

INTRODUCTION

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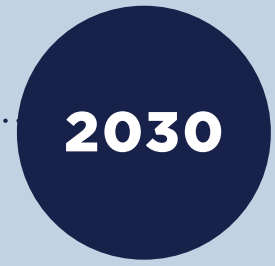
2020

**HNC
2030**



2025

**NC SHA 2025
Mid-Cycle Review**



2030

**HNC
2040**



**"All 86 Local Health Department
Community Health Assessments
align with HNC 2030"**



2025 North Carolina State Health Assessment

Mid-Cycle Review of Healthy North Carolina 2030

The 2025 North Carolina State Health Assessment (SHA) provides a comprehensive look at the health and well-being of the state's 10.8 million people and serves as the official mid-cycle review of Healthy North Carolina 2030 (HNC 2030). Developed through a year-long, collaborative, and data-driven process led by the North Carolina Department of Health and Human Services (NCDHHS), Division of Public Health (DPH), the SHA evaluates progress on statewide health goals, identifies emerging trends, and assesses opportunities to strengthen community conditions that influence health.

Anchored in the HNC 2030 framework, this assessment synthesizes secondary statistical data, primary qualitative insights, and an inventory of statewide assets to provide a balanced view of where North Carolina is making progress and where disparities persist. The SHA precedes and informs the North Carolina State Health Improvement Plan (SHIP), guiding the selection of shared priorities for coordinated action across public health, health care, community organizations, and other sectors. The assessment offers valuable information for stakeholders, including local leaders, community-based organizations, businesses, non-profits, and academic institutions.

Purpose and Approach

Results-Based Accountability (RBA) is a disciplined, data-driven approach to improving population and program outcomes by defining clear results, selecting measurable indicators, and using performance measures to drive continuous improvement and accountability.

The 2025 SHA was conducted using RBA and designed to answer three core questions:

1. **How are we doing on the HNC 2030 indicators?**
2. **Are we focused on the right priorities?**
3. **What new opportunities or emerging issues require attention before identifying the next decadal Healthy North Carolina 2040 (HNC 2040) framework?**

The assessment incorporates:

- **Secondary data:** population health statistics from state and national sources; trend analyses for all HNC 2030 indicators; demographic, environmental, economic, and social determinants of health profiles.
- **Primary data:** key informant interviews with maternal health professionals, offering grounded insights on barriers to care, system navigation challenges, and community needs.
- **Asset inventory:** mapping of statewide resources, partnerships, programs, and infrastructure supporting health improvement at state and local levels.
- **Cross-sector engagement:** contributions from more than 50 partners serving on the Steering and Advisory Committees; collaboration with NC AHEC, NCIOM, and local health departments (LHDs) in all 86 public health jurisdictions.



Key Themes and Findings

/ 01 Progress and Persistent Disparities in HNC 2030 Indicators

Mid-cycle analysis shows improvement in some statewide indicators, while others remain off-trend or indicate widened disparities. Many of the persistent gaps are tied to structural drivers such as income inequality, housing instability, limited access to preventive care, a rapidly aging and changing population, and geographic isolation affecting rural communities.

/ 02 The Impact of Medicaid Expansion

North Carolina's 2023 Medicaid expansion has broadened insurance coverage for hundreds of thousands of people. Early data indicate increased enrollment in preventive and behavioral health services, though challenges remain in provider availability, system navigation, and continuity of care. At time of publication, political uncertainties remain around sustained implementation of Medicaid expansion.

/ 03 Maternal and Child Health Challenges

Primary data collection highlighted significant barriers to maternal health care, including workforce shortages, transportation barriers, fragmentation across service systems, and limited access to culturally responsive care. Maternal health staff emphasized resilience and deep commitment to the families they serve, underscoring the need for integrated, community-centered approaches.

/ 04 Mental Health and Substance Use

Communities across North Carolina continue to report growing behavioral health needs, including increasing rates of anxiety, depression, suicide risk, and overdose. Additionally, local health departments and health systems describe increasing pressures on their workforce, limited service capacity, and the need for stronger prevention and early-intervention strategies.

/ 05 The Social and Economic Context of Health

Economic growth in North Carolina is strong; however, it is not evenly shared. Rural communities, older adults, individuals with low income, and some racial and ethnic minority groups face disproportionate barriers related to broadband access, transportation, workforce participation, affordable housing, and chronic disease prevalence.

/ 06 Environmental and Infrastructure Pressures

Through related workstreams, including the Environmental Health Data Workshop Series, DPH and partners identified growing vulnerabilities in drinking water systems, wastewater infrastructure, food and lodging inspection findings, and other environmental health domains. Recent climate-related disasters, including Hurricane Helene, have heightened awareness of long-term resilience needs.

Community Assets and Strengths

North Carolina possesses robust assets that support health improvement statewide, including:

- A strong network of local health departments serving all 100 counties
- Extensive NC AHEC workforce development infrastructure
- Health systems and academic partners contributing data, research, and innovation
- Cross-sector collaboratives aligned around HNC 2030 and emerging HNC 2040 planning
- Community-based organizations providing culturally grounded, locally responsive services
- Statewide partnerships, including NCIOM, The Duke Endowment (TDE), and other philanthropic networks supporting collaborative impact

These assets create a strong foundation for coordinated measurable improvement.

Looking Ahead to Healthy North Carolina 2040 (HNC 2040)

The findings of the 2025 SHA directly inform planning for the North Carolina State Health Improvement Plan (NC SHIP) and the next decadal HNC 2040 framework. The assessment highlights the need for:

- Stronger cross-sector alignment
- Continued investment in data and analytics capacity
- Workforce recruitment and retention strategies
- Scalable models for community engagement
- Resilient infrastructure and environmental health protections
- Sustained attention to the health needs and lived experiences of communities most affected by disparities

Conclusion

The 2025 SHA offers a data-driven, and community-informed picture of health in North Carolina at the midpoint of the HNC 2030 decade. It reflects the dedication of hundreds of partners across public health, health care, education, business, philanthropy, and community organizations. Most importantly, it elevates the voices of those closest to the work, including health professionals, local practitioners, community leaders, and individuals whose lived experiences guide the path toward better health outcomes.

This assessment sets the stage for the next phase of statewide action, ensuring that the NC SHIP, local community health assessments (CHAs) and community health improvement plans (CHIPs) and the forthcoming HNC 2040 plan are aligned, responsive, and grounded in measurable improvement for all North Carolinians.

STATE HEALTH ASSESSMENT

North Carolina DHHS/DPH conducted the 2025 State Health Assessment (SHA) from January 2025 through January 2026. The assessment was led by a project team and guided by a steering committee of internal stakeholders. The 2025 SHA meets all Public Health Accreditation Board (PHAB) requirements for state health agencies and informs the 2026 State Health Improvement Plan (SHIP).

The Public Health Accreditation Board (PHAB) is the national accrediting body for state, local, tribal, and territorial public health departments. The set of standards and measures is organized around the Foundational Public Health Services Framework (FPHS) and defines a minimum package of public health capabilities and programs that no jurisdiction can be without.

PHAB accreditation standards specify that the state health agency must participate in or lead a collaborative process resulting in a comprehensive state health assessment. The guidance states that the assessment must

- Describe demographics of the population (age, sex, race/ethnicity, subpopulations, etc.)
- Include health status (morbidity, mortality, disease burdens, behavioral risk factors, quality of life, chronic diseases, etc.)
- Include social, economic, environmental, structural determinants of health (e.g., socioeconomic status, housing/poverty, access to services, environmental exposures, built environment, inequities)
- Include community assets and resources: services, programs, social supports, protective factors, infrastructure, community strengths — not just deficits.

- Provide analysis and interpretation of data, including identification of health inequities, disparities, root causes, social determinants, subpopulation differences, and priority health issues.
- Document the collaborative development process, highlighting evidence of community involvement and engagement with stakeholders and partners, especially the inclusion of marginalized or underrepresented groups.
- Disseminate results: make findings accessible and available to stakeholders and the public via reports, dashboards, meetings, etc., to support transparency and guide improvement planning (Public Health Accreditation Board [PHAB], 2022)

NCDHHS, Division of Public Health (DPH) used a combination approach: a state-based model, MAPP 2.0, and RBA:

- The state-based model involves 12 steps including establishing an advisory committee, authentic community engagement, primary data, dissemination, and evaluation.
- We incorporated MAPP 2.0 principles for the Asset Inventory.
- We have adopted RBA which is best characterized as a community participatory process. RBA focuses on bringing stakeholders together, reviewing data, prioritizing health problems and crafting clear statements of desired results.



STATE HEALTH IMPROVEMENT PLAN (SHIP)

PHAB requires state health agencies to develop a state health improvement plan (SHIP) through a collaborative, data-driven process that reflects SHAs; identifies priorities, goals, and strategies; involves partners in implementation; monitors and reports progress annually; addresses gaps in health; and makes the plan publicly accessible.

Develop the SHIP based on findings from the SHA

- Use a collaborative, multisector process to develop priorities and strategies
- Identify statewide priority areas supported by data and evidence
- Include measurable goals and objectives for each priority
- Ensure the plan includes strategies/actions that address:
 - Root causes of health issues
 - Social and economic factors
 - Gaps in health
- Describe the roles and commitments of partners in implementing the plan
- Establish a timeline for implementation
- Make the SHIP publicly accessible

Show evidence that partners are actively involved in implementing SHIP strategies.

- Document shared responsibilities, including how partners contribute staff, expertise, or resources
- Maintain a coordinated process (e.g., councils, committees, workgroups) to oversee implementation
- Demonstrate ongoing engagement of community and cross-sector partners

Monitor and Report Progress

- Track progress toward goals, including performance measures and health indicators
- Analyze results to identify improvements, challenges, disparities, and equity impacts.
- Produce regular public reports (at least annually) on SHIP progress
- Provide updates to partners and community stakeholders
- Use progress findings to adjust strategies as needed

Alignment With Other Plans (Crosswalk)

- Align SHIP priorities and objectives with:
 - Agency strategic plan
 - Statewide initiatives (e.g., HNC 2030)
- Ensure metrics and implementation structures support consistent direction across plans (Public Health Accreditation Board [PHAB], 2022)

Population Health Model

Frameworks and models are foundational to facilitating community health assessment (CHA) processes because they provide a structured and intentional approach to identifying needs, guiding data selection and analysis, and framing a shared narrative. By standardizing definitions and prioritizing different data sets, they create opportunities to establish goals and benchmarks and explore disparities across populations (Green & Kreuter, 2005). Leveraging frameworks and models strengthens processes like this state health assessment by promoting intentional and structured approaches to assessing health and well-being and informing collaborative prioritization and planning.

Models and frameworks that are used to guide community health assessments typically include several key practices and elements to structure the organization of the assessment and planning process. Models and frameworks emphasize stakeholder engagement and shape shared visions of the assessment. They establish a common understanding of factors impacting health and quality of life, prioritizing data to be gathered and analyzed to ensure that findings are systematically examined and effectively communicated. Together these core principles of a framework ensure that the assessment can be leveraged to inform collaborative planning and action to improve health (Centers for Disease Control and Prevention [CDC], 2024).

The population health model was developed to provide a multi-sectoral approach to improving community health and quality of life by identifying key factors across health care, public health, economic, structural, and social determinants (Kindig & Isham, 2014). This model has been widely used over the past decade, informing the theoretical foundations for public health assessment and planning efforts including the County Health Rankings and Roadmaps model, Healthy People 2030, and Healthy North Carolina 2030 (HNC 2030), providing shared context and alignment across local, state, and

national partners; U.S. Department of Health and Human Services [USDHHS], 2020; North Carolina Institute of Medicine [NCIOM], 2020). The population health model emphasizes that improving multiple determinants can foster healthier environments where individuals live, learn, work, and play.

The population health model acknowledges that health and well-being are shaped by a complex interplay of individual, community, and systemic factors. It integrates traditional data sources regarding morbidity, mortality, and quality of life while also incorporating measures related to structural health drivers such as poverty, education, and environmental conditions. This approach transcends a narrow, individualistic view of health and emphasizes the broader systems that influence population health.

The selection of the population health model for a state health assessment is driven by its comprehensive and inclusive approach. Unlike traditional models focusing primarily on health care, morbidity, and mortality, the population health model incorporates behavioral, social, and environmental determinants. This allows us to identify upstream factors influencing health outcomes and define how all sectors of a community contribute to quality of life while analyzing disparities and potential root causes.

The model also provides a shared context for meaningful conversations and intentional collaboration among multi-sector partners about drivers of health that extend beyond health care alone. Notably, only 20% of health outcomes are attributed to clinical care, while 80% are influenced by the intersection of health behaviors, physical environment, and social and economic factors (Kindig & Isham, 2014). Using this model helps shape priorities that foster opportunities for health and quality of life for all community members while providing specific attention to certain health outcomes or populations.



Utilizing the population health model in a state health assessment enables systematic selection of relevant indicators that reflect community needs. The model guides the gathering and analysis of data, ensuring that key determinants are incorporated. This structured process supports the creation of a comprehensive community health profile, essential for evidence-based decision-making and resource allocation.

Additionally, the model supports effective communication of findings through data storytelling. By framing health information within broader context, public health professionals can convey narratives that resonate with policymakers, stakeholders, and the public. This enhances engagement and promotes collaboration in implementing health improvement strategies.

The model is not without limitations, however. Its broad, multifactorial structure can be perceived as difficult to translate from conceptual theory to actionable strategies (Krieger, 2012). The data used in population health models can sometimes overemphasize individual-level factors, potentially underrepresenting systemic determinants and the root causes of disparities (Braveman & Gottlieb, 2014; Marmot, 2005). Further, the model's emphasis on outcomes may fall short in addressing structural power dynamics and inequities that shape health opportunities for different populations (Navarro, 2009).

In conclusion, the population health model provides a robust foundation for conducting a state health assessment. Its emphasis on multifactorial determinants of health, the integration of social determinants, and its capacity for addressing disparities make it a valuable tool for shaping public health strategies and policies.

