2017

COMMUNITY HEALTH NEEDS ASSESSMENT

Presented by:
Robeson County Health Department and
Southeastern Health in partnership with
Healthy Robeson

Table of Contents

Acknowledgements.....2

Executive Summary 3

Chapter 1 - Background and Introduction.....4-7

Community Health Assessment Process.....4

Community Health Assessment Team.....6

Chapter 2 - County Description.....8-10

Geographic.....8

History.....9

Demographics.....10

Chapter 3 - Data Collection Process.....11-12

Health Resource Inventory.....11

Community Health Survey.....12

Chapter 4 – Health Data Results.....13-33

Community Health Survey Results.....16-33

Demographics 14

Preparedness & Response Data.....30

Community Listening Tours 34

Secondary Data Results.....35-45

Mortality.....36

Morbidity.....39

Substance Misuse.....40

Health Care.....42

Determinants of Health 43

Chapter 5 – Prevention & Health Promotion.....46

Chapter 6 – Robeson County's Priorities.....47

Chapter 7 – Next Steps.....49

Appendices.....50-140

(A) Community Health Assessment Team.....50

(B) Resource Directory.....54

(C) Community Health Assessment Survey.....57

(D) Narratives.....60

(E) Implementation Strategies (Action Plans).....66

(F) Tobacco.....79

September 2017

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. In October 2016, Hurricane Matthew hit our county especially hard and many of our residents were and still are trying to recover. However, in light of this catastrophic event, it allowed us to once again appreciate and value the strong partnerships and alliances in our county. We know that these partnerships are working together to create a healthier and vibrant county and we hope that you will join us in our journey to create optimal health for all Robeson residents.

In March 2017, 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 grow, we must make sure that we take the necessary steps to ensure that the needs of all our citizens are being addressed. We realize that 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 and Healthy Robeson, which is inclusive of multiple non-profit, government, faith-based, education, media, and business organizations. The many hours contributed 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, listening tours, and 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
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 2014. 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). Southeastern Health and Robeson County Department of Public Health in collaboration with Healthy Robeson, were responsible for the results of the data collections tools, collecting primary data and analysis.

Data Collection and Process of Data Collection

The Community Health Survey was distributed both online and hard copy in order to ensure as many community members as possible took part in the survey. Five focus groups were conducted throughout Robeson County to supplement the information gathered through the survey. Healthy Robeson members agreed to distribute surveys 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 out of 1,114 distributed.

Survey Question	Top Five Responses
Leading causes of death	Heart disease, cancer, stroke/cerebrovascular disease, homicide/violence, diabetes
Priority health issues	Chronic disease, prescription drug abuse, illegal drug abuse, alcohol abuse, obesity
Priority risk factors	Job opportunities, healthier food options, mental health services, recreation facilities, 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, literacy, race, sex/gender, language barrier

Based on the responses received, three priority areas were identified: obesity, substance misuse, and social determinants of health (education). We felt that we had 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.

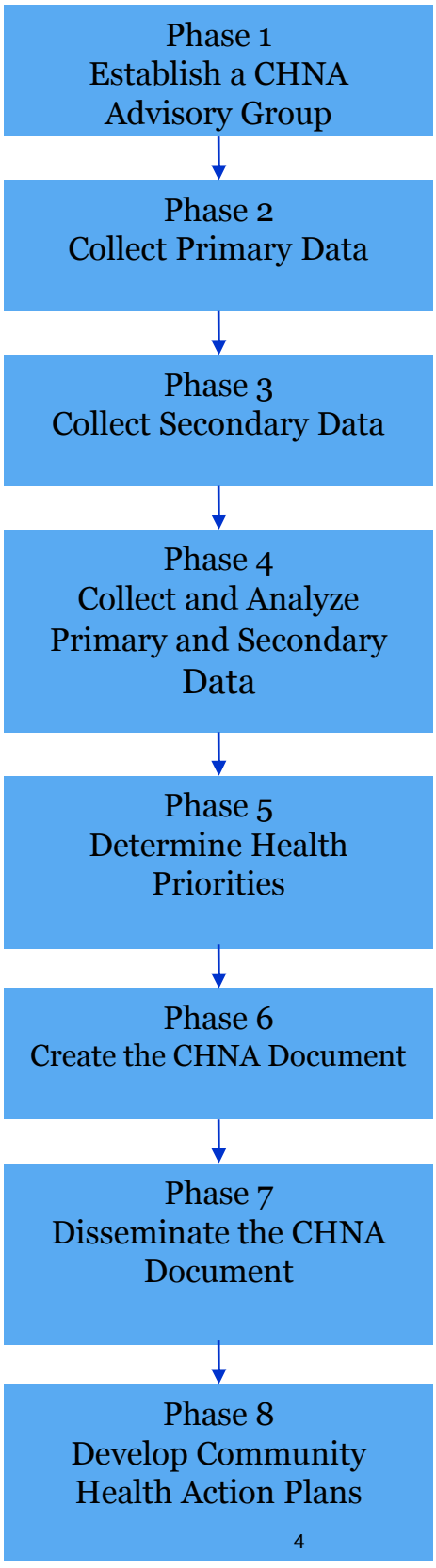
Chapter 1: Background & Introduction

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 Needs 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 Coordinator 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 2016. Initial meetings included the review and re-evaluation of the 2014 community health assessment process and the resulting widely disseminated documentation of findings, priorities and action steps.

By February 2017, 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 in June 2017 to hear the findings of the assessment and to identity leading health problems.

From left to right: May Lample, Phillip Richardson, Lekisha Hammonds, Sarah Gray, Al Bishop.
Not pictured: Lori Dove, Melissa Packer, Whitney McFarland, and Latricia Freeman

Assessment Team Structure

Work Group 1: Community Health Survey Team

Project Co- Facilitators

2017 Community Health Assessment Team

Advisory Group

Work Group 2: Data Collection and Analysis Team

Chapter 2: County Description

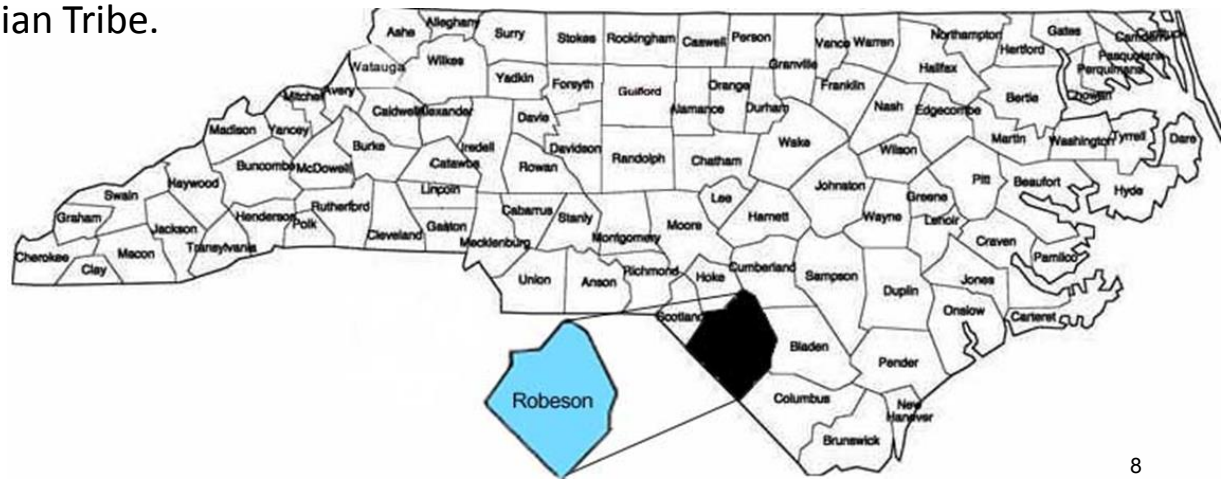
Geographic Features

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.

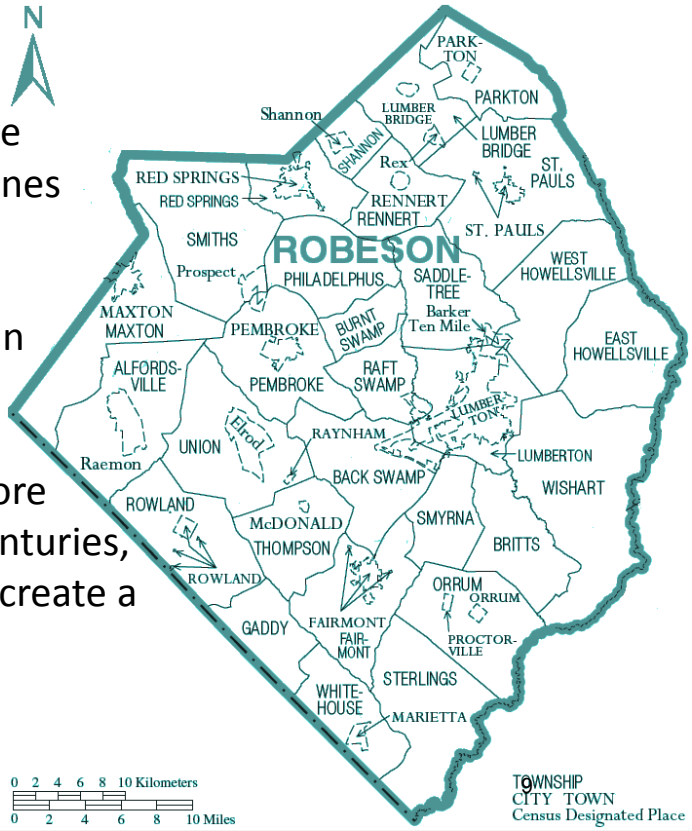


History

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 2010 U.S. Census, Robeson County's total population is 134,188. This is an 8.8% population change from 2000 when the total population was 123,339. Robeson is a rural county with over 65% of the total population living in farm and nonfarm areas.

Robeson County's population is young. The largest percentage (30.2%) of the population is between the ages of 0-19 and the median age is 34, which increased by 2 years since the 2000 Census data.

Population & Growth	**Population**	**Annual Growth Rate**
July 2015 Certified Population Est.	133,375	
2010 Total Population	134,168	
2000 Total Population	123,339	
Population Change, 2000 to 2010	10,829	8.8%
Urban/Rural Representation	**Population**	**Urban/Rural Percent**
2010 Total Population: Urban	50,161	37.39%
2000 Total Population: Urban	42,540	34.50%
2010 Total Population: Rural	84,007	62.61%
2000 Total Population: Rural	80,799	65.50%
Estimated Population by Age	**Population**	**Population by Age, % Est.**
2019 Projected Median Age	36	
2010 Median Age	34	
2000 Median Age	32	
2010 Total Pop 0-19	39,860	30.2%
2010 Total Pop 20-29	18,953	14.3%
2010 Total Pop 30-39	17,701	13.4%
2010 Total Pop 40-49	17,458	13.2%
2010 Total Pop 50-59	16,837	12.7%
2010 Total Pop 60+	21,283	16.1%

Robeson County is one of 10% of United States counties that are majority-minority; its combined population of Native American, 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, community health survey and listening tours. 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 and listening tours. The community health survey was revised from the 2014 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 *The Robesonian*. 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 interns from the Robeson County Department of Public Health 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 conducted by an intern working with Southeastern Health. Drawing on United Way 2-1-1 directory as well as the Health Resource Inventory from the 2014 Community Health Needs Assessment, resources were chosen that impact the health of the population.

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, 4 pertained to Emergency preparedness 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.

Location	# of Surveys Distributed
Lumberton	700
Red Springs	94
Pembroke	87
Fairmont	72
Maxton	67
St. Pauls	66
Rowland	28

The Community Health Survey Team distributed 1114 surveys with a goal of 500 surveys returned. The surveys were distributed by zip codes and quantities were based upon the number of persons residing within the codes. This method helped to ensure that representation was received from communities throughout the county.

Surveys were distributed by members of the CHNA Advisory Group. The CHNA Work Group was responsible for tallying and analyzing the results. A total of 713 surveys were returned, thus surpassing the team's initial expectation. Survey data was analyzed by entering information into Survey Monkey, an online survey tool used to find trends and statistical significance.

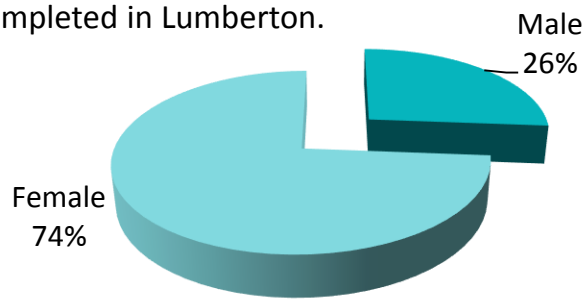
Chapter 4: Health Data Results

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, 74% were completed by females and 26% by males. Surveys were received from all age groups with the majority of the respondents being between the ages of 31-40. Additionally, there was representation from all areas in Robeson County. The majority of the surveys were completed in Lumberton.

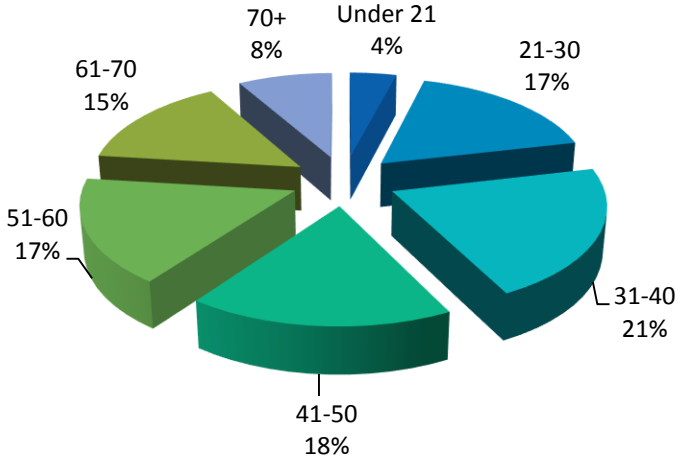
Gender

Male	179
Female	503



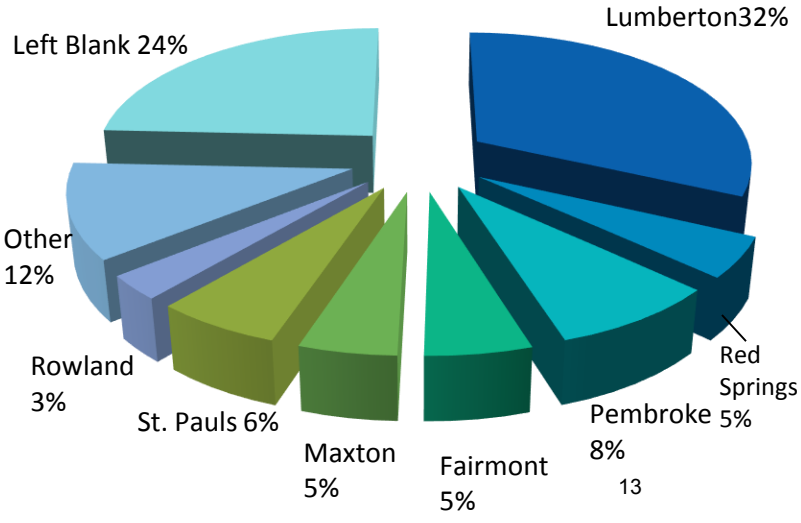
Age

Under 21	28
21-30	118
31-40	144
41-50	120
51-60	118
61-70	101
70+	57

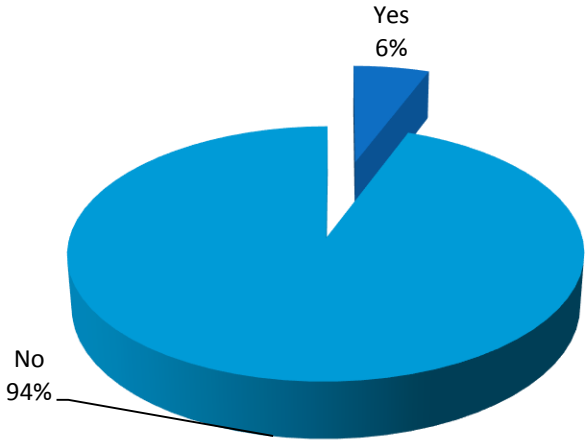


Residence

Lumberton	227
Red Springs	35
Pembroke	60
Fairmont	37
Maxton	34
St. Pauls	44
Rowland	21
Other	82
Left blank	173



The race and ethnicity of respondents mirrors that of Robeson County. As indicated on page 12, Robeson County's racial and ethnic makeup consists of the following: Native American-35%, Caucasian-28%, African American-25% and Hispanic-6%. Survey respondents included the following: Caucasian-34%, Native American-35%, African American-25%. 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.

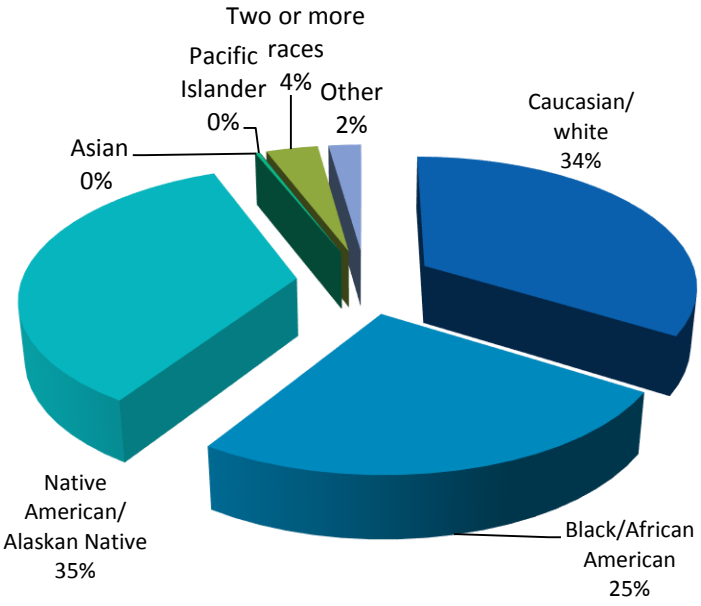


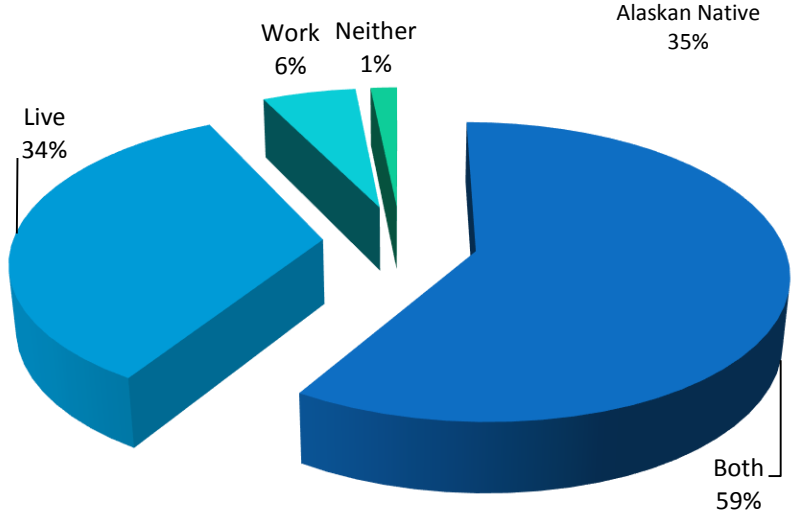
Hispanic, Latino, or Spanish origin?

Yes	38
No	628

Race

White/Caucasian	227
Black/African American	170
Native American/Alaskan Native	234
Asian	2
Pacific Islander	0
Two or more races	24
Other	15





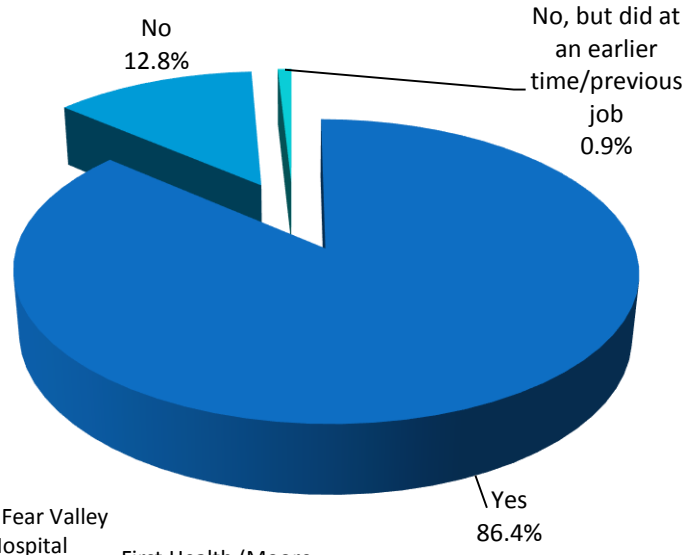
Residence

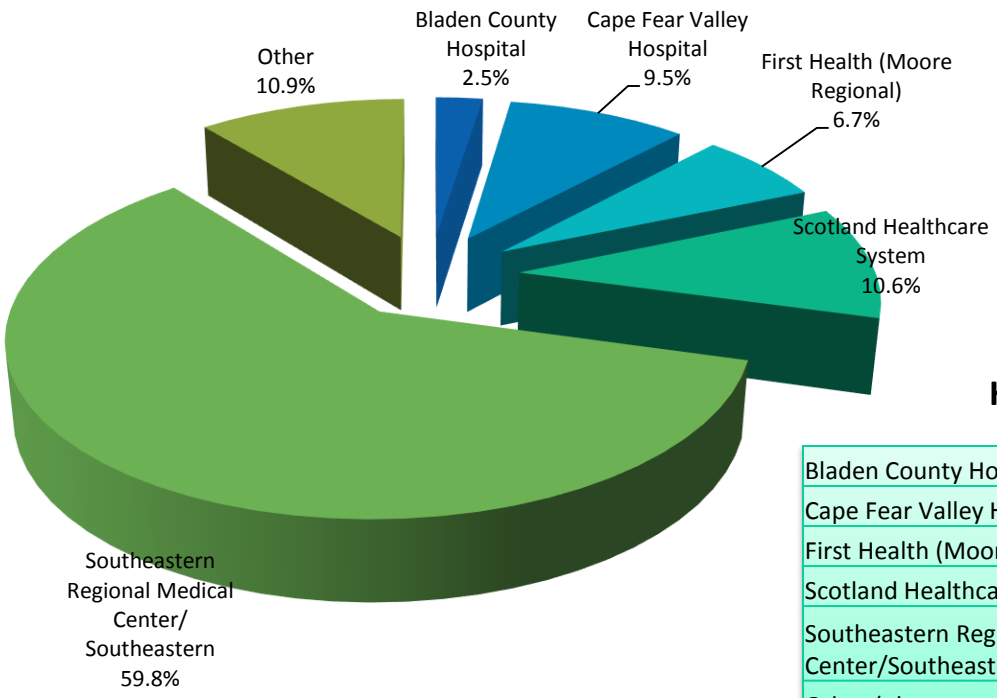
Both Live & Work	404
Live	233
Work	39
Neither	11

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 13% of people surveyed do not have health insurance and 40% seek hospital care outside of the county. As previously mentioned on page 10, 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	595
No	88
No, but did at an earlier time/previous job	6

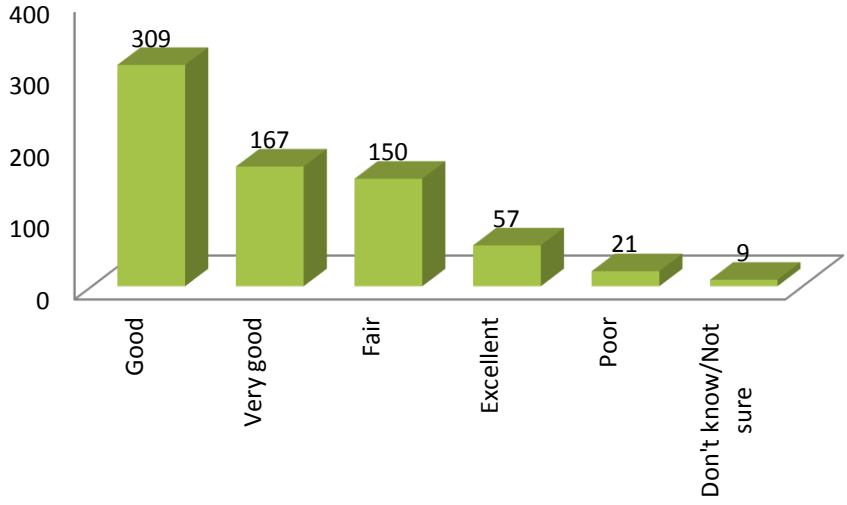




Hospitals

Bladen County Hospital	17
Cape Fear Valley Hospital	65
First Health (Moore Regional)	46
Scotland Healthcare System	73
Southeastern Regional Medical Center/Southeastern Health	411
Other (please specify)	75

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



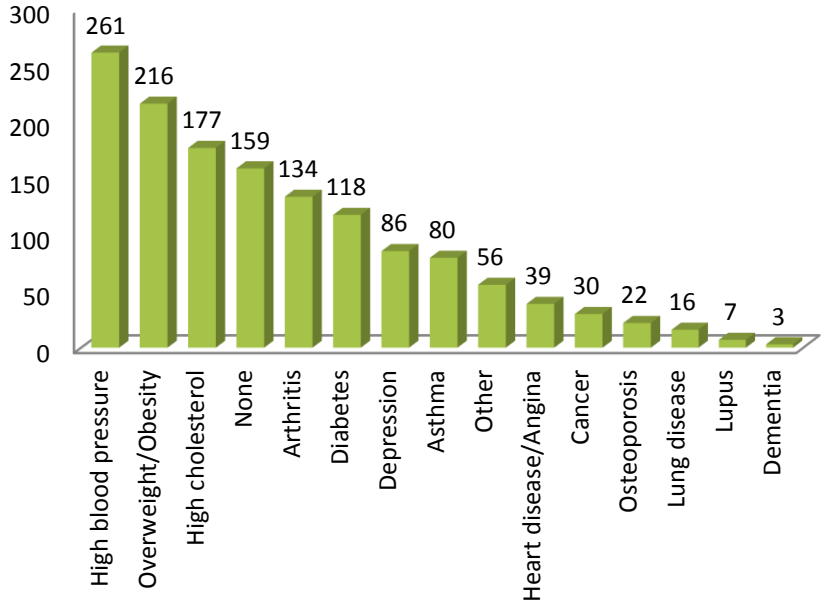
Good	43.3%
Very Good	23.4%
Fair	21%
Excellent	8.0%
Poor	2.9%
Don't Know/Not Sure	1.3%
Total Responses: 713	

Disparities

	Caucasian	African American	Native American
Good	41.9%	41.8%	43.6%
Very Good	26.9%	23.5%	22.2%
Fair	18.9%	24.1%	20.9%
Excellent	9.3%	6.5%	9%
Poor	2.2%	2.9%	2.6%
Don't Know/ Not Sure	0.9%	1.2%	1.7%

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 changes from the 2014 assessment were noted.
Disparities: African Americans have a lower percentage for self-reported "excellent" health compared to Native Americans and Caucasians.
Impact on community: African Americans may need enhanced health interventions due to the decreased number that self-reported "excellent" health.

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

	Caucasian	African American	Native American
High Blood Pressure	29.7%	50.6%	41.4%
Overweight/ obese	33.8%	28.3%	30%
High Cholesterol	27.4%	24.7%	24.2%
None	19.2%	23.5%	23.8%
Arthritis	21.9%	21.1%	16.7%
Diabetes	12.8%	21.7%	18.5%

High Blood Pressure	37.7%
Overweight/Obesity	31.2%
High Cholesterol	25.5%
None	22.9%
Arthritis	19.3%
Diabetes	17.0%
Depression	12.4%
Asthma	11.5%
Other	8.1%
Heart Disease/Angina	5.6%
Cancer	4.3%
Osteoporosis	3.2%
Lung Disease	2.3%
Lupus	1.0%
Dementia	0.4%
Total Responses: 693	

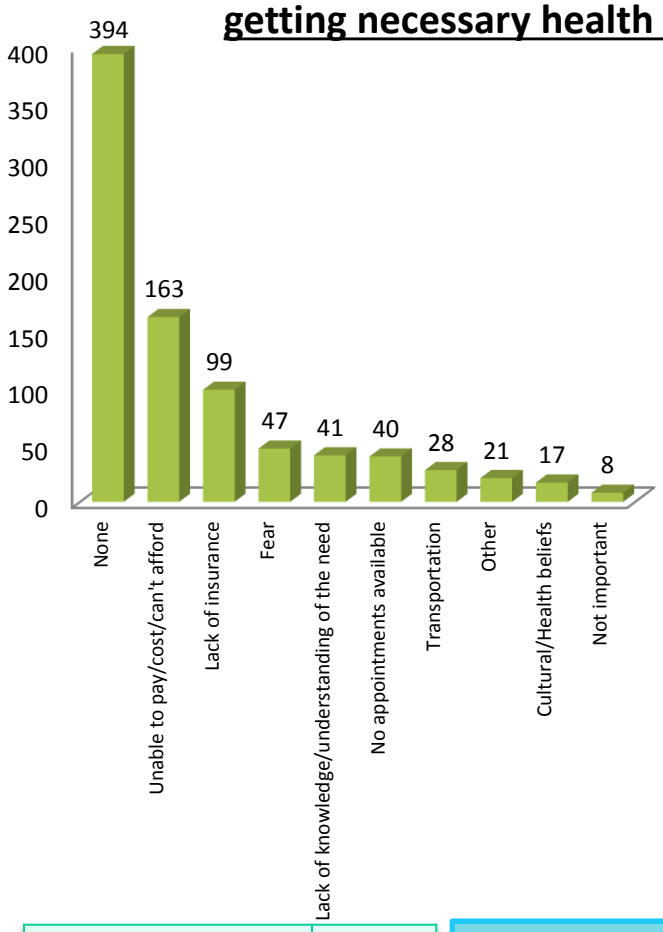
Summary: The graph and chart above show the number and percentage of the population surveyed who self-reported a medical concern that they have been told by their healthcare provider. As shown, the majority of respondents said they have "high blood pressure."

Trend Data: No change from 2014.

Disparities: Native Americans and African Americans have higher percentages of responding "high blood pressure." Furthermore, 1 in 2 African American respondents reported that they had been told by a medical provider that they have "high blood pressure."

Impact on community: This illustrates the need to address high blood pressure and obesity through targeted health education programs. Programs exist in Robeson County and are currently offered by the Robeson County Department of Public Health, churches, Wellness on Wheels, Healthy Communities A-Z. However, creating new opportunities for residents to increase awareness while reducing barriers to accessing healthcare is essential for creating a healthy and vibrant county.

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



None	57.4%
Unable to pay/cost/ can not afford	23.7%
Lack of insurance	14.4%
Fear	6.8%
Lack of knowledge/ Understanding of the need	6.0%
No appointments available	5.8%
Transportation	4.1%
Other	3.1%
Cultural/Health Beliefs	2.5%
Not important	1.2%
Total Responses: 687	

Disparities

	Caucasian	African American	Native American
None	61.1%	56.1%	56.5%
Unable to pay/cost/can't afford	20.4%	27.4%	24.2%
Lack of Insurance	9.5%	16.5%	16.6%
Fear	7.7%	6.1%	4.5%
Lack of Knowledge	5.0%	9.8%	3.6%
No appointments Available	8.1%	3.7%	4.9%
Transportation	3.2%	6.1%	4.5%
Other	3.2%	1.8%	3.6%
Cultural/Health Beliefs	1.4%	3.7%	2.2%
Not Important	0.5%	1.2%	1.8%

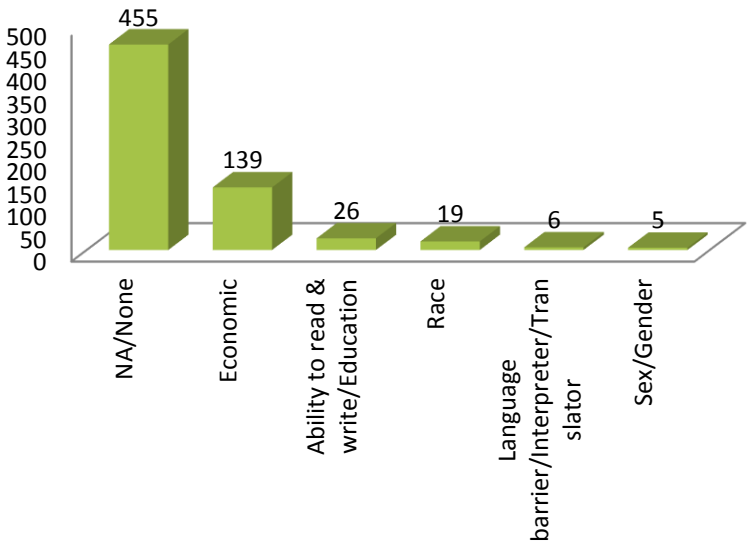
Summary: The graph and chart above show the number and percentage of the population surveyed who self-reported their biggest barrier for seeking medical treatment. "None" and "unable to pay/cost/can't afford" were the top two self-reported barriers.

Trend Data: For the 2016 Community Health Assessment, the Task Force decided to introduce a new option for those completing the survey; "unable to pay/cost/can't afford. " This new option changed the intent of question and therefore a comparison with 2014 data is difficult.

Disparities: Caucasians have a lower percentage who self-reported "none." African Americans and Native Americans have a high self-reported percentage for "unable to pay/cost/can't afford" and "lack of insurance." African Americans have a higher percentage for lack of knowledge/understanding of need.

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

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



Not Applicable/None	70.0%
Economic (Low Income, No Insurance, etc.)	21.4%
Ability to read & write/Education	4.0%
Race	2.9%
Language Barrier/Interpreter/Translator	0.9%
Sex/Gender	0.8%
Total Responses: 650	

Disparities

	Caucasian	African American	Native American
Not applicable/None	77.0%	67.5%	69.4%
Economic (low income, no insurance, etc.)	14.9%	22.1%	24.8%
Ability to read & write/ education	3.3%	5.8%	2.4%
Race	2.3%	3.9%	1.9%
Sex/Gender	1.4%	0.0%	1.0%
Language barrier/ interpreter/ translator	0.9%	0.6%	0.5%

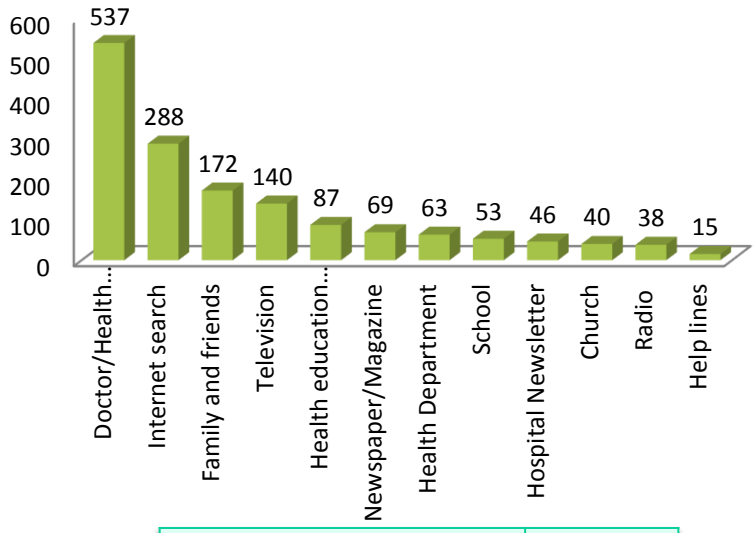
Summary: The graph and chart above show the number and percentage of the population surveyed who self-reported their quality of health care received. The majority answered “none” and second was “economic impact.”

Trend Data: The question has been reworded from 2014 version to encourage respondents to think in practical terms. The percentages that chose “economic factors” are lower and “none/not applicable” is higher in 2017.

Disparities: Native Americans and African Americans have a lower percentage for “none/not applicable” but a higher percentage for “economic factors” as impacting the quality of healthcare that they receive.

Impact on community: The additional years of the Affordable Care Act could have contributed to respondents’ access to health care.

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



Doctor/Health Professional	75.8%
Internet Search	40.7%
Family or Friends	25.1%
Television	19.8%
Health Education Center	12.3%
Newspaper/Magazine	9.7%
Health Department	8.9%
School	7.5%
Hospital Newsletter	6.5%
Church	5.6%
Radio	5.4%
Help lines	2.1%
Total Responses: 708	

Disparities

	Caucasian	African American	Native American
Doctor/Health Professional	77.5%	80.4%	73.0%
Internet Search	44.9%	33.9%	42.9%
Family or Friends	26.4%	25.6%	21.0%
Television Hospital Newsletter	20.7%	38.1%	22.3%
Health Education Center	12.3%	15.5%	8.2%
Newspaper/ Magazine	9.7%	11.3%	9.4%
Health Department	7.0%	15.5%	6.4%
Radio	4.4%	8.9%	3.9%
School	4.0%	10.7%	6.4%
Church	3.5%	10.7%	3.9%
Help Lines	2.2%	0.0%	3.0%

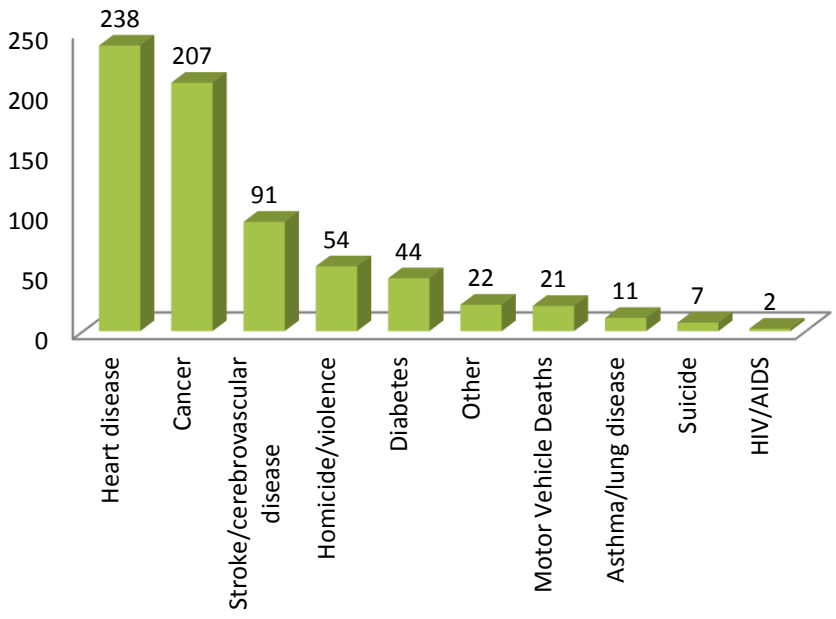
Summary: The graph and chart above show the number and percentage of the population surveyed who self-reported where they get their health information. “Doctors and health professionals” received the highest percentage, followed by the “Internet”.

Trend Data: On this assessment survey, respondents were allowed to check all that apply. Respondents were also given a new option for this assessment, “church” as some residents participate in faith-based health promotion programs. The data follows a similar pattern from 2014 even with the new option.

Disparities: African Americans percentage for “Internet” is lower, while “television” is higher.

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)



Heart Disease	34.1%
Cancer	29.7%
Stroke/Cerebrovascular Disease	13.1%
Homicide/Violence	7.7%
Diabetes	6.3%
Other	3.2%
Motor Vehicle Deaths	3.0%
Asthma/Lung Disease	1.6%
Suicide	1.0%
HIV/AIDS	0.3%
Total Responses: 697	

Disparities

	Caucasian	African American	Native American
Heart Disease	44.2%	23.2%	32.5%
Cancer	22.8%	32.9%	35.9%
Stroke	10.7%	20.1%	10.0%
Homicide/ Violence	8.0%	7.9%	8.7%
Diabetes	6.3%	7.9%	5.2%
Other	3.1%	3.7%	3.0%
Asthma/ Lung Disease	1.8%	0.6%	1.7%
Motor Vehicle Death	1.8%	2.4%	2.6%
Suicide	0.9%	0.6%	40.0%
HIV/AIDS	0.4%	0.6%	0.0%

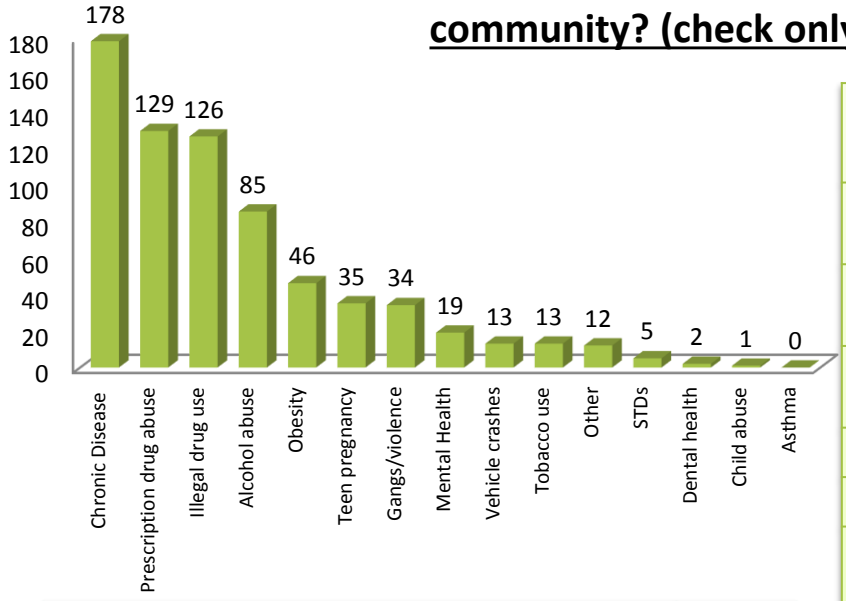
Summary: The graph and chart above show the number and percentage of the population surveyed who self-reported on what they think most people die of in their community. The survey indicated that "heart disease" followed by "cancer" are the top responses.

Trend Data: In this assessment, "heart disease" followed by "cancer" were selected. This differs from the 2014 assessment as "cancer" was the first choice, followed by "heart disease." "Homicide/violence" was selected by respondents as the fourth choice for leading cause of death followed by "diabetes" as fifth while the 2014 assessment indicated that "diabetes" was the fourth leading cause of death followed by "homicide/violence."

Disparities: African Americans have twice the percentage of selecting "stroke/cerebrovascular disease" selected and half the percentage of "heart disease" selected compared to Caucasians.

Impact on community: The community's perception matches the first two causes of death as indicated by 2016 North Carolina Health Statistics data.

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



Chronic Disease (Cancer, Diabetes, Heart or Lung Disease)	25.5%
Prescription Drug Abuse	18.5%
Illegal Drug Use	18.1%
Alcohol Abuse	12.2%
Obesity	6.6%
Teen Pregnancy	5.0%
Gangs/Violence	4.9%
Mental Health	2.7%
Vehicle Crashes	1.9%
Tobacco Use	1.9%
Other	1.7%
Sexually Transmitted Diseases (Syphilis, Gonorrhea, Chlamydia)	0.7%
Dental Health	0.3%
Child Abuse	0.1%
Asthma	0.0%
Total Responses: 698	

Disparities

	Caucasian	African American	Native American
Chronic Disease	28.7%	32.3%	20.3%
Illegal Drug Use	17.9%	16.5%	21.2%
Prescription Drug Abuse	14.3%	8.5%	29.9%
Alcohol Abuse	10.8%	14%	11.3%
Obesity	10.3%	4.9%	3.5%
Teen Pregnancy	4.5%	5.5%	3.5%
Gangs/ Violence	4.5%	9.1%	2.6%
Mental Health	2.7%	4.9%	0.9%
Other	1.8%	2.4%	1.3%
Vehicle Crashes	1.3%	0.6%	1.7%
Tobacco Use	1.3%	1.2%	2.2%
STIs	1.3%	0%	0.9%
Child Abuse	0.4%	0%	0%
Asthma	0%	0%	0%
Dental Health	0%	0%	0.9%

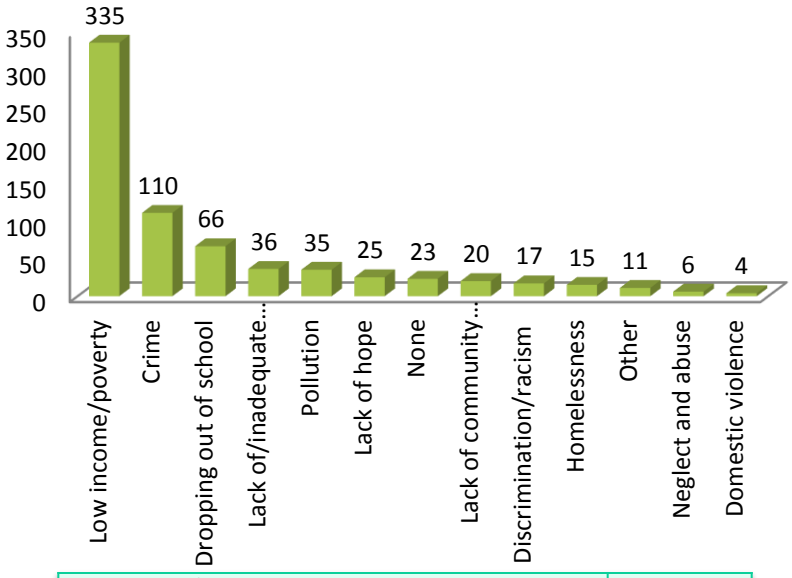
Summary: The graph and chart above show the number and percentage of the population surveyed who self-reported the biggest health issue of concern in their community. “Chronic disease” and “prescription drug abuse” received the highest percentage of responses.

Trend Data: “Obesity” dropped by more than 50% from the 2014 assessment as a self-reported concern. “Prescription drug abuse” switched places with “illegal drug use” and increased 3% compared to the 2014 assessment.

Disparities: “Chronic disease” had a lower percentage for Native Americans indicating that this was a health concern. “Prescription drug abuse” is an increased concern for Native Americans, while being lower for African Americans. African Americans have a higher percentage for “gangs/violence” and “mental health.”

Impact on community: Robeson County’s Substance Misuse Awareness and Recovery Taskforce will work more closely with the Lumbee Tribe, local medical providers and law enforcement in order to address concerns around prescription drug misuse. Increased education on chronic disease prevention will continue.

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



Low income/poverty	47.7%
Crime (murder, assault, theft, rape/sexual assault)	15.6%
Dropping out of school	9.4%
Lack of/inadequate health insurance	5.1%
Pollution (air, water, land)	5.0%
Lack of hope	3.6%
None	3.3%
Lack of community support	2.8%
Discrimination/racism	2.4%
Homelessness	2.1%
Other	1.6%
Neglect and Abuse	0.9%
Domestic Violence	0.6%
Total Responses: 703	

Disparities

	Caucasian	African American	Native American
Low income/poverty	55.4%	43.7%	46.6%
Crime	13.4%	13.8%	20.1%
Dropping out of school	7.6%	11.4%	8.5%
Lack of hope	6.7%	3.0%	1.3%
Lack of/inadequate health insurance	4.0%	7.2%	3.8%
Pollution	3.6%	4.8%	6.4%
None	2.7%	2.4%	2.7%
Homelessness	1.8%	2.4%	2.1%
Discrimination/ racism	1.3%	3.0%	1.3%
Other	1.3%	1.8%	2.1%
Lack of community support	0.9%	4.2%	3.4%
Domestic violence	0.9%	1.2%	0.0%
Neglect and abuse	0.4%	1.2%	0.4%

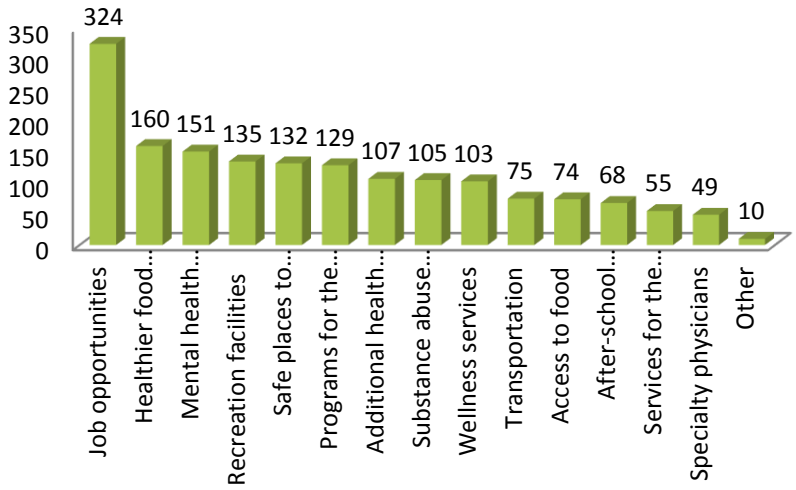
Summary: The graph and chart above show the number and percentage of the population who self-reported what most affects the quality of life in their county. The highest percentage of responses received was for "low income/poverty."

Trend Data: This is a new question added to our community health survey to allow community leaders, organizations and residents a better understanding of factors that affect their quality of life.

Disparities: Native Americans have higher percentage for "crime" as affecting their quality of life and Caucasians have higher percentage for "low income" and "lack of hope."

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	46.5%
Healthier Food Choices	23.0%
Mental Health Services	21.7%
Recreation Facilities	19.4%
Safe places to Walk/Play	18.9%
Programs for the Elderly	18.5%
Additional Health Services	15.4%
Substance Abuse Rehabilitation Service	15.1%
Wellness Services	14.8%
Transportation	10.8%
Access to Food	10.6%
After-School Programs	9.8%
Services for the Disabled	7.9%
Specialty Physicians	7.0%
Other	1.4%
Total Responses: 697	

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: This question was changed from 2014 to allow respondents to select three choices instead of one, yet the top two options stayed the same ("job opportunities" and "healthier food choices.") Those that selected "mental health services" increased from 2014.

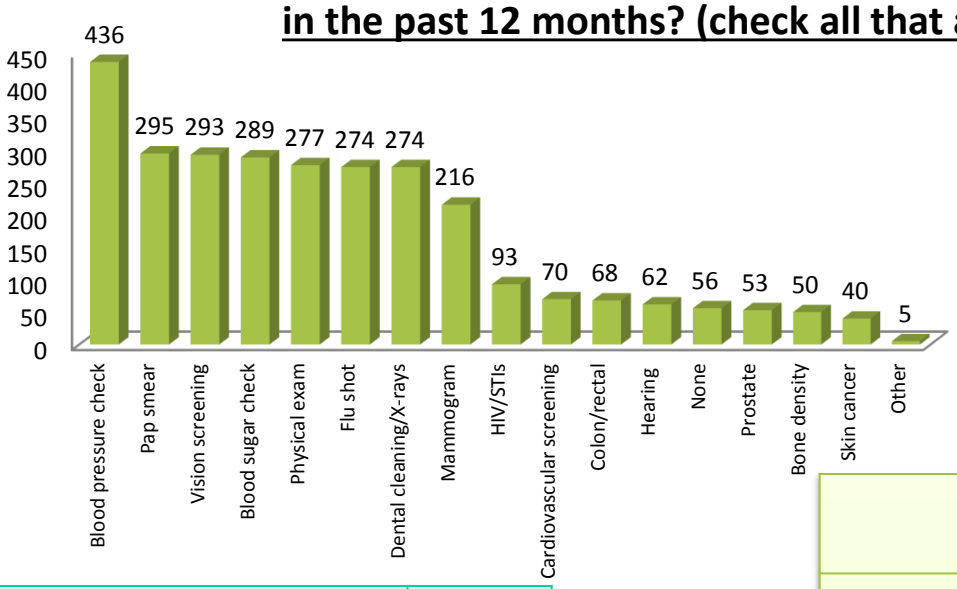
Disparities: Caucasians have a higher percentage for "mental health services" and lower for "job opportunities" and "after school programs." African Americans have a higher percentage for "healthier food options."

Impact on community: The needs, as identified by respondents, will help to shape our future priority areas.

Disparities

	Caucasian	African American	Native American
Job Opportunities	42.7%	52.1%	49.6%
Mental Health Services	27.3%	20.1%	18.7%
Healthier Food Choices	24.1%	27.8%	18.3%
Safe places to walk/play	22.7%	13.6%	17.8%
Recreation Facilities	18.6%	23.1%	17.0%
Programs for the Elderly	15.9%	21.3%	17.4%
Substance abuse rehabilitation services	15.5%	10.7%	18.3%
Wellness Services	14.5%	10.1%	18.3%
Additional Health Services	14.1%	16.6%	15.7%
Transportation	10.9%	10.7%	9.6%
Access to food	9.5%	12.4%	9.6%
Services for the Disabled	7.3%	10.1%	7.8%
After-school programs	4.1%	12.4%	13.0%
Other	2.3%	0.6%	1.3%

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



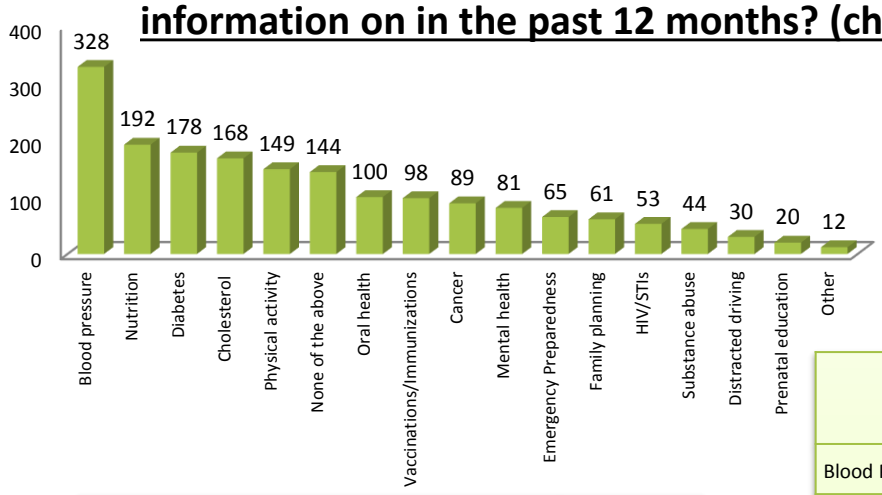
Blood pressure check	61.8%
Pap smear (if woman)	41.8%
Vision screening	41.6%
Blood sugar check	41.0%
Physical exam	39.3%
Flu shot	38.9%
Dental cleaning/X-rays	38.9%
Cholesterol screening	38.2%
Mammogram (if woman)	30.6%
HIV/Sexually Transmitted Infections	13.2%
Cardiovascular screening	9.9%
Colon/rectal exam	9.6%
Hearing screening	8.8%
None of the above	7.9%
Prostate cancer screening (if man)	7.5%
Bone density test	7.1%
Skin cancer screenings	5.7%
Other	0.7%
Total Responses: 705	

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," "pap smear" and "vision screening" were highest.
Trend data: This is a new question that was not included in the 2014 assessment.
Disparities: A higher percentage of "HIV screenings" among African Americans was self- reported and Caucasians had a higher percentage of self reported "skin cancer" screenings.
Impact on community: Targeted advertising for HIV testing in lower income neighborhoods could contribute to higher percentage of testing among African Americans. Skin cancer myths around those more vulnerable to skin cancer could contribute to the response from Caucasians.

Disparities

	Caucasian	African American	Native American
Blood pressure check	64.9%	67.1%	59.2%
Flu shot	47.1%	33.5%	33.5%
Vision Screening	44.9%	44.1%	41.2
Physical exam	43.6%	42.9%	34.8%
Dental cleaning/x-rays	43.1%	37.6%	38.2%
Blood sugar check	42.2%	44.1%	40.3%
Pap smear	37.3%	43.5%	46.4%
Mammogram	31.3%	34.7%	27.5%
Skin cancer screening	12.0%	1.2%	2.1%
Colon/rectal exam	10.2%	11.8%	9.4%
Cardiovascular screening	10.2%	11.2%	9.9%
Hearing screening	9.8%	7.1%	8.6%
HIV/STI	9.8%	18.8%	12.9%
Prostate Cancer Screening	8.0%	9.4%	6.0%
Bone density Test	6.7%	10.0%	5.6%
None of the above	6.2%	7.6%	7.7%
Other	0.4%	0.0%	0.4%

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



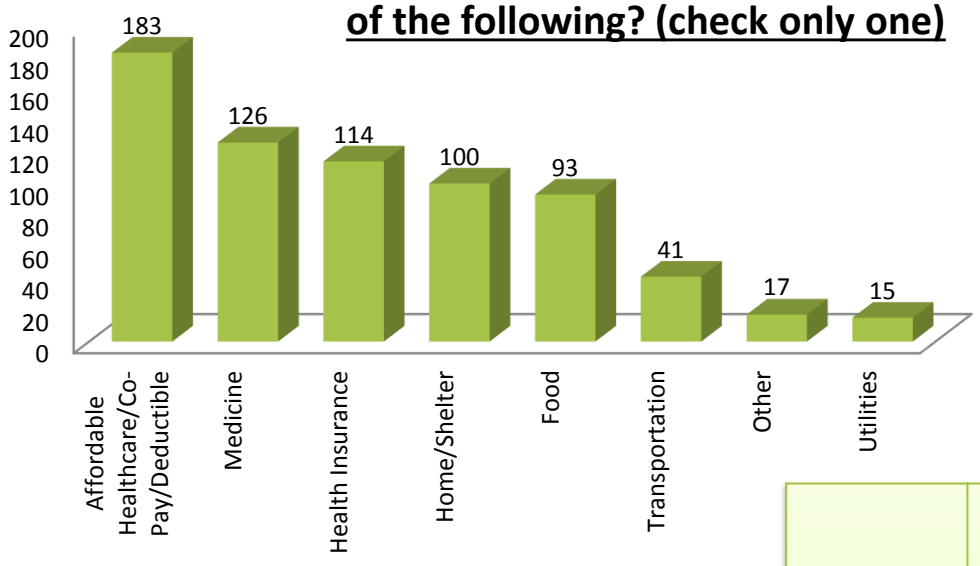
Blood Pressure	46.9%
Nutrition	27.4%
Diabetes	25.4%
Cholesterol	23.1%
Physical Activity	21.3%
None of the above	20.6%
Oral Health	14.3%
Vaccinations/Immunizations	14.0%
Cancer	12.7%
Mental Health	11.6%
Emergency Prepardness	9.3%
Family Planning	8.7%
HIV/Sexually Transmitted Infections	7.6%
Substance Abuse	6.3%
Distracted driving/Seatbelts/Child car seats	4.3%
Prenatal education	2.9%
Other	1.7%
Total Responses: 700	

Disparities

	Caucasian	African American	Native American
Blood Pressure	38.7%	60.5%	48.7%
Nutrition	29.8%	31.7%	23.5%
Physical Activity	23.6%	25.1%	19.1%
Cholesterol	22.7%	24.0%	26.1%
None of the above	21.3%	14.4%	21.7%
Diabetes	20.9%	31.7%	27.0%
Vaccinations/ Immunizations	16.2%	15.6%	11.7%
Oral Health	14.2%	15.6%	13.9%
Mental Health	12.4%	13.2%	9.6%
Emergency Preparedness	11.6%	9.6%	7.0%
Cancer	10.7%	18.6%	11.7%
Substance Abuse	6.7%	7.8%	5.2%
HIV/STIs	6.7%	9.0%	7.4%
Family Planning	6.2%	9.0%	11.3%
Distracted driving/seatbelts/ child car seats	3.6%	5.4%	3.9%
Other	2.2%	0.6%	1.3%
Prenatal Education	1.8%	1.8%	4.8%

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," "nutrition" and "diabetes."
Trend Data: This is a new question and was not on the previous 2014 assessment.
Disparities: African Americans have a higher percentage of self-reported "blood pressure" information that they had received. Native Americans have almost double the percentage for "family planning" and "prenatal education" as Caucasians and 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. There are many resources in the community relevant to family planning and prenatal education/support. More awareness of those resources and ease in attaining them is necessary.

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



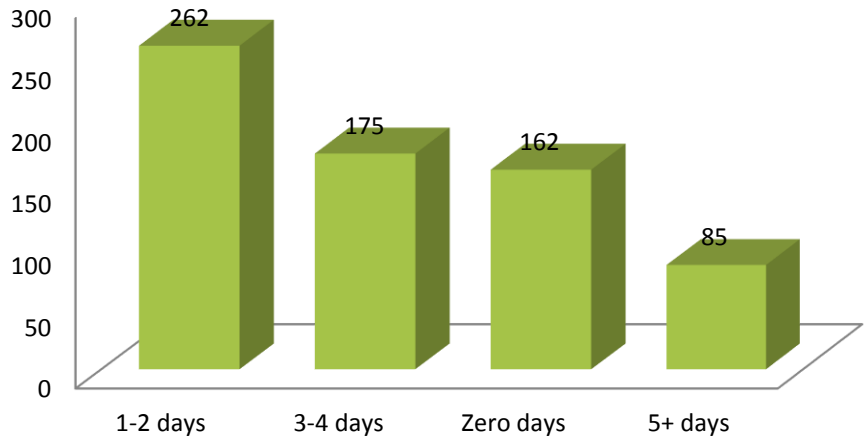
Affordable Healthcare/Co-Pay/Deductible	26.6%
Medicine	18.3%
Health Insurance	16.5%
Home/Shelter	14.5%
Food	13.5%
Transportation	6.0%
Other	2.5%
Utilities	2.2%
Total Responses: 689	

Disparities

	Caucasian	African American	Native American
Affordable Healthcare/ Co-pay/ deductible	30.0%	19.3%	29.5%
Medicines	17.7%	19.3%	18.5%
Health Insurance	15.5%	11.4%	21.1%
Food	14.1%	15.7%	11.5%
Home/shelter	13.6%	19.3%	11.5%
Transportation	4.5%	8.4%	4.8%
Other	3.6%	3.0%	0.9%
Utilities	0.9%	3.6%	2.2%

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, followed by "medicine."
Trend data: A new option was added this year, "affordable healthcare/co-pay/deductible." This addition might have been the reason the percentage for "health insurance" decreased. "Home and shelter" responses doubled in 2017 from the results in 2014. "Medicine" and "health insurance" remain in the top two responses.
Disparities: African Americans have almost double the percentage for "transportation" than Caucasians and Native Americans and a lower percentage for "affordable health care." Native Americans have a higher percentage for "health insurance."
Impact on community: With changes to health care as part of the Affordable Care Act, people might not have understood their options fully or experienced difficulty navigating the system. The Department of Social Services assists its clients to access Medicaid and could perhaps help make that process easier for those it serves. 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."

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"?



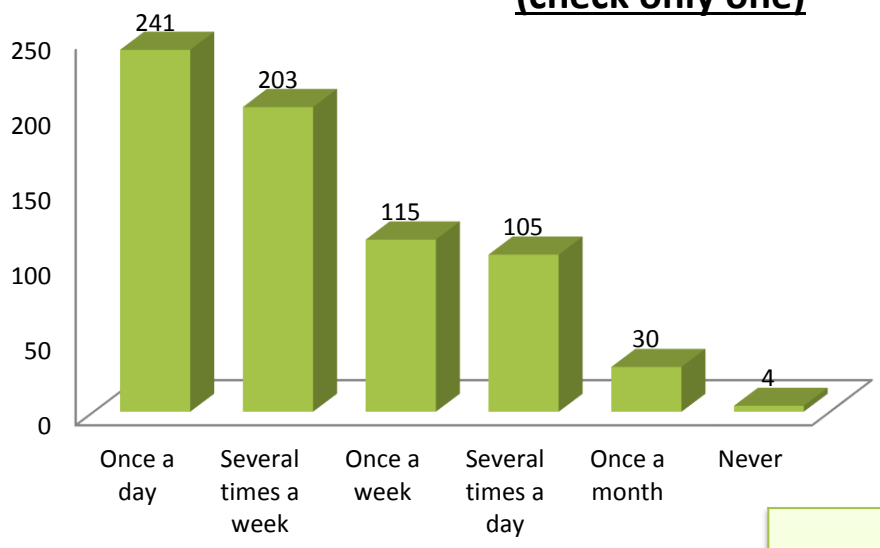
One to two (1-2) days a week	38.3%
Three to four (3-4) days a week	25.6%
Zero days	23.7%
Five (5) or more days a week	12.4%
Total Responses: 684	

Disparities

	Caucasian	African American	Native American
One to two days a week	38.20%	36.0%	39.70%
Three to four days a week	27.10%	23.60%	25.90%
Zero days	21.30%	26.10%	24.60%
Five or more days a week	13.30%	14.30%	9.80%

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 exercising. The majority of responses were "several times a week."
Trend Data: This question was reworded from the 2014 assessment and this may have caused the change in responses to "zero days," which increased. "Three-to-four days" dropped slightly but remains the second highest response rate.
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)



Once a day	34.5%
Several times a week	29.1%
Once a week	16.5%
Several times a day	15.0%
Once a month	4.3%
Never	0.6%
Total Responses: 698	

Disparities

	Caucasian	African American	Native American
Once a day	44.6%	25.1%	34.1%
Several times a week	23.2%	33.1%	33.2%
Several times a day	16.1%	18.6%	11.6%
Once a week	12.5%	19.8%	17.2%
Once a month	3.6%	4.8%	3.0%
Never	0.0%	0.06%	0.9%

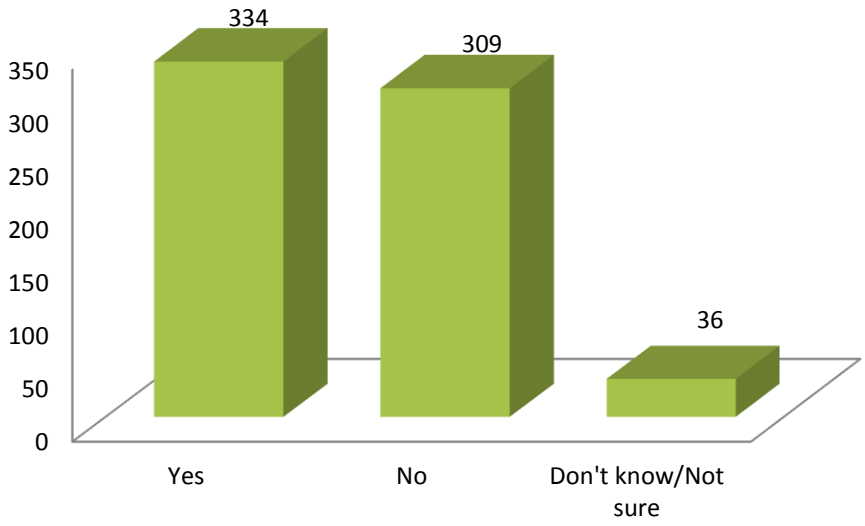
Summary: The graph and chart above show the number and percentage of the population surveyed who self-reported the amount of fruits or vegetables consumed in a month. As shown, the majority selected "once a day."

Trend: "Once a day" increased from 2014, while "several times a week" decreased. "Several times a day" dropped almost 50 percent. "Once a month" was a new option in 2017.

Disparities: "Several times a day" increased among Caucasians and Native Americans since 2014, while "once a day" increased among Caucasians. No significant disparities between races.

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. There are regional grants working with corner stores to get fresh foods to customers. Homegrown Health and a mobile food pantry work to make healthier food options more accessible to communities that need it most. Community gardening is also increasing in popularity.

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	49.2%
No	45.5%
Don't Know/Not Sure	5.3%
Total Responses:	679

Disparities

	Caucasian	African American	Native American
Yes	50.7%	43.5%	50.5%
No	45.2%	52.8%	43.6%
Don't know/not sure	4.1%	3.7%	5.9%

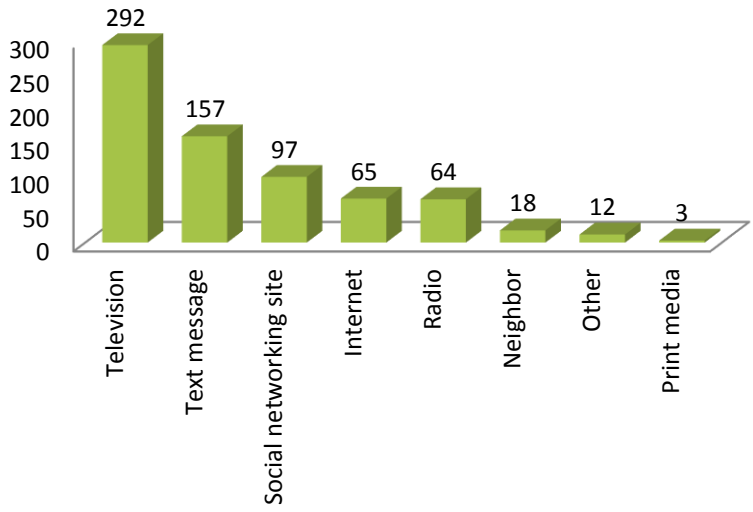
Summary: The graph and chart above show the number and percentage of the population surveyed who reported whether they have an emergency kit at home. "No" received the greatest number of responses.

Trend: No significant change from 2014 were noted.

Disparities: African Americans had a higher percentage for "no" and a lower percentage for "yes."

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. However, many residents were unprepared during Hurricane Matthew, which occurred October 2016.

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



Television	41.2%
Text Message (Emergency Alert System)	22.2%
Social networking site	13.7%
Internet	9.2%
Radio	9.0%
Neighbor	2.5%
Other	1.7%
Print Media (ex: newspaper)	0.4%
Total Responses: 708	

Disparities

	Caucasian	African American	Native American
Television	38.7%	46.7%	39.5%
Text Message (emergency alert system)	24.4%	18.9%	23.2%
Social networking site	12.4%	12.4%	14.6%
Radio	10.7%	7.1%	9.9%
Internet	8.4%	8.9%	10.3%
Other	3.6%	1.2%	0.9%
Print media (ex: newspaper)	0.9%	0%	0%
Neighbor	0.9%	4.7%	1.7%

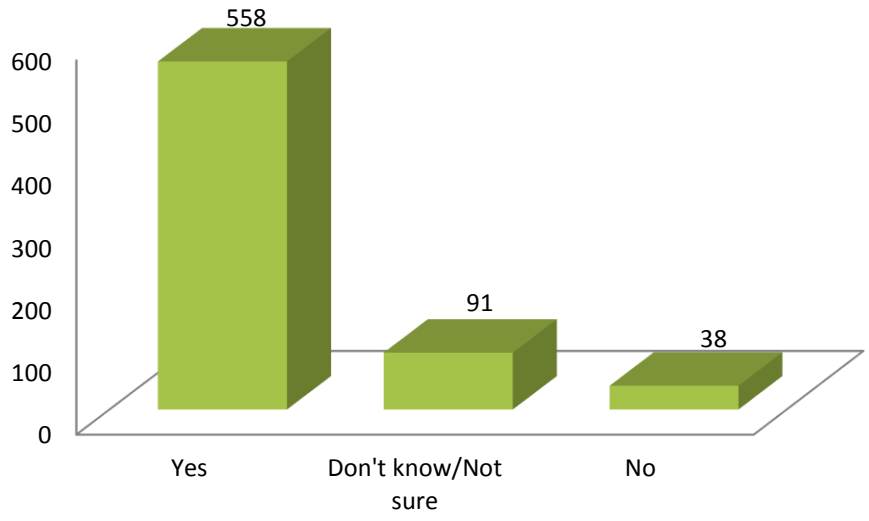
Summary: The graph and chart above show the number and percentage of the population surveyed who self-reported the best way to receive information during an emergency. As shown, “television” and “text messages” were the top two responses.

Trend: “Social networking” sites increased, while “television” and “text message” remain consistent with 2014 results.

Disparities: Native American dropped in “television” since 2014, while “social networking” and “internet” increased. No significant disparities between the races were noted.

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: If public authorities announced a mandatory evacuation from your neighborhood or community due to a large-scale disaster or emergency, would you evacuate? (check only one)



Yes	81.2%
Don't Know/Not Sure	13.2%
No	5.5%
Total Responses:	687

Disparities

	Caucasian	African American	Native American
Yes	73.3%	88.0%	83.6%
Don't know/not sure	19.5%	6.6%	11.9%
No	7.2%	5.4%	4.4%

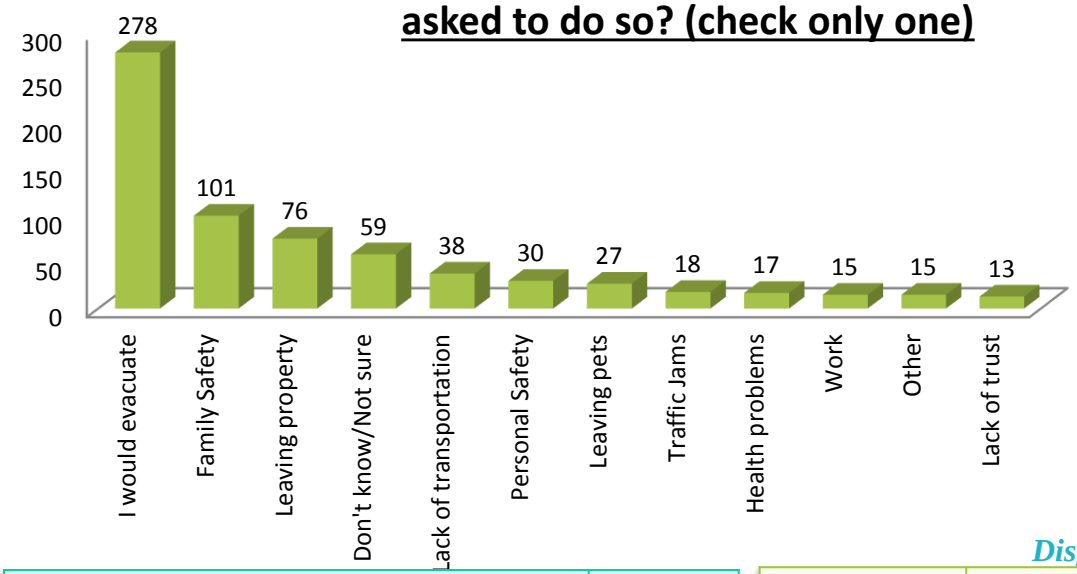
Summary: The graph and chart above show the number and percentage of the population surveyed who self-reported whether or not they would evacuate in the likelihood of an emergency. The top response was "yes."

Trend: No change since 2014.

Disparities: No significant disparities and no change from 2014.

Impact on community: Encouraging residents to reconsider why they may not evacuate in an emergency is important.

Question 18: What would be the main reason you might NOT evacuate if asked to do so? (check only one)



Not applicable, I would evacuate	40.5%
Concern about family safety	14.7%
Concern about leaving property behind	11.1%
Don't know/Not Sure	8.6%
Lack of transportation	5.5%
Concern about personal safety	4.4%
Concern about leaving pets	3.9%
Concern about traffic jams and inability to get out	2.6%
Health problems (could not be moved)	2.5%
Work	2.2%
Other	2.2%
Lack of trust in public officials	1.9%
Total Response: 687	

Summary: The graph and chart above show the number and percentage of the population surveyed who self-reported the main reason they would not evacuated if asked to do so. The top three responses were "not applicable, I would evacuate," "family safety" and "leaving property behind."

Trend: "Work" was added in 2017 as a response. "Concern about leaving property" increased from 2014 responses.

Disparities: Caucasians have a high percentage for responding that "leaving pets" behind is a reason to not evacuate. African Americans have higher percentage for "lack of transportation" for not evacuating.

Impact on community: Moving forward, it is important to address the barriers that prevent people from evacuating in order to decrease serious injury or death and minimize emergency rescue.

Disparities

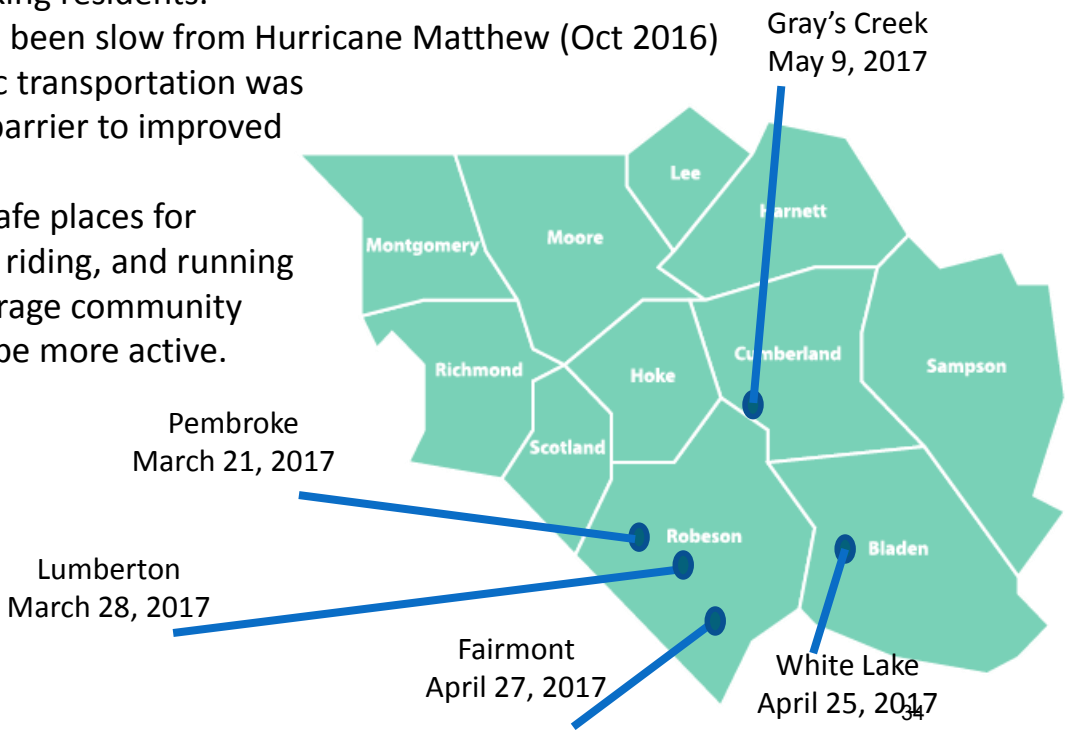
	Caucasian	African American	Native American
Not applicable, I would evacuate	37.1%	43.3%	45.5%
Concern about family safety	12.7%	15.2%	15.6%
Concern about leaving property behind	10.4%	9.8%	12.5%
Concern about leaving pets	9.5%	0.0%	0.9%
Don't know/not sure	9.0%	10.4%	7.6%
Concern about personal safety	5.0%	5.5%	2.2%
Lack of transportation	3.6%	8.5%	5.4%
Concern about traffic jams and inability to get out	2.7%	1.2%	2.2%
Health problems (could not be moved)	2.7%	2.4%	2.2%
Other	2.7%	1.8%	1.8%
Lack of trust in public officials	2.3%	1.2%	1.8%
Work	2.3%	0.6%	2.2%

Community Listening Tours

The community listening tours are another means of primary data collection designed to collect information from the community. This process serves to provide assistance to Southeastern Health's Board of Trustees in setting priorities for the strategic planning process. Additionally, Southeastern Health was able to identify community partners who will help lead our communities to better health. One system cannot change the health problems facing residents, but a strong partnership across many sections of the region can make significant improvements.

Key Findings & Suggestions

- Respondents felt that mental health services are lacking in Robeson County, making it difficult for people to get the treatment they need.
- A lack of affordable insurance/co-pay prevents residents from accessing appropriate or timely care.
- Nearby counties provide free health services for those in need, a suggestion was made to develop such services in Robeson County.
- A lack of resources for kids, youth, and the elderly leave certain segments of the population vulnerable.
- Crime and safety is major health concern.
- Churches can play a significant role in community outreach and supporting populations that have difficulty accessing services such as indigent and non-English speaking residents.
- Recovery has been slow from Hurricane Matthew (Oct 2016)
- Lack of public transportation was viewed as a barrier to improved health.
- Creation of safe places for walking, bike riding, and running would encourage community members to be more active.



Secondary Data Results

Secondary data was obtained from various local and state-level resources. Mortality data pertaining to the county's leading causes of death are featured, and infant mortality rates and reviewed as well. Morbidity and substance misuse data are cited in an effort to portray the burden of disease among our residents. Health care data illustrates the county's needs and resources and how county residents view these needs and resources. Finally determinants of health data provide an overview of the various factors influencing the health of our county's residents.

Mortality Data

According to the 2011-2015 data obtained from the State Center for Health Statistics, the 10 leading causes of death for Robeson County are the following: (1) diseases of heart, (2) cancer, (3) Alzheimer's disease, (4) cerebrovascular diseases, (5) diabetes mellitus, (6) chronic lower respiratory diseases, (7) all other unintentional injuries, (8) motor vehicle injuries, (9) homicide, (10) nephritis, nephrotic syndrome and nephrosis. Diabetes mellitus and cerebrovascular disease have moved down in rank from previous years. While Chronic lower respiratory diseases, motor vehicle injuries and homicide have moved up in rank.

Rank	Top 5 Causes of Death 2011-2015	Robeson County	NC
1	Diseases of the heart	281.1	163.7
2	Cancer	191.7	169.1
3	Alzheimer's disease	50.9	30.2
4	Chronic lower respiratory diseases	45.4	45.9
5	Diabetes mellitus	46.5	22.8

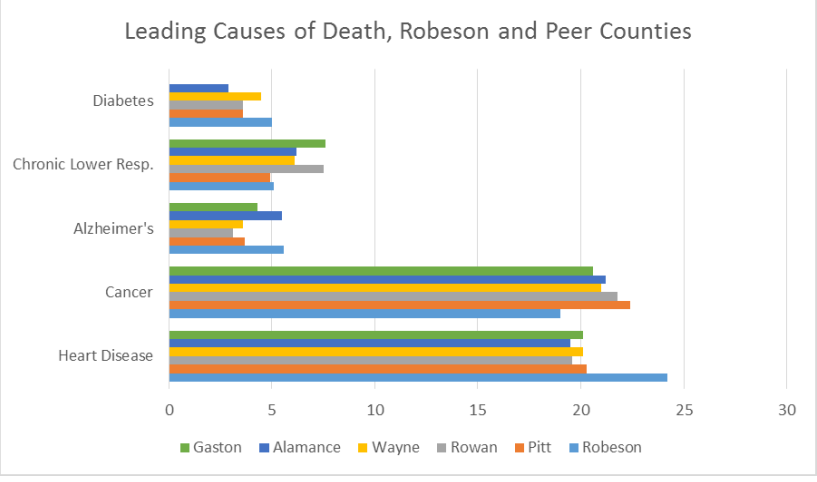
Source: State Center for Health Statistics, North Carolina

As a whole, Robeson's rates exceed the state rates. In some instances, the rates in Robeson County double those of the state, for example with diabetes mellitus. In some cases Robeson County's rates are more than double the state's, for example North Carolina's homicide rate is 5.8 while Robeson County's is 21.3.

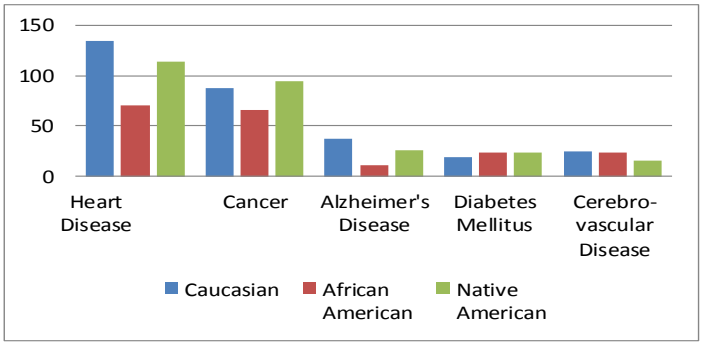
2015 Leading Causes of Death for Robeson
(*Rates per 100,000 Population)*
Peer County and Racial Comparison

Leading Causes of Death

The top five leading causes of Robeson County's deaths are, in order: heart disease, cancer, Alzheimer's, chronic lower respiratory diseases and diabetes. The North Carolina State Center for Health Statistics has identified peer counties that closely resemble Robeson County's population and other demographic variables. Robeson had higher death percentages compared to our peer counties for heart disease, Alzheimer's and diabetes.



Source: 2015 Data from the NC State Center for Health Statistics



Overall, Robeson County's minority residents tend to have higher mortality rates than the state of North Carolina. The graphs on this page illustrate the rates by race for the county's five leading causes of death. As shown, African Americans have higher cancer, diabetes and cerebrovascular disease death rates than other races & ethnic groups in the county. Caucasians report higher heart disease rates. New to the list, Native Americans report the highest rates of Alzheimer's disease. This data clearly indicates that we must continue our interventions targeting diverse populations.

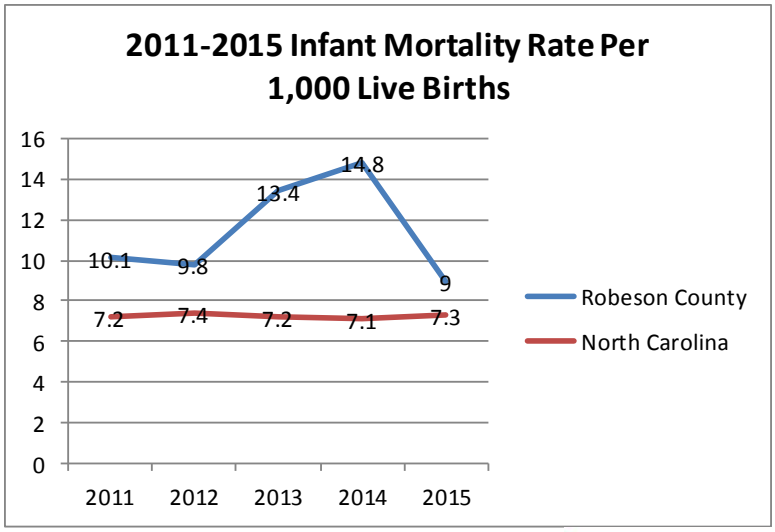
Health Rankings

The County Health Rankings report measures the health of nearly every county in the nation and are released annually from the Robert Woods Johnson Foundation. In 2016, Robeson County was ranked last in the state for health factors and health outcomes (100 being the worst). Health factor rankings are based on weighted scores of factors such as behavioral, clinical, social, economic, and environmental factors. Health outcome rankings are based on equal weighting of mortality and morbidity factors such as years of potential life lost, overall health, physical health, and mental health and birth outcomes (in this case, babies born with a low birth weight).

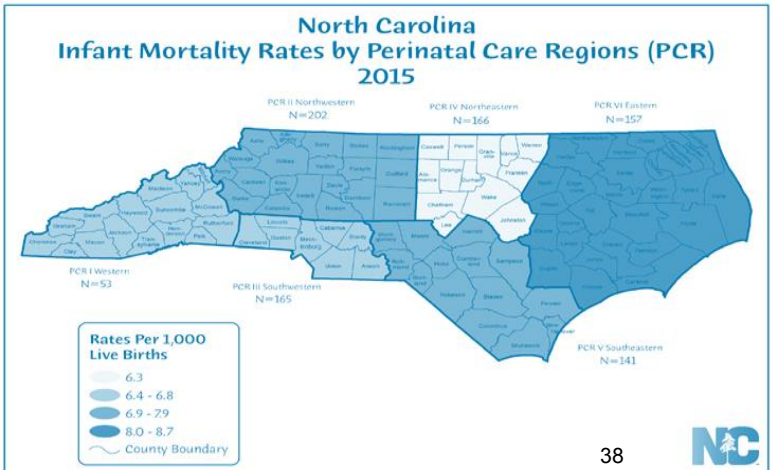
Year	Health Factor Ranking	Health Outcome Ranking
2010	100	98
2011	100	98
2012	100	99
2013	100	97
2014	100	97
2015	100	95
2016	100	100

Infant Mortality

Robeson County's infant mortality rates have decreased since 2011. The 2011 rate was 10.4 per 1,000 live births and the 2015 rate was 9. The five-year average rate (2011-2015) for Robeson was 11.42 per 1,000 live births. Although rates have slightly improved, they remain higher than the state's. The 2015 infant death rate for whites was 13.5 per 1,000 live births and the minority rates for: African Americans was 14.1. The infant mortality rate among persons of Hispanic ethnicity was 8 per 1,000 live births. Local infant mortality reduction efforts include the following programs: Pregnancy Care Management, Nurse Family Partnership, Healthy Start, and Newborn Postpartum Home Assessment. Additionally, the public health department and Southeastern Health provide SIDS education to both patients and the community at large.



Source: NC State Center for Health Statistics



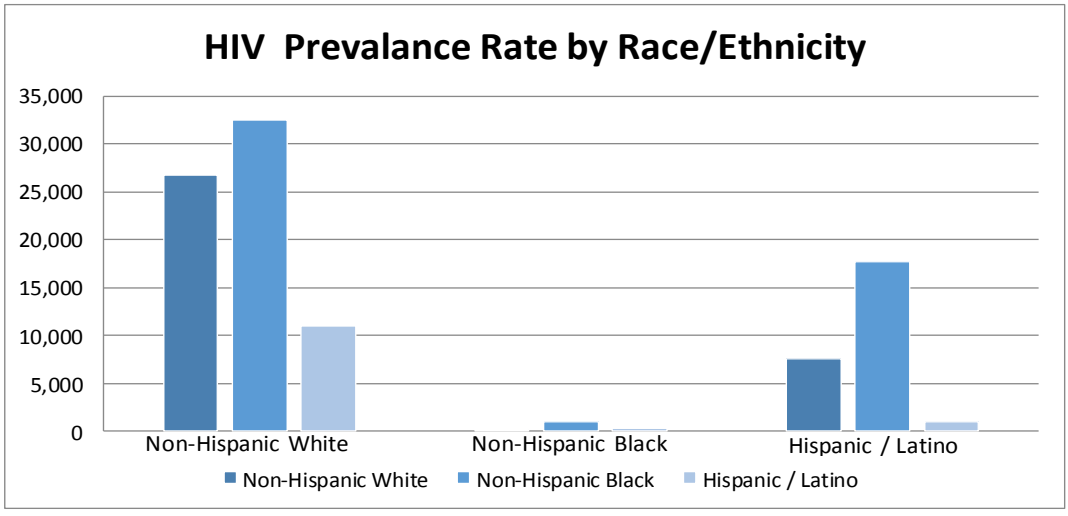
Morbidity / Disease Data

Sexually transmitted infections (STIs), including human immunodeficiency virus (HIV) infection, affect tens of thousands of North Carolinians every year. These preventable conditions can lead to reduced quality of life, premature disability and death, as well as result in millions of dollars in preventable health expenditures annually. As with many diseases and health conditions; the burden of STDs falls disproportionately on disadvantaged populations, young people, and minorities.

Report Area	Total Population	Population with HIV / AIDS	Population with HIV / AIDS, Rate (Per 100,000 Pop.)
Robeson County, NC	134,197	360	268.3
North Carolina	9,535,483	29,935	313.9
United States	326,289,788	1,107,700	339.5

The above chart shows the prevalence rate of HIV per 100,000 population.
Source: Centers for Disease Control and Prevention, National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention:2015.

Report Area	Non-Hispanic White	Non-Hispanic Black	Hispanic / Latino
Robeson County, NC	26,714	32,513	11,028
North Carolina	135.4	955.13	290.7
United States	7,570	17,670	1,013



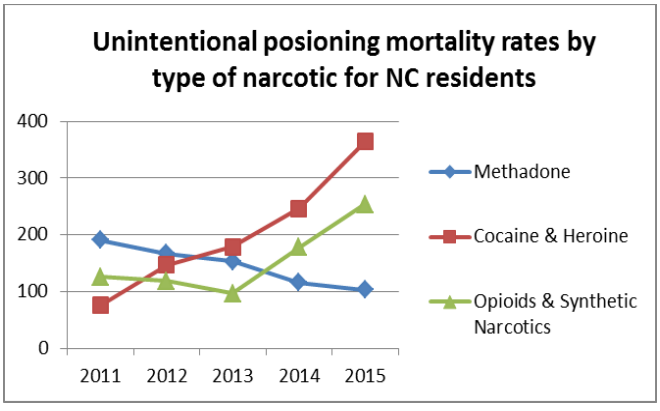
The above chart & graph shows the racial and ethnic disparities in HIV per 100,000 population.
Source: Centers for Disease Control and Prevention, National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention: 2015.

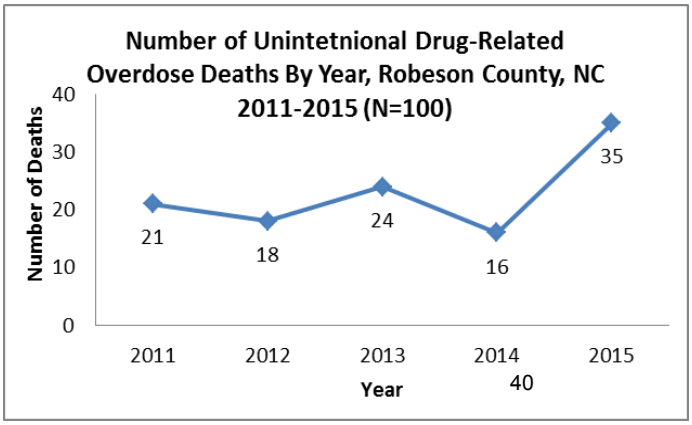
Substance Misuse

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

Obesity is a common, serious and costly epidemic in the United States. More than one-third (or 78.6 million) of U.S. adults are obese. Obesity-related conditions include heart disease, stroke, type 2 diabetes and certain types of cancer, some of the leading causes of preventable death. The estimated annual medical cost of obesity in the U.S. was $161 billion in 2010, according to the Center for Disease Control and Prevention. Forty percent of adults aged 20 and older self-report that they have a Body Mass Index (BMI) greater than 30.0 (obese) in Robeson County. Excess weight may indicate an unhealthy lifestyle and puts individuals at risk for further health issues.

Report Area	Total Population (20 and older)	Population with BMI > 30.0 (Obese levels)	Percent of Population with BMI > 30.0 (Obese levels)
Robeson County, NC	93,279	37,311	40.0%
North Carolina	9,535,483	2,870,180	30.1%
United States	225,477,982	85,005,199	37.7%

The above chart shows the rate of obese persons over 20 years old.
Source: Centers for Disease Control and Prevention, National Center for Health Statistics, National Health and Nutrition Examination Survey, 2011-2014.

Report Area	Total Males Obese	Percent Males Obese	Total Females Obese	Percent Females Obese
Robeson County, NC	33,393	35.8%	40,016	42.9%
North Carolina	2,755,754	28.9%	2,984,606	31.3%
United States	77,789,903	34.5%	86,809,023	38.5%

The above chart shows the rate of obese persons with a BMI > 30.0, males and females.
Source: Centers for Disease Control and Prevention, National Center for Health Statistics, National Health and Nutrition Examination Survey, 2011-2014.

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

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.

Chapter 5: Prevention & Health Promotion

Preventative screens, along with eating healthy, regular exercise, and avoiding tobacco are crucial ways people can stay healthy. Preventing diseases before they start helps people live longer, healthier lives and also keeps health care costs low. Some insurance policies cover preventive screens fully in order to encourage people to attend their yearly doctor visits. In Robeson County, residents are falling short of preventative screens compared to North Carolina as a whole. To address this, health education can promote the importance of preventive screens as well as the availability of this option to those who need it.

Chronic Disease Screening

Source: Behavioral Risk Factor Surveillance System

Indicator	Robeson	Wake AHEC	NC
% of Adults Without Any Regular Doctor, 2015	23.0	22.9	21.7
% of Adults Told By Doctor They Have Diabetes, 2012-2015	17.4	8.6	10.7
% of Adults Who Ever Had Either a Sigmoidoscopy or Colonoscopy, 2012-2014	66.8	76.4	73.2
% of Adults Who Have Received the Pneumonia Vaccine Ages 65+, 2012-2015	52.5	66.0	73.6
% of Women Ages 18+ Who Had a Pap Smear in the last 3 Years, 2014-2015	78.0	83.0	78.2
% of Adults Not Taking Blood Pressure Medication (When Needed), 2010-2015	18.8	21.2	19.0

Included in the above chart are prevention indicators comparing Robeson County to Wake Area Health Education Centers (Durham, Franklin, Granville, Johnston, Lee, Person, Vance, Wake, Warren counties.

In general, health education and awareness programs can help residents change individual health behaviors that can make them more susceptible to chronic diseases. Lifestyle changes can contribute toward improved health outcomes and reduced risk factors.

Chapter 6: Robeson County's Priorities

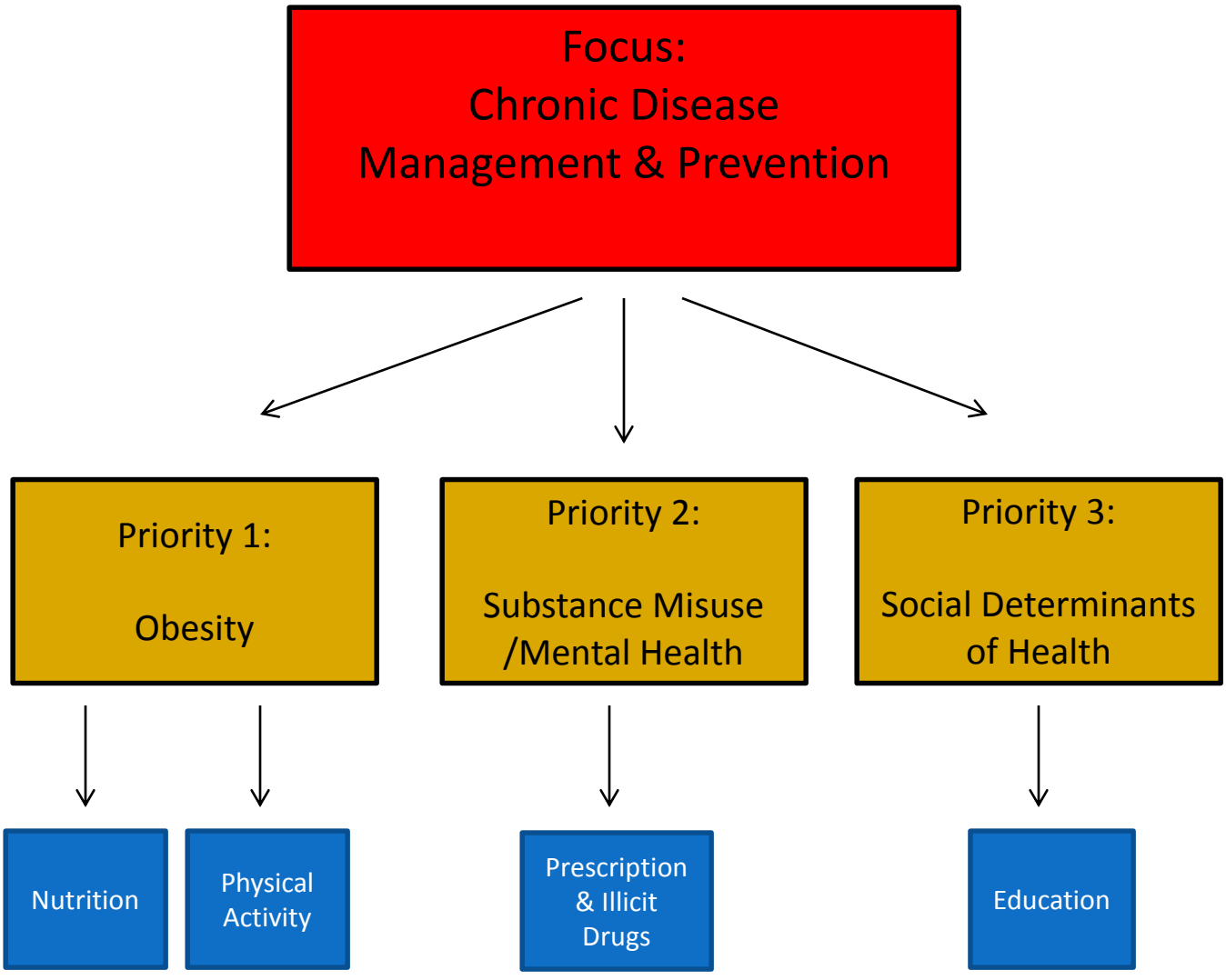
The Community Health Needs Assessment Advisory Team met in June 2017 to review the results of the community health survey and identify priority areas. Five potential priority areas were chosen on the basis of the needs identified by the health survey and each individual present was allowed three votes 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 three priority areas. (1) Obesity (2) Substance Misuse/Mental Health and (3) Social Determinants of Health. These priority areas were selected because chronic diseases continue to contribute to much of the poor health in Robeson County, substance misuse continues to be one of the self identified highest needs in the county and focusing on social determinants of health as a way of addressing underlying causes of poor health.

Robeson County's 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

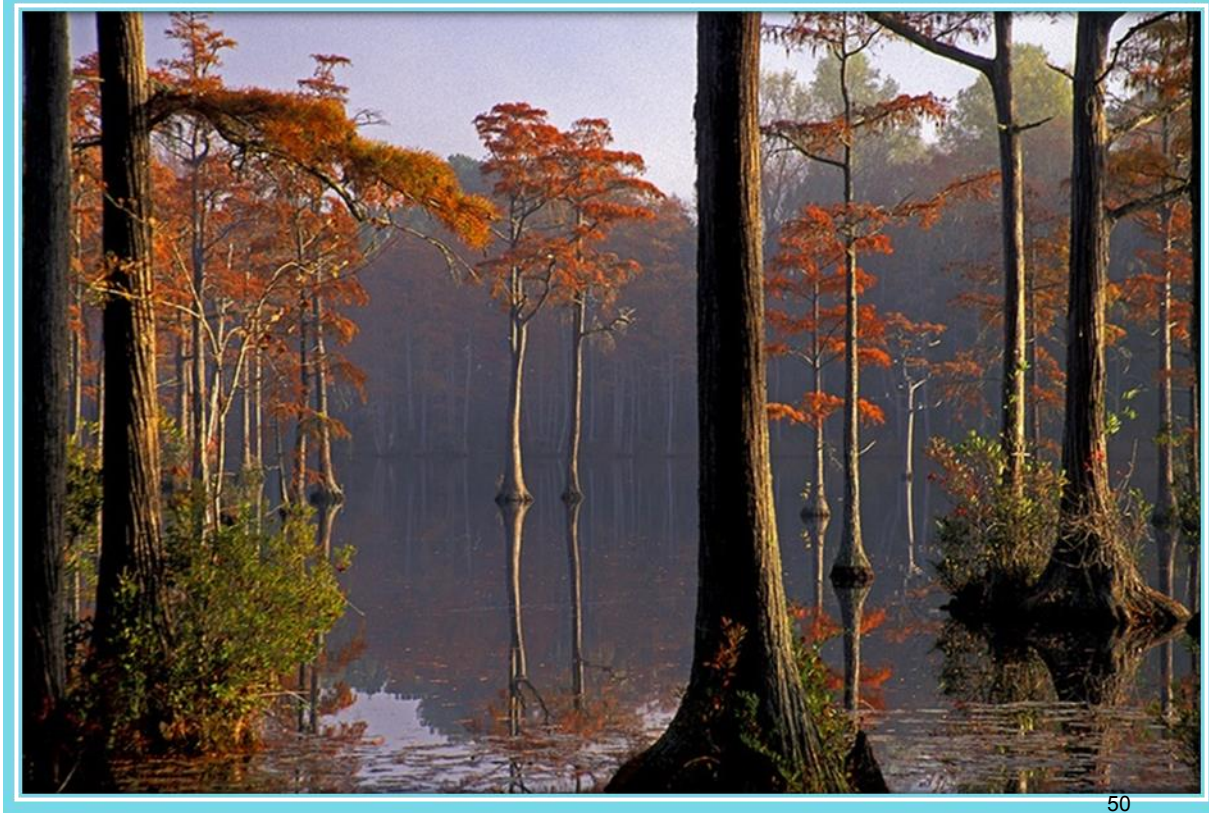
- Presentations will be conducted in the community

- Actions plans will be created for the selected priority areas. Sub-committees will be formed to implement and evaluate the strategies.

2017

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	Community Health Needs Assessment Work Group
Resamarie Bullard	Southeastern Health	Southeastern Health Intern	Secondary data researcher
Reverend Dean Carter	Southeastern Health	Coordinator, Dept. of Pastoral Care	Community Health Survey Distribution
Wesley Clark	Southeastern Health	Physician Services Administrative Assistant	Community Health Survey Distribution
Valerie Comrie	Robeson County Drug Court System	Family Drug Treatment Court Coordinator	Community Health Survey Distribution
Katina Dial-Scott	Eastpointe	Member Call Center Director	Community Health Survey Distribution
Noelle Fields	Southeastern Health Fitness Center	Manager of Fitness Services Southeastern Lifestyle Center of Red Springs	Community Health Survey Distribution
Latricia Freeman	United Way of Lumberton	Director	Community Health Needs Assessment Work Group
Marie Gaumont	UNCP	Southeastern Health Intern	Community Listening Tours
Sarah Gray	Robeson County Health Department	Health Education Supervisor	CHNA Co-Facilitator
Travis Greer	Robeson County Health Department	Regional Worksite-Faith Coordinator Obesity, Diabetes, Heart Disease, and Stroke Prevention Grant	Contributing writer
Amy Hall	Guardian Ad Litem	Guardian ad Litem District Administrator	Community Health Survey Distributor
Amy Hammond	Wesley Pines	Marketing Director	Community Health Survey Distributor
Lekisha Hammonds	Southeastern Health	Director, Community Health Services	Community Health Needs Assessment Work Group
Adam Hunt	UNCP	Southeastern Health Intern	Community Listening Tours
Cathy Hunt	Southeastern Health	Healthy People, Healthy Carolinas Grant Facilitator	Community Health Survey Distributor

Name	Agency/Community	Title	CHA Role
Darlene Jacobs	Robeson County Church and Community Center	Director	Community Health Survey Distributor
Katelynn Jacobs	Robeson County Health Department	Intern	Secondary data researcher
Michael Jimenez	Southeastern Health Fitness Center	Manager, Fitness Services	Community Health Survey Distributor
Niakeya Jones	Robeson County Housing Authority	Director	Community Health Survey Distributor
Shareen Jones	Southeastern Health/Maxton Chamber of Commerce	Coalition and Taskforce Operations Assistant	Community Health Survey Distributor
Adrienne Kennedy	The Center of H.O.P.E.	Store Manager	Contributing Writer
Dencie Lambdin	Communities in Schools of Robeson County	Executive Director	Community Health Survey Distributor
May Lample	Southeastern Health	Community Mobilization Coordinator	CHNA Co-Facilitator
Jan Lowery	Robeson County Health Department	Minority Diabetes Prevention Program Coordinator, Region 8	Community Health Survey Distributor
Whitney McFarland	Robeson County Health Department	Public Health Educator II	Community Health Needs Assessment Work Group
Jeremiah McLeod	UNCP	Southeastern Health Intern	Community Listening Tours
Melissa Memoli	Southeastern Homecare Services	Manager, Homecare Compliance	Community Health Survey Distributor
Latasha Murray	Robeson Health Care Corporation	Substance Abuse Program Director	Community Health Survey Distributor
Janice Oxendine	Robeson Health Care Corporation—Healthy Start	Health Educator	Community Health Survey Distributor

Name	Agency/Community	Title	CHA Role
Melissa Packer	Robeson County Health Department	Assistant Director	Community Health Needs Assessment Work Group
Adam Peele	UNCP	Southeastern Health Intern	Data Entry
Jael Pembrick	UNCP	Southeastern Health Intern	Community Listening Tours
Kristian Phillips	Southeastern Health	Community Health Education Center Specialist	CHNA Document Designer
Phillip Richardson	Southeastern Health	Coordinator, Community Health Services	Community Health Needs Assessment Work Group
Lekeesha Robinson	United Way of Robeson County	Community Impact Director	Community Health Needs Assessment Action Team
Leah Tietje-Davis	Robeson County Library	Adult Services Librarian	Community Health Needs Assessment Action Team
Dolores Vasquez	Robeson Health Care Corporation—Healthy Start	Program Director	Community Health Needs Assessment Action Team
Joquen White	UNCP	Southeastern Health Intern	Community Listening Tours
Cayla Winn	UNCP	Southeastern Health Intern	Community Listening Tours
Carlotta Winston	Southeastern Health	Healthy Communities Project Specialist	Community Health Survey Distributor

2017

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

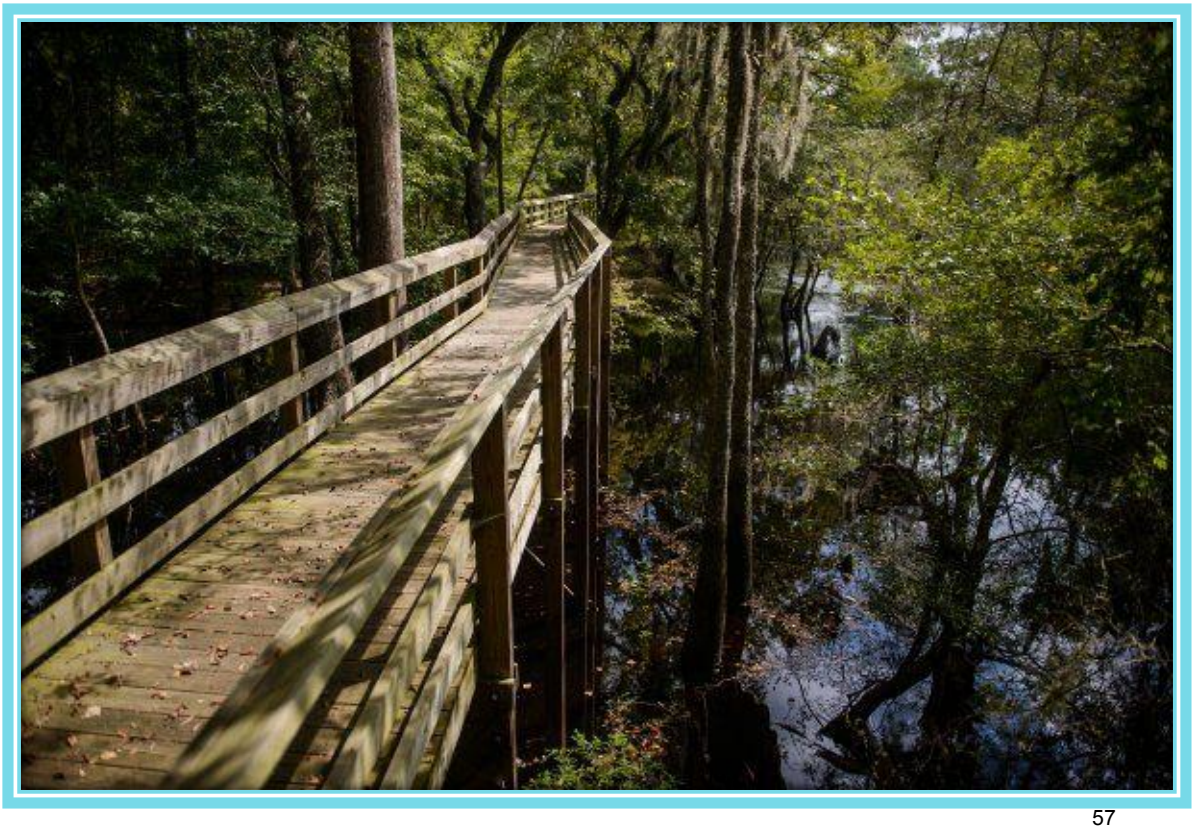
Support Groups
Alcoholics Anonymous……272-3030
Alzheimer's disease……671-5703
Bereavement……735-8887
Cancer (Breast & Reproductive)……1-877-227-9416 or 671-5730
Cancer (Prostate)……1-877-227-9416 or 671-5730
Diabetes ……618-0655
Heart disease ……671-5000 ext. 7718
Lung disease ……738-5403
Narcotics Anonymous……272-3030

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

2017

APPENDIX C:

COMMUNITY HEALTH ASSESSMENT SURVEY



2017 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) If public authorities announced a mandatory evacuation from your neighborhood or community due to a large-scale disaster or emergency, would you evacuate?
__Yes __No __Don't know/not sure

18. (Check only one) What would be the main reason you might not evacuate if asked to do so?
__Not applicable, I would __Concern about family safety __Health problems (could not be moved) __Concern about personal safety
__Lack of transportation __Don't know/not sure __Concern about traffic jams and inability to get out
__Concern about leaving property behind __Lack of trust in public officials __Concern about leaving pets __Work __Other **(please specify)**_____

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)_____

2017 Encuesta de Evaluación de Necesidades de Salud de la Comunidad del Condado de Robeson

1. **(Marque sólo una)** ¿Cómo califica usted su propia salud?
__Excelente __ Muy buena __Bueno __Mas o menos __Muy mal __ No sabe/No estoy seguro

2. **(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 pulmonary __Ninguno __Presión sanguínea alta __Artritis
__Otros **(especifique)**_____

3. **(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)**_____

4. **(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

5. **(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

6. **(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)**_____

7. **(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 cardiaca o pulmonar) __ Infecciones de transmisión sexual (sífilis, gonorrea, clamidia)
__Otros **(especifique)**_____

8. **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)**_____

9. **(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)**_____

10. **(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)**_____

11. **(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)**_____

12. **(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 economicamente accesible /Co-Pay/deducible __Utilidades/biles __Otros **(especifique)**_____

13. **(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

14. **(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

15. **(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

16. **(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)**_____

17. **(Marque sólo una)** Si las autoridades públicas anunció una evacuación obligatoria de su vecindario o comunidad a causa de un desastre a gran escala o de emergencia, habría que evacuar?
__Sí __No __No sabe/no estoy seguro

18. **(Marque sólo una)** ¿Cuál sería la principal razón por la que quizás no evacuar si lo pide?
__No aplicable, quiero __preocupación acerca de la seguridad de la familia __problemas de salud (no podría ser movido)
__Preocupación acerca de la seguridad personal __la falta de transporte __No sabe/no estoy seguro
__Preocupación por los atascos de tráfico y la imposibilidad de salir __Preocupación por dejar atrás la propiedad __La falta de confianza en los funcionarios públicos

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+

21. ¿Cuál es el código postal? _____**22**. Y/o ciudad donde vives _____

23. Mi raza es:
__Blanco/caucásico __Native America/nativos de Alaska __Isleño del Pacífico. __Black/Afro-americano
__Asian
__dos o más carreras __Otros **(especifique)**_____

23. ¿De Los Hispanos, latinos o de origen español?
__Sí __No

23. Actualmente usted tiene seguro de salud?
__Sí __No __No, pero sí en un momento anterior/trabajo anterior

23. ¿vive o trabaja en el condado de Robeson?
__ Los dos __Vivo __Trabajo
__Ninguno

23. Cuando buscan atención médica, ¿qué hospital visitar primero? **(marque sólo una)**
__Bladen County Hospital __Cape Fear Valley Hospital __First Health (Moore) Regional
__ Scotland Healthcare System
__ Southeastern Regional Medical Center/Southeastern Health __Otros **(especifique)**_____

23. ¿Dónde vas más a menudo cuando usted está enfermo? **(marque sólo una)**
__La sala de emergencias del hospital __Remedios caseros __Departamento de Salud
__Clínica de atención urgente
__Al consultorio de su medico __Farmacia /clinica rapida __Otros **(especifique)**_____

2017

APPENDIX D:

NARRATIVES

Faith-based Wellness Support

Travis Greer

Over the years the North Carolina Division of Public Health and North Carolina Cooperative Extension Service has had a dynamic duo approach in working with communities of faith in delivering evidence-based programs for health and wellness. For example, Faithful Families Eating Smart and Moving More being one of those evidence-based health programs that promotes healthy eating and physical activity in communities of faith. Resources for the program include a nine-session Faithful Families Eating Smart and Moving More curriculum and the Eating Smart and Moving More Planning Guide for Faith Communities. The curriculum is co-taught by health educators, extension associates and trained lay leaders from faith communities in small group sessions. Lay leaders bring spiritual elements into each lesson and assist faith leaders in adopting policy and environmental change for their faith communities.

To add to the dynamic duo, in 2014, Robeson County Department of Public Health/Public Health Region 8 was the sub-awardee of a grant from the North Carolina Division of Public Health: ODHDSP (Obesity, Diabetes, Heart Disease and Stroke Prevention) which funds the implementation of population-wide and priority population approaches to prevent obesity, diabetes, heart disease and stroke, and the reduction of related health disparities among adults. This funding allows for a regional worksite/faith coordinator to coordinate health and wellness efforts and funding opportunities to support policy and environmental supports in county churches and worksites across a nine county region. The coordinator is tasked to utilize the Faithful Families Program as a catalyst to partner with churches and program facilitators to facilitate and foster chronic disease prevention efforts within the faith community.

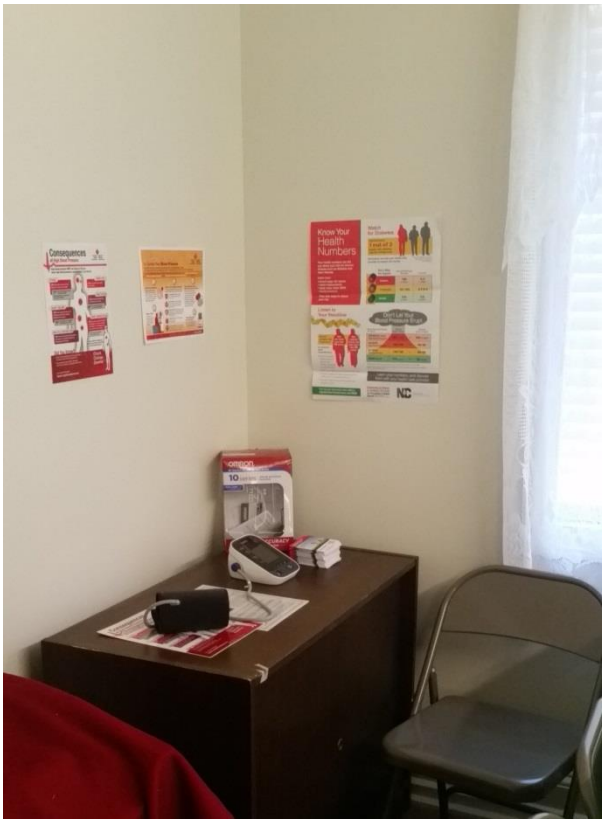
Since 2014, the Public Health Region 8 ODHDSP grant along, with invaluable Faithful Families Facilitators across the nine county regions, has partnered with seven different churches to deliver this program. A little over 100 participants have graduated the Faithful Families program and have learned the knowledge and skills to eat smart and move more, resulting in healthier lifestyles and decreased risk of chronic disease. Various policies and environmental supports adopted by these churches have had an even larger impact on the entire church congregation and community reaching 500 people.

Policy Example:
A water pitcher policy that Shoreline Baptist Church of Southport, NC adopted has been proven to make a difference in the choice of beverage that congregants choose during events at church. It's not that water was never served at the church meetings, but it was the posted policy (proclamation) that made the connection to why the church is serving water and the health/spiritual benefit it would have on one's health.

Access to: Guide to Creating a Blood Pressure Station
A self-monitoring blood pressure station was placed in two African-American churches. The reason why: About 2.7 million North Carolina adults (35%) have been diagnosed with high blood pressure by a health care professional. Assuming that national prehypertension rates also apply to North Carolina, up to an additional 2.5 million adults in North Carolina are at risk of high blood pressure. High blood pressure causes or contributes to at least 26% of all deaths in North Carolina each year. Self-monitoring blood pressure is an evidence-based strategy that can help reduce the risk of illness or death from high blood pressure.

Faithful Families

Eating Smart AND Moving More



"Compassion for U Congregational Wellness Network"

A Faith-Based Community Health and Wellness Network

Reverend 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. 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 in order to maximize the value of 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; care Transitions and navigation 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.

"Compassion for U Congregational Wellness Network"
A Faith-Based Community Health and Wellness Network

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. Network members assist with health management, facilitate communication between patients and providers, assess social and non-clinical barriers to health, and connect patients to appropriate treatment and other needed resources. The Network model incorporates a range of traditional and non-clinical health providers such as community health workers, peers, and navigators. These additional team members can help address the complex and multifaceted needs that chronically ill, underserved patients face but that may fall outside the typical clinical interaction.

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 that possess many of the same characteristics as the populations they serve. Network members use written materials, computer and web-based technologies, one-on-one or group-oriented education, counseling, and case management methods to serve individuals. Through these activities, the Network facilitates patient-centered health care and social service connections that are culturally appropriate, high-quality, and cost-effective.

Examples of our 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?; 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 Efforts to Outcomes events include: Camp Care Bereavement Experience for Children, North Carolina Med-Assist OTC Medication Giveaway, Trinity Holiness Church Health Fair, Antioch Baptist Church Health Fair, Caring and Sharing Senior Citizens Christmas Meal Gift Bags, Hurricane Matthew Critical Information and Inspiration, Hurricane Matthew Recovery, Care Connections Medical Transportation Ministry, Healthy Communities A-Z, National Healthcare Decisions Day (Advanced Directives), Joint Effort with Nurse Family Partnership post hurricane, assistance with 2017 Community Health Needs Assessment, teach Robeson Community College Nursing Students on End of Life Studies.

Hurricane Matthew

On October 7, 2016, Robeson County was hit by Hurricane Matthew. Although the hurricane hit as a Category 1, it brought with it 12-18 inches of rain, 67 mph wind, causing damage to vehicles, buildings and homes. On October 8, the water levels were dangerous, causing much of the town of Lumberton and surrounding areas to evacuate. Many residents and their animals were recused on canoe boats due to the high water and transported to one of the open shelters. The historic flooded exceeded that caused by Hurricane Floyd, the previous strongest storm to hit the area. The University of North Carolina at Pembroke housed and fed the national guard that came in for relief efforts.

The Lumber River is a 133-mile river runs through the county offers a great deal of scenery as well as recreational activities. With the continuous rainfall of the hurricane the river that typically maintained high water couldn't contain any more water. The high water resulted in numerous bridge wash outs, with over 80 road closures; portions of I-95 and Hwy 74 were closed. The accumulated water was sweeping in cars that attempted to travel. Water entered cars leaving over 5,000 cars destroyed by Hurricane Matthew resulting in having them auctioned due to the water damage.

In Robeson County alone, nearly 7,100 structures were flooded – houses, churches, schools, school operations, and businesses. Two Robeson County schools were flooded as well as the Board of Education facilities, resulting in a loss of many records, books and materials. School was not able to resume for nearly three weeks. The city of Lumberton's water plant was flooded with more than five feet of water, making the water supply unavailable. Some residents were out of water for nearly two weeks, even then still under a contamination advisory. Ninety-seven percent of Robeson County experienced power outages, with a majority without power for several days. The outages created hindrances in communication and even medical treatment.

Despite the warnings that had been issued, the county was not fully prepared to react and respond to the hurricane. In the early 1990's when the manufacturing and factory industries went overseas, unemployment skyrocketed, which translated to decreased employment and homeownership, an increased in stress related problems for families, and local businesses that remained (retail, restaurants) were then in what is called " a struggling state". Since then, jobs have not been able to be restored and family and communal life has been disrupted as a result. The hurricane only added stress to these situations as a county that has a 30% rate of poverty was struck again by economic devastation. However, Hurricane Mathew did not only cause damage but also sparked a collective response by Robeson County residents. The county is has been working as a team to better prepare and prevent the high levels of flooding. State medical agencies, relief groups, American Red Cross, and over 100 more agencies pulled together to tackle the effects of the storm.

Recovery efforts have been ongoing in the aftermath of the hurricane. The Robeson County Disaster Recovery Committee was established to develop and manage recovery efforts for individuals impacted by the hurricane. The committee provides case management services and directs individuals and families to resources. RCDRC also works collaboratively with other organizations in the county on hurricane preparedness and recovery initiatives. Although there is a dedicated committee for recovery that brings together resources and agencies, recovery efforts require all community stakeholders continued participation and any lack of participation can disrupt the recovery timeline. These phases take anywhere from months to years to be able to manage, monitor and measure a disaster in its entirety. Disaster funding has to align and be in place with an expected disaster timeline. Agencies that attend to physical and mental aspects of recovery especially need more support because they are working with populations that are hard to reach, which takes longer to ensure needs are being met.

The physical and mental damages have been increasingly addressed by faith-based groups as well as grant funding. Donations were received by many other counties as well as other states. Robeson County is still grieving the losses that Hurricane Mathew caused. Some families are still displaced, with many others having left the county with no plans to return, but the majority of families have received assistance from FEMA. Officials are analyzing strategies that will improve their response in these situations.

2017

APPENDIX E:

IMPLEMENTATION STRATEGIES

Action Plan

The 2017 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. Three priority areas were identified that required action: obesity, substance misuse and social determinants of health.

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 500 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, 2020 four chronic disease self-management workshops will take place among two African American local faith organizations and 2 Native American faith organizations. By January 1 2020, four Faithful Families workshops will be held at two African American faith organizations and two Native American faith organizations. 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. Both CATCH and 5,4,3,2,1 Go! are evidence-based interventions that teach children about healthy eating and ensure they get physical activity. By January 1 2020, seven Robeson County schools will have implemented the CATCH program. By January 1 2020, 9 Robeson County schools will have implemented the 5,4,3,2,1 Go! program.

Our second priority area will be reducing reduce the percentage of individuals aged 12 years and older reporting any illicit drug use in the past 30 days. 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. By May 31, 2020, approximately 500 individuals will be reached through the Family Drug Treatment Court, assisting residents to connect to care for substance use disorders. We will also have four medicine take back events and have trained 4 Police Department to administer naloxone to those who have overdosed.

Our third priority area will be focused on the four-year high school graduation rate and decreasing the percentage of people living in poverty. The 2016 US Census Data indicates that 30.6% of Robeson residents live in poverty; 72.9 % are high school graduates. USDA data from 2015 indicates that Robeson is consistently poor, for both adults and children. In order to address these root causes of ill health, we will offer education programs and job training through schools and the local community college. By May 31, 2018, 420 middle school students will have participated in the “WhyTry” Resilience Program. By May 31, 2019, an estimated 400 10th graders at Purnell Swett High School will have completed the Job’s for America’s Graduates (JAG) program. By May 31, 2019, Robeson Community College will implement a Single Stop Program. By May 31, 2020, Robeson County Board of Education, Board of Health and Robeson Community College will hold a joint meeting and establish a plan of action to collaborate.

Community Health Action Plan 2017

County: Robeson **Period Covered:** 2017-2020
Partnership/Health Steering Committee, if applicable: Healthy Robeson Task Force
Community Health Priority identified in the most recent CHA: yes(Obesity number 3 priority recognized by residents)
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 2013 through 2015, non-Hispanic blacks had the highest prevalence of self-reported obesity (38.1%), followed by Hispanics (31.9%) and non-Hispanic whites (27.6%). 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 2020 Objective* that most closely aligns with focus area chosen below**: Increase the percentage of adults who are neither overweight nor obese.
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: : 63.3% of population; 25.11 % African American and 38.02% Native American(approx. number= 83,000, 33,500 African Americans, 50920 Native Americans)30.5% of population
Total number of persons in the target population to be reached by this action plan: 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 2020* Focus Area Addressed:** Each of the CHA priorities selected for submission must have a corresponding *Healthy NC 2020* 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:
http://publichealth.nc.gov/hnc2020/foesummary.htm AND http://publichealth.nc.gov/hnc2020/

☐ Tobacco Use	☐ Maternal & Infant Health	☐ Social Determinants of Health
☐ Physical Activity & Nutrition	☐ Substance Abuse	☐ Environmental Health
☐ Injury	☐ Mental Health	☐ Chronic Disease
☐ Sexually Transmitted Diseases/Unintended Pregnancy	☐ Infectious Disease/Foodborne Illness	☒ Cross-cutting
	☐ Oral Health	

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:** Many of these workshops have been implemented in Robeson County faith organizations and 2 Master Trainers are available to assist with workshops	**S.M.A.R.T Goals:** By May 31 2020, 4 Chronic Disease Self-Management workshops will take place among 2 African American local faith organizations and 2 Native American faith organizations.	**Target Population(s):** African American, Native American adults **Venue:** Faith Organizations	**Resources Needed:** Monies to support Chronic Disease Self-Management workshop materials, including participant books; 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 2020, (4)Faithful Families workshops will be held at 2 African American faith organizations and 2 Native American faith organizations.	**Target Population(s):** African American Adults, Native American **Venue:** Faith Organizations	**Resources Needed:** Monies to support Chronic Disease Self-Management workshop materials, including participant books; staff time
Name of Intervention: CATCH **Community Strengths/Assets:** Southeastern Health, Robeson County Parks and Recreation and Healthy Robeson are working collaboratively to implement CATCH in 7 Robeson Schools	**S.M.A.R.T Goals:** By January 1 2020, (7) Robeson County Schools will have implemented the CATCH program.	**Target Population(s):** Elementary and middle school children **Venue:** Education	**Resources Needed:** Dedicated staff, grant monies, CATCH materials, support from school administrators
Name of Intervention: 5,4,3,2,1 Go! **Community Strengths/Assets:** Southeastern Health, Lumberton Parks and Recreation and Healthy Robeson are working collaboratively to implement 5,4,3,2,1 Go! in 9 Robeson Schools	**S.M.A.R.T Goals:** By January 1 2020, (9) Robeson County Schools will have implemented the 5,4,3,2,1 Go! Program.	**Target Population(s):** Elementary school children **Venue:** Education	**Resources Needed:** Dedicated staff, grant monies,5,4,3,2,1 Go! materials, support from school administrators

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 (mm/yy):** 09/17- December 31, 2020 **Targets health disparities: Yes**	**Individual/Interpersonal Behavior**	**Lead Agency:** Robeson County Health Department **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	Expected outcomes: 72 African Americans/ Native American community members will complete the Chronic Disease Self-Management Program(18 participants for each series of workshops) Anticipated barriers: : Providing workshops that do not interfere with holidays **List anticipated intervention team members:** Whitney McFarland, Sarah Gray Do intervention team members need additional training? No Quantify what you will do: 4 Chronic Disease series of workshops will occur **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 the 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

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): 09/17-December 31, 2020 Targets health disparities: Yes	Individual/Interpersonal Behavior Organizational/Policy Environmental Change	**Lead Agency:** Robeson County Health Department **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.	**Expected Outcomes:** At least 2 African American and 2 Native American faith organizations will adopt policy and/or environmental changes to address healthy eating and physical activity. Anticipated barriers: Dedicated staff persons to implement program and providing workshops that do not interfere with holidays/church events **List anticipated intervention team members:** Whitney McFarland, Travis Greer, Janice Fields, Sarah Gray Do intervention team members need additional training? No Quantify what you will do: 4 Faithful Families series of workshops will occur **List how agency will monitor intervention activities and feedback from participants/stakeholders: R**eports 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

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) New Setting: Schools Target population: Children enrolled in 7 Public Schools of Robeson County New Target Population: No Start Date – End Date (mm/yy): 09/17-December 31, 2020 Targets health disparities: Yes	Individual/Interpersonal Behavior Organizational/Policy Environmental Change	**Lead Agency:** Southeastern Health **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, Lumberton Lion's Club, ECU Dental, NC Highway Patrol, Robeson Sheriff's Office **Role**: Assist in the implementation of CATCH **Established partner** **How you market the intervention:** Through School administrators	**Expected Outcomes:** At least 7 Robeson County Schools will implement the CATCH program, either during or after school hours. **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 **List anticipated intervention team members:** Cathy Hunt,, Cameron Karrenbaur, Lekisha Hammonds, Phillip Richardson, Knuckles, West Lumberton, Townsend, Littlefield Middle, Pembroke Middle, Parkton, Red Springs Middle school administrators/staff **Do intervention team members need additional training?** No **Quantify what you will do:** 7 schools will implement CATCH **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 gathered evaluation forms from workshop participants and will list ideas of how to improve workshop delivery, if needed

INTERVENTIONS: SETTING & TIMEFRAME	LEVEL OF INTERVENTION CHANGE	COMMUNITY PARTNERS' Roles and Responsibilities	PLAN HOW YOU WILL EVALUATE EFFECTIVENESS
Intervention: 5,4,3,2,1 Go! New Setting: Schools Target population: Children enrolled in 9 Public Schools of Robeson County New Target Population: No Start Date – End Date (mm/yy): 09/17-December 31, 2020 Targets health disparities: Yes	Individual/Interpersonal Behavior Organizational/Policy Environmental Change	**Lead Agency:** Southeastern Health **Role:** Lead **Established partner** **Target population representative:** School Administrators, Teachers of 9 K-3 Schools **Role:** lead efforts/assist in the implementation of 5,4,3,2,1 Go! **Established partner** **Partners:** UNCP Dept. of Health Promotion, Healthy Robeson members **Role**: Assist in the implementation of 5,4,3,2,1 Go! **Established partner** **How you market the intervention:** Through School administrators	**Expected Outcomes:** 9 Robeson County K-3 Schools will implement the 5,4,3,2,1 Go! program **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 cultural attitudes to food also need to be considered. **List anticipated intervention team members:** Cameron Karrenbaur**,** Cathy Hunt, Lekisha Hammonds, Phillip Richardson, UNCP School of Health and Human Performance **Do intervention team members need additional training?** No **Quantify what you will do:** 9 Robeson County K-3 schools will implement 5,4,3,2,1 Go! **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 gathered evaluation forms from workshop participants and will list ideas of how to improve workshop delivery, if needed

Community Health Action Plan 2017

County: Robeson **Period Covered:** 2017-2020
Partnership/Health Steering Committee, if applicable: Healthy Robeson
Community Health Priority identified in the most recent CHA: Social Determinants of Health (Education)
Local Community Objective: (*Working description/name of community objective*) Improving Education, Resources and Collaboration
(check one): x **New** ___ **Ongoing** (*addressed in previous Action Plan*)
Baseline Data: *(State measure/numerical value. Include date and source of current information)*: 2016 US Census Data indicates that 30.6% of Robeson residents live in poverty; 72.9 % are high school graduates; 2015 USDA data indicates that Robeson is persistently poor, for both adults and children
For continuing objective provide the updated information: *(State measure/numerical value. Include date and source of current information)*:
Healthy NC 2020 Objective that most closely aligns with focus area chosen below: Increase the four-year high school graduation rate; Decrease the percentage of people living in poverty
Population(s)
Describe the local target population that will be impacted by this community objective: Middle and high school students enrolled in Robeson County Public Schools, School Administrators, Local Public Health Officials, Board of Education, Robeson Community College
Total number of persons in the target population specific to this action plan: 25% of the population are under the age of 18(approx.)
Total number of persons in the target population to be reached by this action plan: 420 middle school students; Purnell Swett High School 10th graders= estimated 425 students
Calculate the impact of this action plan:
(Total # in B divided by total # in A) X 100% =3% **of the target population reached by the action plan.)**
***Healthy North Carolina 2020* Focus Area Addressed:** Each of the CHA priorities selected for submission must have a corresponding *Healthy NC 2020* 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:
http://publichealth.nc.gov/hnc2020/foesummary.htm AND
http://publichealth.nc.gov/hnc2020/

☐ Tobacco Use	☐ Maternal & Infant Health	☒ Social Determinants of Health
☐ Physical Activity & Nutrition	☐ Substance Abuse	☐ Environmental Health
☐ Injury	☐ Mental Health	☐ Chronic Disease
☐ Sexually Transmitted Diseases/Unintended Pregnancy	☐ Infectious Disease/Foodborne Illness	☐ Cross-cutting
	☐ Oral Health	

Strategy/Intervention(s)	Strategy/Intervention Goal(s)	Implementation Venue(s)	Resources Utilized/Needed for Implementation
Name of Intervention: WhyTry Resilience- EVIDENCED BASED Strategy **Community Strengths/Assets**: Communities in School of Robeson County has Student Support Specialists in schools already placed; grant funded program	**S.M.A.R.T Goals:** By May 31, 2018 420 middle school students will have participated in the "WhyTry" Resilience Program	**Target Population(s):** Middle School Students, Robeson County **Venue:** 7 Middle Schools	**Resources Needed:** WhyTry Training completed by staff located in the 7 middle schools and adequate time to implement the program; continued grant support; parental and community involvement
Name of Intervention: Jobs for America's Graduates(JAG)- EVIDENCED BASED Strategy **Community Strengths/Assets:** A certified teacher will be trained in the JAG program and will be supported by Communities in Schools of Robeson County; grant funded program	**S.M.A.R.T Goals:** By May 31, 2019 Rising 10th graders at Purnell Swett High School will(estimated 400 students) will have completed the JAG program	**Target Population(s):** rising 10th graders **Venue:** Purnell Swett High School, Pembroke	**Resources Needed:** JAG Program training for one certified teacher; adequate time to implement the program; continued grant support; parental and community involvement
Name of Intervention: Supplementary Strategy(not evidenced based) Single Stop at Robeson Community College	**S.M.A.R.T Goals:** By May 31, 2019 Robeson Community College will implement a Single Stop Program	**Target Population(s):** Robeson Community College Students, Staff, Community Members	**Resources Needed:** Single Stop will serve as a resource center for students, staff and community members to provide information regarding community support services from non-profits, community agencies/organizations, etc. Participation from various organizations will be necessary to provide the Robeson Community College Community with accurate and timely resources and support services
Name of Intervention: Supplementary Strategy(not evidenced based) Joint Partnership established with Board of Education, Board of Health, Robeson Community College	**S.M.A.R.T Goals:** By May 31, 2020 Robeson County Board of Education, Board of Health, Robeson Community College will hold a joint meeting and establish a plan of action to collaborate	**Target Population(s):** Board members representing 3 boards	**Resources Needed:** Time and dedication provided by all board members; facilitator to guide discussions for a common future vision

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: WhyTry Resiliency Program **New** **Setting: Education** **Target population:** Middle Schoolers **New Target Population: Yes** **Start Date – End Date (mm/yy): 09/17-05/18** **Targets health disparities: Yes**	**Individual/Interpersonal Behavior** **Organizational/Policy**	**Lead Agency:** Communities in Schools, Robeson County **Role:** Lead **Established partner** **Target population representative:** Middle Schoolers, School Administrators **Role:** participate and support program **Established partner** **Partners:** Healthy Robeson Task Force **Role:** provide overall support **Established partner** **How you market the intervention:** Via letters, notifications to parents/guardians and through Communities in Schools; School assemblies	**Expected outcomes**: 460 Middle School Students **Anticipated barriers**: None **List anticipated intervention team members:** Communities in Schools Middle grades staff; middle school teachers, administrators, **Do intervention team members need additional training?** No **Quantify what you will do**: 460 middle school students will participate in WhyTry **List how agency will monitor intervention activities and feedback from participants/stakeholders:** Communities in Schools will monitor activities by collecting student performance measures, including social-emotional skills, student attendance, and number of in-school and out- of school suspensions, and academic performance **Evaluation**: **Please provide plan for evaluating intervention:** Pre and Post Test evaluation tool by WhyTry's Measure R to measure student social and emotional growth; Powerschool Data(collects attendance) will show attendance improvement among participants; coursework quantitatively tracked through grades, as measured by Powerschool Data
INTERVENTION: SETTING & TIMEFRAME	**LEVEL OF INTERBENTION CHANGE**	**COMMUNITY PARTNERS' Roles and Responsibilities**	**PLAN HOW YOU WILL EVALUATE EFFECTIVENESS**
Intervention: JAG Program **New** **Setting:** Education **Target population:** High School Students **New Target Population: Yes** **Start Date – End Date (mm/yy):** 09/17-09/19 **Targets health disparities: Yes**	**Individual/Interpersonal Behavior** **Organizational/Policy**	**Lead Agency:** Communities in Schools, Robeson County **Role:** Lead **Established partner** **Target population representative:** Purnell Swett Staff **Role:** Lead **Established partner** **Partners:** Healthy Robeson Task Force Role: To support and assist in the promotion of the JAG program **Established partner** **How you market the intervention:** Via school assemblies, parent/guardian notification, press releases	**Expected outcomes**: The JAG program will be implemented at Purnell Swett High School **Anticipated barriers**: None **List anticipated intervention team members:** Communities in School and Purnell Swett High School staff **Do intervention team members need additional training?** No **Quantify what you will do**: 400 students will complete the JAG program **List how agency will monitor intervention activities and feedback from participants/stakeholders: School administrators and community members will** receive information on the number of participant graduates that have enrolled in postsecondary education and/or employment **Evaluation**: **Please provide plan for evaluating intervention:** JAG pre and post tests will be administered to participants to measure effectiveness

INTERVENTION: SETTING & TIMEFRAME	LEVEL OF INTERBENTION CHANGE	COMMUNITY PARTNERS' Roles and Responsibilities	PLAN HOW YOU WILL EVALUATE EFFECTIVENESS
Intervention: One Stop at Robeson Community College **New** **Setting:** Education **Target population:** RCC Students, Staff **New Target Population: Yes** **Start Date – End Date (mm/yy): 09/17-05/19** **Targets health disparities: Yes**	**Organizational/Policy**	**Lead Agency:** Robeson Community College **Role:** Lead **Established partner** **Target population representative:** RCC students and staff **Role**: participate, provide feedback and support program **Established partner** **Partners: Healthy Robeson Task Force** **Role:** provide information from partnering agencies and organizations on services **Established partner** **How you market the intervention:** Via letters, notifications to students and staff	**Expected outcomes**: One Stop will provide a comprehensive list of area agencies/organizations and the services they provide; creating an easy access for students/staff to acquire information **Anticipated barriers:** None **List anticipated intervention team members:** Robeson Community College staff; Healthy Robeson Task Force members, community representatives **Do intervention team members need additional training?** No **Quantify what you will do:** At least 25 Robeson County organizations will provide information for the One Stop program **List how agency will monitor intervention activities and feedback from participants/stakeholders:** Robeson Community College will provide updates at Healthy Robeson Task Force meetings on student and staff usage **Evaluation:** **Please provide plan for evaluating intervention:** Qualitative feedback will be provided by Robeson Community College students and staff after 1 year of implementation to determine if improvements/modifications need to be made
INTERVENTION: SETTING & TIMEFRAME	**LEVEL OF INTERBENTION CHANGE**	**COMMUNITY PARTNERS' Roles and Responsibilities**	**PLAN HOW YOU WILL EVALUATE EFFECTIVENESS**
Intervention: Joint Board Collaborative Project (Board of Education, Board of Health, Robeson Community College) **New** **Setting:** Education/Health **Target population:** Board members from 3 organizations **New Target Population: Yes** **Start Date – End Date (mm/yy): 09/17-05/2020** **Targets health disparities: Yes**	**Organizational/Policy**	**Lead Agency:** Robeson County Board of Health **Role:** Lead **Established partner** **Target population representative:** Board Chairs and Vice Chairs, Board Members **Role:** participate, provide feedback and support future collaborative interventions **Established partner** **Partners:** Healthy Robeson **Role:** provide updates/ information to task force members **Established partner** **How you market the intervention:** Board of Health members will host initial joint meeting- notifications through email, letters	**Expected outcomes**: A joint board will identify and plan future interventions that will allow increased collaboration among all 3 board members **Anticipated barriers:** Barriers include convening all 3 boards at one time; planning will need to include ample notification for meetings so that board members can plan accordingly **List anticipated intervention team members:** Robeson County Board of Health, Board of Education and Community College Board **Do intervention team members need additional training?** Training will need to include an emphasis on collaborations and how to develop a strategic plan **Quantify what you will do:** The joint board members will develop a strategic plan **List how agency will monitor intervention activities and feedback from participants/stakeholders:** Robeson Community College will provide updates at Healthy Robeson Task Force meetings on progress **Evaluation:** **Please provide plan for evaluating intervention:** A joint strategic plan that is developed and adopted for implementation

Community Health Action Plan 2017

County: Robeson **Period Covered:** 2017-2020

Partnership/Health Steering Committee, if applicable: Healthy Robeson

Community Health Priority identified in the most recent CHA: yes(Substance Misuse recognized as number 2 concern of residents)

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 2020 Objective that most closely aligns with focus area chosen below: Reduce the percentage of individuals aged 12 years and older reporting any illicit drug use in the past 30 days.

Describe the local target population that will be impacted by this community objective:

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 2020* Focus Area Addressed:** Each of the CHA priorities selected for submission must have a corresponding *Healthy NC 2020* 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:*
http://publichealth.nc.gov/hnc2020/foesummary.htm **AND**
http://publichealth.nc.gov/hnc2020/

☐ Tobacco Use	☐ Maternal & Infant Health	☐ Social Determinants of Health
☐ Physical Activity & Nutrition	☒ Substance Abuse	☐ Environmental Health
☐ Injury	☐ Mental Health	☐ Chronic Disease
☐ Sexually Transmitted Diseases/Unintended Pregnancy	☐ Infectious Disease/Foodborne Illness	☐ Cross-cutting
	☐ Oral Health	

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:** Work around substance abuse prevention has occurred for the past 5 years	**S.M.A.R.T Goals:** By May 31 2020, 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 Healthcare Corporation, Robeson Department of Social Services, Robeson County law enforcement, Healthy Robeson
Name of Intervention: Increase the number of drug takeback events	**S.M.A.R.T Goals:** By May 31, 2020 4 takeback events will have occurred	**Target Population(s):** Community at large **Venue:** Robeson Law Enforcement	**Resources Needed:** Resources from Lockyourmeds.org; Robeson County Safekids, Local Law Enforcement

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 **New** **Setting: Community at large** **Target population: residents 18 years and older** **New Target Population: No** **Start Date – End Date (mm/yy): 09/17-05/2020** **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 partner** **Partners:** Local judicial representatives, department social services, Parents as Teachers, Healthy Robeson Task Force **Role:** Participating with Drug Court Interventions **Established partner** **How you market the intervention:** DSS, local law enforcement/judicial Healthy Robeson Task Force	**Expected outcomes**: 500 Robeson residents will participate in Family Drug Treatment Court **Anticipated barriers**: Working with local law enforcement and families could be difficult **List anticipated intervention team members:** Robeson Healthcare 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 Task Force **Evaluation**: **Please provide plan for evaluating intervention:** Evaluation based on outcome- 500 participants complete the family drug court program

INTERVENTION: SETTING & TIMEFRAME	LEVEL OF INTERBENTION CHANGE	COMMUNITY PARTNERS' Roles and Responsibilities	PLAN HOW YOU WILL EVALUATE EFFECTIVENESS
Intervention: Project Lazarus/Policy for administering Naloxone **New Ongoing Completed** **Setting: Law enforcement** **Target population: community at large** **New Target Population:** Yes **Start Date – End Date (mm/yy): 09/17-05/20** **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, Substance Misuse Awareness & Recovery Taskforce **Role: Co- Leads** **New partner** **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** **New partner** **How you market the intervention:** Local media, Substance Misuse Awareness & Recovery Taskforce	**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:** 1 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 local substance misuse recovery task force **Evaluation:** **Please provide plan for evaluating intervention:** Evaluation based on policy adoption

2017

APPENDIX F:

TOBACCO

TOBACCO FREE / SMOKE FREE HOUSING IN REGION 8.

	# of units	Type of housing
BLADEN		
Elm Tree	28	USDA Rural for Elderly
No website	910 647-2973	10759 College Street, Clarkton
(Smoke free on outside common areas with a designated smoking area)		
Dogwood Apartments	8	Family, USDA Rural Development Section 515 Rural Rental Housing
www.landura.com	910 863-4989	312 Ivey Street, Bladenboro
(Smoke Free Campus)		
Woodcroft	32	USDA Rural for Elderly
No website	910 862-6241	209 Mercer Mill Road, Elizabethtown
(Smoke free on outside common areas with a designated smoke area)		
Tall Oaks Apartments	28	USDA Rural for Elderly
No website	910 401-3391	502 Tall Oak Drive, Elizabethtown
(Note- 100% smoke free on common and private indoor and outdoor private and common, smoking allowed across ditch on undeveloped property)		
Gooden Village	24	Private, USDA Rural Renter, Assistance, Elderly
goodenvillage@partnershippm.com	910 862-6230	412-A Swanzy Street, Elizabethtown
(Smoke free apartments with 25 foot perimeter)		
Swanzy Ridge	40	Private, Family
swanzyridge@centurylink.net	910 862-3014	402 Swanzy Ridge Way, Elizabethtown
(Note- four of five apartment buildings are indoor smoke free with smoking on outdoor common areas, no single designated common areas)		
Oak Estates	56	Private, Section 8, USDA Rural Renter, Elderly
mcleod.village@gmail.com	910 862-3339	620 McLeod St., Elizabethtown
(Smoke Free with Twenty Foot Perimeter)		
Hilltop Apartments	22	Private, USDA Rural Renter, Family
hilltopestatesapts@gmail.com	910 862-2872	680 Smith Circle Elizabethtown
(Smoke Free with Twenty Foot Perimeter)		
Hill Estates I Apartments	22	Private, USDA Rural Renter, Elderly
villagestreetapts@gmail.com	910-862-4491	208 Village Street, Bladenboro
(Smoke Free with Twenty Foot Perimeter)		

Rosewood I Estates 40 Private, USDA Rural Renter, Elderly
rosewoodestatesapts@gmail.com 910-862-8436 549 NC Hwy 410, Dublin
(Smoke Free with Twenty Foot Perimeter)

Rosewood II Estates 16 Private, USDA Rural Renter, Elderly
rosewoodestatesapts@gmail.com 910-862-8436 549 NC Hwy 410, Dublin
(Smoke Free with Twenty Foot Perimeter)

Mercer Road Apartments 44 Private, USDA Rural Renter, Family
hilltopestatesapts@gmail.com 910 862-3339 680 Smith Circle, Elizabethtown
(Smoke Free with Twenty Foot Perimeter)

Village Street 24 Private, USDA Rural Renter, Elderly
villagestreetapts@gmail.com 910-863-4491 208 Village Street 4D, Bladenboro
(Smoke Free with Twenty Foot Perimeter)

BRUNSWICK
Abbington Oaks 72 Private, Family
www.greystar.com 910 477-6305 4744 Abbington Oaks Way, Southport
(Tobacco Free Campus)

Alan Holden Vacations 241 Private, Family
www.Vacations@Alan HoldenVacations.com 910 842-6061 128 Ocean Blvd West, Holden Beach
(Smoke Free Office and Rentals)

Arbor Landing at Ocean Isle 70 Private, Elderly
acausey@ridgecare.com 910 754-8080 5490 Arbor Branch Drive SW,
Shallotte
(Smoke free indoors all buildings)

Better Beach Rentals 267 Private, Family
www.betterbeachrentals.com 910 278-1147 8601 East Oak Island Drive, Oak Island
(100 % Tobacco Free)

Birch
Pond Apartments 24 Private, Family
www.birchpondapts.com 910 755 0600 5 Birch Pond Drive, Shallotte
(Tobacco Free all interior public areas, designated outside smoking areas)

Brunswick Village 30 Private, HUD subsidized Section 8, Elderly
brunswickvillage@wcsites.net 910 457-4495 249 East 11th Street, Southport
(Smoke free in indoor areas, expanded to 20 foot perimeter)

Brunswickland Realty 117 Private, Family
www.brunswicklandrealty.com 910 842-6949 123 Ocean Blvd West, Holden Beach
(Tobacco Free rentals)

Coastal Vacation Resorts at Holden Beach 230 Private, Family
www.CoastalVacationResorts.com 910 846-4726 131 Ocean Blvd. West, Holden Beach
(Smoke Free buildings)

6/27/2017

NORTH CAROLINA COUNTYWIDE 100% TOBACCO-FREE OR SMOKE-FREE WRITTEN REGULATIONS

LEGEND:

- ☑ 100% Tobacco Free Policy
- ☑ 100% Smoke Free Policy
- ⊗ No Written Regulation or Less than 100% Written Regulation

Tobacco Prevention and Control Branch

		Local Health Dept. Region	Government Buildings	Government Vehicles	Government Grounds	Gov't-Owned Parks Only	Recreation Areas	Public Places
BLADEN	8	☑	☑	☑	☑	☑	⊗	
BRUNSWICK	8	☑	☑	⊗	⊗	⊗	⊗	
COLUMBUS	8	☑	⊗	⊗	⊗	⊗	⊗	
DUPLIN	8	☑	⊗	⊗	⊗	⊗	⊗	
NEW HANOVER	8	☑	☑	⊗	⊗	⊗	⊗	
ONSLOW	8	☑	☑	⊗	⊗	⊗	⊗	
PENDER	8	☑	☑	⊗	⊗	⊗	⊗	
ROBESON	8	☑	⊗	⊗	⊗	☑	⊗	
SAMPSON	8	☑	⊗	⊗	⊗	⊗	⊗	
TOTAL # OF PLACES STATEWIDE		82	59	19	27	32	2	

Definitions: *Government Buildings- area owned, leased, and occupied by the County; Government Vehicles-passenger-carrying vehicles owned, leased, or otherwise controlled by the County; Government Grounds-unenclosed area owned, leased or occupied by the County; Government-Owned Parks- any tract of land or body of water comprising part of the County's parks system; Recreation Areas- includes recreational fields, athletic fields, gymnasiums, etc.; Public Places- an enclosed area to which the public is invited or in which the public is permitted*

Note: *Table based on current policies that have been passed and reported to the TPCB and therefore does not reflect the status of ongoing efforts by counties to pass legislation. For resources and guidance on implementing Smoke-Free and Tobacco-Free policies, see the Local Government Implementation Toolkit (www.tobaccopreventionandcontrol.ncdhhs.gov/lgtoolkit).*

Source: *Information updated on a regular basis. Please contact NC TPCB at 919-707-5400 with questions, or to provide updated information. Visit www.tobaccopreventionandcontrol.ncdhhs.gov/ for more information.*

NORTH CAROLINA MUNICIPALITY 100% TOBACCO-FREE OR SMOKE-FREE WRITTEN REGULATIONS

LEGEND:

- ☑ 100% Tobacco Free Policy
- ☑ 100% Smoke Free Policy
- ⊗ No Written Regulation or Less than 100% Written Regulation

TPC Tobacco Prevention and Control Branch

	County	Local Health Dept. Region	Gov't Buildings	Gov't Vehicles	Gov't Grounds	Gov't-Owned Parks Only	Recreation Areas	Public Places
Bladenboro	BLADEN	8	⊗	⊗	⊗	⊗	⊗	⊗
Clarkton	BLADEN	8	⊗	⊗	⊗	⊗	⊗	⊗
Dublin	BLADEN	8	⊗	⊗	⊗	⊗	⊗	⊗
East Arcadia	BLADEN	8	⊗	⊗	⊗	⊗	⊗	⊗
Elizabethtown	BLADEN	8	⊗	⊗	⊗	☑	☑	⊗
Tar Heel	BLADEN	8	⊗	⊗	⊗	⊗	⊗	⊗
White Lake	BLADEN	8	☑	⊗	⊗	⊗	⊗	⊗
Bald Head Island	BRUNSWICK	8	☑	☑	☑	⊗	⊗	⊗
Belville	BRUNSWICK	8	☑	⊗	⊗	⊗	⊗	⊗
Boiling Spring Lakes	BRUNSWICK	8	☑	⊗	⊗	⊗	⊗	⊗
Bolivia	BRUNSWICK	8	⊗	⊗	⊗	⊗	⊗	⊗
Brunswick	BRUNSWICK	8	☑	⊗	⊗	⊗	⊗	⊗
Calabash	BRUNSWICK	8	⊗	⊗	☑	⊗	⊗	⊗
Carolina Shores	BRUNSWICK	8	☑	☑	⊗	⊗	⊗	⊗
Caswell Beach	BRUNSWICK	8	⊗	⊗	⊗	⊗	⊗	⊗
Holden Beach	BRUNSWICK	8	☑	⊗	⊗	⊗	⊗	⊗
Leland	BRUNSWICK	8	☑	☑	☑	☑	☑	⊗
Navassa	BRUNSWICK	8	⊗	⊗	⊗	⊗	⊗	⊗
Northwest	BRUNSWICK	8	⊗	⊗	⊗	⊗	⊗	⊗
Oak Island	BRUNSWICK	8	⊗	⊗	⊗	⊗	⊗	⊗
Ocean Isle Beach	BRUNSWICK	8	☑	☑	⊗	☑	☑	⊗
Saint James	BRUNSWICK	8	☑	☑	⊗	⊗	⊗	⊗
Sandy Creek	BRUNSWICK	8	⊗	⊗	⊗	⊗	⊗	⊗
Shallotte	BRUNSWICK	8	☑	⊗	☑	⊗	⊗	⊗
Southport	BRUNSWICK	8	⊗	⊗	⊗	⊗	⊗	⊗
Sunset Beach	BRUNSWICK	8	☑	☑	⊗	⊗	⊗	⊗
Varnamtown	BRUNSWICK	8	⊗	⊗	⊗	⊗	⊗	⊗
Boardman	COLUMBUS	8	⊗	⊗	⊗	⊗	⊗	⊗
Bolton	COLUMBUS	8	⊗	⊗	⊗	⊗	⊗	⊗
Cerro Gordo	COLUMBUS	8	☑	⊗	⊗	⊗	⊗	⊗
Chadbourn	COLUMBUS	8	☑	⊗	☑	⊗	⊗	⊗
Fair Bluff	COLUMBUS	8	☑	⊗	⊗	⊗	⊗	⊗
Lake Waccamaw	COLUMBUS	8	☑	⊗	⊗	⊗	⊗	⊗
Sandyfield	COLUMBUS	8	☑	⊗	⊗	⊗	⊗	⊗
Tabor City	COLUMBUS	8	⊗	⊗	⊗	⊗	⊗	⊗
Whiteville	COLUMBUS	8	☑	☑	⊗	⊗	⊗	⊗

6/27/2017

LEGEND:

- ☑ 100% Tobacco Free Policy
- ☑ 100% Smoke Free Policy
- ⊗ No Written Regulation or Less than 100% Written Regulation

	County	Local Health Dept. Region	Gov't Buildings	Gov't Vehicles	Gov't Grounds	Gov't-Owned Parks Only	Recreation Areas	Public Places
Beulaville	DUPLIN	8	⊗	⊗	⊗	⊗	⊗	⊗
Calypso	DUPLIN	8	⊗	⊗	⊗	⊗	⊗	⊗
Greenevers	DUPLIN	8	⊗	☑	⊗	⊗	⊗	⊗
Kenansville	DUPLIN	8	⊗	⊗	⊗	⊗	⊗	⊗
Magnolia	DUPLIN	8	⊗	⊗	⊗	⊗	⊗	⊗
Rose Hill	DUPLIN	8	⊗	⊗	⊗	⊗	⊗	⊗
Teachey	DUPLIN	8	⊗	⊗	⊗	⊗	⊗	⊗
Wallace	DUPLIN	8	☑	⊗	⊗	⊗	⊗	⊗
Warsaw	DUPLIN	8	⊗	⊗	⊗	⊗	⊗	⊗
Faison	DUPLIN/SAMPSON	8	⊗	⊗	⊗	⊗	⊗	⊗
Carolina Beach	NEW HANOVER	8	☑	⊗	⊗	⊗	⊗	⊗
Kure Beach	NEW HANOVER	8	⊗	⊗	⊗	⊗	⊗	⊗
Wilmington	NEW HANOVER	8	☑	☑	⊗	⊗	☑	⊗
Wrightsville Beach	NEW HANOVER	8	☑	⊗	⊗	⊗	⊗	⊗
Holly Ridge	ONSLOW	8	☑	⊗	☑	⊗	⊗	⊗
Jacksonville	ONSLOW	8	☑	☑	⊗	⊗	⊗	⊗
North Topsail Beach	ONSLOW	8	☑	☑	⊗	⊗	⊗	⊗
Richlands	ONSLOW	8	☑	⊗	⊗	⊗	⊗	⊗
Swansboro	ONSLOW	8	⊗	⊗	⊗	⊗	⊗	⊗
Atkinson	PENDER	8	⊗	⊗	⊗	⊗	⊗	⊗
Burgaw	PENDER	8	☑	⊗	⊗	⊗	⊗	⊗
Saint Helena	PENDER	8	⊗	⊗	⊗	⊗	⊗	⊗
Surf City (Part)	PENDER	8	☑	⊗	⊗	⊗	⊗	⊗
Topsail Beach	PENDER	8	⊗	⊗	⊗	⊗	⊗	⊗
Watha	PENDER	8	⊗	⊗	⊗	⊗	⊗	⊗
Fairmont	ROBESON	8	⊗	⊗	⊗	⊗	⊗	⊗
Lumber Bridge	ROBESON	8	⊗	⊗	⊗	⊗	⊗	⊗
Lumberton	ROBESON	8	⊗	⊗	⊗	⊗	⊗	⊗
Marietta	ROBESON	8	⊗	⊗	⊗	⊗	⊗	⊗
Maxton	ROBESON	8	⊗	⊗	⊗	⊗	⊗	⊗
McDonald	ROBESON	8	⊗	⊗	⊗	⊗	⊗	⊗
Orrum	ROBESON	8	⊗	⊗	⊗	⊗	⊗	⊗
Parkton	ROBESON	8	☑	⊗	⊗	⊗	⊗	⊗
Pembroke	ROBESON	8	☑	⊗	⊗	⊗	⊗	⊗
Proctorville	ROBESON	8	⊗	⊗	⊗	⊗	⊗	⊗
Raynham	ROBESON	8	⊗	⊗	⊗	⊗	⊗	⊗
Red Springs	ROBESON	8	⊗	⊗	⊗	⊗	⊗	⊗
Rennert	ROBESON	8	⊗	⊗	⊗	⊗	⊗	⊗
Rowland	ROBESON	8	⊗	⊗	⊗	⊗	⊗	⊗

6/27/2017

LEGEND:

☑ 100% Tobacco Free Policy

☑ 100% Smoke Free Policy

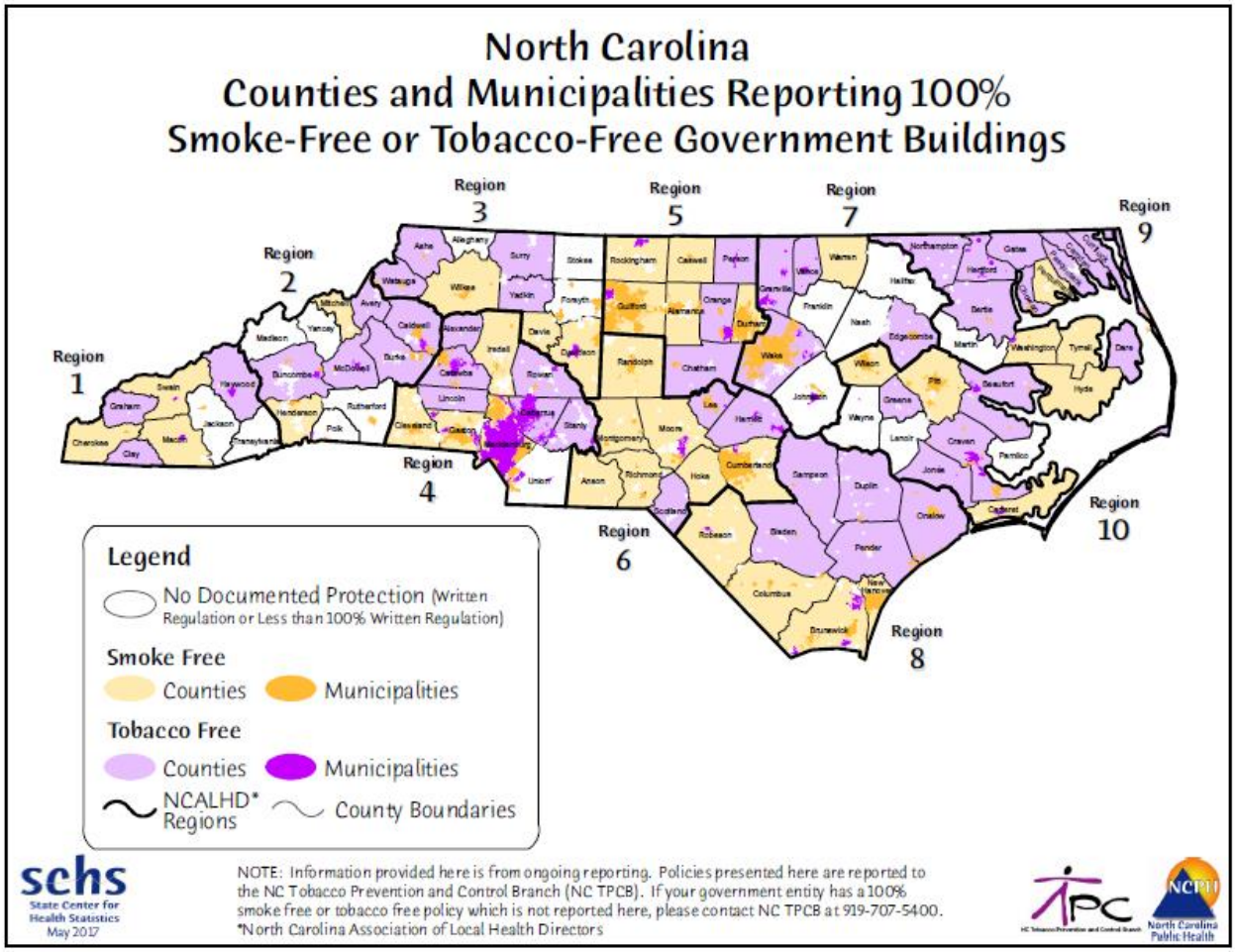
⊗ No Written Regulation or Less than 100% Written Regulation

	County	Local Health Dept. Region	Gov't Buildings	Gov't Vehicles	Gov't Grounds	Gov't-Owned Parks Only	Recreation Areas	Public Places
Saint Pauls	ROBESON	8	⊗	⊗	⊗	⊗	⊗	⊗
Autryville	SAMPSON	8	⊗	⊗	⊗	⊗	⊗	⊗
Clinton	SAMPSON	8	⊗	⊗	⊗	⊗	⊗	⊗
Garland	SAMPSON	8	☑	☑	☑	⊗	⊗	☑
Newton Grove	SAMPSON	8	⊗	⊗	⊗	⊗	⊗	⊗
Roseboro	SAMPSON	8	☑	☑	⊗	⊗	⊗	⊗
Salemburg	SAMPSON	8	⊗	⊗	⊗	⊗	⊗	⊗
Turkey	SAMPSON	8	⊗	⊗	⊗	⊗	⊗	⊗
Harrells	SAMPSON	8	⊗	⊗	⊗	⊗	⊗	⊗
TOTAL # OF PLACES STATEWIDE			228	151	68	95	92	10

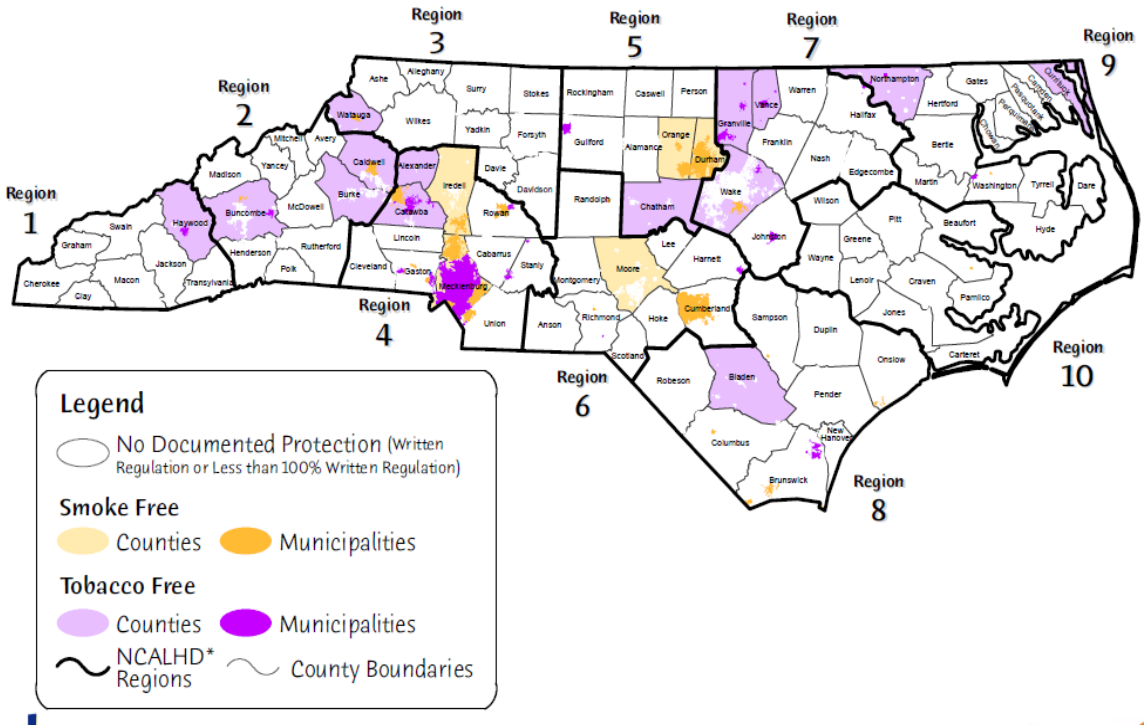
Definitions: Government Buildings- area owned, leased, and occupied by the Municipality; Government Vehicles-passenger-carrying vehicles owned, leased, or otherwise controlled by the Municipality; Government Grounds-unenclosed area owned, leased or occupied by the Municipality; Government-Owned Parks- any tract of land or body of water comprising part of the Municipality's parks system; Recreation Areas- includes recreational fields, athletic fields, playgrounds, etc.; Public Places- an enclosed area to which the public is invited or in which the public is permitted

Note: Table based on current policies that have been passed and reported to the TPCB and therefore do not reflect the status of ongoing efforts by counties to pass legislation. For resources and guidance on implementing SF and TF policies, see the Local Government Implementation Toolkit (http://www.tobaccopreventionandcontrol.ncdhhs.gov/lgtoolkit/index.htm).

Source: Information updated on a regular basis. Please contact NC TPCB at 919-707-5400 with questions, or to provide updated information. Visit http://www.tobaccopreventionandcontrol.ncdhhs.gov/ for more information.


North Carolina
Counties and Municipalities Reporting 100%
Smoke-Free or Tobacco-Free Government Buildings
Region 1
Region 2
Region 3
Region 4
Region 5
Region 6
Region 7
Region 8
Region 9
Region 10
Legend
No Documented Protection (Written Regulation or Less than 100% Written Regulation)
Smoke Free
Counties
Municipalities
Tobacco Free
Counties
Municipalities
NCALHD* Regions
County Boundaries
schs
State Center for Health Statistics
May 2017
NOTE: Information provided here is from ongoing reporting. Policies presented here are reported to the NC Tobacco Prevention and Control Branch (NC TPCB). If your government entity has a 100% smoke free or tobacco free policy which is not reported here, please contact NC TPCB at 919-707-5400.
*North Carolina Association of Local Health Directors
TPC
NCPH
North Carolina Public Health

North Carolina
Counties and Municipalities Reporting 100% Smoke-Free or Tobacco-Free on Government Grounds



schs
State Center for Health Statistics
May 2016

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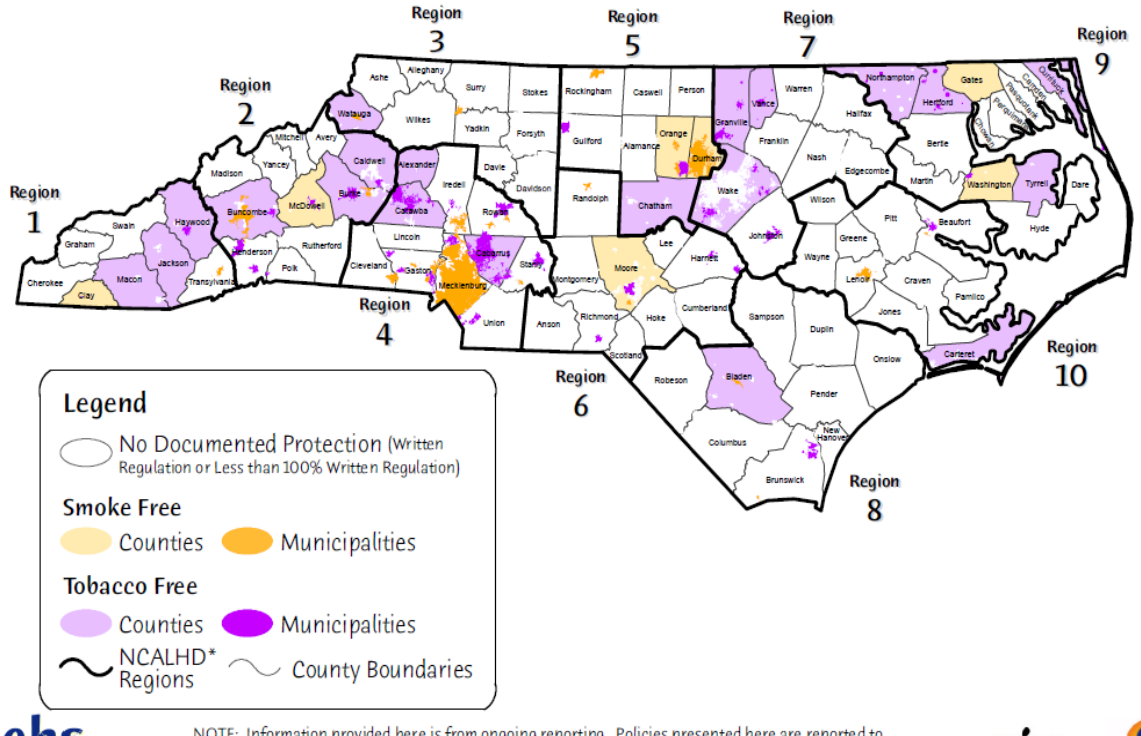
*North Carolina Association of Local Health Directors

NC Tobacco Prevention and Control Branch
North Carolina Public Health

North Carolina
Counties and Municipalities Reporting 100% Smoke-Free or Tobacco-Free Government Owned Parks



schs
State Center for Health Statistics
May 2017

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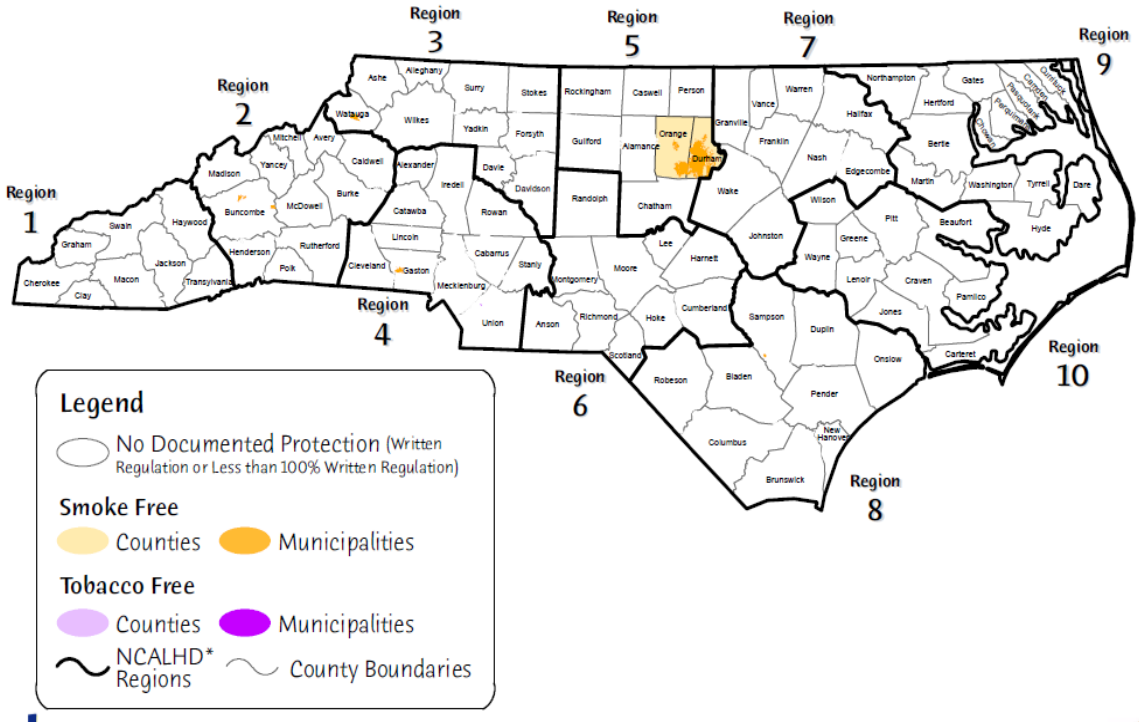
*North Carolina Association of Local Health Directors

North Carolina
Counties and Municipalities Reporting 100% Smoke-Free or Tobacco-Free in Public Places



schs
State Center for Health Statistics
May 2017

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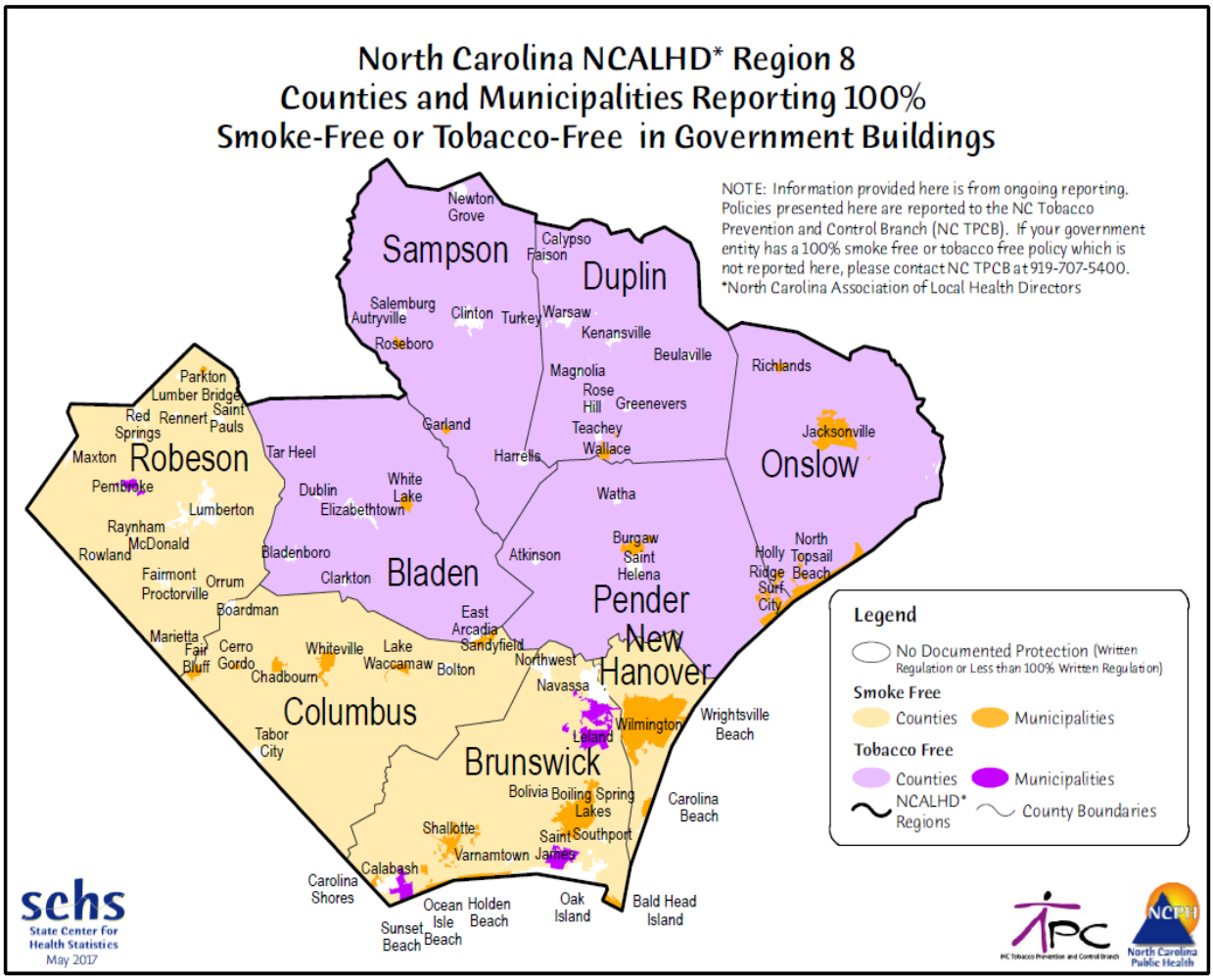
*North Carolina Association of Local Health Directors


North Carolina NCALHD* Region 8
Counties and Municipalities Reporting 100%
Smoke-Free or Tobacco-Free in Government Buildings
NOTE: Information provided here is from ongoing reporting. Policies presented here are reported to the NC Tobacco Prevention and Control Branch (NC TPCB). If your government entity has a 100% smoke free or tobacco free policy which is not reported here, please contact NC TPCB at 919-707-5400.
*North Carolina Association of Local Health Directors
Sampson
Duplin
Robeson
Onslow
Bladen
Pender
New Hanover
Columbus
Brunswick
Newton Grove
Calypso
Faison
Salemburg
Autryville
Clinton
Turkey
Warsaw
Kenansville
Roseboro
Beulaville
Richlands
Magnolia
Rose Hill
Greenevers
Parkton
Lumber Bridge
Red Springs
Rennert
Saint Pauls
Maxton
Garland
Teachey
Wallace
Harrells
Jacksonville
Tar Heel
Pembroke
Dublin
White Lake
Elizabethtown
Watha
Lumberton
Raynham
McDonald
Rowland
Bladenboro
Atkinson
Burgaw
Saint Helena
Holly Ridge
North Topsail Beach
Surf City
Fairmont
Proctorville
Orrum
Clarkton
Boardman
East Arcadia
Sandyfield
Marietta
Fair Bluff
Cerro Gordo
Whiteville
Lake Waccamaw
Bolton
Northwest
Navassa
Chadbourn
Tabor City
Wilmington
Wrightsville Beach
Leland
Bolivia
Boiling Spring Lakes
Carolina Beach
Shallotte
Saint James
Southport
Varnamtown
Calabash
Carolina Shores
Ocean Isle Beach
Holden Beach
Oak Island
Bald Head Island
Sunset Beach
Legend
No Documented Protection (Written Regulation or Less than 100% Written Regulation)
Smoke Free
Counties
Municipalities
Tobacco Free
Counties
Municipalities
NCALHD* Regions
County Boundaries
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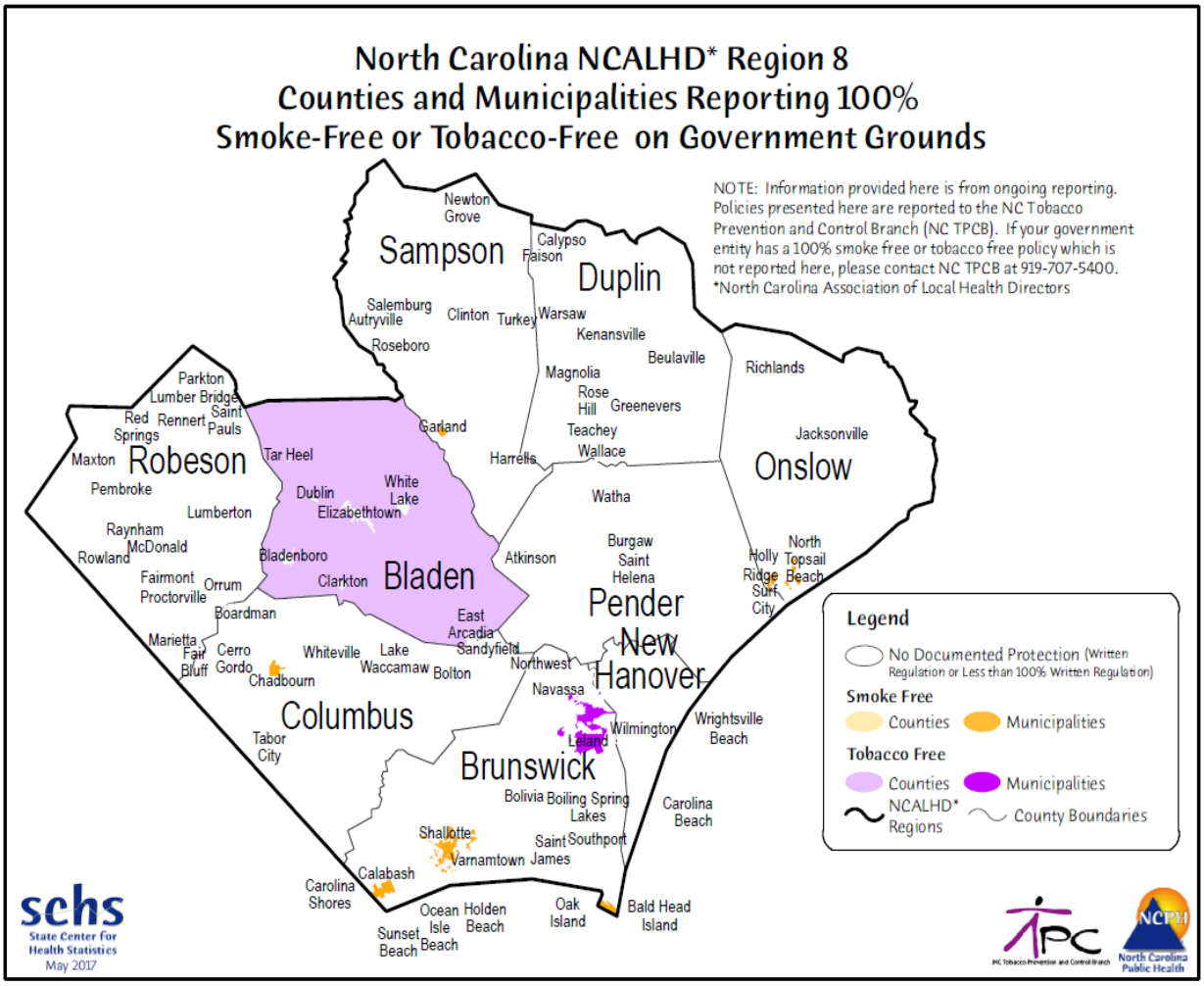
North Carolina Public Health


North Carolina NCALHD* Region 8
Counties and Municipalities Reporting 100%
Smoke-Free or Tobacco-Free on Government Grounds
NOTE: Information provided here is from ongoing reporting. Policies presented here are reported to the NC Tobacco Prevention and Control Branch (NC TPCB). If your government entity has a 100% smoke free or tobacco free policy which is not reported here, please contact NC TPCB at 919-707-5400.
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Garland
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Saint Pauls
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Lumberton
Raynham
McDonald
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Boardman
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Atkinson
Burgaw
Saint Helena
Holly Ridge
North Topsail Beach
Surf City
East Arcadia
Sandyfield
Marietta
Fair Bluff
Cerro Gordo
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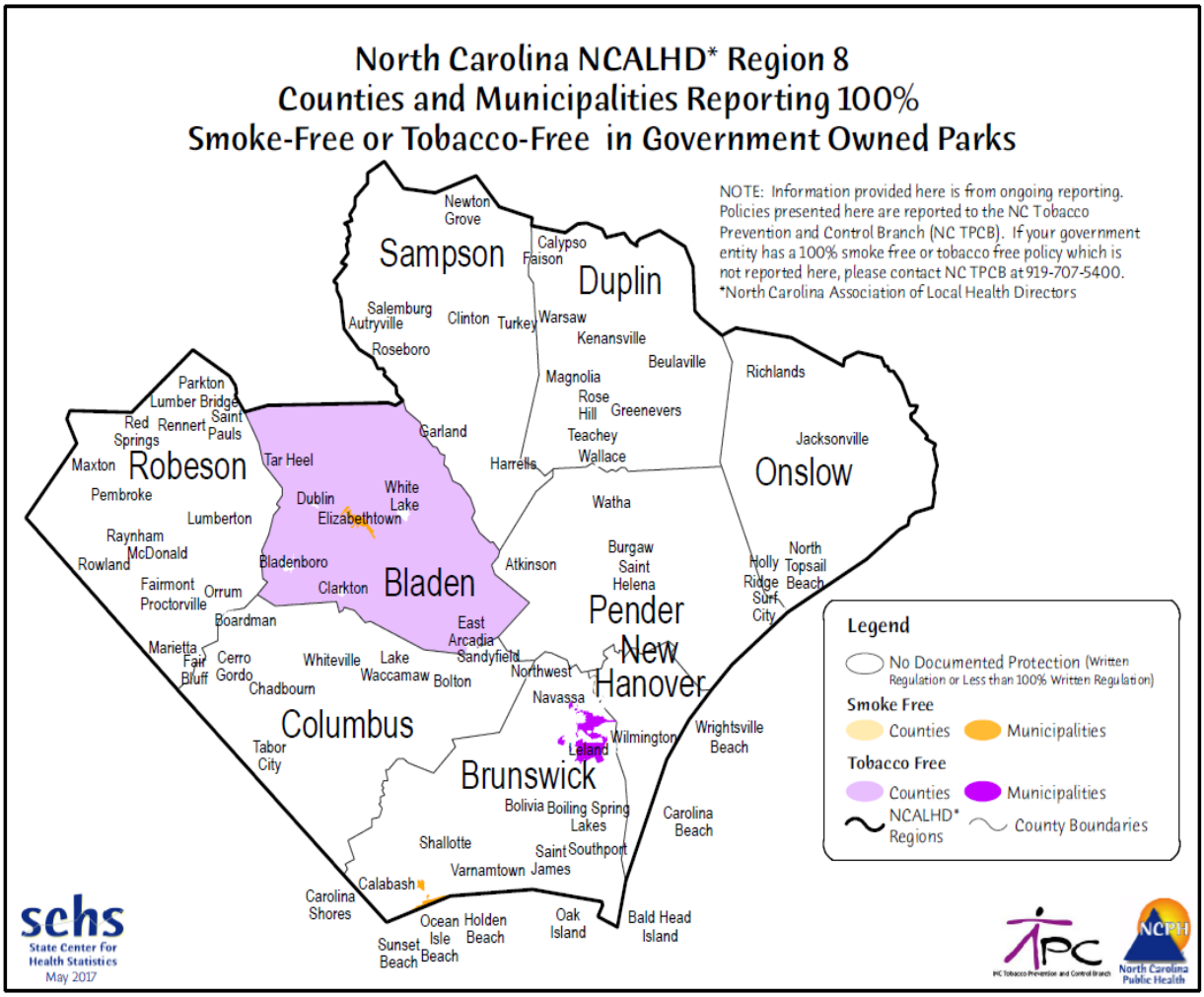
North Carolina NCALHD* Region 8
Counties and Municipalities Reporting 100%
Smoke-Free or Tobacco-Free in Government Owned Parks
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