



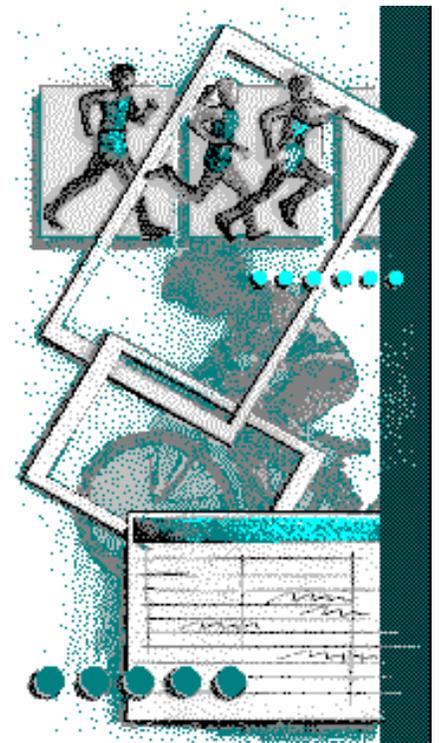
# The Health of Buncombe County 2000

*Buncombe County, North Carolina*

## *Community Report*

*Prepared for Buncombe County Health Center,  
HealthPartners, Mission St. Joseph's Health System,  
Mountain Area Family Health Center, and other  
Buncombe County health care organizations.*

*... Never doubt that a small group of  
thoughtful, committed citizens can change the  
world; indeed, it's the only thing that ever has.  
— Margaret Mead*



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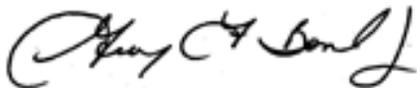
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# Foreword

Buncombe County has a strong history of creative pioneering in the field of health care. We have forged new territories in creating unique partnerships amongst all levels of providers and for differing populations within our communities. Hospitals have merged, a community safety-net system for uninsured, low-income residents has achieved national recognition, and community health initiatives are well known for their impact. We are well on our way toward an unsurpassed integrated primary health care system.

Being able to honestly assess our strengths and boldly identify our needs and challenges has been crucial to this progress. This health assessment is a key component of our ongoing commitment to gathering solid, varied data to support the best in decision-making and monitor our progress.

However, this assessment is most useful to Buncombe County, if, as trailblazers, we respond to what we see and understand. Let us celebrate with gratitude where there has been progress and act out of deep concern and commitment where there is need. Let's move forward together!



George F. Bond, Jr.  
HealthPartners Chair, Board of Directors  
Director, Buncombe County Health Center

# **SUMMARY OF ASSESSMENT FINDINGS**

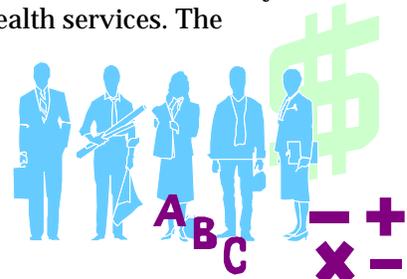
# Summary of Findings

The following sections relate some of the key findings of this assessment. Note that source types for data elements are identified by icon: randomized telephone survey data (☎); secondary data (📊); or Perceptions Data (🗣️).

## Key Points by Issue

### Underlying Issues

- 📊 18.9% of Buncombe County adults aged 25 and older do not have a high school diploma. 50.1% are high school graduates, and 31.0% have received postsecondary degrees.
- 📊 82.5% of school children in grades 3 through 8 in Buncombe County schools and 72.3% in Asheville City schools passed end-of-year tests in reading and math during the 1998-99 school year. However, there was a wide discrepancy in the proportions of White students and the proportions of African-American and Latino students passing these tests.
- 📊 Regarding adult literacy, it is estimated that 24% of Asheville City adults and 18% of Buncombe County adults demonstrate the lowest level of proficiency. Those adults who score at Level I have difficulty performing such everyday tasks as locating an intersection on a street map, reading and comprehending a short newspaper article, or calculating total costs on an order form.
- 📊 Annual average wages in Buncombe County in 1998 were below the state average, and only 39.3% of Buncombe County workers earned over the state average.
- 📊 The 1990 mean income of two-parent families in Buncombe County was \$42,093, slightly less than the state mean. For single-parent, female-headed families, the county's mean income was only \$14,779.
- 📊 In 1998, nearly 20% of Buncombe County children aged 5 and under lived in poverty. One out of four single-parent families lived in poverty.
- 📊 The top industries in terms of numbers of employees in Buncombe County are retail trade, the manufacture of non-durable goods, and health services. The largest net increase in jobs is expected in the health services industry.



-  As found statewide, manufacturing as a percentage of total employment has consistently declined in Buncombe County over the past several years.
-  The unemployment rate in Buncombe County is low (2.0% in April 2000). This rate has remained below state and national rates as it has continued to decrease over the past decade.
-  However, Perceptions Data cite a proliferation of low-paying service industry jobs, as opposed to higher-paying technical and professional jobs which would better enable workers to support families.
-  Ratings of air quality and the water quality of Buncombe County's rivers, lakes and streams have declined considerably in the past few years.
-  Perceptions Data point out that air quality has certain impact on the health of residents.

## Buncombe County at a Glance

### *Demographic Profile*

-  The 1997 Buncombe County population was estimated at 192,997. This is expected to increase 13.7% by the year 2007 to 219,452.
-  The 1997 population was made up of 21.7% children (0-17); 39.1% aged 18 to 44; 23.3% aged 45 to 64; and 16.8% aged 65 and older. The largest segment, 18- to 44-year olds, is expected to increase 28.7% by the year 2007.
-  The county is predominantly white (90.6%), with an 8.5% African-American population. Hispanic community members make up approximately 1% of the population. While minority populations will grow considerably, these proportions are expected to be similar in the year 2007.

### *Housing*

-  In 1999, only 56.3% of homes were considered to be affordable to the median income family in the Asheville MSA (Buncombe and Madison Counties). This compares to 64.4% nationwide.
-  Perceptions Data suggest that affordable housing is a significant need in Buncombe County, particularly for minority and senior populations.

### *Transportation*

-  While use of public transit is up, transportation — both public and medical — is seen as a real need according to the Perceptions Data.

## Medical Service Providers & Facilities

-  Perceptions of local health care are generally positive, including Buncombe County Health Center and MSJ Health Systems. Still, Perceptions Data stress continued efforts to be sensitive to the needs of those of different socio-economic or cultural backgrounds.
-  In Buncombe County, there is one primary care physician for every 889 residents; this ratio is more favorable than found statewide (1:1,281). Further, there is one dentist for every 2,012 residents (again more favorable than the 1:2,495 statewide).

## Community-Based Health Promotion Services

-  Several community-based health promotion services have been put into place in our community, including: Project ACCESS; school health and school nurse services; Mission St. Joseph's Community Outreach Care Clinics, Mobile Services, Parish Nursing, Medical Assistance, and Mobile Mammography; Asheville Buncombe Community Christian Ministry; Buncombe County Health Center; Western North Carolina Community Health Services; and WELCOA (Wellness Council).

## Community Assets & Resources

-  Key Informants expressed a great deal of gratitude toward many existing agencies and resources in the community. Those agencies that were given the highest acclaim were ABCCM, Eblen Foundation, churches, Department of Social Services, Buncombe County Health Center, Mission St. Joseph's Community Outreach, Veterans Administration, United Way, Project Access, Manna Food Bank, Blue Ridge Center, Housing Authority, AB Tech, UNC-A, Mountain Mobility, Meals on Wheels, Catholic Social Services, Police Department, Sheriffs Department.

## Health Status

### General Health

-  Over one-half (56.6%) of survey participants characterize their general health as "excellent" or "very good," while 15.5% characterize it as "fair" or "poor." "Fair/poor" responses were notably higher among seniors, African-American residents and those without health insurance coverage.

### Mental Health & Depression

-  22.0% of respondents report that they have had a period of two weeks or longer in the past year during which they felt sad, blue, depressed, or lost all interest or pleasure in things they usually cared about or enjoyed. Of these people, 30.5% have sought professional help for their depression; another 14.1% said they needed help, but did not receive it for a variety of reasons.



-  Depression was most prevalent among persons living below the 200% poverty threshold, uninsured adults, and African-American residents.
-  Hospitalization rates for mental disorders in Buncombe County exceed state rates by 27%.
-  Buncombe County's age-adjusted suicide rate (14.7 per 100,000 population) is higher than both state (12.0) and national (10.8) rates, and more than twice the goal for the year 2010 (6.0 or fewer).

## Substance Abuse

-  Hospitalization rates for substance abuse in Buncombe County exceed state rates by 28%. Medicaid costs for a single hospitalization for substance abuse and/or mental disorder average \$4,577 per case in Buncombe County, 14% above the state average.
-  Perceptions Data suggest that illegal drug use and sales are major problems in our area. **Drug-related crime and violence** was the number-one health concern mentioned by the majority of Key Informants. **Drug and substance abuse** followed very closely as the second major health risk in the community at large, and many times the two issues overlapped.

## Crime

-  Violent crime has increased in Buncombe County over the past several years (from 343.4 violent crimes per 100,000 population in 1993 to 487.1 in 1998). Statewide, these rates have declined during this period.
-  Buncombe County experiences a high rate of child abuse and neglect reports (106.7 per 1,000 children in fiscal year 1997-98; this compares to a rate of only 71.1 statewide).
-  10.8% of Buncombe County adults acknowledge having been punched, kicked, or otherwise hurt by a family member or someone close to them at some time in the past. A total of 1.9% report this occurring in the past year. Victimization was highest among lower-income and uninsured persons, also among respondents to the Latino survey.

## Births

-  The percentage of mothers receiving timely prenatal care in Buncombe County (92.3%) has improved over the past five years, and is currently favorable compared to the statewide percentage (83.1%) and the year 2010 goal (90% or higher).
-  A high percentage (14.2%) of minority births are of low birthweight (less than 5 pounds, 8 ounces). Adolescent pregnancy rates are also high among minority girls (108.6 births per 1,000 girls aged 15-17), higher than found statewide (93.0) and above the statewide target for the year 2010 (86.7 or lower).
-  One out of five births (19.8%) between 1994 and 1998 in Buncombe County were to mothers who smoke, higher than statewide (15.7%) and nearly twice the goal for the

year 2010 (10.0% or less). Three out of four minority births (73.5%) between 1993 and 1997 in Buncombe County were to unmarried women.

-  The 1994-98 infant death rate among African-American births in Buncombe County (18.9 infant deaths per 1,000 births) is significantly higher than found either statewide (16.2) or nationwide (13.7).

## Disease

-  The incidence of AIDS in Buncombe County (15.2 cases per 100,000 annually) is above the statewide rate (11.4).
-  Perceptions Data suggest a need for more HIV awareness and compassion to eliminate the stigma of HIV. Testing for earlier diagnosis would also be helpful.
-  Incidence rates for sexually transmitted diseases in Buncombe County are low overall.
-  Perceptions Data point out that STD education and prevention should be a priority among teens.
-  Incidence of vaccine-preventable illness and enteric disease (e.g., salmonella, E. coli, etc.) are relatively low in Buncombe County.
-  The hospitalization rate for asthma in Buncombe County is favorable overall, but is considerably high among children under 15 years old (353.8 hospitalizations per 100,000, compared to 267.4 statewide and a year 2010 goal of 225 or lower).
-  Of several tested chronic conditions, survey respondents report the highest prevalence of: **loss of hearing or vision** (29.7%); **arthritis or rheumatism** (23.5%); **chronic back problems, headache or other pain** (22.6%); and **asthma, emphysema or chronic bronchitis** (14.5%). Furthermore, local prevalence levels for diabetes (10.2%) and heart disease (9.9%) are higher than reported nationwide.

## Leading Causes of Death

-  The leading causes of death in Buncombe County are **heart disease** (accounting for 29.6% of deaths in 1994-98), followed by **cancers** (22.4%) and **stroke** (7.9%).
-  Buncombe County demonstrates higher rates than both the state and nation for death resulting from **female breast cancer, chronic obstructive pulmonary disease** (COPD or lung disease), **suicide, HIV/AIDS, liver disease/cirrhosis** and **nephritis, nephrosis and nephrotic syndrome** (kidney disease). Age-adjusted death rates are generally much higher among minority residents, as well as among men in general.
-  Buncombe County fails to satisfy each of the *Healthy People 2010* targets set forth for selected causes of death, most notably **AIDS, suicide, homicide** and **unintentional injuries**.



Over the past two decades, deaths from heart disease, stroke, unintentional injuries and pneumonia/influenza have declined. However, deaths attributed to **female breast cancer, lung disease, diabetes, AIDS and kidney disease** are trending upward.

## Modifiable Health Risks

### Nutrition



County residents average 2.6 servings of vegetables per day and 1.6 servings of fruit. Overall, 37.8% of adults eat the recommended 5 or more servings per day of fruits and/or vegetables.



The following proportions of respondents report “always or often” practicing the following healthy eating habits: **eating two or more vegetables at the main meal** (74.9%); **eating only fruit for dessert** (30.0%); **eating chicken or poultry without the skin** (19.2%).



Most survey respondents (56.2%) characterize their diets as "medium" in fat content, while 9.9% report "high-fat" diets, and 33.9% report "low-fat" diets. (Note that these are self-reported, and the terms are self-defined.)

### Physical Activity



18.6% of respondents did not participate in any type of leisure-time physical activity in the past month. This marks a statistically significant decrease since the 1995 study was conducted.



18.3% partake in moderate physical activity (exercising at moderate levels at least 5 times a week for 30 minutes at a time); in addition, 38.0% participate in vigorous physical activity (exercising vigorously at least 3 times a week for 20 minutes at a time). Another 33.8% of local adults engage in some activity which enhances and maintains strength and endurance at least twice weekly. However, activity levels among lower-income individuals and among African-American residents are less favorable.

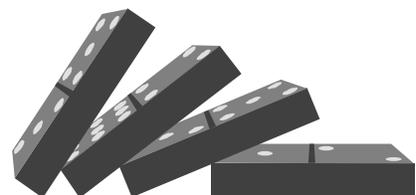
### Overweight



By reported heights and weights, 51.7% of survey participants are overweight (including 20.6% who are obese), marking a *statistically significant increase* since 1995 (45.2% overweight in 1995). This includes 64.9% of African-American adults in Buncombe County (compared to 50.4% of Whites).



Among overweight residents, 52.5% are trying to lose weight.



## Tobacco Use

- ☎ A total of 24.2% of adults are current cigarette smokers. This increases to 48.1% among uninsured adults. Among current smokers, 15.5% smoke more than one pack daily.
- ☎ 53.3% of regular (everyday) smokers have quit smoking for one day or longer during the past year.
- ☎ 28.4% of adults live or work with someone who smokes around them (19.7% among nonsmokers).
- ☎ 3.9% of survey participants currently use a smokeless tobacco product, such as chewing tobacco or snuff.

## Alcohol Consumption

- ☎ 43.9% are **current drinkers** (having had alcohol in the past month).
- ☎ 3.9% of county residents are **chronic drinkers** (having at least 60 drinks in the past month), and 10.4% are considered to be **binge drinkers** (having 5 or more alcoholic drinks on any one occasion in the past month), failing to satisfy the *Healthy People 2010* goal (6% or less).

## Blood Pressure & Cholesterol

- ☎ 96.0% of survey participants have had their blood pressure checked by a health professional in the past five years. Over one-fourth (28.8%) of adults have been diagnosed with high blood pressure, 73.2% of whom take medication to control it. High blood pressure is particularly prevalent among African Americans.
- ☎ Over one-fourth (28.0%) of adults have been told they have high cholesterol; 10.1% have never had their cholesterol checked. Among adults with high cholesterol levels, 63.8% are taking action to control their levels.

## Prevention

### Utilization of Health Providers

- ☎ In the past year, 82.9% of Buncombe County adults report utilizing the services of a **physician**; another 64.1% have visited a **dentist** at some point in the past year. More than one in 10 adults have used the services of a **chiropractor** (12.4%) or a **massage therapist** (11.5%).
- ☎ Fewer than 10% of county residents have used the services of the following providers in the past year: mental health professional, podiatrist, herbalist, ophthalmologist, OB/GYN, acupuncturist, homeopath, or naturopath.



-  68.1% of local adults surveyed have visited a physician for a routine checkup within the past year.

### **Medications**

-  56.4% of local adults currently take at least one medication for health reasons. Among adults aged 65 and older, this percentage is 81.1%.

### **Dental Care**

-  50.2% of adults report that they have had permanent teeth removed due to tooth decay or gum disease.

### **Alternative/Complementary Health Care**

-  20.0% of survey participants report that they sometimes seek alternative or complementary health care before using a formal health care provider.
-  One-third (33.7%) of county residents report using some kind of herbal remedy when they are not feeling well or to maintain their health; Echinacea was the most commonly reported herbal remedy used (30.5%).

### **Immunization**

-  70.2% of the seniors surveyed (aged 65 and older) have had a flu shot in the past year. Somewhat fewer (64.0%) have ever had a pneumonia vaccine.
-  Buncombe County Health Center data supports that **86% of all children** born in Buncombe County between November 1, 1996 and October 31, 1997 have received the immunization recommended or required by North Carolina law for their age group.

### **Women's Cancer Screenings**

-  Of those women aged 40 and older, approximately three-fourths have had a mammogram in the past two years.
-  83.3% of women have had a Pap smear to test for cancer of the cervix in the past three years, compared to a Healthy People 2010 goal of 90% or higher.
-  3 in 10 local women have had a hysterectomy; this proportion is unchanged from the 1995 survey results.

## Access to Health Care Services

Access is a key issue for communities across the country. Barriers such as cost, transportation, insurance acceptance, physician and appointment availability, and inconvenient office hours are prohibitive factors for many residents. For this issue particularly, the important analysis lies in how these barriers impact various subsegments of the population, particularly low-income and minority residents. A significant amount of the Perceptions Data reflects issues relating to access to health care services.

### Regular Use of Physicians

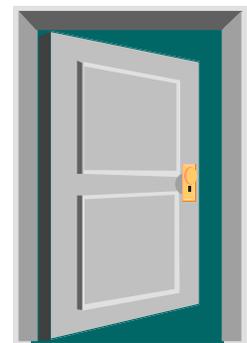
-  8 in 10 local adults surveyed use a physician's office when in need of medical care. Another 6.8% visit an urgent care center and 4.6% report seeking care at a clinic. Note that 3.3% of local adults rely on the local emergency room for regular medical care.
-  7.0% report that they do not have a place they usually go, such as a doctor's office or clinic, when they are sick or need advice about their health (other than a hospital emergency room). Most say it is because they have not needed a doctor (although a notable number mentioned cost or lack of insurance).
-  83.1% of adults have a personal physician, comparable to the *Healthy People* 2010 goal of 85% or higher.

### Use of Emergency Room

-  In the past year, 23.3% of local adults have used an emergency room for medical care, an increase since 1995.
-  While the total number of emergency room visits in Buncombe County increased between fiscal years 1997 and 1999, both the number and proportion of visits classified as "primary care" visits (i.e., Level 1,2 or F cases; those which may be better addressed in a primary care setting) have **declined** (decreasing from 48.9% of cases in FY1997 to 44.1% in FY1999).

### Insurance Coverage

-  88.9% of employed adults report that their employer offers health coverage as a benefit; 83.1% of these individuals take advantage of this (most of whom state that the premium cost is split between employer and employee).
-  Among survey participants aged 18 to 64, 18.5% report that they have no type of insurance coverage (public or private) for health care costs.
-  Almost one-half (47.3%) of local adults currently have dental insurance coverage; among local parents of children under 18, 62.9% have dental coverage for their children.



 15.2% of adults with children state that their children are enrolled in Health Check, the state Medicaid program, and 16.0% state that their children are enrolled in North Carolina Health Choice.

 In combining percentages of uninsured and underinsured persons of all ages in Buncombe County as revealed in 1995 estimates, 29.6% were considered to be “at risk” (compared to 32.8% statewide). Among those living below poverty, 51.4% were “at risk” (compared to 54.7% statewide).

### ***Barriers to Health Care Access***

 Buncombe County residents report an average 7-day wait for an appointment at their doctor’s office or at the clinic; in the waiting room, they report an average 28-minute wait to see a medical person.

 11.3% report that there was a time in the past year when they wanted to get **medical care**, but did not. One-half of these individuals say they tried to get care, but could not due to such factors as a lack of insurance, difficulty getting an appointment, inconvenient office hours and a lack of available physicians.

 13.1% report that there was a time in the past year when they wanted to get **dental care**, but did not. Approximately one-third of these individuals say they tried to get care, but could not, mostly due to cost or a lack of insurance.

 6.4% of adults report that there was a time in the past year when they wanted a **prescribed medicine** but did not get it. One-half of these individuals say they tried, but could not get the medicine due to such factors as cost/lack of insurance, and medication not being in stock.

 4.5% of adults say that there was a time in the past year when they wanted **mental health care** or counseling, but did not get it at that time. Among these people, one-half tried to get care but were unsuccessful. Reasons included cost, fear or embarrassment, and difficulty in scheduling an appointment.

 Some of the barriers to accessing health care services which surfaced in the Perceptions Data include: cost of health services and medications; physician relationships; transportation; discrimination; language and cultural differences; and age. Unique barriers were discussed as they relate to subgroups within the population, such as Latinos, immigrants, gays/lesbians, the impoverished, and the elderly.

# 1995-2000 Comparisons

The following table outlines comparisons between the 1995 and 2000 telephone survey data, along with the results of tests for statistical significance between the two studies.

Health Status		Buncombe	Buncombe	2000 vs. 1995
		2000	1995	
Physical Health	% "Fair" or "Poor" Physical Health	<b>15.5</b>	13.8	similar
	% Overweight (old definition)	<b>33.3</b>	23.5	WORSE
	% Overweight Trying to Lose (old definition)	<b>52.5</b>	55.8	similar
	% Unhealthy Weight (BMI <18.5 or 25+)	<b>55.1</b>	49.4	WORSE
	% Obese (new definition)	<b>20.6</b>	14.2	WORSE
Mental Health	% Depression (2+ Wks)	<b>22.0</b>	20.8	similar
	% Depressed Persons Seeking Help	<b>30.5</b>	28.8	similar
<b>Health Risk</b>				
CV Risk	% 1+ Cardiovascular Risk Factor	<b>84.2</b>	75	WORSE
Nutrition	% "High" Fat Diet	<b>9.9</b>	9.8	similar
	% "Always/Often" Eat 2+ Vegetables w/Dinner	<b>64.0</b>	74.9	BETTER
	% "Always/Often" Eat Only Fruit for Dessert	<b>26.5</b>	30.0	similar
	% "Always/Often" Eat Poultry w/out Skin	<b>18.7</b>	19.2	similar
Exercise	% No Leisure-Time Physical Activity	<b>18.6</b>	30.6	BETTER
Tobacco	% Current Smoker	<b>24.2</b>	24.3	similar
	% Smoke >1 Pack/Day	<b>15.5</b>	19.6	similar
	% Have Quit 1+ Days in Past Yr	<b>53.3</b>	55.1	similar
	% Use Smokeless Tobacco	<b>3.9</b>	5.1	similar
	% Work/Live With Smoker	<b>28.4</b>	32.2	similar
Substance Use	% Current Drinker	<b>43.9</b>	46.5	similar
	% Chronic Drinker	<b>3.9</b>	4.6	similar
	% Binge Drinker	<b>10.4</b>	11.2	similar
Hypertension	% Blood Pressure Checked in Past 2 Yrs	<b>96.0</b>	93.2	similar
	% Told Have High Blood Pressure	<b>28.8</b>	26.5	similar
Cholesterol	% Cholesterol Checked in Past 5 Yrs	<b>89.9</b>	78.3	BETTER
	% Told Have High Cholesterol	<b>28.0</b>	24.2	similar
<b>Prevention</b>				
Preventive	% Have Had Routine Checkup in Past Yr	<b>68.1</b>	69.7	similar
Immunization	% Flu Shot in Past Yr (65+)	<b>70.2</b>	65.2	similar
Cancer Screen	% Mammogram in Past 2 Yrs (W40+)	<b>74.8</b>	70.4	similar
	% Pap Smear in Past 3 Yrs (W)	<b>83.3</b>	85.2	similar
<b>Access</b>				
Insurance Cvg	% Lack Health Insurance (18-64)	<b>18.5</b>	10.8	WORSE
Primary Care	% Have a Regular Clinic or Physician	<b>93.0</b>	78.7	BETTER

## Key Community-Based Health Promotion Services Since 1995

The results of the 1995 Buncombe County Community Health Assessment and the community's response prompted the development new community health initiatives. Since then, access to health care has improved significantly.

### ***Project ACCESS***

Coordinates services from volunteer health care providers who provide free care for individuals who are ineligible for Medicaid and below 200% of poverty, but cannot afford health insurance. Can help provide primary health care, hospital coverage and help with medications. Works through the Buncombe County Health Center and several free clinics including: ABCCM Doctor's Clinic, Emma Family Resource Center, Minnie Jones Family Health Center and Western North Carolina Community Health Services.

### ***School Health/School Nurses***

School health services are provided at Asheville High School, Asheville Middle School and Erwin Middle School. Additional services include acute care, nutritional counseling, mental health and substance abuse counseling, health behavior modification, and health education on substance abuse, obesity, violence, and related health topics. School nurses provide health appraisal, consultation, screening, and referral for all elementary schools.

### ***Mission St. Joseph's Community Outreach***

Provides health promotion activities and medical screenings on a mobile basis, as well as through fixed sites. Contributes staffing and financial assistance to programs which provide acute episodic and primary care services for the underserved. Partners through funding opportunities and in-kind donations with other community agencies to ensure the ongoing success of family resource centers, school health programs, parish health initiatives, and senior services programs. Provides targeted transportation services to complement existing transportation resources.

### ***Mammogram Van***

Provides mammography screenings for women who are over 40 years of age. Screenings are completed "on location" at businesses or industries through advanced scheduling. Regularly scheduled screenings also are provided at the Buncombe County Health Center and the Asheville- Buncombe Community Christian Ministry. Program is offered jointly by Mission St. Joseph Health System, Helen Powers Women's Center, and Asheville Radiology Associates.

### ***Asheville Buncombe Community Christian Ministry (ABCCM)***

Provides access to health care services for the uninsured through the use of community volunteers. Services include acute medical needs, job physical, medication, lab, X-ray, medical referrals, dental services, and an orthopedic clinic.

### ***Buncombe County Health Center***

Protects, promotes and assures the health of all Buncombe County citizens. Maintains a safe and healthy environment by providing surveillance of health status and conditions in the county and key public health services. During past five years has expanded adult primary care services, dental services, medication assistance services, student health centers, and various community health initiatives.

### ***Western North Carolina Community Health Services (WNCCHS)***

Provides affordable and high-quality primary health care to vulnerable and underserved populations with a commitment to HIV/AIDS care. Operates a variety of community-based services - Hope House, Kenilworth Wellness Center, Minnie Jones Family Health Center, Ridgelawn Health Center and WNC Wellness Network.

# Areas of Opportunity for Community Health Improvement

The following “health priorities” represent recommended areas of intervention, based on the information gathered through this Community Health Assessment and the guidelines set forth in *Healthy People 2010*. From these data, significant opportunities for health improvement exist in Buncombe County with regard to the following:

- **Access to Health Care Services**
- **Cancer**
- **Chronic Disabling Conditions**
- **Family Planning, Teen Pregnancy & Infant Health**
- **Heart Disease & Stroke**
- **Mental Health & Substance Abuse**
- **Violent & Abusive Behavior**
- **Underlying Issues**

## Selecting Health Priorities

There are various mechanisms through which individual organizations may wish to identify priority areas, such as through community direction and feedback, through analyses of primary and secondary data, or through a combination of the two. Regardless of which mechanism is applied, a variety of criteria must be considered when identifying priority areas, and these are outlined below. Keep in mind that no single criterion determines a specific area of need. Rather, the interplay among the different criteria should be considered in identifying priority areas.

Furthermore, it is important to recognize two important facts: 1) that many local efforts are currently active in addressing aspects of several of the outlined issues; and 2) that no individual or organization acting alone can remedy all of the implications of a given issue or problem.

In identifying priorities for community action and designing strategies for implementation, a variety of criteria should be applied to the consideration process, including:

- **Impact.** The degree to which the issue affects or exacerbates other quality of life and health-related issues.
- **Magnitude.** The number of persons affected, also taking into account variance from benchmark data and Year 2010 targets.
- **Seriousness.** The degree to which the problem leads to death, disability or impairs one's quality of life.
- **Feasibility.** The ability of organizations to reasonably impact the issue, given available resources.
- **Consequences of Inaction.** The risk of exacerbating the problem by not addressing at the earliest opportunity.

The following section outlines potential health priorities and supporting health status and risk reduction data, accompanied by Perceptions Data. These areas of concern are presented in no particular order, and are subject to the discretion of area providers, the steering committee, or other local organizations and community leaders as to actionability and priority.

## Access to Health Care Services

The following table outlines the key data findings related to access to and use of clinical preventive services in Buncombe County. Also presented, where available, are Buncombe County 1995 findings, current North Carolina and U.S. levels, as well as available *Healthy People 2010* targets. Results of statistical testing for significance indicate whether Buncombe County 2000 compares favorably (+), compares unfavorably (-) or is similar to (=) the benchmark items. Any other applicable survey data, secondary data, or Perceptions Data are also used to supplement this summary.

Clinical Preventive Services	Buncombe County					Buncombe County 2000 versus:			
	2000	1995	NC	US	HP2010	1995	NC	US	HP2010
% Lack Health Insurance (18-64)	18.5	10.8	14.7	14.8	0	-	=	=	-
% Flu Shot in Past Yr (65+)	70.2	65.2	64.6	78.8	90	=	+	-	-
% Have Had Routine Checkup in Past Yr	68.1	69.7		63.8		=		=	
% Have a Regular Clinic or Physician	93.0	78.7		85.5	96	+		+	-
<b>Other Survey Findings:</b>									
<ul style="list-style-type: none"> <li>Among employed adults, 11.5% report that their employer does not offer health care insurance benefits. In the separate Latino Survey, this percentage is 46.0% among respondents.</li> </ul>									
<ul style="list-style-type: none"> <li>Among employed adults who do use their employer's health care coverage, 7.8% report that they are responsible for all of the premium cost.</li> </ul>									
<ul style="list-style-type: none"> <li>The proportion of adults under 65 who lack health care insurance coverage has increased significantly since 1995.</li> </ul>									
<ul style="list-style-type: none"> <li>More than one-half of local adults have no dental insurance coverage; among local parents, 37.1% do not have dental coverage for their children.</li> </ul>									
<ul style="list-style-type: none"> <li>In the Latino Survey, only 22.6% of respondents have a personal physician.</li> </ul>									
<ul style="list-style-type: none"> <li>In the past year, 13.1% of local adults needed dental care but did not receive it. Another 11.3% needed medical care but did not receive it, and 6.4% of county residents needed medications but did not obtain them.</li> </ul>									
<ul style="list-style-type: none"> <li>Inconvenient office hours was often the reason local adults did not obtain needed medical or dental care in the past year, as well as needed medications.</li> </ul>									
<ul style="list-style-type: none"> <li>One-fifth of county residents seek alternative care before they use conventional medical care; this increases to 31.5% of uninsured adults.</li> </ul>									
<b>Key Perceptions Data Findings:</b>									
<ul style="list-style-type: none"> <li>A significant share of the Perceptions Data related to problems with access to health care services. Some of the barriers identified include: cost of health services and medications; physician relationships; transportation; discrimination; language and cultural differences; and age.</li> </ul>									
<ul style="list-style-type: none"> <li>Unique barriers were discussed in the Perceptions Data as they relate to subgroups within the population, such as Latinos, immigrants, gays/lesbians, the impoverished, and the elderly.</li> </ul>									
<ul style="list-style-type: none"> <li>Access to mental health services, medications and dental care were among specific areas of concern.</li> </ul>									
<ul style="list-style-type: none"> <li>Transportation — both medical and public — surfaced in the Perceptions Data as a need in Buncombe County, especially for immigrant and minority populations, CNAs and home health workers, persons who are HIV-positive, the elderly and teens.</li> </ul>									

## Cancer

The following table outlines the key data findings related to cancer in Buncombe County. Also presented, where available, are Buncombe County 1995 findings, current North Carolina and U.S. levels, as well as available *Healthy People 2010* targets. Results of statistical testing for significance indicate whether Buncombe County 2000 compares favorably (+), compares unfavorably (-) or is similar to (=) the benchmark items. Any other applicable survey data, secondary data, or Perceptions Data are also used to supplement this summary.

Cancer	Buncombe County					Buncombe County 2000 versus:			
	2000	1995	NC	US	HP2010	1995	NC	US	HP2010
Age-Adjusted Breast Cancer Deaths/100,000	<b>33.3</b>	34.8	28.6	27.7	22.2	+	-	-	-
Age-Adjusted Lung Cancer Deaths/100,000	<b>58.3</b>	62.8	62.6	57.4	44.8	+	+	-	-
% Cancer (Other Than Skin)	<b>5.3</b>			3.9				=	
% "High" Fat Diet	<b>9.9</b>	9.8		11.2		=		=	
% Mammogram in Past 2 Yrs (W40+)	<b>74.8</b>	70.4		70.8	70	=		=	=
% Pap Smear in Past 3 Yrs (W)	<b>83.3</b>	85.2		84.5	90	=		=	-
% Current Smoker	<b>24.2</b>	24.3	25.9	24	12	=	=	=	-
Age-Adjusted Cancer Deaths/100,000	<b>198.4</b>	220.8	210.1	201.4	158.7	+	+	+	-
% Skin Cancer	<b>1.8</b>			3.8				+	
% Eat 5+ Servings of Fruit or Vegetables/Day	<b>37.8</b>		21.4	31.4			+	+	
<b>Other Survey Findings:</b>									
<ul style="list-style-type: none"> <li>According to the separate Latino Survey, just 38.9% of women respondents have had a mammogram at some point in their lives.</li> </ul>									
<ul style="list-style-type: none"> <li>Nearly one-half (48.1%) of uninsured adults currently smoke cigarettes.</li> </ul>									
<ul style="list-style-type: none"> <li>Nearly one-half (48.6%) of local adults live or work with someone who smokes near them.</li> </ul>									
<b>Other Secondary Data Findings:</b>									
<ul style="list-style-type: none"> <li>Cancers are the second-leading cause of death and accounted for 22.4% of all deaths between 1994 and 1998 in Buncombe County. Cancers are the leading cause of death among individuals aged 40 to 64.</li> </ul>									
<ul style="list-style-type: none"> <li>The <b>overall cancer death rate</b> in Buncombe County is 25% above the Healthy People 2010 target; the <b>female breast cancer</b> death rate is 50% above and the <b>lung cancer death</b> rate is 30% above the year 2010 goals. Female breast cancer death rates have been trending upward over the past two decades.</li> </ul>									
<ul style="list-style-type: none"> <li>Cancer death rates are higher among men (for cancers which are not gender-specific, such as lung cancer) and among nonwhites.</li> </ul>									
<ul style="list-style-type: none"> <li>More than one-half of all cancer deaths are attributed to <b>lung cancer</b> (29.5%), <b>colorectal cancer</b> (10.1%), <b>female breast cancer</b> (9.2%) or <b>prostate cancer</b> (6.8%).</li> </ul>									
<ul style="list-style-type: none"> <li>The Buncombe County 1995-97 incidence rate for female breast cancer (number of new cases each year per 100,000 population) is higher than the state incidence rate (158.3 vs. 144).</li> </ul>									

## Chronic Disabling Conditions

The following table outlines the key data findings related to chronic disabling conditions in Buncombe County. Also presented, where available, are Buncombe County 1995 findings, current North Carolina and U.S. levels, as well as available *Healthy People 2010* targets. Results of statistical testing for significance indicate whether Buncombe County 2000 compares favorably (+), compares unfavorably (-) or is similar (=) the benchmark items. Any other applicable survey data, secondary data, or Perceptions Data are also used to supplement this summary.

Chronic Disabling Conditions	Buncombe County					Buncombe County 2000 versus:			
	2000	1995	NC	US	HP2010	1995	NC	US	HP2010
Age-Adjusted HIV Deaths/100,000	11.7	5.7	10.1	4.9	0.8	-	-	-	-
% Diabetes/High Blood Sugar	10.2			6				-	
% "Fair" or "Poor" Physical Health	15.5	13.8	16.1	10.1		=	=	-	
% Arthritis/Rheumatism	23.5			19.2				-	
% No Leisure-Time Physical Activity	18.6	30.6	40.7	17		+	+	=	
Age-Adj Diabetes Mellitus Deaths/100,000	19.1	17.4	25.3	23.4		-	+	+	
AIDS Incidence/100,000	15.2		11.4	17.1			-	+	
<b>Other Survey Findings:</b>									
<ul style="list-style-type: none"> <li>• Indications of "fair" or "poor" health increase to 18.8% among women, to 32.2% among adults living at or near poverty, and to 27.5% of African-Americans. According to the Senior Survey, 53.3% of seniors respondents experience "fair" or "poor" physical health.</li> </ul>									
<ul style="list-style-type: none"> <li>• A total of 3 in 10 local adults have experienced a loss of vision or hearing.</li> </ul>									
<ul style="list-style-type: none"> <li>• Another 22.6% experience some type of chronic pain, such as backaches or headaches.</li> </ul>									
<b>Other Secondary Data Findings:</b>									
<ul style="list-style-type: none"> <li>• The incidence of AIDS in Buncombe County (15.2 cases per 100,000 population annually) is above the statewide rate (11.4).</li> </ul>									
<ul style="list-style-type: none"> <li>• The most costly hospitalizations in Buncombe County are for AIDS.</li> </ul>									
<b>Key Perceptions Data Findings:</b>									
<ul style="list-style-type: none"> <li>• Perceptions Data suggest a need for testing for earlier diagnosis, and eliminating the stigma of HIV.</li> </ul>									
<ul style="list-style-type: none"> <li>• Many of those interviewed in the Perceptions Data, regardless of their ethnic background, voiced awareness that hypertension, heart disease, and diabetes were high among African-American males.</li> </ul>									

## Family Planning, Teen Pregnancy & Infant Health

The following table outlines the key data findings related to family planning, teen pregnancy and infant health in Buncombe County. Also presented, where available, are Buncombe County 1995 findings, current North Carolina and U.S. levels, as well as available *Healthy People 2010* targets. Results of statistical testing for significance indicate whether Buncombe County 2000 compares favorably (+), compares unfavorably (-) or is similar to (=) the benchmark items. Any other applicable survey data, secondary data, or Perceptions Data are also used to supplement this summary.

Infant Health	Buncombe County					Buncombe County 2000 versus:			
	2000	1995	NC	US	HP2010	1995	NC	US	HP2010
Neonatal Death Rate	5.7	4.3	6.5	4.8	2.9	-	+	-	-
Infant Death Rate	7.9	5.1	9.4	7.2	4.5	-	+	-	-
% No Prenatal Care in 1st Trimester	7.7	10.0	16.9	10		+	+	+	
Adolescent Birth Rate (15-17)/1,000	56.0		60.9		46		+		-
% of Low Birthweight Births	8.3	8.0	8.8	7.5	5	-	+	-	-
<b>Other Secondary Data Findings:</b>									
<ul style="list-style-type: none"> <li>The proportions of mothers receiving timely prenatal care in Buncombe County are quite favorable, among both white and minority populations.</li> </ul>									
<ul style="list-style-type: none"> <li>However, 14.2% of minority births between 1994 and 1998 were of low birthweight. This is higher than the statewide proportion (13.2% among minority births), the Healthy Carolinians goal (10.4% or lower) and the Healthy People 2010 goal (5% or lower). Furthermore, a high 4.5% of African-American births in Buncombe County were of very low birthweight.</li> </ul>									
<ul style="list-style-type: none"> <li>While the overall adolescent pregnancy rate in Buncombe County is favorable in comparison to the statewide rate and goal, it remains above the Healthy People 2010 target. Furthermore, the adolescent pregnancy rate among minorities is quite high (108.6 pregnancies per 1,000 girls aged 15-17) in comparison to the state (93.0), Healthy Carolinians goal (86.7) and Healthy People 2010 target (46.0).</li> </ul>									
<ul style="list-style-type: none"> <li>Likewise, the 1998 adolescent fertility rate (births per 1,000 girls aged 15 to 19) was quite high among Buncombe County minority births (101.9) in comparison to the statewide minority rate (88.3).</li> </ul>									
<ul style="list-style-type: none"> <li>Between 1994 and 1998, one out of five births in Buncombe County (19.8%) was to a mother who smoked, higher than the 15.7% found statewide. Healthy People 2010 targets to reduce this percentage to less than 10% of births.</li> </ul>									
<ul style="list-style-type: none"> <li>Between 1993 and 1997, 73.5% of Buncombe County minority births were to unmarried women. A total of 29.4% were to women with less than a high school education, 24.2% were to women with a prior pregnancy termination, and 18.0% were to women with four or more prior births. Each of these proportions is higher than found among white births in Buncombe County.</li> </ul>									
<b>Key Perceptions Data Findings:</b>									
<ul style="list-style-type: none"> <li>Perceptions Data suggest specific needs for Latina mothers, especially as related to prenatal nutrition and stress.</li> </ul>									

## Heart Disease & Stroke

The following table outlines the key data findings related to heart disease and stroke in Buncombe County. Also presented, where available, are Buncombe County 1995 findings, current North Carolina and U.S. levels, as well as available *Healthy People 2010* targets. Results of statistical testing for significance indicate whether Buncombe County 2000 compares favorably (+), compares unfavorably (-) or is similar to (=) the benchmark items. Any other applicable survey data, secondary data, or Perceptions Data are also used to supplement this summary.

Heart Disease & Stroke	Buncombe County					Buncombe County 2000 versus:			
	2000	1995	NC	US	HP2010	1995	NC	US	HP2010
% Chronic Heart Disease	<b>9.9</b>			4.5				-	
% Told Have High Cholesterol	<b>28.0</b>	24.2	26.5	20.5	17	=	=	-	-
% Told Have High Blood Pressure	<b>28.8</b>	26.5	23.3	23.2	16	=	-	-	-
% Moderate Physical Activity	<b>18.3</b>		18.5	39.1	30		=	-	-
Age-Adjusted Stroke Deaths/100,000	<b>68.3</b>	66.5	78.0	60	48	-	+	-	-
% "High" Fat Diet	<b>9.9</b>	9.8		11.2		=		=	
% No Leisure-Time Physical Activity	<b>18.6</b>	30.6	40.7	17		+	+	=	
% Vigorous Physical Activity	<b>38.0</b>		11.6	36.4	30		+	=	+
% Overweight (old definition)	<b>33.3</b>	23.5	32.4	35.6		-	=	=	
% Overweight Trying to Lose	<b>52.5</b>	55.8		55.1		=		=	
% Taking Action to Control High Cholesterol	<b>63.8</b>			61.6				=	
% 1+ Cardiovascular Risk Factor	<b>84.2</b>	75.0		82.5		-		=	
% Blood Pressure Checked in Past 2 Yrs	<b>96.0</b>	93.2	93.9	95	95	=	=	=	=
% Current Smoker	<b>24.2</b>	24.3	25.9	24	12	=	=	=	-
% Obese (revised definition)	<b>20.6</b>	14.2	18.3	20.6	15	-	=	=	-
Age-Adj Coronary Heart Dis Deaths/100,000	<b>188.3</b>			215.9	166			+	-
% Overweight (revised definition)	<b>51.7</b>	45.2	53.9	60.1		-	=	+	
% Cholesterol Checked in Past 5 Yrs	<b>89.9</b>	78.3	72.1	79.2	80	+	+	+	+
% Unhealthy Weight (BMI <18.5 or 25+)	<b>55.1</b>	49.4	53.9	63.1	40	-	=	+	-

<b>Other Survey Findings:</b>
<ul style="list-style-type: none"> <li>• The proportion of adults who self-report eating “low-fat” diets has decreased significantly since 1995 (from 40.1% to 33.9%).</li> </ul>
<ul style="list-style-type: none"> <li>• Lack of leisure-time physical activity increases to 32.8% among African-Americans.</li> </ul>
<ul style="list-style-type: none"> <li>• In the Latino Survey, 44.4% of respondents had no leisure-time physical activity in the past month.</li> </ul>
<ul style="list-style-type: none"> <li>• A full 57.8% of local men are overweight, compared to 46.1% of local women. In a related finding, the proportion of adults who are at an “unhealthy” weight has increased significantly since 1995 (55.1% vs. 49.4%).</li> </ul>
<ul style="list-style-type: none"> <li>• Nearly one-half (48.1%) of uninsured adults currently smoke cigarettes.</li> </ul>
<ul style="list-style-type: none"> <li>• Nearly one-half (48.6%) of local adults live or work with someone who smokes near them.</li> </ul>
<ul style="list-style-type: none"> <li>• In the Latino Survey, a full 59.6% of respondents have never had their blood cholesterol checked.</li> </ul>
<b>Other Secondary Data Findings:</b>
<ul style="list-style-type: none"> <li>• Heart disease is the leading causes of death in Buncombe County (accounting for 29.6% of deaths in 1994-98). Stroke is the third leading cause (7.9%).</li> </ul>
<ul style="list-style-type: none"> <li>• While the 1994-98 age-adjusted death rate for coronary heart disease in Buncombe County (188.3 per 100,000) is below the national rate (215.9), it fails to satisfy the Healthy People 2010 goal (166.0). The stroke death rate (68.3) is above the national rate (60.0) and Healthy People 2010 goal (48.0), although below the statewide rate (78.0). Over the past two decades, deaths from heart disease and stroke have declined.</li> </ul>
<ul style="list-style-type: none"> <li>• Heart disease death rates are considerably higher among men and among nonwhites. Stroke death rates are fairly even between men and women, but are notably higher among nonwhites when compared with whites.</li> </ul>
<ul style="list-style-type: none"> <li>• Heart disease accounts for the greatest number of hospitalizations, and the longest hospital stays in Buncombe County. The average hospital charge per heart disease case is second only to AIDS.</li> </ul>

## Mental Health & Substance Abuse

The following table outlines the key data findings related to mental health and substance abuse in Buncombe County. Also presented, where available, are Buncombe County 1995 findings, current North Carolina and U.S. levels, as well as available *Healthy People 2010* targets. Results of statistical testing for significance indicate whether Buncombe County 2000 compares favorably (+), compares unfavorably (-) or is similar to (=) the benchmark items. Any other applicable survey data, secondary data, or Perceptions Data are also used to supplement this summary.

Mental Health & Substance Abuse	Buncombe County					Buncombe County 2000 versus:			
	2000	1995	NC	US	HP2010	1995	NC	US	HP2010
Age-Adjusted Suicide Deaths/100,000	<b>14.7</b>	14.8	12.0	10.8	6	+	-	-	-
Age-Adj Cirrhosis/Liver Dis Deaths/100,000	<b>11.4</b>	12.2	9.5	9.6		+	-	-	
% Depressed Persons Seeking Help	<b>30.5</b>	28.8		33.3	50	+		=	-
% Chronic Drinker	<b>3.9</b>	4.6	2.7	4.6		=	=	=	
% Depression (2+ Wks)	<b>22.0</b>	20.8				=			
% Binge Drinker	<b>10.4</b>	11.2	9.0	16.3	6	=	=	+	-
% Current Drinker	<b>43.9</b>	46.5	37.0	55.8	50	=	-	+	+
<b>Other Survey Findings:</b>									
<ul style="list-style-type: none"> <li>The proportion of adults experiencing at least two weeks of depression increases to 32.2% among uninsured residents, to 35.6% among adults living below the 200% poverty threshold, and to 34.6% of African-Americans.</li> <li>In the Senior Survey, 22.5% of senior respondents feel "worthless," and 18.7% report that their lives are "empty." Another 10.8% feel that their personal situation is "hopeless," and 8.0% are afraid that "something bad is going to happen" to them.</li> <li>Among those who say that there was a time in the past year when they wanted mental health care or counseling, but did not get it at that time, one-half tried to get care but were unsuccessful. Reasons included cost, fear or embarrassment, and difficulty in scheduling an appointment.</li> </ul>									
<b>Other Secondary Data Findings:</b>									
<ul style="list-style-type: none"> <li>Hospitalization rates for mental disorders in Buncombe County exceed state rates by 27%.</li> <li>Buncombe County's age-adjusted suicide rate (14.7 per 100,000 population) is higher than both state (12.0) and national (10.8) rates, and more than twice the goal for the year 2010 (6.0 or fewer).</li> <li>Hospitalization rates for substance abuse in Buncombe County exceed state rates by 28%. Medicaid costs for a single hospitalization for substance abuse and/or mental disorder average \$4,577 per case in Buncombe County, 14% above the state average.</li> </ul>									

**Key Perceptions Data Findings:**

- Some of those interviewed in the Perceptions Data see a great need for mental health services in Asheville and Buncombe County.
- Perceptions Data suggest that illegal drug use and sales are major problems in our area. Drug-related crime and violence was the number-one health concern mentioned by the majority of Key Informants. Drug and substance abuse followed very closely as the second major health risk in the community at large, and many times the two issues overlapped.
- Perceptions Data pointed out that substance abuse and sexuality issues are key concerns for Buncombe County youth.

## Violent & Abusive Behavior

The following table outlines the key data findings related to violence in Buncombe County. Also presented, where available, are Buncombe County 1995 findings, current North Carolina and U.S. levels, as well as available *Healthy People 2010* targets. Results of statistical testing for significance indicate whether Buncombe County 2000 compares favorably (+), compares unfavorably (-) or is similar to (=) the benchmark items. Any other applicable survey data, secondary data, or Perceptions Data are also used to supplement this summary.

Violent & Abusive Behavior	Buncombe County					Buncombe County 2000 versus:			
	2000	1995	NC	US	HP2010	1995	NC	US	HP2010
Age-Adjusted Suicide Deaths/100,000	<b>14.7</b>	14.8	12.0	10.8	6	+	-	-	-
Age-Adjusted Homicide Deaths/100,000	<b>7.8</b>	7.4	9.3	6.2	3.2	-	+	-	-
Violent Crime Rate/100,000	<b>487.1</b>	343.4	591.8	566.4		-	+	+	
<b>Survey Findings:</b>									
<ul style="list-style-type: none"> <li>10.8% of Buncombe County adults acknowledge having been punched, kicked, or otherwise hurt by a family member or someone close to them at some time in the past. A total of 1.9% report this occurring in the past year. Victimization was highest among lower-income and uninsured persons, also among respondents to the Latino survey.</li> </ul>									
<b>Secondary Data Findings:</b>									
<ul style="list-style-type: none"> <li>Although still below statewide and nationwide rates, violent crime has increased somewhat in Buncombe County over the past several years (from 343.4 violent crimes per 100,000 population in 1993 to 487.1 in 1998). Statewide and nationwide, these rates have declined during this period.</li> <li>Buncombe County experiences a high rate of child abuse and neglect reports (106.7 per 1,000 children in fiscal year 1997-98; this compares to a rate of only 71.1 statewide).</li> </ul>									
<b>Perceptions Data Findings:</b>									
<ul style="list-style-type: none"> <li>Drug-related crime and violence was the number-one health concern mentioned by the majority of Key Informants.</li> <li>Some Key Informants characterized violence as the physical manifestation of underlying feelings of hopelessness or frustration.</li> <li>Those participating in the Perceptions Data see the incidence of violence in area schools as being more prevalent in city schools than in county schools. However, the general feeling was that the schools in our community are safe.</li> </ul>									

## Underlying Issues

Inequalities in income and education underlie many health disparities in the United States. In general, population groups that suffer the worst health status are also those that have the highest poverty rates and least education. Disparities in income and education levels are associated with differences in the occurrence of illness and death, including heart disease, diabetes, obesity, elevated blood lead level, and low birth weight. Furthermore, higher incomes permit increased access to medical care, enable one to afford better housing and live in safer neighborhoods, and increase the opportunity to engage in health-promoting behaviors.<sup>1</sup>

In addition, environmental factors play a central role in human development, health, and disease. Many chronic conditions are long term and are affected by the environment where people live, work, and play. Human exposures to hazardous agents in the air, water, soil, and food, and to physical hazards in the environment are major contributors to illness, disability and death. Broadly defined, the environment, including infectious agents, is one of three primary factors that affect human health (the other two are behavior/lifestyle and genetics).<sup>2</sup>

With these underlying issues in mind, achieving health equity requires a multidisciplinary approach that involves improving health, education, housing, labor, justice, transportation, and the environment. Our greatest opportunities for reducing health disparities are in empowering individuals to make informed health care decisions and in promoting communitywide safety, education, and access to health care.<sup>3</sup>

The following table outlines the key data findings related to some of the underlying issues impacting health and quality of life in Buncombe County. Also presented, where available, are Buncombe County 1995 findings, current North Carolina and U.S. levels, as well as available *Healthy People 2010* targets. Results of statistical testing for significance indicate whether Buncombe County 2000 compares favorably (+), compares unfavorably (-) or is similar to (=) the benchmark items. Any other applicable Perceptions Data are also used to supplement this summary.

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<sup>1</sup> U.S. Department of Health and Human Services. *Healthy People 2010* (Conference Edition, in Two Volumes). Washington, DC: January 2000.

<sup>2</sup> Ibid.

<sup>3</sup> Ibid.

Underlying Issues	Buncombe County					Buncombe County 2000 versus:			
	2000	1995	NC	US	HP2010	1995	NC	US	HP2010
% Children 0-5 in Poverty	18.3		18.7				=		
% Household Income <\$20,000	26.7								
Mean Income: 2-Parent Family	\$42,093		\$43,462				-		
Mean Income: 1-Parent, Female Head	\$14,779		\$14,802				=		
Annual Average Wage	\$25,872		\$28,004				-		
% Homes Affordable to Median Income	56.3			64.4				-	
Unemployment Rate	2.0		2.7				+		
Manufacturing as % of Total Employment	18.4		23.0				-		
% Lack Health Insurance (18-64)	18.5	10.8	14.7	14.8	0	-	=	=	-
% 25+ Without High School Diploma	18.9								
% Students Passing End-of-Grade Tests Buncombe County Schools	82.5		75.0				+		
% Students Passing End-of-Grade Tests Asheville City Schools	72.3		75.0				-		
Average Combined SAT Scores Buncombe County Schools	1056		986	1016			+	+	
Average Combined SAT Scores Asheville City Schools	1069		986	1016			+	+	
% Adults Level I Literacy Proficiency	18		22				+		
% Adults Level I or II Literacy Proficiency	45		52				+		
% "Moderate/Poor" Air Quality Days	46	22				-			
% "Poor" Environmental Water Samples	42.9								
<b>Perceptions Data Findings:</b>									
<ul style="list-style-type: none"> <li>• A significant share of the Perceptions Data related to problems with access to health care services. Some of the barriers identified include: cost of health services and medications; physician relationships; transportation; discrimination; language and cultural differences; and age.</li> </ul>									
<ul style="list-style-type: none"> <li>• Key Informants pointed out that there are many who are struggling financially in Buncombe County, and emphasized the gap between those doing very well financially and those doing very poorly.</li> </ul>									
<ul style="list-style-type: none"> <li>• The Perceptions Data revealed that low-income people of all backgrounds often face the same issues: working too many jobs for too little income (often for no benefits and with no reserve income), little food and shelter, difficulties with transportation, and little time with the families they are raising.</li> </ul>									
<ul style="list-style-type: none"> <li>• Concerns about satisfactory housing related to issues of economic disparity and an aging and increasingly frail elderly population in Buncombe County.</li> </ul>									
<ul style="list-style-type: none"> <li>• In the Perceptions Data, there was a consistent outcry regarding the proliferation of low-paying service industry jobs as opposed to higher-paying technical and professional jobs which would better enable workers to support families.</li> </ul>									
<ul style="list-style-type: none"> <li>• Air quality was cited as an issue related to health problems such as allergies and lung disease.</li> </ul>									

# INTRODUCTION

# Project Overview

## Community Health Improvement Goals

*The Health of Buncombe County 2000* project is a follow-up to a similar comprehensive Community Health Assessment project conducted in 1995. A Community Health Assessment is a systemic, data-driven approach to determining the health status, behaviors and needs of residents in a defined geographical region. Subsequently, this information may be used to formulate strategies to improve community health and wellness.

A Community Health Assessment provides the data necessary to identify the issues of greatest concern for the community. This allows local organizations to appropriately allocate resources to make the greatest possible impact on community health status. This Community Health Assessment will serve as a tool toward reaching three basic goals:

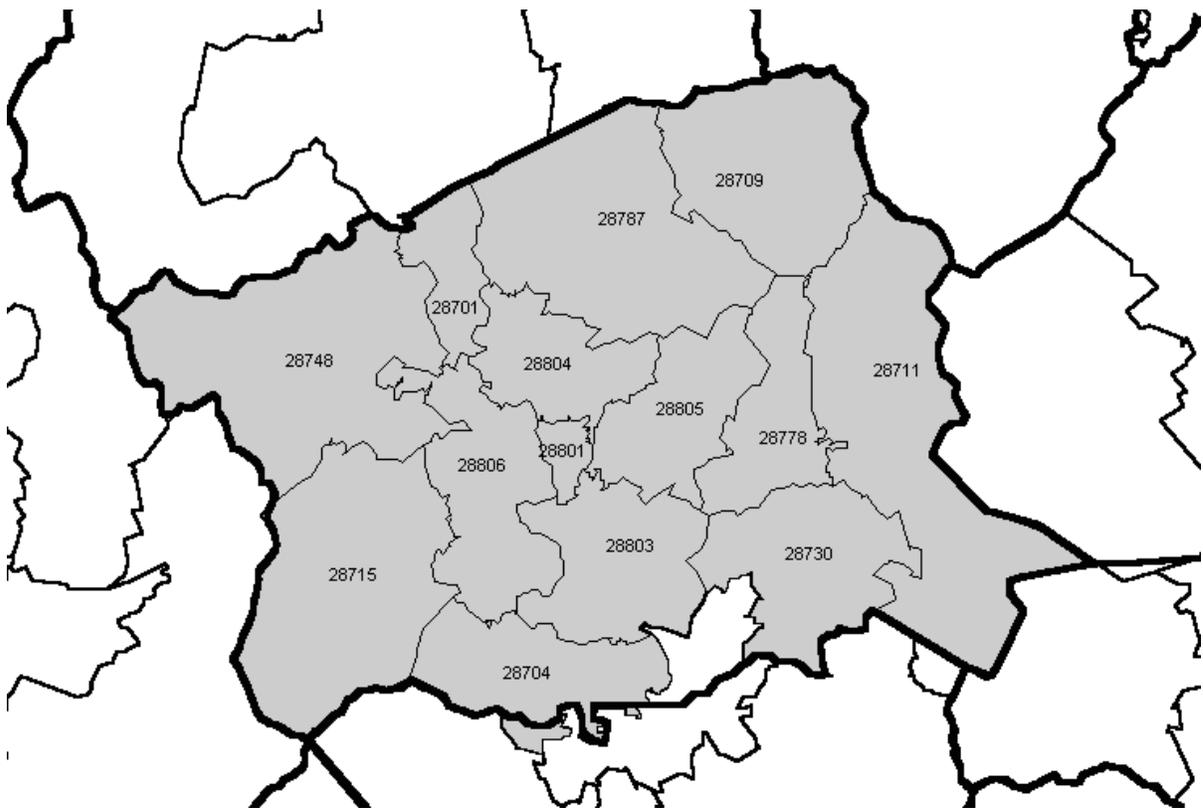
- **To improve residents' health status, increase their life spans, and elevate their overall quality of life.** A healthy community is not only one where its residents suffer little from physical and mental illness, but also one where its residents enjoy a high quality of life.
- **To reduce the health disparities among residents.** By gathering demographic information along with health status and behavior data, it will be possible to identify population segments that are most at-risk for various diseases and injuries. Intervention plans aimed at targeting these individuals may then be developed to combat some of the socio-economic factors which have historically had a negative impact on residents' health.
- **To increase accessibility to preventive services for all community residents.** More accessible preventive services will prove beneficial in accomplishing the first goal (improving health status, increasing life spans, and elevating the quality of life), as well as lowering the costs associated with caring for late-stage diseases resulting from a lack of preventive care.
- **To acknowledge the underlying issues that contribute to diminished health and quality of life among residents.** Societal, economic and environmental issues and circumstances exert a certain impact on the health and quality of life of Buncombe County residents. It is important to recognize that these are often the root causes of the health disparities outlined in this report.



## Community Defined for This Assessment

The “community” defined for this assessment includes each of the ZIP Codes comprising Buncombe County, North Carolina. These include ZIP Codes 28701, 28704, 28709, 28711, 28715, 28730, 28748, 28778, 28787, 28801, 28803, 28804, 28805, and 28806.

The following map portrays this geographical definition.



# Methodology

The components employed to render a complete picture of the health of Buncombe County include: the community health survey and special population surveys (primary quantitative data); existing data (secondary quantitative data); and community Perceptions Data (primary qualitative data).

- The **PRC Community Health Survey** developed for Buncombe County gives us a remarkably complete and accurate view of the health status of area residents through a randomized telephone survey of the health and behaviors of community members.
- **Special Population Surveys** used in this assessment include the *Buncombe County Senior Survey* and the *Buncombe County Latino Survey*. Each of these written surveys were administered one-on-one to these special populations in order to augment their input to this process.
- **Existing data** — especially public health data and statewide and nationwide risk assessments — complement the survey process and, in some cases, provide a benchmark against which the results of the survey may be compared.
- **Perceptions Data** offer a unique perspective by gathering language-based input from both citizens and Key Informants within the community.

## Community Health Survey

A precise and carefully executed methodology is critical in asserting the validity of the results gathered in the **2000 PRC Community Health Survey**. Thus, to ensure the best representation of the population surveyed, a telephone interview methodology was employed. The primary advantages of telephone interviewing are timeliness, efficiency and random selection capabilities.

### Sample Design

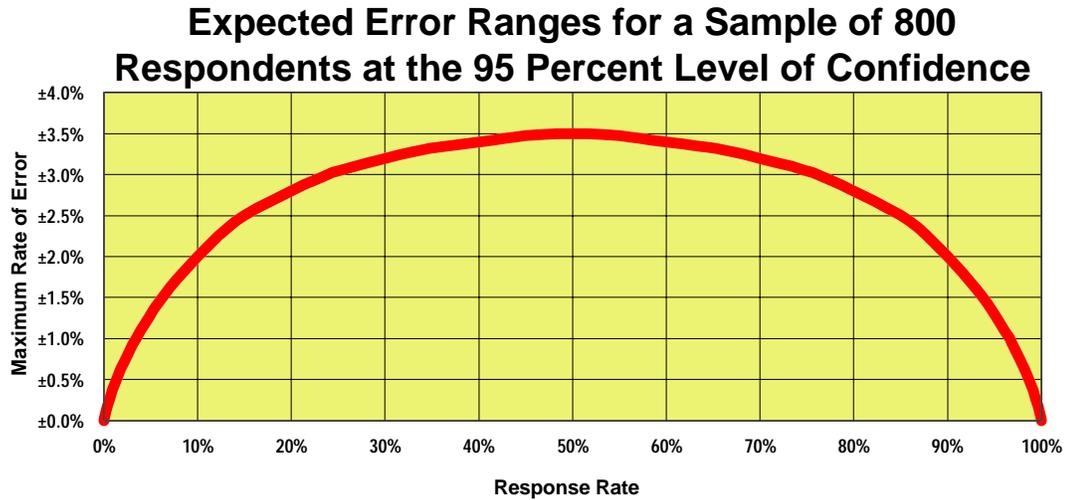
The sample design utilized for this effort consists of a random sample of 800 individuals aged 18 and older in Buncombe County. Once these data were collected, the sample was weighted in proportion to the actual population distribution at the ZIP Code level. Population estimates were based on the latest census projections of adults aged 18 and over provided in the *2000/2000 CACI Census Update*.



All administration of the surveys, data collection and data analysis was conducted by Professional Research Consultants, Inc. (PRC).

### Sampling Error

For statistical purposes, the maximum rate of error associated with a sample size of 800 respondents is  $\pm 3.5\%$  at the 95 percent level of confidence.



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

Example 1: For example, if 10% of the sample of 800 respondents answered a certain question with a "yes," it can be asserted that between 8.0% and 12.0% ( $10\% \pm 2.0\%$ ) of the total population would offer this response.

Example 2: If 50% of respondents said "yes," one could be certain with a 95 percent level of confidence that between 46.5% and 53.5% ( $50\% \pm 3.5\%$ ) of the total population would respond "yes" if asked this question.

Among smaller subsamples of the population, however, the corresponding sampling error varies according to the sample size. The following chart outlines the survey samples and maximum error rates corresponding to various demographic segments of the population. Note that some categories may not add to the total number of interviews due to non-response/non-classification.

Population Segment	Survey Sample (n=)	Maximum Rate of Error at the 95% Confidence
Men	378	$\pm 5.0\%$
Women	502	$\pm 4.3\%$
18 to 39	233	$\pm 6.4\%$
40 to 64	389	$\pm 4.9\%$
65 and Older	244	$\pm 6.2\%$
Insured	769	$\pm 3.4\%$
Uninsured	111	$\pm 9.3\%$
<200% Poverty	205	$\pm 6.8\%$
$\geq 200\%+$ Poverty	499	$\pm 4.3\%$
White	726	$\pm 3.5\%$
African-American	115	$\pm 9.1\%$

In addition, for further analysis, keep in mind that each percentage point recorded among the total sample of survey respondents is representative of approximately 1,500 residents aged 18 and older in Buncombe County (based on current population estimates). Thus, in a case where 3.4% of the total population responds to a survey question, this is representative of more than 4,000 people and therefore must not be dismissed as too small to be significant.

The sample design and the quality control procedures used in the data collection ensure that the sample is representative. Thus, the findings may be generalized to the total population of community members in Buncombe County with a high degree of confidence.

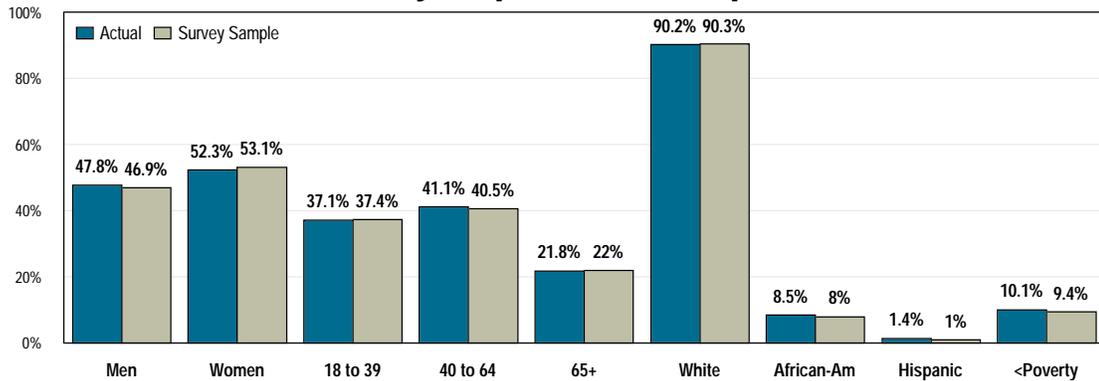
In addition, for comparative purposes of the study, results from the *1995 PRC Community Health Assessment* survey conducted for Buncombe County are presented where possible and applicable throughout the report.

### Sample Characteristics

To accurately represent the population studied, it was necessary to constantly monitor the demographic composition (e.g., age, gender, household location) of the community sample throughout the data collection process. PRC strives to minimize bias through application of a proven telephone methodology and random-selection techniques. And, while this random sampling of the population produces a highly representative sample, it is a common and preferred practice to “weight” the raw data to improve this representativeness even further. This is accomplished by adjusting the results of a random sample to match the demographic characteristics of the population surveyed, so as to eliminate any naturally occurring bias. Specifically, once the raw data are gathered, respondents are examined by key demographic characteristics (namely gender, age, race, ethnicity, income and ZIP Code) and a statistical application package applies weighting variables which produce a sample which more closely matches the population for these characteristics. Thus, while the integrity of each individual’s responses is maintained, one respondent’s responses may contribute to the whole the same weight as 1.1 respondents. Another respondent, whose demographic characteristics may have been slightly oversampled, may contribute the same weight as 0.9 respondents.

The following chart outlines the characteristics of the sample for key demographic variables, compared to actual population characteristics revealed in census data. [Note that the sample consisted solely of area residents aged 18 and older; data on children were given by proxy by the person most responsible for that child’s health care needs, and these children are not represented demographically in this chart.]

## Buncombe County Population/Sample Characteristics



Sources: 1. CACI 2000 Census Update.  
2. 2000 PRC Community Health Survey, Professional Research Consultants

Further note that the poverty descriptions and segmentation used in this report are based on 1999 administrative poverty thresholds determined by the U.S. Department of Health & Human Services. These guidelines define poverty status by household income level and number of persons in the household (e.g., the 1998 guidelines place the poverty threshold for a family of four at \$16,950 annual household income or lower). In sample segmentation: “<200% Poverty” refers to community members living in a household with defined poverty status combined with those households living just above the poverty level, earning up to twice the poverty threshold; and “>200% Poverty” refers to households with incomes more than twice the poverty threshold defined for their household size.

### Oversampling of African-Americans

In addition to the random sample of 800 adults in Buncombe County, PRC conducted an oversample of 80 telephone survey interviews with African-American respondents. This was done so as to augment the reliability of results obtained from this important population (which, in a strictly proportional sample, represents a relatively small percentage of the sample). Thus, in addition to the 35 African-American respondents naturally occurring in the random sample of 800 adults, an additional 80 interviews brought the total completions to 115 African-Americans participating in this survey.

Because this was an “oversample” of the population, these added interviews were then “weighted” back into the sample of 800 (similar to the weighting described above), so as not to unduly impact the whole (i.e., weighted back to the actual proportion of African-Americans in the Buncombe County adult population). When considering survey responses by race, however, the segment of African-Americans retains the reliability of the full 115 interviews.

## Special Population Surveys

### Latino Survey

To augment input from the Latino community, this assessment process included the *2000 Buncombe County Latino Survey*, a separate survey (similar to the phone survey) which was administered one-on-one by various Buncombe County organization representatives among a convenience sample of 92 local Latinos. The maximum error rate associated with a sample of this size is  $\pm 10.2\%$  at the 95 percent confidence level.

When interpreting and comparing results, it is important to note that the Latino survey, unlike the countywide telephone survey, was not administered among a random sample of community members.

The findings from this survey are outlined throughout this report, and summarized in the “Needs of Special Populations” section (page 284).

### Senior Survey

This process also paid special attention to the local senior population to better understand the health and related issues of this specialized, often health resource-intensive population. To do this, a specialized, shortened survey tool, the *2000 Buncombe County Senior Survey*, was used for face-to-face interviews with 75 residents aged 65 and older. The maximum error rate associated with a sample of this size is  $\pm 11.3\%$  at the 95 percent confidence level.

The sampling was one of convenience and included clients of Meals-on-Wheels, that is, those who were, in addition to being 65 years of age or older, also homebound, most with multiple disease processes. Sampling also occurred within a senior housing complex.

The findings from this survey are summarized in the “Needs of Special Populations” section (page 269).

## Existing Data

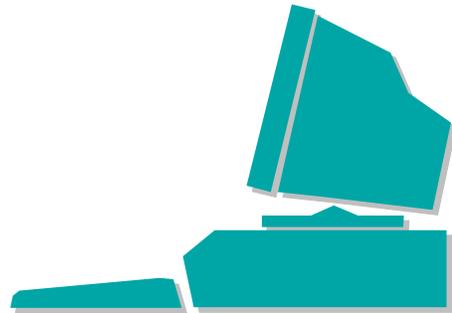
### Public Health, Vital Statistics and Other Data

A variety of existing (secondary) data sources was consulted to complement the research quality of this Community Health Assessment. Data were obtained from the following sources (specific citations are included with the graphs throughout this report):

- *Buncombe County Government*
- *CACI 2000/2000 Census Update*
- *North Carolina Department of Commerce*
- *State Center for Health Statistics, North Carolina Department of Health & Human Services*
- *US Census Bureau*
- *Vision for Asheville-Buncombe County*

### Statewide Risk Factor Data

Statewide risk factor data are provided where available as an additional benchmark against which to compare local findings. These data are reported in the *1998 BRFSS (Behavioral Risk Factor Surveillance System) Summary Prevalence Report* published by the Centers for Disease Control and Prevention and the U.S. Department of Health & Human Services. It should be noted, however, that individual state health departments are responsible for the administration and oversight of the BRFSS project; PRC can vouch for neither their methodological correctness nor the validity of state findings.



### Nationwide Risk Factor Data

Nationwide risk factor data, which are also provided in comparison charts, are taken from the *2000 PRC National Health Survey*. The methodological approach for the national study is identical to that employed in this assessment. Therefore, PRC assures that these data may be generalized to the U.S. population with a high degree of confidence.

## Healthy People 2010 Goals

*Healthy People 2010: Understanding and Improving Health* is part of the Healthy People 2010 initiative that is sponsored by the U. S. Department of Health and Human Services. Healthy People 2010 outlines a comprehensive, nationwide health promotion and disease prevention agenda. It is designed to serve as a roadmap for improving the health of all people in the United States during the first decade of the 21st century.



With [specific] health objectives in 28 focus areas, Healthy People 2010 will be a tremendously valuable asset to health planners, medical practitioners, educators, elected officials, and all of us who work to improve health. Healthy People 2010 reflects the very best in public health planning-it is comprehensive, it was created by a broad coalition of experts from many sectors, it has been designed to measure progress over time, and, most important, it clearly lays out an series of objectives to bring better health to all people in this country. - Donna E. Shalala, Secretary of Health & Human Services

Like the preceding Healthy People 2000 initiative, Healthy People 2010 is also intended to be an ambitious, yet achievable, 10-year strategy for improving the Nation's health. Healthy People 2010 is committed to a single, overarching purpose: promoting health and preventing illness, disability, and premature death.

## Healthy Carolinians Goals

Similarly, *Healthy Carolinians* is "a vision of health and safety for communities in North Carolina beyond the Year 2000."



Healthy Carolinians is a process that results in community-based partnerships to improve the health of North Carolinians. This process is based on the concept that community members are the most qualified to effectively prioritize the health and safety problems in their community and to plan and execute creative solutions to these problems.

## Perceptions Data

### Rationale

Health education research and practice have found that personal health behaviors are related to individual perceptions of need. Further, personal health risks and behaviors are related to conditions found in one's immediate physical and social environment.

Cultural, political and economic conditions can exert important influences on individuals' ability to act on the basis of need. While the quantitative health research phase of this project can adequately appraise community health needs, the qualitative Perceptions Data phase can reveal how community members believe those needs could best be met with existing resources. Thus, in order to gain community-based information, a qualitative study of the perceptions of community members was conducted as part of this assessment.

### Approach

The method of qualitative data collection and analysis chosen is as solution-oriented as it is problem-oriented, providing ample opportunity for interweaving data interpretation with techniques for organizing collective action.

A team of seven community researchers, referred to as the Perceptions Team, was established to conduct one-on-one interviews with area Key Informants to provide the Perceptions Data presented in this report. A total of 38 Key Informant interviews were conducted by trained members of the Perceptions Team. This team includes four Health Educators from Buncombe County Health Center, two Family Nurse Practitioners from Mission St. Joseph's Health System and a Social Worker working with a children's advocacy group (Children First). The goal of the Perceptions Team was to uncover perceptions of existing community conditions, skills, and resources that can serve as the basis for possible future interventions. The personal interaction occurring in Key Informant interviews between the community-based health agency and the formal/informal community leader provides a unique opportunity to build the rapport necessary for successful action planning and sustainable interventions.

An interview tool was adapted from MESH, Lehigh Valley Hospital, Rider Pool Trust, L. Dawson. The interview tool provided access to underlying issues that relate to the health of the community as a whole, as well as those socio-ecological factors that contribute the to personal health risks and behaviors.

## Key Informant & Community Member Identification

Key Informants were chosen initially through brainstorming within the Strategic Planning Group. Obvious candidates were identified as gatekeepers from several priority sub-populations, selected based on feedback received from the 1995 survey and from demand within the community. These sub-populations are: African-Americans, Older Adults, Latinos and Immigrants, and Youth.

The Key Informant candidate list was broadened by asking initial gatekeepers for contacts who would act as a rich source of community perceptions. These formal and informal leaders who work with or in some way represent these sub-populations were then asked to participate in gathering or providing Perceptions Data. An effort was made to interview people who had been in direct contact with the communities of interest for several years.

The Key Informants were contacted first and each was also asked to provide the name of a Community Member who might be willing to be interviewed based on their own life experience as a member of these sub-populations or communities. In this way, the perceptions of average citizens were weighted as heavily in the data analysis process as were those of community leaders.

## Data Collection

The average interview time was 1.5 hours with a range of 45 minutes to 2.5 hours. While the interviews were audio taped, Key informants were guaranteed anonymity. The audio tapes were transcribed by a professional medical transcription service. The interviewer then analyzed the written copies of the interviews. A common sense approach to qualitative data analysis was used based on a coding system previously developed by PRC.

Each transcribed interview was analyzed by the perceptions team and comments were placed within a theoretical framework of the four components derived from the Assessment Model: Health, Status/Risk Factors, Utilization of Resources and Capacity, Barriers to Access of Health Services, and Community Assets and Resources. During the final analysis, two of the four components, Utilization of Resources and Barriers to Access of Health Services were combined into one component herein entitled Barriers to Access of Health Services. No attribution was assigned to the quotes to ensure anonymity. Rather, each quote was placed within a context that informed the original intention of its author.

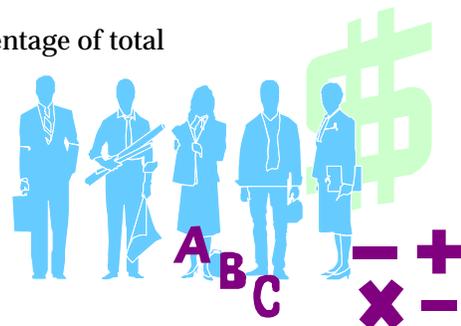
# **BUNCOMBE COUNTY AT A GLANCE**

# Fast Facts

## Overview of the Findings: Buncombe County at a Glance

### Underlying Issues

- 18.9% of Buncombe County adults aged 25 and older do not have a high school diploma. 50.1% are high school graduates, and 31.0% have received postsecondary degrees.
- 82.5% of school children in grades 3 through 8 in Buncombe County schools and 72.3% in Asheville City schools passed end-of-year tests in reading and math during the 1998-99 school year. However, there was a wide discrepancy in the proportions of White students and the proportions of African-American and Latino students passing these tests.
- Regarding adult literacy, it is estimated that 24% of Asheville City adults and 18% of Buncombe County adults demonstrate the lowest level of proficiency. Those adults who score at Level I have difficulty performing such everyday tasks as locating an intersection on a street map, reading and comprehending a short newspaper article, or calculating total costs on an order form.
- Annual average wages in Buncombe County in 1998 were below the state average, and only 39.3% of Buncombe County workers earned over the state average.
- The 1990 mean income of two-parent families in Buncombe County was \$42,093, slightly less than the state mean. For single-parent, female-headed families, the county's mean income was only \$14,779.
- In 1998, nearly 20% of Buncombe County children aged 5 and under lived in poverty. One out of four single-parent families lived in poverty.
- The top industries in terms of numbers of employees in Buncombe County are retail trade, the manufacture of non-durable goods, and health services. The largest net increase in jobs is expected in the health services industry.
- As found statewide, manufacturing as a percentage of total employment has consistently declined in Buncombe County over the past several years.



-  The unemployment rate in Buncombe County is low (2.0% in April 2000). This rate has remained below state and national rates as it has continued to decrease over the past decade.
-  However, Perceptions Data cite a proliferation of low-paying service industry jobs, as opposed to higher-paying technical and professional jobs which would better enable workers to support families.
-  Ratings of air quality and the water quality of Buncombe County's rivers, lakes and streams have declined considerably in the past few years.
-  Perceptions Data point out that air quality has certain impact on the health of residents.

## Buncombe County at a Glance

### *Demographic Profile*

-  The 1997 Buncombe County population was estimated at 192,997. This is expected to increase 13.7% by the year 2007 to 219,452.
-  The 1997 population was made up of 21.7% children (0-17); 39.1% aged 18 to 44; 23.3% aged 45 to 64; and 16.8% aged 65 and older. The largest segment, 18- to 44-year olds, is expected to increase 28.7% by the year 2007.
-  The county is predominantly white (90.6%), with an 8.5% African-American population. Hispanic community members make up approximately 1% of the population. While minority populations will grow considerably, these proportions are expected to be similar in the year 2007.

### *Housing*

-  In 1999, only 56.3% of homes were considered to be affordable to the median income family in the Asheville MSA (Buncombe and Madison Counties). This compares to 64.4% nationwide.
-  Perceptions Data suggest that affordable housing is a significant need in Buncombe County, particularly for minority and senior populations.

### *Transportation*

-  While use of public transit is up, transportation — both public and medical — is seen as a real need according to the Perceptions Data.

### *Medical Service Providers & Facilities*

-  Perceptions of local health care are generally positive, including Buncombe County Health Center and MSJ Health Systems. Still, Perceptions Data stress continued efforts to be sensitive to the needs of those of different socio-economic or cultural backgrounds.

-  In Buncombe County, there is one primary care physician for every 889 residents; this ratio is more favorable than found statewide (1:1,281). Further, there is one dentist for every 2,012 residents (again more favorable than the 1:2,495 statewide).

### ***Community-Based Health Promotion Services***

-  Several community-based health promotion services have been put into place in our community, including: Project ACCESS; school health and school nurse services; Mission St. Joseph's Community Outreach Care Clinics, Mobile Services, Parish Nursing, Medical Assistance, and Mobile Mammography; Asheville Buncombe Community Christian Ministry; Buncombe County Health Center; Western North Carolina Community Health Services; and WELCOA (Wellness Council).

### ***Community Assets & Resources***

-  Key Informants expressed a great deal of gratitude toward many existing agencies and resources in the community. Those agencies that were given the highest acclaim were ABCCM, Eblen Foundation, churches, Department of Social Services, Buncombe County Health Center, Mission St. Joseph's Community Outreach, Veterans Administration, United Way, Project Access, Manna Food Bank, Blue Ridge Center, Housing Authority, AB Tech, UNC-A, Mountain Mobility, Meals on Wheels, Catholic Social Services, Police Department, Sheriffs Department.

# Underlying Issues

## Poverty

### Income Distribution

1997 annual household income distribution in Buncombe County was as follows:

- 26.7%: under \$20,000
- 28.3%: \$20,000-\$39,999
- 31.9%: \$40,000-\$74,999
- 11.1%: \$75,000-\$149,999
- 2.0%: \$150,000 or over

***“I think people are having financial difficulty...(based on) the number of people I see who are working, making minimum wage and who sometimes are carrying even two jobs and...fall through the cracks...(they) are not surviving.”***

The following table illustrates the projected income distribution for the year 2007.

### Projected Household Income, Buncombe County

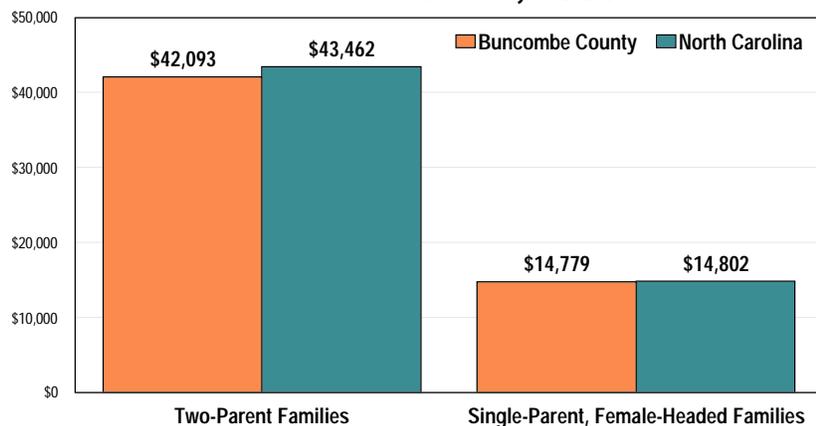
	1997	2002	2007	1997-2007 Net Change	1997-2007 % Change
<\$20,000	20,844	18,235	15,004	-5,840	-28.0%
\$20,000-\$39,999	22,125	20,733	19,930	-2,195	-9.9%
\$40,000-\$74,999	24,935	27,087	27,975	3,040	12.2%
\$75,000-\$149,999	8,639	14,648	21,587	12,948	149.9%
\$150,000+	1,586	2,828	4,501	2,915	183.8%

Source: United States Census Bureau.

### Mean Income

In 1990 Census data, two-parent families in Buncombe County earned a mean income of \$42,093 annually. For single-parent families with a female head of household, the mean income was only \$14,779.

### Mean Income, 1990

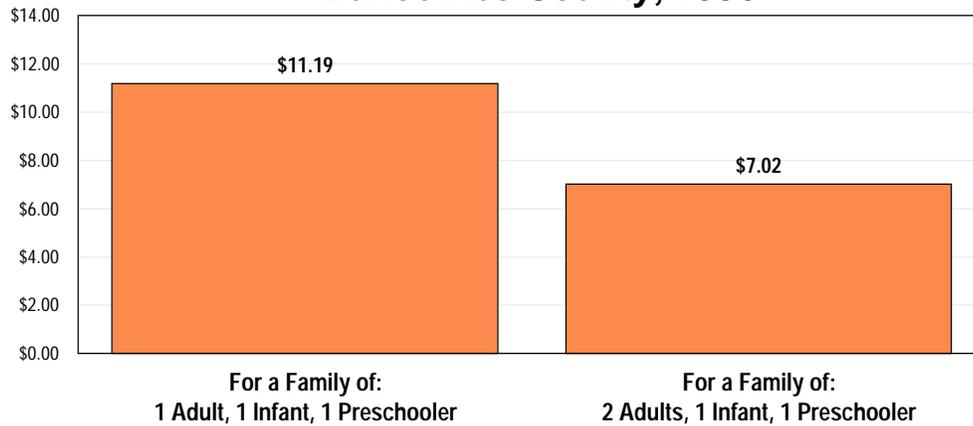


Sources: "Assessing the Needs and Resources for North Carolina's Smart Start Population," North Carolina Child Advocacy Institute on behalf of NC Department of Health and Human Services 1999.

## Hourly Self-Sufficiency Wage

In 1996, the wage required for a Buncombe County family of one adult, one infant and one preschooler to maintain self-sufficiency was \$11.19 per hour. For a family with two adults, one infant and one preschooler, each wage earner would need to earn \$7.02 per hour to maintain self-sufficiency for their family.

### Hourly Self-Sufficiency Wage, Buncombe County, 1996

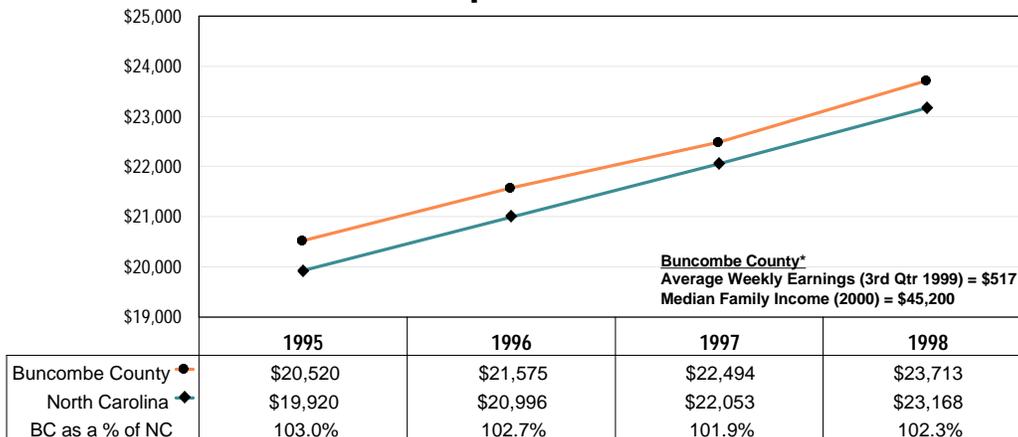


Sources: "Assessing the Needs and Resources for North Carolina's Smart Start Population," North Carolina Child Advocacy Institute on behalf of NC Department of Health and Human Services 1999.

## Per Capita Personal Income

Per capital personal income in Buncombe County in 1998 was \$23,713 according to estimates from the North Carolina Department of Commerce, just above the state income and likewise trending upward.

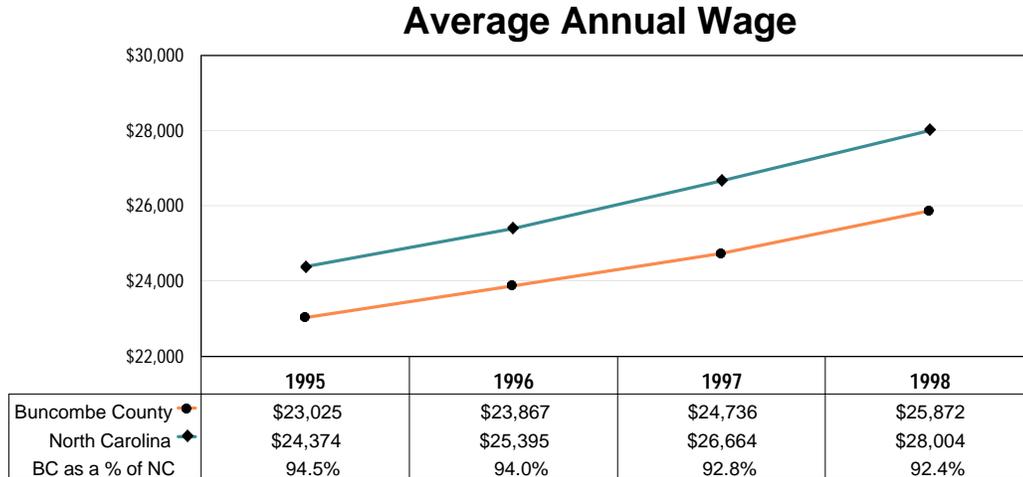
### Per Capita Personal Income



Sources: 1. Vision for Asheville-Buncombe County: Benchmarks; www.abvision.org. (Bureau of Economic Analysis CA1-3)  
2. \*Economic Development Information System, a service of the North Carolina Department of Commerce.

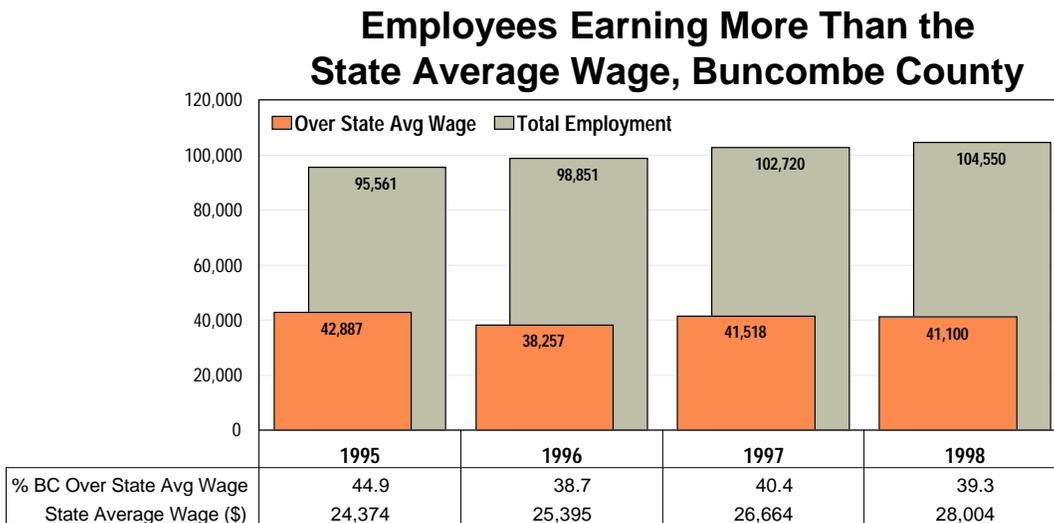
## Average Annual Wage

However, annual average wages in Buncombe County in 1998 (\$25,872) were below the state average annual wage, and this gap appears to be widening slightly.



Source: Vision for Asheville-Buncombe County: Benchmarks; www.abvision.org. (North Carolina Employment Security Commission)

In 1998, only 39.3% of employees in Buncombe County earned wages above the state average wage. This percentage has declined over the past few years (44.9% in 1995).

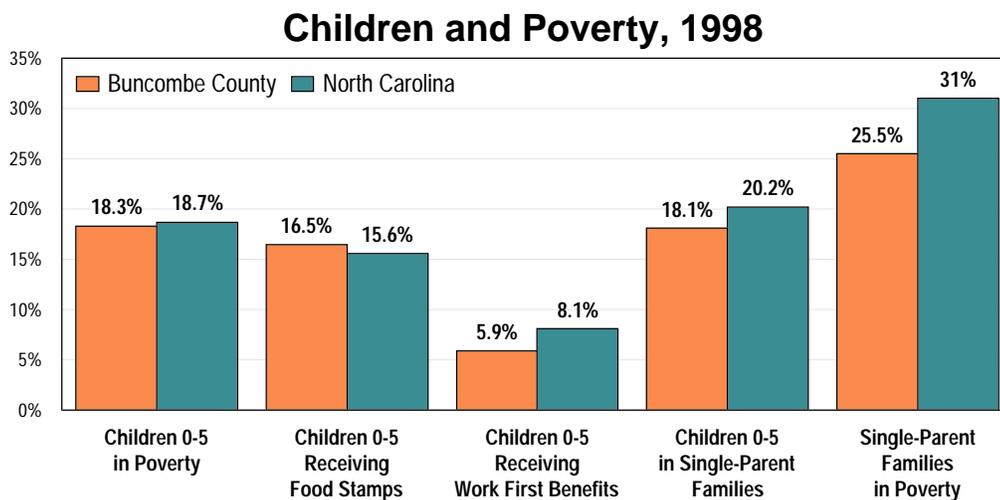


Source: Vision for Asheville-Buncombe County: Benchmarks; www.abvision.org. (North Carolina Employment Security Commission)

## Children & Poverty

It is estimated that 18.3% of Buncombe County children aged 5 and younger were living in poverty in 1998, similar to the proportion found statewide. In addition, 16.5% of children aged 5 and younger were in families receiving Food Stamps, and 5.9% were in families receiving Work First benefits.

Further note in the following table that 18.1% of Buncombe County children were in single-parent families in 1998, and that 25.5% of these families earned incomes below the poverty threshold (roughly \$16,000 for a family of four).



Source: "Assessing the Needs and Resources for North Carolina's Smart Start Population," North Carolina Child Advocacy Institute on behalf of NC Department of Health and Human Services 1999.

## Health Insurance Coverage

A total of 18.5% of adults between the ages of 18 and 64 in Buncombe County have no insurance coverage to pay for health care expenses, representing a *statistically significant increase* in lack of coverage since 1995.

Not surprisingly, health insurance coverage is directly related to income, and, in fact, lack of insurance increases sharply among individuals living at lower income levels (35.5% of those living below the 200% poverty threshold). Also, lack of insurance coverage is relatively high among African-Americans and younger adults. For information related to the lack of insurance coverage in Buncombe County, refer to page 241.

## Perceptions Data\*

### *Economic Barriers*

There was a plea by immigrants and minority ethnic groups to be welcomed to the community-at-large and given a helping hand toward reaching the status of “belonging.” Issues which arose most often included lack of bilingual service providers, lack of affordable housing, lack of dependable transportation, lack of affordable and culturally appropriate child care, and lack of supervised recreational opportunities for older children.

There was a consistent outcry regarding the proliferation of low-paying service industry jobs as opposed to higher-paying technical and professional jobs which would better enable workers to support families. Improvements in the public school system were cited as a means of helping young people prepare for post-secondary training and qualify for better jobs. Mentoring by community professionals was also seen as a way to expose youth to new career possibilities and to model the discipline and motivation required to reach one's goals. However, education alone did not receive responsibility for the plight of the workforce. Most felt that advocacy was needed to implore politicians and the tourism industry to wake up and realize that other industries should be recruited.

When questioned regarding our area's most serious problems, one Latino put it succinctly: “Minorities [not] being able to get good jobs. I think if we could take care of that, then they [minority families] could have health insurance and people would be able to take care of their children better.”

An African-American felt that the trend toward becoming a retirement haven has influenced the attempt to recruit employers. To her, it seemed obvious that a graying community should be concerned about retaining the young who might be necessary for its support.

“We need to be stepping up to the plate with housing and employment...making it a place conducive not only to the retirement community but for young adults. In order to thrive and grow, not only do you need the wisdom of the older adults, you need the energy of the young.”

Many of the community's minorities are felt to be working two, three, or even up to five or six jobs per couple in order to survive. The impact of this financial struggle is felt throughout the family. The isolation of these circumstances, especially for new immigrants, was felt to increase the likelihood of feelings of depression and of involvement in substance abuse and crime.

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\* *The Perceptions Data are valuable in identifying issues and providing context to the findings of this assessment. Keep in mind, however, that these qualitative comments are attributable only to those citizens and Key Informants participating in this effort and are not necessarily representative of the study sponsors nor the community at large.*

Said one parish nurse, “They’re working 60 to 70 hours a week and they have no other outlets.”

A Latina mom expressed her concern for children whose mothers work full-time or more: “ You get home at six o'clock and you have to cook dinner. The children are tired by that time. You don't have time to see how your children are progressing in school. My heart really goes out to those single parents because I know they are trying to work and make a living but their children are not benefiting from it either because of poor performance in their school work.”

## *Poverty*

Poverty among other age groups, or among minorities, or throughout the population as a whole, was mentioned during other interviews. Low-income people of all backgrounds often face the same issues: working too many jobs for too little income, often for no benefits, with no reserve income, little food and shelter, difficulties with transportation, and little time with the families they are raising.

“It’s not only the minorities, but I think it’s true for low-income people that are not minorities: poverty. That’s one of the main problems.”

“There are a few people at the top that are doing really well...there are some people in the middle...and people at the end who have less economic opportunity and advantage and are in vast need of improvement...so we have people who are poor and really poor.”

One resident, a lay person who grew up in another region of the U.S., agrees with the nurse who felt many in this region age faster because of poverty. In addition to this, she notes dental health in particular as evidence of the effects of poverty and lack of health care.

“I see people walking down the street who are 25 years old and have had all their teeth pulled already.”

“I sat in that waiting room and I saw horrendous things happen to people. A young woman came in and she had a babe in her arms and a toddler. She asked for food and the woman at the desk told her that she had to manage her money better, and the woman walked out without milk - she begged for milk for the baby. And she walked out the door without any assistance – walked.”

“People have to be educated that poor people aren't creepy crawly, take advantage of the system, ignorant people. Poor people are from all segments of society and standings. They have all kinds of backgrounds. There are a lot of educated poor people who need help to get them steered in the right direction to get them to be able to be a functioning segment of society. To stigmatize the poverty segment of society is to eradicate a segment of society and to not see what is going on.”

“I would say that poverty is a huge problem (among the elderly).”

“Because of Social Security Income...most older adults may live above the poverty line, so I’m not saying it’s great, but I think if we’re going to worry about who’s in poverty, it’s really our children.”

“Welfare recipients are a segment of society made up predominantly of females with children or elderly women that are underemployed... earning wages lower than men.”

Several community workers commented on a recent trend to live outside of marriage to qualify for more assistance. There is no longer a strong negative social stigma related to cohabitation outside of marriage.

“Being married is definitely a penalty. I think that a mother quickly sees that she can qualify for food stamps, housing an apartment.”

“There is no (economic) advantage of being married.”

## Education & Literacy

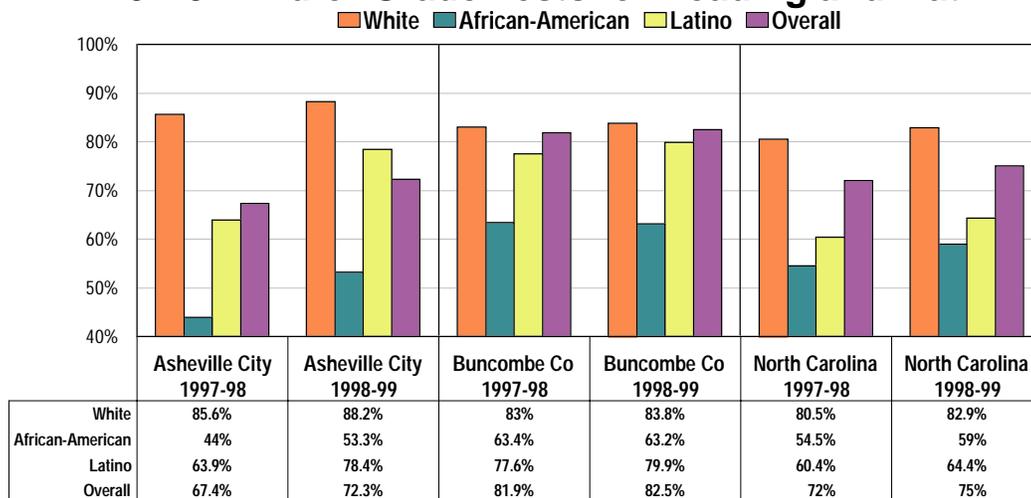
### School Performance

In the 1998-99 school year, 82.5% of children in grades 3 through 8 in Buncombe County schools passed end-of-grade tests for reading, writing and math. By race and ethnicity, White students had the highest proportion of students passing end-of-grade tests, followed closely by Latino students. However, a considerably lower proportion of Buncombe County African-American students received passing marks (63.2%).

An even greater disparity is noted among racial and ethnic groups in Asheville City schools. In fact, only 53.3% of African-American students passed end of grade tests in Asheville schools in 1998-99. However, passing scores among Asheville school children of all races/ethnicities increased notably between the 1997-98 and 1998-99 school years.

In comparison to North Carolina, Asheville City has a lower overall percentage of passing students, while Buncombe County has an overall higher percentage. Proportions of African-American students passing end-of-grade testing is likewise lower in Asheville schools than statewide, but higher in Buncombe County schools than statewide. Proportions of Latino students passing end-of-grade tests are higher in both Asheville and Buncombe County schools than statewide.

### Average Percentage of Students Passing 3<sup>rd</sup>-8<sup>th</sup> End-of-Grade Tests for Reading and Math



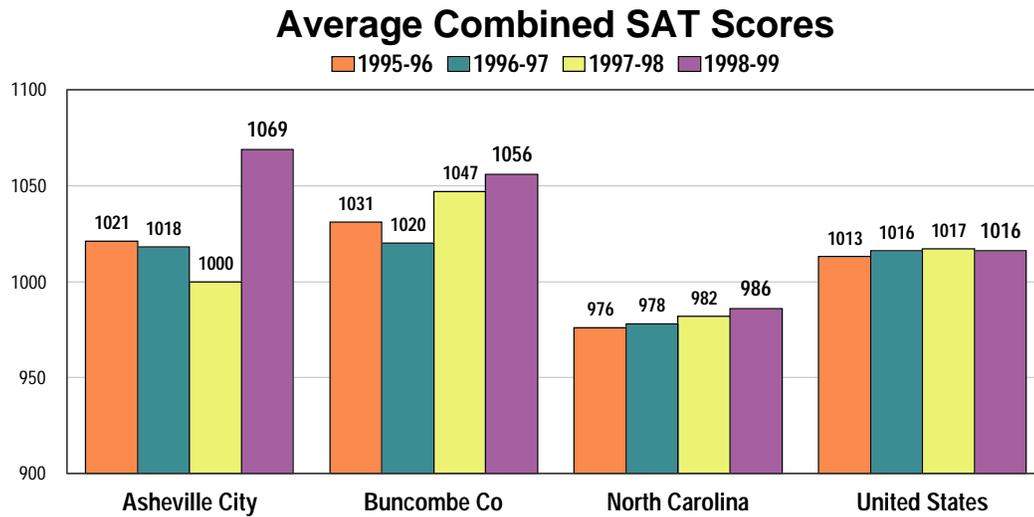
Source: Vision for Asheville-Buncombe County: Benchmarks; [www.abvision.org](http://www.abvision.org). (NC Department of Public Instruction, A Report Card for the ABC's of Public Education, 1999)

Note: Average percentage is the percentage of end-of-grade tests passed by students. Tests are given annually in reading and math. The writing test is given during the 4th and 7th grades.

## SAT Scores

1998-99 Scholastic Assessment Test (SAT) scores among high school students in both Asheville schools and Buncombe County schools (with average combined scores of 1069 and 1056, respectively) are notably higher than found either statewide (986) or nationally (1016).

Furthermore, SAT scores have improved in Buncombe County over the past two school years, and Asheville City scores increased notably between the 1997-98 and 1998-99 school years, as shown in the following chart.

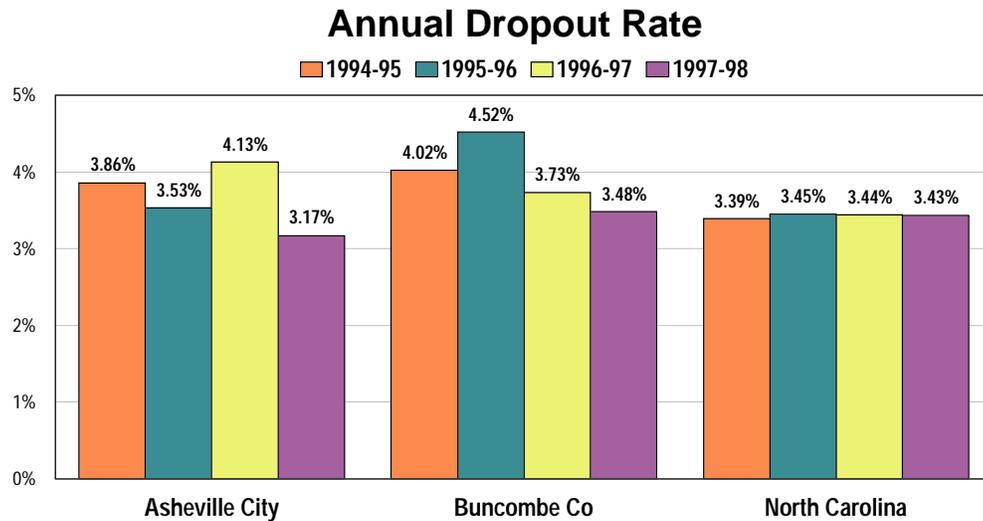


Source: Vision for Asheville-Buncombe County: Benchmarks; [www.abvision.org](http://www.abvision.org). (NC Department of Public Instruction, (The North Carolina 1999 Scholastic Assessment Test [SAT] Report)

## School Dropout Rate

During the 1997-98 school year, Buncombe County schools experienced a 3.48% dropout rate among students in grades 7 through 12. Asheville City schools experienced a rate of 3.17%, compared to a statewide dropout rate of 3.43%.

As shown in the following chart, dropout rates have declined in the past year for Asheville City schools, and have declined over the past two school years in Buncombe County.



Source: Vision for Asheville-Buncombe County: Benchmarks; [www.abvision.org](http://www.abvision.org). (NC Department of Public Instruction, Statistical Profile of North Carolina Schools, 1998-99)

Note: Dropout rate is the annual percentage of students in grades 7 through 12 who leave school for any reason other than death, transfer to another school, or completion of program.

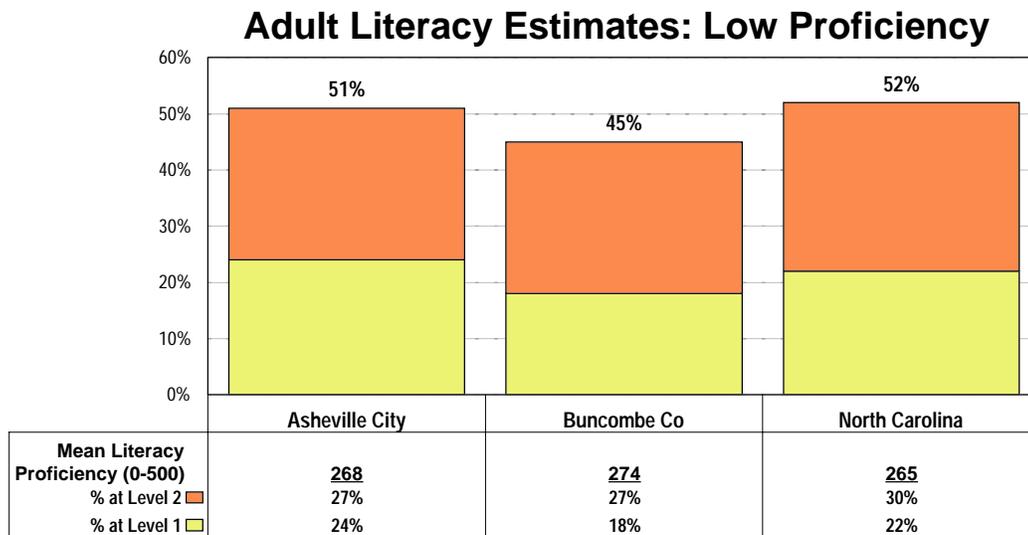
## Literacy

Adult literacy is increasingly seen as indispensable to the social and economic health of the United States. A common definition of literacy used today is *"the ability to read, write, and speak in English, and compute and solve problems at levels of proficiency necessary to function on the job and in society, achieve one's goals, and develop one's knowledge and potential."* It is important to remember, however, that the level of essential skills needed to meet any definition of literacy will necessarily change as the demands of the workplace, the family, and the society change.

The following data includes a compilation of literacy proficiency estimates, calculated by analyzing previous national literacy studies (National Adult Literacy Survey) and comparing the primary indicators for literacy found in those earlier studies to local statistics provided by the Census Bureau. Literacy skills were measured on a scale of 1 to 5, with Level 5 reflecting the highest skills and Level 1, the lowest.

Although local mean proficiency estimates are above the state mean estimate, 24% of Asheville adults and 18% of Buncombe County adults are estimated to be at Level I proficiency. Generally, those adults who score at Level 1 have difficulty performing such everyday tasks as locating an intersection on a street map, reading and comprehending a short newspaper article, or calculating total costs on an order form.

Furthermore, 51% of Asheville adults and 45% of Buncombe County adults are estimated to have literacy proficiencies in one of the lower two categories (Level I or II).



Source: Portland State University, 1996. Permission granted to CASAS for internet delivery at [www.casas.org](http://www.casas.org).  
 Note: Respondents' abilities to perform everyday literacy tasks such as interpreting graphs and charts, extracting needed information from prose materials, completing forms, and so forth, was used to estimate individuals' Prose, Document and Quantitative proficiencies, each reported on a 0 to 500 scale. Five performance levels were designated on each scale: Level 1 (225 and under), Level 2 (226-275), Level 3 (276-325), Level 4 (326-375) and Level 5 (above 375).

## Economy

### Industries

The 1997 top industries in terms of numbers of employees in Buncombe County include retail trade, the manufacture of non-durable goods, and health services. Note in the following table that the greatest projected number of added jobs between 1997 and 2007 will be in the health services industry.

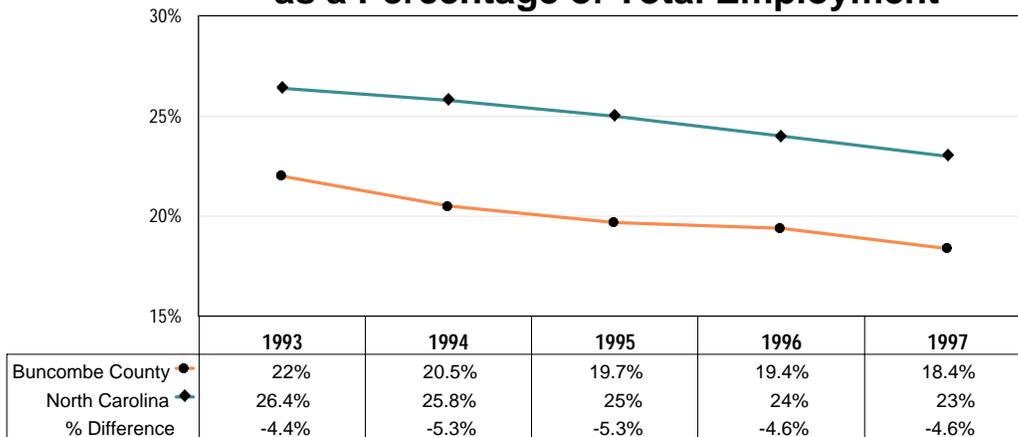
### Projected Employment by Industry, Buncombe County

	1997	2002	2007	1997-2007 Net Change	1997-2007 % Change
Retail Trade	17,459	19,029	20,383	2,924	16.7%
Health Services	10,035	11,765	13,394	3,359	33.5%
Manuf Non-Durable	11,165	11,275	11,229	64	0.6%
Education Services	7,238	8,012	8,728	1,490	20.6%
Manuf Durable	9,029	8,985	8,696	-333	-3.7%
Other Professional Svcs	6,235	7,286	8,277	2,042	32.8%
Construction	6,862	7,533	8,105	1,243	18.1%
Bus/Repair Svc	4,035	4,835	5,598	1,563	38.7%
Finance/Ins/Real Est	4,081	4,396	4,721	640	15.7%
Personal Svcs	3,853	4,213	4,500	647	16.8%
Wholesale Trade	3,587	3,835	4,042	455	12.7%
Transportation	3,339	3,654	3,917	578	17.3%
Public Admin	2,861	3,075	3,280	419	14.6%
Agr/Forestry/Fish	1,880	1,939	1,955	75	4.0%
Entertain/Rec	1,508	1,686	1,867	359	23.8%
Commun/Pub Utilities	1,691	1,609	1,519	-172	-10.2%
Mining	83	83	86	3	3.6%

Source: United States Census Bureau.

However, note that the proportion of manufacturing jobs in Buncombe County as a percentage of total employment is below the state average, and this proportion is declining as it is statewide (decreasing from 22.0% of jobs in 1993 to 18.4% in 1997).

## Manufacturing Jobs as a Percentage of Total Employment



Source: Vision for Asheville-Buncombe County: Benchmarks; www.abvision.org. (North Carolina Employment Security Commission)

### 20 Largest Manufacturers <sup>4</sup>

- **Sonopress LLC**, Weaverville, Electronic Components
- **Pillowtex Corp/Beacon**, Swannanoa, Housefurnishings
- **Square D Schneider Electric**, Asheville, Electrical Machinery, Equipment & Supplies
- **Cutler-Hammer**, Arden, Power, Distribution & Specialty Transformers
- **Owen, Charles D Manufacturing**, Swannanoa, Housefurnishings: Textile
- **GS Laboratory Equipment**, Asheville, Analytical Instruments
- **BASF Corp**, Enka, Fabrics Coated Not Rubberized
- **Kearfott Guidance & Navigation**, Black Mountain, Search, Detection, Navigation & Guidance Systems & Instruments
- **Borg-Warner Turbo Systems**, Asheville, Motor Vehicle Parts & Accessories
- **Cooper/Bussman Industries Inc**, Black Mountain, Switchgear & Switchboard Apparatus
- **Day International Inc**, Arden, Fabricated Rubber Products
- **TDP Electronics**, Swannanoa, Electronic Components
- **CII Technologies Inc**, Fairview, Relays & Industrial Controls
- **Lustar Dyeing & Finishing**, Asheville, Cotton Fabric Finishers
- **Anvil Knitwear Inc**, Swannanoa, Silk & Man-Made Fiber
- **Plasti-Form Spotless Group**, Asheville, Plastic Products
- **Superior Modular Products**, Swannanoa, Communications Equipment
- **Volvo Construction Equipment**, Skyland, Industrial Trucks, Tractors, Trailers & Stackers
- **Continental Teves**, Asheville, Motor Vehicle Parts & Accessories
- **Milkco Inc**, Asheville, Milk

<sup>4</sup> <http://cmedis.commerce.state.nc.us/countyprofiles/>

## Occupations

By occupation, 1997 Buncombe County employment is led by professional specialty occupations, administrative support, and precision production and repair. By 2007, the greatest increases in numbers of jobs are expected in the general service occupations, followed by professional specialty. None of the occupations shown below are projected to lose jobs between 1997 and 2007.

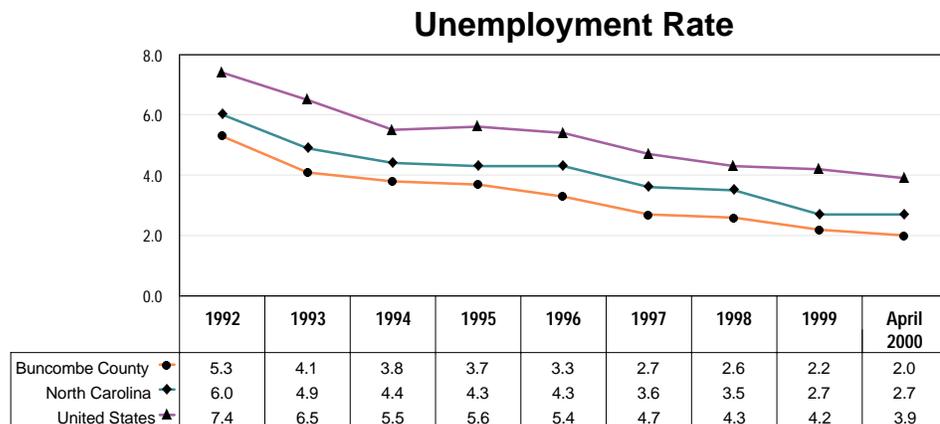
### Projected Employment by Occupation, Buncombe County

	1997	2002	2007	1997-2007 Net Change	1997-2007 % Change
Prof Specialty	13,159	14,821	16,323	3,164	24.0%
General Service	11,417	13,296	15,027	3,610	31.6%
Admin Support	12,651	13,443	14,084	1,433	11.3%
Prec Prod/Repair	12,133	12,852	13,419	1,286	10.6%
Sales	11,770	12,603	13,308	1,538	13.1%
Exec/Adm/Manag	10,591	11,393	12,071	1,480	14.0%
Machine	8,814	8,984	9,018	204	2.3%
Transportation	3,816	4,139	4,408	592	15.5%
Technicians	3,498	3,846	4,168	670	19.2%
Misc Labor	3,570	3,801	3,980	410	11.5%
Farm/Forest/Fish	1,779	1,984	2,165	386	21.7%
Protective Serv	1,368	1,628	1,866	498	36.4%
Priv Household	375	420	460	85	22.7%

Source: United States Census Bureau

## Unemployment

Unemployment rates in Buncombe County remain below the state and national rates, and have likewise declined considerable in the last decade.



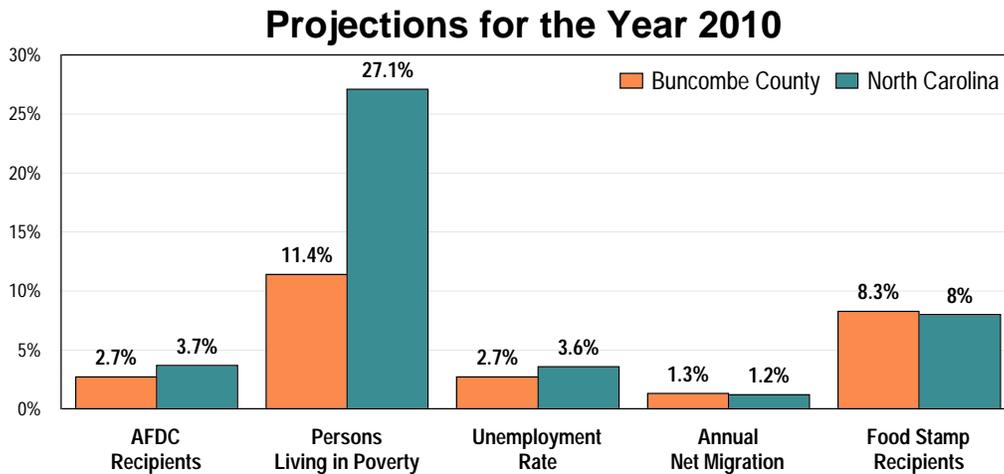
Sources: 1. North Carolina Office of State Planning.  
 2. Asheville-Buncombe County Vision Benchmarks: [www.abvision.org](http://www.abvision.org). (North Carolina Employment Security Commission)  
 3. Economic Development Information System, North Carolina Department of Commerce.

## Tax Rates <sup>5</sup>

The FY2001 General Fund budgeted revenues of \$172.8 million include property tax revenues of \$81,999,980. This reflects a 4 percent growth in our tax base of \$13.2 billion and a 98 percent collection rate. We will continue with a tax rate of 63 cents. (1999 Property Taxes/\$100 Value: \$.6300)

## Year 2010 Projections

Projections for the year 2010 predict economic prosperity for Buncombe County which closely matches the state projections for most economic indicators. The exception is that the proportion of persons living in poverty in Buncombe County is projected to be much lower than the statewide proportion.



Source: State Center for Health Statistics (SCHS), NC Department of Health and Human Services.

## Perceptions Data <sup>\*</sup>

Perceptions were varied regarding the overall economic condition of the county. There was consensus, however, that many parents are working at two low-paying jobs. This puts stress on one and two parent families who are left with little time to nurture their children.

“I think overall, we’re doing well. I really do. Maybe my blinders are on, but I think overall Asheville-Buncombe County is doing well.”

<sup>5</sup> Buncombe County Government, [www.buncombecounty.org/Dept\\_Adms\\_Budget/FY2001\\_BudgetEst.htm](http://www.buncombecounty.org/Dept_Adms_Budget/FY2001_BudgetEst.htm)

<sup>\*</sup> The Perceptions Data are valuable in identifying issues and providing context to the findings of this assessment. Keep in mind, however, that these qualitative comments are attributable only to those citizens and Key Informants participating in this effort and are not necessarily representative of the study sponsors nor the community at large.

“I think people are either doing very well or they’re doing very bad. I don’t think there’s too much middle ground.”

However, for the Russian/Ukrainian community, which is perceived as being well-educated and cohesive, one disappointment is the loss of professional positions as they emigrated.

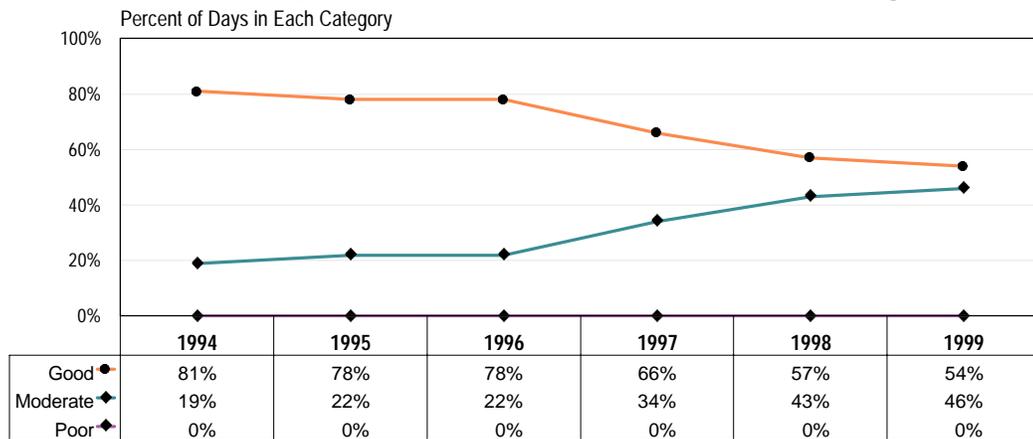
“There is a sad and frustrated group of professionals from these other countries...their professional credentials are not recognized in this country at all and they are very underemployed,” said one professional. “They are very thankful to be here, but feel under-appreciated...doctors, lawyers, architects...working at very menial jobs here.”

## Environmental Health Trends

### Air Quality

Air quality appears to have declined in Buncombe County during the latter half of the 1990s. As shown in the following chart, through 1996, the county earned “good” ratings on nearly 80% of days using the Pollutant Standards Index. However, by 1999, the proportion of “good” days had decreased to 54%, while “moderate” ratings increased to 46% of days. Even so, Buncombe County has not earned any air quality days with a “poor” PSI rating.

### Buncombe County PSI (Pollutant Standards Index) Ratings



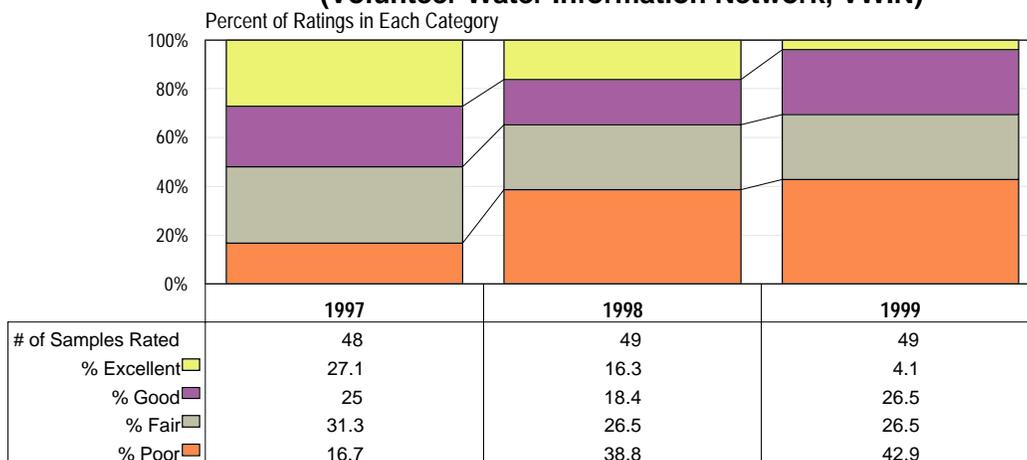
Source: Vision for Asheville-Buncombe County: Benchmarks. (U.S. Environmental Protection Agency, Office of Air Quality Planning & Standards, Information Transfer & Program Integration Division, PSI Report, 1999)

Note: Rating determined by measuring quantities of the following pollutants: carbon monoxide (CO), ground-level ozone (O<sub>3</sub>), lead (Pb), nitrogen dioxide (NO<sub>2</sub>), particulate matter (PM<sub>10</sub>), sulfur dioxide (SO<sub>2</sub>). Criterion set by NAAQS, National Ambient Air Quality Standards.

### Water Quality

Likewise, quality ratings of Buncombe County streams, creeks and rivers declined between 1997 and 1999. In 1997, 52% of water samples were rated as “excellent” or “good” by the Volunteer Water Information Network (48% “fair” or “poor”). By 1999, “excellent/good” ratings had decreased to 31%, while “fair/poor” ratings had increased to 69%.

## Monitoring Site Ratings for Buncombe County Streams, Creeks and Rivers (Volunteer Water Information Network, VWIN)



Source: Vision for Asheville-Buncombe County: Benchmarks. (UNCA Environmental Quality Institute, Technical Reports #97-035, May 1997; #98-050, April 1998; #99-061, May 1999)

- Note:
1. Rating determined from a scale aggregating site performance against standard criteria for turbidity, total suspended solids, conductivity, copper, lead, zinc, phosphorous, NH<sub>3</sub> and NO<sub>3</sub>.
  2. Ratings based on a three-year average terminating on the year indicated.

### Perceptions Data\*

“Air quality is a major factor with COPD, it keeps all those people indoors for so much longer.”

“Given our geographic location, we are a prime candidate for pulmonary problems, allergies, stuff that gets sucked in here and can’t get out. I think air quality is much different than it was a few years ago...it’s going to be a serious problem.”

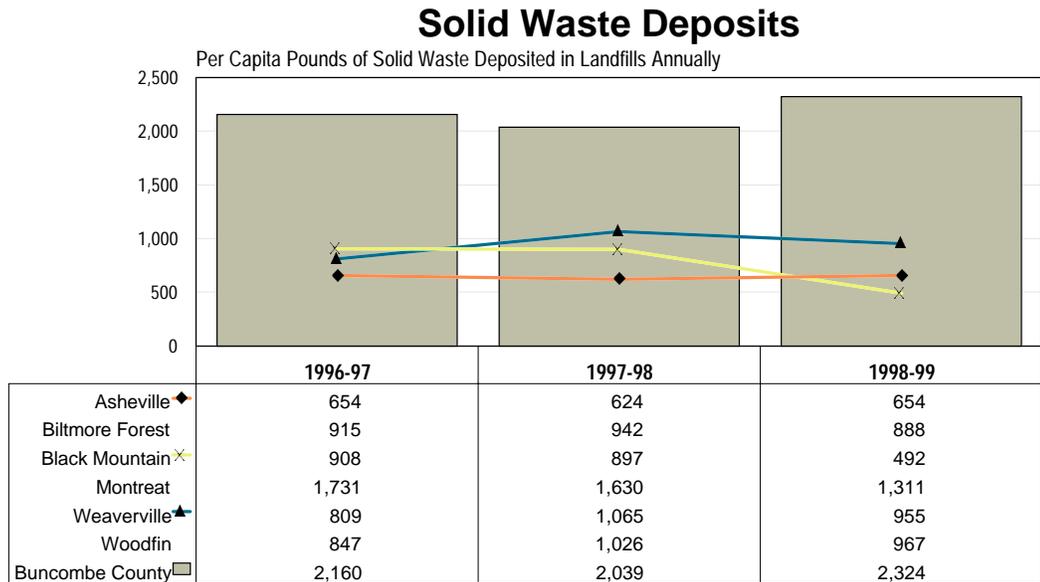
“(In Mexico and Latin America) the (environmental) quality is terrible. Here it’s wonderful. The water and air are perfect.”

“[Regarding] health problems coming from poor controls in clean air and water, slash and burn forestry, our endangered species and plant life. It has to be stopped for our future generations – more education visible through the media, through school. They ought to have a class for each grade all the way up through that is spent on the environment and ways to improve it.”

\* The Perceptions Data are valuable in identifying issues and providing context to the findings of this assessment. Keep in mind, however, that these qualitative comments are attributable only to those citizens and Key Informants participating in this effort and are not necessarily representative of the study sponsors nor the community at large.

## Solid Waste Deposits

In 1998-99, Buncombe County deposited 2,324 pounds per capita of solid waste into landfills, as shown in the following chart. (Note the shortcomings of reporting for both Asheville and Montreat, due to city waste collection and seasonal residents and students.)



Source: Vision for Asheville-Buncombe County: Benchmarks; [www.abvision.org](http://www.abvision.org). (North Carolina Department of Environment, Health and Natural Resources)

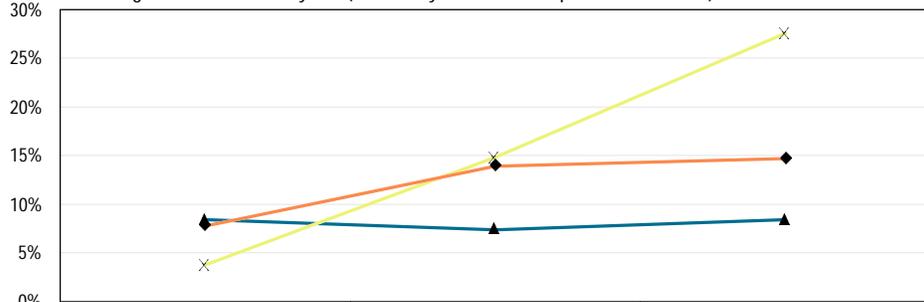
- Note:
1. Asheville rate may be under-inflated since it does not include the waste collected by **Waste Management of Asheville**
  2. Montreat per capita rates may be over-inflated since these are based on residential population size (662) which does not include the large number of seasonal residents and students (300+).

## Recycling Efforts

The following chart outlines, by location, the percentages of Buncombe County solid waste recycled in 1996-97 through 1998-99. As shown, Black Mountain has increased its percentage of waste that is recycled from just 3.8% in 1996-97 to 27.6% in 1998-99. Asheville and Montreat have also increased solid waste recycling during this period, while recycling at Biltmore Forest and Woodfin has decreased.

## Solid Waste Recycling

Percentage =  $100 \times \text{Tons Recycled} / (\text{Tons Recycled} + \text{Tons Deposited in Landfills})$



	1996-97	1997-98	1998-99
Asheville	7.8%	13.9%	14.7%
Biltmore Forest	22.7%	21.2%	13.9%
Black Mountain	3.8%	14.8%	27.6%
Montreat	13.2%	13.4%	17.4%
Weaverville	8.4%	7.4%	8.4%
Woodfin	13.7%	12.8%	10.9%

Source: Vision for Asheville-Buncombe County: Benchmarks. (North Carolina Department of Environment, Health and Natural Resources)  
 Note: Recycled materials include glass, plastic, paper, cardboard and metal.

# Physical & Social Context

## Geography

Buncombe County was established in 1791 and is located in the southwestern portion of North Carolina. It has a total land and water area of 660 square miles and an estimated population of 193,284, at July 1, 1998.

There are six municipalities within the County, the largest being the city of Asheville (population of 68,294 or approximately 35.3% of the County), which lies at the geographic center of the County and serves as the county seat. The City of Asheville is approximately 240 miles west of the state capital, Raleigh, North Carolina; 205 miles north of Atlanta, Georgia; and 120 miles east of Knoxville, Tennessee. <sup>6</sup>

## Demographic Profile

1997 estimates place the Buncombe County population at 192,977 persons. Between 1997 and 2007, the county population is expected to increase 13.7%, with a net increase of 26,455 persons.

## Projections, Buncombe County

	1997	2002	2007	1997-2007 Net Change	1997-2007 % Change
<b>Total Population</b>	192,997	206,214	219,452	26,455	13.7%
<b>Families</b>	54,283	57,571	60,829	6,546	12.1%
<b>Households</b>	78,129	83,531	88,997	10,868	13.9%

Source: United States Census Bureau.

<sup>6</sup> Buncombe County Government, [www.buncombecounty.org/Dept\\_Adm\\_Budget/AFRDescCnty.htm](http://www.buncombecounty.org/Dept_Adm_Budget/AFRDescCnty.htm)

## Age

***“A greater proportion of general population (in Buncombe County) is made up of seniors than that of North Carolina averages.”***

In the 1997 Buncombe County population, the age distribution is as follows:

- 21.7% under the age of 18
- 39.1% aged 18 to 44
- 23.3% aged 45 to 64
- 16.8% aged 65 and older (2.0% 85 and older).

The following table illustrates projected population increases in Buncombe County by age for the year 2007. As shown, as the baby boomer generation ages, the 65+ segment is expected to increase by more than 25%. A considerable increase is also expected in the 18 to 44 segment.

### Population Projections by Age, Buncombe County

	1997	2002	2007	1997-2007 Net Change	1997-2007 % Change
0-17	41,960	39,653	40,477	-1,483	-3.5%
18-44	73,567	87,491	94,652	21,085	28.7%
45-64	45,051	41,625	43,253	-1,798	-4.0%
65-84	28,545	33,170	36,242	7,697	27.0%
85+	3,874	4,275	4,828	954	24.6%

Source: United States Census Bureau.

### Perceptions Data<sup>\*</sup>

“This community by and large realizes that not only is this community changing, but the demographics of America are changing. And for that reason, I think there is a greater degree of tolerance than there was...years ago.”

“Many people who would have died in earlier generations are alive today but with more frailty.”

<sup>\*</sup> The Perceptions Data are valuable in identifying issues and providing context to the findings of this assessment. Keep in mind, however, that these qualitative comments are attributable only to those citizens and Key Informants participating in this effort and are not necessarily representative of the study sponsors nor the community at large.

## Population Distribution

By race, Buncombe County is predominantly White (90.6% in 1997). African-Americans make up 8.5% of the population, with all other races comprising roughly 1%. Hispanic community members (Hispanic is considered an ethnicity, and can be of any race) make up 0.8% of the population.

Projections for 2007 anticipate that the distribution of the population by race/ethnicity will not change greatly overall. Note below, however, that this means higher percentage increases in nonwhite, non-African-American races, as well as Hispanics.

### Population Projections by Race & Ethnicity, Buncombe County

	1997	2002	2007	1997-2007 Net Change	1997-2007 % Change
White	174,838	185,862	197,087	22,249	12.7%
African-Am	16,317	17,977	18,859	2,542	15.6%
Am Indian/Esk/Aleut	615	680	729	114	18.5%
Asian/Pac Islander	982	1,349	2,121	1,139	116.0%
Other	245	346	656	411	167.8%
Hispanic	1,545	1,945	2,437	892	57.7%

Source: United States Census Bureau.  
Note: Hispanic can be of any race.

### Perceptions Data\*

“...Three years ago, we probably had half Latino and half other ethnic groups (within the migrant education program of Buncombe County schools). Now we are (a majority) Latino...We have found that as the Latino population has increased in the migrant population, it has also increased in Asheville.”

## Education

Among adults aged 25 and older in Buncombe County in 1997:

- 18.9% did not graduate high school
- 50.1% have a high school diploma (may include some college, but no degree)
- 9.0% hold an Associate's Degree
- 14.8% hold a Bachelor's Degree
- 7.2% hold a graduate or professional degree

\* The Perceptions Data are valuable in identifying issues and providing context to the findings of this assessment. Keep in mind, however, that these qualitative comments are attributable only to those citizens and Key Informants participating in this effort and are not necessarily representative of the study sponsors nor the community at large.

As shown in the following table, there is a projected increase of 5,961 adults aged 25 and older without a high school education between the years 1997 and 2007, representing a 23.3% increase.

### Population Projections by Education (Persons Aged 25 and Older), Buncombe County

	1997	2002	2007	1997-2007 Net Change	1997-2007 % Change
No HS Diploma	25,562	28,918	31,523	5,961	23.3%
HS Graduate	67,701	76,016	82,471	14,770	21.8%
Associate Degree	12,172	13,608	14,705	2,533	20.8%
Bachelor's Degree	19,986	22,152	23,776	3,790	19.0%
Grad/Prof Degree	9,696	10,482	11,657	1,961	20.2%

Source: United States Census Bureau.

Note: High school graduates include persons with some postsecondary education, but no degree.

## Housing

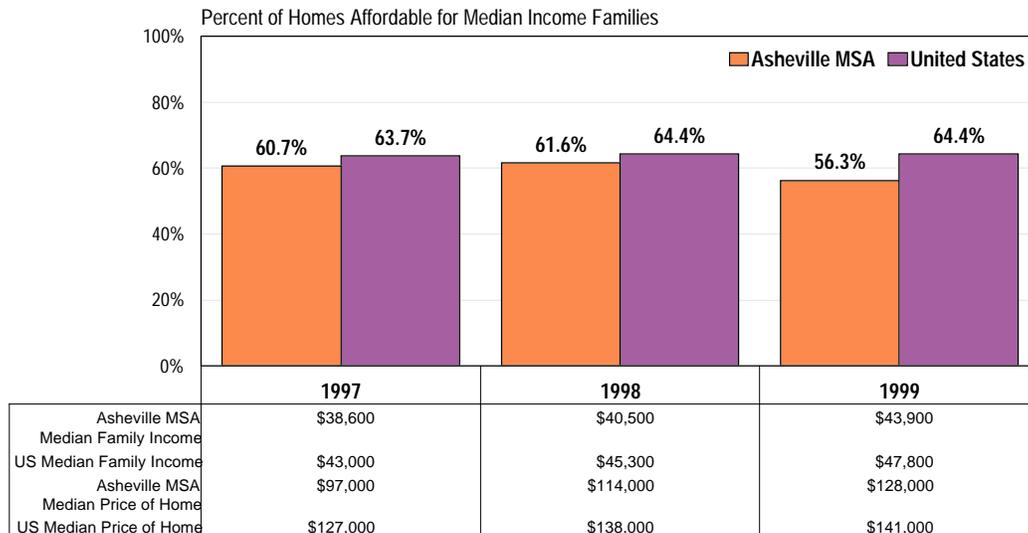
### Housing Affordability

While the median family income increased between 1997 and 1999 in the

Asheville Metropolitan Statistical Area (which includes both Buncombe and Madison Counties), the percentage of homes affordable to these families decreased. As shown in the following chart, 56.3% of homes locally are considered affordable to the median income family, lower than the 64.4% national finding.

***"Anybody who is low income is having problems with housing right now."***

### Housing Affordability



Source: Vision for Asheville-Buncombe County: Benchmarks. (National Association of Homebuilders Housing Opportunity, Housing Statistics)

- Note:
1. Median is the value below which (and above which) 50% of the data falls.
  2. 1997 and 1998 estimates based on third quarter observations.
  3. Asheville MSA (Metropolitan Statistical Area) includes Buncombe and Madison Counties.

### Perceptions Data

Most of those interviewed expressed the sentiment that decent, affordable housing in a safe neighborhood should be a reasonable expectation for all citizens of Asheville and Buncombe County, not just for those with financial means. An interesting dichotomy expressed by some was the perception that, while salaries in Asheville are significantly lower than in many parts of the country, the cost of living is considered rather high.

*\* The Perceptions Data are valuable in identifying issues and providing context to the findings of this assessment. Keep in mind, however, that these qualitative comments are attributable only to those citizens and Key Informants participating in this effort and are not necessarily representative of the study sponsors nor the community at large.*

“The average Asheville citizen, who is trying to buy a first home or an affordable home...is having difficulty coming up with the funds. I don't believe there is enough being done in terms of building affordable housing. There seems to be more and more of a disparity between luxury homes [and affordable homes for those with less money]. There are very few multi-family dwellings where people feel like they are safe and where there is safe and healthy recreation for children.”

“The ones that are at about the mid-range of economic levels have an average chance of finding affordable homes. The ones that are below that find it very difficult to find affordable housing.”

“Anybody who is low income is having problems with housing right now.”

The housing dilemma seemed to cross all cultural and ethnic lines, becoming a unifying factor. African-Americans spoke of “slum landlords.”

One landlord who maintains decent housing said, “I wish I had a house to rent for every person who asks me. Many people are tired of living in apartments.”

One rural Caucasian native admitted, “It's hard to buy land here. There are a tremendous number of mobile homes [because that's what people can afford].”

One newcomer felt she had seen the worst of the worst in one mobile home park, and found it hard to believe that such conditions existed in the land of plenty:

“The floors (in those mobile homes) are cold, the walls have big holes, the stoves are appalling, and most of them are without any heat. They are renting those mobile homes at \$350 or \$400 per month. We couldn't believe the condition of that mobile home and we were concerned at how in the world the government here in Asheville would let somebody rent mobile homes in this condition. It [extremely poor housing] is not general, but it exists.”

Economic disparity was not the only factor leading to unsatisfactory housing. Advancing age and the increase in health problems that tends to go with frailty make for housing concerns among seniors. The presence of physical disability, at any age, also puts one at risk for inadequate housing.

One senior expert who is very familiar with Asheville's public housing said, “Relatively speaking, in my opinion, public housing in Asheville is preferable to what I've seen in many cities. The downside to it is that these buildings have been here a long time and they're really not elder-friendly in terms of bathroom access and handicap-accessible kinds of things....federal programs for revitalization are continuing to be cut so I have some real concerns about that.”

“There's a lot more we could be doing and we may need to look to our local government and local private organizations [to work in partnership to solve this problem creatively].”

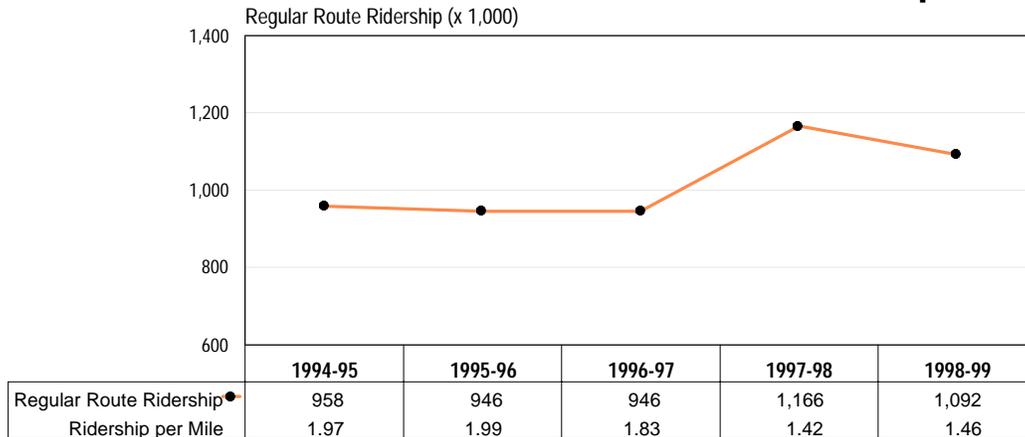
## Transportation – Public & Medical

### Public Transit

*"Transportation is a huge issue."*

Public transit ridership in Asheville dropped slightly from 1997-98 to 1998-99, but remains well above levels reported between 1994-95 and 1996-97.

### Asheville Public Transit Ridership

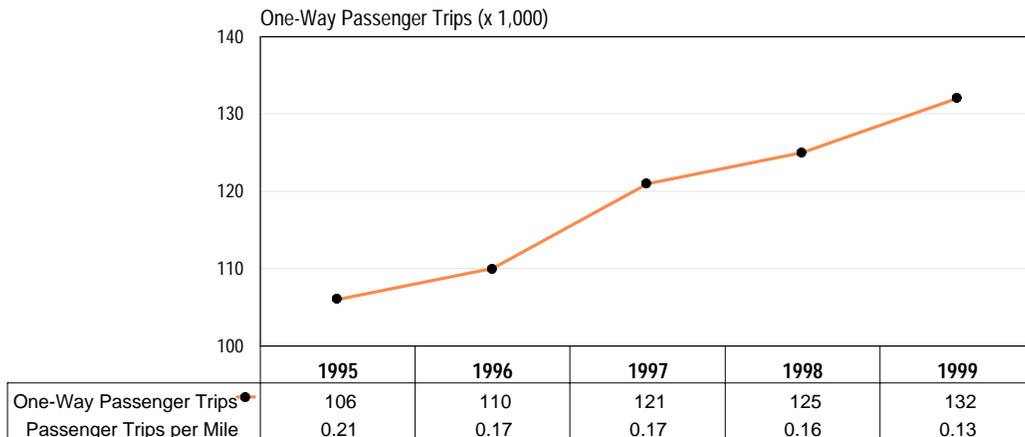


Source: Vision for Asheville-Buncombe County: Benchmarks. (Asheville Transit Service Department)

Note: Ridership per mile is the regular route ridership divided by vehicle miles.

Likewise, passenger trips on Mountain Mobility Systems (formerly BOOST System) have increased steadily since 1995.

### Mountain Mobility Systems (Formerly BOOST System)



Source: Vision for Asheville-Buncombe County: Benchmarks. (Buncombe County planning departments)

Note: Passenger trips per mile is the number of passenger trips divided by vehicle miles.

## Perceptions Data\*

***"If you don't have a car here, you are lost.  
Without a car you can't go anywhere."***

While use of public transit appears to be up, Perceptions Data suggest that significant transportation needs remain. Transportation issues — both medical and public — were often cited as a major problem throughout Buncombe County. Key Informants expressed the desire for more convenient bus routes, schedules and locations of bus stops to accommodate all segments of our population from the elderly to the poor and inclusive of working adults wishing to commute to work in the city. A need for more handicap accessible buses was mentioned.

"Public transportation needs to be coordinated."

"One reason for the shortage of CNAs and Home Health Workers is related to transportation. The CNAs cannot get to work."

"We would like to see more bus lines. Taxis are terrible. You call a taxi and they will be here one hour later, if they come at all."

Bikeways and pedestrian walkways are needed in the city and throughout the county. There is a need for more public awareness of pedestrian rights and law enforcement at pedestrian crossings. Alternative forms of transportation were thought to be one solution to improve air quality.

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\* *The Perceptions Data are valuable in identifying issues and providing context to the findings of this assessment. Keep in mind, however, that these qualitative comments are attributable only to those citizens and Key Informants participating in this effort and are not necessarily representative of the study sponsors nor the community at large.*

## Day Care

### Child Care Enrollment

In 1998, there were 6,218 children in regulated child care in 209 child care centers and homes. In addition, there were 407 enrolled children in family child care in 83 homes.

***“Out of all the wonderful groups we have going in this community, there is still a shortage of quality daycare in this community.”***

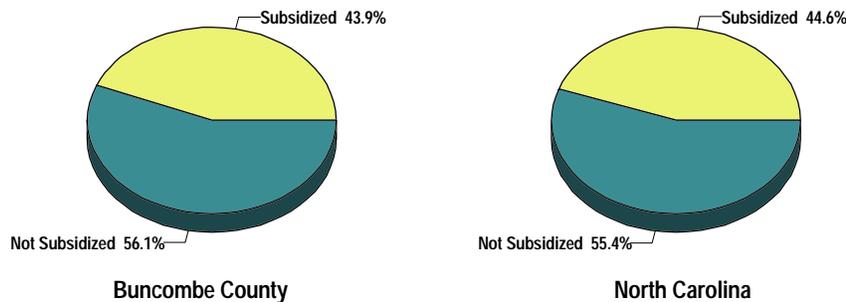
### Child Care Enrollment, 1998

	# Regulated Child Care Centers & Homes	# Enrolled in Regulated Child Care	# Regulated Family Child Care Homes	# Enrolled in Family Child Care
Buncombe County	209	6,218	83	407
North Carolina	8,961	212,544	5,150	22,658

Source: State Center for Health Statistics (SCHS), NC Department of Health and Human Services (Child Advocacy Institute).

In 1999, 43.9% of Buncombe County children in regulated day care were receiving subsidized care. This proportion is similar to that found statewide.

### Percentage of Children Receiving Subsidized Child Care



Source: "Assessing the Needs and Resources for North Carolina's Smart Start Population," North Carolina Child Advocacy Institute on behalf of NC Department of Health and Human Services 1999.

These data, however, do not fully speak to the issues of capacity, affordability and need, issues which surfaced in the Perceptions Data.

### Perceptions Data\*

“I think one of the biggest needs is daycare and respite care, but mainly daycare, affordable, quality daycare.”

\* The Perceptions Data are valuable in identifying issues and providing context to the findings of this assessment. Keep in mind, however, that these qualitative comments are attributable only to those citizens and Key Informants participating in this effort and are not necessarily representative of the study sponsors nor the community at large.

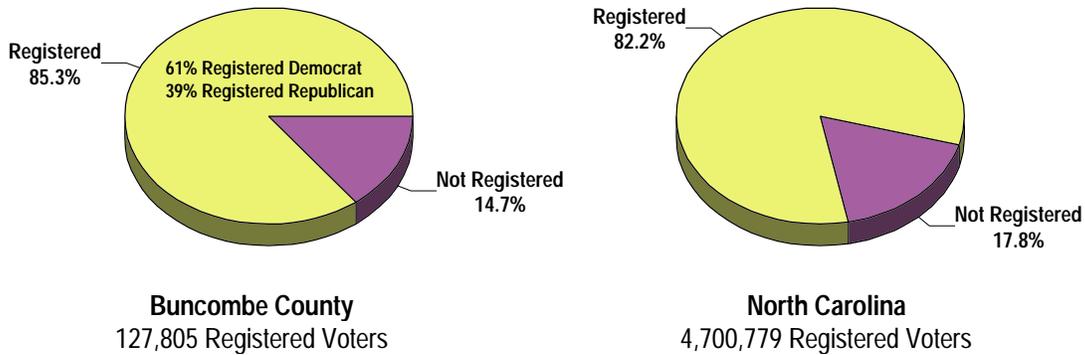
## Community Involvement: Political

### Voter Registration

Of the eligible voting population in Buncombe County, 85.3% were registered in 1998, similar to the proportion statewide. Of these, 60.9% are registered as Democrats, 38.8% as Republicans.

***“It’s not politically correct to worry about the very poor. The very poor don’t vote.”***

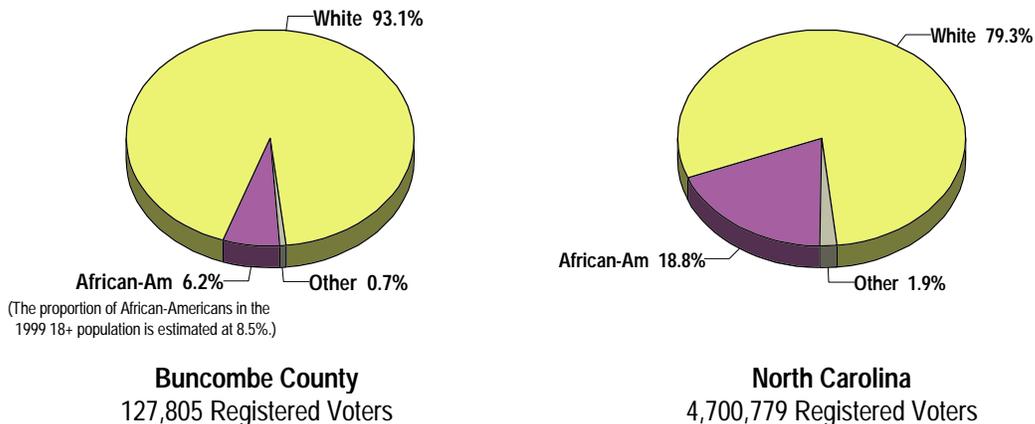
### Percent of Eligible Population Registered to Vote, 1998



Source: State Center for Health Statistics (SCHS), NC Department of Health and Human Services (Log Into North Caroline [LINC]).

A total of 93.1% of registered voters are white, while 6.2% are African-American; this is roughly similar to the overall adult population distribution of the county, with African-Americans slightly underrepresented.

### Racial Distribution of Registered Voters, 1998



Source: State Center for Health Statistics (SCHS), NC Department of Health and Human Services (Log Into North Caroline [LINC]).

## Perceptions Data\*

Many informants felt representation in local politics was fairly good with some areas for improvement. The criminal justice system was frequently criticized as being unfair especially to the poor and/or minorities.

“Folks here (rural district) ... feel there is not a lot of representation on City Council or Buncombe County boards ... of folks (southern native Appalachians) in this area, and this is true. Folks feel intimidated by the system ... They feel that they are truly becoming a minority.”

“County Commissioners (deserve credit because they) came through with money to support the Aging Consortium.”

“City Council has tried to help with education issues, but more parent involvement is needed.” (Comment from an African-American.)

“Local government should support affordable housing and the environment.”

“At City Hall they can do better, I know they can do better (regarding needs of the poor and minorities).”

“It is all governments responsibility, whether it is national, state, or local to see that everybody get their fair shake.”

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\* *The Perceptions Data are valuable in identifying issues and providing context to the findings of this assessment. Keep in mind, however, that these qualitative comments are attributable only to those citizens and Key Informants participating in this effort and are not necessarily representative of the study sponsors nor the community at large.*

# Medical Service Providers & Facilities

## Perceptions of Local Health Care

***“There is a need for integrated care: for the spiritual, emotional, mental, and physical. There should be a broader list of referrals than just specializing MDs.”***

### Perceptions Data\*

Perceptions of local health care were generally positive. There was some frustration regarding a lack of compassion and understanding among health care providers for their patients often of different socio-economic or cultural backgrounds. Patients of all ages and backgrounds had a strong preference for seeing one physician consistently as opposed to seeing many different physicians. The knowledge and expertise among health care providers is perceived as very good. However, business and billing issues continue to confound many patients, especially non-English speaking ones.

“The medical care I got here was top-notch.”

“Our community has about everything you need in the way of medical and health services.”

“There is a feeling that the (overall health care system) does not care, you don’t get good treatment because you’re an African-American and you go to a free clinic. I think that’s a challenge we have to meet.”

“Immigrants are frustrated with (lack understanding of) our medical system.”

“It was sad to see Dr. Blair’s health center being closed down.... Anytime when a center like that closes, they just don’t come back. Most times, they just give up.”

\* The Perceptions Data are valuable in identifying issues and providing context to the findings of this assessment. Keep in mind, however, that these qualitative comments are attributable only to those citizens and Key Informants participating in this effort and are not necessarily representative of the study sponsors nor the community at large.

## Availability of Primary Care & Specialty Providers

### Numbers of Providers by Category

In 1998, there were 602 non-Federal physicians licensed in Buncombe County, including 230 primary care physicians (family/general practice, internal medicine, OB/GYN, pediatrics) and 372 physicians of other specialties.

Regarding nurses and mid-level providers, there were 2,938 RNs, 785 LPNs, 56 nurse practitioners, and 72 physician assistants.

Other health professionals include 101 dentists, among others outlined in the following table.

### Health Care Resources, Buncombe County, 1998

Physicians		Mid-Levels & Nurses		Other Health Professionals	
Total Non-Federal Physicians	602	Physician Assistants	72	Chiropractors	42
Population per Non-Federal Physician	321	Nurse Practitioners	56	Dentists	101
Non-Federal Primary Care Physicians	230	Registered Nurses	2,938	Dental Hygienists	130
<i>Family Practice</i>	92	Licensed Practical Nurses	785	Optometrists	25
<i>General Practice</i>	11			Pharmacists	205
<i>Internal Medicine</i>	60			Physical Therapists	166
<i>OB/GYN</i>	29			Physical Therapy Assts	52
<i>Pediatrics</i>	38			Podiatrists	7
Non-Federal Physician, Other Specialty	372			Psychological Associates	53
Federal Physicians	32			Practicing Psychologists	77
Residents-in-Training	48				

Source: "North Carolina Health Professions Data System," Cecil G. Sheps Center for Health Services Research, University of North Carolina at Chapel Hill. [www.shepscenter.unc.edu](http://www.shepscenter.unc.edu).

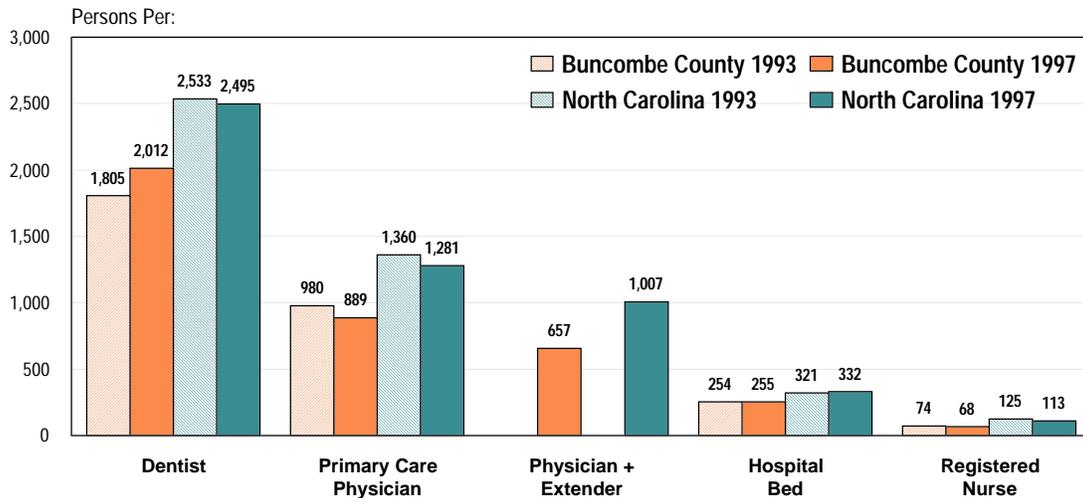
### Ratio of Population to Providers

The following chart describes the ratio of population to health care providers for Buncombe County and North Carolina for the years 1993 and 1997. Note that 1997 data suggest that, in Buncombe County, there are:

- 889 persons for every primary care physician (a more favorable ratio than in 1993, and considerably more favorable than the statewide ratio)
- 657 persons for every primary care physician plus physician extender (a more favorable ratio than statewide)

- 2,012 persons for every dentist (less favorable than in 1993, but more favorable than the statewide ratio)
- Ratios for hospital beds and persons per registered nurse are relatively unchanged since 1993, and each remains more favorable than the statewide ratio.

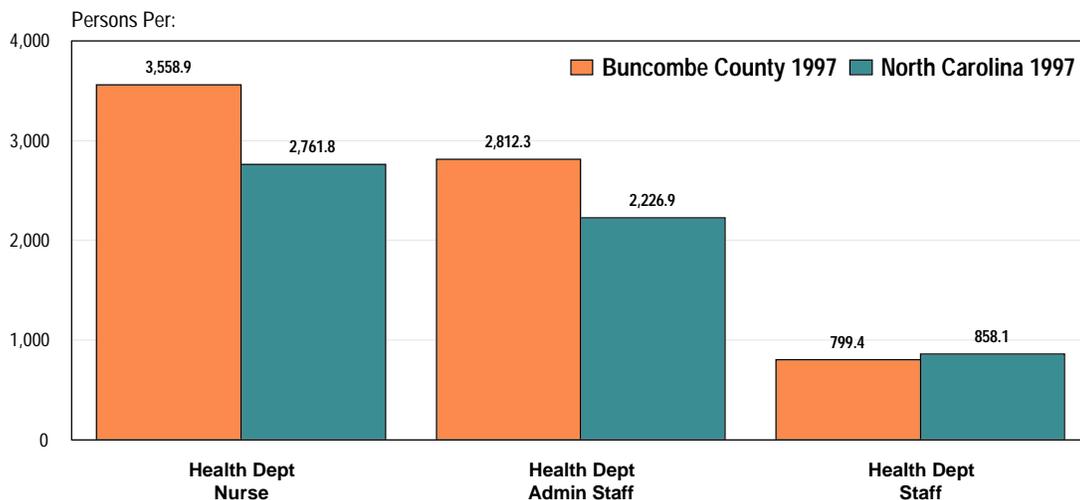
### Health Care Professionals and Hospital Beds



Source: State Center for Health Statistics (SCHS), NC Department of Health and Human Services.

In terms of population per public health department staff, the Buncombe County ratio is more favorable than the state as it relates to overall staff, but is considerably less favorable in terms of persons per health department nurse or per health department administrative staff.

### Health Department Personnel



Source: State Center for Health Statistics (SCHS), NC Department of Health and Human Services.

## Perceptions Data\*

The Perceptions Data reveal specific needs for providers, especially to care for seniors in Buncombe County.

“We are a community that prides itself on having pediatricians...why no geriatricians in private practice?”

“We need MDs in clinics for the poor and disenfranchised.”

“In a town this big, with a retirement population as large as it is, we don’t have a geriatric health care model where people can get a second opinion or have the whole work-up done and still continue with their private care provider. We are very short of people who are experts in geriatrics.”

“At the moment, the most serious problem (facing older adults in our area) is the lack of Certified Nursing Assistants and In Home Aides. It is a huge issue in that there are people who are eligible for help, eligible to receive assistance with bathing or housekeeping or personal assistance and are on a waiting list, not because there’s not money, although that is an issue too, but because they can’t get Aides. Every week it is someone new and the professionalism and the quality of person actually doing that task has really gone downhill in the last number of years so that for some older adults it’s just not worth it. They would rather not have any help than to get the kind of scattered, poor help that they are receiving. That is a real crisis, not only for the homebound elderly, but also the institutionalized elderly. It puts them at high risk for exploitation, neglect and even abuse, but certainly neglect.”

“CNAs may be working with significant other personal stresses within their life, low income and having childcare situations, transportation problems sometimes, so all of those are issues that I think are community issues that really do impact our health care system.”

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## Primary Health Care Clinics & Practices

There are currently 80 primary health care clinics, practices and urgent care centers in Buncombe County (primary care includes family practice, OB/GYN, pediatrics and internal medicine specialties).

### Perceptions Data\*

#### *Perceptions of Buncombe County Health Center*

Perceptions about the local public health department, Buncombe County Health Center were generally good. Latinos use the health center primarily and appreciate many recent efforts to incorporate bilingual services.

“I think the Health Department does an especially good job. It’s just remarkable, they do the best they can there.”

“The Health Center plays a vital role in trying to help people and kids who have problems.”

There is some room for improvement in human relations. BCHC can improve their attitudes toward clients and their personal touch by *“treating people with dignity.”*

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## Hospitals

### Perceptions Data\*

#### *Perceptions of MSJ Health Systems*

Perceptions of the hospital's good will has improved since community outreach services began. MSJ is taking a proactive positive role in the community according to many members of the community including minorities. One spokesperson felt the health system encompassed "two great hospitals" with an increasing number of interpreters available, and developing brochures in Spanish.

Hospital services are meeting the community's needs "pretty well."

The MSJ Health System is "making advances with having a more diversified employee team and getting this word out to the community."

Many comments were directed toward the need for a more holistic approach to health where the patient's psycho/spiritual needs were addressed.

"It would be helpful to have a list of Hispanic chaplains or lay ministers. The health system should be purposeful about contacting someone to be of spiritual support for patients and families."

While admitting that the ER gets over-utilized for routine care, comments reflect a desire for more time and concern for patients.

"ER Staff who, in a hurry, give partial information and don't realize a patient may worry for hours over a misconception."

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## Hospice

Buncombe County's hospice provider, Mountain Area Hospice, is a member of the Community Care Partners, a coalition of community-based, non-profit organizations providing the continuum of medical and health care services in the community. Mountain Area Hospice served 695 terminally ill patients and their families in fiscal year 1999.

The average length of care was 45 days and included an average daily census of 72. Mountain Area Hospices' program of comprehensive care for those at the end of life includes facility-based care in area long-term care facilities, as well as its own facility, Solace. Solace had an average daily census of 14 in 1999.

In addition, 1,446 people were served by Hospice's bereavement care and services, and over 23,000 volunteer hours were contributed in 1999.

# Community Resources & Assets

## Perceptions Data\*

Key Informants expressed a great deal of gratitude toward many existing agencies and resources in the community. Those agencies that

***“Ingredients for success: creativity, commitment, love, win-win, flexibility, giving up ownership.”***

were given the highest acclaim were ABCCM, Eblen Foundation, churches, Department of Social Services, Buncombe County Health Center, Mission St. Joseph’s Community Outreach, Veterans Administration, United Way, Project ACCESS, Manna Food Bank, Blue Ridge Center, Housing Authority, AB Tech, UNC-A, Mountain Mobility, Meals on Wheels, Catholic Social Services, Police Department, Sheriffs Department.

Many community workers and leaders were also mentioned as great assets to our community. The commitment of caring people was often cited as a community asset. In spite of the widely-spoken perceptions that the community has much to work on, strong feelings of potential were expressed. Most concurred that open dialogue, grassroots brainstorming, and political activism have a place in the development of solutions.

“I think, in general, the Asheville community wants to help all people have a better life, a better quality of life here,” said one newcomer.

## Suggestions for Improvements

- Teens as members of Junior County Commissioner or sit on Board of Health
- More activities and centers for teens, as well as for older adults
- Better dissemination of information especially in Spanish
- Need for a good downtown grocery store
- Tap into the creativity of the private sector with regard to housing and other social issues.
- Better utilization of the media, print and electronic to encourage healthy behaviors.

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# HEALTH STATUS

# Fast Facts

## Overview of the Findings: Health Status

### General Health

- ☎ Over one-half (56.6%) of survey participants characterize their general health as “excellent” or “very good,” while 15.5% characterize it as “fair” or “poor.” “Fair/poor” responses were notably higher among seniors, African-American residents and those without health insurance coverage.

### Mental Health & Depression

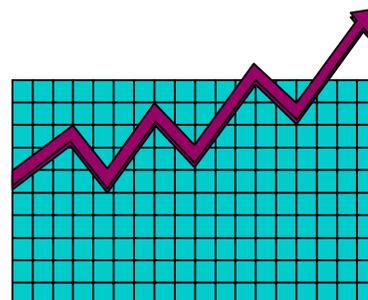
- ☎ 22.0% of respondents report that they have had a period of two weeks or longer in the past year during which they felt sad, blue, depressed, or lost all interest or pleasure in things they usually cared about or enjoyed. Of these people, 30.5% have sought professional help for their depression; another 14.1% said they needed help, but did not receive it for a variety of reasons.
- ☎ Depression was most prevalent among persons living below the 200% poverty threshold, uninsured adults, and African-American residents.
- 📊 Hospitalization rates for mental disorders in Buncombe County exceed state rates by 27%.
- 📊 Buncombe County’s age-adjusted suicide rate (14.7 per 100,000 population) is higher than both state (12.0) and national (10.8) rates, and more than twice the goal for the year 2010 (6.0 or fewer).

### Substance Abuse

- 📊 Hospitalization rates for substance abuse in Buncombe County exceed state rates by 28%. Medicaid costs for a single hospitalization for substance abuse and/or mental disorder average \$4,577 per case in Buncombe County, 14% above the state average.

### Crime

- 📊 Violent crime has increased in Buncombe County over the past several years (from 343.4 violent crimes per 100,000 population in 1993 to 487.1 in 1998). Statewide, these rates have declined during this period.
- 📊 Buncombe County experiences a high rate of child abuse and neglect reports (106.7 per 1,000 children in fiscal year 1997-98; this compares to a rate of only 71.1 statewide).





10.8% of Buncombe County adults acknowledge having been punched, kicked, or otherwise hurt by a family member or someone close to them at some time in the past. A total of 1.9% report this occurring in the past year. Victimization was highest among lower-income and uninsured persons, also among respondents to the Latino survey.

## Births



The percentage of mothers receiving timely prenatal care in Buncombe County (92.3%) has improved over the past five years, and is currently favorable compared to the statewide percentage (83.1%) and the year 2010 goal (90% or higher).



A high percentage (14.2%) of minority births are of low birthweight (less than 5 pounds, 8 ounces). Adolescent pregnancy rates are also high among minority girls (108.6 births per 1,000 girls aged 15-17), higher than found statewide (93.0) and above the statewide target for the year 2010 (86.7 or lower).



One out of five births (19.8%) between 1994 and 1998 in Buncombe County were to mothers who smoke, higher than statewide (15.7%) and nearly twice the goal for the year 2010 (10.0% or less). Three out of four minority births (73.5%) between 1993 and 1997 in Buncombe County were to unmarried women.



The 1994-98 infant death rate among African-American births in Buncombe County (18.9 infant deaths per 1,000 births) is significantly higher than found either statewide (16.2) or nationwide (13.7).

## Disease



The incidence of AIDS in Buncombe County (15.2 cases per 100,000 annually) is above the statewide rate (11.4).



Perceptions Data suggest a need for more HIV awareness and compassion to eliminate the stigma of HIV. Testing for earlier diagnosis would also be helpful.



Incidence rates for sexually transmitted diseases in Buncombe County are low overall.



Perceptions Data point out that STD education and prevention should be a priority among teens.



Incidence of vaccine-preventable illness and enteric disease (e.g., salmonella, E. coli, etc.) are relatively low in Buncombe County.



The hospitalization rate for asthma in Buncombe County is favorable overall, but is considerably high among children under 15 years old (353.8 hospitalizations per 100,000, compared to 267.4 statewide and a year 2010 goal of 225 or lower).



Of several tested chronic conditions, survey respondents report the highest prevalence of: **loss of hearing or vision** (29.7%); **arthritis or rheumatism** (23.5%);

**chronic back problems, headache or other pain (22.6%); and asthma, emphysema or chronic bronchitis (14.5%).** Furthermore, local prevalence levels for diabetes (10.2%) and heart disease (9.9%) are higher than reported nationwide.

### **Leading Causes of Death**

-  The leading causes of death in Buncombe County are **heart disease** (accounting for 29.6% of deaths in 1994-98), followed by **cancers (22.4%)** and **stroke (7.9%)**.
-  Buncombe County demonstrates higher rates than both the state and nation for death resulting from **female breast cancer, chronic obstructive pulmonary disease (COPD or lung disease), suicide, HIV/AIDS, liver disease/cirrhosis and nephritis, nephrosis and nephrotic syndrome (kidney disease)**. Age-adjusted death rates are generally much higher among minority residents, as well as among men in general.
-  Buncombe County fails to satisfy each of the *Healthy People 2010* targets set forth for selected causes of death, most notably **AIDS, suicide, homicide and unintentional injuries**.
-  Over the past two decades, deaths from heart disease, stroke, unintentional injuries and pneumonia/influenza have declined. However, deaths attributed to **female breast cancer, lung disease, diabetes, AIDS and kidney disease** are trending upward.

# Physical Health Status

This section describes various assessments of the general physical health of community residents, including such elements as perceived health status and local death rates.

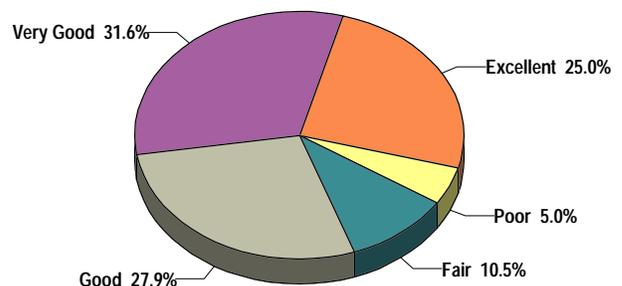
## Self-Reported Physical Health

### Overall Health Status

The *2000 Buncombe County Health Survey* reveals that, in Buncombe County, 56.6% of adults view their individual physical health as “excellent” or “very good.” On the other hand, 15.5% say that their general physical health is overall “fair” or “poor.” This is further outlined in the adjacent chart.

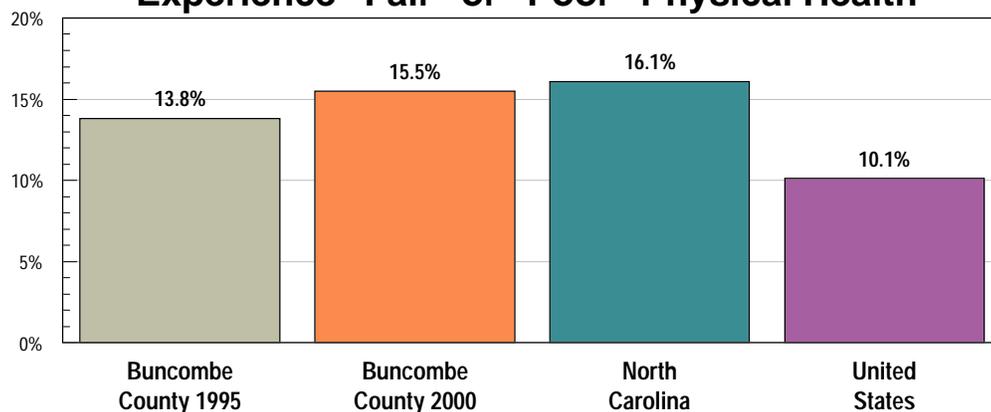
The percentage of area residents reporting “fair” or “poor” physical health is higher than the percentage giving this indication nationwide (10.1%). Compared to 1995 findings, the percentage of residents with “fair” or “poor” health has not changed significantly.

**Self-Reported Health Status**  
(Buncombe County 2000)



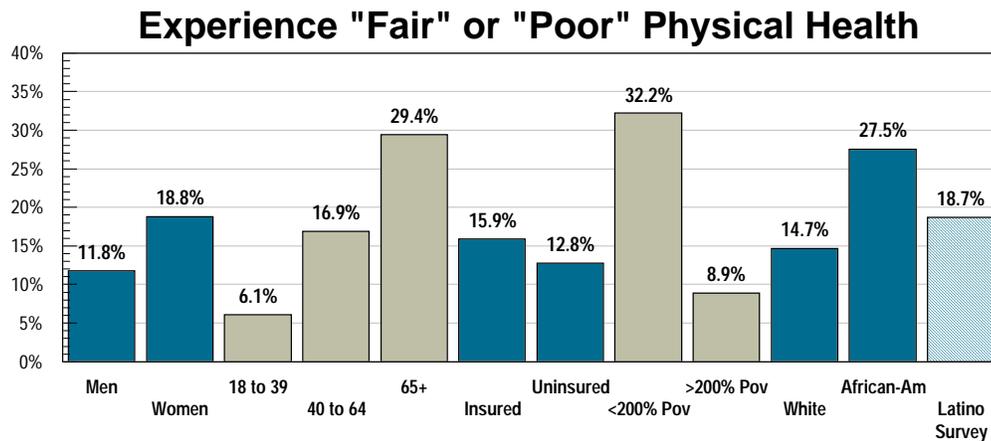
Source: 2000 PRC Community Health Survey, Professional Research Consultants  
Note: Asked of all respondents.

### Experience "Fair" or "Poor" Physical Health



Sources: 1. 1995 & 2000 PRC Community Health Surveys, Professional Research Consultants  
2. Behavioral Risk Factor Surveillance System, Centers for Disease Control, 1997 North Carolina Data  
3. 2000 PRC National Health Survey, Professional Research Consultants  
Note: Asked of all respondents.

The following chart further examines self-reported health status by various demographic characteristics. As might be expected, indications of “fair” or “poor” health increase with age; that is, older residents much more often report their health as “fair” or “poor.” Perhaps more surprising is that there is also a strong correlation with race (27.5% of African-Americans report “fair” or “poor” health compared to 14.7% of Whites), gender (18.8% of females versus 11.8% of males), and income (32.2% of those living at or near the national poverty level compared to 8.9% of those living at twice or more the poverty level). The Latino survey also suggests that 18.7% of local Latinos currently live with “fair” or “poor” physical health, as shown below.



Sources: 1. 2000 PRC Community Health Survey, Professional Research Consultants  
 2. 2000 Buncombe County Latino Health Survey

Notes: 1. Demographic breakouts are among findings in Buncombe County in 2000.  
 2. Asked of all respondents.  
 3. Latino survey data was derived from an independent written survey administered one-on-one by various Buncombe County organization representatives among a convenience sample. In interpreting and comparing results, it is important to note that the Latino survey, unlike the countywide telephone survey, was not administered among a random sample of community members. For this reason, the data from these Latino surveys are not incorporated into the overall county percentage, nor in other demographic breakout percentages.

# Mental Health Status

The following section outlines general assessments of the prevalence of depression among area residents, along with the number of people seeking professional help for problems with depression, stress and emotions.

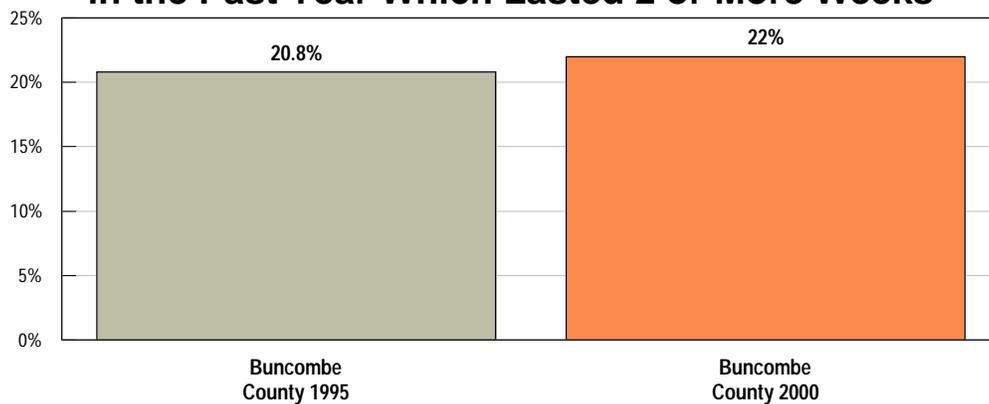
## Depression

Depression is a serious illness affecting the U.S. population, whether occasionally or, in many cases, for prolonged periods of time.

### Recent Bouts of Depression

In Buncombe County, 22.0% of adults report that they have had two or more weeks in the past year during which they felt sad, blue, depressed, or when they lost all interest or pleasure in the things they usually cared about or enjoyed. This figure is statistically similar to the 20.8% reported in Buncombe County in 1995.

**Have Experienced Periods of Depression  
in the Past Year Which Lasted 2 or More Weeks**



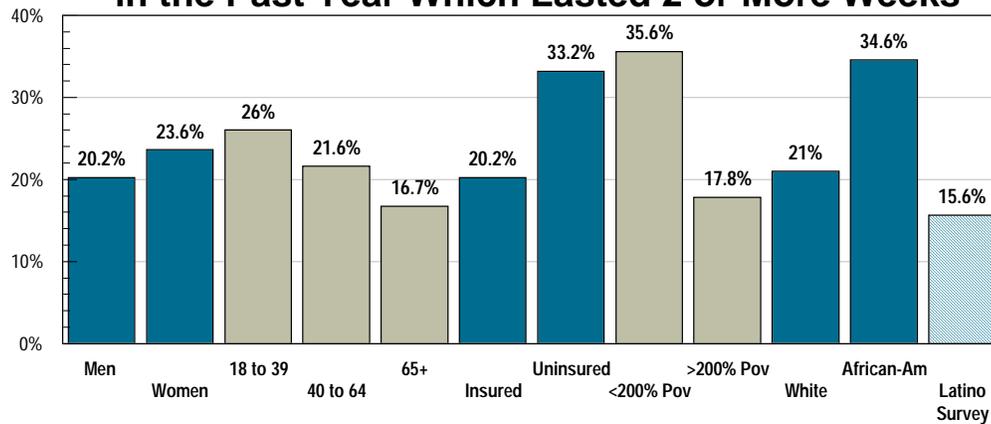
Source: 1995 & 2000 PRC Community Health Surveys, Professional Research Consultants

- Notes:
1. Asked of all respondents.
  2. North Carolina data not available.

Based on the adult population, this prevalence represents approximately 33,000 community members in Buncombe County who have recently faced or are facing bouts with depression.

African-Americans and adults at the lower income level more often report experiencing bouts of depression, as do uninsured residents and adults under 40, as shown below. Note also that 15.6% of respondents to the Latino survey reported experiencing at least two years of depression.

### Have Experienced Periods of Depression in the Past Year Which Lasted 2 or More Weeks



- Sources: 1. 2000 PRC Community Health Survey, Professional Research Consultants  
 2. 2000 Buncombe County Latino Health Survey

- Notes: 1. Demographic breakouts are among findings in Buncombe County in 2000.  
 2. Asked of all respondents.  
 3. Latino survey data was derived from an independent written survey administered one-on-one by various Buncombe County organization representatives among a convenience sample. In interpreting and comparing results, it is important to note that the Latino survey, unlike the countywide telephone survey, was not administered among a random sample of community members. For this reason, the data from these Latino surveys are not incorporated into the overall county percentage, nor in other demographic breakout percentages.

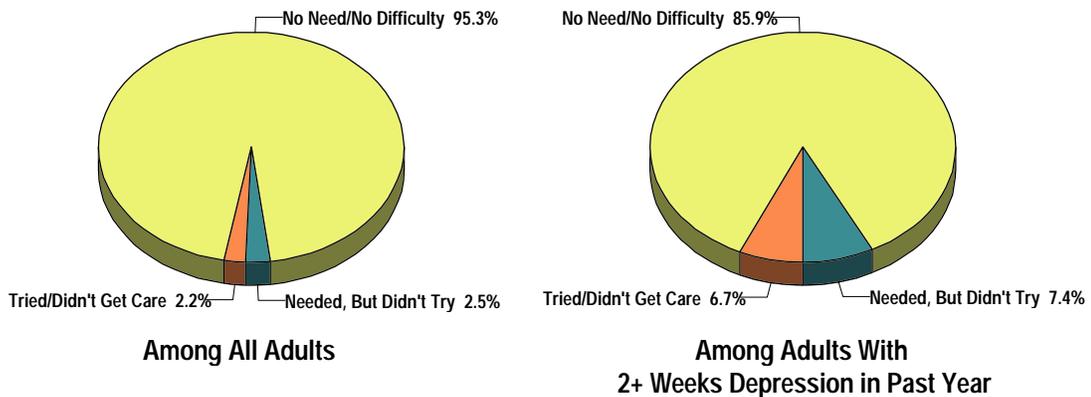
## Utilization of Mental Health Services

### Access to Mental Health Services

A total of 4.7% of county residents reported that, in the past year, they did not obtain professional help for mental health when they needed it (2.5% did not attempt to get care when needed, while 2.2% tried to obtain professional help but were unsuccessful). [The remaining 95.3% said that they did not need such care, or if they did, did not have trouble getting it.]

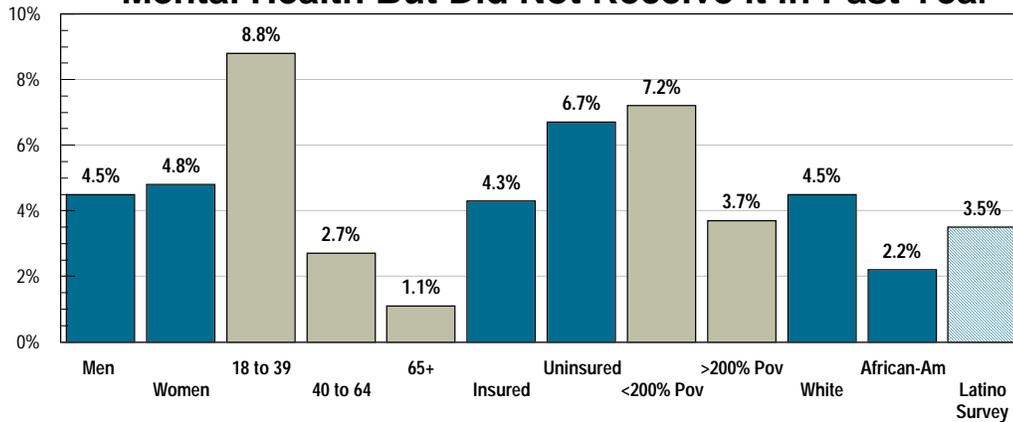
It is important to note that the percentage of adults with recent depression who felt they needed professional help but did not receive it increases to 14.1%, as shown below.

### Attempts to Obtain Professional Help for Mental Health in Past Year



Viewed demographically, Buncombe County adults most likely to report that they did not receive the professional help needed for mental health in the past year include those under 40, adults living at or near the poverty level, those who are uninsured, and Whites.

## Persons Who Needed Professional Help for Mental Health But Did Not Receive it in Past Year

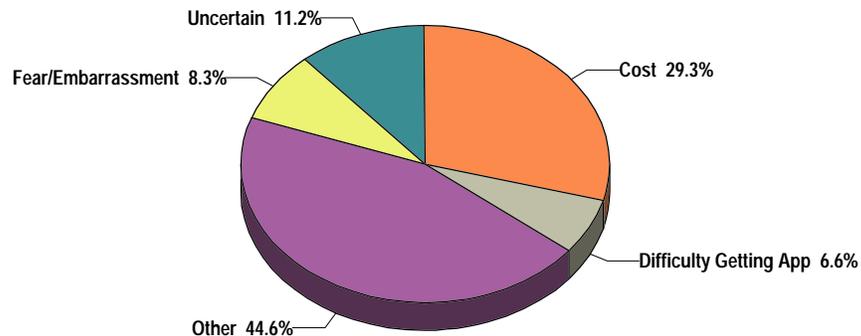


Sources: 1. 2000 PRC Community Health Survey, Professional Research Consultants  
 2. 2000 Buncombe County Latino Health Survey

Notes: 1. Demographic breakouts are among findings in Buncombe County in 2000.  
 2. Asked of all respondents.  
 3. Latino survey data was derived from an independent written survey administered one-on-one by various Buncombe County organization representatives among a convenience sample. In interpreting and comparing results, it is important to note that the Latino survey, unlike the countywide telephone survey, was not administered among a random sample of community members. For this reason, the data from these Latino surveys are not incorporated into the overall county percentage, nor in other demographic breakout percentages.

Adults who did not receive professional help for mental health when needed in the past year (including those who attempted to get help and those who did not) were next asked to give the main reason that they did not receive the needed care. As shown in the adjacent chart, **cost prohibited 29.3%** of these adults, while **8.3%** noted **fear or embarrassment** as their reason for not getting care and **6.6%** reported a **difficulty in getting an appointment**. Another **11.2%** were uncertain as to why they did not receive the needed care.

## Main Reason Did Not Obtain Professional Help for Mental Health

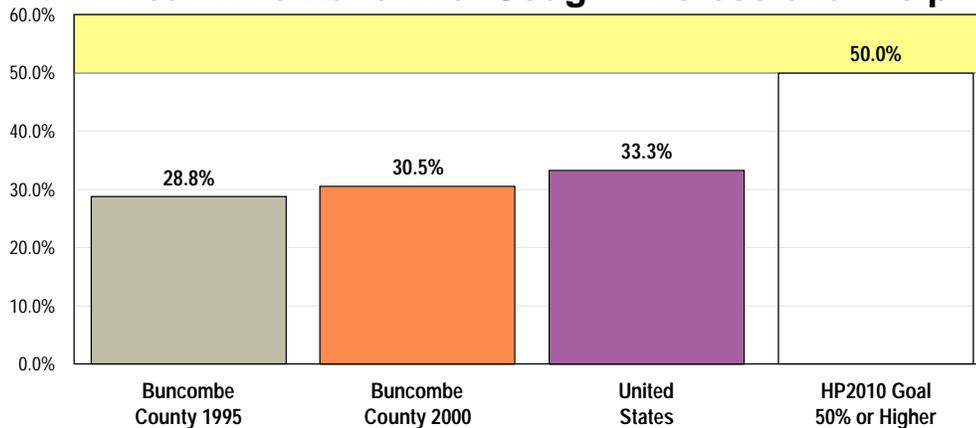


Source: 2000 PRC Community Health Survey, Professional Research Consultants  
 Note: Asked of those respondents who did not receive the professional mental health help they wanted.

## Access to Mental Health Services Among Persons With Depression

Throughout Buncombe County, 30.5% of adults who have experienced two or more weeks of depression in the past year report that they have sought professional help for mental health needs at some time in their lives. This appears similar to the U.S. level (33.3% among those with *prolonged* depression anytime in the past). The *Healthy People 2010* goal is to increase to at least 50% the proportion of adults aged 18 and older with depression who seek professional help.

**Persons With 2+ Weeks of Depression in the Past Year Who Have Ever Sought Professional Help**



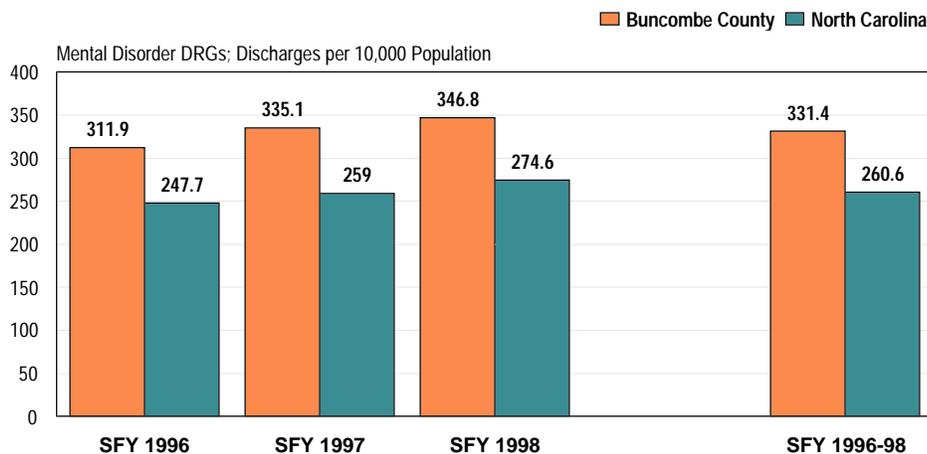
- Sources: 1. 1995 & 2000 PRC Community Health Surveys, Professional Research Consultants  
 2. 2000 PRC National Health Survey, Professional Research Consultants  
 3. *Healthy People 2010* National Center for Health Statistics/CDC/Public Health Service
- Notes: 1. Asked of respondents who have experienced 2 or more weeks of depression.  
 2. North Carolina data not available.

## Hospitalization Rates

[NOTE: Mental health is one area where communities frequently cite an unmet need for data. Hospitalization data indicate the level of serious cases requiring inpatient treatment. Data on hospital discharges related to mental disorders have been compiled using two sources: 1) data from the Division of Mental Health, Mental Retardation, and Substance Abuse Services on inpatient use of state psychiatric hospitals and alcohol and drug abuse treatment centers, and 2) data from public and private general and specialty hospitals on inpatient hospital use for mental disorders. By combining these two data sources to look at hospitalization rates *by county of residence*, a relatively complete picture of hospitalizations for mental disorders is presented. Excluded are data from military hospitals. Also missing from the data are discharges of North Carolina residents from hospitals outside of North Carolina].

Between fiscal years 1996 and 1988, there was an annual average of 331.4 hospital discharges related to mental disorders per 10,000 population in Buncombe County. This hospitalization rate for mental illness is considerable higher than the statewide rate (260.6 discharges per 10,000).

### Mental Disorder Hospitalization Rates



Source: State Center for Health Statistics (SCHS), NC Department of Health and Human Services.

Note: Represents all hospitalizations with any listed diagnosis of a mental disorder (ICD-9CM 290 to 319).

## Perceptions Data\*

“Mental Health is the biggest need in this county – many are disenfranchised due to mental diagnosis or using substances or due to depression, and the shame and the guilt.”

“Adults are accessing medical, that’s a strength, but mental health...nothing to speak of.”

“There is a need for more case workers to do home visits.”

“Our clinicians really started targeting depression because patients are non-compliant with treatment if their mental health is in need of anything.”

“I think loneliness and isolation...are probably the main problems (among the elderly).”

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# Substance Abuse

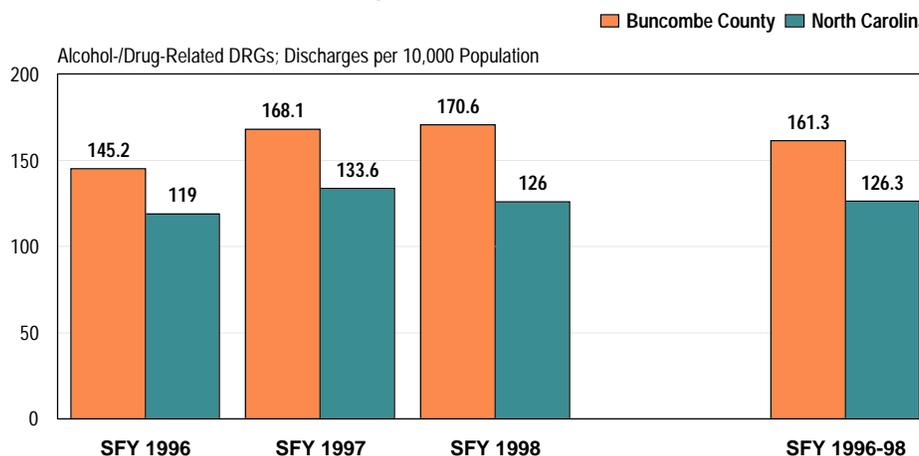
The misuse of alcohol and other drugs is associated with several health risks (including HIV transmission) and has tremendous societal and economic costs, as well. Alcohol/drug use is implicated in nearly one-half of all deaths from motor vehicle accidents and intentional injuries (including homicides and suicides), and drinking during pregnancy is the leading preventable cause of birth defects.

## Hospitalization Rates

[NOTE: Alcohol- and drug-related hospitalization data indicate the level of serious cases requiring inpatient treatment. Data on these hospital discharges have been compiled using two sources: 1) data from the Division of Mental Health, Mental Retardation, and Substance Abuse Services on inpatient use of statewide psychiatric hospitals and alcohol and drug abuse treatment centers, and 2) data from public and private general and specialty hospitals/facilities with any alcohol- or drug-related diagnosis. By combining these two data sources to look at hospitalization rates *by county of residence*, a relatively complete picture of hospitalizations is presented. Excluded are data from military hospitals. Also missing from the data are discharges of North Carolina residents from facilities outside of North Carolina].

Between fiscal years 1996 and 1998, there was an annual average of 161.3 hospital discharges related to substance abuse (alcohol and drugs) per 10,000 population in Buncombe County. This hospitalization rate is considerably higher than the statewide rate (126.3 discharges per 10,000).

### Alcohol- and Drug-Related Hospitalization Rates



Source: State Center for Health Statistics (SCHS), NC Department of Health and Human Services.

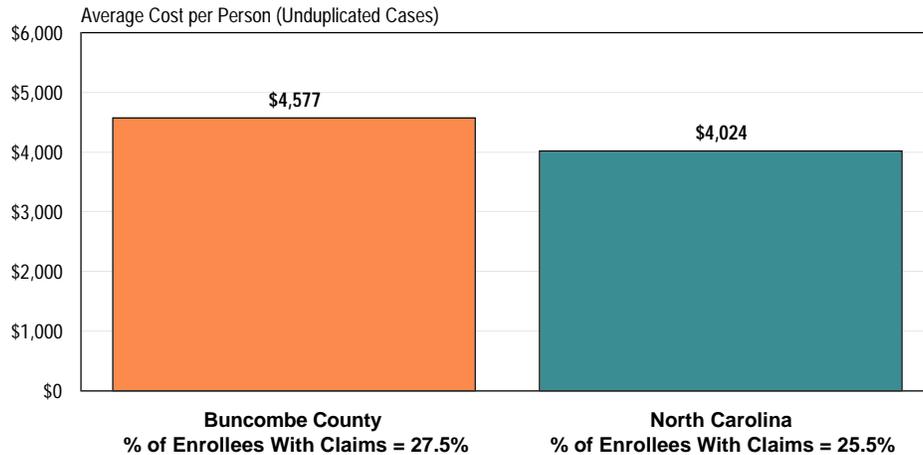
Note: Represents all hospitalizations with any listed diagnosis of Alcohol and Drug Abuse (ICD-9CM 291,292,303-305).

## Medicaid Costs

[NOTE: The data in the following table reflect, *by county of residence*, an unduplicated count of persons on Medicaid who had a medical care claim with a diagnosis of a mental disorder (principal or contributing; ICD-9-CM codes 290-319) or had a prescription for a drug used in the treatment of mental disorders. These data are for calendar year 1998.]

Based on paid Medicaid claims in 1998, the average Medicaid cost of a single hospitalization for mental disorders or substance abuse was \$4,577 per case. This is 14% higher than the average cost statewide. Note also in the following chart that 27.5% of Buncombe County Medicaid enrollees had such claims in 1998.

### Paid Medicaid Claims for Mental Disorder or Alcohol & Substance Abuse, Calendar Year 1998



Source: State Center for Health Statistics (SCHS), NC Department of Health and Human Services.

Note: Represents all hospitalizations with any listed diagnosis of a mental disorder (ICD-9CM 290 to 319) or Alcohol/Drug Abuse (ICD-9CM 291,292,303-305).

## Perceptions Data

### Substance Abuse Among Youth

Among youth and teens, substance abuse is also a big concern.

“Parents aren’t able to parent because they have so many problems or they’re drinking. Because of that non-supervision youth make choices that affect their health. One kid said to me, ‘Well, you know there’s nothing to do around here so kids just get drunk and have sex.’ So that drug and sex problem, hand in hand with

\* *The Perceptions Data are valuable in identifying issues and providing context to the findings of this assessment. Keep in mind, however, that these qualitative comments are attributable only to those citizens and Key Informants participating in this effort and are not necessarily representative of the study sponsors nor the community at large.*

no adult supervision around...leaves them (teens) wide open to any kind of accidents like drunk driving (and unsafe sex)." (Teen advocate)

"Working with the kids, the drugs they are using are, of course tobacco, alcohol, marijuana, ecstasy or acid seem to be big around here and those are all cheap things that can be made and don't have to be smuggled in. This is a big pot-growing area."

"I think you have a lot of abuse of drugs, especially among young people. And I find it is especially true for the African-American male who may be a high school drop out and not willing to go on to AB Tech and get his GED and go on and acquire some technical skills that will provide him a decent income."

For Perceptions Data about drug-related crime and violence, refer to page 197.

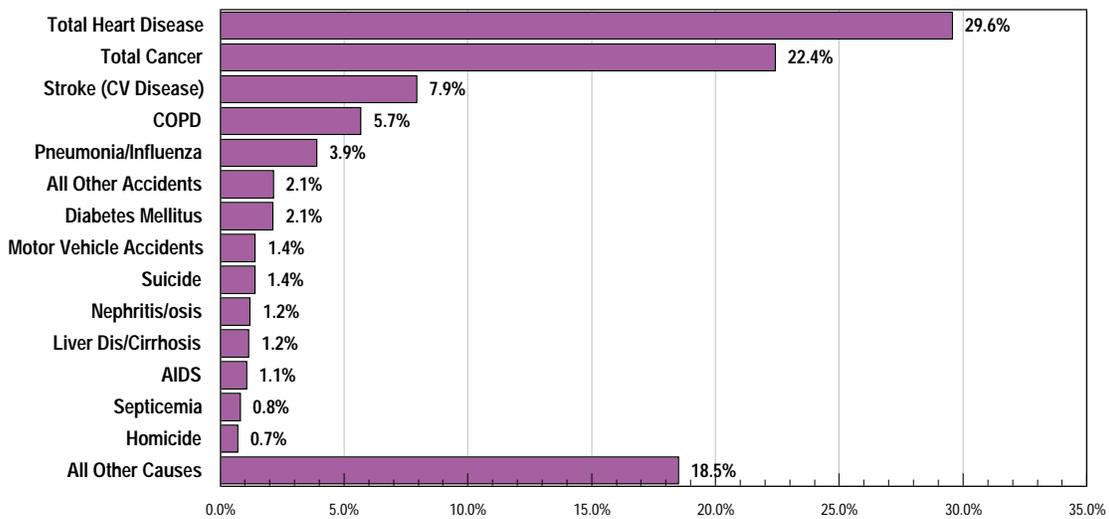
# Mortality

Certainly no community assessment of health would be complete without an examination of the rates and causes of death found in the population. Such an assessment is detailed in the following section.

## Leading Causes of Death

**Heart disease** is the leading cause of death in Buncombe County, accounting for an annual average of 29.6% of deaths between 1994 and 1998. **Cancers (all sites)** accounted for 22.4% of deaths during this period, and **cerebrovascular disease (stroke)** accounted for 7.9%.

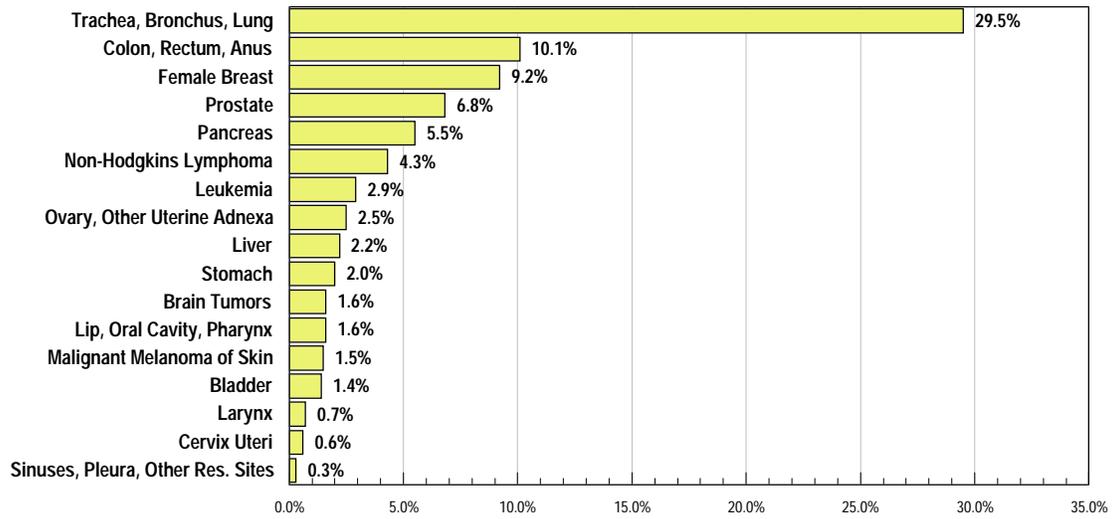
**Leading Causes of Death, Buncombe County  
1994-1998**



Source: State Center for Health Statistics (SCHS), NC Department of Health and Human Services.

With regard to cancer deaths, the leading type of cancer death is **trachea, bronchus and lung cancer**, accounting for 29.5% of all cancer deaths. Other cancer sites leading cancer deaths include **colorectal cancer, female breast cancer and prostate cancer**, as shown in the following chart.

## Leading Causes of Cancer Deaths by Site, Buncombe County 1994-1998



Source: State Center for Health Statistics (SCHS), NC Department of Health and Human Services.

## Leading Causes of Death by Age Group

The following chart further details leading causes of death by distinct age segments, expressed in the annual average number of deaths by cause per 100,000 population within each age segment. As shown:

- **Prenatal conditions and unintentional injuries** are the leading causes of death for those under the age of 20, followed by congenital anomalies (birth defects) and intentional injuries (suicide and homicide).
- **Unintentional injuries** (including motor vehicle and other accidents) and **AIDS** are the leading causes among young adults (20 to 39 years of age).
- **Cancer and heart disease** become leading causes for those aged 40 to 84.
- For those aged 85 and older, **heart disease** is by far the leading killer, followed by **stroke and cancer**.

## Age-Specific Death Rates per 100,000 Population by Leading Causes, Buncombe County 1994-98

Under 20		20-39 Years		40-64 Years		65-84 Years		85+ Years	
Prenatal Conditions	17.7	Unintentional Injuries	38.9	Total Cancer	193.3	Heart Disease	1,105.3	Heart Disease	5355.7
Unintentional Injuries	17.7	Motor Vehicle Injuries	21.9	Lung Cancer	62.2	Total Cancer	1,017.9	Stroke	1737.1
Motor Vehicle Injuries	13.4	Other Injuries	17.0	Female Breast Cancer	50.5	Lung Cancer	324.6	Total Cancer	1567.0
Other Injuries	4.3	AIDS	25.3	Heart Disease	153.1	Prostate Cancer	188.0	Prostate Cancer	691.3
Congenital Anomalies	10.4	Suicide	17.7	Unintentional Injuries	26.0	Female Breast Cancer	121.6	Pneumonia/Influenza	1010.3
Suicide	6.5	Homicide	15.5	Other Injuries	16.6	Colorectal Cancer	96.2	COPD	525.8
Homicide	4.8	Heart Disease	12.8	Motor Vehicle Injuries	9.5	COPD	302.9	Diabetes Mellitus	180.4
SIDS	3.0	Total Cancer	12.1	Liver Disease/Cirrhosis	24.7	Stroke	291.3		
Total Cancer	2.2			Stroke	22.3	Pneumonia/Influenza	119.3		
				Diabetes Mellitus	18.9	Diabetes Mellitus	88.9		
				Suicide	17.9				

Source: State Center for Health Statistics (SCHS), NC Department of Health and Human Services.

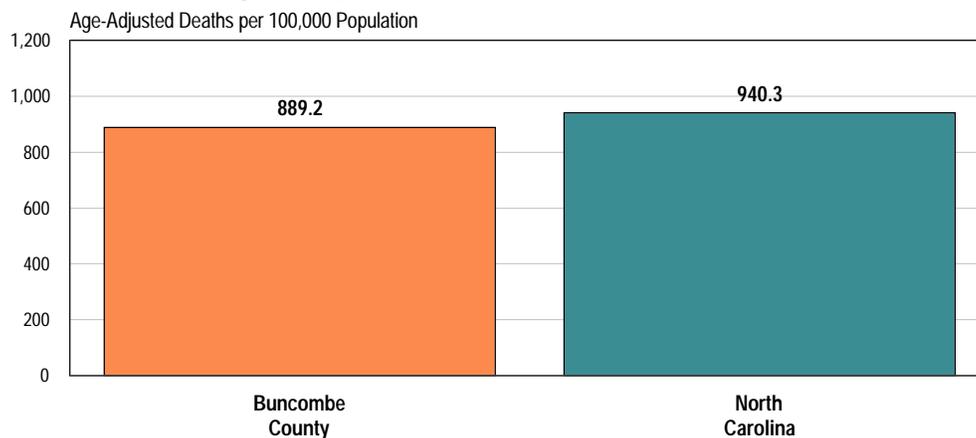
## Age-Adjusted Death Rates for Selected Causes

Note: In order to compare mortality in Buncombe County with other localities (in this case, North Carolina and the United States), it is necessary to look at *rates* of death — these are figures which represent the number of deaths in relation to the population size such as deaths per 100,000 population as is used here.

Furthermore, in order to compare localities without undue bias toward younger or older populations, the common convention is to adjust the data to some common baseline age distribution (such as the 2000 U.S. population, as is used in this report). Use of these “age-adjusted” rates provides the most valuable means of gauging mortality against normative or benchmark data.

Between 1994 and 1998, Buncombe County experienced an annual average of 889.2 age-adjusted deaths per 100,000 population, lower than the statewide death rate.

### Age-Adjusted Death Rates, 1994-98



Source: State Center for Health Statistics (SCHS), NC Department of Health and Human Services.  
Note: Figures are age-adjusted to the 2000 U.S. population.

The following chart illustrates the annual average age-adjusted death rates measured between 1994 and 1998 in Buncombe County for selected causes of death. Age-adjusted North Carolina and national death rates are also provided, along with any applicable goals set forth in *Healthy People 2010*.

In comparison to North Carolina and United States age-adjusted death rates, Buncombe County demonstrates higher rates than both the state and nation for death resulting from **female breast cancer, chronic obstructive pulmonary disease (COPD or lung**

disease), **suicide**, **HIV/AIDS**, **liver disease/cirrhosis** and **nephritis, nephrosis and nephrotic syndrome** (kidney disease).

Buncombe County experiences rates comparable to or better than the state, but higher than the U.S., for **lung cancer, prostate cancer, stroke, unintentional injuries and homicide**.

### Age-Adjusted Death Rates by Selected Causes

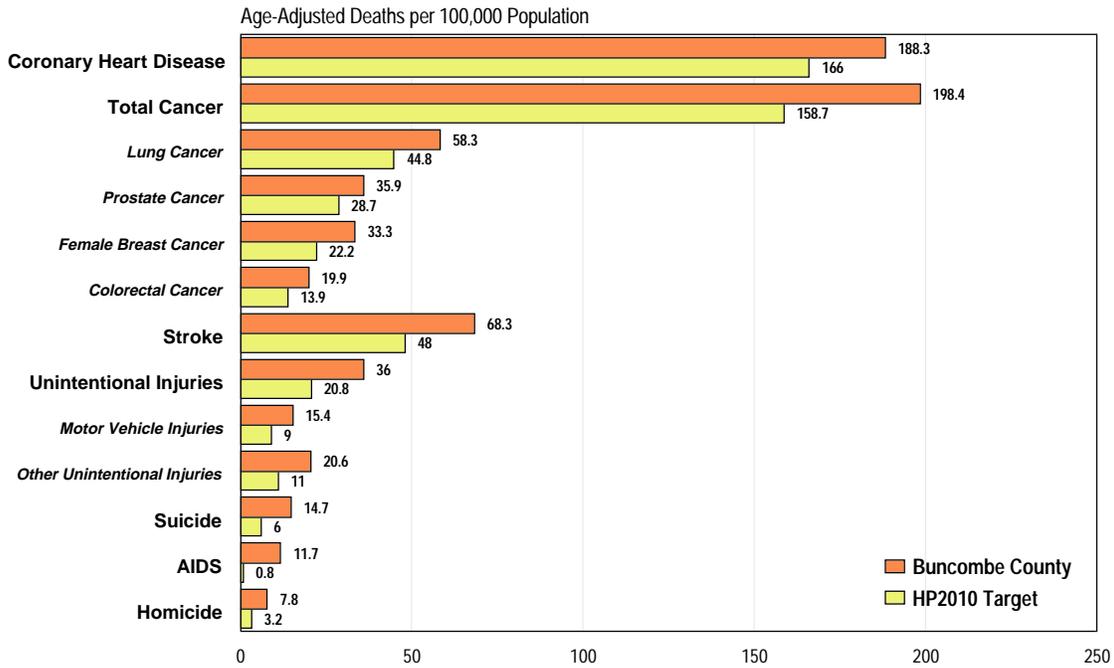
	Buncombe County	North Carolina	United States	HP2010 Target
Total Heart Disease	257.3	282.0	n/a	n/a
<i>Coronary Heart Disease</i>	188.3	n/a	**215.9	166.0
Total Cancer	198.4	210.1	201.4	158.7
<i>Lung Cancer</i>	58.3	62.6	57.4	44.8
<i>Prostate Cancer</i>	35.9	41.0	31.9	28.7
<i>Female Breast Cancer</i>	33.3	28.6	27.7	22.2
<i>Colorectal Cancer</i>	19.9	21.3	21.1	13.9
Stroke (Cerebrovascular Disease)	68.3	78.0	60.0	48.0
COPD	48.6	41.9	* 40.5	n/a
Unintentional Injuries	36.0	42.1	33.3	20.8
<i>Motor Vehicle Injuries</i>	15.4	20.6	15.6	9.0
<i>Other Unintentional Injuries</i>	20.6	21.5	17.7	11.0
Pneumonia/Influenza	33.6	36.8	* 33.8	n/a
Diabetes Mellitus	19.1	25.3	* 23.4	n/a
Suicide	14.7	12.0	10.8	6.0
HIV/AIDS	11.7	10.1	4.9	0.8
Chronic Liver Disease/Cirrhosis	11.4	9.5	** 9.6	n/a
Nephritis/Nephrosis/Neph Syndrome	10.4	10.0	* 9.5	n/a
Homicide	7.8	9.3	6.2	3.2
Septicemia	7.1	9.8	* 8.4	n/a

Source: State Center for Health Statistics (SCHS), NC Department of Health and Human Services.

- Notes:
1. Death rates are per 100,000 residents, age-adjusted to the 2000 standard U.S. population.
  2. Buncombe County and North Carolina data are 1994-98, except coronary heart disease (1995-97).
  3. U.S. data are 1998, unless noted with a "\*" (1995) or "\*\*" (1997).

As can be seen, Buncombe County fails to satisfy each of the *Healthy People 2010* targets set forth for these selected causes. Most notable of these are **AIDS** (1,362.5% higher), **suicide** (145.0% higher), **homicide** (143.8% higher), **unintentional injuries** (73.1% higher), **stroke** (42.3% higher) and **cancer** (25.0% higher than the target).

## Age-Adjusted Death Rates by Selected Causes, (1994-98 Buncombe County vs. Healthy People 2010 Targets)

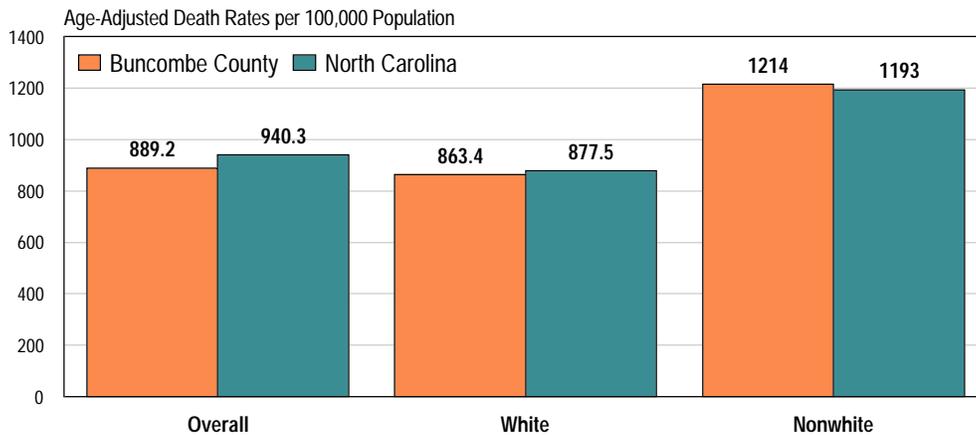


Source: State Center for Health Statistics (SCHS), NC Department of Health and Human Services.  
 Note: Death rates are age-adjusted to the 2000 U.S. standard population.

## Age-Adjusted Deaths by Race

Age-adjusted death rates are considerably higher among nonwhite populations than among whites. Furthermore, while the overall Buncombe County age-adjusted death rate is below the statewide rate, its nonwhite death rate is not, as shown in the following chart.

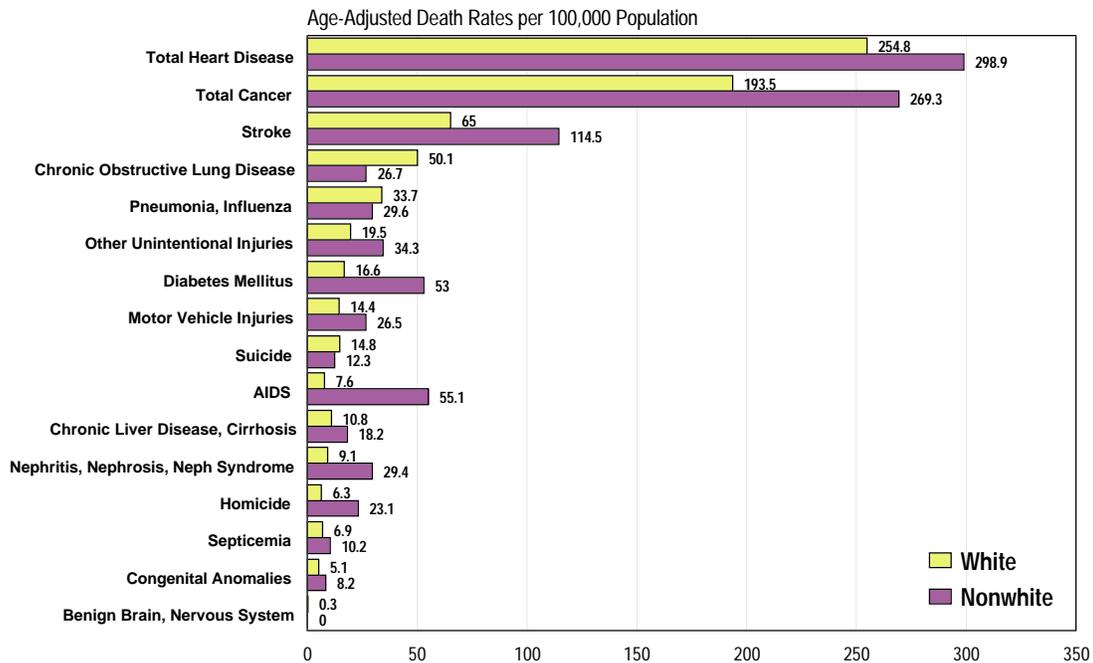
## Age-Adjusted Death Rates by Race, 1994-98



Source: State Center for Health Statistics (SCHS), NC Department of Health and Human Services.  
 Note: Death rates are age-adjusted to the 2000 U.S. standard population.

The following chart further compares age-adjusted death rates by selected causes between whites and nonwhites in Buncombe County. As can be seen, death rates among nonwhites are much higher for many of these causes, including heart disease, cancer, unintentional injuries, diabetes and AIDS.

### Buncombe County Age-Adjusted Death Rates for Selected Causes by Race, 1994-98

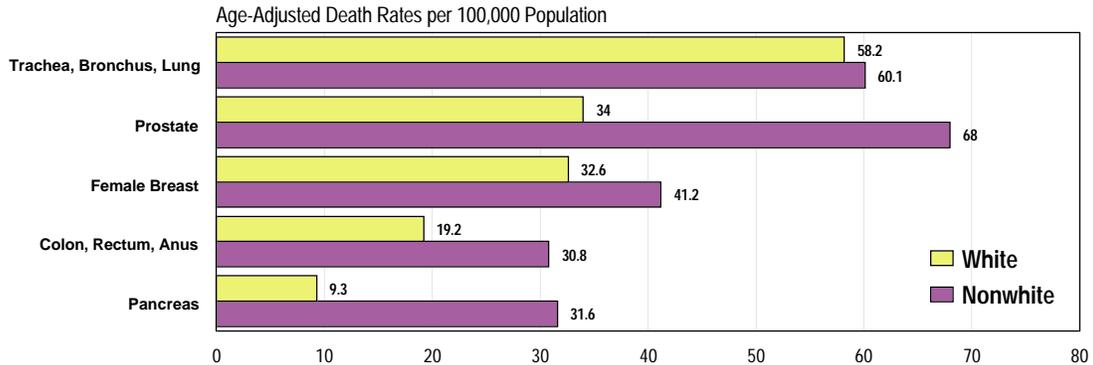


Source: State Center for Health Statistics (SCHS), NC Department of Health and Human Services.  
 Note: Death rates are age-adjusted to the 2000 U.S. standard population.

### Cancer Deaths

The following chart shows that nonwhites experience higher age-adjusted death rates for most types of cancer, as well. These include especially prostate, colorectal and pancreatic cancers.

## Buncombe County Age-Adjusted Death Rates for Selected Cancers by Race, 1994-98

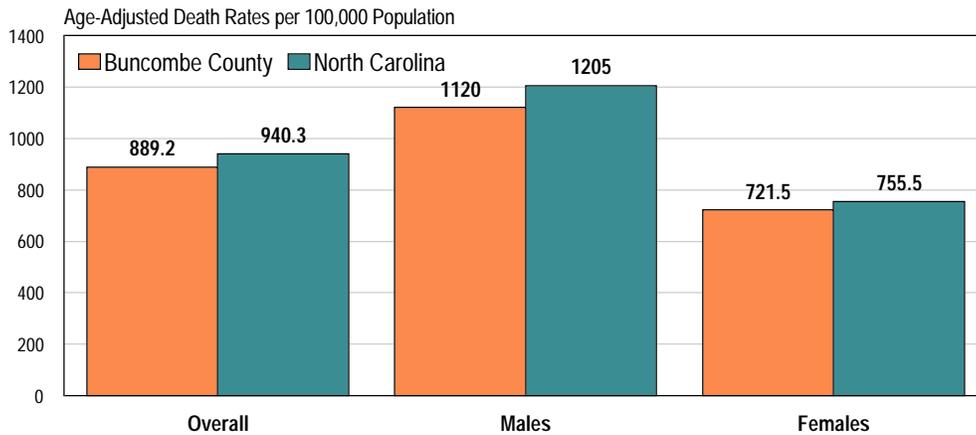


Source: State Center for Health Statistics (SCHS), NC Department of Health and Human Services.  
 Note: Death rates are age-adjusted to the 2000 U.S. standard population.

### Age-Adjusted Deaths by Gender

Age-adjusted death rates are also considerable higher among males than among females, as shown in the following chart.

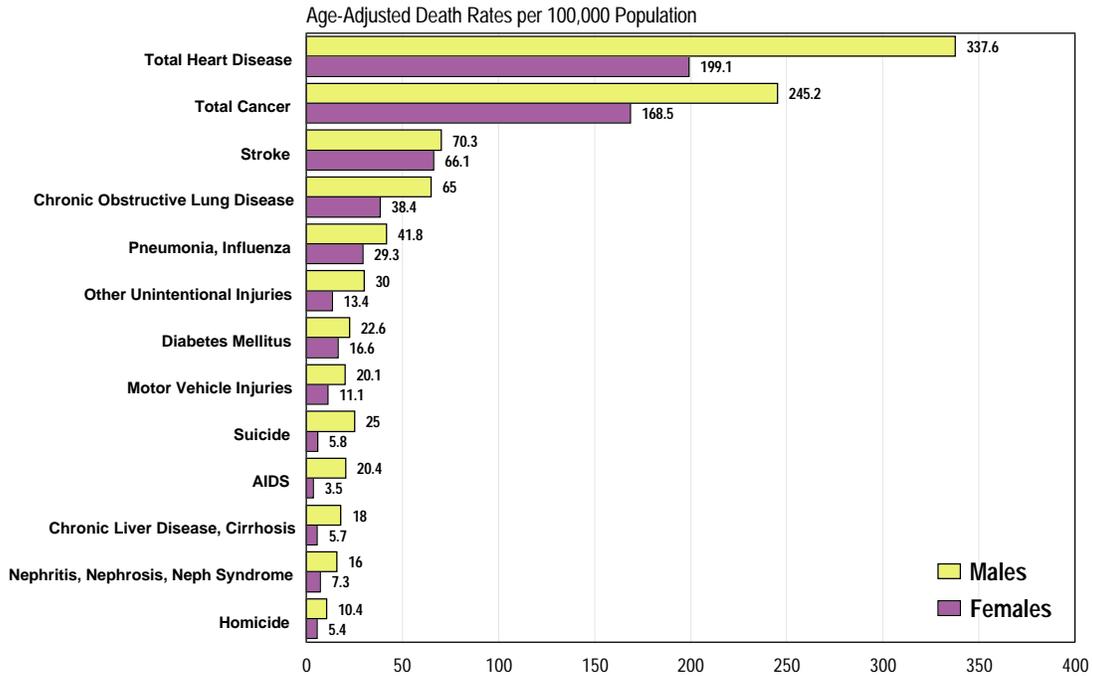
### Age-Adjusted Death Rates by Gender, 1994-98



Source: State Center for Health Statistics (SCHS), NC Department of Health and Human Services.  
 Note: Death rates are age-adjusted to the 2000 U.S. standard population.

Note that, with the exception of stroke deaths, males experience considerably higher death rates than females for each of the selected causes illustrated below.

### Buncombe County Age-Adjusted Death Rates for Selected Causes by Gender, 1994-98

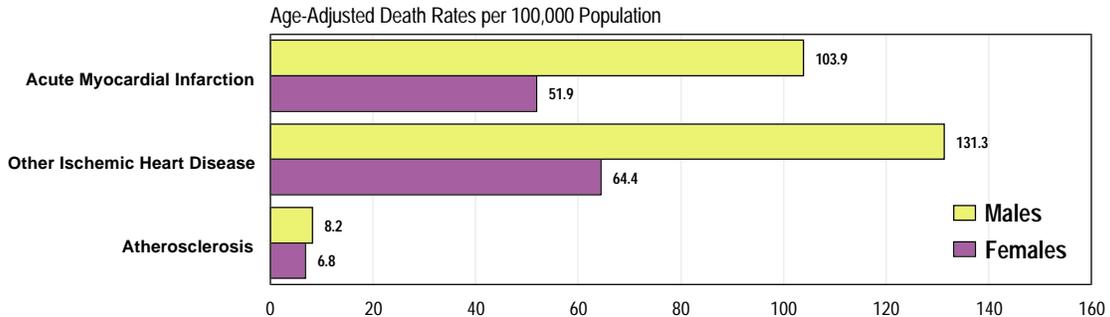


Source: State Center for Health Statistics (SCHS), NC Department of Health and Human Services.  
 Note: Death rates are age-adjusted to the 2000 U.S. standard population.

### Heart Disease Deaths

Males also experience significantly higher age-adjusted death rates due to acute myocardial infarction and other ischemic heart disease.

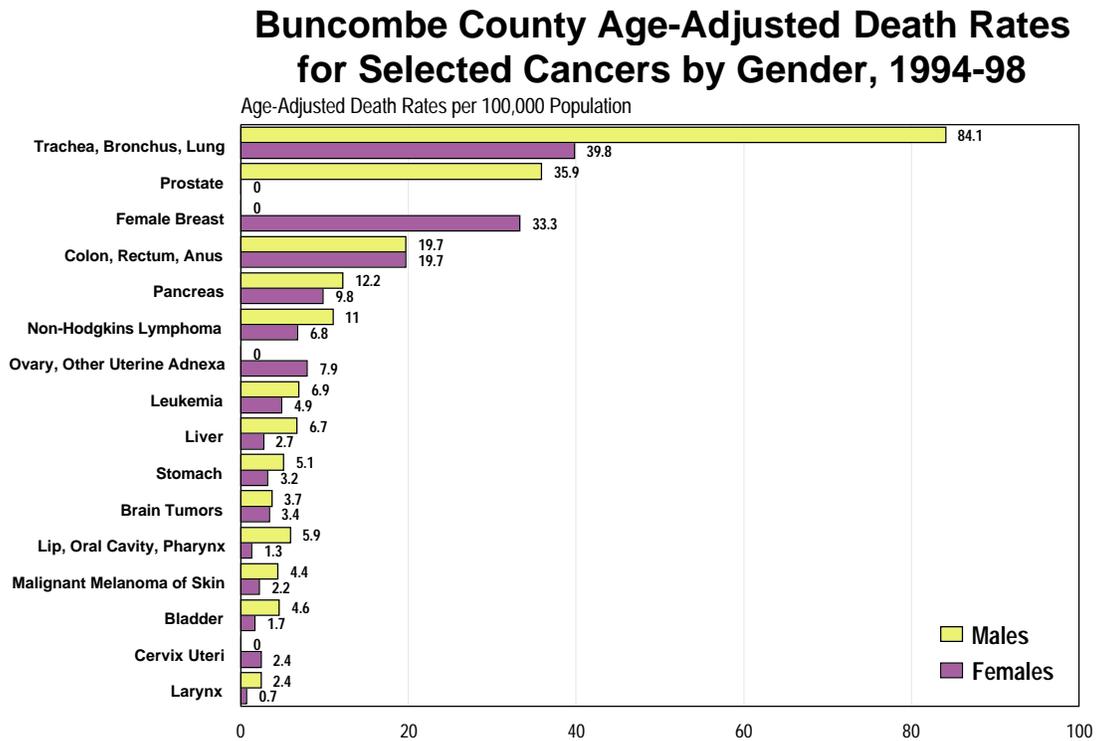
### Buncombe County Age-Adjusted Cardiovascular Death Rates by Gender, 1994-98



Source: State Center for Health Statistics (SCHS), NC Department of Health and Human Services.  
 Note: Death rates are age-adjusted to the 2000 U.S. standard population.

## Cancer Deaths

In examining cancer deaths by disease site, males experience a significantly higher age-adjusted death rate due to lung cancer than do females. Males also experience higher rates for other non-gender-specific cancers, as shown below.

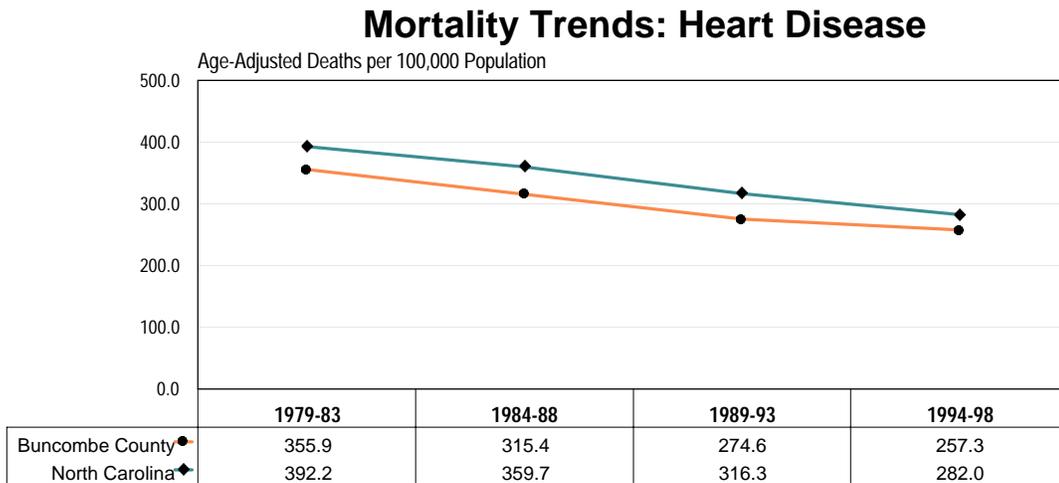


Source: State Center for Health Statistics (SCHS), NC Department of Health and Human Services.  
 Note: Death rates are age-adjusted to the 2000 U.S. standard population.

## Trends in Age-Adjusted Death Rates

### Heart Disease

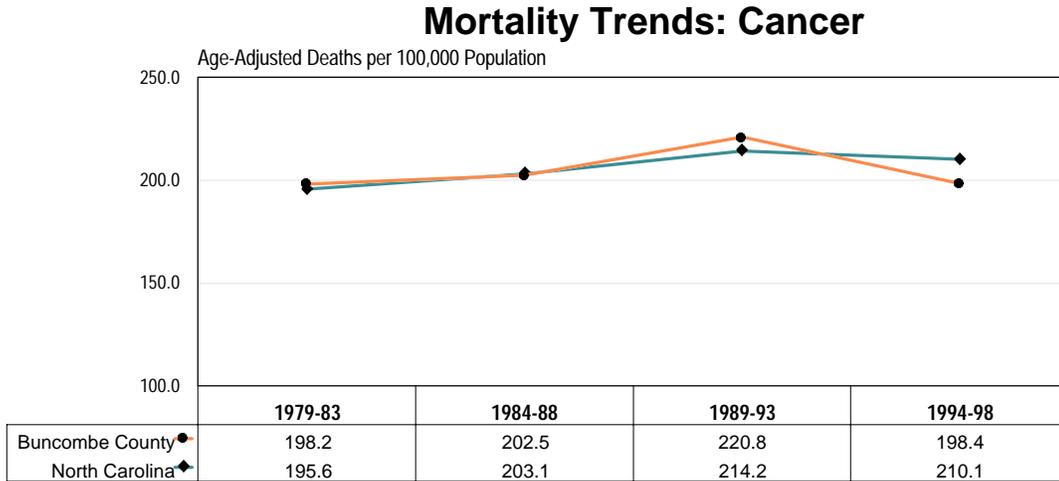
Over the past 20 years, heart disease death rates have declined steadily, as found statewide and nationwide. During this period, the Buncombe County rate has remained below the North Carolina rate. [Note: the reason five-year averages are used is to minimize the natural fluctuations occurring from year to year, which can be quite pronounced in smaller populations.]



Source: State Center for Health Statistics (SCHS), NC Department of Health and Human Services.  
Note: Death rates are age-adjusted to the 2000 U.S. standard population.

## Cancers

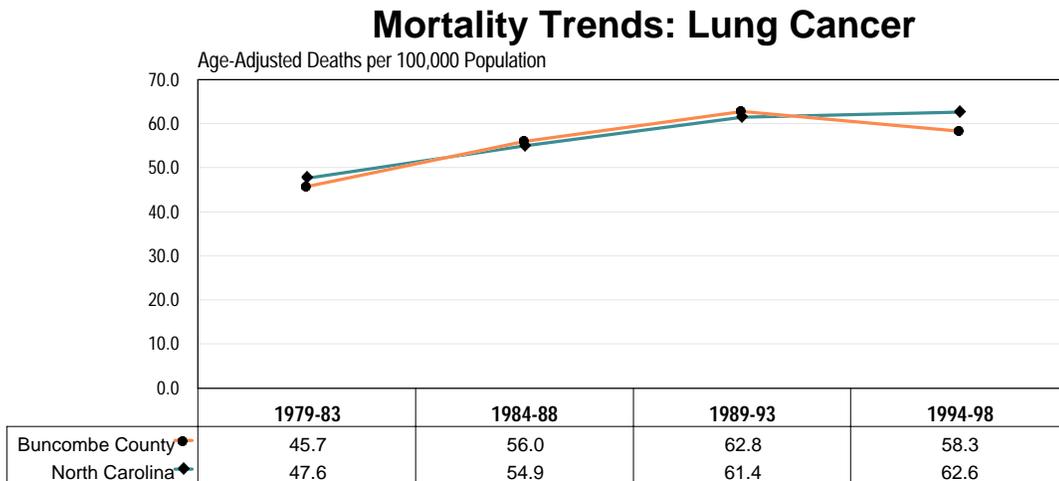
In Buncombe County, the cancer death rate dipped in the 1994-98 period to closely match that experienced in 1979-83 (after increasing during interim five-year periods). Until the recent decline, the Buncombe County rate had tracked closely with the statewide rate.



Source: State Center for Health Statistics (SCHS), NC Department of Health and Human Services.  
 Note: Death rates are age-adjusted to the 2000 U.S. standard population.

## Lung Cancer

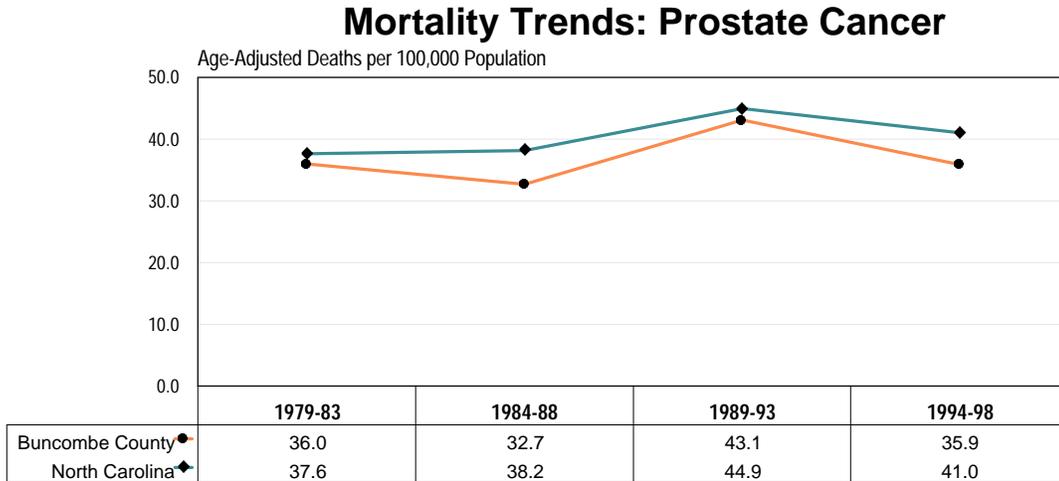
Likewise, the Buncombe County lung cancer death rate dropped in 1994-98 after successive increases since the 1979-83 period. Again, until the recent decline, the county rate had tracked closely with the North Carolina rate.



Source: State Center for Health Statistics (SCHS), NC Department of Health and Human Services.  
 Note: Death rates are age-adjusted to the 2000 U.S. standard population.

## Prostate Cancer

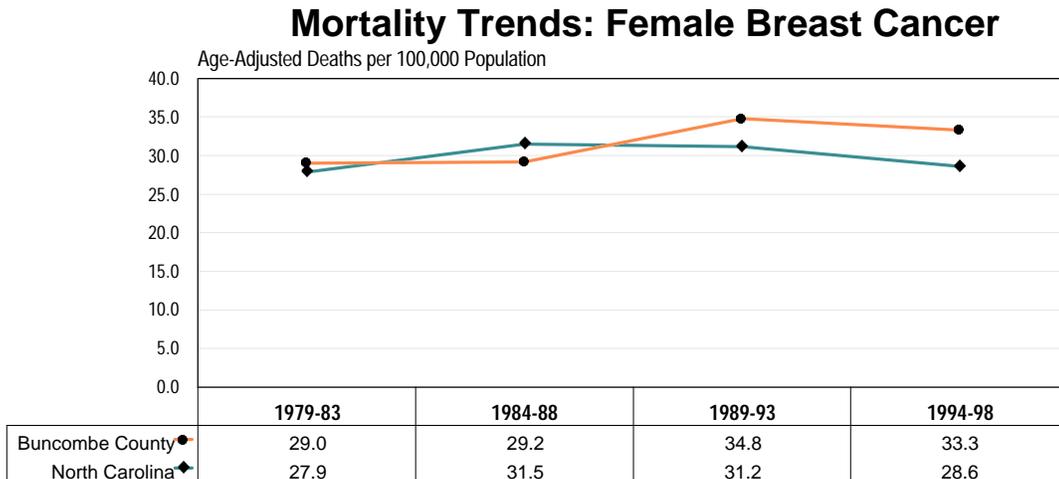
As found statewide, prostate cancer deaths have fluctuated over the past 20 years, showing no clear trend.



Source: State Center for Health Statistics (SCHS), NC Department of Health and Human Services.  
 Note: Death rates are age-adjusted to the 2000 U.S. standard population.

## Female Breast Cancer

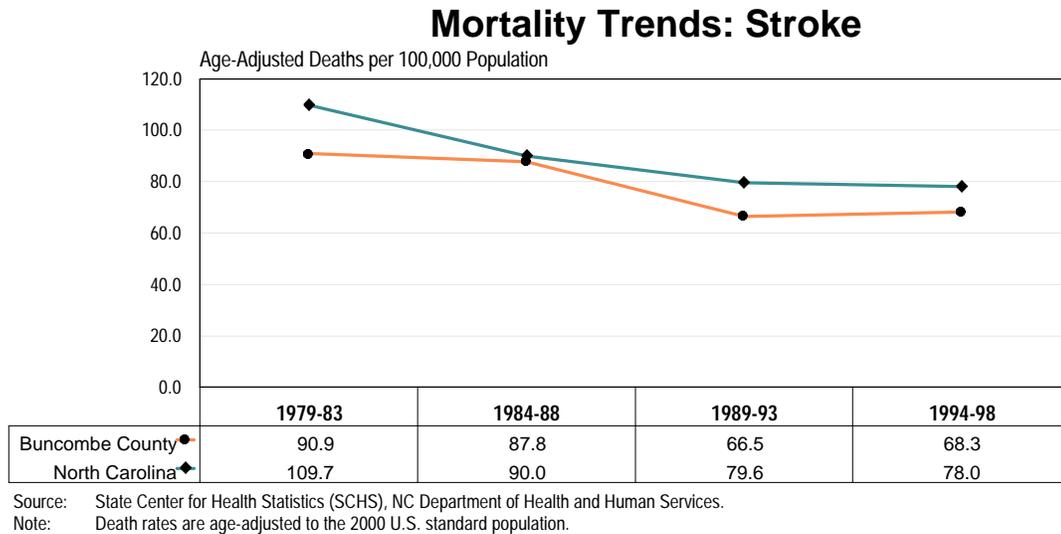
The Buncombe County female breast cancer death rate is currently above that of North Carolina, and, unlike the state rate, appears to be following an upward trend.



Source: State Center for Health Statistics (SCHS), NC Department of Health and Human Services.  
 Note: Death rates are age-adjusted to the 2000 U.S. standard population.

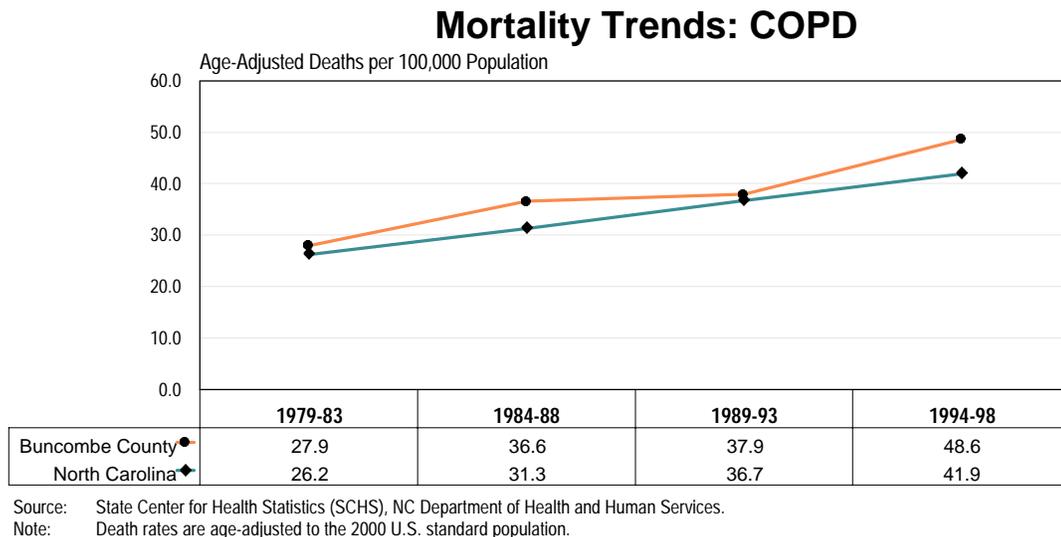
## Stroke

The age-adjusted stroke death rate in Buncombe County appears to be on a downward trend and remains below the statewide rate.



## Chronic Obstructive Pulmonary Disease

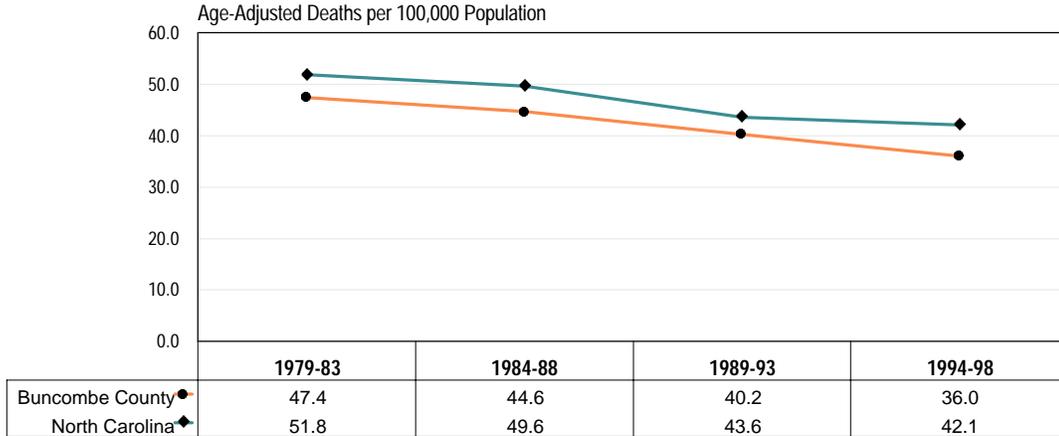
The age-adjusted COPD death rate in Buncombe County has followed an upward trend over the past 20 years, mirroring (but slightly higher than) the statewide rate.



## Unintentional Injuries

The age-adjusted death rate for unintentional injuries has declined over the past 20 years. The statewide rate has also declined, but remains above the Buncombe County rate.

### Mortality Trends: Unintentional Injuries

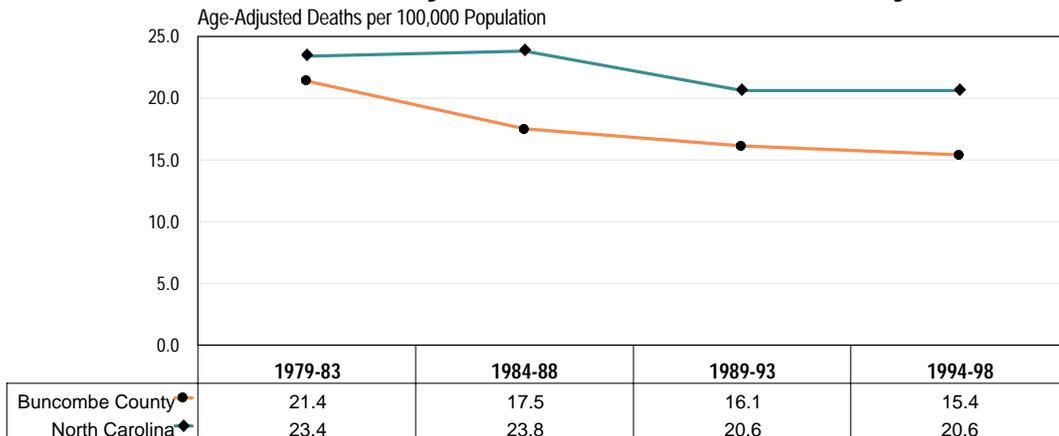


Source: State Center for Health Statistics (SCHS), NC Department of Health and Human Services.  
 Note: Death rates are age-adjusted to the 2000 U.S. standard population.

## Motor Vehicle Injuries

Over the past 20 years, the age-adjusted death rate for motor vehicle injuries has declined in Buncombe County, most notably during the early 1980s. The current rate is 25% below the North Carolina rate.

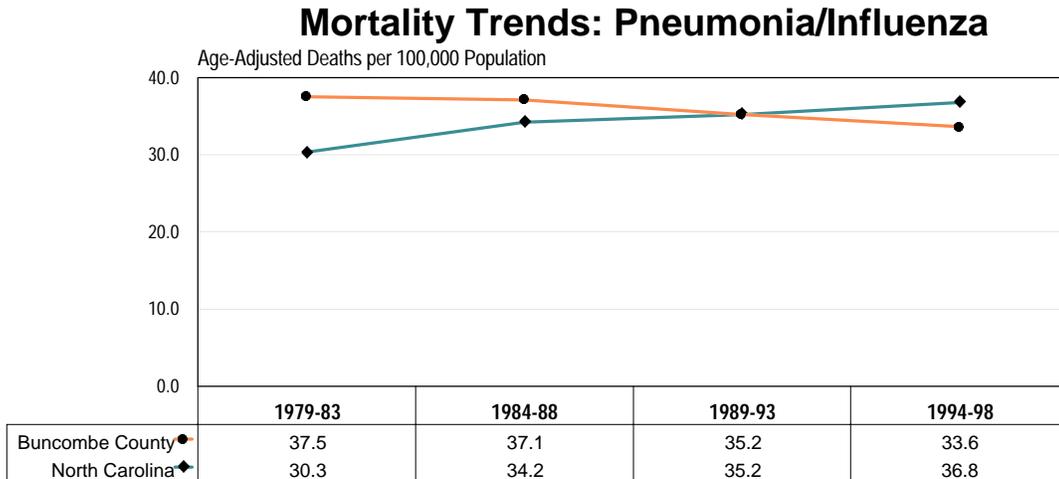
### Mortality Trends: Motor Vehicle Injuries



Source: State Center for Health Statistics (SCHS), NC Department of Health and Human Services.  
 Note: Death rates are age-adjusted to the 2000 U.S. standard population.

## Pneumonia/Influenza

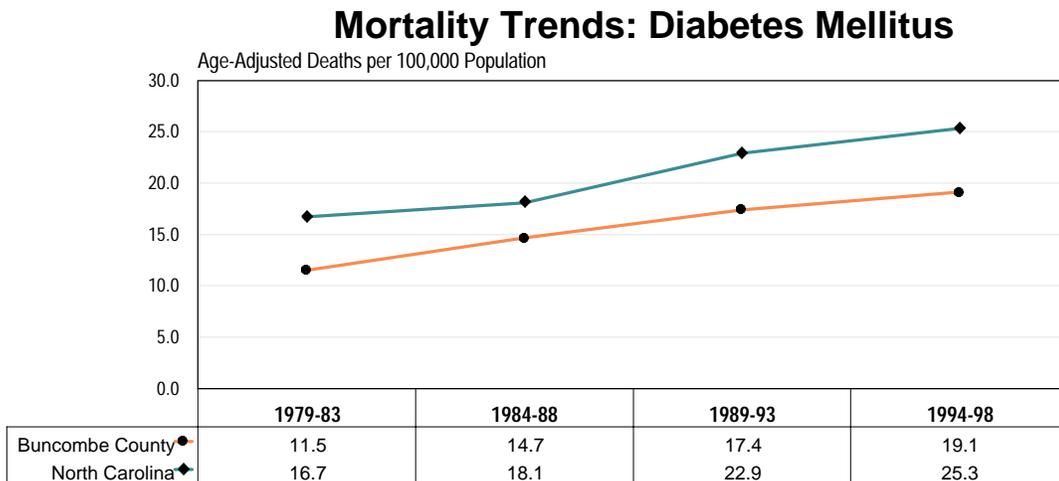
While the age-adjusted death rate for pneumonia/influenza has risen over the past 20 years statewide, the Buncombe County rate has declined, and is currently below the statewide rate.



Source: State Center for Health Statistics (SCHS), NC Department of Health and Human Services.  
Note: Death rates are age-adjusted to the 2000 U.S. standard population.

## Diabetes Mellitus

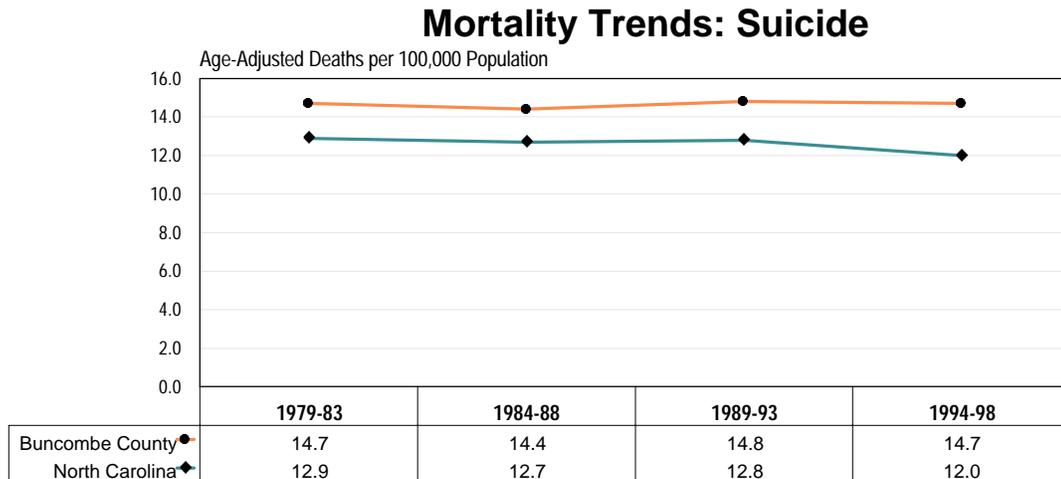
Following the statewide trend, diabetes deaths are on the rise in Buncombe County. However, the county rate remains somewhat below the statewide rate.



Source: State Center for Health Statistics (SCHS), NC Department of Health and Human Services.  
Note: Death rates are age-adjusted to the 2000 U.S. standard population.

## Suicide

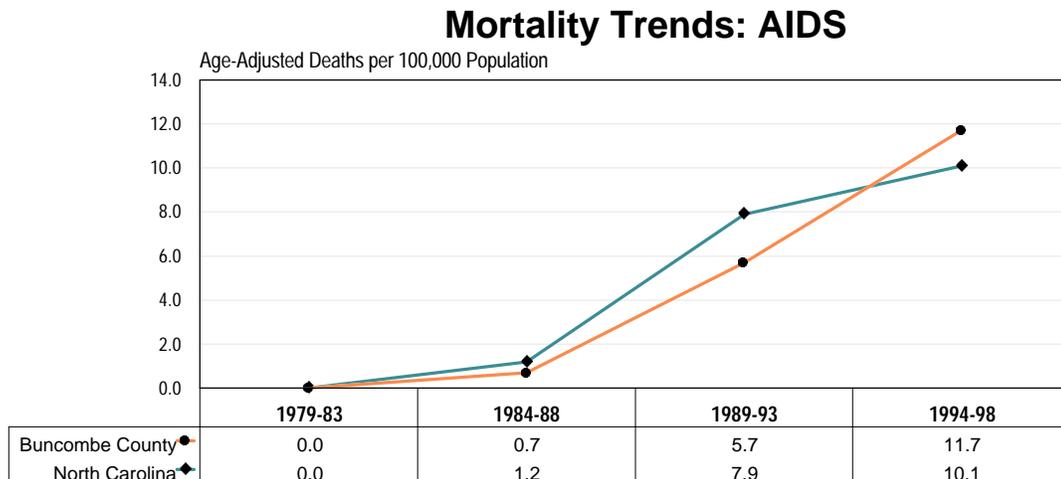
The age-adjusted death rate for suicide has remained fairly steady over the past 20 years in Buncombe County and consistently remains above the statewide suicide death rate.



Source: State Center for Health Statistics (SCHS), NC Department of Health and Human Services.  
 Note: Death rates are age-adjusted to the 2000 U.S. standard population.

## AIDS

Since the advent of AIDS in the early 1980s, age-adjusted death rates continue to rise both statewide and in Buncombe County. However, note in the following chart that the county rate surpassed the state rate during the 1994-98 period.

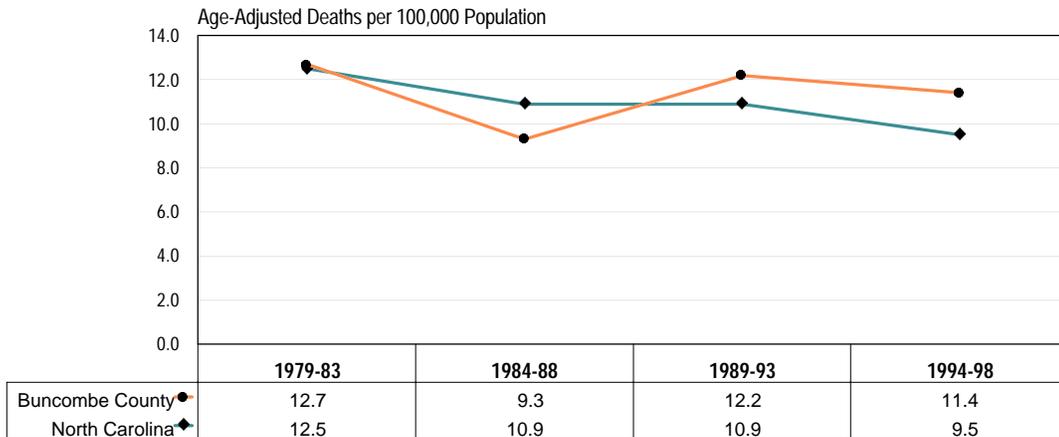


Source: State Center for Health Statistics (SCHS), NC Department of Health and Human Services.  
 Note: Death rates are age-adjusted to the 2000 U.S. standard population.

## Chronic Liver Disease/Cirrhosis

While the age-adjusted death rate for chronic liver disease/cirrhosis appears to be decreasing slightly statewide, the county rate has fluctuated and does not show such a trend.

### Mortality Trends: Chronic Liver Disease/Cirrhosis

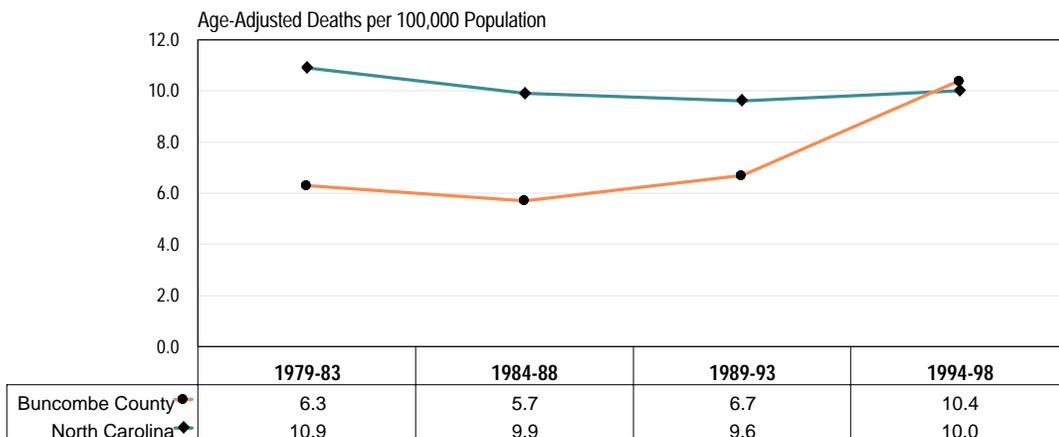


Source: State Center for Health Statistics (SCHS), NC Department of Health and Human Services.  
Note: Death rates are age-adjusted to the 2000 U.S. standard population.

## Nephritis, Nephrosis & Nephrotic Syndrome (Kidney Disease)

Whereas the Buncombe County age-adjusted death rate for kidney disease was once well below the statewide rate, a sharp increase over the past three reporting periods now places it very close to the statewide rate.

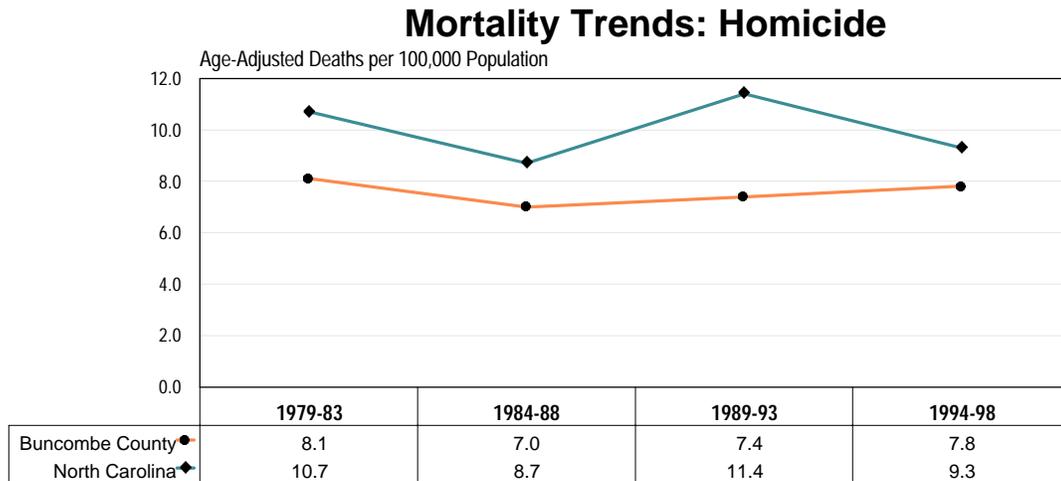
### Mortality Trends: Nephritis/Nephrosis/Nephrotic Syndrome



Source: State Center for Health Statistics (SCHS), NC Department of Health and Human Services.  
Note: Death rates are age-adjusted to the 2000 U.S. standard population.

## Homicide

The age-adjusted death rate for homicide has been stable over the past several years, and remains below the statewide rate. In contrast, the statewide rate has fluctuated sharply.

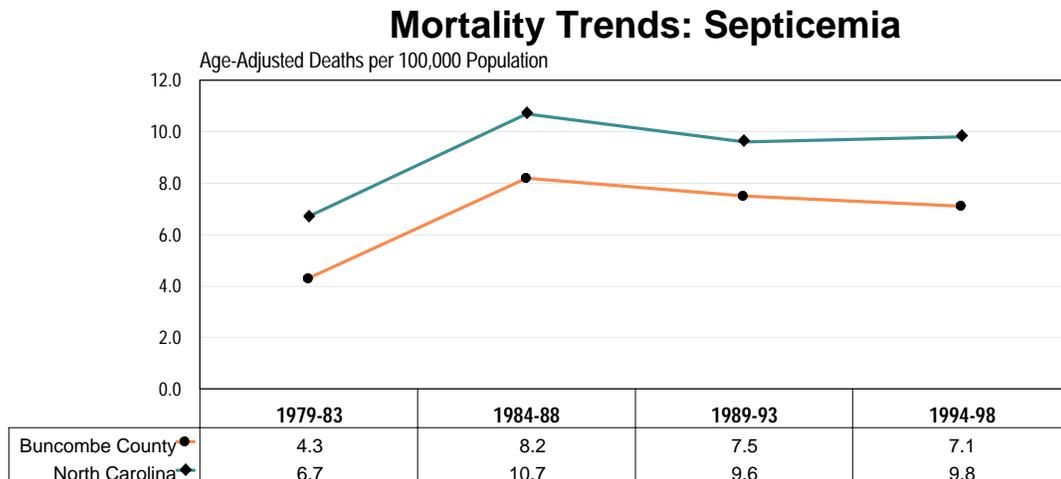


Source: State Center for Health Statistics (SCHS), NC Department of Health and Human Services.

Note: Death rates are age-adjusted to the 2000 U.S. standard population.

## Septicemia (Blood Poisoning)

Age-adjusted deaths due to septicemia rose sharply, both statewide and in Buncombe County, between the 1979-83 and 1984-88 reporting periods. Since that time, the rates have declined slightly, and the Buncombe County rate remains below the state rate.



Source: State Center for Health Statistics (SCHS), NC Department of Health and Human Services.

Note: Death rates are age-adjusted to the 2000 U.S. standard population.

# Morbidity

“Morbidity” is defined as the rate of disease or the proportion of diseased persons in a given locality. The following section outlines data relating to the incidence or prevalence of various conditions in Buncombe County. Note that an “*incidence rate*” refers to the number of new cases of a particular condition (relative to population size) reported in a given timeframe (usually delimited by calendar years); this is not to be confused with “*prevalence level*,” which describes the proportion of the population living with a particular condition at a given moment in time (regardless of when the condition was contracted, diagnosed or reported).

## Incidence of Selected Reported Diseases

The following chart outlines the reported incidence of selected infectious diseases in Buncombe County. As shown, Buncombe County rates compare favorably to North Carolina rates for overall gonorrhea and syphilis incidence (including minority syphilis cases). Rates for the remaining diseases are above statewide rates, most notably the incidence rate for AIDS.

Furthermore, Buncombe County fails to satisfy *Healthy People 2010* goals for gonorrhea, syphilis, AIDS and hepatitis A (available hepatitis B data is not comparable to the age-specific targets set forth in *Healthy People 2010*).

### Incidence Rates for Selected Reported Diseases

	Buncombe County	North Carolina	HP2010 Target
<b>Gonorrhea - All</b>	163.3	293.3	19.0
Minority Gonorrhea	1258.6	1063.1	19.0
<b>Syphilis - All</b>	1.5	14.5	0.2
Minority Syphilis	11.7	53.5	0.2
<b>AIDS</b>	15.2	11.4	1.0
<b>Hepatitis B</b>	6.2	4.0	see note
<b>Hepatitis A</b>	2.4	2.2	4.5
<b>Rocky Mountain Spotted Fever</b>	2.1	1.7	

Source: State Center for Health Statistics (SCHS), NC Department of Health and Human Services.

Notes: 1. Rates are per 100,000 population.

2. County and state data are 1994-1998 annual averages.

3. Hepatitis B targets are age-specific: 9.0 among those aged 2-18; 2.4 among 19-24; 5.1 among 25-39; 3.8 among 40+.

In comparing these 1994-98 rates with single-year 1993 rates:

- Gonorrhea incidence is higher than the 1993 single-year rate (121.6)
- Syphilis incidence is down (from 8.8)
- AIDS incidence is lower (from 19.8)
- Hepatitis A and B incidence are similar (2.2 and 8.8, respectively)

## Perceptions Data\*

### AIDS

“The message isn’t out there – in churches and schools. You don’t have to be gay or use drugs to get HIV. The newly diagnosed are frequently teens, younger than 25, and women.”

“I was full-blown when I was diagnosed and admitted to the hospital. People won’t get tested, especially African-Americans. They are full blown when diagnosed – it scares me. They don’t want to own the AIDS epidemic. And even after diagnosed, they don’t get plugged in to the AIDS situation. They don’t want to get out there due to the shame of AIDS.”

“I’ve known several families that have lost two members to AIDS. I asked (the hospitals) what the system’s outreach is doing in reference to AIDS and teen pregnancy.”

“HIV is the most important thing to be addressed by the health care system. The two criticals are a definite lack of transportation and of housing. These have such impact on people’s health.”

“African-Americans are getting treatment – but (they are sexually active and) walk around till they drop.”

“It’s challenging because people are coming in late.”

“People don’t want counseling and testing services...due to the confidentiality issue, so we offer broader health services.”

“As a physician, my frustrations relate to public awareness – the perpetual stigma and shame my patients deal with – patients look to us for a lot of emotional support.”

### Sexually Transmitted Diseases

“Unsafe sex and drug use are the highest (priority health problems among teens).”

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\* *The Perceptions Data are valuable in identifying issues and providing context to the findings of this assessment. Keep in mind, however, that these qualitative comments are attributable only to those citizens and Key Informants participating in this effort and are not necessarily representative of the study sponsors nor the community at large.*

“It should be a priority that kids and teens have whatever prevention is available. And the community should be more active about kids and AIDS.”

“There are health implications for learning as a gay teen not to share about yourself – if I had gotten an STD, I would have been reluctant to seek treatment.”

## Vaccine-Preventable Disease Incidence

### Measles, Rubella & Pertussis

Between 1996 and 1998 there were no reported cases of measles or congenital rubella syndrome in Buncombe County.

During this same time, there were six reported cases of pertussis; however, this is below the “expected” case number (13) based on the occurrence of cases among peer (similar) counties throughout the United States.<sup>7</sup>

### Rabies

In 1997, Buncombe County’s first confirmed case of animal rabies was reported, followed by one more case in 1998. Although no cases were confirmed in 1999, rabies is spreading across Western North Carolina, primarily among raccoons and other wild animals such as foxes and squirrels. According to normal patterns related to the spread of rabies in others states, Buncombe County’s rabies numbers will likely increase over the next several years.

In order to decrease human exposure to rabies, it is important to continue to follow state laws requiring vaccination for dogs and cats and to observe appropriate quarantine laws.

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<sup>7</sup> Community Health Status Report, Buncombe County, North Carolina. July 2000. U.S. Department of Health and Human Services Health Resources and Services Administration (HRSA).

## Enteric Disease Incidence

Enteric diseases are gastrointestinal illnesses caused by bacteria, parasites or viruses. Transmission from person to person is via hand-to-mouth. A person must actually ingest the organism in order to become infected. Enteric diseases are among the most frequently reported diseases. Prevention of these diseases is linked to having clean water, and proper hygiene and food handling.

### E. Coli, Salmonella, Shigella, Hepatitis A

The numbers of reported cases of enteric disease in Buncombe County between 1996 and 1998 are below expected rates based on the incidence of these diseases in peer (similar) counties throughout the United States:<sup>8</sup>

- 1 reported case of **E. coli** (expected: 4)
- 44 reported cases of **salmonella** (expected: 72)
- 13 reported cases of **shigella** (expected: 42)
- 14 reported cases of **hepatitis A** (expected: 27)

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<sup>8</sup> Community Health Status Report, Buncombe County, North Carolina. July 2000. U.S. Department of Health and Human Services Health Resources and Services Administration (HRSA).

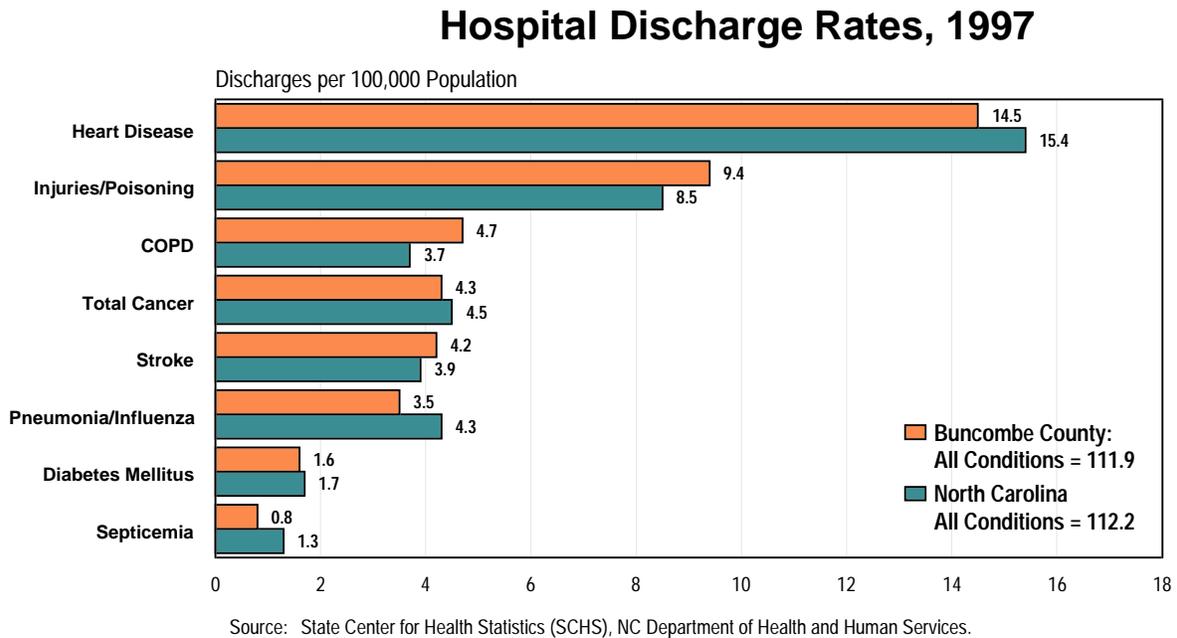
## Hospitalization Rates

### Hospitalizations by Condition

In 1997, there were 111.9 hospital discharges per 100,000 population, similar to statewide discharge rate (112.2).

The highest discharge rates in Buncombe County were found for **heart disease** (14.5 discharges per 100,000 population) and **injuries/poisoning** (9.4 per 100,000).

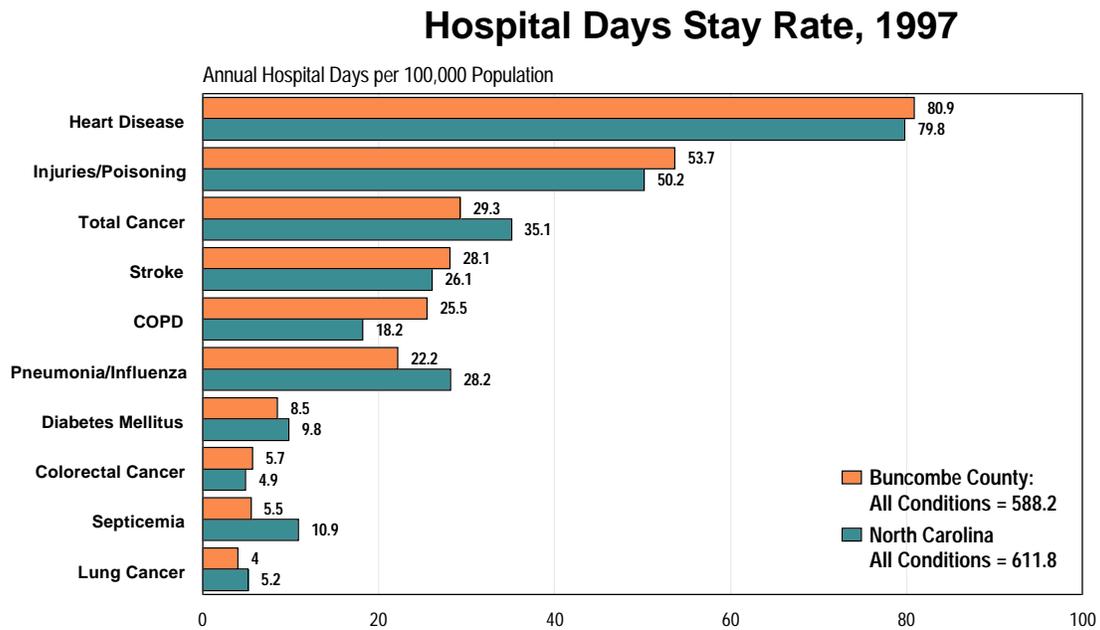
Compared to statewide discharge rates, Buncombe County rates are higher for hospitalizations related to **injuries/poisoning, COPD and stroke**.



## Hospital Stay Rate

In 1997, there was an average of 588.2 hospital days per 100,000 population, lower than the statewide average (611.8).

**Heart disease and injuries/poisoning** also represent the greatest number of hospitalized days per 100,000 population. In comparison to the statewide stay rate by cause, Buncombe County reports higher stay rates for heart disease, injuries/poisoning, stroke, COPD and colorectal cancer.



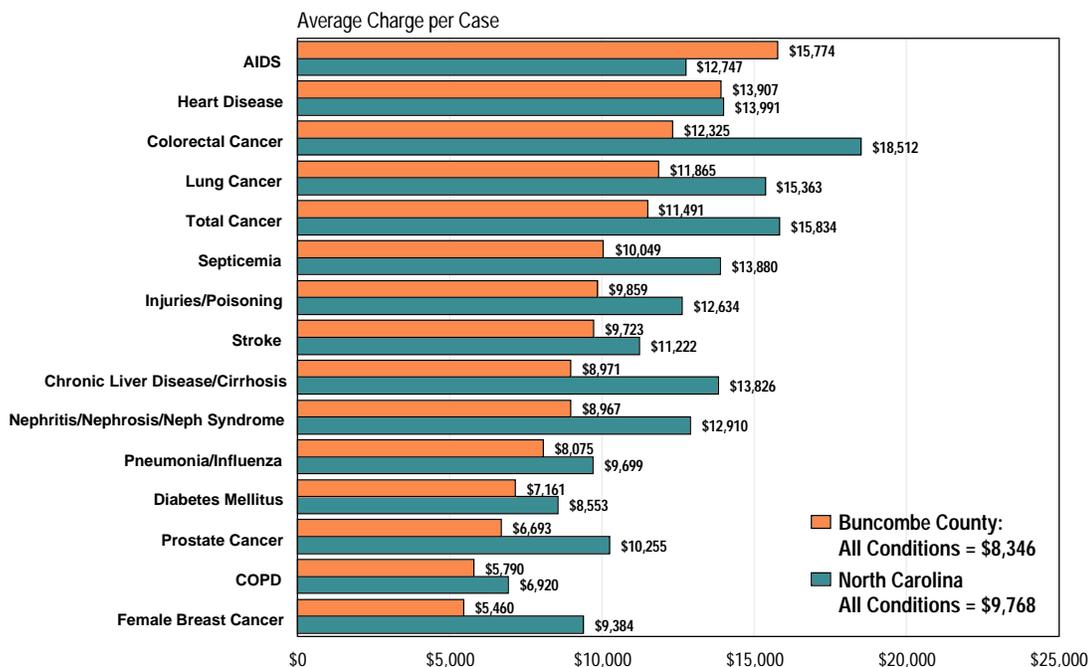
Source: State Center for Health Statistics (SCHS), NC Department of Health and Human Services.

## Average Hospital Charges

The most costly hospitalizations in Buncombe County are for AIDS, heart disease and cancer (including colorectal and lung cancer), with cases for these averaging between \$11,491 and \$15,774.

Cancers (including colorectal and lung cancer) are the most costly statewide, followed by heart disease, septicemia (blood poisoning), chronic liver disease/cirrhosis and nephritis/nephrosis/nephrotic conditions (kidney disease).

## Hospital Charges, 1997



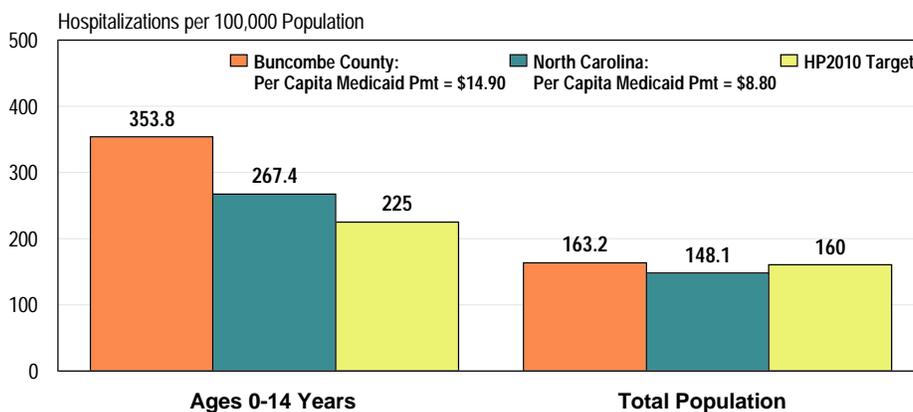
Source: State Center for Health Statistics (SCHS), NC Department of Health and Human Services.

## Asthma Hospitalizations

The overall hospitalization rate for asthma in Buncombe County is 163.2 per 100,000 population, higher than the statewide rate, but close to satisfying the *Healthy People 2010* target. However, per capita Medicaid payments are considerably higher in Buncombe County for asthma than statewide (69% higher).

Among children in Buncombe County (aged 14 and younger), asthma hospitalization rates are rather high, as shown in the following chart.

## Asthma Hospitalization Rates

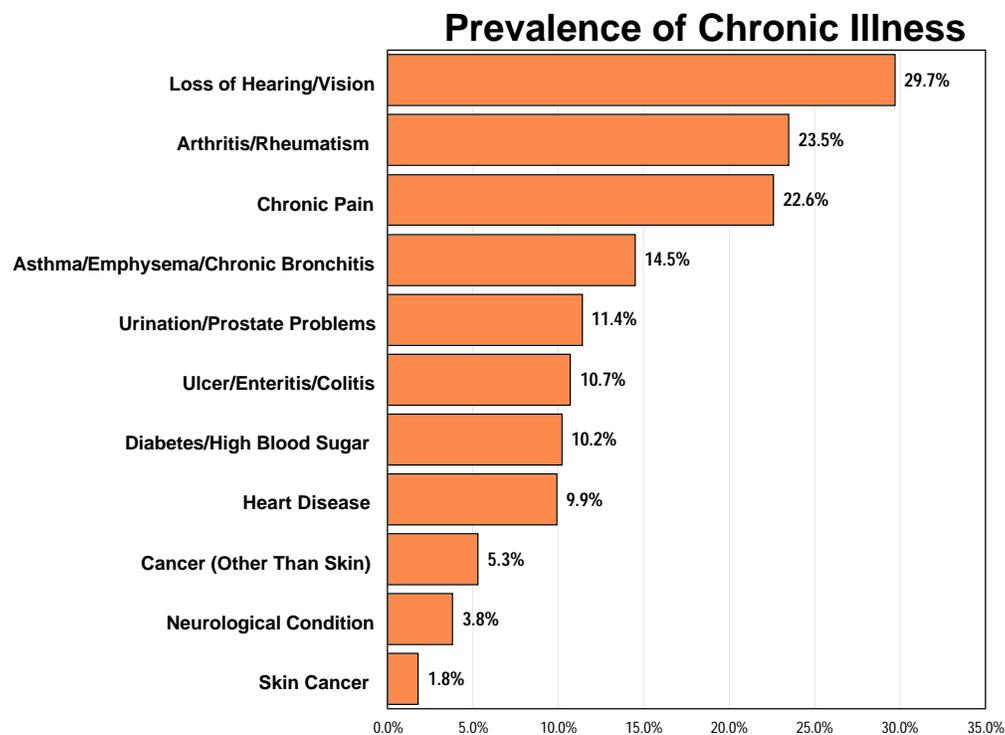


Source: State Center for Health Statistics (SCHS), NC Department of Health and Human Services.

## Prevalence of Chronic Illness

As part of the 2000 PRC Community Health Survey, area residents were asked to report the prevalence of any of a variety of chronic conditions. As shown below, 3 in 10 (29.7%) report that they currently suffer from a loss of **hearing and/or vision**, while just under one-fourth (23.5%) of adults in Buncombe County suffer from **arthritis or rheumatism** (this includes 52.4% of those aged 65 and older), much higher than the national prevalence of 19.2%. More than 1 in 5 adults also currently suffer from some type of **chronic pain** (22.6%) such as chronic back problems or chronic headaches.

Another 14.5% of local adults report having asthma, emphysema, or chronic bronchitis, while approximately 1 in 10 local adults responded affirmatively when asked about urination or prostate problems, ulcer/enteritis/colitis, diabetes or high blood sugar, and heart disease. It should be noted that the local prevalence of diabetes and chronic heart disease are much higher than national figures.



Source: 2000 PRC Community Health Survey, Professional Research Consultants  
 Note: Asked of all respondents.

Keep in mind that each percentage point above represents approximately 1,500 adults in Buncombe County.

## Lead Poisoning

According to 1999 North Carolina statistics, 6% of North Carolina children are estimated to have elevated blood lead levels. According to statistics available through special lead testing efforts at Buncombe County Health Center, only 1% of Buncombe County children have blood lead levels higher than 10 mg/dl. From August 1, 1997 through August 1, 2000, there have been 39 children confirmed with elevated blood lead levels, and 5 children with levels greater than 20 mg/dl, indicating actual lead poisoning.

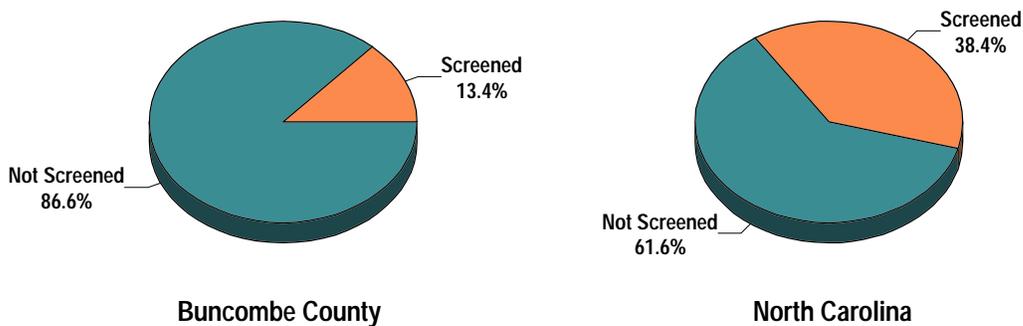
In an effort to identify and treat children with lead poisoning, Buncombe County Health Center has initiated an intense community outreach program, identifying nine specific communities meeting criteria which identify children in these communities as “high risk” for elevated blood lead levels. As of August 2000, 404 children in several of the targeted areas have been screened for lead. Of those screened, none had blood lead levels exceeding 20 mg/dl (lead poisoning) and only 9 had elevated levels between 10 and 19 mg/dl. Approximately half of the “high risk” communities have already been targeted.

Children between 6 months to 6 years need to be screened and counseled by their health care provider about lead poisoning. Removal of mini blinds made with lead based vinyl can significantly reduce lead exposure to children. Buncombe County investigations in households with children that were found to have elevated blood lead levels have linked their exposure to mini blinds tainted with lead.

## Public Health Lead Screening

Among children aged 12 to 24 months of age who were seen at public health department sites in 1997 and 1998, 13.4% were screened for lead levels using a direct blood lead test. [Total screened is unduplicated for repeat tests within the calendar year.]

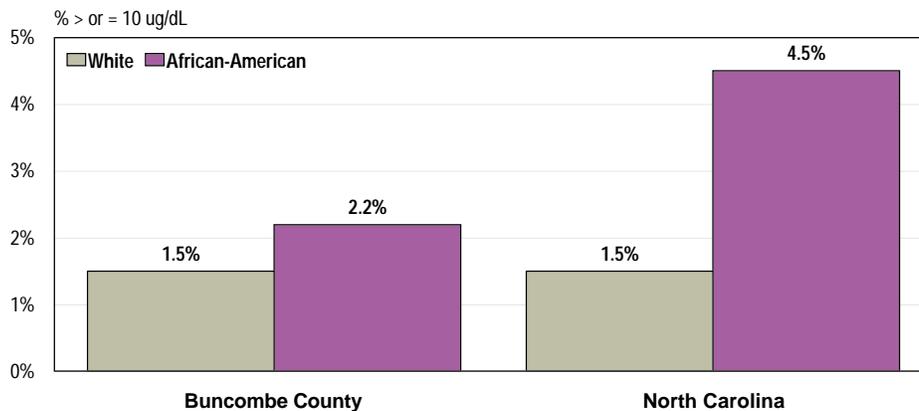
### Percentage of Resident Children 12 to 24 Months of Age Who Received a Direct Blood Lead Test, 1997-98



Source: State Center for Health Statistics (SCHS), NC Department of Health and Human Services. (Child Health Contract Addenda Baseline)  
 Note: Represents only children seen at public health department sites. Lead Screen - Percentage of resident children 12 to 24 months of age who received a direct blood lead test.

Of the 1,549 screened in Buncombe County in 1998, elevated blood lead levels were found among 1.5% of white children and 2.2% of African-American children. In comparison to statewide testing results, the Buncombe County African-American proportion is considerably lower than the statewide proportion.

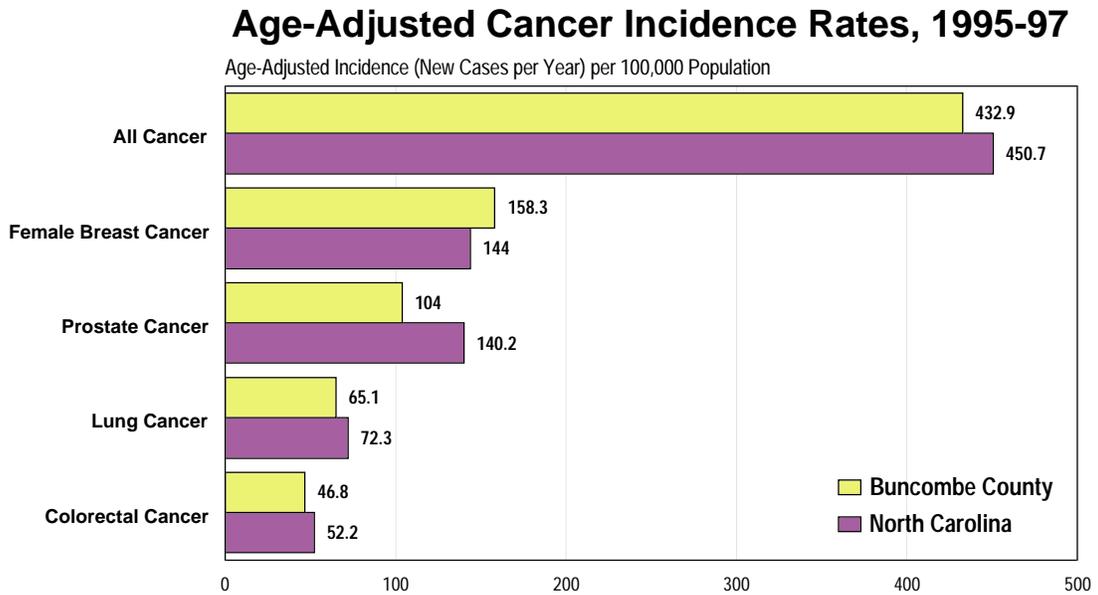
### Lead Screening Data for Children Ages 6 Months to 6 Years, Calendar Year 1998



Source: State Center for Health Statistics (SCHS), NC Department of Health and Human Services (Children's Environmental Health).  
 Note: Among 1,549 children screened in Buncombe County (95,587 statewide)

## Cancer Incidence

Incidence rates for cancer (number of new cases per year per 100,000 population) in Buncombe County are lower overall than the statewide rate. However, note in the following chart that the Buncombe County incidence rate for female breast cancer is higher than the state incidence rate.



Source: State Center for Health Statistics (SCHS), NC Department of Health and Human Services.  
Note: Age-adjusted to the 1970 U.S. population standard.

# Nativity

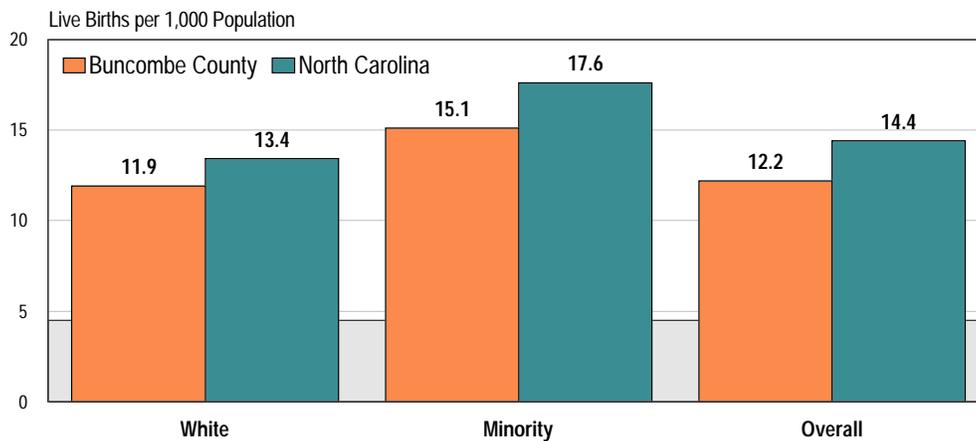
The following section details findings in Buncombe County relating to births and maternal and infant health issues.

## Crude Birth Rate

Between 1994 and 1998, there was an annual average of 12.2 births per 1,000 population in Buncombe County, below the statewide birth rate (14.4).

Note in the following chart that the crude (i.e., unadjusted) birth rate is higher among the minority population than among whites in Buncombe County, as it is throughout the state. Both minority and white birth rates are below state rates.

### Birth Rates, 1994-1998



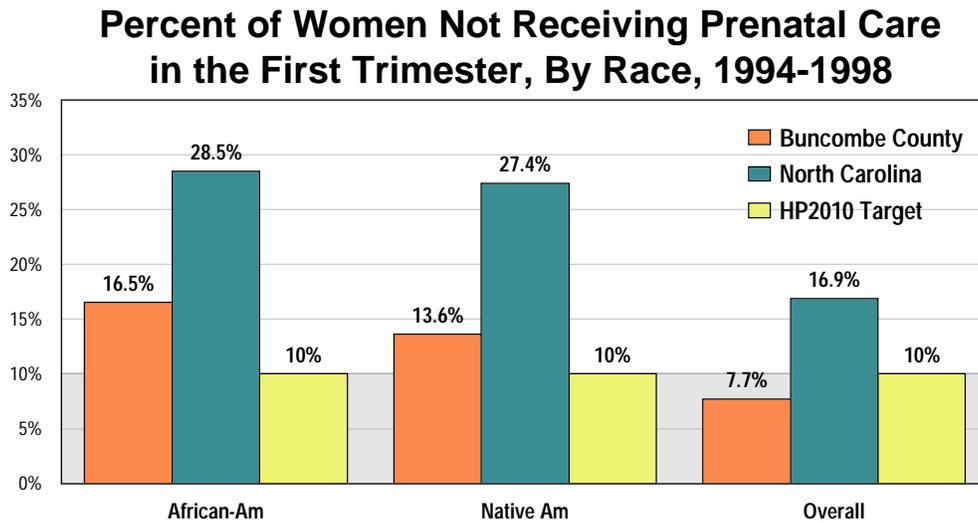
Source: State Center for Health Statistics (SCHS), NC Department of Health and Human Services.

## Prenatal Care

### Lack of Timely Prenatal Care

Early and continuous prenatal care is the best assurance of infant health. However, in Buncombe County between 1994 and 1998, 7.7% of women giving birth did not receive prenatal care during the first trimester of pregnancy. This percentage is well below the statewide proportion (16.9%) and currently satisfies the *Healthy People 2010* target for the overall population.

Note, however, that while the proportions of African-American and Native American mothers lacking timely prenatal care in Buncombe County is well below the statewide proportions, these remain above the *Healthy People 2010* target of a reduction to 10% or less.



Source: State Center for Health Statistics (SCHS), NC Department of Health and Human Services.

Note that the 1994-98 percentage represents a decrease from the 10.0% reported in 1993 (8.5% among white, and 20.5% among nonwhite births).

### Perceptions Data\*

“We need better prenatal care especially with regard to nutrition and stress, with young (Latino) mothers.”

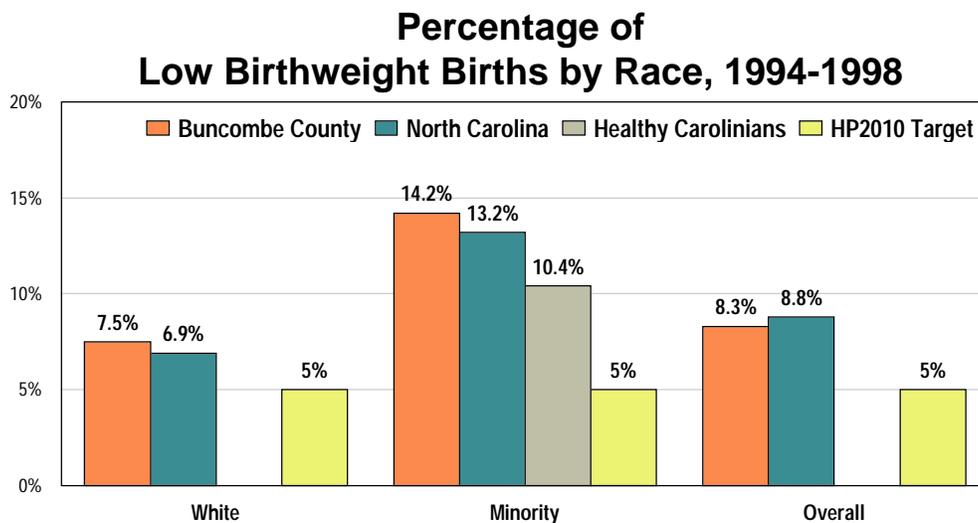
\* *The Perceptions Data are valuable in identifying issues and providing context to the findings of this assessment. Keep in mind, however, that these qualitative comments are attributable only to those citizens and Key Informants participating in this effort and are not necessarily representative of the study sponsors nor the community at large.*

## Low-Weight Births

Low birthweight babies, those who weigh less than 2,500 grams (approximately 5 pounds, 8 ounces) at birth, are much more prone to illness and infant death than are babies of normal birthweight. Inadequate prenatal care and other health behavior factors contributing to low-weight births and the consequent health problems are preventable.

Between 1994 and 1998, an annual average of 8.3% of babies born in Buncombe County were classified as being of low birthweight. This compares to 8.8% of low birthweight babies recorded statewide. Note, however, that the *Healthy People 2010* goal is to reduce to 5% or less the number of women delivering low-weight babies.

Further note that this percentage among minority births is nearly twice that among whites. Individual white and minority percentages of low-weight births in Buncombe County exceed the proportions found statewide.



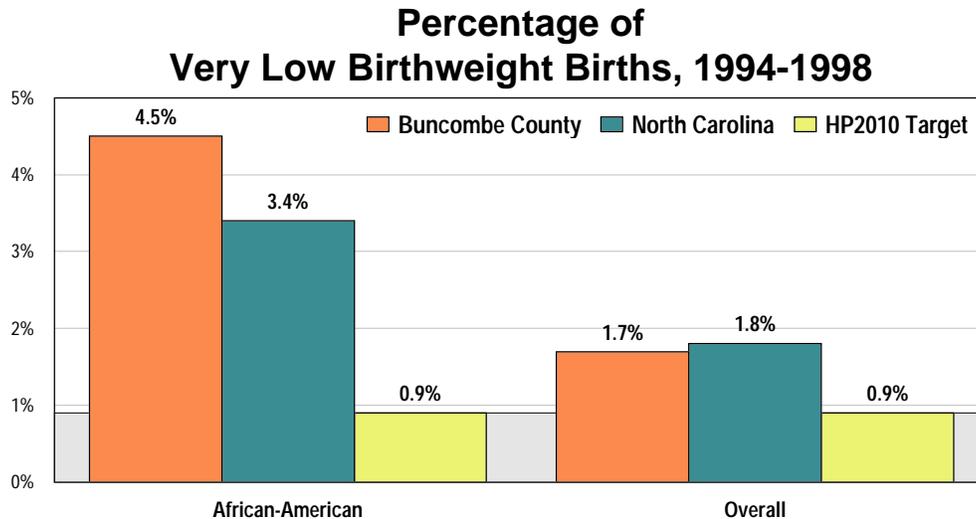
Source: State Center for Health Statistics (SCHS), NC Department of Health and Human Services.

Note: Low-weight births are those weighing less than 2,500 grams (approximately 5 pounds, 8 ounces) at birth.

The proportion of 1994-98 low-weight births is similar to that reported for 1993 (8.0%) in the last assessment.

## Very Low Birthweight

Very low-weight births are births of babies weighing less than 1,500 grams (approximately 3 pounds, 5 ounces). In Buncombe County between 1994 and 1998, 1.7% of all live births fell into this category, similar to statewide. Note that this percentage is considerably higher among African-American births (4.5% in Buncombe County). The *Healthy People 2010* target is to reduce these proportions to no more than 0.9%.



Source: State Center for Health Statistics (SCHS), NC Department of Health and Human Services.

Note: Very low birthweight births are those weighing less than 1,500 grams at birth (approximately 3 pounds, 5 ounces).

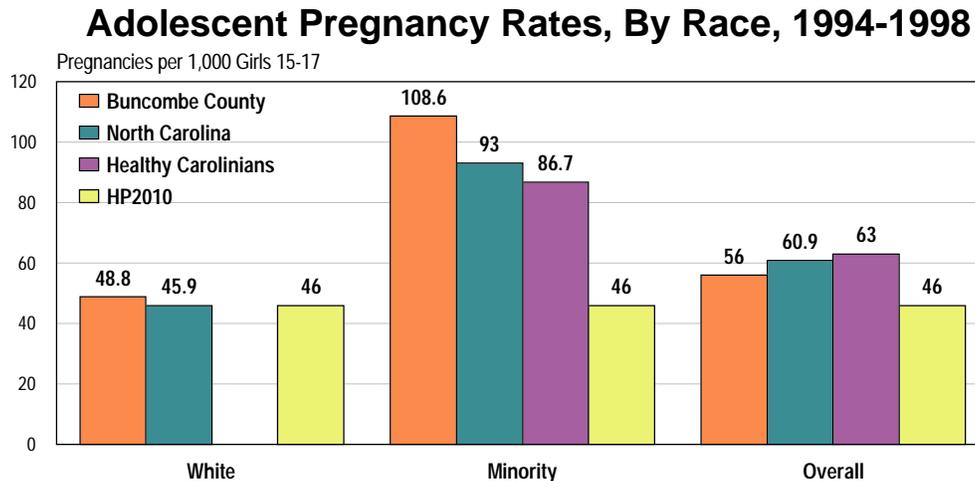
## Adolescent Pregnancy

Teenage mothers are often at higher risk of problems associated with improper or inadequate prenatal care, especially in minority and lower socio-economic populations. They have a higher-than-average chance of suffering pregnancy complications, are less likely to ever complete a high school education, and earn about half the lifetime income of women who first give birth in their 20's.

### Pregnancies Among Adolescents Aged 15 to 17

In Buncombe County, there were an annual average of 56 pregnancies per 1,000 girls aged 15 to 17 between 1994 and 1998. This rate of adolescent pregnancy is lower than found statewide (60.9 per 1,000) and satisfies the *Healthy Carolinians* target (63 or fewer), but remains higher than the targeted *Healthy People 2010* reduction (46 or fewer).

Note in the following chart, however, that the minority pregnancy rate among girls aged 15 to 17 in Buncombe County (108.6 pregnancies per 1,000 girls) far exceeds the statewide minority pregnancy rate (93.0), as well as both *Healthy Carolinians* (86.7) and *Healthy People 2010* (46.0) targets.

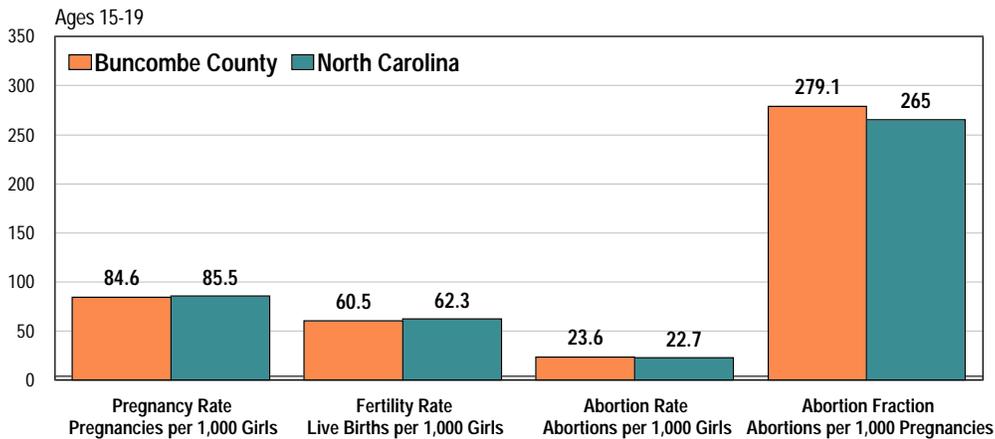


Source: State Center for Health Statistics (SCHS), NC Department of Health and Human Services.

### Pregnancies Among Adolescents Aged 15 to 19

As summarized in the following chart, the Buncombe County adolescent pregnancy rate, fertility rate and abortion rate among girls aged 15 to 19 is similar to rates reported statewide. The abortion fraction, or number of abortions per 1,000 pregnancies, is slightly higher than found statewide.

## Rates Associated With Adolescent Pregnancy, 1998



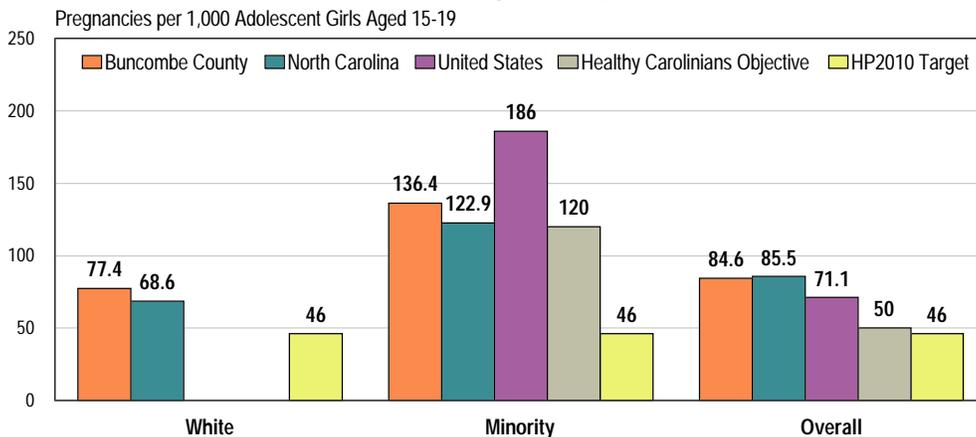
Source: State Center for Health Statistics (SCHS), NC Department of Health and Human Services.

### Pregnancy Rate

In Buncombe County in 1998, there were 84.6 pregnancies for every 1,000 girls aged 15 to 19 years old. As mentioned, this is similar to the statewide rate; however, it is well above the U.S. rate of 71.1 per 1,000, and fails to satisfy either the *Healthy Carolinians* or the *Healthy People 2010* targets (50 or lower and 46 or lower, respectively).

Buncombe County adolescent pregnancy rates are considerably higher among the minority population than among whites, although the disparity between the two is not as dramatic as is seen nationwide.

## Adolescent Pregnancy Rates, 1998



Source: State Center for Health Statistics (SCHS), NC Department of Health and Human Services.

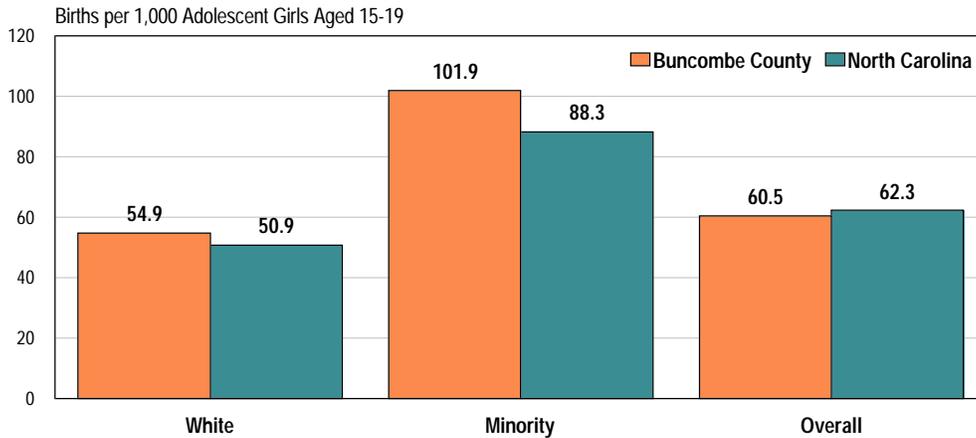
- Notes:
1. County and State figures are 1998 data.
  2. U.S. figures are 1985 data.
  3. Adolescent pregnancy rate is the number of pregnancies per 1,000 girls aged 15 to 19.

## ***Fertility Rate***

The adolescent fertility rate is an expression of the number of live births (rather than pregnancies) per 1,000 girls aged 15 to 19. In Buncombe County in 1998, the adolescent fertility rate was 60.5 births per 1,000 adolescent girls, similar to the rate (62.3) reported statewide.

However, Buncombe County fertility rates are much higher among the adolescent minority population, and both white and minority population rates in Buncombe County are above those reported statewide.

### **Adolescent Fertility Rates, 1998**



Source: State Center for Health Statistics (SCHS), NC Department of Health and Human Services.

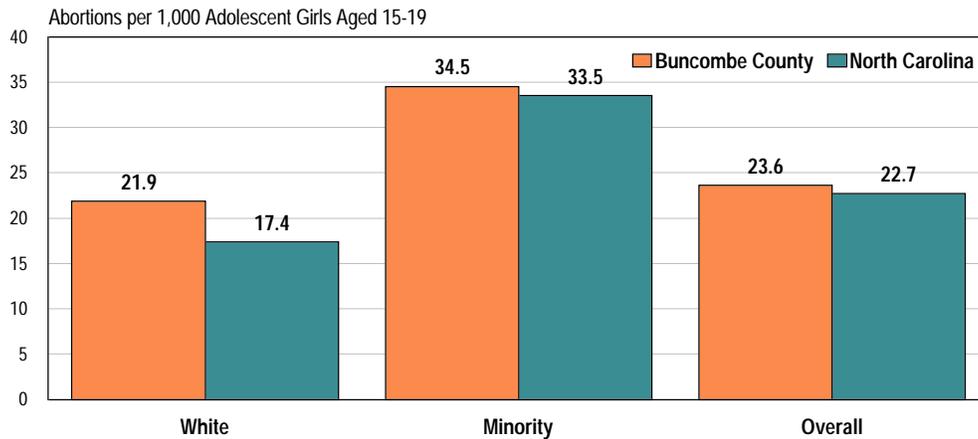
Notes: 1. County and State figures are 1998 data.

2. Adolescent fertility rate is the number of live births per 1,000 girls aged 15 to 19.

## ***Abortion Rate & Abortion Fraction***

In addition, there were 23.6 induced abortions reported in Buncombe County in 1998 for every 1,000 adolescents aged 15 to 19. Note in the following chart that the rate is once again higher among minority adolescents, but also that the white adolescent abortion rate in Buncombe County is somewhat higher than that found statewide.

## Adolescent Abortion Rates, 1998

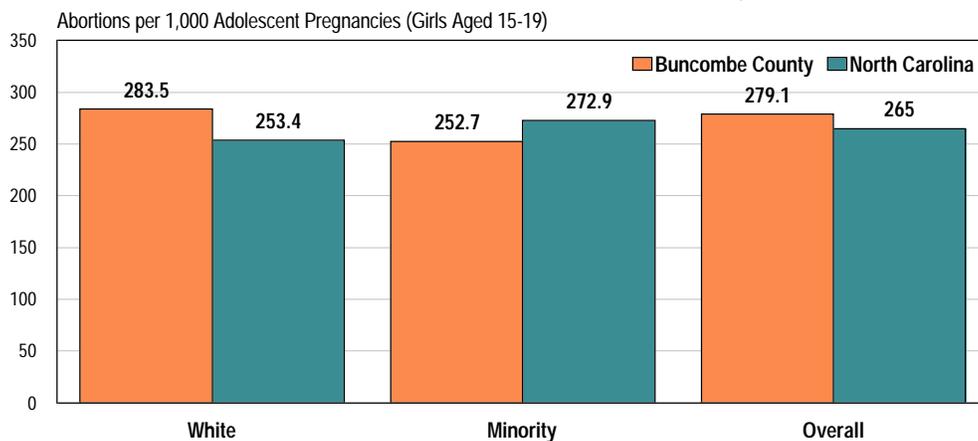


Source: State Center for Health Statistics (SCHS), NC Department of Health and Human Services.  
 Notes: 1. County and State figures are 1998 data.  
 2. Adolescent abortion rate is the number of induced abortions per 1,000 girls aged 15 to 19.

The adolescent abortion fraction is an expression of the number of induced abortions per 1,000 adolescent pregnancies (rather than per population). In Buncombe County in 1998, there were 279.1 abortions for every 1,000 adolescent pregnancies. This is just above the statewide fraction.

Further, in this case, the white adolescent abortion fraction in Buncombe County exceeds that for the adolescent minority population. The white adolescent abortion fraction is above the corresponding state rate as well.

## Adolescent Abortion Fraction, 1998

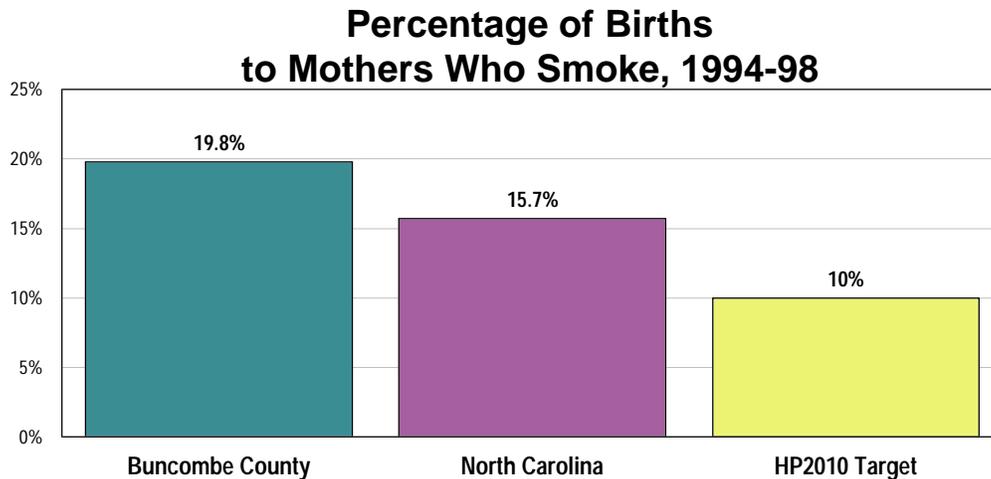


Source: State Center for Health Statistics (SCHS), NC Department of Health and Human Services.  
 Notes: 1. County and State figures are 1998 data.  
 2. Adolescent abortion fraction is the number of induced abortions per 1,000 reported pregnancies among girls aged 15-19 (live births + fetal deaths of 20 or more weeks of gestation + induced abortions), NC Department of Health and Human Services.

## Maternal Risk Factors

### Maternal Cigarette Smoking

Between 1994 and 1998, one out of five births in Buncombe County were to mothers who smoke, higher than the 15.7% found statewide. *Healthy People 2010* targets to reduce this percentage to less than 10% of births.



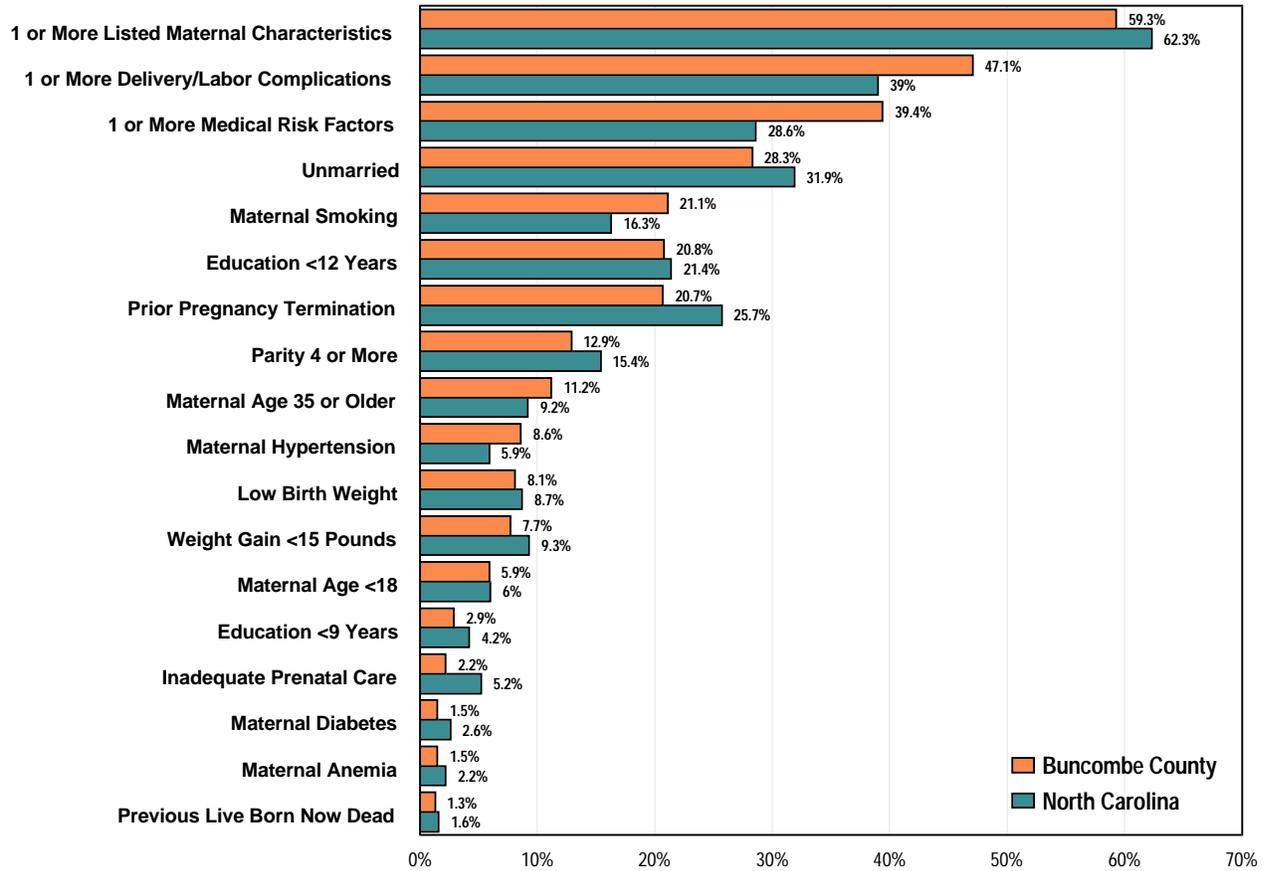
Source: State Center for Health Statistics (SCHS), NC Department of Health and Human Services.

### Other Maternal Risk Factors

The following table outlines a variety of maternal risk factors recorded for live births in Buncombe County and in North Carolina between 1993 and 1997. As shown, most births presented one or more of the outlined risk factors, and approximately one-half experienced one or more delivery and/or labor complications.

Specific risk factors associated with the greatest percentages of births include: **unmarried mothers (28.3%), maternal smoking (21.1%, higher than statewide), mothers with less than a high school education (20.8%) and prior pregnancy termination (20.7%).**

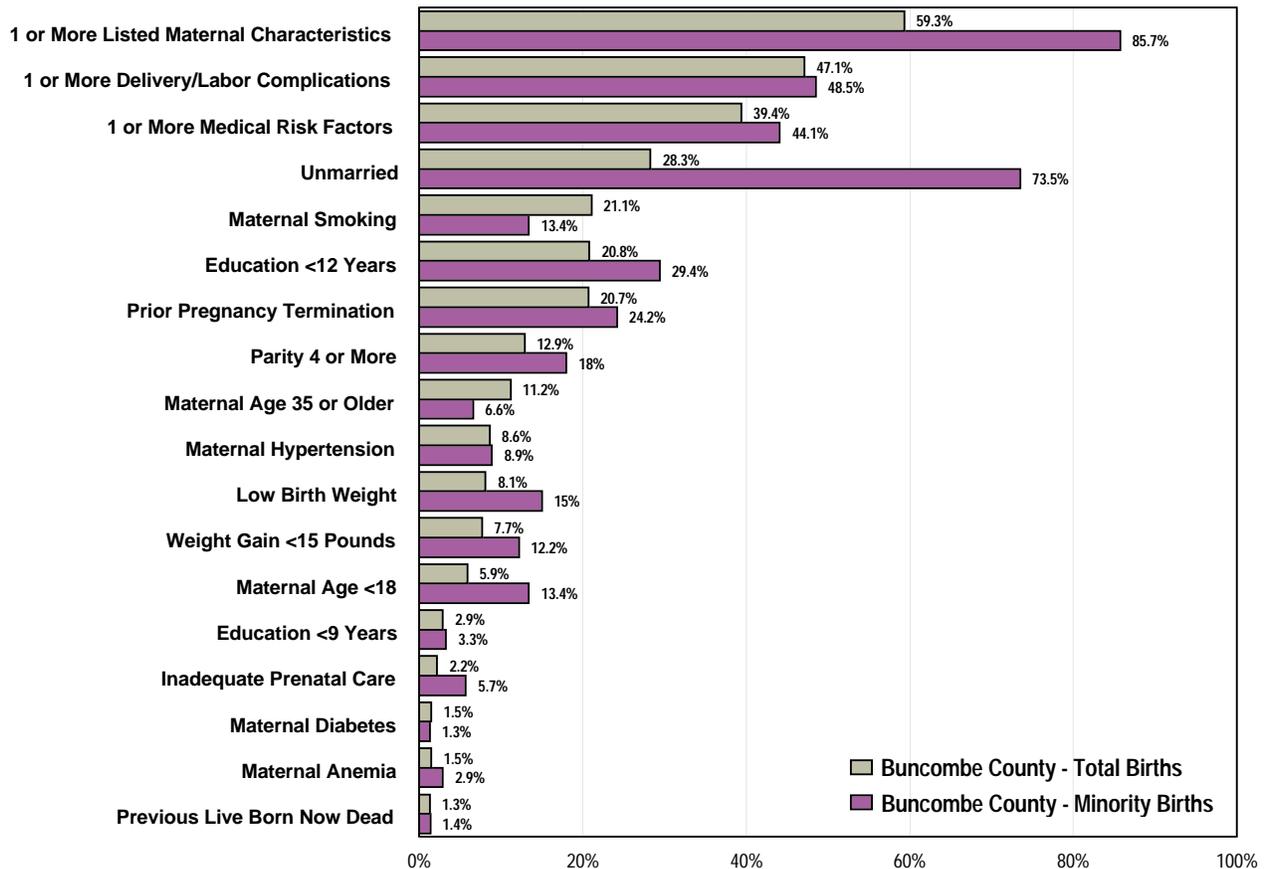
## Total Live Births Associated With Maternal Risk Factors, 1993-97



Source: State Center for Health Statistics (SCHS), NC Department of Health and Human Services.

The following chart describes that maternal risk factors are much more prevalent in minority births in Buncombe County. Specifically, minority births present much higher proportions of maternal risk such as **unmarried mothers (73.5%)**, mothers **with less than a high school education (29.4%)**, **low-weight births (15%)** and **births to mothers under 18 years old (13.4%)**.

## Total Live Births Associated With Maternal Risk Factors, 1993-97



Source: State Center for Health Statistics (SCHS), NC Department of Health and Human Services.

## Perinatal & Infant Deaths

### Fetal, Neonatal & Postneonatal Deaths

The following table outlines rates of infant death in Buncombe County, North Carolina and the U.S. during the fetal, neonatal, postneonatal and infant stages. As shown, Buncombe County rates are overall lower than corresponding statewide rates. However, Buncombe County exceeds U.S. rates for fetal, neonatal and infant deaths, and fails to satisfy *Healthy People 2010* targets for each of these. Buncombe County also fails to satisfy established *Healthy Carolinians* targets for fetal and neonatal deaths.

### Fetal, Neonatal and Infant Death Rates

	Buncombe County	North Carolina	United States	Healthy Carolinians Goal	HP 2010 Target
Fetal Death Rate	7.8	8.2	6.8	5.0	4.1
Neonatal Death Rate	5.7	6.5	4.8	4.5	2.9
Postneonatal Death Rate	2.2	2.8	2.4	2.5	1.9
Infant Death Rate	7.9	9.4	7.2		4.5

Source: State Center for Health Statistics (SCHS), NC Department of Health and Human Services.

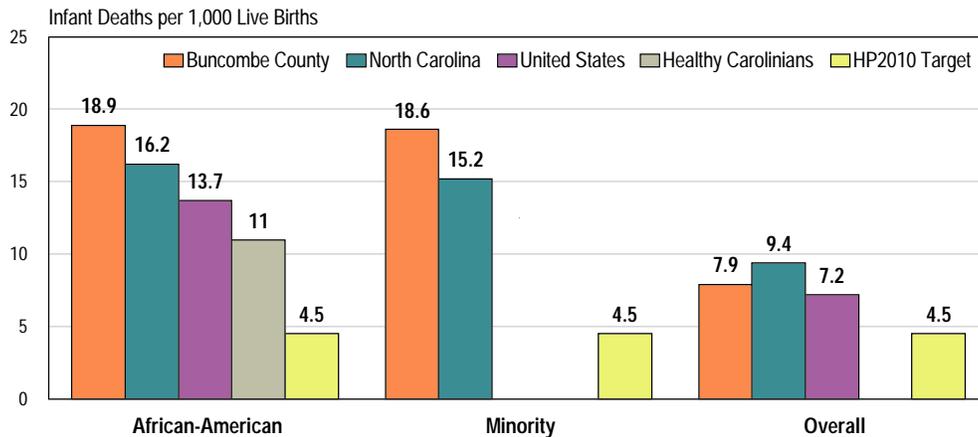
- Notes:
1. County and state data are 1994-1998 annual averages. U.S. data are 1998.
  2. Fetal death is a birth which fails to show any sign of life after delivery regardless of the gestational age. Rates are per 1,000 live births plus fetal deaths.
  3. Neonatal death is the death of a liveborn infant under 28 days old. Rates are per 1,000 live births.
  4. Postneonatal death is the death of a liveborn infant between 29 days and one year old. Rates are per 1,000 live births.
  5. Infant death is the death of a liveborn infant under one year of age. Rates are per 1,000 live births.

### Infant Deaths

Between 1994 and 1998, there was an annual average of 7.9 infant deaths per 1,000 live births in Buncombe County. This rate is lower than the statewide rate, but above the U.S. infant death rate. It also fails to satisfy the *Healthy People 2010* target to reduce infant deaths to fewer than 4.5 per 1,000 births.

By race, the following chart illustrates that infant death rates among African-Americans are significantly higher than found either statewide or nationwide. Between 1994 and 1998, there were 18.9 infant deaths per 1,000 live births to African-Americans in Buncombe County, also well above the *Healthy Carolinians* target of 11.0 or less.

## Infant Death Rates



Source: State Center for Health Statistics (SCHS), NC Department of Health and Human Services.

- Notes:
1. Infant death is the death of a liveborn infant under one year of age. Rates are per 1,000 live births.
  2. County and state data are 1994-1998 annual averages. U.S. data are 1998.

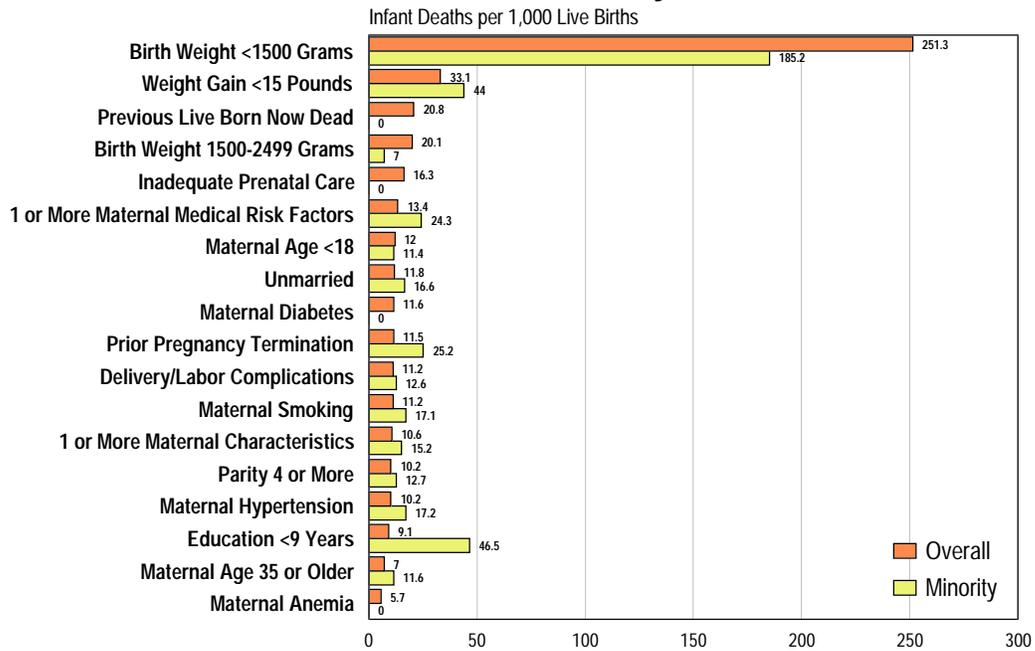
Note that the 1994-98 infant death rate in Buncombe County is higher than the single-year 1993 rate (5.1) reported in the 1995 assessment.

### *Infant Deaths by Selected Risk Factors*

There is a strong relationship between infant death and the maternal risk factors previously discussed. Most notably of these is the birth of babies with very low birthweight (1,500 grams or less; the infant death rate among these births is 251.3 per 1,000). Other risk factors presenting high infant deaths include low maternal weight gain, previous infant deaths, and low birthweight (all births under 2,500 grams).

The following chart also illustrates that infant death rates are higher among minority births associated with several of the risk factors, for example, low maternal weight gain, prior pregnancy termination, and low maternal education level.

## Infant Death Rates by Selected Risk Factors, Buncombe County 1993-97



Source: State Center for Health Statistics (SCHS), NC Department of Health and Human Services.

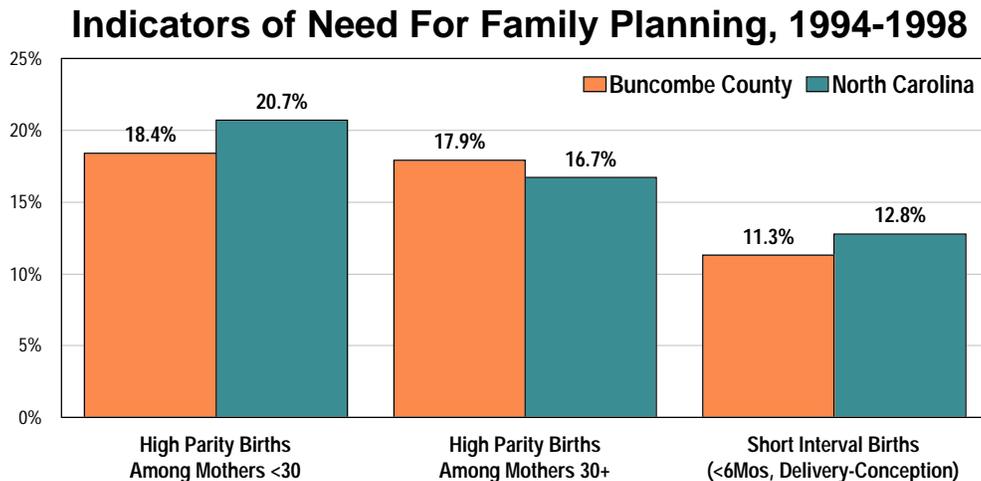
## Need for Family Planning

The following chart outlines factors reported as 1994-98 indicators of need for family planning by the North Carolina Department of Health and Human Services.

Among mothers under the age of 30 years, 18.4% were considered high parity births (high number of prior live births). This is lower than the proportion statewide.

Among mothers aged 30 and older, 17.9% were high parity births, just above the statewide proportion.

Among all births, 11.3% were designated as short interval, meaning the time of conception for this pregnancy was within 6 months of a prior delivery. This is just below the statewide percentage.



Source: State Center for Health Statistics (SCHS), NC Department of Health and Human Services.

# **MODIFIABLE HEALTH RISKS**

# Fast Facts

## Overview of the Findings: Modifiable Health Risks

### Nutrition

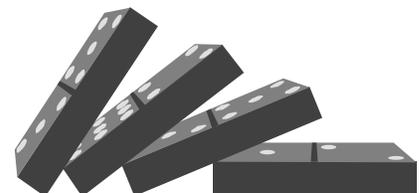
- ☎ County residents average 2.6 servings of vegetables per day and 1.6 servings of fruit. Overall, 37.8% of adults eat the recommended 5 or more servings per day of fruits and/or vegetables.
- ☎ The following proportions of respondents report “always or often” practicing the following healthy eating habits: **eating two or more vegetables at the main meal** (74.9%); **eating only fruit for dessert** (30.0%); **eating chicken or poultry without the skin** (19.2%).
- ☎ Most survey respondents (56.2%) characterize their diets as "medium" in fat content, while 9.9% report "high-fat" diets, and 33.9% report "low-fat" diets. (Note that these are self-reported, and the terms are self-defined.)

### Physical Activity

- ☎ 18.6% of respondents did not participate in any type of leisure-time physical activity in the past month. This marks a statistically significant decrease since the 1995 study was conducted.
- ☎ 18.3% partake in moderate physical activity (exercising at moderate levels at least 5 times a week for 30 minutes at a time); in addition, 38.0% participate in vigorous physical activity (exercising vigorously at least 3 times a week for 20 minutes at a time). Another 33.8% of local adults engage in some activity which enhances and maintains strength and endurance at least twice weekly. However, activity levels among lower-income individuals and among African-American residents are less favorable.

### Overweight

- ☎ By reported heights and weights, 51.7% of survey participants are overweight (including 20.6% who are obese), marking a *statistically significant increase* since 1995 (45.2% overweight in 1995). This includes 64.9% of African-American adults in Buncombe County (compared to 50.4% of Whites).
- ☎ Among overweight residents, 52.5% are trying to lose weight.



## ***Tobacco Use***

-  A total of 24.2% of adults are current cigarette smokers. This increases to 48.1% among uninsured adults. Among current smokers, 15.5% smoke more than one pack daily.
-  53.3% of regular (everyday) smokers have quit smoking for one day or longer during the past year.
-  28.4% of adults live or work with someone who smokes around them (19.7% among nonsmokers).
-  3.9% of survey participants currently use a smokeless tobacco product, such as chewing tobacco or snuff.

## ***Alcohol Consumption***

-  43.9% are **current drinkers** (having had alcohol in the past month).
-  3.9% of county residents are **chronic drinkers** (having at least 60 drinks in the past month), and 10.4% are considered to be **binge drinkers** (having 5 or more alcoholic drinks on any one occasion in the past month), failing to satisfy the *Healthy People 2010* goal (6% or less).

## ***Blood Pressure & Cholesterol***

-  96.0% of survey participants have had their blood pressure checked by a health professional in the past five years. Over one-fourth (28.8%) of adults have been diagnosed with high blood pressure, 73.2% of whom take medication to control it. High blood pressure is particularly prevalent among African Americans.
-  Over one-fourth (28.0%) of adults have been told they have high cholesterol; 10.1% have never had their cholesterol checked. Among adults with high cholesterol levels, 63.8% are taking action to control their levels.

# Nutrition & Diet Behaviors

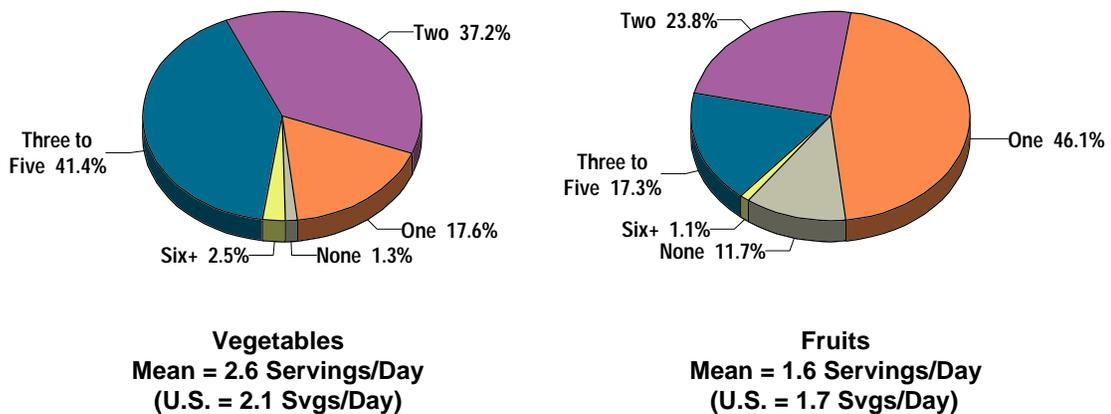
Diet is a key component of good health. In fact, dietary habits have been linked to five of the 10 leading causes of death in the United States, including coronary heart disease, some types of cancer (colorectal, breast and prostate), stroke, noninsulin-dependent diabetes mellitus and atherosclerosis. A well-balanced, low-fat diet can also help limit the risks associated with excessive weight, high blood pressure and high blood cholesterol.

Whereas nutrient deficiencies may have once been a primary concern, the greatest problems today involve the excesses and imbalances of some foods in the American diet. Ideally, one's diet should: be low in fat, saturated fat and cholesterol; include plenty of vegetables, fruits and grain products; contain moderate amounts of sugars, salt and sodium; and include alcohol use in moderation if at all.

## Dietary Habits: Fruits & Vegetables

Residents of Buncombe County report eating an average of 2.6 servings of vegetables per day and an average of 1.6 servings of fruits per day. The following chart shows a specific breakout of the servings of fruits and vegetables eaten daily by community members.

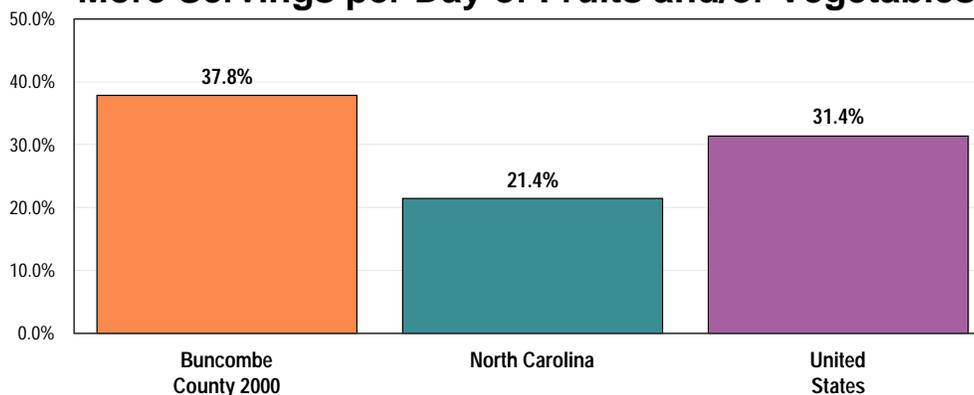
### Self-Reported Daily Servings of Fruits and Vegetables



Sources: 1. 2000 PRC Community Health Survey, Professional Research Consultants  
 2. 2000 PRC National Community Health Survey, Professional Research Consultants  
 Note: Asked of all respondents.

Furthermore, 37.8% of residents eat the recommended five or more servings per day of fruits and/or vegetables. This is more favorable than the national prevalence level and much higher than the 21.4% reported across North Carolina.

## Self-Reported: Eat the Recommended 5 or More Servings per Day of Fruits and/or Vegetables

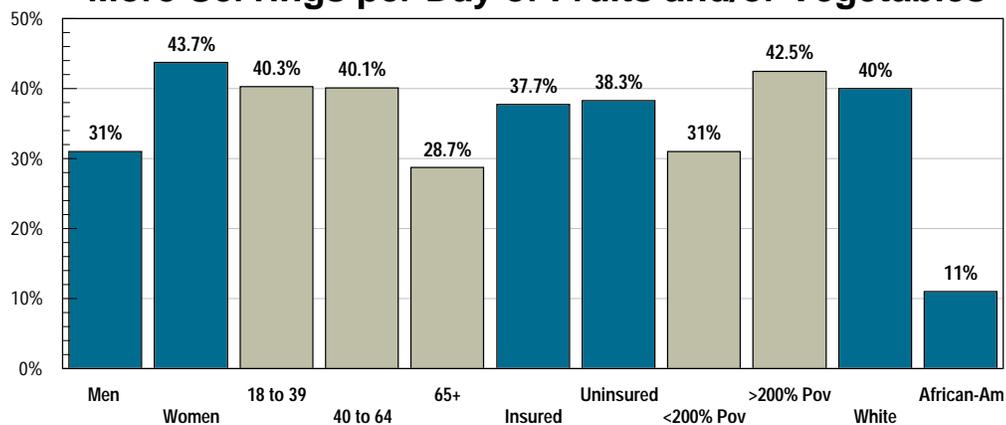


Source: 1. 2000 PRC Community Health Survey, Professional Research Consultants  
 2. Behavioral Risk Factor Surveillance System, Centers for Disease Control, 1998 North Carolina Data  
 3. 2000 PRC National Health Survey, Professional Research Consultants

Notes: 1. Asked of all respondents.  
 2. This question was not addressed in 1995.

Adults most likely to eat the recommended five or more servings per day of fruits and/or vegetables include women, adults under 65, Whites, and those living in the higher income bracket, as shown below. This indicator is particularly low among African Americans.

## Self-Reported: Eat the Recommended 5 or More Servings per Day of Fruits and/or Vegetables



Sources: 1. 2000 PRC Community Health Survey, Professional Research Consultants  
 2. 2000 Buncombe County Latino Health Survey

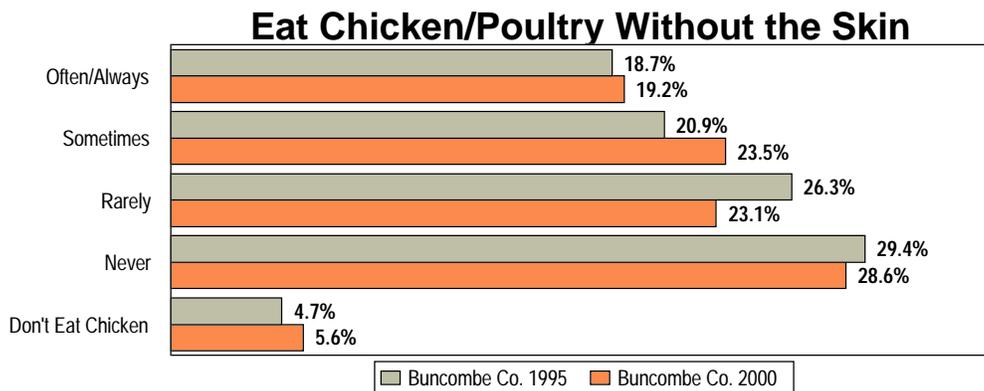
Notes: 1. Demographic breakouts are among findings in Buncombe County in 2000.  
 2. Asked of all respondents.  
 3. This specific inquiry was not asked in the separate Latino survey.

## Specific Diet Behaviors

### Poultry

Buncombe County survey participants were asked a series of questions about their dietary behaviors, such as eating skinless poultry, fruit for dessert, two or more vegetables for dinner, and type of milk consumed.

As shown below, one in five local adults reports “often” or “always” eating chicken or other poultry without the skin, comparable to the 18.7% reported in 1995. Another 23.5% of local adults report that they “sometimes” eat their chicken without the skin. On the other hand, one-half of county residents “rarely” or “never” eat skinless poultry (5.6% do not eat chicken).

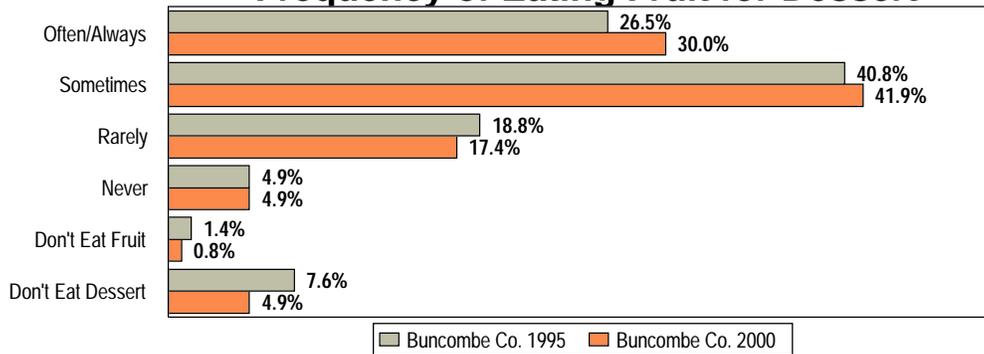


Source: 1995 & 2000 PRC Community Health Surveys, Professional Research Consultants  
Note: Reflects the total sample of respondents.

### Fruit

When asked how often residents eat only fruit as their dessert, 30.0% responded with “often” or “always,” statistically similar to the 26.5% reported in 1995. While 41.9% of Buncombe County residents “sometimes” eat fruit for dessert after a meal, 22.3% of local adults “rarely” or “never” eat fruit as their sole dessert.

### Frequency of Eating Fruit for Dessert

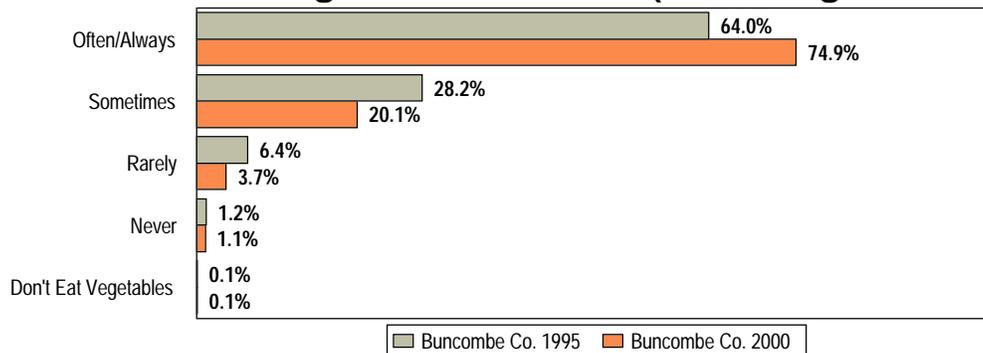


Source: 1995 & 2000 PRC Community Health Surveys, Professional Research Consultants  
 Note: Reflects the total sample of respondents.

### Vegetables

Respondents were further asked to indicate how often they eat two or more vegetables (excluding potatoes) at dinner. A full three-fourths (74.9%) reported “often” or “always” eating at least two vegetables with dinner (up significantly from the 64.0% reported in 1995). Another 20.1% of local adults “sometimes” eat 2+ vegetables with dinner, while less than 5% of local adults responded with “rarely” or “never.”

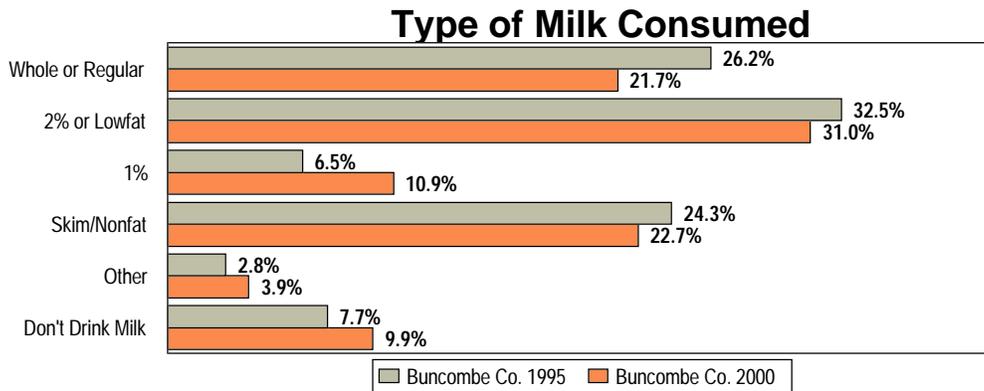
### Eat 2+ Vegetables at Dinner (Excluding Potatoes)



Source: 1995 & 2000 PRC Community Health Surveys, Professional Research Consultants  
 Note: Reflects the total sample of respondents.

## Milk

Local adults were also asked to specify which type of milk, if any, they usually consume. As shown in the following chart, the largest share of responses (31.0%) was for 2% or lowfat milk, followed by skim/nonfat milk (mentioned by 22.7%), whole or regular milk (21.7%), and 1 percent milk (10.9%).

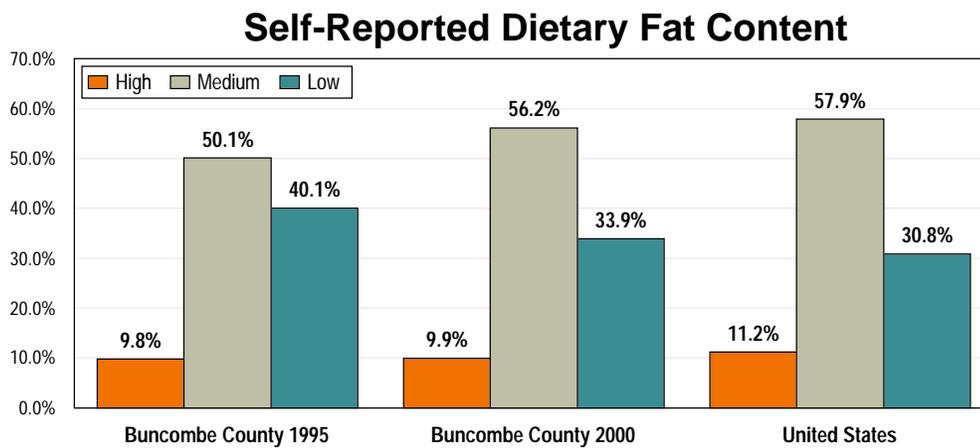


Source: 1995 & 2000 PRC Community Health Surveys, Professional Research Consultants  
Note: Reflects the total sample of respondents.

## Self-Reported Dietary Fat Content

When asked to indicate the level of fat consumed in their typical daily diet, approximately one in 10 adults nationwide reports eating a diet “high” in fat content, while the majority (57.9%) eat diets “medium” in fat content and the remaining three in 10 U.S. adults eat a “low-fat” diet.

Across Buncombe County, the proportion of people who report eating a high-fat diet (9.9%) is virtually unchanged from that reported in 1995. On the other hand, the number of adults who report diets “low” in fat content has undergone a *statistically significant decrease* since the 1995 survey was conducted.



Sources: 1. 1995 & 2000 PRC Community Health Surveys, Professional Research Consultants

2. 2000 PRC National Health Survey, Professional Research Consultants

Notes: 1. Asked of all respondents.

2. Data are self-reported, and the terms "high," "medium" and "low" are self-defined by the respondent.

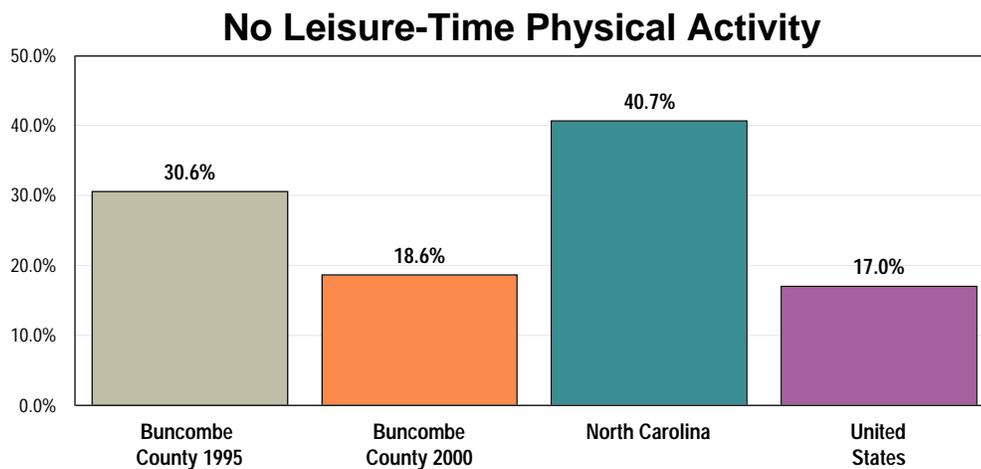
# Physical Activity

Regular physical activity contributes to a longer and healthier life. The health benefits of exercise are irrefutable; it has been asserted that employing regular physical activity toward cardiorespiratory fitness can prevent or limit one's risk for such afflictions as coronary heart disease, hypertension, noninsulin-dependent diabetes mellitus, osteoporosis, obesity, depression, colon cancer, stroke and back injury.

## Leisure-Time Physical Activity

### No Leisure-Time Physical Activity

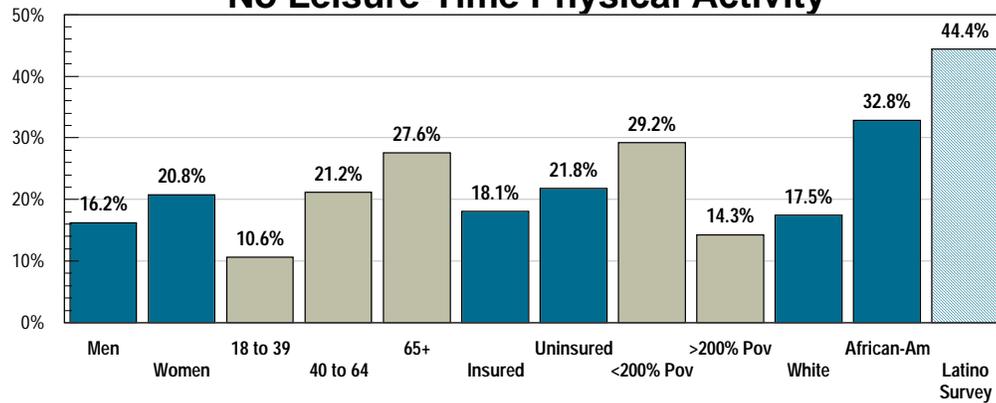
Less than 1 in 5 residents in Buncombe County have *not* participated in any type of physical activity outside work during the past month. This percentage is comparable to the 17.0% recorded nationwide and marks a *statistically significant decrease* in lack of physical activity since 1995, as shown below.



Sources: 1. 1995 & 2000 PRC Community Health Surveys, Professional Research Consultants  
2. 2000 PRC National Health Survey, Professional Research Consultants  
3. Behavioral Risk Factor Surveillance System, Centers for Disease Control, 1996 North Carolina Data  
Note: Asked of all respondents.

The following chart segments levels of inactivity by various demographic characteristics. As shown, the lack of leisure-time activity is highest among African-Americans, older adults, women, and people in the lower income bracket. Note also that, according to the survey administered to Latino adults in Buncombe County, 44.4% of Latinos had no leisure-time physical activity last month.

## No Leisure-Time Physical Activity



Sources: 1. 2000 PRC Community Health Survey, Professional Research Consultants  
 2. 2000 Buncombe County Latino Health Survey

Notes: 1. Demographic breakouts are among findings in Buncombe County in 2000.

2. Asked of all respondents.

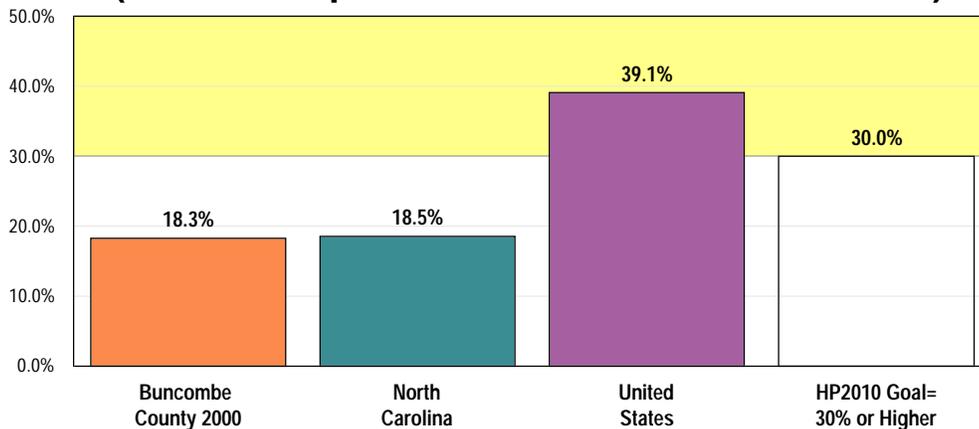
3. Latino survey data was derived from an independent written survey administered one-on-one by various Buncombe County organization representatives among a convenience sample. In interpreting and comparing results, it is important to note that the Latino survey, unlike the countywide telephone survey, was not administered among a random sample of community members. For this reason, the data from these Latino surveys are not incorporated into the overall county percentage, nor in other demographic breakout percentages.

## Activity Levels

### Moderate Physical Activity

Moderate physical activity (exercising at a moderate intensity for 30 or more minutes per time at least five times per week) is reported by 18.3% of community members in Buncombe County in the past month (this question was not asked in the 1995 survey), comparable to the 18.5% reported across the state. Nationwide, a less favorable 39.1% of adults participate in moderate physical activity. Note the *Healthy People 2010* goal for exercising 30 minutes a day, “preferably daily,” is 30% or higher.

**Exercise at Moderate Intensity  
(Five Times per Week for 30 Minutes at a Time)**

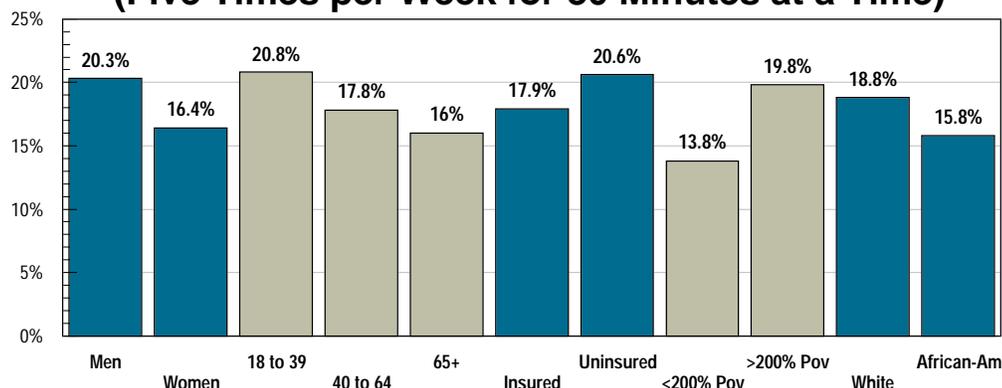


- Sources: 1. 2000 PRC Community Health Survey, Professional Research Consultants  
 2. 2000 PRC National Health Survey, Professional Research Consultants  
 3. Behavioral Risk Factor Surveillance System, Centers for Disease Control, 1996 North Carolina Data  
 4. *Healthy People 2010* National Center for Health Statistics/CDC/Public Health Service

- Notes: 1. Asked of all respondents.  
 2. "Moderate physical activity" refers to exercising at moderate intensity at least 5 times a week for 30 minutes at a time.  
 3. The *Healthy People 2010* goal is to increase to at least 30% the proportion of people who engage regularly, preferably daily, in light to moderate physical activity for at least 30 minutes per day.

When viewed by demographic characteristics, adults least likely to perform moderate exercise include women, older adults, those living at or near the poverty level, and African-Americans, as shown in the following chart.

## Exercise at Moderate Intensity (Five Times per Week for 30 Minutes at a Time)



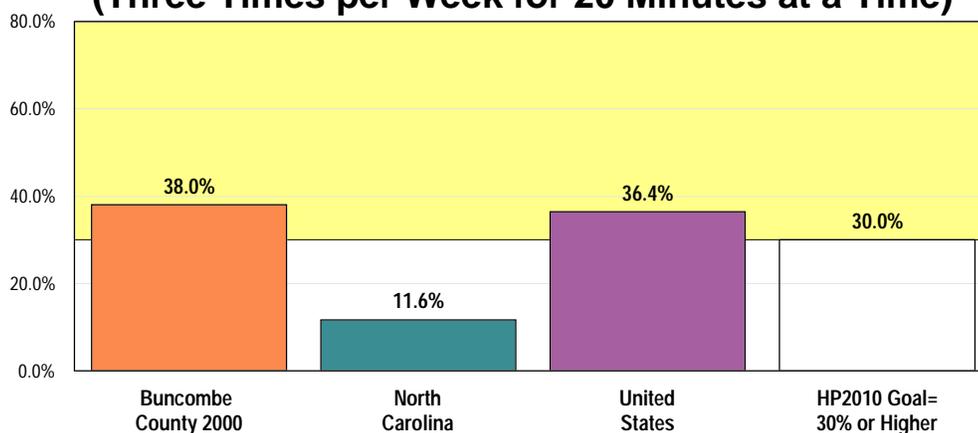
Sources: 1. 2000 PRC Community Health Survey, Professional Research Consultants  
 2. 2000 Buncombe County Latino Health Survey

Notes: 1. Demographic breakouts are among findings in Buncombe County in 2000.  
 2. Asked of all respondents.  
 3. This question was not covered in the separate Latino survey.  
 4. "Moderate physical activity" refers to exercising at moderate intensity at least 5 times a week for 30 minutes at a time.

## Vigorous Activity

Vigorous physical activity (exercising *vigorously* for 20 or more minutes per time at least three times per week) is reported by 38.0% of community members in Buncombe County in the past month (this question was not asked in the 1995 survey), much higher than the 11.6% reported across the state. Nationwide, a similar 36.4% of adults participate in moderate physical activity. Note the *Healthy People 2010* goal for exercising 30 minutes a day, "preferably daily but at least three times weekly," is 30% or higher.

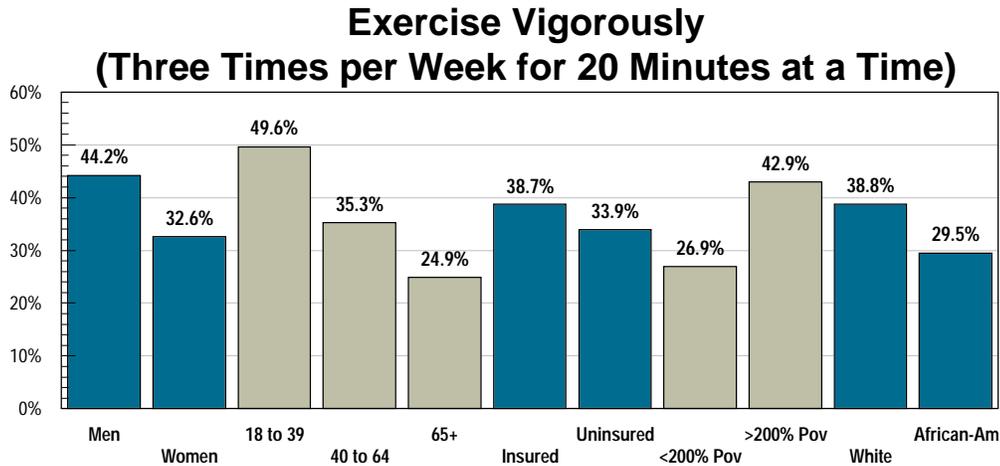
## Exercise Vigorously (Three Times per Week for 20 Minutes at a Time)



Sources: 1. 2000 PRC Community Health Survey, Professional Research Consultants  
 2. 2000 PRC National Health Survey, Professional Research Consultants  
 3. Behavioral Risk Factor Surveillance System, Centers for Disease Control, 1996 North Carolina Data  
 4. *Healthy People 2010* National Center for Health Statistics/CDC/Public Health Service

Notes: 1. Asked of all respondents.  
 2. "Vigorous physical activity" refers to exercising vigorously at least 3 times a week for 20 minutes at a time.  
 3. The *Healthy People 2010* goal is to increase to at least 30% the proportion of people who engage regularly, preferably 3 times or more weekly, in vigorous physical activity for at least 20 minutes per exercise session.

Further note that adults most likely to report regular vigorous activity include males, adults under 40, Whites, insured adults, and those in the higher income bracket, as shown below.

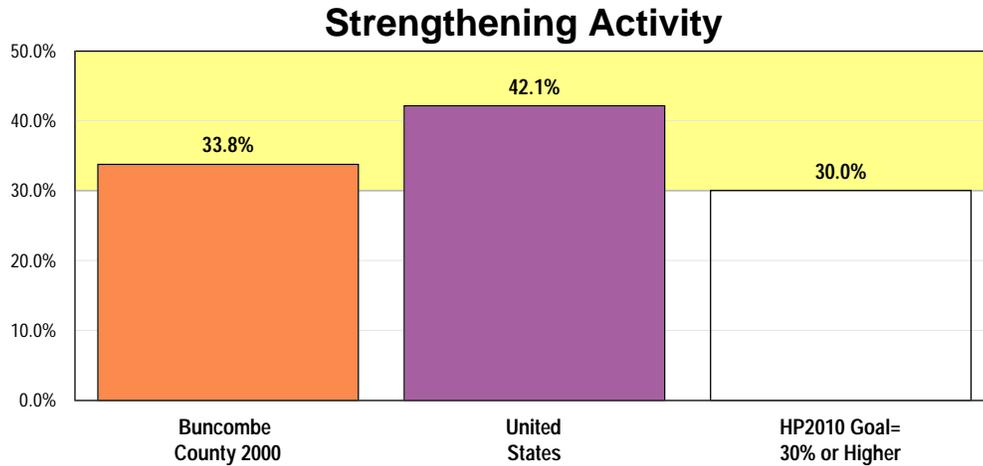


Sources: 1. 2000 PRC Community Health Survey, Professional Research Consultants  
2. 2000 Buncombe County Latino Health Survey

Notes: 1. Demographic breakouts are among findings in Buncombe County in 2000.  
2. Asked of all respondents.  
3. This question was not covered in the separate Latino survey.  
4. "Vigorous physical activity" refers to exercising vigorously at least 3 times a week for 20 minutes at a time.

## Strengthening Activity

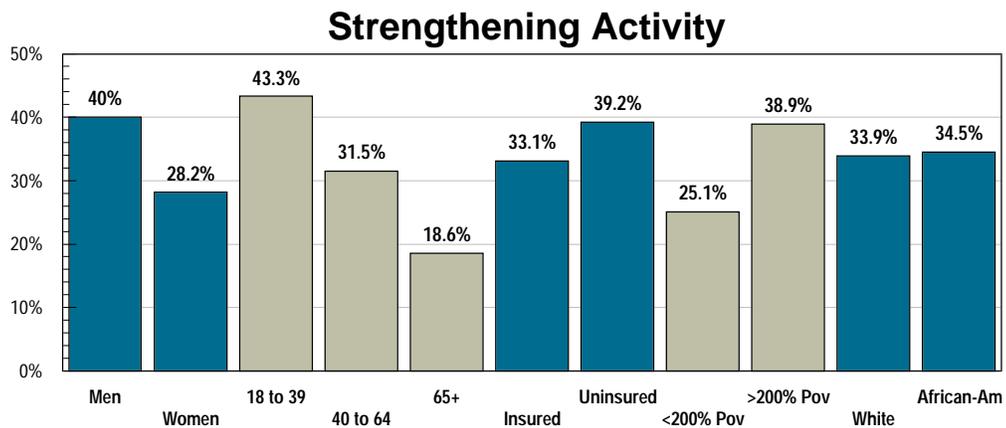
*Healthy People 2010* hopes that, by the year 2010, at least 30% of adults will participate in strengthening activity, performing any activity which enhances and maintains strength and endurance at least twice a week. In Buncombe County, one-third (33.8%) of local adults report that they participate in strengthening activity at least twice weekly, compared to 42.1% nationwide and meeting the *Healthy People 2010* goal.



Sources: 1. 2000 PRC Community Health Survey, Professional Research Consultants  
 2. 2000 PRC National Health Survey, Professional Research Consultants  
 3. *Healthy People 2010* National Center for Health Statistics/CDC/Public Health Service

Notes: 1. Asked of all respondents.  
 2. In this case, "strengthening activity" refers to performing any activity which enhances and maintains strength and endurance at least twice a week.  
 3. The *Healthy People 2010* goal is to increase to at least 30% the proportion of people who engage in activity which enhances and maintains strength and endurance at least two times weekly.  
 4. State data not available.  
 5. This information was not covered in 1995.

Adults most likely to report regular strengthening activity include males, adults under 40, adults without health care insurance coverage, and those in the higher income bracket, as shown below.



Sources: 1. 2000 PRC Community Health Survey, Professional Research Consultants  
 2. 2000 Buncombe County Latino Health Survey

Notes: 1. Demographic breakouts are among findings in Buncombe County in 2000.  
 2. Asked of all respondents.  
 3. This inquiry was not asked in the separate Latino survey.  
 4. In this case, "strengthening activity" refers to performing any activity which enhances and maintains strength and endurance at least twice a week.

## Recreation & Leisure

Buncombe County and Asheville have much to offer residents to support leisure and recreational interests. Our geographic location in the mountains of Western North Carolina is a unique and rich asset in leisure and recreational pursuits. Buncombe County Government's Vision includes several key goals such as meeting the changing needs of our diverse community by developing, supporting, and encouraging access to appropriate technological, educational, and recreational programs and enhancing citizens' quality of life by developing library and recreation facilities with easy access to neighborhoods.

### Area Resources

#### ***Buncombe County***

Buncombe County operates the following facilities:

- Aston Park Tennis Center
- Buncombe County Golf Course
- Lake Julian
- Skyland Recreation Center
- Six outdoor pools (Cane Creek, Erwin Community, Hominy Valley Park, North Buncombe Park, Owen, and Recreation Park)
- Eight River Parks (Bent Creek, Corcoran Paige, Glen Bridge, Hominy Creek, Jean Webb, Ledges Whitewater, Sandy Bottoms, and Walnut Island)

Programs include junior tennis, swim lessons, youth soccer, water exercise, senior games, tennis, Special Olympics, and special events ranging from a snake beauty pageant to a firework show.

#### ***City of Asheville***

The City of Asheville is likewise committed to a mission of *“providing quality recreation and cultural experiences to citizens and visitors, regardless of race, gender, age religion or disability, while preserving our natural resources and cultural heritage. The Department of Parks and Recreation encourages people to help themselves through an open dialogue and assist in the development of better physical, mental, moral and economic health of the community.”*

Recreation Programs include:

- 12 community centers (Burton Street, East Asheville, Harvest House, Montford, Murphy-Oakley, North Asheville, W.C. Reid, Senior Opportunity, Shiloh, Stephens-Lee, West Asheville, and YMI Cultural)
- Six after-school/day care-camp programs (Claxton, Dickson, Hall Fletcher, Jones, Reid, and Vance)
- Two city-operated pools (Malvern Hills and Walton Street)
- Four summer youth programs, including 'Rec and Roll', summer playground, teen, and youth employment
- Athletics includes basketball, flag football, softball, tennis, volleyball, Little League, golf, cheerleading, and Skateboard Park with a dual focus on youth and adults

Additionally there are a variety of outdoor recreational opportunities. Attendance at all city-sponsored events in 1999 was 197,273.

### Other Resources in Buncombe County & the City of Asheville

- YMCA
- YWCA –SOS program
- Girls and Boys Club
- Church Camps, Summer
- Civic Center
- The College for Seniors and the Center for Creative Retirement
- Project Steam
- Teen Reach
- Girls Incorporated
- United Way
- Council on Aging
- Churches are providing some activities for youth and teens, but not reaching all.

## Barriers to Accessing Leisure & Recreational Services

### *Perceptions Data\**

Perceptions Data reveal several issues related to accessing leisure and recreational services in our area:

1. Lack of transportation to activities for elderly and teens
2. Few activities for teens and lack of supervised activities for teens
3. Unsafe to walk in some neighborhoods and downtown because of crime or perception of crime
4. Lack of sidewalks creates unfriendly environment toward activity
5. Vehicle traffic
6. Unsafe to bicycle because of highway designs, no shoulders or bike lanes, vehicle traffic unfriendly toward bicycles
7. Need for more parks
8. Lack of things for children to do

### **Citizen quotes from perception interviews:**

“(At) sports events and some of the civic events, I’ve seen a fairly sizeable cross-section of the community, black and white come together at these events. There are opportunities but then you still have that segment in the community that is not able to go because they can’t afford it. If they should go, that means they made a sacrifice either for the children or for some other need of the family.”

“(Jogging) has become a form of medication and therapy for me. A lot of people manage their stress by drinking or smoking and other forms of activity. I manage my stress by jogging and having a consistent exercise program. For the last 22 years, I’ve taken no medicine for my blood pressure.”

“Problems like alcohol and substance abuse occur more often when people feel like they are isolated and they don’t have any healthy recreation. If there were more opportunities for healthy recreation we would see less (drug use/sales).”

“The message about (the importance of) exercise has to be greater and in Spanish for our community (Latinos).”

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*\* The Perceptions Data are valuable in identifying issues and providing context to the findings of this assessment. Keep in mind, however, that these qualitative comments are attributable only to those citizens and Key Informants participating in this effort and are not necessarily representative of the study sponsors nor the community at large.*

In addition, several believe more “places of community support” are needed.

“Have Mass and have church but offer them another place to congregate and to develop a sense of community...socialization that is not necessarily worship-based...where kids could come and gather and do things.”

“I think we really need to get out and market to seniors and make it possible for seniors to use (facilities). One example is the YWCA. They have a real good pool and they have a lift to get people into the pool and its very much under-utilized. I hope that will change. I know that people from the Y are doing everything they can to expand the scope of inclusion.”

“We (ALAS) want to be a vehicle to improve programs for youth. Because we have heard from the Latino community that there aren’t enough recreational activities for youth of any community. It seems like less for people who don’t speak English. And affordable recreation also is what we are trying to develop.”

“We have a dynamite center for creative retirement and school for seniors. We have a good parks and recreation program. We have some good things going for us. We can make it better. We need to work on organization and easy access for older adults.”

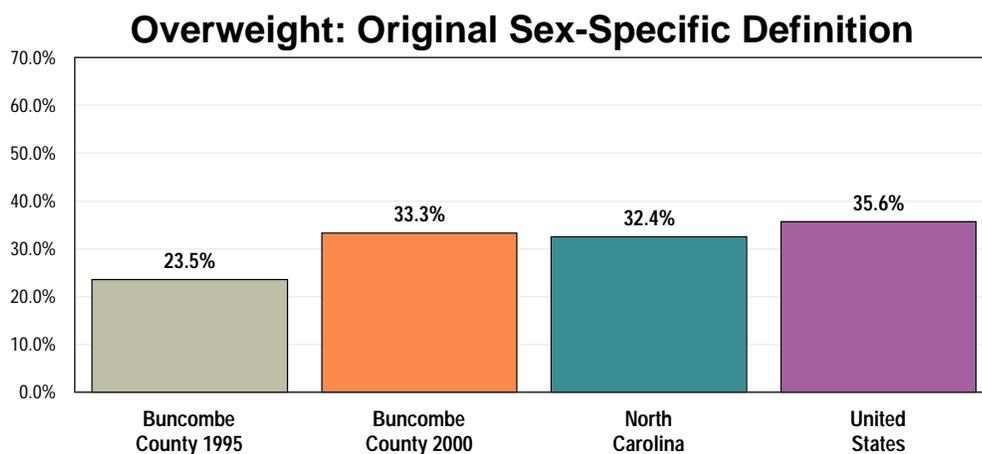
“We’ve got a lot of inactive kids and parents whose lifestyle promotes kids sitting in front of TVs with video games.”

# Overweight Prevalence

Being overweight afflicts a considerable portion of the U.S. population and carries significant health risks. Individuals who are overweight are at increased risk for high blood pressure, high blood cholesterol, coronary heart disease, stroke, diabetes, atherosclerosis, gall bladder disease, some types of cancer, and osteoarthritis. To maintain a proper body weight, experts recommend a well-balanced diet which is low in fat and high in fiber, accompanied by regular exercise.

One of the more precise measurements of being overweight is body mass index (BMI), a ratio of weight to height ( $\text{kg}/\text{m}^2$ ). It was originally established that a person is considered to be overweight if his or her body mass index exceeds the 85th percentile for young American adults (27.8 for men and 27.3 for women). In 1998, this definition was modified to include all those with a BMI greater than or equal to 25.0, regardless of gender; the definition of for obesity is a BMI greater than or equal to 30.0. This change is meant to reflect the level at which *health risk* actually increases (rather than based simply on population weight averages as in the old model).

Based on the original, sex-specific definition for overweight prevalence, a total of 33.3% of adults in Buncombe County are overweight, similar to the national prevalence of 35.6% but marking a *statistically significant increase* over the 23.5% reported in the 1995 survey. Across North Carolina, 32.4% of adults are overweight, based on the original definition, as shown below.

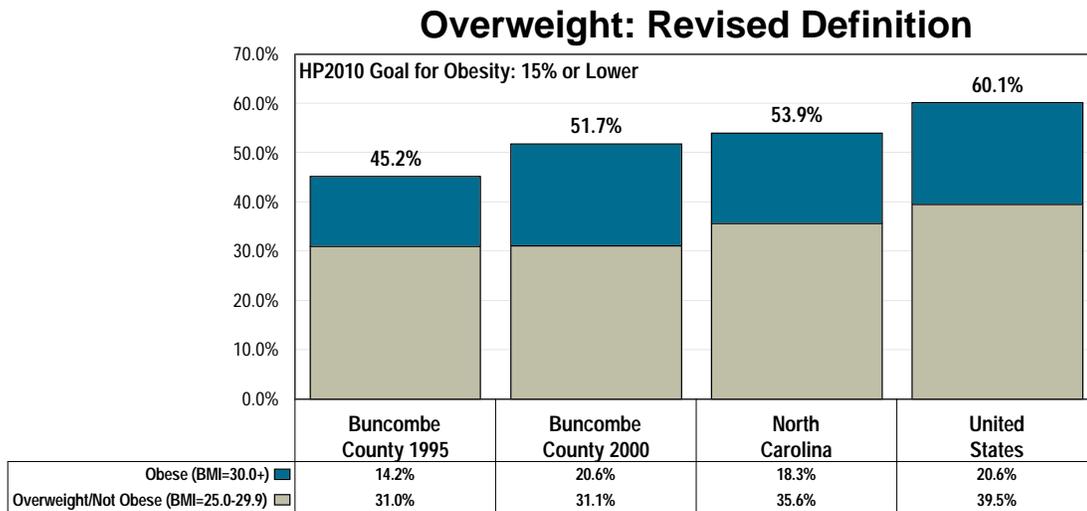


- Sources: 1. 1995 & 2000 PRC Community Health Surveys, Professional Research Consultants  
2. Behavioral Risk Factor Surveillance System, Centers for Disease Control, 1997 North Carolina Data  
3. 2000 PRC National Health Survey, Professional Research Consultants

- Notes: 1. The original definition as outlined in Healthy People 2000 is having a body mass index (BMI), a ratio of weight to height (kilograms divided by meters squared), equal to or greater than 27.8 for men or 27.3 for women.  
2. Asked of all respondents.

## Overweight: Revised Definition

Under the revised definition for overweight prevalence, a full 51.7% of adults in Buncombe County are overweight (including 20.6% who are obese, and 31.1% who are otherwise overweight). The obesity level in Buncombe County is identical to that found nationwide. Again, however, this year's percentage marks a *statistically significant increase* in overweight since 1995 (45.2%), specifically in the "obese" category, as shown below.

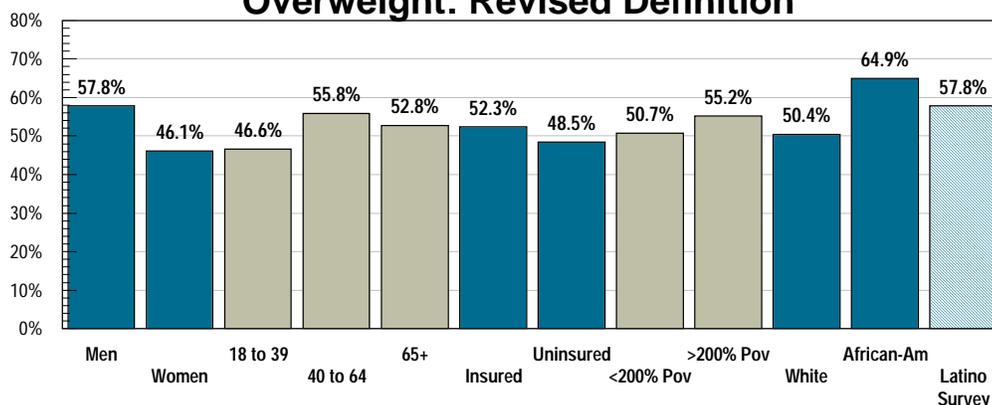


- Sources:
- 2000 PRC Community Health Survey, Professional Research Consultants
  - Behavioral Risk Factor Surveillance System, Centers for Disease Control, 1997 North Carolina Data
  - 2000 PRC National Health Survey, Professional Research Consultants
  - Healthy People 2010, National Center for Health Statistics/CDC/Public Health Service

- Notes:
- The revised definition of overweight is having a body mass index (BMI), a ratio of weight to height (kilograms divided by meters squared), greater than or equal to 25.0, regardless of gender. The definition for obesity is a BMI greater than or equal to 30.0.
  - Asked of all respondents.

As shown in the following chart, African-Americans in Buncombe County show the greatest level of overweight prevalence, with 64.9% overweight. Women and adults under 40 exhibit the lowest overweight prevalence levels.

## Overweight: Revised Definition



Sources: 1. 2000 PRC Community Health Survey, Professional Research Consultants

2. 2000 Buncombe County Latino Health Survey

Notes: 1. Demographic breakouts are among findings in Buncombe County in 2000.

2. Asked of all respondents.

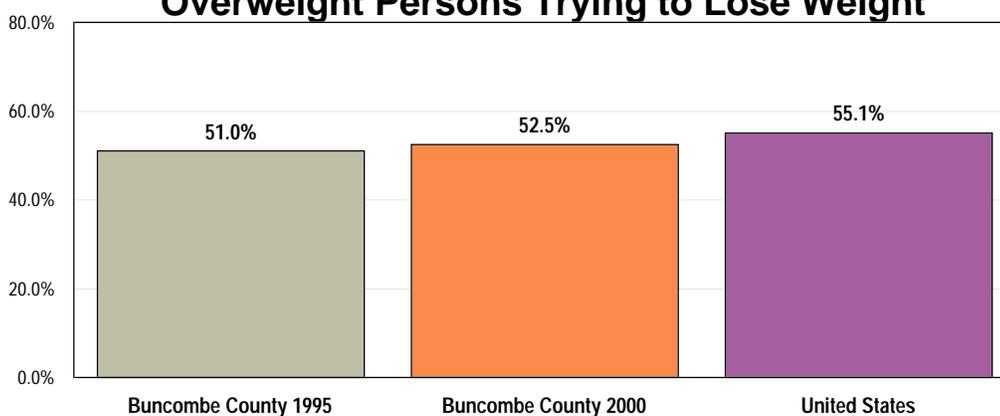
3. Latino survey data was derived from an independent written survey administered one-on-one by various Buncombe County organization representatives among a convenience sample. In interpreting and comparing results, it is important to note that the Latino survey, unlike the countywide telephone survey, was not administered among a random sample of community members. For this reason, the data from these Latino surveys are not incorporated into the overall county percentage, nor in other demographic breakout percentages.

4. The revised definition of overweight is having a body mass index (BMI), a ratio of weight to height (kilograms divided by meters squared), greater than or equal to 25.0, regardless of gender. The definition for obesity is a BMI greater than or equal to 30.0.

## Weight Control

Among those who are overweight (under the revised definition), 52.5% are trying to lose weight, similar to the 51.0% recorded in 1995.

## Overweight Persons Trying to Lose Weight



Sources: 1. 1995 & 2000 PRC Community Health Surveys, Professional Research Consultants

2. 2000 PRC National Health Survey, Professional Research Consultants

Notes: 1. Asked of all overweight respondents, as defined under the revised definition.

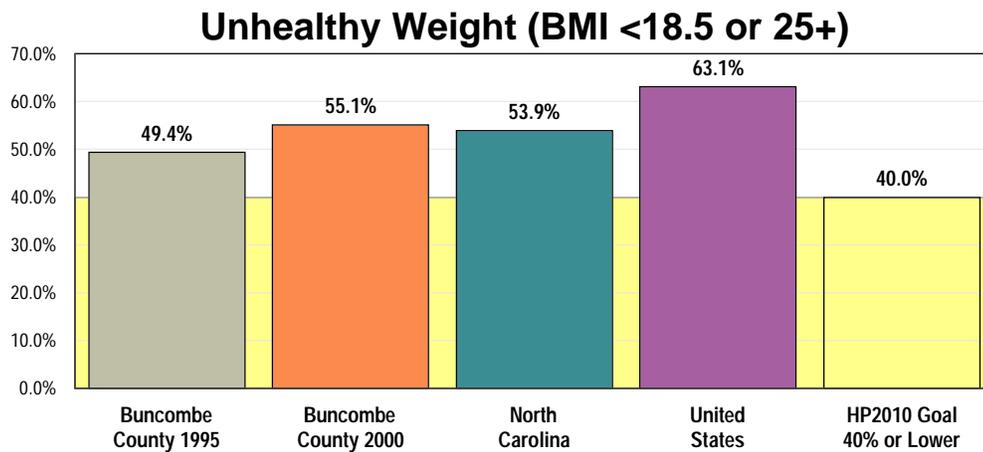
2. North Carolina data not available.

3. 1995 county data is based on the revised definition of overweight and queries whether respondents are trying to lose weight (but does not specify modifying diet or increasing exercise).

4. In contrast, 2000 county data and the U.S. percentage reflects overweight adults (based on the revised version) who are both exercising and changing their eating habits in order to lose weight.

## Unhealthy Weight

*Healthy People 2010* hopes that, by the year 2010, 40% or fewer adults will be of unhealthy weight (those with a BMI less than 18.5 or greater than 25.0). In Buncombe County, 55.1% of residents are at an unhealthy weight, representing a *statistically significant increase* since the 1995 study was conducted, and failing to meet the *Healthy People 2010* goal. On the other hand, this percentage is more favorable than the 63.1% reported nationwide, as shown below.

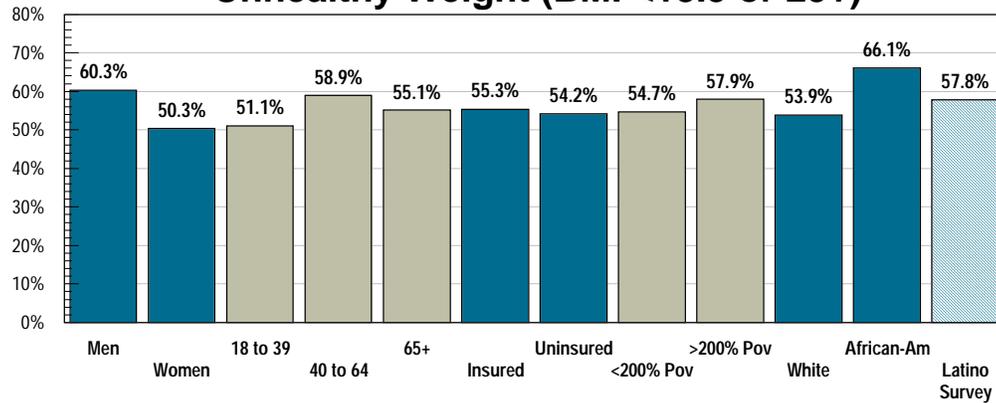


Sources: 1. 2000 PRC Community Health Survey, Professional Research Consultants  
 2. Behavioral Risk Factor Surveillance System, Centers for Disease Control, 1997 North Carolina Data  
 3. 2000 PRC National Health Survey, Professional Research Consultants  
 4. Healthy People 2010, National Center for Health Statistics/CDC/Public Health Service

Notes: 1. The original definition as outlined in Healthy People 2000 is having a body mass index (BMI), a ratio of weight to height (kilograms divided by meters squared), less than 18.5 or greater than 25.0.  
 2. Asked of all respondents.

As shown in the following chart, unhealthy weight does not vary dramatically when viewed by demographic characteristics, but increases somewhat among males, middle-aged adults, and African-Americans. The Latino survey revealed that 57.8% of local Latinos are at an unhealthy weight.

## Unhealthy Weight (BMI <18.5 or 25+)



Sources: 1. 2000 PRC Community Health Survey, Professional Research Consultants

2. 2000 Buncombe County Latino Health Survey

Notes: 1. Demographic breakouts are among findings in Buncombe County in 2000.

2. Asked of all respondents.

3. Latino survey data was derived from an independent written survey administered one-on-one by various Buncombe County organization representatives among a convenience sample. In interpreting and comparing results, it is important to note that the Latino survey, unlike the countywide telephone survey, was not administered among a random sample of community members. For this reason, the data from these Latino surveys are not incorporated into the overall county percentage, nor in other demographic breakout percentages.

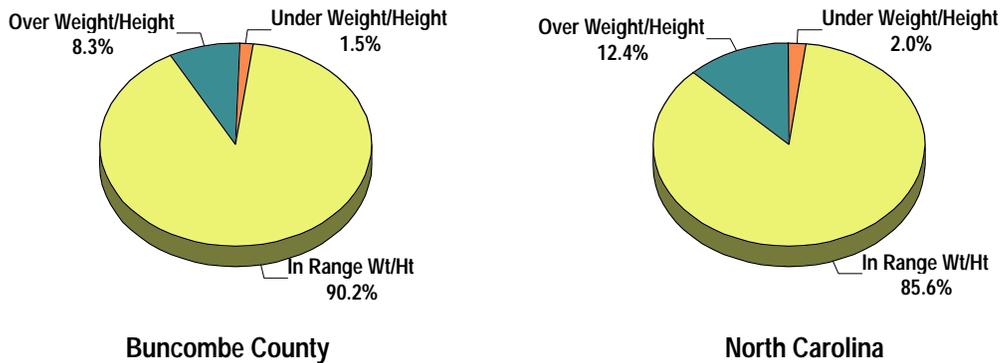
4. The original definition as outlined in *Healthy People 2010* is having a body mass index (BMI), a ratio of weight to height (kilograms divided by meters squared), less than 18.5 or greater than 25.0.

## Overweight Status in Children: Public Health Assessments

Among children 4 to 5 years of age who received well and/or WIC services from the public health department, 90.2% were found to be “in range” — between the 5<sup>th</sup> and 95<sup>th</sup> percentile — for weight-to-height.

A total of 8.3% were found to be over the 95<sup>th</sup> percentile (“over weight/height”), while 1.5% were found to be under the 5<sup>th</sup> percentile (“under weight/height”). Comparisons to statewide reporting suggest that Buncombe County experiences a lower proportion of overweight children.

### Child Health Contract Addenda Baseline, Weight Status, 1997-98



Source: State Center for Health Statistics (SCHS), NC Department of Health and Human Services.

Note: Percentage of children 48 to 60 months of age who received well and/or WIC services from the health department. "In Range" includes those who have weight-for-height between the 5th and 95th percentile

# Tobacco Use

Tobacco use remains the single-most avoidable cause of death in our society. The predominant form of tobacco use is cigarette smoking, which has been associated with coronary heart disease, cancer (of the lung, larynx, pharynx, oral cavity, esophagus, pancreas and bladder), stroke, emphysema and other health problems such as respiratory infections and stomach ulcers.

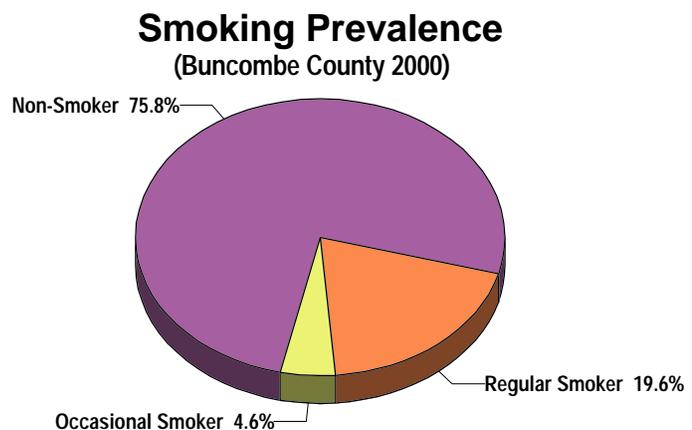
Cigarette smoking is responsible for more than one in six deaths in the United States. It accounts for 21% of coronary heart disease deaths, 87% of lung cancer deaths, and 30% of all cancer deaths. Cigarette smoking is also a substantial contributor to chronic morbidity and disability in the U.S.

Furthermore, the dangers of smoking are not limited to the smoker alone. Cigarette smoking during pregnancy contributes to low birthweight, preterm delivery and infant death. Passive or second-hand smoke can cause disease (including lung cancer) in nonsmokers and severe respiratory and other problems in young children and infants.

## Cigarette Smoking

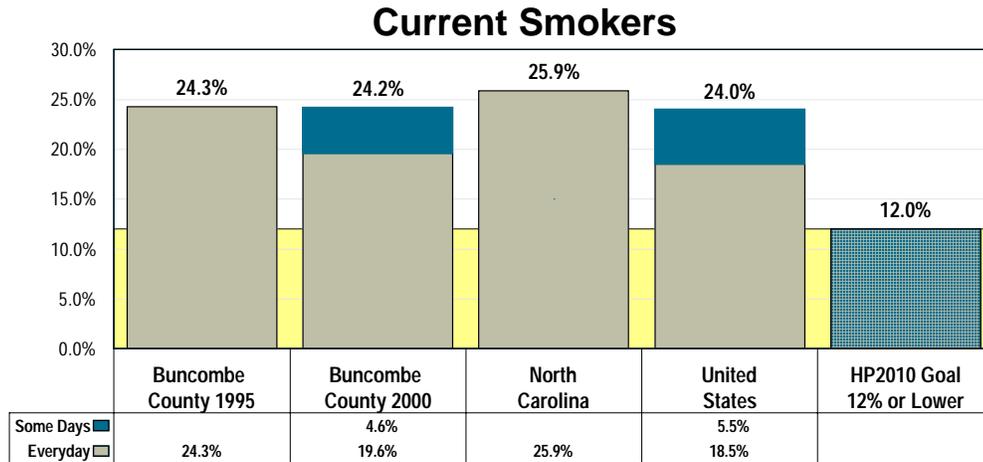
### Cigarette Smoking Prevalence

A total of 24.2% of adults in Buncombe County are classified as “regular” or “occasional” cigarette smokers. This group is comprised of 4.6% of the population which smokes occasionally (those who smoke cigarettes on some days) and 19.6% of the population which smokes regularly (on a daily basis).



Source: 2000 PRC Community Health Survey, Professional Research Consultants  
Note: Asked of all respondents.

The 24.2% prevalence of current smokers (regular plus occasional smokers) recorded in Buncombe County is comparable to the 24.0% prevalence recorded nationwide, but fails to satisfy the Year 2010 goal to reduce smoking prevalence to 12% or less of adults aged 18 and over. This year's smoking prevalence is almost identical to that in 1995 (24.3%) and is comparable to the 25.9% recorded among adults across North Carolina.



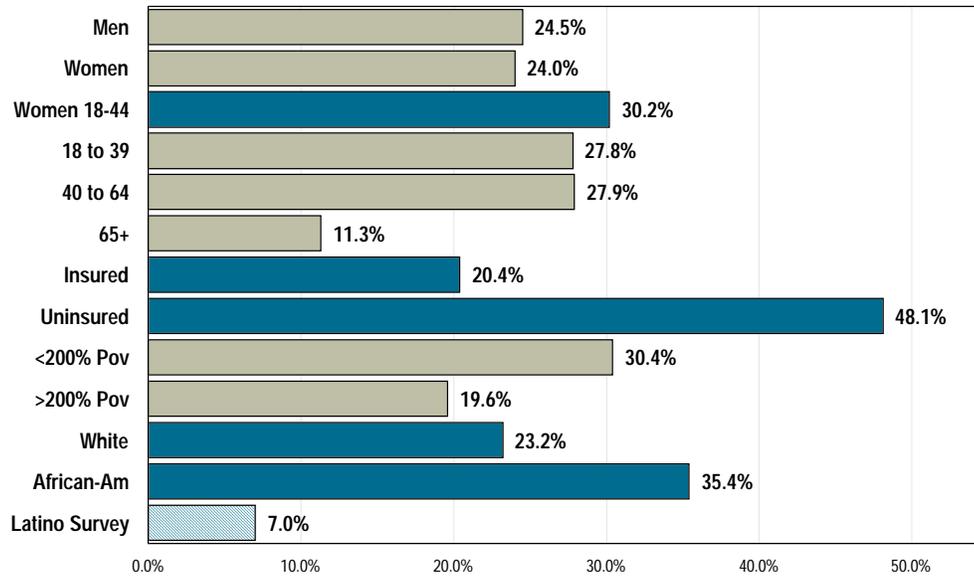
Sources: 1. 1995 & 2000 PRC Community Health Surveys, Professional Research Consultants  
 2. Behavioral Risk Factor Surveillance System, Centers for Disease Control, 1997 North Carolina Data  
 3. 2000 PRC National Health Survey, Professional Research Consultants  
 4. *Healthy People 2010* National Center for Health Statistics/CDC/Public Health Service

Notes: 1. Includes regular and occasional smokers (everyday and some days).  
 2. North Carolina and 1995 county data do not distinguish between, but include both, regular and occasional smokers.  
 3. Asked of all respondents.

The following chart outlines smoking prevalence in Buncombe County, segmented by various demographic characteristics. As shown, 24.0% of women and 24.5% of men currently smoke, either regularly or occasionally. By analysis, it can be seen that a 30.2% prevalence of cigarette smoking is noted among women in their child-bearing years (ages 18 to 44). This is notable, given that tobacco use increases the risk of infertility, as well as the risks for miscarriage, stillbirth and low birthweight for women who smoke during pregnancy.

In examining cigarette smoking by income levels and insurance coverage, a negative correlation is evident; smoking prevalence levels are highest among the groups of community residents with lower income classification and those who are not insured. In the separate survey administered among Latino adults, just 7.0% reported being current smokers.

## Current Smokers



Sources: 1. 2000 PRC Community Health Survey, Professional Research Consultants

2. 2000 Buncombe County Latino Health Survey

Notes: 1. Demographic breakouts are among findings in Buncombe County in 2000.

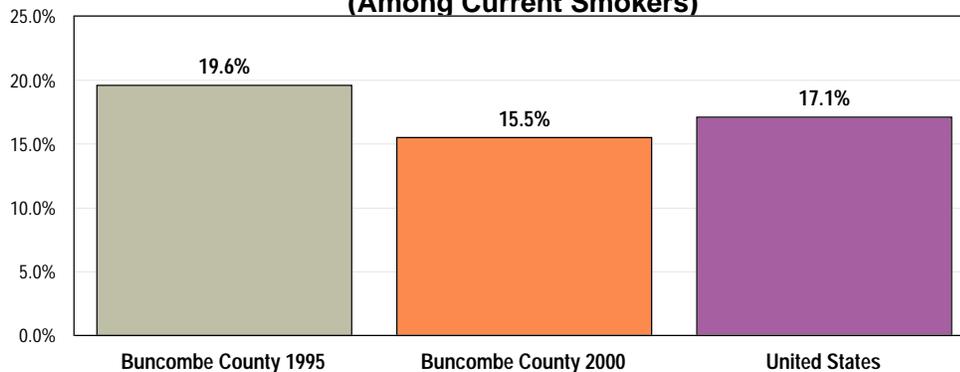
2. Asked of all respondents.

3. Latino survey data was derived from an independent written survey administered one-on-one by various Buncombe County organization representatives among a convenience sample. In interpreting and comparing results, it is important to note that the Latino survey, unlike the countywide telephone survey, was not administered among a random sample of community members. For this reason, the data from these Latino surveys are not incorporated into the overall county percentage, nor in other demographic breakout percentages.

## Number of Cigarettes Smoked per Day

Among current smokers in Buncombe County (those who smoke everyday or on some days), 15.5% report smoking more than one pack (20 cigarettes) a day on the days that they smoked, compared to 19.6% in 1995 and 17.1% across the country. The average regular (everyday) smoker smokes 17 cigarettes per day (nearly one pack). The average occasional (some days) smoker smokes 6 cigarettes per day on the days that they smoke.

## Smoke More Than 1 Pack of Cigarettes Per Day (Among Current Smokers)



Sources: 1. 1995 & 2000 PRC Community Health Surveys, Professional Research Consultants

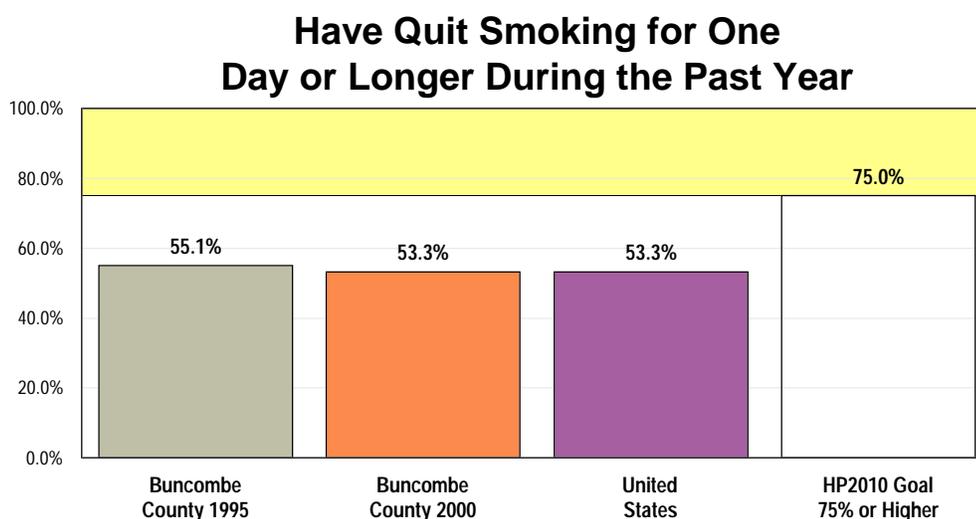
2. 2000 PRC National Health Survey, Professional Research Consultants

Notes: 1. Asked of current (everyday and occasional) smokers.

2. One pack of cigarettes is equal to 20 cigarettes.

## Smoking Cessation Attempts

A majority of regular smokers in Buncombe County (53.3%) have actually quit smoking for one day or more during the past year. This is identical to the 53.3% recorded nationwide and similar to the 55.1% reported in 1995. Note that these levels fall short of the *Healthy People 2010* goal; the *Healthy People 2010* goal for cessation attempts is to have 75% of smokers quit smoking for at least one day during the year.



Sources: 1. 1995 & 2000 PRC Community Health Surveys, Professional Research Consultants  
2. 2000 PRC National Health Survey, Professional Research Consultants  
3. Healthy People 2010, National Center for Health Statistics/CDC/Public Health Service

Notes: 1. Asked of regular (everyday) smokers.  
2. North Carolina data not available.

## Perceptions Data\*

Community Members recognized that smoking is a major issue in Buncombe County.

“It’s a big problem for our state because so many families get their income from tobacco.”

“North Carolina has an investment in tobacco.”

“It’s a health risk. People who smoke get lung cancer.”

“Yesterday I went to pick up [an item] at a health care facility, and standing outside of the health care facility was a gentleman smoking who had a portable oxygen tank and oxygen supply. My God, what does it take...[for people to understand tobacco’s dangers].”

“We could do more to get information out to people about the importance of not smoking or chewing tobacco.”

\* The Perceptions Data are valuable in identifying issues and providing context to the findings of this assessment. Keep in mind, however, that these qualitative comments are attributable only to those citizens and Key Informants participating in this effort and are not necessarily representative of the study sponsors nor the community at large.

Specific concerns about tobacco use were cited with regard to youth, Latino and other immigrant populations.

“There are lots of smokers, and at an early age, too. People tell me they’ve been smoking since they were eight or ten years old out here [rural county location]. They started with ‘rabbit tobacco’ and have gone on to real tobacco.”

“More teenagers are smoking...Mission St. Joseph’s is making an effort to reach people about the dangers of smoking.”

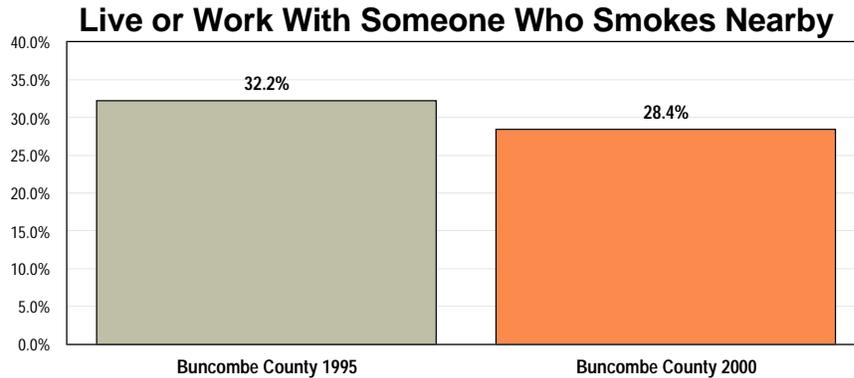
“Kids experiment with it too young. I’ve just been smoke free for three months [at age 52]. I think it’s one of the most addictive drugs.”

“I would say that, for the overall community here, smoking is a big problem. People don’t see how it really affects them or will affect them in the future. It’s not a good thing to do...it’s like polluting our bodies. Overall, the community would be better off without cigarette smoking, and the same is true for the Hispanic community.”

“Many immigrants come from countries where tobacco use is high and I think we will see more health problems relating to tobacco use, emphysema, and asthma.” [She faults cigarette companies for marketing to third-world countries so aggressively as the domestic market is perceived to decline.]

## Exposure to Second-Hand Smoke

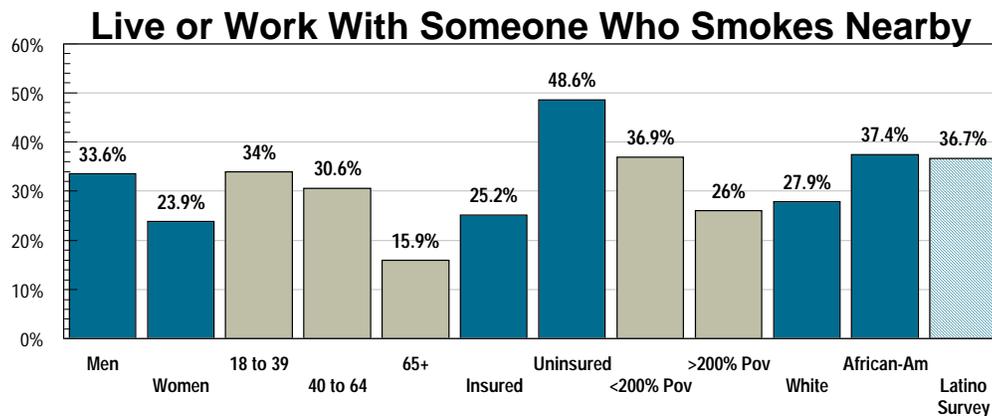
Currently, 28.4% of adults in Buncombe County indicate that they live or work with someone who smokes near them, statistically similar to the 32.2% recorded in 1995. Among non-smokers, this percentage decreases to 19.7% this year.



Source: 1995 & 2000 PRC Community Health Surveys, Professional Research Consultants

- Notes:
1. Asked of all respondents.
  2. North Carolina and national data not available.

Viewed demographically, adults most likely to report that they live or work with someone who smokes nearby include those without insurance, African-Americans, men, young adults, and people in the lower income bracket. Also, according to the separate Latino survey, 36.7% of Latinos live or work with someone who smokes near them.



Sources: 1. 2000 PRC Community Health Survey, Professional Research Consultants

2. 2000 Buncombe County Latino Health Survey

Notes: 1. Demographic breakouts are among findings in Buncombe County in 2000.

2. Asked of all respondents.

3. Latino survey data was derived from an independent written survey administered one-on-one by various Buncombe County organization representatives among a convenience sample. In interpreting and comparing results, it is important to note that the Latino survey, unlike the countywide telephone survey, was not administered among a random sample of community members. For this reason, the data from these Latino surveys are not incorporated into the overall county percentage, nor in other demographic breakout percentages.

## Perceptions Data\*

Community Members also commented on the dangers of second-hand smoke.

“Second-hand smoke is just as dangerous as smoking a cigarette.”

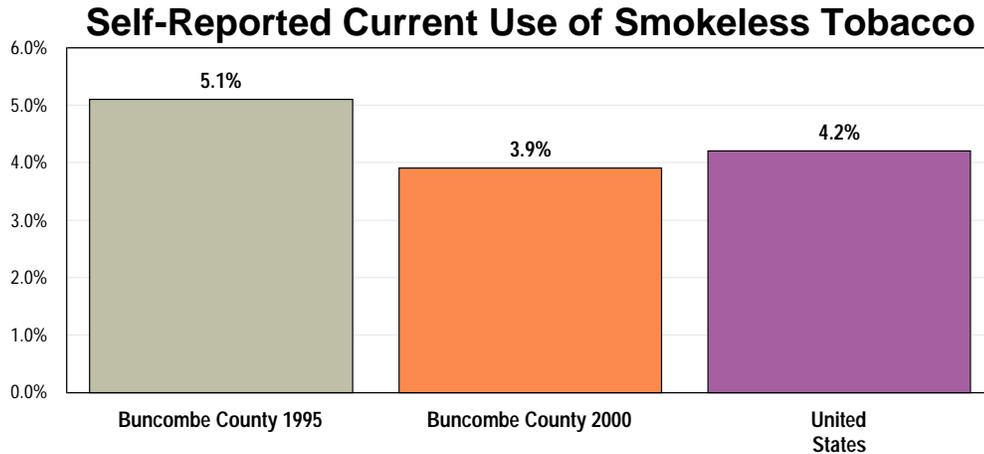
“If I go out where someone is smoking my eyes start watering and I have to use my inhaler [second-hand smoke triggers her asthma]...second hand smoke pollutes the atmosphere.”

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*\* The Perceptions Data are valuable in identifying issues and providing context to the findings of this assessment. Keep in mind, however, that these qualitative comments are attributable only to those citizens and Key Informants participating in this effort and are not necessarily representative of the study sponsors nor the community at large.*

## Smokeless Tobacco

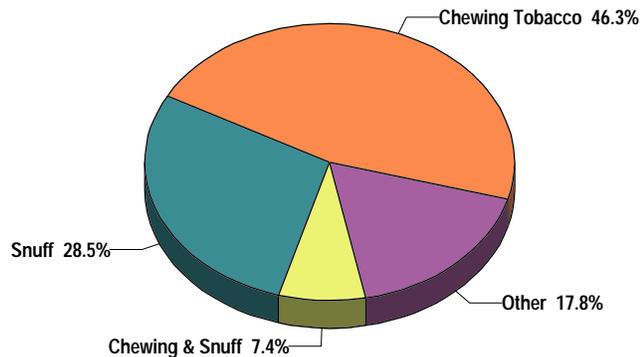
A total of 3.9% of adults in Buncombe County currently use smokeless tobacco products such as chewing tobacco or snuff. This is similar to the percentage of Americans currently using smokeless tobacco as well as the 5.1% prevalence noted countywide in 1995.



Sources: 1. 1995 & 2000 PRC Community Health Surveys, Professional Research Consultants  
 2. 2000 PRC National Health Survey, Professional Research Consultants  
 Notes: 1. Asked of all respondents.  
 2. North Carolina data not available.

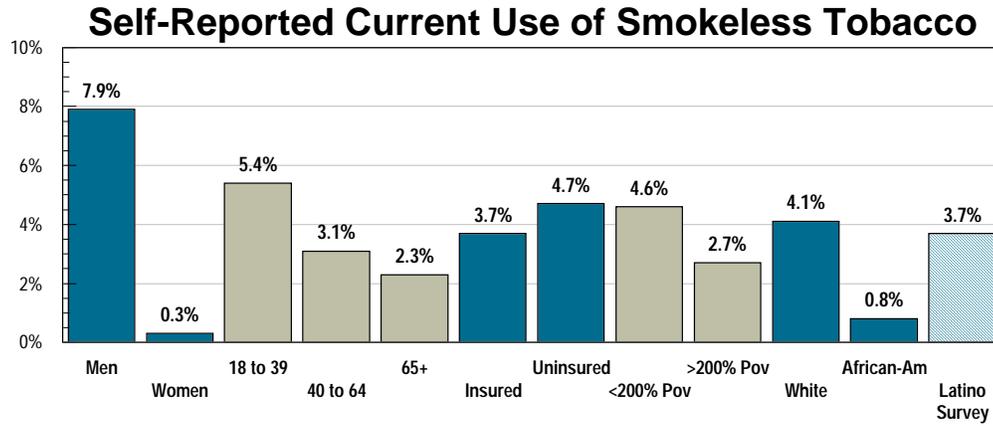
Users of smokeless tobacco were asked to indicate which type of smokeless tobacco products they currently use. As shown below, the largest share of responses (46.3%) was for chewing tobacco, while 28.5% use snuff and 7.4% use both snuff and chewing tobacco.

### Smokeless Tobacco Products Used (Self-Reported)



Source: 2000 PRC Community Health Survey, Professional Research Consultants  
 Note: Asked of those respondents who currently use smokeless tobacco products.

Viewed demographically, men, Whites, adults living in poverty and those under 40 are most likely to report using smokeless tobacco.



Sources: 1. 2000 PRC Community Health Survey, Professional Research Consultants

2. 2000 Buncombe County Latino Health Survey

Notes: 1. Demographic breakouts are among findings in Buncombe County in 2000.

2. Asked of all respondents.

3. Latino survey data was derived from an independent written survey administered one-on-one by various Buncombe County organization representatives among a convenience sample. In interpreting and comparing results, it is important to note that the Latino survey, unlike the countywide telephone survey, was not administered among a random sample of community members. For this reason, the data from these Latino surveys are not incorporated into the overall county percentage, nor in other demographic breakout percentages.

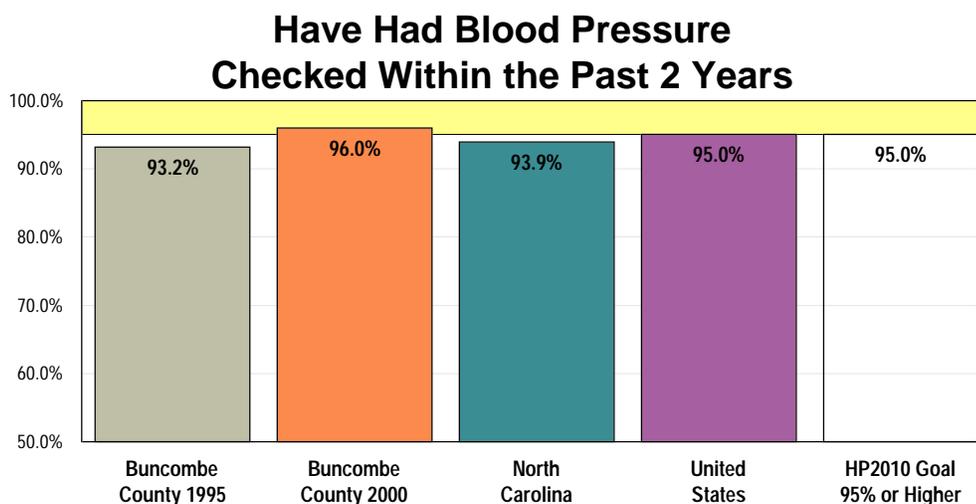
# Hypertension

Hypertension, or high blood pressure, is a condition wherein one’s systolic blood pressure is equal to or greater than 140 mm Hg and/or his or her diastolic blood pressure is equal to or greater than 90 mm Hg. Hypertension prevalence increases with age, and women and African-Americans are generally at higher risk.

The implications of hypertension are great, placing an individual at increased risk for a variety of health problems, including coronary heart disease, stroke, congestive heart failure, kidney failure, and peripheral vascular disease. However, high blood pressure can often be controlled through medication and/or behavior modification. The health risks associated with high blood pressure can be greatly reduced through weight reduction, increased physical activity, reduced sodium intake, and reduced alcohol consumption. It is also recommended that hypertensive patients eliminate tobacco use and reduce intake of saturated fat and cholesterol since these compound the risk for coronary heart disease and stroke.

## Blood Pressure Testing

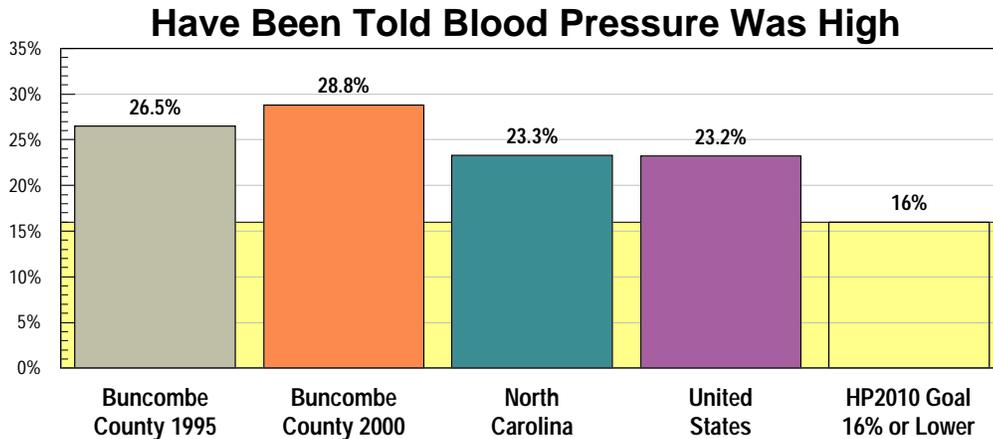
A total of 96.0% of adults in Buncombe County have had their blood pressure tested within the past two years, marking a *statistically significant increase* over the 93.2% reported in 1995. This percentage is comparable to that recorded nationwide, and satisfies the *Healthy People 2010* goal of 95% or higher.



Sources: 1. 1995 & 2000 PRC Community Health Surveys, Professional Research Consultants  
 2. Behavioral Risk Factor Surveillance System, Centers for Disease Control, 1997 North Carolina Data  
 3. 2000 PRC National Health Survey, Professional Research Consultants  
 4. Healthy People 2010, National Center for Health Statistics/CDC/Public Health Service  
 Note: Reflects the total sample of respondents.

## High Blood Pressure Prevalence

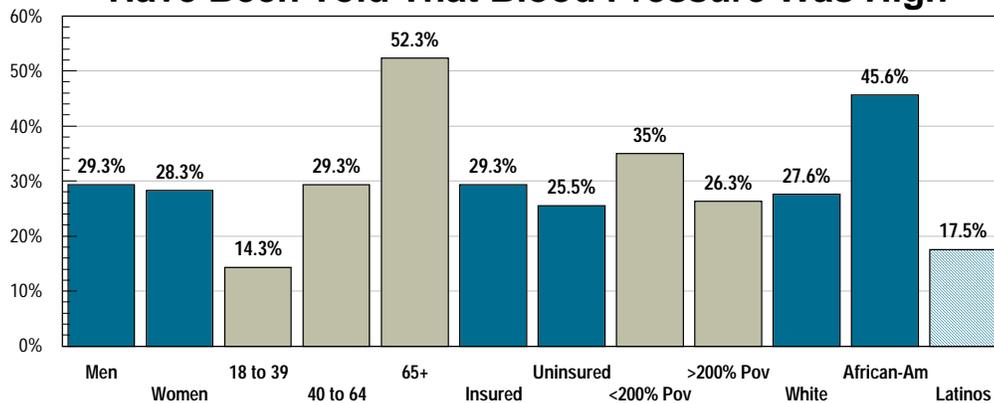
The prevalence of adults in Buncombe County who have been told they have high blood pressure (28.8%) is less favorable than the 23.2% recorded nationwide. Note also that this year's prevalence does not satisfy the *Healthy People 2010* goal to decrease to 16% or fewer the number of hypertensive adults nationwide.



Sources: 1. 1995 & 2000 PRC Community Health Surveys, Professional Research Consultants  
 2. Behavioral Risk Factor Surveillance System, Centers for Disease Control, 1997 North Carolina Data  
 3. 2000 PRC National Health Survey, Professional Research Consultants  
 4. Healthy People 2010, National Center for Health Statistics/CDC/Public Health Service  
 Note: Reflects the total sample of respondents.

Also, in looking at age cohorts, hypertension rates vary from 14.3% among adults under 40 to 52.3% among those 65 and older. African-Americans experience a higher prevalence than Whites (45.6% vs. 27.6%), and those in the lower income bracket note a higher prevalence than those living at twice or more the poverty level (35.0% vs. 26.3%).

## Have Been Told That Blood Pressure Was High



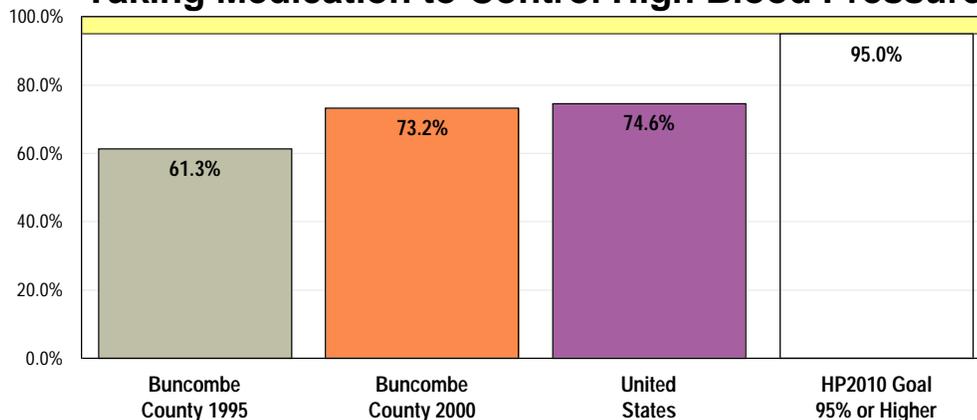
Sources: 1. 2000 PRC Community Health Survey, Professional Research Consultants  
2. 2000 Buncombe County Latino Health Survey

Notes: 1. Demographic breakouts are among findings in Buncombe County in 2000.  
2. Asked of all respondents.  
3. Latino survey data was derived from an independent written survey administered one-on-one by various Buncombe County organization representatives among a convenience sample. In interpreting and comparing results, it is important to note that the Latino survey, unlike the countywide telephone survey, was not administered among a random sample of community members. For this reason, the data from these Latino surveys are not incorporated into the overall county percentage, nor in other demographic breakout percentages.

## Controlling High Blood Pressure

Medication is one means of controlling high blood pressure; other means involve behavior modification such as dietary control and regular exercise. In Buncombe County, among those who have been told that their blood pressure was high, the majority (73.2%) are currently taking **medication** to control it. This marks a *statistically significant increase* in hypertension medication use since 1995 (61.3%).

## Taking Medication to Control High Blood Pressure



Sources: 1. 1995 & 2000 PRC Community Health Surveys, Professional Research Consultants  
2. 2000 PRC National Health Survey, Professional Research Consultants  
3. *Healthy People 2010* National Center for Health Statistics/CDC/Public Health Service

Notes: 1. Asked of respondents with high blood pressure.  
2. North Carolina data not available.  
3. The U.S. survey questioned hypertensive adults' use of medication, exercise, and/or any other means of controlling high blood pressure.  
4. Likewise, the *Healthy People 2010* goal seeks to have 95% of hypertensive people take some action to reduce their hypertension (such as losing weight, increasing physical activity, or reducing sodium intake).

Note that the 74.6% reported nationwide represents adults who use medication, exercise, and/or any other means of controlling high blood pressure. The *Healthy People 2010* goal also involves more than medication: it seeks to increase to 95% or higher the number of adults who are taking action to reduce their hypertension (such as losing weight, increasing physical activity, or reducing sodium intake).

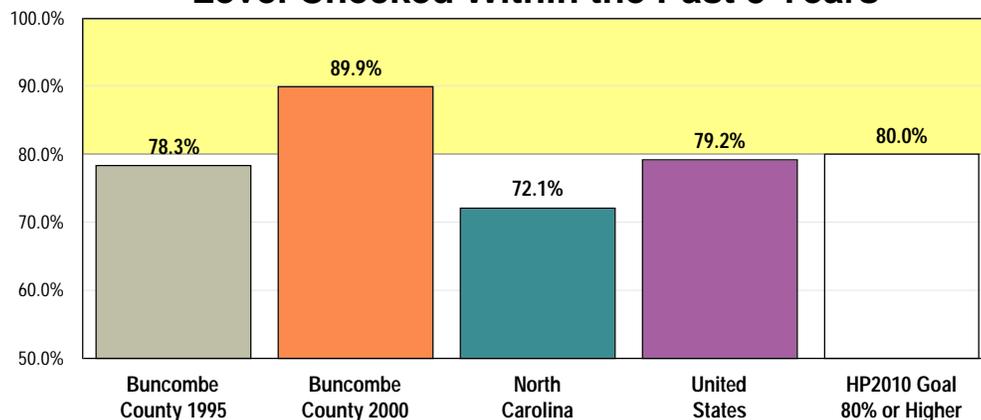
# Cholesterol

High blood cholesterol is one of the major risk factors for coronary heart disease (along with cigarette smoking, high blood pressure and physical inactivity). High cholesterol is defined as having a serum total cholesterol level of 240 mg/dL or greater.

## Blood Cholesterol Testing

A full 89.9% of adults in Buncombe County have had a blood cholesterol screening within the past 5 years, higher than Americans overall and marking a *statistically significant increase* in cholesterol screenings since 1995 (78.3%). Note that testing in Buncombe County this year satisfies the goal for the Year 2010 (80% or higher).

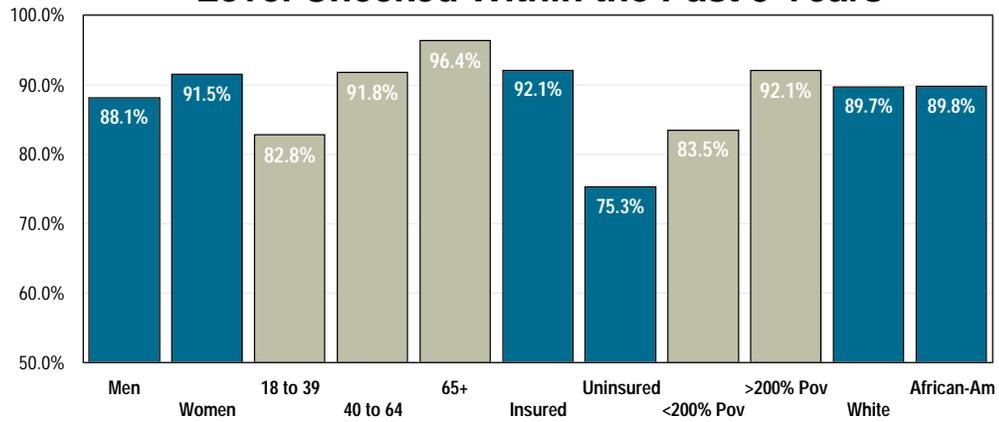
### Have Had Blood Cholesterol Level Checked Within the Past 5 Years



Sources: 1. 1995 & 2000 PRC Community Health Surveys, Professional Research Consultants  
2. Behavioral Risk Factor Surveillance System, Centers for Disease Control, 1997 North Carolina Data  
3. 2000 PRC National Health Survey, Professional Research Consultants  
4. Healthy People 2010, National Center for Health Statistics/CDC/Public Health Service  
Note: Reflects the total sample of respondents.

Further note in the demographic breakout illustrated in the adjacent graph that age, income level, and insurance status are key variants in blood cholesterol testing.

## Have Had Blood Cholesterol Level Checked Within the Past 5 Years

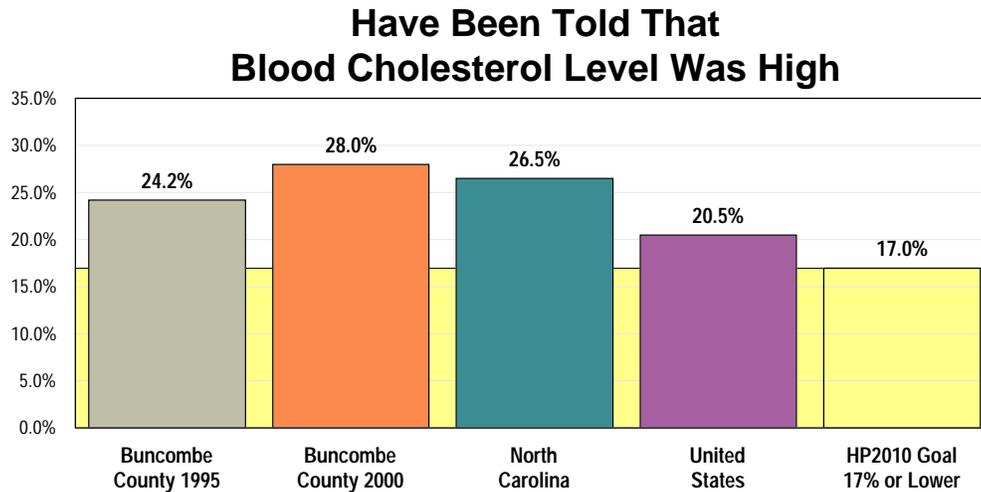


Sources: 1. 2000 PRC Community Health Survey, Professional Research Consultants  
 2. 2000 Buncombe County Latino Health Survey

Notes: 1. Demographic breakouts are among findings in Buncombe County in 2000.  
 2. Asked of all respondents.  
 3. This inquiry was not asked in the separate Latino survey.

## High Blood Cholesterol Prevalence

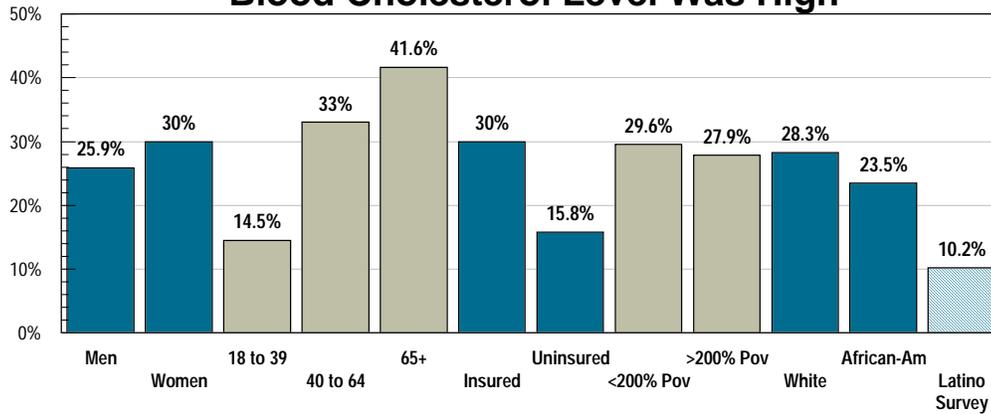
A total of 28.0% of adults in Buncombe County have been told by a health professional that their cholesterol level was high; this level is less favorable than the 20.5% recorded nationwide but statistically similar to the 24.2% reported in 1995.



Sources: 1. 1995 & 2000 PRC Community Health Surveys, Professional Research Consultants  
2. Behavioral Risk Factor Surveillance System, Centers for Disease Control, 1997 North Carolina Data  
3. 2000 PRC National Health Survey, Professional Research Consultants  
4. Healthy People 2010, National Center for Health Statistics/CDC/Public Health Service  
Note: Reflects the total sample of respondents.

Also note in the following chart that high blood cholesterol prevalence exhibits a positive correlation with age, varying from 14.5% among adults under 40 to 41.6% among those 65 and older. While insured adults are twice as likely as uninsured residents to note high cholesterol levels, it is important to keep in mind that insured adults were also more likely than adults without coverage to have been screened in the past five years

## Have Been Told That Blood Cholesterol Level Was High

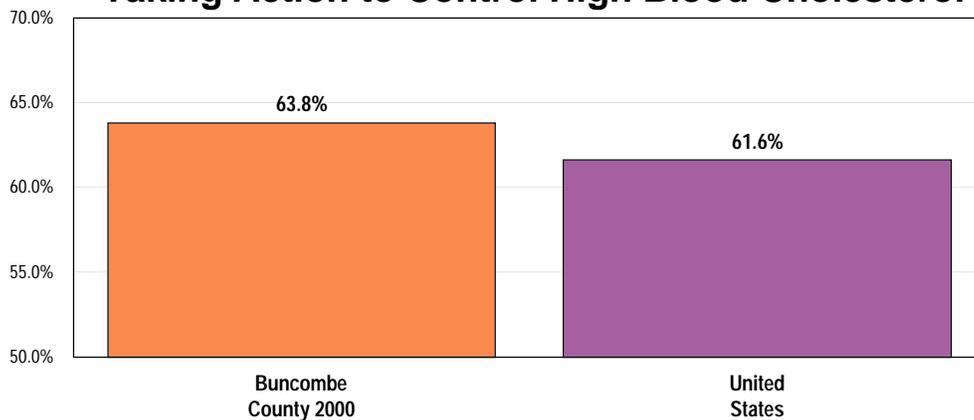


- Sources: 1. 2000 PRC Community Health Survey, Professional Research Consultants  
 2. 2000 Buncombe County Latino Health Survey
- Notes: 1. Demographic breakouts are among findings in Buncombe County in 2000.  
 2. Asked of all respondents.  
 3. Latino survey data was derived from an independent written survey administered one-on-one by various Buncombe County organization representatives among a convenience sample. In interpreting and comparing results, it is important to note that the Latino survey, unlike the countywide telephone survey, was not administered among a random sample of community members. For this reason, the data from these Latino surveys are not incorporated into the overall county percentage, nor in other demographic breakout percentages.

## Controlling High Blood Cholesterol

The following graph illustrates the percentage of those people with high blood cholesterol levels who are taking action to control those levels. In all, 63.8% of adults in Buncombe County with high blood cholesterol levels are taking some type of action to control their condition. This is comparable to the nationwide figure.

## Taking Action to Control High Blood Cholesterol



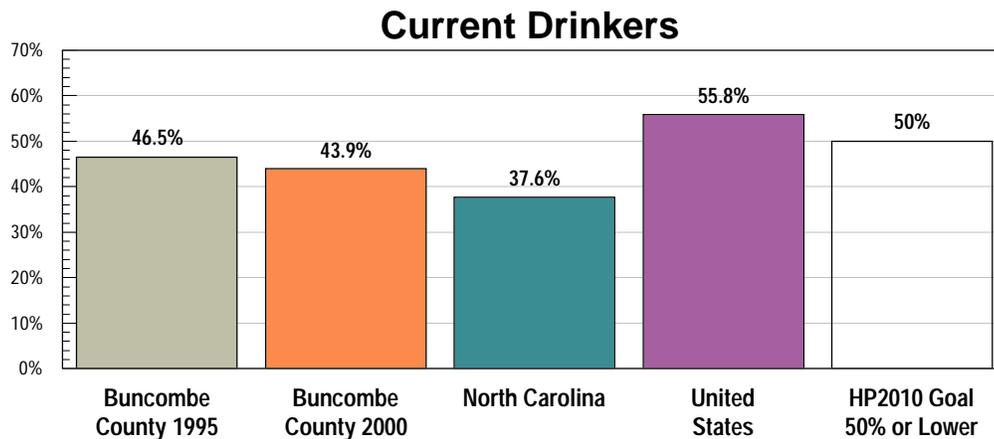
- Sources: 1. 2000 PRC Community Health Survey, Professional Research Consultants  
 2. 2000 PRC National Health Survey, Professional Research Consultants
- Notes: 1. Asked of respondents with high blood cholesterol.  
 2. North Carolina data not available.  
 3. This question was not asked in the 1995 survey.

# Alcohol Consumption

Alcohol abuse has also been linked to heart disease and stroke, and is the primary contributor to cirrhosis of the liver. The alcohol-related behaviors that place one at risk include: chronic drinking, binge drinking, and drinking and driving. Local drinking levels are addressed in the following section of this report.

## Current Drinkers

“Current” drinkers are those who have had one or more drinks within the past month (for the purpose of this study, a “drink” is defined as one can or bottle of beer, one glass of wine, one can or bottle of wine cooler, one cocktail or one shot of liquor). A total of 43.9% of adults in Buncombe County fall into this category, more favorable than the nationwide level and satisfying the *Healthy People 2010* goal of 50% or lower. In 1995, a similar 46.5% of adults were current drinkers.

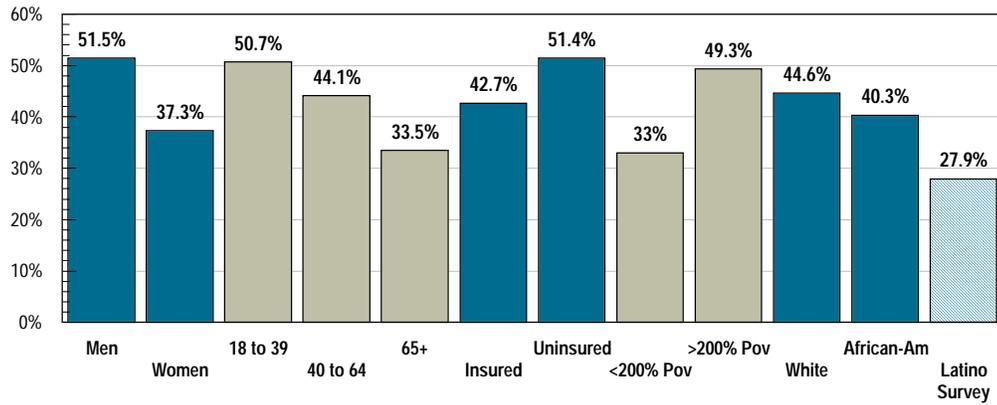


- Sources:
1. 1995 & 2000 PRC Community Health Surveys, Professional Research Consultants
  2. Behavioral Risk Factor Surveillance System, North Carolina Survey Data, 1997
  3. 2000 PRC National Health Survey, Professional Research Consultants
  4. Healthy People 2010, National Center for Health Statistics/CDC/Public Health Service

- Notes:
1. Current drinkers are defined as those who have had any alcoholic beverages during the past month.
  2. Reflects the total sample of respondents.

Note in the following table that men are much more likely than women to drink. Furthermore, there appears to be a strong positive correlation between drinking and income, but a negative correlation between drinking and age. Adults with health care insurance coverage appear to be less likely to drink than uninsured adults.

## Current Drinkers



Sources: 1. 2000 PRC Community Health Survey, Professional Research Consultants

2. 2000 Buncombe County Latino Health Survey

Notes: 1. Demographic breakouts are among findings in Buncombe County in 2000.

2. Asked of all respondents.

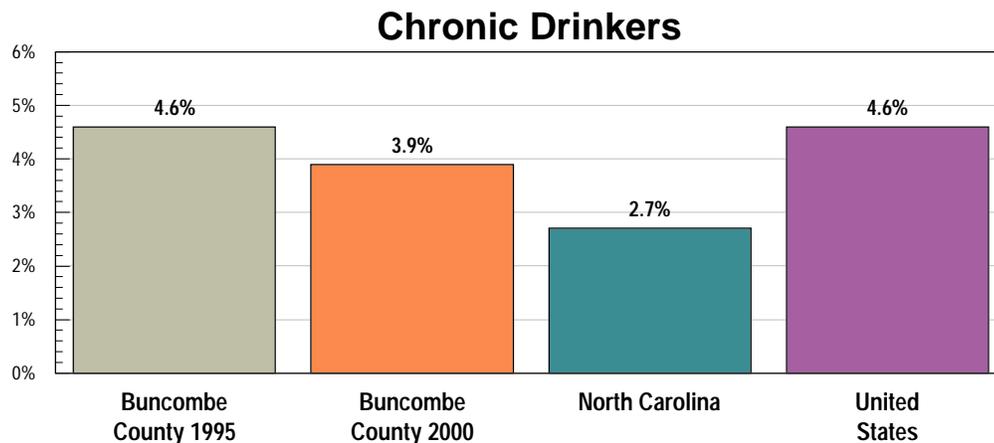
3. Latino survey data was derived from an independent written survey administered one-on-one by various Buncombe County organization representatives among a convenience sample. In interpreting and comparing results, it is important to note that the Latino survey, unlike the countywide telephone survey, was not administered among a random sample of community members. For this reason, the data from these Latino surveys are not incorporated into the overall county percentage, nor in other demographic breakout percentages.

4. Current drinkers are defined as those who have had any alcoholic beverages during the past month.

## Alcohol Abuse

### Chronic Drinkers

“Chronic” drinkers are those who average two or more drinks per day (60 drinks within the past month). A total of 3.9% (translating to more than 5,800 adults) in Buncombe County fall into this category. This is comparable to the 4.6% level of chronic drinking nationwide as well as the 4.6% reported countywide in 1995. Across North Carolina, just 2.7% of residents are considered to be chronic drinkers.

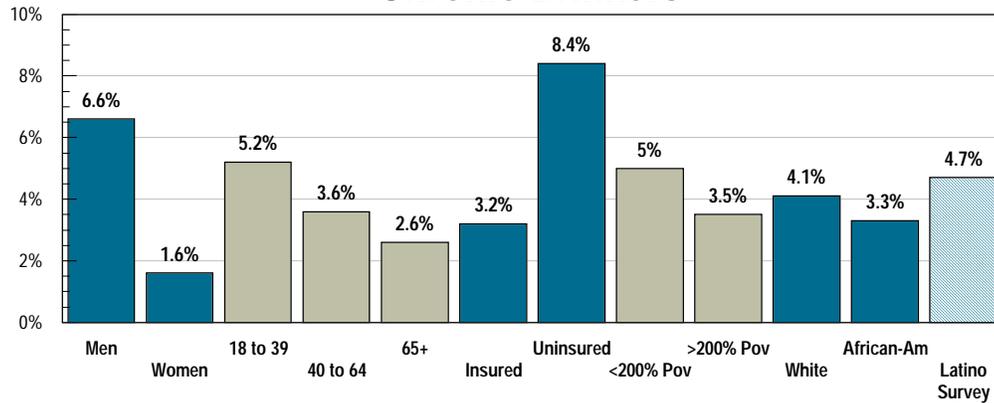


Sources: 1. 1995 & 2000 PRC Community Health Surveys, Professional Research Consultants  
2. Behavioral Risk Factor Surveillance System, Centers for Disease Control, 1993 North Carolina Data  
3. 2000 PRC National Health Survey, Professional Research Consultants

Notes: 1. Chronic drinkers are defined as those who have had at least 60 drinks of alcoholic beverages during the past month.  
2. Reflects the total sample of respondents.

Note in the following table that chronic drinking increases dramatically among men and uninsured adults.

## Chronic Drinkers



Sources: 1. 2000 PRC Community Health Survey, Professional Research Consultants

2. 2000 Buncombe County Latino Health Survey

Notes: 1. Demographic breakouts are among findings in Buncombe County in 2000.

2. Asked of all respondents.

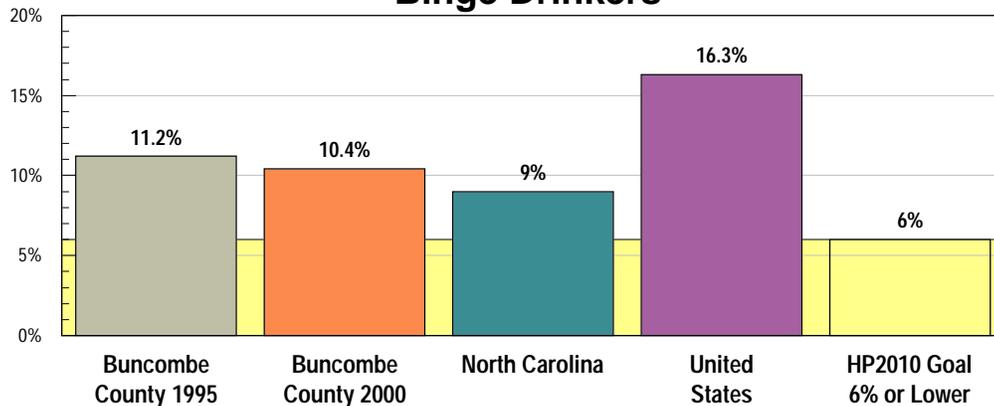
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4. Chronic drinkers are defined as those who have had at least 60 drinks of alcoholic beverages during the past month.

## Binge Drinkers

“Binge” drinking involves the consumption of five or more alcoholic beverages on any one occasion. A total of 10.4% of adults in Buncombe County report that they have “binged” at least once during the past month (translating to approximately 15,600 adults), more favorable than the nationwide prevalence of 16.3% but failing to satisfy the Year 2010 goal of 6% or lower.

## Binge Drinkers



Sources: 1. 1995 & 2000 PRC Community Health Surveys, Professional Research Consultants

2. Behavioral Risk Factor Surveillance System, Centers for Disease Control, 1997 North Carolina Data

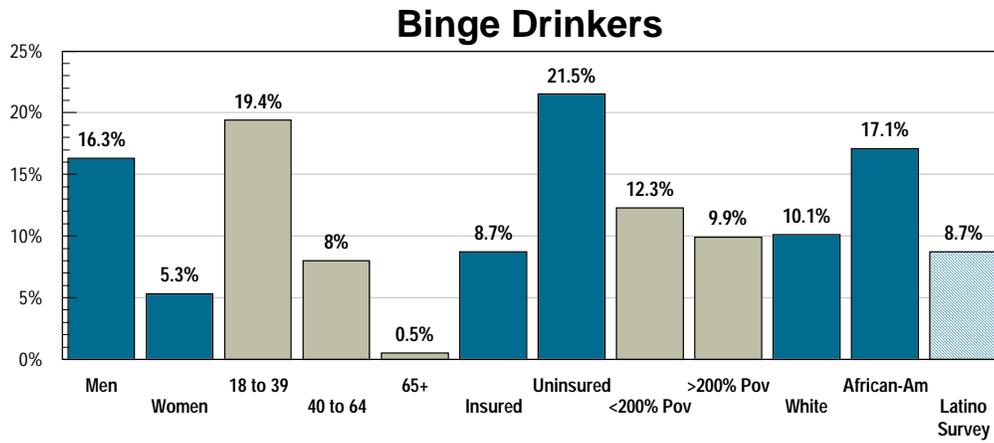
3. 2000 PRC National Health Survey, Professional Research Consultants

4. Healthy People 2010, National Center for Health Statistics/CDC/Public Health Service

Notes: 1. Binge drinkers are those who have had 5 or more alcoholic drinks on any one occasion at least once during the past month.

2. Reflects the total sample of respondents.

Binge drinking in Buncombe County includes 16.3% of men, 19.4% of persons aged 18 to 39, 17.1% of African-Americans, and 21.5% of uninsured adults. In contrast, “bingeing” is particularly low among women and persons aged 65 and older.



Sources: 1. 2000 PRC Community Health Survey, Professional Research Consultants

2. 2000 Buncombe County Latino Health Survey

Notes: 1. Demographic breakouts are among findings in Buncombe County in 2000.

2. Asked of all respondents.

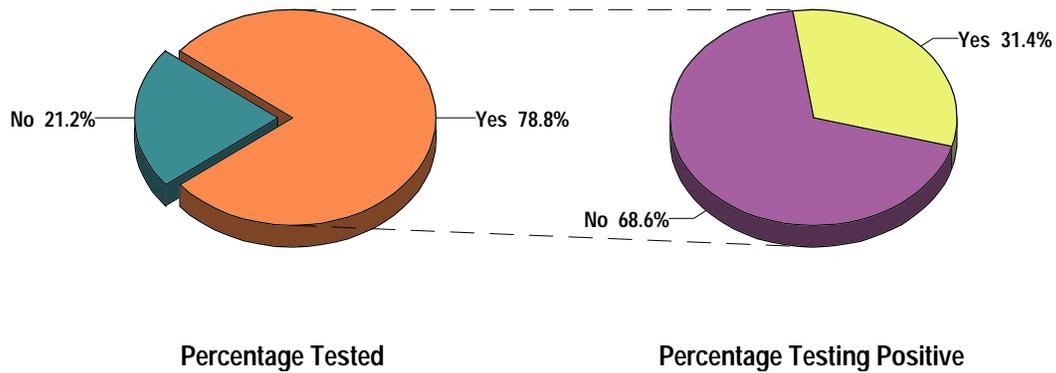
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4. Binge drinkers are those who have had 5 or more alcoholic drinks on any one occasion at least once during the past month.

## Presence of Alcohol in Injury-Related Deaths

Among all injury-related deaths occurring between 1996 and 1998, over three-fourths of decedents were tested for the presence of alcohol. Among those tested, nearly one-third were positive.

### Injury-Related Deaths in Which Decedent Tested Positive for Alcohol, 1996-98



Source: State Center for Health Statistics (SCHS), NC Department of Health and Human Services.

# Violence & Crime

## Index Crime Rates

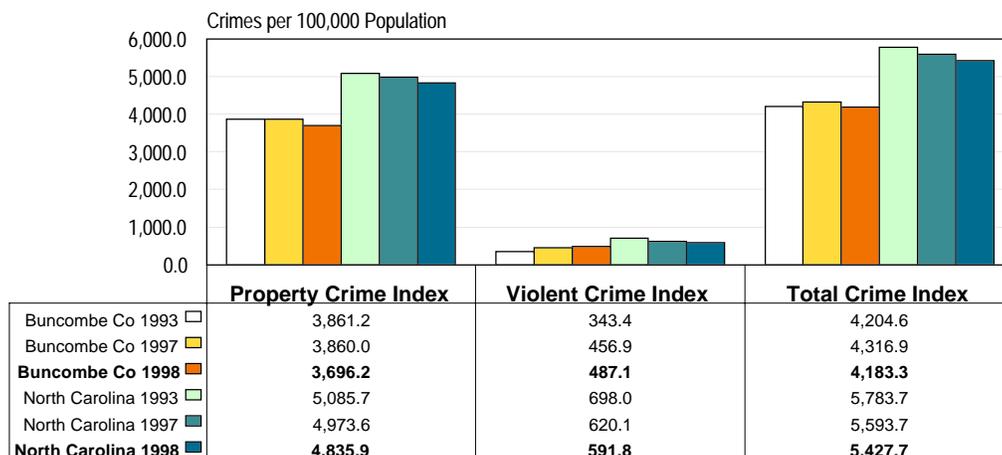
The following chart outlines property and violent crime index rates for Buncombe County and North Carolina in 1993, 1997 and 1998.

***“I don’t think you can relegate violence to any one segment of the community. Violence doesn’t know any socioeconomic group of people.”***

Regarding *violent crimes* (murder, rape, robbery and aggravated assault/battery), Buncombe County experiences a lower rate than North Carolina (487.1 violent crimes per 100,000 population in 1998, versus 591.8 statewide). This Buncombe County rate is slightly higher than reported in 1997 (456.9), and notably higher than reported in 1993 (343.4).

For *non-violent property crimes* (burglary, larceny and motor vehicle theft), Buncombe County had 3,696.2 crimes per 100,000 population in 1998, again lower than the state rate (4,835.9). The property crime index dropped slightly in Buncombe County from 1997 to 1998.

### Crime Index Rates



Source: State Center for Health Statistics (SCHS), NC Department of Health and Human Services. State Bureau of Investigation.  
 Note: Index Crime includes the total number of violent crimes (murder, rape, robbery and aggravated assault) and property crimes (burglary, larceny and motor vehicle theft).

## Perceptions Data\*

The number-one health concern mentioned by the majority of the informants in the Key Informant Interviews was **drug- related crime and violence**. **Drug and substance abuse** as the second major health risk in the community at large followed this issue very closely. Many times the issues overlapped. The majority of all violent crimes are related to substance use or abuse.

### **Violence**

Violence was perceived to be the physical manifestation of underlying feelings of hopelessness or frustration. Several existing conditions were thought to contribute to violence in the county.

“There are a lot of persons in this community, black and white, who are endeavoring to be productive, hard-working citizens...but they are being squeezed by the economic entity of the community. Even though they may be working full time jobs, it is what we call a welfare job. Keep them poor; keep them working hard, demanding more of them. The downside of all of this is that you see a lot of violence in the workplace now and you’ve seen some examples locally and nationally. People are stressed out – the employer is demanding more for less pay, and they are stressed out. When you couple that with children crying at home, basic necessities not being met, the lack of nutritional food and bills to contend with, you create a walking time bomb. I don’t think we’re being as intentional as we ought to be in being sensitive to that.”

**Geography of violence.** Some community members perceived their neighborhoods to be unsafe, while others perceived violence to be in decline in housing project areas.

“I don’t feel safe if I wanted to take a stroll around my neighborhood.”

“I wouldn’t walk around downtown after dark by myself.”

“I wouldn’t go downtown at night alone because there have been so many carjackings and robberies downtown. Otherwise, I feel pretty safe.”

“We used to hang out on The Block sometimes, and would be sitting there and gunshots be fired around us.”

“Most of the violence I see is robbery. Immigrants who don’t speak English are often wary of trusting banking institutions and they are at risk for being robbed.”

“We have some crime, but I don’t think it’s bad. The city does a good job of handling crime. In my neighborhood, we look out for one another.”

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\* *The Perceptions Data are valuable in identifying issues and providing context to the findings of this assessment. Keep in mind, however, that these qualitative comments are attributable only to those citizens and Key Informants participating in this effort and are not necessarily representative of the study sponsors nor the community at large.*

[For senior citizens] “Violence is definitely an issue. And fear. Fear of violence even more than actual violence.”

“The elderly are afraid to come out of their houses at night because of corner drug sales.”

“You heard about a lot of violence (a few year ago) in some of the housing projects, but I don’t hear a whole lot about that now. Because I think the people in those settings, have decided that they are just not going to tolerate those things. In working in partnership with the agencies whose various sponsors are owners of that housing, there is a new level of awareness.”

Others felt *“There is a good deal of violence in African-American neighborhoods.”* Regarding the need for more outreach workers in violent neighborhoods one young Key Informant commented, *“Somebody’s going to have to really have some strong heart to walk in my neighborhood (to do outreach). I ain’t seen nobody yet.”*

### ***Other Types of Violent Activity***

Some Interviewees felt that “breaking and entering is common” in some neighborhoods. Domestic violence and child abuse were cited as problems with less frequency than drug-related crime and violence. The incidence of violence in area schools was seen as being more prevalent in city rather than county schools. However, the general feeling was that the schools in our community are safe.

“I think there is some domestic abuse. I know there have been some break-ins.”

“A lot of folks say they still don’t lock their doors, but others I go visit have three or four locks on the door.”

“Most of what I hear about is people having their homes burglarized...a lot of them are not living in decent housing areas.”

“The house fifty feet from my house was broken into not long ago.”

“We have a lot of break-ins, and there is increased drug activity. Also some ‘copy-cat’ violence among school kids.”

“In the news there’s always something and usually it’s breaking and entering, or stealing to get drugs. Lately there’s been a lot of crime against kids. Also date rape is a problem.”

### ***Law Enforcement***

Comments regarding the Asheville Police Department and the County Sheriff’s Department were generally good. There were comments calling for more compassion from law enforcement officers in dealing with crime and violence. One interviewee felt that media coverage of city crime was exaggerated over that of crime occurring out in the

county. Many people felt the DARE outreach program has been effective in trying to decrease drug use and violence problems.

“The APD is working to make our community safer and to keep drugs off our streets.”

“Satellite Police Stations are working.”

“...the Sheriff’s Department and the Police Department and the state law enforcement could do a better job of...helping us educate people about what their rights are and also what the laws are so that our people (Latinos) will be able to live within the law and protect themselves.”

“Our community patrol officers [downtown housing apartment for low-income seniors] are very good. They try to get to know residents and identify themselves and talk with people so that the officers become a part of the community. They don’t just sit somewhere and wait for problems to come to them.”

### ***Drug-Related Crime & Violence***

The number-one health concern mentioned by the majority of the informants in the Key Informant Interviews was **drug-related crime and violence**. **Drug and substance abuse** as the second major health risk in the community at large followed this issue very closely. Many times the issues overlapped. The majority of all violent crimes are related to substance use or abuse.

“I think a lot of people would be surprised to know that although crack is not as popular as it used to be, it’s still pretty popular and crack is the drug of choice unfortunately, for a number of older adults in housing. There is a fair amount of marijuana. And certainly the number-one abused drug is alcohol (among older adults).”

“I heard that some break-ins were just pranks, but that another group was doing it to get drug money.”

“Shelters are not appropriate for the sick or for those with substance abuse issues.”

“Certainly substance abuse is a problem (among teens). I think the kids are too sexually active and too caught up in using drugs. I think those are real scary situations, the substance abuse and the sexuality issues.”

“AIDS put a clamp on rampant sexuality. Now people are consumed with drugs and alcohol. Drug use used to be recreational; today people are medicating themselves.”

**Illegal Drug Use & Sales.** Illegal drug use and drug sales were most often cited as a major problem in our area. The African-American communities expressed the most concern especially regarding drug dealing in housing projects and among youth.

“It’s out of control now. I feel we are on the verge of losing an entire generation (to crime, drugs and alcohol).”

“Sometimes when I am driving through (a housing project) they (drug dealers) think maybe I’m coming to buy something so they run up to my car. When they find out who I am they become overly apologetic.”

“If you talk to kids, a lot of them, especially in the housing communities, will not even count marijuana as a drug really, it’s just something everybody does.”

**Economic Issues Underlying Drug Sales.** The allure of making quick money by selling drugs is tempting to disadvantaged youths who see no other way to achieve the material success that is touted in popular media.

“They (drugs) are a big, big problem because I’ve had fellows tell me that it would be stupid to go and work somewhere for five dollars an hour when I could make \$500 a night (selling drugs).”

“They want to make quick money without working; they don’t see any hope, anyway out of the project out at Pisgah View or Deaverview. When they were coming up they didn’t have any kind of role model; they didn’t have anybody to look up to. So they get trapped somehow into drug pushing, they’re seventeen years old. You know you’re going to see them again at Craggy, soon. It’s just a matter of time.”

“The goal should be to have a skill that will enable them to get a job that will generate the income. They need help identifying skill sets and they need exposure to courses, advance courses. They can succeed, but they need help.”

### **Geography of Drug Activity**

“You don’t find drugs just in public housing. You find drugs everywhere.”

The issue of drugs and crime surfaced as a major source of frustration and concern for African-Americans interviewed. Several interviewees felt that African-Americans get blamed for drugs, when the actual source of the drugs is outside the Black community. Historically black neighborhoods were perceived as being falsely labeled “drug areas” when substance abuse occurs in every segment of the county’s population.

“Even though the drugs are IN the Black community, they are not OF the Black community, BY the Blacks. I think there is a problem there. Blacks get accused of doing things there is no way we could do without the Whites. I think it’s real important not to always blame minorities.”

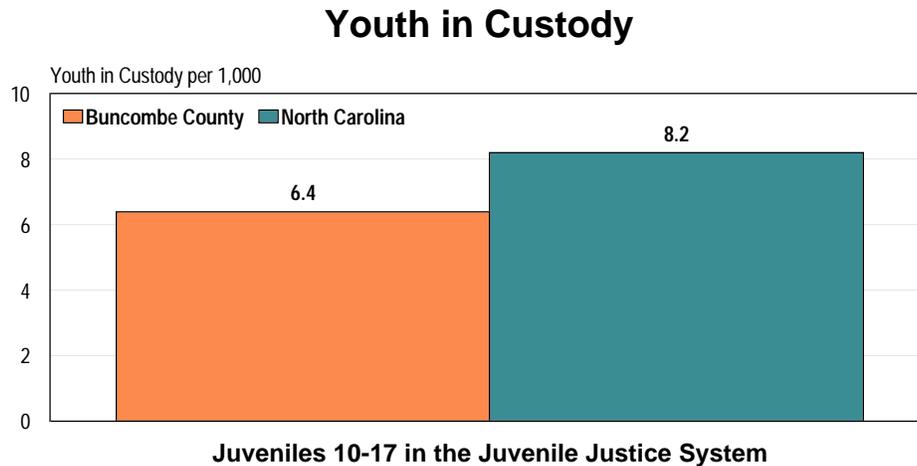
**Drug-Related Crime Sentences.** Several Key Informants expressed concern for young African-American males caught up in the criminal justice system. These young men were cited as targets for long serious crime sentences when someone much more powerful is behind the drug activity and reaping the major profit. The main suppliers of drugs to the street dealers (youths) are typically protected from arrest.

“What they do, once they have a (drug) raid, they don’t raid the man that’s doing the main thing and getting all the money. They raid over at these projects or that trailer park. Then they come out with about ten of them with handcuffs behind their backs, most of them Black, a few Whites sometimes and they are off to jail. The next thing you know they’re facing the judge and when they stand there, they’re facing 30 to 40 years. That’s not fair, it’s wrong, it’s terribly wrong and I don’t have any sympathy for them. Even being a Christian, I don’t have sympathy for them because they are hooking somebody’s child on this mess. But is the system fair? No!”

“Many of the people that I come in contact with are caught up with astronomical criminal charges that they don’t have money for. Which means that when it’s played out in the media, you would think that violence is more prevalent in the African-American community and that’s not necessarily true. Statistically, they are a minority. Other segments of the community have resources and are networked.”

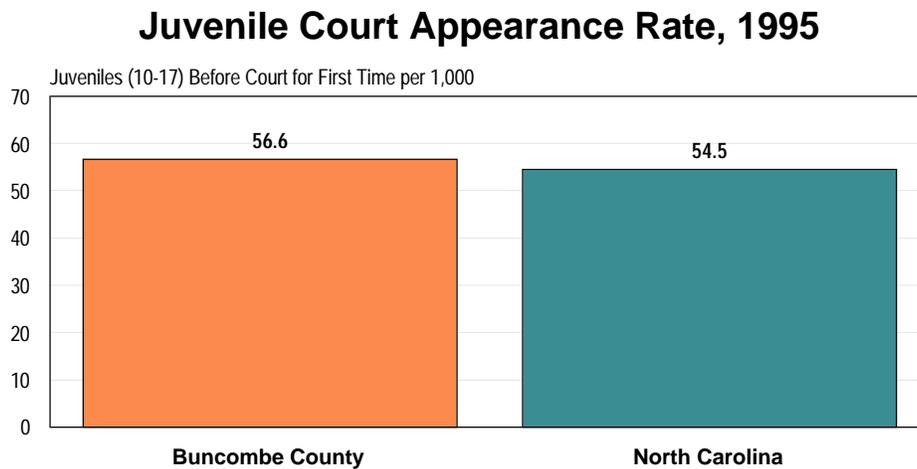
## Youth Crime

The youth custody rate for Buncombe County juveniles aged 10-17 in the juvenile justice system is 6.4 per 1,000 juveniles. This is below the state rate of 8.2, as shown in the following chart.



Source: State Center for Health Statistics (SCHS), NC Department of Health and Human Services (Child Advocacy Institute).

In 1995, 56.6 out of every 1,000 juveniles aged 10 to 17 in Buncombe County appeared before court for the first time. This is similar to the North Carolina juvenile court appearance rate.

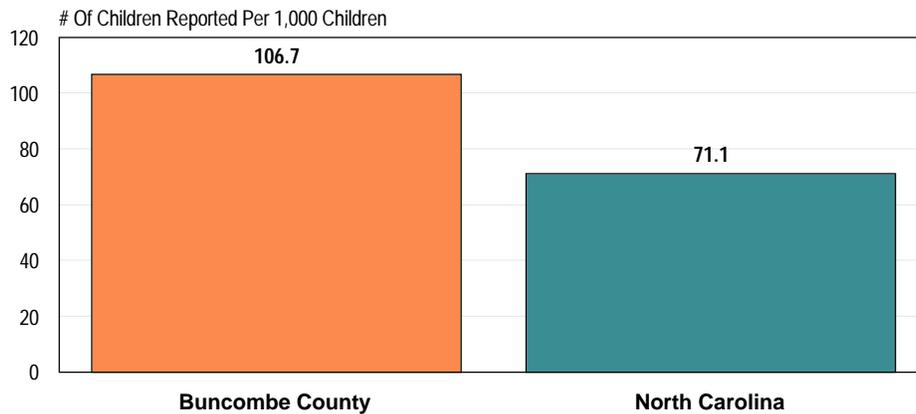


Source: State Center for Health Statistics (SCHS), NC Department of Health and Human Services (Log Into North Carolina [LINC]).

## Child Abuse & Neglect

In Buncombe County during fiscal year 1997-98, 106.7 out of every 1,000 children was reported as abused or neglected. This is dramatically higher than the North Carolina rate, as shown in the following chart.

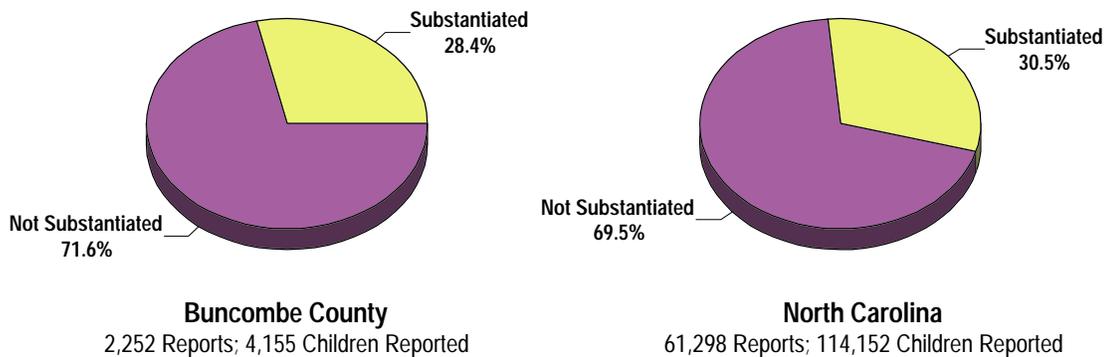
### Reports Of Child Abuse, Neglect, And Dependency, SFY 1997-1998



Source: State Center for Health Statistics (SCHS), NC Department of Health and Human Services (NC Division of Social Services).

Of the 4,255 children reported as abused or neglected (2,252 reports, some referencing multiple children), 28.4% of children were substantiated as abused or neglected. This is similar to the proportion substantiated throughout the state.

### Substantiation of Children Reported as Abused, SFY 1997-1998



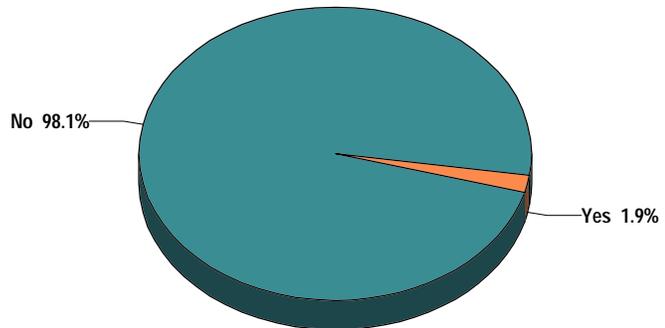
Source: State Center for Health Statistics (SCHS), NC Department of Health and Human Services (NC Division of Social Services).

## Domestic Violence

### Victimization

Buncombe County adults were asked whether a family member or someone close to them has hit, punched, kicked, or otherwise hurt them **in the past 12 months**. As shown in the adjacent chart, just 1.9% (or 2,850 local adults) reported that they had been the victim of this type of domestic violence in the past year. Also note that, according to the separate survey conducted among Latinos in Buncombe County, 7.9% of local Latinos have been victims of domestic violence in the past year.

#### Victim of Domestic Violence in the Past 12 Months

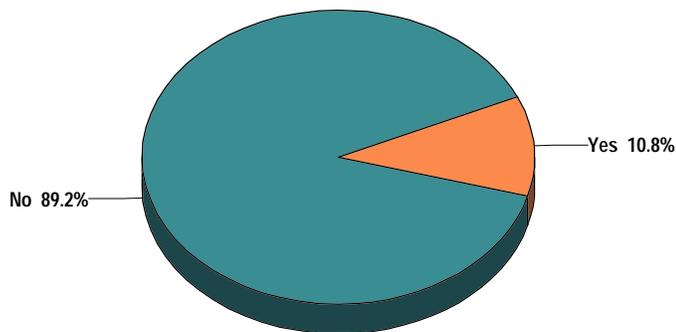


Source: 2000 PRC Community Health Survey, Professional Research Consultants

- Notes:
1. Asked of all respondents.
  2. State and 1995 data not available.

A much larger percentage (10.8%) of local residents **have ever been** victims of domestic violence.

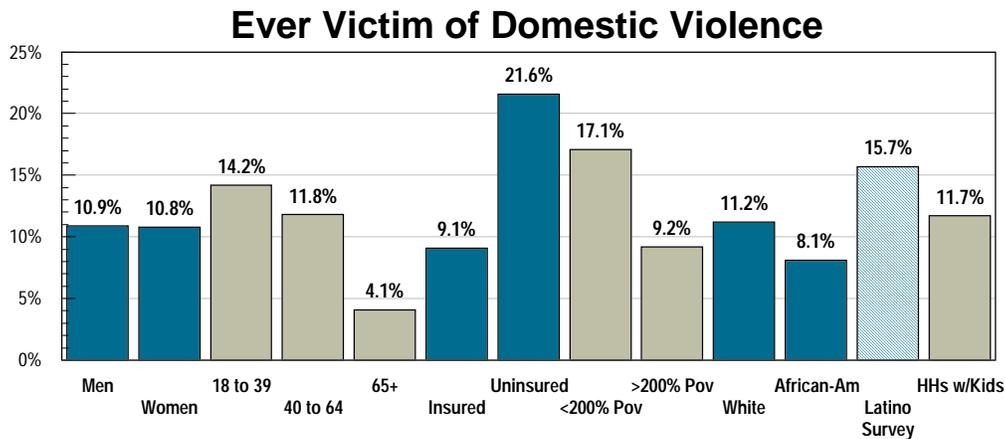
#### Ever Victim of Domestic Violence



Source: 2000 PRC Community Health Survey, Professional Research Consultants

- Notes:
1. Asked of all respondents.
  2. State and 1995 data not available.

Viewed demographically, this prevalence increases dramatically among uninsured adults (21.6%), those living at or near poverty (17.1%), and young adults (14.2%). Another 15.7% of Latinos surveyed separately noted that they have been domestic violence victims at some point in their lives. Also, 11.7% of respondents in households with children noted that they have been hurt in domestic violence at some point in their lives.



Sources: 1. 2000 PRC Community Health Survey, Professional Research Consultants  
 2. 2000 Buncombe County Latino Health Survey

Notes: 1. Demographic breakouts are among findings in Buncombe County in 2000.  
 2. Asked of all respondents.  
 3. Latino survey data was derived from an independent written survey administered one-on-one by various Buncombe County organization representatives among a convenience sample. In interpreting and comparing results, it is important to note that the Latino survey, unlike the countywide telephone survey, was not administered among a random sample of community members. For this reason, the data from these Latino surveys are not incorporated into the overall county percentage, nor in other demographic breakout percentages.

## Domestic Violence Crisis Assistance

HELPMATE, Buncombe County's organization committed to assisting survivors of domestic violence and preventing domestic violence, reports the following activities for 1999-2000:

- 211 Person's sheltered (113 women and 98 children)
- 969 nights of emergency shelter provided to women
- 1,072 nights provided to their dependent children
- 659 women attended support groups
- Crisis contacts - 3,716 contacts from people with 2,033 children
- 703 counseling appointments
- 1,731 court advocacy appointments
- 7,848 total volunteer service hours
- 128 community education programs reaching 3, 153 people

- 21 media contacts reaching 267,000 people

Key trends identified by HELPMATE include:

- Increased need for mental health and substance abuse treatment/counseling for survivors of domestic violence, with fewer services to offer this usually low-income, insured population.
- Increased language and cultural differences.
- More people are seeking judicial and court involvement including but not limited to protective orders.
- There is some backlash associated with those who are troubled or angry that there are not more services, particularly for the batterers.

# PREVENTION

# Fast Facts

## Overview of the Findings: Prevention

### Utilization of Health Providers

-  In the past year, 82.9% of Buncombe County adults report using the services of a **physician**; another 64.1% visited a **dentist** at some point in the past year. More than one in 10 used the services of a **chiropractor** (12.4%) or a **massage therapist** (11.5%).
-  Fewer than 10% of county residents have used the services of the following providers in the past year: mental health professional, podiatrist, herbalist, ophthalmologist, OB/GYN, acupuncturist, homeopath, or naturopath.
-  68.1% of local adults visited a physician for a routine checkup within the past year.

### Medications

-  56.4% of local adults currently take at least one medication for health reasons. Among adults aged 65 and older, this percentage is 81.1%.

### Dental Care

-  50.2% of adults report that they have had permanent teeth removed due to tooth decay or gum disease.

### Alternative/Complementary Health Care

-  20.0% of survey participants report that they sometimes seek alternative or complementary health care before using a formal health care provider.
-  One-third (33.7%) of county residents report using some kind of herbal remedy when they are not feeling well or to maintain their health; Echinacea was the most commonly reported herbal remedy used (30.5%).

### Immunization

-  70.2% of seniors surveyed (aged 65 and older) report that they have had a flu shot in the past year. Somewhat fewer (64.0%) report that they have ever had a pneumonia vaccine.
-  Buncombe County Health Center data supports that **86% of all children** born in Buncombe County between November 1, 1996 and October 31, 1997 have received the immunization recommended or required by North Carolina law for their age group.



## ***Women's Cancer Screenings***

-  Of those women aged 40 and older, approximately three-fourths have had a mammogram in the past two years.
-  83.3% of women have had a Pap smear to test for cancer of the cervix in the past three years, compared to a Healthy People 2010 goal of 90% or higher.
-  3 in 10 local women have had a hysterectomy; this proportion is unchanged from the 1995 survey results.

# Utilization of Health Providers

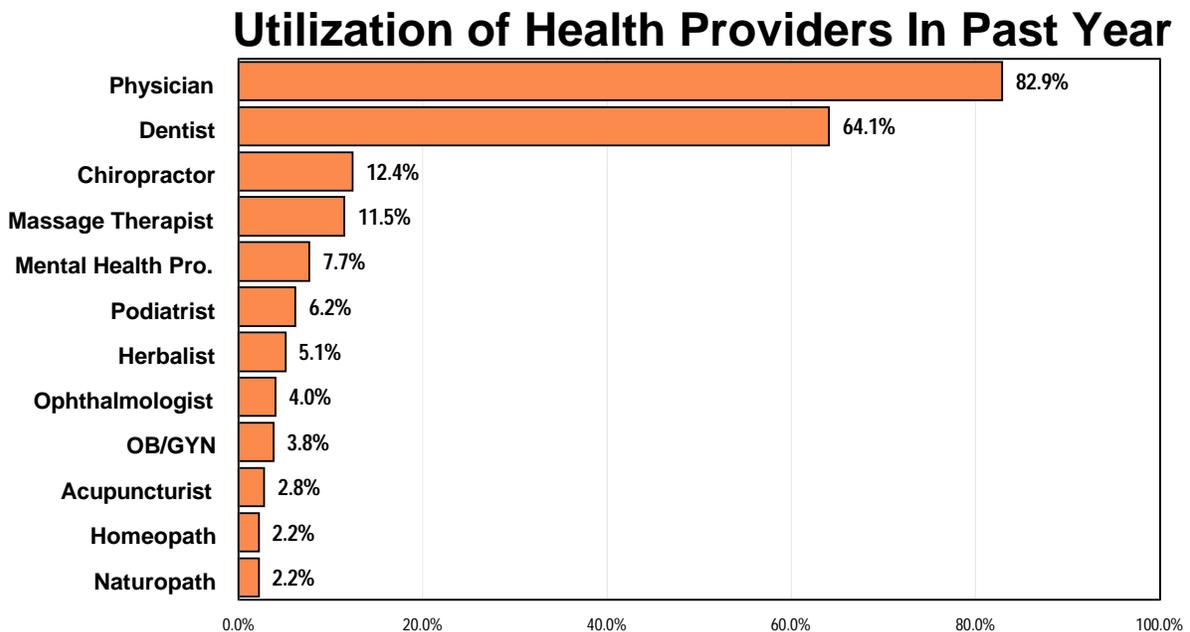
## Provider Contacts

Buncombe County adults were asked to indicate whether they have used any of 12 various health providers in the past year, including both “conventional” and alternative, or complementary, health care providers.

The largest share of responses (82.9%) was for **physicians**, followed by **dentists** (mentioned by 64.1%).

**Chiropractors** received a 12.4% response rate, followed by **massage therapists** (11.5%), **mental health professionals** (7.7%), **podiatrists** (6.2%), and **herbalists** (5.1%).

Somewhat fewer local adults have seen an **ophthalmologist** in the past year (4.0%), along with **OB/GYNs** (3.8%), **acupuncturists** (2.8%), **homeopaths** (2.2%), and **naturopaths** (2.2%).



Source: 2000 PRC Community Health Survey, Professional Research Consultants

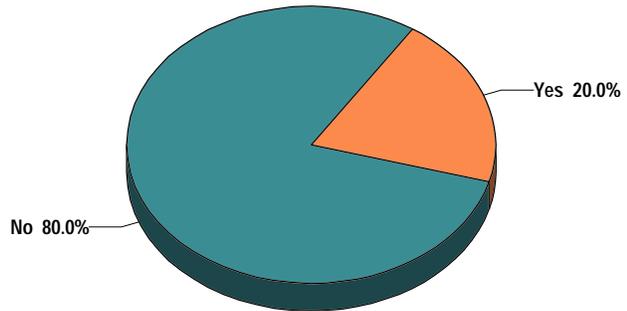
Note: Asked of all respondents.

## Use of Alternative & Complementary Care

One-fifth (20.0%) of local adults report that they seek some type of alternative or complementary care (such as herbal therapy, chiropractic medicine, or acupuncture) before using a formal health care provider (i.e. physicians, dentists, or nurses). This is further illustrated in the adjacent chart.

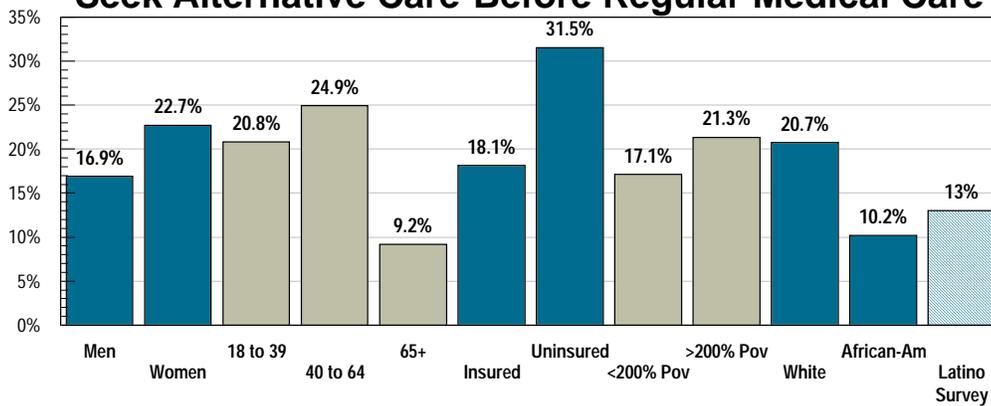
Viewed by specific demographics, adults more inclined to seek alternative care before using a formal health care provider include uninsured adults, Whites, middle-aged adults, and women.

### Seek Alternative Care Before Regular Medical Care



Source: 2000 PRC Community Health Survey, Professional Research Consultants  
 Note: Asked of all respondents.

### Seek Alternative Care Before Regular Medical Care



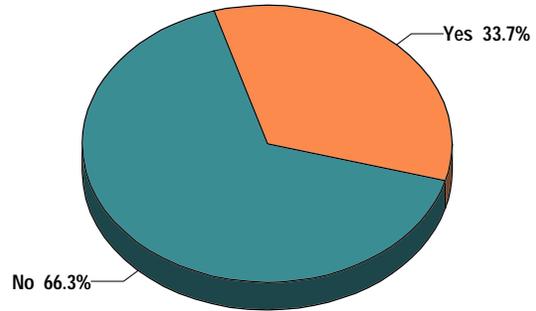
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## Herbal Remedies

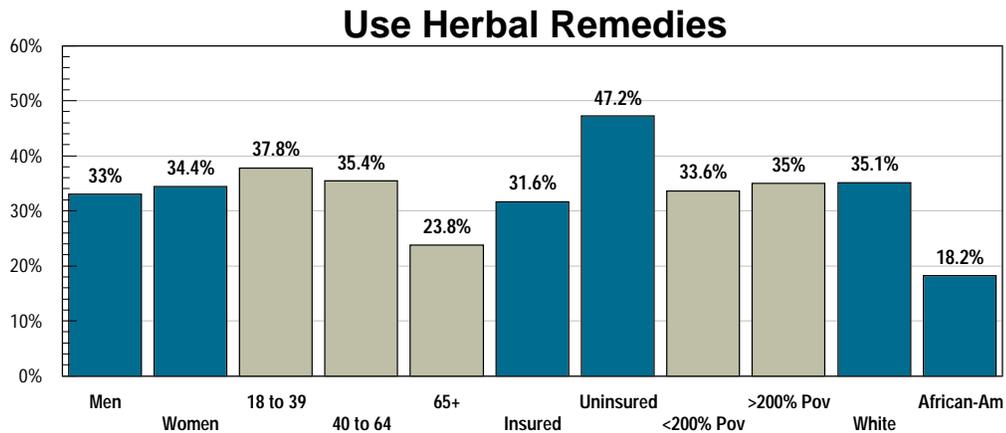
Respondents were asked to report whether or not they use herbal remedies when they are not feeling well or to maintain their health. As shown in the adjacent chart, one-third (33.7%) of local adults do use herbal remedies for health reasons.

### Use Herbal Remedies



Source: 2000 PRC Community Health Survey, Professional Research Consultants  
 Note: Asked of all respondents.

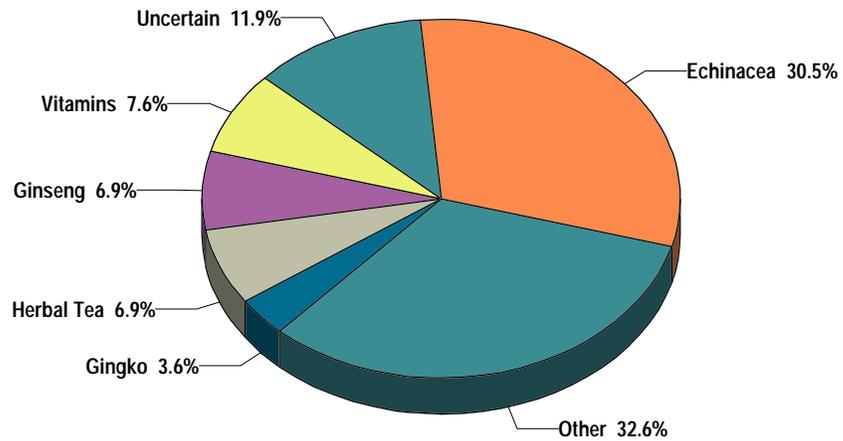
The following chart illustrates a breakout of demographic characteristics. As shown, local adults most likely to use herbal remedies include young adults, uninsured residents, and Whites.



Sources: 1. 2000 PRC Community Health Survey, Professional Research Consultants  
 2. 2000 Buncombe County Latino Health Survey  
 Notes: 1. Demographic breakouts are among findings in Buncombe County in 2000.  
 2. Asked of all respondents.  
 3. This inquiry was not asked in the separate Latino survey.

The 33.7% of adults who do report using herbal remedies were next asked to specify which remedies they use most often. As shown in the following chart, Echinacea received the largest share of responses (30.5%), followed by vitamins (mentioned by 7.6%), Ginseng (6.9%), herbal tea (6.9%), and Gingko (3.6%).

### Type of Herbal Remedy Used Most

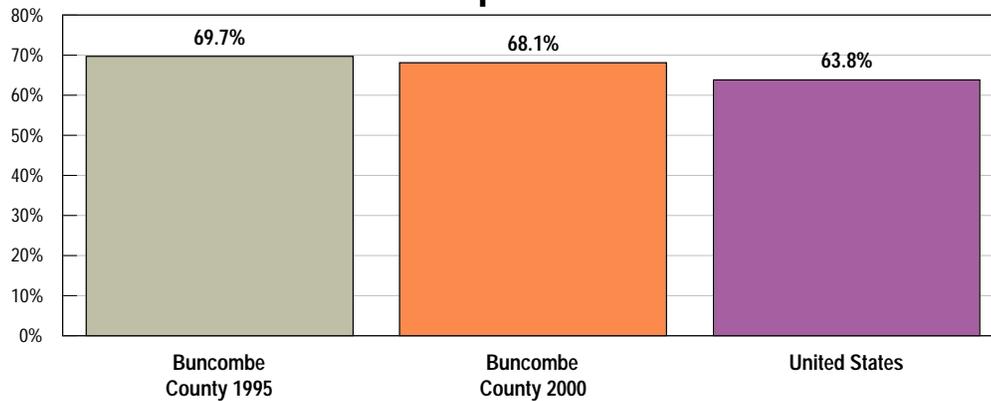


Source: 2000 PRC Community Health Survey, Professional Research Consultants  
Note: Asked of those respondents who use herbal remedies.

## Use of Physicians for Primary Care

A total of 68.1% of adults in Buncombe County have visited a physician for a routine checkup within the past year (versus a comparable 69.7% in 1995). Nationwide, a similar 63.8% of adults have done the same.

### Have Visited a Physician for a Routine Checkup Within the Past Year

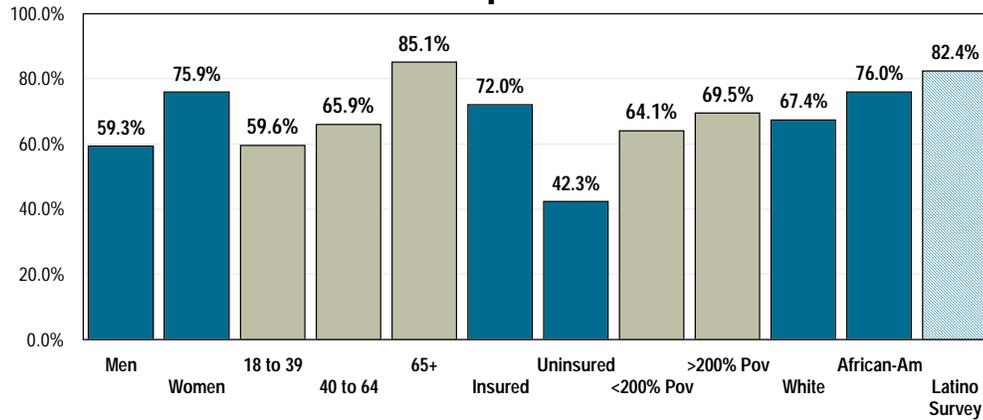


Sources: 1. 1995 & 2000 PRC Community Health Surveys, Professional Research Consultants  
2. 2000 PRC National Health Survey, Professional Research Consultants

Notes: 1. Asked of all respondents.  
2. State data not available.

Note in the following chart that women are much more likely than men to have been to a doctor in the past year. In addition, visits to physicians in Buncombe County increase with age, as they should. As might be expected, recent medical visits are lowest among uninsured adults in Buncombe County.

## Have Visited a Physician for a Routine Checkup Within the Past Year



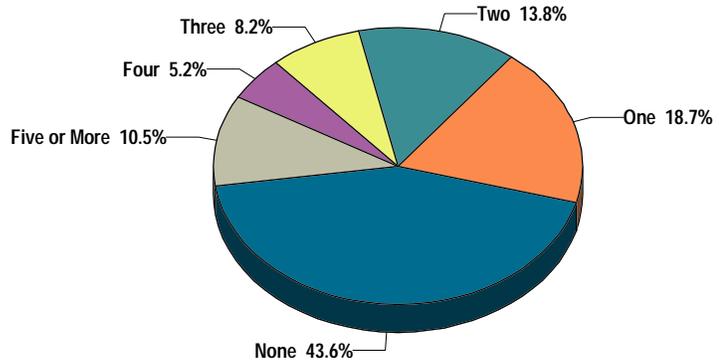
Sources: 1. 2000 PRC Community Health Survey, Professional Research Consultants  
 2. 2000 Buncombe County Latino Health Survey

Notes: 1. Demographic breakouts are among findings in Buncombe County in 2000.  
 2. Asked of all respondents.  
 3. Latino survey data was derived from an independent written survey administered one-on-one by various Buncombe County organization representatives among a convenience sample. In interpreting and comparing results, it is important to note that the Latino survey, unlike the countywide telephone survey, was not administered among a random sample of community members. For this reason, the data from these Latino surveys are not incorporated into the overall county percentage, nor in other demographic breakout percentages.

## Use of Medications

Although 43.6% of local adults do not currently take any medications, 18.7% report taking **one** current medication and 13.8% of adults report currently taking **two** medications. Another 8.2% of local adults are on **three** medications, while 5.2% report taking **four** medications and a full 10.5% of local adults are on **five or more** medications.

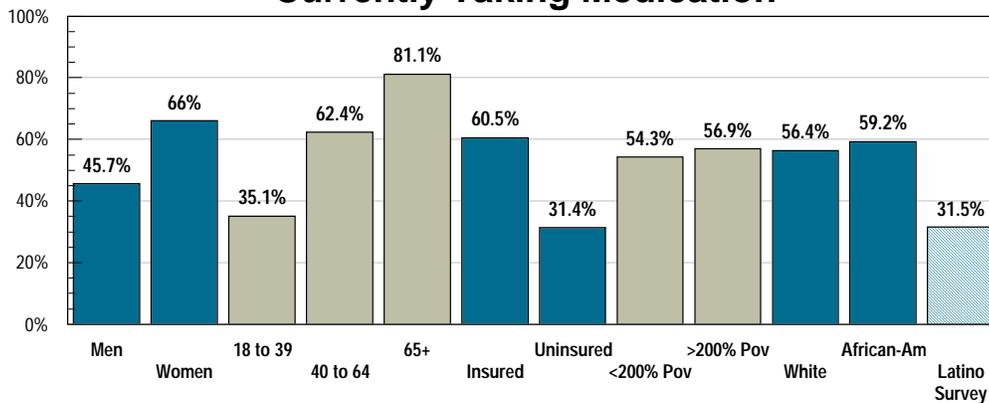
### Number of Current Medications



Source: 2000 PRC Community Health Survey, Professional Research Consultants  
 Note: Asked of all respondents.

When segmented by demographics, community residents most likely to be taking at least one medication include women, individuals aged 65 and older, and adults with health care insurance coverage. According to the separate survey conducted among local Latinos, 31.5% of Latinos are currently taking at least one medication, as shown below.

### Currently Taking Medication



Sources: 1. 2000 PRC Community Health Survey, Professional Research Consultants  
 2. 2000 Buncombe County Latino Health Survey

Notes: 1. Demographic breakouts are among findings in Buncombe County in 2000.  
 2. Asked of all respondents.  
 3. Latino survey data was derived from an independent written survey administered one-on-one by various Buncombe County organization representatives among a convenience sample. In interpreting and comparing results, it is important to note that the Latino survey, unlike the countywide telephone survey, was not administered among a random sample of community members. For this reason, the data from these Latino surveys are not incorporated into the overall county percentage, nor in other demographic breakout percentages.

# Dental Care

## Perceptions Data

“Buncombe County Dental Society and NC Dental Society, both have been very responsive to seeking some positive resolution to the tremendous need for dental care.”

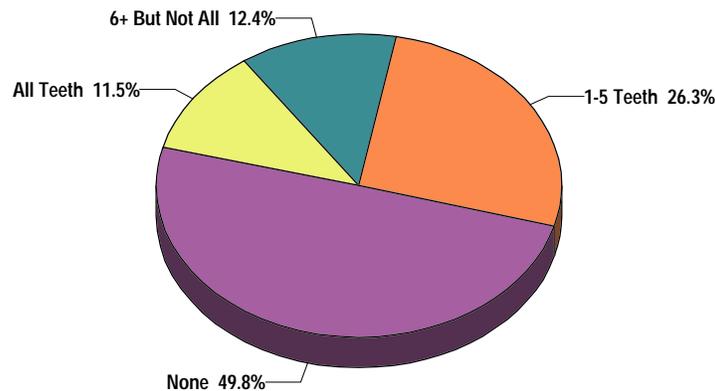
“Access to dental care is a big problem.”

“Dentists don’t take Medicaid.”

## Adult Tooth Loss Due to Tooth Decay or Gum Disease

As part of the health survey, Buncombe County adults were asked to indicate whether they have had any teeth removed due to decay or gum disease. The adjacent chart illustrates the total sample breakout. As shown, one-half (49.8%) of all local adults have not had any teeth removed, while 26.3% have had between one and five teeth removed, 12.4% have had six or more (but not all) teeth removed, and 11.5% of local adults have had **all** of their teeth removed.

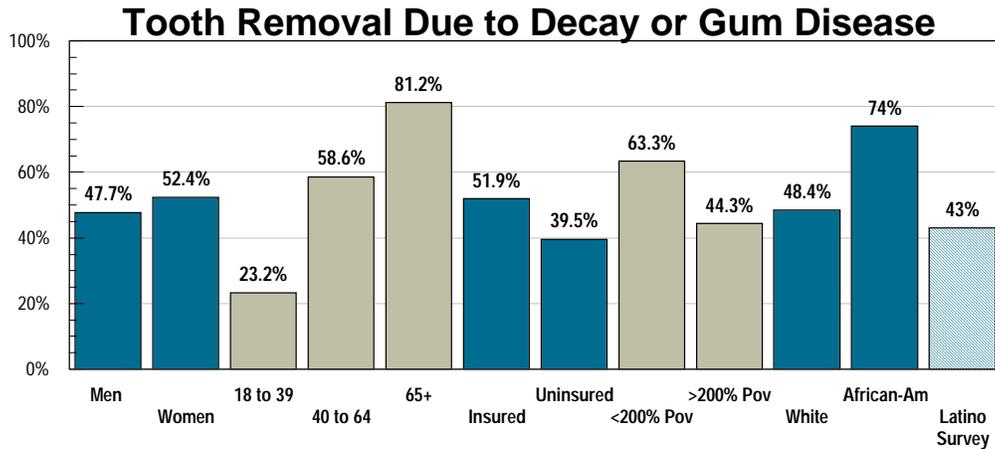
### Tooth Removal Due to Decay or Gum Disease



Source: 2000 PRC Community Health Survey, Professional Research Consultants  
Note: Reflects the total sample of respondents.

\* The Perceptions Data are valuable in identifying issues and providing context to the findings of this assessment. Keep in mind, however, that these qualitative comments are attributable only to those citizens and Key Informants participating in this effort and are not necessarily representative of the study sponsors nor the community at large.

Note below that local residents most likely to have had a tooth removed due to decay or gum disease include those aged 65 and older, African-Americans, and adults in the lower income bracket.



- Sources: 1. 2000 PRC Community Health Survey, Professional Research Consultants  
 2. 2000 Buncombe County Latino Health Survey
- Notes: 1. Demographic breakouts are among findings in Buncombe County in 2000.  
 2. Asked of all respondents.  
 3. Latino survey data was derived from an independent written survey administered one-on-one by various Buncombe County organization representatives among a convenience sample. In interpreting and comparing results, it is important to note that the Latino survey, unlike the countywide telephone survey, was not administered among a random sample of community members. For this reason, the data from these Latino surveys are not incorporated into the overall county percentage, nor in other demographic breakout percentages.

## Dental Screenings of Children

During the 1998-99 school year, 91% of Buncombe County kindergartners and 92% of Buncombe County 5<sup>th</sup> graders were screened by state and locally employed dental public health staff.

These screenings revealed 61% of kindergartners and 82% of 5<sup>th</sup> graders to be cavity-free, similar to statewide findings. Other measures of 5<sup>th</sup> graders were likewise similar to statewide findings. However, the screenings also revealed a higher proportion of Buncombe County kindergartners (27%) with untreated decay when compared to the state. Kindergartners also had a slightly higher average number of decayed, missing or filled teeth per child (1.7 versus 1.5 statewide).

### Calibrated Dental Screening, 1998-99

	Buncombe Co. Kindergartners	North Carolina Kindergartners	Buncombe Co. 5th Graders	North Carolina 5th Graders
% of Children Screened	91%	89%	92%	81%
% Children Cavity-Free	61%	62%	82%	79%
% Children w/ Untreated Decay	27%	23%	5%	5%
% Children w/ Sealants			45%	31%
Average DT per Child	0.8	0.7	0.1	0.1
Average D/M/FT per Child	1.7	1.5	0.4	0.4

Source: State Center for Health Statistics (SCHS), NC Department of Health and Human Services.

- Notes:
1. Screenings were performed by state and locally employed dental public health staff.
  2. Fifth grade enrollment for Fall 1998, Department of Public Instruction.  
Kindergarten enrollment for Fall 1998, Department of Public Instruction.
  3. Children who have never had a cavity or filling in a permanent tooth (5th Graders).  
Children who have never had a cavity or filling in a baby tooth (kindergartners).
  4. Average number of decayed teeth (DT) per child: permanent teeth (5th Graders) or baby teeth (Kindergartners).
  5. Average number of decayed teeth (D), missing molars (M) and filled teeth (FT) per child: permanent teeth (5th Graders) or baby teeth (Kindergartners).

# Immunization

Immunization is the best line of defense against many infectious diseases. For example, vaccination can significantly limit pneumonia and influenza outbreaks, which hit older Americans particularly hard. Immunization may even lead to the complete eradication of such diseases as tetanus and diphtheria.

## Childhood Immunizations

Each fiscal year the Immunization Branch of the North Carolina Department of Health and Human Services (DHHS) conducts a local health department, age appropriate, immunization rate review based upon data from the North Carolina Immunization Registry (NCIR). For the fiscal year 1998 –1999, the review examined the immunization record of children who had information in the state's Health Service Information System (HSIS) and were born between November 1, 1996 and October 31, 1997. Based on information in the North Carolina Immunization Registry (NCIR), Buncombe County's rates for children who were appropriately immunized was **23%**.

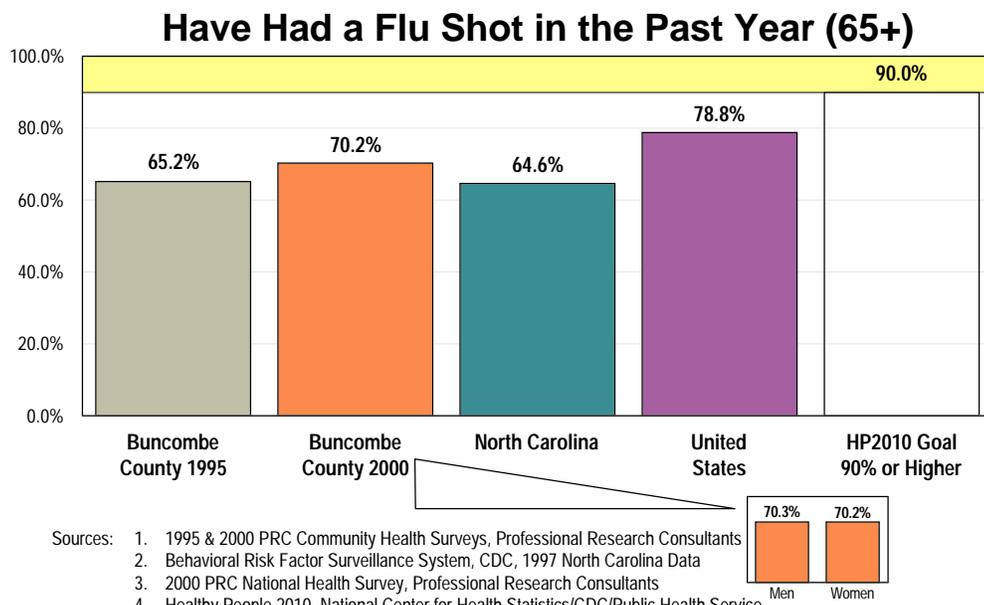
Buncombe County Health Center believes this figure is based on incomplete immunization histories in the NCIR. Therefore, a separate, randomized survey of 300 children in Buncombe County from 14 area medical offices was conducted in January 2000. The data supports that **86% of all children** born in Buncombe County between November 1, 1996 and October 31, 1997 have received the immunization recommended or required by North Carolina law for their age group. This information was not recorded in the NCIR. Therefore, the state Immunization Branch did not have information to complete an accurate review of immunizations in Buncombe County.

Information sharing and reporting continues to be a barrier regarding accurate reports of immunization rates in our county.

## Vaccinations for Seniors

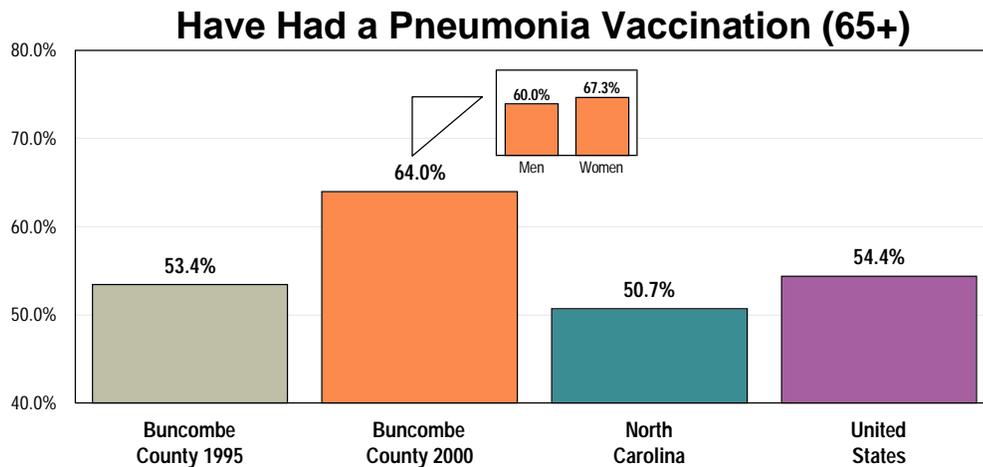
### Influenza

Seven in 10 Buncombe County adults aged 65 and older (70.2%) participating in the survey report that they have had an influenza shot within the past year, statistically similar to the national average, as well as the 1995 Buncombe County prevalence of 65.2%. Statewide, prevalence of flu immunization among those aged 65 and older is 64.6%. *Healthy People 2010* hopes that, by the year 2010, at least 90% of adults aged 65 and older will have had an influenza shot last in the past year. Vaccinations do not appear to vary by gender in Buncombe County this year.



## Pneumonia

Almost two-thirds (64.0%) of Buncombe County seniors (aged 65 and older) participating in the survey report that they have been vaccinated for pneumonia, more favorable than the national average and marking a *statistically significant increase* in pneumonia immunizations since 1995. Statewide prevalence of pneumonia immunization among those aged 65 and older is 50.7%. This time, vaccinations are higher among local women (67.3%) than men aged 65+ (60.0%).



- Sources:
1. 1995 & 2000 PRC Community Health Surveys, Professional Research Consultants
  2. Behavioral Risk Factor Surveillance System, Centers for Disease Control, 1997 North Carolina Data
  3. 2000 PRC National Health Survey, Professional Research Consultants
- Notes:
1. Asked of respondents aged 65 and older.
  2. National data not available.

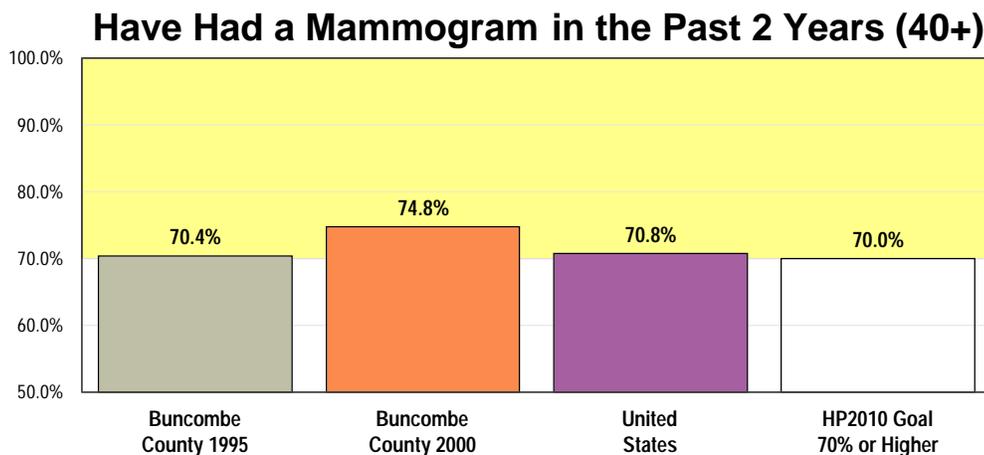
# Cancer Screenings

Cancer, the second leading cause of death in America, refers to a family of more than 100 different diseases characterized by the uncontrolled growth and spread of abnormal cells throughout the body. Together, these diseases account for 1 of every 5 deaths in the United States. Many forms of cancer are preventable, and some, if detected and treated early, are curable. Thus, the greatest potential for reducing cancer prevalence in years to come lies in stronger prevention strategies, improved means of early detection, and wider use of screening techniques.

## Female Breast Cancer

### Mammography

One of the most effective screening tools for breast cancer is the **mammogram**, an x-ray of the breast. *Healthy People 2010* has set the goal that 70% of women aged 40 and over have a mammogram within the previous two years. In Buncombe County, 74.8% of women aged 40 and older have had a mammogram within the past 2 years, comparable to the figure found nationwide as well as the 70.4% reported in 1995.

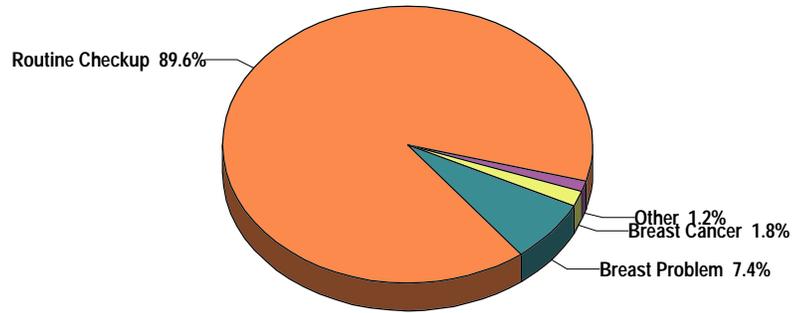


Sources: 1. 1995 & 2000 PRC Community Health Surveys, Professional Research Consultants  
2. 2000 PRC National Health Survey, Professional Research Consultants  
3. Healthy People 2010, National Center for Health Statistics/CDC/Public Health Service

Notes: 1. Reflects women aged 40 and over.  
2. North Carolina data not available.

Women with recent mammograms were next asked to specify the reason for their mammograms. As shown in the adjacent chart, almost all (89.6%) of these women had their mammogram at a routine checkup. Another 7.4% received a mammogram as the result of a breast problem (other than cancer), while 1.8% of these women had their mammogram during treatment for breast cancer.

### Reason for Recent Mammogram



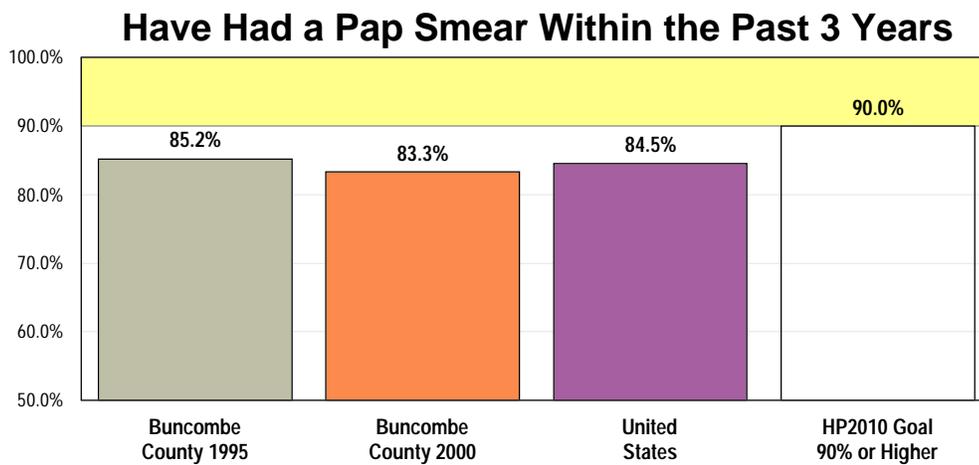
Source: 2000 PRC Community Health Survey, Professional Research Consultants  
Note: Asked of those female respondents who have had a mammogram.

## Cervical Cancer

### Pap Smear Testing

The most effective means of detecting cervical cancer in women is through a **Pap smear** test. Women over the age of 18 should undergo a Pap smear test every year. Early detection of cervical cancer through a Pap smear can dramatically increase a woman's probability of long-term survival.

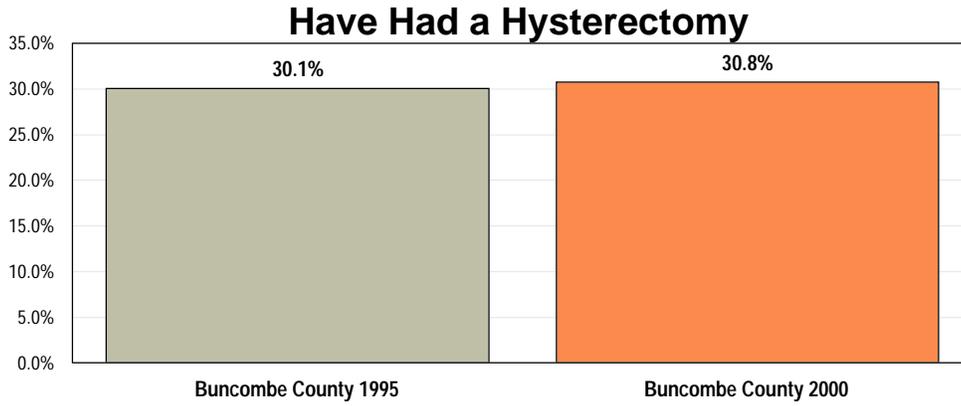
More than four out of five area women in Buncombe County (83.3%) have had a Pap smear within the past 3 years. This is similar to the 84.5% recorded nationwide, but fails to satisfy the 90% goal for the year 2010. In 1995, a comparable 85.2% of women had had a Pap smear in the past three years.



Sources: 1. 1995 & 2000 PRC Community Health Surveys, Professional Research Consultants  
2. 2000 PRC National Health Survey, Professional Research Consultants  
3. Healthy People 2010, National Center for Health Statistics/CDC/Public Health Service

Notes: 1. Asked of all female respondents.  
2. North Carolina data not available.

In a related inquiry, local women were asked to indicate whether they have had a hysterectomy (a surgical removal of the uterus). As shown, 3 in 10 local women responded affirmatively both in 1995 and this year.



Source: 1995 & 2000 PRC Community Health Surveys, Professional Research Consultants  
Note: Asked of all female respondents.

# ACCESS

# Fast Facts

## Overview of the Findings: Access to Care

Access is a key issue for communities across the country. Barriers such as cost, transportation, insurance acceptance, physician and appointment availability, and inconvenient office hours are prohibitive factors for many residents. For this issue particularly, the important analysis lies in how these barriers impact various subsegments of the population, particularly low-income and minority residents. A significant amount of the Perceptions Data reflects issues relating to access to health care services.

### Regular Use of Physicians

-  93.0% of Buncombe County adults now have a place to go when they are sick or need advice about their health, up from 78.7% in 1995.
-  8 in 10 local adults use a physician's office when in need of medical care. Another 6.8% visit an urgent care center and 4.6% report seeking care at a clinic. Note that 3.3% of local adults rely on the local emergency room for regular medical care.
-  7.0% report that they do not have a place they usually go, such as a doctor's office or clinic, when they are sick or need advice about their health (other than a hospital emergency room). Most say it is because they have not needed a doctor (although a notable number mentioned cost or lack of insurance).
-  83.1% of adults have a personal physician, comparable to the *Healthy People 2010* goal of 85% or higher.

### Use of Emergency Room

-  In the past year, 23.3% of local adults have used an emergency room for medical care, marking a statistically significant increase since 1995.
-  While the total number of emergency room visits in Buncombe County increased between fiscal years 1997 and 1999, both the number and proportion of visits classified as "primary care" visits (i.e., Level 1,2 or F cases; those which may be better addressed in a primary care setting) have **declined** (decreasing from 48.9% of cases in FY1997 to 44.1% in FY1999).



## *Insurance Coverage*

-  88.9% of employed adults report that their employer offers health coverage as a benefit; 83.1% of these individuals take advantage of this (most of whom state that the premium cost is split between employer and employee).
-  Among survey participants aged 18 to 64, 18.5% report that they have no type of insurance coverage (public or private) for health care costs. This percentage is significantly higher than that reported in 1995 (10.8%).
-  Almost one-half (47.3%) of local adults currently have dental insurance coverage; among local parents of children under 18, 62.9% have dental coverage for their children.
-  15.2% of adults with children state that their children are enrolled in Health Check, the state Medicaid program. 16.0% state that their children are enrolled in North Carolina Health Choice.
-  In combining percentages of uninsured and underinsured persons of all ages in Buncombe County as revealed in 1995 estimates, 29.6% were considered to be “at risk” (compared to 32.8% statewide). Among those living below poverty, 51.4% were “at risk” (compared to 54.7% statewide).

## *Barriers to Health Care Access*

-  Buncombe County residents report an average 7-day wait for an appointment at their doctor’s office or at the clinic; in the waiting room, they report an average 28-minute wait to see a medical person.
-  11.3% report that there was a time in the past year when they wanted to get **medical care**, but did not. One-half of these individuals say they tried to get care, but could not due to such factors as a lack of insurance, difficulty getting an appointment, inconvenient office hours and a lack of available physicians.
-  13.1% report that there was a time in the past year when they wanted to get **dental care**, but did not. Approximately one-third of these individuals say they tried to get care, but could not, mostly due to cost or a lack of insurance.
-  6.4% of adults report that there was a time in the past year when they wanted a **prescribed medicine** but did not get it. One-half of these individuals say they tried, but could not get the medicine due to such factors as cost/lack of insurance, and medication not being in stock.
-  4.5% of adults say that there was a time in the past year when they wanted **mental health care** or counseling, but did not get it at that time. Among these people, one-half tried to get care but were unsuccessful. Reasons included cost, fear or embarrassment, and difficulty in scheduling an appointment.



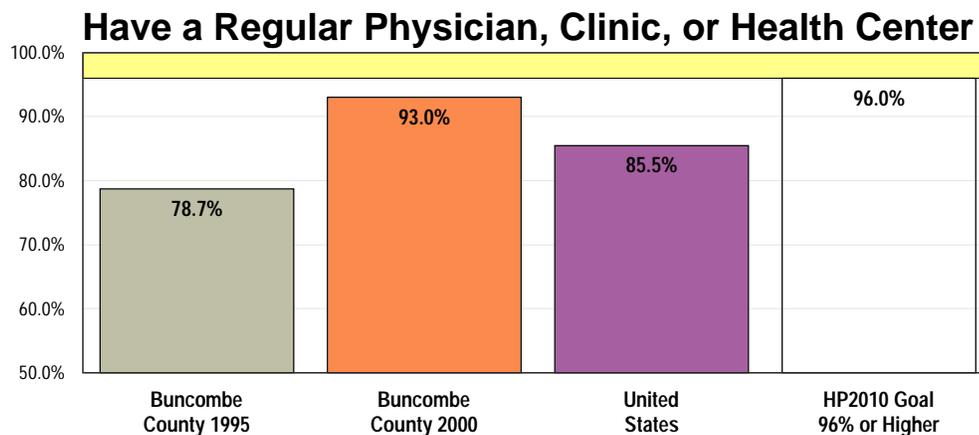
Some of the barriers to accessing health care services which surfaced in the Perceptions Data include: cost of health services and medications; physician relationships; transportation; discrimination; language and cultural differences; and age. Unique barriers were discussed as they relate to subgroups within the population, such as Latinos, immigrants, gays/lesbians, the impoverished, and the elderly.

# Primary Care Services

The following section illustrates residents' use of specific medical facilities, regular use of physicians and personal providers, and utilization of the local emergency room.

## Physician/Clinic Relationships

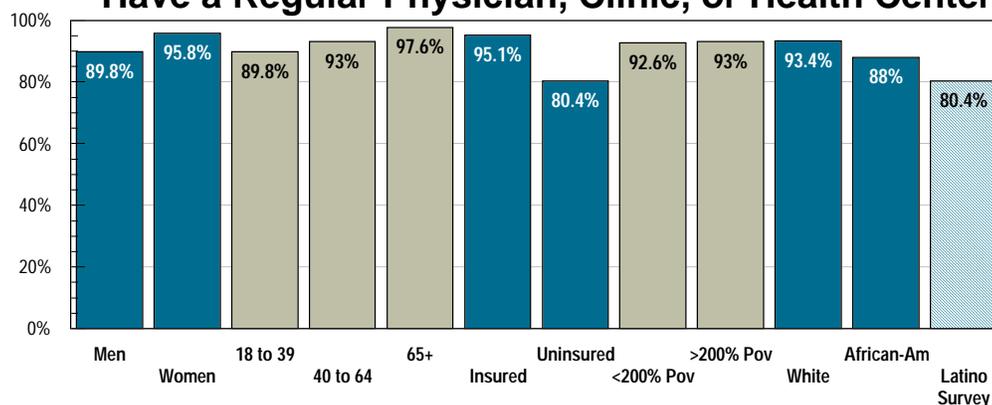
The majority (93.0%) of area residents indicate that they have a physician's office or clinic that they visit when in need of regular medical care, more favorable than the 85.5% found nationwide. This marks a *statistically significant increase* since the 1995 study was conducted. Note the related *Healthy People 2010* goal to increase to 96% or higher the proportion of adults who have a specific source of ongoing care.



- Sources: 1. 1995 & 2000 PRC Community Health Surveys, Professional Research Consultants  
 2. 2000 PRC National Health Survey, Professional Research Consultants  
 3. Healthy People 2010, National Center for Health Statistics/CDC/Public Health Service
- Notes: 1. Asked of all respondents.  
 2. North Carolina data not available.

Not surprisingly, when segmented by demographics, community residents least likely to have a regular physician are those without health care insurance coverage, as shown below.

## Have a Regular Physician, Clinic, or Health Center



Sources: 1. 2000 PRC Community Health Survey, Professional Research Consultants

2. 2000 Buncombe County Latino Health Survey

Notes: 1. Demographic breakouts are among findings in Buncombe County in 2000.

2. Asked of all respondents.

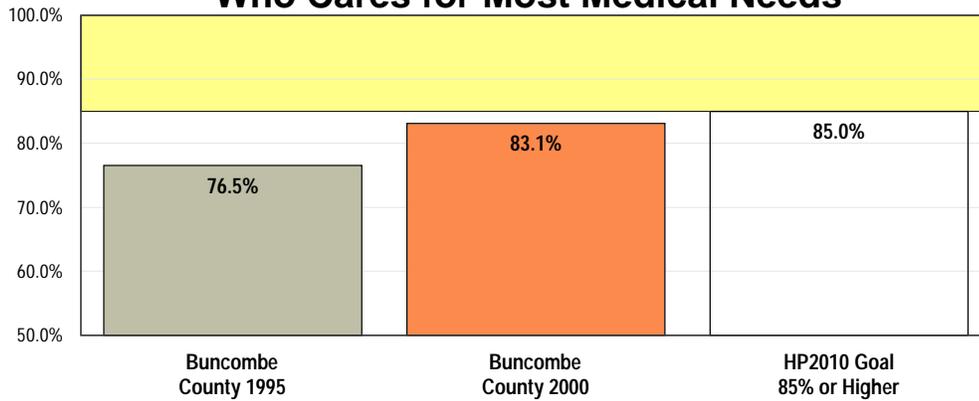
3. Latino survey data was derived from an independent written survey administered one-on-one by various Buncombe County organization representatives among a convenience sample. In interpreting and comparing results, it is important to note that the Latino survey, unlike the countywide telephone survey, was not administered among a random sample of community members. For this reason, the data from these Latino surveys are not incorporated into the overall county percentage, nor in other demographic breakout percentages.

It should be noted that all groups shown in the above graph demonstrate a higher percentage with a usual source of care than the overall percentage of 78.7% in 1995; even among the uninsured, over 80% have a usual source of care.

### Personal Physician

In a follow-up inquiry, local adults were asked to indicate whether they have a personal physician who cares for most of their medical needs. *Healthy People 2010* hopes that, by the year 2010, at least 85% of adults will have a usual primary care provider. This year, 83.1% of Buncombe County adults report having a personal physician who cares for most medical needs; this marks another *statistically significant increase* in personal primary care physicians among county adults since 1995 (76.5%).

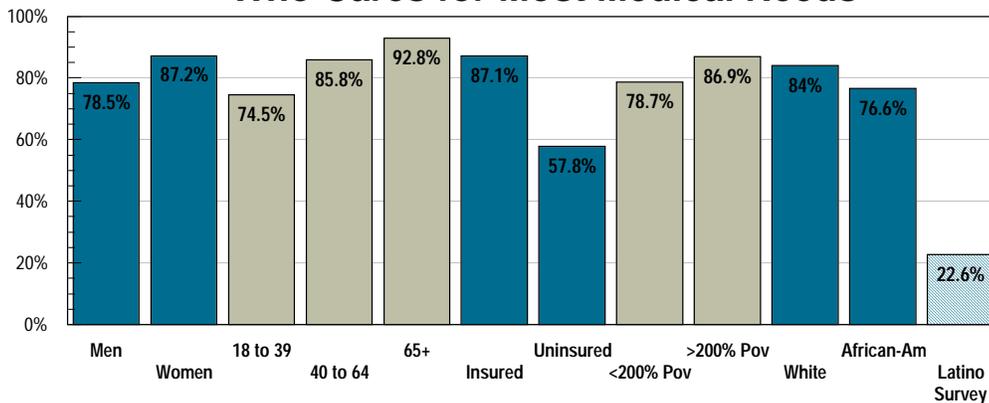
## Have a Personal Physician Who Cares for Most Medical Needs



- Sources: 1. 1995 & 2000 PRC Community Health Surveys, Professional Research Consultants  
 2. Healthy People 2010, National Center for Health Statistics/CDC/Public Health Service
- Notes: 1. Asked of all respondents.  
 2. North Carolina and U.S. data not available.  
 3. The *Healthy People 2010* target is to increase to 85% the proportion of persons with a usual primary care provider.

Personal physicians were reported most often among adults with insurance coverage, women, and adults over 40. The separate survey conducted among Latinos reveals that just 22.6% of local Latinos have a personal physician to care for most medical needs.

## Have a Personal Physician Who Cares for Most Medical Needs

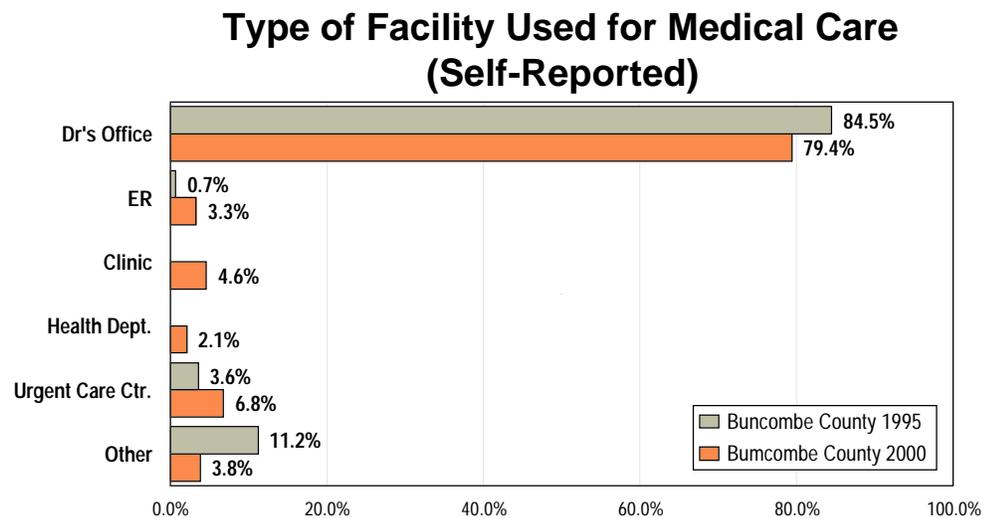


- Sources: 1. 2000 PRC Community Health Survey, Professional Research Consultants  
 2. 2000 Buncombe County Latino Health Survey
- Notes: 1. Demographic breakouts are among findings in Buncombe County in 2000.  
 2. Asked of all respondents.  
 3. Latino survey data was derived from an independent written survey administered one-on-one by various Buncombe County organization representatives among a convenience sample. In interpreting and comparing results, it is important to note that the Latino survey, unlike the countywide telephone survey, was not administered among a random sample of community members. For this reason, the data from these Latino surveys are not incorporated into the overall county percentage, nor in other demographic breakout percentages.

## Usual Source of Medical Care

The following chart summarizes local findings regarding facilities used for regular medical care. The majority of Buncombe County adults (79.4%) visit a **physician's office** when in need of medical care. This compares to 84.5% reported in 1995.

Use of a local **emergency room** is up to 3.3% this year from 0.7% in 1995, and 4.6% of adults this year mentioned using a **clinic** for regular medical services (not mentioned in 1995). Another 2.1% of local adults use the Health Department for regular medical care, and 6.8% use an urgent care center.

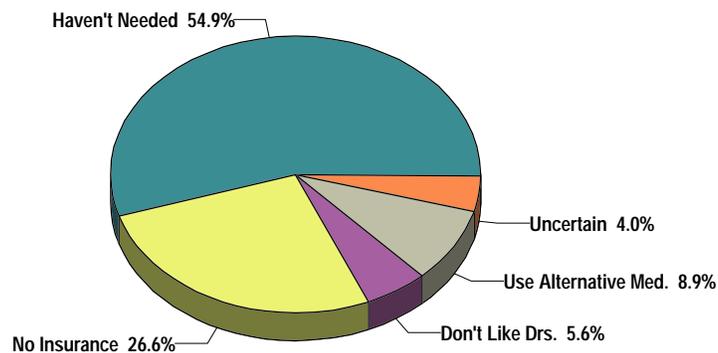


Source: 1995 & 2000 PRC Community Health Surveys, Professional Research Consultants

- Notes:
1. Reflects the total sample of respondents.
  2. "Clinic" and "health department" are included in the 1995 "other" category.

Adults with no regular source for medical care were asked the main reason that they do not have a regular site for care. Responses included "*haven't needed care*" (mentioned by 54.9%), "*no insurance*" (26.6%), "*use alternative medicines*" (8.9%), and "*don't like doctors*" (5.6%).

## Main Reason No Regular Source for Medical Care (Self-Reported Among Adults Who Do Not Have a Regular Source for Care)



Source: 2000 PRC Community Health Survey, Professional Research Consultants  
 Note: Reflects those people who do not have a regular source for medical care.

## Perceptions Data

Many times working families with two parents are making low wages, often working two jobs each but cannot afford health insurance.

“After I got SSI, my Medicaid was dropped. I have to pay a \$3,044 deductible before getting a Medicaid card. And I cannot be eligible for Medicare for a year. And there is also a major backlog in paper work in these agencies.”

“I think that access to medical care for kids whose families don't have insurance is certainly a big problem.”

“A lot of seniors who move here, for whatever reason, don't initiate establishing themselves with a primary care physician. Then when they need it, they don't have it. I think they are not aware of how difficult it is to establish with a primary care physician.”

“Most people I know go to family doctors, but there are a lot of people who use the ER.”

“I think the African-American community uses the ER, Urgent Cares, ABCCM and the health department, and then private doctors.”

“We have a challenge to see that all the community gets the care.”

Many comments about physicians in Buncombe County were positive.

“For the most part, they [rural folk and older folk] feel pretty good about their physicians. But you always hear some stories [of not-so-positive experiences].”

*\* The Perceptions Data are valuable in identifying issues and providing context to the findings of this assessment. Keep in mind, however, that these qualitative comments are attributable only to those citizens and Key Informants participating in this effort and are not necessarily representative of the study sponsors nor the community at large.*

“It’s been great [health care in Asheville/Buncombe County]. I have no complaints—we always get treated very well.”

“I have a wonderful doctor who listens to me, addresses my problems, and doesn’t keep me waiting a long time.”

“I go to the health department or to ABCCM because I don’t have insurance. I like them, even though it’s not a private doctor’s office. The attention is very good.”

However, some cited concerns over the amount of time physicians spend with patients, how well physicians explain problems to patients, and how well minority patients are respected.

“Older rural folks are scared to ask questions of the doctor because they’re on Medicare or Medicaid, and they feel if they offend somebody or ask too many questions, then they won’t be seen by the practice anymore. They won’t have a doctor anymore.”

“Fifteen minutes is not enough time for an older adult to have a beneficial visit with a health care practitioner.”

“I hear a lot of people say their doctors won’t spend time with them. They’re ‘in and out’ [referring to be rushed in for the visit and back out shortly].”

“Older folks don’t feel they can challenge doctors’ opinions and ask questions of them.”

“Doctors need to repeat educational information in a down-to-earth language, and slow enough that people can understand it.”

“People who work in doctors’ offices and public agencies need to remember to respect others, to treat others with dignity even if they are poor or are single mothers. They need to be conscious of other people’s feelings.”

“There is still a feeling of being treated differently because you are poor or black, or immigrant or female.”

Other comments related to primary care in Buncombe County include the following:

“If I know I have an infection, I see my doctor. I may try a cold medicine, or try to take care of myself. If my children are sick with fever, then I don’t wait.”

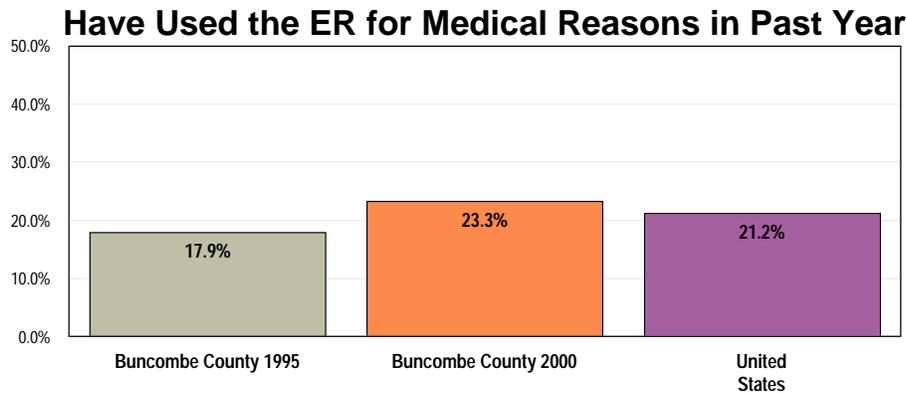
“Most people do some self-diagnosing and self-medicating.”

“Some people are afraid of getting a big bill and they don’t know about the free clinics, so they just don’t get care.”

## Emergency Room Utilization

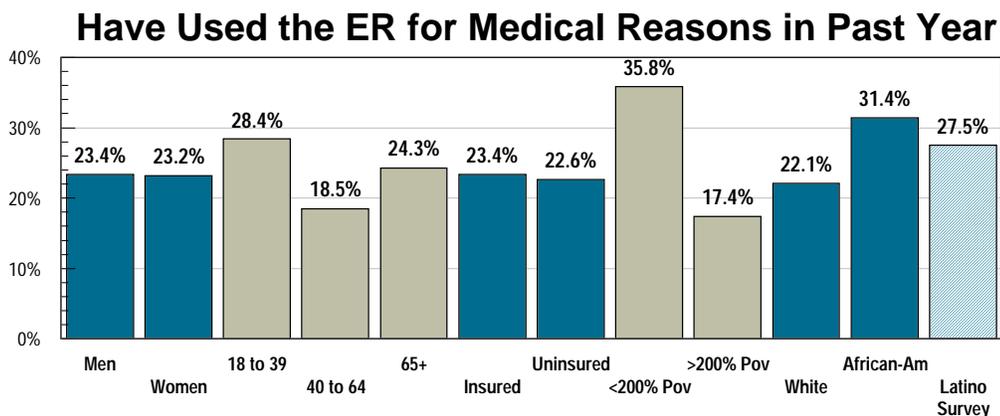
### Utilization

A total of 23.3% of adults in Buncombe County have used a local emergency room in the past year, representing a *statistically significant increase* in ER usage since 1995 (17.9%). Nationwide, a similar 21.2% of adults report emergency room usage in the past year.



Sources: 1. 1995 & 2000 PRC Community Health Surveys, Professional Research Consultants  
 2. 2000 PRC National Health Survey, Professional Research Consultants  
 Notes: 1. Asked of all respondents.  
 2. State data not available.

In Buncombe County, emergency room utilization is higher (35.8%) in the past year among those living at or near the poverty threshold (a significant increase over the 24.8% reported in 1995). Furthermore, 31.4% of African-Americans have visited a local emergency room in the past year, compared to 22.1% of local Whites. It may be interesting to note that use of the ER in the past year does not vary by insurance coverage (nor do findings by insurance coverage vary significantly from 1995 findings).

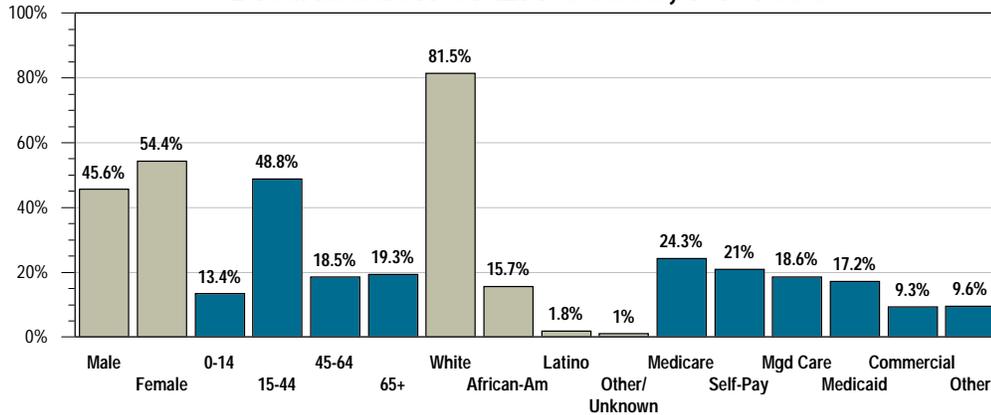


Sources: 1. 2000 PRC Community Health Survey, Professional Research Consultants  
 2. 2000 Buncombe County Latino Health Survey  
 Notes: 1. Demographic breakouts are among findings in Buncombe County in 2000.  
 2. Asked of all respondents.  
 3. Latino survey data was derived from an independent written survey administered one-on-one by various Buncombe County organization representatives among a convenience sample. In interpreting and comparing results, it is important to note that the Latino survey, unlike the countywide telephone survey, was not administered among a random sample of community members. For this reason, the data from these Latino surveys are not incorporated into the overall county percentage, nor in other demographic breakout percentages.

## Profile of ER Cases

Among emergency room cases seen at Mission St. Joseph's in fiscal year 1999 among patients with residence in Buncombe County, roughly one-half were between the ages of 15 and 44, as shown in the following chart. Further, ER patients were 81.5% White, 15.7% African-American, and 1.8% Latino. By payor, 24.3% of ER visits were covered by Medicare, while 18.6% were covered by managed care, and 17.2% were covered by Medicaid. A total of 21.0% were not covered by insurance.

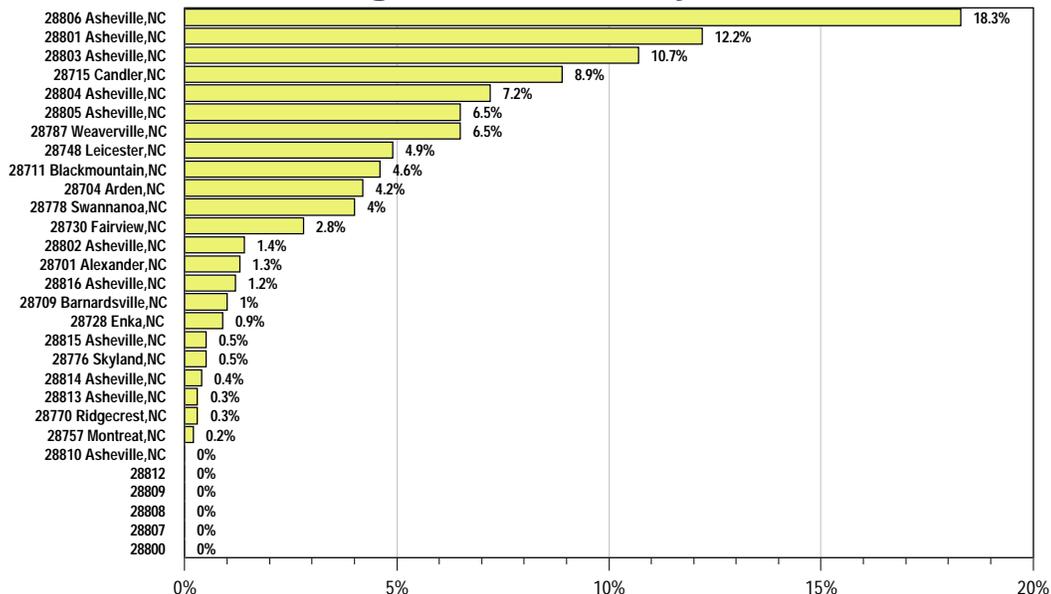
### Distribution of ER Cases, FY 1999



Source: Mission St. Joseph's Health System. ER Cases defined as cases with an Emergency Care Level charge.  
 Note: Includes only patients with residence in Buncombe County.

Geographically, the greatest proportion of ER patients maintain residence within Asheville, predominantly the 28806, 28801 and 28803 ZIP Codes.

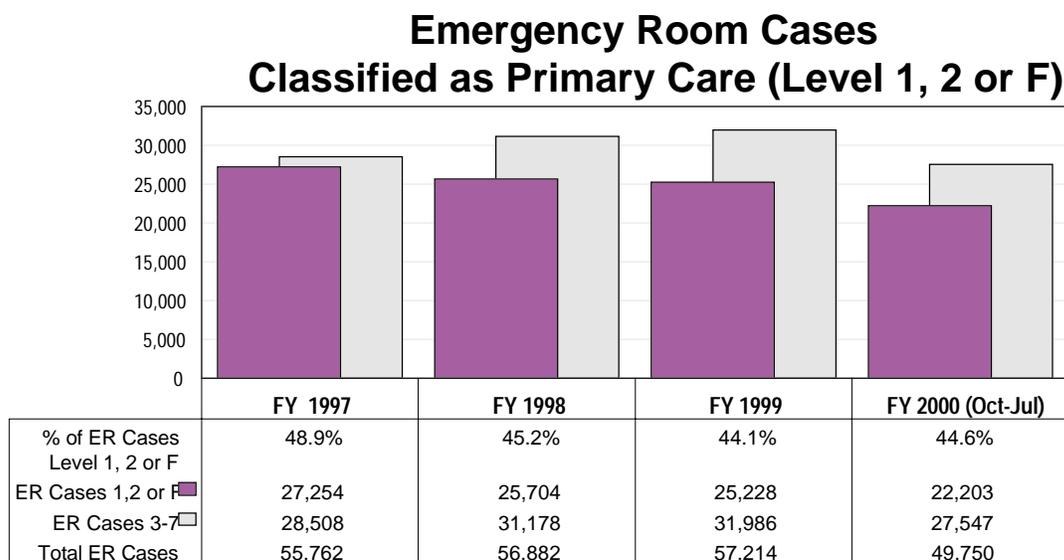
### Percentage of ER Cases by ZIP Code, FY 1999



Source: Mission St. Joseph's Health System. ER Cases defined as cases with an Emergency Care Level charge.  
 Note: Includes only patients with residence in Buncombe County.

## Appropriateness of ER Use

While the total number of emergency room visits in Buncombe County increased between fiscal years 1997 and 1999, both the number and proportion of visits classified as "primary care" visits (i.e., Level 1,2 or F cases; those which may be better addressed in a primary care setting) have **declined** (decreasing from 48.9% of cases in FY1997 to 44.1% in FY1999).



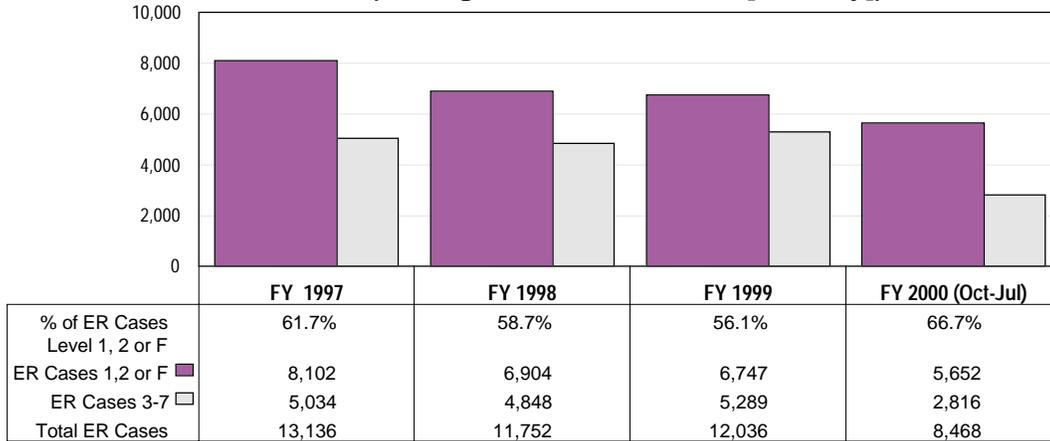
Source: Mission St. Joseph's Health System. ER Cases defined as cases with an Emergency Care Level charge.

Note: Includes only patients with residence in Buncombe County.

By payor, the greatest share of "primary care" ER visits are among those without any type of insurance coverage (self-pay); 56.1% of FY1999 ER visits among this group were classified as Level 1,2 or F. Among self-pay ER visits, Level 1,2 and F cases make up a majority of cases.

However, the number and proportion of "primary care" emergency room visits within this uninsured/underinsured group have decreased as well over the past few years. This decrease may be attributable to the community clinics created since 1995 and the development of Project ACCESS, which have created more primary options in the community.

## Emergency Room Cases Classified as Primary Care (Level 1, 2 or F) (Among Uninsured Persons [Self-Pay])



Source: Mission St. Joseph's Health System. ER Cases defined as cases with an Emergency Care Level charge.  
Note: Includes only patients with residence in Buncombe County.

## Perceptions Data

Community members cited heightened usage of the emergency room for primary care needs among some Latino residents. Others commented on the length of waits for ER patients.

“The Latin community for a long time would come right to the ER for health problems. They would often call me to drive them. I would tell them if it’s not an emergency, then go to a clinic instead, that there are several clinics available. Sometimes they wait, and then it may be a major problem, and they end up at the ER.”

“There have been some misunderstandings out there among Hispanic people who thought they had to wait in ER for hours. They thought it was something against them, that they had to wait so long. Then we explained about the triage system, that the sickest people are seen first. Even if you work at the hospital, you still have to wait your turn.”

“I heard of one man who was having chest pain, and they said he waited eight hours in the ER to be seen, because there was no one who spoke Spanish. Now there are interpreters. The bad news stories always spread fast, but the good news often doesn’t.”

Another Community Member called for greater sensitivity among ER physicians and staff.

“I had an experience in the ER during which the doctor and nurse did not explain the details about what they thought was wrong with me. They probably didn’t think I

*\* The Perceptions Data are valuable in identifying issues and providing context to the findings of this assessment. Keep in mind, however, that these qualitative comments are attributable only to those citizens and Key Informants participating in this effort and are not necessarily representative of the study sponsors nor the community at large.*

would understand. So I ended up thinking during the whole visit that I had this awful cancerous growth, when it turned out to be only a benign cyst. I wish they had told me all they knew, at the very beginning. Sometimes they forget what it's like to be that patient, the one who is having the personal experience of a health problem.”

# Health Insurance Coverage

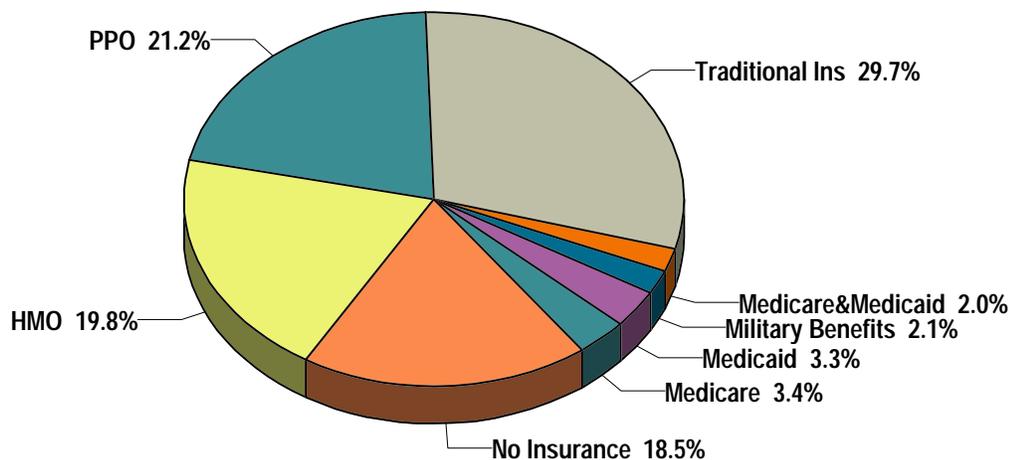
Along with enhancing quality and moderating costs, improving the accessibility of health care services is one of the principal hopes for the American health care system and a key element in any preventive approach to community health. Certainly one of the various barriers to access is a lack of insurance coverage for many Americans.

## Insurance Coverage by Type of Provider

A total of 81.5% of adults in Buncombe County aged 18 to 64 currently have some type of health care insurance coverage. More specifically, 29.6% maintain **traditional commercial health care insurance**, while 19.8% have an **HMO** (health maintenance organization) and 21.2% maintain a **PPO** (preferred provider organization). Another 3.3% use **Medicaid**, 3.4% are on **Medicare**, and 2.0% are covered by both **Medicaid and Medicare**.

On the other hand, 18.5% of residents under the age of 65 have no health insurance coverage.

### Health Care Insurance Providers (Buncombe County 2000; Ages 18-64)

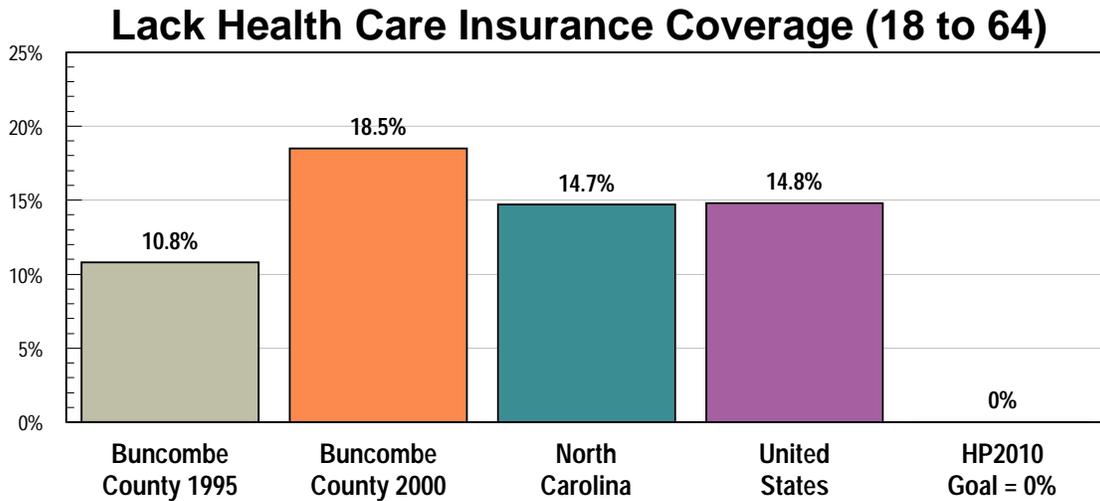


Source: 2000 PRC Community Health Survey, Professional Research Consultants  
Note: Reflects respondents aged 18 to 64.

## Lack of Health Insurance Coverage

### Uninsured Adults Aged 18 to 64

As noted previously, 18.5% of adults between the ages of 18 and 64 in Buncombe County have no insurance coverage to pay for health care expenses, similar to the national level of 14.8% but representing a *statistically significant increase* in lack of coverage since 1995. By the year 2010, *Healthy People 2010* hopes that no one will be without health care coverage.

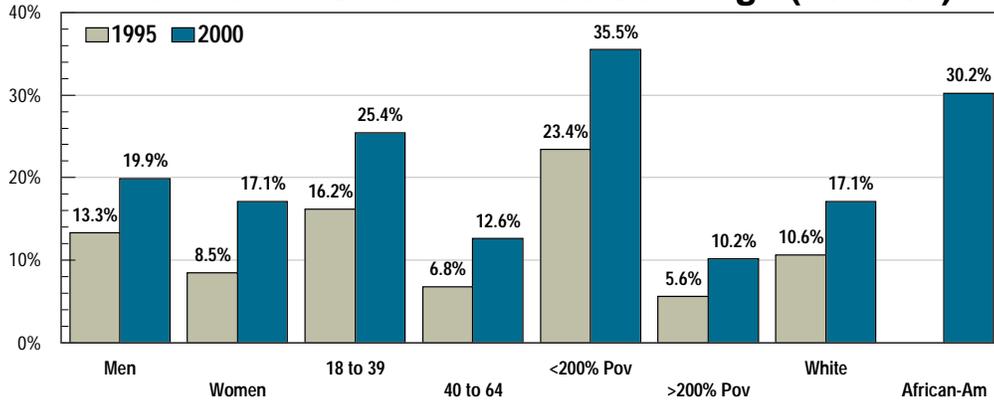


Sources: 1. 1995 & 2000 PRC Community Health Surveys, Professional Research Consultants  
2. Behavioral Risk Factor Surveillance System, Centers for Disease Control, 1997 North Carolina Data  
3. 2000 PRC National Health Survey, Professional Research Consultants  
4. Healthy People 2010, National Center for Health Statistics/CDC/Public Health Service  
Note: Reflects respondents aged 18 through 64.

Not surprisingly, coverage is directly related to income, and, in fact, lack of insurance increases sharply among individuals living at lower income levels. Note also that lack of insurance coverage is relatively high among African-Americans and adults under 40.

The demographic breakouts illustrated in the following chart suggest that lack of insurance has increased across the board in Buncombe County since 1995.

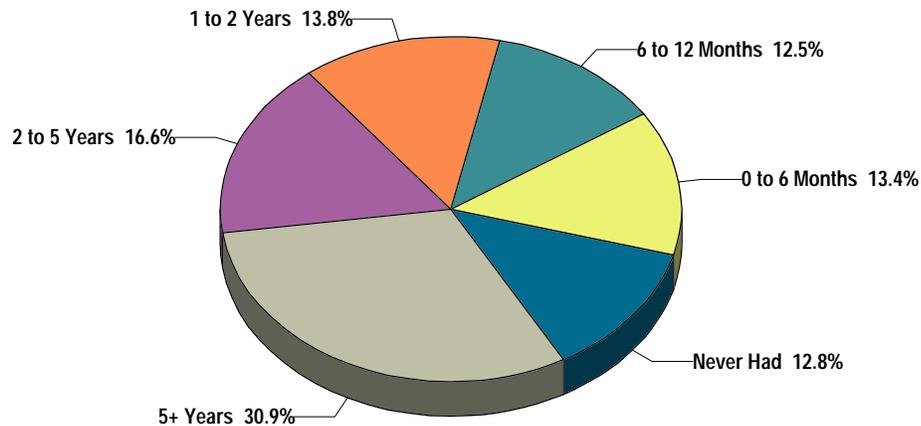
## Lack Health Care Insurance Coverage (18 to 64)



Source: 2000 PRC Community Health Survey, Professional Research Consultants  
 Notes: 1. Demographic breakouts are among findings in Buncombe County in 2000.  
 2. Asked of all respondents aged 18 through 64.  
 3. 1995 findings among African-American residents represent too few respondents to be reliable.

In a follow-up inquiry, adults without health care coverage were asked to indicate how long they have been without coverage. As shown in the adjacent chart, 12.8% of these adults have never had insurance coverage, while 30.9% have been without coverage for five or more years. Another 30.4% of these adults have not had insurance coverage for one to five years, and 25.9% have been without coverage for less than a year.

## Length of Time Since Health Care Insurance Coverage (Buncombe County 2000 Uninsured Adults)



Source: 2000 PRC Community Health Survey, Professional Research Consultants  
 Note: Reflects respondents who currently have no health care insurance coverage.

## 1995 Uninsured & Underinsured: Total Population

### *Uninsured*<sup>9</sup>

The Duke Center for Health Policy, Law and Management estimated the average daily health insurance coverage proportion of persons uninsured (all or part of the year) in Buncombe County in 1995 to be 13.7% of the total population (including both seniors and children). This proportion is below the 17.3% estimated for North Carolina.

Among those living below the poverty level, this uninsured rate was 34.9%, close to the statewide estimate (35.2%).

### *Underinsured*<sup>10</sup>

Furthermore, the Duke Center for Health Policy, Law and Management estimated that 15.9% of the Buncombe County adult and child population in 1995 was underinsured, compared to 15.5% statewide.

Among persons in poverty, 16.5% were underinsured in 1995, compared to 19.5% statewide.

### *Total At Risk*<sup>11</sup>

In combining percentages of uninsured and underinsured persons of all ages in Buncombe County in 1995, 29.6% were considered to be “at risk” (compared to 32.8% statewide). Among those living below poverty, 51.4% were “at risk” (compared to 54.7% statewide).

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<sup>9</sup> The Duke Center for Health Policy, Law and Management.

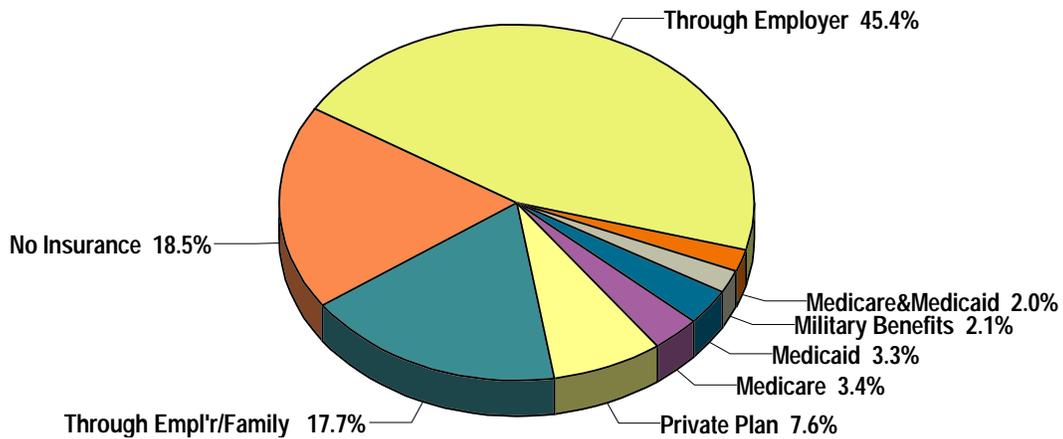
<sup>10</sup> Ibid.

<sup>11</sup> Ibid.

## Employer-Sponsored Coverage

Adults with health care coverage who are not covered by a government program were asked whether they receive their coverage through their employer or through the employer of a family member. The following chart shows another breakout of health care insurance coverage, and specifies the number of adults covered through their employer (45.3%) and those covered through the employer of a spouse or family member (17.7%).

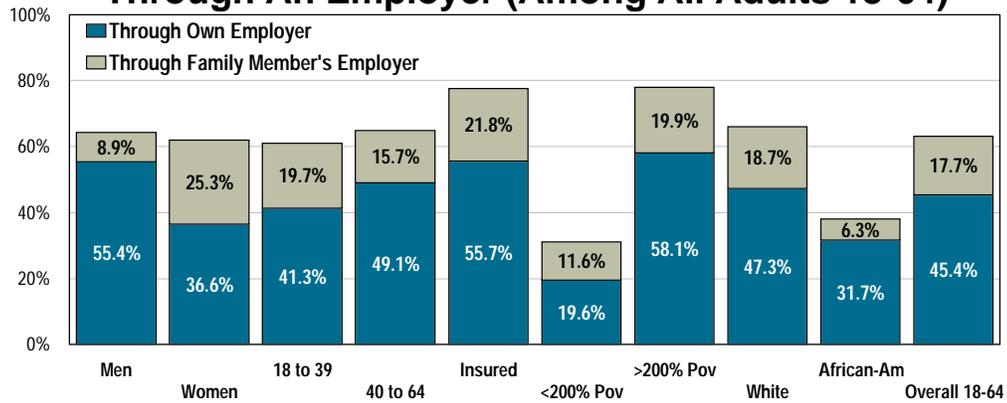
### Health Care Insurance Coverage (Buncombe County 2000; Ages 18-64)



Source: 2000 PRC Community Health Survey, Professional Research Consultants  
Note: Reflects respondents aged 18 to 64.

Viewed demographically, local adults under the age of 65 most likely to be covered through their own employer include Whites, men, middle-aged adults, and those in the higher income bracket, as shown below. Least likely are those at lower income levels.

## Have Insurance Coverage Provided Through An Employer (Among All Adults 18-64)



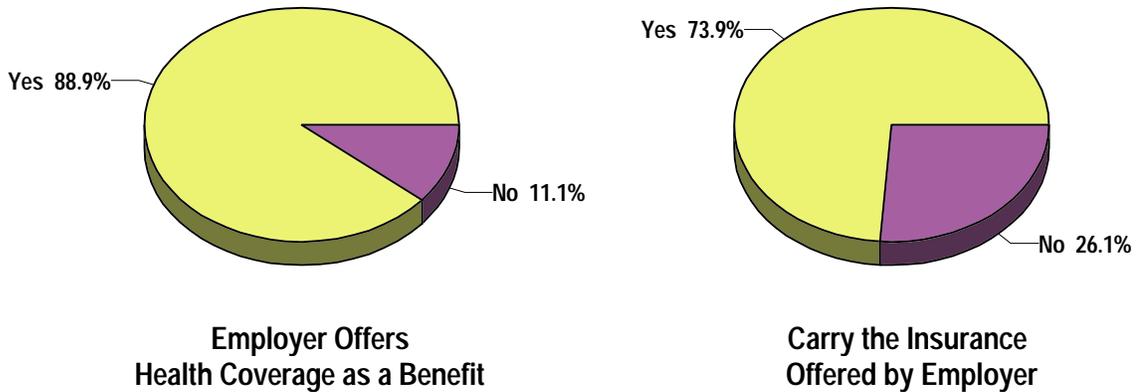
Sources: 1. 2000 PRC Community Health Survey, Professional Research Consultants  
 2. 2000 Buncombe County Latino Health Survey  
 Notes: 1. Demographic breakouts are among findings in Buncombe County in 2000.  
 2. Reflects all respondents aged 18 through 64, regardless of employment status or health care coverage.  
 3. This question was not covered in the separate Latino survey.

### Health Care Coverage as a Benefit

Buncombe County residents who are currently employed for wages were also asked a series of questions dealing with availability of employer-provided health care coverage.

A total of 88.9% employed adults reported that their employer does offer health coverage as a benefit to employees. A total of 73.9% of employed residents of Buncombe County carry their employers' health insurance (83.1% of those to whom it is offered).

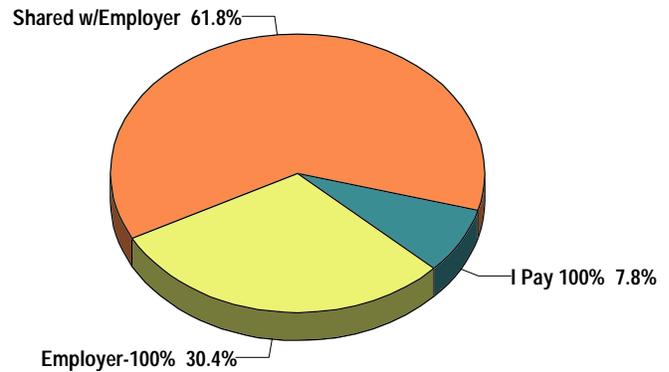
### Employer-Offered Health Coverage Benefits (Among Employed Adults)



Source: 2000 PRC Community Health Survey, Professional Research Consultants  
 Note: Reflects respondents who are currently employed for wages.

Employees who carry their employer-sponsored coverage were next asked to indicate who pays for that coverage premium. As can be seen in the following chart, 6 in 10 (61.8%) reported that they pay for part of their insurance premium and their employer pays for the other part. Another 30.4% reported that the employer pays for the entire premium, while 7.8% pay for the whole premium amount themselves.

### Payor for Coverage Premium (Among Adults Who Use Employer Coverage)

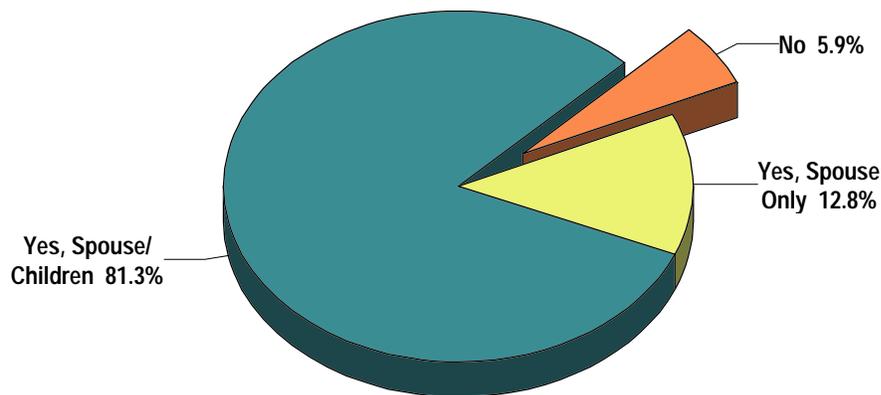


Source: 2000 PRC Community Health Survey, Professional Research Consultants  
 Note: Reflects respondents who have coverage through their employer.

### Family Coverage

Workers who have health care insurance coverage through their employer were further asked to indicate whether their employer offers coverage for family members of employees. Only 5.9% of these adults reported that their employer does not offer coverage to family members; in contrast, 81.3% indicated that their employer offers health care benefits to spouses and children of employees, and 12.8% mentioned that their employer offers coverage to spouses only.

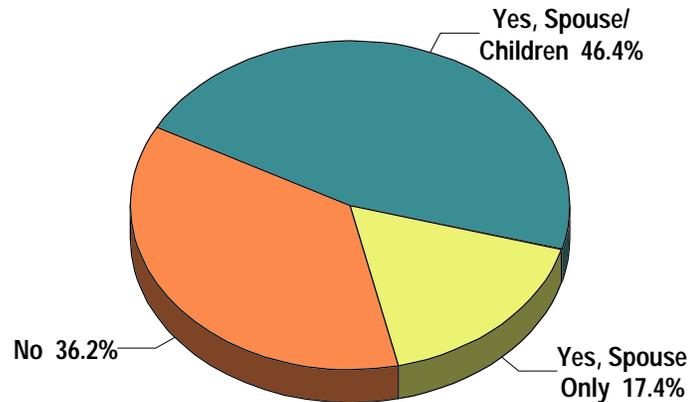
### Employer Offers Health Coverage for Family (Among Adults Who Use Employer Coverage)



Source: 2000 PRC Community Health Survey, Professional Research Consultants  
 Note: Reflects respondents who have coverage through their employer.

Adults whose employer offers family coverage were next asked to indicate whether their family carries the coverage. As shown below, over one-third (36.2%) do not carry the health care insurance for their family through their employer; in contrast, 46.4% indicate that their spouse and children are covered, while 17.4% noted that their spouse alone is covered through the employer benefit.

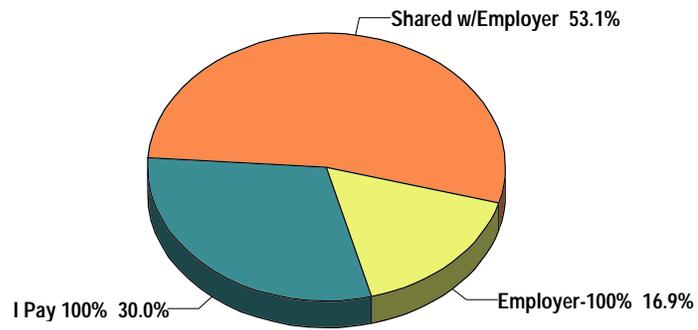
### Utilize Employer-Sponsored Coverage for Family (Among Adults Whose Employer Offers Family Coverage as a Benefit)



Source: 2000 PRC Community Health Survey, Professional Research Consultants  
Note: Reflects respondents whose employer offers family coverage as a benefit.

Finally, the employed adults who carry health insurance coverage for family members through their employer were asked to indicate the payor of the insurance premiums. More than one-half (53.1%) of these adults reported that they pay for part of the premium and the employer pays for the remainder. Another 16.9% mentioned that the employer pays for the entire premium, while 30.0% of these adults reported paying for the whole premium themselves.

## Payor for Family Coverage Premium (Among Adults Who Utilize Employer's Coverage for Families)



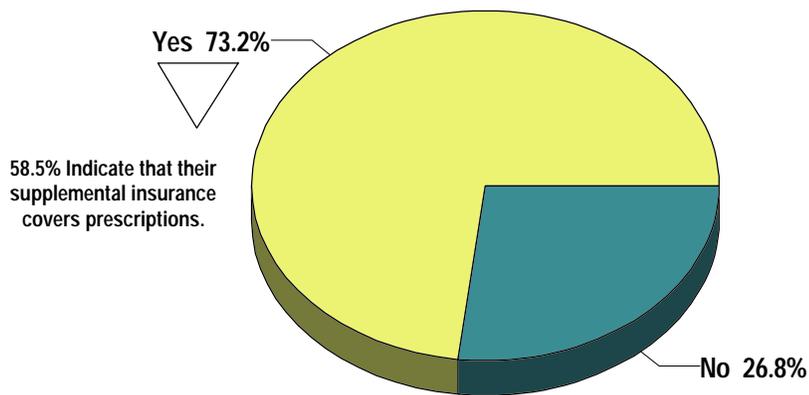
Source: 2000 PRC Community Health Survey, Professional Research Consultants  
Note: Reflects respondents who have coverage for their families through their employer.

## Medicaid/Medicare Supplemental Health Insurance

Adults currently covered by Medicaid and/or Medicare were also asked to indicate whether they carry supplemental insurance coverage and, if so, whether their supplemental insurance covers prescription medications. As shown in the following chart, almost three-fourths (73.2%) of adults with governmental coverage are also covered by supplemental insurance.

Of this group, 58.5% indicate that their supplemental insurance covers prescriptions.

**Utilize Supplemental Health Insurance**  
(Among Adults Covered by Medicaid and/or Medicare)

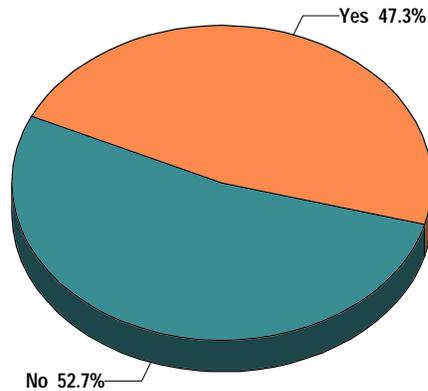


Source: 2000 PRC Community Health Survey, Professional Research Consultants  
Note: Reflects adults covered by Medicaid and/or Medicare.

## Dental Coverage

Respondents to this year's health survey were asked questions concerning dental coverage. Just under one-half (47.3%) of local adults currently carry dental insurance coverage, while 52.7% do not (representing over 79,000 adults countywide).

### Have Dental Insurance Coverage

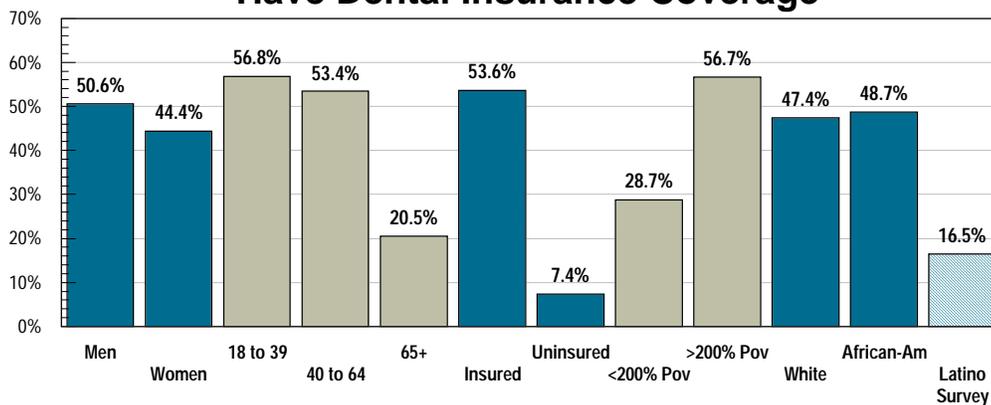


Source: 2000 PRC Community Health Survey, Professional Research Consultants  
 Note: Reflects the total sample of respondents.

Not surprisingly, coverage is directly related to income; dental insurance coverage is much higher among adults living at twice or more the national poverty level. Adults under 65

are much more likely to carry dental coverage than those aged 65 and older. According to the survey conducted separately among local Latinos, just 16.5% of Latinos currently have dental coverage.

### Have Dental Insurance Coverage



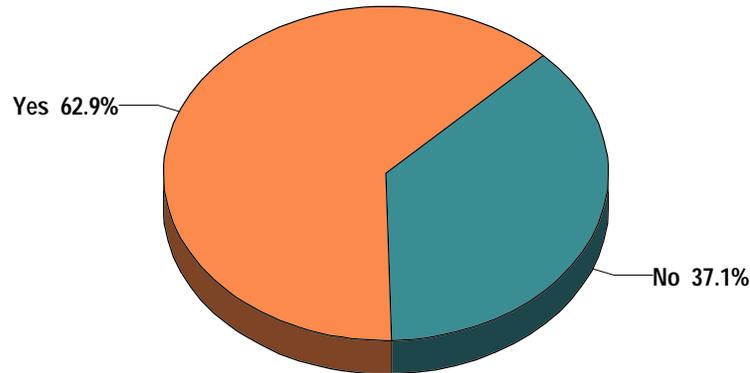
Sources: 1. 2000 PRC Community Health Survey, Professional Research Consultants  
 2. 2000 Buncombe County Latino Health Survey

Notes: 1. Demographic breakouts are among findings in Buncombe County in 2000.  
 2. Asked of all respondents.  
 3. Latino survey data was derived from an independent written survey administered one-on-one by various Buncombe County organization representatives among a convenience sample. In interpreting and comparing results, it is important to note that the Latino survey, unlike the countywide telephone survey, was not administered among a random sample of community members. For this reason, the data from these Latino surveys are not incorporated into the overall county percentage, nor in other demographic breakout percentages.

## Dental Coverage for Children

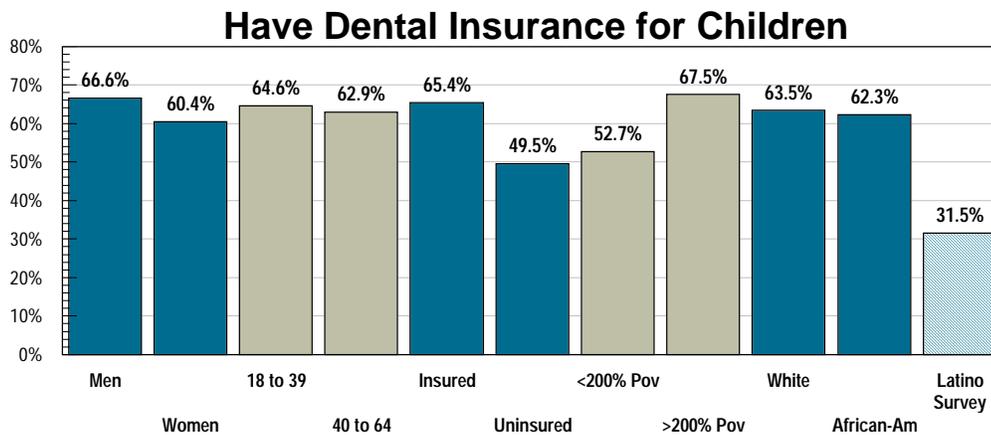
Among adults with children under the age of 18, two-thirds (62.9%) report that they carry dental insurance coverage for their child, compared to 37.1% of local parents who do not.

### Have Dental Insurance for Children (Self-Reported Among Adults With Children Under 18)



Source: 2000 PRC Community Health Survey, Professional Research Consultants  
Note: Reflects respondents with children under 18.

As might be expected, dental coverage for children decreases in households that are otherwise uninsured, as well as those living at or near the national poverty level. Also, according to the separate Latino survey, just 31.5% of Latino households with children currently carry dental coverage.



Sources: 1. 2000 PRC Community Health Survey, Professional Research Consultants  
2. 2000 Buncombe County Latino Health Survey

Notes: 1. Demographic breakouts are among findings in Buncombe County in 2000.  
2. Asked of respondents with children under 18.  
3. Latino survey data was derived from an independent written survey administered one-on-one by various Buncombe County organization representatives among a convenience sample. In interpreting and comparing results, it is important to note that the Latino survey, unlike the countywide telephone survey, was not administered among a random sample of community members. For this reason, the data from these Latino surveys are not incorporated into the overall county percentage, nor in other demographic breakout percentages.

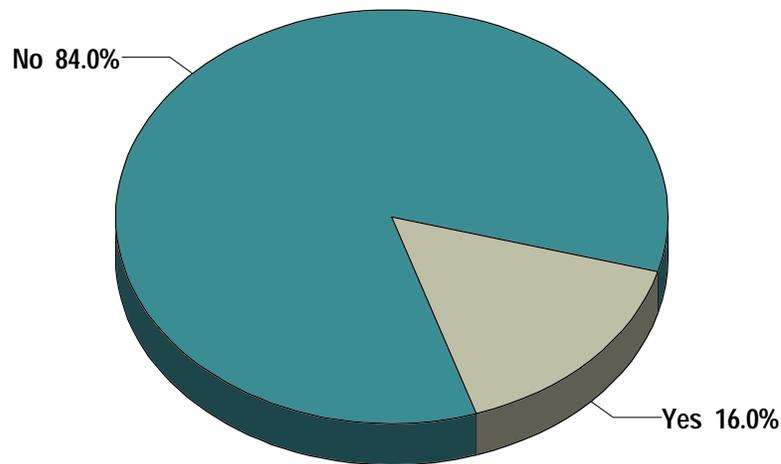
## Enrollment in Health Choice & Health Check

Respondents with children were asked about two state programs available to assist with insurance coverage for families with children who might otherwise not be able to afford it. North Carolina Health Choice is available to families with uninsured children aged birth to 18 years old whose incomes are too high for Medicaid but not high enough to afford private health insurance. Health Check is the state Medicaid program for children aged birth to 21 years old.

### Health Choice

A total of 16.0% of local parents reported that their children are enrolled in Health Choice, as shown in the adjacent chart.

**Children Are Enrolled in Health Choice**  
(Among Adults With Children Under 18)



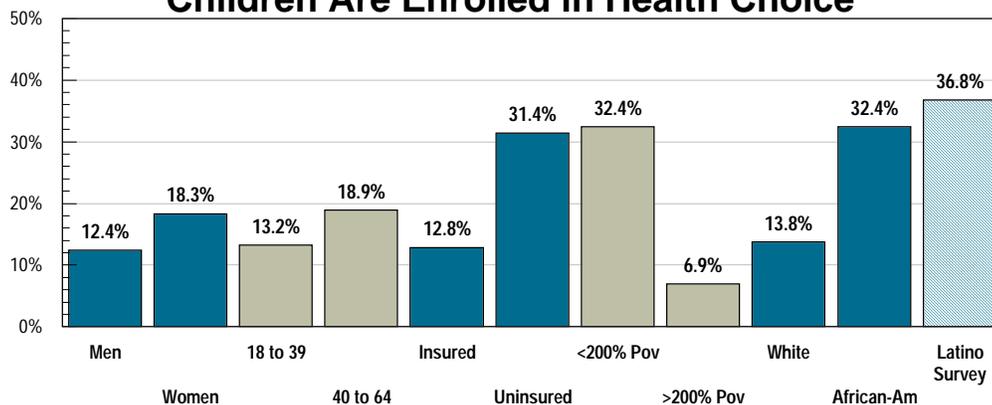
Source: 2000 PRC Community Health Survey, Professional Research Consultants

Notes: 1. Reflects respondents with children under 18.

2. Health Choice is available to families with uninsured children through the age of 18 whose incomes are too high for Medicaid but not high enough to afford private coverage.

Viewed by demographic breakout, enrollment appears to be highest among African-American families and those in the lower income bracket. The Latino survey reveals that 36.8% of Latino children are enrolled in Health Choice.

## Children Are Enrolled in Health Choice



Sources: 1. 2000 PRC Community Health Survey, Professional Research Consultants

2. 2000 Buncombe County Latino Health Survey

Notes: 1. Demographic breakouts are among findings in Buncombe County in 2000.

2. Asked of respondents with children under 18.

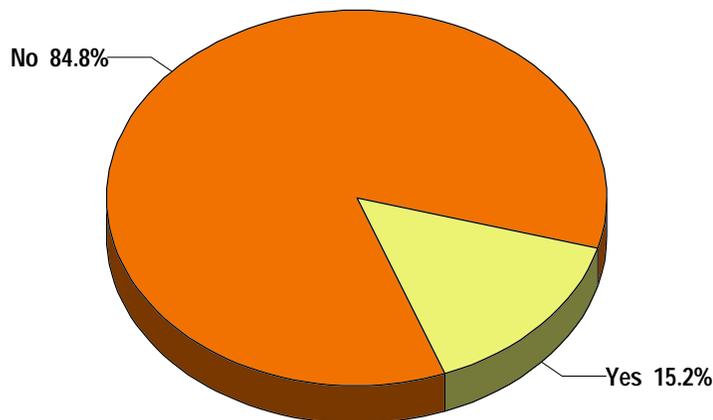
3. Latino survey data was derived from an independent written survey administered one-on-one by various Buncombe County organization representatives among a convenience sample. In interpreting and comparing results, it is important to note that the Latino survey, unlike the countywide telephone survey, was not administered among a random sample of community members. For this reason, the data from these Latino surveys are not incorporated into the overall county percentage, nor in other demographic breakout percentages.

4. Health Choice is available to families with uninsured children through the age of 18 whose incomes are too high for Medicaid but not high enough to afford private coverage.

## Health Check

Another 15.2% of local children are enrolled in Health Check, the state Medicaid program for children aged birth through 21 years old.

## Children Are Enrolled in Health Check (Among Adults With Children Under 18)

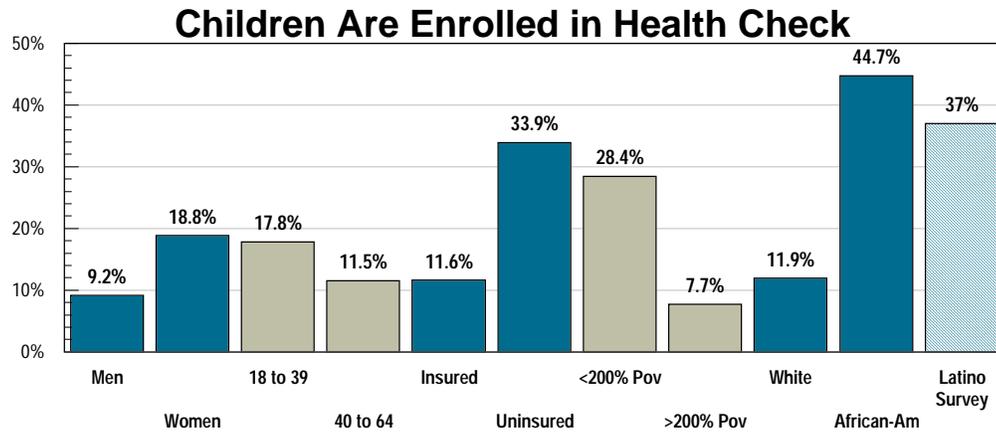


Source: 2000 PRC Community Health Survey, Professional Research Consultants

Notes: 1. Reflects respondents with children under 18.

2. Health Check is the state Medicaid program for children through the age of 21 years old.

This time, enrollment increases to a full 44.7% of African-American families, and is twice as likely to be mentioned among female respondents than among male respondents. Among Latinos, another 37.0% of families report that their children are enrolled in Health Check.



Sources: 1. 2000 PRC Community Health Survey, Professional Research Consultants

2. 2000 Buncombe County Latino Health Survey

Notes: 1. Demographic breakouts are among findings in Buncombe County in 2000.

2. Asked of respondents with children under 18.

3. Latino survey data was derived from an independent written survey administered one-on-one by various Buncombe County organization representatives among a convenience sample. In interpreting and comparing results, it is important to note that the Latino survey, unlike the countywide telephone survey, was not administered among a random sample of community members. For this reason, the data from these Latino surveys are not incorporated into the overall county percentage, nor in other demographic breakout percentages.

4. Health Check is the state Medicaid program for children through the age of 21 years old.

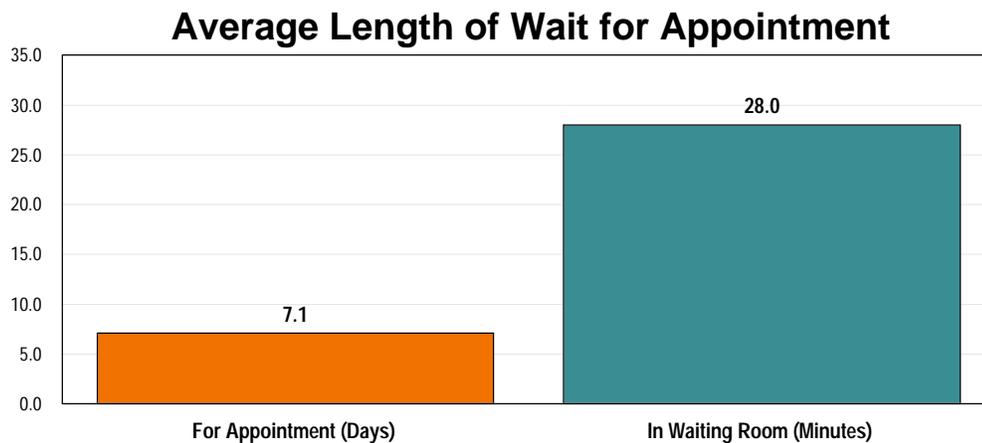
# Barriers to Primary Care

This section examines access to preventive care services, including community members' length of waiting time for appointments, and attempts to access both medical and dental care in the past year.

## Attempts to Access Medical Care

### Length of Wait for Appointment

Buncombe County adults were asked to indicate how long they have to wait for care at their specific facilities. On average, adults wait 7.1 days for an appointment with their medical care provider. Once there, they wait an average of 28 minutes in the waiting room for medical care.

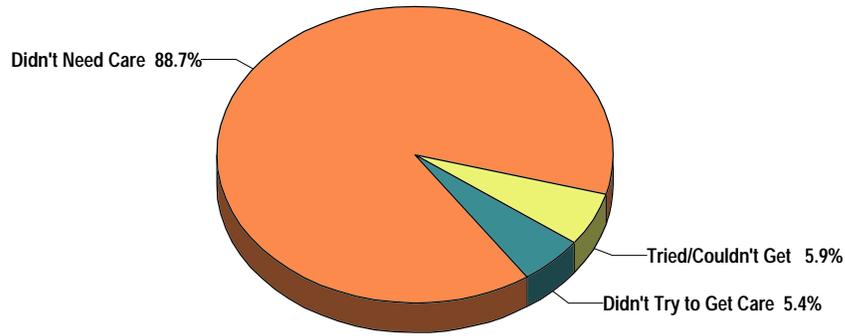


Source: 2000 PRC Community Health Survey, Professional Research Consultants  
Note: Reflects the total sample of respondents.

### Ability to Get Medical Care

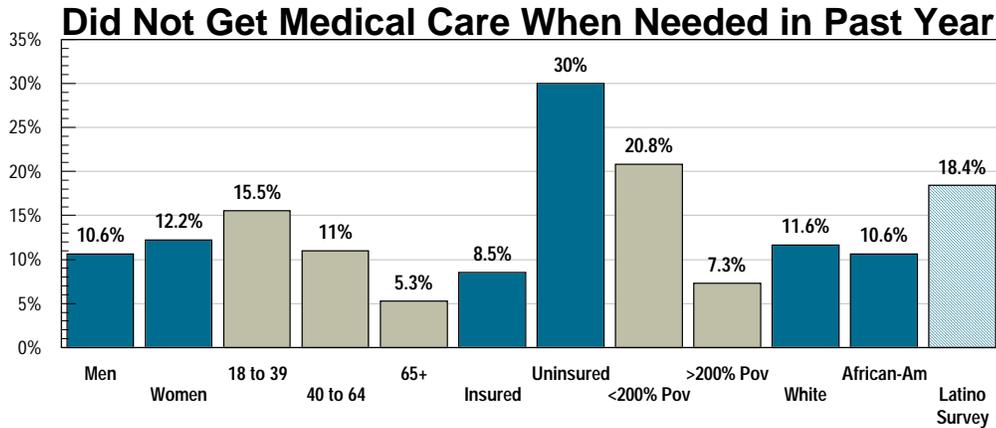
A full 88.7% of local adults report that there was not a time in the past year when they needed medical care but did not receive it. On the other hand, 5.4% of county residents indicate that they needed medical care at some point in the past year, but did not try to obtain it (and therefore did not receive it). The remaining 5.9% of adults tried to get medical care but were unsuccessful.

## Attempts to Get Medical Care in Past Year



Source: 2000 PRC Community Health Survey, Professional Research Consultants  
 Note: Asked of all respondents.

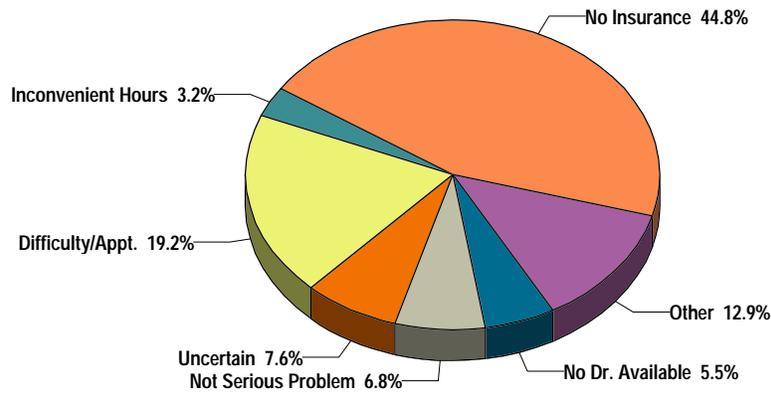
As can be seen in the next graph, uninsured adults, people under 40, and those living in poverty more often report that they did not get medical care when necessary at some point last year. This number is higher (18.4%) among Latinos, as well.



Sources: 1. 2000 PRC Community Health Survey, Professional Research Consultants  
 2. 2000 Buncombe County Latino Health Survey  
 Notes: 1. Demographic breakouts are among findings in Buncombe County in 2000.  
 2. Asked of all respondents.  
 3. Latino survey data was derived from an independent written survey administered one-on-one by various Buncombe County organization representatives among a convenience sample. In interpreting and comparing results, it is important to note that the Latino survey, unlike the countywide telephone survey, was not administered among a random sample of community members. For this reason, the data from these Latino surveys are not incorporated into the overall county percentage, nor in other demographic breakout percentages.

Adults who tried to get medical care in the past year but did not succeed were next asked to give their reason for not obtaining the necessary medical care. As can be seen in the adjacent chart, the largest share of responses (44.8%) was for “no insurance,” followed by “difficulty scheduling an appointment” (mentioned by 19.2%). Another 6.8% indicated that their medical problem was “not serious,” while 5.5% reported that there was “no doctor available” and 3.2% cited problems with *inconvenient office hours*.

**Main Reason No Medical Care**  
 (Among Adults Who Tried to Get Medical Care but Did Not Succeed)



Source: 2000 PRC Community Health Survey, Professional Research Consultants  
 Note: Reflects those people who tried to get medical care in the past year but could not succeed.

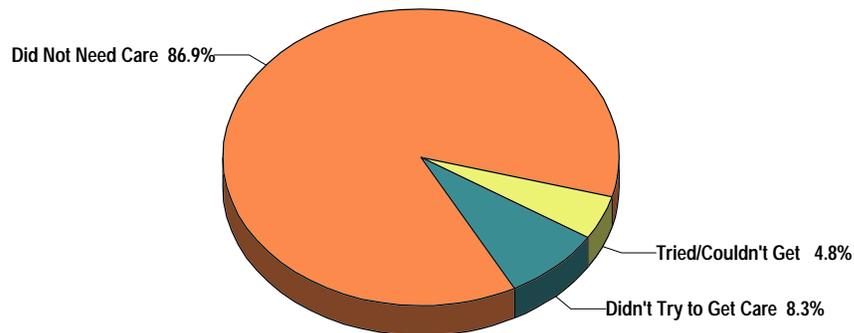
## Attempts to Access Professional Help for Mental Health

*Mental health access issues are outlined in the “Mental Health” section of this report, page 92.*

## Attempts to Access Dental Care

The great majority of adults (86.9%) report that there was not a time in the past year when they needed dental care but did not receive it. On the other hand, 8.3% of county residents indicate that they needed dental care at some point in the past year, but did not try to obtain it (and therefore did not receive it). The remaining 4.8% of adults tried to get dental care but were unsuccessful.

### Attempts to Get Dental Care in Past Year

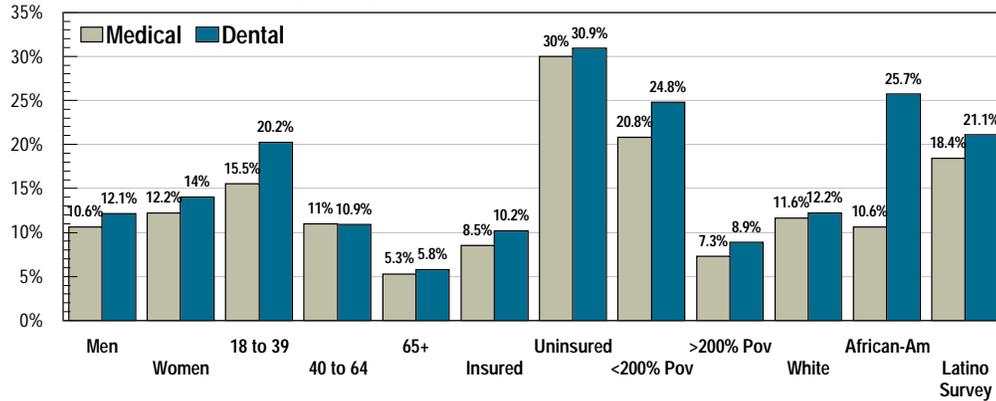


Source: 2000 PRC Community Health Survey, Professional Research Consultants  
Note: Asked of all respondents.

Viewed by demographic characteristics, local adults most likely to report that they did not obtain dental care when they needed it at some point in the past 12 months include adults under 40, African-Americans, uninsured adults, and those in the lower income bracket.

The following chart compares, by demographics, the proportions of residents not receiving needed dental care and medical care (as discussed previously). As shown, in all groups but one, a slightly higher percentage failed to get needed dental care than medical care. However, among African-Americans, two and one-half times as many did not get needed dental care as compared to medical care.

## Did Not Get Care When Needed in Past Year

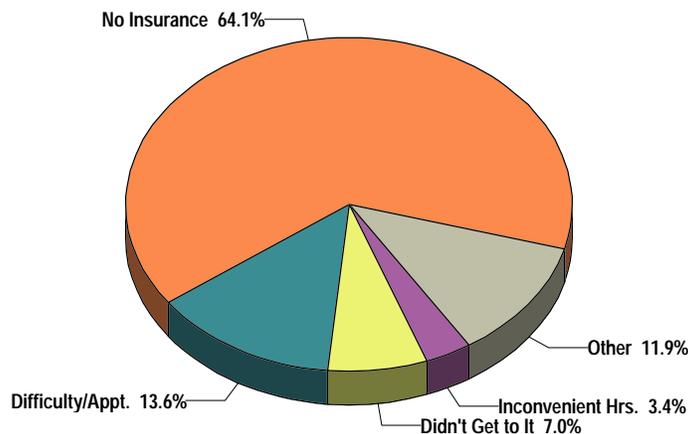


Sources: 1. 2000 PRC Community Health Survey, Professional Research Consultants  
 2. 2000 Buncombe County Latino Health Survey

Notes: 1. Demographic breakouts are among findings in Buncombe County in 2000.  
 2. Asked of those respondents who tried to get dental care in the past year but did not succeed.  
 3. Latino survey data was derived from an independent written survey administered one-on-one by various Buncombe County organization representatives among a convenience sample. In interpreting and comparing results, it is important to note that the Latino survey, unlike the countywide telephone survey, was not administered among a random sample of community members. For this reason, the data from these Latino surveys are not incorporated into the overall county percentage, nor in other demographic breakout percentages.

The adults who tried to obtain dental care in the past year but did not succeed were next asked to give their reason for not obtaining the necessary dental care. As can be seen in the adjacent chart, the largest share of responses (64.1%) was for “no insurance,” followed by “difficulty scheduling an appointment” (mentioned by 13.6%). Another 7.0% indicated that they “just didn’t get to it,” while 3.4% cited problems with *inconvenient office hours*.

## Main Reason Unable to Receive Dental Care (Among Adults Who Tried to Get Dental Care but Did Not Succeed)

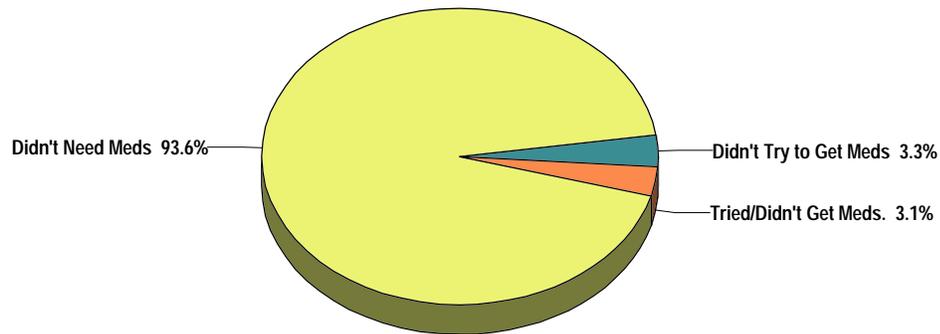


Source: 2000 PRC Community Health Survey, Professional Research Consultants  
 Note: Reflects those people who tried to get dental care but could not succeed.

## Attempts to Obtain Needed Medications

Almost all (93.6%) county residents report that there was not a time in the past year when they needed medication but did not receive it. In contrast, just 3.3% of adults indicate that they needed some type of medication at some point in the past year, but did not try to obtain it. The remaining 3.1% of adults tried to get the needed medication but were unsuccessful.

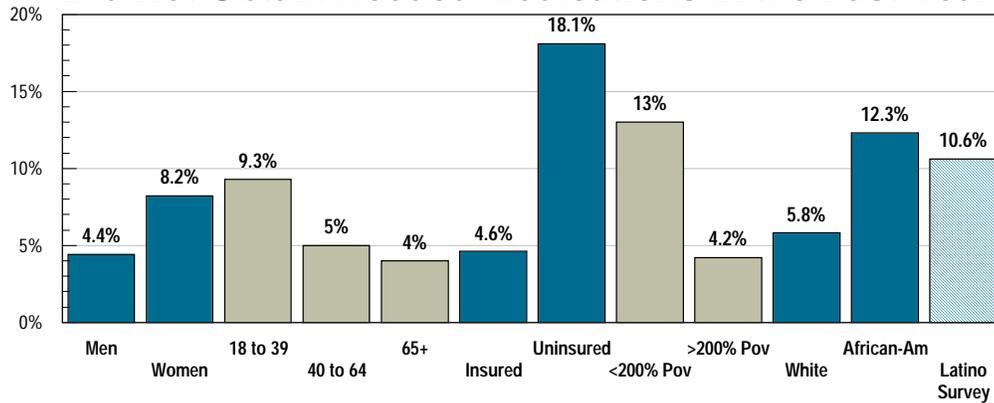
### Experience With Obtaining Medications When Needed in Past Year



Source: 2000 PRC Community Health Survey, Professional Research Consultants  
Note: Asked of all respondents.

Viewed by demographic characteristics, local adults most likely to report that they did not obtain medications that were needed in the past 12 months include African-Americans, adults in the lower income bracket, young adults, women, and those who are uninsured.

## Did Not Obtain Needed Medications in the Past Year



Sources: 1. 2000 PRC Community Health Survey, Professional Research Consultants

2. 2000 Buncombe County Latino Health Survey

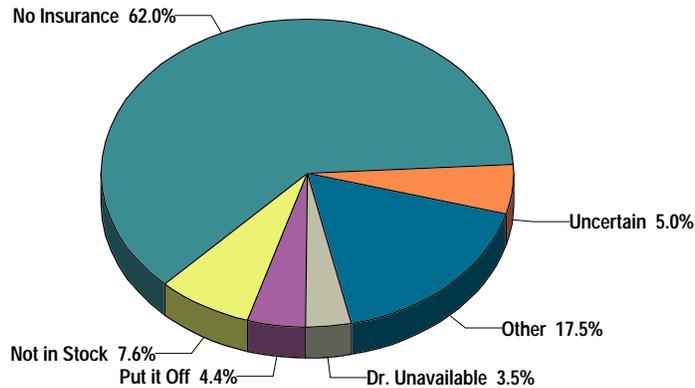
Notes: 1. Demographic breakouts are among findings in Buncombe County in 2000.

2. Asked of those respondents who tried to get medications in the past year but did not succeed.

3. Latino survey data was derived from an independent written survey administered one-on-one by various Buncombe County organization representatives among a convenience sample. In interpreting and comparing results, it is important to note that the Latino survey, unlike the countywide telephone survey, was not administered among a random sample of community members. For this reason, the data from these Latino surveys are not incorporated into the overall county percentage, nor in other demographic breakout percentages.

The adults who tried to obtain medication in the past year but did not succeed were next asked to give their reason for not obtaining the necessary medication. As can be seen in the adjacent chart, the largest share of responses (62.0%) was for “no insurance,” followed by “medication was not in stock” (mentioned by 7.6%). Another 4.4% indicated that they “just put it off,” while 3.5% noted that their physician was *unavailable to write the prescription*.

## Main Reason No Medications (Among Adults Who Did Not Obtain Needed Medications)



Source: 2000 PRC Community Health Survey, Professional Research Consultants

Note: Reflects those people who did not obtain the needed medications.

## Overview of Health Care Barriers

### Perceptions Data\*

#### ***Cost of Health Services***

“We have to somehow not penalize these children (of seasonal farm workers) for being here. They came with their families and they need adequate health care. It’s more expensive for us (all)...in the long run if they do not have proper health care at the beginning. We have got to find a way to get every child basic health care either through a state or federal or a local program.”

“The (diabetic) person may be working, a child may get sick or the main breadwinner comes down with the flu and is out of commission for a week. Then the whole family potentially is derailed because they will never be able to catch up. That means they will either neglect having the (child’s) medication or the needed diabetic medicine, they will neglect having adequate food. So you have multifaceted negatives converging all at the same time because of the economic factors that family finds themselves in.”

#### ***Medications***

“If you have a \$185 or \$305 dollars a month, you can see your doctor and get your scripts for anti-depressants. If you don’t have that much, you can score on the (street) corner and you can get 30 years in jail.”

“Medicines are so expensive, and you do have people who literally do not take what’s prescribed for them because they just cannot afford it. So, I think that is a major issue for a lot of older adults who are not on Medicaid, people who are above the Medicaid amount.”

“Most of our patients (at BCHC) are not very (interested in adopting healthy behaviors). They expect pills, they expect drugs for a cure.”

#### ***Physician Relationships***

“... it’s real hard for people when you don’t have a consistent physician that you see every time. It’s like, ‘Okay, is he going to have to go through all my history again and he really doesn’t know me.’”

#### ***Transportation to Health Care Services***

“I think all the people who are involved with transportation need to come together and talk about what our priorities are, and if our priorities truly are medical transportation then how are we going to prioritize those needs.”

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\* *The Perceptions Data are valuable in identifying issues and providing context to the findings of this assessment. Keep in mind, however, that these qualitative comments are attributable only to those citizens and Key Informants participating in this effort and are not necessarily representative of the study sponsors nor the community at large.*

## ***Discrimination as a Barrier***

The Perceptions Data was reviewed for themes regarding discrimination. In this work, discrimination was defined broadly. It might refer to lack of reasonable services, lack of access to said services, economic differences, loss of appreciation for the wisdom of the aged, or failure to value the safety and security of those unable to care for themselves. It might also refer to subtle attitudes conveyed toward individuals of a different background or sexual orientation than that of the health services provider.

One non-native with over a decade of residency in the area felt it all boiled down to “*growth stress*.” In a “diverse” and “changing” community, the struggles we face seemed like “a clash between the natives and the newcomers, the old and the new.” Intolerance of nonwhites and of those with different religious beliefs was cited by this interviewee. Civic, social, and political activities were sometimes perceived as being off-limits to African-Americans and other minority groups.

“If you walk down Biltmore Avenue, how many Black merchants do you see owning businesses on Biltmore Avenue?”

Another compared this perception with his memories of the black business community of his youth in Asheville: “The good side of segregation was that there were a lot of minority-owned businesses, real estate agents, property appraisers, shoe repairers, a lot of small businesses that don’t exist today for various reasons...I think for African-American professionals, the jobs are few now.”

Another spoke from experience about professional gatherings and retreats: “When we do retreats and we have fifty people and only two African-Americans, I’d say there is definitely not enough upper-crust employment [available to minorities].”

Health care was not without criticism, for lack of professional jobs occupied by minorities, and for lack of sensitivity to the concerns of nonwhites and of immigrants. While there was an almost universal sentiment that positive change was occurring incrementally, feelings of disenfranchisement remained.

“We have a challenge to make sure that all of the community gets the care.”

“There’s some feeling that the health care system doesn’t really care, that you don’t get good treatment because you’re an African-American and you go to a free clinic.”

## ***Barriers for Lesbians & Gays***

According to the perceptions of Key Informants, Buncombe County has a relatively large and active Gay and Lesbian community. In the Gay/Lesbian community, mental health issues surfaced as a primary concern; the stress of living as a gay person in this society was cited as a health risk factor by several Key Informants. Lack of acceptance or a feeling of

isolation sometimes contributes to substance abuse and/or depression. Acceptance by health care providers is especially important to lesbians and gays.

“It has great potential to support their healing.”

There is a desire for equal rights among those who have a same sex committed partnership. These rights include: property and financial rights from home ownership to check accounts to will enforcement, inheritance and tax consequences. Additionally, homosexuals require job security, health insurance for committed partners/families with children, and courtesy and rights afforded to their significant others in medical situations. Among men who have sex with men, there is need for increased education regarding HIV/AIDS.

“The community should be more active about kids and AIDS. It should be a priority that kids and teens have whatever prevention is available.”

### **Language Barriers**

The foremost need expressed by non-English-speaking peoples was the need for more bilingual professionals and service providers. Until this is accomplished, there will need to be an effort to have more interpreters available. Sometimes interpreters are needed on short notice especially for situations such as sick visits to doctors or clinics and admission to hospitals.

Put succinctly by one businesswoman: “Not enough people in the health profession speak a language other than English and too many people in the community speak one language and it's not English.”

The Russian/Ukrainian and Asian communities share with the Latinos the value that children should be respectful and obedient to parents. There are well-defined roles for both parent and child. The language barrier has sometimes forced children, who are learning English at school faster than a parent may be learning it at home or at work, to interpret for adults in a health care situation. This is viewed as a problem throughout the non-English-speaking cultures. Two of those interviewed mentioned the trend of mothers having to take “8 year-old sons and daughters” to interpret at medical visits.

“There may be things that are going to be discussed that should be privileged information between adults, between a woman and her doctor. Instead, this woman may have to use her child as an interpreter. That, for us, is a cultural no-no. To put the power that one would have as an adult and a parent into the hand of a child [is culturally unacceptable].”

Though a professional interpreter is viewed as more acceptable than having one's child interpret, most people felt that the best solution was to encourage professionals to learn foreign languages, and to recruit new professionals who are bilingual.

“Until we get to that point, I think there really has to be some type of stress or pressure put on organizations to provide professional translators and interpreters.”

“I talk to a lot of people who work for agencies and organizations who feel tremendously overworked because they’re being depended on to do the translating and interpreting. This may not even fall in their job description. They may not be getting paid extra for it, but they’re doing it because they want to maintain their commitment to their employer, and because they want to help the community.”

Getting health information out to communities in their native languages, both in printed format and in the form of media reports, was also considered an important component of health care and prevention. There was acknowledgement that many agencies are wise to this and working on the problem, but that much room for progress remained. Some voiced disillusionment toward the major media outlets in print and electronic media because there is little being done to develop Spanish language media.

“I think some agencies in the community are making some excellent efforts to bridge the language gap. However, because we don’t have any Spanish language media in this area, there is almost no way for people who are in a service related agency to say to the Latino community, ‘Here we are. We have Spanish speakers—we are trying to meet your needs,’” says one Latino resident.

She elaborates, “I would like to see public affairs programs or health affairs programs on the radio, on the television, in the newspaper or the cable network [in Spanish]. We can’t even get health programs that are coming out of Atlanta or Chicago or Houston or New York that are in our language...and for those who are not literate even in their own language, whether English or Spanish, that message has to come to them through electronic media.”

Another interviewee understood the reality of the language barrier, but also saw a “complexity barrier” of sorts.

“I think our health care system has gotten so complex, it’s difficult for even Americans to understand it, let alone immigrants. And, I think, for the elderly and for people with lower education, trying to understand the system and how it works is a real challenge.”

Some were concerned that 911 service had no phone intake personnel who were bilingual, so that immigrants who speak only a foreign language are reluctant to call and report violence or emergency needs.

### ***Cultural Barriers***

“I think the most long lasting intervention that could occur is raising community awareness and cultural sensitivity...understanding people’s cultural perspective...their uniqueness and background.”

Cultural sensitivity was regarded as an important value to be sought in delivery of services within the community. For example, a minority leader was asked, “When someone from

the majority population comes to you and asks, ‘What can I do to better understand the needs of the minority’, what do you say to them?” This was the response:

“I would say we would need to get close to the person or to the area, the needs that you’re concerned about so that you understand it. I think there is a difference between understanding a person’s need and having acceptance of that need. Now what I mean by that is, a person who is in a position of needing a service...we can always look back and say, ‘if that person had done so and so or if their parents had done so and so, then the person wouldn’t be in that position. Well, we don’t have any control of that so we must accept them as they are and then try to make it better...that’s not to say that people should not be responsible for their own actions...but I think we must move from this point forward.”

Public service agencies, private nonprofit organizations, government agencies, and health care facilities were encouraged to develop programs for helping employees deal with the many cultures present in the community.

Said one person who works among diverse communities, “I think, for our health care professionals, the diversity is a blessing, but we need to work at helping folks understand cultural differences...not everyone is going to see or hear things the way that you are used to seeing and hearing them. That goes from a rural White person to an African-American to a Cherokee person, as well as our immigrants—any people of color.”

### ***Age & Poverty***

Age and poverty know no skin color nor ethnic affiliation. Many spoke of older adults having to choose between buying food, paying for rent or utilities, and buying medicines, because the cost of medications precludes doing both. Poor pay for CNAs, poor transportation, and federal legislation which cut home health care reimbursement, all conspired to create more aged adults who need home care aides but can’t get them.

Said one person with expertise in care of the elderly: “Sometimes being elderly is a disability in itself.”

Another, frustrated with lack of insurance for some, and “red-tape” in coverage for others said, “Health care needs to be left up to the care providers instead of the insurance companies!”

“*My heart goes out to her...*” said a neighbor of one senior who struggles with chronic kidney failure alone at home, with few resources.

# NEEDS OF SPECIAL POPULATIONS

# Children & Youth

## Perceptions Data\*

“I think that in the county we have some very brilliant young people. Very, very imaginative young people. Young people who really care about the future of this world.”

“Everybody always overlooks the children and their attitudes coming up. Our future society is going to be based on the attitudes of these children and how they’re treated. People have to be concerned about every child that is in our community.”

“Minority children need help resisting peer pressure.”

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\* *The Perceptions Data are valuable in identifying issues and providing context to the findings of this assessment. Keep in mind, however, that these qualitative comments are attributable only to those citizens and Key Informants participating in this effort and are not necessarily representative of the study sponsors nor the community at large.*

# Older Populations

## Senior Survey Findings

**Frail Elderly.** The following highlights the findings of the *2000 Buncombe County Senior Survey* administered one-on-one to a convenience sample of 75 residents aged 65 and older who were homebound or who lived in a senior housing complex. Due to the population targeted, these findings are more descriptive of the frail elderly in Buncombe County, rather than of the senior population at large. Also, keep in mind that the maximum error rate associated with this small sample is  $\pm 11\%$  at the 95 percent confidence level. A full description of the methodology for the special senior survey can be found on page 36.

**Senior Population At Large.** *[Where available, comparisons to findings among the random sample of older adults reached through the telephone survey are provided, shown in italics. Note that the findings from the telephone survey are more representative of the senior population at large.]*

## Demographic Characteristics

### *Age & Race*

- Frail elderly respondents range in age from 63 to 97.
- Most (71%) of the frail elderly are White, while 29% are African-American.

### *Education*

- 44% of frail elderly survey participants have not completed a high school education. 56% have a high school diploma, including 16% who have had schooling beyond high school.

### *Marital Status*

- 23% are currently married, while 56% are widowed, 13% are separated or divorced, and 8% have never been married.

## Health Status

### *General Health*

- 17% of frail elderly survey participants characterize their general health as “excellent” or “very good,” while 53% characterize it as “fair” or “poor.” *[In the random telephone survey — which is more representative of the senior population at large — respondents were notably healthier, with only 29.3% reporting “fair/poor” health.]*

## *Aspects of Mental Health in the Past Month*

- Reflecting on the past four weeks, almost 9 in 10 frail elderly are basically satisfied with their lives, are in good spirits or feel happy “most of the time,” and think that “it is wonderful to be alive now.”
- On the other hand, 53% of frail elderly prefer to stay at home rather than go out and do new things, and 60% do not feel full of energy.
- Approximately 3 in 10 frail elderly survey respondents have dropped many of their activities and interests, and report that they “often get bored” or “often feel helpless.”
- A total of 23% of frail elderly reported that they “feel pretty worthless the way they are now” and 19% feel that their lives are empty. Another 19% feel that they have more problems with memory than most, and 15% feel that most people are better off than they are.
- Sadly, 11% of frail elderly feel that their situation is “hopeless,” and 8% are afraid that something “bad” is going to happen to them.

## *Chronic Conditions*

- According to the survey, frail elderly respondents have been diagnosed or had problems with the following chronic medical conditions: **difficulty walking** (69%); **arthritis** (69%); **pain problems** (61%); **high blood pressure or hypertension** (56%); **heart disease** (45.9%); **prostate trouble** (among males; 35%); **incontinence or inability to hold the urine** (35%); **dizziness** (33%); **high blood sugar or diabetes** (22%); **falling** (21%), **cancer** (19%), and **lung disease** (18%). [*The random sample of seniors in the telephone survey noted markedly lower prevalence for some of these conditions, such as arthritis (51.6%), pain problems (25.2%), and incontinence or inability to hold the urine (25.6%).*]

## Modifiable Health Risks

### *Nutrition*

- Almost all frail elderly respondents (95%) eat two or more meals on most days.
- Another two-thirds (67%) of frail elderly drink five to six glasses of water on most days.
- 45% of frail elderly survey participants indicate that their appetite has changed in the past year. Of these, 65% report that it has decreased, while the remaining 35% indicate that their appetite has increased in the past year.
- In addition, just under one-half (49%) of frail elderly respondents have gained or lost more than 10 pounds in the last year.

## **Alcohol & Tobacco Use**

- More than one-fifth (23%) of frail elderly use tobacco in some form. Of those who do not currently use tobacco, 43% report that they used to use it in the past. Two-thirds of these people gave it up because of their health. *[Tobacco use among the random sample of older adults in the telephone survey was much lower (11.4%).]*
- Just 11% of frail elderly have two or more drinks of alcohol three or more times weekly. Of these, all say they would know where to seek help if they decided to stop drinking.
- Among the frail elderly who drink at least two drinks three times weekly, 38% (or three people) have tried to stop drinking. Of these three, one got sick when trying to quit.

## **Activity Limitations**

- While only 7% of frail elderly survey participants use a wheelchair to get around, another 27% consider themselves to be housebound. All five of the wheelchair users report relying on their wheelchairs both inside and outside their homes.
- Almost all (95%) of the frail elderly survey participants report that they can **bathe** for themselves. More than 8 in 10 frail elderly can take care of their own **money** or do their own **laundry**. Somewhat fewer (74%) cook, while two-thirds report that they are capable of **cleaning** their own homes or **grocery shopping**.
- 77% of frail elderly survey respondents indicate that they have someone to help out when needed; of these, 32% mentioned that they can depend on an **adult child or family member**, while 19% mentioned a **spouse** and 17% rely on a **paid aide**.
- When asked about transportation, one-fourth of the frail elderly report that they drive themselves when they need to get somewhere. Another 36% rely on friends or family members. Most others mentioned using some type of public transportation.

## **Domestic Violence**

- Only one frail elderly survey respondent indicated being concerned or afraid that someone they live with or are close to might hurt them. *[In the random telephone survey, 4.0% of older adults report that they have ever been hit, punched, kicked, threatened or hurt by a family member or someone close to them.]*

## **Prevention**

### **Utilization of Primary Care Services**

- A total of 8 in 10 frail elderly have a family physician; of these, 97% have been seen by their physicians or in the physician's clinic in the past year. Frail elderly without a

family physician were asked to indicate whether they use the health department clinic (three-fourths of these people responded affirmatively). *[Among the random sample of older adults in the telephone survey, 93.1% report that they have a primary care physician for their medical needs.]*

- Just over 1 in 3 frail elderly has been to an emergency room in the past year, averaging 1.8 trips for medical care. *[In the random telephone survey, 24.2% of older adults report that they have had an emergency room visit in the past year.]*

### **Dental Care**

- In the past year, 44% of frail elderly survey participants have been to the dentist for care *[versus 53.5% among older adults in the random telephone survey]*. The majority (68%) of frail elderly reported that they are able to afford dental care if and when they need it.

### **Prescription Medications**

- 21% of the frail elderly report taking one or two prescription medications *[32.0% in the random telephone survey]*. Another 24% take three prescription medications, while 33% report that they take four to six medications. The remaining one-fifth of frail elderly currently take between seven and eleven prescription medications.
- In the past year, 10% of frail elderly respondents wanted a prescription medication but did not get it at that time *[3.9% in the random telephone survey]*. Of these seven, six tried to obtain the medication but did not succeed. Most gave “insurance” or “cost” as their reason for not receiving the needed prescription medication.
- 86% of frail elderly indicate that they always tell their family physician when another doctor gives them a prescription.

### **Immunization**

- 74% of frail elderly survey participants report that they have had a flu shot in the past year *[70.2% in the random telephone survey]*; in addition, 65% report that they have ever had a pneumonia vaccine *[64.0% in the random telephone survey]*.
- Somewhat fewer frail elderly (45%) have had a tetanus booster shot in the last 10 years.

### **Access to Care**

#### **Insurance Coverage**

- Among frail elderly survey participants, 37% carry Medicare plus a supplemental insurance policy to cover health care costs *[72.1% in the random telephone survey]*. Another 24% rely on both Medicare and Medicaid *[7.3% in the random telephone survey]*,

while 16% are covered by Medicare alone [8.9% in the random telephone survey] and 4% have a combination of Medicare and Blue Cross/Blue Shield.

- Among the 64 frail elderly with supplemental insurance, 64% indicate that their supplement covers prescription drugs [58.9% in the random telephone survey].

## Perceptions Data\*

With the older population growing fast and becoming more frail, there are many needs to be met, such as a need for more in-home services to provide care, nutrition and companionship. More senior-oriented services are needed at Primary Care Facilities, such as human rather than automated phone operators and providers who can communicate effectively with an aging population.

“(There is) a critical need for more staff in these (nursing and adult care) homes. If there are not enough people to provide care then people do not get the adequacy of care that they require.”

“I have seen so many instances of older adults coming away from medical appointments which are pretty important to them, misunderstanding completely what went on during that visit, not understanding why they are being asked to do certain things to improve their health or to take certain medications. They are not able to challenge the doctors and they are not able to ask the kinds of questions that they have.”

“When we need to help an older adult who has gotten too frail to maintain independence...and they are on Medicaid...it’s pretty doggoned hard to find a decent place them (adult care home). We have some very poor operators in this county and very few that I would feel comfortable recommending to a family.”

“In the African-American community, very seldom do you see a lot of long term care. African-Americans prefer keeping them (elderly family members who are sick at home)...that’s beginning to be difficult because patients are getting sicker, their families are not being able to take care of them and there are not good resources here.”

“I have come to admire tremendously the informal network of support that older adults give each other.”

Says one geriatric nurse, “Poverty is a huge problem among the elderly.”

The other major factor in the health of an aging population: frailty.

“My own feeling is that frailty as a phenomenon in aging is a great equalizer. Frailty is defined as loss of function and therefore some degree of dependence on others. When that kicks in, it’s pretty hard to tell the haves from the have nots.”

\* The Perceptions Data are valuable in identifying issues and providing context to the findings of this assessment. Keep in mind, however, that these qualitative comments are attributable only to those citizens and Key Informants participating in this effort and are not necessarily representative of the study sponsors nor the community at large.

“[Seniors with economic frailty] have an *extra* disease. It’s called the disease of poverty...it causes them to have a more rapid decline during aging...they may be chronologically younger but disease-wise older than their counterparts who haven’t had poverty and the diseases that go along with poverty. Like alcoholism, tobacco addiction, malnutrition, starvation, untreated hypertension and therefore earlier congestive heart failure.”

One elder specialist commented dryly: “When we have low-income elderly in this county who move from being able to live independently to having to go to the next level of care, in North Carolina it’s called an Adult Care Home. Only, if you have money, it’s called Assisted Living [the higher end alternative to adult care homes].” She also states that it’s difficult to find a “decent place” in the way of a care home for seniors who have Medicaid, or worse, no Medicaid and no money.

“The next ten years are going to be very scary for low-income older adults who don’t have the wherewithal to buy it [home care].”

A final insult to seniors is that, while the area has a general surplus of physician specialists, including pediatricians who handle medical care at the beginning of life, there is not a single geriatrician [specialist in care of elderly and end-of-life issues] in private practice available to the general public in the Asheville/Buncombe County area.

Advocates for the elderly spoke about the needs of children, and advocates for children cared about quality of life among the elderly, whether they could afford medications and food. Some were firm about not letting politicians frame all progress for one population as an affront to another.

“I’m tired of hearing that we can’t take care of the elderly without taking away from the children...it can’t be about that. It has to be about a culture change. It has to be about supporting families, even nontraditional families, and coming back into communities and churches and making opportunities for intergenerational connections.”

Some complaints might better be termed as insensitivity to the developmental needs of seniors. Says one provider activist:

“I don’t think 15 minutes is long enough for an older adult to have a beneficial visit with a health care practitioner.”

She also wishes the communication dynamics of health visits could be altered so that seniors could ask questions, receive real answers they can understand, and leave a visit knowing what they are supposed to do. She would encourage the elderly to “prepare themselves ahead by writing down their questions” and “be assertive enough to ask the doctor to stay until their questions get resolved.”

And to providers, she sends this alert: “Get rid of their automated phone system, the things where there is no human available and there’s a long litany of instructions...Put a human back on the phone and it would be nice if it were a polite human.”

### *Home Health Care*

“People are discharged quicker and sicker from the hospital. Medicare made some changes in Home Health because we all want to save Medicare dollars, so they are no longer funding things that they used to fund for older adults that would help keep them at home.”

### *Disability*

“I think we need more resources to keep people at home.”

“There are quite a few people who are disabled (living in this area). As far as I know, if they are persistent long enough, eventually they will get a hearing.”

“Agencies have to work together.”

“People are treated — they’re humiliated, they’re beggars, you know — and they’re treated in that fashion instead of with respect.”

# African-American

## Survey Findings Among African-American Adults

The *2000 Buncombe County Community Health Survey* targeted a total of 115 telephone interviews with African-American adults. This sample includes 35 contacted through the random sampling procedure, plus 80 additional interviews conducted as an oversampling of this population. The maximum error rate associated with a sample of this size is  $\pm 9.1\%$  at the 95 percent confidence level.

### Demographic Characteristics

#### *Residence & Household Members*

- 53% of African-American survey participants live in the 28801 ZIP Code; 20% live in ZIP Code 28803; 15% live in ZIP Code 28806.
- 43% of African-American respondents live in households with children.
- Most African-American respondents (92%) live in a household of three people or fewer.

#### *Gender & Age*

- African-American respondents are 59% female, 41% male.
- 39% of African-American survey participants are between the ages of 18 and 39. 36% are aged 40 to 64, and 25% are aged 65 or older.

#### *Employment, Education & Income*

- 49% of African-American respondents are currently employed for wages, while 7% are out of work, and 84% are unable to work. A full 24% are retired.
- 50% of African-American survey participants have not completed a high school education. 50% have a high school diploma, including 35% who have had schooling beyond high school.
- 30% of African-American survey participants live below the poverty level; 24% live just above, but less than twice, the poverty level.

## ***Marital Status***

- 37% are currently married, while 39% are widowed, separated or divorced, and 24% have never been married.

## **Health Status**

### ***General Health***

- 34% of African-American survey participants characterize their general health as “excellent” or “very good,” while 28% characterize it as “fair” or “poor”.

### ***Mental Health & Depression***

- 35% of African-American respondents report that they have had a period of two weeks or longer in the past year during which they felt sad, blue, depressed, or lost all interest or pleasure in things they usually cared about or enjoyed.

### ***Chronic Conditions***

- African-American respondents have been diagnosed with or treated for the following: **arthritis or rheumatism (22%); chronic back problems, headache or other pain (19%); diabetes (17%); loss of hearing or vision (16%); chronic problems with urination, chronic bladder infections, prostate problems, incontinence or inability to hold the urine (16%); asthma, emphysema or chronic bronchitis (13%); stomach ulcer, chronic inflamed bowel, enteritis or colitis (6%); heart disease (6%); cancer (6%); and a neurological problem (3%).**

## **Modifiable Health Risks**

### ***High Blood Pressure & Cholesterol***

- 91% of African-American survey participants have had their blood pressure checked by a health professional in the past five years. 46% have been told that they have high blood pressure, 78% of whom currently take medication to control hypertension.
- 24% of African-American respondents have been told they have high cholesterol; 24% have never had their cholesterol checked.

### ***Alcohol & Tobacco Use***

- A full 36% of African-American respondents currently smoke cigarettes. A total of 37% live or work with someone who smokes around them (32% among nonsmokers).
- 1% of African-American survey participants currently use a smokeless tobacco product, such as chewing tobacco or snuff.

- 40% of African-American respondents currently drink alcohol, and 3% average two or more drinks per day (chronic drinkers). 17% have consumed five or more drinks on any one occasion in the past month (binge drinkers).

### ***Nutrition***

- The following proportions of African-American respondents report “always or often” practicing the following healthy eating habits: **eating two or more vegetables at the main meal** (70%); **eating only fruit for dessert** (31%); **eating chicken or poultry without the skin** (61%).
- 40% of African-American survey participants drink regular or **whole milk**, while 31% drink low-fat or **2% milk**, 13% drink **1% or skim milk**. (11% don’t drink milk at all.)
- Most (63%) of African-American survey participants characterize their diet as "medium" in fat content. 16% report "high-fat" diets, while 21% report "low-fat" diets. (Note that these are self-reported, and the terms are self-defined.)
- Just 11% of African-Americans report eating the recommended five fruits and/or vegetables on a daily basis.

### ***Physical Activity***

- 67% of African-American respondents report participating in some type of physical activity (outside of their job duties) in the past month, mostly walking.
- 33% of African-American respondents have had no leisure-time physical activity in the past month.

### ***Overweight***

- By reported heights and weights, 65% of African-American survey participants are overweight. Among these, 48% are trying to lose weight.

### ***Domestic Violence***

- 8% of African-American respondents report that someone close to them has hit, punched, kicked, threatened or hurt them in some way at some time in the past. 1% report that this has happened in the past year.

### ***Prevention***

#### ***Utilization of Primary Care Services***

- 12% of African-American respondents report that they do not have a place they usually go, such as a doctor’s office or clinic, when they are sick or need advice about their

health (other than a hospital emergency room). Most say it is because they have no insurance and/or cannot afford the care.

- 77% of African-American respondents have a personal physician. 76% have been to see a physician for a routine checkup in the past year.
- 31% of African-American respondents have been to a hospital emergency room in the past year. 63% have been in the past five years.

### ***Dental Care***

- 49% of African-American survey participants have dental insurance coverage for themselves; a larger number (62%) of those with children have dental insurance coverage for their children.
- 74% of African-American respondents report that they have had permanent teeth removed due to tooth decay or gum disease.

### ***Mental Health Care***

- Only 2% of African-American respondents have ever used or tried to use a service or program for people with mental or emotional problems.

### ***Alternative/Complementary Health Care***

- 10% of African-American survey participants report that they sometimes seek alternative or complementary health care before using a formal health care provider; 18% report using some kind of herbal remedy when they are not feeling well or to maintain their health.
- In the past year, African-American respondents have used the following types of health care providers: physician (75%); dentist (36%); therapeutic massage therapist (6%); and a chiropractor (4%).

### ***Women's Cancer Screenings***

- Of those African-American women respondents aged 40 and older, almost three-fourths have had a mammogram in the past two years.
- 99% of African-American women respondents have had a Pap smear to test for cancer of the cervix, nearly two-thirds of which were done in the past year.

## *Immunization*

- 52% of African-American survey participants aged 65 and older have had a flu shot in the past year . Only 39% of African-American seniors have ever had a pneumonia vaccine.

## *Access to Care*

### *Insurance Coverage*

- 83% of employed African-American respondents report that their employer offers health coverage as a benefit; 65% of these individuals take advantage of this (most of whom state that the premium cost is split between employer and employee).
- Among African-American survey participants aged 18 to 64, 30% report that they have no type of insurance coverage (public or private) for health care costs.
- 45% of African-American respondents with children state that their children are enrolled in Health Check, the state Medicaid program. 32.4% state that their children are enrolled in North Carolina Health Choice.

### *Barriers to Health Care Access*

- African-American respondents report an average 5-day wait for an appointment at their doctor's office or at the clinic; in the waiting room, they report an average 25-minute wait to see a medical person.
- 11% of African-American respondents report that there was a time in the past year when they wanted to get **medical care**, but did not. Just under 6 in 10 of these individuals say they tried to get care, but could not due to such factors as a lack of insurance, difficulty getting an appointment, and inconvenient office hours.
- A full 59% of African-American respondents currently take one or more prescription medicines. 12.3% of respondents report that there was a time in the past year when they wanted a **prescribed medicine** but did not get it. Three-fourths of these individuals say they tried, but could not get the medicine due mainly to factors relating to cost or lack of insurance.
- 26% of African-American respondents report that there was a time in the past year when they wanted to get **dental care**, but did not. A total of 4 in 10 of these individuals say they tried to get care, but could not, mostly due to cost/lack of insurance or a dislike of dentists.

- Just 2% of African-American respondents say that there was a time in the past year when they wanted **mental health care** or counseling, but did not get it at that time.

## Perceptions Data\*

African-Americans are now becoming more aware of their health risks. Some comments reflect positive changes in diet and physical activity. Others feel there has been little improvement through healthy diet and lifestyle. Most of those interviewed, regardless of their ethnic background, voiced awareness that hypertension, heart disease, and diabetes were high among African-American males.

“African-Americans are a diverse groups. There are proud accomplished middle class professional people as well as folks that are struggling and living in high crime areas. (They are concerned about) kids, gangs, drugs, dropout rate, and longing for decent jobs that will keep their children in their home community.”

“Economic problems are the greatest (problems). You have families,...that are working sometimes three jobs to try to supply the basic necessities of life.”

“We ought to deal with the social inequities that divide and sometimes even destroy families. If you’ve got a husband and a wife working two and three jobs, that means they have very little time to spend with the children. They’re not going to be able to focus on the children and nurture them and give them the kind of added nurturing that will make them good students in school and good and vibrant citizens ultimately in the community.”

“The dead end jobs...it goes back to the school system. Instead of passing someone along, make sure they’re getting a good education. Have job opportunities out there for them and nurturing, stepping in and trying to say (dealing drugs) is not that glamorous life.”

“I think that schools should begin to look at being intentional about designing curriculums that will speak to the needs of the community.”

There is a lack of positive role models for many young adults.

“Many of these kids are looking for a chance to excel...when they were coming up they didn’t have any kind of role model; they didn’t have anybody to look up to.”

### **Strengths**

African-Americans see the church as a major resource and a source of strength. Ministers and personal faith and/or devotion to God are often cited as sources of strength. The respondents also commented frequently on the strength of the family and females within the family.

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“We see children being born to crack mothers, with weight problems, not a balanced meal, going to school hungry, we’ll see a lot of these things corrected but not until we do what we need to do at our church.”

“In the African-American community, church seems to be the stronghold that gets you through the tough times.”

“I go to church myself, so I think it is like fuel. It gives you strength or encouragement to do what you have to do.”

“They (churches) should take care of people that can’t take care of themselves.”

“The churches are a great area of communication and networking (for getting information out to the public about community events and services).”

“Come as you are, this is where you find solace, this is where you find sanctuary. I think opening yourself up to that and allowing God to make the changes and not you make the changes is what is really making the changes in young people and people across this city.”

# Latino & Immigrants

## Latino Survey Findings

The following highlights the findings of the *2000 Buncombe County Latino Survey* administered one-on-one to 92 Latino residents. The maximum error rate associated with a sample of this size is  $\pm 10\%$  at the 95 percent confidence level. A full description of the methodology for this survey can be found on page 36.

### Demographic Characteristics

#### *Residence & Household Members*

- 46% of participants in the specialized Latino survey live in the 28806 ZIP Code; 19.8% live in ZIP Code 28803; 12.1% live in ZIP Code 28804.
- 74% of participants in the specialized Latino survey have lived in Buncombe County for one year or longer.
- 74% of participants in the specialized Latino survey live in households with children.
- Respondents in the specialized Latino survey report an average of 4.4 persons living in their household (3.4 immediate family members).

#### *Gender & Age*

- Respondents in the specialized Latino survey are 66% female, 34% male.
- Two-thirds (68%) of participants in the specialized Latino survey are between the ages of 18 and 39. 25% are aged 40 to 64, and 7% are aged 65 or older.

#### *Employment, Education & Income*

- 60% of participants in the specialized Latino survey are currently employed for wages, while 16% are out of work, and 7% are unable to work.
- 49% of participants in the specialized Latino survey have not completed a high school education. 51% have a high school diploma, including 32% who have had schooling beyond high school.
- 36% of participants in the specialized Latino survey live below the poverty level; 22% live just above, but less than twice, the poverty level.

## ***Marital Status***

- 53% of participants in the specialized Latino survey are currently married, while 16% are widowed, separated or divorced, and 27% have never been married.

## ***Country of Origin***

- 62% of participants in the specialized Latino survey identify Mexico as their country of origin; other countries receiving multiple mention include Colombia, El Salvador and Chile.

## **Health Status**

### ***General Health***

- 43% of participants in the specialized Latino survey characterize their general health as “excellent” or “very good,” while 19% characterize it as “fair” (none responded “poor”).

### ***Mental Health & Depression***

- 16% of participants in the specialized Latino survey report that they have had a period of two weeks or longer in the past year during which they felt sad, blue, depressed, or lost all interest or pleasure in things they usually cared about or enjoyed.

### ***Chronic Conditions***

- In the past three years, respondents in the specialized Latino survey have been diagnosed with or treated for the following: **loss of hearing or vision (19%); hypertension (18%); arthritis or rheumatism (12%); chronic back problems, headache or other pain (11%); stomach ulcer, chronic inflamed bowel, enteritis or colitis (10%); heart disease (4%); chronic problems with urination, chronic bladder infections, prostate problems, incontinence or inability to hold the urine (4%); asthma, emphysema or chronic bronchitis (3%); diabetes (3%); and cancer (1%).**

## **Modifiable Health Risks**

### ***Nutrition***

- The following proportions of respondents in the specialized Latino survey report “always or often” practicing the following healthy eating habits: **eating two or more vegetables at the main meal (46%); eating only fruit for dessert (41%); eating chicken or poultry without the skin (16%).**
- 71% of participants in the specialized Latino survey drink regular or **whole milk**, while 17% drink low-fat or **2% milk**, 5% drink **1% or skim milk**. (7% don’t drink milk at all.)

- Most participants in the specialized Latino survey (67%) characterize their diet as "medium" in fat content. 6% report "high-fat" diets, while 28% report "low-fat" diets. (Note that these are self-reported, and the terms are self-defined.)

### ***Physical Activity***

- 56% of participants in the specialized Latino survey report participating in some type of physical activity (outside of their job duties) in the past month, mostly walking.
- 44% of participants in the specialized Latino survey have had no leisure-time physical activity in the past month.

### ***Overweight***

- By reported heights and weights, 58% of participants in the specialized Latino survey are overweight. Among these persons, 46% are trying to lose weight.

### ***Alcohol & Tobacco Use***

- Only 7% of participants in the specialized Latino survey currently smoke cigarettes. However, 37% live or work with someone who smokes around them (35% among nonsmokers).
- 4% of participants in the specialized Latino survey currently use a smokeless tobacco product, such as chewing tobacco or snuff.
- 28% of participants in the specialized Latino survey currently drink alcohol, and 5% average two or more drinks per day (chronic drinkers). 9% have consumed five or more drinks on any one occasion in the past month (binge drinkers).

### ***High Blood Pressure & Cholesterol***

- 88% of participants in the specialized Latino survey have had their blood pressure checked by a health professional in the past five years. 18% of respondents have been told in the past three years that they have high blood pressure, and 13% currently take medication to control hypertension.
- 10% of participants in the specialized Latino survey have been told they have high cholesterol; 60% have never had their cholesterol checked.

### ***Domestic Violence***

- 16% of participants in the specialized Latino survey report that someone close to them has hit, punched, kicked, threatened or hurt them in some way at some time in the past. 8% report that this has happened in the past year.

## Prevention

### *Utilization of Primary Care Services*

- 17% of participants in the specialized Latino survey report that they do not have a place they usually go, such as a doctor's office or clinic, when they are sick or need advice about their health (other than a hospital emergency room). Most say it is because they have not needed a doctor.
- Only 23% of participants in the specialized Latino survey have a personal physician. Among these individuals, 82% say they have had a routine checkup in the past year.
- 28% of participants in the specialized Latino survey have been to a hospital emergency room in the past year. 60% have been in the past five years.

### *Dental Care*

- 17% of participants in the specialized Latino survey have dental insurance coverage for themselves; only 32% of those with children have dental insurance coverage for their children.
- 43% of participants in the specialized Latino survey report that they have had permanent teeth removed due to tooth decay or gum disease.

### *Mental Health Care*

- Only 2% of participants in the specialized Latino survey have ever used or tried to use a service or program for people with mental or emotional problems.

### *Alternative/Complementary Health Care*

- 13% of participants in the specialized Latino survey report that they sometimes seek alternative or complementary health care before using a formal health care provider; 57% report using some kind of herbal remedy when they are not feeling well or to maintain their health.
- In the past year, respondents in the specialized Latino survey have used the following types of health care providers: physician (42%); dentist (28%); chiropractor (3%); podiatrist (3%); and mental health professional (2%).

### *Women's Cancer Screenings*

- Of women respondents in the specialized Latino survey aged 40 and older, approximately one-half have had a mammogram in the past two years.

- 91% of women respondents in the specialized Latino survey have had a Pap smear to test for cancer of the cervix, two-thirds of which were done in the past year.

### *Immunization*

- 26% of participants in the specialized Latino survey have had a flu shot in the past year (including 3 out of 6 participating respondents aged 65 and older). Only 8% have ever had a pneumonia vaccine (including 1 out of 6 seniors).

## Access to Care

### *Insurance Coverage*

- 54% of employed respondents in the specialized Latino survey report that their employer offers health coverage as a benefit; 85% of these individuals take advantage of this (most of whom state that the premium cost is split between employer and employee).
- Among participants in the specialized Latino survey aged 18 to 64, two-thirds (66%) report that they have no type of insurance coverage (public or private) for health care costs.
- 37% of participants in the specialized Latino survey with children state that their children are enrolled in Health Check, the state Medicaid program. 37% state that their children are enrolled in North Carolina Health Choice.

### *Barriers to Health Care Access*

- Respondents in the specialized Latino survey report an average 10-day wait for an appointment at their doctor's office or at the clinic; in the waiting room, they report an average 48-minute wait to see a medical person.
- 18% of participants in the specialized Latino survey report that there was a time in the past year when they wanted to get **medical care**, but did not. Two-thirds of these individuals say they tried to get care, but could not due to such factors as a lack of insurance, difficulty getting an appointment, inconvenient office hours and long waits in the office or clinic.
- 32% of participants in the specialized Latino survey currently take one or more prescription medicines. 11% of respondents report that there was a time in the past year when they wanted a **prescribed medicine** but did not get it. Two-thirds of these individuals say they tried, but could not get the medicine due to such factors as cost/lack of insurance, not really needing it, and not having a way to get to the pharmacy.

- 21% of participants in the specialized Latino survey report that there was a time in the past year when they wanted to get **dental care**, but did not. Nearly three-fourths of these individuals say they tried to get care, but could not, mostly due to cost or a lack of insurance.
- 4% of participants in the specialized Latino survey say that there was a time in the past year when they wanted **mental health care** or counseling, but did not get it at that time.

## Perceptions Data\*

Latinos interviewed shared the concern that professional and technical jobs were difficult to obtain. Good jobs are associated with good benefits, which infers that families can provide health care for family members via health insurance. There was also some concern that those who are new to our culture may not understand job expectations, and that young adults of any background, who are new to the job market, need mentorship and understanding.

When questioned about the community’s most serious problems, one Latino immediately said, “What I see as serious is minorities [not] being able to get good jobs.”

This Latino advocate for diversity says, “I see that minorities don’t get the jobs. They’re qualified and they have everything they need [to get the job], but still can’t get the job. I’d like to see that change.”

“Once they are held accountable, I believe the local business community will do more [to help Latinos join the business and civic community].”

“(Latinos must become a presence at the policy level on boards and commissions such as) “boards of regents at local universities, hospital boards, health commissions, and corporate leadership positions...not just for Latinos but for all people of color. We must be purposely grooming and setting goals for our young people that do include community and civic involvement.”

Other Latinos spoke about loving the friendliness and opportunities found in the Asheville/Buncombe County area, yet still experiencing moments of prejudice.

“We like to be here, we love the people even though sometimes people don’t like us because we’re Hispanics. We feel there are people who still need to get the fear away. That we’re not going to [hurt] them, we’re going to love them and be kind to them.”

“I think prejudice is still a big issue. I think a lot of people come with a preconceived notion about these families or about the population in general...Once they’ve had one-on-one contact with the families, that perception changes a lot. They see that the families

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are hardworking...that they are very respectful and that they do have close families. [We need to be] lifting them up and encouraging them instead of being critical...helping them with the adjustment rather than criticizing them for not adjusting fast enough. It's a big change: language, culture, the jobs they do and the places they live in. Help them focus on their strengths."

"They (Latinos) do pay taxes in many forms and they deserve services from the government...they should have equal access to services."

"The school system locally needs to make sure that it is in full compliance with North Carolina law to provide English as a Second Language."

"There has been little or no membership of the Latino community in the (Asheville) Chamber of Commerce."

"The responsibility of our elected and appointed officials is that the whole community be served and currently it's not being served."

"The Sheriff's Department and the Police Department and the state law enforcement could do a better job of...helping us educate people about what their rights are and also what the laws are so that our people (Latinos) will...be able to live within the law and protect themselves."

### *Latino Strengths*

A resounding theme among the Latinos interviewed was the desire to be respected and appreciated for their own cultural strengths and resources. For instance, Latino immigrants sometimes feel they are represented as being a new burden on already stretched resources. It was important to one Latino that others understand the strong work ethic of his culture:

"The men in the Hispanic and Latino community are very hard workers and they usually have no problem with working. That's one of their strong attributes, that they're not shy of work."

As with the African-American population, the Latinos see the Church and their faith as a major source of strength as well as a resource for food, shelter, and social support. Latinos feel further supported by family members and a tight knit network of fellow immigrants. The strong family values of the Latino culture were also seen as compatible with those of other Americans. One woman, not herself of Hispanic descent, found admiration for Hispanic culture in the families she works with daily; she notes that, even when there is no blood kinship, Hispanic families often bind together to strengthen their resources.

"Religion is at the core of the Latino culture."

"...There is a tremendous responsibility on the faith community in this area to do outreach to the Latino community..."

“There is such a love for each other...their love and their closeness in the family is just a wonderful thing. They support each other very well, but it goes beyond the family. So many of them come here as groups and they’re not related in a physical way but yet you can tell they almost act as a family unit. The way that they help each other with cooking or watching the kids or driving one another. They are always there for each other.”

When asked what he liked most about his own culture, one Latino father said: “What I like about my community is their passion for their family, for values...for the Hispanic culture and how it's an important part of who we are...our food, family, the way that we stay together, the music, the excitement that is in our culture.”

A Latino grandmother explained, “...a sense of cohesiveness with my hermanos y hermanas, brothers and sisters — that's the thing I like best about my culture.”

“I really see that there is such a love for each other...their love and their closeness in the family is just a wonderful thing. They support each other very well but it goes beyond the family. They help each other with cooking or watching the kids...or driving one another places. They are always there for each other....I think that's a big strength, the close-knittedness of the families.

“I think the children have respect for adults...they are very polite and well-mannered and they are pretty obedient to their parents. I think a lot of the things that they still require in Hispanic families, we no longer do in our families, and I don't see the disintegration of the family as much in Hispanic families as in the standard population.”

### ***Health Care Barriers for Immigrants***

Of particular frustration for those health care workers who deal with immigrants who have non-refugee designation upon entry to the country, is the lack of health care coverage for these families and children.

The population primarily affected by this are the Latinos. Because many may enter as undocumented foreigners, they are only eligible for “emergency” Medicaid, which covers very limited inpatient visits for very serious medical problems, only retroactively and only temporarily. A previous North Carolina program which covered preventive services for children only, called the Caring Program for Children, allowed children to be enrolled without using social security numbers. This meant that some undocumented children could receive basic services in doctors’ offices such as well checkups and sick visits. However, the newer and more comprehensive North Carolina Health Choice program for children requires a social security number and a period of residency. This means that all undocumented children immigrants are ineligible, even though they may qualify financially and have parents working locally and paying full taxes.

An advocate for migrant families notes that many of the migrant children are actually documented citizens because they were born in the U.S. while their parents were working here.

“They [Latinos] do pay taxes in many forms and I do believe they deserve services from the government...equal access to services as we do.”

A similar thought expressed by another non-Hispanic person: “When we have people who are being productive and are supporting our economy and contributing to the services that make this community work, those people need to be provided the basic services of any person, irregardless of whether or not they are citizens or residents, with papers or without papers.”

Another perceived form of governmental discrimination was the feeling of intimidation of Latino residents by the federal Immigration and Naturalization Service. One woman with Latino friends explained the paradox of employers courting the hardworking Latino community, documented or not, while INS hovers, leaving the Latino worker to wonder whether his importance to the local economy will be enough to discourage INS from invading the workplace. Another Latino, born and raised in the U.S., is indignant about the fact that U.S. citizens who happen to be Latino can be stopped and asked to provide proof of citizenship. She challenges a Caucasian interviewer, also a U.S. citizen:

“Do YOU carry your birth certificate in your billfold? Could you PROVE you are a citizen right now,”?

# Rural Appalachian

## Survey Findings

The following items detail telephone survey findings among 143 adults residing in the following ZIP Codes, characterized as "Rural Appalachian" for the purpose of this assessment: 28701, 28709, 28711, 28715 and 28728. The maximum error rate associated with a sample of this size is  $\pm 8\%$  at the 95 percent confidence level.

### Demographic Characteristics

#### *Residence & Household Members*

- 53% of Rural Appalachian survey participants live in the 28715 ZIP Code, and 35% live in ZIP Code 28711.
- 33% of Rural Appalachian respondents live in households with children.
- Almost all Rural Appalachian respondents (99%) live in a household of three people or fewer.

#### *Gender & Age*

- Rural Appalachian respondents are 51% female, 49% male.
- 34% of Rural Appalachian survey participants are between the ages of 18 and 39. 43% are aged 40 to 64, and 23% are aged 65 or older.

#### *Employment, Education & Income*

- 55% of Rural Appalachian respondents are currently employed for wages (including 14% who are self-employed), while 5% are out of work, and 8% are unable to work. A full 21% are retired.
- 12% of Rural Appalachian survey participants have not completed a high school education. 31% have a high school diploma, and a full 57% have had schooling beyond high school.
- 7% of Rural Appalachian respondents live below the poverty level; 26% live just above, but less than twice, the poverty level; and two-thirds (67%) live at twice or more the poverty level.

## ***Marital Status***

- 63% of Rural Appalachian respondents are currently married, while 18% are widowed, separated or divorced, and 16% have never been married.

## **Health Status**

### ***General Health***

- 53% of Rural Appalachian respondents characterize their general health as “excellent” or “very good,” while 18% characterize it as “fair” or “poor”.

### ***Mental Health & Depression***

- 24% of Rural Appalachian respondents report that they have had a period of two weeks or longer in the past year during which they felt sad, blue, depressed, or lost all interest or pleasure in things they usually cared about or enjoyed.

### ***Chronic Conditions***

- Rural Appalachian respondents have been diagnosed with or treated for the following: **loss of hearing or vision (31%); chronic back problems, headache or other pain (26%); arthritis or rheumatism (25%); chronic problems with urination, chronic bladder infections, prostate problems, incontinence or inability to hold the urine (17%); heart disease (16%); asthma, emphysema or chronic bronchitis (16%); diabetes (13%); stomach ulcer, chronic inflamed bowel, enteritis or colitis (13%); cancer (8%); and a neurological problem (5%).**

## **Modifiable Health Risks**

### ***High Blood Pressure & Cholesterol***

- 96% of Rural Appalachian respondents have had their blood pressure checked by a health professional in the past five years. 30% of respondents have been told that they have high blood pressure, and 83% of these people currently take medication to control hypertension.
- 32% of Rural Appalachian respondents have been told they have high cholesterol; 94% have had their cholesterol checked within the past five years.

### ***Alcohol & Tobacco Use***

- A total of 24% of Rural Appalachian respondents currently smoke cigarettes, whether regularly or on occasion. However, 33% live or work with someone who smokes around them (22% among nonsmokers).

- 7% of Rural Appalachian survey participants currently use a smokeless tobacco product, such as chewing tobacco or snuff.
- 34% of Rural Appalachian survey participants currently drink alcohol, and 5% average two or more drinks per day (chronic drinkers). 9% have consumed five or more drinks on any one occasion in the past month (binge drinkers).

### ***Nutrition***

- The following proportions of Rural Appalachian respondents report “always or often” practicing the following healthy eating habits: **eating two or more vegetables at the main meal (78%); eating only fruit for dessert (27%); eating chicken or poultry without the skin (20%)**.
- 23% of Rural Appalachian survey participants drink regular or **whole milk**, while 39% drink low-fat or **2% milk**, 25% drink **1% or skim milk**. (9.5% don’t drink milk at all.)
- Most Rural Appalachian survey participants (57%) characterize their diet as "medium" in fat content. 12% report "high-fat" diets, while 31% report "low-fat" diets. (Note that these are self-reported, and the terms are self-defined.)
- 43% of Rural Appalachian survey participants eat the recommended five fruits and/or vegetables on a daily basis.

### ***Physical Activity***

- 82% of Rural Appalachian survey participants report participating in some type of physical activity (outside of their job duties) in the past month, mostly walking.
- 18% of Rural Appalachian survey participants have had no leisure-time physical activity in the past month.

### ***Overweight***

- By reported heights and weights, 51% of Rural Appalachian survey participants are overweight. Among these persons, 50% are trying to lose weight.

### ***Domestic Violence***

- 10% of Rural Appalachian survey participants report that someone close to them has hit, punched, kicked, threatened or hurt them in some way at some time in the past. 2% report that this has happened in the past year.

## Prevention

### *Utilization of Primary Care Services*

- 14% of Rural Appalachian survey participants report that they do not have a place they usually go, such as a doctor's office or clinic, when they are sick or need advice about their health (other than a hospital emergency room). Many say it is because they have no insurance and/or cannot afford the care, while others use an alternative method of care.
- 84% of Rural Appalachian survey participants have a personal physician. Another 66% of Rural Appalachian survey participants have been to see a physician for a routine checkup in the past year.
- 23% of Rural Appalachian survey participants have been to a hospital emergency room in the past year. 56% have been in the past five years.

### *Dental Care*

- 44% of Rural Appalachian survey participants have dental insurance coverage for themselves; a larger number (62%) of those with children have dental insurance coverage for their children.
- 54% of Rural Appalachian survey participants report that they have had permanent teeth removed due to tooth decay or gum disease.

### *Mental Health Care*

- 13% of Rural Appalachian survey participants have ever used or tried to use a service or program for people with mental or emotional problems.

### *Alternative/Complementary Health Care*

- 16% of Rural Appalachian survey participants report that they sometimes seek alternative or complementary health care before using a formal health care provider; 28% report using some kind of herbal remedy when they are not feeling well or to maintain their health.
- In the past year, Rural Appalachian respondents have used the following types of health care providers: physician (85%); dentist (60%); therapeutic massage therapist (10%); a mental health professional (10%); and a chiropractor (9%).

### *Women's Cancer Screenings*

- Of those Rural Appalachian women aged 40 and older, 7 in 10 have had a mammogram in the past two years.

- 98% of Rural Appalachian women respondents have had a Pap smear to test for cancer of the cervix, three-fourths of which were done in the past year.

### *Immunization*

- 71% of Rural Appalachian survey participants aged 65 and older have had a flu shot in the past year . Another 70% of Rural Appalachian seniors have ever had a pneumonia vaccine.

## Access to Care

### *Insurance Coverage*

- 86% of employed Rural Appalachian respondents report that their employer offers health coverage as a benefit; 82% of these individuals take advantage of this (most of whom state that the premium cost is split between employer and employee).
- Among Rural Appalachian survey participants aged 18 to 64, 22% report that they have no type of insurance coverage (public or private) for health care costs.
- 12% of Rural Appalachian respondents with children state that their children are enrolled in Health Check, the state Medicaid program. 18% state that their children are enrolled in North Carolina Health Choice.

### *Barriers to Health Care Access*

- Rural Appalachian respondents report an average 9-day wait for an appointment at their doctor's office or at the clinic; in the waiting room, they report an average 33-minute wait to see a medical person.
- 11% of Rural Appalachian survey participants report that there was a time in the past year when they wanted to get **medical care**, but did not. Just one-half of these individuals say they tried to get care, but could not due to such factors as a lack of insurance, difficulty getting an appointment, and lack of available physicians.
- A full 57% of Rural Appalachian respondents currently take one or more prescription medicines. 7% of respondents report that there was a time in the past year when they wanted a **prescribed medicine** but did not get it. one-fifth of these individuals say they tried, but could not get the medicine due mainly to factors relating to cost or lack of insurance, and specific medications not being in stock.
- 15% of Rural Appalachian survey participants report that there was a time in the past year when they wanted to get **dental care**, but did not. A total of 1 in 3 of these

individuals say they tried to get care, but could not, mostly due to cost/lack of insurance or a difficulty getting an appointment.

- Just 4% of Rural Appalachian survey participants say that there was a time in the past year when they wanted **mental health care** or counseling, but did not get it at that time.

## Perceptions Data\*

Southern Appalachian natives still living in the rural areas of Buncombe County expressed feelings of discrimination in finding jobs and in voicing political views. Most express affiliation with either agricultural life and/or a “blue collar” manufacturing livelihood, both of which have largely ceased to exist. Minimum wage service industry and tourism jobs, often without benefits, will not adequately support a family as their previous manufacturing jobs did.

There is a sense that they have become the “new minority.”

“You have to have a Master’s degree and experience and move in from somewhere else [to get hired for what few technical and professional jobs exist].“

Admitting that it seems awful to say this since minority ethnic groups often feel they can’t get jobs either, one woman says, “I’ve often heard from folks out here, that it’s ‘who you know’ ... that there is very little [in the way of jobs or political opportunity] for them [native Southern Appalachian Caucasians]...I would not encourage my children to stay in this area...I would encourage them to move on.”

“They are honest folks. Real people. It takes a lot to get to know them but I guess I love the culture, the caring, stick-to-it-ness of the folks.”

“A lot of these folks have been here for two or three generations.”

“Native Southern Appalachians feel a need to be independent and (they are) hesitant to access services, (there is) a fear of not being able to take care of themselves as their ancestors were able to do.”

“People raised here feel industries will hire someone from outside with experience, rather than help build a local labor force.”

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\* *The Perceptions Data are valuable in identifying issues and providing context to the findings of this assessment. Keep in mind, however, that these qualitative comments are attributable only to those citizens and Key Informants participating in this effort and are not necessarily representative of the study sponsors nor the community at large.*