FaithHealthNC
Community Health Assets Mapping Partnership
CHAMP

Seeker-Level Workshop Report

October 3, 2014

Asheboro, NC
Randolph County

CHAMP Access to Care Workshop

FaithHealthNC
A Shared Mission of Healing

Wake Forest™ School of Medicine

IRHAP
International Religious Health Assets Programme
ARHAP African Religious Health Assets Programme

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This report is available online at: www.faithhealthnc.org

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SECTION A

WORKSHOP INFORMATION

Section A

1. AREA AND LEVEL

A workshop facilitated by Wake Forest University Baptist Hospital's FaithHealthNC, was offered in Asheboro, North Carolina (NC) at the health care seeker level. As part the Community Health Asset Mapping Partnership in Asheboro, the workshop focused on residents of the community who seek health care services within Asheboro and Randolph County. Therefore, Randolph County was the area of focus. **Image 1** is a map outlining the boundaries of Randolph County.

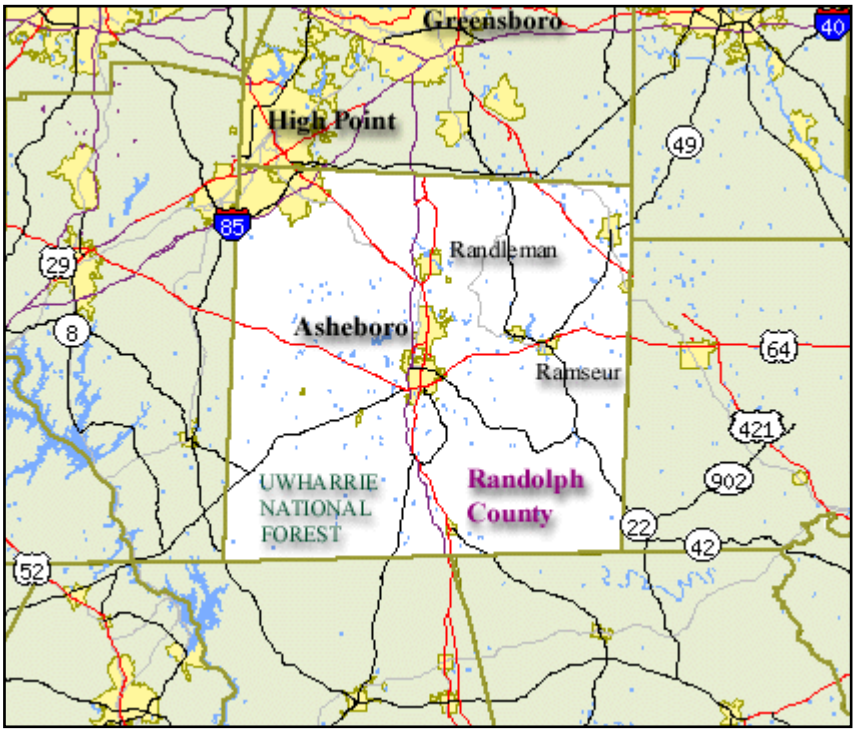


Image 1

2. DATE & PLACE OF WORKSHOP

The workshop took place on October 3, 2014 at Central United Methodist Church, which has a predominantly Caucasian congregation. The church is located downtown on N. Main St. in Asheboro, Randolph County. The workshop began at 9:00 am and was completed by 3:00 pm.

3. FACILITATION TEAM

Lead Facilitators:	Teresa Cutts, PhD Beth Kennett, MDiv
Local Hosts/Facilitators:	Barry Morris, MDiv, Randolph Hospital Helen Milleson, BA

Scribes:	Allison Griffin, MSW Intern Melissa Ingram-CAP/Community Case Manager
Primary Report Writer:	Allison Griffin, MSW Intern
Registration:	Lisa Keifer, Administrative Assistant, Care Continuum & Support Services

4. PHYSICAL DESCRIPTION

The workshop was held in the Central United Methodist Church fellowship hall, located adjacent to their sanctuary. The fellowship hall was handicap accessible and a small breakfast was available for participants as they entered the space. There were four large tables located in the center of the room. Each table had six to eight chairs placed around them. The two center tables were then consolidated to make one larger table. Throughout the workshop, these three tables represented the three various activity groups comprised of participants. At the front of the room were three easels holding boards, charts, and maps for the activities. Registration for the event took place outside this room in the hallway. **Image 2** depicts the layout of Central United Methodist Church fellowship hall during the health seeker workshop.

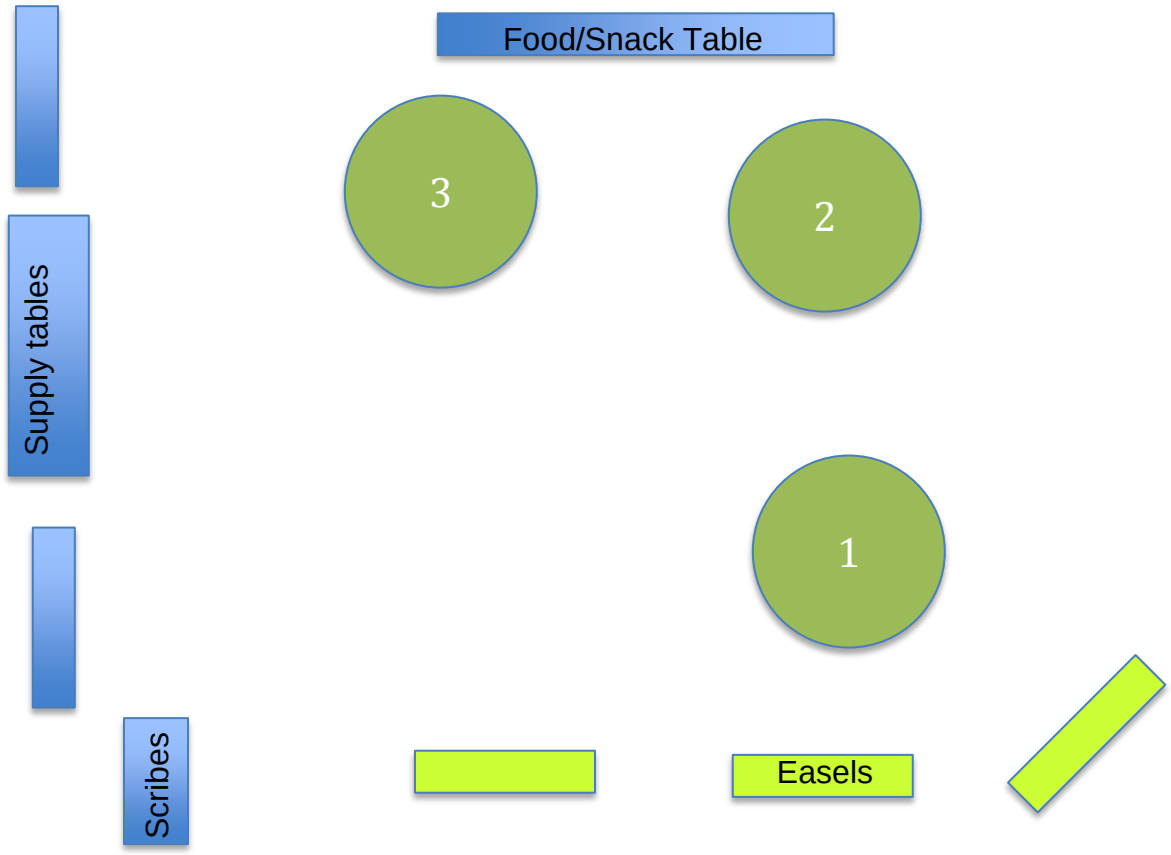


Image 2

5. PREPARATORY WORK

Preparatory work for this CHAMP workshop included several different activities including: background research, field study, data collection, map generation, facilitation team training, workshop planning, and workshop materials preparation.

Background Research included a review of Religious Health Assets Mapping projects in southern African, various approaches to community mapping, and models for participatory research projects.

Field Study included a series of transect drives through the study area with team members familiar with this area and the initial identification of key assets and potential key informants. These transect drives, in combination with the insights from key informants, were used to decide the preliminary boundaries for this mapping exercise.

Data Collection included the acquisition of basic demographic, socioeconomic and psychographic data in the study area. Study staff compiled lists of known assets and interviewed key community informants.

Map Generation involved the processing and analysis data on the study area, the incorporation of these data into a geographic information system, and the generation of geographical and special representation of area information through a series of GIS map layers.

Facilitation Team Training occurred through team member's participation in training events, past workshops held in similar locations, and a familiarity with the CHAMP methodology and other participatory models for focused group discussion.

Workshop Planning involved identifying potential participants for the Health Providers workshop, developing and disseminating a letter of invitation, and following up with potential participants. Workshop staff held several planning meetings prior to the event, sent emails, and made follow-up telephone calls during the weeks prior to the workshop. Workshop staff also identified Central United Methodist as an appropriate site for the workshop.

Workshop Materials Preparation included the purchase of area maps, the printing of materials to be handed out, the packaging of these materials, and the organization of all the materials needed for the workshop exercises (for example, large pieces of paper, post-it notes, writing utensils, flip charts, and markers).

6. PARTICIPANTS

Thirteen people participated in the health seeker level workshop. Upon registration, each participant was asked to document their address and contact information, gender, race and/or ethnicity, marital status, age, level of completed education, occupation and/or school, church/organizational affiliation, the length of time they have lived in Randolph County, and if the registrant spoke a language other than English.

Based on the information collected during registration a wide range of demographics were collected. The average age of the participants was fifty-nine (59) years old. The oldest participant was eighty-four (84) years old while the youngest was thirty-four (34) years old. Nine participants identified as female and four identified as male. Twelve participants identified as Caucasian while one participant did not identify their race and/or ethnicity. Six participants identified as single/divorced/widowed and seven were married. The highest level of education for one participant was a Master of Arts degree; 3 participants listed completion of a Bachelor's degree; eight participants identified as having taken college classes and one participant listed completion of the 10th grade. Every participant identified English as their primary language with one person also speaking French.

The information collected through registration also depicted each participant's relation to Asheboro and Rockingham County. Seven participants each live within the 27205 zip code, three in the 27203 zip code, two in the 27350 zip code and one in the 27317 zip code. The average number of years spent in Randolph County is 32.5 years. Five participants are currently retired, two are unemployed, one is disabled, two are students, others did not list their occupation. Represented at the workshop were six different faith/church traditions—Baptist, Universal Unitarian, Wesleyan, Non-denominational, protestant and Catholic. Three participants did not list a faith tradition. Only one local congregation was identified—Totally Committed Ministries.

7. INTRODUCTION TO WORKSHOP

The workshop began with a greeting and introduction by The Reverend Barry Morris, Director of Spiritual Care at Randolph Hospital. He shared with the participants the excitement of Randolph Hospital in being able to host the event for the community along with Central UMC. He also shared his hopes and what he believes to be the eventual outcome of this process. Rev. Morris introduced the facilitation team and informed the group of their roles within FaithHealthNC.

Following Rev. Morris's introduction, the facilitation team described the purpose of the event. Lead facilitators, Dr. Teresa Cutts ("TC") and Rev. Beth Kennett, introduced the background of the Community Health Asset Mapping Partnership (CHAMP) program. Participatory Inquiry into Religious Health Assets, Networks, and Agency (PIRHANA) is a research model developed by Dr. Gary Gunderson, Dr. James Cochrane and Dr. Deborah McFarland in South Africa that focused on identifying positive health assets present within communities in the midst of the HIV/AIDS epidemic within sub-Sahara Africa. CHAMP was further developed and refined by Dr. Teresa Cutts and team in Memphis from 2007-2013. The objective of CHAMP is to translate the

PIRHANA research method for North Carolina communities to discover positive health and faith based assets within their respective counties and regions.

The participants within these workshops on both the health provider level and the health seeker level contribute their knowledge and community understanding in a variety of activities and exercises throughout the workshop.

The participants of the workshop were then asked to each introduce themselves, their churches, and the areas in which they live. Most participants have lived in Randolph County for several years and shared their fondness of the community. Several of the participants present stated they currently are or have been primary caregivers for loved ones, and wished to learn of more health care resources. Many of the participants were members or friends of Central United Methodist Church and were excited to be contributing to and learning from the workshop. As the participants introduced themselves, the number of years each had lived in Randolph County was recorded in order to obtain the group's total number of years living in the county.

SECTION B

HEALTH SEEKER EXERCISES

SECTION B

1. COMMUNITY MAPPING

a. OBJECTIVE

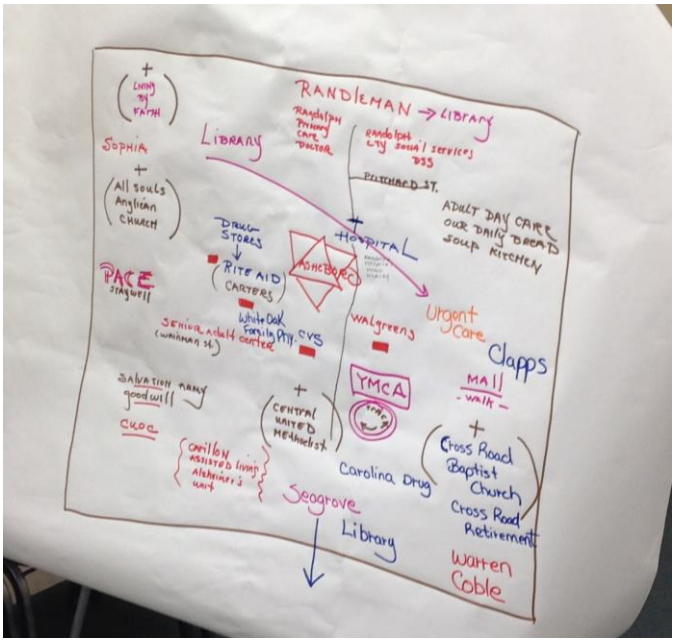
The first activity of the day involved community mapping. The three groups were asked to discuss what they collectively know about Asheboro and to construct a map based on what they believe to be important assets of Asheboro. The purpose of this exercise was to serve as an "icebreaker" and to allow participants to identify and map community and religious health assets that they deem essential to improve access to care in Randolph County and Asheboro in particular.

b. METHOD

The participants broke into three small groups, one group per each activity table. Each table was equipped with colorful markers and large white sheets of paper. "Group 1" had four participants all of whom were women. Three appeared to be over sixty years old and one appeared to be in her fifties. "Group 2" had four participants comprised of men. Two of the men appeared to be over sixty and two appeared in their thirties. "Group 3" had four participants comprised of women, three were over sixty and one was middle-aged. The participants began discussing the areas in which they live and formed connections based on their respective neighborhoods.

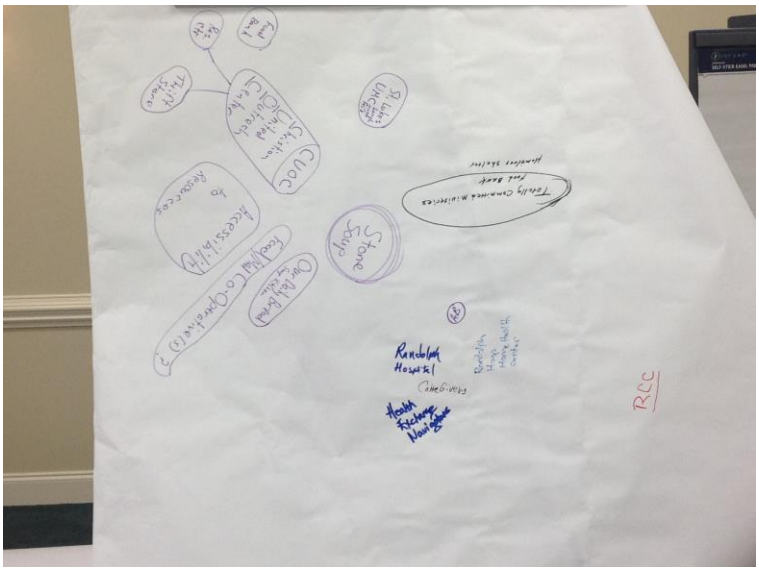
Once they established relationships through discussing commonalities and differences, one member of each group became the primary scribe and outlined a map of Asheboro. The groups then came to a consensus among themselves regarding what they considered to be positive community assets, with the scribe mapping the location of each asset. After approximately ten minutes, each group was asked to post their maps on an easel in the front of the room and share them with the group.

c. DISCUSSION

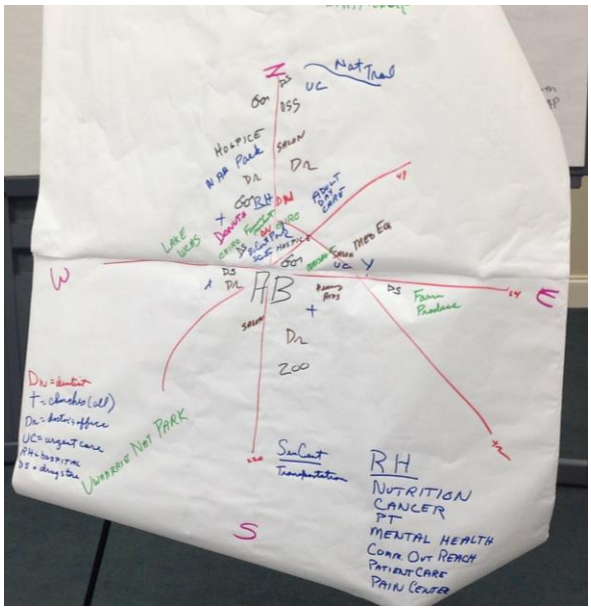


Group 1 documented social services, YMCA, Pace Senior Center, Warren Coble (SSA expert), Drug stores, Randolph Hospital, Cross Road Retirement Center, 2 Libraries, Cross Road Baptist Church, the YMCA and the CUOC, Our Daily Bread, which has a soup kitchen and adult daycare, pharmacies, the Salvation Army, Goodwill, Urgent Care, the mall, Hospice, Randolph Hospital, Randolph Hospital Home Health, and various physician's offices. The group believed there to be several resources the community could tap into to improve health and wellbeing. They focused on the locations around the area for people to get exercise such as the YMCA and

the mall for walking. They also discussed resources that are available to those caring for loved ones, such as the senior center and the adult day care center. Discussion of how area churches help provide food to those in need also occurred.



Group 2 documented Randolph Hospital, Home Health, Insurance Navigators, Caregiver Support Groups, Food Banks, St Lukes Food Program, Our Daily Bread Ministries, RCC, RCATS, Arts Guild, and the Community Choir, Randolph Community College, Christian United Outreach Center (CUOC), and food cooperatives. This group began a conversation between themselves and the rest of the participants about the collaboration among different congregational communities to provide food, medicine, and other care to vulnerable people in the area. Most participants agreed that the partnership was effective and a valuable resource in the community. The discussion also brought up the fact that despite resources being available, they are not enough to completely meet the needs of everyone in the community who is at a disadvantage. This reality could be due to food pantries not having enough products to give out or that those in need feel uncomfortable going to a religious group for support, especially if they are unaffiliated with that group.



Group 3 documented churches, dentist and physician offices, urgent care, Randolph Hospital, pharmacies, hospice, the Arts Guild, parks, a hair salon, the adult day care facility, dialysis center, North Carolina Zoo, Randolph County DSS, the nature trail, the Senior Center, and areas in which farm produce is available as community assets. Group 3 echoed earlier conversations which focused on the many locations within the area in which community members can engage in physical exercise such as parks and the nature trail. The group also brought up the topic of healthy eating and how access to fresh produce has a positive effect on health. They felt that having access to a garden and places in which farm produce is sold is vital to the community's health and wellbeing.

All three maps were considerably different as each group utilized different streets to define their boundaries.

2. HEALTH AND WELL-BEING INDEX

a. OBJECTIVE

The second activity was comprised of a two-part brainstorming session. Part I consisted of the participants brainstorming the most important factor or factors that work *against* health and well-being and access to care within Randolph County. Part II consisted of brainstorming the most important factor or factors that work *for* health and well-being and access to care in the community.

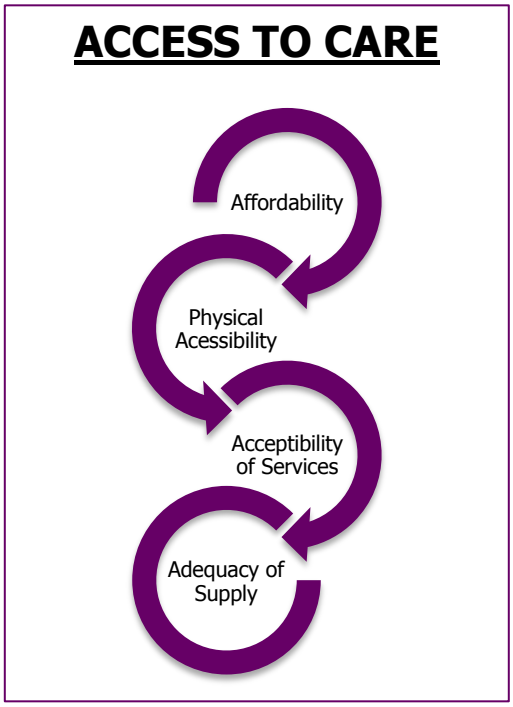


Image 3

b. METHOD

Each participant was asked to write one factor that works against health and well-being on two separate post-it notes, which were then combined and categorized. On the flip chart at the front of the room, the facilitators listed four components FaithHealthNC perceives to be key factors regarding access to care in order to prompt thoughts and ideas (**Image 3**). After brainstorming the negative factors, each participant was then asked to document two positive factors that work in favor of health care access.

c. DISCUSSION

Access to care is the product of people getting what they need in order to be the healthiest they can be. Care is also supportive families, work friends, belonging to a caring faith community, and having relationships that provide a sense of connection to others. After each participant wrote their negative factors on two separate post-it notes, the facilitators shared the information with the group. The post-it notes were then combined into specific categories:

- **Transportation**- In order to access the community's assets, you have to be able to get to them. There is a need for a mass transit system. Not owning a car and being too old to drive makes access to care difficult. Buses only come to certain areas at certain times of the day making accessibility difficult.
- **Finances**- Everything gets more expensive every year. In order to use some assets (e.g. YMCA), people need money. Having to get credit checked to acquire insurance. Not having a POA, being a non-English speaker, etc. may cause difficulty in setting up payment plans and credit often suffers.
- **Unemployment**-Unemployment affects accessibility of health insurance and finances.
- **Location of Doctors**- Difficulty getting to the *right* doctor and a *good* doctor because of their location.
- **Lack of Insurance**-Insurance determines care that is provided. Sometimes insurance does not allow you to get the care you need. Lack of information and/or access to information decreases access to care. The health care and insurance systems are not user friendly.
- **Willingness to Treat All**- Need to lower the costs of medical care to make it more affordable for everyone.

Legal issues and other drivers that propel a broken system.
- **Fear of recrimination/non-compassionate care**- Many people don't ask for help because they feel they're going to get a slap on the wrist. Lack of advocacy
- **Time**-A person needing to take time off to care for a family member may not be able to do so or could risk losing their job. A person who is sick may have difficulty getting off work to obtain the care they need.
- **Freeloaders**-People who get Medicaid, food stamps, etc. when other people work and seemingly can't get any assistance.
- **Invasion of Privacy**-Having to give your Social Security number and other personal information to receive care.
- **Lack of prevention at a young age**

Using two post-it notes, each participant was then asked to vote on the top two categories from the list above that she or he believed worked against health and well-being and access to care within Randolph County. The following list depicts the top five factors voted upon:

Question	Results
What is the most important factor or factors that work ***against*** health and well-being in regard to access to care in Randolph County.	1. Finances/Lack of Money & Job Opportunities 2. Rising Cost of Insurance 3. Transportation 4. Lack of Advocacy 5. Fairly Priced Healthier Food Alternatives

In Part II of this exercise, each participant provided two post-it notes regarding what they considered to be the most important factors that worked for health and well-being and access to care within their community. The post-it notes were then combined into five categories. The following list depicts the top five factors voted upon:

Question	Results
What is the most important factor or factors that work ***for*** health and well-being in regard to access to care in Randolph County.	1. Compassionate Doctors/Medical Community 2. Suitable Insurance/Availability of Care 3. Compassionate Community 4. Affordable Medication/Medical Care 5. Access to Rec/Wellness Facilities

3. FACILITY/HEALTH RANKING

a. OBJECTIVE

The final exercise consisted of ranking various community assets on their levels of efficiency in various contexts. The objective of this activity was to picture the ways in which different public entities contribute to health and well-being as it relates to access to care.

b. METHOD

The participants broke into three groups, which were the same as the earlier exercises. "Group 1" met on the furthest side of the hall, "Group 2" convened in the middle of the space, and "Group 3" met closest to the main entrance.

Each group was asked to rate various community entities on a scale of one to five (one being poor and five being great). Community assets ranked included: hospitals and urgent care; churches and ministries; drug stores/pharmacy; library, Art Guild, and community resources; adult day care, senior services, and assisted living; fitness centers, YMCA, mall, parks, and zoo; Christian United Outreach Center; farmer's market, grocery stores, Fresh Cuts meat market; home health; and soup kitchen, food pantry, and Our Daily Bread. Each was ranked based on their ability to offer care based on the factors that contribute to access to care established in exercise 2: compassionate doctors; dedicated healthcare professionals; understanding doctors; number of doctors available; Medicare and insurance; suitable insurance; availability of healthcare resources; finances; health education and health screenings; compassionate community; health asset workshops; choices in resources; EMS; Randolph home health care system; affordable medication; access to recreational facilities.

c. DISCUSSION

Table 2, **Table 3,** and **Table 4** depict the various community assets rankings of each group. Each group engaged in thoughtful conversation concerning the information in each of the tables below. There was not a strong sense that Good Doctors/medical personnel were influenced by community organizations.

Table 2: Group 1

	Hospital Urgent Care	Churches Ministries	Pharmacy Drug Stores	Library Art Guild Comm.	Adult Day Care/Sr. Services	Fitness Ctrs. YMCA, Parks	COUC	Farmer's Mkts Groc. Stores	Home Health	Soup Kitchen Food Pantry
Good Drs. medical personnel	5	NA	4	NA	5	NA	NA	NA	5	NA
Health Coverage	5	NA	3	4	5	3	NA	NA	5	NA
Compassionate Community	5	5	4	5	5	5	5	4	5	5
Variety/Choices Of services	5	5	5	4	5	4	5	NA	4	3
Access to Medications	5	2	5	3	5	NA	4	NA	5	NA
Access to natural resources	NA	4	NA	3	4	5	NA	3	NA	NA

Table 3: Group 2

	Hospital Urgent Care	Churches Ministries	Pharmacy Drug Stores	Library Art Guild Comm.	Adult Day Care/Sr. Services	Fitness Ctrs. YMCA, Parks	COUC	Farmer's Mkts Groc. Stores	Home Health	Soup Kitchen Food Pantry
Good Drs. medical personnel	4	NA	NA	NA	NA	NA	NA	NA	5	NA
Health Coverage	4	NA	4	NA	4	NA	NA	NA	4	NA

Compassionate Community	5	4	5	4	5	5	5	NA	5	5
Variety/Choices Of services	3	5	3	5	5	5	5	4	3	4
Access to Medications	NA	NA	5	NA	4	NA	4	NA	NA	NA
Access to natural resources	NA	NA	NA	5	NA	5	NA	5	NA	NA

Table 4: Group 3

	Hospital Urgent Care	Churches Ministries	Pharmacy Drug Stores	Library Art Guild Comm.	Adult Day Care/Sr. Services	Fitness Ctrs. YMCA, Parks	COUC	Farmer's Mkts Groc. Stores	Home Health	Soup Kitchen Food Pantry
Good Drs. medical personnel	4	NA	NA	NA	NA	NA	NA	NA	4	NA
Health Coverage	4	NA	4	NA	4	3	NA	NA	5	NA
Compassionate Community	4	5	4	5	5	5	4	5	5	5
Variety/Choices Of services	5	NA	5	5	3	4	4	3	5	3
Access to Medications	4	NA	5	NA	NA	NA	5	NA	NA	NA
Access to natural resources	NA	NA	NA	5	NA	5	NA	3	NA	NA

Overall, each group ranked the community assets highest in regard to proximity to care and transportation. The community assets ranked below average in regard to good health care coverage, jobs and adequate funds. In Exercise 2 participants believed transportation to be the most important factor working against health and well-being. However, they ranked most of the assets within Randolph county to be above average in regard to transportation and access to care. The second most important factor working against health and well-being as noted in exercise 2 was a lack of education and information. However, overall, each community asset is rated as average in regard to information/knowledge/education. The average of all groups is located on page 22 (**Appendix II**).

4. WAYS RELIGION CONTRIBUTES TO HEALTH

a. OBJECTIVE

This exercise comprised of a short discussion facilitated by the facilitators. The purpose of this activity was to acquire a participant driven list of ways in which spirituality/religion contribute to access to care.

b. METHOD

Participants returned to their seats, and as one large group, began to discuss a question posed by the facilitators, "How does religion faith or spirituality play a role in Randolph to promote health and well-being for those seeking care?"

c. DISCUSSION

Participants discussed the many ways that Religion/Faith/Spirituality contributes to health and well-being. They spoke of availability for congregational members while there seems to be much less for non-members; there are opportunities for those connected to faith communities that non-members have to create or find on their own. Faith communities offer a place for expressing compassion. Churches frequently provide financial resources for assistance. Churches create the space and opportunities for volunteer to do meaningful work, such as building ramps for those who are new to wheelchair accessibility needs. The Baptist Aging Ministry (BAM) has a wonderful ministry for senior adults and for volunteers. Congregations provide home repair. Churches provide prayer shawl and snack ministries, in hospitals, for patients and families. Some congregations have caregiving ministries such as "Stephen's ministry", or pregnancy care counseling, and visitation and sitter's for those who need a break from caregiving. Many Hospice volunteers come from local congregations. Churches in the area contribute to CUOC (Christians United Outreach Center). Cross Roads offers a large program for aging, Alzheimer's, assisted living, group homes and child care. There is a yoga group in the community that is very large as well. It would be helpful to have information about different congregations and faith communities as well as other opportunities for nurturing spirituality and faith.

5. CHARACTERISTICS OF EXEMPLARY ORGANIZATIONS AND NEXT ACTION STEPS

Participants were probed on what characteristics of exemplary organizations defined them as such. The group collaboratively created a list of exemplary organizations and their characteristics:

Christian United Outreach Center:

- Reasonably priced clothing, food, utilities, medicatons, furniture
- Stand behind what they stand for—integrity and example
- Well organized locally
- Seek congregational involvement
- Get help and Do help—volunteers and clients
- Resource for congregations
- Not a hand-out a hand-up

Chick-fil-a

- Golf tournament—fundraising
- Employ young people and offer scholarships
- Socially conscious locally

YMCA
- Education and workshops
- Intergenerational—broad continuum of services
- Scholarships
- Rehab services in facility
- Special education services

RCATS
- Courteous Services
- Go as far as allowed
- Compassionate, respectful
- Seek/find other resources

Senior Center
- Fans for those with no AC
- Meals on Wheels
- Depends/blue pads for those in need
- Senior issues
- Store of items made by Seniors
- Sr. Insurance Medicines (SHIPP)
- Legal Services
- Sitters list
- Innovation—active seniors

Hospice of Randolph
- Treatment of patients
- Care of family
- Listens and tries to meet the needs
- Assist in dying with grace
- Medicare/Medicaid self-pay
- Hospice Home

Randolph Hospital
- Does an excellent job—homehealth
- Desire to improve in their work and in other's health
- Desire to engage with the community
- Volunteers—compassion to patients and family
- Cancer center, surgical center
- Foundation funds a lot in the community
- Encouragement to engage people in their own care (patient/family centered care)

Following the conversation on exemplary organizations, the group began to discuss next steps—responding to the question, "What do you want to happen now?"

The group named several opportunities before them including:

- More unity in the community—the churches could collaborate more and find ways to include non-members
- Fewer siloes inside hospitals, churches, community agencies, etc..
- Share findings of workshops like this one in a wide manner
- Develop respite care
- Find out how to access zoo and other resources available for free
- Mass transport for elders, others
- A3 coalition formed to create walking track downtown
- Develop caregiver advocacy program—caregiver mentors
- Senior "navigators"—like "candy stripers in the hospital or pipeline program in high schools
- High school senior projects in community and health care opportunities
- RCC nursing
- Culinary course credits for students serving at Our Daily Bread
- Hispanic mapping
- Start program like Haywood co—churches helping homeless leaving the hospital
- Make opportunities more available to public
- Preventive care efforts at younger age
- Pull children and youth into healthier behaviors—school/community gardens; teach fun healthy education, sustainability, cooking classes
- Programs teaching self-sufficiency and self-management of conditions (communication)
- Caregiver college
- Prevention of falls, obesity, chronic disease
- Teach resiliency
- Support for the homosexual community in the area

There will be a follow-up and report session on Friday, December 5, 2014.

APPENDICES

I. Randolph County Demographic Data

Randolph Demographic Information	27341 Zip Code	27298 Zip Code	North Carolina	United States
Total Population	5,360	10,336	9,535,483	308,745,538
Gender				
Male	2,684 (50.07%)	5,202 (50.33%)	48.72%	49.16%
Female	2,676 (49.93%)	5,134 (49.67%)	51.28%	50.84%
Race				
White	4,925 (91.88%)	8,813 (85.27%)	68.47%	72.41%
Black/African American	253 (4.72%)	886 (8.57%)	21.48%	12.61%
Hispanic	180 (3.36%)	738 (7.14%)	8.39%	16.35%
Asian	19 (0.35%)	15 (0.15%)	2.19%	4.75%
Native	10 (0.19%)	62 (0.60%)	1.35%	1.12%
One Race, Other	96 (1.79%)	333 (3.22%)	4.34%	6.19%
Two or more races	57 (1.06%)	227 (2.20%)	2.16%	2.92%
Educational Achievement (25 years and over)				
Less than High School	1,014 (26.05%)	1,200 (18.28%)	15.49%	14.28%
High School Graduate	1,295 (33.26%)	2,262 (34.46%)	27.24%	28.24%
Some College or Associate Degree	1,143 (29.36%)	2,251 (34.29%)	30.44%	28.99%
Bachelor's Degree	346 (8.89%)	472 (7.19%)	17.82%	17.88%
Graduate or Professional Degree	95 (2.44%)	380 (5.79%)	9.01%	10.61%
Marital Status (15 years and over)				
Males- Never Married	677 (28.77%)	842 (23.63%)	32.82%	35.08%
Males -Married	1,313 (55.80%)	2,368 (66.46%)	55.55%	52.93%
Males- Widowed	117 (4.97%)	158 (4.43%)	2.48%	2.53%
Males-Divorced	246 (10.45%)	195 (5.47%)	9.15%	9.46%
Females- Never Married	426 (18.67%)	617 (15.79%)	26.93%	28.74%
Females- Married	1,340 (58.72%)	2,195 (56.18%)	51.62%	49.95%
Females- Widowed	261 (11.44%)	496 (12.70%)	9.83%	9/34%
Females- Divorced	255 (11.17%)	599 (15.33%)	11.62%	11.97%
Employment (16 years and over)				
Males- In labor force	1,546 (69.02%)	2,394 (69.35%)	69.94%	70.20%
Females- In labor force	1,306 (57.28%)	2,347 (60.87%)	58.94%	59.43%
Males- Employed	1,440 (93.14%)	2,067 (86.96%)	89.23%	90.27%
Females- Employed	1,126 (86.22%)	2,178 (92.80%)	89.81%	91.21%
Males- Unemployed	106 (6.86%)	310 (13.04%)	10.77%	9.73%
Females- Unemployed	180 (13.78%)	169 (7.20%)	10.19%	8.79%
Nativity	5,828 (95.46%)	8,655 (97.29%)	92.47%	87.13%
Median Age	41.10	40.90	37.40	37.20
Households	2,129	4,149	3,745,155	116,716,292
Family Households	1,542 (72.43%)	2,908 (70.09%)	66.73%	66.43%
Married-couple family	1,224 (57.49%)	2,214 (53.36%)	48.38%	48.42%
Nonfamily households	587 (27.57%)	1,241 (29.91%)	33.27%	33.57%
Income				
Median Household Income	$42,208	$42,796	$46,450	$53,046
Families in Poverty	225 (15.05%)	250 (9.86%)	12.41%	10.92%

Source: www.usa.com (Based on 2008-2012 government census data)

Randolph County Demographic Data

Randolph Demographic Information	27205 Zip Code	North Carolina	United States
Total Population	33,216	9,535,483	308,745,538
Gender			
Male	16,613 (50.02%)	48.72%	49.16%
Female	16,603 (49.98%)	51.28%	50.84%
Race			
White	29,008 (87.33%)	68.47%	72.41%
Black/African American	1,330 (4.00%)	21.48%	12.61%
Hispanic	3,561 (10.72%)	8.39%	16.35%
Asian	244 (0.73%)	2.19%	4.75%
Native	202 (0.61%)	1.35%	1.12%
One Race, Other	2,006 (6.04%)	4.34%	6.19%
Two or more races	426 (1.28%)	2.16%	2.92%
Educational Achievement (25 years and over)			
Less than High School	4,305 (19.45%)	15.49%	14.28%
High School Graduate	7,274 (32.86%)	27.24%	28.24%
Some College or Associate Degree	6,860 (30.99%)	30.44%	28.99%
Bachelor's Degree	2,717 (12.27%)	17.82%	17.88%
Graduate or Professional Degree	981 (4.43%)	9.01%	10.61%
Marital Status (15 years and over)			
Males- Never Married	3,334 (25.41%)	32.82%	35.08%
Males -Married	8,065 (61.46%)	55.55%	52.93%
Males- Widowed	392 (2.99%)	2.48%	2.53%
Males-Divorced	1,332 (10.15%)	9.15%	9.46%
Females- Never Married	2,378 (17.79%)	26.93%	28.74%
Females- Married	8,163 (61.06%)	51.62%	49.95%
Females- Widowed	1,410 (10.55%)	9.83%	9/34%
Females- Divorced	1,418 (10.61%)	11.62%	11.97%
Employment (16 years and over)			
Males- In labor force	8,997 (69.92%)	69.94%	70.20%
Females- In labor force	7,873 (60.30%)	58.94%	59.43%
Males- Employed	8,121 (90.26%)	89.23%	90.27%
Females- Employed	7,254 (92.14%)	89.81%	91.21%
Males- Unemployed	876 (9.74%)	10.77%	9.73%
Females- Unemployed	619 (7.86%)	10.19%	8.79%
Nativity	30,231 (90.91%)	92.47%	87.13%
Median Age	40.40	37.40	37.20
Households	12,739	3,745,155	116,716,292
Family Households	9,463 (74.28%)	66.73%	66.43%
Married-couple family	7,513 (58.98%)	48.38%	48.42%
Nonfamily households	3,276 (25.72%)	33.27%	33.57%
Income			
Median Household Income	$51,951	$46,450	$53,046
Families in Poverty	948 (9.97%)	12.41%	10.92%

Source: www.usa.com (Based on 2008-2012 government census data)

II. FACILITY/HEALTH RANKING

The chart below depicts the average of Group 1, Group 2 and Group 3 during the Facility/Health Ranking exercise.

Averages of all groups:

	Hospital Urgent Care	Churches Ministries	Pharmacy Drug Stores	Library Art Guild Comm.	Adult Day Care/Sr. Services	Fitness Ctrs. YMCA, Parks	COUC	Farmer's Mkts Groc. Stores	Home Health	Soup Kitchen Food Pantry
Good Drs. medical personnel	4.5	NA	4.5	NA	5	NA	NA	NA	4.66	NA
Health Coverage	4.5	NA	3.69	4	4.3	3	NA	NA	4.66	NA
Compassionate Community	4.66	4.66	4.3	4.66	5	5	4.66	4.5	5	5
Variety/Choices Of services	4.5	5	4.3	4.66	4.3	4.3	4.66	3.5	4	3.33
Access to Medications	4.5	2	5	3	4.5	NA	4.3	NA	5	NA
Access to natural resources	NA	4	NA	4.3	4	5	NA	3.69	NA	NA

ACKNOWLEDGEMENTS

We wish to thank the Wake Forest Baptist Medical Center and the North Carolina Baptist Hospital Foundation for funds that helped support staff and underwrite the mapping activities as well as Central United Methodist church for allowing use of their space for the workshop and First Baptist Church for allowing use of their space for the follow up meeting on Dec. 5, 2014. For more information on local Randolph county efforts, contact Chaplain Barry Morris at phone 336.328.3851 or e-mail, Bmorris@randolphhospital.org and/or Navigator Helen Milleson at 336.302.2839 or hmilleson@randolphhospital.org. For information about the CHAMP process, please contact Dr. Teresa Cutts at tcutts@wakehealth.edu or 336.713.1434.