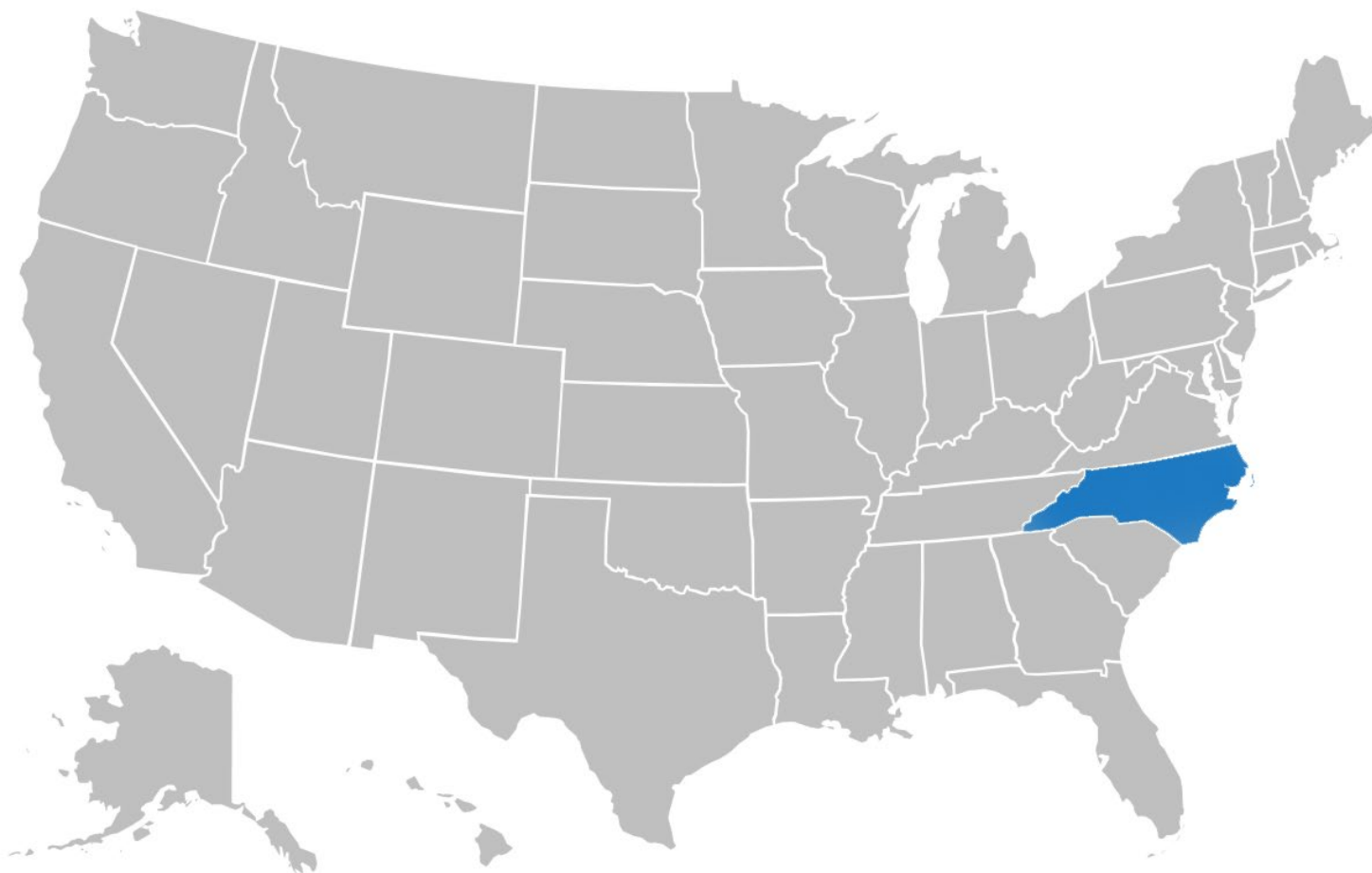


County Health Rankings & Roadmaps

Building a Culture of Health, County by County

2022 State Report

North Carolina



2022 County Health Rankings for the 100 Ranked Counties in North Carolina

County	Health Outcomes	Health Factors	County	Health Outcomes	Health Factors	County	Health Outcomes	Health Factors	County	Health Outcomes	Health Factors
Alamance	37	51	Cumberland	52	70	Johnston	20	27	Randolph	65	65
Alexander	39	55	Currituck	9	17	Jones	70	77	Richmond	93	94
Alleghany	63	78	Dare	4	10	Lee	56	53	Robeson	100	100
Anson	94	93	Davidson	54	59	Lenoir	90	82	Rockingham	81	73
Ashe	27	30	Davie	21	20	Lincoln	22	22	Rowan	61	62
Avery	32	39	Duplin	75	74	Macon	25	28	Rutherford	66	68
Beaufort	80	54	Durham	7	9	Madison	40	33	Sampson	62	76
Bertie	89	84	Edgecombe	99	98	Martin	88	72	Scotland	98	99
Bladen	85	89	Forsyth	33	29	McDowell	46	42	Stanly	53	46
Brunswick	26	24	Franklin	35	43	Mecklenburg	6	14	Stokes	43	58
Buncombe	19	8	Gaston	50	52	Mitchell	51	36	Surry	47	67
Burke	49	61	Gates	78	40	Montgomery	77	69	Swain	96	85
Cabarrus	10	12	Graham	71	80	Moore	17	6	Transylvania	18	16
Caldwell	68	63	Granville	34	34	Nash	64	66	Tyrrell	16	91
Camden	5	15	Greene	59	88	New Hanover	14	7	Union	3	5
Carteret	28	18	Guilford	31	31	Northampton	86	86	Vance	95	96
Caswell	76	79	Halifax	97	97	Onslow	23	26	Wake	1	2
Catawba	30	32	Harnett	36	50	Orange	2	1	Warren	92	95
Chatham	11	3	Haywood	42	25	Pamlico	79	37	Washington	87	90
Cherokee	73	56	Henderson	12	11	Pasquotank	55	57	Watauga	8	4
Chowan	67	64	Hertford	84	75	Pender	29	23	Wayne	74	60
Clay	38	38	Hoke	57	81	Perquimans	48	47	Wilkes	72	48
Cleveland	83	71	Hyde	60	83	Person	58	44	Wilson	82	87
Columbus	91	92	Iredell	15	19	Pitt	44	35	Yadkin	69	49
Craven	45	21	Jackson	41	45	Polk	13	13	Yancey	24	41

For more information on how these ranks are calculated, view the technical notes at the end of this report and visit www.countyhealthrankings.org

County Health Rankings & Roadmaps (CHR&R) brings actionable data, evidence, guidance, and stories to diverse leaders and residents so people and communities can be healthier. The University of Wisconsin Population Health Institute created CHR&R for communities across the nation, with funding from the Robert Wood Johnson Foundation.

What are the County Health Rankings?

The Rankings help us understand what influences how long and how well we live. They provide measures of the *current* overall health (health outcomes) of each county in all 50 states and the District of Columbia. Rankings data include a variety of measures, such as high school graduation rates, access to nutritious foods, and the percent of children living in poverty, all of which impact the *future* health of communities (health factors).



We believe in a future where everyone has opportunities to be healthy and to thrive. Many factors impact how long and how well we live. Our data show how these factors shape community conditions, while highlighting the stark differences in health that stem from injustices and barriers to opportunity. Use our resources to take action toward better health for all.

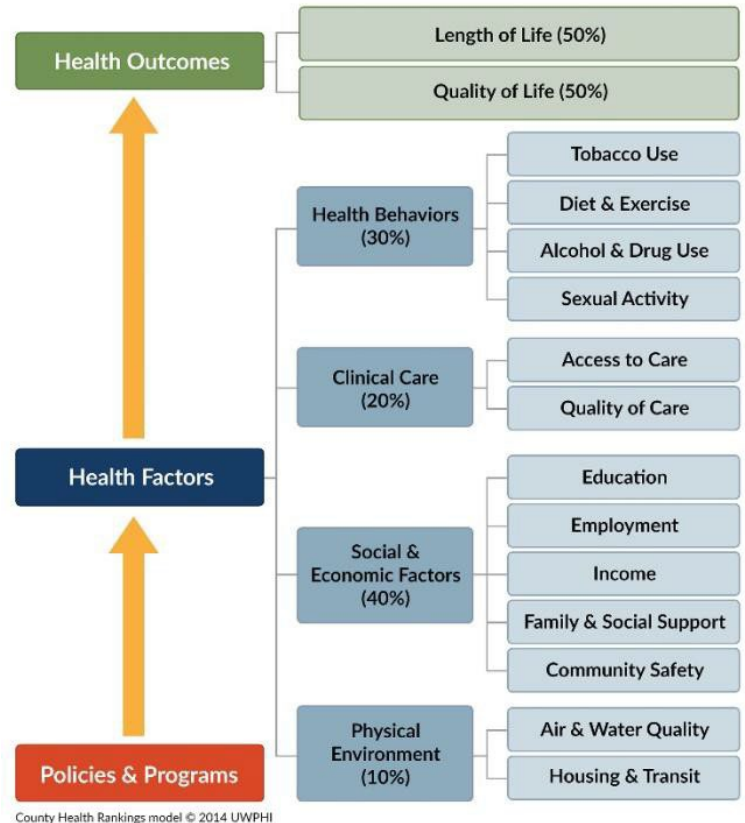
Communities use the Rankings to build support for local health improvement initiatives by engaging many sectors including public health, health care, business, policymakers, and local residents.

The County Health Rankings Model

The County Health Rankings Model illustrates a broad vision for health. The model shows that policies and programs at the local, state, and federal levels play an important role in shaping health factors that in turn, influence a community's health outcomes.

Health factors represent things that, if modified, can improve length and quality of life. They are predictors of how healthy our communities can be in the future. The four health factor areas in the model include Health Behaviors, Clinical Care, Social & Economic Factors, and Physical Environment.

Health outcomes represent how healthy a county is right now. They reflect the physical and mental well-being of residents through measures representing the length and quality of life typically experienced in the community.



Growing Healthy Places Means Ensuring Opportunities for All

Communities thrive when all people can be healthy in their neighborhoods, schools, and workplaces. CHR&R brings actionable data and strategies to communities working to ensure that healthy places are available to all. Pages 5 and 6 of this report highlight how health outcomes and health factors differ by place within North Carolina. On page 7, we outline how economic security – or the ability of individuals, households, and communities to meet basic needs with dignity – is important to health. We call attention to childcare cost burden as a barrier to economic security and health.



Growing Community Power to Improve Health Equity

The [Take Action to Improve Health](#) section of the CHR&R website helps communities find tools and guidance to take action, select evidence-informed strategies, and make lasting changes. Take Action to Improve Health is a hub for information to help improve a community's health and foster health equity. Find resources including:

- [What Works for Health](#), a searchable menu of evidence-informed strategies.
- [Action Learning Guides](#), self-directed learning modules that combine guidance, tools, and reflection activities.

Using Data to Improve Health Equity

Data show a persistent pattern across the country in barriers to opportunity for people with lower incomes and for people of color. Differences in the opportunities available to different groups of people are related to unfair policies and practices.

Our progress toward health equity will be measured by how health disparities change over time. Visit www.countyhealthrankings.org to learn more about:

1. Health outcome and factor measures for your state and county.
2. Measures with data available by race and ethnicity to illuminate differences in opportunities for health.
3. Additional data resources for North Carolina that provide information about health and opportunity by age group, gender, and zip code.

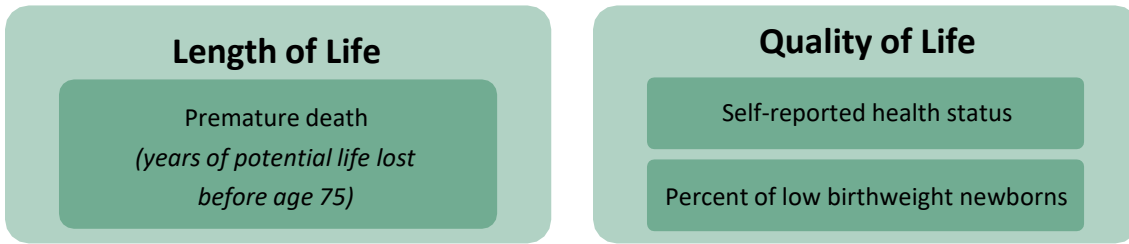
What Has Been Done Can Be Undone

Achieving health equity means eliminating unjust and avoidable differences in access and opportunity. What can communities do to tackle unfair differences in how long and how well people live? Check out new strategies at [What Works for Health](#) that can address past harms and create conditions for thriving communities for everyone.

Many communities are mobilizing to harness the collective power of residents, organizations, and policymakers. They are working together to address past and present policies that cause harm and are ensuring the growth of healthy places for all. To learn about these efforts, visit countyhealthrankings.org.

What are Health Outcomes?

We measure length and quality of life to understand the health outcomes among counties in North Carolina.



How Do Counties Rank for Health Outcomes?

The green map shows North Carolina’s **health outcome rankings** by county. The map is divided into four quartiles with less color intensity indicating better health outcomes. Specific county ranks can be found in the table on page 2.

Detailed information on the measures and their associated weights is available toward the end of this report. Learn about how we calculate health outcome ranks at www.countyhealthrankings.org.

What Do Differences Between Ranks Mean?

Counties are ordered by the health outcome rank, with a top-ranked county (rank = 1) having the best health outcome score. Ranks are good for sparking conversations, but they do not show differences in health within counties or describe the magnitude of difference in community health experienced between ranks. The chart next to the map shows the spread of health outcome scores (ranks) for each county (green circles) in North Carolina. This graphic shows the size of the gaps *between* ranked counties. The background colors correspond to the map legend.

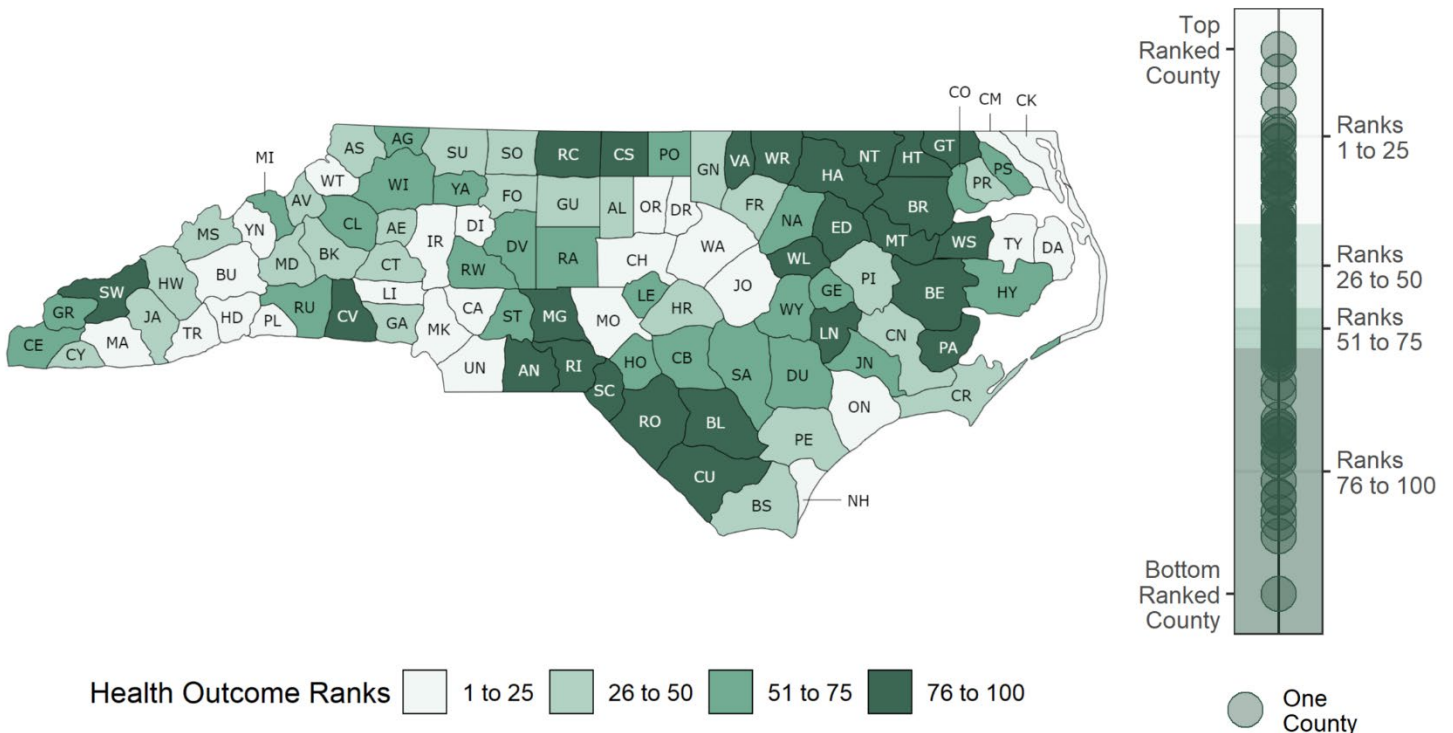
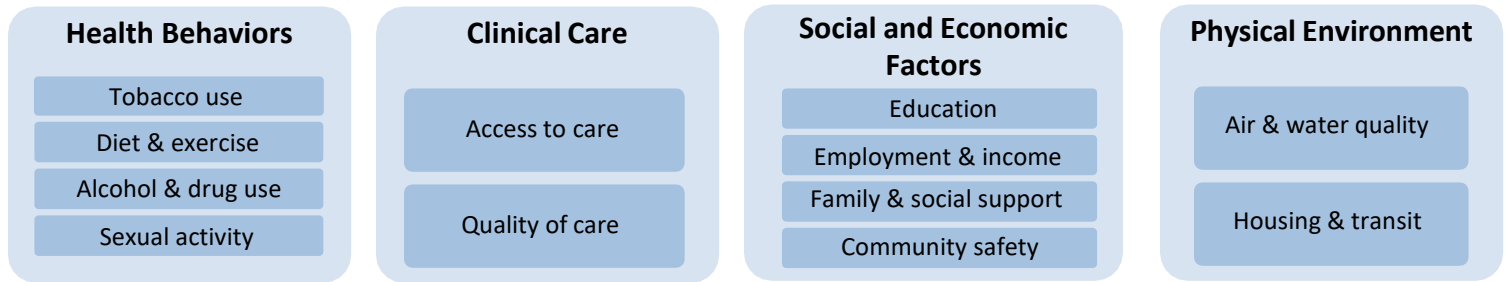


Figure 1. Health outcome ranks displayed using quartiles (map) and underlying health outcome scores (chart)

What are Health Factors?

Health factors represent community conditions that we can change to improve health and opportunity, such as access to quality education, living wage jobs, quality clinical care, nutritious foods, green spaces, and secure and affordable housing. We measure four health factor areas.



How Do Counties Rank for Health Factors?

The blue map shows North Carolina’s **health factor rankings** by county. The map is divided into four quartiles with less color intensity indicating better health factors. Specific county ranks can be found in the table on page 2.

Detailed information on the measures and their associated weights is available toward the end of this report. You can also learn about how we calculate health factor ranks at www.countyhealthrankings.org.

What Do Differences Between Ranks Mean?

Counties are ordered by the health factor rank, with a top-ranked county (rank = 1) having the best health factor score. The chart next to the map shows the spread of health factor scores (ranks) for each ranked county (blue circles) in North Carolina. This graphic shows the size of the gaps *between* ranked counties. The background colors correspond to the map legend.

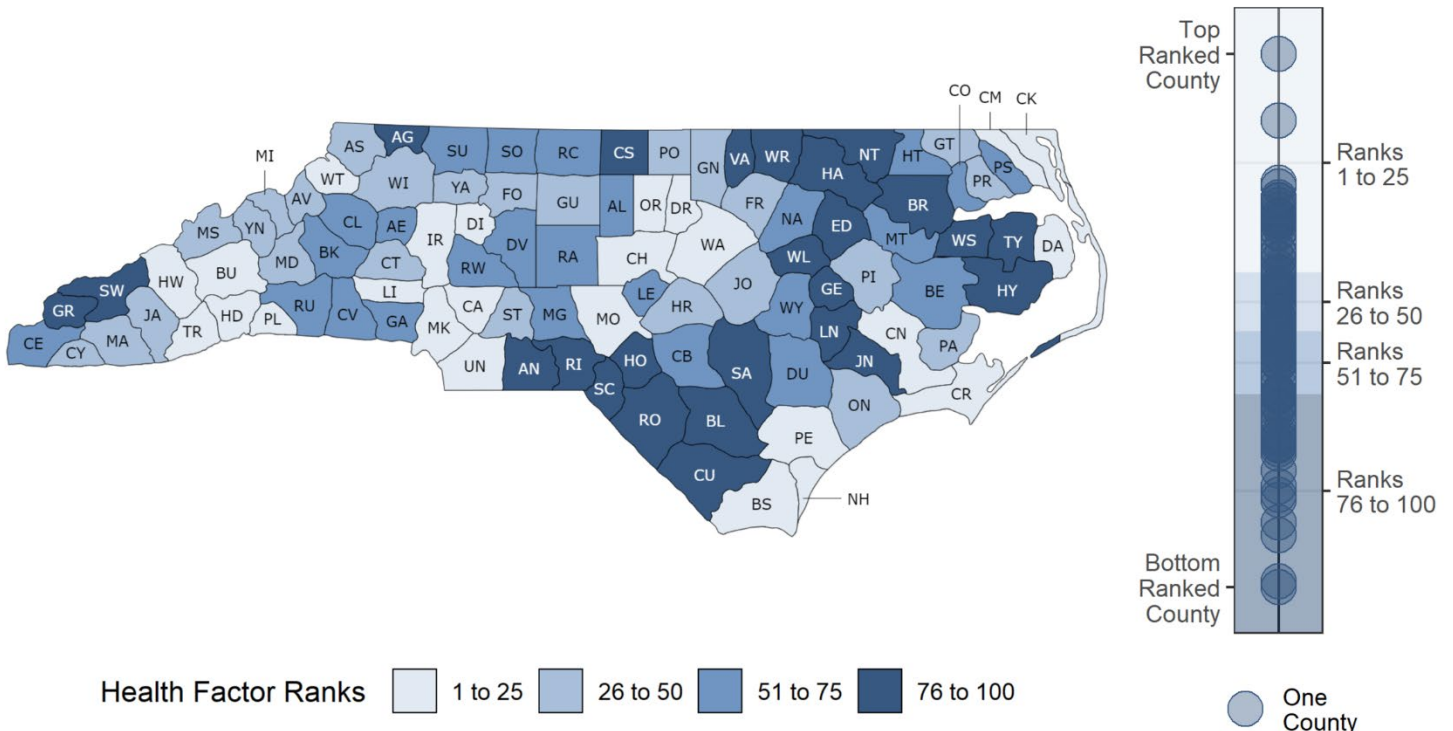


Figure 2. Health factor ranks displayed using quartiles (map) and underlying health factor scores (chart)

Economic Security is Key to Thriving Communities

Economic security enables families to cover basic needs such as housing, education, childcare, food, and medical care. Each of these needs has demonstrated ties to health. However, economic security is not equally accessible to all people. When a single household expense consumes the majority of a paycheck, it becomes difficult to meet competing needs and can force households into tough decisions like choosing between quality childcare, paying rent, and purchasing nutritious food. Individuals, households, and communities deserve the opportunity to meet basic needs with dignity. Advancing a just recovery from the COVID-19 pandemic, and the layered impacts of racism and economic exclusion requires intentional action to ensure all people and places have what they need to thrive. Check out policies and programs that can be implemented in your community at [What Works for Health](#).

Childcare Cost Burden in North Carolina and the U.S.

Childcare cost burden measures the percentage of household income needed to pay for childcare. When childcare is affordable and accessible, it can support parents' and guardians' ability to participate in paid work and can provide lifelong benefits to children. The U.S. Department of Health and Human Services' benchmark suggests childcare is no longer affordable if it exceeds 7% of a household's income. This measure of childcare cost burden reflects the experience of a household with two children.

Childcare Cost Burden in North Carolina Counties

The childcare cost burden among counties in North Carolina ranges from 18% to 61%.

In Context

- Similar levels of childcare cost burden exist across all levels of urbanization.
- Median household income varies by race and ethnicity across North Carolina counties ranging between \$39,857 for American Indian & Alaska Native households to \$89,314 for Asian households. These income disparities demonstrate how economic security is not equally accessible to all people living in North Carolina.

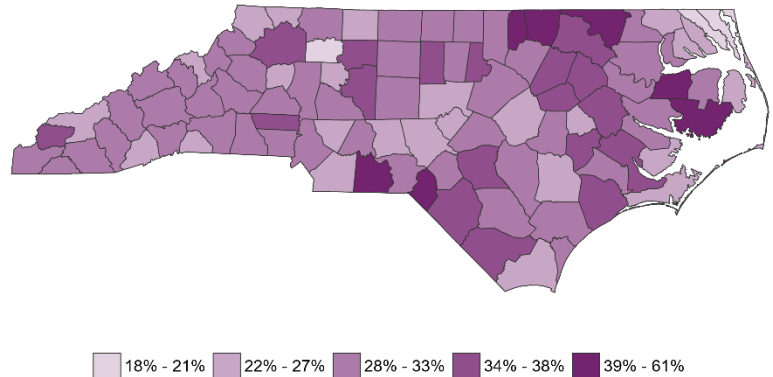


Figure 3. Childcare cost burden in North Carolina by county

Childcare Cost Burden Across the U.S.

The typical cost burden of childcare among counties in the U.S. is about 25% of household income – meaning a quarter of every dollar earned goes to paying for childcare. Families in every state experience a childcare cost higher than the 7% federal benchmark of affordability. The childcare cost burden in North Carolina is 29%.

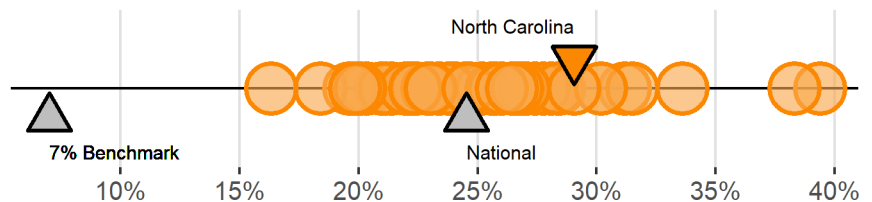


Figure 4. Childcare cost burden in the U.S. by state

Want to learn more? Visit our [State Reports page at www.countyhealthrankings.org](http://www.countyhealthrankings.org) to interact with the data.

2022 County Health Rankings: National and North Carolina State Values for Ranked Measures

Measure	Description	US	NC	NC Minimum	NC Maximum
HEALTH OUTCOMES					
Premature death*	Years of potential life lost before age 75 per 100,000 population (age-adjusted).	7,300	8,000	4,800	14,900
Poor or fair health	Percentage of adults reporting fair or poor health (age-adjusted).	17%	18%	14%	32%
Poor physical health days	Average number of physically unhealthy days reported in past 30 days (age-adjusted).	3.9	3.7	3.1	5.7
Poor mental health days	Average number of mentally unhealthy days reported in past 30 days (age-adjusted).	4.5	4.4	3.8	5.7
Low birthweight*	Percentage of live births with low birthweight (< 2,500 grams).	8%	9%	5%	14%
HEALTH FACTORS					
HEALTH BEHAVIORS					
Adult smoking	Percentage of adults who are current smokers (age-adjusted).	16%	19%	13%	29%
Adult obesity	Percentage of the adult population (age 18 and older) that reports a body mass index (BMI) greater than or equal to 30 kg/m ² (age-adjusted).	32%	34%	28%	44%
Food environment index	Index of factors that contribute to a healthy food environment, from 0 (worst) to 10 (best).	7.8	6.6	4.1	8.5
Physical inactivity	Percentage of adults age 18 and over reporting no leisure-time physical activity (age-adjusted).	26%	26%	20%	36%
Access to exercise opportunities	Percentage of population with adequate access to locations for physical activity.	80%	68%	11%	100%
Excessive drinking	Percentage of adults reporting binge or heavy drinking (age-adjusted).	20%	17%	14%	21%
Alcohol-impaired driving deaths	Percentage of driving deaths with alcohol involvement.	27%	26%	0%	42%
Sexually transmitted infections	Number of newly diagnosed chlamydia cases per 100,000 population.	551.0	669.9	102.9	1,292.7
Teen births*	Number of births per 1,000 female population ages 15-19.	19	21	4	47
CLINICAL CARE					
Uninsured	Percentage of population under age 65 without health insurance.	11%	13%	10%	22%
Primary care physicians	Ratio of population to primary care physicians.	1,310:1	1,400:1	19,730:1	530:1
Dentists	Ratio of population to dentists.	1,400:1	1,710:1	3,770:0	440:1
Mental health providers	Ratio of population to mental health providers.	350:1	360:1	11,460:1	140:1
Preventable hospital stays*	Rate of hospital stays for ambulatory-care sensitive conditions per 100,000 Medicare enrollees.	3,767	4,096	1,745	7,296
Mammography screening*	Percentage of female Medicare enrollees ages 65-74 that received an annual mammography screening.	43%	48%	24%	61%
Flu vaccinations*	Percentage of fee-for-service (FFS) Medicare enrollees that had an annual flu vaccination.	48%	53%	35%	62%
SOCIAL & ECONOMIC FACTORS					
High school completion	Percentage of adults ages 25 and over with a high school diploma or equivalent.	89%	89%	76%	94%
Some college	Percentage of adults ages 25-44 with some post-secondary education.	67%	68%	29%	85%
Unemployment	Percentage of population ages 16 and older unemployed but seeking work.	8.1%	7.3%	5.4%	12.0%
Children in poverty*	Percentage of people under age 18 in poverty.	16%	18%	8%	46%
Income inequality	Ratio of household income at the 80th percentile to income at the 20th percentile.	4.9	4.7	3.3	6.3
Children in single-parent households	Percentage of children that live in a household headed by a single parent.	25%	27%	10%	56%
Social associations	Number of membership associations per 10,000 population.	9.2	11.3	5.6	26.4
Violent crime	Number of reported violent crime offenses per 100,000 population.	386	351	33	753
Injury deaths*	Number of deaths due to injury per 100,000 population.	76	82	48	131
PHYSICAL ENVIRONMENT					
Air pollution - particulate matter	Average daily density of fine particulate matter in micrograms per cubic meter (PM2.5).	7.5	7.5	3.5	10.0
Drinking water violations*	Indicator of the presence of health-related drinking water violations. 'Yes' indicates the presence of a violation, 'No' indicates no violation.	N/A	N/A	N/A	N/A
Severe housing problems	Percentage of households with at least 1 of 4 housing problems: overcrowding, high housing costs, lack of kitchen facilities, or lack of plumbing facilities.	17%	15%	8%	22%
Driving alone to work*	Percentage of the workforce that drives alone to work.	75%	79%	65%	89%
Long commute - driving alone	Among workers who commute in their car alone, the percentage that commute more than 30 minutes.	37%	34%	17%	60%

*Indicates subgroup data by race and ethnicity is available; *Not available in all states

2022 County Health Rankings: Ranked Measure Sources and Years of Data

	Measure	Weight	Source	Years of Data
HEALTH OUTCOMES				
Length of Life	Premature death*	50%	National Center for Health Statistics - Mortality Files	2018-2020
Quality of Life	Poor or fair health [†]	10%	Behavioral Risk Factor Surveillance System	2019
	Poor physical health days [†]	10%	Behavioral Risk Factor Surveillance System	2019
	Poor mental health days [†]	10%	Behavioral Risk Factor Surveillance System	2019
	Low birthweight*	20%	National Center for Health Statistics - Natality files	2014-2020
HEALTH FACTORS				
HEALTH BEHAVIORS				
Tobacco Use	Adult smoking [†]	10%	Behavioral Risk Factor Surveillance System	2019
Diet and Exercise	Adult obesity [†]	5%	Behavioral Risk Factor Surveillance System	2019
	Food environment index	2%	USDA Food Environment Atlas, Map the Meal Gap from Feeding America	2019
	Physical inactivity [†]	2%	Behavioral Risk Factor Surveillance System	2019
	Access to exercise opportunities	1%	Business Analyst, ESRI, YMCA & US Census Tigerline Files	2010 & 2021
Alcohol and Drug Use	Excessive drinking [†]	2.5%	Behavioral Risk Factor Surveillance System	2019
	Alcohol-impaired driving deaths	2.5%	Fatality Analysis Reporting System	2016-2020
Sexual Activity	Sexually transmitted infections	2.5%	National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention	2019
	Teen births*	2.5%	National Center for Health Statistics - Natality files	2014-2020
CLINICAL CARE				
Access to Care	Uninsured	5%	Small Area Health Insurance Estimates	2019
	Primary care physicians	3%	Area Health Resource File/American Medical Association	2019
	Dentists	1%	Area Health Resource File/National Provider Identification file	2020
	Mental health providers	1%	CMS, National Provider Identification	2021
Quality of Care	Preventable hospital stays*	5%	Mapping Medicare Disparities Tool	2019
	Mammography screening*	2.5%	Mapping Medicare Disparities Tool	2019
	Flu vaccinations*	2.5%	Mapping Medicare Disparities Tool	2019
SOCIAL & ECONOMIC FACTORS				
Education	High school completion	5%	American Community Survey, 5-year estimates	2016-2020
	Some college	5%	American Community Survey, 5-year estimates	2016-2020
Employment	Unemployment	10%	Bureau of Labor Statistics	2020
Income	Children in poverty*	7.5%	Small Area Income and Poverty Estimates	2020
	Income inequality	2.5%	American Community Survey, 5-year estimates	2016-2020
Family and Social Support	Children in single-parent households	2.5%	American Community Survey, 5-year estimates	2016-2020
	Social associations	2.5%	County Business Patterns	2019
Community Safety	Violent crime	2.5%	Uniform Crime Reporting - FBI	2014 & 2016
	Injury deaths*	2.5%	National Center for Health Statistics - Mortality Files	2016-2020
PHYSICAL ENVIRONMENT				
Air and Water Quality	Air pollution - particulate matter	2.5%	Environmental Public Health Tracking Network	2018
	Drinking water violations [‡]	2.5%	Safe Drinking Water Information System	2020
Housing and Transit	Severe housing problems	2%	Comprehensive Housing Affordability Strategy (CHAS) data	2014-2018
	Driving alone to work*	2%	American Community Survey, 5-year estimates	2016-2020
	Long commute - driving alone	1%	American Community Survey, 5-year estimates	2016-2020

*Indicates subgroup data by race and ethnicity is available; *Not available in all states; [†]2018 data for New Jersey.

2022 County Health Rankings: Additional Measure Sources and Years of Data

	Measure	Source	Years of Data
HEALTH OUTCOMES			
Length of Life	COVID-19 age-adjusted mortality	National Center for Health Statistics - Mortality Files	2020
	Life expectancy*	National Center for Health Statistics - Mortality Files	2018-2020
	Premature age-adjusted mortality*	National Center for Health Statistics - Mortality Files	2018-2020
	Child mortality*	National Center for Health Statistics - Mortality Files	2017-2020
	Infant mortality*	National Center for Health Statistics - Mortality Files	2014-2020
Quality of Life	Frequent physical distress [†]	Behavioral Risk Factor Surveillance System	2019
	Frequent mental distress [†]	Behavioral Risk Factor Surveillance System	2019
	Diabetes prevalence [‡]	Behavioral Risk Factor Surveillance System	2019
	HIV prevalence [‡]	National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention	2019
HEALTH FACTORS			
HEALTH BEHAVIORS			
Diet and Exercise	Food insecurity	Map the Meal Gap	2019
	Limited access to healthy foods	USDA Food Environment Atlas	2019
Alcohol and Drug Use	Drug overdose deaths*	National Center for Health Statistics - Mortality Files	2018-2020
	Motor vehicle crash deaths*	National Center for Health Statistics - Mortality Files	2014-2020
Other Health Behaviors	Insufficient sleep	Behavioral Risk Factor Surveillance System	2018
CLINICAL CARE			
Access to Care	Uninsured adults	Small Area Health Insurance Estimates	2019
	Uninsured children	Small Area Health Insurance Estimates	2019
	Other primary care providers	CMS, National Provider Identification	2021
SOCIAL & ECONOMIC FACTORS			
Education	High school graduation [‡]	EDFacts	2018-2019
	Disconnected youth	American Community Survey, 5-year estimates	2016-2020
	Reading scores**	Stanford Education Data Archive	2018
	Math scores**	Stanford Education Data Archive	2018
	School segregation	National Center for Education Statistics	2020-2021
	School funding adequacy [‡]	School Finance Indicators Database	2019
Income	Gender pay gap	American Community Survey, 5-year estimates	2016-2020
	Median household income*	Small Area Income and Poverty Estimates	2020
	Living wage	The Living Wage Calculator	2021
	Children eligible for free or reduced price lunch [‡]	National Center for Education Statistics	2019-2020
Family and Social Support	Residential segregation - Black/White	American Community Survey, 5-year estimates	2016-2020
	Residential segregation - non-White/White	American Community Survey, 5-year estimates	2016-2020
	Childcare cost burden	The Living Wage Calculator, Small Area Income and Poverty Estimates	2021 & 2020
	Childcare centers	Homeland Infrastructure Foundation-Level Data (HIFLD)	2021
Community Safety	Homicides*	National Center for Health Statistics - Mortality Files	2014-2020
	Suicides*	National Center for Health Statistics - Mortality Files	2016-2020
	Firearm fatalities*	National Center for Health Statistics - Mortality Files	2016-2020
	Juvenile arrests [‡]	Easy Access to State and County Juvenile Court Case Counts	2019
PHYSICAL ENVIRONMENT			
Housing and Transit	Traffic volume	EJSCREEN: Environmental Justice Screening and Mapping Tool	2019
	Homeownership	American Community Survey, 5-year estimates	2016-2020
	Severe housing cost burden	American Community Survey, 5-year estimates	2016-2020
	Broadband access	American Community Survey, 5-year estimates	2016-2020

*Indicates subgroup data by race and ethnicity is available; *Not available in all states; [‡]2018 data for New Jersey.

See additional contextual demographic information and measures online at www.countyhealthrankings.org

Glossary of Terms, Technical Notes, and FAQs

Glossary of Terms

Health equity: Assurance of conditions for optimal health for all people. Achieving health equity requires valuing all individuals and populations equally, recognizing and rectifying historical injustice, and providing resources according to need.

Health inequity: Differences in health factors or outcomes that are systematic, avoidable, unnecessary, unfair, and unjust.

Health disparities: The numerical or statistical differences in health outcomes, such as mortality rate differences. Reducing and ultimately eliminating disparities in health and its determinants of health is how we measure progress toward health equity.

Technical Notes

- Figures 1 and 2 depict each county as a single, semi-transparent circle. Counties with very similar values are displayed as overlapping circles having greater color saturation. Similarly, circles representing states may be overlapping in Figure 4.
- The state and national values for childcare cost burden represent the median of counties within the state and nation, respectively.

FAQs

How does CHR&R select evidence-informed solutions?

Evidence-informed solutions are supported by robust studies or reflect recommendations made by experts. To learn more about our evidence analysis methods, visit [What Works for Health](#).

How does CHR&R rank counties?

To calculate the ranks, we first standardize each of the measures using z-scores. Z-scores allow us to combine multiple measures because the measures are now on the same scale. The ranks are then calculated based on weighted sums of the measure z-scores within each state to create an aggregate z-score. The county with the best aggregate z-score (healthiest) gets a rank of #1 for that state. The aggregate z-scores are graphed next to the maps for health outcomes and health factors on pages 5 and 6 to show the distribution of the values that contribute to the rank. To see more detailed information on rank calculations please visit Our Methods section in **Explore Health Rankings** at: countyhealthrankings.org.

How did the 7% benchmark for childcare affordability originate?

The Department of Health and Human Services published a 2016 update to rules and regulations for the Child Care and Development Fund (CCDF) program, which helps cover childcare costs for children from low-income households. The updated rules established a federal benchmark for an enrolled family's childcare co-payments not to be considered affordable if costs exceed 7% of household income. The benchmark has since been applied outside of the context of the CCDF program to indicate that low- and middle-income families should not spend more than 7% of their income on childcare for it to be considered affordable.

How does CHR&R define county levels of urbanization?

We define levels of urbanization as: Rural (non-metropolitan counties with less than 50,000 people); Smaller Metro (counties within a metropolitan statistical area (MSA) with between 50,000 and 1 million people); Large Suburban Metro (non-central fringe counties within an MSA with more than 1 million people); Large Urban Metro (central urban core counties within an MSA with more than 1 million people).

How does CHR&R define racial and ethnic groups?

We recognize that "race" or "ethnicity" are social categories. Society may identify individuals based on their physical appearance or perceived cultural ancestry, as a way of characterizing individuals' value. These categories are not based on biology or genetics. A strong and growing body of empirical research provides support for the fact that genetic factors are not responsible for racial differences in health factors and very rarely for health outcomes.

We are bound by data collection and categorization of race and ethnicity according to the U.S. Census Bureau definitions, in adherence with the 1997 Office of Management and Budget standards. Our analyses also do not capture those reporting more than one race, of "some other race", or who do not report their race. This categorization can mask variation within racial and ethnic groups and can hide historical context that underlies health differences.

How does CHR&R define gender?

We recognize that while the terms "gender" and "sex" are often used interchangeably, they do not represent the same concept. Sex is generally assigned at birth based on observed anatomy, while gender is a social construct wherein certain tendencies or behaviors are assigned by society to labels of masculine or feminine. We know that neither gender nor sex are binary constructs and that people living intersectional identities (e.g., transgender women) experience compounding power differentials, which are not captured in a binary delineation between men and women.

Credits

Report Authors:

Christine Muganda, PhD
Jess Hoffelder, MPH
Hannah Olson-Williams
Keith Gennuso, PhD
Marjory Givens, PhD, MSPH
Sheri Johnson, PhD

Research Assistance:

Jennifer Robinson	Ganhua Lu, PhD	Elizabeth Blomberg, PhD
Matthew Rodock, MPH	Molly Burdine	Nicholas Schmuhi, PhD
Anne Roubal, PhD	Eunice Park, MIS	Suryadewi Nugraheni, MD, MA, PhD

With key contributions from:

Michael Stevenson, MPH
Lindsay Garber, MPA
Beth Silver, MCM
Cathy Vos
and the entire County Health Rankings & Roadmaps Team

Data collaborations :

- The Centers for Disease Control and Prevention
- Dr. Amy Glasmeier, PhD and The Living Wage Calculator at the Massachusetts Institute of Technology

Communications & website support:

- Burness
- Forum One

This work is made possible with support from the Robert Wood Johnson Foundation.

Recommended citation: University of Wisconsin Population Health Institute. County Health Rankings North Carolina State Report 2022.

Talk to a Team Member:

Have questions about your data?
Need help finding an evidence-informed strategy?
Looking for more information on how to take action?

CHR&R team members are available to help you navigate the many resources we have available to support you on your journey to create healthy, equitable communities.

To contact us, please go to www.countyhealthrankings.org/contact-us. We're here to help!

University of Wisconsin Population Health Institute, County Health Rankings & Roadmaps
610 Walnut St, #524, Madison, WI 53726 | (608) 265-8240 | info@countyhealthrankings.org