





# RANDOLPH COUNTY




2025 Community Health Assessment

# Randolph County

# Community Health Assessment

# 2025 Final Report

## Contributors

This report was prepared through the collaborative efforts of contributors who supported research, analysis, writing, editing, and design.


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## Acknowledgments

We would like to thank the members of the Steering Committee for their leadership, insight, and ongoing commitment throughout the 2025 Community Health Assessment process. Their guidance in shaping the vision, identifying priorities, reviewing findings, and ensuring diverse community perspectives were represented was instrumental to this work. We are grateful for their time, expertise, and dedication to improving the health and well-being of Randolph County.

2025 Steering Committee Members

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**Tammy Bennett**, Insight Human Services

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FIRE DEPT.


RAMSEUR
PUBLIC LIBRARY
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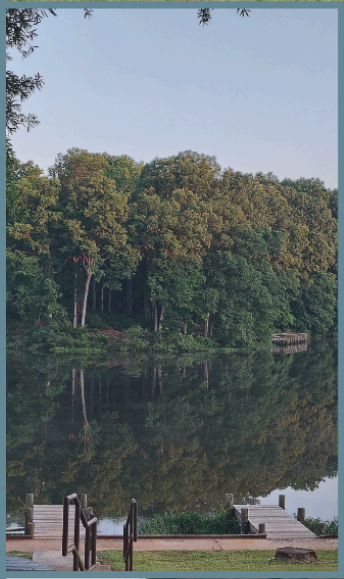
ALLEN H. LEONARD MEMORIAL PARK
DEDICATED BY THE TOWN OF
RAMSEUR, N. C.
1976


RAMSEUR



# RAMSEUR


IN GOD WE TRUST
RAMSEUR
MUNICIPAL
BUILDING


Ramseur
Community
Museum
MUSEUM


Coca-Cola
Have a Coke


Millstone Creek
Orchards

## OVERVIEW

The 2025 Community Health Assessment (CHA) was conducted to understand the health of Randolph County residents and the social, economic, and environmental conditions that influence well-being. Completed in partnership with Randolph Health, the CHA serves as a planning tool to guide the selection of priority health issues and inform the development of Community Health Improvement Plans (CHIPs) for the 2026–2028 cycle. The assessment provides a shared foundation for understanding health across the county and supports coordinated, community-informed action.

The CHA was intentionally designed to emphasize context rather than rankings or individual indicators. Health in Randolph County reflects long-term patterns related to where people live, work, learn, and age, as well as how systems respond to those conditions over time. Integrating quantitative data with community perspectives allowed the assessment to examine how social determinants of health shape lived experience and influence health across the life course.

## MISSION AND CORE VALUES

The CHA process was guided by a shared mission and set of core values established through early partner engagement.

**Mission:** To ensure the best quality of life for our community by elevating their voices and empowering leadership to promote positive change.

**Value 1: Transparency**

Be transparent with our process and outcomes by being open, honest, accessible, and genuine.

**Value 2: Caring**

Show equal care and respect for all members of our community.

**Value 3: Community**

Build a sense of safety/security through inclusivity, listening, and nonjudgmental acceptance in our process and outcomes.

These values informed engagement strategies, data interpretation, and decision-making throughout the CHA cycle.

## CHA LEADERSHIP

The CHA was guided by a Core Committee composed of representatives from Randolph County Public Health, Randolph Health, and North Carolina Cooperative Extension. The Core Committee led planning efforts, coordinated assessment activities, synthesized data, integrated community input, and prepared findings for review throughout the process.

| Core Committee Members | |
|---|---|
| Amaris Avalos | Randolph County Public Health |
| Alejandra Chavez-Ramirez | Randolph County Public Health |
| Sophie Farlow | Randolph County Cooperative Extension |
| Wendy Kennon | Randolph County Public Health |
| Meagan Klinkenberg | Randolph County Public Health |
| Jennifer Layton | Randolph County Public Health |
| Kyle McLeod | Randolph Health |

A Steering Committee, consisting of representatives from county departments, health care organizations, education, emergency services, social services, housing, environmental and agricultural sectors, community-based organizations, faith-based partners, and local leadership, provided oversight and guidance. Steering Committee members contributed their time, expertise, and commitment to improving community health and played a key role in reviewing findings and identifying priority health issues. Their partnership was essential to the success of the 2025 CHA. A complete list of names and agencies can be found in the **Acknowledgements** section.

## THEORETICAL FRAMEWORK

The CHA is grounded in the 2025 University of Wisconsin Population Health Institute Model of Health, as applied through the Community Health Rankings and Roadmaps (CHR&R) Model of Population Health. This framework organizes health into two domains:

**Population Health and Well-Being**
Data Measures: Length of Life and Quality of Life

**Community Conditions**
Data Measures: Health Infrastructure, Physical and Built Environment, and Social and Economic Factors

Use of this framework supported a focus on social determinants of health and the conditions that influence outcomes over time.

## COLLABORATIVE PROCESS

The CHA followed the Mobilizing for Action through Planning and Partnerships (MAPP) 2.0 framework, which was used as the organizing structure for the assessment and planning process.

| Winter 2025 | Spring-Summer 2025 | Summer-Fall 2025 | Fall-Winter 2025 |
|---|---|---|---|
| The **Starting Point Assessment** was conducted in February 2025 and focused on reviewing the previous CHA cycle, including strengths, challenges, and lessons learned. | The **Community Partner Assessment** followed in spring 2025 and examined programs, partnerships, and capacity across sectors. The Community Status Assessment was completed throughout mid-2025. | The **Community Context Assessment,** including surveys and focus groups, was conducted in late summer and fall 2025. | Findings from all assessment activities were reviewed with the Steering Committee between September and November 2025, leading to the selection of priority health issues. Final reporting was completed in December 2025. |

## KEY FINDINGS

Findings from the CHA demonstrate consistent themes across secondary data and primary community input, highlighting how health in Randolph County is shaped by long-term conditions and daily lived experience. These findings suggest that improving health will require attention to systems, access, and sustainability. Key themes include:

**Access to care**, with data indicating limitations related to provider availability and insurance coverage, and community input describing challenges with appointment availability, wait times, and navigating services

**Chronic disease and substance use burden**, identified in both data and community input as major factors affecting quality of life

Economic pressure and daily stressors, including **housing costs, childcare, food, and health care expenses**, which affect residents' ability to manage health needs

Community conditions including **housing and transportation**, and environmental health concerns such as **water quality and infrastructure**

Community **strengths**, including **engagement in preventive care** when services are accessible, **strong personal support networks**, and established partnerships working to improve health

## HEALTH PRIORITIES

Using a structured prioritization process informed by data and community input, the CHA Steering Committee evaluated potential health priorities based on feasibility, size of the problem, and community importance, with feasibility weighted most heavily to highlight local capacity and resources.

Through this process, two priority health issues were identified for the 2025 CHA cycle:

| SUBSTANCE USE DISORDER | CHRONIC DISEASE |
|---|---|

These priorities reflect alignment between data trends and community-identified concerns and represent areas where coordinated action can have meaningful impact.

## NEXT STEPS

With priority health issues identified, the CHA transitions into the development of Community Health Improvement Plans (CHIPs). CHIP development will focus on strengthening existing programs and partnerships while addressing identified gaps. Priority-specific subcommittees will be formed to review current efforts, identify opportunities to expand reach, and develop shared goals, strategies, and evaluation measures. CHIP development will align with the Randolph County Public Health 2026–2028 Strategic Plan. The final CHIPs will be submitted to the North Carolina Department of Public Health in September 2026.


K 3
TRINITY COLLEGE
STOOD HERE. UNION IN-
STITUTE, 1839, NORMAL
COLLEGE, 1851, TRINITY,
1859, DUKE UNIVERSITY,
1924. MOVED TO DURHAM,
1892.
STATE HISTORICAL COMMISSION 1937

# TRINITY


Trinity
Community Park
Established 2005


SPADE BROOM
7123


Zimmerman
Vineyards

## Background and Goals

Randolph County Public Health (RCPH) conducts a Community Health Assessment (CHA) every three years to better understand the health of residents and the conditions that influence well-being across the county. The 2025 CHA was led by RCPH with support from Randolph Health and in collaboration with countywide community organizations, agencies, educational institutions, and community members. This collaborative approach ensures that the assessment displays both data trends and the perspectives of those who live and work in the community.

The purpose of the CHA is to evaluate the health of Randolph County in relation to peer counties and statewide benchmarks, including Healthy North Carolina 2030 objectives. Findings from the assessment are used to identify and prioritize key health issues that pose a threat to community health and well-being. These priorities then guide the development of Community Health Improvement Plans (CHIPs), which outline strategies, partnerships, and actions to address the most pressing health concerns and improve health outcomes for Randolph County residents.

### Lead Agencies and Partners

**Figure 1**. Lead Agencies and Community Partners in Randolph County

| Sector | Organizations and Partners |
|---|---|
| Agriculture & Extension Services | North Carolina Cooperative Extension |
| Community-Based & Faith-Based Organizations | Mount Nebo Holiness Church; Randolph Senior Adults Association; Asheboro/Randolph YMCA; Cross Road Retirement Community, Asheboro Latinx; Lazos Hispanos |
| Education & Youth Services | Randolph County School System; Asheboro City Schools; Randolph Community College; Communities In Schools; Randolph County Cooperative Extension - 4-H; Regional Consolidated Services (RCS) Head Start |
| Emergency Services & Public Safety | Randolph County Emergency Medical Services; Randolph County Juvenile Day Reporting Center |
| Environmental & Natural Resources | North Carolina Conservation Network; Trails and Natural Heritage Coordinator |
| Healthcare & Clinical Services | Randolph Health; Cone Health; Prevo Drug; Kintegra Health; BrightView |
| Housing & Economic Stability | Asheboro Housing Authority; Pinnacle Financial Partners |
| Local Government & Public Administration | Randolph County Government; Randolph County Manager's Office; Randolph County Board of Health; Randolph County Board of Commissioners |
| Public Health & Human Services | Randolph County Public Health; Randolph County Department of Social Services; Trillium Health Resources; Alcohol Drug Services; Insight Human Services; Keaton's Place |

The agencies, organizations, and community partners outlined in **Figure 1** contributed to the 2025 Randolph County Community Health Assessment through data sharing, outreach, survey distribution, community engagement, technical expertise, and review of findings. Organizations are grouped by sector.

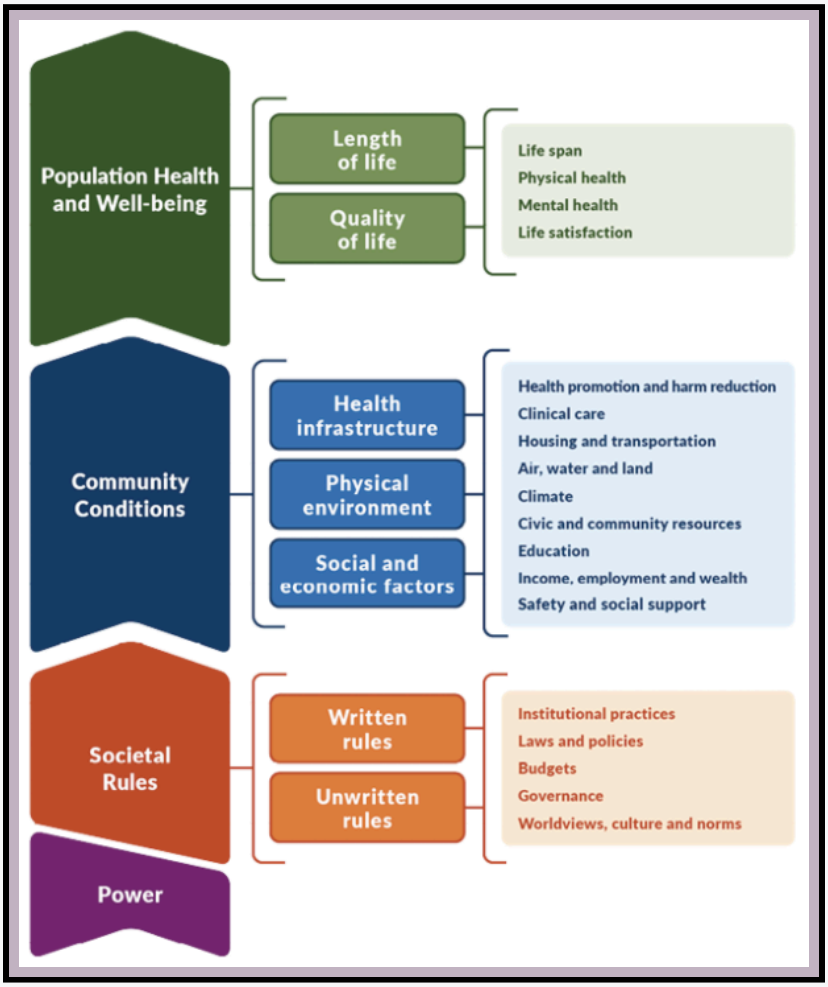
## Theoretical Frameworks

### Population Health Model

**Figure 2**. 2025 UWPHI Model of Health[2]

The 2025 CHA was guided by the the 2025 University of Wisconsin Population Health Institute (UWPHI) Model of Health as applied through the Community Health Rankings and Roadmaps (CHR&R) Model of Population Health. This approach was selected to remain in alignment with Healthy NC 2030 goals and key health indicators to connect broader state priorities to work happening at the local level.

The model takes a wide view of health, looking beyond individual behavior or clinical care to the social, economic, and environmental conditions that shape outcomes[1]. These include education, income, housing, transportation, and access to care. By using this framework, the CHA team identified root causes of health disparities, focused on "upstream" factors, and strengthened connections between state strategies and local action.



## Mobilizing for Action through Planning and Partnerships (MAPP) 2.0

**Figure 3**. Three Phases of MAPP 2.0 Framework

To enhance the use of the Population Health Model and deepen community engagement, the CHA team also incorporated key components of the Mobilizing for Action through Planning and Partnerships (MAPP) 2.0 framework[3]. Developed by the National Association of County and City Health Officials (NACCHO), MAPP provides a structured, collaborative process for improving community health. It is designed to be inclusive, data-informed, and action-oriented[3].

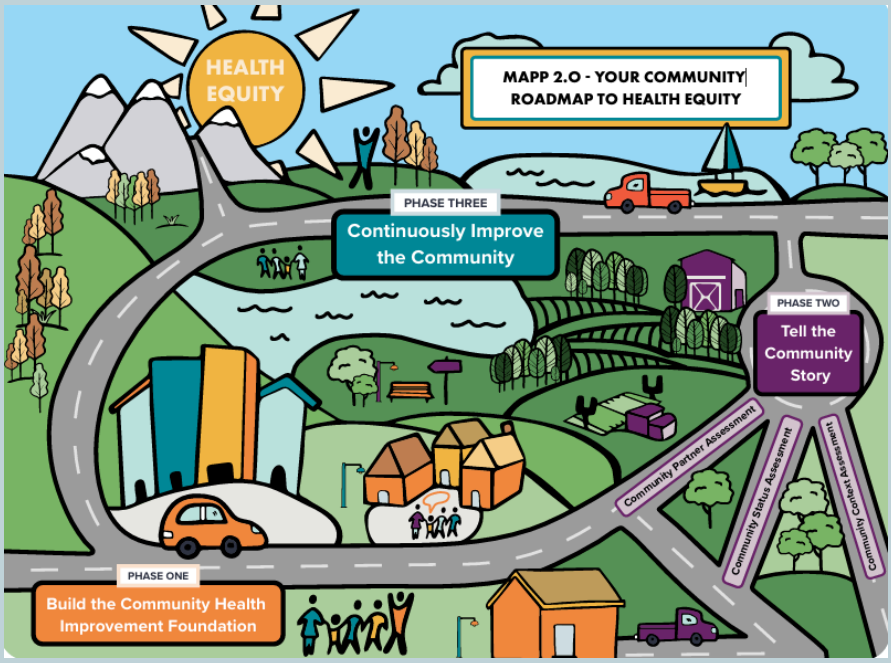



Image Source: Mobilizing for Action through Planning and Partnerships (MAPP) 2.0 Guidebook[4]

During Phase I and II, four assessments were completed: Starting Point Assessment (SPA), Community Partner Assessment (CPA), Community Status Assessment (CSA), Community Context Assessment (CCA)[3].

**Figure 4**. MAPP 2.0 Four Assessments

| Starting Point Assessment | Community Partner Assessment | Community Status Assessment | Community Context Assessment |
|---|---|---|---|
| Reviewed the previous CHA cycle to identify successes, gaps, and opportunities for improvement and to inform planning for the current assessment. | Examined the strengths, resources, and capacity of organizations addressing health and social needs, as well as gaps in services and collaboration. | Used secondary data to describe health outcomes and the conditions that influence health across the county. | Gathered input from residents and stakeholders to understand community priorities, perceptions, and lived experiences related to health and quality of life. |

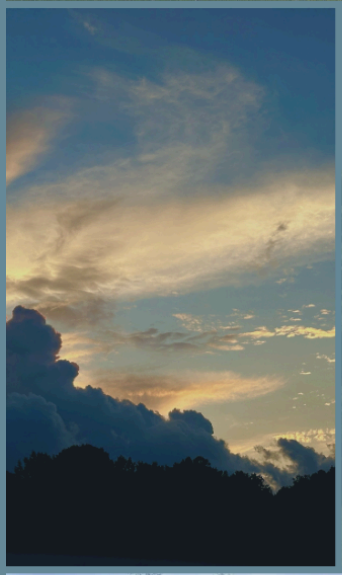
### An Integrated Approach

By combining the Population Health Model with targeted components of the MAPP 2.0 framework, the CHA team used a data-informed, equity-focused, and community-driven approach. This integration provided a deeper understanding of Randolph County's health challenges and laid a strong foundation for collaborative planning, resource alignment, and long-term strategies to improve health and promote equity for all residents.


Mobilgas
LUNA'S
Filling Station
Mobilgas
Staley N.C.
Mobilgas


STALEY FIRE DEPARTMENT
STATION #7

# STALEY




RANDOLPH
COUNTY


SERVICE


Main Street GRILL
622-1306

## Peer County Selection Process

Understanding how Randolph County compares to similar communities helps paint a clearer picture of local health trends. As part of the Community Health Assessment (CHA), peer counties - places with similar population characteristics, economies, and community structures - were identified for comparison[5]. These comparisons help identify where Randolph County is doing well, where challenges are shared, and where strategies used in similar settings may be adapted locally.

The CHA Core Committee reviewed key measures related to the social determinants of health, including factors that influence where people live, work, and age. These measures demonstrate both individual and community-level conditions such as education, housing stability, economic opportunity, and access to services[6].

**Figure 5**. Key indicators used for county health comparisons (left) and sources used to gather secondary data for selected counties (right).

### Key Indicators Used

**Population:** Age, racial and ethnic makeup, and size.

**Rural/Urban Mix:** Percent of residents living in rural versus urban areas.

**Education:** Graduation rates, educational attainment, and school performance.

**Employment:** Unemployment rates and types of jobs.

**Housing:** Affordability, stability, and quality.

**Social Vulnerability Index (SVI):** A CDC score that measures how vulnerable a community is to challenges like disasters or disease outbreaks.

### Data Sources

**NC Data Portal:** Demographic, health, and environmental data.

**County Health Rankings & Roadmaps:** Annual comparisons of health factors and outcomes.

**MyFutureNC:** Statewide education and workforce indicators.

**Environmental Justice Index** (EJI): Demographic, health, and environmental data.

Using these indicators, the committee initially identified ten potential peer counties. After reviewing the data, **Alamance, Catawba, and Davidson** counties were selected as the most comparable to Randolph County across multiple community measures.

By learning from similar counties, Randolph County can better understand how the social determinants of health impact local outcomes. This knowledge helps target resources where they are most needed, adapt proven strategies, and build partnerships that strengthen community health.

**Figure 6**. Map of North Carolina, Randolph County, and Selected Peer Counties

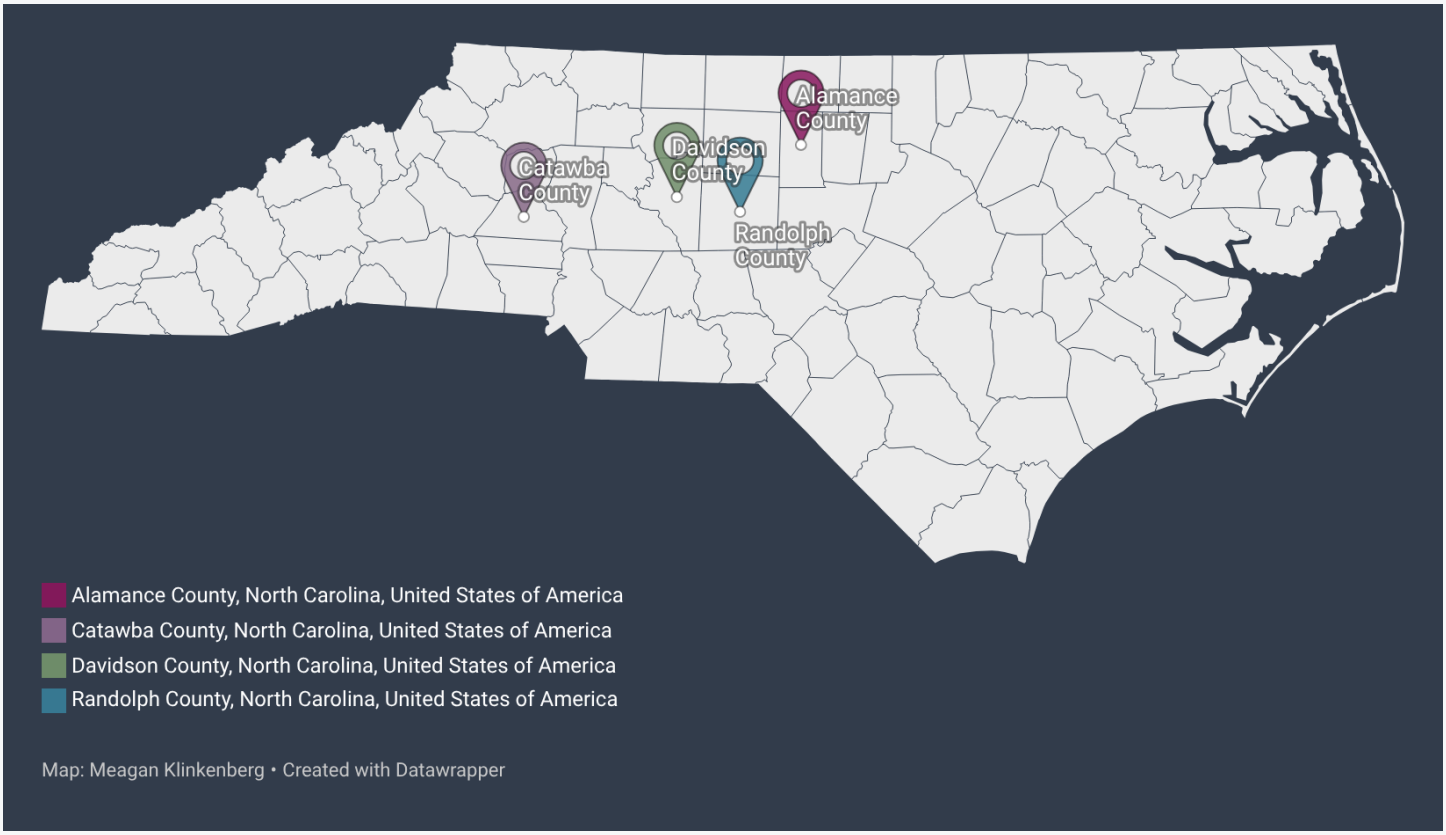



**Figure 7**. Stages of the Peer County Selection Process

The selected peer counties will serve as comparison points throughout the CHA to:

Highlight differences and similarities in health outcomes.

Identify programs and policies that have worked in similar settings.

Compare the availability of key resources such as healthcare, transportation, and healthy food.

Inform strategic planning and guide local priorities.

# Three Phases of MAPP 2.0 Framework

## Phase I: Build the Community Health Improvement Foundation

Within the MAPP 2.0 framework, the Stakeholder and Power Analysis is used to identify key partners, community voices, and decision-makers involved in or impacted by community health efforts. This process supports engagement by recognizing influence, relationships, and perspectives that shape community health planning and action.

### Stakeholder and Power Analysis

In November 2024, the CHA Core Committee conducted the Stakeholder and Power Analysis using the MAPP 2.0 Stakeholder Wheel. This meeting involved reviewing the membership of the previous Steering Committee and identifying gaps in representation from the 2022 CHA cycle. Findings from this process informed efforts to broaden participation and ensure diverse community perspectives were included.

### Mission, Values, and Community

The 2025 CHA Steering Committee met in January 2025 to complete an onboarding to the MAPP 2.0 framework. The meeting began with an orientation on the MAPP process and how it would guide this CHA cycle, establishing a shared understanding of the framework and its use throughout the assessment. The primary focus of the onboarding centered on building a collective foundation for the work ahead. Steering Committee members worked together to define what “community” means in the context of Randolph County, recognizing the many ways people connect to the county through living, working, learning, worshiping, visiting or seeking services. The committee also developed a mission statement and identified values to shape the CHA process, emphasizing transparency, care, and trust as principles for engagement and decision-making.

### Starting Point Assessment

The Starting Point Assessment (SPA) provided an opportunity to reflect on the 2022 CHA and prepare for the 2025 cycle. Steering Committee members and community partners shared feedback on strengths, challenges, and opportunities for improvement.

Participants highlighted strong organization, engagement, effective use of meeting time, and clear communication. Challenges included difficulties with data collection, low survey response rates, and meeting times that did not work for everyone. This feedback informed outreach strategies and partner engagement for the current CHA cycle.

When reflecting on outreach, participants highlighted that word of mouth, social media, and direct interviews were the most effective tools. Looking ahead, there was a shared interest in expanding outreach beyond the Asheboro area, increasing representation from underserved communities, and building stronger connections with sectors such as government, businesses, schools, and nonprofits.

Starting Point Assessment questions and data can be found in **Appendix A.**

## Phase II: Tell the Community Story

### Community Partner Assessment

The Community Partner Assessment (CPA) examined the network of organizations working to improve health in Randolph County. Over six weeks, 36 organizations completed the assessment, providing insight into existing strengths, available resources, populations served, existing data, and opportunities to strengthen collaboration.

Partners described a community rich with resources, talent, and dedication. Many organizations bring strong programs, skilled staff, translation services, and established networks that can be leveraged to improve health outcomes. The assessment also revealed the ways partners are addressing the social determinants of health, including housing, education, transportation, and food access, though some areas still need greater attention.

Gaps in representation and collaboration also emerged. While there is a strong foundation, there are opportunities to connect with organizations not yet involved in CHA work and to fill service areas that remain underserved. These findings will guide efforts to build stronger, more effective partnerships in the years ahead.

Community Partner Assessment questions in English and Spanish can be found in **Appendix B.**

### Community Status Assessment

The Community Status Assessment (CSA) provided the quantitative foundation for understanding health in Randolph County. Guided by MAPP 2.0, the CHA Core Committee developed a detailed data matrix aligned with the 2025 UWPHI Model of Health as outlined in CHR&R county profiles.

This framework allowed the committee to examine length of life indicators, quality of life indicators, clinical care access, physical and built environment, and the broader social and community context. Data came from both public databases and local sources shared by partners identified in the CPA.

The CSA process spanned eight weeks, during which the committee worked to ensure data accuracy and completeness. The results offered a clear baseline of the county's health and helped identify gaps that would be addressed in the third assessment.

For a more comprehensive review of this process, please see **Section IV: Community Status Assessment.**

**Figure 8**: Local Public Health System Jellybean Diagram[4]

## Community Context Assessment

### *Community Opinion Survey*

The community opinion survey collected resident perspectives on health, quality of life, and community conditions across Randolph County.

The survey was available in English and Spanish and offered in both paper and online formats. Responses were collected between October and December 2025 using a combination of randomized direct mail and convenience sampling.

For the randomized direct mail survey, residential address data were extracted from a statewide address dataset (NC OneMap, AddressNC) and stratified by census tract to support geographic representation across the county. A proportional random sample of households was then selected and mailed a survey packet that included a paper survey, prepaid return envelope, and an option to complete the survey online.

Using multiple distribution methods helped expand reach and capture a broader range of community perspectives.

The 2025 CHA Community Opinion Survey questions can be found in **Appendix C.**

### *Focus Groups*

The focus groups collected qualitative input to provide additional context to the community opinion survey and better understand lived experiences across Randolph County.

Five focus groups were conducted in the fall of 2025 across several demographic groups. After applying eligibility criteria and reviewing data quality, only two of them met inclusion standards for this assessment.

The two focus groups included members of the Hispanic Spanish-speaking community. The first group included mothers who live in Asheboro and the second group included adults living in various municipalities across the county, ages 18-65+.

Both were planned and implemented in collaboration with trusted local nonprofit partners - Lazos Hispanos and Asheboro Latinx Services - to increase accessibility, responsiveness, and participant comfort

Discussions were recorded, transcribed, and translated as needed and then analyzed to identify key themes.

For a more comprehensive review of this process, including key themes, please see **Section V: Community Context Assessment.**

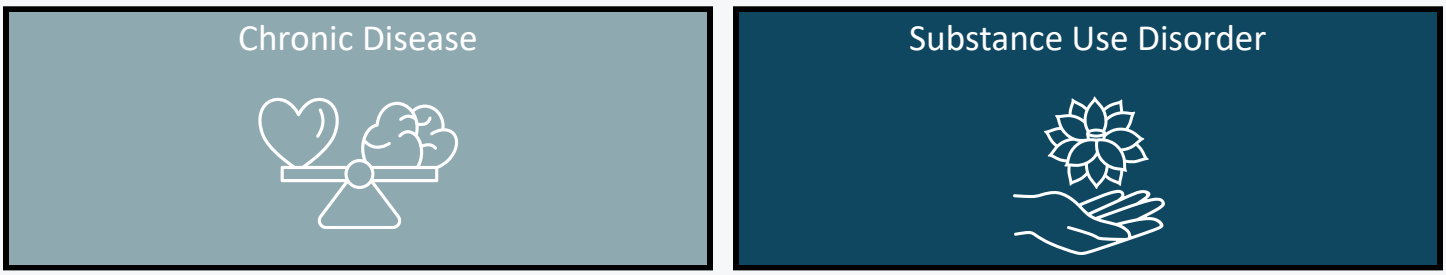
## Phase III: Continuously Improve the Community

### Priority Health Selection

The CHA team used a structured, data-informed process to identify priority health issues for Randolph County. In November 2025, the core planning committee identified the health issues to be considered, selected evaluation criteria, reviewed the 2022 CHA prioritization approach, and examined prioritization methods outlined in the National Association of County and City Health Officials (NACCHO) *Guide to Prioritization Techniques*[7]. This planning phase helped establish a shared understanding and reduce selection bias.

In December 2025, secondary data and community survey results from both household and convenience samples were then reviewed and scored using a prioritization matrix. Health issues were evaluated based on feasibility, size of the problem, and community importance. Through this process, substance use disorder and chronic disease emerged as the highest priorities and were selected to guide Community Health Improvement Plans (CHIPs) development over the next three years.

**Figure 9**. 2025 Priority Health Issues

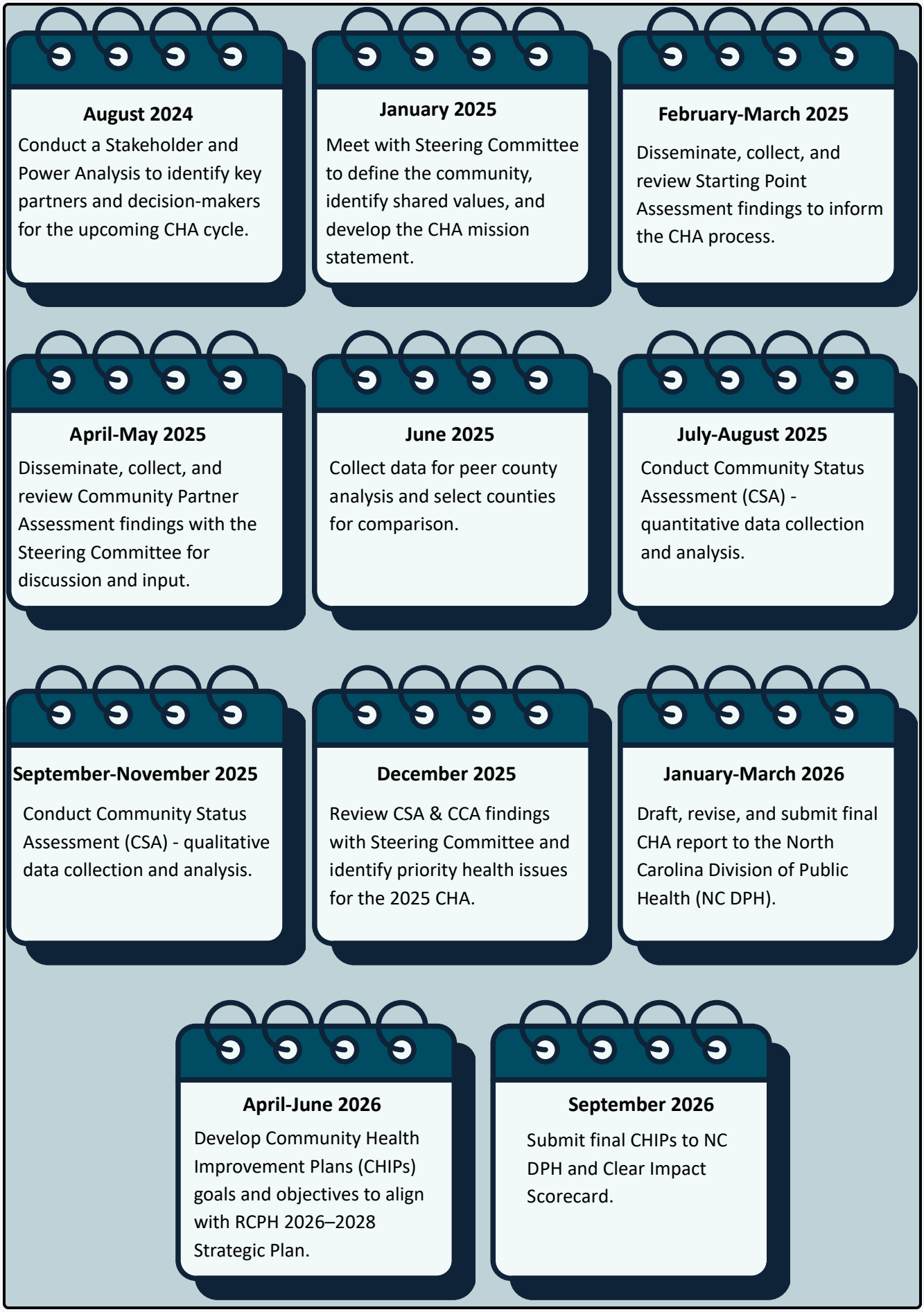



### Community Health Improvement Plans (CHIPs)

Community Health Improvement Plans (CHIPs) will be developed to align with Randolph County Public Health's 2026-2028 Strategic Plan and the selected health priorities identified above. These plans will focus on strengthening community health education efforts, sustaining and enhancing existing programs, and expanding targeted strategies for populations most impacted by chronic disease and substance use.

For a more comprehensive overview of this process, please see **Section VI: Continuously Improve the Community.**

**Figure 10**. 2025 Community Health Assessment Timeline





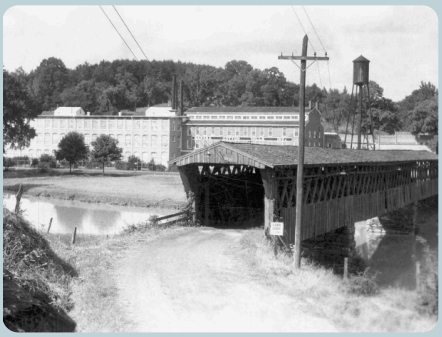

# FRANKLINVILLE

## History

Randolph County's history is rooted in North Carolina's Piedmont region, where rolling hills, fertile soils, and a central location supported early settlement and economic growth. Established in 1779 and named for Peyton Randolph, the first president of the Continental Congress, the county developed first as an agricultural community and later as a center for textiles, furniture manufacturing, and other industrial trades[8]. These industries, along with small town commerce, supported generations of families and shaped the county's economic identity.

Although the textile industry has declined over time, manufacturing remains a key part of Randolph County's economy. Residents continue to take pride in the county's history of craftsmanship, strong work ethic, and close community ties. These values remain visible today in the county's local businesses, civic life, and shared sense of place[8].

**Figure 11**. Historical photos of Cedar Falls Covered Bridge (left), Sunset Avenue in Asheboro (middle) and Coffin's Mill on Deep River (right).



*Cedar Falls Covered Bridge over Deep River, 1930*[9]


*Christmas decorations hanging over Sunset Avenue in Asheboro, 1946*[9]

*Construction Coffin's Mill on Deep River at Franklinville Manufacturing Company, 1801*[9]

Image Source: Randolph County Historical Photographs, Randolph County Public Library - Randolph Room

Randolph County's history is also evident in its civic traditions. Public meetings have long been open and accessible, creating opportunities for residents to engage directly in local decision making[10]. This tradition, combined with a strong value of self reliance, has helped foster a sense of community identity that continues to influence public life and local governance.

## Geography and Physical Characteristics

Randolph County covers approximately 790 square miles and includes a mix of open farmland, forested areas, and small towns connected by local roads and highways[10]. The county is located within the Piedmont Triad area, offering residents access to urban amenities while maintaining a largely rural character[10].

The Uwharrie Mountains extend into the southwestern portion of the county and are among the oldest mountain ranges in North America[11]. These natural features provide opportunities for outdoor recreation and contribute to the county's scenic landscape. Agriculture remains an important land use, supported by efforts to promote soil and water conservation and effective storm water management. Residential development has increased in some areas, particularly near major transportation corridors, indicating gradual population growth and changing land use patterns[11].

**Figure 12**. Topographic map of Randolph County terrain and highways (left) and Randolph County Tourism Development Authority (TDA) tourism map (right).


Image source: U.S. Geological Survey Topographic Maps

Situated in the **Piedmont Triad region**, Randolph County is home to the towns of Archdale, Asheboro, Franklinville, Liberty, Ramseur, Randleman, Seagrove, Staley, and Trinity, ranking as the **11th largest** and the **19th most populous** county in North Carolina[12].


Image source: Heart of NC Visitors Bureau

Randolph County is also a tourism destination, drawing state, national, and international visitors to the **North Carolina Zoo, Uwharrie National Forest**, **North Carolina Pottery Center**, and **Richard Petty Museum**[10].

## Governance and Infrastructure

Randolph County operates under a commissioner/manager form of government. Elected commissioners establish policy and direction, while a county manager oversees daily operations and implementation. This structure supports efficient service delivery while maintaining accountability to community priorities[8].

County fiscal planning demonstrates a commitment to essential services that influence health and well being. In fiscal year 2023-2024, the county budget totaled approximately $205 million[13]. The largest portion supported public safety, including law enforcement, emergency response, and related services. Education accounted for another significant share, supporting school operations and facility maintenance. Human services, including public health and social services, also received dedicated funding to address community needs[13].

County departments provide a wide range of services that affect health outcomes and quality of life, including public health, social services, emergency management and preparedness, animal services, and veterans services. Infrastructure planning focuses on maintaining reliable services, improving connectivity across rural and suburban areas, and protecting natural resources[14.] County leadership continues to balance growth with preservation, recognizing the importance of economic opportunity while maintaining the rural character and environmental assets that define Randolph County.

**Figure 13**. Randolph County Seal[9]

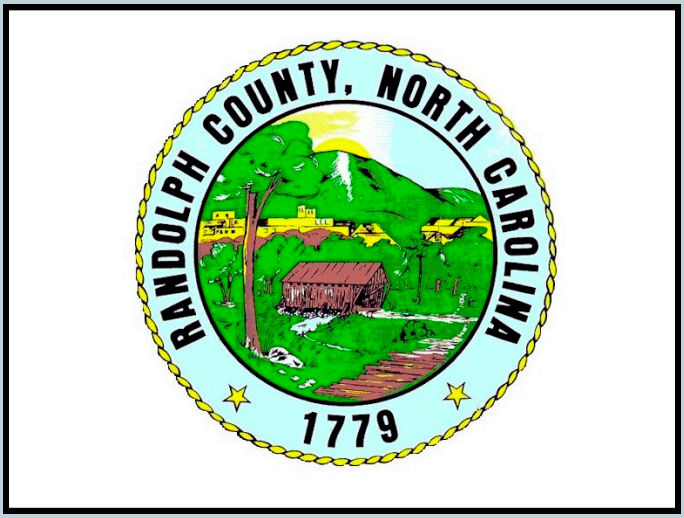



**Figure 14**. 1838 Courthouse Belfry Bell[9]

Image Source: Randolph County Historical Photographs, Randolph County Public Library - Randolph Room

## Demographic Overview

Randolph County is home to an estimated 145,322 residents as of 2023, indicating modest and steady population growth in recent years[15]. The median age of residents is 41.4, which is slightly higher than the North Carolina median age. This indicates a community with a substantial proportion of middle aged and older adults[15].

The population of Randolph County is predominantly White and non-Hispanic, accounting for approximately 75.9% of residents. The county has become more diverse over time, with Hispanic and Latinx residents representing about 13.6% of the population[15]. Black or African American residents account for approximately 5.9% of the population, while smaller percentages of residents identify as Asian, Native American or Alaska Native, Native Hawaiian or Pacific Islander, or two or more races. Approximately 6.1% of residents are foreign born, and the majority of residents are United States citizens[15].

These demographic patterns have important implications for public health planning. An aging population increases demand for health care services, transportation options, and age supportive housing. Growing racial and ethnic diversity highlights the importance of culturally responsive services and equitable access to health care, education, and economic opportunity.

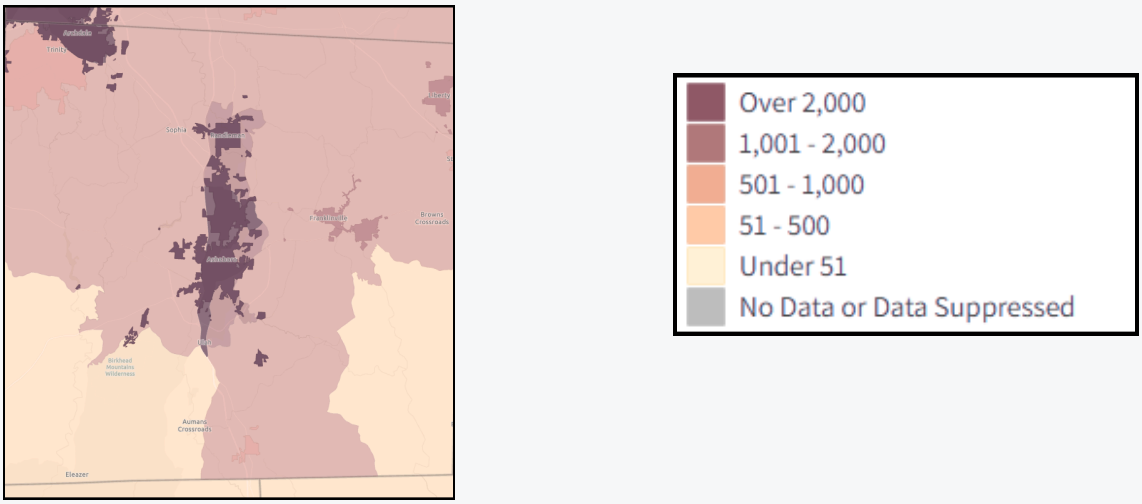
---

### Total Population

This data shows the total population of Randolph County  from 2019–2023. Randolph County has 145,322 residents across 782.33 square miles. The population density is 186 people per square mile, which is lower than the national average of 218. Knowing the size of the population helps measure community needs, plan services, and decide where to distribute resources.

**Limitations:** Estimates come from census and survey data, which may have gaps or errors. The 2020 Census faced challenges, including the COVID-19 pandemic and natural disasters, that may have affected accuracy.

**Figure 15.** Population Density by Place in Randolph County, 2019 to 2023[17]

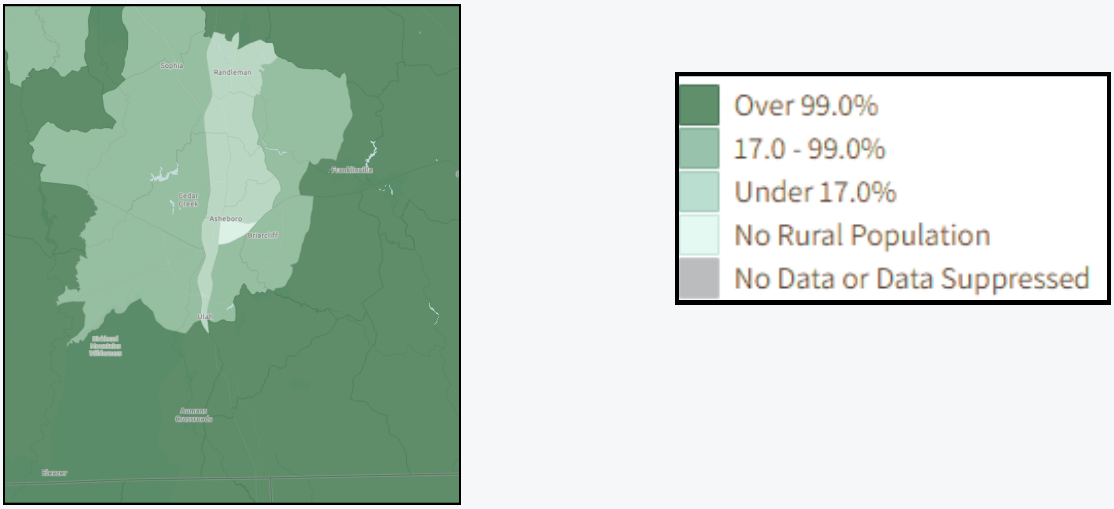


## Urban and Rural Population

This data shows the urban and rural population of Randolph County in 2020. Urban areas are based on population density, size, and development patterns. Rural areas are all other areas. Of Randolph County's 144,171 residents in 2020, 39.8% live in urban areas and 60.2% live in rural areas. Urban and rural areas often have different needs for health care, jobs, and infrastructure.

**Limitations:** The definition of "rural" and "urban" can vary between agencies, so classifications may differ between reports.

**Figure 16.** Population Living in Rural Areas, Percent by Tract, US Census Bureau 2020[17]

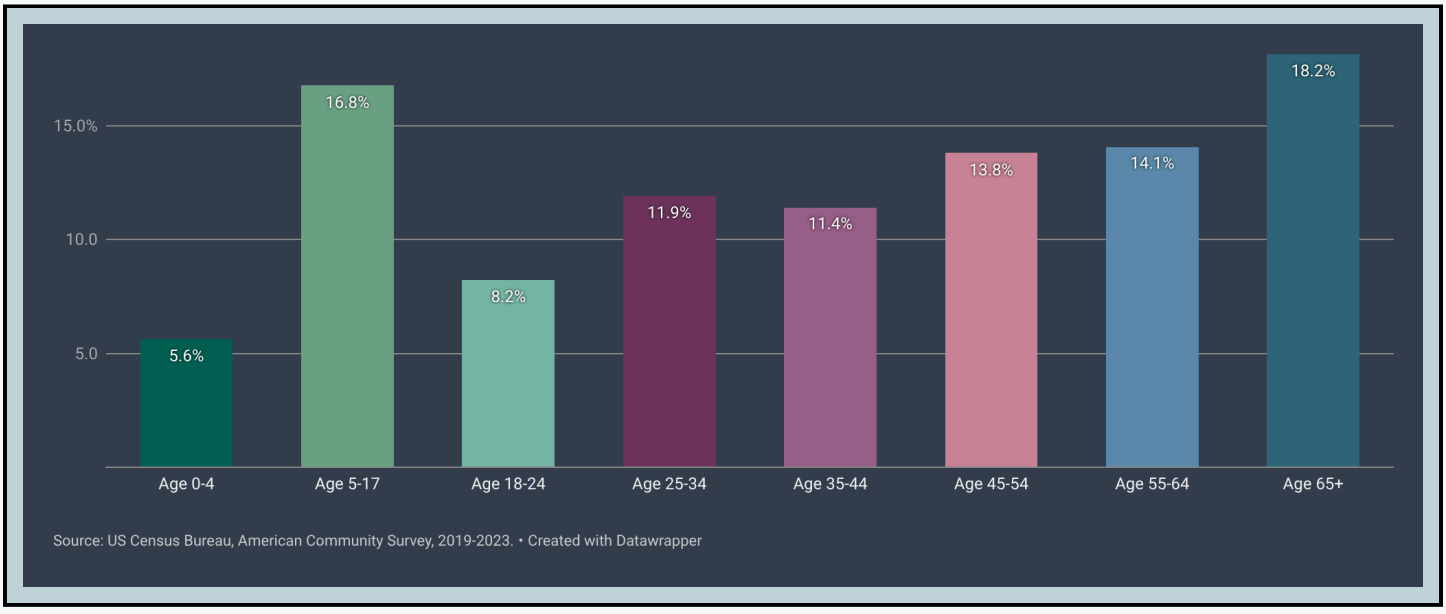



## Age

This data shows the population by age group in Randolph County from 2019–2023. The age groups with the highest population are 5-17 (16.8%) and 65+ (18.2%). Children and older adults often have unique needs. For example, older adults are more likely to face mobility issues or chronic diseases, while children's health is shaped by early growth and development.

**Limitations:** Estimates come from census and survey data, which may not capture every household.

**Figure 17.** Total Population by Age Group, 2019-2023, Randolph County[15]

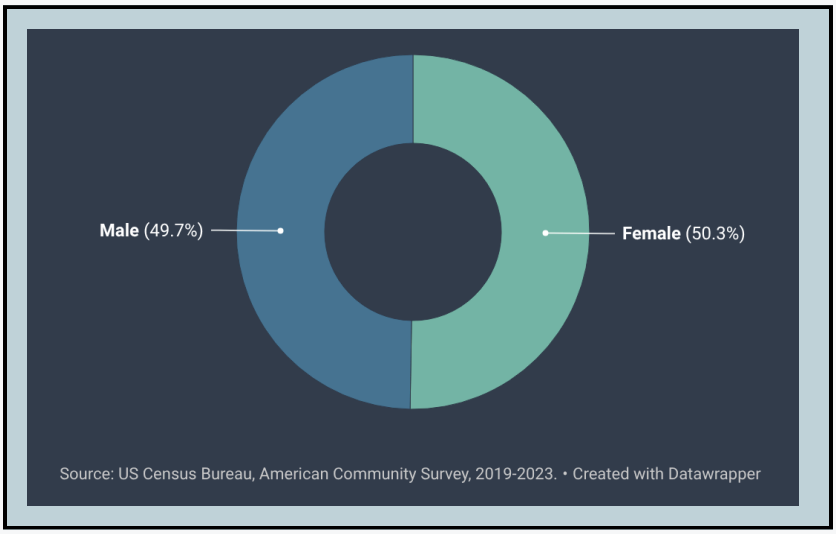


## Sex

This data shows the population by sex in Randolph County from 2019–2023. Of all residents, 49.7% are male and 50.3% are female. Gender can affect health needs and access to care.

**Limitations:** Sex demographic data are based on U.S. Census reporting and are limited to the categories collected through that source.

**Figure 18.** Total Population by Sex, 2019-2023, Randolph County[15]




## Race & Ethnicity

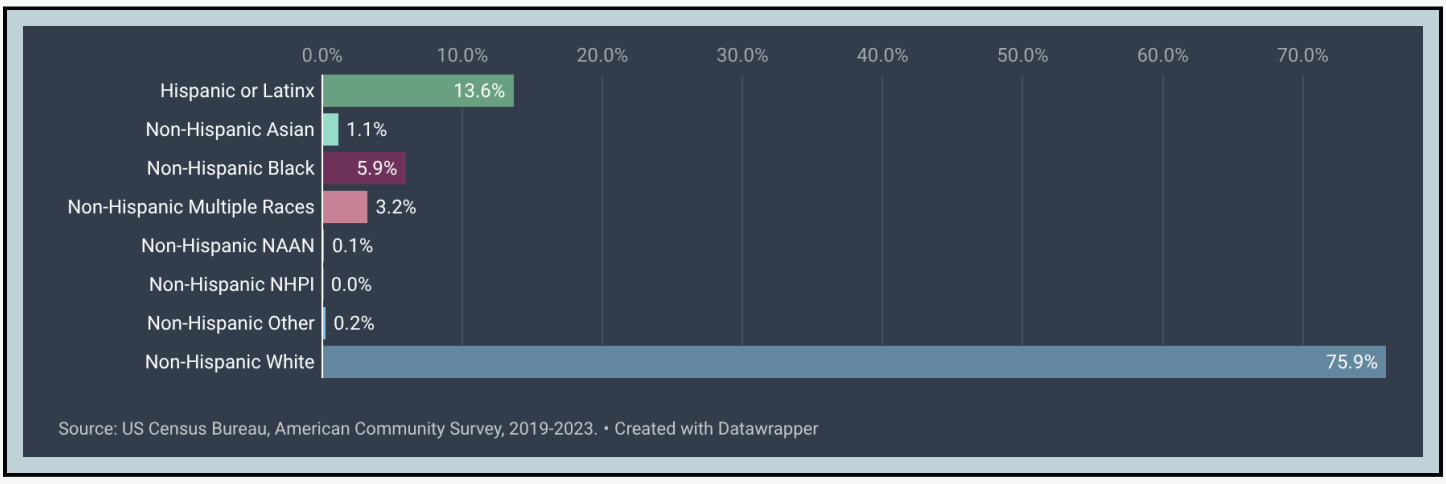
This data shows the population by race and ethnicity in Randolph County from 2019–2023. Race and ethnicity data can show differences in access to education, employment, housing, and health care.

**Limitations:** Data may be incomplete if race or ethnicity is not reported. Some categories are estimated based on other information.

**Note**: The following table and chart use acronyms for some of the combined race/ethnicity groups. The full forms are as follows:

- Non-Hispanic NAAN = Non-Hispanic Native American or Alaska Native
- Non-Hispanic NHPI = Non-Hispanic Native Hawaiian or Pacific Islander
- Non-Hispanic Other = Non-Hispanic Some Other Race

**Figure 19.** Population by Race and Ethnicity in Randolph County, 2019 to 2023[15]

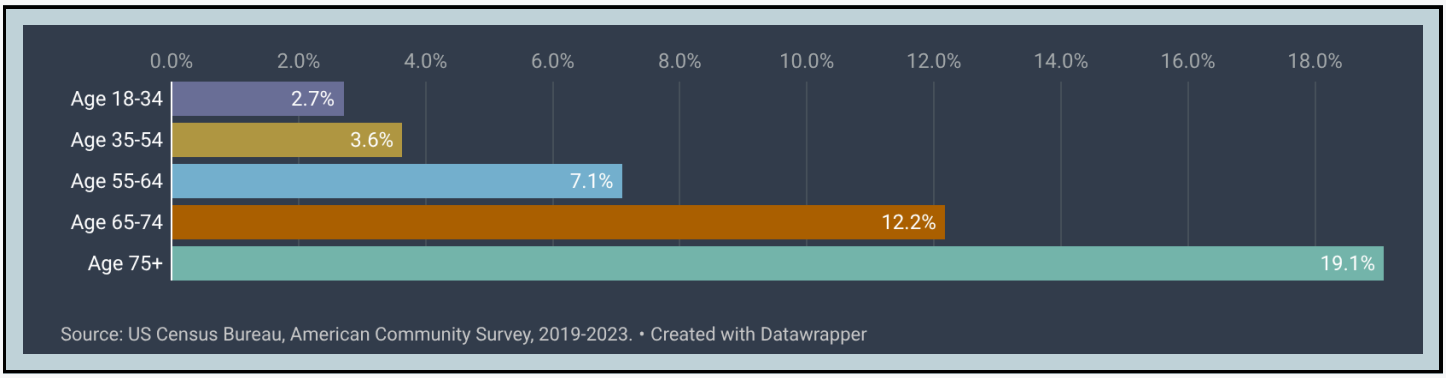


## Veteran Population

This data shows the veteran population in Randolph County from 2019–2023. Of the 112,699 people age 18 and older, 7,554 (6.70%) are veterans. Veteran status can affect access to health care and other essential services.

**Limitations:** Some veterans may not self-identify or be included in surveys.

**Figure 120.** Veteran Population as a Percentage of Adults by Age Group in Randolph County, 2019 to 2023[15]




## Disability

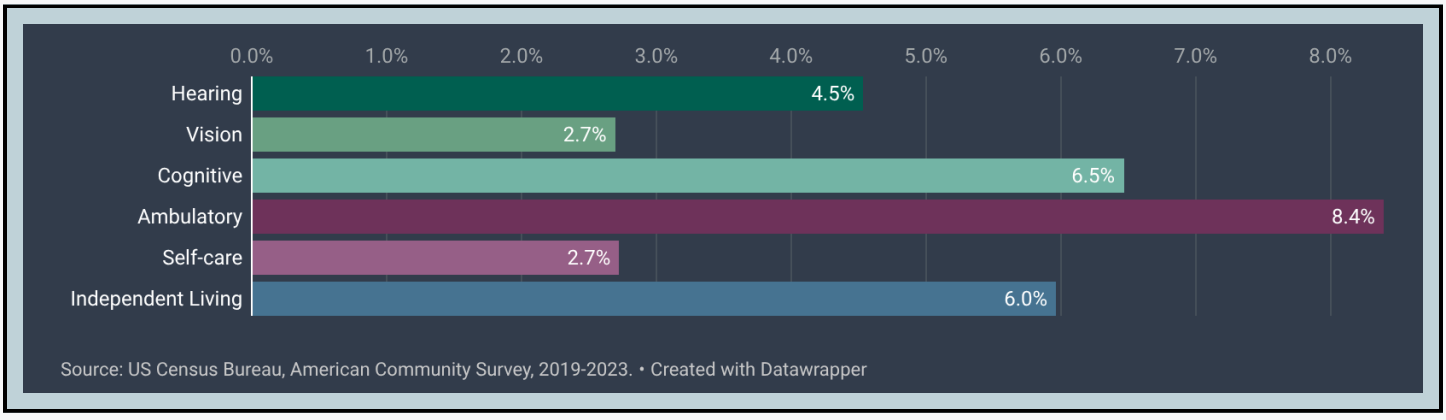
This data shows the percentage of the total civilian non-institutionalized population with a disability by disability status in Randolph County from 2019-2023. The ACS measures disability status within different age groups:

- Hearing and vision difficulty for all the people
- Cognitive, ambulatory, and self-care for people 5 years and older
- Independent living for people 15 years and older

Data values for Randolph County can be interpreted as follows: Individuals with hearing difficulty are 4.5% of the total population; individuals with vision difficulty are 2.7% of the total population; individuals with cognitive difficulty are 6.5% of the total population age 5+; individuals with ambulatory difficulty are 8.4% of the total population age 5+; individuals with self-care difficulty are 2.7% of the total population age 5+; and individuals with independent living difficulty are 6.0% of the total population age 18+.

**Limitations:** This measure only includes six disability types and may not reflect all experiences of disability.

**Figure 21**. Population With Any Disability by Disability Status in Randolph County, 2019 to 2023[15]

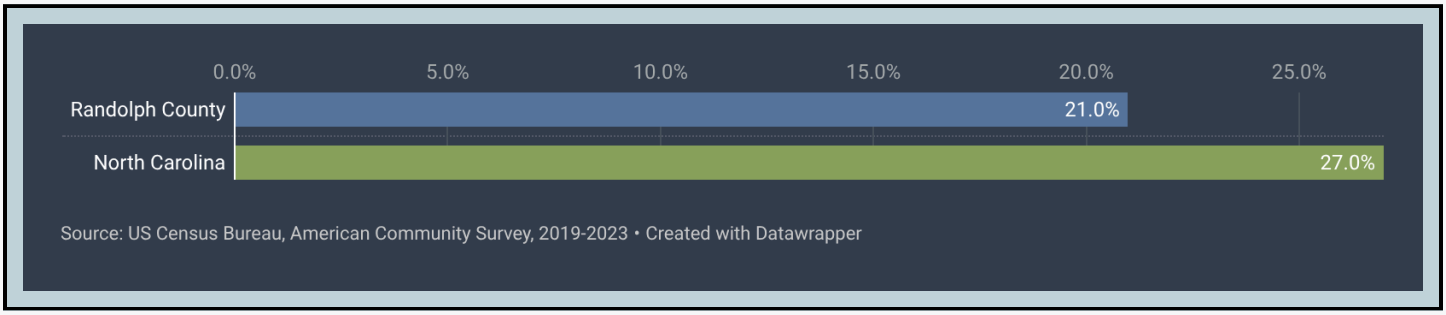


## Children Living in Single Parent Households

This data shows the population of children under 18 living in family households that are headed by a single parent in Randolph County compared to the state from 2019–2023. About 21% of children in Randolph County live in single-parent households. Family structure can influence access to resources and overall well-being.

**Limitations:** Single-parent households vary greatly in support and stability, so health risks are not the same for all.

**Figure 22**. Percentage of the Population of Children Under 18 Living in a Single-Parent Household, 2019-2023[19]

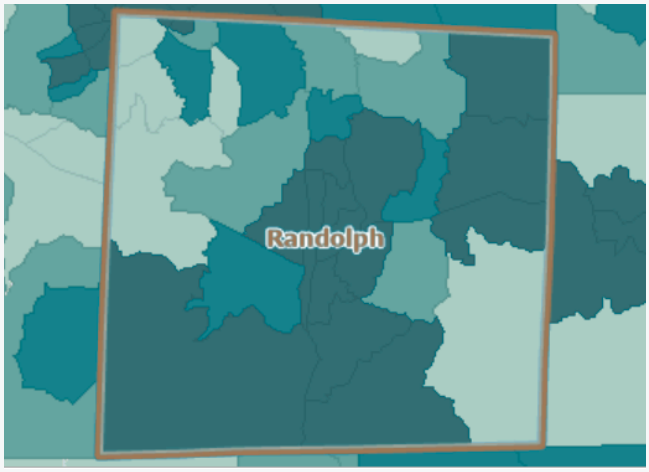


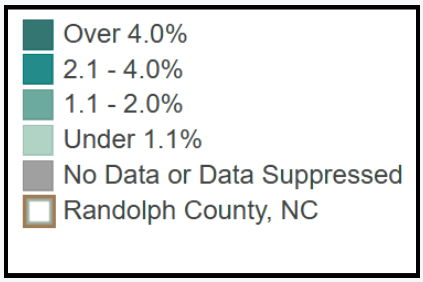

## Limited English Proficiency

This map shows the population of Randolph County residents age five and older who speak a language other than English at home in Randolph County from 2019–2023. In Randolph County, of residents aged 5 and older, 4.9% speak a language other than English at home and speak English less than "very well." Language barriers can limit access to services, especially during emergencies.

**Limitations:** Surveys may not offer all language options, and some households may be undercounted.

**Figure 23**. Population Age Five and Older With Limited English Proficiency, Percent by Tract, in Randolph County 2019 to 2023[19]




The demographic information presented in the County Profile helps explain why certain health issues are becoming more visible in Randolph County. An aging population, a largely rural geographic distribution, and differences in household structure influence access to care, transportation needs, and demand for health and social services. Together, these demographic patterns provide important context for understanding emerging health issues, which will be examined in greater detail in the following sections.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## Overview

The Community Status Assessment (CSA) describes health outcomes and the conditions that influence health in Randolph County using secondary data sources. This section provides a snapshot of length of life, quality of life, and community conditions by examining indicators related to health infrastructure, the physical and built environment, and social and economic factors.

As part of the MAPP 2.0 framework, the CSA helps answer the question, "How healthy is our community?" Indicators in this section are organized using County Health Rankings and Roadmaps (CHR&R) structure and the 2025 University of Wisconsin Population Health Institute (UWPHI) Model of Health theoretical framework to support clear interpretation and comparison with peer counties and the state.

Data presented in this section highlight patterns, trends, and differences across indicators and peer counties, and provide additional perspective for understanding the factors that shape health and well-being in Randolph County. The findings from the CSA will inform the identification of priority health issues and complement the community perspectives presented in **Section V: Community Context Assessment**.

## Population Health and Well-Being

### Length of Life

Length of life indicators describe how long residents live and the extent to which deaths occur earlier than expected for residents of Randolph County, with comparisons to peer counties and North Carolina, using data collected between 2019 and 2024. Measures in this table include life expectancy at birth, premature mortality, and cause-specific death rates related to injury and substance use.

Based on 2020–2022 data, life expectancy in Randolph County was 72.9 years, lower than Alamance County (75.3 years), Catawba County (73.9 years), Davidson County (73.3 years), and North Carolina overall (76.2 years). During 2021–2023, premature mortality, defined as deaths occurring before age 75, occurred at a rate of 538 deaths per 100,000 residents, exceeding the state rate (440 per 100,000) and the rate in Alamance County (438 per 100,000), while remaining similar to Catawba and Davidson counties.

Several cause-specific mortality rates were higher in Randolph County than statewide levels. Between 2019 and 2023, drug overdose deaths occurred at a rate of 65.4 per 100,000 residents, higher than North Carolina (42.1) and all peer counties. Suicide mortality, based on 2024 data, was 16.0 deaths per 100,000, exceeding the statewide rate (14.2) and Alamance County (15.4), while remaining lower than Davidson County (21.0) and Catawba (18.5). Motor vehicle crash deaths occurred at a rate of 19.0 per 100,000 residents during 2019–2023, higher than North Carolina (16.1). Firearm-related mortality (16.3 per 100,000) was similar to the statewide average, while unintentional fall deaths (31.2 per 100,000) were higher than all peer counties and the state.

Early life mortality indicators showed rates within the regional range, with some variation. From 2019 to 2023, infant mortality in Randolph County was 7.5 deaths per 1,000 live births, higher than Alamance (5.8) and Catawba (6.6) counties and North Carolina (6.9), but lower than Davidson County (8.9). During the same period, child mortality among ages 0–17 was 58.3 deaths per 100,000 children, higher than Alamance and Catawba counties, slightly lower than the statewide rate (61.5), and lower than Davidson County (69.4).

Length of life indicators reflect how patterns of early death and injury vary across communities. Differences in mortality rates help describe where preventable causes of death may contribute more heavily to health inequities and where opportunities exist to support longer, healthier lives.

**Table IV-1.** Length of Life Indicators, Randolph County, Peer Counties, and North Carolina

| Indicator | What This Measures | Randolph County | Benchmark Comparison* | Data Year(s) |
|---|---|---|---|---|
| Life expectancy at birth[20] | Average number of years a person is expected to live | 72.9 years | **A**: 75.3 **C**: 73.9 **D:** 73.3 **NC**: 76.2 | 2020 – 2022 |
| Premature age-adjusted mortality[21] | Deaths before age 75 per 100,000 residents | 538 | **A:** 438 **C:** 513 **D:** 556 **NC:** 440 | 2021 – 2023 |
| Drug overdose mortality[23] | Deaths due to drug poisoning per 100,000 (age-adjusted) | 65.4 | **A:** 32.6 **C:** 58.9 **D:** 64.4 **NC:** 42.1 | 2019 – 2023 |
| Suicide mortality[23] | Deaths due to suicide per 100,000 (age-adjusted) | 16.0 | **A:**15.4 **C:** 18.5 **D:** 21.0 **NC**: 14.2 | 2024 |
| Firearm mortality[23] | Firearm-related deaths per 100,000 (5-year avg.) | 16.3 | **A:** 7.8 **C:** 12.7 **D:** 20.6 **NC:** 16.7 | 2019 – 2023 |
| Motor vehicle crash mortality[23] | Traffic-related deaths per 100,000 | 19.0 | **A:** 13.9 **C:** 18.2 **D:** 21.2 **NC:** 16.1 | 2019 – 2023 |
| Unintentional fall mortality[23] | Deaths from falls per 100,000 | 31.2 | **A:** 27.8 **C:** 18.8 **D:** 20.0 **NC:** 18.4 | 2019 – 2023 |
| Infant mortality[22] | Deaths under age 1 per 1,000 live births | 7.5 | **A:** 5.8 **C:** 6.6 **D:** 8.9 **NC:** 6.9 | 2019 – 2023 |
| Child mortality (ages 0–17)[22] | Deaths among children per 100,000 | 58.3 | **A:** 38.2 **C:** 48.2 **D:** 69.4 **NC:** 61.5 | 2019 – 2023 |

* Benchmark Comparison: Peer counties include Alamance (A), Catawba (C), and Davidson (D) Counties. Peer values are shown for each county, with the North Carolina value provided for additional context.

## Quality of Life

Quality of life indicators describe how residents experience physical and mental health in daily life for Randolph County, with comparisons to peer counties and North Carolina, using data collected in 2022 and 2023. Measures in this table include self-reported physical health, mental health, emotional well-being, and selected birth outcomes.

Behavioral Risk Factor Surveillance System (BRFSS) survey data from 2022 show that adults in Randolph County reported an average of 4.4 poor physical health days and 5.2 poor mental health days in the past month. Both measures were higher than the North Carolina averages (4.1 physical health days and 4.9 mental health days) and higher than those reported in Alamance, Catawba, and Davidson counties. Frequent mental distress, defined as experiencing 14 or more poor mental health days in a month, affected 19% of adults in Randolph County, exceeding peer county rates and the statewide level (16%). In addition, 21% of adults rated their health as fair or poor, a higher share than peer counties and North Carolina (18%).

Birth outcome indicators were more consistent across the region. In 2022, 9% of live births in Randolph County were classified as low birthweight, meaning infants weighed less than 2,500 grams (5.5 lbs) at birth, matching peer counties and the statewide rate. Preterm births, defined as births occurring before 37 weeks of gestation, accounted for 10% of live births in 2023, comparable to peer counties and slightly lower than the statewide level (11%).

Quality of life indicators communicate how health affects daily functioning and well-being. Differences in physical and mental health experiences help describe where residents may face greater challenges to maintaining good health and where conditions influence well-being across the lifespan.

**Table IV-2.** Quality of Life Indicators, Randolph County, Peer Counties, and North Carolina

| Indicator | What This Measures | Randolph County | Benchmark Comparison* | Data Year(s) |
|---|---|---|---|---|
| Poor physical health days[24] | Avg. days physical health was not good in past 30 days | 4.4 | **A:** 4.1 **C:** 3.9 **D:** 4.1 **NC**: 4.1 | 2022 |
| Poor mental health days[24] | Avg. days mental health was not good in past 30 days | 5.2 | **A:** 5.1 **C:** 5.0 **D:** 5.1 **NC:** 4.9 | 2022 |
| Frequent mental distress[24] | Percent of adults with 14+ poor mental health days/month | 19.0% | **A:** 18.0% **C:** 17.0% **D:** 18.0% **NC:** 16.0% | 2022 |
| Self-rated fair or poor health[24] | Percent of adults reporting fair or poor health | 21.0% | **A:** 20.0% **C:** 18.0% **D:** 18.0% **NC:** 18.0% | 2022 |
| Low birthweight[25] | Percent of live births under 2,500 grams | 9.0% | **A:** 9.0% **C:** 9.0% **D:** 10.0% **NC:** 9.0% | 2022 |
| Preterm births[25] | Percent of live births before 37 weeks | 10.0% | **A:** 10.0% **C:** 10.0% **D:** 11.0% **NC:** 11.0% | 2023 |

* Benchmark Comparison: Peer counties include Alamance (A), Catawba (C), and Davidson (D) Counties. Peer values are shown for each county, with the North Carolina value provided for additional context.

# Disparities: Population Health and Well-Being

## Length of Life

The following figures display death rates in Randolph County across leading causes of preventable death, disaggregated by race and ethnicity, sex, age, and year. Reviewing these data together helps identify which populations are most affected and whether trends are improving, worsening, or remaining stable over time.

### Mortality Trends by Race & Hispanic Ethnicity

**Figure 24.** Racial Disparities in Motor Vehicle Death Rates in Randolph County, 2019-2023[23]

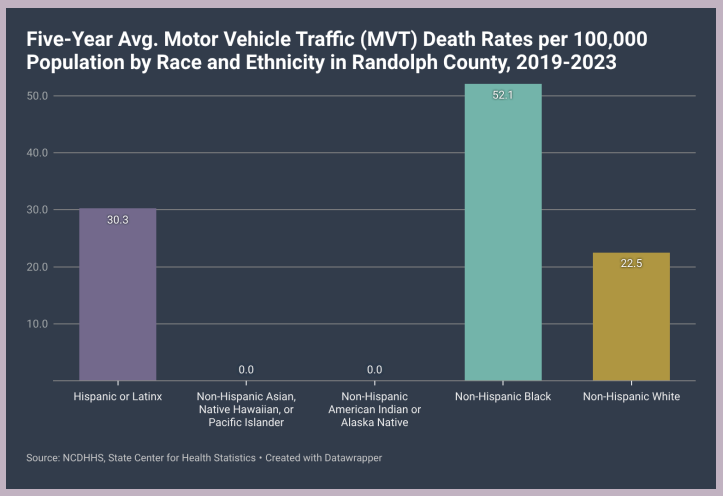
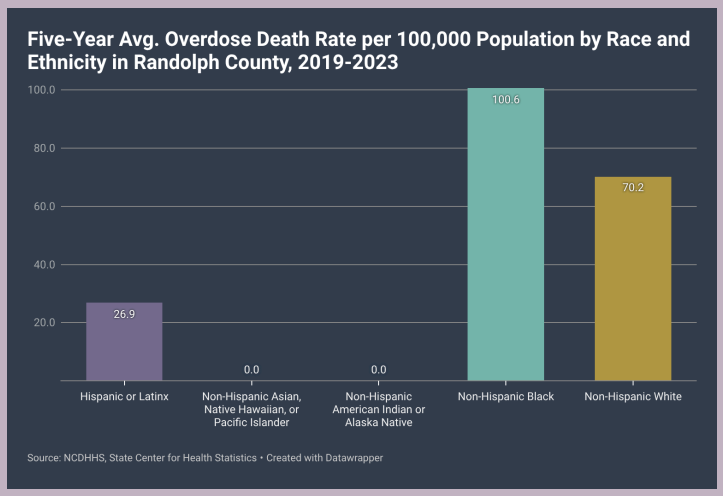



**Figure 25.** Racial Disparities in Overdose Death Rates in Randolph County, 2019-2023[23]




There are clear differences in death rates by race and ethnicity in Randolph County.

Motor vehicle traffic deaths are highest among non-Hispanic Black residents, followed by non-Hispanic White residents, with Hispanic residents also experiencing elevated rates compared to other groups.

Overdose deaths show even larger gaps. Non-Hispanic Black residents have the highest overdose death rate, followed by non-Hispanic White residents, while Hispanic residents have lower rates but are still affected. Non-Hispanic Asian, Native Hawaiian, and Pacific Islander and non-Hispanic American Indian or Alaskan Native populations show very small or no reported rates in these tables, which suggests small population size rather than absence of impact.

Overall, non-Hispanic Black residents are experiencing a disproportionate burden of both injury related and overdose deaths, indicating inequities in exposure to risk, prevention access, and underlying social conditions.

## Infant & Child Mortality Trends

**Figure 26.** Trends in Child Death Rates, 2019-2023[22]

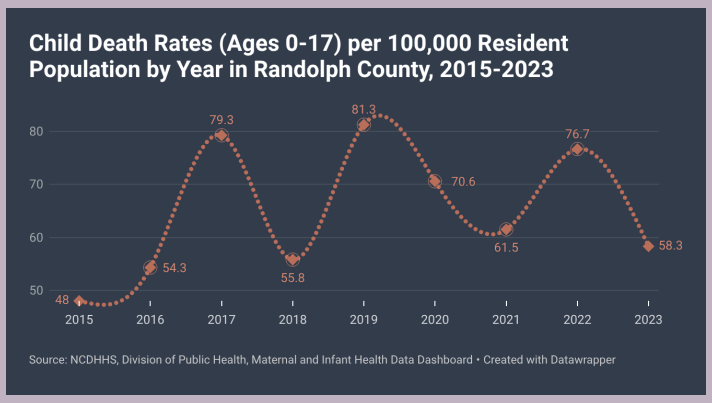
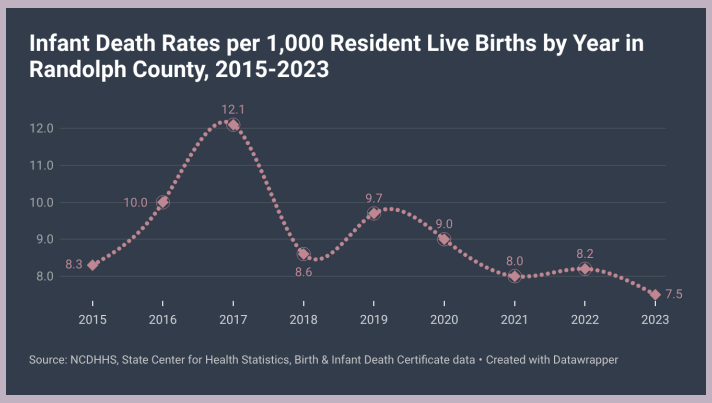



**Figure 27.** Trends in Infant Death Rates, 2019-2023[22]




Child death rates fluctuate significantly from year to year. There are notable spikes around 2017, 2019, and 2022, followed by declines, suggesting instability rather than steady improvement.

Infant death rates also vary over time, with a peak around 2017 and lower rates in more recent years, including a decline in 2023. While recent decreases are encouraging, the year to year variation highlights ongoing vulnerability among children and infants.

These patterns suggest that families with young children may be experiencing changing conditions related to health care access, safe environments, economic stability, and other early life factors that influence survival.

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## Mortality Trends by Sex

**Figure 28.** Sex Disparities in Opioid Overdose Death Rates in Randolph County, 2019-2023[23]

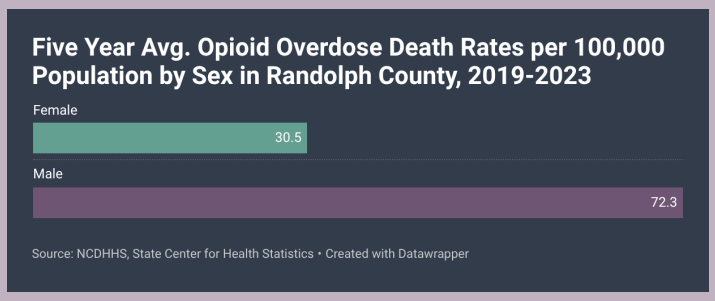
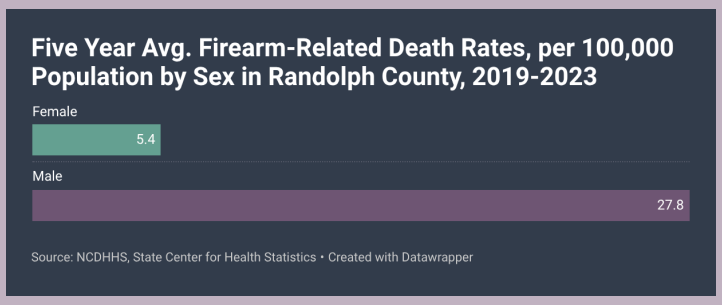



**Figure 29.** Sex Disparities in Firearm-Related Death Rates in Randolph County, 2019-2023[23]

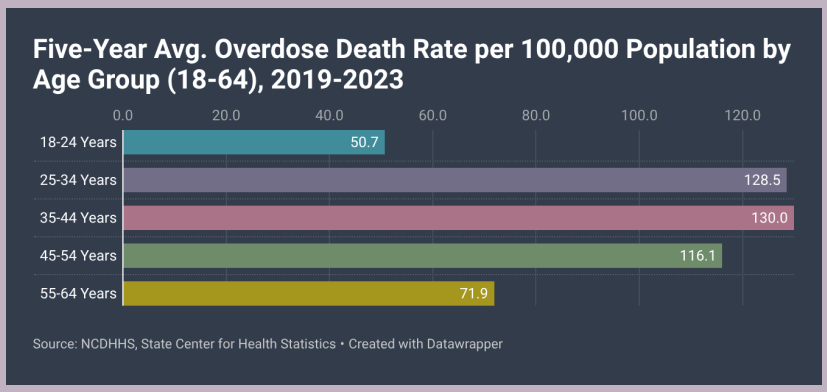



There are substantial differences in overdose and firearm related deaths by sex. Males have more than double the overdose death rate compared to females. The gap is also pronounced for firearm related deaths, with males experiencing rates several times higher than females.

These differences indicate that men are at significantly higher risk for fatal overdose and firearm-related injury in Randolph County. The pattern suggests the need to better understand behavioral health access, substance use risk, mental health support, and help seeking behaviors among men.

## Mortality Trends by Age

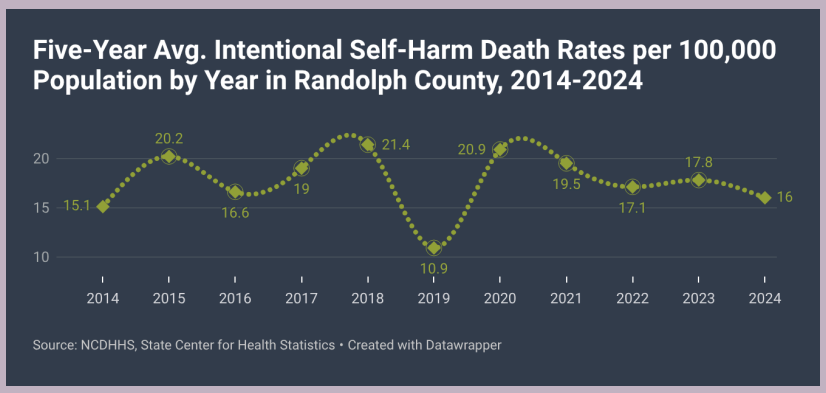
**Figure 30.** Age Disparities in Opioid Overdose Trends, 2019-2023[23]




Overdose deaths vary widely by age group. Adults ages 35 to 44 have the highest overdose death rate, followed closely by those ages 25 to 34 and 45 to 54. Rates are lower among young adults ages 18 to 24 and adults 55 to 64, though they remain concerning.

This pattern shows that overdose deaths are concentrated among working age adults, particularly those in midlife. These years often carry pressures related to employment, caregiving, financial strain, and health conditions, which may contribute to increased risk.

**Figure 31.** Trends in Intentional Self-Harm Death Rates, 2019-2023[23]




Intentional self harm death rates have fluctuated over the past decade. Rates increased around 2015, declined in 2016, rose again in 2018 and 2020, and have remained elevated though somewhat lower in recent years. While there is not a steady upward trend, the overall pattern shows persistent levels of suicide over time rather than sustained decline.

These fluctuations suggest that community stressors, access to mental health care, social connection, and economic conditions may be influencing suicide risk from year to year.

## Chronic Disease Mortality

**Figure 32.** Racial and Ethnic Disparities in Chronic Disease Mortality, 2019-2023[26]

**Age-Adjusted Chronic Disease Death Rates per 100,000 Population by Race and Ethnicity in Randolph County, 2019-2023**

| | Cancer | Chronic Lower Respiratory Disease | Diabetes Mellitus | Heart Disease | Kidney Disease |
|---|---|---|---|---|---|
| Non-Hispanic White | 173.5 | 53.4 | 29.8 | 206.8 | 16.6 |
| Non-Hispanic Black | 209.1 | 38.1 | 48.7 | 196.9 | 33.3 |
| Non-Hispanic American Indian or Alaskan Native | N/A | N/A | N/A | N/A | N/A |
| Non-Hispanic Asian, Native Hawaiian, or Pacific Islander | N/A | N/A | N/A | N/A | N/A |
| Hispanic or Latinx | 84.0 | N/A | N/A | 83.1 | N/A |

16.6 209.1

*NA: Data not available for this combination of variables or data have been suppressed to ensure confidentiality and stability of rate estimates. Counts are suppressed if fewer than 16 records were reported in a specific area-sex-race category.*

Source: National Institute on Minority Health and Health Disparities, HDPulse, NC Mortality Table • Created with Datawrapper

The chronic disease mortality table shows meaningful differences by race and ethnicity across several leading causes of death. Non-Hispanic Black residents have the highest death rates for cancer and diabetes, and also experience elevated rates of kidney disease compared to non-Hispanic White residents. Non-Hispanic White residents have the highest rates for chronic lower respiratory disease and slightly higher rates for heart disease compared to non-Hispanic Black residents. Hispanic or Latinx residents show lower reported rates for cancer and heart disease in this table, though data are not available for several other conditions.

For non-Hispanic American Indian or Alaska Native residents and for non-Hispanic Asian, Native Hawaiian, or Pacific Islander residents, most data are listed as not available. The footnote explains that these values are suppressed to protect confidentiality and to ensure stability of rate estimates when case counts are small. When fewer than a certain number of deaths occur in a specific race and sex category, rates are not reported. This does not mean that chronic disease is absent in these populations, rather the number of deaths is too small to calculate a reliable rate.

Overall, the table shows that non-Hispanic Black residents carry a disproportionate burden for several chronic conditions, particularly cancer, diabetes, and kidney disease, while non-Hispanic White residents experience higher mortality for chronic lower respiratory disease. The absence of data for some groups reflects small population size, not lack of need, and highlights the importance of cautious interpretation when working with smaller communities.

## Quality of Life

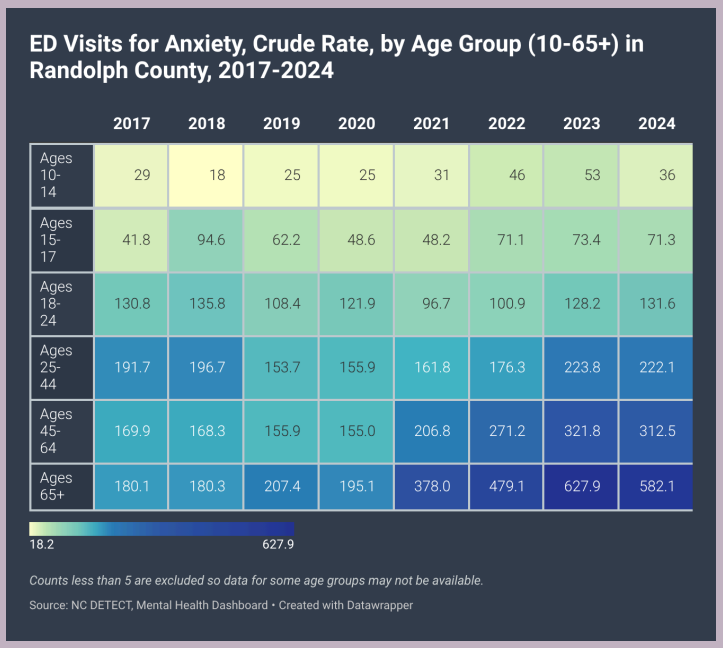
The following data from the North Carolina Disease Event Tracking and Epidemiologic Collection Tool (NC DETECT) Mental Health Dashboard show Emergency Department (ED) visit rates in Randolph County from 2017-2024 for anxiety, depression, and trauma/stress-related conditions[68]. The data are disaggregated by age, sex, race, and Hispanic ethnicity to better understand patterns across population groups. Examining ED visits helps identify trends in crisis-level mental health needs and highlights differences across communities within the county.

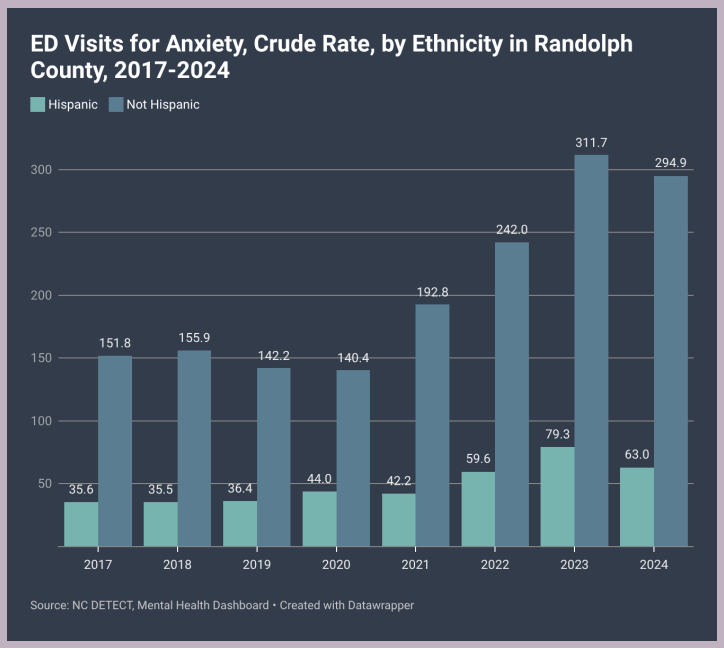
**Note:** Data reported by NC DETECT reflect ED visits by county of residence rather than the location of the hospital. This means visits are attributed to Randolph County residents regardless of where care was received.

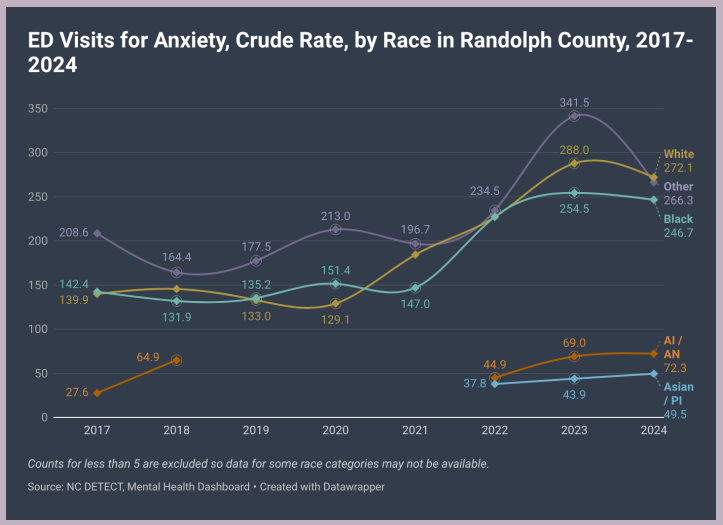
**Limitations:** These data are based on diagnostic codes from the International Classification of Diseases, Tenth Revision (ICD-10). ED visits may include multiple diagnoses, so conditions such as anxiety, depression, or trauma and stress-related disorders may be listed alongside other primary reasons for the visit. As a result, these data reflect visits where these conditions were identified but do not necessarily indicate that they were the main reason for seeking care.

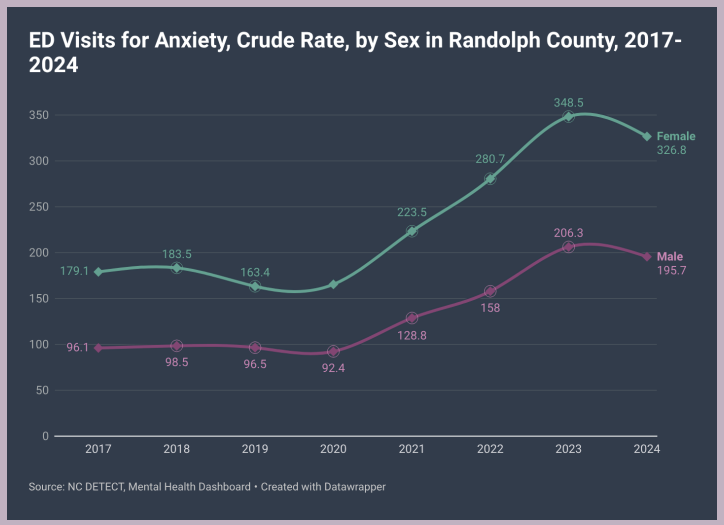
## Trends in Anxiety-Related Emergency Department Visits

**Figure 33.** Trends in Anxiety-Related Emergency Department Visits by Age, Sex, Race, and Hispanic Ethnicity in Randolph County, 2017-2024[27]




ED visit rates for anxiety increased notably after 2020 and remain elevated compared to earlier years.

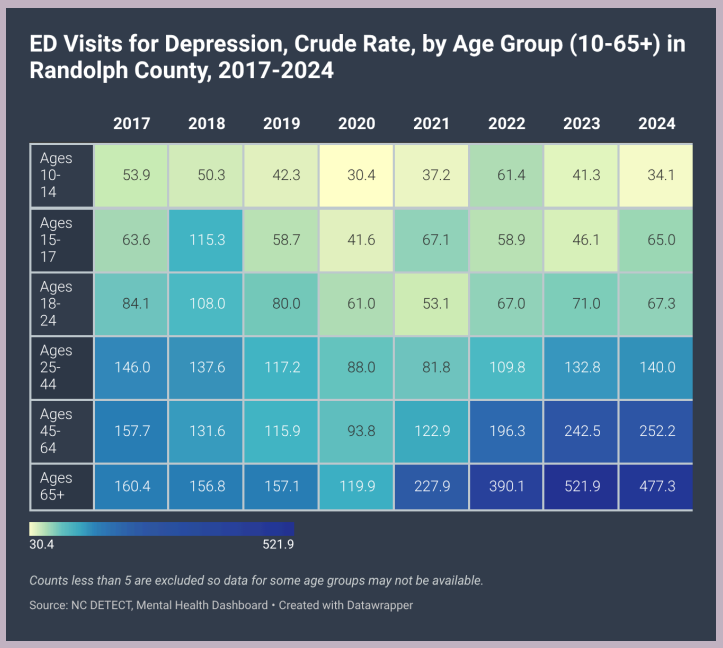
Women consistently have higher ED visit rates for anxiety than men across all years. Adults age 65 and older show one of the most significant increases over time, particularly beginning in 2021.

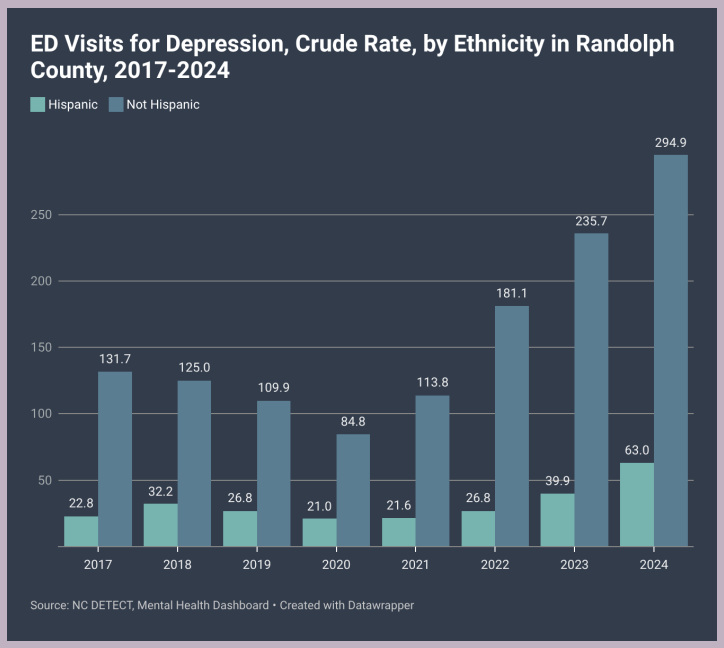
Non-Hispanic White residents have the highest overall ED visit rates for anxiety. Non-Hispanic residents consistently show higher rates than Hispanic residents. While Hispanic residents have lower recorded ED visit rates, differences in utilization may be influenced by factors such as language access, cultural stigma, insurance coverage, or other barriers to care.

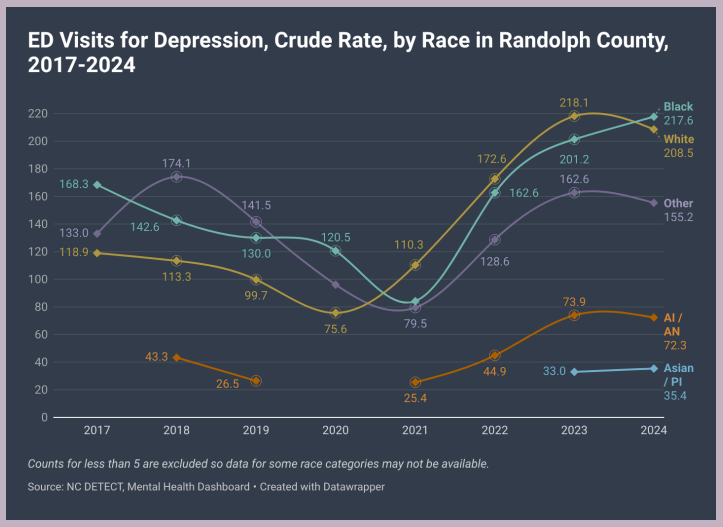
These patterns indicate clear disparities by sex, age, and ethnicity, with older adults and women experiencing a growing burden of anxiety-related emergency visits.

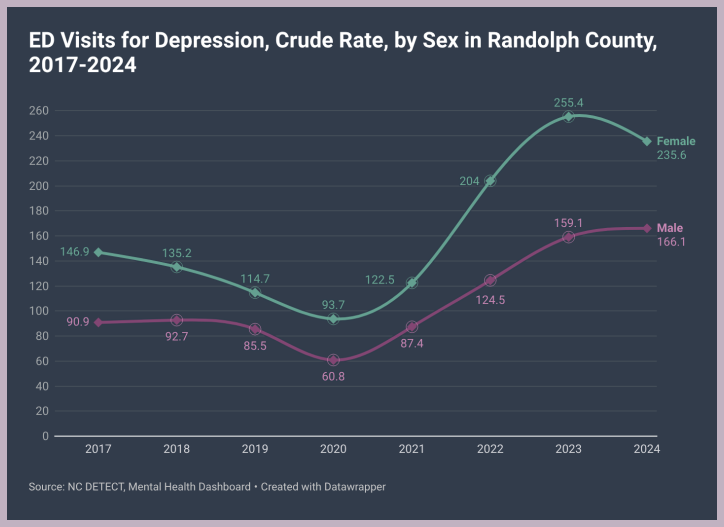
## Trends in Depression-Related Emergency Department Visits

**Figure 34.** Trends in Depression-Related Emergency Department Visits by Age, Sex, Race, and Ethnicity in Randolph County, 2017-2024[27]




ED visits for depression increased sharply beginning in 2021 and remain elevated through 2024.

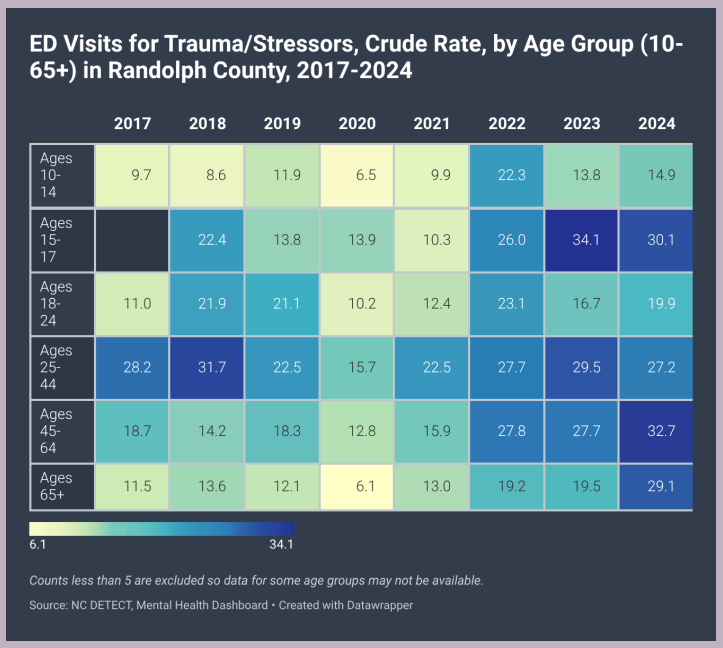
Females have consistently higher ED visit rates for depression than males. Adults age 65 and older experienced the most substantial increases in recent years.

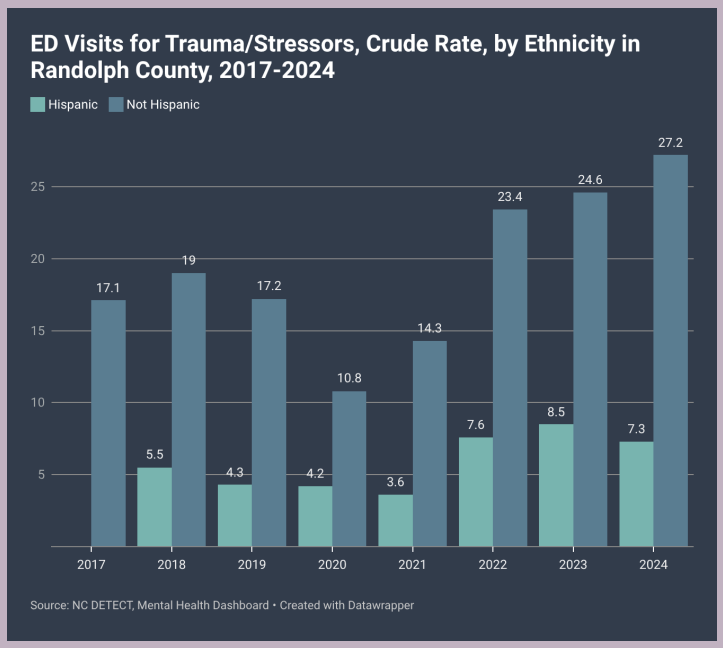
Non-Hispanic White residents have the highest overall ED visit rates. However, non-Hispanic Black residents show rising rates in recent years, narrowing the gap in some reporting periods. Non-Hispanic residents continue to show higher ED visit rates than Hispanic residents. As with anxiety, lower visit rates among Hispanic residents may indicate differences in healthcare access, utilization patterns, language barriers, or stigma.

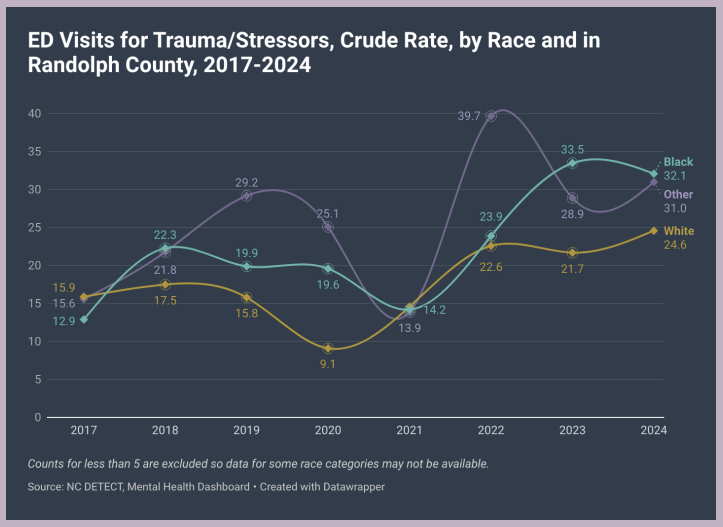
The data show sustained disparities by age and sex, with emerging racial disparities in recent years.

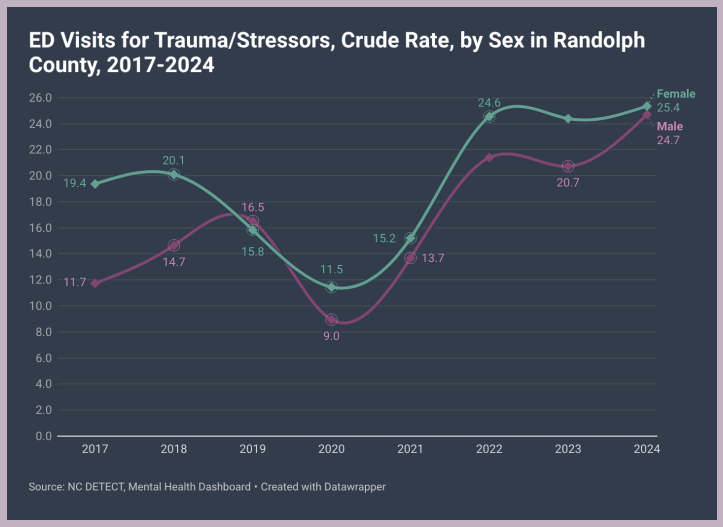
## Trends in Trauma/Stressor-Related Emergency Department Visits

**Figure 35.** Trends in Trauma- and Stressor-Related Emergency Department Visits by Age, Sex, Race, and Ethnicity in Randolph County, 2017-2024[27]




ED visits related to trauma and stressors increased after 2021 across multiple demographic groups.

Non-Hispanic Black residents experienced a marked increase in recent years and show some of the highest rates in the most recent data. Older adults ages 45-64 and adults age 65 and older also demonstrate steady increases over time. Differences between males and females are present but less pronounced than in anxiety and depression. Both sexes experienced steady increases since 2021 with females maintaining slightly elevated rates over males.

Non-Hispanic residents show higher ED visit rates than Hispanic residents. As in other categories, lower observed rates among Hispanic populations may reflect differences in access to care, language barriers, or cultural factors that influence help-seeking behaviors.

The most notable disparities in this category are by race and age, particularly the recent rise among non-Hispanic Black residents and older adults.

## Community Conditions: Health Infrastructure

Health infrastructure includes the systems, services, and resources that support access to health care, disease prevention, and long-term health management. The tables in this section present indicators related to insurance coverage, health care provider availability, prevention and vaccination efforts, chronic disease management, and maternal and child health for Randolph County, with comparisons to peer counties and North Carolina, providing insight on how residents access care and engage with the health system.

### Health Insurance Coverage

Health insurance coverage indicators describe access to coverage among residents of Randolph County, with comparisons to peer counties and North Carolina, using data collected between 2019 and 2025. Measures in this table include overall insurance coverage, uninsured rates among adults, and types of insurance coverage.

Between 2019 and 2023, 87.6% of Randolph County residents had health insurance, lower than Alamance (90.1%), Catawba (88.2%), Davidson (89.5%), and North Carolina (89.6%). In 2023, 13.4% of adults under age 65 were uninsured, higher than peer counties and the state. During 2019–2023, 65.5% of residents had private insurance, while 44.5% had public coverage, including Medicaid and Medicare, a higher share than peer counties and North Carolina. Medicaid enrollment reached 30.2% of residents in 2025, exceeding the statewide share (26.9%) and similar to Alamance County. As of March 2024, 78.0% of Medicare eligible residents were enrolled in a Medicare Advantage (MA) plan, higher than all peer counties and notably higher than the state (58.7%).

Health insurance coverage influences access to preventative care, treatment, and ongoing health services. Differences in coverage levels and types help describe where some residents may face greater challenges in accessing care or maintaining continuity of care over time.

**Table IV-3.** Health Insurance Coverage Indicators, Randolph County, Peer Counties, and North Carolina

| Indicator | What This Measures | Randolph County | Benchmark Comparison* | Data Year(s) |
|---|---|---|---|---|
| Population with health insurance[15] | Percent of residents with any form of health insurance | 87.6% | **A:** 90.1% **C:** 88.2% **D:** 89.5% **NC:** 89.6% | 2019 – 2023 |
| Uninsured population[28] | Percent of adults under age 65 without health insurance | 13.4% | **A:** 12.1% **C:** 12.3% **D:** 11.8% **NC:** 11.1% | 2023 |
| Private insurance coverage[15] | Percent of residents with private health insurance | 65.5% | **A:** 72.7% **C:** 71.6% **D:** 68.0% **NC:** 74.8% | 2019 – 2023 |
| Public insurance coverage[15] | Percent of residents with public health insurance | 46.5% | **A:** 41.0% **C:** 41.8% **D:** 43.5% **NC:** 39.5% | 2019 – 2023 |
| Medicaid enrollment[29] | Percent of residents enrolled in Medicaid | 30.2% | **A:** 31.4% **C**: 25.5% **D:** 29.4% **NC:** 26.9% | 2025 |
| Medicare Enrollment[30] | Percent of Medicare eligible residents enrolled in Medicare Advantage (MA) plan | 78.0% | **A:** 73.0% **C**: 61.0% **D:** 75.3% **NC:** 58.7% | 2024 |

* Benchmark Comparison: Peer counties include Alamance (A), Catawba (C), and Davidson (D) Counties. Peer values are shown for each county, with the North Carolina value provided for additional context.

## Primary & Preventive Care Access

Primary and preventive care access indicators describe health system capacity and care use for residents of Randolph County, with comparisons to peer counties and North Carolina, using data from 2017 to 2025. Measures include provider availability, health professional shortage areas, emergency department use, and preventable hospital stays.

In 2025, Randolph County had 50.6 primary care providers per 100,000 residents, fewer than Alamance (78.8) and Catawba (85.9) and well below the state (110.6). Dentist availability (35.4 per 100,000 in 2024) and mental health provider availability (140.8 per 100,000 in 2025) were also lower than peer counties and North Carolina. In addition, 73.2% of residents lived in a designated dental health professional shortage area (HPSA) in 2025, meaning there were fewer dentists available relative to population need.

Care use indicators mirrored these access patterns. In 2022, preventable hospital stays occurred at a rate of 3,273 per 100,000 Medicare enrollees, higher than peer counties and the state. Emergency department visits, measured between 2017 and 2024, totaled 4,231 visits per 10,000 residents, slightly lower than some peer counties but high overall.

Access to primary and preventative care affects how and when health needs are addressed. Differences in provider availability and patterns of utilizing care services help describe where residents may face barriers to receiving routine care outside of hospital settings.

**Table IV-4.** Primary and Preventive Care Access Indicators, Randolph County, Peer Counties, and North Carolina

| Indicator | What This Measures | Randolph County | Benchmark Comparison* | Data Year(s) |
|---|---|---|---|---|
| Primary care providers[31] | Primary care providers per 100k pop. (crude rate) | 50.6 | **A:** 78.8 **C:** 85.9 **D:** 48.5 **NC:** 110.6 | 2025 |
| Dentist providers[31] | Dentists per 100k pop. (crude rate) | 35.4 | **A:** 56.6 **C:** 66.0 **D:** 23.7 **NC:** 60.9 | 2024 |
| Mental health providers[31] | Mental health providers per 100k pop. (crude rate) | 140.8 | **A:** 173.3 **C:** 258.4 **D:** 137.9 **NC:** 327.6 | 2025 |
| Substance use treatment providers[31] | Providers specializing in substance use disorder treatment per 100k pop. (crude rate) | 26.4 | **A:** 14.6 **C:** 33.0 **D:** 29.6 **NC:** 30.9 | 2025 |
| Dental HPSA population[31] | Percent of residents living in a designated dental HPSA | 73.2% | **A:** 80.2% **C:** 87.5% **D:** 86.2% **NC:** 78.4% | 2025 |
| Federally Qualified Health Centers[31] | FQHCs per 100k pop. | 2.8 | **A:** 3.5 **C:** 18.7 **D:** 2.4 **NC:** 4.5 | 2025 |
| Preventable hospital stays[32] | Hospital stays for ambulatory-care sensitive conditions per 100,000 Medicare enrollees (age-adjusted) | 3,273 | **A:** 2,740 **C:** 2,376 **D:** 3,185 **NC:** 2,670 | 2022 |
| Emergency department visits[33] | Annual emergency department visits per 10,000 pop. (crude rate) | 4,231 | **A:** 4,576 **C:** 4,823 **D:** 4,685 **NC:** 4,579 | 2017 – 2024 |

* Benchmark Comparison: Peer counties include Alamance (A), Catawba (C), and Davidson (D) Counties. Peer values are shown for each county, with the North Carolina value provided for additional context.

## Communicable Disease Prevention & Control

Communicable disease indicators describe infection prevention, detection, and protection among residents of Randolph County, with comparisons to peer counties and North Carolina, using data from 2023 to 2025. Measures in this table include incidence rates (new cases) of select sexually transmitted infections (STIs), human immunodeficiency virus (HIV) diagnoses, and vaccination coverage.

During 2023 and 2024, chlamydia rates in Randolph County declined from 348.8 to 315.4 cases per 100,000 residents, lower than Alamance and Davidson counties and similar to Catawba County. Gonorrhea rates declined from 106.3 to 101.1 per 100,000 residents over the same period and followed a similar pattern. Primary and secondary syphilis rates remained lower than Alamance and Davidson counties and comparable to Catawba County.

HIV diagnoses increased from 6.4 per 100,000 residents in 2023 to 11.1 per 100,000 in 2024, higher than Alamance and Catawba counties and closer to the statewide rate. Childhood immunization coverage reached 95.0% in 2024, meeting recommended coverage levels and aligning with peer counties. In contrast, adult influenza vaccination coverage during the 2024–2025 season was 17.1%, lower than peer counties and North Carolina. Respiratory syncytial virus (RSV) protection among eligible mothers and infants reached 55.5% in 2025, comparable to peer counties.

Prevention and protecting against infectious disease depend on access to vaccines, testing sites, and timely care. Differences in infection rates and vaccination coverage help describe how protection from preventable illness may vary across communities and age groups.

**Table IV-5.** Communicable Disease Prevention and Control Indicators, Randolph County, Peer Counties, and North Carolina

| Indicator | What This Measures | Randolph County | Benchmark Comparison* | Data Year(s) |
|---|---|---|---|---|
| Chlamydia infection rate[34] | Reported chlamydia cases per 100k pop. (crude rate) | 348.8<br>315.4 | **A:** 572.9 \| 543.1 **C:** 332.2 \| 319.1<br>**D:** 434.6 \| 417.9 **NC:** 606.0 \| 561.5 | 2023 – 2024 |
| Gonorrhea infection rate[34] | Reported gonorrhea cases per 100k pop. (crude rate) | 106.3<br>101.1 | **A:** 207.1 \| 204.3 **C:** 143.7 \|121.5<br>**D:** 144.7 \| 122.0 **NC:** 242.6 \| 201.5 | 2023 – 2024 |
| Secondary syphilis infection rate[34] | Secondary syphilis cases per 100k pop. (crude rate) | 5.4<br>5.4 | **A:** 11.1 \| 8.7 **C:** 7.3 \| 3.0<br>**D:** 6.9 \| 4.5 **NC:** 11.7 \| 10.7 | 2023 – 2024 |
| HIV incidence[35] | New HIV diagnoses per 100k pop. (crude rate) | 6.4<br>11.1 | **A:** 10.5 \| 10.3 **C:** 11.4 \| 7.0<br>**D:** 10.1 \| 7.3 **NC:** 15.2 \| 14.6 | 2023 – 2024 |
| Childhood immunization coverage[36] | Percent of children meeting required school immunizations | 95.0% | **A:** 95.1% **C:** 91.8%<br>**D:** 96.4% **NC:** 92.8% | 2024 |
| Adult influenza vaccination[37] | Percent of adults receiving a flu vaccine | 17.1% | **A:** 19.6% **C:** 20.0%<br>**D:** 18.3% **NC:** 21.6% | 2024 – 2025 |
| RSV protection[38] | Percent of eligible infants protected during RSV season | 55.5% | **A:** 51.0% **C:** 49.9%<br>**D:** 59.0% **NC:** 62.0% | 2025 |

* Benchmark Comparison: Peer counties include Alamance (A), Catawba (C), and Davidson (D) Counties. Peer values are shown for each county, with the North Carolina value provided for additional context.

## Non-Communicable Disease Prevention & Management

Non-communicable disease indicators describe the prevalence (new and old cases) and incidence (new cases only) of chronic conditions and cancer among adults in Randolph County, with comparisons to peer counties and North Carolina, using data from 2021 to 2023. Measures include diabetes, high blood pressure, obesity, heart disease, high cholesterol, asthma, and cancer (all sites).

In 2023, 10.0% of adults in Randolph County had diabetes, 34.3% had high blood pressure, and 6.3% had heart disease, each higher than the statewide rate. In 2021, the prevalence of adults with obesity, defined as having a body mass index (BMI) of 30 or higher, was 32.8%. High cholesterol affected 32.6% of adults, and asthma affected 10.9%, rates similar to peer counties and North Carolina. Cancer incidence in 2022 was 510.5 new cases per 100,000 residents, higher than the state (495.3) and higher than Catawba County, while similar to Davidson County.

Chronic conditions and cancer affect quality of life, life expectancy, and long term health needs. Differences in disease prevalence and incidence help describe where the burden of chronic illness may be greater and where prevention and management efforts are especially important.

**Table IV-6.** Non-Communicable Disease Prevention and Management Indicators, Randolph County, Peer Counties, and North Carolina

| Indicator | What This Measures | Randolph County | Benchmark Comparison* | Data Year(s) |
|---|---|---|---|---|
| Diabetes prevalence (adults 20+)[39] | Adults age 20+ diagnosed with diabetes (age-adjusted) | 10.0% | **A:** 9.1% **C:** 7.7% **D:** 9.2% **NC:** 9.0% | 2023 |
| High blood pressure prevalence[39] | Adults age 18+ with hypertension (age-adjusted) | 34.3% | **A:** 33.4% **C:** 32.7% **D:** 33.4% **NC:** 33.7% | 2023 |
| Adult obesity prevalence[39] | Adults age 20+ with BMI ≥30 (age-adjusted) | 32.8% | **A:** 32.1% **C:** 25.8% **D:** 33.2% **NC:** 29.7% | 2021 |
| Heart disease prevalence[39] | Adults age 18+ ever diagnosed with CHD (age-adjusted) | 6.3% | **A:** 5.7% **C:** 5.7% **D:** 6.0% **NC:** 5.5% | 2023 |
| High cholesterol prevalence[39] | Adults age 18+ with high cholesterol (age-adjusted) | 32.6% | **A:** 30.8% **C:** 32.4% **D:** 31.3% **NC:** 31.4% | 2023 |
| Asthma prevalence[39] | Adults age 18+ with asthma (age-adjusted) | 10.9% | **A:** 10.9% **C:** 10.7% **D:** 11.1% **NC:** 10.8% | 2023 |
| Cancer incidence (all sites)[40] | New cancer cases per 100k pop. (age-adjusted) | 510.5 | **A:** 525.1 **C:** 475.3 **D:** 506.7 **NC:** 495.3 | 2022 |

* Benchmark Comparison: Peer counties include Alamance (A), Catawba (C), and Davidson (D) Counties. Peer values are shown for each county, with the North Carolina value provided for additional context.

## Maternal & Child Health

Maternal and child health indicators describe conditions related to pregnancy, childbirth, and early life for residents of Randolph County, with comparisons to peer counties and North Carolina, using data from 2023 and 2024. Measures include birth outcomes, pregnancy-related conditions, and infant feeding practices.

In 2023, the teen birth rate in Randolph County was 18.1 births per 1,000 females ages 15–19, higher than peer counties and the state (14.8). Gestational diabetes, defined as diabetes diagnosed during pregnancy, affected 10.6% of births, exceeding peer county and statewide rates. Perinatal mental health conditions, identified during pregnancy or at delivery, were documented in 12.2% of deliveries in 2024, lower than peer counties and North Carolina.

Several indicators identified strengths in maternal and infant care. First-trimester prenatal care occurred for 79.3% of births in 2023, higher than the state (72.0%) and most peer counties. Severe maternal morbidity, measured as 83.9 cases per 10,000 deliveries in 2024, was lower than peer counties and the state. Breastfeeding at hospital discharge occurred for 77.7% of births, similar to peer counties.

**Note:** Perinatal mental health conditions are a spectrum of mood and anxiety disorders occurring during pregnancy and up to 12 months after childbirth. These conditions include depression, anxiety, obsessive compulsive disorder (OCD), and psychosis[41].

**Note:** Severe maternal morbidity (SMM) refers to unexpected, serious health complications (kidney failure, stroke, hemorrhaging (bleeding), sepsis, etc.) that occur during pregnancy, labor, or delivery that can result in life-threatening situations or long-term health consequences. These often result in higher medical costs and longer hospital stays[42].

Health during pregnancy and early childhood influences outcomes across the lifespan. Differences in maternal and infant health indicators help describe where some families may face greater challenges in achieving healthy pregnancies and early development.

**Table IV-7.** Maternal and Child Health Indicators, Randolph County, Peer Counties, and North Carolina

| Indicator | What This Measures | Randolph County | Benchmark Comparison* | Data Year(s) |
|---|---|---|---|---|
| Teen birth rate[43] | Births to females ages 15–19 per 1,000 pop. (crude rate) | 18.1 | **A:** 13.0 **C:** 14.4 **D:** 14.0 **NC:** 14.8 | 2023 |
| Gestational diabetes[44] | Percent of births with gestational diabetes | 10.6% | **A:** 5.2% **C:** 8.8% **D:** 5.7% **NC:** 8.8% | 2023 |
| Perinatal mental health conditions[44] | Percent of mental health, mood, and anxiety disorders that occur during pregnancy or within first year after giving birth | 12.2% | **A:** 18.6% **C:** 31.8% **D:** 28.2% **NC:** 19.0% | 2024 |
| Severe maternal morbidity (SSM)[44] | SSM per 10,000 deliveries (crude rate) | 83.9 | **A:** 117.6 **C:** 104.2 **D:** 98.6 **NC:** 112.7 | 2024 |
| First-trimester prenatal care[44] | Percent of births with prenatal care beginning in the first trimester (within the first 92 days of pregnancy) | 79.3% | **A:** 70.3% **C:** 76.8% **D:** 80.4% **NC:** 72.0% | 2023 |
| Breastfeeding at delivery discharge[44] | Percent of infants who received any breastmilk or colostrum prior to hospital discharge | 77.7% | **A:** 86.0% **C:** 77.0% **D:** 66.4% **NC:** 80.9% | 2023 |

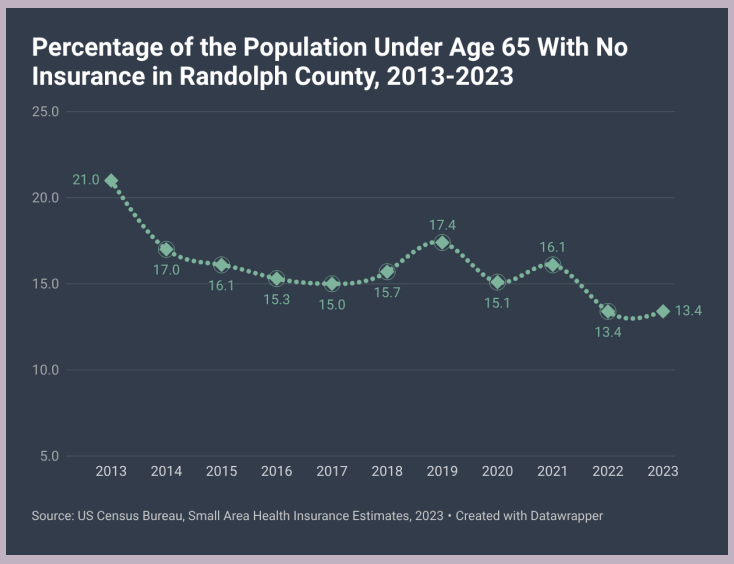
* Benchmark Comparison: Peer counties include Alamance (A), Catawba (C), and Davidson (D) Counties. Peer values are shown for each county, with the North Carolina value provided for additional context.

# Disparities: Health Infrastructure

The following figures display patterns in insurance coverage, overdose-related emergency department visits, cancer incidence trends, chronic disease prevalence, and maternal health indicators in Randolph County. Reviewing these indicators together helps identify where residents may face barriers to care and how health conditions are experienced across different population groups.

## Access to Health Coverage

**Figure 36.** Trends in Uninsured Rates Among Residents Under Age 65 in Randolph County, 2013–2023[28]




The percentage of residents under age 65 without health insurance in Randolph County has declined over the past decade. Rates decreased from approximately 21% in 2013 to 13.4% in 2023, though several fluctuations occurred during the middle of the reporting period. Short-term increases appeared around 2019 and 2021 before declining again in more recent years.

While overall coverage has improved, a portion of residents continue to lack health insurance. Individuals without insurance may face challenges accessing preventive services, routine care, and early treatment for health conditions.

Continued gaps in insurance coverage can influence when and how residents seek medical care. Even small changes in coverage levels can affect access to primary care, chronic disease management, and early detection of illness.

## Overdose-Related Emergency Department Visits

**Figure 37.** Age Differences in Overdose Emergency Department Visits in Randolph County, 2020–2024[33]

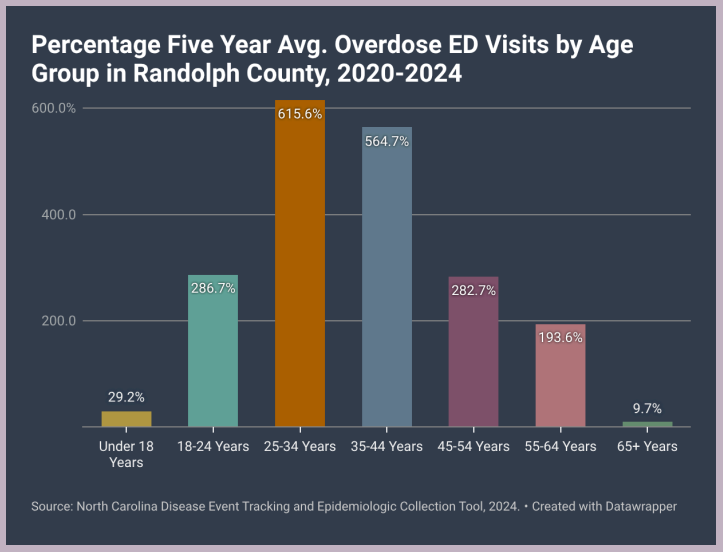
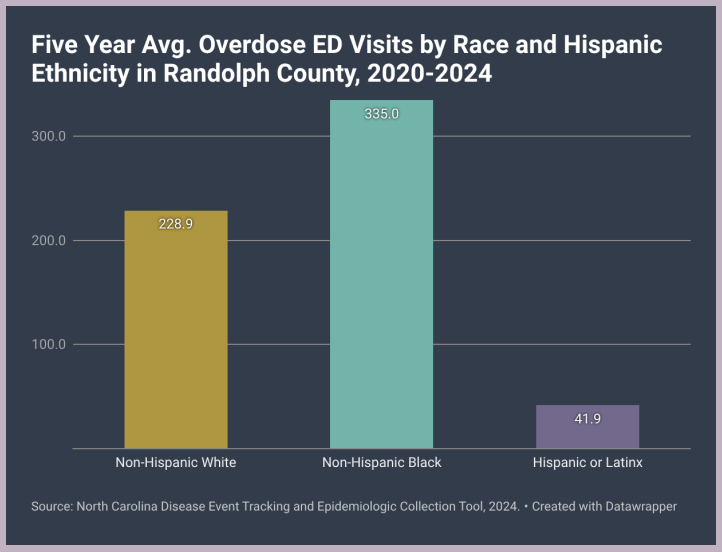



**Figure 38.** Disparities in Overdose ED Visits by Race and Ethnicity in Randolph County, 2020–2024[33]



Emergency department visits related to overdose vary across both racial and age groups.

Non-Hispanic Black residents experience the highest overdose-related emergency department visit rates, followed by non-Hispanic White residents. Hispanic or Latinx residents show lower recorded rates in these data, while several other racial groups have limited reported values due to smaller population sizes.

Age patterns show that overdose-related visits are concentrated among working-age adults. Adults ages 25 to 34 experience the highest rates, followed by those ages 35 to 44 and 45 to 54. Lower visit rates occur among adolescents, children, and older adults.

The concentration of overdose-related emergencies among working-age adults demonstrates the significant health and economic impact of substance use disorders. Differences across racial groups also highlight the importance of ensuring equitable access to prevention, treatment, and recovery services.

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## Cancer Incidence Trends

**Figure 39.** Trends in Female Breast Cancer Incidence Rates in Randolph County, 2014–2022[40]

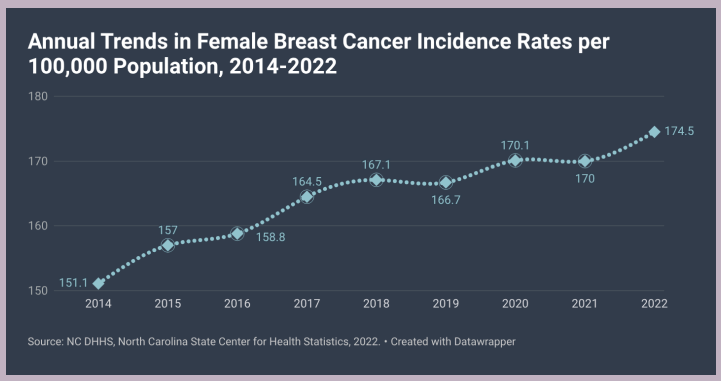
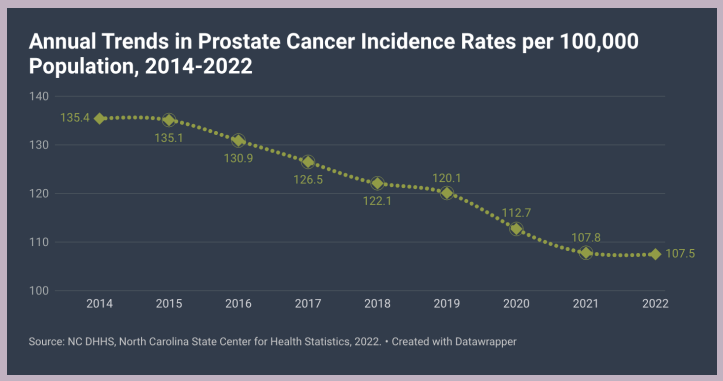



**Figure 40.** Trends in Prostate Cancer Incidence Rates in Randolph County, 2014–2022[40]




Cancer incidence trends differ by type of cancer.

Female breast cancer incidence increased gradually during the reporting period, rising from 151.1 cases per 100,000 residents in 2014 to 174.5 cases per 100,000 residents in 2022.

Prostate cancer incidence followed a different pattern, declining from 135.4 cases per 100,000 residents in 2014 to 107.5 cases per 100,000 residents in 2022.

Monitoring changes in cancer incidence helps communities understand where screening, prevention, and early detection efforts may have the greatest impact.

## Chronic Disease Risk Factors

**Figure 41.** Trends in Diabetes Prevalence by Sex in Randolph County, 2013–2023[39]

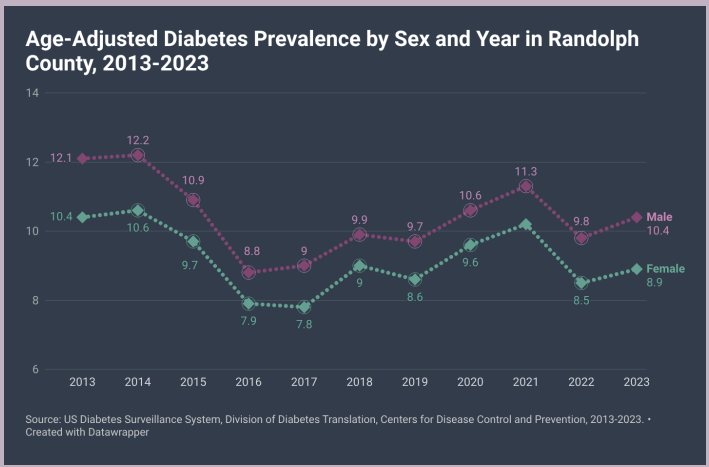
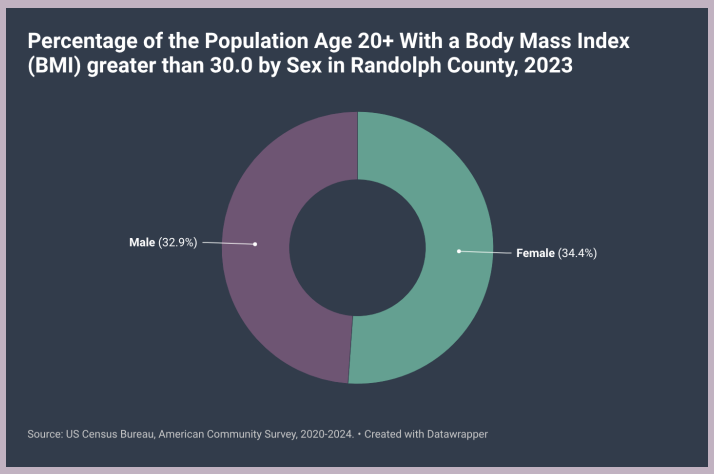



**Figure 42.** Obesity Prevalence Among Adults Age 20 and Older by Sex in Randolph County, 2023[39]




Chronic disease indicators differ between males and females.

Age-adjusted diabetes prevalence has remained consistently higher among males compared to females across most years between 2013 and 2023. Obesity prevalence shows a similar pattern, with males reporting slightly higher rates than females among adults age 20 and older.

Differences in chronic disease risk factors point to the long-term influence of lifestyle, environmental conditions, and access to preventive healthcare services.

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## Maternal & Child Health Trends

**Figure 43.** Hypertension During Pregnancy by Race and Hispanic Ethnicity in Randolph County, 2019–2023[44]

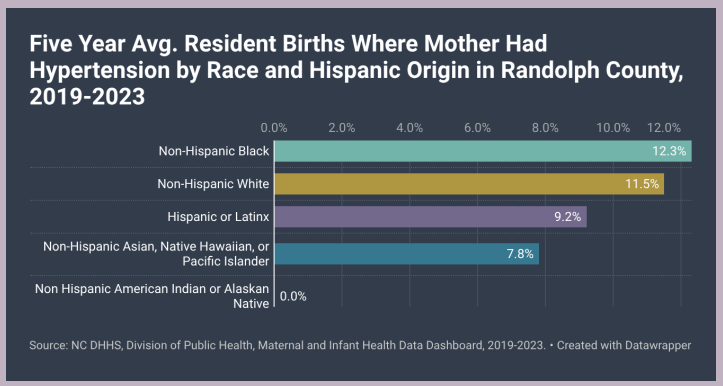
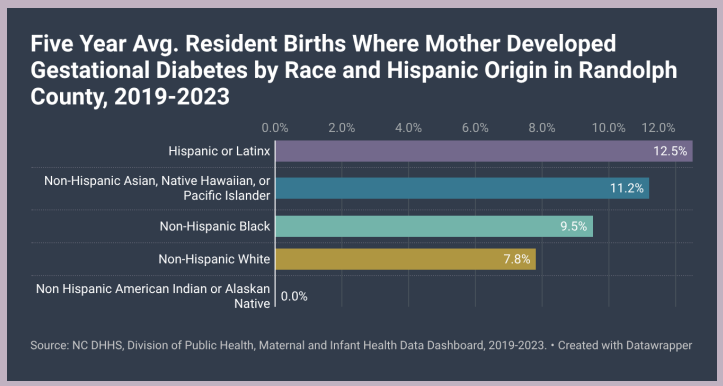



**Figure 44.** Gestational Diabetes During Pregnancy by Race and Hispanic Ethnicity in Randolph County, 2019–2023[44]



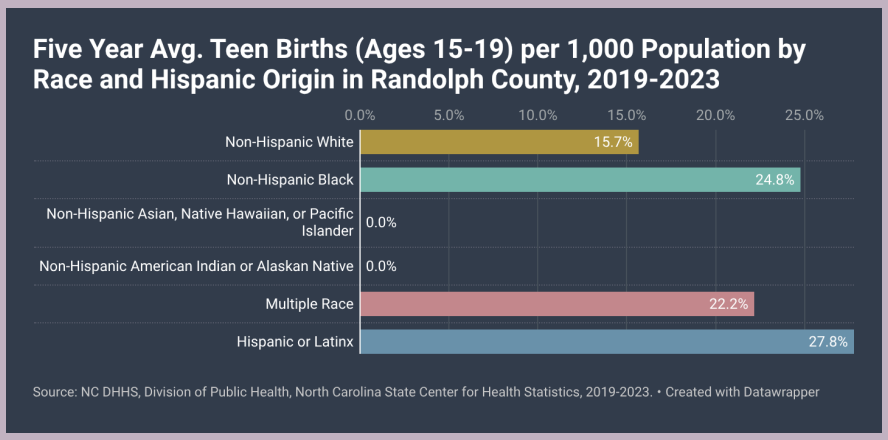

Maternal health indicators show variation across racial and ethnic groups in Randolph County.

Hypertension during pregnancy occurs most frequently among Hispanic residents (12.3%) and non-Hispanic White residents (11.5%). Lower rates are observed among non-Hispanic Asian, Native Hawaiian, or Pacific Islander residents (7.8%), while data for some populations such as non-Hispanic American Indian or Alaskan Native residents are limited due to small numbers.

Gestational diabetes shows a different pattern. Hispanic residents experience the highest rates (12.5%), followed by non-Hispanic Asian, Native Hawaiian, or Pacific Islander residents (11.2%) and non-Hispanic Black residents (9.5%). Non-Hispanic White residents show lower rates compared with several other groups.

Differences in maternal health conditions during pregnancy highlight how risk factors and access to prenatal care can vary across populations. Monitoring these patterns helps identify opportunities to strengthen maternal health services and support healthy pregnancies.

**Figure 45.** Teen Birth Rates by Race and Hispanic Ethnicity in Randolph County, 2019–2023[43]




Teen birth rates differ across racial and ethnic groups in Randolph County. Hispanic residents experience the highest teen birth rates (27.8%), followed by non-Hispanic Black residents (24.8%) and residents identifying as multiple races (22.2%). Non-Hispanic White residents show lower rates (15.7%), while data for some populations are limited due to small numbers.

Teen birth rates can suggest differences in access to reproductive health education, family planning services, and community supports for adolescents.

**Figure 46.** Deliveries with Perinatal Mental Health Conditions by Race and Hispanic Ethnicity in Randolph County, 2019–2023[44]

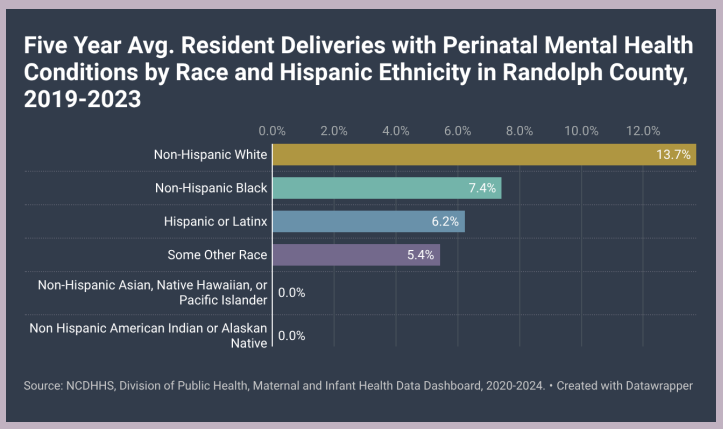
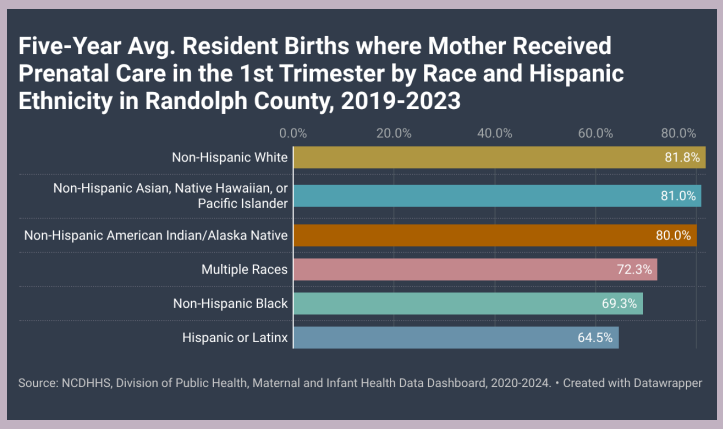



**Figure 47.** Prenatal Care in the First Trimester by Race and Hispanic Ethnicity in Randolph County, 2019–2023[44]




Perinatal mental health conditions vary across racial and ethnic groups. Non-Hispanic White residents report the highest percentage (13.7%) of deliveries with a diagnosed perinatal mental health condition. Lower reported rates appear among non-Hispanic Black residents (7.4%), Hispanic residents (6.2%), and other racial groups.

Access to prenatal care during the first trimester also varies across populations. Non-Hispanic White residents show the highest percentage of early prenatal care, followed by non-Hispanic Asian, Native Hawaiian, or Pacific Islander residents. Lower percentages are observed among Hispanic residents, non-Hispanic Black residents, and residents identifying as multiple races.

Differences in reported perinatal mental health conditions may suggest variation in screening, diagnosis, and access to behavioral health services during pregnancy and the postpartum period. Additionally, early prenatal care plays an important role in monitoring maternal health and supporting healthy birth outcomes. Differences in early prenatal care utilization may indicate variation in healthcare access, insurance coverage, and availability of supportive services.

# Community Conditions: Physical and Built Environment

The physical and built environment includes housing, infrastructure, transportation, and environmental conditions that shape daily living and influence health and safety. The tables in this section present indicators related to housing, transportation and mobility, environmental conditions, and access to food and recreational resources for Randolph County, with comparisons to peer counties and North Carolina, providing insight into how the community environment supports access to services, safety, and healthy daily living.

## Housing

Housing indicators describe conditions related to housing availability, affordability, quality, and stability for residents of Randolph County, with comparisons to peer counties and North Carolina, using data collected between 2017 and 2025. Measures in this table include housing assistance availability, housing cost burden among homeowners and renters, housing quality, homelessness, and eviction patterns.

In 2024, Randolph County had 260.6 Housing and Urban Development (HUD)–assisted housing units per 10,000 households, fewer than Alamance (377.2) and Catawba (304.7) counties and the state (319.8). Between 2019 and 2023, 21.1% of homeowners in the county spent 30% or more of household income on housing costs, a lower share than the statewide rate (25.9%) and Alamance County (24.4%). During the same period, 36.6% of renter households experienced housing cost burden, similar to Alamance (37.3%) and Davidson (35.4%) counties and higher than Catawba County (28.6%).

Housing quality indicators were comparable across counties. From 2017 to 2021, 11.1% of households in Randolph County lacked complete plumbing or kitchen facilities, similar to peer counties and slightly lower than North Carolina (12.6%). In 2025, the annual Point-in-Time (PIT) count identified 233 people experiencing homelessness in the county. Eviction activity, measured by county ranking during 2022–2023, placed Randolph County 36th, reflecting a mid-range position among peer counties.

**Note:** County eviction rankings in North Carolina are determined by analyzing the volume of court-ordered eviction filings relative to the total number of renter households. Counties are ranked on a scale of 1 to 100, with one being the highest percentage of evictions and 100 representing the lowest[43].

Housing affordability and stability influence daily stress, access to services, and overall well-being. Differences in housing conditions and cost help show where some residents may face greater challenges in securing stable and affordable housing.

**Table IV-8.** Housing Indicators, Randolph County, Peer Counties, and North Carolina

| Indicator | What This Measures | Randolph County | Benchmark Comparison* | Data Year(s) |
|---|---|---|---|---|
| Assisted housing units[45] | Total number HUD-funded assisted housing units available to eligible renters, reported as units per 10,000 total households | 260.6 | **A:** 377.2 **C:** 304.7 **D:** 248.8 **NC:** 319.8 | 2024 |
| Homeowner cost burden[15] | Percent of owner-occupied households where housing costs are 30% or more of total household income | 21.1% | **A:** 24.4% **C:** 20.2% **D:** 21.0% **NC:** 25.9% | 2019 – 2023 |
| Renter cost burden[15] | Percent of renter-occupied households paying 35% or more of total household income toward rent | 36.6% | **A:** 37.3% **C:** 28.6% **D:** 35.4% **NC:** 38.6% | 2019 – 2023 |
| Substandard housing[46] | Percent of households lacking complete plumbing or kitchen facilities | 11.1% | **A:** 11.9% **C:** 11.6% **D:** 12.4% **NC:** 12.6% | 2017 – 2021 |
| People experiencing homelessness[47] | Total number of sheltered and unsheltered people experiencing homelessness, based on the annual (PIT) count | 233 | **A:** 61 **C:** 499 **D:** 288 **NC:** 6,746 | 2025 |
| County eviction ranking[48] | Number of eviction cases initiated by landlords compared to the total population of renters | 36 | **A:** 15 **C:** 44 **D:** 38 **NC:** N/A | 2022 – 2023 |

* Benchmark Comparison: Peer counties include Alamance (A), Catawba (C), and Davidson (D) Counties. Peer values are shown for each county, with the North Carolina value provided for additional context.

## Transportation & Mobility

Transportation and mobility indicators describe how residents of Randolph County access employment, health care, food, education, and other daily needs, with comparisons to peer counties and North Carolina, using data from 2018 to 2023. Measures include vehicle access, commute patterns, proximity to public transit, walkability, and roadway safety.

Between 2019 and 2023, 3.5% of occupied households in Randolph County reported having no vehicle available, a smaller share than Alamance (4.4%), Catawba (5.2%), Davidson (4.0%), and North Carolina (5.3%). Average commute time during the same period was 23.8 minutes, similar to peer counties and slightly shorter than the statewide average (25.1 minutes). Although only 2.3% residents live more than three-quarters of a mile from a public transit stop (compared with 15.9% statewide), public transportation options in the county are limited in availability and frequency, and most residents rely on personal vehicles.

Neighborhood design indicators showed fewer walkable areas. The walkability index score of 5 in 2021 was lower than peer counties and North Carolina. Roadway safety data from 2018 to 2022 show a motor vehicle crash rate of 306.1 per 100 million vehicle miles traveled, lower than Alamance (346.3) and Catawba (332.4) counties but higher than the statewide rate (297.9).

Transportation access affects how easily residents reach jobs, health care, food, and other daily needs. Differences in vehicle access, walkability, public transit, and safety help describe where mobility options may limit access to essential services.

**Table IV-9.** Transportation and Mobility Indicators, Randolph County, Peer Counties, and North Carolina

| Indicator | What This Measures | Randolph County | Benchmark Comparison* | Data Year(s) |
|---|---|---|---|---|
| Households with no vehicles available[15] | Percent of occupied housing units with no vehicles available | 3.5% | **A:** 4.4% **C:** 5.2% **D:** 4.0% **NC:** 5.3% | 2019 – 2023 |
| Mean commute time[15] | Average travel time to work in minutes | 23.8 | **A:** 24.7 **C:** 22.7 **D:** 25.2 **NC:** 25.1 | 2019 – 2023 |
| Population living far from public transit[49] | Percent of residents living more than ¾ mile from the nearest transit stop | 2.3% | **A:** 1.7% **C:** 0.0% **D:** 2.1% **NC:** 15.9% | 2021 |
| Walkability index score[49] | Composite score (1–20) measuring walkability based on density, land use mix, and proximity to transit | 5 | **A:** 7 **C:** 6 **D:** 6 **NC:** 7 | 2021 |
| Motor vehicle crash rate[50] | Total crash rate per 100 million vehicle miles traveled | 306.1 | **A:** 346.3 **C:** 332.4 **D:** 253.5 **NC:** 297.9 | 2018 – 2022 |

* Benchmark Comparison: Peer counties include Alamance (A), Catawba (C), and Davidson (D) Counties. Peer values are shown for each county, with the North Carolina value provided for additional context.

## Climate & Environmental Health

Climate and environmental health indicators describe environmental conditions that affect respiratory health, safety, and community resilience for residents of Randolph County, with comparisons to peer counties and North Carolina, using data collected between 2020 and 2024. Measures include air quality, drinking water safety, flood exposure, extreme heat, and social vulnerability.

Air quality is measured using fine particulate matter (PM2.5), which refers to very small particles in the air that can be inhaled into the lungs. From 2021 to 2023, Randolph County's average PM2.5 level was 8.1 micrograms per cubic meter, similar to peer counties and higher than the statewide average (6.7). Drinking water monitoring recorded three violations between 2022 and 2024, fewer than Alamance (4) and substantially fewer than North Carolina (194).

Environmental exposure indicators showed lower flood risk. In 2020, 2.5% of residents lived in areas vulnerable to 100-year flooding, compared with 5.6% statewide. Between 2021 and 2023, Randolph County experienced an average of 14 high heat index days per year, similar to peer counties. The Social Vulnerability Index (SVI) score of 0.65 in 2022 indicates moderate vulnerability and summarizes factors such as income, housing, transportation access, age, disability status, and household composition that influence how communities prepare for and recover from emergencies.

**Note:** The SVI combines information on income, housing, transportation access, age, disability status, and household composition to describe how communities may be affected by and recover from emergencies or environmental hazards. Each index measure receives a score between 0 (lowest vulnerability) to 1 (highest vulnerability)[49].

Environmental conditions shape exposure to health risks and affect how communities prepare for and recover from emergencies. Differences in air quality, heat, flooding, and community vulnerability help identify where environmental burdens may be experienced more unevenly.

**Table IV-10.** Climate and Environmental Health Indicators, Randolph County, Peer Counties, and North Carolina

| Indicator | What This Measures | Randolph County | Benchmark Comparison* | Data Year(s) |
|---|---|---|---|---|
| Drinking water violations[51] | Total number of drinking water violations recorded over a two-year period | 3 | **A:** 4 **C:** 1 **D:** 0 **NC:** 194 | 2022 – 2024 |
| Air quality (PM2.5)[52] | Average daily concentration of fine particulate matter (µg/m³) | 8.1 | **A:** 7.4 **C:** 7.9 **D:** 8.3 **NC:** 6.7 | 2021– 2023 |
| Flood vulnerability[53] | Percent of population living in 100-year flood hazard areas | 2.5% | **A:** 2.3% **C:** 3.1% **D:** 4.1% **NC:** 5.6% | 2020 |
| High heat index days[54] | Average annual days exceeding the 95th percentile heat index threshold | 14 | **A:** 13 **C:** 13 **D:** 14 **NC:** 13 | 2021 – 2023 |
| Social Vulnerability Index (SVI)[55] | Composite measure of social vulnerability (higher values indicate greater vulnerability) | 0.65 | **A:** 0.71 **C:** 0.68 **D:** 0.55 **NC:** 0.63 | 2022 |

* Benchmark Comparison: Peer counties include Alamance (A), Catawba (C), and Davidson (D) Counties. Peer values are shown for each county, with the North Carolina value provided for additional context.

## Recreation & Food Environment

Recreational and food environment indicators describe access to healthy food, physical activity opportunities, and community amenities for residents of Randolph County, with comparisons to peer counties and North Carolina, using data collected between 2018 and 2024.

Between 2019 and 2023, 95.9% of residents in Randolph County had access to reliable broadband service, similar to peer counties and slightly lower than the statewide rate (98.4%). The Food Environment Index score of 6.9, based on 2018–2022 data, reflects a combination of food access and food insecurity and was similar to peer counties and slightly higher than North Carolina (6.8). Despite this, 16.3% of residents experienced food insecurity in 2023, compared with 15.0% statewide.

Access to physical activity resources was more limited. Between 2020 and 2024, 56.0% of residents had access to exercise opportunities, lower than all peer counties and North Carolina (78.0%). Park access reached 12.0%, similar to Catawba County (13.0%) but well below the statewide level (41.0%)

Access to healthy food and places to be physically active supports everyday health and well-being. Differences in food security and recreation access help describe where opportunities for healthy choices may be limited.

**Table IV-11**. Recreational and Food Environment Indicators, Randolph County, Peer Counties, and North Carolina

| Indicator | What This Measures | Randolph County | Benchmark Comparison* | Data Year(s) |
|---|---|---|---|---|
| Broadband access[56] | Percent of population with access to reliable broadband service | 95.9% | **A:** 96.2% **C:** 96.0% **D:** 98.5% **NC:** 98.4% | 2019 – 2023 |
| Food Environment Index[57] | Composite index (0–10) measuring food access and food insecurity | 6.9 | **A:** 7 **C:** 7 **D:** 7 **NC:** 6.8 | 2018 – 2022 |
| Food insecurity[57] | Percent of population lacking reliable access to food | 16.3% | **A:** 15.1% **C:** 15.0% **D:** 15.6% **NC:** 15.0% | 2023 |
| Access to exercise opportunities[58] | Percent of residents living near locations for physical activity | 56.0% | **A:** 81.0% **C:** 61.0% **D:** 64.0% **NC:** 78.0% | 2020, 2024 |
| Park access[58] | Percent of residents living near a park | 12.0% | **A:** 32.0% **C:** 13.0% **D:** 20.0% **NC:** 41.0% | 2020, 2024 |

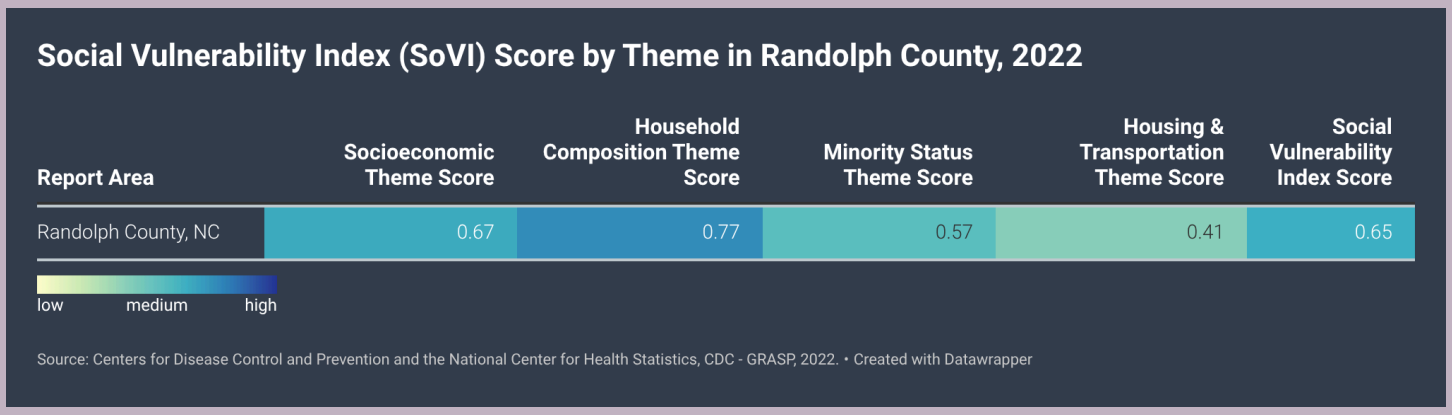
* Benchmark Comparison: Peer counties include Alamance (A), Catawba (C), and Davidson (D) Counties. Peer values are shown for each county, with the North Carolina value provided for additional context.

## Disparities: Physical and Built Environment

The following data display patterns related to community vulnerability, access to healthy food, environmental exposures, walkability, and opportunities for physical activity in Randolph County. These indicators describe conditions in the physical and built environment that can influence daily living, including where people live, how they move through their communities, and the resources available to support healthy behaviors. Reviewing these indicators together helps illustrate how community environments shape opportunities for health and well-being across the county.

### Community Vulnerability

**Figure 48.** Social Vulnerability Index Scores by Theme in Randolph County, 2022[55]

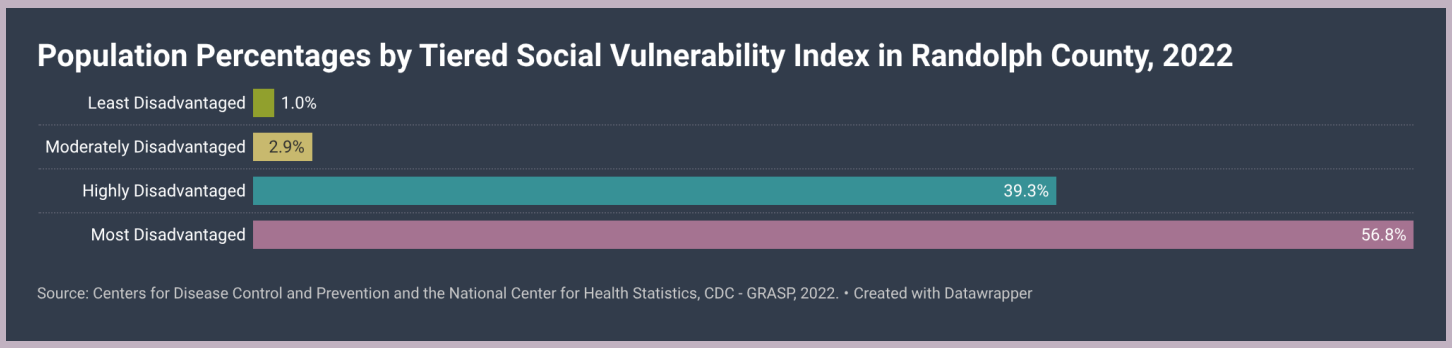



The Social Vulnerability Index (SVI), developed by the Centers for Disease Control and Prevention (CDC), measures how community characteristics influence a community's ability to respond to and recover from emergencies such as natural disasters, disease outbreaks, or economic disruptions[55]. The index combines multiple social and economic indicators into four themes that describe different aspects of vulnerability.

- Socioeconomic Status includes indicators such as poverty, unemployment, income, and educational attainment, which can influence financial stability and access to resources.
- Household Composition and Disability reflects populations that may require additional support during emergencies, including children, older adults, and individuals with disabilities.
- Minority Status and Language considers the proportion of residents who identify as racial or ethnic minorities and those who may have limited English proficiency, which can affect access to information and services.
- Housing Type and Transportation includes housing density, housing conditions, and access to reliable transportation, which can influence mobility and the ability to reach services or evacuate during emergencies.

In Randolph County, the highest vulnerability score appears in household composition (0.77), followed by socioeconomic conditions (0.67). Minority status and language show moderate vulnerability, while housing type and transportation show comparatively lower vulnerability.

**Figure 49.** Distribution of the Population Living in Socially Vulnerable Communities in Randolph County, 2022[55]




SVI rankings also classify communities into levels of disadvantage based on the number and severity of vulnerability factors present. Communities identified as least disadvantaged generally face fewer barriers to preparing for and responding to emergencies. Areas classified as moderately disadvantaged may experience some challenges related to income, transportation, or household composition. Communities considered highly disadvantaged or most disadvantaged often experience multiple overlapping factors that can make emergency response and recovery more difficult, such as higher levels of poverty, limited transportation options, or language barriers.

Population distribution across vulnerability tiers shows that most residents in Randolph County live in areas classified as highly disadvantaged (39.3%) or most disadvantaged (56.8%), while a smaller portion of residents live in communities considered moderately or least disadvantaged.

Communities experiencing higher social vulnerability may face greater challenges responding to emergencies or accessing essential resources. Understanding these patterns helps identify where additional support or resources may be needed to strengthen community resilience.

## Food Environment

**Figure 50.**Trends in Food Insecurity Rates in Randolph County, 2017–2022[57]

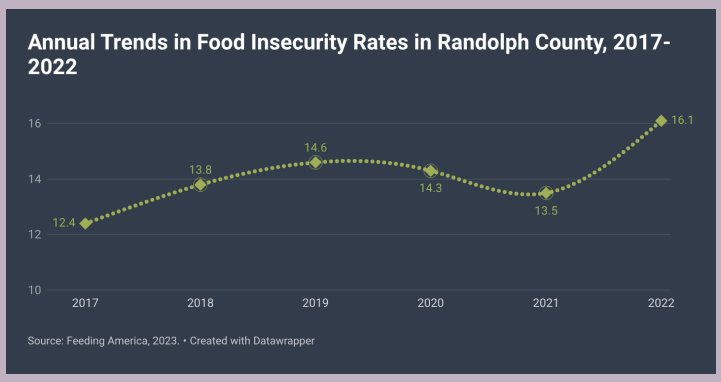
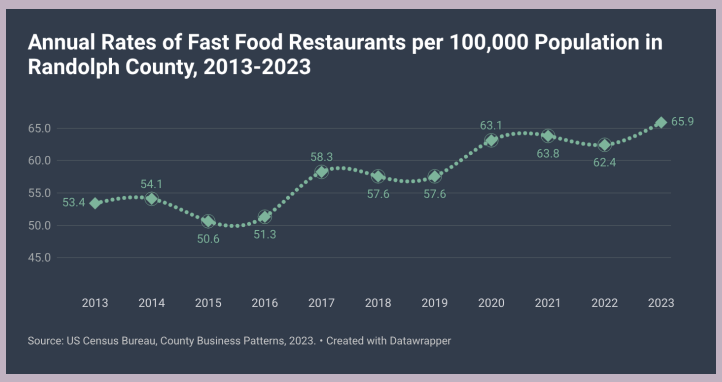



**Figure 51.** Trends in Fast Food Restaurant Availability in Randolph County, 2013–2023[57]




Food environment indicators describe how community conditions influence residents' access to nutritious and affordable food. Food insecurity refers to the lack of consistent access to enough food for an active, healthy life and is often linked to household income, employment stability, and food affordability.

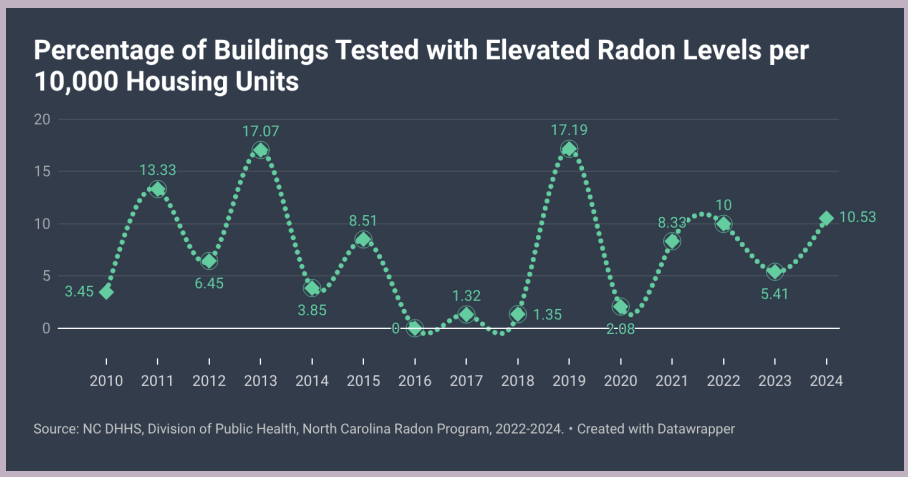
Food insecurity increased between 2017 and 2019, remained relatively stable for several years, and rose again in 2022. During the same period, the number of fast food restaurants per 100,000 residents increased steadily across the county.

These patterns show that while food outlets have become more available over time, some households continue to experience difficulty accessing enough healthy food.

Access to nutritious food is shaped by multiple factors, including income, household size, transportation, and local food availability. Additionally, food insecurity can influence chronic disease risk and lead to poorer health outcomes.

## Environmental Health

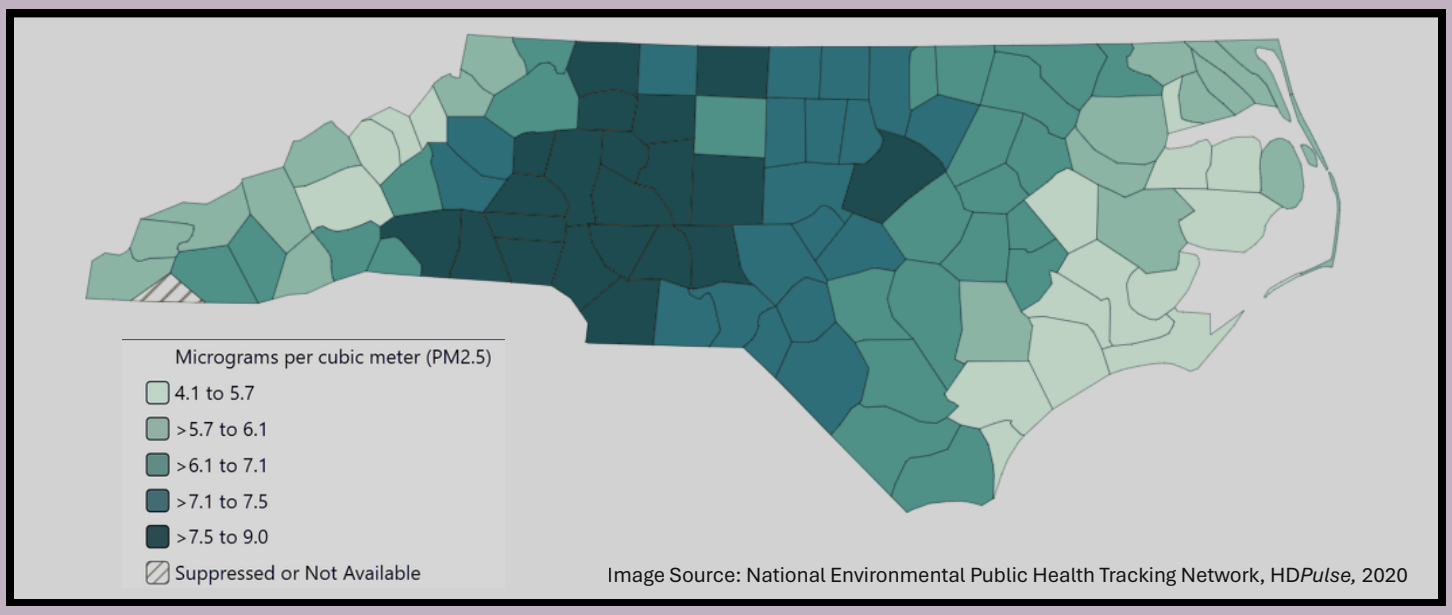
**Figure 52.** Trends in Elevated Radon Levels Detected in Buildings in Randolph County, 2010–2024[59]




Radon is a naturally occurring radioactive gas that can enter homes through soil and building foundations[59]. Long-term exposure to elevated radon levels is a known risk factor for lung cancer.

Radon testing results in Randolph County show fluctuations in the number of buildings with elevated radon levels across the reporting period.

**Figure 53.** Geographic Distribution of Fine Particulate Air Pollution (PM2.5) Across North Carolina Counties, 2020[60]




Air quality indicators measure fine particulate matter (PM2.5), which refers to tiny airborne particles that are small enough to enter the lungs and bloodstream[60]. Exposure to elevated PM2.5 levels can affect respiratory and cardiovascular health. Air quality data show variation in particulate matter concentrations across North Carolina counties, with Randolph County falling within the highest range displayed, 7.5 to 9.0 micrograms per cubic meter.

Environmental exposures such as radon and air pollution can influence respiratory and cardiovascular health over time. Monitoring these conditions helps communities identify potential risks and guide efforts to reduce environmental health hazards.

## Walkability & Recreation

**Figure 54.** Population Distribution by National Walkability Index in Randolph County, 2021[49]

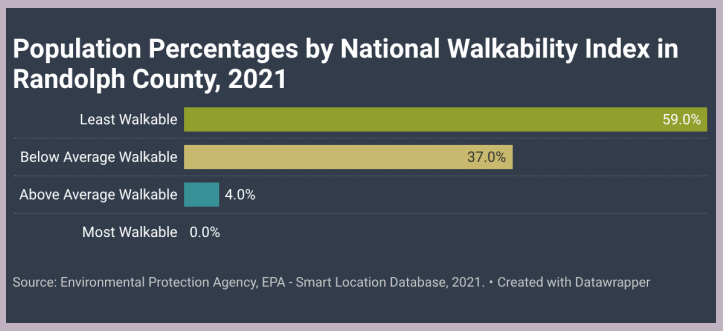
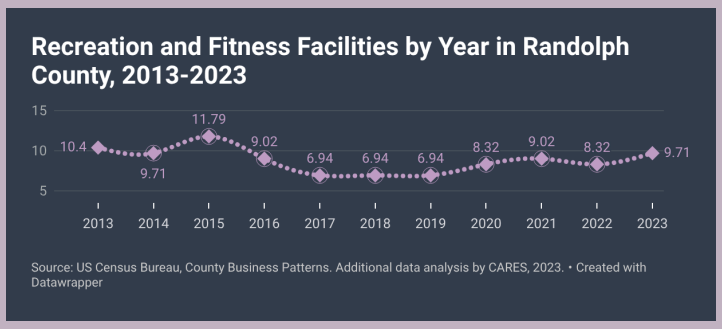



**Figure 55.** Trends in Recreation and Fitness Facilities per 100,000 Residents in Randolph County, 2013–2023[61]




The National Walkability Index, developed by the U.S. Environmental Protection Agency, measures how easily residents can walk to destinations such as schools, workplaces, and services based on factors including street connectivity, land use, and proximity to amenities[49].

Walkability data show that most residents in Randolph County live in areas classified as least walkable (58.0%) or below average walkability (37.0%). Only a small portion of residents live in areas considered above average walkable.

Access to recreation and fitness facilities has varied over the past decade. The number of facilities per 100,000 residents declined during the late 2010s before increasing again in more recent years.

Community design can influence opportunities for physical activity, transportation, and recreation. Walkable environments and access to parks and recreation facilities can support active lifestyles and contribute to long-term health and well-being.

## Community Conditions: Social and Economic Factors

Social and economic factors describe conditions that influence access to resources, stability, and opportunity within a community and shape daily experiences over time. The tables in this section present indicators related to education access and quality, employment and economic stability, and community safety and social support for Randolph County, with comparisons to peer counties and North Carolina, providing context for how social and economic environments influence health and well-being across the lifespan.

### Education Access & Quality

Education access and quality indicators describe educational attainment, academic readiness, and access to learning opportunities from early childhood through postsecondary education for residents of Randolph County, with comparisons to peer counties and North Carolina, using data collected between 2019 and 2024. Measures in this table include graduation rates, educational attainment among adults, academic performance, postsecondary participation, early childhood enrollment, childcare affordability, and school funding adequacy.

Based on 2022–2023 data, 87.1% of students in Randolph County graduated high school within four years, similar to Catawba County (87.8%) and slightly higher than Alamance (85.0%) and Davidson counties (83.2%). During 2019–2023, 16.0% of adults age 25 and older lacked a high school diploma, exceeding all peer counties and the statewide share (10.3%).

Academic readiness indicators were lower relative to peers. Fourth-grade reading proficiency during 2022–2023 was 43.7%, below Catawba (51.8%), Davidson (48.8%), and North Carolina (50.6%). During the same period, college and career readiness was 22.7%, lower than peer counties and the state (29.0%). Postsecondary enrollment among recent graduates was 49.2%, compared with 54.1% in Alamance, 57.6% in Catawba, 55.3% in Davidson, and 59.3% statewide.

Early childhood and system-level indicators show mixed patterns. In 2023–2024, 41.2% of eligible four-year-olds were enrolled in North Carolina Pre-K, higher than Alamance (32.1%) and Davidson (30.9%) counties but lower than Catawba (54.1%) and the state (57.0%). Childcare cost burden affected 25.1% of households with children in 2023, matching the statewide rate and higher than Alamance and Catawba counties. School funding adequacy data from 2022–2023 showed a –$2,737 per-pupil funding gap, larger than Alamance and Catawba counties and similar to the statewide gap.

**Note:** School funding adequacy measures the average gap in dollars between actual spending per pupil and required spending (an estimate of what is needed to achieve U.S. average test scores in each district) per pupil. Increased spending can lead to improved educational outcomes among students, reductions in class size, increased instructional time, and higher educator salaries[62].

Education shapes health across the lifespan. Gaps in early learning, academic readiness, and postsecondary participation can contribute to unequal opportunities that affect economic security and well-being later in life.

**Table IV-12.** Education Access and Quality Indicators, Randolph County, Peer Counties, and North Carolina

| Indicator | What This Measures | Randolph County | Benchmark Comparison* | Data Year(s) |
|---|---|---|---|---|
| High school graduation rate[63] | Percent of students graduating high school within four years | 87.1% | **A:** 85.0% **C:** 87.8% **D:** 83.2% **NC:** 86.9% | 2022 – 2023 |
| Adults without high school diploma[15] | Percent of adults age 25+ without a high school diploma or equivalent | 16.0% | **A:** 11.6% **C:** 12.7% **D:** 13.1% **NC:** 10.3% | 2019 – 2023 |
| Fourth-grade reading proficiency[63] | Percent of fourth-grade students reading at grade level | 43.7% | **A:** 43.0% **C:** 51.8% **D:** 48.8% **NC:** 50.6% | 2022 – 2023 |
| College and Career Readiness[63] | Percent of students meeting college- and career-ready benchmarks | 22.7% | **A:** 25.9% **C:** 30.4% **D:** 27.1% **NC:** 29.0% | 2022 – 2023 |
| Postsecondary enrollment[15] | Percent of recent high school graduates enrolling in postsecondary education | 49.2% | **A:** 54.1% **C:** 57.6% **D:** 55.3% **NC:** 59.3% | 2019 – 2023 |
| Early childhood education enrollment[64] | Percent of eligible four-year-olds enrolled in NC Pre-K | 41.2% | **A:** 32.1% **C:** 54.1% **D:** 30.9% **NC:** 57.0% | 2023 – 2024 |
| Childcare cost burden[65] | Percent of households with children spending a high share of income on childcare | 25.1% | **A:** 22.0% **C:** 21.7% **D:** 25.8% **NC:** 25.1% | 2023 |
| School funding adequacy[62] | Difference between actual per-pupil spending and estimated adequate funding level | –$2,737 per pupil | **A:** - $2,234 **C:** -$2,117 **D:** -$3,929 **NC:** -$2,391 | 2022 2023 |

* Benchmark Comparison: Peer counties include Alamance (A), Catawba (C), and Davidson (D) Counties. Peer values are shown for each county, with the North Carolina value provided for additional context.

## Employment & Economic Stability

Employment and economic stability indicators describe labor force participation, income, and financial security for residents of Randolph County, with comparisons to peer counties and North Carolina, using data from 2019 to 2023. Measures include unemployment, income levels, poverty, public assistance participation, and income inequality.

In 2023, the unemployment rate in Randolph County was 3.7%, lower than Alamance (4.9%), Catawba (4.2%), Davidson (4.1%), and North Carolina (4.8%). Despite relatively low unemployment, median household income during 2019–2023 was $70,917, lower than peer counties and notably lower the statewide median ($86,947).

Indicators of economic hardship show a higher share of residents facing financial strain. During 2019–2023, 37.6% of residents and 52.7% of children lived in households with income below 200% of the federal poverty level, exceeding peer counties and the state. Supplemental Nutrition Assistance Program (SNAP) participation reached 16.9% of households, compared with 13.8% in Alamance, 14.2% in Catawba, 15.1% in Davidson, and 14.0% statewide. Income inequality, measured using the 80/20 income ratio, was 4.2, similar to peer counties and slightly lower than North Carolina (4.7).

Employment alone does not ensure economic security. These measures show where income and cost pressures may place greater strain on some households, shaping daily choices and long-term well-being.

**Table IV-13.** Employment and Economic Stability Indicators, Randolph County, Peer Counties, and North Carolina

| Indicator | What This Measures | Randolph County | Benchmark Comparison* | Data Year(s) |
|---|---|---|---|---|
| Unemployment rate[15] | Percent of the labor force unemployed | 3.7% | **A:** 4.9% **C:** 4.2% **D:** 4.1% **NC:** 4.8% | 2019 – 2023 |
| Median household income[15] | Median annual household income | $70,917 | **A:** $77,121 **C:** $75,458 **D:** $74,612 **NC:** $86,947 | 2019 – 2023 |
| Population below 200% FPL[15] | Percent of residents living below 200% of the federal poverty level | 37.6% | **A:** 33.1% **C:** 34.2% **D:** 35.8% **NC:** 31.0% | 2019 – 2023 |
| Children below 200% FPL[15] | Percent of children living below 200% of the federal poverty level | 52.7% | **A:** 45.9% **C:** 47.3% **D:** 49.1% **NC:** 40.4% | 2019 – 2023 |
| SNAP participation[66] | Percent of households receiving SNAP benefits | 16.9% | **A:** 13.8% **C:** 14.2% **D:** 15.1% **NC:** 14.0% | 2022 |
| Income inequality (80/20 ratio)[15] | Ratio of household income at the 80th percentile to the 20th percentile | 4.2 | **A:** 4.5 **C:** 4.3 **D:** 4.4 **NC:** 4.7 | 2019 – 2023 |

* Benchmark Comparison: Peer counties include Alamance (A), Catawba (C), and Davidson (D) Counties. Peer values are shown for each county, with the North Carolina value provided for additional context.

## Community Safety & Social Support

Community safety and social support indicators describe public safety, justice involvement, and social connection for residents of Randolph County, with comparisons to peer counties and North Carolina, using data collected between 2019 and 2023. Measures include crime rates, incarceration, youth justice involvement, youth disconnection, and social connection.

In 2023, the violent crime rate in Randolph County was 204.9 incidents per 100,000 residents, lower than Alamance (462.0), Catawba (405.8), and North Carolina (380.9), and similar to Davidson County (199.8). The property crime rate was 1,451.7 per 100,000 residents, lower than Alamance (2,768.4), Catawba (2,311.6), and the state (2,268.9), and similar to Davidson County (1,392.8).

Justice involvement indicators varied. The incarceration rate in 2023 was 234.6 per 100,000 residents, higher than Alamance (197.0) and the state (182.2) and similar to Catawba (240.2) and Davidson (229.7). Juvenile justice involvement, measured as 20.9 delinquency complaints per 1,000 youth ages 8–17, was lower than Alamance (48.2) and the state (28.3) and similar to peer counties. During 2019–2023, 11.6% of youth ages 16–19 were disconnected, meaning they were not in school and not employed, a higher share than peer counties and North Carolina.

Indicators of social connection suggest lower levels of isolation. In 2022, 21.0% of adults in Randolph County reported social isolation, a smaller share than peer counties and the state. Social associations, measured as 10.5 membership organizations per 10,000 residents in 2020, were similar to Davidson County and slightly lower than the statewide level.

**Note:** Disconnected youth are at an increased risk of experiencing poor mental and physical health outcomes, performing low academically, becoming justice involved, and developing substance use disorder. Over time, this can lead to chronic unemployment, poverty, incarceration, mental health disorders, chronic illness, and shorter length of life[67].

Community safety and social ties influence trust, stress levels, and access to support. Understanding differences across these measures helps build a broader picture of how community environments shape health outcomes.

**Table IV-14.** Community Safety and Social Support Indicators, Randolph County, Peer Counties, and North Carolina

| Indicator | What This Measures | Randolph County | Benchmark Comparison* | Data Year(s) |
|---|---|---|---|---|
| Violent crime rate[68] | Violent crimes per 100,000 residents | 204.9 | **A:** 462.0 **C:** 405.8 **D:** 199.8 **NC:** 380.9 | 2023 |
| Property crime rate[68] | Property crimes per 100,000 residents | 1,451.70 | **A:** 2,768.4 **C:** 2,311.6 **D:** 1,392.8 **NC:** 2,268.9 | 2023 |
| Incarceration rate[69] | Jail and prison population per 100,000 residents | 234.6 | **A:** 197.0 **C:** 240.2 **D:** 229.7 **NC:** 182.2 | 2023 |
| Juvenile justice involvement[70] | Delinquency complaints per 1,000 youth ages 8–17 | 20.9 | **A:** 48.2 **C:** 22.5 **D:** 21.3 **NC:** 28.3 | 2023 |
| Disconnected youth[15] | Percent of population age 16-19 not in school and not employed | 11.6% | **A:** 5.1% **C:** 10.1% **D:** 6.8% **NC:** 7.3% | 2019 – 2023 |
| Social isolation[24] | Percent of adults reporting limited social connection | 21.0% | **A:** 23.4% **C:** 22.1% **D:** 21.6% **NC:** 24.0% | 2022 |
| Social Associations[61] | Number of membership associations per 10,000 population, data year 2022 | 10.5 | **A:** 9.8 **C:** 14.3 **D:** 10.2 **NC:** 11.3 | 2023 |

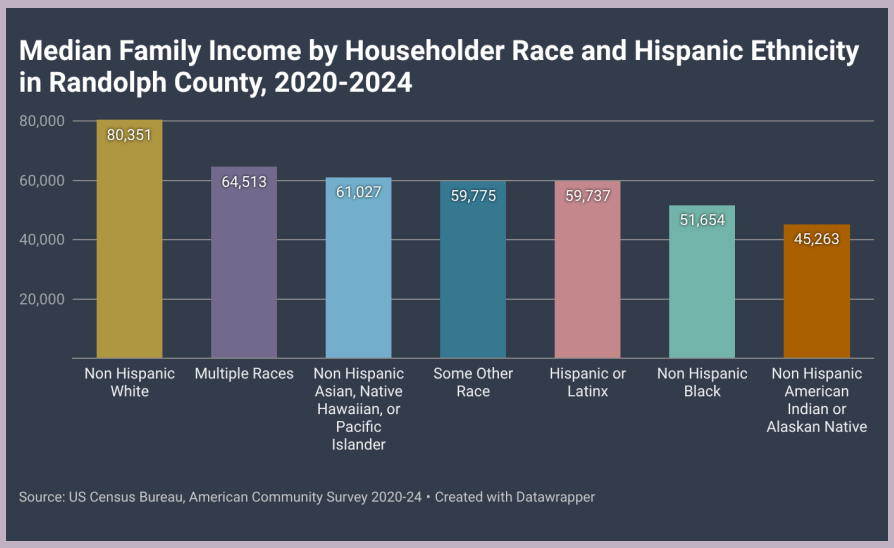
* Benchmark Comparison: Peer counties include Alamance (A), Catawba (C), and Davidson (D) Counties. Peer values are shown for each county, with the North Carolina value provided for additional context.

## Disparities: Social and Economic Factors

The following data display patterns related to income, poverty, employment, education, housing affordability, and community safety in Randolph County. These indicators describe social and economic conditions that influence access to resources such as stable employment, educational opportunities, safe housing, and financial security. Reviewing these indicators together helps illustrate how broader social and economic conditions may shape health and well-being across the county.

### Income & Poverty

**Figure 56.** Median Family Income by Race and Hispanic Ethnicity in Randolph County, 2020–2024[72]




Median family income varies across racial and ethnic groups in Randolph County. Non-Hispanic White households report the highest median family income, followed by non-Hispanic Asian, Native Hawaiian, or Pacific Islander households and households identifying as multiple races. Hispanic households report lower median incomes, while non-Hispanic Black households and American Indian or Alaska Native households report the lowest median income levels among the groups included in these data.

**Figure 57.** Cost-Burdened Households by Hispanic Ethnicity in Randolph County, 2020–2024[72]

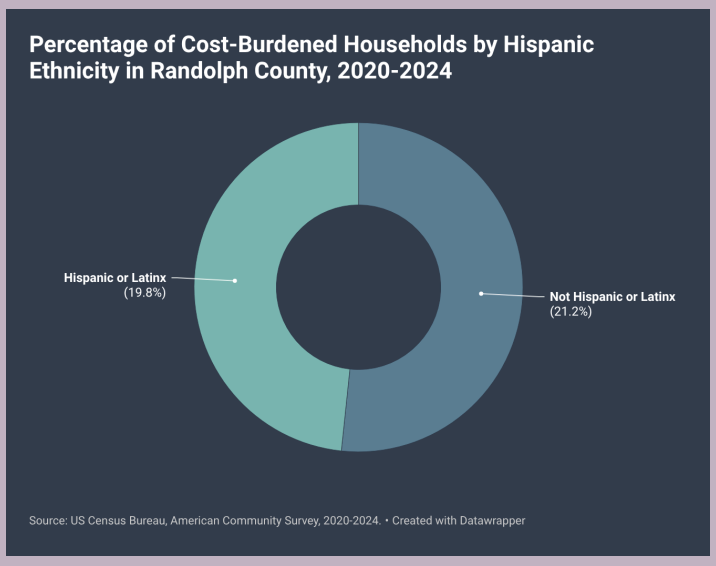
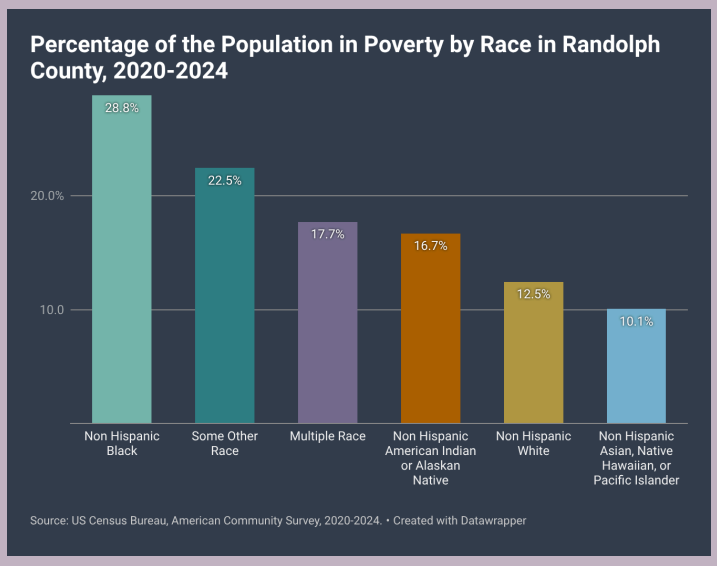



**Figure 58.** Poverty Rates by Race and Hispanic Ethnicity in Randolph County, 2020–2024[72]

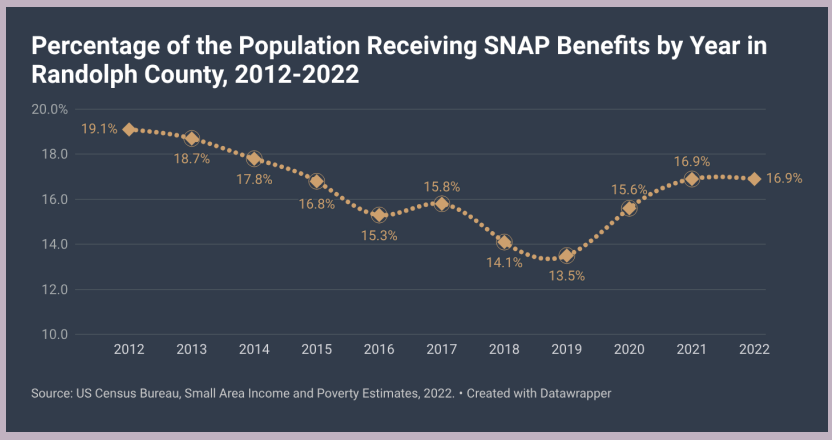



Poverty rates show a similar pattern. Hispanic or Latinx residents experience higher poverty rates than non-Hispanic residents. When examined by race, poverty rates are also elevated among non-Hispanic Black residents (28.8%) and non-Hispanic American Indian or Alaskan Native residents (16.7%), while non-Hispanic White and non-Hispanic Asian, Native Hawaiian, or Pacific Islander residents report comparatively lower poverty rates.

Income and poverty influence access to many resources that support health, including stable housing, nutritious food, transportation, and healthcare. Differences in economic opportunity can shape health outcomes across communities.

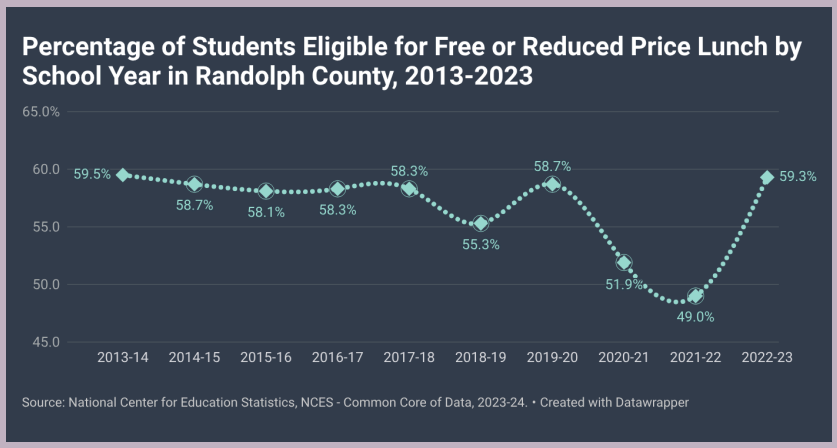
## Economic Assistance & Employment

**Figure 59.** Trends in SNAP Participation in Randolph County, 2012–2022[67]



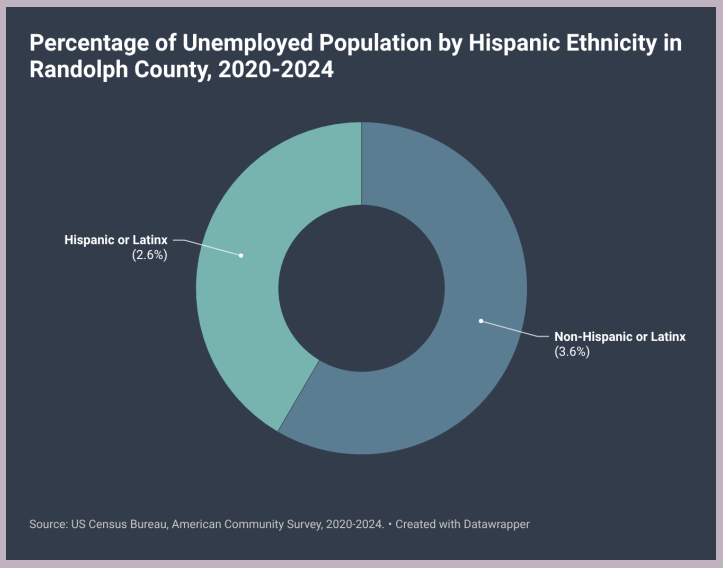

Participation in the Supplemental Nutrition Assistance Program (SNAP) highlights changes in economic need among households. SNAP participation declined from 19.1% to 13.5% between 2012 and 2019 before increasing again in recent years, reaching 16.9% of residents by 2022.

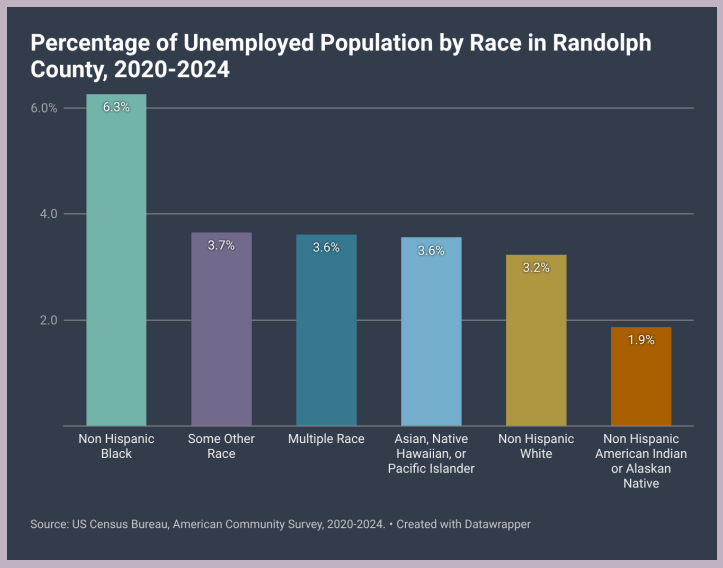
**Figure 60.** Students Eligible for Free or Reduced-Price Lunch in Randolph County, 2013–2023[73]




Eligibility for free or reduced-price school lunch, which is based on household income, provides another indicator of economic conditions among families with children. The percentage of students eligible for free or reduced-price lunch declined gradually from 59.5% to 55.3% between 2013-2019. Percentages dropped notably between 2019-2022, likely caused by pandemic school closures, and quickly increased again during the 2022-2023 school year.

**Figure 61.** Unemployment Rates by Race and Hispanic Ethnicity in Randolph County, 2020–2024[72]



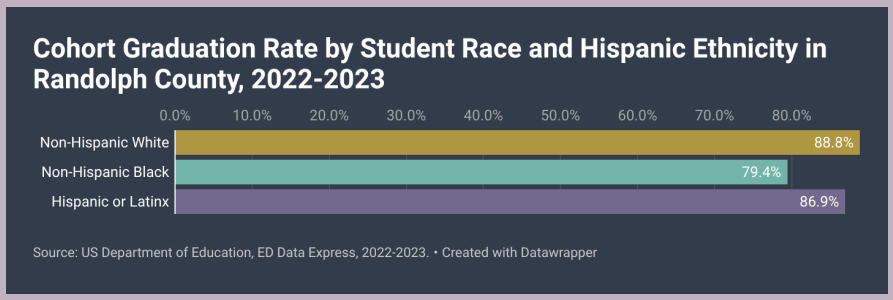



Unemployment rates also vary across demographic groups. Non-Hispanic Black residents experience the highest unemployment rates at 6.3 % compared with other racial groups, while non-Hispanic White residents report lower unemployment rates at 3.2%.

Indicators such as SNAP participation, unemployment, and free or reduced-price lunch eligibility help illustrate how economic conditions affect both households and children. Changes in these measures can indicate shifts in employment opportunities, household income, and financial stability across the community.

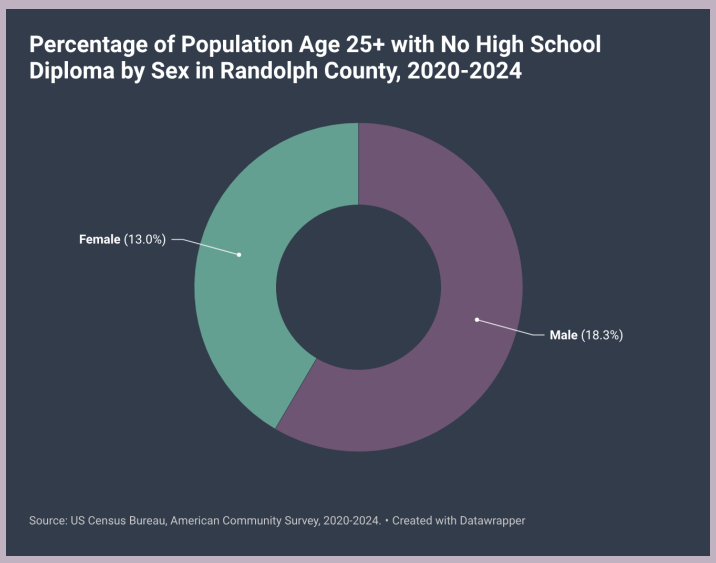
## Education

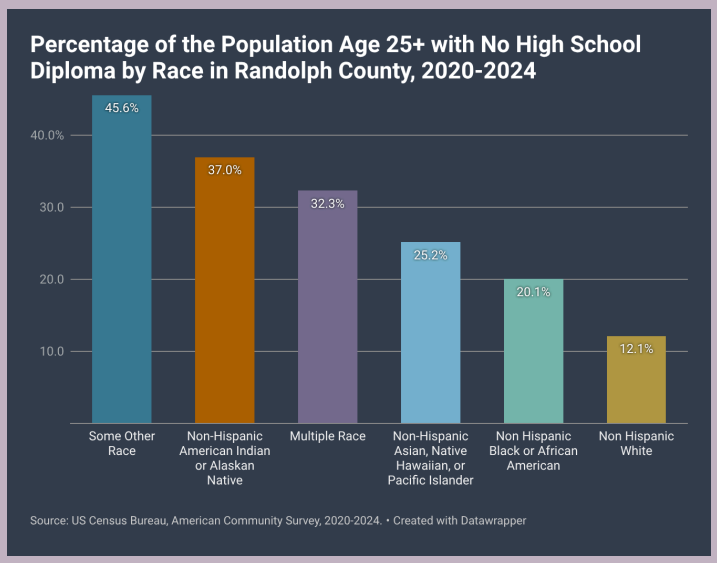
**Figure 62.** Cohort Graduation Rates by Race and Hispanic Ethnicity in Randolph County[67]




High school graduation rates are highest among non-Hispanic White students (88.8%) and slightly lower among Hispanic or Latinx students (86.9%). Non-Hispanic Black students show lower graduation rates in comparison at a rate of 79.4%.

**Figure 63.** Adults Without a High School Diploma by Sex and Race in Randolph County, 2020–2024[72]



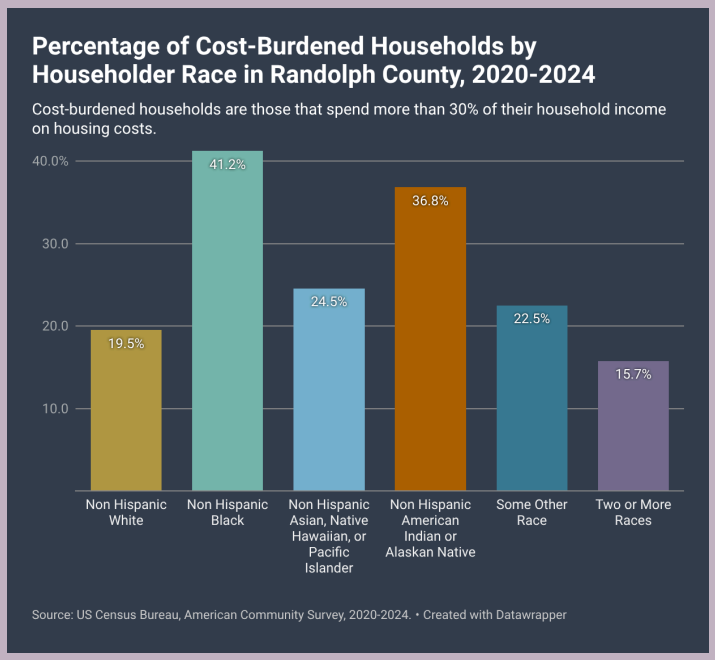



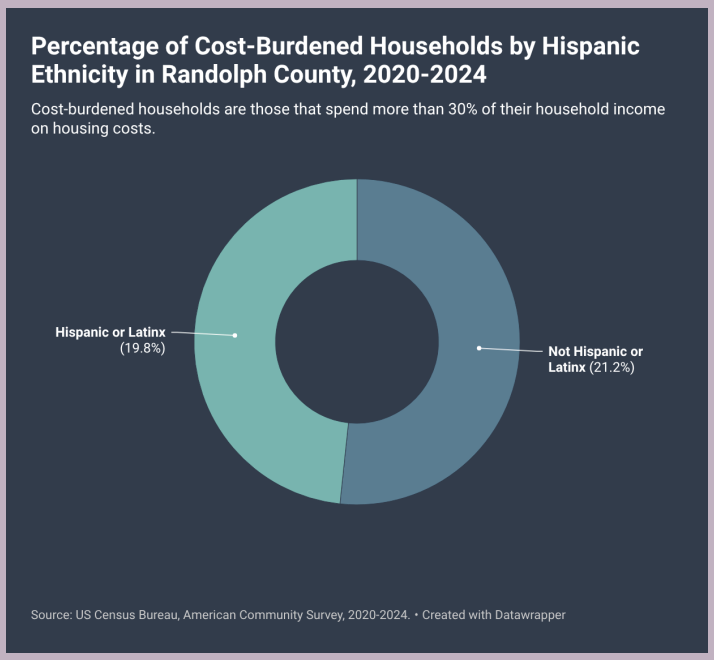

Educational attainment among adults also differs by both sex and race. A higher percentage of males age 25 and older lack a high school diploma compared with females. When examined by race, the highest percentages of adults without a high school diploma occur among residents identifying as other races (45.6%), non-Hispanic American Indian or Alaskan Native residents (37.0%) and residents identifying as multiple races (32.3%).

Education influences employment opportunities, income potential, health literacy, and access to economic resources that support long-term health and stability.

## Housing Affordability

**Figure 64.** Cost-Burdened Households by Race and Hispanic Ethnicity in Randolph County, 2020–2024[72]




Housing affordability reflects the share of household income spent on housing costs. Households are considered cost-burdened when they spend more than 30% of their income on housing expenses.

Housing cost burden varies across racial groups in Randolph County. Non-Hispanic Black households (41.2%) experienced the highest levels of housing cost burden, followed by non-Hispanic American Indian or Alaskan Native households (36.8%) and residents identifying as other races (22.5%). Non-Hispanic White households show comparatively lower levels of housing cost burden.

Housing stability plays an important role in financial security and health. High housing costs can limit resources available for food, healthcare, transportation, and other essential needs.

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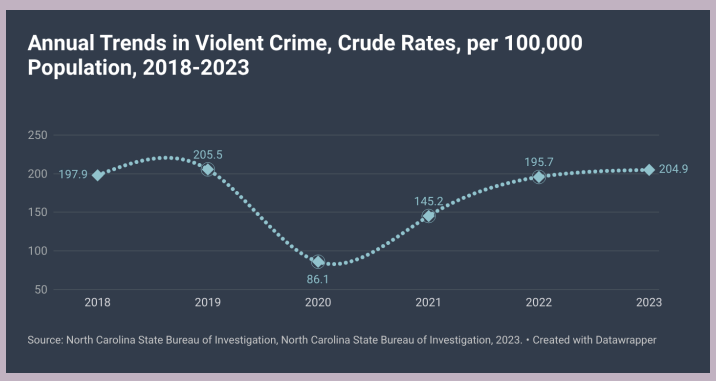
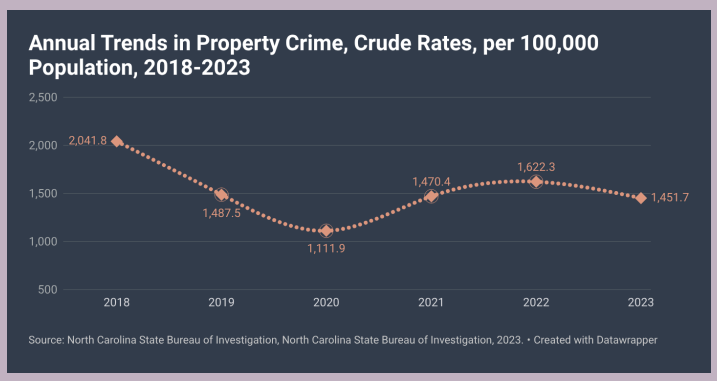
## Community Safety & Incarceration

**Figure 65.** Trends in Violent Crime and Property Crime Rates in Randolph County, 2018–2023[69]



Crime trends in Randolph County show changes over time in both violent and property-related offenses.

Violent crime rates declined from 197.9 in 2018 to 86.1 in 2020 before increasing again in subsequent years. By 2023, rates had risen to 204.9 compared with the previous two years, though they remain within the range observed earlier in the reporting period.

Property crime followed a similar pattern. Rates declined from 2,041.8 in 2018 to 1,111.9 in 2020, increased again through 2022, and then showed a slight decrease in 2023. Sudden declines in both violent crime and property crime rates in 2020 may be attributed to pandemic related lockdown or quarantine regulations.

Changes in crime trends can suggest shifts in economic conditions, community resources, and local prevention efforts. Monitoring these patterns helps communities understand how safety conditions evolve over time and where prevention strategies may be needed.

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## Justice System Involvement

**Figure 66.** Incarceration Rates by Race and Hispanic Ethnicity in Randolph County, 2023[70]

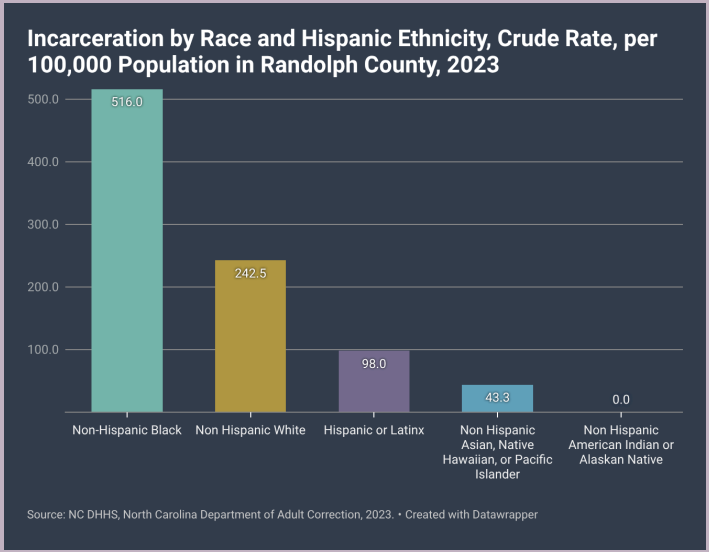
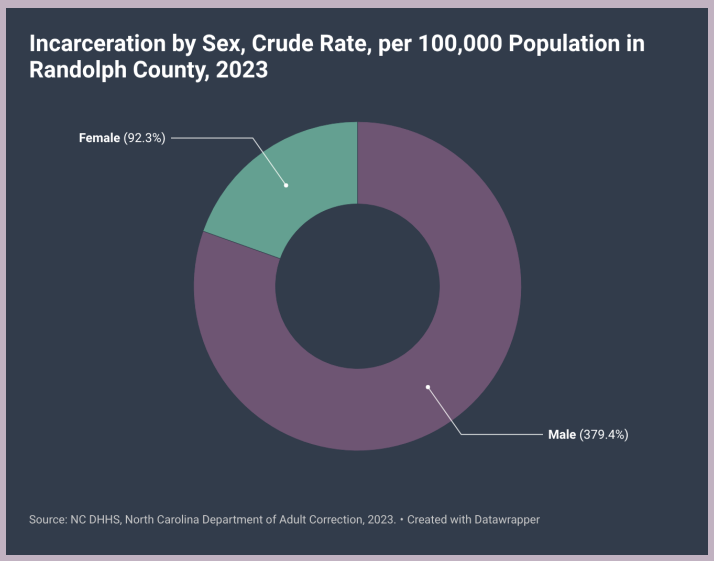



**Figure 67.** Incarceration Rates by Sex in Randolph County, 2023[70]




Incarceration rates vary across both race and sex in Randolph County.

Non-Hispanic Black residents experience the highest incarceration rates at 516.0 compared with non-Hispanic White residents (242.5) and non-Hispanic Asian, Native Hawaiian, or Pacific Islander (43.3). Hispanic residents show lower rates than both groups in these data.

Differences are also substantial by sex. Males represent the majority of incarcerated individuals at a rate of 379.4%, while females represent a significantly smaller rate of 92.3%

Justice system involvement can influence economic opportunity, housing stability, and family well-being. Differences in incarceration rates suggest broader social and economic conditions that affect communities.

## Discussion: Community Status Assessment Findings

The data in this assessment tell a story about Randolph County that is both familiar and complex. Health here is not defined by a single outcome or trend. It is shaped by how people live their daily lives, how far they must travel to reach services, and how well systems respond with the realities of a largely rural community.

Overall health outcomes show that many residents are living with challenges that develop over time rather than developing suddenly. Shorter life expectancy and higher rates of early death point to the longer-term effects of chronic illness, injury, substance use disorder, and ongoing stress. In a rural setting, these patterns are often shaped by distance, limited service availability, and few points of contact with care. Health in Randolph County is influenced by what happens long before someone becomes seriously ill and by how easy or difficult it is to access support along the way.

There are also clear signs of strength. When preventative care is available and accessible, residents make use of it. Strong childhood immunization coverage and positive maternal health indicators show that families engage with care when systems are trusted and reasonably close to home. These patterns highlight existing capacity within the county and signals a community that values prevention when it is within reach.

Access to care, however, is uneven. Fewer available providers for primary, dental, substance use, and mental health care mean that routine services may require longer travel times, longer wait times, or both. As a result, hospitals often become the place where health needs are addressed, even when those needs could be managed earlier. This does not point to poor choices by residents; it points to how people in rural communities adapt when options are limited. Insurance coverage plays an important role in this dynamic. Public and private insurance programs help many residents stay connected to care, while gaps in coverage or continuity create additional barriers, especially for those managing chronic conditions.

Health is also shaped outside of clinics and hospitals. Housing costs affect financial stability and stress, particularly for renters. Transportation access determines whether appointments, jobs, healthy foods, and basic services are reachable, which is especially important in areas where public transit is limited. Environmental conditions influence daily comfort, preparedness, recovery, and resiliency. While some community conditions compare well to other places, access within the county varies. Where people live can make a meaningful difference in how easily they can maintain health, even when services exist in the county.

Social and economic factors further explain how opportunity and stability influence health. Many students complete high school, and early learning programs reach a large portion of young children. Differences in academic readiness and postsecondary participation affect long-term opportunity, particularly in a rural economy with few nearby vocational or higher education options. Employment data show that people are working, yet income patterns point to ongoing financial pressure for many households. Community safety and social connection provide important sources of support, while experiences of isolation or justice involvement create additional strain for some residents.

Looking across all the data, a consistent picture emerges: health in Randolph County depends on how well systems align with the conditions people face. Strengths are present, and they matter. So do gaps in access and opportunity. Understanding  health in this way moves the conversation away from rankings and comparisons and towards context. It helps explain where the county is today and provides a clearer foundation for thinking about how existing strengths can support better health for all residents over time.

The next section builds on this understanding by centering the voices of community members. While the data describe patterns and conditions, the Community Context Assessment provides insight into how resident experience these realities, what they see as strengths, and where they identify needs and opportunities. Together, these perspectives offer a fuller picture of community health in Randolph County.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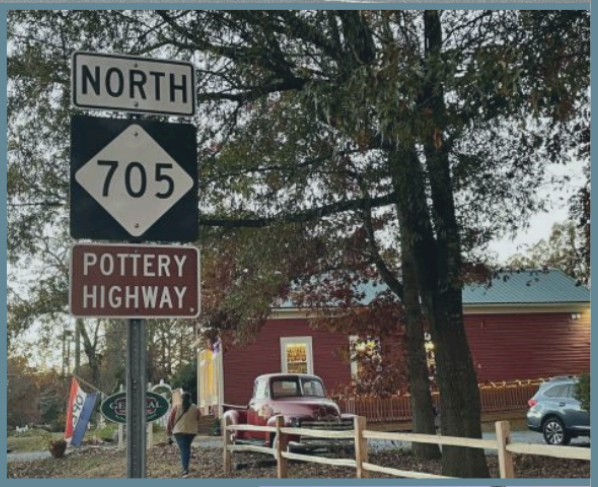
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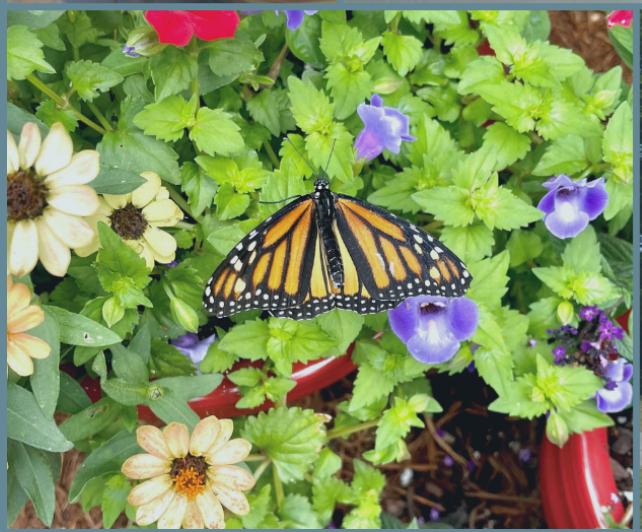
# SEAGROVE


Seagrove CAFE

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## Overview

The Community Context Assessment (CCA) describes how Randolph County residents experience health, quality of life, and access to services in their everyday lives. As outlined earlier in **Section I: Introduction**, the CCA is a core component of the MAPP 2.0 framework, which emphasizes understanding community conditions, strengths, and priorities through direct input from residents.

While secondary data describe health outcomes and trends, community input helps explain what those data mean in real life. Hearing directly from residents provides insight into how health-related conditions affect daily experiences and which issues matter most across the county.

This section summarizes perspectives gathered through the Community Opinion Survey and focus groups to add insight to earlier findings and to inform future planning and priority setting.

## Focus Groups

In November 2025, five focus groups were conducted across several demographic groups. After applying eligibility criteria and reviewing data quality, only two of them met inclusion standards for this assessment. The two focus groups included members of the Hispanic Spanish-speaking community and were conducted to gather additional perspectives from Spanish-speaking residents:

1. One discussion included Hispanic and Latinx mothers living in Asheboro
2. The second included Hispanic and Latinx residents from across the county representing a range of ages, sexes, and zip codes. Each group included between eight and ten participants

Although the Community Opinion Survey was offered in English and Spanish, participation among Spanish-speaking residents was limited. These discussions were organized to ensure that Hispanic and Latinx residents had meaningful opportunities to share their experiences, concerns, and priorities related to health and well being in Randolph County.

Conversations were facilitated in Spanish using a structured set of questions focused on community health, service access, social support, and system gaps.

**Note:** In recognition of the importance of preserving participant voice, questions and quoted responses are provided first in Spanish with English translation included after for accessibility. Translation was completed with attention to meaning and intent; however, some phrases may not reflect precise word-for-word equivalency due to interpretation and linguistic differences.

### Questions & Responses

1. ¿Qué hace una comunidad que sea saludable?

**What makes a community healthy?**

Participants described a healthy community as one where residents have access to clear information about services, prevention is prioritized, and people support one another. Good communication, clean environments, physical activity, and routine medical care for children were emphasized. Keeping children up to date on vaccinations and maintaining regular pediatric visits were described as important responsibilities for families.

| | |
|---|---|
| "El primero es que uno que haya información. Respecto a los servicios que hay disponibles y a los cuales podemos acceder. Y la otra, pues ya vienen las campañas de prevención y otras actividades, se pueden entender para que la para que haya una sociedad que se pueda considerar sana." | "The first thing is that there needs to be information about the services that are available and that we can access. And also, when prevention campaigns and other activities are offered, they should be easy to understand so that there can be a society that can be considered healthy." |

2.¿Cuáles considera que son los recursos o cualidades más valiosos de nuestra comunidad para apoyar la salud y el bienestar?

**What do you consider the most valuable resources or qualities in our community to support health and well-being?**

Participants identified connection, engagement, and access as key qualities that support health. Friendships, community events, and parks help build belonging and support mental well being. Hospital services and translation services were described as valuable because they help people understand care and available resources. Social media and community networks were also noted as important ways to share information.

| | |
|---|---|
| "Ser activo en los eventos de la comunidad ayuda mejorar nuestro bienestar mental." | "Being active in community events helps improve our mental well-being." |
| "Otro recurso valioso que pienso yo, que se podría aprovechar, pues son las redes, las redes sociales para informar a la gente, pues de los recursos a los que uno puede tener acceso que necesita los requisitos para tener acceso a la salud." | "Another valuable resource that I think could be better used is social networks, social media, to inform people about the resources they can access and what requirements are needed to receive health services." |

3. ¿Cuáles cree que son los problemas / condiciones más importantes que deben abordarse para mejorar la salud y el bienestar en nuestra comunidad?

**What do you believe are the most important problems/conditions that must be addressed to improve health and well-being in our community?**

Economic pressure emerged as a central concern. Low wages, job instability, rising rent, food costs, and medical expenses create ongoing strain. Documentation status and fear of deportation were also identified as factors that influence feelings of safety and willingness to seek services. Participants noted limited access to understandable information about services and health topics. Language barriers and difficulty using translation tools were described as additional obstacles.

| | |
|---|---|
| "Pues cuando uno va a las citas, cuando te ponen esa Tablet y te dicen que hables en frases cortas y consignas, y entonces al intentar uno expresarte lo más claro posible para el intérprete. A veces no te expresas bien lo que necesitas en mi caso, pues para mi hijo, para mi hija, mi hijo tiene esto y esto y eso, pero ellos nada más, quieren que digas una frase corta y pues. Es difícil hacer, pero también lo malo, la verdad nosotros." | "When you go to appointments and they put that tablet in front of you and tell you to speak in short phrases, you try to explain yourself as clearly as possible for the interpreter. But sometimes you are not able to fully express what you need. In my case, for my son, for my my daughter, my child has this and this and that, but they just want you to say one short sentence. It is difficult to do, and honestly that is also hard for us." |

4. ¿Qué falta en nuestra comunidad que podría apoyar mejor la salud y el bienestar?

**What is missing in our community that could support the improvement of health and well-being in our community?**

Participants described a need for more affordable clinics, additional medical specialists, and expanded women's health services including mammograms, Pap smears, menopause care, and mental health services. Dental and vision services were also mentioned. There was interest in bringing services available in neighboring counties to Randolph County. Participants also emphasized the importance of educational presentations for youth and young adults on topics such as financial aid, trade schools, college, scholarships, sexual health, vaping, and safe driving. Stronger communication with the Hispanic community and more workshops were identified as ways to improve awareness.

5. ¿A quién recurren las personas cuando necesitan ayuda, emocional, financiera o de otro tipo?

**Who do people turn to when they need help - emotional, financial, or otherwise?**

Participants reported turning to a combination of service agencies, health providers, schools, and trusted community organizations. The Department of Social Services, Salvation Army, and Christians United Outreach Center were identified for basic needs. Health providers including Randolph County Public Health, Kintegra, Piedmont Health Services, and mobile clinics were mentioned for medical care. Schools, the community college, Lazos Hispanos, and Asheboro Latinx Services were described as important sources of support and guidance.

6. ¿Dónde ve brechas en ese apoyo?

**Where do you see gaps in that support?**

Participants described barriers related to access, communication, cultural competence, and system navigation. Long wait times, rising costs, and difficulty receiving clear answers were mentioned in healthcare settings. Transportation challenges across the county were identified as limiting access. Confusion about Medicaid coverage and eligibility requirements was also noted. Participants expressed a need for more bilingual communication and improved coordination among services.

7. ¿Qué tipos de servicios de atención médica necesitan usted o su familia para mantener su salud y bienestar?

**What types of health care services do you/your family need to maintain your health and well-being?**

Residents emphasized the importance of accessible primary care, pediatric services, and specialty providers such as OBGYN, psychiatry, vision, and hearing services. Preventive services and behavioral health care were also identified as necessary components of family centered care.

8. ¿Qué le ha impedido a usted o a alguien en su hogar obtener atención médica, acceder a programas de salud comunitarios o ir a citas médicas?

**What has prevented you or someone in your household from getting health care, accessing community health programs, or going to doctor's appointments?**

Financial constraints and lack of insurance remain significant obstacles. Transportation challenges, including scheduling requirements and limited routes, restrict access for some families. Fear related to immigration status also influences decisions about seeking care. Limited provider availability further contributes to delays.

| | |
|---|---|
| “Y es que, perdón, desafortunadamente, no todos tenemos la misma posibilidad. O sea, no todos este también tenemos, pues la pues como servicio no todo lo tenemos y los que lo tienen, pues que bueno. Pero los que no, tenemos que pagarlo. Y obviamente que digan un especialista, pues tiemblas no, porque ya obviamente ya no es un costo que normalmente pagas una consulta privada, aquí yo la he llegado a pagar 250 dolares, imagínate, un especialista me va a cobrar más de 1,000 dolares. Entonces, pues no lo tenemos. ¿Entonces, qué dices, no? Pues aqui me voy a quedar con el dolor y a ver qué pasa.” | “And, sorry, unfortunately not all of us have the same opportunities. Not all of us have access to services, and those who do, that is good. But those of us who do not have it, we have to pay. And when they say you need a specialist, you get scared, because that is not a cost you normally pay for a private visit. I have paid $250 for a visit here. Imagine, a specialist is going to charge me more than $1,000. So we do not have it. So what do you say? I will just stay here with the pain and see what happens.” |

9. ¿De dónde obtiene la información que necesita que respalde su salud y bienestar o el de su familia?

**Where do you get the information you need that supports your or your family’s health and well-being?**

Participants reported receiving information from clinics and providers such as Piedmont Health Services, Randolph County Public Health, Kintegra, pediatricians, and primary care providers. Community organizations including Asheboro Latinx Services and Lazos Hispanos were also important sources. Family members and the internet were frequently used to gather information.

10. ¿Al acceder a la atención, alguna vez ha tenido que usar a un familiar para acceder a los servicios? Si es así, cuéntanos más sobre su experiencia.

**When accessing care, have you ever had to use a family member to access services? If so, tell us more about your experience.**

Participants shared that they have relied on family members, sometimes children, to help interpret during healthcare visits. This created stress and confusion, especially when medical language was complex.

| | |
|---|---|
| “Un hijo no es un traductor porque el idioma que habla el doctor no es un idioma que todos los días o común y corriente que nosotros hablamos.” | “A child is not a translator because the language the doctor speaks is not the kind of language we use every day.” |

11. ¿Tiene alguna sugerencia sobre cómo se pueden abordar o solucionar los problemas que discutimos hoy para mejorar la salud en la comunidad?

**Do you have any suggestions as to how the problems we discussed today can be addressed or fixed in order to improve health in the community?**

Recommendations included increasing outreach through health fairs, festivals, and workshops. Prevention programs addressing tobacco use, substance use, and chronic conditions such as diabetes were encouraged. Improved communication in both English and Spanish was viewed as essential for strengthening awareness and engagement.

These discussions highlight strong community ties and trusted local organizations alongside challenges related to affordability, transportation, language access, and system navigation. Economic strain and communication barriers are closely linked to health and access to care. These perspectives add important context to the quantitative findings presented in the Community Opinion Survey section that follows.

## Community Opinion Survey

The community opinion survey was conducted to gather resident perspectives on health, quality of life, and community conditions across Randolph County. Data collection took place between October and December 2025 and was implemented in collaboration with Randolph Health and community partners.

The survey included 19 questions focused on community health, environmental conditions, social support, and access to care, along with open-ended questions to better understand lived experiences and quality of life. The survey was available in both English and Spanish and offered in paper and online formats to support accessibility.

A mixed-methods approach was used to reach a broad range of residents:

1. Randomized direct mail, sent to 10,000 households across the county
2. Convenience sampling, shared through online platforms and in-person outreach

For the household survey, residential address data were obtained from NC OneMap using the AddressNC dataset. All addresses within Randolph County were extracted and organized by census tract. A proportional, stratified random sampling approach was then applied to determine the number of households selected within each tract based on the total number of addresses. Random selection methods were used within each tract to identify households for inclusion.

Selected households received a mailed survey packet that included an introductory letter, a paper survey, a prepaid return envelope, and a QR code to complete the survey online.

In addition to the household survey, convenience sampling was conducted through community partners, events, and outreach efforts. Steering Committee members and partner organizations distributed paper surveys and shared digital access through flyers, websites, listservs, and social media to reach residents who may not have been captured through the mailed survey.


This mixed-methods approach resulted in a combined survey sample of **847** eligible responses.

**Limitations:** While multiple outreach strategies were used, the survey sample is not fully representative of the Randolph County population, and findings should be interpreted as reflective of participant perspectives. Response patterns differed by distribution method, with the household survey reaching more older adults and the convenience sample reaching more younger and middle-aged adults and individuals with higher levels of income and education. Despite these limitations, the combined approach provided valuable insight into a range of community experiences and perspectives.

**Note:** Unless otherwise noted, figures and findings presented in this section communicate combined responses from both randomized sample and convenience sample survey participants. Where relevant, differences by survey method are described to highlight variation in lived experience across populations.

## Survey Results

### Geographic Distribution of Responses

**Figure 68.** Survey Respondent Zip Codes in Randolph County, Community Opinion Survey (2025)


Survey respondents were most concentrated in Asheboro zip codes 27205 and 27203, demonstrating higher population density in these areas. Strong participation was also observed in Randleman, Trinity, and Archdale. Participation was lower in more rural areas of the county, highlighting opportunities to strengthen outreach and engagement in more remote communities.

This map shows the zip codes within Randolph County reported by respondents to the Community Opinion Survey. Zip codes are highlighted to indicate where survey respondents live, with sizing of the icon based on percentage of respondents per zip code.

### Demographics

Understanding who participated in the Community Opinion Survey offers additional perspective to support interpretation of findings throughout this assessment. Characteristics such as age, income, education, employment, and insurance coverage influence how residents experience health, access services, and identify community priorities.

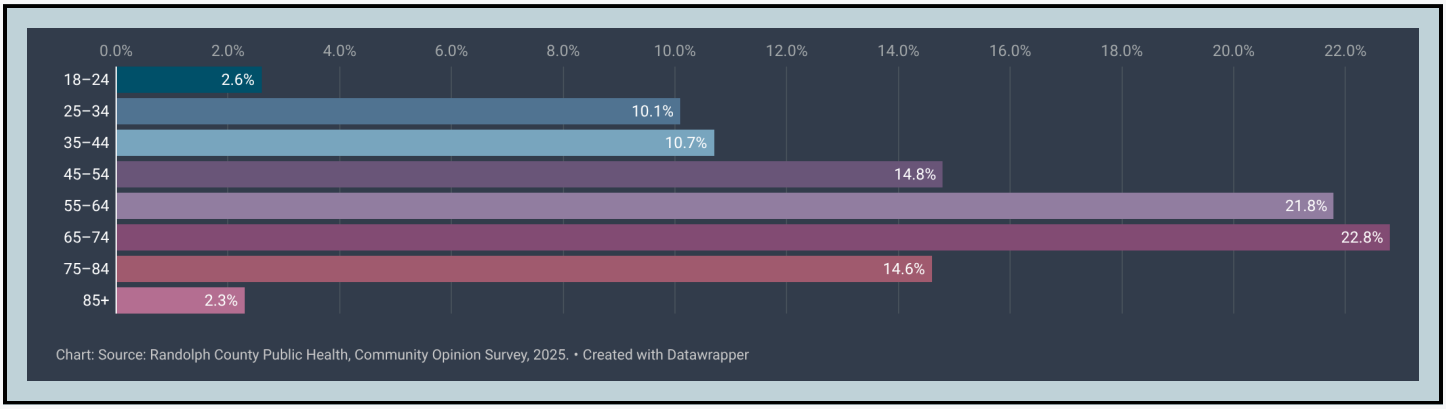
Variation among respondents indicates differences in outreach methods and life stage. Reviewing these patterns helps clarify whose perspectives were captured and where gaps may remain, reinforcing the importance of interpreting survey findings alongside secondary data, focus group input, and community partner engagement.

### Age

Clear differences in age distribution were observed between respondents reached through different outreach approaches. Direct mail surveys were more effective in engaging older adults, with approximately 78.0% of respondents being aged 55 and older. In contrast, convenience sampling captured a younger population, with a higher proportion (57.6%) of respondents between the ages of 18 and 54.

These patterns suggest variation in outreach methods and life stage. Older adults may be more likely to respond to mailed surveys, while younger adults are often reached through online platforms and in-person engagement. Age distribution is important to consider when interpreting findings related to health care access, chronic disease, social connection, and emergency communication preferences.

**Figure 69.** Age Distribution of Survey Respondents, Randolph County Community Opinion Survey (2025)




## Race, Ethnicity, & Sex

Survey respondents were primarily non-Hispanic White and female, highlighting trends commonly seen in voluntary survey participation. Responses were also received from residents identifying as Hispanic or Latinx, non-Hispanic Black, and other racial and ethnic groups, though these populations were underrepresented relative to the overall county population.

This underrepresentation reinforces the need for continued efforts to engage historically underrepresented populations in future assessment and planning activities.

**Figure 70.** Sex of Survey Respondents, Randolph County Community Opinion Survey (2025)

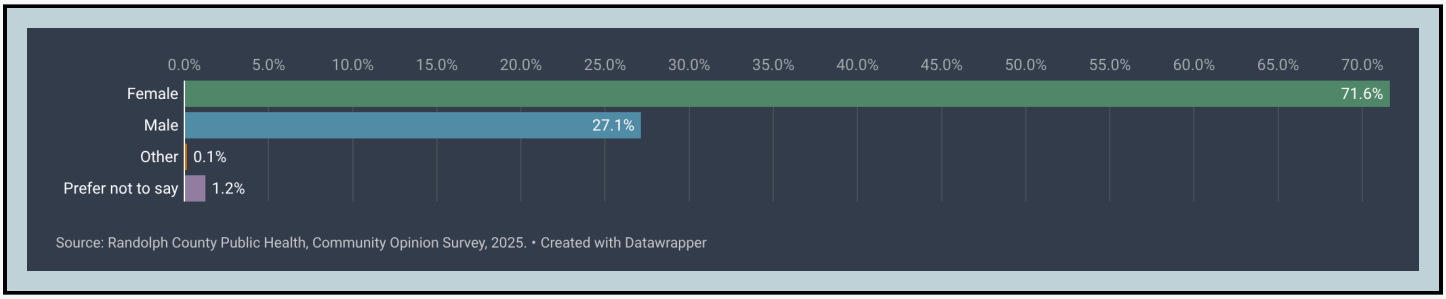
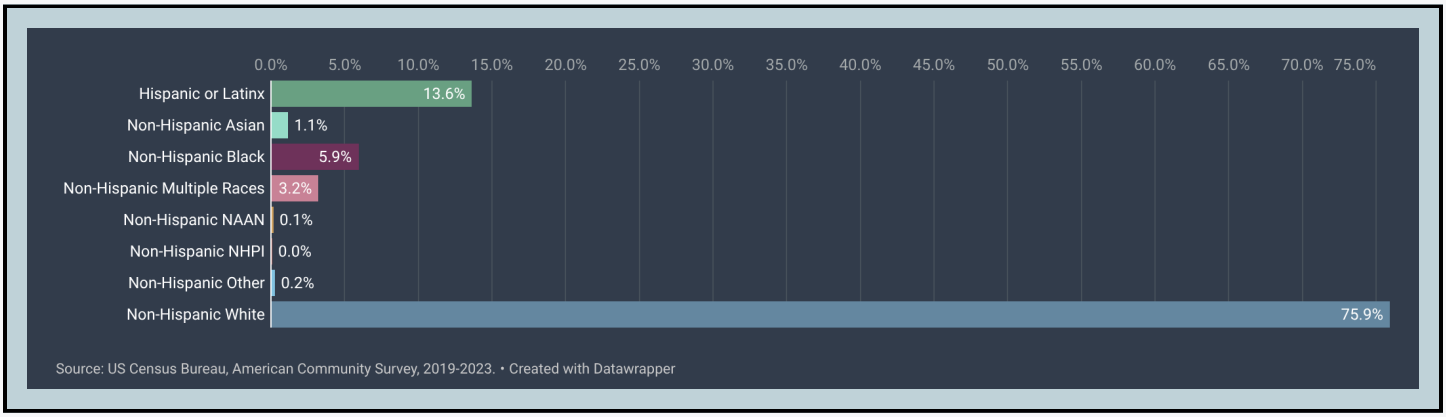



**Figure 71.** Race and Ethnicity of Survey Respondents, Randolph County Community Opinion Survey (2025)



## Income & Employment

Household income varied among respondents, reflecting differences in employment status and life stage. Some participants reported lower household incomes or preferred not to disclose income, while others reported earnings above $100,000 annually.

Employment patterns mirrored these income differences. Some respondents were retired or not currently working, while others reported full-time employment. These patterns help explain variation in concerns related to affordability, insurance coverage, work-related stress, and access to services during standard business hours outlined later in this section.

**Figure 72.** Employment Status of Survey Respondents, Randolph County Community Opinion Survey (2025)

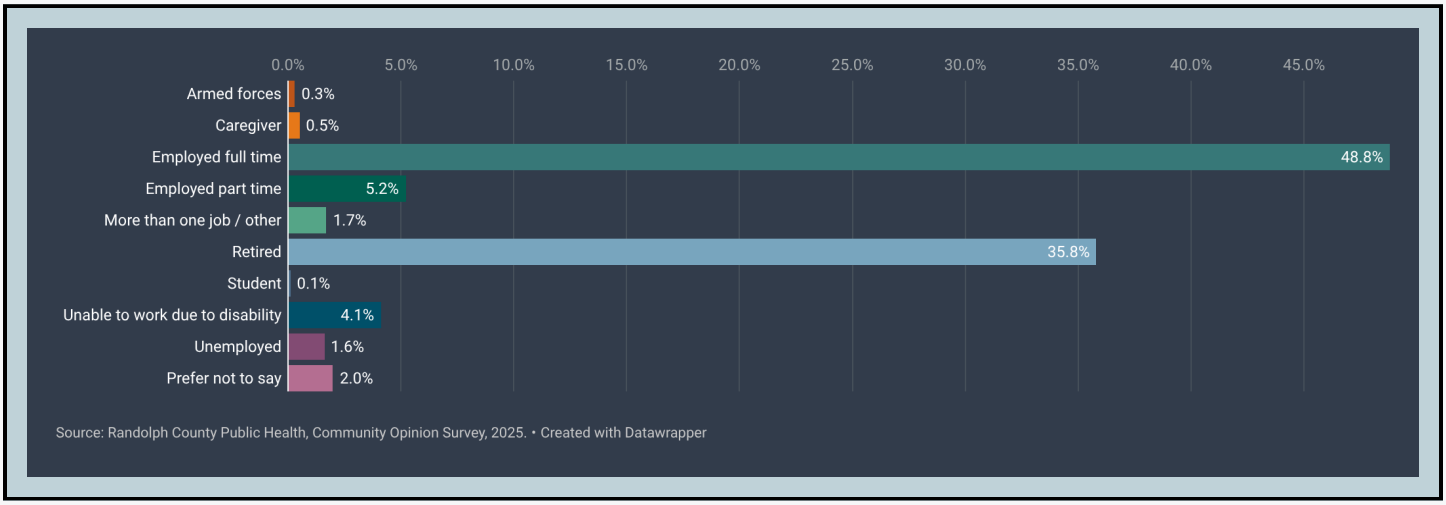
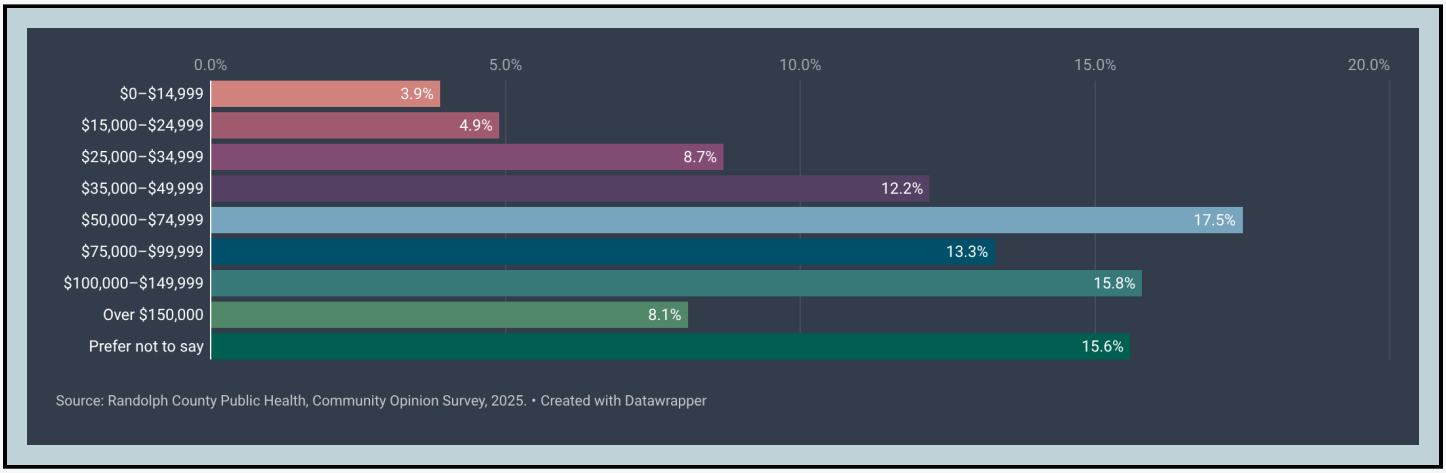



**Figure 73.** Household Income Distribution of Survey Respondents, Randolph County Community Opinion Survey (2025)

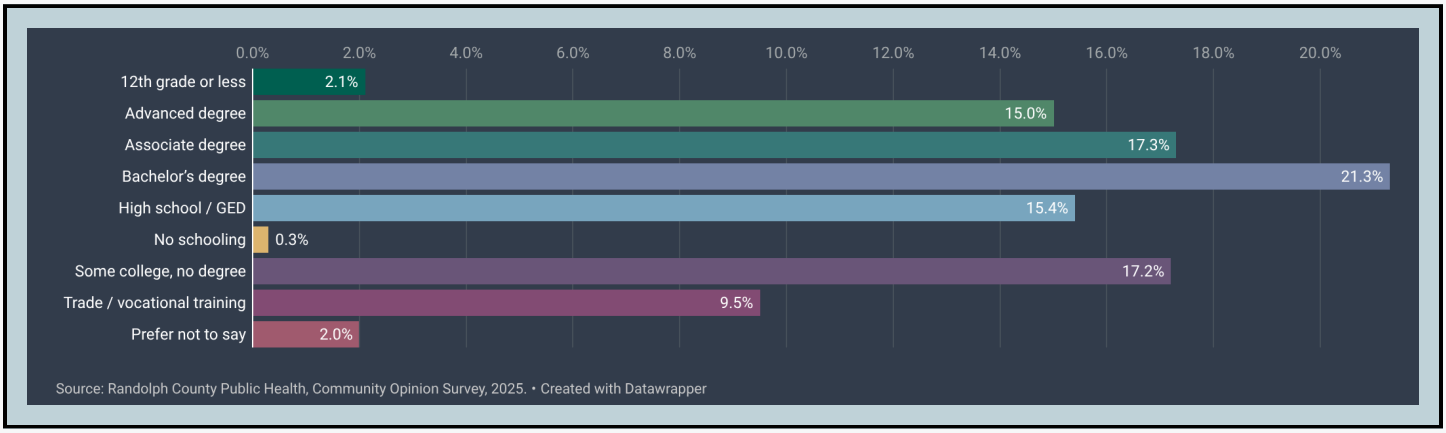


## Education

Educational attainment varied across respondents, with representation spanning from individuals with a high school education or less to those holding advanced degrees. Higher levels of educational attainment are often associated with greater access to information, resources, and health services, which may influence how individuals perceive community needs and available supports.

Including responses from residents with a wide range of educational backgrounds strengthens the assessment by capturing diverse perspectives and lived experiences across the community.

**Figure 74.** Educational Attainment of Survey Respondents, Randolph County Community Opinion Survey (2025)

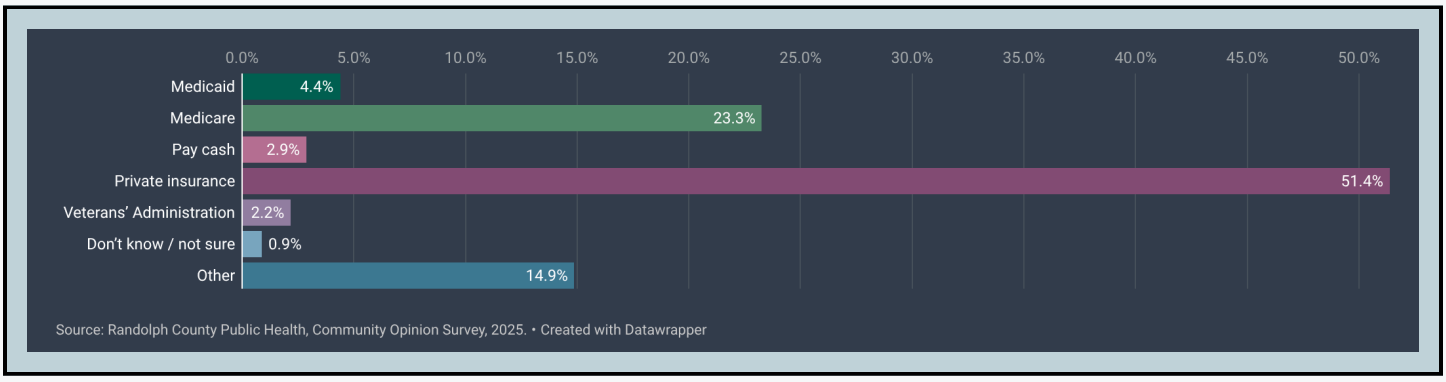



## Health Insurance Coverage

Health insurance coverage signaled differences in age and employment status among respondents. Some participants reported coverage through private insurance, while others reported Medicare, Medicaid, or less common insurance types. Respondents that have dual eligibility status - qualifying for both Medicare and Medicaid - represent the 14.9% that selected "other".

These patterns provide important context for understanding reported barriers to care, affordability concerns, and experiences navigating the health care system, and they help explain variation in access-to-care findings presented later in this section.

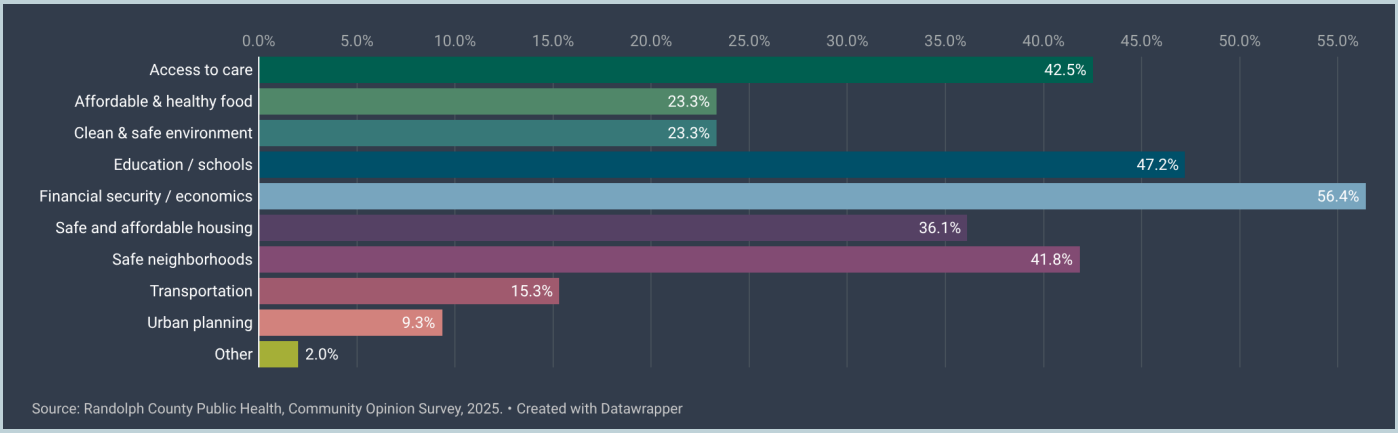
**Figure 75.** Health Insurance Coverage of Survey Respondents, Randolph County Community Opinion Survey (2025)



## Quality of Life Priorities

Respondents identified financial security and education as the most important factors influencing quality of life. Access to health care and safe neighborhoods were also frequently selected. These findings show the importance residents place on social and economic conditions as key contributors to overall well-being.

**Figure 76.** Community Identified Quality of Life Priorities, Randolph County Community Opinion Survey (2025)



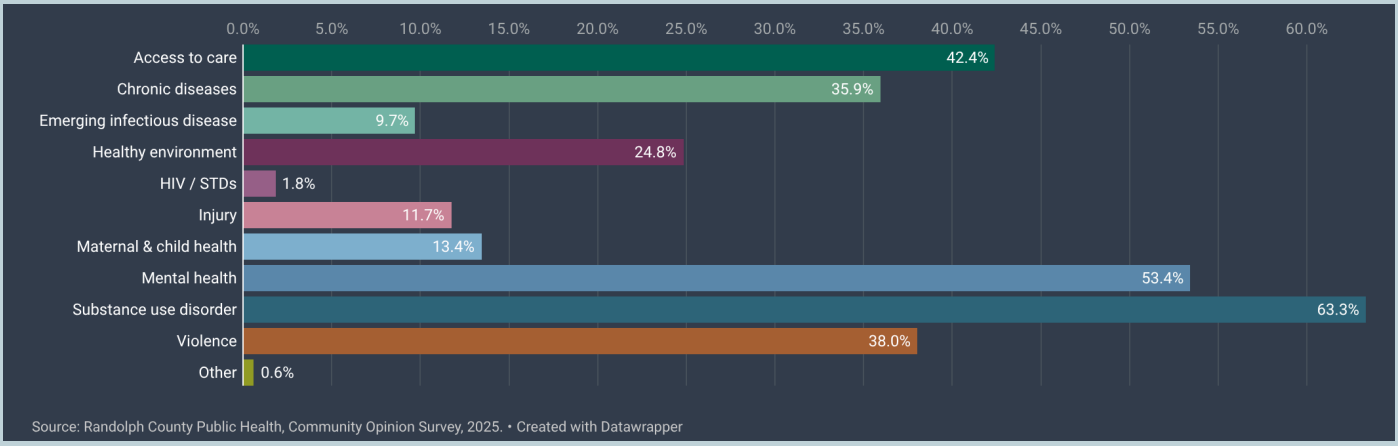

*Respondents were asked to select the **three** most important factors that can improve quality of life in Randolph County

## Community Identified Health Concerns

Mental health and substance use disorder were the most frequently identified health concerns. Residents also reported concerns related to access to care, including appointment availability, wait times, and insurance coverage. Chronic disease and violence were generally viewed as moderate concerns, but received higher response rates than other listed health issues, such as emerging infectious diseases and HIV/STDs.

Some variation was observed across respondent groups, with environmental health and emerging infectious diseases more frequently selected by mail survey respondents and maternal and child health and injury more commonly identified by convenience sampling respondents. Overall, priorities showed strong alignment and suggest differences in lived experience rather than conflicting concerns.

**Figure 77.** Health Issues Identified as Community Concerns, Randolph County Community Opinion Survey (2025)



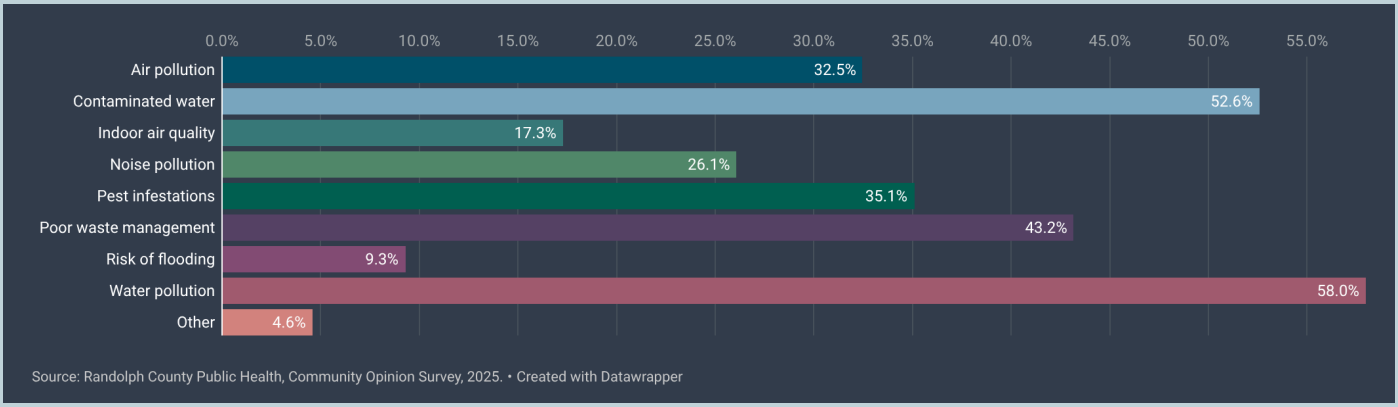

*Respondents were asked to select the **three** most important concerns impacting health in their community

## Environmental Health Concerns

Water quality was the most frequently identified environmental health concern, including issues related to contaminated drinking water and polluted rivers and lakes. Residents also reported concerns related to waste management, air quality, and pest infestations.

Differences in specific concerns suggest geographic variation in environmental conditions. Indoor air quality and pest infestations were a higher concern among convenience sampling survey respondents, while flooding, poor waste management, and noise pollution was reported more frequently among the randomized sampling respondents. Despite these differences, concern for water safety and environmental infrastructure was shared across the community.

**Figure 78.** Environmental Health Issues Reported by Residents, Randolph County Community Opinion Survey (2025)



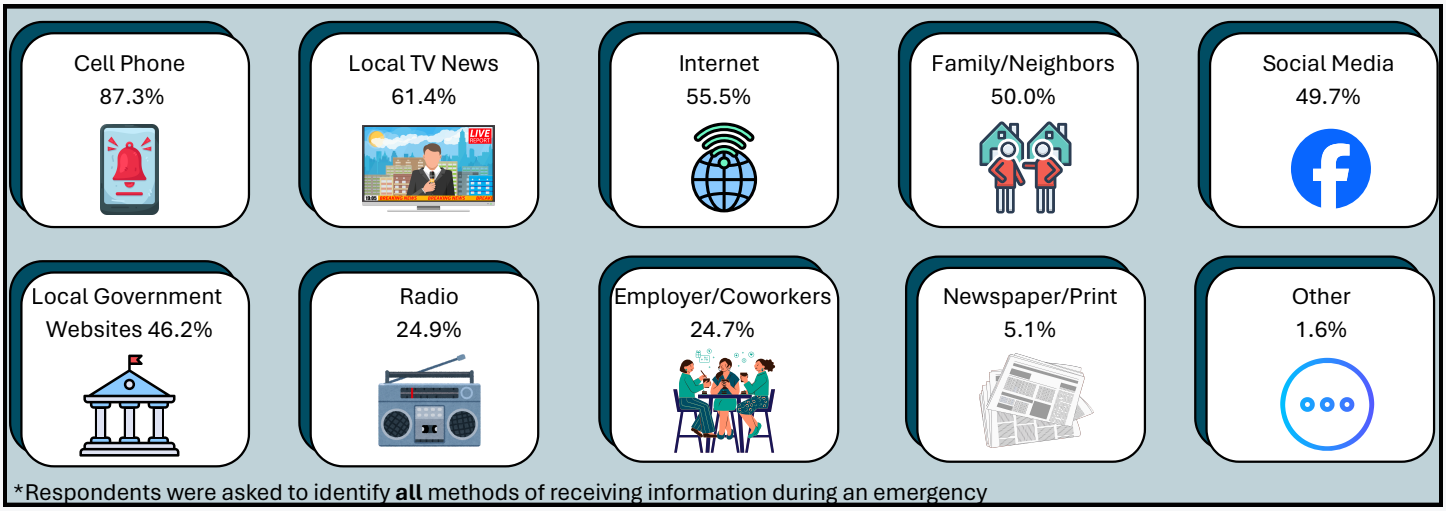

*Respondents were asked to identify **all** environmental issues affecting their community

## Emergency Communication Preferences

Cell phones were the most preferred method for receiving emergency information, followed by local television and internet-based platforms. Preferences varied among respondents, with some relying more on digital and workplace communication and others preferring television or personal networks.

These findings support continued use of mobile-friendly, multi-platform communication strategies to ensure emergency information is timely and accessible.

**Figure 79.** Preferred Methods of Receiving Emergency Information, Randolph County Community Opinion Survey (2025)



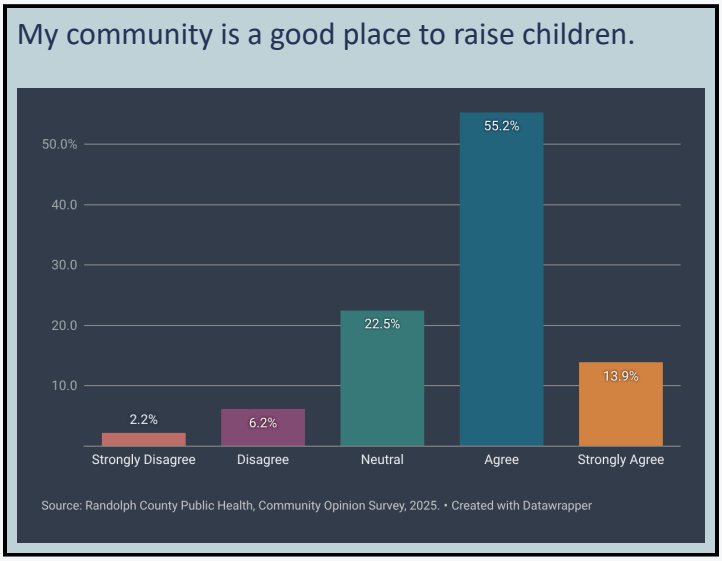

*Respondents were asked to identify **all** methods of receiving information during an emergency

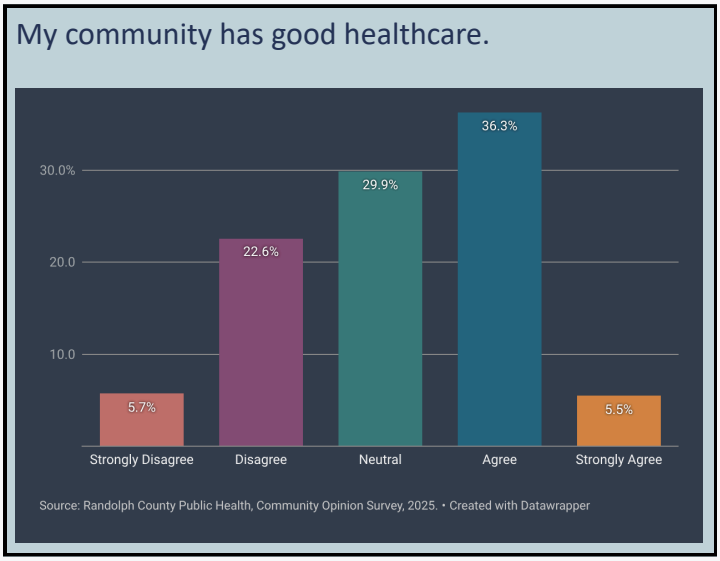
## Community Perceptions of Place & Support

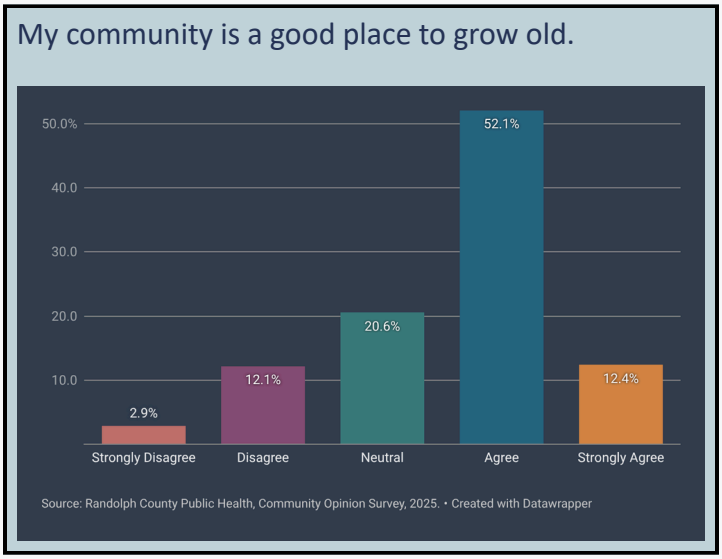
Most respondents indicated that Randolph County is a good place to grow older and raise children, and many reported feeling safe in their communities. Perceptions of economic opportunity were less favorable, reinforcing economic stability as a key concern. Views on health care availability and quality were mixed, suggesting varied experiences or limited awareness of available services.

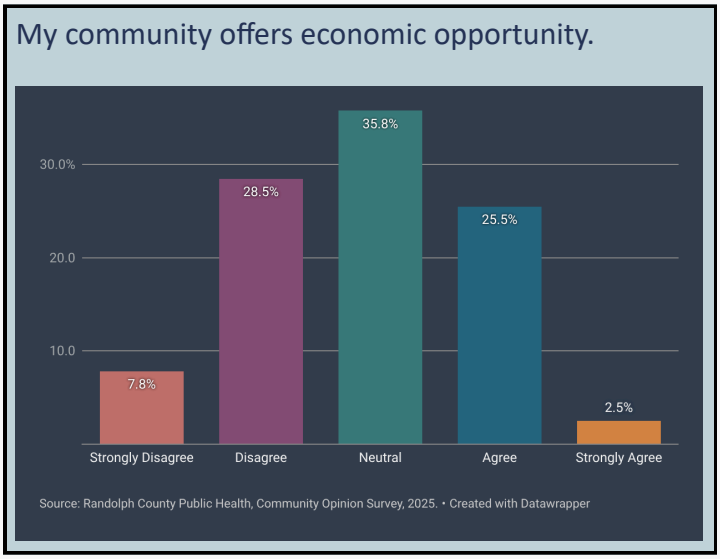
Perceptions of community support during times of need were also mixed. While many residents reported strong personal support networks, fewer expressed high confidence in community-level support systems, indicating opportunities to improve coordination, visibility, and communication of existing resources.

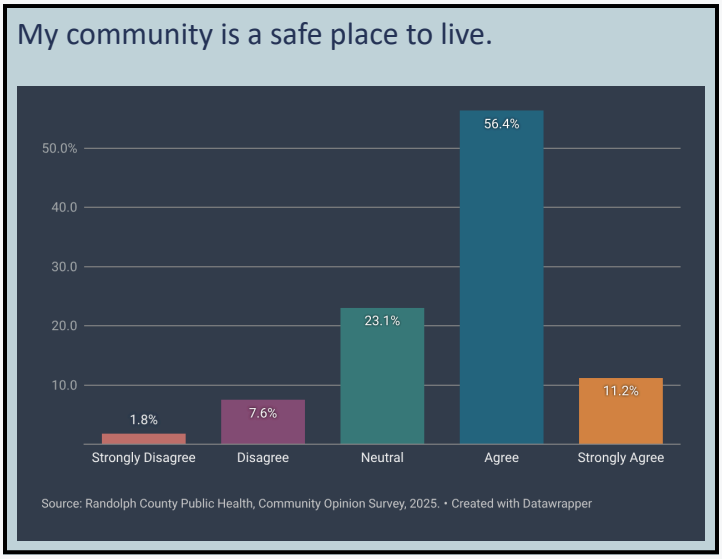
**Figure 80.** Perceptions of Community Conditions, Randolph County Community Opinion Survey (2025)

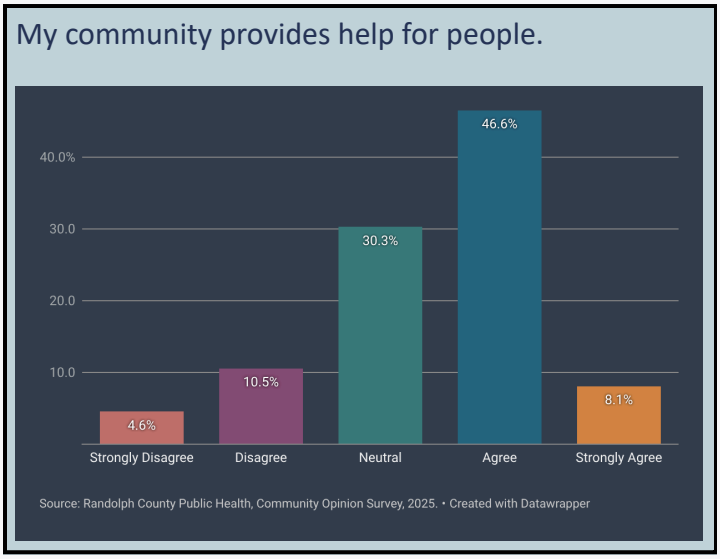




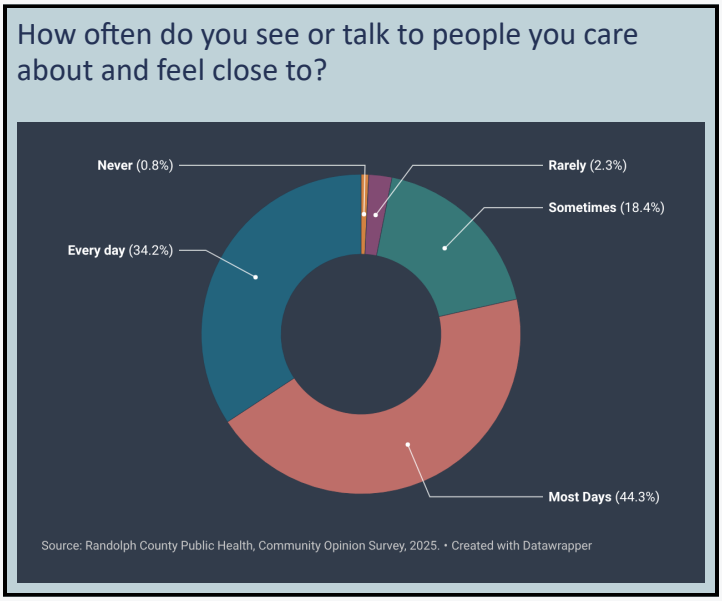



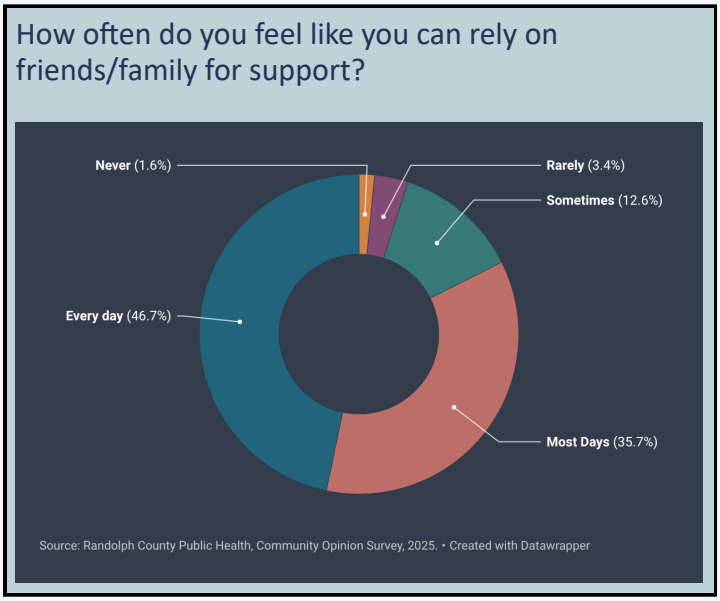

## Social Connection & Isolation

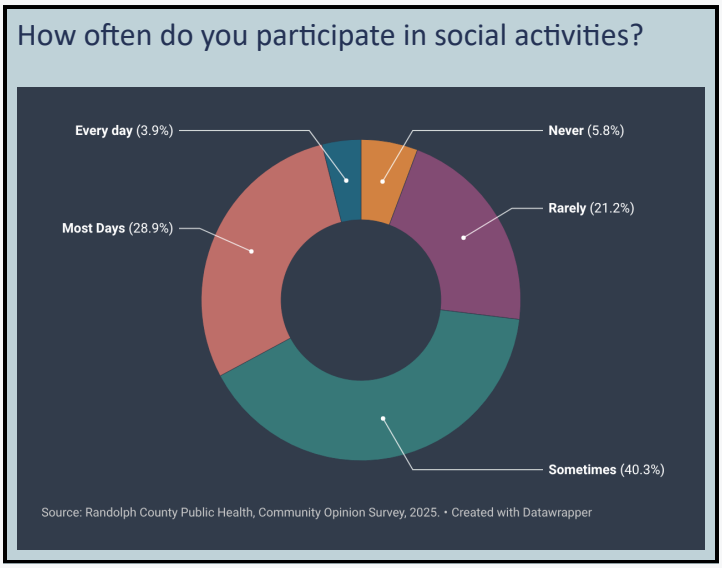
Many respondents reported strong personal support networks, including regular contact with family or friends and confidence in relying on others for help. Feelings of loneliness were generally low, though about one quarter of respondents reported feeling lonely at least occasionally.

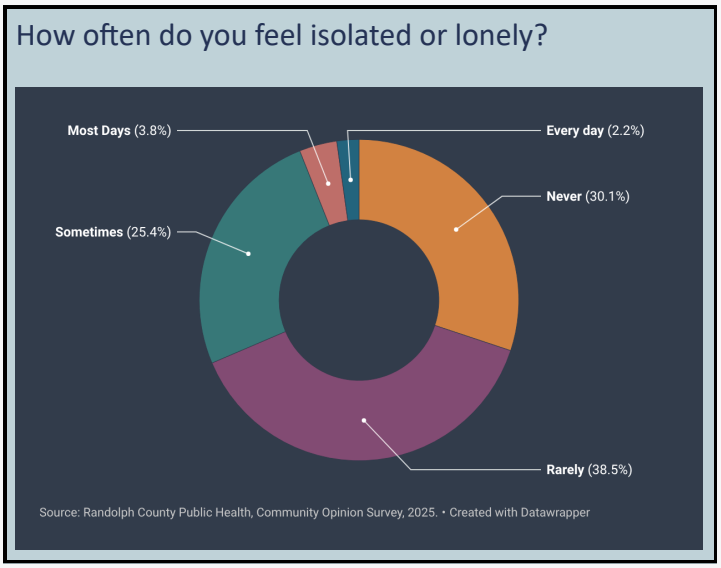
Participation in social or group activities was moderate, suggesting that time, transportation, or access may limit engagement for some residents. Overall, social connection emerged as a community strength, with opportunities to expand participation and reduce isolation for certain groups.

**Figure 81.** Social Connection and Feelings of Isolation Among Residents, Randolph County Community Opinion Survey (2025)





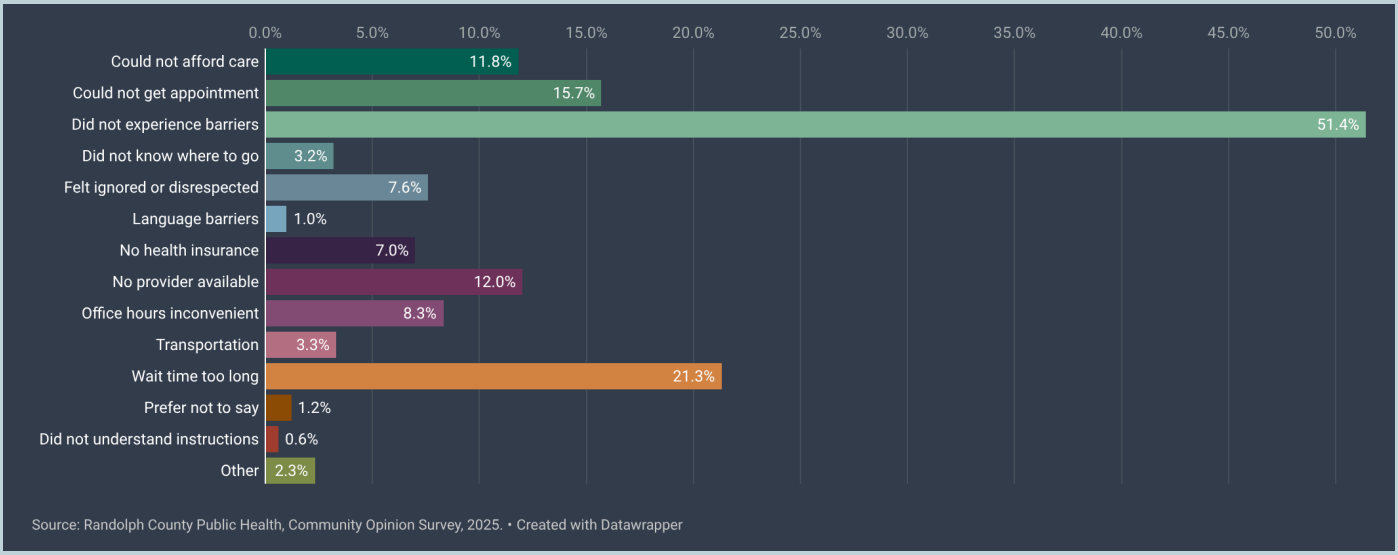




## Access to Care

About half of respondents reported no barriers to accessing care. Among those who experienced challenges, the most commonly reported barriers included long wait times, limited appointment availability, and insurance-related concerns. Specialty care, dental, vision, and primary care services were most frequently reported as difficult to access.

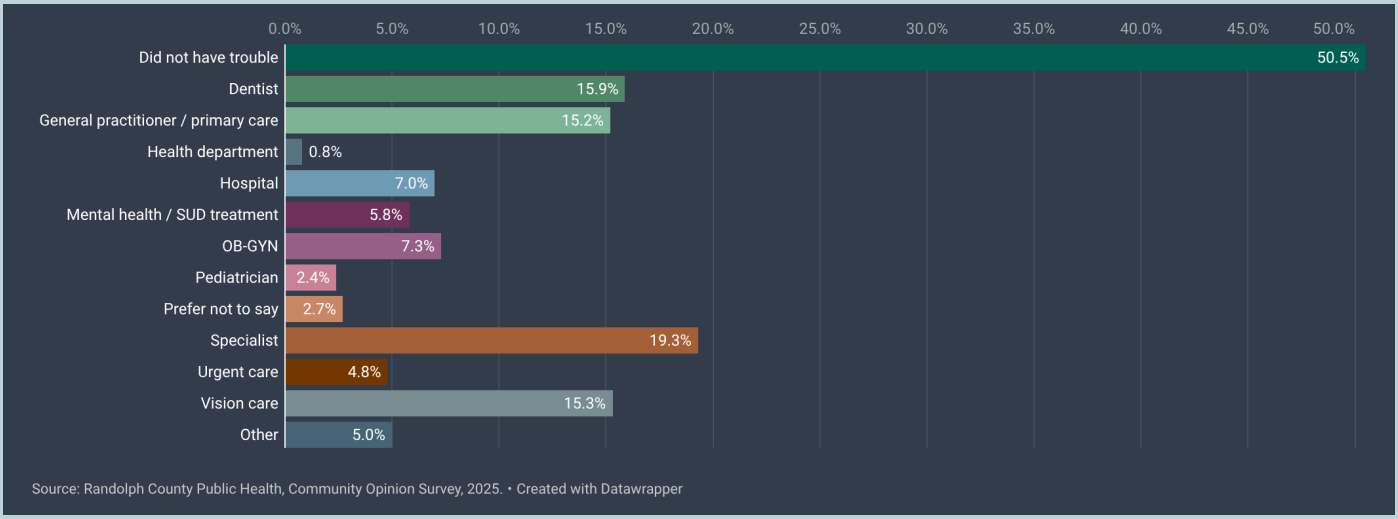
Differences in reported barriers suggest that some populations face additional challenges related to affordability, office hours, and language access. Overall, access to care remains an important concern and indicates factors related to how health systems operate rather than individual behavior.

**Figure 82.** Reported Barriers to Accessing Health Care, Randolph County Community Opinion Survey (2025)




*Respondents were asked to select **all** types of barriers faced to receiving health care

**Figure 83.** Reported Barriers to Types of Health Care Services, Randolph County Community Opinion Survey (2025)




*Respondents were asked to select **all** types of providers or facilities they had trouble getting health care from

## Open-Ended Survey Response Themes

Open-ended survey responses provided additional insight into understanding how residents experience health, quality of life, and community conditions in their daily lives. Responses to Questions 17 through 19 show how economic pressures, caregiving responsibilities, environmental conditions, and community systems are interconnected and shape overall well-being.

> “Education, sense of community, and pride in living conditions matter.”

> “A community is only as strong as the infrastructure will allow it to be.”

Many residents described economic strain as a major source of stress, particularly related to housing costs, utilities, food, and health care expenses. Financial stability was closely tied to emotional well-being, family security, and the ability to plan for the future.

> “Trying to pay bills without a living wage is stressful.”

> “There’s no room for a hiccup without it setting you back.”

Residents also connected health needs and caregiving responsibilities to stress and community priorities. Responses highlighted the demands of managing chronic illness, accessing care, and supporting aging family members, while emphasizing the value of mental health services, substance use treatment, and preventive care.

> “Access to mental health care would make a big difference.”

> “Caring for older parents while working is overwhelming.”

Environmental and infrastructure concerns were especially prominent, with residents frequently citing water quality, air pollution, rapid development, and loss of natural spaces. These concerns were often linked to long-term health, safety, and community identity.

> “Drinking water should be safe for everyone.”

> “I was born here and want to protect this place for our kids.”

Throughout all three questions, residents emphasized community connection and shared responsibility. Responses communicated a desire for safer, cleaner, and more supportive communities, along with compassion and cooperation in addressing challenges such as substance use and homelessness.

> “To come together, listen, and celebrate the good things in our communities.”

> “Communities taking care of one another.”

This synthesis of open-ended responses provides important perspective for understanding how residents experience health and quality of life in Randolph County and offers insight into the values and priorities that underlie the survey’s quantitative findings.

> “We love Randolph County and have always lived here. Everyone needs to stop bickering and work together for our communities.”

## Key Takeaways

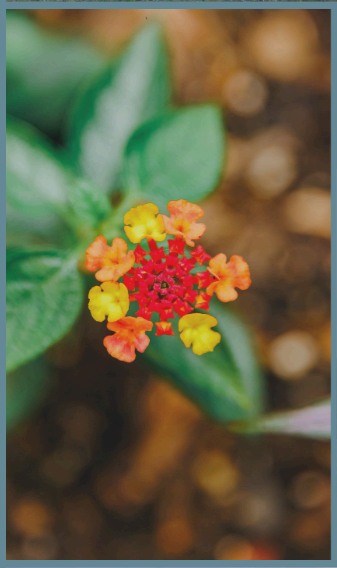
Differences between survey distribution methods reflect variation in age, employment status, education, and lived experience rather than conflicting priorities. Together, these approaches provide a more complete picture of how residents across Randolph County experience health and quality of life.

Overall, findings show strong consistency in community priorities, particularly related to economic stability, access to care, environmental quality, and community support. Closed-ended responses identify the issues residents view as most important, while open-ended responses explain how these issues affect daily life.

Environmental health concerns, especially water quality and infrastructure, were widely shared across geographic areas. Taken together, findings highlight the interconnected nature of health, economic conditions, environmental factors, and social support and point to opportunities for coordinated, cross-sector strategies during future planning and priority health selection.

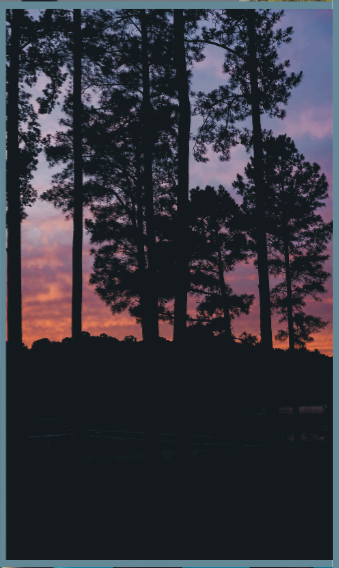

43

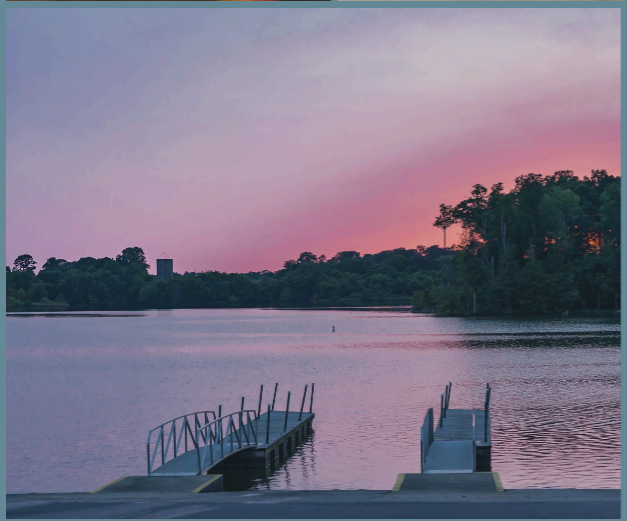

LEGENDS & LORE
NAOMI WISE
DROWNED IN DEEP RIVER BY HER LOVER IN 1807. BECAME SUBJECT OF WELL-KNOWN NORTH CAROLINA BALLAD BEARING HER NAME.
NORTH CAROLINA FOLKLIFE INSTITUTE
WILLIAM C. POWEROY FOUNDATION 2019
48
FARMERS MARKET



# RANDLEMAN


Randleman City Hall



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# Methodology

## Prioritization Matrix

In December 2025, the CHA Steering Committee met to review secondary data and community survey findings describing health concerns in Randolph County. Survey results included responses from both household and convenience samples, allowing the committee to consider perspectives gathered through multiple engagement methods. Health concerns identified within each sample, as well as across the combined results, were summarized to inform discussion.

Community health categories evaluated through the prioritization process were drawn from the third question of the 2025 Community Opinion Survey, which asked residents to identify factors they believed most affected community health. Secondary data related to each category were reviewed alongside survey findings to ensure that both data trends and community perspectives were considered.

The Core Committee confirmed the use of a prioritization matrix outlined in the National Association of County and City Health Officials (NACCHO) *Guide to Prioritization Techniques* to guide evaluation and scoring[7]. The matrix incorporated three criteria: feasibility, size of the problem, and community importance. Definitions for each criterion were provided in advance to support shared understanding and consistent application throughout the process.

**Figure 84.** Prioritization Matrix Factors Used for Scoring

| Feasibility | Size of the Problem | Community Importance |
|---|---|---|
| Resources available to address the issue (staff, budget, time, etc.)<br><br>Existing coalitions, programs, and services available to address the issue.<br><br>Community support of the issue. | Emphasizes the magnitude and severity of the issue.<br><br>Considers key data indicators in comparison to selected peer counties and the state. | Includes community voice by incorporating survey results from question 3 in the Community Opinion Survey:<br><br>"In the following list, what do you think are the THREE most important concerns impacting health in our community?" |

Each community health category was listed in a spreadsheet, with evaluation criteria applied consistently across categories. Weights were assigned to each criterion to demonstrate their relative influence on the ability to move an issue forward through community action. Feasibility received the highest weight to highlight the importance of available resources, existing programs and services, and community support. Community importance received the lowest weight, recognizing that survey data capture only part of community voice. Each criteria received a score of 1, 2, or 3, based on the following rating scale:

**Figure 85.** Prioritization Matrix Criteria Used for Rating

| Feasibility | Size of the Problem | Community Important |
|---|---|---|
| • 1 if 1 out of 3 criteria met<br>• 2 if 2 out of 3 criteria met<br>• 3 if 3 out of 3 criteria met | • 1 - below average<br>• 2 - similar to NC/peers<br>• 3 - above average | • 1 - low (<33%)<br>• 2 - medium (34-66%)<br>• 3 - high (>67%) |

## Priority Health Issue Selection

Steering committee members reviewed secondary data comparing Randolph County to selected peer counties and North Carolina. Following this review, feasibility and size of the problem were discussed for each category. Community importance scores were entered based on aggregated survey results.

**Table VI-1**. Prioritization Matrix Results

| 2025 CHA Community Health Categories | Feasibility Weight = 0.5 | Size of Problem Weight = 0.35 | Community Importance Weight = 0.15 | TOTAL SCORE (rating x weight) |
|---|---|---|---|---|
| Injury (Car crashes, traumatic brain injuries, drownings, etc.) | 2 | 2 | 1 | 1.85 |
| HIV/STDs (Testing and treatment for HIV, chlamydia, gonorrhea, syphilis, etc.) | 1 | 1 | 1 | 1.00 |
| Maternal & Child Health (Affordable birth control, prenatal care, low birth weight, premature babies, infant mortality, etc.) | 2 | 2 | 1 | 1.85 |
| Healthy Environment (Clean air, land, water, etc.) | 2 | 2 | 1 | 1.85 |
| Violence (Bullying, domestic violence, child abuse, assault, homicides, etc.) | 2 | 1 | 2 | 1.65 |
| Access to Care (Affordable healthcare; flexible hours; specialty services like dental, vision, hearing, translation services are unavailable, etc.) | 1 | 3 | 2 | 1.85 |
| Mental Health (Anxiety, depression, suicide, etc.) | 1 | 3 | 2 | 1.85 |
| **Substance Use Disorder (Alcohol, opioids, prescription drugs, other drugs, etc.)** | **2** | **3** | **2** | **2.35** |
| **Chronic Disease (Cancer, heart disease and stroke, high blood pressure, diabetes, etc.)** | **3** | **3** | **2** | **2.85** |

Source: 2025 Steering Committee Prioritization Matrix Results • Created with Datawrapper

*The table above is a visualization of the original matrix used to identify the priority health issues during the December 2025 Steering Committee meeting. This matrix can be found in **Appendix D.**

Weighted scores were calculated at the conclusion of the process. The highest overall scores received were **substance use disorder (2.35)** and **chronic disease (2.85)**. Steering Committee members discussed the results and confirmed that these priorities were feasible to address, reflected a meaningful health burden, and aligned with community needs. Consensus was reached to move forward with these priorities to guide Community Health Improvement Plans (CHIPs) development over the next three years.

## Community Health Improvement Plans (CHIPs)

With the selection of the 2025 priority health issues, the CHA team will move into the development of CHIPs with a focus on building from existing strengths while addressing persistent gaps. In a rural context where resources are limited, it is especially important to understand what programs, partnerships, and community efforts are already in place, who they are serving, and where areas of improvement remain. Avoiding duplication of efforts helps protect limited resources and ensures that effective programs can continue supporting communities most impacted by health inequities. CHIPs will therefore be developed with intention, centering approaches that are culturally responsive, trauma-informed, and sustainable.

The planning tools developed through the MAPP framework support a value-based transition from assessment to action. Tools such as the Stakeholder Power and Analysis and Community Partner Assessment help identify not only organizational capacity, but also whose voices and experiences must be included in decision-making. These tools will guide the formation of priority-specific subcommittees that include community members, partners, and stakeholders who mirror the populations most affected by each priority health issue.

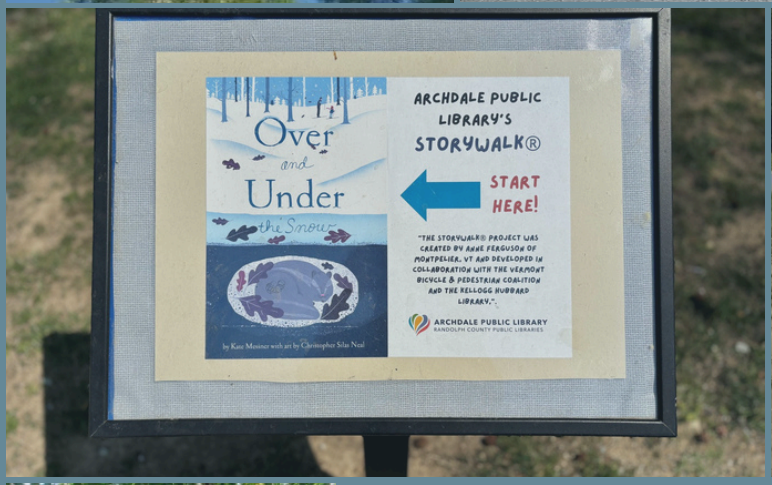
Once subcommittees are established, members will work collaboratively to define shared goals, strategies, and objectives rooted in community priorities and lived experience. Guided by the *MAPP 2.0 Guidebook, Phase III, Step 5, Develop Shared Goals and Long-Term Measures*, this process will connect the community's vision and values to long-term outcomes and meaningful measures of progress[4]. As part of this work, subcommittees will also review ongoing efforts led by Randolph County Public Health staff, as well as the work of existing collaboratives and coalitions, to ensure that CHIP strategies strengthen and enhance current initiatives while also identifying new approaches, partnerships, and populations in need of services. Particular attention will be given to identifying barriers that may limit participation or access, and to ensuring that individuals and communities most impacted by health disparities are actively involved in the planning, implementation, and evaluation of CHIPs.

As goals, objectives, strategies, and measures are established, subcommittees will move into action planning for each priority health issue CHIP, with an emphasis on shared accountability and continuous learning. Evaluation measures will be used to track outcomes and assess whether strategies are reaching intended populations and responding to community-identified needs.

The CHIP process will take time and require consistency, commitment, flexibility, and adaptability. Like all program planning efforts, it will evolve and remain responsive to the changing needs of our communities. The success of the CHIPs will not be defined by how well a plan is written, but by how well we listen to what the data and community voices are telling us, and by how effectively we continue to work together to improve quality of life for everyone living in Randolph County.


Archdale


ARCHDALE
SODA SHOP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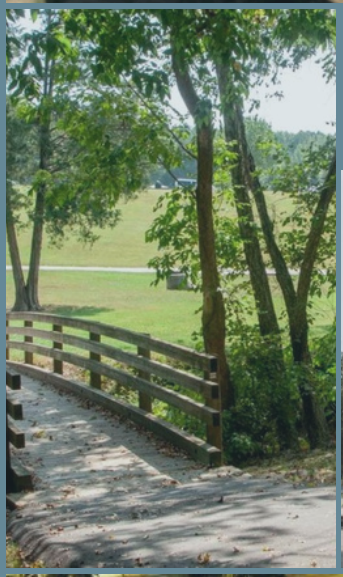
# ARCHDALE




ESSO

## Overview of Available Services

Randolph County has a broad network of public agencies, nonprofit organizations, educational institutions, faith based groups, and regional partners that support health and well-being. Services span preventive health care, behavioral health, food access, housing stability, education, workforce development, transportation, legal assistance, and culturally specific outreach.

Public health and clinical services provide a strong foundation. Available services include immunizations, preventive screenings, family planning, WIC, children's dental care, primary care, hospital based acute care, outpatient mental health treatment, substance use treatment, crisis response, medication assisted treatment, and residential supports for individuals with intellectual and developmental disabilities. These services support children, families, uninsured residents, individuals experiencing mental health or substance use challenges, and the broader community.

| | |
|---|---|
|  | Basic needs and social supports include food assistance, utility support, clothing, benefits enrollment, emergency financial assistance, senior nutrition programs, and caregiver support. |
|  | Housing resources include public housing, housing choice vouchers, emergency shelter, and services for survivors of domestic violence. |
|  | Youth and family services include early childhood education, K-12 schools, youth development programs, recreation opportunities, and community college workforce training. |
|  | Culturally specific and advocacy organizations provide bilingual navigation, immigration related assistance, civil legal support, disability services, veteran services, and outreach to historically underserved populations. |

**Note:** A list of agencies and organizations identified through this inventory is available in **Appendix E**. This list represents agencies identified during the assessment process and may not include every organization serving Randolph County. Readers should use caution when referencing this list, as contact information, services provided, populations served, and organizational locations may change over time.

## Gaps and Opportunities

Although Randolph County benefits from a diverse service network, several structural gaps align with the priority health issues identified in this assessment.

| | |
|---|---|
|  | Geographic distribution remains a concern. The concentration of services in Asheboro may limit access for residents in rural areas, particularly those facing transportation challenges. Expanding outreach and service access beyond central locations will be important in reducing disparities in care. |
|  | Housing stability continues to affect community well being. While emergency shelter and voucher programs exist, the supply of affordable and long term supportive housing remains limited relative to need. Housing insecurity contributes to financial strain, stress, and difficulty managing chronic health conditions. |
|  | Transportation barriers affect multiple priority areas. Route coverage, advance scheduling requirements, and work hour conflicts can delay access to health care, employment, and supportive services. |
|  | Access to specialty and preventive care remains constrained. Primary care and crisis behavioral health services are available, yet specialty services, women's health care, dental specialty care, and bilingual behavioral health providers are more limited. Strengthening preventive and specialty care capacity would support efforts to address chronic disease, maternal and child health, and mental health priorities. |
|  | Language access and system navigation also require continued attention. Interpretation and bilingual communication are not consistent across all systems, which can limit equitable access for Hispanic and Latinx residents and others with limited English proficiency. |

Opportunities exist to strengthen coordination across sectors, improve referral pathways, expand preventive programming, and align services more intentionally with identified priority health issues. Continued collaboration among healthcare providers, social service agencies, schools, nonprofit organizations, and community partners will be essential to advancing community health improvement efforts and reducing disparities across Randolph County.

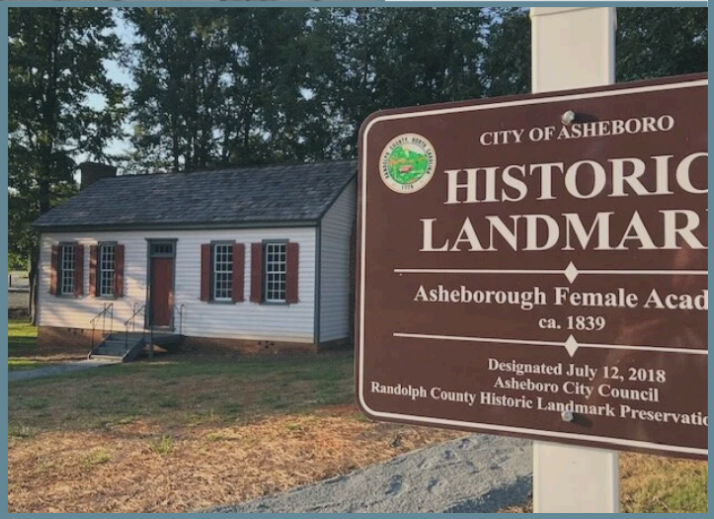

ss Murphy:
"There's not enough
of us that give
of ourselves"


ASHEBORO
HIGH SCHOOL


PARKS AND RECREATION DEPARTMENT
NORTH ASHEBORO CITY PARK
CITY OF ASHEBORO

# ASHEBORO


THE TABLE


CITY OF ASHEBORO
HISTORIC
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Designated July 12, 2018
Asheboro City Council
Randolph County Historic Landmark Preservatio

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Images represent landmarks and community assets across Ramseur. Images were sourced from the following sources and contributors: Heart of North Carolina, Official Website: Coca Cola mural, Allen H. Leonard Park | Millstone Creek Orchards, Official Website: Orchard Front Sign | Randolph Record: Water tower | Town of Ramseur, Official Website: Public library, Ramseur Museum | Ramseur Fire Department Facebook: Fire department | Town of Ramseur Facebook Page: Ramseur Lake | Google Maps: Municipal building

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### Trinity Divider Page

Images represent landmarks and community assets across Trinity. Images were sourced from the following sources and contributors: Heart of North Carolina, Official Website: Linbrook Heritage Estate, Bell gazebo, Trinity history mural | City of Trinity, Official Website: Trinity College history, municipal building | Adaumont Farm, Official Website: Wedding venue | Zimmerman Vineyards, Official Website: Vineyard | Spade and Broom, Official Website: Local business, home goods | Google Maps: Trinity Community Park

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### Staley Divider Page

Images represent landmarks and community assets across Staley. Images were sourced from the following sources and contributors: Heart of North Carolina, Official Website: Antique Festival | Google Images: Satellite Sheriff's Office | Sammy's Grill, Official Website: Sammy's Grill | Christin Coats, RCPH Environmental Health Specialist: Sunset | Staley Volunteer Fire Department Facebook: Fire department | Google Street View: Staley Wesleyan Church | Nextdoor: Scenic view of Staley | DenZenPhotography: Luna's Trading Post filling station truck | Luna's Trading Post (Owner Photos): Antiques

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### Franklinville Divider Page

Images represent landmarks and community assets across Franklinville. Images were sourced from the following sources and contributors: Randolph County Tourism Development Authority (TDA): Park trailhead | Heart of North Carolina, Official Website: Bush Creek Bridge | Christin Coats, RCPH Environmental Health Specialist: Horse | Town of Franklinville, Official Website: Municipal building, Faith Rock, library, Riverside Park | Franklinville Diner, Official Website: Franklinville Diner

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### Liberty Divider Page

Images represent landmarks and community assets across Liberty. Images were sourced from the following websites: Homes Local Guide - Liberty, NC: Vintage bike, Shadow Box Antiques, farmers market, water tower | Randolph County Tourism Development Authority (TDA): Band performing | SSOE Group: Toyota plant | Liberty Public Library Facebook: Public library | Liberty Veterans Memorial Gardens, Official Website: Veterans memorial and gardens | Randolph Community College Hardshell Headlines: Downtown Liberty

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### Seagrove Divider Page

Images represent landmarks and community assets across Seagrove. Images were sourced from the following sources and contributors: Heart of North Carolina, Official Website: NC 705 Highway, pottery, visitor center, mural | Luck's Cannery, Official Website: Luck's Cannery | Seagrove Cafe, Official Website: Seagrove Cafe | Our State Magazine: Seagrove Fire Department | Randolph County Tourism Development Authority (TDA): Pottery with hands | Christin Coats, RCPH Environmental Health Specialist: Butterfly

## Randleman Divider Page

Images represent landmarks and community assets across Randleman. Images were sourced from the following sources and contributors: Heart of North Carolina, Official Website: Commerce Square Park, Randleman Lake, Richard Petty | Historical Marker Database: Water tower | Google Maps: Municipal building | Christin Coats, RCPH Environmental Health Specialist: Flower, sunset with trees, sunset at Randleman Lake | Victory Junction, Official Website: Victory Junction campus

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## Archdale Divider Page

Images represent landmarks and community assets across Archdale. Images were sourced from the following sources and contributors: City of Archdale, Official Website: Municipal building | City of Archdale Archive Center: Water tower | Heart of North Carolina, Official Website: Archdale Soda Shop, park bridge, Archdale Antiques, Creekside Park Mural | RCPH Health Promotion & Policy Team: Archdale Library photo walk | Holly Ridge Golf Links: Golf course | Christin Coats, RCPH Environmental Health Specialist: Flower

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## Asheboro Divider Page

Images represent landmarks and community assets across Asheboro. Images were sourced from the following sources and contributors: Heart of North Carolina, Official Website: Eastside Parks Russ Murphy mural | North Carolina Judicial Branch: Randolph County Courthouse | Randolph Record: Asheboro High School | City of Asheboro Parks & Recreation: North Asheboro City Park | The Table, Official Website: The Table restaurant | Randolph Library NC: Asheboro Municipal Building | Randolph County Tourism Development Authority (TDA): Elephants, Caraway Speedway | Asheboro Female Academy, Official Website: Female Academy

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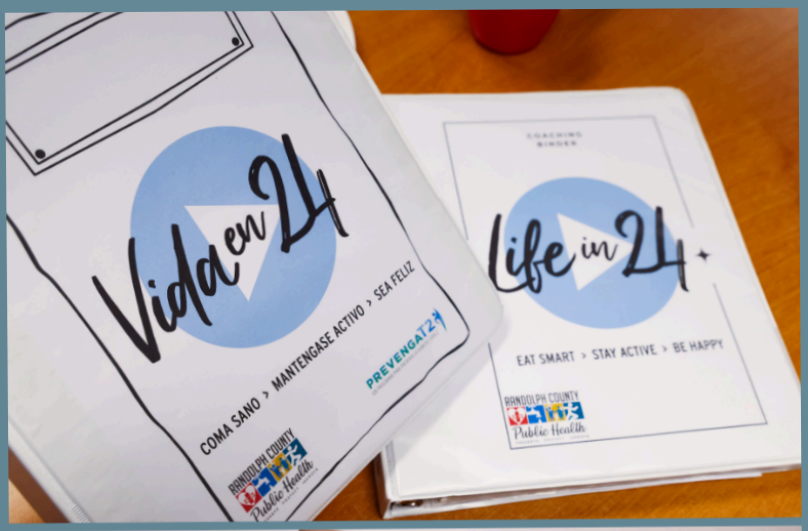
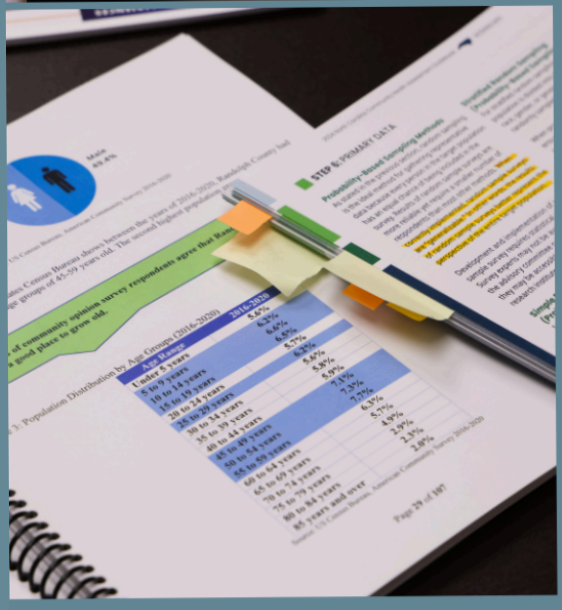
## Appendices Divider Page Photo Credit

Appendices divider page photos represent the history, accomplishments, work, and mission of Randolph County Public Health. These photos are a product of a collaborative effort between Randolph County Public Health and the North Carolina Institute of Public Health Photo Library Project.




# Appendices


# 2025 Community Health Assessment

# APPENDIX A: Starting Point Assessment

## Starting Point Assessment Questionnaire

1. Organization/Agency Name that you represent on the Steering Committee.

2. What worked well during the last CHA cycle (2022)?

3. What did not work well during the last CHA cycle (2022)?

4. Please rate your organization/agency's level of difficulty in effectively engaging the community during the last CHA cycle.

- ◯ Not Challenging
- ◯ Somewhat Challenging
- ◯ Very Challenging

5. If you selected "somewhat challenging" or "very challenging" for the previous question, why was it challenging?

6. What outreach methods did your organization use to gather community input during the last cycle (e.g., word of mouth, flyers, website, social media)?

Please list your methods in the "successful" textbox or the "not successful" textbox based on your experience.

Successful:

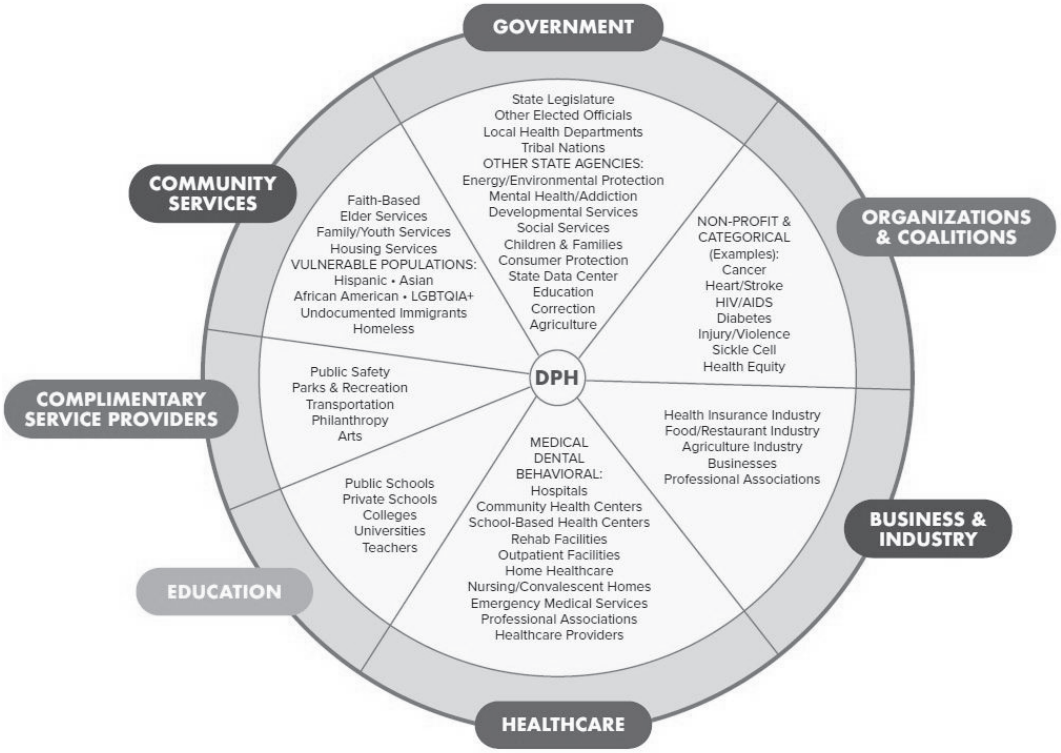
Not Successful:

7. Do you feel there was a lack of representation of certain sectors or organizations within the Steering Committee? If "yes", identify which sectors were missing from the Steering Committee.

Please reference the image below for a list of various stakeholder categories.

## Stakeholder Wheel

This stakeholder wheel, adapted from the Connecticut Department of Public Health, shows the range of potential sectors and non-traditional stakeholders that can be involved in the public health system. You could create a table for each sector and sub-category and fill in local community organizations, coalitions, and people for each.




MAPP 2.0 USER'S HANDBOOK

- ◯ No
- ◯ Unsure
- ◯ Yes

8. Does your organization/agency participate in sharing and receiving data from other organizations/agencies? If "yes" please identify the type of data shared (i.e. clinical data, administrative data such as vital/educational records, patient health records, group studies data, etc.).

- ◯ No
- ◯ Yes

9. What resources and assistance can your organization contribute during this CHA cycle to help improve health outcomes for the entire community?

10. Are the expectations and responsibilities of your organization's role in the Steering Committee clear? If "no", please provide a brief explanation.

- ◯ Yes
- ◯ No

11. Are there any resources that your organization did not use last CHA cycle that you think would be helpful to incorporate this cycle?

12. What would you like to improve in this CHA cycle?

13. What were the successes and challenges of addressing Mental Health as a priority area?

Successes

Challenges

14. What were the successes and challenges of addressing Substance Use Disorder as a priority area?

Successes

Challenges

# APPENDIX B: Community Partner Assessment (English & Spanish)

## 2025 CHA: Community Partner Assessment

* 1. What is the full name of your organization?

* 2. Which best describes your position or role in your organization?

- ◯ Administrative staff
- ◯ Front line staff (client facing)
- ◯ Supervisor (not senior management)
- ◯ Senior management level/unit or program lead
- ◯ Leadership team
- ◯ Community Member
- ◯ Community Leader
- ◯ Other (please specify)

* 3. Has your organization/agency ever participated in a community health improvement process?

- ◯ Yes
- ◯ No
- ◯ Unsure

* 4. Has your organization/agency ever participated in or facilitated community-led decision-making around policies, actions, and/or programs?

- ◯ Yes
- ◯ No
- ◯ Unsure

* 5. Which of the following best describe(s) your organization? (check all that apply)

- [ ] County health department
- [ ] State health department
- [ ] Other city government agency
- [ ] Other county government agency
- [ ] Other state government agency
- [ ] Private hospital
- [ ] Public hospital
- [ ] Private clinic
- [ ] Public clinic
- [ ] Emergency response
- [ ] Schools/education (PK-12)
- [ ] College/University
- [ ] Library
- [ ] Non-profit Organization
- [ ] Grassroots community organizing group/organization
- [ ] Social service provider
- [ ] Housing provider
- [ ] Mental health provider
- [ ] Foundation/philanthropy
- [ ] For-profit organization/private business
- [ ] Faith-based organization
- [ ] Center for Independent Living
- [ ] Skilled Nursing Facility
- [ ] Other (please specify)

* 6. What are your organization/agency's top-three interests in joining a community health improvement partnership?

- [ ] To deliver programs effectively and efficiently and avoid duplicated efforts
- [ ] To pool resources
- [ ] To increase communication among groups
- [ ] To break down stereotypes
- [ ] To build networks and friendships
- [ ] To revitalize low energy of groups who are trying to do too much alone
- [ ] To plan and launch community-wide initiatives
- [ ] To develop and use political power to gain services or other benefits for the community
- [ ] To improve line of communication from communities to government decision-making
- [ ] To improve line of communication from government to communities
- [ ] To create long-term, permanent social change
- [ ] To obtain or provide services
- [ ] Other (please specify)

7. (Optional) Why is your organization/agency interested in participating in a community health initiative? (check all that apply)

- [ ] Access to data
- [ ] Connections to communities with lived experience
- [ ] Connections to other organizations/agencies
- [ ] Connections to decision-makers
- [ ] Connections to potential funders
- [ ] Positive publicity (e.g., our organization supports community health)
- [ ] Helps achieve requirements for IRS non-profit tax status
- [ ] Helps achieve requirements for Federally Qualified Health Center (FQHC) status
- [ ] Helps achieve other requirements
- [ ] Improving conditions for members/constituents
- [ ] Other (please specify)

8. (Optional) Any comments about your organization's interest in participating in a community health initiative?

9. What resources might your organization contribute to support CHA activities? (check all that apply)

- [ ] I'm unsure
- [ ] Funding to support assessment activities (e.g., data collection, analysis)
- [ ] Funding to support community engagement (e.g., stipends, gift cards)
- [ ] Food for community meetings
- [ ] Childcare for community meetings
- [ ] Policy/advocacy skills
- [ ] Media connections
- [ ] Social media capacities
- [ ] Physical space to hold meetings
- [ ] Coordination with tribal government
- [ ] Technology to support meetings
- [ ] Staff time to support community engagement involvement
- [ ] Staff time to support interpretation and translation
- [ ] Lending interpretation equipment for use during meetings
- [ ] Staff time to support relationship-building between MAPP staff and other organizations (e.g., introductions to government agencies or organizers)
- [ ] Staff time to support focus group facilitation or interviews
- [ ] Staff time to help analyze quantitative data
- [ ] Staff time to help analyze qualitative data
- [ ] Staff time to participate in MAPP meetings and activities
- [ ] Staff time to help implement MAPP priorities
- [ ] Note-taking support during qualitative data collection
- [ ] Staff time to transcribe meeting notes/recordings
- [ ] Other (please specify)

* 10. What racial/ethnic population does your organization work with? (check all that apply)

- [ ] Black/African American
- [ ] African
- [ ] Native American/Indigenous/Alaskan Native
- [ ] Latinx/Hispanic
- [ ] Asian
- [ ] Asian American
- [ ] Pacific Islander/Native Hawaiian
- [ ] Middle Eastern/North African
- [ ] White/European
- [ ] Other (please specify)

* 11. Who are your priority populations?

- [ ] Rural communities
- [ ] LGBTQIA+
- [ ] Low-income individuals
- [ ] People with disabilities
- [ ] Immigrant/Refugees
- [ ] Individuals involved with criminal justice system
- [ ] Individuals with specific insurance status
- [ ] Groups identifiable by gender
- [ ] Specific neighborhoods
- [ ] Other (please specify)

* 12. Does your organization have access to interpretation and translation services?

- ◯ Yes
- ◯ No
- ◯ Unsure
- ◯ Not Applicable
- ◯ If yes, list what languages are offered:

* 13. What do you do to reach/engage/work with your clientele or community? (check all that apply)

- [ ] We hire staff from specific racial/ethnic groups that mirror our target population
- [ ] We hire staff/interpreters who speak the language/s of our target populations
- [ ] We support leadership development in our target population
- [ ] We have leadership who speak the language/s of our target populations
- [ ] We receive many clients from our target populations
- [ ] We receive many referrals from our target populations
- [ ] We work closely with community organizations from our target populations
- [ ] We have done extensive outreach to our target populations
- [ ] Other (please specify)

14. (Optional) What languages do staff at your organization speak? (check all that apply)

- [ ] English
- [ ] Spanish
- [ ] Chinese (Mandarin, Cantonese, Hokkien, etc.)
- [ ] Tagalog (Fillipino)
- [ ] Vietnamese
- [ ] French and French Creole
- [ ] Arabic
- [ ] Urdu
- [ ] Sign Language
- [ ] Other (please specify)

15. (Optional) Please add comments about your organization and the demographics of the community you serve:

* 16. How much does your organization/agency focus on each of the topics listed below (see definitions in image)?

| | A lot | A little | Not at all | Unsure |
|---|---|---|---|---|
| Economic Stability | ○ | ○ | ○ | ○ |
| Education Access and Services | ○ | ○ | ○ | ○ |
| Healthcare Access and Quality | ○ | ○ | ○ | ○ |
| Neighborhood and Built Environment | ○ | ○ | ○ | ○ |
| Social and Community Context | ○ | ○ | ○ | ○ |

* 17. Which of the following categories does your organization work on/with? (check all that apply)

- [ ] Arts and culture
- [ ] Business and for-profit organizations
- [ ] Criminal legal system
- [ ] Disability/independent living
- [ ] Early childhood development/childcare
- [ ] Education
- [ ] Community economic development
- [ ] Economic security
- [ ] Environmental justice/climate change
- [ ] Faith communities
- [ ] Family well-being
- [ ] Financial institutions (e.g., banks, credit unions)
- [ ] Food access and affordability (e.g., food bank)
- [ ] Food services/restaurants
- [ ] Gender discrimination/equity
- [ ] Government accountability
- [ ] Healthcare access/utilization
- [ ] Housing
- [ ] Human services
- [ ] Immigration
- [ ] Jobs/labor conditions/wages and income
- [ ] Land use planning/development
- [ ] LGBTQIA+ discrimination/equity
- [ ] Parks, recreation, and open space
- [ ] Public health
- [ ] Public safety
- [ ] Racial justice
- [ ] Seniors/elder care
- [ ] Transportation
- [ ] Utilities
- [ ] Veterans' issues
- [ ] Violence
- [ ] Youth development and leadership
- [ ] Other (please specify)

* 18. Which of the following health topics does your organization work on? (check all that apply)

- [ ] Cancer
- [ ] Chronic disease (e.g. asthma, diabetes/obesity, cardiovascular disease)
- [ ] Family/maternal health
- [ ] Immunizations and screenings
- [ ] Infectious disease
- [ ] Injury and violence prevention
- [ ] HIV/STD prevention
- [ ] Healthcare access/utilization
- [ ] Health equity
- [ ] Health insurance/Medicare/Medicaid
- [ ] Mental or behavioral health (e.g., PTSD, anxiety, trauma)
- [ ] Physical activity
- [ ] Tobacco and substance use prevention
- [ ] Special Supplemental Nutrition Program for Women, Infants, and Children (WIC)/food stamps
- [ ] None of the above/Not applicable
- [ ] Other (please specify)

19. (Optional) Please share any comments or questions about your organization's commitment to and practice of equity internally or in the community:

* 20. Does your organization have an advisory board of community members, stakeholders, youth, or others who are impacted by your organization?

- ◯ Yes
- ◯ No
- ◯ If yes, please describe how you engage your advisory board.

* 21. To whom is your organization accountable? By accountable we mean whom your organization/agency must report to because they determine or oversee your funding as an organization/agency, determine your priorities, etc. This could be who has power over your organization's decision-making - for example, city government agencies may be accountable to the mayor or city council; a business may be accountable to its shareholders; and an organizing group may be accountable to its members. (check all that apply)

- [ ] Mayor, governor, or other elected executive official
- [ ] City council, board of supervisors/commissioners, or other elected legislative officials
- [ ] State government
- [ ] Federal government
- [ ] Tribal government
- [ ] Foundation
- [ ] Community Members
- [ ] Members of the organization/association
- [ ] Customers/clients
- [ ] Board of directors/trustees
- [ ] Shareholders
- [ ] Voters
- [ ] Voting Members
- [ ] National/parent organization
- [ ] Other governmental agencies
- [ ] Other (please specify)

* 22. Please select whether your organization regularly does the following activities. (check all that apply)

- [ ] **Assessment**: My organization conducts assessments of living and working conditions and community needs and assets.
- [ ] **Investigation of Hazards**: My organization investigates, diagnoses, and addresses health problems and hazards affecting the population.
- [ ] **Communication and Education**: My organization works to communicate effectively to inform and educate people about health or well-being, factors that influence well-being, and how to improve it.
- [ ] **Community Engagement and Partnerships:** My organization works to strengthen, support, and mobilize communities and partnerships to improve health and well-being.
- [ ] **Policies, Plans, Laws:** My organization works to create, champion, and apply policies, plans, and laws that impact health and well-being.
- [ ] **Legal and Regulatory Authority**: My organization has legal or regulatory authority to protect health and well-being and uses legal and regulatory actions to improve and protect the public's health and well-being.
- [ ] **Access to Care:** My organization provides healthcare and social services to individuals or works to ensure equitable access and an effective system of care and services.
- [ ] **Workforce:** My organization supports workforce development and can help build and support a diverse, skilled workforce.
- [ ] **Evaluation And Research**: My organization conducts evaluation, research, and continuous quality improvement and can help improve or innovate functions.
- [ ] **Organizational Infrastructure**: My organization is helping build and maintain a strong organizational infrastructure for health and well-being.
- [ ] **Other** (please specify)

* 23. Does your organization have sufficient capacity to meet the needs of your clients/ members? For example, do you have enough staff/funding/support to do your work?

- ◯ Yes
- ◯ No
- ◯ Unsure
- ◯ If unsure, please elaborate:

* 24. Which of the following strategies does your organization use to do your work? (check all that apply)

- [ ] **Research and Policy Analysis**: Gathering and analyzing data to create credibility and inform policies, projects, programs, or coalitions.
- [ ] **Social and Health Services:** Providing services that reach clients and meet their needs (including clinical and healthcare services).
- [ ] **Organizing:** Involving people in efforts to change their circumstances by changing the underlying structures, decision-making processes, policies, and priorities that produce inequities.
- [ ] **Communications:** Messaging that resonates with communities, connects them to an issue, or inspires them to act.
- [ ] **Leadership Development**: Equipping leaders with the skills, knowledge, and experiences to play a greater role within their organization or movement.
- [ ] **Litigation**: Using legal resources to reach outcomes that further long-term goals.
- [ ] **Alliance and Coalition-Building**: Building collaboration among groups with shared values and interest.
- [ ] **Arts and Culture**: Nurturing the multiple skills of an individual through the arts and encouraging connection through shared experiences.
- [ ] **Campaigns**: Using organized actions that address a specific purpose, policy, or change.
- [ ] **Healing**: Addressing personal and community trauma and how they connect to larger social and economic inequalities.
- [ ] **Inside-Outside Strategies:** Coordinating support from organizations on the “outside” with a team of like-minded policymakers on the “inside” to achieve common goals.
- [ ] **Integrated Voter Engagement:** Connecting, organizing, and voter-engagement strategies to build a strong base over multiple election cycles.
- [ ] **Movement-Building**: Scaling up from single organizations and issues to long-term initiatives, perspectives, and narratives that seek to change systems.
- [ ] **Narrative Change**: Harnessing arts and expression to replace dominant assumptions about a community or issue with dignified narratives and values.
- [ ] **Other** (please specify)

25. (Optional) What capacities would you like to grow as an organization, including any mentioned above?

* 26. Does your organization conduct assessments (e.g., of basic needs, community health, neighborhood)?

- ◯ Yes
- ◯ No
- ◯ Unsure
- ◯ If yes, please describe what they assess:

* 27. Can you share the assessments you described above with the CHA committee?

- ◯ Yes
- ◯ No
- ◯ Unsure
- ◯ Not applicable—My organization does not conduct assessments

* 28. What data does your organization collect? (check all that apply)

- ☐ Demographic information about clients or members
- ☐ Access and utilization data about services provided and to whom
- ☐ Evaluation, performance management, or quality improvement information about services and programs offered
- ☐ Data about health status
- ☐ Data about health behaviors
- ☐ Data about conditions and social determinants of health (e.g., housing, education, or other conditions)
- ☐ We don’t collect data
- ☐ Other (please specify)

* 29. Can you share any of that data with the CHA committee?

- ◯ Yes, already being shared
- ◯ Yes, can share
- ◯ No
- ◯ Unsure

* 30. How does your organization collect data? (check all that apply)

- ☐ Surveys
- ☐ Focus groups
- ☐ Interviews
- ☐ Feedback forms
- ☐ Photovoice or other participatory research
- ☐ Notes from community meetings
- ☐ Videos
- ☐ Secondary data sources
- ☐ Electronic health records
- ☐ Data tracking systems
- ☐ Other (please specify)

* 31. What data skills does your organization have? (check all that apply)

- [ ] Survey design and analysis
- [ ] Secondary data analysis
- [ ] Needs assessment
- [ ] Focus group facilitation
- [ ] Interviewing
- [ ] Detailed note-taking or transcription
- [ ] Participatory research
- [ ] Facilitators of community or town hall meetings
- [ ] Asset mapping
- [ ] Mapping/visualization skills
- [ ] Other quantitative or qualitative methods:

32. (Optional) Please add comments about how your organization could support data collection and analysis in the CHA process:

33. (Optional) What type of community-engagement practices does your organization do most often (check one): Note: We will explore this more deeply in the CPA partner discussion.

- [ ] **Inform**: Provide the community with relevant information.
- [ ] **Consult:** Gather input from the community.
- [ ] **Involve:** Ensure community needs and assets are integrated into process and inform planning.
- [ ] **Collaborate:** Ensure community capacity to play a leadership role in implementation of decisions.
- [ ] **Defer to:** Foster democratic participation and equity through community-driven decision-making. Bridge divide between community and governance.
- [ ] **Other** (please specify)

* 34. Which of the following methods of community engagement does your organization use most often? (check all that apply):

- [ ] Customer/patient satisfaction surveys
- [ ] Fact sheets
- [ ] Open houses
- [ ] Presentations
- [ ] Billboards
- [ ] Videos
- [ ] Public comment
- [ ] Focus group
- [ ] Community forums/events
- [ ] Advocacy
- [ ] House meetings
- [ ] Interactive workshops
- [ ] Polling
- [ ] Memorandums of understanding (MOUs) with community-based organizations
- [ ] Citizen advisory committees
- [ ] Open planning forums with citizen polling
- [ ] Community-driven planning
- [ ] Participatory action research
- [ ] Consensus building
- [ ] Participatory action research
- [ ] Participatory budgeting
- [ ] Social media
- [ ] Other (please specify)

* 35. When you host community meetings, do you offer: (check all that apply)

- [ ] Stipends or gift cards for participation
- [ ] Interpretation/translation to other languages including sign language
- [ ] Food/snacks
- [ ] Transportation vouchers if needed
- [ ] Childcare if needed
- [ ] Accessible materials for low literacy populations
- [ ] Virtual ways to participate
- [ ] Venue for meeting
- [ ] Not applicable
- [ ] Other (please specify)

36. (Optional) Please add comments about how your organization could support community engagement in the CHA process:

* 37. What policy/advocacy work does your organization do? (check all that apply)

- [ ] Develop close relationships with elected officials
- [ ] Educate decision-makers and respond to their questions
- [ ] Respond to requests from decision-makers
- [ ] Use relationships to access decision-makers
- [ ] Write or develop policy
- [ ] Advocate for policy change
- [ ] Build capacity of impacted individuals/communities to advocate for policy change
- [ ] Lobby for policy change
- [ ] Mobilize public opinion on policies via media/communications
- [ ] Contribute to political campaigns/political action committees (PACs)
- [ ] Voter outreach and education
- [ ] Legal advocacy
- [ ] Not applicable
- [ ] Unsure
- [ ] Other (please specify)

* 38. Please review the following statements.

| | Strongly Agree | Agree | Neutral | Disagree | Strongly Disagree |
|---|---|---|---|---|---|
| Our organization has a strong presence in local earned media (print/radio/TV) | ◯ | ◯ | ◯ | ◯ | ◯ |
| Our organization has strong communications infrastructure and capacity. | ◯ | ◯ | ◯ | ◯ | ◯ |
| Our organization has a clear communications strategy. | ◯ | ◯ | ◯ | ◯ | ◯ |
| Our organization has good relationships with other organizations who can help share information. | ◯ | ◯ | ◯ | ◯ | ◯ |

* 39. What communications work does your organization do most often? (check all that apply)

- ☐ Internal newsletters to staff
- ☐ External newsletters to members/the public
- ☐ Ongoing and active relationships with local journalists and earned media organizations
- ☐ Media contact list for press advisories/releases
- ☐ Social media outreach (e.g., on Facebook, Twitter, Instagram)
- ☐ Ethnicity-specific outreach in non-English language
- ☐ Press releases/press conferences
- ☐ Data dashboard
- ☐ Meet to discuss narrative and messaging to the public
- ☐ Other (please specify)

40. (Optional) If your organization has publicly available materials, are they translated into other languages?

- ◯ All publicly available materials are translated into other languages
- ◯ Most publicly available materials are translated into other languages (e.g., when conducting outreach to various populations or when hosting events for various populations)
- ◯ Few publicly available materials are translated into other languages (e.g., only when requested)
- ◯ No publicly available materials are translated into other languages
- ◯ Not applicable (we do not have publicly available materials)

41. (Optional) Please describe if and how your organization would like to be involved in or support policy, advocacy, or communications in the CHA process:

* 42. Please add any questions, comments, or suggestions about the CHA process and our next steps together to improve community health:

## 2025 CHA: Evaluación de socios de la comunidad (Community Partner Assessmer

* 1. ¿Cuál es el nombre completo de su organización?

* 2. ¿Cuál describe mejor su posición o función en su organización?

- ◯ Personal administrativo
- ◯ Personal de primera línea (de contacto directo con el cliente)
- ◯ Supervisor (no personal directivo superior)
- ◯ Jefe de nivel directivo/líder de unidad o programa
- ◯ Equipo de liderazgo
- ◯ Miembro de la comunidad
- ◯ Líder de la comunidad
- ◯ Otro (especifique)

* 3. ¿Su organización/agencia ha participado alguna vez en un proceso de mejora de la salud de la comunidad?

- ◯ Sí
- ◯ No
- ◯ Inseguro

* 4. ¿Su organización/agencia ha participado alguna vez en la toma de decisiones dirigidas por la comunidad en torno a políticas, acciones y/o programas?

- ◯ Sí
- ◯ No
- ◯ Inseguro

* 5. ¿Cuál de las siguientes opciones describe mejor a su organización? (Seleccione todo lo que corresponda)

- [ ] Departamento de salud del condado
- [ ] Departamento de salud estatal
- [ ] Otra agencia del gobierno de la ciudad
- [ ] Otra agencia del gobierno del condado
- [ ] Otra agencia del gobierno estatal
- [ ] Hospital privado
- [ ] Hospital público
- [ ] Clínica privada
- [ ] Clínica pública
- [ ] Respuesta a emergencias
- [ ] Escuelas/educación (PK-12)
- [ ] Colegio/Universidad
- [ ] Biblioteca
- [ ] Organización sin fines de lucro
- [ ] Grupo/organización de organización comunitaria de base
- [ ] Proveedor de servicios sociales
- [ ] Proveedor de vivienda
- [ ] Proveedor de salud mental
- [ ] Fundación/filantropía
- [ ] Organización con fines de lucro/empresa privada
- [ ] Organización religiosa
- [ ] Centro de Vida Independiente
- [ ] Centro de enfermería especializada
- [ ] Otro (especifique)

* 6. * ¿Cuáles son los tres principales intereses de su organización/agencia al unirse a una asociación para el mejoramiento de la salud de la comunidad?

- [ ] Ejecutar programas de manera eficaz, eficiente y evitar la duplicación de esfuerzos
- [ ] Para reunir recursos
- [ ] Aumentar la comunicación entre los grupos
- [ ] Romper estereotipos
- [ ] Para construir redes y amistades
- [ ] Para revitalizar la baja energía de los grupos que están solos, tratando de hacer demasiado
- [ ] Para planificar y lanzar iniciativas comunitarias.
- [ ] Desarrollar y utilizar el poder político para obtener servicios u otros beneficios para la comunidad
- [ ] Mejorar la línea de comunicación de las comunidades con la toma de decisiones del gobierno
- [ ] Mejorar la línea de comunicación entre el gobierno y las comunidades.
- [ ] Para crear un cambio social permanente y a largo plazo
- [ ] Para obtener o proporcionar servicios
- [ ] Otros (especifique)

7. (Opcional) ¿Por qué su organización/agencia está interesada en participar en una iniciativa de salud comunitaria? (Seleccione todo lo que corresponda)

- [ ] Acceso a los datos
- [ ] Conexiones con comunidades con experiencia de vida
- [ ] Conexiones con otras organizaciones/agencias
- [ ] Conexiones con los responsables de la toma de decisiones
- [ ] Conexiones con posibles financiadores
- [ ] Publicidad positiva (por ejemplo, nuestra organización apoya la salud de la comunidad)
- [ ] Ayuda a cumplir los requisitos para el servicio interno de impuestos (IRS por sus siglas en inglés) sin fines de lucro
- [ ] Ayuda a cumplir con los requisitos para el estado de Centro de Salud Federalmente Calificado (FQHC por sus siglas en inglés)
- [ ] Ayuda a cumplir con otros requisitos
- [ ] Mejora de las condiciones de los miembros/constituyentes
- [ ] Otros (especifique)

8. (Opcional) ¿Algún comentario sobre el interés de su organización en participar en una iniciativa de salud comunitaria?

9. ¿Qué recursos podría aportar su organización para apoyar las actividades de CHA (evaluación de salud comunitaria)? (Seleccione todo lo que corresponda)

- [ ] No estoy seguro
- [ ] Fondos para apoyar las actividades de evaluación (p. ej., recopilación de datos, análisis)
- [ ] Fondos para apoyar la participación comunitaria (p. ej., salario, tarjetas de regalo)
- [ ] Alimentos para reuniones comunitarias
- [ ] Cuidado de niños para reuniones comunitarias
- [ ] Habilidades de política/defensa
- [ ] Conexiones de medios
- [ ] Capacidades en redes sociales
- [ ] Espacio físico para tener las reuniones
- [ ] Coordinación con el gobierno tribal
- [ ] Tecnología para apoyar las reuniones
- [ ] Tiempo del personal para apoyar la participación de la comunidad
- [ ] Tiempo del personal para apoyar la interpretación y la traducción
- [ ] Préstamo de equipo de interpretación para su uso durante las reuniones
- [ ] Tiempo del personal para apoyar la construcción de relaciones entre el personal de MAPP y otras organizaciones (por ejemplo, presentaciones a agencias gubernamentales u organizadores)
- [ ] Tiempo del personal para apoyar la facilitación de grupos focales o entrevistas
- [ ] Tiempo del personal para ayudar a analizar datos cuantitativos
- [ ] Tiempo del personal para ayudar a analizar datos cualitativos
- [ ] Tiempo del personal para participar en las reuniones y actividades de MAPP
- [ ] Tiempo del personal para ayudar a implementar las prioridades de MAPP
- [ ] Apoyo a la toma de notas durante la recopilación de datos cualitativos
- [ ] Tiempo del personal para transcribir notas/grabaciones de reuniones
- [ ] Otros (especifique)

* 10. ¿Con qué población de raza/étnica trabaja su organización? (Seleccione todo lo que corresponda)

- [ ] Negro/Afroamericano
- [ ] Africano
- [ ] Nativo Americano/Indígena/Nativo de Alaska
- [ ] Latinx /Hispano
- [ ] Asiático
- [ ] Asiático-Americano
- [ ] Isleño del Pacífico/Nativo de Hawái
- [ ] Oriente Medio/Norteafricano
- [ ] Blanco/Europeo
- [ ] Otros (especifique)

* 11. ¿Quiénes son sus poblaciones prioritarias?

- [ ] Comunidades rurales
- [ ] LGBTQIA+
- [ ] Personas de bajos ingresos
- [ ] Personas con discapacidades
- [ ] Inmigrantes/Refugiados
- [ ] Personas involucradas con el sistema de justicia penal
- [ ] Personas con un estado de seguro médico específico
- [ ] Grupos identificables por género
- [ ] Vecindarios específicos
- [ ] Otros (especifique)

* 12. ¿Su organización tiene acceso a servicios de interpretación y traducción?

- ◯ Sí
- ◯ No
- ◯ Inseguro
- ◯ No aplica
- ◯ En caso afirmativo, enumere los idiomas que se ofrecen:

* 13. ¿Qué hace para llegar/involucrar/trabajar con su clientela o comunidad? (Seleccione todo lo que corresponda)

- [ ] Contratamos personal de grupos raciales/étnicos específicos que reflejan nuestra población objetivo
- [ ] Contratamos personal/intérpretes que hablan el idioma(s) de nuestras poblaciones objetivo
- [ ] Apoyamos el desarrollo de liderazgo en nuestra población objetivo
- [ ] Contamos con líderes que hablan el idioma de nuestras poblaciones objetivo
- [ ] Recibimos muchos clientes de nuestras poblaciones objetivo
- [ ] Recibimos muchas referencias de nuestras poblaciones objetivo
- [ ] Trabajamos estrechamente con organizaciones comunitarias de nuestras poblaciones
- [ ] Hemos realizado una extensa labor de divulgación con nuestras poblaciones objetivo
- [ ] Otros (especifique)

14. (Opcional) ¿Qué idiomas habla el personal de su organización? (Seleccione todo lo que corresponda)

- [ ] Inglés
- [ ] Español
- [ ] Chino (mandarín, cantonés, hokkien, etc.)
- [ ] Tagalo (Fillipino)
- [ ] Vietnamita
- [ ] Francés y Francés Criollo
- [ ] Árabe
- [ ] Urdu
- [ ] Lenguaje de signos
- [ ] Otros (especifique)

15. (Opcional) Agregue comentarios sobre su organización y los datos demográficos de la comunidad a la que sirve:

* 16. ¿En qué medida se centra su organización/agencia en cada uno de los temas que se enumeran a continuación (consulte las definiciones en la imagen)?

| | Mucho | Un poco | En absoluto | Inseguro |
|---|---|---|---|---|
| Estabilidad económica | ◯ | ◯ | ◯ | ◯ |
| Acceso a la educación y servicios | ◯ | ◯ | ◯ | ◯ |
| Acceso y calidad de la atención médica | ◯ | ◯ | ◯ | ◯ |
| Vecindario y entorno construido | ◯ | ◯ | ◯ | ◯ |
| Contexto social y comunitario | ◯ | ◯ | ◯ | ◯ |

* 17. ¿En cuál de las siguientes categorías trabaja su organización? (Seleccione todo lo que corresponda)

- [ ] Arte y cultura
- [ ] Empresas y organizaciones con fines de lucro
- [ ] Sistema jurídico penal
- [ ] Discapacidad/vida independiente
- [ ] Desarrollo infantil/cuidado de los niños
- [ ] Educación
- [ ] Desarrollo económico de la comunidad
- [ ] Seguridad económica
- [ ] Justicia ambiental/cambio climático
- [ ] Comunidades de fe (religiosas)
- [ ] Bienestar familiar
- [ ] Instituciones financieras (p. ej., bancos, cooperativas de crédito)
- [ ] Acceso y asequibilidad de alimentos (p. ej., banco de alimentos)
- [ ] Servicios de alimentación/restaurantes
- [ ] Discriminación de género/igualdad
- [ ] Rendición de cuentas del gobierno
- [ ] Acceso/utilización de atención médica
- [ ] Vivienda
- [ ] Servicios Humanos
- [ ] Inmigración
- [ ] Empleos/condiciones laborales/salarios e ingresos
- [ ] Planificación/desarrollo del uso de la tierra
- [ ] LGBTQIA+ discriminación/igualdad
- [ ] Parques, recreación y espacios abiertos
- [ ] Salud pública
- [ ] Seguridad pública
- [ ] Justicia racial
- [ ] Personas mayores/cuidado de ancianos
- [ ] Transporte
- [ ] Servicios públicos
- [ ] Problemas de los veteranos
- [ ] Violencia
- [ ] Desarrollo y liderazgo juvenil
- [ ] Otros (especifique)

* 18. ¿En cuál de los siguientes temas de salud trabaja su organización? (Seleccione todo lo que corresponda)

- [ ] Cáncer
- [ ] Enfermedades crónicas (p. ej., asma, diabetes/obesidad, enfermedades cardiovasculares)
- [ ] Salud familiar/maternidad
- [ ] Inmunizaciones y exámenes de detección
- [ ] Enfermedades infecciosas
- [ ] Prevención de lesiones y violencia
- [ ] Prevención del VIH/ETS
- [ ] Acceso/utilización de los servicios de salud
- [ ] Equidad en salud
- [ ] Seguro médico/Medicare/Medicaid
- [ ] Salud mental o conductual (p. ej., trastorno de estrés postraumático, ansiedad, trauma)
- [ ] Actividad física
- [ ] Prevención del consumo de tabaco y sustancias
- [ ] Programa Especial de Nutrición Suplementaria para Mujeres, Infantes y Niños (WIC por sus siglas en inglés) /Servicios de Alimentos y Nutrición (FNS, por sus siglas en inglés).
- [ ] Ninguno de los anteriores/No aplica
- [ ] Otros (especifique)

19. (Opcional) Comparta cualquier comentario o pregunta sobre el compromiso y la práctica de la igualdad de su organización internamente o en la comunidad:

* 20. ¿Su organización tiene un consejo asesor de miembros de la comunidad, partes interesadas, jóvenes u otras personas que se ven afectadas por su organización?

- ◯ Sí
- ◯ No
- ◯ Si la respuesta es afirmativa, describa cómo participa en el comité asesor.

* 21. ¿A quién rinde cuentas su organización? Por responsable, nos referimos a quién debe reportar su organización/agencia, porque determinan o supervisan su financiación como organización/agencia, determinan sus prioridades, etc. Esto podría ser, quién tiene poder sobre la toma de decisiones de su organización: por ejemplo, las agencias del gobierno de la ciudad pueden ser responsables ante el alcalde o el consejo de la ciudad; una empresa puede ser responsable ante sus accionistas; y un grupo organizador puede ser responsable ante sus miembros. (Seleccione todo lo que corresponda)

- [ ] Alcalde, gobernador u otro funcionario ejecutivo electo
- [ ] Concejo municipal, junta de supervisores/comisionados u otros funcionarios legislativos electos
- [ ] Gobierno estatal
- [ ] Gobierno federal
- [ ] Gobierno tribal
- [ ] Fundación
- [ ] Miembros de la comunidad
- [ ] Miembros de la organización/asociación
- [ ] Clientes
- [ ] Consejo de administración/fideicomisarios
- [ ] Accionistas
- [ ] Votantes
- [ ] Miembros con derecho a voto
- [ ] Organización nacional/organización matriz
- [ ] Otras agencias gubernamentales
- [ ] Otros (especifique)

* 22. Seleccione si su organización realiza regularmente las siguientes actividades. (Seleccione todo lo que corresponda)

- [ ] **Evaluación:** Mi organización lleva a cabo evaluaciones de las condiciones de vida y de trabajo, así como de las necesidades y los bienes de la comunidad.
- [ ] **Investigación de riesgos:** Mi organización investiga, diagnostica y aborda los problemas de salud y los riesgos que afectan a la población.
- [ ] **Comunicación y educación:** Mi organización trabaja para comunicarse de manera efectiva para informar y educar a las personas sobre la salud o el bienestar, los factores que influyen en el bienestar y cómo mejorarlo.
- [ ] **Participación comunitaria y asociaciones:** Mi organización trabaja para fortalecer, apoyar y movilizar a las comunidades y asociaciones para mejorar la salud y el bienestar.
- [ ] **Políticas, planes, leyes:** Mi organización trabaja para crear, defender y aplicar políticas, planes y leyes que impactan la salud y el bienestar.
- [ ] **Autoridad legal y reguladora:** Mi organización tiene autoridad legal o regulatoria para proteger la salud y el bienestar, utiliza acciones legales y regulatorias para mejorar y proteger la salud y el bienestar del público.
- [ ] **Acceso a la atención:** Mi organización brinda atención médica y servicios sociales a personas o trabaja para garantizar un acceso equitativo y un sistema eficaz de atención y servicios.
- [ ] **Fuerza laboral:** Mi organización apoya el desarrollo de la fuerza laboral, puede ayudar a construir y respaldar una fuerza laboral diversa y capacitada.
- [ ] **Evaluación e investigación:** Mi organización lleva a cabo la evaluación, la investigación y la mejora continua de la calidad, puede ayudar a mejorar o innovar las funciones.
- [ ] **Infraestructura organizacional:** Mi organización está ayudando a construir y mantener una infraestructura organizacional sólida para la salud y el bienestar.
- [ ] **Otros** (especifique)

* 23. ¿Su organización tiene suficiente capacidad para satisfacer las necesidades de sus clientes/miembros? Por ejemplo, ¿tiene suficiente personal/financiación/apoyo para hacer su trabajo?

- ◯ Sí
- ◯ No
- ◯ Inseguro
- ◯ Si no está seguro, por favor, explique:

* 24. ¿Cuál de las siguientes estrategias utiliza su organización para realizar su trabajo? (Seleccione todo lo que corresponda)

- [ ] **Investigación y análisis de políticas:** Recopilación y análisis de datos para crear credibilidad e informar políticas, proyectos, programas o coaliciones.
- [ ] **Servicios sociales y de salud:** Proporcionar servicios que lleguen a los clientes y satisfacen sus necesidades (incluidos los servicios clínicos y de salud).
- [ ] **Organización:** Hacer participar a las personas en los esfuerzos por cambiar sus circunstancias modificando las estructuras subyacentes, los procesos de toma de decisiones, las políticas y las prioridades que producen inequidades.
- [ ] **Comunicaciones:** Mensajes que resuenan con las comunidades, las conectan con un problema o las inspiran a actuar.
- [ ] **Desarrollo de liderazgo:** Equipar a los líderes con las habilidades, conocimiento y experiencias para desempeñar un papel más importante dentro de su organización o movimiento.
- [ ] **Litigios:** Utilizar recursos legales para alcanzar resultados que promuevan objetivos a largo plazo.
- [ ] **Construcción de alianzas y coaliciones:** Construcción en colaboración entre grupos con valores e intereses compartidos.
- [ ] **Arte y Cultura:** Nutrir las múltiples habilidades de un individuo a través de las artes y fomentar la conexión a través de experiencias compartidas.
- [ ] **Campañas:** Utilizar acciones organizadas que aborden un propósito, una política o un cambio específico.
- [ ] **Sanación:** Abordar los traumas personales, comunitarios y cómo se conectan con desigualdades sociales y económicas más amplias.
- [ ] **Estrategias de adentro hacia afuera:** Coordinar el apoyo de las organizaciones en el "exterior" con un equipo de formuladores de políticas de ideas afines en el "interior" para lograr objetivos comunes.
- [ ] **Participación integrada de los votantes:** Conectar, organizar y estrategias de participación de los votantes para construir una base sólida a lo largo de múltiples ciclos electorales.
- [ ] **Creación de movimientos:** Ampliación de las organizaciones y cuestiones individuales a iniciativas, perspectivas y narrativas a largo plazo que buscan cambiar los sistemas.
- [ ] **Cambio narrativo:** Aprovechar las artes y la expresión para reemplazar las suposiciones dominantes sobre una comunidad o un problema con narrativas y valores dignos.
- [ ] **Otros** (especifique)

25. (Opcional) ¿Qué capacidades le gustaría desarrollar como organización, incluidas las mencionadas anteriormente?

* 26. ¿Su organización realiza evaluaciones (por ejemplo, de necesidades básicas, salud comunitaria, vecindario)?

- ◯ Sí
- ◯ No
- ◯ Inseguro
- ◯ En caso afirmativo, describa lo que evalúan:

* 27. ¿Puede compartir las evaluaciones que describió anteriormente con el comité de CHA?

- ◯ Sí
- ◯ No
- ◯ Inseguro
- ◯ No aplica: mi organización no realiza evaluaciones

* 28. ¿Qué datos recopila su organización? (Seleccione todo lo que corresponda)

- ☐ Información demográfica sobre clientes o miembros
- ☐ Datos de acceso y utilización sobre los servicios prestados y a quién
- ☐ Evaluación, gestión de rendimiento o mejora de la calidad sobre los servicios y programas ofrecidos
- ☐ Datos sobre el estado de salud
- ☐ Datos sobre comportamientos de salud
- ☐ Datos sobre condiciones y determinantes sociales de la salud (p. ej., vivienda, educación u otras condiciones)
- ☐ No recopilamos datos
- ☐ Otros (especifique)

* 29. ¿Puede compartir alguno de esos datos con el comité de CHA?

- ◯ Sí, ya se está compartiendo
- ◯ Sí, se puede compartir
- ◯ No
- ◯ No estoy seguro

* 30. ¿Cómo recopila datos su organización? (Seleccione todo lo que corresponda)

- [ ] Encuestas
- [ ] Grupos focales
- [ ] Entrevistas
- [ ] Formularios de comentarios/opiniónes
- [ ] Fotovoz u otra investigación participativa
- [ ] Notas de las reuniones comunitarias
- [ ] Videos
- [ ] Fuentes de datos secundarias
- [ ] Registros electrónicos de salud
- [ ] Sistemas de seguimiento de datos
- [ ] Otros (especifique)

* 31. ¿Qué habilidades de datos tiene su organización? (Seleccione todo lo que corresponda)

- [ ] Diseño y análisis de encuestas
- [ ] Análisis de datos secundarios
- [ ] Evaluación de necesidades
- [ ] Facilitación de grupos focales
- [ ] Entrevistas
- [ ] Toma de notas detallada o transcripción
- [ ] Investigación participativa
- [ ] Facilitadores de reuniones comunitarias
- [ ] Mapeo de activos
- [ ] Habilidades de mapeo/visualización
- [ ] Otros métodos cuantitativos o cualitativos:

32. (Opcional) Agregue comentarios sobre cómo su organización podría apoyar la recopilación y el análisis de datos en el proceso de CHA:

33. 32. (Opcional) ¿Qué tipo de prácticas de participación comunitaria realiza su organización con más frecuencia? (seleccione una): Nota: Exploraremos esto a profundidad en la discusión de los socios de CPA.

- [ ] **Informar:** Proporcionar a la comunidad información relevante.
- [ ] **Consultar:** Recopilar comentarios de la comunidad.
- [ ] **Involucrar:** Asegurar que las necesidades y los bienes de la comunidad se integren en el proceso e informen la planificación.
- [ ] **Colaborar:** Asegurar la capacidad de la comunidad para desempeñar un papel de liderazgo en la implementación de decisiones.
- [ ] **Ceder ante:** Fomentar la participación democrática y la equidad a través de la toma de decisiones impulsadas por la comunidad. Tender puentes entre la comunidad y la gobernanza.
- [ ] **Otros** (especifique)

* 34. ¿Cuál de los siguientes métodos de participación comunitaria utiliza su organización con más frecuencia? (Seleccione todo lo que corresponda):

- [ ] Encuestas de satisfacción al cliente/paciente
- [ ] Documentos informativos
- [ ] Jornada de puertas abiertas
- [ ] Presentaciones
- [ ] Vallas publicitarias
- [ ] Videos
- [ ] Comentarios públicos
- [ ] Grupos focales
- [ ] Foros comunitarios/eventos
- [ ] Abogacía(apoyo)
- [ ] Reuniones en casa
- [ ] Talleres interactivos
- [ ] Encuestas
- [ ] Memorandos de entendimiento (MOUs) con organizaciones comunitarias
- [ ] Comités de asesoramiento ciudadano
- [ ] Foros abiertos de planificación con encuestas ciudadanas
- [ ] Planificación impulsada por la comunidad
- [ ] Participación en acción para investigación
- [ ] Construcción de consenso
- [ ] Presupuesto participativo
- [ ] Redes sociales
- [ ] Otros (especifique)

* 35. Cuando organiza reuniones comunitarias, ¿ofrece: (Seleccione todo lo que corresponda)

- [ ] Sueldo o tarjetas de regalo por participar
- [ ] Interpretación/traducción a otros idiomas, incluido el lenguaje de señas
- [ ] Alimentos/refrigerios
- [ ] Vales de transporte si es necesario
- [ ] Cuidado de niños si es necesario
- [ ] Materiales accesibles para poblaciones con baja alfabetización
- [ ] Formas virtuales para participar
- [ ] Lugar de la reunión
- [ ] No aplica
- [ ] Otros (especifique)

36. (Opcional) Agregue comentarios sobre cómo su organización podría apoyar la participación de la comunidad en el proceso de CHA:

* 37. ¿Qué trabajo de política/defensa realiza su organización? (Seleccione todo lo que corresponda)

- [ ] Desarrollar relaciones cercanas con los funcionarios electos
- [ ] Educar a los responsables de la toma de decisiones y responder a sus preguntas
- [ ] Responder a las solicitudes de los responsables de la toma de decisiones
- [ ] Utilizar las relaciones para acceder a los responsables de la toma de decisiones
- [ ] Redactar o desarrollar políticas
- [ ] Abogar por un cambio de política
- [ ] Desarrollar la capacidad de las personas/comunidades para abogar por el cambio de políticas
- [ ] Presionar por el cambio de políticas
- [ ] Movilizar a la opinión pública sobre las políticas a través de los medios de comunicación
- [ ] Contribuir a campañas políticas/comités de acción política (PAC)
- [ ] Alcance y educación para los votantes
- [ ] Defensa legal
- [ ] No aplica
- [ ] No estoy seguro(a)
- [ ] Otros (especifique)

* 38. Por favor, revise las siguientes declaraciones.

| | Totalmente de acuerdo | En acuerdo | Neutral | En desacuerdo | Totalmente en desacuerdo |
|---|---|---|---|---|---|
| Nuestra organización tiene una fuerte presencia en los medios de comunicación locales (impresos/radio/televisión) | ○ | ○ | ○ | ○ | ○ |
| Nuestra organización cuenta con una sólida infraestructura y capacidad de comunicaciones. | ○ | ○ | ○ | ○ | ○ |
| Nuestra organización tiene una estrategia de comunicación clara. | ○ | ○ | ○ | ○ | ○ |
| Nuestra organización tiene buenas relaciones con otras organizaciones que pueden ayudar a compartir información. | ○ | ○ | ○ | ○ | ○ |

* 39. ¿Qué trabajo de comunicación realiza su organización con más frecuencia? (Seleccione todo lo que corresponda)

- ☐ Boletines internos para el personal
- ☐ Boletines informativos externos para los miembros/público
- ☐ Relaciones continuas y activas con periodistas locales y organizaciones de medios de comunicación
- ☐ Lista de contactos de los medios de comunicación para avisos/comunicados de prensa
- ☐ Alcance en las redes sociales (por ejemplo, en Facebook, Twitter, Instagram)
- ☐ Alcance específico de la etnia en un idioma distinto al inglés
- ☐ Comunicados de prensa/ruedas de prensa
- ☐ Panel de datos
- ☐ Reunirse para discutir la narrativa y los mensajes al público.
- ☐ Otros (especifique)

40. (Opcional) Si su organización tiene materiales disponibles públicamente, ¿están traducidos a otros idiomas?

- ○ Todos los materiales disponibles públicamente se traducen a otros idiomas
- ○ La mayoría de los materiales disponibles al público se traducen a otros idiomas (por ejemplo, cuando se realizan actividades de divulgación a diversas poblaciones o cuando se organizan eventos para diversas poblaciones)
- ○ Pocos materiales disponibles al público se traducen a otros idiomas (por ejemplo, solo cuando se solicita)
- ○ Ningún material disponible al público se traduce a otros idiomas
- ○ No aplica (no tenemos materiales disponibles al público)

41. (Opcional) Describa cómo, y si le gustaría a su organización participar o apoyar la política, actividades de promoción o comunicaciones en el proceso de CHA:

* 42. Agregue cualquier pregunta, comentario o sugerencia sobre el proceso de CHA y nuestros próximos pasos para mejorar la salud de la comunidad:

# Appendix C: 2025 CHA Community Opinion Survey

## 2025 Community Health Assessment Survey

This survey is brief – approximately 10 minutes to complete. Responses are confidential and added together for reporting. *Esta encuesta es breve – aproximadamente 10 minutos para completarla. Las respuestas son confidenciales y se suman para informar.*

1. **Which zip code / town in Randolph County do you live in?** *¿En qué código postal/ciudad del condado de Randolph vive?*

| | | | |
|---|---|---|---|
| ○ 27263 Archdale / High Point | ○ 27239 Denton | ○ 27316 Ramseur | ○ 27355 Staley |
| ○ 27203 Asheboro | ○ 27248 Franklinville | ○ 27317 Randleman | ○ 27360 Thomasville |
| ○ 27205 Asheboro | ○ 27298 Liberty | ○ 27341 Seagrove | ○ 27370 Trinity |
| ○ 27233 Climax | ○ 27313 Pleasant Garden | ○ 27350 Sophia | ○ Not applicable |

### COMMUNITY HEALTH AND IMPROVEMENT / Mejorar la Salud de la Comunidad

2. What do you think are the **THREE** most important factors that can improve quality of life in Randolph County? ***(Check only three)*** *En la siguiente lista, ¿cuáles cree que son los TRES factores más importantes que pueden mejorar la calidad de vida en el condado de Randolph?* ***(Seleccione solo tres)***

- ○ **Financial Security / Economics** (More jobs with better pay, affordable childcare, reduced childhood poverty, etc.)
  ***Seguridad financiera/economía*** *(Más trabajos con mejores salarios; cuidado infantil económico; reducción de la pobreza infatil; etc.)*
- ○ **Transportation** (Public transportation, access to reliable transportation, safe roads, etc.)
  ***Transporte*** *(Transporte público; acceso a transporte confiable; carreteras seguras; etc.)*
- ○ **Safe and Affordable Housing** (Affordable and quality houses/apartments; homes free of mold, lead, asbestos, and harmful substances, etc.)
  ***Viviendas seguras y económicas*** *(Casas/apartamentos económico y de calidad; casas libre de moho, plomo, asbesto y sustancias dañinos)*
- ○ **Education / Schools** (Better schools, programs to help children and adolescents do well in school, access to job skills training, improved graduation rates, etc.)
  ***Educación/Escuelas*** *(Mejores escuelas; programas para ayudar a los niños y adolescentes a obtener un buen desempeño escolar; accesso a capacitaciónes de habilidades laborales; mejores porcentajes de graduación; etc.)*
- ○ **Safe Neighborhoods** (Neighbors with low crime, sidewalks in good repair, communities with access to job skills training, improved graduation rates, etc.)
  ***Vecindarios seguros*** *(Vecindarios con baja tasa de criminalidad; aceras (banquetas) en buen estado; comunidades con acceso a aire y agua limpios; lugares seguros para que jueguen los niños, etc.)*
- ○ **Affordable and Healthy Food Choices** (More access to healthy and affordable food choices, etc.)
  ***Opciones de Alimentos Económicos y Saludables*** *(Más acceso a opciones de alimentos saludables y económicos, etc.)*
- ○ **Urban Planning** (Easy access to services such as grocery stores, parks, and healthcare facilities; minimal interruption to transportation and mobility; community participation in decision-making process)
  ***Planificación Urbana*** *(Acceso fácil a servicios como supermercados, parques y centros de salud; mínima interrupción del transporte y la movilidad; participación de la comunidad en la toma de decisiones; etc.)*
- ○ **Clean and Safe Environment** (Walkability to parks, playgrounds, and greenways; access to safe drinking water; good air quality)
  ***Ambiente Limpio y Seguro*** *(Accesibilidad para caminar a parques infantiles, y vías verdes; acceso a agua potable segura; buena calidad del aire)*
- ○ **Access to Care** (Affordable health insurance, more dental providers, access to mental health services, etc.)
  ***Acceso al Cuidado Médico*** *(Seguro médico económico; más proveedores dentales; acceso a servicios de salud mental; etc.)*

Other (please specify) / *Otro (por favor especifique)*:

_____

3. What do you think are the **THREE** most important concerns impacting health in our community? ***(Please select only three)*** *En la siguiente lista, ¿cuáles cree que son las TRES preocupaciones más importantes que afectan la salud de nuestra comunidad?* ***(Seleccione hasta tres)***

- ○ **Injury** (Car crashes, traumatic brain injuries, drownings, etc.)
  ***Lesiones/Heridas*** *(Accidentes automovilísticos; lesiones cerebrales traumáticas; ahogamientos; etc.)*
- ○ **HIV / Sexually Transmitted Diseases (STDs)** (Testing and treatment for HIV, chlamydia, gonorrhea, syphilis, etc.)
  ***VIH/Enfermedades de Transmisión Sexual (ETS)*** *(Pruebas y tratamiento para el VIH; clamidia, gonorrea, sífilis, otras ETS; etc.)*
- ○ **Maternal and Child Health** (Affordable birth control, prenatal care, low birth weight, premature babies, infant mortality, etc.)
  ***Cuidado Médico de Maternidad y Salud Infatil*** *(Anticonceptivos económicos; atención prenatal; bajo peso al nacer; bebés prematuros; mortalidad infantil; etc.)*
- ○ **Healthy Environment** (Clean air, land, water, etc.)
  ***Ambiente Saludable*** *(Aire limpio, tierra, y agua, etc.)*
- ○ **Emerging and Re-emerging Infectious Disease** (Hepatitis A, measles, tuberculosis, COVID-19, etc.)
  ***Enfermedades Infecciosas Emergentes y Re-Emergentes*** *(Hepatitis A, sarampión, tubercolosis, COVID-19, etc.)*
- ○ **Violence** (Bullying, domestic violence, child abuse, assault, homicides, etc.)
  ***Violencia*** *(Acoso escolar (bullying), violencia doméstica, abuso infantil, agresión, homicidios, etc.)*
- ○ **Access to Care** (Affordable healthcare; flexible hours; specialty services like dental, vision, hearing, translation services are unavailable, etc.)
  ***Acceso al Cuidado Médico*** *(Atención médica económica; horarios flexibles; servicios especializados como servicios dentales, de la vista, audición; traducción no disponible, etc.)*
- ○ **Mental Health** (Anxiety, depression, suicide, etc.)
  ***Salud Mental*** *(Ansiedad, depresión, suicidio, etc.)*
- ○ **Substance Use Disorder** (Alcohol, opioids, prescription drugs, other drugs, etc.)
  ***Trastorno por uso de Sustancias*** *(Alcohol, opioides, medicamentos recetados, otras drogas, etc.)*
- ○ **Chronic Diseases** (Cancer, heart disease and stroke, high blood pressure, diabetes, etc.)
  ***Enfermedades Crónicas*** *(Cáncer, enfermedades cardíacas y accidentes cerebrovasculares, presión arterial alta, diabetes, etc.)*

Other (please specify) / *Otro (por favor especifique)*:

---

## ENVIRONMENTAL HEALTH / *SALUD AMBIENTAL*

4. Identify environmental health issues you feel are affecting your community. ***(Check all that apply)*** *Identifique los problemas de salud ambiental que cree están afectando a su comunidad.* ***(Marque todo lo que corresponda)***

- ○ **Water pollution** (local rivers, lakes)
  ***Contaminación del Agua*** *(Ríos locales, lagos)*
- ○ **Air pollution** (car exhaust, factory pollution, smog)
  ***Contaminación del Aire*** *(Escape de automóviles, contaminación de fábricas, smog)*
- ○ **Contaminated water** (bacteria, chemicals, lead)
  ***Agua Contaminada*** *(Bacterias, productos químicos, plomo)*
- ○ **Indoor air quality** (poor ventilation, smoke, radon)
  ***Calidad del Aire Interior*** *(Mala ventilación, humo, radón/gas reactivo natural)*
- ○ **Risk of flooding /** *Riesgo de Inundación*
- ○ **Poor waste management** (lack of recycling, waste collection)
  ***Mal manejo de Residuos*** *(Falta de reciclaje, recolección de residuos)*
- ○ **Noise pollution** (loud traffic, industrial noise, noise from construction)
  ***Contaminación Acústica*** *(Tráfico ruidoso, ruido industrial, ruido de la construcción)*
- ○ **Infestations / invasions of mosquitoes, rats, or other pests /** *Infestaciones/invasiones de Mosquitos, ratas u otras plagas*

Other (please specify) / *Otra (por favor especifique)*:

---

5. In the event of an emergency or disaster in your community, how would you get information about the event? ***(Check all that apply)*** *En caso de una emergencia o desastre en su comunidad, ¿cómo obtendría información sobre el evento?* ***(Marque todo lo corresponda)***

- ○ **Local Government Websites** (Randolph County, Randolph County Emergency Services, Randolph County Public Health, Randolph County Sheriff's Office) ***Sitios web del gobierno local*** *(Condado de Randolph, Servicios de Emergencia del Condado de Randolph, Salud Pública del Condado de Randolph, Oficina de Sheriff del Condado de Randolph)*
- ○ **Cell Phone** (emergency alert apps, text messages) ***Teléfono celular*** *(Aplicaciones de alerta de emergencia; mensajes de texto; WhatsApp)*
- ○ **Internet**
- ○ **Local TV News Stations /** ***Estación de noticias de televisión local***
- ○ **Radio** (battery operated, etc.) / ***Radio*** *(de batería, del auto)*
- ○ **Social Media (Facebook)** ***Redes Sociales (Facebook)***
- ○ **Family / Neighbors** ***Familia/Vecino***
- ○ **Employer / Coworkers** ***Empleador/Compañeros de Trabajo***
- ○ **Newspaper / Printed Materials** ***Periódicos/Materiales Impresos***

Other (please specify) / *Otro (por favor especifique)*:

_____

## COMMUNITY AND SOCIAL SUPPORT / *APOYO COMUNITARIO Y SOCIAL*

6. When you read the statements below, think about the neighborhood or part of town where you live. **How much do you agree or disagree with each statement? (Mark your response with an "X")** *Cuando lea las declaraciones a continuación, piense en el vecindario o parte del pueblo donde vive.* ***¿Cuánto está de acuerdo o en desacuerdo con la afirmación? (Marca tu respuesta con una "X")***

| | Strongly Disagree *Totalmente en desacuerdo* | Disagree *Desacuerdo* | Neutral | Agree *De acuerdo* | Strongly Agree *Totalmente en acuerdo* |
|---|---|---|---|---|---|
| **My community has good health care.** (Consider the cost, quality, number of options, and availability of healthcare where you live.) ***Mi comunidad tiene buen cuidado médico.*** *(Considere el costo, la calidad, la cantidad de opciones y la disponibilidad de atención médica donde vive.)* | | | | | |
| **My community is a good place to raise children.** (Consider the accessibility, quality and safety of schools, child care programs, after school programs, and places to play where you live.) **Mi comunidad es un buen lugar para la crianza de niños.** (Considere la accessibilidad, calidad y seguridad de las escuelas, los programas de cuidado infantil, los programas extracurriculares y los lugares para jugar donde vive.) | | | | | |

| | Strongly Disagree *Totalmente en desacuerdo* | Disagree *Desacuerdo* | Neutral | Agree *De acuerdo* | Strongly Agree *Totalmente en acuerdo* |
|---|---|---|---|---|---|
| **My community is a good place to grow old.** (Consider elder-friendly housing, transportation to medical services, recreation, and services for the elderly where you live.)<br>***Mi comunidad es un buen lugar para envejecer.*** *(Considere viviendas adaptadas para personas mayores, transporte a servicios médicos, recreación y servicios para personas mayores donde vive.)* | | | | | |
| **My community offers economic opportunity.** (Consider the number and quality of jobs that offer a living wage, job training / higher education opportunities, and availability of affordable housing where you live.)<br>***Mi comunidad ofrece oportunidades económicas.*** *(Considere la cantidad y la calidad de los trabajos que ofrecen un salario digno, oportunidades de capacitación laboral/educación superior y disponibilidad de viviendas económicas donde vive.)* | | | | | |
| **My community is a safe place to live.** (Consider how safe you feel at home, at work, in schools, at playgrounds, parks, and shopping centers where you live, work, and play.)<br>***Mi comunidades un lugar Seguro para vivir.*** *(Considere qué tan seguro se siente en casa, en eltrabajo, en las escuelas, en los patios de recreo, parques, y centros comerciales donde vive, trabaja, y juega.)* | | | | | |
| **My community provides help for people during times of need.** (Consider supports like neighbors, faith communities, food pantries, temporary housing and financial assistance programs where you live.)<br>***Mi comunidad ofrece ayuda a las personas durante los tiempos de necesidad.*** *(Considere apoyos como vecinos, comunidades religiosas, despensa de alimentos, viviendas temporales y programas de asistencia financiera donde vive.)* | | | | | |

7. **When you read the statements below, think about your social support network.** ***Cuando lea las declaraciones a continuación, piense en su grupo de apoyo social.***

| | **Never** ***Nunca*** | **Rarely** ***Raramente*** | **Sometimes** ***A veces*** | **Most of the time** ***La mayor parte del tiempo*** | **Every day** ***Todos los días*** |
|---|---|---|---|---|---|
| How often do you participate in social activities or group activities? *¿Qué tan frecuente participa en actividades sociales o grupales?* | | | | | |
| How often do you see or talk to people you care about and feel close to? *¿Qué tan frecuente ve o habla con personas que son importantes y cercanos a usted?* | | | | | |
| How often do you feel like you can rely on your family and/or friends or support? *¿Qué tan frecuente se siente que puede confiar con el apoyo de sus amigos o familiares?* | | | | | |
| How often do you feel isolated or lonely? *¿Qué tan frecuente se siente aislado o solo?* | | | | | |

## ACCESS TO CARE / *ACCESO AL CUIDADO MÉDICO*

8. In the **past 12 months**, what type of provider or facility did you have trouble getting health care from? ***(Check all that apply)*** *En los últimos 12 meses, ¿Qué tipo de proveedor o centro/instalación tuvo problemas para obtener atención médica?* ***(Marque todo lo que corresponda)***

- ○ Dentist / *Dentista*
- ○ General practitioner / primary care doctor / *Médico general/médico de atención primaria*
- ○ Health department / *Departamento de Salud*
- ○ Hospital
- ○ Mental health / substance use disorder treatment *Tratamiento de salud mental/uso de sustancias*
- ○ Pediatrician / children's doctor *Pediatría/Médico de niños*
- ○ Specialist / *Especialista*
- ○ Urgent care / *Atención de urgencia*
- ○ Vision / *Visión*
- ○ Women's doctor / obstetrics / gynecologist (OB/GYN) *Doctora/Obstetricia/Ginecóloga de la mujer*
- ○ N/A: Did not have any trouble *No aplicable/no tuve problemas*
- ○ Prefer not to say *Prefiero no decir*

Other (please specify) / *Otro (por favor especifique)*:

_____

9. In the **past 12 months**, have any of the following prevented you, or someone in your household, from getting health care? ***(Check all that apply)*** *En los últimos 12 meses, ¿Alguno de los siguientes le ha prevenido a usted o a alguien en su hogar recibir atención médica?* ***(Marque todo lo que corresponda)***

- ○ No health insurance / *Sin seguro medico*
- ○ No transportation / *Sin transporte*
- ○ Could not get an appointment / *No pude conseguir una cita*
- ○ The wait to receive care was too long / *La espera para recibir atención fue demasiado larga*
- ○ Did not know where to go / *No sabía dónde ir*
- ○ No one spoke my language / no translation services *Nadie hablaba mi idioma/no había servicios de traducción*
- ○ Office hours are not convenient / *El horario de oficina no es conveniente*
- ○ N/A: Did not have any trouble *No aplicable/No he sufrido estos problemas*
- ○ Prefer not to say / *Prefiero no decir*
- ○ Felt ignored, not taken seriously, or disrespected *Me sentí ignorado, no tomado en serio o faltado al respeto*
- ○ No provider available in my area to treat my need(s) *No hay un proveedor disponible en mi área para tratar mis necesidades*
- ○ Could not afford to get treatment *No podía pagar el tratamiento*
- ○ Provider, service, or medication was not covered by my insurance *El proveedor, servicio, o medicamento no estaba cubierto por el Seguro*
- ○ Did not understand the doctor's / pharmacist's instructions *No entendí las instrucciones de los médicos/ farmacéuticos*

Other (please specify) / *Otro (por favor especifique)*:

_____

## DEMOGRAPHICS / *Población*

Please answer questions 10-16 so we can see how people of different groups feel about local health issues.
*Responda las preguntas 10-16 para que podamos ver cómo se sienten los diferentes tipos de personas sobre los problemas de salud locales.*

10. **What is your age?** ***¿Cuántos años tiene?***
    - ○ Under 18 / *Menos de 18*
    - ○ 18-24
    - ○ 25-34
    - ○ 35-44
    - ○ 45-54
    - ○ 55-64
    - ○ 65-74
    - ○ 75-84
    - ○ 85+
    - ○ Prefer not to say / *Prefiero no decir*

11. **What is your gender?** ***¿Cuál es su género?***
    - ○ Female / *Mujer*
    - ○ Male / *Hombre*
    - ○ Prefer not to say / *Prefiero no decir*

Other (please specify) / Otro (por favor especifique):

_____

12. **Which of the following best describes your race, ethnicity, or origin?** ***(Check all that apply)***
    ***¿Cuál de las siguientes opciones describe mejor su raza, etnia, u origen? (Marque todo lo que corresponda)***
    - ○ American Indian or Alaska Native *Indio americano o nativo de Alaska*
    - ○ Asian or Asian American *Asiático o Asiático Americano*
    - ○ Black or African American *Negro o afroamericano*
    - ○ Hispanic or Latinx *Hispano o Latinx*
    - ○ Middle Eastern or North African *Oriente Medio o África del Norte*
    - ○ White or Caucasian *Blanco o Caucásico*
    - ○ Native Hawaiian or other Pacific Islander *Nativo de Hawái u otras Islas del Pacífico*
    - ○ Prefer not to say *Prefiero no decir*

Other (please specify) / Otro (por favor especifique): _____

13. **What range best describes your total household income for all members in your household combined?**
***¿Qué rango describe mejor el ingreso total de su hogar para todos los miembros de su hogar combinados?***

- ○ $0 - $14,999
- ○ $15,000 - $24,999
- ○ $25,000 - $34,999
- ○ $35,000 - $49,999
- ○ $50,000 - $74,999
- ○ $75,000 - $99,999
- ○ $100,000 - $149,999
- ○ Over $150,000
- ○ Prefer not to say / *Prefiero no decir*

14. **What is the highest level of school, college, or vocational training that you have received?**
***¿Cuál es el nivel más alto de escuela, universidad o capacitación vocacional que ha recibido?***

- ○ No schooling completed
*No se completó la escuela*
- ○ 12th grade or less, no diploma
*Menos de grado 12 o sin diploma*
- ○ High school graduate or GED
*Graduado(a) de la preparatoria o GED*
- ○ Some college, no degree
*Algo de universidad, sin título*
- ○ Trade school or vocational training
*Escuela de oficios o formación professional*
- ○ Associate degree
*Título de asociado*
- ○ Bachelor's degree
*Licenciatura*
- ○ Advanced college degree beyond bachelor's degree
*Título universitario avanzado más allá de la licenciatura*
- ○ Prefer not to say
*Prefiero no decir*

15. **What is your employment status? / *¿Cuál es su situación laboral principal?***

- ○ Employed full time
*Empleado(a), tiempo complete*
- ○ Employed part time
*Empleado(a), tiempo parcial*
- ○ Retired
*Jubilado(a)*
- ○ Unemployed / looking for work
*Desempleado/buscando Empleo*
- ○ Caregiver
*Cuidada a alguien*
- ○ Student
*Estudiante*
- ○ Armed forces / military
*Fuerzas armadas/militares*
- ○ Unable to work due disability, illness, or injury
*Incapacidad para trabajar debido a una discapacidad, enfermedad, o lesion*
- ○ Prefer not to say
*Prefiero no decir*

16. **How do you pay for your health care? / *¿Cómo paga su cuidado médico?***

- ○ **Pay cash** (no insurance)
*Pagar en efectivo (sin seguro)*
- ○ **Private health insurance** (Aetna, Cigna, Blue Cross Blue Shield NC, etc.)
*Seguro de salud (Seguro privado, Blue Cross Blue Shield NC, Cigna, Aetna, etc.)*
- ○ **Medicaid** (Alliance Health, AmeriHealth, Carolina Complete Health, Healthy Blue, Partners, Trillium, United Healthcare, Vaya, WellCare)
***Medicaid*** *(Alliance, AmeriHealth, Carolina Complete Health, Healthy Blue, Partners, Trillium, United Healthcare, Well Care)*
- ○ **Medicare**
- ○ **Veteran's Administration**
***Administración de Veteranos***
- ○ **I don't know / not sure**
***No lo sé/no estoy seguro***

Other (please specify) / Otro (por favor especifique):

_____

## QUALITY OF LIFE / *CALIDAD DE VIDA*

17. When thinking about your mental health, what are the **primary causes of stress** that you experience?
*Al pensar en su salud mental, ¿Cuáles son las **principales causes** de estrés que experimenta?*

_____

_____

18. What **changes** would make life **better** for everyone in Randolph County?
*¿Qué **cambios mejorarían** la vida de todos en el condado de Randolph?*

_____

_____

19. Please describe your key **environmental health concern(s)** affecting your community.
*Describa su(s) inquietud(es) principal(es) de **salud ambiental** que afectan su comunidad.*

_____

_____

## APPENDIX D: Prioritization Matrix

| 2025 CHA Community Health Categories | Feasibility | Size of Problem | Community Importance | |
|---|---|---|---|---|
| Weight | 0.5 | 0.35 | 0.15 | |
| | 1 if 1 criteria met<br>2 if 2 criteria met<br>3 if 3 criteria met | 1 - below avg<br>2 - similar to NC/peers<br>3 - above avg | 1 - low (<33%)<br>2 - medium (34-66%)<br>3 - high (>67%) | TOTAL SCORE (rating x weight) |
| **Injury** (Car crashes, traumatic brain injuries, drownings, etc.) | 2 | 2 | 1 | **1.85** |
| **HIV/STDs** (Testing and treatment for HIV, chlamydia, gonorrhea, syphilis, etc.) | 1 | 1 | 1 | **1** |
| **Maternal & Child Health** (Affordable birth control, prenatal care, low birth weight, premature babies, infant mortality, etc.) | 2 | 2 | 1 | **1.85** |
| **Healthy Environment** (Clean air, land, water, etc.) | 2 | 2 | 1 | **1.85** |
| **Violence** (Bullying, domestic violence, child abuse, assault, homicides, etc.) | 2 | 1 | 2 | **1.65** |
| **Access to Care** (Affordable healthcare; flexible hours; specialty services like dental, vision, hearing, translation services are unavailable, etc.) | 1 | 3 | 2 | **1.85** |
| **Mental Health** (Anxiety, depression, suicide, etc.) | 1 | 3 | 2 | **1.85** |
| **Substance Use Disorder** (Alcohol, opioids, prescription drugs, other drugs, etc.) | 2 | 3 | 2 | **2.35** |
| **Chronic Disease** (Cancer, heart disease and stroke, high blood pressure, diabetes, etc.) | 3 | 3 | 2 | **2.85** |

**FEASIBILITY** - include 3 components:
> Resources available to address the issue ($, staff, volunteers, time)
> Existing coalitions, programs, & services available to address issue
> Community support of the issue

**SIZE OF PROBLEM** - emphasizes the magnitude & severity of the issue. Considers key data indicators in comparison to peer counties & NC.

**COMMUNITY IMPORTANCE** - includes the community voice by incorporating survey results (CHA Q3 - community health

## Appendix E: Inventory of Resources

| Organization | Services Provided | Populations Served | Phone | Address | Link to Website |
|---|---|---|---|---|---|
| Archdale Police Department | Law enforcement | General public | 336-434-3134 | 305 Balfour Dr., Archdale | Archdale Police Department Public Website |
| Asheboro City Schools | Public K-12 schools | Students/families | 336-625-5104 | 1126 S. Park St, Asheboro | Asheboro City Schools Public Website |
| Asheboro Cultural & Recreation Services | Parks, recreation, cultural programs | General public | 336-626-1240 | 241 Sunset Ave, Asheboro | Asheboro Cultural & Recreation Services Public Website |
| Asheboro Housing Authority | Public housing and housing choice vouchers | Low-income households | 336-629-4146, 336-625-7034 | 338 W. Wainman Ave. Asheboro | Asheboro Housing Authority Public Website |
| Asheboro Latinx Services (ALS) | Health navigation, legal/social referrals, LGBTQI+ Latinx advocacy, bilingual support | Hispanic/Latinx, LGBTQ+ | 336-964-8957 | 122 N Fayetteville St, Suite B, Asheboro, NC 27203 | Asheboro Latinx Services Public Website |
| Asheboro Police Department | Law enforcement | General public | 336-626-1300 | 205 East Academy St., Asheboro | Asheboro Police Department Public Website |
| Autism Society of NC – Randolph County Hispanic Support Group | Spanish-language autism family support group | Hispanic/Latinx families | 800-442-2762 | 224 N. Fayetteville St., Asheboro, NC (Meetings Only) | Autism Society of NC Public Website |
| Brightview | Substance use, recovery, MAT | People in addiction | 888-502-4571 | 341 N. Fayetteville St., Asheboro | Brightview Public Website |
| Christians United Outreach Center (CUOC) | Food pantry, clothing, assistance | General public | 336-625-1500 | 930 S. Fayetteville St, Asheboro | CUOC Public Website |
| Daymark Recovery Services – Randolph | Mental health & substance use outpatient and crisis care | General public | 336-633-7240 | 110 W. Walker Ave, Asheboro | Daymark Recovery Public Website |

| Organization | Services Provided | Populations Served | Phone | Address | Link to Website |
|---|---|---|---|---|---|
| Easterseals PORT Health – Randolph | Community living supports, respite, supported employment | People with disabilities | 336-521-4988 | 610 N. Fayetteville St, Suite D, Asheboro | Easterseals Public Website |
| El Vínculo Hispano / The Hispanic Liaison | Support for Latino families | Latino community | 919-742-1448 | 404 N. Holly Ave, Siler City | El Vínculo Hispano Public Website |
| Emmy's House | Shelter for women and families | Women and families | 336-610-3060 | 235 East Academy St., Asheboro | Emmy's House Public Website |
| Family Crisis Center (Randolph) | Domestic violence & sexual assault services | Victims/survivors | 336-626-5040, 336-629-4159 | 624-A S. Fayetteville Street, Asheboro | Family Crisis Center - Randolph |
| Family Crisis Center; Archdale | Support for domestic violence, sexual assault of women | Women | 336-781-0021 | 402 Balfour Dr., Archdale | Family Crisis Center - Archdale |
| Family Crisis Center; Asheboro | Support for domestic violence, sexual assault of women | Women | 336-626-5040 | 624-A S. Fayetteville Street, Asheboro | Family Crisis Center - Asheboro |
| Keaton's Place | Substance use, recovery, sober living | People in addiction | 336-628-0070 | 120 Worth St., Asheboro | Keaton's Place Public Website |
| Kintegra Family Medicine - Asheboro | Nonprofit primary care (sliding fee) | General public | 336-672-1300 | 1831 N. Fayetteville St, Asheboro | Kintegra Family Medicine - Asheboro |
| Lazos Hispanos, Inc. | Family support, food/resource drives, community outreach | Hispanic/Latinx | 336-999-3166 | 325 Sunset Ave. Ste B, Asheboro | Lazos Hispanos Facebook Link |
| Liberty Police Department | Law enforcement | General public | 336-622-9053 | 10046 Old Liberty Rd., Liberty | Liberty Police Department Public Website |
| Lydia’s Place | Shelter for women and families | Women and families | 336-628-0659 | 114, Francis Street, Asheboro | Lydia's Place Public Website |
| Mobile Crisis (Daymark) | 24/7 mobile MH/SU crisis response | General public | 866-275-9552 | Countywide | Daymark Mobile Crisis Public Website |

| Organization | Services Provided | Populations Served | Phone | Address | Link to Website |
|---|---|---|---|---|---|
| Monarch – Asheboro School Road Home | Residential supports for IDD | People with disabilities | 336-629-6679 | 2046 N. Asheboro School Rd, Asheboro | Monarch Public Website |
| NAACP – Asheboro/Randolph County Branch | Civil rights advocacy, voter engagement, community events | BIPOC, civil rights | 336-653-4129 | 145 Worth Street, Asheboro, NC 27203 (Meetings Only) | Randolph NAACP Public Website |
| NC 211 (United Way) | 24/7 health and human services information and referrals | General public | Dial 211 | Statewide | NC 211 Public Website |
| NC Cooperative Extension – Randolph County Center | Agriculture, nutrition, 4-H youth programs | Farmers, families, youth | 336-318-6000 | 1003 S. Fayetteville St, Asheboro | RC Cooperative Extension Public Website |
| North Carolina Zoo | State zoo and conservation center | General public | 800-488-0444, 336-879-7000 | 4401 Zoo Parkway, Asheboro | NC Zoo Public Website |
| Our Daily Bread Kitchen | Free hot meals | General public | 336-626-2563 | 831 E. Pritchard St, Asheboro | Our Daily Bread Public Website |
| Piedmont Triad Regional Council – Area Agency on Aging | Caregiver support, ombudsman, health classes | Older adults | 336-904-0300 | 398 Carrollton Crossing Drive, Kernersville | PTRC Public Website |
| Place of Grace | Homeless shelter for men | Men | 336-318-0012 | 133 Wainman Ave., Asheboro | Place of Grace Public Website |
| Randleman Housing Authority | Public housing and housing choice vouchers | Low-income households | 336-498-7686 | 606 S. Main St, Randleman | Randleman Housing Authority Public Website |
| Randleman Police Department | Law enforcement | General public | 336-495-7510 | 101 Hilliary St., Randleman | Randleman Police Department Public Website |
| Randolph Community College | Degrees, workforce training, adult education | General public | 336-633-0200 | 629 Industrial Park Ave, Asheboro | RCC Public Website |
| Randolph County 4-H | Youth clubs and programs | Youth | 336-318-6000 | 1003 S. Fayetteville St, Asheboro | RC 4-H Public Website |

| Organization | Services Provided | Populations Served | Phone | Address | Link to Website |
|---|---|---|---|---|---|
| Randolph County Department of Social Services (DSS) | Benefits, child/adult protective services, Medicaid transport | General public | 336-683-8000 | 1512 N. Fayetteville St, Asheboro | RC DSS Public Website |
| Randolph County Partnership for Children (Smart Start / NC Pre-K) | Early childhood programs, NC Pre-K enrollment | Families, children | 336-629-2128 | 349 Sunset Ave, Asheboro | RCPC Public Website |
| Randolph County Public Health - Care Management | Managed care services for high-risk pregnancy and at-risk children | Children (birth to 5), pregnant women | 336-318-6253 | 2222-B S. Fayetteville St, Asheboro | RCPH Care Management Public Website |
| Randolph County Public Health - Clinic | Immunizations, family planning, STD/HIV testing | General public | 336-318-6882 | 2222-B S. Fayetteville St, Asheboro | RCPH Medical Clinic Public Website |
| Randolph County Public Health - Environmental Health | Facilities and well inspection, outbreak surveillance, lead exposure investigation | General public | 336-318-6262 | 204 E Academy St. Asheboro, NC 27203 | RCPH Environmental Health Public Website |
| Randolph County Public Health - Family Planning | Birth control, annual physical exams (PAP smear, breast exams, testicular exams) | Adolescents, men, and women | 336-318-6200 | 2222-B S. Fayetteville St, Asheboro | RCPH Family Planning Public Website |
| Randolph County Public Health - Health Promotion and Policy (HPP) | Community health education, disease prevention, Safe Kids services | General Public | 336-318-6185 | 2222-B S. Fayetteville St, Asheboro | RCPH HPP Public Website |
| Randolph County Public Health - WIC | Nutrition program for women, infants, children | Women, infants, children | 336-318-6177 | 2222-B S. Fayetteville St, Asheboro | RCPH WIC Public Website |
| Randolph County Public Library (system HQ) | Branches, mobile library | General public | 336-318-6800 | 201 Worth St, Asheboro | RC Public Library Public Website |
| Randolph County School System | Public K-12 schools | Students/families | 336-633-5000 | 2222-C S. Fayetteville St, Asheboro | RC School Systems Public Website |
| Randolph County Sheriff's Office | Law enforcement | General public | 336-318-6699 | 727 McDowell Rd, Asheboro | RC Sheriff's Office Public Website |
| Randolph County Veterans Services Office | Veterans benefits and claims assistance | Veterans | 336-318-6909 | 158 Worth St, Asheboro | RC Veterans Services Public Website |

| Organization | Services Provided | Populations Served | Phone | Address | Link to Website |
|---|---|---|---|---|---|
| Randolph Health | Acute care hospital | General public | 336-625-5151 | 364 White Oak St, Asheboro | Randolph Health Public Website |
| Randolph Senior Adults Association (RSAA) | Senior centers, Meals on Wheels, transportation coordination | Older adults | 336-625-3389 | 347 W. Salisbury St, Asheboro | RSAA Public Website |
| Randolph-Asheboro YMCA | Health, wellness, youth programs | General public | 336-625-1976 | 343 NC Hwy 42 N, Asheboro | Randolph-Asheboro YMCA Public Website |
| RCATS (Randolph County Area Transportation System) | Demand-response and scheduled routes | General public | 336.629.7433 | Countywide | RCATS Public Website |
| Seagrove Police Department | Law enforcement | General public | 336-873-8870 | 798 NC Hwy 705, Seagrove | Seagrove Police Department Public Website |
| St. Joseph's Catholic Church | Spanish Mass services, Hispanic ministry, community hub | Hispanic/Latinx | 336-629-0221 | 512 W. Wainman Ave. Asheboro | St. Joe NC Public Website |
| The Salvation Army of Randolph County | Emergency assistance & social services | General public | 336-625-0551 | 345 N. Church St, Asheboro | RC Salvation Army Public Website |
| Trillium Health Resources | Care management for MH/IDD/SUD services | General public | 1-855-733-7762, 1-877-685-2415 | 938 New Century Drive, Asheboro, NC 27205 | Trillium Health Resources Public Website |
| Uwharrie Charter Academy | Charter K-12 schools | Students/families | 336-610-0818 | 207 Eagle Lane, Asheboro | Uwharrie Charter Academy Public Website |