MCDOWELL COUNTY COMMUNITY HEALTH ASSESSMENT

2024

PREPARED BY

Foothills Health District

FOOTHILLS HEALTH DISTRICT

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Collaboration

This document was developed by Foothills Health District in partnership with Mission Hospital McDowell as part of a local community health assessment process.

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COMMUNITY RESULTS STATEMENT

Healthy minds, healthy bodies, and healthy futures for all in McDowell County

LEADERSHIP FOR THE COMMUNITY HEALTH ASSESSMENT PROCESS

Every three years, the Foothills Health District (FHD), in collaboration with WNC Healthy Impact, conducts a Community Health Assessment (CHA). This assessment outlines the overall health of the community, helping local leaders track health trends, identify priority health concerns, and assess available resources within the county. The CHA serves as a foundation for planning effective disease prevention strategies and health promotion efforts.

Name	Agency	Title	Agency Website
Megan Rollins	Foothills Health District	Public Health Educator	https://www.foothillshd.org/

PARTNERSHIPS

Many valuable partners contributed to this process, offering important insights and expertise. Team members collaborated—both as a group and individually—to collect and analyze both primary and secondary data. The assessment also incorporated a range of perspectives through secondary sources, including demographic, socioeconomic, health, and environmental health indicators.

Name	Agency	Role/ Contribution	Duration of Participation	Agency Website
Crystal Margolin	Foothills Health District	Prioritization Team	April 2025	https://www.foothillshd.org/
Kim McDonald	RHA Prevention	Prioritization Team	April 2025	https://rhahealthservices.org/
Kitty Wilson	MPSA	Prioritization Team	April 2025	https://www.mcdowellpsa.org/
Cindy Meraz	MATCH	Prioritization Team	April 2025	http://matchmcdowell.com/
Samantha Parrow	Vaya	Prioritization Team	April 2025	https://www.vayahealth.com/
Donna Bruce	RHA Prevention	Prioritization Team	April 2025	https://rhahealthservices.org/
Amber Vess	Live Like Megan Foundation	Prioritization Team	April 2025	https://livelikemeganfoundation.com/
Debora Workman	West Marion Inc	Prioritization Team	April 2025	https://www.westmarion.org/
Melisa Tate	SPARC Network	Prioritization Team	April 2025	https://sparcprograms.net/
Dawna Ledbetter	West Marion Inc	Prioritization Team	April 2025	https://www.westmarion.org/
Jonel Brock	Vaya	Prioritization Team	February 2025	https://www.vayahealth.com/

Name	Agency	Role/ Contribution	Duration of Participation	Agency Website
Ginger Webb	West Marion Inc	Prioritization Team	February 2025	https://www.westmarion.org/
Julie McKnney	McDowell County Library	Prioritization Team	February 2025	https://mcdowellpubliclibrary.org/
Jessie Massey	YMCA	Prioritization Team	February 2025	https://www.ymca.org/locations/corpening-memorial-ymca
Kathy Arriola	West Marion Inc	Prioritization Team	February 2025	https://www.westmarion.org/
Laura Galindo	Centro Unido	Prioritization Team	February 2025	https://www.culawnc.org/
Toby Bramblett	YMCA	Prioritization Team	February 2025	https://www.ymca.org/locations/corpening-memorial-ymca

REGIONAL SUPPORT

Our county participates in WNC Healthy Impact. This partnership brings together hospitals, public health agencies, and key regional partners in western North Carolina to improve community health. We work together locally and regionally to assess health needs, develop plans, take action, and evaluate our progress. This regional effort is coordinated by WNC Health Network, a non-profit that exists to support people and organizations to improve community health and well-being across western North Carolina. Learn more at www.WNCHN.org.

THEORETICAL FRAMEWORK/MODEL

WNC Health Network supports local hospitals and public health agencies working on complex community health issues. Community Health Assessment and Improvement processes include the use of Results-Based Accountability™ (RBA). RBA is a practical approach that focuses on achieving real improvements for people, agencies, and communities. The framework relies on both primary (story and number data) and secondary data to provide a comprehensive understanding of community health.

COLLABORATIVE PROCESS SUMMARY

McDowell's collaborative process is supported regionally by WNC Healthy Impact. Locally, the process of identifying our top health priorities began with a comprehensive data review of the Community Health Assessment (CHA) survey results. From this analysis, 6 statistically significant health concerns were identified. A committee of community organizations then convened for a priority-setting workshop, where these 6 issues were evaluated and narrowed down to the top 3. Each priority was rated based on relevance, potential impact, and feasibility for action. Phase 1 officially began in January 2024 with collecting health data. See Chapter 1, Community Health Assessment Process, for details.

KEY FINDINGS

The 2024 Community Health Assessment for McDowell County underscores significant and persistent health challenges affecting the physical, mental, and social well-being of residents. Chronic conditions remain prevalent, with 20.8% of adults reporting diabetes, 49.2% classified as obese, 46.8% experiencing high blood pressure, and 13.5% diagnosed with COPD—all surpassing state and national benchmarks. Mental health indicators are equally concerning: 24.4% rate their mental health as fair or poor, 21.8% reported seven or more poor mental health days in the past month, and 11% have considered suicide within the past year. Additionally, 20.4% of residents were unable to access needed mental health services—suggesting critical service gaps and accessibility barriers.

Social determinants of health reveal substantial vulnerabilities. Over one-third (36.5%) of residents cannot cover a $400 emergency expense, and 34.1% report experiencing food insecurity, both of which exceed regional and national rates. Housing instability remains a key concern: 16% reported unhealthy or unsafe housing conditions in the past year, 13.5% experienced loss of utilities such as water, electricity, or heat, and 6.8% had lived in a car, street, or temporary shelter in the past three years.

Equity challenges are also evident. Approximately 17.1% of residents do not believe McDowell County is welcoming to people of all races and ethnicities, and 7.3% report being treated unfairly when receiving medical care. These disparities point to deeply rooted inequities and emphasize the need for collaborative, equity-focused strategies to improve health outcomes across the county.

HEALTH PRIORITIES

- Mental Health
- Substance Use
- Access to Care

NEXT STEPS

The Foothills Health District will share the Community Health Assessment (CHA) findings with the Mission Hospital McDowell and other interest organizations. An electronic version will be available on the Foothills Health District website at http://www.foothillshd.org/, and printed copies will be accessible at the Health Department, local library, or upon request. In collaboration with community leaders and existing workgroups, the Foothills Health District will help guide planning and action around the identified health priorities. Together, we will work to better understand the underlying causes of these issues and partner with both established and new stakeholders to drive meaningful progress—moving McDowell County closer to the shared vision of a healthier place to live, work, and play.

CHAPTER 1 – COMMUNITY HEALTH ASSESSMENT PROCESS

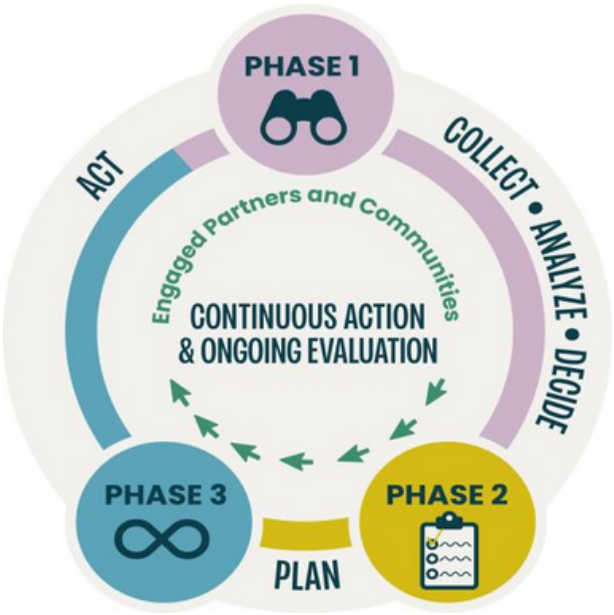
PURPOSE

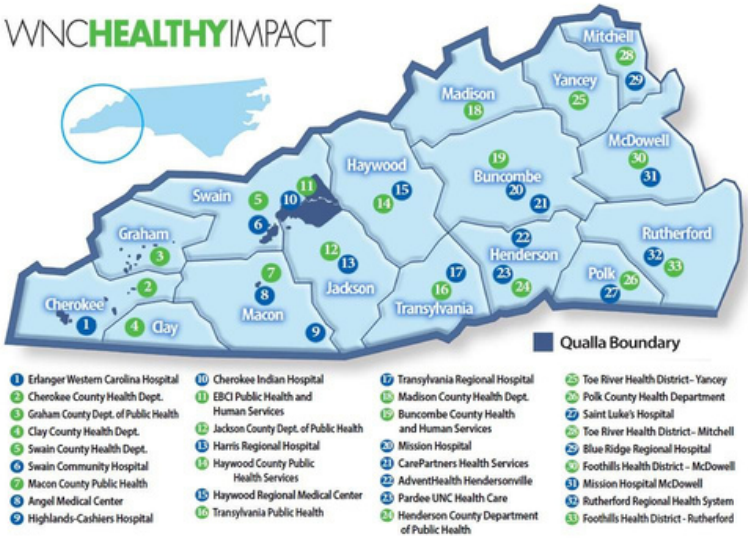
Community health assessment (CHA) is an important part of improving and promoting the health of county residents. A CHA results in a public report which describes the health indicators, status of the community, recent changes, and necessary changes to reach a community's desired health-related results.

[Definition of Community]

Community is defined as "county" for the purposes of the North Carolina Community Health Assessment Process. McDowell county is included in Mission Hospital's community for the purposes of community health improvement, and as such they were key partners in this local level assessment.

[Phases of the Community Health Improvement Process:]





WNC HEALTHY IMPACT

WNC Healthy Impact is a partnership among local and regional hospitals, public health agencies, and key regional partners working towards a vision of improved community health. The vision is achieved by developing collaborative plans, taking action, and evaluating progress and impact. More information is at www.wnchn.org/wnchealthyimpact.

DATA COLLECTION

The set of data reviewed for our community health assessment process is comprehensive, though not all of it is presented in this document. Within this community health assessment, we share a general overview of health and influencing factors, then focus more on priority health issues identified through a collaborative process. Our assessment also highlights some of our community strengths and resources available to help address our most pressing health issues.

WNC Healthy Impact Dataset Collection

Much of the data in this CHA comes from the WNC Healthy Impact dataset. To ensure a comprehensive understanding, the dataset includes both secondary (existing) and primary (newly collected) data. Reviewing secondary data is an essential first step in a community health assessment process because it provides a solid foundation and context. By analyzing existing data, we are able to identify gaps in knowledge and better understand current trends. This ensures that primary data collection is more targeted and relevant, addressing specific needs within the community. The following dataset elements and collection are supported by WNC Healthy Impact Steering Committee, WNC Healthy Impact Data Workgroup, WNC Regional Data Team, Mountain Data Equity and Engagement (DEEP), a survey vendor, and additional partner data needs and input:

- A comprehensive set of publicly available secondary data indicators with our county compared to the 16-county WNC Healthy Impact region
- Set of maps using Census and American Community Survey (ACS) data
- WNC Healthy Impact Community Health Survey (cell phone, landline and internet-based survey) of a random sample of adults in the county
- Online key informant survey

See **Appendix A** for details on the regional data collection methodology.

Health Resources Inventory

We conducted an inventory of available resources of our community by reviewing a subset of existing resources as well as working with partners to include additional information. See **Chapter 7** for more details related to this process.

COMMUNITY INPUT & ENGAGEMENT

Community input plays a vital role in the Community Health Assessment (CHA) process. In McDowell County, we prioritized engagement throughout the assessment in several meaningful ways:

- Collaborating with local partners to guide the assessment process
- Collecting primary data through surveys, key informant interviews, and listening sessions
- Analyzing and interpreting data to better understand the context and stories behind the numbers
- Involving the community in identifying and prioritizing key health issues

Looking ahead, community engagement will remain a central focus as we transition into the collaborative planning phase of the Community Health Improvement Plan. We will continue working with partners and stakeholders who are actively involved in—or have an interest in—addressing our priority health concerns. Together, we aim to ensure that programs and strategies are designed and implemented with input from both community members and partner organizations.

AT-RISK & VULNERABLE POPULATIONS

Throughout our community health assessment process, our team was focused on understanding general health status and related factors for the entire population of our county as well as the groups particularly at risk for health disparities or adverse health outcomes. For the purposes of the overall community health assessment, we aimed to understand differences in health outcomes, correlated variables, and access, particularly among medically underserved, low-income, and/or minority populations, and others experiencing health disparities.

The at-risk and vulnerable populations of focus for our process and product include:

Low-Income Residents

- 36.5% of adults cannot cover a $400 emergency expense.
- 34.1% report food insecurity, higher than state and national averages.
- High rates of housing insecurity: 13.5% experienced utility loss, 6.8% lived in a car, shelter, or on the street in the past 3 years.

Latinx and Immigrant Populations

- Latinx residents face barriers to care due to language, documentation status, and limited financial assistance options.
- Many do not qualify for Medicaid or ACA Marketplace coverage, limiting access to specialty and hospital care.
- Fear of accessing services persists due to immigration-related stigma and costs.

Youth and Children

- 11.0% of residents reported suicidal ideation in the past year, with youth cited as especially vulnerable.
- School-age children experience exposure to vaping at increasingly younger ages.
- Many are impacted by food insecurity, unstable housing, and lack of mental health services.
- Adverse childhood experiences (ACEs) and family instability further compound risks.

People with Mental Health Needs

- 24.4% report fair or poor mental health.
- 21.8% had seven or more poor mental health days in the past month.
- 20.4% were unable to access needed mental health services in the past year.
- Stigma, provider shortages, and cost are consistent barriers to care.

People with Chronic Conditions

- 49.2% are obese and 46.8% have high blood pressure—both well above Healthy People 2030 targets.
- Diabetes prevalence is 20.8%, nearly double state and national rates.
- High rates of COPD (13.5%) and asthma (12.4%) also contribute to disease burden.
- Individuals often face difficulty affording medications, attending appointments, and maintaining lifestyle changes.

Uninsured or Underinsured Individuals

- Many residents fall into coverage gaps despite Medicaid expansion.
- Lack of local dentists who accept Medicaid limits access to oral health services.
- High costs of care deter individuals from seeking treatment, especially preventive services.

People Experiencing Housing Instability

- 16.0% reported unhealthy or unsafe housing conditions.
- 17.5% had to live with others due to a housing emergency in the past three years.
- Unsafe rentals, lack of minimum housing standards, and limited availability of affordable housing are key concerns.

Women and Children Affected by Intimate Partner Violence

- Community leaders report limited availability of domestic violence services.
- The legal and healthcare systems are under-resourced for prevention and response.
- Generational acceptance of violence and stigma remain significant challenges.

Residents Without Reliable Transportation

- Transportation identified as a barrier across nearly all services, including medical care, employment, and healthy food access.
- McDowell Transit is underfunded and limited in capacity, especially for out-of-county medical trips.
- Older adults, low-income workers, and individuals with disabilities are especially affected.

People Experiencing Discrimination or Social Marginalization

- 17.1% of residents disagreed that the community is welcoming to all races and ethnicities.
- 7.3% reported unfair treatment in healthcare settings; 19.6% experienced physical symptoms linked to discrimination.
- Racism, discrimination, and lack of cultural competence in care delivery remain key equity barriers.

Though there are not universally accepted definitions of the three groups, here are some basic definitions from the Health Department Accreditation Self-Assessment Instrument (in some cases definitions have been slightly altered to better represent our region):

- **Underserved populations** relate to those who do not access health care either because there is a lack of services or providers available or because of limitations such as income, literacy/language barriers or understanding on how to access services, cultural competency of clinicians, trust, transportation, or other barriers.

- **At-risk populations** are the members of a particular group who are likely to, or have the potential to, get a specified health condition. This could be from engaging in behavior (e.g. smoking while pregnant) that could cause a specified health condition, having an indicator or precursor (e.g. high blood pressure) that could lead to a specified health condition or having a high ACE score (traumatic experiences), which is correlated with increased risk of specified health conditions.

A vulnerable population is one that may be more susceptible than the general population to risk factors that lead to poor health outcomes. Vulnerable populations, a type of at-risk population, can be classified by such factors as discrimination/ prejudice based on race/ethnicity, socio-economic status, gender. cultural factors and age groups.

Health Department Self-Assessment Instrument (HDSAI) Interpretation Document v.7.0

CHAPTER 2 – MCDOWELL COUNTY

LOCATION, GEOGRAPHY, AND HISTORY OF MCDOWELL COUNTY

Location & Geography

McDowell County is located in the mountainous region of western North Carolina, nestled in the heart of the Blue Ridge Mountains. It shares borders with Buncombe, Rutherford, Burke, Avery, Mitchell, and Yancey counties, and covers approximately 446 square miles. The county's landscape is characterized by a mix of rugged terrain, forested ridges, and river valleys, offering a natural environment that supports outdoor recreation, agriculture, and forestry. Major natural landmarks include Lake James, Catawba Falls, and portions of the Pisgah National Forest. The county seat is Marion, with other key communities including Old Fort, Nebo, Glenwood, and North Cove. McDowell's location along Interstate 40 and proximity to Asheville and Charlotte position it as a vital corridor between rural and urban parts of the state (U.S. Census Bureau, 2020; National Park Service, 2024; McDowell_Maps_2024, 2024).

History

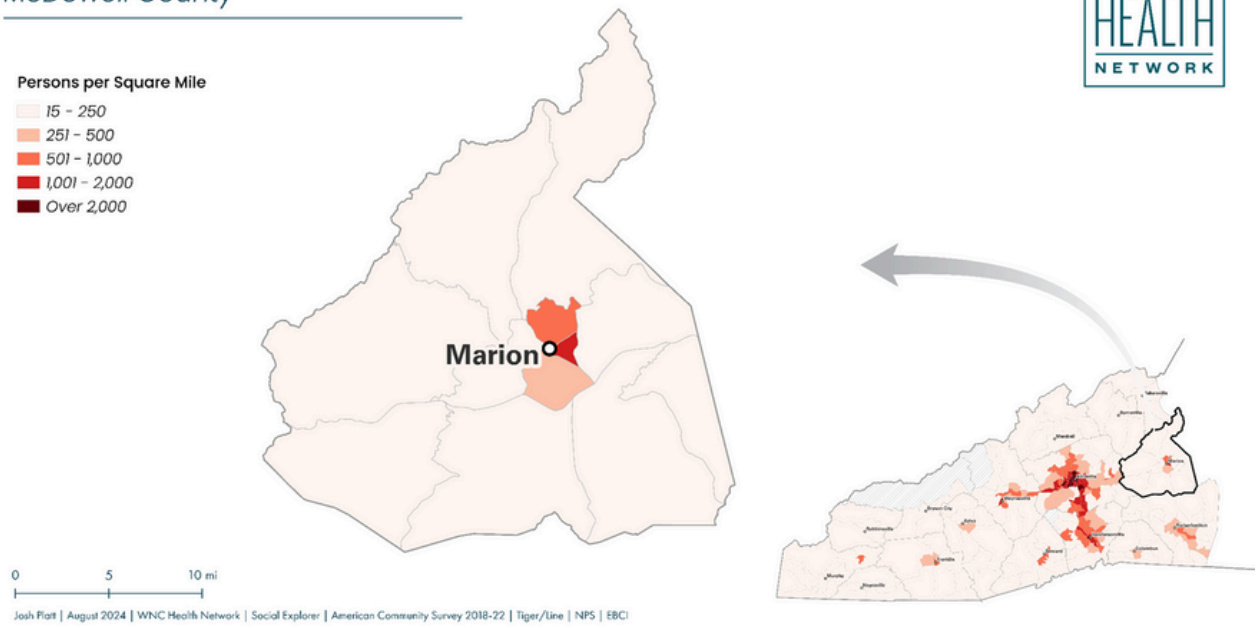
Established in 1842 from portions of Burke and Rutherford counties, McDowell County is named in honor of Joseph McDowell, a Revolutionary War hero and legislator. The area has a deep cultural and historical heritage rooted in Cherokee and Catawba presence prior to European settlement. Throughout the 19th and early 20th centuries, McDowell developed as a center for agriculture, textiles, and timber industries, shaping much of the county's economy and labor force. The arrival of the railroad in the late 1800s connected McDowell to larger markets and played a key role in the growth of Old Fort and Marion. Today, historical landmarks such as the Carson House, Old Fort's Mountain Gateway Museum, and the Blue Ridge heritage trails reflect the county's diverse cultural and historical legacy (North Carolina History Project, n.d.; McDowell County Tourism Development Authority, 2024).

Population

As of the most recent U.S. Census estimates, McDowell County is home to approximately 45,000 residents (U.S. Census Bureau, 2020). The population has grown gradually over the past few decades, though it remains less densely populated than more urban parts of the region. McDowell's population is predominantly White (approximately 90%), with a growing Latinx community and small but meaningful representation from Black, American Indian, and multiracial groups (WNC Health Network, 2024). The county has a higher-than-average proportion of residents aged 65 and older (22.2%), and this segment is projected to increase to 27.2% by 2050 (WNC Healthy Impact, 2024). McDowell's demographic profile reflects both its rural Appalachian heritage and ongoing changes related to aging, migration, and economic transition.

Population Density

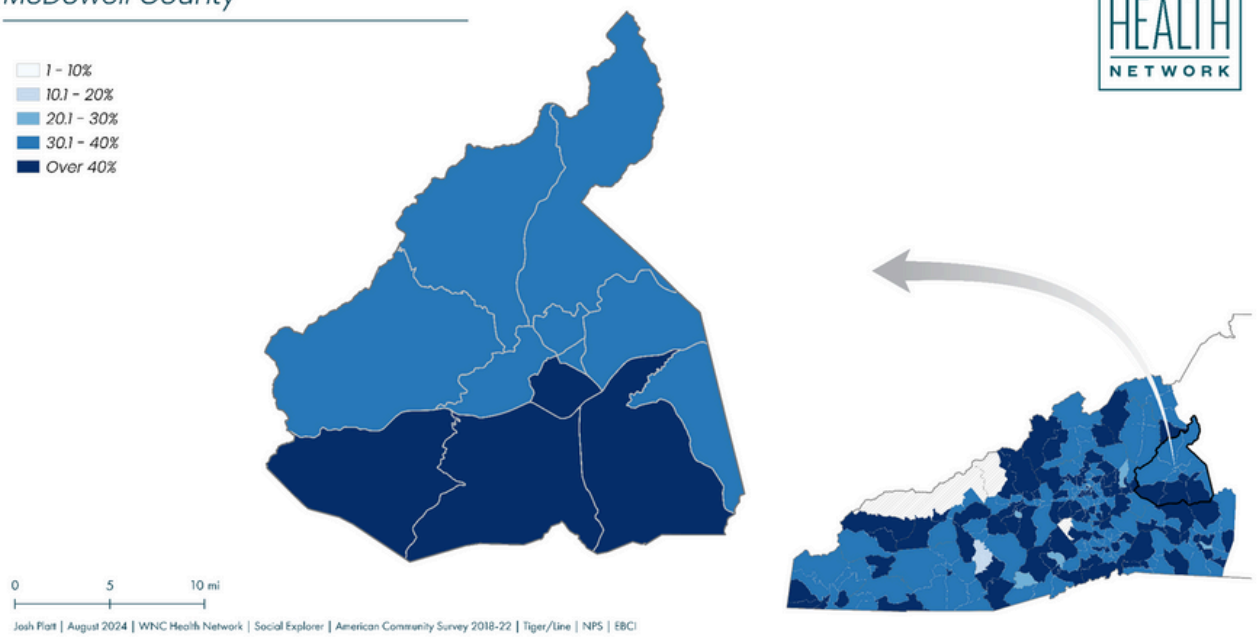
McDowell County



Josh Platt | August 2024 | WNC Health Network | Social Explorer | American Community Survey 2018-22 | Tiger/Line | NPS | EBCI

Percentage of Population Ages 35-64

McDowell County



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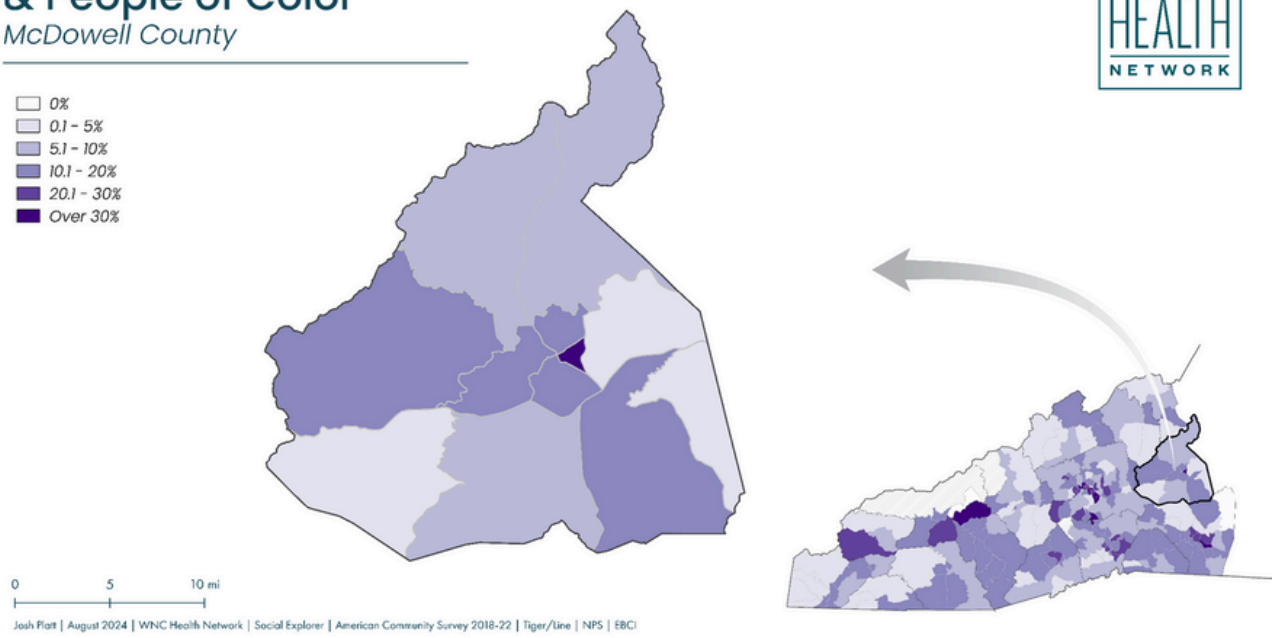
Percentage of Black, Indigenous, & People of Color

McDowell County



Josh Platt | August 2024 | WNC Health Network | Social Explorer | American Community Survey 2018-22 | Tiger/Line | NPS | EBCI

CHAPTER 3 – SOCIAL & ECONOMIC

FACTORS

Social and economic factors are core drivers of health outcomes. According to the County Health Rankings (2024), these conditions account for nearly half of county-level health variation. The CDC's Community Health Improvement Navigator also emphasizes the significance of addressing social determinants of health (CDC, 2022). Healthy People 2030 identifies five key domains that shape well-being: economic stability, education access and quality, healthcare access and quality, neighborhood and built environment, and social and community context (Office of Disease Prevention and Health Promotion [ODPHP], 2020). Social determinants of health (SDOH) are the conditions in the environments where people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks (Office of Disease Prevention and Health Promotion, 2020).

INCOME & POVERTY

Income levels have a direct impact on health outcomes, access to care, and quality of life. In McDowell County, 36.5% of adults report they would be unable to cover a $400 emergency expense, compared to 28.4% regionally and 34.0% nationally (WNC Healthy Impact, 2024). This signals a high level of financial precarity among residents.

The overall poverty rate in the county is estimated at 16.8%, with even higher rates among children and certain racial/ethnic populations (U.S. Census Bureau, 2020). Families and individuals with lower incomes face compounded barriers, including food insecurity, substandard housing, and limited access to care. Food insecurity affects 34.1% of McDowell adults, significantly exceeding both regional and national rates.

Participation in food assistance programs remains a crucial support. A large proportion of families with school-aged children rely on free or reduced-price school meals, and the county participates in food distribution efforts through the Foothills Food Hub and the Health Opportunities Pilot program.

EMPLOYMENT

Employment is a key determinant of income, health insurance coverage, and lifestyle stability. While McDowell County has a mix of industrial, service, and retail sectors, many available jobs offer low wages or limited benefits. Community stakeholders report a lack of livable-wage employment and note that substance use and transportation barriers further limit job access for many residents (OKIS, 2024).

Barriers such as limited vocational training opportunities and insufficient public transit make it difficult for many to enter or remain in the workforce. Those with lower educational attainment are especially vulnerable to unstable employment or underemployment.

EDUCATION

Education is strongly correlated with improved health, economic opportunity, and social mobility. In McDowell County, only 18% of residents hold a bachelor's degree or higher, significantly below state and national averages (U.S. Census Bureau, 2020). Disparities in access to early childhood education and higher dropout rates in certain communities widen this gap.

Community input highlighted frustrations with underfunding of public education and challenges in retaining educators. Preschool availability is limited, with waiting lists for high-quality facilities. Disciplinary actions and disparities in achievement also reflect systemic gaps that can influence long-term health and success.

DISCRIMINATION

Experiences of discrimination are linked to chronic stress, poor mental health, and reduced trust in systems. In McDowell County, 7.3% of residents report being treated unfairly while receiving medical care, and 4.1% experienced unfair treatment in school settings (WNC Healthy Impact, 2024). Additionally, 19.6% reported physical symptoms —such as muscle tension or headaches—as a result of perceived unfair treatment. The most commonly reported reasons for unfair treatment include income level, appearance, and race or ethnicity. These experiences point to underlying social inequities that require continued focus in public health and service delivery.

RACISM

Racism remains a significant structural barrier to health equity. Approximately 17.1% of McDowell respondents disagreed that the county is a welcoming place for people of all races and ethnicities—a rate higher than the WNC average. The county's population is predominantly White (approximately 90%), but Latinx and Black residents, along with newcomers, report feeling excluded from social and service networks.

Such exclusion, combined with limited culturally competent care and language access, contributes to disparities in health outcomes, particularly among Latinx families and undocumented individuals.

COMMUNITY SAFETY

Perceived and actual safety in homes, schools, and neighborhoods greatly impacts physical and mental health. While violent crime data is limited, community input highlighted concerns around intimate partner violence, youth exposure to trauma, and under-resourced prevention systems.

Organizations such as Mission Ministries and local shelters are working to address domestic violence, but gaps in protective services and early intervention programs remain.

HOUSING

Safe, affordable, and stable housing is essential for good health. In McDowell County, 16% of residents report living in unhealthy or unsafe housing conditions, including problems with mold, rodents, or water leaks. Over 13% reported being without electricity, water, or heating at some point in the past year (WNC Healthy Impact, 2024).

The county's housing stock includes aging units, limited rental options, and few protections for tenants. McDowell Mission Ministries and Gateway Wellness Foundation are actively working to expand affordable housing and home repair initiatives, but demand far exceeds availability.

TRANSPORTATION

Transportation access is vital for attending appointments, accessing jobs, and connecting to community. McDowell County residents frequently identify transportation as a barrier to care. Public transit is provided through McDowell Transit, but the system is underfunded and limited in service hours and geographic coverage.

This disproportionately affects older adults, low-income families, and residents needing specialty care in neighboring counties. Lack of sidewalks and bike lanes further limits safe options for non-motorized transportation.

FOOD SECURITY

Access to affordable, nutritious food plays a central role in managing chronic disease and preventing health complications. Over one-third of McDowell residents (34.1%) experience food insecurity. While food pantries, farmers markets, and initiatives like the Foothills Food Hub help improve access, transportation and affordability remain persistent barriers.

Older adults, families with children, and low-income individuals are especially affected. Community education and SNAP participation are helping reduce stigma and improve utilization of nutrition supports.

FAMILY & SOCIAL SUPPORT

Strong support systems improve health outcomes, resilience, and recovery. In McDowell County, 63.5% of residents report "always" or "usually" getting needed emotional support—a rate that has steadily declined over the past decade. Meanwhile, nearly 49% report feeling lonely at least some of the time (WNC Healthy Impact, 2024).

Key informants highlight the importance of informal networks, churches, and community coalitions in filling support gaps, particularly for youth, caregivers, and isolated seniors.

CHAPTER 4 – HEALTH DATA FINDINGS SUMMARY

This chapter provides a summary of McDowell County's overall health status, highlighting key findings from local primary survey data, secondary sources, and trend comparisons. Together, this information helps describe the community's current health profile and identifies persistent disparities and gaps in access. While socioeconomic and environmental factors are addressed in other chapters, the following data focuses on physical and mental health outcomes, behaviors, access to care, and observed inequities among vulnerable groups.

MORTALITY

The leading causes of death in McDowell County mirror those of the region and state, with heart disease, cancer, chronic lower respiratory disease (including COPD), and unintentional injuries among the most prevalent. Life expectancy in McDowell County remains slightly lower than the North Carolina average, reflecting ongoing disparities in chronic disease burden, substance use, and access to care.
Certain causes of death—including drug overdose and suicide—have risen in recent years, particularly among younger adults. Racial and ethnic disparities are present, with non-White and Latinx residents more likely to experience premature mortality due to barriers in care and social determinants of health.

HEALTH STATUS & BEHAVIORS (INCLUDE MORBIDITY AND HEALTH BEHAVIOR DATA)

Health behavior data highlights concerning trends related to chronic disease risk and mental well-being:

- Obesity affects 49.2% of adults, well above the Healthy People 2030 target and higher than regional and national averages.
- 46.8% live with high blood pressure, increasing risk for stroke and heart disease.
- 20.8% of residents report having diabetes, nearly double the national rate.
- 13.5% of adults have COPD, reflecting ongoing tobacco use and environmental exposures.
- 24.4% rate their mental health as fair or poor, and 21.8% experienced seven or more poor mental health days in the past month.
- 11.0% have considered suicide in the past year—above the state and national averages.
- 19.6% report substance use (their own or someone else's) has negatively affected their lives.
- 10.7% report binge drinking, and 12.4% engage in excessive drinking.
- Chronic disease risks are compounded by widespread tobacco use, poor nutrition, and physical inactivity, which continue to challenge public health efforts.

These patterns highlight the critical need for community-wide education, healthy lifestyle support, and accessible mental health and substance use services.

CLINICAL CARE & ACCESS (INCLUDES HEALTH RESOURCES DATA)

Access to clinical care in McDowell County is limited by provider shortages, cost, and insurance gaps:

- The county faces ongoing shortages of healthcare providers, particularly in mental health and specialty care.
- The addition of a local Federally Qualified Health Center (WNCCHS–McDowell Health Center) has improved access but wait times remain long and many services are still out of reach.
- Medicaid expansion has increased coverage, but many residents—especially undocumented individuals and those ineligible for public insurance—remain uninsured or underinsured.
- Pharmacy and prescription access is limited, particularly in rural areas without nearby providers or reliable transportation.
- Mental health access remains a major concern, with 20.4% of residents reporting they were unable to receive needed mental health care in the past year.
- Many private providers do not accept Medicaid, creating gaps in care for low-income residents and working families.
- Transportation, cost, and system navigation barriers further contribute to delayed care, missed appointments, and reliance on emergency services for non-emergency needs.

HEALTH INEQUITIES

Chronic diseases and access issues are disproportionately concentrated among:

- Low-income residents, who face high rates of obesity, diabetes, housing instability, and food insecurity.
- Latinx and immigrant populations, who struggle with insurance access, discrimination, and culturally competent care.
- Older adults, who are more likely to live alone, face transportation barriers, and have multiple chronic conditions.
- Uninsured residents, who often delay care, skip medications, and rely on emergency rooms for basic needs.

These disparities reflect a layered system of barriers that must be addressed through both policy and community collaboration.

CHAPTER 5 – ENVIRONMENTAL FACTORS

Environmental conditions are foundational to public health. The physical environment—including the quality of air and water, exposure to environmental toxins, and safe housing—can significantly impact health outcomes and influence disparities among vulnerable populations. According to County Health Rankings (2024) and the CDC's Community Health Improvement Navigator, a healthy environment supports chronic disease prevention, reduces injury risk, and promotes equitable access to clean and safe resources. Environmental health is especially critical for those with chronic conditions, children, and older adults.

AIR & WATER QUALITY

Clean air and safe water are fundamental to public health. Environmental exposures, particularly poor air or water quality, can have serious health impacts—especially for young children, older adults, and individuals with chronic conditions such as asthma, COPD, or cardiovascular disease (County Health Rankings, 2024).

Air Quality: McDowell County experiences generally good to moderate air quality throughout the year. According to the U.S. Environmental Protection Agency (EPA), air quality in 2022 included 241 days classified as "good" and 118 days classified as "moderate," with no days categorized as unhealthy for sensitive groups (EPA, 2023). While air quality remains within acceptable standards most of the year, temporary increases in pollutants can occur due to factors such as wildfires, vehicle emissions, and weather-related conditions. Continued efforts to monitor and mitigate emissions are important for protecting residents, especially those with respiratory issues.

Toxic Releases: EPA's Toxic Release Inventory (TRI) data shows that McDowell County has a low to moderate level of industrial chemical releases, with most emissions related to manufacturing processes. These emissions generally remain within federally permitted limits, but they highlight the importance of ongoing environmental oversight to prevent long-term exposure risks.

Water Quality: Access to safe and clean drinking water is vital to health. Approximately 94% of McDowell County residents are served by Community Water Systems (CWSs), which are regulated under the Safe Drinking Water Act (EPA, 2023). These systems have generally maintained compliance with federal contaminant standards. However, some rural areas rely on private wells, which are not subject to routine regulatory oversight and may pose additional health risks if improperly maintained or tested infrequently.

Indoor Air Quality: Indoor environmental health is also a concern, particularly in homes with aging infrastructure or poor ventilation. According to 2024 survey data, 13.5% of McDowell County residents report exposure to secondhand smoke inside their homes, and others cited concerns such as mold, inadequate heating or cooling, and moisture problems (WNC Healthy Impact, 2024). These conditions are known to exacerbate asthma, allergies, and other chronic respiratory conditions, particularly in vulnerable populations.

ENVIRONMENTAL EMERGENCIES: HURRICANE HELENE

While McDowell County is not located along the coast, it is still susceptible to the impacts of tropical weather systems and other climate-related events. In September 2024, the remnants of Hurricane Helene brought heavy rain and winds to western North Carolina, including parts of McDowell County. The storm led to localized flash flooding, road washouts, fallen trees, and power outages in several areas. While structural damage was limited, disruption to utilities and hazardous travel conditions posed short-term risks to residents, particularly those in more isolated or flood-prone areas.

Events like Hurricane Helene highlight the importance of emergency preparedness, resilient infrastructure, and robust communication systems to ensure the safety and well-being of the public. Vulnerable populations—such as older adults, individuals with mobility challenges, those experiencing housing insecurity, and residents dependent on medical equipment—face greater risk during extreme weather events. Ensuring access to clean water, safe shelter, and continuity of care during emergencies is critical to reducing health impacts.

Environmental health in McDowell County is shaped not only by air and water quality and indoor housing conditions, but also by the county's ability to respond to weather-related disasters and climate risks. These factors reinforce the need for strong environmental health policies, disaster planning, housing assistance programs, and community education to protect the most vulnerable and promote a resilient, healthy county.

CHAPTER 6 – IDENTIFICATION OF HEALTH PRIORITIES

IDENTIFICATION OF COMMUNITY HEALTH ISSUES

Every three years we take a fresh look at all of the current data from our county that reflects the health of our community. We then use this information to help us assess how well we're doing, and what actions we need to take moving forward.

Data Review and Initial Shortlist

Beginning in September 2024, our team spent time understanding the data and uncovering what issues were affecting the most people in our community. We also interviewed community leaders to find out what they're most concerned about. Our key partners, listed in the Executive Summary, reviewed this data collectively, discussing the unique facts and circumstances impacting our community.

Using the WNC Healthy Impact Data Workbook and its prioritization tools, we applied several criteria to identify significant health issues:

- Data is related to past health priorities
- Data reflects a concerning trend related to size or severity
- Significant disparities exist
- Issue surfaced as a topic of high community concern
- County data deviates notably from the region, state or benchmark

Community Engagement and Prioritization

Once our team made sense of the data, we presented key health issues to a wide range of partners and community members. The participants used the information we presented to score each issue and then vote for their top areas of concern. They considered the severity of the issue, the relevancy of the issue, and the feasibility in improving the issue. This process, often called health issue prioritization, is an opportunity for various community stakeholders, such as Foothills Health District, Mission Hospital McDowell, etc., to agree on which health issues and results we can all contribute to, which increases the likelihood that we'll make a difference in the lives of people in our community.

Identified Indicators

During the above process, the McDowell County CHA Prioritization Team identified the following health issues or indicators:

- Substance Use
- Mental Health
- Access to Care
- Obesity
- Diabetes & Pre-Diabetes
- Housing Instability

PRIORITY HEALTH ISSUE IDENTIFICATION

Process

The issues identified above were further reviewed using a set of criteria to finalize the health priorities for our community for the next three years. The criteria used were:

- Relevance: How important is this issue? (Size of the problem; Severity of problem; Focus on equity; Aligned with HNC 2030; Urgency to solve problem; Linked to other important issues)
- Impact: What will we get out of addressing this issue? (Availability of solutions/proven strategies; Builds on or enhances current work; Significant consequences of not addressing issue now)
- Feasibility: Can we adequately address this issue? (Availability of resources - staff, community partners, time, money, equipment - to address the issue; Political capacity/will; Community/social acceptability; Appropriate socio-culturally; Can identify easy, short-term wins)

Participants used a modified Hanlon method to rate the priorities using the criteria listed above. Then dot-voting and multi-voting techniques were used to narrow to the top 3 priority health issues.

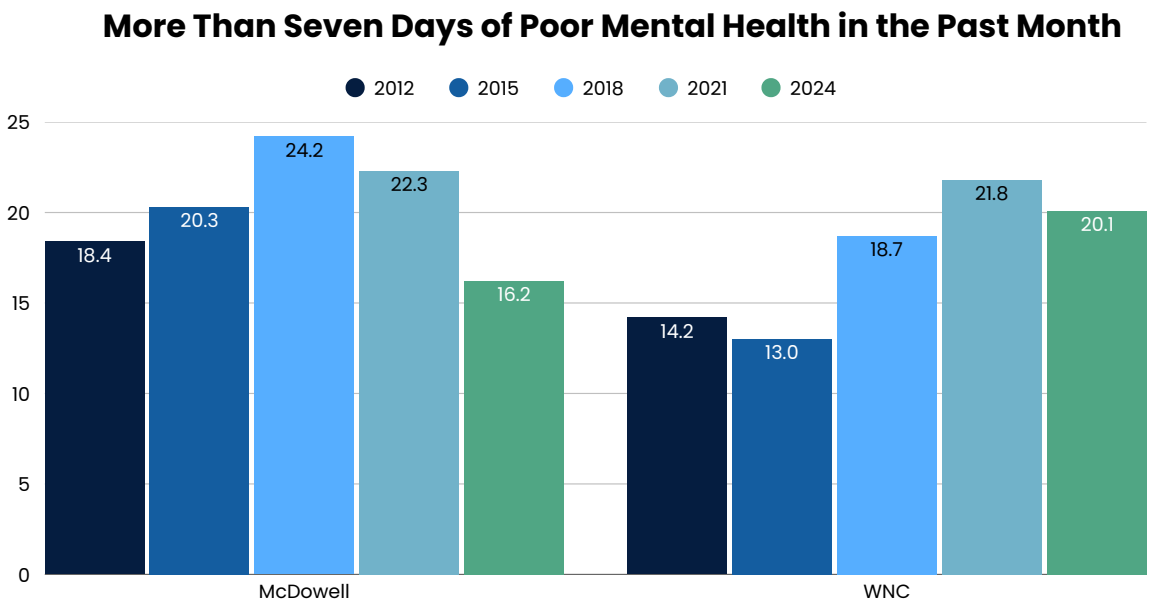
Identified Priorities

The following priority health issues are the final community-wide priorities for our county that were selected through the process described above:

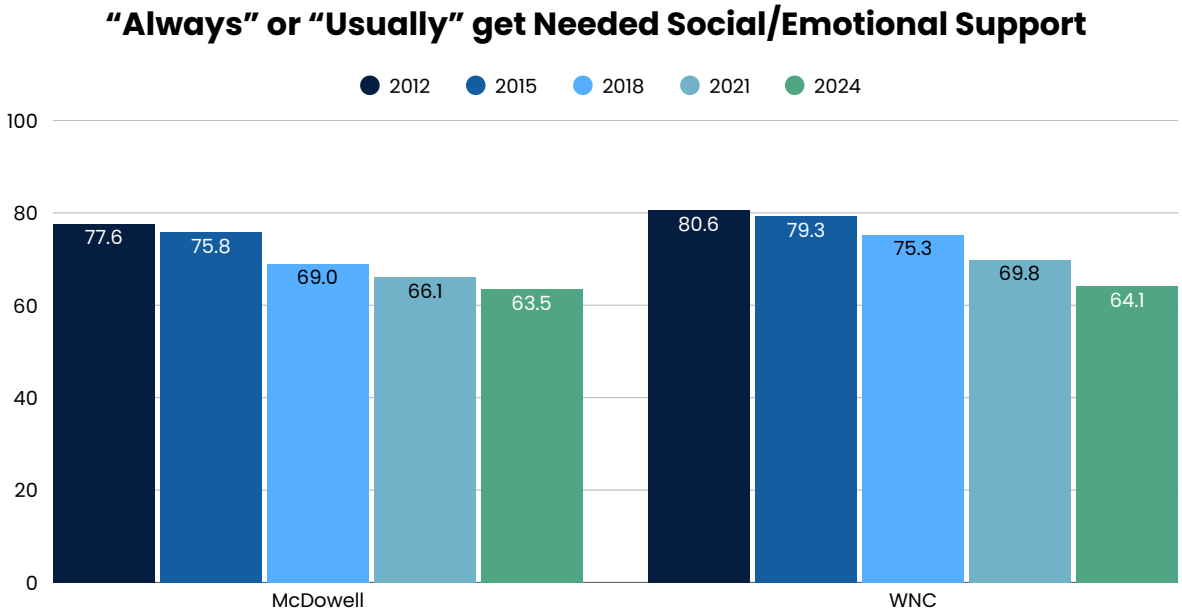
1. Mental Health
2. Substance Use
3. Access to Care

MENTAL HEALTH

THE NUMBERS



Mental health is a critical concern in McDowell County. Approximately 24.4% of adults report their mental health as “fair” or “poor,” far exceeding the North Carolina average of 16.8% and the national average of 18.5% (CDC BRFSS, 2022). About 30% of residents are receiving some form of mental health treatment, indicating strong demand, yet 12.7% were unable to access needed care in the past year due to various barriers. Suicide ideation is a major red flag—9% of respondents reported having considered suicide in the last year, more than double the national rate of 4.3%.



WHAT'S HELPING?

- Heightened community awareness and public conversations about mental health are helping reduce stigma.
- School-based mental health programs, along with partnerships with Vaya Health and other agencies, are improving youth access to early interventions.
- Telehealth services have increased, helping to bridge access gaps for residents in remote or underserved areas.

WHAT'S HURTING?

- Stigma still deters many individuals from seeking help, particularly in rural or older populations.
- A shortage of licensed providers and long waitlists limit timely access to care.
- Transportation challenges and financial hardship disproportionately affect low-income and rural residents.
- The ongoing impact of pandemic-related stress, trauma, and isolation has contributed to deteriorating mental wellness.

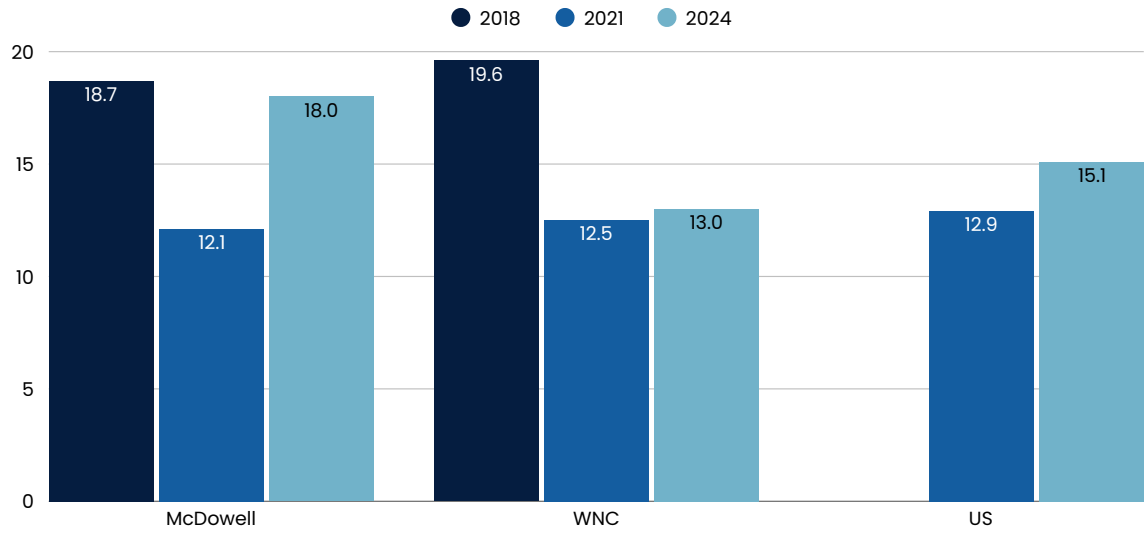
WHO'S IMPACTED?

- Young adults and middle-aged adults, who report the highest rates of mental distress and suicidal ideation.
- Low-income individuals and caregivers, who experience compounding stress from financial strain and caretaking duties.
- People experiencing housing instability or lacking strong social networks, leaving them especially vulnerable to emotional hardship.

SUBSTANCE USE

THE NUMBERS

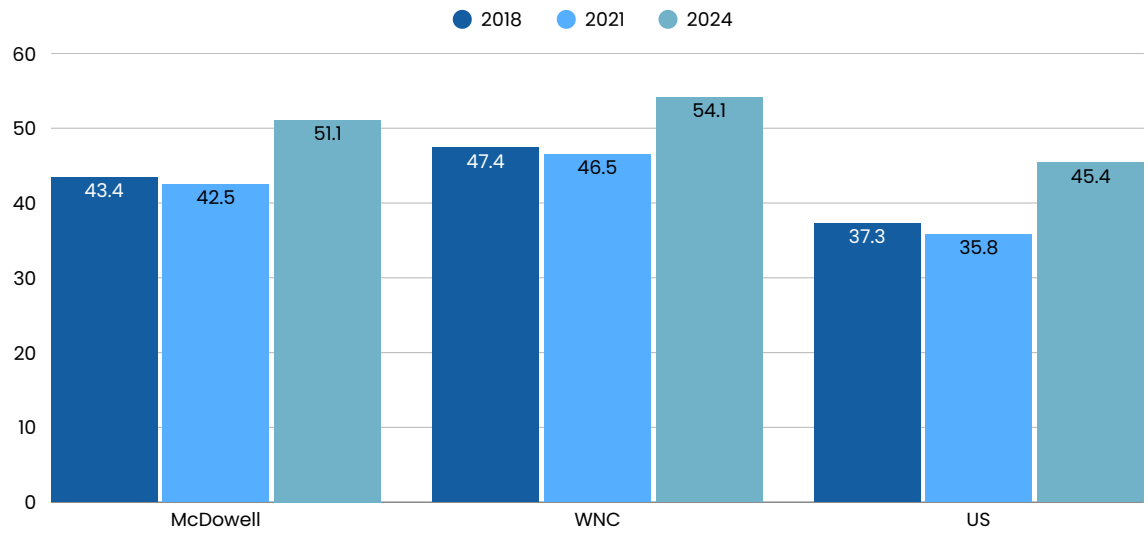
Used a Prescription Opioid in the Past Year, With or Without a Prescription



Substance use in McDowell County is a critical public health challenge with both individual and community-wide consequences. More than half of residents (54.1%) reported that substance use has negatively impacted their lives, either personally or through a loved one. Prescription drug misuse is a key driver, with 15.1% of adults reporting the use of prescription opioids in the past year—above both WNC and national levels.

Alcohol misuse is also a concern, as 27.2% reported engaging in excessive drinking, and 16.6% engaged in binge drinking. These behaviors are linked to increased risks of injury, chronic disease, and poor mental health. Tobacco use remains high, with 23.9% of adults smoking cigarettes—nearly four times the Healthy People 2030 target of 6.1%. Vaping, particularly among youth and young adults, continues to rise, compounding respiratory health concerns.

Life Has Been Negatively Affected by Substance Use (by Self or Someone Else)



WHAT'S HELPING?

- Peer support programs and harm reduction initiatives are expanding and providing new pathways to recovery.
- Public education through health department campaigns, school programs, and coalition efforts is raising awareness.
- Collaboration with EMS, law enforcement, and behavioral health providers has improved response time and outreach during crises, including overdoses.

WHAT'S HURTING?

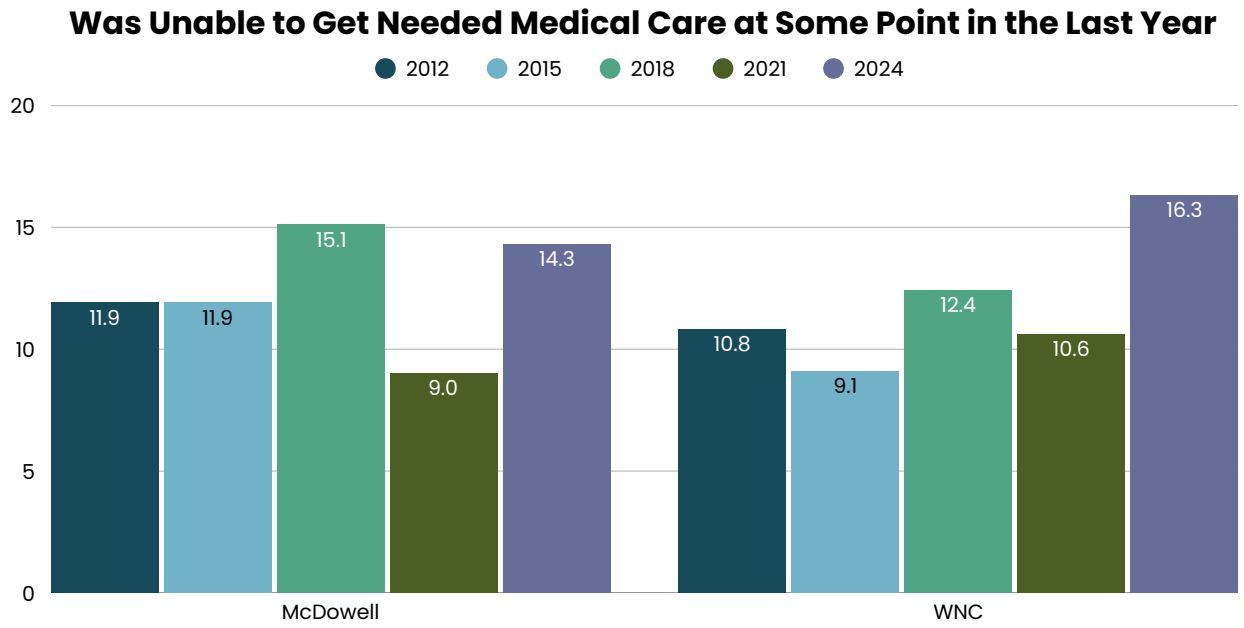
- Easy availability of opioids, vaping products, and other addictive substances continues to drive misuse.
- Multi-generational substance use and gaps in early prevention education perpetuate cycles of addiction.
- Stigma, fear of legal consequences, and a lack of understanding about treatment options often prevent people from seeking help.
- The county has limited detox and inpatient treatment centers, requiring many residents to travel out of county for care—an insurmountable barrier for some.

WHO'S IMPACTED?

- Families and caregivers, who experience emotional, physical, and financial strain from supporting loved ones with substance use disorders.
- Young adults and teens, especially those in transition or lacking strong support systems.
- Children living in households with active substance use, who are at increased risk for adverse childhood experiences (ACEs), trauma, and future behavioral health concerns.

ACCESS TO HEALTHCARE

THE NUMBERS



Access to healthcare continues to be a significant challenge for many McDowell County residents, particularly in terms of affordability, insurance coverage, and the availability of local services. Data from the 2024 WNC Healthy Impact Community Health Survey show that 16.9% of adults under age 65 are uninsured, more than double the Healthy People 2030 target of 7.6%. Among all residents, 14.3% were unable to access needed medical care due to cost, and 17.4% could not afford prescription medications. These affordability challenges directly impact chronic disease management and preventive care access.

Shortages of healthcare providers, especially in specialty areas such as endocrinology, pulmonology, and behavioral health, further contribute to this outmigration and delay in receiving necessary care. Many residents also note that existing healthcare infrastructure is not adequate to support the growing need for chronic disease management, particularly for conditions such as diabetes, COPD, and heart disease.

WHAT'S HELPING?

- Community health workers and nurse navigators are assisting residents in navigating the healthcare system and connecting them with affordable resources.
- The growing availability of telehealth services has offered a lifeline to many, especially for behavioral health and follow-up appointments, provided residents have reliable internet access.
- Medicaid expansion and related policy changes at the state level are starting to reduce insurance gaps and open up coverage to more working-age adults.

WHAT'S HURTING?

- A high proportion of uninsured adults under age 65 remains a persistent barrier to accessing care.
- Limited availability of specialty services locally forces residents to travel out of the county, which can delay or prevent needed treatment.
- Ongoing workforce shortages, particularly in behavioral health and chronic disease specialties, are straining the capacity of existing providers.
- Cost barriers—including for prescriptions, labs, and follow-up visits—cause some patients to delay or skip care altogether, leading to poorer outcomes.

WHO'S IMPACTED?

- Uninsured and underinsured working-age adults, who often fall into coverage gaps despite being employed.
- Individuals with chronic conditions, who require consistent, coordinated care but face delays or disruptions due to provider shortages or transportation issues.
- Low-income households, who may struggle to balance healthcare costs with basic needs like housing, food, and utilities, especially in rural parts of the county.

CHAPTER 7 - HEALTH RESOURCES

"We have some incredible community partners doing good work, but the need far outweighs the resources. We're all stretched thin."
– 2024 McDowell County Key Informant Survey Respondent

HEALTH RESOURCES

Process

To ensure an accurate and current listing of local health resources, McDowell County Community Health Assessment (CHA) partners collaborated to review and update the existing 2-1-1 Health Resource Directory provided by WNC Healthy Impact. The team identified outdated or incorrect information, which was corrected and retained for documentation purposes. All updates were submitted to the 2-1-1 coordinator to ensure the online directory remained up-to-date and accessible to the public. 2-1-1 is a free, confidential, 24/7 referral service that connects individuals to health and human services across North Carolina. Services are available in multiple languages and can be accessed by calling 2-1-1 or visiting www.nc211.org.

Findings

McDowell County is home to a strong network of health-related services, supported by a collaborative spirit among healthcare providers, nonprofits, government agencies, and grassroots organizations. Residents have access to primary care services through private practices, Blue Ridge Health, and the Foothills Health District's clinics, including mobile health units. Behavioral health and substance use support are available through organizations like Partners Health Management, Blue Ridge Hope, Freedom Life, and local faith-based groups, although access remains limited in scope. Social support services are another area of strength, with agencies such as McDowell Mission Ministries, United Way, and DSS helping to address housing, food insecurity, and basic needs. The Foothills Food Hub and local food banks have played a pivotal role in increasing food access and nutrition education.

Community partners emphasized the value of local collaboration, flexible service delivery models, and a shared commitment to serving vulnerable populations. Public-private partnerships and coordinated response efforts have emerged as effective strategies, particularly during times of crisis. However, the community also faces growing strain as demand for services continues to increase. Stakeholders report rising mental health needs, particularly among youth and older adults, along with more complex chronic disease cases requiring coordinated, long-term care. Transportation, housing, and healthcare workforce shortages also emerged as significant barriers to care, particularly in rural and underserved areas. The growing Latinx population has highlighted the need for bilingual services and culturally competent care. As these needs evolve, McDowell County's existing resources will require both expansion and innovation to remain responsive to its changing population.

RESOURCE GAPS

Despite existing resources, there are several critical gaps that continue to affect health outcomes in McDowell County:

- Mental health services remain limited, particularly for youth and those without insurance. Wait times are long, and few providers offer crisis response or trauma-informed care.
- Specialty care access, such as endocrinology, cardiology, or dermatology, is largely unavailable within the county, forcing residents to travel or go without needed care.
- Dental services for uninsured adults are severely limited. Existing dental clinics often have waitlists or are only accessible to certain populations.
- Transportation remains one of the most commonly cited barriers to accessing care, especially for rural residents, older adults, and those without a vehicle or driver's license.
- Affordable housing and shelter services are insufficient to meet the growing needs of families, older adults, and individuals in recovery. Housing instability directly impacts the ability to maintain health, adhere to medications, or access services consistently.
- Culturally competent and bilingual services are lacking, creating barriers to care for Latinx residents and non-English-speaking families. Limited access to interpretation or translated materials can lead to misinformation, fear, or delayed care.
- Workforce shortages, especially in nursing, behavioral health, and public health roles, limit service availability and overburden existing staff across sectors.

These resource gaps compound existing health inequities and require coordinated efforts to strengthen and expand services. As McDowell County continues to face growing health needs, sustainable funding, workforce development, and stronger infrastructure are essential to building an equitable and accessible health system.

CHAPTER 8 – NEXT STEPS

COLLABORATIVE PLANNING

Collaborative planning with hospitals and other community partners will result in the creation of a community-wide plan that outlines what will be aligned, supported and/or implemented to address the priority health issues identified through this assessment process.

SHARING FINDINGS

This document was made available to the public as of July 1, 2025.

The McDowell County CHA data was made available on the Foothills Health District website on January 6th, 2025. This data was also shared via email with the CHA Team, those who participated in the Health Priority Workshop, the Foothills Health District Board of Health, and other interested groups and agencies. A summary of the findings was presented to the Foothills Health District Board of Health, the McDowell County Board of Commissioners, and other interested community groups upon request.

WHERE TO ACCESS THIS REPORT

This CHA report will be posted on the Foothills Health District website. A link can be found at https://www.foothillshd.org/healthprom/

This report and the Data Workbook from which the data was derived is also posted on the WNC Healthy Impact website.

A hard copy of there port will also be made available at the McDowell County Public Library.

FOR MORE INFORMATION AND TO GET INVOLVED

For more information or to get involved please visit the Foothills Health District website at https://www.foothillshd.org/healthprom/ or contact the CHA facilitator via email at mrollins@foothillshd.org.

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PHOTOGRAPHY CREDITS

WNC CHACycleGraphic:Co-designedbyWNCHealthyImpact, graphic design by Jessicca Griffin, 2021

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APPENDICES

Appendix A – Data Collection Methods & Limitations

Appendix B – Data

Appendix C – County Maps

Appendix D – Key-Informant Survey Findings

APPENDIX A – DATA COLLECTION METHODS & LIMITATIONS

SecondaryData Methodology

To learn about the specific factors affecting the health and quality of life of residents of WNC, the WNC Healthy Impact Data Workgroup, WNC Regional Data Team, and Mountain DEEP identified and tapped numerous secondary data sources accessible in the public domain. For data on the demographic, economic and social characteristics of the region sources included: the US Census Bureau; NC Department of Health and Human Services; NC Office of State Budget and Management; NC Department of Commerce; UNC-CH Jordan Institute for Families; NC Department of Public Instruction; NC Department of Public Safety; NC Division of Health Benefits; NC Department of Transportation; and the Cecil B. Sheps Center for Health Services Research. The WNC Healthy Impact Regional Data Team made every effort to obtain the most current data available at the time the WNC Healthy Impact Dataset was prepared. It is not possible to continually update the data past a certain date; in most cases that end- point is August 2024. Secondary data is updated every summer in between Community Health Assessment (CHA) years.

The principal source of secondary health data for the WNC Healthy Impact Dataset is the NC State Center for Health Statistics (NC SCHS), including its County Health Data Books, Behavioral Risk Factor Surveillance System, Vital Statistics unit, and Cancer Registry. Other health data sources included: NC Division of Public Health (DPH) Epidemiology Section; NC Division of Mental Health, Injury and Violence Prevention branch of (DPH); Opioid and Substance Use Action Plan Data Dashboard (DPH); Developmental Disabilities and Substance Abuse Services; the Centers for Disease Control and Prevention; Nutrition Services Branch (DPH); and NC DETECT.

Environmental data were gathered from sources including: US Environmental Protection Agency; US Department of Agriculture; and Department of Environmental Quality.

Because in any CHA it is instructive to relate local data to similar data in other jurisdictions, throughout this report representative county data is compared to “like data” describing the 16-county region and the state of NC as a whole. The WNC regional comparison is used as “peer” for the purposes of this assessment. Where appropriate and available, trend data has been used to show changes in indicators over time.

The WNC Healthy Impact Dataset contains only secondary data that are : (1) retrieved directly from sources in the public domain or by special request; and (2) are available for all 16 counties in the WNC Healthy Impact region. All secondary data included in the workbook are the most current available, but in some cases may be several years old. Names of organizations, facilities, and geographic places presented in the tables and graphs are quoted exactly as they appear in the source data. In some cases, these names may not be those in current or local usage; nevertheless, they are used so readers may track a particular piece of information directly back to the source.

Gaps in Available Information

Despite efforts to collect a wide range of primary and secondary data during the Community Health Assessment process, several important gaps in available information were identified.

There is limited local data on emerging issues such as long COVID, vaping among youth, housing instability, and social isolation. These concerns were frequently raised by community members and stakeholders but are not always captured in traditional data sets or public health surveillance systems.

Qualitative data gaps were also noted. While surveys and key informant interviews provided valuable insights, there remains a need for more targeted community engagement with underrepresented groups, including non-English speakers, individuals with disabilities, LGBTQ+ residents, and people experiencing homelessness. These perspectives are critical for ensuring that assessment findings and resulting strategies are inclusive and equitable.

WNC HEALTHY IMPACT COMMUNITY HEALTH SURVEY (PRIMARY DATA)

Survey Methodology

The in-text citation for 2024 WNC Healthy Impact Community Health Survey data is (WNC Health Network, 2024).

The 2024 WNC Healthy Impact Community Health Survey was conducted from March to June 2024. The purpose of the survey was to collect primary data to supplement the secondary dataset, and allow individual counties in the region to collect data on specific issues of concern. The survey was conducted throughout the entire WNC Healthy Impact region, which includes the following 16 counties: Buncombe, Cherokee, Clay, Graham, Haywood, Henderson, Jackson, Macon, Madison, McDowell, Mitchell, Polk, Rutherford, Swain, Transylvania and Yancey.

Professional Research Consultants, Inc. (PRC) designed and implemented the mixed-mode survey methodology, which included a combination of telephone (both landline and cell phone) interviews, online survey, as well as a community outreach component promoted by WNC Health Network and its local partners through social media posting, in-person events and other methods of communication. The survey methodology was designed to achieve a representative sample of the regional population that would allow for stratification by certain demographic characteristics, while also maximizing data collection timeliness and efficiency. Survey sampling and implementation methodology is described in greater detail below.

Survey Instrument

The survey instrument was developed by the WNC Healthy Impact Data Workgroup, WNC Regional Data Team, and Mountain DEEP, with assistance from PRC. Many of the questions were derived from the CDC Behavioral Risk Factor Surveillance System (BRFSS) and other validated public health surveys. Other questions were developed specifically by WNC Healthy Impact, with input from regional and local partners, to address particular issues of interest to communities in western North Carolina. Each county was given the opportunity to include three additional questions of particular interest to their county, which were asked only of their residents.

The three additional county questions included in the 2024 survey were:

1. How often do you choose fast food over groceries due to cost?
2. Do you think that there are sufficient local resources for chronic disease management?
3. What is your main reason for leaving the county for medical care?

Sampling Approach & Design

PRC designed the survey methodology to minimize sample bias and maximize representativeness by using best practice random-selection sampling techniques. They also used specific data analysis techniques, including poststratification, to further decrease sample bias and account for underrepresented groups or nonresponses in the population. Poststratification involves selecting demographic variables of interest within the population (here, gender, age, race, ethnicity, and poverty status) and then applying "weights" to the data to produce a sample which more closely matches the actual regional population for these characteristics. This technique preserves the integrity of each individual's responses while improving overall representativeness.

In order to determine WNC regional estimates, county responses were weighted in proportion to the actual population distribution to appropriately represent Western North Carolina as a whole. Since the sample design and quality control procedures used in the data collection ensure that the sample is representative, the findings may be generalized to the region with a high degree of confidence.

Survey Administration

PRC piloted the survey through 30 interviews across the region and consulted with WNC Health Network staff to resolve substantive issues before full implementation. PRC used trained, live interviewers and an automated computer-aided telephone interviewing system to administer the survey region-wide. Survey interviews were conducted primarily during evening and weekend hours, with some daytime weekday attempts. Interviewers made up to five call attempts per telephone number. Interviews were conducted in either English or Spanish, as preferred by respondents. PRC worked with a third-party provider to identify and invite potential respondents for an online survey for a small proportion of the sample population. The online survey was identical to the telephone survey instrument and allowed better sampling of younger and more urban demographic segments. The final sample included 3,313 random sample surveys (PRC).

PRC also created a link to an online version of the survey, and WNC Health Network in collaboration with Mountain DEEP, Survey Ambassadors and local partners promoted this online survey link throughout the various communities in order to drive additional participation and bolster overall samples. This yielded 1,927 additional community outreach surveys for the region.

About the McDowell County Sample

Size: The total regional sample size was 5,240 individuals age 18 and older, with 223 from our county. PRC conducted all analysis of the final, raw dataset.

Sampling Error: For statistical purposes, the maximum rate of error associated with the WNC regional sample is ±1.3% at the 95 percent confidence level. For county-level findings, the maximum error rate ranges from ±3.3% (Buncombe County) to ±9.8% (Graham County). Expected error ranges for a sample of 231 respondents at the 95% confidence level in McDowell is 6.9.

The "response rate" (the percentage of a population giving a particular response) determines the error rate associated with that response. A "95 percent level of confidence" indicates that responses would fall within the expected error range on 95 out of 100 trials.

Examples:

- If 10% of a sample of 200 respondents answered a certain question with a "yes," it can be asserted that between 6.0% and 14.0% (10% ± 4.0%) of the total population would offer this response.
- If 50% of respondents said "yes," one could be certain with a 95 percent level of confidence that between 43.1% and 56.9% (50% ± 6.9%) of the total population would respond "yes" if asked this question.

Characteristics: The following chart outlines the characteristics of the survey sample for Rutherford County by key demographic variables, compared to actual population characteristics from census data. Note that the sample consists solely of area residents age 18 and older.

North Carolina Risk Factor Data: Statewide risk factor data are provided where available as an additional benchmark against which to compare local survey findings; these data are reported in the most recent BRFSS (Behavioral Risk Factor Surveillance System) Prevalence and Trend Data published by the Centers for Disease Control and Prevention and the US Department of Health & Human Services.

Nationwide Risk Factor Data: Nationwide risk factor data, which are also provided in comparison charts where available, are taken from the 2024 PRC National Health Survey; the methodological approach for the national study is identical to that employed in this assessment, and this data may be generalized to the US population with a high degree of confidence.

Healthy People 2030: Since 1980, the Healthy People initiative has set goals and measurable objectives to improve health and well-being in the United States. The initiative's fifth edition, Healthy People 2030, builds on knowledge gained over the past 4 decades to address current and emerging public health priorities and challenges. An interdisciplinary team of subject matter experts developed national health objectives and targets for the next 10 years. These objectives focus on the most high-impact public health issues, and reflect an increased focus on the social determinants of health — how the conditions where people live, work, and play affect their health and well-being.

Survey Limitations and Information Gaps

Limitations: The survey methodology included a combination of telephone (both landline and cell phone) interviews, as well as an online survey. Limitations exist for these methods. For example, potential respondents must have access to a landline or a cell phone to respond to the telephone survey. In addition, the telephone survey sample included landlines (versus cell phones), which may further skew responses to individuals or households with landlines.

The PRC online survey component also has inherent limitations in recruitment and administration. Respondents were recruited from a pre-identified panel of potential respondents. The panel may not be representative of the overall population.

Additionally, PRC created an online survey link, which was promoted by WNC Health Network and its local partners through social media posting and other communications. The online survey link respondents might not be representative of the overall population.

A general limitation of using online survey technology is that respondents must interpret survey questions themselves, rather than have them explained by a trained, live interviewer. This may change how they interpret and answer questions.

Lastly, the technique used to apply post stratification weights helps preserve the integrity of each individual's responses while improving overall representativeness. However, this technique can also exaggerate an individual's responses when demographic variables are under-sampled.

Information Gaps: This assessment was designed to provide a comprehensive and broad picture of the health of the community overall. It does not measure all possible aspects of health in the community, nor does it represent all possible populations of interest. For example, due to low population numbers, members of certain racial/ethnic groups (e.g. Black, AI/AN, Hispanic/Latinx, etc.) may not be identifiable or represented in numbers sufficient for independent analyses. In these cases, information gaps may limit the ability to assess the full array of the community's health needs.

Online Key Informant Survey (Primary Data)

Online Survey Methodology

***Survey Purpose and Administration*:** The 2024 Online Key Informant Survey was conducted in July 2024. WNC Healthy Impact, with support from PRC, implemented an Online Key Informant Survey to solicit input from local leaders and stakeholders who have a broad interest in the health of the community. WNC Healthy Impact shared with PRC a list of recommended participants, including those from our county. This list included names and contact information for physicians, public health representatives, other health professionals, social service providers, and a variety of other community leaders. Potential participants were chosen because of their ability to identify primary concerns of the populations with whom they work, as well as of the community overall.

Key informants were contacted through an email that introduced the purpose of the survey and provided a link to take the survey online. Reminder emails were sent as needed to increase participation.

***Survey instrument*:** The survey provided respondents the opportunity to identify important health issues in their community, what is supporting or getting in the way of health and wellbeing in their community, and who in their community is most impacted by these health issues.

***Participation*:** In all, 11 community stakeholders took part in the Online Key Informant Survey for our county, as outlined below:

MCDOWELL COUNTY: ONLINE KEY INFORMANT SURVEY PARTICIPATION	
KEY INFORMANT TYPE Public	Number Participating
Health Representatives Other	1
Health Providers Social	5
Community Leaders	10

Through this process, input was gathered from several individuals whose organizations work with low-income, minority populations, or other medically underserved populations.

Survey Limitations: The Online Key Informant Survey was designed to gather input from participants regarding their opinions and perceptions of the health of the residents in the area. Thus, these findings are based on perceptions, not facts.

To collect this data, purposive sampling (a type of non-probability sampling which targets a specific group of people) was used. Unlike the random sampling technique employed in the telephone survey, the purpose is not to make generalizations or statistical inferences from the sample to the entire population, but to gather in-depth insights into health issues from a group of individuals with a specific perspective.

Data Definitions

Reports of this type customarily employ a range of technical terms, some of which may be unfamiliar to many readers. Health data, which composes a large proportion of the information included in this report, employs a series of very specific terms which are important to interpreting the significance of the data. While these technical health data terms are defined in the report at the appropriate time, there are some data caveats that should be applied from the onset.

Error: First, readers should note that there is some error associated with every health data source. Surveillance systems for communicable diseases and cancer diagnoses, for instance, rely on reports submitted by health care facilities across the state and are likely to miss a small number of cases, and mortality statistics are dependent on the primary cause of death listed on death certificates without consideration of co-occurring conditions.

Age-adjusting: Secondly, since much of the information included in this report relies on mortality data, it is important to recognize that many factors can affect the risk of death, including race, gender, occupation, education and income. The most significant factor is age, because an individual's risk of death inevitably increases with age. As a population ages, its collective risk of death increases; therefore, an older population will automatically have a higher overall death rate just because of its age distribution. At any one time some communities have higher proportions of "young" people, and other communities have a higher proportion of "old" people. In order to compare mortality data from one community with the same kind of data from another, it is necessary first to control for differences in the age composition of the communities being compared. This is accomplished by age-adjusting the data.

Age-adjustment is a statistical manipulation usually performed by the professionals responsible for collecting and cataloging health data, such as the staff of the NC State Center for Health Statistics (NC SCHS). It is not necessary to understand the nuances of age-adjustment to use this report. Suffice it to know that age-adjusted data are preferred for comparing most health data from one population or community to another and have been used in this report whenever available.

Rates: Thirdly, it is most useful to use rates of occurrence to compare data. A rate converts a raw count of events (deaths, births, disease or accident occurrences, etc.) in a target population to a ratio representing the number of same events in a standard population, which removes the variability associated with the size of the sample. Each rate has its own standard denominator that must be specified (e.g., 1,000 women, 100,000 persons, 10,000 people in a particular age group, etc.) for that rate.

While rates help make data comparable, it should be noted that small numbers of events tend to yield rates that are highly unstable, since a small change in the raw count may translate to a large change in rate. To overcome rate instability, another convention typically used in the presentation of health statistics is data aggregation, which involves combining like data gathered over a multi-year period, usually three or five years. The practice of presenting data that are aggregated avoids the instability typically associated with using highly variable year-by-year data, especially for measures consisting of relatively few cases or events. The calculation is performed by dividing the sum number of cases or deaths in a population due to a particular cause over a period of years by the sum of the population size for each of the years in the same period.

Health data for multiple years or multiple aggregate periods is included in this report wherever possible. Sometimes, however, even aggregating data is not sufficient, so the NC SCHS recommends that rates based on fewer than 20 events—whether covering an aggregate period or not—be considered unstable. In fact, in some of its data sets the NC SCHS no longer calculates rates based on fewer than 20 events. To be sure that unstable data do not become the basis for local decision-making, this report will highlight and discuss primarily rates based on 20 or more events in a five-year aggregate period, or 10 or more events in a single year. Where exceptions occur, the text will highlight the potential instability of the rate being discussed.

Regional arithmetic mean: Fourthly, sometimes in order to develop a representative regional composite figure from sixteen separate county measures the consultants calculated a regional arithmetic mean by summing the available individual county measures and dividing by the number of counties providing those measures. It must be noted that when regional arithmetic means are calculated from rates the mean is not the same as a true average rate but rather an approximation of it. This is because most rates used in this report are age adjusted, and the regional mean cannot be properly age-adjusted.

Describing difference and change: Fifthly, in describing differences in data of the same type from two populations or locations, or changes over time in the same kind of data from one population or location—both of which appear frequently in this report—it is useful to apply the concept of percent difference or change. While it is always possible to describe difference or change by the simple subtraction of a smaller number from a larger number, the result often is inadequate for describing and understanding the scope or significance of the difference or change. Converting the amount of difference or change to a percent takes into account the relative size of the numbers that are changing in a way that simple subtraction does not, and makes it easier to grasp the meaning of the change.

For example, there may be a rate of for a type of event (e.g., death) that is one number one year and another number five years later. Suppose the earlier figure is 12.0 and the latter figure is 18.0. The simple mathematical difference between these rates is 6.0. Suppose also there is another set of rates that are 212.0 in one year and 218.0 five years later. The simple mathematical difference between these rates also is 6.0. But are these same simple numerical differences really of the same significance in both instances? In the first example, converting the 6-point difference to a

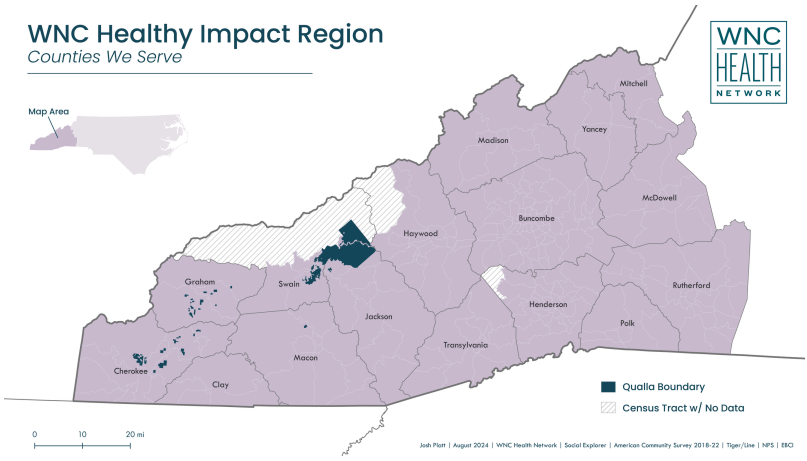
percent yields a relative change factor of 50%; that is, the smaller number increased by half, a large fraction. In the second example, converting the 6-point difference to a percent yields a relative change factor of 2.8%; that is, the smaller number increased by a relatively small fraction. In these examples the application of percent makes it very clear that the difference in the first example is of far greater degree than the difference in the second example. This document uses percentage almost exclusively to describe and highlight degrees of difference and change, both positive (e.g., increase, larger than, etc.) and negative (e.g., decrease, smaller than, etc.).

Data limitations: Some data that is used in this report may have inherent limitations, due to the sample size, its geographic focus, or its being out-of-date, for example, but it is used nevertheless because there is no better alternative. Whenever this kind of data is used, it will be accompanied by a warning about its limitations.

APPENDIX B – DATA

2024 COMMUNITY HEALTH SURVEY

McDowell County



Methodology

Survey methodology

- 5,898surveysthroughout WNC (including Avery & Burke)
  - 2,356surveys were completedvia the telephone (bothlandlinesand cell phones); another 1,308 surveys were completed online by individuals invited through third-party providers to participate.
  - 2,234 were completed via a link to the online survey promoted by WNC Healthy Impact and community partners through social media, email campaigns,and various other outreach efforts.
- Allows for high participation and random selection for a large portion of the sample
  - These are critical to achieving a sample representative of county and regional populations by gender, age, race/ethnicity, income
- English and Spanish

Methodology

5,898surveys throughoutWNC

- Adults age 18+
- Gathered data for each of 18 counties
- Weights were added to enhance representativeness of data at county and regional levels

Methodology

FullWNCsampleallowsfordrill-down by:

- County
- Age
- Gender
- Race/ethnicity
- Income
- Other categories, based on question responses
  Individual county samples allow for drill-down by:
  - Gender Income Other categories, based on
  - question responses
  -

Survey Instrument

Basedlargelyon nationalsurveymodels

- When possible, question wording from public surveys (e.g., CDC BRFSS)
  75 questions asked of all counties
- Each county added three county-specific questions
- Approximately 15-minute interviews
- Questions determined by WNC stakeholder input

Keep in mind

Sampling levels allowfor goodlocal confidence intervals, but you should still keep in mind that error rates are larger at the county level than for WNC as a region

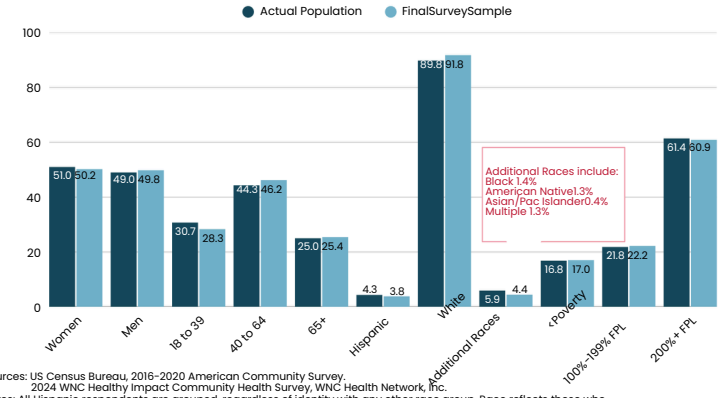
- Results for WNC regional data have maximum error rate of ±1.3% at the 95% confidence level
- Results for each of the 18 counties have maximum error rates ranging from ±3.3% to ±9.8% at the 95% confidence level
  PRC indicates in regional report when differences – between county and regional results, different demographic groups, and data years – are statistically significant

Approximate Error Ranges at the 95 Percent Level of Confidence

	Sample	Error Rate
Avery County	n = 166	± 8.0%
Buncombe County	n = 908	± 3.3%
Burke County	n = 492	± 4.6%
Cherokee County	n = 213	± 6.9%
Clay County	n = 208	± 6.9%
Graham County	n = 136	± 9.8%
Haywood County	n = 393	± 5.2%
Henderson County	n = 755	± 3.6%
Jackson County	n = 345	± 5.7%
Macon County	n = 272	± 6.2%
Madison County	n = 294	± 6.2%
McDowell County	n = 231	± 6.9%
Mitchell County	n = 203	± 6.9%
Polk County	n = 246	± 6.9%
Rutherford County	n = 223	± 6.9%
Swain County	n = 247	± 6.9%
Transylvania County	n = 264	± 6.2%
Yancey County	n = 302	± 5.7%
WNC Service Area	n = 5,898	± 1.3%

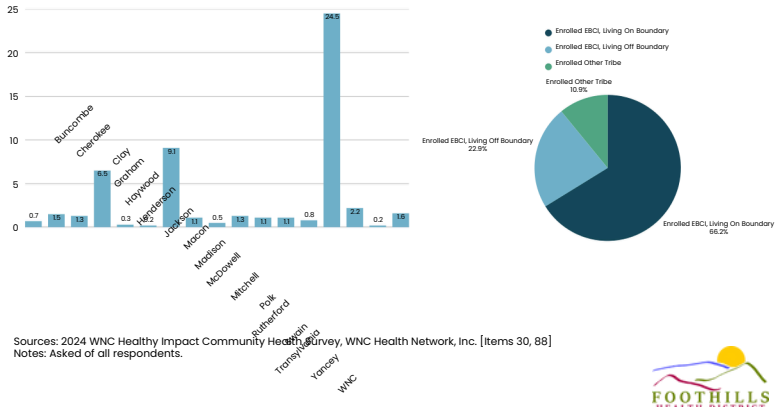
Note: The "response rate" (the percentage of a population giving a particular response) determines the error rate associated with that response. A "95 percent level of confidence" indicates that responses would fall within the expected error range on 95 out of 100 trials. Example: If 50% of the sample of 5,898 respondents answered a certain question with a "yes one could be certain with a 95 percent level of confidence that between 48.7% and 51.3% (50% ± 1.3%) of the total population would respond "yes" if asked this question.

Population & Survey Sample Characteristics
(McDowell County, 2024)



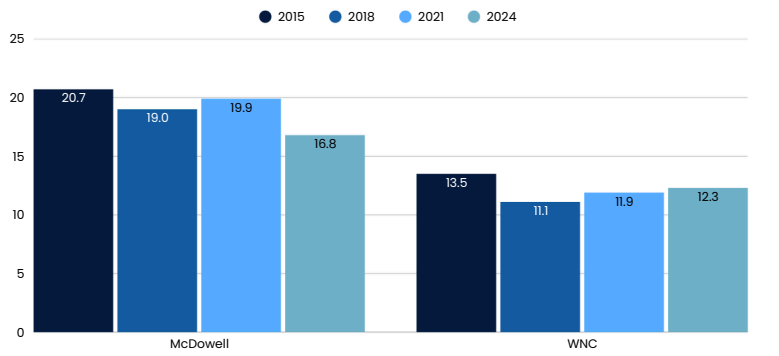
Sources: US Census Bureau, 2016-2020 American Community Survey.
2024 WNC Healthy Impact Community Health Survey, WNC Health Network, Inc.
Notes: All Hispanic respondents are grouped, regardless of identity with any other race group. Race reflects those who identify with a single race category, without Hispanic origin. "Additional Races" includes those who identify as Black or African American, American Indian or Alaska Native, Asian, Native Hawaiian/Pacific Islander, or as being of multiple races, without Hispanic origin.

American Indian/AlaskaNative Sample
(By County, 2024)



Sources: 2024 WNC Healthy Impact Community Health Survey, WNC Health Network, Inc. [Items 30, 88]
Notes: Asked of all respondents.

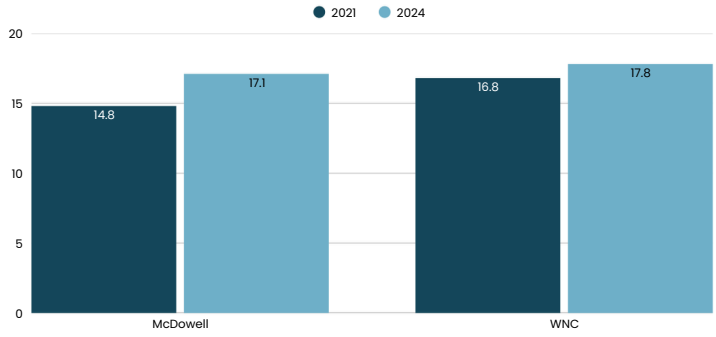
County Is a "Fair/Poor"Place to Live
(By County)



Sources: 2024 WNC Healthy Impact Community Health Survey, WNC Health Network, Inc. [Item 5]
Notes: Asked of all respondents.

Disagree That the Community Is a Welcoming Place for People of All Races and Ethnicities

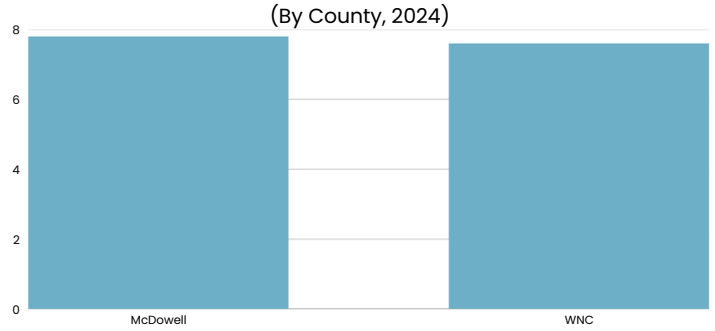
("Disagree" or "Strongly Disagree" Responses; By County)



Sources: 2024 WNC Healthy Impact Community Health Survey, WNC Health Network, Inc. [Item 75]
Notes: Asked of all respondents.

"Often/Sometimes" Threatened or Harassed in the Past Year

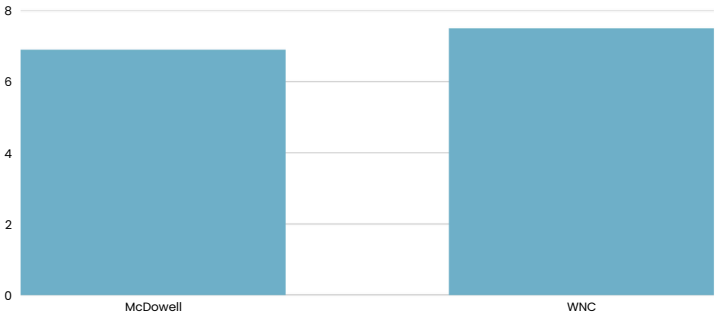
(By County, 2024)



Sources: 2024 WNC Healthy Impact Community Health Survey, WNC Health Network, Inc. [Item 70]
Notes: Asked of all respondents.

"Often/Sometimes" Treated Unfairly When Getting Medical Care in the Past Year

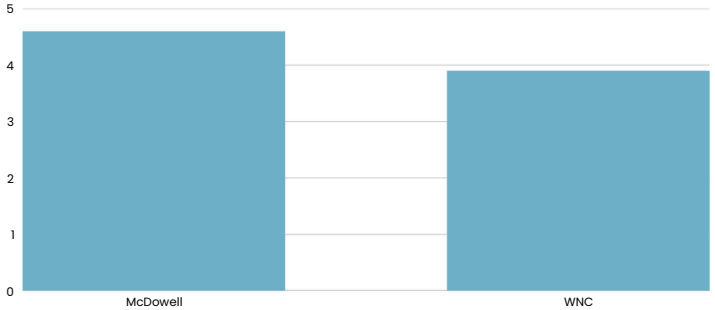
(By County, 2024)



Sources: 2024 WNC Healthy Impact Community Health Survey, WNC Health Network, Inc. [Item 71]
Notes: Asked of all respondents.

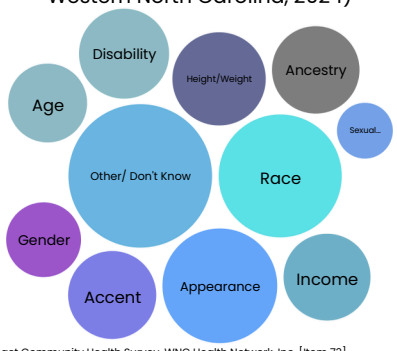
"Often/Sometimes" Treated Unfairly at School in the Past Year

(By County, 2024)



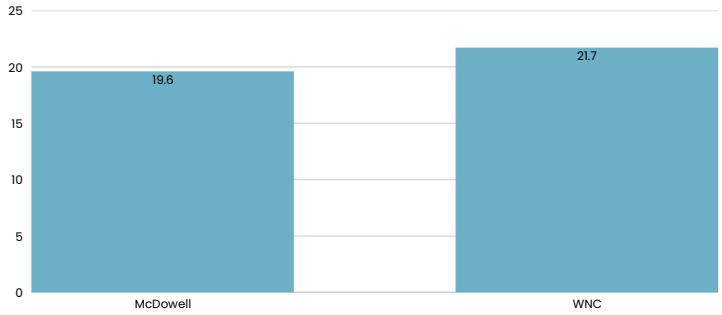
Sources: 2024 WNC Healthy Impact Community Health Survey, WNC Health Network, Inc. [Item 72]
Notes: Asked of all respondents.

Perceived Main Reason for Unfair Treatment in the Past Year
(Among Those Treated Unfairly "Often" or "Sometimes"; Western North Carolina, 2024)



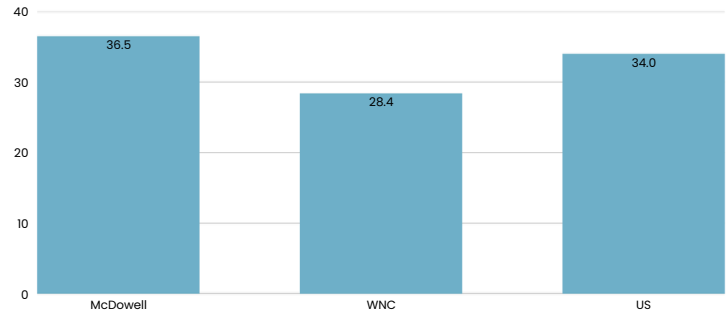
Sources: 2024 WNC Healthy Impact Community Health Survey, WNC Health Network, Inc. [Item 73]
Notes: Asked of respondents reporting they received unfair treatment "often" or "sometimes" in the past year.
Unfair treatment includes threats, harassment, discrimination when receiving medical care, and/or discrimination at school.

Experienced Negative Physical Symptoms in the Past Month as a Result of Any Unfair Treatment
(By County, 2024)



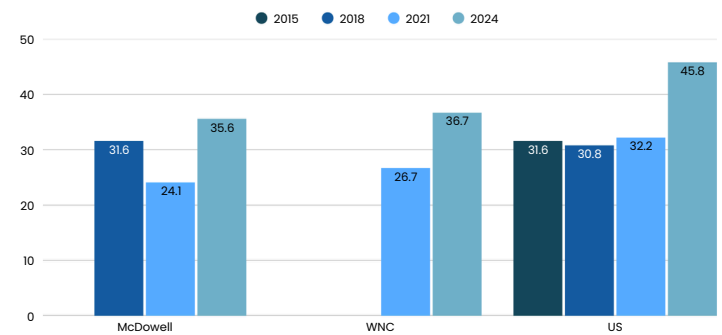
Sources: 2024 WNC Healthy Impact Community Health Survey, WNC Health Network, Inc. [Item 74]
Notes: Asked of all respondents.
Examples of physical symptoms include a headache, an upset stomach, tensing of muscles, or a pounding heart.

Do Not Have Cash on Hand to Cover a $400 Emergency Expense
(By County, 2024)



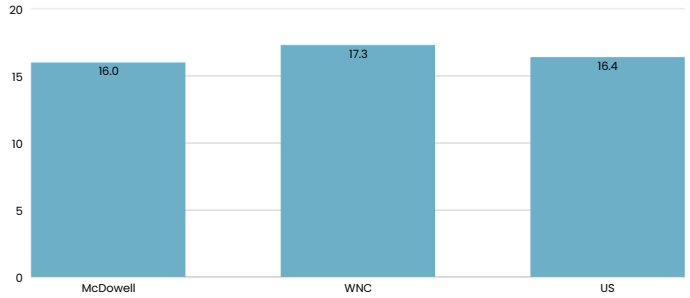
Sources: 2024 WNC Healthy Impact Community Health Survey, WNC Health Network, Inc. [Item 37]
2023 PRC National Health Survey, PRC, Inc.
Notes: Asked of all respondents.
Includes respondents who say they would not be able to pay for a $400 emergency expense either with cash, by taking money from their checking or savings account, or by putting it on a credit card that they could pay in full at the next statement.

"Always/Usually/Sometimes" Worried About Paying Rent/Mortgage in the Past
(By County)



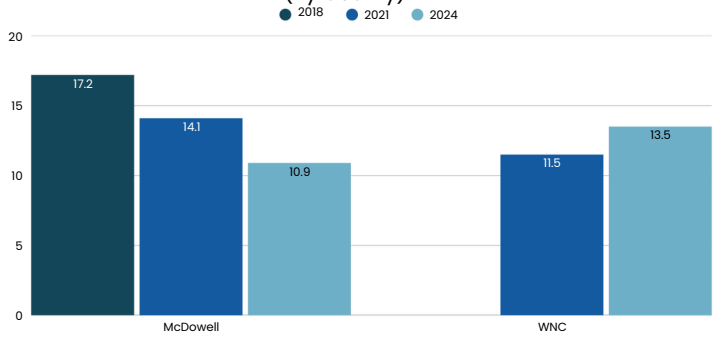
Sources: 2024 WNC Healthy Impact Community Health Survey, WNC Health Network, Inc. [Item 38]
2023 PRC National Health Survey, PRC, Inc.
Notes: Asked of all respondents.

Unhealthy or Unsafe Housing Conditions in the Past Year
(By County, 2024)



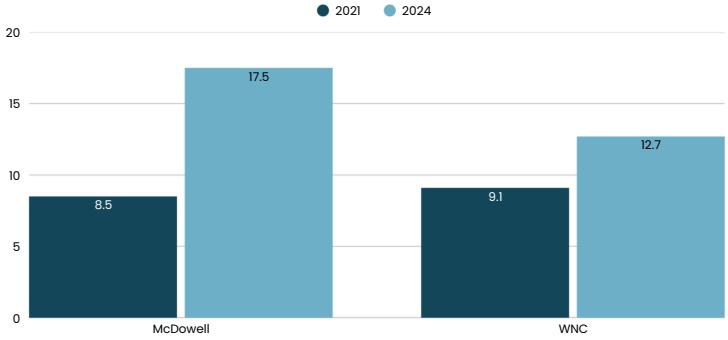
Sources: 2024 WNC Healthy Impact Community Health Survey, WNC Health Network, Inc. [Item 39]
2023 PRC National Health Survey, PRC, Inc.
Notes: Asked of all respondents.
Includes respondents who say they experienced ongoing problems in their current home with water leaks, rodents, insects, mold, or other housing conditions that might make living there unhealthy or unsafe.

Had a Time in the Past Year When Home Was Without Electricity, Water, or Heating
(By County)



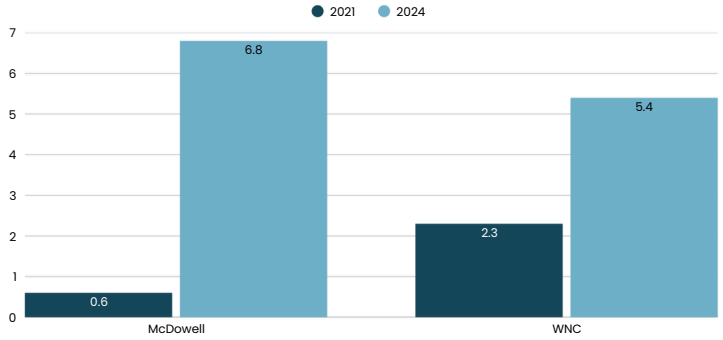
Sources: 2024 WNC Healthy Impact Community Health Survey, WNC Health Network, Inc. [Item 40]
Notes: Asked of all respondents.

Have Had to Live With a Friend/Relative in the Past Three Years Due to a Housing Emergency
(By County)



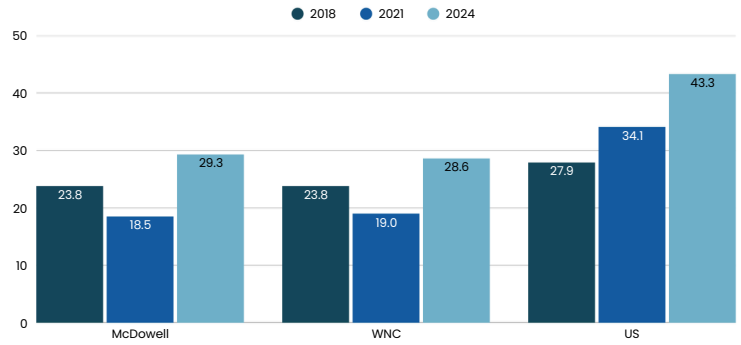
Sources: 2024 WNC Healthy Impact Community Health Survey, WNC Health Network, Inc. [Item 41]
Notes: Asked of all respondents.

Lived on the Street, in a Car, or in a Temporary Shelter in the Past Three Years
(By County)



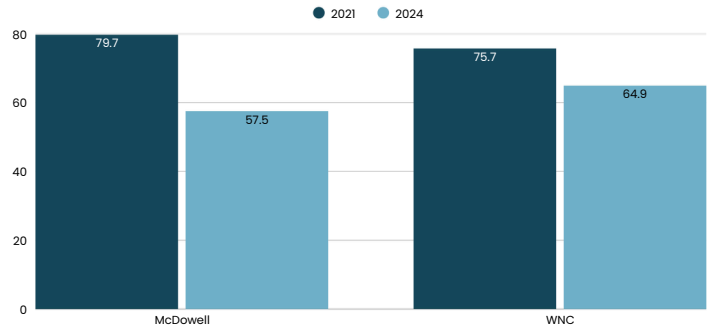
Sources: 2024 WNC Healthy Impact Community Health Survey, WNC Health Network, Inc. [Item 42]
Notes:Asked of all respondents.

Food Insecurity
(By County)



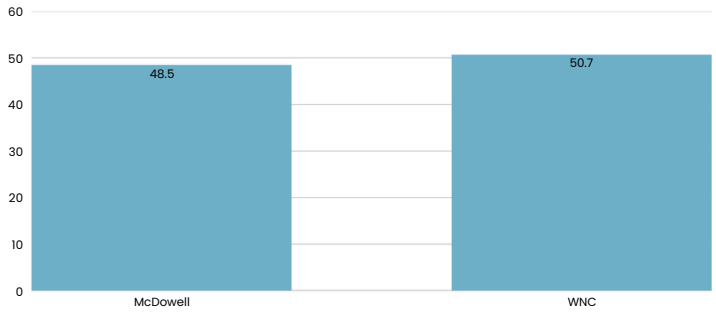
Sources: 2024 WNC Healthy Impact Community Health Survey, WNC Health Network, Inc. [Item 77]
2023 PRC National Health Survey, PRC, Inc.
Notes: Asked of all respondents.
Includes adults who A) ran out of food at least once in the past year and/or B) worried about running out of food in the past year.

"Always" or "Usually" Have Someone to Rely on for Help When Needed (By County)



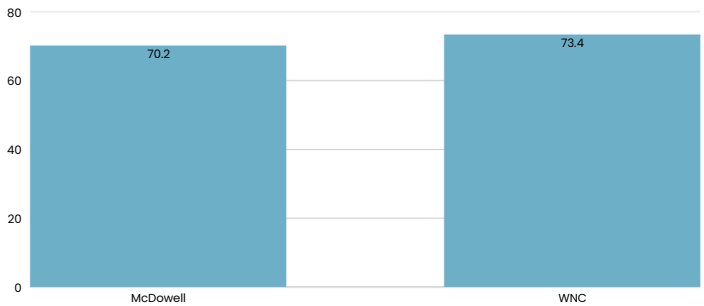
Sources: 2024 WNC Healthy Impact Community Health Survey, WNC Health Network, Inc. [Item 62]
Notes: Asked of all respondents.

Feel Lonely "Often/Some of the Time/Occasionally" (By County, 2024)

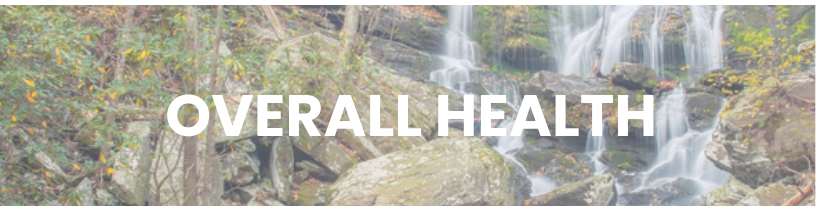


Sources: 2024 WNC Healthy Impact Community Health Survey, WNC Health Network, Inc. [Item 65]
Notes: Asked of all respondents.

Climate is "Very/Somewhat Connected" to Health Risks (By County, 2024)

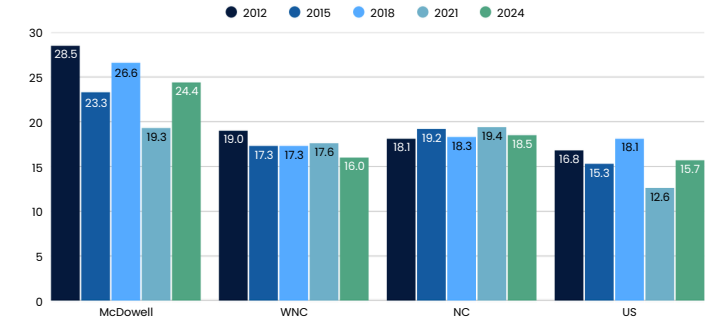


Sources: 2024 WNC Healthy Impact Community Health Survey, WNC Health Network, Inc. [Item 57]
Notes: Asked of all respondents.
Climate was defined as the weather conditions in an area in general or over a long period, with extreme heat, flooding, or drought given as examples.



OVERALL HEALTH

Experience "Fair" or "Poor" Overall Health
(By County)

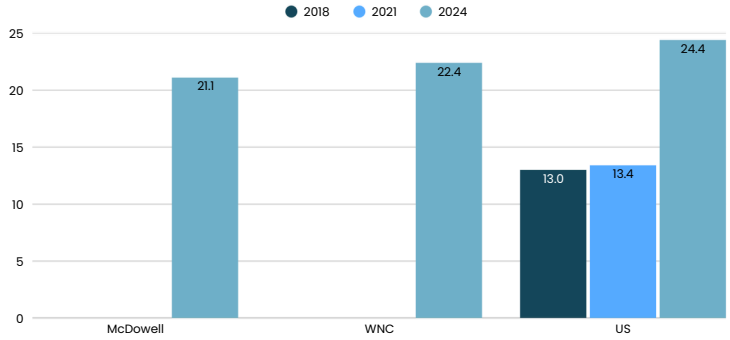


Sources: 2024 WNC Healthy Impact Community Health Survey, WNC Health Network, Inc. [Item 6]
Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2022 North Carolina data.
2023 PRC National Health Survey, PRC, Inc.

Notes: Asked of all respondents.

MENTAL HEALTH & MENTAL DISORDERS

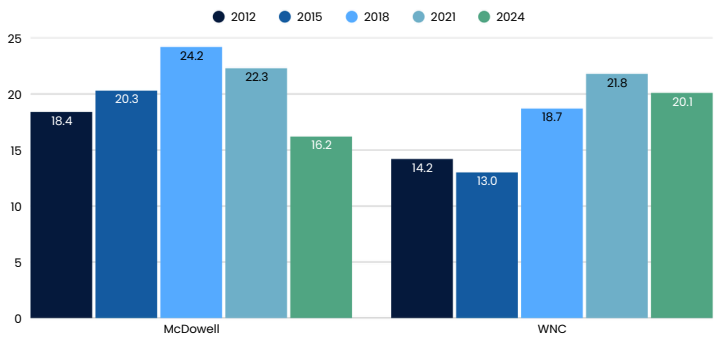
Experience "Fair" or "Poor" Mental Health
(By County)



Sources: 2024 WNC Healthy Impact Community Health Survey, WNC Health Network, Inc. [Item 59]
2023 PRC National Health Survey, PRC, Inc.

Notes: Asked of all respondents.
Only Jackson and Swain counties were tested previously.

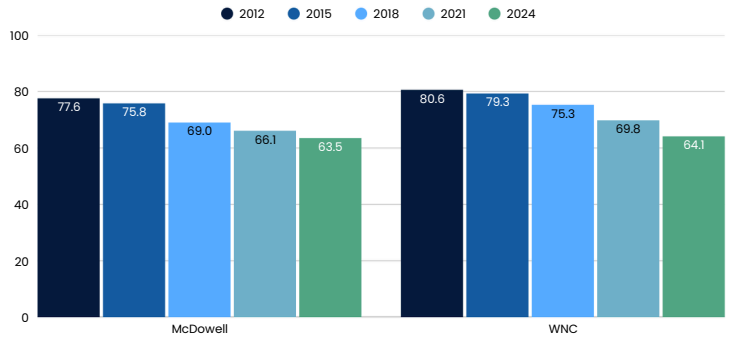
More Than Seven Days of Poor Mental Health in the Past Month
(By County)



Sources: 2024 WNC Healthy Impact Community Health Survey, WNC Health Network, Inc. [Item 60]

Notes: Asked of all respondents.

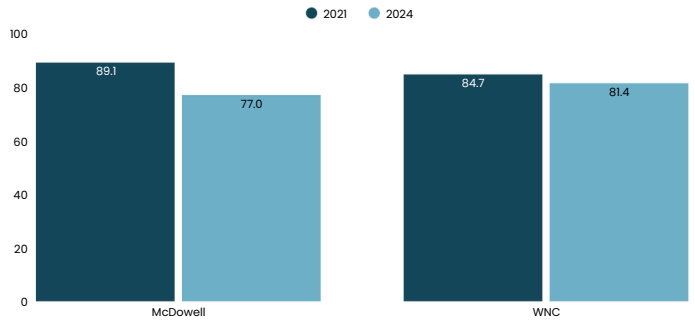
"Always" or "Usually" Get Needed Social/Emotional Support
(By County)



Sources: 2024 WNC Healthy Impact Community Health Survey, WNC Health Network, Inc. [Item 63]

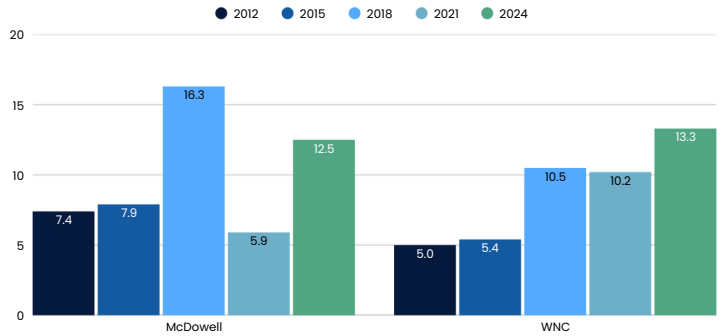
Notes: Asked of all respondents.

Able to Stay Hopeful in Difficult Times
(By County)



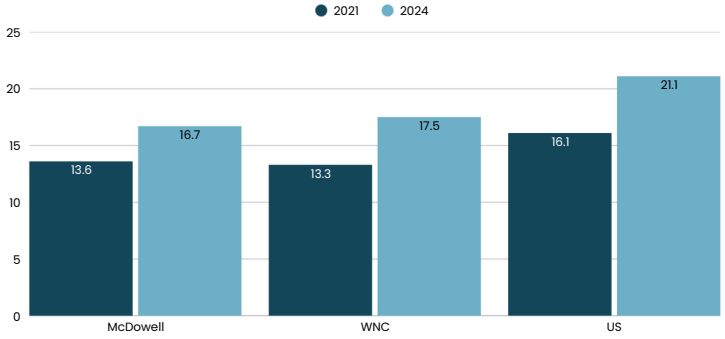
Sources: 2024 WNC Healthy Impact Community Health Survey, WNC Health Network, Inc. [Item 64]
Notes: Asked of all respondents.
Includes "strongly agree" and "agree" responses.

Dissatisfied with Life
(By County)



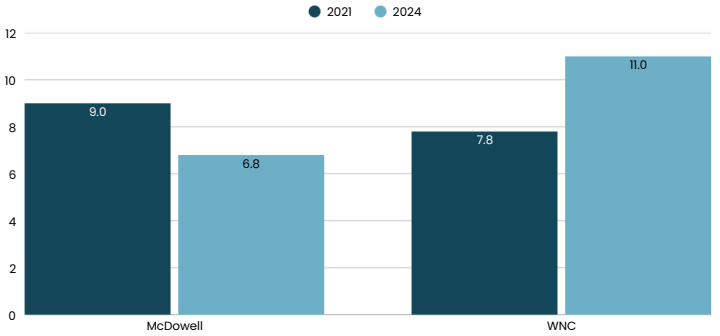
Sources: 2024 WNC Healthy Impact Community Health Survey, WNC Health Network, Inc. [Item 58]
Notes: Asked of all respondents.
Includes "dissatisfied" and "very dissatisfied" responses.

Typical Day is "Extremely/Very Stressful"
(By County)



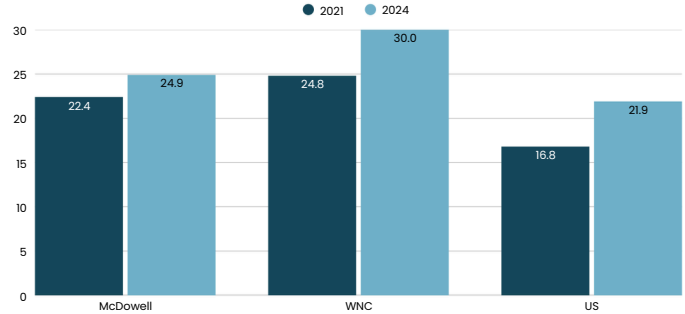
Sources: 2024 WNC Healthy Impact Community Health Survey, WNC Health Network, Inc. [Item 61]
2023 PRC National Health Survey, PRC, Inc.
Notes: Asked of all respondents.

Have Considered Suicide in the Past Year
(By County)



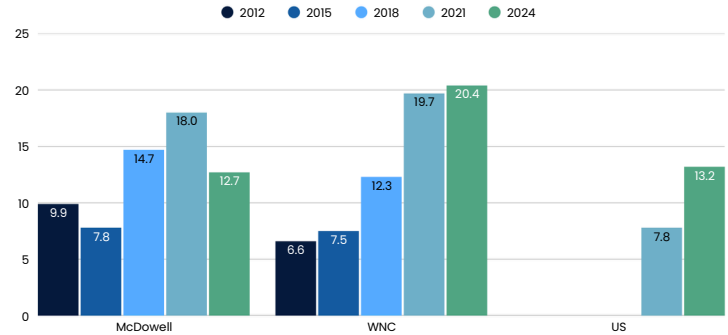
Sources: 2024 WNC Healthy Impact Community Health Survey, WNC Health Network, Inc. [Item 66]
Notes: Asked of all respondents.

Currently Receiving Mental Health Treatment
(By County)



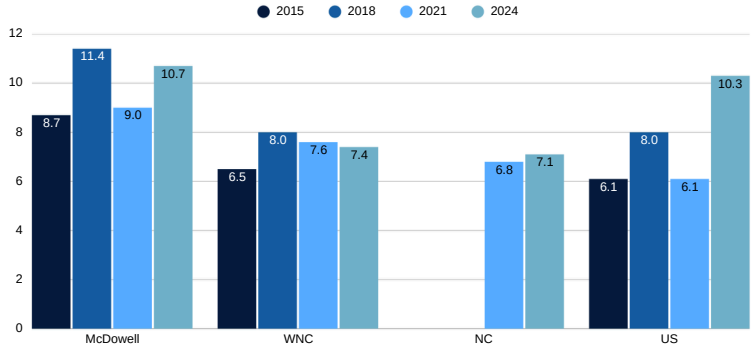
Sources: 2024 WNC Healthy Impact Community Health Survey, WNC Health Network, Inc. [Item 69]
2023 PRC National Health Survey, PRC, Inc.
Notes: Asked of all respondents.
Includes those now taking medication or otherwise receiving treatment, therapy, or counseling for any type of mental or emotional health need.

Unable to Get Mental Health Services When Needed in the Past Year
(By County)



Sources: 2024 WNC Healthy Impact Community Health Survey, WNC Health Network, Inc. [Item 67]
2023 PRC National Health Survey, PRC, Inc.
Notes: Asked of all respondents.

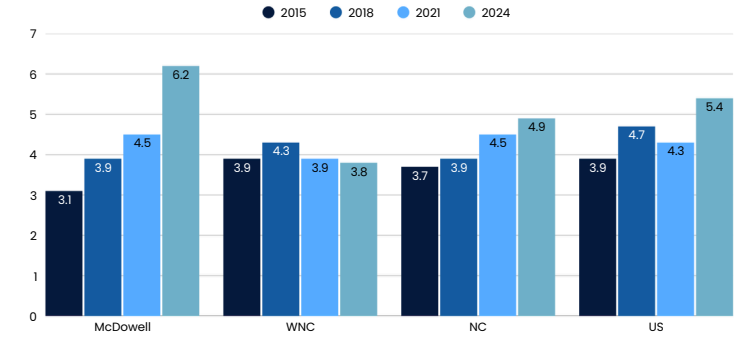
Prevalence of Heart Disease
(By County)



Sources: 2024 WNC Healthy Impact Community Health Survey, WNC Health Network, Inc. [Item 12]
Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2020 North Carolina data.
2023 PRC National Health Survey, PRC, Inc.

Notes: Asked of all respondents.
Includes diagnoses of heart attack, angina, or coronary heart disease.

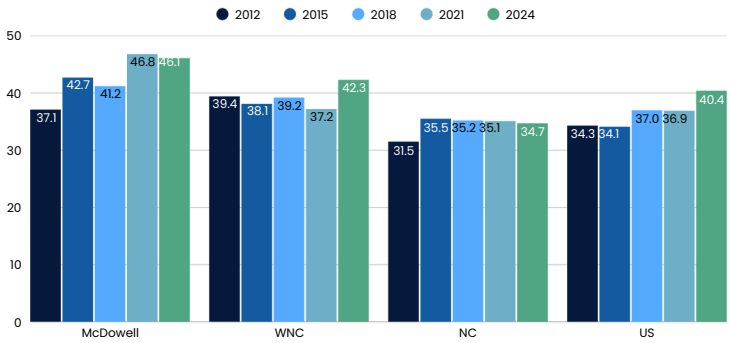
Prevalence of Stroke
(By County)



Sources: 2024 WNC Healthy Impact Community Health Survey, WNC Health Network, Inc. [Item 13]
Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2022 North Carolina data.
2023 PRC National Health Survey, PRC, Inc.

Notes: Asked of all respondents.

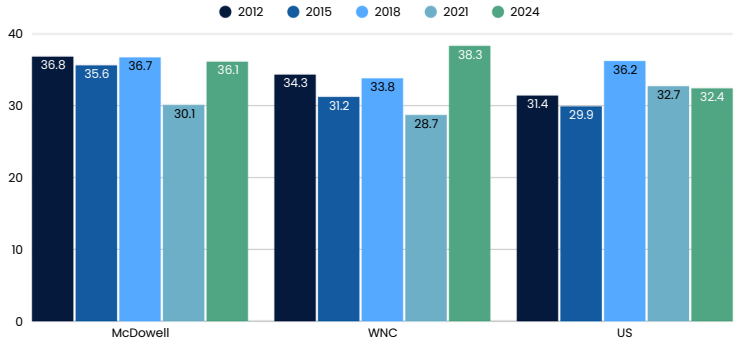
Prevalence of High Blood Pressure
(By County)
Healthy People2030Target=42.6% or Lower



Sources: 2024 WNC Healthy Impact Community Health Survey, WNC Health Network, Inc. [Item 18]
Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2022 North Carolina data.
2023 PRC National Health Survey, PRC, Inc.
US Department of Health and Human Services. Healthy People 2030. http://www.healthypeople.gov.

Notes: Asked of all respondents.

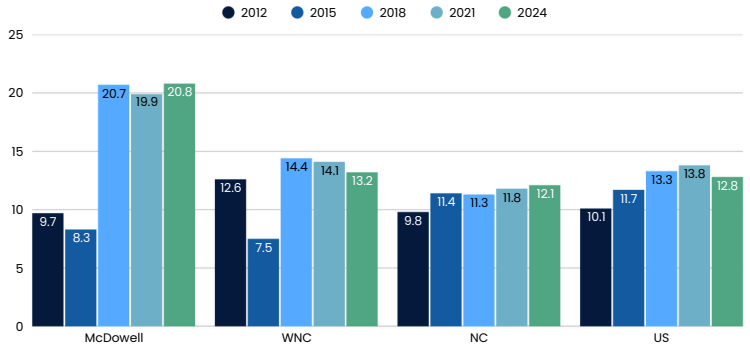
Prevalence of High Blood Cholesterol
(By County)



Sources: 2024 WNC Healthy Impact Community Health Survey, WNC Health Network, Inc. [Item 19]
2023 PRC National Health Survey, PRC, Inc.

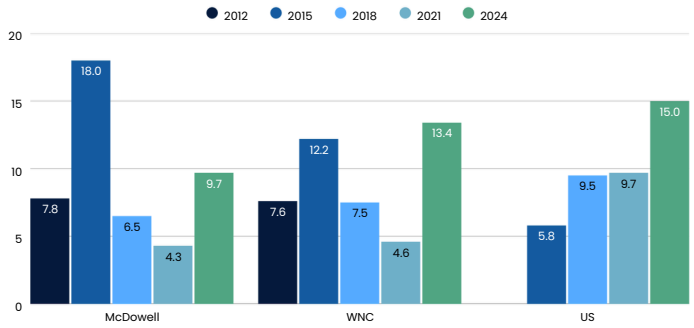
Notes: Asked of all respondents.

Prevalence of Diabetes
(By County)



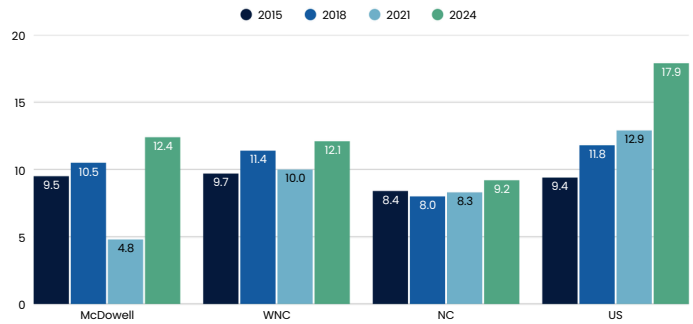
Sources: 2024 WNC Healthy Impact Community Health Survey, WNC Health Network, Inc. [Item 80]
Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2022 North Carolina data.
2023 PRC National Health Survey, PRC, Inc.
Notes: Asked of all respondents.

Prevalence of Borderline or Pre-Diabetes
(By County)



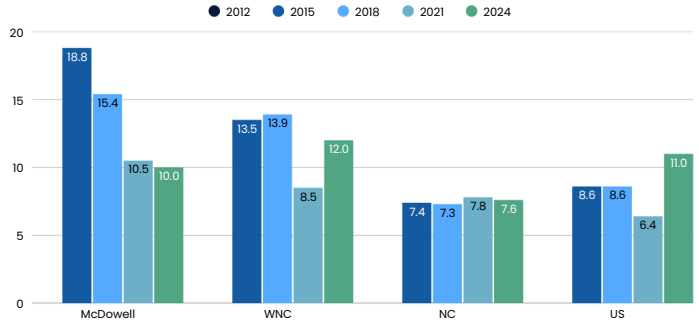
Sources: 2024 WNC Healthy Impact Community Health Survey, WNC Health Network, Inc. [Item 80]
2023 PRC National Health Survey, PRC, Inc.
Notes: Asked of all respondents.

Prevalence of Asthma
(By County)



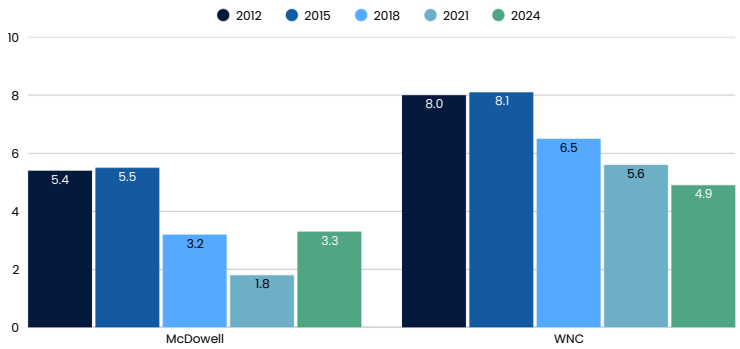
Sources: 2024 WNC Healthy Impact Community Health Survey, WNC Health Network, Inc. [Item 79]
Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2022 North Carolina data.
2023 PRC National Health Survey, PRC, Inc.
Notes: Asked of all respondents.

Prevalence of Chronic Obstructive Pulmonary Disease (COPD)
(By County)



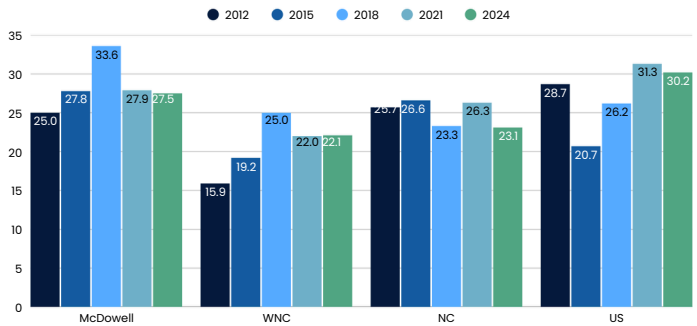
Sources: 2024 WNC Healthy Impact Community Health Survey, WNC Health Network, Inc. [Item 11]
Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia, United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2022 North Carolina data.
2023 PRC National Health Survey, PRC, Inc.
Notes: Asked of all respondents.
Includes conditions such as chronic bronchitis and emphysema.

Consume Five or More Servings of Fruits/Vegetables Per Day
(By County)



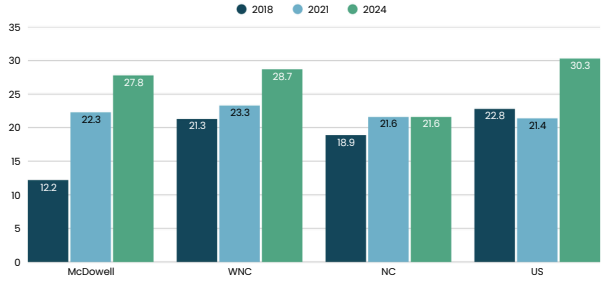
Sources: 2024 WNC Healthy Impact Community Health Survey, WNC Health Network, Inc. [Item 81]
Notes: Asked of all respondents.
For this issue, respondents were asked to recall their food intake during the previous week.
Reflects 1-cup servings of fruits and/or vegetables in the past week, excluding potatoes. Surveys before 2021 also excluded lettuce salads.

No Leisure-Time PhysicalActivity in the Past Month
(By County)
Healthy People2030=21.8% or Lower



Sources: 2024 WNC Healthy Impact Community Health Survey, WNC Health Network, Inc. [Item 49]
Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia, United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2022 North Carolina data.
2023 PRC National Health Survey, PRC, Inc.
US Department of Health and Human Services. Healthy People 2030. http://www.healthypeople.gov.
Notes: Asked of all respondents.

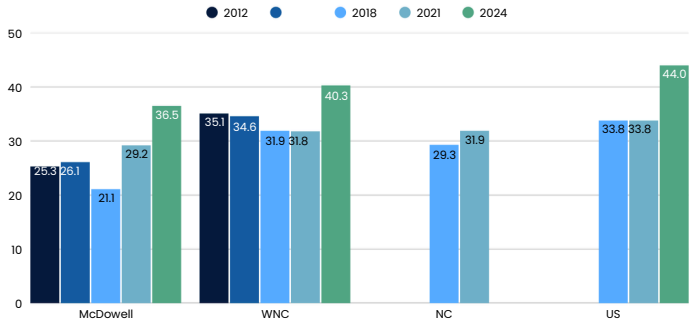
Meets Physical Activity Recommendations
(By County)
Healthy People2030Target=29.7% or Higher



Sources: 2024 WNC Healthy Impact Community Health Survey, WNC Health Network, Inc. [Item 82]
Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2020 North Carolina data.
2023 PRC National Health Survey, PRC, Inc.
US Department of Health and Human Services. Healthy People 2030. http://www.healthypeople.gov.
Notes: Asked of all respondents.
Meeting both guidelines is defined as the number of persons age 18+ who report light or moderate aerobic activity for at least 150 minutes per week or who report vigorous physical activity 75 minutes per week (or an equivalent combination of moderate and vigorous-intensity activity) and who also report doing physical activities specifically designed to strengthen muscles at least twice per week.

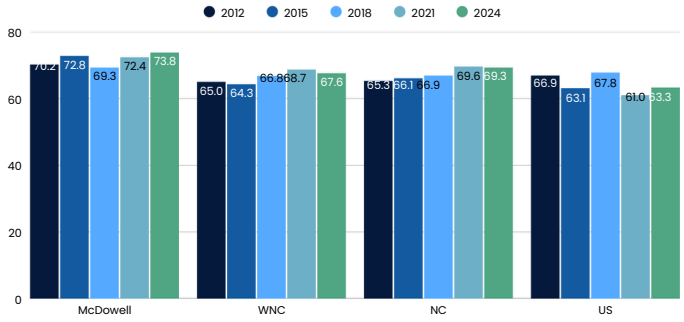
Strengthening Physical Activity (By County)

2015



Sources: 2024 WNC Healthy Impact Community Health Survey, WNC Health Network, Inc. [Item 56]
2023 PRC National Health Survey, PRC, Inc.
Notes: Asked of all respondents.
Takes part in physical activities or exercises that strengthen muscles at least 2 times per week.

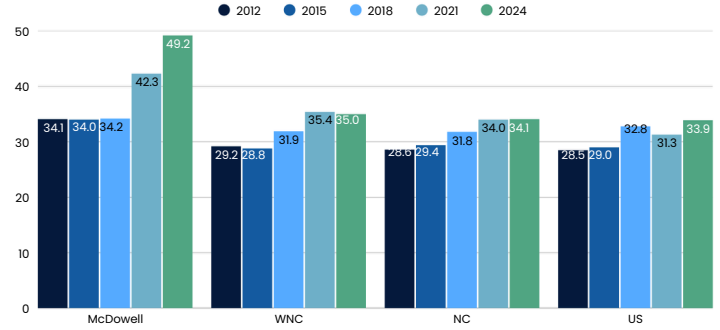
Prevalence of Total Overweight(Overweight or Obese) (By County)



Sources: 2024 WNC Healthy Impact Community Health Survey, WNC Health Network, Inc. [Item 84]
Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2022 North Carolina data.
2023 PRC National Health Survey, PRC, Inc.
Notes: Based on reported heights and weights; asked of all respondents.
The definition of overweight is having a body mass index (BMI), a ratio of weight to height (kilograms divided by meters squared), greater than or equal to 25.0, regardless of gender. The definition for obesity is a BMI greater than or equal to 30.0.

Prevalence of Obesity (By County)

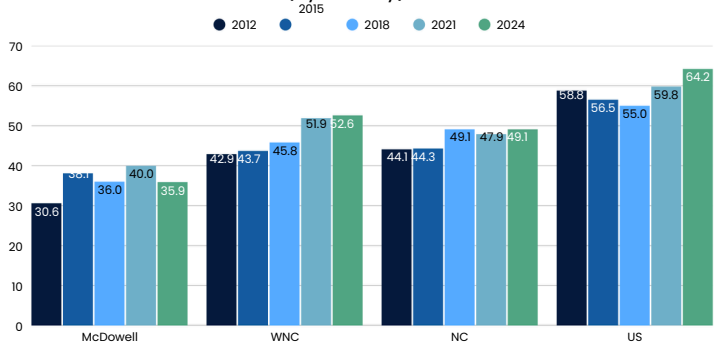
Healthy People2030Target=36.0% or Lower



Sources: 2024 WNC Healthy Impact Community Health Survey, WNC Health Network, Inc. [Item 84]
Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2022 North Carolina data.
2023 PRC National Health Survey, PRC, Inc.
US Department of Health and Human Services. Healthy People 2030. http://www.healthypeople.gov.
Notes: Based on reported heights and weights; asked of all respondents.
The definition of obesity is having a body mass index (BMI), a ratio of weight to height (kilograms divided by meters squared), greater than or equal to 30.0, regardless of gender.

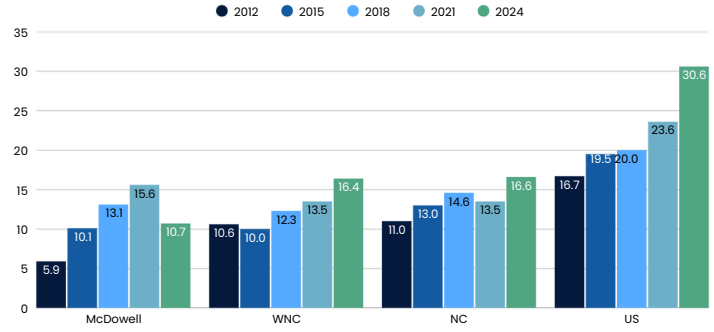
Current Drinking (By County)

2015



Sources: 2024 WNC Healthy Impact Community Health Survey, WNC Health Network, Inc. [Item 338]
Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2022 North Carolina data.
2023 PRC National Health Survey, PRC, Inc.
Notes: Asked of all respondents.
Current drinking reflects persons age 18 years and over who had at least one alcoholic drink in the past month.

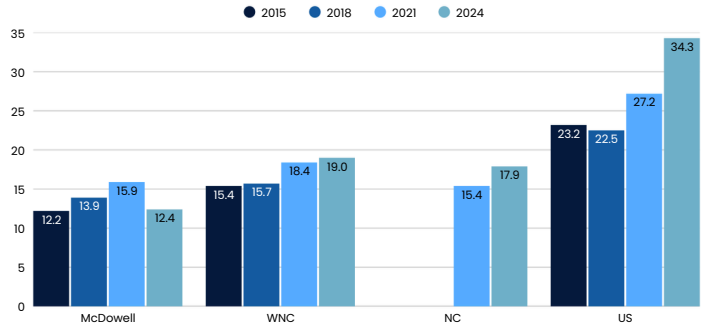
Binge Drinking
(By County)
Healthy People2030Target=25.4% or Lower



Sources: 2024 WNC Healthy Impact Community Health Survey, WNC Health Network, Inc. [Item 337]
Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2022 North Carolina data.
2023 PRC National Health Survey, PRC, Inc.
US Department of Health and Human Services. Healthy People 2030. http://www.healthypeople.gov.

Notes: Asked of all respondents.
Binge drinking is defined as men consuming 5+ alcoholic drinks on any one occasion in the past month or women consuming 4+ alcoholic drinks on any one occasion in the past month.
Before 2021, survey data classified both men and women as binge drinkers if they had 5+ alcoholic drinks on one occasion in the past month.

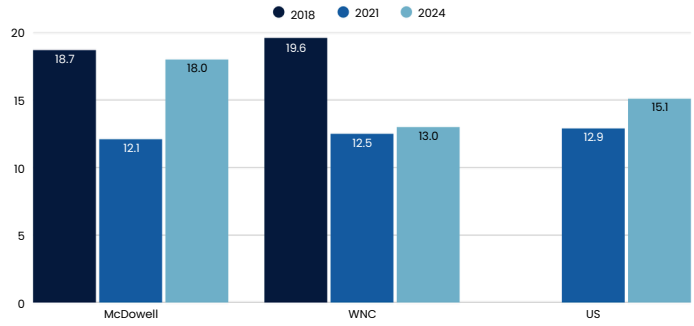
Excessive Drinking
(By County)



Sources: 2024 WNC Healthy Impact Community Health Survey, WNC Health Network, Inc. [Item 85]
Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2022 North Carolina data.
2023 PRC National Health Survey, PRC, Inc.

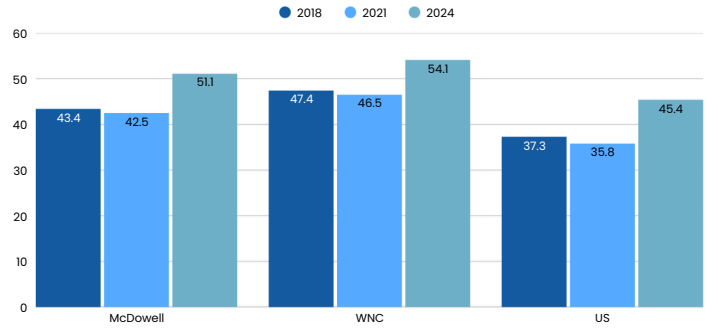
Notes: Asked of all respondents.
Excessive drinking reflects the number of persons age 18 years and over who drank more than two drinks per day on average (for men) or more than one drink per day on average (for women) OR who drank 5 or more drinks during a single occasion (for men) or 4 or more drinks during a single occasion (for women) during the past 30 days.

Used a Prescription Opioid in the Past Year, With or Without a Prescription
(By County)



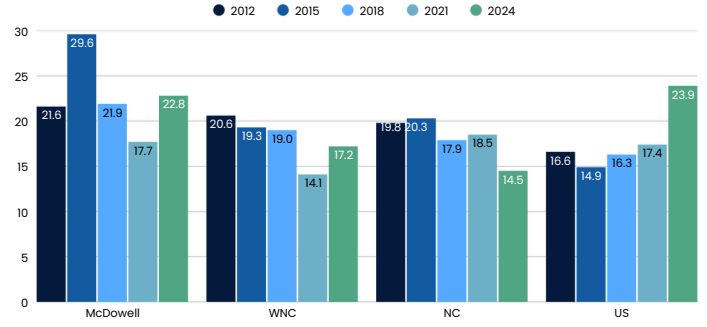
Sources: 2024 WNC Healthy Impact Community Health Survey, WNC Health Network, Inc. [Item 23]
2023 PRC National Health Survey, PRC, Inc.
Notes: Asked of all respondents.

Life Has Been Negatively Affected by Substance Use (by Self or Someone Else)
(By County)



Sources: 2024 WNC Healthy Impact Community Health Survey, WNC Health Network, Inc. [Item 24]
2023 PRC National Health Survey, PRC, Inc.
Notes: Asked of all respondents.

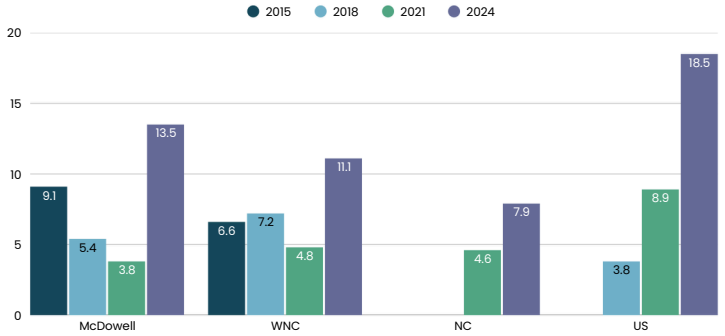
Currently Smoke Cigarettes
(By County)
Healthy People2030Target= 6.1% or Lower



Sources: 2024 WNC Healthy Impact Community Health Survey, WNC Health Network, Inc. [Item 25]
Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2022 North Carolina data.
2023 PRC National Health Survey, PRC, Inc.
US Department of Health and Human Services. Healthy People 2030. http://www.healthypeople.gov.

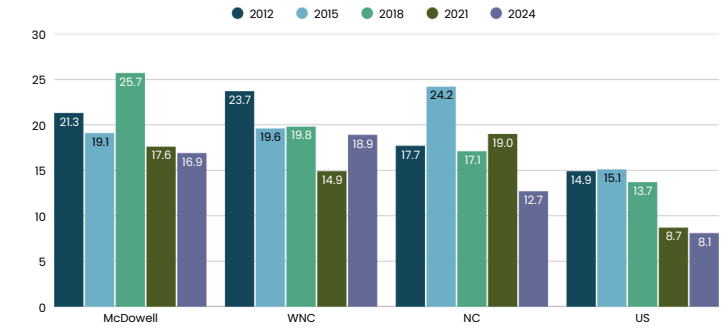
Notes: Asked of all respondents.
Includes those who smoke cigarettes every day or on some days.

Currently Use Vaping Products
(By County)



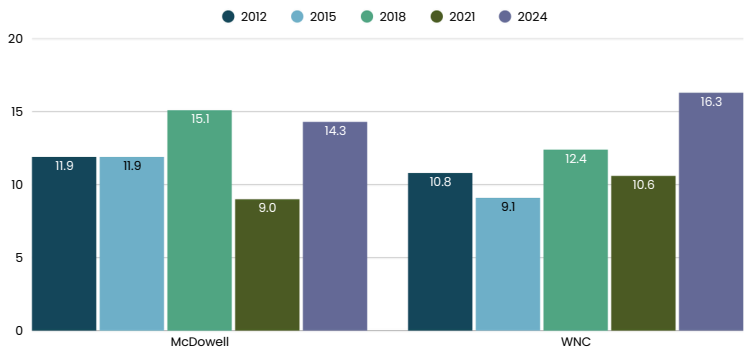
Sources: 2024 WNC Healthy Impact Community Health Survey, WNC Health Network, Inc. [Item 26]
Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human
Services, Centers for Disease Control and Prevention (CDC): 2022 North Carolina data.
2023 PRC National Health Survey, PRC, Inc.
Notes: Asked of all respondents.
Includes those who use vaping products every day or on some days.

Lack of Health Care Insurance Coverage
(By County)
Healthy People2030Target=7.6% or Lower



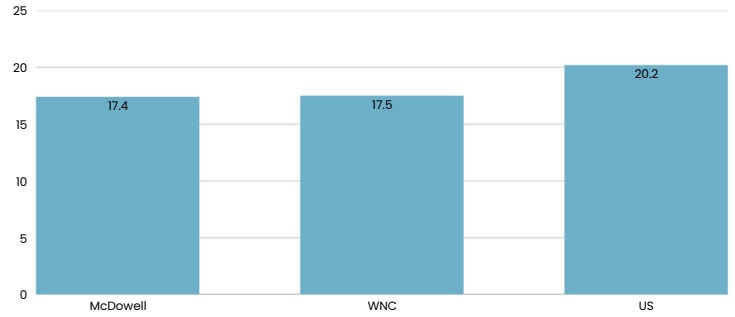
Sources: 2024 WNC Healthy Impact Community Health Survey, WNC Health Network, Inc. [Item 86]
Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2022 North Carolina data.
2023 PRC National Health Survey, PRC, Inc.
US Department of Health and Human Services. Healthy People 2030. http://www.healthypeople.gov.
Notes: Reflects all respondents under the age of 65.
Includes any type of insurance, such as traditional health insurance, prepaid plans such as HMOs, or government-sponsored coverage (e.g., Medicare, Medicaid, Indian Health Services, etc.).

Was Unable to Get Needed Medical Care at Some Point in the Past Year
(By County)



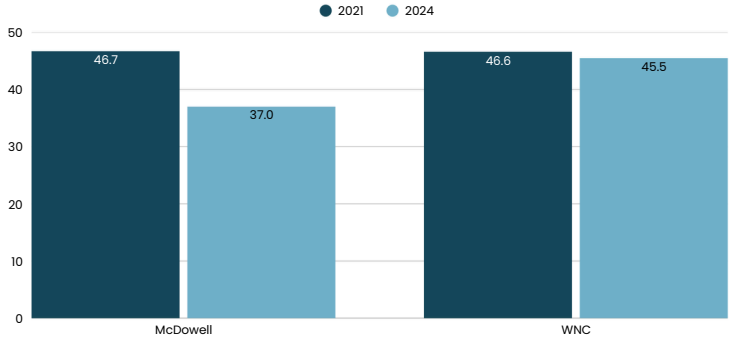
Sources: 2024 WNC Healthy Impact Community Health Survey, WNC Health Network, Inc. [Item 7]
Notes: Asked of all respondents.

Cost Prevented Getting a Prescription in the Past Year
(By County, 2024)



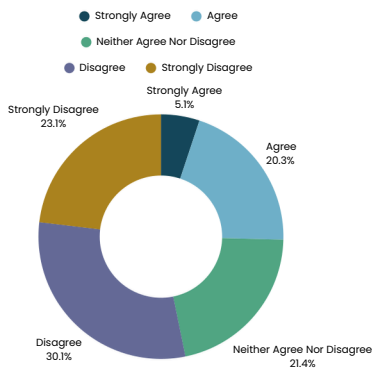
Sources: 2024 WNC Healthy Impact Community Health Survey, WNC Health Network, Inc. [Item 9]
2023 PRC National Health Survey, PRC, Inc.
Notes: Asked of all respondents.

"Extremely/Very Likely" to Use Telemedicine for Routine Care
(By County)



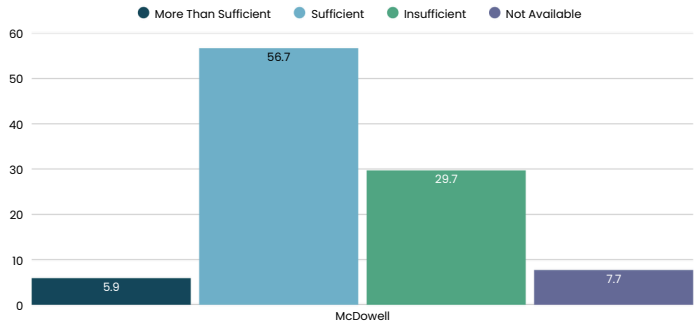
Sources: 2024 WNC Healthy Impact Community Health Survey, WNC Health Network, Inc. [Item 10]
Notes: Asked of all respondents.
During a telemedicine visit, a patient uses a computer, smartphone, or telephone to communicate with a health care professional in real time without being face-to-face.

"Sometimes my family chooses fast food over groceries because of the cost"
(McDowell County, 2024)



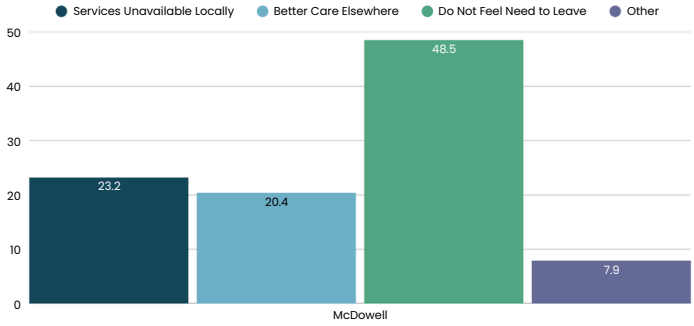
Sources: 2024 WNC Healthy Impact Community Health Survey, WNC Health Network, Inc. [Item 320]
Notes: Asked of all respondents.

Ratings of Local Resources for Chronic Diseases (Such as Diabetes, Heart Disease, and COPD)
(By County, 2024)



Sources: 2024 WNC Healthy Impact Community Health Survey, WNC Health Network, Inc. [Item 306]
Notes:Asked of all respondents.

Main Reason for Leaving County for Medical Care
(By County, 2024)

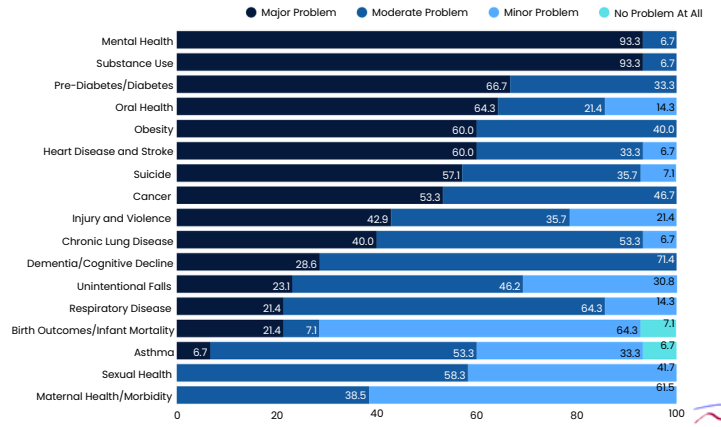


Sources: 2024 WNC Healthy Impact Community Health Survey, WNC Health Network, Inc. [Item 304]
Notes:Asked of all respondents.

FOOTHILLS HEALTH DISTRICT

FOOTHILLS HEALTH DISTRICT

McDowell County Key Informants: Relative Position of Health Topics as Problems in the Community



FOOTHILLS HEALTH DISTRICT

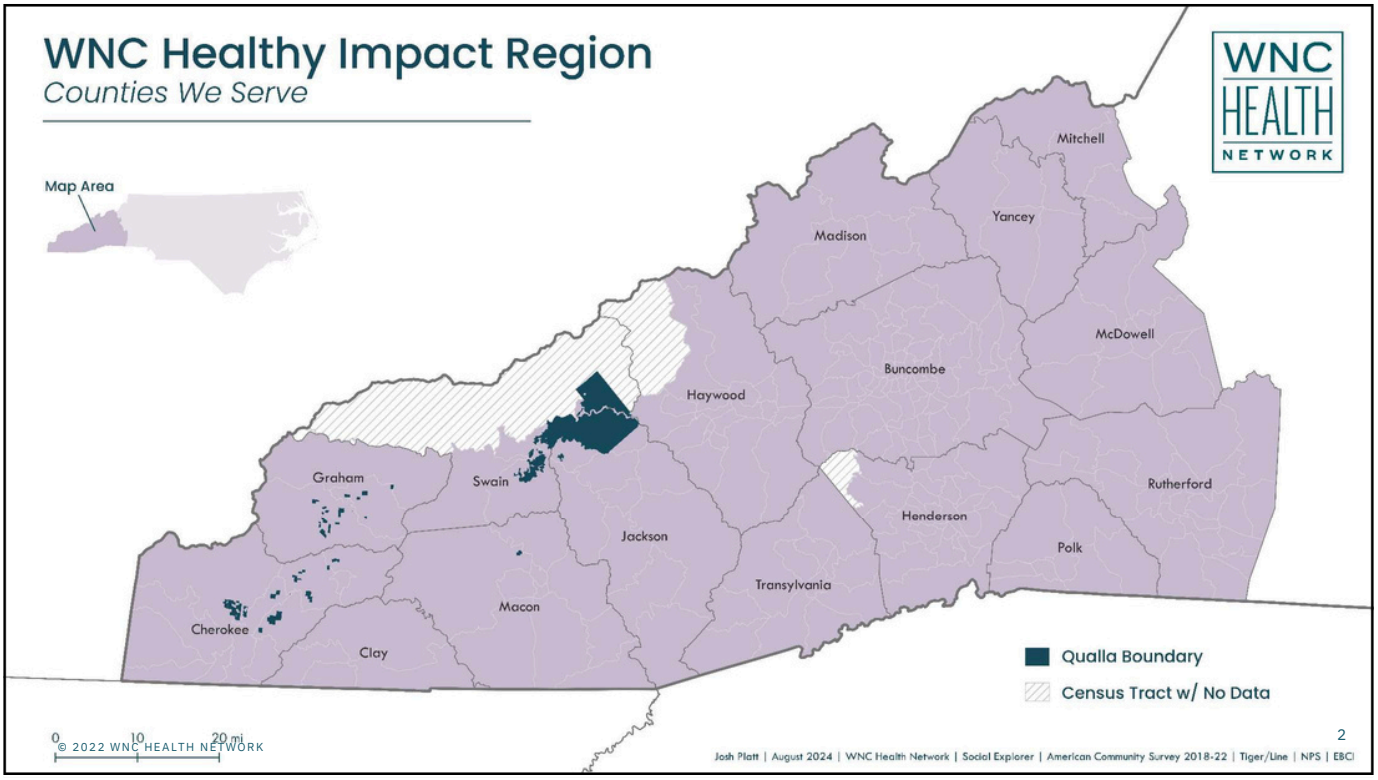
APPENDIX C – County Maps

McDowell County Maps

Sources: SocialExplorer, American Community Survey 5-Year Estimates 2018-2022,

Social VulnerabilityIndex(2022),ShapefilefromTiger/Line,NationalParkService,and Eastern Band of Cherokee Indians

1



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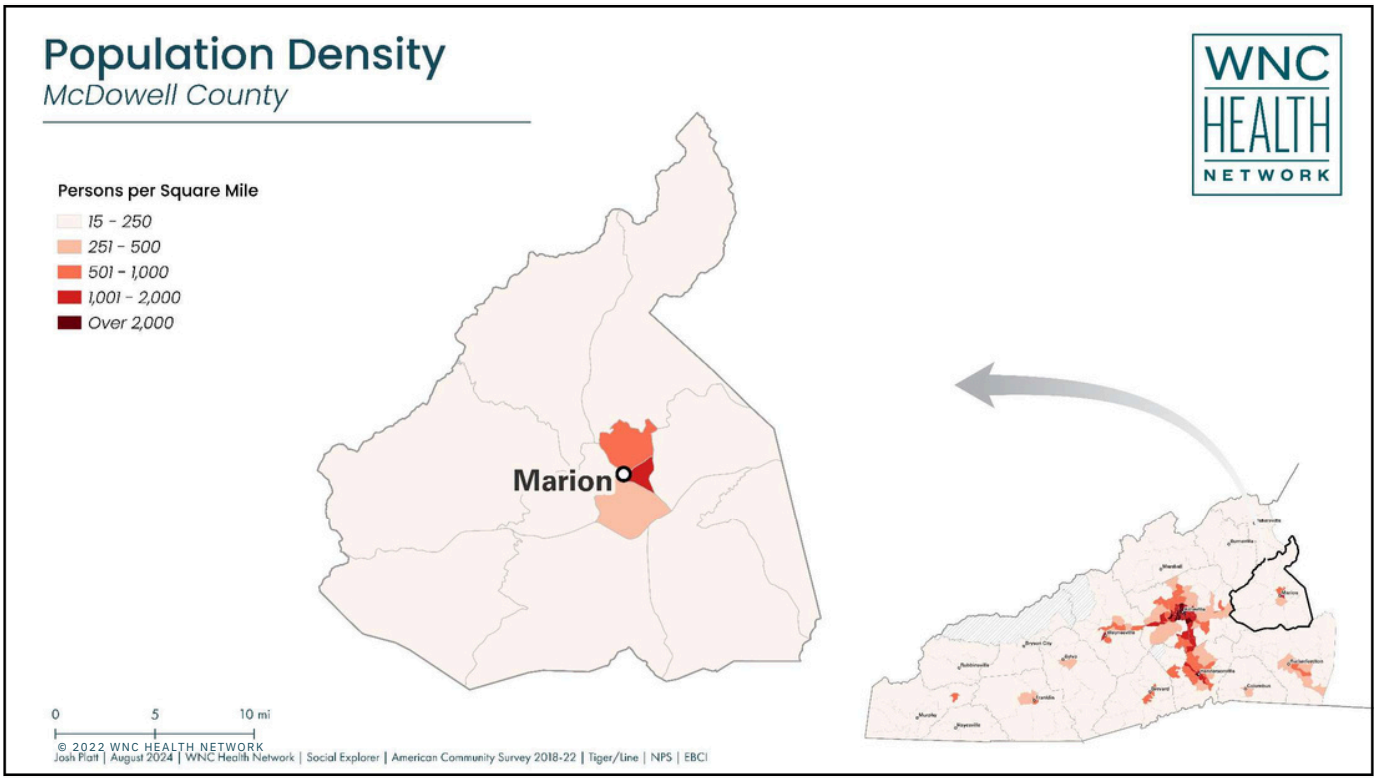
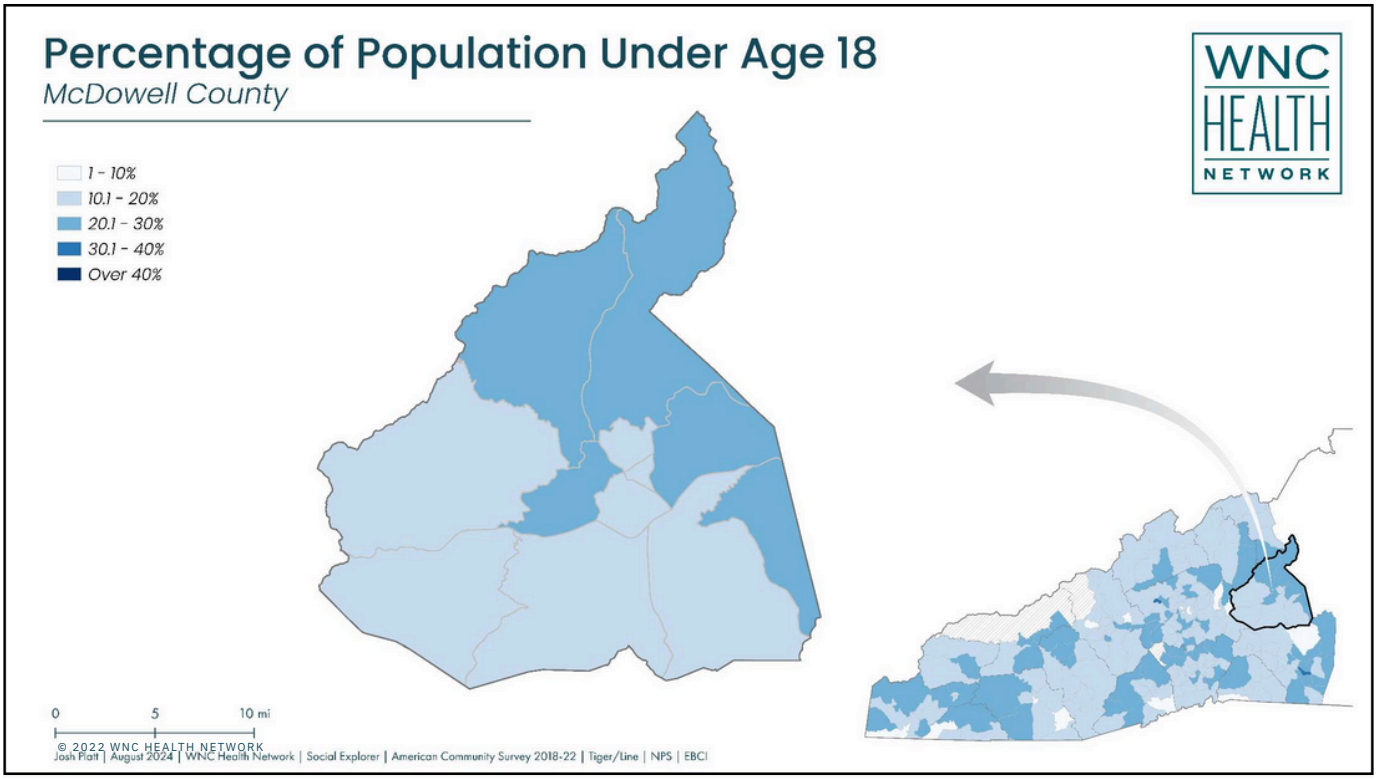
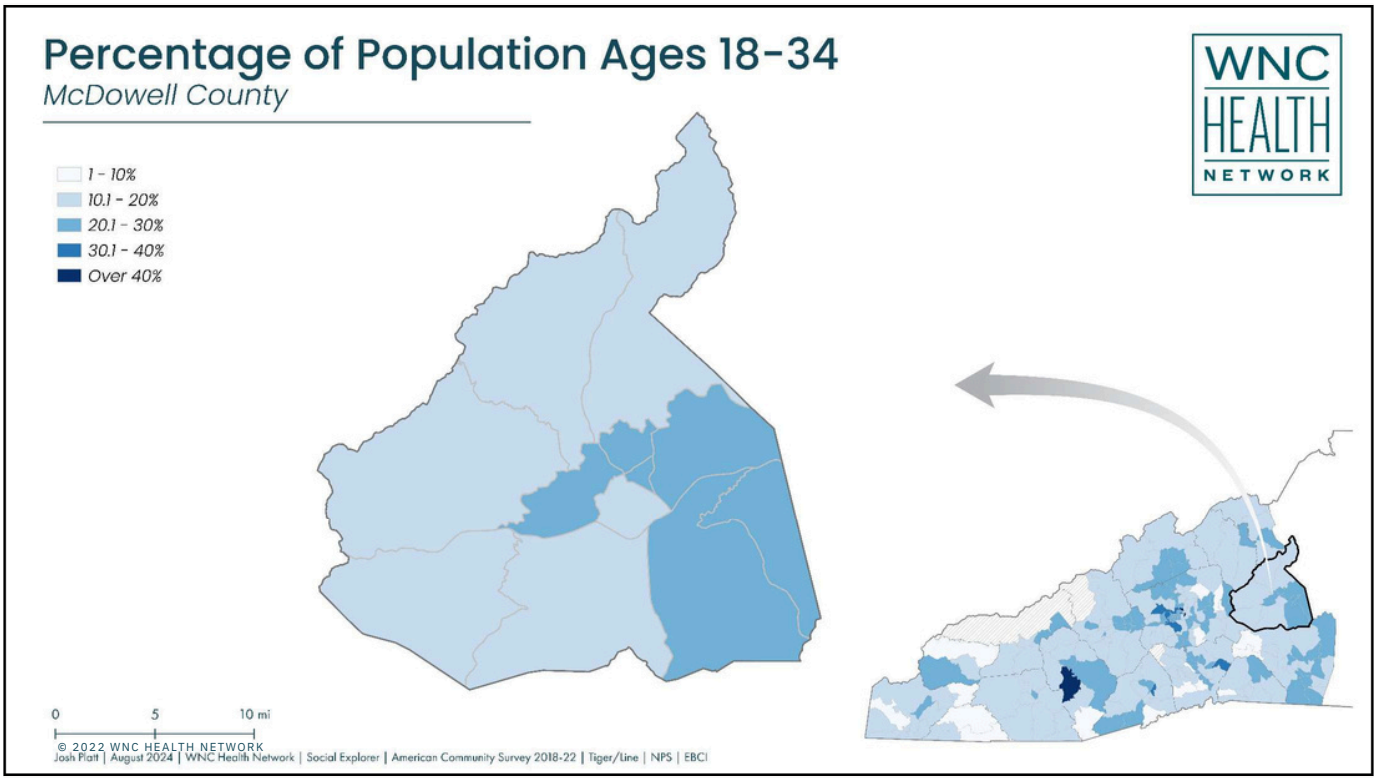

Population Density
McDowell County
WNC HEALTH NETWORK
Persons per Square Mile
15 - 250
251 - 500
501 - 1,000
1,001 - 2,000
Over 2,000
Marion
0
5
10 mi
© 2022 WNC HEALTH NETWORK
Josh Platt | August 2024 | WNC Health Network | Social Explorer | American Community Survey 2018-22 | Tiger/Line | NPS | EBCI

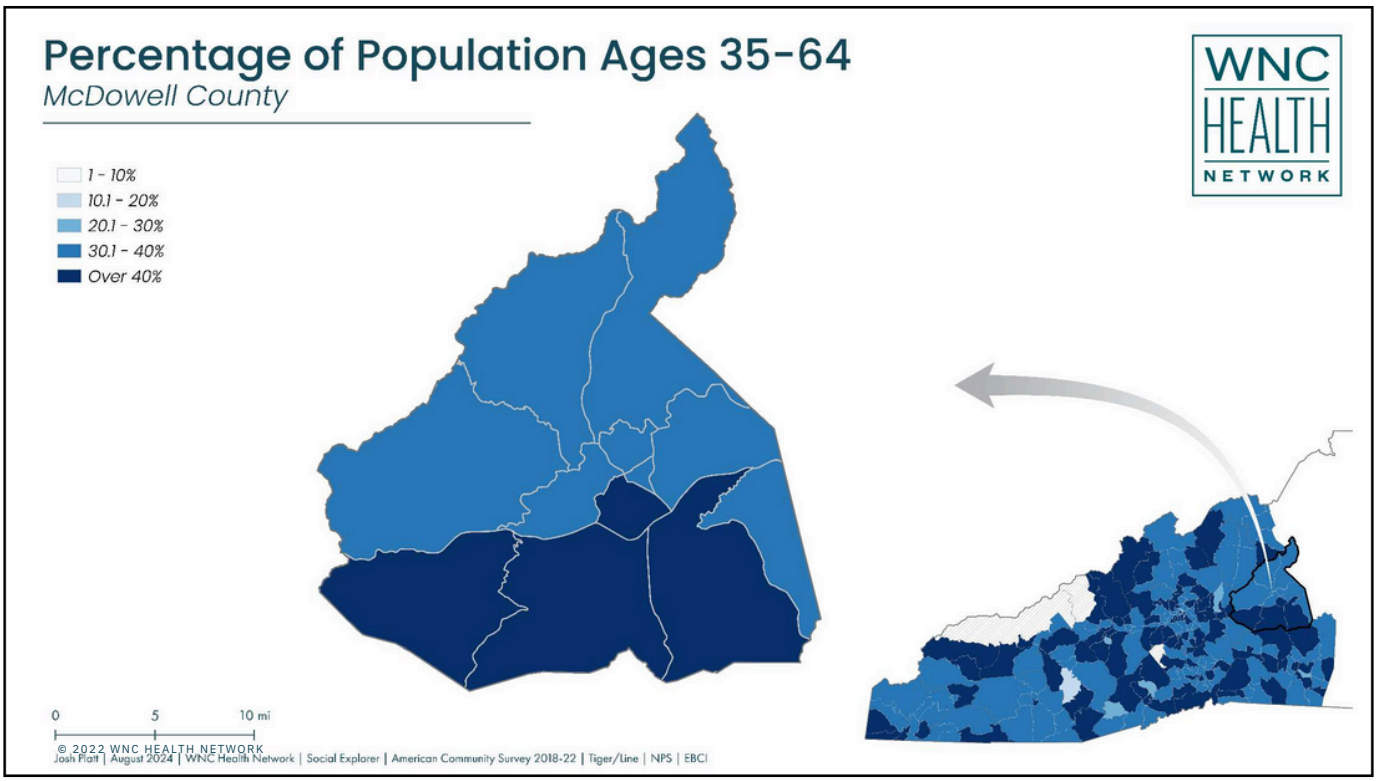
3


Percentage of Population Under Age 18
McDowell County
WNC HEALTH NETWORK
1 - 10%
10.1 - 20%
20.1 - 30%
30.1 - 40%
Over 40%
0
5
10 mi
© 2022 WNC HEALTH NETWORK
Josh Platt | August 2024 | WNC Health Network | Social Explorer | American Community Survey 2018-22 | Tiger/Line | NPS | EBCI

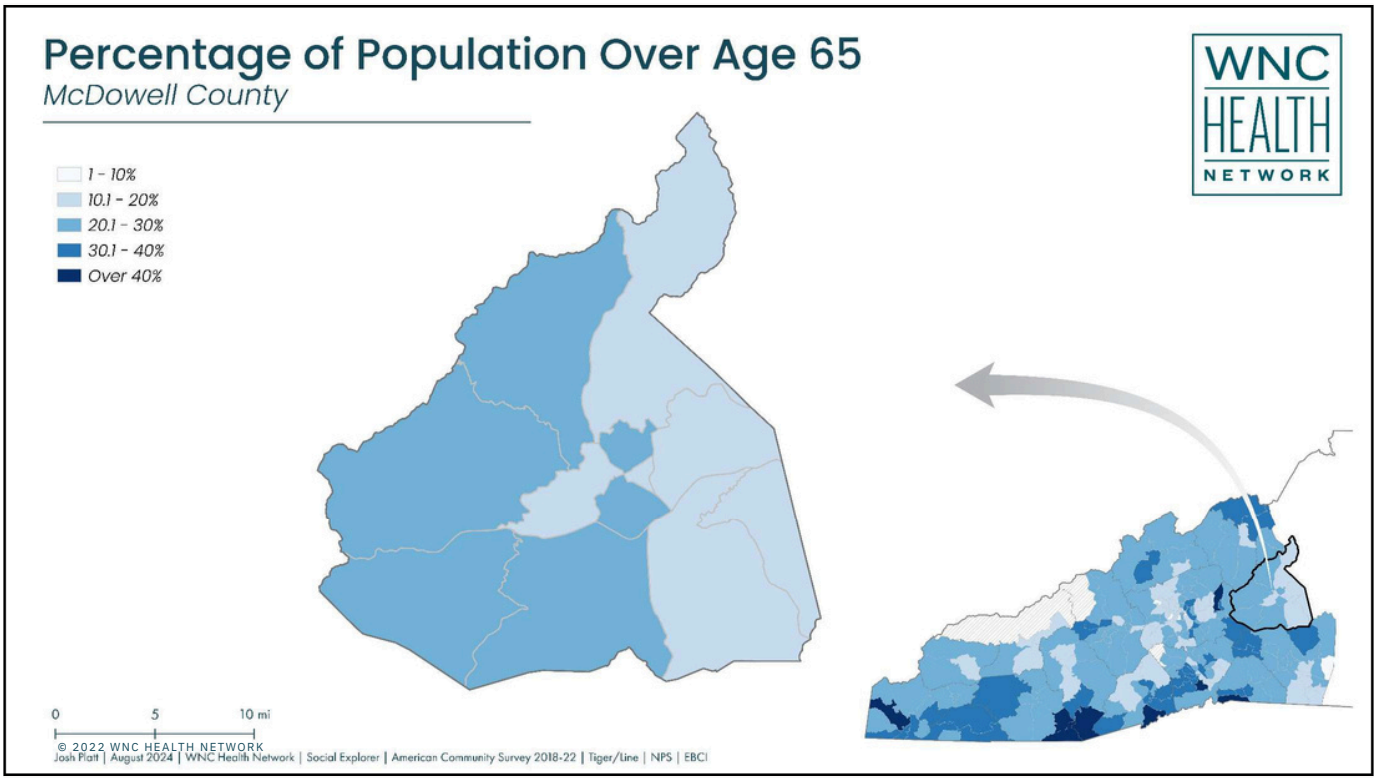
4


Percentage of Population Ages 18-34
McDowell County
1 - 10%
10.1 - 20%
20.1 - 30%
30.1 - 40%
Over 40%
WNC HEALTH NETWORK
0
5
10 mi
© 2022 WNC HEALTH NETWORK
Josh Platt | August 2024 | WNC Health Network | Social Explorer | American Community Survey 2018-22 | Tiger/Line | NPS | EBCI

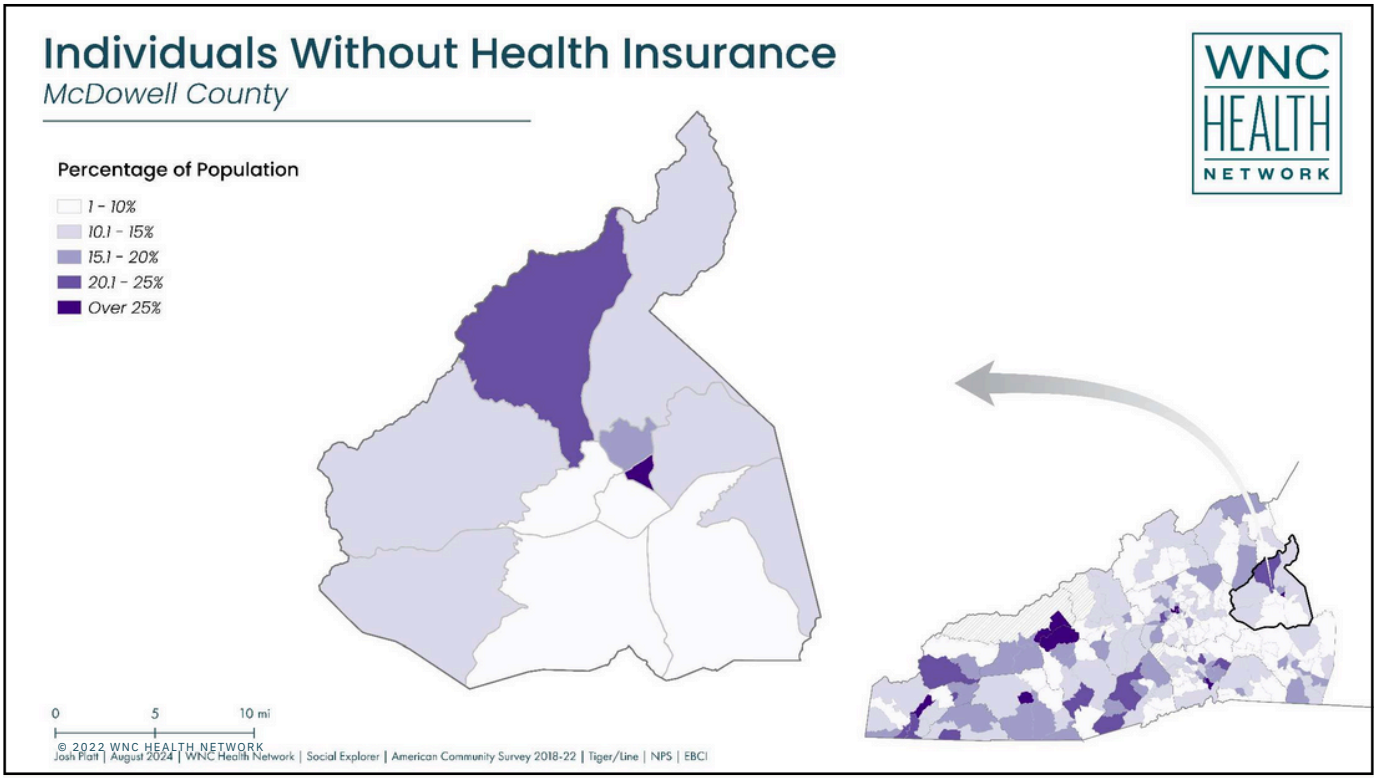
5


Percentage of Population Ages 35-64
McDowell County
1 - 10%
10.1 - 20%
20.1 - 30%
30.1 - 40%
Over 40%
WNC HEALTH NETWORK
0
5
10 mi
© 2022 WNC HEALTH NETWORK
Josh Platt | August 2024 | WNC Health Network | Social Explorer | American Community Survey 2018-22 | Tiger/Line | NPS | EBCI

6


Percentage of Population Over Age 65
McDowell County
1 - 10%
10.1 - 20%
20.1 - 30%
30.1 - 40%
Over 40%
WNC HEALTH NETWORK
0
5
10 mi
© 2022 WNC HEALTH NETWORK
Josh Platt | August 2024 | WNC Health Network | Social Explorer | American Community Survey 2018-22 | Tiger/Line | NPS | EBCI

7


Individuals Without Health Insurance
McDowell County
Percentage of Population
1 - 10%
10.1 - 15%
15.1 - 20%
20.1 - 25%
Over 25%
WNC HEALTH NETWORK
0
5
10 mi
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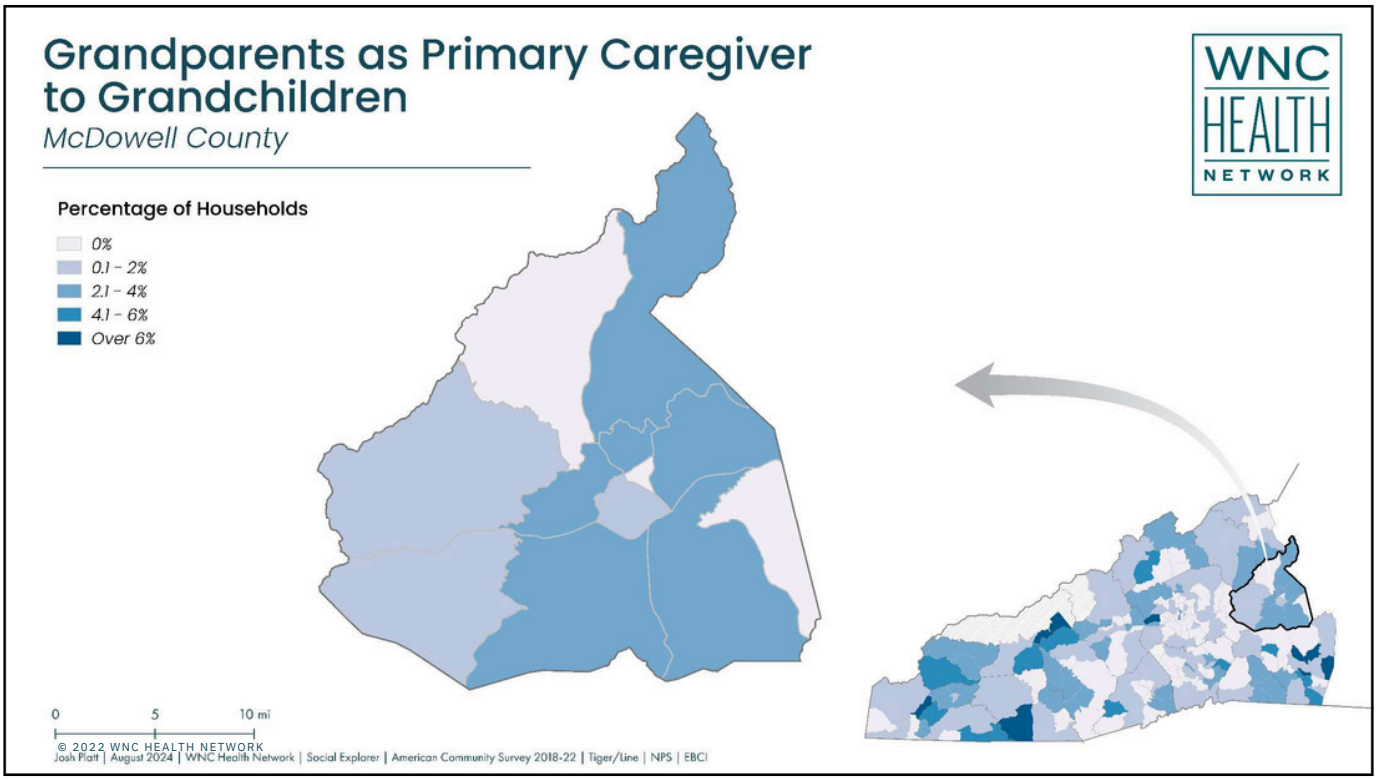
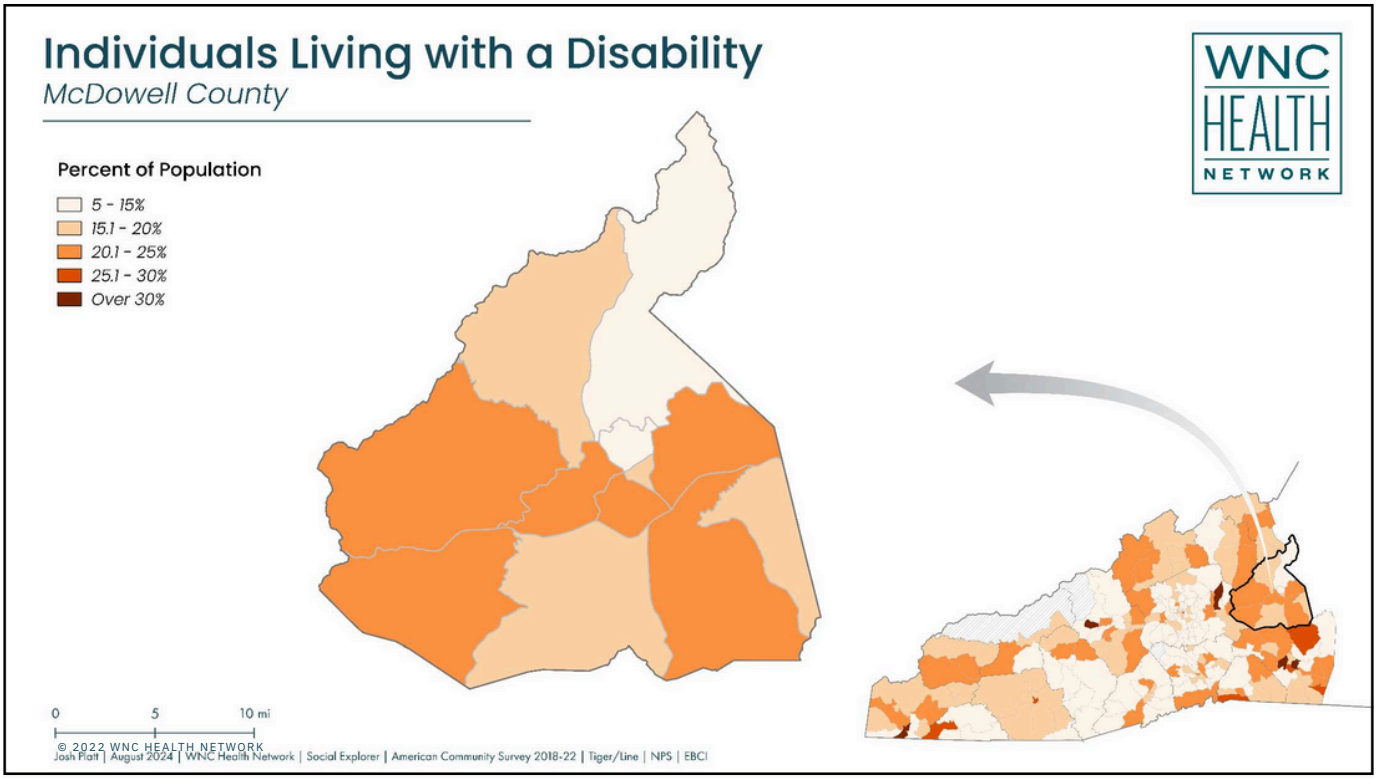
Josh Platt | August 2024 | WNC Health Network | Social Explorer | American Community Survey 2018-22 | Tiger/Line | NPS | EBCI

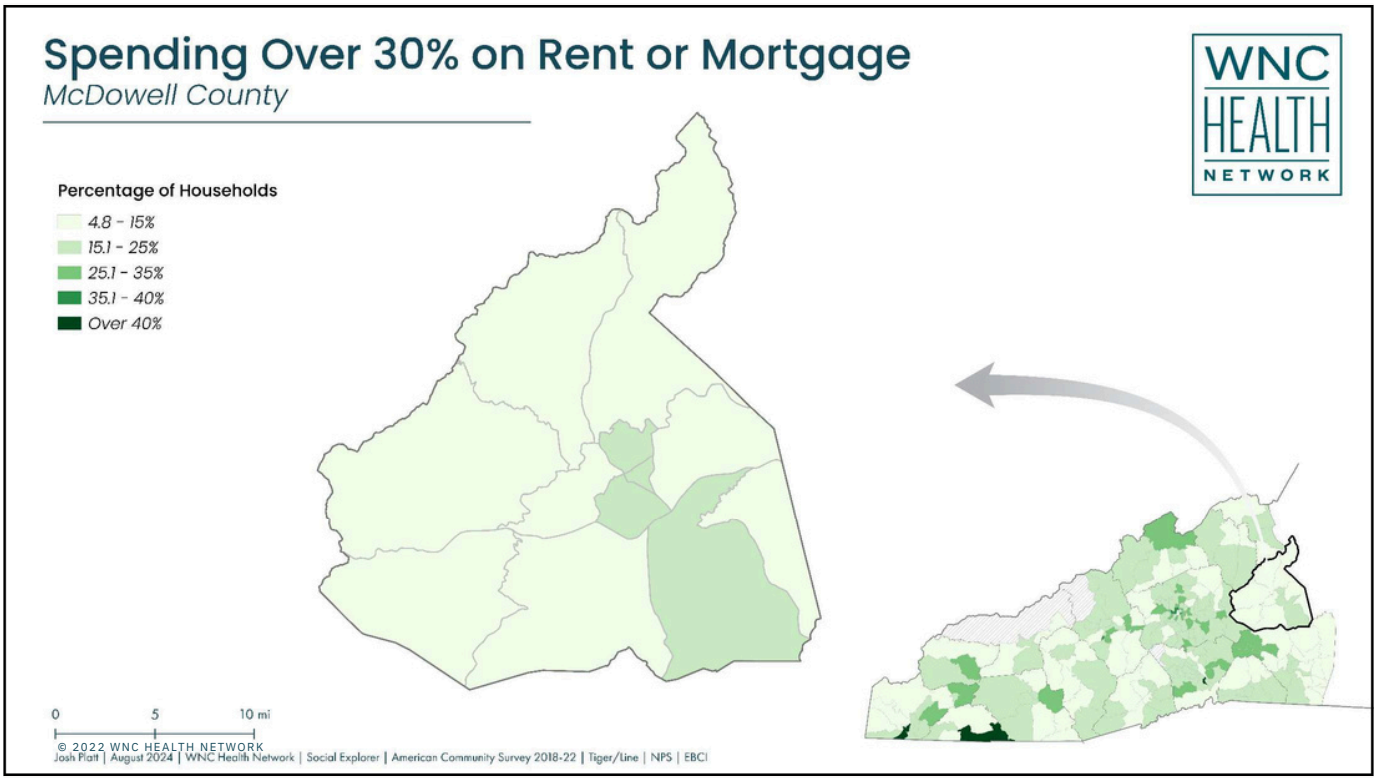
8


Grandparents as Primary Caregiver to Grandchildren
McDowell County
WNC HEALTH NETWORK
Percentage of Households
0%
0.1 - 2%
2.1 - 4%
4.1 - 6%
Over 6%
0
5
10 mi
© 2022 WNC HEALTH NETWORK
Josh Platt | August 2024 | WNC Health Network | Social Explorer | American Community Survey 2018-22 | Tiger/Line | NPS | EBCI

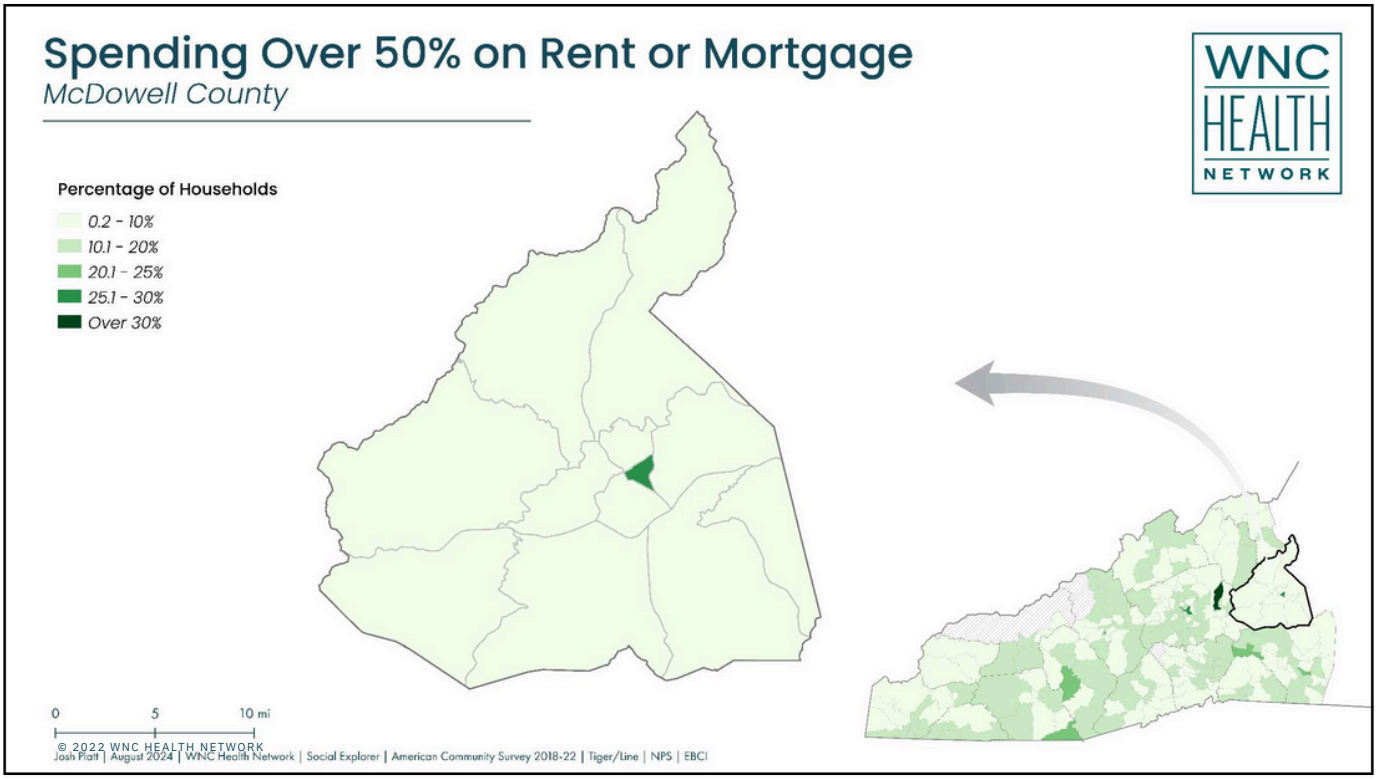
9


Individuals Living with a Disability
McDowell County
WNC HEALTH NETWORK
Percent of Population
5 - 15%
15.1 - 20%
20.1 - 25%
25.1 - 30%
Over 30%
0
5
10 mi
© 2022 WNC HEALTH NETWORK
Josh Platt | August 2024 | WNC Health Network | Social Explorer | American Community Survey 2018-22 | Tiger/Line | NPS | EBCI

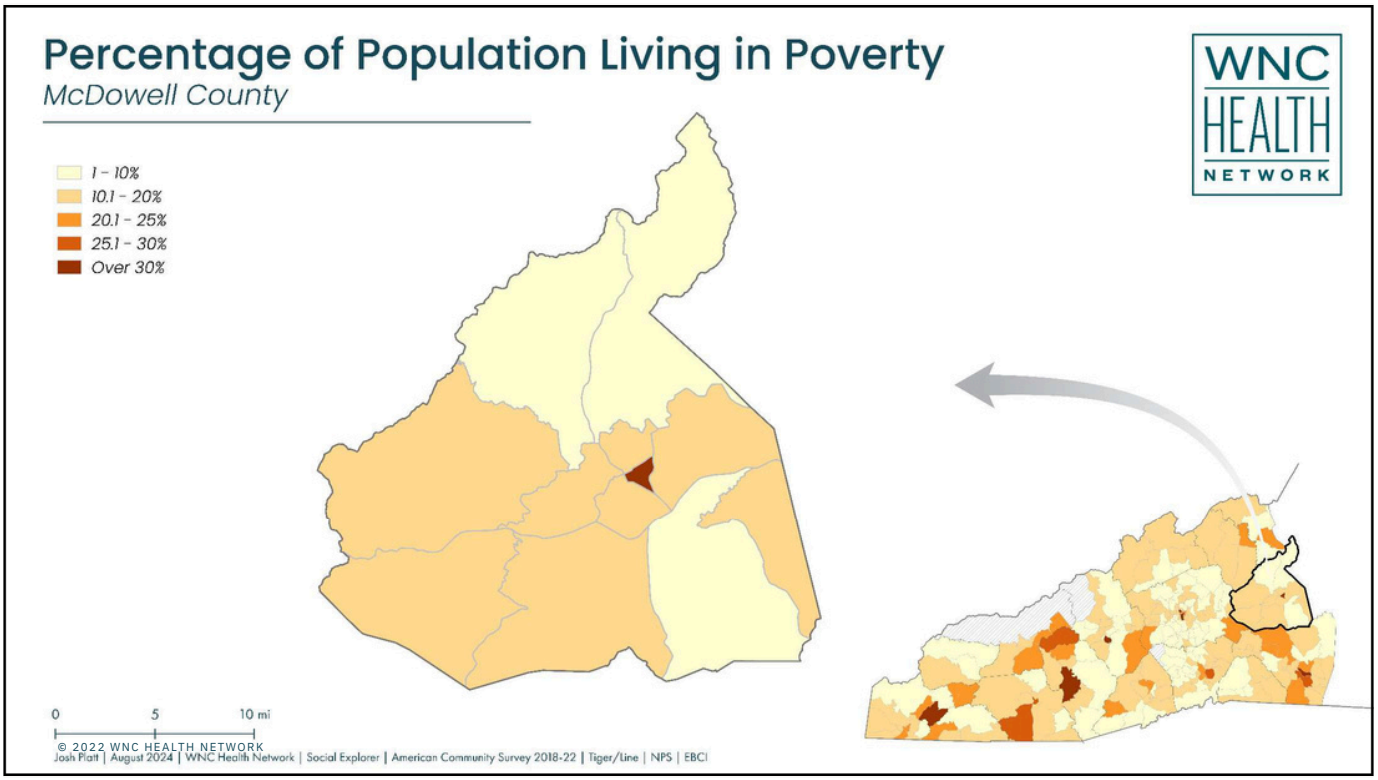
10


Spending Over 30% on Rent or Mortgage
McDowell County
WNC HEALTH NETWORK
Percentage of Households
4.8 - 15%
15.1 - 25%
25.1 - 35%
35.1 - 40%
Over 40%
0
5
10 mi
© 2022 WNC HEALTH NETWORK
Josh Platt | August 2024 | WNC Health Network | Social Explorer | American Community Survey 2018-22 | Tiger/Line | NPS | EBCI

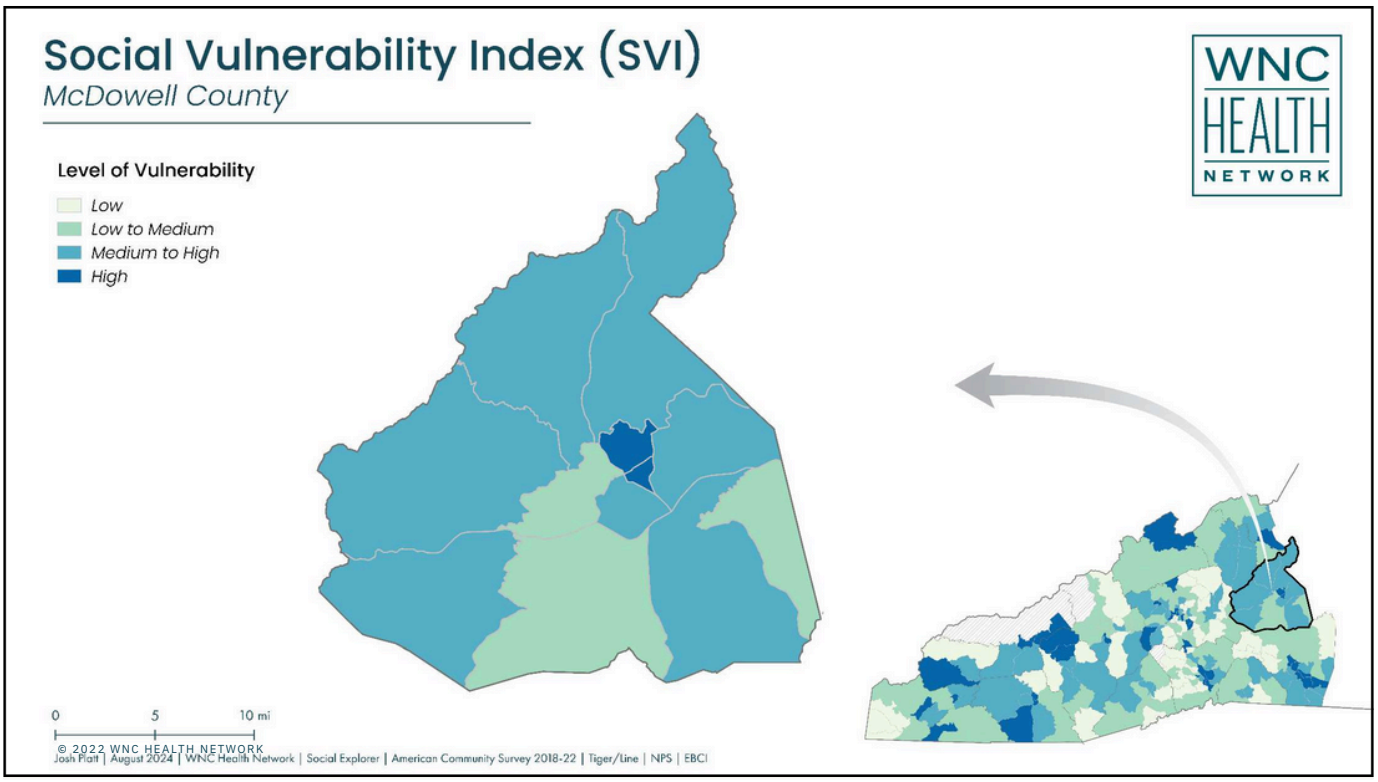
11


Spending Over 50% on Rent or Mortgage
McDowell County
WNC HEALTH NETWORK
Percentage of Households
0.2 - 10%
10.1 - 20%
20.1 - 25%
25.1 - 30%
Over 30%
0
5
10 mi
© 2022 WNC HEALTH NETWORK
Josh Platt | August 2024 | WNC Health Network | Social Explorer | American Community Survey 2018-22 | Tiger/Line | NPS | EBCI

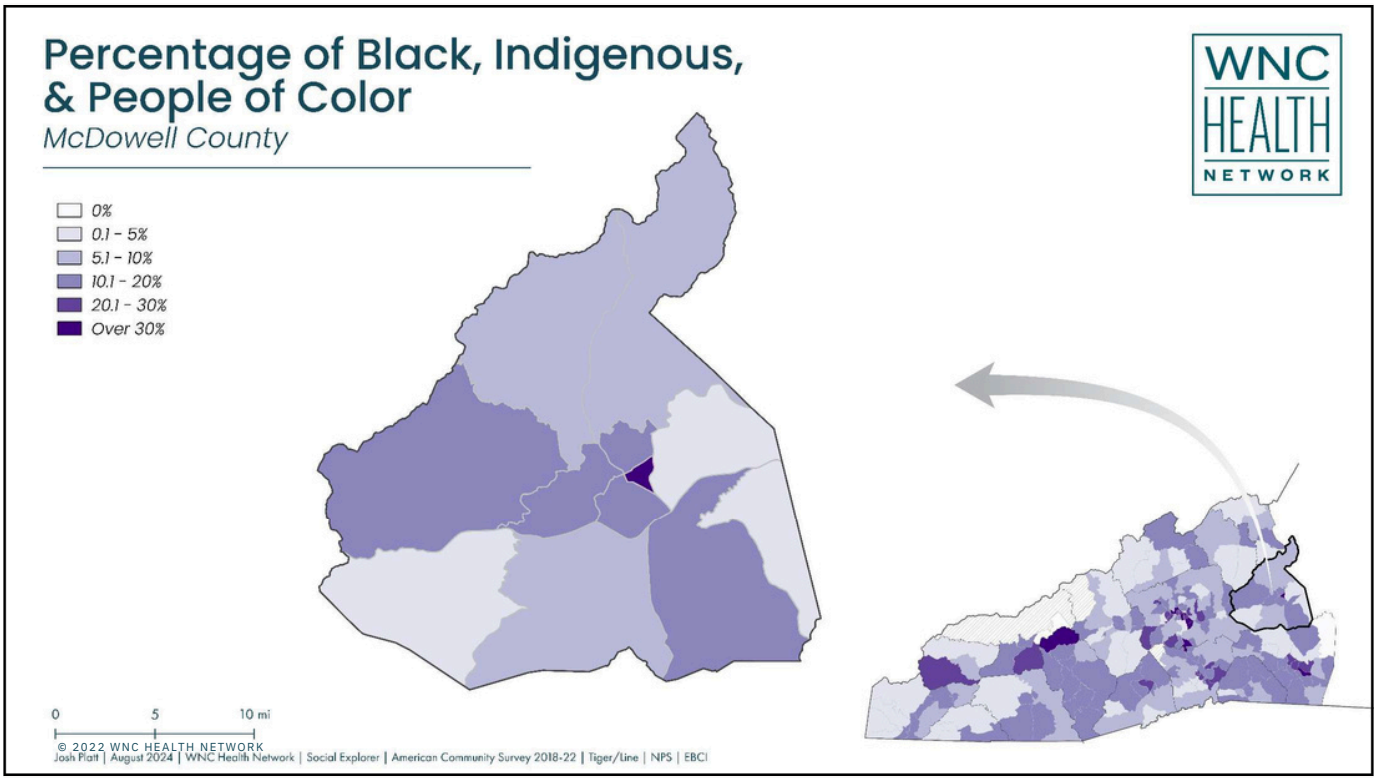
12


Percentage of Population Living in Poverty
McDowell County
WNC HEALTH NETWORK
1 - 10%
10.1 - 20%
20.1 - 25%
25.1 - 30%
Over 30%
0
5
10 mi
© 2022 WNC HEALTH NETWORK
Josh Platt | August 2024 | WNC Health Network | Social Explorer | American Community Survey 2018-22 | Tiger/Line | NPS | EBCI

13


Social Vulnerability Index (SVI)
McDowell County
WNC HEALTH NETWORK
Level of Vulnerability
Low
Low to Medium
Medium to High
High
0
5
10 mi
© 2022 WNC HEALTH NETWORK
Josh Platt | August 2024 | WNC Health Network | Social Explorer | American Community Survey 2018-22 | Tiger/Line | NPS | EBCI

14


Percentage of Black, Indigenous, & People of Color
McDowell County
WNC HEALTH NETWORK
0%
0.1 - 5%
5.1 - 10%
10.1 - 20%
20.1 - 30%
Over 30%
0
5
10 mi
© 2022 WNC HEALTH NETWORK
Josh Platt | August 2024 | WNC Health Network | Social Explorer | American Community Survey 2018-22 | Tiger/Line | NPS | EBCI

15

APPENDIX D - Key-Informant Survey Findings

2024 COMMUNITY HEALTH NEEDS ASSESSMENT —

KEY INFORMANT FINDINGS

McDowell County, NorthCarolina

Sponsored by
WNC Health Network
for WNC Healthy Impact

2024-0260-02

TABLE OF CONTENTS

INTRODUCTION

METHODOLOGY

Online Key Informant Survey

To solicit input from key informants, those individuals who have a broad interest in the health of the community, an Online Key Informant Survey also was implemented as part of this process. A list of recommended participants was provided by WNC Healthy Impact; this list included names and contact information for physicians, public health representatives, other health professionals, social service providers, and a variety of other community leaders and representatives. Potential participants were chosen because of their ability to identify primary concerns of the populations with whom they work, as well as of the community overall.

Key informants were contacted by email, introducing the purpose of the survey and providing a link to take the survey online; reminder emails were sent as needed to increase participation. In all, 16 community stakeholders took part in the Online Key Informant Survey, as outlined below:

MCDOWELL COUNTY: ONLINE KEY INFORMANT SURVEY PARTICIPATION

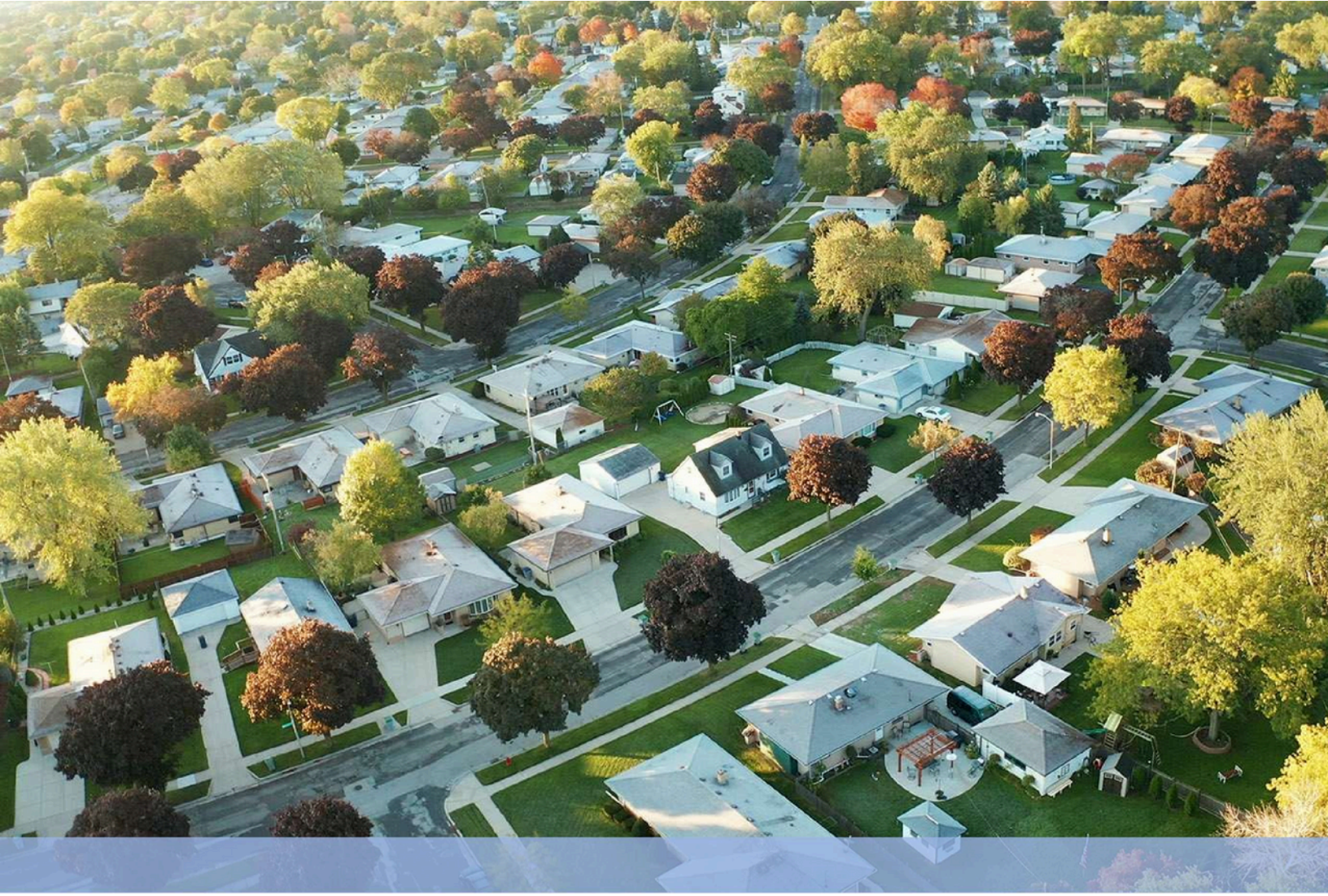
KEYINFORMANT TYPE	NUMBER PARTICIPATING
Public Health Representatives	1
Health Providers	5
Community Leaders	10

Final participation included representatives of the organizations outlined below.

- Board of Health
- CareNET Counseling
- Chamber of Commerce
- Expanded Food Nutrition Education Prog. Educator
- Foothills Health District
- Marion East Recreation Complex
- McDowell County Ag Extension
- McDowell County Board of Commissioners
- McDowell County DSS
- McDowell County Schools
- McDowell Hospital Board of Trustees
- McDowell Senior Center/McDowell Health Coalition
- RHA Health Services
- West Marion Community Forum, Inc.

Through this process, input was gathered from several individuals whose organizations work with low-income, minority, or other medically underserved populations.

In the online survey, key informants were asked to evaluate specific health issues, as well as provide their perceptions about quality of life and social determinants of health in their communities. For many of these, they were asked to evaluate both strengths and opportunities in these areas. Their perceptions, including verbatim comments, are included throughout this report.



QUALITY OF LIFE

METHODOLOGY

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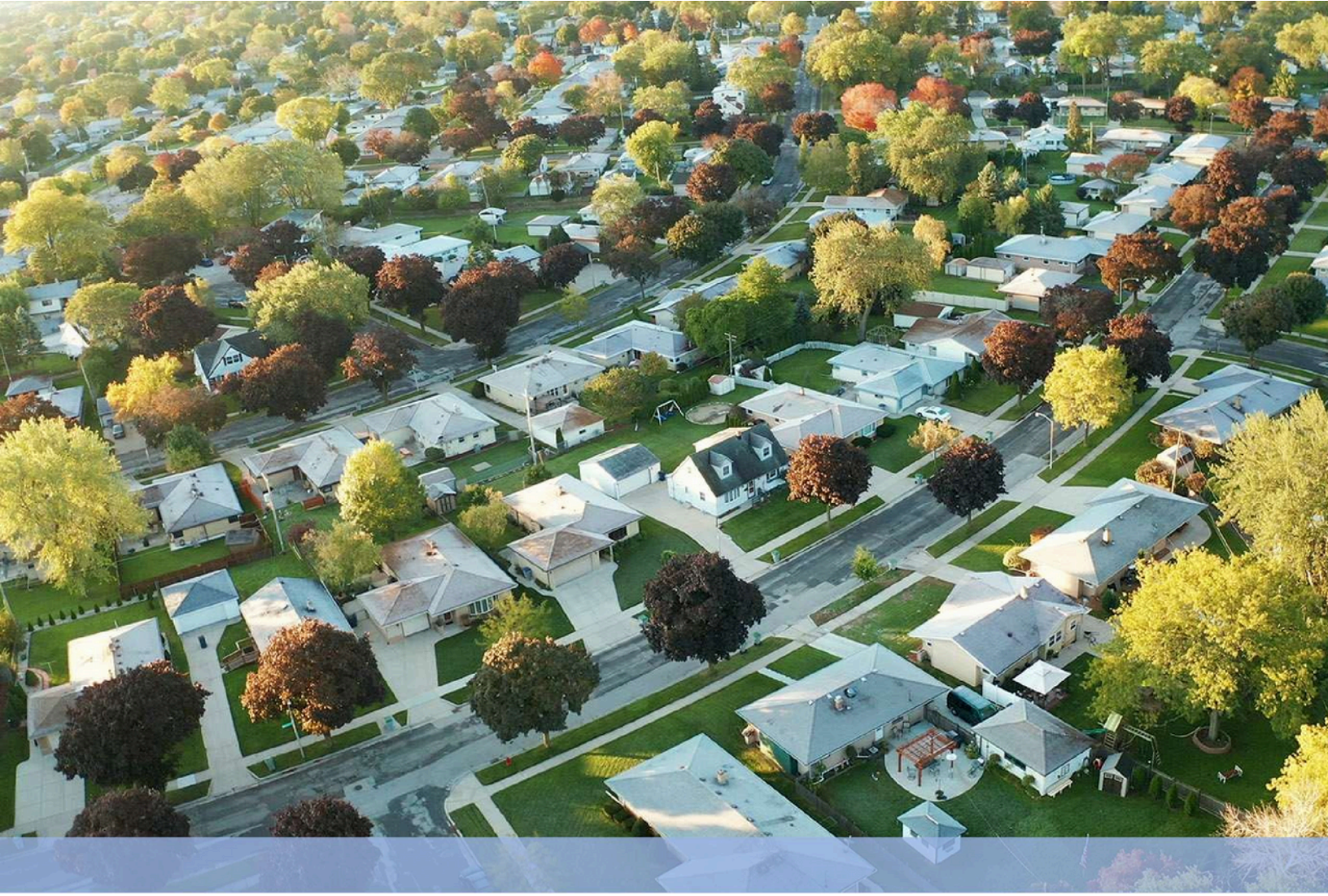


QUALITY OF LIFE

PERCEPTIONS OF LOCAL QUALITY OF LIFE

Key Informant Perceptions of Community Resilience

IntheOnlineKeyinformantSurvey,communitystakeholderswereasked:“Thinkingback overthepast 12 months, what have you experienced in your community that has helped you feel inspired, confident, or hopeful related to thehealth and wellbeing of people in your community?” The following represent their verbatim responses.

Community-Based Organizations

> We have two coalitions dedicated to addressing substance use issues. One is McDowell Youth Forward, and it focuses on preventing youth substance use in community, schools, faith communities, coalitions/collaboratives etc. through environmental level changes. We also have McDowell Partnership for Substance Awareness, who focuses on all facets of substance use, including prevention, treatment, recovery and harm reduction. These groups are working on strategies to prevent youth from using substances and helping adults and youth with substance use issues to achieve their own success in healing. This is exciting and is a great asset to our community. – Health Care Provider (McDowell County)
>
> New program for healthy foods for Medicaid participants through our food hub. – Health Care Provider (McDowell County)
>
> I have seen people young and old accessing the YMCA. Free yoga classes are offered at the First Baptist
>
> Church ofMarionas well. Access to services is helpful. – Health Care Provider (McDowell County)

Parks and Recreation

> There seems tobesome transaction on the future development of the Peavine Trail in East Marion. With the Medicaid expansion, more people seem to be getting access to health care and other social determinants to health. – Community Leader (McDowell County)
>
> There is a strong emphasis in our community about developing the outdoors for all, citizens and visitors. This promotes a healthy and active McDowell County. – Community Leader (McDowell County)
>
> New trails. – Health Care Provider (McDowell County)

Hospitals

> The recent expansion of our nearly new hospital. – Community Leader (McDowell County)
>
> Our local Hospital continues to win awards for excellent service. In addition, our EMS has established a working agreement with the HCA Mission hospital in Asheville to provide faster turnaround service for the EMS vehicles tobe back inour community as soon as possible. – Community Leader (McDowell County)

Community Events

> Being actively engaged in various grassroots, community led activities including workshops, town halls, resource fairs, attending public meetings with elected officials, contributing news articles on various subjects related to health andwellbeing to the local newspaper. – Community Leader (McDowell County)

Awareness/Education

> Increasedawarenessand programming around substance use disorder prevention, treatment, and recovery. Racial Equity roundtables focused on promoting equity and inclusion in McDowell County. New programming such as MATCH's VITA program to help local residents access tax credits that can lift families out of poverty. – Health Care Provider(McDowell County)

Medicaid Expansion

> Medicaidexpansion gives me hope that people will get the medical care that they desperately need. – CommunityLeader (McDowell County)

More Options for Physical Activity

> Theinvestmentinphysicalactivity.–PublicHealth Representative (McDowell County)

Federally Qualified Health Centers

> Theopening andcontinued operationofthe local federally qualified health center WNCCHS—McDowell Health Center. The opening of new trails including the Catawba Falls access trail. – Community Leader (McDowell County)

> Addition of new FQHC. – Community Leader (McDowell County)

Juneteenth Celebration

> Juneteenth Celebration. – Community Leader (McDowell County)

Key Informant Perceptions of a Healthy Community

Thefollowingrepresent characteristicsthat keyinformants identified(in an open-endedquestion) when asked what they feel are the most important characteristics or qualities of a "healthy community" (up to three responses allowed).

FIRST MENTION

Access to Quality Care/Services

> Individuals areable to accessneededmedical services without transportation issues. – Community Leader (McDowell County)
>
> Access to health care providers. – Community Leader (McDowell County)
>
> Access to quality care. – Community Leader (McDowell County)
>
> Resources in our community to assist physically, mentally, with food, and housing. – Community Leader (McDowell County)

Community Engagement

> People willingtohelp others.– Health Care Provider (McDowell County)
>
> Social engagement. – Community Leader (McDowell County)
>
> Open conversations about health-related dangers/risks (obesity, high blood pressure, substance use etc.) and how to avoidoraddressthem.–Health CareProvider (McDowell County)

Access to Affordable Care/Services

> Access toqualityaffordablehealth,mental,dental, and behavioral care. – Health Care Provider (McDowell County)

Awareness/Education

> Knowledge. Be willing to listen to someone else's experience. You don't know what you don't know. Only seeking information that supports your view is not knowledge. – Health Care Provider (McDowell County)
>
> Affordable health care. – Community Leader (McDowell County)

Equitable Access to Health Services

> Equitable access to providers and treatment. This includes the importance of cultural sensitivity being engrained within the provider network, e.g. language translation and providers matching the demographics of the communities they serve. There are ingrained biases within health providers – whether that be clinical or behavioral or mental health – that require intention to change. Providers need to ask more probing questions than "How are you today. How can I help you." When a provider asks the question about how much the client/patient drinks, a follow-up might be, "How much is in the glass/bottle?" – Community Leader (McDowell Count y)

Positive Social Interaction

> Peoplelistentoeachotherrespectfully; civility. – Health Care Provider (McDowell County)

Cultural Opportunities

> CulturalandRecreationalopportunities. – Community Leader (McDowell County)

Spiritual Health

> Peoplelistentoeachotherrespectfully; civility. – Health Care Provider (McDowell County)

SECOND MENTION

Access to Quality Care/Services

> Abundance ofhealth care resources,especially those who accept Medicaid. – Health Care Provider (McDowell County)
>
> Individuals supported in the medical/mental health community for their needs. This includes medical follow up beyond initial treatments to stabilize patients. – Community Leader (McDowell County)

Awareness/Education

> Accesstohealthcareeducation.–CommunityLeader (McDowell County)

Access to Affordable Healthy Food

> Accesstoaffordable,healthyfood.–CommunityLeader (McDowell County)

Access to Affordable Care/Services

> Programsthatareopentoallpeopleforaffordable health care. – Health Care Provider (McDowell County)

Nutrition

> adequatefoodandaffordablehousing.–HealthCare Provider (McDowell County)

Outdoor Recreation

> Recreationalopportunities.–CommunityLeader(McDowell County)

Diverse Population

> Peopleare accepting and engaging with people different from themselves. Embracing differences makes the community stronger and more resilient during difficult times. Everyone needs to feel accepted, needed and connected to the community. This is more than being considered for what the person brings to the table, but how to make the person feel that they belong at the table just because they live here. – Community Leader (McDowell County)

Transportation

> AFreeRobustPublicTransportation System. – Health Care Provider (McDowell County)

Economic Stability

> Economicstability.–Community Leader (McDowell County)

Willingness

> Willingnesstousethatcare. – Community Leader (McDowell County)

Community Attitudes

> Tolerance.Everyone inthe community matters and every voice needs to be heard, not just the loud ones that want to control the systems. Just like any public system, it should be designed to support everyone regardless of race, gender, sexual orientation, etc. You don't have to agree but you can walk away or opt out without hate and disrespect. – Health Care Provider (McDowell County)

THIRD MENTION

Mental Health Services

> Mental Health Support. –Community Leader (McDowell County)
>
> Lackof mental health facilities.–Community Leader (McDowell County)

Collaboration

> Multitudeofinformalsocialsupports.–Community Leader (McDowell County)

Access to Affordable Healthy Food

> Accesstohealthyfoods.–CommunityLeader (McDowell County)

Transportation

> Anon-motorizedtransportationsystem,outdoor recreational opportunities. – Community Leader (McDowell Count y)

Quality Employment Opportunities

> Access to employmentthat providesalivingwage and treats workers with respect and dignity. – Health Care Provider (McDowell County)

Nutrition

> Mostpeopledonothavefood insecurity issues. – Community Leader (McDowell County)

Less Stigma

> Lackofstigmaaboutseeking help to deal with health issues. – Health Care Provider (McDowell County)

Walkable Communities

> Placestowalkandrecreation. – Health Care Provider (McDowell County)

Communication

> Communication.Willingness to come to the table and discuss topics rationally without partisan politics and conservativereligiouscontrol. – Health Care Provider (McDowell County)

Focus on the Whole Person

> Service providers, as much as possible, focus on whole-person health and understand that mind, body, and spirit are intertwined. Treating one without understanding the impact on the other is not going to produce long-term health. The whole person's health or a 'recovery-oriented system of care' looks at everything that impacts that person. This means addressing food or housing insecurity, transportation, substance use, employment, access to services – all the elements comprising a system that enables a person to heal and thrive. – Community Leader (McDowell County)

SOCIAL DETERMINANTS OF HEALTLH

Key Informant Perceptions of Social Determinants of Health & Physical Environment

In the Online Key Informant Survey, community stakeholder respondents wereasked to identifyup tothree social determinants of health about which they feel they have personal or professional insight, experience, or knowledge. For each of these, respondents were then asked to identify strengths and challenges for that issue, as well as populations they feel are most impacted.

Accessibility of Reproductive Care/Family Planning Services

No comments.

Adverse Childhood Experiences

STRENGTHS

Awareness/Education

> Ourresidents,thanks to efforts of various organizations, are more aware of the challenges faced by the larger county. Until the past few years, residents only had knowledge about issues in their own families. – Community Leader (McDowell County)

> Education. Teaching people about the impact of trauma and not just the people that seek to learn about it but the people who arecaught in the generationaltrauma cycles. – Health Care Provider (McDowell County)

Community-Based Organizations

> Vaya.–PublicHealthRepresentative(McDowell County)

Community Support

> Weattempttosupportthe familyasawhole, but the supports in the community have dwindled. – Community Leader (McDowell County)

CHALLENGES

Access to Care/Services

> Limited resources,includingsubstance abuse and mental health resources. – Community Leader (McDowell County)

Denial/Stigma

> Thestigma of mental health and funding systems promote the ongoing cycle of failure to seek mental health services and employment. Individual refusal to acknowledge, accept and access help. This community is very closedand promotes secrecy. – Health Care Provider (McDowell County)

Income/Poverty

> Poverty – limited number of living-wage jobs that residents are qualified to fill. Poverty is a generational issue with few opportunities supporting breaking the cycle. There is also a resistance of adult residents to get actively engaged with the schools, e.g., parent-teacher meetings, or events/programs providing information and alternativesto the current way of living. – Community Leader (McDowell County)

Insurance Coverage

> Insurance.–PublicHealth Representative (McDowell County)

POPULATIONS MOST IMPACTED

Children

> Themost impactedacross the spectrumis children. Children, regardless of culture or race, are surrounded by poverty, family disfunction, and disinterest in community engagement, including connections with the faith communities. – Community Leader (McDowell County)

> Children; older adults; those affected by mental health and substance use; those affected by homelessness or withlimited resources. – Community Leader (McDowell County)

Parents

> Theparents of our children who are not caring for their children but leaving them in the care of aged grandparents who do not have the capacity or resources to get the help they need. They don't know how to support them or set boundaries in today's world of electronics, etc. – Health Care Provider (McDowell County)

Availability of Providers/Sources of Care

STRENGTHS

Hospitals

> We have access to a very good local Hospital who provide specialists that can treat our residents without them have to drive to another city. The Hospital also has a clinic that some people use as their primary care. We also have a good number of Primary Doctors, PAs, and CNPs. throughout the community. – Community Leader (McDowell County)
>
> New hospital with wonderful, caring staff and being part of a larger health care system. – Community Leader (McDowell County)
>
> Hospitaland Health Department. – Public Health Representative (McDowell County)

Affordable Care/Services

> Wehave programs that are free to some and absolutely out of reach for some. Honestly the people that are working and trying are being discriminated against big time because the costs of their services are greatly impacted due to the so-called free programs for the nonemployed citizens. Nothing in life is free. Some pay for trying is what it amounts to. – Community Leader (McDowell County)
>
> too expensive; billing not transparent; lack of transportation to appointments. – Health Care Provider (McDowell County)

Local Medical Providers/Clinics

> Forindividualstohaveaprimarycarephysician. – Community Leader (McDowell County)

Community-Based Organizations

> MATCHprogram.–HealthCareProvider(McDowell County)

Community Support

> Localsupporttoincludecommunitygroups,neighbors and churches. – Community Leader (McDowell County)

Medicaid Expansion

> Medicaid expansion, anew FQHCinMcDowell, increase in # of primary care options in McDowell. – Health Care Provider (McDowell County)

CHALLENGES

Transportation

> Unclearcosts; need transportation. – Health Care Provider (McDowell County)
>
> Transportation, costs. – Health Care Provider (McDowell County)
>
> Transportation for non-emergency transportation in timely manner for health concerns. – Community Leader (McDowellCounty)

Access to Care/Services

> Lackofaccessandabilitytoaccess resources. – Community Leader (McDowell County)

Awareness/Education

> Alot of the less educatedpeople will not take responsibility for their own health and that keeps getting passed down to the next generation. They are reactive and not proactive. This same group of people are more likely to smoke and drink toexcess. – Community Leader (McDowell County)

Affordable Care/Services

> Affordablefood,affordablehealth care. – Community Leader (McDowell County)

Affordable Insurance

> Lackofhealthcareinsuranceplans and options. – Community Leader (McDowell County)

Access to Dentist Accepting Medicaid/Medicare

> 1-Currently, thereis not a dentist in McDowell whoaccepts Medicaid. WNCCHS has a dental bus, but the availability is sparse and sporadic. McDowell residents with limited resources are having to travel many miles to access dental care.2-We have a large Latinx population in McDowell County who don't qualify for Medicaid or ACA Marketplace due to immigration status. Accessing hospital and specialty care at a for profit hospital with a limited financial assistance policy means this group of community members have another barrier to getting the care they need to be healthy. Many are being turned away due to inability to pay or are forced to travel to neighboring hospitals with charity care programs who can support the need. – Health Care Provider (McDowell County)

Insurance Coverage

> Medicalinsurance.–Public Health Representative (McDowell County)

POPULATIONS MOST IMPACTED

Older Adults

> Older adults.– CommunityLeader(McDowellCounty)
>
> Older. – Health Care Provider (McDowell County)

Hispanic

> TheHispanic population and fear of coming to facilities. – Community Leader (McDowell County)
>
> LatinxCommunityMembers. –Health Care Provider (McDowell County)

Low Income

> Peoplewhocan'taffordhealthcare.– Health Care Provider (McDowell County)

Children and Older Adults

> Children,olderadults.–CommunityLeader (McDowell County)

Uneducated/Undereducated

> Asstated above, it falls on thelesseducated families who pass the same habits to their children. The cycle continues through the next generation. This process is spread across all race and ethnic groups. – Community Leader(McDowell County)

Working Class

> Inadominoeffect it impacts all. Just the blue collar worker seems to be the most impacted to me. – Community Leader(McDowell County)

Undocumented

> Undocumentedpersons. – Public Health Representative (McDowell County)

Climate Change/Extreme Weather Events

STRENGTHS

Emergency Medicine

> EM,EMSandPublicHealth. – Public Health Representative (McDowell County)

CHALLENGES

Income/Poverty

> Income.–PublicHealth Representative (McDowell County)

POPULATIONS MOST IMPACTED

Low Income

> Lowincome.–PublicHealthRepresentative(McDowell County)

Community Safety

No comments.

Early Childhood Education/Child care

STRENGTHS

School System

> Some of our schools offer early childhood education (3-4 years old) and some do not. It is my understanding that it is a funding question. This needs to be addressed and the funding needs to be found and solidified. Child care is a different issue. The Grandparents and relatives are having to fill in the gap for child care. – Community Leader (McDowell County)

Head Start

> HeadStart, for one. – Community Leader (McDowell County)

CHALLENGES

Lack of Funding

> Lackof fundingfor public schools as more "public" money is being spent for private schools. – Community Leader (McDowell County)

Government/Policy

> TheState and local politicians talk a lot about childhood education but do nothing to improve it. Until it is recognized as a real need, it will continue to be an issue, with our young children falling further and further behind. Child care alternatives are the same way. The State puts more and more policies in place, require more and more documentation from the day cares, hire more and more inspectors, and yet don't consider the cost effects related to their actions. The people can only pay so much which doesn't allow the day cares to run a successful business, so they go out of business. – Community Leader (McDowell County)

POPULATIONS MOST IMPACTED

Low Income

> Themostimpacted arethepeoplemakingminimum wages, and the people on government subsidies. – Community Leader (McDowell County)

Everyone

> Everyone. – Community Leader (McDowell County)

Education

STRENGTHS

Awareness/Education

> We haveeducationalopportunities in the area, locally & regionally. Workforce training, vocational skills, as well as professional. – Community Leader (McDowell County)

CHALLENGES

Government/Policy

> Good'ol boy networkthat wants to control access to true history and not addressing issues and making DEI irrelevant. – CommunityLeader (McDowell County)

Access to Care/Services

> Lackofqualityresources.–Community Leader (McDowell County)

Affordable Care/Services

> Costsof education. Wehave alow tax base so in no way, the youth of McDowell are getting the same quality education as youth in Wake County. Our youth are at a disadvantage. – Community Leader (McDowell County)

POPULATIONS MOST IMPACTED

Children

> Children.–CommunityLeader(McDowellCounty)

Low Income

> Ourhistorically underserved populations seem to be at a disadvantage. And our lower income folks. If someone is struggling to pay the bills, they might not have time to focus on their child's education. – Community Leader (McDowell County)

Everyone

> All.–Community Leader (McDowell County)

Family/Social Support

STRENGTHS

Churches

> church,informal community relationships. – Community Leader (McDowell County)

Accountability

> Accountability. When individuals are held to a high standard and have reasonable expectations to meet in order to provide a loving home to their children or are held accountable for how they treat public service officials who are setting boundaries for their children that they do not set at home. – Health Care Provider (McDowell County)

CHALLENGES

Lack of Support

> Poorfamilystructures, broken homes, unhealthy relationships. – Community Leader (McDowell County)

Parental Influence

> Parentsneed to be held more accountable for failure to support their children in a healthy manner that is supported by research and not just "minimum standards." By allowing parents to only provide minimum standards of care and housing, we are perpetuating childhood trauma, poverty and reliance on a failing system. – Health Care Provider (McDowell County)

POPULATIONS MOST IMPACTED

Children

> Children. – Community Leader (McDowellCounty)
>
> Children who are not advocated for by someone will only grow up to perpetuate the cycles we are struggling to interrupt. – Health Care Provider (McDowell County)

Healthy Foods

STRENGTHS

Community-Based Organizations

> Foothills FoodHub andthe fewfoodpantries and food distributions we have around the county. – Health Care Provider (McDowell County)
>
> Communitygroups. –Community Leader (McDowell County)

Health Opportunities Pilot

> TheHealth Opportunities Pilot has increased access to healthy food to Medicaid recipients. The Historic Marion Tailgate Market has programs that aid in the purchasing of local food like the Seniors Farmer's Market Nutrition Program. Also, the fact that many small farmers in the community sell direct to consumer. They are not selling Chee-tos. – Community Leader (McDowell County)

Nutrition

> Morevariety. – Health Care Provider (McDowell County)

Social Media

> There continues to be a lot of education around healthy foods on the social media and in schools. The establishment of the Food hub and the growth of the farmer's market have been welcome additions. A number of local grocery/convenience stores are now carrying produce and making it more accessible by the public. – Community Leader (McDowell County)

CHALLENGES

Access to Affordable Healthy Food

> Theperception thathealthyfood is expensive. The perception that fresh produce is hard to prepare. Not convenient.– CommunityLeader (McDowell County)

Access to Care/Services

> Accessandknowledge.–Community Leader (McDowell County)

Nutrition

> Fooddesserts.–HealthCareProvider (McDowell County)

Transportation

> Transportationandfoodcost.– Health Care Provider (McDowell County)

Awareness/Education

> Education, education,education, and the refusal by the folks to take advantage of it. – Community Leader (McDowell County)

POPULATIONS MOST IMPACTED

Older Adults

> Older adults. – Health Care Provider(McDowell County)
>
> Older adults tend to not want to prepare meals because they may not want to prepare meals just for themselves. –Community Leader (McDowell County)

Low Income

> Lowincome residents. – Community Leader (McDowell County)

Children

> Thechildren suffer the most. When they are being trained to eat junk food, and junk food is all that is available to them, that's all they know. – Community Leader (McDowell County)

Families

> Families and senior citizens. – Health Care Provider (McDowell County)

Healthy Environment

STRENGTHS

Parks and Recreation

> Weliveinoneofthemost beautiful and protected areas of the US. – Community Leader (McDowell County)

CHALLENGES

Lack of Funding

> Lackoffundingand turning a blind eye to science. – Community Leader (McDowell County)

POPULATIONS MOST IMPACTED

Everyone

> Allofus.–CommunityLeader(McDowellCounty)

Housing

STRENGTHS

Access to Affordable/Safe Housing

> Thereare agencies andprogramsworking to create safer affordable housing such as the Gateway Wellness Foundation, who are focused on home repairs for low income residents and a work force housing initiative. Mission Ministries Alliance is working hard to support the unsheltered population through their Housing First Model. – Health Care Provider (McDowell County)
>
> There are some houses available now in the community. – Community Leader (McDowell County)
>
> For individuals having a safe and secure housing situation. – Community Leader (McDowell County)
>
> There is a push to create affordable housing. McDowell Mission Ministries is also working very successfully to help unhoused individuals to find employment and housing. – Health Care Provider (McDowell County)

CHALLENGES

Affordable/Safe Housing

> Availabilityof housingfor individuals with limited incomes. – Community Leader (McDowell County)
>
> Most people need income based housing or low-income housing. – Community Leader (McDowell County)
>
> Lack of affordable, safe rental properties. The cost of real estate makes home ownership virtually unattainable for many. The county refuses to adopt a minimum housing standard leaving room for landlords to charge excessive amounts of money for unsafe unsanitary rentals. – Health Care Provider (McDowell County)

Employment

> Lackofgood paying jobs and affordable housing opportunities. – Health Care Provider (McDowell County)

POPULATIONS MOST IMPACTED

Everyone

> Theentirecommunityisaffected.–Community Leader (McDowell County)

Low Income

> Lowincomeresidents/middleincomeresidents/ single parents/ older adults. – Health Care Provider (McDowell Count y)

Older Adults

> Senioradultsor families need housing they can afford. – Community Leader (McDowell County)

Single Parents

> Singlemothers. – Health Car e Provider (McDowell County)

Income/Employment

STRENGTHS

Employment Opportunities

> Agenciesworkingondevelopingastrongworkforce. – Health Care Provider (McDowell County)

Community-Based Organizations

> Thereare a numberof organizations engaged in clinical and behavioral health along with various social initiatives. The community grass-roots organizations are leading efforts to improve the wellbeing of McDowell residents. – Community Leader (McDowell County)

CHALLENGES

Lack of Motivation

> What getsin the way is the organizations, including health providers in all categories, are not integrated in any way. Working in a silo is a weakness that is holding back what a unified system of care for all residents could accomplish. What gets in the way is the perception of inequity – there isn't enough funding for each silo to do more thantry to keep up. – Community Leader (McDowell County)

Transportation

> Transportation,lowlivable wages. – Health Care Provider (McDowell County)

Alcohol/Drug Use

> Substanceuseissues that interfere with people being able to obtain and retain employment. – Health Care Provider (McDowell County)

POPULATIONS MOST IMPACTED

Low Income

> Anyone who is deemedmiddle or lower class.– Health Care Provider (McDowell County)
>
> People with low socio-economic status and those with lower education levels. – Health Care Provider (McDowell County)

Children

> Asnoted above, children are the most impacted. Children adapt to their environment and learn from their support systems – whatever that looks like becomes their understanding of 'normal' and of what's 'acceptable.'. – Community Leader (McDowell County)

Intimate Partner Violence

STRENGTHS

Community-Based Organizations

> Thereare organizations focusedon domestic violence/intimate partner violence. The two women's shelters are working in this area (both are small). – Community Leader (McDowell County)

CHALLENGES

Access to Care/Services

> There isn't enough professional assistance available to handle the volume of cases. We are in a reactive/ response situation rather than being proactive toward awareness, education, and training. The legal system and trained personnel in crisis intervention and motivational interviewing are overwhelming. There is limited protection, especially for women and children, when violence occurs. In addition, there is generational acceptance of violence as long as it doesn't get out of hand. – Community Leader (McDowell County)

POPULATIONS MOST IMPACTED

Women and Children

> WomenandtheirchildrenaremostImpacted:intimate partner violence. – Community Leader (McDowell County)

Physical Activity Opportunities

STRENGTHS

Parks and Recreation

> InMcDowell,weliveinagreat place that has many recreational opportunities like our trail system. – Community Leader (McDowell County)

CHALLENGES

Insufficient Physical Activity

> People's mindset that theydon'thave time to exercise. Our terrible/non-existent non-motorized transportation system. Streets with no sidewalks, roads with no bike lanes. And the lack of interest/funds to develop. I could go on, but I won't. – Community Leader (McDowell County)

POPULATIONS MOST IMPACTED

Low Income

> EastMarion community.BaldwinAvenueneeds a sidewalk the length of the Avenue. US-70 needs a bike lane. – Community Leader (McDowell County)

Public Transport

STRENGTHS

Public Transportation

> Availabilityoffreepublictransportation.–Community Leader (McDowell County)

Community-Based Organizations

> McDowellTransitisour only sourceofpublic transportation. The staff and leadership of this agency works hard tomaketransportation more accessible. – Health Care Provider (McDowell County)

Neighbors

> Neighbors. – Community Leader (McDowell County)

Isolation

> Reduceisolation. – Health Care Provider (McDowell County)

CHALLENGES

Transportation

> PublicTransportation is limited in staffing and funding to transport the needed trips for individuals in McDowell County. – Community Leader (McDowell County)
>
> NoUber/ RealLimitationsto McDowell Transit. – Health Care Provider (McDowell County)

Access to Care/Services

> Lackofaccess.–CommunityLeader (McDowell County)

Lack of Funding

> Local County government is not supporting and funding this agency to meet the increasing need. It can be weeks to get on the list to receive transportation to employment. Transit only travels out of county on specific days during a narrow time window creating a barrier for those who may need to receive medical care in surrounding counties. A robust free public transit system, especially in such a rural community, is vital to the health and economic wellbeing of our community. The staff and leadership of this agency are doing their best to meet the need through a lack of funding. Additionally, on multiple occasions local county government has expressed a desire to impose fees, which would make transportation even harder to access. – Health Care Provider (McDowell County)

POPULATIONS MOST IMPACTED

Older Adults

> Older adults, thisleads tomoreEMS transportation for non-life threatening issues. – Community Leader (McDowell County)
>
> Older adults. – Health Care Provider (McDowell County)

Low Income

> Lowincome residents/older adults. – Health Care Provider (McDowell County)

Everyone

> All.–Community Leader (McDowell County)

Racism/Discrimination

STRENGTHS

Communication

> Realisticconversation. Having safe dialogue about what it means to be a person of color in a predominantly white conservative county. Being realistic about what is being taught at school and what should just be expected forall peopleregardless of color. – Health Care Provider (McDowell County)

Family/Friends

> Familymembers stay in this community if they have grown up here. – Community Leader (McDowell County)

CHALLENGES

Government/Policy

> Old ideologies. When the county elects' people into public office who openly state that children that experience racism are just too sensitive and they need to get over it, that is a problem. Old white men who feel threatened that their power will be taken away versus sharing it. The idea that this conversation is an attack on white people is a barrier. While anger on the part of the people of color is justified, it also will not bring people to the table to talk. –HealthCare Provider (McDowell County)

Community Viewpoint

> The community is veryset in its ways and does not want to move forward in thinking, which prevents new people from moving into this community. It also prevents educated people from moving here and bringing new life. – Community Leader (McDowell County)

POPULATIONS MOST IMPACTED

Children

> Our children. Racism and discrimination is taught from a young age, in the home. If we don't teach tolerance early and help people understand that it is OK if someone thinks differently than we do, we are not even beginning to address the problem. – Health Care Provider (McDowell County)

Uneducated/Undereducated

> This communityonly has18 percent of its population with a bachelor's degree or higher. This is impacting getting educated or more qualified individuals to move here. Even if they don't move here, getting those individuals to come here to work. – Community Leader (McDowell County)

Tobacco/Vape-Free Spaces

STRENGTHS

Tobacco Free Policies

> Governmentspacesaretobacco free already. – Health Care Provider (McDowell County)

CHALLENGES

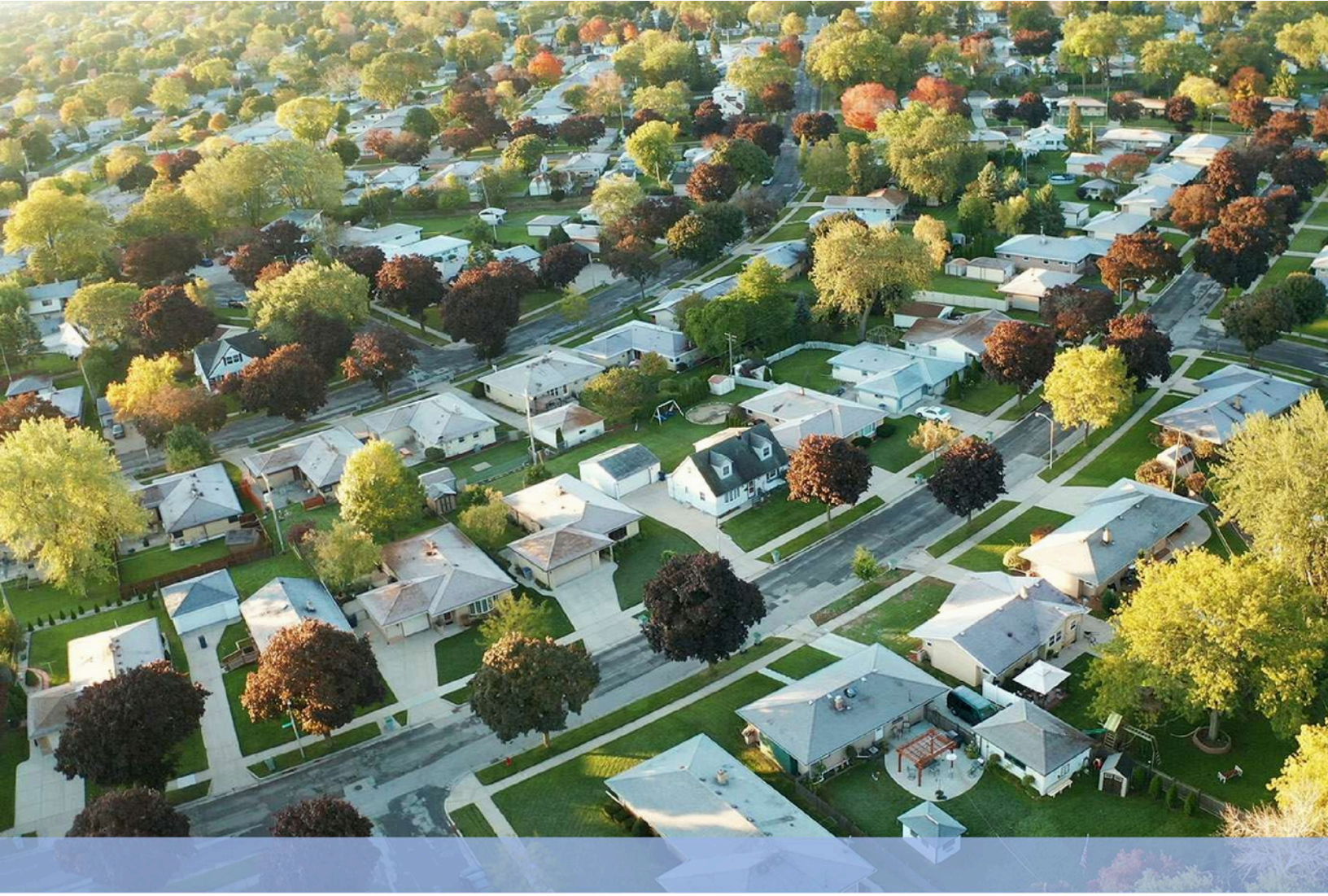
Awareness/Education

> McDowell county residents do not understand the potential impact of smoking, and more specifically vaping to their health and the health of their children. Vaping is an epidemic with youth and the age of onset of use is getting younger and younger. It is no longer unusual for a 2nd or 3rd grader to use vapes and around a quarter of the middle/high school age youth use them on a regular basis. Educating the public on these dangers needs to be a priority and it isn't. – Health Care Provider (McDowell County)

POPULATIONS MOST IMPACTED

Children

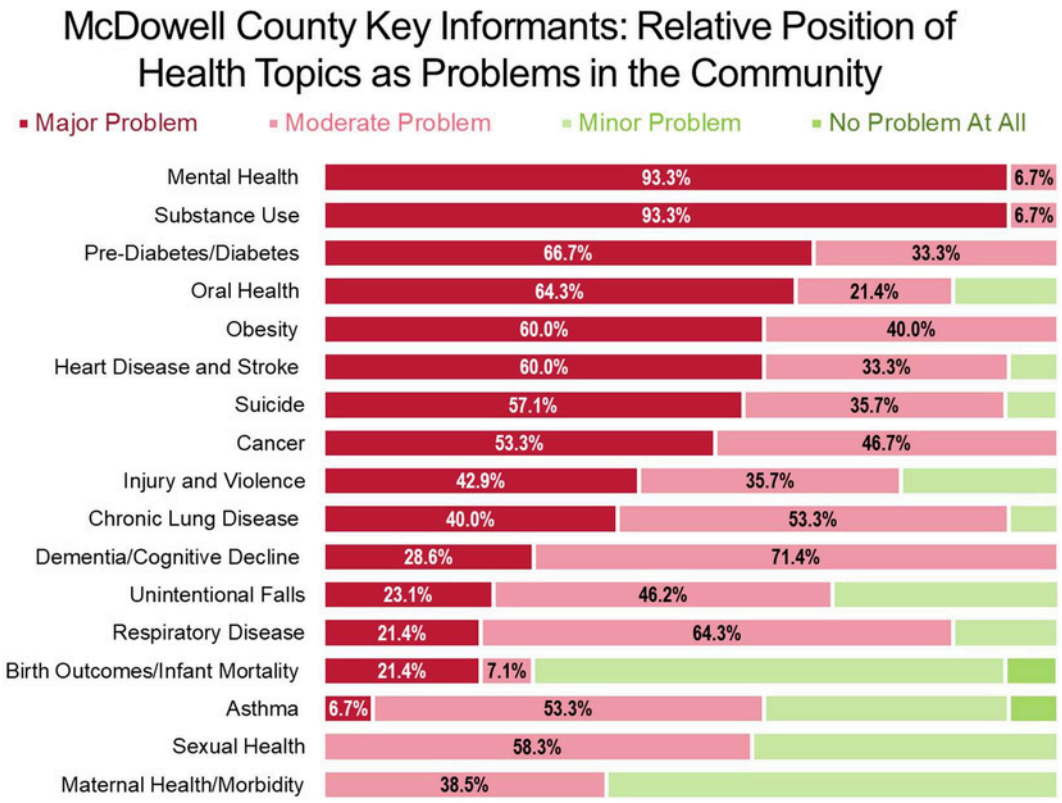
> Youth.–HealthCareProvider(McDowellCounty)



HEALTH ISSUES

KEY INFORMANT RATINGS OF HEALTH ISSUES

When keyinformantstakingpartintheOnlineKeyInformantSurvey were asked to rate each of 17 health issues.



SPECIAL TOPICS

For the following, key informantswho acknowledged having personal or professional insight, experience, and/or knowledge about youth mental health and/or Medicaid expansion were further asked to outline what they see as going well or currently working (strengths) and what is missing or not helping (challenges).

Key Informant Perceptions of Youth Mental Health

STRENGTHS

Resources Available to Child/Youth

> Therearesomeoutsideprogramswe are working with. – Community Leader (McDowell County)
>
> Recreational activities such as sports and the YMCA. Church youth groups are also supportive and helpful. – Community Leader (McDowell County)
>
> There are organizations who are attempting to raise awareness and educate the youth that 'not being ok is ok.' The grassroots community organizations are organizing youth to work in community gardens and perform other nonprofit work asaway to becomeconnected to the community. – Community Leader (McDowell County)

Counselors in the School System

> The school system hasbuilt a strong network of providers that support students both for school-based services and office-based services. These providers are invested in the community and open to feedback on the accessibility of their services. There are more providers and access for outpatient mental health than there used to be. If a family is experiencing a wait list, they are not educated on all the resources available to them. – Health Care Provider (McDowell County)

Stigma/Denial

> Havingopenand honest conversations with adults. – Community Leader (McDowell County)

CHALLENGES

Access to Care/Services

> lack of mental healthresources. Parenting education. Formal and informal support for families. – Community Leader (McDowell County)
>
> Most programs are fullor have waiting lists. – Community Leader (McDowell County)

Awareness/Education

> Ignoranceabout what mental health in youth means is the greatest challenge. The next challenge is engaging with parents and other supportive adults when an issue has been identified or a concern is raised around a child or adolescent. For example, a teacher can refer a student to a counselor or social worker, but if the parent chooses not to participate in discussions and problem solving, the child/adolescent is on their own OR their situation becomes worse as they engage in destructive behaviors or self-medicate. – Community Leader (McDowellCounty)

Affordable Care/Services

> Notenoughfreehelp.–HealthCare Provider (McDowell County)

Culture

> Aculturallyappropriateprogram. – Community Leader (McDowell County)

Barriers

> There are someproviders thatare still not open to feedback and really need to go. Access to higher levels of care like FCT and IIH for families that have private insurance would be great. The ongoing stigma and reluctance of parents to allow their child who is asking for help to access it is concerning and should be considered neglect. – Health Care Provider (McDowell County)

Key Informant Perceptions of Medicaid Expansion

STRENGTHS

More People are Enrolled

> McDowell Access To Care and Health (MATCH) is a well-trained team who have been certified in care options. They are doing a wonderful job of informing people about the expansion and what it means. This is a small team working to schedule sessions with people to review their needs and explore possibilities. – Community Leader (McDowell County)
>
> There is a larger segment of people that has been covered with the Expansion, thanks to the willingness of the hospital association to cover the state's additional costs; however, at some point, the rising costs are going to be a bigger and bigger tax burden for the taxpayer. – Community Leader (McDowell County)
>
> More individuals are qualifying for Medicaid in our community and addressing their health care needs. – Community Leader (McDowell County)
>
> Increasing number of folkswith access to Medicaid. – Community Leader (McDowell County)

Increased Access to Care/Services

> People thathavesigneduporaregettingtheservices needed like dental care. – Community Leader (McDowell County)

Awareness/Education

> Theknowledgeisoutinthe community and people are signing up. – Community Leader (McDowell County)

Health Navigators

> Through the MATCH program, the community has three federally certified Navigators who are focused on Medicaid outreach, education, and enrollment. Through strong partnerships, MATCH co-locates throughout the community, increasing access to Medicaid. MATCH partners and collaborates to focus on reaching our most vulnerable population to increase Medicaid Enrollment AND helping residents understand Medicaid Transformation, PHP's, Healthy Opportunities Pilot, and other benefits. – Health Care Provider (McDowell County)

CHALLENGES

Failure to Apply

> Westill have alarge segment of people who only come in contact with the medical community when it is necessary. It will take time, but the medical staffs are educating these people as fast as they can. – Community Leader (McDowell County)
>
> Having people sign up. I think more people are, but it takes time to get the word out. – Community Leader (McDowellCounty)

Awareness/Education

> Lack ofknowledgeabout Medicaid expansion and lack of knowledge about benefits associated with different PHP plans.–Community Leader (McDowell County)

Lack of Providers

> Toomany people, too few knowledge workers to move through a very complicated system. – Community Leader (McDowell County)

Understaffed

> Weare being overwhelmed with applications and our staff cannot keep up. – Community Leader (McDowell County)

Stigma

> Forsome there is stigma around Medicaid and mistrust of government programs. Lack of trust at local DSS agencies. As a rural county, there are pockets of residents who are hard to reach. – Health Care Provider (McDowell County)

Loss of Coverage

> For older adults aged 64 that are now included in the Medicaid expansion losing that coverage when they turn 65. The premiums for Medicare and the limited options for those just over income limit for aged Medicaid make it difficult to take care of personal medical needs without unnecessary costs. – Community Leader (McDowell County)