2024 Community Health Needs Assessment

Floyd, Polk & Chattooga Counties, Georgia

Cherokee County, Alabama

Sponsored by

Atrium Health

Atrium Health Floyd Cherokee Medical Center

2024-0187-02

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 Floyd, Polk, and Chattooga counties in Georgia and in Cherokee County in Alabama. These four counties represent the service area of Atrium Health Floyd Cherokee 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 Atrium Health Floyd Cherokee 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.

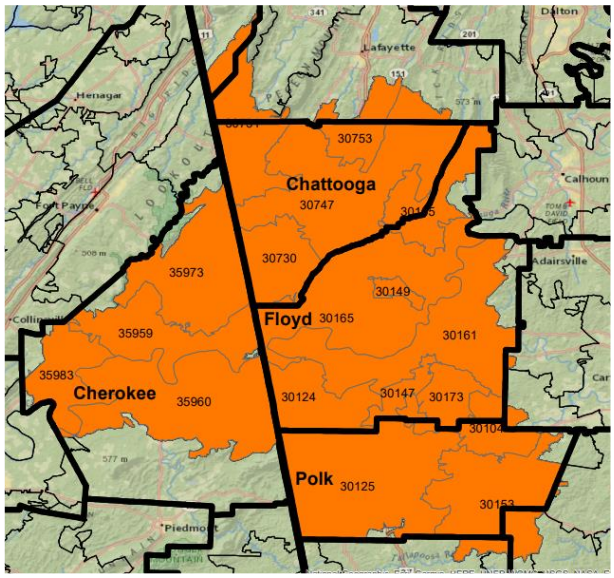
PRC Community Health Survey

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 (referred to as the "Total Service Area" in this report) included each of the ZIP Codes comprising Floyd, Polk, and Chattooga counties in Georgia and Cherokee County in Alabama, 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 surveys conducted via telephone (landline and cell phone), as well as through online questionnaires.

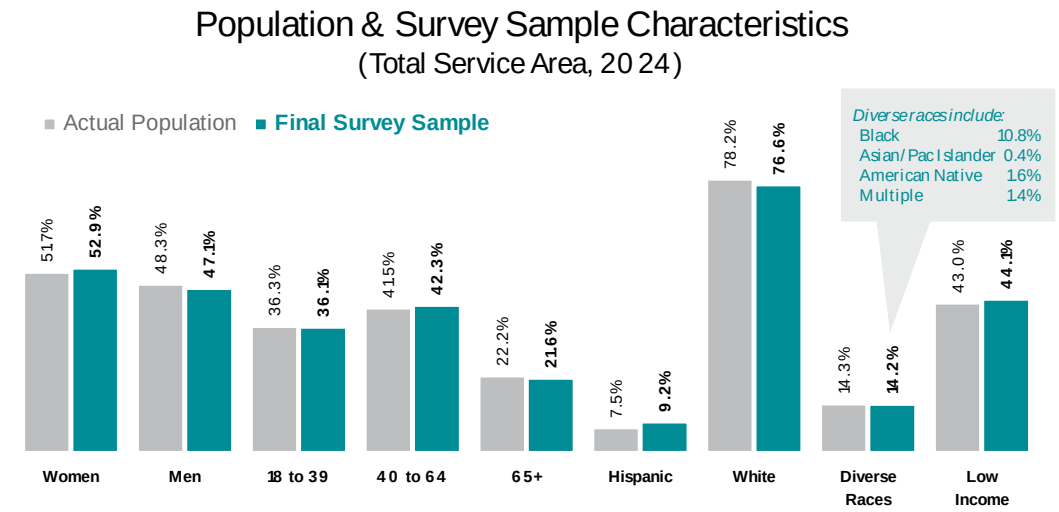
The sample design used for this effort consisted of a random sample of 400 individuals age 18 and older in the Total Service Area. Once the interviews were completed, these were weighted in proportion to the actual population distribution so as to appropriately represent the Total Service Area as a whole. 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 400 respondents is ±4.9% 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 Total Service Area 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 Floyd Cherokee 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, 30 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
Public Health Representatives	1
Other Health Providers	3
Social Services Providers	11
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.

- 100 Black Men of Rome
- Boys & Girls Clubs of Northwest Georgia
- Chattooga County Commission
- Cherokee County Emergency Management
- Cherokee County Hospital Authority
- City of Cedartown
- City of Rockmart
- City of Rome Police Department
- Davies Homeless Shelters
- Department of Public Health – Northwest Georgia
- Development Authority of Polk County
- Floyd County Sheriff's Office
- Helping Hands Ending Hunger, Inc.
- Lakeside Primary Care
- Northwest Georgia Hunger Ministries
- Northwest Georgia Regional Cancer Coalition
- Polk County Chamber of Commerce
- Polk County Sheriff's Office
- Polk Family Connection
- Polk School District
- RHA Health Services
- Rome City Schools
- Rome Floyd Chamber
- Rome-Floyd County Commission on Children and Youth
- YMCA of Rome & Floyd County

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 the Total Service Area 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

Georgia & Alabama 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.

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 Floyd Cherokee Medical Center made the prior Community Health Needs Assessment (CHNA) report publicly available on its website; through that mechanism, they requested from the public written comments and feedback regarding the CHNA and implementation strategy. At the time of this writing, Atrium Health Floyd Cherokee 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 Floyd Cherokee 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	27
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	114
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)	119

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	
Access To Health Care Services	▪ Lack of Health Insurance ▪ Barriers to Access – Cost of Physician Visits ▪ Lack of Financial Resilience ▪ Routine Medical Care (Adults)
Cancer	▪ Leading Cause of Death ▪ Cancer Deaths ▪ Cervical Cancer Screening
Diabetes	▪ Diabetes Prevalence ▪ Kidney Disease Deaths
Disabling Conditions	▪ Multiple Chronic Conditions ▪ Activity Limitations ▪ High-Impact Chronic Pain ▪ Alzheimer's Disease Deaths ▪ Caregiving
Heart Disease & Stroke	▪ Leading Cause of Death ▪ Heart Disease Deaths ▪ Heart Disease Prevalence ▪ Stroke Deaths ▪ High Blood Pressure Prevalence ▪ High Blood Cholesterol Prevalence

— *continued on the following page* —

Areas of Opportunity (continued)	
Injury & Violence	▪ Unintentional Injury Deaths – Including Motor Vehicle Crash Deaths ▪ Homicide Deaths ▪ Intimate Partner Violence
Mental Health	▪ Diagnosed Depression ▪ Suicide Deaths ▪ Receiving Treatment for Mental Health ▪ Key Informants: *Mental Health* ranked as a top concern.
Nutrition, Physical Activity & Weight	▪ Difficulty Accessing Fresh Produce ▪ Leisure-Time Physical Activity ▪ Meeting Physical Activity Guidelines ▪ Overweight & Obesity ▪ Key Informants: *Nutrition, Physical Activity & Weight* ranked as a top concern.
Oral Health	▪ Dental Insurance Coverage ▪ Regular Dental Care [Adults]
Respiratory Disease	▪ Lung Disease Deaths ▪ Pneumonia/Influenza Deaths ▪ Asthma Prevalence [Adults & Children] ▪ Chronic Obstructive Pulmonary Disease (COPD) Prevalence
Substance Use	▪ Drug Overdose Deaths ▪ Use of Prescription Opioids ▪ Key Informants: *Substance Use* ranked as a top concern.

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. Substance Use
2. Mental Health
3. Nutrition, Physical Activity & Weight
4. Diabetes
5. Cancer
6. Heart Disease & Stroke
7. Oral Health
8. Disabling Conditions
9. Access to Health Care Services
10. Injury & Violence
11. Respiratory Disease

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 Floyd Cherokee 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 hospitals 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 hospitals' action plan to guide community health improvement efforts in the coming years.

Note: An evaluation of the hospitals' 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, Total Service Area results are shown in the larger, teal column.

■ The columns to the right of the Total Service Area column provide comparisons between local data and any available state and national findings, and Healthy People 2030 objectives. Symbols indicate whether the Total Service Area 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	Total Service Area	Total Service Area vs. Benchmarks			
		vs. GA	vs. AL	vs. US	vs. HP2030
Population in Poverty (Percent)	14.5	12.7	16.2	12.6	h 8.0
High School Graduates (Age 25+, Percent)	85.4	89.5	88.8	89.6	
Unemployment Rate (Age 16+, Percent)	3.3	B 4.2	B 4.3	B 4.3	
% Unable to Pay Cash for a $400 Emergency Expense	40.3			h 34.0	
% Worry/Stress Over Rent/Mortgage in Past Year	37.3			B 45.8	
% Unhealthy/Unsafe Housing Conditions	19.4			16.4	
% Went Without Utilities in the Past Year	13.1				
Population With Low Food Access (Percent)	44.6	B 56.6	44.6	50.2	
% Food Insecure	45.4			43.3	
			B better	similar	h worse

Total Service Area vs. Benchmarks

Overall Health	Total Service Area	vs. GA	vs. AL	vs. US	vs. HP2030
% "Fair/Poor" Overall Health	23.2	h 18.5	☁ 23.2	h 15.7	
			B better	☁ similar	h worse

Access to Health Care	Total Service Area	Total Service Area vs. Benchmarks			
		vs. GA	vs. AL	vs. US	vs. HP2030
% [Age 18-64] Lack Health Insurance	15.8	☁ 15.9	☁ 12.8	h 8.1	h 7.6
% Difficulty Accessing Health Care in Past Year (Composite)	46.8			☁ 52.5	
% Cost Prevented Physician Visit in Past Year	23.2	h 14.9	h 14.2	☁ 21.6	
% Cost Prevented Getting Prescription in Past Year	24.8			☁ 20.2	
% Difficulty Getting Appointment in Past Year	22.1			B 33.4	
% Inconvenient Hrs Prevented Dr Visit in Past Year	15.1			B 22.9	
% Difficulty Finding Physician in Past Year	17.7			☁	

				22.0	
% Transportation Hindered Dr Visit in Past Year	12.8			B 18.3	
% Language/Culture Prevented Care in Past Year	3.0			5.0	
% Stretched Prescription to Save Cost in Past Year	18.6			19.4	
% Difficulty Getting Child's Health Care in Past Year	13.2			11.1	
% Have a Specific Source of Ongoing Care	66.8			69.9	h 84.0
% Routine Checkup in Past Year	69.3	h 74.5	h 79.0	65.3	
% [Child 0-17] Routine Checkup in Past Year	81.6			77.5	
% Two or More ER Visits in Past Year	19.6			15.6	
% Rate Local Health Care "Fair/Poor"	12.3			11.5	
			B		h
			better	similar	worse

Cancer	Total Service Area	Total Service Area vs. Benchmarks			
		vs. GA	vs. AL	vs. US	vs. HP2030
Cancer Deaths per 100,000 (Age-Adjusted)	183.4	h 153.1	167.3	h 149.4	h 122.7

% Cancer	10.1	10.8	B 13.9	7.4	
% [Women 50-74] Breast Cancer Screening	79.4	76.3	76.4	B 64.0	80.5
% [Women 21-65] Cervical Cancer Screening	66.3			h 75.4	h 84.3
% [Age 50-75] Colorectal Cancer Screening	78.7	B 69.3	B 71.1	71.5	74.4
			B better	similar	h worse

Diabetes	Total Service Area	Total Service Area vs. Benchmarks			
		vs. GA	vs. AL	vs. US	vs. HP2030
Diabetes Deaths per 100,000 (Age-Adjusted)	19.7	21.8	20.5	22.1	
% Diabetes/High Blood Sugar	17.3	h 12.1	15.5	h 12.8	
% Borderline/Pre-Diabetes	14.0			15.0	
Kidney Disease Deaths per 100,000 (Age-Adjusted)	22.3	h 18.4	h 16.9	h 12.9	
			B better	similar	h worse

Disabling Conditions	Total Service Area	Total Service Area vs. Benchmarks			
		vs. GA	vs. AL	vs. US	vs. HP2030
% 3+ Chronic Conditions	48.8			h 38.0	
% Activity Limitations	35.6			h 27.5	
% High-Impact Chronic Pain	28.3			h 19.6	h 6.4
Alzheimer's Disease Deaths per 100,000 (Age-Adjusted)	61.4	h 45.0	h 46.2	h 30.8	
% Caregiver to a Friend/Family Member	31.4			h 22.8	
			B better	similar	h worse

Heart Disease & Stroke	Total Service Area	Total Service Area vs. Benchmarks			
		vs. GA	vs. AL	vs. US	vs. HP2030
Heart Disease Deaths per 100,000 (Age-Adjusted)	268.8	h 183.7	similar 237.5	h 168.2	h 127.4

% Heart Disease	12.8	h 6.3	☁ 9.7	☁ 10.3	
Stroke Deaths per 100,000 (Age-Adjusted)	45.2	☁ 43.2	☁ 51.8	h 37.6	h 33.4
% Stroke	5.0	☁ 4.0	☁ 5.3	☁ 5.4	
% High Blood Pressure	49.1	h 36.6	h 42.7	h 40.4	h 42.6
% High Cholesterol	39.8			h 32.4	
% 1+ Cardiovascular Risk Factor	90.1			☁ 87.8	
			B better	☁ similar	h worse

Infant Health & Family Planning	Total Service Area	Total Service Area vs. Benchmarks			
		vs. GA	vs. AL	vs. US	vs. HP2030
% (W18-50 With Past Pregnancy) Experienced Complications	50.4				
% (W18-50 With Past Pregnancy) 1+ Pregnancy Did Not Result in Live Birth	46.3				
Low Birthweight (Percent of Births)	9.0	☁ 10.2	B 10.6	☁ 8.4	
			B better	☁ similar	h worse

Injury & Violence	Total Service Area	Total Service Area vs. Benchmarks			
		vs. GA	vs. AL	vs. US	vs. HP2030
Unintentional Injury Deaths per 100,000 (Age-Adjusted)	65.1	h 46.3	 56.6	h 52.4	h 43.2
Motor Vehicle Crash Deaths per 100,000 (Age-Adjusted)	22.1	h 14.5	 20.7	h 11.5	h 10.1
Homicide Deaths per 100,000 (Age-Adjusted)	7.6	 8.4	B 12.8	h 6.4	h 5.5
Violent Crimes per 100,000	367.7	 367.0	 409.1	 380.7	
% Victim of Violent Crime in Past 5 Years	7.0			 7.0	
% Victim of Intimate Partner Violence	27.5			h 20.3	
			B better	 similar	h worse

Mental Health	Total Service Area	Total Service Area vs. Benchmarks			
		vs. GA	vs. AL	vs. US	vs. HP2030

% "Fair/Poor" Mental Health	**26.6**			24.4	
% Diagnosed Depression	**37.5**	h 19.2	h 24.0	h 30.8	
% Symptoms of Chronic Depression	**50.2**			46.7	
% Typical Day Is "Extremely/Very" Stressful	**22.5**			21.1	
Suicide Deaths per 100,000 (Age-Adjusted)	**20.4**	h 14.0	h 16.2	h 13.8	h 12.8
% Receiving Mental Health Treatment	**29.5**			h 21.9	
% Unable to Get Mental Health Services in Past Year	**14.3**			13.2	
			B better	similar	h worse

Nutrition, Physical Activity & Weight	**Total Service Area**	Total Service Area vs. Benchmarks			
		vs. GA	**vs. AL**	**vs. US**	**vs. HP2030**
% "Very/Somewhat" Difficult to Buy Fresh Produce	**35.9**			h 30.0	
% No Leisure-Time Physical Activity	**36.8**	h 23.8	h 29.1	h 30.2	h 21.8
% Meet Physical Activity Guidelines	**21.5**	24.1	17.6	h 30.3	h 29.7

% [Child 2-17] Physically Active 1+ Hours per Day	**44.5**			B 27.4	
% Overweight (BMI 25+)	**69.9**	☁ 68.9	☁ 72.0	h 63.3	
% Obese (BMI 30+)	**41.4**	☁ 37.0	☁ 38.3	h 33.9	h 36.0

Nutrition, Physical Activity & Weight (continued)	**Total Service Area**	Total Service Area vs. Benchmarks			
		vs. GA	**vs. AL**	**vs. US**	**vs. HP2030**
% [Child 5-17] Overweight (85th Percentile)	**46.2**			h 31.8	
% [Child 5-17] Obese (95th Percentile)	**26.2**			☁ 19.5	h 15.5
			B better	☁ similar	h worse

Oral Health	**Total Service Area**	Total Service Area vs. Benchmarks			
		vs. GA	**vs. AL**	**vs. US**	**vs. HP2030**
% Have Dental Insurance	**63.3**			h 72.7	h 75.0
% Dental Visit in Past Year	**44.7**	h 59.9	h 58.2	h 56.5	☁ 45.0
% [Child 2-17] Dental Visit in Past Year	**73.8**			☁ 77.8	B 45.0

B		h
better	similar	worse

Respiratory Disease	Total Service Area	Total Service Area vs. Benchmarks			
		vs. GA	vs. AL	vs. US	vs. HP2030
Lung Disease Deaths per 100,000 (Age-Adjusted)	65.6	h 45.5	56.8	h 40.2	
Pneumonia/Influenza Deaths per 100,000 (Age-Adjusted)	19.1	h 13.6	18.6	h 13.6	
% Asthma	17.6	h 9.6	h 9.6	17.9	
% [Child 0-17] Asthma	28.3			h 16.7	
% COPD (Lung Disease)	13.1	h 7.1	h 9.4	11.0	

B		h
better	similar	worse

Sexual Health	Total Service Area	Total Service Area vs. Benchmarks			
		vs. GA	vs. AL	vs. US	vs. HP2030
Chlamydia Incidence per 100,000	373.9	B 629.1	B 625.2	B 495.5	
Gonorrhea Incidence per 100,000	158.6	158.6	B 296.3	B 214.0	

B		h

better similar worse

Substance Use	Total Service Area	Total Service Area vs. Benchmarks			
		vs. GA	vs. AL	vs. US	vs. HP2030
Alcohol-Induced Deaths per 100,000 (Age-Adjusted)	8.8	8.0	7.7	B 10.5	
% Excessive Drinking	14.9	15.7	14.1	B 34.3	
Drug Overdose Deaths per 100,000 (Age-Adjusted)	20.0	h 14.5	17.9	22.4	
% Used an Illicit Drug in Past Month	9.2			8.4	
% Used a Prescription Opioid in Past Year	21.2			h 15.1	
% Ever Sought Help for Alcohol or Drug Problem	9.5			6.8	
% Personally Impacted by Substance Use	45.0			45.4	

B better · similar · h worse

Tobacco Use	Total Service Area	Total Service Area vs. Benchmarks			
		vs. GA	vs. AL	vs. US	vs. HP2030
% Smoke Cigarettes	22.8	h 12.5	h 15.6	☁ 23.9	h 6.1
% Someone Smokes at Home	22.0			☁ 17.7	
% Use Vaping Products	20.2	h 7.7	h 10.4	☁ 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.

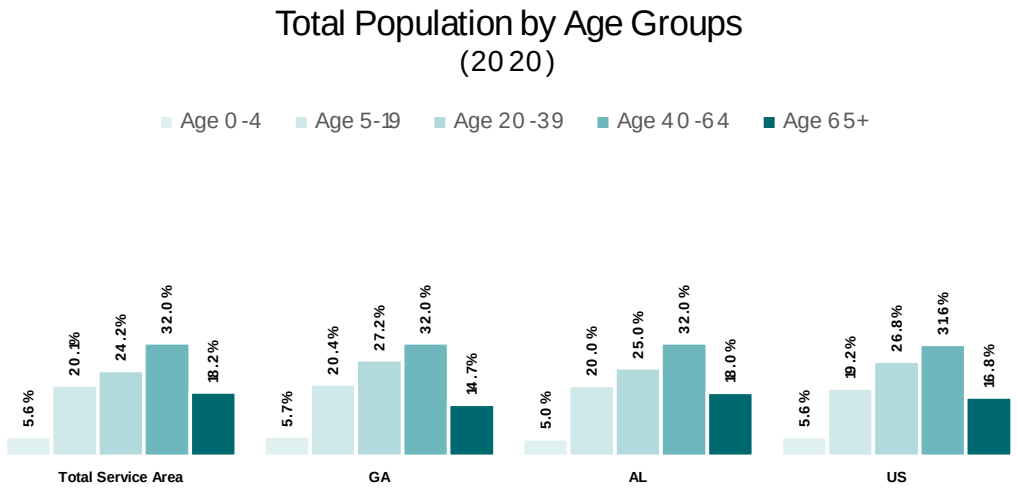
Total Population
(Estimated Population, 2018-2022)

	Total Population	Population Density (per square mile)
Total Service Area	**191,531**	**113.53**
Georgia	10,722,325	185.77
Alabama	5,028,092	99.28
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.



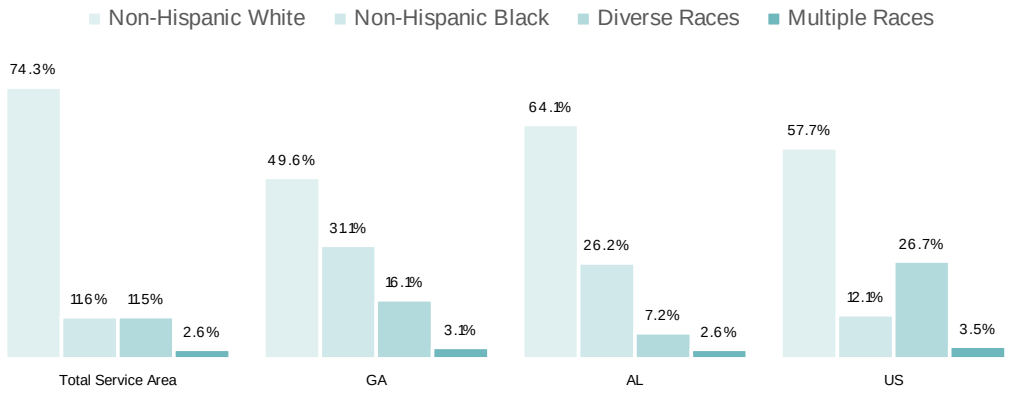
Sources: • American Community Survey (ACS), U.S. Census Bureau. Retrieved May 2024 via Metopio.

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.

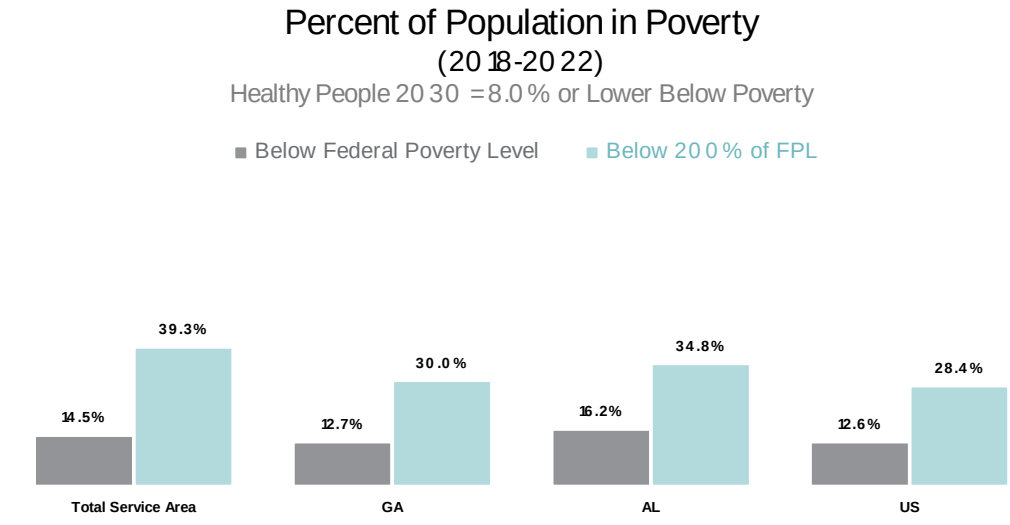
– Healthy People 2030 (https://health.gov/healthypeople)

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.

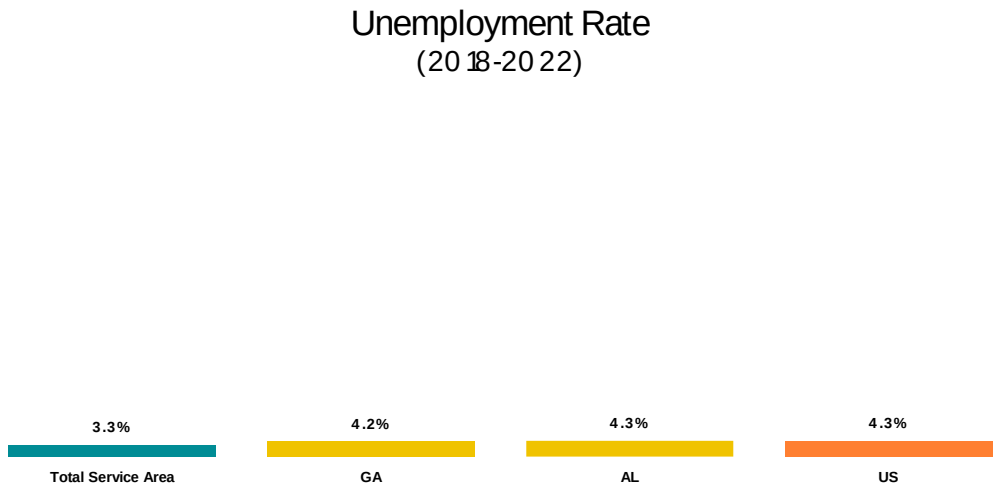


Sources:
- American Community Survey (ACS), U.S. Census Bureau. Retrieved May 2024 via Metopio.
- US Department of Health and Human Services. Healthy People 2030. https://health.gov/healthypeople.

Notes:
- National percentages are 2022 data.

Employment

The following outlines the unemployment rate in the Total Service Area during 2018-2022 in comparison to state and national unemployment.



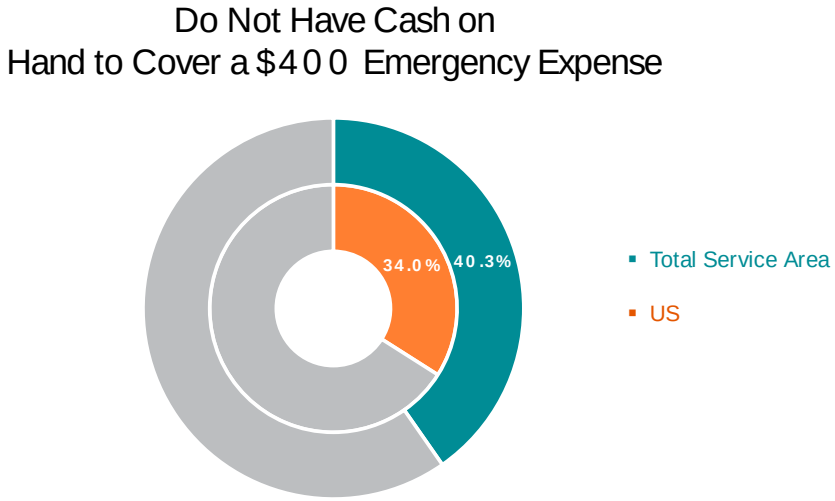
Sources:
- American Community Survey (ACS), U.S. Census Bureau. Retrieved May 2024 via Metopio.

Notes:
- Percent of residents 16 and older in the civilian labor force who are actively seeking employment.
- 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?"

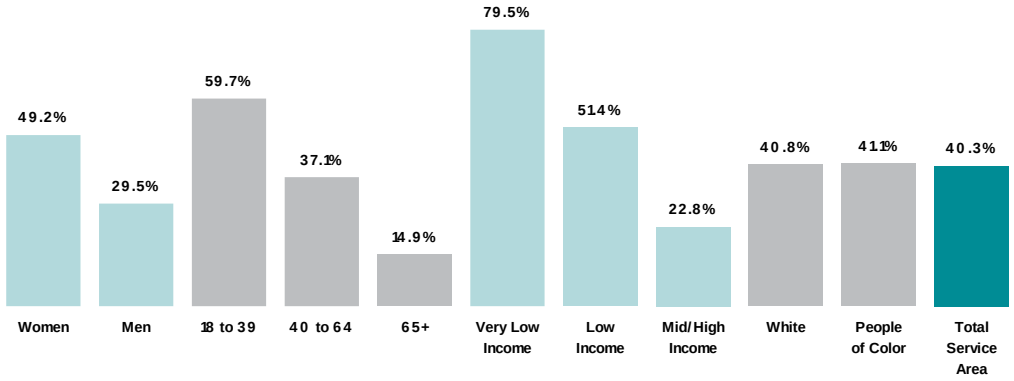
The following charts detail "no" responses in the Total Service Area in comparison to benchmark data, as well as by basic demographic characteristics (such as gender, age groupings, income [based on poverty status], and race/ethnicity).



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.

Do Not Have Cash on Hand to Cover a $400 Emergency Expense
(Total Service Area, 2024)



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

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.

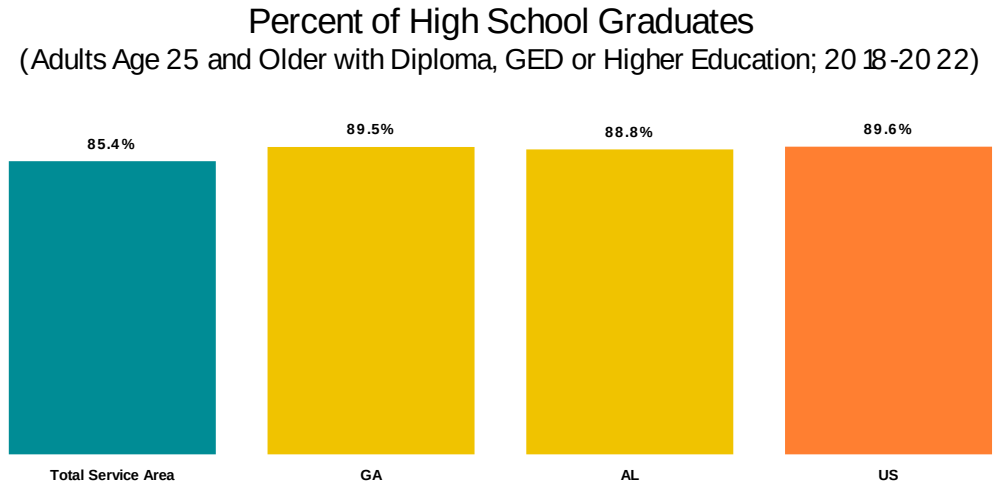
Income & Race/Ethnicity

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. All Hispanic respondents are grouped, regardless of identity with any other race group. Data are also detailed for individuals identifying with a race category, without Hispanic origin. "White" reflects those who identify as White alone, without Hispanic origin. "People of Color" includes those who identify as Hispanic, Black or African American, American Indian or Alaska Native, Asian, Native Hawaiian/ Pacific Islander, or as being of multiple races, without Hispanic origin.

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.



Sources: • American Community Survey (ACS), U.S. Census Bureau. Retrieved May 2024 via Metopio.
Notes: • National percentage is 2022 data.

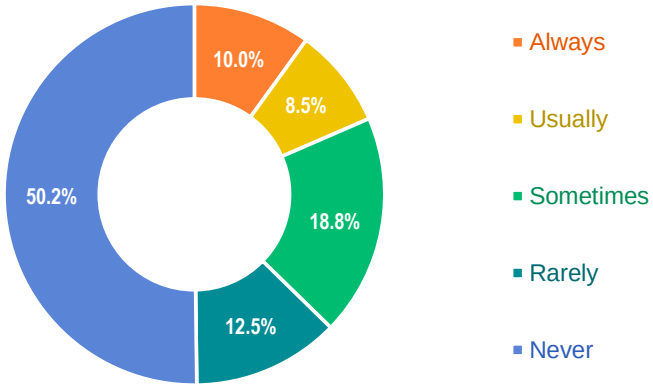
Housing

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
(Total Service Area, 2024)

Nationally, 45.8% of Americans "always," "usually," or "sometimes" worry about housing costs.



Sources:
- 2024 PRC Community Health Survey, PRC, Inc. [Item 56]
- 2023 PRC National Health Survey, PRC, Inc.

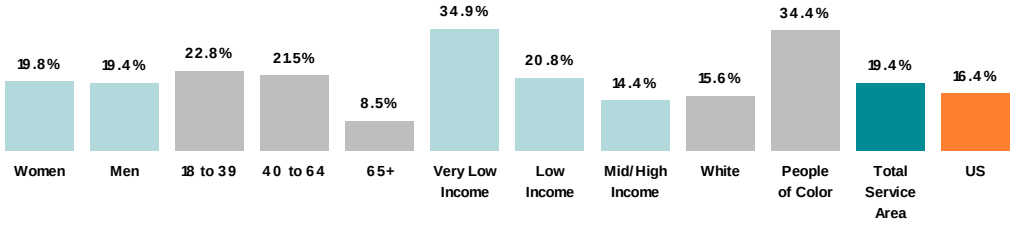
Notes:
- Asked of all respondents.

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
(Total Service Area, 2024)

Among homeowners	15.0%
Among renters	27.4%



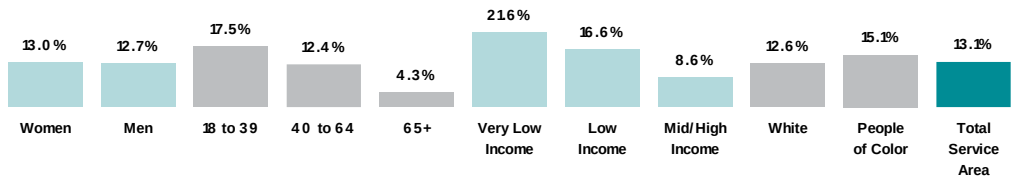
Sources:
- 2024 PRC Community Health Survey, PRC, Inc. [Item 55]
- 2023 PRC National Health Survey, PRC, Inc.

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
(Total Service Area, 2024)



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

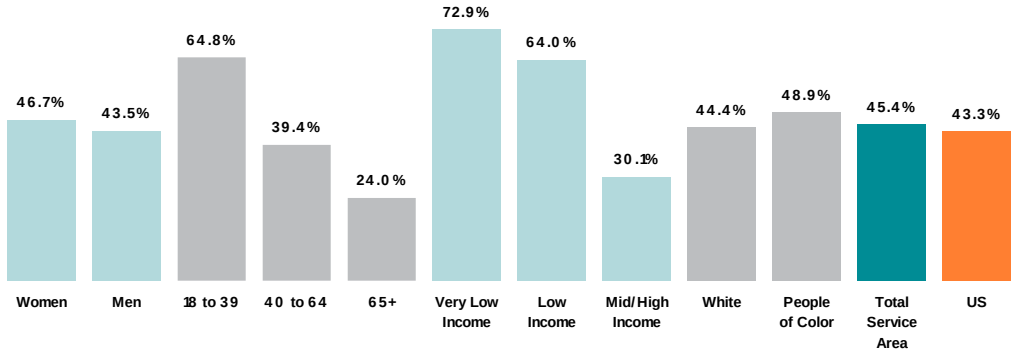
Food Insecurity

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.

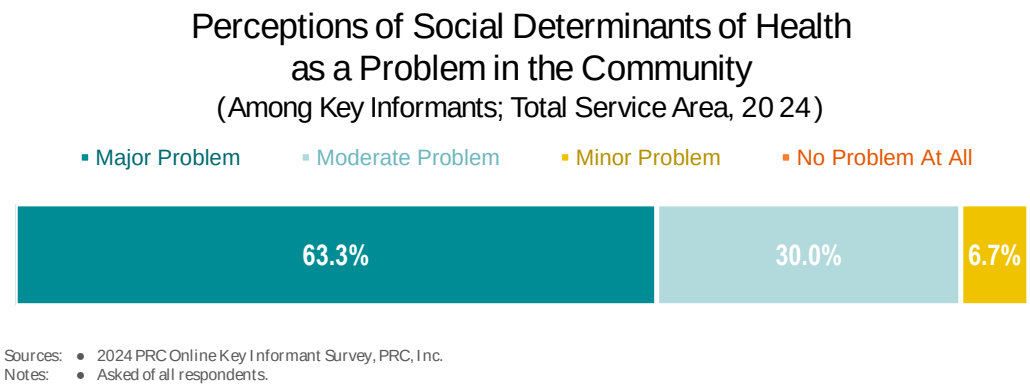
Food Insecurity
(Total Service Area, 2024)



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

> Low affordable housing. – Community Leader
>
> There is a lack of affordable housing for individuals making less than $50,000 a year. Housing that is available for this price range is unsanitary or in high-crime areas. There are barriers to individuals obtaining housing, e.g. previous evictions and criminal background. While some of these are in place to protect landlords, the barriers unfairly penalize individuals who may have made mistakes in the past but are attempting to get on their feet and do the right thing. There is a need for transitional housing to help individuals moving out of homelessness or shelter care get on their feet. – Social Service Provider
>
> Oftentimes, social determinants enable health problems to emerge. Example: Unstable housing results in inconsistent resources, creates a survival mode that neglects all health concerns and causes more, and results in learned helplessness. Income usually decides whether or not someone might make an effort to seek health care, the quality or frequency of care, and usually results in reactive care instead of preventative care. Education limitations can result in lower opportunities to afford/seek health care, all the while not being able to afford/seek health care often results in even more detrimental impacts to educational opportunities. The environment, whether it be externalities (pollution, water quality, land contamination) or physical (distance to nearest health care provider, available transportation environments, food deserts, etc.), has a major impact on health outcomes, especially on those of lower socioeconomic status. All of these things persist in low-income communities. – Community Leader
>
> Lack of affordable housing for the working poor and transitional housing for the homeless, lack of adequate, affordable mental health services for the homeless and unemployed; with rising costs of food and daily living costs, families feel forced to make hard choices, and preventative health care is not a priority when they cannot meet the basic needs of their families. – Social Service Provider
>
> Many people who lack income or education oftentimes have to find affordable housing in the worst environments, and oftentimes cannot afford healthy food choices. – Community Leader
>
> While there is a housing authority property, many feel defeated living there. Income is low. Many who live there do not have their high school diploma. Systemic racism is prevalent. The environment doesn't encourage self-development. – Social Service Provider
>
> Housing: Job income is disproportionate to the cost of living for about 25% of the community. Unchallenging educational systems, dangerous levels of use and dependence on social media and smartphone/devices. – Social Service Provider

Income/Poverty

> Polk County has a significant population in poverty, and a lot of people don't have insurance, which is needed for medical care. – Community Leader
>
> High poverty rates and lack of education/awareness of residents. – Social Service Provider
>
> There are so many people in this community that live under the poverty line, and even families who are not below the poverty line are struggling with finances, so they don't do regular checkups, attend doctors' appointments, eat healthy, and attempt self-care. Some of this stems from lack of knowledge. – Social Service Provider
>
> Individuals who are experiencing low income, incarceration, returning from incarceration have very low access to resources such as housing, income, and education. – Social Service Provider

Homelessness

> Homelessness is a huge problem in Rome. – Community Leader

Access to Care/Services

> Citizens do not have access to health care, housing. Jobs are not available that pay more than minimum wage, leaving the person to live paycheck to paycheck. What should be routine care becomes a luxury, such as oral health, fitness programs, and mental health. – Social Service Provider

Awareness/Education

> Lower percentage of high school graduates and even lower number of college graduates. Also, a high number of government-assisted households. – Community Leader

Transportation

> Hard to access resources, especially with no transportation in the community. – Community Leader

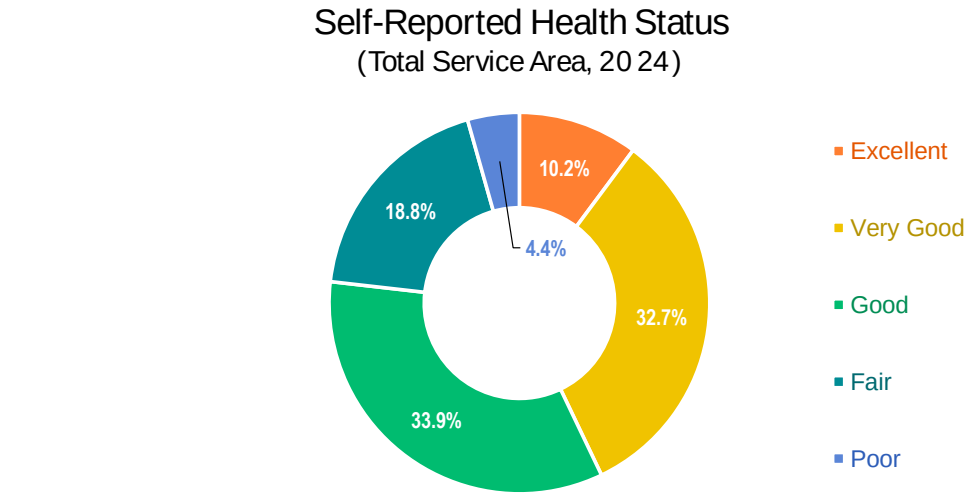
Access to Affordable Healthy Food

> Overall general opportunity to affect the social determinants of health – most importantly, the availability of low-cost healthy foods and affordable housing. – Health Provider

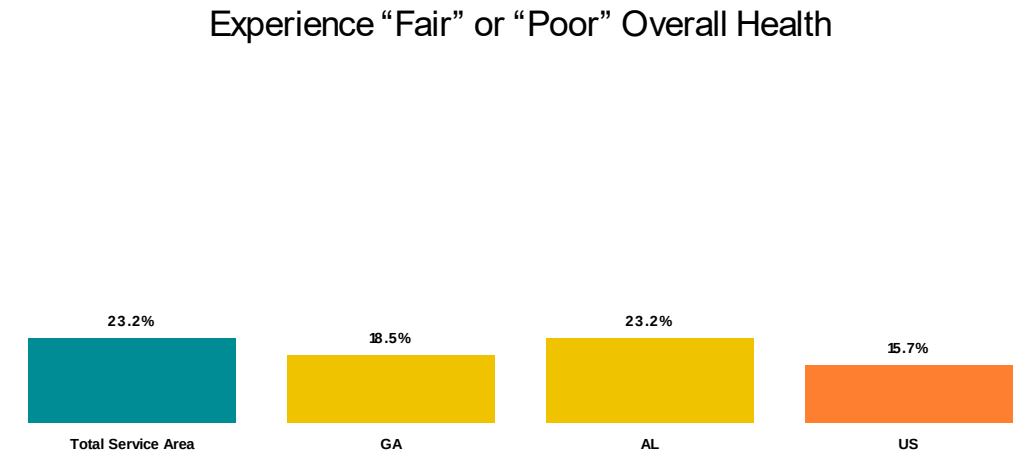
Health Status

Overall Health

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

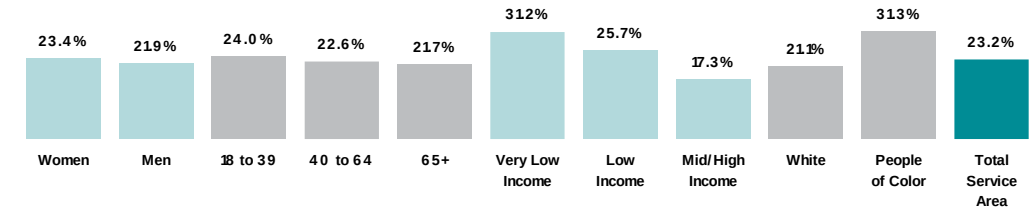


Sources: • 2024 PRC Community Health Survey, PRC, Inc. [Item 4]
Notes: • Asked of all respondents.



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 Georgia and Alabama data.
• 2023 PRC National Health Survey, PRC, Inc.
Notes: • Asked of all respondents.

Experience "Fair" or "Poor" Overall Health
(Total Service Area, 2024)



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

Mental Health

About Mental Health & Mental Disorders

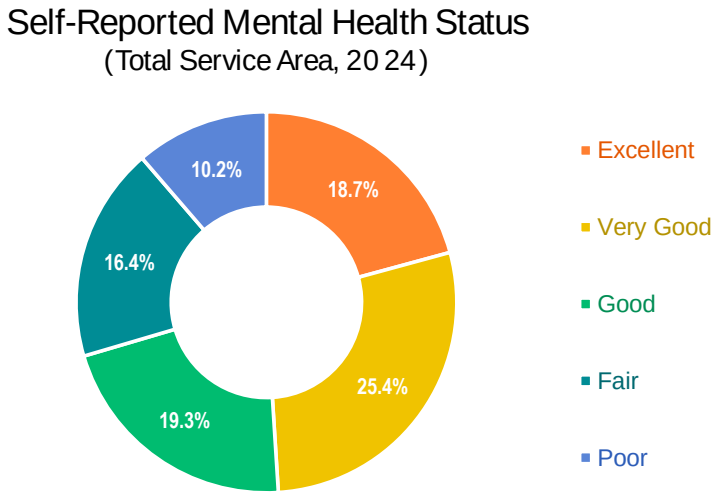
About half of all people in the United States will be diagnosed with a mental disorder at some point in their lifetime. …Mental disorders affect people of all age and racial/ethnic groups, but some populations are disproportionately affected. And estimates suggest that only half of all people with mental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

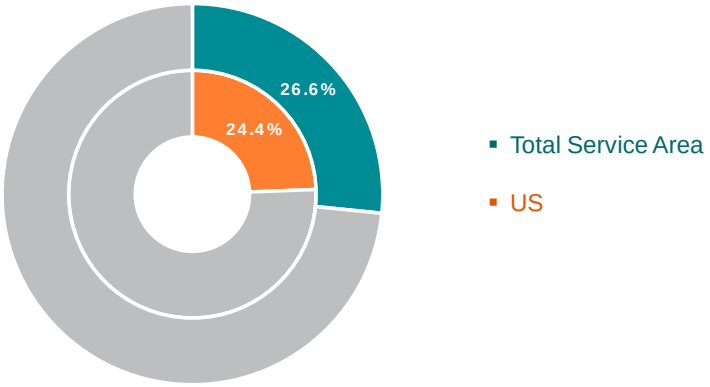
Mental Health Status

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.

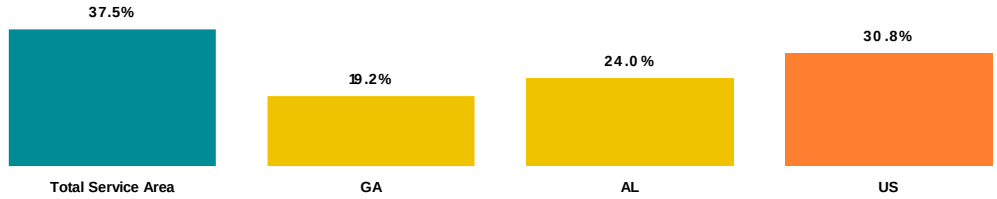
Notes:
- Asked of all respondents.

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

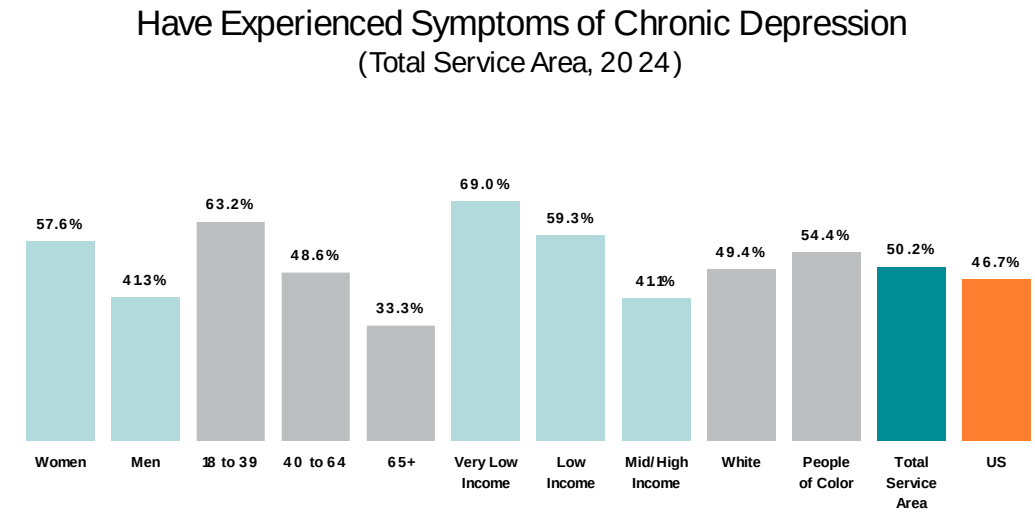


Sources:
- 2024 PRC Community Health Survey, PRC, Inc. [Item 80]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2022 Georgia and Alabama data.
- 2023 PRC National Health 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?"

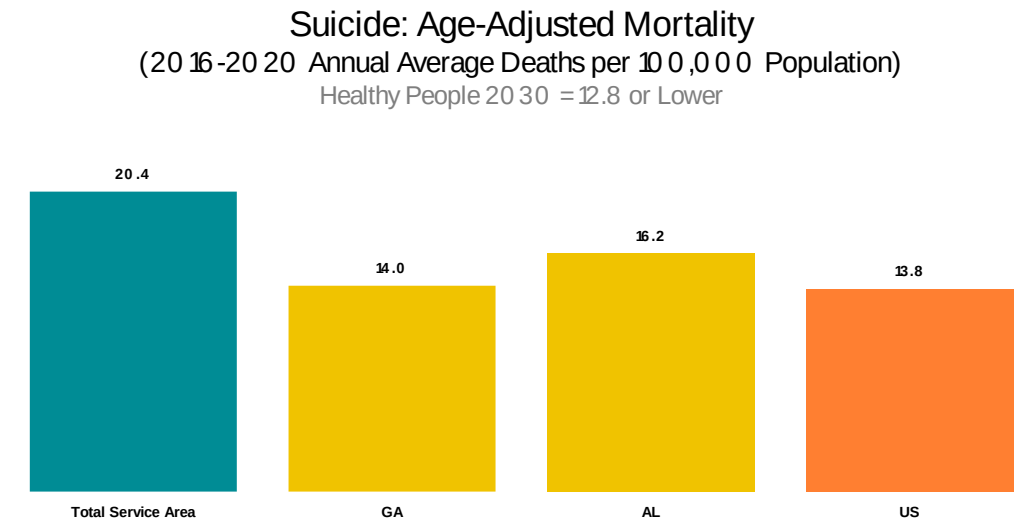


Sources:
- 2024 PRC Community Health Survey, PRC, Inc. [Item 78]
- 2023 PRC National Health Survey, PRC, Inc.

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.



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, Georgia or Alabama 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.

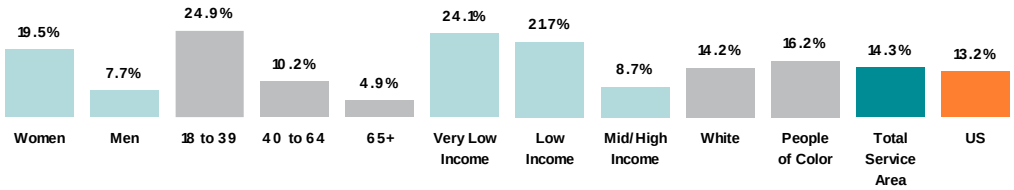
PRC Survey ► "Was there a time in the past 12 months when you needed mental health services but were not able to get them?"

Note 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 the Total Service Area.

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

Unable to Get Mental Health Services When Needed in the Past Year
(Total Service Area, 2024)

In 2021, there were 222 mental health providers practicing in Total Service Area.

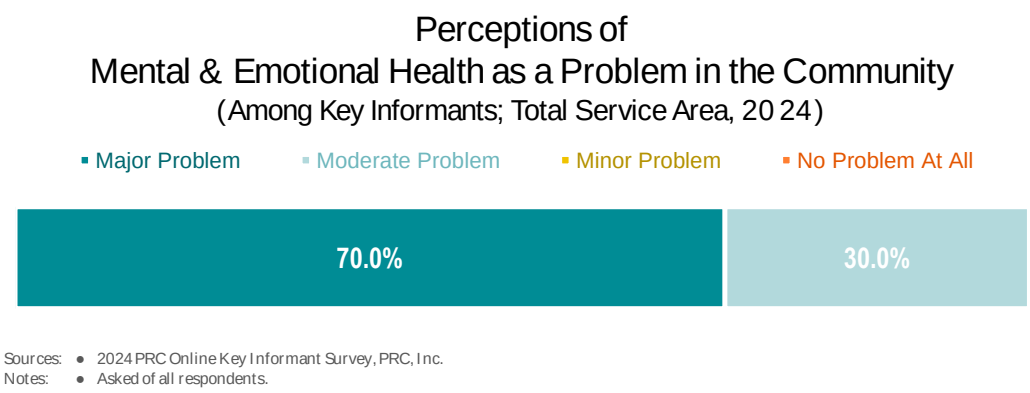


Sources:
- 2024 PRC Community Health Survey, PRC, Inc. [Item 82]
- National Provider Identifier Files (NPI), Centers for Medicare & Medicaid Services (CMS). Retrieved May 2024 via Metopio.

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:



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 quality mental health care. – Community Leader
>
> Consistent access to care. If you cannot stay on your medication and have a crisis, most of the time you will end up in jail. There is almost no access to follow-up care and case management. – Social Service Provider
>
> Limited resources and many come to our jail. Our involuntary transport orders have tripled in the last couple of years. – Community Leader
>
> Provider availability, expensive mental health medications, homeless with mental health issues and no medications. – Social Service Provider
>
> There is no access to mental health services in our community. – Community Leader
>
> No resources and/or facilities to house patients. – Community Leader
>
> Not enough resources available in the community for mental health support. – Social Service Provider
>
> Very limited access for mental health care. Drug and alcohol abuse is very common. – Health Provider
>
> Access to counseling, therapy. Overreliance on medication as a solution, as opposed to therapeutic aid. Oversimplification of struggle by managed care systems (emphasis is diagnosis, as opposed to understanding and integration of psychological fluidity) while simultaneously pathologizing normal human experiences. High stress due to everyday cost of living vs. employment and/or disability income. Access to affordable housing. – Social Service Provider
>
> There is either a major lack of easily accessible mental health resources or simply a lack of acknowledgement that mental health issues often generate other issues as a byproduct. – Community Leader
>
> Limited resources to address a spectrum of issues. – Social Service Provider
>
> No access to services. – Community Leader
>
> There used to be places to deal with mental health-diagnosed people. Those places have lost federal/state funding and have closed. Many people are not being diagnosed properly and are living among all other citizens and are not being given the proper attention, as well as many people don't have the proper training to deal with mental health patients. – Community Leader
>
> Access to resources, have no help. Organizations that can help tend to work in silos, all doing the same thing. Can do more together than alone. Cost of medication and stigma of asking for help. Program availability is cost-prohibitive. – Social Service Provider
>
> Lack of care resources, providers and beds for acute care, environmental stigmas. – Health Provider

Alcohol/Drug Use

> Mental health is a huge issue across the county, which I truly believe stems from substance abuse or a child of someone who chose to abuse substances. Our mental health system is broken, and there's no vision moving forward of it getting any better. – Community Leader

Transportation

> Hard to access resources, especially with no transportation in the community. – Community Leader

> Lack of transportation to access resources. Services available only during regular work hours, and individuals needing services cannot get off work. Lack of financial resources or insurance to cover the cost of medications or counseling. Lack of providers. – Social Service Provider

Access for Medicare/Medicaid Patients

> Medicaid patients only have access to a psych provider at CED Mental Health. There are no counseling options for Medicaid patients in Cherokee County. The closest counselor that accepts Medicaid is in Fort Payne. Psych referrals generally take months; when a patient needs to see psych, they generally cannot wait months for an appointment. – Health Provider

Diagnosis/Treatment

> Overdiagnosis in the mental health field. – Social Service Provider

Homelessness

> Connection between mental health and homelessness. – Community Leader

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.

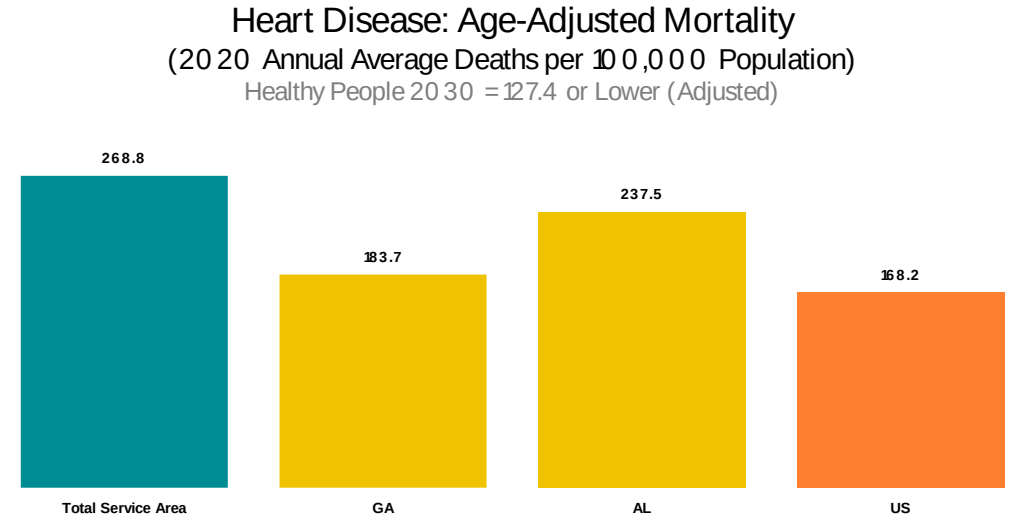
In addition, making sure people who experience a cardiovascular emergency — like stroke, heart attack, or cardiac arrest — get timely recommended treatment can reduce their risk for long-term disability and death. Teaching people to recognize symptoms is key to helping more people get the treatment they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



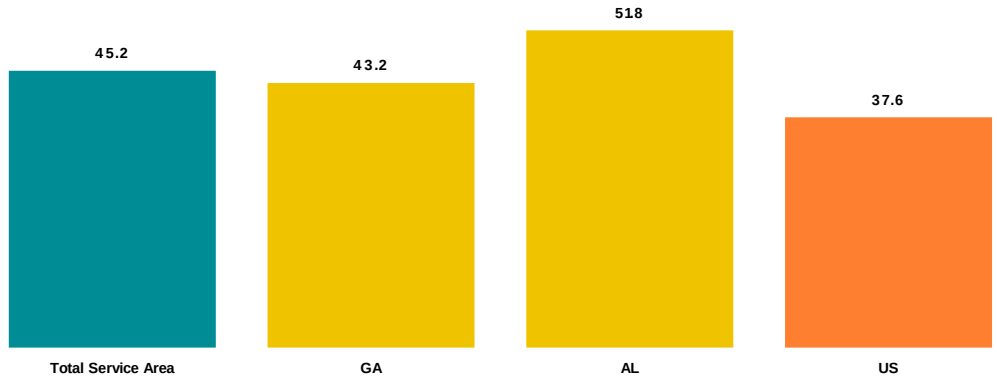
Sources:
- National Vital Statistics System-Mortality (NVSS-M), Centers for Disease Control and Prevention (CDC). Retrieved May 2024 via Metopio.
- US Department of Health and Human Services. Healthy People 2030. https://health.gov/healthypeople

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.

Stroke: Age-Adjusted Mortality

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

Healthy People 2030 = 33.4 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.

Prevalence of Heart Disease & Stroke

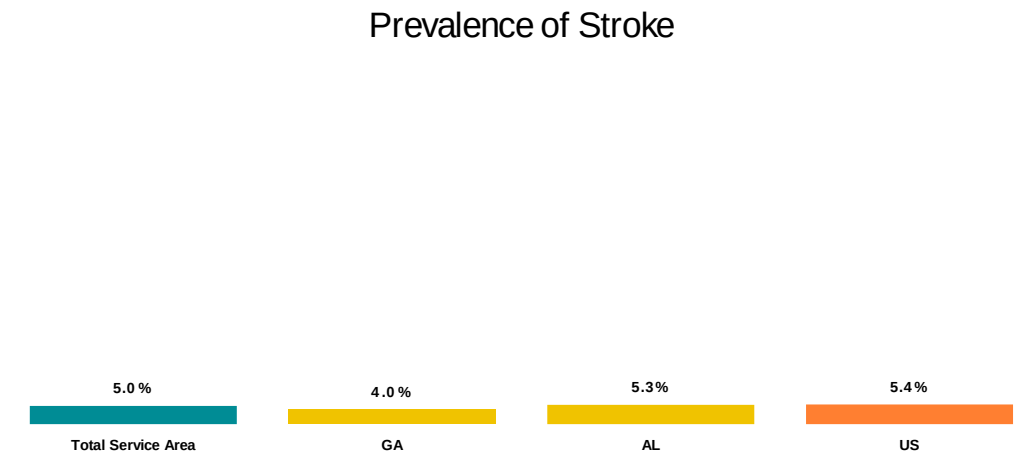
PRC Survey ► "Have you ever suffered from or been diagnosed with heart disease, including heart attack or myocardial infarction, angina, or coronary heart disease?"

Prevalence of 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 Georgia and Alabama 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?"**



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 Georgia and Alabama data.
- 2023 PRC National Health Survey, PRC, Inc.

Notes:
- Asked of all respondents.

Cardiovascular Risk Factors

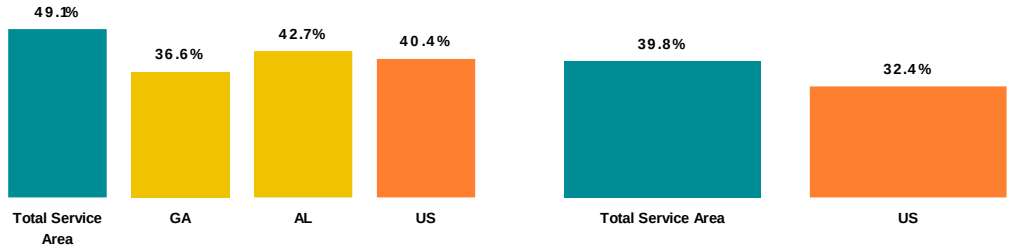
Blood Pressure & Cholesterol

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

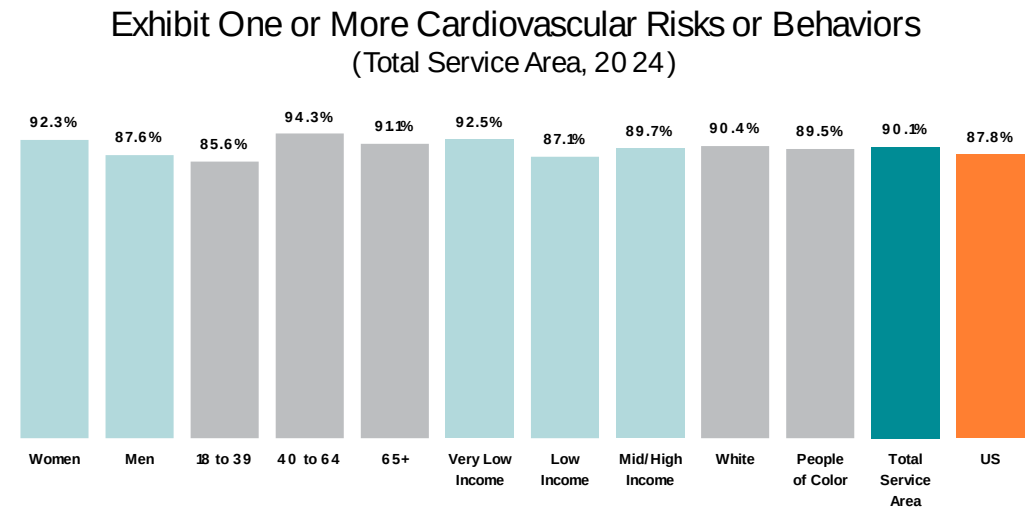
- High Blood Pressure
- High Blood Cholesterol
- Cigarette Smoking
- Physical Inactivity
- Overweight/Obesity

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

Total Cardiovascular Risk

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

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

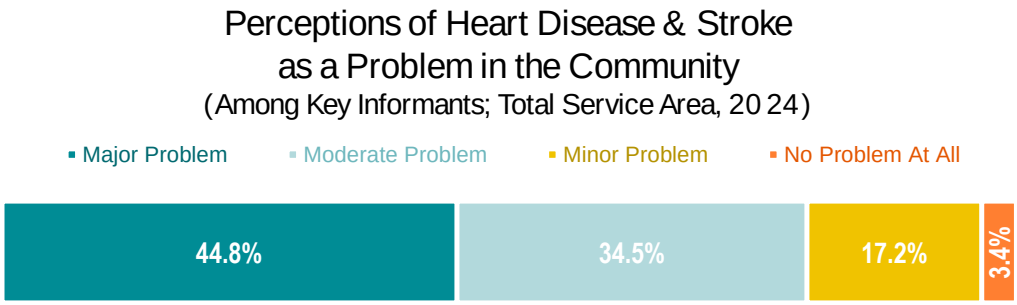


Sources:
- 2024 PRC Community Health Survey, PRC, Inc. [Item 100]
- 2023 PRC National Health Survey, PRC, Inc.

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:



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

> These are problems in our community due to the unhealthy lifestyles for many residents, which leads to obesity, untreated high blood pressure, and heart failure. It is a major concern without a medical provider that accepts fees by income. Many lower income families will return to going to the ER for all health issues. – Social Service Provider
>
> High prevalence of these conditions due to unhealthy living and other chronic issues. – Social Service Provider
>
> Unhealthy diets and lack of exercise. Healthy foods are expensive, and many are not taught to cook healthy meals. – Community Leader
>
> Poor nutrition choices and lack of exercise. Cost and knowledge. – Health Provider
>
> We have a large percentage of heart disease and stroke, which I believe is caused by diet and hereditary issues. – Community Leader

Incidence/Prevalence

> Cardiac disease is a very common diagnosis in Polk County. – Health Provider
>
> Combined, they affect more people in our community than any other disease or situation. – Social Service Provider

Awareness/Education

> Lack of education and focus on prevention. Also, past family history and genetics plays a major factor. – Community Leader

Affordable Care/Services

> There are growing numbers of people living below the poverty line who can't afford and don't have access to healthy foods due to lack of transportation or knowledge. Some people lack the resources to stay healthy through exercise. There is already a genetic disposition to heart disease. – Social Service Provider

Prevention/Screenings

> Heart disease and stroke are huge concerns. Early detection and early treatment are vital when dealing with heart disease and stroke. Again, for heart disease and stroke, people have to travel out of the county in order to receive care. – Community Leader

Transportation

> Hard to access resources, especially with no transportation in the community. – Community Leader

Cancer

About Cancer

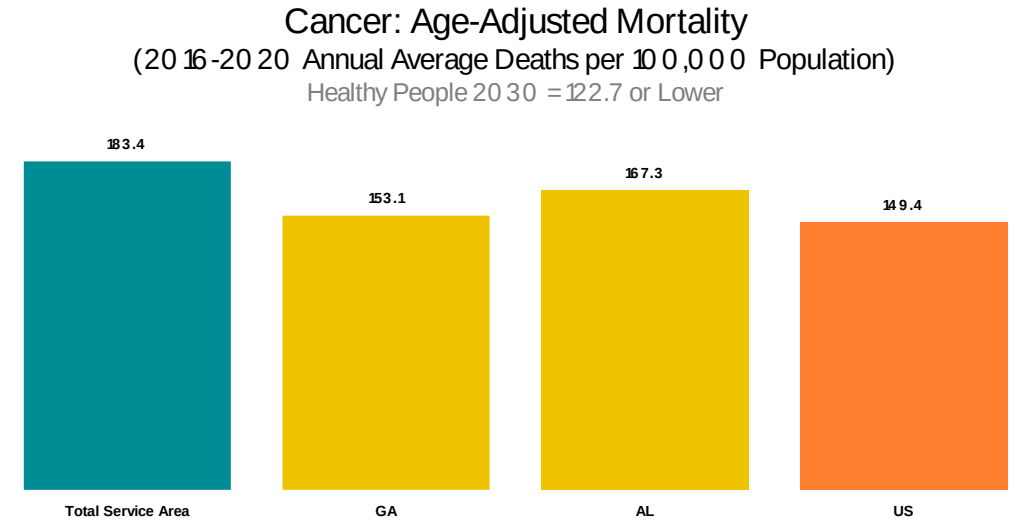
Cancer is the second leading cause of death in the United States. …The cancer death rate has declined in recent decades, but over 600,000 people still die from cancer each year in the United States. Death rates are higher for some cancers and in some racial/ethnic minority groups. These disparities are 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 the Total Service Area.

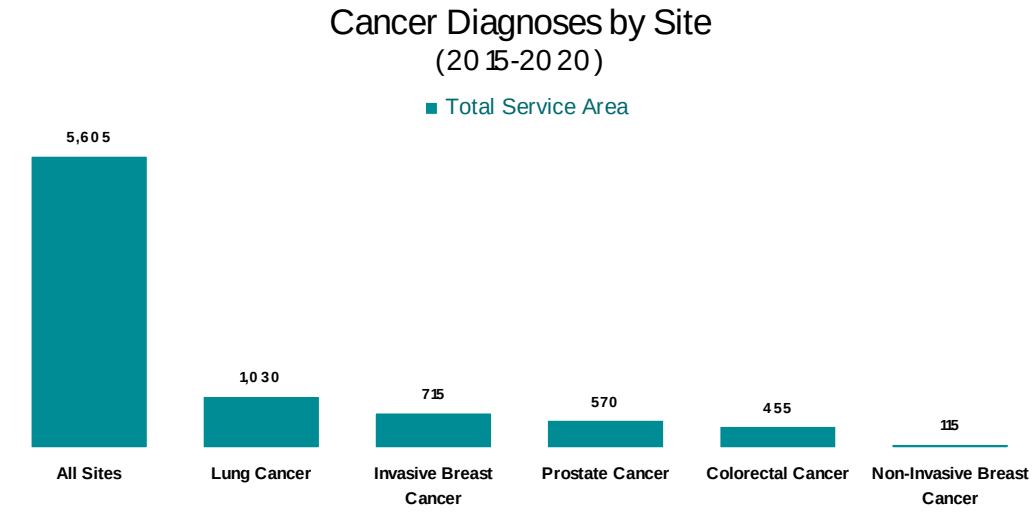


Sources:
- National Vital Statistics System-Mortality (NVSS-M), Centers for Disease Control and Prevention (CDC). Retrieved May 2024 via Metopio.
- US Department of Health and Human Services. Healthy People 2030. https://health.gov/healthypeople

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

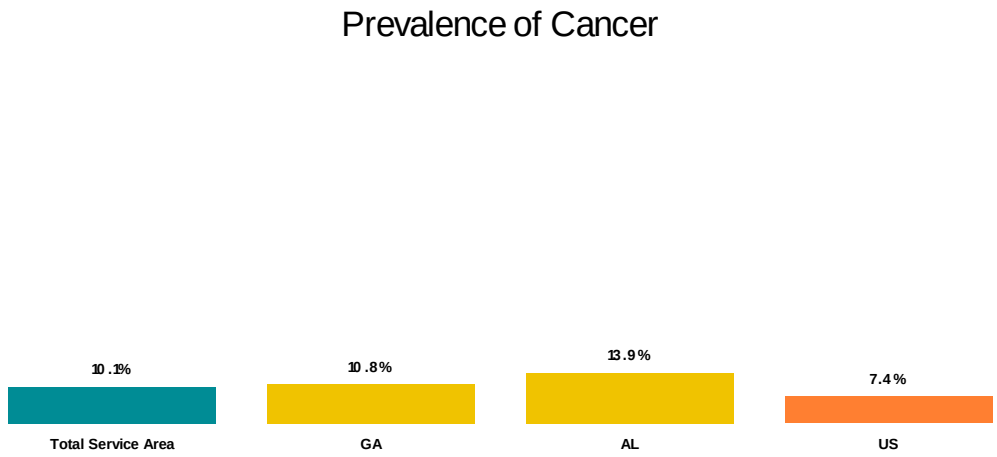
The following chart outlines the numbers of cases of cancer diagnosed between 2015 and 2020 in the Total Service Area for selected cancer sites.



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?"



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 Georgia and Alabama 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?"

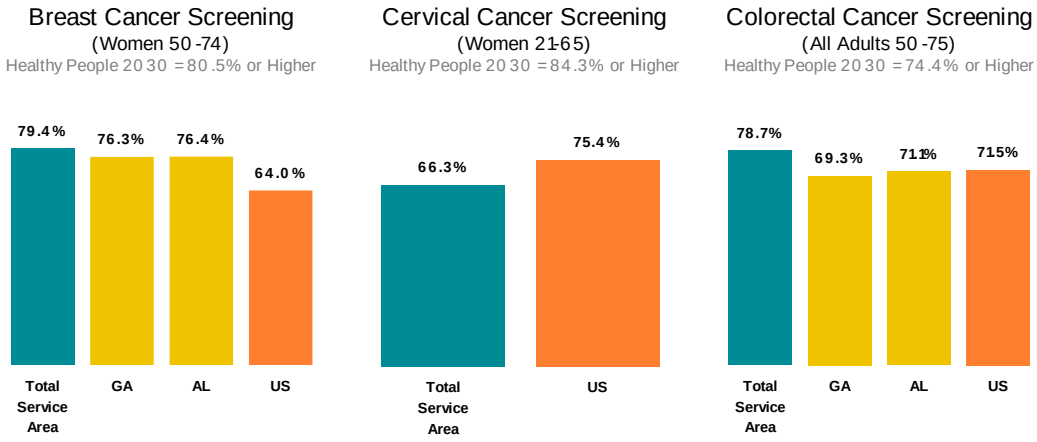
"Appropriate cervical cancer screening" includes Pap smear testing (cervical cytology) every three years in women age 21 to 29 and Pap smear testing and/or HPV testing every 5 years in women age 30 to 65.

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.

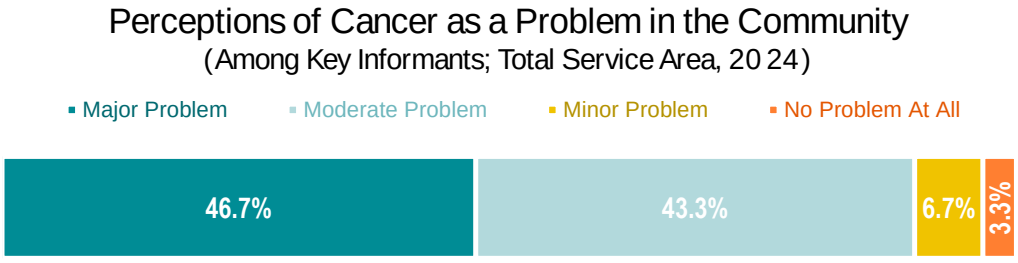


Sources:
- 2024 PRC Community Health Survey, PRC, Inc. [Items 101-103]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2022 Georgia and Alabama data.
- 2023 PRC National 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:



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

> High percentage of cancer diagnoses with no local treatment facilities available. – Community Leader
>
> If I had more time, I would love to get statistical data on cancer rates within the communities. I hear that our incidence of cancer is higher in the community, but unfortunately, I'm relying on hearsay. – Community Leader
>
> Cancer is prevalent in the community. Many are undiagnosed because they do not get screened. – Social Service Provider
>
> The number of patients that receive treatment and those that feel the disease is fatal. My thoughts have always been that if there is a cancer clinic in your area, cancer is a major problem. – Social Service Provider
>
> There seems to be a large percentage of cancer incidences and deaths related to cancer issues over the past few years. Our unhealthy population increases the likelihood of a cancer diagnosis. – Social Service Provider
>
> Seems like there are a lot of people diagnosed with cancer, and they have to travel for treatment. – Health Provider
>
> We are seeing more and more cases of multiple types of cancer in our communities. – Community Leader

Tobacco Use

> Smoking, nutrition, and possibly chemicals in the water system. – Community Leader

Access to Care/Services

> Affects all families. Often those affected have to cross tremendous hurdles to get to resources. – Social Service Provider

Prevention/Screenings

> Lack of annual checkups as a preventative measure. – Social Service Provider

Lack of Providers

> There are no providers located within Cherokee County who specialize in cancer. You either have to go to Rome or Gadsden to see or have access to an oncologist. It would be beneficial for someone to visit Cherokee County a couple of days a week to provide those services to those who may not be able to travel. – Community Leader

Diagnosis/Treatment

> Many cancers in my community are not diagnosed until the late stages. When diagnosed, oftentimes there is little to no support offered or clear direction of the options needed to get well. – Community Leader

Transportation

> Hard to access resources, especially with no transportation in the community. – Community Leader

Respiratory Disease

About Respiratory Disease

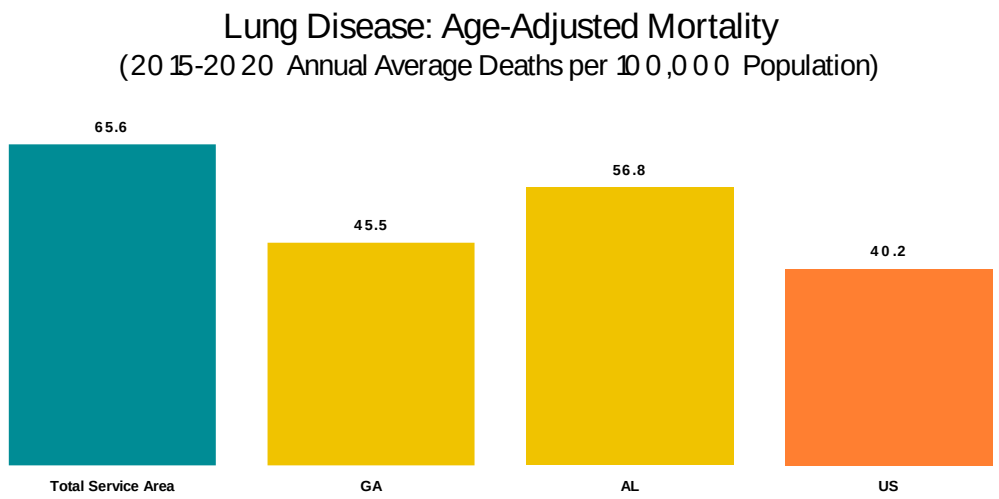
Respiratory diseases affect millions of people in the United States. …More than 25 million people in the United States have asthma. Strategies to reduce environmental triggers and make sure people get the right medications can help prevent hospital visits for asthma. In addition, more than 16 million 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)

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.

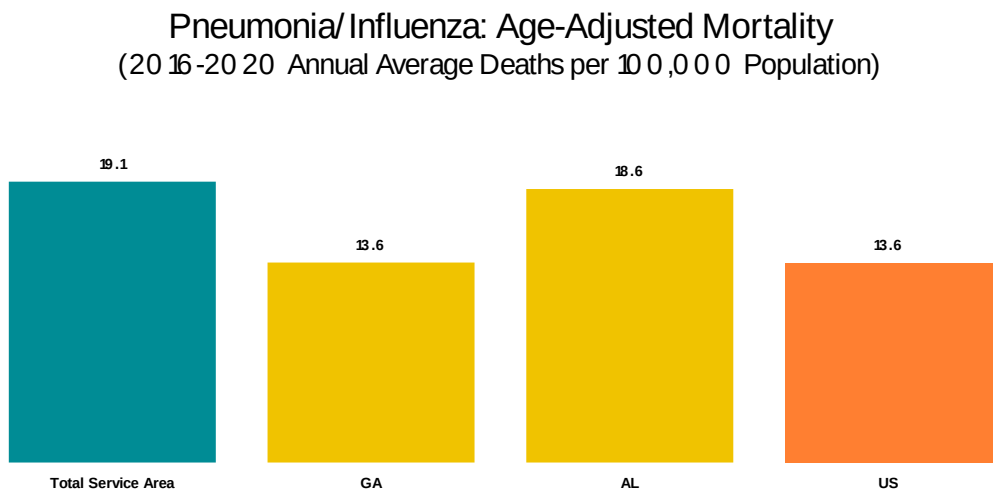


Sources:
- National Vital Statistics System-Mortality (NVSS-M), Centers for Disease Control and Prevention (CDC). Retrieved May 2024 via Metopio.

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.



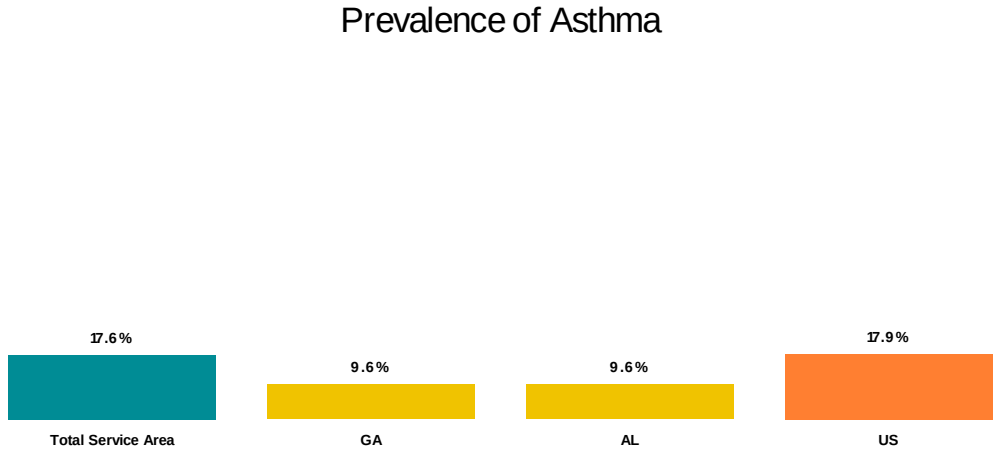
Sources:
- National Vital Statistics System-Mortality (NVSS-M), Centers for Disease Control and Prevention (CDC). Retrieved May 2024 via Metopio.

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

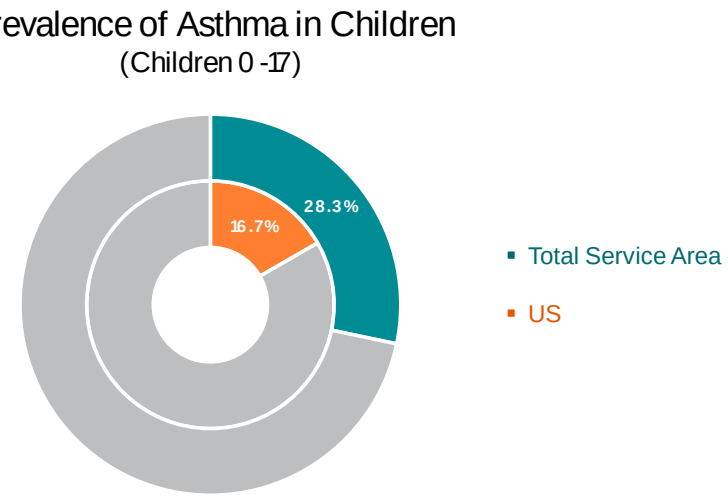
PRC Survey ► "Do you currently have asthma?"



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 Georgia and Alabama 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?"**

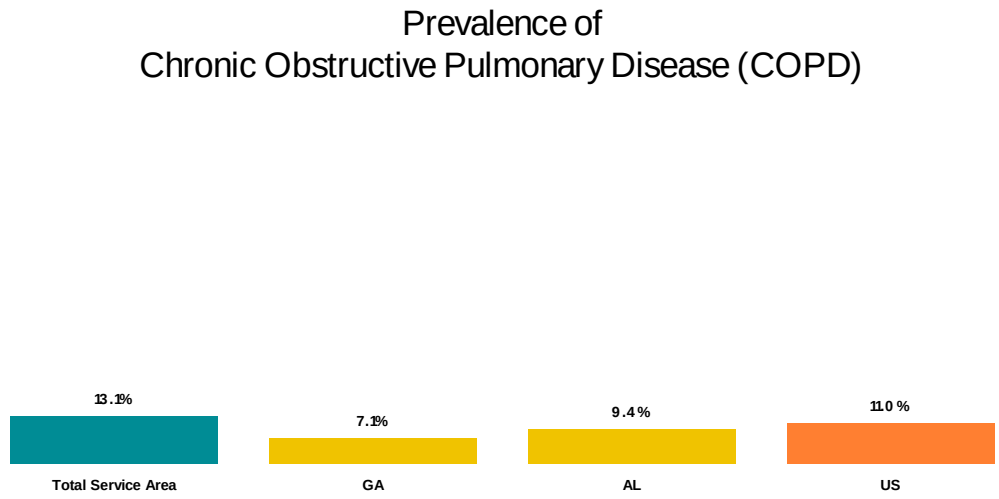


Sources:
- 2024 PRC Community Health Survey, PRC, Inc. [Item 92]
- 2023 PRC National Health Survey, PRC, Inc.

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?"**

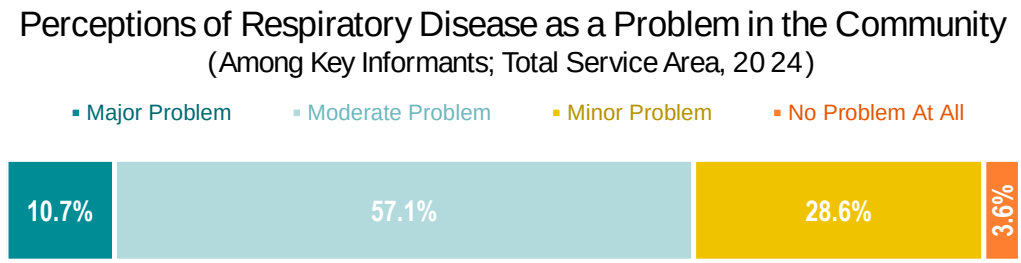


Sources:
- 2024 PRC Community Health Survey, PRC, Inc. [Item 21]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2022 Georgia and Alabama data.
- 2023 PRC National Health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



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:

Environmental Contributors

> Cherokee County has a lot of environmental allergens with our cotton and produce fields. Many patients are sick when cotton is picked due to dust in the air. Many patients have COPD from years of smoking or exposure to secondhand smoke. More education is needed in the school system regarding the dangers of vaping and smoking. I see many teenagers vaping without regard to their respiratory health. – Health Provider

Transportation

> Hard to access resources, especially with no transportation in the community. – Community Leader

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.

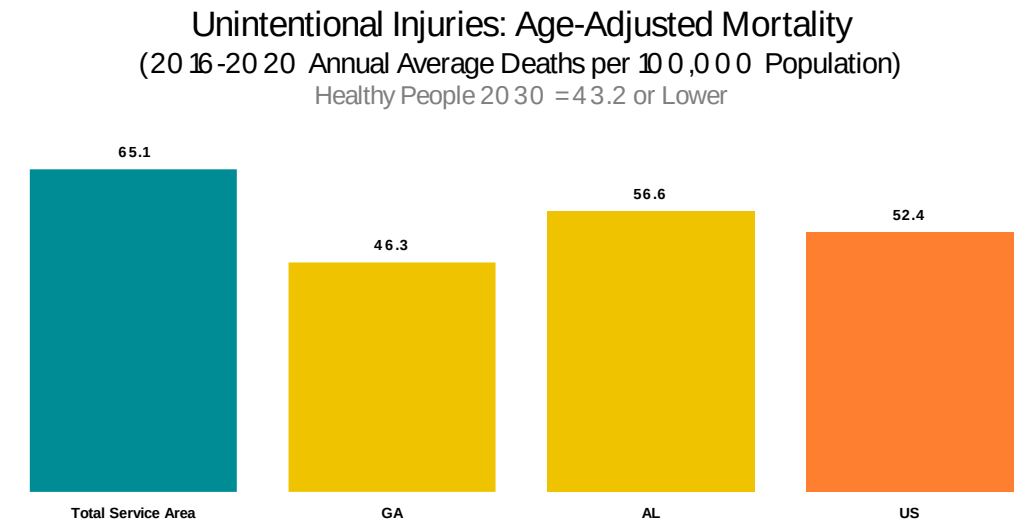
Children who experience violence are at risk for long-term physical, behavioral, and mental health problems. Strategies to protect children from violence can help improve their health and well-being later in life.

– 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.



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

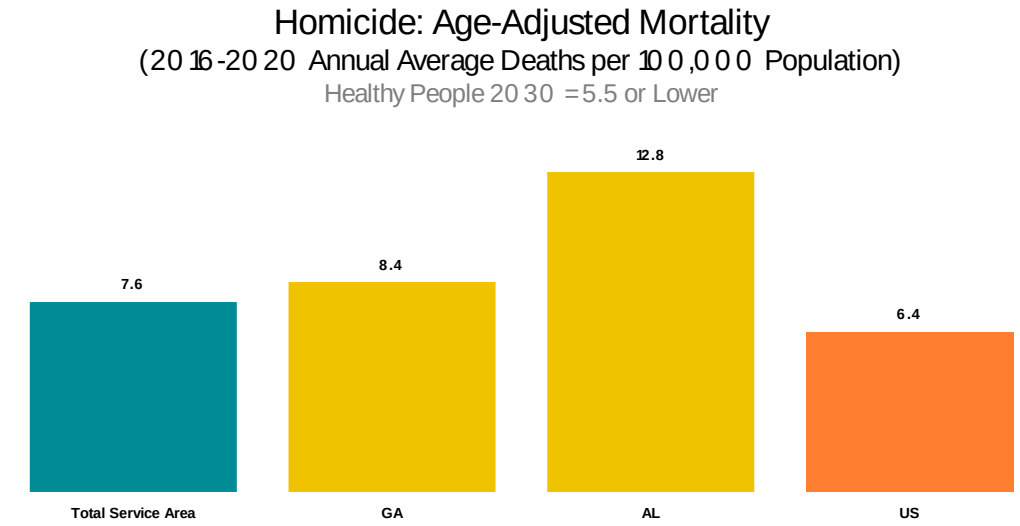
Notes:
- Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
- Rates are per 100,000 population, age-adjusted to the 2000 US Standard Population.

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.



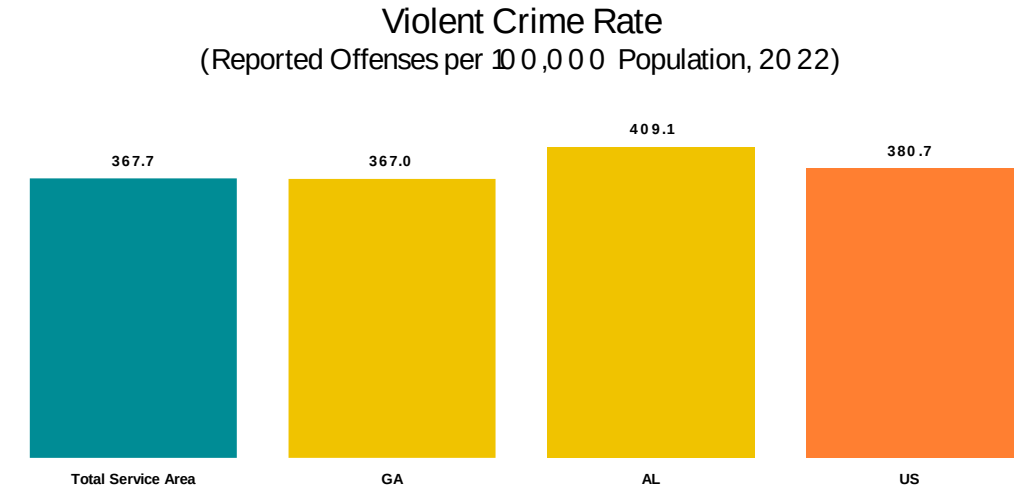
Sources:
- National Vital Statistics System-Mortality (NVSS-M), Centers for Disease Control and Prevention (CDC). Retrieved May 2024 via Metopio.
- US Department of Health and Human Services. Healthy People 2030. https://health.gov/healthypeople

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.



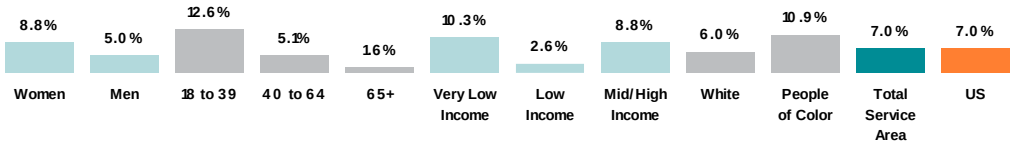
Sources:
- FBI Crime Data Explorer, Federal Bureau of Investigation. Retrieved May 2024 via Metopio.

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
(Total Service Area, 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

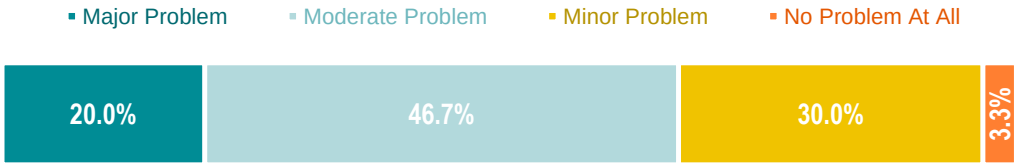
Sources:
- 2024 PRC Community Health Survey, PRC, Inc. [Item 33]
- 2023 PRC National Health Survey, PRC, Inc.

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; Total Service Area, 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:

Alcohol/Drug Use

> The East Rome area is susceptible to injury and violence due to substance abuse and distribution. – Social Service Provider

Income/Poverty

> Too many nonworking young adults in the community after high school, leading to injury and violence among these age groups. Not enough workforce development programs are available for young people who are not interested in pursuing postsecondary education. – Social Service Provider

Affordable Care/Services

> Many people do not seek treatment of injury and violence because of the cost – not only financially, but socially as well as emotionally. – Social Service Provider

Awareness/Education

> Due to many reasons, such as lack of education, inflation, closure of mental hospitals, etc., this has led to many people being in high-stress, more difficult situations, which oftentimes leads to assault, injury, or violence as a means to deal with their problems. – Community Leader

Government/Policy

> Lack of effective legislation, apathy, and mental health challenges. – Health Provider

Transportation

> Hard to access resources, especially with no transportation in the community. – Community Leader

Diabetes

About Diabetes

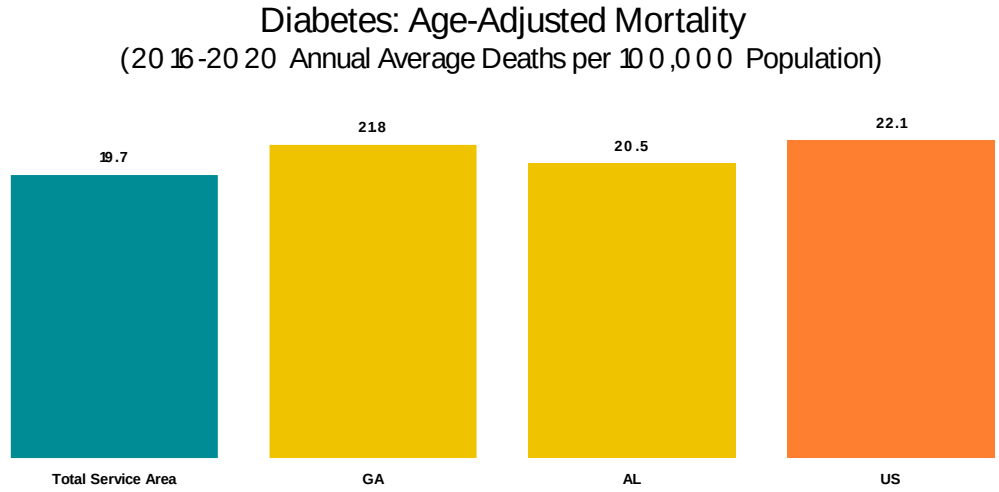
More than 30 million people in the United States have diabetes, and it's the seventh leading cause of death. …Some racial/ethnic minorities are more likely to have diabetes. And many people with diabetes don't know they have it.

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?"

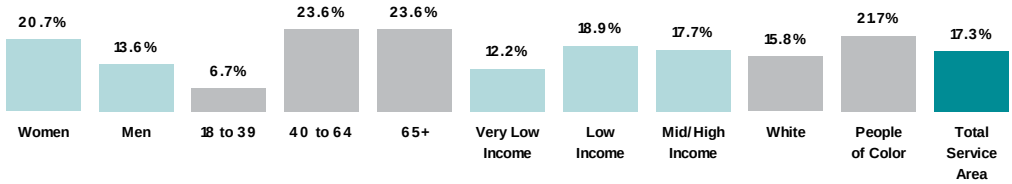
Prevalence of Diabetes

Another 14.0% 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 Georgia and Alabama data.
- 2023 PRC National Health Survey, PRC, Inc.

Notes:
- Asked of all respondents.
- Excludes gestational diabetes (occurring only during pregnancy).

Prevalence of Diabetes
(Total Service Area, 2024)

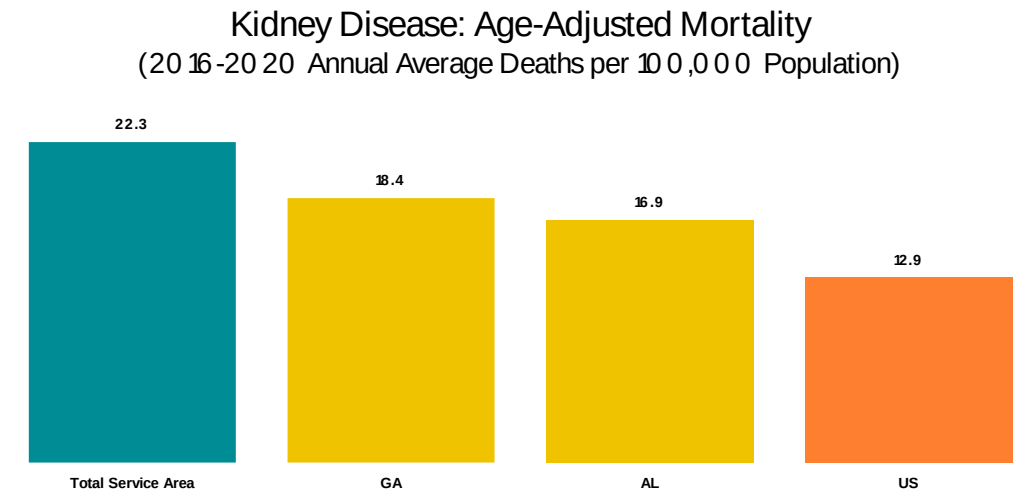


Sources:
- 2024 PRC Community Health Survey, PRC, Inc. [Item 106]

Notes:
- Asked of all respondents.
- Excludes gestational diabetes (occurring only during pregnancy).

Age-Adjusted Kidney Disease Deaths

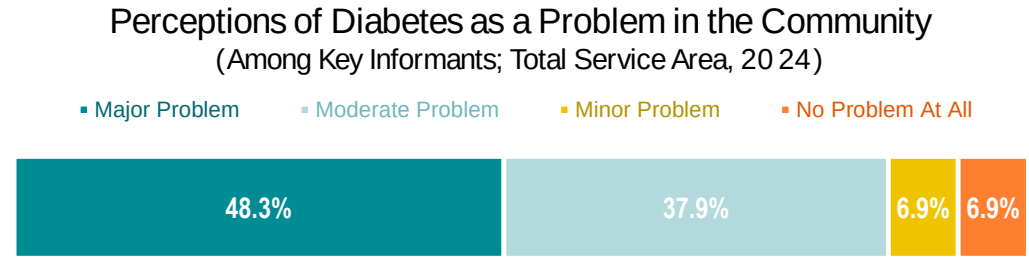
Diabetes is a leading cause of kidney disease. The following chart shows the local age-adjusted kidney disease mortality rate.



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:



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:

Awareness/Education

> Education about healthier food choices. – Community Leader
>
> Feeling of defeat and lack of understanding of the disease in order to control it. – Social Service Provider
>
> Education and financial assistance for medicine. – Community Leader
>
> Lack of diabetes education is a challenge for me as a primary care provider. My patients need access to a dietician in Cherokee County. Most of my patients are not able to travel for a dietician consult. – Health Provider

> Knowing the causes, so education. – Community Leader
>
> Awareness and education about food, healthy living, and exercise. – Social Service Provider

Affordable Medications/Supplies

> Diabetes is common in our area. Patients have a hard time affording medications and a healthy diet. Very hard to get nutritional counseling for patients and their family. A large group that can't afford insurance and have a hard time affording medical care. – Health Provider
>
> Cost of medications and money to pay for physicals and ongoing medical care. Unhealthy communities contribute to blood sugar issues. – Social Service Provider
>
> The cost of diabetic medications and healthy eating habits. – Community Leader
>
> Rising cost of medicines to treat diabetes. Access to proper health care for people in disadvantaged communities. Lack of knowledge about diabetes, rising numbers of people who are prediabetic. – Social Service Provider

Access to Affordable Healthy Food

> Healthy food is becoming super expensive. – Community Leader
>
> Access to healthy foods (cost, knowledge), environmental supports for increased healthy behaviors, lack of understanding of how to effectively control blood sugars, apathy, and access to needed resources for cost of supplies and/or assistive devices as needed. – Health Provider

Transportation

> Hard to access resources, especially with no transportation in the community. – Community Leader

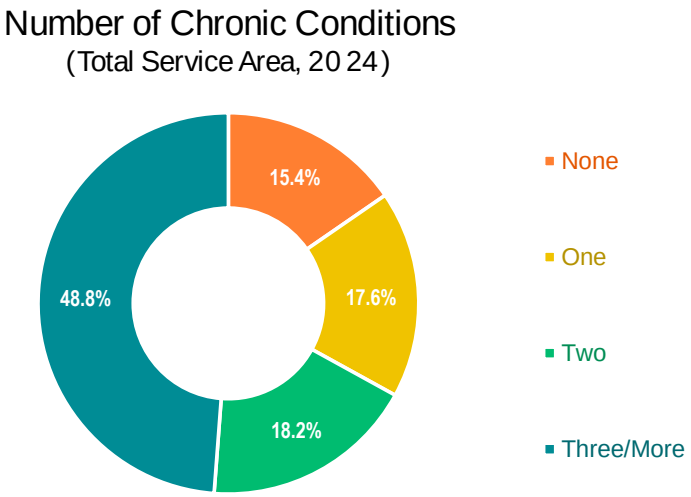
Disabling Conditions

Multiple Chronic Conditions

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.

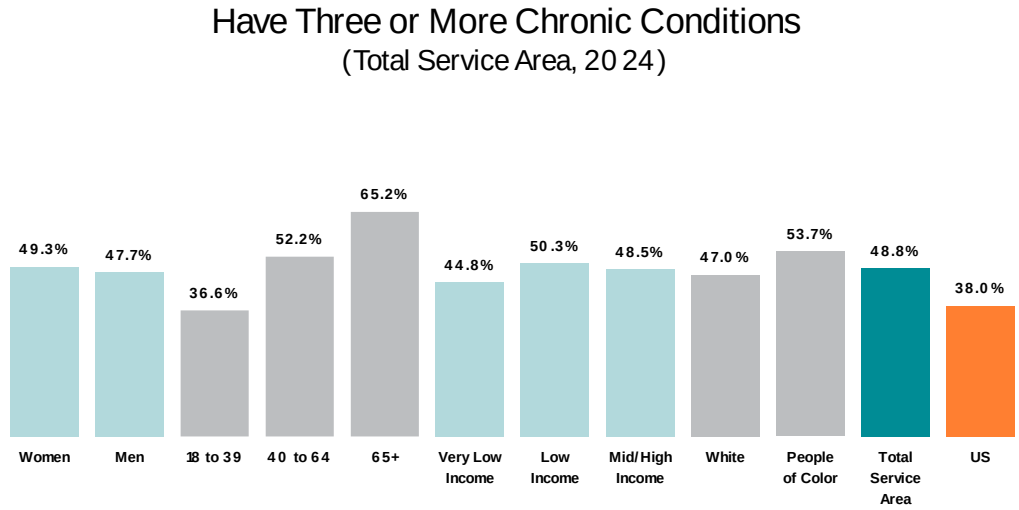
For the purposes of this assessment, chronic conditions include:

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



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.



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/or stroke.

Activity Limitations

About Disability & Health

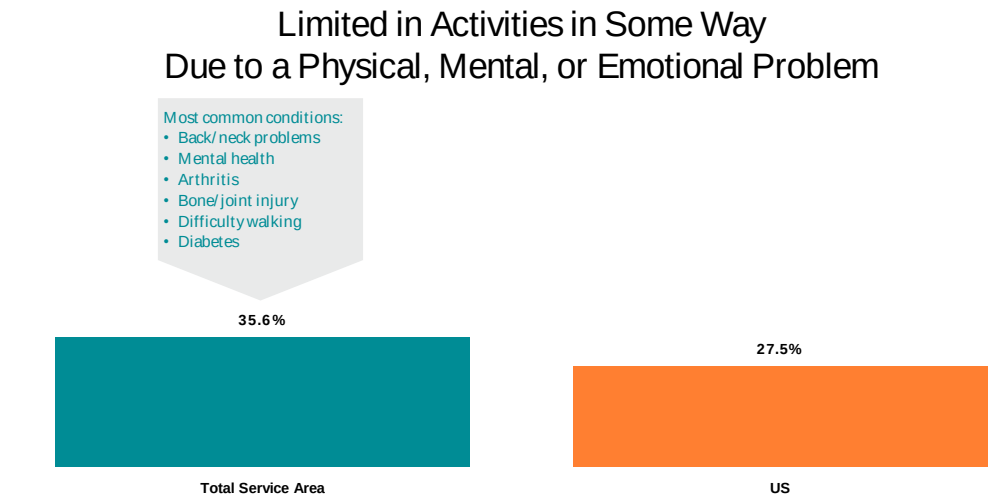
Studies have found that people with disabilities are less likely to get preventive health care services they need to stay healthy. Strategies to make health care more affordable for people with disabilities are key to improving their health.

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)

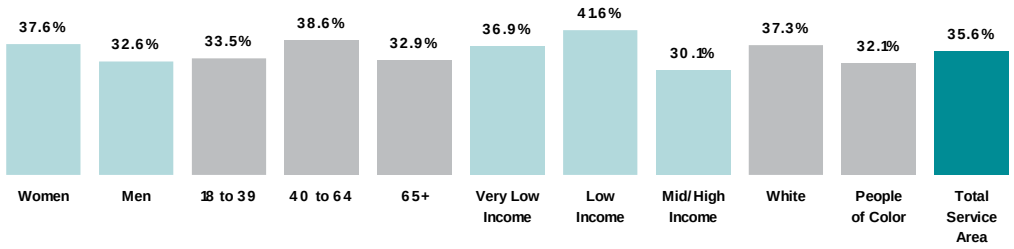
PRC Survey ► "Are you limited in any way in any activities because of physical, mental, or emotional problems?"

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
(Total Service Area, 2024)

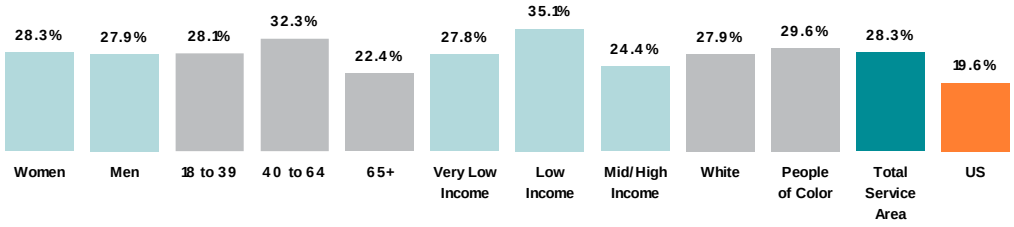


Sources: • 2024 PRC Community Health Survey, PRC, Inc. [Item 83]
Notes: • Asked of all respondents.

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
(Total Service Area, 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

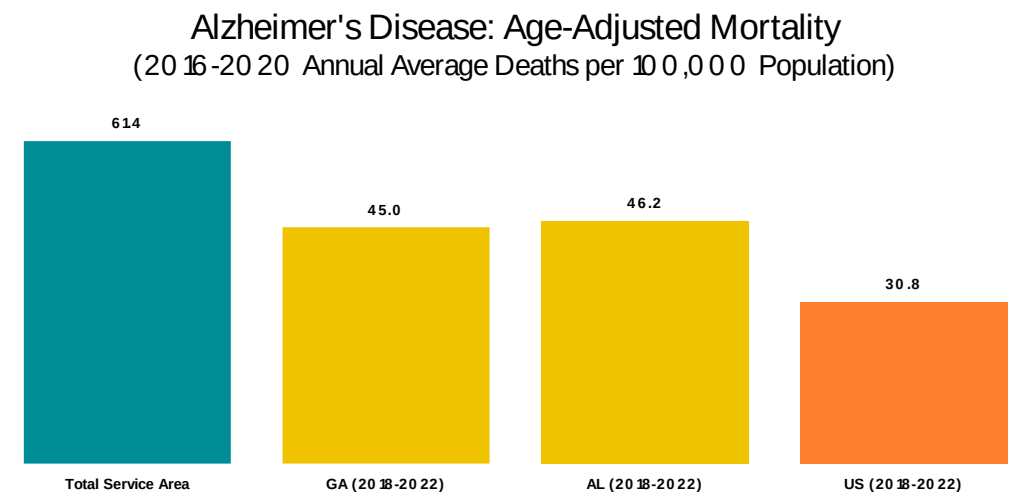
Alzheimer's disease is the most common cause of dementia… . Dementia refers to a group of symptoms that cause problems with memory, thinking, and behavior. People with dementia are more likely to be hospitalized, and dementia is linked to high health care costs.

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.



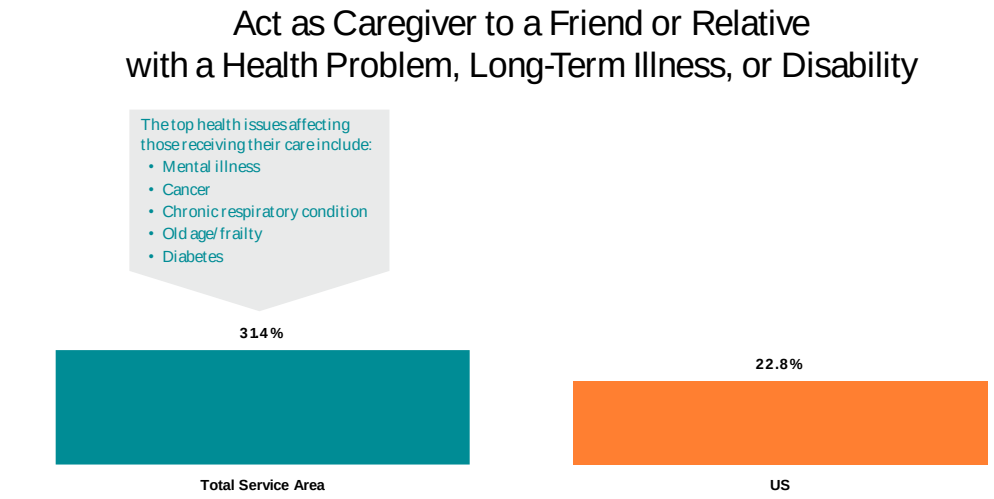
Sources:
- National Vital Statistics System-Mortality (NVSS-M), Centers for Disease Control and Prevention (CDC). Retrieved May 2024 via Metopio.

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?"

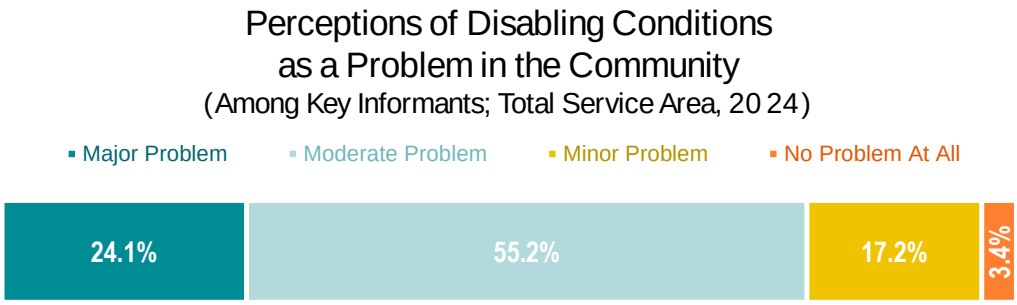
PRC Survey ► [Among those providing care] "What is the main health problem, long-term illness, or disability that the person you care for has?"



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

> Chronic pain patients have to go to Rome to see a provider. They are limited and require insurance. – Health Provider

> Access to these services is very limited in our community. New-patient wait times can be months to a year for some specific doctors. – Social Service Provider

Aging Population

> We have an aging population and limited assisted living and nursing facilities for needed care. – Social Service Provider

> This area is becoming a retirement community with large numbers of dementia patients. – Community Leader

Transportation

> Hard to access resources, especially with no transportation in the community. – Community Leader

Obesity

> Due to higher obesity rates, as well as the aging population, and other medical issues that cause issues with limited activities and chronic pain. Many of these issues are difficult for lower-income families to have treated due to lack of prevention treatment. That population is less likely to seek prevention care due to lack of funds to pay. – Social Service Provider

Insufficient Physical Activity

> Exercise is not a regular activity for many, so it leads to these issues. – 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.

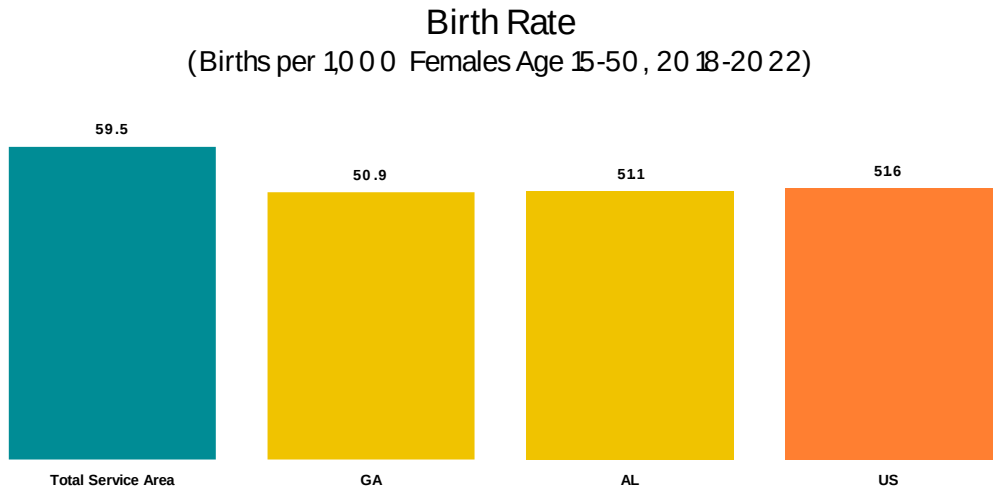
The infant mortality rate in the United States is higher than in other high-income countries, and there are major disparities by race/ethnicity. Addressing social determinants of health is critical for reducing these disparities.

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

Birth Rate

Here, birth rate include 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 the Total Service Area, compared to the state and nation.



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

Birth Outcomes & Risks

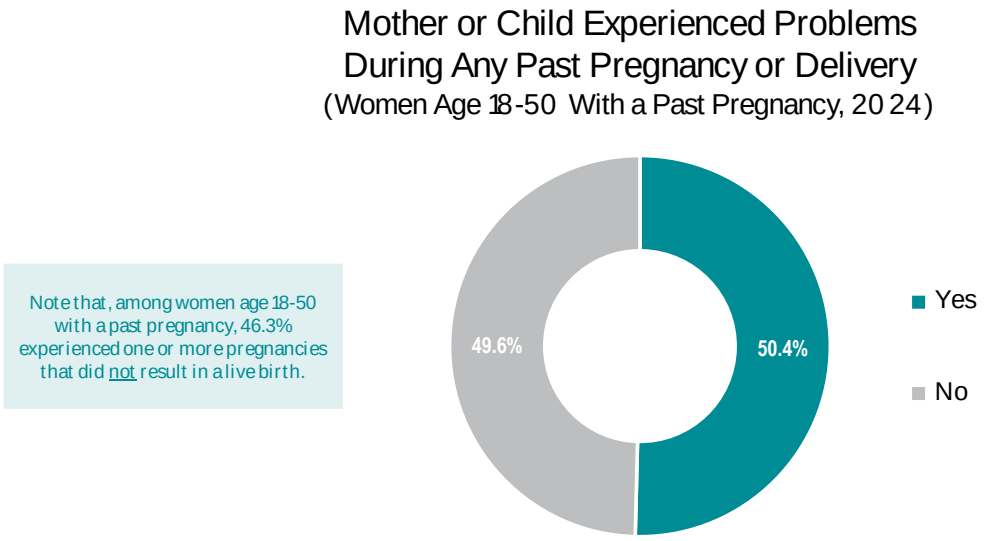
Pregnancy Complications

PRC Survey ► Among women age 18 to 50 with a past pregnancy or pregnancies: **"Did <u>you</u> 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 <u>your baby</u> experience any health or medical problems?"**

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

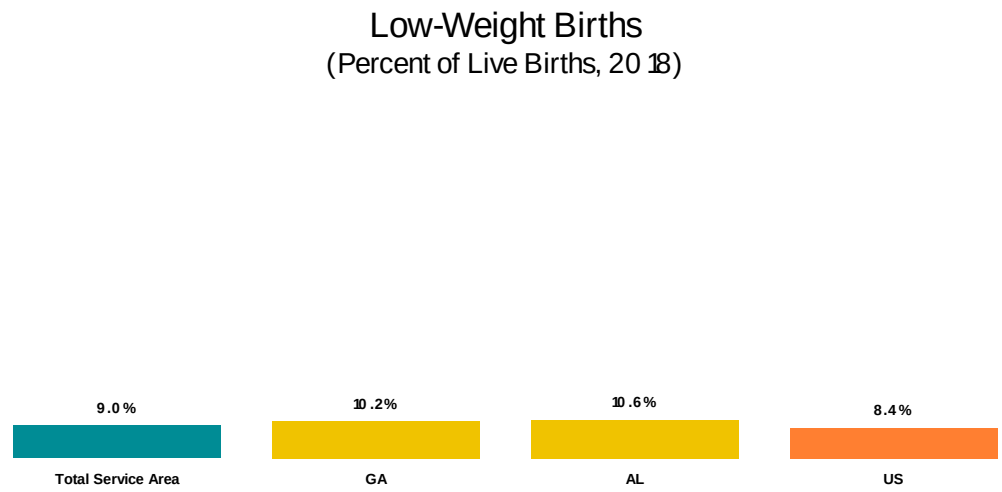
PRC Survey ► Among women age 18 to 50 with a past pregnancy or pregnancies: **"In all, how many of your pregnancies resulted in a live birth? Please count the birth of twins or multiples as one birth."**



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

Low-Weight Births

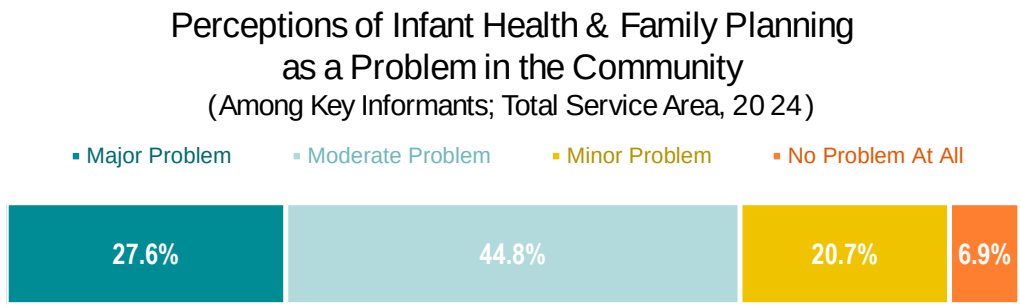
Low birthweight babies, those who weigh less than 2,500 grams (5 pounds, 8 ounces) at birth, are much more prone to illness and neonatal death than are babies of normal birthweight. Largely a result of receiving poor or inadequate prenatal care, many low-weight births and the consequent health problems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



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.

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:



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

> Cherokee County does not currently have any type of pediatrician or pediatric care. – Community Leader
>
> There is a lack of resources for infant and medical health in some of the underserved communities. There is a large need for foster care in this community, largely due to substance abuse. – Social Service Provider

Awareness/Education

> There is not a big push around here for family planning without bias. The resource we have only addresses one view on this. – Social Service Provider
>
> Lack of awareness and education for minorities and families living in poverty. – Social Service Provider

Lack of Providers

> Infant health could be a problem due to the lack of pediatricians in the county and of pediatric specialists. Families are unable to afford preventative care and lack a healthy lifestyle during pregnancy. Family planning is a priority and specialty of the Polk County Health Department and seems to support prevention and teach about postpartum and family planning issues. – Social Service Provider

Transportation

> Hard to access resources, especially with no transportation in the community. – Community Leader

Child Abuse and Neglect

> Child abuse and neglect: Our communities have a high rate of abuse/neglect, and services are needed to reduce the impact of Adverse Childhood Experiences (ACEs). ACEs negatively impact growth, development, and future health of children and can have negative impacts on their graduation rates, employment, and mental health. There is a need for increased education and support of families through home visitation and general education. Our communities would benefit from general parenting education (low-barrier access; perhaps through texting education program), a First Steps program to identify at-risk families more quickly (before ACEs occur), and increased home visitation services to provide ongoing support. We have limited home visitation services in Floyd and Polk and almost no general education services targeting families with young children. – Social Service Provider

Affordable Care/Services

> There are not enough financially reasonable services available to low-income families. – Social Service Provider

Childhood Illness

> Have we discussed autism and/or childhood illness specifically? If not, the reason it's a problem is a tremendous lack of support and local resources. – Social Service Provider

Modifiable Health Risks

Nutrition

About Nutrition & Healthy Eating

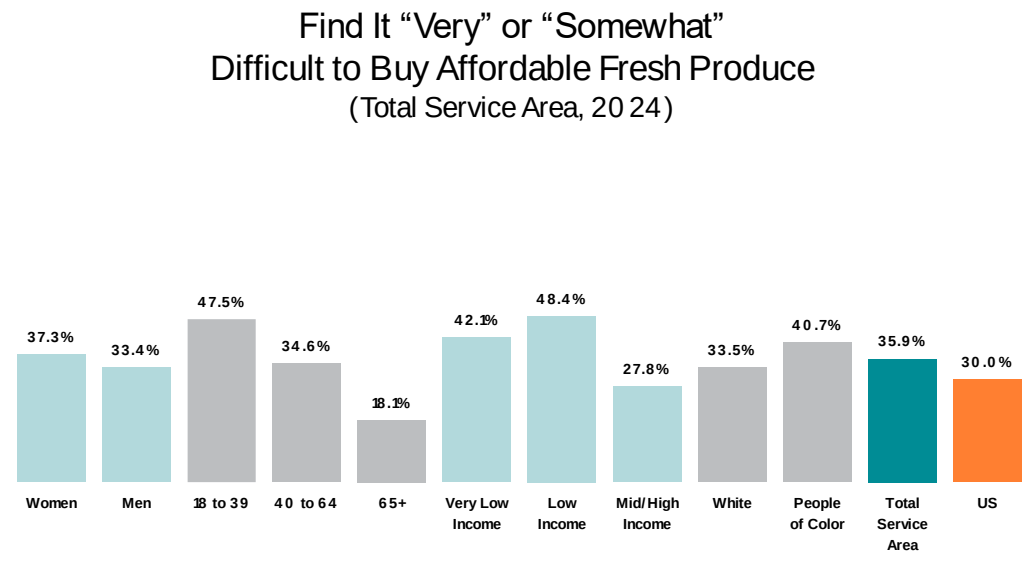
Many people in the United States don't eat a healthy diet. …People who eat too many unhealthy foods — like foods high in saturated fat and added sugars — are at increased risk for obesity, heart disease, type 2 diabetes, and other health problems. Strategies and interventions to help people choose healthy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

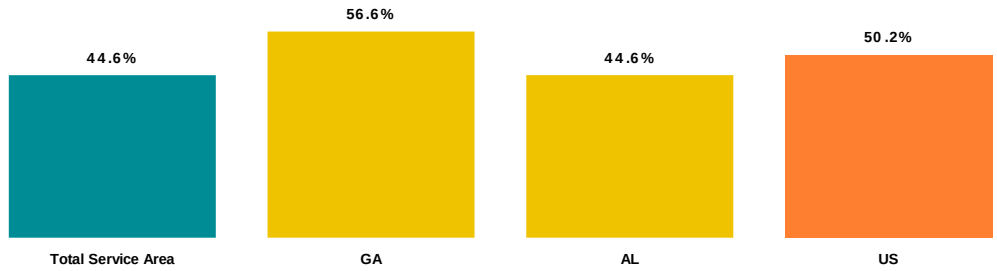


Sources: • 2024 PRC Community Health Survey, PRC, Inc. [Item 66]
• 2023 PRC National Health Survey, PRC, Inc.
Notes: • Asked of all respondents.

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

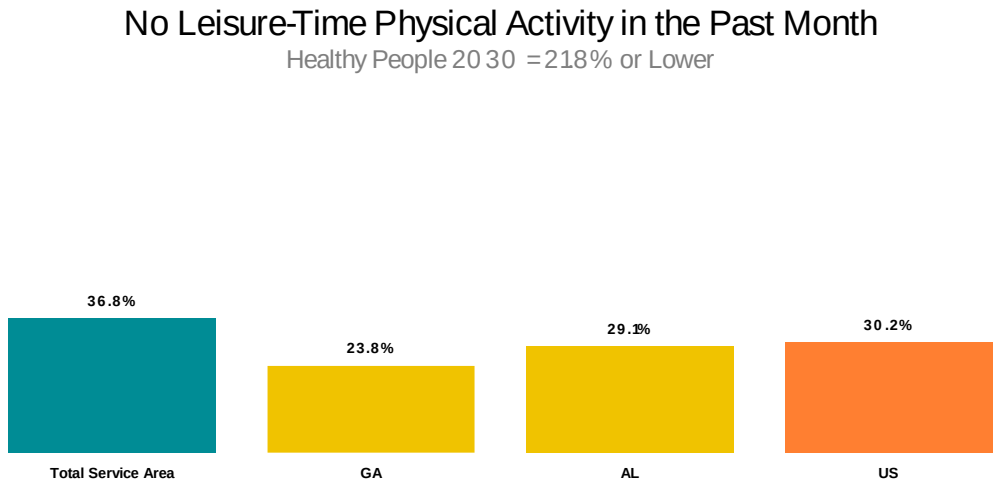
Physical activity can help prevent disease, disability, injury, and premature death. The Physical Activity Guidelines for Americans lays out how much physical activity children, adolescents, and adults need to get health benefits. Although most people don't get the recommended amount of physical activity, 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?"



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 Georgia and Alabama 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:

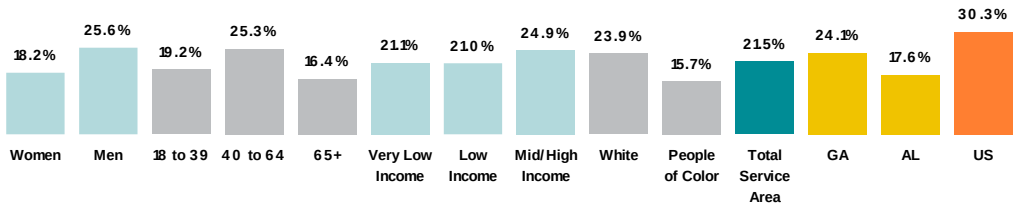
PRC Survey ► "During the past month, how many times per week or per month did you do physical activities or exercises to strengthen your muscles? Do not count aerobic activities like walking, running, or bicycling. Please include activities using your own body weight, such as yoga, sit-ups, or push-ups,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

(Total Service Area, 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 Georgia and Alabama 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 $\geq$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 $\geq$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	$\geq$30.0

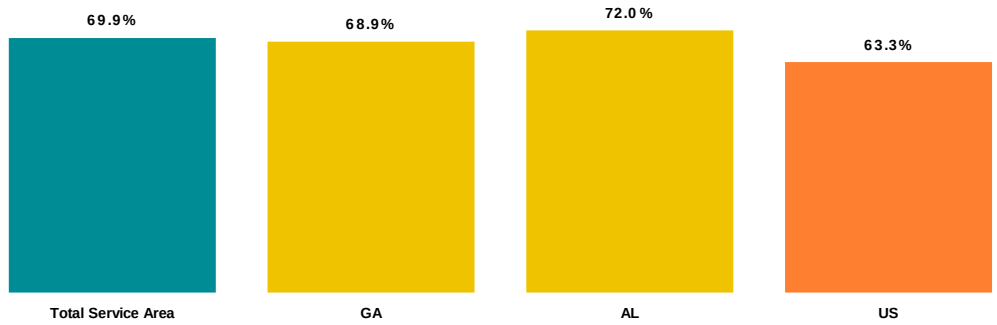
Source: Clinical Guidelines on the Identification, Evaluation, and Treatment of Overweight and Obesity in Adults: The Evidence Report. National Institutes of Health. National Heart, Lung, and Blood Institute in Cooperation With The National Institute of Diabetes and Digestive and Kidney Diseases. September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

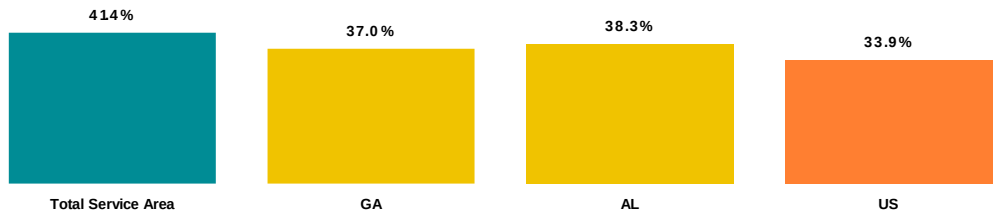


Sources:
- 2024 PRC Community Health Survey, PRC, Inc. [Item 112]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2022 Georgia and Alabama data.
- 2023 PRC National Health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

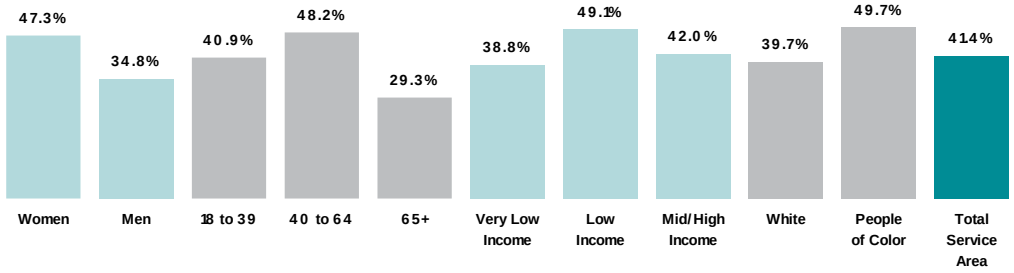
Healthy People 2030 = 36.0% or Lower



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 Georgia and Alabama 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
(Total Service Area, 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)

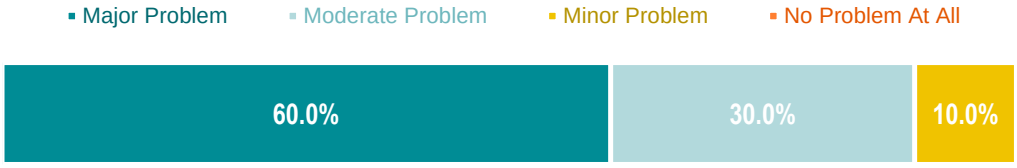
Sources:
- 2024 PRC Community Health Survey, PRC, Inc. [Item 113]
- 2023 PRC National Health Survey, PRC, Inc.

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; Total Service Area, 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:

Awareness/Education

> Education and programs that promote activity in children and adults. – Community Leader
>
> There are not enough resources available to teach the community how to live a healthy lifestyle at affordable costs. A lot of the cheaper but quality nutrition is available in all parts of the community. – Social Service Provider
>
> Apathy, lack of education on healthy meals; nutritious foods are more expensive and need more prep. For many of our families who are working long hours and have small children, walking trails, healthy foods, etc., are a luxury and not a priority for them. McDonald's drive-thru makes the kids happy and is quick and easy (but not inexpensive). – Social Service Provider
>
> Lack of knowledge and understanding of consequences. Accessible environmental resources, access to low-cost health foods. – Health Provider
>
> Not enough education or importance placed upon nutrition and physical activity. – Community Leader

Access to Affordable Healthy Food

> No access to purchase fresh fruits and vegetables in rural county areas and no educational opportunities for rural adults. – Community Leader
>
> Access to healthy food. – Social Service Provider
>
> In many communities, especially underserved and underresourced communities, there are issues in getting healthy foods to families. Lack of transportation and lack of money to buy healthy options plays a part. Many of our residents live in food deserts. The lack of activity stems from several factors, including lack of options for exercise, lack of knowledge about the importance of exercise, and lack of discipline to exercise. – Social Service Provider

Lifestyle

> Access to too much fast food and sedentary lifestyle. Cheaper to get preprocessed foods vs. fresh fruit and vegetables. Families and individuals now have overcommitted schedules and do not commit to regular exercise. – Social Service Provider

Obesity

> Alabama ranks in the top 10 for obese states in the nation. Cherokee County is above the national average for Healthy People 2030-recommended rates for obesity. There are only a few places for people to exercise for free (three outdoor walking tracks) in Cherokee County. There are no dieticians in Cherokee County. – Health Provider

Income/Poverty

> It's my opinion that these resources are often sought out by more economically stable individuals. There may be a challenge in meeting people in the lower socioeconomic status, where they are and providing affordable resources. – Community Leader

Access to Care/Services

> Lack of resources, lack of education. – Public Health Representative

Built Environment

> Limited areas for outdoor activities. – Community Leader

Insufficient Physical Activity

> Lack of activity and cost of food. – Community Leader

Transportation

> Hard to access resources, especially with no transportation in the community. – Community Leader

Cultural/Personal Beliefs

> Cultural and generational unhealthy choices and lack of awareness and education tied to social determinants of health. – Social Service Provider

Denial/Stigma

> Shame and access to care. – Social Service Provider

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.

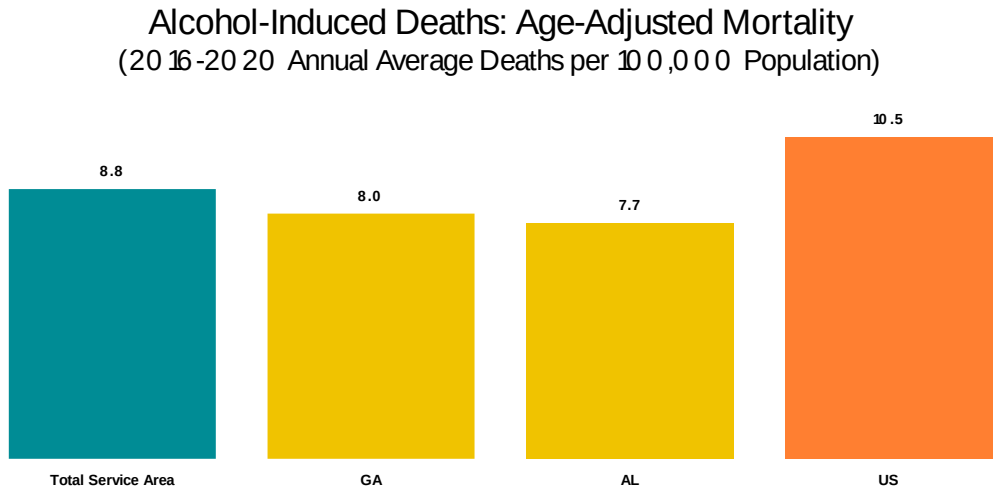
Effective treatments for substance use disorders are available, but very few people get the treatment they need. Strategies to prevent substance use — especially in adolescents — and help people get treatment can reduce drug and alcohol misuse, related health problems, and deaths.

– 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

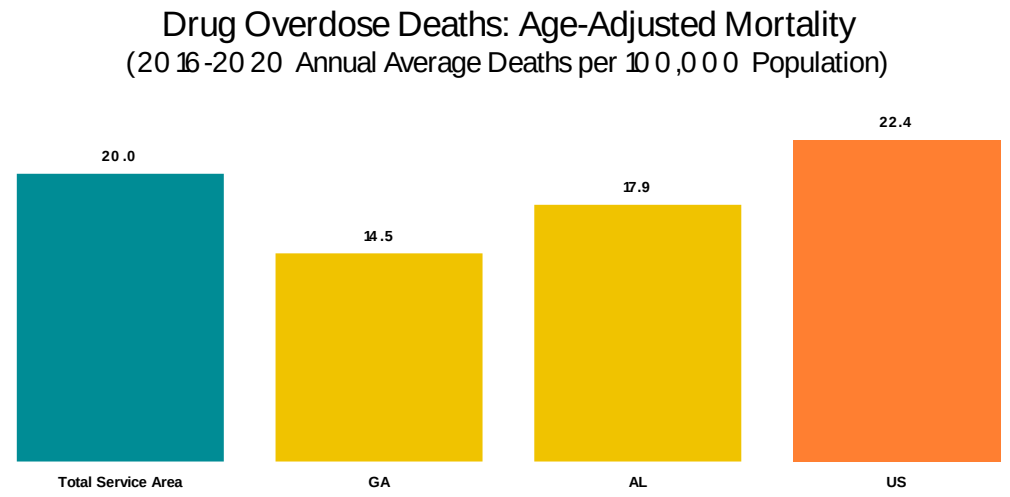
Sources:
- 2024 PRC Community Health Survey, PRC, Inc. [Item 116]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2022 Georgia and Alabama data.
- 2023 PRC National Health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



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

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

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.

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
(Total Service Area, 2024)

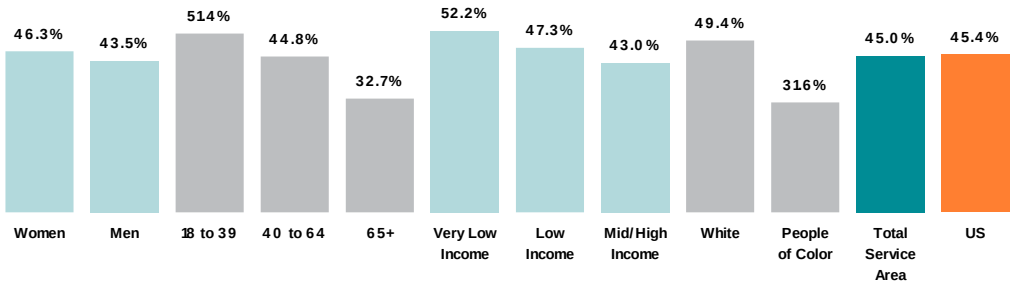
Sources:
- 2024 PRC Community Health Survey, PRC, Inc. [Item 41]
- 2023 PRC National Health Survey, PRC, Inc.

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)
(Total Service Area, 2024)



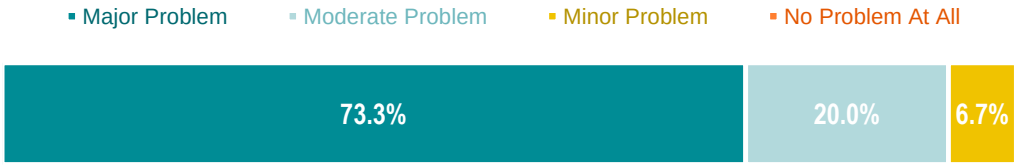
Sources:
- 2024 PRC Community Health Survey, PRC, Inc. [Item 43]
- 2023 PRC National Health Survey, PRC, Inc.

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; Total Service Area, 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

> Availability. – Community Leader
>
> Quality facilities and programs to get the help that is needed. I think we have a program for substance abuse, but once they are released, there is no follow-up. No transportation once released, which creates homelessness. Substance abuse treatment is a step-by-step process. Success requires all the steps. – Community Leader
>
> Treatment facilities and insurance. – Health Provider
>
> I feel that the biggest barrier in substance use treatment is accessibility here in our community. For instance, someone is released from incarceration and wanting to live a life in recovery, but the only treatment option we have here in our community is Highland Rivers. Sadly, they cannot sign up for these services while incarcerated, so they have to start the LONG process by going to open access. They may get in, they may not. Now they have missed a day of work, possibly to have no services. Another is transportation to these services. There is a good bit of support meetings here in the community and Mosaic Place Support Center. If someone goes to the hospital to get help with substance use, if they do not need what is defined as medical detox, they are sent away sometimes. Transportation is another issue in being able to get to these services. Also, follow-up and warm handoffs do not happen often. Lots of times, it is "here is a list of places, go figure it out" situation. – Social Service Provider

> A large percentage of substance abuse individuals. There are limited resources, but addiction is difficult to break. – Social Service Provider

> Absence of facilities and professionals to provide treatment services and prevalence of illicit drug availability. – Social Service Provider

> Most of these treatments are not in our area. – Community Leader

Follow Up/Support

> The greatest barrier is consistent and continued long-term care to support recovery. It is my understanding that the help can only be covered for so long before the system releases people, often prematurely, back into society with little to no continued support. These are often the people with the most fragile and volatile living situations, socioeconomic backgrounds, and health history. – Community Leader

> Lack of substance abuse support. – Social Service Provider

Awareness/Education

> Education and the lack of support centers available in the areas where needed. – Community Leader

> A lack of knowledge, a lack of desire to change, a lack of financial support to seek treatment. Also, there is so much availability to drugs and alcohol. – Social Service Provider

Transportation

> Hard to access resources, especially with no transportation in the community. – Community Leader

> Transportation, hours of operation. – Social Service Provider

Denial/Stigma

> Citizens don't want facilities in or near their communities because it brings in what they feel are the untouchables. They want them to get help, just not near them and their families. The stigma, and not having available resources. – Social Service Provider

Funding

> Need more funding for current substance abuse programs and for a substance abuse facility. – Community Leader

Easy Access

> It is harder to come by solutions for SUD than it is to come by substances. Illegal and illicit substances are often more reliable, affordable, and accessible than solutions are. – Social Service Provider

Incidence/Prevalence

> Too many people choose to get hooked on drugs. – Community Leader

Insurance Issues

> Coverage. – Public Health Representative

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.

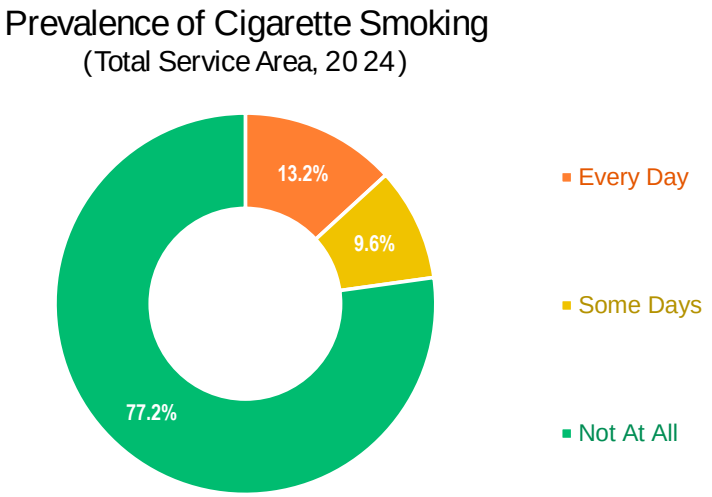
Most deaths and diseases from tobacco use in the United States are caused by cigarettes. Smoking harms nearly every organ in the body and increases the risk of heart disease, stroke, lung diseases, and many types of cancer. Although smoking is widespread, it's more common in certain groups, including 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 Georgia and Alabama data.
- 2023 PRC National Health Survey, PRC, Inc.
- US Department of Health and Human Services. Healthy People 2030. https://health.gov/healthypeople

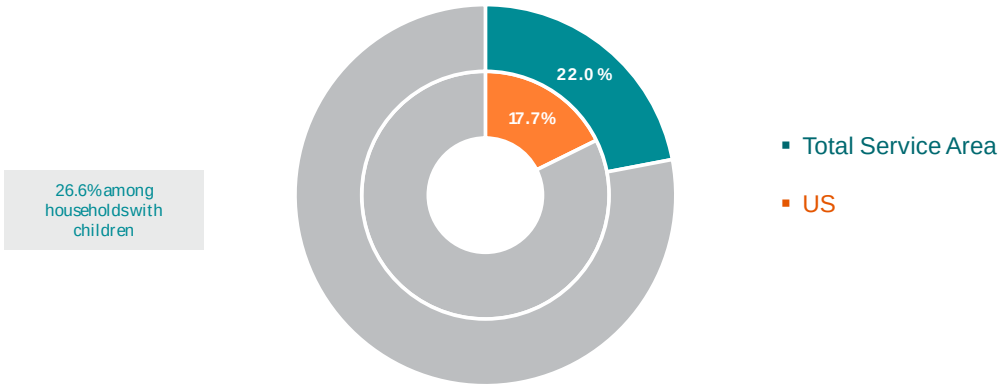
Notes:
- Asked of all respondents.
- Includes those who smoke cigarettes every day or on some days.

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



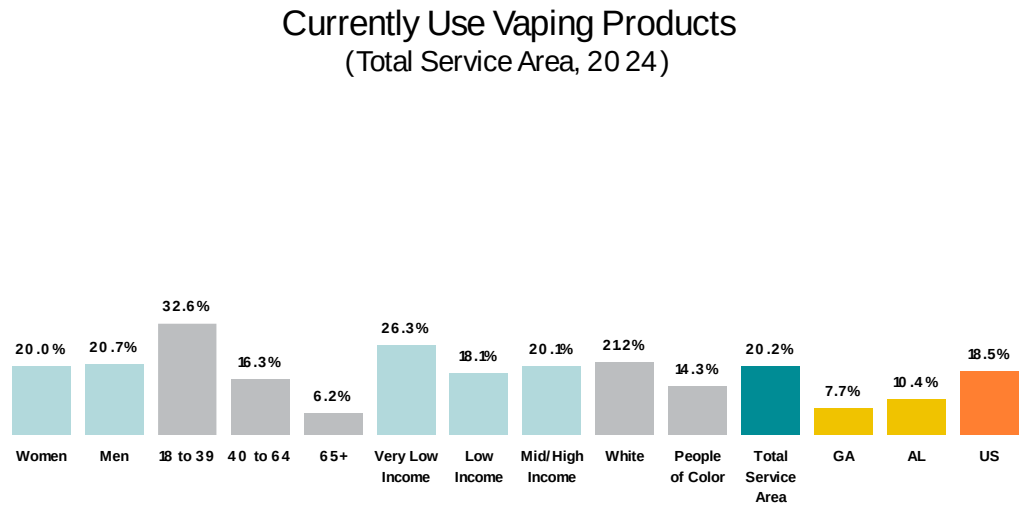
Sources:
- 2024 PRC Community Health Survey, PRC, Inc. [Items 35, 114]
- 2023 PRC National Health Survey, PRC, Inc.

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.")

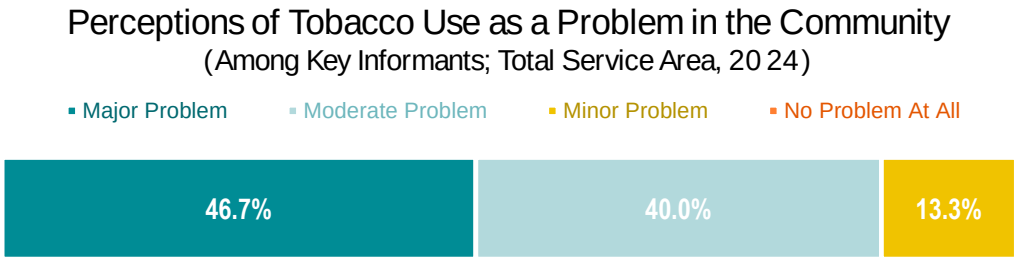


Sources:
- 2024 PRC Community Health Survey, PRC, Inc. [Item 36]
- 2023 PRC National Health Survey, PRC, Inc.
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2022 Georgia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



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

> It is everywhere, and way too many people are using it. – Social Service Provider
>
> It's visible. – Community Leader

> Too many residents smoke or chew tobacco. – Social Service Provider
>
> A lot of tobacco abuse. Smoke and smokeless used. – Health Provider
>
> Just about everyone uses tobacco in Cherokee County. It almost seems like a requirement to live here. – Community Leader

Easy Access

> This is an anecdotal response from me. It's a cheap, legal de-stressor. Lots of people with whom I work smoke cigarettes. – Social Service Provider
>
> Our number of convenience stores opening in this county has tripled in the last three years. Deaths due to lung cancer are very high. – Community Leader
>
> Easier to access, less costly than other drugs, and more acceptable and legal in public. Generational use, parents see less harm than drugs for their teens. – Social Service Provider
>
> Easily assessable to youth. Still a generation of parents and grandparents who think it is okay to provide tobacco. Youth are consumed with peer pressure and the act of vaping, causing them to be nonchalant about dangers. – Social Service Provider

E-Cigarettes

> Vaping is so glorified. – Social Service Provider
>
> Nicotine is widely abused by the youth with vapes flooding the market and being easily accessible and flavored to attract addiction. – Community Leader

Awareness/Education

> Education. – Community Leader

Stress

> Smoking is used as a stress reliever. – Social Service Provider

Transportation

> Hard to access resources, especially with no transportation in the community. The majority of individuals do not see this as an issue. – Community Leader

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)

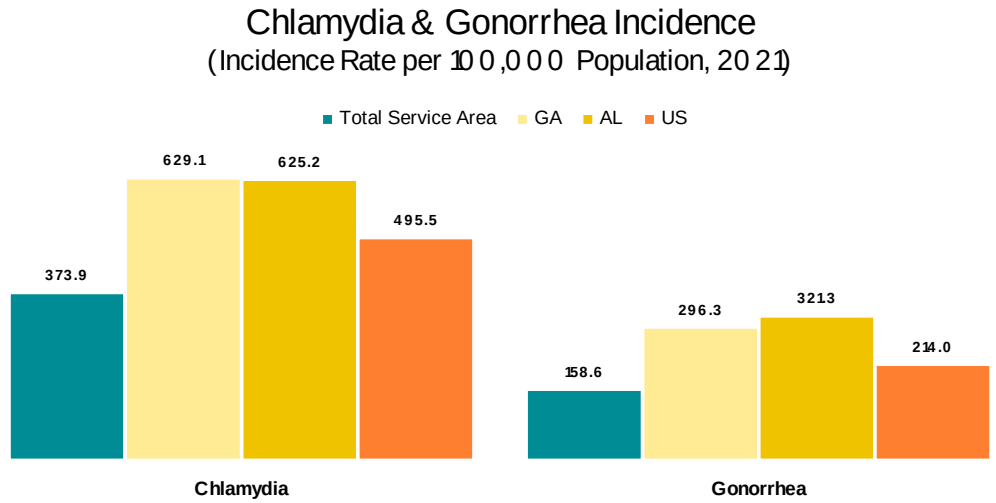
Chlamydia

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.

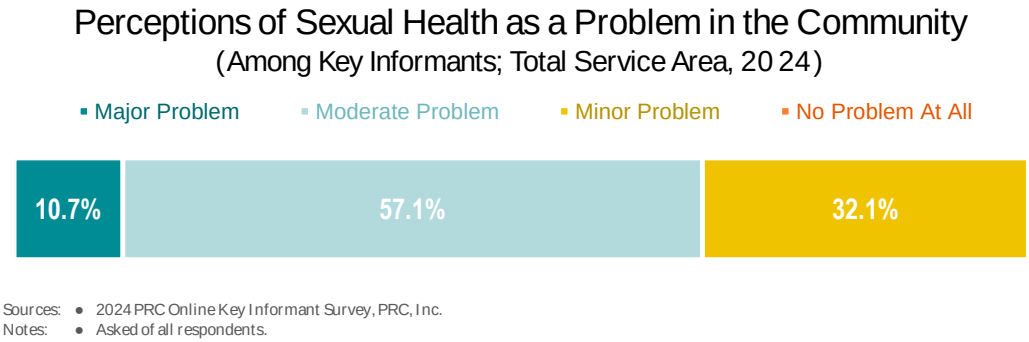
The following chart outlines local incidence for these STIs.



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

> Sexually transmitted disease. – Public Health Representative

Denial/Stigma

> Shame. – Social Service Provider

Transportation

> Hard to access resources, especially with no transportation in the community. – Community Leader

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)

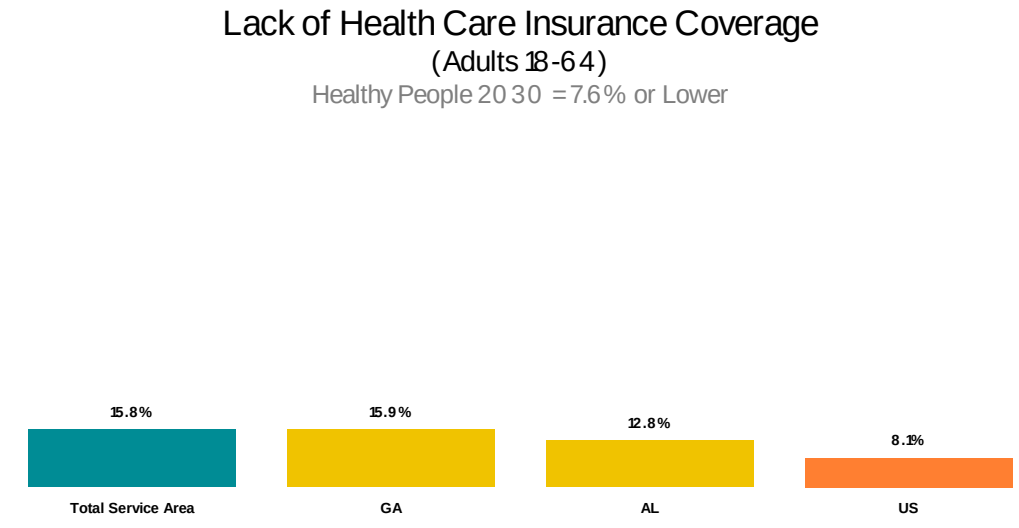
Lack of Health Insurance Coverage

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?"



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 Georgia and Alabama 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; Total Service Area, 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?"

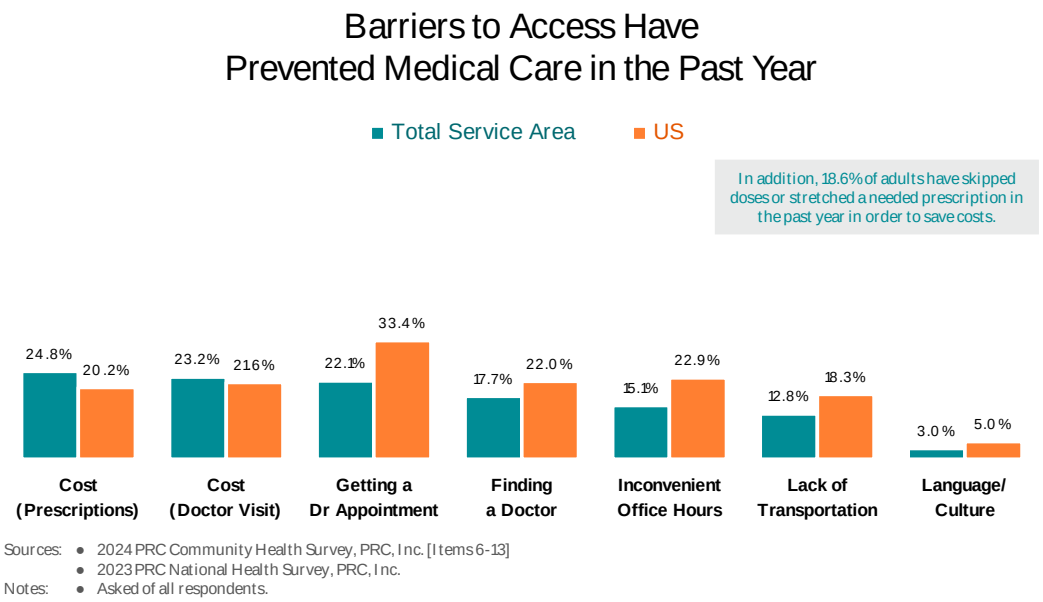
PRC Survey ► "Was there a time in the past 12 months when you needed a prescription medicine but did not get it because you could not afford it?"

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?"

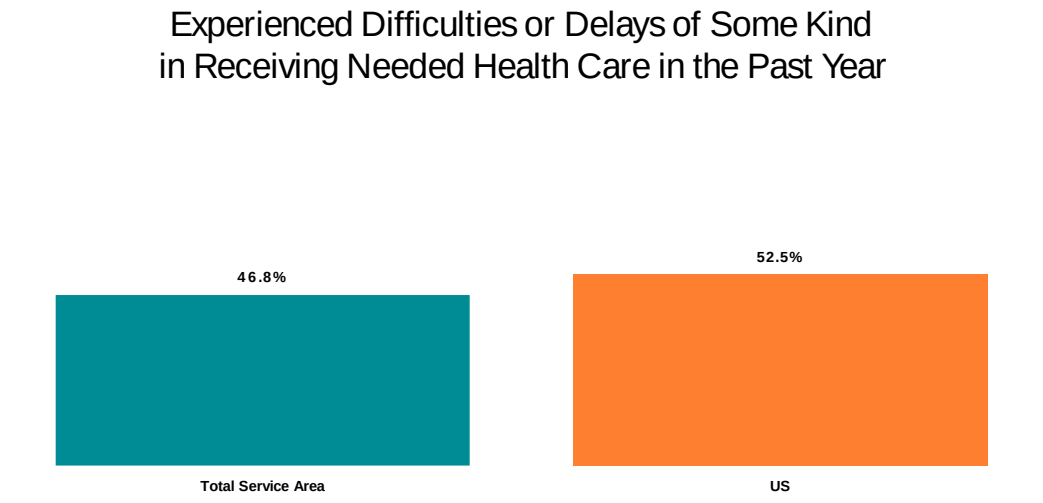
The percentages shown in the following chart reflect the total population, regardless of whether medical care was needed or sought.



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

Notes:
- Asked of all respondents.

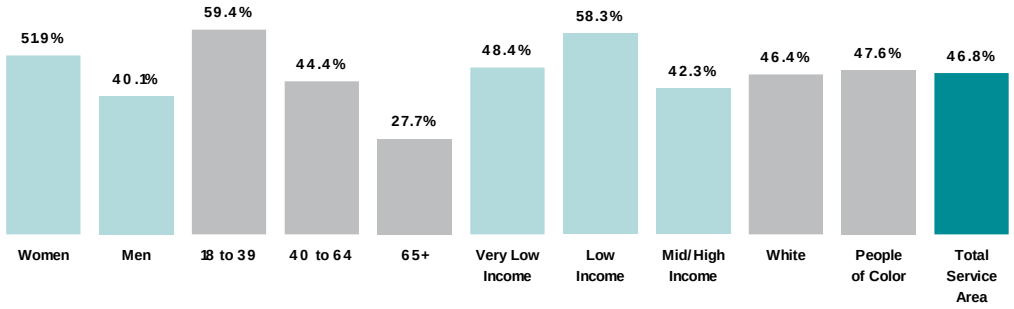
The following charts reflect the composite percentage of the total population experiencing problems accessing health care in the past year (indicating one or more of the aforementioned barriers or any other problem not specifically asked), again regardless of whether they needed or sought care.



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
(Total Service Area, 2024)



Sources:
- 2024 PRC Community Health Survey, PRC, Inc. [Item 119]

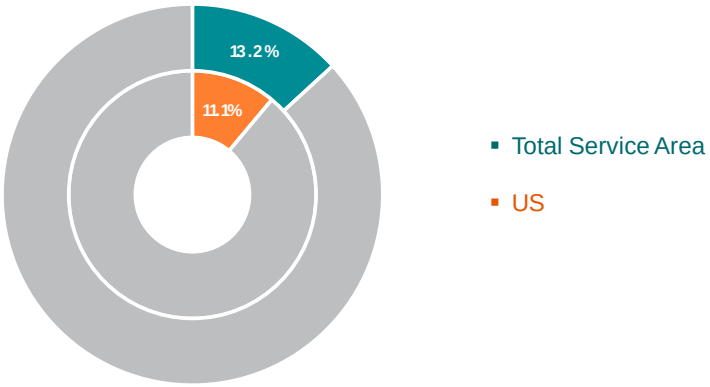
Notes:
- Asked of all respondents.
- Percentage represents the proportion of respondents experiencing one or more barriers to accessing health care in the past 12 months.

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)

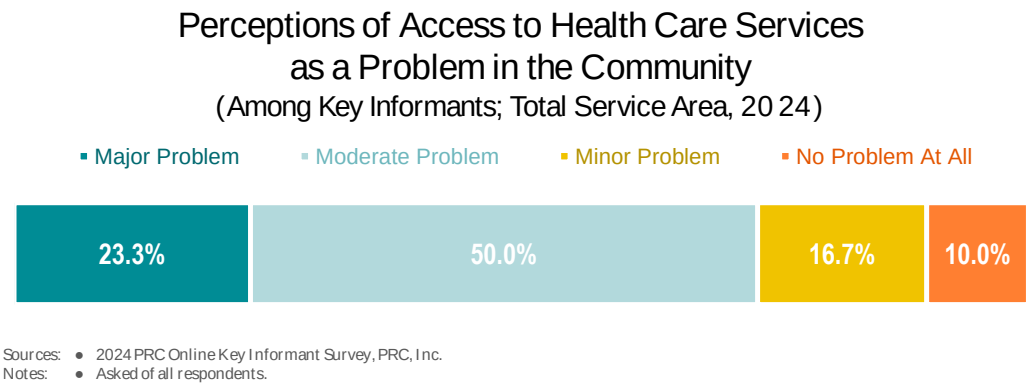


Sources:
- 2024 PRC Community Health Survey, PRC, Inc. [Item 90]
- 2023 PRC National Health Survey, PRC, Inc.

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:

Transportation

> Being a rural community, many of the individuals do not have access to reliable transportation. Missed appointments result in being discontinued from care at certain offices when people cannot get there. I know that we have certain services that are in Cedartown, but for someone in Rockmart, that could be a 12- to 13-mile trip sometimes. They cannot be expected to walk to their appointments. Many individuals who are coming from incarceration where they were able to access to their maintenance medications for physical and mental health do not know or have access to get them in the community. We have a local CSB, but they only start services on a first-come, first-served basis. When people have a job to try and support themselves and their families, this makes it almost an ultimatum between mental health and paying the bills. There is not a lot of options for case management and care coordination that I am aware of, if any at all. – Social Service Provider
>
> Lack of transportation and lack of confidence to go and receive services. When there was a health care service attached to the building where my office was, people didn't frequent it due to lack of relationships being built and the mere fact that it was attached to the building where my office is located. – Social Service Provider
>
> Travel to major health care facilities for treatment and quality health care, which includes primary care physicians. – Community Leader

Access to Care/Services

> With the closing of the primary health care centers in Polk and Floyd, the biggest challenge is for families who are underinsured and are not making a livable wage. They cannot access much-needed health care. Many also do not have transportation to travel out-of-county for physicians who will accept Medicaid. – Social Service Provider
>
> Available resources for desired programs of community needs. If there are resources, it is sometimes hard to locate them. – Social Service Provider

Lack of Providers

> The absence of providers, lack of physical locations that are conveniently located, and lack of citizen awareness about prevention and options. – Social Service Provider

Access to Care for Uninsured/Underinsured

> Lack of health care for uninsured. Paulding County has a program sponsored by Wellstar, where the uninsured can see a primary care physician for no charge or a minimal fee. This program does service people from Polk County, but transportation is an issue. – Community Leader

Access to Specialty Care

> Lack of access to specialists in Cherokee County. Patients must drive to Rome, Gadsden, or Birmingham to see any specialty. In the past, we had gastroenterology and cardiology in Centre, but that is no longer true. – Health Provider

Income/Poverty

> Individuals who are considered "working poor" or without health insurance are unable to access well checks, screenings, or other services. We see that these individuals typically visit the ER for health care services either because a condition has become worse enough to make it difficult for the patient to focus or work (but perhaps really not rising to the level of a true emergency). Sometimes these individuals cannot get off work to access health care during daytime hours, but we often see that families simply cannot afford to use even urgent care facilities. In short, it is the lack of insurance coverage or ability to make a copay that decreases access to basic health care. We also see individuals who are without transportation being unable to access prescriptions after discharge – they may be sick already, and without transportation cannot access needed medications. – Social Service Provider

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.

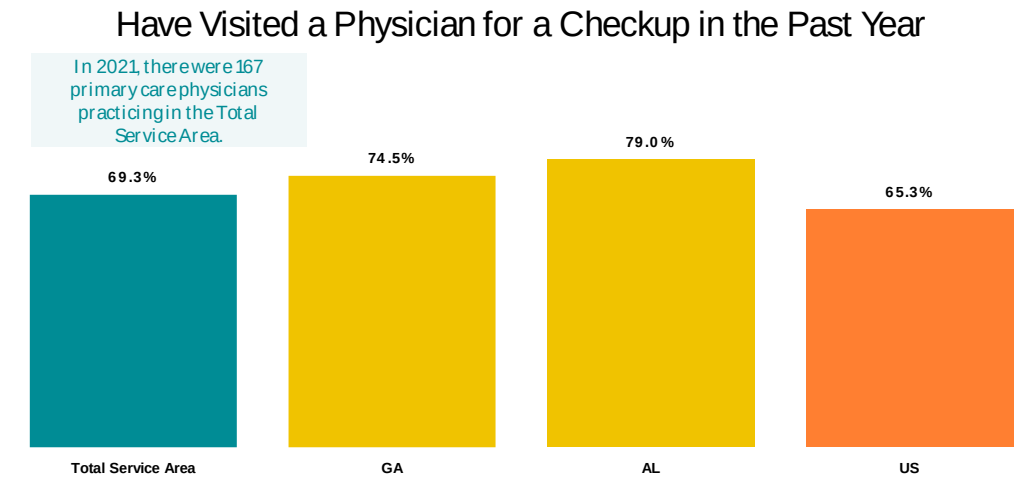
Children need regular well-child and dental visits to track their development and find health problems early, when they're usually easier to treat. Services like screenings, dental check-ups, and vaccinations are key to keeping people of all ages healthy. But for a variety of reasons, many people don't 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?"

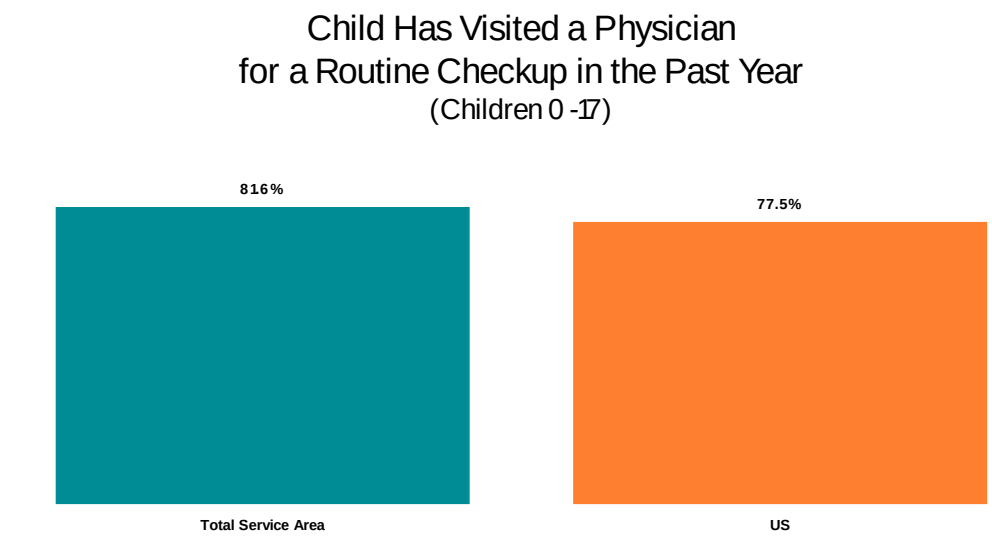


Sources:
- 2024 PRC Community Health Survey, PRC, Inc. [Item 16]
- Area Health Resources Files, Health Resources & Services Administration. Retrieved May 2024 via Metopio.
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services,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



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

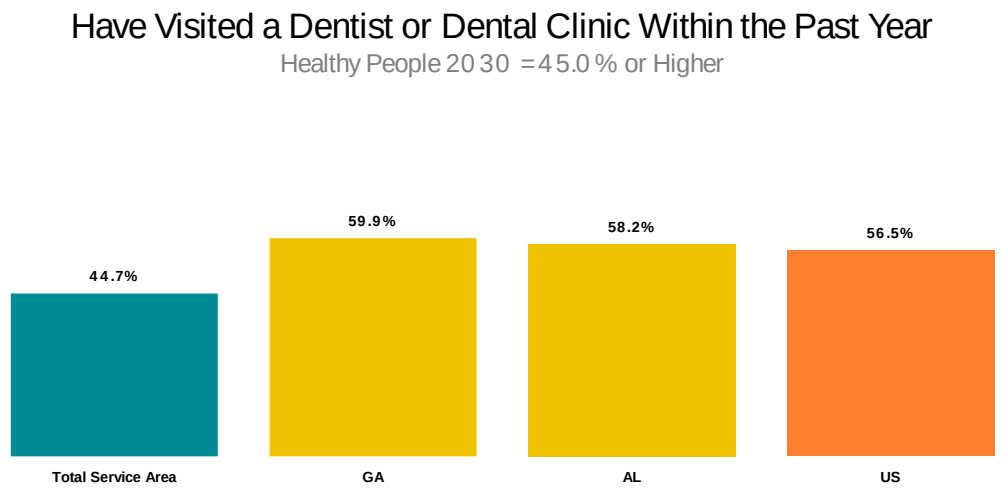
Tooth decay is the most common chronic disease in children and adults in the United States. …Regular preventive dental care can catch problems early, when they're usually easier to treat. But many people don't get the care they need, often because they can't afford it. Untreated oral health problems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

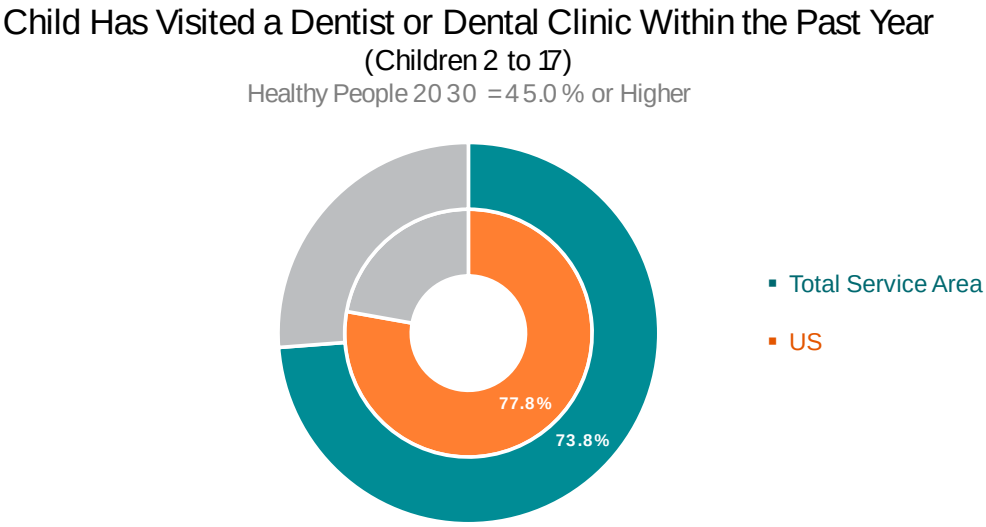
PRC Survey ► "About how long has it been since you last visited a dentist or a dental clinic for any reason?"



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 Georgia and Alabama 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?"

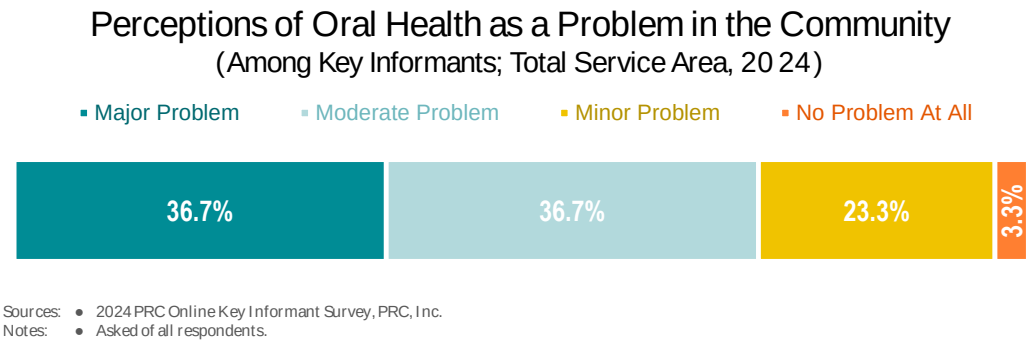


Sources:
- 2024 PRC Community Health Survey, PRC, Inc. [Item 93]
- 2023 PRC National Health Survey, PRC, Inc.
- US Department of Health and Human Services. Healthy People 2030. https://health.gov/healthypeople

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: • 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:

Affordable Care/Services

> There are no affordable programs that I am aware of. Primary Health Care had a dental program for a very short period of time. – Community Leader
>
> Access to affordable options. – Social Service Provider
>
> There is not any dental care for those with limited funds. – Health Provider

Access to Care for Uninsured/Underinsured

> Individuals do not have insurance coverage for dental costs and/or cannot afford copays or fees to access services. Dental services are only available during standard workweeks, and individuals in many jobs cannot get paid time off to access care. – Social Service Provider

Access for Medicare/Medicaid Patients

> Lack of providers willing to take Medicaid, uninsured, lack of coverage. – Public Health Representative

Awareness/Education

> Uneducated people don't understand the need for oral health. – Community Leader

Access to Care/Services

> Limited access to dental services, cost, and lack of education and awareness of importance. – Social Service Provider

Lack of Providers

> Too few dentists. – Social Service Provider

Prevention/Screenings

> People do not go for preventative care, and oral health has a direct correlation to heart health. – Social Service Provider

Transportation

> Hard to access resources, especially with no transportation in the community. – Community Leader

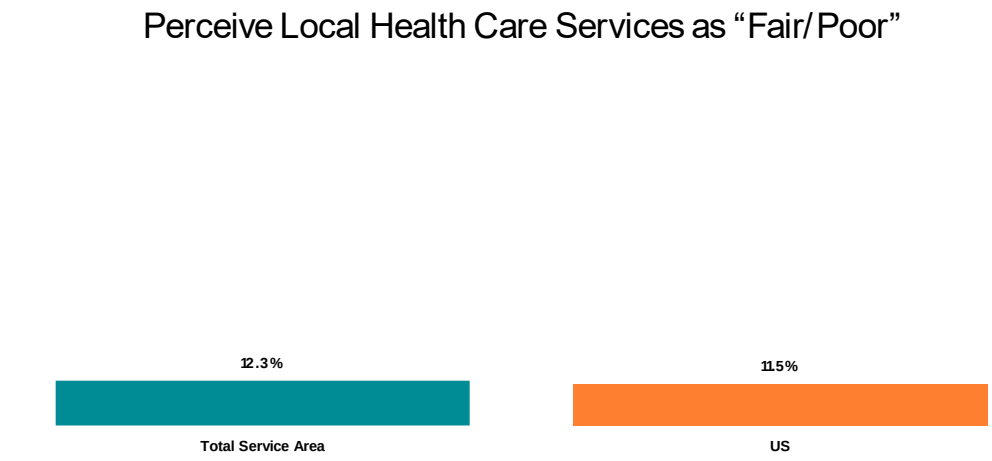
Alcohol/Drug Use

> Huge meth use causes major oral issues, as well as spit tobacco and lack of preventative dental care. Many residents do not have dental insurance and cannot afford dental care. – Social Service Provider

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?"



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

- Advent Health
- Atrium Health
- Atrium Health Floyd
- Atrium Health Polk Medical Center
- Atrium Health Primary Care and Endocrinology Clinics
- Cancer Navigators
- Doctor's Offices
- Free Clinic
- Healing Grace Mobile Clinic
- Health Department
- Highland Rivers
- LivingProof Recovery
- NAMI
- Northwest Georgia Regional Cancer Coalition
- Rockmart Urgent/Primary Care
- Taylorsville Primary Care
- Vital Grace

Cancer

- Advent Health
- Atrium Health
- Atrium Health Floyd
- Atrium Health Primary Care and Endocrinology Clinics
- Camp Sunshine
- Cancer Navigators
- Cancer Treatment Center
- Chattooga County Health Department
- Doctor's Offices
- Harbin Clinic
- Health Department
- Hospitals
- Northwest Georgia Regional Cancer Coalition
- Pansy’s Post-Mastectomy Boutique
- Vital Grace

Diabetes

- 100 Black Men of Rome
- Advent Health
- Area Agency on Aging
- Atrium Health
- Atrium Health Floyd
- Atrium Health Primary Care and Endocrinology Clinics
- Diabetes Treatment Center
- Doctor's Offices
- Harbin Clinic
- Healing Grace Mobile Clinic
- Health Department
- Hospitals
- Public Health
- YMCA/YWCA

Disabling Conditions

- Area Agency on Aging
- Briggs & Associates
- Center for Independent Living
- Davies Shelters
- Doctor's Offices
- ESP
- Hospice
- Hospitals
- NAMI
- Nursing Home
- Oakview
- Rockmart Lion's Club

Heart Disease & Stroke

- Advent Health
- American Heart Association
- Atrium Health
- Atrium Health Floyd
- Atrium Health Primary Care and Endocrinology Clinics
- CHF Clinic
- Doctor's Offices
- Harbin Clinic
- Health Department

- Helping Hands Ending Hunger
- Hunger Ministries
- Northwest Georgia Regional Cancer Coalition
- Parks and Recreation
- Public Health
- YMCA/YWCA

Infant Health & Family Planning

- Advent Health
- Atrium Health
- Atrium Health Primary Care and Endocrinology Clinics
- Community Programs
- Doctor's Offices
- Family Connections
- Harbin Clinic
- Health Department
- Healthy Mothers Healthy Babies
- Hospitals
- Life Matters Outreach
- LMO Pregnancy Care Center
- Polk County Health Department

Injury & Violence

- Area Agency on Aging
- Boys & Girls Clubs
- DFACS
- Homeless Shelter/Domestic Violence Shelters
- Law Enforcement
- Rally/Town Hall Discussion
- Recovery Organizations
- Sexual Assault Center

Mental Health

- 988
- AA/NA
- Advent Health
- Atrium Health
- Atrium Health Behavioral Health
- Atrium Health Primary Care and Endocrinology Clinics
- CED Mental Health
- Davies Shelters
- Doctor's Offices
- Elevation House
- Family Connections
- Floyd Behavioral Health
- Government Mental Health Center
- Growing Roots Counseling
- Highland Rivers
- HOPE
- Jail
- LivingProof Recovery
- NAMI
- Northwest Georgia Hunger Ministries
- Polk County Sheriff's Office
- REACH Ministries
- Rome Housing Authority
- School System
- Solas Counseling
- State of Georgia
- Summit Quest/Cancer Navigators
- Three Rivers

Nutrition, Physical Activity, & Weight

- Advent Health
- Atrium Health
- Atrium Health Primary Care and Endocrinology Clinics
- Boys & Girls Clubs
- City/County Government
- Community Kitchen
- CrossFit
- Davies Shelters
- Doctor's Offices
- Fitness Centers/Gyms
- Fork Spoon & Plate
- Harbin Clinic
- Helping Hands Ending Hunger
- Hospitals
- Hunger Ministries
- Journey Food Bank
- Live Well Polk
- Northwest Georgia Hunger Ministries
- Parks and Recreation
- Planet Fitness
- Public Health
- School System
- Weight Watchers
- YMCA/YWCA

Oral Health

- Compton Dentist
- Dental Hygiene School
- Dentist's Offices
- Doctor's Offices
- Georgia Highlands' Dental Program
- Marshall Mann
- Muller
- Northwest Georgia Dentists
- Williams Edwards

Sexual Health

- Health Department

Social Determinants of Health

- A Teen's Choice
- Advent Health
- Atrium Health
- Cancer Navigators
- Churches
- City/County Government
- Community College
- Community Resource Center
- Davies Shelters
- GICH
- GNTC
- Harbin Clinic
- Haven Health
- Health Department
- Helping Hands Ending Hunger
- Housing Authority
- Hunger Ministries
- Law Enforcement
- LivingProof Recovery
- Mental Health Providers
- Mosaic Place
- My Brother's House
- NAMI
- Napoleon Fielder Recreation Center
- Northwest Georgia Hunger Ministries
- Northwest Georgia Regional Cancer Coalition
- One Door Polk
- REACH Ministries
- Salvation Army
- School System
- TLC
- UGA Extension
- United Way
- YMCA/YWCA

Substance Use

- AA/NA
- Atrium Health
- Celebrate Recovery
- Churches
- Davies Shelters
- Floyd Against Drugs
- Floyd Behavioral Health
- Highland Rivers
- Hospitals
- Jail
- Law Enforcement
- LivingProof Recovery
- Mosaic Place
- NAMI
- Nonprofits
- Polk County Government
- Polk County Sheriff's Office
- Polk Prevention and Recovery Alliance
- School System
- State of Georgia
- Three Rivers
- Women's Outreach

Tobacco Use

- 1-800-Quitline
- A Teen's Choice
- American Cancer Society
- Health Department
- Northwest Georgia Regional Cancer Coalition
- One Door Polk
- Polk Against Drugs
- Polk Prevention and Recovery Alliance
- PSD
- School System

Appendix

Evaluation of Past Activities

Health Priority: Access to Care

Strategy 1: Provide dental care to underserved patients

Specific Interventions	**Collaborative Partners**
1. Plan and fund the construction and operation of a comprehensive dental clinic 2. Provide surgery and staff to perform dental clinic surgeries	District Public Health office, Rome Center for Pediatric Dentist, Atrium Health Floyd surgical services

Results/Impact

The construction of the comprehensive dental clinic was never completed because of Public Health's difficulty in securing a dentist for oversight. However, Atrium Health Floyd provides surgery space and staff for dental surgery. About 120 dental patients undergo care annually.

Strategy 2: Provide mobile mammography to the service area

Specific Interventions	**Collaborative Partners**
1. Provide mobile clinics at job sites, schools, and primary care clinics	Various area industries, faith partners, civic organizations, and school systems. Department of Health and Human Services, U.S. Senator Jon Ossoff

Results/Impact

Atrium Health Floyd's Mobile Mammography Coach screened 8,504 women since 2021. Of those, 699 were first-time mammograms and 2,392 were past due. There were 475 abnormalities found during the screenings and 22 women were diagnosed with breast cancer. The Mobile Mammography Coach traveled almost 28,000 miles across eleven counties in Georgia and Alabama to provide these screenings. In 2023, Atrium Health Floyd received a $1 million Congressional Appropriation from U.S. Senator Jon Ossoff for the purchase of a second mobile mammography coach, which will be put into service in fall 2024.

Strategy 3: Provide primary care access to school aged children

Specific Interventions	**Collaborative Partners**
1. Provide student athlete physicals annually 2. Provide school nursing within Rome, Floyd County and Polk County schools	Rome City Schools, Floyd County Schools, and Polk County Schools, Chattooga County Schools, Bartow County Schools, Trion City Schools, Unity Christian Schools, Darlington School

Results/Impact

By providing school nurses and athletic trainers throughout schools within its service areas, Atrium Health Floyd offers care to more than 40,000 students, faculty and staff annually. These clinicians provide daily immediate care in the schools, physical therapy on site at the school and at sporting events and annual physicals for student-athletes. Additionally, Atrium Health Floyd opened an onsite Primary Care Clinic at Rome High School, which offers in-person care to students and staff at Rome High School and Rome Middle School, as well as telehealth services for students and staff at other schools throughout the region.

Health Priority: Cardiovascular Disease Management

Strategy 1: Provide heart education and efforts for early detection

Specific Interventions	Collaborative Partners
1. Provide blood pressure, diabetes and cholesterol screenings to community members	Department of Public Health, various faith, civic and industry partners, cardiology service line.

Results/Impact

In addition to providing free screenings at numerous community events throughout the year, Atrium Health Floyd has offered thirteen-week hypertension prevention and management programs to church groups and employers throughout northwest Georgia. These programs lead groups of 10-20 participants through weekly diet/nutrition, exercise, and stress management education sessions. These classes are led by a team of cardiology clinicians, including physicians, advanced practice providers, nurses, EMTs and other clinical professionals.

Strategy 2: Provide healthy lifestyle opportunities for at-risk community members

Specific Interventions	Collaborative Partners
1. Provide membership scholarships 2. Provide youth activity scholarships 3. Provide educational programs	Floyd County YMCA, Atrium Health Floyd service line leaders.

Results/Impact

Atrium Health Floyd has planned a multi-year sponsorship and partnership agreement with the Floyd County YMCA. Through the partnership, Atrium Health Floyd offers regular education sessions on diet/nutrition, education, first aid, hands-only CPR, stop the bleed and disease management. In the future, the program will also fund scholarships for YMCA memberships and activities.

Strategy 3: Enhance community partnerships to address health equity

Specific Interventions	Collaborative Partners
1. Continue More Heart Initiative 2. Place blood pressure monitoring kiosks in public housing locations **3.** Provide vaccine clinics for underserved community members	More Heart Ambassadors, More Heart Advisory Committee, various places of worship, Public Housing administration, 100 Black Men of Rome, cardiology service line leaders.

Results/Impact

Atrium Health Floyd placed five blood pressure monitoring kiosks throughout the community, each at a location that provides goods and services for a predominantly minority population. This includes a place of worship, a barbershop/beauty salon, a public housing facility, the local YMCA, and a local community center. Additionally, Atrium Health Floyd provided several community-based vaccine clinics, offering the COVID-19 vaccine. In total, more than 20,000 residents were vaccinated, many of which lived in underserved areas. Finally, Atrium Health Floyd continued its More Heart initiative under the guidance of an advisory board and ambassador program made up of approximately 25 African American leaders throughout our community. The program offers heart health education specifically designed to reach the underserved minority community throughout northwest Georgia.

Health Priority: Mental Health Services

Strategy 1: Provide services to undeserved community members considering access and equity

Specific Interventions	Collaborative Partners
1. Create telepsychiatry locations 2. Provide inpatient and outpatient psychiatric services to adults in the service area.	Atrium Health Floyd Behavioral Health, local law enforcement agencies, QLER Psychiatry

Results/Impact

In 2021, Atrium Health Floyd funded and launched a telepsychiatry program that has cared for over 3,500 patients since its inception. During that same time, Atrium Health Floyd Behavioral Health provided over 6,000 in-person services to patients throughout its service area.

Strategy 2: Create space for behavioral health support

Specific Interventions	Collaborative Partners
1. Host community support groups focusing on behavioral health issues	Alcoholics Anonymous, Narcotics Anonymous Atrium Health Floyd Behavioral Health, various, faith-based, and community-based shelters and referrers

Results/Impact

Atrium Health Floyd Behavioral Health hosts twice monthly Alcoholic Anonymous and Narcotics Anonymous group meeting, serving almost 400 participants annually.

Health Priority: Nutrition Support

Strategy 1: Create food access for underserved community members	
Specific Interventions 1. Provide voucher system for WIC participants to obtain food at the farmer's market 2. Sustain summer feeding program with area school systems	**Collaborative Partners** Rockmart Farmers market, Rome Schools, Floyd County Schools, and Polk County Schools
Results/Impact Atrium Health Floyd acts as the primary financial sponsor of farmers markets in Polk County, Georgia. The funding keeps the market sustainable. SNAP recipients can receive 2-for-1 discounts when shopping at the market, making locally grown fruits and produce affordable to individuals with limited income. Additionally, Atrium Health Floyd has helped summer feeding programs through school systems and faith organizations, allowing students to have access to nutritional meals while not in school.	

Final Report Approved: November 25, 2024