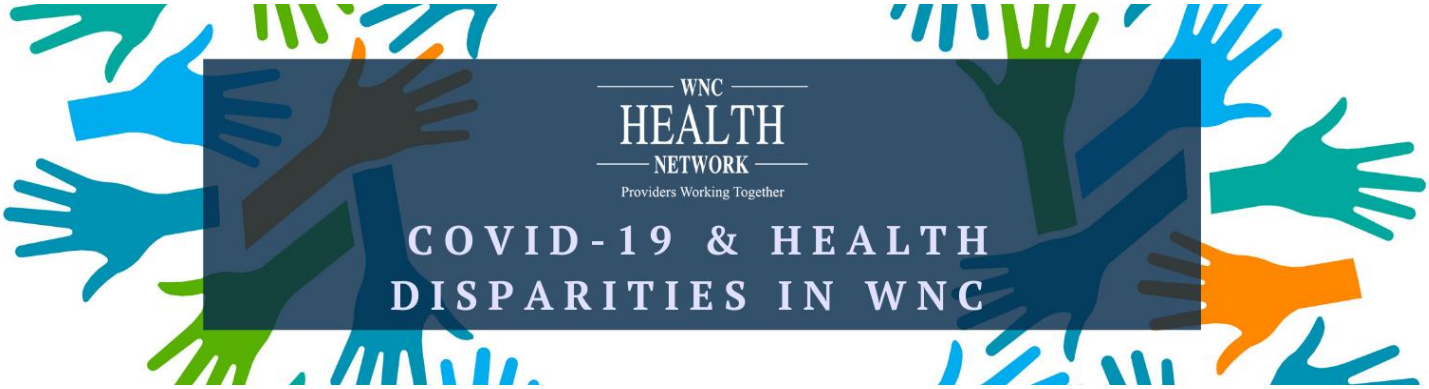


"Public health crises take a significantly increased toll on groups who were marginalized before the crisis."
(FSG, 2020)

Even before the COVID-19 pandemic, inequities in western North Carolina meant that individuals who were low-income, uninsured, unemployed, or belonging to communities of color were more at risk for poor health outcomes.

The health, economic, and social impacts of COVID-19 are likely to perpetuate and exacerbate existing disparities in the region, such as those around race, income, and employment. These increased disparities may, in turn, have both short- and longer-term impacts on health status and outcomes. National data shows that people of color are experiencing a disproportionate burden of serious illness and death associated with COVID-19. In North Carolina, African Americans make up 22 percent of the population; however, they currently account for 36 percent of the state's COVID-19 deaths. In an emerging trend, statewide and regionally, a disproportionate number of Hispanic/ Latinx people are testing positive for COVID-19. This group makes up 9 percent of the state population; however, they currently account for 32 percent of laboratory confirmed COVID-19 cases in North Carolina. Accurate and complete race and ethnicity data is necessary to understand the true burden of the disease on people of color and to inform appropriate COVID-19 planning and response. Additional race and ethnicity impact data is available **here**.

Our region is already experiencing negative impacts in the social determinants of health that experts have predicted from this pandemic:

- Low-income and working poor individuals will lose valuable income
- Food insecurity will increase
- More people will experience mental health and substance use disorders
- Housing insecurity and instability will increase
- Children and family members will be at increased risk of trauma and violence
- Children will have their educational progress upended by prolonged school closures and suffer associated "learning loss"

Sources: FSG, CDC, AMA

The work many agencies, collaboratives, funders, and other local and regional partners are doing together to address these challenges is more important than ever. Together, we can—and must—ensure that we are addressing the needs of our most at risk populations during this public health emergency and creating systems and policies that will put western North Carolina on a path to eliminating health disparities in the future. With each decision made during this crisis, we have an opportunity to either perpetuate the inequities that contribute to these disparities or, together, to build a future that is fair for everyone.

The data below highlights preliminary results from an exploratory data analysis of the WNC Healthy Impact Community Health Survey 2012, 2015, 2018 that illuminates inequities in our region. WNC Health Network chose to release this report to give communities information for use in COVID-19 planning and response. We do not propose to know the depth of story behind these issues, and we hope these numbers will prompt deeper questioning into the root causes of these issues.

How can you use this data right now?

Existing health disparities, such as underlying health issues and barriers/ access to health care, might make some groups of people more at risk during public health emergencies. Regional health disparity data can help partners with a role to play in responding to the COVID-19 pandemic to:

- Better understand the social determinants of health impacting coronavirus spread
- Prioritize where communities should start to stabilize, rebuild and repair
- Help identify who should receive COVID-19 tests
- Allow medical providers to cater the type of care they deliver based on social need
- Coordinate medical resources to leverage the greatest and most equitable level of care possible for all
- Target or solicit funding
- Tailor community outreach and engagement
- Inform public health initiatives and communication campaigns
- Strengthen governmental processes to address inequities strategically and comprehensively
- Better understand what contributes to disparities
- Advocate for more just systems or policies

Sources: National Academy for State Health Policy, American Medical Association, CDC

What do the numbers say about health disparities in WNC before COVID-19?

WNC Data
(For more information about data source and methodology, see pg. 6)

Findings below highlight that **low socioeconomic status, lack of insurance, inability to work, unemployment, rural residency, and certain racial and ethnic membership** persist as determinants of poor health outcomes in our region.

Income - Compared to high income groups, people in the lowest income group were:

- 70% more likely to be obese
- 2.4 times more likely to have asthma
- 2.7 times more likely to have COPD
- 3.1 times more likely to report poor mental health
- 3.6 times more likely to have heart disease
- 3.8 times more likely to report poor physical health
- 4.9 times more likely to be limited by impairment

Lack of Insurance - Compared to people with insurance, people who were uninsured were:

- 31% more likely to experience high blood pressure
- 64% more likely to be limited by impairment
- 84% more likely to experience high cholesterol
- 2.1 times more likely to have prediabetes
- 2.2 times more likely to have diabetes

Employment - Compared to people with jobs, people who were unable to work were:

- 77% more likely to be obese
- 88% more likely to experience high cholesterol
- 2.1 times more likely to have prediabetes
- 2.6 times more likely to have asthma
- 2.8 times more likely to have COPD
- 3.5 times more likely to report poor mental health
- 3.9 times more likely to have diabetes

Compared to people with jobs, people who were unemployed were:

- 2.2 times more likely to report poor mental health
- 3.2 more likely to be limited by impairment
- 5.6 times more likely to report poor physical health

Rural Residency - Compared to people who live in urban areas, people living in rural areas were:

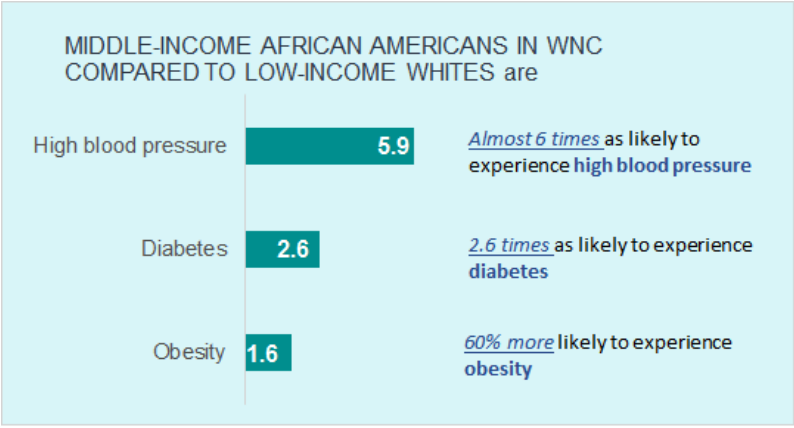
- 15% more likely to be limited by impairment
- 19% more likely to experience high blood pressure
- 20% more likely to experience high cholesterol
- 33% more likely to be obese

Race/ Ethnicity - Compared to whites, people self-identifying in the following race/ ethnicity categories were more likely to experience certain health issues:

- Hispanic/ Latinx were 39% more likely to have diabetes.
- American Indians/ Alaska Natives were 56% more likely to experience high cholesterol
- People self-identifying as 'other' (for example, American Indian/ Alaska Natives, mixed-race, etc.) category were 43% more likely to report COPD
- American Indians/ Alaska Natives were 2 times more likely to have COPD
- African Americans were 79% more likely to have prediabetes
- African Americans were 87% more likely to experience high blood pressure

We acknowledge the use of "whites" as the normative reference group for statistical analysis, and the role it plays in sustaining social privilege. We used "whites" as the reference group for this analysis because it was both the group with the largest numbers (n) and lowest risk of health outcomes.

Race and Poverty - Race and poverty had a combined effect on health inequalities in the region. For example, African Americans emerged as a particularly high-risk group. Having a higher income was expected to provide protection and reduce disparities in health for this group. However, African Americans with the same or higher income level as whites were still more likely to have or experience high blood pressure, diabetes, obesity, prediabetes, and COPD.



State/National Findings

- Racial and Ethnic Health Disparities in North Carolina: North Carolina Health Equity Report 2018 (NCDHHS, 2018) *Measures and monitors the state's progress toward eliminating the health status gaps experienced by racial/ethnic groups.*
- Statistics and Reports: Minority Health (NC DHHS, 2018) *Statistics and Reports featuring racial/ ethnic disparities.*

- Racial/ Ethnic Health Disparities among Rural Adults – United States, 2012-2015 (CDC, 2017) *Overview of racial/ ethnic health disparities for selected indicators in rural areas of the United States.*
- Health Disparities and Strategies Reports (CDC, 2018) *Highlights effective public health strategies that have reduced disparities.*

What is the story behind the numbers?

In addition to looking at the "number data," understanding the "story behind the numbers" is an essential component of making responsive, data-driven decisions. Story data helps us understand why the numbers are the way they are in our communities—they help us uncover root causes. When we understand the root causes of our community problems, we have a better chance of finding the right solutions, together.

We explore the story behind the numbers when we ask:

What's Helping? What conditions, policies, programs or other factors are helping us do as well as we are doing? *These are the positive forces at work in our community and beyond that influence this issue in our community.*

A prompting question can be, "Why aren't these data disparities bigger?" Ask "why?" multiple times to a single cause to get to root causes. Challenge assumptions. Seek input about what's helping at the individual, organizational, environment and policy levels.

What's Hurting? What conditions, policies, programs or other factors are contributing to this problem and keeping us from doing better? *These are the negative forces at work in our community and beyond that influence this issue in our community.*

Prompting questions can be, " Why are these data disparities as bad as they are?; What is getting in the way of things getting better?; and What are we holding in place that prevents progress?" Challenge assumptions. Seek input about what's hurting at the individual, organizational, environment and policy levels.

Gather "helping" and "hurting" data from a range of key stakeholders, particularly people most affected by the issue. Use this deeper understanding of the issue to point you to strategic action and what works to do better.

What is already happening regionally?

- The Asheville Buncombe Institute of Parity Achievement (ABIPA) has launched a Community-Activated Response Equitably initiative that supports seniors and medically vulnerable African American/Black residents of Buncombe, Burke, and Rutherford counties and residents in those counties who work in regular contact with others. CARE activities include: COVID-19 health education; Distribution of free reusable and disposable masks; Sanitation care packages for individuals and families in need.
- Kathey Avery, RN, BSN, DCCC, Frank Castelblanco, RN, DNP and Shuchin Shukla, MD, are fellows in the RWJF Clinical Scholars program. These local health care professionals lead the regional project, Health Engagement Leading to Prevention (H.E.L.P.). H.E.L.P.'s goal is to address and mitigate social determinants of health with specific focus on mental health. H.E.L.P is addressing the COVID-19 pandemic by using their trained community health workers to educate and distribute supplies to low-income and individuals with cognitive disabilities to encourage them to follow public health guidelines.
- The NC Inclusive Disaster Recovery (NCIDR) network has developed a living document for organizations serving historically under-resourced and marginalized communities to quickly share and access resources and discover engagement opportunities. The online document is updated frequently.
- Any organization in any county is now able to join NCCARE360. The focus right now is to support

organizations currently providing services for COVID-19 and to prepare for the social service impact.

If you would like to suggest or share an addition to *What's already happening regionally*, contact Jo Bradley, Data Manager & Improvement Specialist, at Jo.Bradley@wnchn.org.

Additional Resources

- NC Cases COVID-19 – NC DHHS Dashboard by Race/Ethnicity (NC DHHS, 2020)
- As Covid-19 Spreads, Different Communities See Different Changes (American Communities Project, 2020) *The American Communities Project uses community typologies as well as data to explore differences in rural America. Explore the impact of the COVID-19 pandemic on the 15 community types.*
- Racial Disparities Magnified by COVID-19 Cases and Deaths (PolicyMap, 2020) *Discusses and displays how tracking and mapping, paired with demographic, health and jobs data, can be used to reveal specific groups disproportionately affected by the virus.*
- The COVID Racial Data Tracker (The COVID Tracking Project) *The COVID Racial Data Tracker tracks inequity by collecting, publishing, and analyzing racial data on the pandemic from across the United States. It is a collaboration of the COVID Tracking Project and the Antiracist Research & Policy Center.*
- Coronavirus and Socioeconomic Status Map (Broadstreet, 2020) *Measures socioeconomic status with The Area Deprivation Index (ADI). The ADI combines measures of poverty, education, employment, and housing into a single indicator. Here, they have mapped ADI alongside of COVID-19 Cases to demonstrate emerging disparities within the United States.*

About the WNC Data:

Data Stories for Equity in WNC: The WNC disparity data highlighted above is the product of an ongoing WNC Health Network project, *Data Stories for Equity in Western North Carolina*. The project aims to improve the stories we tell with our data by using an equity lens and collaborating across sectors to gather feedback from community members with lived experience. Due to COVID-19, we have extended the project deadline and our community member collaboration and feedback through summer 2020.

Funding & Support: The regional dataset is available thanks to the investment of hospitals in western North Carolina and from the collaboration and in-kind contributions from hospitals, public health agencies, and partners, and is housed and coordinated by WNC Health Network. The Data Stories for Equity in Western North Carolina project and data analysis was funded by Data Across Sectors for Health (DASH) through their DASH CIC-START program.

Data Analysis Methods: Every three years, WNC Health Network compiles a comprehensive regional dataset, through WNC Healthy Impact, to describe health challenges and opportunities in the 16 counties western North Carolina counties. WNC Healthy Impact's regional dataset includes secondary (existing) data and primary (newly collected by WNC Health Network) data compiled to reflect a comprehensive look at health. The purpose of the WNC Healthy Impact Community Health Survey is to collect primary data to supplement the secondary core dataset, allow individual counties in the region to collect data on specific issues of concern, and hear from community members about their concerns and priorities. The survey is conducted throughout the entire WNC Healthy Impact region every three years and aligned with the region's CHNA cycle and hospital and health department requirements. Data from the WNC Healthy Impact Community Health Survey were analyzed for the years 2012, 2015, and 2018 (n=9876) for all 16 counties in the region. All analysis accounted for the complex survey design and used sample survey weights. Adjusted and unadjusted logistic regression models were used to examine the association between health outcomes and a number of personal and social factors, including race, income, employment status, educational attainment, and insurance status. Analysis used pooled data across survey years when possible for each outcome of interests (2012-2018).

Learn more: WNC Healthy Impact Data Collection Methods and Limitations

Citations: Please use the following citation when referring to this report: WNC Health Network. (2020). COVID-19 & Health Disparities in WNC, May 2020. (Report v. 5.27.20). Asheville, NC: WNC Health Network. Retrieved from https://www.wnchn.org/covid-19-health-disparities/.
Please use the following citation when referring to the data: WNC Health Network. (2020). WNC Healthy Impact Community Health Survey 2012, 2015, and 2018. [Unpublished raw data].

For More Information or to suggest edits and additions to this document, contact Jo Bradley, Data Manager & Improvement Specialist, at Jo.Bradley@wnchn.org

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