2024
Community Health Needs Assessment

Forsyth County, North Carolina

Sponsored by

Atrium Health Wake Forest Baptist Medical Center

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Prepared by

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Introduction

Project Overview

A Community Health Needs Assessment provides information so that communities may identify issues of greatest concern and decide to commit resources to those areas, thereby making the greatest possible impact on community health status. This Community Health Needs Assessment is a systematic, data-driven approach to determining the health status, behaviors, and needs of residents in Forsyth County, the service area of Atrium Health Wake Forest Baptist Medical Center. Subsequently, this information may be used to inform decisions and guide efforts to improve community health and wellness.

This assessment was conducted on behalf of North Carolina Baptist Hospital (dba Atrium Health Wake Forest Baptist Medical Center) by PRC, Inc., a nationally recognized health care consulting firm with extensive experience conducting Community Health Needs Assessments in hundreds of communities across the United States since 1994.

Methodology

This assessment incorporates data from multiple sources, including primary research (through the PRC Community Health Survey and PRC Online Key Informant Survey), as well as secondary research (vital statistics and other existing health-related data). It also allows for comparison to benchmark data at the state and national levels.

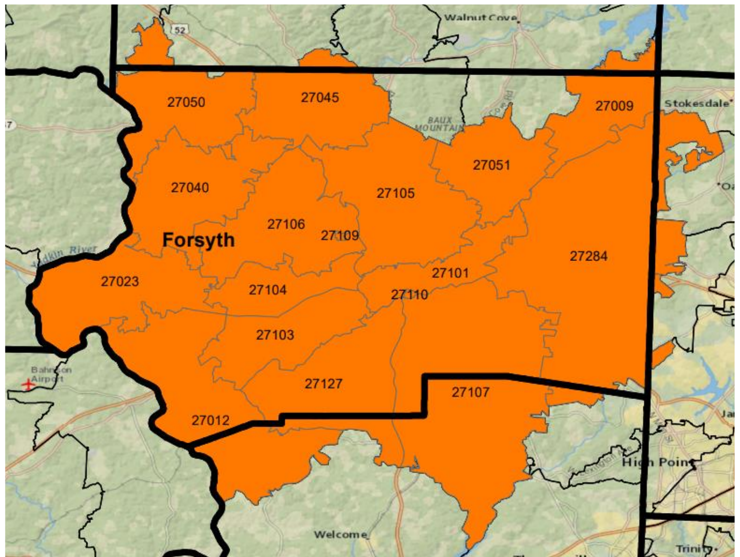
PRC Community Health Survey

Survey Instrument

The survey instrument used for this study is based largely on the Centers for Disease Control and Prevention (CDC) Behavioral Risk Factor Surveillance System (BRFSS), as well as various other public health surveys and customized questions addressing gaps in indicator data relative to health promotion and disease prevention objectives and other recognized health issues. The final survey instrument was developed by Atrium Health and PRC.

Community Defined for This Assessment

The targeted population for this survey effort included each of the residential ZIP Codes comprising Forsyth County, North Carolina, as outlined in the following map.



Sample Approach & Design

A precise and carefully executed methodology is critical in asserting the validity of the results gathered in the PRC Community Health Survey. Thus, to ensure the best representation of the population surveyed, a mixed-mode

methodology was implemented. This included targeted surveys conducted by PRC via telephone (landline and cell phone) as well as through online questionnaires.

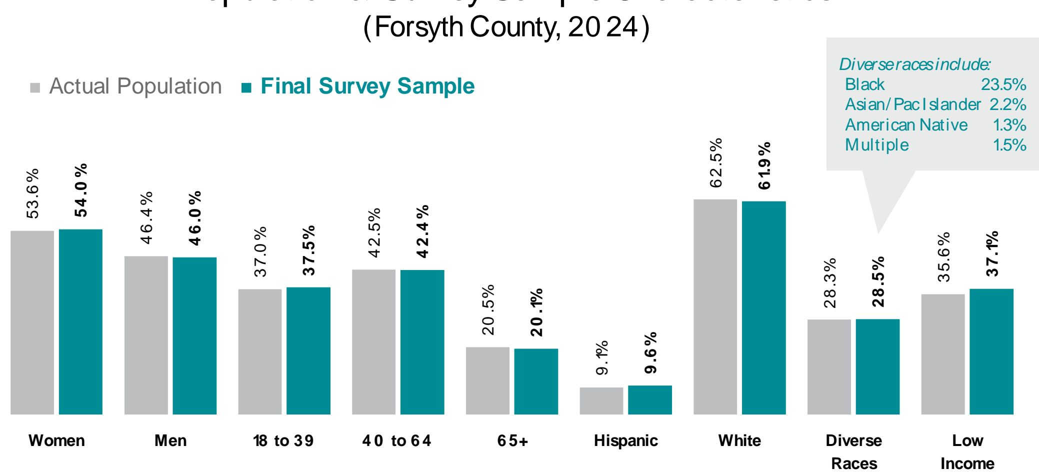
The sample design for this effort consisted of a random sample of 302 individuals age 18 and older in Forsyth County. Once the interviews were completed, these were weighted in proportion to the actual population distribution so as to appropriately represent Forsyth County as a whole. All administration of the surveys, data collection, and data analysis was conducted by PRC.

For statistical purposes, the maximum rate of error associated with a sample size of 302 respondents is ±5.7% at the 95 percent confidence level.

Sample Characteristics

To accurately represent the population studied, PRC strives to minimize bias through application of a proven telephone methodology and random-selection techniques. While this random sampling of the population produces a highly representative sample, it is a common and preferred practice to “weight” the raw data to improve this representativeness even further. This is accomplished by adjusting the results of a random sample to match the geographic distribution and demographic characteristics of the population surveyed (poststratification), so as to eliminate any naturally occurring bias.

The following chart outlines the characteristics of the Forsyth County sample for key demographic variables, compared to actual population characteristics revealed in census data. [Note that the sample consisted solely of area residents age 18 and older; data on children were given by proxy by the person most responsible for that child’s health care needs, and these children are not represented demographically in this chart.]



Sources:
- US Census Bureau, 2016-2020 American Community Survey.
- 2024 PRC Community Health Survey, PRC, Inc.

Notes:
- “Low Income” reflects those living under 200% of the federal poverty level, based on guidelines established by the US Department of Health & Human Services.
- All Hispanic respondents are grouped, regardless of identity with any other race group. Race reflects those who identify with a single race category, without Hispanic origin. “Diverse Races” includes those who identify as Black or African American, American Indian or Alaska Native, Asian, Native Hawaiian/Pacific Islander, or as being of multiple races, without Hispanic origin.

The sample design and the quality control procedures used in the data collection ensure that the sample is representative. Thus, the findings may be generalized to the total population of community members in the defined area with a high degree of confidence.

Online Key Informant Survey

To solicit input from key informants, those individuals who have a broad interest in the health of the community, an Online Key Informant Survey was also implemented as part of this process. A list of recommended participants was provided by Atrium Health Wake Forest Baptist Medical Center; this list included names and contact information for physicians, public health representatives, other health professionals, social service providers, and a variety of other community leaders. Potential participants were chosen because of their ability to identify primary concerns of the populations with whom they work, as well as of the community overall.

Key informants were contacted by email, introducing the purpose of the survey and providing a link to take the survey online; reminder emails were sent as needed to increase participation. In all, 54 community representatives took part in the Online Key Informant Survey, as outlined in the table that follows:

Online Key Informant Survey Participation	
Key Informant Type	Number Participating
Physicians	9
Public Health Representatives	3
Other Health Providers	21
Social Services Providers	6
Other Community Leaders	15

Through this process, input was gathered from individuals whose organizations work with low-income, minority, or other medically underserved populations. Final participation included representatives of the organizations outlined below.

- Action4Equity
- Atrium Health Wake Forest Baptist Medical Center
- Atrium Health Wake Forest Baptist – Center for Advancing Racial Equity
- Atrium Health Wake Forest Baptist – Mobile Health Clinic
- Crisis Control Ministry
- Downtown Health Plaza & Winston East Pediatrics
- Endocrinology
- FaithHealth
- Family Services
- Forsyth Backpack Program
- Forsyth County Health Department
- Forsyth Futures
- Gastroenterology – Pediatric
- Healthy Forsyth
- Hispanic League
- Iglesia Cristiana Sin Fronteras
- Love Out Loud
- Maya Angelou Center for Health Equity
- Ministers' Conference of Winston-Salem & Vicinity
- Novant Forsyth Medical Center
- Salem College
- St. Peter's Church and World Outreach Center
- The Shalom Project
- The Shepherd's Center of Greater Winston-Salem
- The Winston-Salem Foundation
- United Health Centers
- Wake Forest University School of Medicine Division of Public Health Sciences (PHS)

In the online survey, key informants were asked to rate the degree to which various health issues are a problem in their own community. Follow-up questions asked them to describe why they identify problem areas as such and how these might better be addressed. Results of their ratings, as well as their verbatim comments, are included throughout this report as they relate to the various other data presented.

Public Health, Vital Statistics & Other Data

A variety of existing (secondary) data sources was consulted to complement the research quality of this Community Health Needs Assessment. Data for Forsyth County were obtained in collaboration with Metopio and draw from the following sources (specific citations are included with the graphs throughout this report):

- American Community Survey (ACS), U.S. Census Bureau
- Area Health Resources Files, Health Resources & Services Administration
- FBI Crime Data Explorer, Federal Bureau of Investigation
- Food Access Research Atlas, US Department of Agriculture (USDA) - Economic Research Service
- National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention: Atlas Plus, Centers for Disease Control and Prevention (CDC)
- National Provider Identifier Files (NPI), Centers for Medicare & Medicaid Services (CMS)
- National Vital Statistics System-Mortality (NVSS-M), Centers for Disease Control and Prevention (CDC)
- National Vital Statistics System-Natality (NVSS-N), Centers for Disease Control and Prevention (CDC)
- Rural-Urban Continuum Codes, US Department of Agriculture (USDA) - Economic Research Service
- State Cancer Profiles, National Cancer Institute (NCI)

Benchmark Data

North Carolina Data

Statewide risk factor data are provided where available as an additional benchmark against which to compare local survey findings; these data represent the most recent *BRFSS (Behavioral Risk Factor Surveillance System) Prevalence and Trends Data* published online by the Centers for Disease Control and Prevention. For other indicators, these draw from vital statistics, census, and other existing data sources.

National Data

Nationwide risk factor data, which are also provided in comparison charts, are taken from the *2023 PRC National Health Survey*; the methodological approach for the national study is similar to that employed in this assessment, and these data may be generalized to the US population with a high degree of confidence. National-level vital findings (from various existing resources) are also provided for comparison of secondary data indicators.

Healthy People 2030

Healthy People provides 10-year, measurable public health objectives — and tools to help track progress toward achieving them. Healthy People identifies public health priorities to help individuals, organizations, and communities across the United States improve health and well-being. Healthy People 2030, the initiative's fifth iteration, builds on knowledge gained over the first four decades.

HEALTHY PEOPLE 2030

The Healthy People 2030 framework was based on recommendations made by the Secretary's Advisory Committee on National Health Promotion and Disease Prevention Objectives for 2030. After getting feedback from

individuals and organizations and input from subject matter experts, the US Department of Health and Human Services (HHS) approved the framework which helped guide the selection of Healthy People 2030 objectives.

Determining Significance

Differences noted in this report represent those determined to be significant. For survey-derived indicators (which are subject to sampling error), statistical significance is determined based on confidence intervals (at the 95 percent confidence level), using question-specific samples and response rates. For the purpose of this report, "significance" of secondary data indicators (which do not carry sampling error but might be subject to reporting error) is determined by a 15% variation from the comparative measure.

Information Gaps

While this assessment is quite comprehensive, it cannot measure all possible aspects of health in the community, nor can it adequately represent all possible populations of interest. It must be recognized that these information gaps might in some ways limit the ability to assess all of the community's health needs.

For example, certain population groups — such as the homeless, institutionalized persons, or those who only speak a language other than English or Spanish — are not represented in the survey data. Other population groups — for example, pregnant women, LGBTQ+ residents, undocumented residents, and members of certain racial/ethnic or immigrant groups — while included in the overall findings, might not be identifiable or might not be represented in numbers sufficient for independent analyses.

In terms of content, this assessment was designed to provide a comprehensive and broad picture of the health of the overall community. However, there are certainly medical conditions that are not specifically addressed.

Public Comment

Atrium Health Wake Forest Baptist Medical Center made its prior Community Health Needs Assessment (CHNA) report publicly available on its website; through that mechanism, the hospital requested from the public written comments and feedback regarding the CHNA and implementation strategy. At the time of this writing, Atrium Health Wake Forest Baptist Medical Center had not received any written comments. However, through population surveys and key informant feedback for this assessment, input from the broader community was considered and taken into account when identifying and prioritizing the significant health needs of the community. Atrium Health Wake Forest Baptist Medical Center will continue to use its website as a tool to solicit public comments and ensure that these comments are considered in the development of future CHNAs.

IRS Form 990, Schedule H Compliance

For non-profit hospitals, a Community Health Needs Assessment (CHNA) also serves to satisfy certain requirements of tax reporting, pursuant to provisions of the Patient Protection & Affordable Care Act of 2010. To understand which elements of this report relate to those requested as part of hospitals' reporting on IRS Schedule H (Form 990), the following table cross-references related sections.

IRS Form 990, Schedule H (2022)	See Report Page
Part V Section B Line 3a A definition of the community served by the hospital facility	4
Part V Section B Line 3b Demographics of the community	26
Part V Section B Line 3c Existing health care facilities and resources within the community that are available to respond to the health needs of the community	113
Part V Section B Line 3d How data was obtained	4
Part V Section B Line 3e The significant health needs of the community	10
Part V Section B Line 3f Primary and chronic disease needs and other health issues of uninsured persons, low-income persons, and minority groups	Addressed Throughout
Part V Section B Line 3g The process for identifying and prioritizing community health needs and services to meet the community health needs	11
Part V Section B Line 3h The process for consulting with persons representing the community's interests	6
Part V Section B Line 3i The impact of any actions taken to address the significant health needs identified in the hospital facility's prior CHNA(s)	120

Summary of Findings

Significant Health Needs of the Community

The following "Areas of Opportunity" represent the significant health needs of the community, based on the information gathered through this Community Health Needs Assessment. From these data, opportunities for health improvement exist in the area with regard to the following health issues (see also the summary tables presented in the following section).

The Areas of Opportunity were determined after consideration of various criteria, including: standing in comparison with benchmark data (particularly national data); the preponderance of significant findings within topic areas; the magnitude of the issue in terms of the number of persons affected; and the potential health impact of a given issue. These also take into account those issues of greatest concern to the key informants giving input to this process.

Areas of Opportunity Identified Through This Assessment	
Cancer	▪ Leading Cause of Death
Diabetes	▪ Prevalence of Borderline/Pre-Diabetes ▪ Kidney Disease Deaths ▪ Key Informants: *Diabetes* ranked as a top concern.
Disabling Conditions	▪ Alzheimer's Disease Deaths
Heart Disease & Stroke	▪ Leading Cause of Death ▪ High Blood Pressure Prevalence ▪ High Blood Cholesterol Prevalence ▪ Key Informants: *Heart Disease & Stroke* ranked as a top concern.
Housing	▪ Key Informants: *Social Determinants of Health (especially Housing)* ranked as a top concern.
Infant Health & Family Planning	▪ Low-Weight Births ▪ Infant Deaths ▪ Key Informants: *Infant Health & Family Planning* ranked as a top concern.
Injury & Violence	▪ Unintentional Injury Deaths ▪ Homicide Deaths ▪ Violent Crime Rate
Mental Health	▪ Diagnosed Depression ▪ Key Informants: *Mental Health* ranked as a top concern.

— continued on the following page —

Areas of Opportunity (continued)	
Nutrition, Physical Activity & Weight	▪ Leisure-Time Physical Activity ▪ Low Food Access ▪ Overweight & Obesity ▪ Key Informants: *Nutrition, Physical Activity & Weight* ranked as a top concern.
Sexual Health	▪ Chlamydia Incidence ▪ Gonorrhea Incidence
Substance Use	▪ Drug Overdose Deaths

Community Feedback on Prioritization of Health Needs

Prioritization of the health needs identified in this assessment ("Areas of Opportunity" above) was determined based on a prioritization exercise conducted among providers and other community leaders (representing a cross-section of community-based agencies and organizations) as part of the Online Key Informant Survey.

In this process, these key informants were asked to rate the severity of a variety of health issues in the community. Insofar as these health issues were identified through the data above and/or were identified as top concerns among key informants, their ranking of these issues informed the following priorities:

1. Mental Health
2. Diabetes
3. Infant Health & Family Planning
4. Heart Disease & Stroke
5. Nutrition, Physical Activity & Weight
6. Injury & Violence
7. Substance Use
8. Disabling Conditions
9. Cancer
10. Sexual Health

It is also important to note that Social Determinants of Health are a cross-cutting issue that impact all of the above and also ranked highly among key informants' concerns.

Hospital Implementation Strategy

Atrium Health Wake Forest Baptist Medical Center will use the information from this Community Health Needs Assessment to develop an Implementation Strategy to address the significant health needs in the community. While the hospital will likely not implement strategies for all of the health issues listed above, the results of this prioritization exercise will be used to inform the development of the hospital's action plan to guide community health improvement efforts in the coming years.

Note: An evaluation of the hospital's past activities to address the needs identified in prior CHNAs can be found as an appendix to this report.

Summary Tables: Comparisons With Benchmark Data

Reading the Summary Tables

■ In the following tables, Forsyth County results are shown in the larger, teal column.

□ The columns to the right of the Forsyth County column provide comparisons between local data and any available state and national findings, and Healthy People 2030 objectives. Symbols indicate whether Forsyth County compares favorably (B), unfavorably (h), or comparably (☁) to these external data.

Note that blank table cells signify that data are not available or are not reliable for that area and/or for that indicator.

Tip: Indicator labels beginning with a "%" symbol are taken from the PRC Community Health Survey; the remaining indicators are taken from secondary data sources.

Social Determinants of Health	Forsyth County	Forsyth County vs. Benchmarks		
		vs. NC	vs. US	vs. HP2030
Population in Poverty (Percent)	15.1	h 12.8	h 12.6	h 8.0
High School Graduates (Age 25+, Percent)	89.8	90.2	89.6	
Unemployment Rate (Age 16+, Percent)	5.5	h 3.8	h 4.3	
% Unable to Pay Cash for a $400 Emergency Expense	32.5		34.0	
% Worry/Stress Over Rent/Mortgage in Past Year	32.1		B 45.8	
% Unhealthy/Unsafe Housing Conditions	16.1		16.4	
% Went Without Utilities in the Past Year	10.7			
Population With Low Food Access (Percent)	72.5	h 47.1	h 50.2	
% Food Insecure	34.5		B 43.3	

B		h
better	similar	worse

Overall Health	Forsyth County	Forsyth County vs. Benchmarks		
		vs. NC	vs. US	vs. HP2030

	Forsyth County	vs. NC	vs. US	vs. HP2030
% "Fair/Poor" Overall Health	17.0	18.5	15.7	

B better

similar

h worse

	Forsyth County	Forsyth County vs. Benchmarks		
Access to Health Care		**vs. NC**	**vs. US**	**vs. HP2030**
% [Age 18-64] Lack Health Insurance	11.4	12.7	8.1	7.6
% Difficulty Accessing Health Care in Past Year (Composite)	49.4		52.5	
% Cost Prevented Physician Visit in Past Year	19.8	h 11.9	21.6	
% Cost Prevented Getting Prescription in Past Year	19.9		20.2	
% Difficulty Getting Appointment in Past Year	27.6		33.4	
% Inconvenient Hrs Prevented Dr Visit in Past Year	16.2		B 22.9	
% Difficulty Finding Physician in Past Year	13.4		B 22.0	
% Transportation Hindered Dr Visit in Past Year	11.9		B	

			18.3	
% Language/Culture Prevented Care in Past Year	1.7		B 5.0	
% Stretched Prescription to Save Cost in Past Year	20.3		19.4	
% Difficulty Getting Child's Health Care in Past Year	6.8		11.1	
% Have a Specific Source of Ongoing Care	73.0		69.9	h 84.0
% Routine Checkup in Past Year	72.0	h 77.5	B 65.3	
% [Child 0-17] Routine Checkup in Past Year	86.9		B 77.5	
% Two or More ER Visits in Past Year	14.5		15.6	
% Rate Local Health Care "Fair/Poor"	12.7		11.5	

B better | similar | h worse

Cancer	Forsyth County	Forsyth County vs. Benchmarks: vs. NC	vs. US	vs. HP2030
Cancer Deaths per 100,000 (Age-Adjusted)	155.6	154.5	149.4	h 122.7
% Cancer	8.8	12.1	7.4	

	Forsyth County	vs. NC	vs. US	vs. HP2030
% [Women 50-74] Breast Cancer Screening	79.7	79.1	B 64.0	80.5
% [Women 21-65] Cervical Cancer Screening	74.3		75.4	h 84.3
% [Age 50-75] Colorectal Cancer Screening	79.1	73.2	71.5	74.4

B better | similar | h worse

Forsyth County vs. Benchmarks

Diabetes	Forsyth County	vs. NC	vs. US	vs. HP2030
Diabetes Deaths per 100,000 (Age-Adjusted)	23.5	24.4	22.1	
% Diabetes/High Blood Sugar	14.6	12.1	12.8	
% Borderline/Pre-Diabetes	20.2		h 15.0	
Kidney Disease Deaths per 100,000 (Age-Adjusted)	17.1	16.4	h 12.9	

B better | similar | h worse

Disabling Conditions	Forsyth County	Forsyth County vs. Benchmarks vs. NC	vs. US	vs. HP2030
% 3+ Chronic Conditions	39.0		38.0	
% Activity Limitations	30.3		27.5	
% High-Impact Chronic Pain	19.7		19.6	h 6.4
Alzheimer's Disease Deaths per 100,000 (Age-Adjusted)	39.2	37.3	h 30.8	
% Caregiver to a Friend/Family Member	28.3		22.8	
		B better	similar	h worse

Heart Disease & Stroke	Forsyth County	Forsyth County vs. Benchmarks vs. NC	vs. US	vs. HP2030
Heart Disease Deaths per 100,000 (Age-Adjusted)	143.9	156.2	B 168.2	127.4
% Heart Disease	6.8		B	

		7.1	10.3	
Stroke Deaths per 100,000 (Age-Adjusted)	**43.2**	☁ 42.6	☁ 37.6	h 33.4
% Stroke	**2.9**	B 4.9	B 5.4	
% High Blood Pressure	**47.0**	h 34.7	h 40.4	☁ 42.6
% High Cholesterol	**39.8**		h 32.4	
% 1+ Cardiovascular Risk Factor	**87.6**		☁ 87.8	
		B better	☁ similar	h worse

Infant Health & Family Planning	**Forsyth County**	Forsyth County vs. Benchmarks **vs. NC**	**vs. US**	**vs. HP2030**
% (W18-50 With Past Pregnancy) Experienced Complications	**56.1**			
% (W18-50 With Past Pregnancy) 1+ Pregnancy Did Not Result in Live Birth	**44.3**			
Low Birthweight (Percent of Births)	**10.6**	☁ 9.4	h 8.4	
Infant Deaths per 1,000 Births	**8.7**	h 6.6	h 5.7	h 5.0
		B	☁	h

better similar worse

Injury & Violence	Forsyth County	Forsyth County vs. Benchmarks vs. NC	vs. US	vs. HP2030
Unintentional Injury Deaths per 100,000 (Age-Adjusted)	63.4	58.6	h 52.4	h 43.2
Motor Vehicle Crash Deaths per 100,000 (Age-Adjusted)	11.7	B 14.5	11.5	10.1
Homicide Deaths per 100,000 (Age-Adjusted)	8.3	7.3	h 6.4	h 5.5
Violent Crimes per 100,000	911.0	h 405.1	h 380.7	
% Victim of Violent Crime in Past 5 Years	6.6		7.0	
% Victim of Intimate Partner Violence	16.4		20.3	

B better similar h worse

Mental Health	Forsyth County	Forsyth County vs. Benchmarks vs. NC	vs. US	vs. HP2030
% "Fair/Poor" Mental Health	23.9			

	Forsyth County	vs. NC	vs. US	vs. HP2030
			24.4	
% Diagnosed Depression	32.3	h 21.7	30.8	
% Symptoms of Chronic Depression	48.5		46.7	
% Typical Day Is "Extremely/Very" Stressful	18.1		21.1	
Suicide Deaths per 100,000 (Age-Adjusted)	11.5	B 13.4	B 13.8	12.8
% Receiving Mental Health Treatment	23.5		21.9	
% Unable to Get Mental Health Services in Past Year	13.8		13.2	

B better | similar | h worse

Nutrition, Physical Activity & Weight	Forsyth County	Forsyth County vs. Benchmarks		
		vs. NC	vs. US	vs. HP2030
% "Very/Somewhat" Difficult to Buy Fresh Produce	25.8		30.0	
% No Leisure-Time Physical Activity	28.9	h 23.1	30.2	h 21.8
% Meet Physical Activity Guidelines	26.4	21.6	30.3	29.7
% [Child 2-17] Physically Active 1+ Hours per Day	42.9		B 27.4	

	Forsyth County	vs. NC	vs. US	vs. HP2030
% Overweight (BMI 25+)	71.7	69.3	h 63.3	
% Obese (BMI 30+)	41.0	h 34.1	h 33.9	36.0

Nutrition, Physical Activity & Weight (continued)	Forsyth County	Forsyth County vs. Benchmarks		
		vs. NC	vs. US	vs. HP2030
% [Child 5-17] Overweight (85th Percentile)	45.1		31.8	
% [Child 5-17] Obese (95th Percentile)	26.7		19.5	h 15.5

B better | similar | h worse

Oral Health	Forsyth County	Forsyth County vs. Benchmarks		
		vs. NC	vs. US	vs. HP2030
% Have Dental Insurance	73.3		72.7	75.0
% Dental Visit in Past Year	60.9	63.6	56.5	B 45.0
% [Child 2-17] Dental Visit in Past Year	71.2		77.8	B 45.0

B better | similar | h worse

Respiratory Disease	Forsyth County	vs. NC	vs. US	vs. HP2030
		Forsyth County vs. Benchmarks		
Lung Disease Deaths per 100,000 (Age-Adjusted)	45.2	43.9	40.2	
Pneumonia/Influenza Deaths per 100,000 (Age-Adjusted)	15.8	15.7	13.6	
% Asthma	19.4	h 9.2	17.9	
% [Child 0-17] Asthma	17.4		16.7	
% COPD (Lung Disease)	7.4	7.6	B 11.0	

B better | similar | h worse

Sexual Health	Forsyth County	vs. NC	vs. US	vs. HP2030
		Forsyth County vs. Benchmarks		
Chlamydia Incidence per 100,000	745.5	h 603.3	h 495.5	
Gonorrhea Incidence per 100,000	388.6	h 271.2	h 214.0	

B better | similar | h worse

Substance Use	Forsyth County	vs. NC	vs. US	vs. HP2030
		Forsyth County vs. Benchmarks		

	Forsyth County	vs. NC	vs. US	vs. HP2030
Alcohol-Induced Deaths per 100,000 (Age-Adjusted)	**8.6**	9.3	B 10.5	
% Excessive Drinking	**20.6**	17.9	B 34.3	
Drug Overdose Deaths per 100,000 (Age-Adjusted)	**27.4**	23.9	h 22.4	
% Used an Illicit Drug in Past Month	**8.9**		8.4	
% Used a Prescription Opioid in Past Year	**12.7**		15.1	
% Ever Sought Help for Alcohol or Drug Problem	**5.4**		6.8	
% Personally Impacted by Substance Use	**37.1**		B 45.4	
		B better	similar	h worse

Forsyth County vs. Benchmarks

Tobacco Use	**Forsyth County**	**vs. NC**	**vs. US**	**vs. HP2030**
% Smoke Cigarettes	**19.7**	h 14.5	23.9	h 6.1

% Someone Smokes at Home	17.2		17.7	
% Use Vaping Products	16.9	h 7.9	18.5	
		B better	similar	h worse

Data Charts & Key Informant Input

The following sections present data from multiple sources, including the population-based PRC Community Health Survey, public health and other existing data sets (secondary data), as well as qualitative input from the Online Key Informant Survey.

Data indicators from these sources are intermingled and organized by health topic. To better understand the source data for specific indicators, please refer to the footnotes accompanying each chart.

Community Characteristics

Population Characteristics

Land Area, Population Size & Density

Data from the US Census Bureau reveal the following statistics for our community relative to population and density.

Total Population
(Estimated Population, 2018-2022)

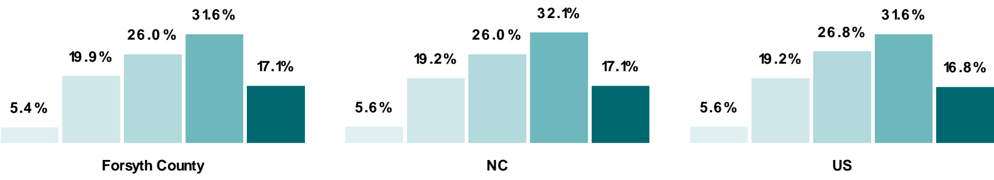
	Total Population	Population Density (per square mile)
Forsyth County	**383,739**	**940.88**
North Carolina	10,470,214	215.33
United States	331,097,593	93.62

Sources: • American Community Survey (ACS), U.S. Census Bureau. Retrieved May 2024 via Metopio.

Age

It is important to understand the age distribution of the population, as different age groups have unique health needs that should be considered separately from others along the age spectrum.

Total Population by Age Groups
(2020)



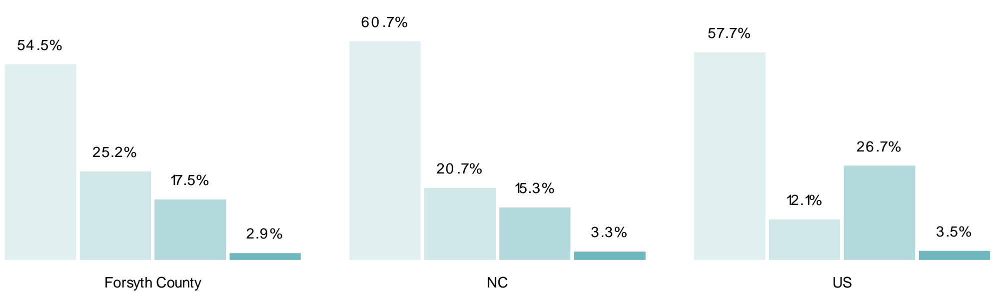
Sources: • American Community Survey (ACS), U.S. Census Bureau. Retrieved May 2024 via Metopio.

Race & Ethnicity

Race reflects those who identify with a single race category, regardless of Hispanic origin. People who identify their origin as Hispanic, Latino, or Spanish may be of any race.

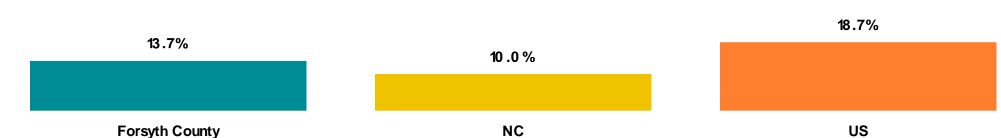
The following charts illustrate the racial and ethnic makeup of our community.

Total Population by Race Alone
(2018-2022)



Sources: • American Community Survey (ACS), U.S. Census Bureau. Retrieved May 2024 via Metopio.
Notes: • "Diverse Races" includes those who identify as American Indian or Alaska Native, Asian, or Native Hawaiian/Pacific Islander, without Hispanic origin.
• State and national percentages for non-Hispanic White are 2022 data.

Hispanic Population
(2018-2022)



Sources: • American Community Survey (ACS), U.S. Census Bureau. Retrieved May 2024 via Metopio.
Notes: • People who identify their origin as Hispanic, Latino, or Spanish may be of any race.

Social Determinants of Health

About Social Determinants of Health

Social determinants of health (SDOH) are the conditions in the environments where people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks.

Social determinants of health (SDOH) have a major impact on people's health, well-being, and quality of life. Examples of SDOH include:

- Safe housing, transportation, and neighborhoods
- Racism, discrimination, and violence
- Education, job opportunities, and income
- Access to nutritious foods and physical activity opportunities
- Polluted air and water
- Language and literacy skills

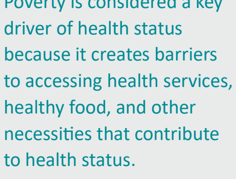
SDOH also contribute to wide health disparities and inequities. For example, people who don't have access to grocery stores with healthy foods are less likely to have good nutrition. That raises their risk of health conditions like heart disease, diabetes, and obesity — and even lowers life expectancy relative to people who do have access to healthy foods.

Just promoting healthy choices won't eliminate these and other health disparities. Instead, public health organizations and their partners in sectors like education, transportation, and housing need to take action to improve the conditions in people's environments.

– Healthy People 2030 (https://health.gov/healthypeople)

Income & Poverty

Poverty

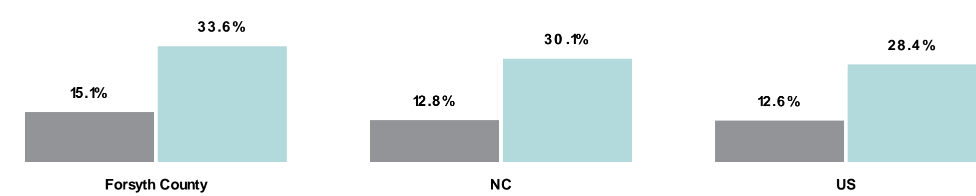


Poverty is considered a key driver of health status because it creates barriers to accessing health services, healthy food, and other necessities that contribute to health status.

The proportions of our population living below, or just above, the federal poverty threshold in comparison to state and national proportions are shown below.

Percent of Population in Poverty
(2018-2022)
Healthy People 2030 = 8.0% or Lower Below Poverty

■ Below Federal Poverty Level ■ Below 200% of FPL



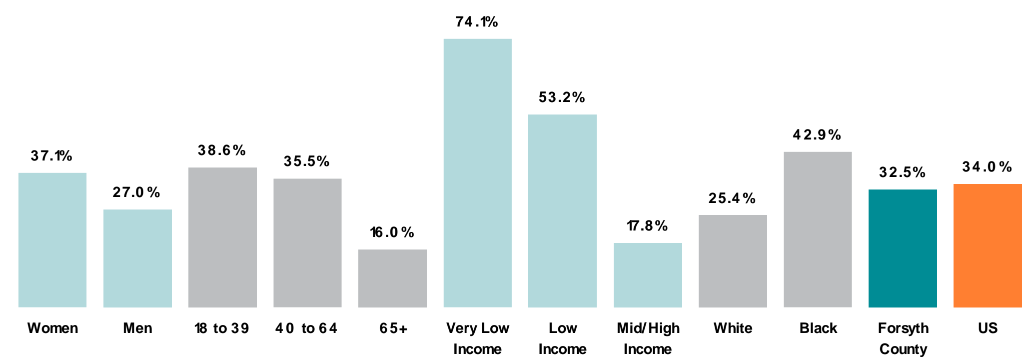
Sources: ● American Community Survey (ACS), U.S. Census Bureau. Retrieved May 2024 via Metopio.
● US Department of Health and Human Services. Healthy People 2030. https://health.gov/healthypeople.
Notes: ● State and national percentages are 2022 data.

Financial Resilience

PRC Survey ▶ "Suppose that you have an emergency expense that costs $400. Based on your current financial situation, would you be able to pay for this expense either with cash, by taking money from your checking or savings account, or by putting it on a credit card that you could pay in full at the next statement?"

The following chart details "no" responses in Forsyth County in comparison to benchmark data, as well as by basic demographic characteristics (such as gender, age groupings, income [based on poverty status], and race/ethnicity).

Do Not Have Cash on Hand to Cover a $400 Emergency Expense
(Forsyth County, 2024)



Sources:
- 2024 PRC Community Health Survey, PRC, Inc. [Item 53]
- 2023 PRC National Health Survey, PRC, Inc.

Notes:
- Asked of all respondents.
- Includes respondents who say they would not be able to pay for a $400 emergency expense either with cash, by taking money from their checking or savings account, or by putting it on a credit card that they could pay in full at the next statement.

Income & Race/Ethnicity

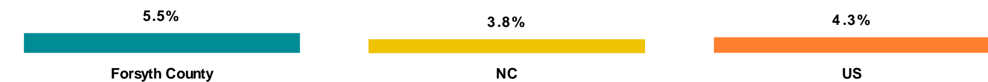
INCOME ▶ Income categories used to segment survey data in this report are based on administrative poverty thresholds determined by the US Department of Health & Human Services. These guidelines define poverty status by household income level and number of persons in the household (e.g., the 2023 guidelines place the poverty threshold for a family of four at $30,000 annual household income or lower). In sample segmentation: "very low income" refers to community members living in a household with defined poverty status; "low income" refers to households with incomes just above the poverty level and earning up to twice (100%-199% of) the poverty threshold; and "mid/high income" refers to those households living on incomes which are twice or more (≥200% of) the federal poverty level.

RACE & ETHNICITY ▶ In analyzing survey results, mutually exclusive race and ethnicity categories are used. Data are detailed for individuals identifying with a race category, without Hispanic origin. "White" reflects those who identify as White alone, without Hispanic origin; "Black" includes those who identify as Black or African American, without Hispanic origin.

Employment

The following outlines the unemployment rate in Forsyth County during 2018-2022 in comparison to state and national unemployment.

Unemployment Rate
(2018-2022)

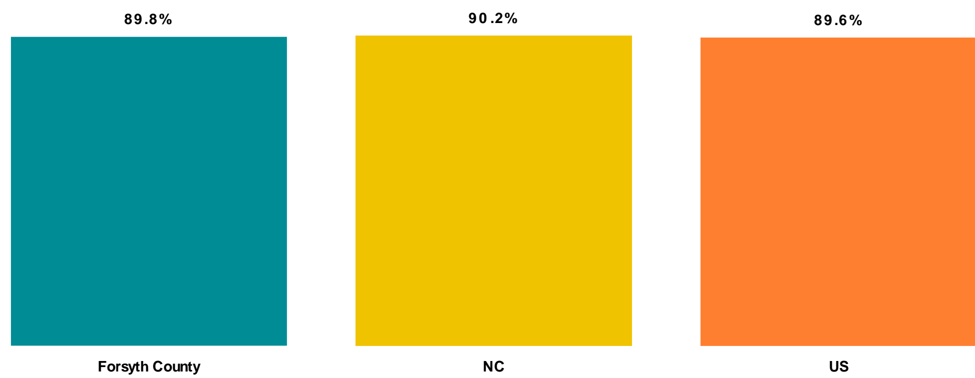


Sources: • American Community Survey (ACS), U.S. Census Bureau. Retrieved May 2024 via Metopio.
Notes: • Percent of residents 16 and older in the civilian labor force who are actively seeking employment.
• State and national percentages are 2022 data.

Education

Education levels are reflected in the proportion of our population with high school diplomas. This indicator is relevant because educational attainment is linked to positive health outcomes.

Percent of High School Graduates
(Adults Age 25 and Older with Diploma, GED or Higher Education; 2018-2022)



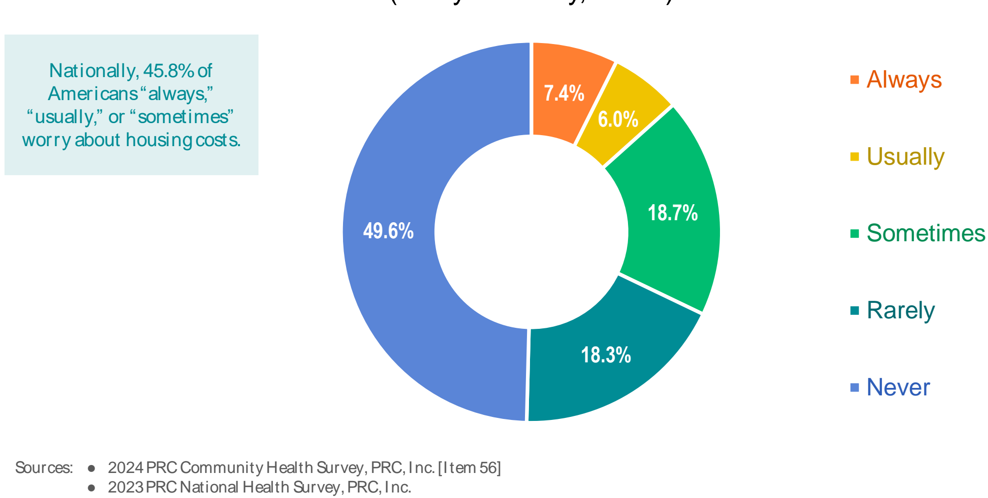
Sources: • American Community Survey (ACS), U.S. Census Bureau. Retrieved May 2024 via Metopio.
Notes: • State and national percentages are 2022 data.

Housing

Housing Insecurity

PRC Survey ▶ "In the past 12 months, how often were you worried or stressed about having enough money to pay your rent or mortgage? Would you say you were worried or stressed: always, usually, sometimes, rarely, or never?"

Frequency of Worry or Stress Over Paying Rent or Mortgage in the Past Year
(Forsyth County, 2024)



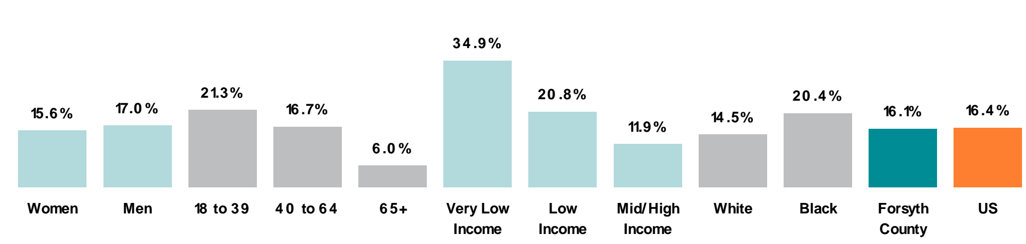
Sources: • 2024 PRC Community Health Survey, PRC, Inc. [Item 56]
• 2023 PRC National Health Survey, PRC, Inc.
Notes: • Asked of all respondents.

Unhealthy or Unsafe Housing

PRC Survey ▶ "Thinking about your current home, over the past 12 months have you experienced ongoing problems with water leaks, rodents, insects, mold, or other housing conditions that might make living there unhealthy or unsafe?"

Unhealthy or Unsafe Housing Conditions in the Past Year
(Forsyth County, 2024)

Among homeowners	9.1%
Among renters	28.3%

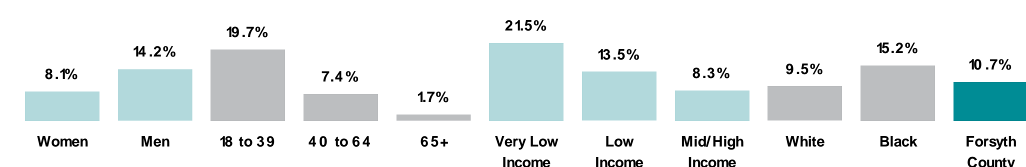


Sources: • 2024 PRC Community Health Survey, PRC, Inc. [Item 55]
• 2023 PRC National Health Survey, PRC, Inc.
Notes: • Asked of all respondents.
• Includes respondents who say they experienced ongoing problems in their current home with water leaks, rodents, insects, mold, or other housing conditions that might make living there unhealthy or unsafe.

Utilities

PRC Survey ▶ "Was there a time in the past 12 months when you did not have electricity, water, or heating in your home?"

Went Without Electricity, Water, or Heating in Home at Some Point in the Past Year
(Forsyth County, 2024)



Sources: ● 2024 PRC Community Health Survey, PRC, Inc. [Item 301]
Notes: ● Asked of all respondents.

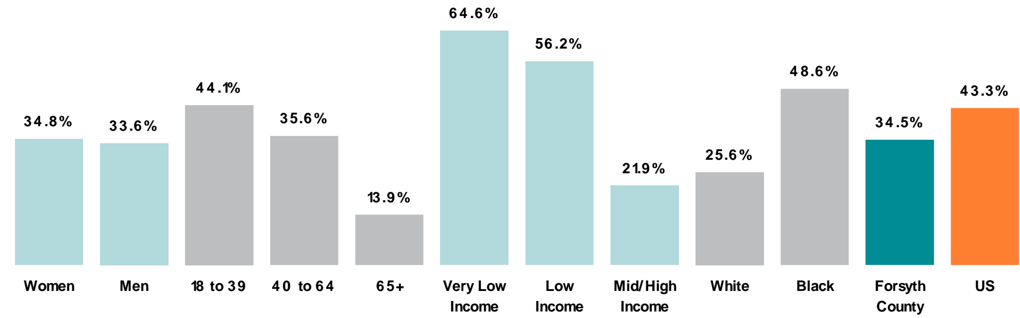
Food Insecurity

PRC Survey ▶ "Now I am going to read two statements that people have made about their food situation. Please tell me whether each statement was 'often true,' 'sometimes true,' or 'never true' for you in the past 12 months.

- 'I worried about whether our food would run out before we got money to buy more.'
- 'The food that we bought just did not last, and we did not have money to get more.'"

Agreement with either or both of these statements ("often true" or "sometimes true") defines food insecurity for respondents.

Food Insecurity
(Forsyth County, 2024)

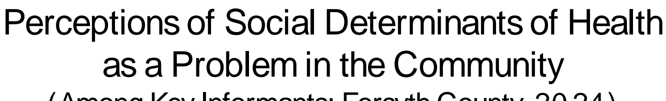


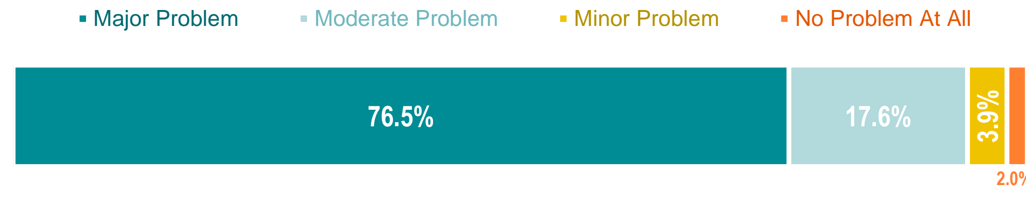
Sources: • 2024 PRC Community Health Survey, PRC, Inc. [Item 98]
• 2023 PRC National Health Survey, PRC, Inc.

Notes: • Asked of all respondents.
• Includes adults who A) ran out of food at least once in the past year and/or B) worried about running out of food in the past year.

Key Informant Input: Social Determinants of Health

Note key informants' perceptions of the severity of *Social Determinants of Health* as a problem in the community:





Sources: • 2024 PRC Online Key Informant Survey, PRC, Inc.

Notes: • Asked of all respondents.

Among those rating this issue as a "major problem," reasons related to the following:

Housing

> We have large sections of Winston-Salem that have poor housing and discrimination by businesses who do not want to locate in areas of low income. Education is a problem because the North Carolina legislature continues to refuse to support our public schools. – Community Leader
>
> Housing costs are increasing, and food insecurity is, as well. – Physician
>
> Our community has a wide variety of programs to service needs; however, affordable housing is not well-attended to, nor is poverty mobility. This community has been upwards of 16,000 units short of affordable housing and has no set plan how to address this crisis. This means that individuals and families are paying as much as 85% of their income for housing. – Social Service Provider
>
> SDOH explains 80% of health outcomes. This area is no different. You can't find an apartment for less than $1,200 a month. Main problem in educational system is how kids who are put in suspension are written off by the teachers who supervise them – those kids have no chance – need to keep them from being labeled to save them and give them opportunities to thrive. Local food pantries have seen a significant rise in new families coming through. Last year, 40% of clients coming to the Clemmons Food Pantry came through one time only – not many people like the shame of picking up supplemental groceries, and yet we see the need spreading. This year, the new clients are predominantly new immigrants from Venezuela. Public school teachers, meat packers, and hospital janitors – people with full-time jobs – have to pick up food from the pantry. There is a large number of people you might call the working poor. – Health Provider

> We are ranked very high nationally for lack of housing, lack of funds or programs for home repairs, crooked landlords, economic inequality, the minimum wage, not paying service or direct care workers a living wage, lack of funding for public schools, low salaries for teachers, teacher shortage, tuitions being too high, environmental racism, etc. – Social Service Provider
>
> Lack of affordable housing. This leads to stress, anxiety, and depression. – Community Leader

Racism

> Social determinants of health are a major problem because structural and systematic racism continues to pervade every aspect of our communities. We can look at the data that clearly highlights the disparities that Black and Brown communities face every day in housing, income, education, employment, etc. Leaders tend to want to address the "people" or "communities" rather than look at the systems/root causes that contribute to the outcomes that we see. Additionally, they are reticent to do the hard work and often generational work that it takes to make true change. – Community Leader
>
> Racial and ethnic disparities in health, housing segregation, a long history of discrimination steeped in segregation. This is a key upstream factor which, if addressed, will pay off across multiple health issues. – Health Provider
>
> Structural racism. – Community Leader
>
> Structural racism in our community that impacts care. – Physician
>
> This is the greatest issue in our community – they stem from racism, segregation, and policies that do not support all people. We have a 15,000-unit housing shortage, people are being evicted from their homes at high rates, and food insecurity is around 20% for Black and Latino families in Winston-Salem. – Health Provider
>
> Our community is deeply segregated, and historic and continued disinvestment in neighborhoods that are majority residents of color on the east side of town has resulted in residents in those neighborhoods having less access to services and facilities like clean and safe parks, full-service grocery stores, doctor's offices, walkable neighborhoods, clean and safe housing, etc., that are critical for thriving. – Community Leader

Impact on Quality of Life

> We serve a large population that has gaps in social drivers of health, which contribute to poorer outcomes. – Physician
>
> Social determinants of health influence health outcomes. – Public Health Representative
>
> They are the underlying things that affects the community's overall health and mental well-being. – Health Provider
>
> SDOH represents fundamental causes for nearly all diseases, violence, etc., as well as a major contributor in being able to get adequate treatment and follow-through with recommendations. While Forsyth County does better than average on a number of social and economic issues (especially affordable housing), there is extreme variation across the local population in how SDOH affects their health. For a sizeable subset of the population, there are multiple economic, political, and social factors (including racism) that are front and center every day. Moreover, Forsyth scores low on economic mobility, so that people are locked into their situations. – Health Provider
>
> These social determinants of health affect EVERY aspect of managing our safety net for the patient population's chronic diseases and quality metric outcomes. Many of our efforts to close health care gaps and improve population health are often thwarted by transportation barriers, unstable housing, or financial instability that forces choices between basic needs and health care. – Physician

Income/Poverty

> Very poor local population. – Physician
>
> Imbalance of income/wealth in our community. Lack of affordable housing. – Health Provider

Vulnerable Populations

> Social determinants can dramatically impact physical and mental health outcomes, especially for vulnerable populations. Providers must account for circumstances like patient income, education, and environment for providers to deliver the holistic care necessary for health and well-being. – Community Leader
>
> Health equity strategic priority for enterprise is to close the gap in life expectancy and increase the well-being of underserved communities by addressing clinical outcome priorities and SDOH priorities, including affordable housing, food security, and employment. – Health Provider

Homelessness

> Increased unhoused population, limited public transportation lines, high food insecurity, and Winston-Salem has one of the largest wealth gaps in the country AND the highest probability of being born into poverty and dying in poverty. – Health Provider

Incidence/Prevalence

> They are the number-one focus of our health systems and come up in every needs assessment and major body of research that I've seen in the community. People want to move upstream and get to the root causes of health challenges. – Health Provider

Awareness/Education

> We, as a community, do not want to address the determinants of health such as education, housing, employment, etc. – Community Leader

Affordable Care/Services

> We need more resources in the community for low-income individuals. – Health Provider

Lack of Coordination Among Agencies

> There is VERY little coordination between agencies and organizations that provide these services. – Social Service Provider

Workforce

> Overworked, in all jobs, people are being asked to do more work for no additional pay, and with fewer resources. Salaried positions are expecting 60 hours of work with no pay increase or retirement match increase. – Health Provider

Co-Occurrences

> These greatly contribute to increased rates of depression, barriers to health, and lower life expectancy. There is a lack of resources, lack of knowledge about these resources, and lack of action being done by communities and health care organizations. – Health Provider

Lack of Community Connections

> We live in very difficult times where the sense of solidarity, love of neighbor has been lost. But this is still an exceptional county. We have hospitals and organizations that work for the common good of its citizens. We must work more united and with honest and fluid conversations. – Community Leader

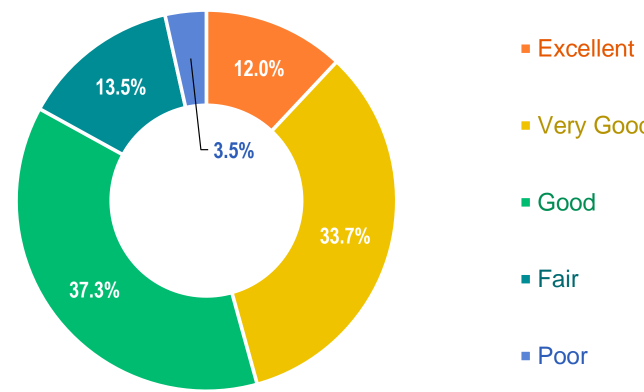
Screening

> Increased screening data demonstrates food insecurity and housing are significant issues. – Health Provider

Health Status

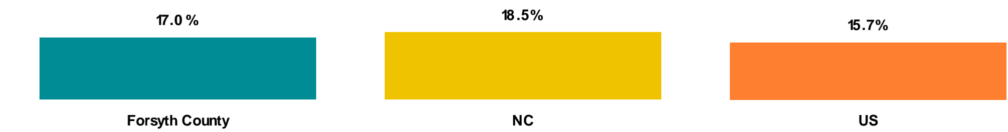
Overall Health

PRC Survey ▶ "Would you say that in general your health is: excellent, very good, good, fair, or poor?"



Sources: • 2024 PRC Community Health Survey, PRC, Inc. [Item 4]
Notes: • Asked of all respondents.

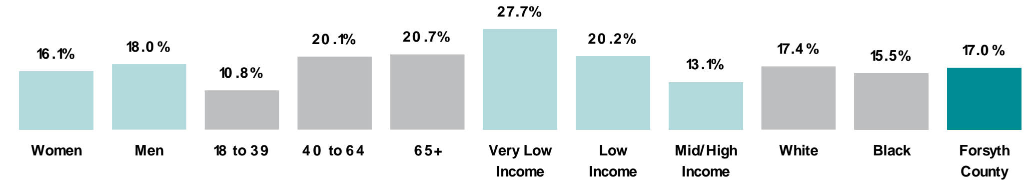
Experience "Fair" or "Poor" Overall Health



Sources:
- 2024 PRC Community Health Survey, PRC, Inc. [Item 4]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2022 North Carolina data.
- 2023 PRC National Health Survey, PRC, Inc.

Notes:
- Asked of all respondents.

Experience “Fair” or “Poor” Overall Health
(Forsyth County, 2024)



Sources: • 2024 PRC Community Health Survey, PRC, Inc. [Item 4]
Notes: • Asked of all respondents.

Mental Health

About Mental Health & Mental Disorders

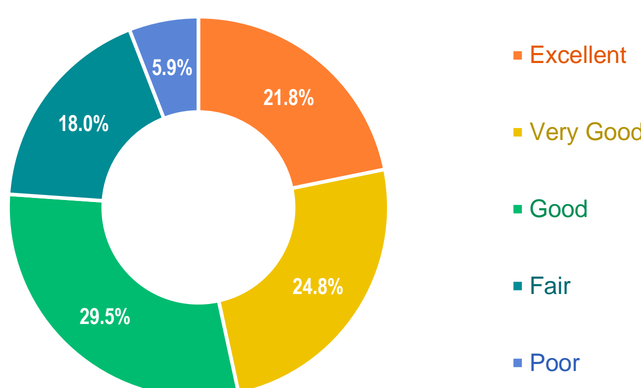
About half of all people in the United States will be diagnosed with a mental disorder at some point in their lifetime. …Mental disorders affect people of all age and racial/ethnic groups, but some populations are disproportionately affected. And estimates suggest that only half of all people with mental disorders get the treatment they need.

In addition, mental health and physical health are closely connected. Mental disorders like depression and anxiety can affect people’s ability to take part in healthy behaviors. Similarly, physical health problems can make it harder for people to get treatment for mental disorders. Increasing screening for mental disorders can help people get the treatment they need.

– Healthy People 2030 (https://health.gov/healthypeople)

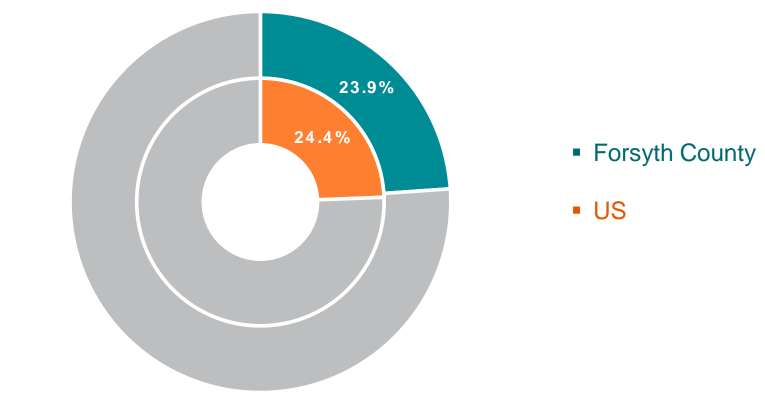
Mental Health Status

PRC Survey ▶ **“Now thinking about your mental health, which includes stress, depression, and problems with emotions, would you say that, in general, your mental health is: excellent, very good, good, fair, or poor?”**



Sources: • 2024 PRC Community Health Survey, PRC, Inc. [Item 77]
Notes: • Asked of all respondents.

Experience "Fair" or "Poor" Mental Health



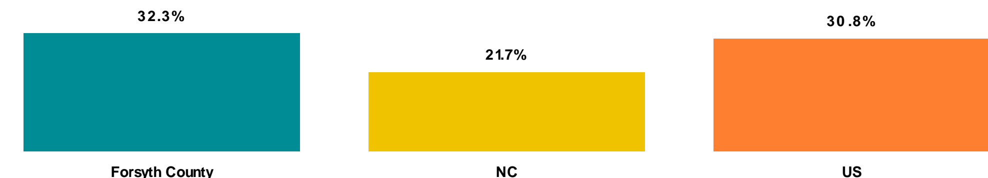
Sources: ● 2024 PRC Community Health Survey, PRC, Inc. [Item 77]
● 2023 PRC National Health Survey, PRC, Inc.
Notes: ● Asked of all respondents.

Depression

Diagnosed Depression

PRC Survey ▶ "Has a doctor, nurse, or other health professional ever told you that you have a depressive disorder, including depression, major depression, dysthymia, or minor depression?"

Have Been Diagnosed With a Depressive Disorder

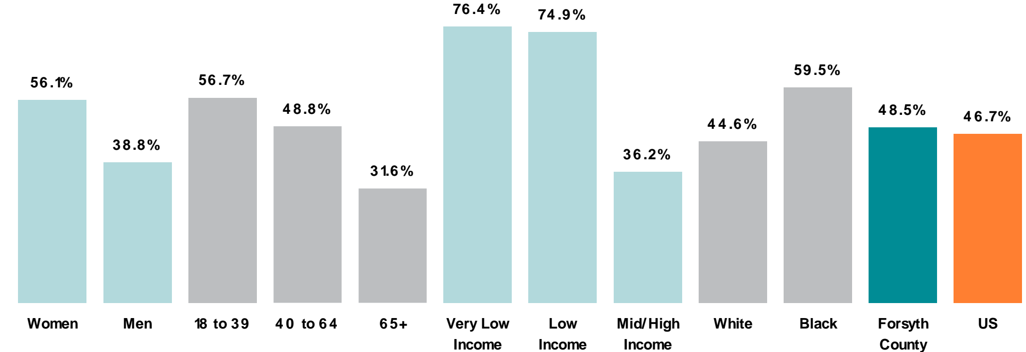


Sources: ● 2024 PRC Community Health Survey, PRC, Inc. [Item 80]
● Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2022 North Carolina data.
● 2023 PRC National Health Survey, PRC, Inc.
Notes: ● Asked of all respondents.
● Depressive disorders include depression, major depression, dysthymia, or minor depression.

Symptoms of Chronic Depression

PRC Survey ► "Have you had two years or more in your life when you felt depressed or sad most days, even if you felt okay sometimes?"

Have Experienced Symptoms of Chronic Depression
(Forsyth County, 2024)



Sources:
- 2024 PRC Community Health Survey, PRC, Inc. [Item 78]
- 2023 PRC National Health Survey, PRC, Inc.

Notes:
- Asked of all respondents.
- Chronic depression includes periods of two or more years during which the respondent felt depressed or sad on most days, even if (s)he felt okay sometimes.

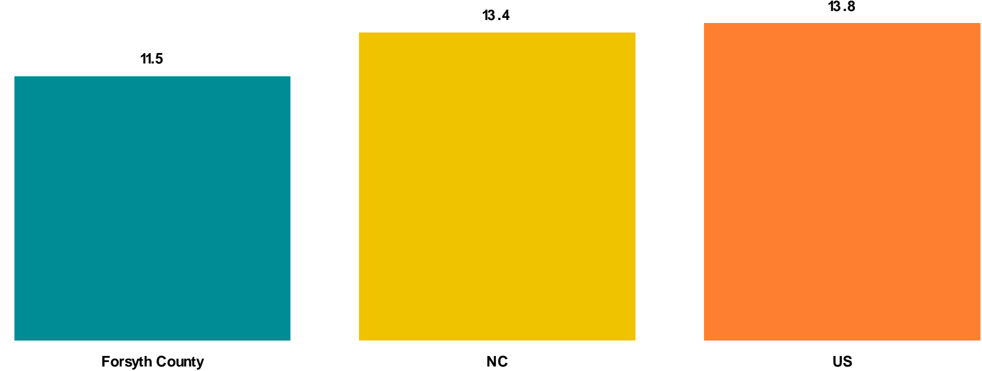
Suicide

Age-adjusted mortality rates attributed to suicide in our population are illustrated below.

Suicide: Age-Adjusted Mortality

(2016-2020 Annual Average Deaths per 100,000 Population)

Healthy People 2030 = 12.8 or Lower



Sources:
- National Vital Statistics System-Mortality (NVSS-M), Centers for Disease Control and Prevention (CDC). Retrieved May 2024 via Metopio.
- US Department of Health and Human Services. Healthy People 2030. https://health.gov/healthypeople

Notes:
- Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
- Rates are per 100,000 population, age-adjusted to the 2000 US Standard Population.

Age-Adjusted Death Rates

In order to compare mortality in the region with other localities (in this case, North Carolina and the United States), it is necessary to look at rates of death — these are figures which represent the number of deaths in relation to the population size (such as deaths per 100,000 population, as is used here).

Furthermore, in order to compare localities without undue bias toward younger or older populations, the common convention is to adjust the data to some common baseline age distribution. Use of these “age-adjusted” rates provides the most valuable means of gauging mortality against benchmark data, as well as Healthy People 2030 objectives.

Note that deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10). Rates are per 100,000 population, age-adjusted to the 2000 US Standard Population.

Mental Health Treatment

PRC Survey ▶ "Are you now taking medication or receiving treatment from a doctor, nurse, or other health professional for any type of mental health condition or emotional problem?"

Currently Receiving Mental Health Treatment

Sources: • 2024 PRC Community Health Survey, PRC, Inc. [Item 81]
• 2023 PRC National Health Survey, PRC, Inc.
Notes: • Asked of all respondents.
• Includes those now taking medication or otherwise receiving treatment for any type of mental health condition or emotional problem.

PRC Survey ▶ "Was there a time in the past 12 months when you needed mental health services but were not able to get them?"

Note that the mental health provider count only reflects providers practicing in Forsyth County; it does not account for the potential availability of providers in surrounding areas.

Note also the number of mental health providers (such as psychiatrists, psychologists, and specialists in addiction medicine, counseling, therapy, and behavioral health. Includes advanced practice nurses and nurse practitioners specific to behavioral health) currently practicing in Forsyth County.

Unable to Get Mental Health Services When Needed in the Past Year
(Forsyth County, 2024)

In 2021, there were 1,482 mental health providers practicing in Forsyth County.

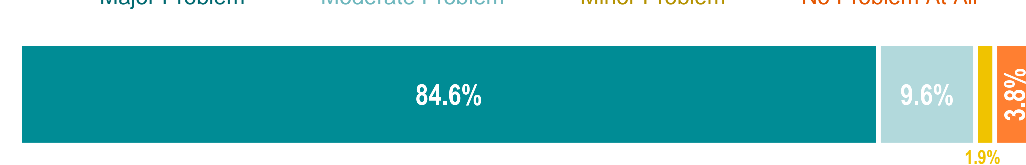
Sources: • 2024 PRC Community Health Survey, PRC, Inc. [Item 82]
• National Provider Identifier Files (NPI), Centers for Medicare & Medicaid Services (CMS). Retrieved May 2024 via Metopio.
Notes: • Asked of all respondents.
• Number of mental health providers, such as psychiatrists, psychologists, and specialists in addiction medicine, counseling, therapy, and behavioral health. Includes advanced practice nurses and nurse practitioners specific to behavioral health.

Key Informant Input: Mental Health

Note key informants' perceptions of the severity of *Mental Health* as a problem in the community:

Perceptions of Mental & Emotional Health as a Problem in the Community
(Among Key Informants; Forsyth County, 2024)

▪ Major Problem ▪ Moderate Problem ▪ Minor Problem ▪ No Problem At All



Sources: • 2024 PRC Online Key Informant Survey, PRC, Inc.
Notes: • Asked of all respondents.

Among those rating this issue as a "major problem," reasons related to the following:

Access to Care/Services

> Not enough services, resources, and outpatient options. – Health Provider
>
> Not enough resources to meet the mental health demands, particularly related to pediatric adolescent patients. – Health Provider
>
> Lack of available services in a timely way. – Physician
>
> Community care centers are all working on providing more resources and improvements in mental health. – Community Leader
>
> Lack of high-quality psychiatric care for patients with severe mental illness, difficulty with care coordination when patients are seen at local community psychiatrists (Daymark, Monarch) as our AHWFB psychiatry team does not see Medicaid patients at their outpatient office; lack of buy-in for substance use treatment in the primary care setting. – Physician
>
> Inadequate services and failure to get support for funding ancillary services. – Community Leader

> Mental health services are few and far between. Health insurance does not cover mental health care the same as physical health care. Those without insurance have reported being unhappy with their options. – Health Provider
>
> There is no place for people to get help. Programs for the homeless are mostly band-aids. People end up at the hospitals but do not have conditions that qualify them for admission, and beds are needed for other patients. – Community Leader
>
> Access to counseling and clinics. – Health Provider
>
> Mind-body connection is huge. We don't have sufficient resources to take care of mental health needs. We see this in our young people, and we don't seem to be able to combat it. We have a lot more anxiety and depression it seems than in previous years. – Community Leader

Lack of Providers

> More people with mental health challenges and not enough mental health providers. Many don't know what they are experiencing is a mental health issue, and for those that do recognize it, wait times and cost can keep people from the care they need. – Health Provider
>
> Difficult access for those insured and uninsured due to a lack of psychiatrists. Need to increase the pipeline. Also, need to make it so that doctors can refer to psychiatrist and it is not only a patient referral. – Physician
>
> Lack of behavioral health providers. – Physician
>
> Crisis in the number of available providers. – Physician

Incidence/Prevalence

> Increasing prevalence and severity of mental health, both of which have been exacerbated by and partially contributed to trauma inflicted from the pandemic. Insufficient inpatient and outpatient support. – Physician
>
> All ages are impacted, increase in younger population, impacts all chronic diseases. – Health Provider
>
> National crisis. – Health Provider
>
> High school and middle school have high rates, but they are masking. College students speak out loudly that they are suffering. No PE in middle school is problematic, and team sports are limited to the very best players in middle school and high school. Making sports school-based and JV and varsity leaves too many kids out. – Health Provider

Affordable Care/Services

> Lack of resources. How do we offer low-cost or free counseling? What about helping the homeless population that may need inpatient psychiatric care? – Health Provider
>
> Finding free or low-cost services. Cultural shame is attached to the need for mental health care. – Social Service Provider

Access to Care for Uninsured/Underinsured

> Hard to access if you don't have private insurance. – Physician
>
> Lack of health insurance, lack of services, stigma, inappropriate response by first responders, housing crisis, cost of medications, cost of services, and lack of resources for wartime veterans. – Social Service Provider

Diagnosis/Treatment

> Individuals are undiagnosed. There is still a lot of stigma around mental health. Limited resources to address mental health needs. – Health Provider
>
> Many people are undiagnosed, or they ignore taking their medications. – Community Leader

Denial/Stigma

> Stigma and accessing affordable care, sometimes a matter of not knowing how to access services, not that they aren't available. There is a lack of residential providers for youth services, and in some areas, a lack of providers. – Public Health Representative

Awareness/Education

> I think of people who lack the education or knowledge to even ask for help. Homeless people in particular who, because of their mental health issues, refuse treatment that would ultimately help them. – Social Service Provider

Due to COVID-19

> The most recent YRBS data around youth mental health is extremely troubling, and the publicly-available data is from before the pandemic. Access to mental health services can be really challenging for everyone because there are not enough providers, and different providers have different insurance policies. Providers that accept a wider range of insurance options often have waitlists to see mental health professionals. The shortage of providers is especially severe for children. There aren't enough resources to meet the need. There are also not enough Black, Latinx, and Spanish-speaking mental health professionals, and many of the existing professionals are not necessarily culturally or linguistically competent. – Community Leader

Isolation/Loneliness

> Social interaction. Making yourself a priority. Reaching out. Some community members with mental health issues have no access to these services because of language barriers, lack of bilingual mental health providers, costs, stigma, identifying moods and feelings. Maintaining good routines. Living up to expectations. The unknown hurdles symptoms bring. Planning and navigating the world. – Community Leader

Lack of Culturally Relevant Services

> One of the biggest challenges is access to services that is culturally relevant. Also, cost is prohibitive to accessing mental health services. – Community Leader

Stress

> Increased stress and anxiety among younger people and financial stressors for adults that impact children. Increased use of deadly substances. Segregation and racism that promotes inequitable access to resources such as housing, food, and others. – Health Provider

Death, Disease & Chronic Conditions

Cardiovascular Disease

About Heart Disease & Stroke

Heart disease is the leading cause of death in the United States, and stroke is the fifth leading cause. …Heart disease and stroke can result in poor quality of life, disability, and death. Though both diseases are common, they can often be prevented by controlling risk factors like high blood pressure and high cholesterol through treatment.

In addition, making sure people who experience a cardiovascular emergency — like stroke, heart attack, or cardiac arrest — get timely recommended treatment can reduce their risk for long-term disability and death. Teaching people to recognize symptoms is key to helping more people get the treatment they need.

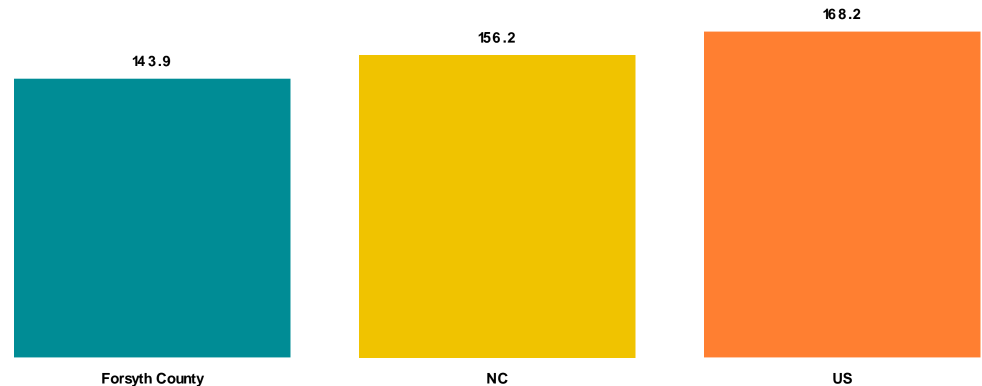
– Healthy People 2030 (https://health.gov/healthypeople)

Age-Adjusted Heart Disease & Stroke Deaths

Age-adjusted mortality rates for heart disease and for stroke are illustrated below.

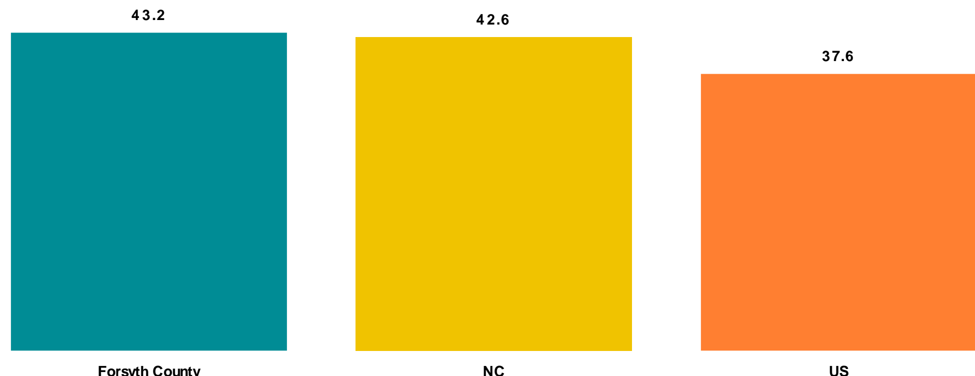
The greatest share of cardiovascular deaths is attributed to heart disease.

Heart Disease: Age-Adjusted Mortality
(2020 Annual Average Deaths per 100,000 Population)
Healthy People 2030 = 127.4 or Lower (Adjusted)



Sources:
- National Vital Statistics System-Mortality (NVSS-M), Centers for Disease Control and Prevention (CDC). Retrieved May 2024 via Metopio.
- US Department of Health and Human Services. Healthy People 2030. https://health.gov/healthypeople

Notes:
- The Healthy People 2030 coronary heart disease target is adjusted here to account for all diseases of the heart.
- Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
- Rates are per 100,000 population, age-adjusted to the 2000 US Standard Population.

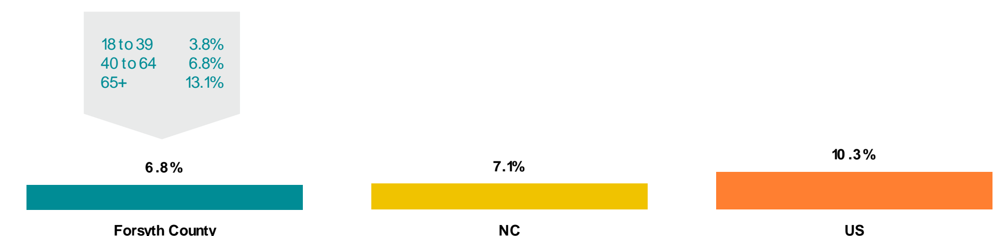


Sources:
- National Vital Statistics System-Mortality (NVSS-M), Centers for Disease Control and Prevention (CDC). Retrieved May 2024 via Metopio.
- US Department of Health and Human Services. Healthy People 2030. https://health.gov/healthypeople

Notes:
- Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
- Rates are per 100,000 population, age-adjusted to the 2000 US Standard Population.

Prevalence of Heart Disease & Stroke

PRC Survey ► "Have you ever suffered from or been diagnosed with heart disease, including heart attack or myocardial infarction, angina, or coronary heart disease?"

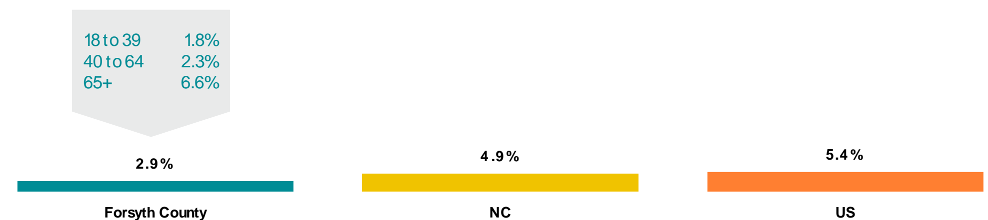


Sources:
- 2024 PRC Community Health Survey, PRC, Inc. [Item 22]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2022 North Carolina data.
- 2023 PRC National Health Survey, PRC, Inc.

Notes:
- Asked of all respondents.
- Includes diagnoses of heart attack, angina, or coronary heart disease.

PRC Survey ▶ "Have you ever suffered from or been diagnosed with a stroke?"

Prevalence of Stroke



Sources:
- 2024 PRC Community Health Survey, PRC, Inc. [Item 23]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2022 North Carolina data.
- 2023 PRC National Health Survey, PRC, Inc.

Notes:
- Asked of all respondents.

Cardiovascular Risk Factors

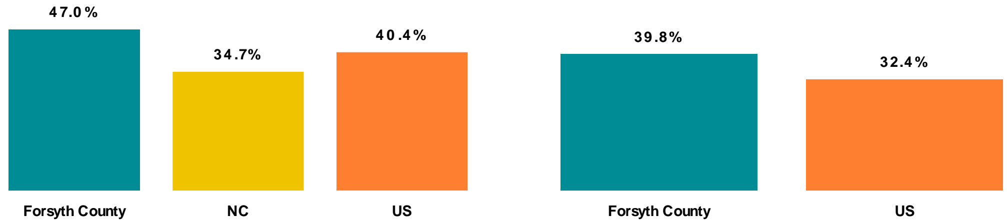
Blood Pressure & Cholesterol

PRC Survey ▶ "Have you ever been told by a doctor, nurse, or other health care professional that you had high blood pressure?"

PRC Survey ▶ "Blood cholesterol is a fatty substance found in the blood. Have you ever been told by a doctor, nurse, or other health care professional that your blood cholesterol is high?"

Prevalence of High Blood Pressure
Healthy People 2030 = 42.6% or Lower

Prevalence of High Blood Cholesterol



Sources:
- 2024 PRC Community Health Survey, PRC, Inc. [Items 29-30]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2022 North Carolina data.
- 2023 PRC National Health Survey, PRC, Inc.
- US Department of Health and Human Services. Healthy People 2030. https://health.gov/healthypeople

Notes:
- Asked of all respondents.

Total Cardiovascular Risk

Total cardiovascular risk reflects the individual-level risk factors which put a person at increased risk for cardiovascular disease, including:

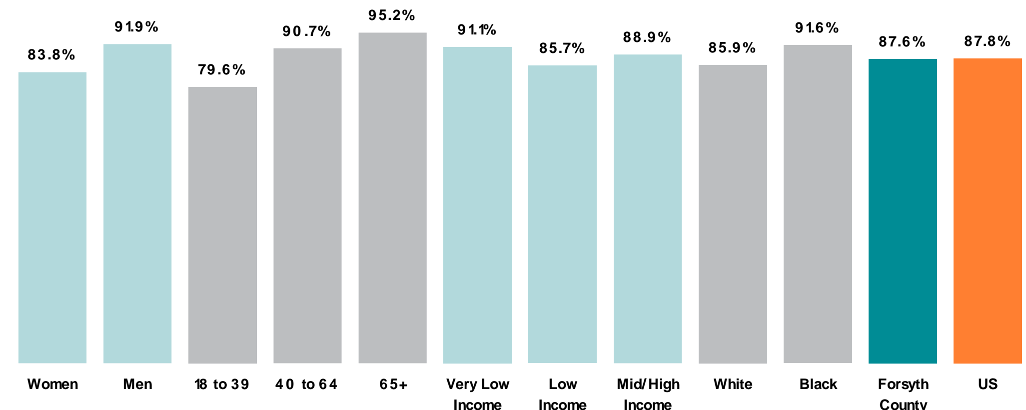
- High Blood Pressure
- High Blood Cholesterol
- Cigarette Smoking
- Physical Inactivity
- Overweight/Obesity

Modifying these behaviors and adhering to treatment for high blood pressure and cholesterol are critical both for preventing and for controlling cardiovascular disease.

RELATED ISSUE
See also *Nutrition, Physical Activity & Weight* and *Tobacco Use* in the **Modifiable Health Risks** section of this report.

The following chart reflects the percentage of adults in Forsyth County who report one or more of the following: being overweight; smoking cigarettes; being physically inactive; or having high blood pressure or cholesterol.

Exhibit One or More Cardiovascular Risks or Behaviors
(Forsyth County, 2024)



Sources:
- 2024 PRC Community Health Survey, PRC, Inc. [Item 100]
- 2023 PRC National Health Survey, PRC, Inc.

Notes:
- Reflects all respondents.
- Cardiovascular risk is defined as exhibiting one or more of the following: 1) no leisure-time physical activity; 2) regular/occasional cigarette smoking; 3) high blood pressure; 4) high blood cholesterol; and/or 5) being overweight/obese.

Key Informant Input: Heart Disease & Stroke

Note key informants' perceptions of the severity of *Heart Disease & Stroke* as a problem in the community:

Perceptions of Heart Disease & Stroke as a Problem in the Community
(Among Key Informants; Forsyth County, 2024)

▪ Major Problem ▪ Moderate Problem ▪ Minor Problem ▪ No Problem At All

Major Problem	Moderate Problem	Minor Problem	No Problem At All
52.0%	42.0%	2.0%	4.0%

Sources: ● 2024 PRC Online Key Informant Survey, PRC, Inc.
Notes: ● Asked of all respondents.

Among those rating this issue as a "major problem," reasons related to the following:

Incidence/Prevalence

> Common cause of morbidity and mortality in Forsyth County with persistent disparities. – Physician
>
> North Carolina remains the buckle of the stroke belt. 40% of Wake Forest Baptist stroke survivors did not know that high blood pressure was a risk factor when we surveyed several years ago. Atrium Wake Forest Baptist's stroke center no long offers chronic care management after stroke as it once did. – Health Provider
>
> Elevated risk compared to other parts of the country. – Physician
>
> Cardiometabolic disease is a strategic clinical outcome priority for Atrium Health. – Health Provider
>
> Statistics show the numbers are high. – Health Provider
>
> Very high rates of stroke and heart disease in our community. – Physician

Lifestyle

> Poor eating habits and lack of exercise. This is exacerbated when an individual is uninsured. – Health Provider
>
> Obesity, lack of exercise, tobacco use, lack of access to healthy foods, social media, drug and alcohol abuse, and lack of access to health care. – Social Service Provider
>
> This is the second-leading cause of death in Forsyth County. Food deserts worsen disparities related to heart disease and stroke for underserved and racialized communities. – Health Provider
>
> Excessive unhealthy foods, neglect of health, not changing toxic habits, lack of information, overworking, and not knowing how to talk about symptoms in time, or not talking about their emotional problems. – Community Leader

Vulnerable Populations

> Because it is the number-one cause of death with Black Americans. – Health Provider
>
> High penetration in the African American population with high risk. Healthy diet and exercise. Smoking and obesity. – Health Provider
>
> I see high levels of effort in the community to address heart disease, particularly with Black and Brown communities who have high risk factors. Red Heart is one of those efforts. – Health Provider

Co-Occurrences

> Due to complications related to high hypertension numbers, obesity, and again, lack of access to healthy, affordable foods. – Health Provider
>
> For a person living with chronic stress, the result can be chest pain, irregular heartbeats, shortness of breath, and an increased risk of heart attack and stroke. – Community Leader

Tobacco Use

> High tobacco use and high fat foods and inactivity. – Physician

Aging Population

> Aging of population, diet, and exercise culture. – Health Provider

Cancer

About Cancer

Cancer is the second leading cause of death in the United States. …The cancer death rate has declined in recent decades, but over 600,000 people still die from cancer each year in the United States. Death rates are higher for some cancers and in some racial/ethnic minority groups. These disparities are often linked to social determinants of health, including education, economic status, and access to health care.

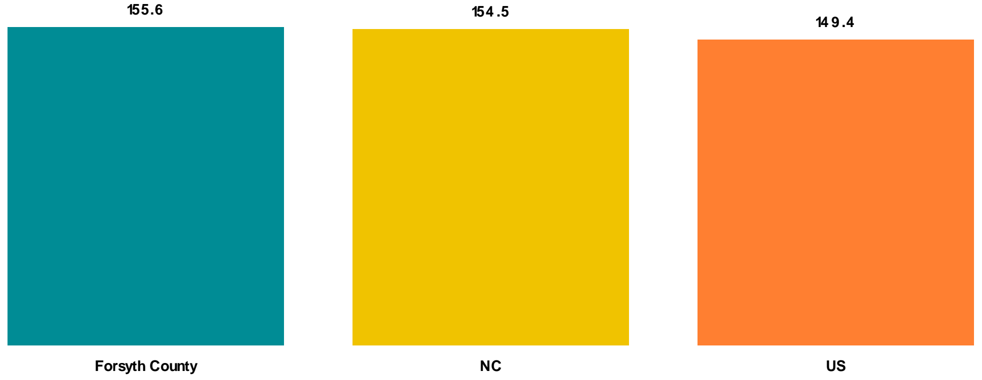
Interventions to promote evidence-based cancer screenings — such as screenings for lung, breast, cervical, and colorectal cancer — can help reduce cancer deaths. Other effective prevention strategies include programs that increase HPV vaccine use, prevent tobacco use and promote quitting, and promote healthy eating and physical activity. In addition, effective targeted therapies and personalized treatment are key to helping people with cancer live longer.

– Healthy People 2030 (https://health.gov/healthypeople)

Age-Adjusted Cancer Deaths

The chart below illustrates age-adjusted cancer mortality (all types) in Forsyth County.

Cancer: Age-Adjusted Mortality
(2016-2020 Annual Average Deaths per 100,000 Population)
Healthy People 2030 = 122.7 or Lower

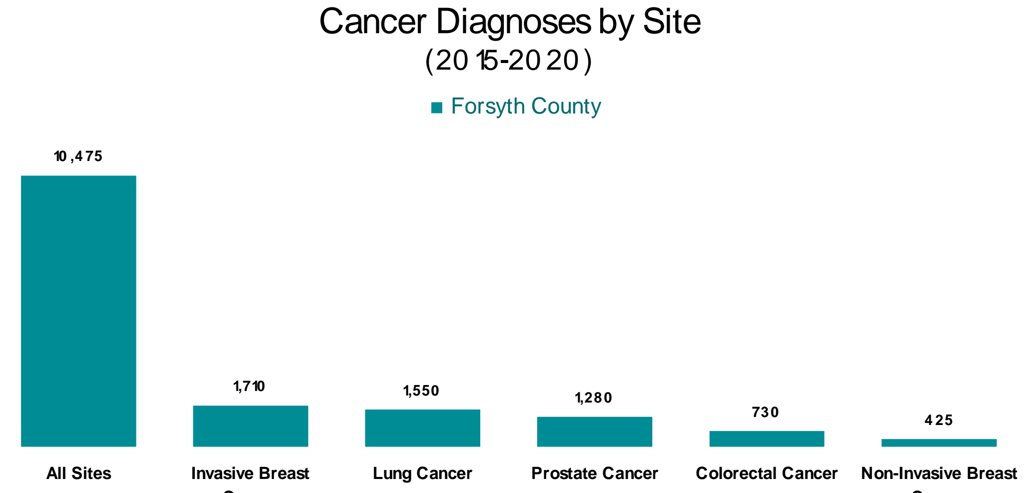


Sources:
- National Vital Statistics System-Mortality (NVSS-M), Centers for Disease Control and Prevention (CDC). Retrieved May 2024 via Metopio.
- US Department of Health and Human Services. Healthy People 2030. https://health.gov/healthypeople

Notes:
- Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
- Rates are per 100,000 population, age-adjusted to the 2000 US Standard Population.

Cancer Diagnoses

The following chart outlines the numbers of cases of cancer diagnosed between 2015 and 2020 in Forsyth County for selected cancer sites.

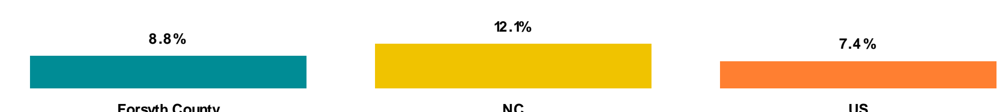


Sources: • State Cancer Profiles, National Cancer Institute (NCI). Retrieved May 2024 via Metopio.
Notes: • This indicator reports the 2015-2020 number of diagnosed cases of cancers by selected sites.

Prevalence of Cancer

PRC Survey ▶ "Have you ever suffered from or been diagnosed with cancer?"

Prevalence of Cancer



Sources: • 2024 PRC Community Health Survey, PRC, Inc. [Item 24]
• Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2022 North Carolina data.
• 2023 PRC National Health Survey, PRC, Inc.
Notes: • Asked of all respondents.

Cancer Screenings

Female Breast Cancer

The US Preventive Services Task Force (USPSTF) recommends biennial screening mammography for women age 50 to 74 years.

Cervical Cancer

The US Preventive Services Task Force (USPSTF) recommends screening for cervical cancer every 3 years with cervical cytology alone in women age 21 to 29 years. For women age 30 to 65 years, the USPSTF recommends screening every 3 years with cervical cytology alone, every 5 years with high-risk human papillomavirus (hrHPV) testing alone, or every 5 years with hrHPV testing in combination with cytology (cotesting). The USPSTF recommends against screening for cervical cancer in women who have had a hysterectomy with removal of the cervix and do not have a history of a high-grade precancerous lesion (i.e., cervical intraepithelial neoplasia [CIN] grade 2 or 3) or cervical cancer.

Colorectal Cancer

The US Preventive Services Task Force (USPSTF) recommends screening for colorectal cancer starting at age 50 years and continuing until age 75 years.

– US Preventive Services Task Force, Agency for Healthcare Research and Quality, US Department of Health & Human Services

Note that other organizations (e.g., American Cancer Society, American Academy of Family Physicians, American College of Physicians, National Cancer Institute) may have slightly different screening guidelines.

Screening levels in the community were measured in the PRC Community Health Survey relative to the following cancer sites:

Breast Cancer Screening

PRC Survey ► "A mammogram is an x-ray of each breast to look for cancer. How long has it been since you had your last mammogram?"

Breast cancer screening is calculated here among women age 50 to 74 who indicate mammography within the past 2 years.

Cervical Cancer Screening

PRC Survey ► "A Pap test is a test for cancer of the cervix. How long has it been since you had your last Pap test?"

[If Pap test in the past five years] "HPV, or the human papillomavirus, is a common infection that can cause several types of cancer. When you received your last Pap test, were you screened for HPV?"

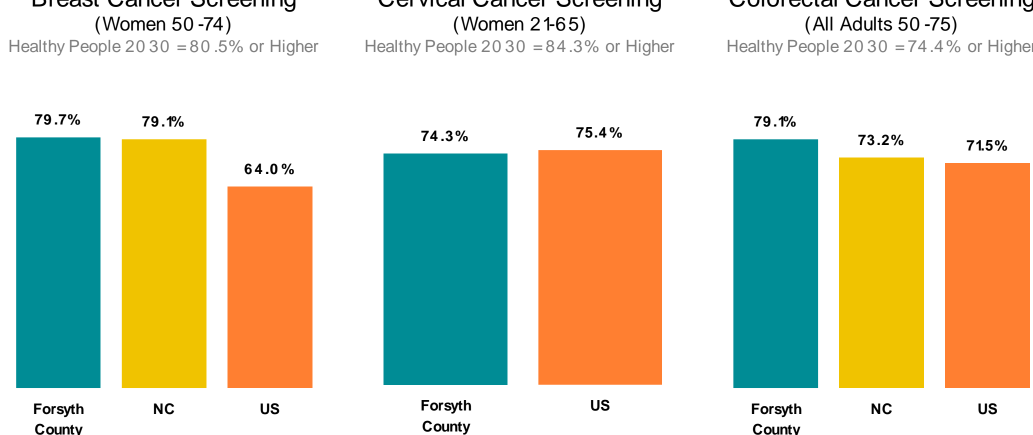
"Appropriate cervical cancer screening" includes Pap smear testing (cervical cytology) every three years in women age 21 to 29 and Pap smear testing and/or HPV testing every 5 years in women age 30 to 65.

Colorectal Cancer Screening

PRC Survey ► "Sigmoidoscopy and colonoscopy are exams in which a tube is inserted in the rectum to view the colon for signs of cancer or other health problems. How long has it been since your last sigmoidoscopy or colonoscopy?"

PRC Survey ▶ “A blood stool test is a test that may use a special kit at home to determine whether the stool contains blood. How long has it been since you had your last blood stool test?”

“Appropriate colorectal cancer screening” includes a fecal occult blood test within the past year and/or lower endoscopy (sigmoidoscopy or colonoscopy) within the past 10 years.



Sources:
- 2024 PRC Community Health Survey, PRC, Inc. [Items 101-103]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2022 North Carolina data.
- 2023 PRC National Health Survey, PRC, Inc.
- US Department of Health and Human Services. Healthy People 2030. https://health.gov/healthypeople

Notes:
- Each indicator is shown among the gender and/or age group specified.

Key Informant Input: Cancer

Note key informants' perceptions of the severity of *Cancer* as a problem in the community:

Perceptions of Cancer as a Problem in the Community
(Among Key Informants; Forsyth County, 2024)

Sources:
- 2024 PRC Online Key Informant Survey, PRC, Inc.

Notes:
- Asked of all respondents.

Among those rating this issue as a "major problem," reasons related to the following:

Incidence/Prevalence

> Many patients are getting diagnosed and need special services. – Community Leader
>
> It is the second-leading cause of death in the United States. More than 550,000 people will die from cancer this year. Cancer is the costliest illness in the United States, and people with cancer often have high out-of-pocket health care costs. – Community Leader
>
> I know a lot of people with cancer. – Community Leader
>
> I know a number of people who are not very old who are battling cancer. – Health Provider
>
> There are disproportionately higher rates of cancer in underserved communities, and cancer is still the leading cause of death in Forsyth County. Black and Latino communities have disproportionate late-stage diagnoses of breast and colon cancer. – Health Provider

Vulnerable Populations

> In the Latino community, there is a lot of fear in receiving the news about a cancer diagnosis. In the community at large, there are not equal resources for people with good health insurance as for others with mediocre insurance or no health insurance. Finally, there is a lack of information or campaigns for early detection or prevention of cancer. – Community Leader
>
> African American women are 50% more likely to die of breast cancer because of lack of access to services, cost of services, and mistrust. We live in a city housing cigarette/tobacco production and have significant cancer rates and stroke rates because of it. Inequities in our economic structure and workplaces prevent time off for routine health screenings, the money to pay for it, and transportation to get there. – Social Service Provider
>
> The numbers are quickly rising in the African American community, as well as being diagnosed at a later date. – Health Provider

Tobacco Use

> High rate of smoking and high penetration in marginalized communities who lack screenings. – Health Provider

Access to Care/Services

> Strategic priority area for a comprehensive cancer center. – Health Provider

Prevention/Screenings

> Do not have equitable screenings for all members of our community and higher cancer causes nationally. – Physician

About Respiratory Disease

Respiratory diseases affect millions of people in the United States. …More than 25 million people in the United States have asthma. Strategies to reduce environmental triggers and make sure people get the right medications can help prevent hospital visits for asthma. In addition, more than 16 million people in the United States have COPD (chronic obstructive pulmonary disease), which is a major cause of death. Strategies to prevent the disease — like reducing air pollution and helping people quit smoking — are key to reducing deaths from COPD.

– Healthy People 2030 (https://health.gov/healthypeople)

Respiratory Disease

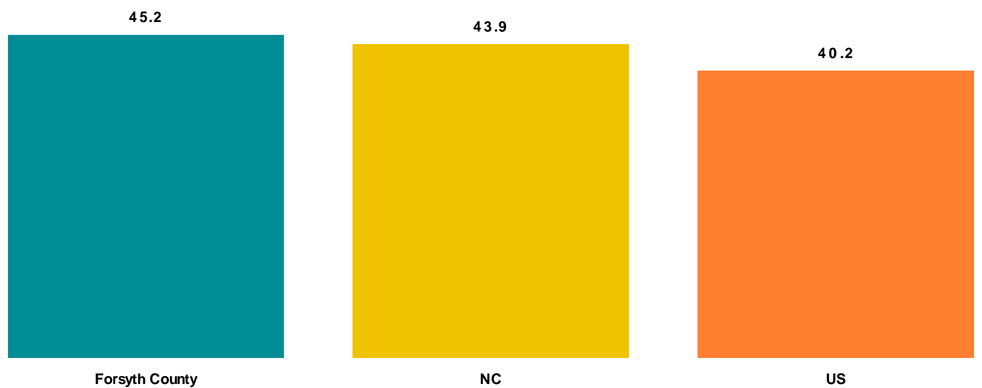
Age-Adjusted Respiratory Disease Deaths

Lung Disease

Chronic lower respiratory diseases (CLRD) are diseases affecting the lungs; the most deadly of these is chronic obstructive pulmonary disease (COPD), which includes emphysema and chronic bronchitis. Mortality for lung disease is illustrated in the charts that follow.

Lung Disease: Age-Adjusted Mortality

(2015-2020 Annual Average Deaths per 100,000 Population)

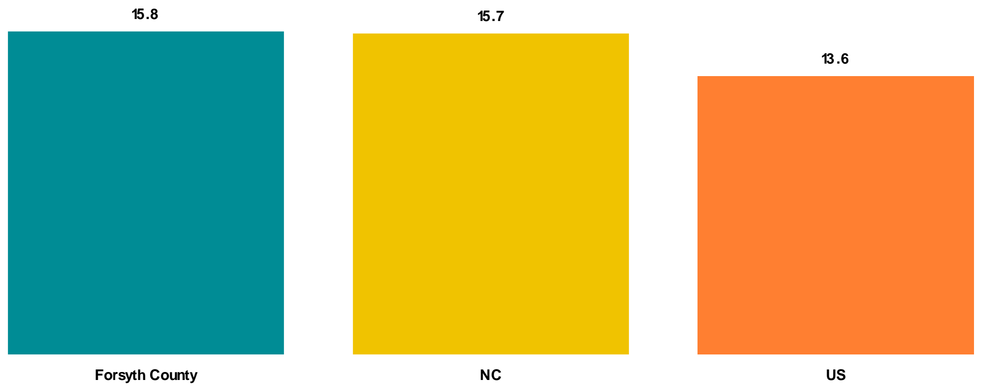


Sources: • National Vital Statistics System-Mortality (NVSS-M), Centers for Disease Control and Prevention (CDC). Retrieved May 2024 via Metopio.

Notes:
- Here, lung disease reflects chronic lower respiratory disease (CLRD) deaths and includes conditions such as emphysema, chronic bronchitis, and asthma.
- Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
- Rates are per 100,000 population, age-adjusted to the 2000 US Standard Population.

Pneumonia/Influenza

Pneumonia and influenza mortality is illustrated here.



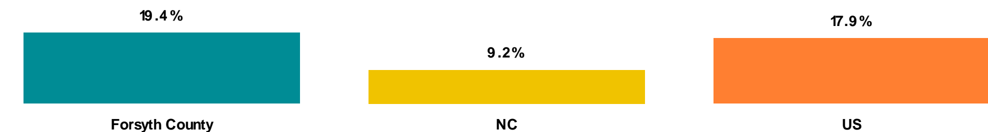
Sources: • National Vital Statistics System-Mortality (NVSS-M), Centers for Disease Control and Prevention (CDC). Retrieved May 2024 via Metopio.
Notes: • Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
• Rates are per 100,000 population, age-adjusted to the 2000 US Standard Population.

Prevalence of Respiratory Disease

Asthma

PRC Survey ▶ "Do you currently have asthma?"

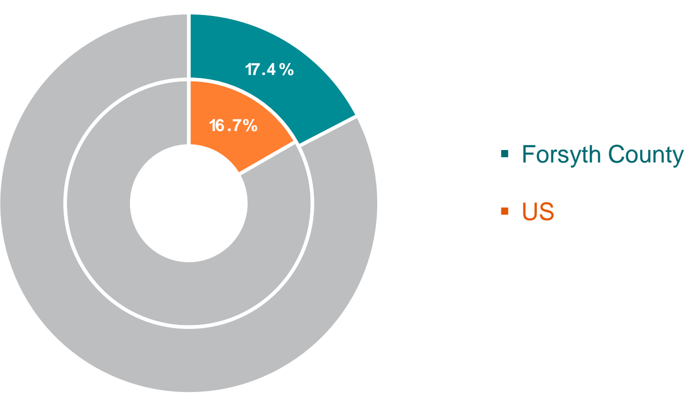
Prevalence of Asthma



Sources: • 2024 PRC Community Health Survey, PRC, Inc. [Item 26]
• Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2022 North Carolina data.
• 2023 PRC National Health Survey, PRC, Inc.
Notes: • Asked of all respondents.

PRC Survey ► **"Has a doctor, nurse, or other health professional ever told you that this child had asthma?"**

Prevalence of Asthma in Children
(Children 0 -17)



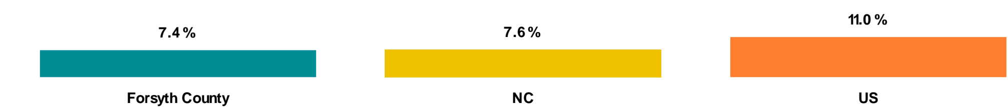
Sources: • 2024 PRC Community Health Survey, PRC, Inc. [Item 92]
• 2023 PRC National Health Survey, PRC, Inc.

Notes: • Asked of all respondents with children 0 to 17 in the household.

Chronic Obstructive Pulmonary Disease (COPD)

PRC Survey ▶ "Would you please tell me if you have ever suffered from or been diagnosed with COPD or chronic obstructive pulmonary disease, including bronchitis or emphysema?"

Prevalence of
Chronic Obstructive Pulmonary Disease (COPD)



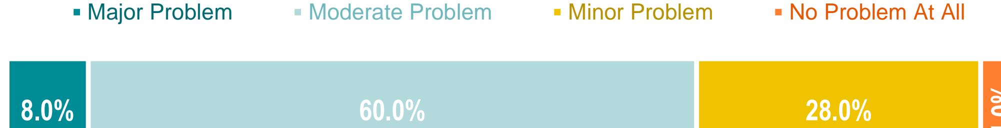
Sources: • 2024 PRC Community Health Survey, PRC, Inc. [Item 21]
• Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2022 North Carolina data.
• 2023 PRC National Health Survey, PRC, Inc.

Notes: • Asked of all respondents.
• Includes conditions such as chronic bronchitis and emphysema.

Key Informant Input: Respiratory Disease

Note key informants' perceptions of the severity of *Respiratory Disease* as a problem in the community:

Perceptions of Respiratory Disease as a Problem in the Community
(Among Key Informants; Forsyth County, 2024)



Sources: • 2024 PRC Online Key Informant Survey, PRC, Inc.

Notes: • Asked of all respondents.

Among those rating this issue as a "major problem," reasons related to the following:

COVID-19

> The impact of COVID is still being discovered as long-lasting effects. – Health Provider

Injury & Violence

About Injury & Violence

INJURY ▶ In the United States, unintentional injuries are the leading cause of death in children, adolescents, and adults younger than 45 years. …Many unintentional injuries are caused by motor vehicle crashes and falls, and many intentional injuries involve gun violence and physical assaults. Interventions to prevent different types of injuries are key to keeping people safe in their homes, workplaces, and communities.

Drug overdoses are now the leading cause of injury deaths in the United States, and most overdoses involve opioids. Interventions to change health care providers' prescribing behaviors, distribute naloxone to reverse overdoses, and provide medications for addiction treatment for people with opioid use disorder can help reduce overdose deaths involving opioids.

VIOLENCE ▶ Almost 20,000 people die from homicide every year in the United States, and many more people are injured by violence. …Many people in the United States experience physical assaults, sexual violence, and gun-related injuries. Adolescents are especially at risk for experiencing violence. Interventions to reduce violence are needed to keep people safe in their homes, schools, workplaces, and communities.

Children who experience violence are at risk for long-term physical, behavioral, and mental health problems. Strategies to protect children from violence can help improve their health and well-being later in life.

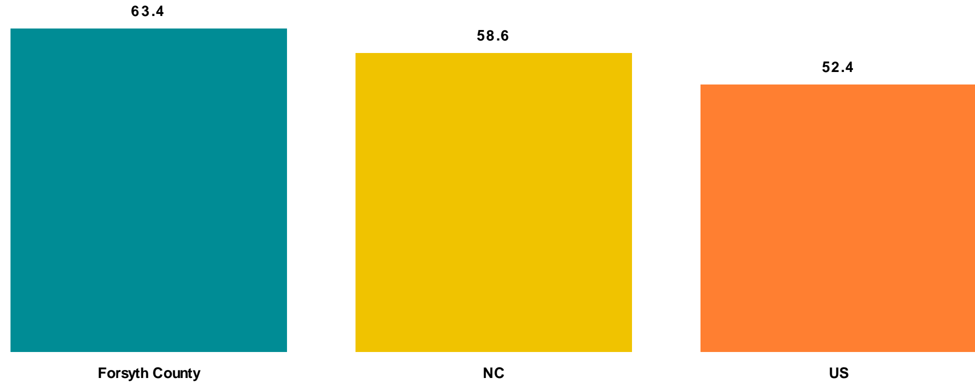
– Healthy People 2030 (https://health.gov/healthypeople)

Unintentional Injury

Age-Adjusted Unintentional Injury Deaths

The following chart outlines age-adjusted mortality rates for unintentional injury in the area.

Unintentional Injuries: Age-Adjusted Mortality
(2016-2020 Annual Average Deaths per 100,000 Population)
Healthy People 2030 = 43.2 or Lower



Sources:
- National Vital Statistics System-Mortality (NVSS-M), Centers for Disease Control and Prevention (CDC). Retrieved May 2024 via Metopio.
- US Department of Health and Human Services. Healthy People 2030. https://health.gov/healthypeople

Notes:
- Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
- Rates are per 100,000 population, age-adjusted to the 2000 US Standard Population.

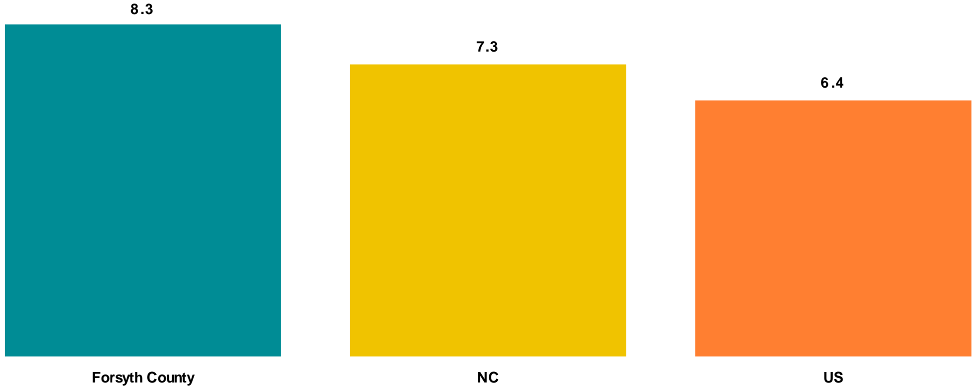
Intentional Injury (Violence)

Age-Adjusted Homicide Deaths

RELATED ISSUE
See also *Mental Health (Suicide)* in the **General Health Status** section of this report.

Age-adjusted mortality attributed to homicide is shown in the following chart.

Homicide: Age-Adjusted Mortality
(2016-2020 Annual Average Deaths per 100,000 Population)
Healthy People 2030 = 5.5 or Lower



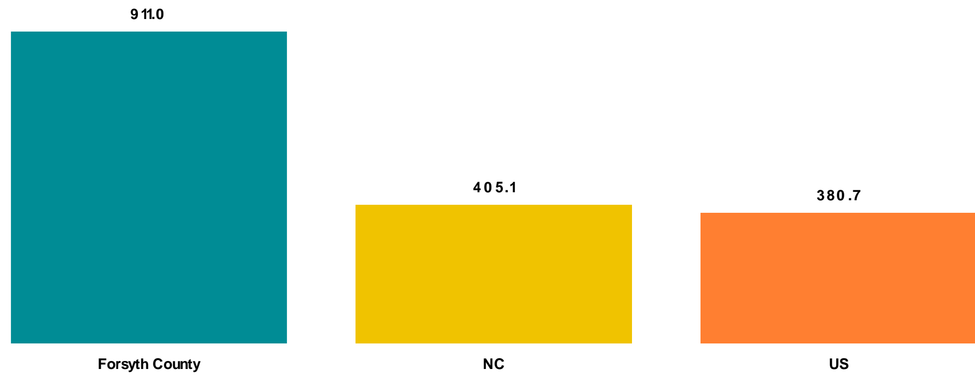
Sources: • National Vital Statistics System-Mortality (NVSS-M), Centers for Disease Control and Prevention (CDC). Retrieved May 2024 via Metopio.
• US Department of Health and Human Services. Healthy People 2030. https://health.gov/healthypeople
Notes: • Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
• Rates are per 100,000 population, age-adjusted to the 2000 US Standard Population.

Violent Crime

Violent crime is composed of homicide, criminal sexual assault, robbery, aggravated assault, and aggravated battery.

Note that the quality of crime data can vary widely from location to location, depending on the consistency and completeness of reporting among various jurisdictions.

Violent Crime Rate
(Reported Offenses per 100,000 Population, 2022)

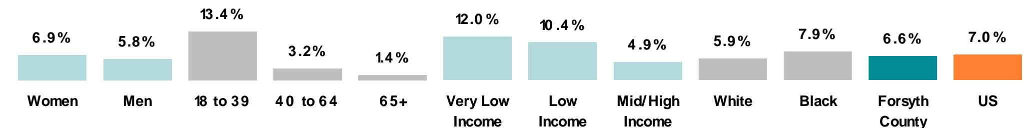


Sources: • FBI Crime Data Explorer, Federal Bureau of Investigation. Retrieved May 2024 via Metopio.
Notes: • Crimes related to violence (yearly rate). Includes homicide, criminal sexual assault, robbery, aggravated assault, and aggravated battery.
• Because agency-level participation in these programs varies, some states have more complete data than others. Data reported by the FBI is checked to make sure it accurately reflects figures reported by police agencies. However, users should proceed with caution, data may still include errors that originated at the agency level.

Violent Crime Experience

PRC Survey ▶ "Thinking about your own personal safety, have you been the victim of a violent crime in your area in the past 5 years?"

Victim of a Violent Crime in the Past Five Years
(Forsyth County, 2024)



Sources: • 2024 PRC Community Health Survey, PRC, Inc. [Item 32]
• 2023 PRC National Health Survey, PRC, Inc.

Notes: • Asked of all respondents.

Intimate Partner Violence

PRC Survey ▶ "The next question is about violence in relationships with an intimate partner. By an intimate partner, I mean any current or former spouse, boyfriend, or girlfriend. Someone you were dating, or romantically or sexually intimate with, would also be considered an intimate partner. This information will help us to better understand the problem of violence in relationships. This is a sensitive topic. Remember, you do not have to answer any question you do not want to. Has an intimate partner ever hit, slapped, pushed, kicked, or hurt you in any way?"

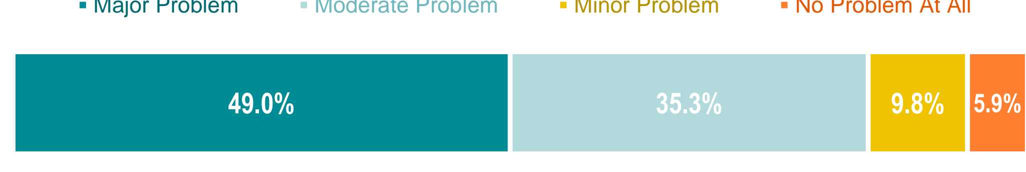
Have Ever Been Hit, Slapped, Pushed, Kicked, or Hurt in Any Way by an Intimate Partner

Sources: • 2024 PRC Community Health Survey, PRC, Inc. [Item 33]
• 2023 PRC National Health Survey, PRC, Inc.
Notes: • Asked of all respondents.

Key Informant Input: Injury & Violence

Note key informants' perceptions of the severity of *Injury & Violence* as a problem in the community:

Perceptions of Injury & Violence as a Problem in the Community
(Among Key Informants; Forsyth County, 2024)



Sources: • 2024 PRC Online Key Informant Survey, PRC, Inc.
Notes: • Asked of all respondents.

Among those rating this issue as a "major problem," reasons related to the following:

Incidence/Prevalence

> Injuries – both unintentional and violence-related – take the lives of 4.4 million people around the world each year and constitute nearly 8% of all deaths. For people aged 5 to 29 years, three of the top five causes of death are injury-related, namely road traffic injuries, homicide, and suicide. Injuries and violence are responsible for an estimated 10% of all years lived with disability. Injuries and violence place a massive burden on national economies, costing countries billions of U.S. dollars each year in health care, lost productivity, and law enforcement. – Community Leader
>
> The legalization of assault weapons, poverty, lack of economic mobility, illegal drugs, lack of mental health services, gangs, cost of living, housing crisis, unsafe streets and neighborhoods, unsafe housing, unsafe roads. – Social Service Provider
>
> Domestic violence and access to guns. Reckless motor vehicle driving. Gangs. – Health Provider
>
> Violence and crime statistics have been rising in our community (although I just heard it had been greatly reduced) and we are witnessing violence in our schools, in our medical centers, etc. Mental health and substance use, as well as other social determinants, are likely connected. – Health Provider
>
> Increasing prevalence of injury and violence, impacting all ages, including children. We as a community are coping with traumas inflicted by the pandemic and need a concerted effort to heal. – Physician

Gun Violence

> Gun violence is at an all-time high as well. – Health Provider
>
> Gun violence, particularly among youth, is a concern commonly voiced by community members. – Community Leader

> Increased incidences of gun violence and gang activity, particularly in low-income areas in Winston-Salem. – Social Service Provider
>
> We seem to have a lot of gun violence. We have violence even in our emergency departments. We need to work on this multifaceted problem to solve in communities that might then have larger health impacts. – Community Leader

Income/Poverty

> Poverty, racism, and bias are pervasive in all our systems. These inequities in all systems fuel violence in our community when communities lack resources to thrive. – Community Leader

Built Environment

> The community has voiced that safety is a major issue. This has been documented through surveys that the health department has produced. This could mean better lighting in areas at night or better mental health services that really lack resources in our community. – Health Provider

Vulnerable Populations

> Many cases of gender violence. Neighborhoods that have become dangerous. – Community Leader

Diabetes

About Diabetes

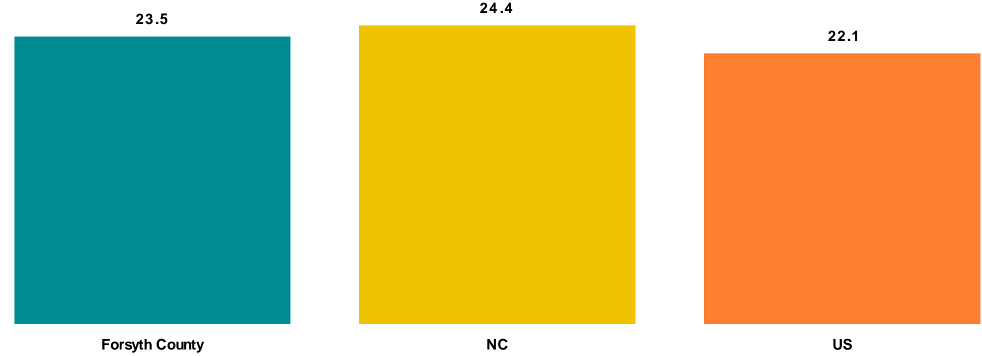
More than 30 million people in the United States have diabetes, and it's the seventh leading cause of death. …Some racial/ethnic minorities are more likely to have diabetes. And many people with diabetes don't know they have it.

Poorly controlled or untreated diabetes can lead to leg or foot amputations, vision loss, and kidney damage. But interventions to help people manage diabetes can help reduce the risk of complications. In addition, strategies to help people who don't have diabetes eat healthier, get physical activity, and lose weight can help prevent new cases.

– Healthy People 2030 (https://health.gov/healthypeople)

Age-Adjusted Diabetes Deaths

Age-adjusted diabetes mortality for the area is shown in the following chart.



Sources: • National Vital Statistics System-Mortality (NVSS-M), Centers for Disease Control and Prevention (CDC). Retrieved May 2024 via Metopio.

Notes: • Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
• Rates are per 100,000 population, age-adjusted to the 2000 US Standard Population.

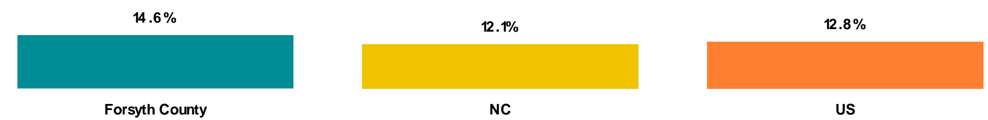
Prevalence of Diabetes

PRC Survey ▶ "Have you ever been told by a doctor, nurse, or other health professional that you have diabetes, not counting diabetes only occurring during pregnancy?"

PRC Survey ▶ "Other than during pregnancy, have you ever been told by a doctor, nurse, or other health professional that you have pre-diabetes or borderline diabetes?"

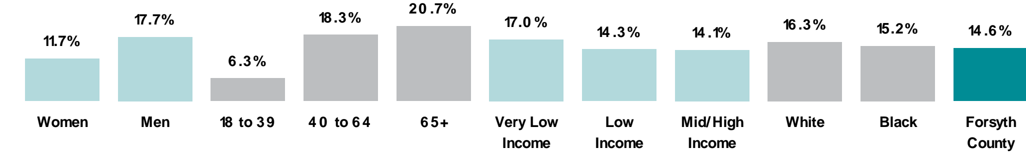
Prevalence of Diabetes

Another 20.2% of adults have been diagnosed with "pre-diabetes" or "borderline" diabetes.



Sources: • 2024 PRC Community Health Survey, PRC, Inc. [Item 106]
• Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2022 North Carolina data.
• 2023 PRC National Health Survey, PRC, Inc.
Notes: • Asked of all respondents.
• Excludes gestational diabetes (occurring only during pregnancy).

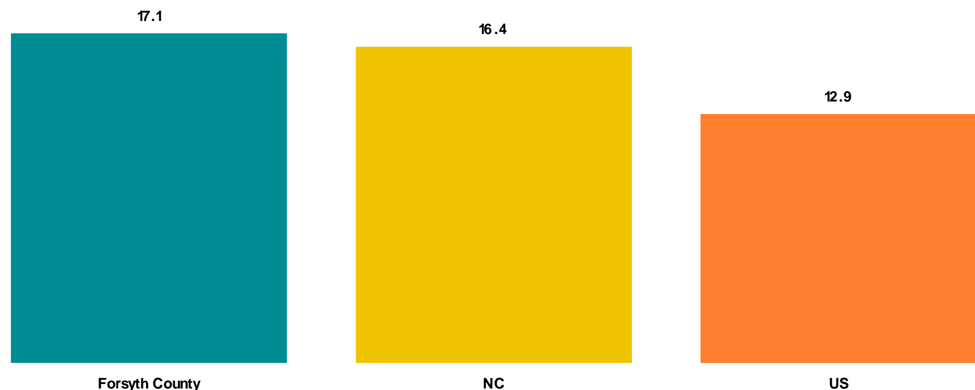
Prevalence of Diabetes
(Forsyth County, 2024)



Sources: • 2024 PRC Community Health Survey, PRC, Inc. [Item 106]
Notes: • Asked of all respondents.
• Excludes gestational diabetes (occurring only during pregnancy).

Age-Adjusted Kidney Disease Deaths

Diabetes is a leading cause of kidney disease. The following chart shows the local age-adjusted kidney disease mortality rate.



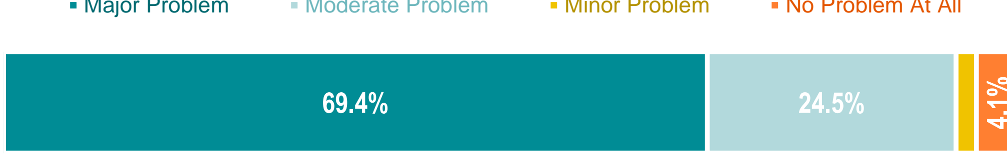
Sources: • National Vital Statistics System-Mortality (NVSS-M), Centers for Disease Control and Prevention (CDC). Retrieved May 2024 via Metopio.

Notes: • Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
• Rates are per 100,000 population, age-adjusted to the 2000 US Standard Population.

Key Informant Input: Diabetes

Note key informants' perceptions of the severity of *Diabetes* as a problem in the community:

Perceptions of Diabetes as a Problem in the Community
(Among Key Informants; Forsyth County, 2024)



Sources: • 2024 PRC Online Key Informant Survey, PRC, Inc.

Notes: • Asked of all respondents.

Among those rating this issue as a "major problem," reasons related to the following:

Access to Affordable Healthy Food

> Access to healthy foods. Difficulty getting care. Difficulty following medical guidance, resulting in other health concerns, often leading to amputations and dialysis. – Social Service Provider
>
> Access to healthy, affordable food. Much of Forsyth County is a food desert. Many patients lack the education to prepare healthy foods, which assists in maintaining their health goals. Also, many of the diets which help with healthy living are outside of the cultural norms of patients. – Health Provider

> Not all neighborhoods have access to fresh foods, and many people do not cook and rely too much on inappropriately fatty fast foods. – Community Leader
>
> Ways to combat it with food and nutrition that is affordable. – Health Provider
>
> Access to healthy food. – Community Leader
>
> Access to healthy foods. Willingness to live a healthy lifestyle. Ability to exercise, either due to health or unsafe spaces. – Community Leader

Affordable Medications/Supplies

> Access to medication and access to specialty care. – Health Provider
>
> Access to medications and testing supplies. Lack of knowledge to nonmedical interventions, which would improve health. For example, diet, exercise, etc. – Community Leader
>
> Access to affordable insulin as the primary, followed by limited to no access to healthy foods in low-income areas, and lack of health education for newly diagnosed diabetics. – Social Service Provider
>
> Access to medications and healthy dietary choices. Also, major educational gaps. – Health Provider
>
> Access to medication and/or wearable devices and cost of insurance to provide them. If there is no insurance, the cost in general. People have to decide between medications or other critical expenses. – Health Provider

Nutrition

> People in the community don't have access to grocery stores. Mostly in the neighborhoods are convenience stores. With limited access to healthier options, people are forced to purchase foods that further cause health issues. – Community Leader
>
> People need to change their eating habits, nutrition education, and more exercise. – Community Leader
>
> Diet and exercise. – Health Provider

Awareness/Education

> Health care literacy, access to medications, access to prevention services. – Health Provider
>
> Individuals seem to not understand the condition very well and how to best manage the condition. For some residents, it is difficult to manage the condition because they don't have access to quality food and/or they don't have the financial means to purchase what is needed. For individuals without insurance, they may opt to not come to the doctor on a regular basis because it is another bill that they can't afford. Then there are the medications they can't afford. – Health Provider

Disease Management

> Ability and willingness to manage it. In many African American/Black families, it is accepted as fate. – Health Provider
>
> Diabetes self-management, access to evidence-based medications and monitoring devices, access to needed specialty care. Diabetes eye exams. – Physician

Affordable Care/Services

> Poor control and affordability of treatments, including drug therapy. – Physician
>
> Access to care for low-income community members is an issue. There are a number of services available, such as health care access, but I believe that many people do not know of them or know how to apply or qualify. – Social Service Provider

Access to Care/Services

> Lack of good treatment and disease management resources. – Physician

Incidence/Prevalence

> Lots of patients suffer from diabetes. – Physician

Obesity

> Obesity, caused by the social determinants of health, such as ZIP code, unsafe neighborhoods, unsafe housing, food deserts, and lack of access to health care. Until recently, the cost of medications, such as insulin, and the need for in-depth chronic disease management and nutrition counseling. – Social Service Provider

Lack of Trust

> Trust, clear and consistent communication, supportive environment with support needed to address health challenges for families. – Physician

Disabling Conditions

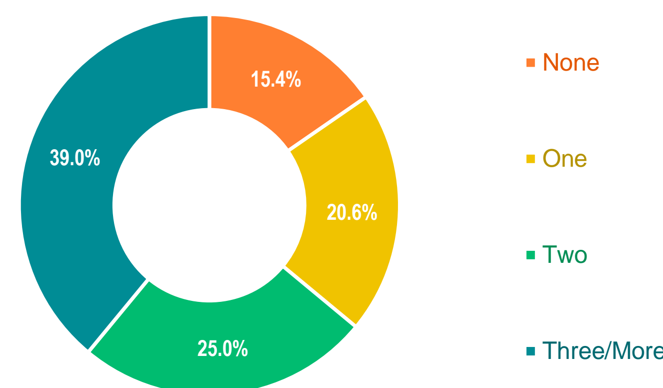
Multiple Chronic Conditions

For the purposes of this assessment, chronic conditions include:

- Asthma
- Cancer
- Chronic pain
- Diabetes
- Diagnosed depression
- Heart disease
- High blood cholesterol
- High blood pressure
- Lung disease
- Obesity
- Stroke

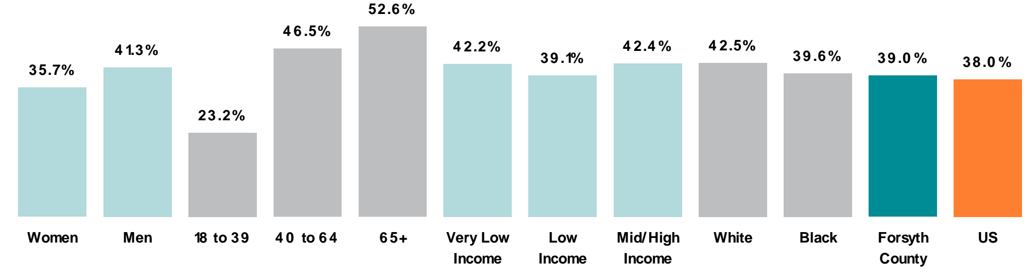
The following charts outline the prevalence of multiple chronic conditions among surveyed adults, taking into account all of the various conditions measured in the survey.

Number of Chronic Conditions
(Forsyth County, 2024)



Sources: • 2024 PRC Community Health Survey, PRC, Inc. [Item 107]
Notes: • Asked of all respondents.
• In this case, chronic conditions include asthma, cancer, chronic pain, diabetes, diagnosed depression, heart disease, high blood cholesterol, high blood pressure, lung disease, obesity, and stroke.

Have Three or More Chronic Conditions
(Forsyth County, 2024)



Sources: • 2024 PRC Community Health Survey, PRC, Inc. [Item 107]
• 2023 PRC National Health Survey, PRC, Inc.
Notes: • Asked of all respondents.
• In this case, chronic conditions include asthma, cancer, chronic pain, diabetes, diagnosed depression, heart disease, high blood cholesterol, high blood pressure, lung disease, obesity, and stroke.

Activity Limitations

About Disability & Health

Studies have found that people with disabilities are less likely to get preventive health care services they need to stay healthy. Strategies to make health care more affordable for people with disabilities are key to improving their health.

In addition, people with disabilities may have trouble finding a job, going to school, or getting around outside their homes. And they may experience daily stress related to these challenges. Efforts to make homes, schools, workplaces, and public places easier to access can help improve quality of life and overall well-being for people with disabilities.

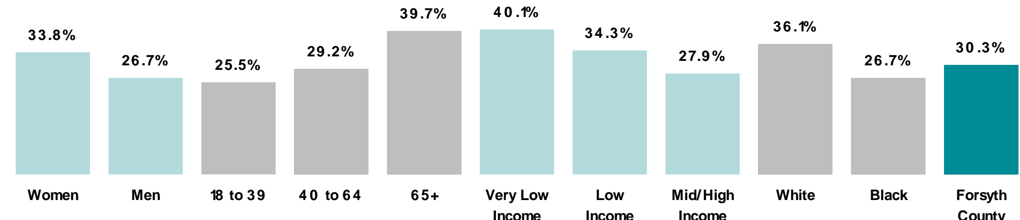
– Healthy People 2030 (https://health.gov/healthypeople)

PRC Survey ▶ "Are you limited in any way in any activities because of physical, mental, or emotional problems?"

PRC Survey ▶ [Adults with activity limitations] "What is the major impairment or health problem that limits you?"

Sources: • 2024 PRC Community Health Survey, PRC, Inc. [Items 83-84]
• 2023 PRC National Health Survey, PRC, Inc.
Notes: • Asked of all respondents.

Limited in Activities in Some Way
Due to a Physical, Mental, or Emotional Problem
(Forsyth County, 2024)

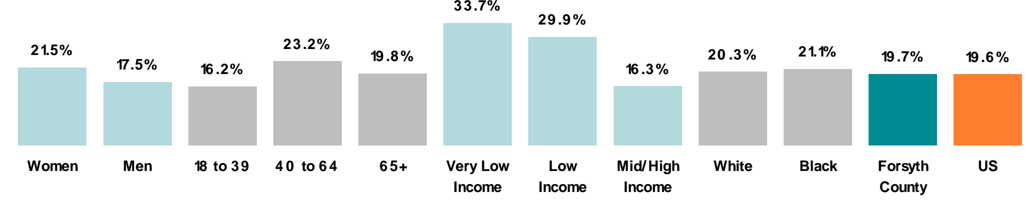


Sources: ● 2024 PRC Community Health Survey, PRC, Inc. [Item 83]
Notes: ● Asked of all respondents.

High-Impact Chronic Pain

PRC Survey ▶ "Over the past six months, how often did physical pain limit your life or work activities? Would you say: never, some days, most days, or every day?" (Reported here among those responding "most days" or "every day.")

Experience High-Impact Chronic Pain
(Forsyth County, 2024)
Healthy People 2030 = 6.4% or Lower



Sources: ● 2024 PRC Community Health Survey, PRC, Inc. [Item 31]
● 2023 PRC National Health Survey, PRC, Inc.
● US Department of Health and Human Services. Healthy People 2030. https://health.gov/healthypeople
Notes: ● Asked of all respondents.
● High-impact chronic pain includes physical pain that limits life or work activities on "most days" or "every day" of the past six months.

Alzheimer’s Disease

About Dementia

Alzheimer’s disease is the most common cause of dementia… . Dementia refers to a group of symptoms that cause problems with memory, thinking, and behavior. People with dementia are more likely to be hospitalized, and dementia is linked to high health care costs.

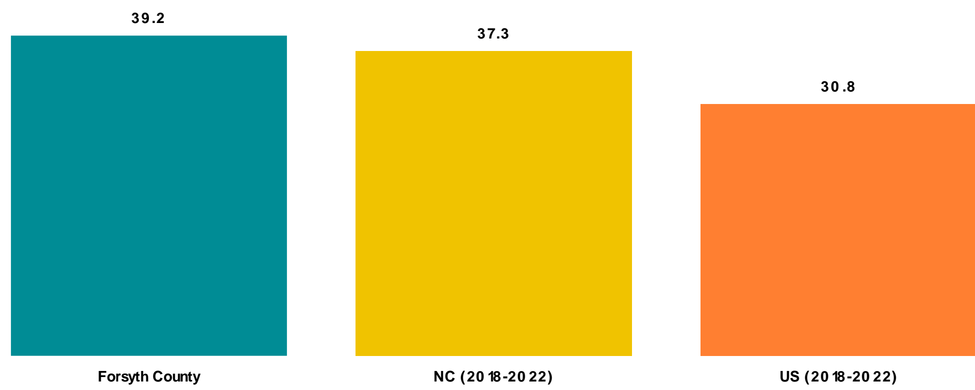
While there’s no cure for Alzheimer’s disease, early diagnosis and supportive care can improve quality of life. And efforts to make sure adults with symptoms of cognitive decline — including memory loss — are diagnosed early can help improve health outcomes in people with dementia. Interventions to address caregiving needs can also help improve health and well-being in people with dementia.

– Healthy People 2030 (https://health.gov/healthypeople)

Age-Adjusted Alzheimer’s Disease Deaths

Age-adjusted Alzheimer’s disease mortality is outlined in the following chart.

Alzheimer's Disease: Age-Adjusted Mortality
(2016-2020 Annual Average Deaths per 100,000 Population)



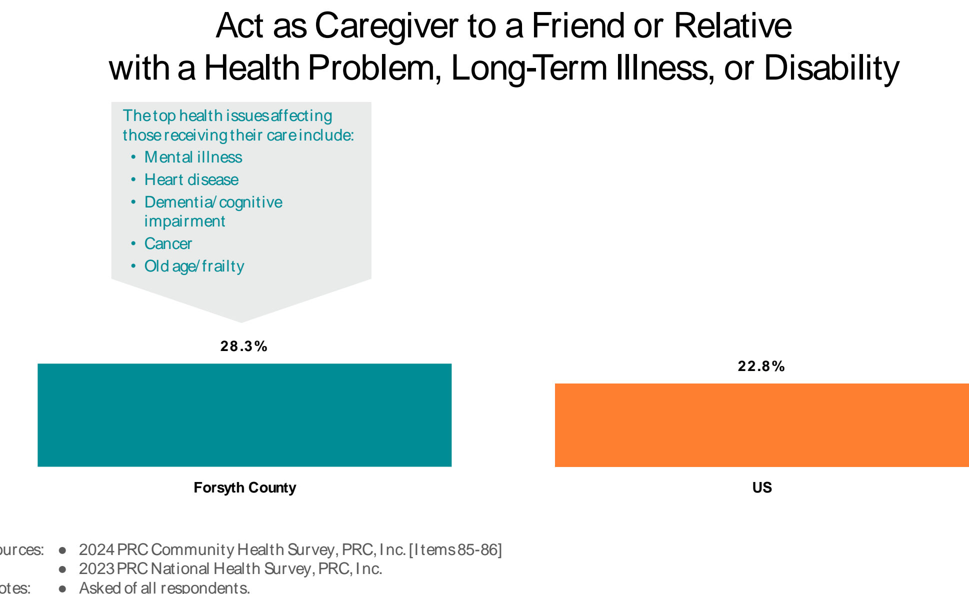
Sources: • National Vital Statistics System-Mortality (NVSS-M), Centers for Disease Control and Prevention (CDC). Retrieved May 2024 via Metopio.

Notes: • Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
• Rates are per 100,000 population, age-adjusted to the 2000 US Standard Population.

Caregiving

PRC Survey ▶ **"People may provide regular care or assistance to a friend or family member who has a health problem, long-term illness, or disability. During the past 30 days, did you provide any such care or assistance to a friend or family member?"**

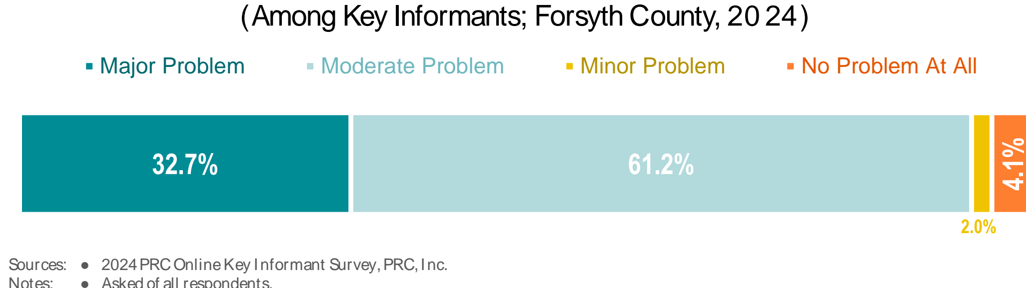
PRC Survey ▶ **[Among those providing care] "What is the main health problem, long-term illness, or disability that the person you care for has?"**



Sources: • 2024 PRC Community Health Survey, PRC, Inc. [Items 85-86]
• 2023 PRC National Health Survey, PRC, Inc.
Notes: • Asked of all respondents.

Key Informant Input: Disabling Conditions

Note key informants' perceptions of the severity of *Disabling Conditions* as a problem in the community:



Sources: • 2024 PRC Online Key Informant Survey, PRC, Inc.
Notes: • Asked of all respondents.

Among those rating this issue as a "major problem," reasons related to the following:

Access to Care/Services

> Disabling conditions often create additional hurdles to overcome when seeking medical care and obtaining medications and supplies. These disabling conditions can further erode medical conditions. – Health Provider
>
> Resources, don't have many. – Health Provider

Incidence/Prevalence

> Loss of vision is a major problem. People use the provided magnifying glass and ask around for glasses or ask for someone to read the ballot to them. THIS IS SO COMMON in East Winston. Low-income families often do not have CVS readers, let alone prescription glasses. The cost of prescription glasses is too high for even middle-income families. It is very difficult to get vision appointments, and many have to travel across counties. Atrium Health is funding an eye center because it was deemed a community need. – Health Provider
>
> There has been an increase in caregivers and patients requesting health services in their homes due to mobility issues. Many of these issues result from chronic pain. – Health Provider

Aging Population

> We have an aging population, and all of these conditions affect them. – Community Leader

Impact on Quality of Life

> It seems that in hearing community members, this is a key issue that keeps them from living active lives, and this can lead to mental health decline, too. – Community Leader

Health care Workforce

> The direct care worker shortage crisis impacts the medical system across the spectrum, from skilled home health agencies not having any CNAs to provide in-home bathing, hygiene care, etc. and the terrible shortage of help in nursing homes causing anything from hospital readmissions, bed sores, and even death by hydration. We must pay our direct-care workers a living wage. The average salary for a direct-care worker in NC is $17,600, barely above poverty level. – Social Service Provider

Awareness/Education

> A lot of people experience chronic pain, and this is not as recognizable as most conditions, and people are not as considerate in terms of employment and care. – Health Provider

Co-Occurrences

> Loss of vision due to not treating diabetes in time. Obesity, high cholesterol, very high blood pressure, and many cases of stroke and hemiplegia. – Community Leader

Births

About Infant Health

Keeping infants healthy starts with making sure women get high-quality care during pregnancy and improving women's health in general. After birth, strategies that focus on increasing breastfeeding rates and promoting vaccinations and developmental screenings are key to improving infants' health. Interventions that encourage safe sleep practices and correct use of car seats can also help keep infants safe.

The infant mortality rate in the United States is higher than in other high-income countries, and there are major disparities by race/ethnicity. Addressing social determinants of health is critical for reducing these disparities.

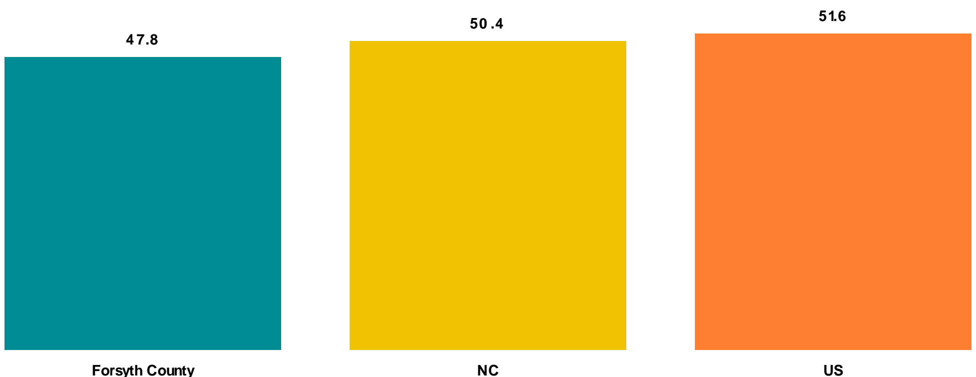
– Healthy People 2030 (https://health.gov/healthypeople)

Birth Rate

Here, birth rate includes births to women age 15 to 50 years old, expressed as a rate per 1,000 female population in this age cohort.

Note the birth rate in Forsyth County, compared to the state and nation.

Birth Rate
(Births per 1,000 Females Age 15-50, 2018-2022)



Sources: • American Community Survey (ACS), U.S. Census Bureau. Retrieved May 2024 via Metopio.

Birth Outcomes & Risks

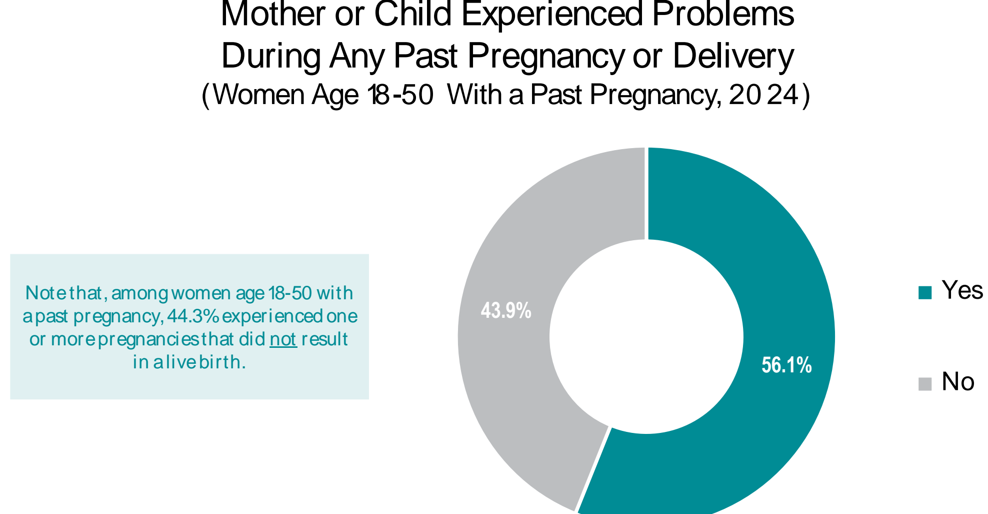
Pregnancy Complications

PRC Survey ► Among women age 18 to 50 with a past pregnancy or pregnancies: **"Did you have any health problems, such as gestational diabetes, high blood pressure, depression, or any other complications during any of your pregnancies?"**

PRC Survey ► Among women age 18 to 50 with a past pregnancy or pregnancies: **"During any of your pregnancies or during the birthing process, did your baby experience any health or medical problems?"**

The following chart outlines the percentage of women encountering complications for themselves or for their babies during any past pregnancy.

PRC Survey ► Among women age 18 to 50 with a past pregnancy or pregnancies: **"In all, how many of your pregnancies resulted in a live birth? Please count the birth of twins or multiples as one birth."**

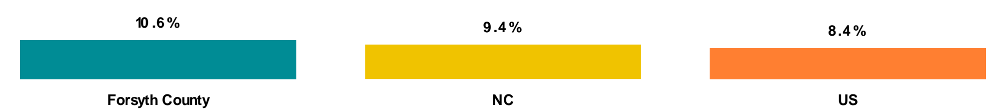


Sources: • 2024 PRC Community Health Survey, PRC, Inc. [Items 306-307]
Notes: • Among women age 18-50 with a past pregnancy.

Low-Weight Births

Low birthweight babies, those who weigh less than 2,500 grams (5 pounds, 8 ounces) at birth, are much more prone to illness and neonatal death than are babies of normal birthweight. Largely a result of receiving poor or inadequate prenatal care, many low-weight births and the consequent health problems are preventable.

Low-Weight Births
(Percent of Live Births, 2018)



Sources: • National Vital Statistics System-Natality (NVSS-N), Centers for Disease Control and Prevention (CDC). Retrieved May 2024 via Metopio.
Note: • This indicator reports the percentage of total births that are low birth weight (Under 2500g).
• State and US percentages represent 2018-2022 data.

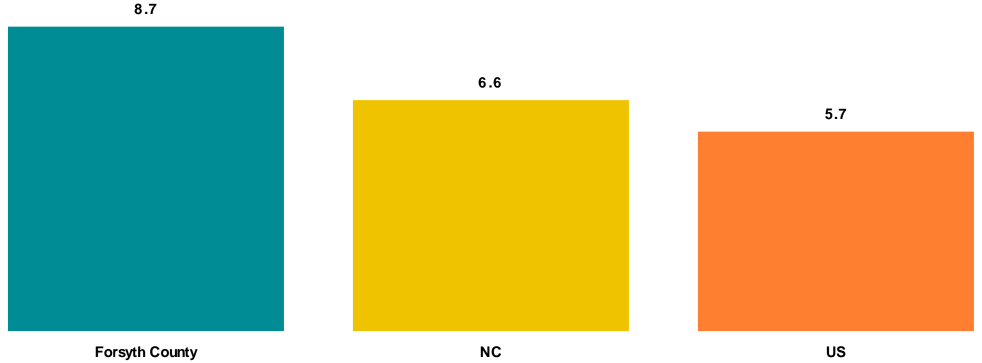
Infant Mortality

Infant mortality rates reflect deaths of children less than one year old per 1,000 live births. High infant mortality can highlight broader issues relating to health care access and maternal/child health.

Infant Mortality Rate

(Annual Average Infant Deaths per 1,000 Live Births, 2021)

Healthy People 2030 = 5.0 or Lower



Sources: • National Vital Statistics System-Natality (NVSS-N), Centers for Disease Control and Prevention (CDC). Retrieved May 2024 via Metopio.
• US Department of Health and Human Services. Healthy People 2030. https://health.gov/healthypeople

Notes: • Infant deaths include deaths of children under 1 year old.

Key Informant Input: Infant Health & Family Planning

Note key informants' perceptions of the severity of *Infant Health & Family Planning* as a problem in the community:

Perceptions of Infant Health & Family Planning as a Problem in the Community

(Among Key Informants; Forsyth County, 2024)

Sources: • 2024 PRC Online Key Informant Survey, PRC, Inc.

Notes: • Asked of all respondents.

Among those rating this issue as a "major problem," reasons related to the following:

Infant Mortality

> High infant mortality and maternal mortality rate in Forsyth County with Grade D. – Physician
>
> The infant mortality rate is high. – Public Health Representative
>
> Reports indicate that we have extremely high rates of infant mortality in our community. – Health Provider
>
> Infant mortality and maternal mortality are higher in the areas than most of the United States and Europe, which matches some developing countries' rates. Health inequity is visible in the data, too, as White, Latina, and Asian are much lower than Black. – Health Provider
>
> We are told from data that this is an issue and has been in our area for over 10 to 20 years. – Community Leader
>
> Forsyth County infant mortality is higher than North Carolina and United States, with persistent disparities. – Physician
>
> Infant mortality rate, lack of social support. – Health Provider
>
> Infant mortality rate is very high, some of the highest disparities in the nation. – Physician

Vulnerable Populations

> We have unacceptably high infant mortality rates, particularly for Black infants. – Community Leader

> The black maternal infant mortality rate is at an all-time high. – Health Provider
>
> We have a higher-than-average infant mortality rate, especially among Black babies. – Physician
>
> Black maternal and child health. – Health Provider
>
> Minority mothers continue to be at high risk of maternal fatality and injury from birth. Their infants are less likely to have their needs met. Family planning is a difficult barrier to cross in our ever-growing Latinx community. – Health Provider
>
> The disparity between African American infant mortality and White infant mortality is very concerning and must be addressed. – Public Health Representative

Access to Care/Services

> Inadequate access to services. Financial limitations, lack of knowledge. – Community Leader
>
> The county is practically overwhelmed with the demand for family planning and infant care. – Community Leader

Transportation

> Transportation and time to get to appointments. – Physician

Government/Policy

> The overturning of Roe v. Wade, companies who limit birth control access in their health insurance policies, men not sharing in the responsibility, lack of prenatal care, early birth caused by cumulative stress across the lifespan of minority women, funding cuts to public programs, teaching abstinence-only in schools. – Social Service Provider

Modifiable Health Risks

Nutrition

About Nutrition & Healthy Eating

Many people in the United States don't eat a healthy diet. …People who eat too many unhealthy foods — like foods high in saturated fat and added sugars — are at increased risk for obesity, heart disease, type 2 diabetes, and other health problems. Strategies and interventions to help people choose healthy foods can help reduce their risk of chronic diseases and improve their overall health.

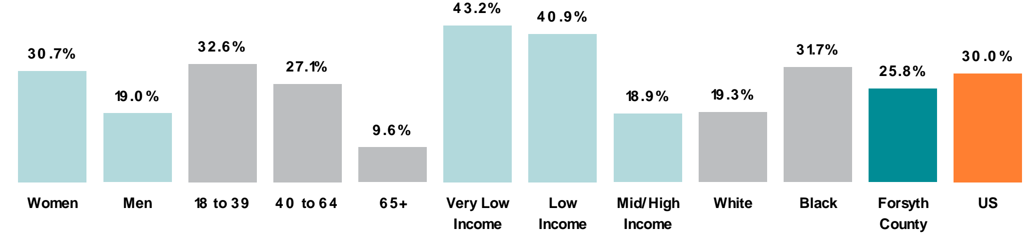
Some people don't have the information they need to choose healthy foods. Other people don't have access to healthy foods or can't afford to buy enough food. Public health interventions that focus on helping everyone get healthy foods are key to reducing food insecurity and hunger and improving health.

– Healthy People 2030 (https://health.gov/healthypeople)

Access to Fresh Produce

PRC Survey ▸ "How difficult is it for you to buy fresh produce like fruits and vegetables at a price you can afford — would you say: very difficult, somewhat difficult, not too difficult, or not at all difficult?"

Find It "Very" or "Somewhat"
Difficult to Buy Affordable Fresh Produce
(Forsyth County, 2024)

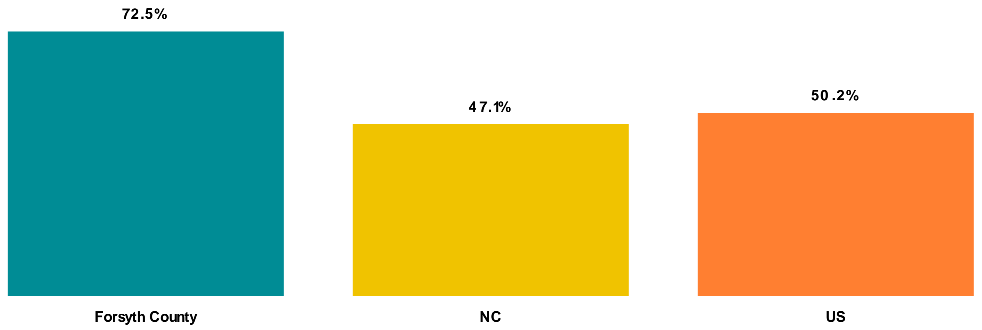


Sources: • 2024 PRC Community Health Survey, PRC, Inc. [Item 66]
• 2023 PRC National Health Survey, PRC, Inc.
Notes: • Asked of all respondents.

Low Food Access

Low food access is defined as living more than one-half mile from the nearest supermarket, supercenter, or large grocery store for those living in urban areas (or >10 miles for those in rural areas). This related chart is based on US Department of Agriculture data.

Population With Low Food Access
(2019)



Sources: ● Food Access Research Atlas, US Department of Agriculture (USDA) - Economic Research Service. Retrieved May 2024 via Metopio.
Notes: ● Low food access is defined as living more than 1/2 mile from the nearest supermarket, supercenter, or large grocery store for urban census tracts, and 10 miles for rural ones.

Physical Activity

About Physical Activity

Physical activity can help prevent disease, disability, injury, and premature death. The Physical Activity Guidelines for Americans lays out how much physical activity children, adolescents, and adults need to get health benefits. Although most people don't get the recommended amount of physical activity, it can be especially hard for older adults and people with chronic diseases or disabilities.

Strategies that make it safer and easier to get active — like providing access to community facilities and programs — can help people get more physical activity. Strategies to promote physical activity at home, at school, and at childcare centers can also increase activity in children and adolescents.

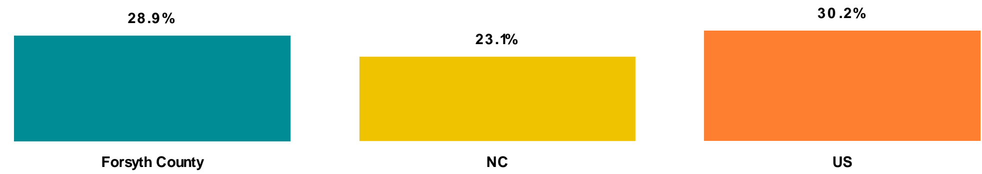
– Healthy People 2030 (https://health.gov/healthypeople)

Leisure-Time Physical Activity

PRC Survey ► "During the past month, did you participate in any physical activities or exercises, such as running, calisthenics, golf, gardening, or walking for exercise?"

No Leisure-Time Physical Activity in the Past Month

Healthy People 2030 = 21.8% or Lower



Sources:
- 2024 PRC Community Health Survey, PRC, Inc. [Item 69]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2022 North Carolina data.
- 2023 PRC National Health Survey, PRC, Inc.
- US Department of Health and Human Services. Healthy People 2030. https://health.gov/healthypeople

Notes:
- Asked of all respondents.

Meeting Physical Activity Recommendations

Adults: Recommended Levels of Physical Activity

"Meeting physical activity recommendations" includes adequate levels of both aerobic and strengthening activity:

- **Aerobic activity** is at least 150 minutes per week of light-to-moderate activity, 75 minutes per week of vigorous physical activity, or an equivalent combination of both;
- **Strengthening activity** is at least 2 sessions per week of exercise designed to strengthen muscles.

– 2013 Physical Activity Guidelines for Americans, US Department of Health and Human Services. www.cdc.gov/physicalactivity

To measure physical activity frequency, duration and intensity, respondents were asked:

PRC Survey ► **"During the past month, what type of physical activity or exercise did you spend the most time doing?"**

PRC Survey ► **"And during the past month, how many times per week or per month did you take part in this activity?"**

PRC Survey ► **"And when you took part in this activity, for how many minutes or hours did you usually keep at it?"**

Respondents could answer the above series for up to two types of physical activity. The specific activities identified (e.g., jogging, basketball, treadmill, etc.) determined the intensity values assigned to that respondent when calculating total aerobic physical activity hours/minutes.

Respondents were also asked about strengthening exercises:

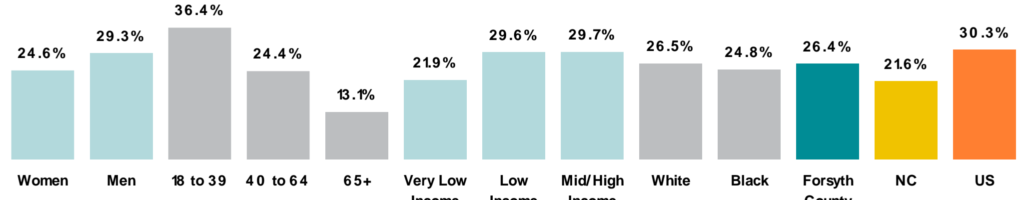
PRC Survey ► **"During the past month, how many times per week or per month did you do physical activities or exercises to strengthen your muscles? Do not count aerobic activities like walking, running, or bicycling. Please include activities using your own body weight, such as yoga, sit-ups, or push-ups, and those using weight machines, free weights, or elastic bands."**

Percentages below represent the proportion of adults meeting physical activity recommendations based on the above guidelines.

Meets Physical Activity Recommendations

(Forsyth County, 2024)

Healthy People 2030 = 29.7% or Higher



Sources:
- 2024 PRC Community Health Survey, PRC, Inc. [Item 110]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2022 North Carolina data.
- 2023 PRC National Health Survey, PRC, Inc.
- US Department of Health and Human Services. Healthy People 2030. https://health.gov/healthypeople

Notes:
- Asked of all respondents.

Children's Physical Activity

Children: Recommended Levels of Physical Activity

Children and adolescents should do 60 minutes (1 hour) or more of physical activity each day.

– 2013 Physical Activity Guidelines for Americans, US Department of Health and Human Services. www.cdc.gov/physicalactivity

PRC Survey ▶ "During the past 7 days, on how many days was this child physically active for a total of at least 60 minutes per day?"

Child Is Physically Active for One or More Hours per Day
(Children 2-17)

Sources:
- 2024 PRC Community Health Survey, PRC, Inc. [Item 94]
- 2023 PRC National Health Survey, PRC, Inc.

Notes:
- Asked of all respondents with children age 2-17 at home.
- Includes children reported to have one or more hours of physical activity on each of the seven days preceding the survey.

Weight Status

About Overweight & Obesity

Obesity is linked to many serious health problems, including type 2 diabetes, heart disease, stroke, and some types of cancer. Some racial/ethnic groups are more likely to have obesity, which increases their risk of chronic diseases.

Culturally appropriate programs and policies that help people eat nutritious foods within their calorie needs can reduce overweight and obesity. Public health interventions that make it easier for people to be more physically active can also help them maintain a healthy weight.

– Healthy People 2030 (https://health.gov/healthypeople)

Body Mass Index (BMI), which describes relative weight for height, is significantly correlated with total body fat content. The BMI should be used to assess overweight and obesity and to monitor changes in body weight. In addition, measurements of body weight alone can be used to determine efficacy of weight loss therapy. BMI is calculated as weight (kg)/height squared (m^2). To estimate BMI using pounds and inches, use: [weight (pounds)/height squared ($inches^2$)] x 703.

In this report, overweight is defined as a BMI of 25.0 to 29.9 kg/m^2 and obesity as a BMI ≥30 kg/m^2. The rationale behind these definitions is based on epidemiological data that show increases in mortality with BMIs above 25 kg/m^2. The increase in mortality, however, tends to be modest until a BMI of 30 kg/m^2 is reached. For persons with a BMI ≥30 kg/m^2, mortality rates from all causes, and especially from cardiovascular disease, are generally increased by 50 to 100 percent above that of persons with BMIs in the range of 20 to 25 kg/m^2.

– Clinical Guidelines on the Identification, Evaluation, and Treatment of Overweight and Obesity in Adults: The Evidence Report. National Institutes of Health. National Heart, Lung, and Blood Institute in Cooperation With The National Institute of Diabetes and Digestive and Kidney Diseases. September 1998.

Adult Weight Status

Classification of Overweight and Obesity by BMI	BMI (kg/m^2)
Underweight	<18.5
Healthy Weight	18.5 – 24.9
Overweight	25.0 – 29.9
Obese	≥30.0

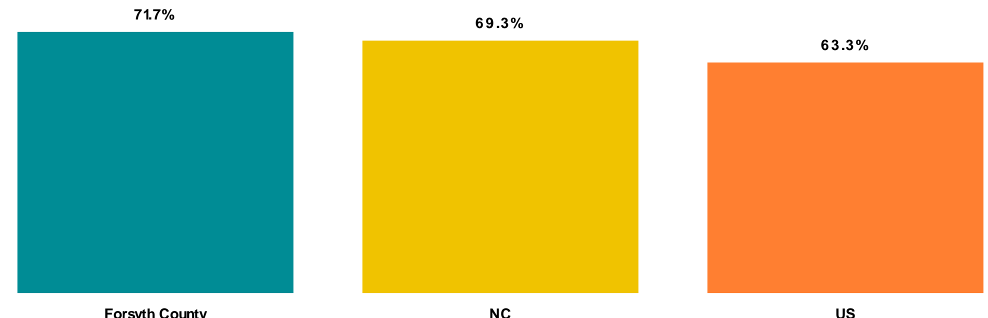
Source: Clinical Guidelines on the Identification, Evaluation, and Treatment of Overweight and Obesity in Adults: The Evidence Report. National Institutes of Health. National Heart, Lung, and Blood Institute in Cooperation With The National Institute of Diabetes and Digestive and Kidney Diseases. September 1998.

PRC Survey ▶ "About how much do you weigh without shoes?"

PRC Survey ▶ "About how tall are you without shoes?"

Reported height and weight were used to calculate a Body Mass Index or BMI value (described above) for each respondent. This calculation allows us to examine the proportion of the population who is at a healthy weight, or who is overweight or obese (see table above).

Prevalence of Total Overweight (Overweight and Obese)

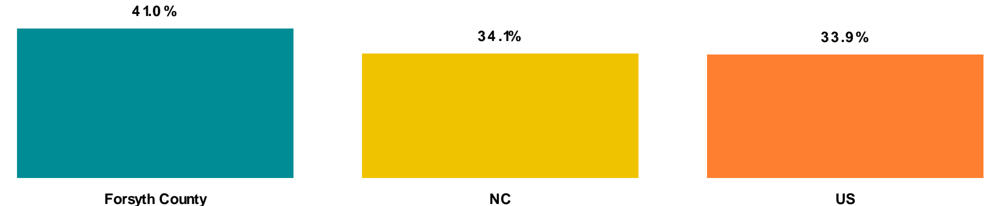


Sources:
- 2024 PRC Community Health Survey, PRC, Inc. [Item 112]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2022 North Carolina data.
- 2023 PRC National Health Survey, PRC, Inc.

Notes:
- Based on reported heights and weights, asked of all respondents.
- The definition of overweight is having a body mass index (BMI), a ratio of weight to height (kilograms divided by meters squared), greater than or equal to 25.0,.
  The definition for obesity is a BMI greater than or equal to 30.0.

Prevalence of Obesity

Healthy People 2030 = 36.0% or Lower



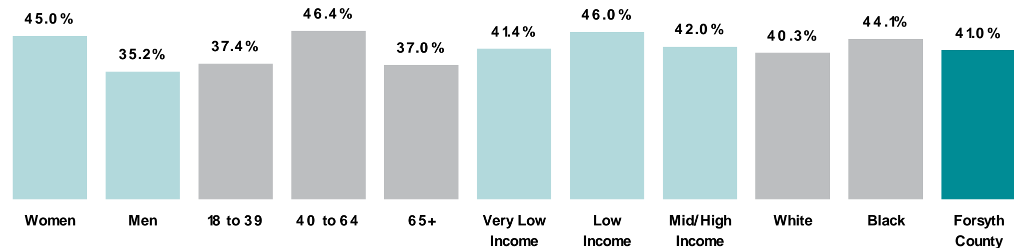
Sources:
- 2024 PRC Community Health Survey, PRC, Inc. [Item 112]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2022 North Carolina data.
- 2023 PRC National Health Survey, PRC, Inc.
- US Department of Health and Human Services. Healthy People 2030. https://health.gov/healthypeople

Notes:
- Based on reported heights and weights, asked of all respondents.
- The definition of obesity is having a body mass index (BMI), a ratio of weight to height (kilograms divided by meters squared), greater than or equal to 30.0.

Prevalence of Obesity

(Forsyth County, 2024)

Healthy People 2030 = 36.0% or Lower



Sources:
- 2024 PRC Community Health Survey, PRC, Inc. [Item 112]
- US Department of Health and Human Services. Healthy People 2030. https://health.gov/healthypeople

Notes:
- Based on reported heights and weights, asked of all respondents.
- The definition of obesity is having a body mass index (BMI), a ratio of weight to height (kilograms divided by meters squared), greater than or equal to 30.0, regardless of gender.

Children's Weight Status

About Weight Status in Children & Teens

In children and teens, body mass index (BMI) is used to assess weight status – underweight, healthy weight, overweight, or obese. After BMI is calculated for children and teens, the BMI number is plotted on the CDC BMI-for-age growth charts (for either girls or boys) to obtain a percentile ranking. Percentiles are the most commonly used indicator to assess the size and growth patterns of individual children in the United States. The percentile indicates the relative position of the child's BMI number among children of the same sex and age.

BMI-for-age weight status categories and the corresponding percentiles are shown below:

- Underweight <5th percentile
- Healthy Weight ≥5th and <85th percentile
- Overweight ≥85th and <95th percentile
- Obese ≥95th percentile

– Centers for Disease Control and Prevention

The following questions were used to calculate a BMI value (and weight classification as noted above) for each child represented in the survey:

PRC Survey ► **"How much does this child weigh without shoes?"**

PRC Survey ► **"About how tall is this child?"**

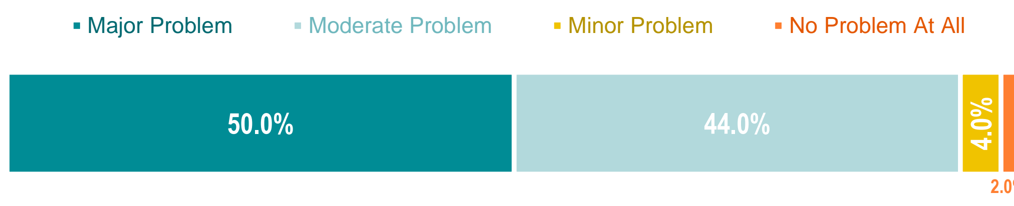
Prevalence of Overweight in Children
(Children 5-17)

Sources: • 2024 PRC Community Health Survey, PRC, Inc. [Item 113]
• 2023 PRC National Health Survey, PRC, Inc.
Notes: • Asked of all respondents with children age 5-17 at home.
• Overweight among children is determined by children's Body Mass Index status at or above the 85th percentile of US growth charts by gender and age.

Key Informant Input: Nutrition, Physical Activity & Weight

Note key informants' perceptions of the severity of *Nutrition, Physical Activity & Weight* as a problem in the community:

Perceptions of Nutrition, Physical Activity & Weight as a Problem in the Community
(Among Key Informants; Forsyth County, 2024)



Sources: • 2024 PRC Online Key Informant Survey, PRC, Inc.
Notes: • Asked of all respondents.

Among those rating this issue as a "major problem," reasons related to the following:

Lifestyle

> Stress, cost, easy access to support services. – Health Provider
>
> Consistent pattern of increasing weight and decreasing physical activity as seen in North Carolina and the United States. Increasing food prices are making nutritious choices more challenging for families. – Physician
>
> Food insecurity, lack of access to affordable physical activity programs, difficulty with affording evidence-based pharmacologic therapies for obesity. Limited understanding of nutrition and the role in chronic disease management. – Physician
>
> Grocery costs, food deserts, unsafe neighborhoods for walking, lack of parks and greenspaces, social media, and gaming, unsafe to ride bikes. – Social Service Provider

> Behavior change is a process that does not generally produce quick results. Behavior change is a difficult process. – Health Provider
>
> Access to safe spaces and healthy foods, mobility issues, transportation, and affordability. – Health Provider

Access to Affordable Healthy Food

> Disadvantaged communities have poor access to healthy foods, with over 50% of people who live in underserved (redlined) communities lacking reliable transportation outside of the bus system. There are increasing rates of crime that prevent people from feeling safe to go outside of their homes to exercise or walk, and there is a lack of support for communities that need access to healthy foods (grocery stores, farmer's markets, land use agreements). – Health Provider
>
> Access to healthier foods based on the communities in which they live, financial resources to purchase healthy food. Encouraging activity among our younger generations. Overstimulation and schedules/activities with little or no time to prepare and eat meals with nutritional value. At the core, choices with sugar, salt, and fat are the low-cost items, which begin the addiction cycle to cravings for less healthy items. – Health Provider
>
> Access to healthy foods, grocery stores, parks, and exercise facilities. Also, the community doesn't know the importance of healthy foods and the impact it plays on one's overall health. – Community Leader

Obesity

> Obesity is a national problem. Healthy food is more expensive and harder to find, especially in food deserts, which oftentimes are located in the lower socioeconomic parts of the community. People also need to be better educated in regard to healthy eating that is culturally specific. – Health Provider
>
> High rates of obesity. – Physician

Nutrition

> Fast food, areas with no fresh groceries, too few modest-sized community events that encourage neighbors to be active outside. – Community Leader

Substance Use

About Drug & Alcohol Use

More than 20 million adults and adolescents in the United States have had a substance use disorder in the past year. ...Substance use disorders can involve illicit drugs, prescription drugs, or alcohol. Opioid use disorders have become especially problematic in recent years. Substance use disorders are linked to many health problems, and overdoses can lead to emergency department visits and deaths.

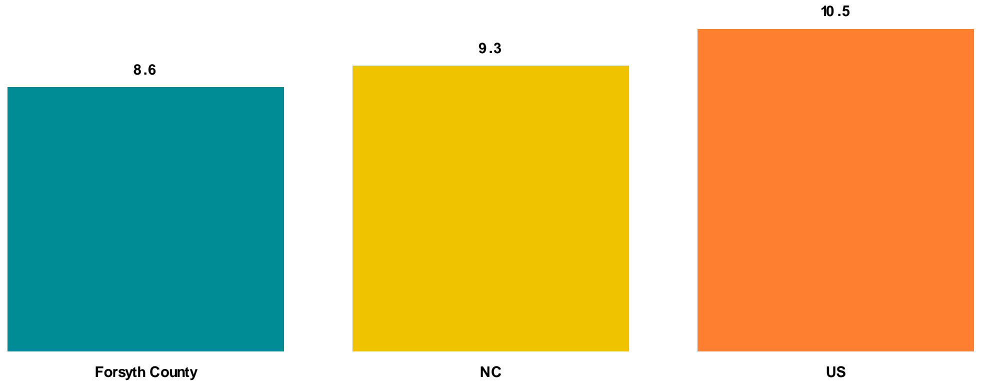
Effective treatments for substance use disorders are available, but very few people get the treatment they need. Strategies to prevent substance use — especially in adolescents — and help people get treatment can reduce drug and alcohol misuse, related health problems, and deaths.

– Healthy People 2030 (https://health.gov/healthypeople)

Alcohol

Age-Adjusted Alcohol-Induced Deaths

The following outlines age-adjusted, alcohol-induced mortality in the area.



Sources: • National Vital Statistics System-Mortality (NVSS-M), Centers for Disease Control and Prevention (CDC). Retrieved May 2024 via Metopio.

Notes: • Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
• Rates are per 100,000 population, age-adjusted to the 2000 US Standard Population.

Excessive Drinking

PRC Survey ► "During the past 30 days, on how many days did you have at least one drink of any alcoholic beverage such as beer, wine, a malt beverage, or liquor?"

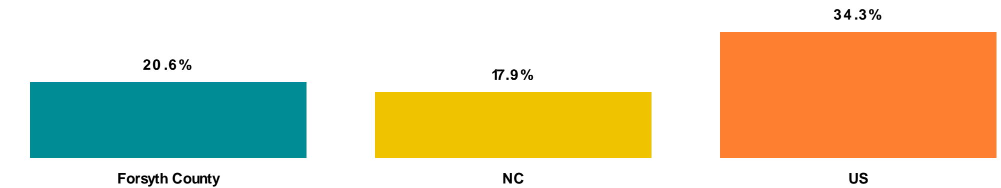
PRC Survey ► "On the day(s) when you drank, about how many drinks did you have on average?"

PRC Survey ► "Considering all types of alcoholic beverages, how many times during the past 30 days did you have 5 (if male)/4 (if female) or more drinks on an occasion?"

Excessive drinking includes heavy and/or binge drinkers:

- Heavy Drinking ► men reporting 2+ alcoholic drinks per day or women reporting 1+ alcoholic drink per day in the month preceding the interview.
- Binge Drinking ► men reporting 5+ alcoholic drinks or women reporting 4+ alcoholic drinks on any single occasion during the past month.

Engage in Excessive Drinking



Sources:
- 2024 PRC Community Health Survey, PRC, Inc. [Item 116]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2022 North Carolina data.
- 2023 PRC National Health Survey, PRC, Inc.

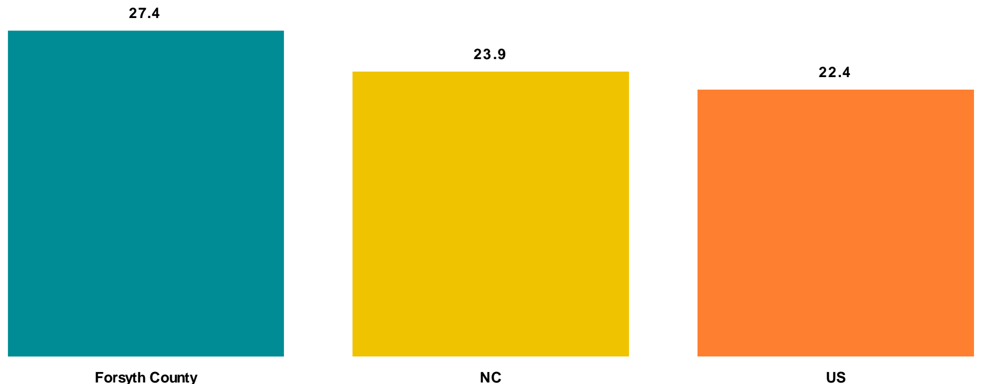
Notes:
- Asked of all respondents.
- Excessive drinking reflects the percentage of persons age 18 years and over who drank more than two drinks per day on average (for men) or more than one drink per day on average (for women) OR who drank 5 or more drinks during a single occasion (for men) or 4 or more drinks during a single occasion (for women) during the past 30 days.

Drugs

Age-Adjusted Drug Overdose Deaths

Data below present local age-adjusted mortality for drug overdose deaths. Drug overdose deaths include deaths due to drug poisoning (such as overdose), whether accidental or intentional. Increases during the 2010s is largely due to the opioid overdose epidemic, but other drugs are also included here.

Drug Overdose Deaths: Age-Adjusted Mortality
(2016-2020 Annual Average Deaths per 100,000 Population)



Sources: • National Vital Statistics System-Mortality (NVSS-M), Centers for Disease Control and Prevention (CDC). Retrieved May 2024 via Metopio.

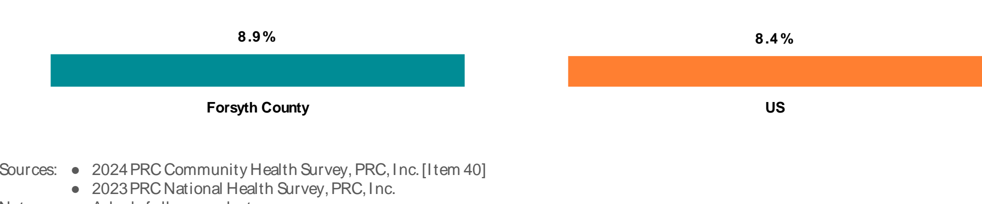
Notes: • Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
• Rates are per 100,000 population, age-adjusted to the 2000 US Standard Population.
• Deaths per 100,000 residents due to drug poisoning (such as overdose), whether accidental or intentional. The increase during the 2010s is largely due to the opioid overdose epidemic, but other drugs are also included here.

Illicit Drug Use

Note: As a self-reported measure – and because this indicator reflects potentially illegal behavior – it is reasonable to expect that it might be underreported, and that actual illicit drug use in the community is likely higher.

PRC Survey ► "During the past 30 days, have you used an illegal drug or taken a prescription drug that was not prescribed to you?"

Illicit Drug Use in the Past Month



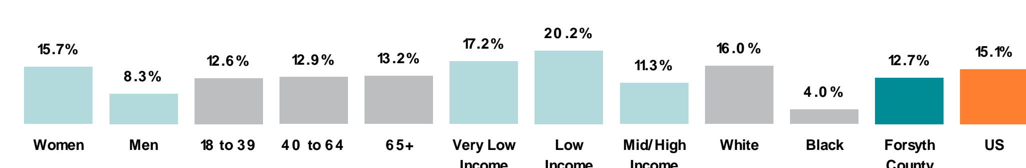
Sources: • 2024 PRC Community Health Survey, PRC, Inc. [Item 40]
• 2023 PRC National Health Survey, PRC, Inc.
Notes: • Asked of all respondents.

Use of Prescription Opioids

Opioids are a class of drugs used to treat pain. Examples presented to respondents include morphine, codeine, hydrocodone, oxycodone, methadone, and fentanyl. Common brand name opioids include Vicodin, Dilaudid, Percocet, OxyContin, and Demerol.

PRC Survey ▶ "Opiates or opioids are drugs that doctors prescribe to treat pain. Examples of prescription opiates include morphine, codeine, hydrocodone, oxycodone, methadone, and fentanyl. In the past year, have you used any of these prescription opiates?"

Used a Prescription Opioid in the Past Year
(Forsyth County, 2024)

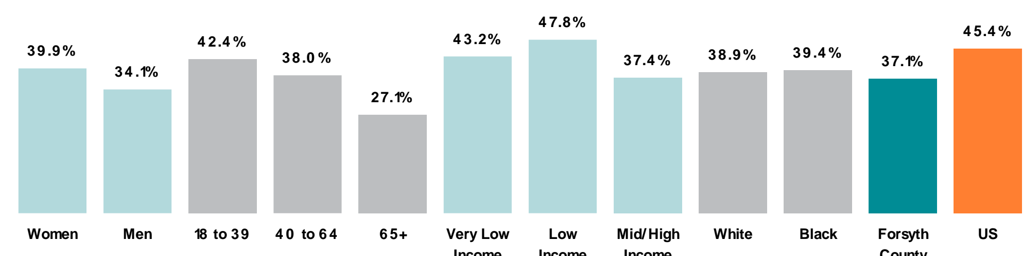


Sources: • 2024 PRC Community Health Survey, PRC, Inc. [Item 41]
• 2023 PRC National Health Survey, PRC, Inc.
Notes: • Asked of all respondents.

Personal Impact From Substance Use

PRC Survey ▶ "To what degree has your life been negatively affected by your own or someone else's substance use issues, including alcohol, prescription, and other drugs? Would you say: a great deal, somewhat, a little, or not at all?"

Life Has Been Negatively Affected by Substance Use (by Self or Someone Else)
(Forsyth County, 2024)

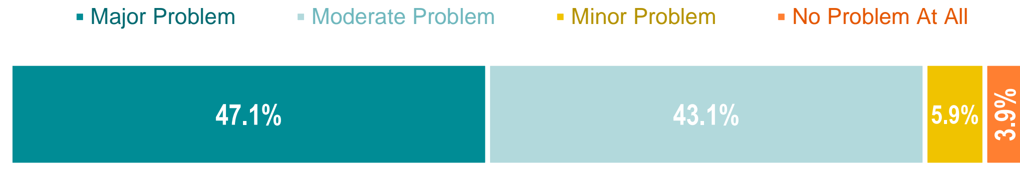


Sources: • 2024 PRC Community Health Survey, PRC, Inc. [Item 43]
• 2023 PRC National Health Survey, PRC, Inc.
Notes: • Asked of all respondents.
• Includes those responding "a great deal," "somewhat," or "a little."

Key Informant Input: Substance Use

Note key informants' perceptions of the severity of *Substance Use* as a problem in the community:

Perceptions of Substance Use as a Problem in the Community
(Among Key Informants; Forsyth County, 2024)



Sources: • 2024 PRC Online Key Informant Survey, PRC, Inc.
Notes: • Asked of all respondents.

Among those rating this issue as a "major problem," reasons related to the following:

Access to Care/Services

> Lack of access to care due to the limited number of providers and affordability. – Physician
>
> Limited resources. – Health Provider
>
> Shortage of publicly available treatment facilities and programs. Long wait lists are a barrier, especially for people with substance dependency disorders who may have short windows of being willing and able to enroll in treatment. – Community Leader
>
> Are there even evidence-based programs in existence anywhere? – Health Provider
>
> Cost, stigma, ease of access to trending drugs (such as opioids), poverty, depression, and other untreated mental health issues, lack of insurance coverage, lack of outpatient treatment, lack of time off or just the need to work. – Social Service Provider

Denial/Stigma

> Stigma of those with the problem and not enough people available to see them. – Health Provider

Stigma and access. – Physician

Stigma, awareness of where to access services and support, access to affordable care, free or low-cost services for individuals that are uninsured or underinsured, and/or have high deductibles. Access and knowing where to access affordable medications. – Public Health Representative

Affordable Care/Services

Cost, limited number of providers, access. – Health Provider

Time and money. – Social Service Provider

Disease Management

Addicted persons refusing treatment. Lack of resources to address the situation for those that want help. – Community Leader

Lack of Providers

Lack of providers. – Health Provider

Tobacco Use

About Tobacco Use

More than 16 million adults in the United States have a disease caused by smoking cigarettes, and smoking-related illnesses lead to half a million deaths each year.

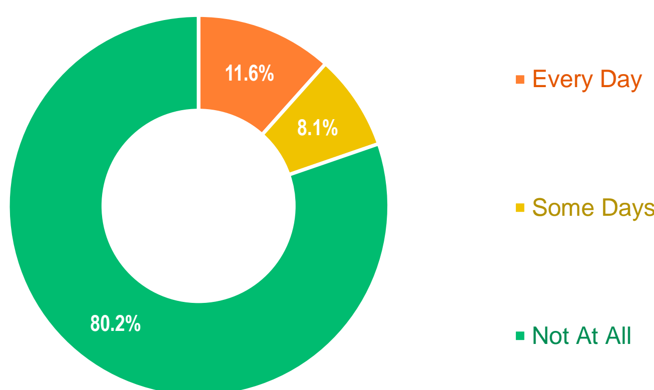
Most deaths and diseases from tobacco use in the United States are caused by cigarettes. Smoking harms nearly every organ in the body and increases the risk of heart disease, stroke, lung diseases, and many types of cancer. Although smoking is widespread, it's more common in certain groups, including men, American Indians/Alaska Natives, people with behavioral health conditions, LGBT people, and people with lower incomes and education levels.

Several evidence-based strategies can help prevent and reduce tobacco use and exposure to secondhand smoke. These include smoke-free policies, price increases, and health education campaigns that target large audiences. Methods like counseling and medication can also help people stop using tobacco.

– Healthy People 2030 (https://health.gov/healthypeople)

Cigarette Smoking

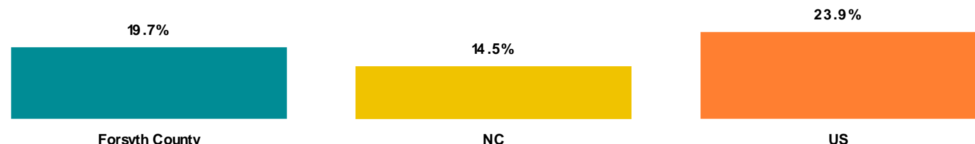
PRC Survey ▶ "Do you currently smoke cigarettes every day, some days, or not at all?" ("Currently Smoke Cigarettes" includes those smoking "every day" or on "some days.")



Sources: • 2024 PRC Community Health Survey, PRC, Inc. [Item 34]
Notes: • Asked of all respondents.

Currently Smoke Cigarettes

Healthy People 2030 = 6.1% or Lower



Sources:
- 2024 PRC Community Health Survey, PRC, Inc. [Item 34]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2022 North Carolina data.
- 2023 PRC National Health Survey, PRC, Inc.
- US Department of Health and Human Services. Healthy People 2030. https://health.gov/healthypeople

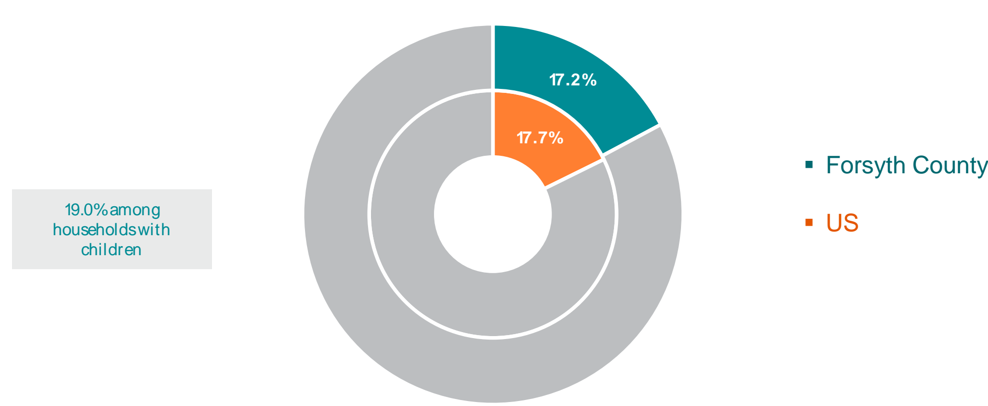
Notes:
- Asked of all respondents.
- Includes those who smoke cigarettes every day or on some days.

Environmental Tobacco Smoke

PRC Survey ▶ "In the past 30 days, has anyone, including yourself, smoked cigarettes, cigars, or pipes anywhere in your home on an average of four or more days per week?"

The following chart details these responses among the total sample of respondents, as well as among only households with children (age 0-17).

Member of Household Smokes at Home



Sources:
- 2024 PRC Community Health Survey, PRC, Inc. [Items 35, 114]
- 2023 PRC National Health Survey, PRC, Inc.

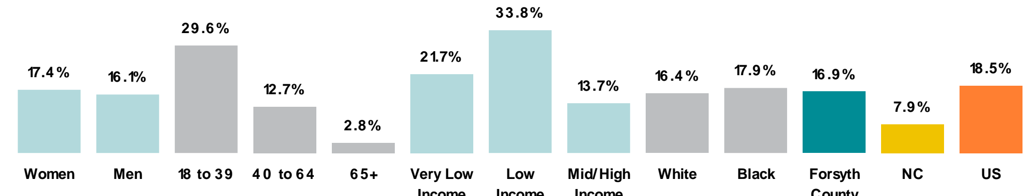
Notes:
- Asked of all respondents.
- "Smokes at home" refers to someone smoking cigarettes, cigars, or a pipe in the home an average of four or more times per week in the past month.

Use of Vaping Products

PRC Survey ▶ "Electronic vaping products, such as electronic cigarettes, are battery-operated devices that simulate traditional cigarette smoking but do not involve the burning of tobacco. Do you currently use electronic vaping products, such as electronic cigarettes, every day, some days, or not at all?"

("Currently Use Vaping Products" includes use "every day" or on "some days.")

Currently Use Vaping Products
(Forsyth County, 2024)



Sources:
- 2024 PRC Community Health Survey, PRC, Inc. [Item 36]
- 2023 PRC National Health Survey, PRC, Inc.
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2022 North Carolina data.

Notes:
- Asked of all respondents.
- Includes those who use vaping products every day or on some days.

Key Informant Input: Tobacco Use

Note key informants' perceptions of the severity of *Tobacco Use* as a problem in the community:

Perceptions of Tobacco Use as a Problem in the Community
(Among Key Informants; Forsyth County, 2024)

▪ Major Problem ▪ Moderate Problem ▪ Minor Problem ▪ No Problem At All

Sources:
- 2024 PRC Online Key Informant Survey, PRC, Inc.

Notes:
- Asked of all respondents.

Among those rating this issue as a "major problem," reasons related to the following:

Incidence/Prevalence

> Legacy of Reynolds Tobacco. – Health Provider
>
> This was big tobacco country, and people have loyalty to the company. – Community Leader
>
> City built on tobacco and still prevalent in our community, leading to cardiovascular disease. – Physician
>
> Prevalence across our region and county. – Physician
>
> The prevalence of smoking is higher than average. – Physician

Awareness/Education

> Education about sequels. – Health Provider

Sexual Health

About HIV & Sexually Transmitted Infections

Although many sexually transmitted infections (STIs) are preventable, there are more than 20 million estimated new cases in the United States each year — and rates are increasing. In addition, more than 1.2 million people in the United States are living with HIV (human immunodeficiency virus).

Adolescents, young adults, and men who have sex with men are at higher risk of getting STIs. And people who have an STI may be at higher risk of getting HIV. Promoting behaviors like condom use can help prevent STIs.

Strategies to increase screening and testing for STIs can assess people's risk of getting an STI and help people with STIs get treatment, improving their health and making it less likely that STIs will spread to others. Getting treated for an STI other than HIV can help prevent complications from the STI but doesn't prevent HIV from spreading.

– Healthy People 2030 (https://health.gov/healthypeople)

Sexually Transmitted Infections (STIs)

Chlamydia

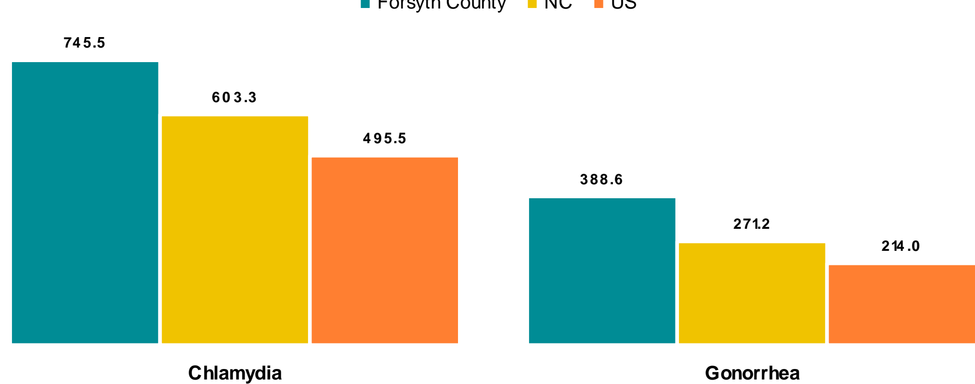
Chlamydia is the most commonly reported STI in the United States; most people who have chlamydia are unaware, since the disease often has no symptoms.

Gonorrhea

Anyone who is sexually active can get gonorrhea. Gonorrhea can be cured with the right medication; left untreated, however, gonorrhea can cause serious health problems in both women and men.

The following chart outlines local incidence for these STIs.

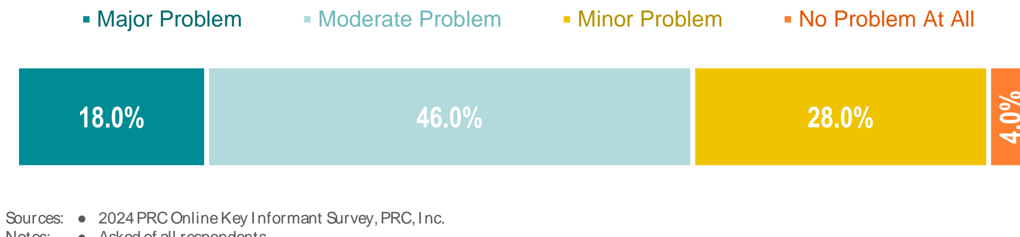
Chlamydia & Gonorrhea Incidence
(Incidence Rate per 100,000 Population, 2021)



Sources: • National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention: Atlas Plus, Centers for Disease Control and Prevention (CDC). Retrieved May 2024 via Metopio.

Key Informant Input: Sexual Health

Note key informants' perceptions of the severity of *Sexual Health* as a problem in the community:



Sources: • 2024 PRC Online Key Informant Survey, PRC, Inc.
Notes: • Asked of all respondents.

Among those rating this issue as a "major problem," reasons related to the following:

Incidence/Prevalence

> Elevated rate of STIs. – Physician
>
> The rise in new STI cases. – Health Provider

Awareness/Education

> Root cause, having been a sex education teacher in a past career post-college education, morality, not having the discussion early on in the game. Open, frank, conversations about pregnancy, STDs, etc. – Health Provider

Access to Care/Services

> There has been a lack of access to health care. – Physician

Access to Health Care

About Health Care Access

Many people in the United States don't get the health care services they need. …About 1 in 10 people in the United States don't have health insurance. People without insurance are less likely to have a primary care provider, and they may not be able to afford the health care services and medications they need. Strategies to increase insurance coverage rates are critical for making sure more people get important health care services, like preventive care and treatment for chronic illnesses.

Sometimes people don't get recommended health care services, like cancer screenings, because they don't have a primary care provider. Other times, it's because they live too far away from health care providers who offer them. Interventions to increase access to health care professionals and improve communication — in person or remotely — can help more people get the care they need.

– Healthy People 2030 (https://health.gov/healthypeople)

Lack of Health Insurance Coverage

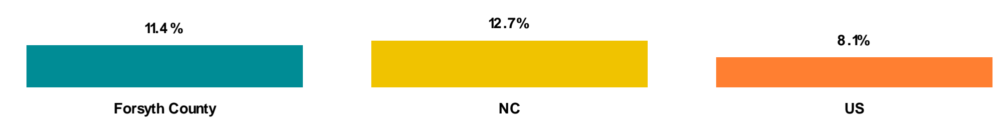
Here, lack of health insurance coverage reflects respondents age 18 to 64 (thus, excluding the Medicare population) who have no type of insurance coverage for health care services – neither private insurance nor government-sponsored plans.

Survey respondents were asked a series of questions to determine their health care insurance coverage, if any, from either private or government-sponsored sources.

PRC Survey ▶ "Do you have any government-assisted health care coverage, such as Medicare, Medicaid (or another state-sponsored program), or VA/military benefits?"

PRC Survey ▶ "Do you currently have: health insurance you get through your own or someone else's employer or union; health insurance you purchase yourself or get through a health insurance exchange website; or, you do not have health insurance and pay entirely on your own?"

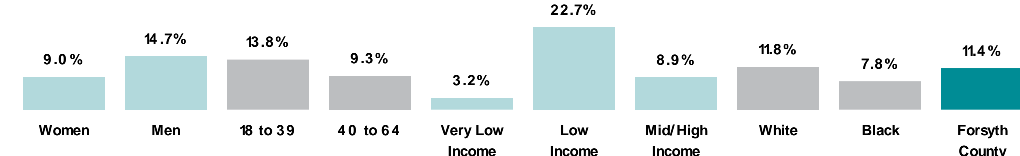
Lack of Health Care Insurance Coverage
(Adults 18-64)
Healthy People 2030 = 7.6% or Lower



Sources:
- 2024 PRC Community Health Survey, PRC, Inc. [Item 117]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2022 North Carolina data.
- 2023 PRC National Health Survey, PRC, Inc.
- US Department of Health and Human Services. Healthy People 2030. https://health.gov/healthypeople

Notes:
- Reflects respondents age 18 to 64.

Lack of Health Care Insurance Coverage
(Adults 18-64; Forsyth County, 2024)
Healthy People 2030 = 7.6% or Lower



Sources: • 2024 PRC Community Health Survey, PRC, Inc. [Item 117]
• US Department of Health and Human Services. Healthy People 2030. https://health.gov/healthypeople
Notes: • Reflects respondents age 18 to 64.

Difficulties Accessing Health Care

Barriers to Health Care Access

To better understand health care access barriers, survey participants were asked whether any of the following barriers to access prevented them from seeing a physician or obtaining a needed prescription in the past year.

PRC Survey ► "Was there a time in the past 12 months when you needed medical care but had difficulty finding a doctor?"

PRC Survey ► "Was there a time in the past 12 months when you had difficulty getting an appointment to see a doctor?"

PRC Survey ► "Was there a time in the past 12 months when you needed to see a doctor but could not because of the cost?"

PRC Survey ► "Was there a time in the past 12 months when a lack of transportation made it difficult or prevented you from seeing a doctor or making a medical appointment?"

PRC Survey ► "Was there a time in the past 12 months when you were not able to see a doctor because the office hours were not convenient?"

PRC Survey ► "Was there a time in the past 12 months when you needed a prescription medicine but did not get it because you could not afford it?"

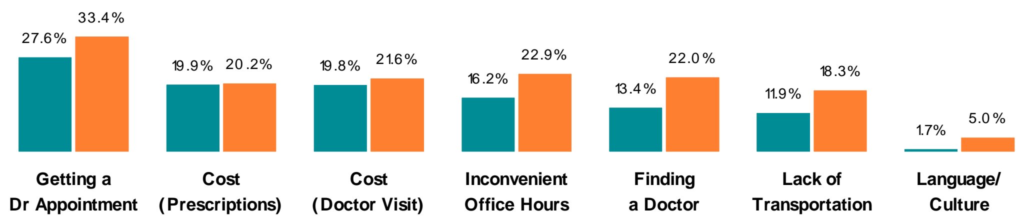
PRC Survey ► "Was there a time in the past 12 months when you were not able to see a doctor due to language or cultural differences?"

Also:

PRC Survey ► "Was there a time in the past 12 months when you skipped doses or took smaller doses in order to make your prescriptions last longer and save costs?"

The percentages shown in the following chart reflect the total population, regardless of whether medical care was needed or sought.

Barriers to Access Have Prevented Medical Care in the Past Year



Sources: • 2024 PRC Community Health Survey, PRC, Inc. [Items 6-13]
• 2023 PRC National Health Survey, PRC, Inc.

Notes: • Asked of all respondents.

The following charts reflect the composite percentage of the total population experiencing problems accessing health care in the past year (indicating one or more of the aforementioned barriers or any other problem not specifically asked), again regardless of whether they needed or sought care.

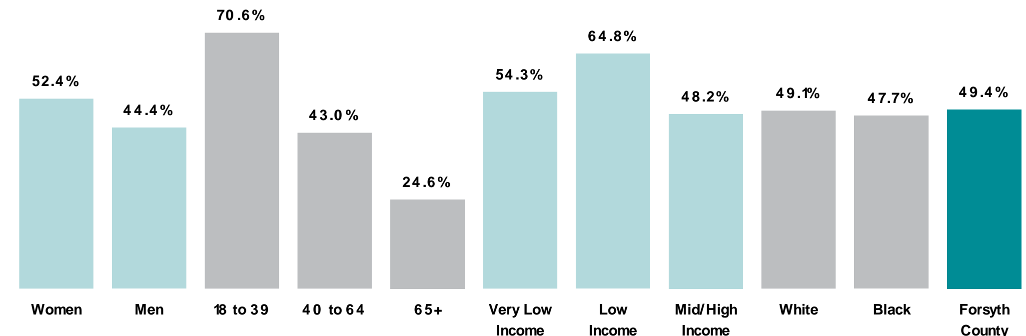
Experienced Difficulties or Delays of Some Kind in Receiving Needed Health Care in the Past Year

Sources: • 2024 PRC Community Health Survey, PRC, Inc. [Item 119]
• 2023 PRC National Health Survey, PRC, Inc.

Notes: • Asked of all respondents.
• Percentage represents the proportion of respondents experiencing one or more barriers to accessing health care in the past 12 months.

Experienced Difficulties or Delays of Some Kind in Receiving Needed Health Care in the Past Year

(Forsyth County, 2024)



Sources: • 2024 PRC Community Health Survey, PRC, Inc. [Item 119]
Notes: • Asked of all respondents.
• Percentage represents the proportion of respondents experiencing one or more barriers to accessing health care in the past 12 months.

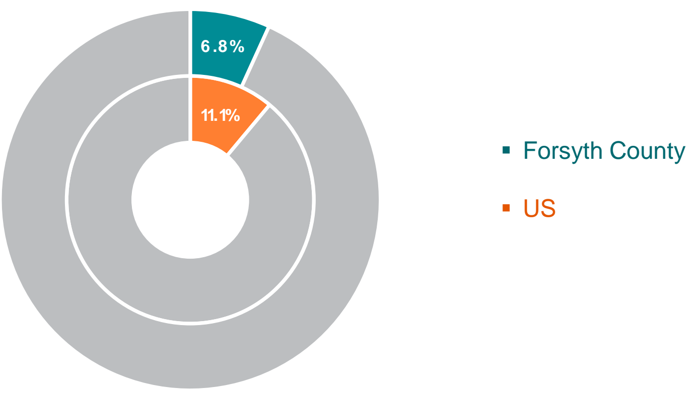
Accessing Health Care for Children

Surveyed parents were also asked if, within the past year, they experienced any trouble receiving medical care for a randomly selected child in their household.

PRC Survey ▶ "Was there a time in the past 12 months when you needed medical care for this child but could not get it?"

Had Trouble Obtaining Medical Care for Child in the Past Year

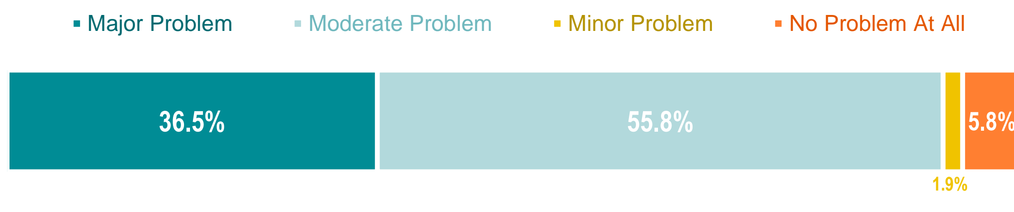
(Children 0-17)



Sources: • 2024 PRC Community Health Survey, PRC, Inc. [Item 90]
• 2023 PRC National Health Survey, PRC, Inc.
Notes: • Asked of all respondents with children age 0 to 17 in the household.

Key Informant Input: Access to Health Care Services

Note key informants' perceptions of the severity of *Access to Health Care Services* as a problem in the community:



Sources: • 2024 PRC Online Key Informant Survey, PRC, Inc.
Notes: • Asked of all respondents.

Among those rating this issue as a "major problem," reasons related to the following:

Access to Care/Services

> The only stand-alone medical services available in East Winston are OB-GYN, with some access to health care through the satellite clinics at the Intergenerational Center for Arts and Wellness through Senior Services. There is a mistrust (rightfully so) of the medical system in the African American Community, and we need more physicians of color. Also, safe, affordable TRANSPORTATION to and from medical appointments has been a daunting issue for decades. The Shepherd's Center of Greater Winston-Salem carries that burden for citizens 60+ years of age and is now keeping a waiting list as grant funding runs dry. They make approximately 500 roundtrips a month. Public transportation is lacking in that there is no transportation (bus or Trans-Aid) outside of the city. Folks who need to access services in, or coming from, places like Clemmons, Bethania, Rural Hall, etc., have nothing. Furthermore, our direct care workforce crisis presents serious issues across the medical continuum. – Social Service Provider
>
> Access to care, infant mortality, food insecurity that impact the solutions health care providers may provide, and mental health. These are not in any particular order. – Community Leader
>
> Lack of sufficient primary care, preventive care, and affordable health care. – Physician
>
> Access to health care services is uneven. Some residents have good, consistent access to primary care services, but a variety of factors prevent other residents from being able to access care regularly. – Community Leader

Affordable Care/Services

> Corporate medical care, profit over people. Health care should be free to all. – Community Leader
>
> Challenges accessing health care services include health care cost, transportation to health care services, location accessibility, culturally inclusive practices to address the needs of a diverse community. Also, baseline knowledge of how and when to access health care services. – Community Leader
>
> Affordability, cost of insurance and medications, transportation, especially for rural areas. – Health Provider
>
> Lack of low-cost primary care services to meet the needs of the community. There are just not enough providers. Our immigrant population often lacks insurance as well. – Physician
>
> Affordability and compassionate providers. – Health Provider

Access to Care for Uninsured/Underinsured

> Lack of health insurance coverage, fragmented, disjointed care, social determinants of health including lack of transportation, housing, and food insecurity issues. – Health Provider
>
> Many in our community are under- or uninsured and cannot afford care and do not know how to access reduced cost/no-cost services. Additionally, transportation, lack of trust, and lack of appointments outside of their work schedule can be barriers to care. Finding providers that culturally represent the individual and that speak the same language can further complicate connections to care. Stigma is also a contributing factor. Several individuals with substance use disorders and/or severe and persistent mental illness have shared that they perceived being treated as "less than" by providers. – Public Health Representative

Transportation

> Transportation challenges, high rates of generational poverty in our community, and limited providers in some of the rural areas. – Physician
>
> Transportation and food insecurity. – Community Leader

Social Determinants of Health

> Food insecurity, maternal and infant health, housing (homeless population around 500 community members), 70% are men and 30% are women without housing, gang activity, dental and vision services, parenting and mentoring for our kids, access to legal identification like state IDs or driver's license, substances abuse, etc. – Community Leader
>
> Patients do not have a desire to access health care oftentimes if they do not feel safe, cannot afford bills and housing costs, or find that transportation is a barrier. If people within the community are in survival mode, access to health care will not be a priority. Also, there is a lack of knowledge of the resources available. The Enterprise offers the clinic with no marketing, so still many people in the community (and Enterprise) do not know about services that the clinic can offer. – Health Provider

Income/Poverty

> Overcoming generational cycles of poverty and related health issues. – Community Leader

Misinformation About Health Care

> Misinformation about health care and programs due to the complete breakdown in local news useful for all citizens. People are relying on social media and word-of-mouth, making the accuracy of information about as useful as in the Dark Ages. – Community Leader

Primary Care Services

About Preventive Care

Getting preventive care reduces the risk for diseases, disabilities, and death — yet millions of people in the United States don't get recommended preventive health care services.

Children need regular well-child and dental visits to track their development and find health problems early, when they're usually easier to treat. Services like screenings, dental check-ups, and vaccinations are key to keeping people of all ages healthy. But for a variety of reasons, many people don't get the preventive care they need. Barriers include cost, not having a primary care provider, living too far from providers, and lack of awareness about recommended preventive services.

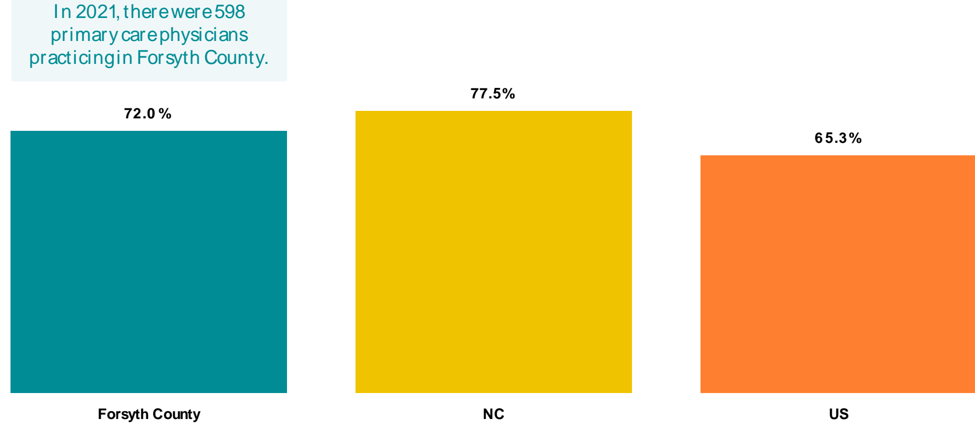
Teaching people about the importance of preventive care is key to making sure more people get recommended services. Law and policy changes can also help more people access these critical services.

– Healthy People 2030 (https://health.gov/healthypeople)

Utilization of Primary Care Services

PRC Survey ▶ "A routine checkup is a general physical exam, not an exam for a specific injury, illness, or condition. About how long has it been since you last visited a doctor for a routine checkup?"

Have Visited a Physician for a Checkup in the Past Year



Sources:
- 2024 PRC Community Health Survey, PRC, Inc. [Item 16]
- Area Health Resources Files, Health Resources & Services Administration. Retrieved May 2024 via Metopio.
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2022 North Carolina data.
- 2023 PRC National Health Survey, PRC, Inc.

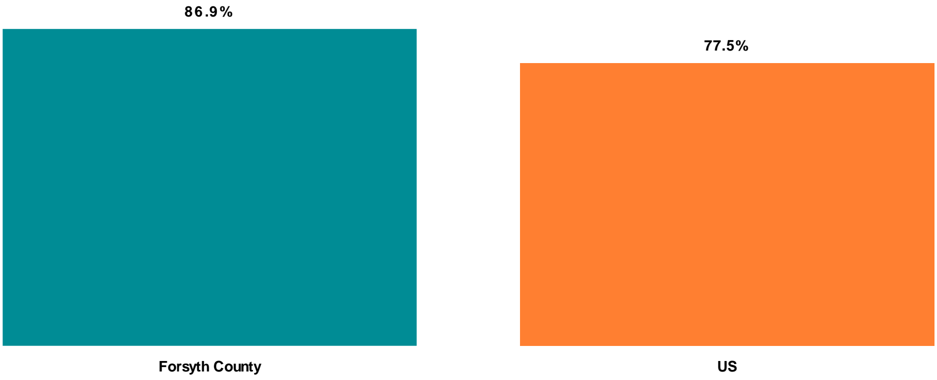
Notes:
- Asked of all respondents.
- Primary care physician count includes the number of clinically active primary care physicians. Includes hospital residents. Excludes federal physicians and physicians age 75 or older.

Note also the number of practicing primary care providers in Forsyth County. This indicator is relevant because a shortage of health professionals contributes to access and health status issues. However, keep in mind that this indicator takes into account *only* primary care physicians; it does not reflect primary care access available through advanced practice providers, such as physician assistants or nurse practitioners.

PRC Survey ► **"About how long has it been since this child visited a doctor for a routine checkup or general physical exam, not counting visits for a specific injury, illness, or condition?"**

Child Has Visited a Physician for a Routine Checkup in the Past Year

(Children 0 -17)



Sources: • 2024 PRC Community Health Survey, PRC, Inc. [Item 91]
• 2023 PRC National Health Survey, PRC, Inc.

Notes: • Asked of all respondents with children age 0 to 17 in the household.

Oral Health

About Oral Health

Tooth decay is the most common chronic disease in children and adults in the United States. …Regular preventive dental care can catch problems early, when they're usually easier to treat. But many people don't get the care they need, often because they can't afford it. Untreated oral health problems can cause pain and disability and are linked to other diseases.

Strategies to help people access dental services can help prevent problems like tooth decay, gum disease, and tooth loss. Individual-level interventions like topical fluorides and community-level interventions like community water fluoridation can also help improve oral health. In addition, teaching people how to take care of their teeth and gums can help prevent oral health problems.

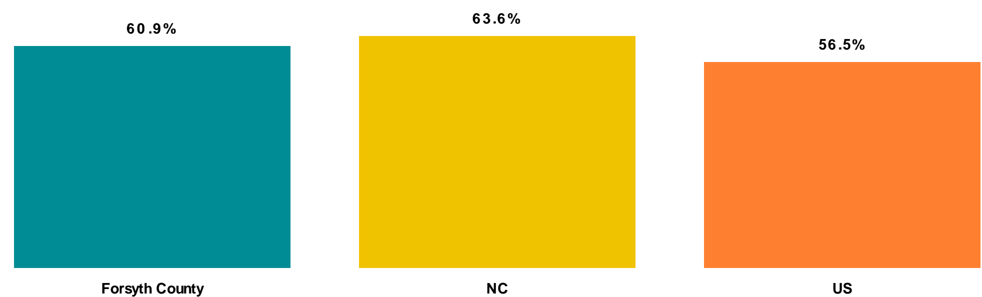
– Healthy People 2030 (https://health.gov/healthypeople)

Dental Care

PRC Survey ▶ **"About how long has it been since you last visited a dentist or a dental clinic for any reason?"**

Have Visited a Dentist or Dental Clinic Within the Past Year

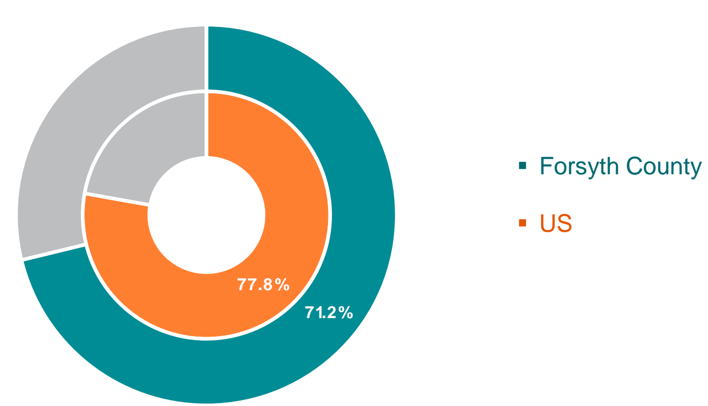
Healthy People 2030 = 45.0% or Higher



Sources:
- 2024 PRC Community Health Survey, PRC, Inc. [Item 17]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2022 North Carolina data.
- 2023 PRC National Health Survey, PRC, Inc.
- US Department of Health and Human Services. Healthy People 2030. https://health.gov/healthypeople

Notes:
- Asked of all respondents.

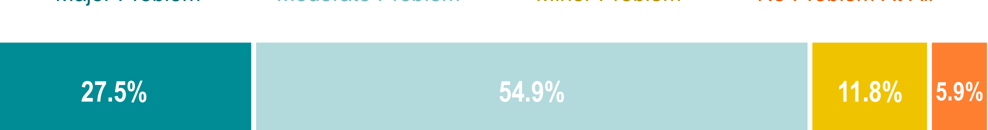
PRC Survey ▶ [Children Age 2-17] "About how long has it been since this child visited a dentist or dental clinic?"



Sources: • 2024 PRC Community Health Survey, PRC, Inc. [Item 93]
• 2023 PRC National Health Survey, PRC, Inc.
• US Department of Health and Human Services. Healthy People 2030. https://health.gov/healthypeople
Notes: • Asked of all respondents with children age 2 through 17.

Key Informant Input: Oral Health

Note key informants' perceptions of the severity of *Oral Health* as a problem in the community:



Sources: • YRNOW PRC Online Key Informant Survey, PRC, Inc.
Notes: • Asked of all respondents.

Among those rating this issue as a "major problem," reasons related to the following:

Affordable Care/Services

> Lack of resources that are cost efficient. – Health Provider
>
> Our clinic sees indigent patients, many in need of oral health care. There are few programs or providers that offer free or low-cost dental services. – Social Service Provider
>
> We do not have enough free or low-priced dental health care in Forsyth County, period. That impacts the people who cannot afford dental care. It is the major problem. – Social Service Provider

Access to Care for Uninsured/Underinsured

> There are few resources for people with or without health insurance. The costs are very high. – Community Leader

> Lack of services for children and adults without insurance. Minimal services for children and adults with Medicaid. – Health Provider
>
> Lack of insurance and high cost. – Physician

Access for Medicare/Medicaid Patients

> Very few dental practices accept Medicaid or a sliding-scale payment. – Physician
>
> Access to pediatric and adult dentists who take Medicaid or uninsured patients is challenging. – Physician

Awareness/Education

> In the community, residents just don't understand the importance and implications that oral health plays in overall health. There isn't an emphasis on oral health. – Community Leader

Local Resources

Perceptions of Local Health Care Services

PRC Survey ▶ **"How would you rate the overall health care services available to you? Would you say: excellent, very good, good, fair, or poor?"**

Perceive Local Health Care Services as "Fair/Poor"

Sources: • 2024 PRC Community Health Survey, PRC, Inc. [Item 5]
• 2023 PRC National Health Survey, PRC, Inc.
Notes: • Asked of all respondents.

Resources Available to Address Significant Health Needs

The following represent potential measures and resources (such as programs, organizations, and facilities in the community) identified by key informants as available to address the significant health needs identified in this report. This list only reflects input from participants in the Online Key Informant Survey and should not be considered to be exhaustive nor an all-inclusive list of available resources.

Access to Health Care Services

- Atrium Health
- Atrium Health Mobile Medicine Unit
- Atrium Health Wake Forest Baptist Medical Center
- City with Dwellings
- Community Care Center
- Community Care Clinic
- Crisis Control
- Daymark
- Doctor's Offices
- Downtown Health Plaza
- Forsyth County
- Forsyth County Health Department
- Forsyth County Opioid Settlement Funding
- Forsyth Futures
- Free Clinic
- Green Tree Peer Center
- HealthCare Access
- Health Department
- Highland Avenue Primary Care Clinic
- Insurance Companies
- Medical Transportation
- Medicare/Medicaid
- Mobile Integrated Healthcare
- Novant Health
- Public Health
- Robinhood Integrative Health
- Senior Services
- Sunnyside Ministry
- Telemedicine
- The Shepherd's Center of Greater Winston-Salem
- Trans-Aid Transportation
- Twin City Harm Reduction Collective
- Una Bendicion
- United Health Centers
- Urgent Care Facilities
- WSTA

Cancer

- American Cancer Society
- Angelic Warrior Foundation
- Atrium Health Cancer Center
- Atrium Health Wake Forest Baptist Medical Center
- Breast Navigator
- Cancer Services
- Cancer Treatment Center
- Colon Cancer Coalition
- DEAC Clinic
- Downtown Health Plaza
- Forsyth Futures
- Forsyth County Mental Health Services
- Mobile CT
- Novant Health
- Public Health
- Susan B. Komen Foundation
- The Shepherd's Center of Greater Winston-Salem
- Wake Forest Comprehensive Cancer Center
- WomanWise

Diabetes

- Area Agency on Aging
- Atrium Health
- Atrium Health Diabetes Program
- Atrium Health Mobile Medicine Unit
- Atrium Health Wake Forest Baptist Medical Center
- Brenner FIT
- Cancer Services
- Community Care Clinic
- Crisis Control
- Diabetes Education
- Diabetes Free NC
- Doctor's Offices

- Downtown Health Plaza
- Endocrinology/Diabetes Education
- Federally Qualified Health Centers
- Food Kitchens
- Forsyth County Health and Human Services
- Forsyth County Health Department
- Group Medical Visits
- Healthy Forsyth
- H.O.P.E./Help Our People Eat
- MedHelp - Helping Patients Afford Medications
- NC State Extension
- North Carolina Minority Diabetes Prevention Program
- Novant Health
- Novant Health Diabetes Management
- Novant Health Primary Care
- Pharmacies
- Population Health
- Public Health
- The Shalom Project
- United Health Centers
- WS/FCS Diabetes Care Management
- YMCA/YWCA

Disabling Conditions

- Atrium Health
- Atrium Health Eye Center
- Atrium Health Wake Forest Baptist Medical Center
- Crisis Control
- Daymark
- Department of Social Services
- Downtown Health Plaza
- Federally Qualified Health Centers
- Food Banks/Food Pantries
- Health Department
- Mental Health Association
- Novant Health
- Novant Health Pain Management
- Senior Services
- Sunnyside Ministry
- The Shepherd's Center of Greater Winston-Salem
- TROSA

Heart Disease & Stroke

- American Heart Association
- Atrium Health
- Atrium Health Wake Forest Baptist Medical Center
- Comprehensive Stroke Center
- Doctor's Offices
- Downtown Health Plaza
- Forsyth County Health Department
- Free Clinic
- Health Department
- Healthy Forsyth
- Heart Disease and Stroke Walks/Events
- H.O.P.E./Help Our People Eat
- Maya Angelou Center for Health Equity
- NCOA
- North Carolina Stroke Association
- Novant Health
- Novant Health Heart and Vascular
- Senior Services Williamson Adult Day Center
- WSSU
- YMCA/YWCA

Infant Health & Family Planning

- Atrium Health
- Atrium Health Wake Forest Baptist Medical Center
- Brenner Children's Hospital
- CenteringPregnancy
- Community Care Center
- Deacon Doulas
- Doctor's Offices
- Downtown Health Plaza
- Family Connect
- Family Planning Services
- Family Services
- Forsyth County Health Department
- Forsyth County/Guilford County
- Health Department
- Home Health Services
- Imprints Cares
- Infant Mortality Reduction Coalition
- Insurance Companies
- March of Dimes
- Novant Health
- Novant Health Family Medicine
- Nurse-Family Partnership
- One Love Strong Foundation
- Planned Parenthood
- Public Health

- The Parenting PATH Welcome Baby Program
- Today's Woman OB/GYN
- United Health Centers
- Wake Forest School of Medicine
- WIC

Injury & Violence

- Action4Equity
- Atrium Health
- Atrium Health Wake Forest Baptist Medical Center
- Bridges to Hope Family Justice Center of Forsyth County
- City/County Government
- Cure Violence
- Eliza's Helping Hands
- Episcopal Diocese of North Carolina
- Family Justice Center
- Family Services
- Family Services of Forsyth County
- FCEMS
- Forsyth County Health Department
- Forsyth County Sheriff's Office
- Forsyth WINS/CURE Violence
- Juvenile Crime Prevention Council
- Law Enforcement
- Mental Health Court
- My Brother's Keeper
- NCSHHS
- Our Opportunity to Love and Heal
- PTRC Criminal Justice Program
- We Heal Together
- Winston-Salem Police Department
- YMCA/YWCA

Mental Health

- Apogee
- Atrium Health
- Atrium Health Wake Forest Baptist Medical Center
- BEAR
- Behavioral Health Services
- Bethesda Center for the Homeless
- Black/Latino Mental Health Providers
- CareNET Counseling
- Catholic Charities
- Crisis Center
- Crossnore Communities for Children
- CTRC
- Daymark
- Doctor's Offices
- Downtown Health Plaza
- Family Services
- Family Services of Forsyth County
- Forsyth County Behavioral Health Services
- Forsyth County Health Department
- Forsyth Focused
- Green Tree Peer Center
- Health Systems
- Hospitals
- Insight
- Mental Health Association
- Mental Health Center
- Mobile Crisis
- Monarch
- Mood Treatment Center
- Novant Health
- Old Vineyard Behavioral Health Services
- Partners Health Management
- Private Counseling Practices
- Reset and Heal
- Salud Mental Health
- School System
- Strong Minds
- The Arc
- Therapeutic Day Program
- Trellis Supportive Care
- Wake Forest School of Medicine
- Youth Sports

Nutrition, Physical Activity, & Weight

- Atrium Health Wake Forest Baptist Medical Center
- Brenner FIT
- Catholic Charities
- Childcare Facilities
- City of Winston-Salem
- Doctor's Offices
- Downtown Health Plaza
- Forsyth County Department of Public Health
- Food Rx
- H.O.P.E./Help Our People Eat
- Hospitals
- Meals on Wheels
- NC State Extension
- New Communion

- Parks and Recreation
- Piedmont Wellness Alliance
- Public Health
- Second Harvest Food Bank
- Senior Services
- Silver Sneakers
- SNAP
- WIC
- YMCA/YWCA

Oral Health

- Cleveland Avenue Dental Center
- Community Care Clinic
- Doctor's Offices
- Forsyth Tech
- Rescue Mission
- United Health Centers
- University Dentist
- Winston Mission Dental Clinic
- Winston-Salem Rescue Mission

Sexual Health

- Forsyth County Health Department
- Health Department
- Planned Parenthood

Social Determinants of Health

- Action4Equity
- Affordable Housing Coalition
- Atrium Health Mobile Medicine Unit
- Atrium Health Wake Forest Baptist Medical Center
- Care Plus
- Center for Homeownership
- Churches
- City with Dwellings
- Clemmons Food Pantry
- Crisis Control
- Department of Social Services
- Duke
- Experiment in Self-Reliance
- Family Justice Center
- Family Services
- Food Banks/Food Pantries
- Food Rx
- Forsyth County
- Forsyth County Health and Human Services
- Forsyth County Health Department
- Forsyth Futures
- Forsyth Tech
- Freedom Schools
- Green Street Urban Farm
- Health Department
- H.O.P.E./Help Our People Eat
- Housing Authority
- Island CultureZ
- Medical Legal Partnership
- Metropolitan Village
- North Carolina Coalition on Aging
- Population Health
- Public Health
- Reading Warriors
- Samaritan Ministries Shelter
- School System
- Second Harvest Food Bank
- Senior Services
- Share Co-op
- Strong Minds
- The Shalom Project
- The Shepherd's Center of Greater Winston-Salem
- Trans-Aid Transportation
- Unity Health Center
- WIC
- Winston-Salem Mediation Services
- WS RISE

Substance Use

- AA/NA
- ARCA
- Atrium Health Dean Melton's Outpatient Program
- Atrium Health Wake Forest Baptist Medical Center
- Beacon Recovery
- Cognitive Behavioral Therapy
- Community Care Center
- Comprehensive Treatment Center
- Daymark
- Department of Psychiatry
- Doctor's Offices
- Downtown Health Plaza
- Forsyth County Opioid Settlement Funding
- H.O.P.E./Help Our People Eat
- Insight

- Mobile Integrated Healthcare
- Novant Health
- Peer Counseling
- Private Centers
- Rescue Mission
- TDC Substance Abuse Treatment
- The Freedom Center
- Twin City Harm Reduction Collective

Tobacco Use

- 1-800-Quitline
- Atrium Health Mobile Medicine Unit
- DEAC Clinic
- Pharmacies

Appendix

Evaluation of Past Activities

Health Priority: Access to Care

Strategy 1: Expand and enhance preventative care opportunities to underserved individuals experiencing health care barriers such as lack of insurance, transportation, disability, and other factors.

Specific Interventions	Collaborative Partners
1. Mobile Health Clinic ("MHC"), which provides primary care, preventive care, cancer screening, health coaching, and vaccines for flu and COVID-19 at no cost.	Forsyth County Health Department · Love Out Loud · YMCA COACH program · NC Association of Free and Charitable Clinics · NCDHHS Office of Rural Health · Novant Health Mobile Team · Minster's Conference of Winston Salem and Vicinity · Second Harvest Food Bank · New Communion Mobile Pantry · American Cancer Society · Alzheimer's Disease Research Center · St. John CME Church · Winston Lake YMCA · Iglesia Cristiana Sin Fronteras · Sprague Street Community Center · Carl Russell Community Center · St. Peter's Church and World Outreach Center

Result/impact:

The Mobile Health Clinic (MHC) continues to address the medical needs of people in the community. The program is a partnership between Atrium Health Wake Forest Baptist Community Health Alliance, several community-based organizations and faith communities. The MHC provides medical, nursing, nutrition, cancer screenings and health education services to both adults and teens who are uninsured in underserved communities. Adults and teens who do not have health insurance can receive a wide range of services, including preventive care, care for minor illnesses and management of chronic health conditions such as hypertension, diabetes and asthma. Health education, no-cost lab services and referrals to specialists are provided, if needed.

During the calendar year of 2022, 752 individual patients were served over 1,547 clinic visits. Only 19.4% of patients with a diabetes diagnosis had an unmanaged A1c of 9% or above. Out of the patients with a diagnosis of hypertension, 52.5% were able to control their blood pressure under 140/90. There were 211 patients who received colorectal cancer screenings with 186 FIT tests given, which identified that 14 were positive (10.7%). Twenty-two colonoscopies were completed (number includes patients screened with symptoms and did not need a FIT test). There were 76 mammogram referrals made with 54 mammograms completed. It is estimated that the average hospital emergency department diversion savings was $3,365,952 based on the NC average patient charge in 2020 (2021/2022 not published) for treat and release ED visit.

During the calendar year of 2023, 676 individual patients were served over 1,532 clinic visits. Only 37.2% of patients with a diabetes diagnosis had an unmanaged A1c of 9% or above. Out of the patients with a diagnosis of hypertension, 50.0% were able to control their blood pressure under 140/90 with the help of a registered dietitian and health coach who left the clinic halfway through 2023. There were 162 patients screened for colorectal cancer with 151 FIT tests given. Seventeen tests were positive (18.0%) and 14 colonoscopies completed (number includes patients screened with symptoms and did not need a FIT test). Sixty-seven mammogram referrals were made with 33 mammograms completed. Six patients were screened for lung cancer with the Lung Bus from Levine Cancer Center. The estimated average hospital emergency department diversion savings was $3,322,540 based on the NC average patient charge in 2021 (2022/2023 not published) for treat and release ED visit.

On June 26, 2024, the midyear mobile clinic review showed that 813 patient visits were completed across all four sites with only a 16% no show rate. The team worked with 81 volunteers including medical students, graduate and undergraduate students, interpreters, and Geriatric fellows who served 1,213 hours. There were 95 new patients seen who are defined as someone who has not had medical care in the last three years.

Strategy 2: Reduce transportation barriers through implementation for transportation navigation at Downtown Health Plaza.

Specific Interventions	Collaborative Partners
Provide transportation through cab service and bus passes Connect patients to transportation resources offered by health insurance and/or transportation services	Classic Cab Company · Winston Salem Transportation Authority

Results/Impact

This service continues to provide support to Downtown Health Plaza patients who have access to care barriers due to lack of transportation. Transportation options are shared with patients upon request or when they identify a transportation barrier when scheduling an appointment for a clinic visit or other health related appointment. During 2022, 581 patients were served through 934 cab trips, and 102 were served through 201 free bus vouchers.

Strategy 3: Support and expand partnership for federally qualified health clinics and free clinics

Specific Interventions	Collaborative Partners
Downtown Health Plaza (DHP) health clinics and support services Highland Avenue Primary Care (HAPC) primary care services	Novant Health · Forsyth County Govt

Results/Impact

Downtown Health Plaza (DHP) is a large primary care outpatient department in the Wake Forest Baptist Health system. DHP, through multiple clinics and support services, provides access to quality healthcare to the underserved community of Forsyth County, including the uninsured or underinsured, racial/ethnic minorities and Medicaid recipients.

During the calendar year of 2022 through 2024, the Downtown Health Plaza clinic served 52,884 patients, specifically covering the Adult Medicine, Pediatrics, Obstetrics and Gynecology populations. This clinic also provided free specialty clinic visits for 851 patients, which covers visits for dermatology, renal and neurology. Overall, 26,020 patients received preventative/routine care provided at no cost, including for vaccination and testing.

Health Priority: Social Impact and Justice

Strategy 1: Utilize AHWFB FaithHealth Connectors to serve as health advocates, navigators, and liaisons to community members for social services by getting individuals in need to the right door, at the right time

Specific Interventions	Collaborative Partners
Assisting underserved community members obtain access to resources for food/meals, clothing, medication, housing, primary care, health insurance, education and early childhood needs Increasing the number of partner congregations connected with community members	AHWFB CareNet Services · Hispanic League · Interfaith Alliance of Clemmons & Lewisville · Local Associations of the Baptist State Convention of NC · Local Associations of the General Baptist State Convention · Christ's Beloved Community · The Western Conference of The United Methodist Church · Love Out Loud · Minister's Conference of Winston-Salem & Vicinity · Mars Hill Baptist Church · Union Chapel Baptist Church · Morningstar Missionary Baptist Church · Disciples of Grace Ministries · Iglesia Cristiana Sin Fronteras

Results/Impact

FaithHealth Connectors continue to make an impact by offering hands-on caregiving in the community for social, emotional, and spiritual support. The Connectors provided 27,669 total caregiving encounters in 2022 in addressing needs including food insecurity, transportation, paperwork, light home repair, clothing, household goods, pet and lawn care, social and spiritual support, and financial and medication assistance. In 2023, they provided 12,014 total caregiving encounters in addressing these same needs. The FaithHealth Connectors not only rely on individual volunteers, but also the support of faith communities and congregations within their networks. During 2022, there were 553 partnering congregations in support of FaithHealth and the Connectors, and in 2023 there were over 571 partnering congregations.

Strategy 2: Collaborate with Maya Angelou Center for Health Equity to dismantle systemic inequity and support the health of communities through:

Specific Interventions	Collaborative Partners
Building and nurturing mutually beneficial and reciprocal relationships Respecting and honoring community as experts and equal partners; engaging, educating, and empowering communities Cultivating formal and informal leadership Creating a culture of transparency and fairness in research; and promoting advocacy and policy change. Key programs for collaboration are: The Caregivers College and Black Men's Health Initiative Congregational Health Ambassadors The Triad Pastoral Network (TPN)	Various African American congregations and clergy members · Historically Black Colleges and Universities (e.g. Winston-Salem State University, NC A&T State University)

Results/Impact

• In the first year of the program, 19 churches began to establish health ministries within their local churches.

•The first cohort of health ministries hosted at least 3 health promotion events for their local church, which raised awareness on the topics of: Heart Health, Cardiometabolic Health, Diabetes & Blood Glucose, Stress & Mental Health, and Alzheimer's Disease and Dementia.

•Each participating church in the cohort received equipment to establish a Health Monitoring Station to monitor congregants blood pressure and heart rate.

•The faith leaders and their respective churches participated in the 2022 and 2023 American Heart Association – Heart and Stroke Walk, raising over $10,000 in donations, with ~300 walkers registered, and many more walkers participating for 2022.

• Faith leaders and their congregants participated in a COVID awareness and vaccine hesitancy survey resulting in ~1400 study respondents who shared their views and perspectives on the virus and associated vaccine.

•Thirty churches are targeted for enrollment during the second year of the CHA program.

•Several current TPN members have shared the excitement of their experiences and benefits of being a Network member with fellow clergy/faith leaders, who have applied/are applying for membership in the TPN, and slated for participation in the CHA program in future years.

•With the current TPN membership, we approximate that >250,000 congregants have participated in health promotion events, including virtual town-halls and seminars, in-person and virtual health education sessions.

Strategy 3: Implement community resource hub in collaboration with Find Help

Specific Interventions	Collaborative Partners
Refer patients to FindHelp portal Create closed loop referrals for patients needed resources	Novant Health · Find Help · Community-based Organizations (100+)

Results/Impact

By way of providers, community health workers, discharge planners, social workers and other health system teammates; patients are connected to programs that improve outcomes through a closed loop referral pathway. The platform allows staff to assess and manage complex care, improve health outcomes, and build healthier communities. Care coordination is streamlined to provide access to resources and care not otherwise found. Over the last 36 months there have been 1,516 referrals made with the most referrals going to food assistance and emergency financial assistance. Looking toward the future, the teams are working to increase staffing to navigate referrals and incorporate referral pathways into the electronic health record.

Health Priority: Chronic and Emerging Disease

Strategy 1: Work with physicians or Advanced Practice Providers (APPs), and community organizations to improve care, prevention and management of diabetes

Specific Interventions	Collaborative Partners
Refer any known member of the community diagnosed with this disease to Gateway to Success program to get better management with their diabetes through lifestyle changes.	The YMCA of Winston Salem Forsyth County · Novant Health

The Gateway to Success is a strategic Alliance with Atrium Health Wake Forest Baptist, Novant Health and the YMCA of Winston Salem Forsyth County. The evidence-based program is an integrated care model for diabetes prevention and management for low-income participants diagnosed as pre-diabetic or with Type 2 diabetes.

This program served a total of 434 individuals. There was consistent improvement over a five-year period, with 70-80% maintained or improved A1c, BMI and overall health wellness score.

81% patients had maintained or improved A1c
68% patients had maintained or improved BMI
76% patients had maintained or improved wellness score

Finally, there was strong track record of physician referrals with over 600 patients utilizing public transportation to the YMCA wellness center.

Strategy 2: Improve community approaches to childhood obesity

Specific Interventions	Collaborative Partners
Obtain research projects focused on obesity and community engagement Focus on numbers of participants in virtual, family-based weight management programming	YMCA of Northwest North Carolina · American Heart Association · Imprints Cares, Parenting Path

Results/Impact

BrennerFIT is a comprehensive program continuing to focus on the care of children with weight and associated health concerns and their families. It strives to meet families where they are with a focus on inclusivity of culture and language. It has a dedicated Spanish-speaking team, Brenner FIT En Espanol. Most children see improvements in weight status, regardless of background, and most families see improvements in key health behaviors. During 2023, the cooking classes in Brenner FIT Teaching Kitchen had 61 classes with 585 participants. Also, the activity classes at Amos Cottage and other locations had 16 classes with 182 participants. In addition, the Brenner FIT Academy for Families online course held three 8-week sessions with 47 participants. Furthermore, the free Brenner Fit Academy for Professionals CME course had one session with 20 participants. Finally, the Brenner FIT Clinic had 2,669 total arrived visits.

Strategy 3: Manage indigent community members with chronic conditions by deploying care management resources through Wake Health Connect, a program created to provide free healthcare coverage (not insurance) for patients who meet set requirements

Specific Interventions	Collaborative Partners
Identify and enroll community members who meet requirements: Meet the Wake Forest Baptist Health financial assistance requirements Have no private or government issued medial insurance Have had more than 3 ED visits in the past six months, and Two or more chronic conditions. Schedule PCP visits to establish ongoing source of care. Connect patients with social service resources	MedCost OptumRX Classic Cba Company Population Health Ambulatory Team

Results/Impact

WakeHealth Connect is an Atrium Health Wake Forest Baptist managed care program established in 2017. This program was created to increase access to primary care, enhance coordinated care practices, reduce improper ED

utilization, and assist in connecting patients with social service resources. WakeHealth Connect is designed to establish a usual source of care and improve patients' health by enhancing coordinated care practices among primary care providers, nurse navigators, and patients. This design allows for improved continuity of care, builds positive provider-patient rapport, and fosters self-efficacy in patients to take responsibility for their health. By providing coverage (NOT INSURANCE!) for primary care services, at no cost to the patient, WakeHealth Connect reduces the overall cost of care by supporting patients proper use of Wake Forest Baptist Health's services.

Between January 2023 and February 2024, Wake Health Connect served 130 patients. There were 10 patients who gained alternative coverage (Medicaid, private insurance). The outcomes associated with the program included lowering unnecessary ED visits, increasing engagement with primary care providers in lower cost settings, and increasing patient satisfaction with the health system.

Strategy 4: Collaborate with the Office of Cancer Health Equity's commitment to educate the public about cancer

Specific Interventions	Collaborative Partners
free community engagement and education events tobacco education and cessation	NC Division of Public Health – Cancer Prevention and Control Branch · Forsyth County Department of Public Health

Results/Impact

The Office of Cancer Health Equity's (OCHE) mission is the advance community engagement, clinical care and research focused on improving outcomes for everyone in our communities. The OCHE offers health fairs, cancer education sessions, staff/faculty training, research support, and cancer clinical trials. In 2023, the Office of Cancer Health Equity provided community outreach at 784 events where 46,611 people were served. It provided 3,576 screenings where 35 cancer diagnoses were identified. There were 854 people who received navigation through screening, including 587 patients.

Health Priority: Maternal and Child Health

Strategy 1: Ensure all newborns discharged have a place that they can sleep safely at home.

Specific Interventions	Collaborative Partners
Identify discharged newborns that do not have a safe place to sleep Provide pack-n-play units to at risk families	Cribs for Kids

Results/Impact

Pack-N-Plays were provided to 152 families across the birth centers since October 2020. The peak need was 90 in 2021 during the COVID-19 pandemic, and in 2023 it was 33. Evaluation of the home addresses for these families confirms that the pack-n-plays are going to neighborhoods of high need. Approximately half speak Spanish and the majority self-report being Hispanic, Black, or multiracial.

Strategy 2: Ensure children in the community have proper protection and safety while traveling in vehicles

Specific Interventions	Collaborative Partners
Distribute car seats to families with children	

Results/Impact
The data for this strategy was not available by the time of publication

Strategy 3: Increase availability of pre and postnatal care services, especially with high-risk populations, through support programs including the Nurse Education and Support Teams (NEST)	
Specific Interventions Increase postpartum women's access to community resources and services Provide detailed nurse assessments during a potentially high health risk period, approximately 2-3 weeks after delivery Facilitate linkage to the health system for management of care for postpartum women and infants	**Collaborative Partners** Departments of obstetrics and Gynecology and pediatrics, Department of Epidemiology and Prevention Forsyth county Health Department Shalom Project Smart Start Inprints Cares
Results/Impact The NEST is a home visiting program designed to meet the needs of all women residing in Forsyth County, NC that receive postpartum care at The Birth Center. Information and/or referrals for local services and resources are provided within the first few days after delivery by a NEST Coordinator. Then, an assessment, either in person, in the home, by video, or by phone, is completed by a NEST Nurse within the first 2-3 weeks postpartum. The nurse evaluates and addresses acute postpartum issues and provides education and support for postpartum women and their families. Lastly, a follow-up phone call is made by one of our NEST Coordinators about 6 weeks after delivery to determine the utilization of, or need for, additional services, resources, and/or referrals. The number of postpartum women residing in Forsyth County scheduled to have a nurse home visit 2-3dow weeks after delivery was 1,128 include home and telehealth visits (81% of deliveries). The number of scheduled/completed 2-3 weeks postpartum nurse visits completed: 901 (including telehealth and phone encounters (79.9%). The number of follow-up calls at 6 weeks post-partum: 934 (82.8% of those scheduled a visit)	

Strategy 4: Connect youth to primary medical and mental health providers	
Specific Interventions Utilize the mobile health clinic Conduct medical and mental health screenings	**Collaborative Partners** School Health Alliance · Winston-Salem Forsyth County School System · Forsyth County Health Department · The Salvation Army · Love Out Loud · WSSU RAMS clinic
Results/Impact During Fiscal Year 2022-23, the SHA treated 1,624 students with a total of 5,192 encounters conducted. SHA also administered universal risk assessments at a local high school to 293 additional students, for a combined total of 1,917 students served. SHA staff performed 12,023 procedures for the year; of these, 29% were Medical procedures, 26% Mental/ Behavioral Health, 45% Preventive (e.g., well-child visits, risk assessments), and 0.02% Nutrition (most nutrition counseling occurred within the context of a preventive well-child visit)**.** The preventive procedures included 1,414 vaccinations to students. The overall racial composition of students consisted of 37.2% African American, 41.0% white (although 2/3 of these identified as Hispanic), 2.4% Asian, 1.1% American Indian/ Alaskan Native, 0.4% Native Hawaiian/ Other Pacific Islander, and 18.0% Other/ Unknown (of which 89% identified as Hispanic). Overall ethnic composition consisted of 52% Not Hispanic and 48% Hispanic. Insurance coverage of students seen in the SHA school-based health centers and other programs consisted of 51% uninsured, 40% Medicaid, 8% private insurance, and 1% other government (e.g., Medicare, TRICARE).	

Health Priority: Mental Health and Poly-Substance Use

Strategy 1: Assist homeless adults with exiting homelessness through access to mental health and/or substance abuse services, other health care services, housing opportunities, employment assistance, disability assistance.

Specific Interventions	Collaborative Partners
Enroll patients in case management services	United Way's Continuum of Care · City with Dwellings · Samaritan Ministries · Bethesda Center for the Homeless · Experiment in Self Reliance (ESR) · Salvation Army

Results/Impact

This program was discontinued due to funding no longer being provided by community partners, including the mental health Local Management Entity (LME), to support the full-time positions that provided case management services. In addition, the health system maintained these positions prior to 2022 through operational funds budgeted within the FaithHealth Division; however, cuts to operational budgets prevented the continuation of these funded positions.

Strategy 2: Collaborate with CareNet

Specific Interventions	Collaborative Partners
Provide community-based, outpatient behavioral health across the total AHWFB service area and beyond	CareNet local boards · Screening for Mental Health (nonprofit organization) · Various civic, religious, and professional groups

Results/Impact

Total hours of care provided in Forsyth County:

2022 = 6940

2023 = 6656

Total= 13,596

The decrease in hours in 2023 is due to a decrease in the number of clinicians working for CareNet in Forsyth county. There is an additional impact upon access to behavioral health provided through CareNet through the philanthropic efforts of the local CareNet boards of directors in Forsyth County. These boards raised $16,238 in 2022 which provided financial support for 28 uninsured/underinsured clients and $27,634 in 2023 and assisted 41 uninsured/underinsured clients. The total number of uninsured/underinsured clients served for the two-year period was 69 and the total amount of care provided for the uninsured and underinsured is $43,872. The increase in the number of uninsured/underinsured clients from 2022 to 2023 is 46% in Forsyth County. This percentage increase in uninsured/underinsured clients served demonstrates fulfillment of the goal to increase access to behavioral health services for the target population during the specific period covered by the CHNA.

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