crime prevention
Elder care
Child care/parenting
Rape/sexual abuse awareness/resources
COVID-19
Going to a dentist for check-ups/preventive care
Quitting smoking/tobacco use prevention
Substance misuse prevention
Harm reduction
Breastfeeding
Going to the doctor for yearly check-ups and screenings
Getting prenatal care during pregnancy
Getting flu shots and other vaccines
Preparing for an emergency/disaster
Caring for family members with special needs / disabilities
Preventing pregnancy and sexually transmitted infections/disease ...
None
Other (please specify)
0
10
20
30
40
50
60
70
80
90
100
110
120
130
140
150
160
170
180
190
200

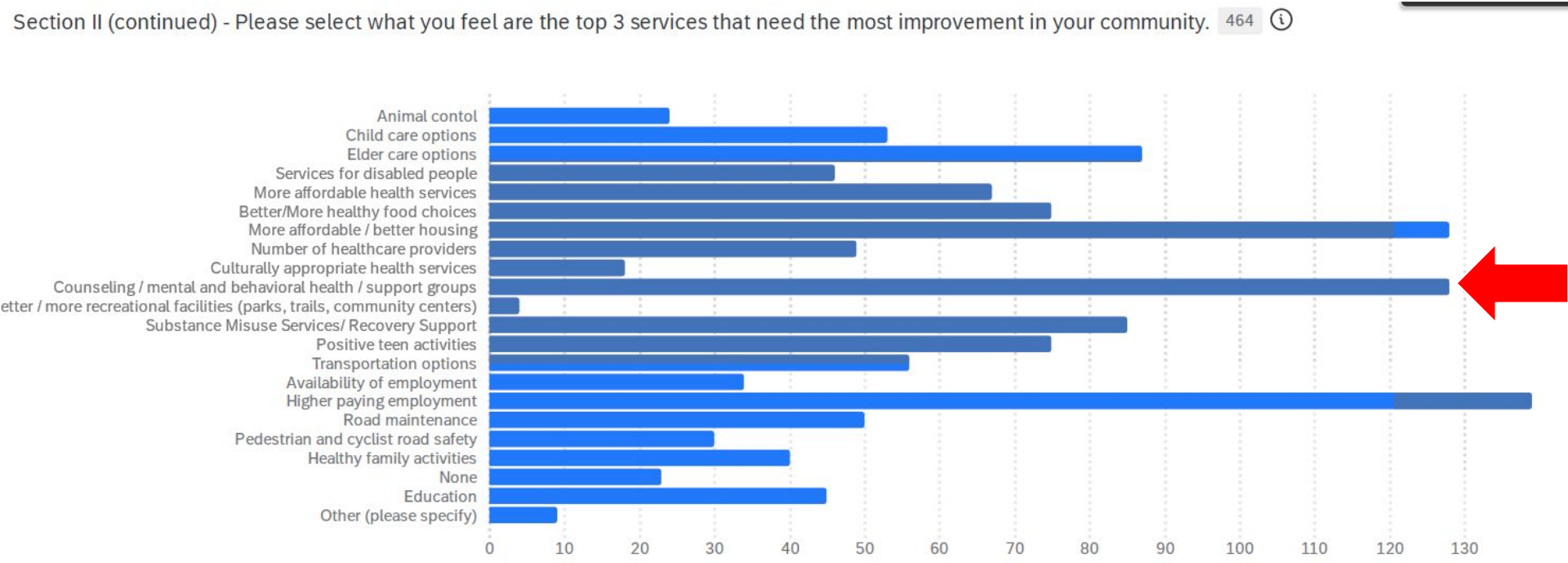
Mental/Behavioral Health

Section II (continued) - Please select the top 3 health behaviors that you feel people in your community need more information about.	**Woman Rank**	**Man Rank**
Mental/Behavioral Health	**1**	**1**
Substance misuse prevention	**2**	**5**
Eating well/nutrition	**3**	**2**
Elder care	**4**	**11**
Managing weight	**5**	**9**
Caring for family members with special needs / disabilities	**6**	**16**
Going to the doctor for yearly check-ups and screenings	**7**	**5**
Exercising/fitness	**8**	**4**
Child care/parenting	**9**	**5**
Driving safely	**10**	**18**
Suicide prevention	**11**	**16**
Crime prevention	**12**	**3**

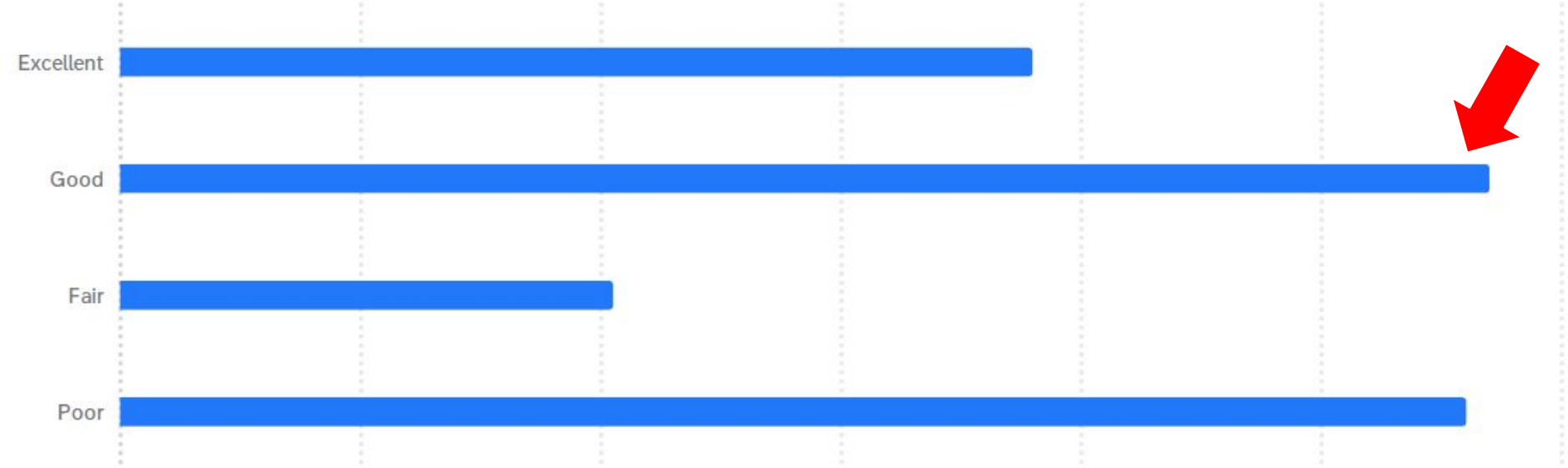
Mental Health



Mental Health



How would you rate the overall mental health services available in our community? 501



Substance Use & Overdose Prevention

Leading Causes of Death Ranking (2018-2022)

1. Diseases of the heart
2. Cancer - all sites
3. Other unintentional injuries
4. Chronic lower respiratory diseases
5. Cerebrovascular disease
6. COVID-19
7. Alzheimer's disease
8. Diabetes mellitus
9. Nephritis, nephrotic syndrome, & nephrosis
10. Pneumonia & influenza

Leading Causes of Death Ranking (2018-2022)

1. Diseases of the heart
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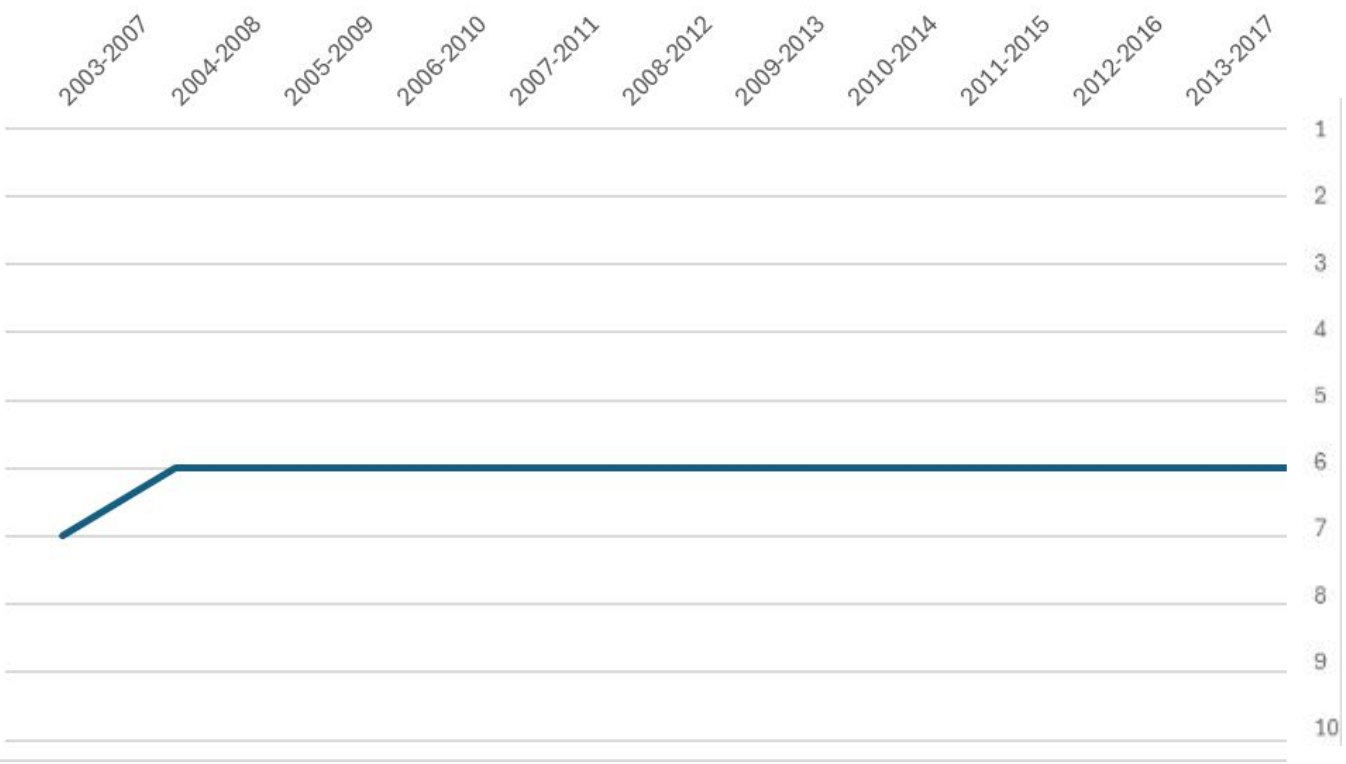
4. Chronic lower respiratory diseases
5. Cerebrovascular disease
6. COVID-19
7. Alzheimer's disease
8. Diabetes mellitus
9. Nephritis, nephrotic syndrome, & nephrosis
10. Pneumonia & influenza

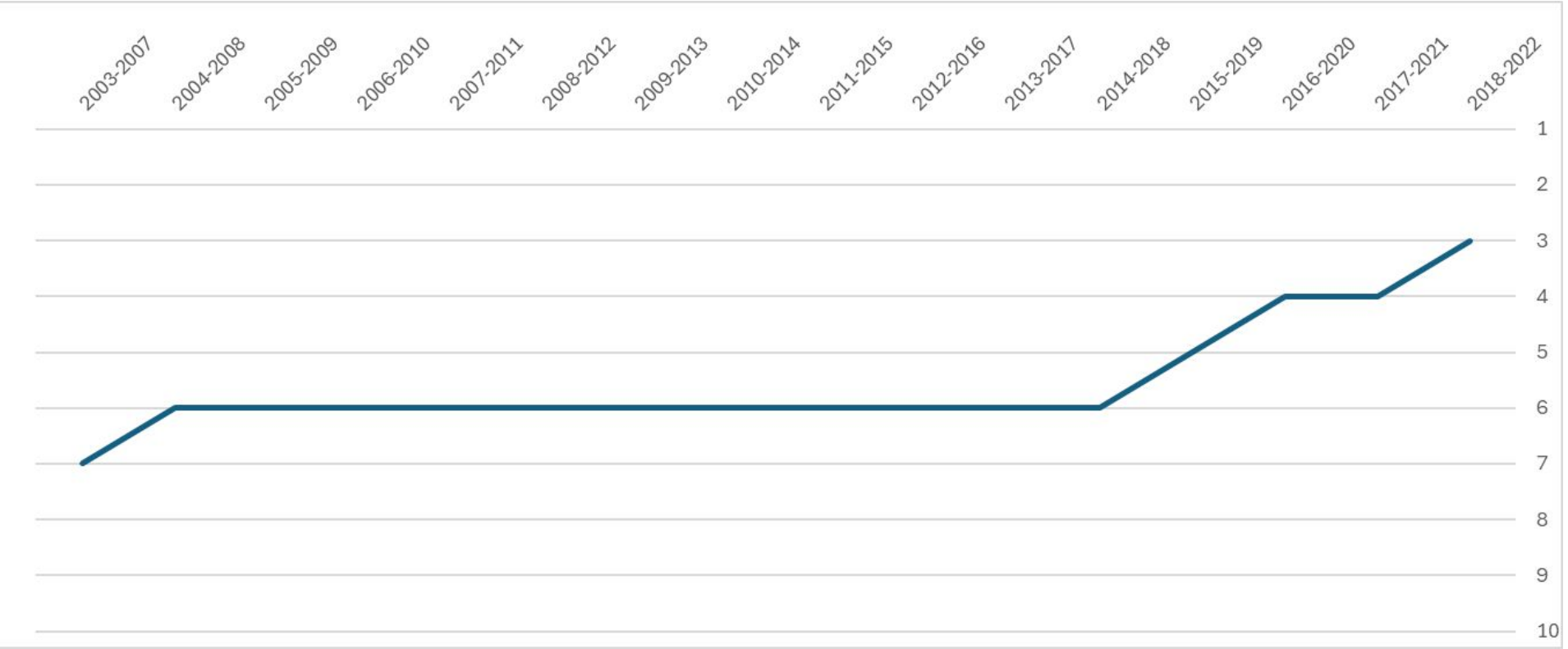
2014-2018	2015-2019	2016-2020	2017-2021	2018-2022
Cancer - All Sites	Cancer - All Sites	Cancer - All Sites	Cancer - All Sites	Diseases of the heart
Diseases of the heart	Diseases of the heart	Diseases of the heart	Diseases of the heart	Cancer - All Sites
Chronic lower respiratory diseases	Chronic lower respiratory diseases	Chronic lower respiratory diseases	Chronic lower respiratory diseases	Other Unintentional injuries
Cerebrovascular disease	Cerebrovascular disease	Other Unintentional injuries	Other Unintentional injuries	Chronic lower respiratory diseases
Alzheimer's disease	Other Unintentional injuries	Cerebrovascular disease	Cerebrovascular disease	Cerebrovascular disease
Other Unintentional injuries	Alzheimer's disease	Alzheimer's disease	Alzheimer's disease	COVID-19
Diabetes mellitus	Diabetes mellitus	Diabetes mellitus	COVID-19	Alzheimer's disease
Nephritis, nephrotic syndrome, & nephrosis	Nephritis, nephrotic syndrome, & nephrosis	Nephritis, nephrotic syndrome, & nephrosis	Diabetes mellitus	Diabetes mellitus
Pneumonia & influenza	Pneumonia & influenza	Pneumonia & influenza	Nephritis, nephrotic syndrome, & nephrosis	Nephritis, nephrotic syndrome, & nephrosis
Septicemia	Septicemia	Septicemia	Pneumonia & influenza	Pneumonia & influenza

2014-2018	2015-2019	2016-2020	2017-2021	2018-2022
Cancer - All Sites	Cancer - All Sites	Cancer - All Sites	Cancer - All Sites	Diseases of the heart
Diseases of the heart	Diseases of the heart	Diseases of the heart	Diseases of the heart	Cancer - All Sites
Chronic lower respiratory diseases	Chronic lower respiratory diseases	Chronic lower respiratory diseases	Chronic lower respiratory diseases	Other Unintentional injuries
Cerebrovascular disease	Cerebrovascular disease	Other Unintentional injuries	Other Unintentional injuries	Chronic lower respiratory diseases
Alzheimer's disease	Other Unintentional injuries	Cerebrovascular disease	Cerebrovascular disease	Cerebrovascular disease
Other Unintentional injuries	Alzheimer's disease	Alzheimer's disease	Alzheimer's disease	COVID-19
Diabetes mellitus	Diabetes mellitus	Diabetes mellitus	COVID-19	Alzheimer's disease
Nephritis, nephrotic syndrome, & nephrosis	Nephritis, nephrotic syndrome, & nephrosis	Nephritis, nephrotic syndrome, & nephrosis	Diabetes mellitus	Diabetes mellitus
Pneumonia & influenza	Pneumonia & influenza	Pneumonia & influenza	Nephritis, nephrotic syndrome, & nephrosis	Nephritis, nephrotic syndrome, & nephrosis
Septicemia	Septicemia	Septicemia	Pneumonia & influenza	Pneumonia & influenza

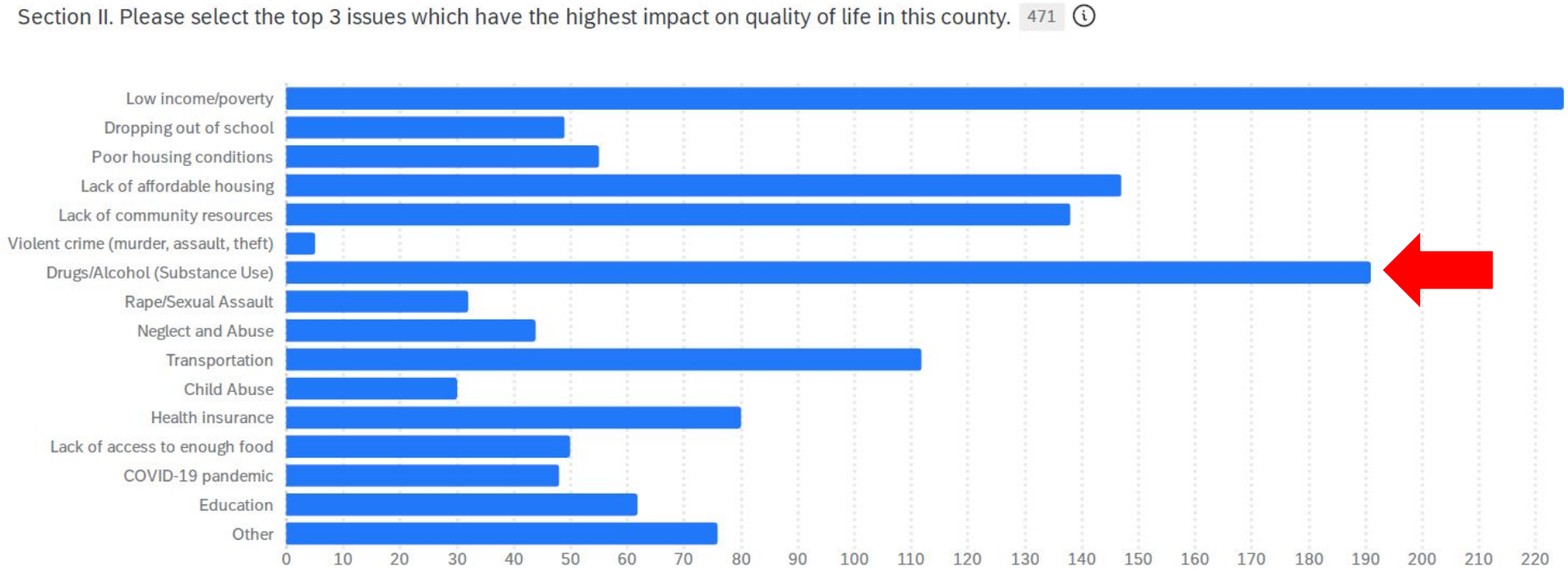
Other Unintentional Injuries - Leading Causes of Death Ranking (Since 2003-2007)



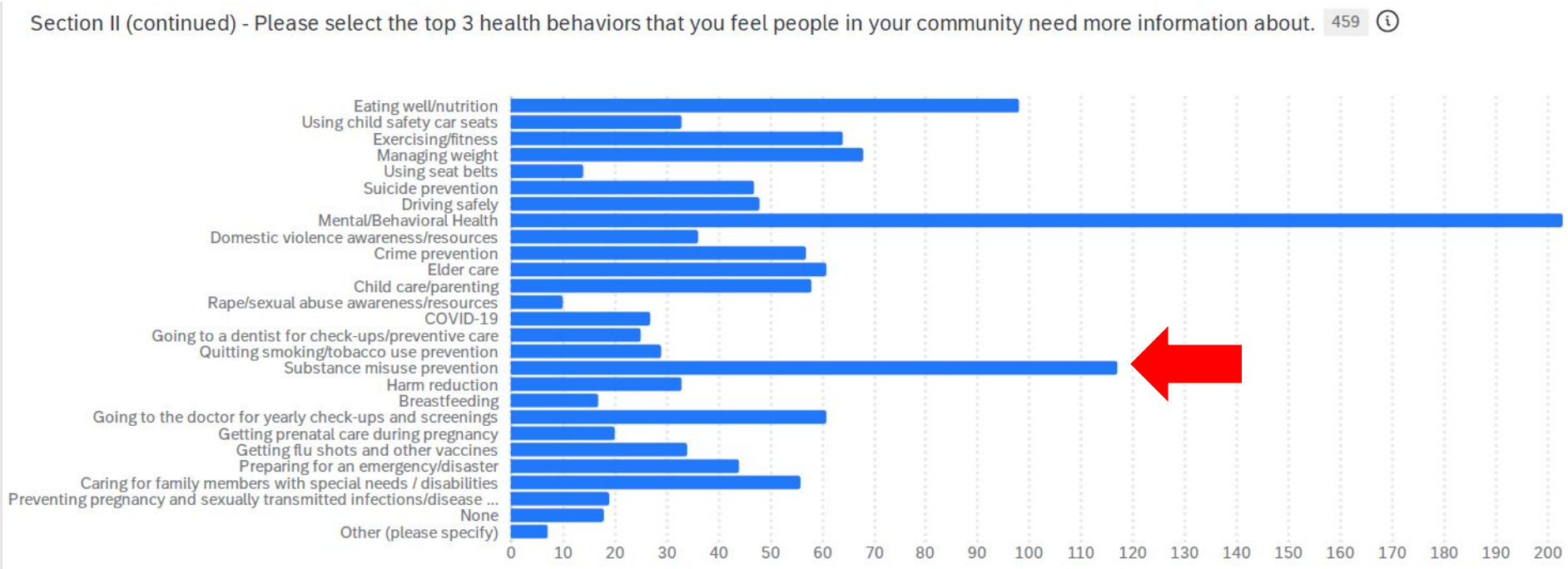
Other Unintentional Injuries - Leading Causes of Death Ranking (Since 2003-2007)



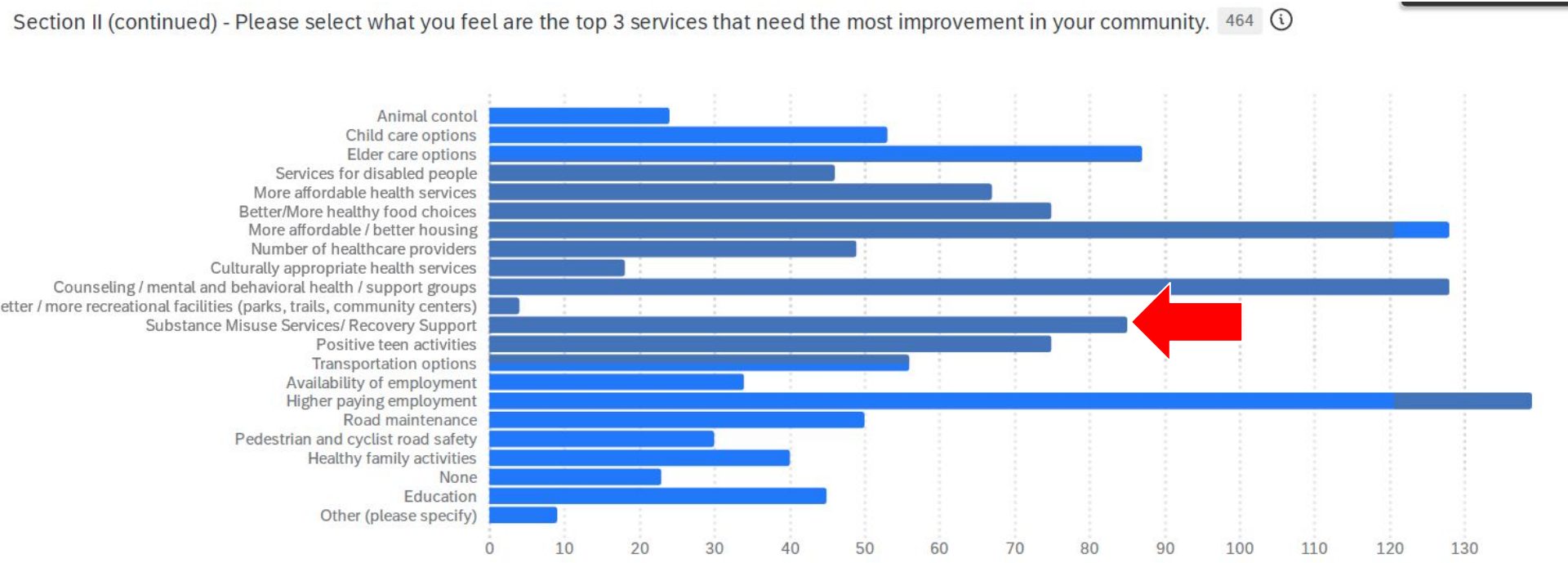
Substance Use



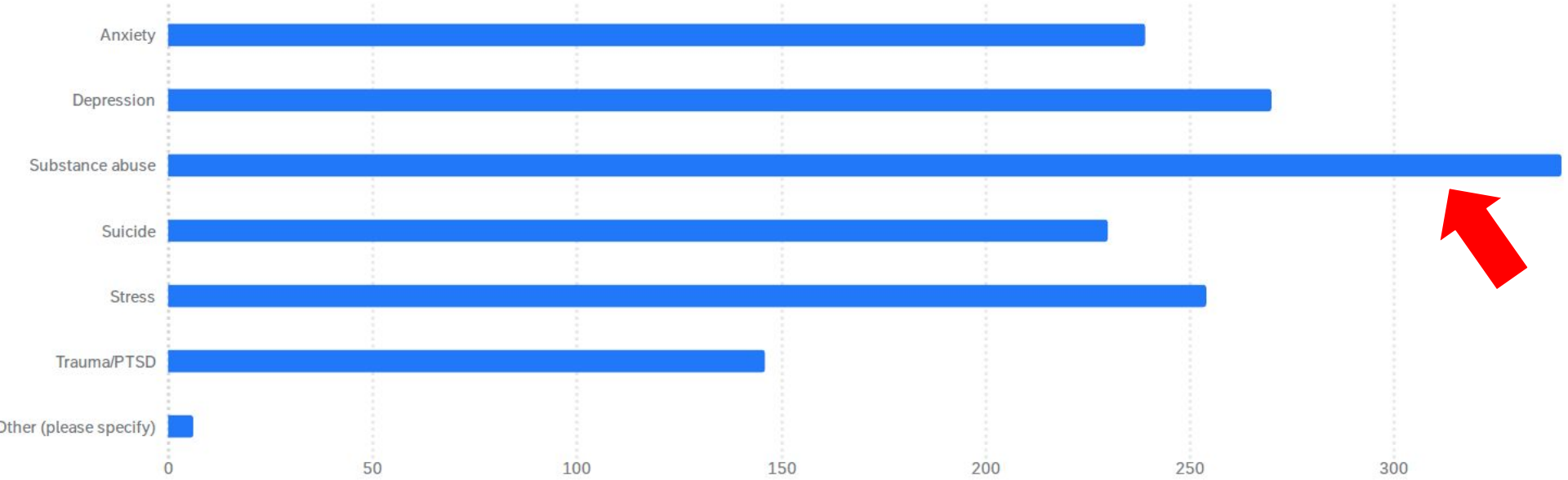
Substance Use



Substance Use

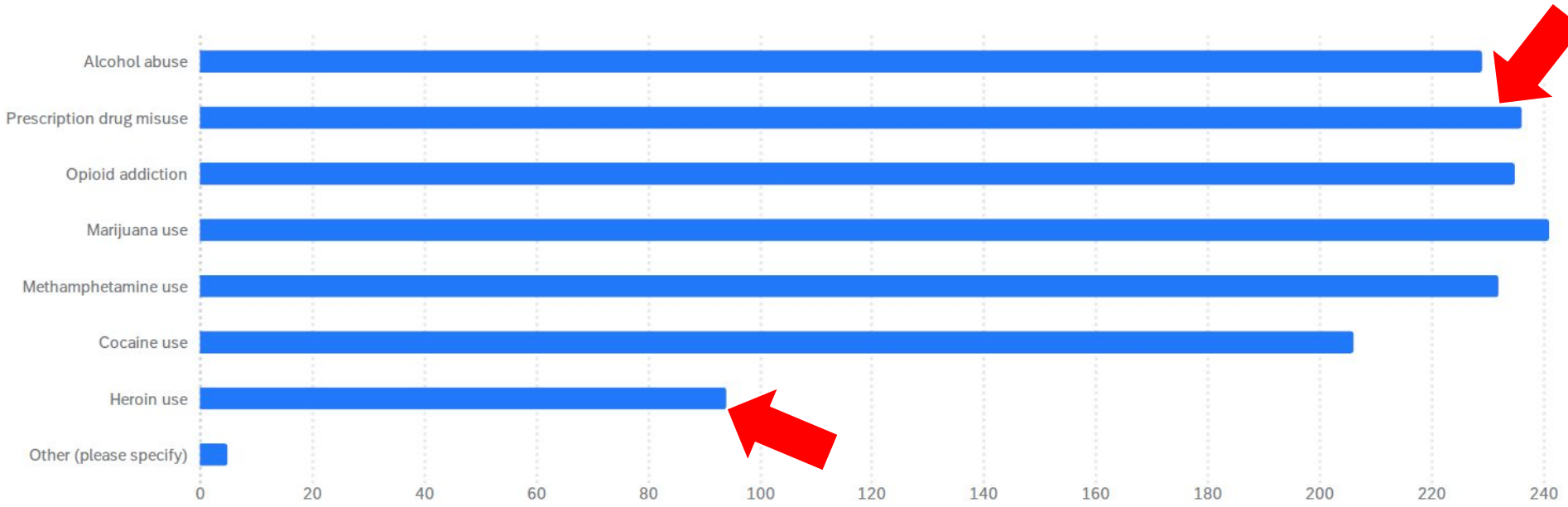


What do you believe are the top 3 mental health issues facing our community? (Select up to 3) 501



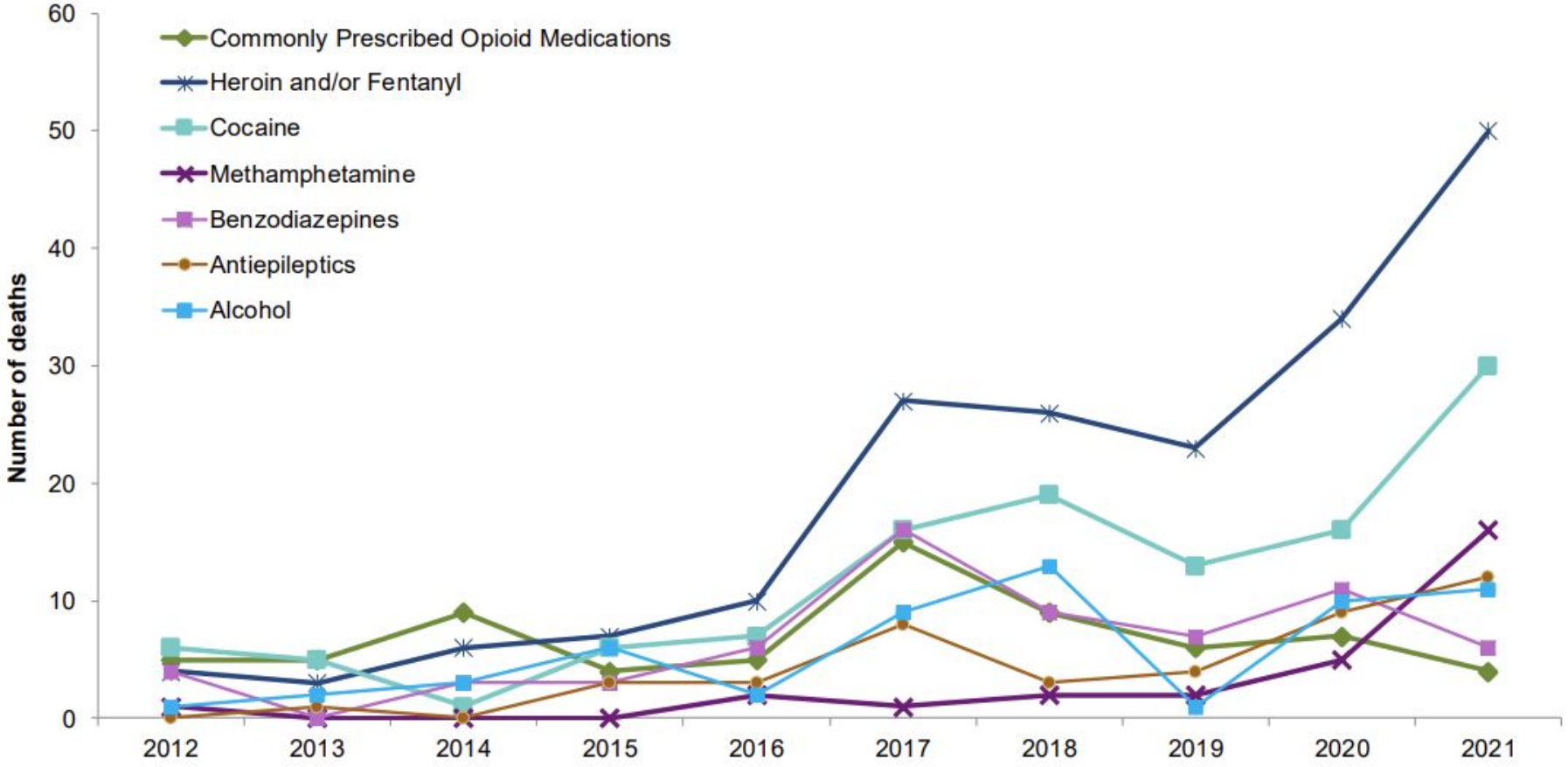
How would you rate the overall availability of substance use disorder services in our community? 501

What do you believe are the top 3 substance use issues facing our community? (Select up to 3) 499



Substances* Contributing to Overdose Deaths

Alamance County Residents, 2012-2021



Substances* Contributing to Overdose Deaths

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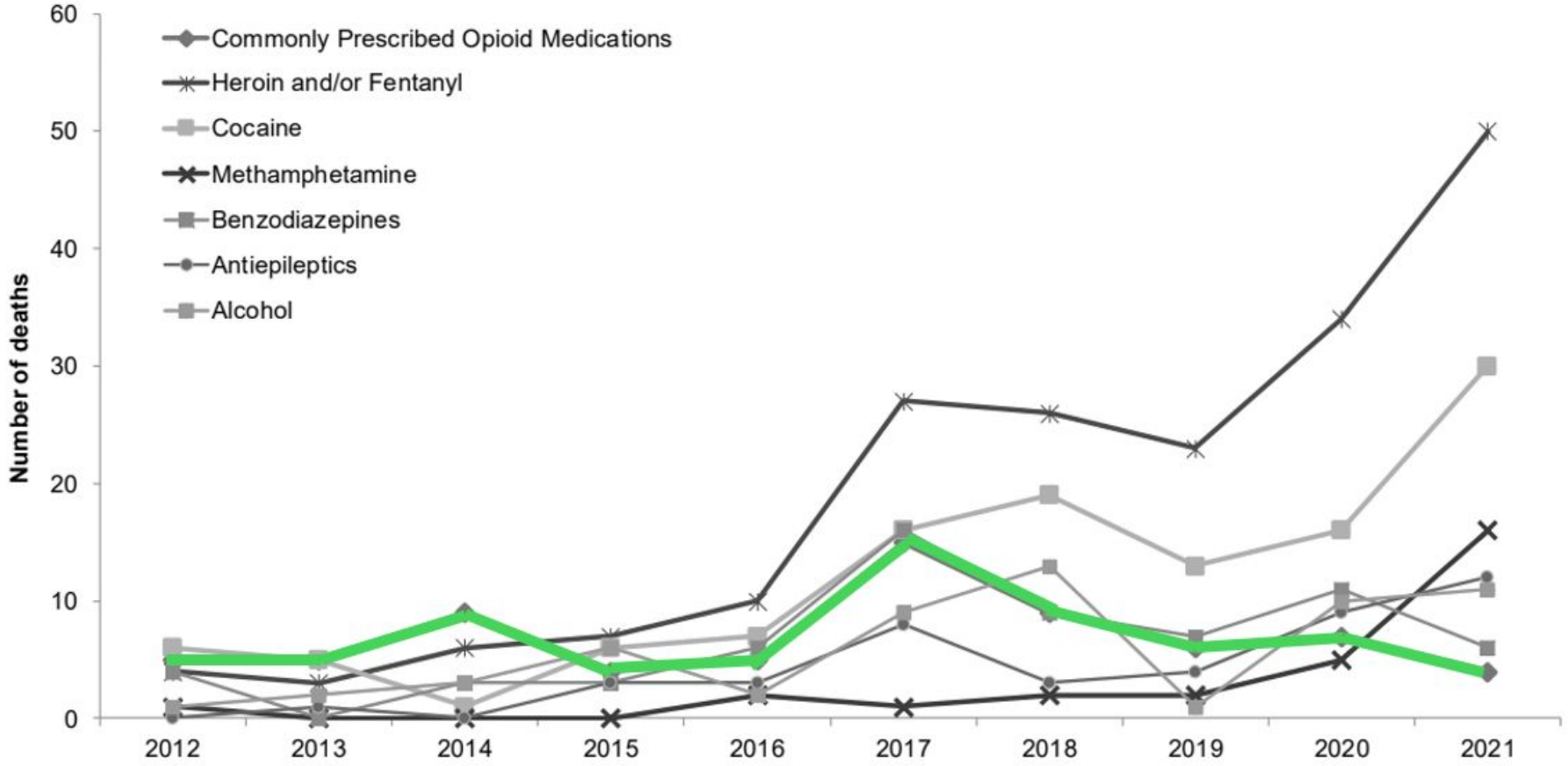

Agenda

1. Introductions
2. The Theoretical Framing: Adapted MAPP 2.0
3. Initial Visioning Meeting
4. Community Health Survey
5. Overview of Potential CHA Priorities
6. **Final Priorities & Next Steps**

1. **Food Access**
2. **Mental/Behavioral Health**
3. **Substance Use/Overdose Prevention**

	HEALTH INDICATOR	DESIRED RESULT	TOTAL POPULATION CURRENT (YEAR)	2030 TARGET
1	INDIVIDUALS BELOW 200% FPL	Decrease the number of people living in poverty	36.8% (2013-17)	27.0%
2	UNEMPLOYMENT	Increase economic security	7.2% (2013-17)	Reduce unemployment disparity ratio between white and other populations to 1.7 or lower
3	SHORT-TERM SUSPENSIONS (PER 10 STUDENTS)	Dismantle structural racism	1.39 (2017-18)	0.80
4	INCARCERATION RATE (PER 100,000 POPULATION)		341 (2017)	150
5	ADVERSE CHILDHOOD EXPERIENCES	Improve child well-being	23.6% (2016-17)	18.0%
6	THIRD GRADE READING PROFICIENCY	Improve third grade reading proficiency	56.8% (2018-19)	80.0%
7	ACCESS TO EXERCISE OPPORTUNITIES	Increase physical activity	73% (2010/18)	92%
8	LIMITED ACCESS TO HEALTHY FOOD	Improve access to healthy food	7% (2015)	5%
9	SEVERE HOUSING PROBLEMS	Improve housing quality	16.1% (2011-15)	14.0%
10	DRUG OVERDOSE DEATHS (PER 100,000 POPULATION)	Decrease drug overdose deaths	20.4 (2018)	18.0
11	TOBACCO USE	Decrease tobacco use	YOUTH 19.8% (2017)	9.0%
			ADULT 23.8% (2018)	15.0%
12	EXCESSIVE DRINKING	Decrease excessive drinking	16.0% (2018)	12.0%
13	SUGAR-SWEETENED BEVERAGE CONSUMPTION	Reduce overweight and obesity	YOUTH 33.6% (2017)	17.0%
			ADULT 34.2% (2017)	20.0%
14	HIV DIAGNOSIS (PER 100,000 POPULATION)	Improve sexual health	13.9 (2018)	6.0
15	TEEN BIRTH RATE (PER 1,000 POPULATION)		18.7 (2018)	10.0
16	UNINSURED	Decrease the uninsured population	13% (2017)	8%
17	PRIMARY CARE CLINICIANS (COUNTIES AT OR BELOW 1:1,500 PROVIDERS TO POPULATION)	Increase the primary care workforce	62 (2017)	25% decrease for counties above 1:1,500 providers to population
18	EARLY PRENATAL CARE	Improve birth outcomes	68.0% (2018)	80.0%
19	SUICIDE RATE (PER 100,000 POPULATION)	Improve access and treatment for mental health needs	13.8 (2018)	11.1
20	INFANT MORTALITY (PER 1,000 BIRTHS)	Decrease infant mortality	6.8 (2018)	6.0
			Black/white disparity ratio = 2.4	Black/white disparity ratio = 1.5
21	LIFE EXPECTANCY (YEARS)	Increase life expectancy	77.6 (2018)	82.0

Copy of CHA Survey

ALAMANCE COUNTY HEALTH DEPARTMENT

English

Default Question Block

Community Health Needs Assessment

Hello, please take a few minutes to complete the survey below. The purpose of this survey is to get your opinion about community health issues. Once we have gathered all of the surveys, we plan to compile this information and use it to develop a community health improvement plan with our community public health partners in the area. Thank you for taking time to help identify our most pressing health problems and issues to make our community a better and healthier place to live!

The following survey is solely for the citizens of Alamance County. Are you a resident of Alamance County?

- ○ Yes (You are eligible to complete this survey.)
- ○ No (You will not be able to complete the survey.)

Section I.
Please take a moment to think about living in Alamance County and tell us how you feel about each of the following;

	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
There is good healthcare in Alamance County.	○	○	○	○	○
Alamance County is a good place to raise children.	○	○	○	○	○
Alamance County is a good place to grow old.	○	○	○	○	○
There is plenty of economic opportunity in Alamance County.	○	○	○	○	○
Alamance County is a safe place to live.	○	○	○	○	○
There is plenty of help for people during times of need in Alamance County.	○	○	○	○	○
There is affordable housing that meets the needs in Alamance County.	○	○	○	○	○

	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
There are good parks and recreation facilities in Alamance County..	○	○	○	○	○
It is easy to buy healthy foods in Alamance County.	○	○	○	○	○

Section II.

Please select the top 3 issues which have the **highest impact on quality of life** in this county.

- ☐ Low income/poverty
- ☐ Dropping out of school
- ☐ Poor housing conditions
- ☐ Lack of affordable housing
- ☐ Lack of community resources
- ☐ Violent crime (murder, assault, theft)
- ☐ Drugs/Alcohol (Substance Use)
- ☐ Rape/Sexual Assault
- ☐ Neglect and Abuse
- ☐ Transportation
- ☐ Child Abuse
- ☐ Health insurance
- ☐ Lack of access to enough food
- ☐ COVID-19 pandemic
- ☐ Education

- [ ] Other

If you selected "Other," please explain:

Section II (continued) - Please select what you feel are the top 3 services that need **the most improvement** in your community.

- [ ] Animal contol
- [ ] Child care options
- [ ] Elder care options
- [ ] Services for disabled people
- [ ] More affordable health services
- [ ] Better/More healthy food choices
- [ ] More affordable / better housing
- [ ] Number of healthcare providers
- [ ] Culturally appropriate health services
- [ ] Counseling / mental and behavioral health / support groups
- [ ] Better / more recreational facilities (parks, trails, community centers)
- [ ] Substance Misuse Services/ Recovery Support
- [ ] Positive teen activities
- [ ] Transportation options

- [ ] Availability of employment
- [ ] Higher paying employment
- [ ] Road maintenance
- [ ] Pedestrian and cyclist road safety
- [ ] Healthy family activities
- [ ] None
- [ ] Education
- [ ] Other (please specify)

If you selected "Other," please explain:

Section II (continued) - Please select the top 3 health behaviors that you feel **people in your community need more information about**.

- [ ] Eating well/nutrition
- [ ] Using child safety car seats
- [ ] Exercising/fitness
- [ ] Managing weight
- [ ] Using seat belts
- [ ] Suicide prevention
- [ ] Driving safely

- [ ] Mental/Behavioral Health
- [ ] Domestic violence awareness/resources
- [ ] Crime prevention
- [ ] Elder care
- [ ] Child care/parenting
- [ ] Rape/sexual abuse awareness/resources
- [ ] COVID-19
- [ ] Going to a dentist for check-ups/preventive care
- [ ] Quitting smoking/tobacco use prevention
- [ ] Substance misuse prevention
- [ ] Harm reduction
- [ ] Breastfeeding
- [ ] Going to the doctor for yearly check-ups and screenings
- [ ] Getting prenatal care during pregnancy
- [ ] Getting flu shots and other vaccines
- [ ] Preparing for an emergency/disaster
- [ ] Caring for family members with special needs / disabilities
- [ ] Preventing pregnancy and sexually transmitted infections/disease (safe sex)
- [ ] None
- [ ] Other (please specify)

If you selected "Other," please explain:

Section II (continued) - Please select the top 3 **areas where COVID-19 have impacted** you most severely/significantly?

- [ ] Employment/Loss of Job
- [ ] Access to food
- [ ] Access to safe housing
- [ ] Transportation
- [ ] Education
- [ ] Physical Health
- [ ] Mental/Behavioral Health
- [ ] Substance Misuse
- [ ] Stress and anxiety
- [ ] Economic Resources
- [ ] Ability to seek medical care
- [ ] Social isolation
- [ ] Grief from loss of loved one
- [ ] Access to medication
- [ ] Lack of comfort in seeking medical care
- [ ] Spiritual Health/Well-being
- [ ] Child care
- [ ] Other

If you selected "Other," please explain:

Section III -

Where do you get most of your **health-related information?** (Check all that apply.)

- [ ] Friends and family
- [ ] Internet
- [ ] Social Media
- [ ] Employer
- [ ] Television
- [ ] Radio
- [ ] Doctor / Nurse
- [ ] My child's school
- [ ] Help lines
- [ ] Pharmacist
- [ ] Hospital
- [ ] Books / magazines
- [ ] Church
- [ ] Health department
- [ ] Community health worker
- [ ] Newspaper
- [ ] Other (please specify)

If you selected "Other," please explain:

Section III (continued) - Which of the following **preventative services** have you had in the past 12 months? (Check all that apply.)

- [ ] Mammogram
- [ ] Prostate cancer screening
- [ ] Colon / Rectal exam
- [ ] Blood sugar check
- [ ] Cholesterol
- [ ] Hearing Screening
- [ ] Bone density test
- [ ] Physical Exam
- [ ] Pap Smear
- [ ] Flu shot
- [ ] Blood pressure check
- [ ] Skin cancer screening
- [ ] Vision screening
- [ ] Cardiovascular screening
- [ ] Dental cleaning / x-rays

- [ ] None of the above

Section III (continued) - During a normal week, other than in your regular job, do you engage in any physical activity or exercise that lasts at least a half an hour?

- ○ Yes
- ○ No
- ○ Don't know or not sure

Section III (continued) - If yes, how many times per week?

- ○ 1
- ○ 2
- ○ 3
- ○ 4 times or more per week

Section III (continued) - If you do not exercise at least a half hour a few days each week, please select the reasons why you do not exercise? (Check all that apply.)

- [ ] My job is physical or hard labor
- [ ] Exercise is not important to me.

- [ ] It costs too much to exercise.
- [ ] There is no safe place to exercise.
- [ ] I don't have enough time to exercise.
- [ ] I'm too tired to exercise.
- [ ] I would need child care and I don't have it.
- [ ] I'm physically disabled.
- [ ] I don't know how to find exercise partners.
- [ ] I don't know how to safely
- [ ] I would need transportation and I don't have it.
- [ ] I don't like to exercise.
- [ ] I don't have access to a facility that has the things I need, like a pool, golf course, or a track.
- [ ] Facilities closed due to COVID 19
- [ ] Low self-image
- [ ] Other (please specify)

If you selected "Other," please explain:

Section IV- Please answer the following about any tobacco products you currently use, whether you have had a flu shot and/ or COVID vaccine or problems getting health care in your community.

Section IV - Do you currently use any tobacco products?

- ○ Yes
- ○ No
- ○ Prefer not to respond.

Section IV (continued) - Select any tobacco products you currently use. (Check all that apply.)

- ☐ Cigarettes
- ☐ E-cigs / electronic cigarettes
- ☐ Chewing Tobacco
- ☐ Vaping
- ☐ Pipe
- ☐ Cigars
- ☐ Snuff / Dip
- ☐ None

Section IV (continued) - Where would you go for help if you wanted to quit? (Check all that apply.)

- [ ] Quit Line NC
- [ ] Doctor
- [ ] Pharmacy
- [ ] Health Dept
- [ ] Private counselor / therapist
- [ ] I don't know
- [ ] N/A, I don't want to quit
- [ ] Other

If you selected "Other," please explain:

Section IV (continued) - An influenza / flu vaccine can be a "flu shot" injected into your arm or a spray like "Flu Mist" which is sprayed into your nose. During the past 12 months, have you received a seasonal flu vaccine?

- ○ Flu shot
- ○ Flu mist
- ○ No
- ○ Don't know or not sure

Section IV (continued) - If you did not get your flu vaccine, why not? (Check all that apply.)

- [ ] Cost
- [ ] Transportation
- [ ] Access
- [ ] Time
- [ ] Fear
- [ ] Need more info / have questions
- [ ] Personal preference

Section IV (continued) - Have you had a COVID-19 vaccine?

- ○ Yes
- ○ No
- ○ Don't know or not sure

Section IV (continued) - If you did not get your COVID-19 vaccine, why not? (Check all that apply.)

- [ ] Cost
- [ ] Transportation
- [ ] Access
- [ ] Time

- [ ] Fear
- [ ] Need more info / have questions
- [ ] Personal preference
- [ ] Other

If you selected "Other," please explain:

Section IV (continued) - In the past 12 months, did you have a problem getting the health care you needed for you personally or for a family member from any type of health care provider, dentist, pharmacy, or other facility?

- ○ Yes
- ○ No
- ○ Don't know or not sure

Section IV (continued) - If yes, what type of provider or facility did you have trouble getting healthcare from? (Check all that apply.)

- [ ] Dentist

- [ ] Primary Care Doctor
- [ ] Pediatrician
- [ ] OB / GYN
- [ ] Urgent care center
- [ ] Medical clinic
- [ ] Hospital
- [ ] Health department
- [ ] Specialist
- [ ] Eye care / optometrist / opthamologist
- [ ] Pharmacy / prescriptions
- [ ] Mental/Behavioral Health Providers
- [ ] Other (please specify)

If you selected "Other," please explain:

Section IV (continued) - Which of these problems prevented you from getting the necessary health care? (Check all that apply.)

- [ ] No health insurance
- [ ] Insurance didn't cover what I/we needed.
- [ ] My / our share of the cost (deductible/co-pay) was too high.

- [ ] Service provider would not take my/our insurance or Medicaid.
- [ ] No way to get there.
- [ ] Didn't know where to go
- [ ] Couldn't get an appointment
- [ ] The wait was too long
- [ ] Did not speak my language
- [ ] Could not miss work to go
- [ ] Hours did not work with my availability
- [ ] COVID 19

Section V - Please answer the questions below regarding finding information about natural disasters, staying safe, having enough food and any other thing you would like for us to know about your community.

Section V (continued) - In a natural disaster (hurricane, flooding, tornado, etc.), do you feel like you know how to access or find the information you need to stay safe?

- ○ Yes
- ○ No
- ○ Don't know or not sure

Section V (continued) - If so, where do you get your information to stay safe? (Check all that apply.)

- [ ] Television
- [ ] Radio
- [ ] Internet
- [ ] Telephone (landline)
- [ ] Cell phone
- [ ] Print media (i.e. newspaper)
- [ ] Social media
- [ ] Neighbors
- [ ] Family
- [ ] Text message (emergency alert system)
- [ ] Don't know or not sure
- [ ] Other (please specify)

If you selected "Other," please explain:

Section V (continued) - In the past 12 months, were you ever worried about whether your family's food would run out before you got money to buy more?

- ○ Yes
- ○ No
- ○ Don't know or not sure

Do you feel that everyone in our community has equal access to quality healthcare services?

- ○ Yes
- ○ No
- ○ Unsure

What are some barriers that you think might prevent people in our community from accessing healthcare? (Select all that apply)

- ☐ Transportation
- ☐ Cost of services
- ☐ Lack of insurance
- ☐ Language barriers
- ☐ Availability of healthcare providers
- ☐ Knowledge about available services
- ☐ [ ] Other (please specify)

In your opinion, what are the most important steps that could be taken to improve access to healthcare in our community? (Select up to 3)

- [ ] Increasing the number of healthcare providers
- [ ] Providing more affordable healthcare services
- [ ] Offering services in multiple languages
- [ ] Increasing community awareness about available health services
- [ ] Improving transportation options to healthcare facilities
- [ ] Ensuring culturally sensitive healthcare practices
- [ ] Enhancing support for low-income families
- [ ] Other (please specify) _____

Do you believe that certain groups in our community face more significant health challenges than others?

- [ ] No
- [ ] Unsure
- [ ] Yes

Please specify:

- ○ Elderly
- ○ Low-income individuals
- ○ Racial/Ethnic Minorities
- ○ Immigrants
- ○ Children

How would you rate the overall mental health services available in our community?

- ○ Excellent
- ○ Good
- ○ Fair
- ○ Poor
- ○ No Opinion

What do you believe are the top 3 mental health issues facing our community? (Select up to 3)

- ☐ Anxiety
- ☐ Depression
- ☐ Substance abuse
- ☐ Suicide
- ☐ Stress
- ☐ Trauma/PTSD
- ☐ [ ] Other (please specify)

Have you or someone you know experienced difficulty accessing mental health services in the past 12 months?

- [ ] Yes
- [ ] No
- [ ] Unsure

In your experience, what are the barriers to accessing mental health services? (Select all that apply)

- [ ] Cost of services
- [ ] Lack of insurance
- [ ] Stigma associated with seeking mental health help
- [ ] Limited availability of mental health providers
- [ ] Transportation issues
- [ ] Lack of awareness about available services
- [ ] Long wait times for appointments
- [ ] Other (please specify):

In your opinion, what are the best ways to improve mental health awareness and reduce stigma in our community? (Select up to 3)

- [ ] Community education programs

- [ ] Mental health awareness campaigns
- [ ] School-based mental health education
- [ ] Support groups and peer support networks
- [ ] Employer-sponsored mental health initiatives
- [ ] Public discussions and forums on mental health
- [ ] Other (please specify)

How would you rate the overall availability of substance use disorder services in our community?

- ○ Excellent
- ○ Good
- ○ Fair
- ○ Poor
- ○ No opinion

What do you believe are the top 3 substance use issues facing our community? (Select up to 3)

- [ ] Alcohol abuse
- [ ] Prescription drug misuse
- [ ] Opioid addiction
- [ ] Marijuana use
- [ ] Methamphetamine use

- [ ] Cocaine use
- [ ] Heroin use
- [ ] Other (please specify) _____

In your experience, what are the barriers to accessing substance use disorder services? (Select all that apply)

- [ ] Cost of services
- [ ] Lack of insurance
- [ ] Stigma associated with seeking help
- [ ] Limited availability of providers
- [ ] Transportation issues
- [ ] Lack of awareness about available services
- [ ] Long wait times for appointments
- [ ] Other (please specify): _____

What types of substance use disorder services do you think are most needed in our community? (Select up to 3)

- [ ] Inpatient treatment programs
- [ ] Outpatient treatment programs
- [ ] Detoxification services
- [ ] Counseling/therapy

- [ ] Support groups (e.g., AA, NA)
- [ ] Medication-assisted treatment
- [ ] Prevention education programs
- [ ] Community outreach and education
- [ ] Telehealth/online services
- [ ] Naloxone (Narcan) distribution and access
- [ ] Other (please specify):

How accessible do you believe naloxone (Narcan) is in our community?

- ○ Very accessible
- ○ Somewhat accessible
- ○ Not accessible
- ○ Unsure

ADDITIONAL COMMENTS/CONCERNS: Is there anything else you would like for us to know about your community?

Demographics - Please answer questions so we can know a little more about you.

Demographics - What is your sex?

- ○ Woman
- ○ Man
- ○ Prefer not to answer

If you answered "Not listed," please explain what you would have selected:

Demographics (continued) - How old are you?

- ○ 15-19
- ○ 20-24
- ○ 25-29
- ○ 30-34
- ○ 35-39
- ○ 40-44

- 45-49
- 50-54
- 55-59
- 60-64
- 65-69
- 70-74
- 75-79
- 80-84
- 85 +

Demographics (continued) - How do you describe your race/ethnicity?

- Asian
- Black / African American
- Hispanic / Latino
- Native American
- Pacific Islander
- White / Caucasian
- More than 1 race
- Prefer not to answer

Demographics (continued) - Are you a person living with a disability?

- ○ Yes
- ○ No
- ○ Prefer not to respond

Demographics (continued) - Is English the primary language spoken in your home?

- ○ Yes
- ○ No

Demographics (continued) - If no, please share which primary language is spoken in your home.

- ○ Spanish
- ○ Creole / Kreyol
- ○ French
- ○ Chinese
- ○ Other

Demographics (continued) - What is your marital status?

- ○ Never married / Single
- ○ Married

- ○ Unmarried partner
- ○ Divorced
- ○ Widowed
- ○ Separated

Demographics (continued) - What is the highest level of education you have completed?

- ○ Less than 9th grade
- ○ 9th - 12th grade, no diploma
- ○ High School graduate (or GED/equivalent)
- ○ Associate's Degree or Vocational Training
- ○ Some college (no degree)
- ○ Bachelor's Degree
- ○ Graduate or professional degree

Demographics (continued) - What is your employment status?

- ○ Employed full-time
- ○ Employed part-time
- ○ Employed in multiple jobs
- ○ Seasonal Worker/Temporary
- ○ Retired
- ○ Armed forces

- Disabled
- Student
- Homemaker
- Self-employed
- Unemployed for 1 year or less
- Unemployed for more than 1 year

Demographics (continued) - How is your current job best described?

- Agriculture
- Business / Industry
- Retail
- Homemaker
- Government
- Healthcare
- Student
- Education
- Food Service
- Other

Demographics (continued) - What is your total household income?

- Less than $10,000

- ○ $10,000 to $14,999
- ○ $15,000 to $24,999
- ○ $25,000 to $34,999
- ○ $35,000 to $49,999
- ○ $50,000 to $74,999
- ○ $75,000 to $99,999
- ○ $100,000 or more

Demographics (continued) - How many people live in your household?

- ○ I live alone
- ○ 2-3
- ○ 4-5
- ○ 6-7
- ○ 8-9
- ○ 10
- ○ More than 10

Demographics (continued) - What type of internet access do you have at your home?

- ○ Dial up
- ○ Broadband / High-Speed
- ○ Wi-Fi

- ○ Cellular or Hotspot
- ○ None

Thank you for your participation! Please feel free to include any final comments in the box below.

Powered by Qualtrics

Community Recruiting/Engagement Exemplars

SESIÓN DE VISIÓN COMUNITARIA

El condado de Alamance está realizando una evaluación de la salud de la comunidad y necesitamos su ayuda. ¡Únase a la conversación hoy y participe en la configuración del futuro de nuestra comunidad!

SOBRE LA SESIÓN

¡Ven a participar en un taller interactivo en línea diseñado para crear nuestra visión de una comunidad saludable!

Este es un componente clave para la evaluación de la salud de la comunidad y necesitamos todas las voces en este proceso.

- **Servicios de intérprete disponibles**
- **Facilitado por Evident Analytics**
- **Evento de zoom**
- **¡Confirma tu asistencia antes del 3 de junio!**

Confirme su asistencia haciendo clic aquí

¿Preguntas?

(984) 477-1081

healtheducationstaff@alamancecountync.gov

ALAMANCE COUNTY HEALTH DEPARTMENT

@6PM

6 JUNIO

EVENTO VIRTUAL

¡ESCANEE EL CÓDIGO QR PARA CONFIRMAR SU ASISTENCIA!

COMMUNITY VISIONING SESSION

ALAMANCE COUNTY HEALTH DEPARTMENT

Alamance County is conducting a Community Health Assessment, and we need your help. Join the conversation today and get involved in shaping our community's future!

ABOUT THE SESSION

Come take part in an online interactive workshop designed to create our vision for a healthy community!

This is a key component to the community health assessment and we need all voices in this process.

- **Interpreter Services Available**
- **Facilitated by Evident Analytics**
- **Zoom Event**
- **RSVP by June 3rd!**

RSVP by Clicking Here

Questions?

(984) 477-1081

healtheducationstaff@alamancecountync.gov

@6PM

6 JUNE

VIRTUAL EVENT

SCAN THE QR CODE TO RSVP!

COMMUNITY HEALTH SURVEY

ALAMANCE COUNTY HEALTH DEPARTMENT

Alamance County Residents, We Need Your Help!

We invite you to participate in an important Community Health Survey to help us better understand the health needs and concerns of our residents.

Your input is crucial in shaping the future of health in Alamance County.

About the Survey

- Responses are confidential
- Share your experiences and concerns about health-related topics
- Your feedback will guide local health initiatives and improvements

Together, we can make Alamance County a healthier place to live.

Click Here to Complete the Survey!

Questions?

(336) 570-6382

healtheducationstaff@alamancecountync.gov

2024 COMMUNITY HEALTH ASSESSMENT

SURVEY OPEN TO ALL RESIDENTS!

SCAN THE QR CODE TO BEGIN!

ENCUESTA DE SALUD COMUNITARIA

ALAMANCE COUNTY HEALTH DEPARTMENT

Residentes del condado de Alamance, ¡necesitamos su ayuda!

Le invitamos a participar en una importante encuesta de salud comunitaria para ayudarnos a comprender mejor las necesidades y preocupaciones de salud de nuestros residentes.

Su aporte es crucial para dar forma al futuro de la salud en el condado de Alamance.

Acerca de la encuesta

- Las respuestas son confidenciales.
- Comparte tus experiencias e inquietudes sobre temas relacionados con la salud
- Sus comentarios orientarán las iniciativas y mejoras sanitarias locales.

Juntos, podemos hacer del condado de Alamance un lugar más saludable para vivir.

¡Haga clic aquí para completar la encuesta!

¿Preguntas?

(336) 570-6382

healtheducationstaff@alamancecountync.gov

2024 EVALUACIÓN DE LA SALUD DE LA COMUNIDAD

¡ENCUESTA ABIERTA A TODOS LOS RESIDENTES!

¡ESCANEE EL CÓDIGO QR PARA COMENZAR!

Community Partner Assessment Survey

Default Question Block

Which Organizations do you represent? (List all)

Please describe the groups that you serve (e.g., schools, families and children, seniors, churches, specific groups of Alamance County residents, etc.):

How much does your organization focus on each of these topics?

	None at all	A little	A moderate amount	A lot	A great deal
Food Access	○	○	○	○	○
Mental/Behavioral Health	○	○	○	○	○

	None at all	A little	A moderate amount	A lot	A great deal
Substance Use/Overdose Prevention	○	○	○	○	○

Which of the following health topics does your organization work on? (check all that apply)

- ☐ Cancer
- ☐ Chronic disease (e.g., asthma, diabetes/obesity, cardiovascular disease)
- ☐ Family/maternal health
- ☐ Immunizations and screenings
- ☐ Infectious disease
- ☐ Injury and violence prevention
- ☐ HIV/STD prevention
- ☐ Healthcare access/utilization
- ☐ Access to services
- ☐ Health insurance/Medicare/Medicaid
- ☐ Mental or behavioral health (e.g., PTSD, anxiety, trauma)
- ☐ Physical activity
- ☐ Tobacco and substance use and prevention
- ☐ Special Supplemental Nutrition Program for Women, Infants, and Children (WIC)/food stamps
- ☐ Other ____

Please indicate how frequently your organization does the following activities related to **FOOD ACCESS**.

	Never				Regularly
Assessment: My organization assesses food access, affordability, and community nutrition needs.	○	○	○	○	○
Investigation of Hazards: My organization addresses food insecurity, nutrition issues, and food safety hazards.	○	○	○	○	○
Communication and Education: My organization educates communities on healthy eating and solutions to access barriers.	○	○	○	○	○
Community Engagement and Partnerships: My organization mobilizes communities and partnerships to improve food security and systems.	○	○	○	○	○

	Never				Regularly
Policies, Plans, Laws: My organization advances policies and plans to enhance food access.	○	○	○	○	○
Legal and Regulatory Authority: My organization uses authority to ensure food safety and access.	○	○	○	○	○
Access to Care: My organization ensures access to nutrition programs and community food resources.	○	○	○	○	○
Workforce: My organization supports developing a skilled workforce for food systems and nutrition.	○	○	○	○	○
Evaluation and Research: My organization evaluates and innovates strategies to improve food access and reduce insecurity.	○	○	○	○	○

	Never				Regularly
Organizational Infrastructure: My organization strengthens systems to support sustainable food access.	○	○	○	○	○

Please indicate how frequently your organization does the following activities related to **MENTAL/BEHAVIORAL HEALTH.**

	Never				Regularly
Assessment: My organization assesses mental and behavioral health needs, barriers to care, and community resources.	○	○	○	○	○
Investigation of Hazards: My organization addresses mental health risks, behavioral health challenges, and systemic barriers to care.	○	○	○	○	○

	Never				Regularly
Communication and Education: My organization educates communities on mental health awareness, reducing stigma, and accessing support services.	○	○	○	○	○
Community Engagement and Partnerships: My organization mobilizes communities and partnerships to improve mental health services and systems.	○	○	○	○	○
Policies, Plans, Laws: My organization advocates for policies and plans that enhance mental health care access.	○	○	○	○	○
Legal and Regulatory Authority: My organization leverages authority to protect and promote access to mental health care.	○	○	○	○	○

	Never				Regularly
Access to Care: My organization ensures access to mental and behavioral health services and support systems.	○	○	○	○	○
Workforce: My organization supports the development of a skilled workforce to deliver effective mental health care.	○	○	○	○	○
Evaluation and Research: My organization evaluates and innovates strategies to enhance mental health care and reduce barriers.	○	○	○	○	○
Organizational Infrastructure: My organization strengthens systems to support sustainable mental health care access.	○	○	○	○	○

Please indicate how frequently your organization does the following activities related to **SUBSTANCE USE / OVERDOSE PREVENTION.**

	Never				Regularly
Assessment: My organization assesses substance use trends, overdose risks, and community prevention resources.	○	○	○	○	○
Investigation of Hazards: My organization addresses substance use risks, overdose hazards, and systemic barriers to prevention.	○	○	○	○	○
Communication and Education: My organization educates communities on substance use prevention, harm reduction, and overdose response strategies.	○	○	○	○	○
Community Engagement and Partnerships: My organization mobilizes communities and partnerships to reduce substance use and prevent overdoses.	○	○	○	○	○

	Never				Regularly
Policies, Plans, Laws: My organization advocates for policies and plans that support prevention, harm reduction, and recovery efforts.	○	○	○	○	○
Legal and Regulatory Authority: My organization uses authority to promote harm reduction, ensure safe practices, and support prevention initiatives.	○	○	○	○	○
Access to Care: My organization ensures access to treatment, harm reduction services, and recovery support systems.	○	○	○	○	○
Workforce: My organization supports the development of a skilled workforce for prevention, treatment, and recovery services.	○	○	○	○	○

	Never				Regularly
Evaluation and Research: My organization evaluates and innovates strategies to prevent substance use and reduce overdose risks.	○	○	○	○	○
Organizational Infrastructure: My organization strengthens systems to support sustainable prevention and recovery efforts.	○	○	○	○	○

What do you identify as your organization's top 1–3 core competencies or strengths?

What data does your organization collect? (check all that apply)

- ☐ Demographic information about clients or members
- ☐ Access and utilization data about services provided and to whom

- [ ] Evaluation, performance management, or quality improvement information about services and programs offered
- [ ] Data about health status
- [ ] Data about health behaviors
- [ ] Data about conditions and social determinants of health (e.g., housing, education, or other
- [ ] conditions)
- [ ] We don't collect data
- [ ] Other

Which of the following methods of community engagement does your organization use most often? (check all that apply)

- [ ] Surveys (including customer/patient satisfaction surveys)
- [ ] Focus groups
- [ ] Community forums/events
- [ ] Interactive workshops
- [ ] Social media
- [ ] Advocacy
- [ ] Collaborative Community Planning
- [ ] Citizen advisory committees
- [ ] Presentations

What policy/advocacy work does your organization do? (check all that apply)

- [ ] Develop close relationships with elected officials
- [ ] Educate decision-makers and respond to their questions
- [ ] Respond to requests from decision-makers
- [ ] Use relationships to access decision-makers
- [ ] Write or develop policy
- [ ] Advocate for policy change
- [ ] Build capacity of impacted individuals/communities to advocate for policy change
- [ ] Lobby for policy change
- [ ] Mobilize public opinion on policies via media/communications
- [ ] Legal advocacy
- [ ] Not applicable
- [ ] Unsure
- [ ] Other: _____

Describe how your organization can best support the CHA priority - **FOOD ACCESS.**

Describe how your organization can best support the CHA priority - **MENTAL/BEHAVIORAL HEALTH.**

Describe how you organization can best support the CHA priority - **SUBSTANCE USE / OVERDOSE PREVENTION.**

Community Conversations

Focus Group/Community Conversation	Conversation Topics
Faith-Based Community Conversations	Community safety, accessibility, and youth opportunities
Alamance Wellness Collaborative (SAFE)	Isolation, internet access, crime, housing, homelessness
AWC - Green Level	Housing, business development, social connections
AWC - Hispanic/Latino Community	Hispanic/Latino community experiences, safety, resources
Green Level Community Conversation	Local growth, resources for seniors and youth
Women's Faith Group Conversation	leadership, safety, education
Dream Center ESL Class Conversations	Safety, working conditions, healthcare access
Twin Lakes Community Conversation	Community engagement, housing, local government
Cummings HS - Youth Wellness Team	Safety, youth activities, economic challenges
Cummings HS - Girls Soccer Team	Safety, school reputation, community perceptions
SAFE Community Conversation	Community support, isolation, transportation issues
Empodera Te Latina Community Conversation	Hispanic/Latino experiences, discrimination, resource access
SAFE (Southern Alamance County)	Community safety, isolation, transportation, and local resources
CDC Bridging the Gap in Green Level	Housing, community growth, social connections
Impact Alamance - Hispanic/Latino Community	Hispanic/Latino community experiences, safety, and resources

Summary of Qualitative Themes from Community Conversations in Alamance County

Aspirations Across Communities

1. **Safety & Security**
    - Reduction in crime, gun violence, and drug-related issues.
    - Safer neighborhoods, parks, and schools for children.
    - Protection for all community members, including immigrants and racial minorities.
2. **Community & Connectedness**
    - More welcoming, supportive spaces across race, ethnicity, and language.
    - Community cohesion, where people feel valued and represented.
    - Investment in intergenerational communication and cultural appreciation.

3. **Civic Engagement & Representation**
    - More opportunities for diverse leadership, especially young people and minorities.
    - Calls for better government transparency and district-based elections to ensure equal representation.
4. **Economic Development & Job Opportunities**
    - Need for minority-owned businesses and economic support for local entrepreneurs.
    - Better working conditions, especially for immigrant workers.
    - Fair wages and improved job security.
5. **Education & Youth Investment**
    - Improved school infrastructure and teacher pay.
    - More tutoring and mental health resources for students.
    - Investment in safe spaces and recreational activities for youth.
6. **Infrastructure & Public Services**
    - Expansion of sidewalks, bike lanes, and street lighting for safer transportation.
    - Affordable housing and community-driven urban development.
    - Enhanced public transportation, particularly for rural and marginalized populations.
7. **Health & Wellness**
    - More accessible healthcare, particularly for at-risk populations.
    - Increased bilingual healthcare services and culturally competent care.
    - Better mental health resources.

Concerns Across Communities

1. **Education System Challenges**
    - Lack of investment in public schools and poor facility maintenance (e.g., mold issues).
    - Low teacher salaries driving educators out of the county.
    - Need for better civic engagement in educational decision-making.
2. **Housing & Cost of Living**
    - High rent and limited affordable housing options.
    - Concerns about and displacement.
    - Poor housing conditions, including landlord neglect and safety concerns.
3. **Transportation & Accessibility**
    - Lack of reliable public transportation, especially for those without vehicles.
    - Unsafe walking and biking conditions due to poor infrastructure.
    - High costs associated with transportation limit mobility for lower-income residents.
4. **Public Safety & Crime**
    - Concerns about increasing crime, particularly gun violence.
    - Distrust in law enforcement and uneven policing practices.
5. **Social Isolation & Mental Health**
    - Older adults and rural residents experience high levels of isolation.
    - Limited spaces for community gatherings and support networks.
    - Increased anxiety, depression, and emotional distress due to economic and social pressures.

Community Resources

Alamance County Resource Guide can be accessed at: https://alamance-county-resource-guide.netlify.app/