FaithHealthNC
Community Health Assets Mapping Partnership
CHAMP

Seeker-Level Workshop Report

January 09, 2016

Mocksville, NC
Davie 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 Baptist Medical Center's FaithHealthNC, was offered in Mocksville, NC at the health care seeker level. As part of the Community Health Asset Mapping Partnership in Mocksville, the workshop focused on residents of the community who seek health care services within Davie County. Therefore, Davie County was the area of focus. **Image 1** is a map outlining the boundaries of Davie County.

Image 1

2. DATE & PLACE OF WORKSHOP

The workshop took place on January 09, 2016 at First Baptist Church. The church is located downtown at 412 N. Main St. Mocksville, NC 27028 in Davie County. The workshop began at 9:00 am and was completed by 3:00 pm.

3. FACILITATION TEAM

Lead Facilitators:	Teresa Cutts, PhD Emily Viverette, MDiv Leland Kerr, Baptist Healthcare Liaison
Background Content and Materials Experts:	Leland Kerr
Local Hosts:	Rev Shane Nixon
Scribes:	Tom Nesbit, MDiv Emily Viverette, MDiv Nicole Johnson, BA
Primary Report Writer:	Nicole Johnson
Registration:	Judy MCClamrock

4. PHYSICAL DESCRIPTION

The workshop was held in the main sanctuary of First Baptist Church. The sanctuary is a large space and an area was arranged in the rear of the sanctuary for the workshop. The registration table was available just inside the entrance to the sanctuary. In addition to the registration table, a table with breakfast items was available for participants. The space where the workshop occurred was comprised of three large tables. Each table had six to eight chairs placed around them. Throughout the workshop, these three tables represented the three various activity groups identified as participants in this report. Facing the participants was an easel holding boards, charts, and maps for the activities. **Image 2** depicts the layout of the workshop held in the sanctuary of First Baptist Church during the health seeker workshop.

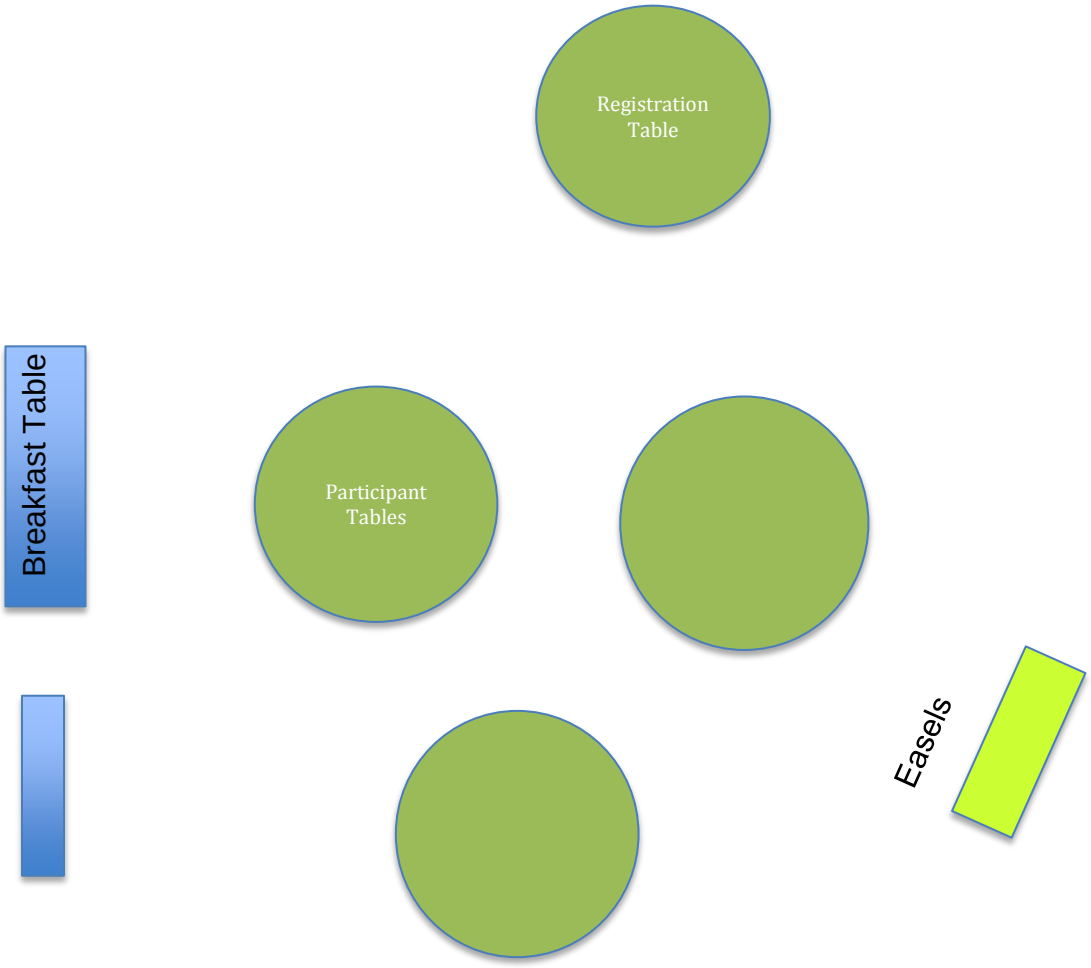

Image 2

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 Davie County, 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 First Baptist Church 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

Six individuals participated in an abbreviated 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 Davie 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 sixty-one (61) years old. The oldest participant was sixty-eight (68) years old while the youngest was fifty-six (56) years old. Four participants identified as female and two identified as male. Five participants identified as Caucasian while one participant did not identify their race and/or ethnicity. Two participants identified as single/divorced/widowed and four were married. The highest level of education for three participants was a Master's level graduate degree; one participant identified as having taken college classes, one participant listed completion of the 12th grade, one participant identified as having completed their G.E.D. Every participant identified English as their primary language with none identifying another spoken language.

The information collected through registration also depicted each participant's relation to Mocksville and Davie County. Four participants live within the 27028 zip code, three were unidentified. The average number of years spent in Davie County is 31.5 years with one identifying as living in another county. Three participants are currently working in healthcare settings, one is a homemaker, two work in a congregational setting. Represented at the workshop were two different faith/church traditions—Methodist and Presbyterian.

7. INTRODUCTION TO WORKSHOP

The workshop began with a greeting and introduction by Dr. Teresa Cutts. She invited participants to take part in a shortened version of the workshop based on the number of people present. She shared with the participants a summary of the goals of the seeker level workshop and introduced the facilitation team. Most of the participants present were aware of 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 introduce themselves, their churches, and the areas in which they live. Most participants had lived in Davie County for several years and shared their fondness of the community. Two were lifetime residents.

SECTION B

HEALTH SEEKER EXERCISES

SECTION B

1. COMMUNITY MAPPING

a. OBJECTIVE

The first activity of the day involved community mapping. The participants were asked, as one group, to discuss what they collectively know about Davie County and to construct a map based on what they believe to be important assets of Davie County. 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 Davie County and Mocksville in particular.

b. METHOD

One table was equipped with colorful markers and large white sheets of paper. The participants began discussing the areas in which they live, or are familiar with, and formed connections based on their respective neighborhoods.

Participants shared established relationships, as well as past events in the county and ways in which things had changed. One member of the group became the primary scribe and outlined a map of Davie County. The group oriented themselves by dividing the county into sections, North, South, East and West, as well as major road markers. They then proceeded to mark the locations of significant community markers such as the high school and elementary schools. The group 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, the group was asked to post the map on an easel in the front of the room and discuss in more depth the selected markers.

c. DISCUSSION

Group 1 They identified the location of the elementary and high schools as a main route for offering services to families, and as a consequence, the community. They identified the need for sufficient food and the intersection of sufficient food and positive educational outcomes. The schools are major advocates for kids in the community. The hospital and the community college are developing partnerships to offer services. Participants discussed the lack of emergency care that covered the entire county with respect to accessibility for county residents. There are urgent care facilities for circumstances where emergency room care is not necessary. Participants noted that the county has a significant number of churches. They also identified the senior center, Meals on Wheels, YVEDDI, the Rec Center, and nursing homes. Participants noted the minute clinic at CVS. Another marker which generated significant discussion was Storehouse for Jesus. Storehouse for

Jesus has been around for 20-30 years and was initiated by a member of the community who felt inspired to help the community.

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 Davie 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.

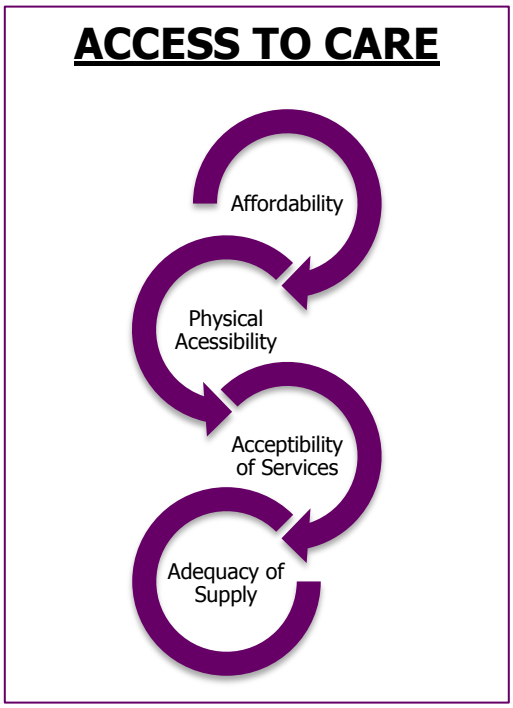

Image 3

b. METHOD

Each participant was asked to write one factor that works against health and well-being on two separate post-it notes, and then discuss with the group. The factors generated through individual and group discussion 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 defined as 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.
- **Lack of Insurance** – How this affects a person's sense of well-being mentally, emotionally, and physically. Leads to more immediate survival and less about long term health services.
- **Proximity to health care** – Not proximal to health care settings
- **Person's lack of willingness to accept care** – Person has to be willing to do so
- **Finances** – Finances may limit ability to utilize health insurance
- **Lack of Trust** – 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.
- **Lack of education/knowledge of right places to seek need**
- **Employment** – The level of unemployment or underemployment in the county is very high and this affects financial resources and lack of insurance and sense of well-being.
- **Lack of Childcare**
- **Caregiving** – Many people doing caregiving for adults in need.
- **Hopelessness and Depression**
- **Healthcare is lack of priority when in survival mode**

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 Davie County. These were graphed according to frequency. The following list depicts the top four 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 Davie County.	1. Lack of Transportation 2. Lack of Finances/Insurance/Finances for Health Care 3. Proximity to Health Care Settings 4. Hopelessness/Depression

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

Question	Results
What is the most important factor or factors that they personally believe work ***for*** health and well-being in regard to access to care in Davie County.	1. Transportation 2. Finances 3. Education and Knowledge of health Care 4. Mutual trust and partnership 5. Availability of Care

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 participated as one group, which was the same as the earlier exercises. The 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: schools,

DSS/Health Department, Hospitals, Storehouse for God, Community Centers/Senior Centers, Long Term Care/Nursing Homes, Churches, For Profit Pharmacies/Minute Clinic.

c. DISCUSSION

Table 2 depicts the various community assets rankings of each group.
The group engaged in thoughtful conversation concerning the information in each of the tables below.

Table 2:

	Schools	DSS Health Department	Hospitals	Storehouse for Jesus	Community Centers/Senior Centers	Long Term Care (Nursing Homes	Churches	Fr Profit Pharmacies (Minute Clinic)	Average
Transportation	5	1	3	1	1	3	5	1	2.5
Finances	5	3	2	5	2	1	4	1	2.875
Education/Knowledge	4	3	4	4	4	1	3	3	3.25
Mutual Trust/Compassionate Partnership	4	3	2	5	3	2	3	1	2.875
Humble Providers	4	2	1	5	4	2	3	1	2.75
Proximity to Care	5	2	1	3	3	2	4	2	2.75

Overall, the group ranked the community assets highest in regard to education and knowledge. The community assets ranked below average in regards to transportation, finances, mutual trust/compassionate partnership, humble providers, and proximity to care. In Exercise 2 participants believed transportation to be the most important factor working against health and well-being. The group's ranking identified transportation as below average in Davie County. But, they also identified in Exercise 2 transportation as the highest factor that worked for health care and access to care in Davie County. The second most important factor working against health and well-being as noted in exercise 2 was a lack of finances. Again the group identified finances as below average for Davie County. Consistently, across the board, Storehouse for Jesus and schools stood out as rating above average in most categories.

4. WAYS RELIGION CONTRIBUTES TO HEALTH

a. OBJECTIVE

This exercise was comprised of a short discussion led 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 Davie County 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. The discussion coalesced around the general idea that Christians reach out in their immediate community and do a good job of supporting those who are in the immediate community. Outside their own community, the idea of support takes on a different dimension and becomes more oriented towards a program or mission done for the community. This perspective comes from the idea of the church as community and the church tends to take on a more tribal nature. The comfort zone for active church members is inside the church.

The group also discussed the difference between giving money and interfacing with issues and/or people in the community. Churches and religion are becoming more polarized politically. This acts as a barrier to creating a culture that promotes health and well-being in the community. The examples used as a standard are still not nearly engaged enough with the issues named in the workshop such as transportation, finances and access to care in Davie County. Another area of growth identified that was peculiar to the church community was the need for collaboration. Mocksville has a great missional network of 12 churches but rarely do they come together around one common issue.

Davie County has one of the lower numbers of unchurched people than some other western NC counties. Davie County is about 36% unchurched. How do churches work for the 36% who are unchurched? The participants gave voice to the idea that older models of evangelism no longer work, therefore churches must be more willing to walk alongside others to help them to be who God has called them to be. Service draws people together. One participant mentioned the numbers who were drawn to help people post-Katrina—people who were unchurched went on the mission trips. Churches need to grow in our ability to meet people where they are.

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:

Storehouse for Jesus

- Ability to provide a range of services for those in need
- Inspire and engage a large number of volunteers
- Conviction
- Walk the Talk
- Reputation
- Personal experience of the founder Marie Collins with need
- Leadership embodies the work
- Don't require payment/ pure benevolence

Health Department/SS

- Provide healthcare
- Educate

- Huge number of clients and still have need
- Tracie – knowledgeable, humble, compassionate care provider, fit in easily, complementary of others/communities, confirming of Davie County

School System
- Variety of roles and services they provide (food, counselling, healthcare, education)
- Role Models
- Integrity
- Community focused

Davie Domestic Violence and Rape Crisis Center
- Provide support for those in crisis who have nowhere else to turn
- Focused on Prevention
- Awareness of these issues and proactivity about making services more accessible
- Partnerships
- Many educational events and experiences

Churches (Breakfast Fund)
- Funds are local
- Variety of churches are engaged
- Supports local charities
- Social cohesion-building event
- Raises awareness of needs

Davie Foundation – Healthy Davie Initiative
- Supports women's health
- Convened Healthy Davie Initiative
- Willingness to collaborate with church efforts

Advocacy Center
- Do an excellent job of helping those who fall through state supported safety net
- Goal is to help people stay in their home during times of crisis
- Keep list of abusers of the system and share that information
- Collaborative
- Supported by many churches

CareNet Counselling
- Counselling they provide (key issues of depression/hopelessness)
- Moderately priced/affordable
- One of the few mental health service providers in Davie County

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:

- Learn more about YVEDDI (Yadkin Valley Economic Development District, Incorporated) for partnerships
- Find ways to gather more seeker voices
- Explore collaborating and partnering with Healthy Davie, as well as learning more about their asset mapping
- Enlist more grassroots seekers in more underserved parts of the county to hear their voices (Coolemee, Northern Davie Co, William R. Davie area, Hispanic/Latino)
- Focus on transportation—it's a huge need; could churches come together to help with transportation or hire a nurse practitioner for the county? Explore improving/developing transportation options for Davie County.

The follow-up and report session was held on Thursday, February 25, 2016 from 5:30-7:15 p.m. at Oak Grove United Methodist Church in Mocksville. The Oak Grove Team provided a great dinner.

Nine Attendees were all Caucasian (5 males, 4 females), with four FaithHealth staff.

Representatives from the Sheriff's office, EMS, YVEDDI, Parks and Recreation, Senior Services, the Advocacy Center, Oak Grove UMC and others were present. Four participants were present from previous workshops held in Davie County.

The session began with introductions from Leland Kerr, Emily Viverette and Teresa Cutts.

Reflections from those who participated in earlier workshops were shared. One participant wished more providers had been involved and obviously, the process findings reflect the view of whomever you have sitting in the room. The question was posed, "How come we don't know more about each other's efforts" in terms of initiatives. This points to a need for communication between multiple entities. Perhaps the mapping reports could be taken to the other entities for conversation starters and potential partnerships. One participant referenced Stakeholder Health's

(a national learning collaborative of over 50 hospitals trying to find better ways to partner with community to care for the poor) image of webs of trust and how connected everything in the community really is. One Oak Grove participant would have liked to have heard more from the seekers and another found the provider side really interesting—appreciated having people from Storehouse for Jesus. This participant has been in touch with some of the people she met at the mapping—it created an opportunity for connection. Another question was asked, "What common needs have you seen as you've engaged in FH work in the community?" One response was that transportation is a big issue—Oak Grove is now getting these referrals from other community members. The Oak Grove team is enjoying helping those in need and the pastor shared about a lady whom they had helped who came all the way to the church to show doctor's bills and prove that she was really in need. Even in smaller communities, the provider workshop gives providers an opportunity to learn about one another in more depth. Some people feel embarrassed to ask for help and feel that Oak Grove is safe enough for many to make that request. Financial insecurity is a huge issue.

One participant who is retired, works part-time at YVEDDI and senior services, and attends a Methodist Church, is also the chair of the Davie Aging Planning Committee. This committee provides some funds for transportation for health needs. There is a volunteer program—volunteers are paid for training-- and YVEDDI has a van that can be used to transport people for free. This van is rarely used because of a lack of volunteers. (It can be used to transport people who don't qualify for YVEDDI services.) He works for YVEDDI, recruiting volunteers, and would welcome more volunteers from the churches. Funding is distributed across various needs: transportation, senior services, meals, etc. At one time, there existed both a Human Services Council for communication and a Pastors' Council, which helped to communicate need and awareness of service. The Aging Committee could be a resource for smaller churches whose older members struggle with transportation.

FaithHealth staff offered opportunities for Mental Health First Aid, Community Resiliency Model trainings and an upcoming Soul Shop—Suicide Prevention Conference, already scheduled for Davie County.

The EMS participant noted that they see people only in crisis—there's a real struggle with education around how to teach persons when go to the doctor at the right time. It's getting slightly better with Obamacare, though now the hospitals are bearing the brunt of those costs and many still overuse the ED.

EMS can refer to Social Services if things are difficult and not emergent. He shared some care pathways with the Oak Grove team that could be helpful to both the EMS and people being served in the county. Social Services are overrun, getting calls to serve the same people repeatedly. Davie County EMS is government-run and can't bring in big grants to really help with para-medicine in such a rural county.

The Sheriff's office representative noted that they, too, can't quite compete for larger grants with metro areas and are too large to compete for smaller grants. Needs include a transitional care/half-way house (a church is working on this), for needed help with transitioning people. The Sheriff's office now receives over five times the calls that they did in the 1990's—although the population is no larger and the crime statistics are lower. They receive calls about "life stuff": people wanting help with their 3 year old, or to mediate disputes about mowing lawns across

property lines. There might be some opportunities for education of church care teams in providing for these types of needs.

APPENDICES

I. Davie County Demographic

People	North Carolina	UNITED STATES	Davie County, North Carolina
Population			
Population estimates, July 1, 2015, (V2015)	10042802	321418820	NA
Population estimates, July 1, 2014, (V2014)	9943964	318857056	41434
Population estimates base, April 1, 2010, (V2015)	9535692	308758105	NA
Population estimates base, April 1, 2010, (V2014)	9535691	308758105	41222
Population, percent change - April 1, 2010 (estimates base) to July 1, 2015, (V2015)	5.3	4.1	NA
Population, percent change - April 1, 2010 (estimates base) to July 1, 2014, (V2014)	4.3	3.3	0.5
Population, Census, April 1, 2010	9535483	308745538	41240
Age and Sex			
Persons under 5 years, percent, July 1, 2014, (V2014)	6.1	6.2	5.1
Persons under 5 years, percent, April 1, 2010	6.6	6.5	5.7
Persons under 18 years, percent, July 1, 2014, (V2014)	23.0	23.1	21.9
Persons under 18 years, percent, April 1, 2010	23.9	24.0	23.6
Persons 65 years and over, percent, July 1, 2014, (V2014)	14.7	14.5	19.3
Persons 65 years and over, percent, April 1, 2010	12.9	13.0	16.6
Female persons, percent, July 1, 2014, (V2014)	51.3	50.8	51.1
Female persons, percent, April 1, 2010	51.3	50.8	51.2
Race and Hispanic Origin			
White alone, percent, July 1, 2014, (V2014) (a)	71.5	77.4	90.4
White alone, percent, April 1, 2010 (a)	68.5	72.4	87.5
Black or African American alone, percent, July 1, 2014, (V2014) (a)	22.1	13.2	6.5
Black or African American alone, percent, April 1, 2010 (a)	21.5	12.6	6.3
American Indian and Alaska Native alone, percent, July 1, 2014, (V2014) (a)	1.6	1.2	0.6
American Indian and Alaska Native alone, percent, April 1, 2010 (a)	1.3	0.9	0.4
Asian alone, percent, July 1, 2014, (V2014) (a)	2.7	5.4	0.8
Asian alone, percent, April 1, 2010 (a)	2.2	4.8	0.6
Native Hawaiian and Other Pacific Islander alone, percent, July 1, 2014, (V2014) (a)	0.1	0.2	0
Native Hawaiian and Other Pacific Islander alone,	0.1	0.2	Z

percent, April 1, 2010 (a)			
Two or More Races, percent, July 1, 2014, (V2014)	2.1	2.5	1.6
Two or More Races, percent, April 1, 2010	2.2	2.9	1.7
Hispanic or Latino, percent, July 1, 2014, (V2014) (b)	9	17.4	6.4
Hispanic or Latino, percent, April 1, 2010 (b)	8.4	16.3	6.1
White alone, not Hispanic or Latino, percent, July 1, 2014, (V2014)	64.1	62.1	84.9
White alone, not Hispanic or Latino, percent, April 1, 2010	65.3	63.7	85.5
Population Characteristics			
Veterans, 2010-2014	709471	20700711	3320
Foreign born persons, percent, 2010-2014	7.6	13.1	4.4
Housing			
Housing units, July 1, 2014, (V2014)	4452334	133957180	18197
Housing units, April 1, 2010	4327528	131704730	18238
Owner-occupied housing unit rate, 2010-2014	65.8	64.4	80.4
Median value of owner-occupied housing units, 2010-2014	153600	175700	164100
Median selected monthly owner costs -with a mortgage, 2010-2014	1272	1522	1212
Median selected monthly owner costs -without a mortgage, 2010-2014	373	457	347
Median gross rent, 2010-2014	790	920	685
Building permits, 2014	49911	1046363	82
Families and Living Arrangements			
Households, 2010-2014	3742514	116211092	16117
Persons per household, 2010-2014	2.54	2.63	2.54
Living in same house 1 year ago, percent of persons age 1 year+, 2010-2014	84.7	85.0	93.3
Language other than English spoken at home, percent of persons age 5 years+, 2010-2014	11.1	20.9	7.6
Education			
High school graduate or higher, percent of persons age 25 years+, 2010-2014	85.4	86.3	85.4
Bachelor's degree or higher, percent of persons age 25 years+, 2010-2014	27.8	29.3	25.6
Health			
With a disability, under age 65 years, percent, 2010-2014	9.5	8.5	8.8
Persons without health insurance, under age 65 years, percent	15.2	12.0	18.2
Economy			
In civilian labor force, total, percent of population age 16 years+, 2010-2014	62.1	63.5	59.7

In civilian labor force, female, percent of population age 16 years+, 2010-2014	58.0	58.7	55.3
Total accommodation and food services sales, 2007 ($1,000) (c)	16126939	613795732	28967
Total health care and social assistance receipts/revenue, 2007 ($1,000) (c)	46688776	1668276808	67052
Total manufacturers shipments, 2007 ($1,000) (c)	205867299	5319456312	1001617
Total merchant wholesaler sales, 2007 ($1,000) (c)	88795885	4174286516	139129
Total retail sales, 2007 ($1,000) (c)	114578173	3917663456	407832
Total retail sales per capita, 2007 (c)	12641	12990	10066
Transportation			
Mean travel time to work (minutes), workers age 16 years+, 2010-2014	23.7	25.7	26.4
Income and Poverty			
Median household income (in 2014 dollars), 2010-2014	46693	53482	49591
Per capita income in past 12 months (in 2014 dollars), 2010-2014	25608	28555	26739
Persons in poverty, percent	17.2	14.8	13.8
Businesses	North Carolina	UNITED STATES	Davie County, North Carolina
Total employer establishments, 2013	218285(1)	7488353	782
Total employment, 2013	3421195(1)	118266253	8145
Total annual payroll, 2013	143341880(1)	5621697325	251111
Total employment, percent change, 2012-2013	2.1(1)	2	-1.7
Total nonemployer establishments, 2013	679725	23005620	2888
All firms, 2007	798791	27092908	4018
Men-owned firms, 2007	421114	13900554	2130
Women-owned firms, 2007	225500	7792115	1060
Minority-owned firms, 2007	131728	5759209	S
Nonminority-owned firms, 2007	634155	20100926	3628
Veteran-owned firms, 2007	84350	2447608	375
Nonveteran-owned firms, 2007	652713	22627611	3344
Geography	North Carolina	UNITED STATES	Davie County, North Carolina
Population per square mile, 2010	196.1	87.4	156.2
Land area in square miles, 2010	48617.91	3531905.43	264.11
FIPS Code	"37"	"00"	"37059"

This geographic level of poverty and health estimates are not comparable to other geographic levels of these estimates

Some estimates presented here come from sample data, and thus have sampling errors that may render some apparent differences between geographies statistically indistinguishable.

The vintage year (e.g., V2015) refers to the final year of the series (2010 thru 2015). Different vintage years of estimates are not comparable.

(1) Includes data not distributed by county.

(a) Includes persons reporting only one race
(b) Hispanics may be of any race, so also are included in applicable race categories
(c) Economic Census - Puerto Rico data are not comparable to U.S. Economic Census data

D: Suppressed to avoid disclosure of confidential information
F: Fewer than 25 firms
FN: Footnote on this item in place of data
NA: Not available
S: Suppressed; does not meet publication standards
X: Not applicable
Z: Value greater than zero but less than half unit of measure shown

QuickFacts data are derived from: Population Estimates, American Community Survey, Census of Population and Housing, Current Population Survey, Small Area Health Insurance Estimates, Small Area Income and Poverty Estimates, State and County Housing Unit Estimates, County Business Patterns, Nonemployer Statistics, Economic Census, Survey of Business Owners, Building Permits.

Source: www.census.gov

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