2020

COMMUNITY HEALTH NEEDS ASSESSMENT

Presented by:
Robeson County Health Department,
Southeastern Health,
and the University of NC at Pembroke
in partnership with
Healthy Robeson

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September 2020

Dear Robeson County Residents,

We are pleased to bring you this community health report as a snapshot of our community health successes and challenges that we currently face as a county. Over the past four years, our county has experienced several devasting ordeals in terms of natural disasters. During the specified period for this report; Robeson County residents have recovered from Hurricane Florence (September 2018); many of which were still in the process of trying to recover from Hurricane Matthew (October 2016). If this period of recovery and rebuilding were not challenging enough, in March 2020, Robeson County residents along with the nation, experienced the emergence of the novel coronavirus (COVID-19). These catastrophic events have taken a tremendous toll and yet again put the resiliency of Robeson County residents to the test. In light of these ongoing catastrophic events, strong partnerships and alliances continue to prevail in Robeson County. We sincerely appreciate and value these partnerships as we know these groups are working together to create a healthier and vibrant county and we hope that you will join us in our journey towards creating optimal health for all Robeson residents.

In March 2020, Robeson was ranked as the least healthy county in North Carolina for health, according to the County Health Rankings Report. This emphasizes the importance of our Community Health Needs Assessment, because it helps us identify and address factors that affect the health of our community. As our county continues to evolve and recover, we must make sure we take the necessary steps to ensure that the needs of all our citizens are being addressed. We realize when it comes to public health, the community itself is the patient, and the health of the community must be assessed by focusing on key areas such as behavioral and social health, the economy, education, environmental health, physical health and safety.

Every three years, Robeson County conducts a comprehensive community examination through a process known as the Community Health Needs Assessment (CHNA). This year, the assessment process was a collaborative effort between Robeson County Health Department, Southeastern Health, The University of North Carolina at Pembroke and Healthy Robeson, which is inclusive of multiple non-profit, government, faith-based, education, media, and business organizations. The many hours dedicated by the Community Health Needs Assessment Team and the input provided by Robeson County residents has been invaluable to this process.

Working with our partners, the assessment included collecting information from citizen opinion surveys and the analysis of statistical data to identify community health needs and resources. We hope the findings of this Community Health Needs Assessment will be used to develop strategies that address our community's priorities and promote the health of residents across Robeson County.

We know that with all of us working together, we can create a healthier, safer community while having a better idea of where we need to focus our resources over the next few years.

In Health,

Joann Anderson

Joann Anderson
President & CEO
Southeastern Health

William J. Smith
Health Director

Executive Summary

The Community Health Needs Assessment is conducted every three years and the last assessment was conducted in 2017. The Community Health Needs Assessment process is designed to allow organizations to gather information from our community members (primary data) to gauge the health of the county, while comparing this data with health statistics (secondary data). Robeson County Department of Public Health, Southeastern Health, and The University of North Carolina at Pembroke in collaboration with Healthy Robeson, were responsible for the results of the data collection tools, collecting primary data and analysis.

Data Collection and Process of Data Collection

The Community Health Survey was distributed via survey monkey and hard copy in order to ensure as many community members as possible took part in the survey. Surveys were distributed to organizations and residents within their own communities, thereby creating opportunities to ensure responses collected were truly representative of county residents. Over 700 surveys were returned surpassing the goal of a return rate of 500 surveys.

Survey Question	Top Five Responses
Leading causes of death	Cancer, heart disease, homicide/violence, stroke/cerebrovascular disease and motor vehicle deaths
Priority health issues	Illegal drug abuse, prescription drug abuse, chronic disease, gangs/violence and alcohol abuse
Priority risk factors	Job opportunities, mental health services, substance abuse/rehabilitation services, healthier food options and safe places to walk/play
Leading factors affecting families seeking medical treatment	Unable to pay, lack of insurance, fear, lack of knowledge/understanding of need, no appointments available
Barriers impacting quality of health care	Economic, race, literacy, language barrier and sex/gender

Based on the responses received, two priority areas were identified: obesity and substance misuse. We feel we have the capacity to address these issues as a group, due to the current undertakings of community agencies and organizations to address these health topics. Furthermore, our efforts to address chronic diseases and substance misuse will be a continuation of efforts that began with the 2011 Community Health Needs Assessment as we know impact in these areas is not measured instantly.

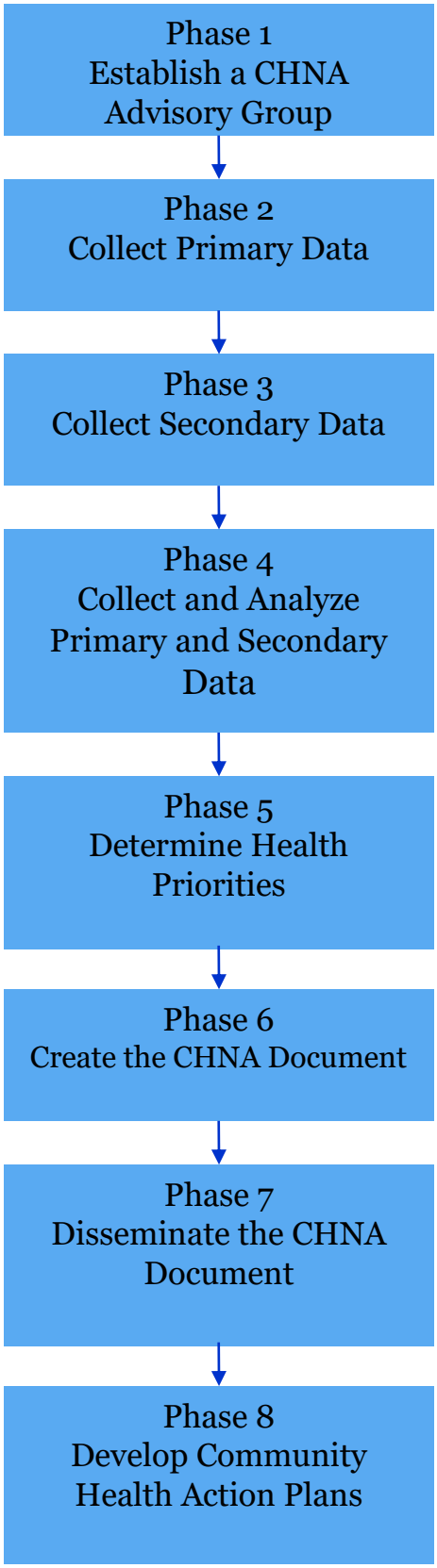
Chapter 1: Background & Introduction

Community Health Assessment Process

The North Carolina Community Health Needs Assessment process engages communities in eight phases, which are designed to encourage a systematic approach to involving residents in assessing problems and strategizing solutions. The eight phases are as follows:

Phase 1: **Establish a CHNA team**- the first step is to establish a Community Health Needs Assessment team to lead the community assessment process. This group consists of motivated individuals who act as advocates for a broad range of community members and appropriately represents the concerns of various populations within the community.

Phase 2: **Collect Primary Data**- in this phase, the Community Health Needs Assessment Team collects local data to discover resident's viewpoints and concerns about life in the community, health concerns and other issues important to the people. Community interests and concerns extend beyond the statistical information readily available to health organizations involved in conducting the assessment process. Methods of collecting primary data include a survey and focus groups. A process of "asset mapping" is also helpful. Through this process, residents assist the health assessment team in identifying the community's many positive aspects.



Phase 3: **Collect Secondary Data** - In this phase, the Community Health Needs Assessment Team compares the local health statistics with those of the state and previous years to identify possible health problems in the community. Local data that other agencies or institutions have researched is often included in the analysis. Putting this information together provides a clearer picture of what is happening in the community.

Phase 4: **Analyze and Interpret County Data** - In this phase, the Community Health Needs Assessment Team reviews the data from Phases 2 and 3 in detail. By the end of this phase, the Team has obtained a general understanding of the community's major health issues.

Phase 5: **Determine Health Priorities** - The Community Health Needs Assessment Team reports the results of the assessment to the community and encourages the input of residents. Then, the Community Health Needs Assessment Team, along with other community members, determines the priority health issues to be addressed.

Phase 6: **Create the Community Health Assessment Document** - In this phase, the Community Health Needs Assessment Team develops a standalone report to document the process, as well as the findings, of the entire assessment effort. The purpose of this report is to share assessment results and plans with the entire community and other interested stakeholders. At the end of this phase, the community transitions from assessment to action by initiating the development of Community Health Action Plans.

Phase 7: **Disseminate the Community Health Assessment Document** - In this phase, the Community Health Needs Assessment Team informs the community of the assessment findings. Results are shared through a variety of approaches including the use of local media, website postings and public presentations.

Phase 8: **Develop Community Health Action Plans** - In this phase, the Community Health Assessment Team develops a plan of action for addressing the health issues deemed as priorities in Phase 5. Community Health Action Plans feature strategies for developing intervention and prevention activities.

Community Health Assessment Team

The first step in putting Robeson County's Community Health Needs Assessment Team in motion was to designate the ***Co-Facilitators.*** The county's Health Education Supervisor and the local hospital's Community Mobilization Specialist were selected to fulfill these roles. These two individuals were ultimately responsible for maintaining the overall flow of the community health needs assessment process and ensuring that others participating in the process were kept abreast of progress made as well as tasks yet to be completed.

Meetings of the ***Co-Facilitators*** began in the Fall of 2019. Initial meetings included the review and re-evaluation of the 2017 community health assessment process and the resulting widely disseminated documentation of findings, priorities and action steps.

From there, the ***CHNA Team*** was formed and subcommittees were established. The ***Team's Advisory Group*** was made up of a variety of partners from Healthy Robeson. The ***Advisory Group*** met for a defined period of time; reviewed the CHNA process materials, statistics and survey data, and served as community advocates for the assessment process, which included identification of resources and support. The ***CHNA Work Group*** was a subset of the ***Advisory Group***. The ***Work Group*** planned for collecting, analyzing, and interpreting the data.

The ***Work Group*** met to discuss survey distribution; as well as data availability, collection and analysis. A wide variety of secondary data was reviewed, including local, state and national. When available, trend data was analyzed. The ***CHNA Team*** met virtually in June 2020 to hear the findings of the assessment and to identity leading health problems.

From left to right: Lekisha Hammonds, Tanya Underwood, Phillip Richardson, Melissa Packer, and Karen Woodell.
Not pictured: Lori Dove, Dr. Cherry Beasley, and Tamara Adams.

Assessment Team Structure

Work Group 1: Community Health Survey Team

(Design and Distribution)

Project Co- Facilitators

2020 Community Health Assessment Team

Advisory Group

Work Group 2: Data Collection and Analysis Team

Chapter 2: County Description

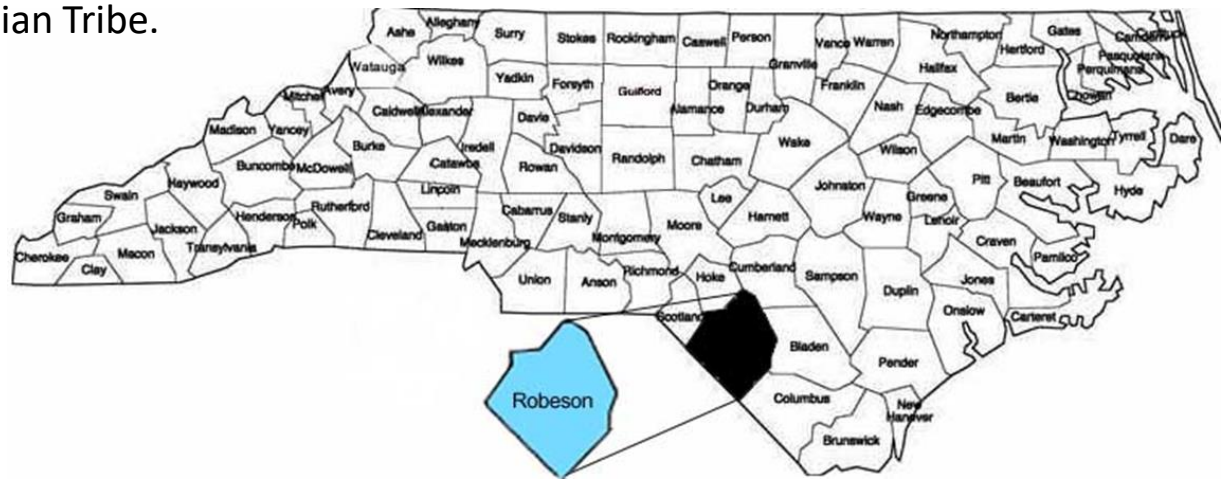
Geographic Features

Robeson County is bordered by the North Carolina counties of Bladen, Columbus, Cumberland, Hoke and Scotland, and the state of South Carolina.

According to the U.S. Census Bureau, the county has a total area of 951 square miles making it the largest in North Carolina. Of that figure, 949 square miles are land and 2 are water (0.23%).

Moreover, numerous swamps that generally flow in a northwest to southeast course characterize the area and eventually drain into the Lumber River.

The highest densities of swamps are found in the areas of the county most widely populated by the Lumbee Indian Tribe.

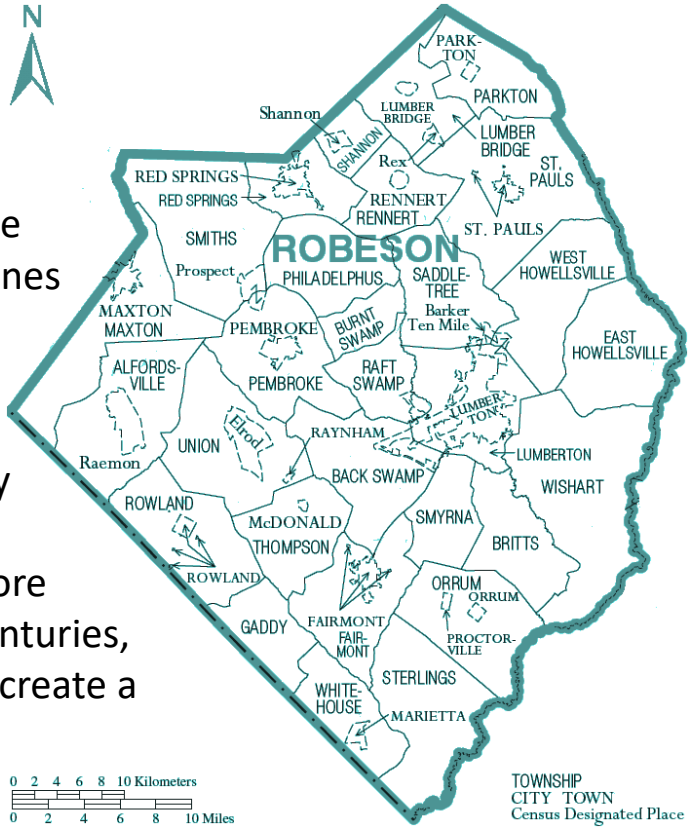


History

Robeson County has a rich history that goes back farther than 1787 when it was carved out of Bladen County, the Mother County. It was created because the residents of the area felt that their center of government needed to be closer and that the huge county of Bladen was simply too unwieldy. It was named for Colonel Thomas Robeson, hero of the Revolutionary War Battle of Elizabethtown.

The courthouse was erected on land which formerly belonged to John Willis. A lottery was used to dispose of the lots and to establish the town. In 1788, Lumberton, which is the county seat, was established. The county is divided into twenty-nine townships: Alfordsville, Back Swamp, Britts, Burnt Swamp, East Howellsville, Fairmont, Gaddy, Lumber Bridge, Maxton, Orrum, Parkton, Pembroke, Philadelphus, Raft Swamp, Raynham, Red Springs, Rennert, Rowland, Saddletree, Shannon, Smiths, Smyrna, St. Pauls, Sterlings, Thompson, Union, West Howellsville, Whitehouse and Wishart.

The county is called “The State of Robeson” not only because of its size, but because of its fierce independence and self-reliance. It is unique in its large minority population. The county combines a rich heritage of the Native American Lumbee tribe (largest Native American tribe east of the Mississippi), the African American community and many descendants of the numerous Scottish and European settlers who arrived before and during the Revolution. Over the centuries, these groups have worked together to create a culturally diverse community.



Demographics

According to the 2019 U.S. Census, Robeson County's total population is 130,625. This is a 2.7% population change from 2010 when the total population was 134,168. Robeson is a rural county with over 62% of the total population living in farm and nonfarm areas.

Robeson County's population is young. The largest percentage (31.4%) of the population is between the ages of 0-19 and the median age is 35.9, which increased by 1 year since the 2010 Census data.

Population & Growth	Population	% Annual Growth
2018 Est Population	133,442	0.6%
2010 Census Total Population	134,168	0.9%
Jul2018 NC Certified Population Estimate	131,600	0.5%
Urban/Rural Representation	**Population**	**Urban/Rural Percent**
2010 Census Total Population: Urban	50,161	37.4%
2010 Census Total Population: Rural	84,007	62.6%
Estimated Population by Age	**Population**	**% Pop by Age**
2018 Est Median Age	36	
2018 Est Total Pop 0-19	38,284	28.7%
2018 Est Total Pop 20-24	9,500	7.1%
2018 Est Total Pop 25-34	16,816	12.6%
2018 Est Total Pop 35-44	16,233	12.2%
2018 Est Total Pop 45-54	16,851	12.6%
2018 Est Total Pop 55-64	16,803	12.6%
2018 Est Total Pop 65+	18,955	14.2%

Robeson County is one of the 10% of United States counties that are majority-minority; its combined population of American Indian, African American and Latino residents comprise over 70% of the total population.

Health disparities are well documented in minority populations such as African Americans, Native Americans, Asian Americans, and Latinos. When compared to European Americans, these minority groups have a higher incidence of chronic diseases, poorer health outcomes and mortality.

Chapter 3: Data Collection Process

Given the entire CHNA is centered upon listening and learning from the voices of the community, the CHNA team collected data from a diverse representation of Robeson County residents. In order to ensure that data collected was representative of the county's entire population; surveys were geographically dispersed among Robeson County's cities and townships. The three types of data methods included an inventory of health resources and a community health survey. The collaboration of various community partners and the availability of data resources eliminated any information gaps that would have limited the hospital's ability to assess the needs of its community.

Primary and Secondary Data Collection

Our primary data was obtained through the community health survey. The community health survey was revised from the 2017 survey and changed to more accurately collect the information needed for the CHNA. The survey was distributed with the assistance of the team members on the advisory group as well as a web link shared through partner listservs. Thought was given to ensure the survey was distributed in a manner that would be representative to the population of Robeson County.

Secondary data was collected by representatives from the University of North Carolina at Pembroke and Southeastern Health, mainly from the State Center for Health Statistics as well as other state-level resources. Primary data is essentially "what the community tells us" and secondary statistics consist of "what other resources show us."

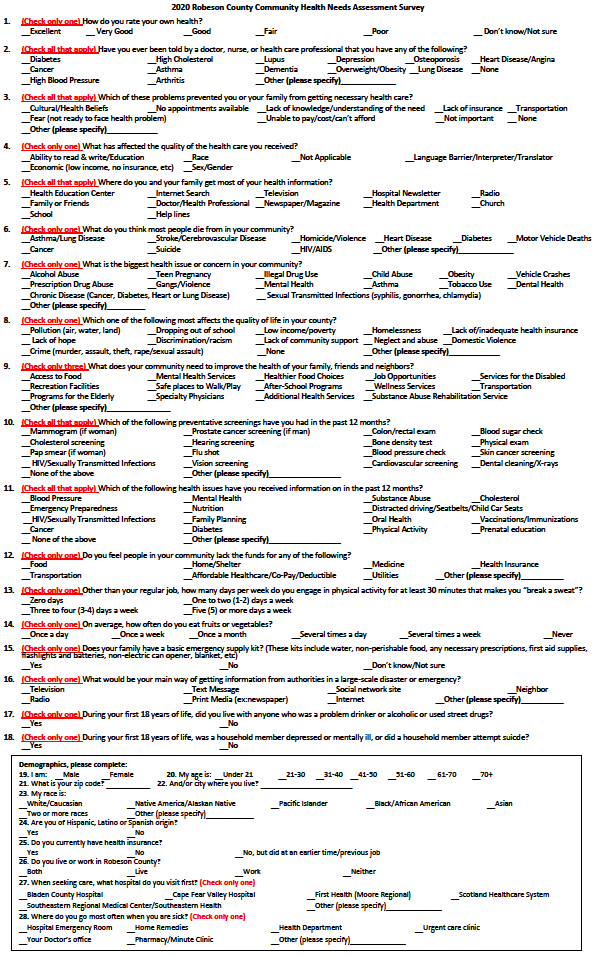
Health Resource Inventory

An inventory of health resources was provided by the Robeson County Health Department. Please see Appendix for an abbreviated listing or contact Karen Woodell at the Robeson County Health Department for full listing.

Community Health Survey

The Community Health Needs Assessment Work Group was responsible for developing the assessment tool. The tool was then shared with the CHNA Advisory Group for feedback. The tool was modified to better determine the needs of Robeson County residents and included a question from the Regional Community Health Needs Assessment.

The survey included 28 questions. Of that number, 14 were relevant to health and human services, 2 pertained to Emergency preparedness, 2 pertained to Adverse Childhood Experiences and 10 were designed to capture the demographic makeup of persons completing the survey.
This one page assessment tool was available in both English and Spanish.



2020 Robeson County Community Health Needs Assessment Survey

1. (Check only one) How do you rate your own health?
__Excellent __Very Good __Good __Fair __Poor __ Don't know/Not sure

2. (Check all that apply) Have you ever been told by a doctor, nurse, or health care professional that you have any of the following?
__Diabetes __High Cholesterol __Lupus __Depression __Osteoporosis __Heart Disease/Angina
__Cancer __Asthma __Dementia __Overweight/Obesity __Lung Disease __None
__High Blood Pressure __Arthritis __Other (please specify)_____

3. (Check all that apply) Which of these problems prevented you or your family from getting necessary health care?
__Cultural/Health Beliefs __No appointments available __Lack of knowledge/understanding of the need __Lack of insurance __Transportation
__Fear (not ready to face health problem) __Unable to pay/cost/can't afford __Not important __None
__Other (please specify)_____

4. (Check only one) What has affected the quality of the health care you received?
__Ability to read & write/Education __Race __Not Applicable __Language Barrier/Interpreter/Translator
__Economic (low income, no insurance, etc) __Sex/Gender

5. (Check all that apply) Where do you and your family get most of your health information?
__Health Education Center __Internet Search __Television __Hospital Newsletter __Radio
__Family or Friends __Doctor/Health Professional __Newspaper/Magazine __Health Department __Church
__School __Help lines

6. (Check only one) What do you think most people die from in your community?
__Asthma/Lung Disease __Stroke/Cerebrovascular Disease __Homicide/Violence __Heart Disease __Diabetes __Motor Vehicle Deaths
__Cancer __Suicide __HIV/AIDS __Other (please specify)_____

7. (Check only one) What is the biggest health issue or concern in your community?
__Alcohol Abuse __Teen Pregnancy __Illegal Drug Use __Child Abuse __Obesity __Vehicle Crashes
__Prescription Drug Abuse __Gangs/Violence __Mental Health __Asthma __Tobacco Use __Dental Health
__Chronic Disease (Cancer, Diabetes, Heart or Lung Disease) __ Sexual Transmitted Infections (syphilis, gonorrhea, chlamydia)
__Other (please specify)_____

8. (Check only one) Which one of the following most affects the quality of life in your county?
__Pollution (air, water, land) __Dropping out of school __Low income/poverty __Homelessness __Lack of/inadequate health insurance
__Lack of hope __Discrimination/racism __Lack of community support __Neglect and abuse __Domestic Violence
__Crime (murder, assault, theft, rape/sexual assault) __None __Other (please specify)_____

9. (Check only three) What does your community need to improve the health of your family, friends and neighbors?
__Access to Food __Mental Health Services __Healthier Food Choices __Job Opportunities __Services for the Disabled
__Recreation Facilities __Safe places to Walk/Play __After-School Programs __Wellness Services __Transportation
__Programs for the Elderly __Specialty Physicians __Additional Health Services __Substance Abuse Rehabilitation Service
__Other (please specify)_____

10. (Check all that apply) Which of the following preventative screenings have you had in the past 12 months?
__Mammogram (if woman) __Prostate cancer screening (if man) __Colon/rectal exam __Blood sugar check
__Cholesterol screening __Hearing screening __Bone density test __Physical exam
__Pap smear (if woman) __Flu shot __Blood pressure check __Skin cancer screening
__HIV/Sexually Transmitted Infections __Vision screening __Cardiovascular screening __Dental cleaning/X-rays
__None of the above __Other (please specify)_____

11. (Check all that apply) Which of the following health issues have you received information on in the past 12 months?
__Blood Pressure __Mental Health __Substance Abuse __Cholesterol
__Emergency Preparedness __Nutrition __Distracted driving/Seatbelts/Child Car Seats
__HIV/Sexually Transmitted Infections __Family Planning __Oral Health __Vaccinations/Immunizations
__Cancer __Diabetes __Physical Activity __Prenatal education
__None of the above __Other (please specify)_____

12. (Check only one) Do you feel people in your community lack the funds for any of the following?
__Food __Home/Shelter __Medicine __Health Insurance
__Transportation __Affordable Healthcare/Co-Pay/Deductible __Utilities __Other (please specify)_____

13. (Check only one) Other than your regular job, how many days per week do you engage in physical activity for at least 30 minutes that makes you "break a sweat"?
__Zero days __One to two (1-2) days a week
__Three to four (3-4) days a week __Five (5) or more days a week

14. (Check only one) On average, how often do you eat fruits or vegetables?
__Once a day __Once a week __Once a month __Several times a day __Several times a week __Never

15. (Check only one) Does your family have a basic emergency supply kit? (These kits include water, non-perishable food, any necessary prescriptions, first aid supplies, flashlights and batteries, non-electric can opener, blanket, etc)
__Yes __No __Don't know/Not sure

16. (Check only one) What would be your main way of getting information from authorities in a large-scale disaster or emergency?
__Television __Text Message __Social network site __Neighbor
__Radio __Print Media (ex:newspaper) __Internet __Other (please specify)_____

17. (Check only one) During your first 18 years of life, did you live with anyone who was a problem drinker or alcoholic or used street drugs?
__Yes __No

18. (Check only one) During your first 18 years of life, was a household member depressed or mentally ill, or did a household member attempt suicide?
__Yes __No

Demographics, please complete:

19. I am: __Male __Female 20. My age is: __Under 21 __21-30 __31-40 __41-50 __51-60 __61-70 __70+
21. What is your zip code?_____ 22. And/or city where you live?_____
23. My race is:
__White/Caucasian __Native America/Alaskan Native __Pacific Islander __Black/African American __Asian
__Two or more races __Other (please specify)_____
24. Are you of Hispanic, Latino or Spanish origin?
__Yes __No
25. Do you currently have health insurance?
__Yes __No __No, but did at an earlier time/previous job
26. Do you live or work in Robeson County?
__Both __Live __Work __Neither
27. When seeking care, what hospital do you visit first? (Check only one)
__Bladen County Hospital __Cape Fear Valley Hospital __First Health (Moore Regional) __Scotland Healthcare System
__Southeastern Regional Medical Center/Southeastern Health __Other (please specify)_____
28. Where do you go most often when you are sick? (Check only one)
__Hospital Emergency Room __Home Remedies __Health Department __Urgent care clinic
__Your Doctor's office __Pharmacy/Minute Clinic __Other (please specify)_____

The Community Health Survey Team distributed surveys with a goal of 500 surveys returned. The surveys were distributed by zip codes and quantities based upon the number of persons residing within the codes. This method helped to ensure that representation was received from communities throughout the county.

Paper surveys were distributed by members of the CHNA Advisory Group and electronic surveys by a Survey Monkey link. The CHNA Work Group was responsible for tallying and analyzing the results. A total of 718 surveys were completed , including 161 from the Survey Monkey link and 557 paper surveys. Survey data was analyzed by entering information into Survey Monkey, an online survey tool used to find trends and statistical significance.

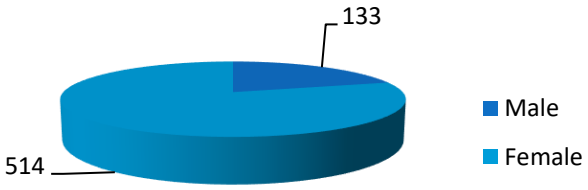
Chapter 4: Health Data Results

This chapter uses data summarized from the Community Health Needs Assessment survey to describe the overall health status, opinion and needs of county residents. Results of the primary data collected using the Community Opinion are included as well as secondary data obtained from various other local and state-level resources.

Demographics- This section of the survey included questions pertaining to the characteristics of the respondents. Of the surveys returned, 79.44% were completed by females and 20.56% by males. Surveys were received from all age groups with the majority of the respondents being between the ages of 21-30. Additionally, there was representation from all areas in Robeson County. The majority of the surveys were completed in Lumberton.

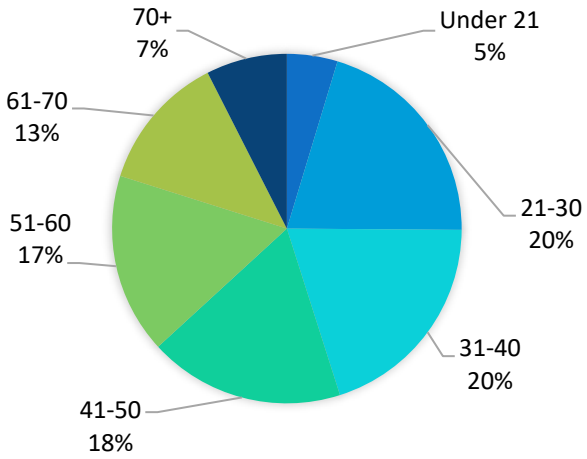
Gender

Female	79.44%
Male	20.56%



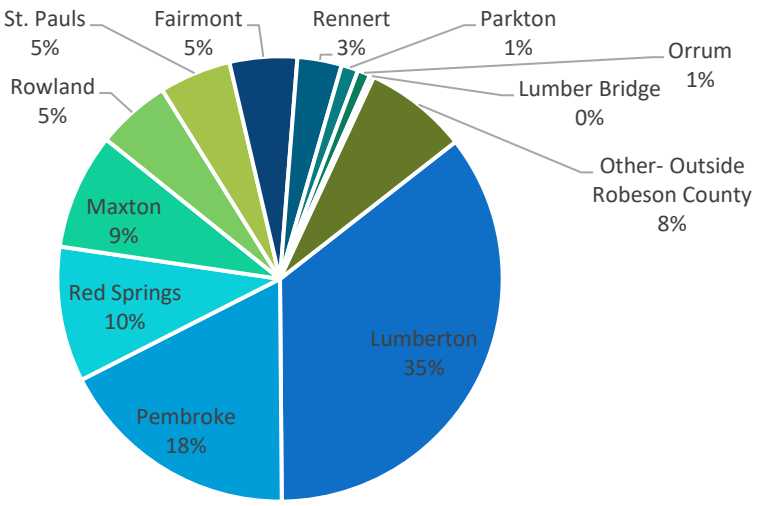
Age

Under 21	30
21-30	131
31-40	128
41-50	116
51-60	107
61-70	81
70+	48

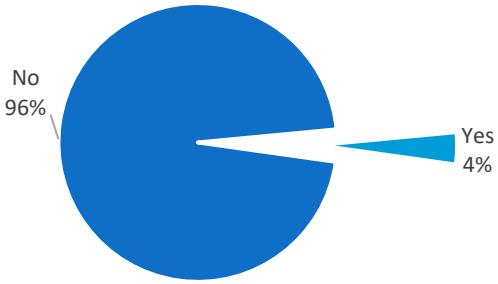


Residence

Lumberton	231
Pembroke	115
Red Springs	64
Maxton	55
Rowland	35
St. Pauls	34
Fairmont	32
Rennert	21
Parkton	8
Orrum	6
Lumber Bridge	2
Other- Outside Robeson County	49



The race and ethnicity of respondents mirrors that of Robeson County. As indicated earlier, Robeson County's racial and ethnic makeup consists of the following major groups: Native American, Caucasian and African American. Survey respondents included the following: Caucasian-27%, Native American-42%, African American-27%. Although the percentages do not exactly match those of the county, the Community Health Assessment Team felt they received a diverse representation of Robeson County's racial and ethnic makeup.

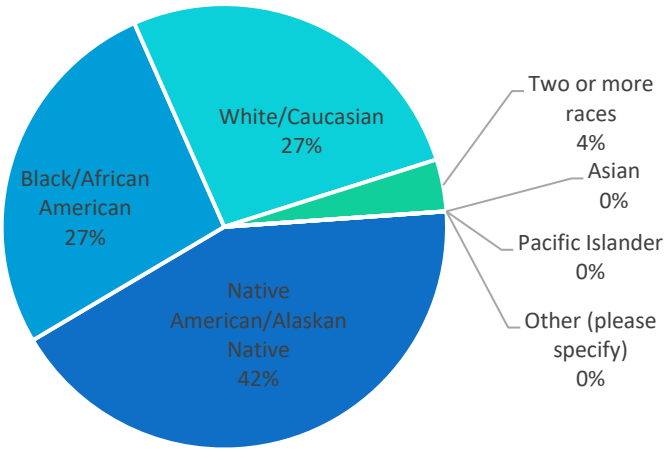


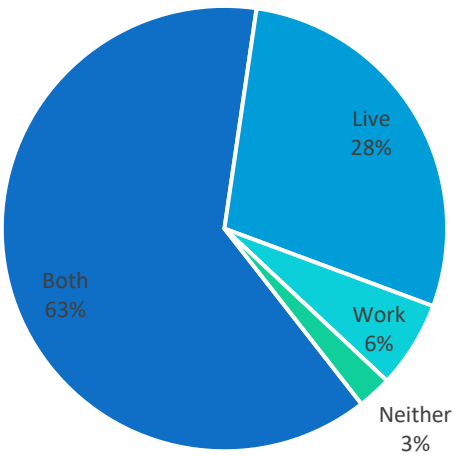
Hispanic, Latino, or Spanish origin?

Yes	24
No	621

Race

Native American/Alaskan Native	282
Black/African American	178
White/Caucasian	177
Two or more races	25
Asian	0
Pacific Islander	0
Other (please specify)	0





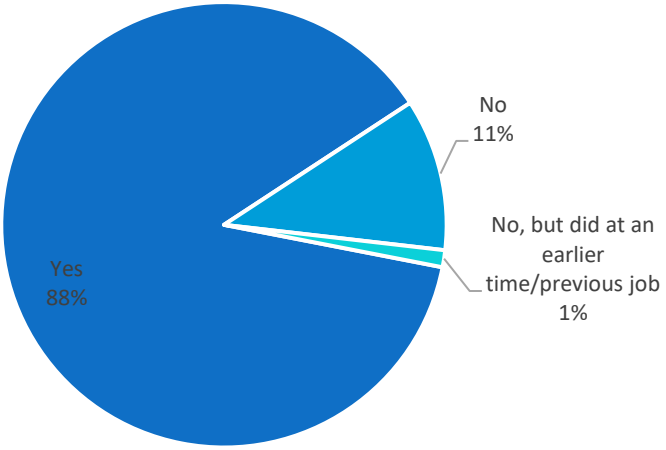
Residence

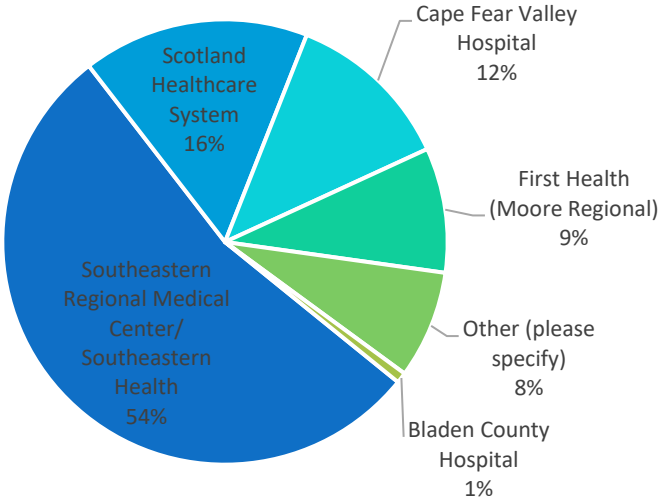
Both Live & Work	408
Live	184
Work	41
Neither	16

Questions were asked to determine if the respondent had health insurance, which area hospital he/she visited when seeking care and where the survey was completed. The majority of people completing the survey live and work in Robeson County.
Results also indicate that 11% of people surveyed do not have health insurance and 46% seek hospital care outside of the county. As previously mentioned, Robeson County is bordered by the state of South Carolina and the North Carolina counties of Bladen, Columbus, Cumberland, Hoke and Scotland. Therefore, persons residing in the outlying areas are inclined to travel to neighboring counties for both emergency department visits and inpatient care.

Health Insurance

Yes	571
No	72
No, but did at an earlier time/previous job	8

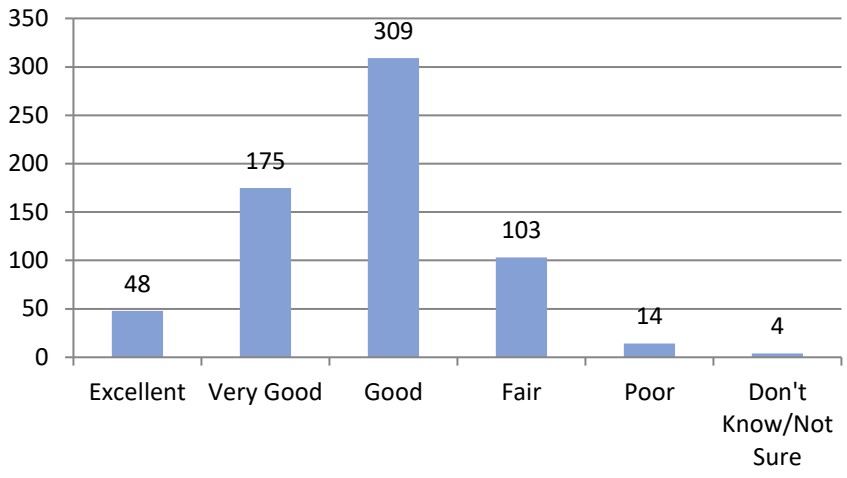




Hospitals

Southeastern Regional Medical Center/ Southeastern Health	349
Scotland Healthcare System	107
Cape Fear Valley Hospital	79
First Health (Moore Regional)	59
Other (please specify)	51
Bladen County Hospital	5

Question 1: How do you rate your own health? (check only one)



Good	47.32%
Very Good	26.80%
Fair	15.77%
Excellent	7.35%
Poor	2.14%
Don't Know/Not Sure	0.61%
Total Responses: 653	

Disparities

	White/ Caucasian	Black/ African American	Native American/ Alaskan Native
Good	50.29%	43.75%	46.98%
Very Good	25.73%	28.98%	26.33%
Fair	15.79%	19.32%	13.52%
Excellent	4.09%	6.25%	10.32%
Poor	3.51%	1.70%	1.78%
Don't Know/ Not Sure	0.58%	0.00%	1.07%

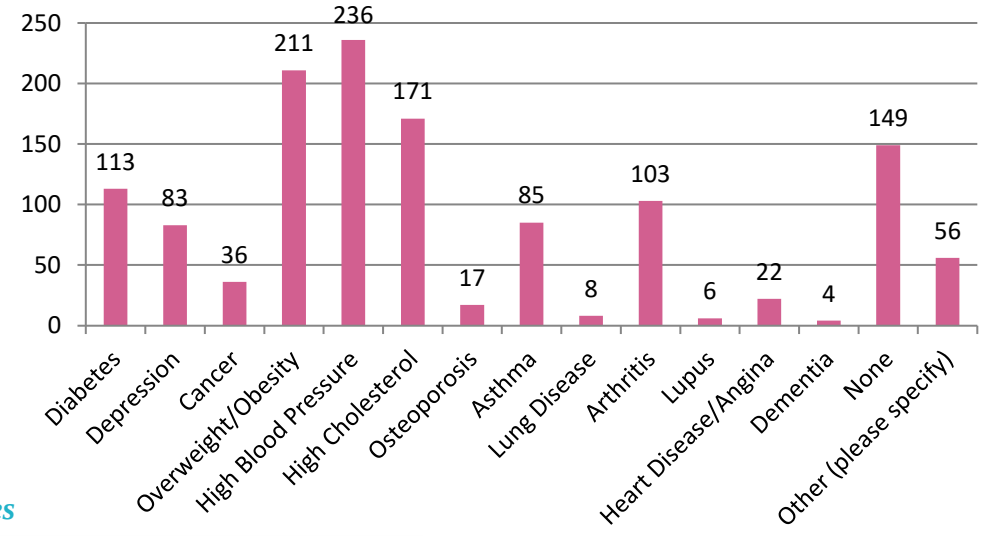
Summary: The graph and chart above show the number and percentage of the population surveyed who self-reported their personal health. As shown, the majority of the respondents feel that they are in "good" health.

Trend data: No significant changes from the 2017 assessment were noted.

Disparities: Native Americans have a higher percentage for self-reported "excellent" health compared to African Americans and Caucasians.

Impact on community: Some community members may need enhanced health interventions due to the decreased number that self-reported "fair" or "poor" health. These numbers are not reflective of secondary data.

Question 2: Have you ever been told by a doctor, nurse, or health care professional that you have any of the following? (check all that apply)



Disparities

	White/ Caucasian	Black/ African American	Native American /Alaskan Native
High Blood Pressure	45.14%	38.64%	30.77%
Overweight/Obesity	38.86%	29.55%	31.87%
High Cholesterol	36.57%	23.86%	21.98%
None	14.86%	23.86%	27.84%
Diabetes	22.29%	17.61%	14.29%
Arthritis	18.86%	14.77%	15.75%
Asthma	9.71%	15.34%	13.19%
Depression	17.71%	9.09%	11.36%
Other	12.57%	5.68%	7.69%
Cancer	8.00%	5.11%	4.40%
Heart Disease/ Angina	5.71%	4.55%	1.47%
Osteoporosis	4.00%	2.27%	2.20%
Lung Disease	1.14%	3.41%	0.00%
Lupus	1.14%	1.14%	0.37%
Dementia	1.14%	1.14%	0.00%

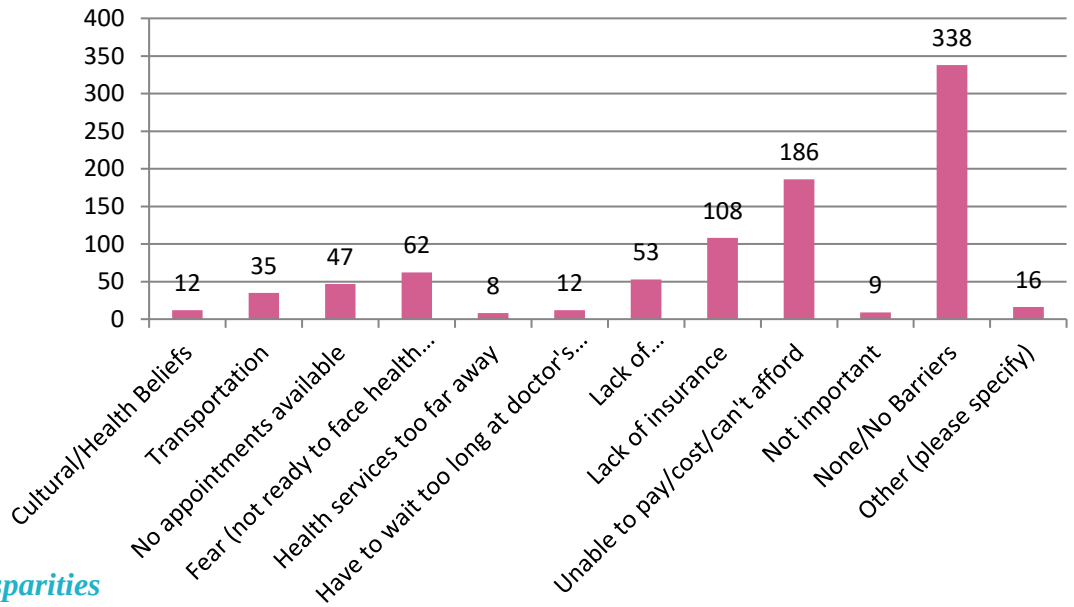
Summary: The graph and chart above show the number and percentage of the population surveyed who self-reported a medical concern that they have been told by their healthcare provider. As shown, the majority of respondents said they have "high blood pressure."

Trend Data: No significant change from 2017.

Disparities: The overall leading response for this question is "high blood pressure." This is also true among Caucasian and African Americans that completed this survey. However, diagnosed Diabetes and High Cholesterol appears to be higher among Caucasians than other groups, but this is not reflected in secondary data. This may actually indicate a large number of undiagnosed Diabetes and High Cholesterol in other groups.

Impact on community: This illustrates the need to address and educate on chronic health diseases throughout the county but especially in the African American and Native American communities. Other issues may be preventing these groups from receiving adequate and timely care for their chronic conditions which will result in increased mortality from manageable chronic diseases.

Question 3: Which of these problems prevented you or your family from getting necessary health care? (check all that apply)



Disparities

	White/ Caucasian	Black/ African American	Native American/ Alaskan Native
None/No Barriers	55.23%	54.82%	50.18%
Unable to pay/ cost/can't afford	24.42%	27.71%	32.49%
Lack of insurance	12.79%	15.66%	19.86%
Fear (not ready to face health problem)	9.30%	10.24%	9.03%
Lack of knowledge/ understanding of the need	4.65%	12.65%	7.58%
No appointments available	10.47%	9.04%	4.33%
Transportation	3.49%	6.02%	6.14%
Other	4.65%	3.01%	1.08%
Cultural/Health Beliefs	0.58%	3.01%	1.81%
Have to wait too long at doctor's office	1.74%	1.20%	2.53%

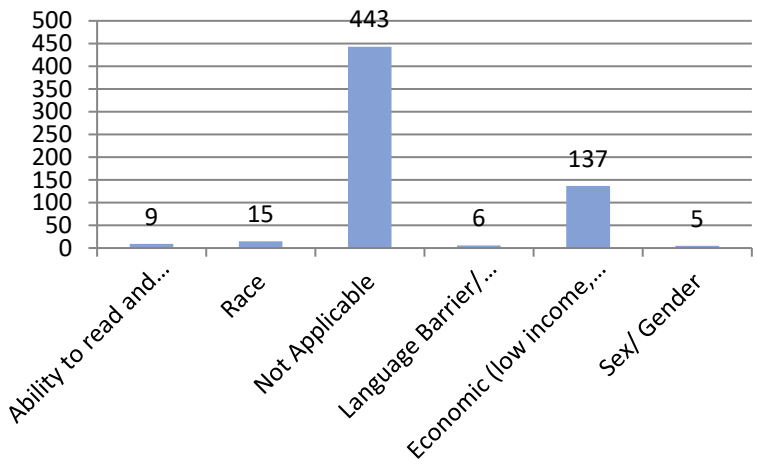
Summary: The graph and chart above show the number of the population surveyed who self-reported their biggest barrier for seeking medical treatment. "None" and "unable to pay/cost/can't afford" were the top two self-reported barriers.

Trend Data: No significant change from 2017.

Disparities: The Native American respondents report a higher rate of both "Lack of insurance" and "Unable to pay/can't afford' than other groups when reporting what kept them from getting the healthcare they needed. "Lack of knowledge" seems to be higher among African American respondents.

Impact on community: Affordability and health insurance coverage remain one of the biggest barriers in people seeking health care.

Question 4: What has affected the quality of the health care you receive? (check only one)



Not Applicable	80.36%
Economic (low income, no insurance, etc)	14.29%
Race	0.60%
Ability to read and write/ Education	1.79%
Language Barrier/ Interpreter/ Translator	1.79%
Sex/ Gender	1.19%
Total Responses: 615	

Disparities

	White/ Caucasian	Black/ African American	Native American/ Alaskan Native
Not Applicable	80.36%	65.24%	70.54%
Economic (low income, no insurance, etc)	14.29%	25.61%	25.19%
Race	0.60%	6.71%	1.16%
Ability to read and write/ Education	1.79%	1.83%	1.16%
Language Barrier/ Interpreter/ Translator	1.79%	0.00%	1.16%
Sex/ Gender	1.19%	0.61%	0.78%

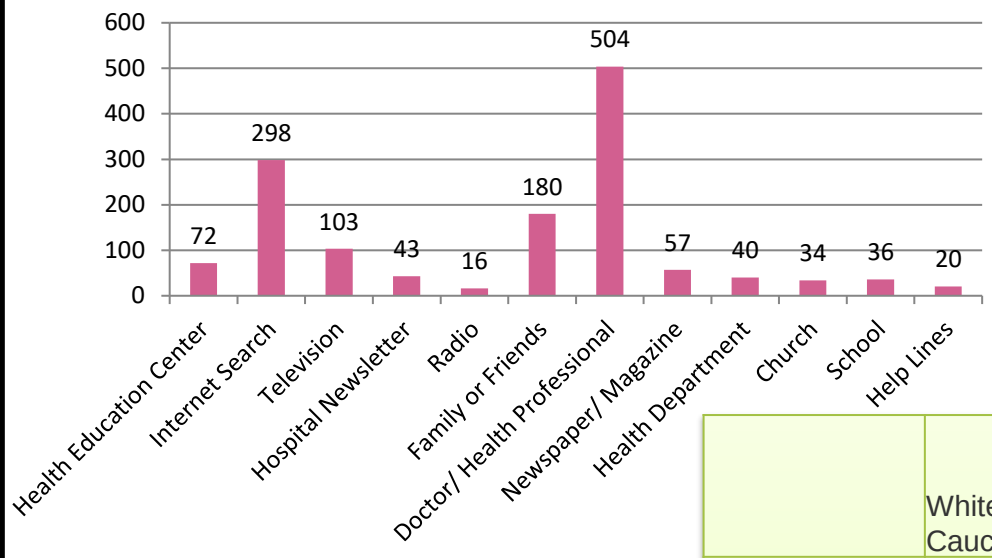
Summary: The graph and chart above show the number and percentage of the population surveyed who self-reported their quality of health care received. The majority answered “not applicable” and second was “economic.”

Trend Data: No significant change from 2017.

Disparities: Native Americans and African Americans have a lower percentage for “not applicable” but this may be reflected in their overall higher response of “economic” such as not having insurance and a lower income has a greater chance of impacting the quality of healthcare that they receive. Additionally, African Americans feel that “Race” is a significant factor impacting the healthcare that they receive. This is much higher than the other two major groupings.

Impact on community: While many respondents feel that this is not applicable, it is clear that most feel economic challenges significantly contribute to the healthcare that they receive.

Question 5: Where do you and your family get most of your health information? (check all that apply)



Doctor/ Health Professional	139
Internet Search	81
Family or Friends	37
Television	21
Health Education Center	13
Newspaper/ Magazine	15
Hospital Newsletter	10
Health Department	7
School	6
Church	5
Help Lines	2
Radio	3
Total Responses: 655	

Disparities

	White/ Caucasian	Black/ African American	Native American/ Alaskan Native
Doctor/ Health Professional	79.43%	76.44%	76.16%
Internet Search	46.29%	44.83%	45.20%
Family or Friends	21.14%	33.33%	27.40%
Television	12.00%	21.84%	14.59%
Health Educ. Center	7.43%	22.41%	6.41%
Newspaper/ Magazine	8.57%	10.34%	8.54%
Hospital Newsletter	5.71%	10.92%	4.63%
Health Dept.	4.00%	6.90%	6.05%
School	3.43%	8.62%	4.27%
Church	2.86%	12.64%	2.14%
Help Lines	1.14%	6.32%	2.49%

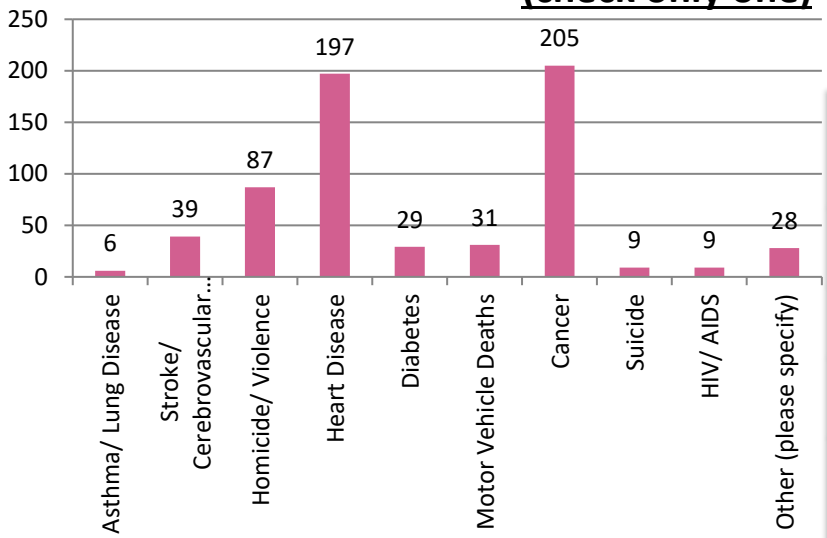
Summary: The graph and chart above show the number and percentage of the population surveyed who self-reported where they get their health information. "Doctors and health professionals" received the highest percentage, followed by the "Internet".

Trend Data: As seen in previous surveys, the internet keeps having an increased importance with the spread of technology into all sectors of society.

Disparities: Across the board, all groups identify Doctors or Health Professionals as the leading way to receive health information. Additionally, internet searches are second for all groups. However, some disparities are visible in regards to "family or friends", "television" and "health education center" areas as is evidenced above.

Impact on community: With the "Internet" being a high percentage, it could be useful for health organizations to consider developing websites that offer accurate and clear health information.

Question 6: What do you think most people die from in your community? (check only one)



Cancer	32.03%
Heart Disease	30.78%
Homicide/ Violence	13.59%
Stroke/ Cerebrovascular Disease	6.09%
Motor Vehicle Deaths	4.84%
Diabetes	4.53%
Other (please specify)	4.38%
Suicide	1.41%
HIV/ AIDS	1.41%
Asthma/ Lung Disease	0.94%
Total Responses: 640	

Disparities

	White/ Caucasian	Black/ African American	Native American/ Alaskan Native
Cancer	28.32%	30.59%	35.77%
Heart Disease	45.09%	21.76%	28.47%
Homicide/ Violence	8.09%	16.47%	14.96%
Stroke/ Cerebrovascular Disease	6.94%	8.82%	3.65%
Motor Vehicle Deaths	1.73%	8.24%	4.38%
Diabetes	6.36%	3.53%	3.65%
Other (please specify)	2.89%	5.29%	4.74%
Suicide	0.00%	2.35%	1.46%
HIV/ AIDS	0.00%	1.18%	2.55%
Asthma/ Lung Disease	0.58%	1.76%	0.36%

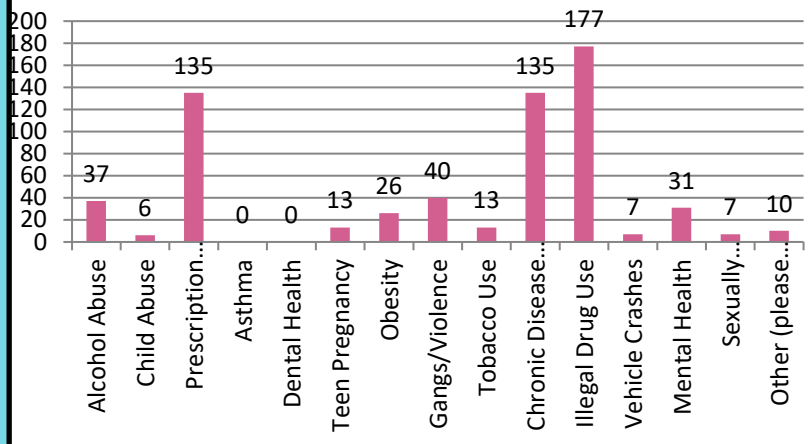
Summary: The graph and chart above show the number and percentage of the population surveyed who self-reported on what they think most people die of in their community. The survey indicated that "cancer" followed by "heart disease" as the top responses.

Trend Data: In this assessment, "cancer" followed by "heart disease" were the top two selected. This differs from the 2017 assessment as "heart disease" was the first choice, followed by "cancer."

Disparities: Caucasian respondent's choice of "heart disease" was nearly twice the rate of other groups. However, African American and Native American respondents felt that "Homicide/violence" was a much bigger reason why people die in their community.

Impact on community: The community's perception matches the first two causes of death as indicated by secondary data, but homicide and violence also play a significant role.

Question 7: What is the biggest health issue or concern in your community? (check only one)



Illegal Drug Use	27.79%
Prescription Drug Abuse	21.19%
Chronic Disease (Cancer, Diabetes, Heart or Lung Disease)	21.19%
Gangs/Violence	6.28%
Alcohol Abuse	5.81%
Mental Health	4.87%
Obesity	4.08%
Teen Pregnancy	2.04%
Tobacco Use	2.04%
Other (please specify)	1.57%
Vehicle Crashes	1.10%
Sexually transmitted infections (syphilis, gonorrhea, chlamydia)	1.10%
Child Abuse	0.94%
Asthma	0.00%
Dental Health	0.00%
Total Responses: 637	

Disparities

	White/ Caucasian	Black/ African American	Native American/ Alaskan Native
Illegal Drug Use	26.44%	22.02%	32.84%
Presc Drug Abuse	18.39%	10.12%	29.15%
Chronic Disease	28.74%	22.02%	16.97%
Gangs/ Violence	4.02%	11.31%	3.69%
Alcohol Abuse	2.30%	11.90%	4.43%
Mental Hlth	4.02%	7.14%	4.06%
Obesity	7.47%	3.57%	1.48%
Teen Preg	1.72%	3.57%	1.48%
Tobacco Use	2.30%	2.38%	1.48%
Other	2.30%	1.79%	1.11%
Vehicle Crs	0.00%	1.79%	1.48%
Sexually transmitted infections	1.15%	2.38%	0.37%
Child Abuse	1.15%	0.00%	1.48%
Asthma	0.00%	0.00%	0.00%
Dental Health	0.00%	0.00%	0.00%

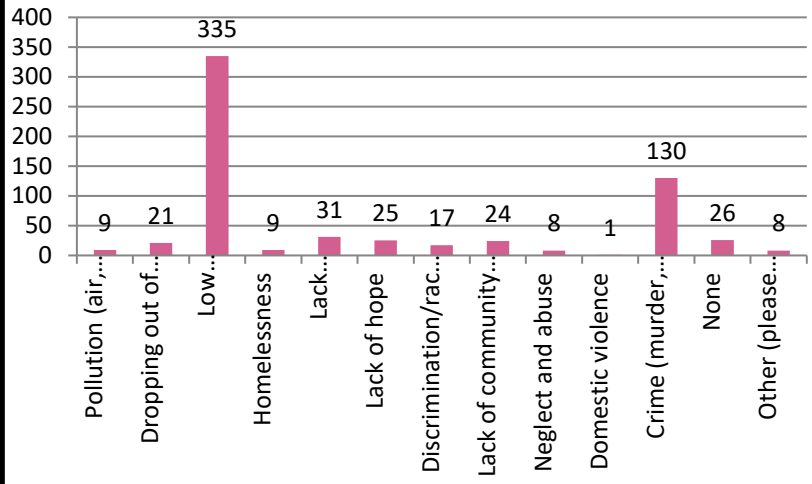
Summary: The graph and chart above show the number and percentage of the population surveyed who self-reported the biggest health issue of concern in their community. " Illegal drug use", "Prescription drug abuse" and "chronic disease" received the highest percentage of responses.

Trend Data: "Illegal drug use" and "prescription drug use" have soared to the top among all respondents and "illegal drug use" was near the top among all racial groupings.

Disparities: Multiple disparities can be noted above. Although "illegal drug use" is near the top for all groupings, there are notable differences when it comes to "prescription drug abuse" and the Native American respondents. Likewise, "gangs/violence" and "alcohol abuse" are strikingly more important to African American respondents.

Impact on community: Increased education on chronic disease prevention will continue as well as exploration of treatment options for illegal and prescription drug misuse in Robeson County.

Question 8: Which of the following most affects the quality of life in your county? (check only one)



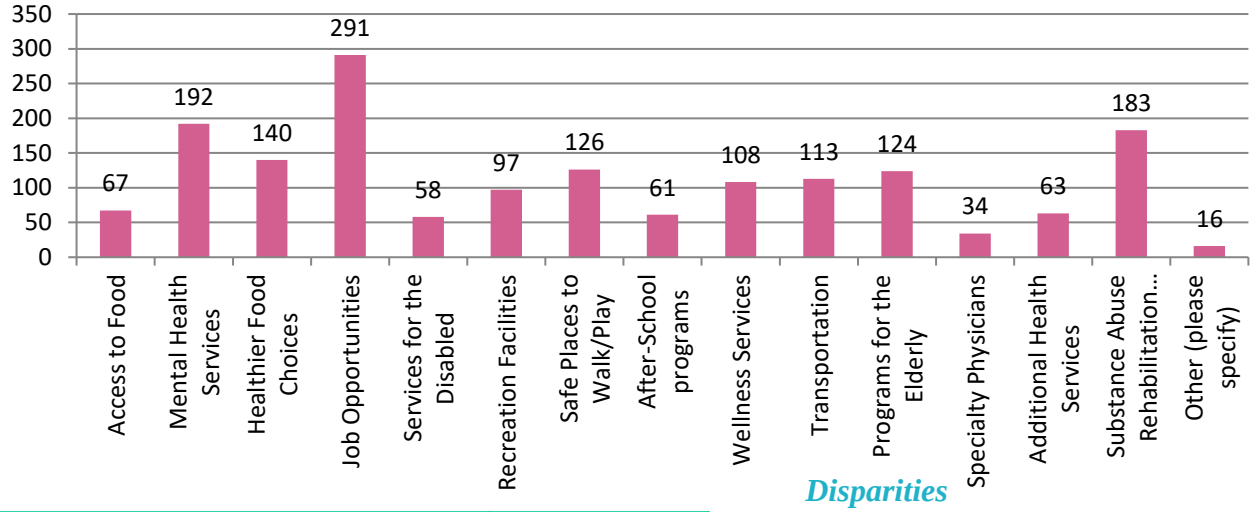
Low income/poverty	52.02%
Crime (murder, assault, theft, rape/sexual assault)	20.19%
Lack of/inadequate health insurance	4.81%
None	4.04%
Lack of hope	3.88%
Lack of community support	3.73%
Dropping out of school	3.26%
Discrimination/racism	2.64%
Pollution (air, water, land)	1.40%
Homelessness	1.40%
Neglect and abuse	1.24%
Other (please specify)	1.24%
Domestic violence	0.16%
Total Responses: 644	

Disparities

	White/ Caucasian	Black/ African American	Native American/Alaskan Native
Low income/ poverty	64.57%	45.03%	48.18%
Crime	12.57%	18.71%	25.91%
Lack of/ inadequate hlth insur.	4.00%	6.43%	4.74%
None	4.00%	5.26%	3.65%
Lack of hope	3.43%	3.51%	3.65%
Lack of community support	4.00%	4.09%	3.65%
Dropping out of school	1.14%	5.85%	3.28%
Discrimination / racism	1.14%	5.26%	1.82%
Pollution	0.57%	1.75%	1.46%
Homelessnes s	1.71%	1.17%	1.09%
Neglect and abuse	0.57%	2.34%	1.09%
Other	2.29%	0.58%	1.09%
Domestic violence	0.00%	0.00%	0.36%

Summary: The graph and chart above show the number and percentage of the population who self-reported what most affects the quality of life in their county. The highest percentage of responses received was for “low income/poverty.”
Trend Data: No significant change from 2017.
Disparities: The most notable disparity here is in regard that respondents feel “crime” affects different respondents. Native American and African Americans significantly identify “crime” as a greater influencer than Caucasians.
Impact on community: The economic condition of a community affects the quality of life. There are opportunities for those who are responsible for economic development in Robeson County to contribute to positive health outcomes.

Question 9: What does your community need to improve the health of your family, friends, and neighbors? (check only three)



Job Opportunities	45.12%
Mental Health Services	29.77%
Substance Abuse Rehabilitation Services	28.37%
Healthier Food Choices	21.71%
Safe Places to Walk/Play	19.53%
Programs for the Elderly	19.22%
Transportation	17.52%
Wellness Services	16.74%
Recreation Facilities	15.04%
Access to Food	10.39%
Additional Health Services	9.77%
After-School programs	9.46%
Services for the Disabled	8.99%
Specialty Physicians	5.27%
Other (please specify)	2.48%
Total Responses: 645	

Summary: The graph and chart above show the number and percentage of the population surveyed who self-reported on what they think are the needs for their community. As shown, the majority of the respondents said "job opportunities" are the biggest need in Robeson County.

Trend Data: The top choice of "job opportunities" in 2017 remained the top choice this year. However, this year did see a significant jump in the demand for 'mental health services" and "substance abuse rehabilitation services" replacing "healthier food choices" from earlier assessments.

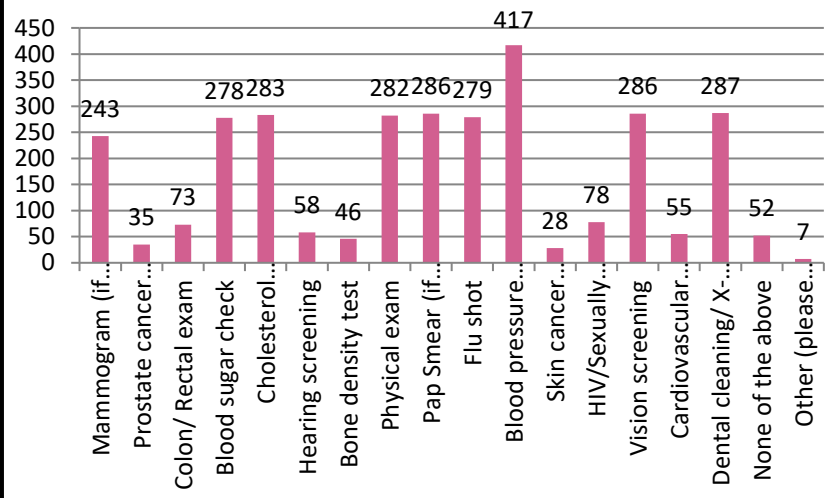
Disparities: Caucasians have a higher percentage for "mental health services." Caucasians and Native American have a higher percentage of "substance abuse rehabilitation services" than African Americans.

Impact on community: The community as a whole seems to be requesting more mental health assistance and substance misuse treatment options.

Disparities

	White/ Caucasian	Black/ African American	Native American/ Alaskan Native
Job Opportunities	44.77%	45.66%	45.29%
Mental Health Services	37.21%	28.32%	25.72%
Substance Abuse Rehabilitation Services	27.91%	21.97%	33.33%
Healthier Food Choices	24.42%	24.86%	18.12%
Safe Places to Walk/Play	18.60%	19.65%	20.29%
Programs for the Elderly	18.60%	22.54%	18.12%
Transportation	15.12%	22.54%	16.67%
Wellness Services	18.60%	15.61%	16.30%
Recreation Facilities	11.63%	19.65%	13.77%
Access to Food	9.30%	11.56%	9.42%
Additional Health Services	7.56%	10.98%	10.87%
After-School programs	7.56%	16.18%	6.52%
Services for the Disabled	6.98%	13.87%	7.97%
Specialty Physicians	5.81%	5.78%	4.35%

Question 10: Which of the following preventative screenings have you had in the past 12 months? (check all that apply)



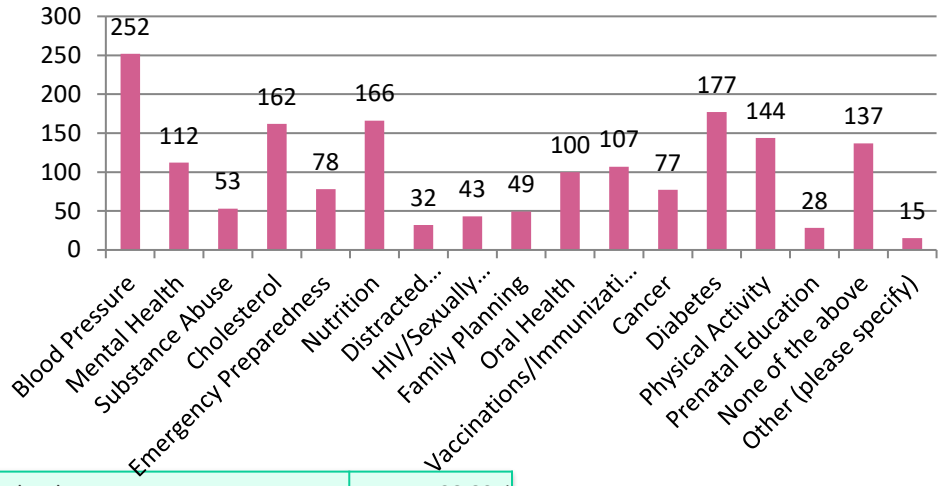
Blood pressure check	63.28%
Dental cleaning/ X-rays	43.55%
Pap Smear (if woman)	43.40%
Vision screening	43.40%
Cholesterol screening	42.94%
Physical exam	42.79%
Flu shot	42.34%
Blood sugar check	42.19%
Mammogram (if woman)	36.87%
HIV/Sexually Transmitted Infections	11.84%
Colon/ Rectal exam	11.08%
Hearing screening	8.80%
Cardiovascular screening	8.35%
None of the above	7.89%
Bone density test	6.98%
Prostate cancer screening (if man)	5.31%
Skin cancer screening	4.25%
Other (please specify)	1.06%
Total Responses: 659	

Summary: The graph and chart above show the number and percentage of the population surveyed who self-reported what preventative screenings they had in the past 12 months. "Blood pressure" was the highest in this year's survey.
Trend data: "Dental cleaning" has moved to just behind "blood pressure check." In 2017, the second choice behind "blood pressure check" was "Pap smear."
Disparities: A higher percentage of "dental cleaning" and "vision screening" is reported by Caucasians which shows that African Americans and Native Americans many not be receiving proper preventative care.
Impact on community: Preventative screenings are a valuable part of every person's overall health and will allow chronic conditions being diagnosed at an earlier stage.

Disparities

	White/ Caucasian	Black/ African American	Native American/ Alaskan Native
Blood pressure check	69.49%	62.50%	60.14%
Dental cleaning/ X-rays	55.37%	36.93%	41.99%
Pap Smear (if woman)	39.55%	48.86%	41.28%
Vision screening	53.11%	39.77%	39.50%
Cholesterol screening	57.06%	38.07%	39.15%
Physical exam	51.41%	41.48%	37.37%
Flu shot	55.93%	43.18%	34.16%
Blood sugar check	47.46%	43.75%	38.43%
Mammogram (if woman)	44.63%	39.20%	32.74%
HIV/Sexually Transmitted Infections	5.65%	22.16%	8.54%
Colon/ Rectal exam	16.95%	10.80%	8.54%
Hearing screening	11.30%	7.95%	8.19%
Cardiovascular screening	12.43%	7.95%	6.41%
None of the above	5.08%	9.09%	9.25%
Bone density test	9.60%	7.95%	5.34%
Prostate cancer screening (if man)	8.47%	3.41%	4.98%
Skin cancer screening	13.56%	0.00%	1.42%

Question 11: Which of the following health issues have you received information on in the past 12 months? (check all that apply)



Blood Pressure	38.89%
Diabetes	27.31%
Nutrition	25.62%
Cholesterol	25.00%
Physical Activity	22.22%
None of the above	21.14%
Mental Health	17.28%
Vaccinations/Immunizations	16.51%
Oral Health	15.43%
Emergency Preparedness	12.04%
Cancer	11.88%
Substance Abuse	8.18%
Family Planning	7.56%
HIV/Sexually Transmitted Infections	6.64%
Distracted Driving/Seatbelts/Child Car Seats	4.94%
Prenatal Education	4.32%
Other (please specify)	2.31%
Total Responses: 648	

Summary: The graph and chart above show the number and percentage of the population surveyed who self-reported what health information they had received in the past 12 months. The top three results were "blood pressure," "diabetes" and "nutrition."

Trend Data: This is the second time that this question has been asked of participants. As with the previous assessment, the top three types of information that people reported receiving were "blood pressure," "diabetes" and "nutrition."

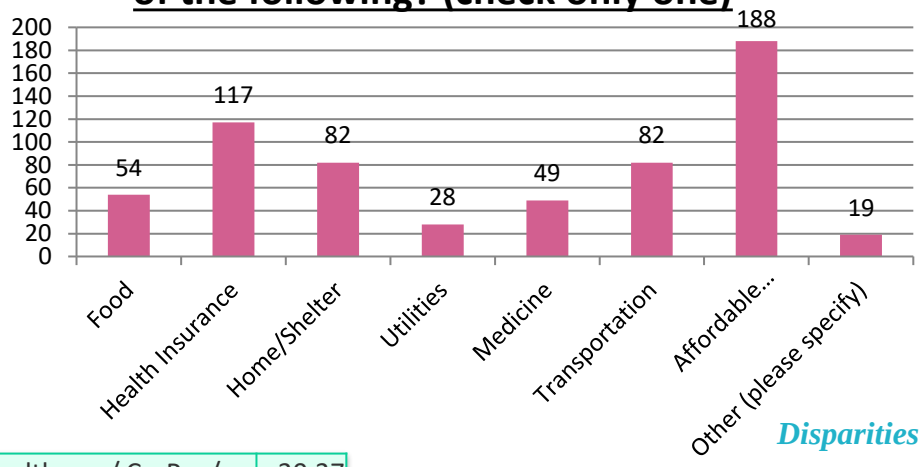
Disparities: African Americans have a higher percentage of self-reported "mental health" information that they had received. Caucasians reported a tremendously lower rate of information on "family planning" than Native Americans or African Americans.

Impact on community: There are potential opportunities for strengthening the relationship between behavioral health providers and substance misuse treatment. Strengthening the relationship between those care workers could improve quality of care and accessibility for residents of Robeson County.

Disparities

	Caucasian	African American	Native American
Blood Pressure	38.37%	44.83%	36.10%
Diabetes	27.33%	31.61%	24.91%
Nutrition	28.49%	29.31%	21.66%
Cholesterol	31.40%	22.99%	23.47%
Physical Activity	25.00%	23.56%	20.22%
None of the above	21.51%	16.09%	24.19%
Mental Health	12.79%	24.14%	13.36%
Vaccinations/ Immunizations	18.60%	17.24%	15.52%
Oral Health	15.12%	13.22%	16.25%
Emergency Preparedness	12.79%	16.67%	9.03%
Cancer	11.63%	14.94%	10.47%
Substance Abuse	8.14%	8.05%	7.22%
Family Planning	1.74%	9.20%	10.11%
HIV/Sexually Transmitted Infections	2.33%	11.49%	6.14%
Distracted Driving/Seatbelts/ Child Car Seats	4.07%	6.90%	4.33%
Prenatal Education	4.07%	5.75%	3.61%
Other (please specify)	2.91%	1.72%	2.53%

Question 12: Do you feel people in your community lack the funds for any of the following? (check only one)



Affordable Healthcare/ Co-Pay/ Deductible	30.37 %
Health Insurance	18.90 %
Home/Shelter	13.25 %
Transportation	13.25 %
Food	8.72%
Medicine	7.92%
Utilities	4.52%
Other (please specify)	3.07%
Total Responses: 619	

Disparities

	Caucasian	African American	Native American
Affordable Healthcare/ Co-Pay/ Deductible	30.86%	22.42%	35.56%
Health Insurance	24.69%	16.97%	17.04%
Home/Shelter	12.35%	15.15%	13.33%
Transportation	12.35%	15.15%	12.22%
Food	9.26%	11.52%	5.93%
Medicine	5.56%	9.09%	8.52%
Utilities	2.47%	6.06%	4.81%
Other (please specify)	2.47%	3.64%	2.59%

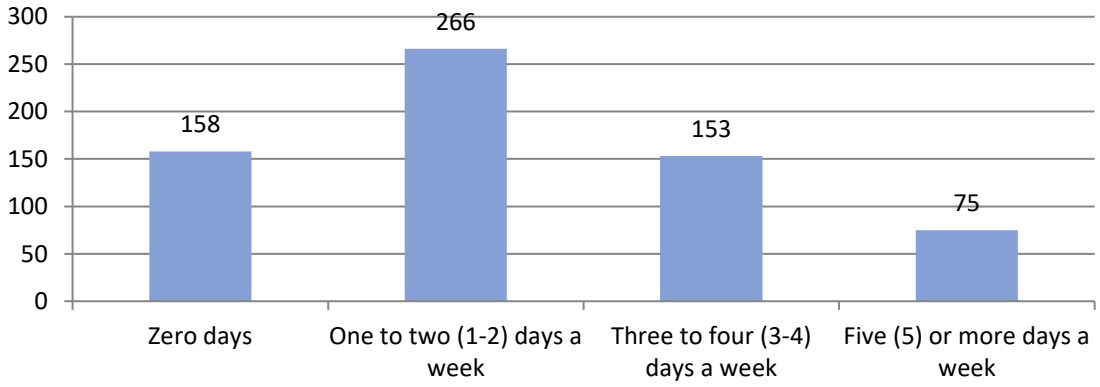
Summary: The graph and chart above show the number and percentage of the population surveyed who self-reported what resources they felt their community members could not afford. “Affordable healthcare/co-pay/deductible” was identified as the hardest to attain.

Trend data: The 2017 assessment brought a new choice of “affordable healthcare/co-pay/deductible and once again with this year’s survey that is the leading choice. Different from the 2017 assessment, 2020 saw a rise in people not having the funds for “health insurance,” “home/shelter” and ”transportation.”

Disparities: African Americans have a lower percentage for “affordable healthcare/co-pay/deductible” than Caucasians and Native Americans but a slightly higher percentage for “home/shelter.” Caucasians have a higher percentage for lacking the funds for “health insurance.”

Impact on community: The number of people in the county that are employed but still cannot afford health care are likely the main contributors towards the high percentage of those who chose “healthcare/co-pay/deductible.” Choices of “food” and “medicine” seem to have fallen downward in importance, but this may be a direct result of shifting priorities focusing on health insurance and health care.

Question 13: Other than your regular job, how many days per week do you engage in physical activity for at least 30 minutes that makes you "break a sweat"?



One to two (1-2) days a week	40.80%
Zero days	24.23%
Three to four (3-4) days a week	23.47%
Five (5) or more days a week	11.50%
Total Responses: 652	

Disparities

	Caucasian	African American	Native American
One to two (1-2) days a week	40.91%	38.29%	41.30%
Zero days	24.43%	25.14%	24.64%
Three to four (3-4) days a week	20.45%	22.29%	26.45%
Five (5) or more days a week	14.20%	14.29%	7.61%

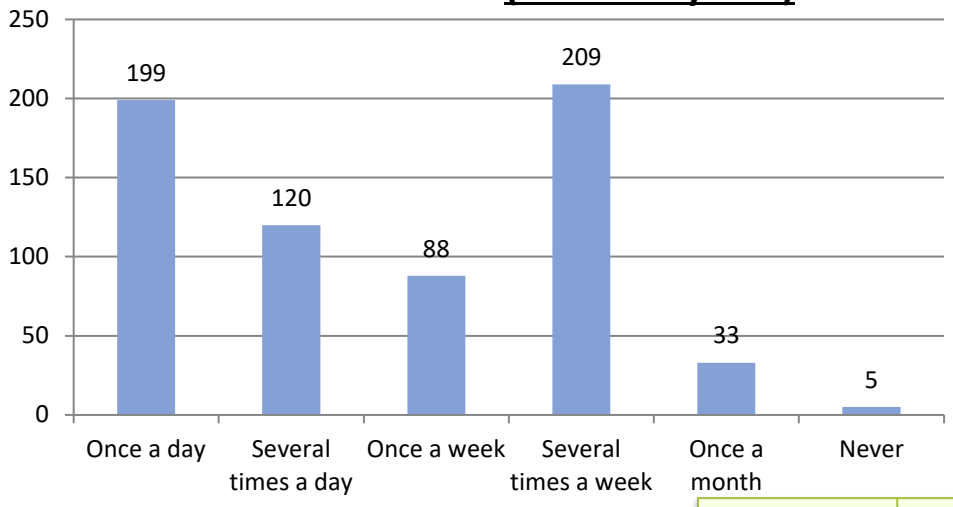
Summary: The graph and chart above show the number and percentage of the population surveyed who self-report the number of days per week they spend engaging in physical activity.

Trend Data: Very similar to the 2017 assessment, regular physical activity of "five or more days a week" was not as widespread as even no regular physical activity. It seems as though the trend of very little physical activity continues to plague Robeson County.

Disparities: No significant disparities.

Impact on community: Information on proper physical activity and exercise is necessary based on the gap between how many people responded to engaging in exercise compared to the results seen on the health issues responses. This is an opportunity to partner with schools to provide education onsite or with fitness centers to do outreach to the community.

Question 14: On average, how often do you eat fruits or vegetables? (check only one)



Several times a week	31.96%
Once a day	30.43%
Several times a day	18.35%
Once a week	13.46%
Once a month	5.05%
Never	0.76%
Total Responses: 654	

Disparities

	Caucasian	African American	Native American
Several times a week	30.86%	31.43%	33.69%
Once a day	34.86%	28.00%	28.67%
Several times a day	18.29%	18.29%	18.28%
Once a week	11.43%	14.86%	14.70%
Once a month	3.43%	7.43%	3.94%
Never	1.14%	0.00%	0.72%

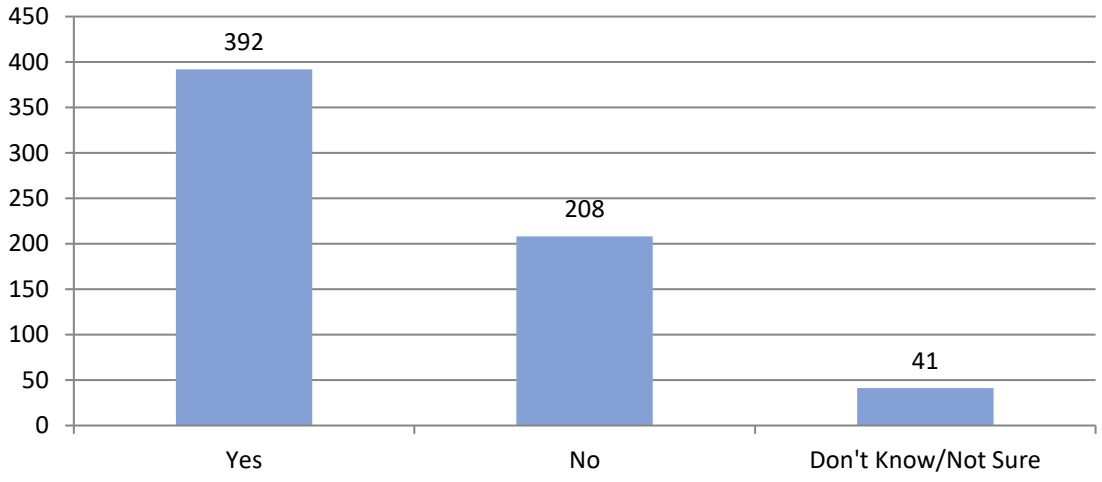
Summary: The graph and chart above show the number and percentage of the population surveyed who self-reported the amount of fruits or vegetables consumed in a month. As shown, the majority selected "several times a week."

Trend: "Several times a week" beat out "once a day" just slightly which is the opposite of what was observed in the 2017 assessment. These numbers still indicate a need for more fruit and vegetable consumption on a daily basis with multiple servings each day.

Disparities: It seems that "once a day" is the one choice that may see some disparity. According to this year's data, Caucasians report more often that they eat fruits and vegetable "once a day" than other groups.

Impact on community: In Robeson County there is a disparity in food access and high food prices can cause lower income populations to be priced out of healthy food options. Increased consumption of fruits and vegetables will certainly improve health outcomes.

Question 15: Does your family have a basic emergency supply kit? (These kits include water, non-perishable food, any necessary prescriptions, first aid supplies, flashlights and batteries, non-electric can opener, blanket, etc.) (check only one)



Yes	61.15%
No	32.45%
Don't Know/Not Sure	6.40%
Total Responses: 641	

Disparities

	Caucasian	African American	Native American
Yes	68.42%	54.97%	61.31%
No	26.90%	36.26%	33.21%
Don't Know/Not Sure	4.68%	8.77%	5.47%

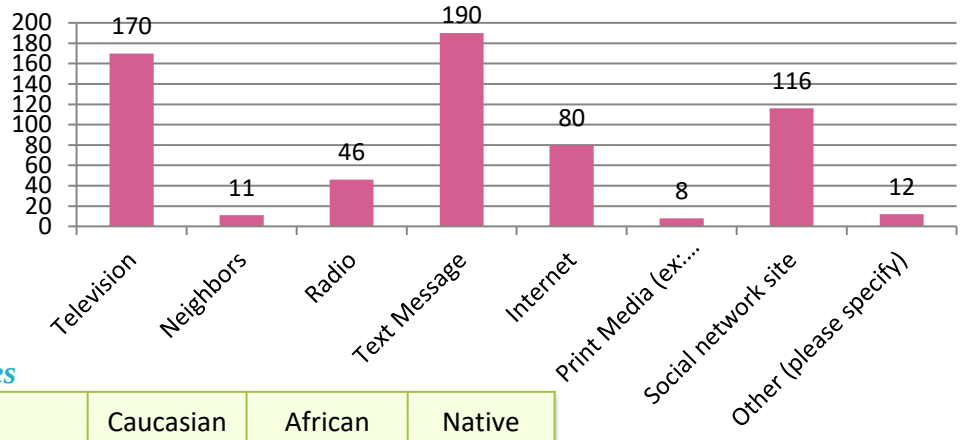
Summary: The graph and chart above show the number and percentage of the population surveyed who reported whether they have an emergency kit at home. "Yes" received the greatest number of responses.

Trend: The trend here tends to be a positive one. The 2017 assessment reported only 49.2% reporting "yes," but this year witnessed over a 61% "yes" response.

Disparities: African Americans had a higher percentage for "no" than other groups.

Impact on community: Red Cross helps with emergency preparedness in the county, along with the Health Department which has supplied emergency kits for some residents. The impact of two major hurricanes in recent memory may be increasing the public's recognition of this need.

Question 16: What would be your main way of getting information from authorities in a large-scale disaster or emergency? (check only one)



Disparities

	Caucasian	African American	Native American
Text Message	32.16%	27.27%	29.78%
Television	22.22%	33.94%	26.47%
Social network site	19.88%	18.79%	17.28%
Internet	12.28%	10.91%	13.24%
Radio	8.19%	6.06%	6.99%
Other (please specify)	2.34%	1.21%	2.21%
Neighbors	2.92%	1.21%	1.47%
Print Media (ex: newspaper)	0.00%	0.61%	2.57%

Text Message	30.02%
Television	26.86%
Social network site	18.33%
Internet	12.64%
Radio	7.27%
Other (please specify)	1.90%
Neighbors	1.74%
Print Media (ex: newspaper)	1.26%
Total Responses: 633	

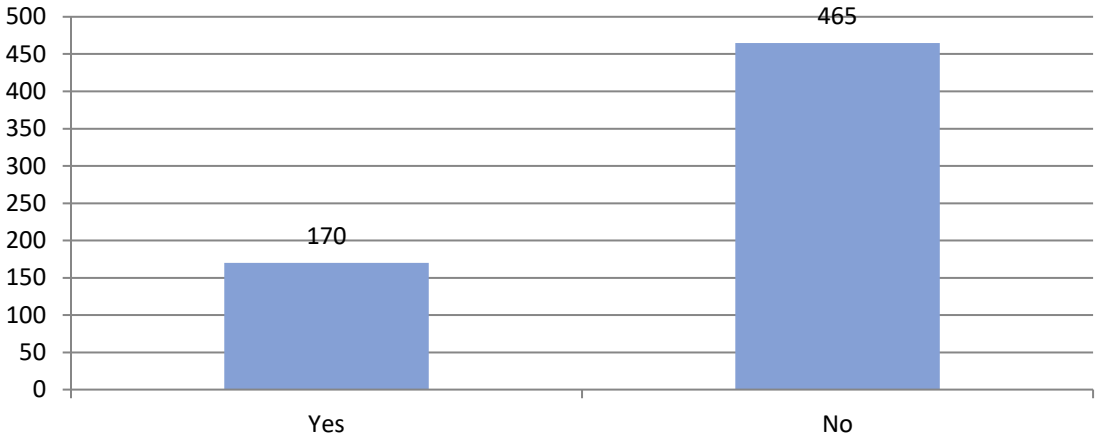
Summary: The graph and chart above show the number and percentage of the population surveyed who self-reported the best way to receive information during an emergency.

Trend: The top choice in 2017 was "television" with 41.2% and text messaging following a distant second at 22.2%. However, the advent of emergency texting systems seems to have over taken "television" with this assessment.

Disparities: African American respondents seemed to still prefer "television" and "neighbor" more than other groups.

Impact on community: With an increase in social networking sites being utilized by more residents, local organizations may need to make future considerations on how they alert people during emergencies.

Question 17: During your first 18 years of life, did you live with anyone who was a problem drinker or alcoholic or used street drugs? (Check only one)



No	73.23%
Yes	26.77%
Total Responses: 635	

Disparities

	Caucasian	African American	Native American
No	72.67%	71.78%	74.28%
Yes	27.33%	28.22%	25.72%

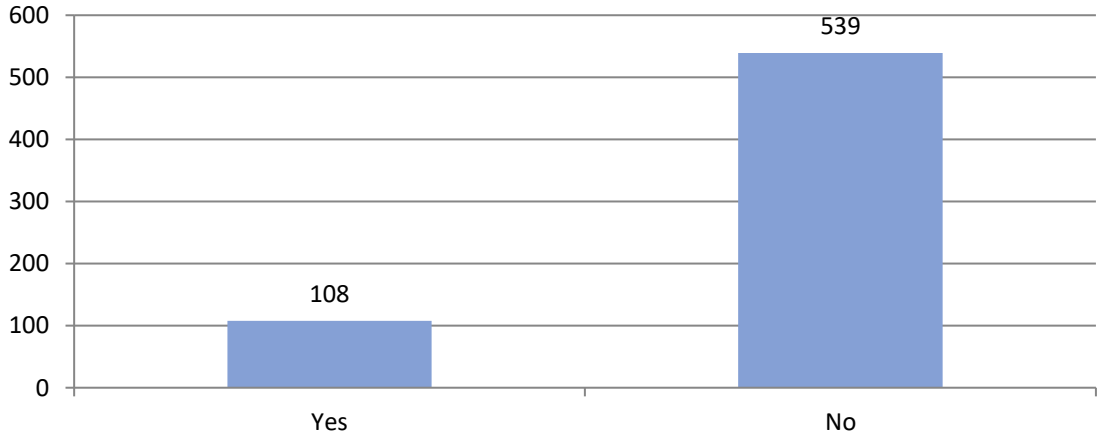
Summary: The graph and chart above show the number and percentage of the population surveyed who self-reported living with a problem drinker, alcoholic or street drugs user during their first 18 years.

Trend: This is a new question, so there is no available trend data.

Disparities: It appears that there are no significant disparities among racial groupings.

Impact on community: This question attempts to gauge Adverse Childhood Experiences and make a correlation to health concerns in later life. Adverse Childhood Experiences often lead to a cyclic environment of poor choices in later life and with the next generation.

Question 18: During your first 18 years of life, was a household member depressed or mentally ill, or did a household member attempt suicide? (Check only one)



No	83.31%
Yes	16.69%
Total Response: 647	

Disparities

	Caucasian	African American	Native American
No	82.86%	84.30%	83.70%
Yes	17.14%	15.70%	16.30%

Summary: The graph and chart above show the number and percentage of the population surveyed who self-reported living in their first 18 years of life with a household member that was depressed, mentally ill or with a household member that attempted suicide.

Trend: This is a new question, so there is no available trend data.

Disparities: It appears that there are no significant disparities among racial groupings.

Impact on community: This question attempts to gauge Adverse Childhood Experiences and make a correlation to health concerns in later life. Adverse Childhood Experiences often lead to a cyclic environment of poor choices in later life and with the next generation.

Secondary Data Results

Secondary data was obtained from various local and state-level resources. Key public resources of existing data on Robeson County were reviewed and compared to state and national data. These resources were used to compare the determinates of health as well as health outcomes. The determinates or drivers of health reviewed were demographic, social and economic status, education levels and environmental health. Health outcome data in the areas of overall health status, disease trends, mental/behavior health (including substance abuse) and modifiable health risk behaviors were compared against state and national data sources.

Population's Demographic Data

According to the United States Census The Robeson County population is declining while both the population of the state and nation are increasing. Robeson County has a larger minority population, having no majority population. The Robeson County, North Carolina and US population are similar in person's per household and percentage of females. The population of Robeson County is younger, poorer and less likely to have health insurance compared to the populations of North Carolina and the United States, The higher level of poverty can be contributed to the lower education attainment, the percentage of the populations who are not yet of employment age, and the higher percentage of adults reporting disabilities. Key concerns for future educational attainment and health are the lower per centage of households with computers and broadband services.

Rank	Top 5 Causes of Death 2014-2018 for Robeson County	Robeson County	North Carolina (UnRanked)
1	Diseases of the Heart	215.6	158.0
2	Total Cancer	191.6	161.3
3	Alzheimer's Disease	59.1	35.7
4	Chronic Lower Respiratory Diseases	46.6	44.7
5	Cerebrovascular Disease	45.1	43.0

Source: https://schs.dph.ncdhhs.gov/data/databook/

Mortality

Infant Mortality and Life Expectancy

Two measures of mortality are used to compare the overall health of populations. Infant mortality is a key marker of overall health as a key measurement of the health of women and infant, the outcome of good nutrition, social-economic status as well as access to services. The other key marker is life expectancy at birth that is an estimate of the expected average number of years of life. This key indicator measures health status across all age groups.

Robeson County has a higher infant mortality rate than the United States and North Carolina. Robeson County with the lowest life expectancy of any county in North Carolina also has a lower life expectancy than the general population of the United States. Therefore, a resident of Robeson County experiences significantly poorer health than the average resident in the state and nation. **(Source: North Carolina Center for Health Statistics 2019**

	US	North Carolina	Robeson County
Infant Mortality Rate (per 1,000)	5.6 (2018)	7.1 (2014-2018)	14
Life Expectancy (years)	78.7 (2018)	78.3	73.2

2018 Leading Causes of Death for Robeson
(*Rates per 100,000 Population)*
Peer County and Racial Comparison

Leading Causes of Death

According to the North Carolina State Center for Health Statistics (NCSCHS 2020) and the Robert Wood Johnson's Foundations County Health Rankings the top five leading causes of Robeson County's deaths in 2018 are, in order: heart disease, cancer, accidents, stroke and lung diseases Because of the age difference in the US, NC and Robeson County populations, to more accurately compare the rate of the leading causes of death, age-adjusted rates are used. The use of age-adjusted rates allows for populations with different age populations be compared. This is especially important since many of the current leading causes of death increase with age.

The NCSCHS provides trend data for key areas including the top five leading causes of death. Adjusting for age, Robeson County has a higher mortality rate for heart disease, cardiovascular disease, colorectal, and trachea, bronchus and lung cancer, diabetes, intentional motor vehicle injury and injury excluding motor vehicle deaths, and homicide. We are near or state average mortality rates for stroke, breast and prostrate cancer, and suicide rates. Trend data (2002-2016) shows a decrease in deaths rates from cardiovascular and heart disease, stroke, cancer (except colorectal) and diabetes. Cancer is the second leading cause of death in the United States, North Carolina and Robeson County. The etiology of cancer is still being investigated; however, the primary site of the different types of cancer is used to determine risk-factors. The age-adjusted death rate for the leading cancers are lower in Robeson County except for colon and lung/bronchus cancers.

We have experienced increased death rates from colorectal cancer, motor vehicle and other injuries, homicide and suicide. It is noteworthy that for the data about the recent opioid crisis shows that the mortality rate for opioid deaths are twice has high for Robeson County as for the state (114.2 and 72 respectively.)

According to the Center for Disease Control Wonder, (https://wonder.cdc.gov/; 2020) the leading causes of premature death (deaths that occur to persons under the age of 75) in Robeson County are in the Figure 1. This list indicates that the leading causes of death are a combination of chronic physical disease and injury and violence. All of these diseases are influenced by behavior and access to care.

Figure 1

	Robeson	NC	US (Top performers)
Premature deaths (deaths before 75 years of age)	12,600	7,700	5,500
Poor or fair health	30%	18%	12%
Poor physical health days (# of days out of 30)	5.6	3.9	3.1
Poor mental health days (# of days out of 30)	5.2	4.1	3.4
Low birthweight (% of births)	12 %	0 %	6 %

Cancer Death rates

Cancer is the second leading cause of death in the United States, North Carolina and Robeson County. The etiology of cancer is still being investigated; however, the primary site of the different types of cancer is used to determine risk-factors. The age-adjusted death rate for the leading cancers are lower in Robeson County except for colon and lung/bronchus cancers.

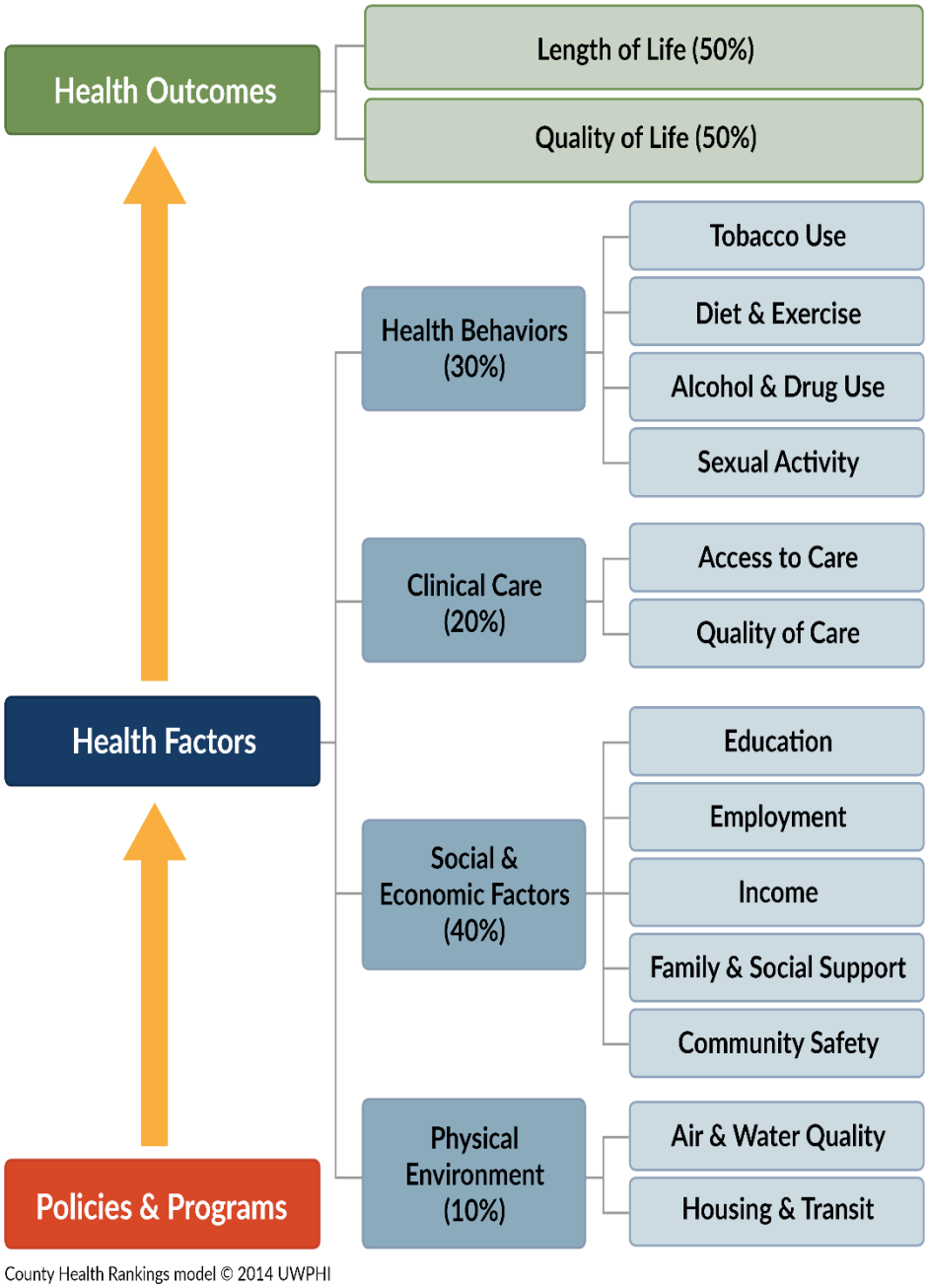
We have experienced increase death rates from colorectal cancer, motor vehicle and other injuries, homicide and suicide. It is noteworthy that for the data about the recent opioid crisis shows that the mortality rate for opioid deaths are twice has high for Robeson County as for the state (114.2 and 72 respectively.)

By Cancer Types

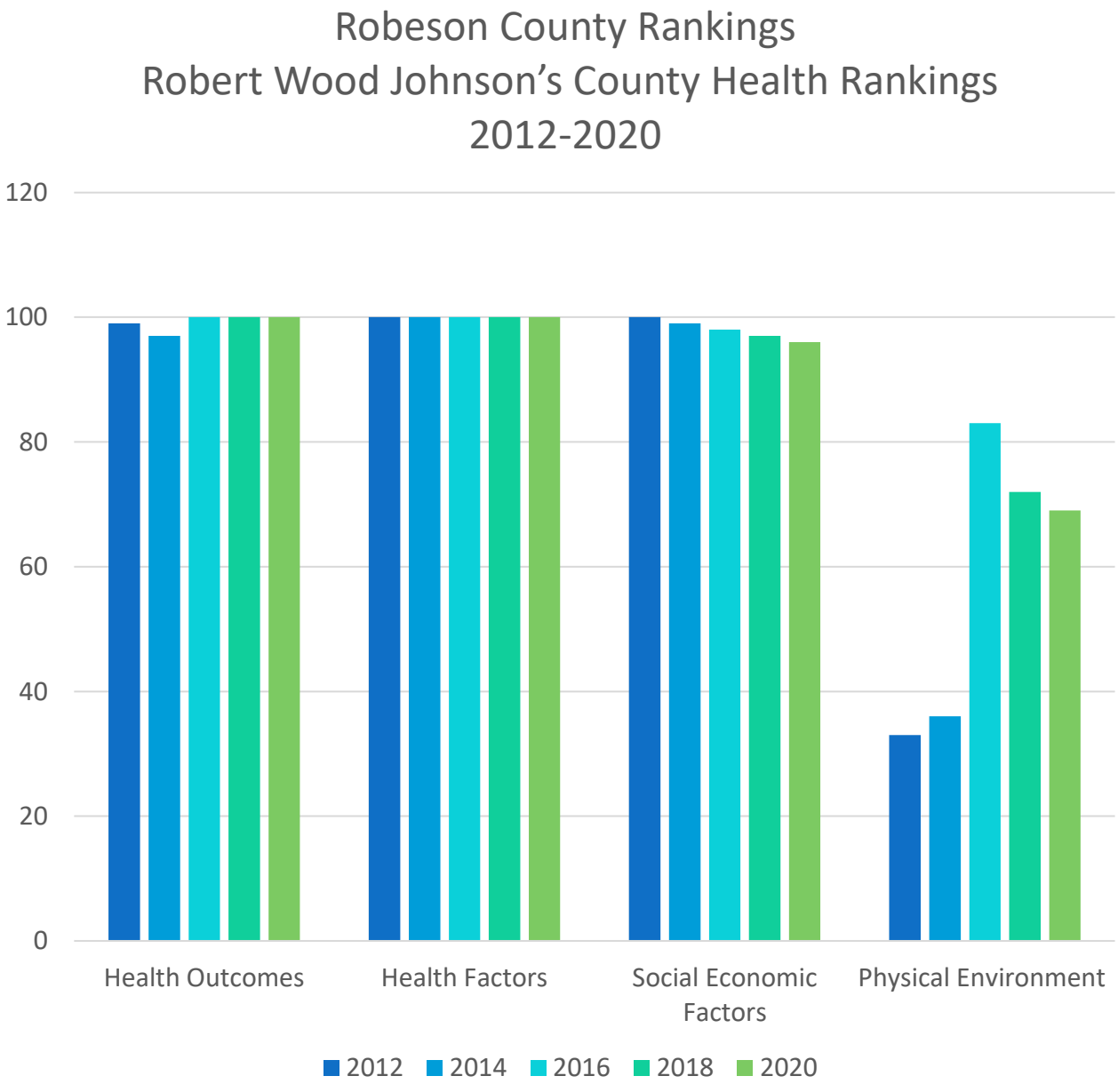
Type of Cancer	Robeson Co	NC	USA
All cancers	385.8	457.3	
Colon	36.7	35.1	
Lung/Bronchus	67.1	62.0	
Female breast	105.5	158.7	
Prostrate	103.1	113.6	

Morbidity / Disease Data

The rate of disease or morbidity data is consistent with the 2020 Robert Wood Johnson's National Health Rankings. Robeson County ranked 100 out of 100 counties in North Carolina. The RWJ Health Rankings also collected data not used in determining the national, state and county health ranks. Figure 2 shows the model used by RWJ to determine the county health rankings.



While the picture presented in 2020 dismissal, the fact that Robeson County has consistently ranked in the lowest tier for each of the years the data has been collected, clearly demonstrates that the problems are entrenched. The Figure below indicates Robeson County's overall rankings since 2012.

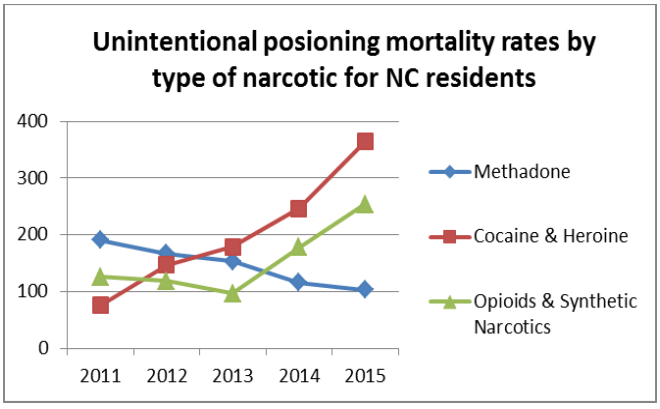


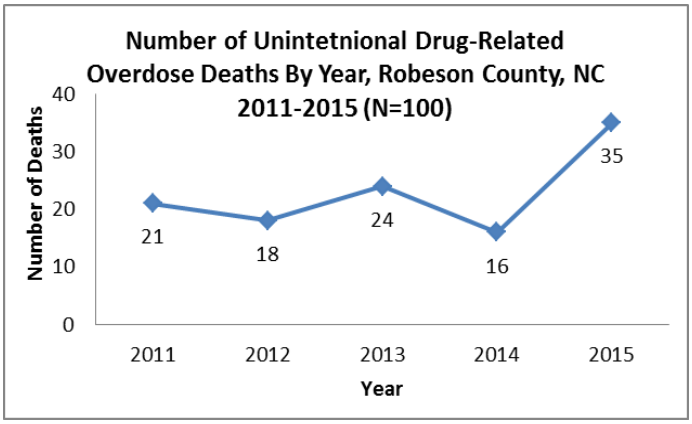
Substance Misuse

Substance use and misuse are major contributors to death and disability in North Carolina, as well as Robeson County. Addiction to drugs and/or alcohol is a chronic health problem and people who suffer from substance use disorders are at risk for injuries and disability, co-morbid health conditions and premature death. Substance misuse has adverse consequences for families, communities and society. Furthermore, it impacts both local and state crime rates, as well as motor vehicle fatality rates. The most commonly overdosed drug is opioid prescription drugs, comprising nearly half of the U.S. overdoses in 2015.

The most common drugs involved in prescription opioid overdose deaths include: Methadone, Oxycodone (such as Oxycontin®), Hydrocodone (such as Vicodin®). Overdose rates were highest among people aged 25 to 54 years. Overdose rates were higher among non-Hispanic whites and Native American or Alaskan Natives, compared to non-Hispanic blacks and Hispanics.

The graphs below shows the rank of unintentional poisoning mortality rates, broken down by specific narcotic in North Carolina between 2010-2015. Also shown is the number of unintentional drug-related overdose deaths by year in Robeson County. The rates were highest in 2013 and 2015, showing a sense of urgency to educate the community about the harmful effects of these drugs and the high mortality rates as a cause for concern.

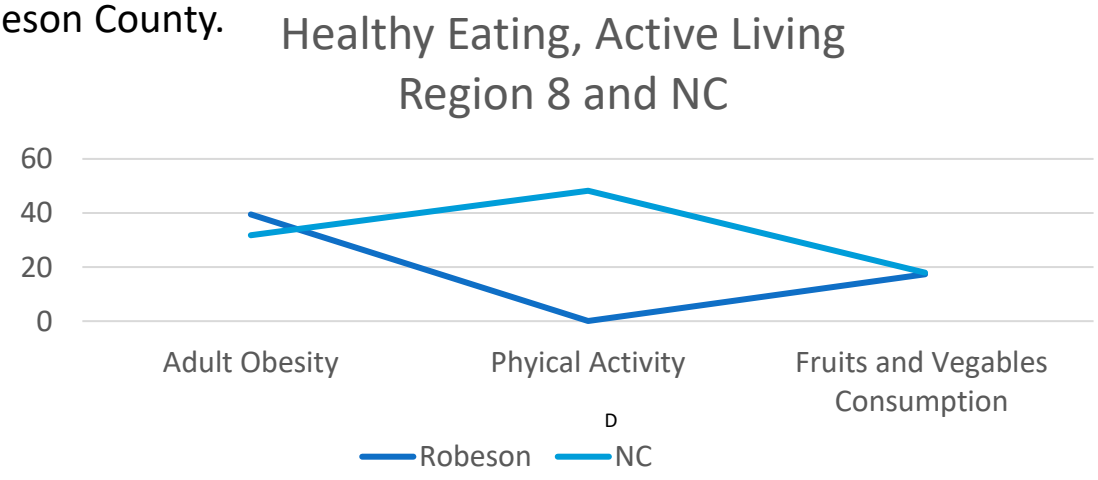




Obesity and Overweight

According to the National Institute of Health, obesity and overweight are the second leading cause of preventable deaths in the United States, close behind tobacco usage. The results from the 2013-2014 National Health and Nutrition Examination Survey (CDC.gov) estimated that 80% of all adults aged 20 and above in the United States are classified as overweight, obese or severely obese, a trend that has been steadily increasing since 1999. The same study estimated that 38% of children and adolescents classified as overweight, obese or severely obese. If Robesonians experiencing increased rates of premature deaths and other diseases linked to obesity (cardio-vascular, some cancers, diabetes and some disabilities) the prevalence of overweight and obesity is a continued concern. Like the national trend, overweight and obesity differ by gender.

In the 2018 report, State of Obesity funded by Robert Wood Johnson Foundation, the causes of obesity are complex and interconnected, ranging from economic and environmental influences, social norms as well as genetic factors. While it is true that individuals and families are key to addressing this problem so are communities (safe places to walk) and environment (limited availability of reasonably priced, high-quality foods) are essential. Demographic factors such as high poverty, rural and communities of color combine to contribute to the high prevalence of overweight and obesity in Robeson County.



Health Care

Access to appropriate, quality health care is one of Healthy People 2020's goals. Health care access can be perceived of as timely access to health providers. Access to health care can reduce or prevent disease, disability, or unnecessary death. The Affordable Care Act passed in 2010 sought to reduce disparities in access to health care.

Barriers to health care access in Robeson County include lack of transportation, long waiting times to secure an appointment, low health literacy, and inability to pay the high-deductibles of many insurance plans and/or co-pays for receiving treatment.

At 28.3%, Robeson County has one of the highest percentages of uninsured adults ages 18 and over in the state. Additionally, 6.5% of children ages 0 to 18 lack health insurance coverage, with the state's average at 6%. Furthermore, over the past year, 23.4% of county residents ages 18 and over opted not to visit a physician for needed health care due to cost.

		North Carolina	Neighboring Counties	Robeson County
1	% of Adults (age 18+) without any type of health care coverage, (Small Area Health Insurance Estimates, 2014 :BRFSS, 2015	15.4	15.5	28.3
2	% of Adults (age 18+) who could not afford healthcare costs to see a doctor, 2010-2015 (BRFSS)	15.5	16.8	23.4
3	% of Adults (age 18+) who have not seen a doctor for a routine checkup, in the LAST FIVE years, 2010-2015 (BRFSS)	6.6	8.7	9.2
1	Dentists per 10,000 Population, 2016 (UNC Sheps Center for Health Services Research)	4.9	N/A	2.2
2	Physicians per 10,000 Population, 2016 (UNC Sheps Center for Health Services Research)	23	N/A	13.0
3	Primary Care Physicians per 10,000 Population, 2016 (UNC Sheps Center for Health Services Research)	7.0	N/A	4.5
4	Psychologists per 10,000 Population, 2015 (UNC Sheps Center for Health Services Research)	2.2	N/A	0.1

Included in the above chart Robeson County is being compared to Neighboring Counties (Bladen, Cumberland, Harnett, Hoke, Moore, Richmond, Sampson, Scotland counties.)

Determinants of Health

Social determinants of health are structural conditions that influence the health of a population. These determinants include physical environment, housing, socioeconomic status, education and racism. These factors influence individual health because they are in the arena in which people live, work and play. People with higher incomes, more years of education and a healthy and safe environment in which to live tend to have better health outcomes and generally longer life expectancies than people who have unstable income, live in unsafe neighborhoods and receive poor education.

Below is a chart of the economic indicators that impact the quality of life for Robeson's residents. Almost 30% of the population does not have a high school degree which can be an indicator of poor health. The unemployment rate is greater than the state's rate and the need for state and federal resources is extremely high. Teenage mothers and fathers tend to have less education and are more likely to live in poverty than their peers who are not teen parents.

Economic Indicators		
Indicator	Robeson	N.C.
High school graduates, percent of persons age 25+, 2012-2015	70.9%	86.6%
Persons below poverty level, less than 100 percent, 2015	30.6%	16.4%
Unemployment, December 2016	7.4%	5.1%
Median household income, 2015	$32,128	$47,884
% of WIC mothers, 2015	67.1	45.4
% of Residents Eligible for Medicaid,2015	39.0	22.0
Children eligible for Free/Reduced Price Lunch, 2013-2014	96.4%	54.0%
Rate of teen birth to women ages 15-19 years old per 1,000 female population, 2015	50.9	30.2

Chapter 5: Prevention and Health Promotion

Risk Factors

Poor nutrition, low physical activity and regular tobacco use increases people's risk for chronic diseases such as heart disease, cancer and diabetes. Robeson County has some of the worst behavioral risks factors in North Carolina. The percentages of adults who currently smoke and are physically inactive are among the worst in the state.

In Robeson County an estimated 71,890, or 88% of adults over the age of 18 are consuming less than 5 servings of fruits and vegetables each day.

Additionally, 32,647 or 35% of adults aged 20 and older self-report no leisure time for activity, based on the question: "During the past month, other than your regular job, did you participate in any physical activities or exercises such as running, calisthenics, golf, gardening, or walking for exercise?"

Furthermore, an estimated 19,688 or 24.1% of adults age 18 or older self-report currently smoking cigarettes some days or every day.

		North Carolina	Neighboring Counties	Robeson County
1	Percent of population with inadequate fruit and vegetable consumption	87.0	90.1	88.0
2	Percent of population with no leisure time physical activity	24.4	24.3	35.0
3	Percent of population self reporting regular smoking activity	19.0	19.5	24.1

Robeson County is being compared to Neighboring Counties (Bladen, Cumberland, Harnett, Hoke, Moore, Richmond, Sampson, Scotland counties.)

Sources

1. Behavioral Risk Factor Surveillance System, 2015
2. Behavioral Risk Factor Surveillance System, 2011-2014
3. Behavioral Risk Factor Surveillance System, 2012-2015

Environmental Health

Environmental health looks at the interaction of people and their environment. The food people eat, the air they breathe and the water they drink all influence health. Additionally, safe spaces for recreation also promotes a healthy community. In Robeson County, most residents do not live near parks, thereby limiting their ability to leisurely walk, run or play. Furthermore, there is a lack of indoor spaces for residents to get exercise.

		North Carolina	Robeson County
1	Percentage of days exceeding standards of air quality particulate matter 2.5	0.48	1.02
2	Number of days exceeding standards for ozone	0.27	2
3	Percent of population within one-half mile of a park	20.8	8.5
4	Recreation and Fitness Facilities per 100,000 population	11	7

Sources
1. National Environmental Public Health Tracking Network, 2012
2. National Environmental Public Health Tracking Network, 2012
3. ESRI Map Gallery, 2013; Open Street Map, 2013
4. US Census Bureau, County Business Patterns, 2012

This indicator reports the percentage of days with particulate matter 2.5 levels above the National Ambient Air Quality Standard (35 micrograms per cubic meter) per year, calculated using data collected by monitoring stations and modeled to include counties where no monitoring stations occur. This indicator is relevant because poor air quality contributes to respiratory issues and overall poor health

This indicator reports the percentage of days per year with Ozone (O3) levels above the National Ambient Air Quality Standard of 75 parts per billion (ppb). Figures are calculated using data collected by monitoring stations and modeled to include census tracts where no monitoring stations exist.

This indicator reports the number per 100,000 population of recreation and fitness facilities as defined by North American Industry Classification System (NAICS) Code 713940. This indicator is relevant because access to recreation and fitness facilities encourages physical activity and other healthy behaviors.

This indicator reports the percentage of population living within 1/2 mile of a park. This indicator is relevant because access to outdoor recreation encourages physical activity and other healthy behaviors.

Health Rankings

The County Health Rankings report measures the health of nearly every county in the nation. Published online at www.countyhealthrankings.org the rankings help counties understand what influences how healthy residents are and how long they will live. Counties receive two rankings: Health Outcomes and Health Factors. Health Outcomes rankings are based on an equal weighting of mortality and morbidity measures. Health Factors rankings are based on weighted scores of four types of factors: behavioral, clinical, social and economic, and environmental.

Year	Health Factor Ranking	Health Outcome Ranking
2016	100	100
2017	100	100
2018	100	100
2019	100	100
2020	100	100

Chapter 6: Robeson County's Priorities

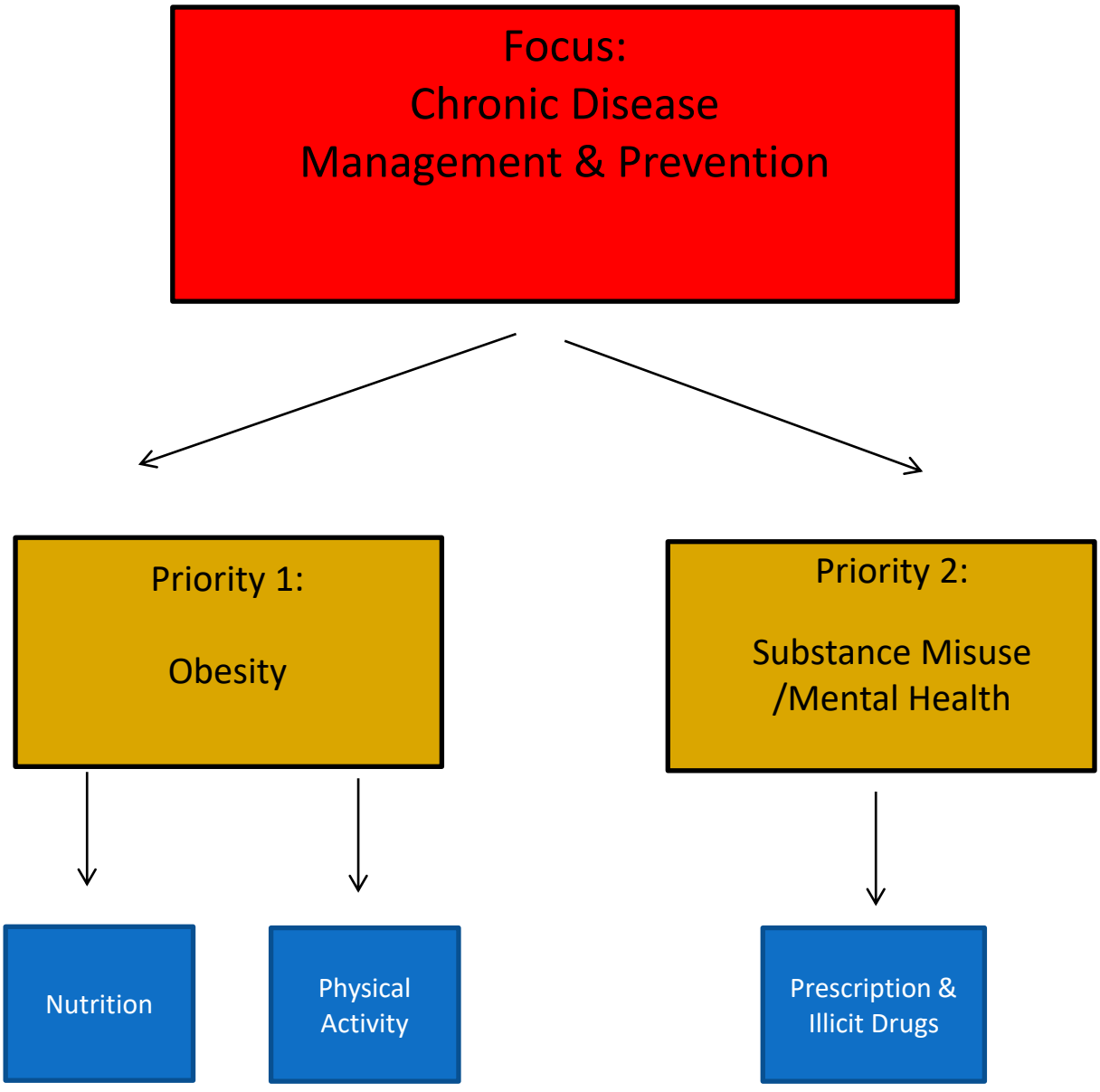
The Community Health Needs Assessment Advisory Team met in June 2020 to review the results of the community health survey and identify priority areas. Five potential priority areas were chosen on the basis of the needs identified by the health survey and each individual present was allowed three votes to cast for any of the five priorities areas. The top five areas identified by Robeson County residents were chronic disease, obesity, substance misuse, teenage pregnancy, and gangs/violence.

The following three criteria were used in rating the community health problems: (1) **magnitude**: how many persons does the problem affect, either actually or potentially? (2) **seriousness of the consequences:** what degree of disability or premature death occurs because of the problem or premature death occurs because of the problem? What are the potential burdens to the community, such as economic or social burdens? (3) **feasibility of correcting:** is the problem amenable to interventions?

Prioritization discussion around the top five areas identified by residents were guided by the above-mentioned criteria. A decision was made by the CHNA Advisory Group to widen substance misuse to include mental health needs, to collapse obesity and chronic disease and to add an additional option of social determinants of health to add issues identified around job opportunities and poverty.

The CHNA Advisory Group decided to identify two priority areas. (1) Obesity (2) and Substance Misuse/Mental Health. These priority areas were selected because chronic diseases continue to contribute to much of the poor health in Robeson County and substance misuse continues to be one of the self identified highest needs in the county.

Robeson County's 2020 Priority Areas



Chapter 7: Next Steps

- The Community Health Needs Assessment document will be posted on the Southeastern Health Website.
- The Robeson County Health Department will place the CHNA document on its website.
- Presentations will be made to Healthy Robeson, the Robeson County Board of Health Members and the Southeastern Health Board of Trustees.
- Presentations will be shared in the community
- Actions plans will be created for the selected priority areas. Sub-committees will be formed to implement and evaluate the strategies.

2020

APPENDIX A:

COMMUNITY HEALTH ASSESSMENT TEAM

Name	Agency/Community	Title	CHNA Role
Al Bishop	Robeson Health Care Corporation	Director of Performance Improvement & Corporate Compliance Officer	
Amy Shooter	Wesley Pines	Marketing Director	
Lekisha Hammonds	Southeastern Health	Director, Community Health Services	Community Health Needs Assessment Work Group; Co-Facilitator
Ivine Lucas	Southeastern Health	Healthy People, Healthy Carolinas EBI Specialist	
Cathy Hunt	Southeastern Health	Healthy People, Healthy Carolinas Grant Facilitator	
Dencie Lambdin	Communities in Schools of Robeson County	Executive Director	
Jan Lowery	Robeson County Health Department	Minority Diabetes Prevention Program Coordinator, Region 8	
Phillip Richardson	Southeastern Health	Manager, Community Health Services	Community Health Needs Assessment Work Group
Ashely McRae	NC Cooperative Extension	Educator of Expanded Food and nutrition Education Program	
Codi Pait	UNCP	Summer Intern	
Erica Little	UNCP	Director of Healthy Start Robeson	
Veronica Freeman	Vocational Rehabilitations Services	Rehabilitation Counselor	
Sandra Cox	DSS	Program Manager	
Bill Smith	Robeson County Health Department	Director	
Cherry Beasly	UNCP	Director, Nursing Department	Community Health Needs Assessment Work Group
William Puentes	UNCP	Interim Assistant Dean of Research (College of Health Science)	

Name	Agency/Community	Title	CHA Role
Tamara Adams	Southeastern Health	Nurse, Emergency Department	
Karen Woodell	Robeson County Health Department	Health Education Supervisor	Community Health Needs Assessment Work Group; Co-Facilitator
Asa Revels	UNCP	Clinical Trials Research Coordinator	
Melissa Packer	Robeson County Health Department	Assistant Director	Community Health Needs Assessment Work Group
Kristian Phillips	Southeastern Health	Community Health Education Center Specialist	CHNA Document Designer
Tanya Underwood	Southeastern Health	Community Mobilization Specialist	

2020

APPENDIX B:

RESOURCE DIRECTORY

Alcohol and Drug Misuse

Crisis Line……1-800-913-6109
Grace Court ……618-9912
Lumberton Treatment Center……739-9160
Palmer Drug Prevention Program…… 522-0421
Robeson Health Care Corporation Crystal Lake (women) ……245-4339
Robeson Health Care Corporation Men's Recovery……. ……910-785-5545
Robeson Health Care Corporation Our House (Pregnant and Postpartum Women)……521-1464
Robeson Health Care Corp. Substance Abuse Service…….. ……521-1464
Robeson Health Care Corporation The Village (Women) ……752-5555
Southeastern Psychiatry Clinic……272-3030

Children and Youth

Boys and Girls Club of Lumberton/Robeson County……738-8474
Child Protective Services (Dept. of Social Services)……671-3770
Communities in Schools of Robeson County……738-1734
Dolly Parton's Imagination Library, United Way of Robeson County……739-4249
Exploration Station ……738-1114
First Baptist Home……738-6043
Four-H, Robeson County……671-3276
Girl Scout Council, Pines of Carolina……739-0744
Guardian Ad Litem……671-3077
Health Check (Medicaid, birth to 21 years) ……671-3413
Health Choice (Health insurance for children)……671-3425
Immunizations (Robeson County Health Dept.)….671-3200
Indian Education Resource Center……521-2054
Lumberton Children's Clinic……739-3318
NC Youth Violence Prevention Center……739-3064
Odum Baptist Home for Children……521-3433
Robeson Child Health +……671-3236
Safe Kids Robeson County Coalition……671-3422
Shining Stars Preschool……671-4343
Juvenile Justice & Delinquency Prevention……671-3350
Smart Start (Robeson County Partnership for Children) ……738-6767

Emergency Services: Food, Shelter, Clothing

Native American Mothers ……843-9911
American Red Cross (Robeson County Chapter)..738-5057
Lumberton Christian Care Center……739-1204
Rape Crisis Center……739-6278
Robeson County Church and Community Center ……738-5204 or 843-4120
Robeson County Disaster Recovery Committee…370-1648
Second Harvest Food Bank……. 1-800-758-6923
Southeastern (SE) Family Violence Center…..739-8622
Tar Heel Freewill Baptist Church….866-4359 or 876-4218

Financial Assistance

Department of Social Services……671-3560
Food stamps (Dept. of Social Services)……671-3560
Social Security Administration……1-800-772-1213
SeHealth financial assistance inquiry……671-5147

Health Services

AIDS (BARTS - Border Belt AIDS Resource Team……739-6167
Cardiopulmonary Rehabilitation Services…..738-5403
Carolina Access (Medicaid recipients)…919-855-4780
Child Health Plus Clinic (RC Health Dept.)….608-2100
Child services coordination (Special needs, birth to 5 years) ……671-6266
Clinic (Lumberton) ……739-0133
Diabetes Community Center ……618-0655
Cancer Center ……671-5730
Home Medical Equipment ……671-5606
Hospice ……671-5655
Hospice House ……671-4803
Hospice services (listing)……671-5842
Julian T. Pierce Health Center (RHCC)……521-2816
Maternity care ……737-4000
Migrant Outreach Program (RHCC)……521-2900
Nursing homes and long term care (Medical supplies)……671-5842
Robeson County Health Department……671-3200
Robeson County Home Health ……671-3236
Lifestyle Center for Fitness and Rehabilitation ……738-4554
Lifestyle Fitness Center ……738-5433
Red Springs ……843-9355
Pembroke ……521-4777
Lumberton Health Center (RHCC)……674-3174
Ryan White HIV/AIDS Services (RHCC)……738-2110
Southeastern Radiology Associates ……671-5594
For information ……738-8222
Mammography ……671-4000
South Robeson Medical Center (RHCC)….535-4003
Urgent Care Pembroke ……521-0564
Wound Healing Center ……738-3836
WoodHaven Nursing, Alzheimer's and Rehabilitation Care Center ……671-5703

*Area code is 910 unless otherwise indicated

Housing
Fairmont Housing Authority……628-7467
First Baptist Home……738-6043
Maxton Housing Authority……844-3967
Lumberton Housing Authority……671-8200
Pembroke Housing Authority……521-9711
Providence Place at Red Springs……843-7100
Robeson County Housing Authority……738-4866
Rural Development……739-3349

In-Home Services
Community Alternatives Program (CAP)……671-5388
Home Health/Personal Care Services (listing).671-5842

Information and Referral
Advance Directives (Living Wills, etc.)……671-5592
American Cancer Society……1-800-227-2345
American Diabetes Association……1-800-342-2383
American Heart Association……1-800-242-8721
Carolina Donor Services……1-800-200-2672
Center for Community Action…739-7854 or 739-7851
Cooperative Extension Service Center……671-3276
Committee for the Disabled……738-8138
Community Health Education Center (CHEC)
……671-5593
Four-County Community Services, Inc. (Lumberton, Fairmont & St. Pauls Neighborhood Service Center)……738-6809
Lumbee Regional Development Association
……521-8602
Lumbee Tribal Government ……521-7861
Lumber River Council of Governments……618-5533
Migrant Outreach Program ……521.2900
N.C. Services for the Blind……1-800-422-1897
Robeson Job Link Career Center……618-5500
Vocational Rehabilitation Services……618-5513

Legal Services
Lumbee River Legal Service (Legal Aid of N.C.)……521-2831

Maternal/Child Health
Prepared Childbirth Classes (SRMC) ……671-5011
Breastfeeding information (SRMC) ……671-5042
Breastfeeding equipment (SRMC) ……671-5580
Homespun Nurturing Breastfeeding Program (Ro. Co. Health Dept.) ……608-2114
Maternity care (Robeson County Health Dept.)..
……671-3410
WIC (Women, Infant, Children) Nutrition Services
……671-3262
Women's Preventive Health (contraception)…671-3200
RHCC Healthy Start……1-855-305-6987

Mental Health/Mental Retardation Services
Crisis Line: ……1-800-672-8255
Monarch……618-5606
Robeson Family Counseling Center……738-8558
Southeastern Psychiatry Clinic……272-3030

Pain Management
Southeastern Pain Management Clinic……735-8818
Southeastern Spine and Pain Clinic……671-9298

Recreation/Activities
Lumberton Recreation and Parks Commission
……671-3869
Pine Street Senior Center ……671-3881
RC Recreation and Parks Commission……671-3090

Senior Services
Adult Protective Services (DSS)……671-3500
Meals on Wheels ……671-8242
Fairmont ……628-9766
Maxton ……844-3967
Pembroke ……521-1030
Red Springs ……843-4120
Rowland ……422-9717
St. Pauls ……865-4589
Pine Street Senior Center ……671-3881
Privileges*Plus* ……671-5593
Social Security Administration……1-866-931-7099
Veteran's Service, Robeson County……671-3071

Support Groups
Alcoholics Anonymous……272-3030
Alzheimer's disease……671-5703
Bereavement……735-8887
Cancer (Breast & Reproductive)……1-877-227-9416 or 671-5730
Cancer (Prostate)……1-877-227-9416 or 671-5730
Diabetes ……618-0655
Heart disease ……671-5000 ext. 7718
Lung disease ……738-5403
Narcotics Anonymous……272-3030

Transportation
Southeastern Area Transit System (SEATS)…..618-5679

2020

APPENDIX C:

COMMUNITY HEALTH ASSESSMENT SURVEY

2020 Robeson County Community Health Needs Assessment Survey

(Check only one) How do you rate your own health?
__Excellent __ Very Good __Good __Fair __Poor __ Don't know/Not sure

(Check all that apply) Have you ever been told by a doctor, nurse, or health care professional that you have any of the following?
__Diabetes __High Cholesterol __Lupus __Depression __Osteoporosis __Heart Disease/Angina
__Cancer __Asthma __Dementia __Overweight/Obesity __Lung Disease __None
__High Blood Pressure __Arthritis __Other (please specify)_____

(Check all that apply) Which of these problems prevented you or your family from getting necessary health care?
__Cultural/Health Beliefs __No appointments available __Lack of knowledge/understanding of the need __Lack of insurance __Transportation
__Fear (not ready to face health problem) __Unable to pay/cost/can't afford __Not important __ None __Other
(please specify)_____

(Check only one) What has affected the quality of the health care you received?
__Ability to read & write/Education __Race __Not Applicable __Language Barrier/Interpreter/Translator
__Economic (low income, no insurance, etc) __Sex/Gender

(Check all that apply) Where do you and your family get most of your health information?
__Health Education Center __Internet Search __Television __Hospital Newsletter __Radio
__Family or Friends __Doctor/Health Professional __Newspaper/Magazine __Health Department __Church
__School __Help lines

(Check only one) What do you think most people die from in your community?
__Asthma/Lung Disease __Stroke/Cerebrovascular Disease __Homicide/Violence __Heart Disease __Diabetes __Motor Vehicle Deaths
__Cancer __Suicide __HIV/AIDS __Other (please specify)_____

(Check only one) What is the biggest health issue or concern in your community?
__Alcohol Abuse __Teen Pregnancy __Illegal Drug Use __Child Abuse __Obesity __Vehicle Crashes
__Prescription Drug Abuse __Gangs/Violence __Mental Health __Asthma __Tobacco Use __Dental Health
__Chronic Disease (Cancer, Diabetes, Heart or Lung Disease) __ Sexual Transmitted Infections (syphilis, gonorrhea, chlamydia)
__Other (please specify)_____

(Check only one) Which one of the following most affects the quality of life in your county?
__Pollution (air, water, land) __Dropping out of school __Low income/poverty __Homelessness __Lack of/inadequate health insurance
__ Lack of hope __Discrimination/racism __Lack of community support __ Neglect and abuse __Domestic Violence
__Crime (murder, assault, theft, rape/sexual assault) __None __Other (please specify)_____

(Check only three) What does your community need to improve the health of your family, friends and neighbors?
__Access to Food __Mental Health Services __Healthier Food Choices __Job Opportunities __Services for the Disabled
__Recreation Facilities __Safe places to Walk/Play __After-School Programs __Wellness Services __Transportation
__Programs for the Elderly __Specialty Physicians __Additional Health Services __Substance Abuse Rehabilitation Service
__Other (please specify)_____

(Check all that apply) Which of the following preventative screenings have you had in the past 12 months?
__Mammogram (if woman) __Prostate cancer screening (if man) __Colon/rectal exam __Blood sugar check
__Cholesterol screening __Hearing screening __Bone density test __Physical exam
__Pap smear (if woman) __Flu shot __Blood pressure check __Skin cancer screening
__ HIV/Sexually Transmitted Infections __Vision screening __Cardiovascular screening __Dental cleaning/X-rays __None of the above
__Other (please specify)_____

(Check all that apply) Which of the following health issues have you received information on in the past 12 months?
__Blood Pressure __Mental Health __Substance Abuse __Cholesterol
__Emergency Preparedness __Nutrition __Distracted driving/Seatbelts/Child Car Seats
__HIV/Sexually Transmitted Infections __Family Planning __Oral Health __Vaccinations/Immunizations
__Cancer __Diabetes __Physical Activity __Prenatal education
__ None of the above __Other (please specify)_____

(Check only one) Do you feel people in your community lack the funds for any of the following?
__Food __Home/Shelter __Medicine __Health Insurance
__Transportation __Affordable Healthcare/Co-Pay/Deductible __Utilities __Other (please specify)_____

(Check only one) Other than your regular job, how many days per week do you engage in physical activity for at least 30 minutes that makes you "break a sweat"?
__Zero days __One to two (1-2) days a week
__Three to four (3-4) days a week __Five (5) or more days a week

(Check only one) On average, how often do you eat fruits or vegetables?
__Once a day __Once a week __Once a month __Several times a day __Several times a week __Never

(Check only one) Does your family have a basic emergency supply kit? (These kits include water, non-perishable food, any necessary prescriptions, first aid supplies, flashlights and batteries, none electric can opener, blanket, etc)
__Yes __No __Don't know/Not sure

(Check only one) What would be your main way of getting information from authorities in a large-scale disaster or emergency?
__Television __Text Message __Social network site __Neighbor
__Radio __Print Media (ex: newspaper) __Internet __Other (please specify)_____

(Check only one) During your first 18 years of life, did you live with anyone who was a problem drinker or alcoholic or used street drugs?
__Yes __No

(Check only one) During your first 18 years of life, was a household member depressed or mentally ill, or did a household member attempt suicide?
__Yes __No

Demographics, please complete:

19. I am: Male Female 20. My age is: Under 21 21-30 31-40 41-50 51-60 61-70 70+
21. What is your zip code? 22. And/or city where you live?
23. My race is:
White/Caucasian Native America/Alaskan Native Pacific Islander Black/African American Asian
Two or more races Other (please specify)
24. Are you of Hispanic, Latino or Spanish origin?
Yes No
25. Do you currently have health insurance?
Yes No No, but did at an earlier time/previous job
26. Do you live or work in Robeson County?
Both Live Work Neither
27. When seeking care, what hospital do you visit first? (Check only one)
Bladen County Hospital Cape Fear Valley Hospital First Health (Moore Regional) Scotland Healthcare System
Southeastern Regional Medical Center/Southeastern Health Other (please specify)
28. Where do you go most often when you are sick? (Check only one)
Hospital Emergency Room Home Remedies Health Department Urgent care clinic
Your Doctor's office Pharmacy/Minute Clinic Other (please specify)

2020 Encuesta de Evaluación de Necesidades de Salud de la Comunidad del Condado de Robeson

(Marque sólo una) ¿Cómo califica usted su propia salud?
Excelente Muy buena Bueno Mas o menos Muy mal No sabe/No estoy seguro

(Marque todas las que correspondan) ¿Le han comentado alguna vez por un médico, enfermera o profesional de la salud que usted tiene alguno de los siguientes?
Diabetes Colesterol alto Lupus Depresión Osteoporosis
enfermedades cardíacas/Angina de pecho El cáncer Asma Demencia Sobrepeso/Obesidad
Enfermedad pulmonar Ninguno Presión sanguínea alta Artritis Otros (especifique)_____

(Marque todas las que correspondan) ¿Cuál de estos problemas impidieron que usted o su familia recibiendo la atención médica necesaria?
Culturales o creencias de salud No hay citas disponibles La falta de conocimientos y la comprensión de la necesidad La falta de seguros
Transporte Miedo (no está preparada para hacer frente a problemas de salud) Incapaz de pagar/Coste/no pueden permitirse
No importante Ninguno Otros (especifique)_____

(Marque sólo una) Lo que ha afectado la calidad de la atención de salud recibida?
La capacidad de leer y escribir/Educación Raza No aplicable barrera lingüística/intérprete/traductor
Económico (ingresos bajos, no seguros, etc) Sexo/género

(Marque todas las que correspondan) ¿Dónde usted y su familia a obtener la mayor parte de su información de salud?
Centro de Educación para la salud Búsqueda en internet Television Carta informativa del hospital Radio
Familiares o amigos Médico/profesional de la salud Revista o periódico Departamento de Salud Iglesia
La escuela Líneas de ayuda

(Marque sólo una) ¿Qué piensa la mayoría de la gente muere de tu comunidad?
Asma o enfermedad pulmonar Derrame /Enfermedad Cerebrovascular Homicidio/Violencia Enfermedad Cardíaca Diabetes
Muertes de vehículos de motor El cáncer El suicidio El VIH/SIDA
Otros (especifique)_____

(Marque sólo una) ¿Cuál es el principal problema de salud o preocupación en su comunidad?
Abuso de Alcohol El embarazo adolescente El uso de drogas ilegales Maltrato infantil
La obesidad Colisiones de vehículos El uso indebido de drogas de prescripción Las pandillas y la violencia
La Salud Mental Asma Tabaco Salud Dental
Enfermedad crónica (cáncer, diabetes, enfermedad cardíaca o pulmonar) Infecciones de transmisión sexual (sífilis, gonorrea, clamidia) Otros (especifique)
_____

Marque sólo una) Uno de los siguientes que más afecta la calidad de vida en su condado?
La contaminación (aire, agua, suelo) La deserción escolar Bajos ingresos/pobreza Desamparo
La falta de seguro de salud inadecuada Falta de esperanza Discriminación o racismo La falta de apoyo de la comunidad
El descuido y el abuso La Violencia Doméstica El delito (asesinato, agresión, robo, violación o agresión sexual)
Ninguno Otros (especifique)_____

(Marque sólo tres) ¿Cuál es tu comunidad necesitan para mejorar la salud de su familia, amigos y vecinos?
Acceso a alimentos Los Servicios de Salud Mental Opciones de comida saludable Oportunidades de trabajo
Servicios para Discapacitados Instalaciones Recreativas Lugares seguros para caminar/Para jugar Programas extracurriculares
De salud Transporte Programas para los ancianos Médicos Especialistas
La prestación de servicios de salud adicionales Servicio de Rehabilitación de abuso de sustancias Otros (especifique)_____

(Marque todas las que correspondan) ¿Cuál de los siguientes análisis preventivos ha tenido en los últimos 12 meses?
Mamograma (si es mujer) cribaje del cáncer de próstata (si es hombre) Colon y rectal Controlar el nivel de azúcar en la sangre
Evaluación del colesterol Prueba de audición Prueba de densidad ósea Examen físico
Papanicolao (si la mujer Gripe Chequeo de la presión arterial El cribado del cáncer de piel
VIH/Enfermedades de Transmisión Sexual Exámenes de visión Deteccion Cardiovascular La limpieza dental/rayos X
Ninguna de las anteriores Otros (especifique)_____

(Marque todas las que correspondan) ¿Cuáles de los siguientes problemas de salud ha recibido información en los últimos 12 meses?
La presión arterial La Salud Mental Toxicomanía Colesterol La preparación para situaciones de emergencia
Nutrición Distraído de conducción/Cinturones de seguridad y asientos de coche de niño VIH/Enfermedades de Transmisión Sexual
La planificación familiar Salud Bucal Las vacunas/inmunizaciones El cancer Diabetes
La actividad física La educación prenatal Ninguna de las anteriores. Otros (especifique)_____

(Marque sólo una) ¿Sientes que la gente en su comunidad, carecen de los fondos para cualquiera de los siguientes?
Comida Hogar/refugio Medicina Seguro de Salud
Transporte Healthcare económicamente accesible /Co-Pay/deducible Utilidades/bills Otros (especifique)_____

(Marque sólo una) Aparte de su trabajo regular, ¿cuántos días a la semana ¿participar en actividad física por lo menos 30 minutos que te hace "romper un sudor"?
Cero días. Uno a dos (2) días a la semana
Tres a cuatro (4) días a la semana Cinco (5) o más días a la semana

(Marque sólo una) En promedio, ¿con qué frecuencia usted come frutas o verduras?
Una vez al día Una vez a la semana Una vez al mes Varias veces al día Varias veces a la semana. Nunca

(Marque sólo una) ¿ Su familia tiene un kit de suministro básico de emergencia? (Estos kits incluyen agua, alimentos no perecederos, las necesarias prescripciones, suministros de primeros auxilios, linternas y baterías no eléctrica, abrelatas, manta, etc.).
Sí No No sabe/No estoy seguro

(Marque sólo una) ¿Cuál sería su principal forma de obtener información de las autoridades en un gran desastre o emergencia?
Television Mensaje de texto Sitio de red social Vecino
Radio Print Media (ex periódico) Internet Otros (especifique)

(Marque sólo una) ¿Durante tus primeros 18 años de vida, riviste con alguien que tenía problemas de alcohol o drogas?
Sí No

(Marque sólo una) ¿Durante tus primeros 18 años de vida, algun meimbro de la familia estubo deprimido o con enfermedad mental o alguien trató de suicidarse?
Sí No

Demografía, por favor complete:
Soy: Hombre Mujer **20.** Mi edad es: Menores de 21 años. 21-30 31-40 41-50 51-60 61-70 70+
¿Cuál es el código postal? **22.** Y/o ciudad donde vives
Mi raza es:
Blanco/caucásico Native America/nativos de Alaska Isleño del Pacífico. Black/Afro-americano Asian
dos o más carreras Otros (especifique)
¿De Los Hispanos, latinos o de origen español?
Sí No
Actualmente usted tiene seguro de salud?
Sí No No, pero sí en un momento anterior/trabajo anterior
¿vive o trabaja en el condado de Robeson?
Los dos Vivo Trabajo Ninguno

2020

APPENDIX D:

NARRATIVES

"Compassion for U Congregational Wellness Network"
A Faith-Based Community Health and Wellness Network
Rev. George Dean Carter

The Compassion for U Congregational Wellness Network exists to nurture and connect local healthcare provisions to a faith-based and community missions' initiative to promote healthy lifestyles including prevention, care transitions, follow-ups and overall wellness. The Compassion for U Congregational Wellness Network is an expansion of a project funded by the HRSA Rural Network Planning grant of 2014, written and granted to the Dept. of Pastoral Care. The network is adapted from the "Memphis Model" developed by Dr. Gary Gunderson and the African Religious Health Assets Programme. This model aligns and leverages existing assets to integrate congregational and community care-giving with traditional healthcare. The result is a system of health built on webs of trust.

The Compassion for U Network coordinates patient care services with volunteer services in order to maximize the value of these services delivered to patients. Compassion for U has adapted the program developed by Methodist Le Bonheur Healthcare which integrates a faith-based and community health outreach and education program into health system initiatives. The outcomes of the network include: reducing avoidable emergency department usage; hospital readmission reduction; improved chronic disease management; charity care management; improved HCAHPS performance; navigation; care transitions, and overall community wellness. The result is expanding the economy of healing which will be community-centric and patient-value based rather than hospital-centric.

Underserved populations, such as the community in Robeson County, are at a disproportionate risk of facing chronic illnesses and experiencing lower quality health care. While insurance reform is a primary focus for improving population health, innovative approaches to care delivery are also emerging to improve quality, lower costs, and increase the value of healthcare. The Compassion for U Network serves as a safety net to ensure that those most at risk receive high quality, patient-centered care. This safety net brings together churches, community clinics, the local health department, clinical nursing and resident education, public hospital and other healthcare providers that share a common mission to be the boundary leaders for holistic health and well-being in the southeast region of North Carolina.

The safety-net population includes anyone, whether insured or uninsured, who relies on safety net providers for care. This population experiences social and clinical vulnerabilities that make them challenging patients in healthcare. Often referred to as "super-utilizers," these individuals have complex physical, behavioral, and social needs that are not well met through the current fragmented, hospital-centric health care system. As a result, these individuals often bounce from emergency department to emergency department, from inpatient admission to readmission or institutionalization.

In contrast to traditional healthcare teams that focus solely on an individual's clinical needs, the Network addresses medical issues and the social determinants of health. The Network facilitates the implementation of programs in the community that promote, maintain, and improve individual and community health. A key strength of the Compassion for U Network is the availability of community health workers and volunteers. Through our activities, the Network facilitates patient-centered health care and social service connections that are culturally appropriate, high-quality, and cost-effective.

Examples of our *CFU Congregational Wellness* **Network Education** include: "Compassion for U" Congregational Wellness Basics; Congregational Care and Visitation; Advanced Directives, Health Care Ethics and Surrogate Decision Making; Caring for the Dying; Grief, Bereavement and Mourning; Aftercare Training; Navigating the Health System; Today's Health Issues; Cancer, Medicine and Miracles; Healthy Communities A-Z curriculum; Food, Nutrition and Wellness Policies for Your Church, Community and Home; What Would Jesus Eat? Cookbook; Behavioral Health First; Better Brains; The Search for Significance; Glad Reunion; Disaster Preparations and "Well Check" Communications; Violence and Safety; Home, Church and Personal Safety; AED and Heart-Saver Training.

Food, Nutrition and Wellness Policies for Your Church, Community and Home; What Would Jesus Eat? Cookbook; Behavioral Health First; Better Brains; The Search for Significance; Glad Reunion; Disaster Preparations and “Well Check” Communications; Violence and Safety; Home, Church and Personal Safety; AED and Heart-Saver Training.

Examples of our **ETO’s**, or *“Efforts to Outcomes”* events include: Camp Care Bereavement Experience for Children, North Carolina Med-Assist OTC Medication Giveaways, Church Health Fairs, Caring and Sharing Senior Citizens Christmas Meal Gift Bags, Hurricane Matthew and Florence Critical Information and Inspiration, Morning Prayer instituted for COVID 19 spiritual relief, U-Care Connections Medical Transportation Ministry, Healthy Communities A-Z, National Healthcare Decisions Day (Advanced Directives), teaching “Living In Mortal Time” person death awareness exercise to University of North Carolina at Pembroke and Robeson Community College Nursing Students regarding End of Life Studies.

Great emphasis has been placed on the need to overcome transportation barriers which substantially impede healthcare access in Robeson County, leading to missed appointments, delayed care and possibly abandoned pursuit of treatment. These barriers are even more significant to post discharge patients who are battling one or more chronic diseases. These patients require timely follow up care, regular clinical visits, access to medication and regularly updated treatment plans in order to prevent readmission to the hospital.

CFU CWN has designed an ETO called **U–Care Connections** to assist transportation disadvantaged patients through qualified, compassionate volunteers providing their own vehicle and encouragement to pursue healthcare needs despite social and financial barriers. Without assistance, transportation disadvantaged patients may not receive the appropriate treatments necessary to avoid chronic disease exacerbation or unmet healthcare needs. As a result, these patients have a higher likelihood of a worsened healthcare crisis and outcomes due to lack of maintained clinical care, including premature death, all of which result in increased healthcare costs*. The least effective most expensive healthcare occurs in accessing the Emergency Department of the hospital. The most effective least expensive care involves an encouraging relationship and appropriate utilization of clinical services.*

These patients require timely follow up care, regular clinic visits, access to medication, nutrition, and regularly updated treatment plans in order to prevent hospital readmission. U–Care Connections assists transportation disadvantaged patients through qualified, compassionate volunteers providing their own vehicle and encouragement to pursue healthcare needs despite social and financial barriers.

U-Care Connections promotes volunteer driving assistance in an effort to help all Southeastern Health services and clinics meet the no-show rate goal established by the hospital system. The Connector, who is a vetted and scheduled volunteer driver, will be encouraged to promote and support the health of the patient by providing their own vehicle for transportation. The service and encouragement of the Connector will improve access for patients who would otherwise miss post hospital discharge appointments to access timely care, medication and treatment planning. Loneliness, depression, and apathy to complete appointments is improved by the relationship with the volunteer.

The need for appointments are communicated to the grant-supported U-Care Connections Transportation Scheduler who manages a potential needs calendar. A transport has the potential of accruing mileage from the home of the Connector to the home of the patient, continuing to the medical service destination; patient’s return to their home and continuing to the Connectors’ home. Volunteer Connectors for this ETO are recruited through the Department of Pastoral Care/Compassion for U Congregational Wellness Network. The key to success of this goal lies in creating a volunteer friendly environment.

U-Care Connections began with one volunteer who allowed his contact information to be circulated among patients in need of transportation starting in 2015. Even as others were recruited as Connectors to provide volunteer transportation, the practice of direct scheduling continued and proved to be overwhelming. We are

now in the second grant cycle of the Kate B. Reynolds Charitable Trust for the ETO “U-Care Connections” Volunteer Transportation Ministry. Southeastern Health is also being joined to the North Carolina Health Care Association in this current 2 year cycle to research this model for adaptability and scalability. This ministry has 12 active Connectors. With the impact and interruption of the COVID 19 Coronavirus from March until this reporting in October, our number of volunteers has wavered because of categorical personal health risk. Yet, our volunteers remain alone in continuation of service during the pandemic. Grant fund have allowed for PPE and sanitation necessary for both volunteer and patient. The goal for the grant was to recruit to 30 active drivers with the 2 year cycle. The Dept. of Pastoral Care is assembling a series of dashboards and a SharePoint site for an internal database. Driver’s logs and client demographics are recorded for dashboards that create real-time scheduling from outpatient services or from the driver/client input. Mileage reimbursement and volunteer hours are also gathered for appropriate acknowledgement of the volunteer. There are plans to convert the data gathering and reporting capabilities into a serviceable application for use on various platforms to include email, text, and website. Various appropriate permission levels are available for Dept. of Pastoral Care Administration, Kate B. Reynolds Charitable Trust and North Carolina Hospital Association, Patient Navigators, and Drivers. Reportable outcomes include the number of patient transportation events, mileage, mileage reimbursement, volunteer hours, volunteer hour estimation of worth per hour, and a projected patient cost avoidance benefit by adding the mileage reimbursement total with the volunteer estimation of worth per hour.

The following is based on logged information from February 2019 through September 2020; 3026 patient transports, 97,199.80 miles, $56,375.88 mileage reimbursement, 3688.6qual 5 volunteer hours valued at $89,258.68. Total cost avoidance benefit to patient $145,634.57. The benefit to the provider of these clinical services would equal completed appointments and the gain versus potential loss incurred in reimbursement for 3026 appointments, improved patient satisfaction and overall patient outcomes including morbidity.

2020

APPENDIX E:

IMPLEMENTATION STRATEGIES

Action Plan

The 2020 Community Health Needs Assessment gave insights into the pressing health issues in Robeson County. The combination of primary and secondary data enabled the Healthy Robeson Task Force to identify key health needs and begin to identify evidence-based interventions to address those needs. The results of the Community Health Needs Assessment were crucial for the development of implementation plans. Two priority areas were identified that required action: obesity, substance misuse.

Our local community objective is to see a decrease in overall adults who are obese or overweight. In Robeson County, 40% of adults are obese, only 34% of adults report being physically active. Cardiovascular disease is one of the leading causes of death (NC State Center for Health Statistics, 2015). We will target African American and Native American residents of Robeson County. Through partnering with churches, we plan to offer health education classes that teach participants how to manage chronic diseases as well as prevention through nutrition and physical activity. By May 31, 2023. at least 85% of participants in Chronic Disease Self Management (CDSMP) classes will show an increase of knowledge and/or confidence as evidenced by surveys in the CDSMP goals. By May 31, 2023, 85% of participants in Faithful Families workshops will show an increase in knowledge and or changed behavior. The goal of Faithful Families is to provide participants with doable techniques to control sugar intake and move more. In addition to working with adult populations, physical education and nutrition will be encouraged in schools, thereby ensuring a healthier adult population through early intervention. CATCH is an evidence-based intervention that teaches children about healthy eating and ensures they get physical activity. By January 1, 2023, Robeson County elementary schools will have implemented the CATCH program (current school structure has 20 elementary schools). In addition, all Head Start Centers will implement Early Childhood CATCH. Another initiative to guide children into healthier eating is Color Me Healthy (CMH). By June 30, 2023, CMH will see 30% of pre-school participants show an increase in willingness to taste new fruits and vegetables.

Our second priority area will be reducing reduce the percentage of individuals decrease drug overdose deaths through education. Robeson County will align with the Healthy NC 2030 Focus areas to decrease drug overdose deaths in the state from 20.4 (per 1000,000 population) to 18 in 2030. For our part in the first third of the state's timeline, we plan to serve families, support Naloxone use, and educate school aged children. By May 31, 2023, approximately 500 individuals will be reached through the Family Drug Treatment Court, assisting residents to connect to care for substance use disorders. We will increase the number of medicine take back events by holding three events before May, 31, 2023. Medicine take back events allow people to bring unused medicines to be safely destroyed and keeping said drugs from being used by unintended parties. By May 31, 2023, at least one more local law enforcement agency and/or emergency management organization will adopt/implement a policy to administrate life-saving Naloxone. To support youth in this area, "Too Good For Drugs", will expand its implementation to more K-12 schools in the county.

Community Health Action Plan 2020

County: Robeson **Period Covered:** 2020-2023
Partnership/Health Steering Committee, if applicable: Healthy Robeson Coalition
Community Health Priority identified in the most recent CHA: yes (Obesity was technically #7 in the survey; however, #3 community stated issues is chronic disease, many of which obesity is a factor)
Local Community Objective: (*Working description/name of community objective*) **Obesity Prevention**
(check one): ___ **New** x **Ongoing** (*addressed in previous Action Plan*)
Baseline Data: *(State measure/numerical value. Include date and source of current information)*: 2015 North Carolina State Center for Health Statistics for Robeson: 40% of Robeson adults are obese; 34% of adults report being physically inactive; 24.2% die from cardiovascular disease, 19% from cancer, 5.0% from diabetes and all of which have been linked to lifestyle behaviors such as physical inactivity and nutrition)
For continuing objective provide the updated information: *(State measure/numerical value. Include date and source of current information)*: Combining CDC North Carolina data from 2017 through 2019, non-Hispanic blacks had the highest prevalence of self-reported obesity (44.8%), followed by Hispanics (30.1%) and non-Hispanic whites (29.9%). According to the CDC, Obesity-related conditions include heart disease, stroke, type 2 diabetes and certain types of cancer, some of the leading causes of preventable death.
***Healthy NC 2030 Objective* that most closely aligns with focus area chosen below**: Access to Exercise Opportunities.
Population(s)

Describe the local target population that will be impacted by this community objective: Chronic Disease and Obesity objectives will be focused on minority populations in the county due to the following statistics provided by the CDC(2016):
•Percent of African American men 20 years and over with obesity: 37.6% (CDC, 2011-2014)
•Percent of African American women 20 years and over with obesity: 56.9% (CDC, 2011-2014)
•A comparison of rates by race reveals that black women and men have much higher coronary heart disease (CHD) death rates in the 45–74 age group than women and men of the three other races. A higher percentage of black women (37.9%) than white women (19.4%) died before age 75 as a result of CHD, as did black men (61.5%) compared with white men (41.5%).
• The same black-white difference was seen among women and men who died of stroke: a higher percentage of black women (39%) died of stroke before age 75 compared with white women (17.3%) as did black men (60.7%) compared to white men (31.1%).

Total number of persons in the target population specific to this action plan (based on 2016 data): 63.3% of population; 25.11 % African American and 38.02% Native American(approx. number= 83,000; 33,500 African Americans; 50,920 Native Americans)30.5% of population
Total number of persons in the target population to be reached by this action plan: At least 500 African American and Native American adults(18 years and older)
•Calculate the impact of this action plan:
•(Total # in B divided by total # in A) X 100% 1% of minority populations in the county, including African Americans and Native Americans of the target population reached by the action plan.)
***Healthy North Carolina 2030* Focus Area Addressed:** Each of the CHA priorities selected for submission must have a corresponding *Healthy NC 2030* focus area that aligns with your local community objectives.
•Check below the applicable Healthy NC 2030 focus area(s) for this action plan.
For more detailed information and explanation of each focus area, please visit the following website:
https://nciom.org/healthy-north-carolina-2030/

☐ **Individuals below 200% FPL**	☐ **Unemployment**	☐ **Short Term Suspensions**
☐ **Incarceration Rate**	☐ **Adverse Childhood Experiences**	☐ **Third Grade Reading Proficiency**
☒ **Access to Exercise Opportunities**	☐ **Limited Access to Healthy Food**	☐ **Severe Housing Problems**
☐ **Drug Overdose Deaths**	☐ **Tobacco Use**	☐ **Excessive Drinking**
☐ **Sugar-Sweetened Beverage Consumption**	☐ **HIV Diagnosis**	☐ **Teen Birth Rate**
☐ **Uninsured**	☐ **Primary Care Physician**	☐ **Early Prenatal Care**
☐ **Suicide Rate**	☐ **Infant Mortality**	☐ **Life Expectancy**

Strategy/Intervention(s)	Strategy/Intervention Goal(s)	Implementation Venue(s)	Resources Utilized/Needed for Implementation
Name of Intervention: Chronic Disease Self Management (Stanford University) **Community Strengths/Assets:** Several of these workshops have been implemented in Robeson County faith organizations and 1 Master Trainer is available to assist with workshops	**S.M.A.R.T Goals:** By May 31, 2023; increase the number of workshops with a focus on both African American and Native American populations. Workshop locations will target these populations in houses of faith and community buildings for ease of access for participants.	**Target Population(s):** African American, Native American adults **Venue:** Faith Organizations, Community Buildings	**Resources Needed:** Faith based organization/ community building cooperation for meeting space, staff time
Name of Intervention: Faithful Families Diabetes Prevention Program **Community Strengths/Assets:** four individuals have been trained in the Faithful Families Curriculum, and this program has also been delivered at faith organizations	**S.M.A.R.T Goals:** By January 1, 2023; increase the number of workshops with a focus on both African American and Native American populations. Workshop locations will target these populations in houses of faith and community buildings for ease of access for participants.	**Target Population(s):** African American Adults, Native American **Venue:** Faith Organizations/ Community Buildings	**Resources Needed:** Faith based organization/ community building cooperation for meeting space, staff time
Name of Intervention: CATCH **Community Strengths/Assets:** UNC Health Southeastern, Robeson County Parks and Recreation , Public Schools of Robeson County, and Healthy Robeson Coalition are working collaboratively to implement CATCH in all county elementary schools	**S.M.A.R.T Goals:** By January 1, 2023; Public Schools of Robeson County will have implemented the CATCH program at the Elementary level. Current school structure has 20 elementary schools.	**Target Population(s):** Elementary aged children **Venue:** Education	**Resources Needed:** Support from school administrators HPHC grant funding UNC Health Southeastern Foundation's Best Health Forward funding to compliment HPHC grant funds
Name of Intervention: Early Childhood CATCH **Community Strengths/Asserts:** UNC Health Southeastern, Community and Family Services, and Healthy Robeson are working collaboratively to implement programming in 8 Head Start Centers	**S.M.A.R.T Goals:** By January 1, 2023; Early Childhood CATCH will be implemented in all Robeson County Head Start Centers	**Target Population(s):** Pre-School **Venue**: Education	**Resources Needed:** Support from program administrators

Strategy/Intervention(s)	Strategy/Intervention Goal(s)	Implementation Venue(s)	Resources Utilized/Needed for Implementation
Name of Intervention: Color Me Healthy **Community Strengths/Assets:** Pre-K, Daycares, Head Start Centers	**S.M.A.R.T Goals:** By June 30, 2023, 50% of participants will demonstrate increased knowledge in the recognition of fruits and vegetables as measured on pre- and post-visual recognition tests. By June 30, 2023, 30% of participants will increase their agreement to taste new fruits and vegetables as measured by teacher feedback form. By June 30, 2023, 20% NC Pre K/Four-Year-Old Classrooms in the county will adopt a School Environmental Change (centered on a healthy school environment) as measured by pre- and post-check lists.	**Target Population(s):** Four and Five-year old children **Venue:** Pre-K Classrooms	**Resources Needed:** Dedicated staff, grant monies

Interventions Specifically Addressing Chosen Health Priority

INTERVENTIONS: SETTING, & TIMEFRAME	LEVEL OF INTERVENTION CHANGE	COMMUNITY PARTNERS' Roles and Responsibilities	PLAN HOW YOU WILL EVALUATE EFFECTIVENESS
Intervention: Chronic Disease Self-Management **Ongoing** **Setting:** Faith **Target population:** African American and Native American **New Target Population: No** **Start Date – End Date:** 01/21 – 09/23 **Targets health disparities: Yes**	**Individual/Interpersonal Behavior**	**Lead Agency:** Healthy Robeson Coalition **Role:** Lead **Established partner** **Target population representative:** African American and Native American faith leaders **Role:** advocate for churches to host program **Established partner** **Partners:** Robeson County Cooperative Ext. **Role**: Co-Lead **Established partner** **How you market the intervention:** Through bulletin inserts at local faith organizations and community buildings	**Expected outcomes**: 85% of participants will show an increase in knowledge and/or confidence as evidenced by pre- and post- surveys **Anticipated barriers:** : Providing workshops that do not interfere with holidays/ church events; potential COVID 19 barriers such as limited class size allowed by government or church leadership **List anticipated intervention team members:** Ivine Lucas and Cathy Hunt of UNC Health Southeastern **Do intervention team members need additional training?** No **Quantify what you will do:** 85% of participants in multiple workshops will show an increase in knowledge and/or confidence as evidenced by pre- and post- surveys **List how agency will monitor intervention activities and feedback from participants/stakeholders:** Yearly reports to Stanford to maintain license and evaluations are given at the end of each six week series **Evaluation:** **Please provide plan for evaluating intervention:** Team will review gathered evaluation forms from workshop participants and will list ideas of how to improve workshop delivery, if needed **Physical activity and/or lifestyle improvement measure** CDSMP is an evidence- based program with clear results that show improvement in exercise and ability communicate with providers. These, along with other established program outcomes, will combat obesity and increase confidence to speak with providers accurately so they may receive an increased level of care for chronic disease.

Interventions Specifically Addressing Chosen Health Priority

INTERVENTIONS: SETTING, & TIMEFRAME	LEVEL OF INTERVENTION CHANGE	COMMUNITY PARTNERS' Roles and Responsibilities	PLAN HOW YOU WILL EVALUATE EFFECTIVENESS
Intervention: Faithful Families Ongoing Setting: Faith Target population: African American and Native American New Target Population: No Start Date – End Date (mm/yy): 01/21 – 05/23 Targets health disparities: Yes	Individual/Interpersonal Behavior Organizational/Policy Environmental Change	**Lead Agency:** Robeson County Health Department **Role:** Lead **Target population representative:** African American and Native American faith leaders **Role:** advocate for churches to host program **Established partner** **Partners:** Robeson County Cooperative Ext. **Role**: Co-Lead **Established partner** **How you market the intervention:** Through bulletin inserts at local faith organizations.	**Expected Outcomes:** 85% of participants will show an increase in knowledge and/or changed behavior as evidenced by pre- and post- surveys **Anticipated barriers:** Providing workshops that do not interfere with holidays/ church events; potential COVID 19 barriers such as limited class size allowed by government or church leadership **List anticipated intervention team members:** Whitney Adams and/or RCHD Health Education Staff **Do intervention team members need additional training?** No **Quantify what you will do:** 85% of participants will show an increase in knowledge and/or changed behavior as evidenced by pre- and post- surveys **List how agency will monitor intervention activities and feedback from participants/stakeholders:** Reports to NCDHHS to maintain trainer certification and evaluations that are given at the end of each series **Evaluation:** **Please provide plan for evaluating intervention:** Team will review gathered evaluation forms from workshop participants and will list ideas of how to improve workshop delivery, if needed **Physical activity and/or lifestyle improvement measure** Faithful Families is a practice tested program providing participants doable techniques to control sugar and move more. This program will combat obesity and diabetes; both known issues in Robeson County particularly in the African American and Native American populations.

INTERVENTIONS: SETTING & TIMEFRAME	LEVEL OF INTERVENTION CHANGE	COMMUNITY PARTNERS' Roles and Responsibilities	PLAN HOW YOU WILL EVALUATE EFFECTIVENESS
Intervention: CATCH (Coordinated Approach to Child Health) Ongoing Setting: Schools Target population: Children enrolled in Public Schools of Robeson County Elementary Schools New Target Population: No Start Date – End Date (mm/yy): 01/21 – 05/23 Targets health disparities: Yes	Individual/Interpersonal Behavior Organizational/Policy Environmental Change	**Lead Agency:** Healthy Robeson Coalition **Role:** Lead **Established partner** **Target population representative:** School Administrators, Teachers, Cafeteria Staff **Role:** lead efforts/assist in the implementation of CATCH **Established partner** **Partners:** Robeson County Health Department, Robeson Parks and Recreation, Cooperative Extension, NC Highway Patrol, Robeson Sheriff's Office, Public Schools of Robeson County **Role**: Assist in the implementation of CATCH **Established partner** **How you market the intervention:** Through School administrators	**Expected Outcomes:** All Public Schools of Robeson County Elementary Schools (20) will implement the CATCH program, either during or after school hours. 85% (17 of 20) teachers trained in CATCH program will show increased knowledge and satisfaction with program at end of year via EOY survey **Anticipated barriers:** Barriers- school leadership changes so it will be important to ensure other staff as well as administrators are aware of the program and support the program; potential COVID-19 barrier as schools may continue to be virtual and/or have changes in after school programming **List anticipated intervention team members:** Cathy Hunt, Ivine Lucas, Lekisha Hammonds and Phillip Richardson of UNC Health Southeastern, Elementary Schools administrators/staff **Do intervention team members need additional training?** No **Quantify what you will do:** All public school elementary schools will implement CATCH, currently 20 elementary schools in the system. 85% (17 of 20) teachers trained in CATCH program will show increased knowledge and satisfaction with program at end of year via EOY survey **List how agency will monitor intervention activities and feedback from participants/stakeholders:** Reports to grant funders to maintain trainer certification and evaluations that are given at the end of each series **Evaluation:** **Please provide plan for evaluating intervention:** Team will review end of year surveys from trained teachers. Teachers will show increase in knowledge and satisfaction with the program. Teachers will be asked to share success stories.

INTERVENTIONS: SETTING & TIMEFRAME	LEVEL OF INTERVENTION CHANGE	COMMUNITY PARTNERS' Roles and Responsibilities	PLAN HOW YOU WILL EVALUATE EFFECTIVENESS
Intervention: CATCH Early Childhood Ongoing Setting: 8 Head Start Centers Target population: Children enrolled in 8 Head Start Centers New Target Population: No Start Date – End Date (mm/yy): 01/21 – 05/23 Targets health disparities: Yes	Individual/Interpersonal Behavior Organizational/Policy Environmental Change	**Lead Agency:** UNC Health Southeastern **Role:** Lead **Established partner:** **Target population representative:** Pre School Administrators/Staff/Parents **Role:** lead efforts/assist in the implementation of CATCH Early Childhood **Established partner** **Partners:** Southeastern Community and Family Services, Healthy Robeson Coalition members **Role**: Assist in the implementation of CATCH Early Childhood **Established partner** **How you market the intervention:** Through Head Start Administrators and staff	**Expected Outcomes:** 8 Robeson County Head Start Centers will implement the CATCH Early Childhood program – 85% (7 of 8) teachers trained in CATCH program will show increased knowledge and satisfaction with program at end of year via EOY survey **Anticipated barriers:** Barriers- Program leadership changes so it will be important to ensure other staff as well as administrators are aware of the program and support the program. Potential cultural attitudes to food also need to be considered. Potential COVID-19 barriers as centers adhere to state mandates regarding openings and limitations in class size **List anticipated intervention team members:** Cathy Hunt, Ivine Lucas, Lekisha Hammonds and Phillip Richardson of UNC Health Southeastern, Southeastern Community and Family Services **Do intervention team members need additional training?** No **Quantify what you will do:** 8 Robeson County Head Start Centers will implement Early Childhood CATCH **List how agency will monitor intervention activities and feedback from participants/stakeholders:** Reports to grant funders to detail progress/evaluations that have occurred **Evaluation:** **Please provide plan for evaluating intervention:** Team will review end of year surveys from trained teachers. Teachers will show increase in knowledge and satisfaction with the program. Teachers will be asked to share success stories

INTERVENTIONS: SETTING & TIMEFRAME	LEVEL OF INTERVENTION CHANGE	COMMUNITY PARTNERS' Roles and Responsibilities	PLAN HOW YOU WILL EVALUATE EFFECTIVENESS
Intervention: Color Me Healthy New Setting: Daycares/Head Start centers/Pre-K classrooms Target population: 20 NC Pre-K/Four-year-old classrooms (300 four and five-year old children) New Target Population: No Start Date – 06/21 End Date 06/23: Targets health disparities: Yes	Individual/Interpersonal Behavior Organizational/Policy Environmental Change	**Lead Agency:** Robeson County Health Department **Role:** Lead **Established partner** **Target population representative:** Daycares, Head Start Centers and Pre=K Classrooms **Role:** lead efforts/assist in the implementation of Color Me Healthy **Established partner** **Partners:** Robeson County Health Department, Robeson County Cooperative Extension **Role**: Assist in the implementation of Color Me Healthy **Established partner** **How you market the intervention:** Through daycares/Head Start centers/Pre-K classrooms	**Expected Outcomes:** Color Me Healthy will be implemented in 20 daycares/head start centers/Pre-K classrooms throughout Robeson County with a goal to serve 300 children **Anticipated barriers:** Recent school and Head Start administration changes, administration support, potential COVID-19 barriers as centers adhere to state mandates regarding openings and limitations in class size **List anticipated intervention team members:** Kimberly Lowery, Color Me Healthy Coordinator, and Karen Woodell **Do intervention team members need additional training?** No **Quantify what you will do:** 20 classrooms will receive Color Me Healthy Curriculum **List how agency will monitor intervention activities and feedback from participants/stakeholders:** Reports to grant funders to maintain trainer certification and evaluations that are given at the end of each series **Evaluation:** **Please provide plan for evaluating intervention:** CMH Coordinator will review gathered evaluation forms from participants and will review for improvements.

Community Health Action Plan 2023

County: Robeson **Period Covered:** 2020-2023

Partnership/Health Steering Committee, if applicable: Healthy Robeson Coalition

Community Health Priority identified in the most recent CHA: yes (Illegal Drug Use and Prescription Drug Abuse were recognized respectively as the first and second concern of residents for a combined percentage of 48.98 indicating substance misuse is perceived as grave concern in the community)

Local Community Objective: (*Working description/name of community objective*) **Substance Misuse** (check one): **New** x **Ongoing** (*addressed in previous Action Plan*)

Baseline Data: *(State measure/numerical value. Include date and source of current information)*: Robeson County has an average of 113.3 opioids(pills) per resident and statewide average is 78.3; Robeson has 147.6 opioid prescriptions per resident with statewide average 1.06; Robeson had 11 overdose deaths in 2017 as of July 2017(all data North Carolina State Center for Health Statistics, 2017)

For continuing objective provide the updated information: *(State measure/numerical value. Include date and source of current information)*:

Healthy NC 2030 Objective that most closely aligns with focus area chosen below: Decrease Drug Overdose Deaths (per 100,000 population) from 20.4 (2018 data) to 18 in 2030.

Describe the local target population that will be impacted by this community objective (based on 2016 data)**:**

A. Total number of persons in the target population specific to this action plan: approx. 45% of Robeson residents are between the ages of 18 and 65=49,500

B. Total number of persons in the target population to be reached by this action plan: 4950

C. Calculate the impact of this action plan:

(Total # in B divided by total # in A) X 100% = of the target population reached by the action plan.) 10%

***Healthy North Carolina 2030* Focus Area Addressed:** Each of the CHA priorities selected for submission must have a corresponding *Healthy NC 2030* focus area that aligns with your local community objectives.

Check below the applicable Healthy NC 2020 focus area(s) for this action plan. *For more detailed information and explanation of each focus area, please visit the following websites:* https://nciom.org/healthy-north-carolina-2030/

☐ Individuals below 200% FPL	☐ Unemployment	☐ Short Term Suspensions
☐ Incarceration Rate	☐ Adverse Childhood Experiences	☐ Third Grade Reading Proficiency
☐ Access to Exercise Opportunities	☐ Limited Access to Healthy Food	☐ Severe Housing Problems
☒ Drug Overdose Deaths	☐ Tobacco Use	☐ Excessive Drinking
☐ Sugar-Sweetened Beverage Consumption	☐ HIV Diagnosis	☐ Teen Birth Rate
☐ Uninsured	☐ Primary Care Physician	☐ Early Prenatal Care
☐ Suicide Rate	☐ Infant Mortality	☐ Life Expectancy

Strategy/Intervention(s)	Strategy/Intervention Goal(s)	Implementation Venue(s)	Resources Utilized/Needed for Implementation
Name of Intervention: Family Drug Treatment Court **Community Strengths/Assets:** Family Drug Treatment Court has successfully served families for over 5 years	**S.M.A.R.T Goals:** By May 31 2023, approx. 500 individuals will have been reached through the family drug treatment court program in Robeson County	**Target Population(s):** Robeson residents over the age of 18 **Venue:** Judicial	**Resources Needed:** Assistance from Robeson Health Care Corporation, Robeson County Department of Social Services, Robeson County Law Enforcement, Healthy Robeson Coalition
Name of Intervention: Increase the number of drug take back events	**S.M.A.R.T Goals:** By May 31, 2023, three takeback events will have occurred	**Target Population(s):** Community at large **Venue:** Robeson Law Enforcement	**Resources Needed:** Resources from lockyourmeds.org; Robeson County Safe Kids, Local Law Enforcement
Name of Intervention: Emergency Management Services/ Policy for administering Naloxone	**S.M.A.R.T Goals:** By May 31, 2023, at least one policy will be adopted/implemented by local law enforcement and/or emergency management	**Target Population(s):** Community at large **Venue:** Robeson Law Enforcement	**Resources Needed:** Local Law Enforcement, EMS
Name of Intervention/Activities: Expand implementation of the "Too Good for Drugs" to K-12 schools across the county and to parents and teachers.	**S.M.A.R.T Goals:** Increase and support the use of school- and community-based prevention programs that are evidence-based to prevent use of opioids and other substances in multiple populations.	**Target Population(s):** K-12 schools, staff, students, and parents	**Resources Needed:** RCORP Consortium Members

Interventions Specifically Addressing Chosen Health Priority

INTERVENTION: SETTING & TIMEFRAME	LEVEL OF INTERBENTION CHANGE	COMMUNITY PARTNERS' Roles and Responsibilities	PLAN HOW YOU WILL EVALUATE EFFECTIVENESS
Intervention: Family Drug Treatment Court **Ongoing** Setting: **Community at large** Target population: **residents 18 years and older** New Target Population: No Start Date – End Date (mm/yy): 0**1/21 - 05/23** Targets health disparities: No	Organizational/Policy	Lead Agency: Robeson Health Care Corp. Role: **Leads** Established partner Target population representative: local Robeson Drug Court representative Role: implementing and advocating for participation in drug court Established partners Partners: Local judicial representatives, Robeson County Department of Social Services, Parents as Teachers, Healthy Robeson Coalition Role: Participating with Drug Court Interventions Established partner How you market the intervention: DSS, local law enforcement/judicial, Healthy Robeson Coalition	Expected outcomes: 500 Robeson residents will participate in Family Drug Treatment Court Anticipated barriers: Working with local law enforcement and families could be difficult; potential COVID-19 barrier dependent on government mandates such as shut downs **List anticipated intervention team members:** Robeson Health Care Corporation Drug Treatment Court Coordinator Do intervention team members need additional training? No Quantify what you will do: 500 residents will participate in Family Drug Treatment Court **List how agency will monitor intervention activities and feedback from participants/stakeholders:** By reporting local law and judicial reps, Board of Health, County Commissioners, local mental health providers, Healthy Robeson Coalition Evaluation: **Please provide plan for evaluating intervention:** Evaluation based on outcome- 500 participants complete the family drug court program

INTERVENTION: SETTING & TIMEFRAME	LEVEL OF INTERVENTION CHANGE	COMMUNITY PARTNERS' Roles and Responsibilities	PLAN HOW YOU WILL EVALUATE EFFECTIVENESS
Intervention: Increase number of Take Back Events **Ongoing** **Setting: Law enforcement** **Target population:** community at large **New Target Population:** No **Start Date – End Date (mm/yy): 01/21 - 05/23** **Targets health disparities:** No	**Individual/ Interpersonal Behavior** **Organizational/Policy** **Environmental Change**	**Lead Agency:** Robeson County Health Dept, Safe Kids, Robeson Health Care Corp, local law agencies **Role: Co- Leads** **Target population representative:** Safe Kids **Role:** host take back events; dispose of drugs properly **How you market the intervention:** Local Media, Social Media, Rural Communities Opioid Response Program; Healthy Robeson Coalition	**Expected outcomes**: Host Take Back Events to provide a safe, convenient, and responsible means of disposing of prescription drugs to reduce supply **Anticipated barriers:** Working with law enforcement, since their schedules change and getting cooperation from all law enforcement; possible COVID-19 barrier depending on government mandates regarding shut downs and community events **List anticipated intervention team members:** Robeson County Health Dept, Safe Kids, Robeson Health Care Corp, local law agencies **Do intervention team members need additional training?** No **Quantify what you will do:** Host at least 3 Take Back Events **List how agency will monitor intervention activities and feedback from participants/stakeholders:** Reports are compiled by the Robeson County Health Dept and reported to Safe Kids among other organizations **Evaluation:** **Please provide plan for evaluating intervention:** Successful implementation of 3 events resulting in reduced supply of unused medicines in the community

INTERVENTION: SETTING & TIMEFRAME	LEVEL OF INTERVENTION CHANGE	COMMUNITY PARTNERS' Roles and Responsibilities	PLAN HOW YOU WILL EVALUATE EFFECTIVENESS
Intervention: Emergency Management Services/Policy for administering Naloxone **Ongoing** **Setting: Law enforcement** **Target population:** community at large **New Target Population:** No **Start Date – End Date (mm/yy): 01/21 - 05/23** **Targets health disparities:** No	**Individual/ Interpersonal Behavior** **Organizational/Policy** **Environmental Change**	**Lead Agency:** Robeson County Emergency Management, Sheriff's Office, Local Police Departments, Health Department, Rural Communities Opioid Response Program **Role: Co- Leads** **New partner** Rural Communities Opioid Response Program **Target population representative: local** Emergency Management Agency Director, Sheriff, Local Police Departments **Role:** lead and monitor policy that will be adopted **New partner Partners:** local law enforcement **Role:** administering Naloxone **How you market the intervention:** Local Media, Social Media, Rural Communities Opioid Response Program	**Expected outcomes***:* Policy will be developed and adopted for local law enforcement to administer Naloxone. **Anticipated barriers:** Working with law enforcement, since their schedules change and getting cooperation from all law enforcement **List anticipated intervention team members:** Sheriff, Emergency Management Director, Local Police Chiefs **Do intervention team members need additional training?** Emergency Management/Sheriff's Office is scheduling naloxone training for staff **Quantify what you will do:** At least one policy will be adopted/implemented by local law enforcement and/or emergency management **List how agency will monitor intervention activities and feedback from participants/stakeholders:** By reporting to Sheriff's Department and/or EMS Director **Evaluation:** **Please provide plan for evaluating intervention:** Evaluation based on policy adoption

INTERVENTION: SETTING & TIMEFRAME	LEVEL OF INTERVENTION CHANGE	COMMUNITY PARTNERS' Roles and Responsibilities	PLAN HOW YOU WILL EVALUATE EFFECTIVENESS
Intervention: "Too Good for Drugs" to K-12 schools across the county and to parents and teachers. **New** **Setting: Public Schools** **Target population:** Robeson County Public Schools Elementary teachers and parents **New Target Population:** Yes **Start Date – End Date (mm/yy): 01/21 - 05/23** **Targets health disparities:** No	**Individual/ Interpersonal Behavior** **Organizational/Policy** **Environmental Change**	**Lead Agency:** Robeson Health Care Corp, Public Schools of Robeson County **Role: Co- Leads** **Target population representative: Public Schools of Robeson County teachers and parents** **Role:** implementation of program **New partner** **How you market the intervention:** Public Schools of Robeson County administration, counselors, and staff	**Expected outcomes**: participants will develop skills to mitigate the risk factors and enhance protective factors related to alcohol, tobacco, and other drug (ATOD) use **Anticipated barriers:** Working with schools with recent administration changes; potential COVID-19 barrier as schools may continue to be virtual and/or have changes in after school programming **List anticipated intervention team members:** Robeson Health Care Corp Prevention Team **Do intervention team members need additional training?** No **Quantify what you will do:** implement program in 7 schools **List how agency will monitor intervention activities and feedback from participants/stakeholders:** By reporting to local RHCC Prevention Team **Evaluation:** **Please provide plan for evaluating intervention:** Implement program in 7 schools

2020

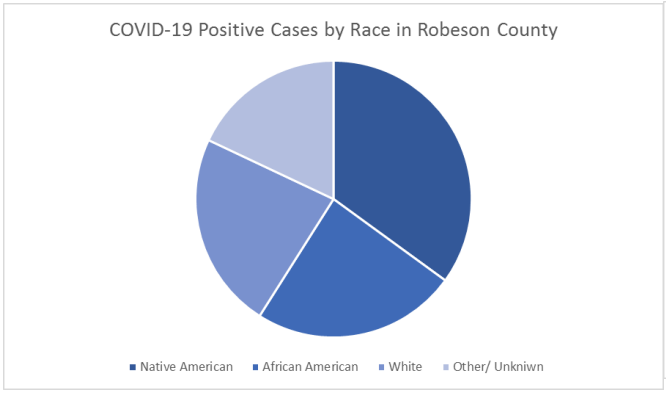
APPENDIX F:

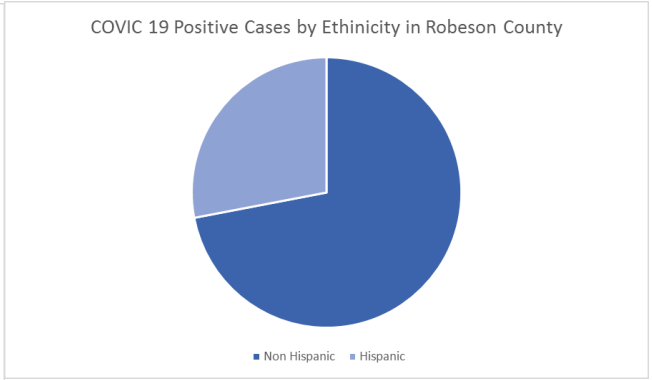
COVID-19

COVID-19
The Novel Coronavirus

Robeson County's first positive case of Coronavirus (COVID-19) was reported on March 21, 2020. Since that time, COVID-19 has been a rapidly evolving situation in our county. As of November 13, 2020; the number of Robeson County residents testing positive was 6,674. Also as of November 13, 2020; the number of deaths was 105. In terms of race, 35% of our county's positive cases to date are American Indian, 24% are Black or African American, 23% are white, and 18% are other/unknown. In terms of ethnicity, 72% of positive cases reported to date are non-Hispanic; and 28% are Hispanic. In terms of gender, 54% are females and 46% are males. Thirty-eight percent of persons testing positive are 25 to 49 years of age. Twenty-one percent are between the ages of 50-64; and 18% range between the ages of 18-24. As of November 12, 2020; 9.7% of county residents tested for coronavirus were positive.

According to the most recent weekly White House report for NC, the city of Lumberton is ranked the 4th worst metro area for cases (with Laurinburg and Fayetteville in the top 10 as well). Robeson County, according to the aforementioned report, was also ranked 4th worst in the county division (along with Cumberland, Scotland, Hoke and Columbus).

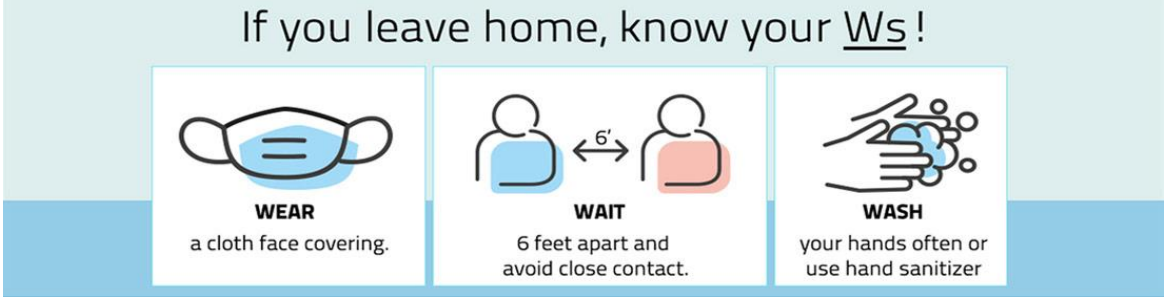




The goal of our local health department is to test a minimum of 5% of Robeson County's population within a 30-day period. Currently around 3,000 residents are tested each week in Robeson County; so we are exceeding this goal. In order to ensure that we meet or exceed this goal on a consistent basis, we must:

- Assure capacity to quickly, accurately, and safely test for COVID-19 among all symptomatic individuals, and secondarily expand capacity to achieve community-based surveillance, including testing of asymptomatic individuals.
- Strengthen our ability to quickly scale testing as necessary to assure optimal utilization of existing and new testing platforms; and to help meet increases in testing demand in a timely manner.

Through existing and newly formed alliances, the local health department will continue to offer COVID-19 testing opportunities in cities and townships encompassing Robeson County's 17 zip codes. To date, the local health department has hosted drive-thru testing sites at churches (representing historically marginalized congregation and community members) and public schools settings (located in predominantly minority neighborhoods). Additionally, we have tested at local municipal landmarks (inclusive of a local train depot). Recent efforts have also included drive-thru testing at our local community college and university. Case investigations and contract tracing are conducted by public health personnel in a timely manner.



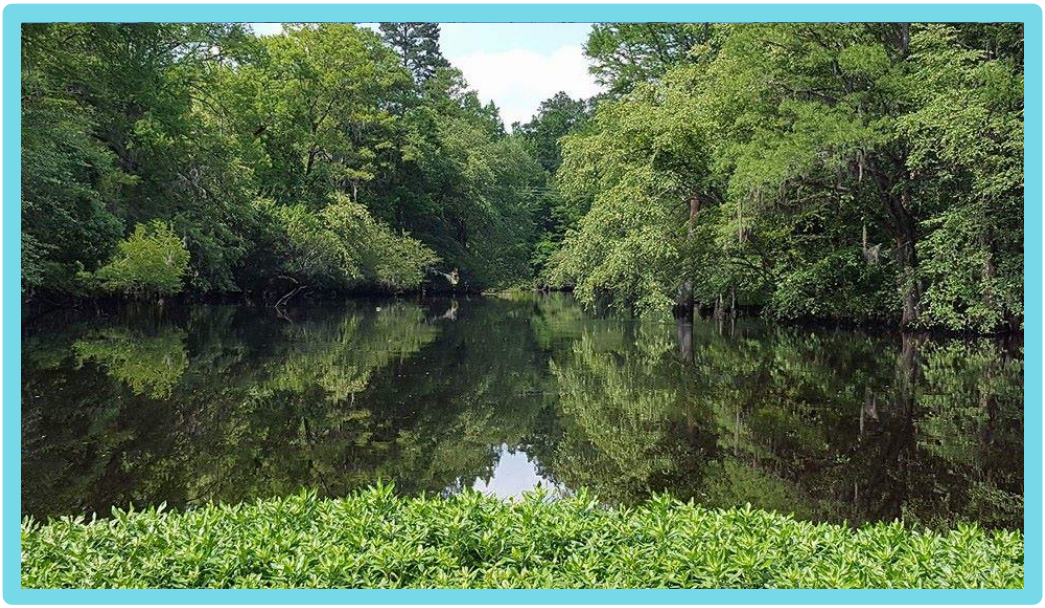
In addition to working in conjunction with NC Division of Public Health contracted vendors, the local health department will build upon our existing rapport with the Lumbee Tribe of NC, the local Chapter of the National Association for the Advanced of Colored People (NAACP), and the Lumber River Baptist Association (represents nearly 40 predominantly African American churches which are geographically dispersed throughout Robeson County's 17 zip codes). These combined efforts will ensure that Robeson County is on target to meet or exceed the 5% testing goal within 30 days. Additionally, the local health department will continue to promote testing opportunities offered via clinics operated by our county's Federally Qualified Health Center, hospital, urgent care clinics, private providers, etc. The goal the local health department is to link our county residents with testing opportunities that are most convenient for them (in terms of location, hours of operation, etc.). Each of the aforementioned efforts attests to our local health department's goal of increasing testing opportunities to our historically marginalized populations; along with the medically vulnerable, symptomatic and asymptomatic. Such efforts will continue.

In addition to testing, education is also key. All local health and human service providers must continue to educate our county's residents regarding the importance of wearing a masking and social distancing. Lack of compliance is the driving force between our consistently increasing case numbers.

2020

APPENDIX G:

Hurricane History



Hurricane History

Robeson County has been hit by multiple hurricanes in the recent years; most notably Matthew in 2016 and Florence in 2018. Both storms brought record breaking rain and flooding issues throughout the county.

Hurricane Matthew & Florence statistics:

- 16 – combined # of shelters opened – both hurricanes
- 25 – combined # of days the shelters were opened – both hurricanes
- More than 3,300 people in shelters (both hurricanes)
- 540 animals rescued – both hurricanes
- Interstate 95 shut down during Florence, as well as Highways 74, 211, and 41, virtually cutting the county off
- 5,977.50 – total number hours worked by public health staff during Hurricane Florence – this includes shelter staffing by our nurses, other staffing in the EOC, as well as animal control, environmental health staff, etc.
- $157,417.42 – Hurricane Matthew costs to our health department – includes things such as replacement ceiling tiles, lost vaccines, generator fuel, missing shelter kits/items such as blood pressure cuffs, car seats given out, etc.
- $108,308.74 – building repairs, upgrades, and purchases via onsite maintenance and county maintenance -- years 2015-2019 – some of this attributed to hurricanes
- 600,000 acres – aerial application for mosquito control (fall 2018)
- 8,060 total # of mosquito dunks purchased
- 600 cans of OFF Deep Woods
- $1,241,413.74 total cost of mosquito control

2020

APPENDIX H:

TOBACCO

VAPING IN ROBESON COUNTY

Vaping" is an e-cigarette industry term for what a person does who is using an e-cigarette. E-cigarettes are known by many different names. They are sometimes called "e-cigs," "e-hookahs," "mods," "vape pens," "vapes," "tank systems," and "electronic nicotine delivery systems.". The term is a misnomer since there is no water vapor associated with these products. Some e-cigarettes are made to look like regular cigarettes, cigars, or pipes. Some resemble pens, USB sticks, and other everyday items. E-cigarettes produce an aerosol by heating a liquid that usually contains nicotine—the addictive drug in regular cigarettes, cigars, and other tobacco products (nicotine is more addictive than heroin, cocaine, or marijuana)—flavorings, and other chemicals that help to make the aerosol. Users inhale this aerosol into their lungs. Bystanders can also breathe in this aerosol when the user exhales into the air. E-cigarettes can be used to deliver marijuana, Fentanyl and other drugs. What is Juuling? According to the CDC "JUUL is a brand of e-cigarette that is shaped like a USB flash drive. Like other e-cigarettes, JUUL is a battery-powered device that heats a nicotine-containing liquid to produce an aerosol that is inhaled. All JUUL e-cigarettes have a high level of nicotine. According to the manufacturer, a single JUUL pod contains as much nicotine as a pack of 20 regular cigarettes. News outlets and social media sites report widespread use of JUUL by students in schools, including classrooms and bathrooms. Although JUUL is currently the top-selling e-cigarette brand in the United States, other companies sell e-cigarettes that look like USB flash drives. Examples include the MarkTen Elite, a nicotine delivery device, and the PAX Era.

VAPING IN ROBESON COUNTY - Continued

How are these different than smoking cigarettes?

The user inhales through a cigarette like mouthpiece, the air flow triggers a sensor that switches on the atomizer, a rechargeable battery powered heater. The heater vaporizes the liquid nicotine in a small cartridge as it also activates a small light at the end of the e-cig. The pull of the hot gas reached the lungs similar to tobacco smoke. As the user exhales, a cloud of PEG vapor (theatrical smoke also contain in the cartridge quickly dissipates. What are the dangers of vaping/juuling? According to the CDC" they contain nicotine (which is more addictive than heroin) Fine and ultrafine particles delivered are *similar* to conventional cigarettes Some tobacco specific carcinogens and toxins have been documented. Propylene glycol – can cause respiratory distress and illness, Heavy Metals: tin, silver, iron, nickel aluminum, sodium, chromium, copper, magnesium, manganese, lead, potassium and silicate nanoparticles. All of which are also contained in the vaping/juuling second hand smoke. The Public Health concerns are the appeal to youth with the flavoring and target marketing, the potential for graduation to cigarettes, they are harmful to adolescent brain development, renormalization of smoking, use of other drugs in vaporizer, delays quitting among smokers, exposure to secondhand aerosol, Defective e-cigarette batteries have caused fires and explosions, some of which have resulted in serious injuries, and reported cases of child poisoning from nicotine e-liquid" The rate of tobacco use in Robeson County was 26.8 percent among adults in Robeson County during 2019, far higher than the state rate of 17.9 percent, and the national rate of 17.1 percent. Youth tobacco use is increasing in Robeson County, with 30.3% in high school and 12.9% in middle school using tobacco products, with the majority vaping. The proliferation of the use of these products can only be stemmed by awareness, education, and diligence.