| HNC 2030 Scorecard: Clay County (2024-2026)

ID: 91659

Community Health Assessment (CHA)

2024 Clay County Health Assessment

Executive Summary

CLAY COUNTY 2024 COMMUNITY HEALTH ASSESSMENT

EXECUTIVE SUMMARY

COMMUNITY RESULTS STATEMENT

All people in Clay County are healthy and resilient.

LEADERSHIP FOR THE COMMUNITY HEALTH ASSESSMENT PROCESS

The leadership for the CHA process included the Health Director and Public Health Educator within Clay County Health Department.

Name	Agency	Title	Agency Website
Clarissa Rogers	Clay County Health Department	Health Director	www.clayhdnc.us
Regina Harper	Clay County Health Department	Public Health Educator	www.clayhdnc.us

PARTNERSHIPS

Partnerships during the CHA process were particularly crucial. The main partnership came from the CHA Team, which is comprised of multiple entities from around the county. CHA Team was developed to enhance the health of Clay County through networking to determine how we can support each other within our county.

Name	Agency	Title	Agency Website
Becky Grindstaff	Clay County Senior Center	Senior Center Director	https://seniors.claync.us
Ben English	Clay County Health Department	Community Paramedic	www.clayhdnc.us
Hannah Miller	Community for Students	Community for Students Director	www.claycountycfs.com
Jamie Thomas	Clay County School System	School Health Nurse	www.clayschools.org

Lisa Edwards	Clay County Health Department	CMARC-CMHRP Care Manager	www.clayhdnc.us
Lorrie Ross	Mountain Projects	Preventionist, Mountain Strong Prevention Team	https://mountainstrongwnc.org
Marie Gunther	Clay County Transportation	Transportation Director	www.clayconc.us
Sherry Harrison-Hughes	Clay County Health Department	Dental Hygienist	www.clayhdnc.us
Sherry Reece	Clay County Health Department	Deputy Registrar for Vital Records/ Processing Assistant	www.clayhdnc.us
Sonya McCulloch	Clay County Health Department	Nursing Supervisor	www.clayhdnc.us
Todd Goins	Clay County Department of Social Services	Health and Human Services Director	https://dss.claync.us

REGIONAL SUPPORT

Our county participates in WNC Healthy Impact. This partnership brings together hospitals, public health agencies, and key regional partners in western North Carolina to improve community health. We work together locally and regionally to assess health needs, develop plans, take action, and evaluate our progress. This regional effort is coordinated by WNC Health Network, a non-profit that exists to support people and organizations to improve community health and well-being across western North Carolina. Learn more at www.WNCHN.org.

THEORETICAL FRAMEWORK/MODEL

WNC Health Network supports local hospitals and public health agencies working on complex community health issues. Community Health Assessment and Improvement processes include the use of Results-Based Accountability™ (RBA). RBA is a practical approach that focuses on achieving real improvements for people, agencies, and communities. The framework relies on both primary (story and number data) and secondary data to provide a comprehensive understanding of community health.

COLLABORATIVE PROCESS SUMMARY

Clay County's collaborative process is supported regionally by WNC Healthy Impact.

Locally, our process is to share our Community Health Assessment Primary and Secondary data with our CHA team to identify and prioritize our priorities for the CHA. Clay County examined the data that was distributed by WNC Healthy Impact and distributed the information to the CHA team. To determine the key issues for Clay County, the Public Health Educator created a survey with a PowerPoint to help determine which issue is the highest priority that can be obtained within Clay County. The results showed that **Mental Health/ Substance Use** and **Chronic Disease Prevention and Control** are two areas of need that are still troubling our county. Phase 1 officially began in January 2024 with collecting health data. See Chapter 1, Community Health Assessment Process for details.

KEY FINDINGS

The data gathered from the 2024 Community Health Assessment reveals a pressing need for improved prevention and management of chronic illnesses within the community. The leading causes of death identified were heart disease, cancer, and chronic lower respiratory diseases. Unfortunately, lifestyle factors such as physical inactivity, obesity, poor nutrition, and smoking continue to play a significant role in the prevalence of these chronic conditions, contributing to the overall health burden.

The findings also underscored the importance of addressing substance use and mental health, which have emerged as critical areas of concern. The data analysis revealed a strong correlation between mental health disorders and substance use, highlighting that these issues often co-occur and may exacerbate each other. This co-occurrence suggests that interventions targeting both mental health and substance use are essential for effective treatment and prevention.

Furthermore, the assessment pointed to the need for community-based strategies aimed at improving health behaviors and promoting healthier lifestyles. Focused efforts on increasing physical activity, improving dietary habits, and reducing smoking rates are key to combating the root causes of many chronic diseases. Additionally, enhancing mental health resources and substance use treatment programs is vital to addressing the complex relationship between mental health and addiction. Implementing comprehensive, integrated public health initiatives will be crucial in tackling these ongoing health challenges and improving overall community well-being.

HEALTH PRIORITIES

The following health issues were identified as priorities:

1. **Substance Use and Mental Health**
2. **Chronic Diseases Control and Prevention**

NEXT STEPS

The next steps for developing the community health improvement plans include:

- Working with partners and community members to understand the root cause of the problem and determine how to implement changes to improve the overall health of the county
- Using evidence-based strategies when working on health issues within the county.
- Selecting priority strategies and creating performance measures to help us evaluate how people are better off because of the strategies.
- Publish the Community Health Improvement Plan (CHIP) on an electronic Scorecard that anyone can access to monitor progress.
- To access the full data set that was used for the CHA please email Regina Harper at reginaharper@clayhdnc.us

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Priorities

The following priority health issues are the final community-wide priorities for our county that were selected through the process described above:

- **Priority 1 – Mental Health and Substance Use / Access to Care**
  Mental health and substance use remain growing concerns, with an increasing number of individuals affected by these serious health challenges. In Clay County, access to necessary services for those struggling with mental health issues and/or substance abuse is limited, creating a significant gap in care and support.
- **Priority 2 – Chronic Disease Prevention and Control**
  Chronic diseases such as heart disease, diabetes, and obesity continue to impact the health and well-being of residents in Clay County. Many of these conditions are preventable through healthy lifestyle choices, yet there remains a need for greater awareness, education, and access to preventive care. Strengthening efforts around prevention, early detection, and effective management is essential to improving long-term health outcomes in the community.

Mental Health and Substance Use

R CHIP

All people in Clay County experience improved mental health and reduced substance use through accessible services, community support, and effective prevention programs

Most Recent Period	Current Actual Value	Current Trend	Baseline % Change

Experience

How would we experience all people in Clay County experiencing improved mental health and reduced substance use through accessible services, community support, and effective prevention programs?

Clay County would experience more individuals achieving improved mental well-being and reduced risk of substance misuse. Access to mental health and substance use services would increase, including counseling, support groups, and treatment programs. Community members will follow appropriate care plans when diagnosed with a mental health condition or substance use disorder. Individuals will become more aware of their symptoms and recognize when professional help should be sought. Clay County will see a decrease in emergency room visits, hospitalizations, and overdose incidents related to mental health and substance use. Overall, Clay County strives for a community where all individuals are mentally well, free from the burden of substance use, and able to live healthier and happier lives.

Importance

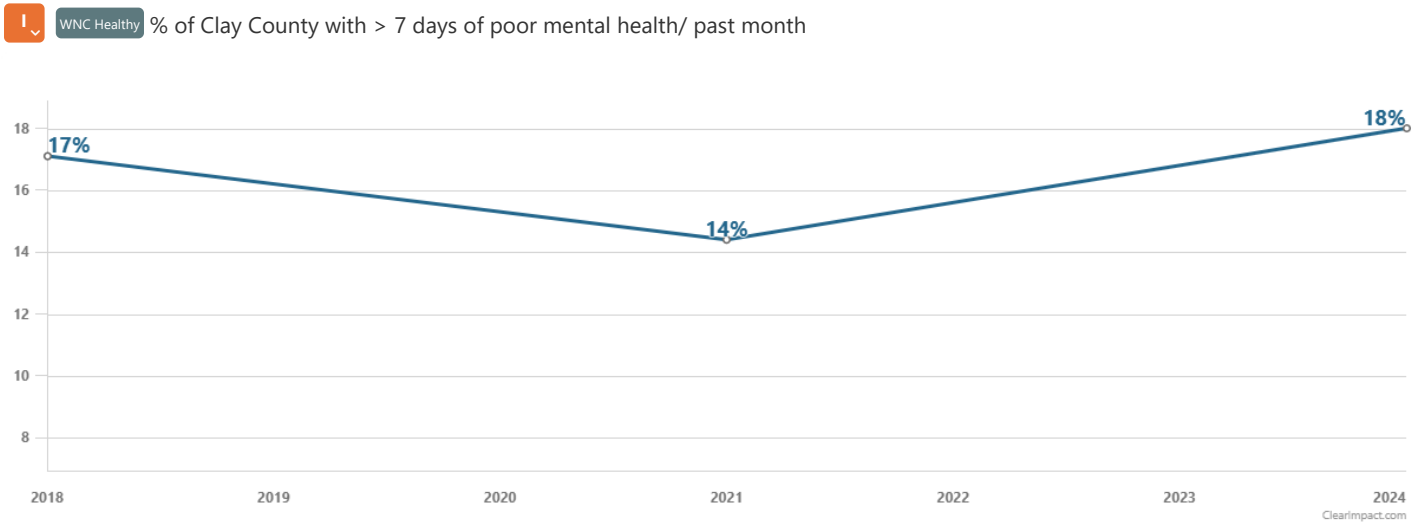
What information led to the selection of this health issue and related results?

In 2024, Clay County reported that 18.2% of individuals used opiates or opioids, with or without a prescription. This is significantly higher than the Western North Carolina average of 13% and the national average of 15.1%. Over half of survey respondents (50.7%) said substance use had negatively impacted their lives, either personally or through someone close to them (WNCHN, 2024). This growing crisis is placing a heavy burden on the community and highlights the urgent need for expanded prevention, treatment, and recovery services.

The impact of substance use extends beyond addiction, as mental health concerns are also increasing. Nearly one in five individuals reported experiencing seven or more days of poor mental health in the past month, and 20% are currently receiving treatment. Despite this, 16% said they were unable to access the care they needed. Particularly concerning is the sharp rise in suicidal thoughts. In 2024, 7.3% of residents reported considering suicide, up from just 1.8% in 2021.

These statistics underscore the critical need for accessible and coordinated mental health and substance use services. Both issues are complex and influenced by a mix of biological, psychological, and social factors. Symptoms often present differently from person to person, which can make diagnosis and treatment more challenging. Early identification and intervention are key to preventing more serious outcomes such as hospitalization or death.

Certain groups such as adolescents, pregnant women, individuals with chronic illnesses, and those experiencing economic hardship are particularly vulnerable to complications. For this reason, the Clay County Health Department prioritizes prevention, early treatment, and comprehensive support to improve individual well-being and strengthen the overall health of the community.



2024	18%	↗ 1	75% ↗
2021	14%	↘ 1	40% ↗
2018	17%	↗ 1	66% ↗
2015	7%	↘ 1	-29% ↘
2012	10%	→ 0	0% →

Story Behind the Indicator

The "Story Behind the Curve" helps us understand why the data on Mental Health is the way that it is in our community. When we understand the root causes of our community problems, we have a better chance of finding the right solutions, together.

What's Helping? These are the positive forces at work in our community and beyond that influence this issue in our community.

- Opioid Settlement Funds

- Faith based Community
- Appalachian Community Service
- Vaya Health
- Appalachian Mountain Health
- Clay County Transportation
- Community Outreach Services
- Mountain Projects- ACEs training
- Chatuge Family Practice
- Clay County EMS
- Clay County Fire & Rescue
- Clay County DSS

What's Hurting? These are the negative forces at work in our community and beyond that influence this issue in our community.

- Housing Insecurity
- Poverty
- Unemployment
- Lack of Mental Health In-Patient Services
- Limited Resources
- Stigma and Shame
- Underfunded Systems
- Unhealed Trauma or Grief

Partners

Partners in our Community Health Improvement Process:

- Clay County Senior Center
- Community Paramedic
- Clay County School System
- Clay County Transportation
- Community for Students
- WNC Healthy Impact
- Mountain Projects
- Clay County Dental Clinic

Partners with a Role in Helping Our Community Do Better on This Issue:

- Chatuge Family Practice
- County Leadership

- Clay County Senior Center
- Mountain Projects
- Rock Bottom Recovery
- Appalachian Community Service
- Vaya Health
- Erlanger Western Carolina Hospital
- Union General Hospital
- Clay County DSS
- Appalachian Mountain Health
- Clay County Transportation
- Clay County EMS
- Clay County Fire & Rescue

What Works to Do Better (Performance)?

Process for Selecting Priority Program/ Strategies

The following actions have been identified by our Clay County Health Department and community members as ideas for what can work for our community to make a difference with Mental Health and Substance Use.

Actions and Approaches Identified by Our Partners *these are actions and approaches that our partners think can make a difference with Mental Health and Substance Use.*

- Peer Support Specialist
- PORT Team (Post Overdose Response Team)
- Narcan Distribution
- Mental Health First Aid Training
- ACE's Training
- Educating the Youth
- Encouraging Extracurricular Activities- Sports, Art Program, Book Clubs, Music, Dance. Anything that gives a person a sense of belonging.

What is Currently Working in Our Community *these are actions and approaches that are currently in place in our community to make a difference with Mental Health and Substance Use.*

- Faith-based Community Outreach
- Appalachian Community Services
- Vaya Health
- Chatuge Family Practice- Dr. Travis Williams
- Youth Extracurricular Activities
- Mountain Projects- ACEs Trainings
- Narcan Training

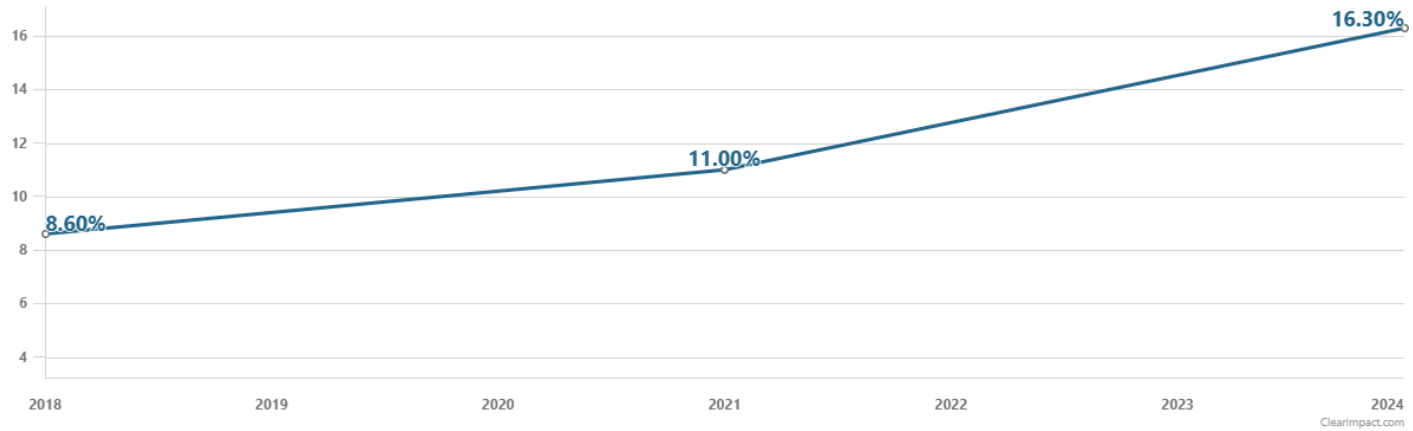
Evidence-Based Strategies *these are actions and approaches that have been shown to make a difference with Mental Health and Substance Use.*

Name of Strategy Reviewed	Level of Intervention
Adverse Childhood Experiences (ACEs) Training. https//www.cdc.gov/aces/php/public-health-strategy/index.html	Organization and Community.

What Community Members Most Affected by Mental Health and Substance Use Say *these are the actions and approaches recommended by members of our community who are most affected by Mental Health and Substance Use.*

- The need for more specialized providers
- Decreased Stigma
- Education about Mental Health and Substance Use
- Engaging Community Members in the planning/ Implementation of how to address Mental Health and Substance Use.

WNC Healthy % of Clay County did Not Get Mental Health Care or Counseling that was Needed in the Past Year



2024	16.30%	↗ 3	60% ↗
2021	11.00%	↗ 2	8% ↗
2018	8.60%	↗ 1	-16% ↘
2015	3.40%	↘ 1	-67% ↘
2012	10.20%	→ 0	0% →

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- Faith based Community
- Appalachian Community Service
- Vaya Health
- Appalachian Mountain Health
- Clay County Transportation

- Community Outreach Services
- Mountain Projects- ACEs training
- Chatuge Family Practice
- Clay County EMS
- Clay County Fire & Rescue
- Clay County DSS

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- Vaya Health

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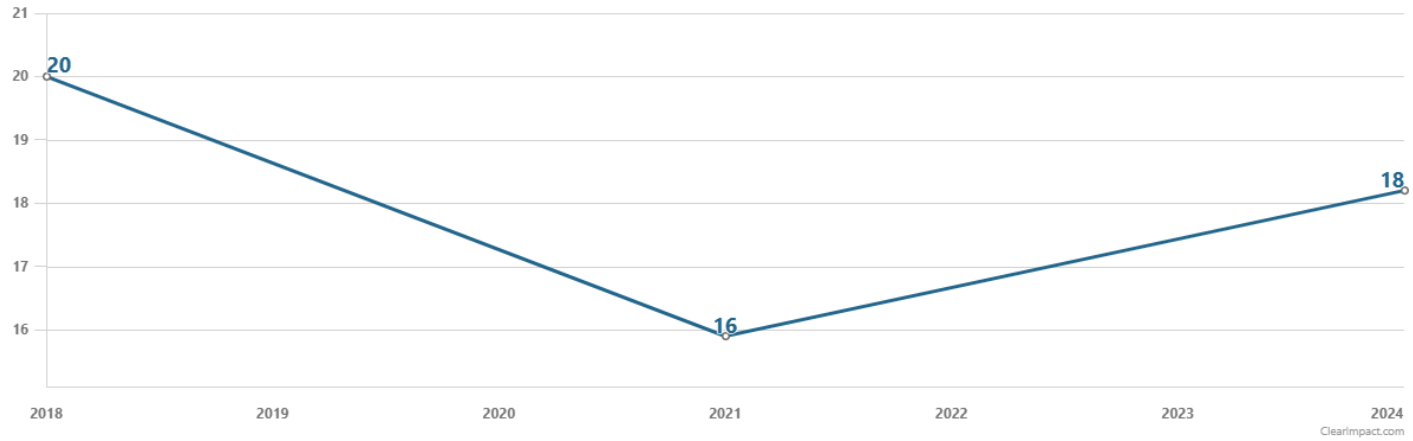
WNC Healthy Number of Opioids dispensed in Clay Couty



2024	18	↗ 1	-9% ↘
2021	16	↘ 1	-21% ↘
2018	20	→ 0	0% →

Story Behind the Indicator

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What's Helping? These are the positive forces at work in our community and beyond that influence this issue in our community.

- Opioid Settlement Funds
- Appalachian Community Service/ Vaya Health
- Appalachian Mountain Health
- Rock Bottom Recovery
- Suboxone Clinics
- Clay County Transportation
- Sheriffs Office supplied with Narcan
- Narcan Spray readily available
- Peer Support Groups
- Community Outreach Services
- Mountain Projects

- Chatuge Family Practice
- Faith based Community
- Implementation of a PORT (Post- Overdose Response Team) team
- Critical Incident Debriefings
- Clay County EMS
- Clay County Fire & Rescue
- Clay County DSS

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- Housing Insecurity
- Poverty
- Unemployment
- Lack of Mental Health In-Patient Services
- Limited Resources
- Stigma and Shame
- Underfunded Systems
- Easy Access to Harmful Substances
- Unhealed Trauma or Grief

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- Clay County School System
- Clay County Transportation
- Community for Students
- WNC Healthy Impact
- Mountain Projects
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- Clay County Senior Center
- Mountain Projects
- Rock Bottom Recovery

- Appalachian Community Service/ Vaya Health
- Erlanger Western Carolina Hospital
- Union General Hospital
- Clay County Sheriff's Office
- Appalachian Mountain Health
- Clay County Transportation
- Clay County EMS
- Clay County Fire & Rescue

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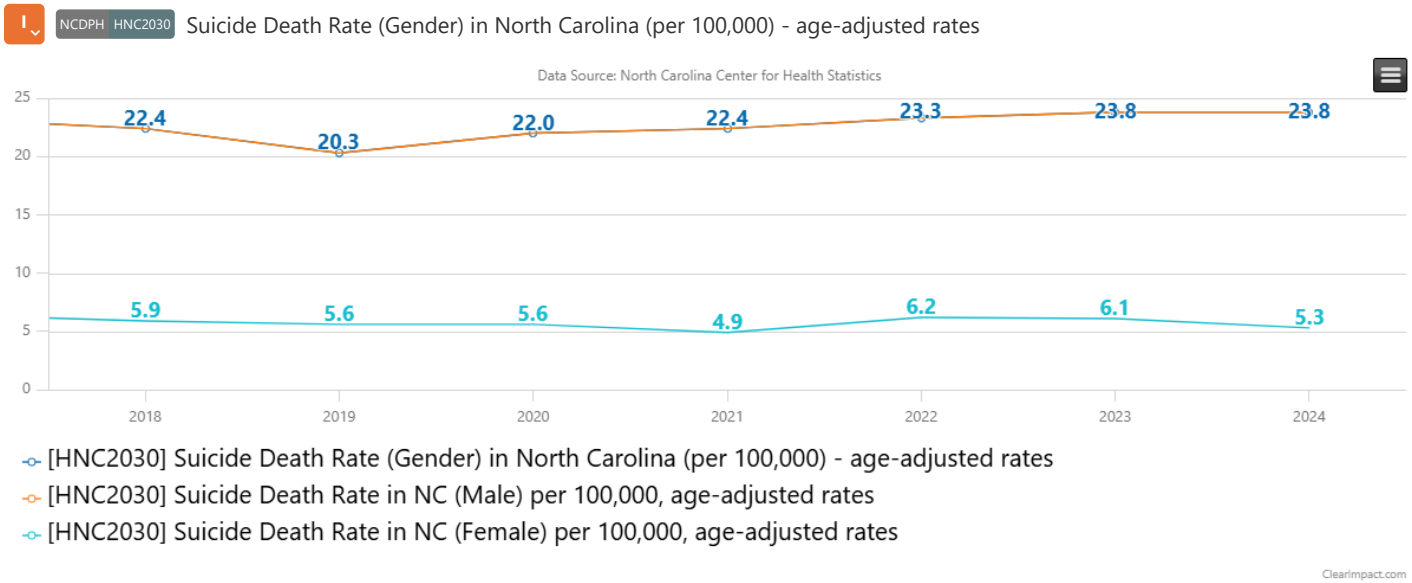


2024	23.8	→ 1	20% ↗
2023	23.8	↗ 4	20% ↗
2022	23.3	↗ 3	18% ↗
2021	22.4	↗ 2	13% ↗
2020	22.0	↗ 1	11% ↗
2019	20.3	↘ 2	3% ↗
2018	22.4	↘ 1	13% ↗
2017	23.2	↗ 1	17% ↗
2016	20.1	↘ 1	2% ↗

Story Behind the Curve

Rates are age-adjusted.

Overall, the suicide rate is trending upwards (from 13.0 in 2014 to 14.8 in 2023).

The suicide rate is approximately four times higher for males than for females.

Indicator Notes

Definition:

Age-Adjusted Suicide Death Rates per 100,000 Population

Why is this Important?

The impacts of suicide are experienced at the personal and community level. Suicide burdens family, friends, and the community at large (emotionally and often financially).

Suicide is closely linked to mental health and well-being, which can be negatively impacted by trauma, financial insecurity, housing instability, or physical illness.

Insurance status may also play a role when it affects the ability of individuals to seek mental health care and treatment. [*HNC2030*]

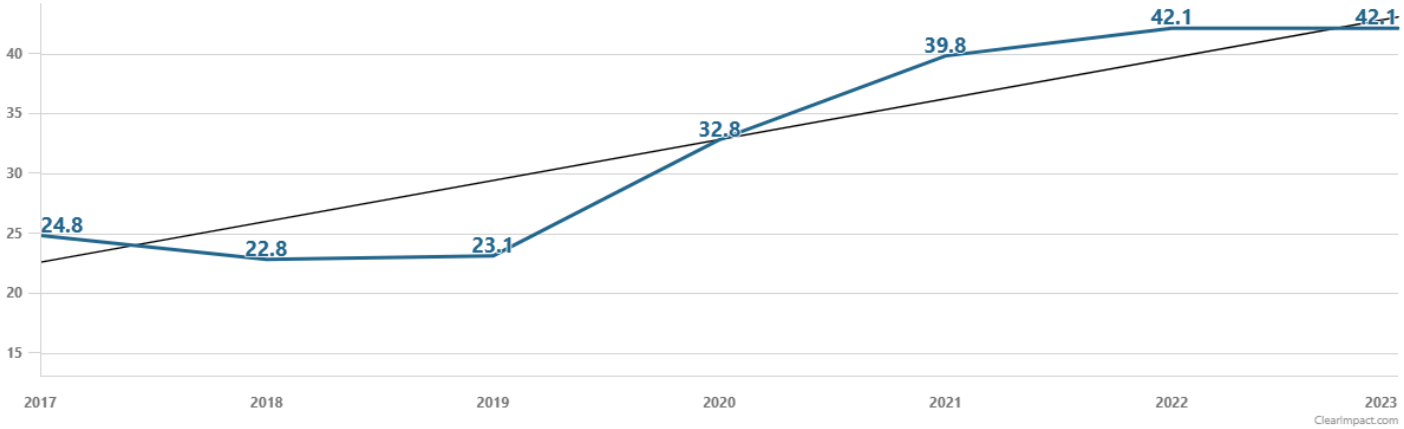
Additional Information:

Rates are age-adjusted.

References and Links:

HNC-REPORT-FINAL-Spread2.pdf

NCDPH HNC2030 Drug Poisoning Death Rate in North Carolina (Total): Drug Poisoning Deaths per 100,000 population (age-adjusted rates)



2023	42.1	→ 1	205% ↗
2022	42.1	↗ 4	205% ↗
2021	39.8	↗ 3	188% ↗
2020	32.8	↗ 2	138% ↗
2019	23.1	↗ 1	67% ↗
2018	22.8	↘ 1	65% ↗
2017	24.8	↗ 3	80% ↗
2016	19.8	↗ 2	43% ↗
2015	15.8	↗ 1	14% ↗

Story Behind the Curve

Along with the rest of the country, North Carolina experienced a sharp increase in drug overdose deaths since 2019, largely due to the opioid epidemic, and more recently involving a preponderance of poisonings from illegally manufactured fentanyl.

The age-adjusted drug overdose death rate more than tripled from 2014 (13.8) to 2023 (42.1).

Indicator Notes

Definition:

Number of persons in North Carolina who die as a result of drug poisoning per 100,000 population, adjusted by age.

Why is this Important?

Substance misuse is a chronic condition, requiring ongoing care and treatment for individuals to regain and maintain health and recovery.

This chronic condition affects the individual's relationship with family and community. It can impair ability to attend school or work and negatively impacts both physical and mental health. It can also lead to social complications and negative interactions with the justice system. [HNC2030]

Additional Information:

The *Drug Poisoning Death Rate* indicator is aligned with HNC2030.

References and Links:

North Carolina's Opioid and Substance Use Action Plan | NCDHHS

HNC-REPORT-FINAL-Spread2.pdf

Post Overdose Response Team (PORT)

Most Recent Period	Current Actual Value	Current Trend	Baseline % Change

What is it?

A Post Overdose Response Team (PORT) is a coordinated, community-based initiative that engages individuals after a nonfatal drug overdose, using the event as a unique window of opportunity to provide harm reduction, recovery support, and connections to treatment before another overdose occurs. This multidisciplinary team is made up of first responders, public health professionals, peer recovery specialists, addiction specialists, and a social worker that will work to reduce the risk of future overdoses and connect individuals to supportive services that promote long-term recovery and stability.

Partners

The partners for the Post Overdose Response Team (PORT) includes:

Agency	Role
Clay County Health Department	Lead, Collaboration, Support
Clay County Emergency Medical Services	Collaboration, Support
Clay County Community Paramedic	Collaboration, Support
Chatuge Family Practice	Lead, Collaboration, Support
Rock Bottom Recovery	Collaboration Support

Story Behind the Curve

What's Helping What We Do?

These are the positive forces at work in our strategy/program that influence how much we do or how well we do it.

- Opioid Settlement Funds
- Peer Recovery Specialist
- Narcan Education
- Community Partners
- Mental Health Education
- Recovery Meetings
- Mental Health First Aid Training

What's Hurting What We Do?

These are the negative forces at work in our strategy/program that influence how much we do or how well we do it.

- Stigma and Mistrust
- Readiness to Change

- Limited Availability of Team Members
- Temporary Funding
- Insufficient Harm Reduction Supplies
- Limited Mental Health Facilities

What Works to Do Better (Performance)?

The following actions have been identified by the CHA team as ideas for what can work for this performance measure to make a difference on Mental Health and Substance Misuse

Actions and Approaches Identified by Our CHA Team. *These are actions and approaches that we think can make a difference for this performance measure.*

- Post Overdose Response Team (PORT)
- Youth Mental Health Facilities
- Substance Use Education
- Address Social Determinants of Health
- Increased Peer Recovery Specialists
- Mobile Crisis Services
- Shorter Wait Times for Services
- Recovery Meetings

No-cost and Low-cost Ideas Identified by Our CHA Team. *These are no-cost and low-cost actions and approaches that we think can make a difference for this performance measure.*

- Recovery Meetings
- Peer Support Specialist
- Free Crisis Lines
- Free Naloxone
- Social Media Campaigns

What your customers think would work to do better. *These are actions and approaches that our customers think can make a difference to this performance measure.*

- Faith-based Organizations
- More Mental Health Options
- Education to reduce stigma

List of Questions/Research Agenda. *These are questions to follow-up on for this performance measure.*

- How do we get people willing to participate in recovery?
- What partnerships could help fill the gaps?

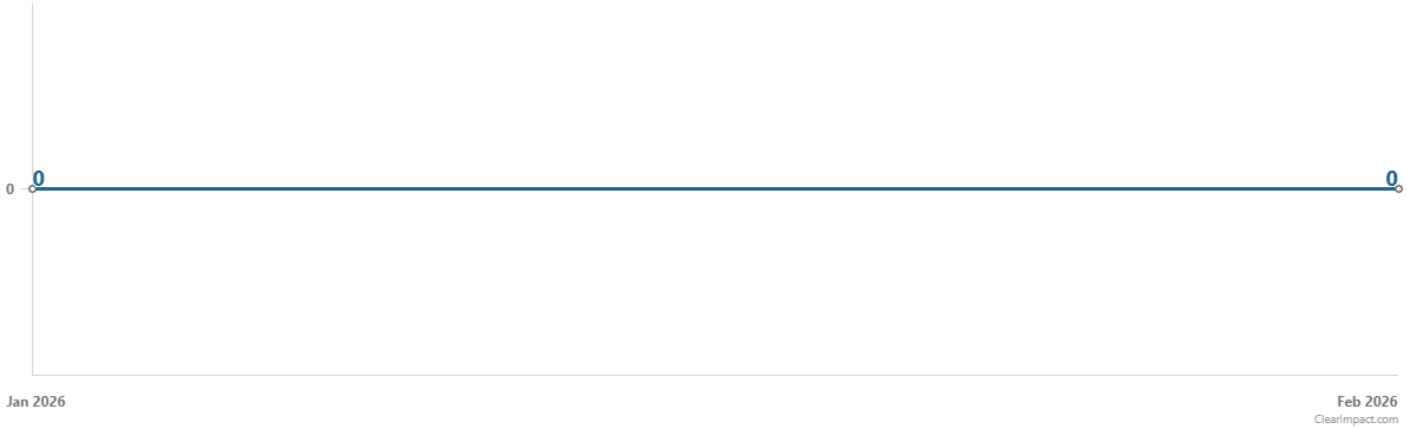
Progress in 2025

The Post Overdose Response Team (PORT) is currently in the implementation stage, with program initiation planned for the beginning of 2026. While outcome data is not yet available, implementation planning is actively underway to ensure comprehensive, consistent, and meaningful data collection upon program launch.

Key preparatory steps have already been completed, including the assignment of dedicated PORT team members and the development of a standardized toolkit to guide response activities, documentation, and follow-up. The PORT program will operate as a collaborative, multidisciplinary effort involving Community Paramedics (CP), Emergency Medical Services (EMS), Dr. Williams and members of his care coordination team, and Stacie with Rock Bottom Recovery. This coordinated approach is designed to improve post-overdose outreach, enhance access to treatment and support services, and strengthen continuity of care for individuals at risk.

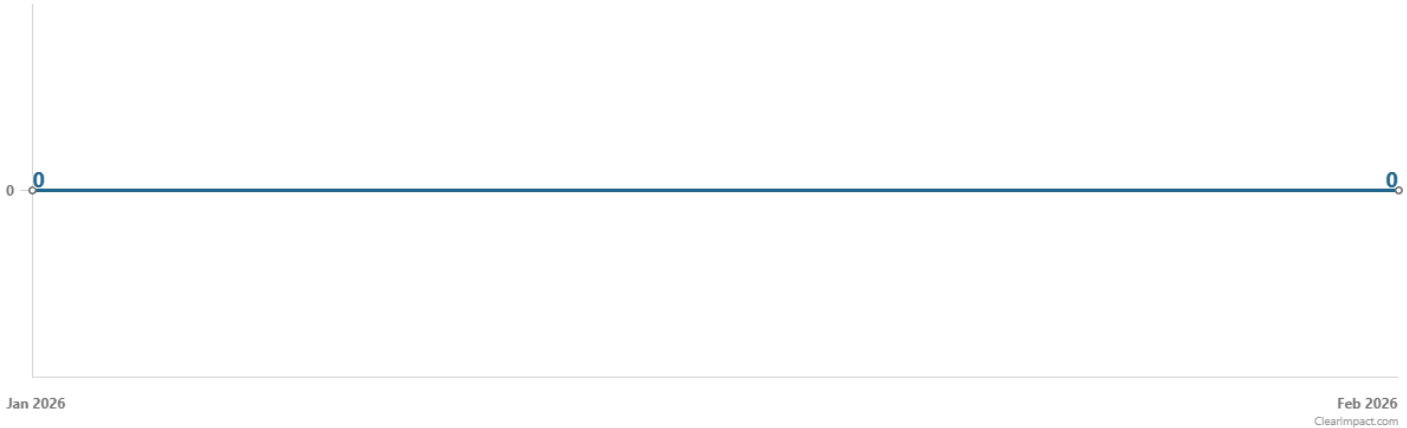
PM How Much # of participants that required assistance

Feb 2026	0	→ 1	0% →
Jan 2026	0	→ 0	0% →



PM How Much # of participants that were assisted more than once

Feb 2026	0	→ 1	0% →
Jan 2026	0	→ 0	0% →



S PHQ 9 Assessment

Most Recent Period	Current Actual Value	Current Trend	Baseline % Change

What is it?

The Patient Health Questionnaire-9 (PHQ-9) is a standardized, evidence-based screening tool widely used to identify, assess, and monitor depression in clinical settings. It is based directly on the nine diagnostic criteria for major depressive disorder in the DSM-5 and is designed to capture both the presence and severity of depressive symptoms over the past two weeks. The PHQ-9 is quick test that can be completed by the patient or provider. Each question is scored on a scale from 0 to 3 producing a total score of 0 to 27. This score categorizes depression as minimal, mild, moderate, moderately severe, or severe, which helps inform next steps for care.

Partners

The partners for the PHQ 9 include

Agency	Role
Clay County Health Department	Lead
Dr. Paula Boyle	Collaborate and Support

Story Behind the Curve

What's Helping What We Do?

These are the positive forces at work in our strategy/program that influence how much we do or how well we do it.

- Community Partners
- Mental Health Education
- Mobile Crisis Unit
- Mental Health First Aid Training
- Appalachian Community Health
- Vaya Health

What's Hurting What We Do?

These are the negative forces at work in our strategy/program that influence how much we do or how well we do it.

- Stigma and Reluctance to Disclose
- Limited Mental Health Facilities
- Language and Literacy Barriers
- Limited Transportation
- Poverty

What Works to Do Better (Performance)?

The following actions have been identified by the CHA team as ideas for what can work for this performance measure to make a difference on Mental Health.

Actions and Approaches Identified by Our CHA Team. *These are actions and approaches that we think can make a difference for this performance measure.*

- Youth Mental Health Facilities
- Address Social Determinants of Health
- Mobile Crisis Services
- Shorter Wait Times for Services

- Reduce Stigma
- Provide Staff Training

No-cost and Low-cost Ideas Identified by Our CHA Team. *These are no-cost and low-cost actions and approaches that we think can make a difference for this performance measure.*

- Administering PHQ-9 to all patients that express or exhibit depressive symptoms
- Free Crisis Lines
- Client Education Materials
- Healthcare programs with sliding- scale fees
- Social Media Campaigns

What your customers think would work to do better. *These are actions and approaches that our customers think can make a difference to this performance measure.*

- Faith-based Organizations
- More Mental Health Options
- Education to reduce stigma

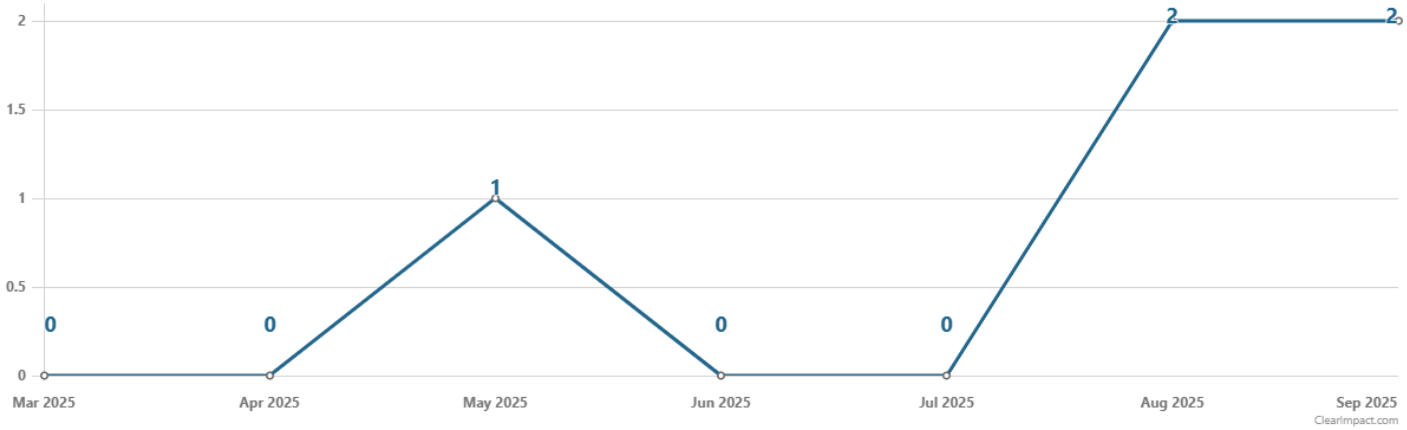
List of Questions/Research Agenda. *These are questions to follow-up on for this performance measure.*

- Are clients answering questions honestly, and if not, why?
- What challenges do staff face in administering or following up on the PHQ-9?
- Are there community partnerships we could leverage to improve follow-up care?

Progress in 2025

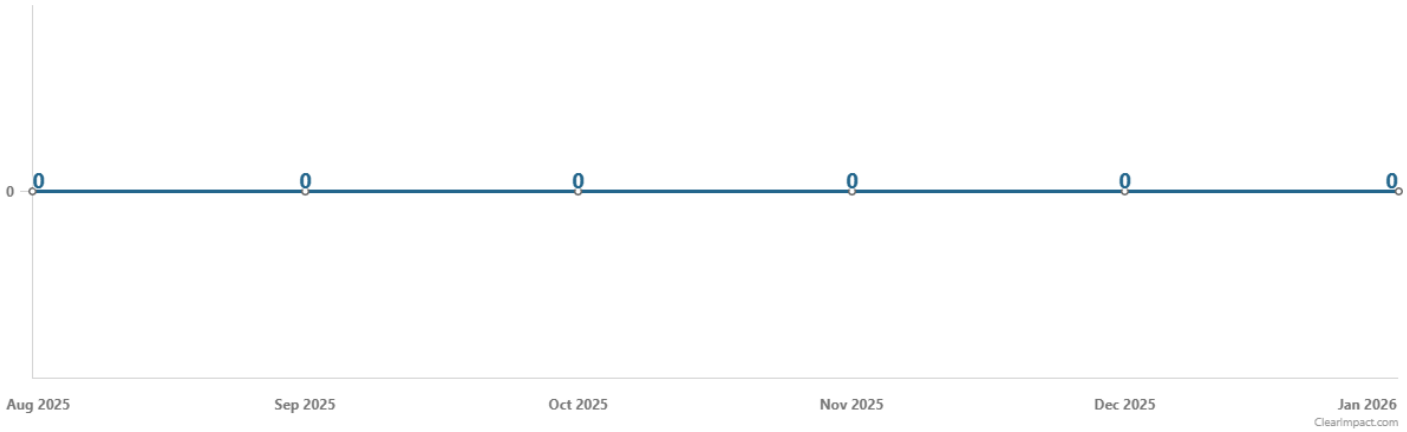
PHQ-9 screening has been an established component of patient care. We are now enhancing our approach through structured data collection and tracking to better monitor depression outcomes, strengthen care coordination, and support performance measurement. We will continue refining this process to ensure consistent use, timely follow-up, and meaningful use of data to guide patient care, identify trends, support early intervention, and continuously improve depression care across our patient population.

PM How Much # of participants that required PHQ 9 assessments



Sep 2025	2	→ 1	100% ↗
Aug 2025	2	↗ 1	100% ↗
Jul 2025	0	→ 1	-100% ↘
Jun 2025	0	↘ 1	-100% ↘
May 2025	1	↗ 1	0% →
Apr 2025	0	→ 2	-100% ↘
Mar 2025	0	→ 1	-100% ↘
Feb 2025	0	↘ 1	-100% ↘

PM How Much # of participants that required referral after PHQ9 assessments was completed



Jan 2026	0	→ 5	0% →
Dec 2025	0	→ 4	0% →
Nov 2025	0	→ 3	0% →
Oct 2025	0	→ 2	0% →
Sep 2025	0	→ 1	0% →
Aug 2025	0	→ 0	0% →

Chronic Disease Control and Prevention

R CHIP All people in Clay County are empowered to prevent, manage, and overcome chronic diseases, leading healthier, longer, and more resilient lives.

Most Recent Period	Current Actual Value	Current Trend	Baseline % Change

Experience

How would we experience all people in Clay County being empowered to prevent, manage, and overcome chronic diseases, leading healthier, longer, and more resilient lives in our community?

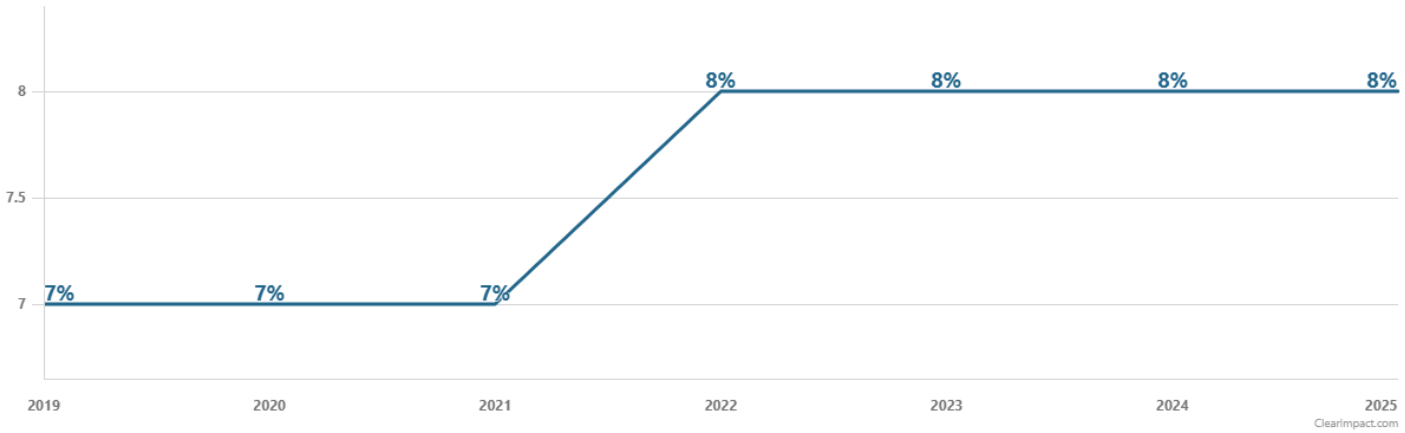
Clay County will see a growing number of residents actively engaging in their health by preventing and managing chronic conditions such as diabetes, heart disease, and hypertension. More individuals will regularly monitor their blood pressure and blood glucose levels, supported by increased access to health screenings and monitoring tools. Community wellness will thrive as more residents utilize walking trails, participate in fitness programs, and make use of the local recreational gym. Healthy eating will become more common with greater support for local food stands and farmers markets and an increase in nutritious food choices among families. The Clay County Health Department will experience higher attendance in health promotion classes, workshops, and support groups. Individuals will become more proactive in managing their health by seeking preventive care, adhering to treatment plans, and making informed decisions about their lifestyles. As a result, Clay County expects to see a decline in preventable emergency room visits related to unmanaged chronic diseases. This shift toward wellness will not only improve individual and community health outcomes but also position Clay County as a model for chronic disease prevention and control across the region.

Importance

What information led to the selection of this health issue and related results?

Between 2018 and 2022, Clay County reported 180 deaths from heart disease, which was higher than the state average and slightly below the rate for the western region of North Carolina (NC SCHS, 2024). During the same period, cancer-related deaths also increased to 153, up from 148 during the 2016–2020 timeframe. These trends highlight the rising burden of chronic disease within the community. Many of these conditions are closely linked to preventable risk factors such as tobacco use, obesity, poor nutrition, and lack of physical activity. In 2024, 41.7% of Clay County residents were classified as obese (WNCHN, 2024), underscoring the urgent need for increased health education, accessible wellness programs, and expanded preventive care. Chronic disease remains one of the most significant public health challenges in the county, contributing to more premature deaths than overdoses and motor vehicle accidents combined. Prevention is critical, as research shows that many chronic conditions can be delayed or prevented through early intervention and consistent management. When unmanaged, one chronic illness can increase the risk of developing additional health problems, compounding the impact over time. The most effective approach is to proactively manage existing conditions and promote long-term stability. Doing so helps prevent complications and lowers the risk of future illness. Our ultimate goal is to reduce the burden of chronic disease and improve health outcomes for both individuals and the community as a whole.

NCDPH HNC2030 Limited Access to Healthy Foods: Percent of People in North Carolina (Total) with Limited Access to Healthy Foods



2025	8%	→ 3	0% →
2024	8%	→ 2	0% →
2023	8%	→ 1	0% →
2022	8%	↗ 1	0% →
2021	7%	→ 4	-13% ↘
2020	7%	→ 3	-13% ↘
2019	7%	→ 2	-13% ↘
2018	7%	→ 1	-13% ↘

Story Behind the Curve

The trend from 2021-2025 reflects North Carolina population food insecurity from 2015-2019. The graph reflects a slight improvement in access to reliable food between 2015 and 2019 (as reported in 2025 County Health Rankings measures).*

*County Health Rankings *Annual Data Releases* for the years 2022-2025 used data from 2019 for this measure.

Indicator Notes

The HNC2030 indicator *Limited Access to Healthy Foods* includes *County Health Rankings* data. These numbers are not frequently updated; refer also to alternative indicator: *Food Insecurity.*

HNC 2030 target: decrease limited access to healthy foods to 5% by 2030.

County Health Rankings & Roadmaps discontinued this measure in 2020, rendering it inappropriate for measuring progress.

Definition of *Limited Access to Healthy Foods*:

The *Limited Accesss to Healthy Foods* indicator measures the percentage of population who are low-income and do not live close to a grocery store. The 2025 Annual Data Release used data from 2019 for this measure.

Why is this Important?

Living in a "food desert" (including lack of access to fresh produce) has been correlated with increased prevalence of obesity and premature death.

Supermarkets traditionally provide healthier options than convenience stores or smaller grocery stores.

Additional Information:

Limited Access to Healthy Foods indicator is aligned with HNC2030.

References and Links:

https://www.countyhealthrankings.org/health-data/north-carolina?year=2025&measure=Limited+Access+to+Healthy+Foods*

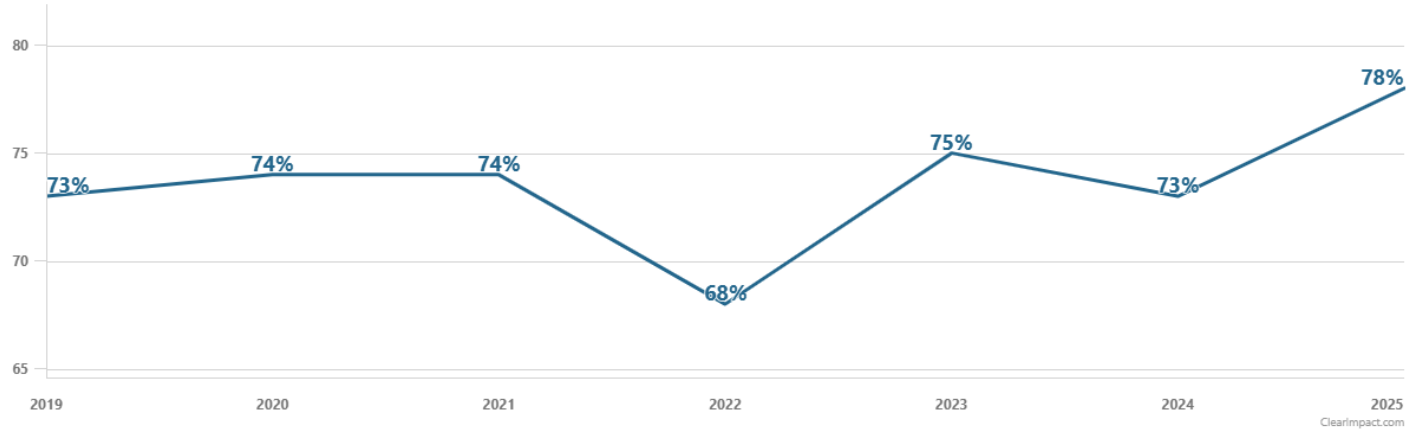
County level data is available at the following link: https://www.countyhealthrankings.org/health-data/north-carolina/data-and-resources

County Health Rankings (countyhealthrankings.org)

County Health Rankings and Roadmaps (CCR&R) - Business Analyst, Delorme map data, ESRI, & US Census Tiger line Files

**Should not compare ranked data from year to year*

NCDPH HNC2030 Access to Exercise Opportunities: Percent of People in North Carolina (Total) with Access to Exercise Opportunities



2025	78%	↗ 1	15% ↗
2024	73%	↘ 1	7% ↗
2023	75%	↗ 1	10% ↗
2022	68%	↘ 1	0% →
2021	74%	→ 1	9% ↗
2020	74%	↗ 1	9% ↗
2019	73%	↘ 1	7% ↗
2018	76%	→ 0	12% ↗

Story Behind the Curve

Access to exercise in the state of North Carolina has remained in the mid-seventy percentiles for the past seven years, with the exception of a significant drop to 68% in 2021 (recorded in 2022 data). This post pandemic dip may reflect the closure of many public structures (along with decreased social interactions) arising from the COVID-19 pandemic.

Note that the HNC2030 target percent (for access to exercise) is 92%.

https://www.countyhealthrankings.org/app/north-carolina/2024/measure/factors/132/data)*

**The measure is not inclusive of all exercise opportunities within a community. For instance, sidewalks, which serve as locations for running or walking; malls, which may have walking clubs; and schools, which may have gyms open to community members, are not able to be captured in the measure.*

Indicator Notes

Definition:

Percentage of population with adequate access to locations for physical activity.

The *Percent of People with Access to Exercise Opportunities* indicator is aligned with HNC2030.

Why is this Important?

Increased physical activity is associated with lower risks of type 2 diabetes, cancer, stroke, hypertension, cardiovascular disease, and premature mortality, independent of obesity. Individuals who live closer to sidewalks, parks, and gyms are more likely to exercise. [countyhealthrankings.org]

Additional Information:

Source of data: County Health Rankings and Roadmaps (CCR&R)*

**Should not compare ranked data from year to year*

Additional Links and References:

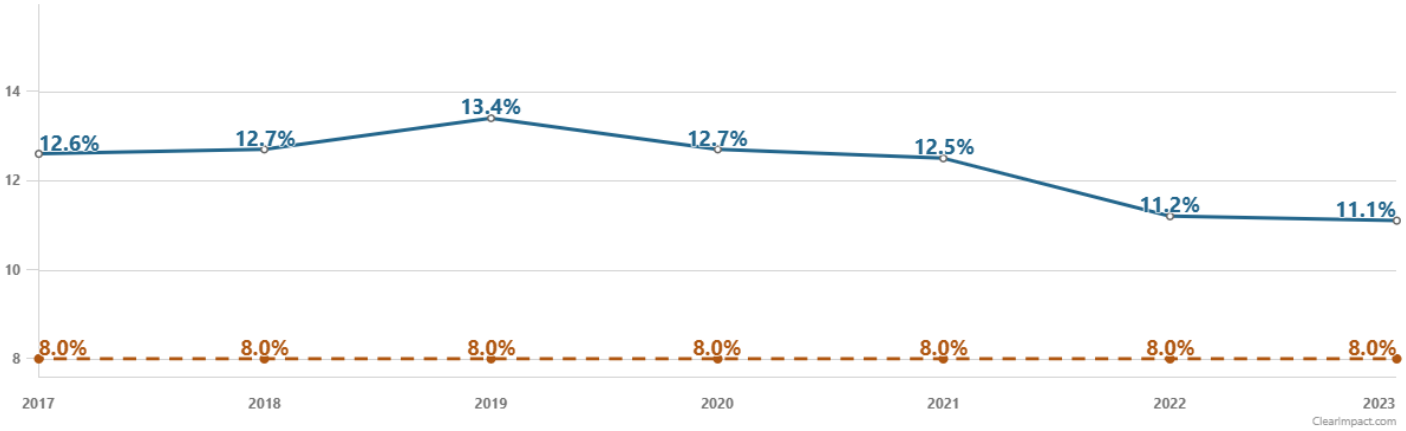
https://www.cdc.gov/physical-activity-basics/benefits/

County Health Rankings and Roadmaps (CCR&R) - Business Analyst, Delorme map data, ESRI, & US Census Tiger line Files

https://www.countyhealthrankings.org/health-data/health-factors/health-behaviors/diet-and-exercise/access-to-exercise-opportunities?year=2024

HNC-REPORT-FINAL-Spread2.pdf

NCDPH HNC2030 Uninsured: Percent of North Carolina population under age 65 years without health insurance (Total) - SAHIE



2023	11.1%	↘ 4	-27% ↘
2022	11.2%	↘ 3	-26% ↘
2021	12.5%	↘ 2	-18% ↘
2020	12.7%	↘ 1	-16% ↘
2019	13.4%	↗ 3	-12% ↘
2018	12.7%	↗ 2	-16% ↘
2017	12.6%	↗ 1	-17% ↘
2016	12.2%	↘ 2	-20% ↘
2015	13.0%	↘ 1	-14% ↘

Story Behind the Curve

Small Area Health Insurance Estimates (SAHIE) are reported annually by the U.S. Census Bureau.

North Carolina expanded Medicaid eligibility on December 1, 2023, extending coverage to adults aged 19-64 years with incomes up to 138% of the federal poverty line, estimated to benefit around 600,000 people.

2023 data suggested that North Carolina was 11.1% uninsured with the target being 8%.

ADDITIONAL NOTES:

- From 2014-2020, data were only available for uninsured white/Black/Hispanic populations.
- Uninsured data for "All Other Races" were available only for the years 2021 & 2022.
- Anticipate 2024 data release summer 2026.

Indicator Notes

Definition:

Individuals who did not have health insurance coverage for the entire calendar year. [US Census]

Why is this Important?

Access to affordable, quality health care positively impacts individual health and well-being. Health insurance is the most common means of accessing affordable health care.

Uninsured individuals may be unable to access affordable health insurance. Lack of health insurance can result in poor health outcomes and create financial burdens, further impacting health and well-being. [HNC2030]

Additional Information:

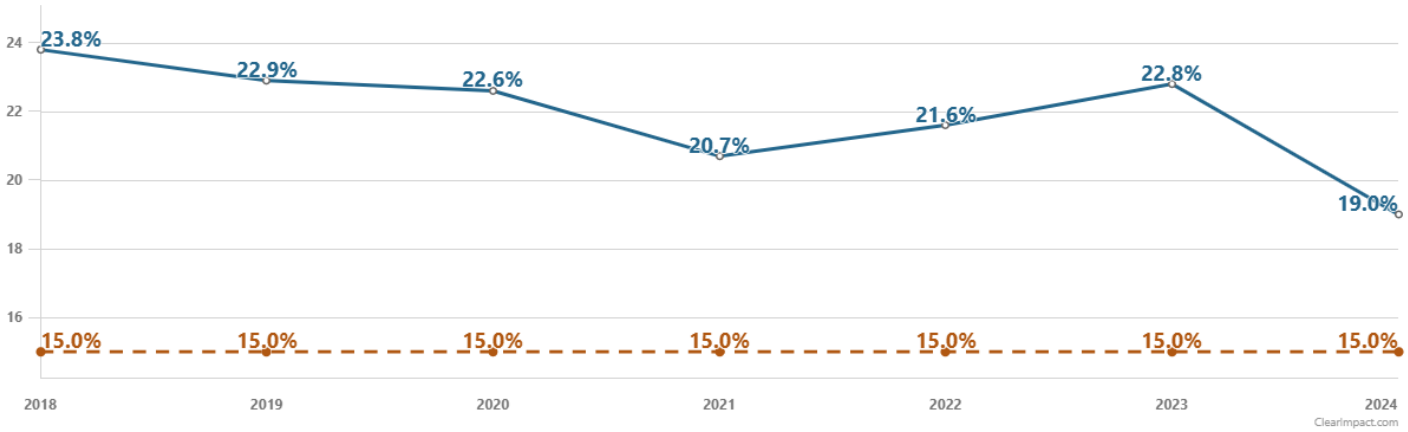
- In 2023 the “Uninsured” data source changed from SCHS to SAHIE.
- Only white/Black/Hispanic population data were available for 2014-2020.
- Only 2021 & 2022 data are available for "All Other Race" group.

References and Links:

HNC-REPORT-FINAL-Spread2.pdf

Small Area Health Insurance Estimates (SAHIE) Program (census.gov)

NCDPH HNC2030 Tobacco use: Percent of Adults Using Tobacco in North Carolina (Total)



2024	19.0%	↘ 1	-21% ↘
2023	22.8%	↗ 2	-5% ↘
2022	21.6%	↗ 1	-10% ↘
2021	20.7%	↘ 4	-13% ↘
2020	22.6%	↘ 3	-5% ↘
2019	22.9%	↘ 2	-4% ↘
2018	23.8%	↘ 1	0% →
2016	23.9%	→ 0	0% →

Story Behind the Curve

The percentage of North Carolina adults using tobacco has decreased over the past six years, from 23.8% in 2018 to 19.0% in 2024, but remains well over the target rate of 15.0%.

Indicator Notes

Definition:

Tobacco use is the act of consuming tobacco products(e.g., cigarettes, cigars, pipes, smokeless tobacco, and e-cigarettes). Measurement of tobacco use includes frequency, amount and type of tobacco product used.

Why is this indicator important?

Tobacco consumption in North Carolina is responsible for a significant amount of disease and death. Tobacco causes significant public and private costs (e.g., financial costs of healthcare, lost productivity), including costs associated with exposure to secondhand smoke.

Nicotine is a highly addictive and dangerous drug found in tobacco products. It is especially dangerous to the health of developing babies. Youth and young adults are also especially vulnerable to the harmful effects of nicotine. [CDC]

Additional Information:

Behavioral Risk Factor Surveillance System (BRFSS) is a random telephone survey of state residents aged 18 and older. The survey collects information on health behaviors and preventive health practices related to the leading causes of death and disability. [NC SCHS, CDC]

The *Percent of Adults Using Tobacco* indicator is aligned with HNC2030.

References and Links:

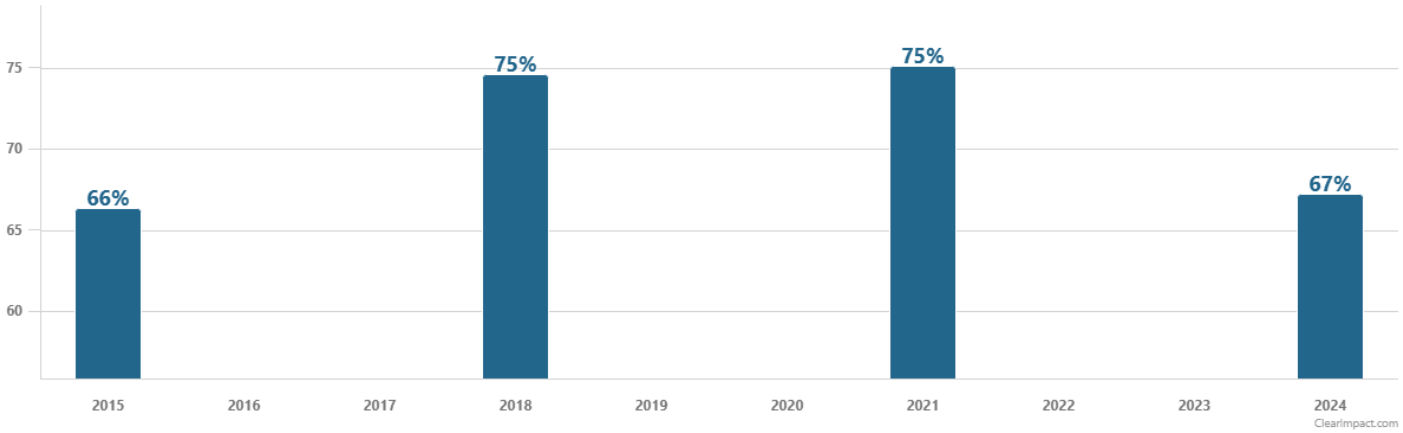
https://www.cdc.gov/

Behavioral Risk Factor Surveillance System (adult tobacco use)

https://schs.dph.ncdhhs.gov/units/stat/brfss/

NCDHHS: DPH: NC SCHS: 2023 BRFSS Annual Survey Results

WNC Healthy Percent of Clay County residents who are overweight or obese



2024	67%	↘ 1	14% ↗
2021	75%	↗ 3	28% ↗
2018	75%	↗ 2	27% ↗
2015	66%	↗ 1	13% ↗
2012	59%	→ 0	0% →

Story Behind the Indicator

The "Story Behind the Curve" helps to explain why the numbers for obesity are high within our community. When we understand the root causes of our community problems, we have a better chance of finding the right solutions, together.

What's Helping? *These are the positive forces at work in our community and beyond that influence this issue in our community.*

- Local food stands
- Chatuge Dam paved walking/ bicycling path
- Quanassee Path for walking/ bicycling
- Sidewalks throughout the town of Hayesville

- County Transportation
- Jack Rabbit trails for mountain bicycling and hiking along with other hiking trails.
- Clay County Recreation Center with reduced prices
- Meals on wheels
- Food pantry
- WIC Program with nutritional education
- Health Fairs
- Recreational sports for kids

What's Hurting? *These are the negative forces at work in our community and beyond that influence this issue in our community.*

- Fast food
- Food insecurity
- Poverty
- Tobacco and Alcohol use
- Economy
- Time management
- Lack of structured exercise classes or programs in our community
- Lack of any public Pool within the county, an enclosed/heated community pool would provide exercise for people of all ages during all months of the year.
- Lack of an indoor walking track that could also provide exercise opportunities for people all month.
- No registered dietician is available for consultation within the area
- Cultural background
- Lack of education regarding exercise and nutrition as it relates to unhealthy weights
- Grocery store quality
- Limited access to healthcare options

Partners

Partners in our Community Health Improvement Process:

- Clay County Public Health
- Clay County Senior Center
- Community Paramedic
- Clay County Public Schools
- Clay County Transportation
- Community for Students
- WNC Healthy Impact

Partners with a Role in Helping Our Community Do Better on This Issue:

- Clay County Public Health
- Clay County Senior Center
- Community Paramedic
- Clay County Public Schools
- Clay County Transportation
- Community for Students
- WNC Healthy Impact

What Works to Do Better (Population)?

Process for Selecting Priority Program/ Strategies

The following actions have been identified by our CHIP team and community members as ideas for what can work for our community to make a difference with nutrition, physical activity, and obesity as it relates to chronic disease.

Actions and Approaches Identified by Our Partners *These are actions and approaches that our partners think can make a difference with nutrition, physical activity, and obesity as it relates to chronic disease.*

- Education to all individuals
- Worksite Wellness
- Media campaigns
- Conduct a health fair for the community
- Better hours for the Gym
- Offer more exercise classes
- Offer healthy cooking classes
- Offer classes on how to shop healthier

What is Currently Working in Our Community *These are actions and approaches that are currently in place in our community to make a difference with nutrition, physical activity, and obesity as it relates to chronic disease.*

- Healthy Carolinians Partnership
- WIC Program
- Health Department Primary Care Clinic
- Clay County Parks & Recreation Department
- Local food stands
- MountainWise

Evidence-Based Strategies *These are actions and approaches that have been shown to make a difference with nutrition, physical activity, and obesity as it relates to chronic disease.*

Name of Strategy Reviewed	Level of Intervention
Special Supplemental Nutrition Program for Women, Infants, and, Children (WIC)	Individual families

What Community Members Most Affected by Chronic Disease Say *These are the actions and approaches recommended by members of our community who are most affected by Chronic Diseases.*

- More physical activity classes offered at a convenient time.
- Education on healthier ways to cook
- Accessibility to specialty providers

Healthy Heart and Smiles

Most Recent Period	Current Actual Value	Current Trend	Baseline % Change

What is it?

Healthy Heart and Smiles was identified by the CHA Team as a promising action that, when combined with other interventions, has the potential to improve cardiac health while promoting good oral hygiene. Although this is a new initiative in our community and not yet classified as an evidence-based strategy, it addresses two critical and often interconnected aspects of health: heart disease and oral health.

The program is designed for individuals who are experiencing prehypertension or hypertension, as well as those who are unable to afford routine dental care. By targeting these groups, the initiative aims to reduce risk factors and complications associated with unmanaged blood pressure and poor oral hygiene, both of which can contribute to broader chronic health issues. The goal is to support health improvement at the individual level by providing access to services that may otherwise be out of reach.

Clients will be screened to determine eligibility for one or both components of the program. Once approved, they will receive personalized education, blood pressure monitoring, and/or affordable dental care when applicable. Implementation will take place at the Clay County Health Department, where staff will collaborate to ensure a seamless and supportive experience for participants.

Partners

The partners for the Healthy Heart and Smiles program includes:

Agency	Role
Clay County Health Department	Lead, Collaborate, and Support
Clay County Dental Department	Collaborate and Support
County Leadership	Collaborate and Support

Story Behind the Curve

What's Helping What We Do?

These are the positive forces at work in our strategy/program that influence how much we do or how well we do it.

- Grant funding for supplies
- Provider and Clinical Staff that recognized the need.
- Health Education

- Clay County Dental Clinic

What's Hurting What We Do?

These are the negative forces at work in our strategy/program that influence how much we do or how well we do it.

- No funding sustainability
- Noncompliance with patient follow-ups
- Limited Dentist that accept Medicaid

What Works to Do Better (Performance)?

The following actions have been identified by the CHA team as ideas for what can work for this performance measure to make a difference on Chronic Disease Prevention and Control.

Actions and Approaches Identified by Our CHA Team. *These are actions and approaches that we think can make a difference for this performance measure.*

- Worksite Wellness
- Affordable Dental Care
- Conduct a health fair for the community
- Offer more exercise classes
- Offer healthy cooking classes
- Offer classes on how to shop healthier
- Educations through all media outlets (newspaper, social media, radio)
- Dentist that accept medicaid

No-cost and Low-cost Ideas Identified by Our CHA Team. *These are no-cost and low-cost actions and approaches that we think can make a difference for this performance measure.*

- Resources to promote healthier lifestyles
- Education to all individuals
- 24/7 Gym
- Media campaigns
- Health Fairs

What your customers think would work to do better. *These are actions and approaches that our customers think can make a difference for this performance measure.*

- Pediatric Dentist
- Indoor track
- More bicycle trails
- Pool with water aerobics class

List of Questions/Research Agenda. *These are questions to follow-up on for this performance measure.*

- How do we get people excited to become healthy?
- How do we get people to follow-up?
- How do we get people to focus on Dental Health?

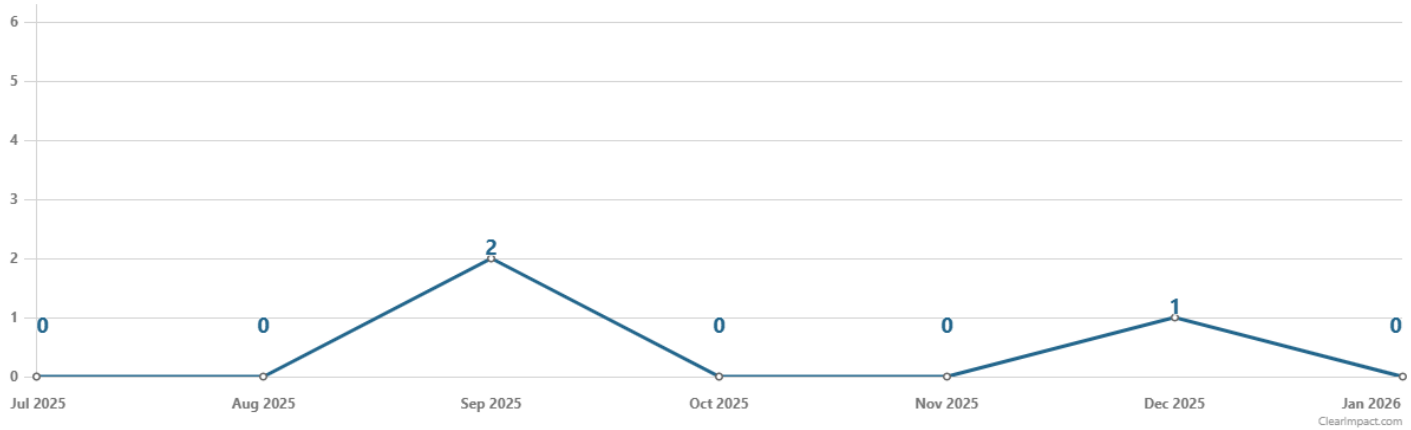
Progress in 2025

The Clay County Health Department continues to successfully implement the Healthy Heart and Smiles program, addressing both cardiovascular health and access to dental care.

Healthy Heart Component: Since 2024, 22 individuals have received blood pressure cuffs through the program. Providing patients with home blood pressure monitors has empowered them to take greater control of their health and increased their willingness to engage in proactive care. All participants receive follow-up support, and documented home blood pressure readings provide healthcare providers with valuable insight to guide ongoing management and treatment decisions.

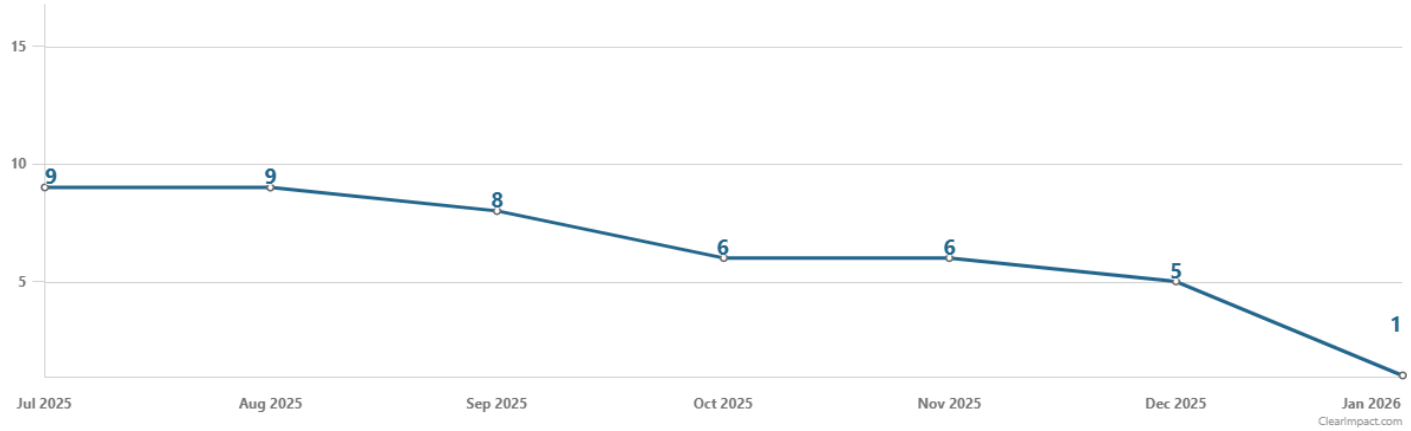
Smiles (Dental) Component: Since 2024, 56 individuals have received dental services through the program, with a total of $20,636.84 invested in dental care. These services addressed a range of oral health needs, helping to reduce barriers to care for underserved individuals. Several participants required follow-up visits to complete their treatment plans, ensuring continuity of care, and improved overall oral health outcomes.

PM How Much # of blood pressure cuffs provided to clients



Jan 2026	0	↘ 1	-100% ↘
Dec 2025	1	↗ 1	-50% ↘
Nov 2025	0	→ 1	-100% ↘
Oct 2025	0	↘ 1	-100% ↘
Sep 2025	2	↗ 1	0% →
Aug 2025	0	→ 2	-100% ↘
Jul 2025	0	→ 1	-100% ↘
Jun 2025	0	↘ 1	-100% ↘
May 2025	3	↗ 1	50% ↗

PM How Much # of participants seen for dental care



Jan 2026	1	↘ 2	0% →
Dec 2025	5	↘ 1	400% ↗
Nov 2025	6	→ 1	500% ↗
Oct 2025	6	↘ 2	500% ↗
Sep 2025	8	↘ 1	700% ↗
Aug 2025	9	→ 1	800% ↗
Jul 2025	9	↘ 1	800% ↗
Jun 2025	11	↗ 1	1000% ↗
May 2025	5	↘ 2	400% ↗

Clay County School Wellness

Most Recent Period	Current Actual Value	Current Trend	Baseline % Change

What is it?

Clay County School Wellness was identified by the CHA Team as a community-based action that, when combined with other local efforts, has the potential to positively impact overall health and well-being. While it is not currently classified as an evidence-based strategy, it is an ongoing initiative that supports a culture of health within the school system. The target audience for the Clay County School Wellness program includes school system employees who are seeking to improve their physical health and well-being. The program is designed to make a difference at both the individual and organizational level by promoting preventive health practices and increasing awareness of personal health status. Participants will have the opportunity to engage in various health checkup options, including blood pressure screenings, fasting bloodwork, weight and BMI measurements, hearing screenings, and vision screenings. In addition to these services, educational materials and resources may be provided to encourage healthier lifestyle choices such as physical activity, healthy eating, stress management, and tobacco cessation. Implementation will take place within the Clay County Schools, making it accessible and convenient for employees. By empowering school staff to prioritize their health, the program aims to reduce risk factors for chronic disease, improve productivity and morale, and ultimately create a healthier school environment that benefits both staff and students. As participation grows, the initiative may also provide valuable insights for future workplace wellness programming in other sectors of the community.

Partners

The partners for Clay County School Wellness includes:

Agency	Role
Clay County Health Department	Collaborate, and Support
Clay County School System	Lead, Collaborate, and Support

Many local businesses collaborate with the school to help provide assistance to the school wellness event.

Story Behind the Curve

What's Helping What We Do?

These are the positive forces at work in our strategy/program that influence how much we do or how well we do it.

- Strong partnership with school system
- Offering on-site screenings
- Low cost to participants
- Educational resource access
- Offering multiple health screenings

What's Hurting What We Do?

These are the negative forces at work in our strategy/program that influence how much we do or how well we do it.

- Maintaining ongoing participation
- Limited awareness
- Staffing limitations

- Lack of follow-up after being advised of results.

What Works to Do Better (Performance)?

The following actions have been identified by the CHA team as ideas for what can work for this performance measure to make a difference on Chronic Disease Prevention and Management.

Actions and Approaches Identified by Our CHA Team. *These are actions and approaches that we think can make a difference for this performance measure.*

- Worksite Wellness
- Health Fair for community
- Offer more exercise classes
- Offer healthy cooking classes
- Provide health education

No-cost and Low-cost Ideas Identified by Our CHA Team. *These are no-cost and low-cost actions and approaches that we think can make a difference for this performance measure.*

- Free Educational Material
- Discounted Labs
- Flexible Schedule to hold employee wellness events

What your customers think would work to do better. *These are actions and approaches that our customers think can make a difference to this performance measure.*

- Indoor Track
- More Bicycle Trails
- Pool for Water Aerobics
- 24/7 hour Gym

List of Questions/Research Agenda. *These are questions to follow-up on for this performance measure.*

- What barriers prevented some staff from participating?
- Are participants motivated to continue healthy behaviors after the program?
- How can the program be improved to reach more employees or address identified gaps?

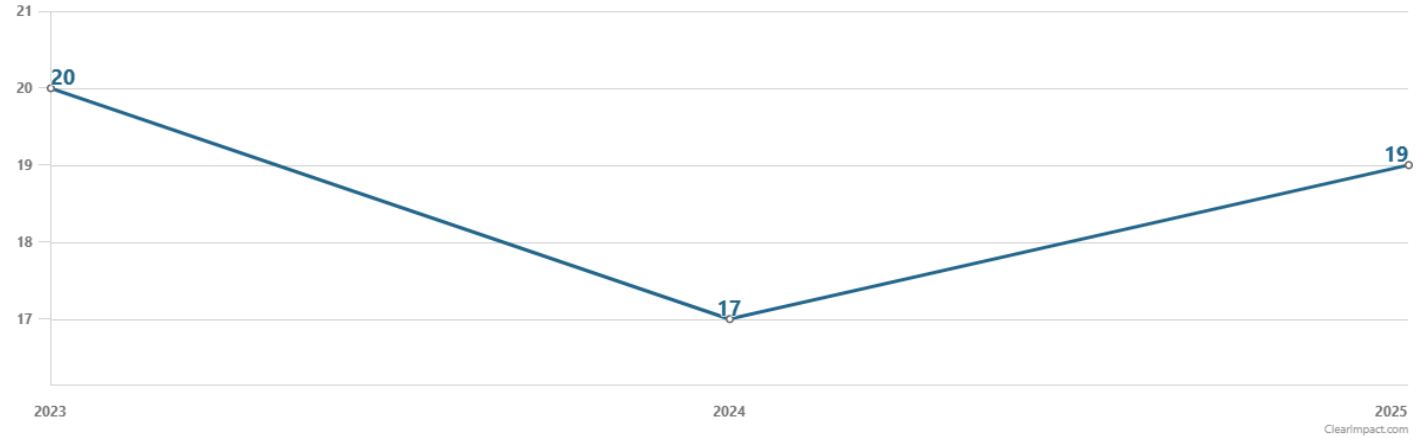
Progress in 2025

The Clay County Health Department has joined the wellness team for the Clay County School System, supporting the district's commitment to promoting employee health and well-being. The Clay County School System recognizes the importance of maintaining a healthy and satisfied workforce and has prioritized staff wellness initiatives.

Over the past several years, the Clay County Health Department has provided a variety of wellness services, including bloodwork, blood pressure screenings, Tanita Body Composition Scale education (weight, height, body fat percentage, water percentage, and muscle percentage), as well as hearing and vision screenings. Following the completion of bloodwork, the Clay County Health Department contacts each participant to address any abnormal findings and to ensure appropriate follow-up with a healthcare provider.

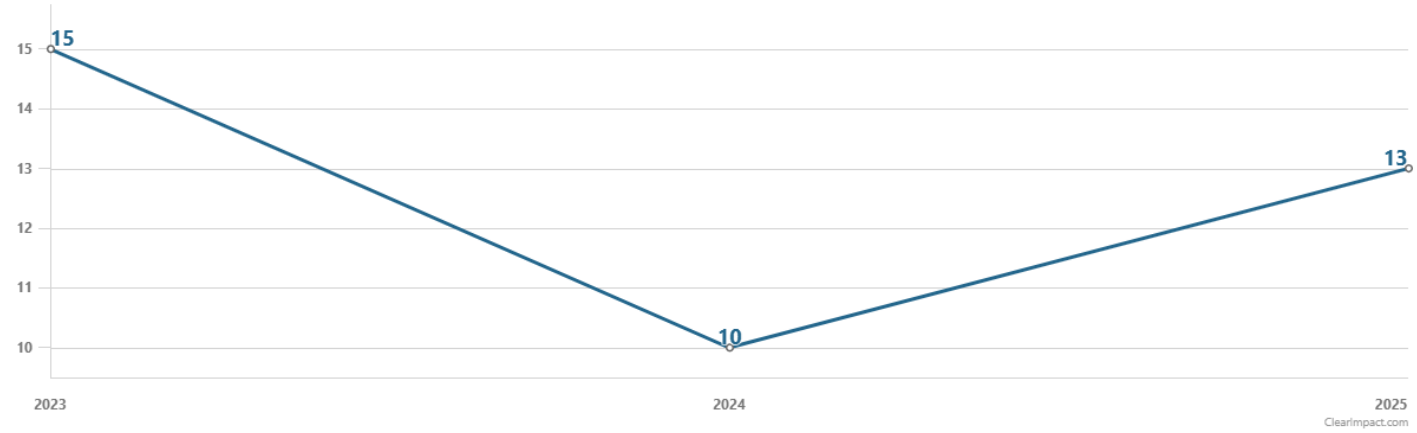
The next staff wellness event is scheduled for March 13, 2026.

PM How Much # of school staff enrolled in the wellness program



2025	19	↗ 1	-5% ↘
2024	17	↘ 1	-15% ↘
2023	20	→ 0	0% →

PM How Much # of participants that are at risk or have a chronic disease



2025	13	↗ 1	-13% ↘
2024	10	↘ 1	-33% ↘
2023	15	→ 0	0% →

S NC Quitline Referrals

Most Recent Period	Current Actual Value	Current Trend	Baseline % Change

What is it?

Referral to Quitline NC identified by the Clay County Health Department as a strategic action that, when combined with other community efforts, has a strong potential to reduce lung cancer rates and improve respiratory health. This is an ongoing program within our community and forms part of our broader tobacco cessation and chronic disease prevention strategy. During clinic visits, clients are routinely asked about their tobacco use. If a client expresses interest in quitting, nursing staff provide information about Quitline NC, a free, evidence-based resource that offers counseling and support to help individuals quit tobacco. Nurses also provide brief counseling on the importance of quitting and the health benefits of doing so. While many clients are open to the conversation and take the materials home, a common challenge is the lack of follow-through in contacting Quitline NC for further support. To improve engagement and outcomes, new approaches should be explored, such as follow-up calls, real-time referral assistance during appointments, or motivational interviewing to enhance readiness and commitment to quit. The target audience for Quitline NC includes individuals who currently use tobacco products and are motivated to quit. The service works at the individual level by providing tailored counseling, support, and coping strategies to manage cravings and sustain long-term behavior change. Ongoing implementation and referral efforts will continue through the Clay County Health Department, with the ultimate goal of increasing the number of successful quit attempts and reducing tobacco-related health risks in our community.

Partners

The partners for NC Quitline Referrals program includes:

Agency	Role
Clay County Health Department	Lead, Collaborate, and Support
Clay County Health Department	Collaborate and Support
WNC Health Network	Collaborate and Support
Health Communities Program	Collaborate and Support

Story Behind the Curve

What's Helping What We Do?

These are the positive forces at work in our strategy/ program that influence how much we do or how well we do it.

- Quitline embedded within clinical notes
- Services are available for free or reduced cost
- Sending referral during time of visit
- Education

What's Hurting What We Do?

These are the negative forces at work in our strategy/program that influence how much we do or how well we do it.

- Lack of individuals wanting to quit
- Patients lack follow-up with calling the 1-800-quitnow line
- Electronic Cigarettes

What Works to Do Better (Performance)?

The following actions have been identified by the CHA Team as ideas for what can work for this performance measure to make a difference with Chronic Disease Prevention and Management.

Actions and Approaches Identified by Our CHA Team. *These are actions and approaches that we think can make a difference for this performance measure.*

- Education to all individuals
- Catch My Breath Program
- Routine Physical Exams
- Quitline NC
- MountainWise

No-cost and Low-cost Ideas Identified by Our CHA Team. *These are no-cost and low-cost actions and approaches that we think can make a difference for this performance measure.*

- Quitline NC
- Physical Exams (Health Department)
- Community Rec Center

What your customers think would work to do better. *These are actions and approaches that our customers think can make a difference for this performance measure.*

- Education on lifestyle choices (tobacco, alcohol, use of sunscreen, healthier diets)
- Access to receive appropriate screenings

List of Questions/Research Agenda. *These are questions to follow-up on for this performance measure.*

- How do we get individuals interested in quitting tobacco and alcohol?
- How do we get more individuals to use the Health Department resources?

Progress in 2025

Quitline NC is a statewide program that provides counseling and evidence-based techniques to support individuals who want to quit smoking. Within our clinic, all patients are routinely asked whether they are interested in quitting tobacco use. To date, the Clay County Health Department has had two patients who agreed to have a referral faxed to Quitline NC.

In addition, outreach efforts have been made to local providers to encourage participation as a Quitline referral site. Currently, one provider has agreed to enroll as a participating referral site. While many patients decline a referral at the time of their visit, educational materials and Quitline NC resources are consistently provided to encourage future engagement.

The Clay County Health Department continues to explore more effective and appealing strategies to motivate individuals to consider quitting tobacco and to utilize Quitline NC services.

PM	How Much	# of healthcare professionals signed up to be a referral provider	Feb 2026	0	↘ 1	0% →
PM	How Much	# of participants that were referred to the Quitline NC	Jan 2026	0	→ 5	0% →

State of the County Health Reports (SOTCH)

S 2025 SOTCH Report

Progress on CHIPs

The 2025 State of the County Health (SOTCH) Report presents an update on the current health status of Clay County residents. The SOTCH provides health information that is intended to augment the Community Health Assessment (CHA) that is conducted every four years and includes a more comprehensive analysis of the overall health status of the county. The main priorities identified from the 2024 Community Health Assessment were:

1. **Mental Health and Substance Use**
2. **Chronic Disease Prevention and Control**

This report demonstrates progress made in the last year as it relates to these health priorities, recent health statistics, new initiatives and emerging issues that may impact the health status of residents in Clay County. The 2024 CHA and previous SOTCH reports may be found at the county library, the health department, or online at https://www.health.claync.us/community-health-assessment

Clay County Snapshot

Population (2024 est.)	12,042	Percent Hispanic/Latino	4.7%
Est. Percent change of Population (2020-2024)	8.6%	Households (2020-2024)	5,081

Percent Female	50.9%	Percent High school graduate or higher (2020-2024)	92.5%
Percent Male	49.1%	Median Household Income (2020-2024)	$56,971
Percent Under 18 Years Old	14.7%	Per Capital Income (2020-2024)	$40,205
Percent Under 5 Years Old	3.8%	Percent of Persons in Poverty	11.5%
Percent 65 Years and Older	35.2%	Population that are Veterans (2020-2024)	644
Median Age	55	Median monthly owner costs with a mortgage (2020-2024)	$1,476
Percent White	94.7%	Median gross rent (2020-2024)	$804
Percent African American	1.7%	Percent of Persons without health insurance, under the age 65 years	13.1%

(U.S Census Bureau, 2024 Quick Facts; N.C Institute of Medicine)

Progress on Community Health Improvement PLAN

Priority One: Mental Health and Substance Use

Post Overdose Response Team (PORT)

The Post Overdose Response Team (PORT) is currently in the implementation stage, with program initiation planned for early 2026. While outcome data is not yet available, structured implementation planning is actively underway to ensure comprehensive, consistent, and meaningful data collection beginning at program launch.

Key preparatory steps have already been completed, including the assignment of dedicated PORT team members and the development of a standardized toolkit to guide response activities, documentation, outreach protocols, and follow-up procedures. Internal workflows and communication pathways have been established to ensure timely notification and coordinated response following overdose events.

The PORT program will operate as a collaborative, multidisciplinary initiative involving Community Paramedics (CP), Emergency Medical Services (EMS), Dr. Williams and members of his care coordination team, and Stacie with Rock Bottom Recovery. This coordinated approach is designed to strengthen post-overdose outreach, reduce repeat overdose risk, enhance rapid connection to treatment and recovery services, and improve continuity of care for individuals at high risk.

In addition to direct outreach efforts, the program will emphasize harm reduction education, naloxone distribution and training, referrals to medication-assisted treatment (MAT), and connection to behavioral health and social support resources. The initiative aligns with county and state priorities to reduce opioid-related morbidity and mortality while advancing a data-driven, community-centered response model.

As implementation progresses, ongoing evaluation and stakeholder collaboration will guide program refinement to ensure sustainability, effectiveness, and measurable impact within the community.

PHQ 9

PHQ-9 screening has been an established and routine component of patient care within our clinical services. We are now enhancing this process through structured data collection, standardized documentation practices, and systematic tracking to more effectively monitor depression outcomes, strengthen care coordination, and support performance measurement initiatives.

Enhancements include improved integration of PHQ-9 scoring into electronic health records, development of internal tracking mechanisms to monitor screening rates and follow-up compliance, and implementation of defined workflows for positive screenings. This structured approach allows for timely identification of patients with moderate to severe depressive symptoms and ensures appropriate referrals, safety assessments, and care plan adjustments when indicated.

We will continue refining this process to promote consistent administration, timely reassessment, and appropriate follow-up interventions. Ongoing reviews of aggregate data will help identify trends across age groups, service lines, and risk categories, supporting early intervention strategies and targeted resource allocation. Additionally, this initiative strengthens our ability to measure program effectiveness and support quality improvement efforts.

Through continuous monitoring, interdisciplinary collaboration, and data-informed decision-making, we aim to improve patient outcomes, enhance behavioral health integration within primary care, and advance equitable access to depression screening and treatment services across our patient population.

Priority Two: Chronic Disease Prevention and Control

Healthy Heart and Smiles

The Clay County Health Department developed the Healthy Heart and Smiles program to proactively address two critical and interconnected public health concerns: cardiovascular health and oral health. Although this initiative is new to the community and not yet classified as an evidence-based strategy, it fills an identified local gap by increasing access to preventive services for underserved populations.

The program targets individuals experiencing prehypertension or hypertension, as well as those who face financial barriers to routine dental care. By focusing on these populations, Healthy Heart and Smiles aims to reduce risk factors and complications associated with unmanaged blood pressure and poor oral hygiene; both of which contribute to chronic disease and overall health disparities. The program supports individual-level health improvement by providing education, monitoring, and access to services that may otherwise be unattainable.

Participants are screened to determine eligibility for one or both program components. Once approved, clients receive individualized education, blood pressure monitoring support, and/or access to affordable dental services as appropriate. Program implementation occurs at the Clay County Health Department, where interdisciplinary staff collaborate to ensure a coordinated and supportive experience for participants.

Since 2024, the Healthy Heart component has provided blood pressure cuffs to 22 individuals. Access to home blood pressure monitors has empowered participants to take a more active role in managing their health and has increased engagement in ongoing care. Follow-up support is provided to all participants, and documented home blood pressure readings offer valuable data to healthcare providers for informed management and treatment decisions.

During the same period, the Smiles (Dental) component has served 56 individuals, with a total investment of $20,636.84 in dental services. These services addressed a variety of oral health needs and reduced barriers to care for individuals who may not otherwise have access to dental treatment. Several participants required follow-up visits to complete their treatment plans, supporting continuity of care and improved oral health outcomes.

Overall, the Clay County Health Department continues to successfully implement the Healthy Heart and Smiles program, demonstrating progress toward improving cardiovascular health, increasing access to dental care, and addressing key community health priorities identified in the Community Health Improvement Plan.

Clay County School Wellness

The Clay County School Wellness Initiative is a collaborative effort supporting employee health within the Clay County School System. The program fosters a supportive environment that encourages healthier lifestyles, preventive care, and awareness of personal health. It serves school system employees interested in improving their physical health and overall well-being, creating impact at both the individual and organizational levels by promoting healthy behaviors and early identification of potential health concerns.

At these on-site wellness events, participants can take part in a variety of health screenings, including blood pressure checks, weight and BMI measurements, and hearing and vision screenings. Laboratory testing, including fasting bloodwork such as CBC, CMP, lipid panel, hemoglobin A1C, thyroid panel, and uric acid, is also provided to give a comprehensive view of employees' health. In addition, participants receive educational materials and resources to support healthier lifestyle choices, including guidance on physical activity, nutrition, and tobacco cessation, making it easy and convenient to take steps toward better health.

In 2024, the Clay County Health Department completed 17 blood draws along with several additional health screenings for school system employees. In 2025, participation increased, with 19 blood draws completed and several additional screenings conducted. Following each wellness event, the health department contacts participants to review abnormal results and ensure appropriate follow-up with a healthcare provider, supporting continuity of care and early intervention when needed.

Due to the success and positive response to the wellness events, the Clay County Health Department continues to collaborate with the Clay County School System as a member of the district's wellness team. The school system has demonstrated a strong commitment to employee health and recognizes the importance of maintaining a healthy, supported, and productive workforce.

The next staff wellness event is scheduled for March 13, 2026, and the Clay County Health Department plans to continue its partnership with the school system to expand and sustain wellness programming. As participation grows, this initiative may provide valuable insights to inform future workplace wellness efforts across other sectors of the Clay County community.

Promotion and Referral to Quitline NC

The Clay County Health Department promotes referrals to Quitline NC as an effective community-based approach to support respiratory health and help reduce lung cancer rates in conjunction with other local efforts. As part of routine clinical practice, all clients are asked about their tobacco use during clinic visits, and those interested in quitting receive education on Quitline NC, a free, evidence-based service that provides counseling, personalized quit plans, and ongoing support. Nursing staff also offer brief counseling on the health benefits of quitting and the importance of tobacco cessation, making this initiative a central component of the department's broader strategy for tobacco cessation and chronic disease prevention.

The primary target population for this strategy includes individuals who currently use tobacco products and demonstrate readiness or interest in quitting. Quitline NC operates at the individual level by offering tailored counseling, coping strategies for cravings, and continued support to promote sustained behavior change.

To date, the Clay County Health Department has had two patients who agreed to have a referral faxed directly to Quitline NC. In addition to patient-level referrals, outreach has been conducted with local healthcare providers to expand Quitline NC utilization. Currently, one local provider has agreed to enroll as a participating Quitline NC referral site, helping to strengthen community-wide referral capacity.

While many patients are receptive to education and take Quitline NC materials home, a continued challenge is limited follow-through in initiating contact with the Quitline after the clinic visit. Educational materials and Quitline NC resources are consistently provided to encourage future engagement, even when a referral is declined at the time of service.

The Clay County Health Department continues to assess and explore strategies to improve referral uptake and engagement, including follow-up contact, real-time referral assistance during appointments, and enhanced counseling approaches such as motivational interviewing. Ongoing implementation efforts will continue with the goal of increasing successful quit attempts, strengthening referral pathways, and reducing tobacco-related health risks within the Clay County community.

Morbidity and Mortality Changes Since Last CHA

Current reports from the North Carolina State Center for Health Statistics indicate that Clay County continues to experience high rates of chronic disease, with many conditions increasing over recent years. Between 2019 and 2023, cancer deaths rose from 151 to 161, and deaths from diseases of the heart increased from 180 to 191. During this period, there were also 12 deaths by suicide and 41 deaths due to unintentional injuries. For comparison, **Table 1** presents the most recent statistical data, while **Table 2** reflects the data used in the 2023 State of the County Health Report.

Although these numbers are concerning, the Clay County Health Department remains committed to improving health outcomes and increasing life expectancy in the community. Progress toward these goals is detailed throughout this document. One ongoing challenge is ensuring residents understand the impact of their personal choices and behaviors on their health, highlighting the importance of individual awareness and preventive action.

Table 1 - Leading Causes of Death 2019-2023.

Rank	Cause of Death	Clay	
		# Deaths	Death Rate
	All Causes (some not listed)	834	800.9
1	Diseases of Heart	191	175.2
2	Cancer	161	127.7
3	COVID-19	74	64.7
4	All Other Unintentional Injuries	41	64.5
5	Chronic Lower Respiratory Diseases	36	34.9
6	Cerebrovascular Disease	29	26.2
7	Alzheimer's Disease	26	22.5
8	Diabetes Mellitus	18	21.7
9	Suicide	12	18.4
10	Pneumonia and Influenza	14	13.8

11	Unintentional Motor Vehicle Injuries	6	13.7
12	Chronic Liver Disease and Cirrhosis	13	12.1
13	Septicemia	14	12.1
14	Nephritis, Nephrotic Syndrome, and Nephrosis	11	10.5
15	Homicide	3	5.7
16	Acquired Immune Deficiency Syndrome	1	0.9

(North Carolina State Center for Health Statistics (NC SCHS)

Table 2 - Leading Causes of Death 2017-2021.

Rank	Cause of Death	Clay	
		# Deaths	Death Rate
1	Acquired Immune Deficiency Syndrome	**1**	
2	All Other Unintentional Injuries	43	66.2
3	Alzheimer's disease	37	34.0
4	Cancer	151	133.6
5	Cerebrovascular Disease	42	39.8
6	Chronic Liver Disease and Cirrhosis	**11**	
7	Chronic Lower Respiratory Diseases	41	37.6
8	COVID-19	51	48.5
9	Diabetes Mellitus	25	26.4
10	Diseases of Heart	180	172.8
11	Homicide	**2**	
12	Nephritis, Nephrotic Syndrome, and Nephrosis	**17**	
13	Pneumonia and Influenza	**16**	
14	Septicemia	**7**	
15	Suicide	**14**	

16	Unintentional Motor Vehicle Injuries	7	
	All Causes (some not listed)	831	850.0

(North Carolina State Center for Health Statistics (NC SCHS)

Emerging Issues Since Last CHA

- An emerging issue with teenagers vaping within the local school system.
- Mental Health continues to be a concern as there are limited providers/resources available.
- Social determinates of health continue to be a challenge for our residents along with the lack of access to healthcare.
- Increase interest in new weight loss medication but lack of funding for patients to have access to the medication.
- Workforce recruitment and retention.
- Substance use disorder continues to be a concern.
- Affordable housing
- An increase in infant mortality cases associated with unsafe sleep practices, particularly co-sleeping.
- Limited access to nutrition counseling services

New/Paused/Discontinued Initiatives Since Last CHA

- The PORT team initiative has been implemented to strengthen coordinated response and prevention efforts within the community.
- Updated PCV vaccine guidelines now allow for protection with a single dose rather than requiring a multi-dose series, simplifying the vaccination schedule while maintaining effective coverage.
- Smoky Mountain Pregnancy Center now provides services to pregnant women at the Clay County Health Department through their mobile unit and has increased visits from monthly to weekly, improving access to care for our community.
- Pregnancy Care Management has expanded education efforts to ensure all pregnant mothers are informed about the risks associated with co-sleeping and unsafe sleep practices. The program is also actively seeking funding opportunities to provide essential safe sleep resources to families to help reduce the risk of sleep-related infant deaths.
- Clay County Health Department has expanded laboratory services to include select tests that may be obtained without a physician’s order, including Executive III, PSA, Hemoglobin A1c, Vitamin B12, and Vitamin D.
