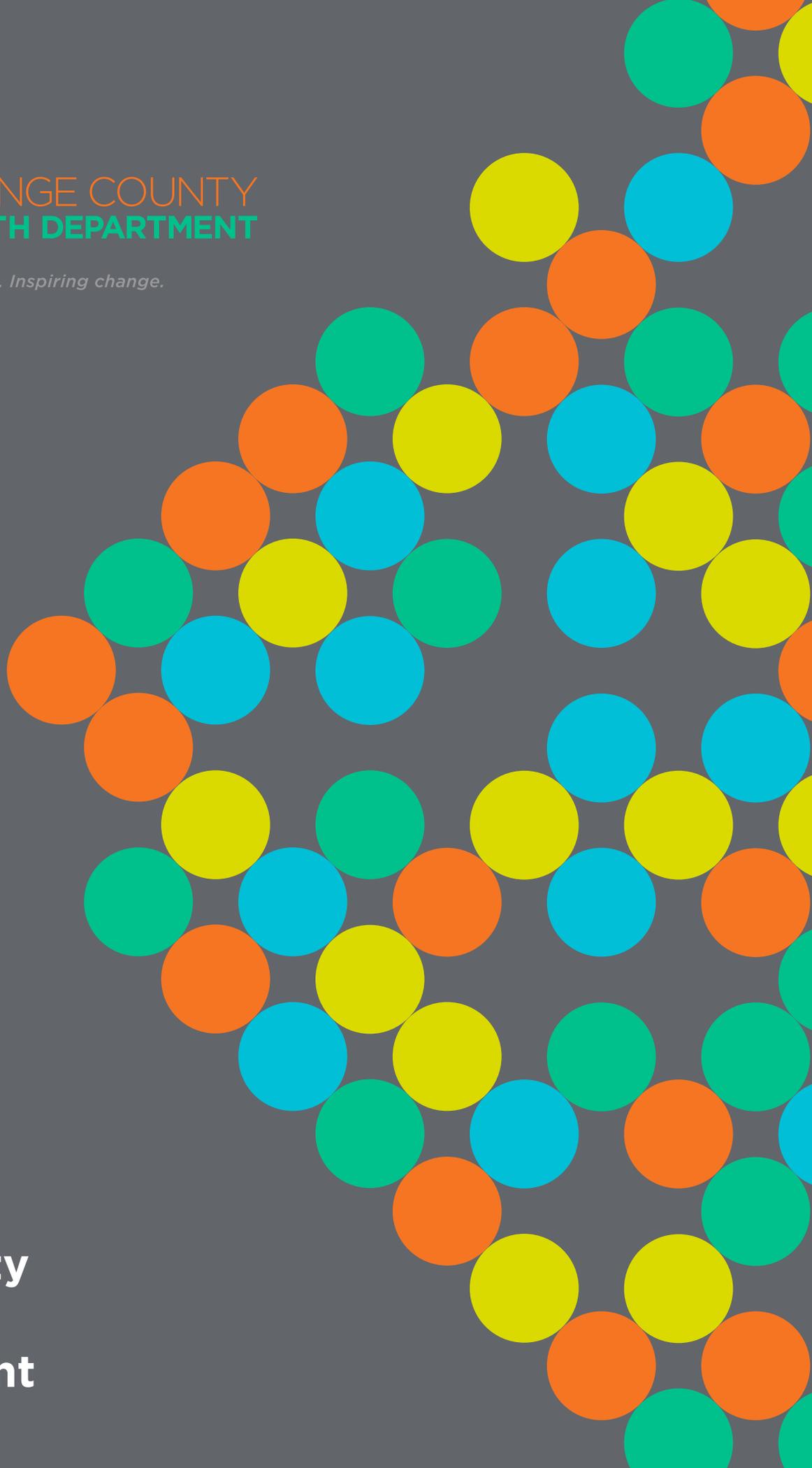




ORANGE COUNTY
HEALTH DEPARTMENT

Improving health. Inspiring change.



**2019
Community
Health
Assessment**

2019 Community Health Assessment

Orange County, NC

Submitted to the
North Carolina Department of Health and Human Services
Division of Public Health

By the Orange County Health Department
And Healthy Carolinians of Orange County



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The goal of this document is to publish a report that is easy to navigate and enables the reader to quickly locate information on a topic of interest. In the electronic version, internal and external links are identified to ease movement through and beyond the document. Internal links are underlined in [green](#) font and external links are underlined in [blue](#) font.

Thank you to the volunteers who conducted the door-to-door surveys, community partners for hosting focus groups and community input sessions, and multilingual interpreters who provided translation and interpretation services during the data collection process. With the help of these individuals, the voices of community members were heard throughout this process.

The 2019 CHA process and report was coordinated and compiled by Ashley Rawlinson, MPH, Program Manager and Healthy Carolinians Coordinator with the Orange County Health Department. A number of committee members, partners and public health professionals reviewed and/or provided information to the CHA.

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Executive Summary

Introduction

Every four years, the Orange County Health Department (OCHD) and Healthy Carolinians of Orange County (HCOC) conduct a Community Health Assessment (CHA). Regular assessment of Orange County's health enables public health officials to monitor trends in health status, determine priorities among health issues, and determine the availability of resources within Orange County to help best protect and promote the public's health.

The overall goal of the community health opinion survey is to address health disparities and identify needs of populations who are most disadvantaged. 240 households were randomly selected from 40 census blocks using the [Center for Disease Control and Prevention \(CDC's\) CASPER survey methodology](#), with emphasis on low-income and predominantly minority communities. Surveyors visited close to 800 households and received 197 door-to-door survey responses. A duplicated health opinion survey was placed online and was completed by 147 community residents, using a non-random snowball approach of sharing the link with partner organizations and mailing lists. This created 355 total surveys completed, which were complemented with data from six focus groups and three community input sessions.

Selected Priorities

Results from secondary data, opinion surveys, and community input sessions resulted in the identification of the three priority areas that will be addressed over the next four years (2020-2024). Those priority areas are 1) Access to Care, 2) Health Behaviors, and 3) Health Equity.

Access to Care

Access to comprehensive, quality health care services is important for promoting and maintaining health, preventing and managing disease, reducing unnecessary disability and premature death, and achieving health equity for all. Areas included under *access to care* are: health care, dental care, health insurance, and transportation.

Health Behaviors

Health behaviors are not always determined by a choice to be healthy or unhealthy but rather the influence from one's community, systemic racism, exposure to trauma, physical activity, food accessibility, substance use, sexual health and one's social and economic status.

Health Equity

Health equity is achieved when every person has the opportunity to attain their full health potential and no one is disadvantaged from achieving this potential because of social position or other socially determined circumstances. Areas included under *health equity* are: environmental justice, criminal justice, and social determinants of health to include employment and income, poverty, education, housing and homelessness.

Next Steps

Findings from this CHA report will help influence strategic planning around the three priority health issues. HCOC will disseminate the full report broadly so that entities contributing to the health of Orange County residents can develop new or modify existing programs, services, and resources to address the community health needs relevant to their stated missions.

It is the intended purpose that this 2019 CHA report, and its follow up activities, will be of use to community members and service providers alike, for all are working towards the common goal of making Orange County a healthy place to live, work, play and pray. To get involved in community efforts targeting the three priority areas, visit <https://www.orangecountync.gov/346/Healthy-Carolinians>.

Background & Introduction

Introduction

Every three-to-four years, Local Health Departments in North Carolina (NC) are required by the NC Department of Health and Human Services to conduct a Community Health Assessment (CHA). Regular assessment of a community's health enables local public health officials to monitor trends in health status, determine priorities among health issues and determine the availability of resources within the community to best protect and promote the public's health. A primary goal of the assessment process is to involve the community in every phase of the process including planning, data collection, evaluation, identification of health issues and community strengths, and the development of strategies to address identified problems. The information in this 2019 CHA will be compared to information and data from previous years, peer counties and NC. You can access the 2015 CHA [here](#).

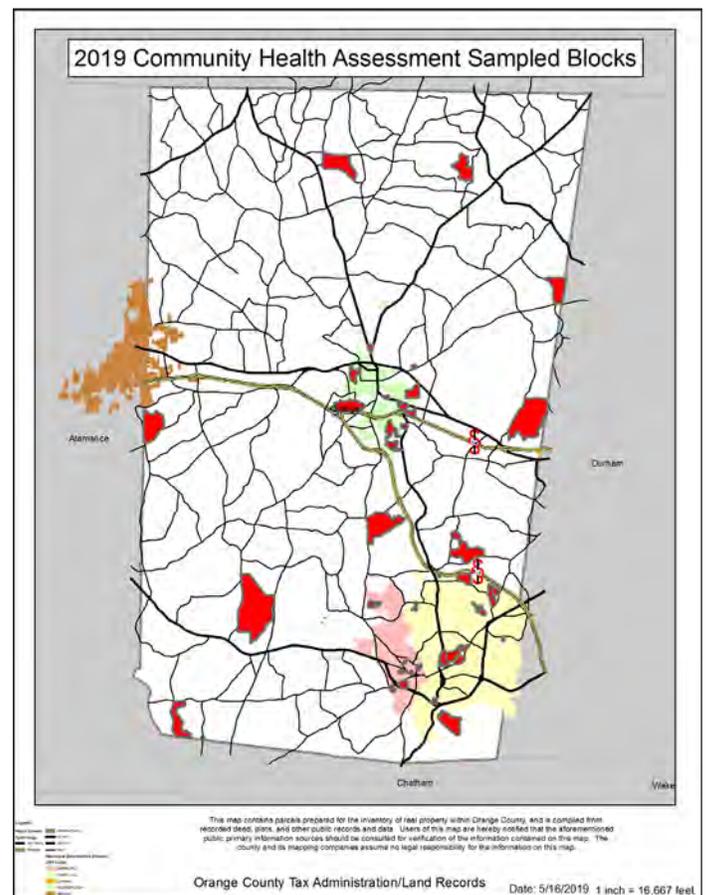
The Assessment Process



The completion and success of the CHA is not possible without input, support, and participation from our community and our partners. Collaboration was essential in order to effectively identify and assess the health of Orange County. As a result, four teams were created to assist in the 2019 process. Those teams were made up of: (1) a CHA Leadership Team (CHALT) - the governing body and final decision makers, (2) a Community

Engagement Team - those responsible for ensuring that the voices of the community are heard as well as engaging the community in every step of the process, (3) a Volunteer Recruitment Team - those responsible for recruiting volunteers to assist with data collection and community events, and (4) a Data Team - those responsible for the format and analysis of the collected data. Community partners served on committees, went door-to-door to collect survey responses, and coordinated and implemented community efforts such as focus groups and community input sessions (see [Appendix A - Committee Members](#) and [Appendix B - Survey Volunteers](#)).

Data Collection and Analysis



This report was created using both primary (community input) and secondary (previously collected) data sources. Primary data was collected through community health opinion surveys (door-to-door and online), focus groups, and community input sessions. Using both primary and secondary data yields a more in-depth and reliable assessment of the specific factors that affect our community's health.

With the overall goal to address health disparities and identify needs of populations who are most disadvantaged, 240 households were randomly selected from 40 census blocks using the [CDC's CASPER survey methodology](#), with the goal to over sample low-income and predominantly minority communities. Surveyors visited close to 800 households and received 197 door-to-door survey responses, compared to 166 door-to-door survey responses in 2015. A duplicated health opinion survey was placed online and was completed by 147 community residents, using a non-random, snowball approach of sharing the link with partner organizations and mailing lists. Combined, this created 355 total survey responses.

Over a two month period, survey collection was carried out by a team of [85 volunteers](#). Prior to surveying, all volunteers participated in a mandatory training which covered safety plans and procedures for conducting surveys (e.g. techniques for conducting unbiased surveys, what to do if someone was not home or chose not to participate, procedures for non-English speaking residents, etc.). Volunteers conducted surveys in teams of two and each team was assigned a specific list of addresses grouped by proximity. Households who were unable to participate in person were given the option to either complete the survey over the phone or online, via a personalized link, to complete at a later date. All survey respondents who completed a door-to-door survey were given a small incentive for their participation.

A 53-question door-to-door survey was administered by hand (pen and paper) and entered into data analyzing software. Online health opinion surveys were administered and analyzed through Survey Monkey. All data was combined and analyzed, by the Health Department's Informatics Manager, through custom formulas and reports, comparing all question responses against multiple categories of age, race/ethnicity, and gender. Community findings and responses are presented throughout the document under *Survey Data* headings.

Promotion of both online and door-to-door surveying was created through: electronic emailing, postal mail, local media outlets (newspapers, radio), social media, community partners, various community coalitions and partnerships, HCOC member listserv, Orange County Government, community and neighborhood newsletters and listservs, county agencies and organizations, HCOC committees, Orange County Board of Health, and the Orange County Board of County Commissioners.

Focus Groups

Six focus groups (47 voices) were conducted among under-represented populations to gain an in-depth understanding of the health concerns, strengths, and challenges that are experienced in Orange County. Focus group questions explored important aspects of good health, community strengths and barriers to overall well-being, with additional questions tailored to specific groups. Focus groups were held in partnership with [Refugee Community Partnership, Orange County Public Library, Inter-Faith Council \(IFC\)](#) and [Family Success Alliance](#). Focus groups were successfully facilitated among youth, individuals experiencing homelessness, Spanish speakers, Kinyarwanda speakers, Karen speakers, and Burmese speakers.

Recruitment for focus group participation was done through existing networks and relationships with community partners. Each focus group was led by a facilitator and all feedback was captured by a note-taker and was digitally recorded and transcribed to help ensure that participants' thoughts, concerns, expressed barriers, and recommended methods for improvement were thoroughly captured. Community findings and responses are presented throughout the document under the *Focus Group* headings.

Community Input Sessions

Three community input sessions were held where community members had a chance to learn and hear the results from the data collection process; discuss concerns with elected officials, people who work in government, and the health department; and help prioritize and decide what health issues will be selected for 2020-2024.

Each community input session had representation from an Orange County Board of Health member, where Board members encouraged community members to share their honest opinions and feedback on the health of Orange County. Sessions were held at Cedar Grove Community Center, Southern Human Services Center and Chapel Hill Public Library, where input was received from 55 community residents.

2020-2024 Priority Areas

Results from secondary data, opinion surveys, and community input sessions resulted in the identification of the three priority areas that will be addressed over the next four years. Those priority areas are 1) Access to Care, 2) Health Behaviors, and 3) Health Equity.

County Description

Orange County covers approximately 400 square miles, or 254,720 acres, and is centrally located between Research Triangle Park (RTP) and the Triad (Greensboro, Winston-Salem, and High Point) with Interstates 85 and 40 providing primary transit avenues. Orange County is an attractive place with mild winters and blue skies and is known for the University of North Carolina (UNC) at Chapel Hill (the oldest state-supported university in the United States). Its diverse population includes dairy farmers, professors, small business owners, corporate executives, newly settled refugees, and students from all over the world. The diversity of the population and workforce make Orange County a lively and vibrant place to work, live, and play.

General Population

With a population of approximately 146,027, Orange County includes historic Hillsborough, the county seat, with a population of 7,239; Chapel Hill, with a population of 60,988; Carrboro, with a population of 21,314; and parts of Mebane, (which is mostly in Alamance County), with a population of 2,000.¹ Below are in-depth details about the population, compared to peer counties - counties that are similar based on key demographic, social, and economic indicators.

In terms of where people reside, 71.5% of Orange County residents live in the southern “urban” areas of Chapel Hill and Carrboro, while the remaining 28.5% live throughout the rural areas of the County.²

In 2010, there were about 336 people per square mile compared to 366 people per square mile in 2018. The effects of a high population density could include: high cost of living, overcrowding and traffic congestion, high land prices and reduced affordability due to restricted land supply, higher crime levels, less green spaces and trees, and air and noise pollution.

Orange County Race & Ethnicity

The largest racial and ethnic minorities differ in the three municipalities.

African American residents are the largest group of minorities in Hillsborough making up 23%; and Asian residents are the largest groups in Carrboro (10.6%) and Chapel Hill (12.5%).³

Figure 1: Orange County Race & Ethnicity

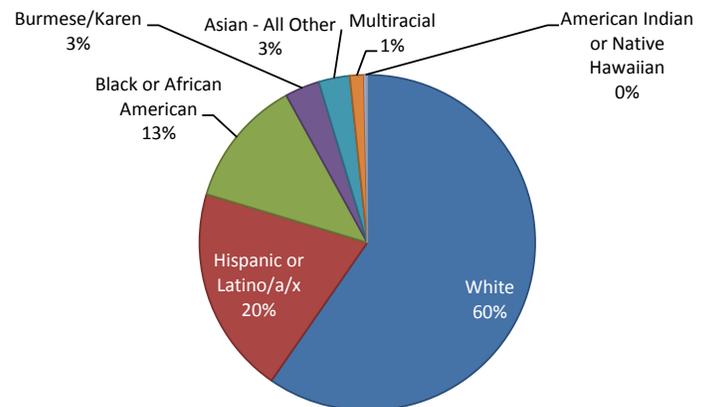


Table 1: Orange County General Population Compared to Peer Counties and NC

PEOPLE	Orange County	Brunswick County	New Hanover County	Buncombe County
Population, 2018	146,027	136,744	232,274	259,103
Population, % change (April 2010 to July 2018)	9.2%	27.3%	14.6%	8.7%
Persons under 5 (2018)	4.5%	3.9%	4.9%	5.0%
Persons under 18 (2018)	19.7%	15.3%	18.4%	18.5%
Persons 65 and over (2018)	14.0%	31.5%	17.7%	20.0%
Female Persons (2018)	52.2%	52.2%	52.3%	52.1%

Immigrant and Refugee Populations

Orange County has a growing immigrant and refugee population – 13.3% of the population is foreign-born – mostly comprised of Hispanic/Latinx immigrants of Latin American origin, and Asian immigrants from various locations, including China, Burma/Myanmar, Korea, and Japan.

In addition to its diversity in countries of origin, Orange County is home to a linguistically-diverse population. With 18.7% of the population speaking a language other than English, there are a substantial number of households that require language access for county services. The Limited English Proficient (LEP) population, which is measured by those who speak English “less than very well” is 6.45% (or 8,523 people) according to the 2018 American Community Survey 5-year estimates. Among that group, the top languages spoken are: 1) Spanish, 2) Chinese, 3) Other Asian, 4) Korean, and 5) Japanese.

Several languages and dialect subsets are spoken by refugees from Burma including: Burmese, Karen- Sgaw and Pwo/Poe, Chin –Falam, Hakha, Tedim, and Rohingya. Additional languages spoken by refugee neighbors include: Kinyarwanda and Swahili, spoken by refugees from DRC (Democratic Republic of Congo) and Arabic, spoken by refugees from Syria. Due to in-and-out migration, available data are limited for the refugee populations; nevertheless, tracking of direct arrivals to Orange County, for those served by the Refugee Health Program, provides a glimpse into a basic number of the population living in the county.

Table 2: Orange County Population Demographics⁴

Foreign-born population	13.3%
Speak a language other than English at home	18.7% – Majority Spanish
Speak English less than very well (LEP – Limited English Proficient)	6.45% (8,523) Spanish (4,838) Chinese (1,432)
Top languages spoken by LEP population	Other Asian (628) Korean (620) Japanese (132)

Refugees in Orange County

Nationwide, refugee arrivals have significantly decreased annually since 2016-2017, after the change in federal administration. In 2017, the Trump Administration used an Executive Order to reduce the number of refugee admissions previously set by the Obama Administration. Since then the number of refugee admissions has been reduced even further. In addition, in March 2020, the International Office of Migration and United Nations High Commissioner for Refugees announced a temporary suspension of travel for refugees during the COVID-19 (coronavirus) pandemic.

OCHD Language Services:

When looking at the OCHD language services provision over the last several years, this increase in the linguistic needs of the Orange County population is evident. Staff and on-site contract interpreters have annually increased the number of interpretation encounters covered at OCHD. These include medical and dental clinical appointments and a range of interpretation services for other OCHD programs such as: the Home Visiting Program, Family Success Alliance Navigator appointments and parent meetings, Diabetes Self-Management Education (DSME) classes for the Nutrition Services program, and Healthy Homes appointments. Patients speaking over 20 languages (including American Sign Language) were served using these services.

Table 3: Direct Refugee Arrivals in Orange County⁵

COUNTY FISCAL YEAR	New Direct Refugee Arrivals	Countries of Origin
2015-2016	83	DRC, Burma, Iraq, Russia
2016-2017	102	Burma, Syria, DRC, El Salvador
2017-2018	22	Burma, DRC, Nepal
2018-2019	34	Burma, DRC, Syria, El Salvador
2019-2020 (YTD as of 4/1/2020)	9	Burma, DRC, Ethiopia

Table 4: OCHD Interpretation Services

COUNTY FISCAL YEAR	On-Site Interpretation Encounters*	Telephonic Interpretation Calls**	Video Interpretation Calls***
2015-2016	4,732	1,528	N/A
2016-2017	5,195	1,910	393
2017-2018	5,362	1,816	230
2018-2019	5,651	2,749	305
2019-2020 (YTD as of 4/1/2020)	4,350 (9 months)	1,582 (7 months)	273 (8 months)

*On-site interpretation encounters include appointments covered by an in-person interpreter, across all programs and divisions of the department. This number does not include no-shows or cancellations with less than 24-hour notice.

**Telephonic interpretation calls include patient encounters and patient calls across the department for a wide variety of languages.

***Video interpretation calls during this time only include medical and dental clinic appointments.

Table 5: OCHD Translation Services

COUNTY FISCAL YEAR	Translations	Languages
2015-2016	171	Spanish, Karen, Burmese, Chinese, Arabic
2016-2017	173	Spanish, Karen, Burmese, Chinese, Arabic, Kinyarwanda
2017-2018	142	Spanish, Karen, Burmese, Chinese, Arabic, Kinyarwanda, Vietnamese
2018-2019	228	Spanish, Karen, Burmese, Chinese, Arabic, Kinyarwanda
2019-2020 (YTD as of 4/1/2020)	240+	Spanish, Karen, Burmese, Chinese, Arabic, Kinyarwanda

In addition to interpretation services, the demand for translation service continues to increase. Translations were produced by multiple services and divisions ranging from Medical and Dental clinical services to Family Success Alliance and Family Home Visiting, Emergency Preparedness, Environmental Health, Finance, and Vital Records. As part of the COVID-19 (coronavirus) pandemic, the need for translations and multilingual audio/visual communications has increased dramati-

cally. In March 2020, community members asked for the inclusion of Swahili as well as Kinyarwanda, as there are some Congolese members of the community who do not speak both, and communication with all in the community is even more critical during this public health emergency. It is expected that the multilingual needs will continue to grow as we continue to work closely with immigrant and refugee partners in ensuring inclusion and language justice for all.

Political Profile

Orange County is considered a progressive county, voting primarily Democratic. In the 2016 presidential election, 72.8% voted for Hillary Clinton, the Democratic candidate, as opposed to 22.5% who voted for Donald Trump, the Republican candidate. According to the NC State Board of Elections, as of November 30, 2019, there were 108,426 registered voters in Orange County. The party affiliations and racial/ethnic demographics, of those registered, are listed below.⁶

Table 6: Orange County Political Profile

AFFILIATION	Count
Democratic	50,282
Republican	14,817
Green	36
Constitution	26
Libertarian	693
Unaffiliated	42,572
Demographic	Count
White	77,494
African American	12,006
American Indian	258
Other	18,668
Hispanic	3,670
Male	45,988
Female	55,191

County Infrastructure

Similar to other NC counties, Orange County is governed by a [seven-member board of commissioners](#) who are elected to four-year terms by district and at-large partisan elections. The results of the 2019 CHA found that county residents had varying concerns related to county government and infrastructure including: tax burden, transportation and traffic issues, over-development, and increased population density.

County commissioners are responsible for establishing the annual property tax rate. Property taxes are charged to residential and commercial entities (or persons) that own land in the county. The median property tax in Orange County is \$2,829 for a home worth a median value of \$258,000. This is compared to \$933 in Brunswick County, \$1,257 in Buncombe County, and \$1,394 in New Hanover County, Orange County's peer counties. This puts Orange County as having the highest median property tax in the U.S. The average yearly property tax paid by Orange County resident's totals about 3.31% of their yearly income.⁷ Property taxes are used to fund county and municipality infrastructure and operations, including public schools.

History

On September 9, 1752, Orange County was founded and named after William V of Orange. Hillsborough, the county seat, was founded in 1754 and had several names over the years. Its first name was Corbin Town, then Childsburgh, and in 1766 the town's final name became Hillsborough. Hillsborough is an old and interesting town located on land where the Great Indian Trading Path crossed the Eno River and was the center of much colonial activity. The county is divided into the seven townships of Bingham, Cedar Grove, Chapel Hill, Cheeks, Eno, Hillsborough, and Little River.⁸



Originally home to a succession of Native American tribes that included the Haw, Eno, Occaneechi, and others, the area including what is now Orange County covered 3,500 square miles. This large area also included all of present day Alamance, Caswell, Person, Durham and Chatham counties as well as parts of Wake, Lee, Randolph, Guilford and Rockingham counties.

Faith and Spirituality

There are hundreds of places to worship in Orange County, including churches, mosques, synagogues and other faith organizations. These institutions provide a source of spiritual nourishment, community support and resources to the residents of Orange County. As residents face the challenge of trying to stay connected to their community in an area where the population is growing and changing quickly, their spiritual homes become sources of social interaction, information exchange, and health care.

2020-2024 Community Priorities

The results from secondary data, opinion surveys, and the community input sessions allowed the identification of three priorities that will be addressed over the next four years. Those priority areas are 1) **Access to Care**, 2) **Health Behaviors**, and 3) **Health Equity** all of which are detailed below.

Access to Care

Access to comprehensive, quality health care services is important for promoting and maintaining health, preventing and managing disease, reducing unnecessary disability and premature death, and achieving health equity for all. Health inequities are systemic differences in the health status of different populations and often exist due to cost and income status, access to the healthcare system and primary care physicians, employment status, ethnicity, transportation, and preventative health services.

Among survey responders:

- 28% of responders felt that access to care was an issue, with concerns around cost and affordability, insurance coverage and hours of availability of care.

Access to Health Care

Access to health care means “the timely use of personal health services to achieve the best health outcomes.” An individual’s ability to access health care, including dental care, can be impacted by a variety of factors such as; availability of services, high cost of care, lack of health coverage, and lack of culturally competent care. The inequities around accessing care are often based on race, ethnicity, socioeconomic status, age, sex, disability status, sexual orientation, gender identity, and residential location. Individuals facing inequities often experience unmet health needs, delays in receiving appropriate care, inability to get preventive services, financial burdens, and preventable hospitalizations.⁹

Orange County has a strong health care community that includes a nationally-ranked hospital system, an accredited School of Public Health, a federally qualified health center, a local public health department, a medical and dental school, and various private medical practices. Even though Orange County has a physician rate of 119.62 per 10,000 population, compared to the state rate of 24, residents continue to report problems accessing health care services. In addition to not having medical

insurance, additional barriers include: 1) the concentration of health care resources in the southern part of the county, 2) inadequate transportation systems in the central and northern part of the county, 3) language barriers, and 4) perceived discrimination (or racism) within health care facilities.

Among survey responders:

- Over the past 12 months, 15% reported having a problem getting needed health care for themselves or a family member.
- 25% expressed having issues accessing health care, including dental care.
- 10% reported problems accessing health care because their deductible/co-pay was too high.
- 9% reported problems accessing health care because their insurance did not cover what they (or their family member) needed.
- 9% reported problems accessing health care because the wait (at health care facilities) was too long.

Among Focus Group responders:

- Karen and Burmese speaking focus group participants shared the lack of language services and interpreters that are available, in their language, when it comes to health care facilities.
- Spanish speaking focus group participants shared the lack of health information that is available in Spanish.

Access to Dental Care

Dental care is one of the nation’s greatest unmet health needs. Issues in oral health include availability of affordable dental insurance, access to regular and preventive care, and population specific issues like children’s dental health, increasing refugee population needs, and language barriers. According to the NC Department of Health and Human Services, poor oral health can lead to diseases and injuries of the skull and face. As a result, public health has been focusing on improving oral health by reducing disparities and expanding access to effective preventative programs. Such efforts include work around community water fluoridation, school dental sealant programs, baby and prenatal oral health programs, and incorporating oral health programs into

chronic disease prevention and medical care. Research from the East Carolina University School of Dental Medicine found that community water fluoridation (CWF) and telehealth services are two examples of cost-effective and equitable public health services that can help reduce dental decay.¹⁰

Communities of color have much higher rates of tooth decay, tooth loss, fewer dental visits and preventive treatments than White populations. Economic hardship negatively affects access to dental care for many people of color.¹¹ In NC, children of minority backgrounds have high rates of tooth decay. 55% of American Indian children and 52% of Hispanic/Latinx children experience tooth decay, compared to 30% of White children. However, 29% of American Indian and 23% of Asian American children have untreated tooth decay, compared to 13% of White children. When it comes to adults, 32% of White adults in NC did not visit a dentist in 2016 and that percentage was significantly higher among African Americans (44.5%) and Hispanic/Latinx (51.2%).¹

[According to the CDC](#), fluoridated water reduces tooth decay by 25% among children and adults. Fluoride also helps with reducing cavities, less severe cavities, less need for fillings and removing teeth, and less pain and suffering because of tooth decay. As of March 2020, the Orange County Board of Health recently approved continued fluoridation of Orange Water and Sewer Authority's (OWASA) water supply, at the current levels, as deemed effective for prevention of tooth decay and for promotion of good oral health.¹²

Orange County has a dentist rate of 18 per 10,000 population compared to NC (5.08), with OCHD Dental Clinic and Carrboro Community Health Center listed as Orange County's oral health safety net providers.

Among survey responders:

- 6% expressed having issues accessing dental services.
- 72% support local fluoridation of water from OWASA.
- 68% support fluoridation of water because in the right amounts, it helps prevent dental decay, fluoridation is a social justice issue for those who have trouble paying for dental care, and it's equitable and reaches all citizens.

OCHD Medical and Dental Patients & Encounters:

With an increase in linguistic diversity and numbers in Orange County, the patients served by OCHD have also increased. In fiscal year (FY) 2018-2019, which occurs July to June, 42% of dental encounters and 36% of medical encounters required an interpreter or bilingual staff for language access. OCHD served these Limited English Proficient (LEP) clinical patients using interpreter services (on site, telephonic and video) in the top languages of 1) Spanish, 2) Karen, 3) Chinese, 4) Burmese and 5) Arabic.

Table 7: OCHD Patient Encounters

	% of Patients that were LEP	% of Encounters that were with LEP Patients
MEDICAL	32%	36%
DENTAL	41%	42%

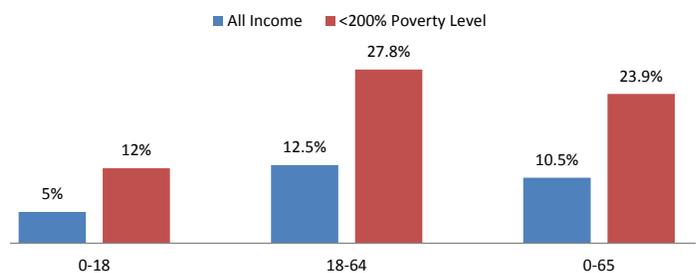
Access to Health Insurance

According to small areas health insurance estimates, 10.5% of Orange County residents, between 0-65 years of age, are currently uninsured, compared to the NC rate of 12.6%, and the U.S. rate of 10.2%.¹³ NC children and seniors enjoy higher rates of coverage due largely to Medicaid and Medicare. Approximately 28% of those uninsured in Orange County are adults 18-64.

Among survey responders:

- 17% reported not having any health insurance.

Figure 2: % Uninsured by Age and Income Status



Having health insurance provides individuals access into the health care system. Lack of coverage creates barriers that can limit or prohibit individuals from receiving the health care that they need and can cause an individual to have poor health status, late diagnoses, and/or premature death.

The Affordable Care Act (ACA), the largest health care legislation since the enactment of Medicaid and Medicare, helped to reduce racial and ethnic disparities in access and extended care to millions of Americans¹⁴. Data from the Kaiser Family Foundation also points to improvements in health care access, coverage, and utilization by race and ethnicity as compared to the ACA¹⁵.

Out of more than 10 million NC residents, approximately 30% are either uninsured, on Medicaid, or are dually eligible for Medicare and Medicaid¹⁶. Between 2010-2016, the number of uninsured in NC and Orange County declined with the passage of the ACA; however, in 2017 the uninsured rate began to rise¹⁷. Approximately 100,000 Medicaid eligible and non-elderly uninsured individuals live within a four-county radius of Orange County¹⁸. While a single disease does not dominate within these subgroups, the work through [Carolina Health Net](#) (the local system of care for the uninsured) and [Community Care of North Carolina](#) (the local system of care for Medicaid) indicates that approximately 82% of patients often have multiple health and psychosocial needs¹⁹.

While the ACA called for Medicaid expansion in every state, which would cover all legally-present residents with income up to 133% of poverty, NC rejected Medicaid expansion. Due to the non-expansion, NC is missing out on billions of federal dollars, and is causing NC hospitals to provide approximately \$1 billion in uncompensated care each year – an amount that would drastically decline if Medicaid were expanded. Expanding Medicaid could have created 40,000 jobs, which could have assisted with rural hospitals being able to remain open²⁰.

Access to Transportation



In 2017, there were 70,923 Orange County residents, 16 years and over, commuting to Orange County for work, compared to 66,130 in 2014. 68% of the population drive alone, 8% utilize public transportation, 9% carpool,

5% walk, and 3% utilize other means²¹. Orange County Commuter Options (OCCO) is an available program that helps one get to work without having to drive alone.

Orange County's three transit providers operate in and through the county to connect people to both rural and urban destinations. Orange County Public Transportation (OCPT) connects Hillsborough to other regional towns, and provides service for the rural areas of the county and into Chapel Hill, as well as regional connections to Durham and Mebane. Chapel Hill Transit provides mobility needs to the residents of Chapel Hill and Carrboro, UNC students, employees and visitors. Go Triangle connects Orange County to neighboring Durham and Wake Counties, including express service to Duke University, NC State University and frequent service to RTP.

Among survey responders:

- 17% reported that bus routes do not go where they need them to go.
- 15% reported that public transportation doesn't operate in the hours/times they need them.
- 15% reported that public transportation takes too long.

Among focus group responders:

- Karen and Burmese speaking participants shared the lack of language services and interpreters that are available, in their language, when it comes to public transportation.

In 2020, there are a number of new transportation projects aimed at providing increased service to individuals in Orange County. A few of those projects include: 1) Americans with Disabilities Act (ADA) compliant improvements at bus stops for Chapel Hill Transit, 2) construction of the Hillsborough train station, 3) a park-and-ride lot in north Hillsborough, and 4) bus stop improvements throughout Orange County, as well as in Mebane. OCPT will add a new service on two routes; Hillsborough-Mebane on the Alamance Health Connector, and a new Cedar Grove-Durham Express. The Hillsborough Circulator will be expanded and counter-circular service will be provided and OCPT will increase service for mobility on-demand.

Transportation infrastructure in Orange County has improved over the years. [The 2030 Comprehensive Plan](#) outlines future efforts of the Transit Department. Those efforts even include alternative transportation efforts such as interconnected pedestrian and bicycle trail, transit lanes along major thoroughfares, and the

development of park-and-ride lots that would encourage use of public transportation to travel to and from work. While the Comprehensive Plan outlines future efforts to improve connectivity throughout the county, those efforts will be met with funding constraints, frequency of users, and the rural nature of certain areas in the county. To aid in access and utilization of transportation services, transit academies and ride-a-longs have been introduced to health and human service providers, older adults, and non-profit agencies to help educate and provide awareness of available local, regional and state transportation resources. For more information on current transportation routes, fees, and ridership criteria visit the [Transportation Services](#) website.

Below is a non-inclusive list of local and state programs and initiatives to help address Access to Care.

[Affordable Care Act](#)

[Cardinal Innovations Healthcare](#)

[Carolina Health Net](#)

[Carrboro Community Health Center](#)

[Chapel Hill Transit](#)

[Community Care of North Carolina](#)

[Go Triangle](#)

[Piedmont Health](#)

[Orange County Health Department Dental Clinic](#)

[Orange County Public Transportation](#)

Health Behaviors

Health behaviors are not always determined by a choice to be healthy or unhealthy but rather the influence from one's community, systemic racism, exposure to trauma, physical activity, food accessibility, substance use, sexual health and one's social and economic status.

Mental Health

Mental health is defined as an individual's emotional, psychological and social well-being²². Mental health shapes and helps to determine how individuals relate to themselves and others, how to deal with stress and how to make choices, and handle everyday life activities. Mental health problems are common, and it is estimated that 21% of adults in Orange County and 19% of adults in NC live with depression²³.

Although rates of depression are lower among African Americans and Hispanic/Latinx than in Whites, depression among African Americans and Hispanic/Latinx are likely to occur more often. LGBTQ+ individuals are 2.5 times more likely to experience depression, anxiety and substance misuse compared to heterosexual individuals. Twice as many women will experience depression, generalized anxiety disorder or PTSD (post-traumatic stress disorder) in their lifetime, versus men²⁴. About 1 in 5 American adults have a mental health condition, yet about 56% of mentally ill adults lack treatment. Barriers to care include a chronically underfunded mental healthcare system, the social stigma of mental health conditions, high costs of care, lack of mental health professionals, and a scarce number of community-based resources²⁵.

Among survey responders:

- Mental health concerns were one of the most common issues, being more prevalent than high blood pressure, diabetes, or high cholesterol.

- 11% felt that mental health was an issue.
- 52% said they would refer a family member/friend to a private counselor/therapist if they needed counseling.
- 14% did not know who to refer a family member or friend to for counseling.

Suicide

The rate of suicide (2014-2018) in Orange County is 9.8 per 100,000, accounting for 70 deaths, compared to 66 deaths from 2013-2017. 66 of the 70 suicides were among White, non-Hispanic individuals and 55 of the 70 deaths were completed by men.

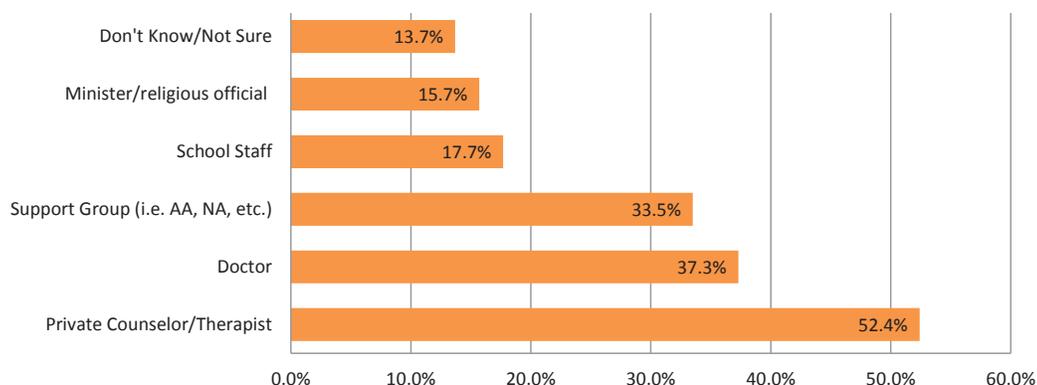
Suicide is the 9th leading cause of death for all ages in Orange County, the 7th leading cause of death among those 0 – 19 years of age, the 2nd leading cause of death among those 20-39 years of age, and the 5th leading cause of death among those 40 – 64 years of age. While suicide in Orange County is higher among White males, the data also shows that the suicide rate is significantly lower among African Americans, American Indians and Hispanic/Latinx to the point where the numbers are too low (or non-existent) to produce a rate. Racial and ethnic differences in suicide and suicidal behaviors are often related to underreporting and limitations among data collection systems.

Suicide is preventable and there are a number of signs and symptoms to be aware of that can ultimately save a life. Warning signs of suicide ideation include²⁶:

- Talking about wanting to kill oneself
- Sleeping more or less than usual



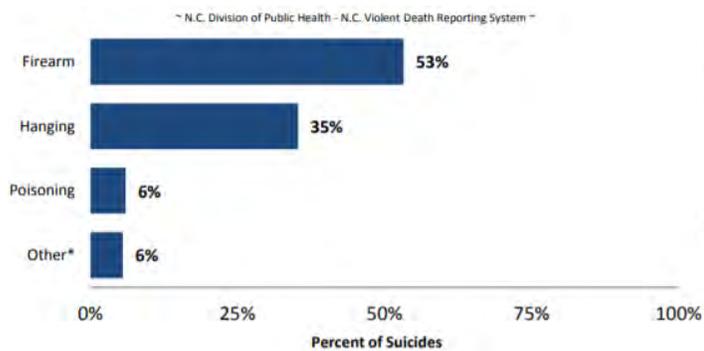
Figure 3: Where Survey Responders Would Refer Someone for Counseling



- Indicating feeling hopeless, isolated and extremely lonely
- Withdrawal from family, friends or activities
- Extreme mood swings
- Acting recklessly
- High anxiety or agitation
- Increased alcohol or drug use

From 2007 to 2016, 3,157 NC youth, ages 10 to 24, died as a result of violence. Of these violent deaths, 1,505 (47.7%) were suicides. Regardless of age, males consistently had a higher number of deaths by suicide than females. The number of NC suicides peaked for males at age 22 with 171 suicides, and for females at age 23 with 38 suicides. 73% of all youth suicide victims were identified as non-Hispanic White, 16.3% were identified as non-Hispanic African American, 6.2% identified as Hispanic/Latinx, and 4.5% identified as belonging to another racial/ethnic group. Overall, the most common method of suicide among youth is firearms²⁷.

Figure 4: Method of Death: NC-VDRS, 2007-2016



[Healthy Carolinians of Orange County \(HCOO\)](#) adopted the [#BeTheOneTo](#) campaign with hopes that together lives can be changed. There are five evidence supported steps for communicating with someone who may be suicidal. Those steps are: 1) **Ask**, 2) **Keep Them Safe**, 3) **Be There**, 4) **Help Them Connect**, and 5) **Follow Up**. Though rarely talked about or reported, suicides outnumber homicides two-to-one, resulting in nearly 1,200 suicides in NC each year²⁸. Preparing communities, organizations, and individuals to skillfully reach out to help others in need is an important responsibility, and one that Orange County and NC takes seriously. To help do this, NC has the [2015 Suicide Prevention Plan](#).

Below is a non-inclusive list of local and state programs and initiatives to help address mental health.

[Cardinal Innovations Healthcare](#)

[El Futuro](#)

[Faith Connections on Mental Illness](#)

[Freedom House Recovery Center](#)

[National Alliance on Mental Illness \(NAMI\)](#)

[National Suicide Prevention Lifeline](#)

[NC Injury and Violence Prevention Branch](#)

[Orange County Behavioral Health Systems Analysis](#)

[UNC Center for Excellence in Community Mental Health](#)

Substance Use

Substance abuse is generally defined as a harmful pattern of use of any mood-altering substance. Substances include alcohol and other drugs, whether legal or illegal. Included in this section will be information on the use, misuse and/or abuse of the top three most misused/abused substances - opioids, tobacco and alcohol.

Among survey responders:

- 8% stated that substance use was an issue with concerns around alcohol, drugs and tobacco.

Opioids

America's opioid and heroin epidemic claimed nearly 64,000 lives in 2016 - more than guns, car accidents, homicides, or HIV/AIDS. Opiate-related overdoses are now the leading cause of death for Americans under the age of 50²⁹.

Opioids are a large cause of unintentional drug overdose deaths. When it comes to opioid overdose, Orange County has a rate of 6.6 per 100,000 (shown below). In 2015, over 1,100 North Carolinians died due to opioid-related causes, which was a 73% increase over the past 10 years³⁰.

Among survey responders:

- 89% said they would refer their friend or family member to a doctor or private counselor for counseling.

A 2016 report found that people who use opioids are more likely to live in the rural south than anywhere else in America. Of the 25 most addicted American cities, four are located in NC. Fayetteville ranked 18th (7.9%), Jacksonville ranked 12th (8.2%), Hickory ranked 5th (9.9%) and Wilmington is at the very top with more than 11.6% of its population abusing opiates³¹.

Historically, prescription drugs—often painkillers—were the major contributor to this epidemic, and today opioids are a class of drug that include, but are not limited to: “heroin, fentanyl, oxycodone, hydrocodone, codeine and morphine”. Below, is a graph of substances that contribute to the unintentional overdose deaths here

in Orange County over the past ten years, with a significant increase occurring among heroin and/or other synthetic narcotics.

Due to the consistent increase in opioid overdoses, Governor Roy Cooper declared NC as having an opioid epidemic. To help combat this crisis at the state level,

Figure 5: Rate of Unintentional Opioid Overdose Deaths

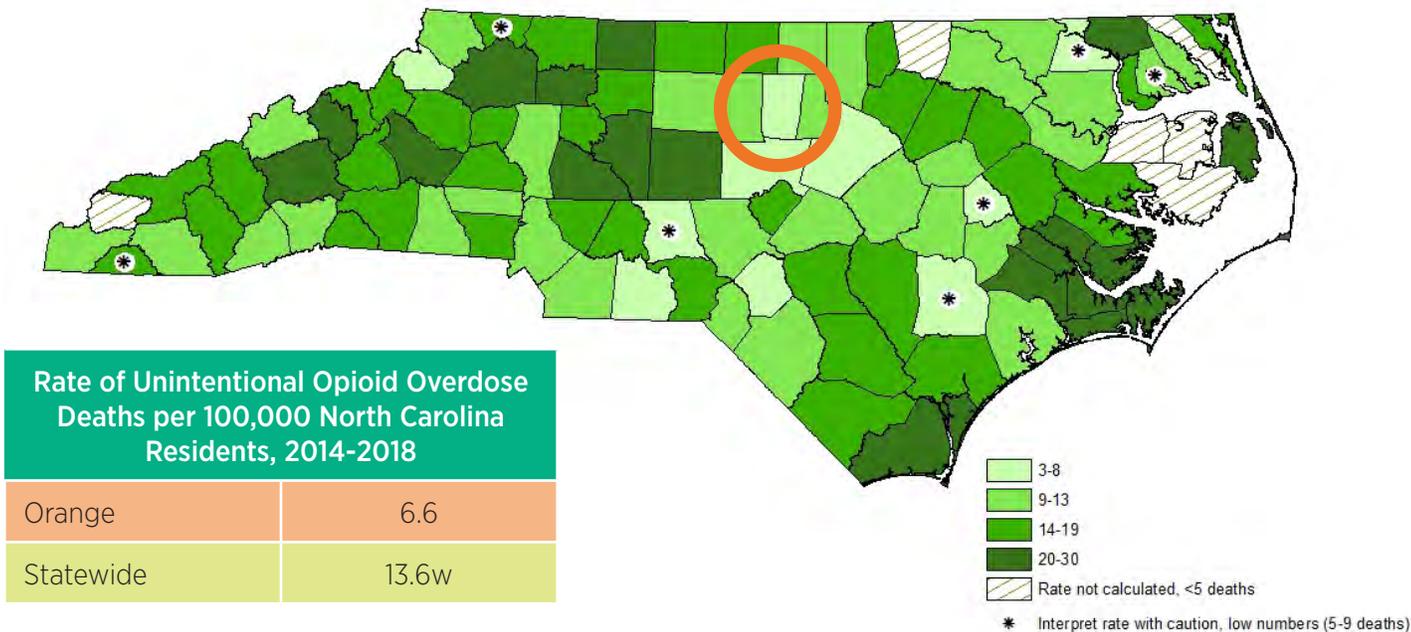
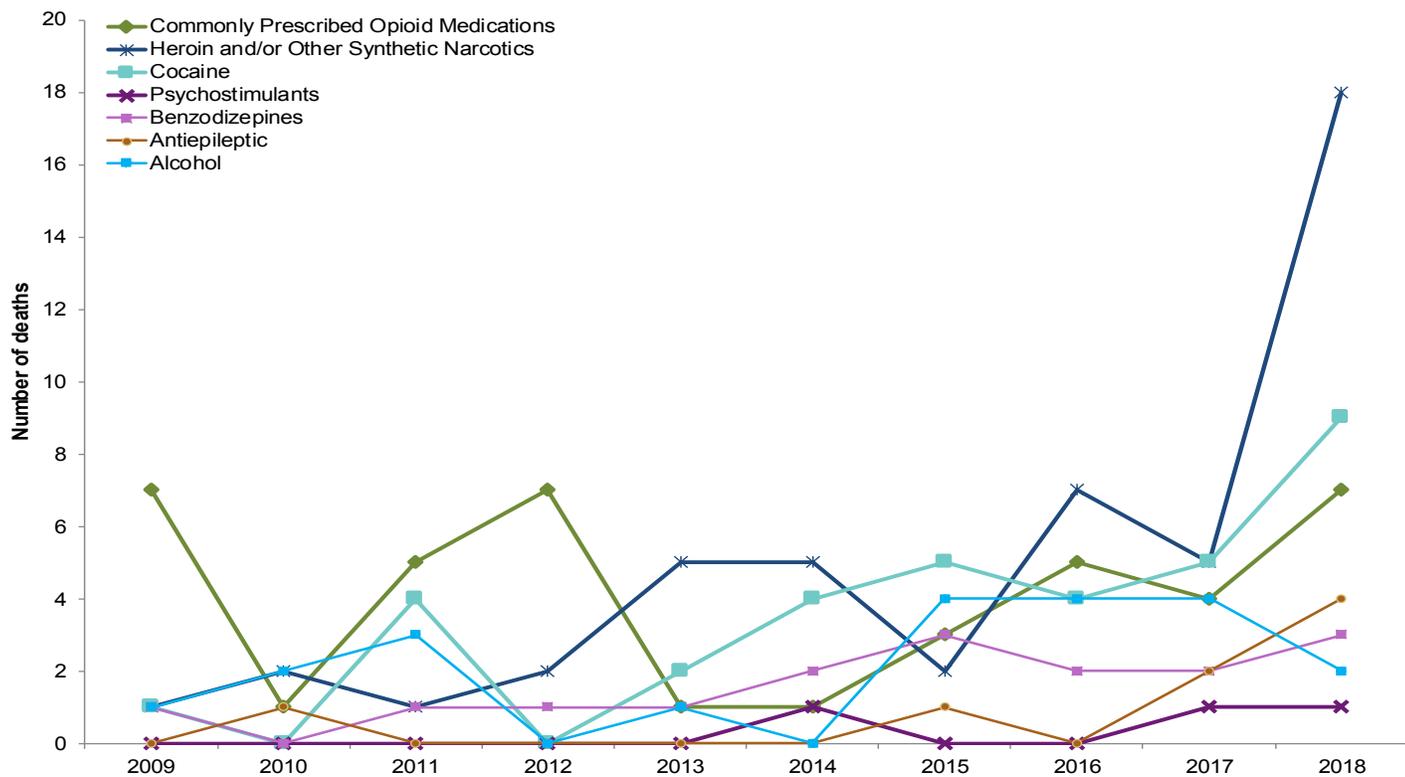


Figure 6: Number of Deaths Caused by Drug Overdose



state and local partners created and updated the [Opioid Action Plan 2.0](#).

In 2013, the OCHD became the first in the state to pursue a standing order to allow public health nurses to dispense the drug naloxone to its clinic patients. Naloxone, also known as Narcan, is an antidote that reverses opiate overdoses within minutes of being administered via intramuscular injection or intranasal spray. OCHD's naloxone kit distribution is one innovative and replicable way to help tackle NC's opioid-related deaths. In 2019, the Orange County Board of County Commissioners supported the formation of the Orange County Opioid Taskforce. This group will work together to address education around opioids, reducing the oversupply of prescription opioids by prescribers, and expand treatment and recovery oriented systems of care.

Below is a non-inclusive list of local and state programs and initiatives to help address and combat the opioid epidemic.

[COORE](#) (Coordinated Opioid Overdose Reduction Effort)

[Drug Treatment Courts](#)

[NC Safe Syringe Initiative](#)

[Orange County Health Department Syringe Exchange](#)

[Overdose Reversal - Naloxone](#)

[Prescription Drug Drop Boxes](#)

Tobacco

Tobacco use and smoking remains the leading cause of preventable death in the U.S., NC, and Orange County. Smoking and tobacco use can cause cardiovascular disease, cancer, stroke and upper respiratory infections³². Tobacco products include cigarettes, cigars, chew tobacco, hookah, and electronic cigarettes.

Over the past 60 years, tobacco companies have been known to spend billions of dollars each year in marketing that disproportionately impacts low-income and people of color communities. Targeting has been seen through distributing free cigarettes to children in housing projects, dispensing tobacco coupons with food stamps, discounting tobacco products, and increasing the number of retailers selling tobacco products in certain communities³³.

Here's how tobacco impacts different segments of the population:

- Tobacco use varies among racial, income, geographic and other demographic groups.
- Low-income persons, those with lower levels of education, persons with mental illness and substance disorders, and those who are unemployed smoke at higher rates than other groups.
- American Indians have a higher prevalence of smoking than any other racial or ethnic group.
- African American tobacco users die from tobacco-related causes at higher rates than any other racial or ethnic group.
- LGBTQ+ individuals are more likely to be smokers than their heterosexual counterparts.
- Infants and children exposed to second-hand smoke are more likely to experience asthma attacks, ear infections, and sudden infant death syndrome (SIDS).
- Adolescents who use nicotine become addicted more quickly than adults.
- Educational level and household income are key indicators of smoking status.

In 2018, cigarette smoking among Orange County adults holds steady at approximately 14.2%, compared to NC (17.6%) and the Region 5 (combined) surrounding counties (17.4%). Alamance, Wake, Durham, Chatham, Orange, Rockingham, Guilford and Caswell counties all make up Region 5. Of the current smokers within Region 5, 18.2% are non-Hispanic Whites, 17.2% are non-Hispanic other, 12.2% are non-Hispanic African

Americans, and 10.8% are Hispanic/Latinx. Current smokers by age, within Region 5, are shown below, with the highest percentage of smokers occurring among those aged 45-54. Individuals with a college degree or higher and a household income of more than \$75,000 per year were less likely to smoke³⁴.

The emergence of new tobacco products such as electronic cigarettes and the dramatic rise in their use, especially by adolescents and young adults, are a significant public health concern. The 2017 percentage of NC students using e-cigarettes or vaping is 17%, compared to 16.8% in 2015, and 1.7% in 2011. Electronic cigarettes have become the most popular tobacco product for youth and adolescents in the U.S. and are attracting youth to new avenues for nicotine addiction. While electronic cigarettes have been known to help some smokers quit, the long-term health effects of these products, and the net public health effect associated with their use, remain unclear.

Among students in Orange County:

- 29% of high school students in Orange County Schools (OCS) reported having not smoked traditional cigarettes within the past 30 days.
- 1 in 5 OCS students reported using an electronic vapor product or vaping within the past 30 days.
- Approximately 56% of OCS high school students did not think electronic-cigarettes or vaping products posed a risk to their health.
- In 2017, 13% of high school students in Chapel Hill Carrboro City Schools (CHCCS) reported using an e-cigarette within the past 30 days.
- In 2017, 29% of CHCCS high school students reported ever having used an e-cigarette.

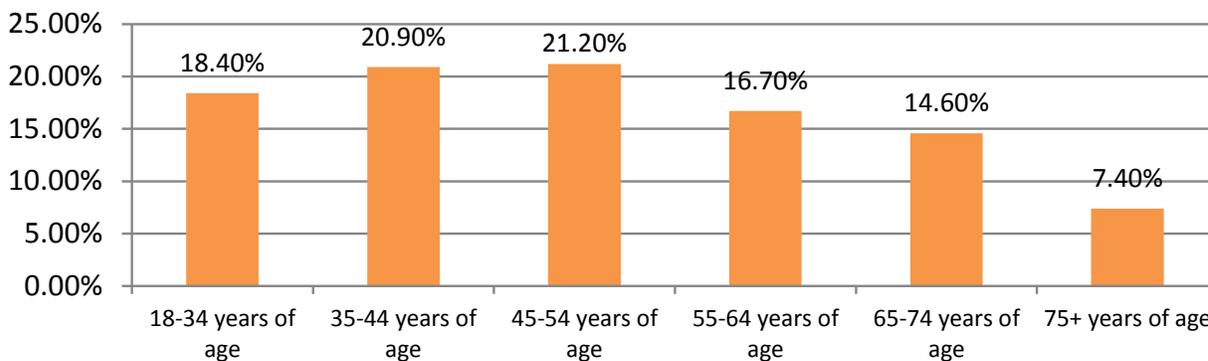
Orange County middle school students' use of traditional cigarettes follows the statewide NC declining trend; however, the increasing trend of e-cigarette use by middle schoolers both statewide and in Orange County is alarming. The use of traditional cigarettes fell from 15% in 1999, to 10% in 2013, to 2.5% in 2017 among NC middle school students. Meanwhile, in 2011, approximately 1% of NC middle school students used e-cigarettes, and in 2017 this percentage increased to approximately 5.3%. As of November 2019, electronic cigarette or vaping associated lung injury (Vaping/EVALI) has been reported in 73 individuals in NC and in one individual in Orange County.

OCHD has taken a three pronged approach to help curb the local use and addiction of tobacco and nicotine. This approach includes: 1) educating Orange County youth, among both school systems, on electronic cigarette use and its dangers, 2) offering tobacco cessation through Nicotine Replacement Therapy (NRT) patches, gum or lozenges to those who live or work in Orange County, and 3) continued implementation and education around the Smoke-Free Public Places Rule, that was adopted in October of 2012 by the Orange County Board of Health to ban smoking in public places including bars and restaurants.

Below is a non-inclusive list of local and state programs and initiatives to help address and combat tobacco use and prevention.

- [Freedom House Recovery Center](#)
- [NC QuitLine](#)
- [NC Tobacco Prevention and Control Branch](#)
- [Orange County Health Department](#)
- [UNC Horizons Program](#)
- [UNC Nicotine Tobacco Treatment Center](#)
- [You Quit Two Quit](#)

Figure 7: Current Smokers by Age - Region 5



Alcohol

Excessive use of alcohol is considered to be four or more drinks/day for women and five or more drinks/day for men. Alcoholism is the dependence on alcohol that results in preoccupation with alcohol, frequent impaired control over drinking alcohol, use and abuse of alcohol despite negative or adverse consequence, and the inability to recognize one's dependence on alcohol or distorted thinking (denial) about alcohol use. Alcoholism comes from a variety of factors including family history of alcoholism, environmental stressors, and psychosocial and mental health factors.

Regardless of the intake amount, alcohol has been known to increase one's risk for mouth, throat, voice box, esophagus, female breast, liver, and colorectal cancer. Alcohol use has a greater effect on one's cancer risk than occupational hazards, UV radiation or protective behaviors like physical exercise and breastfeeding. In the U.S., alcohol use contributes to approximately 3.5% of all cancers and 15% of breast cancer deaths³⁵. Alcohol intake while pregnant can result in a woman's baby being born with birth defects and developmental disabilities. Babies exposed to alcohol in the womb can develop fetal alcohol spectrum disorders (FASDs) that include a wide range of physical, behavioral, and learning problems. The most severe type of FASD is

fetal alcohol syndrome (FAS), which is caused by heavy drinking during pregnancy³⁶.

In 2017, over 33,000 NC Emergency Department (ED) visits were due to acute alcohol intoxication, 477 occurred in Orange County, and from 2010 – 2018, close to 300 Orange County individuals lost their life due to an alcohol-related death³⁷. One of the single largest issues negatively impacting colleges, universities and their surrounding communities is high-risk excessive drinking. Orange County, particularly in the Town of Chapel Hill where the University of North Carolina is located, is no exception. Data from 2013-2017 indicates that Orange County had 13,217 car crashes, and of the 13,217 crashes, 27% (52) resulted in an alcohol related death.

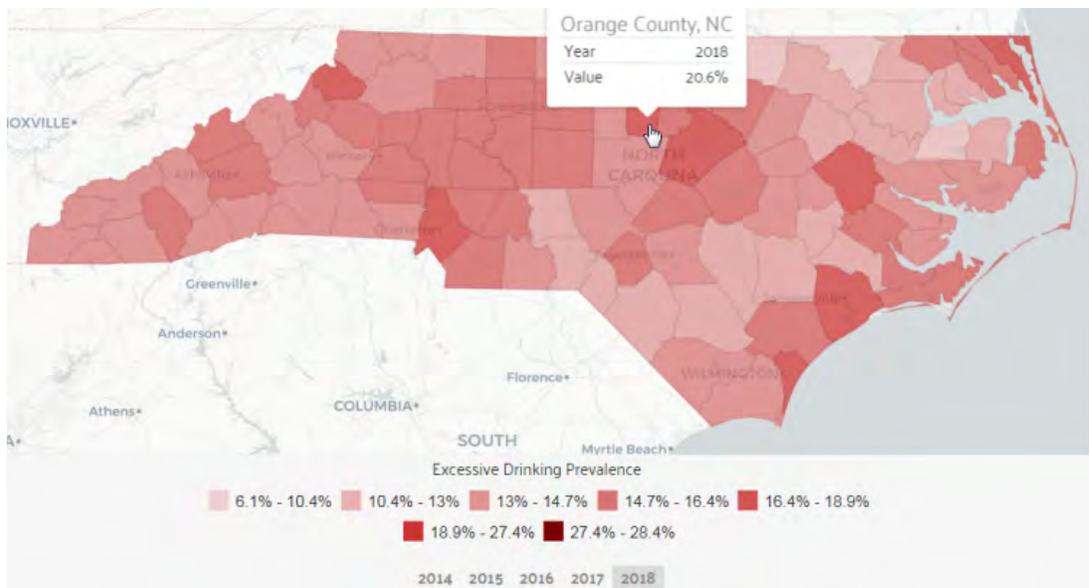
In 2018, Orange County had the second highest prevalence of excessive drinking (20.6%), followed by Wake County (20%), and led by Onslow County (22.6%)³⁸. Excessive drinking is defined as binge drinking, heavy drinking and/or any drinking by pregnant women or people younger than age 21.

There are 270 alcohol outlets (retailers where alcohol can be purchased) in Orange County and 17,782 outlets in NC. African American, Hispanic/Latinx, and Native American communities are more likely to have a higher prevalence of alcohol retailers than White communities.

Table 8: Orange County Alcohol Related Deaths

	2010	2011	2012	2013	2014	2015	2016	2017	2018	Total
Alcohol Related Deaths	27	23	28	22	26	33	38	39	37	278

Figure 8: Excessive Drinking Rate



In most NC counties, African American and Hispanic/Latinx neighborhoods are exposed to greater alcohol retailers than White non-Hispanic neighborhoods³⁹.

Below is a non-inclusive list of local and state programs and initiatives to help address and combat alcohol use and prevention.

[Freedom House Recovery Center](#)

[Orange Partnership for Alcohol and Drug Free Youth](#)

[The Campus and Community Coalition to Reduce the Negative Impacts of High Risk Drinking](#)

[UNC Healthcare Alcohol and Substance Abuse Treatment Program \(ASAP\)](#)

Physical Activity & Obesity

Physical Activity

According to the World Health Organization, physical activity is any bodily movement that requires using energy. Physical activity is important for both children and adults of all ages. It is recommended that adults receive 150 minutes a week of physical activity and children receive 60 minutes a day⁴⁰. According to the Behavioral Risk Factor Surveillance System (BRFSS), adults who are physically inactive are those who did not engage in physical activity or exercise during the previous 30 days other than for their regular job. 23.7% of NC adults are physically inactive⁴¹.

Physical inactivity is estimated to be the main cause for approximately 21–25% of breast and colon cancers, 27% of type two diabetes, and approximately 30% of acute heart disease burden. Physical activity is often confused with exercise; however, exercise is a component of

physical activity that is planned, structured, repetitive, and purposeful in the sense that maintenance of one or more components of physical fitness is the objective. Physical activity includes exercise as well as playing, working, active transportation, house chores, and recreational activities. Many American communities are discouraged from participating in physical activity due to reasons such as violence, increased traffic, pollution, and a lack of sidewalks, parks and recreational facilities⁴².

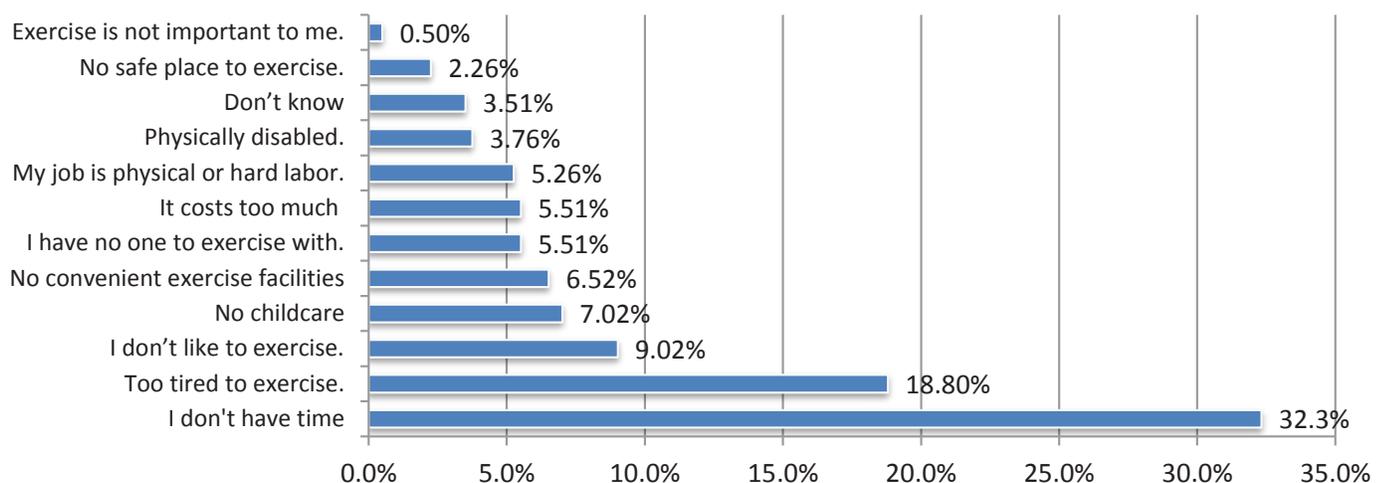
Among survey responders:

- 16% stated that physical activity was an issue with concerns around safe places to exercise, access to healthy food, overweight and obesity and hunger.
- 31% stated that they engage in physical activity or exercise three to four (3-4) days a week.
- 32% stated that they do not engage in physical activity because they do not have time.

Overweight and Obesity

Overweight and obesity are defined as abnormal or excessive fat accumulation that presents a risk to health. Overweight and obesity serve as risk factors for a number of chronic diseases, including diabetes, cardiovascular (heart) diseases, stroke, and cancer⁴³. The study of obesity varies based on the cause of weight gain. There is not one single type or cause for obesity. Components of obesity include genetic, stress-induced, and menopause-related, to name a few. Obesity is related to genetic, psychological, physical, metabolic, neurological, and hormonal impairments. It is intimately linked to heart disease, sleep apnea, and certain cancers. As a result of stigma, obesity is one of the few diseases that can negatively influence social and interpersonal relationships⁴⁴.

Figure 9: Reasons why survey responders don't exercise



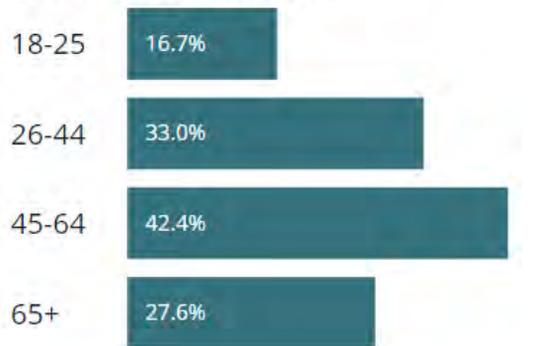
Among survey responders:

- 32% stated that they have been told by a doctor, nurse or healthcare professional that they are obese.

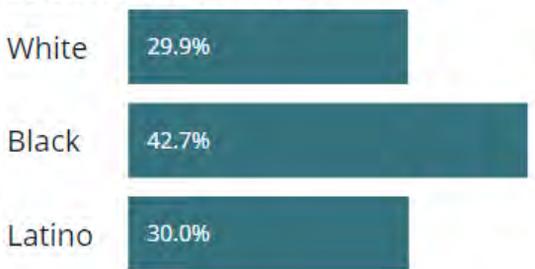
As of 2018, 23% of Orange County and 30% of NC adults are obese. The highest obesity rates are seen among NC residents aged 45-64 (42.4%) and among African Americans (42.7%).

Figure 10: Obesity Rate by Age, Race and Gender (2018)

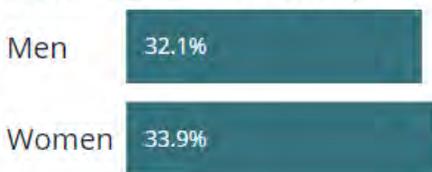
OBESITY RATE BY AGE (2018)



OBESITY RATE BY RACE (2018)



OBESITY RATE BY GENDER (2018)



Nutrition

Nutrition is about eating a healthy and balanced diet, where energy and nutrients are obtained through food and beverage. Understanding these nutrition terms may make it easier to make healthy and necessary food choices. Foods eaten provide energy (calories) and nutrients such as protein, fat, carbohydrate, vitamins, minerals, and water. Eating healthy foods, in the right amounts, gives the body energy to perform daily activities, helps to maintain a healthy body weight, and can lower the risk of chronic diseases⁴⁵.

Poor diet is often the cause of adults living with one or more chronic disease. In order to start and maintain a healthy lifestyle, it is recommended that individuals 1) focus on variety, amount and nutrition of foods, 2) eat the right amount of calories - based on age, sex, height, weight, and physical activity, 3) choose foods with less saturated fat and low sodium and beverages with no added sugars, 4) make half the plate fruits and vegetables, 5) make half the grains whole grains, and 6) vary your protein routine. Orange County is the home to five local Farmers' Markets - Carrboro, Chapel Hill, Southern Village, Eno River and Hillsborough Farmers Markets, and a number of farms and Community Supported Agriculture (CSA) outlets.

Among survey responders:

- 73% stated that at the store where they typically buy food, there is a good selection of fruits and vegetables available.

Food Insecurity

Food insecurity refers to the uncertainty, lack of, or inability to obtain nutritious food in a safe and socially acceptable manner. Food insecurity refers to the percentage of households unable to provide adequate food for one or more household members due to lack of resources. Approximately 18,030 residents are food insecure, which gives Orange County a food insecurity rate of 12.7%, compared to NC (16.5%) and the U.S. (11.1%)⁴⁷.

Table 9: Food Insecurity in Orange County

Number of people who are food insecure	18,030
Percentage of people who are food insecure	12.7%
Children under 18 who are food insecure	4,420
Percentage of children under 18 who are food insecure	15.5%
Individuals over 65 who are living below the poverty level	914

Among survey responders:

- 14% shared that in the past month, they had to cut the size of meals, or skip meals, because there wasn't enough money for food.

- When asked if they, or a family member they lived with, were unable to access a service when it was really needed, 15.9% shared that they had trouble accessing food.

Food inequalities are experienced most among racial and ethnic minorities, low-income families, and single parent households. Among women, food insecurity is associated with obesity, anxiety and depressive symptoms, risky sexual behavior, and negative pregnancy outcomes such as low birthweight and gestational diabetes. When we consider children, food insecurity is associated with anemia, asthma, depression and anxiety, cognitive and behavioral problems, and higher risk of being hospitalized⁴⁸.

Additional definitions of food security and insecurity by the USDA are explained as⁴⁹:

- High food security - no reported indications of food-access problems or limitations,
- Marginal food security - one or two reported indications—typically of anxiety over food sufficiency or shortage of food in the house. Little-or-no indication of changes in diets or food intake,
- Low food security (food insecurity without hunger) - reports of reduced quality, variety, or desirability of diet. Little or no indication of reduced food intake, and
- Very low food security (food insecurity with hunger) - Reports of multiple indications of disrupted eating patterns and reduced food intake.

There is limited data on food insecurity for older adults in the county; however, most food insecure seniors are living in the rural parts of the county. It is estimated that between 900-1,000 seniors over the age of 65 are living below the poverty level⁵⁰. The [Orange County Master Aging Plan](#) identifies food insecurity of older adults as a primary issue - especially for those living in the northern or rural areas of the county. Objective 7.4 in the aging plan outlines a number of strategies for addressing the issue of food access for older adults.

There are local, state and national programs that have been known to assist with reducing food insecurity by providing either cash or food assistance to those in need. Such programs are: [Supplemental Nutrition Assistance Program](#) (SNAP), special supplemental nutrition program for [Women, Infants and Children](#) (WIC), [National School Lunch Program](#) (NSLP) and local food banks.

In 2017, SNAP lifted 3.4 million people out of poverty. Despite this success, it is estimated that 27% of food-insecure individuals live in a household that does not qualify for assistance³⁵. In Orange County, SNAP or Federal Nutrition Service (FNS) program enrollment decreased by 6.5% between 2017-2018 and 2018-2019. 14,478 Orange County residents were enrolled in SNAP/EBT from June 2018 – July 2019, compared to the recorded 15,499 participants in 2017- 2018. A number of issues may have impacted enrollment during this time including new [USDA rules that increased work requirements](#) for SNAP participants, the spread of misinformation about new rules, and a fear of endangering immigration status by participating in FNS programs.

As of December 2019, the percentage of CHCCS students enrolled in free and reduced lunch was 26.2%. Over the past few years, enrollment in the free and reduced lunch program in OCS has remained between 39-42%. The current enrollment for the 2019-2020 school year is 41%. OCS offers a universal free breakfast program and served 89,350 during the 2017-2018 school year. As of December 2019, the total number of breakfasts served had already reached 101,153. Unlike the free and reduced lunch program, the universal free breakfast program requires no enrollment process or eligibility requirements⁵¹.

The Orange County Food Council (OCFC) plans to address food insecurity and food access by coordinating a gap analysis, to include food access and insecurity for the Orange County Food System. The gap analysis will serve as the initial phase in developing a Food Policy Agenda (FPA). The Orange County Food Council's FPA will serve as a tool for each jurisdiction in Orange County to implement practices and policies to address issues of food insecurity and food access, the local food economy, agriculture, and food waste using a systems change approach that is grounded in racial equity principles.

Below is a non-inclusive list of local and state programs and initiatives to help address and food insecurity and hunger:

[Anathoth Community Garden](#)

[Carrboro Farmers Market](#)

[Chapel Hill Farmers Market](#)

Community Food Resource Guide {[English](#)} {[Spanish](#)}

[Department of Social Services](#)

[Eno River Farmers Market](#)

[Freedom House Recovery Center](#)

Hillsborough Church of God

[Inter-Faith Council](#)

[Orange Congregations in Mission](#)

[Orange County Cooperative Extension](#)

[Orange County Food Council](#)

[Transplanting Traditions Community Farm](#)

Health Equity

According to the CDC, health equity is achieved when every person has the opportunity to attain their full health potential and no one is “disadvantaged from achieving this potential because of social position or other socially determined circumstances.” Health inequities are reflected in differences in length of life; quality of life; rates of disease, disability and death; severity of disease; and access to treatment⁵².

Equity and Equality

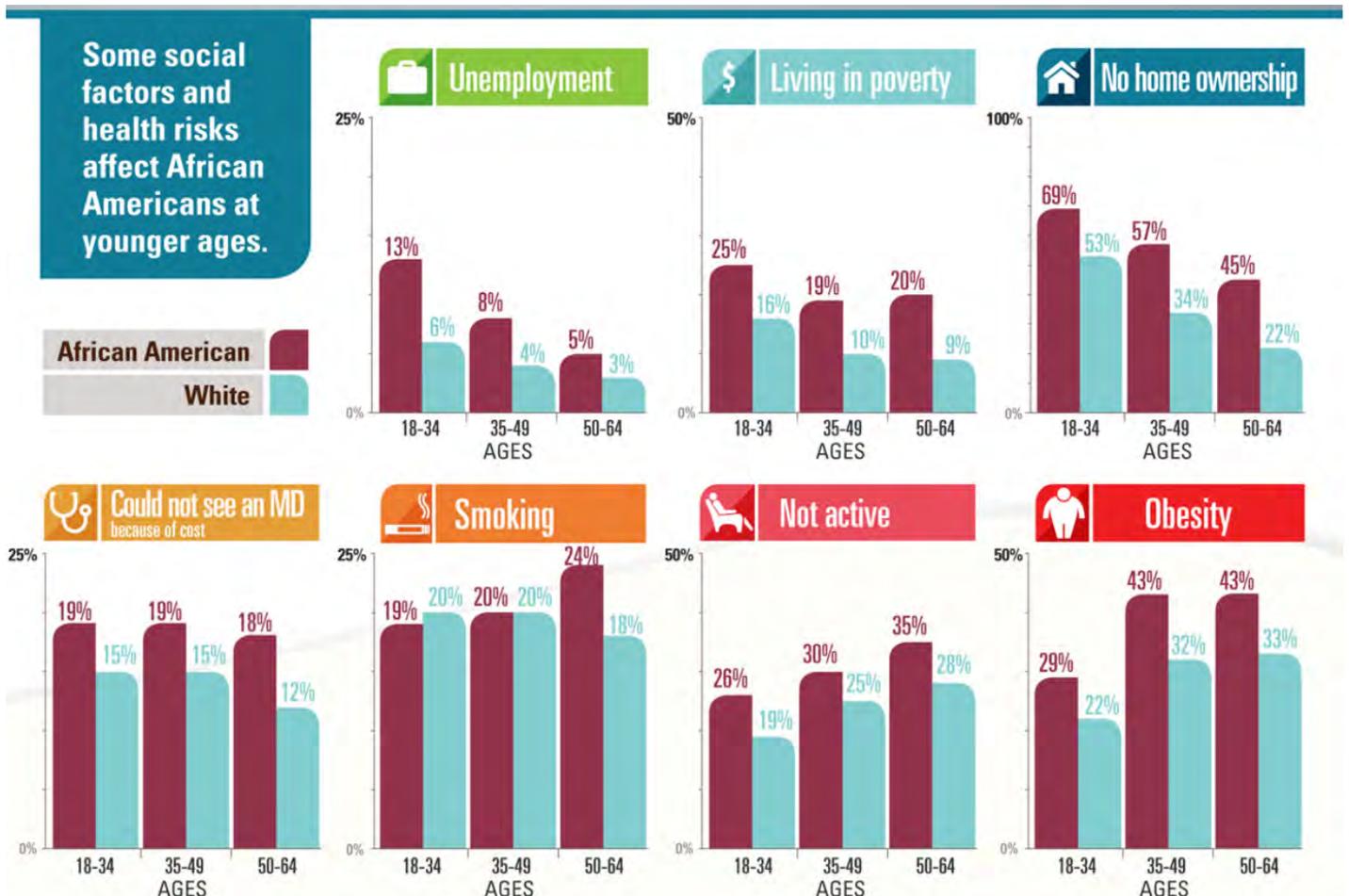
Equity involves trying to understand and give people what they need to enjoy full, healthy lives. **Equality** helps to ensure that everyone gets the same things in order to enjoy full, healthy lives. Like equity, equality promotes fairness and justice but can only work if everyone starts from the same place and needs *the* same things. Equality ignores factors such as language, place of residence, sexual orientation and gender, race, socio-economic status, etc. – that can act as barriers. Understanding the differences between equity and equality is important to be able to recognize and respond to differences in health and well-being that are unfair, avoidable and changeable⁵³.

Despite the many strides that have been made to improve health in the U.S., racial and ethnic disparities are the most unyielding inequities experienced⁵⁴. While progress has been made around extending the length and quality of life for everyone, there is clear evidence that certain racial and ethnic groups—African American, Hispanic/Latinx, American Indian, Asian and Pacific Islander—suffer a disproportionate burden of premature illness and preventable death compared to Whites⁵⁵. Below are social and health disparities that affect African Americans in the U.S. compared to non-Hispanic Whites⁵⁶.

Among Focus Group responders:

- Hispanic/Latinx participants stated that they notice hate from workers when they go to certain offices and agencies.
- Hispanic/Latinx participants stated that they feel unsafe in the community due to being left uneasy after certain marches (i.e. KKK march in Hillsborough).
- Hispanic/Latinx participants stated that they have gone to local agencies where no one looks at or addresses them at the check-in windows.

Figure 12: Social Factors and Health Risks



Below is a non-inclusive list of local and state programs and initiatives to help address health and race equity.

[NC Office of Minority Health and Health Disparities](#)

[North Carolina Health Equity Report 2018](#)

[Orange County Health Department](#)

[Orange County Health Equity Report Card](#)

[Organizing Against Racism](#)

[Racial Equity Institute](#)

[The State of Exclusion: Orange County, NC](#)

Environmental Justice

The [Environmental Protection Agency \(EPA\)](#) defines environmental justice as “the fair treatment and meaningful involvement of all people regardless of race, color, national origin, or income with respect to the development, implementation, and enforcement of environmental laws, regulations, and policies.” Because historically underdeveloped communities have lower property values and less political power, they can be targets for unwanted facilities. Placing and permitting potentially polluting facilities ignores race results in environmental justice.

According to the [Orange County State of Exclusion Report](#), the Rogers Eubanks neighborhood Association (RENA), between Carrboro and Chapel Hill, is well known locally for its 40-year struggle against the landfills and a proposed waste transfer station sited in the community by Chapel Hill, Carrboro and Orange County. As one of only a handful of African American neighborhoods in southern Orange County, Rogers Eubanks served as a host to the county’s only solid waste facility from the 1970’s until 2013. The county’s recycling facility and a solid waste “convenience center” remain in the neighborhood, which still lacks sewer service despite promises made when the landfill opened. As a result, the rate of exposure to solid waste facilities for residents of census blocks that are 75% or more non-White is 17%, as opposed to only 3% for the county as a whole.

Compared to other wealthy counties, or to the state, Orange County has a smaller overall rate of exposure to solid waste facilities, but a higher exposure rate for majority non-White census blocks. Unfortunately, issues of environmental racism in Orange County are not limited to the Rogers Eubanks neighborhood.

Fairview, a historically African-American neighborhood in Hillsborough, did not gain access to city water until 1988, after it was annexed into the Town of Hillsborough. In 1999, the “Field of Dreams” baseball field was built

Table 10: Orange County Solid Waste Exposure

	Residents Of Census Blocks That Are 75% Or More Non-White		Entire Population	
	POPULATION	EXPOSURE RATE	POPULATION	EXPOSURE RATE
Orange county residents exposed to a solid waste facilities	6,315	16.72%	133,80	3.20%
Tier 3 county residents exposed to a solid waste facility	732,614	16.72%	4,823,641	6.21%
North Carolina residents exposed to a solid waste facility	1,309,105	9.37%	9,535,483	5.34%
Tier 3 county residents exposed to an EPA monitored pollution source	6,315	46.57%	133,80	28.27%
North Carolina residents exposed to an EPA monitored pollution source	732,614	51.06%	4,823,641	29.77%
North Carolina residents exposed to an EPA monitored pollution source	1,309,105	41.82%	9,535,483	24.25%

atop of the Hillsborough Landfill site that closed in 1975. This baseball field served as a place for neighborhood children to gather and play. Shortly after the Field of Dreams was built, contamination problems were discovered. The community continued using the field until debris from the old landfill began to surface. Eventually, it became too hazardous for use and closed.

In 2001, Orange County voters approved a Parks and Open Space Bond that secured \$850,000 for the development of a park in Fairview. These funds were not invested until 2008, and by then, were not enough to cover the cost of the originally planned improvements; however, additional funding was added in 2009. By 2011, Fairview Park was completed and features a 0.25 mile paved walking trail, basketball courts, picnic shelter, playground, tennis courts, and of course, a baseball field⁵⁷.

Criminal Justice

Criminal justice is the act of delivering justice to those who have committed crimes. The criminal justice system is made up of government agencies and institutions, law enforcement, lawyers, courts and prisons that offer rehabilitation to offenders and provides moral support to victims.

The inequities around the cash bail system are something Orange County officials have long understood. The county is one of dozens across the state that support pretrial services — a jail alternative system that identifies poor people who are low risks for violence and likely to show up for their court dates and allows them to be released on very low or no bail. Below are local Detention Center numbers over the past two years.

The mission of the Criminal Justice Resource Department (CJRD) is to support and increase jail alternatives,

opportunities for diversion from the criminal justice system, and provide treatment needs assessment and programming for justice-involved individuals. CJRD’s primary objective is to reduce the number of individuals diagnosed with mental illness and substance use issues, safely and successfully reduce the overall rates of justice involvement and pretrial incarceration, reduce repetition, and address racial and economic disparities. CJRD seeks to ensure a productive collaboration between county and court system stakeholders that promotes sharing of information and implementation of evidence-based and equitable best practices and programs.

Some quick 2019-2020 facts:

- Approximately 800 individuals will be screened by Pretrial Services and 375 individuals will be released to Pretrial Services for supervision.
- The Criminal Case Assessment Specialist will assist 140 justice-involved and/or incarcerated adults to help them receive direct CJRD mental health or substance use services.
- The Youth Mental Liaison will assist over 40 justice-involved youth and their families to help them receive CJRD mental health and/or substance use services.
- Close to 100 individuals will be diverted from arrest or charge to the Misdemeanor Diversion Program or Orange County Pre-Arrest Diversion.
- An estimated 50 individuals will be served by Recovery Court and Family Treatment Court.
- 56 individuals will be enrolled in and will receive reentry case management and support.

Table 11: Orange County Detention Center Bookings

Cost per day to house an individual at the Detention Center	\$110
2019 Total Pretrial Detention Center Bookings	1,918
2018 Total Pretrial Detention Center Bookings	2,031
2019 Average Daily Population at Detention Center	124 (72 Pretrial; 42 Federal; 10 State serving)
2018 Average Daily Population at Detention Center	125 (77 Pretrial; 35 Fed; 13 State serving)
2019 Average length of stay for Pretrial inmates (felonies and misdemeanors)	14 days

- Since its October 2019 inception, the Restoration Legal Counsel Program handles approximately 35 intakes per month which has resulted in approximately 40% of individuals proving to be eligible for relief from traffic debt.
- 19 individuals in the Jail have received suboxone since the Medication-Assisted Treatment pilot began.

Each year, approximately 2 million people, with serious mental illnesses, are admitted to jails across the U.S., where approximately 15% are men and 30% are women. Almost three-quarters of these adults also have drug and alcohol use problems. In counties across the nation, jails house more people with mental illnesses than psychiatric hospitals. Once incarcerated, individuals with mental illnesses tend to stay longer in jail and upon release, are at a higher risk of returning to incarceration than those without a mental illness.

In 2015, the Orange County Board of County Commissioners adopted the Stepping Up Initiative, a national initiative whose goal is to achieve a measurable reduction in the number of people in jails who have mental illnesses. The CJRD has two clinical positions dedicated to providing support to individuals in the Orange County Detention Center who have mental health and substance use diagnoses through:

- Assessment
- Crisis support and counseling
- Referrals to treatment
- Court advocacy
- Linkage to other community supports
- Follow up and support during the transition back to the community
- Psychiatric referral

Although jail-based mental health and substance use services are helpful to those in need, the Detention Center is not designed to serve as a treatment facility. In April of 2019, Orange County stakeholders participated in a 2-day Sequential Intercept Mapping Workshop to help advance community-based solutions for justice-involved people with mental health and substance use disorders.

The top five priority gaps identified in Orange County were:

1. Crisis Diversion Center and Day Center
2. Increased Access to Case Management
3. Affordable and Accessible Housing
4. Data Collection
5. Addressing Social Determinants of Health

Formally Incarcerated Transition (FIT) Program

The FIT Program is designed to connect formerly incarcerated people with chronic illness to health care services. Community Health Workers from the FIT program work closely with Piedmont Medical Health Center, OCHD, UNC Family Medicine, and NC Department of Public Safety to connect participants to appropriate and necessary health services, as well as community reentry resources to help them develop a comprehensive reentry plan.

Over 20,000 people are released annually from NC prisons without a link to primary health care services so the FIT Program is in place to assist people who suffer from chronic diseases during their reentry process (while still incarcerated), after release, and up to two years later. FIT participants receive assistance with issues that include, but are not limited to, diabetes, hypertension, congestive heart failure, COPD or emphysema, kidney failure, liver disease, mental illness, and substance use disorders.

Below is a non-inclusive list of local and state programs and initiatives to help address environmental and criminal justice.

[Carrboro Police Department](#)

[Chapel Hill Police Department](#)

[Criminal Justice Resource Department](#)

[FIT Program of Orange County](#)

[Hillsborough Police Department](#)

[Orange County Sheriff Department](#)

[RENA Community Center](#)

Social Determinants of Health

Many factors can create or limit opportunities for good health. Some communities are rich in resources while others lack the social, economic and environmental investments that are needed to support good health. One's socioeconomic status including education, employment, income and housing are all factors that influence health.

Employment and Income

Orange County's unemployment rate (5.2%), among individuals 16 and over, is lower than NC (7.2%), Brunswick County (7.8%) and New Hanover County (7.0%)⁵⁸. When we look at race, in NC, the highest unemployment rates are experienced by African Americans, American Indians and Hispanic/Latinx populations⁵⁹.

According to income inequality measures, wealth in Orange County is not evenly distributed across resident populations. Orange County has an income inequality Gini coefficient of 0.51 and is the second highest in NC. This coefficient is also higher among Buncombe County (0.429), Brunswick County (0.478), and New Hanover County (0.475), Orange County's peer counties. The Gini coefficient ranges between zero and one, where zero represents perfect wealth equality and everyone has the same level or share of wealth and one represents total inequality and only one person has all the wealth and everyone else has nothing⁶⁰.

The county's median household income (\$65,522) is above both NC (\$50,320) and the U.S. (\$57,652), but hides various pockets of poverty. The chart below shows household income among survey respondents compared to Orange County residents, with the highest percentage of individuals making \$100,000 - \$249,999.

Among Focus Group participants:

- Homeless participants shared that sufficient income

is one thing that they will need in order to survive if they left the shelter tomorrow.

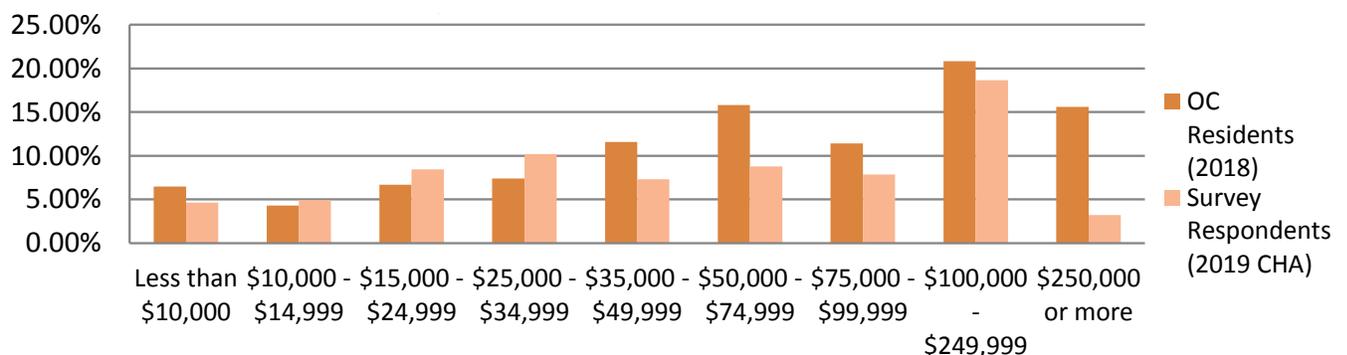
- Karen speaking participants shared that “money/income is an issue that keeps us from having the best quality of life. We don't make enough money to support our families because when income is calculated, they only take into account the rent. Nothing else is factored”.
- Karen speaking participants shared that “there is not enough money to support health issues due to all the co-pays. My husband works but I don't”.
- Karen speaking participants shared that “no one can support a family by working in housekeeping or in the cafeteria”.
- Karen speaking participants shared that “money is enough but not enough to obtain food stamps and Medicaid because they say our spouse makes too much. So it looks like we have too much money when we don't because we are living pay-check-to-paycheck, day-by-day, with 5-6 kids”.

Poverty

The U.S. measures poverty by the federal poverty level (FPL). The FPL uses food costs to estimate basic income levels for families. Research suggests that most families need an approximate income of twice the FPL to meet their basic needs. Children living in families with incomes below the FPL are referred to as low income. In 2018, twice the FPL was \$50,200 for a family of four with two children. More than 1 million children in NC live in poor or low-income households⁶¹.

14% of Orange County residents live in poverty. Poverty is experienced the highest among individuals 18 to 64 years of age (17.3%), followed by those 18 and younger (9.3%) and then those 65 years and older (5.3%). The most common racial or ethnic group living below the

Figure 13: Household Income



poverty line in Orange County is White, followed by African American and Hispanic/Latinx⁶².

Poverty guidelines are identified based on family size and income to determine financial eligibility for federal programs. Programs using the guidelines (or percentage multiples of the guidelines — for instance, 125% or 185% of the guidelines) in determining eligibility include [Head Start](#), SNAP, the [National School Lunch Program](#), the [Low-Income Home Energy Assistance Program](#), and the [Children’s Health Insurance Program](#)⁶³.

Among survey responders:

- 8.16% of participants shared that they do not have enough financial resources to meet basic needs, including food, shelter, clothing, utilities, etc.

Childhood Poverty

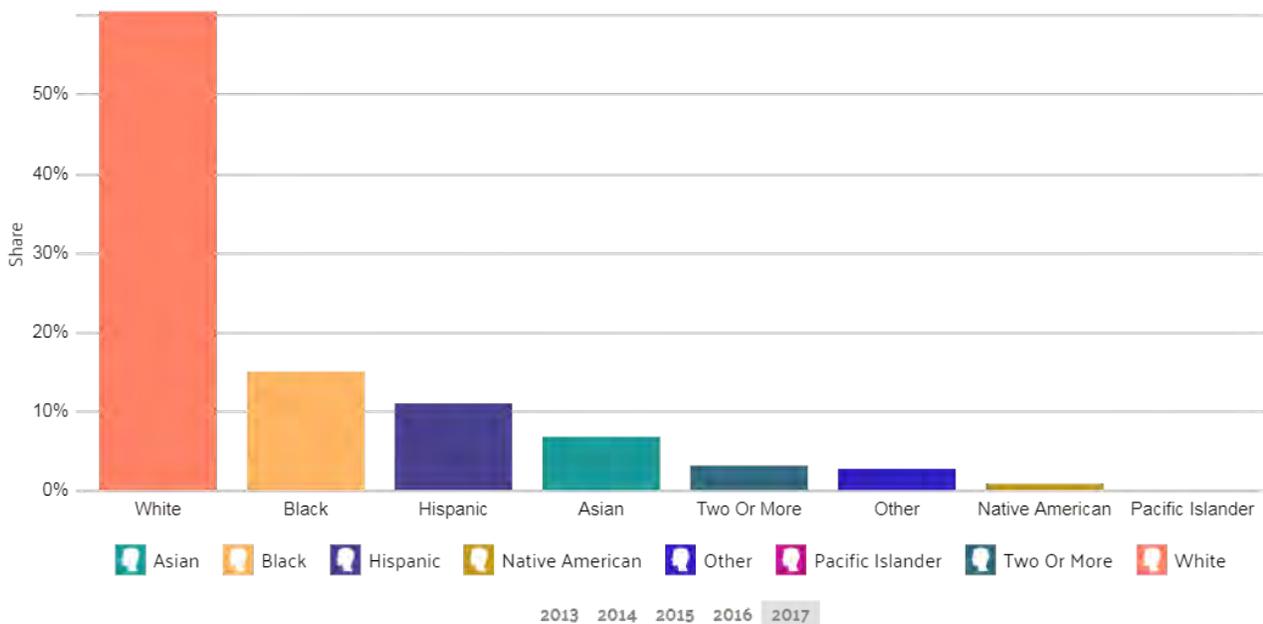
Young children are more likely than older children to live below the poverty line. In 2016, in NC, approximately one in four children ages 0-5 lived in poverty, compared to one in five older children, with American Indian, African American, and Hispanic/Latinx children being more likely to live in low-income families. Despite making up only 41% of the child population, African American and Hispanic/Latinx children account for 63% of NC’s children in poverty. Among all 100 counties in 2014, the 20 highest poverty rates in the state were all in rural counties⁴⁹.

The Family Success Alliance (FSA) is a collective impact initiative with the explicit goal to close the achievement

gap and end generational poverty in Orange County. FSA was designed to reduce the effects of poverty on development and academic achievement by fulfilling practices that are responsive to the priorities and needs of children and their families, and by affecting larger systems and policy change. FSA works to address the needs of the community through individual-level and system-level strategies that are implemented via various FSA programs and partnerships. FSA’s programs are: the Navigator Program – a peer support program for low-income, at-risk families; the Connections Program – support that allows FSA to maintain contact with families formerly assigned to a navigator and provides services to families on the Family Navigator waitlist to ensure that needs are addressed pending a navigator assignment; the Community Council – a collaborative partnership between local community leaders and FSA family navigators to create positive change on individual, institutional, and systemic levels; and the Partner Network – a collaboration with cross-sector agencies to center parent expertise and priorities to problem solve and work towards positive and sustaining outcomes for families.

For several years, FSA has sponsored a four-week Kindergarten Readiness camp in the two zones of Orange County where FSA was being piloted, to include four elementary schools. To date, 378 rising kindergarteners have participated in the program. The Kindergarten Readiness camps have shown to have a great impact on children in attendance over the years. To measure the success of the program, UNC conducted evaluations that suggested that children who engaged in the program gained increased attentional, basic reading,

Figure 14: Poverty by Race/Ethnicity



literacy, and classroom behavior skills. Of the children who entered the program, those who entered at lower skill levels made the largest gains. When compared to a comparison group during the school year, FSA children were healthier according to their teachers, and had higher levels of attention, math, and social skills. Of equal importance was that the gains made during the summer program were not lost during the school year. After multiple years of FSA sub-granting funds to the CHCCS system for summer programming, CHCCS will now provide funding to serve an additional 80 children at seven elementary schools.

Education

Education is defined as the act or process of informing or obtaining knowledge; developing the powers of reasoning and judgment; and intellectually preparing oneself (or others) for life. In NC, 87% of adults have a high school diploma or GED. 84.7% of African Americans, 75.7% of American Indians and 59.5% Hispanic/Latinx have lower proportions of adults with a high school diploma or GED than Whites⁶⁴⁵.

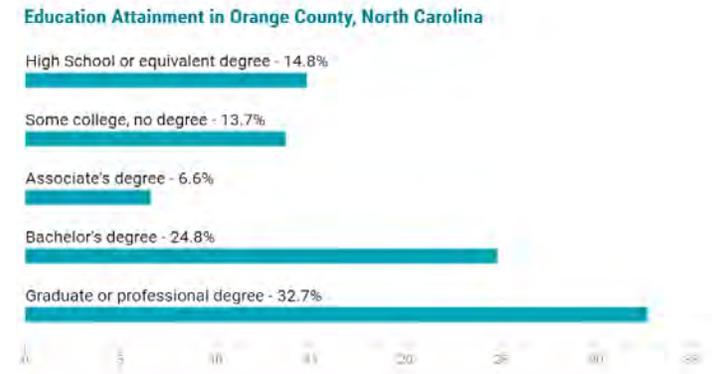
Among Orange County residents, 7.28% of individuals, aged 25 and older, do not have a high school diploma (or equivalent)⁶¹⁵.

Among survey responders:

- 7% of resp stated that they have a 9th - 12th grade education with no diploma.

Orange County is divided into two school districts, the Chapel Hill-Carrboro City School District, that serves the southeastern corner of the county, and the Orange County School District, that serves the remainder. Both CHCCS and OCS receive significant local financial support for education. Orange County has the highest local per-pupil education expenditure of any county in NC,

Figure 15: Education Attainment in Orange County



spending nearly three-times as much money per student than the average county in the state.

Beyond the county appropriation, a special tax district brings CHCCS an additional 20.84 cents per \$100 of assessed property value. During the 2015-2016 fiscal year, the special tax district brought CHCCS more than \$22 million, bumping CHCCS's local per-pupil funding up to \$5,503, while OCS' local per-pupil funding is \$3,697. Further comparison of the two school districts reflects the high concentration of wealth that exists in the towns of Chapel Hill and Carrboro. CHCCS has a larger student population, fewer students who are eligible for free or reduced lunch, and better overall performance on standardized tests than OCS. With a student population of over 12,000, CHCCS serves a higher percentage of non-White students because of its high Asian student population. However, OCS has a total student population of 7,630 and has higher percentages of both African American and Hispanic/Latinx students.

Student test performance levels vary among the two school districts. Data shows that 32% of students in

Table 12: Racial Demographics in Orange County School Districts (2020)

SCHOOL	Student Population	% Of White Non-Hispanic Students	% Of African American Students	% Of Latinx Students	% Of Asian Students
Chapel Hill Carrboro City District	12,115	52%	11%	16%	15%
Orange County District	7,630	54%	14%	25%	1%
Orange Charter	304	84%	4%	6%	1%
The Expedition School	336	84%	1%	5%	1%

Figure 16: Math Performance Rates

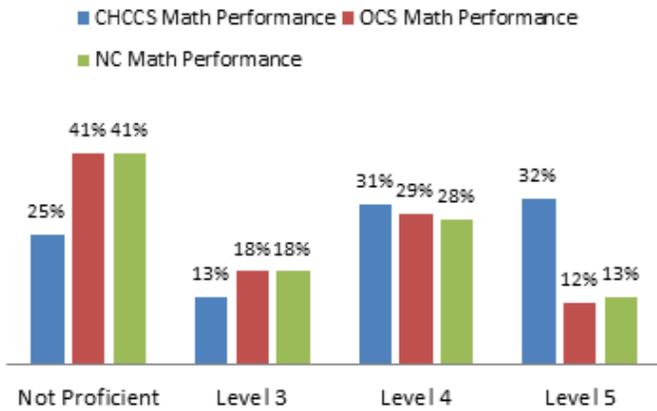
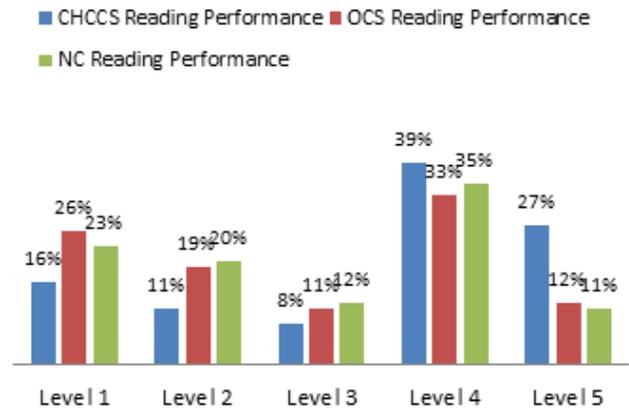


Figure 17: Reading Performance Rates



CHCCS scored a level five in math, compared to 12% of students in OCS. When we look at students who scored ‘not proficient’ in math, 41% of students are from OCS compared to 25% of students in CHCCS. 27% of students in CHCCS scored a level five in reading compared to 12% of OCS students. Test performance is reported as one of five achievement levels. Levels one and two are below grade level, level three is grade level proficient, and levels four and five indicate students are on track for career and college readiness⁶⁶.

Housing

Orange County has a positive reputation in NC as it is considered one of the healthiest counties in the state. Despite this accolade, Orange County has the second highest measure of income inequality in NC. Communities of color throughout the county are burdened with inequities, including substandard housing, less income, and lack of access to healthcare. Families with children are also more likely to bear the burden of higher costs, especially in regards to housing.

Approximately 48% of Orange County families who rent their home are cost burdened, paying over 30% of their income on housing expenses. In order for a family to be able to afford to live in Orange County, they would need to have an annual income of \$37,980, or \$18.25 per hour, to cover rental costs for a two-bedroom apartment. [2020 Fair Market Rent in Orange County](#) averages around \$1,055. Additionally, renters who have a full-time job that pays the mean renter wage would still only be able to afford \$711, or less, per month in rent. Due to the lack of affordable housing and rising housing costs, many families are forced to relocate and tend to move to neighboring counties, including Alamance, Durham, Chatham and Person.

If Orange County continues to grow without adding sufficient affordable housing, lower wealth residents, predominantly African Americans, will be pushed out. Orange County’s high property tax rates, water and sewer bills, and housing costs all likely contribute to the push out of lower wealth residents⁶⁷.

Among survey responders:

- 15% indicated that they would have to move within the next year, from Orange County, due to housing costs.

Among Focus Group participants:

- Karen and Burmese speaking participants shared that there is a lack of interpreters present at public housing complexes.
- Karen and Burmese speaking participants shared the intense need for more affordable housing, including Habitat homes.
- Formerly incarcerated and homeless individuals described their constant engagement with local government and feel that there isn’t enough being done to address the affordable housing crisis in Orange County.

The Orange County Housing and Community Development Department’s primary mission is to promote adequate and affordable housing, economic opportunity and a suitable living environment free from discrimination. The department’s strategic goals include:

- Expand the supply of assisted housing
- Improve the quality of assisted housing
- Increase assisted housing choices

Homelessness

On any given night in Orange County, between 130 and 150 people experience homelessness. Among those individuals, 30-40 are living unsheltered and the rest are in shelters and transitional housing. 68% of the individuals are male, 86% are adults age 25 or older, and 90% of the sheltered households are adults only.

In 2019, Orange County community members counted 131 people experiencing homelessness, 29 of whom were unsheltered⁶⁸. Homelessness in Orange County has remained virtually flat since 2010, with a 15% decline in the U.S. and 24% decline statewide.

The Orange County Partnership to End Homelessness (OCPEH) works with service providers to secure federal funding for homeless programs and incorporate best practices and data-driven decision making into the work to end homelessness. In 2019, service providers came together to house 78 extremely vulnerable households. Clients gave their consent to be part of a case conferencing list, either with their name or anonymously, and service providers worked together to provide households with permanent housing quickly and effectively.

Through this process, and by concentrating funding efforts, Orange County has seen a 37% decrease in people experiencing chronic homelessness.

The OCPEH is aligned with federal goals working to make homelessness rare, brief, and one time. Currently people are experiencing homelessness an average of 340 days, an increase from 272 days reported in 2018. The HMIS (homeless management information system) database recorded 298 de-duplicated people served in the homeless service system over 12 months, 197 of whom were experiencing homelessness for the first time. 33% (73 people) are exiting to permanent housing and 18% of people who are exiting to permanent housing return to homelessness.

As a result of both historical and current housing discrimination practices, as well systemic racism, Orange County has similar racial disparities in the number of people experiencing homelessness compared to NC and the U.S. 12% of Orange County's overall population is African-American, however, 51% of African Americans experience homelessness.

Figure 18: Individuals Experiencing Homelessness in Orange County

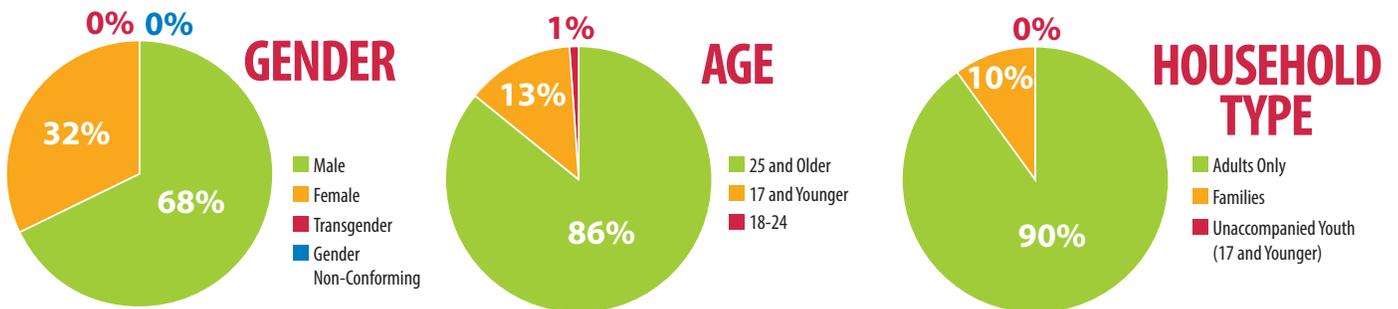


Figure 19: Special Populations Experiencing Homelessness

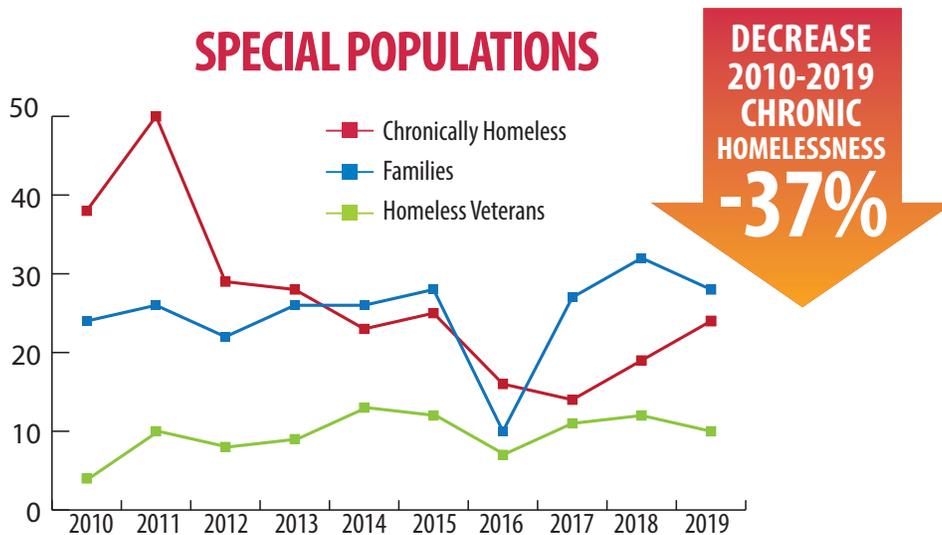
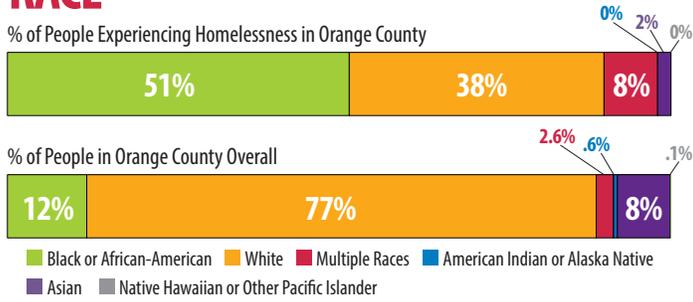


Figure 20: People Experiencing Homeless by Race

RACE



Starting in 2017, the OCPEH issued a gap analysis for the homeless service system. The most recent update to this came in June 2019 where ten gaps were recognized. As of February 2020, \$512,613 has been secured for gap funding with \$1.4 million remaining. Six of the ten gaps have funding estimates identified and four are still under discussion. It is thought that by filling these gaps, homelessness can be eliminated in Orange County⁶⁹.

Below is a non-inclusive list of local and state programs and initiatives to help address social determinant of health.

[Chapel Hill Carrboro City Schools](#)

[Chapel Hill Carrboro NCAACP](#)

[Family Success Alliance](#)

[Housing for New Hope](#)

[Orange County Habitat for Humanity](#)

[Orange County Housing and Community Development](#)

[Orange County Partnership to End Homelessness](#)

[Orange County Schools](#)

Death and Disease

Life expectancy is a measure for the total health of a population. Chronic diseases and injuries are responsible for approximately two-thirds of all deaths in NC, or about 50,000 deaths each year. When we look at life expectancy in Orange County, we see that the overall average life expectancy is 82 years old. Male life expectancy (80 years) is slightly lower than the county's average, female life expectancy (84 years) is slightly higher, White individuals life expectancy (83 years) is almost equal, and African Americans life expectancy (75 years) is significantly lower⁷⁰. The disparities for African Americans, compared to Whites, are highly associated with limited health care access, lack of trust in medical providers, social racism, unemployment, and firearm deaths among young African American men⁷¹. Cancer, heart disease, stroke, chronic lower respiratory diseases, and unintentional injuries make up the top five causes of death in in Orange County⁷².

Leading Causes of Death

The top leading causes of death vary by age group and the top three leading causes of death by age are shown on page 32⁷³.

Cancer

Cancer is the number one disease killer among Orange County residents, with trachea, bronchus and lung cancer being the most common cancers experienced. From 2014-2018, Orange County lost 247 lives to trachea, bronchus and/or lung cancer, followed by prostate

cancer (55 lives lost), and breast cancer (59 lives lost). Majority of cancers are related to personal lifestyle or environmental factors, such as smoking and diet and are therefore preventable. Prevention and early detection has successfully helped with the control of the disease and ultimately deaths. Less preventable factors include age, gender, and family history. For some cancers, prevention is more valuable than early detection. For example, lung cancer takes many years to develop and often spreads to other parts of the body before it is detected; because of this, lung cancer is better prevented⁷⁴.

Among survey responders:

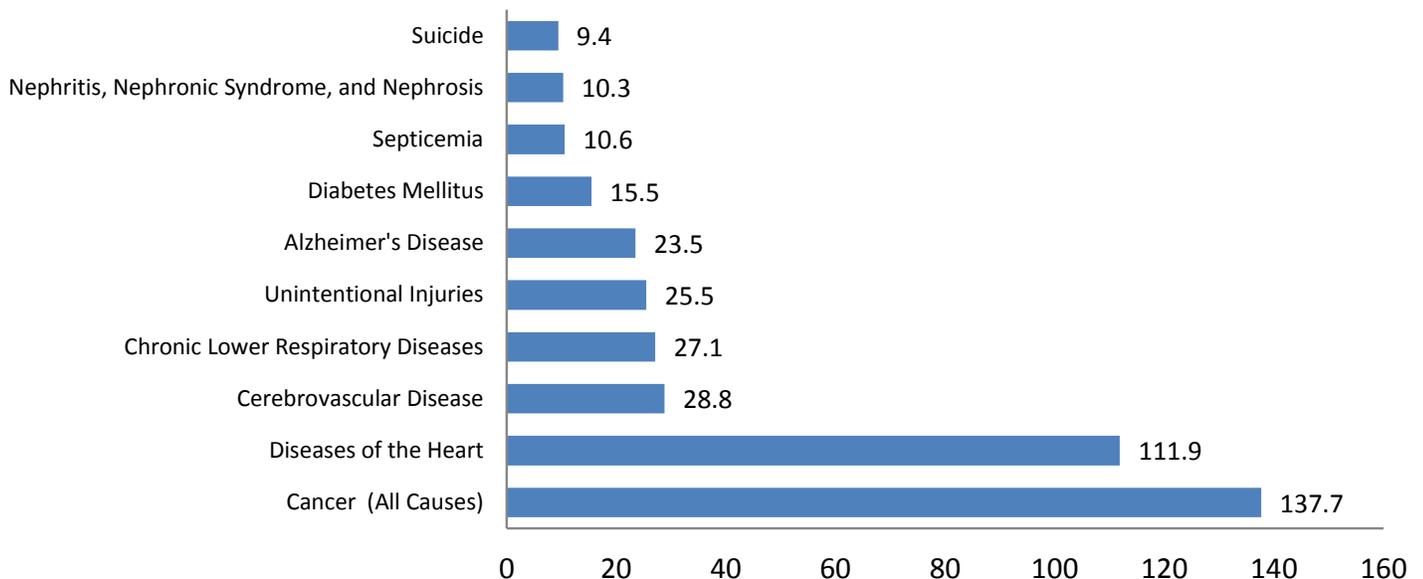
6% have been told by a doctor, nurse or health professional that they have cancer.

40% of female responders have had a mammogram.

13% of male responders have been screened for prostate cancer.

In the U.S., African Americans experience a higher burden of cancer having the highest death rate, and the lowest survival rate than any racial or ethnic group. This is often due to the lower socioeconomic status and less access to medical care. Among cancers, prostate cancer is the most commonly diagnosed cancer among African American men and breast cancer is the most commonly diagnosed among African American women⁷⁵.

Figure 21: Orange County Leading Causes of Death, 2014-2018, Age-Adjusted Mortality Rates per 100,000



Heart Disease

Coronary heart disease is the most common cause of a heart attack, and is caused by the narrowing of blood vessels used to supply blood to the heart. High blood pressure, high cholesterol, and smoking are the main risk factors for heart disease. Close to one-third of heart disease deaths are caused by smoking and secondhand smoke exposure. Other risk factors include family history, physical inactivity, obesity, diabetes, poor diet, and excessive alcohol use⁷⁶.

Among survey responders:

6.6% have been told by a doctor, nurse or health professional that they have heart disease.

Cerebrovascular Disease

Cerebrovascular disease consists of all disorders in which an area of the brain is temporarily or permanently

affected by bleeding or the lack of blood (ischemia) to the brain. Cerebrovascular disease includes stroke, carotid stenosis, vertebral and intracranial stenosis, aneurysms, and vascular malformations⁷⁷.

Chronic Disease

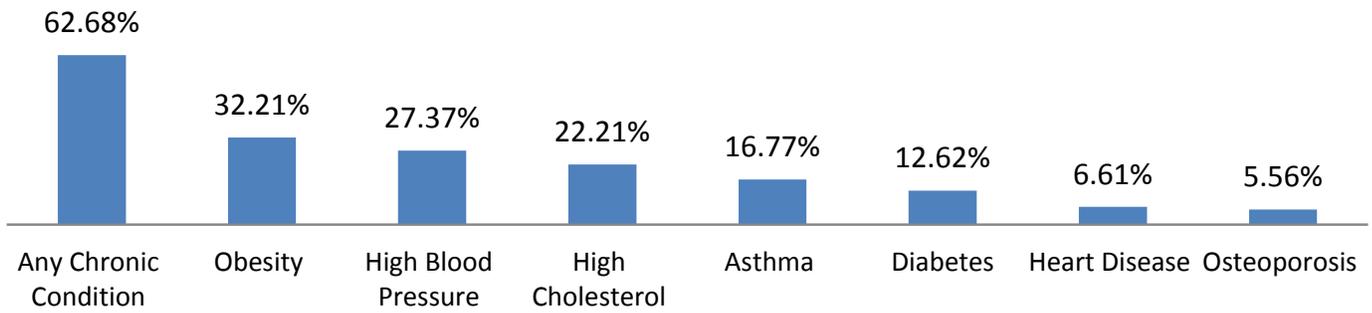
Chronic diseases are defined as conditions that last one year or more and require ongoing medical attention, limits activities of daily living, or both. Chronic diseases and injuries are responsible for approximately two-thirds of all deaths or about 50,000 deaths in NC each year. Many deaths in the state are preventable and involve risky behaviors or lifestyles such as tobacco use, unhealthy diet, physical inactivity, alcohol and drug use, and motor vehicle crashes⁷⁸.

Among survey responders, below are the percent of residents who have been told by a healthcare professional that they have a chronic disease.

Table 13: Leading Causes of Death by Age

AGE GROUP	Rank	Cause of Death	# of Deaths	Death Rate
All Ages	1	All Cancers	972	136.0
	2	Heart Disease	752	105.2
	3	Cerebrovascular	187	26.2
0-19	1	Perinatal	11	6.0
	1	Birth Defects	11	6.0
	3	Homicide	7	3.8
20-39	1	Unintentional Injuries	33	15.1
	2	Suicide	19	8.7
	3	Motor Vehicle Injuries	16	7.3
40-64	1	All Cancers	267	120.0
	2	Heart Disease	136	61.1
	3	Unintentional Injuries	56	25.2
65-84	1	All Cancers	512	624.3
	2	Heart Disease	304	370.7
	3	Chronic Lower Respiratory Diseases	100	121.9
85+	1	Heart Disease	299	3071.7
	2	All Cancers	178	1828.6
	3	Alzheimer's Disease	93	955.4

Figure 22: I have been told that I have...



Communicable Disease

Communicable diseases spread from one person to another or from an animal to a person. The spread often happens via airborne viruses or bacteria, through blood, or other bodily fluids. The terms infectious and contagious are often used interchangeably to describe communicable diseases⁷⁹.

COVID-19 (Coronavirus)

Coronaviruses are a large family of viruses that can cause illness in animals and humans. COVID-19 is a disease that was identified in late 2019 and was declared a pandemic in March 2020. COVID-19 is the name given to the specific coronavirus that originated in Wuhan, China. The most common symptoms of COVID-19 are similar to the flu and include fever, cough and shortness of breath and can take two to 14 days to appear from the time of exposure. Older adults and people with severe chronic conditions are at a higher risk for a more serious COVID-19 illness, if affected⁸⁰.

Influenza (flu)

The flu (influenza) is a contagious respiratory illness caused by flu viruses and can spread from person to person through droplets such as coughing, talking and sneezing. Adults age 65+ are at a greater risk of flu than the rest of the population, as are those with chronic lung disease, heart disease, and compromised immune systems. Healthcare workers and residents of nursing homes and long-term care facilities are also at a greater risk. Symptoms of the flu include fever, cough, runny/stuffy nose, headache and fatigue (tiredness). Seasonal flu vaccines change annually as the virus naturally changes over time. Flu season typically occurs during the winter and fall months, with a peak between December and February.

There were 203 flu deaths reported in NC during the 2018-2019 flu season, with 128 deaths occurring among people 65 years of age and older⁸².

Figure 23: Confirmed Flu Associated Deaths by Age in NC

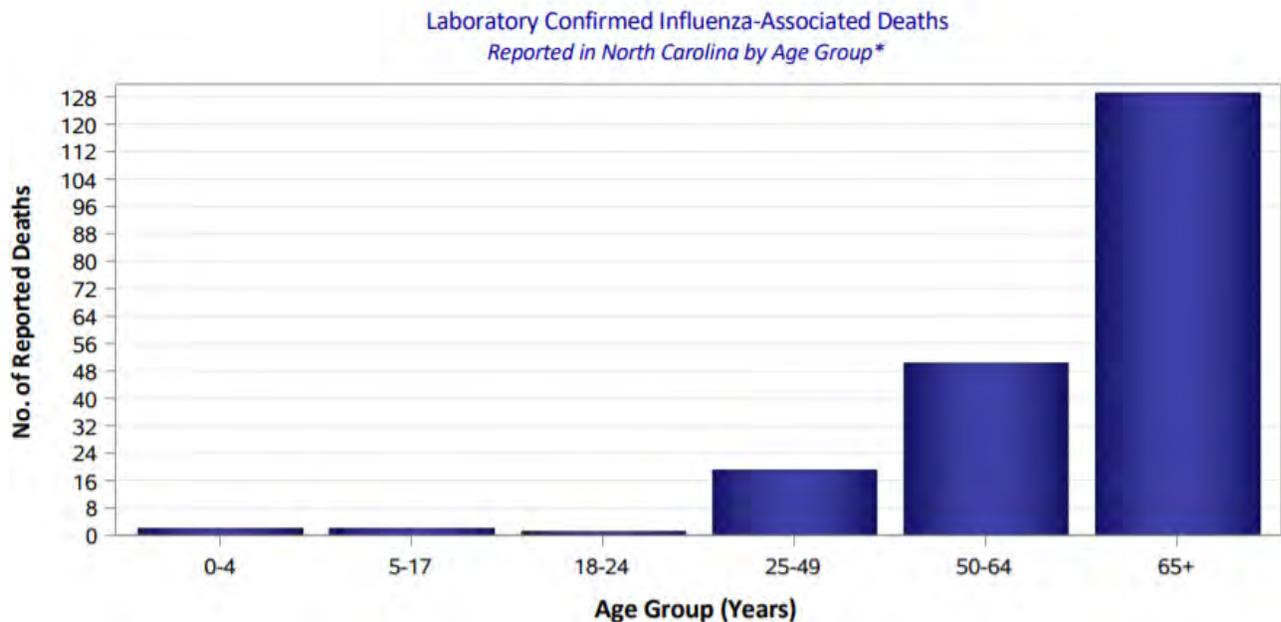


Table 14: Reported Communicable Diseases and Conditions in Orange County (by Year)⁸¹

DISEASE/CONDITION	2016	2017	2018
Campylobacter Infection	19	29	32
CJD	0	0	1
Cyclosporiasis	0	0	0
Dengue	1	0	1
E.coli (Shiga-toxin producing)	5	9	1
Ehrlichiosos (granulocytic)	4	2	1
Ehrlichiosos (monocytic)	5	5	14
Foodborne Other/unknown	0	0	0
Haemophilus influenza, invasive	5	4	2
Hepatitis A	0	0	2
Hepatitis B (Acute)	0	2	1
Hepatitis C (Acute)	0	3	1
Influenza Death (< 18 yo)	1	4	1
Leptosporiasis	0	0	0
Lyme	3	6	5
Malaria	1	0	0
Measles	0	0	0
Meningococcal Disease	0	0	0
Meningitis (Pneumococcal)	0	0	0
Mumps	0	4	0
Pertussis	14	10	25
RMSF (Rocky Mountain Spotted Fever)	12	8	14
Rabies (Animal)	7	9	7
Salmonellosis	46	31	33
Shigellosis	5	5	5
Tuberculosis	0	1	2
Vibrio	1	1	0

Pneumonia

Pneumonia is an infection of the lungs causing inflammation of the air sacs. Pneumonia can be caused by influenza and respiratory syncytial virus. People that are at risk for pneumonia include elderly, young children, smokers, and those with pre-existing health conditions.

In 2017, influenza and pneumonia ranked 11th in leading causes of death in NC, with a total of 2,076 deaths compared to 1,886 deaths the previous year.

Vaccine Preventable Diseases

Vaccine preventable diseases are diseases that can typically be prevented by obtaining required or recommended vaccinations prior to exposure to the illness. Vaccinations are widely recognized as one of the most important public health strategies ever created. New immigrants are at greater risks of vaccine preventable diseases, specifically if they have not received vaccinations in their home countries. The use of vaccines has led to major improvements in child health. Many of the infectious illnesses that were previously experienced by older generations, from chickenpox to polio to measles, no longer affect most children today. Following the recommended immunization guidelines, by the American Academy of Pediatrics, can help make children healthier. Vaccine preventable diseases include^{B3}:

- Diphtheria
- Haemophilus Influenza Type B (Hib)
- Hepatitis A
- Hepatitis B
- Human Papillomavirus (HPV)
- Influenza
- Measles, Mumps, Rubella (MMR)

- Meningococcal Infections
- Pertussis (whooping cough)
- Polio
- Rotavirus
- Tetanus
- Varicella (chicken pox)

Sexually Transmitted Infections (STI)

Sexually Transmitted Infections are diseases that are spread from one person to another, typically during vaginal, anal, and oral sex. STI's are common and the majority of people who have them don't experience symptoms. Without treatment, STIs can lead to serious health problems, however, the good news is that getting tested is effortless and most STIs are treatable. The table below shows the number of reported cases of STIs for Orange County and NC from 2016 - 2018.

While anyone can become infected with an STI,

- Young people and gay and bisexual men are at greatest risk.
- Individuals 15-24 years of age account for 50% of all new STIs, although they represent just 25% of the sexually experienced population.
- Young women face the most serious long-term health consequences of STIs. It is estimated that undiagnosed STIs cause 24,000 women to become infertile each year.
- Compared to older adults, sexually active adolescents 15-19 years of age, and young adults 20-24 years of age are at higher risk for acquiring STIs for a combination of behavioral, biological, and cultural reasons.

Table 15: Sexually Transmitted Reported Cases in Orange County and NC

STI REPORTED CASES	OC (2016)	NC (2016)	OC (2017)	NC (2017)	OC (2018)	NC (2018)
AIDS	4	593	2	582	3	509
Chlamydia	692	58,078	779	62,988	690	66,763
Gonorrhea	175	19,599	229	22,736	189	23,593
HIV	11	1,365	5	1,287	10	1,204
Syphilis (late syphilis)	7	758	15	1,009	14	1,201

There are multiple barriers that prevent individuals, specifically adolescents, from accessing quality STI prevention services. Those barriers include the inability to pay or lack of insurance, lack of transportation, discomfort with facilities and services, and concerns with confidentiality⁸⁴.

Injury and Violence

Unintentional injuries and injuries caused by acts of violence are the leading cause of death for Americans under age 44, and are the leading cause of disability for all ages, regardless of sex, race/ethnicity or socio-economic status. Many unintentional injuries are often referred to as accidents, acts of fate, or as a part of life; however, most occurrences that result in injury, disability or death are preventable⁸⁵.

In 2017, 2,300 NC residents died as a result of violence, with the leading cause of violent death being suicide (65.4%) and homicide (29.8%). Of those 2,300 deaths, the leading methods were firearm (61%), hanging, strangulation or suffocation (17.1%), and poisoning (11.4%). Violent deaths were highest among males and non-Hispanic American Indians⁸⁶.

- Orange County averages 210 violent crimes a year.
- In 2017 there were 273 injury deaths in Orange County.
- In 2018, Orange County had a violent crime rate of 172.8, compared to the NC rate of 374.9 and the U.S. rate of 386.3
- In 2018, Orange County had rape rate of 21.2, compared to the NC rate of 21.1, and the U.S. rate of 36.7.

Figure 24: Injury and Violence Rate by Gender and Race

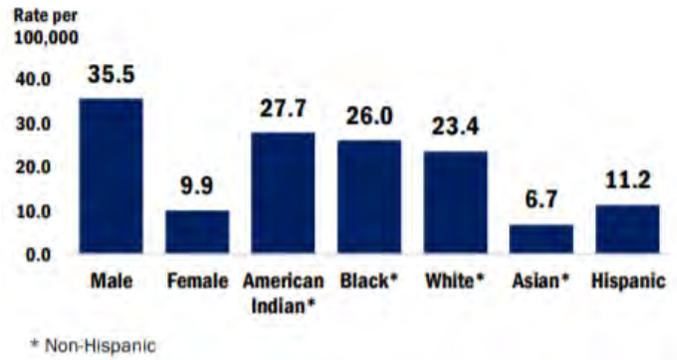


Table 16: 2017 Reported Crime Rates in Orange County and NC⁸⁷

2017 REPORTED CRIME	Murder Rate	Robbery Rate	Assault Rate	Burglary Rate
Orange County	2.8	57.9	103.2	485.2
North Carolina	6.5	95.8	260.8	673.5

Maternal and Infant Health

Maternal Health

The health of women and children is vital to creating a healthy world. Despite great progress, approximately 800 women die every day from preventable pregnancy and childbirth related causes⁸⁸.

There are a number of factors, including preconception health status, age, access to appropriate preconception and prenatal health care, and poverty that can affect pregnancy and childbirth. Infant and child health outcomes are similarly influenced by factors such as education, family income, breastfeeding, and physical and mental health of parents and caregivers.

Maternal health factors are a leading contributor to certain birth outcomes such as preterm birth, low birth-weight, birth defects, and infant mortality. Unfortunately in NC, barriers to affordable and consistent healthcare for women pre- and post-conception contribute to alarmingly high rates of fetal and infant death each year, despite advances in clinical care. NC had the 11th highest single-year infant mortality rate in the country in 2017 at a rate of 7.1 per 1,000 live births, compared to the U.S. rate of 5.8 per 1,000⁸⁹.

Significant racial and ethnic disparities in maternal disease and death exist in the U.S. Non-Hispanic African American women are three-to-four times more likely to die from a pregnancy related death compared to White women. Growing research shows that quality health-care, from preconception through postpartum care, may be a critical component for improving outcomes for racial and ethnic minority women⁹⁰.

Teenage Pregnancy

Teen pregnancy is defined as any woman who conceives between the ages of 15 and 19 years of age. While many believe that teen pregnancy is a growing problem, NC's teen pregnancy rate (24.6) is at an all-time low, with Orange County's rate at 6.2. Between 2016 and 2017, NC's teen pregnancy rate declined by 5%. While significant racial/ethnic disparities still exist, the gaps between White teens and their African American and Hispanic/Latinx counterparts are narrowing. 71% of pregnancies occur among 18 and 19 year olds, while pregnancies to minors are increasingly rare. Fewer teen parents are having subsequent teen pregnancies and the decline in teen pregnancy is due mainly to an increase in contraceptive use⁹¹.

Table 17: 2018 Teen Pregnancies in Orange County and NC

	ORANGE COUNTY	NORTH CAROLINA
Number of pregnancies among 15-19 year old girls	43	8,255
Teen pregnancy rate per 1,000 15-19 year old girls	6.2	24.6
TEEN PREGNANCY RATES BY RACE/ETHNICITY		
African American	*	33.7
Hispanic/Latinx	*	41.4
White	*	16.1
TEEN PREGNANCY RATES BY AGE		
15-17 year olds	*	10.6
18-19 year olds	8.1	44.0
Number of pregnancies among 15-17 year old girls	8	2,075
Number of pregnancies among 18-19 year old girls	35	6,180
Syphilis (late syphilis)	7	758

**Rates based on small numbers (<20 pregnancies) are unstable and not provided.*

Infant Mortality

Infant mortality refers to the death of a baby in its first year of life. NC has an infant mortality rate of 7.2 and Orange County has an infant mortality rate of 4.8, per 1,000 births. Leading causes of infant death are birth defects, low birth weight and preterm birth, maternal pregnancy complications, sudden infant death syndrome (SIDS) and injuries⁹². Risk factors that attribute to infant death include: smoking or alcohol consumption during pregnancy, maternal age – younger than age 20 and older than age 40, maternal obesity, intimate partner violence, food insecurity, and maternal educational status – less than a high school degree.

Non-Hispanic African American mothers have an infant mortality rate more than two times higher than White mothers. Women of color are more likely to live in communities that have fewer educational resources and employment opportunities due to historical segregation through housing and education policies. Women of color also experience added stress due to discrimination regardless of socioeconomic status, while socioeconomic factors are often linked to birth outcomes and infant mortality. Within the medical system, unequal treatment of mothers of color may contribute to worse birth outcomes; and implicit bias in health care delivery may prevent women of color from receiving sufficient patient

education in the prenatal period. Disparities in infant mortality also exist for babies born to women in poverty and those who are uninsured. Women in poverty experience more challenging life circumstances, have lower educational attainment, are more likely to have limited access to adequate food, transportation and housing, and are more likely to have limited access to health care services. Furthermore, in NC, women who are undocumented immigrants are ineligible for Medicaid during pregnancy, severely restricting their access to care⁹³.

Infant & Child Health

Proper access to healthcare services, education, and healthy housing are just a few essentials that are critical to a child's development. Environmental health, lack of access to healthy food, and not having insurance coverage can have long lasting effects on a child's health. Health disparities in children are linked to inequities involving race, ethnicity, and immigrant status. During 2013-2017, when we look at both Orange County and NC, the highest percentage of children living in poverty concentrated areas were African Americans (24.3%).

A healthy home has long lasting impacts on a child's health, particularly in children. A child's health can be influenced in a positive manner by having access to clean water, active spaces that promote physical ac-

Figure 25: 2018 Orange County Infant Death Rate (per 1,000 live births)

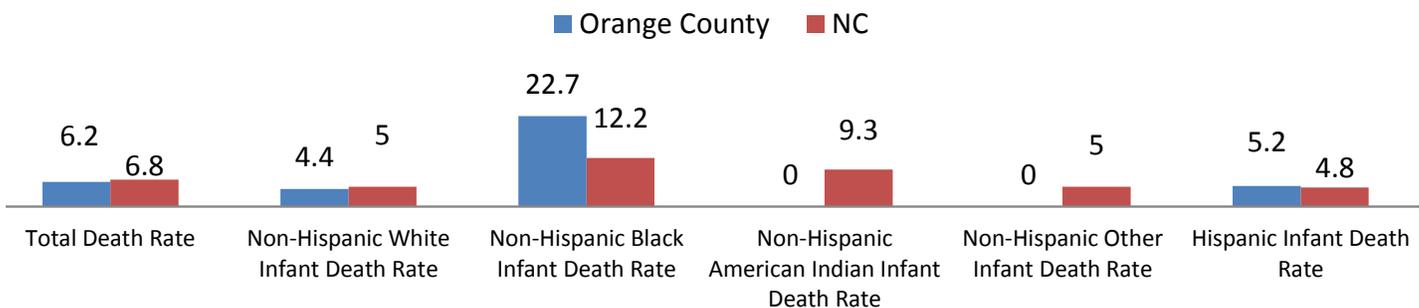
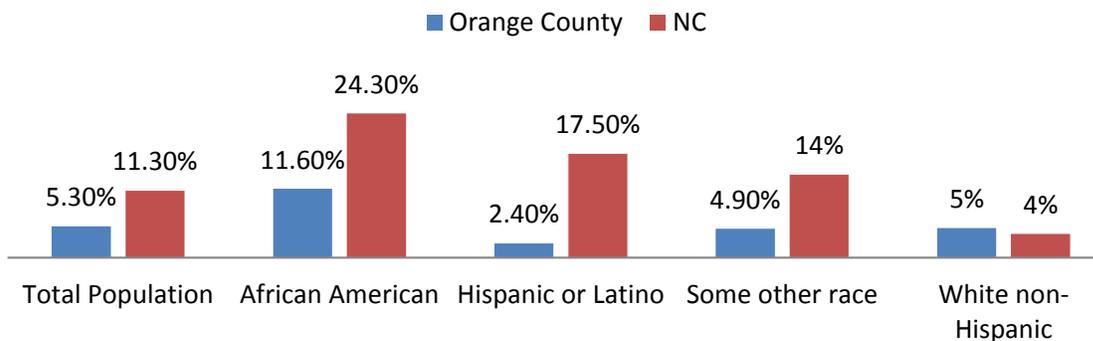


Figure 26: Children living in Poverty Concentrated Areas (2013-2017)



tivity, and no physical hazards in the home. On the flip side, poor quality sub-standard housing can negatively affect a child's health and development. Environmental triggers such as lead paint, poor indoor air quality, mold, pest issues, and safety hazards in the home can put a child's health at risk. While children (birth through age 12) are typically healthy, it is during this time when children are most at risk for developmental and behavioral disorders, child maltreatment, asthma and other chronic conditions, obesity, dental cavities, and unintentional injuries⁹⁴.

Below is a non-inclusive list of local and state programs and initiatives to help support maternal and child health.

[Adolescent Parenting Program](#)

[Compass Center for Women and Children](#)

[Head Start/Early Head Start](#)

[Family Success Alliance](#)

[KidSCOpe](#)

[Orange County Department of Social Services](#)

[Orange County Health Department](#)

[Orange County Healthy Homes Program](#)

[Orange County Partnership for Young Children](#)

[Orange County Rape Crisis Center](#)

[Orange County Safe Kids](#)

[Planned Parenthood](#)

[UNC Horizons](#)

[Women's Birth and Wellness Center](#)

Environmental Health

The World Health Organization defines environment, as it relates to health, as “all the physical, chemical, and biological factors external to a person, and all the related behaviors.” Environmental health consists of preventing or controlling disease, injury, and disability related to the interactions between people and their environment⁹⁵.

[Orange County Environmental Health](#) includes: 1) onsite water protection (subsurface wastewater and private wells), 2) retail food, lodging, and institution inspection, 3) children’s environmental health (childcare sanitation and lead prevention), 4) public swimming pool sanitation, and 5) tattoo artist permitting. In addition, Orange County Environmental Health works closely with partner agencies to assist in matters of public sewerage, public water supply, and indoor air quality.

Water Protection

Drinking Water Quality

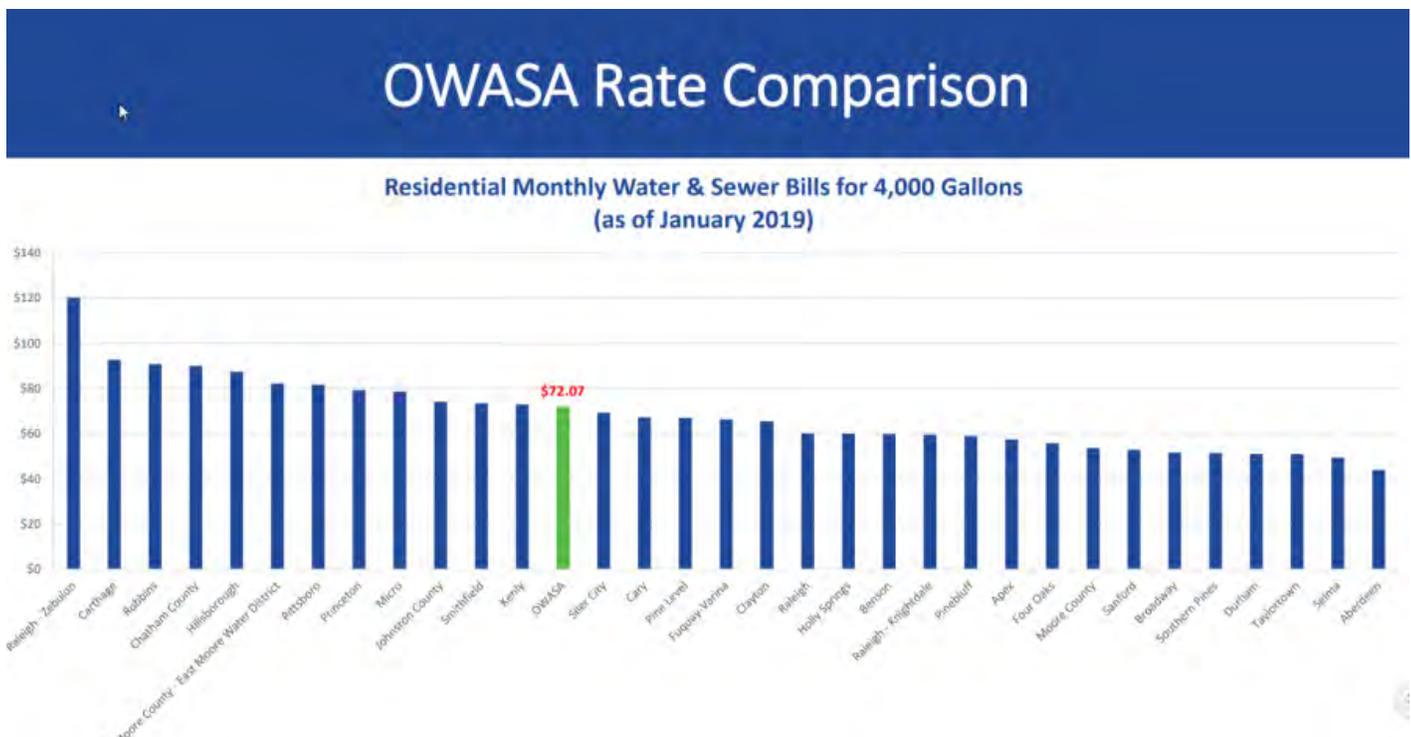
The safety of drinking water can be measured in terms of whether Maximum Contaminant Levels (MCL) is met for various pollutants present in water that could affect health. MCL standards for drinking water quality are set by [Environmental Protection Agency \(EPA\)](#). An MCL is the legal threshold limit on the amount of a substance that is allowed in public water systems under the [Safe Drinking Water Act](#).

Public water supplies, whether a municipal system or public water supply well, are regulated by the [North Carolina Department of Environmental Quality \(DEQ\)](#). Approximately 78% of Orange County populations, served by community water systems, are served by the Orange Water and Sewer Authority (OWASA), and approximately 40% of Orange County community members are served by private water wells. Private drinking water wells, well siting, permitting, inspections, and water sampling are regulated by the OCHD and carried out by the Environmental Health staff.

The vulnerability of the community was exposed during the February 2017 and October 2018 OWASA water crises. Water customers, as well as visitors to Chapel Hill and Carrboro, were placed under an advisory as a result of a water line break. The break resulted in restaurants and hotels closing, schools in Chapel Hill and Carrboro releasing early, and operations at UNC shutting down.

To help support continued delivery of high quality water and infrastructure improvements, a budget increase was approved and adopted by OWASA’s Board of Directors for the July 2018 through June 2019 year. The new budget includes a 2% increase in monthly water and sewer (wastewater) rates, effective October 2018. A monthly water and wastewater bill for a single-family residence (using 4,000 gallons each month) will increase \$1.41 per month. This is the first monthly rate change at OWASA in over six years. Effective July 2018, system development fees (one-time fees charged for new connections

Figure 27: OWASA Rate Comparison



to OWASA's system), have been reduced between 10% and 40%, depending on meter size and property type.

Onsite Wastewater

Most every dwelling and place of business or assembly outside the limits of the Townships in Orange County is served by the onsite disposal of wastewater. Septic system permitting, inspection, monitoring, and enforcement are major services of Orange County Environmental Health. Each year, this program offers an annual training meeting for septic system installers. The repair of existing systems and an existing system inspection program, known as the Wastewater Treatment Monitoring Program (WTMP), are critically important functions of this program for the protection of public health.

Water Supplies

Community members living in the municipal areas of Orange County and in some limited unincorporated areas are served by the following community public water systems:

[City of Durham](#)

[Orange-Alamance Water \(OAW\)](#)

[Orange Water and Sewer Authority \(OWASA\)](#)

[Town of Hillsborough](#)

[Town of Mebane](#)

Inspections

Retail Food, Lodging, and Institutions

Community members and visitors, including those attending athletic events and visiting the medical center, deserve food safety and general sanitation at the places where they frequent as customers. Orange County Environmental Health provides food safety classroom/exam and one-on-one instruction for operators. Orange County will provide courtesy inspections for operators and establishments that are not permitted by the local health department but must have a sanitation inspection to maintain licensure or status with another state agency. Such establishments include jail, residential cares, adult care facilities, and adult day facilities.

In relation to services for children's environmental health, Orange County Environmental Health inspects facilities licensed by the NC Division of Child Development and Early Education, no less than twice per year, and yearly inspections of public/private school buildings. Orange County Environmental Health provides an annual meeting for childcare center operators and keeps a seat at the table of the NC Healthy Homes Taskforce to stay current with the other parts of children's environmental health and childhood lead poisoning prevention.

Table 18: Onsite Water Protection Services Program

	2016	2017	2018	2019
New Wells Completed	195	208	200	263
New Wells Permitted	285	312	334	323
Water Samples Analyzed	1308	1004	934	986
Existing Septic System & WTMP Inspections (monitoring)	915	1881	945	938
Failing Systems Permitted and Repaired	88	98	62	108

Table 19: Food, Lodging, Institutions, Childcare, Pools, Tattoos

	2016	2017	2018	2019
Number of establishments	754	770	791	810
Total number of activities	2,294	2,269	2,592	2,599
Inspections	1,697	1,648	1,602	1,777

Childhood Environmental Health

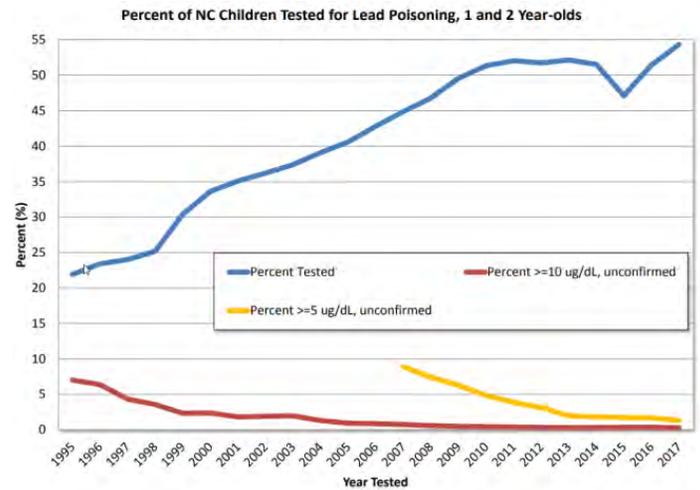
Lead Hazards

Assessment for Risk of Exposure Lead poisoning remains a principle environmental concern for young children. Universal blood lead testing is strongly encouraged at 12 months and again at 24 months of age, and testing for all immigrant children is recommended at the time of arrival to the U.S. While exposure to lead was once thought to be related to paint and older housing, lead exposure through behaviors must also be assessed.

A case is confirmed when two consecutive blood lead test results, within a 12-month period are: $<5 \mu\text{g}/\text{dL}$ = below the reference value, $5-9 \mu\text{g}/\text{dL}$ = elevated blood lead (EBL), $\geq 10 \mu\text{g}/\text{dL}$ = confirmed lead poisoning. Lead exposure is especially harmful to children under six years of age due to their constant hand-to-mouth activity. Lead exposure of women of child-bearing age can also adversely affect developing fetuses during pregnancy, which has resulted in the emphasis on testing pregnant women.

The Childhood Lead Poisoning Prevention Program tracks the number and rate of children in the target populations who are required to be screened for blood lead levels. Orange County Environmental Health conducts lead investigation on all child-occupied facilities (schools and childcare centers) that were constructed prior to 1978 and averages 4 -5 lead investigations in the homes and secondary premises of lead poisoned children identified through lead screening. Orange County Environmental Health has a certified Lead Assessor on staff as well as a bilingual staff person authorized to conduct lead investigations.

Figure 28: Percent of NC Children tested for Lead Poisoning



Environmental Health Activities (2015-2019)

- Radon testing kits are provided during Radon Month awareness campaigns.
- Trainings with housing, inspection, and healthy home community partners and advocates on mold identification and mold remediation
- Consistent monitoring of environmental trends in the media to anticipate the public’s demands for information, referrals, or sampling.
- Consistent work with the Rogers Road Community to resolve well and water quality issues. Three wells that needed replacement were investigated, permitted, inspected, and sampled.
- Received grant funds to implement a vector control program that allowed staff to receive training, licensure, and supplies to respond to mosquito related public health emergencies.

Table 20: Childhood Lead Poisoning Prevention Program⁹⁶

	2014	2015	2016	2017
Number of Children Tested (age Birth - 6yo)	1,263	1,291	1,448	1,228
5-9 $\mu\text{g}/\text{dL}$	4	3	3	3
10-19 $\mu\text{g}/\text{dL}$	1	2	2	1
$>20 \mu\text{g}/\text{dL}$	1	0	0	0

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Appendix A: Community Health Assessment Team Members

CHA Leadership Team (CHALT)

The governing body and final decision makers.

- **April Richard**, Orange County Health Department
- **Ashley Rawlinson**, Orange County Health Department
- **Charles Blackwood**, Orange County Sheriff Department
- **Chris Atack**, Carrboro Police Department
- **Corey Root**, Orange County Partnership to End Homelessness
- **Dominika Gazdzinska**, Orange County Health Department
- **Donna King**, Orange County Health Department
- **Jacqueline Wilson**, Orange County Head Start/Early Head Start
- **Janet Cherry**, Chapel Hill Carrboro City Schools
- **Jen Castello**, Piedmont Health Services
- **Juliet Sheridan**, Orange County Health Department
- **Latonya Brown**, Orange County Department on Aging
- **Liska Lackey**, Orange County Board of Health
- **Margaret Nemitz**, UNC School of Public Health
- **Mark Dorosin**, Orange County Board of County Commissioners
- **Meagan Clawer**, Refugee Community Partnership
- **Quintana Stewart**, Orange County Health Department
- **Ramon Negron**, El Centro Hispano
- **Robin Pulver**, Orange Partnership for Young Children
- **Sherita Cobb**, Orange County Schools
- **Sherry Hay**, UNC Family Medicine

Community Engagement Team

Those responsible for ensuring that the voices of the community are heard as well as engaging the community in every step of the process.

- **Allyson Coltrane**, Orange County Public Transportation
- **Carolyn Hall**, Chapel Hill Carrboro City Schools
- **Elinor Landess**, Campus and Community Coalition
- **Erin Sapienza**, Orange County Public Library
- **Gayane Chambless**, Orange Partnership for Alcohol and Drug Free Youth
- **Kristin Prelipp**, Orange County Health Department
- **LaDean Jones**, Head Start/Early Head Start
- **Liska Lackey**, Orange County Board of Health
- **Meagan Clawer**, Refugee Community Partnership
- **Natasha Snipes**, Inter-Faith Council
- **Ramon Negron**, El Centro Hispano
- **Richard Lewis**, Orange County Schools
- **Sharquilla Howard**, Insight Human Services
- **Sherry Hay**, UNC Family Medicine
- **Stephani Kilpatrick**, Inter-Faith Council
- **Susan Clifford**, Orange County Health Department

Volunteer Recruitment Team

Those responsible for recruiting volunteers to assist with data collection and community events.

- **Kim Lamon-Loperfido**, Orange County Department on Aging
- **Krishnaveni Balakrishnan**, Orange County Health Department
- **Margaret Nemitz**, UNC Gillings School of Public Health
- **Rebecca Crawford**, Orange County Health Department

Data Team

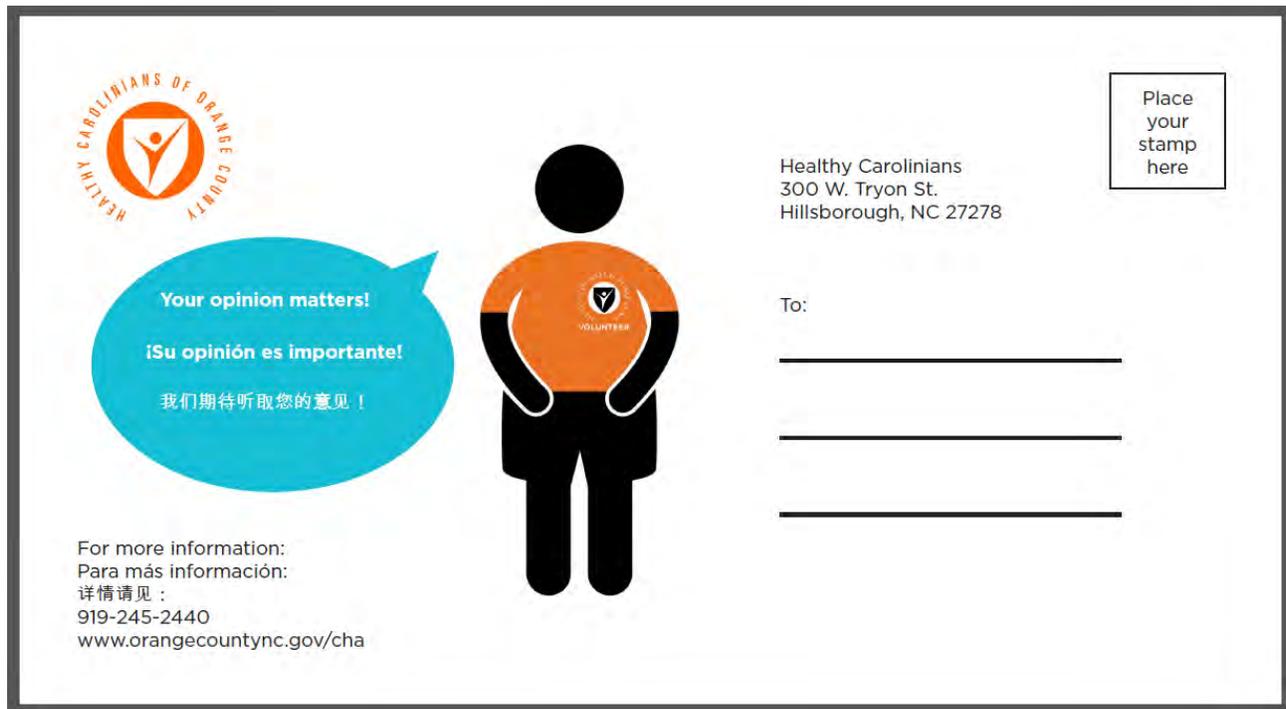
Those responsible for the format and analysis of the collected data.

- **Allison Young**, Duke University
- **Allyson Coltrane**, Orange County Public Transportation
- **Brandy Keys**, Orange County Resident
- **Christy Stanley**, Chapel Hill Carrboro City Schools
- **Coby Austin**, Orange County Health Department
- **Jen Costello**, Piedmont Health Services
- **Juliet Sheridan**, Orange County Health Department
- **Marybeth Grewe**, UNC Chapel Hill
- **Mike Fliss**, Orange County Resident
- **Richard Lewis**, Orange County Schools
- **Sarah Dumas**, NC Birth Center
- **Zin Lyons**, Orange County Health Department

Appendix B: **Survey Volunteers**

- Angela Sowers
- Anna-Lisa Johanson
- Ayah Isleem
- Barbara Hawksworth
- Beverly Scurry
- Bruce Baldwin
- Caroline Hall
- Cheryl Bono-Zehia
- Cierra Hoover
- Dana Crews
- Dominika Gazdzinska
- Donna King
- Gayane Chambless
- Grant Berry
- Jada Rogers
- Joan Melton
- Joe McLean
- John Davis
- Kathryn Hobby
- Katie Comanici
- Kaylin Cooley
- Kenneth Taylor
- Krishnaveni Balakrishnan
- Lauren Frey
- Ling Oy
- Lundan Winchester
- Margaret Nemitz
- Mel Ceasar
- Moira Beck
- Pam McCall
- Phil Vilaro
- Rani Richardson
- Rebecca Bloch
- Rebecca Crawford
- Rhea Colmer
- Roberto Diaz
- Sarah Nahum
- Savannah McCall
- Shade Little
- Sherry Hay
- Sonia Desai
- Steven Campbell
- Tameiah Ross
- Thais Ramirez
- Tim Smith
- Kristin Prelipp
- Julie Johnson

Appendix D: Notification Postcard Sent to Randomly Selected Households



Appendix E:
Community Health Opinion Survey
(Also printed in Chinese, Burmese, Spanish, and Karen)



2019 Orange County Community Health Opinion Survey

Date	COMMENTS

<input type="checkbox"/>	No One Home
<input type="checkbox"/>	Language Barrier (Interpreter not available) <input type="checkbox"/> Spanish <input type="checkbox"/> Karen <input type="checkbox"/> Burmese <input type="checkbox"/> Mandarin <input type="checkbox"/> Other: _____ (Call back to complete? Provide phone number)
<input type="checkbox"/>	Ended Before Survey Completed (Call back to complete? Provide phone number)
<input type="checkbox"/>	No one in home eligible <ul style="list-style-type: none"> ▪ Under 18 years of age ▪ Non-resident of Orange County
<input type="checkbox"/>	Household Refusal
<input type="checkbox"/>	Unoccupied/Vacant/Demolished House/Condemned House
<input type="checkbox"/>	Selected Address Not a Household
<input type="checkbox"/>	Survey Completed <input type="checkbox"/> Yes <input type="checkbox"/> No

ADMIN ONLY
<p>Follow Up?</p> <p>Phone Number: _____</p> <p>Address: _____</p> <p>_____</p> <p>_____</p> <p>Email: _____</p> <p>_____</p>



2019 Orange County Community Health Opinion Survey

READ THE FOLLOWING SECTION TO EACH POTENTIAL PARTICIPANT WITH BADGE/TSHIRT/VEST CLEARLY VISIBLE:

Hello, I am _____ and this is _____ representing Healthy Carolinians of Orange County. The Orange County Health Department is conducting a community survey to learn more about the health and quality of life in Orange County. Your responses will help determine the direction of future programs for the health department and other agencies across the county. Maybe you remember receiving a postcard in the mail recently that described the survey?

[SHOW LAMINATED POSTCARD]

Your address, and/or neighborhood, was randomly selected to answer our community opinion survey. The survey is completely voluntary, and it should only take about 30 minutes to complete. There is no right or wrong answer and you may refuse to answer any question. Your responses will be visible only to our Data Team and will not be linked to you in any way. All reports, presentations and publications of the data will be shared as de-identified, comprehensive data only.

NON-ENGLISH LANGUAGE RESPONDENTS ONLY

IF RESPONDENT DOES NOT SPEAK ENGLISH OR SPANISH

GIVE RESPONDENT A COPY OF THE LANGUAGE POSTCARD FOR THEM TO IDENTIFY THEIR LANGUAGE AND RECORD BELOW.

Language: _____

CALL TELE-LANGUAGE, REQUEST THE DESIRED LANGUAGE (RECORDED ABOVE) AND READ THE FOLLOWING TO THE INTERPRETER

We are conducting a community health survey. We are sorry that we do not have an interpreter present with us right now who speaks *(insert language)*, however, we have an on-call interpreter who can be here shortly, if you're willing to participate?

Would you be willing to participate? YES NO

(If NO, stop the survey here and thank him/her for his/her time.)

ELIGIBILITY

Do you live in Orange County? YES NO

(If NO, stop the survey here and thank him/her for his/her time.)

BEGIN SURVEY

Read: I will now begin asking questions. If at any time you realize that you have already participated in this survey let me know, and I can stop. In this survey, there is no right or wrong answer. We are just interested in your honest opinion, based on what you have seen or experienced. Remember your individual responses will be kept anonymous and will not be linked to you in anyway.

Emergency Preparedness

1. What would be your main way of getting information in a large-scale disaster or emergency? (Choose only one.)

- | | |
|--|---|
| <input type="checkbox"/> Social media (i.e. Twitter, Facebook, etc.) | <input type="checkbox"/> Text message/cell phone alert (emergency alert system) |
| <input type="checkbox"/> Internet | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Television | <input type="checkbox"/> Don't know/not sure |
| <input type="checkbox"/> Radio | <input type="checkbox"/> Prefer not to say |
| <input type="checkbox"/> Neighbors/neighborhood watch/community apps | |

2. Does your household have working smoke and carbon monoxide detectors? (Choose only one.)

- | | |
|--|---|
| <input type="checkbox"/> Yes, smoke detectors only | <input type="checkbox"/> No |
| <input type="checkbox"/> Yes, carbon monoxide detectors only | <input type="checkbox"/> Don't know/not sure |
| <input type="checkbox"/> Yes, both | <input type="checkbox"/> Prefer not to say |

Creating a Healthy Community

3. How do you usually get around town to go to work, school, run errands, shop, etc.? (Choose all that apply)

- | | |
|---|---|
| <input type="checkbox"/> I drive | <input type="checkbox"/> I bike/walk |
| <input type="checkbox"/> I get rides from family members or friends | <input type="checkbox"/> I use a transportation service (i.e. Uber, Lyft, Taxi, etc.) |
| <input type="checkbox"/> I take public transportation | <input type="checkbox"/> Other: _____ |

Prefer not to say

4. In the past year, which of the following transportation concerns have you experienced? (Choose all that apply)

- | | |
|--|---|
| <input type="checkbox"/> Can't afford gas | <input type="checkbox"/> I don't know how to use public transportation (i.e. bus transfers, bus routes, etc.) |
| <input type="checkbox"/> Can't afford car repairs | <input type="checkbox"/> Uber/Lyft/Taxi are not available where I live |
| <input type="checkbox"/> Bus routes don't go where I need them to | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Public transportation doesn't operate in the hours/times I need them to | <input type="checkbox"/> None of these |
| <input type="checkbox"/> Public transportation takes too long | <input type="checkbox"/> Prefer not to say |

5. Do you have access to the Internet?

- | | |
|------------------------------|--|
| <input type="checkbox"/> Yes | <input type="checkbox"/> Prefer not to say |
| <input type="checkbox"/> No | |

6. What ways do you access the internet? (Choose all that apply)

- | | |
|---|--|
| <input type="checkbox"/> I don't have access | <input type="checkbox"/> Public computers (i.e. library) |
| <input type="checkbox"/> At home (i.e. computer, tablet, watch, etc.) | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Smart phone data | <input type="checkbox"/> Prefer not to say |
| <input type="checkbox"/> Public Wi-Fi (i.e. coffee shop, restaurant, government building, etc.) | |

Access to Care

7. Do you have a regular medical home, somewhere you go regularly for your medical care?

- | | |
|------------------------------|--|
| <input type="checkbox"/> Yes | <input type="checkbox"/> Prefer not to say |
| <input type="checkbox"/> No | |

8. Where do you go most often when you are sick? (Choose only one.)

- | | |
|---|--|
| <input type="checkbox"/> My regular doctor | <input type="checkbox"/> Chapel Hill Community Health Center |
| <input type="checkbox"/> Hospital emergency room | <input type="checkbox"/> Specialist |
| <input type="checkbox"/> Urgent Care | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Health Department | <input type="checkbox"/> Prefer not to say |
| <input type="checkbox"/> Carrboro Community Health Center | |

9. The current hours of the Health Department's Medical Clinic are Monday through Friday 8:00am to 5:00pm with extended hours on Tuesday and Thursday until 6:30PM. If you or your family were in need of services, would these hours be convenient for you?

- Yes Don't know/not sure
 No Prefer not to say

10. The current hours of the Health Department's Dental Clinic are Monday through Thursday 8:00am to 5:00pm, and Fridays 8:00 am to noon. If you or your family were in need of services, would these hours be convenient for you?

- Yes Don't know/not sure
 No Prefer not to say

11. If you have received services at the Orange County Health Department in the last year, how satisfied were you with your service? (Including medical, dental, and/or environmental health services)

- Very satisfied Very dissatisfied
 Satisfied Don't know/not applicable
 Dissatisfied Prefer not to say

12. What is your primary health insurance plan? This is the plan which pays your medical bills first or pays most of your medical bills. (Choose only one.)

- No health insurance Medicare
 The State Employee Health Plan Medicaid
 Blue Cross and Blue Shield of North Carolina The Military, Tricare, CHAMPUS, or the VA
 Other private health insurance plan purchased from employer or workplace Other: _____
 Other private health insurance plan purchased directly from an insurance company or through the Affordable Care Act Don't know/not sure
 Prefer not to say

13. In the past 12 months, did you have a problem getting the health care you needed for you personally or for an adult family member from any type of health care provider, dentist, pharmacy, or other facility?

- Yes Don't know/not sure
 No Prefer not to say

14. If you said “yes,” what type of provider or facility did you or your family member have trouble getting health care from? (Choose all that apply).

- | | |
|---|--|
| <input type="checkbox"/> N/A; does not apply | <input type="checkbox"/> Health Department |
| <input type="checkbox"/> Dentist | <input type="checkbox"/> Hospital |
| <input type="checkbox"/> General practitioner/primary care | <input type="checkbox"/> Urgent Care |
| <input type="checkbox"/> Eye care/optometrist/ophthalmologist | <input type="checkbox"/> Medical Clinic |
| <input type="checkbox"/> Pharmacy/prescriptions | <input type="checkbox"/> Specialist: _____ |
| <input type="checkbox"/> Pediatrician | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> OB/GYN | <input type="checkbox"/> Prefer not to say |

15. Do you have children under the age of 19 for whom you are the caretaker? (Includes step-children, grandchildren, or other relatives).

- | | |
|------------------------------|--|
| <input type="checkbox"/> Yes | <input type="checkbox"/> Prefer not to say |
| <input type="checkbox"/> No | |

16. If you answered “yes”, have you ever had trouble getting medical care for the child(ren) you care for?

- | | |
|--|--|
| <input type="checkbox"/> N/A; does not apply | <input type="checkbox"/> No |
| <input type="checkbox"/> Yes | <input type="checkbox"/> Prefer not to say |

17. Concerning access, have any of the below problems prevented you or your family member(s) from getting necessary health care? (Choose all that apply).

- | | |
|--|--|
| <input type="checkbox"/> N/A; does not apply | <input type="checkbox"/> Pharmacy would not take my/our insurance or Medicaid |
| <input type="checkbox"/> No health insurance | <input type="checkbox"/> Didn't know where to go |
| <input type="checkbox"/> Insurance didn't cover what I/we needed | <input type="checkbox"/> Couldn't get an appointment |
| <input type="checkbox"/> Deductible/co-pay was too high | <input type="checkbox"/> The wait was too long |
| <input type="checkbox"/> Doctor would not take my/our insurance or Medicaid | <input type="checkbox"/> The hours and days they are open is not convenient |
| <input type="checkbox"/> Hospital would not take my/our insurance | <input type="checkbox"/> There was no one who spoke my preferred language and no interpreter available |
| <input type="checkbox"/> No transportation to get there | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Dentist would not take my/our insurance or Medicaid | <input type="checkbox"/> Prefer not to say |

18. If a friend or family member needed counseling for a mental health or a drug/alcohol abuse problem, who would you tell them to talk to? (Choose all that apply).

- | | |
|---|--|
| <input type="checkbox"/> Private counselor or therapist | <input type="checkbox"/> Doctor |
| <input type="checkbox"/> Support group (e.g., AA, NA., etc.) | <input type="checkbox"/> Don't know/not sure |
| <input type="checkbox"/> School staff (i.e. counselor, coach, teacher, bus driver, custodian, etc.) | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Minister/religious official | <input type="checkbox"/> Prefer not to say |

19. Have you ever heard of NC 2-1-1?

- | | |
|------------------------------|--|
| <input type="checkbox"/> Yes | <input type="checkbox"/> Don't know/not sure |
| <input type="checkbox"/> No | <input type="checkbox"/> Prefer not to say |

Community Improvement

20. When you think about the health of our community, what issues do you think affect the overall health of the county?

21. If you had to pick one issue from your previous list that is most important to the health of the community, which would it be?

22. Thinking about teenagers in our community, what would you say are the top three problems that they face?

READ: The next group of questions will ask about your personal health. Remember you can skip any question that you are uncomfortable answering.

Personal Health

23. Would you say that, in general, your health is...(Choose only one)

- | | |
|------------------------------------|-------------------------------|
| <input type="checkbox"/> Excellent | <input type="checkbox"/> Fair |
| <input type="checkbox"/> Very good | <input type="checkbox"/> Poor |

Good

Prefer not to say

24. Have you ever been told by a doctor, nurse, or other health professional that you have any of the following health conditions? (DK= Don't know/not sure; P= Prefer not to say)

- | | | | | |
|---|------------------------------|-----------------------------|-----------------------------|----------------------------|
| a. Asthma | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> DK | <input type="checkbox"/> P |
| b. Depression, anxiety or other mental health concern | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> DK | <input type="checkbox"/> P |
| c. High Blood Pressure | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> DK | <input type="checkbox"/> P |
| d. High Cholesterol | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> DK | <input type="checkbox"/> P |
| e. Diabetes (not during pregnancy or Type 1) | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> DK | <input type="checkbox"/> P |
| f. Osteoporosis | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> DK | <input type="checkbox"/> P |
| g. Overweight/obesity | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> DK | <input type="checkbox"/> P |
| h. Heart Disease | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> DK | <input type="checkbox"/> P |
| i. Cancer | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> DK | <input type="checkbox"/> P |

25. How do you identify? (Choose all that apply)

- | | |
|--|---|
| <input type="checkbox"/> Male | <input type="checkbox"/> Prefer to self-describe: |
| <input type="checkbox"/> Female | _____ |
| <input type="checkbox"/> Transgender | <input type="checkbox"/> Prefer not to say |
| <input type="checkbox"/> Gender Queer, Gender Non-Conforming, Non-Binary, Third Gender | |

26. When it comes to Cancer screenings, have you ever had a.....(DK= Don't know/not sure; P = Prefer not to say, NA = Not applicable/does not apply)

Mammogram (Female)? – An x-ray taken only of the breast by a machine that presses against the breast. Yes No DK P NA

Prostate Exam – PSA or DRE (Male)? – The prostate-specific antigen (PSA) test and digital rectal exam (DRE) are tests used to check men for prostate cancer. Yes No DK P NA

Blood Stool Test (Male/Female)? – A test that may use a special kit at home to determine whether the stool contains blood. Yes No DK P NA

27. In the past 30 days, have there been any days when you felt down, depressed or hopeless, and it made it difficult for you to do your work, take care of things at home or get along with other people?

- | | |
|------------------------------|--|
| <input type="checkbox"/> Yes | <input type="checkbox"/> Don't know/not sure |
| <input type="checkbox"/> No | <input type="checkbox"/> Prefer not to say |

28. During a normal week, other than your regular job, how many days do you engage in physical activity or exercise for at least a half an hour?

- | | |
|---|--|
| <input type="checkbox"/> Zero (0) days | <input type="checkbox"/> Five (5) or more days |
| <input type="checkbox"/> One to two (1-2) days | <input type="checkbox"/> Prefer not to say |
| <input type="checkbox"/> Three to four (3-4) days | |

29. Over the past month, were there any times when you wanted to engage in physical activity but couldn't or found it difficult because of the following reasons? (Choose all that apply)

- | | |
|---|---|
| <input type="checkbox"/> I don't have time. | <input type="checkbox"/> I don't like to exercise. |
| <input type="checkbox"/> It costs too much. | <input type="checkbox"/> I'm too tired to exercise. |
| <input type="checkbox"/> I don't have convenient exercise facilities. | <input type="checkbox"/> I'm physically disabled. |
| <input type="checkbox"/> I don't have child care. | <input type="checkbox"/> Exercise is not important to me. |
| <input type="checkbox"/> There is no safe place to exercise. | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> I have no one to exercise with. | <input type="checkbox"/> Don't know/not sure |
| <input type="checkbox"/> My job is physical or hard labor. | <input type="checkbox"/> Prefer not to say |

30. During a normal week, how often do you eat fruits and vegetables?

- | | |
|---|--|
| <input type="checkbox"/> Everyday | <input type="checkbox"/> Never |
| <input type="checkbox"/> Five to six (5-6) days | <input type="checkbox"/> Don't know/not sure |
| <input type="checkbox"/> Three to four (3-4) days | <input type="checkbox"/> Prefer not to say |
| <input type="checkbox"/> One to two (1-2) days | |

31. During the past 12 months, have you had a flu vaccine?

- | | |
|---|--|
| <input type="checkbox"/> Yes, flu shot | <input type="checkbox"/> No |
| <input type="checkbox"/> Yes, flu spray | <input type="checkbox"/> Don't know/not sure |
| <input type="checkbox"/> Yes, both | <input type="checkbox"/> Prefer not to say |

32. About how much do you weigh without shoes?

Weight: _____ pounds

- | |
|--|
| <input type="checkbox"/> Don't know/not sure |
| <input type="checkbox"/> Prefer not to say |

33. About how tall are you without shoes?

Height: _____ feet _____ inches

- Don't know/not sure
- Prefer not to say

READ: We are now about to ask questions regarding your experience with some of the issues facing people who live in Orange County. Remember that you always have the option to skip any question that you are uncomfortable with, and your answers will not linked to you in any way.

34. At the store where you typically buy food, is there a good selection of fruits and vegetables available?

- Always
- Sometimes
- Never
- Don't know/not sure
- Prefer not to say

35. In the past month, could you afford to eat fresh fruits and vegetables?

- Yes
- No
- Prefer not to say

36. In the past month, did you ever cut the size of your meals, or skip meals, because there wasn't enough money for food?

- Yes
- No
- Prefer not to say

READ: Please state how strongly you agree, or disagree, with the next few following statements.

37. In my community, people of all races, ethnicities, backgrounds, and beliefs are treated fairly.

- Strongly agree
- Agree
- Disagree
- Strongly disagree
- Don't know/not sure
- Prefer not to say

38. Orange County offers you all of the necessary resources to build a good life for you and/or your family.

- Strongly agree
- Agree
- Disagree
- Strongly disagree
- Don't know/not sure
- Prefer not to say

39. I have enough financial resources to meet my basic needs (i.e. food, clothing, shelter, and utilities, etc.)

- Strongly agree
- Agree
- Disagree

- Strongly disagree
- Don't know/not sure
- Prefer not to say

40. How likely is it that you'll be able to afford to live in Orange County in a year?

- Highly likely
- Likely
- Unlikely

- Highly unlikely
- Don't know/not sure
- Prefer not to say

41. In the past year, did you ever experience homelessness, whether temporarily or permanently? (Including staying with others, in a hotel, in a shelter, living outside on the street, in a car, in a park, etc.)

- Yes, 1 time
- Yes, multiple times

- No
- Prefer not to say

42. In the past year, have you or any family members you live with been unable to get any of the following when it was really needed? (Choose all that apply.)

- Food
- Utilities
- Medicine
- Health care (medical, dental, mental health, vision care)

- Phone
- Clothing
- Child care
- Other: _____
- Prefer not to say

43. Are you able to access services and receive information in your preferred language?

- Yes, always
- Yes, sometimes
- No

- Don't know/not sure
- Prefer not to Say

Demographic Questions

44. How old are you? _____

45. What is your race/ethnicity? (*Choose all that apply.*)

- | | |
|--|--|
| <input type="checkbox"/> American Indian or Alaska Native | <input type="checkbox"/> Hispanic or Latino/a/x |
| <input type="checkbox"/> Black or African American | <input type="checkbox"/> Middle Eastern or North African |
| <input type="checkbox"/> East Asian including Japanese, Chinese, Korean, Vietnamese, etc. | <input type="checkbox"/> Native Hawaiian or Pacific Islander |
| <input type="checkbox"/> South Asian including Indian, Sri Lankan, Pakistani, Nepalese, etc. | <input type="checkbox"/> White |
| <input type="checkbox"/> Southeast Asian, including Karen, Burmese, Filipino/a, Indonesian, etc. | <input type="checkbox"/> Other: _____ |
| | <input type="checkbox"/> Prefer not to say |

46. Do you regularly speak a language other than English?

- | | |
|------------------------------|--|
| <input type="checkbox"/> Yes | <input type="checkbox"/> Prefer not to say |
| <input type="checkbox"/> No | |

47. If yes, what language do you regularly speak?

48. What is your marital status?

- | | |
|---|--|
| <input type="checkbox"/> Never married/single | <input type="checkbox"/> Widowed |
| <input type="checkbox"/> Married | <input type="checkbox"/> Separated |
| <input type="checkbox"/> Divorced | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Unmarried partner | <input type="checkbox"/> Prefer not to say |

49. What is the highest level of school, college or vocational training that you received? (*Choose only one.*)

- | | |
|--|--|
| <input type="checkbox"/> Less than 9th grade | <input type="checkbox"/> Some college (no degree) |
| <input type="checkbox"/> 9-12th grade, no diploma | <input type="checkbox"/> Bachelor's degree |
| <input type="checkbox"/> High school graduate (or GED/ equivalent) | <input type="checkbox"/> Graduate or professional degree |
| <input type="checkbox"/> Associate's degree or vocational training | <input type="checkbox"/> Other: _____ |
| | <input type="checkbox"/> Prefer not to say |

50. What was your total household income last year, before taxes? Let me know which category you fall into. (Choose only one.)

- | | |
|---|---|
| <input type="checkbox"/> Less than \$10,000 | <input type="checkbox"/> \$50,000 to \$74,999 |
| <input type="checkbox"/> \$10,000 to \$14,999 | <input type="checkbox"/> \$75,000 to \$99,999 |
| <input type="checkbox"/> \$15,000 to \$24,999 | <input type="checkbox"/> \$100,000 to \$249,999 |
| <input type="checkbox"/> \$25,000 to \$34,999 | <input type="checkbox"/> 250,000 or more |
| <input type="checkbox"/> \$35,000 to \$49,999 | <input type="checkbox"/> Prefer not to say |

51. How many people does this income support? (If you are paying child support but your child is not living with you, this still counts as someone living on your income.)_____

52. What is your employment current status? (Choose all that apply)

- | | |
|--|---|
| <input type="checkbox"/> Employed full-time | <input type="checkbox"/> Disabled |
| <input type="checkbox"/> Employed part-time | <input type="checkbox"/> Student |
| <input type="checkbox"/> Retired | <input type="checkbox"/> Stay-at-home parent/spouse |
| <input type="checkbox"/> Armed forces | <input type="checkbox"/> Self-employed |
| <input type="checkbox"/> Unemployed for more than 1 year | <input type="checkbox"/> Prefer not to say |
| <input type="checkbox"/> Unemployed for 1 year or less | |

READ: Thank you for your time answering these questions about health. The Orange County Health Department and Healthy Carolinians of Orange County will use the results of this survey to help identify and address the major health and community issues in our county. After these results are ready, we will host community workshops, which you are invited to, to prioritize and decide on the most important county issues.

53. Would you like to be contacted when this happens?

- | | |
|------------------------------|--|
| <input type="checkbox"/> Yes | <input type="checkbox"/> Prefer not to say |
| <input type="checkbox"/> No | |

ADMIN ONLY

Follow Up (in response to question 53)

Phone Number:

Email:

Appendix F:

Focus Group Template

(Conducted among the Homeless population, youth, Spanish speakers, Burmese speakers, Karen speakers, and Kinyarwanda speakers)

OPENING

Let us start with introductions. One at a time, please introduce yourself and tell us how long you have lived in Orange County.

CORE QUESTIONS

IF PROBING IS NEEDED, FOLLOW ANSWERS WITH PHRASES LIKE, "TELL ME MORE ABOUT..." OR "COULD YOU GIVE ME AN EXAMPLE..." OR "IN WHAT WAYS..." PROBING IS TO HELP EXPLAIN THE QUESTION AND HELP PARTICIPANTS THINK OUTSIDE THEIR INITIAL THOUGHTS.

1. **How do you define health?**
 - **PROBE: Think about physical health. Mental health. Environmental health.**
2. **Describe what healthy looks like to you.**
 - *PROBE: What would be involved in a person being healthy? Think about physical, mental and environmental.*
3. **Describe what a healthy community looks like to you.**
 - *PROBE: By community, that could be your neighborhood, your surroundings, or Orange County as a whole, not just you individually. What would make where you live a healthy (or healthier) community?*
 - Safety
 - Access
 - Transportation/travel time
 - Housing
 - Employment
 - Recreation activities
 - Healthcare
 - Religion
 - Schools
4. **What are the strengths of your community?**
 - *PROBE: This could be your neighborhood, your surroundings or Orange County as a whole.*
 - Parks/trails
 - Recreation activities
 - Numerous medical facilities
 - Farmer's markets
 - Schools
 - Support for your culture/religion/ethnicity
 - Job opportunities
 - Cost of living
 - High graduation rates
 - Low/no crime
5. **Is there anything Orange County can do more of to support your community better?**
 - *PROBE: What can help your community be better?*

- *More funding*
- *More concern for your religion/culture/ethnicity*
- *Police presence*
- *Cleaner water*
- *More medical facilities*
- *More transportation options*

GROUP SPECIFIC QUESTIONS

BASED ON THE POPULATION, ASK ANY ADDITIONAL QUESTIONS, IF NECESSARY, TO GET A BETTER IDEA OF THEIR CONCERNS/ISSUES AS IT SPECIFICALLY RELATES TO THEM.

HISPANIC/LATINX

THE NEXT FEW QUESTIONS IS TO GET A BETTER IDEA OF THE CONCERNS/ISSUES AS IT SPECIFICALLY RELATES TO INDIVIDUALS WHO IDENTIFY AS HISPANIC/LATINX.

6. **Thinking about the people in your community, both where you live and those who are Latinx, what are your main health or safety concerns?**
 - *PROBE: What concerns you most?*
 - *Crime*
 - *Law Enforcement*
 - *Access to services*
 - *Medical Care*
 - *Language Barriers*

7. **Tell us about your experience(s) getting healthcare in Orange County.**
 - *PROBE: What is going well and what makes it difficult?*
 - *Interpretation/translation/communication issues*
 - *Proper help at appointments*
 - *Transportation issues*
 - *Route times and frequency*
 - *Insurance/payment*
 - *Referrals to other agencies/facilities*

8. **Do you feel you are well informed on the county's resources and services that would be helpful to you? If not, do you feel comfortable enough to ask questions and get more information about resources/services?**

9. **Do you feel that you have a way, or connection, to share your opinions, feedback and perspectives with decision makers?**

10. **The last couple of years have been challenging for some immigrants and refugees across the US, due to changes in policies, unwelcoming language, ICE arrests, and increases in immigrant detention. Has this been a challenge for you or for others you know here in Orange County?**
 - *PROBE: Have those stressors affected the health and well-being for you or those you know?*

11. **Are there any specific things that Orange County can do to support the well-being of the Hispanic/Latinx community?**
 - *PROBE: Increase transportation options*
 - *More outreach to neighborhoods*
 - *Clear messages about program eligibility*

- Hire more Dreamers
- More funding
- More concern for your religion/culture/ethnicity
- Police presence
- Cleaner water
- More medical facilities
- More transportation options
- Affordable housing
- Affordable healthcare
- Sharing of information

HOMELESS POPULATION

THE NEXT FEW QUESTIONS IS TO GET A BETTER IDEA OF THE CONCERNS/ISSUES AS IT SPECIFICALLY RELATES TO THOSE INDIVIDUALS EXPERIENCING HOMELESSNESS.

12. Do you feel you are well informed on the county's resources and services that would be helpful to you? If not, do you feel comfortable enough to ask questions and get more information about resources/services?
13. Do you feel that you have a way, or connection, to share your opinions, feedback and perspectives with decision makers?

REFUGEE POPULATION

THE NEXT FEW QUESTIONS IS TO GET A BETTER IDEA OF THE CONCERNS/ISSUES AS IT SPECIFICALLY RELATES TO REFUGEES.

14. Are there any specific places/locations that are hard to access because they do not speak your language or because they have limited-to-no interpreters?
- *PROBE: transportation/public transit*
 - Doctor offices
 - Hospitals
 - Dental agencies
 - Food pantries
 - Religious services
 - County agencies
 - Schools
15. In addition to language barriers, what else keeps you from getting the services that you need/want?
- *PROBE: Public transportation doesn't run where I need*
 - Hours of operation, at agencies, are inconvenient
 - Places do not accept my insurance
 - My culture is not respected
 - Fear
16. Do you feel you are well informed on the county's resources and services that would be helpful to you? If not, do you feel comfortable enough to ask questions and get more information about resources/services?

17. Do you feel that you have a way, or connection, to share your opinions, feedback and perspectives with decision makers?

18. What health/social issues is a priority to you that is preventing you from having the best quality of life that you deserve?

- *PROBE: Well-paying job*
 - Adequate housing
 - Affordable healthcare
 - Higher education
 - Access to interpreters/translators
 - Transportation (personal or public)

19. Do you partake in preventative health care or do you only visit clinics when you are sick or during emergencies?

- *PROBE: Do you get checkups once a year, just to make sure you're in good health?*
 - How often do your children visit the doctor?
 - Do you feel it's more expensive to visit yearly, or on occasion?

YOUTH POPULATION

THE NEXT FEW QUESTIONS IS TO GET A BETTER IDEA OF THE CONCERNS/ISSUES AS IT SPECIFICALLY RELATES TO YOUTH.

20. Do you see a lot of “unhealthy behaviors” among people your age?

- *PROBE: Unhealthy behaviors can be anything from sexual activities, bullying, drug use, alcohol, skipping school, cheating, drunk driving, etc.*

21. What “unhealthy behavior” do you see the most?

22. Do you, or any students you know, vape?

- *PROBE: What do they vape?*
 - What is the culture at your school around vaping?
 - Is it acceptable?
 - Do students feel that it is harmful?

23. Have you ever been tested for HIV (the virus that causes AIDS, not counting blood transfusions)?

- *PROBE: Is there a fear with teens/youth to get tested?*

24. Do students your age care about being physically active?

- *PROBE: What type of activities do you/they engage in?*
 - Traditional sports (football, basketball, cheerleading, track, baseball, soccer, swimming, etc.)

- *Non-traditional sports (hockey, cricket, bowling, martial arts, Polo, etc.)*

25. Do you feel like students your age have access to the help they need?

- *PROBE: Think about the support for students dealing with alcohol or drug use, bullying, suicide thoughts or attempts, stress, anxiety, depression, school/grades, etc.*

26. How prepared was your community in dealing with your release from incarceration?

- *PROBE: By prepared, I mean, was there a plan set in place by Prison Case Managers, Probation Staff and/or Community Agencies to ensure you had adequate access to essentials like food and shelter?*

27. After being released from prison/Jail, were you given an adequate supply of medication? How soon were you able to be seen by another doctor?

28. How did your time in prison/jail affect your overall mental health?

- *PROBE: Thinking both positive and negative*

29. How has your re-entry affected your overall mental health?

- *PROBE: What changes have you noticed, positive or negative, since being released from prison/jail? Are you able to access the help that you need?*

ENDING QUESTIONS

30. We want to make sure that the health programs in this community will help you and your community. With that in mind, is there anything that we have not asked or that you would like to add?

31. Do you have any questions about the community health assessment process?

CLOSING

Are there any questions from the notetaker(s)?

Thank all guests and provide any incentive that is intended for participation

2019 Orange County Community Health Assessment COMMUNITY INPUT SESSIONS



Dates/locations/times

Cedar Grove Community Center

Date: Tuesday October 29th
Address: 5800 NC Highway 86 N. Hillsborough, NC 27278
Time: 12:00pm – 2:00pm

Whitted Human Services Center, Room 230

Date: Tuesday November 12th
Address: 300 W. Tryon St. Hillsborough, NC 27278
Time: 5:30pm – 7:30pm

Chapel Hill Public Library, Meeting Room B

Date: Friday November 15th
Address: 100 Library Dr, Chapel Hill, NC 27514
Time: 12:00pm – 2:00pm

Southern Human Services Center, Room AB

Date: Thursday November 21st
Address: 2501 Homestead Rd. Chapel Hill, NC 27514
Time: 5:30pm – 7:30pm

FREE MEAL SERVED!

HEALTHY CAROLINIANS AND THE BOARD OF HEALTH INVITE YOU TO:

- Learn about what was found in conversations with neighbors during the 2019 Community Health Assessment data collection process.
- Discuss your concerns with elected officials, people who work in government, and the health department.
- Help prioritize and decide what health issues will be selected for 2020-2024.
- Map out next steps toward a plan that improves the health of Orange County.

**To attend a Community Input Session:
e-mail hcoc@orangecountync.gov or call 919.245.2440**

Interpreter services and/or special sound equipment are free and available on request. Call in advance to make arrangements: 919-245-2387 or 919-245-2400.

Los servicios de intérprete y/o equipo de sonido especial son gratuitos y están disponibles por petición. Llame por adelantado para avisarnos: 919-245-2387 ó 919-245-2400.



我們可應您的要求提供免費的口譯服務及(或)特殊語音設備。請致電919-245-2387或919-245-2400。



DIVERSITY, EQUITY AND INCLUSION GLOSSARY

POLITICS, POWER & PRIVILEGE

- **Politics** – 1) The struggle for or over power. 2) The struggle to attain, maintain, build or take power.

Power- 1) The ability to name or define. 2) The ability to decide. 3) The ability to set the rule, standard, or policy. 4) The ability to change the rule, standard, or policy to serve your needs, wants or desires. 5) The ability to influence decision makers to make choices in favor of your cause, issue or concern.

- **Types of Power**

Each of these definitions of power can manifest on personal, social, institutional, or structural levels.

- a. **Personal Power** – 1) Self-determination. 2) Power that an individual possesses or builds in their personal life and interpersonal relationships.

Example: When a person chooses a new name for themselves rather than the one given to them, this is an act of personal power.

- b. **Social Power** – 1) Communal self-determination. 2) A grassroots collective organization of personal power. 3) Power that social groups possess or build among themselves to determine and shape their collective lives.

Example: Over the last few years individuals who identify as multiracial or multiethnic have used their social power to name themselves into existence and build a community around the shared experience of being multiracial or multiethnic. The growing social power of the multiracial/ multiethnic community is a direct challenge to institutions premised on a binary understanding of race (i.e., you are either this or that.)

- c. **Institutional Power** – 1) Power to create and shape the rules, policies and actions of an institution. 2) To have institutional power is to be a decision maker or to have great influence upon a decision maker of an institution.

Example: A school principal or the PTO of a local school have institutional power at that school.

- d. **Structural Power** - To have structural power is to create and shape the rules, policies, and actions that govern multiple and intersecting institutions or an industry.

Example: The city school board, mayor, and the Secretary of Education have structural power in the educational industry.

- **Minoritized Population** – 1) A community of people whose access to institutional and structural power has been severely limited regardless of the size of the population. As a result, the community is constantly being disenfranchised and disempowered by the majoritized population. 2) Also referred to as a subordinated population.
- **Cultural Default** - 1) The status quo; a category or reality specific to one group of people that is used as a rule or standard for all people and groups. 2) Taking the preferences, practices, and policies of a ruling elite and universalizing them so that they feel “natural” or function as social norms. 3) Often referred to in academic circles as hegemony.

Examples: Racial justice movements address the cultural default of Whiteness: beauty standards; definitions of culture, civility and humanity; what counts as knowledge; etc.

- **Eurocentrism** - 1) The process and product of the cultural default of Whiteness. 2) The utilization of European cultural standards as universal standards that all should be judged by. 3) To orient to European people and cultures as the benchmark of: humanity, culture, truth, virtue, style, beauty, civility, knowledge, and ethics; a deification of European people and their cultures.
- **White Privilege**- 1) The unearned privileges associated with identifying as or appearing White in a racist society. 2) Living and existing as a White (appearing) person in a world that operates on the cultural default of Whiteness. 3) A tool that a White ally can use to challenge racist oppression in the spaces and places they have access to.

Privilege- 1) The unearned social, political, economic, and psychological benefits of membership in a group that has institutional and structural power. 2) Living and existing in a world where standards and rules are premised upon your needs wants and desires. 3. To identify with or be identified as a member of a dominant social group (as opposed to a minoritized group).

- **Oppression** – 1) A system for gaining, abusing and maintaining structural and institutional power for the benefit of a limited dominant class. 2) The inequitable distribution of structural and institutional power. 3) A system where a select few hoard power, wealth and resources at the detriment of the many. 4) The lack of access, opportunity, safety, security and resources that minoritized populations experience; a direct result of a vacuum created by privilege. 5) A state of being that is the opposite of social justice.
- **Community Organizing** – 1) The art and science of social movements. 2) The theories, practices and skills that people use to create movements for social transformation. 3) A communal process of using, building and demonstrating power in order to influence decision makers to get things the community needs or wants. 4) The ultimate response on the continuum of responses to social injustice. It is a communal process of building power (often by developing a broad coalition of

stakeholders) to put an extraordinary amount of pressure on a person that has institutional or structural power to change a policy or practice that negatively impacts the stakeholder communities.

Example: The famous Montgomery Bus boycott is a primary example of community organizing. Unfortunately, rather than focusing on all the work the locals did to build power in their community, we instead tell a depoliticized story about Rosa Parks as an elder with tired feet. The truth of the situation is that she was a trained community organizer; she was a member of the local NAACP and a primary organizer of the Boycott movement; and that what she did that day in refusing to yield her seat was a deliberate and planned direct action (tactic) of the Boycott Movement.

- **Ally** – 1) One who is not (most) directly impacted by an issue but works in solidarity with those who are most directly impacted by the issue; 2) One who understands that their primary role is to: a) educate themselves; b) educate their community, and c) lend their support to the leadership of those most directly impacted by the issue.

Example: A White racial justice ally would be someone who has educated themselves on the issue of racial justice, seeks to be anti-racist in their everyday life, participates in the education of other White people about racial justice, actively works to use their White Privilege to support the cause of racial justice, seeks to transform spaces where they have power or influence, and supports people of color leadership on racial justice issues and in racial justice movements. There is a difference between being an ally and being an advocate; allies work closely with and in support of those most impacted by an issue. However, one can be an advocate and not work with or know any of the people or groups that you are advocating for.

- **Theory of Change** - A system of beliefs about how change and transformation happen. Our current theory of change revolves around five basic assumptions: (a) a social justice orientation demands that we actively seek to transform unjust social policies and practices in our present world; (b) democratic practice and plurality are key to social transformation; (c) people working together across lines of difference can transform and improve life for all people; (d) social problems must be addressed on multiple levels (direct service, issue education, policy advocacy) to end social inequities; (e) all people cannot be empowered if we do not address issues of race and racism.
- **People of Color** – 1) Political (not biological) identity of solidarity among and across minoritized ethnic communities historically referred to as ethnic minorities or non-White people. 2) A term used to disrupt the Black/White racial binary in the U.S. 3) A linguistic tool of inclusion and reminder that people of the African diaspora are not the only people who have been racialized or have been impacted by institutional and structural racism; common variations include: people of color, youth of color, students of color, queer or LGBTQ people of color.

Note: The use of this term is not to suggest that all People of Color are the same, or that the term is accepted and used by all. The creation of the People of Color framing came out of political discussions among social activists about how to represent the common needs of various people from minoritized racial/ethnic communities.

- **Xenophobia** - Fear and/or loathing of people who have social group identities or memberships that are different from your own; the “other” or “those people.”

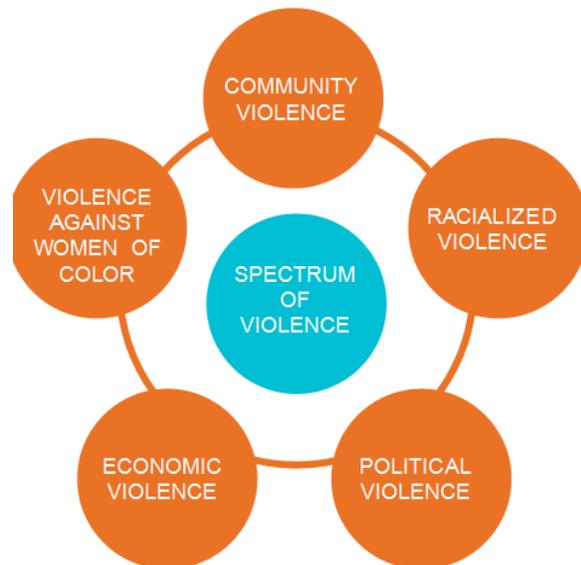
Example: Since Sept. 11, 2001 and the attacks on the World Trade Center and the Pentagon, American people and policy have become explicitly xenophobic. This xenophobia is directed at people who identify as or “appear” to be Muslim. This specific xenophobia is also known as Islamophobia.

SPECTRUM OF VIOLENCE

Spectrum of Violence - See figure below. A model or understanding of violence built upon the assumptions that not all violence is: physical, visible, and/or valued equally. 2) An acknowledgement that there are many types of violence in the world and not all of these types of violence are acknowledged or responded to equally. 3) Beginning with Community Violence, the spectrum, goes clockwise, ordering types of violence from the most “visible” to the least “visible” (noticed in the mainstream). However, each point on the spectrum has “visible” and invisible aspects.

Example: violence against women and girls of color (sex trafficking, murder, sexual assault domestic violence or police brutality receives less attention (invisible) than police violence against men and boys of color (visible).

- **Violence** - 1) A primary tool of oppression. 2) A coercive spectrum of tools used to acquire, build and/or maintain power. 3) A continuum of economic, political, cultural, religious, psychological, and physical resources, behaviors and practices used as vehicles of violence.
- **Community Violence** - A combination of violence directed at communities, such as police violence, war, and colonialism, and violence within communities, such as sexual and domestic violence.
- **Political Violence** – 1) A tool in the spectrum of violence used to exploit the most vulnerable people and communities in our society. 2) The targeted coercive or abusive use of political systems, policies and/or practices in the service of acquiring, maintaining, and/or building power (institutional or structural) for a majoritized community.
- **Economic Violence** – 1) A tool in the spectrum of violence used to exploit the most vulnerable people and communities in our society. 2) The targeted coercive or abusive use of economic systems, policies and/or practices in the service of acquiring, maintaining, and/or building power (institutional or structural) for a majoritized community.



- **Violence against women of color** - A combination of violence directed at women of color or and their communities, such as police violence, war, and colonialism, and violence used within communities against women of color, such as sexual and domestic violence.
- **Hate Crimes** – 1) A form of community violence that targets the most vulnerable populations. 2) Committed when a perpetrator intentionally selects and commits a crime toward someone based on actual or perceived membership in a particular group, usually defined by race, religion, ability, ethnic origin, gender identity or sexual orientation. Current federal laws make it a crime to commit bias-motivated acts against individuals or property. Hate crimes not only cause direct harm to the victim, but have an intimidating and isolating impact on the larger community than targeted originally.

Racialized Violence - 1) A tool in the spectrum of violence used to exploit the most vulnerable people and communities in our society. 2) A form of racialized community violence. 3) Tool of oppression directed against communities of color, such as economic policies, cultural practices, political maneuvers, police brutality, war, criminal justice systems, hate crimes, genocide, and colonialism used in the service of acquiring, building, or maintaining institutional and structural power at the expense of people of color.

- **Microaggressions** - 1) Racial microaggressions are brief and commonplace daily verbal, behavioral, or environmental indignities, whether intentional or unintentional, which communicate hostile, derogatory, or negative racial slights and insults toward people of color. 2) The “normalized” (verbal and non-verbal) violent behaviors that daily challenge the full humanity and dignity of people who are or appear to be members of a minoritized population. Due to their frequency, microaggressions have a cumulative (negative) impact on the psychological, emotional, and/or physical well-being of the recipients of these assaults.





- Racial Profiling** – 1) A form of racialized community violence. 2) Structural and institutional racial xenophobia. 3) Refers to the practice of a law enforcement agent or agency relying, to any degree, on race, ethnicity, religion, national origin in selecting which individuals to subject to routine or investigatory activities such as traffic stops, searches, and seizures. 4) A manifestation of racial prejudice that materializes on institutional and structural levels. 5) The systemic targeting, surveillance, policing, and harassment of people of color that begins with the assumption that people of color are more likely to be criminals. At the community level, the discriminatory practice of racial profiling has emerged as a national concern. African-Americans, Native Americans, Latinos, Asian Americans, and Arab Americans, have reported being unfairly targeted by police who use race, ethnicity, national origin, religion and even gender when choosing which individuals should be subjected to stops, searches,

seizures, and frisks on the streets, during routine traffic stops, at national borders and in airports.

Example: In the aftermath of Sept. 11, law enforcement agents at the federal, state and local levels are permitted to engage in racial profiling to prevent terrorist related activities. Arabs and Muslims, and in many cases, any individual who “appears” to be Arab, Muslim, South Asian or Sikh are vulnerable to unfair treatment at the hands law enforcement who have the dual responsibility to protect communities they work in, while respecting the civil liberties of all those they serve.

- **Human Trafficking** – 1) A form of (targeted) community violence involving kidnapping, forced relocation, and forced labor. 2) The illegal and/or immoral forced relocation of people, typically for the purposes of forced labor and/or commercial sexual exploitation.

Example: a) The kidnapping, transport and selling of African people across the Atlantic Ocean (Trans-Atlantic Slave Trade) to be used as free labor in the “New World.” b) The kidnaping, transport and selling of women and girls across state lines and international borders (often to be used as sex workers); also referred to as sex trafficking.

BIAS, PREJUDICE, STEREOTYPE AND RACISM

- **Bias** - An orientation toward something or someone, this orientation can be positive, negative or neutral; a bias can be informed by a previous experience. In other words, biases can be rational.

Example: Any distrust of the U.S. Government that Native American communities have could be considered a rational bias rather than prejudice because there are actual historical and contemporary reasons for indigenous people not to trust the government: desecration of sacred land, genocide, forced relocation, biological warfare, and broken treaties to name a few.

- **Prejudice** - An assumption of knowledge about something or someone not rooted in personal experiences with the particular something or someone in question; prejudice is informed by stereotype rather than experience.

Example: A White woman clutching her purse when a person of color gets on the elevator with her could be bias but given the prevalence of racism in US culture is more than likely prejudice.

- **Stereotype** – 1) A trait and/or characteristic assumed to be true of all members of a particular social group. Many American cultural practices and public policies are rooted in racial, gendered and class based stereotypes such as Asians are the model minority; meaning submissive, assimilating, and accommodating (e.g., honorary White people). 2) Stereotypes focus on one aspect of a person’s identity to the exclusion of their full humanity.

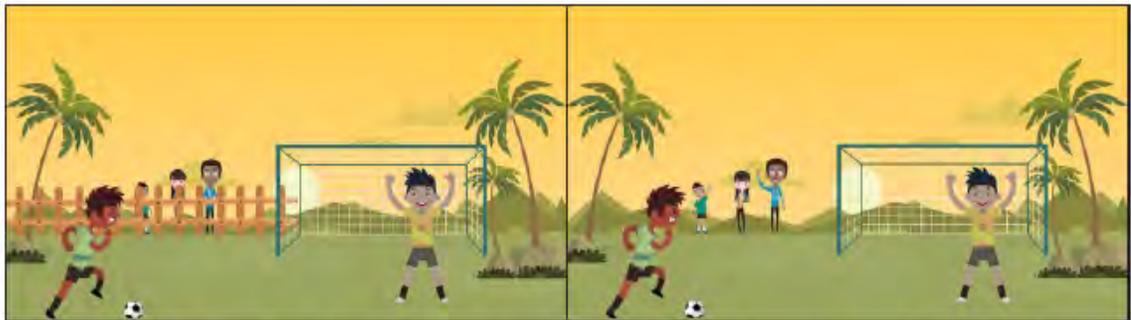
Racism – 1) A form of racialized community violence (economic, political, cultural, and/or physical) that targets or has disproportionate negative impact upon people of color (POC). 2) When one's use of institutional or structural power is premised upon racial stereotype/prejudice or when one's use of institutional/structural power creates, maintains or reinforces policies and practices that further racial inequity. 3. Racial prejudice/stereotypes are symptoms of racism, not racism itself. 4) "Not liking" someone because of their race is a form of bias or prejudice which can exist solely on an individual basis but racism exists on institutional and structural levels. 5) Institutional/ structural power + racial bias/prejudice/stereotype = Racism; 6) Institutional/ structural policies and practices + disproportionate negative impact on POC = Racism.

- **Reverse Racism** - If we apply a power analysis, then reverse racism is not possible because people of color do not have enough institutional and structural power to be racist; though they can be biased or prejudiced. The same is true of "reverse sexism." Despite any bias or prejudices that women may have, they do not have enough institutional/structural power to "oppress" men.
- **Islamophobia** - A form of racism rooted in stereotypes that label all Muslim or Muslim "appearing" people as "terrorist." This form of racism manifests itself in hate crimes, federal actions such as the "Patriot Act" and increased surveillance or racial profiling of Muslims, Arab-Americans or anyone who "appears" to be either.

Example: Post- Sept. 11, islamophobia has been linked to an increase in targeted violence (hate crimes) against Sikhs, who many mistakenly interpret to be Muslim due to their traditional religious garb.

DIVERSITY, EQUITY & INCLUSION

- **Diversity** - A variety of things. Recognition of difference alone does not equal justice or inclusion. A diversity focus emphasizes "how many of these" we have in the room, organization, etc. Diversity programs and cultural celebrations/education programs are not equivalent to doing racial justice. It is possible to name, acknowledge, and celebrate diverse cultures without doing anything to transform the institutional or structural systems that produce, and maintain racialized injustices in our communities.
- **Equality** - To treat everyone exactly the same. An equality emphasis often ignores historical and structural factors that benefit some social groups/ communities and harms other social groups/communities. Often as a response to racism, people will claim a "colorblind" orientation or seek to create "colorblind" policies that will treat all people equally. However, "colorblindness" often leads to inequity because it does not acknowledge the historical and contemporary systemic forces of oppression that do not allow all of us to be our full selves equally.
- **Equity** - To treat everyone fairly. An equity emphasis seeks to render justice by deeply considering structural factors that benefit some social groups/communities and harms other social groups/communities. Sometimes justice demands, for the purpose of equity, an unequal response.



EQUALITY: The assumption that equal treatment benefits everyone equally. In this case the fence only allows one spectator to clearly see the game.

EQUITY: All three can see the game without supports or accommodations because the cause of the inequity was addressed. The **systemic** barrier has been removed.

- **Inclusion** – 1) An intentional effort to transform the status quo by creating opportunity for those who have been historically marginalized. 2) An inclusion focus emphasizes outcomes of diversity rather than assuming that increasing the amount of explicit diversity of people automatically creates equity in access/opportunity, or an enhanced organizational climate. 3) Begins with the needs, wants, and quality of life of the historically Minoritized population rather than the historically privileged.
- **Social Justice** – 1) An anti-oppression orientation to social and political organization. 2) The process and goal of addressing the root causes of institutional and structural “isms.” 3) A vision of the world where all groups of people can live (and be perceived) as fully human on all levels (personal, social, institutional, and structural). 4. A vision of the world not rooted in the dominance of any one group over all others. Such a vision would include recognizing the inherent worth and connectedness of all people, animals, plants, and all other resources of our planet and universe. Additionally, this vision of the world would not be rooted in a scarcity model that devalues things that are abundant (many can have access to or can acquire) and highly values that which is scarce or rare (very few can have access to or acquire).

Inclusive Organization - An organization that proactively enlists intentional strategies to remove barriers to access, participation and success of those who were historically or are currently systematically excluded by or marginalized within the organization. 2) An organization that actively seeks the transformation of its organizational policies and practices, to foster the involvement and success of those who have been excluded or marginalized.

- **Continuum of Response to Social Injustice** – 1) A multipronged or holistic response to addressing social injustices. 2) A belief that social transformation requires a spectrum of responses from meeting immediate needs (via direct service provision) to transforming institutional and structural policies and practices (via public policy advocacy). 3) The Orange County Government continuum of response includes: direct services, issue education and advocacy.

- a. **Direct Service** - The highest priority in the continuum where you help individuals navigate a current crisis situation. This is the most immediate form of response to a social injustice. Direct service may also include skill or capacity development opportunities that are longer term rather than immediate such as leadership development or enhanced vocational skills.
- b. **Issue Education** - To supply people with information or educational materials or other opportunities to learn more about a social justice topic or issue.
- c. **Advocacy** - To work on behalf of those most negatively affected by a specific policy or practice. Those who are being advocated for may not have any idea that this action is taking place.

CULTURE, ETHNICITY & RACE

- **Culture** - A shared way of life among a social group. This shared way of life includes commonalities in: geography, language, history, traditions, rituals, belief systems, etc.
- **Ethnicity** - 1) Membership in a particular cultural group. 2) Often confused with race; ethnic groups are self-formed and identified whereas racial groupings were created by a single group and imposed on everyone else.

Example: U.S. indigenous people are often referred to collectively as Indians, American Indians or Native Americans, however, the indigenous people of North America exist as many separate nations and ethnic groups that have different languages, histories and cultural practices.

- **Social Construction** - An unreal “real” thing. Social constructions are not “natural”; they do not exist outside of language and human imagination; in this sense they are unreal. However, our way of life is built upon the belief in or dedication to socially constructed categories such as “race.” As such, though “unreal” social constructions have real world consequences for all of us. The movie “The Matrix” is often used to teach people how social constructions work.

VARIATIONS ON RACE & RACISM

- **Racialization** – 1) The ongoing process by which we all are shaped by racial grouping or “racialized” by structural policies/practices, institutional/organizational cultures, and interpersonal interactions. 2) Our daily experiences of being “raced” or “racialized.” 3) An acknowledgment that these daily experiences look and are experienced differently across various communities and category of identity.
- **Post- Racial** – 1) A belief that we as a society have moved beyond race; that race and racism are no longer relevant because as a society we have addressed all of the racialized barriers to full and equal participation in American society. 2) The election of

Barack Obama as President of the United States marks for many the moment America became a post-racial society.

- **Racial Justice** – 1) A social justice orientation with a focus on dismantling the root causes of racism (institutional and structural policies and practices) rather than merely the symptoms of racism (racial bias, racial prejudice, racial stereotypes). 2) Requires a focus on and commitment to the communities most directly negatively impacted by racism.
- **Racial Binary** - The Western/U.S. tendency to only think and talk about race and racism in terms of Black and White people; thus making invisible the racialization of other people of color including bi/multiracial and bi/multiethnic people.
- **Multiracial/Multiethnic** – 1) Of or pertaining to two or more racial/ethnic identities. 2) An identity category growing in usage and popularity by those who understand their racial/ethnic identity and heritage to be rooted in more than one racial/ethnic tradition. 3. Made up of, involving or acting in the interest of more than one racial/ethnic group.

Race – 1) A social rather than biological construction. 2) A theoretical invention of a European scientist used to separate and rank human beings into three distinct biological categories: Caucasoid (European), Negroid (African) and Mongoloid (Asian). According to this “science” these three species of humans evolved completely separate from one another with no common ancestors. The science of race proclaimed that White/ Europeans (Caucasoid) are the most evolved of the three human species and Black/Africans are the least evolved. 3) The term race as applied to humans was invented as equivalent to the term species used to reference (non-human) animals and plants. 4) An umbrella term used to minimize ethnic variety and emphasize broader group identity markers most often rooted in appearance, skin tone, and ancestral homelands or origins.

Example: The racialized term Asian includes numerous ethnic groups and nationalities such as Hmong, Korean, Pilipino, Taiwanese, Laotian, Vietnamese, Chinese and Japanese. Despite the fact that some of these nations and people were colonizers and other were colonized, the concept of “race” draws our focus to similarities of these diverse groups of people rather than the many ethnic/cultural differences among the group.

Appendix I: References

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