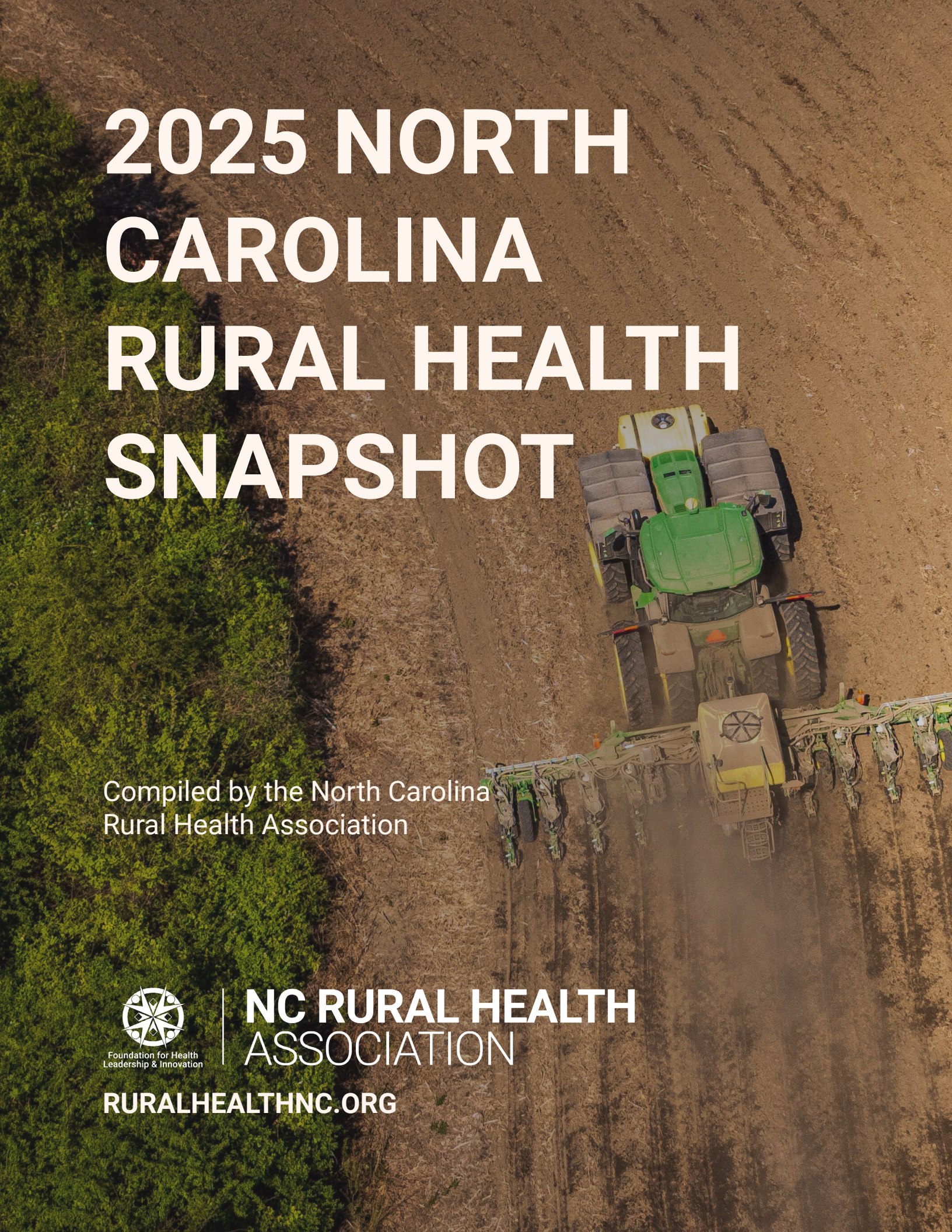
2025 NORTH CAROLINA RURAL HEALTH SNAPSHOT



Compiled by the North Carolina Rural Health Association

Foundation for Health Leadership & Innovation

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CONTENTS

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ABOUT NCRHA

Better Health Begins at Home

Where you live should not impact your options and opportunity to live a happy, healthy life. The North Carolina Rural Health Association (NCRHA) advocates for health access and equity for every North Carolinian, regardless of who they are or where they live.

Nearly 40% of North Carolinians call a rural community home. Building a healthy North Carolina can only happen when those communities have the power to drive decision-making around solutions to the most pressing needs they face. NCRHA exists to listen, learn, and help communities lead toward a healthier future for everyone, regardless of their zip code.

The North Carolina Rural Health Association (NCRHA) is the official state affiliate of the National Rural Health Association (NRHA), led by the Foundation for Health Leadership & Innovation (FHLI). Our extensive membership network includes organizations and individuals committed to advancing health equity and access to care by amplifying the voices of our vibrant rural communities.

Invested in Supporting Rural Health

NCRHA is a collaborative network of associations, organizations, and individuals representing health care, education, economic development, local government, and a variety of other partners invested in supporting rural health. The organization and its membership are committed to amplifying the voice of North Carolina's rural communities, helping foster a movement to improve the health and well-being of all citizens.

NCRHA serves as a single organizer to connect, foster, advocate, and share a unified voice that promotes better rural health outcomes for the people who call rural North Carolina home.

NCRHA 2024–2025 Membership

Thank you to our 2024–2025 members! These organizations and individuals are making their voices heard and contributing to improving rural health across North Carolina.

CARE RING

NORTH CAROLINA DENTAL SOCIETY

ADA

NC AHEC RECRUIT TRAIN RETAIN

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NC DEPARTMENT OF HEALTH AND HUMAN SERVICES Office of Rural Health

NORTH CAROLINA ACADEMY OF FAMILY PHYSICIANS

NORTH CAROLINA NCCHCA Serving Community & Migrant Health Centers Community Health Center Association

NOVANT HEALTH Pender Medical Center

NC RURAL CENTER

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GREEN RURAL ORGANIZATION GRRO

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RHG RURAL HEALTH GROUP healthcare that fits your family

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Reflections: Kody Kinsley's Tenure at NCDHHS

"I hope that, just a little bit, the average person in the public can feel more like their government works well for them. That really matters."

— Former NCDHHS Secretary Kody Kinsley

In January 2025, former Secretary Kody Kinsley concluded his term as head of the North Carolina Department of Health and Human Services (NCDHHS). Since 2018, Kinsley has seen North Carolina's public health institutions through significant changes, from a complete upheaval during the COVID-19 pandemic to the rollout of Medicaid expansion.

Kinsley grew up in Wilmington, North Carolina. He went to college in Brevard, moved to California for graduate school, and was eventually appointed to a federal position by President Barack Obama. He was one of 50 federal appointees who served under both Presidents Obama and Donald Trump. In 2018, North Carolina Governor Roy Cooper tapped Kinsley to lead NCDHHS.

Reflecting on his tenure in North Carolina, Kinsley spoke about four major points he believes will continue to impact future generations. Throughout this 2025 North Carolina Rural Health Snapshot, you will find Kinsley's thoughts on these "big things" and the impact they are having on whole-family health across the state.

Kody Kinsley's Four "Big Things" Impacting Health in North Carolina

- Medical Debt
- Mecicaid Expansion
- Behavioral Health
- The Healthy Opportunities Pilot

HURRICANE RESILIENCE

"Build a coalition of the willing. Grant grace to those who can't join you yet and leave the table open for when they're ready. Every grievance, every complaint holds within it a vision of a hoped-for future. Listen to that vision." — Angela Blanchard

From September 25 through September 28, 2024, rain inundated 17 counties in Western North Carolina, home to the beloved Blue Ridge Mountains, culminating with the arrival of category four Hurricane Helene, the third deadliest in modern history.[1]

As overflowing rivers traveled downstream through the mountains, water continued rising in lower areas, destroying homes, businesses, parks, hospitals, and more. The catastrophic flooding reached over 30 inches, exceeding the historic "Great Flood" of 1916 by more than 1.5 feet at its peak. Busick, in rural Yancey County, recorded a total of 30.78 inches of rain.[2]

The United States Geological Survey reported over 2,000 observed landslides caused by the torrential downpour.[3] Bridges, highways, and roads were washed away, and at one point, all routes in and out of the region were considered closed for non-emergency travel. Neighborhoods and towns, such as Chimney Rock in Rutherford County, were deluged by flood waters, mud, debris, and pollution.

With the hurricane knocking out power lines and cell towers, many residents throughout Buncombe County and surrounding areas were left without electricity or service, unable to communicate or call for outside help for days. Flooding destroyed the North Fork Water treatment plant in Asheville, leaving tens of thousands of people without drinkable water for 53 days.[4]

The National Centers for Environmental Information estimates a total death toll across all impacted states of over 200 people, with nearly half of them dying in North Carolina.[4] According to a North Carolina Governor's Office report, more than an estimated 70,000 homes were damaged. The region is predicted to experience $50 billion or more in economic losses.[2]

[1] *Report: About 40% of Buncombe trees were damaged or downed by Helene*. Asheville Watchdog. https://avlwatchdog.org/report-about-40-of-buncombe-trees-were-damaged-or-downed-by-helene/

[2] *Hurricane Helene's extreme rainfall and catastrophic inland flooding.* NOAA. https://www.climate.gov/news-features/event-tracker/hurricane-helenes-extreme-rainfall-and-catastrophic-inland-flooding

[3] *Asheville restores drinking water 53 days after Hurricane Helene.* The Guardian. https://www.theguardian.com/us-news/2024/nov/22/asheville-drinking-water-hurricane-helene

[4] *Hurricane Helene 2024 Landslide Observations.* USGS. https://www.arcgis.com/apps/dashboards/01b4f51fc0b64002bf7722a9acfc181d

Mirroring the physical effects of the storm, Hurricane Helene has taken a toll on the health and well-being of community members, providers, and frontline workers alike, from inflicting physical injuries to disrupting access to food, water, and resources, accelerating the spread of sickness, and exacerbating chronic conditions.

Damage from the hurricane caused delays in preventative care and intensified challenges related to social drivers of health, such as decreases in income, loss of employment, displacement, and housing instability for hundreds of thousands of people.

According to an NC Health News analysis of preliminary data, at least 2,609 people were experiencing homelessness in the 25 counties impacted by Helene, marking a 20% increase from 2023.[5]

Natural disasters are considered Adverse Childhood Experiences (ACEs), and some researchers estimate that 20-40% of an impacted population may experience post-traumatic stress disorder (PTSD) after a collective disaster like Helene.[6] Symptoms, such as elevated stress, anxiety, depression, sleep disturbances, flashbacks, nightmares, social isolation, and persistent negative thoughts, can continue escalating for months or even years after an event. Along with igniting mental and behavioral health challenges, natural disasters can also compound preexisting conditions.

According to meteorologists, Helene is close to, if not the worst-case, weather event for the region with tiny tributaries suddenly swelling into raging rivers.[2] The full impact—from physical destruction to mental and emotional well-being—is still being realized, and assessing the full scope of the damage will take months, if not years.

Following the aftermath of the storm, the state pledged $25 million in mental health resources, and Congress approved billions of additional dollars for hurricane recovery in December.[7] With natural disasters becoming more common, North Carolina must act now. By prioritizing all forms of preparedness and resilience across the state, we can truly invest in whole-person, whole-family, whole-community, and whole-state health.

In December 2024, WNC Nonprofit Pathways hosted a Nonprofit Leadership Forum called The Power of Nonprofits: Reimagining and Rebuilding a Resilient WNC (Western North Carolina).[8] The keynote speaker, Angela Blanchard, Chief Resilience and Recovery Officer for the City of Houston and expert practitioner in community development and long-term resettlement, shared her abundant wisdom about recovering from natural disasters.

She emphasized the essential need for creative problem-solving, courageous leadership, and cross-sector collaboration to first imagine and then build a better future for everyone where no one gets left behind.

As we examine rural health in North Carolina, the questions Blanchard posed are equally fitting for statewide work and multi-sector partnerships: **“What would this be like if it worked for everyone? What would you be willing to do to make that come about?”**

To that end, she advised, “Build a coalition of the willing. Grant grace to those who can’t join you yet and leave the table open for when they’re ready. Every grievance, every complaint holds within it a vision of a hoped-for future. Listen to that vision.”

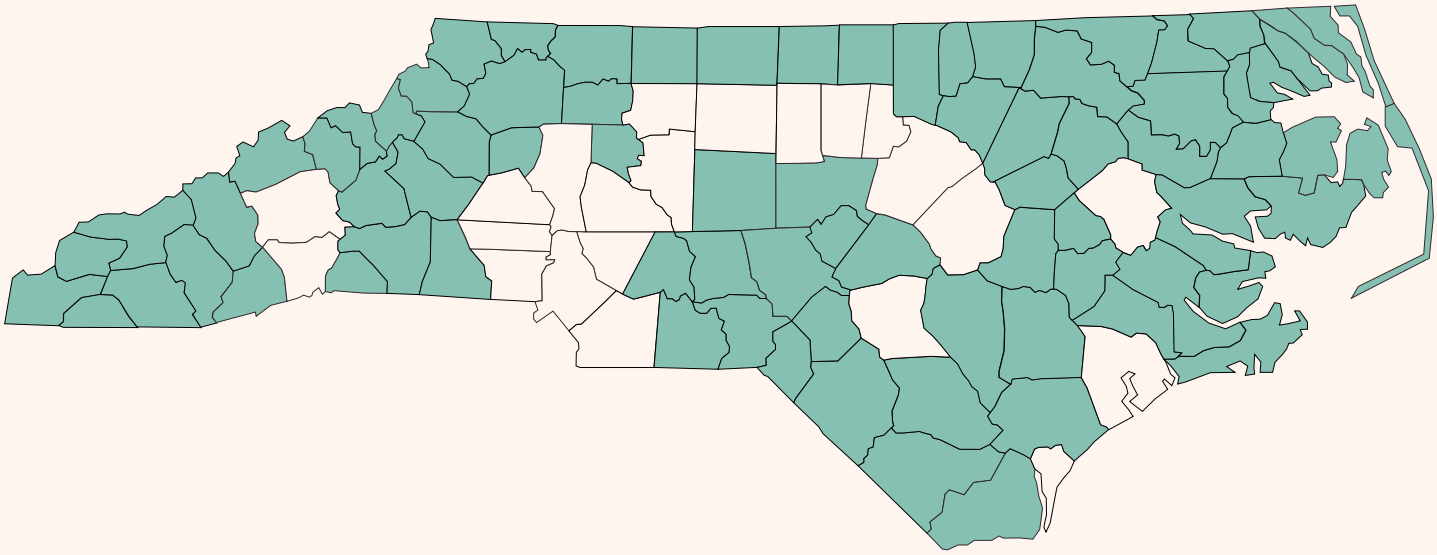
[5] *Helene exacerbated rise in homelessness across western North Carolina.* WUNC. https://www.wunc.org/health/2024-12-16/helene-homelessness-western-north-carolina

[6] *Post-traumatic stress disorder associated with natural and human-made disasters in the World Mental Health Surveys.* Psychol Med. https://pmc.ncbi.nlm.nih.gov/articles/PMC5432967/

[7] *Here’s a look at the $100 billion in disaster relief in the government spending bill.* AP News. https://apnews.com/article/disaster-relief-government-spending-bill-helene-milton-d2b4fed85aabfe5cd1cc45e51d952ca8

[8] *WNC Nonprofit Pathways*. https://nonprofitpathways.org/about-us/

NC COUNTY MAP



78

Rural Counties[1]

22

Urban/Suburban Counties[1]

RURAL COUNTY

County with an average population density of 250 people or fewer per square mile

SUBURBAN COUNTY

Counties with an average population density between 250 and 750 people per square mile

URBAN COUNTY

Counties with an average population density that exceeds 750 people per square mile

[1] *County Data*. NC Rural Center. https://www.ncruralcenter.org/county-data/

POPULATION

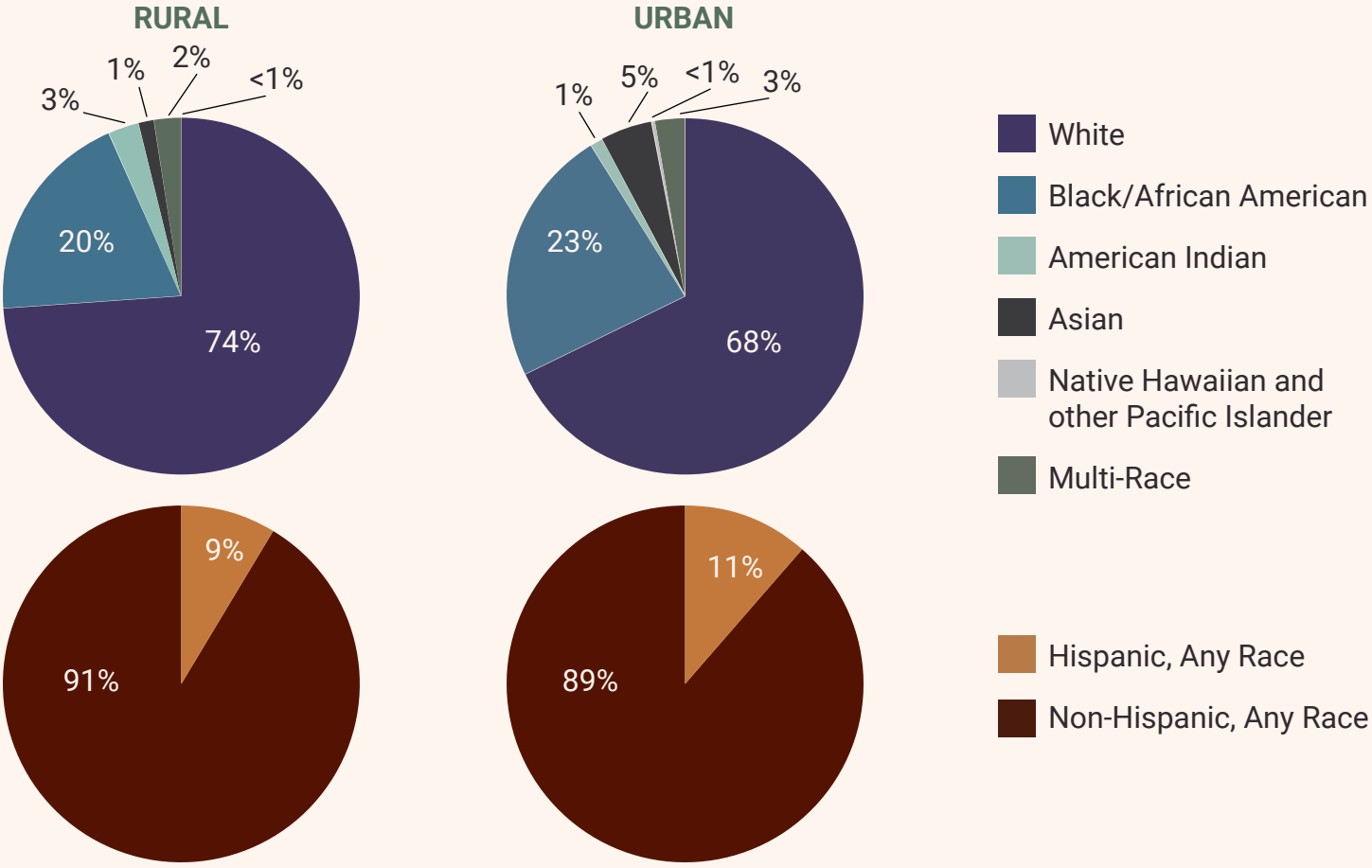
North Carolina is home to the second largest rural population in the country after Texas.[1]

Rural America grew in population from 2020 to 2023, following a decade of population loss. While rural North Carolina followed this trend, overall population growth was felt unequally across every region. All 18 North Carolina counties that lost population from 2020 to 2023 are classified as rural. Of those, half are in the northeastern part of the state.[2]

3.73 million
NC Rural Population[4]

+2.7%
Rural Population Growth, 2020–2023[2]

NORTH CAROLINA RACE AND ETHNICITY: 2022[3]



[1] *15 Things We Learned from the New 2020 Census Data.* NC Office of State Budget and Management. https://www.osbm.nc.gov/blog/2023/05/25/15-things-we-learned-new-2020-census-data

[2] *Rural Resurgence: Recent Population Growth in Rural NC.* NC Rural Center. https://www.ncruralcenter.org/wp-content/uploads/2024/06/DRAFT3_Population.Change.2010-2023.pdf

[3] *Race and Ethnicity by County, July 1, 2022 NC Population Estimates.* North Carolina Department of Health and Human Services. https://www.ncdhhs.gov/2022-ethnicity-and-racial-data-nc-county/download?attachment

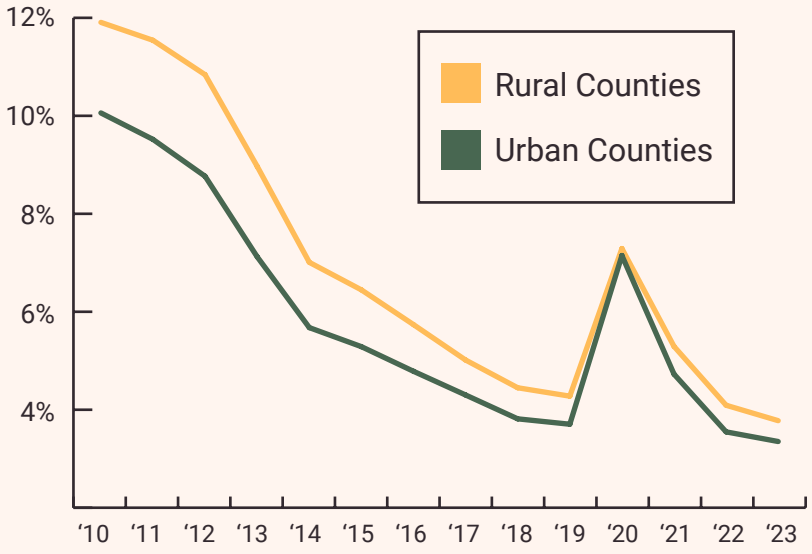
[4] *Certified County Population Estimates.* NC Office of State Budget and Management. https://www.osbm.nc.gov/facts-figures/population-demographics/state-demographer/county-population-estimates/certified-county-population-estimates

INCOME AND POVERTY

2023 RURAL POVERTY RATE	VS	2023 URBAN POVERTY RATE
17.8%		12.3%

In 2023, 17.5% of children in North Carolina lived in poverty, the 14th highest child poverty rate in the nation.[2] In rural counties in 2023, 22.5% of children live in poverty, slightly down from 23.3% in 2020.

UNEMPLOYMENT RATE, 2010–2023



Unemployment is a widely understood social driver of health and is connected to other drivers like education, social support, and the built environment. As a standalone metric, it also carries significant weight.

"Loss of income poses clear financial barriers to accessing resources that protect and improve health. Furthermore, because employer insurance is the most common form of coverage, insuring 56% of the population, job loss can also mean a rise in the uninsured population."

— Healthy North Carolina 2030

[1] *State Fact Sheets.* USDA. https://data.ers.usda.gov/reports.aspx?ID=4035&StateFIPS=37&StateName=North%20Carolina
[2] *Small Area Income and Poverty Estimates.* US Census Bureau. https://www.census.gov/data-tools/demo/saipe/#/
[3] *Local Area Unemployment Statistics*. NC Department of Commerce. https://d4.nccommerce.com/lausselection.aspx
[4] *Healthy North Carolina 2030.* North Carolina Institute of Medicine. https://nciom.org/wp-content/uploads/2020/01/HNC-REPORT-FINAL-Spread2.pdf

Big Thing 1: Medical Debt

"This is what I call the self-licking ice cream cone. It doesn't solve anything, and it exists solely for its own purpose."

"If you owe the hospital $100 or $200, you're not going to the doctor that's associated with that hospital because you can't afford to get in the front door, get past the front desk," said Kinsley. "If you're having some indigestion and it's not going away, you don't go to the primary care doctor to get it handled because you're scared of that 100 bucks. What was a $100 problem becomes a heart attack that lands you in the emergency department, that lands you in even more debt!"

In July 2024, NCDHHS announced a groundbreaking partnership with all 99 acute care hospitals in North Carolina to relieve $4 billion in medical debt for 2 million North Carolinians. Under new policies, Medicaid beneficiaries are eligible for relief of all medical debt dating back to 2014. Other North Carolinians with incomes at or below 350% of the federal poverty level are eligible for relief from all medical debt at least two years old, dating back to 2014.

Along with debt relief, Kinsley spoke about removing red tape in hospital settings. Often, it can be challenging to complete the required paperwork to receive charity care (free or discounted options for people who can't afford the care they need).

"When someone shows up in the ED (emergency department) with a heart attack, that's not the moment to ask them to fill out an application form to get into charity care," he said. "And if someone is on SNAP benefits, then we don't need them to fill out a charity care form. We've already tested their income to be in SNAP, so we know."

By wiping medical debt for millions of North Carolinas and removing red tape to prevent people from going into debt in the first place, Kinsley hopes to increase opportunities for people across the state.

"This matters because medical debt is something that people never wanted in the first place. Nobody chose to have a heart attack, end up in the ED," he said. "And we know that as medical debt ages, the hospitals rarely collect it. Hospitals rarely get much money for debt, but patients carry the entire burden of it. It's both a financial burden and an emotional burden."

By working with hospitals to forgive debt, Kinsley said the health system can "reset these relationships from ones of collection to ones of care for their patients."

EDUCATION

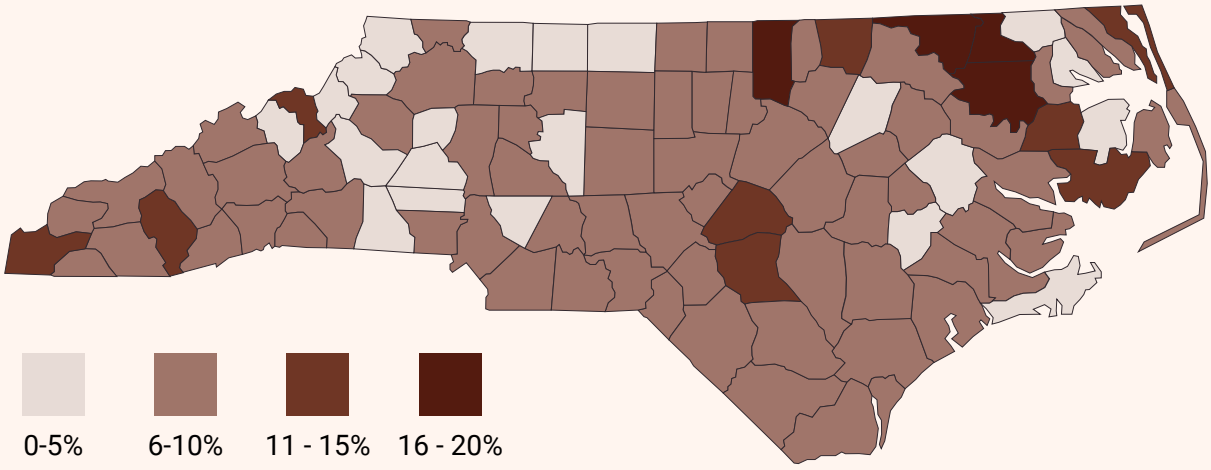
North Carolina has a long history of promoting public education, with many of the best K-12 public schools in the nation located in the state. While there are many excellent schools, funding disparities contribute to stark differences in educational outcomes.

North Carolina ranks among the worst states in the country for teacher pay and per-student spending at 38th out of the 50 states and Washington, D.C., for both measurements.[1] Among North Carolina's neighbors, only Tennessee ranks below North Carolina in average teacher salaries and per-student spending.

How does teacher pay impact health?

While there are direct links between teacher pay and the health of those teachers and their families, there is an additional indirect association between teacher salaries and student health. Data shows a strong association between teacher pay and student outcomes. In turn, educational attainment is an important social driver of health.[2]

PERCENTAGE OF TEACHERS LEAVING THE PROFESSION, 2022[3]



[1] *Rankings of the States and Estimates of School Statistics.* National Education Association. https://www.nea.org/research-publications
[2] *Teachers' Base Salary and Districts' Academic Performance: Evidence From National Data.* Sage Open. https://journals.sagepub.com/doi/full/10.1177/21582440221082138
[3] Local School Finance Study. Public School Forum of North Carolina. https://www.ncforum.org/lsfs/

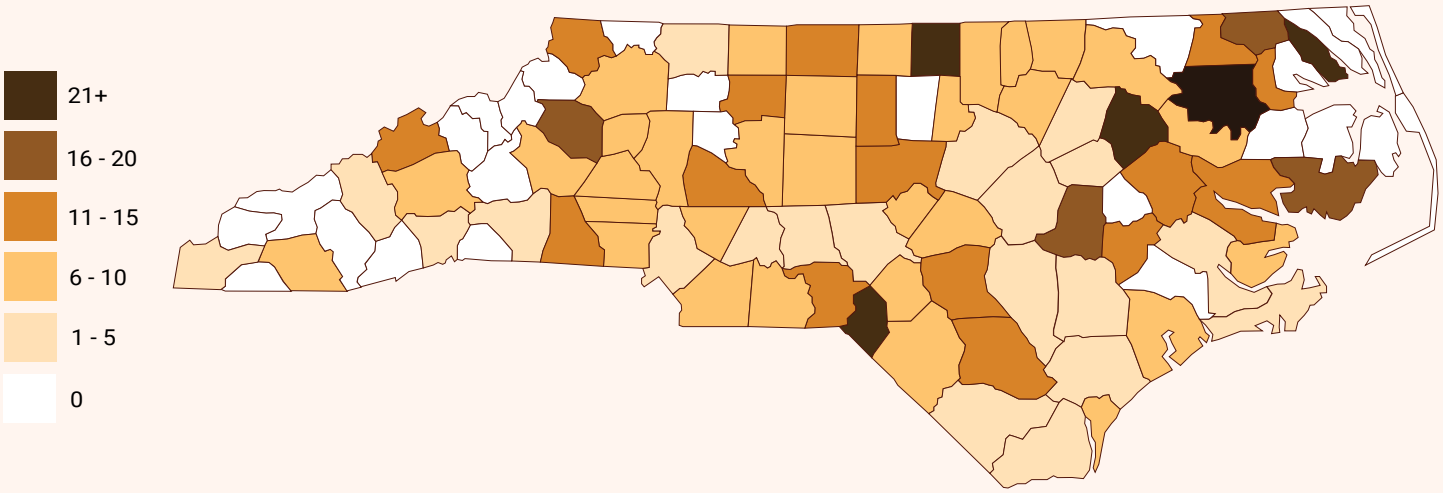
FOOD ACCESS

The United States Departments of Agriculture (USDA), Treasury, and Health and Human Services define food deserts as low-income areas where a substantial number of residents have little access to affordable, healthy food. The USDA provides several measures of food deserts, accounting for distance, personal vehicle access, and public transit options.

In North Carolina, approximately 20% of rural county census tracts are considered food deserts*, compared to approximately 13% of urban county census tracts. Similarly, around 19% of urban county census tracts are flagged by the USDA for having more than 100 residents without vehicle access, compared to around 29% of rural county census tracts.[1]

USDA FOOD DESERTS BY COUNTY, 2019[1]

Number of low-income U.S. Census tracts with substantially low access to affordable, healthy food



* For the purposes of this report, "food deserts" were defined using the USDA's "LI and LA 1 and 10" measure. Measurements were compiled at the county level.

[1] *Food Access Research Atlas*. United States Department of Agriculture. https://www.ers.usda.gov/data-products/food-access-research-atlas/download-the-data

Resilience in Eastern North Carolina

"What we saw was a need to have a safe, welcoming space to learn, grow, and connect with others."

In rural Enfield, North Carolina, Chester Williams and his nonprofit, A Better Chance, A Better Community (ABC2), are reimagining what it means to create opportunity. Williams has dedicated his career to empowering children and families by addressing systematic barriers and fostering community-driven resilience.

"I want to make a difference in the lives of children," said Williams. "I believe that our children have the potential to be successful, but they need the right opportunities to reach their full potential."

ABC2 works to help meet its community's needs across various issues, ranging from food access to transportation, health care, education, and social engagement.

During the COVID-19 pandemic, ABC2 launched the Dawson Resilience Hub in Scotland Neck, a town of just over 1,500 people in eastern North Carolina. Williams said they created the Resilience Hub to respond to community needs by providing food support, among other resources and services.

"What we saw was a need to have a safe, welcoming space to learn, grow, and connect with others," said Williams.

He said people considered to be the most vulnerable often live close to infrastructure that is in place but not being utilized. That's what drew ABC2 to a former school, Dawson Elementary, to serve as their Resilience Hub's physical location.

"We saw that there was a need for a safe and welcoming space where people can begin to come together once we started reconvening and coming out more," said Williams. "And we saw that the school could be a great asset to the community."

ABC2 set up shop and began offering everything from training classes, after-school programs, and "teach-ins" on topics like climate change and emergency preparedness.

"We're also able to talk about the intersectionality of Medicaid with food, with transportation, and come up with some viable community solutions in that space and make it realistic, approachable, and then also sustainable," said Williams.

Through the Dawson Resilience Hub, Williams and ABC2 show how an integrated approach to community needs can empower people to address systemic challenges and create lasting solutions.

HOUSING

Urban Housing Wage	VS	Rural Housing Wage
$28		$21

Housing wage estimates, measured by the North Carolina Housing Coalition, refer to the hourly wage needed to afford a modest rental at the fair market rent. While the hourly housing wage in North Carolina is significantly lower than the national average of $32, it has risen nearly $4/hour since 2023.[1]

48%

of renters are rent burdened, meaning they pay more than 30% of their household income on rent.[1]

139

minimum wage hours worked per week are necessary to afford a two bedroom apartment in North Carolina.[2]

More than a million North Carolinians face a housing cost burden, meaning more than 30% of their income goes toward housing costs.[1]

Cost burden is evenly split across urban and rural counties, but there are significant differences in burden between renters and homeowners. While nearly half of all renters in North Carolina face a significant cost burden, 19% of homeowners face a similar burden.

[1] *2025 North Carolina Profile.* North Carolina Housing Coalition. https://nchousing.org/county-fact-sheets/
[2] HUD Office of Policy Development and Research. https://www.huduser.gov/portal/home.html

Whole-Community Health

"This transcends across homelessness and into the general population. We don't want people to have to wait until they need to see a doctor."

In Burke County, a cross-sector team is working toward a common goal: to improve health care delivery for every resident. Housing prices and shortages have soared in recent years, impacting Burke and other rural communities across the state. Residents who are unsheltered or experiencing housing instability face significant barriers to accessing health services.

Ashley Jarrett, BSN, RN, assistant health director at Burke County Public Health, is leading the development of a street medicine program to meet people where they are and improve whole-community health. "No single agency can do this work," she said. "We want to build a multidisciplinary, multi-agency, health care delivery model that will bring primary and psychiatric care into the streets."

The initiative aims "to take back health care for physicians, nurses, and practitioners and to actually have the time to give back to the patient." Street medicine usually employs evidence-based practices like community health worker and peer-support models. "If you can't depend on anything, you retreat into yourself," she said. "These models pull you out of that by giving you that safe hand to hold the entire time."

Although significant obstacles persist, she sees some forward momentum. Medicaid now has a service code for street medicine, "which means we are inching closer and closer to a better reimbursement model."

This vision for an alternative health care delivery model initially came about during the 2021 Burke County Hepatitis A outbreak when Jarrett realized the health department did not have a way to provide care or deliver vaccines to unsheltered residents.

In response, she assembled a team, including two local health department nurses, Emergency Medical Services (EMS), law enforcement, and a local agency, Burke United Christian Ministry. "We were very intentional about how we approached everything, and I think because of that, we were very successful in not only vaccinating but also building trust," she said.

Drawing on this foundation, she began exploring ways to expand the model. Throughout the process, she said it has been challenging to secure funding and get buy-in from providers, local and state partners, and community members.

"This is a model where the finances will show up on the backside," she said. "They will show up by lower ED (emergency department) utilization. They will show up by improved health outcomes. They will show up by, hopefully, transitioning someone through their unsheltered journey and into a house and into the system again and becoming a productive member of society, if that's what they choose. It will show up in these long-term solutions rather than the short-term game, making money off of this model."

Whole-Community Health, Cont.

Jarrett has begun by identifying community champions to build a successful program. “It’s looking for the people who can get on your side and say, ‘yes,’ we understand that this population doesn’t deserve to be left behind,” she said. “It’s also important to have your community understand that this is a community problem. This is a system failing. This is so complex that it deserves everybody as a system coming together and taking responsibility.”

Implementing this model in a rural county requires a different approach than in more urban areas, she said. “We don’t have as many resources, we don’t have as many staff, we don’t have as much funding.” Insurance restrictions and workforce shortages, especially in the aftermath of the COVID-19 pandemic, have made it difficult to get a team out into the field. Additionally, “We don’t have it fully implemented because there’s a whole different side of the conversation, building up the education behind this,” she said.

Stigmas about homelessness, substance use, and mental and behavioral health challenges are common throughout the county. To address this, Jarrett said education is essential. Last year, the Burke County Public Health Director set up community forums on substance use, which opened a community conversation. “We’re helping with that stigma because we’re constantly talking about it,” she said. “We’re talking about it in a way that is, ‘Did you know that this exists in Burke County?’ and not, ‘You should or should not be doing this.’”

Jarrett also sees a need to update hospital protocols and standing orders for serving unsheltered residents. According to her, an alternative could include referring patients to a social worker and using FHLI’s NCCARE360 network to connect them with other services. By training and educating providers about the impacts of social drivers of health and mental and behavioral health conditions, she hopes to reduce stigma, mitigate bias, and improve outcomes.

She said sustainable systems change starts with having open conversations to find common ground. “We are okay moving slow for long, impactful change. We’re okay with meeting people where they are emotionally, physically, intellectually, and just taking the pace that we need to take.” As part of these efforts, the county is partnering with the UNC-Chapel Hill Gillings School of Public Health to build a more robust mental health coalition equipped with program evaluation. In the future, Jarrett said she would like to get more students involved by incorporating street medicine into rural residency rotations.

She has a vision for expanding this model beyond Burke County. “We just need to start educating people and start getting people to see that system and see where we can take health care,” she said. “What we’re doing is translatable across the state,” she said, citing programs like the Healthy Opportunities Pilot (HOP), FHLI’s NCCARE360 network, the state public health system, mental and behavioral health funding, and the North Carolina Association of County Commissioners.

“North Carolina is positioned incredibly well to support the work of bringing back that community doctor, at bringing back the system that gets out of the office, into the streets and into the houses,” she said. “It will take a lot of statewide leaders, but we have what it takes to make it happen.”

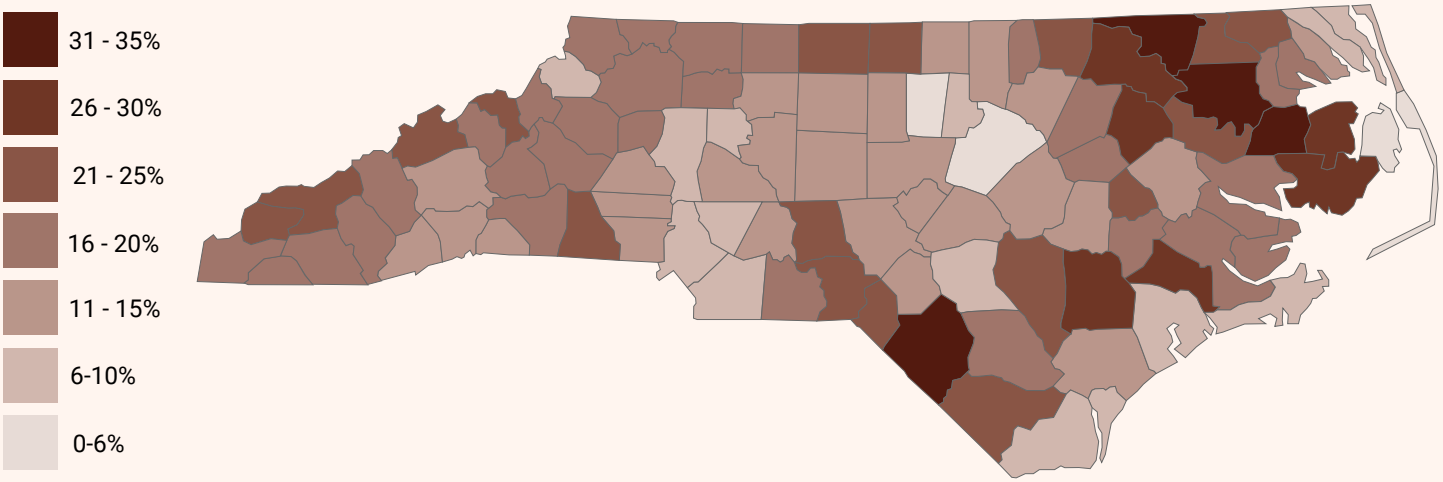
INTERNET ACCESS

RURAL HIGH-SPEED BROADBAND ACCESS	VS	URBAN HIGH-SPEED BROADBAND ACCESS
89.9%		98.9%

Nearly every single North Carolinian has access to some form of broadband internet. However, geography still plays an important role determining the speed, quality, and reliability of broadband service. Especially, in rural North Carolina, poor quality broadband can impact education and job opportunities.

North Carolinians Without Internet

Population percentage without internet in their homes, 2021[1]

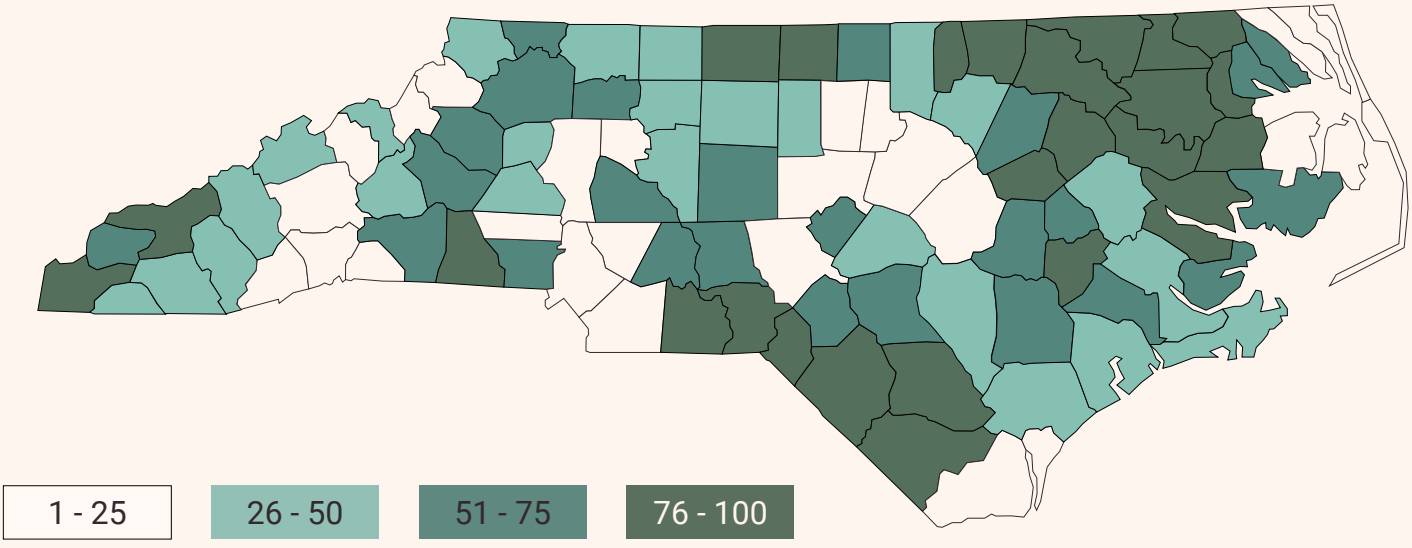


[1] *NC Broadband Indices By County.* North Carolina Department of Information Technology. https://data-nconemap.opendata.arcgis.com/datasets/nconemap::nc-broadband-indices/

RURAL HEALTH

COUNTY HEALTH RANKINGS

County Health Rankings & Roadmaps (CHR&R) is a program of the University of Wisconsin Population Health Institute, funded by the Robert Wood Johnson Foundation. CHR&R tracks data on a wide variety of health factors for nearly every county in all 50 states. By incorporating data on health outcomes, behaviors, care access, social and economic factors, and physical environment, CHR&R assigns a health ranking to each county in each state. Lower numbers correspond with better overall health, with #1 going to the county with the best health score and #100 going to the county with the worst health score.



[1] *Robert Wood Johnson Foundation County Health Rankings, 2023*

HEALTH CARE COVERAGE

More Coverage Across North Carolina

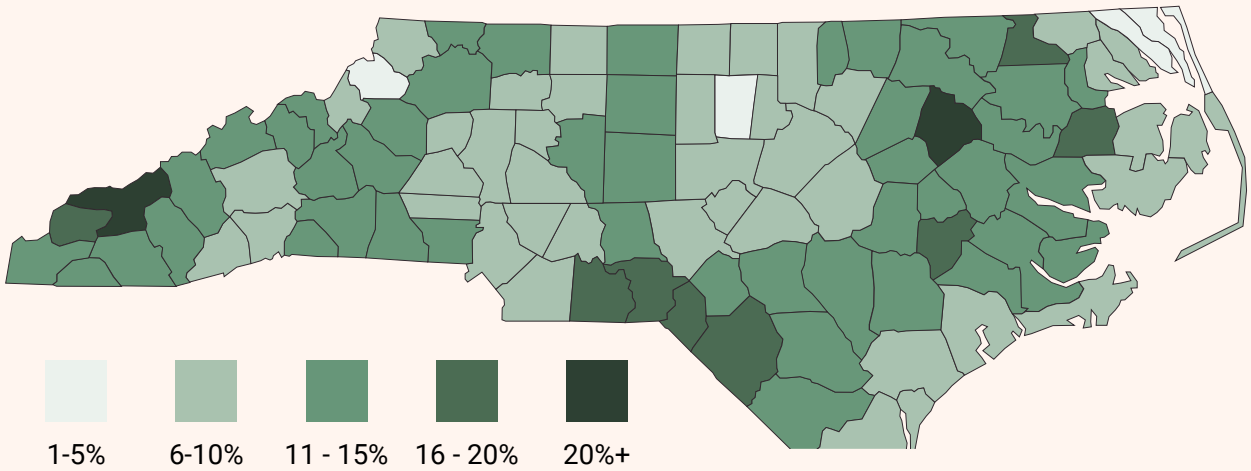
Medicaid expansion coverage has heavily benefited rural North Carolinians. **As of January 2025, 36.7% of North Carolinians enrolled in expansion coverage live in rural North Carolina,** far outpacing the portion of the total North Carolina population ages 19 to 64 who live in a rural area.[1]

+609,811

North Carolinians have gained health insurance through Medicaid expansion since it went into effect at the end of 2023, surpassing initial 3-year estimates.[1]

MEDICAID EXPANSION ENROLLMENT

Percentage of adult population enrolled in expansion coverage[1]



[1] *Medicaid Expansion Dashboard.* North Carolina Department of Health and Human Services. https://medicaid.ncdhhs.gov/reports/medicaid-expansion-dashboard

Big Thing 2: Medicaid Expansion

"We expected 600,000 people to be enrolled in the first two years. We got there in the first year alone. This is life changing, and what's really exciting is it's disproportionately helping rural North Carolina."

"Of the 601,000 people that are currently on Medicaid expansion, 210,000 are in rural communities. Which is what we wanted to see because we knew people living in rural communities were disproportionately likely to be uninsured," said Kinsley.

Kinsley said it took a broad coalition to bring Medicaid expansion to fruition. He described collaborative efforts from the state administration, the North Carolina General Assembly, Governor Roy Cooper, and statewide advocates.

"Credit to Governor Cooper for working to build a coalition of folks all across the state," he said. "And credit to the bipartisan leadership in the General Assembly that finally got there and pushed for it to happen."

Part of what allowed Kinsley to build relationships with Democrat and Republican members of the general assembly was his department's ability to deliver. Kinsley spoke about NC DHHS being able to operationally deliver on its promises, something the department is proving again through Medicaid expansion, from expectation-breaking enrollment numbers to the statistics around care being delivered.

With the first year of Medicaid expansion complete, workforce challenges remain at the top of Kinsley's mind. He spoke about a recent NCDHHS report highlighting data pointing to the need for more health care resources to grow the workforce, especially for nurses, behavioral health providers, and direct support professionals.

"We've got to continue to work together with the medical associations and the boards and our educators," he said. "I'm grateful to the General Assembly that as part of the Medicaid expansion package, there was a $1.8 billion signing bonus that we got from the federal government."

Kinsley said that a significant portion of that $1.8 billion goes toward educational programming, community colleges, and other allied health institutions. Despite continued workforce challenges, Medicaid expansion has exceeded expectations.

"There was a lot of concern at one point that if we put 600,000 people on the rolls that, no one would be able to get care," said Kinsley. "But you know, people are getting care. Four million prescriptions have been filled. Hundreds of millions of dollars in provider claims payments, dental care, vision care, copays never more than $4, and preventative services that require no copay at all."

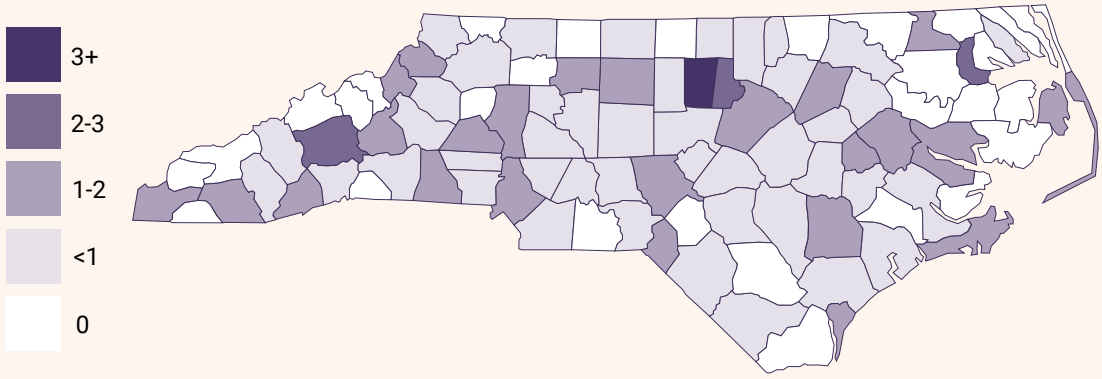
MATERNAL HEALTH

The number of North Carolina counties without OB-GYN physicians has steadily increased over the past decade, from 23 in 2013 to 27 in 2023.[1] This decrease in access, primarily in rural North Carolina, closely tracks a worsening maternal and child health crisis.

According to the March of Dimes, North Carolina has consistently high rates of pre-term births, infant mortality, and maternal mortality.[2]

North Carolina		United States
10.7%	Pre-term birth rate[2]	10.4%
6.8	Infant mortality (per 1,000 births)[2]	5.6
26.7	Maternal mortality (per 100k births)[2]	23.2

OB-GYN Physicians per 10,000 People, 2023[1]



[1] *North Carolina Health Professional Supply Data.* The Cecil G. Sheps Center for Health Services Research. https://nchealthworkforce.unc.edu/interactive/supply/

[2] *2024 March of Dimes report card for North Carolina.* March of Dimes. https://www.marchofdimes.org/peristats/reports/north-carolina/report-card

Whole-Family Health

"There is a need to reassess how the transition into parenthood is approached in our county. If the current systems are not effective, then let's change them because clearly, we can. We learned that through the COVID pandemic. We learned that, unfortunately, through tragedy. We've learned that things can be changed. The time is now; we can do it."

Despite decades of effort, North Carolina still has the eighth-highest infant mortality rate in the country. Black women in the state are four times more likely to lose a child before their first birthday compared with white women and 2.9 times more likely than white women to die while pregnant or within one year of childbirth.

Danielle Little, M.Ed., said we need a comprehensive approach to reimagining maternal and child health to address this ongoing crisis.

"We need to have a conversation with our insurers around reimbursement models, advancing equity, and the infrastructure—why it exists and is it still serving its purpose?" said Little. "Is 15 minutes really enough to care for patients? What happened to the 'care' in 'health care?'"

Little has been a strong advocate for maternal and child health throughout her career. As a maternal and child health consultant, she applies a life-course perspective to support families at every stage of development. Her expertise spans preconception health and wellness during the reproductive years, pregnancy, paternal health, postpartum health, and parenting young children.

She was the lead facilitator for the Maternal and Child Health Equity Action Network (MCHEAN), which recently published a comprehensive report, *Rising from Challenges to Change: A Cross-Sector Action Plan for Maternal and Child Health Equity in North Carolina*.

Little brings a unique perspective to maternal and child health conversations. As a professional, she understands how health systems function and how structural change can meaningfully improve outcomes. As a community advocate, she regularly engages with people across North Carolina to learn about their experiences with giving birth, raising families, and navigating the full spectrum of health services. And as a mother, she draws on her lived experience to inform her work.

One major issue she sees is the lack of consistent perinatal health education. With no dependable way to learn about raising children, parenting education often falls to family, peer networks, scattered classes, and mass media.

She said, "If you didn't receive quality, effective parenting or if your parents weren't able to support you the way you needed, where do you learn the skill? Where does one learn how to parent?" When parents lack the tools they need, she said, it can lead to life-changing challenges.

Whole-Family Health, Cont.

“Unfortunately, when it becomes apparent that a parent is struggling, the response is too quickly met with, ‘well, let me just take your baby away,’ rather than, ‘Let me support you and build your capabilities as a parent,’” Little said.

Regarding solutions, Little highlighted the importance of re-evaluating how we treat parents and childcare in our society.

“There’s a lot of hesitation in this country about giving people money that they ‘don’t deserve,’” she said. “There is a mindset of, ‘What do you mean paid parental leave? They had the baby; why should I have to pay for it?’”

Ultimately, childcare is paid for one way or another.

Little said, “If the ultimate goal is to improve health and outcomes for our communities, then are we truly investing in the community and our future? Perhaps it’s time to reevaluate what it means to invest in our future.”

When equipping parents with what they need, Little highlighted another essential component often left out or treated as an afterthought in maternal and child health—the health and well-being of the father or paternal partner.

“You can’t fully address maternal and infant health without including the paternal partner,” she said.

One MCHEAN participant, Harrison Spencer, leads a nonprofit in Guildford County called Father Figures Forever. The organization supports fathers and paternal figures and drives social change to improve whole family well-being.

Little said, “He often spoke about how the response to fathers lacking the resources to support their families was more punitive compared to mothers.”

For example, she said, fathers and paternal partners do not have the same access to support to address many social drivers of health, such as housing stability and food security, including applying for the Supplemental Nutrition Assistance Program (SNAP).

“If we consider the court system, where fathers are held accountable for paying child support and maintaining visitation, the child still has to have somewhere to go with their father, right? The child has to have something to eat when they’re with their father. So how are we supporting this system to make sure it works?”

Little’s work with MCHEAN applied a human-centered design framework and involved a community co-design process. These evidence-based approaches promote effective, lasting change by centering marginalized voices and driving solutions that address systemic issues and community-identified needs.

“I think these community co-design spaces, focused on human-centered design and amplifying community voices, help us reconnect with what we need in society,” she said. “They remind us that we live among others; we thrive in relationship and are capable of achieving extraordinary things.”

BEHAVIORAL HEALTH

Significant investment in behavioral health across North Carolina has resulted in measurable improvements in outcomes and access to care. However, many North Carolina counties still lack access to care, a disparity that is reduced, but not eliminated, by telehealth services. Youth mental health remains a critical concern, with rates of anxiety and depression nearly doubling since 2017 and suicide now the leading cause of death among youth aged 10 to 14.[1]

Highlights: $1 billion investment in behavioral health[2]

In 2023, former Governor Roy Cooper unveiled a roadmap to invest $1 billion in behavioral health. As of January 2025, new funding has resulted in:

- 111,000 calls or texts to 988 from Sept. 2023–Sept. 2024.
- 4,800+ people diverted from institutional care since 2018 through Transitions to Community Living.
- 19.4% reduction in people held in emergency departments from 2023–2024.

NORTH CAROLINA LANDSCAPE

26 counties with no active psychologists, down from 29 in 2022[3]

31 counties with no active licensed psychological associates[3]

14.9%

of North Carolina children ages 0—17 experienced two or more adverse childhood experiences from 2022–2023[4]

[1] *Prevent youth suicide & address the children's mental health crisis.* NC Child. https://ncchild.org/publications/prevent-youth-suicide-and-address-the-childrens-mental-health-crisis/

[2] *Transforming North Carolina's Behavioral Health System.* North Carolina Department of Health and Human Services. https://www.ncdhhs.gov/transforming-north-carolinas-behavioral-health-system/download?attachment

[3] *North Carolina Health Professional Supply Data.* The Cecil G. Sheps Center for Health Services Research. https://nchealthworkforce.unc.edu/interactive/supply/

[4] *Adverse Childhood Experiences in North Carolina.* Americas Health Rankings. https://www.americashealthrankings.org/explore/measures/ACEs_8_overall/NC

Big Thing 3: Behavioral Health

"One in five people will have a mental illness in a given year, but you know, five in five people have mental health. So, we have to encourage people to be bold, be brave, and tell their stories."

Kinsley touted a nearly $1 billion investment to transform the way behavioral health works in North Carolina, especially when it comes to substance use challenges.

"We know our substance use problems, especially opioid problems, have disproportionately negatively impacted rural communities," he said. "So, we're investing in behavioral health, urgent cares, and harm-reduction strategies to increase access to substance use disorder services."

In North Carolina, overdose deaths have been on the rise since the 2010s. Often, without other treatment or intervention options, people who are addicted to opiates and other substances end up in jail.

"For our justice-involved population, we're getting help to people who really need health care, not handcuffs," said Kinsley. "We have over $100 million going toward pre-arrest diversion, jail-based treatment, and re-entry support. We're trying to break that stigma and that cycle of people that have mental illness who often just end up in jail because there's nowhere else to go."

By changing how the system works, he believes North Carolina has a real opportunity to save both lives and money. Beyond jails, he spoke about shifting the entire behavioral health system to focus more on prevention.

"We know healthy kids require healthy families. How do we provide more family treatment and family care? Kids with really complex needs often end up in facilities. We need those facilities to be of really high quality."

Kinsley also said that, beyond funding for more care, everyone has a role to play in breaking stigma that surrounds mental health issues. Once people have access to services, they need to feel equipped to use them.

"Nobody blinks twice before talking about diabetes or cancer. This stigma isn't there for any other disease," he said. "We have to remind people that mental illness is not a moral failing, it's a medical issue."

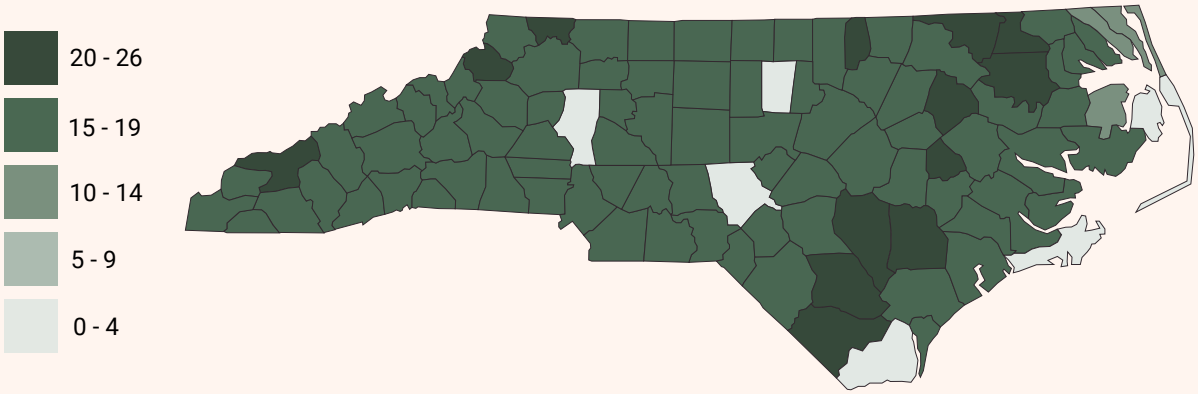
ORAL HEALTH

While most types of oral disease are entirely preventable, regular dental care is out of reach for many. In its 2024 publication, "The Portrait of Oral Health," the North Carolina Oral Health Collaborative reported:[1]

- North Carolina ranks 18th in the nation for community water system fluoridation.
- There are 151 operating safety net dental clinics across North Carolina, 86 in urban counties and 65 in rural counties.
- As of 2024, 93 of North Carolina's 100 counties are dental Health Provider Shortage Areas (dHPSAs).
- Only 28% of dentists are considered "meaningful" Medicaid providers, billing over $10,000 annually for services.
- The rate of emergency department visits for non-traumatic dental conditions is more than double for Black North Carolinians compared with White North Carolinians.
- North Carolina has risen from 37th to 24th in the nation for dentists per capita, but only 20% of new dentists practice in the state's 78 rural counties.
- From December 2023 through July 2024, more than 520,000 North Carolinians gained dental health benefits through Medicaid expansion.

Dental Health Professional Shortage Areas in North Carolina

93 of 100 North Carolina counties are dHPSAs, 2024[2]



[1] *Portrait of Oral Health.* North Carolina Oral Health Collaborative. https://oralhealthnc.org/wp-content/uploads/2024/11/2024-Portrait-of-Oral-Health-FINAL.pdf

[2] *HPSA Find*. US Health Resources & Services Administration. https://data.hrsa.gov/tools/shortage-area/hpsa-find

Dental Integration in North Carolina

"There are so many benefits to integrated care. It's best for improving patient outcomes, reducing costs, and improving satisfaction for patients and providers, especially in rural areas."

Oral health is overall health. Tooth decay and gum disease can impact the rest of the body and vice versa. Unfortunately, oral health care is often experienced in a vacuum, considered separate from traditional medical care and frequently seen as a luxury service.

There is growing interest in oral health integration, from broad medical-dental integration to more specific partnerships between oral health providers and behavioral health, pediatrics, obstetrics and gynecology, special needs care, and more.

According to a 2021 National Institute of Health report, "Oral Health in America: Advances and Challenges," periodontal diseases have been hypothesized to be associated with 57 different systemic conditions. The report identifies several opportunities for partnerships to address overlapping conditions, including integrated electronic health records, dental-primary care integration, the addition of medical screenings at dental appointments and vice versa, and oral health-pediatric care integration.

Dr. Rob Tempel is the Associate Dean for Extramural Clinical Practices at East Carolina University (ECU). Prior to joining ECU, he served 27 years in the United States Army, reaching the rank of Major General and Chief of the United States Army Dental Corps.

He underscored the importance of integrated care in Health Professional Shortage Areas (HPSAs), which extend into almost every county in North Carolina. Dr. Tempel said systems that can provide all services within one building or networks of independent providers with an effective referral system can help bridge gaps made worse by long drives and low provider densities in these areas.

"Especially in a rural area when you're a sole provider, it's stressful and it's isolating," said Dr. Tempel. "When you have a team of professionals working together, it becomes a lot more fun. If you have the satisfaction of being part of a team, you can see the successes, and I think you're going to be able to retain and recruit more people."

Dental Integration in North Carolina, Cont.

Dr. Tempel spoke about examples of integrated care directly related to the ECU School of Dental Medicine. The Roanoke Chowan Community Health Center (RCCHC) is physically connected to one of ECU's Community Service Learning Centers (CSLCs), which has given both organizations' providers an opportunity to explore integrated care.

ECU CSLCs are located across North Carolina and are part of the primary care system in each rural community. They provide dental students with hands-on opportunities to gain experience caring for patients, and they give their communities opportunity to access affordable, high-quality care.

In the town of Ahoskie in Hertford County, the ECU CSLC and RCCHC refer patients to each other when a medical provider identifies a dental need and vice versa.

"It's connected by a walkway and it's connected through leadership," said Dr. Tempel. "When they get a patient needing dental care they refer to us, and we can refer to them for medical needs."

He said that ECU's CSLC model helps RCCHC keep costs low, something that helps make their model work. Additionally, their integrated care efforts have opened up new and unique funding opportunities from the federal government and private grantors.

"Because we have low fees and accept Medicaid, we also get some patients just directly showing up to our clinic and vice versa with the medical clinic," said Dr. Tempel. "Many of these folks don't have a medical or dental home, but with integrated care we can help them get the care they need."

This excerpt is from the North Carolina Oral Health Collaborative's "2024 Portrait of Oral Health." For the full article, "Provider Perspectives: Dental Integration in North Carolina," find the report at oralhealthnc.org/resource-center.

HEALTH CARE INFRASTRUCTURE

WHAT IS THE RURAL SAFETY NET IN NC?

- 15 Small Rural Hospitals
- 20 Critical Access Hospitals
- 90 Free & Charitable Clinics
- 93 Rural Health Clinics or Rural Health Centers
- 107 Health Departments
- 268 School-Based Health Centers (includes telemedicine sites)
- 408 Federally Qualified Health Center (FQHC) Sites

Safety-net providers are either legally mandated or have explicitly chosen to provide health care and related services to patients regardless of their ability to pay. Many patients they serve are uninsured, underinsured, or have Medicaid insurance and are also impacted by social drivers of health and structural barriers to accessing care.

[1] *Safety Net Sites.* North Carolina Department of Health and Human Services. https://www.ncdhhs.gov/divisions/office-rural-health/safety-net-resources/safety-net-sites

Big Thing 4: Healthy Opportunities

"This one is a huge deal. This is changing the way that Medicaid works."

The Healthy Opportunities Pilot (HOP), launched in 2022, is the first comprehensive, state-run program in the United States to provide non-medical services like housing, food, and transportation to Medicaid enrollees.

Kinsley said the goal of HOP was to create a health system that more closely matches people's needs. Around 80% of what drives health happens outside hospitals or doctor's offices. With a federal Medicaid waiver, the HOP program allows NCDHHS to use Medicaid health care dollars on things like food, transportation, and housing.

"Two years into the pilot, it's working," said Kinsley. "We are seeing pilot participants, first off, self-reporting that their needs are getting met. Second, we see a statistically significant reduction in ED visits and hospitalizations. People are ending up in the hospital less."

Kinsley said the pilot program is also financially sustainable. In addition to measurable health improvement, even when accounting for program costs, North Carolina is saving $1,000 per person per year.

"And guess what? Here's the punchline. The pilot regions are primarily in rural communities," said Kinsley. "So, we started this work in a space where people have historically struggled to get access to care, and these pilot participants are getting onto an insurance plan that is really designed to improve their health with all these other added benefits."

HEALTH WORKFORCE

4 Counties with no dentists

9 Counties with no physicians

26 Counties with no psychologists

1 County with no nurse practitioners

3 Counties with no physician assistants

9 Counties with no respiratory therapists

0 Counties with no pharmacists

12 Counties with no optometrists

27 Counties with no physicians with a primary area of practice of obstetrics & gynecology

[1] *North Carolina Health Professional Supply Data.* The Cecil G. Sheps Center for Health Services Research. https://nchealthworkforce.unc.edu/interactive/supply/

Looking Forward: Investing in NC

“We’ve done so many other pieces of this puzzle, but those four things alone, taken together, is really the vision that I think every American wants from their health system,” said Kinsley. “A health system that promotes health and well-being is easier to navigate. That takes the gunk and the cobwebs out of the system so they don’t have to worry about money, and they can just worry about their well-being.”

He is excited for many things on the horizon in North Carolina. For one, NCDHHS was able to secure federal approval to take HOP statewide.

“We will have to work with the General Assembly for funding,” he said. “But we believe it’s a good investment. It’s lowering costs. Why wouldn’t we want more people in it?”

Kinsley also highlighted a continuation of NCDHHS’s focus on jails and prisons, prioritizing diversion programs to keep people who need treatment out of jails.

‘I can’t underscore enough that we have the smartest, most dedicated, most passionate public servants in any organization, in any state, anywhere,” said Kinsley. “They’re driven by their passion, and I’m so deeply grateful for them. And I hope that over the last few years, we’ve been able to make the health care system work better.”

“I hope that, just a little bit, the average person in the public can feel more like their government works well for them. That really matters.”

NCRHA's 2025 Policy Agenda

State Policy Priorities

Invest in Natural Disaster Resilience

Hurricane Helene's devastation in Western North Carolina has exposed critical vulnerabilities in our state's infrastructure. Income loss, school closures, and economic instability all have long-term impacts on health, increasing stress, limiting access to care, and worsening chronic conditions.

Investing in natural disaster preparedness and resilience, including mental health support, emergency health care access, and social services, will better prepare North Carolinians to recover and rebuild after future storms.

Build a Stronger Safety Net

Reimbursement rates for services like oral health care have not been updated in over a decade, forcing many providers to operate at a loss if they want to provide care.

With Medicaid expansion opening new doors to care for nearly 600,000 North Carolinians, reimbursement rates must be modernized to allow providers to serve their communities efficiently and effectively.

Expand and Enhance Access to Rural Broadband

Reliable, high-speed broadband is essential for every North Carolinian, from accessing telehealth services to supporting education, business growth, and social connections.

Expanding broadband infrastructure will ensure rural North Carolina can thrive.

Build a More Robust Rural Health Care Workforce

Every rural resident deserves access to quality health care. However, 95 of North Carolina's 100 counties are geographic or population Health Professional Shortage Areas (HPSAs) for primary care.

Investing in training programs, loan repayment incentives, and workforce development can strengthen the rural health care system and meet our state's needs.

Support Maternal and Child Health

Parents and children face unique challenges, especially in rural North Carolina where more people must contend with long drives and limited access to pregnancy and birth care.

By investing in pregnancy, birth, and early childhood care, North Carolina can better support new families and foster the foundations for health throughout the lifespan.

Address Youth Mental Health

North Carolina's youth mental health epidemic is worsening, with more children and teens experiencing anxiety, depression, and other challenges. Preventive care helps destigmatize mental health conversations and reduce children's risk of developing long-term, untreated mental health disorders that threaten their health, overburden providers, and drive-up costs.

Providing insurance coverage for children up to 17 years old to receive mental health well-checks gives providers the necessary time and support to have preventive conversations. Additionally, children, youth, and families get broader access to whole-person health, building the foundation for a healthier North Carolina.

Federal Policy Priorities

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Extend and Increase Safety-Net Health Center Funding

From rural critical access hospitals to community health centers, North Carolina's safety net is the backbone of care for millions of people. Safety-net sites operate on shoestring budgets, and with short-term funding, they often cannot plan ahead or create financial efficiencies.

By fully supporting North Carolina's safety net and prioritizing multi-year base funding, these vital health care providers will be better able to care for the people they serve.

Protect Medicare Price Negotiations

By allowing Medicare to compete in the health care marketplace, taxpayers save $6 billion, and Americans who receive Medicare benefits save an additional $1.5 billion.

Protecting price negotiations can reduce the cost of life-saving drugs, reduce federal spending, and ensure Medicare recipients can access the care they deserve.

Protect and Increase Access to Affordable Insulin

Capping the cost of insulin for Medicare Part D recipients saves nearly 4 million older Americans hundreds of dollars per year. Protecting this policy will ensure North Carolinians can better manage their health without financial hardship.

By expanding the price cap to include commercial insurance, the nearly 1 million North Carolinian adults with diabetes will have more money in their pockets, more stability in their lives, and a better shot at happy, healthy, productive lives.

The North Carolina Rural Health Association is a collaborative network of associations, organizations, and individuals representing health care, education, economic development, local government, and other partners invested in supporting rural health. The organization and its membership are committed to amplifying the voices of North Carolina's rural communities to foster a movement that improves the health and well-being of all citizens.

Foundation for Health Leadership & Innovation

NC RURAL HEALTH ASSOCIATION

NCRHA brings together a diverse network of partners, including students, community- and faith-based organizations, statewide associations, educational institutions, government representatives, and corporations dedicated to advancing rural health through advocacy, collaboration, and education.

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